PUBLIC HEALTH PROFILE

CLASSIFIED BY PRACTICE BASED COMMISSIONING

(PBC) CONSORTIA

NHS LAMBETH

August 2009

Foreword

This report is created to support the Practice Based Commissioning (PBC) consortias to plan their commissioning intentions. The information is derived from various reliable sources and the main source is the London Health Observatory's (LHO) Practice Profiles from where the QOF (Qualities and Outcomes Framework) information was acquired. The analysis of prevalence using the Association of Public Health Observatories models for specific conditions is enclosed as Appendix 1. The link to the LHO practice profiles is included in Appendix 2.

While every precaution is taken to ensure that the information included in this document is accurate, interpretation of information from certain data sources should be treated with caution. Prevalence rates from GP practice registers (QMAS) are case detected prevalence rates and do not reflect the true prevalence of the disease. If you have any queries or comments, please contact the Lambeth Public Health Intelligence Department.

Contact person:
Ash More
Directorate of Public Health
NHS Lambeth
1, Lower Marsh
Waterloo,
London – SE1 7NT
Email: ash.more@lambethpct.nhs.uk
Tel: (+44) 020-30494236


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1. Background and introduction

In Oct/Nov 2007 all Practice Based Commissioning (PBC) Consortia groups were presented with findings from the work done to understand demography and health profile of the population at Lambeth Locality level (North, Southeast and Southwest). These findings have proved useful to the groups to understand their population better. In 2008, the London Health Observatory (LHO) devised an online tool called the 'Practice Profiles'. All practices were sent their individual practice profile (as word and pdf document) which detailed the demographic and health picture using Quality and Outcomes Framework (QOF) data. The practice were asked to use the findings in their planning and business development and were also offered support from the then Lambeth PCT's Public health directorate.

This year in 2009, we have conducted similar analysis once again and also used the QOF dataset for 2008 to understand the population better and classified the findings according to the present PBC groups in Lambeth. In 2007, the following slide was presented to the PBC groups which detailed the level of information required to develop a strong business case and strategic prioritization.

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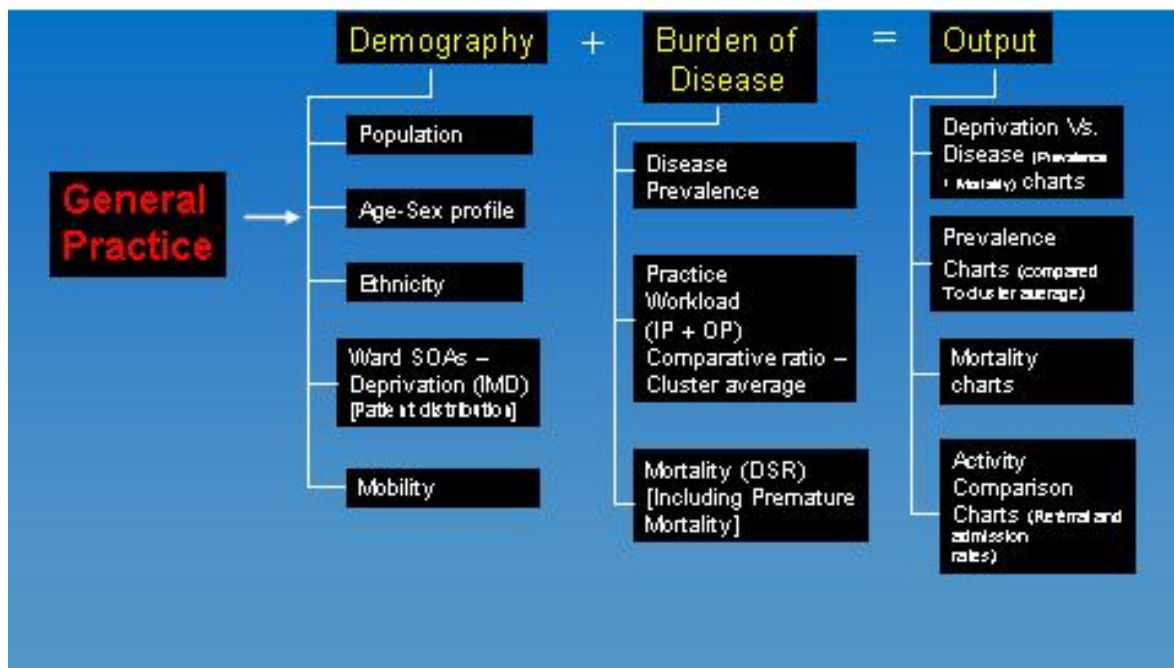
While it is understood that availability of all of the above information in one place is an important issue, every attempt is made to present the demographic and health profile in the best possible way in this document. Not all of the information sets listed above are included in this document, because the scope of this piece of work is to understand the public health profile and there is very limited use of inpatient or out patient activity information in this document.

This document contains a detailed profile of the population derived from the analysis conducted using the demographic and health information from the Quality and Outcomes Framework (QOF) 2008 and is classified according to the Practice Based Commissioning Consortia (PBC) in Lambeth viz.,
- GHD
- GPCG (General Practice Commissioning Group)
- North
- SACH (Streatham and Clapham Health)

The information within this document will support the PBC consortia to plan their commissioning intentions in the next year and develop their individual strategies. The following information is included in detail in this document.

- Demography (Age, Gender, Ethnicity profile, Deprivation, life expectancy)
- Long Term Condition prevalence (CHD, HTN, COPD, DM, Cancer, MH). Abbreviations are explained on page 45.

The prevalence is the QOF prevalence or case detected prevalence estimated using the number of people on the practice register divided by the practice registered population expressed as a percentage. The data on expected prevalence as determined by various disease prevalence models is also used to identify the ratio of estimated to detected prevalence. The findings are presented for all practices in the form of graphs showing performance of each practice, and includes the averages for each PBC Group, Lambeth and London where available.

Ward level analysis was conducted for specific mortality indicators. This is presented with classification at Lambeth Localities level (North, Southeast and Southwest). To understand the ward level population projections and how they attribute to the practices in each PBC consortia group in a better way, the PBC consortia practices are approximated to the Lambeth Localities – North, South East and South West. The alignment is detailed below. This will benefit the practices to understand in which locality their practice lies. An excel tool to filter practice level information is also provided to Primary Care for their use in understanding performance on several indicators for Lambeth practices. A data directory is also provided explaining definitions of certain indicators used in this report.

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2008/09 Consortia	Practice Code	Partner	Practice	Locality	List size (Mar 09)
GHD	G85016	Kheraj	Herne Hill Group Practice	South East	10948
GHD	G85022	White (formerly Elliot)	Crown Dale Medical Centre	South East	6968
GHD	G85039	Evans	Paxton Green Group	South East	18642
GPCG	G85073	Patel H	Drs Patel & Cresswell	South East	7180
GPCG	G85078	Berlyn	Drs Berlyn, Whitmey & Mukhopadhyay	South East	5128
GPCG	G85088	Saif	Brixton Water Lane Practice	South East	7599
GPCG	G85113	Fernandes	Norwood Surgery	South East	4709
GPCG	G85127	Wickstead	The Corner Surgery	South East	4502
GPCG	G85662	Ung & Andlaw	Streatham Hill Group	South West	8799
GPCG	G85133	Ah-Moye	Tulse Hill	South East	8204
GPCG	G85135	Konzon	Iveagh House Surgery	South East	7880
GPCG	G85690	Arora	Herne Hill Road Medical	South East	5751
GPCG	G85695	Mukadam	Foxley Square Surgery	South East	3591
GPCG	G85706	Chabuk	The Rosendale Surgery	South East	6468
GPCG	G85708	Curran	Dr Curran & Partners	South West	9158
North	G85028	Savage RA	Stockwell Group Practice	North	14597
North	G85053	Dudley (formerly Pool)	Hurley Clinic	North	14913
North	G85054	Mitra	Lambeth Walk	North	7656
North	G85060	Irani	Dr Irani	North	1771
North	G85086	Castro (formerly Costa)	The South Lambeth Road	North	6026
North	G85100	McGinn	Beckett House Practice	North	5999
North	G85102	Shah	The Vauxhall Surgery	North	2719
North	G85123	Whittet	Binfield Road	North	7474
North	G85130	Logan	Mawbey Group	North	9637
North	G85136	Harborow	Waterloo Health Centre	North	7291
North	G85673	Cajeat (formerly Buchanan)	Springfield Primary Care Centre	North	3997
North	G85700	Ferreira	Dr Ivor Ferreira	North	3485
North	Y00020	Wickremesinghe	Dr Wickremesinghe	North	5319
North	Y01962	Ellender (formerly Ashworth)	Riverside Medical Centre	North	2550
SACH	G85002	Abbasi (formerly Ashby)	Streatham High Practice	South West	4542
SACH	G85010	Santamaria	Dr Sheila Santamaria	South West	2832
SACH	G85011	Heenan	Clapham Family Practice	South West	14314
SACH	G85014	Savage SJ	Streatham Common Group	South West	7351
SACH	G85021	Masterton	Dr. Masterton's Surgery TH	South West	6396
SACH	G85025	Bennett	Brixton Hill Group Practice	South East	10572
SACH	G85041	Winter (formerly Roberts/Winter)	Palace Road Surgery	South West	7182
SACH	G85044	Peck (Hayes)	Valley Road Surgery (GMS)	South West	5542
SACH	G85045	Burton	Hetherington Group	South West	10379
SACH	G85047	Haxwell (formerly) Hu	Knights Hill Road	South East	2955
SACH	G85083	Gupta	Sandmere Road Practice	South West	15661

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SACH	G85096	Ramanan	Dr. Ramanan's Surgery	South West	2140
SACH	G85109	Shepherd/Block	Clapham Park Surgery (GMS	South West	12207
SACH	G85118	Singh	Streatham Place Surgery	South West	7294
SACH	G85129	Wright	Deerbrook Surgery	South East	3430
SACH	G85137	Bruml (formerly Fine)	Brockwell Park Surgery	South East	4757
SACH	G85618	Ashton	The Courtyard Surgery	South West	3803
SACH	G85645	Patel, SN	Pavilion Practice (GMS)	South East	6076
SACH	G85647	Rowley-Conwy	The Exchange Surgery	South West	2937
SACH	G85674	Ala	Dr Ala's Surgery (GMS)	South West	1641
SACH	G85677	Lidgey & Cartwright	Drakewood Road Medical	South West	3642
SACH	G85682	Gunasuntharam	Dr. Gunasuntharam Surgery	South West	1505
SACH	G85724	Tahir/Bell	Edith Cavell Practice	South West	6643
Total (Mar 2009)					**352762**

Based on the above table, it can be seen that all the GHD consortium practices are based in the Southeast locality. All the practices in the North consortium are based in the North locality geographically. In GPCG consortium, most of the practices are based in Southeast locality barring Streatham group practice and Dr. Curran and partners which are based in the Southwest locality. In the SACH consortium, most of the practices are in the Southwest locality barring Deerbrook Surgery, Brockwell Park Surgery, Brixton hill, Knight's hill and Pavilion practice which are in the Southeast locality. This geographic attribution is based on the location of practice and does not take into account the registered patients residence.

2. Demography

a. Map of Lambeth
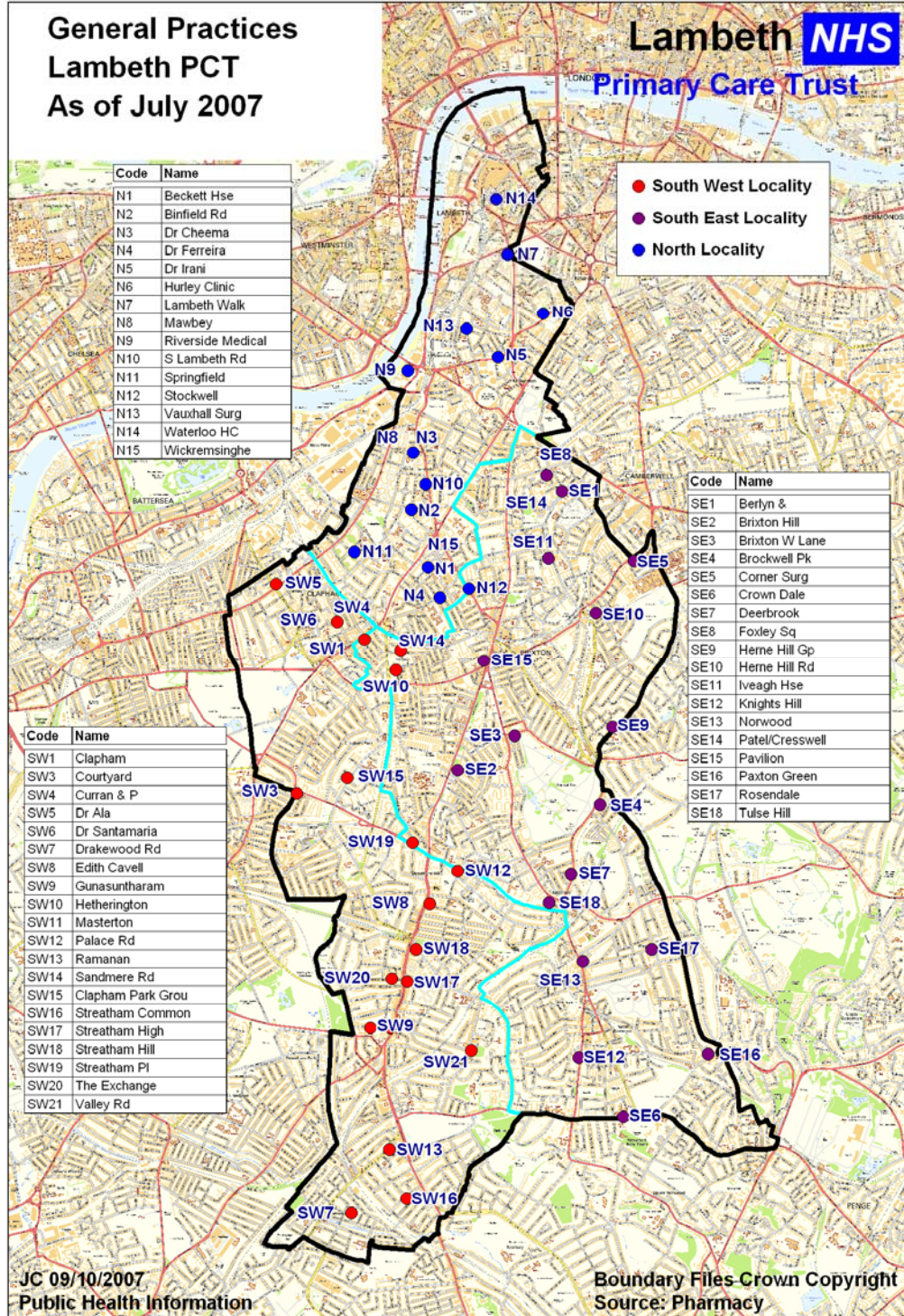
b. Population

The following table and graphs shows the total registered population in each PBC consortia practices as recorded on Lambeth General practices in March 2009.

Population numbers in each PBC consortium in Lambeth
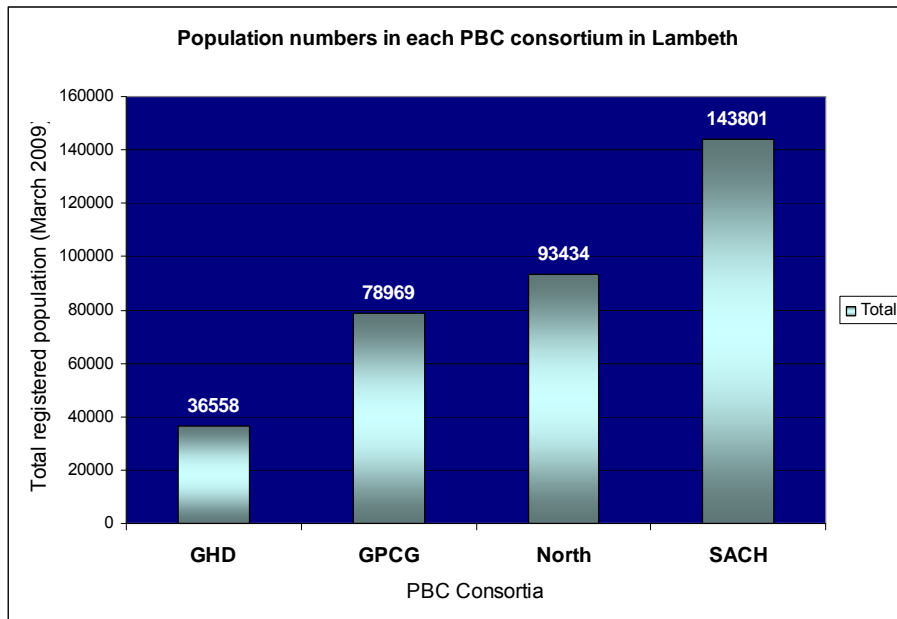
	Total	% Population Share
GHD	36558	10%
GPCG	78969	22%
North	93434	26%
SACH	143801	41%

% Population share by each PBC consortia (Mar 2009)
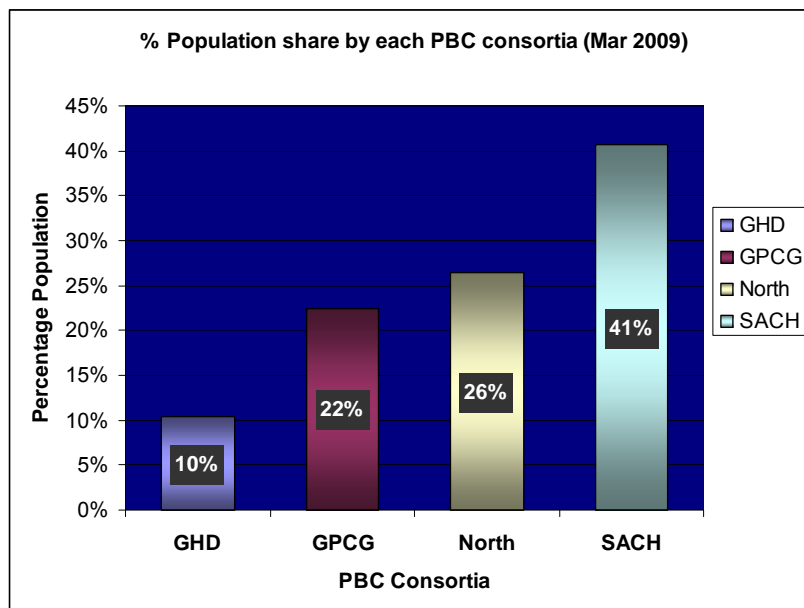
The SACH consortia has the greatest share of registered population of all four consortias at 41%.

c. Population projection by ward

The Greater London Authority (GLA) provides annual estimates of resident population as well as the population projection in London Boroughs at ward level. The following table and corresponding map shows the list of wards in each locality of Lambeth.

North Locality
Bishop's
Larkhall
Oval
Prince's
Stockwell

South East Locality
Brixton Hill
Coldharbour
Ferndale
Gipsy Hill
Herne Hill
Knight's Hill
Thurlow Park
Tulse Hill
Vassall

South West Locality
Clapham Common
Clapham Town
St Leonard's
Streatham Hill
Streatham South
Streatham Wells
Thornton
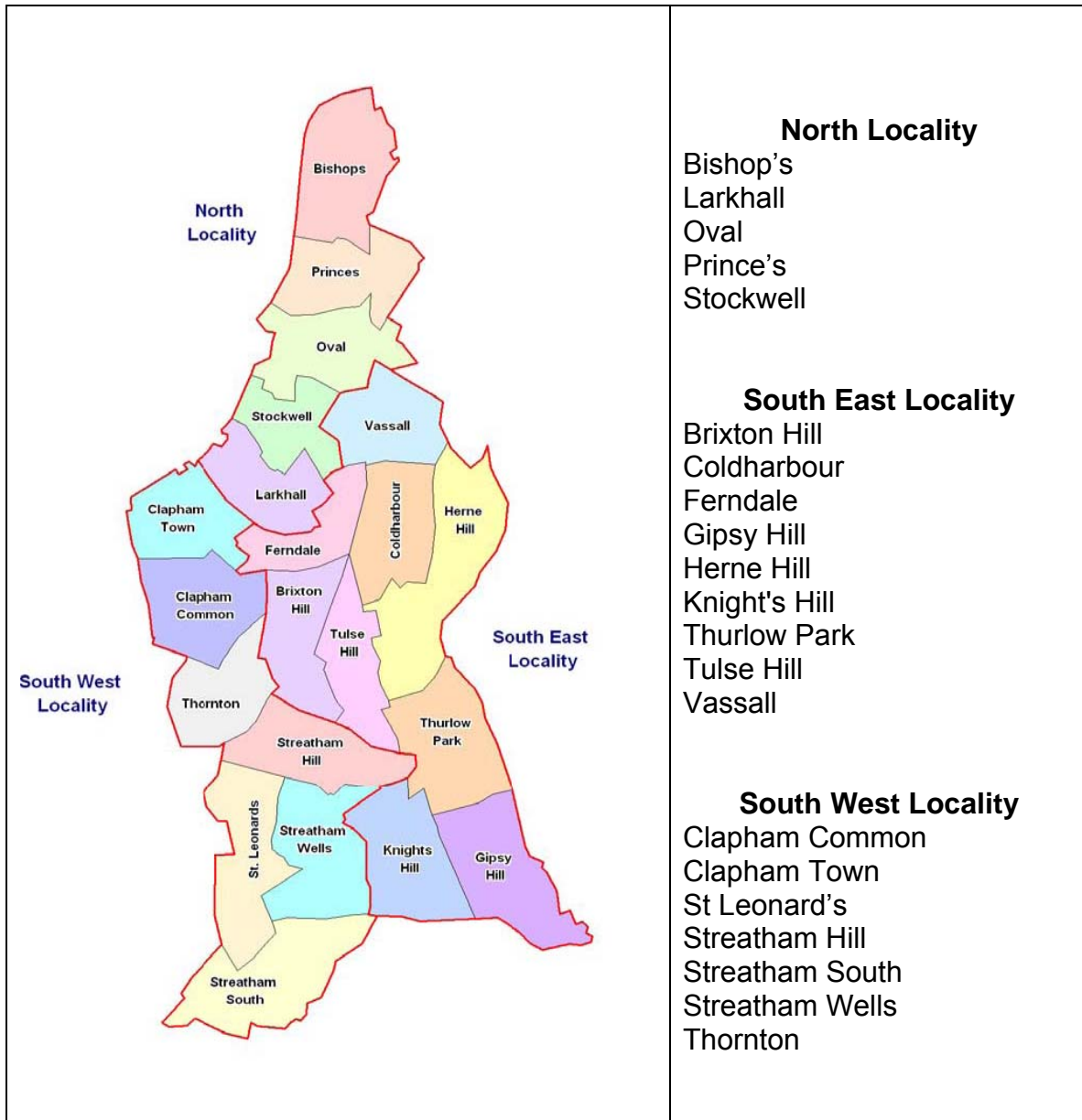
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The reader is requested to study the ward level population projections for the ward/locality in which their practice is located which is the nearest possible estimate of how their population is growing or changing. The following table shows the ward level population projection from 2008-2014 from the GLA© 2008.

	2,008	2009	2,010	2011	2,012	2013	2,014	Locality
LAMBETH	286,893	288,810	290,718	292,616	294,305	295,883	297,448	
Bishop's	9,835	9,977	10,116	10,255	10,387	10,522	10,655	North
Brixton Hill	13,503	13,573	13,640	13,711	13,768	13,984	14,200	Southeast
Clapham Common	13,447	13,480	13,512	13,542	13,567	13,623	13,678	Southwest
Clapham Town	14,299	14,415	14,532	14,651	14,758	14,929	15,097	Southwest
Coldharbour	15,253	15,347	15,436	15,528	15,606	15,669	15,734	Southeast
Ferndale	14,233	14,358	14,482	14,606	14,722	14,803	14,883	Southeast
Gipsy Hill	14,371	14,424	14,480	14,531	14,570	14,592	14,615	Southeast
Herne Hill	12,825	12,833	12,838	12,842	12,837	12,882	12,926	Southeast
Knight's Hill	14,479	14,498	14,518	14,537	14,539	14,613	14,686	Southeast
Larkhall	15,485	15,612	15,739	15,863	15,979	16,027	16,070	North
Oval	13,626	13,820	14,013	14,206	14,392	14,604	14,815	North
Prince's	12,393	12,513	12,633	12,754	12,862	12,972	13,085	North
St. Leonard's	13,174	13,280	13,385	13,489	13,585	13,686	13,786	Southwest
Stockwell	14,270	14,348	14,427	14,505	14,572	14,598	14,620	North
Streatham Hill	14,133	14,144	14,156	14,167	14,171	14,173	14,179	Southwest
Streatham South	14,117	14,144	14,170	14,196	14,211	14,270	14,328	Southwest
Streatham Wells	13,823	13,835	13,845	13,855	13,859	13,871	13,882	Southwest
Thornton	13,203	13,570	13,941	14,312	14,676	14,671	14,665	Southwest
Thurlow Park	12,287	12,397	12,504	12,612	12,708	12,816	12,922	Southeast
Tulse Hill	14,161	14,151	14,141	14,129	14,105	14,116	14,125	Southeast
Vassall	13,976	14,092	14,210	14,326	14,431	14,463	14,496	Southeast
Source: GLA Interim Ward level projection 2008 ©								

The following graphs show the population projection in each locality of Lambeth from 2008-2014.

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Population projections 2008-2014 at Locality level in Lambeth
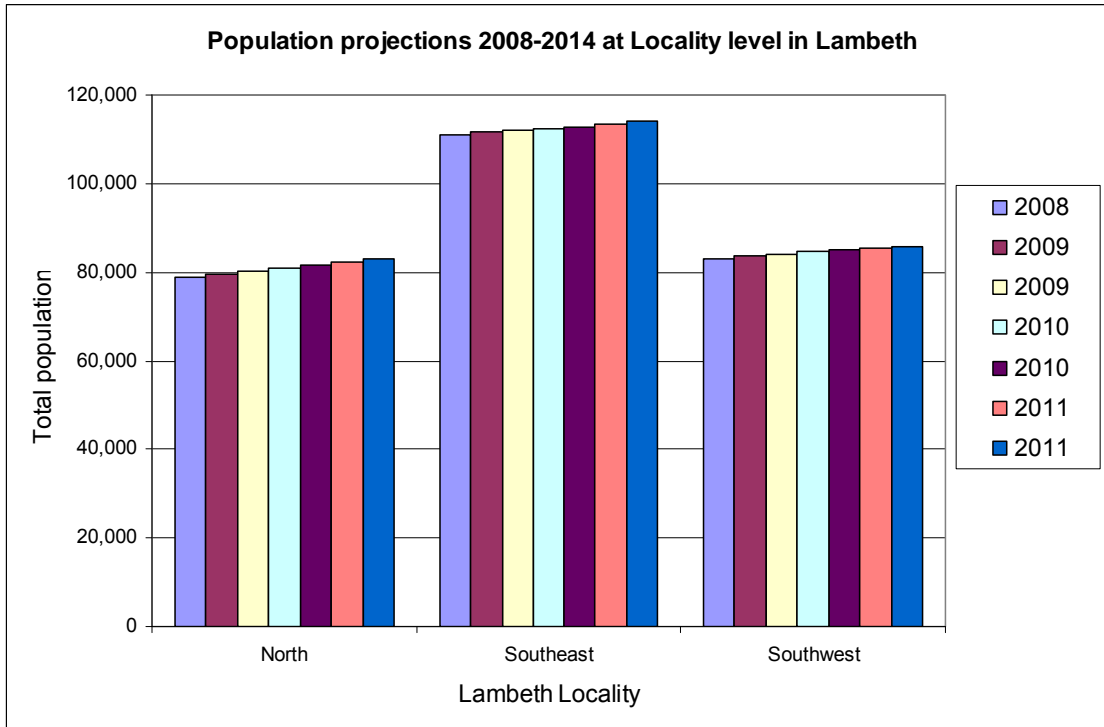

In terms of population growth, the ward level population projections show that the resident population is expected to grow by 5.1% in North locality from 2008 to 2014 and by 2.6% and 3.27% in the Southeast and Southwest locality respectively. This could mean the practice population growth could be most in the North consortium practices. In terms of numbers, the North Locality population is expected to grow from 78,783 in 2008 to 83,033 in 2014. In Southeast locality the population is expected to grow from 111,111 in 2008 to 114,091 in 2014. Similarly, in Southwest from 83,023 in 2004 to 85,829 in 2014.

d. Age and Gender profile

The following graphs shows the age profile of the male population in all PBC consortia compared to Lambeth average (GP registered population, Mar 2009). While the profile does not vary greatly within different age groups, it is observed that GHD and GPCG consortias have a higher proportion of male children and young people within their population compared to other consortias. North and SACH have a relatively higher proportion of male working age population (20-59) which GHD and GPCG have a relatively lower proportion of population in this age group on their registers. There is no significant difference in the proportion of older age population of over 65s in each consortia.
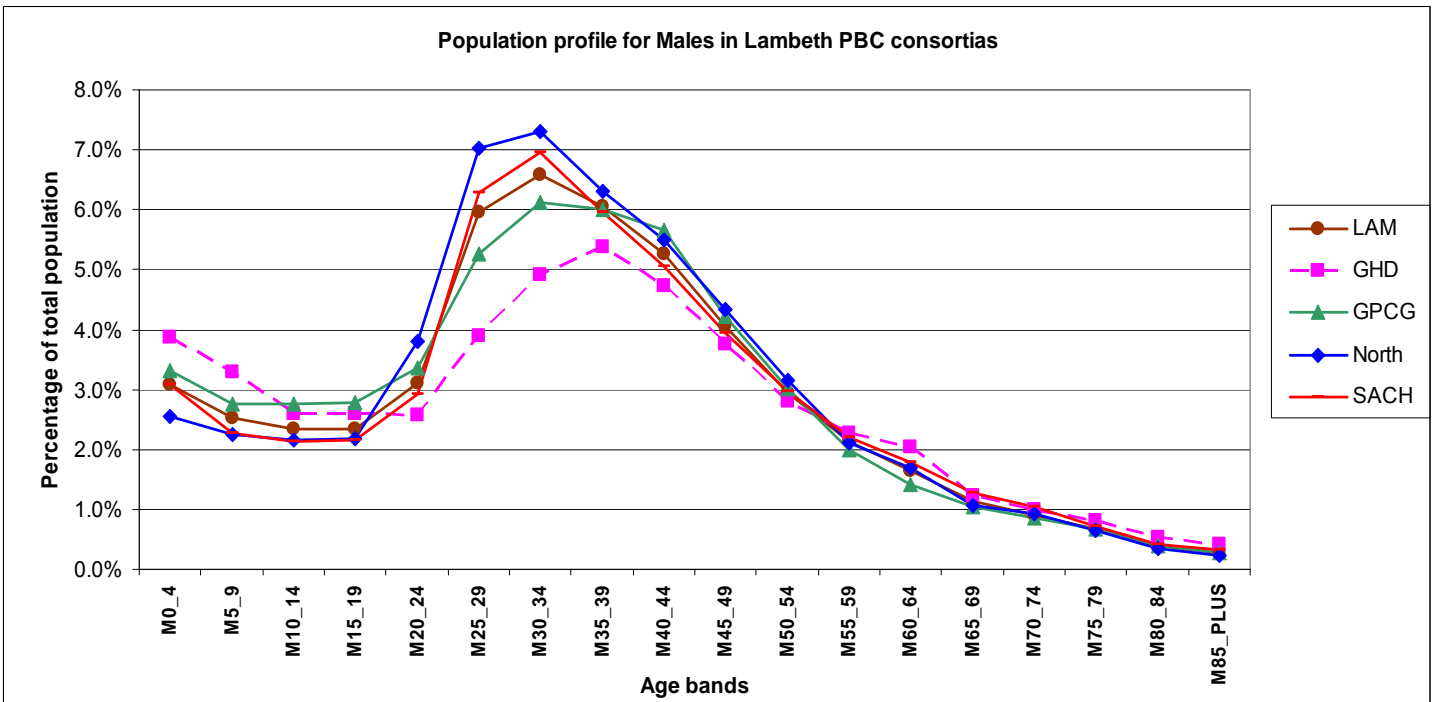

The following graphs shows the age profile of the female population in all PBC consortia compared to Lambeth average (GP registered population, Mar 2009). For females, the children and young children population under 19 is higher in GHD and GPCG consortias while the working age population aged 20-59 is highest in SACH. GHD has a relatively lower proportion of working age female population compared to other consortias as seen in the graph below. The proportion of older female population is relatively higher in the GHD consortia compared to others.

**Population profile for Females in Lambeth PBC consortias**
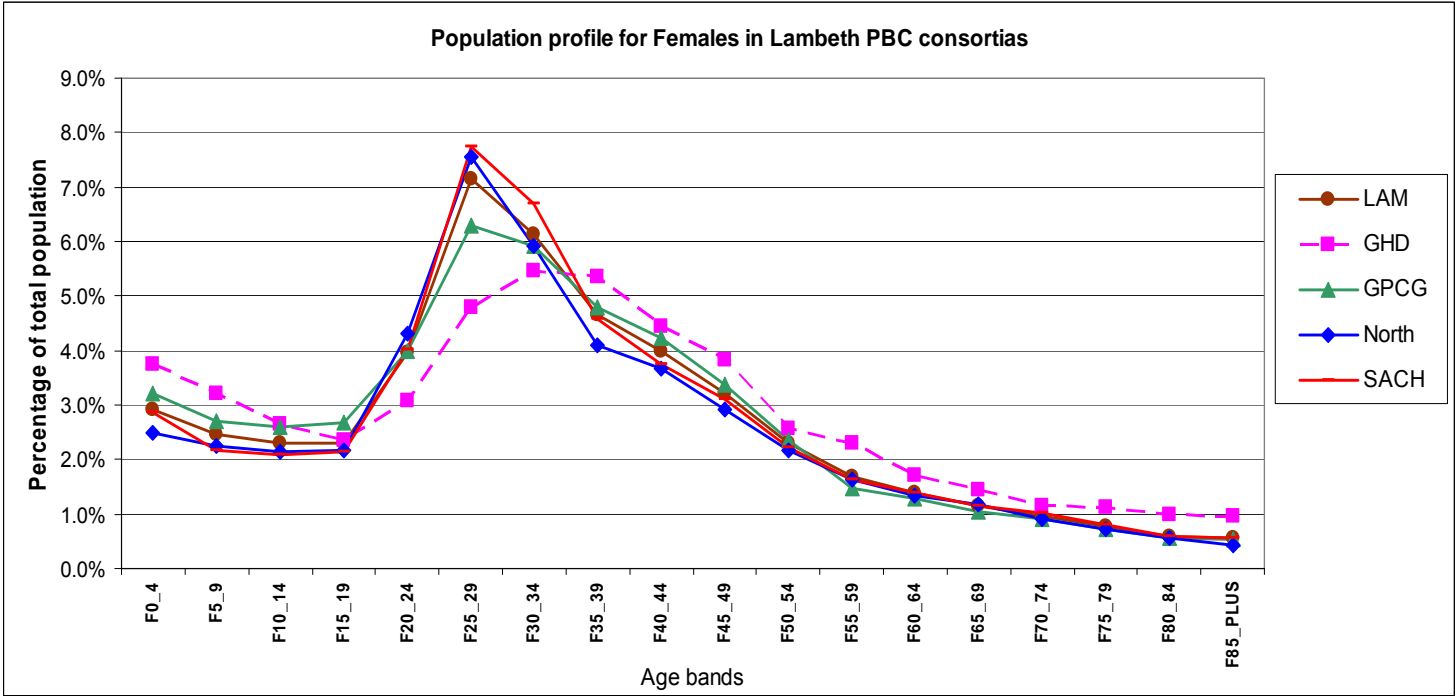
The following graph shows the population breakdown by gender in each PBC consortia.
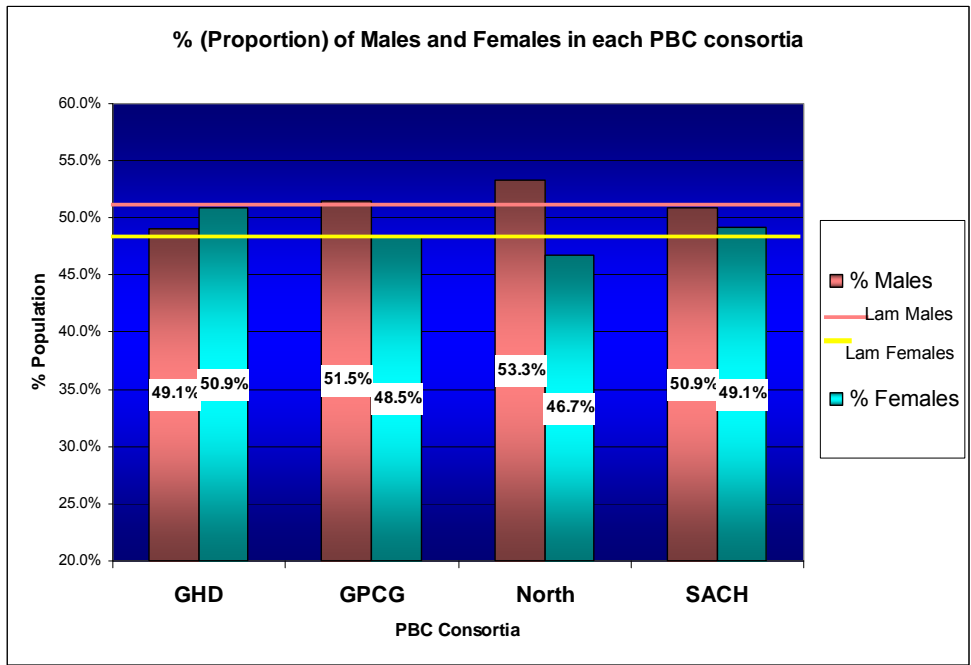
The ratio of males to females in all consortia is similar to Lambeth at Males 51.5%:Females 48.5% except for GHD where it Males are 49.1%:Females 50.9%.

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The following graph and table shows the age breakdown of population in all PBC groups

Age breakdown for each PBC consortia
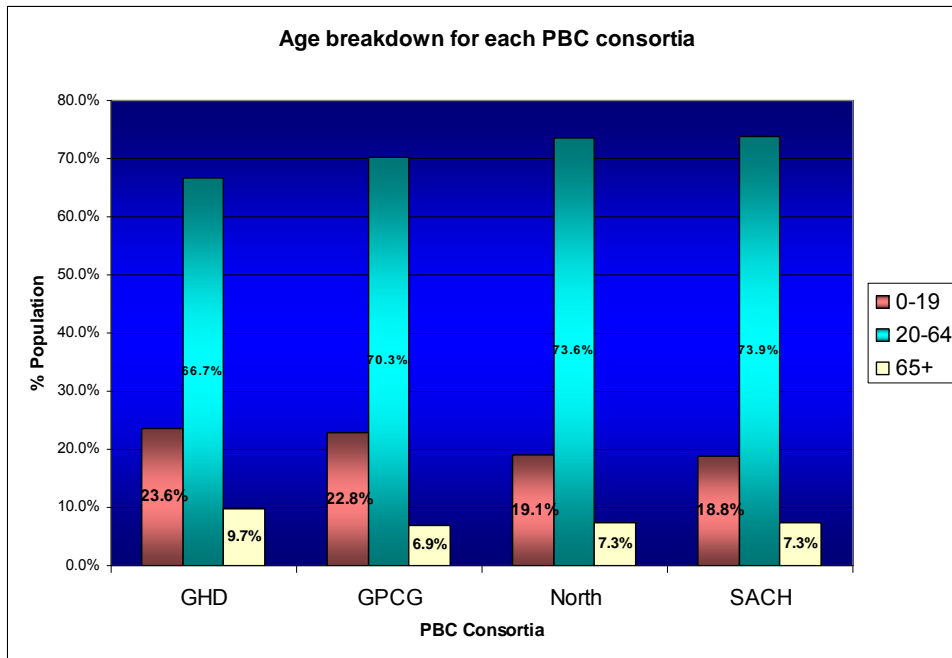
In terms of population breakdown by age, GHD and GPCG have a higher proportion of children and young people at 23.6% and 22.8% respectively; compared to North and SACG at 19.1% and 18.8% respectively. The Lambeth average is 20.3% for 0-19 year olds.

The 20-64 year old population is highest in North and SACH at 73.6% and 73.9% compared to GPCG and GHD at 70.3% and 66.7%. The Lambeth average is 72.3% for 20-64 year olds.

The older population aged 65 years and over is comparatively higher in the GHD at 9.7% compared to North, SACH who are at 7.3% each and GPCG at 6.9%. The Lambeth average is 7.4%.

The table below shows the proportion of population registered by age and gender in each consortia.

% Population by age bands and gender in each PBC consortia						
	0-19		20-64		65+	
	Males	Females	Males	Females	Males	Females
GHD	12.0%	11.6%	32.9%	33.8%	4.1%	5.6%
GPCG	11.6%	11.2%	36.7%	33.6%	3.2%	3.7%
North	9.6%	9.5%	40.3%	33.3%	3.3%	4.0%
SACH	9.6%	9.3%	37.9%	36.0%	3.4%	3.9%
LAM	10.3%	10.0%	37.8%	34.5%	3.4%	4.0%

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The following graphs show the age and gender profile of the population in each consortia in detail compared with the Lambeth average.

GHD
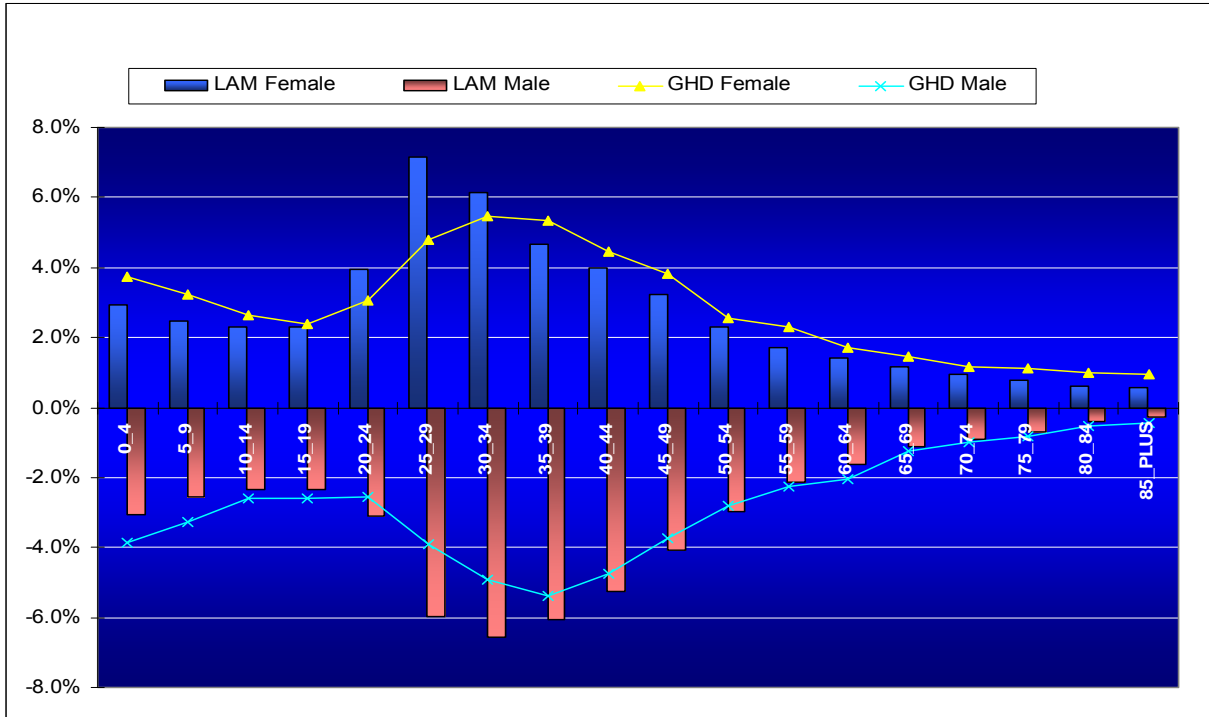
GPCG
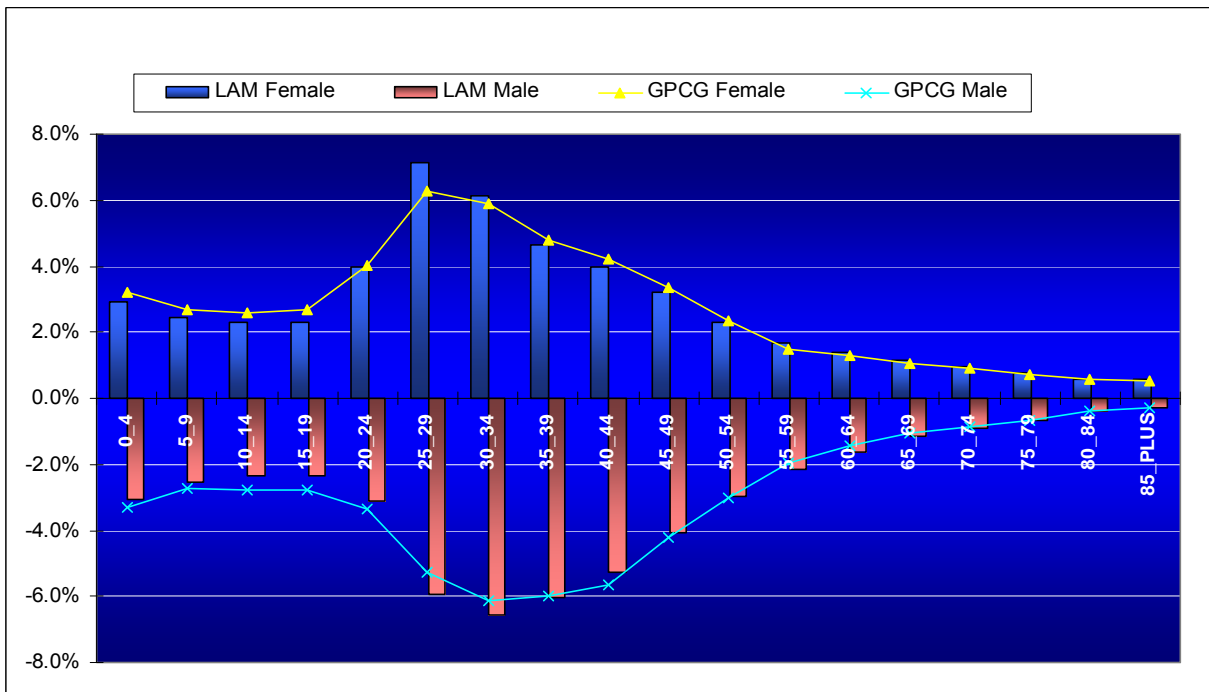
North
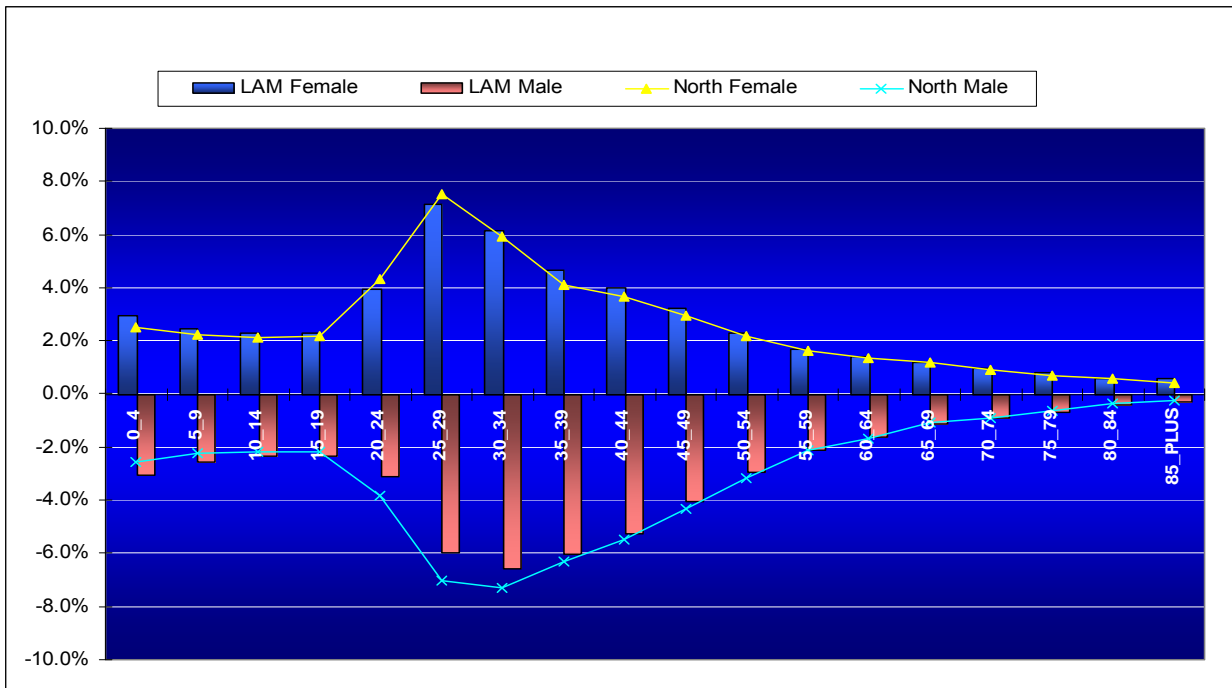
SACH
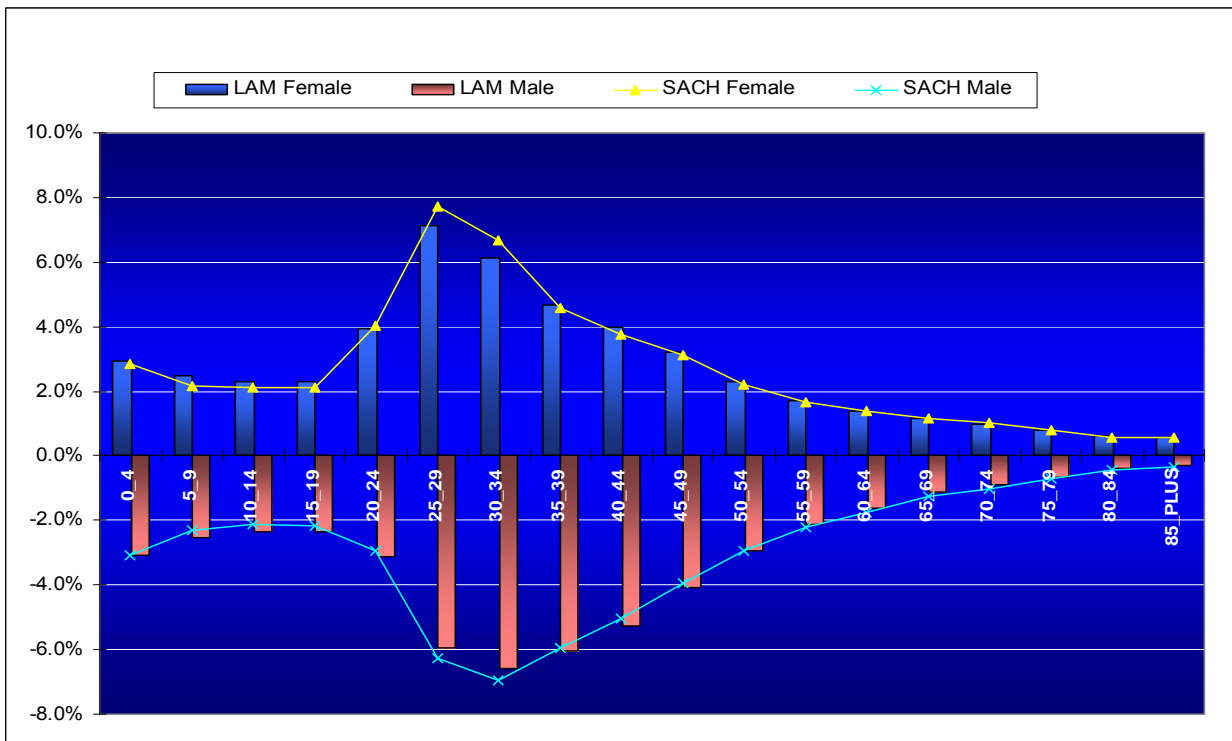
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While comparing population proportions, it should be noted that GHD has the smallest share of the total registered population at 10%.

Population change: The 2005 (March) GP registered population was compared with 2009 (March) GP registered population in Lambeth. The following graphs show the change in population for male and females populations respectively in respective age bands. The proportion of females in the 25-39 and males in 25 to 59 age group shows a rise over last five years

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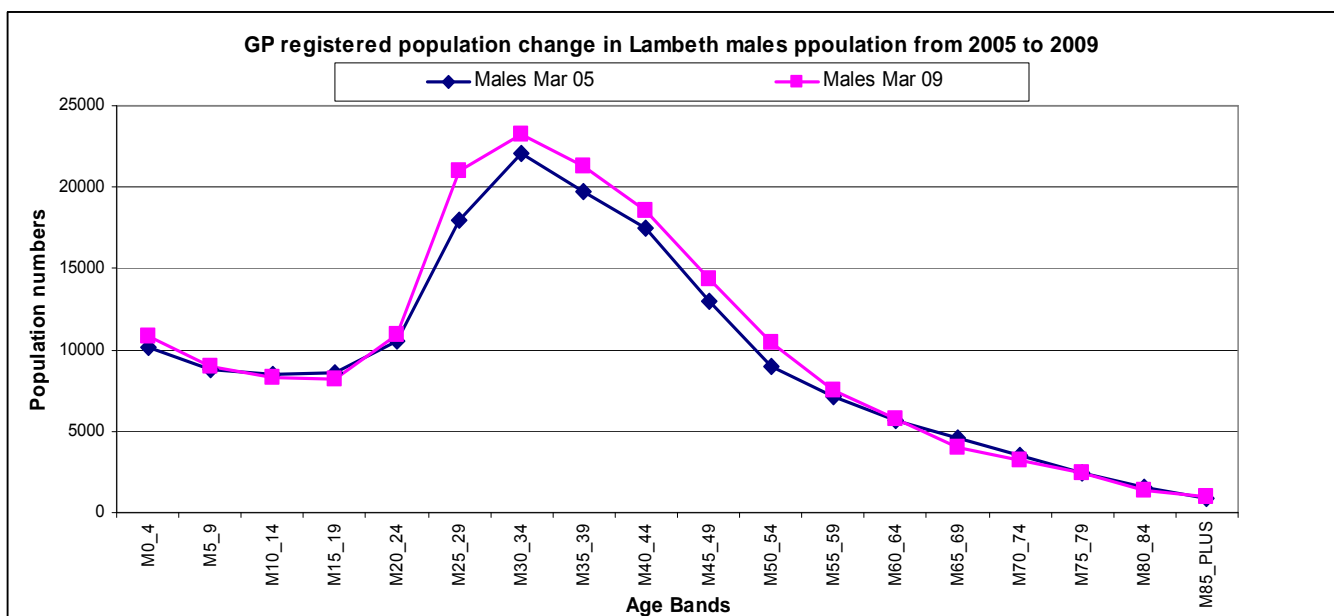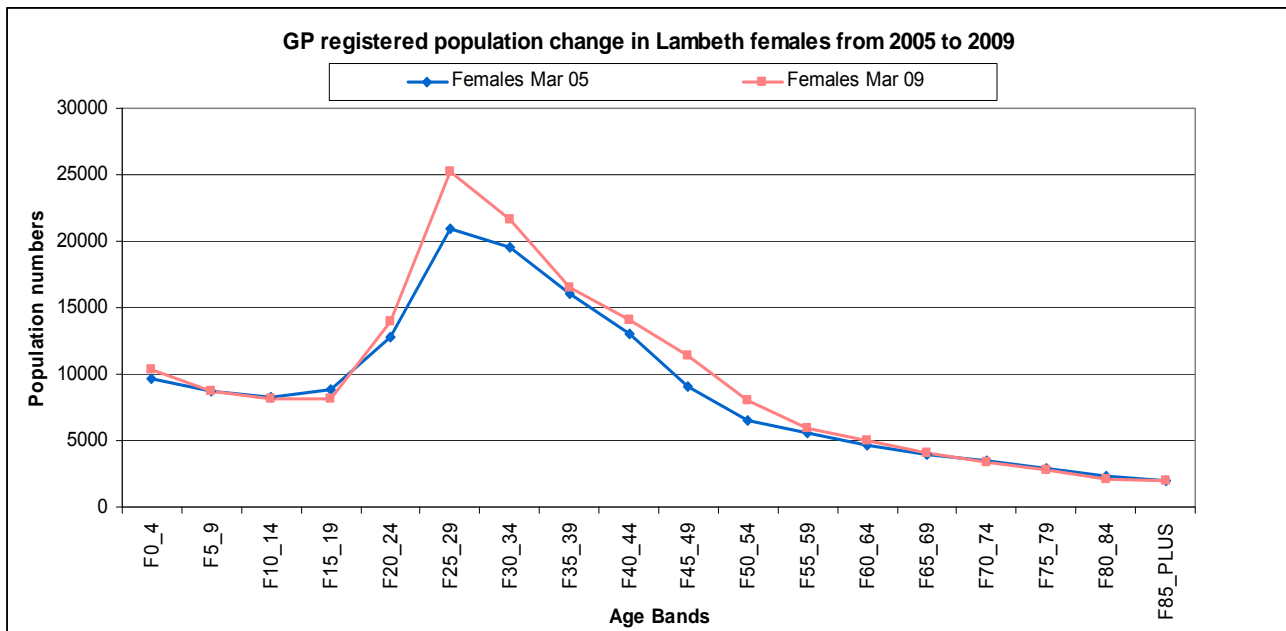
The following graphs shows the percentage change in GP registered population in 5 year age bands.

% Change in male and female population registered with Lambeth Gen Practices from 2005 to 2009
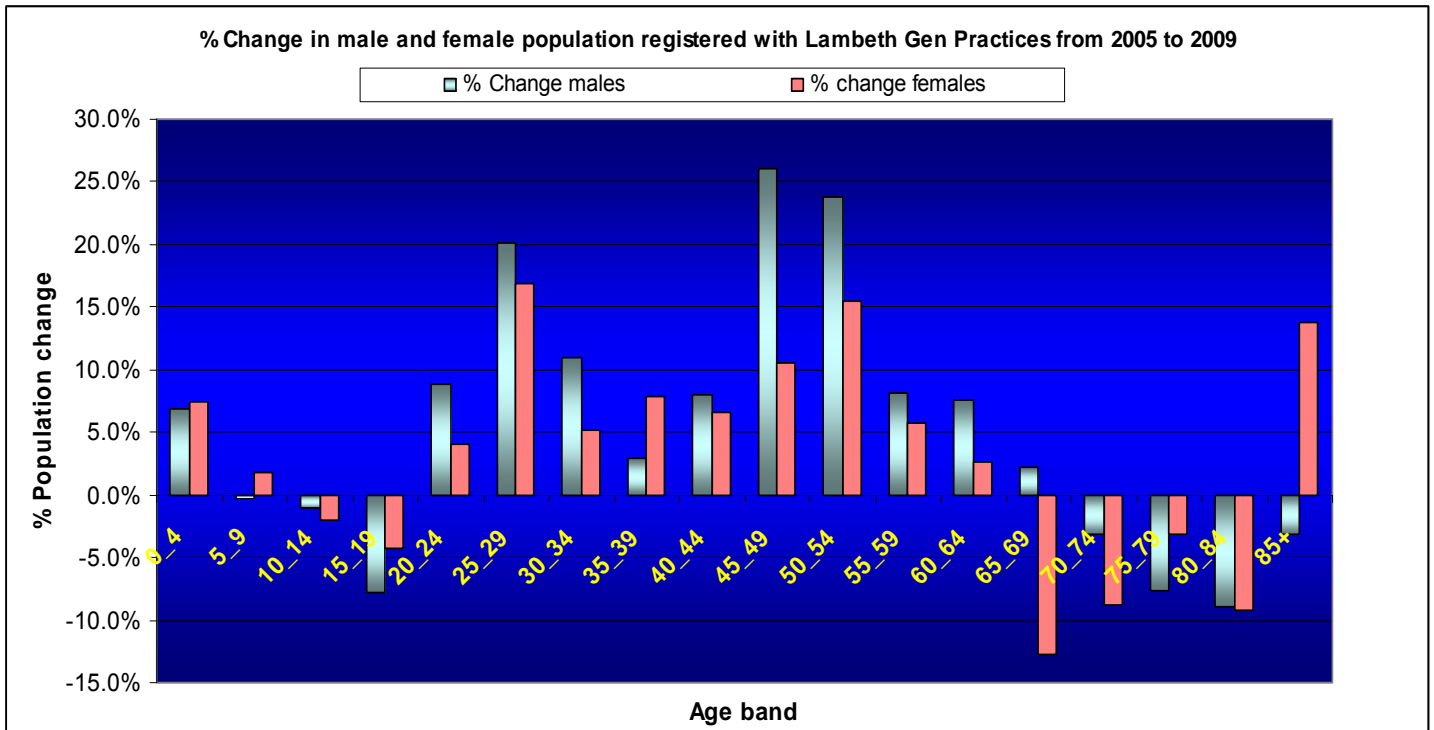
In terms of registrations, there has been a marked increase of up to 20% in the registrations for both males and females in the age group 25-29 years. There is a marked increase in the male population in the age group 45-49 and 50-54 to the tune of up to 25% for males and around 15% for females. There is a reduction in the female registrations in the age group 65 to 84 of approximately 8% but increase in the over 85 population by 14%. For males over 65 there is decrease in the age groups 70-85 of approximately 6% on average. This change does not directly coincide with the Greater London Authority projections, however it should be noted that not every individual registers with practices unless they need treatment. As well as the fact that only a single month (March) registration is used to compare and a mid-year average is not taken for comparison. Issues such as list inflation and de-registrations can affect practice list sizes.

e. Ethnicity

In Lambeth, there is a high level of black and minority ethnic groups in the resident population. The QOF data has been used to split the population into white and non-white population to understand the ethnicity in the population. The percentage of BME population registered with the Lambeth practices ranges from 37% to 54%. The QOF details available classified the population into whites and non-whites only, hence further breakdown of ethnicity by practice is not available. However, the Datanet project extracts can be obtained to understand the ethnic breakdown in detail. In addition the individual practice profiles published by the London Health Observatory are available which breaks the BME population further for each practice. The following graph shows the proportion of whites and non whites registered with Lambeth practices classified by the PBC consortia.

Ethnicity - Proportion of whites and non-whites in the registered population (Mar 2009)

The following table shows the range of BME population proportions in the PBC consortia practices

PBC Consortia	% BME range	PCT % BME	London % BME
GHD	37% to 49%	51.05	44.39
GPCG	34% to 68%	51.05	44.39
North	48% to 65%	51.05	44.39
SACH	38% to 54%	51.05	44.39

On average the North consortia has a higher proportion of BME registered population followed by GPCG, SACH and GHD. The PCT average of all BME population as registered in practices is 51.05% compared to the GLA estimates of 38% in the resident population based on projections using ONS estimates.

f. Deprivation profile

The Indices of Deprivation are an important tool for identifying the most disadvantaged areas in England so that resources can be appropriately targeted. The IMD (Index of Multiple Deprivation) score is a measure of how deprived or how affluent the community is. The new Index of Multiple Deprivation 2007 (IMD 2007) is a Lower layer Super Output Area (LSOA) level measure of multiple deprivation, and is made up of seven LSOA level domain indices viz.,
• Income deprivation
• Employment deprivation
• Health deprivation and disability
• Education, skills and training deprivation
• Barriers to housing and services
• Living environment deprivation
• Crime
There are a total of 38 indicators, distributed across the seven domains which finally accord a score to the super output area which constitutes up to 1500 population.

The deprivation levels for each practice are derived from the IMD (2007) deprivation scores attributed to the ward super output areas based on the national survey of households. These were then aggregated for the practices in each PBC consortia and presented along with the Lambeth average in the following graphs. In terms of IMD (Index of Multiple Deprivation) scores, the more the score the more the deprivation. Lambeth recorded an IMD deprivation score in 2007 of 34.55 compared to its score of 32.01 in 2004 which means in certain domains the deprivation levels have increased in the Lambeth residents. In 2007, the IMD score for London was 26.56. The table below lists the range of IMD scores in each PBC group compared to the Lambeth and London scores.

Consortia	IMD Score range	Lambeth Avg	London Avg
GHD	26.73 to 31.89	34.55	26.56
GPCG	23.43 to 46.45	34.55	26.56
North	30.63 to 40.41	34.55	26.56
SACH	26.60 to 41.29	34.55	26.56

The following graph shows the IMD 2007 scores in each practice classified by Lambeth PBC consortias

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Lambeth IMD Scores attributed to all practices compared to London and Lambeth average
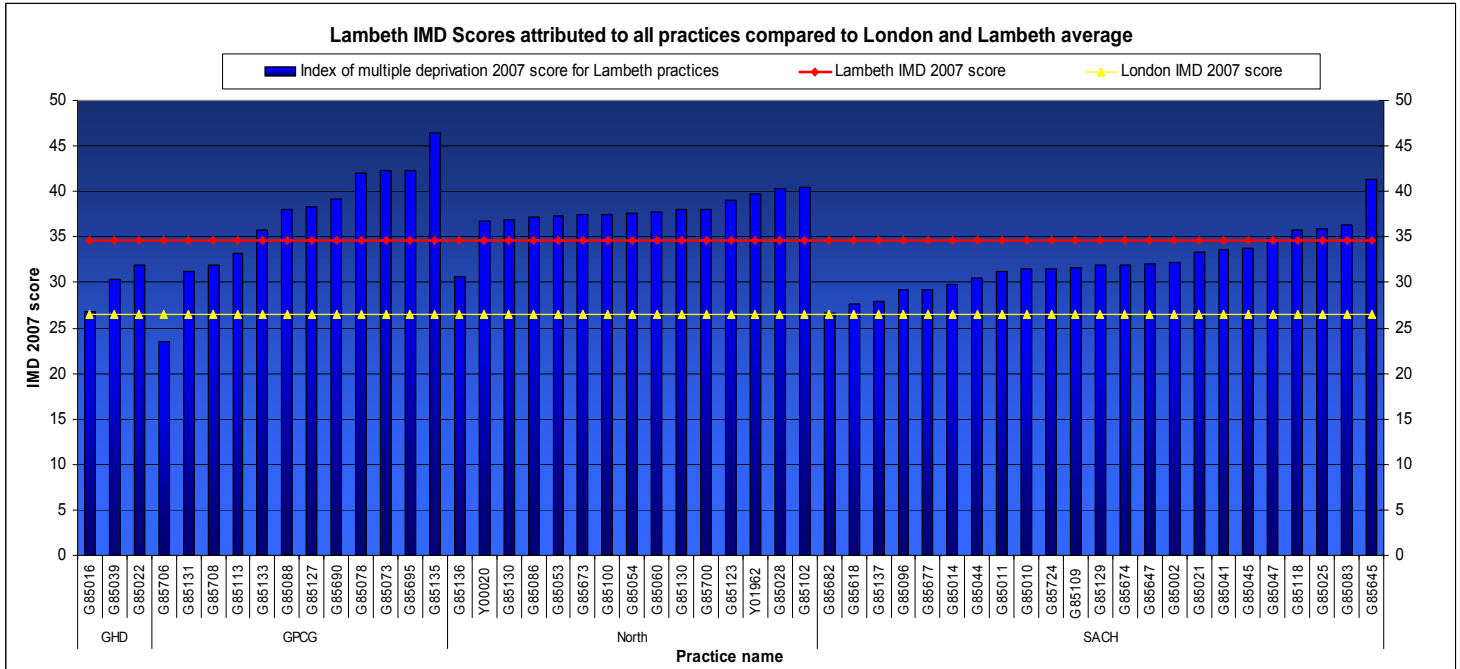
The following graph show that the differing deprivation scores for each practice compared to Lambeth and London average.

Lambeth IMD Scores attributed to all practices compared to London and Lambeth average
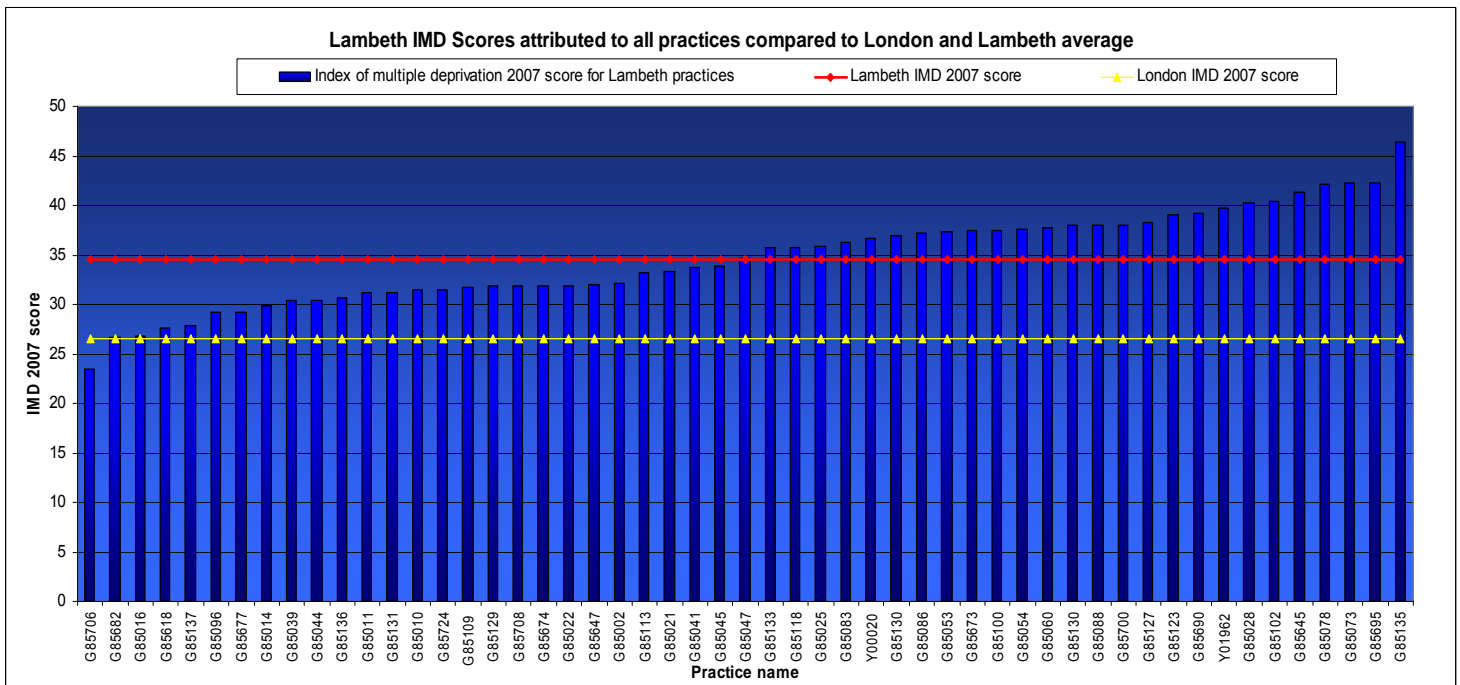
In Lambeth, there is high level of deprivation with 16 out of 21 wards stated to be in the country's most deprived. In terms of practice consortias, in GPCG five practices

have a high deprivation score attached to them compared to the Lambeth average as seen in the graph above. Similarly North consortia have majority of practice with deprivation scores higher than Lambeth average. The prevalence of ill health is associated with deprivation and high prevalence of smoking, mental illness, long term conditions, lower life expectancy due to high premature mortality are some indicators denoting this.

g. Life expectancy

In Lambeth, life expectancy has increased by 3 years for men and 2.1 years for women in Lambeth (see figure 1) since the baseline year 1995-97 to current data year 2005-07. Projected trends show a further improvement in Life Expectancy in Lambeth for both men and women. The following graphs shows the trends in Life Expectancy in Lambeth from baseline year 1995-97.
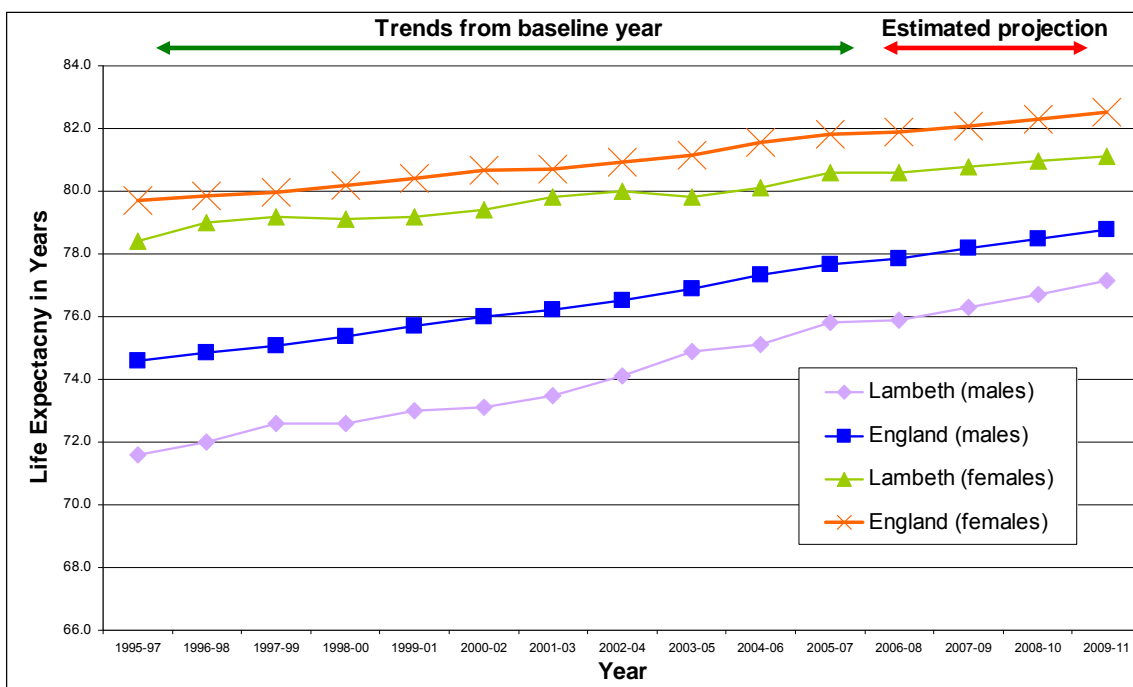
The inequality gap in life expectancy is shown in table below. The gap can be measured using an absolute or relative gap measure (for definitions see notes below table 1). From baseline year the life expectancy inequality gap has reduced by 41% in males and 9% for females. The life expectancy gap is projected to reduce by 48% for men but worsen by 3% for women. This may be because the life expectancy for females in Lambeth is already high and the gap is relatively smaller than for males. Secondly, the estimation of life expectancy is by converting the All Age All Cause Mortality rates using a formula devised by Department of health.

The following table shows the health inequality gap measure for life expectancy in Lambeth compared to England, since England is recommended to be used to measure gap as targets are set using England life expectancy as standard.

	MALES			
Year	Life Expectancy Lambeth	Life Expectancy England	Absolute gap [1]	Relative gap (%) [2]
1995-97	71.6	74.6	3.0	**4.0**
1996-98	72.0	74.8	2.8	**3.8**
1997-99	72.6	75.1	2.5	**3.3**
1998-00	72.6	75.4	2.8	**3.7**
1999-01	73.0	75.7	2.7	**3.6**
2000-02	73.1	76.0	2.9	**3.8**
2001-03	73.5	76.2	2.7	**3.6**
2002-04	74.1	76.5	2.4	**3.2**
2003-05	74.9	76.9	2.0	**2.6**
2004-06	75.1	77.3	2.2	**2.9**
2005-07	75.8	77.7	1.9	**2.4**
	FEMALES			
Year	Life Expectancy Lambeth	Life Expectancy England	Absolute gap [1]	Relative gap (%) [2]
1995-97	78.4	79.7	1.3	**1.6**
1996-98	79.0	79.8	0.8	**1.1**
1997-99	79.2	80.0	0.8	**1.0**
1998-00	79.1	80.2	1.1	**1.4**
1999-01	79.2	80.4	1.2	**1.5**
2000-02	79.4	80.7	1.3	**1.6**
2001-03	79.8	80.7	0.9	**1.1**
2002-04	80.0	80.9	0.9	**1.1**
2003-05	79.8	81.1	1.3	**1.7**
2004-06	80.1	81.6	1.5	**1.8**
2005-07	80.6	81.8	1.2	**1.5**

Absolute gap: Difference in LE rates between England and Lambeth PCT. Relative gap: Difference in LE rates between England and Lambeth PCT as a percentage of the England rate. This is the target measure for the inequality aspect of the target.

Analysis at the ward level is shown in figures 2 & 3. For men 21 of the 23 wards have a life expectancy below national average with 12 of these wards having a significantly lower life expectancy. For women 14 of 21 wards have a life expectancy below national average with 6 of these wards having a significantly lower life expectancy.

The London Health Observatory (LHO) have released the 2001-2005 estimates of life expectancy at ward level for all boroughs. In Lambeth, the male life expectancy ranges from as low at 73.5 in Prince's ward to 77.5 in Streatham South ward compared to the Lambeth average of 74.5 years. Similarly the female life expectancy in Lambeth wards ranges from 78.86 in Larkhall ward to 83.95 in

Thornton ward compared to the Lambeth average of 80.4. The 2001-2005 estimates of life expectancy by ward are detailed in the table below.

Locality	Ward name	Male LE	Female LE
	Prince's	73.5	79.9
	Bishop's	73.9	83.5
	Stockwell	74.5	79.8
	St Leonard's	74.5	81.3
	Larkhall	75.4	78.9
North	Oval	75.4	79.3
	Ferndale	71.4	79.0
	Knight's Hill	71.7	78.6
	Herne Hill	72.3	78.8
	Coldharbour	72.6	78.0
	Vassall	72.7	81.9
	Brixton Hill	72.7	79.5
	Tulse Hill	75.6	80.3
	Gipsy Hill	75.7	80.4
Southeast	Thurlow Park	78.0	82.1
	Clapham Town	74.1	79.1
	Streatham Wells	74.7	79.6
	Clapham Common	75.4	81.1
	Streatham Hill	76.3	80.4
	Thornton	76.3	83.9
Southwest	Streatham South	77.5	82.6
	Lambeth	**74.5**	**80.4**
	London	**76.35**	**81.17**
	England	**76.41**	**80.92**

The following graphs show the ward level life expectancy for males and females by localities in Lambeth compared to the London and England average. It should be noted that life expectancy measure is an indication of overall health in the population and parameters such as age profile of the population, premature mortality rate (deaths under 75 years), all cause mortality rate have a great impact on the life expectancy in a small area such as a ward. The life expectancy does show variation within Lambeth wards with the lowest life expectancy for both males and females recorded in most wards in Southeast locality where there is high level of deprivation.

Male life expectancy in Lambeth at ward level compared to London and England average

Female life expectancy in Lambeth at ward level compared to London and England average
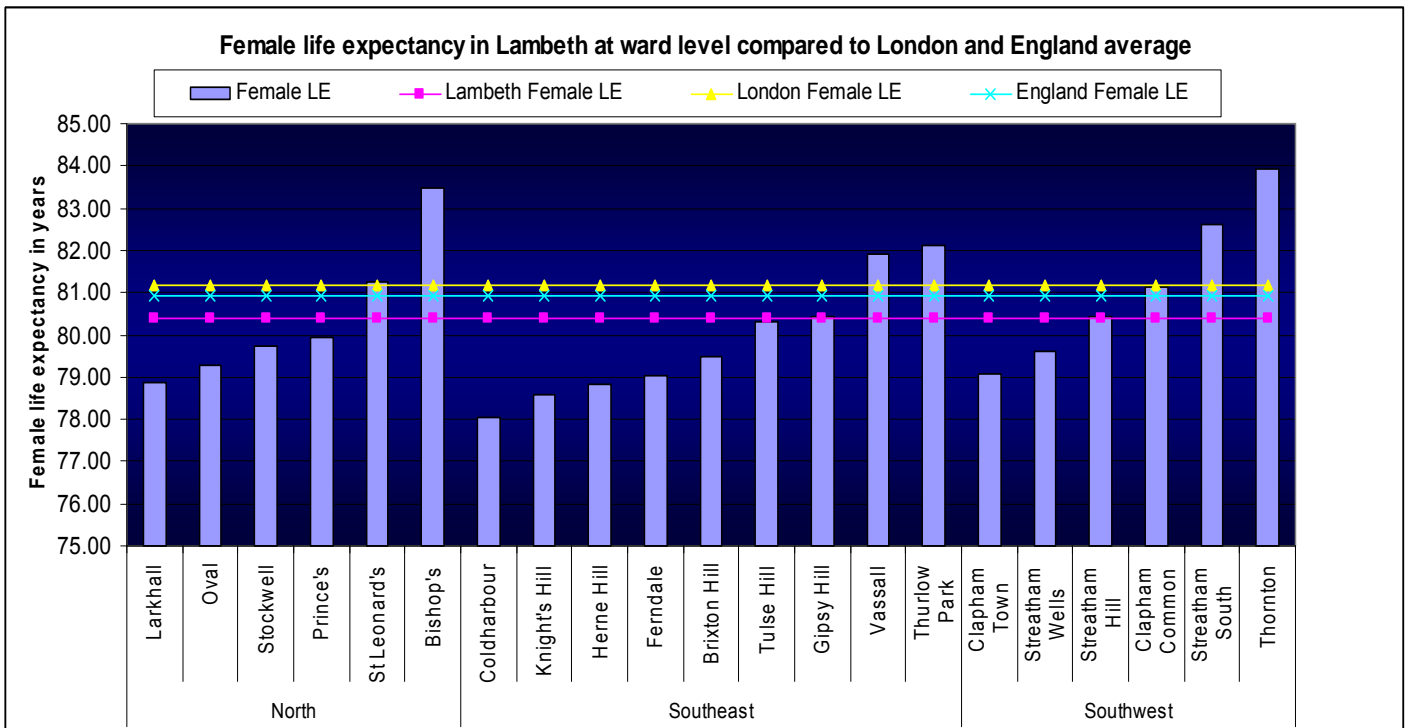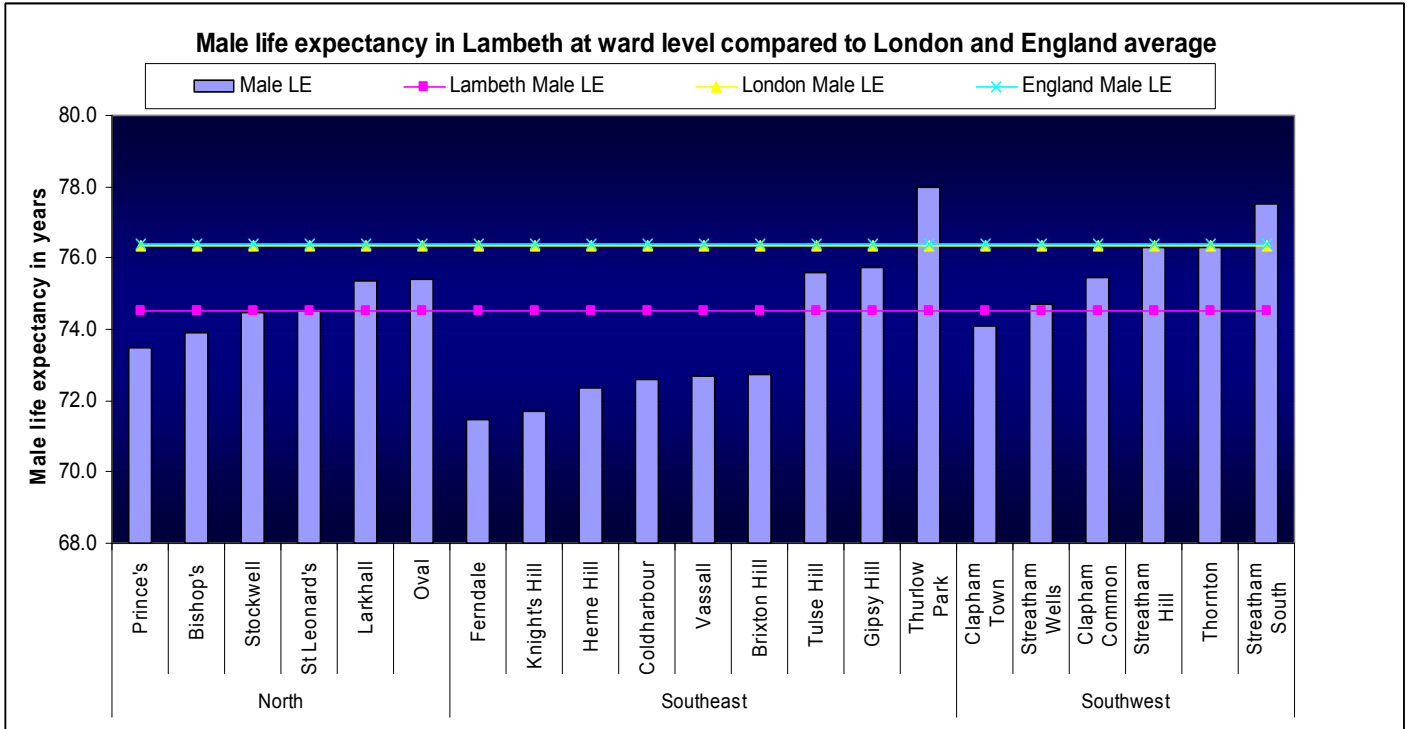
3. Long term conditions

a. Hypertension QOF prevalence
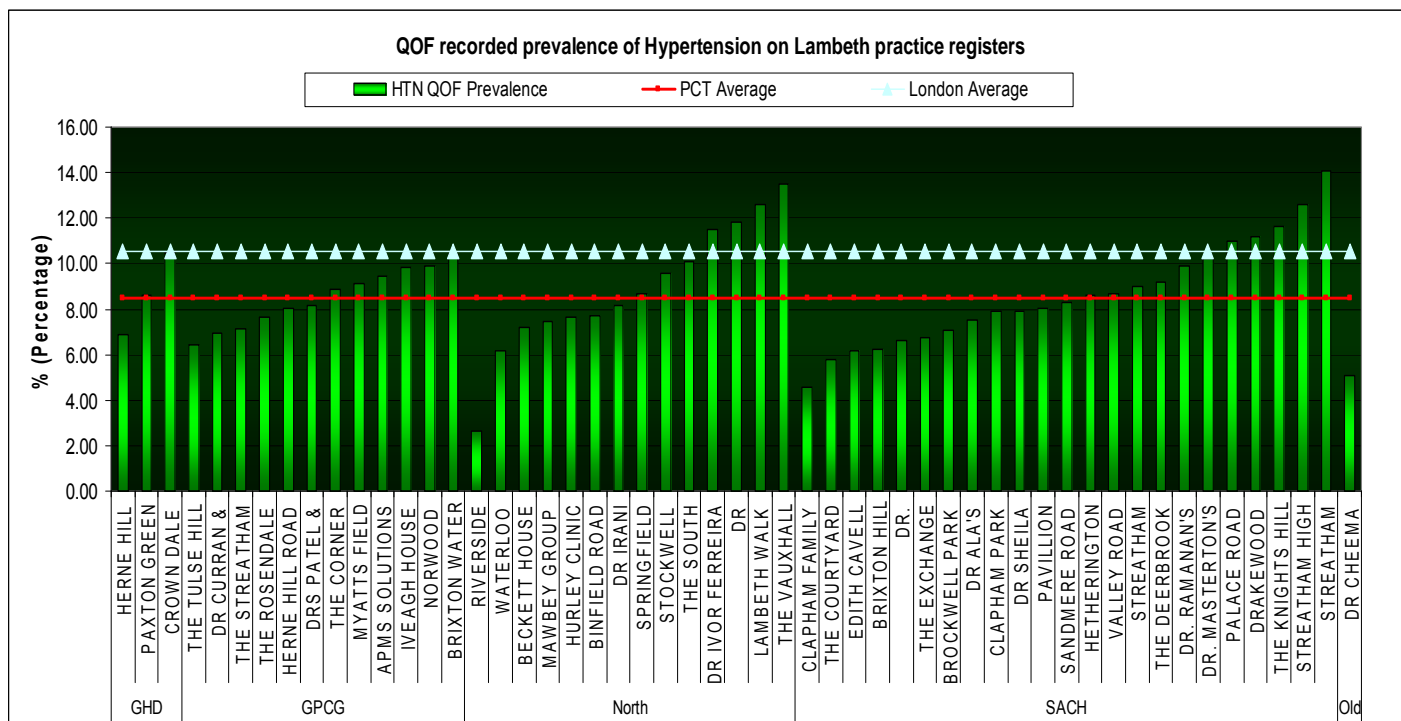
The above graph shows the QOF case detected prevalence of hypertension as recorded on Lambeth practice registers. The range of detected prevalence in various practices is varied. This may be due to variety of factors such as age profile of the population and ethnicity which are important determinants. Secondly, diagnosis and detection are directly related to the QOF prevalence, so a low prevalence does not necessarily mean that there is low prevalence of hypertension in the practices. Based on the QOF records the GHD practices recorded prevalence of hypertension ranged from 6.86% to 10.5% compared to Lambeth average of 8.5%. Similarly the GPCG practices recorded a prevalence ranging from 6.43% to 10.42%. In North the range is from 2.65% to 13.5% while SACG recorded a prevalence range of 4.54% to 14.07%. The next section on ratio of QOF to estimated prevalence is a better judge of the performance of the practices in terms of case detection.

Based on the graph above, there are several practices with a very low recorded (QOF) prevalence of hypertension that is below the Lambeth average. Comparing this with the ratio, it is observed that the practices where there is low recorded prevalence of hypertension show a lower ratio of QOF to estimated prevalence meaning, in these practices there are likely to be more number of hypertensives than those recorded.

b. Hypertension ratio of estimated to detected prevalence

Based on the modeling assumptions, the ratio of QOF to estimated prevalence has been calculated and is presented in the graph below for all practices in Lambeth classified by the PBC consortia.
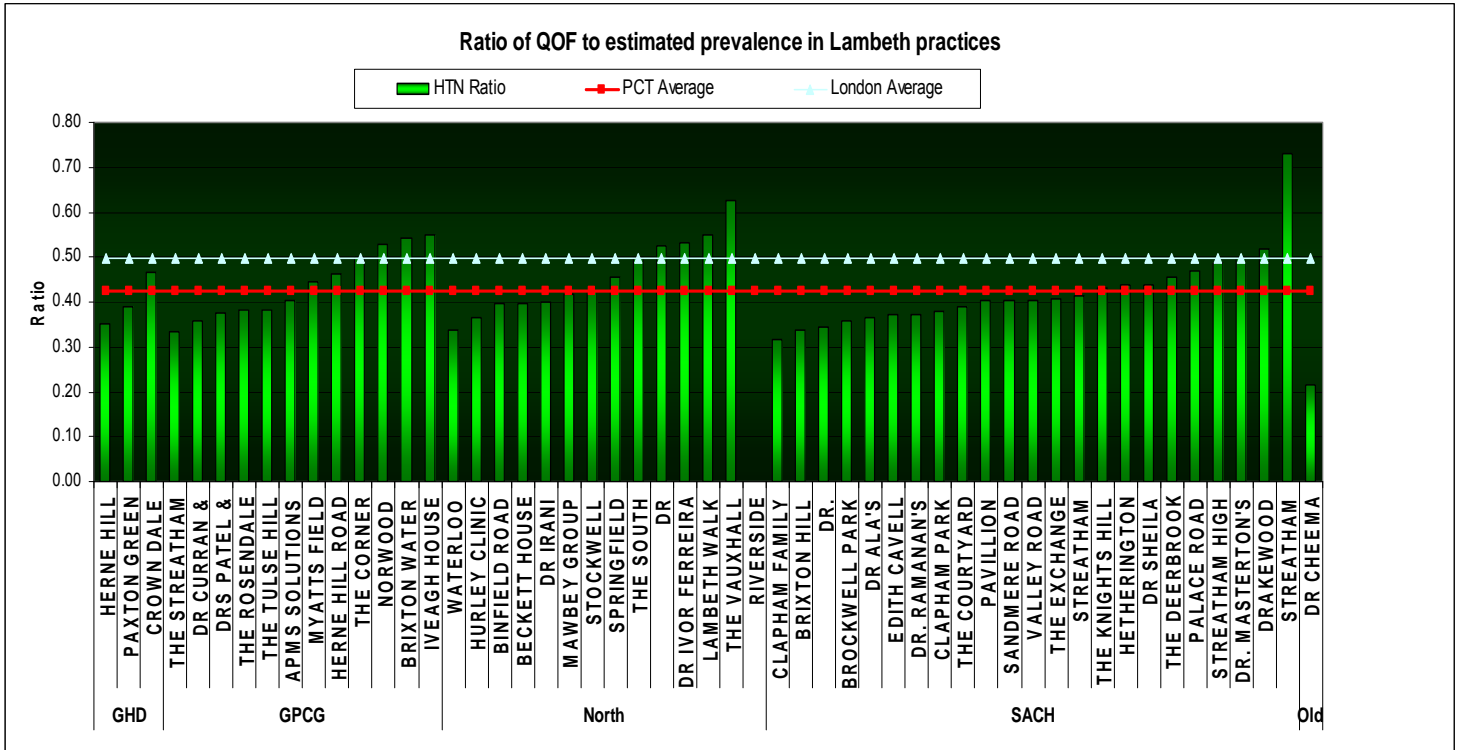
The ratio of QOF detected to estimated prevalence varies across Lambeth practices. In terms of the value if the value is 1 or more than 1, it means that the number of detected case is equal or more than those estimated. Low value indicates that the QOF prevalence is less than the estimated prevalence. The ratio is comparatively lower in practices in GHD consortium ranging from 0.35 to 0.46 with modeled estimates showing up to 3100 cases that may have hypertension but are undetected. In GPCG the ratio ranges from 0.33 to 0.55 with modeled estimates showing up to 6700 cases undetected. In North the range is from 0.34 to 0.63 with approximately 8500 cases in the population estimated to be undetected. The SACG ratios range from 0.32 to 0.73 with approximately 12,300 cases estimated to be still undetected in the population which is 8.5% of the total population. The modeling assumptions regarding predicted cases is enclosed in Appendix 1.

c. Coronary heart disease (CHD) QOF Prevalence

QOF recorded prevalence of CHD on Lambeth Practices
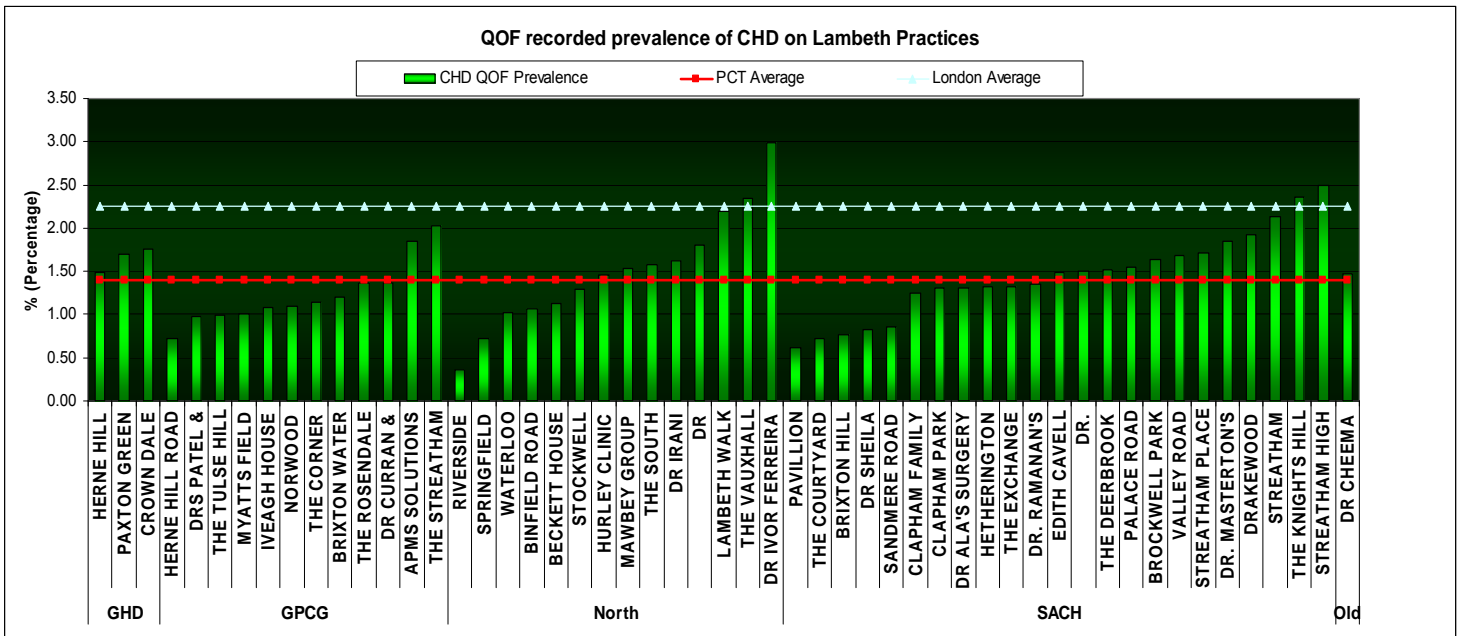
The above graph shows the QOF case detected prevalence of CHD as recorded on Lambeth practice registers. The range of detected prevalence in various practices is varied. This may be due to variety of factors such as age profile of the population and ethnicity which are important determinants. The CHD prevalence as recorded in practice registers shows variance for each practice. When assessed by specific PBC consortias, the GHD has a prevalence range of 1.49% to 1.75% compared to the PCT average of 1.39% and London average of 2.26%. The GPCG shows a recorded prevalence ranging from 0.73% to 2.03%. The North shows prevalence range of 0.37% to 3.99% and SACH 0.61% to 2.49%. The next section on ratio of QOF to estimated prevalence is a better judge of the performance of the practices in terms of case detection.

d. CHD Ratio of QOF to estimated prevalence

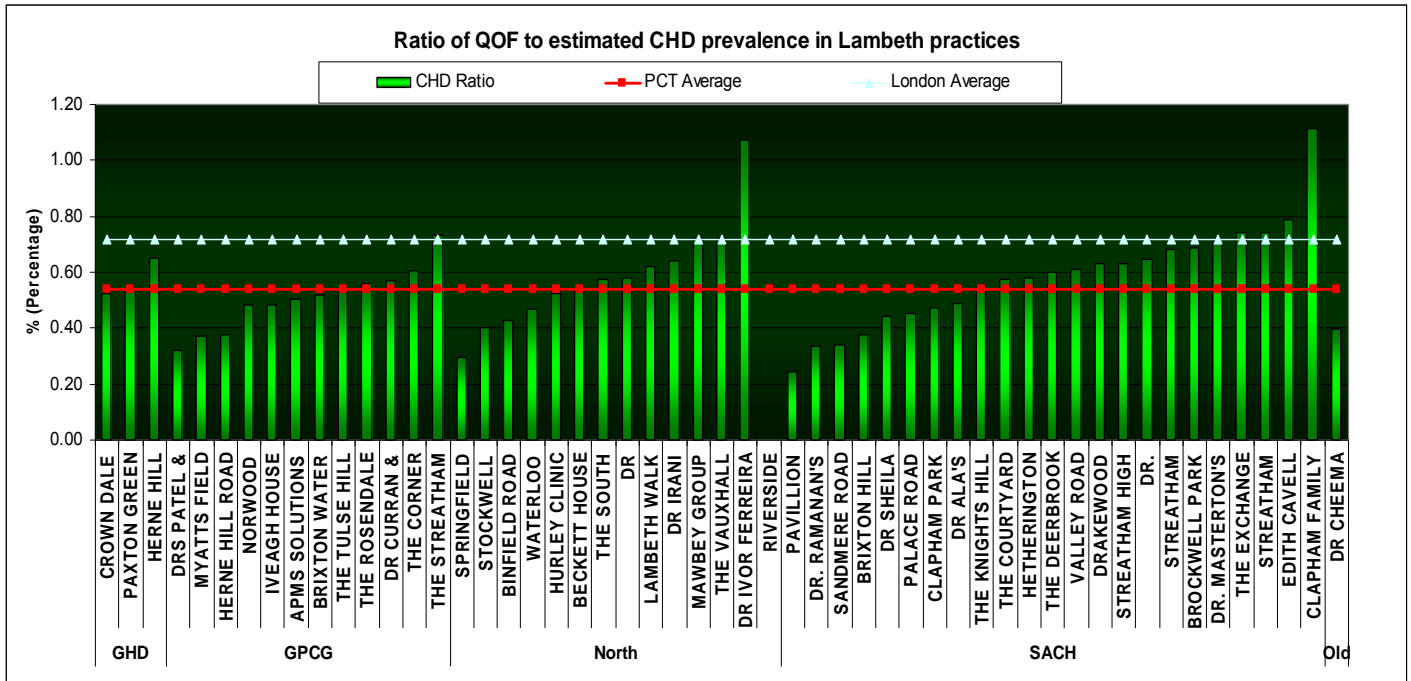**Ratio of QOF to estimated CHD prevalence in Lambeth practices**

The ratio of QOF detected to estimated prevalence of CHD varies across Lambeth practices. In terms of the value, if the value is 1 or more than 1, it means that the number of detected case is equal or more than those estimated using the CHD model. Low value indicates that the QOF prevalence is less than the estimated prevalence. The ratio of estimated to detected prevalence varies across Lambeth practices. In GHD it ranges from 0.52 to 0.65; SACH ranging from 0.24 to 1.11; North with 0.29 to 1.07 and GPCG range from 0.32 to 0.73 with PCT average at 0.54 and London average at 0.72. Meaning there could be up to 5390 cases with CHD who are not detected and treated properly for CHD which is approximately 1.5% of the total population. The modeling assumptions regarding predicted cases is enclosed in Appendix 1.

e. Diabetes QOF prevalence
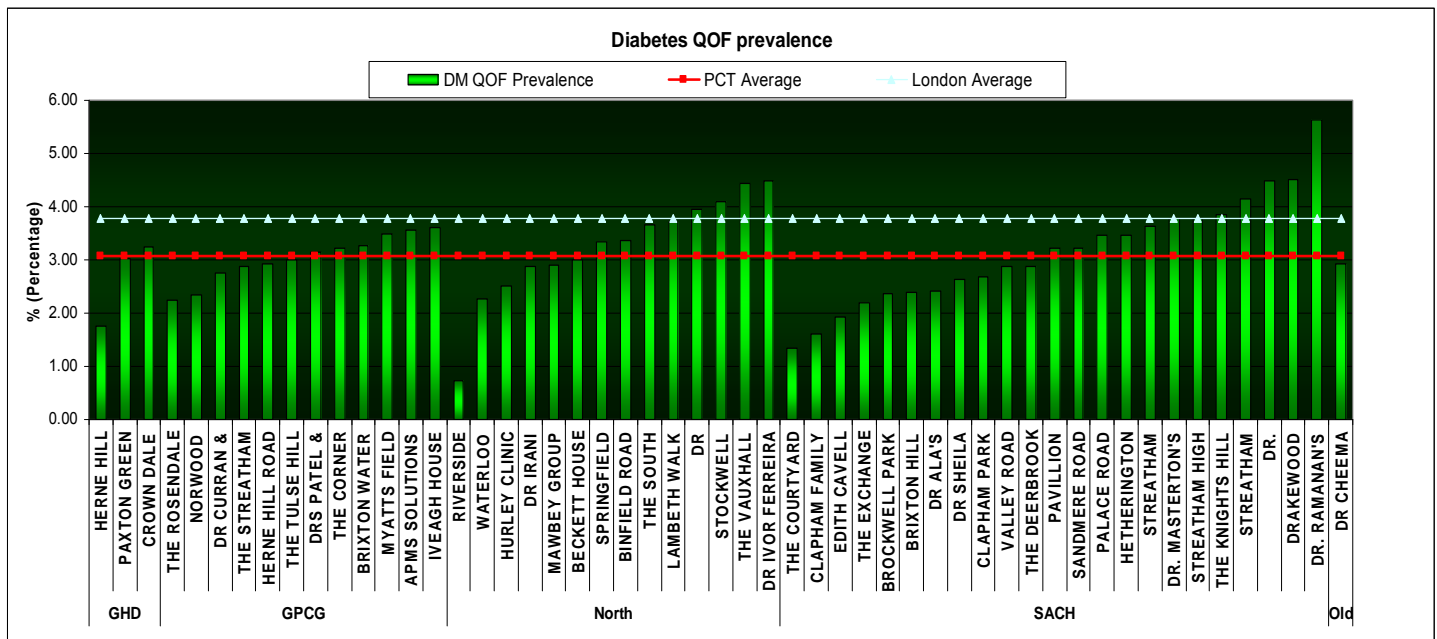

Diabetes QOF prevalence

The above graph shows the QOF case detected prevalence of Diabetes as recorded on Lambeth practice registers. The range of detected prevalence in various practices is varied. This may be due to variety of factors such as age profile of the population and ethnicity which are important determinants. The range of Diabetes prevalence recorded on practice registers for GHD ranges from 1.76% to 3.24%; for GPCG ranges from 2.25% to 3.61%; in North ranges from 0.73% to 4.48% while in SACH ranges from 1.35% to 5.65% with PCT average at 3% and London average at 3.78%.

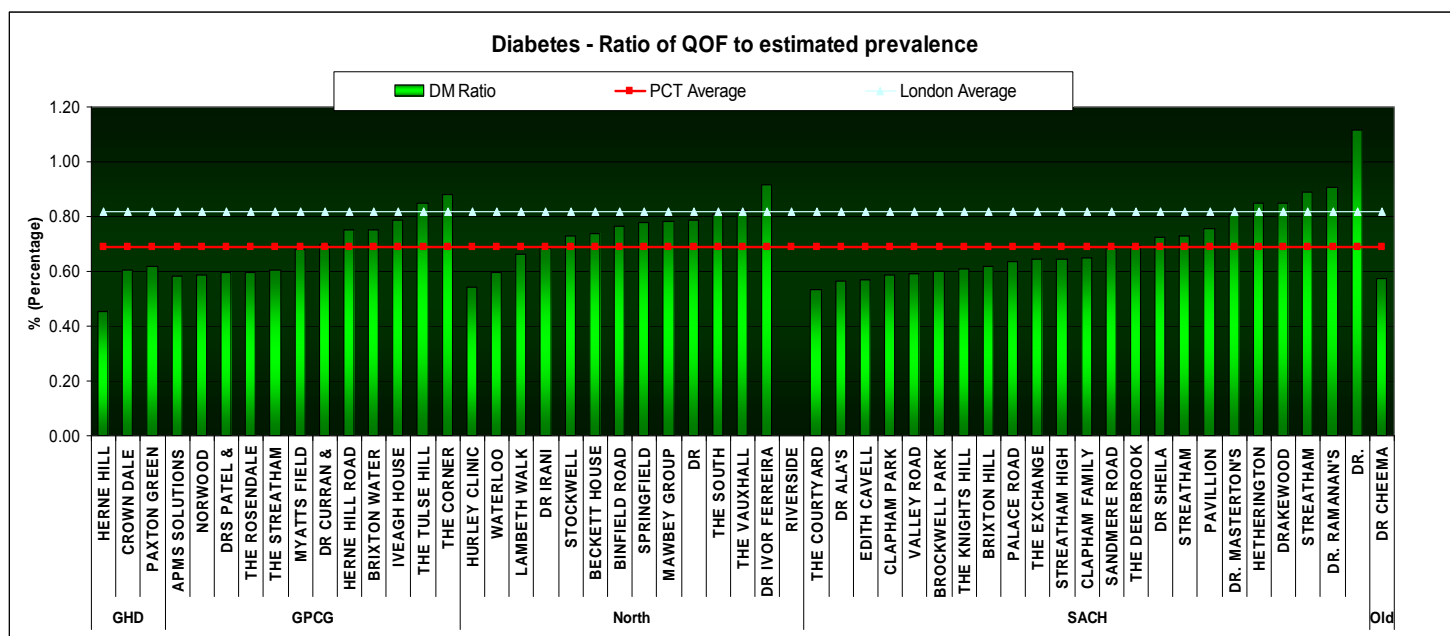## f. Diabetes Ratio of QOF to estimated prevalence

The ratio of QOF detected to estimated prevalence of Diabetes varies across Lambeth practices. In terms of the value, if the value is 1 or more than 1, it means that the number of detected case is equal or more than those estimated using the Diabetes model. Low value indicates that the QOF prevalence is less than the estimated prevalence. In Lambeth the ratio in GHD practices ranges from 0.45 to 0.62; inPCG ranges from 0.58 to 0.88; in North ranges from 0.54 to 0.92 and in SACH ranges from 0.53 to 1.12 compared to the PCT average of 0.69 and London average of 0.82. In Lambeth, the detected ratio for Diabetes is better than that of hypertension and CHD meaning majority of the cases with Diabetes are detected, however based on the modeled estimates, there could still be around 1000 individuals who may have diabetes and may need treatment but are still undetected.

g. Chronic Obstructive Pulmonary disease (COPD) QOF prevalence

QOF recorded prevalence of COPD on Lambeth Practices
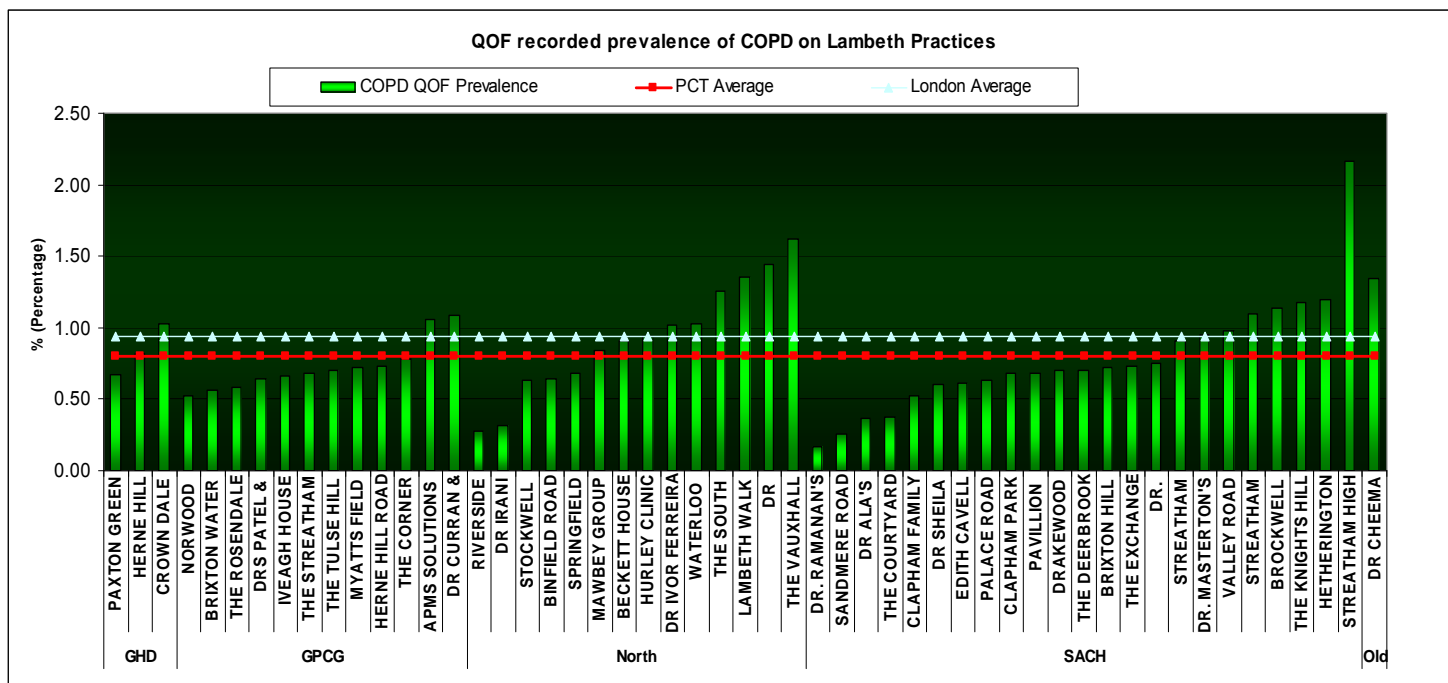
The above graph shows the QOF case detected prevalence of COPD as recorded on Lambeth practice registers. The range of detected prevalence in various practices is varied. This may be due to variety of factors such as age profile of the population and ethnicity which are important determinants. The range of COPD prevalence recorded on practice registers in each PBC compared to the Lambeth and London average is as follows. In GHD the case detected prevalence ranges from 0.67% to 1.03%; in GPCG ranges from 0.52% to 1.08%; in North ranges from 0.27% to 1.62% and in SACH ranges from 0.17% to 2.16% compared to the PCT average of 0.8% and London average of 1%.

h. COPD Ratio of QOF to estimated prevalence
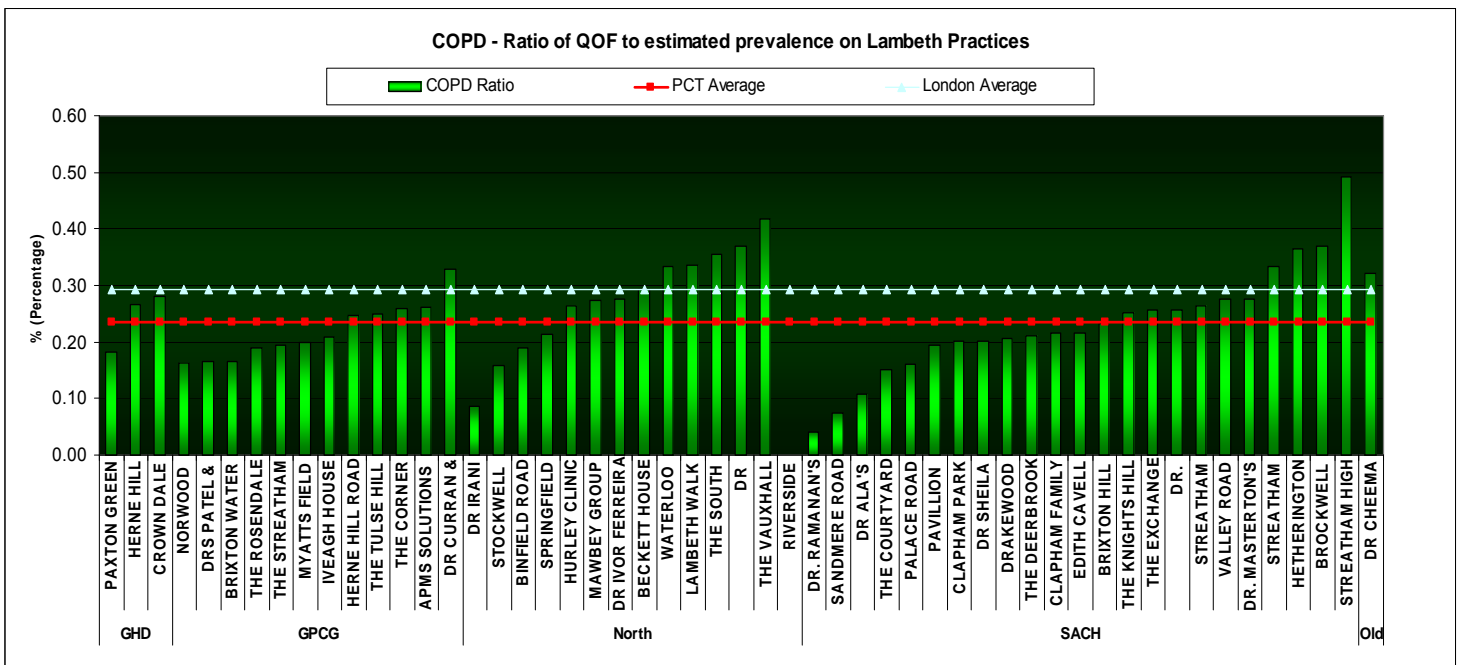
The ratio of QOF detected to estimated prevalence of COPD varies across Lambeth practices. In terms of the value, if the value is 1 or more than 1, it means that the number of detected case is equal or more than those estimated using the COPD model. Low value indicates that the QOF prevalence is less than the estimated prevalence. The ratio of practices in GHD range from 0.18 to 0.28; in GPCG ranges from 0.16 to 0.33; in North ranges from 0.09 to 0.42 and in SACH ranges from 0.04 to 0.49 compared to PCT average of 0.23 and London average of 0.29. The issue of under detection of COPD cases may be relative to the way diagnosis is made in primary care by different GPs as well as the extent of the disease which classifies a patient to have COPD, followed by confirmation by spirometry.

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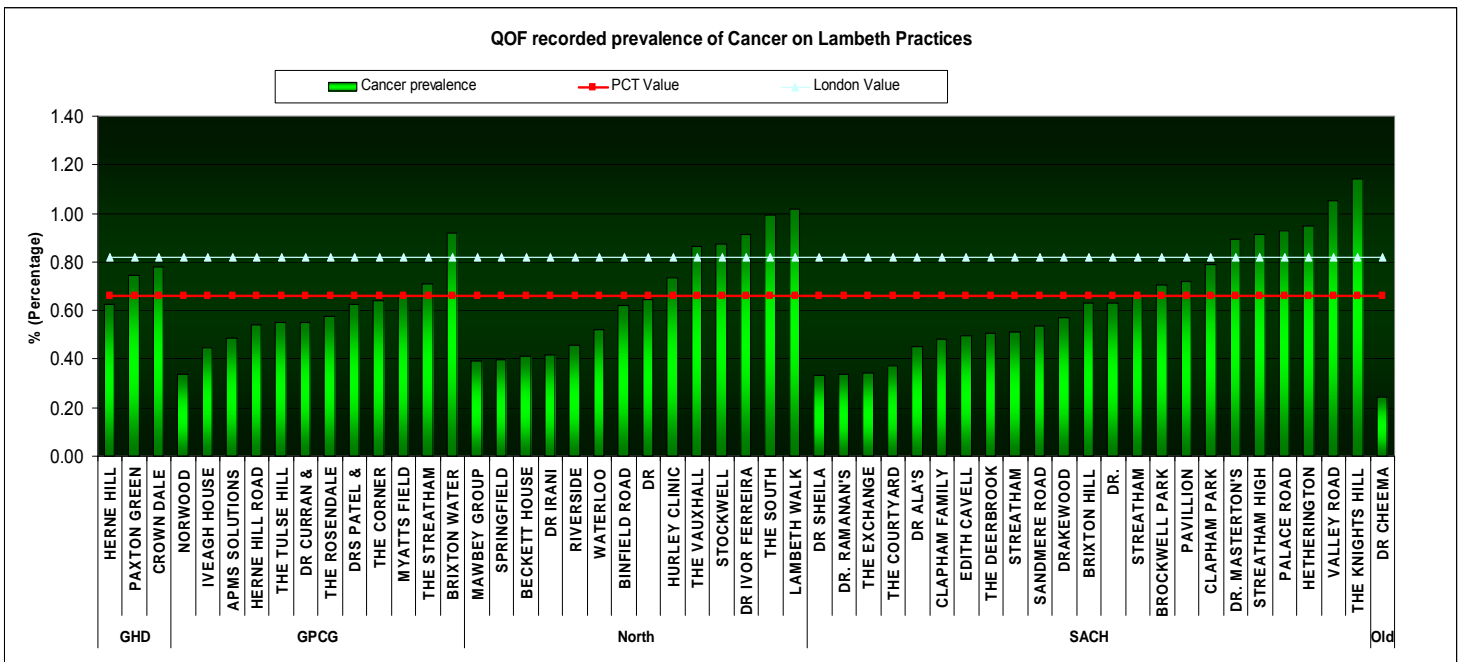
i. Cancer

The above graph shows the QOF case detected prevalence of Cancer as recorded on Lambeth practice registers. The range of detected prevalence in various practices is varied. This may be due to variety of factors such as age profile of the population and ethnicity which are important determinants. The range of Cancer prevalence recorded on practice registers in each PBC compared to the Lambeth and London average is as follows. In GHD ranges from 0.62% to 0.78%; in GPCG ranges from 0.34% to 0.92%; in North ranges from 0.39% to 1.02% and in North ranges from 0.33% to 1.14% compared to the PCT average of 0.66% and London average of 0.82%. A low average may not necessarily mean a low prevalence and may be related to detection of cases; screening of the population etc., which need to be investigated.

j. Mental health

QOF recorded prevalence of Mental health on Lambeth Practices
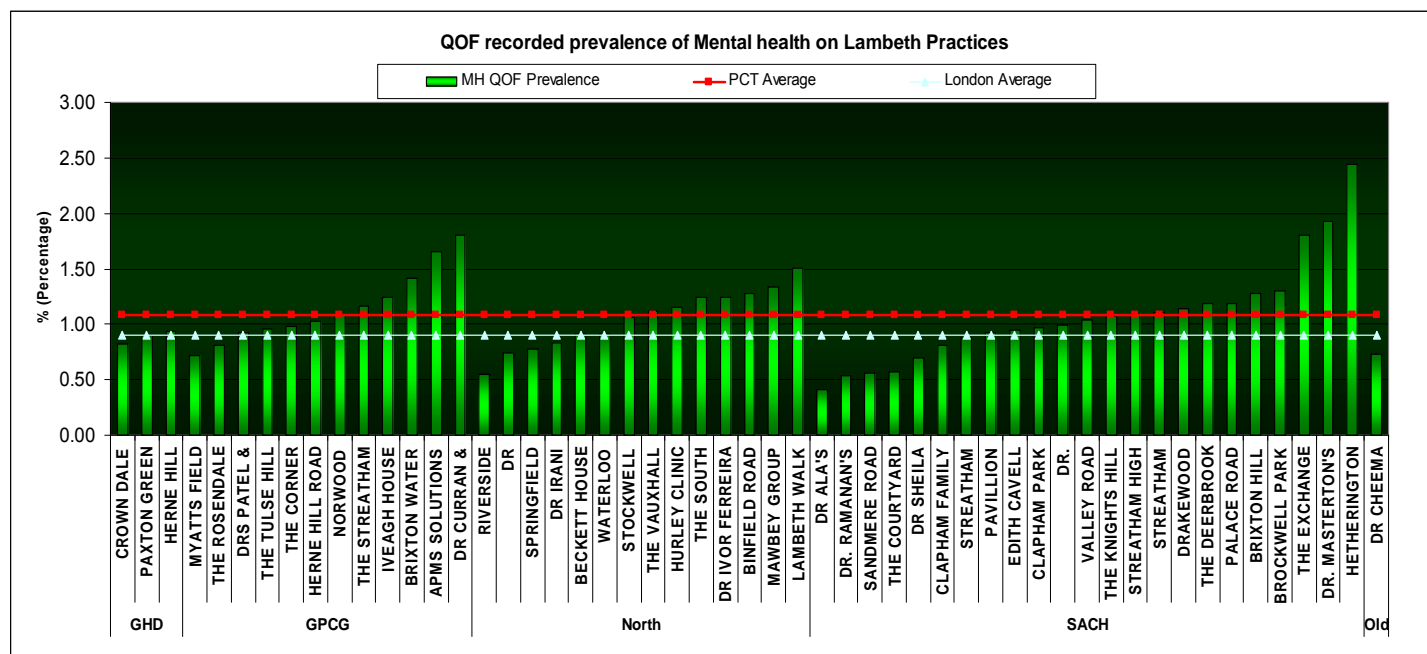
The above graph shows the QOF case detected prevalence of severe mental illness (SMI) as recorded on Lambeth practice registers. The range of detected prevalence in various practices is varied. This may be due to variety of factors such as age profile of the population and ethnicity which are important determinants. The following table shows the range of Mental illness prevalence recorded on practice registers in each PBC compared to the Lambeth and London average.

PBC Consortia	Severe Mental illness prevalence range	PCT Average	London Average
GHD	0.82% to 0.93%	1.09%	0.99%
GPCG	0.72% to 1.8%		
North	0.55% to 1.5%		
SACH	0.41% to 2.45%		

4. Mortality – Ward and locality level SMR (Standardised Mortality Ratios)

The SMR is a measure of how an area is performing with regards to number of deaths compared to Local, regional and national average. The SMR is estimated using England as a standard and any value over 100 indicates more number of deaths than the England average.

a. All causes.

Standardised Mortality Ratio, All causes, All ages 2002-2006
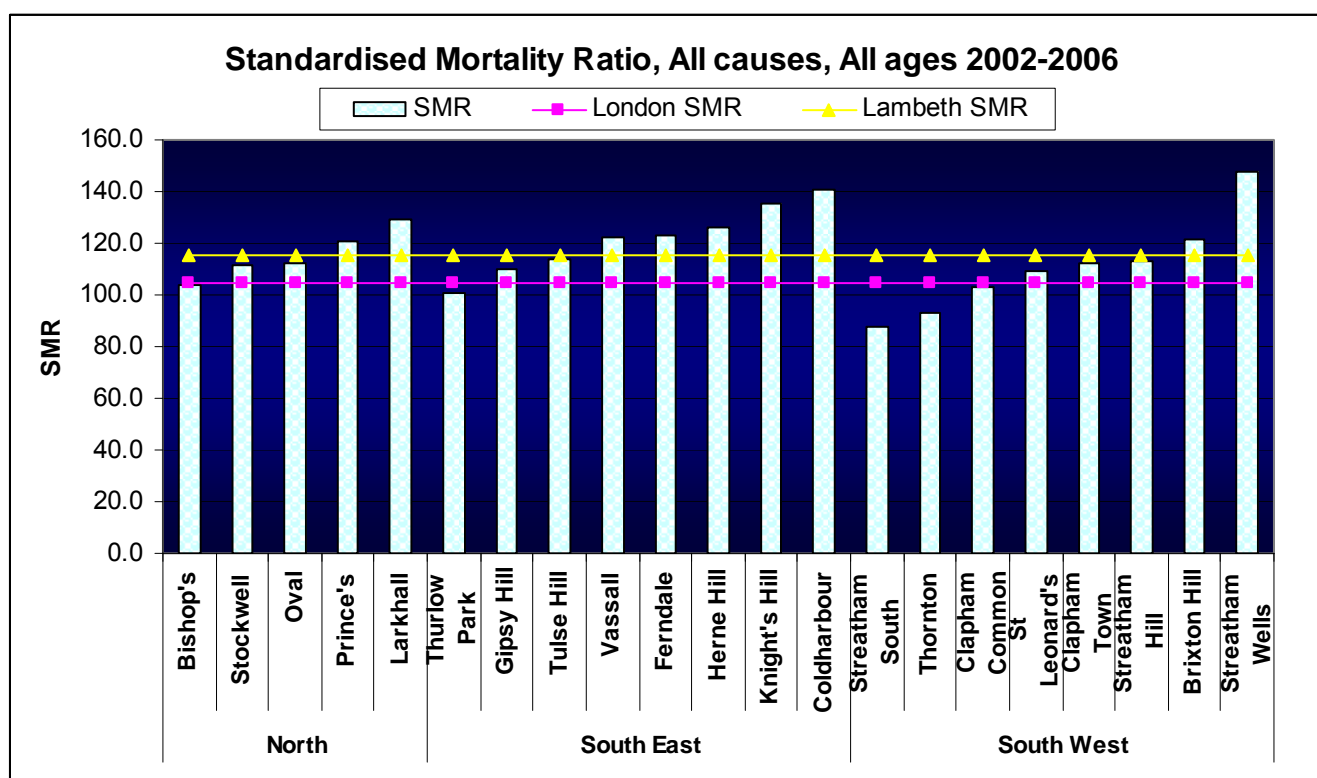
The SMR from all causes and for all ages in 2002-2006 in Lambeth was 115.5 compared to the London average of 104.5 against England. In North locality Prince's and Larkhall ward have a relatively high SMR than Lambeth average. Similary in South East Locality, Knight's Hill and Coldharbour and in South West locality Streatham Wells ward have a relatively higher SMR from all causes than the Lambeth average.

b. Cardio-vascular diseases in <75 year olds.

Standardised Mortality Ratio, CVD 2002-2006
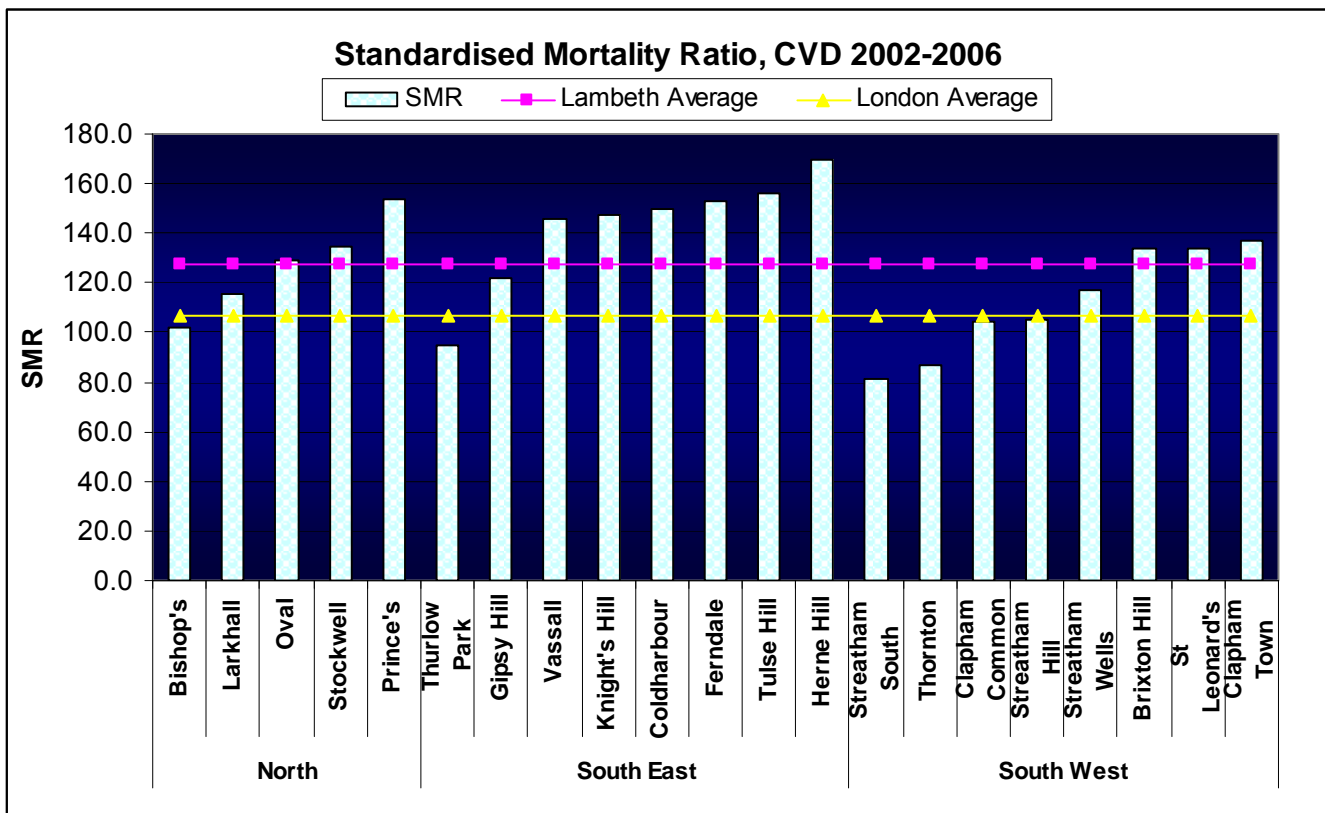
The SMR from cardio-vascular diseases in <75 year olds in 2002-2006 in Lambeth was 127.2 compared to the London average of 106.4 against England. In North locality Prince's ward have a relatively high SMR than Lambeth average. In South East Locality, Tulse Hill and Herne Hill, Coldharbour and Ferndale and in South West locality Clapham Town ward have a relatively higher SMR from cardio-vascular diseases than the Lambeth average.

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c. Cancer in <75 year olds.

Standardised Mortality Ratio, Cancer 2002-2006
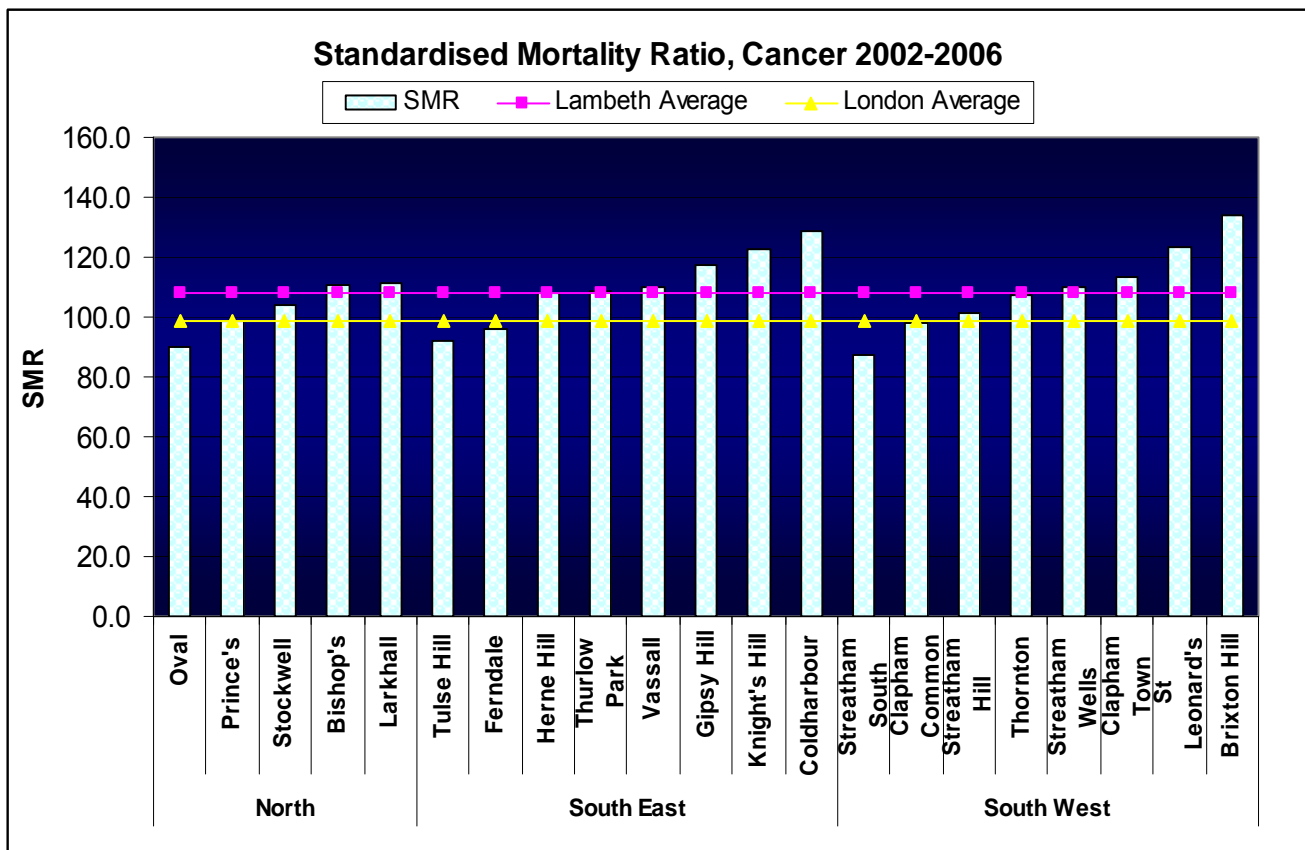
The SMR from cancer in under 75 year olds measured in 2002-2006 is 108.1 compared to London average of 98.5 against England. In Lambeth Knight's hill and Coldharbour wards in South East locality and St Leonard's and Brixton Hill wards in South West Locality have a relatively higher SMR from cancer compared to Lambeth average.

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5. Lambeth health profile and updated 'Red Box'

Inner city London - Lambeth is an inner London borough with a northern boundary on the river Thames and situated between Wandsworth to the west, Southwark to the east and Croydon to the south. Lambeth has 21 wards and is comprised of six town centre areas namely, North Lambeth, Stockwell, Clapham, Brixton, Streatham and Norwood. The census area classifications describe Lambeth as a London Cosmopolitan area similar to Southwark, Lewisham, Hackney, Islington, Haringey and Brent.

Population density, age profile - Lambeth is the most densely populated boroughs in the country with a rapidly growing population and relatively high levels of deprivation. The resident population is projected to grow by a further 15% to 317,000 by 2028. Lambeth has a high proportion of young population compared to the rest of the country with approximately 50% individuals in the 20-44 age group.

Deprivation - The Index of Multiple Deprivation 2007 (IMD) places Lambeth as the 5th most deprived borough in London and 19th most deprived in England. Poverty and social exclusion are some of the social challenges in the borough. One in twenty Lambeth residents live in fuel poverty and the proportion of children and young people living in poverty is higher than average, It is estimated that 40% of Lambeth workers are well qualified (at NVQ level 4 or better) and the average income is above national average. However, there are also high proportions of economically inactive people living here and among those adults seeking jobs, 60% have no qualifications or low level qualifications.

Diversity – Lambeth has a rich and diverse population with a high proportion of black and minority ethnic groups. Recent migrants include those from Africa, Latin America and Eastern Europe. Migration from areas with lower life expectancy poses challenges to improving life expectancy and reducing premature death. This is comparable with many Inner London boroughs like Lewisham, Hackney, Tower Hamlets and Newham.

Mobility – There is very high mobility within and out with the borough which has an impact on estimation of vital public health statistics such as life expectancy of the population over a period of time, screening coverage and other vital statistics.

Birth rate – The birth rate has been on the rise since 2001 and exponential projection shows a continuing rise till 2013. However the birth rate appears to have dipped in 2007 based on provisional statistics available.

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Conception rate - Lambeth has amongst the highest rates of teenage conception in England, although these are now beginning to reduce significantly. The Teenage Pregnancy (TP) rate has dropped from 86.6 per 1000 females aged 15-17 years in 2004 to 78.1 per 1000 females in 2006. The provisional figures released for Lambeth for 2007 by the Office for National Statistics (ONS) shows a further decrease in the TP rate at 74.4 per 1000 females aged 15-17 years. This is a positive change compared with England where there has been a slight increase in the TP rate in 2007 over 2006.

Health and well-being

-   Perceived health - Positively, most Lambeth residents are happy, rate their health well and like the local area in which they live.

-   Fear if crime - While concern about crime remains high, actual crime levels are falling and detection rates are improving.

-   Views of health services – the Lambeth resident survey in 2007 shows increased levels of satisfaction with the health service over 2005 findings. The 2009 findings also show customer/client satisfaction in terms of health service to have risen.

Health inequalities, measured in terms of infant mortality, teenage pregnancy, childhood obesity, primary and secondary school permanent exclusion levels and the proportion of 16-18 year olds who are not in education, employment or training; are high in Lambeth when compared nationally. Healthy lifestyle issues are still an area of concern (e.g. high smoking prevalence, worsening obesity levels related to poor diets and lack of physical activity, alcohol and drug misuse; these indicators appear worse than the national average). These are associated with poorer outcomes such as higher levels of mortality and morbidity related to, for example, chronic liver disease, renal disease and diabetes. In addition, Lambeth has one of the highest incidences of mental health need in London as estimated by the MINI (Mental Illness Needs Index).

Highlights of health and socio-economic indicators

Smoking: Smoking prevalence is high in Lambeth especially in deprived areas, in people in lower socio-economic groups/ manual occupations. Estimates show that up to 350 residents may be dying due to smoking related conditions per year. It is notable however that between April 2005 and March 2007 around 3,000 people per year on average attempted to give up smoking with a success rate of around 50%.

Alcohol: Alcohol and substance misuse is a general problem in the borough. It is estimated that 23%-24% of Lambeth's population (70,000 approx.) drink excessively and Lambeth has higher levels of alcohol-related hospital admissions than both London and England. Mortality rate from liver diseases (including

cirrhosis) in Lambeth men is higher than for the rest of England (30 people compared to 14 in England per 100,000 population).

Obesity and physical activity: It is estimated that 30.3% of Lambeth adults eat a healthy diet. This is in line with the average for London and above the national average of 26.3%. The level of obesity in Lambeth adults (18.6%) is lower than the England average (23.6%), probably as a result of the higher than average levels of physical activity in Lambeth. However obesity in children aged 10-11 is high with up to 1 in 4 obese. 13.3% of children at reception level are obese in Lambeth compared with 11% in London, and 9.9% in England.

Life expectancy – Life expectancy has increased from baseline year 1995-7 by 4.2 years for men (75.8 years in 2005-07) and 2.2 years for women (80.6 years in 2005-07) in Lambeth.   Life expectancy at birth has improved for both men and women at Lambeth. Compared to England the gap in life expectancy has reduced for both men and women but the reduction in gap in women is lower.
The main causes of death leading to the life expectancy gap are heart disease, stroke, cancer of the lung, respiratory disease and peptic ulcers and liver cirrhosis. Life expectancy varies by area based deprivation and income
Tackling avoidable diseases (through primary and secondary prevention) and improving the working and living conditions of people in Lambeth are important in reducing the life expectancy gap

Infant mortality – Infant mortality (deaths of infants aged under 1 year) has dropped from 8.8 per 1000 live births in 1995-97 to 5.7 per 1000 live births in 2005-07 which is a reduction of over 26% however there still is a need for further reduction in the gap between local and national rate which for England is 4.9 per 1000 live births.

Coronary heart disease (CHD) prevalence – The case detection rate of CHD in Lambeth residents is 1.3% compared to 2.3% nationally. The prevalence models have estimated that there could be over 5000 individuals in Lambeth with CHD who are undetected and who need treatment to avoid premature complications and/or death.

Hypertension prevalence – Similarly the case detection rate of hypertension in Lambeth residents is around 9% compared to 11.3% nationally. The prevalence models have estimated that there could be over 34,000 individuals in Lambeth with hypertension who are undetected and who need to be treated to avoid development of CHD and stroke. However the estimates should be treated will some caution as the criteria for registering a patient as hypertensive varies in general practice
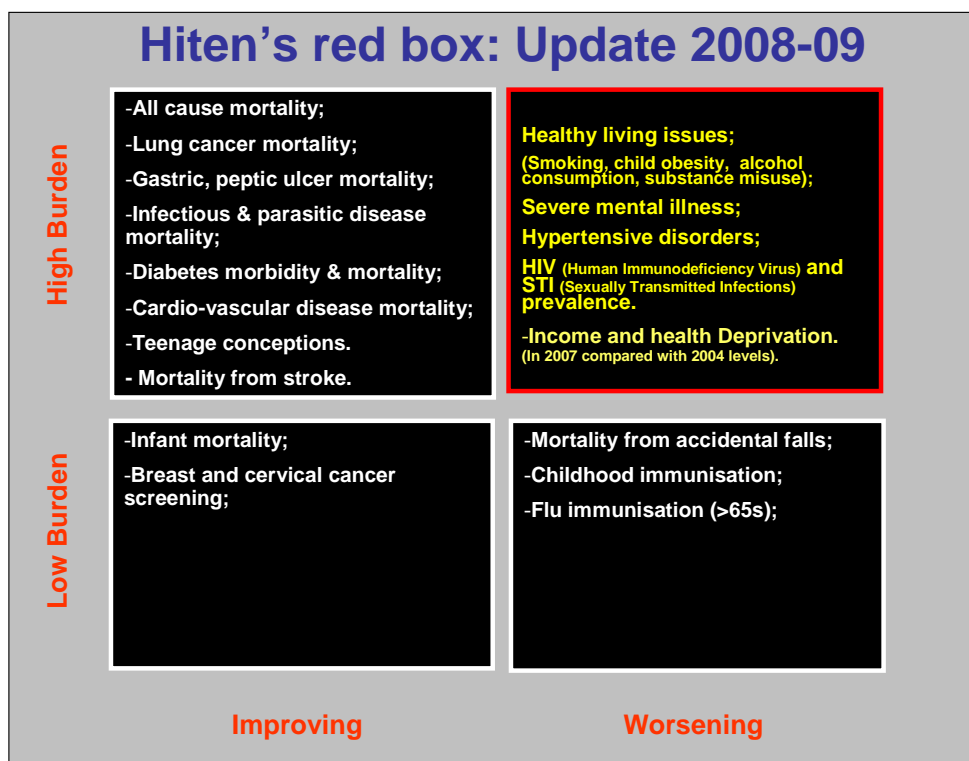
Diabetes prevalence – The case-detection rate of diabetes is around 3% which is similar to the national average however the models predict that around 1000 people may still be undetected who will need treatment.

Premature deaths from cancer – There has been a relatively small change in the reduction in mortality rate from cancers in Lambeth residents in 2005-07 over 2004-06 – from 128.95 (2004-06) to 126.12(2005-07) per 100,000 persons under 75 years old dying from cancer in Lambeth.. The overall current directly standardised rate is 129.59/100,000. Overall there has been a 20% reduction in deaths from cancer in Lambeth (2005-07), with deaths for males reduced by 19% and for females by 20%. Overall there has been 31% narrowing of the absolute gap. For males the death rate from cancer in Lambeth was 31.82 deaths per 100,000 higher than England and Wales in 1995-1997 and the most recent data, 2005-07 shows a 20% narrowing in the absolute gap with a death rate of 19.68 deaths per 100,000 higher than England and Wales. For females the death rate from cancer in Lambeth was 16 deaths per 100,000 higher than England and Wales in 1995-1997 and the most recent data, 2005-07 shows a 39% narrowing in the absolute gap with a death rate of 9.68 deaths per 100,000 higher than England and Wales.

Premature deaths from circulatory diseases – There has been a marked reduction in the death rates in persons under 75 years, from circulatory diseases in 2005-07 (103.5 per 100,000 population) compared to 2004-06 (116.22 per 100,000 population). The overall current directly standardised rate is 103.52/100,000. Overall there has been a 41% reduction in mortality rates from circulatory disease in Lambeth (2005-07). For men there has been a 39% reduction in mortality from circulatory disease and for females 44% reduction. Overall there has been a 28% reduction in the absolute gap from circulatory disease between Lambeth and England and Wales to 2005-07. For males the death rate from circulatory disease in Lambeth was 41 deaths per 100,000 higher than England and Wales in 1995 – 1997 and the most recent data shows an 14% narrowing of the gap with a death rate of 36 deaths per 100,000 in 2005-07. For females the death rate from circulatory disease in Lambeth was 26 deaths per 100,000 higher than England and Wales in 1995 –1997 and the most recent data shows a 62% narrowing of the gap with a death rate of 15 deaths per 100,000 in 2005-07.

The following table summarizes the status of health and well-being indicators with regard to whether they are improving or worsening in Lambeth compared to it's previous value and/or in comparison to the national average.

		Status in 2008
Health indicators	Life expectancy - Males	↑
	Life expectancy - Females	↔
	Infant mortality rate	↑
	Deaths from alcohol related conditions	↔
	Deaths from cancer - Males	↑
	Deaths from cancer - Females	↔
	Deaths from heart disease <75 years – Males	↑
	Deaths from heart disease - Females	↔
	Teenage pregnancy rate	↑
	Smoking	↓
	Obesity in children	↓
	Obesity in adults	↑
Socio-enomic indicators	Employment rate	↓
	Children in poverty	↔
	Crime	↓
↑ = Improving;	↓ = Worsening;	↔ = No change

Hiten's red box: Update 2008-09

High Burden

-All cause mortality;

-Lung cancer mortality;

-Gastric, peptic ulcer mortality;

-Infectious & parasitic disease mortality;

-Diabetes morbidity & mortality;

-Cardio-vascular disease mortality;

-Teenage conceptions.

- Mortality from stroke.

Healthy living issues;
(Smoking, child obesity, alcohol consumption, substance misuse);

Severe mental illness;

Hypertensive disorders;

HIV (Human Immunodeficiency Virus) **and STI** (Sexually Transmitted Infections) **prevalence.**

-**Income and health Deprivation.**
(In 2007 compared with 2004 levels).

Low Burden

-Infant mortality;

-Breast and cervical cancer screening;

-Mortality from accidental falls;

-Childhood immunisation;

-Flu immunisation (>65s);

Improving   **Worsening**

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ABBREVIATIONS

Avg	Average
CHD	Coronary Heart Disease
COPD	Chronic Obstructive Pulmonary Disease
DM	Diabetes Mellitus
GHD	GHD (PBC Consortia)
GLA	Greater London Authority
GPCG	General Practice Commissioning Group
HTN	Hypertension
IMD	Index of Multiple Deprivation
LHO	London Health Observatory
MH	Mental Health
PBC	Practice Based Commissioning
PCT	Primary Care Trust
QOF	Qualities and Outcomes Framework
SACH	Streatham and Clapham Common
SMR	Standardised Mortality Ratio
SOA	Super Output Areas

REFRENCES

Doncaster PCT. Coronary Heart Disease Model - Developed in discussion with Department of Health, Eastern Region Public Health Observatory and Yorkshire and Humber Public Health Observatory. 2006.
Available from: http://www.apho.org.uk/resource/item.aspx?RID=39385

Eastern Region Public Health Observatory and Yorkshire and Humber Public Health Observatory. Hypertension Model. 2006.
Available from: http://www.apho.org.uk/resource/item.aspx?RID=39384

Yorkshire & Humber Public Health Observatory. PBS Diabetes Population Prevalence Model Phase 2. 2005.
Available from: http://www.york.ac.uk/yhpho/diabetes.htm

APPENDIX 1

APPENDIX 1 - Modelled prevalence estimates

LAMBETH PROFILE:
PREVALENCE MODELS

March 2009

NHS LAMBETH

Foreword

This report includes the estimates of diabetes (DM), hypertension (HTN), coronary heart disease (CHD) and chronic obstructive pulmonary disease (COPD) as predicted by the prevalence models. The models also include the ratio of detected to estimated prevalence. Also in this report are the estimates of certain lifestyle conditions such as smoking, obesity, binge drinking, health eating as available.

While every precaution is taken to ensure that the information is accurate; interpretation of information from certain data sources should be treated with caution. The population estimates considered in the models should also be taken into account while verifying the number of people with a disease/condition. If you have any queries or comments, please contact the Lambeth Public Health Intelligence Department.

Contact person:
Ash More
Directorate of Public Health
Lambeth PCT
1, Lower Marsh
Waterloo,
London – SE1 7NT
Email: ash.more@lambethpct.nhs.uk
Tel: (+44) 020-30494236

Created: March 2009.

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LAMBETH PROFILE: PREVALENCE MODELS

The following models and their estimates are presented in this profile:

1. DIABETES
Diabetes Population Prevalence Model, background and method
1.1.1 Prevalence of Type1 & Type2 Diabetes Mellitus, by Gender
1.1.2 Prevalence of Type1 & Type2 Diabetes Mellitus, by Age
1.1.3 Prevalence of Type1 & Type2 Diabetes Mellitus, by Ethnicity
1.2 Prevalence of Type1 Diabetes mellitus, by Gender
1.3 Prevalence of Type2 Diabetes Mellitus, by Gender

2. HYPERTENSION
Model for predicting the total number of people to be Hypertensive, background and method
2.1 Expected prevalence rate of Hypertension, by Gender
2.2.1 Prevalence of Hypertension amongst the general population, 2003-04, by Age
2.2.2 Prevalence of Hypertension amongst the general population, 2003-04, by Ethnicity
2.3 Treatment

3. COPD
Modelled estimates of prevalence of COPD for PCTs in England
3.1.1 Modelled estimates of COPD for 2009, by Gender
3.1.2 Modelled estimates of COPD for 2009, by Ethnicity
3.1.3 Modelled estimates of COPD for 2009, by Age

4.CHD
Model for estimating the prevalence of patient-reported doctor-diagnosed CHD
4.1 Observed relative to expected percentage of Patient-reported Doctor-diagnosed CHD in Lambeth

5. LIFESTYLE
Model Based Estimates of Healthy Lifestyle Behaviours at PCO level (2003-2005)
5.1 Model-Based Estimates of Binge Drinking, 2003-2005
5.2 Model-Based Estimates of Fruit and vegetable consumption, 2003-2005
5.3 Model-Based Estimates of Current smoking, 2003-2005
5.4 Model-Based Estimates of Obesity, 2003-2005

1. DIABETES

The model: PBS Diabetes Population Prevalence Model- Phase 3

Background

A spreadsheet model that generates expected total numbers of persons with Type 1 and Type 2 diabetes mellitus (diagnosed plus undiagnosed combined) in 2005. The model applies age/sex/ethnic group- specific estimates of diabetes prevalence rates, derived from epidemiological population studies, to 2005 mid-year population estimates.

Method

2005 diabetes estimates for all geographies were calculated using ONS 2005 mid-year population estimates for Local Authority Districts by broad-ethnic-group, sex, and quinary age-group, These data were supplied by YHPHO as a commissioned table based on Table EE4, October 2007 release (Experimental Statistics).

For both Type 1 and type 2 diabetes mellitus, the model combines prevalence rates taken from a number of UK studies.

Results

The model estimates a total of 11,382 persons within Lambeth having diabetes mellitus; the vast majority (10,343) of these being of Type 2 and the rest (1,039) Type 1.

1.1 TYPE1 & TYPE2

1.1.1 GENDER:

	TYPE 1 & 2					
	Estimated Prevalence			**Estimated Number**		
	Persons	**Male**	**Female**	**Persons**	**Male**	**Female**
Lambeth LA	4.21%	3.32%	5.15%	11,382	4,589	6,793
London	4.59%	3.98%	5.18%	342,029	146,710	195,319
England	4.48%	3.80%	5.14%	2,262,484	940,502	1,321,983

NHS LAMBETH

Estimated prevalence of Type 1 and Type 2 diabetes by gender
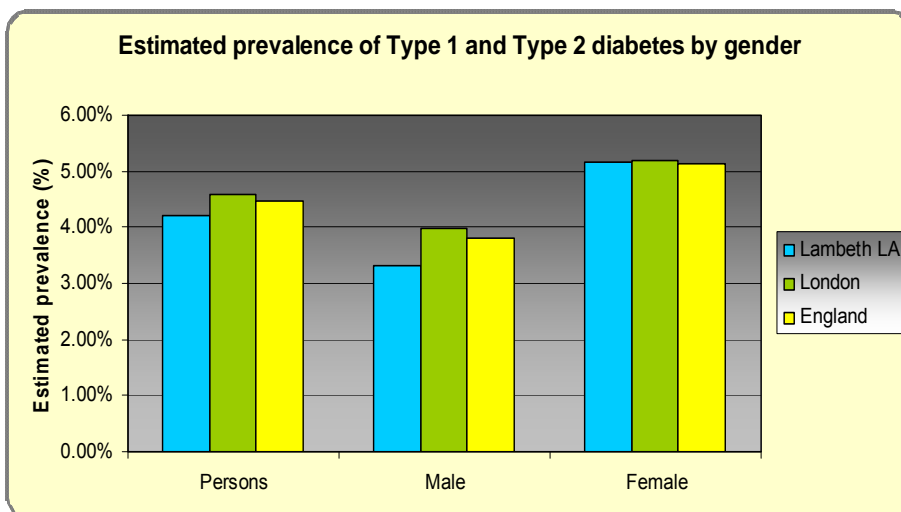
The graph above shows the estimated prevalence of diabetes mellitus (both Type 1 and 2) for all persons and split by gender.

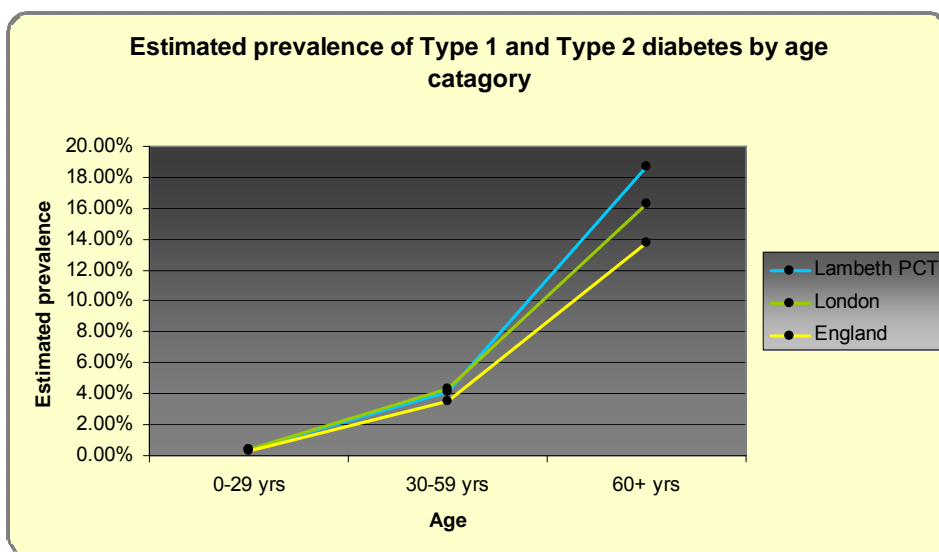 The prevalence of diabetes amongst Lambeth males (3.32%) is nearly same as national figure of 4.48%. The estimated prevalence of diabetes amongst Lambeth females (5.15%) is similar to that of both London and England (5.18% and 5.14% respectively)

1.1.2 AGE:

	0-29 yrs	30-59 yrs	60+ yrs
Lambeth	0.39%	4.16%	18.70%
London	0.39%	4.34%	16.28%
England	0.34%	3.52%	13.73%

Estimated prevalence of Type 1 and Type 2 diabetes by age catagory

The chart shows estimated prevalence of diabetes amongst three age groupings: 0-29yrs, 30-59yrs and 60+yrs. Whilst the prevalence % of diabetes at earlier ages is predicted to be similar to that of London and England, over the age of 60 it is estimated to be around 5% higher than that for England.
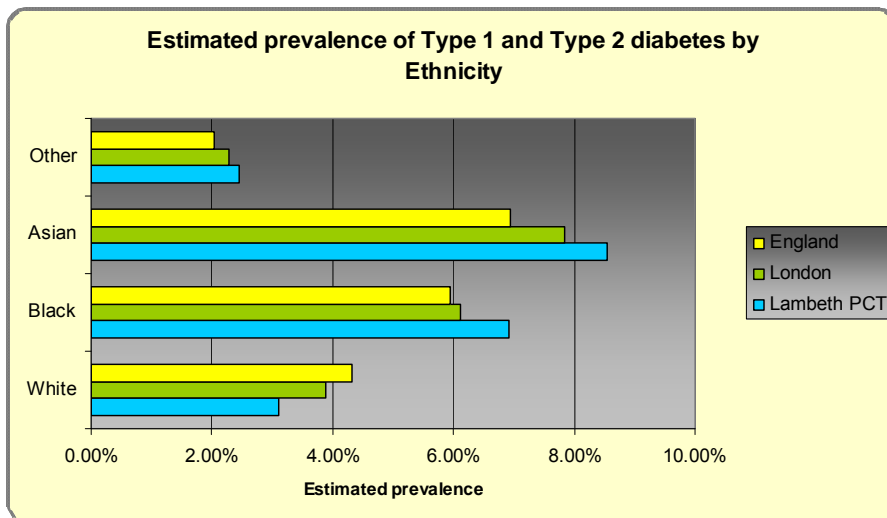
NHS LAMBETH

2008 Lambeth Population prevalence estimates for Type 1 & Type 2 Diabetes, by age group
Population 2008 figures are taken from GLA 2007 Round Ethnic Group Projections

	PERSONS		
	0-29	**30-59**	**60+**
Estimated prevalence	0.39%	4.16%	18.70%
Population 2008	120333.28	133338.16	31908.41
Estimated no. with diabetes 2008	**469.3**	**5546.87**	**5966.87**

The total number of people with Diabetes in the age group 0-29 years is estimated at 469, for the age group 30-59 years the figure is 5547 and for those over 60 years of age 5967.

1.1.3 ETHNICITY:

	White	**Black**	**Asian**	**Other**
Lambeth	3.12%	6.93%	8.54%	2.45%
London	3.89%	6.12%	7.85%	2.29%
England	4.33%	5.95%	6.93%	2.03%

Estimated prevalence of Type 1 and Type 2 diabetes by Ethnicity

The estimates by ethnicity specific prevalence figures included in the model show the Asian population with 8.54% prevalence of diabetes compared to 3.12% in whites and 6.93% in black population. The prevalence of diabetes in Lambeth BME population is proportionately higher than that of England.

2008 Lambeth Population prevalence estimates for Type 1 & Type 2 Diabetes, by ethnicity
Population 2008 figures are taken from GLA 2007 Round Ethnic Group Projections

	PERSONS			
	White	**Black**	**Asian**	**Other**
Estimated prevalence	3.12%	6.93%	8.54%	2.45%
Population 2008	178067.52	64813.07	13562.94	29136.31
Estimated no. with diabetes 2008	**5555.69**	**4491.55**	**1158.28**	**713.84**

In 2008 the number of white persons within the Lambeth population with Diabetes is estimated at 5556, the prevalence figure estimated for black persons is 4492, 1158 Asians and 714 of other ethnic origins are also predicted to have diabetes.

1.2 TYPE1 DIABETES
GENDER:

	TYPE 1		
	Persons	**Male**	**Female**
Lambeth	0.38%	0.45%	0.32%
London	0.36%	0.42%	0.30%
England	0.34%	0.40%	0.28%

Estimated prevalence of Type 1 Diabetes
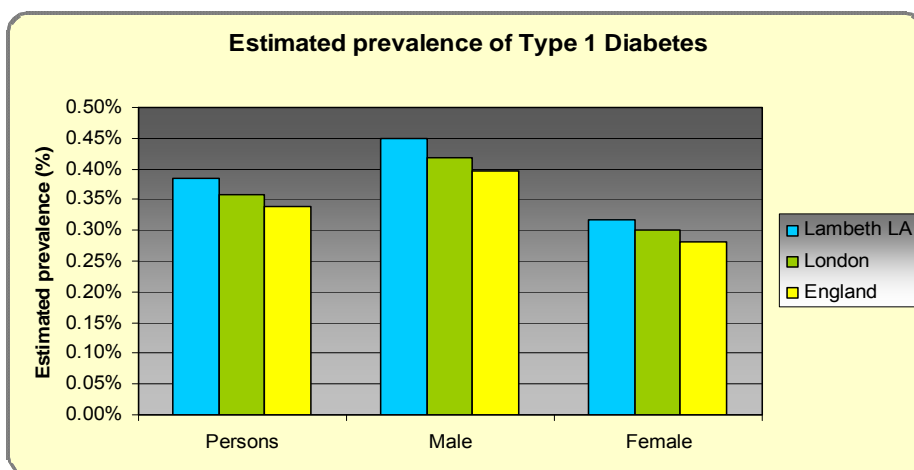
Type 1 diabetes is predicted to affect more males than females as seen in the graph above. The prevalence in Lambeth Males (0.45%) and females (0.32%) is higher than the England average of 0.40% and 0.28% in males and females respectively.

1.3 TYPE2 DIABETES:
GENDER:

	TYPE 2		
	Persons	**Male**	**Female**
Lambeth	3.83%	2.87%	4.83%
London	4.23%	3.56%	4.88%
England	4.14%	3.40%	4.86%

Estimated prevalence of Type 2 Diabetes

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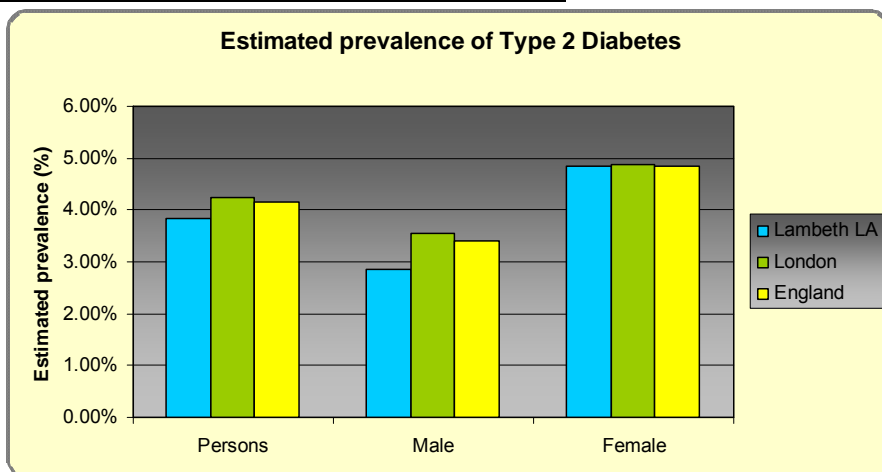
Above is a graph showing the estimated prevalence of Type 2 diabetes mellitus amongst males and females. The prevalence % of Type 2 diabetes is estimated to be around 0.5% lower amongst the male population of Lambeth compared to that of England. The estimated prevalence percentage of Type 2 DM for women is almost 2% higher than that for men and is very similar to predicted figures for both London and England.

Diabetes:

PBS Diabetes Population Prevalence Model- Phase 3
YHPHO (Yorkshire & Humber Public Health Observatory)

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2. HYPERTENSION

The model: Model for predicting the total number of people to be hypertensive

Background & Method

Method of calculation
The numbers of persons predicted to be hypertensive were derived by multiplying April 2006 Primary Care Trust (PCT) registered populations by hypertension prevalence rates identified in the 2003 and 2004 Health Survey for England2,3, modified by ethnic-group age-standardised risk ratios from the 2004 Health Survey for England3. Hypertension prevalence is known to be correlated with age, sex and ethnic-group so calculations were stratified to reflect variations in these factors at PCT level.
The PCT registered populations were derived by aggregating April 2006 GP practice
populations from the Exeter System using a Practice to new PCT lookup in the NACS October Access Database downloaded from the Information Centre NHS net website4.
In the absence of age by sex by ethnic-group PCT populations, the age by sex registered
populations of the current PCTs were attributed the ethnic-group distributions of their
constituent former PCT/s resident populations from the 2001 Census5.

Results

2.1 GENDER:

	HYPERTENSIVE		
	Male	Female	Persons
LAMBETH	21.9%	17.7%	19.9%
LONDON	23.60%	21.20%	22.40%
ENGLAND	24.7%	23.0%	23.8%

NHS LAMBETH

**Expected prevalence rate of hypertension , by gender**
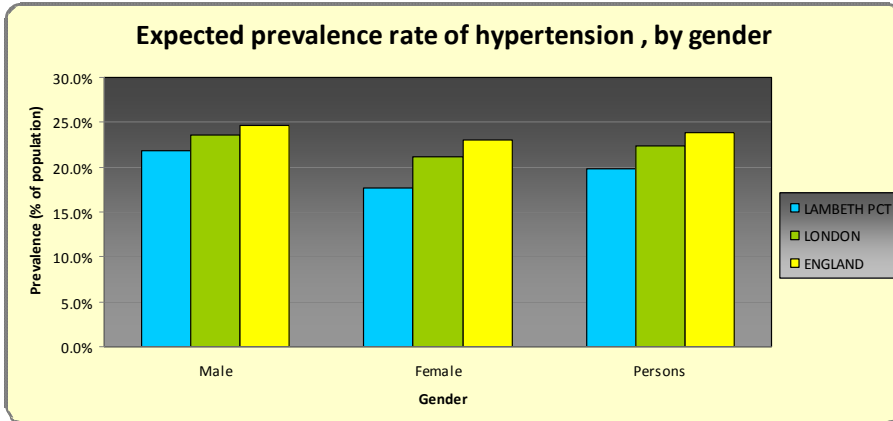
The prevalence of hypertension in Lambeth males is predicted to be at 19.9% with males at 21.9% and females at 17.7%. The QOF prevalence or the case detected prevalence as identified through the primary care registers is around 9% denoting that around 10% of patients who may have hypertension are undetected and untreated.

2.2.1 AGE:

Prevalence of hypertension amongst the general population 2003-04
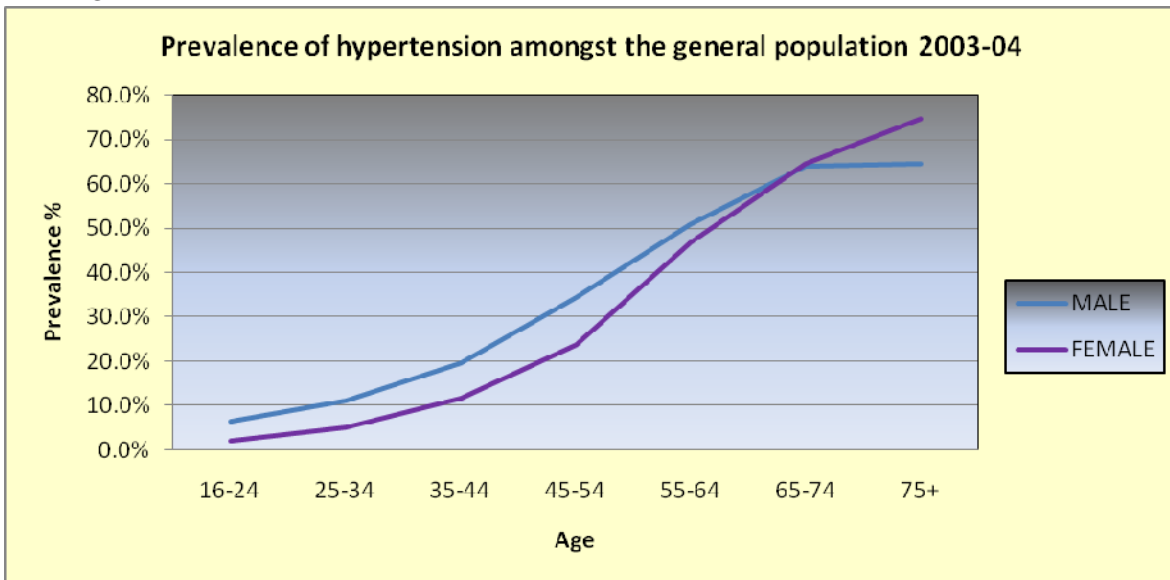
Hypertension is known to be prevalence in the middle-age group of over 40 but in the recent past, young persons are known to have been detected hypertension and although this case-detect prevalence is low in Lambeth, this needs to be evaluated further. The above graph shows that almost 65% of population over 65 may have hypertension. This will need to be compared with the primary care registers to understand what the prevalence of hypertension amongst Lambeth population in different age groups looks like.

2.2.2 ETHNICITY:

Prevalence of hypertension: 2003-04
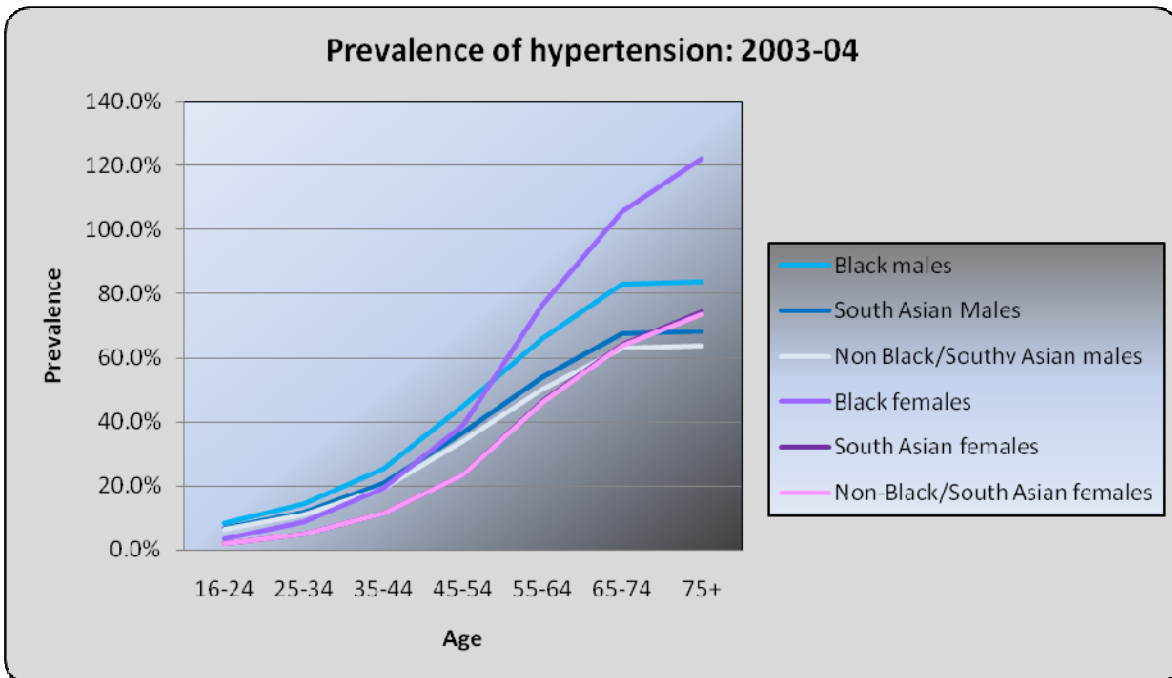
The graph above suggests that black females beyond the age of 54 are at the highest risk of hypertension. Non-black/non-south Asian females bellow the age of 65, are at relatively lower risk. But is obvious that hypertension is an issues in the Black and minority ethnic communities and early detection and treatment can have long term beneficial effects on the population's health.

2.3 TREATMENT:

	% OF HYPERTENSIVES	
	TREATED	TREATED & CONTROLLED
LAMBETH	33.2%	16.0%
LONDON	39.1%	17.9%
ENGLAND	41.2%	18.6%

Expected prevalence rate of treatment amongst hypertensives
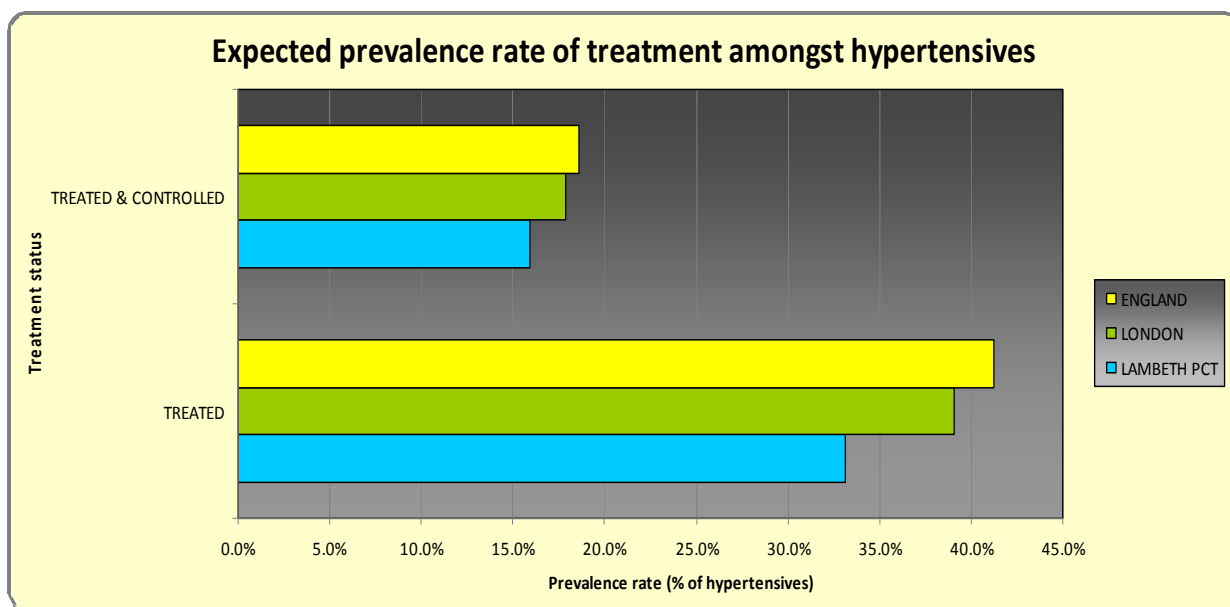
The model predicts that around 33.2% of hypertensives in Lambeth are treated compared to the England average of 41.2% while only 16% of hypertensives in Lambeth are treated and controlled compared to the England figure of 18.6%.

Hypertension:

The model was developed on behalf of the Association of Public Health Observatories by the Yorkshire and Humber PHO and Eastern Region PHO, and builds upon an existing model6 developed by the Faculty of Public Health Medicine which did not include an adjustment for ethnicity.

1. Systolic blood pressure greater than or equal to 140mmHg and diastolic blood pressure
greater than or equal to 90mmHg and/or taking medicine specifically prescribed for high blood pressure.
2. Joint Health Surveys Unit. Health Survey for England 2003: Risk Factors for Cardiovascular Disease. London: The Stationery Office 2004.
3. Joint Health Surveys Unit. Health Survey for England 2004: The Health of Minority Ethnic Groups. London: The Stationery Office 2005.
4. http://nww.connectingforhealth.nhs.uk/nacs/dowloads/access.
5. Office for National Statistics. Census 2001: London: 2003.
6.http://www.fphm.org.uk/policy_communication/publications/toolkits/hypertension/tools.asp

3. COPD

The model: Modelled estimates of prevalence of COPD for PCTs in England

Background & Method

These estimates and projections of the prevalence of CHD in people aged 16+ have been calculated using a model developed at the Dept of Primary Care and Social Medicine, Imperial College, London. The model was developed using data from the 2001 Health Survey for England
The model takes into account age, sex, ethnicity, smoking status, rurality and deprivation score. Ethnicity is defined as White (including mixed and other ethnicities), Black or Asian.

Input data

Deprivation scores are from the Indices of Multiple Deprivation 2004 (IMD2004)
Population data for 2005 by age (quinary age band), sex and ethnic group were provided by ONS (unpublished data)

Smoking prevalence is taken from the model-based estimates of healthy lifestyle behaviours, published by the Information Centre. As the model-based estimates do not include prevalence of ex-smokers, the national prevalence of ex-smokers from Health Survey for England 2003-2005 was applied everywhere.

PCTs are categorised as urban, suburban or rural based on a combination of the percentage of the population living in rural areas and the DEFRA classification as applied to PCTs by NEPHO.

Projections

ONS 2006-based population projections were input into the model to create projections of the prevalence of COPD to 2020.

The 2005 ethnic distribution is used for the 2006 – 2009 projections. The distribution of ethnic groups within the population is lagged by 5, 10 and 15 years for the 2010, 2015 and 2020 projections respectively. So, for example, in 2015 the ethnic distribution in the age group 40-44 is calculated using the ethnic proportions from the 30-34 age group in 2005.

Results

3.1.1 GENDER:

	Prevalence of COPD (16+ yr olds)		
	Males	Females	Persons
Lambeth	4.1%	3.6%	3.9%
LONDON	4.4%	3.4%	3.9%
ENGLAND	4.3%	2.9%	3.6%

Modelled estimates of Prevalence of COPD (persons 16+ yrs old) for 2009
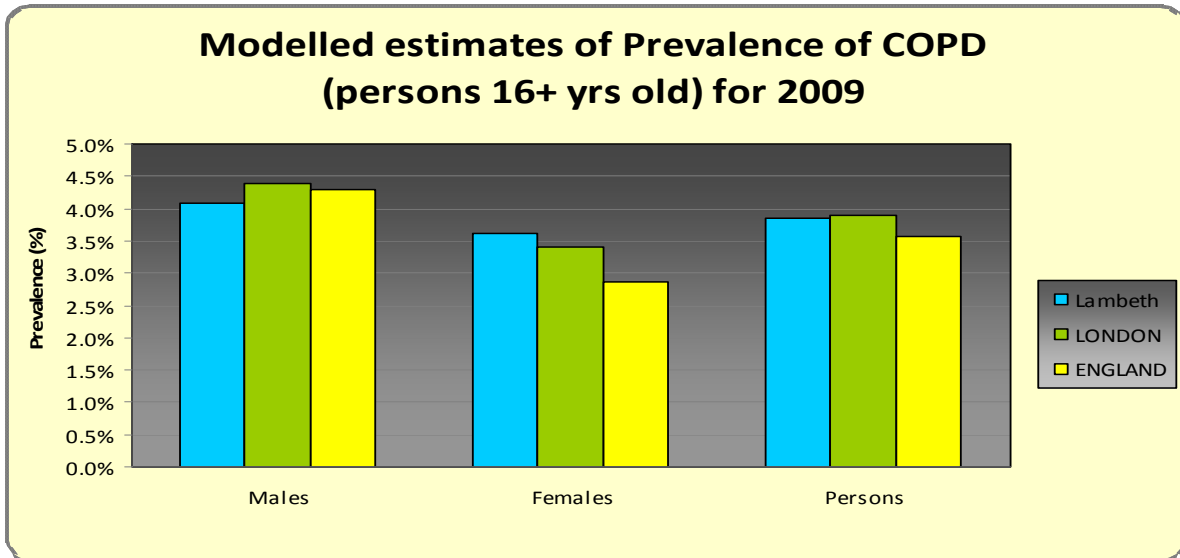
The model estimates the prevalence of COPD in Lambeth population at 3.9% compared to the England average of 3.6%. In Lambeth, the prevalence in males is estimated at 4.1% compared to females at 3.6%.

3.1.2 ETHNICITY:

	Prevalence of COPD		
	White	Black	Asian
Lambeth	3.6%	5.0%	2.8%
LONDON	4.0%	4.3%	2.6%
ENGLAND	3.6%	4.2%	2.3%

Modelled estimates of Prevalence of COPD (persons 16+ yrs old) for 2009
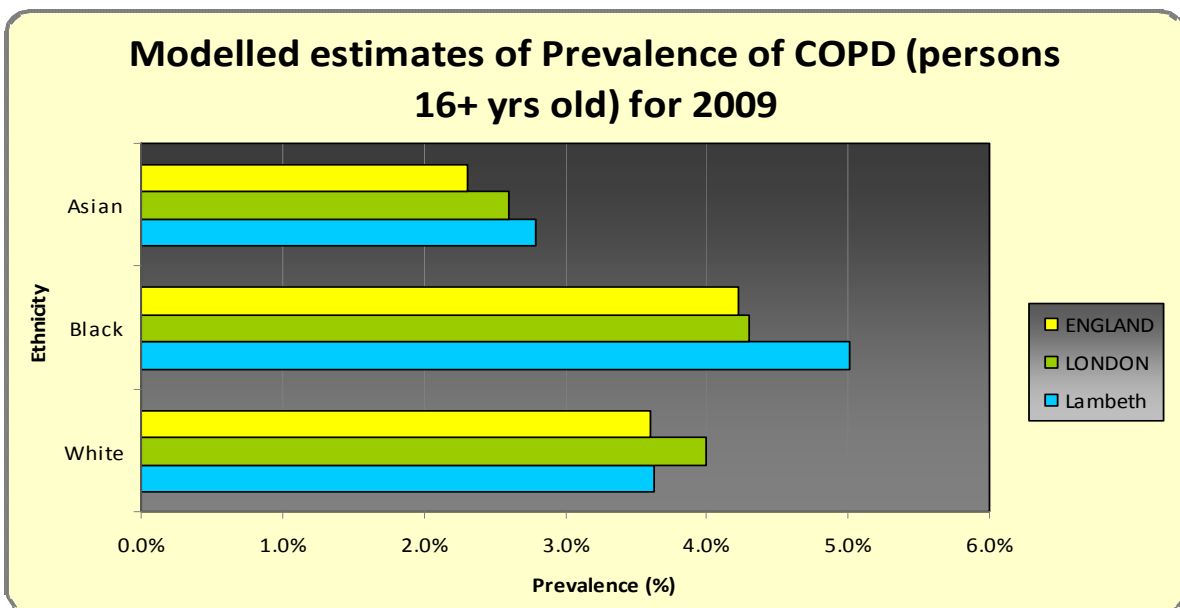
The model estimates the prevalence of COPD in the Black population at 5.0% compared to the white population at 3.6% and Asians at 2.8%. Since Lambeth has a high ethnic population it is important to quantify how many people may have COPD or at risk of developing in order to plan service provision.
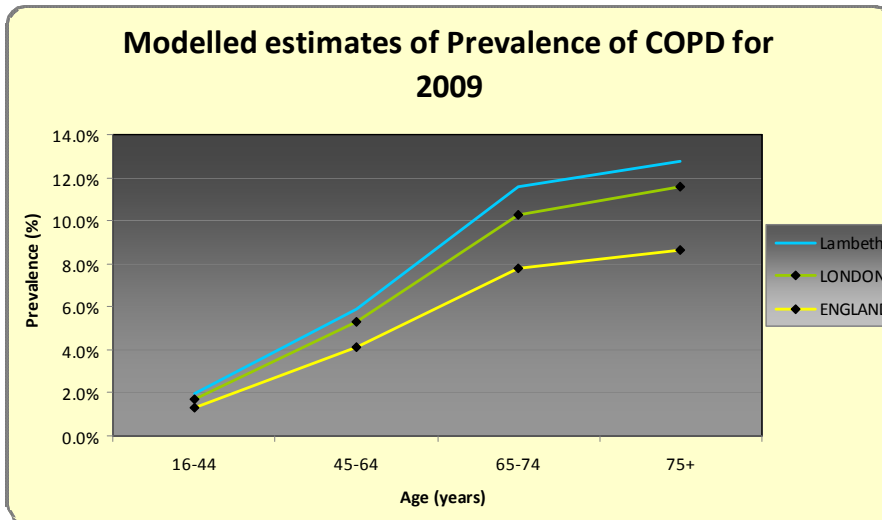
3.1.3 AGE:

	Prevalence of COPD			
	16-44	45-64	65-74	75+
Lambeth	2.0%	5.9%	11.6%	12.8%
LONDON	1.7%	5.3%	10.3%	11.6%
ENGLAND	1.3%	4.1%	7.8%	8.7%

Modelled estimates of Prevalence of COPD for 2009

The chart above shows the modeled estimates of COPD prevalence within certain age brackets. Age-specific prevalence of COPD shows that there is a high prevalence in the 65-74 and 75+ age group at around 12% respectively. This is much higher than the prevalence in England of around 8% individually in both 65-74 and 75+ age group. This attributable factor could be the higher proportion of ethnic minorities in Lambeth.

COPD:

Modelled estimates of prevalence of COPD for PCTs in England
Eastern Region Public Health Observatory, October 2008
Version 3.0

4. CHD
## The model: Model for estimating the prevalence of patient-reported doctor-diagnosed CHD

Background
A CHD Prevalence Model to estimate the prevalence of identified CHD within practice
populations was developed as part of the programme to tackle health inequalities led by Chris
Bentley, Director of Public Health for South Yorkshire. This model has been adapted to provide
PCT-level estimates through a two-stage process.

Method

Stage 1 predicts the number of people with identified CHD within the practice, taking
account only of the demographic distribution of the population.2 The prevalence of doctor
diagnosed CHD in each age/sex stratum is based on national data from the Health Survey for
England.3

	16-24	25-34	35-44	45-54	55-64	65-74	75+
Men	0	0	1	3.4	11.1	21.6	26.5
Women	0.3	0	0.5	1.9	5.8	9.7	18.1
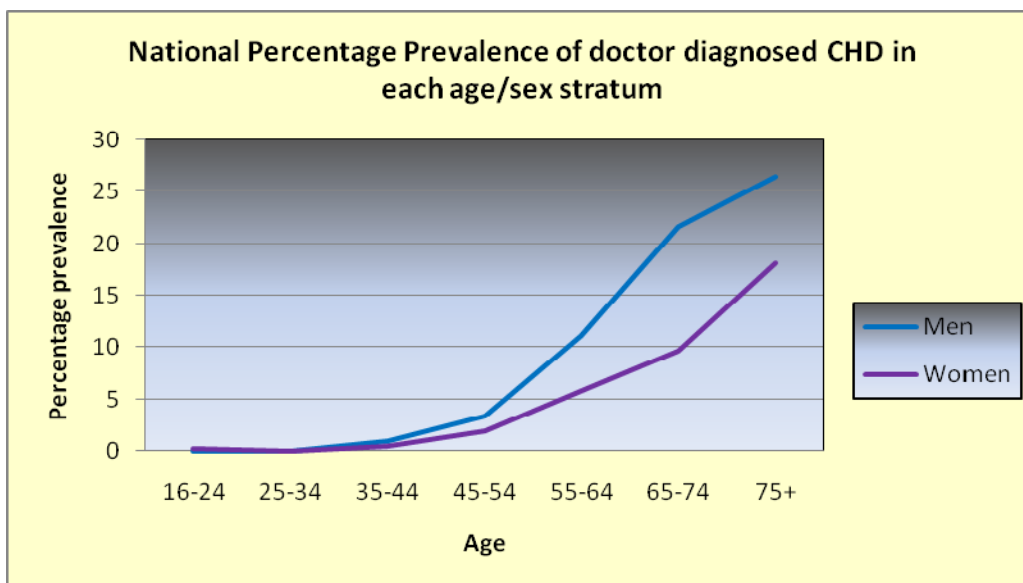
Stage 2 takes account of deprivation levels in different PCTs in England. In the absence of
sufficiently precise published data on the relationship between deprivation and CHD
prevalence, the model makes the assumption that areas with higher CHD mortality rates have
comparably higher prevalence of CHD. Using data for all local authorities in England, a linear
relationship between 2002-04 SMRs for CHD4 and a deprivation score (UV67) derived from the
2001 Census Classification of Deprivation,5 a linear relationship was calculated: **CHD SMR =
(2.604 × UV67) + 25.97**
Using UV67 scores5 calculated for each PCT, the above formula gives a multiplying factor for each
PCT. For example, a practice with a UV67 score of 40% (very deprived) has a multiplying factor of
1.3.

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Results

Table and graph taken from CHD model (Doncaster PCT, 2006) document:

4.1 OBSERVED RELATIVE TO EXPECTED % OF PATIENT-REPORTED DOCTOR-DIAGNOSED
CHD FOR LAMBETH PCT

	Practice Population	Expected Prevalence (Synthetic Estimates)					Observed from QMAS			Relative to Expected	
		Males	Females	Total	99.8% C.I.		%	No.	%		
CHD	15+	5,801	3,264	9,065	(8773,	9363)	3%	4,806	1%	–47.0%	
HTN	15+	39607	29810	69417	68680	70235	20%	27194	8%	-60.8%	

Patient-reported doctor-diagnosed CHD: England
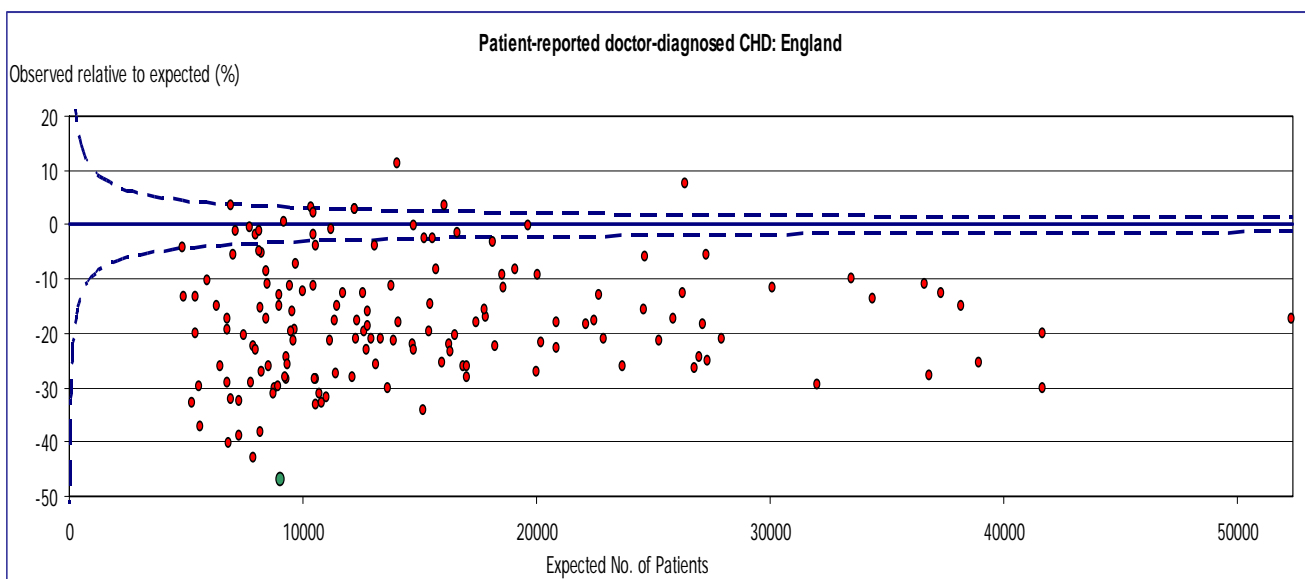
The observed to estimated ratio is displayed in the table above with the numbers and percentage of patients with CHD and HTN as in the model; and the funnel plot shows the PCTs with their observed relative to expected percentage for CHD. This quantifies to around 1000 patients. Further work on quantifying by males and females in terms of undetected/untreated cases is essential to understand the disease burden. More area specific work that will be done as a part of the Vascular risk programme will focus on identifying the number of people at risk in Lambeth localities or even at ward level where possible.

**CHD:**

NHS LAMBETH

Model for estimating the prevalence of patient-reported doctor-diagnosed CHD
Doncaster PCT 2006

1. An original model was developed in Sheffield Health Authority by John Soady and Bruce Laurence. The current model is based on this model, but uses more recent data from the Health Survey for England and a different method of adjusting for deprivation.
2. Population data are obtained from the Patient Register held by the PCT.
3. Joint Health Surveys Unit (2004). Health Survey for England 2003.
4. National Clinical and Health Outcomes Database (2005). Compendium of Clinical and Health Indicators.
5. Calculation of the UV67 score using 2001 Census data is described in detail elsewhere in the help.

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5. LIFESTYLE

The model: Model Based Estimates of Healthy Lifestyle Behaviours at PCO level (2003-2005)

5.1 Model-Based Estimates of Binge Drinking, 2003-2005

	%		
	Upper	Lower	Estimate
Lambeth	19.7	14.2	**16.8**
London	14.0	11.4	**12.7**
England	18.6	17.4	**18.0**

The prevalence percentage of binge drinking in Lambeth at 16.8% is estimated to be lower than the equivalent figure for England (18.0%), but around 4% higher than that of London at 12.7%.

5.2 Model-Based Estimates of Fruit and Vegetable consumption (adults), 2003-2005

	%		
	Upper	Lower	Estimate
Lambeth	33.3	27.5	**30.3**
London	31.9	27.5	**29.7**
England	27.0	25.6	**26.3**

Fruit and vegetable consumption amongst adults in Lambeth is estimated to be similar to the percentage predicted regionally but 4% higher than the national figure.

5.3 Model-Based Estimates of Current Smoking, 2003-2005

	%		
	Upper	Lower	Estimate
Lambeth	31.9	24.6	**28.1**
London	25.1	21.6	**23.3**
England	24.7	23.4	**24.1**

The estimate for current smoking in Lambeth at 28.1% is predicted to be 4% higher than figure for England at 24.1%. Ward level estimates of smoking are available but they are based on the extrapolation of the HSE (health survey for England) data and should be interpreted with caution as there may be issues with the representation in the sample size.

5.4 Model-Based Estimates of Obesity, 2003-2005

	%		
	Upper	Lower	Estimate
Lambeth	21.0	16.3	**18.6**
London	20.1	16.8	**18.4**
England	24.2	23.0	**23.6**

The prevalence of obesity in Lambeth is estimated to be very similar to the regional figure (18.6% compared to 18.4% for London); this figure is 5% lower than the equivalent value for England (23.6%).

Lifestyle:

Model Based Estimates of Healthy Lifestyle Behaviours at PCO level (2003-2005)
Published 14/05/2008

The NHS Information Centre for health and social care, 2008
Source: Health Surveys for England 2003 to 2005
Produced by National Centre for Social Research (NatCen), May 2008

NHS LAMBETH

REFRENCES:

Doncaster PCT. *Coronary Heart Disease Model - Developed in discussion with Department of Health, Eastern Region Public Health Observatory and Yorkshire and Humber Public Health Observatory.* 2006.
Available from: http://www.apho.org.uk/resource/item.aspx?RID=39385

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Available from: http://www.apho.org.uk/resource/item.aspx?RID=39384

Yorkshire & Humber Public Health Observatory. *PBS Diabetes Population Prevalence Model Phase 2.* 2005.
Available from: http://www.york.ac.uk/yhpho/diabetes.htm

London Health Observatory; Practice Profiles. July 2009 available from http://www.lho.org.uk/PracProf/Default.aspx

National Compendium of Health Outcomes Development (NCHOD). Office for National Statistics. Available from www.nchod.nhs.uk

Greater London Authority © (2008). Round Interim Population Projections for London Boroughs. Data Management & Analysis Group, GLA. London.

APPENDIX 2 – LHO (London Health Observatory) practice profiles.

Available from http://www.lho.org.uk/PracProf/Default.aspx

APPENDIX 3

APPENDIX 3 – Data definitions

(More information available from http://www.nchod.nhs.uk/)

1. Prevalence

Proportion of all patients with a specific condition in a GP registered population. Calculated by dividing the number of people with a specific condition with the total practice registered population expressed as a percentage.
Numerator data - Patients registered with GP practices with a coded diagnosis for the condition under review.
Source of numerator data - Quality and Outcomes Framework (QOF).
Denominator data - All patients registered with GP practices (practice list size).

2. Ethnicity

GLA (Greater London Authority) classification compared to ONS (office for national statistics) classification

GLA Aggregated Ethnic Group (AEG) *	ONS 2001 Census Ethnic Category
White	White: British White: Irish White: Other White
Black Caribbean	Black or Black British: Caribbean
Black African	Black or Black British: African
Black Other	Black or Black British: Other Black Mixed: White & Black Caribbean Mixed: White & Black African
Indian	Asian or Asian British: Indian
Pakistani	Asian or Asian British: Pakistani
Bangladeshi	Asian or Asian British: Bangladeshi
Chinese	Chinese or Other: Chinese
Other Asian	Mixed: White & Asian Asian or Asian British: Other Asian
Other	Mixed: Other Mixed Chinese or Other: Other

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3. Deprivation

To provide a measure of deprivation at Local Authority (LA) and Primary Care Organisation (PCO) level. The Indices of Deprivation are used widely to analyse patterns of deprivation, identify areas that would benefit from special initiatives or programmes and as a tool to determine eligibility for specific funding streams. The English Indices of Deprivation 2007 (ID 2007) are the Government's official measure of multiple deprivation at small area level. The 2007 Indices update information provided in the Indices of Deprivation 2004 (ID 2004).
Numerator data - Scores in the ID 2007 are at Lower Layer Super Output Area (LSOA) level indicators in the following seven "domains" of deprivation:
- Income;
- Employment;
- Health Deprivation and Disability;
- Education, Skills and Training;
- Barriers to Housing and Services;
- Crime;
- Living Environment.

The seven LSOA level Domain Indices are combined to make the LSOA level Index of Multiple Deprivation 2007 (IMD 2007). The summary measures are:
- Local Concentration;
- Extent;
- Average Score;
- Average Rank;
- Scale (for Income and Employment only).

Source of numerator data - Department for Communities and Local Government (DCLG).
Statistical methods: The methodology underpinning the ID 2004 and ID 2007 are largely the same though there have been small changes to some of the underlying indicators. Comparison between the two Indices is therefore acceptable. Further information on methodology and guidance on ID 2007 use can be found at: http://www.communities.gov.uk/documents/communities/pdf/733520.pdf

4. Super Output Areas

SOAs are a unit of geography used in the UK for statistical analysis. They are developed and released by Neighbourhood Statistics.

SOAs were created with the intention that they would not be subject to frequent boundary change. This makes SOAs more suitable than other geography units (such as wards) because they are less likely to change over time, and thus SOAs are more suitable to change over time analysis.

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There are three layers of SOAs (i.e. three different but related geography boundaries). These are:

- Lower Layer - Minimum population 1000, mean population 1500. Built from groups of Output Areas. Commonly known as Lower Layer Super Output Area (LSOA).There are 34,378 LSOAs in England and Wales.
- Middle Layer - Minimum population 5000, mean population 7200. Built from Lower Layer SOAs. Commonly known as Middle Layer Super Output Area and abbreviated to MSOA. There are 7,193 MSOAs in England and Wales.
- Upper Layer - Commonly known as Upper Layer Super Output Area (USOA).

Each SOA is identified by a nine character code (for example E01000001). This code consists of three parts:

- The first letter identifies the country:

E	England
W	Wales

- The next two digits indicates the type of SOA layer:

01	Lower Layer SOA
02	Middle Layer SOA

- The final 6 digits provide a unique tag.

5. Life expectancy

Life expectancy at birth (a measure of mortality) for an area in a given period as an estimate of the number of years a new-born baby would survive, were he or she to experience the particular area's age-specific mortality rates for that time period throughout his or her life.
Numerator data - Estimated number of years of life expectancy at birth based on a three-year period for the relevant years.

Comments on numerator data - The figures reflect mortality among those living in the area in each time period. They are not the number of years a baby born in the area in each time period could actually expect to live, both because the death rates of the area are likely to change in the future and because many of those born in the area will live elsewhere for at least some part of their lives.

Life expectancy at birth is also not a guide to the remaining expectancy of life at any given age. For example, if female life expectancy at birth was 80 years for a particular area, life expectancy of women aged exactly 75 years in that area would exceed 5 years. This reflects the fact that survival from a particular age depends only on the mortality rates beyond that age, whereas survival from birth is based on mortality rates for all ages.

Statistical methods: Abridged life tables were constructed using standard methods. Separate tables were constructed for males and females. The tables were created using annual mid-year population estimates and deaths registered in each year. All figures presented here are for life expectancy at birth. The Government Actuary's Department (GAD) compiles data on life expectancy, using data derived from Registrars General on population and deaths. Data are available in the form of life tables on both a period and a cohort basis.

The calculation of the confidence intervals was made using the method developed by Chiang. A report which details research undertaken by the Office for National Statistics on comparing methodologies to enable the calculation of confidence intervals for life expectancy at birth has now been published as No 33 in the National Statistics Methodological Series. This report, "Life expectancy at birth: methodological options for small populations", also presents research carried out to establish if there is a minimum population size below which the calculation of life expectancy may not be considered feasible. It concludes with a summary of methodological conclusions and considers how these could be applied to the calculation of life expectancy at birth for wards in England and Wales. A copy of the report can be found on the ONS website at:
   http://www.statistics.gov.uk/statbase/Product.asp?vlnk=10626

Examples of life tables constructed for the comparison of methodologies are also available in an Excel workbook, "Life Table Templates" which can be found on the ONS website at: http://www.statistics.gov.uk/statbase/Product.asp?vlnk=8841

6. SMR – Standardised Mortality Ratio

An SMR is essentially a comparison of the number of the observed deaths in a population with the number of expected deaths if the age-specific death rates were the same as a standard population. It is expressed as a ratio of observed to expected deaths, multiplied by 100.

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SMRs equal to 100 imply that the mortality rate is the same as the standard mortality rate. A number higher than 100 implies an excess mortality rate whereas a number below 100 implies below average mortality.

A SMR is calculated as the number of deaths observed within an area divided by the expected number of deaths within that area. This ratio is then multiplied by 100. To arrive at the expected number of deaths, for each age group, the standard age-specific death rate is multiplied by the local population in that age group. The number of expected deaths in each age group are then summed across all ages to arrive at the expected number of deaths for the local population.

7. DSR – Directly Standardised Ratio

The ASR for an area is the number of deaths, usually expressed per 100,000, that would occur in that area if it had the same age structure as the standard population and the local age-specific rates of the area applied.

Directly standardised mortality rate is calculated by dividing the number of deaths by the actual local population in a particular age group multiplied by the standard population for that particular age group and summing across the relevant age groups. The rate is usually expressed per 100,000.