HARINGEY HEALTH REPORT 2006

Acknowledgements

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I am particularly grateful for the immense work carried out by Graeme Walsh in preparing all of the data, creating maps and figures, putting the report together and making sure it is presented in the format you see here today.

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Contents

Foreword

Welcome to the Haringey Health Report 2006, the most recent public health report on the population of Haringey.

The focus for this year is to provide a significant update on the figures for the population, on measures of illness and on the death rates for all age groups. These were last reported on in 2003 and it is timely to ensure that there is knowledge of progress since then and also to know if there has been stagnation or deterioration in local measures of health.

This year the report is being published as an electronic document on the Haringey TPCT website and is available for access to all, not just as a straight document but as an interactive report whereby details of the information presented can be interrogated and the raw data behind the graphs retrieved for use by anyone. Over time we will be adding to the information available in the document and will be updating it as time goes by, when new data sets become available.

The presentation this year may be new, but some of the key themes of old are still with us. Haringey continues to be a borough of contrasts with stark differences in affluence and deprivation between the east and the west of the borough. This continues to be reflected also in the many indicators of health presented in this report where the worst indicators are seen for those living in the east of the borough.

Of particular concern are two key indicators of health: Infant Mortality and Life expectancy. Haringey is experiencing more deaths in babies under 1 year compared with most other parts of London or the UK as a whole. This is of serious concern as this is an internationally used marker of the health of a population.

I also have concern about life expectancy for men. While this is improving overall, the gap between Haringey and the national average has widened in recent years. Within Haringey itself there are stark differences in life expectancy for men between those born in the east of the borough and those in the west. This stark inequality in experience of health needs to have persistent and serious focused intervention if we are to ensure good life chances for all and not just for those with high incomes or who live in the best places.

A new and additional aspect of this year's report is the focus on primary care quality and on primary care localities. There are two reasons for this. Primary care is the bedrock of the health services in Haringey, as it is in the UK as a whole. It is imperative that we ensure the provision of the best possible care for the local people. Secondly, Haringey GP practices have now grouped into four 'collaboratives' or working groups, which are sharing information, good practice and commissioning arrangements. It is important to ensure that their work is informed by good information and that the 'collaboratives' are able to compare what they are doing with others in Haringey and outside.

I hope you will find this an interesting read.
Ann Marie Connolly
February 2007

1 The people of Haringey

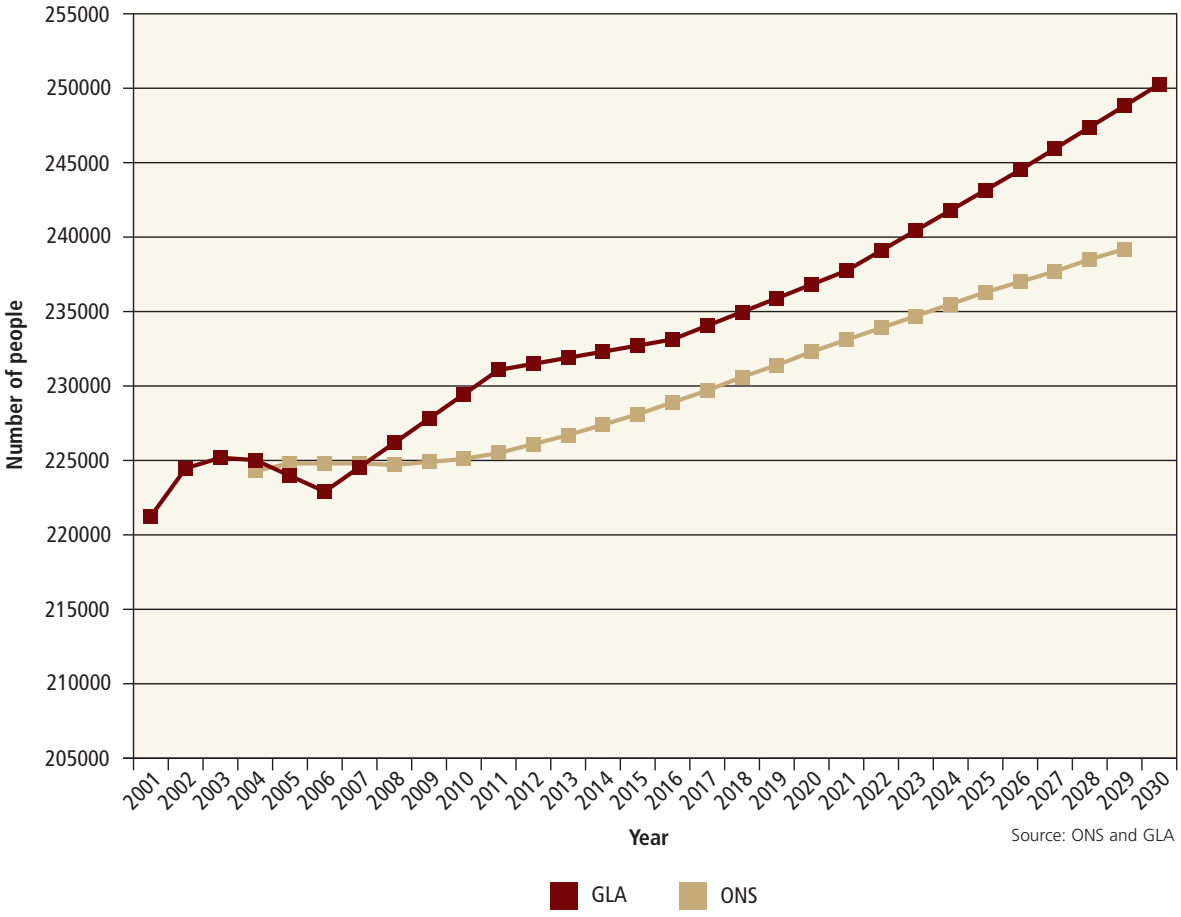
Written by Vicky Hobart

A knowledge of the size, structure, past and future development of a population is fundamental to an understanding of its health. The 2003 Haringey Health Report presented information on people living in Haringey from the 2001 census. We are now half way to the next census, and this chapter reviews the size and growth of the resident population, and anticipated changes in its age and ethnicity profile.

1.1 Will the Haringey population continue to grow?

The Office for National Statistics (ONS) projects that the Haringey population has grown by 3.9% since the 2001 census to 224,800 residents in 2006, or an additional 8,330 residents. The Greater London Authority[1] (GLA) estimates a higher future population growth in Haringey than ONS, with steep growth between 2006 and 2011 giving an estimated population of 237,700 by 2021 (see figure 1 and table 1).

Figure 1 *Future Haringey population: ONS projections and GLA estimates (2001 to 2030)*



Source: ONS and GLA

Table 1 *Population projections / estimates at 5 yearly intervals to 2021*

	GLA estimate		ONS projection	
	Total number of residents	Increase from 2006 (%)	Total number of residents	Increase from 2006 (%)
2001	221,300	–	216,473	–
2006	222,900	–	224,800	–
2011	231,100	3.7%	225,500	0.3%
2016	233,100	4.6%	228,900	1.8%
2021	237,700	6.6%	233,100	3.7%

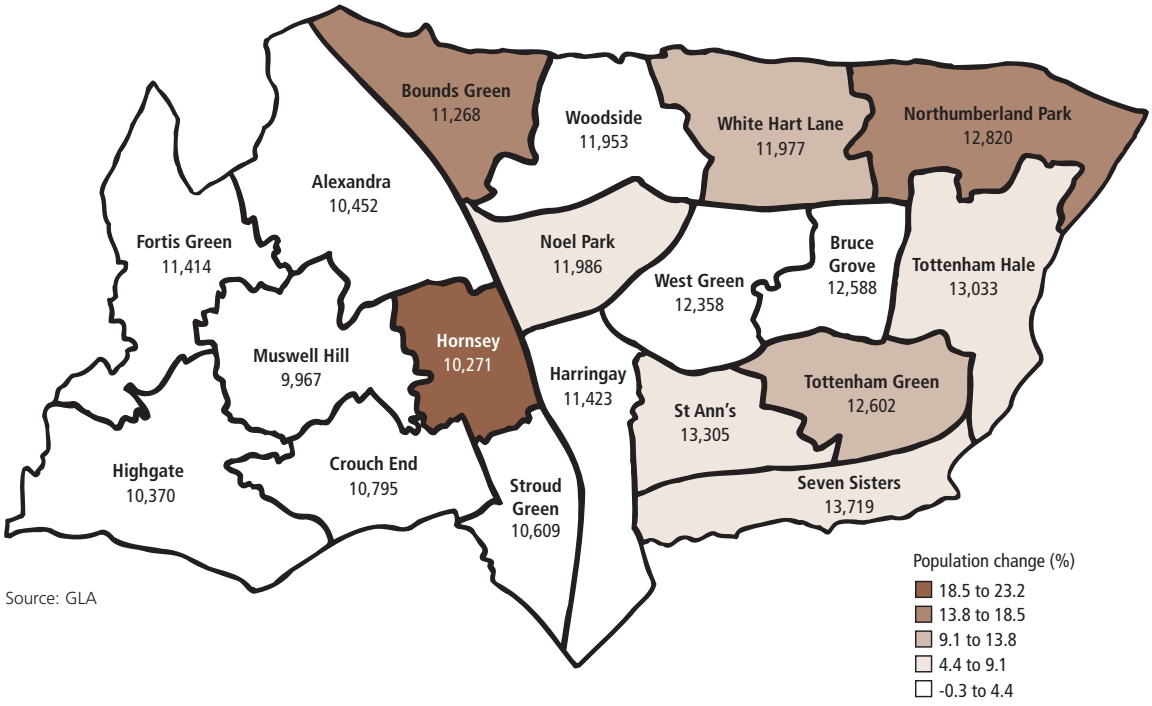
Source: ONS and GLA

We use ONS and GLA sources as they both give us helpful information about the local population. The GLA projections are very helpful for London as they use information of the planned developments for London and for comparison with the rest of the country we need to use ONS information.

1.2 Where is population growth expected to take place in Haringey?

In the short term the most significant growth is expected in Hornsey ward, up by nearly 2,000 residents (or 19%) by 2011. The Heartlands housing development in this ward is an important driver for population growth as are other developments in other parts of the borough. In the longer term an increase of over 10% of the 2006 population by 2021 is also anticipated in Bounds Green (15%), Northumberland Park (15%), Tottenham Green (13%) and White Hart Lane (11%). Significant growth is also anticipated in Tottenham Hale ward with the redevelopment of the area, but this is not currently reflected in GLA estimates. Some ward populations are not anticipated to grow, notably Harringay and Muswell Hill (see figure 2).

Figure 2 *Number of residents by 2021 by ward, and % change from 2006*



Source: GLA

1.3 Will the profile of Haringey residents change?

In the 2003 report Haringey had a young population relative to both London and England. In particular, young adults aged between 20 and 39 made up a larger proportion of those living in Haringey compared to the national picture. We noted that under half of Haringey's residents were of White British ethnic origin, and the changing nature of ethnic diversity within the borough.

Estimates of population growth indicate that there will be a varying growth rate across different age and ethnic groups. This is driven by the continued substantial population mobility in the borough. These are summarised in the following sections.

1.3.1 Age profiles

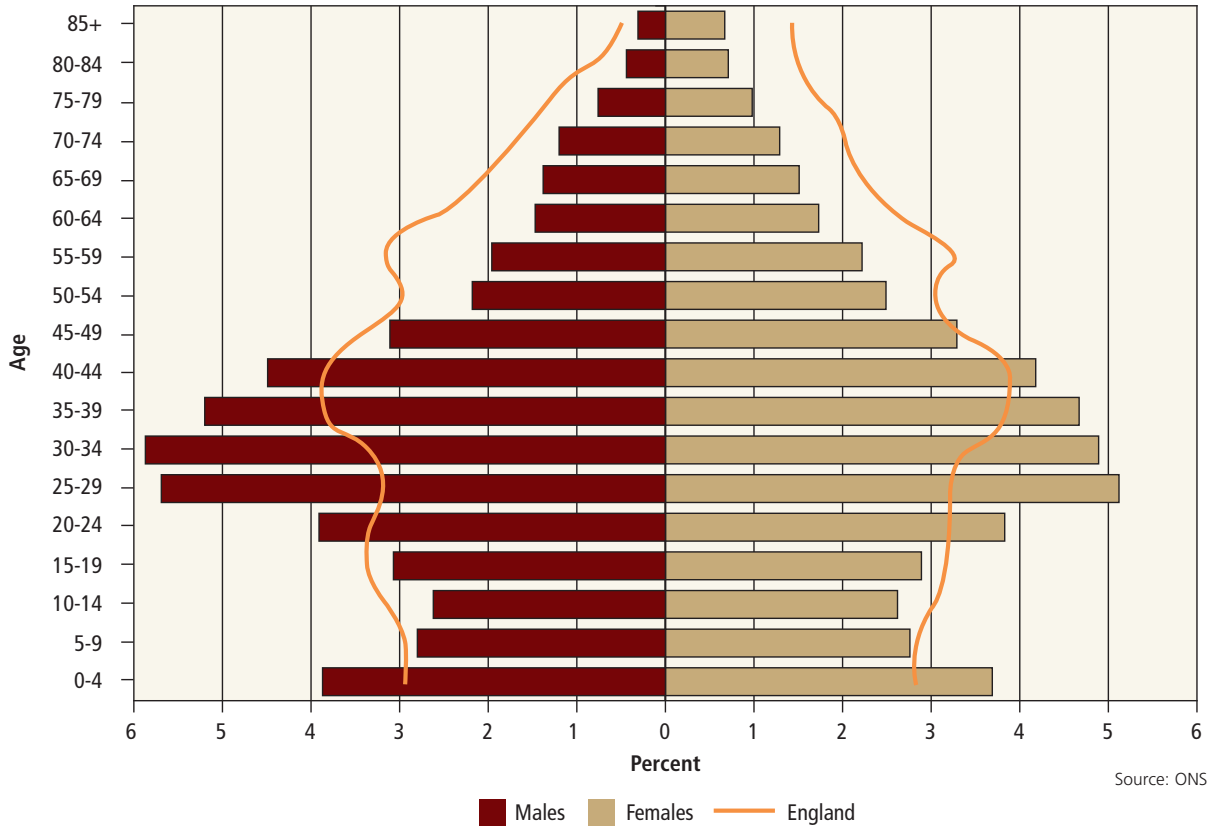
ONS data suggests that the Haringey population continues to be relatively young compared to the national picture. Figure 3 shows the differences in the population by age and sex distribution. In Haringey approximately 43% of the population is under 30 compared to 37% in England. At the other end of the age spectrum only 9% of the Haringey population is over 65 compared to 16% in England as a whole.

1.3.2 Changes in different age groups

Health and health care needs vary considerably across the lifespan, particularly in relation to childbirth and the early years, the onset of long term health problems in middle age, and old age. The GLA estimates that there will be sustained population growth across all age groups up to 2021, except amongst 65-74 year olds (see figure 4).

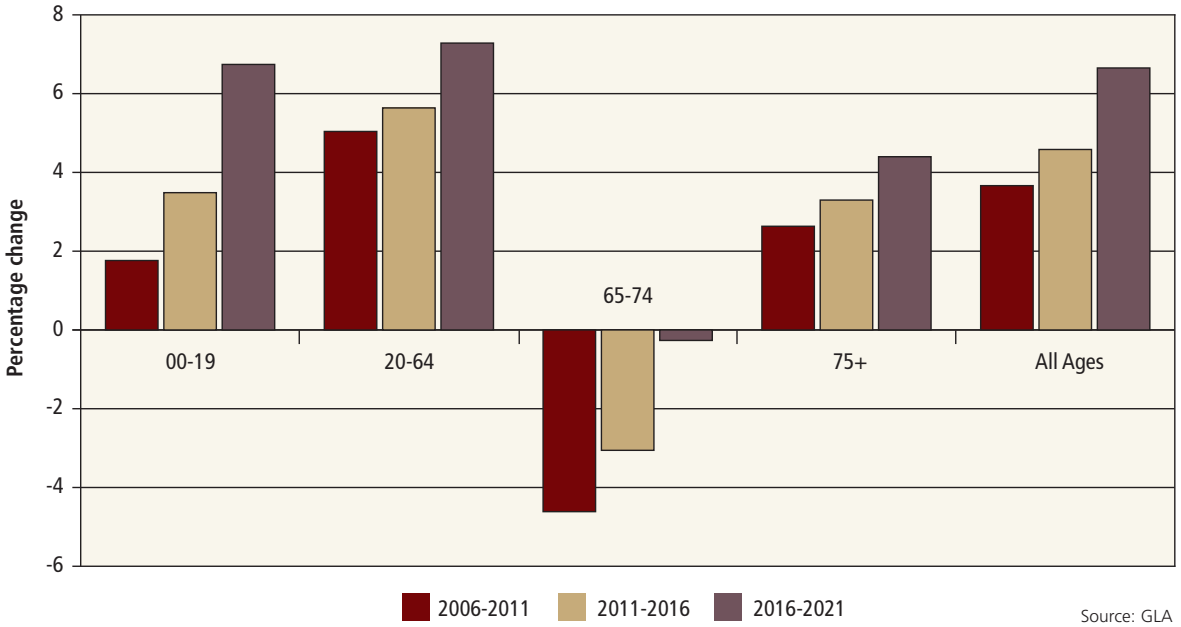
Between 2006 and 2011 the GLA estimates suggest that Haringey will be home to 7,500 more people of working age (20-64 years),

Figure 3 *Population pyramid: Haringey vs England (2006)*



Source: ONS

Figure 4 Age specific population change (2006 to 2021)



Source: GLA

and nearly 1,700 more people aged over 50. There will be a substantial increase in children aged under 5 (up by 960) and the number of children aged 5 to 19 years may decrease slightly (see table 2).

The number of 65-74 year olds is expected to decrease by 4.6% or 530 fewer residents over the next five years to 2011. Reducing premature mortality amongst this age group resulting from long term conditions such as hypertension or diabetes, is a key component of the strategy to improve life expectancy in Haringey. Many of the preventative interventions available need to be initiated at an earlier age to improve health outcomes in this age group. The number of people aged 50-64 is expected to increase over the same period. The number of people aged over 75 years, who have high levels of need for health and social care, is expected to increase by approximately 220.

Table 2 Age profile of Haringey population (2006 and 2011)

Age group in years	No. of residents in 2006	% of total residents in 2006	Additional residents by 2011	Total residents & (%) change 2006-2011
0-19	53,203	23.9%	938	54,141 (1.8%)
<1	3,740	1.7%	153	3,893 (4.1%)
1-4	13,167	5.9%	806	13,973 (6.1%)
5-19	36,296	16.3%	-21	36,275 (-0.1%)
20-64	149,654	67.0%	7,543	157,197 (5.0%)
65-74	11,609	5.2%	-536	11,073 (-4.6%)
75+	8,445	3.8%	222	8,667 (2.6%)
50+	46,542	20.9%	1,677	48,219 (3.6%)
All Haringey	222,911	100%	8,167	231,078 (3.7%)

Source: GLA

1.3.3 Changes in different wards

The 2003 report illustrated how the age profile of individual wards in Haringey varies. In 2006, children aged 0-19 years make up 24% of the Haringey population, which varies from 17% in Highgate ward to nearly 30% in Northumberland Park. People aged over 50 make up 21% of the Haringey population varying from 18% in Harringay ward to 27% in Muswell Hill.

The distribution of different age groups across the borough is important for service planning. Figures 5 to 8 illustrate where individuals in the four key age groups live: Children aged 0-19 years, people of working

Figure 5 *Where do children aged 0-19 years live in 2006?*

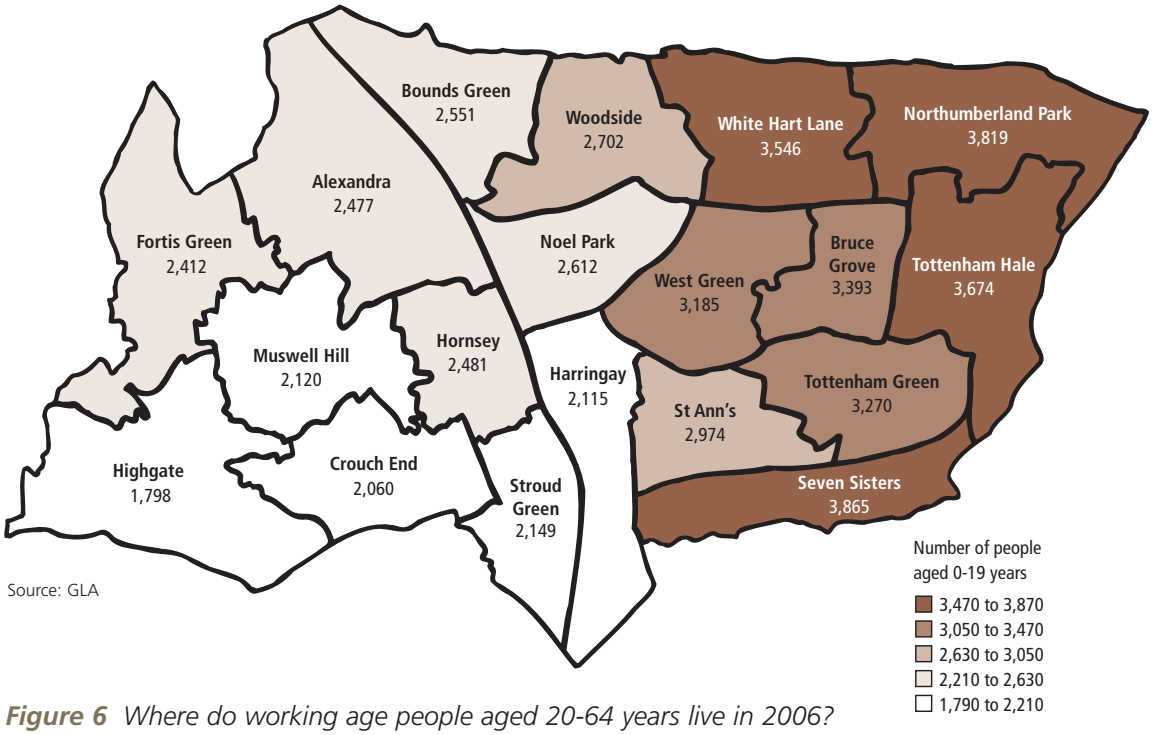


Figure 6 *Where do working age people aged 20-64 years live in 2006?*

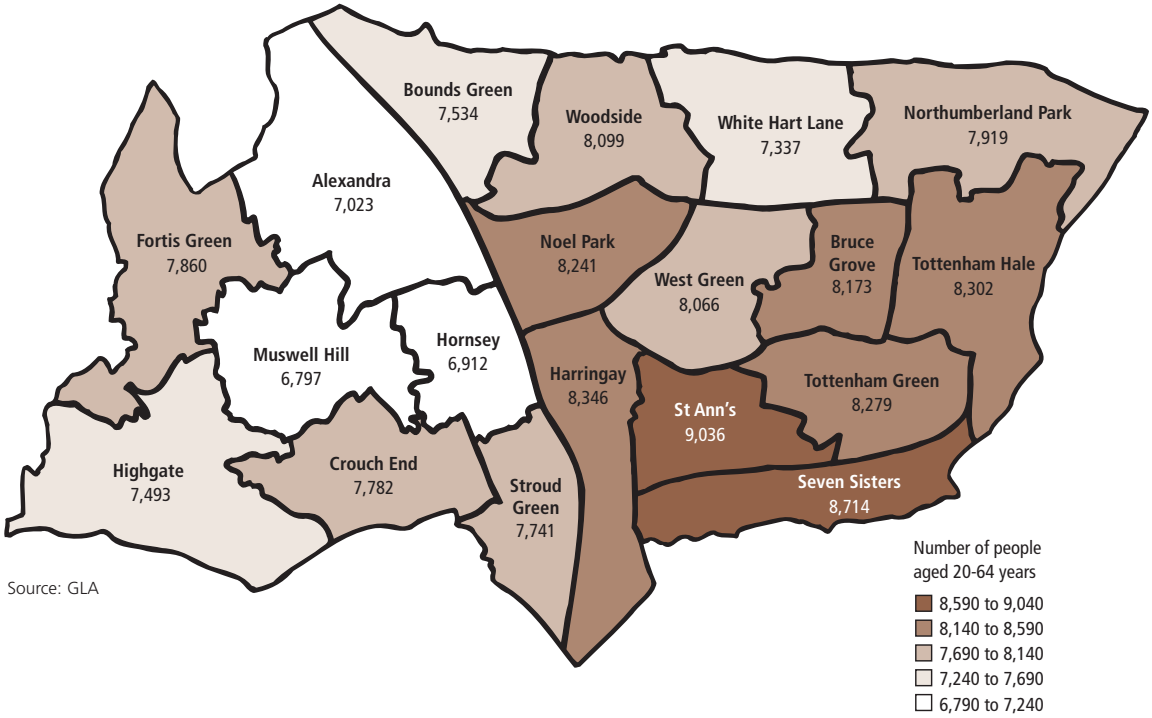


Figure 7 *Where do people aged over 50 years live in 2006?*

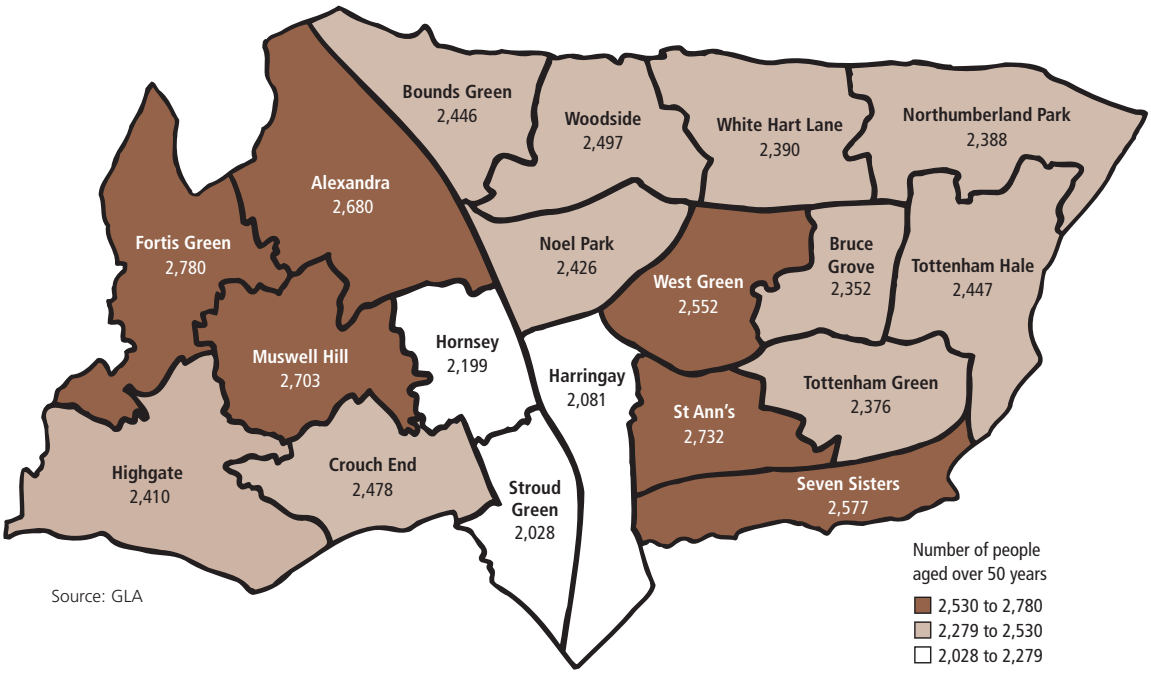
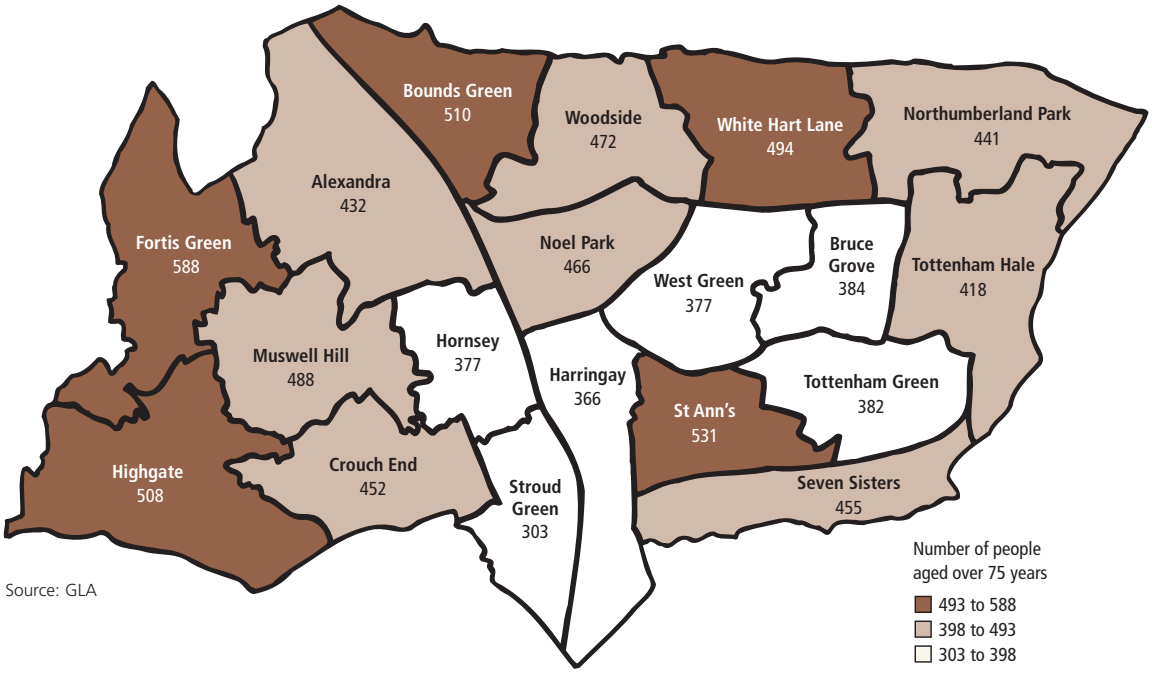


Figure 8 *Where do people aged over 75 years live in 2006?*



age (20-64 years), people aged over 50 most at risk from long term health problems and older people aged over 75 years.

1.3.4 Ethnicity profile of the population

The 2003 Health Report noted that less than half of Haringey residents were of White British ethnic origin with changing ethnic diversity across the borough. In 2001 the Haringey population was more ethnically diverse than London and England, with an under-representation of Asian and Asian British residents and an over representation of black and Black British residents compared

to London. It was also noted that black and minority ethnic groups made up a larger proportion of the population in the east of the borough, and that the ethnic profile of individual wards varied considerably.

The GLA recently published ethnicity profiles for the future population of Haringey that suggest how the ethnic profile and specific age groups may change over the years to 2021 (see table 3). Work by the GLA shows that the ethnic profile of residents will remain relatively stable up to 2021, with a small decrease in the proportion of residents of Black Caribbean, Black African and Indian origins and a small increase in the proportion of residents of Pakistani, Bangladeshi or Chinese origin. This is important for health and health service planning because ethnicity has a significant impact on the health needs of individuals. It can also influence the risk of developing certain health conditions and access to effective services.

Unfortunately the GLA profile does not provide data, as in the census, on the proportion of residents of White Irish ethnic origin, or 'Other White' origins such as Eastern European, which are pertinent to Haringey. While table 3 suggests that the proportion of the population of white ethnicity will fall slightly to 65% by 2021, the proportion of residents of White British origin was 45.3% in 2001 and is likely to decrease. The GLA profiles excludes changes in mixed ethnicity, which was the largest growing ethnic group in the 2001 census.

The ethnic profile of Haringey is likely to remain different from that of London as a whole, including the composition of the 'White' ethnic group.

The ethnic profile of Haringey residents varies within different age groups. Figure 9 illustrates that younger residents are more ethnically diverse than older residents, and that changes in the ethnic profile of the population as it ages should inform health and social care service planning for the future.

Changes in the age profile of residents from different ethnic backgrounds also have significance for health service planning and work to protect and promote good health.

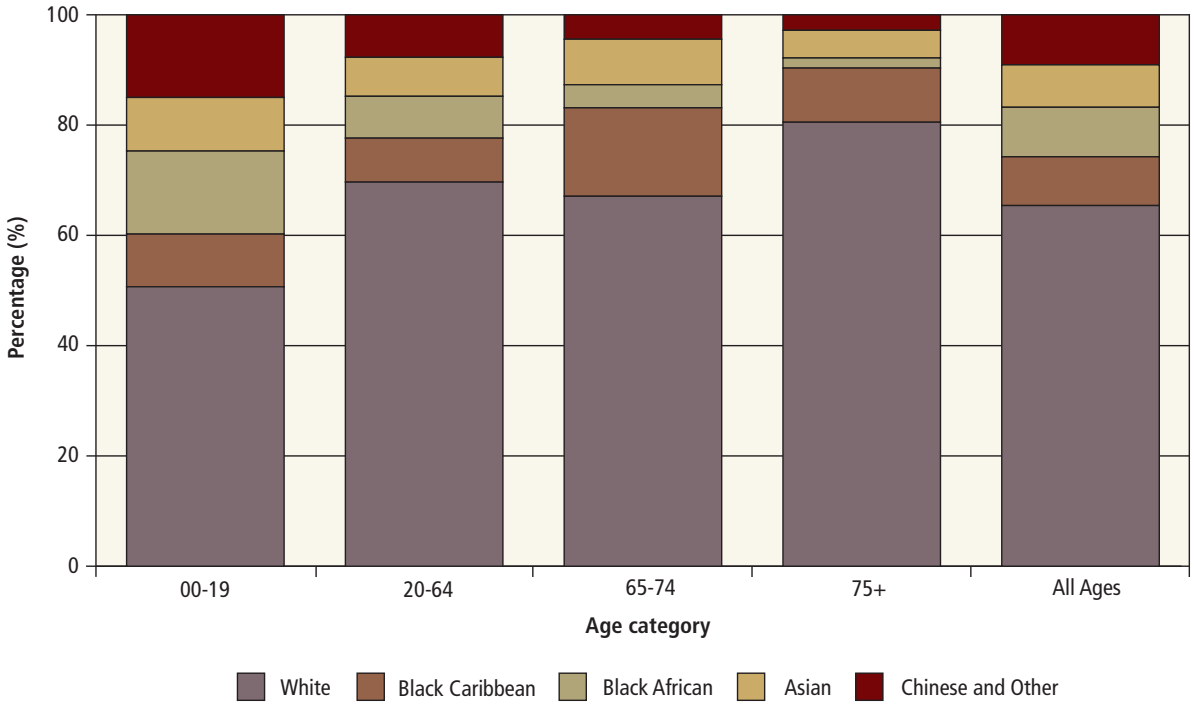
Table 3 *Ethnic origin of Haringey residents (2001 to 2021)*

	Haringey				London
	2001	**2006**	**2011**	**2021**	**2021**
White	65.8	65.4	65.1	64.9	62.0
Black Caribbean	9.4	8.8	8.4	7.7	4.9
Black African	9.1	9.0	8.9	8.8	7.2
Black Other	3.5	3.6	3.7	3.8	2.9
Indian	2.8	2.6	2.5	2.3	7.5
Pakistani	1.0	1.1	1.2	1.2	2.7
Bangladeshi	1.4	1.5	1.6	1.7	3.0
Chinese	1.1	1.4	1.7	1.9	1.7
Other Asian	2.6	2.5	2.5	2.4	3.5
Other	3.2	4.0	4.6	5.2	4.6
All Ethnicities	**221,251 (100%)**	**222,911 (100%)**	**231,078 (100%)**	**237,738 (100%)**	**12,410,029 (100%)**

Note: 'White' includes White British, White Irish and Other White e.g. Turkish, Kurdish, Turkish Cypriot, Greek Cypriot, Polish. 'Other' includes individuals of mixed ethnicity

Source: GLA

Figure 9 Comparison of the ethnic profile of different age groups (2006)



Source: GLA

Age and ethnicity are important determinants of health need for a wide range of health conditions, including long term conditions such as diabetes or sickle cell disease and social care requirements. The following examples illustrate how the age profile of the two largest minority ethnic communities may change over the next 15 years.

Example 1: Black Caribbean Haringey residents

The 2001 census recorded 20,860 Black Caribbean residents in Haringey, or 9.5% of the total population (excluding residents of mixed ethnic heritage). The GLA estimates suggest this has fallen to 19,700 residents in 2006, or 8.8% of the total population, and it will continue to fall to 18,410 (7.7%) by 2021. There are a number of possible explanations for this, including the increasing number of residents from a mixed ethnic heritage, out migration, and the age profile of that community.

GLA estimates indicate that the age profile of Black Caribbean residents will change dramatically in the medium term leading to a smaller number and proportion of younger age groups and a larger number and proportion of older age groups (see table 4).

Table 4 Changing age profile of Black Caribbean residents

Black Caribbean residents		0-19 year olds	20-64 year olds	50+ year olds	75+ year olds
2006	Number of residents	5,080	11,930	4,970	830
	% of total age group	10.5	8.8	10.2	6.2
2021	Number of residents	4,130	11,700	6,560	1,380
	% of total age group	7.3	7.3	12.4	15.6

Source: GLA

Example 2: Black African Haringey residents

The 2001 census recorded 20,220 Black African residents in Haringey, or 9.1% of the total population (excluding residents of mixed ethnic heritage). The GLA estimates suggest this has fallen slightly to 20,010 residents in 2006, or 9.0% of the total population increasing to 20,850 (8.8%) by 2021.

GLA estimates suggest that the age profile of Black African residents will change in the medium term with a smaller number and proportion of children, a similar population of working age and a larger number and proportion of older age groups (see table 5).

1.4 Conclusions – The people of Haringey

- The population of Haringey will continue to grow and is projected to be 237,000 by 2021.
- There will be changes in the ethnic profile of Haringey over time with a decline in the number and proportion of residents who are Black Caribbean.
- There will be an increase in size of all the population age groups, except the 65-74 year old group.
- The growth in population will occur in nearly all wards but will be very significant in Hornsey, Northumberland Park and Bounds Green wards.

Table 5 *Changing age profile of Black African residents*

Black African residents		0-19 year olds	20-64 year olds	50+ year olds	75+ year olds
2006	Number of residents	8,020	11,360	2,450	155
	% of total age group	15.0	7.6	5.3	1.8
2021	Number of residents	7,700	11,910	4,200	404
	% of total age group	13.6	7.4	8.0	4.6

Source: GLA

2 Key health indicators

Written by Ada Okoli

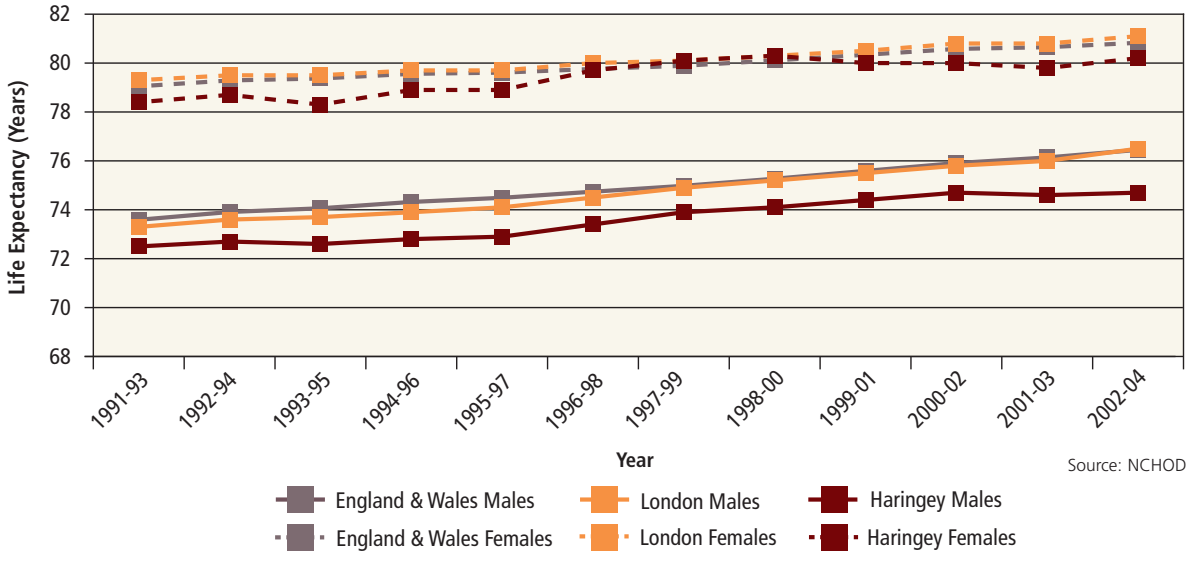
2.1 Life expectancy

Life expectancy at birth measures how long a baby born in an area would be expected to live if they experienced the current age-specific death rates of the area. Life expectancy provides a good overall measure of the health of any population at a given time; and between different populations at different times.

Overall, people in Haringey live longer than they did over a decade ago but on average they die younger when compared to the population of England and Wales. Life expectancy for both males and females has continued to rise in London as well as England and Wales since 1991. This trend for life expectancy for men in Haringey has followed the national average for many years but continues to be lower than the national average. Life expectancy for Haringey women has been as good as the national average but recently has shown a decline and currently Haringey women do not live as long as the average for London or England and Wales (see figure 10).

There has been a slight rise in life expectancy of 0.4 years for females (80.2 years) and 0.1 years for males (74.7 years) in Haringey since the last Public Health Report in 2005. Females born in Haringey in 2002-2004 are expected to live 5.5 years more than males born in the same period. Male life expectancy in Haringey at birth during this period was significantly lower than the national average of 76.5 years by 1.8 years. This gap with the national average is widening, as the difference was only 1.3 years during an equivalent period in 1996-98 (see figure 10).

Figure 10 *Trends in life expectancy in Haringey compared to London and England (1991-2004)*



Source: NCHOD

Female life expectancy in Haringey at birth during this period was 0.6 years less than the national average of 80.8 years. The gap in average life expectancy of females in Haringey and England and Wales has widened compared to figures in 1996-98 (0.1 years) (see figure 10).

2.2 Deprivation and life expectancy in Haringey

Haringey is the 13th most deprived borough in England and the 5th most deprived in London[2]. There are a total of 144 super output areas (SOAs) in Haringey with an average of 7 to 8 per ward. 30% of these SOAs are among the top 10% most deprived in the country. Socio-economic deprivation has a significant impact on people's health. Inequalities in the experience of health and life expectancy exist within Haringey and between neighbourhoods and these are explained by the differences in socio-economic status in different parts of Haringey (see figure 11).

Overall in Haringey, residents in the more affluent wards in the west have higher life expectancy than the less affluent areas in the east (see figures 12 and 13). Life expectancy in males correlates more with deprivation than females suggesting that fewer causes of death in females are deprivation related. This is also mirrored nationally.

2.3 Life expectancy in Haringey and neighbouring boroughs

On average, males and females residing in neighbouring boroughs (with the exception of Islington) are expected to live longer than those in Haringey. These differences are likely to be a reflection of the proportion of deprived population living within each borough (see figure 14).

Figure 11 *Index of deprivation scores by ward*

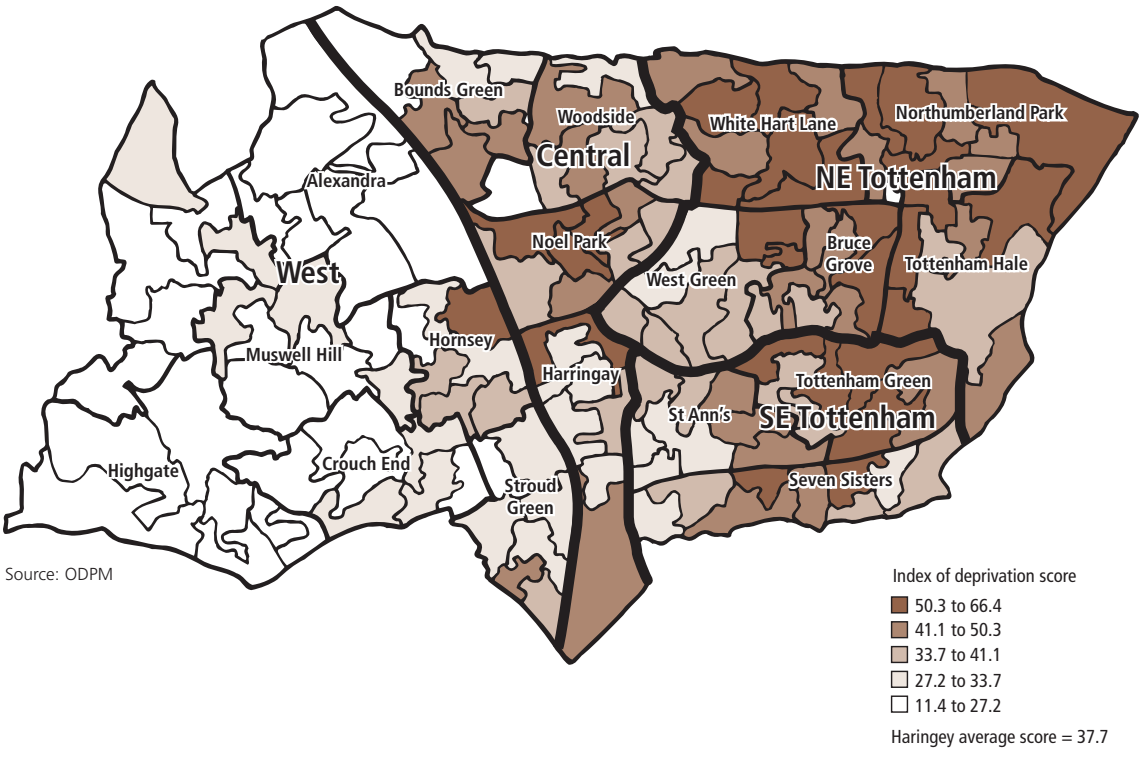
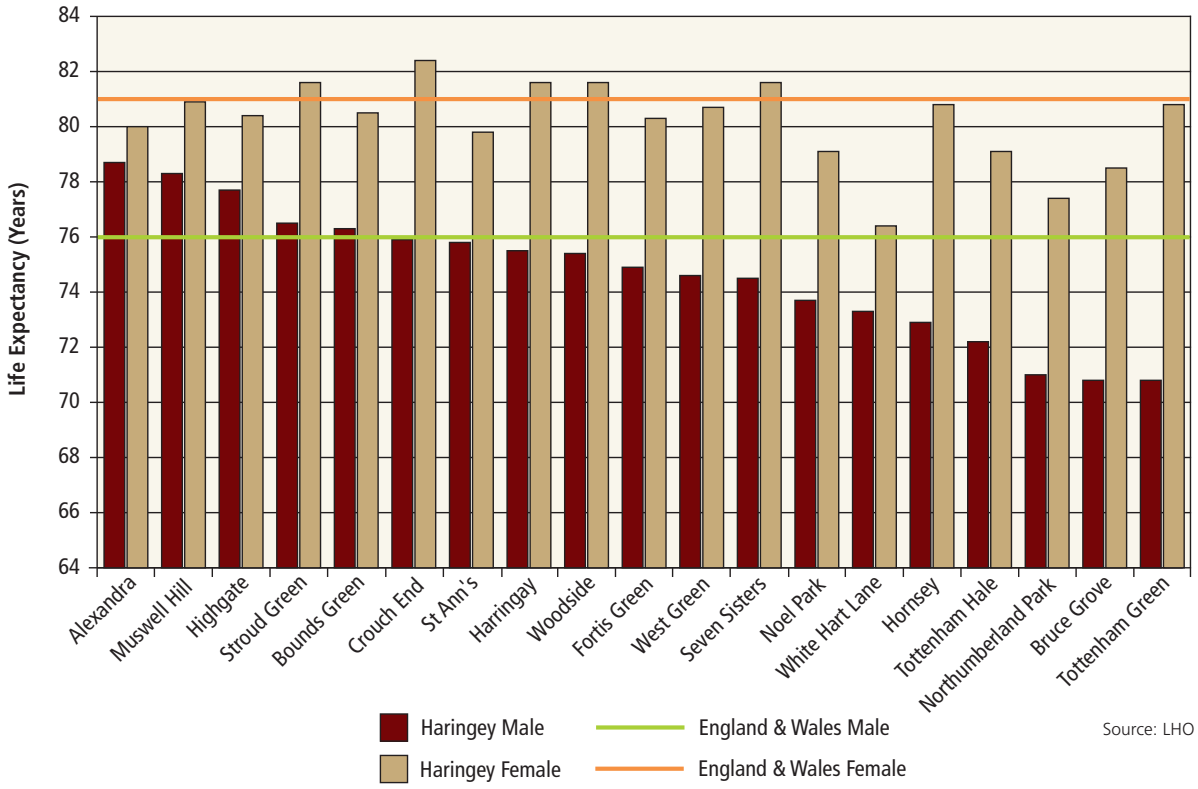
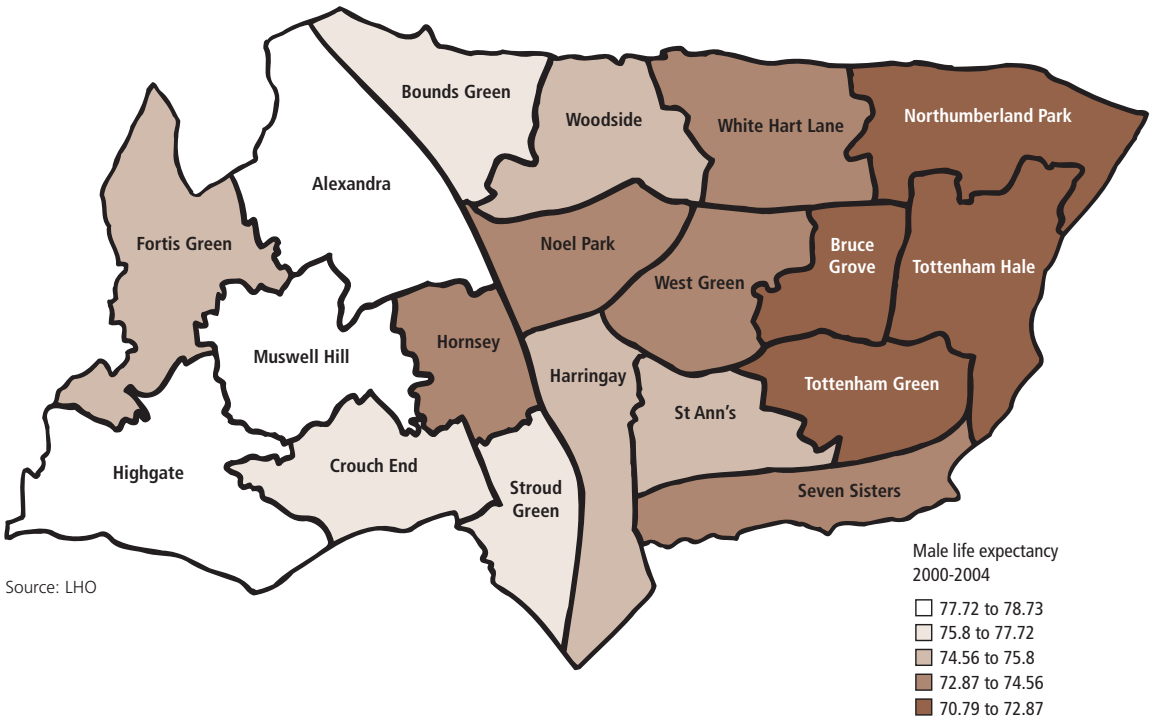


Figure 12 Life expectancy of males and females by ward (2000-2004)



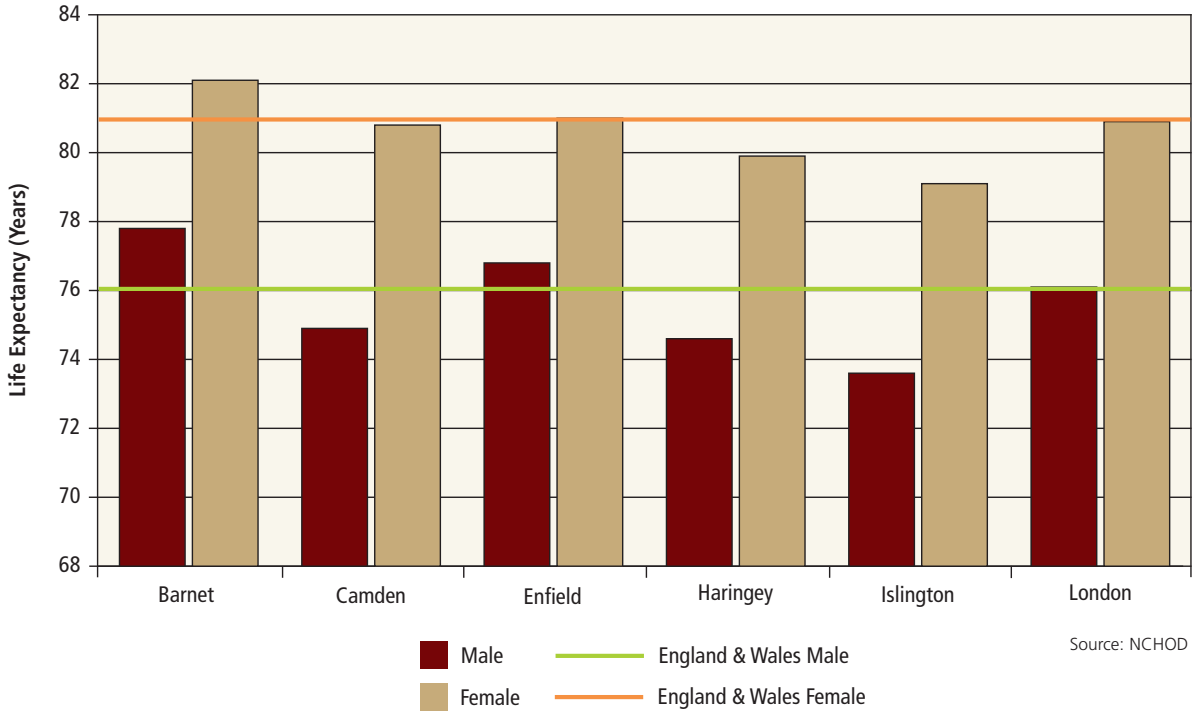
Source: LHO

Figure 13 Male life expectancy in Haringey by ward (2000-2004)



Source: LHO

Figure 14 *Life expectancy in males and females in Haringey compared to London, England and neighbouring boroughs (2002-2004)*



Source: NCHOD

2.4 Self-reported indicators of health

Life expectancy is an internationally used marker of health status. It is one of the best indicators available to measure overall population health and it allows local, national and international comparisons of health. Other markers of health status are used to measure how people experience their health while alive. The most readily available of these in the UK is through the self-reported answers to three questions asked in the 2001 census. Table 6 summarises the results for Haringey compared with London and England and Wales.

For all three indicators Haringey proportions are better than the national average, and the London averages except for one. Given the life expectancy markers for Haringey, these good measures are likely to be a reflection on the relatively young population of Haringey, as these rates are not standardised for age or sex.

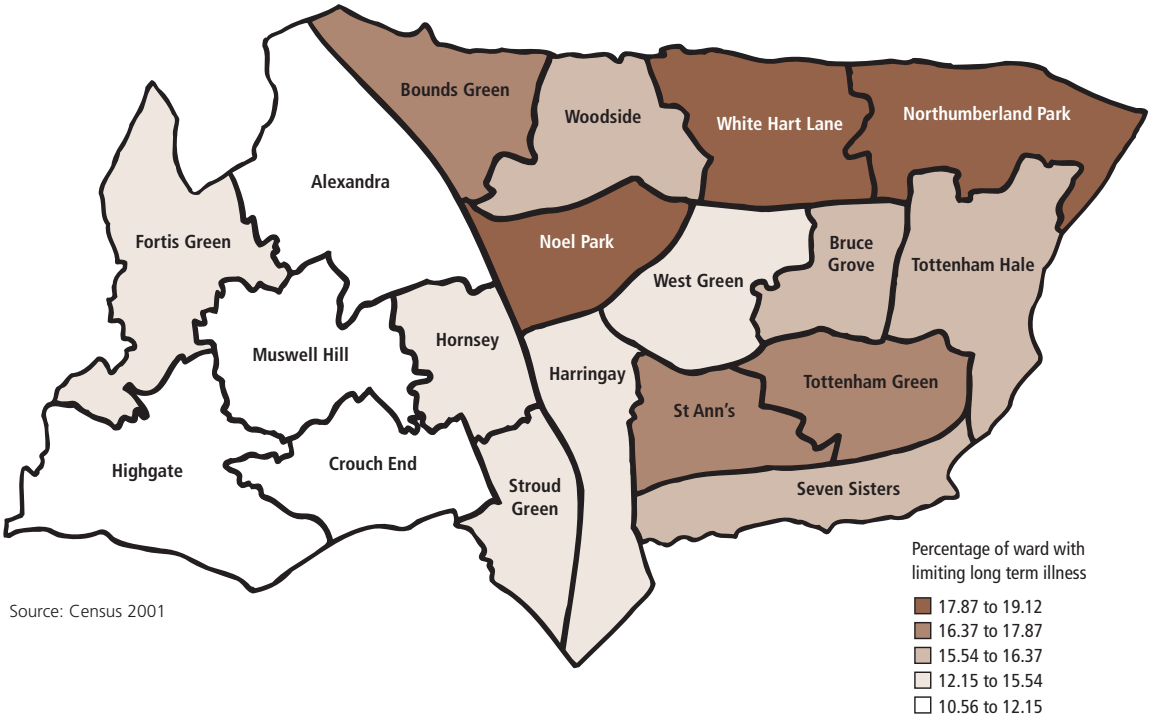
For instance, the proportion of people in Haringey that provided 'unpaid care' looking after or giving help or support to family members, friends, neighbours or others, as a result of long term physical or mental ill-health or disability, or problems related to old age, were lower (7.4%) than in London (8.5%) and in England and Wales (10.0%). This reflects the relatively small proportion of people aged over 65 in Haringey.

Table 6 *Self reported health status*

Health indicator	Haringey	London	England & Wales
People with a "Limiting Long Term Illness" (%)	15.2	15.5	18.2
People with "General Health Not good" (%)	8.8	8.3	9.2
People who "Provide Unpaid Care" (%)	7.4	8.5	10.0

Source: Census 2001

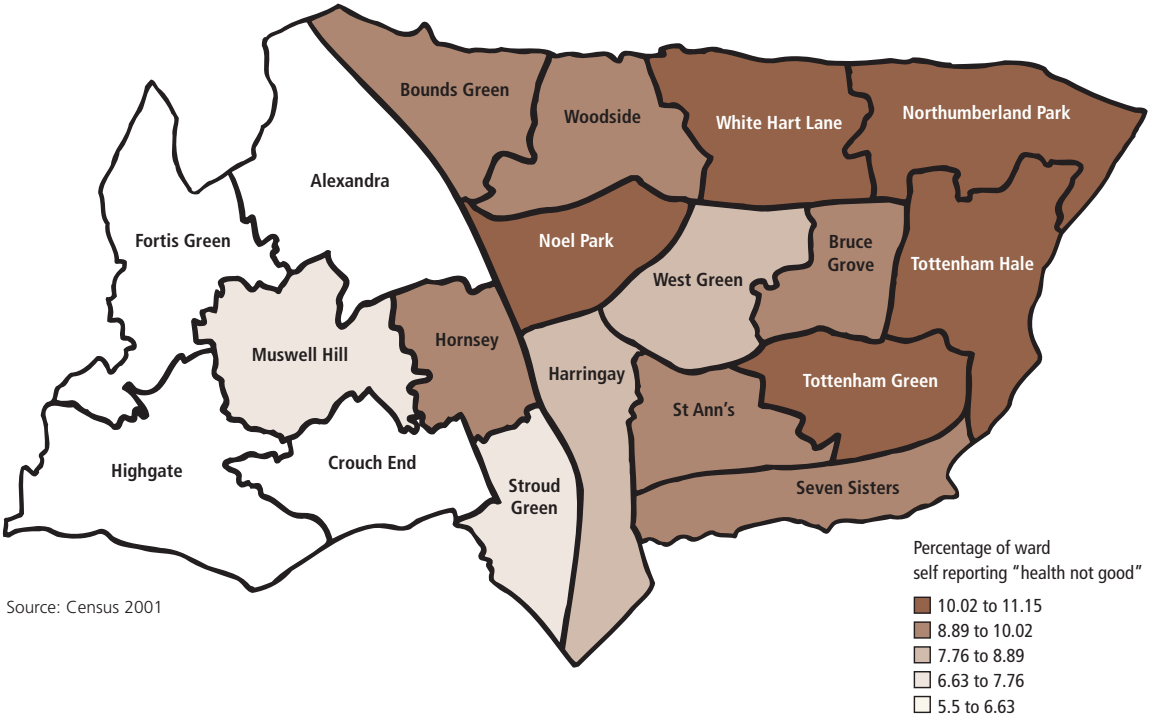
Figure 15 People living with long term limiting illness in Haringey by ward



Source: Census 2001

However, there were marked ward differences in health status in the census results for Haringey. For example, Northumberland Park, which is a relatively deprived ward, had a higher proportion of long term illness (17.9%) and 'health not good' (10.9%) than less deprived wards like Alexandra (11.8% and 6.2% respectively). These figures are much closer to the national average (see figures 15 & 16).

Figure 16 People self reporting "health not good" in Haringey by ward



Source: Census 2001

2.5 Inequalities in health status

The health indicators mentioned in sections 2.1 to 2.4 compare Haringey with national figures. While self reported health status is better than the national average, the measure of absolute health (life expectancy) indicates that Haringey's men continue to do less well than the national average. Life expectancy amongst Haringey women has declined in recent years and the gap between England and Wales and Haringey has increased. There are also large health inequalities that exist between the east and west of the borough. There is scientific evidence that traces the roots of ill health to the determinants of health[3]. These determinants are not evenly distributed across the borough and some communities are affected more than others and show marked differences in health status[4].

2.6 Conclusions – Key health indicators

- Male life expectancy in Haringey is significantly below the national average.
- There is a significant gap in life expectancy between those in the east of the borough and those in the west; a difference of 8 years between wards with the highest and lowest life expectancy.
- There is marked deprivation in much of Haringey with some wards experiencing some of the worst deprivation in the country e.g. Northumberland Park, White Hart Lane and Tottenham Green.
- Despite the deprivation and low life expectancy, the people of Haringey perceive their health to be better with lower levels of self-reported poor health compared with London and national averages.

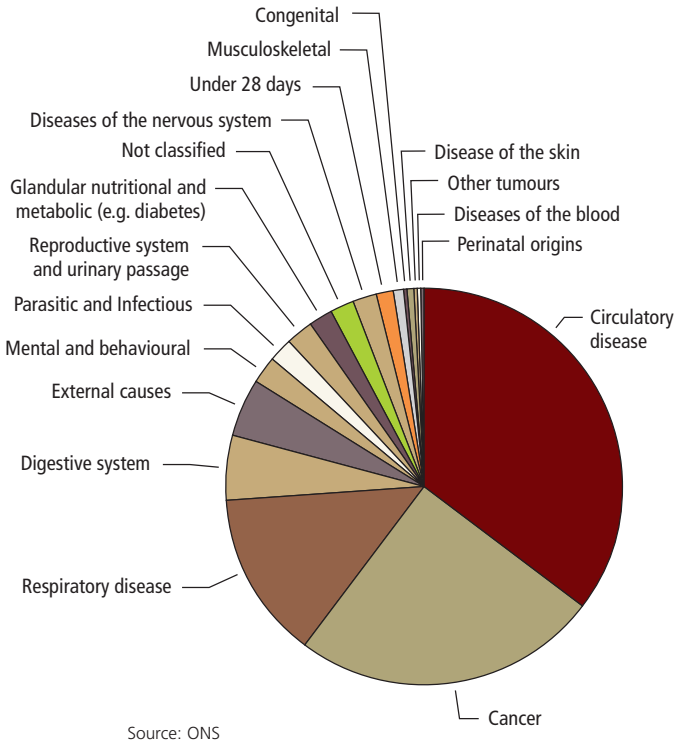
3 What are Haringey people dying from?

Written by Lookman Alli

3.1 Overall number of deaths

In line with national trends there has been a consistent reduction in the number of people dying each year in Haringey since 1993. Between 2003 and 2005 there was a 20% reduction in the number of deaths from 1,517 in 2003 to 1,205 in 2005. During this period a little more than half (51.9%) were males and most deaths occurred in those 50 years and above (86%). This chapter looks at the main causes of death, comparing them with national trends and describing the differences in the local picture.

Figure 17 *Proportion of deaths by cause for all ages (2003-2005)*



Source: ONS

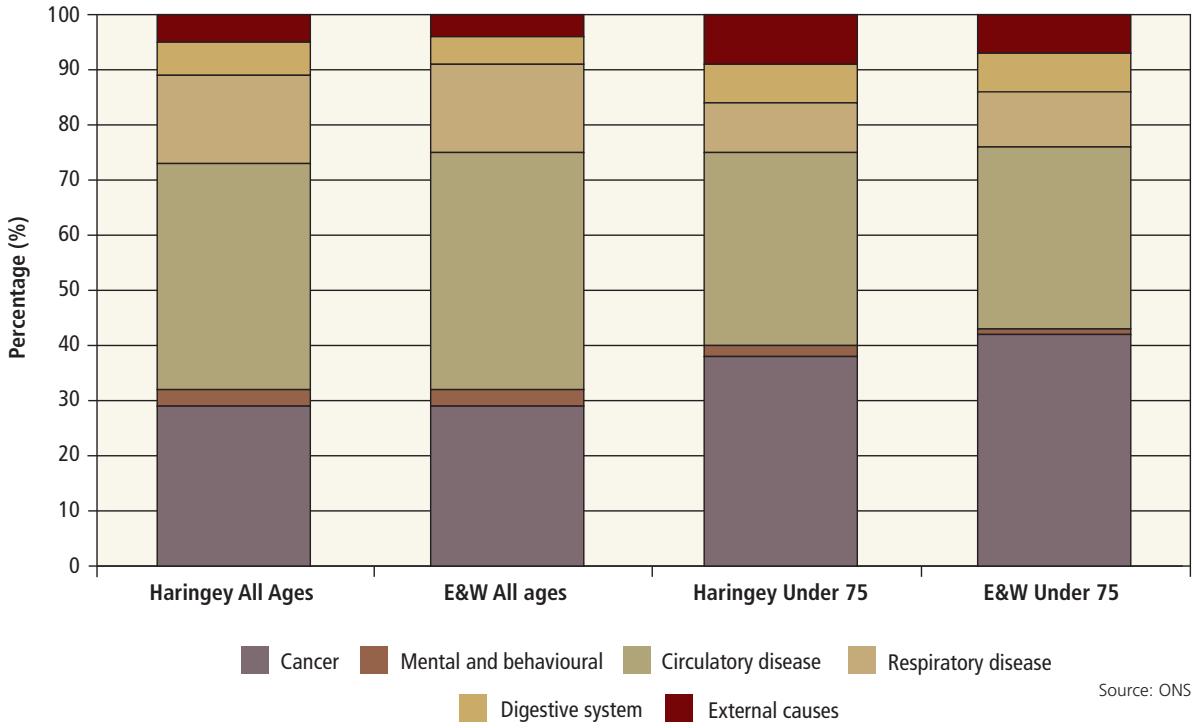
3.2 Causes of death in Haringey

The total number of deaths recorded in Haringey between 2003 and 2005 was 4,072. Out of these, 61 (1.5%) occurred in the first 28 days of life (neonatal death). The main causes of death were; circulatory disease (35.5%), cancer (25.0%), respiratory disease (13.6%) and disease of the digestive system (5.2%). These main causes of death and other causes are summarised in figure 17.

3.3 Proportion of deaths

Figure 18 compares the major causes of death by cause for England and Wales and Haringey for all ages and under 75s. England and Wales recorded a slightly higher all age proportion of deaths from cancer (25.6%) as compared to Haringey (25.0%). This was also the case for those aged under 75 years, (England and Wales 37.1% and Haringey 31.3% respectively). The proportion of all age death due to circulatory disease was slightly higher in England and Wales (37.8%) than Haringey (35.5%). For respiratory disease in all ages, similar figures were recorded for Haringey and England and Wales (13.8% and 13.6% respectively). In those aged under 75 years the proportion was slightly higher in England and Wales (8.8%) than Haringey (7.6%).

Figure 18 *Proportion of deaths due to major causes in Haringey compared to England and Wales (2003-2005)*



Source: ONS

Overall, the reasons why people die in Haringey are similar to the national average. However, the proportion of deaths due to external causes (which include transport, pedestrian, falls, fire related, accidental poisoning, intentional self-harm, assault and deaths from undetermined intent) and mental illness are higher than for England and Wales.

3.4 Death rates

Between 1993 and 2005 the death rate in Haringey fell from 871 per 100,000 to 589 per 100,000, but was consistently higher than the England and Wales rate. During the same period the England and Wales rate fell from 793 per 100,000 to 615 per 100,000. In 2005 the rate for Haringey was below that of England and Wales following a sharp decline since 2003.

The Standardised Mortality Ratio (SMR) allows comparison between populations by comparing Haringey with a standard population after making adjustment for age and sex. The standard population usually used for this purpose is England and Wales and 100 usually expresses the average.

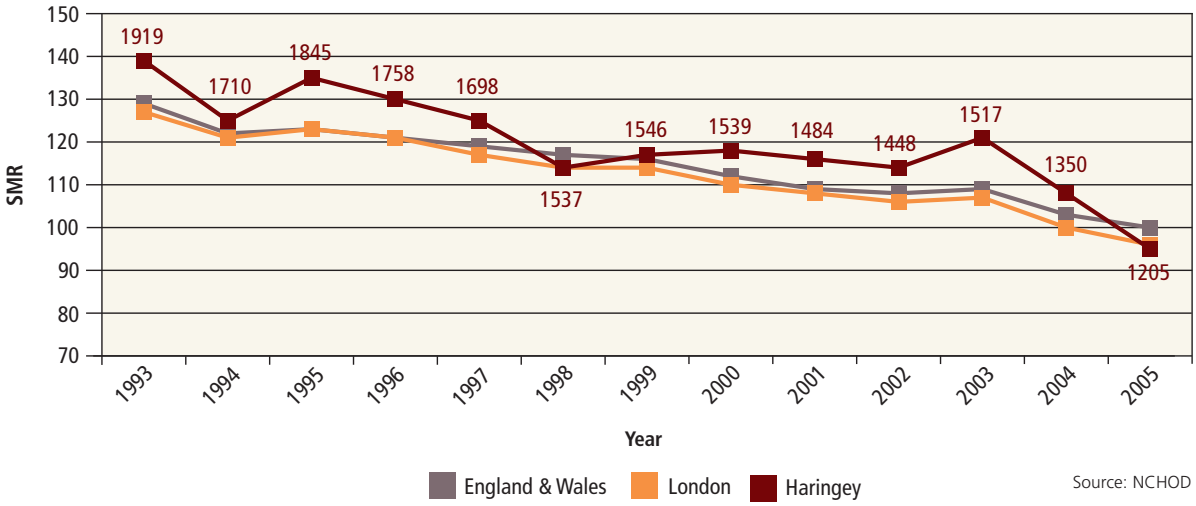
Figure 19 describes the all age, all cause SMR for Haringey and London compared to England and Wales in 2005. This also shows that the death rate in Haringey has improved over the last decade.

Death rates for Haringey women have remained consistently lower than those for men, as mirrored nationally. In 2005 the death rate for Haringey women was 446 per 100,000 women compared to 657 per 100,000 men.

3.5 Age and death rate

While the all age all cause death rate in Haringey is now comparable to that for England and Wales, this is not true of the

Figure 19 *All age all cause SMR (1993-2005)*



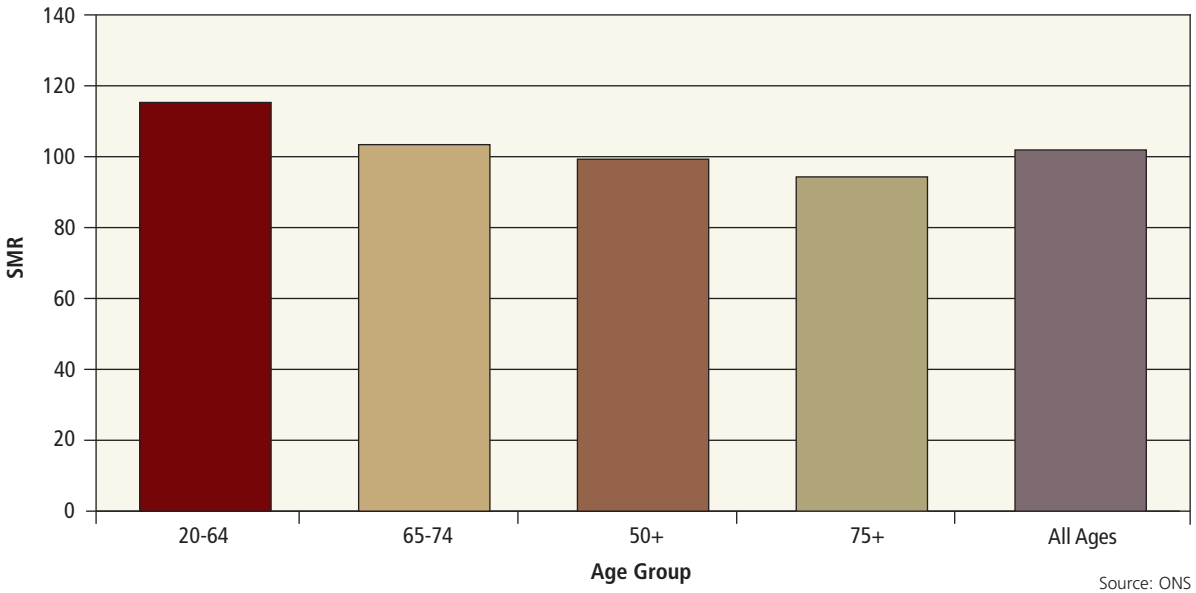
Source: NCHOD

death rate in all age groups. Figure 20 illustrates that the death rate amongst people aged 20-64 in Haringey is 15% higher that that experienced amongst that age group across England and Wales, whilst the death rate amongst the over 75s is lower in Haringey.

This indicates that there is a disproportionately large death rate amongst younger people in Haringey, which contributes to lower life expectancy. Many of these premature deaths are potentially preventable as indicated in the life expectancy action plan, for example, through efforts to improve primary and secondary disease prevention, reduce infant mortality, and improve the wider determinants of health in the borough.

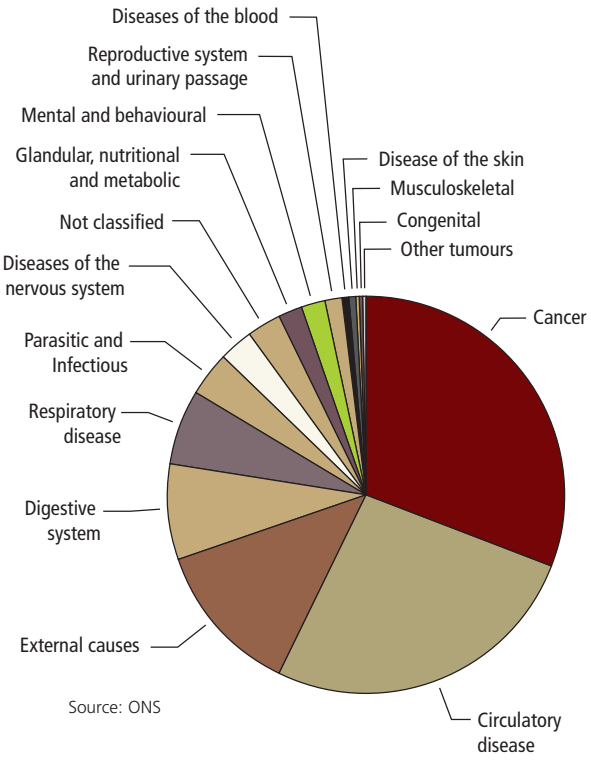
Figure 21 describes the causes of death amongst people aged between 20 and 64. The major causes of death among this group were cancer (31%), circulatory disease (26%) and external causes (12.5%).

Figure 20 *All cause SMR by age group (2003-2005)*



Source: ONS

Figure 21 *Proportion of deaths by cause for 20-64 year olds (2003-2005)*



3.6 Deaths in Haringey localities and wards

As identified earlier in this report there are differences in health status across the borough. Figure 22 compares the SMRs for Haringey by locality with that of England and Wales (SMR = 100). Between 2003 and 2005 the death rate was higher in the eastern part of the borough and lowest in the central and west. This suggests that although rates in 2005 within Haringey are lower than the national average there are areas in Haringey where rates are higher, and a disproportionate number of people are dying prematurely.

Within Haringey localities, particular wards stand out as having the highest mortality rates. Bruce Grove, Harringay, Northumberland Park, Tottenham Green, Tottenham Hale and White Hart Lane wards had particularly high mortality rates. Many of the areas with the lowest rates compared to England and Wales were in the west of Haringey, notably Crouch End and Muswell Hill (see figure 23).

3.7 Cancer

Between 1993 and 2005 the rate of death from cancer amongst all ages in Haringey fell from 206 per 100,000 to 159 per 100,000,

Figure 22 *All age, all cause SMR by locality (2003-2005)*

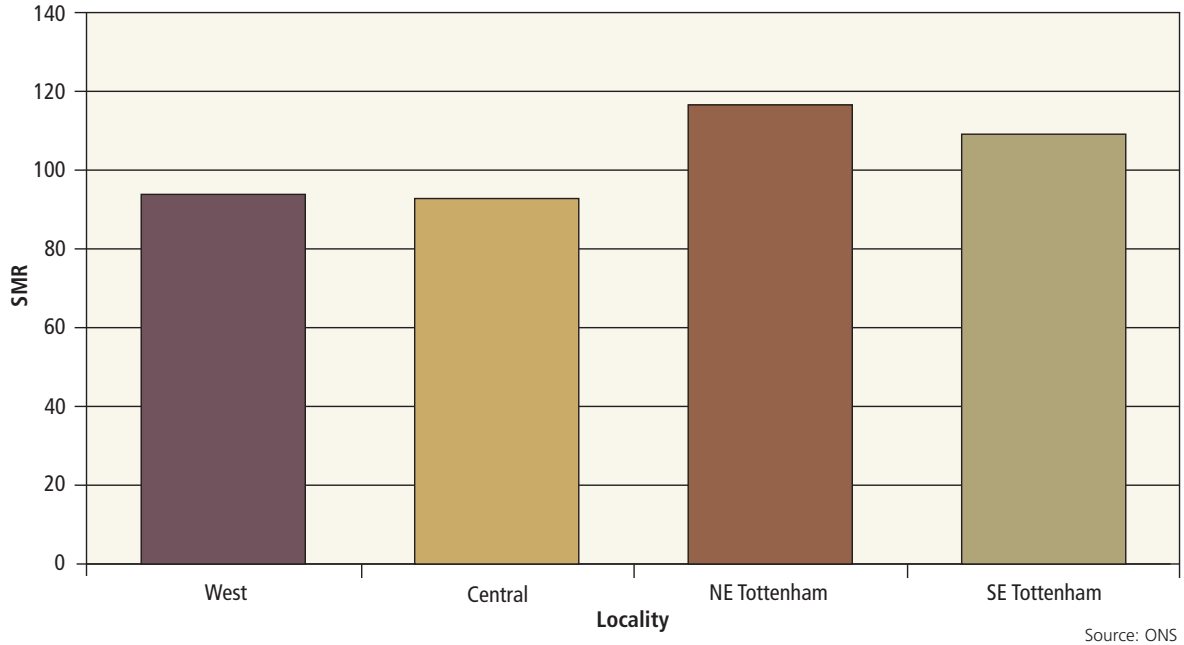
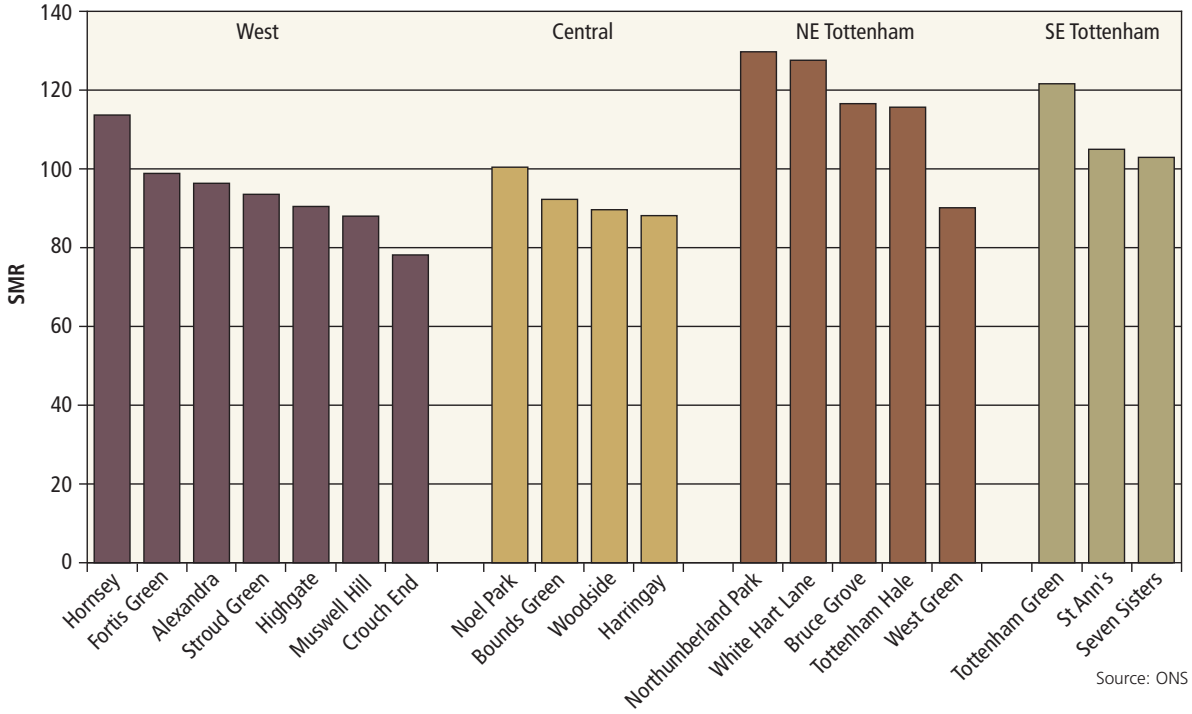


Figure 23 *All age, all cause SMR in Haringey wards (2003-2005)*



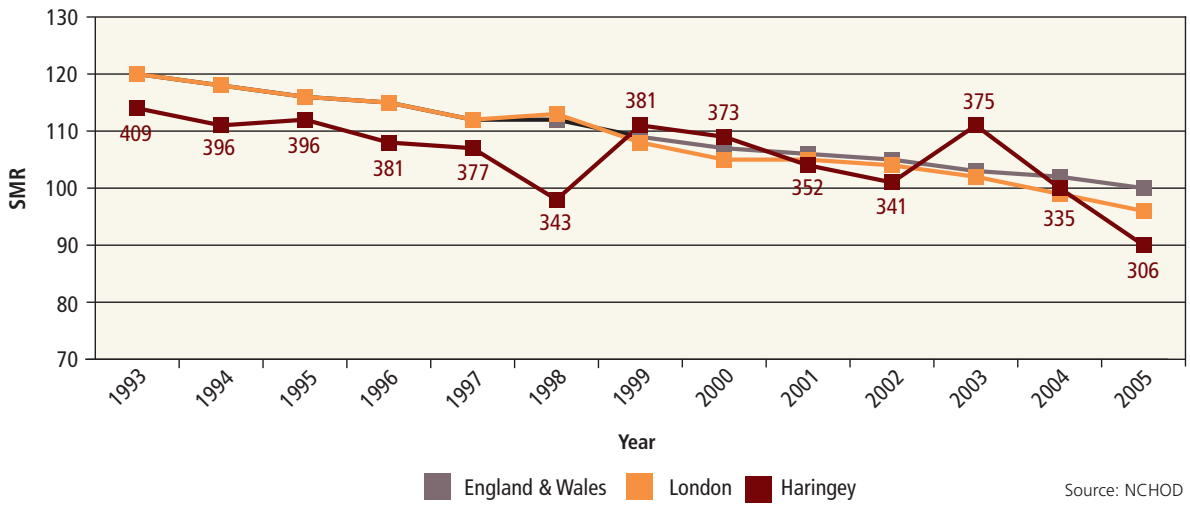
Source: ONS

although between 1998 and 2003 there was an increase. In 2005 cancer accounted for 306 deaths compared to 409 in 1993. Rates in 2005 were lower for women (134 per 100,000) than men (198 per 100,000).

Figure 24 compares the SMRs for Haringey and London with those of England and Wales in 2005. Rates in Haringey were 10% lower in 2005 compared to what would be expected given the age and sex composition of the Haringey population.

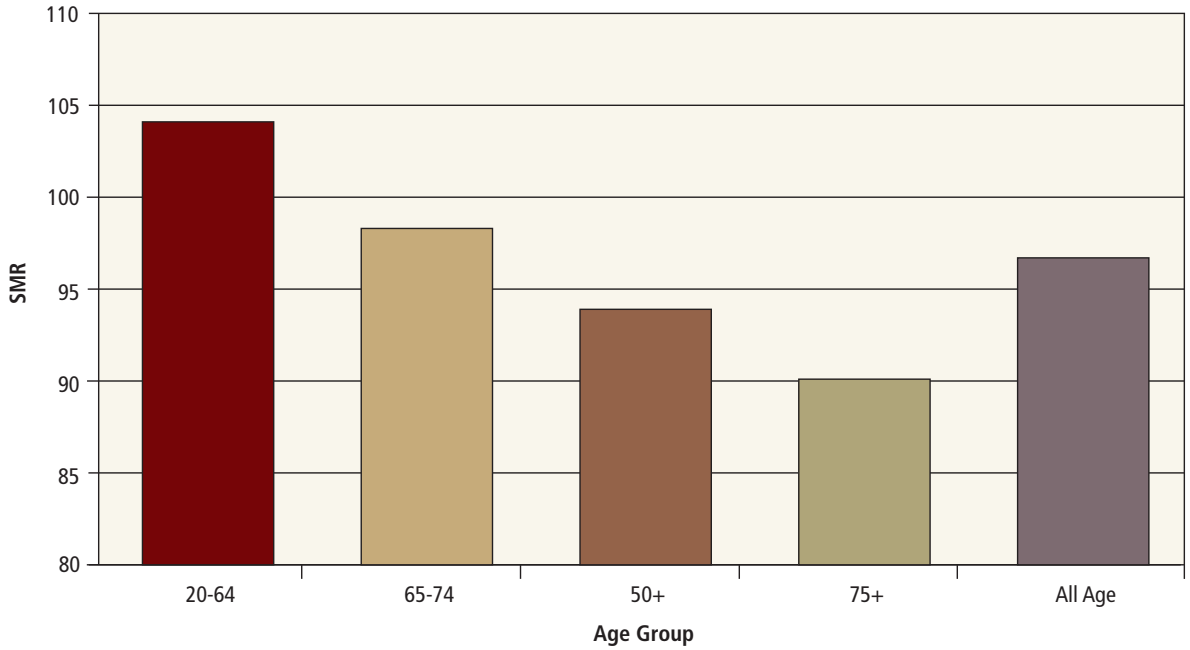
When comparing age groups within Haringey against the England and Wales rate it is clear that the rate of death from cancer was higher amongst the 20-64 age group (SMR =104.1), suggesting that although death rates for cancer are lower than the national average more people are dying in the

Figure 24 *All age cancer SMR (1993-2005)*



Source: NCHOD

Figure 25 *Cancer SMR by age group (2003-2005)*

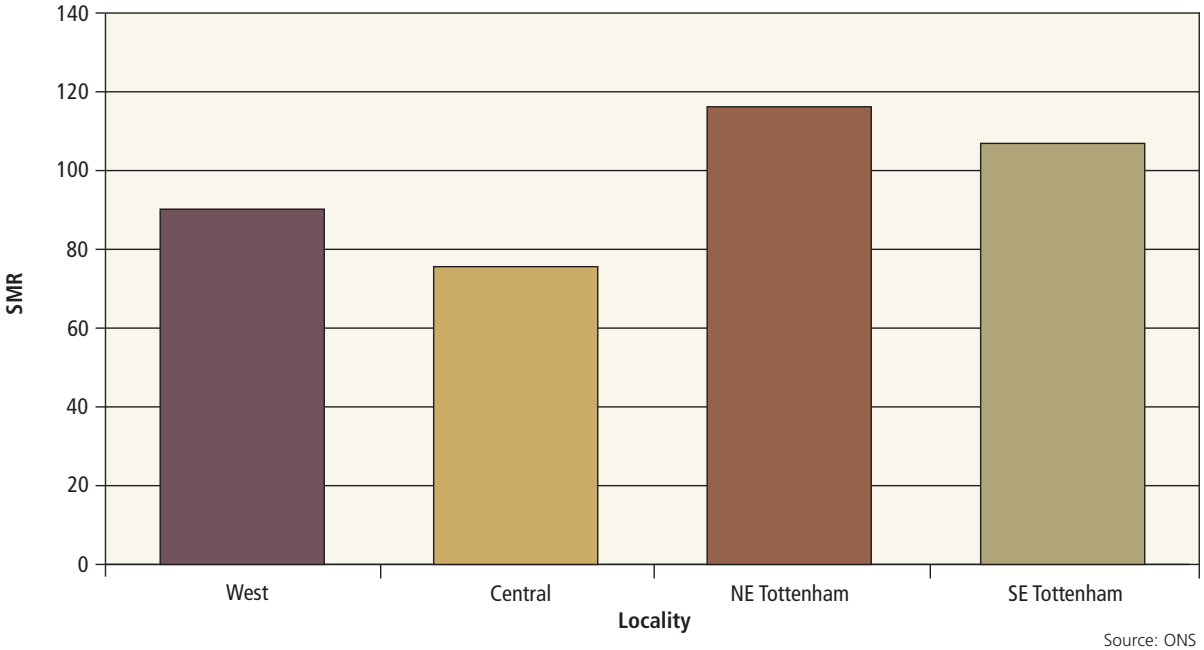


Source: ONS

younger age groups than would be expected. Rates for those aged 65 and over are lower than expected (see figure 25).

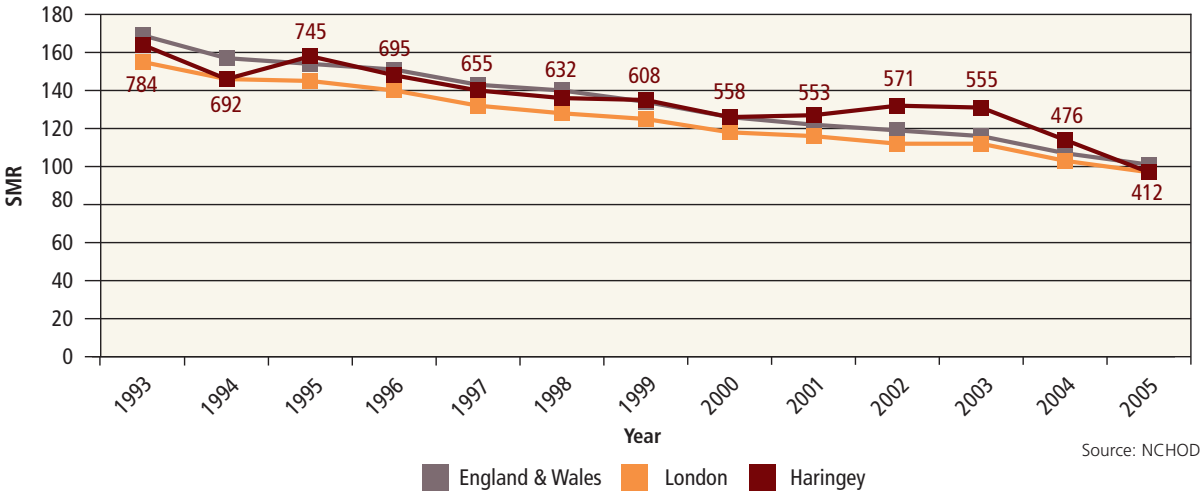
Using the overall England and Wales rate as standard, the rate of death was higher in the eastern more deprived part of the borough, especially in North East Tottenham when compared with other parts of Haringey during the same period. This finding is consistent with previous information about deaths and life expectancy in the east of Haringey (see figure 26).

Figure 26 *All age cancer SMR by locality (2003-2005)*



Source: ONS

Figure 27 All age circulatory disease SMR (1993-2005)



Source: NCHOD

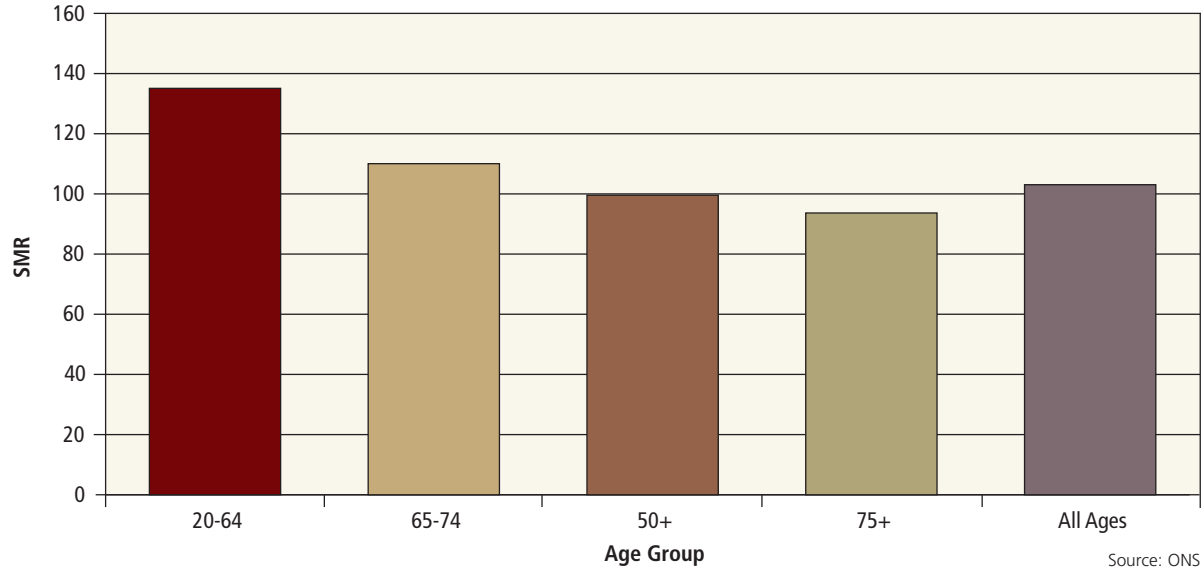
3.8 Circulatory diseases – heart disease and stroke

Diseases of the circulatory system in general relate to problems with the blood vessels that supply the heart (coronary heart disease – CHD), the limbs and organs of the body (blood pressure and peripheral vascular disease) and the brain (stroke).

Between 1993 and 2005 the rate of death from circulatory disease fell from 353 per 100,000 to 200 per 100,000. In 2005 it accounted for 412 deaths compared to 784 in 1993. The rate of death in 2005 amongst all ages is similar to the national picture (207 per 100,000). Rates amongst men in 2005 were double those of females (279 per 100,000 males and 139 per 100,000 females). The SMR chart for circulatory disease (see figure 27) suggests that the death rate in Haringey has tended to be above those of London and England and Wales until recent years when the rate fell below that of both.

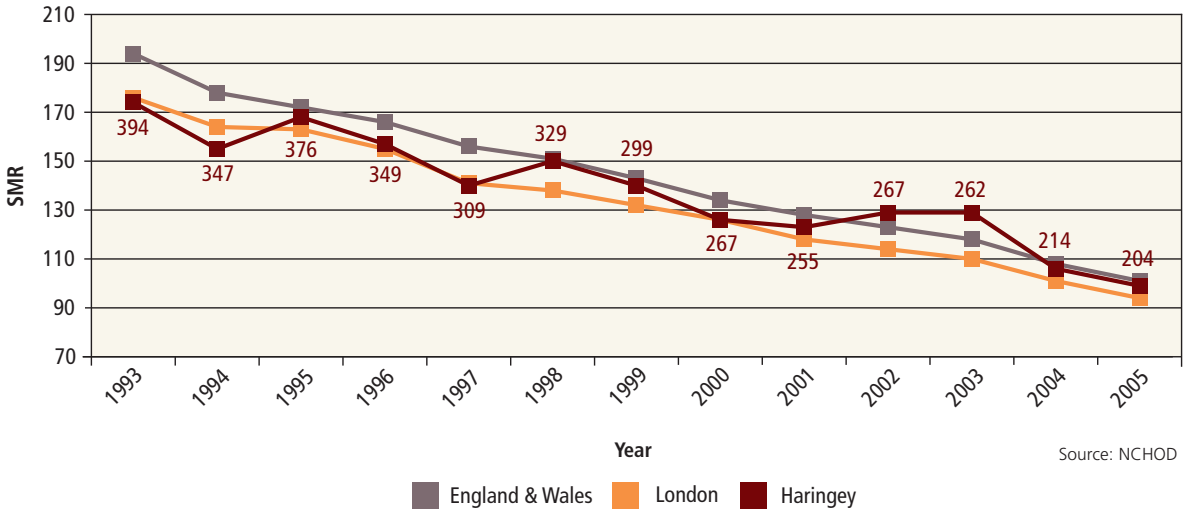
When comparing age groups within Haringey against England and Wales it is clear that the highest rates are among the 20-64 age group where there are 35% more deaths than expected (see figure 28). This suggests that

Figure 28 Circulatory disease SMR by age group (2003-2005)



Source: ONS

Figure 29 All age coronary heart disease SMR (1993-2005)



Source: NCHOD

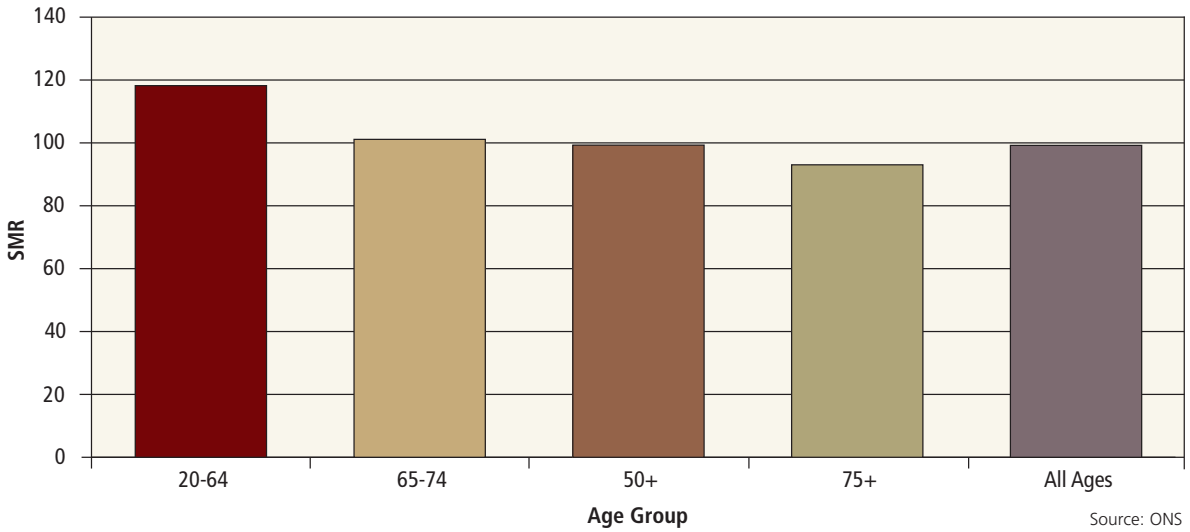
although the rate of disease amongst all age groups is lower than national averages, there is an excess of deaths from circulatory disease among younger age groups. Within the 20-64 age group 49.4% of circulatory disease was accounted for by CHD and a further 5.5% from stroke.

3.9 Coronary heart disease (CHD)

This category of circulatory disease specifically refers to diseases of the heart, problems with its blood vessels and, in particular, heart attack and abnormalities of heart rhythm. The rate of death from coronary heart disease fell from 185 per 100,000 in 1993 to 102 per 100,000 in 2005 (below the England and Wales rate of 103 per 100,000). In 2005 it accounted for 204 deaths. Death rates for CHD have always been lower for females than males and in 2005 the rate for males was 158 per 100,000 compared with 59 per 100,000 for females. Figure 29 compares SMRs for Haringey with those of England and Wales. It shows the general downward trend in rates and shows how these have been mirrored nationally.

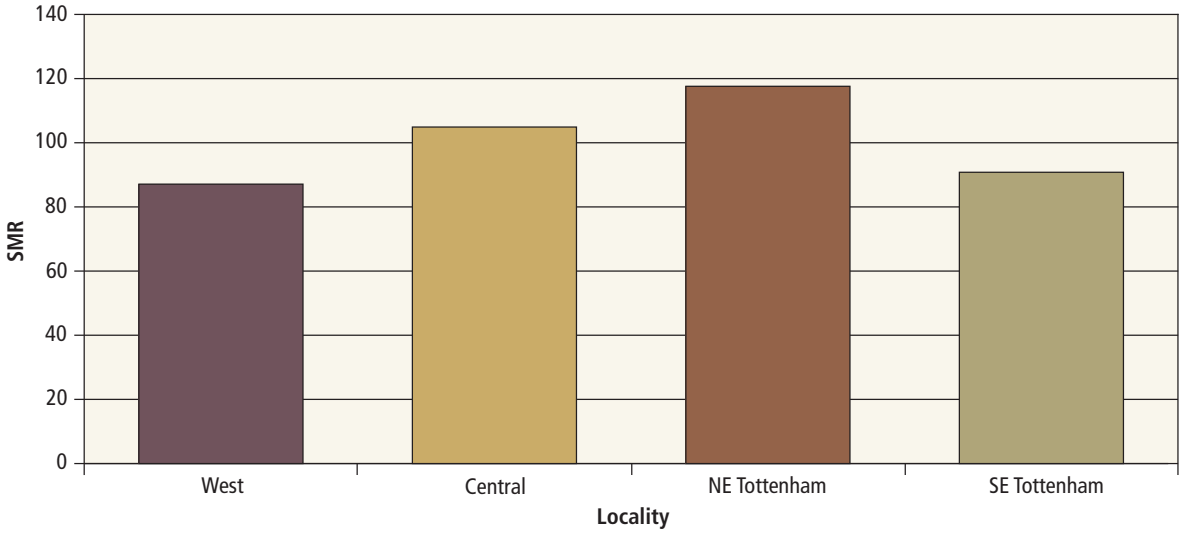
A comparison of SMRs by age groups for Haringey residents suggests that there are higher rates of CHD mortality among the 20-64 age group than expected. This suggests that more people are dying from CHD in younger years than are nationally.

Figure 30 Coronary heart disease SMR by age group (2003-2005)



Source: ONS

Figure 31 *All age coronary heart disease SMR by locality (2003-2005)*



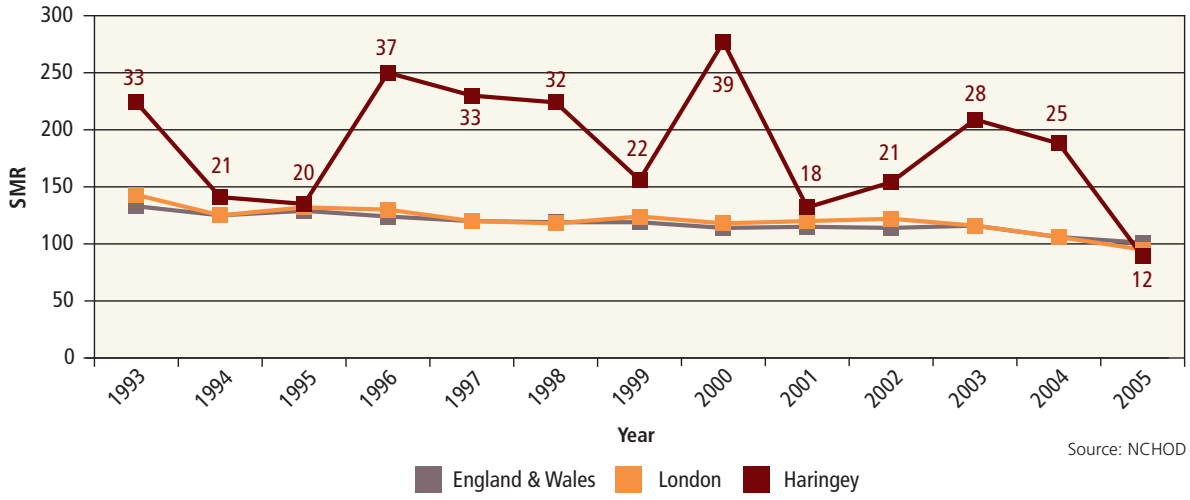
Source: ONS

Within Haringey, the western part of the borough and South East Tottenham appear to have relatively low death rates from coronary heart disease whilst there are higher rates in North East Tottenham and the central part of the borough when compared to England and Wales between 2003 and 2005 (see figure 31).

3.10 Diabetes

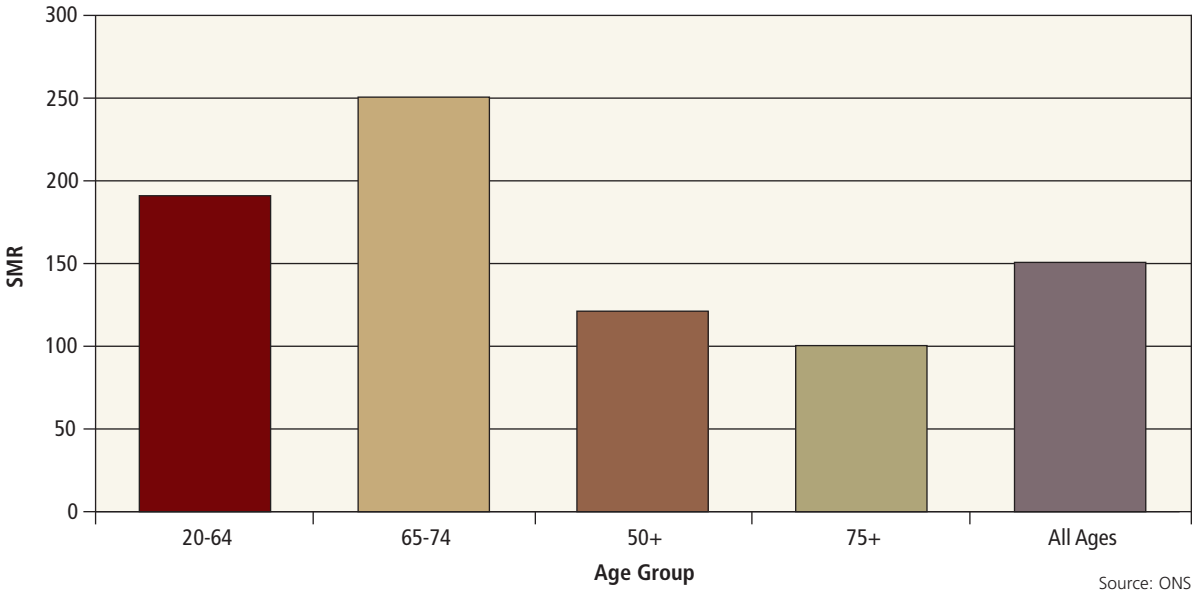
Diabetes is a disorder whereby the body has difficulty handling and metabolising sugar. Two types exist, Type I and Type II. Type II is a much more common disorder and the prevalence rate is increasing every year. It is particularly linked with dietary habits and obesity and also tends to run in families. The death rate from the complications of diabetes in Haringey has remained above that of England and Wales since 1993 falling from 16.6 per 100,000 in 1993 to 5.6 per 100,000 in 2005. A total of 12 people died from diabetes in Haringey in 2005, compared to 28 and 25 in 2003 and 2004 respectively (see figure 32). It is this fluctuation in the small number of deaths that explain the variation in the SMR when compared to England and Wales.

Figure 32 *All age diabetes SMR (1993-2005)*



Source: NCHOD

Figure 33 Diabetes SMR by age group (2003-2005)



Source: ONS

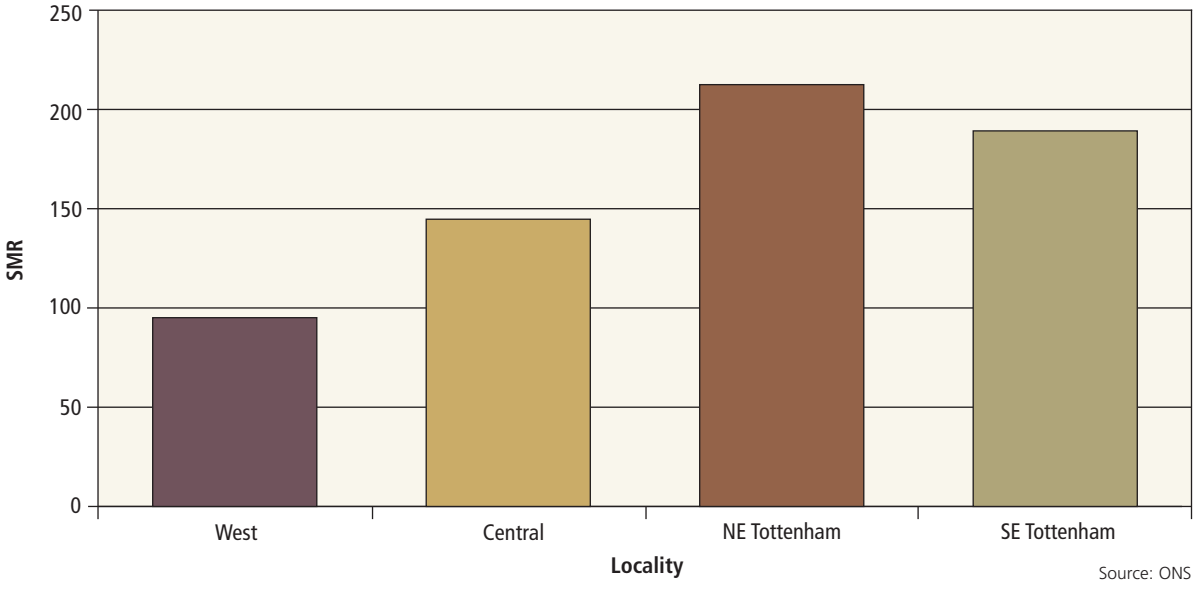
Between 2003 and 2005, a total of 65 deaths from diabetes were recorded in Haringey. The highest rate of death was in the age group 65-74 years while the lowest was among those 75 and above (see figure 33).

The eastern part of the borough appears to have higher mortality rates than the west and central areas (see figure 34) although it should be remembered that the differences may be an artefact due to small numbers of deaths due to this cause. See sections 5.9 and 6.5 for more details about admissions for diabetes and control of the disease in primary care.

3.11 Respiratory disease – disease of the breathing system

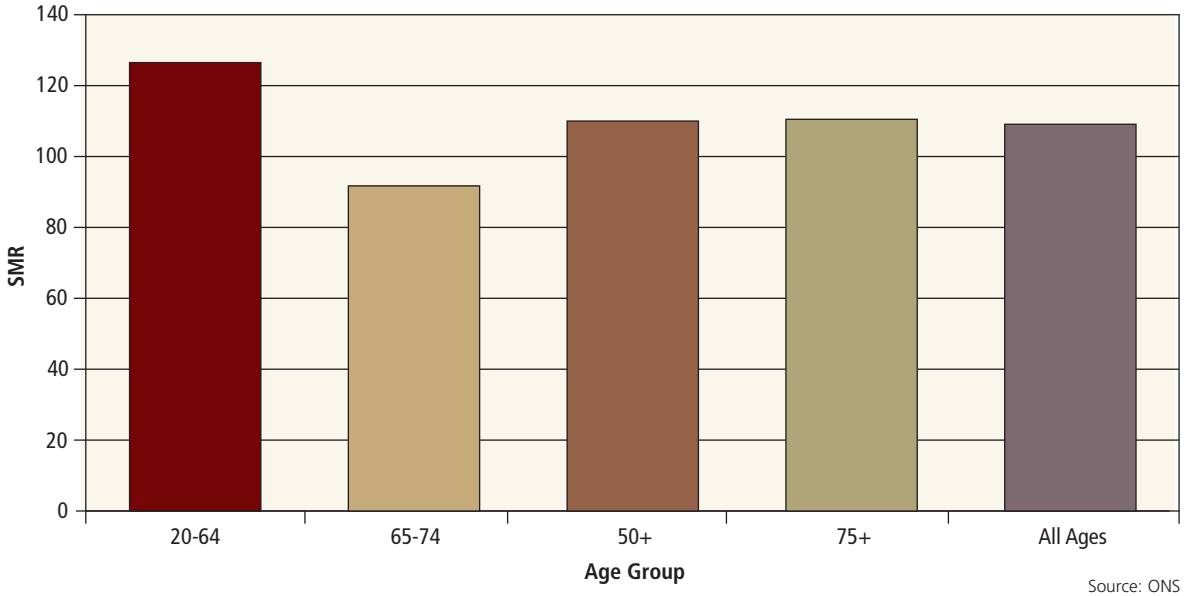
Respiratory disease describes conditions that relate to breathing and include chronic obstructive pulmonary disease (COPD), asthma and pneumonia. Compared to England and Wales the death rate from respiratory diseases between 2003 and 2005

Figure 34 All age diabetes SMR by locality (2003-2005)



Source: ONS

Figure 35 *Respiratory disease SMR by age group (2003-2005)*



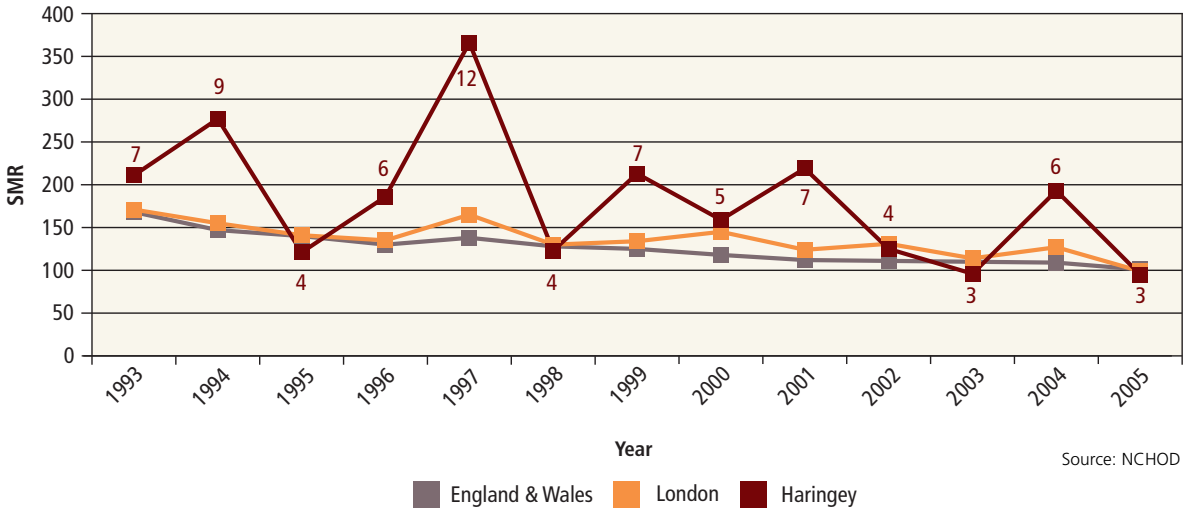
Source: ONS

for all ages was higher than the national picture, accounting for 10% more deaths than expected (see figure 35). This is the case amongst most of the age groups but rates are considerably higher amongst the 20-64 age group.

The SMR for asthma has followed a fluctuating but downward trend since 1993 due to small numbers. Therefore it is difficult to make meaningful comparisons with either London or England and Wales. These small numbers explain why the line for Haringey in figure 36 fluctuates considerably. However, for the most part of the period between 1993 and 2005 the Haringey SMR was higher than the national average (see figure 36).

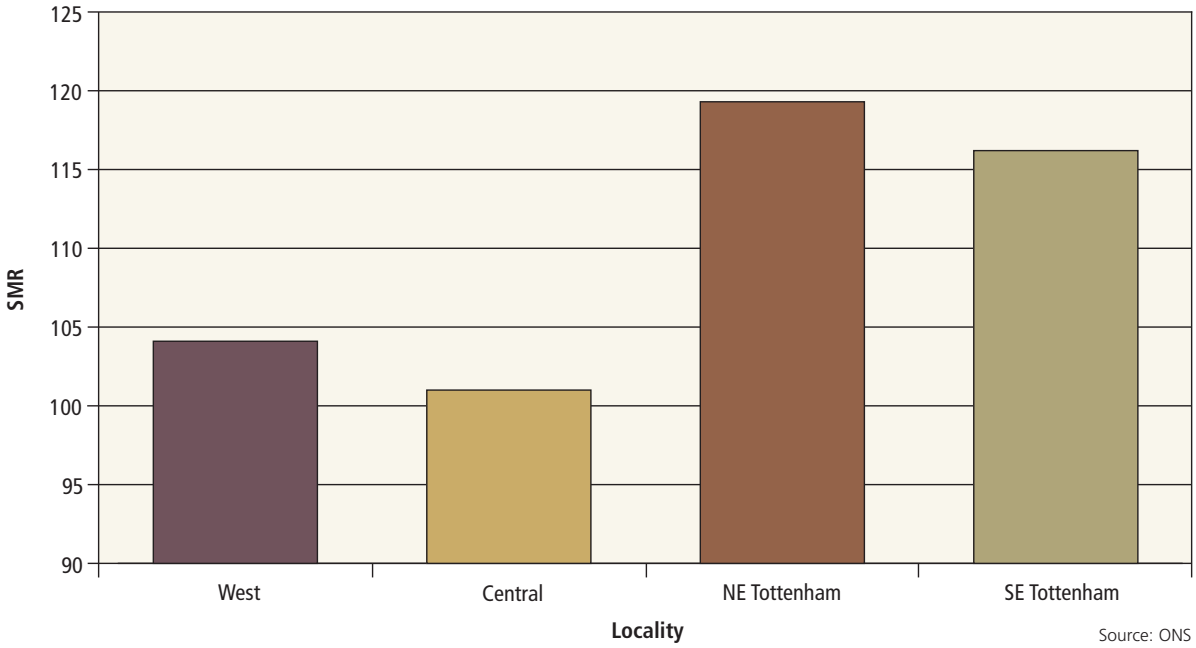
Between 2003 and 2005 respiratory disease attributed more than expected deaths in all parts of Haringey. However, the death rates were higher in the eastern part of the borough than both the central and west (see figure 37).

Figure 36 *All age asthma SMR (1993-2005)*



Source: NCHOD

Figure 37 *All age respiratory disease SMR by locality (2003-2005)*



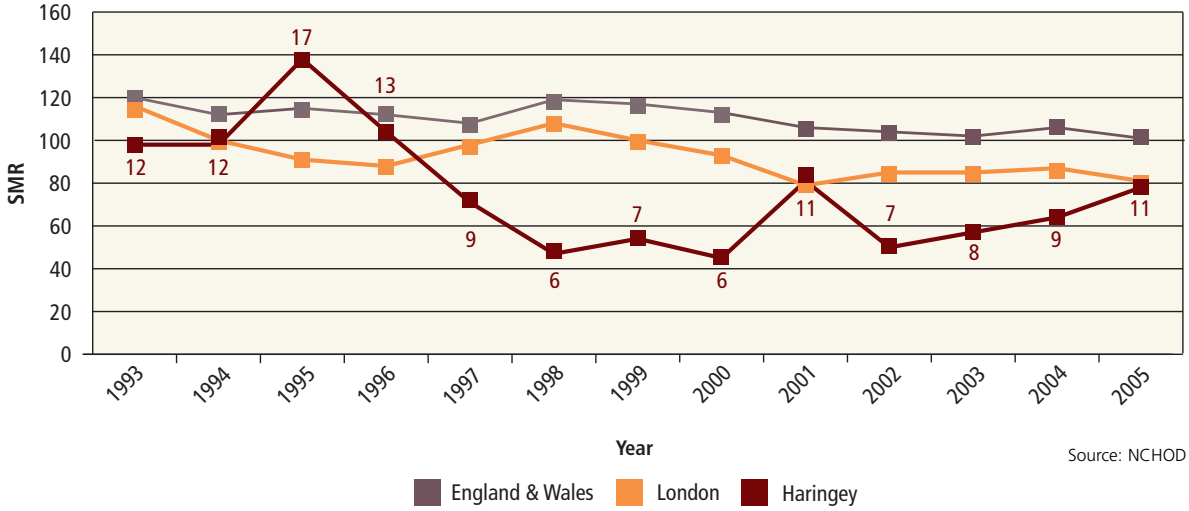
Source: ONS

3.12 Suicide

The suicide rate among all age groups in Haringey has followed a fluctuating pattern between 1993 and 2005 when compared to England and Wales. The number committing suicide is relatively small hence the year on year fluctuations might be expected (see figure 38). The number of suicides per year ranges from 17 in 1995 to 6 in 1998 and 2000. In 2005, of the 11 suicides men committed 10.

The suicide rate was slightly lower (SMR= 93.0) than recorded for England and Wales (SMR= 100.0) for the period between 2003 and 2005.

Figure 38 *All age suicide SMR (1993-2005)*



Source: NCHOD

3.13 Conclusions – Deaths in Haringey

- The Standardised Mortality Ratio for all causes and all age groups in Haringey is improving compared with the national average.
- The eastern part of the borough has higher death rates than the west.
- Compared to the national average mortality is high in the 20-64 year old age group, reducing life expectancy for the population.
- Deaths from cancer are reducing in Haringey. However cancer deaths are higher in the age groups 20-64 compared with the national average and are highest in the eastern part of the borough.
- Deaths from circulatory diseases have decreased since 1993 but within Haringey, rates of death from coronary heart disease are highest in North East Tottenham.
- Rates of death from diabetes have been higher in Haringey than England and Wales but there appears to have been an improvement since 2003.
- The suicide rate has decreased since 1996 but appears to be increasing.
- Rates of death from respiratory diseases were slightly higher than that of England and Wales between 2003 and 2005, and within Haringey higher rates were recorded in the east.
- The life expectancy action plan outlines priorities to reduce premature mortality in Haringey.

4 Children and young people

Written by Sheena Carr and Catherine Kirk

Growing up in Haringey

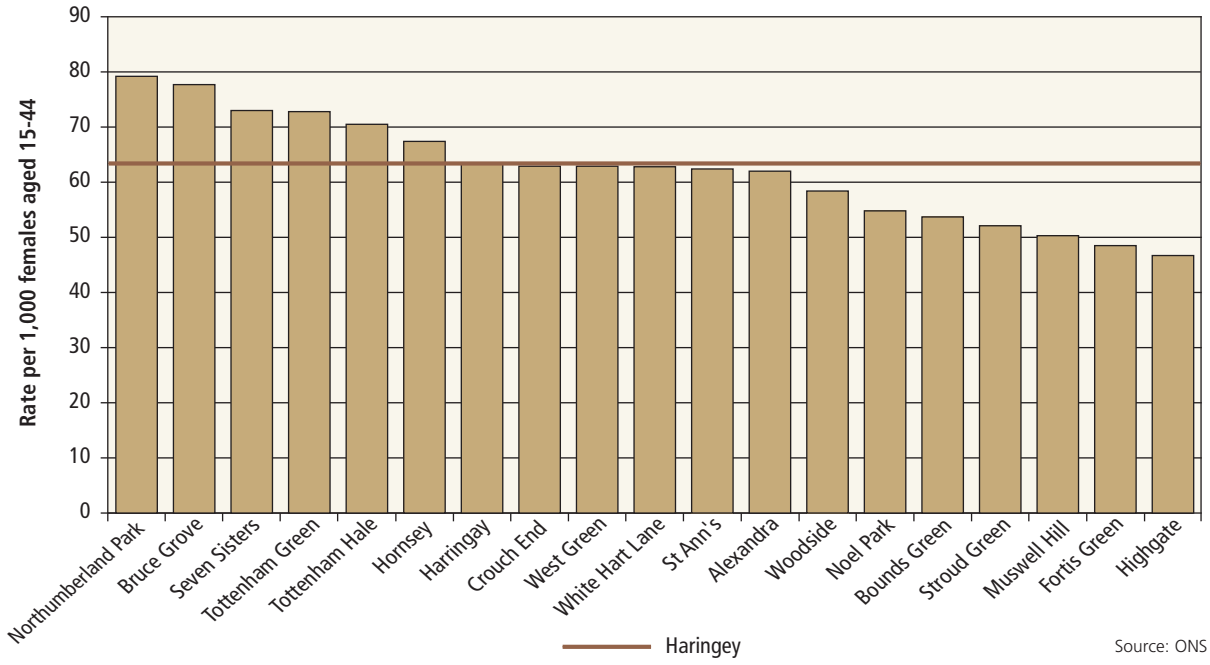
- In 2005 the Haringey Health Report focussed on the health of children and included a detailed profile of their needs and the determinants of health. The following chapter is an update on key areas since the 2005 report.

4.1 Births

In 2005, there were 4,047 babies born to women living in Haringey (3,970 pregnancies). Of these births 5.8% were to women in the 40-44 age group. Haringey has a high and increasing fertility rate at 69.1 per 1,000 women aged 15-44. This has increased from 65.6 in 2003. Over the same period, the rate for London has increased from 61.2 in 2003 to 63.8 in 2005 and the rate for England and Wales has increased from 57 in 2003 to 58.5 in 2005.

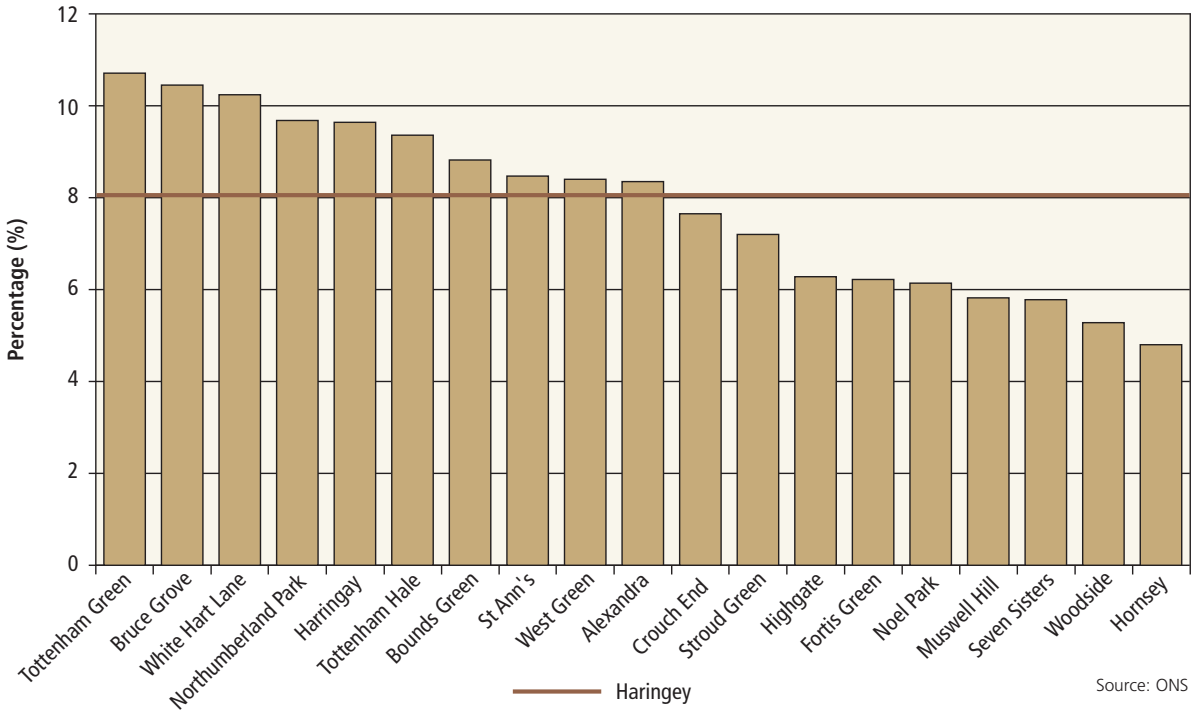
Analysis over a three year period (2003-2005) at a local level shows that the fertility rate varies across the borough, from 79.2 in Northumberland Park to 46.7 in Highgate (see figure 39). Overall, the fertility rate is

Figure 39 *Birth rate per 1,000 females aged 15-44 (2003-2005)*



Source: ONS

Figure 40 Low birth weight by ward (2003-2005)



Source: ONS

higher in wards in the east of the borough. This will have implications for future planning of services for children.

4.2 Birth weight

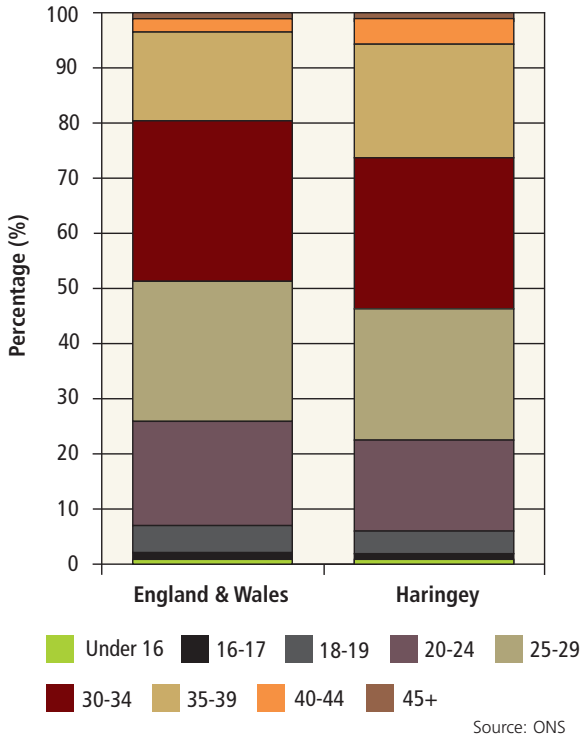
Children who are born weighing less than 2,500 grams are defined as having a low birth weight. Low birth weight is used as an indicator of poorer maternal health and risk of perinatal and infant deaths (deaths under 1 year). It has also been linked with a range of health problems in later life.

Low birth weight is associated with age, smoking, problems with the pregnancy, premature babies, poverty and deprivation. In 2005 8.4% (317) of children were born with a low birth weight of which 0.9% (34) had a very low birth weight (defined as weighing under 1,500 grams). Of the 317, 16 were stillborn and 10 of these weighed under 1,000 grams. The low birth weight rate in Haringey for 2005 was higher than that of England and Wales (7.9%).
Local analysis over a three year period shows that there is variation in low birth weight across the borough. Over 10% of babies born with a low birth weight were in Tottenham Green, Bruce Grove and White Hart Lane (see figure 40). Other than these wards, there was no clear distinction between the east and the west of the borough. This highlights the need for work across Haringey in terms of reducing the risk factors for low birth weight.

4.3 Maternal age

Figure 41 compares the distribution of maternal age between Haringey and England and Wales. Haringey has a higher proportion of births to women in the 35-39 and 40-44 age groups than England and Wales. There is a higher risk of complications in pregnancies to older women with consequent increased risk to their babies.

Figure 41 *Maternal age: Comparison of Haringey with England and Wales (2005)*



Source: ONS

4.4 Deaths in infancy and childhood

In 2005, there were 52 deaths among those aged between 0 and 24. Of these, 31 were deaths in children aged under 1 year.

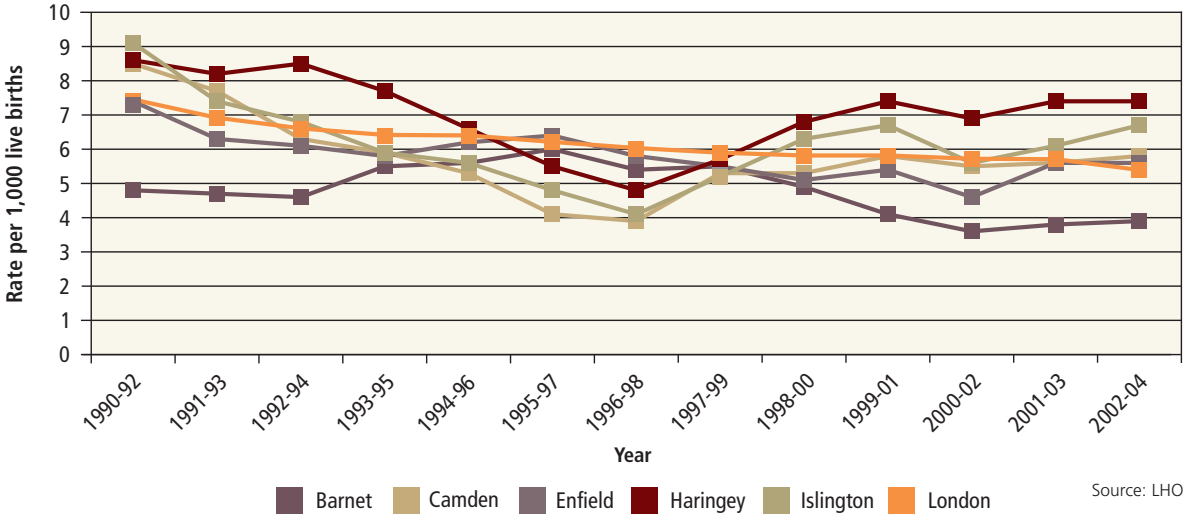
4.4.1 Infant mortality

Infant mortality rates describe the deaths of infants in the first year of life. The rate is the number of live newborns dying under 1 year, per one thousand live births. Figure 42 highlights the trend in Infant Mortality rates for the North Central PCTs and London. Although there was a dip in the mid 1990s, the rate in Haringey has consistently been above that of London and its North London neighbours. It is important to note that as the number of deaths in infancy each year is small there is likely to be some year on year fluctuations that could affect the rate. Nevertheless the Haringey rate continues to be significantly above the London average and is therefore a cause for concern.

The infant mortality rate for Haringey in 2005 was 7.7 per 1,000 live births up from 5.4 in 2003. There was also an increase in the neonatal death rate in 2005, 5.2 compared to 3.8 in 2003. However, the perinatal death rate (stillbirths and deaths in the first 7 days) decreased from 11.4 in 2003 to 9.4 in 2005. This means that more babies are surviving into the neonatal period but higher neonatal death rates may reflect the work to keep very fragile babies alive past the immediate birth but without the success of survival beyond the neonatal period.

For all of the relevant early years death rates Haringey's are higher than the national

Figure 42 *Infant mortality rates across North Central London (1990-2004)*



Source: LHO

Table 7 *Comparison of early years death rates by sex and area (2005)*

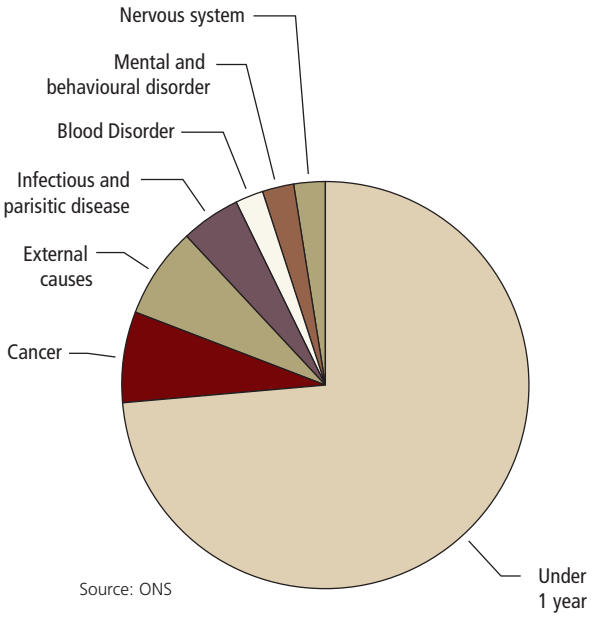
	Haringey			London	England
	Boys	Girls	All		
Live Births	2,032	1,994	4,026		
All Births	2,041	2,006	4,047		
Perinatal death rate (Stillbirths & Infant deaths under 7 days per 1,000 total births)	10.3 (21)	8.5 (17)	9.4 (38)	8.5	8.0
Neonatal death rate (infant deaths under 28 days per 1,000 live births)	7.4 (15)	3.0 (6)	5.2 (21)	3.4	3.4
Infant death rate (Infant deaths under 52 weeks per 1,000 live births)	10.3 (21)	5.0 (10)	7.7 (31)	5.1	5.0

Source: ONS

average (see table 7). The death rates are higher in male babies and infants, although this pattern of high vulnerability is reflected nationally and also is the beginning of the trend whereby a greater proportion of males die than females at all ages.

Analysis over a 3 year period shows that the Infant Mortality rate is higher in wards in the east of Haringey. However, as the numbers are small it is not possible to ascertain a clear pattern across the borough.

Figure 43 *Causes of death amongst under 0-19 year olds (2005)*



Source: ONS

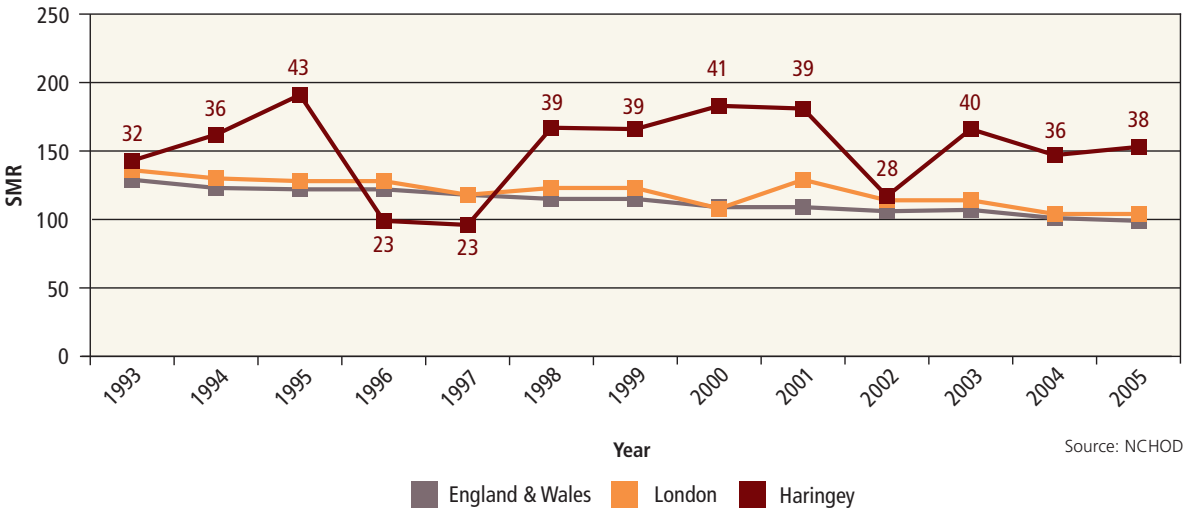
4.4.2 Deaths amongst young people

There were 42 deaths in the 0-19 year old age group in Haringey in 2005. 73% of the deaths in this age group were during the first year of life. Of the remaining 11 deaths, 3 were due to external causes of mortality and morbidity, such as accidents; 1 was due to disease of the nervous system; 3 cancer; 2 infectious/parasitic disease; 1 disease of the blood and 1 due to a mental or behavioural disorder.

There were 38 deaths amongst under 15's in 2005. Standardised Mortality Ratios suggest that this is a higher number than expected, compared to England and Wales. However, the numbers are small and therefore it is difficult to draw firm conclusions around the difference though the ratio has widened since 2004. An additional 1 or 2 deaths could explain this widening (see figure 44).

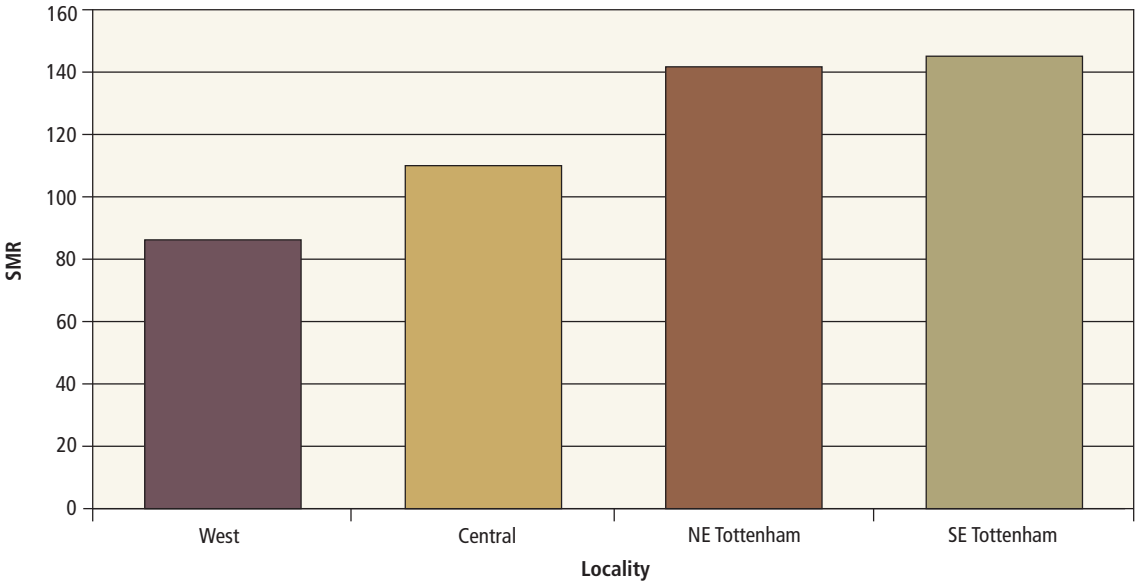
While the overall rate of death amongst young people in Haringey varies from year to year, it is notable that there is a higher death rate amongst young people in the east of the borough compared with the west (see figure 45). This reflects the higher deprivation in the east, leading to increased risks of death from pregnancy onwards through every stage of youth.

Figure 44 All cause mortality SMR for under 15's (1993-2005)



Source: NCHOD

Figure 45 All cause SMR for 00-19 year olds (2003-2005)



Source: ONS

4.5 Young people and illness leading to hospital care

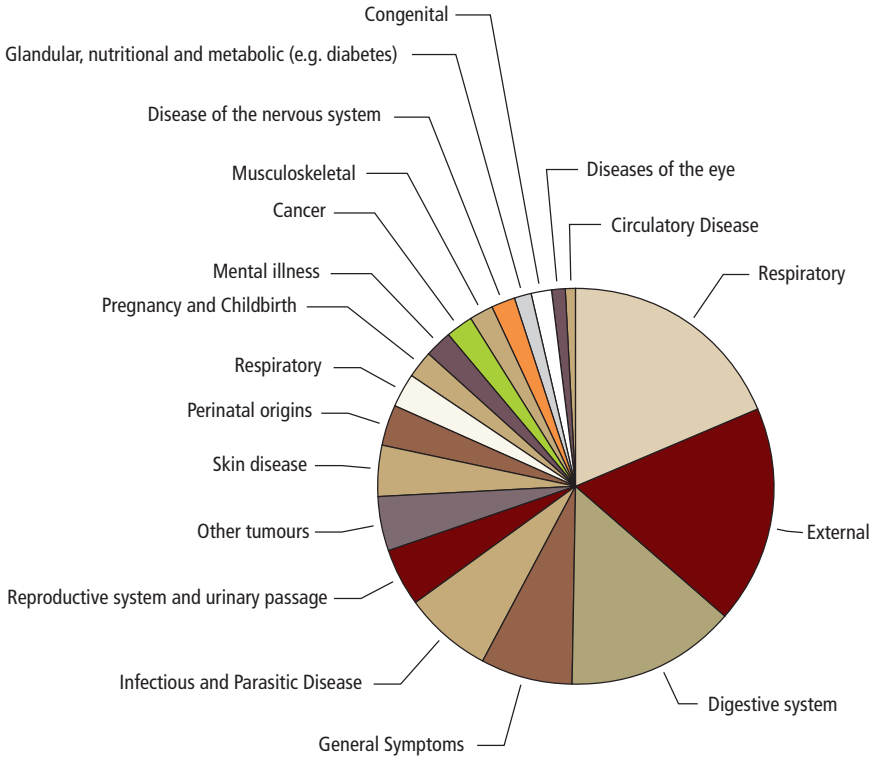
Not all health care for young people is provided through hospitals; an admission to hospital is usually an indication of significant and usually acute illness. Between 2003 and 2005 there were a total of 14,597 admissions of Haringey young people to hospital. Of these, 51.4% were emergency admissions.

4.5.1 Emergency care

Figure 46 describes the causes of emergency admission in Haringey. Respiratory disease, external causes (which include accidents, injury and self harm) and diseases of the digestive system make up 50% of all emergency admission.

The rate of emergency admission to hospital varies considerably with age. The highest emergency admission rate across Haringey amongst young people was for the 0-4 age group, with a rate of 7,600 per 100,000 compared with 2,875 per 100,000 for 5-9

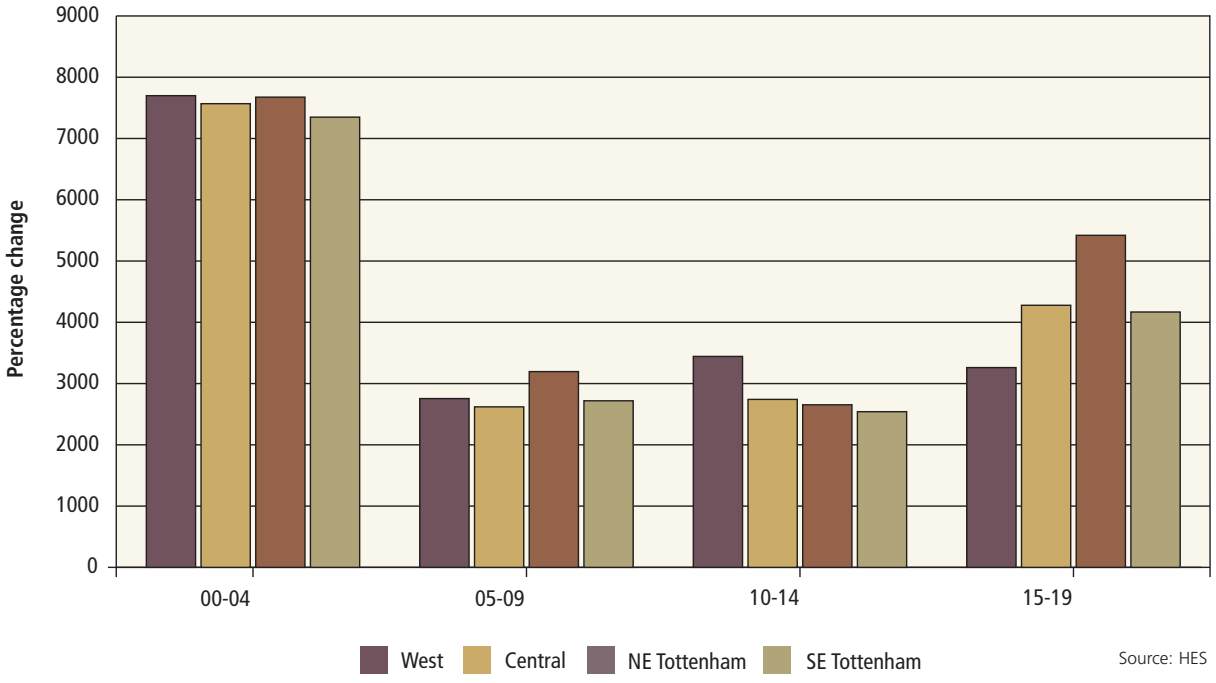
Figure 46 *Causes of emergency admissions to hospitals for under 19s (2003/04-2005/06)*



Source: HES

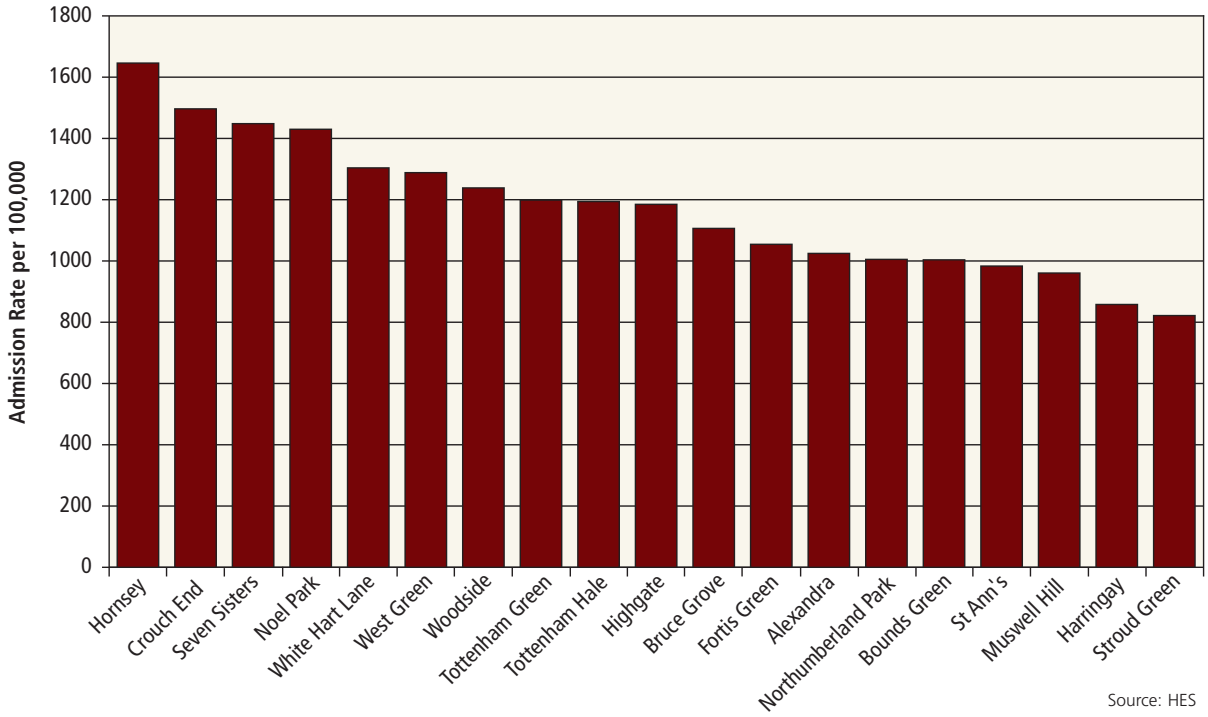
year olds, 2,871 for 10-14s and 4,380 for 15-19 year olds. Rates are similar across Haringey localities (see figure 47) in the 0-4 and 5-9 age groups. In the 10-14 age group there are higher admissions in the west and in the 15-19 age group rates were highest in North East Tottenham.

Figure 47 *Emergency admission rates by age and locality (2003/04-2005/06)*



Source: HES

Figure 48 Respiratory emergency admission rates (2003/04-2005/06)



Source: HES

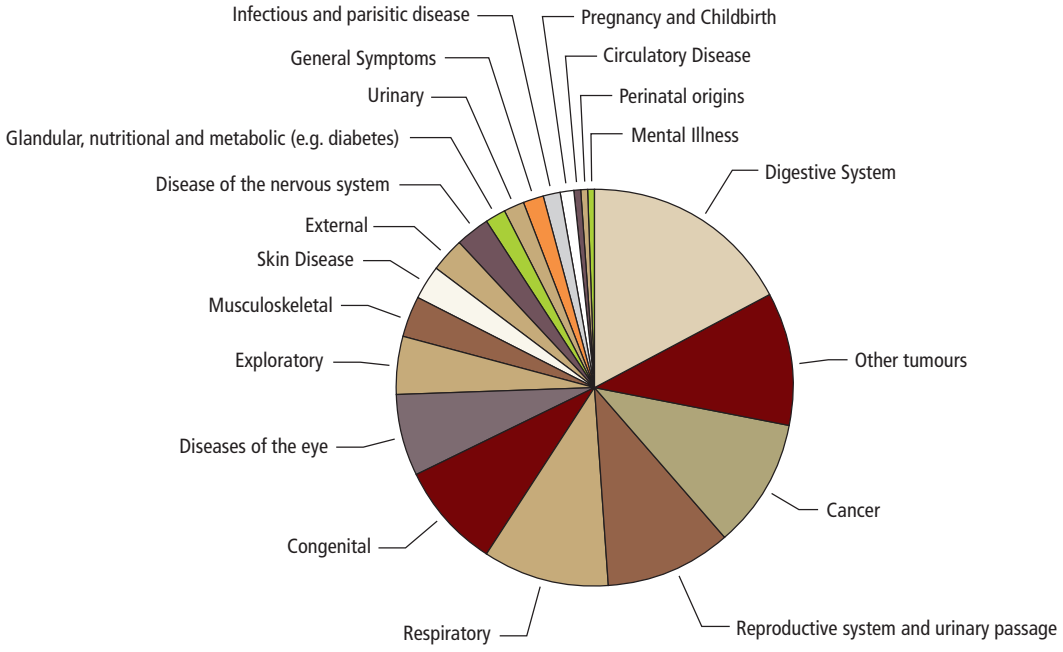
The main cause of emergency admission was for respiratory problems, with the highest rates seen in Hornsey and Crouch End (see figure 48).

4.5.2 Elective care (planned)

Figure 49 describes the causes of elective admissions. Diseases of the digestive system, other tumours, cancer and genito-urinary causes make up 50% of all elective admissions

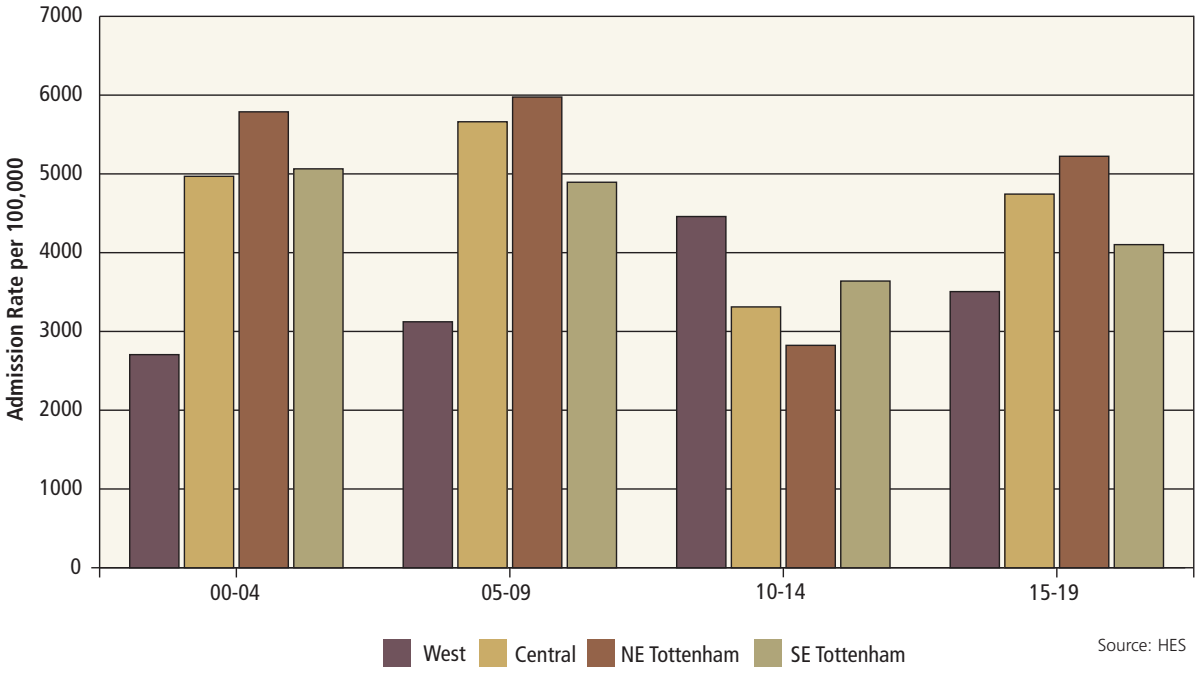
Elective admissions are similar across age bands. However there is a marked variation between areas within Haringey. The highest rates of admissions are in North East

Figure 49 Causes of elective admissions to hospitals for under 19s (2003/04-2005/06)



Source: HES

Figure 50 *Elective admission rates by age and locality (2003/04-2005/06)*



Source: HES

Tottenham except for the 10-14 year old age group where the west of the borough has the highest rates (see figure 50).

4.6 Immunisations

As with many other London boroughs that use the Child Health Surveillance System (CHIA), we have been unable to provide up to date immunisation rates to the Health Protection Agency due to problems with the system. This is an ongoing problem which remains outside of the control of the TPCT due to the nature of the centralised commissioning of IT systems in the NHS.

The latest immunisation figures were presented in the 2005 Annual Public Health Report and these will be updated as soon as the information is available.

There is reason to believe that the immunisation rates in Haringey are falling even further (Haringey and London immunisation rates are lower than national rates and targets) as a neighbouring PCT with the same IT problem has conducted an audit to estimate which showed that uptake rates have fallen significantly. For details of the immunisation schedule see the 2005 Annual Public Health Report.

4.7 Infectious diseases

In 2004 and 2005, there were 196 notifications of infectious disease amongst under 19s in Haringey (see table 8).

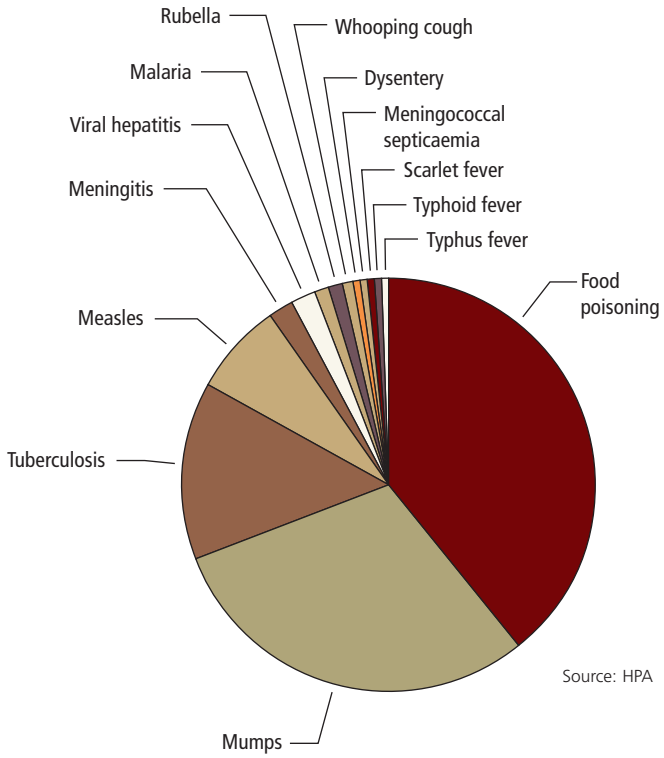
It is interesting to note that of the 59 cases of mumps, 51 were in 2005 and 8 in 2004. The highest number of cases were in the 14

Table 8 *Infectious disease notifications (2004-2005)*

Food poisoning	77
Mumps	59
TB	27
Measles	14

Source: HPA

Figure 51 *Infectious disease notifications for ages 0-19 years (2004-2005)*



year old age group, representing an outbreak in Haringey similar to what happened across the country. This was because young people who were not immunised against mumps as part of the MMR vaccine and not exposed to mumps in childhood were very susceptible to the rapid spread of the infection. It is likely that such outbreaks will occur again unless immunisation with MMR is maintained at a high level.

4.8 Childhood obesity

4.8.1 National focus on obesity

National estimates predict that if levels of overweight and obese children continue to rise as they have in the past 10 years, by 2010 nearly 1 in 5 children will be classified as obese[5]. This represents a real threat to the health of young people and young adults as obesity in turn leads to complications such as heart disease, diabetes, joint problems and emotional problems.

As part of a joint national campaign between the Department of Health and the Department of Education, every borough across the country is required to annually collect height and weight data of all children in maintained schools. School nurses across Haringey visited every primary school during the 2006 summer term to collect information from all children in Reception class (4-5 year olds) and Year 6 (10-11 year olds).

4.8.2 Haringey children, age and obesity

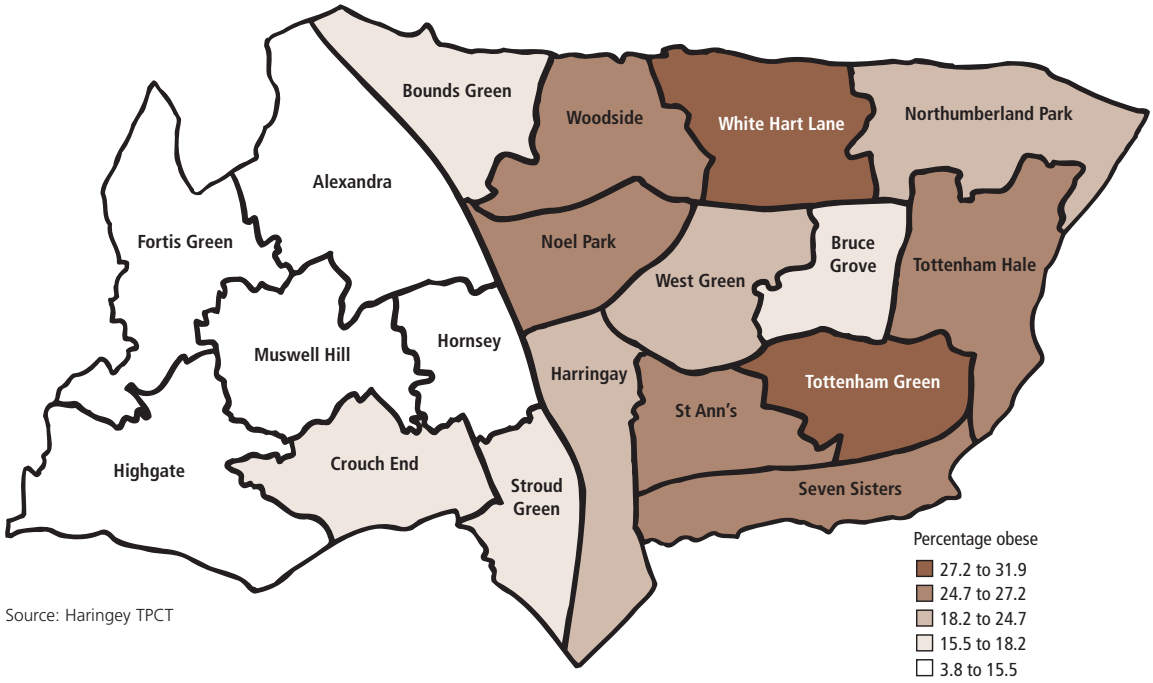
In 2006 average figures across Haringey indicate that 15% of children were obese and a further 15% overweight. However data from individual year groups and between genders reveals large differences between groups. Levels of obesity for 10-11 year olds (Year 6) indicate that over one third of children in this age group are either overweight or obese, compared to one quarter in reception year. These figures are currently above the national predicted levels for 2010. Overall, levels of children who are overweight or obese are higher in boys than girls, with particularly pronounced differences in levels of obese boys and girls in reception year (see table 9).

Table 9 *Percentage of children in Reception and Year 6 who are overweight or obese (2006)*

		Year R			Year 6	
	Girls	Boys	Total (YrR)	Girls	Boys	Total (Yr6)
Overweight	13%	12%	13%	14%	16%	15%
Obese	9%	13%	11%	20%	23%	22%
Total	22%	25%	24%	35%	39%	37%

Source: Haringey TPCT

Figure 52 *Percentage of obese year 6 children by ward (June 2006)*



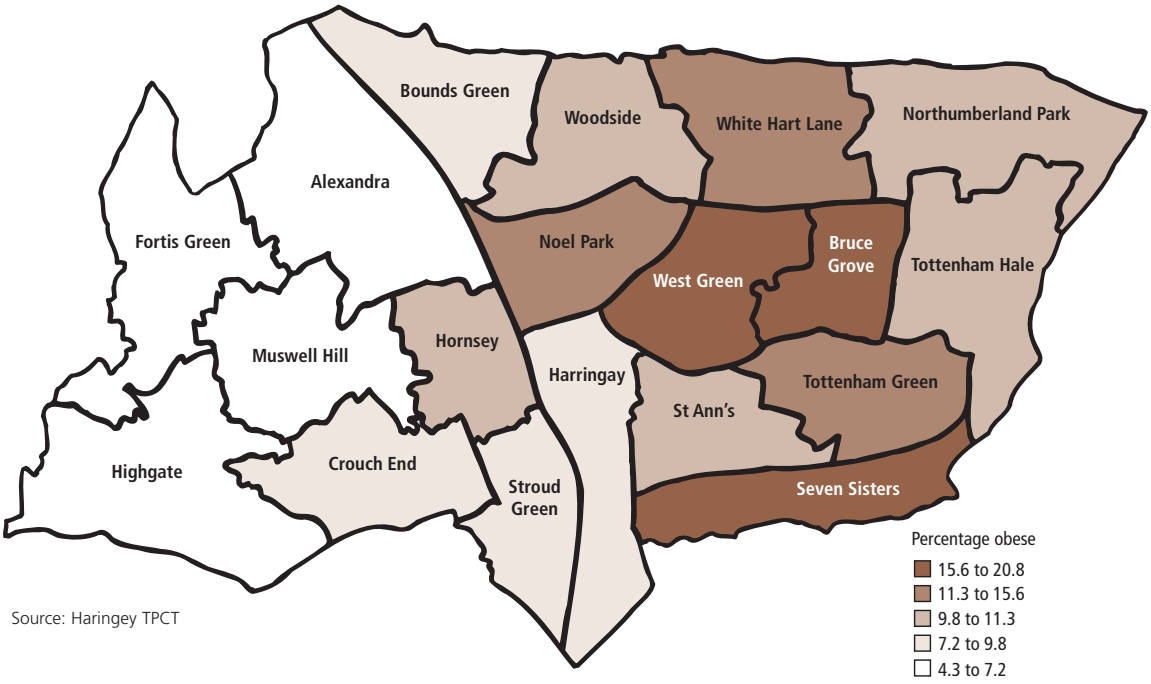
Source: Haringey TPCT

There is also large variation between wards, with higher levels of overweight and obesity in the east of the borough (see figures 52 and 53).

4.8.3 Haringey children, ethnicity and obesity

Analysis of levels of obesity by ethnicity indicated large differences between ethnic groups. The percentage of White British children classified as obese in Year 6 was almost half the percentage of other ethnic groups, particularly Asian or Asian British and Black or Black British where 25% of 10-11 year olds were obese, compared to 11% of White British.

Figure 53 *Percentage of obese reception class children by ward (June 2006)*



Source: Haringey TPCT

Table 10 *Levels of obesity in Haringey and nationally (2006)*

	Haringey	Nationally
Year R	10.96%	10%
Year 6	21.62%	17.3%

Source: Haringey TPCT

For children in Reception year, those classified as White Other (i.e. Turkish, Greek, Polish, Irish) had the highest levels of obesity at 15%, in comparison to White British at 5%, with other ethnic groups being around 10%.

4.8.4 Local levels of obesity in comparison to national data

The data describing obesity levels were collected as part of a national programme and data has been collated from across the country in order to get an accurate picture of levels of childhood obesity (see table 10).

Obesity levels for Reception Year were similar to the national average, however levels in Year 6 were higher than the national average.

These national figures are slightly lower than previous estimates from the Health Survey for England, however this may be due to overall low response rates. The differences in ethnic mix across the borough could explain higher levels of obesity.

4.9 Conclusions – Children and young people

- Infant mortality is a very significant concern for Haringey with higher rates than most other parts of London.
- Some risk factors for infant mortality in Haringey include a greater proportion of low birth weight babies and a higher than average number of older mothers.
- Admission rates to hospital for Haringey children vary with the highest rates being seen in those aged under 5 and a slightly greater proportion from North East Tottenham.
- Obesity is a major risk factor for the future health of Haringey school children. Those in Year 6 especially have much higher rates than the national average, with a greater proportion of overweight and obese children living in the east of the borough.

5 Adults and illness leading to hospital care

Written by Juliet Jensen

5.1 Measuring illness in Haringey

Health services in this country include NHS primary care, community and hospital services as well as those in the independent sector. There are no local data on the reasons why people consult their GP, use community services or the independent sector.

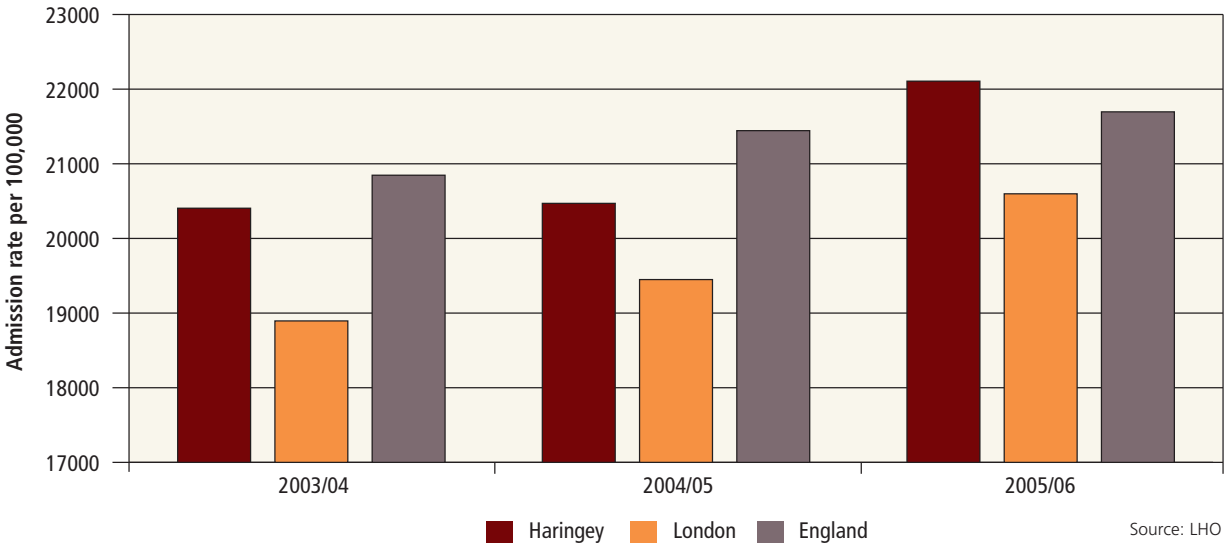
However, illness and health service use is one indicator of morbidity and health care need. Thresholds for accessing care influence access to health services. These thresholds are in turn affected by how people go about seeking help for health problems, how health care professionals (e.g. GPs) respond to patients when they make decisions about treatment and the availability of different types of health care in the area.

Most of this chapter will describe data on use of NHS hospital services over time, by particular area, and for particular conditions. It will be complemented by data from GP disease registers. The disease registers in primary care have enabled estimates to be made of disease prevalence for certain conditions (see section 6.4). In Haringey these prevalence figures are generally lower than would be expected from national studies and data. However they offer an opportunity to provide some comparisons between what is happening in general practice and the information available on patients using hospital services.

5.2 Patterns of hospital use over time and across Haringey

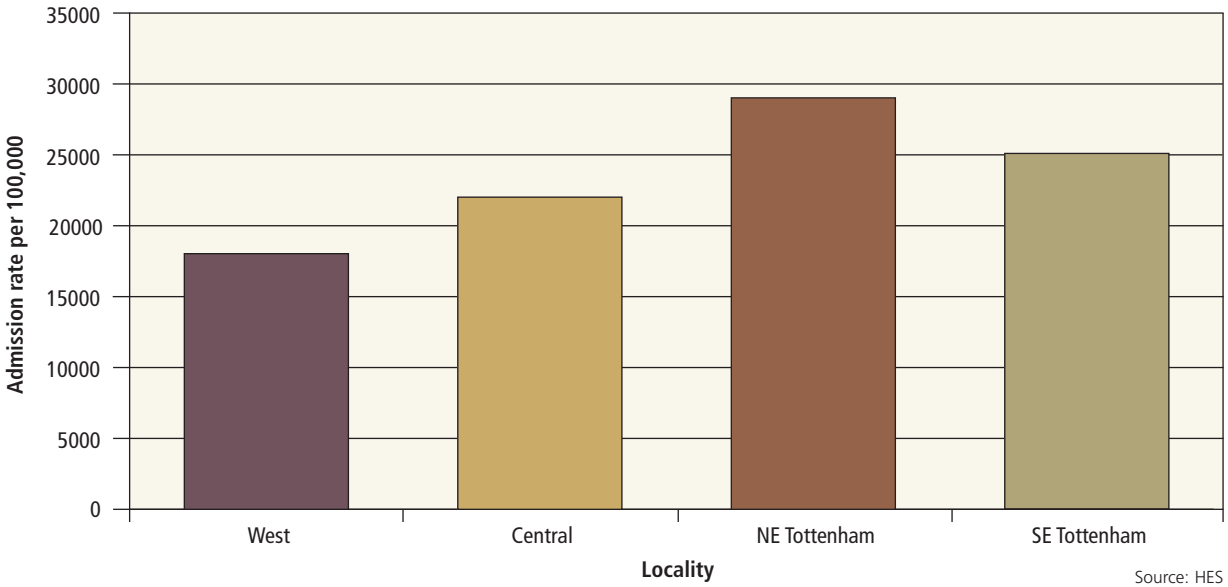
People attend hospital as either an outpatient, accident and emergency attendance or as an

Figure 54 *Directly standardised admission rates per 100,000 population -All ages*



Source: LHO

Figure 55 *Directly standardised admission rates per 100,000 population by locality (2003/04-2005/06)*

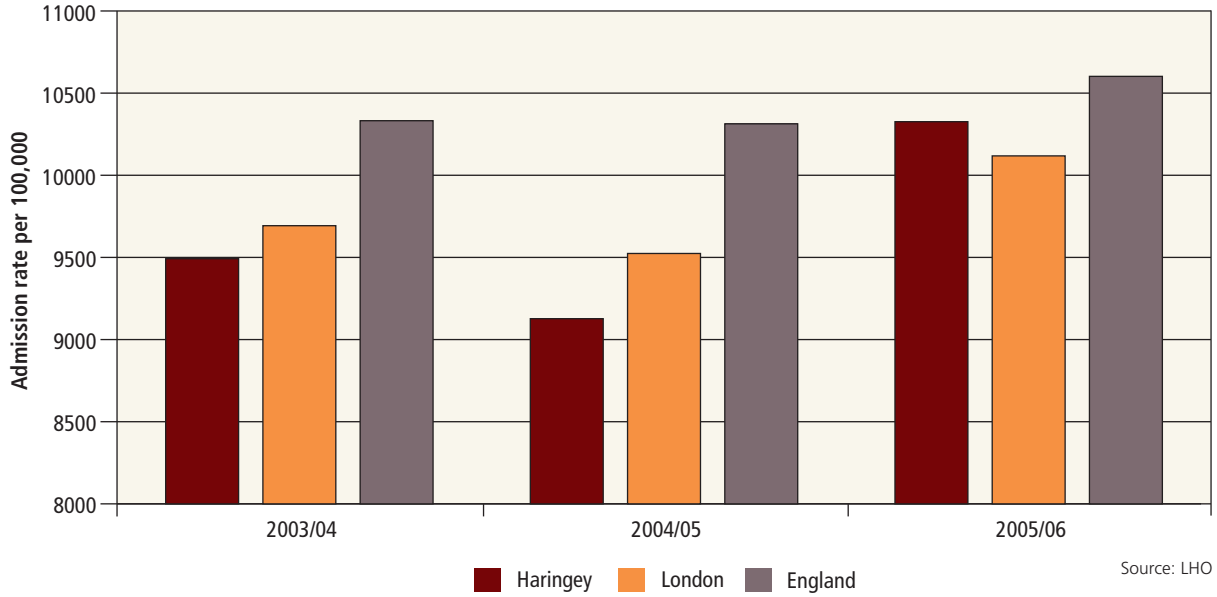


Source: HES

inpatient (admissions). Between April 2005 and March 2006 there were 48,380 admissions to hospital by Haringey residents. The rate of admission to hospital is higher in Haringey than for London, and since 2003/04 and 2004/05 this has increased at a greater rate than in England as a whole (see figure 54) for both emergency and pre-booked (elective) admissions. Haringey's hospital admission rates have increased and are now equivalent to those in England. Admission rates describe episodes of care rather than individuals i.e. a person may be admitted twice or three times in a year and each one of those admissions will be counted separately.

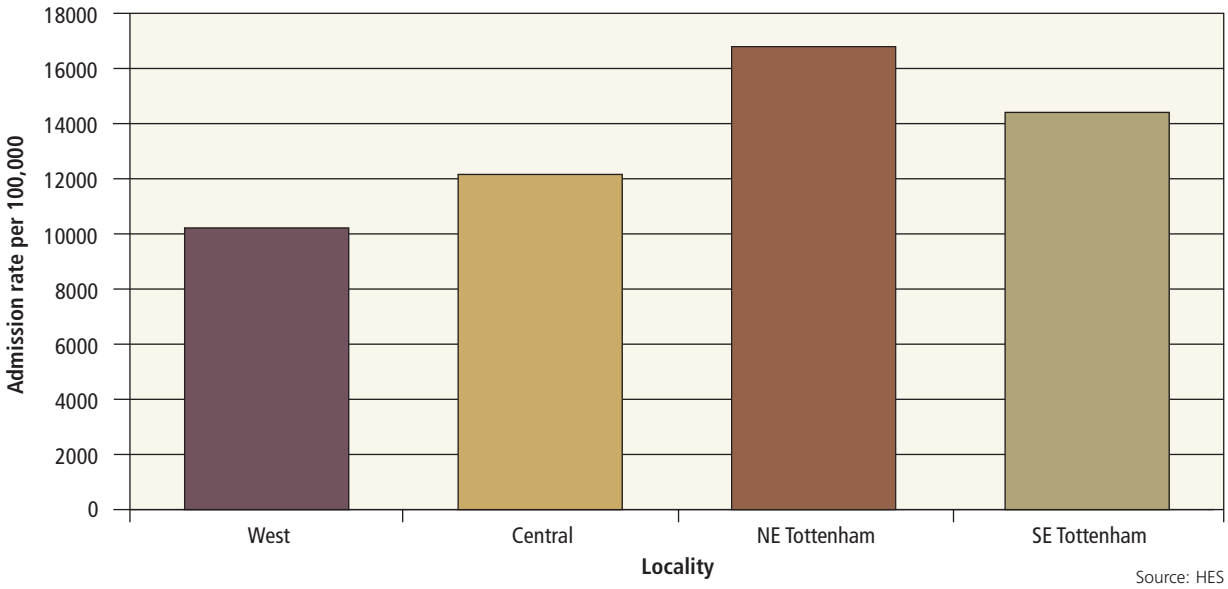
There is considerable variation in admission rates between different geographical areas within Haringey (see figure 55). West Haringey has the lowest rates and North East Tottenham the highest. This pattern holds for both booked

Figure 56 *Directly standardised rates per 100,000 for pre-booked admissions compared with London and England*



Source: LHO

Figure 57 *Directly standardised elective admission rates per 100,000 population by locality (2003/04-2005/06)*



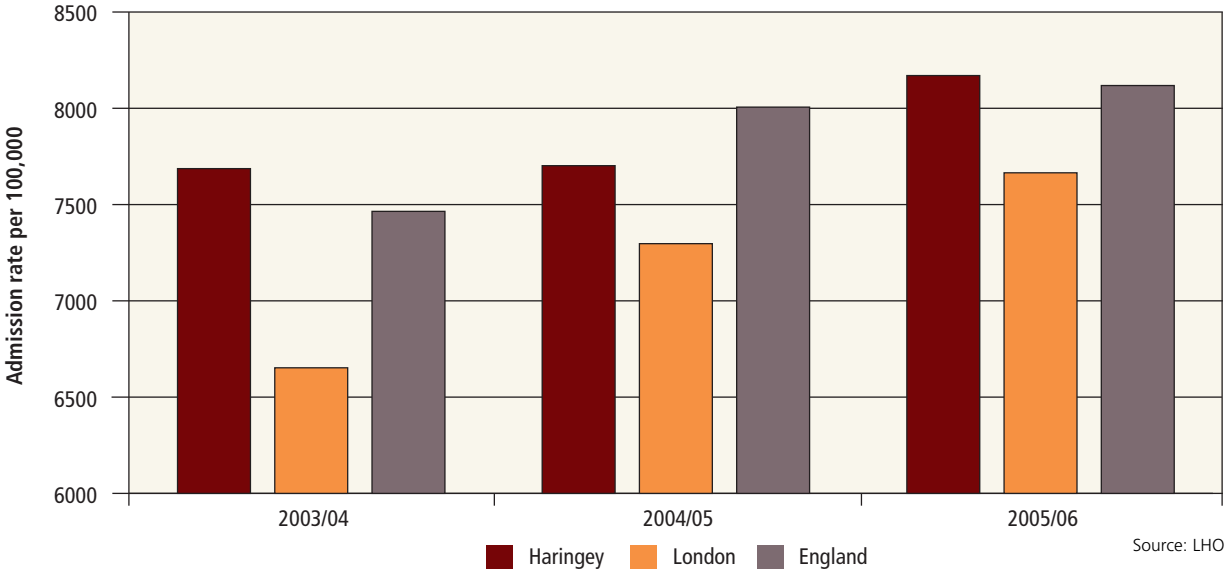
Source: HES

and emergency admissions (see figures 57 and 59). This is likely to reflect differences in health need between the populations but may also be the result of variation in the quality of care that is delivered to patients to reduce the need for admission. Descriptions of cause of admission by geographical area will illustrate this further.

5.3 Booked (elective) admissions

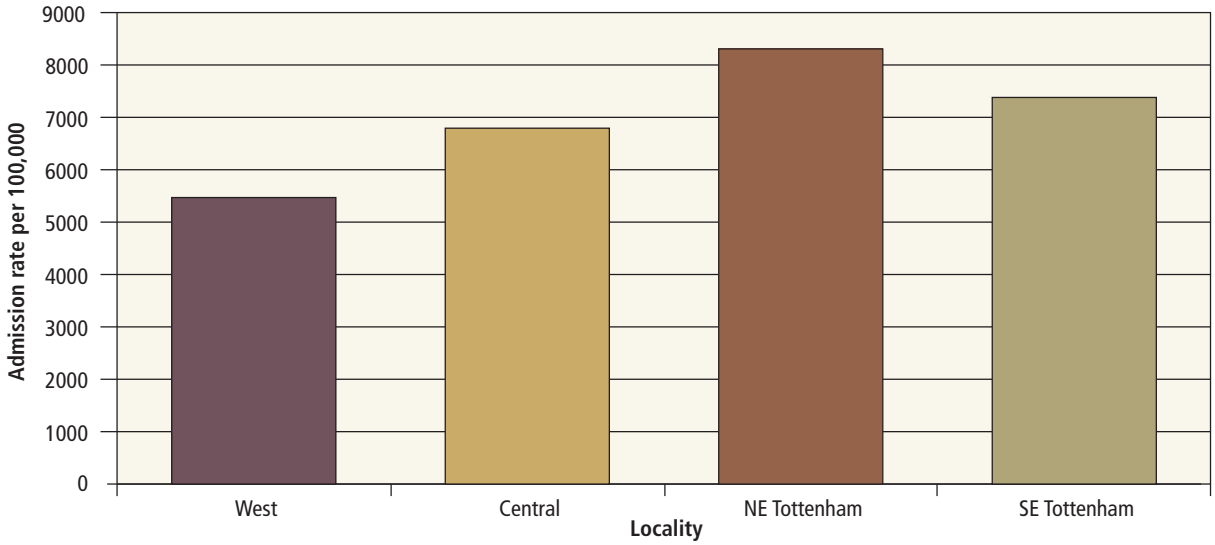
In the past, Haringey had a lower rate of pre-booked admissions than both London and England but in the past year this position has changed significantly (see figure 56). While this increase could be due to increasing health needs of the local population, it is likely to be the result of acute hospital providers being able to deliver more elective activity. This may indicate activity undertaken to meet targets, a shift from private providers to the NHS or lower thresholds for referral and intervention on the part of doctors.

Figure 58 *Directly standardised rates per 100,000 for emergency admissions compared with London and England*



Source: LHO

Figure 59 Directly standardised emergency admission rates per 100,000 population by locality (2003/04-2005/06)



Source: HES

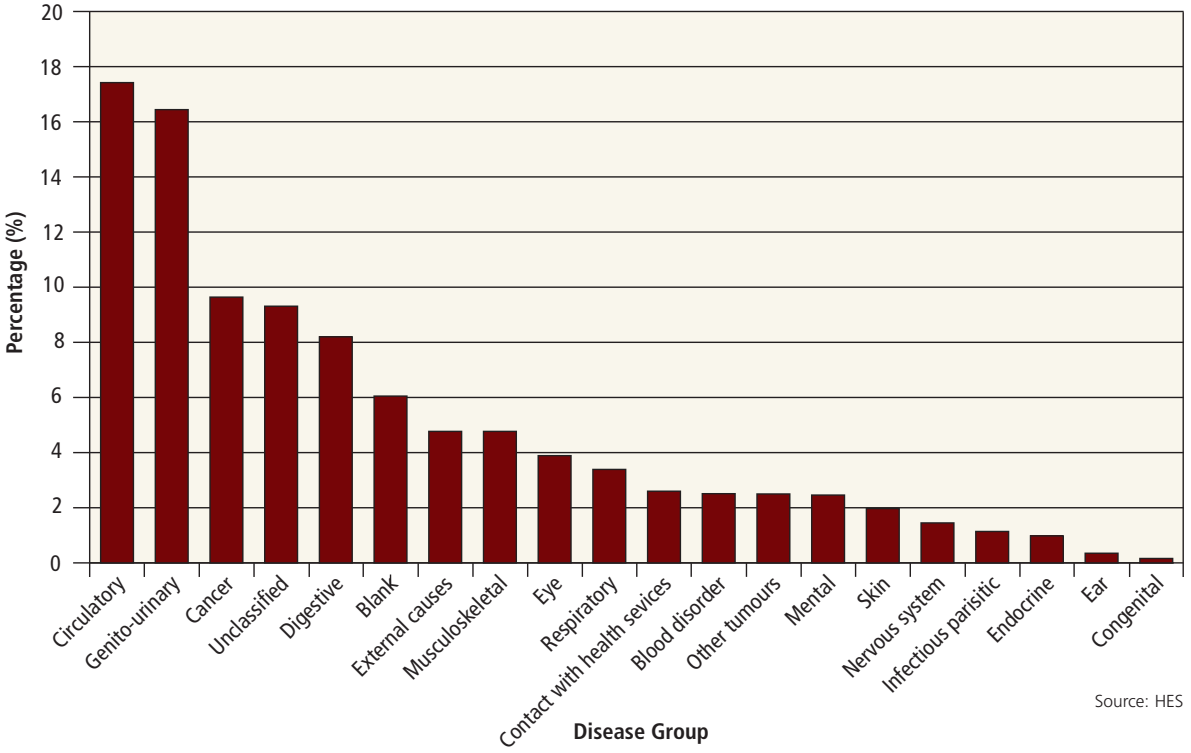
5.4 Emergency admissions

Emergency admissions have increased since 2003/04 for Haringey, London and England as a whole. Haringey has a similar emergency admission rate to England for 2005/06, which continues to remain higher than the rate for London, although the rates for London appear to be increasing substantially too.

5.5 Reasons for admission

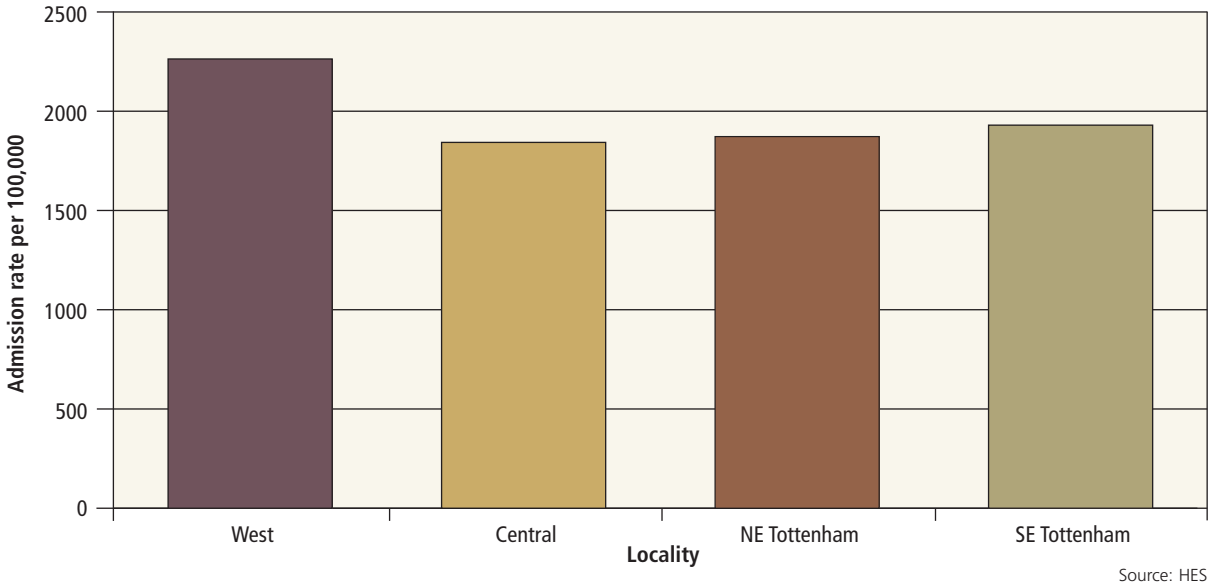
Circulatory disease accounted for 17% of all hospital admissions over the period 2003/04-2005/06 (see figure 60), a higher proportion of all admissions than in 2001/02 (11%). Genito-urinary admissions were the most common reason for admission in 2001/02 (19%) and were the second most common reason for admission in 2003/04-2005/06 (16%). The

Figure 60 All admissions by disease group for ages 20+ (2003/04-2005/06)



Source: HES

Figure 61 *All age admission rate for cancer by locality (2003/04-2005/06)*



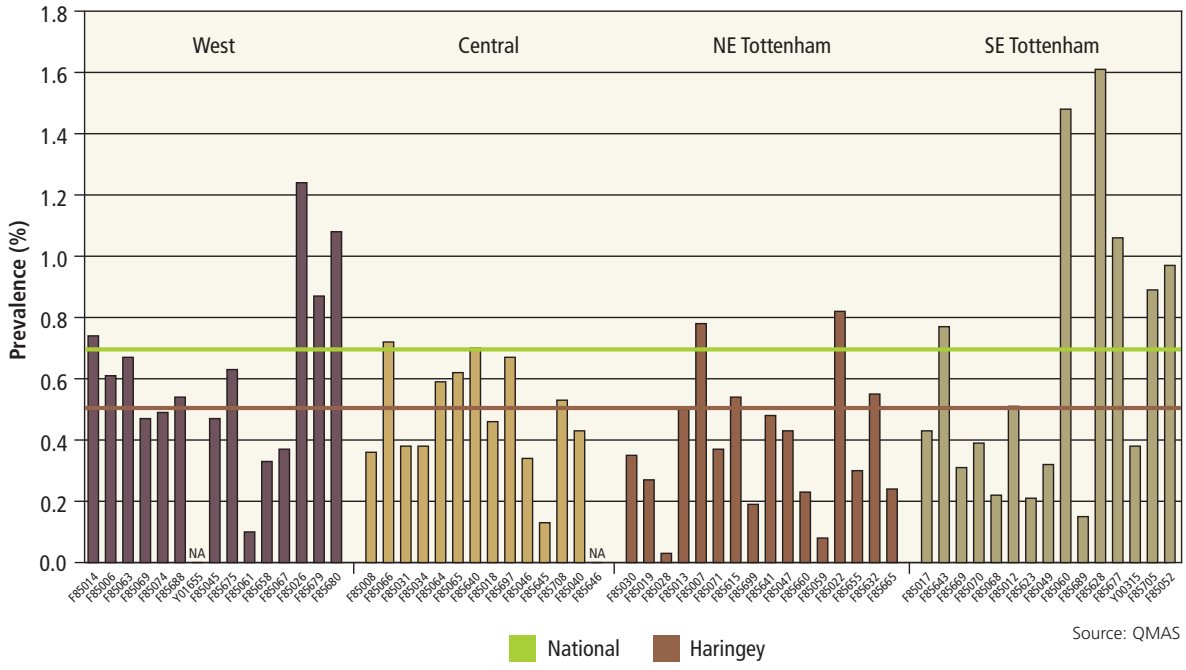
Source: HES

majority of the genito-urinary admissions were day cases as people with kidney failure attend for renal dialysis. Cancer was the third most common reason for admission (9%), and between 2003/04 and 2005/06 accounted for a considerably lower proportion of admissions than in 2001/02 (16%).

5.6 Cancer

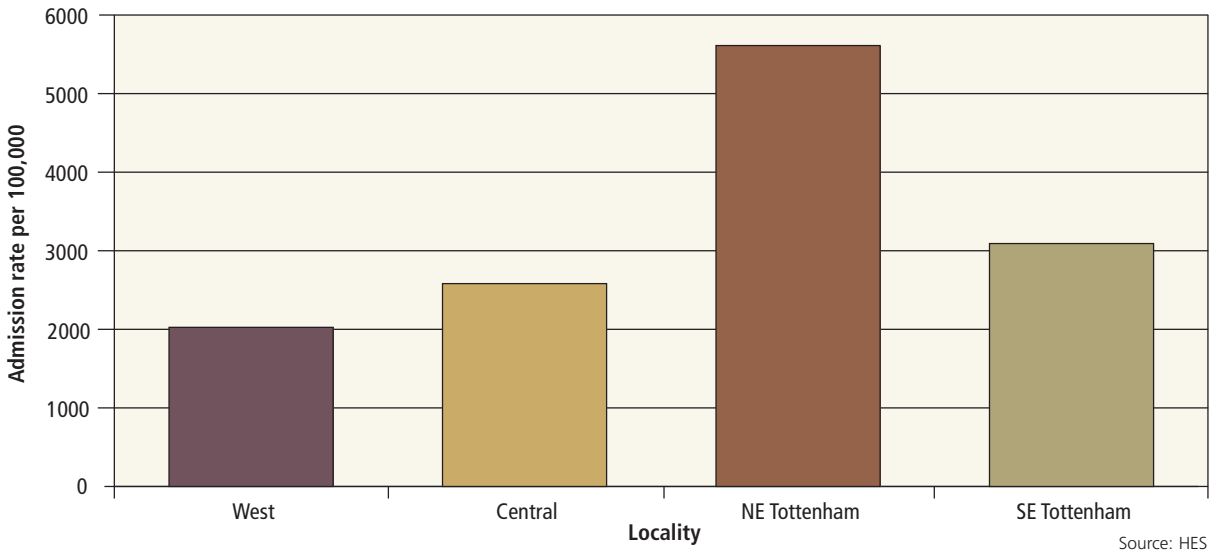
Risk factors for cancer such as smoking and poor diet are more common in deprived areas and one would expect to see higher rates of admission for cancer in the east of Haringey (see figure 61). This pattern is not reflected in admission rates although it is reflected in the mortality rates. There are a number of explanations that could explain this difference. It could be that people living in the west of the borough may be diagnosed earlier, receive better / more timely treatment or that the type of cancers that they get are more treatable.

Figure 62 *Prevalence of cancer on GP registers by collaborative (March 2006)*



Source: QMAS

Figure 63 *All age admission rate for circulatory disease by locality (2003/04-2005/06)*



Source: HES

Data from GP held cancer registers (see figure 62) demonstrates considerable variation suggesting that, whilst need is dependant on the practice population; some practices may be failing to identify all cancer sufferers in their practice and therefore not recording them on their registers.

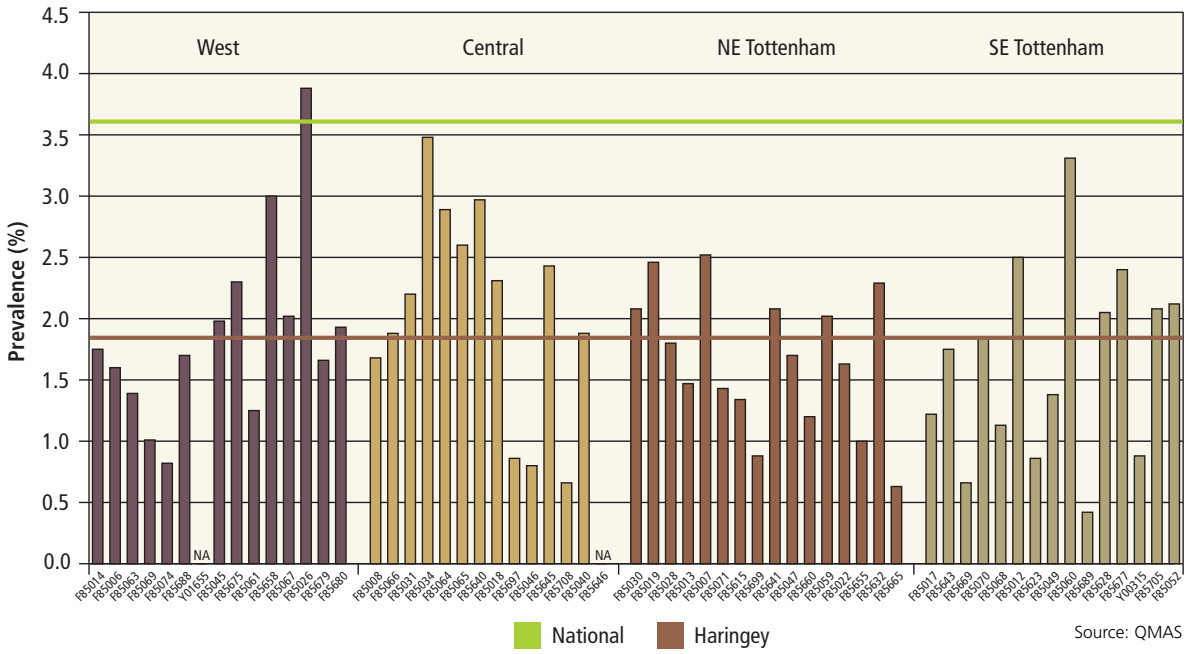
5.7 Circulatory disease

Circulatory disease includes heart disease and stroke. Like cancer, heart disease is also more common in deprived communities and the mortality rates are higher in the east of Haringey (see figure 63). Unlike cancer, increased need in the east of Haringey is reflected in admission rates for circulatory disease. Haringey prevalence for CHD on the GP registers is notably lower than the national prevalence suggesting that there is still more that can be done by GP practices to identify and treat people with CHD earlier (see figure 64).

5.8 Diabetes

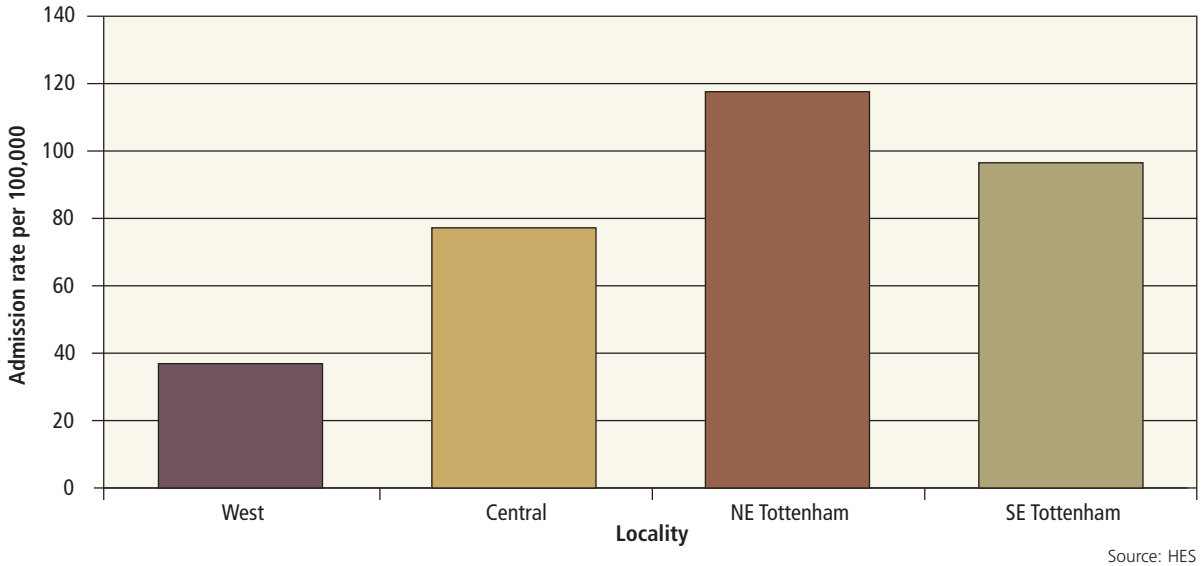
Diabetes is a chronic progressive disease that

Figure 64 *Prevalence of CHD on GP registers by collaborative (March 2006)*



Source: QMAS

Figure 65 *All age admission rate for diabetes by locality (2003/04-2005/06)*



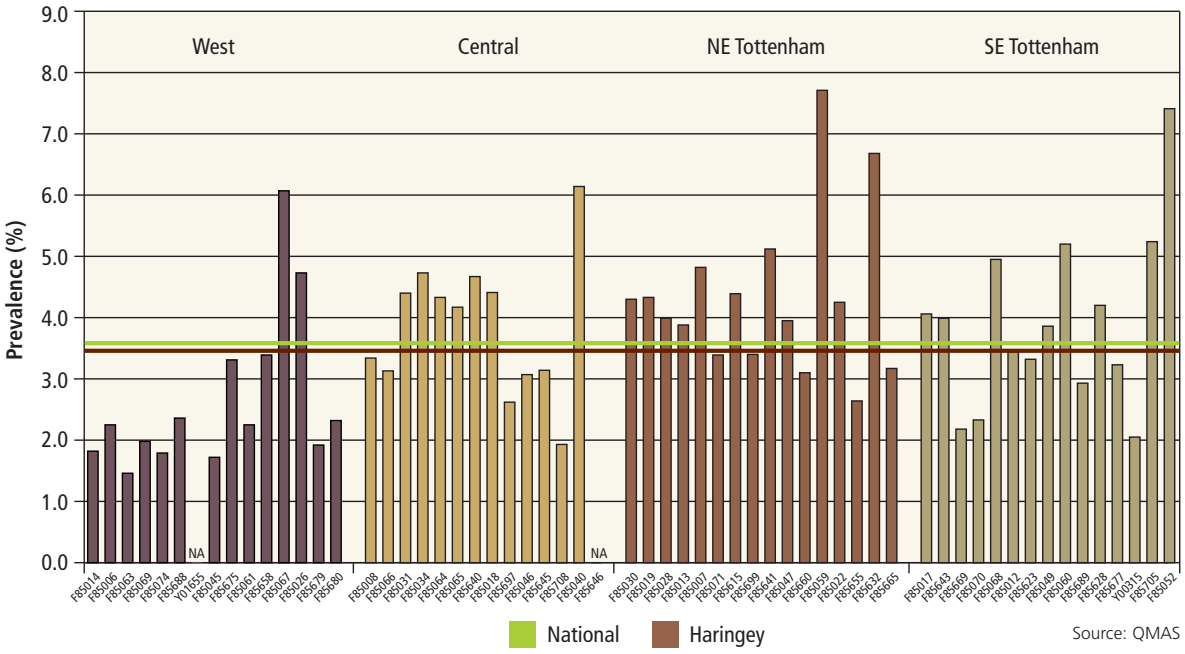
Source: HES

may result in ill health, disability and premature death. It is up to 6 times more common in South Asians and up to 3 times more common amongst African Caribbean groups. Other risk factors for the disease include: being over weight, physically inactive and family history. The prevalence of diabetes identified on GP registers in Haringey (3.5%) is approaching the national recorded prevalence (3.6%) (see figure 66). However, considering the demographics of the Haringey population this would be expected to be much higher and in some practices is around twice the national rate. Admission rates for diabetes follow a similar distribution by area to the death rates, highest in the east of Haringey and lowest in the west (see figure 65).

5.9 Other reasons for admission

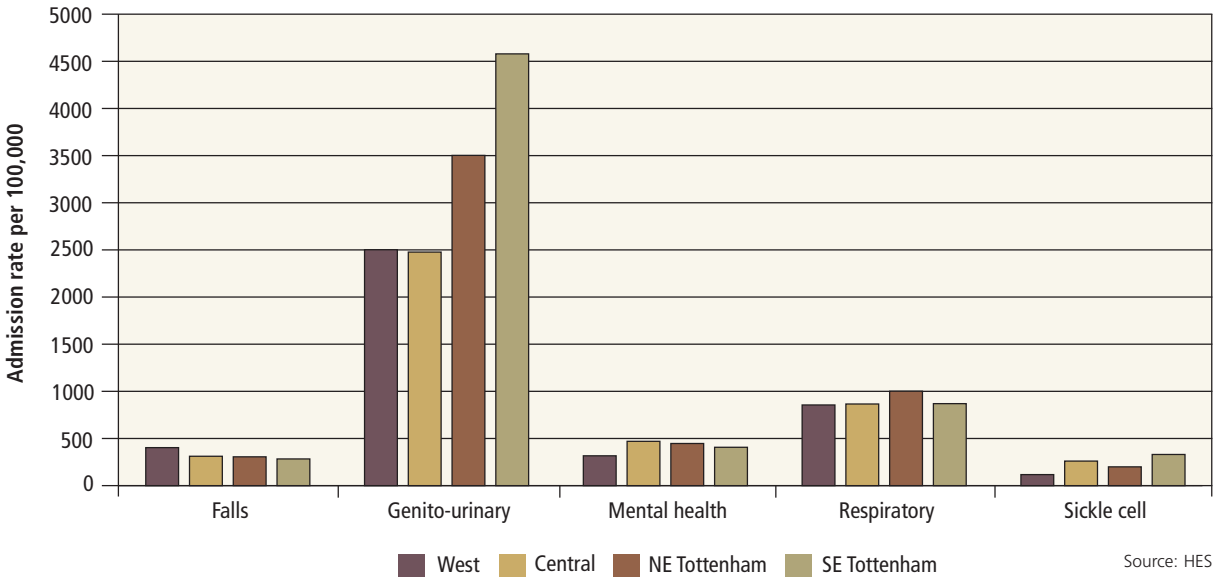
Patterns of genito-urinary admission are similar to those for circulatory disease and diabetes. This is not surprising as both diabetes and circulatory disease may result

Figure 66 *Prevalence of diabetes on GP registers by collaborative (March 2006)*



Source: QMAS

Figure 67 *Selected all age admission rates by locality (2003/04-2005/06)*



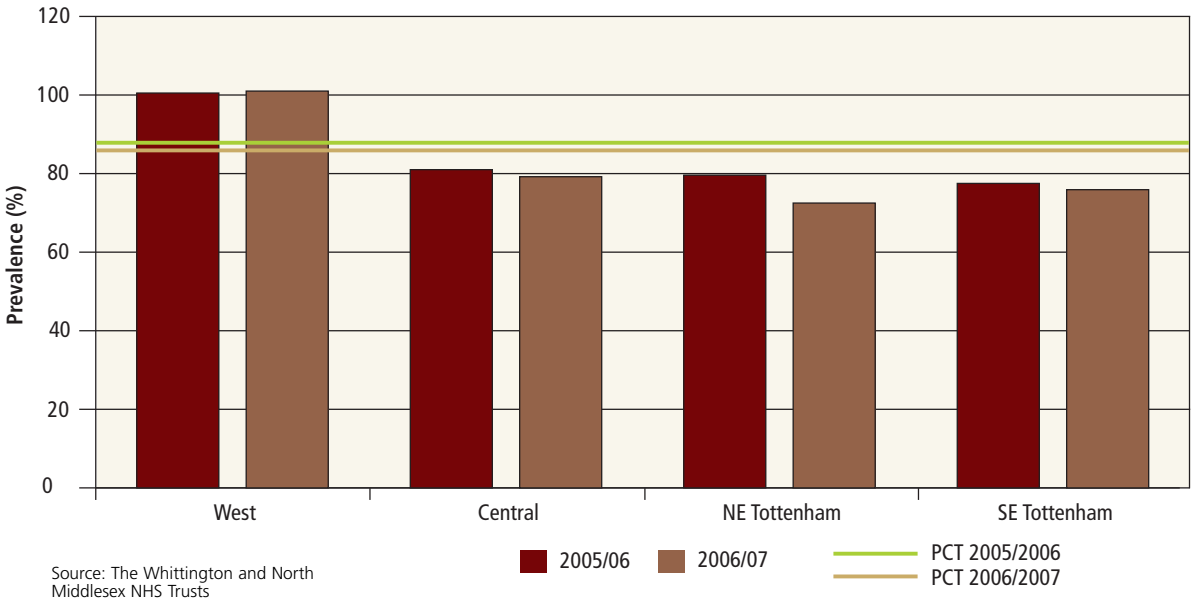
Source: HES

in chronic renal failure and dialysis for chronic renal failure accounts for most of these admissions. Patterns of admission for respiratory disease are similar across Haringey. West Haringey has the lowest admission rates for mental health and sickle cell but the highest for falls (see figure 67).

5.10 Outpatient attendances

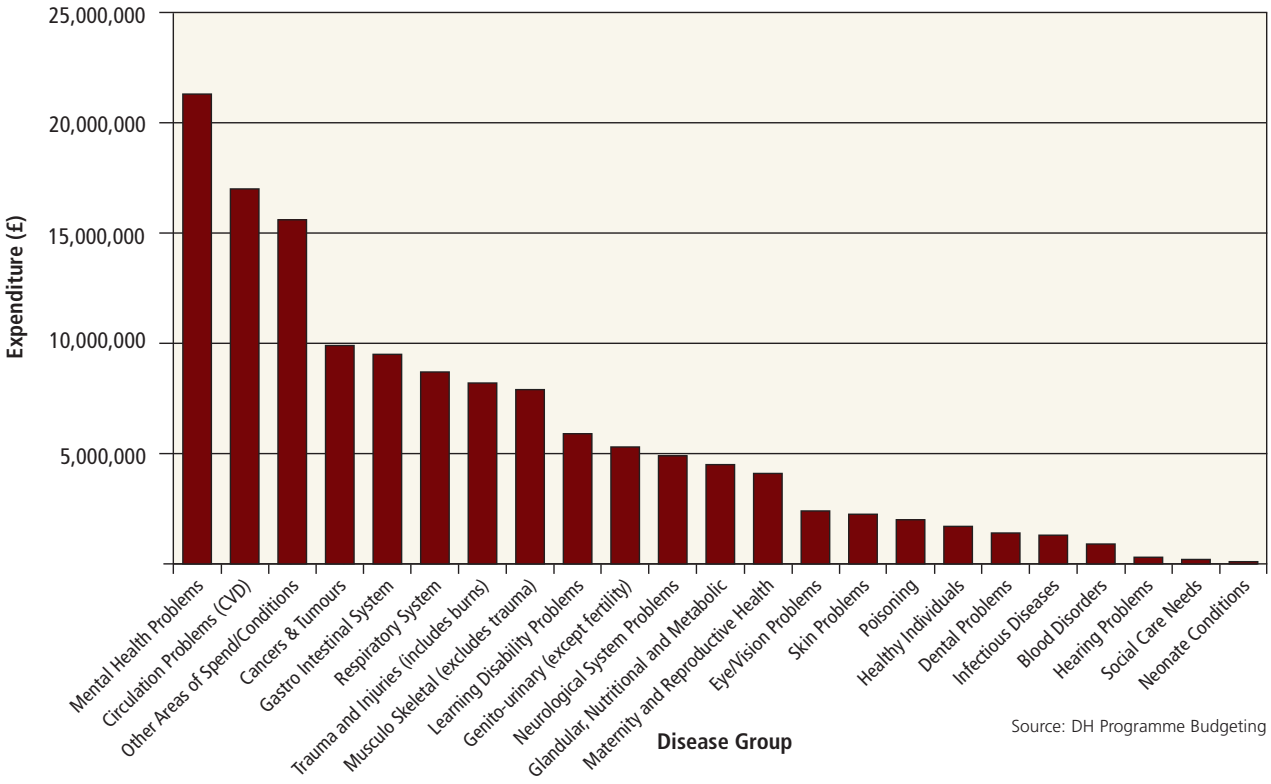
National benchmarks have demonstrated that more outpatient appointments take place for people registered with Haringey GPs than one would expect. Around half of 1st outpatient appointments are initiated by the patients' GP, the vast majority of the other half being initiated by hospital doctors and dentists. In contrast to the admitted hospital care, the rates for GP referred 1st outpatient attendance, which can be used as a proxy for GP referral patterns, reveals the west of Haringey to have the highest referral rate (see figure 68).

Figure 68 *GP referred 1st out patient attendance per 1,000 population (Month 10 of 2005/06 and 2006/07)*



Source: The Whittington and North Middlesex NHS Trusts

Figure 69 Expenditure for services in Haringey: £ per 100,000 population (2005/06)



Source: DH Programme Budgeting

5.11 Total expenditure across different specialty areas

Programme budgeting information is financial information that is intended to support and improve NHS commissioning, in particular, through the provision of comparative information. Health service spend is assigned to different programme areas according to set rules. The data can be compared with other PCTs with a similar population and in time, more sophisticated analysis will be possible as it is linked to other data sets. The areas of care that Haringey TPCT spends considerably more than other similar PCTs are: mental health, cancer and tumours, and diabetes. Surprisingly Haringey appears to spend less on genito-urinary disorders and circulatory disease than other similar areas (see figure 69).

5.12 Conclusions – Adults and illness leading to hospital care

- Admission rates to hospital for Haringey residents have significantly increased over the last three years and emergency admissions are higher than the national average.
- The highest rates of admission are from North East Tottenham.
- The most frequent reasons for admission are circulatory diseases, diseases of the kidney and bladder and cancer.
- Admission rates for Haringey are higher than national rates and this contrasts with the recorded prevalence at GP practices of major diseases, which are well below the national average for cancer and heart disease.
- Outpatient attendances referred from GPs from West Haringey are well above the Haringey average.

6 Health and Primary Care (GPs) in Haringey

Written by Gerry Taylor

6.1 The population registered with Haringey GP practices

There were 264,988 people registered with general practice in Haringey at November 2005; 7.3% more than the resident population. Of these, 24,600 (9.3%) lived outside the borough of which over 90% lived in Enfield. Data are not routinely available on the number of Haringey residents registered with GP practices outside of Haringey.

The GP registered population has a higher proportion of males to females (51% compared to 49%), together with a smaller proportion of under 5s (6.5% compared to 7.4%) than the resident population. This may be due to undercounting of young men in the 2001 census, which is a national phenomenon.

6.2 Profile of patients registered with GP practices in Haringey

Table 11 shows the variation in the number of individuals registered with individual practices across the four collaborative areas of Haringey. Numbers range from 1,120 to 15,686 people per practice. There are six practices that have less that 2,000 people registered with them. Only 15% of the population were registered with a GP practice in the South East, and the average list size in this patch was significantly lower that in the other patches.

Basic age and sex profiles of the population registered with each practice suggest that there may be significant differences in the health needs of practice populations. For example;

Table 11 *Size and range of registered population by patch*

Area	Number of GP practices	Total number of people registered (% of all registered)	Range of practice list sizes (average list size)
West	15	74,736 (28%)	1,380-14,655 (4,982)
Central	17	75,782 (29%)	1,165–15,686 (4,458)
North East	14	74,817 (28%)	1,650-1,563 (5,344)
South East	13	39,653 (15%)	1,120–4,528 (3,050)
All practices	59	264,988	1,120–15,686 (4,491)

Source: Exeter

- While 51% of the total registered population were male, this ranged from 47% to 66% at different practices. Women of child bearing age 15-44 made up 25% of the total registered population, with a range of 18% to 35% at practice level.

- There was significant variation in the age profile of individual practices compared to the registered population as a whole, particularly for under 5s and over 65s. For example, while over 65s made up 9% of the registered population they ranged from 2% to 18% of individual practices.

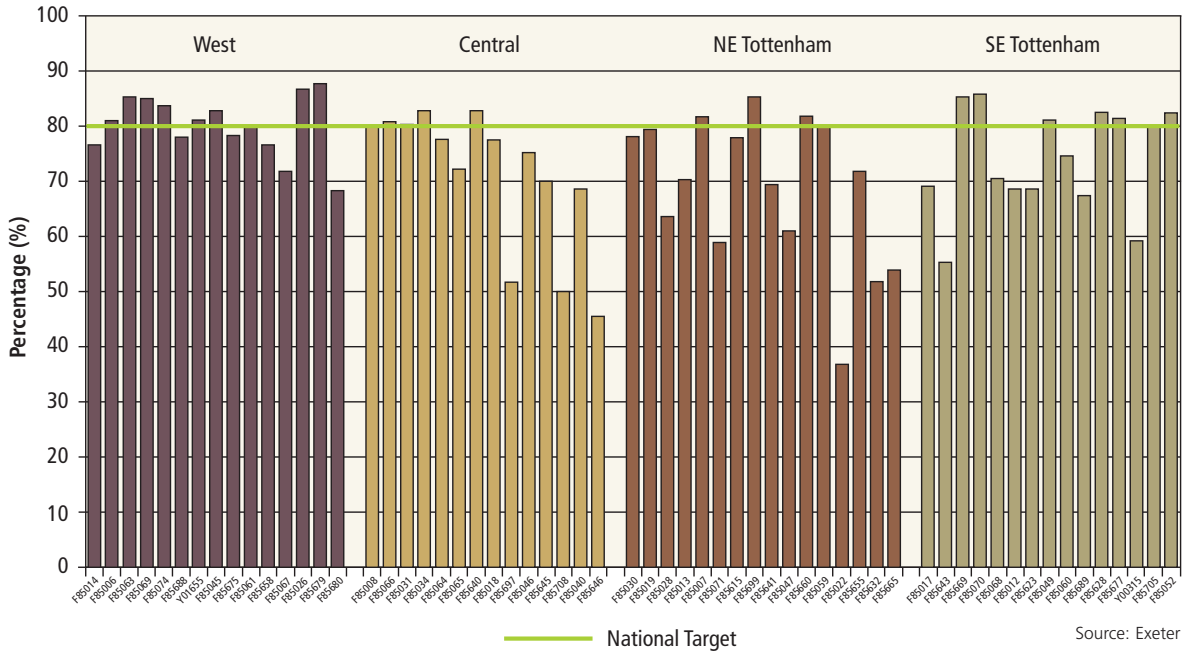
6.3 Quality in primary care

There are a number of indicators that can be used to attempt to assess quality in primary care. This section provides a snapshot of some of the quality data readily available on primary care. Overall these suggest a wide variation in the quality of primary care in Haringey. One example is the amount of GP time that is available to patients, which in Haringey ranges from one practice, which makes 60 hours of GP time available to patients, compared to one that has only 13.5 hours. The average for all practices was approximately 25 hours; ranging from around 22 hours in the South East collaborative to 29 hours in the West.

Other indicators assess how well practices achieve some of their clinical targets, such as screening, flu vaccination and prescribing. Figure 70 shows the uptake of cervical screening across Haringey practices organised into West, Central, North East and South East Tottenham. The Haringey average at September 2006 was 76%, some practices were doing well achieving above the 80% target, whereas at other practices performance was well below target, two practices achieving less than 50%. The poorest performers were in Central Haringey and North East Tottenham.

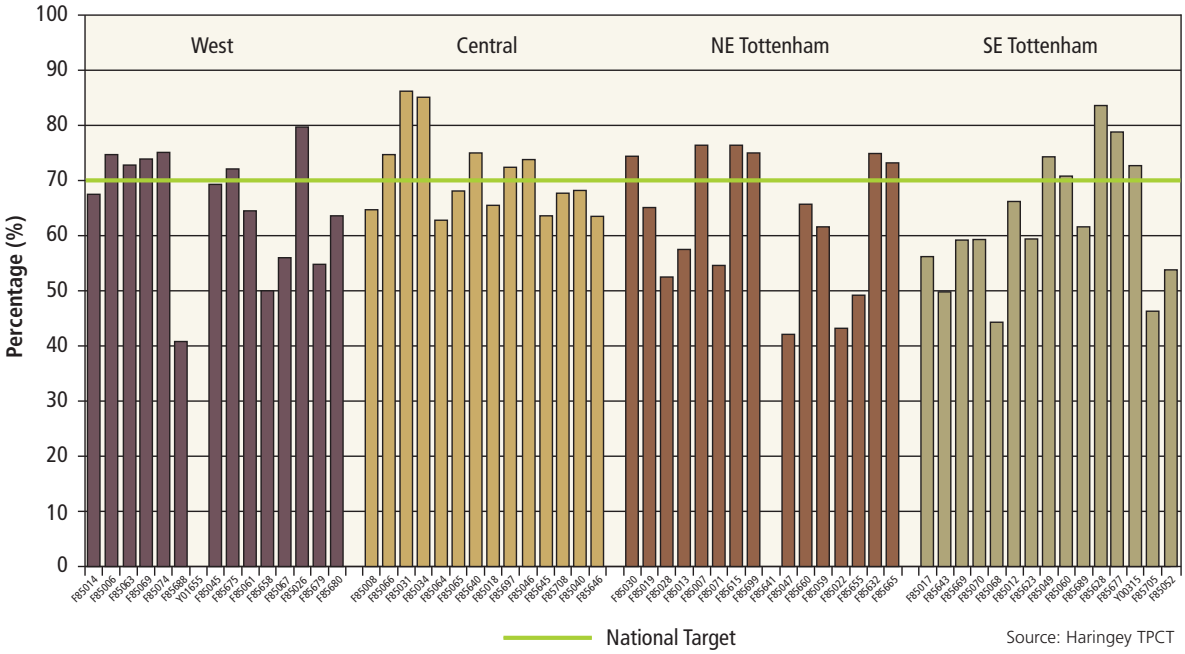
Figure 71 shows the uptake of flu vaccination amongst people aged 65 or more by practice as at January 2007. Again there is wide variation around the Haringey average of 64% with a number of practices meeting the 70% target. However, 6 practices reported

Figure 70 *Cervical cytology – uptake as of September 2006*



Source: Exeter

Figure 71 *Flu vaccination 65+ – Uptake at year to January 2007*



Source: Haringey TPCT

less than 50% uptake and 2 practices had submitted no data. Overall uptake was highest in Central Haringey.

6.4 Quality and outcomes framework

Nationally the Quality and Outcomes Framework (QOF) was introduced as part of the new General Medical Services (GMS) contract on 1 April 2004. The QOF is not a quality measure in itself, but enables payments to be made to general practices according to achievement in caring for patients with certain chronic diseases. The QOF measures achievement against 146 quality indicators, 47 of which relate to clinical quality.

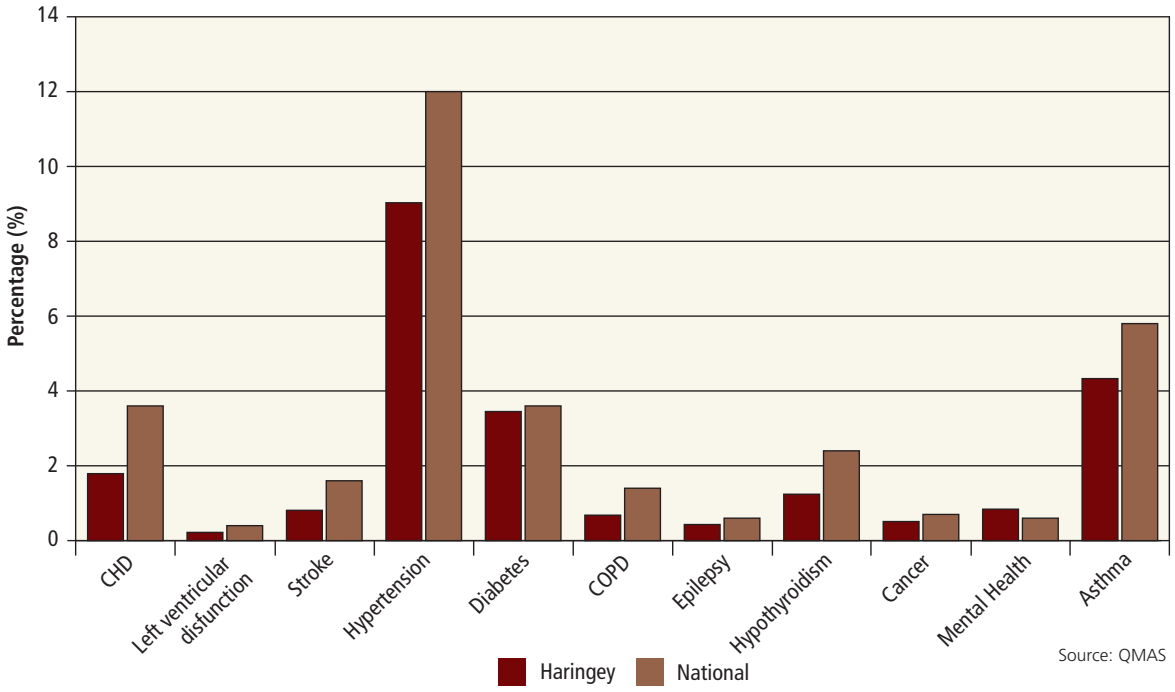
Levels of QOF achievement are related to a variety of local circumstances, and should be interpreted in the context of those circumstances. For example, when looking at prevalence figures it is important to note that although Haringey has a relatively young population, which might lead to a lower prevalence for some long term conditions, there is also a broad ethnic mix which would lead to an increased prevalence of conditions such as diabetes and hypertension. Haringey also has areas of high deprivation which in turn is related to increased health need.

Looking at prevalence for clinical indicators, figures 72 and 73 show that although recorded prevalence has increased between 2004/05 and 2005/06, Haringey's prevalence still falls short of the national average for most clinical areas. This suggests that there may be some undercounting or under-identification for some conditions. There were major increases in recording of prevalence in cancer and mental health, with mental health being the only indicator where Haringey's prevalence was above the national average.

6.5 Quality and long term conditions – Diabetes as example

In determining the quality and variation in quality across the TPCT it is helpful to look in detail at the indicators for one of the long term conditions that make up the Quality and Outcomes Framework. The rest of this section will focus on diabetes, a condition that is

Figure 72 *Disease prevalence as at March 2006*



increasing in prevalence nationally and where there is the potential to prevent diabetes and conditions such as renal failure and blindness that can result from diabetes. Figure 74 shows the recorded prevalence of diabetes across practices. Recorded prevalence varies widely across practices ranging from 1.5% to 7.7%. Overall, practices in North East Tottenham recorded the highest prevalence.

Figure 75 compares the Haringey performance across all of the clinical indicators for diabetes with that of all practices across London. This demonstrates

Figure 73 *Disease prevalence percentage increase (2005-2006)*

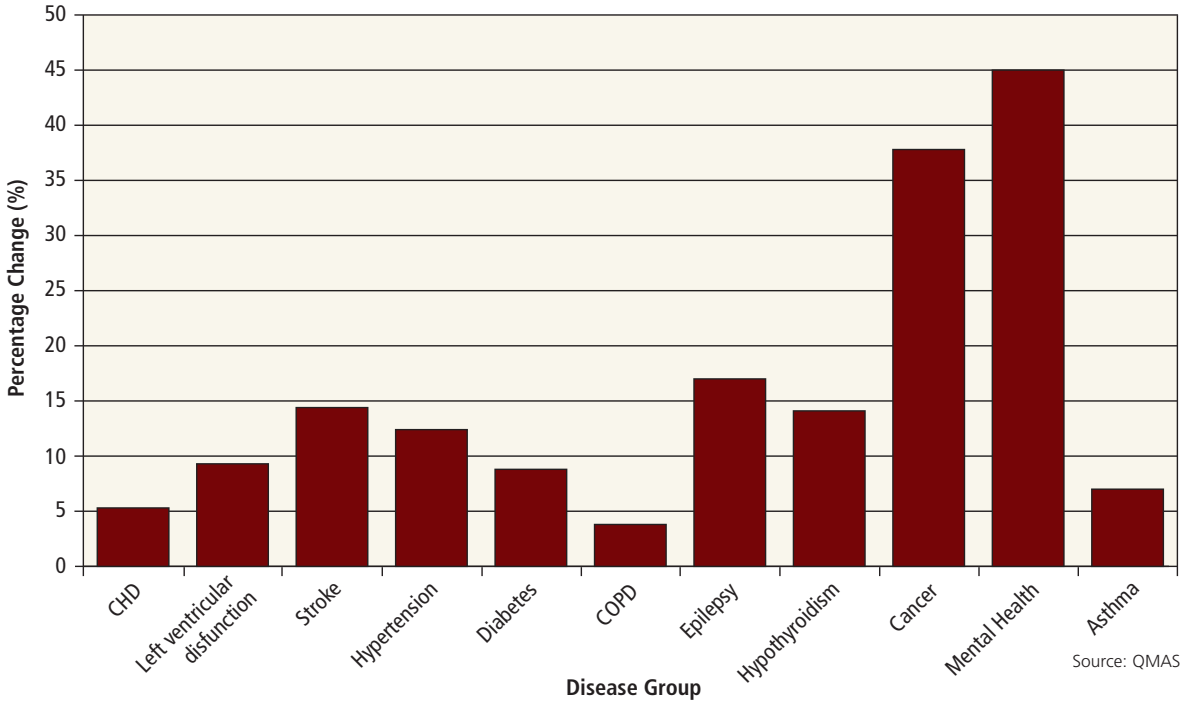
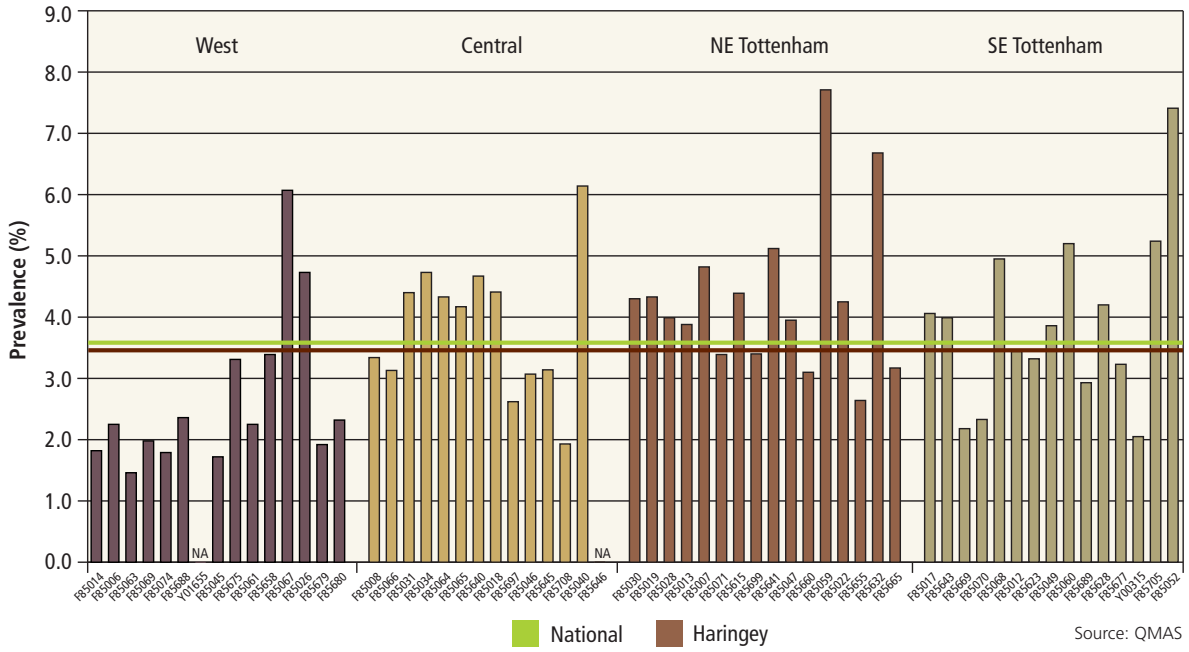


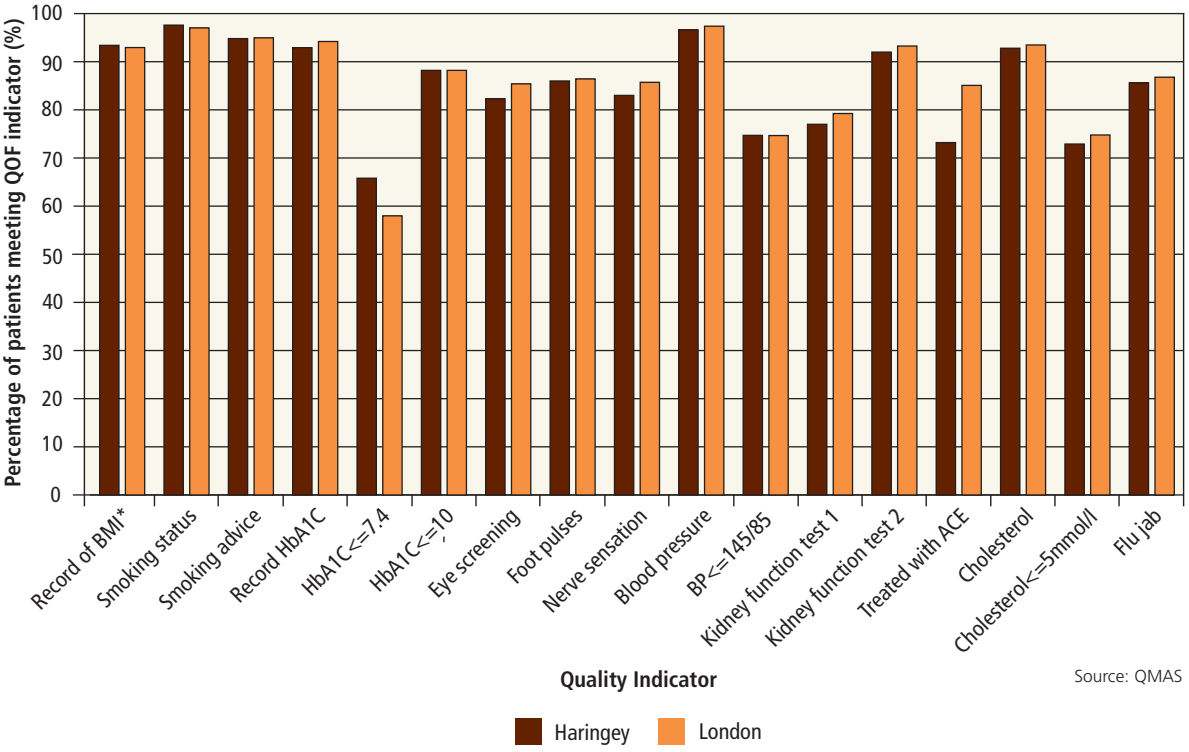
Figure 74 Diabetes prevalence (March 2006)



Source: QMAS

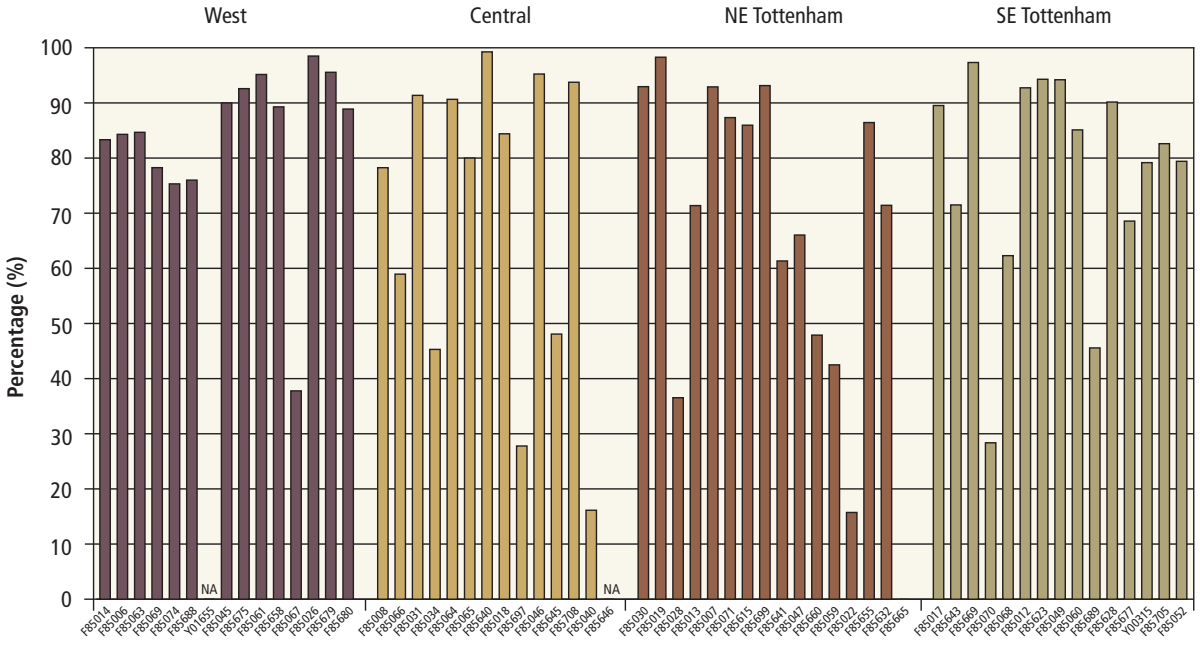
that in general the performance in Haringey is in line with the rest of London for diabetes patients on GP registers. Where performance is slightly worse, it is around identifying and treating patients who are at risk of kidney failure. This is an area of concern in Haringey where we have a population with relatively high levels of risk for kidney failure due to the ethnic mix and high rates of admission to hospital. Beneath these figures, there is a wide range of performance across practices and a need to bring the poor performing practices up to the level of better performing practices.

Figure 75 Diabetes Indicators (March 2006)



Source: QMAS

Figure 76 *Patients with diabetes tested for risk of kidney failure in the previous 15 months (March 2006)*

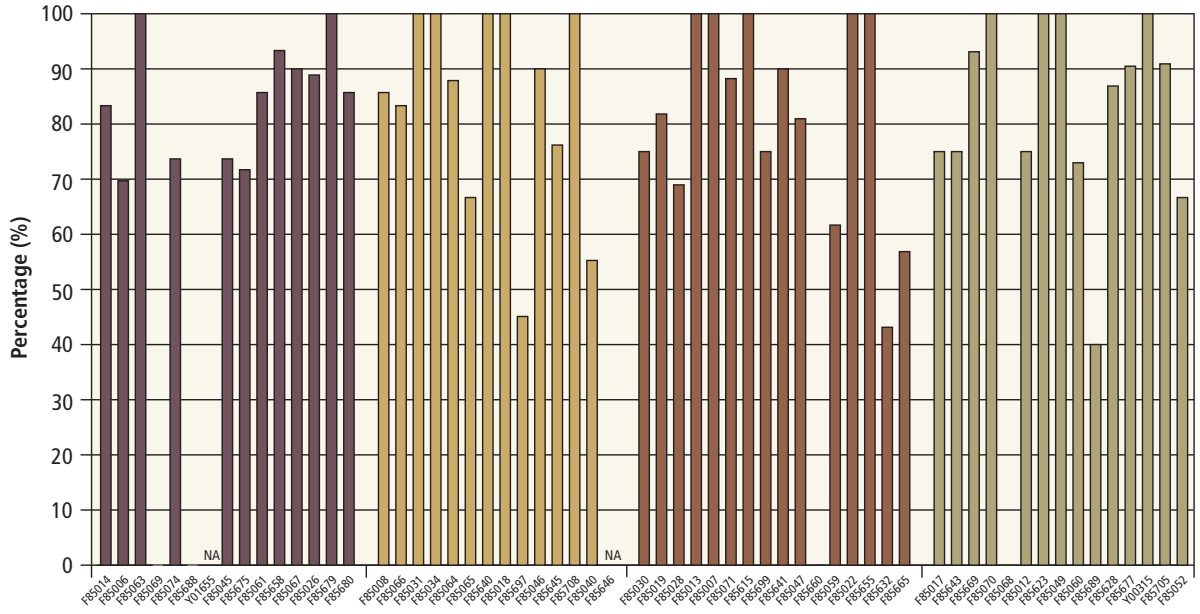


Source: QMAS

For example, figures 76 and 77 show the variation in achievement in terms of identifying people at risk of kidney failure and treating those identified as at risk with ACE inhibitors to reduce hypertension, cardiovascular risk and slow progress towards kidney failure.

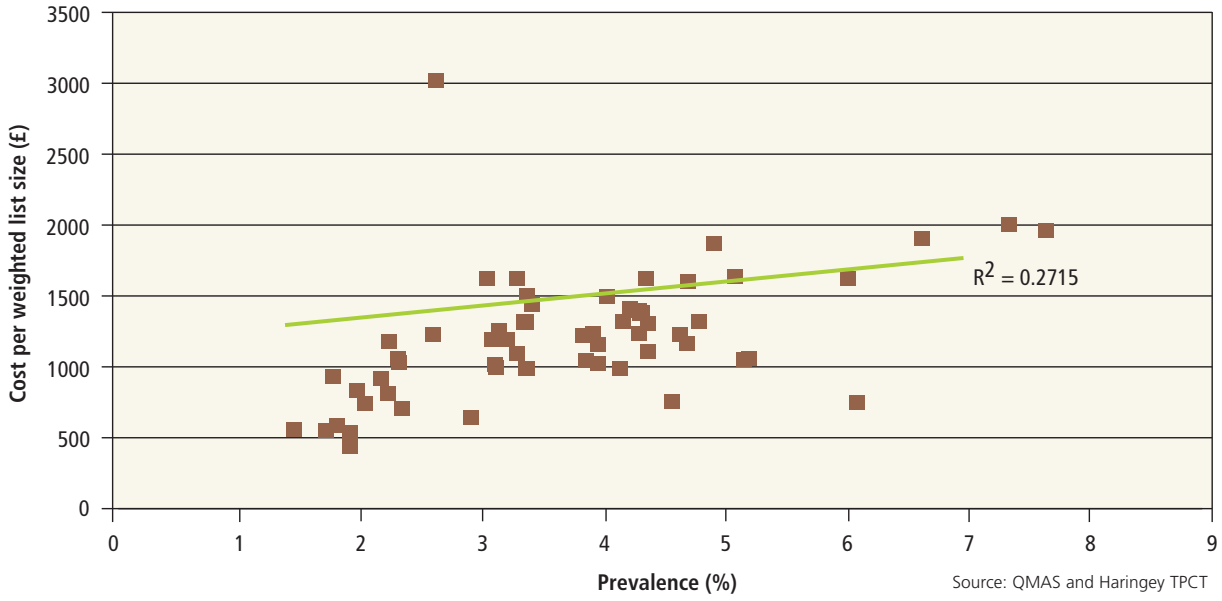
The QOF indicators do not provide a complete picture of the quality of care for diabetes patients and it is important to look at other data at the same time. Figures 78 and 79 look at some of the outcome data around diabetes in terms of prescribing, admission to hospital and mortality. They

Figure 77 *Patients with diabetes at risk of kidney failure treated with ACE inhibitors (March 2006)*



Source: QMAS

Figure 78 Diabetes prevalence against diabetes medication prescribing rate

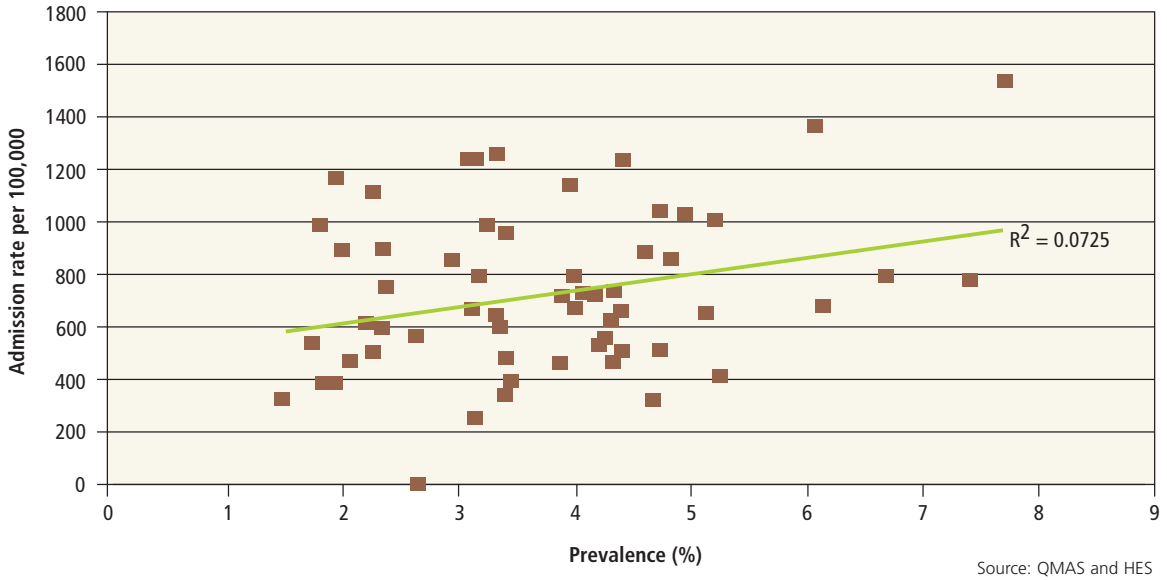


Source: QMAS and Haringey TPCT

suggest that there is little relationship between the numbers of people recorded as having diabetes on GP registers and the number of prescriptions related to diabetes or the number of admissions to hospital. This raises the issue of whether all diabetes patients are being put onto registers to ensure they receive appropriate care and whether some of those on registers are receiving structured pathways of care.

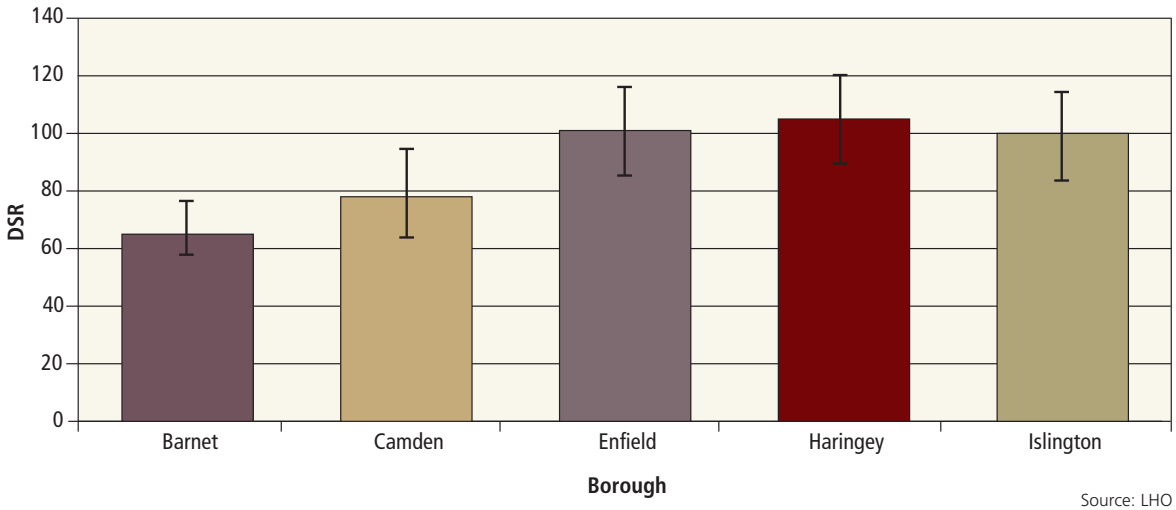
Figures 80 to 82 show that the outcomes for Haringey diabetes patients are also poor when compared with neighbouring boroughs, with a relatively high number of admissions to hospital. There is some fluctuation in the death rate for Haringey, partly due to the small numbers of deaths recorded as being related to diabetes, but rates appear to be higher than the national average until 2005. Finally, figure 82 looks

Figure 79 Diabetes prevalence against admission rate



Source: QMAS and HES

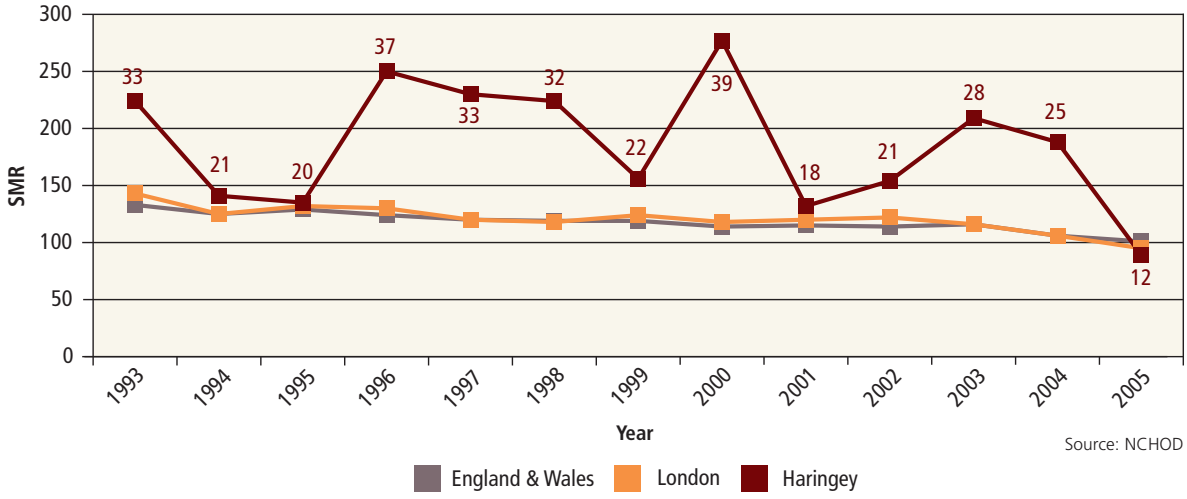
Figure 80 Diabetes standardised admission rate (2005/06)



Source: LHO

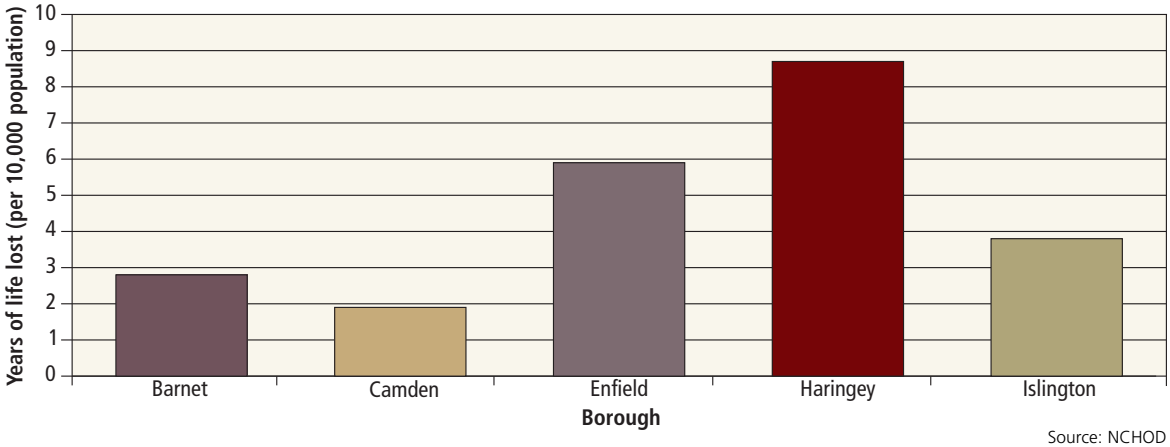
at deaths before the age of 75, which are considered as potentially preventable deaths. This chart compares the years of life lost due to early deaths from diabetes in Haringey with neighbouring PCTs and suggests relatively high rates of early death.

Figure 81 All age diabetes SMR (1993-2005)



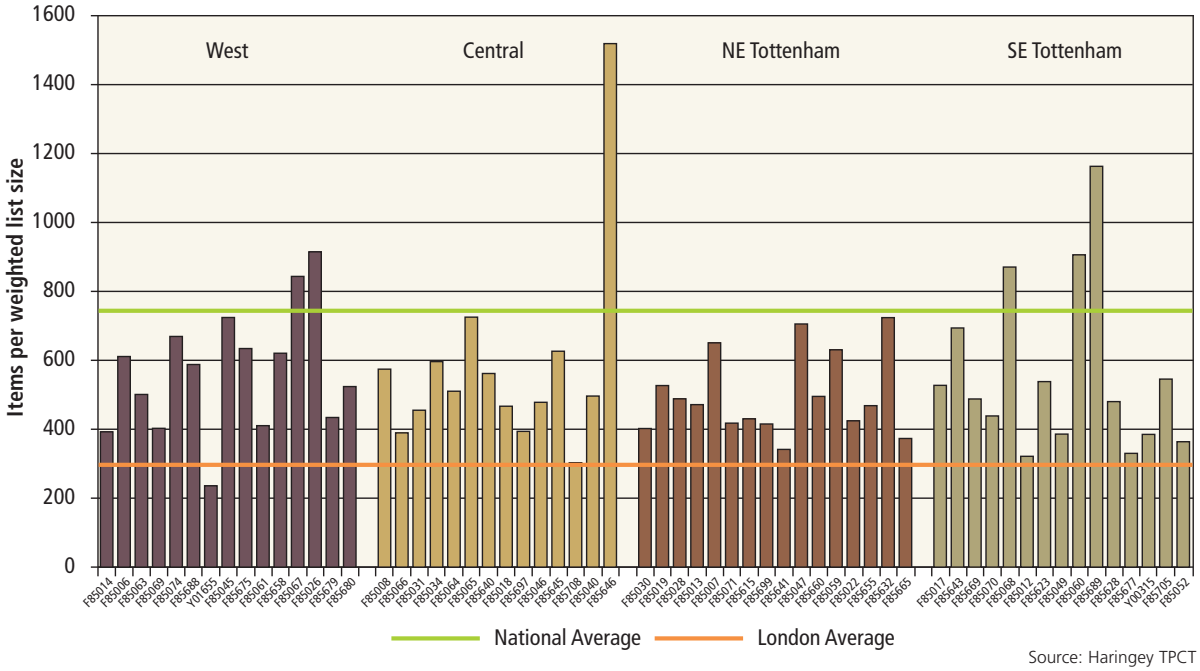
Source: NCHOD

Figure 82 Diabetes – Years of life lost (2003-2005)



Source: NCHOD

Figure 83 Volume of antibiotic prescribing (items per weighted list size)



Source: Haringey TPCT

6.6 Quality and prescribing practice

6.6.1 Variations between practices in prescribing

As with all PCT areas, there is a marked difference between practices in their prescribing in key therapeutic areas. Some of these differences can be explained by the types of patients that register with the practices (e.g. their age, ethnicity, or education) but a proportion of the difference is attributable to variability in prescribing practice by individual clinicians. In the following therapy areas, the graphs show prescribing rates that have been adjusted for variations in practice population and minimise the effect of practices' different demographic profiles.

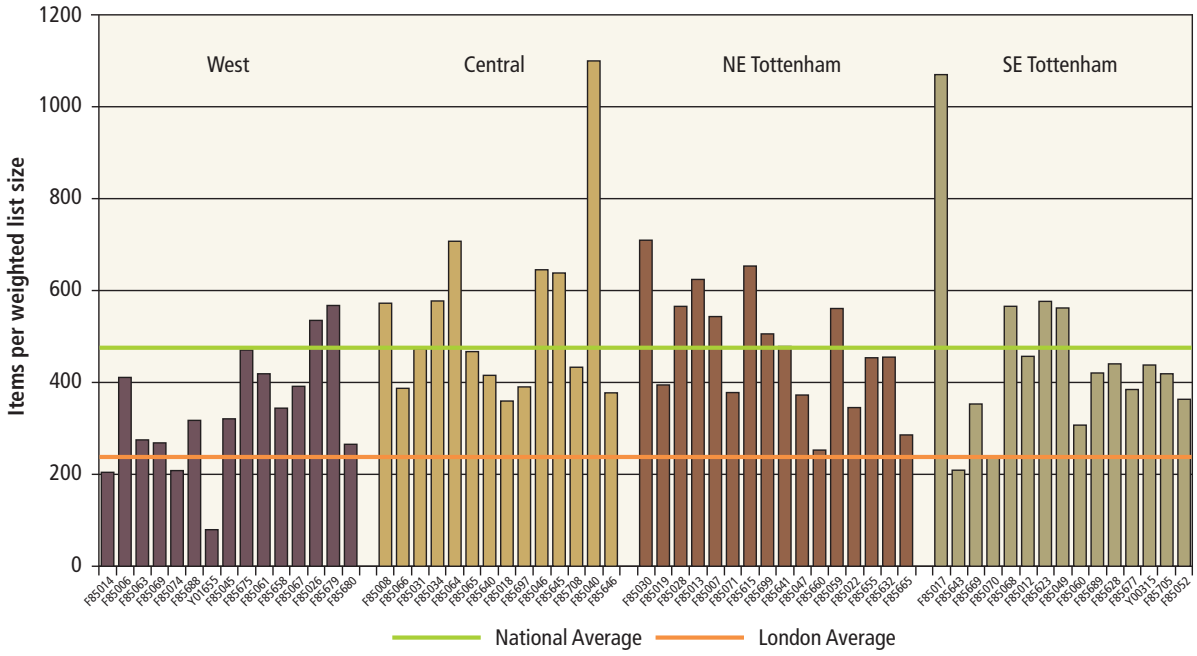
6.6.2 Antibiotic prescribing

Antibiotic prescribing has come to be regarded as unnecessary for many common community-acquired infections. In situations where infections are serious and require hospitalisation, they can be life-saving, but in a community setting they often do not alter the course of disease significantly. This is particularly true of respiratory infections which are more commonly viral in origin and do not respond to antibiotics at all. Figure 83 shows Haringey GP prescribing for oral antibiotics. There is a seven-fold variation between the highest and the lowest prescribers. Overall Haringey performs better than the national average.

6.6.3 Prescribing cholesterol-lowering drugs.

Chapter 3 highlighted that premature deaths from circulatory disease and coronary heart disease amongst people aged under 65 are excessively high in Haringey (figures 28 and 29), most notably in the east of the borough, and are therefore an important contributor to inequalities in life expectancy. These inequalities should be addressed through a range of primary and secondary prevention measures. Longer term, measures to prevent the onset of disease include enabling people to eat a healthy diet and maintain a physically active life. However in the shorter term, secondary prevention measures such as

Figure 84 *Volume of Statin prescribing (items per weighted list size)*



Source: Haringey TPCT

effective management of high blood pressure and high blood cholesterol amongst those most at risk of circulatory disease will be most effective in narrowing the gap in mortality between deprived and affluent parts of the borough.

Chapter 5 highlights that despite the large number of hospital admissions for circulatory disease in North East Tottenham (see figure 63), CHD prevalence does not appear to be excessively high in these practice populations (see figure 64). Equitable management (including prescribing) of patients according to their needs is a key element of strategy to reduce health inequalities. The TPCT has seen a 150% increase in the prescribing of cholesterol lowering drugs (statins) in the last 5 years, mainly due to a growing evidence base for their effect on reducing cardiovascular mortality in those at risk, and the cholesterol targets in the National Service Framework for Coronary Heart Disease. As can be seen from figure 84 there is still a 6-fold variation, although Haringey's average prescribing rate is not out of line with the rest of London or the country.

6.6.4 Prescribing for anxiety and insomnia

It is now good practice to avoid prescribing medicines such as benzodiazepines for anxiety and insomnia. Figure 85 shows Haringey practices' prescribing rates, which are well below the National average. Practices in West Haringey have higher rates than other parts of the borough.

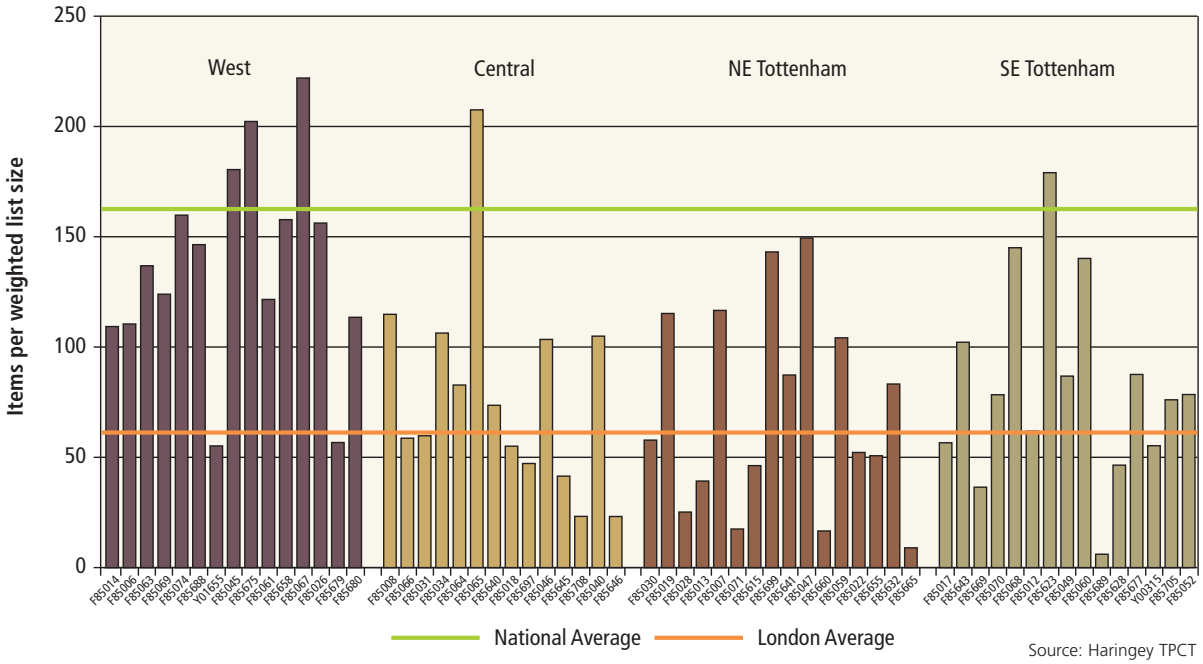
6.6.5 Prescribing for asthma

Asthma attacks can be treated but are best prevented by the use of inhaled corticosteroids. Practices in Haringey show a 4-fold variation in prescribing rates but average the same as other London areas.

6.7 Factors influencing demands on primary care

A health equity audit (HEA) was carried out in November 2005, which looked at factors that might influence demands on primary care. These included age, sex, ethnicity and

Figure 85 Prescribing for anxiety and insomnia (items per weighted list size)

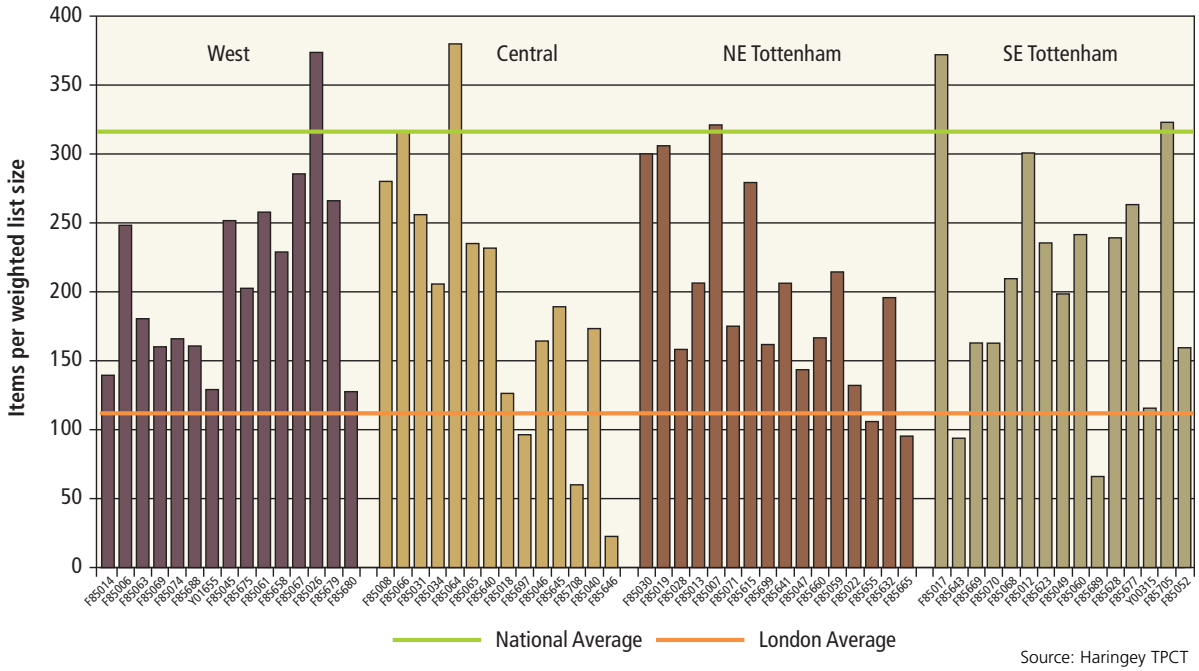


Source: Haringey TPCT

deprivation. For example, boys aged 5-14 years are associated with the lowest workload, whilst women aged over 85 years are associated with the highest workload. Ethnicity is associated with a higher prevalence of some conditions and deprivation with poorer health. However, as ethnicity and socio-economic status were not routinely collected by practices, these data were therefore attributed according to area of residence, based on the 2001 Census. Using this approach:

- approximately half of the total registered population were from a black or minority ethnic community (55.1%), ranging from 31% to 76% at practice level.

Figure 86 Volume of inhaled corticosteriod prescribing (items per weighted list size)



Source: Haringey TPCT

- 31% of the registered population in Haringey lived in an area amongst the 10% most deprived nationally. At practice level this ranged from 0% to 79% of a registered population with practices in North East Tottenham having the highest proportion of people living in the most deprived areas.

An ethnic monitoring action plan has been developed which has amongst its aims the improvement of ethnicity data collection in primary care so that they can be used in this type of analysis in the future.

6.8 Resource allocation to GP practices in Haringey

6.8.1 Analysis of resource allocation

Haringey TPCT commissions primary care services from GP practices using two distinct contractual arrangements, the General Medical Services (GMS) contract and the Personal Medical Services (PMS) contractual framework. A primary care equity audit in 2005 sought to review the financial allocation to each GP practice in the financial quarter October to December 2005. The nationally agreed GMS contract is used to commission 28 practices. The payment formula takes the practice population into account in terms of age and sex, mortality and morbidity and the delivery of services in high-costs areas. The PMS contract is used to commission 31 GP practices in Haringey and contracts are individually agreed.

The average resource allocated to GP practices for the period October to December 2005 was £19.42 per registered patient. Table 12 summarises the range of resource allocation between GMS and PMS practices, and between patches. It shows the wide variation in practice income per patient, ranging from only 68% of the average to 87% above average. This suggests that while PMS practices receive more resource per patient overall, this is not always true at individual practice level.

6.8.2 Equity of resource allocation in relation to need for primary care services

Having undertaken this preliminary analysis to describe the allocation of resources to practices in Haringey, the issue then becomes one of equity. Is the allocation of resources fair i.e. does it reflect the level of health need amongst the patients registered with a particular practice?

We looked at both the implications of workload based on age and sex[a], and

Table 12 *Resource allocation to practices – total and per patient (October – December 2005)*

Practices	Total resource allocation (GS + MPIG or equivalent)	Range of resource allocation to practices (£)	Relative resource per Patient	Range
GMS	£2,061,855	£23,125 – 261,800	0.87	0.68 – 1.22
PMS	£3,083,869	£43,026 – 269,272	1.11	0.80 – 1.87
West	£1,451,217	£39,340 – 269,272	1.00	0.80 – 1.80
Central	£1,391,082	£23,125 – 261,800	0.95	0.68 – 1.31
North East	£1,493,342	£27,785 – 245,251	1.03	0.77 – 1.71
South East	£810,082	£25,156 – 85,023	1.05	0.79 – 1.87
All	£5,145,724	£23,125 – 269,272	1.00	0.68 – 1.87

Source: Haringey TPCT

[a] Workload weightings deprived from the GMS resource allocation formula, based on analysis of GP practice workloads through the General Practice Research Database

Table 13 *Summary of un-weighted and weighted revenue per patient (October – December 2005)*

Practice	Revenue per patient		Workload-weighted revenue per patient		Deprivation-weighted revenue per patient	
	Average	*Range*	*Average*	*Range*	*Average*	*Range*
GMS	0.87	0.68 – 1.22	0.87	0.74 – 1.08	0.86	0.68 – 1.30
PMS	1.11	0.80 – 1.87	1.10	0.77 – 1.98	1.12	0.77 – 1.82
West	1.00	0.80 – 1.80	0.97	0.74 – 1.92	1.09	0.86 – 1.82
Central	0.95	0.68 – 1.31	0.94	0.75 – 1.20	0.95	0.68 – 1.32
North East	1.03	0.77 – 1.71	1.03	0.74 – 1.78	0.96	0.72 – 1.62
South East	1.05	0.79 – 1.87	1.11	0.79 – 1.98	1.01	0.75 – 1.78
ALL	1.00	0.68 – 1.87	1.00	0.74 – 1.98	1.00	0.68 – 1.82

Source: Haringey TPCT

deprivation. This suggested that PMS resources did not necessarily relate to their workload based on the age and sex profile of their patients. When we looked at deprivation GMS practices still received less on average per patient than PMS practices (see table 13).

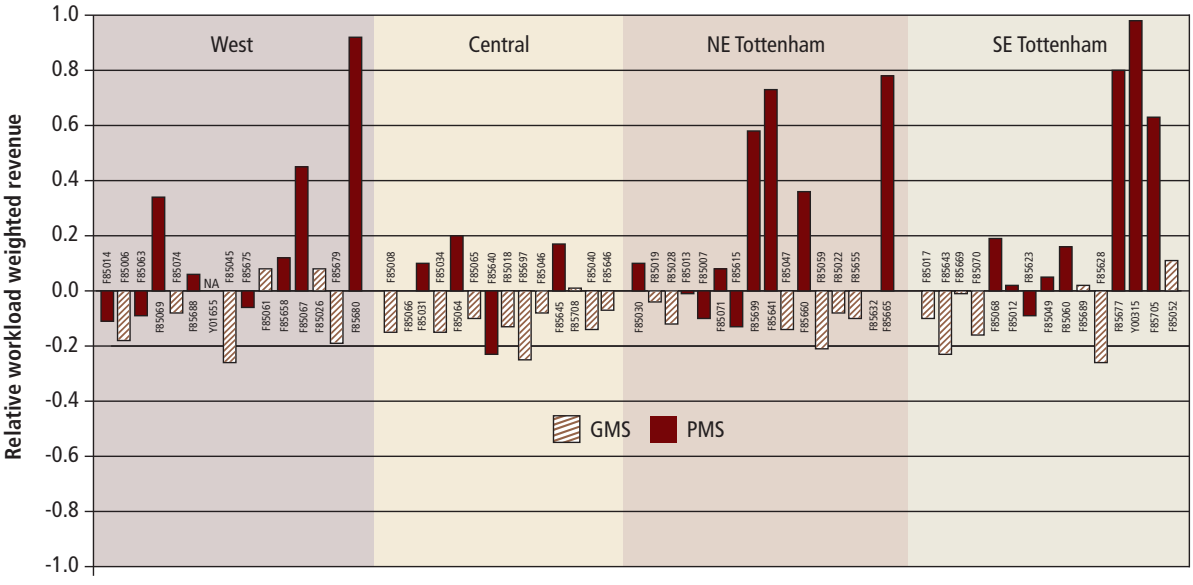
Figure 87 summarises the variation in workload weighted revenue between practices and the current collaboratives. Of the 23 practices that received above average revenue per workload weighted patient, 20 were PMS practices.

6.8.3 How could resources be allocated more equitably?

Based on the analysis outlined above, we estimated how resources could be allocated more equitably between practices in Haringey to take into account the profile of patents registered with them, in terms of workload (age and sex), and deprivation.

Resource allocation under the GMS contract is based on a formula (Carr-Hill) that takes into account the needs of registered patients, although it does not factor in health needs related to the ethnic diversity of a population.

Figure 87 *Workload weighted revenue per patient (October – December 2005) as per current collaborative groupings*



Source: Haringey TPCT

In contrast, PMS contracts were individually negotiated and predominantly based on past activity rather than need.

6.9 Conclusions – Health and primary care

- Quality of care markers vary considerably between different practices in Haringey such as in screening and prescribing.
- There is marked variability in the completion of registers on people with long term conditions between different practices.
- Diabetes is managed very variably between practices in Haringey.
- There is significant variability in need, demand and likely workload of different practices.
- There is significant variation in the resource allocation to different practices that reflect historical patterns but not patient needs.

Conclusions and recommendations

1. Growth of population

The Haringey population is projected to grow by up to 6.6% by 2021. This growth will be concentrated in central and eastern parts of the borough, with a decline in some ethnic minority communities.

Recommendation 1

Planning for health and health services in Haringey must respond to this population growth.

2. Too many people dying too young

- Life expectancy for men in Haringey is too short, especially in Tottenham.
- Infant mortality in Haringey is too high and much higher than the London average.

Recommendation 2

Urgent action by both health services and other statutory and voluntary agencies to impact on these problems by implementing the Haringey Infant Mortality and Life Expectancy Action Plans.

3. Why are so many Haringey children so obese?

There are too many overweight and obese children in Haringey, especially in the most deprived parts of the borough. This is of real concern as patterns of health for later life are now being laid down.

Recommendation 3

Haringey TPCT and Haringey Council should work with schools, fast food outlets, shops, families and community groups to change shopping, eating and cooking habits of Haringey families.

4. Efforts to improve health should be targeted at those most at risk

Haringey has an excess of deaths from heart disease and cancer in the 20-64 year old age groups. There are also too many deaths from these diseases in Tottenham, especially North East Tottenham.

Recommendation 4

Ensure medical and other health resources are prioritised to reducing deaths in adults under 65 and those living in North East Tottenham

5. Variation in quality of care across Haringey

The health data suggests that there may be significant variation in the care residents in Haringey experience. For instance, West Haringey has high admission rates for cancer but low death rates, but with GP registrations for cancer lowest in North East Tottenham, while having the highest death rates. Death rates from diabetes in Haringey are much too high, but practice data shows a wide variation in prescribing habits and admission rates to hospital.

Recommendation 5

Haringey TPCT should further investigate the

causes of these variations and improve care delivery where appropriate.

6. Wide variation in funding to GP practices

The data show wide variations in funding to different practices irrespective of workload or of deprivation of the practice population. The greatest difference appears to be greater funding to PMS practices compared with GMS.

Recommendation 6

Haringey TPCT should reconsider the resource allocation to practices and ensure that it is allocated according to need and invested to improve outcomes and quality of care delivery.

Glossary and bibliography

ACE inhibitor	Drug used in the treatment of hypertension and heart disease.
Antibiotic	Drug used to treat bacterial infection.
BME group	Black and minority ethnic group.
BMI	Body Mass Index.
Cervical Cytology	Screening of the cervix for abnormal cells.
CHD	Coronary Heart Disease – Disease of the heart and its blood vessels leading to abnormal rhythm and poor blood flow to the heart muscles.
Collaborative	Working group of GP practices sharing information, good practice and commissioning arrangements. The 4 in Haringey are West Haringey, Central Haringey and North East and South East Tottenham.
Congenital disorders	Disorders that are present at birth.
Chronic disease	Term used to describe ongoing conditions e.g. diabetes.
Death rate	Number of people per head of population dying in a particular area.
Demography	Age, Sex and locations of populations.
Determinants of health	Factors which impact on the health of a population. They include income and employment, education, the environment, crime and housing.
Directly standardised admission rate (DSR)	The rate of admission per 100,000 population standardised against the European population.
Elective admissions	Scheduled and planned admissions into hospital.
Fertility Rate	Number of females conceiving per 1,000 15-44 year olds.
GP	General Practitioner.
Hba1C	Measure of glucose control amongst diabetics.
HES	Hospital Episode Statistics.
Incidence rate	The number of new cases of a disease in a given population at a given time - usually expressed as the number per 100,000 population for a given year.
Immunisation	Vaccination used to prevent the spread of disease.
Index of Deprivation scores	Indicates the level of deprivation within a geographical area based on factors such as crime, health and income.
Infant mortality	The number of infant deaths in the first year on life in a year per 1,000 live births.
Insomnia	A disorder characterised by an inability to sleep.
Life expectancy	Life expectancy at birth is the number of years a newborn can be expected to live given prevailing mortality conditions within that geographical location and time period.
LBW	Low birth weight (below 2,500 grams). Very low birth weight (below 1,000 grams).
Locality	Haringey has been split into 4 geographical localities (see figure 11). Mortality and admission rates comparing them are presented in this report.
MMR	Combined measles, mumps and rubella vaccine.
NCHOD	National Centre for Health Outcomes Development.
Obesity	Term used to describe those who are clinically obese and are at risk due to their weight.

ONS	Office For National Statistics.
PCT	Primary Care Trust.
PMS and GMS	Personal Medical Service (PMS) and General Medical Service (GMS). These are different forms of contractual arrangement between the GP and the TPCT.
Premature death	Deaths occurring in the under 75 population.
Prevalence	Proportion of people with a disease at a point in time.
QOF	Quality and outcome Framework.
Registered population	Total population registered with the General practice Surgery.
Resident population	Total population living in a defined area.
Screening	Screening is a public health service in which members of a defined population, who do not necessarily perceive they are at risk of, or are already affected by a disease or its complications, are asked a question or offered a test, to identify those individuals who are more likely to be helped than harmed by further tests or treatment to reduce the risk of disease or complications.
Standardised Mortality Ratio (SMR)	An SMR describes the observed number of deaths within an area divided by the expected number of deaths (if national age and sex specific mortality rates were to apply). The ratio is multiplied by 100. An SMR of 100 suggests that mortality rates are the same as the national mortality rates when age and sex differences in the two populations are taken into account.
Standardisation	Allows comparison of populations with different age and sex profiles.
Statins	A group of cholesterol-lowering drugs.
Statistically significant	A mathematical measure of difference between groups. The difference is said to be statistically significant if it is greater than what might be expected to happen by chance alone.
Super Output Area (SOA)	Small geographical area (usually 7 or 8 per ward).
TPCT	Teaching Primary Care Trust.
Ward (geographical)	Local authority constituency boundary for local government.
Years of life lost	Statistical measured used to describe the years of life lost as a result of premature death.

Bibliography

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[2] Index of deprivation 2004, Office of the Deputy Prime Minister, 2004

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