Reducing early deaths: the role of primary care

Juggling health 2010

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THE ANNUAL REPORT OF THE SOUTHWARK DIRECTOR OF PUBLIC HEALTH
Juggling health 2010

Reducing early deaths: the role of primary care
Welcome
to the Annual Public Health Report for 2010

This is the 2010 report of the Director of Public Health about the health of the population of Southwark. For this year the report focuses on the health of those people who are seen in our primary care services (GP practices).

Primary care is at the heart of our health system in London and the UK. Most people are registered with a GP and receive care throughout their lives from their local GP practice. The UK approach to primary care is well recognised as being comprehensive for individuals and their families. The benefits of our services are obvious, in that there is free local access for all legal residents, most people can continue to see the same GP over many years and the GP will know them and their health issues. GPs deal with immediate urgent health problems and also with longer-term problems. GPs are often the first point of contact when a problem is identified, such as harmful drinking. GPs retain very high standing in our society and usually top the polls for being the most trusted profession. In short GPs have a huge influence on their patients' health and well being throughout the course of their lives.

One of the aims of public health is to prevent premature death and to improve the health of people during the course of their lives. What happens in primary care can have a significant impact on both of these issues. GPs and their practices have a very important role in many of the factors that impact on health. It has been shown that GPs can have a large influence with individuals on their smoking habits or if they are drinking too much alcohol. GPs are the main providers of care for people with conditions that can lead to early death if not cared for well, such as high blood pressure or diabetes. In short, good primary care can significantly improve the life expectancy of local people.

We have much high quality local primary care here, with many practices providing superb care, often under difficult circumstances. However we cannot be complacent and the information set out in this report shows that there is still more we can do to achieve better outcomes for local people. The report sets out information on effective approaches to helping people to change their behaviours. It shows where additional lives could be saved each year through better care for people with serious long term conditions. It identifies that there are many people with silent conditions needing treatment that have yet to be identified by doctors. It also tells us where we could reduce the need for urgent admissions to hospital.

Of course not of all of this is in the doctor’s hands. Local people / patients also have a role to play in ensuring that they work with their GP to improve their health. This can be by making sure they are taking all their medications, agreeing treatment goals with their doctor, turning up for appointments, and feeling confident to ask questions about their health if they do not understand. The NHS is everybody’s service that must be used to its best effect, with patients and their doctors all taking full responsibility for getting the very best results. Together we can all make a difference improving health in Southwark.

Acknowledgements
I would like to thank the following people for all their work in getting all the information together and making this report. Piers Simey led the whole project that brought all the information and interpretation together and made this report happen. Karen Phillips and Nilam Jani did excellent work extracting and analysing large quantities of information, and
Karen specifically prepared the section on demographics. Gillian Holdsworth has made sure we have the right understanding of screening and its influence on health. Kate Harvey has done extensive work to show the important role of GPs in promoting health-related behaviours and immunisations. Nigel Field was unstinting in bringing together large amounts of information on the major long term conditions that can shorten lives in Southwark.

Dr Ann Marie Connolly

Director of Public Health

Further acknowledgements

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Murad Ruf
Devika Sennik
Alex Sennik
Helen Williams
Jean Young

& finally, thanks to the Southwark general practice staff who agreed to be photographed.
1 Introduction

Aim of this report
Every year nearly 600 Southwark people die before they reach the age of 75 years, over 10 every week. Early deaths can result from a range of different factors but most of them could be avoided through healthier lifestyles, earlier intervention and better care. This report aims to support primary care and other services in doing just that. By highlighting this issue across the borough and providing evidence-based recommendations we hope that local people will be better equipped to tackle these long-standing issues and further reduce the death toll in future years.

Policy context
Primary care is often described as the cornerstone of the NHS and will have an increasingly important role as the current NHS reforms take effect. General practitioners and their teams are often the first port of call for people seeking health advice or treatment and are the gateway to many other services.

The current NHS reforms have been described in detail elsewhere but the two key developments to note here are the creation of Health and Wellbeing Boards and of GP Consortia. Health and Wellbeing boards will take an overview of health in the local authority area, will undertake joint strategic needs assessment and will develop a local health and wellbeing strategy. GP Consortia will be represented on the board and will themselves take the lead in commissioning the bulk of local NHS services. GPs will therefore have a triple role – as contributors to wider strategy, as commissioners and as providers of primary care services. Together with their staff they will be very well placed to take forward the issues raised in this report.

Note on methodology
This report includes a wide range of information on Southwark’s population, its health status and on local primary care services. It uses the latest available data at the time of writing with most of the primary care data being drawn from the Quality and Outcomes Framework (QOF) 2009/10.

It is of course important to review changes in performance as newer information becomes available. We expect that the final QOF data for 2010/11 will be published from July 2011 and the public health team will then provide local practices with updated profiles for key indicators.

The report also makes use of a modelling tool developed by the Health Inequalities National Support Team (HINST). The tool helps the spearhead primary care trusts to quantify the health benefits of improving primary and secondary preventative services for local people. Like all modelling tools the HINST model is based on a number of assumptions and should be used as a means of illustrating health outcomes rather than making firm predictions. Nevertheless it is a useful way of showing the real health gains that can result from interventions in primary care. The tool is described further in Appendix 1 of this report.
2 Summary
and key recommendations

2.1 Overview

Southwark’s population and its general health
Chapter three shows that:
- The borough’s population is young and diverse compared to the rest of the country and compared to London as a whole.
- The population registered with Southwark GPs is much larger than that actually living in the borough.
- The borough is one of the most socially deprived in the country and there are also great inequalities across Southwark.
- Overall life expectancy is rising and is now slightly longer than the national average.
- There is still great scope for improvement with hundreds of people dying early every year. Many of these deaths are avoidable through better primary care services and other actions.

Primary care services in Southwark
Chapter four shows that:
- There is great diversity in GP practices, ranging from very small single-handed practices up to large group practices.
- The characteristics of practice populations also vary in many ways including age, gender, ethnicity and deprivation levels. This affects health indicators and needs to be taken into account in assessing how well practices meet the needs of their registered populations.
- There is a high turnover of people registered with Southwark practices.

The role of primary care in reducing early deaths
Chapter five shows that:
- Over 3000 local hospital admissions are related to alcohol every year. Brief interventions in primary care are very effective.
- Southwark has a high smoking prevalence compared to London and England and the success rate in quitting is extremely low at 29%.
- Treating obesity-related health problems cost £86m in Southwark every year.
- Physical activity interventions in primary care are cost effective, but have not yet been systematically applied in Southwark.
- There are very large variations in the recording of lifestyles in GP practices, limiting the scope for effective action in primary care.
- Immunisation rates have improved in recent years but are still below target levels in many cases.
- Southwark’s coverage for breast, cervical and bowel cancer screening programmes are all lower than average.
Chapter six (Long Term Conditions) shows that:

- The death rate from coronary heart disease in Southwark has more than halved in the last fifteen years.
- The borough has a high COPD mortality rate.
- More than 10,000 local people are now on GP practice diabetes registers.
- There are however many people with hypertension, diabetes, CHD, COPD and other conditions who are undiagnosed and/or not placed on disease registers. This means that they are unlikely to benefit from effective interventions.
- Many other patients are on GP registers but have been ‘exception-reported’ for various reasons and some may not be receiving optimal care.
- There are great variations between practices in the extent to which they identify and treat their patients with long term conditions.
- Modelling suggests that over 100 early deaths could be prevented each year through implementing some specific interventions in primary care.
- About a third of new HIV diagnoses in Southwark are late diagnoses, which often means worse outcomes for the individual affected.

2.2 Eight interventions to reduce deaths – what could make the difference?

The National Health Inequalities Support Team has identified a number of important evidence based interventions that could impact on local death rates. The table below sets out the most relevant interventions taken from their modelling.

<table>
<thead>
<tr>
<th>Estimated number of deaths in Southwark that could be postponed in one year</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong> Brief alcohol interventions for 10% of harmful drinkers</td>
<td>2 page 28</td>
</tr>
<tr>
<td><strong>2</strong> Smoking cessation (10% of smokers set a quit date)</td>
<td>3 29</td>
</tr>
<tr>
<td><strong>3</strong> All untreated people with a previous cardiovascular event on beta blocker, aspirin, ace inhibitor, statin</td>
<td>CHD: 11 stroke: 6 64</td>
</tr>
<tr>
<td><strong>4</strong> All partially treated people with a previous cardiovascular event on beta blocker, aspirin, ace inhibitor, statin</td>
<td>CHD: 21 stroke: 11 64</td>
</tr>
<tr>
<td><strong>5</strong> Anticoagulant therapy (warfarin) for all aged over 65 with atrial fibrillation</td>
<td>stroke: 8 75</td>
</tr>
<tr>
<td><strong>6</strong> All people with high blood pressure with no previous CVD event to have additional anti-hypertensive therapy</td>
<td>34 81</td>
</tr>
<tr>
<td><strong>7</strong> Statin treatment for those with hypertension at high CVD risk</td>
<td>15 81</td>
</tr>
<tr>
<td><strong>8</strong> For people with diabetes reducing blood sugars that are over 7.5 by one unit</td>
<td>9 87</td>
</tr>
</tbody>
</table>

1 The benefits of these interventions are set at the theoretical maximum level and might need to be scaled down in practice. The estimates are not precise and draw on a range of estimated data. But the table helps focus attention on the interventions that could make a major local impact.
2 Further work is needed using local data where possible
3 for one year, unless stated
4 over two years, more in longer term
5 CHD is coronary heart disease
6 unless contraindicated
2.3 Key recommendations

Specific recommendations relating to individual health issues can be found in chapter five. Some common themes have emerged and to avoid duplication the key overall recommendations are highlighted below.

2.3.1 List validation Southwark GPs should be able to demonstrate on an annual basis that patients on their practice lists are appropriately registered and that the contact details are correct. This is essential for ensuring that the public health impact of primary care services can be effectively monitored and that areas for improvement can be readily identified.

2.3.2 NHS Health Checks This national programme will be rolled out across GP practices in Southwark during 2011/12. Everyone aged 40-75 without cardiovascular disease (such as heart attacks or strokes), diabetes or kidney disease will be eligible for a free health check every five years. Participants have their risk of cardiovascular disease assessed and are then supported to take steps to improve their health. This should result in more systematic health improvement interventions relating to physical activity, smoking, obesity and alcohol. The programme will also help identify those with as yet undiagnosed conditions. High coverage will be needed in primary care.

2.3.3 People with long term conditions and those not eligible for health checks – the interventions described in section 2.3.2 should also be promoted to people with long term conditions (as a core part of their ongoing care) and those high risk groups who are not eligible for health checks due to their age.

2.3.4 Variation There are marked variations between practices for some indicators. This report helps to identify which practices have higher levels of performance and which ones may need support. Action should focus on identifying the reasons for low identification and management of health problems and tailoring action as appropriate in order that outcomes are more equitable.

2.3.5 Inequalities Special efforts should be made to ensure that interventions are also taken up by groups that have higher levels of health need and/or who do not tend to come forward for preventative measures. Uptake and outcomes should be monitored to ensure equity between different areas of the borough and between different population groups.

2.3.6 Updates Information on GP practice coverage and performance on key indicators should be updated and reported as new data become available.

2.3.7 Monitoring The results of action taken to improve health and reduce inequalities should be evaluated and reported to the new Health and Wellbeing Board to help inform future local strategy.
3 Southwark’s population and its health

3.1 Population

Geography of Southwark

Southwark is an inner city borough in South East London with 21 electoral wards. Its northern boundary is on the river Thames, with Lambeth to the west and Lewisham to the east. NHS Southwark has the same geographical boundary as the Borough of Southwark. It is divided into four localities – Borough & Walworth, Bermondsey & Rotherhithe, Peckham & Camberwell, and Dulwich.

The population of Southwark

Estimates of the number of people living in Southwark in 2009 range from 280,504 (GLA shlaa, 2010) to 285,600 (ONS 2009 mid year estimates). The results of the 2011 census will be an opportunity to update population figures and will be a rich source of information on the borough’s people and their characteristics.

Like many London boroughs Southwark has a predominately young adult population (43% of Southwark’s resident population are young adults aged 20-39 years old compared to 27% in England). Conversely, Southwark has a low proportion of its population aged 65 years and over (only 9% compared to 16% nationally). The borough has a high proportion of young children aged 0 to 4 years but relatively few older children and teenagers compared to London and England.

The population of Southwark is growing. The ‘resident’ population is expected to increase by more than a fifth to 355,200 by 2030.1

Figure 3.1 Southwark population profiles by age and sex compared to England and London, 2009 (ONS 2009 mid year population estimates)

Source: ONS 2009 mid-year population estimates
The ‘registered’ population of Southwark is described as those people registered with a Southwark general practice, regardless of where they live. This registered population for Southwark is recorded as being larger than the borough’s resident population. As of December 2010 there were 319,449 registered patients with the 47 practices in Southwark. This figure, as with the resident population, is not thought to be completely accurate as the population will change daily as patients join or leave practices. The registered population figure is thought to be an over-estimate of the real figure, which has implications for a range of performance and finance indicators relating to primary care.

Southwark’s registered population has relatively fewer babies and young children, more adults aged 35 to 54 years and more people aged 75 years and over than the resident population (Table 3.1).

### Table 3.1 Age structure of registered and resident populations (ONS and GLA) for Southwark

<table>
<thead>
<tr>
<th>Age group</th>
<th>GP registered population</th>
<th>Resident population</th>
<th>GLA number</th>
<th>GLA %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>GP list</td>
<td>%</td>
<td>ONS number</td>
<td>ONS %</td>
</tr>
<tr>
<td>0-4</td>
<td>16,667</td>
<td>5.2</td>
<td>20,900</td>
<td>7.3</td>
</tr>
<tr>
<td>5-14</td>
<td>31,616</td>
<td>9.9</td>
<td>26,800</td>
<td>9.4</td>
</tr>
<tr>
<td>15-24</td>
<td>40,238</td>
<td>12.6</td>
<td>40,100</td>
<td>14.0</td>
</tr>
<tr>
<td>25-34</td>
<td>75,777</td>
<td>23.7</td>
<td>66,400</td>
<td>23.9</td>
</tr>
<tr>
<td>35-44</td>
<td>62,012</td>
<td>19.4</td>
<td>50,900</td>
<td>17.8</td>
</tr>
<tr>
<td>45-54</td>
<td>43,045</td>
<td>13.5</td>
<td>33,900</td>
<td>11.9</td>
</tr>
<tr>
<td>55-64</td>
<td>22,417</td>
<td>7.0</td>
<td>19,400</td>
<td>6.8</td>
</tr>
<tr>
<td>65-74</td>
<td>12,759</td>
<td>4.0</td>
<td>12,900</td>
<td>4.5</td>
</tr>
<tr>
<td>75+</td>
<td>14,856</td>
<td>4.7</td>
<td>12,300</td>
<td>4.3</td>
</tr>
<tr>
<td>Total</td>
<td>319,387</td>
<td>100.0</td>
<td>285,600</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Sources: registered population: Exeter December 2010 Resident population: ONS 2009 mid-year population estimates and GLA 2010 shlaa population projections for the year 2009

### Ethnicity

The population of Southwark is ethnically diverse, with around a third (35.2%) of the total population coming from the Black and Minority Ethnic community. This is a higher proportion than for London (31%) and England (11.8%). The largest ethnic minority group in Southwark are those people who identify themselves as Black or Black British, making up around a fifth (20%) of the population. More than half of this group are Black African, representing at least 12% of the total Southwark population. The age profile of the BME groups is younger than that of the White groups, and 69% of school pupils in Southwark are from BME groups.

Figure 3.2 Ethnicity of Southwark population, resident population, 2007

3.2 Influences on health

Deprivation

Southwark is the 12th most deprived borough in London and the 41st most deprived in England according to the 2010 Index of Multiple Deprivation (IMD). More than a third (35%) of the borough’s population live in the most deprived areas of the country (the 20% of areas known as the bottom deprivation quintile). Deprivation varies across the borough with in general, the most deprived areas being in the centre of Southwark. The most affluent parts of Southwark are in the south of the borough and in some areas beside the Thames. A more detailed picture of deprivation levels across the borough is shown in Figure 3.3.

Figure 3.3 Deprivation in Southwark by Lower Super Output Areas (LSOAs)

Housing

Almost half (47.5%) of the dwellings in Southwark are social dwellings. These are dwellings that are owned by the local authority (LA) or accommodation that is owned or leased by registered social landlords (RSL), and other public sector dwellings such as those owned by the LA for non-housing purposes. It does not include dwellings sold under shared ownership or rent-to-mortgage schemes. This is much higher than for London (23.3%) and England (17.8%). There has been a decline in the proportion of social dwellings in Southwark since 2001, when 54.5% were social dwellings. Of the social housing, there has been a reduction in those provided by the LA and a small increase in the registered social landlord dwellings. In 2009 nearly half (47%) of the LA dwellings fell below the ‘decent home standard’.

A quarter of all households in Southwark are of single people, 15% are pensioner households and 13% are single parent households. In 2008/09 there were 909 people in Southwark in temporary accommodation.
Employment

Modelled estimates of unemployment suggest that there are approximately 14,000 people of working age unemployed in Southwark. The unemployment rate is higher in Southwark (9.0%) than London (8.4%) and Great Britain (7.4%). It is higher for females (10.7%) than for males (8.4%) in Southwark, which is the opposite for Great Britain as a whole (males 8.2%, females 6.4%). These estimates are based on data from 2008/09 and in view of the current economic situation it is thought that the current unemployment figures may now be higher.

Education

In Southwark 45% of the working population are well qualified (NVQ level 4 or above). This is higher than the London (39%) and national averages (29%). However, Southwark also has more people with no qualifications (13.3%) than London (12.0%) and the national average (12.4%), suggesting greater inequality within the borough.

For children attending Southwark schools attainment at key stages 1, 2 and 3 is generally lower than in England. In Southwark 46% of children achieved five or more GCSEs graded A*- C including maths and English. The average figure for England was 51%.

3.3 Mortality

Life expectancy at birth

Men in Southwark can expect to live to 77.8 years on average (ONS, 2007-2009). Life expectancy for males at birth in Southwark is lower than the national and London figures but it has increased over the last decade. The life expectancy gap between Southwark and England males has been steadily reducing and is now down to only 0.5 years.

Women in Southwark can expect to live to an average of 82.9 years. Over the last decade female life expectancy in Southwark has also been improving and is now higher than the national average of 82.3 years.

Figures 3.4 and 3.5 show trends in life expectancy over the last ten years. Figure 3.5 illustrates the additional life expectancy for people when they have already reached the age of 65 years. This indicates that older people in Southwark are now living longer than their counterparts in London, and England as a whole.

Within Southwark there is great inequality in life expectancy between people in different localities. The difference in life expectancy between the worst off and best off parts of the borough is some 9.5 years for males and 6.9 years for females.
Figure 3.4  Trends in life expectancy at birth for males & females. Southwark, London & England

Figure 3.5  Trends in life expectancy at age 65 years for males & females. Southwark, London & England

Source: ONS
Causes of death in Southwark

Each year there are approximately 1,500 deaths to Southwark residents. The main causes of death are from circulatory diseases and cancers (29% of all deaths were from circulatory diseases and 29% of deaths were from cancers in 2007-2009). Deaths from respiratory diseases were the third most common cause in Southwark residents. Figure 3.6 gives a breakdown of the average number of deaths among Southwark residents by cause for 2007-2009.

Early deaths

In 2009 there were 584 deaths of Southwark residents under the age of 75 years (known as ‘early deaths’ in this report). Of these:

- 205 (35%) were due to cancers,
- 133 (23%) were due to circulatory diseases,
- 31 (5%) were due to respiratory diseases,
- 215 (37%) were due to other conditions.

For some health conditions people in Southwark have a higher early (under 75 years) death rate than the England average. Males in particular had significantly higher mortality from acute myocardial infarction, stroke and COPD. Females in Southwark also had higher premature mortality for COPD than England (see Figure 3.7)

Figure 3.6 Causes of death: average number of deaths among Southwark residents by cause each year (2007-2009)

Source: ONS, Public Health Mortality Files, 2007/09
Deaths from causes amenable to healthcare

Many deaths could be prevented by healthcare interventions (either treatment or prevention). In the three years from 2006 to 2008 there were 405 deaths of Southwark men aged under 75 and 307 deaths of women that were classified as being amenable to healthcare. Figure 3.8 shows that Southwark had a significantly higher death rate from causes considered to be amenable to health care than England. Specific causes of death in this category will be explored in more detail later in the report.

References

1 Office for National Statistics, 2008 sub-national population projections table 2d, using 2010 (with population of 292,200) as base year for percentage increase
2 Exeter December 2010; (full list count)
3 Office for National Statistics, 2007 Population estimates by ethnic group (experimental)
4 Office for National Statistics, Neighbourhood statistics, 2009
5 Southwark Housing Requirements Study 2008
7 Office for National Statistics, NOMIS 2008-2009
8 London Health Observatory, slope index of inequality in life expectancy 2005-2009 – Marmot indicators for local authorities
4 Primary care services in Southwark

4.1 Introduction

There are 47 GP practices in Southwark. These are grouped geographically into four localities (Bermondsey and Rotherhithe, Borough and Walworth, Dulwich, and Peckham and Camberwell). Figure 4.1 shows the location of each practice within the borough.

Figure 4.1 Southwark GP practices
The practices differ significantly in their characteristics, particularly according to list size, age, ethnic profile of the local population and deprivation score. Figure 4.2 shows that the average GP list size is 6,790 patients and ranges from 23,268 (Aylesbury Partnership) to 1,132 (The Surgery, Lee).

GP practices in Southwark generally have a large young adult population, but their age structure does vary across the borough (Figure 4.3). For example, St James Church practice has a very small number of patients aged under 5 years (1.2%) but has the greatest proportion aged 65 years and over in Southwark (18.4%). New Mill Street surgery has more than two thirds of its patients (69.7%) aged between 15-44 years, whereas for Elm Lodge surgery only 39.3% of its population are in this age group.
Much of this report presents data that compares practice prevalence of diseases and achievement of good care outcomes. While some differences result from the relative performance of an individual practice, others may be due in part to the underlying characteristics of the population they serve. This can include differences in age, ethnicity or deprivation of the local people, all of which will influence their health status.

It is also important to note that many of the statistical calculations are very sensitive to small numbers. Where specific rates for practices are very high or very low, it may be because
small numbers of patients are involved. This report includes all practices in each graph (where data are available) but inferences about practices with very small numbers of patients should be made with caution.

We saw earlier that Southwark contains a relatively high proportion of people in Black and Minority Ethnic (BME) groups. The profile of practices within Southwark varies considerably, with the proportion of patients from BME groups ranging from 15.7% (Elm Lodge surgery) up to 58.4% (Lister, Ullah). Figure 4.4 provides data for each practice.
Figure 4.5 shows the deprivation scores of each of Southwark’s GP practices (the higher the score the more deprived the practice population is). Practices in the Dulwich locality are generally less deprived than those in other parts of the borough, with all but one practice having a lower score than the Southwark average. All practices in the Peckham & Camberwell locality have a relatively high deprivation score and will therefore tend to have higher than average levels of health need.
4.2 Quality and Outcomes Framework

GP practices provide care for a large range of important long term conditions. With good
care and attention they can support people to live as near normal a life as possible, reduce
complications, prevent admissions to hospital and ensure a normal life expectancy. In caring
for people with long term conditions, the practices establish registers of people with specific
conditions. These people are then supported to take the correct medication and have the
correct ongoing investigations for the monitoring of their condition.
This report makes extensive use of clinical data that are collected nationally through the
Quality and Outcomes Framework (QOF). The QOF data are extracted on a monthly basis
from individual practices and focus on the prevalence and the management of important and
common chronic diseases. These data allow an assessment to be made of the achievement
of each practice against an agreed standard. The aim is to encourage good clinical practice,
achieving overall improvements in individual and population health. This performance
and incentive system is unique to the UK, being responsive to practices who manage
their services and patients well. It also provides a unique data system for assessing and
monitoring long term conditions and their care.
The report includes an assessment of the numbers of people on the disease registers in local
practices and compares this with modelled prevalence for the Southwark area. Modelled
data are important because we know that many chronic conditions, such as hypertension
and chronic obstructive pulmonary disease (COPD), are under recognised. There may be
some limitations to modelled data but nevertheless they provide a useful comparator and
thus help to quantify the number of people who may be undiagnosed.

Exception reporting

Not all patients with a given condition will be appropriate for, or will consent to treatments.
The concept of exception reporting was introduced to the QOF to avoid penalising GP
practices when patients’ characteristics that are beyond their control prevent the GPs
achieving optimal patient outcomes. If a patient on a specific disease register
(e.g. COPD) fulfils at least one of the exception criteria, they can be excluded from data on
the achievement of quality targets. The exception criteria include patients who refuse to
attend, patients who have terminal illness or excessive frailty, and new or newly diagnosed
patients.
This report includes exceptions within the denominator for QOF data, so that hard to reach
populations with potentially greater needs are included in the analysis. This means that the
data in this report will not match routine performance reports for each practice.
Where possible, we have provided data on exception reporting by individual practices in

NOTES

1 All models can be limited because they make necessary assumptions about the local population. Inaccuracies derive from the quality of the primary
data (e.g. these may be out of date) and from assumptions about the local population (e.g. overall population structure may be different to an individual
practice list). For all models included in this report except diabetes, the ethnic breakdown of the practice was derived for hospital admissions data. This
may not be a true representation of the practice’s ethnic composition, as hospital admissions will more likely be represented by older people who are
likely to have a different ethnic profile than the practice population as a whole. For the diabetes model, the actual ethnic composition of the practice was
used in the model. All modelled data is for 2008/09 (apart from for diabetes). This is the most recent available data. Although the comparison years do
not match, the change in the registered populations between one year and the next will not be great.

2 Where there are large differences in exception reporting between practices, this may point to possible differences in how practices are organised.
A large study of English data found that exception reporting is generally low and no evidence of ‘gaming’ by practices. However, a Scottish study
suggested that young patients are more likely to refuse attendance or not reply to GP letters about stroke prevention. At a population level, such patients
may be at a disadvantage when trying to provide equitable preventative treatment.
4.3 Population turnover

One of the challenges facing Southwark’s GP practices is the extent of population turnover or ‘churn’. An unstable and rapidly changing population is more difficult to diagnose with chronic diseases (and may be at higher risk of some conditions), is hard to follow up and treat effectively, and means that practice lists become rapidly out of date and distort performance data. ‘List cleaning’ helps but is expensive and, unless done regularly, only provides a temporary solution to inaccurate practice lists.

A 2010 report by Southwark Council suggests that there is much population turnover in Southwark. The report measured ‘gross churn’ i.e. those moving into Southwark and those who left during 2006-07. Southwark had the tenth highest population change in London. High turnover generally seemed to occur in the least deprived areas. Migration was strongly associated with age, with the youngest people being much more likely to move. The report also identified housing tenure as an important issue contributing to population movements.

Figure 4.6 shows gross population turnover in Southwark during 2009-10. The data mapped is measured at Middle Super Output Areas and population turnover ranged from 16.6% to 27.8%. Areas with the highest turnover include Peckham, Camberwell and Walworth. These areas have high levels of deprivation. This finding contrasts with the results from 2006-07.

References
1 The NHS Information Centre: QOF online results database [Internet]. [cited 2011 Jan 27]; Available from: http://www.qof.ic.nhs.uk/
2 Q&A – NHS Primary Care Commissioning [Internet]. [cited 2011 Jan 27]; Available from: http://www.pcc.nhs.uk/qanda.php?article_request=91
4 Simpson CR, Hannaford PC, McGovern M, Taylor MW, Green PN, Lefevre K, et al. Are different groups of patients with stroke more likely to be excluded from the new UK general medical services contract? A cross-sectional retrospective analysis of a large primary care population. BMC Fam Pract. 8:56
5 Southwark Analytical Hub. Population turnover in Southwark. 2010
Figure 4.6  Gross population turnover in Southwark, 2009/10

Source: Office for National Statistics

Population turnover rate/000 inflow and outflow per SOA mid 2008 to mid 2009

- 255 – 278
- 233 – 254
- 211 – 232
- 189 – 210
- 168 – 188
5 Preventing early deaths in primary care: 1 prevention and screening

5.1 Health and health related behaviours

While there are many factors affecting early deaths, the health behaviours in this section have been chosen based on:

- Their contribution to mortality and morbidity in the Southwark;
- The impact on health inequalities within Southwark and between Southwark and other areas;
- The availability of effective (and cost-effective) interventions by GPs;
- The potential to realise a return on any investment through primary care action.

5.1.1 Lifestyle advice following the diagnosis of hypertension

In 2009/10 there were 2,181 new diagnoses of hypertension in Southwark. This ranges from 4 diagnoses in The Surgery (Lee) to 132 at Aylesbury medical centre. People with a diagnosis of hypertension are at increased risk of developing cardiovascular disease. But this risk can be reduced by changing health related behaviours. The QOF specifically recognises the positive impact of increasing physical activity, smoking cessation, moderate alcohol consumption and a healthy diet for people with a new diagnosis of hypertension.

Lifestyle advice can be offered in primary care using a brief intervention approach. A number of evidence based methods and materials are available locally. The percentage of people with new hypertension diagnoses recorded as being offered lifestyle advice is shown for each local practice in Figure 5.1.

GP practices appear to vary quite considerably in their provision of lifestyle advice following a new diagnosis of hypertension, with Borough (Sharma) and St Giles (Patel, Roseman and Vasant) practices providing advice to 100% of new diagnoses (13 and 33 patients respectively). One surgery does not record providing any lifestyle advice (The Surgery, Lee) although the surgery had only 4 new diagnoses of hypertension.

There is also a varied degree of exception reporting, with some surgeries (including Lordship Lane and DMC Silverlock practices) exception reporting more than 70% of patients with a new diagnosis of hypertension.

In total 272 people were exception reported for this indicator. Around three quarters of these people (74%) were either newly registered (36 people) or diagnosed by the practice (201 people) within the last three months of the 2009/10 QOF period. These people could now have received brief lifestyle advice, but there is no way to be certain about this from the routine data collected through QOF.

Recommendation:

- All people with a new hypertension diagnosis should receive lifestyle advice using brief intervention materials relevant to their needs.

- Lifestyle advice should be given at diagnosis if possible, or booked soon after, to help reduce the exception reporting of those newly diagnosed.
Figure 5.1  Percentage of people with a new diagnosis of hypertension given lifestyle advice, 2009/2010

### Bermondsey & Rotherhithe Locality
- Albion Street
- Avicenna
- Bermondsey & Lansdowne
- DMC Silverlock
- Falmouth Road
- Grange Road
- New Mill Street
- Park Medical
- Parkers Row
- St James Church
- Surrey Docks

### Borough & Walworth Locality
- Aylesbury Partnership
- Blackfriars
- Borough (Misra)
- Borough (Sharma)
- Maddock Way
- Manor Place
- Old Kent Road
- Penrose
- Princess Street
- Sir John Kirk Close
- The Surgery (East Street)
- The Surgery (Lee)
- Trafalgar
- Villa Street

### Dulwich Locality
- 3-Zero-6 MC
- Concordia Melbourne
- DMC CPR
- East Dulwich PCC
- Elm Lodge
- Forest Hill
- Hambleden
- Lordship Lane
- Nunhead
- The Gardens

### Peckham & Camberwell Locality
- Acorn
- Camberwell Green
- Concordia Parkside
- DMC Chadwick
- Lister (Anu)
- Lister (Hossain)
- Lister (Hurry Group)
- Lister (Ullah)
- Queens Road
- St Giles (Patel, Roseman & Vasant)
- St Giles (Vijj & Begley)
- Sternhall Lane

Source: QMAS database, 2009/10 data as at end of July 2010
5.1.2 Alcohol

Alcohol misuse has significant health impact in Southwark. In 2008, 64 deaths in the borough were attributable to alcohol use (48 male and 16 female). Southwark had particularly high mortality rates from chronic liver disease with 20.4 deaths per 100,000 population in 2006-08 compared to 14.5 deaths in London and 14.1 in England1. There were 3,262 hospital admissions for alcohol related harm in Southwark residents in 2008/20091. Local admission rates are starting to decrease and were significantly lower than both London and England rates in 2008/09. More recent data will show whether this trend is being maintained.

Figure 5.2 Standardised hospital admissions for alcohol related harm

Local data on alcohol specific admissions (admissions from conditions that are always caused by alcohol use) gives a picture of who is experiencing harm from alcohol use in Southwark. In 2009/2010 some 77% of admissions were for males and ambulance data suggest that this pattern persists for all those aged over 19.

In terms of ethnicity the largest numbers of people admitted to hospital were White British. When adjusted for population size, the highest alcohol specific admission rates in Southwark were for the White Irish population followed by the Black (any other black background) and the White (any other White background) populations. This data has not been adjusted to account for the different age structures of the populations.

Table 5.1 Alcohol specific admission rates by ethnic group in Southwark 2009/2010

<table>
<thead>
<tr>
<th></th>
<th>Admissions</th>
<th>Population (000s)</th>
<th>Admission rate/1000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Irish (White)</td>
<td>71</td>
<td>6,400</td>
<td>11.1</td>
</tr>
<tr>
<td>Any other Black background</td>
<td>46</td>
<td>4,300</td>
<td>10.7</td>
</tr>
<tr>
<td>Any other White background</td>
<td>210</td>
<td>27,100</td>
<td>7.7</td>
</tr>
<tr>
<td>Any other Asian background</td>
<td>13</td>
<td>2,800</td>
<td>4.6</td>
</tr>
<tr>
<td>British (White)</td>
<td>548</td>
<td>144,200</td>
<td>3.8</td>
</tr>
<tr>
<td>White and Black Caribbean (Mixed)</td>
<td>5</td>
<td>2,100</td>
<td>2.4</td>
</tr>
<tr>
<td>Caribbean (Black or Black British)</td>
<td>37</td>
<td>17,500</td>
<td>2.1</td>
</tr>
<tr>
<td>African (Black or Black British)</td>
<td>34</td>
<td>33,600</td>
<td>1.0</td>
</tr>
<tr>
<td>Any other Mixed background</td>
<td>2</td>
<td>3,300</td>
<td>0.6</td>
</tr>
<tr>
<td>Indian (Asian or Asian British)</td>
<td>5</td>
<td>8,700</td>
<td>0.6</td>
</tr>
<tr>
<td>Pakistani (Asian or Asian British)</td>
<td>1</td>
<td>1,900</td>
<td>0.5</td>
</tr>
<tr>
<td>Chinese (other ethnic group)</td>
<td>2</td>
<td>4,700</td>
<td>0.4</td>
</tr>
<tr>
<td>Grand Total</td>
<td>1,084</td>
<td>274,400</td>
<td>4.0</td>
</tr>
</tbody>
</table>

Source: ONS and SUS
Admissions for alcohol problems come from all parts of the borough, but the Nunhead, Livesey, East Walworth, Cathedrals and Brunswick Park wards have the highest rates in Southwark.

National evidence suggests that 12% of emergency admissions are directly due to alcohol consumption\(^2\). If this proportion applies to Southwark this would represent 2,364 A&E admissions locally at an estimated cost of £4,871,143 per year.

The social and economic impacts of alcohol misuse in the borough include alcohol related crime, family impacts (including domestic violence), risk taking behaviour including sexual behaviour (linked to unplanned pregnancies and sexually transmitted infections) and loss of productivity and the inability to work.

Southwark has particularly high rates of alcohol related crime when compared to both London and England. Rates of Incapacity Benefit / Severe Disability Living Allowance due to alcoholism are also much higher in Southwark than London and England averages\(^1\) (201 claims per 100,000 population in Southwark compared to 120 in London and 117 in England).

Guidelines recommend that men should drink no more than 3-4 units per day and women no more than 2-3 units per day. Within Southwark it is estimated that:

- 45% of residents (46.5% of men and 43.5% of women) drink above recommended levels;\(^1\)
- 18.4% of residents aged 16 and over binge drink.

Alcohol related harm increases in a linear fashion. Consumption and the estimated population at each risk level is shown in Figure 5.3.

Whilst higher socio-economic groups tend to drink at a higher level, there is some evidence that those in lower socio-economic groups may experience more alcohol related harm\(^3,4\). This is likely to be due to the effect of other behavioural, social, environmental and economic determinants of health including diet, social support and employment.

**Screening for alcohol use in primary care**

The National Institute for Health and Clinical Excellence recommend screening for alcohol use using a validated screening tool (in Southwark, FAST and AUDIT are suggested) in order to enable provision of, and referral into, appropriate services\(^5\).

A Directed Enhanced Service (DES) currently exists in Southwark to promote the screening of people newly registered with a GP using a validated tool. New patient registrations in Southwark practices in 2009/2010 represented only 13% of all patients, highlighting the importance of extending this service to include all patients. The rates of new patients who have had their alcohol use screened using a validated is shown in Figure 5.4.
Overall, only 48.7% of new GP registrations were screened for alcohol use using FAST or AUDIT-C. The maximum achievement was 94.3% at Park Medical Practice, but five practices screened no new patients:

- Acorn – 1571 new patients
- Lordship Lane – 614 new patients
- St Giles (Patel, Roseman and Vasani) – 560 new patients
- Falmouth Road – 942 new patients
- Trafalgar – 339 new patients

Sources: NHS Southwark, Performance Monitoring Data Extracts
Figure 5.5  Prevalence of harmful/hazardous and dependent drinking amongst new patients who are screened using FAST or AUDIT, Southwark GP practices 2009/2010

The prevalence of increasing and higher risk drinking identified by each practice is shown in Figure 5.5 above.
The proportion of people recorded as ‘increasing/higher risk’ drinking is lower than expected. Estimates suggest that 21.8% of the Southwark population drink at harmful or hazardous levels, yet the practice with the highest identified rates of harmful/hazardous drinking (Borough, Sharma) only identified a prevalence of 8% and the Southwark-wide average rate detected is 1.6%. It is estimated that 2.7% of the Southwark population are dependent on alcohol but Southwark GPs detect a prevalence of 0.9% amongst new patients.

**Evidence Based Action Linked to Primary Care**

Treatment for alcohol misuse can be cost effective for the public sector, with an estimated £5 return to the whole system for every £1 spent. Identification and provision of brief advice in primary care is a particularly effective and highly cost-effective way of reducing drinking in the long term (one year or more) and reducing alcohol related negative outcomes. Modelling work carried out by the Health Inequalities National Support Team suggests that up to two deaths could be prevented in one year by brief intervention with 10% of harmful drinkers in Southwark. Almost two thirds of the estimated eligible population are males (644 men).

**Table 5.2 Modelling the effect of reducing levels of harmful drinking in Southwark**

<table>
<thead>
<tr>
<th>Intervention for reducing alcohol related deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary care initiative:</strong> 10% of harmful drinkers to receive a brief intervention</td>
</tr>
<tr>
<td>Estimated number of people (10% of Southwark’s harmful drinkers)</td>
</tr>
<tr>
<td>Maximum number of deaths postponed in one year</td>
</tr>
</tbody>
</table>

Source: Health Inequalities National Support Team, 2011
Note: See Appendix 1 for more information about this model

**Recommendations:**

- Primary care staff should screen all new patients using the AUDIT tool.
- Extending screening to all those registered with the practice should be considered.
- Alcohol screening should be included as a core component of NHS Health Checks in Southwark.
- Following screening with AUDIT, primary care staff should follow the pathway recommended based on AUDIT scores, providing brief or extended interventions as appropriate and referring into specialist services where required [www.southwark.nhs.uk/a/6421](http://www.southwark.nhs.uk/a/6421)
- The coding of hospital admissions relating to alcohol misuse should be investigated to identify whether apparently low treatment rates reflect the actual situation locally.

**References**

2. NICE. *Alcohol Use Disorders: preventing the development of hazardous and harmful drinking.* 2010
5. UKATT. *Cost effectiveness of treatment for alcohol problems: findings of the randomised UK alcohol treatment trial (UKATT).* BMJ 2005; 331: 544
5.1.3 Smoking

Smoking is a major public health issue for Southwark\(^1\), with 254 deaths being attributed to smoking between 2006 and 2008\(^2\).

The prevalence of smoking in Southwark is estimated to be around a quarter (26.9%) of adults\(^3\), equivalent to 64,000 individuals in 2009\(^4\). This is greater than the estimated London prevalence (20.8%) and the national figure (22.2%). Southwark appears to have a large gender difference in smoking prevalence, with an estimated 32.2% of males smoking compared to 13.6% females\(^5\). This is also reflected in low rates of smoking in pregnancy in the borough (8.9% in Southwark compared to 14.6% England average)\(^6\). There are also different smoking patterns across Southwark, with smoking appearing to be more common in areas of the Bermondsey & Rotherhithe locality and less common in areas in the Dulwich and Peckham & Camberwell localities. Smoking rates are closely related to socio-economic status, with highest rates in routine and manual groups\(^6\).

Smokers are more likely to suffer from a range of diseases that result in significant morbidity and mortality. Half of all lifetime smokers will die from smoking related diseases, with half of these deaths occurring in middle age. Smoking is also a major contributor to health inequalities.

Screening/detection of smoking in primary care

GPs are often unaware of the smoking status of their patients. This can make the targeting of services and provision of support to help individuals stop smoking difficult. The Quality and Outcomes Framework (QOF) rewards GPs for recording the smoking status of patients with a number of chronic conditions including coronary heart disease, stroke, transient ischemic attack, hypertension, chronic obstructive pulmonary disease and diabetes. But QOF does not track smoking behaviour across the wider GP practice population.

Evidence based action linked to primary care

Nationally, 70% of smokers say that they would like to give up. There is some evidence of the effectiveness and cost effectiveness of brief interventions in primary care\(^7\). There is also reliable evidence that pharmacotherapy is highly cost-effective in terms of length and quality of life gained\(^8\). NICE recommends that every smoker who presents to primary care should be advised to quit unless there are exceptional circumstances\(^9\). Those who want to stop should initially be offered referral to an intensive support service, with the offer of pharmacotherapy if this referral is refused.

Supporting patients with COPD to stop smoking is recognised as one of the single most important interventions. Stopping smoking slows the decline in FEV\(_1\) with benefits in terms of both symptoms and survival\(^10\). As such, NICE recommend that all COPD patients who still smoke, regardless of age, should be encouraged to stop and be offered help at every opportunity.

Modelling work carried out by the Health Inequalities National Support Team suggests that three deaths could be prevented over two years if 10% of smokers in Southwark set a quit date. This figure only represents the short term benefit of stopping smoking – much greater health improvements can also be gained in the medium and longer term, including more reductions in deaths.

<table>
<thead>
<tr>
<th>Intervention for reducing smoking related deaths</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary care initiative:</strong> 10% of smokers set a quit date</td>
<td><strong>6,400</strong></td>
</tr>
<tr>
<td>Estimated number of people (10% of Southwark’s smokers)</td>
<td></td>
</tr>
<tr>
<td>Maximum number of deaths postponed over two years</td>
<td><strong>3</strong></td>
</tr>
</tbody>
</table>

Source: Health Inequalities National Support Team, 2011

Note: See Appendix 1 for more information about this model

The percentage of people supported to quit smoking by each GP practice is shown in Figure 5.6. While we know the numbers of those setting a quit date, the denominator (numbers of actual smokers per practice) is based on an estimate. The graph should therefore be seen as a guide only.
There is a wide variation, ranging from 0% of smokers setting a quit date (The Surgery, Lee) up to 6.5% (Camberwell Green Surgery). The figures show great potential for more local people to benefit from support in giving up smoking.

The effectiveness of the services provided in primary care can be assessed by looking at the percentage of individuals setting a quit date who successfully quit for 4 weeks, as shown on Figure 5.7.

Southwark primary care stop smoking services have a particularly low success rate. The average of only 29% of attendees successfully stopping smoking is well below the 46%
Figure 5.7 Effectiveness: percentage of smokers achieving a four week quit after setting a quit date, Southwark GP practices, 2009/2010

for London average and 49% national average. Whilst performance varies widely across Southwark, the vast majority of GP practices perform well below the national and London averages. No practices within the Dulwich or Peckham and Camberwell localities perform as well as the London or England average.
The practices that performed best in Southwark in 2009/2010 were:

- Old Kent Road (75% quit rate, 45 quitters);
- Avicenna (75% quit rate but only 3 quitters);
- Borough (Misra) (56% quit rate, 9 quitters);
- New Mill Street (50% quit rate, 6 quitters);
- Trafalgar (48% quit rate, 12 quitters);
- Manor Place (48% quit rate, 44 quitters).

Recommendations:

- Smoking status should be accurately and completely recorded in primary care.
- All smoking patients should be advised to stop smoking in consultations, with appropriate referral onto more intensive support or pharmacotherapy.
- Stop smoking advisors in GP practices should attend the recommended update sessions. They should also work to improve the effectiveness of their services to bring them up to and above the average quit rate for London (46%).
- The relative cost effectiveness of the Stop When you Shop initiative and primary care stop smoking support should be investigated and the results used to help increase the number of people stopping smoking in Southwark.

References

7. NICE. A rapid review of the cost-effectiveness of national health services treatments for smoking cessation in England. 2008
5.1.4 Obesity

The impact of overweight and obesity on the length and quality of life is very significant, as summarised below. The cost of treating diseases related to overweight and obesity in Southwark is estimated to be £86.1 million in 2010, rising to £92.1 million in 2015.

**Obese adults die eleven years earlier than the general population**

Excess weight is responsible for:

- nearly 9% of all deaths,
- 10% of all cancer deaths amongst non-smokers,
- 85% of all hypertension cases.

For each unit increase in body mass index the risk of coronary artery disease more than trebles

Information on local adult obesity rates is poor but national survey data (2006) suggests that 13% of the borough’s population is obese and 37% overweight. Whilst this is better than the national average, obesity is still a pressing issue locally. It has been estimated that there were 73,964 obese individuals living in Southwark in 2010 although local GP’s obesity registers have only recorded 23,045 people.

Southwark has very high levels of childhood obesity, with an estimated 6,995 obese children aged 2-16 years in the borough. The National Childhood Measurement Programme (NCMP) shows that Southwark has much higher than average rates of obesity at both reception year and year six and in fact has the highest obesity rate in the country for the former group. Some 14.8% of reception year and 25.7% of year 6 pupils in Southwark were recorded as being obese in 2009/2010, compared to 9.8% and 18.7% respectively in England as a whole. Adult obesity levels in the borough will increase if these higher rates are maintained throughout life.

**Screening/detection in primary care**

The QOF incentivises the recording of adult obesity in primary care by assessing the proportion of patients recorded as having a BMI over 30. The proportion of patients aged 16 and over who are listed on the obesity register of GP practices in 2009/2010 is shown in Figure 5.8.
The recorded prevalence of obesity varies considerably between GP practices, ranging from 2.2% (Elm Lodge Surgery, Ledger) to 17.1% (Aylesbury Medical Centre, Kay). The data does not however capture what proportion of all patients have actually had their BMI recorded.
Evidence based action and primary care

NICE has reviewed the evidence with regard to the prevention and treatment of obesity in adults and children. Key conclusions included:

- Lifestyle programmes can be successful as a primary treatment for obesity although the evidence is limited, particularly for men.
- Multi-component commercial programmes may be more effective than standard self-help programmes (NICE Recommendation).
- Programmes should set realistic weight goals, focus on lifestyle changes, address diet and physical activity, offer a variety of approaches, include a component of behaviour change and offer follow up support.
- Drug treatment in adults and children over 12 years who have a significant co-morbidity was recommended.
- Focus on parental obesity to reduce the risk of obesity and overweight in children.
- Family-based interventions that target improved weight maintenance in children and adults, focusing on diet and activity, can be effective, at least for the duration of the intervention.
- It is unclear whether interventions are more effective when delivered by multidisciplinary teams.
- Dietary advice and weight management can contribute to successful management of a range of conditions, including type 2 diabetes and hypertension.

Recommendations:

- Physical activity services and opportunities should be promoted to individuals identified as being obese.
- The costs and benefits of commissioning additional services for both adults and children identified as being overweight and obese should be investigated.
- The full obesity care pathway (ie the process of diagnosis, treatment and care) for both adults and children should be promoted to GPs further.
- Primary care should improve the recording of BMI to support both the management of current patients and also to support prevention of future disease.

References

5.1.5 Physical activity

People who are physically active reduce their risk of developing major chronic diseases (including coronary heart disease, stroke and type 2 diabetes) by up to 50% and reduce their risk of premature death by about 20–30%1.

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### On average an inactive person:

- spends 38% more days in hospital
- has 5.5% more primary care visits
- accesses specialist services 13% more, and
- has 12% more nurse visits than an active person2

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The national recommendation is that people should be moderately active for 30 minutes, five days a week. While 75% of men and 67% of women believe that they are doing enough activity the reality is lower. In an average practice of 10,000 patients while 7,100 think that they are doing enough, only 3,400 are actually sufficiently active to benefit their health.

Brief interventions in primary care to increase physical activity levels are both effective and cost effective in the long term3, costing between £20 and £440 per quality-adjusted life year (QALY) gained when compared with no intervention, with net costs of between £750 and £3,150 saved per QALY gained.

#### Evidence based action and primary care

Physical activity has been shown to be an effective way to treat and prevent a range of health conditions. For an average practice of 10,000 patients (made up equally of men and women) 34 new cases of CHD and 16 new cases of stroke could be prevented each year by promoting physical activity effectively in primary care4. Regular physical activity alone or with dietary change can reduce the development of type 2 diabetes in people with impaired glucose tolerance or metabolic syndrome by almost 40%5,6.

NICE recommends that primary care practitioners should take every possible opportunity to identify inactive adults using a validated tool, the General Practitioner Physical Activity Questionnaire (GPPAQ), and provide a brief intervention to advise them to aim for 30 minutes of moderate activity on 5 days of the week (or more)7.

*Let’s Get Moving* is an evidence based physical activity pathway that sets out the key steps to helping someone become more active. But the pathway is not systematically in place.

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### Bermondsey & Lansdowne Practice

Klair is in her late thirties and weighed over 20 stone. She has manic depression, high cholesterol, high blood pressure and also has diabetes. She rarely went out but was (as she says) nagged by her practice nurse to join the walk from her surgery. Within 4 months of starting the walk the practice nurse had to stand down as walk leader and Klair became one of the volunteer replacements.

The first thing that Klair did was get the walkers to give themselves an identity, so they are now known as *The Bermondsey Bombers*. Walks are promoted through text messages, emails, the local job centre, hospitals and diabetes clinics. The group has been on walks to visit farms, museums, Hampstead Heath, monuments and woods/parkland that walkers had never seen … or even known about.

*The Bombers* celebrated their first birthday in July 2010 when GPs and practice nurses joining the walkers at a party. It was at this time that Klair went back to her diabetes clinic where she was informed that her weight had reduced to 17.5 stone, and her HbA1c (a measure of blood glucose) had reduced from 10% to 6.8%. She says that she now has more control over her own life, that she is much more active, (no more short bus rides) and for the first time she feels confident enough to set herself a goal to get her weight down to 15.5 stone.

Klair understands how hard it is to start to be active, so she is now working with health professionals to start a series of 10 minute walks for morbidly obese patients.
within Southwark GP practices. Key components include:

- using the validated GPPAQ tool to identify inactive individuals,
- promoting physical activity wherever appropriate and possible,
- accounting for individual's needs and preferences when providing physical activity advice, and agreeing goals,
- providing written information about the benefits of physical activity and local opportunities to be active,
- following people up at appropriate intervals over three to six months.

**Exercise referral** is a component part of the *Let's Get Moving Pathway*. In Southwark the number of exercise referrals coming from different GP practices varies considerably. Several practices have not made any referrals whilst others referred over 70 patients in 2009/2010. The most common reason for referral to the programme is to assist in the management of obesity. National evidence suggests that 30% of clients taking up a referral complete the programme and that exercise referral schemes to increase physical activity amongst target groups have only been shown to have a moderate effect on physical activity levels. However, the Department of Health urges the continued provision of exercise referral schemes to address underlying medical conditions or risks. 40% of those who started on Southwark’s exercise on referral scheme completed the programme during 2009/10, but data is limited on their ongoing physical activity levels.

Primary care professionals will vary in how much information and advice on physical activity they provide. A 2009 audit identified well over 30 ‘partners’ involved in delivering a wide range of sport and physical activity initiatives in Southwark, amounting to a collective spend of £7million annually. Some GP surgeries are more directly involved in the training of walk leaders. The case study is a good example of this work.

**Recommendations:**

- Patient physical activity levels should be measured and recorded using the GPPAQ in all Southwark practices.
- Physical activity should be promoted as an effective part of chronic disease management, as well as an effective way to prevent future disease.
- The *Let's Get Moving Pathway* should be piloted and if successful rolled out across all Southwark GP practices as part of the NHS Health Checks intervention.
- GP surgeries should take innovative approaches to providing local physical activity opportunities to their patients, including cycling on referral and hosting walk leaders at the practice.

**References**

3. NICE. *Public Health Intervention Guidance: Four commonly used methods to increase physical activity*. 2006
5.2 Immunisations

5.2.1 Childhood vaccination programme

The aim of the UK routine childhood vaccination programme is to protect all children against key preventable childhood infections. The Department of Health (DH) recommends that all children should be immunised even if they are older than the recommended age-range; no opportunity to immunise should be missed.

The Southwark vaccination schedule, adapted from national guidelines, is shown in Figure 5.9.

Figure 5.9 Summary of the Southwark vaccination schedule for children under 5 years old

<table>
<thead>
<tr>
<th>Optimum age for vaccination</th>
<th>Diseases prevented by immunisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before child’s first birthday</td>
<td>BCG (tuberculosis)</td>
</tr>
<tr>
<td>Two months</td>
<td>5-in-1, first dose (Diphtheria, tetanus, pertussis, polio and Haemophilus influenzae type b, called Hib)</td>
</tr>
<tr>
<td></td>
<td>PCV (pneumococcal infection)</td>
</tr>
<tr>
<td>Three months</td>
<td>5-in-1, second dose</td>
</tr>
<tr>
<td></td>
<td>Meningitis C (MenC), first dose</td>
</tr>
<tr>
<td>Four months</td>
<td>5-in-1, third dose</td>
</tr>
<tr>
<td></td>
<td>PCV, second dose</td>
</tr>
<tr>
<td></td>
<td>Meningitis C, second dose</td>
</tr>
<tr>
<td>12 months</td>
<td>Hib/MenC (this is Hib fourth dose and MenC third dose)</td>
</tr>
<tr>
<td>15 months</td>
<td>PCV, third dose</td>
</tr>
<tr>
<td>3 years and 4 months or soon after</td>
<td>MMR, second dose</td>
</tr>
<tr>
<td></td>
<td>Preschool booster (Diphtheria, tetanus, pertussis and polio, called DtaP/IPV)</td>
</tr>
</tbody>
</table>

Media coverage around vaccination, particularly MMR, has raised concerns among parents. This has led to many taking inappropriate decisions to forego immunisation in their child. The research that underpinned the media coverage around MMR vaccination has been shown to have been fraudulent and the lead author has been declared as unfit to practice by the General Medical Council (GMC). Rates of measles in London, and across the UK, increased following adverse media coverage of the topic, as shown in Figure 5.10.

Figure 5.10 Notified and confirmed measles cases in London by quarter (Jan 2000-Sept 2010)
UK and Southwark vaccination performance

Vaccination coverage is measured against the World Health Organization (WHO) targets of 95% coverage for all vaccines (except Men C) for children aged two years and, nationally, against targets of 95% coverage in each Strategic Health Authority or equivalent (Vital signs²).

In general, the proportion of children vaccinated at each age has improved over the last three years in Southwark. Local targets have, however, only been met for Hib/MenC and MMR in children aged 24 months. National targets (required if outbreaks are to be effectively prevented) have not been reached for any vaccine at any age³ in Southwark.

Three GP practices had lower than average vaccination rates for all six vaccines in 2009/2010:
- Avicenna Health Centre
- Acorn Surgery
- Lordship Lane Surgery

although it should be noted that Avicenna Health Centre has not had a practice nurse for the last year.

Eight GP practices had lower than average vaccination rates for five of the six vaccines:
- DMC Chadwick Road
- DMC Silverlock
- Lister Primary Care Centre (Arunmugaraasah)
- Old Kent Road Surgery
- Queens Road
- St Giles Surgery (Patel, Roseman & Vasant)
- The Surgery (Lee)
- 3-zero-6 Medical Centre.
Figure 5.11 shows that St James’ Church practice, and Blackfriars, vaccinated 100% of the eligible children with the 5-in-1 vaccine. The practices with the most unvaccinated children for this vaccine (i.e. the lowest vaccination rates) are The Surgery (Lee) (25% unvaccinated although this is only 1 child), East Dulwich Primary Care Centre (21.2%, 7 children), Avicenna Health Centre (20.6% unvaccinated, 20 children) and DMC Silverlock (20% unvaccinated, 12 children).
Figure 5.12 shows that Borough (Misra) practice and St James Church practice vaccinated 100% of the eligible children with the MMR1 vaccine. Several of the practices have poor rates of vaccination for MMR1, including The Surgery (Lee) (50% unvaccinated although this is only 3 children), Lister (Arumugaraasah) (22.4% unvaccinated, 22 children and Sternhall Lane Surgery (20.6% unvaccinated, 13 children). Eligible children are defined as all children of eligible age.
Reasons for children NOT being vaccinated

A study undertaken in Southwark in 2006 explored attitudes towards vaccination among young mothers with the aim of increasing MMR uptake. This study concluded that low rates were related to a lack of education about vaccination and a lack of understanding about the reasons for childhood immunisation. A study in America identified children who had received no vaccines and found that these children tend to be clustered geographically, were more likely to be male, and were from more wealthy families. In this study, a distinction was drawn between these children and ‘undervaccinated’ children, who tended to be from more deprived backgrounds and to live in a city.

Accurate vaccination data depends on timely and accurate GP list information on both the number of children vaccinated and also the total number of eligible children. Current problems associated with vaccination data include lack of updates when children move practice or area and also GP list inflation that overestimates the population size and therefore underestimates the vaccination coverage.

5.2.2 Influenza vaccination

The flu vaccination campaign aims to improve the health of vulnerable patients, and reduce the number of hospital admissions caused by the flu virus by offering vaccination to:

- all people aged 65 years and over,
- all people under 65 years of age who are in clinical risk groups,
- pregnant women, who have not previously had H1N1 vaccine or are in clinical risk group.

The programme aims to ensure that all practices vaccinate at least 70% of their patients aged 65 and over and works to ensure that practices submit data detailing number of patients immunised.

There is some evidence that vaccination of older people is an effective and cost effective way of improving health in this age group. However, a 2010 Cochrane Review concluded that the evidence is of poor quality, providing little guidance regarding the safety, efficacy or effectiveness of influenza vaccination for the over 65s. This is largely due to the absence of large randomised controlled trials.

This year (2009/2010) Southwark has improved influenza vaccination rates, for the first time hitting the 70% target for the over-65 age group. Vaccine uptake varies across Southwark, as shown on Figures 5.13, 5.14 and 5.15.
Figure 5.13  Rates of flu vaccination in patients over 65, Southwark GP practices, 2009/2010

<table>
<thead>
<tr>
<th>Locality</th>
<th>% vaccinated</th>
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<tbody>
<tr>
<td>England</td>
<td>72.8%</td>
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<tr>
<td>Southwark</td>
<td>71.0%</td>
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<td>Bermondsey &amp; Rotherhithe Localty</td>
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<td>Avicenna</td>
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<td>Bermondsey &amp; Lansdowne</td>
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<tr>
<td>DMC Silverlock</td>
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<td>Falmouth Road</td>
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<td>The Surgery (East Street)</td>
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<td>The Surgery (Lee)</td>
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<td>3-Zero-6 MC</td>
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<td>Concordia Melbourne</td>
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<td>DMC CPR</td>
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<td>East Dulwich PCC</td>
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<td>St Giles (Patel, Roseman &amp; Vasant)</td>
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<td>St Giles (Virji &amp; Begley)</td>
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<tr>
<td>Sternhall Lane</td>
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Sources: Southwark practices – Primary Care Directorate, NHS Southwark; England figure – Chief Medical Officer, DOH, March 2011 (provisional)
Figure 5.14  Rates of flu vaccination in patients under 65 in clinical risk groups, Southwark GP practices, 2009/2010

Sources: Southwark practices – Primary Care Directorate, NHS Southwark; England figure – Chief Medical Officer; DOH, March 2011 (provisional)
Figure 5.15  Flu vaccination in pregnant women not in clinical risk groups, Southwark GP practices, 1 Sept 2010 to 31 Jan 2011

Sources: Southwark practices – Primary Care Directorate, NHS Southwark; England figure – Chief Medical Officer, DOH, March 2011 (provisional)
Recommendations for childhood vaccination:

▼ Practices with low rates of childhood vaccination should identify the reasons for low coverage.
▼ Where data entry is correct but vaccination coverage is still low, the practice should implement a clear strategy to improve vaccination coverage with appropriate support.
▼ Practices with high rates of childhood vaccination should support and advise poorer performing practices, thereby improving overall vaccination coverage in Southwark.
▼ GP practices should use the first birthday card intervention to inform parents about the vaccination programme and encourage timely vaccination of their children.

Recommendations for flu vaccination:

▼ Implement evidence-based ways of improving flu vaccine uptake amongst specific at risk groups (clinical risk groups and pregnant women) as uptake is low in these groups compared to those aged over 65.
▼ Promote the importance of medical professionals receiving the flu vaccine to avoid exposing vulnerable people to flu and to help to maintain service provision in winter months.

References
1 Godlee F, Smith J, Marchovitch H. Wakefield's article linking MMR vaccine and autism was fraudulent. BMJ 2011; 342: c742.
3 NHS Southwark. Immunisations and Vaccinations – childhood under 5s. 2010
4 NHS Southwark. Evaluation of the knowledge, attitudes and practice regarding childhood preventable diseases and the childhood immunisation programme in young Southwark mothers. 2010
5 Smith PJ, Chu SY, Barker LE. Children who have received no vaccines: who are the and where do they live? Paediatrics; 114(1):187-195
6 Matrix Evidence and Bazin. Prioritising investments in public health. 2008
5.3 Cancer: screening and earlier diagnosis

5.3.1 Cancer deaths in Southwark

Cancer accounts for around a quarter of all deaths in the UK and directly contributed to more than 128,000 deaths in England during 2008. Cancer death rates for the UK at 177.3 per 100,000 population are slightly higher than those for Europe (European Union 172.5 per 100,000 population).

Mortality associated with cancer has fallen in Southwark over the last 10 years, as it has in London and England. Cancer death rates for Southwark people aged under 75 years fell from 178 to 139 per 100,000 for men and from 120 to 108 per 100,000 for women during this decade (Figure 5.16). Between 2007 and 2009 there was an average of 429 cancer deaths for Southwark residents every year. The largest number of these were lung cancer deaths, making up more than a quarter of the total (see Figure 3.6). Lung cancer is the only cancer in Southwark with death rates well above national rates.

Figure 5.16 Directly standardised mortality rates from all cancers amongst males and females aged under 75 years, 1999-2001 to 2007-2009

References
1 Cancer Research UK
2 NHS Information Centre, NCHOD
3 European Cancer Observatory, data 2008
5.3.2 Cancer screening

Screening is a process of identifying apparently healthy people who may be at increased risk of a disease or condition. They can then be offered information, further tests and appropriate treatment to reduce their risk and/or any complications arising from the disease or condition. In England there are national cancer screening programmes for breast, cervical and bowel cancer.

Breast screening

The *NHS Breast Screening Programme* was established in 1988. Women are invited for screening at three yearly intervals between the ages of 50 and 70 years. The programme will be extended by 2012 to cover women aged between 47 and 73 years.

Breast cancer is the most common cancer in women in the UK. Incidence rates have been rising, with overall incidence in England at 123.8 per 100,000 in 2004-2006. Southwark’s incidence is lower than nationally but is following the upward trend (incidence was 111.4 per 100,000 females in 2004-2006, up from 106.6 per 100,000 ten years ago)\(^1\).

In contrast, breast cancer mortality has been decreasing due to earlier detection and improved treatment. Deaths from breast cancer are lower in Southwark at 25.4 per 100,000 in 2005-7, compared to 27.4 per 100,000 across the whole of England\(^1\).

**Figure 5.17** Age-standardised incidence of, and mortality from, female breast cancer (England)

![Breast cancer incidence and mortality](image)

The success and effectiveness of any population-based screening programme relies on its coverage. In breast screening, this is defined as the percentage of 53-70 year old eligible women that have had a breast screen result in the last three years. The national coverage target is 70%. Southwark does not reach this; with 61.5% average coverage in 2009/10 (see Table 5.4 and practice level data in Figure 5.18).

**Table 5.4** Breast screening coverage rates for women aged 53-70 years, 2007/08 to 2009/10

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<thead>
<tr>
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<tbody>
<tr>
<td>Southwark</td>
<td>61.5</td>
<td>61.7</td>
<td>61.1</td>
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<tr>
<td>London</td>
<td>63.6</td>
<td>64.5</td>
<td>67.0</td>
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<tr>
<td>England</td>
<td>75.9</td>
<td>76.5</td>
<td>77.0</td>
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There has been a great deal of work undertaken across London to improve coverage but some real problems remain. The reasons for London’s low uptake rates are complex but key issues include:

- **Awareness**, attitudes towards and understanding of breast screening programmes and breast cancer symptoms.
- **Inflation of GP lists**, Southwark has a very mobile population\(^2\). *The Women’s Health Survey* indicated that 17% of women aged 53-64 in Lambeth, Southwark and Lewisham had
In Figure 5.18, Breast screening coverage – percentage screened in the last three years by practices in Southwark, women aged 50-70 years, June 2010.

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<tr>
<th>Bermondsey &amp; Rotherhithe Locality</th>
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<td>Albion Street</td>
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<td>Avicenna</td>
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<td>Bermondsey &amp; Lansdowne</td>
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<th>Dulwich Locality</th>
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<td>3-Zero-6 MC</td>
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<td>Concordia Melbourne</td>
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<td>DMC CPR</td>
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<td>East Dulwich FPC</td>
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<td>Concordia Parkside</td>
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<td>Lister (Arul)</td>
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<td>Lister (Hossain)</td>
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<td>Lister (Hurley Group)</td>
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<tr>
<td>Lister (Ullath)</td>
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<tr>
<td>Queens Road</td>
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<tr>
<td>St Giles (Patel, Rosenman &amp; Vasant)</td>
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<tr>
<td>St Giles (Vijit &amp; Begley)</td>
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<td>Sternhall Lane</td>
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</table>

Source: LSL quarterly coverage reports, June 2010

changed address in the last three years. Evidence from a recent report suggests that the average level of list inflation in London is around 14%.³

Incomplete data, some women prefer to go privately and as yet these figures do not contribute to the coverage figures collected and collated by local programmes.

Women’s experiences of the service. This includes the location of both static and mobile screening units and their convenience for women.
Improving coverage rates in Southwark
Two new approaches have been commissioned:

1. Improving invitations and awareness: ensure the lists of eligible women are correct; send pre-invitation letters to all eligible women; send a text reminder to women whose mobile number is available; follow up those who do not attend.

2. Better patient navigation (Howard P Freeman approach) was used to focus on BME women to improve breast screening uptake and coverage. Clients from BME groups who did not attend breast screening or assessment were given support through the whole pathway.

Recommendations:

- Regular list validation exercises should be undertaken in primary care (these alone would increase Southwark's breast screening coverage to 66.6%).
- Regular surveys for assessing client satisfaction should be undertaken. It is important that the results of these surveys are used to guide future service planning and delivery.

Cervical screening

The NHS Cervical Screening Programme was launched in 1988 and offers three yearly screening to women between the ages of 25 and 49 years. Women between the ages of 50 and 64 years are screened every five years.

Cancer of the cervix is the thirteenth most common cancer for women in England. National cervical cancer incidence is 8.4 per 100,000 females\(^1\) and has declined over the past decade. As a result of the screening programme and improved treatment, cervical cancer mortality rates in 2008 were nearly 70\% lower than they were 30 years earlier (2.4 per 100,000 females compared to 7.1 per 100,000 in 1979\(^2\)).

Figure 5.19  Age standardised mortality rates, cervical cancer, UK, 1971-2008

Incidence and mortality rates from cervical cancer have declined in Southwark but remain higher than national rates (Table 5.5).

Table 5.5  Incidence and mortality from cervical cancer for Southwark, London and the UK, 2001-2005

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<thead>
<tr>
<th></th>
<th>Southwark</th>
<th>London</th>
<th>England</th>
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<tbody>
<tr>
<td>Incidence (per 100,000 female population)</td>
<td>11.0</td>
<td>7.3</td>
<td>8.4</td>
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<tr>
<td>Mortality (per 100,000)</td>
<td>4.2</td>
<td>2.4</td>
<td>2.6</td>
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</table>

Source: National Cancer Intelligence Centre, 2001-2005

Cervical screening coverage rates have increased locally, especially in the last two years, but still fall short of the 80\% target. At 67.3\%, screening coverage rates are lower in the 25-49 year age group than in the 50-64 year age group (75.3\%).
### Table 5.6  Cervical screening coverage rate, Southwark, London & England, 2003/04 to 2009/10

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<tr>
<td>Southwark PCT</td>
<td>71.3</td>
<td>72.0</td>
<td>70.7</td>
<td>71.4</td>
<td>70.5</td>
<td>72.3</td>
<td>72.8</td>
</tr>
<tr>
<td>London</td>
<td>75.7</td>
<td>75.5</td>
<td>74.2</td>
<td>74.0</td>
<td>73.4</td>
<td>73.4</td>
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<tr>
<td>England</td>
<td>80.6</td>
<td>80.3</td>
<td>79.5</td>
<td>79.2</td>
<td>78.6</td>
<td>78.6</td>
<td>78.9</td>
</tr>
</tbody>
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*Source: NHS Cervical Screening Programme 2009/10
*Coverage (%) less than 5 years since last adequate test

### Figure 5.20  Cervical screening coverage – percentage screened in the last five years by practices in Southwark, women aged 25-64 years, September 2010

Source: Lambeth Southwark and Lewisham quarterly coverage reports, September 2010
In 2010, only 3 practices achieved over 80% coverage (Figure 5.20). All of these were in the Dulwich Locality (Concordia Melbourne Grove, Nunhead and the Gardens). One practice (The Surgery, Lee) had a particularly low coverage rate (below 50%).

**Improving coverage**

Two key issues have been identified as contributing significantly to Southwark failing to achieve the national target:

**GP list inflation** NHS London estimates that GP lists are inflated by 14% in London. Local comparison between ONS population estimates and GP registrations for those aged 25-64 suggest inflation of over 10%. Cervical screening coverage in Southwark calculated with the ONS denominator gives a coverage rate of 80%. A list validation exercise was undertaken in one GP practice in Southwark. Of 311 women on the list with no up to date cervical cytology result, 76 had not been seen at the practice in the preceding three years and were no longer contactable at the practice register address. Removal of these women increased the practice coverage by 5% from 69% to 74%.

**Exception reporting** It is now easier for GPs to report more of their patients as exceptions to achieving the target, for the purposes of QoF targets and payments. For the national programme (and PCTs) the target calculation continues to include all eligible women including those marked as exceptions. This makes it more difficult for PCTs to meet their coverage targets, but easier for practices.

**Recommendations:**

- Practices should be flagging women overdue for cytology on patient records.
- All primary care staff should promote cervical screening and check women’s screening status, current address and contact details at each consultation.

**Bowel cancer screening**

The Bowel Cancer Screening Programme was launched in Southwark in 2008. All men and women registered with a GP between the ages of 60-69 years are sent screening invitations. Unless patients opt out, they are sent a faecal occult blood test (FOBt) kit, instruction pack and return envelope every two years, starting shortly after their 60th birthday. The age range is being extended to include those aged up to 75 years by 2012.

Colorectal cancer (CRC) is the second most common cause of death from cancer in the UK after lung cancer. The incidence is increasing across Europe and the UK is no exception to this. Local incidence was 43.5 per 100,000 population in 2004-6. This was slightly lower than the overall figure for England of 44.6 per 100,000 but was a large increase from the incidence of 33.2 per 100,000 ten years ago.

Mortality from CRC is gradually decreasing at 17.6 per 100,000 population in England in 2005-7 (a reduction from 22.5 in 1994-6). In Southwark deaths from CRC rose slightly from 18.2 per 100,000 in 1994-6 to 19.3 per 100,000 in 2005-7.

**Coverage**

The national target for bowel screening is 60%. The latest figures show that since inception in 2008, national uptake has increased by 1.7% (from 52.0% to 53.7%) and London uptake has increased by 3% (from 39.9% to 42.9%). Southwark does poorly with an average uptake of 36.3%.

**Improving coverage**

Southwark PCT has developed a ‘bowel screening action pack’ to raise awareness of the programme among GP practices. A South East London health promotion specialist works with primary care services and is developing local strategies to increase uptake.

SE London was recently successful in securing £264K from the National Awareness and Early Diagnosis Initiative (NAEDI) to deliver a more systematic programme of health promotion and social marketing for bowel screening across SE London. The project started in March 2011.
Figure 5.21  Age standardised incidence and mortality rates by sex, colorectal cancer, Great Britain, 1975-2007

Recommendations:

▼ Annual GP list validation should be undertaken and would make a major contribution to achieving screening coverage rates in Southwark.

▼ Patient details need to be up to date: including mobile and land line telephone numbers on patient records will enable targeted follow up of those who do not attend or who are overdue for screening.

▼ Impact analysis of the two interventions used to improve breast screening coverage should be undertaken, including a review of value for money. This work can then inform commissioning decisions.

▼ Women overdue for cervical screening should be flagged on their GP practice’s IT system, with the issue discussed at future consultations.

References

1 National Cancer Information Centre. 2001-2005

2 Barter-Godfrey S, Taket A. Women and health: views of women aged 54-64 living in Lambeth Southwark and Lewisham – focus on breast screening. Institute of Primary Care and Public Health, London South Bank University. 2005


4 Cancer research UK info.cancerresearchuk.org/cancerstats/types/cervix/mortality/
5.3.3 Earlier cancer diagnosis

Background
Prompt diagnosis of cancer is essential for effective care. But an early diagnosis depends on a patient with potential symptoms noticing and seeking help from their GP. It also needs the GP to identify the potential cancer symptoms and arrange for prompt specialist assessment and care.

In England, a quarter of cancers are diagnosed when an individual goes to hospital in an emergency
d. At this point the cancer may be well advanced and health outcomes are likely to be poorer.

Reducing the proportion of these late diagnoses is a key part of improving cancer outcomes. If GPs identify someone with suspected cancer, they can refer the individual to be seen in hospital within two weeks (a two week referral). The main impact on early cancer deaths will be from earlier diagnosis. But up to half of cancers are preventable through the health related behaviours described in Section 5.1. Cancer screening also makes an important contribution.

The role of primary care
General practitioners will see relatively few new cases of cancer over a year – on average around nine. But they will see many more people whose symptoms may or may not be cancer related. Deciding which patients to refer on for further investigation will not always be straightforward. All GPs have access to the referral forms for common cancers produced by the South East London Cancer Network (covering the more common cancers). These forms help to identify the specific symptoms or scenarios that should trigger an urgent referral.

Figure 5.22 shows the total number of new cancer cases treated during 2009, grouped by Southwark GP practice. This figure reflects all those recorded as being treated in hospital for cancer. The totals have been split between the number of two week referrals (in colour), and the number of people diagnosed after referral from A&E or outpatient appointments (in grey). Overall the chart follows a trend that the GP practices with the largest numbers of people aged over 65 (Aylesbury Partnership, Forest Hill, Princess Street and Elm Lodge) had the most new cases of cancer among their patients.

To increase the likelihood of an earlier diagnosis, a greater proportion of new cancer cases should be two week referrals. For Southwark PCT, just over a third (37%) of people treated for cancer in 2009 were two week referrals. This is lower than the proportion for England (43%). The proportion varies for Southwark GPs, from 73% for Dr Bhatti’s surgery to 0% in three of our smaller GP practices (Dr Lee, BMC Sharma and East Dulwich Medical Centre).

Recommendations:

▼ GP practices should use the South East London Cancer Network forms to help ensure that the right referral is made at the right time.

▼ GP practices should make use of the practice Cancer Profiles that are available for downloading from the national cancer information service (http://ncin.org.uk/cancer_information_tools/gp_profiles.aspx). The Profiles set out how a GP Practice compares against the Southwark average on demographics, cancer screening, cancer waiting times, and presentation & diagnostics statistics.

▼ GPs should take part in continued education and peer review to improve and maintain their cancer diagnostic skills in accordance with NICE guidance.

Reference
1 Department of Health. Improving outcomes: a strategy for cancer. 2011
Figure 5.22  Number of new cancer cases treated in 2009, by GP practice

Bermondsey & Rotherhithe Locality
- Albion Street
- Avicenna
- Bermondsey & Lansdowne
- DMC Silverlock
- Falmouth Road
- Grange Road
- New Mill Street
- Park Medical
- Parkers Row
- St James Church
- Surrey Docks

Borough & Walworth Locality
- Aylesbury Partnership
- Blackfriars
- Borough (Misra)
- Borough (Sharma)
- Maddock Way
- Manor Place
- Old Kent Road
- Penrose
- Princess Street
- Sir John Kirk Close
- The Surgery (East Street)
- The Surgery (Lee)
- Trafalgar
- Villa Street

Dulwich Locality
- 3-Zero-6 MC
- Concordia Melbourne
- DMC CPR
- East Dulwich PCC
- Elm Lodge
- Forest Hill
- Hambleden
- Lordship Lane
- Nunhead
- The Gardens

Peckham & Camberwell Locality
- Acorn
- Camberwell Green
- Concordia Parkside
- DMC Chadwick
- Lister (Aru)
- Lister (Hossain)
- Lister (Hurley Group)
- Lister (Ulliah)
- Queens Road
- St Giles (Patel, Roseman & Vasant)
- St Giles (Virji & Begley)
- Sternhall Lane

Source: HCN, General Practice Profiles for Cancer

Legend:
- **two week referrals**
- **all other referrals**
6 Preventing early deaths in primary care: 2 people with long term conditions

6.1 Coronary Heart Disease

What is CHD?
Coronary heart disease (CHD) is caused by the build up of fatty deposits (called atheroma) which block the supply of oxygen and nutrients to the heart by gradually narrowing the arteries or triggering acute clotting (thrombosis). This causes angina pain or, when the blockage is sufficiently severe, can cause parts of the muscle to die. This is called a heart attack, or myocardial infarction.

The impact of CHD
CHD accounts for about 20% of all deaths in the UK and directly contributed to more than 71,000 deaths in England in 2008. UK mortality rates remain higher than all other developed countries except Ireland and Finland. Most deaths attributed to CHD are preventable.

Mortality from CHD has fallen dramatically in Southwark over the last 15 years as it has across the country (Figure 6.1). Between 1993 and 2008 the directly standardised mortality rate for people aged under 75 years fell from 164 to 62 per 100,000 population for men and from 56 to 15 per 100,000 for women. The death rate in Southwark is a little below London and England for both men and women. However there are variations from year to year and the average death rate in Southwark males in recent years has been higher than the national average.

Figure 6.1 Trends in directly standardised mortality rates from coronary heart disease males and females, under 75 years, 1993-2008

CHD mortality, aged under 75

Source: The NHS Information Centre for health & Social Care, NCHDD
CHD risk factors
Research has shown that serious disease is in most cases related to the following key modifiable factors 1:
- Smoking and tobacco use
- Poor diet rich in saturated fat and salt
- Diabetes
- High blood cholesterol
- Obesity
- Hypertension
- Physical inactivity
- Excess alcohol consumption

There is a strong association between CHD and socioeconomic deprivation. People in the lowest socioeconomic groups are six times more likely to die early from CHD compared to the most affluent groups 4.

The role of Primary Care
Many studies have shown that primary prevention (averting disease development) is most effective when targeted to those most at risk 5,6. Secondary prevention (diagnosis and treatment of early disease to avoid worsening of health problems) provided by primary care is also clinically and cost effective 7,8.

CHD prevalence
Figure 6.2 shows that the total number of people on a CHD register in Southwark has reduced every year since 2005/06. Changes to the definitions used in the QOF structure have contributed to this trend, but it may also represent a real decline in the number of new cases of CHD in the borough.

Figure 6.2 Number of patients on Southwark Coronary Heart Disease registers, 2005/06 to 2009/10

![Bar chart showing CHD register patients from 2005/06 to 2009/10]

The number of people on CHD registers in each Southwark practice is shown in Figure 6.3, together with the expected prevalence of CHD as modelled by the Association of Public Health Observatories. On average, Southwark’s CHD registers contained 101 patients but there was a large range associated mainly with practice size, from only four patients (The Surgery, Lee) up to 356 patients (Aylesbury). Overall only 53% of the expected number of CHD patients were actually on GP CHD registers in Southwark, compared to 67% in London and 80% in England. This suggests that a large number of patients have not been detected or that their details have not been placed on the register.

There was wide variation across GP practices in the proportion of CHD patients on registers compared with the numbers that might have been expected. This ranged from 13% (The Surgery, Lee) up to 93% (St James Church). Four practices had more than 200 patients ‘missing’ from CHD registers (if the expected prevalence figure is accurate). These were Acorn (211 patients), Forest Hill (212), Camberwell Green (229) and Aylesbury Partnership (421).

CHD prescribing standards
An important method of assessing and comparing GP practice performance in reducing CHD risk is to measure the proportion of their CHD patients taking appropriate preventative treatments.
Anti-thrombotics

Patients with CHD should be treated to reduce the risk of thrombosis (unless otherwise indicated). Figure 6.4 shows the proportion of patients on CHD registers treated with anti-thrombolytic or anticoagulant drugs in the previous 15 months.

Southwark’s overall performance by this measure was similar to London and national averages, with 91.0% of registered CHD patients being treated appropriately, compared with 91.3% in London and 91.2% in England. The range was from 75% (The Surgery, Lee) up to
Figure 6.4 The percentage of CHD patients with a record in the previous 15 months that aspirin, an alternative anti-platelet therapy, or other anti-coagulant is being taken, 2009/2010

97.9% (Albion Street). The QOF upper target is for 90% of the eligible population to be treated.

Practices showed large differences in the proportion of their patients excluded from being counted in the performance target (known as exceptions – this includes those who decline
treatment or those for whom treatment would be inappropriate). Two practices (Concordia Parkside and DMC Silverlock) recorded more than 12% of patients on the CHD register as exceptions, while nine practices did not report any exceptions.

**Beta blockers**

Treatment with beta blocker drugs reduces morbidity and mortality in patients with angina or previous myocardial infarction. Since these drugs are generally well tolerated, this evidence is applied to all patients with CHD, unless there is a contraindication.

Figure 6.5 shows that the average proportion of CHD patients treated with beta blockers in Southwark was 53.4% compared to 55.6% in London and 56.3% in England. The range was from 36% (New Mill Street) to 80% (Lister, Ullah) and (Lister, Aru). Southwark had a high rate of exception reporting, and six local practices excluded over 40% of their CHD patients from this indicator. The QOF upper target is for 60% of the eligible population to be treated with beta blockers.

**ACE inhibitors**

ACE inhibitors are mainly used to control blood pressure. They are indicated in CHD because trials have shown that they reduce deaths following myocardial infarction. In Southwark there were 771 patients with a history of heart attack (myocardial infarction) recorded on GP registers. The proportion of these people treated with ACE inhibitors was high at 83.3% (Figure 6.6). This was slightly below the London figure (84.4%) and similar to the England average (83.1%). Exception reporting varied greatly across the practices. This is partly due to small numbers e.g. the highest exception reporting was for Borough (Sharma) but only one patient was exception reported in this practice, with just two patients on its myocardial infarction register. Nine practices had all their patients on this treatment.
Figure 6.5  The percentage of patients with CHD who are currently treated with a beta blocker, 2009/2010

Source: QMAS database, 2009/10 data as at end of July 2010
### CHD outcomes

Two risk factors for CHD have been used to provide insight into the effectiveness with which practices identify and treat preventable causes of CHD in patients on the CHD register: cholesterol control and blood pressure control.
Figure 6.7  The percentage of patients with CHD whose last measured total cholesterol (measured in the previous 15 months) is 5 mmol/l or less, 2009/2010

Source: QMIS database, 2009/10 data as at end of July 2010
Cholesterol control

Cholesterol control can be achieved through a combination of education, diet, exercise and lipid lowering treatment (mainly statins). At present, national guidelines indicate that therapy should be offered to people with blood cholesterol levels greater than 5 mmol/l.

Southwark GPs achieved cholesterol control in 72.3% of CHD patients. This was below both the London (74.5%) and England (74.9%) averages (Figure 6.7). The range was between 49% (Acorn) and 84% (Nunhead). Sixteen practices performed better than the national average. Exception reporting in Southwark was similar to national averages.

Blood pressure control

Reducing blood pressure is a well established way of reducing the risk of coronary events. A national audit standard has been set for having a last blood pressure reading of 150/90 or less in patients with CHD in the previous 15 months.

The overall proportion of Southwark CHD patients with controlled blood pressure was 83.9%. This was lower than comparator figures for London (87.0%) and England (87.1%). Figure 6.8 shows that performance ranged from 50% (The Surgery, Lee) up to 96% (Avicenna). Exception reporting was 2.2% in the best performing practice but as high as 13% in Grange Road and 10% in St Giles (Virji and Begley).

Modelling work carried out by the Health Inequalities National Support Team examined how many deaths could be postponed in one year if all those with a previous cardiovascular event were prescribed four key treatments. The model suggests that about 32 deaths from heart disease and 17 deaths from stroke could be postponed in Southwark if national assumptions about treatment levels and effectiveness where applied (Tables 6.1 and 6.2). Although these are very much estimated figures they are useful as a general indicator of the potential impact of these treatments on mortality in Southwark.

Table 6.1 Modelled results of improving CVD treatment in those currently untreated in Southwark

<table>
<thead>
<tr>
<th>Intervention to identify and treat all people with a CVD history who are not receiving any of four medications (beta blocker, aspirin, ACE inhibitor and statin)</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care initiative: untreated CVD patients to receive all four medications</td>
<td>1,334</td>
</tr>
<tr>
<td>Maximum number of deaths postponed in one year</td>
<td>CHD: 11 stroke: 6</td>
</tr>
</tbody>
</table>

Source: Health Inequalities National Support Team, 2011
Note: 1 unless contraindicated
See Appendix 1 for more information about this model

Table 6.2 Modelled results of improving CVD treatment in those currently partially treated in Southwark

<table>
<thead>
<tr>
<th>Intervention to identify and treat all people with a CVD history currently on at least one, but not all four medications (beta blocker, aspirin, ACE inhibitor and statin)</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care initiative: partially treated CVD patients to receive all four medications</td>
<td>8,623</td>
</tr>
<tr>
<td>Maximum number of deaths postponed in one year</td>
<td>CHD: 21 stroke: 11</td>
</tr>
</tbody>
</table>

Source: Health Inequalities National Support Team, 2011
Note: 1 unless contraindicated
See Appendix 1 for more information about this model
Figure 6.8  The percentage of patients with CHD in whom the last blood pressure reading (measured in the previous 15 months) is 150/90 or less, 2009/2010

Source: QMIS database, 2009/10 data as at end of July 2010

BP 150/90 or less  BP uncontrolled  exceptions
Figure 6.9 Standardised CHD emergency admission rate per 1000 population, 2009/2010

Source: NHS comparators
Emergency admissions

Emergency hospital admission for CHD should be lower if at-risk patients have been identified, assessed and treated to reduce the probability of further disease. This not only reduces morbidity and mortality amongst patients but also reduces costs to the NHS.

Figure 6.9 shows the emergency admission rate for CHD patients by GP practice. The overall standardised admission rate for Southwark was 2.6 per 1,000 population. This was similar to the London and England rate (2.6 per 1,000). The admission rate ranged between 0 (Lister, Aru) and 5.3 (Park Medical) per 1,000 population but it should be remembered that the small number of patients involved means that these rates should be treated with caution as they can vary from year to year (illustrated by the wide confidence intervals). Park Medical and Acorn had a significantly higher admission rate compared to London and England.

Recommendations:

- The success in reducing deaths from CHD for all people in Southwark should be widely acknowledged and the key reasons made explicit
- Attention should now focus on reducing the high death rate from heart attack amongst men
- The gap between recorded and expected CHD prevalence should be investigated and (where necessary) practices encouraged to improve detection
- Practices with high levels of exclusions from CHD indicators should review the reasons for these high rates and ensure the accuracy of their register information where necessary.
- Efforts should be made to ensure that all patients with CHD who are eligible to receive appropriate drug interventions are offered these treatments without delay

References

## 6.2 Stroke/Transient Ischaemic Attack (TIA)

### What is stroke?
A stroke, or cerebrovascular accident, is caused by disruption of blood flow to the brain. This can be due to blockage of blood vessels (thrombotic stroke) or by bursting of a blood vessel (haemorrhagic stroke). When the brain is starved of oxygen and nutrients, this leads to the symptoms of sudden weakness or numbness, usually on one side of the body. Other symptoms include: confusion, difficulty with speech, blindness, balance problems, headache and loss of consciousness. A range of severity occurs: stroke symptoms which resolve within 24 hours are called transient ischaemic attacks (TIA), but severe stroke can cause sudden death.

### The impact of stroke
Stroke accounts for about 11% of deaths in the UK and in 2009 was directly associated with more than 53,000 deaths. Stroke is also an important cause of morbidity because most people survive their first stroke, often with significant disability. In 2005, the National Audit Office estimated that the direct cost of stroke care for the estimated 300,000 people living with stroke-related disability was £2.8 billion. Stroke costs the economy a further £1.8 billion in lost productivity and the cost of informal care (to patients and families) exceeds £2.4 billion. The causes of stroke are similar to those of CHD and there is again great disparity between socioeconomic groups with the poorest being more likely to be affected. There are also inequalities in stroke risk between different ethnic groups, with people from Black Caribbean, Bangladeshi, Pakistani and Irish backgrounds reporting relatively high prevalence.

Stroke death rates amongst men in Southwark have been well above the London and national averages for most of the last 15 years, with the most recent rate being 24 deaths per 100,000 population in those aged under 75 years (Figure 6.10). For women, mortality is also higher in Southwark but the difference between local and national figures is less marked and Southwark’s rate is currently 12 per 100,000.

**Figure 6.10** Directly standardised mortality rate from stroke, males and females aged under 75 years, 1993 to 2008

Stroke mortality, aged under 75

Source: The NHS Information Centre for Health & Social Care, NCHSD

- **Southwark**
- **London**
- **England**
Risk factors for stroke
Most strokes can be attributed to one or more of ten behaviours or medical conditions. The single biggest risk factor for all types of stroke is high blood pressure. This is important because high blood pressure is easy and cheap to identify through screening and can be treated with cost effective interventions. A large international study has shown that 80% of strokes were due to the following 5:
- high blood pressure (the most important cause)
- smoking
- obesity
- poor diet
- lack of exercise.

The role of Primary Care
The role of GPs in reducing deaths from stroke involves risk assessment for likelihood of a first episode, allowing individuals to be identified for preventative interventions, and close monitoring of patients with a previous history of stroke to help prevent recurrent stroke 6. NICE recommends that risk calculators should be used to estimate an individual’s CVD risk 7.

Three primary care therapeutic interventions reduce risk of stroke:
- Screening and appropriate treatment of hypertension (see section 6.3).
- Antithrombotic treatment for indicated cardiac conditions, including atrial fibrillation, to reduce risk of clot formation.
- Screening and appropriate treatment of high cholesterol.

Stroke prevalence
Figure 6.11 shows that (in contrast with CHD) there has been a gradual increase in the number of people identified with Stroke on GP registers in Southwark in recent years.

Figure 6.12 shows the number of patients on stroke registers compared to the expected number of stroke patients in each GP practice. The number of patients on stroke registers averaged at 56 patients per practice, with a range from 1 patient (The Surgery, Lee) up to 192 patients (Aylesbury Partnership). Overall just over half (54%) of Southwark’s expected number of stroke patients were actually recorded on registers, compared to 68% in London and 87% in England. The proportion recorded varied between 6% (The Surgery, Lee) and 87% (Albion Street). Four practices had more than 100 patients ‘missing’ from the register: Acorn (103 patients), Camberwell Green (103), Princess Street (109) and Aylesbury Partnership (230).
Stroke prevalence and stroke expected prevalence, 2009/10

Bermondsey & Rotherhithe Locality
- Albion Street
- Avicenna
- Bermondsey & Lansdowne
- DMC Silverlock
- Falmouth Road
- Grange Road
- New Mill Street
- Park Medical
- Parkers Row
- St James Church
- Surrey Docks

Borough & Walworth Locality
- Aylesbury Partnership
- Blackfriars
- Borough (Misra)
- Borough (Sharma)
- Maddock Way
- Manor Place
- Old Kent Road
- Penrose
- Princess Street
- Sir John Kirk Close
- The Surgery (East Street)
- The Surgery (Lee)
- Trafalgar
- Villa Street

Dulwich Locality
- 3-Zero-6 MC
- Concordia Melbourne
- DMC CPR
- East Dulwich PCC
- Elm Lodge
- Forest Hill
- Hambleden
- Lordship Lane
- Nunhead
- The Gardens

Peckham & Camberwell Locality
- Acom
- Camberwell Green
- Concordia Parkside
- DMC Chadwick
- Lister (Anu)
- Lister (Hossain)
- Lister (Hurley Group)
- Lister (Ullah)
- Queens Road
- St Giles (Patel, Roseman & Vasant)
- St Giles (Virji & Begley)
- Sternhall Lane

Source: actual prevalence – QMAG database, 2008/09 data as at end July 2010; expected prevalence – NHS comparators, 2008/09

Stroke prescribing standards

Antiplatelet/anticoagulant treatment
Lifelong antiplatelet therapy is associated with a 25% risk reduction for further serious vascular events in people who have had a non-haemorrhagic stroke or TIA.
87.9% of Southwark’s stroke patients receive this treatment, about 3% lower than the
Figure 6.13  Percentage of patients with a non-haemorrhagic stroke, or a history of a TIA, who have a record that an anti-platelet or an anticoagulant is being taken, 2009/2010

<table>
<thead>
<tr>
<th>Locality</th>
<th>Practice Name</th>
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<tbody>
<tr>
<td>Bermondsey &amp; Rotherhithe</td>
<td>Albion Street</td>
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<td>Avicenna</td>
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<td>Bermondsey &amp; Lansdowne</td>
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<td>Park Medical</td>
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<td>Borough &amp; Walworth</td>
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<td>Lister (Aru)</td>
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<td>Queens Road</td>
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<td>St Giles (Patel, Roseman &amp; Vasant)</td>
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<tr>
<td></td>
<td>St Giles (Virji &amp; Begley)</td>
</tr>
<tr>
<td></td>
<td>Sternhall Lane</td>
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</tbody>
</table>

Source: QMIS database, 2009/10 data as at end of July 2010

London (90.5%) and England (90.7%) averages. Fifteen practices reported that 100% of their stroke patients were either on treatment or exception reported (Figure 6.13). The lowest performance was at Sternhall Lane (67%) and Lordship Lane (70%).

Five practices (DMC Silverlock, Grange Road, Trafalgar, Lordship Lane, Sternhall Lane) recorded more than a fifth of patients on the stroke register as exceptions, while 21 practices did not report any exceptions.

**Stroke outcomes**

As with CHD, control of cholesterol levels and blood pressure can dramatically reduce deaths and the risk of future strokes for people who have had a stroke or TIA.

**Cholesterol control**

In Southwark, 65.5% of patients on the stroke register achieved desired cholesterol control, compared to 67.3% in London and 67.9% in England. Figure 6.14 shows that the range was from 35% (Acorn) to 100% (The Surgery, Lee and Borough, Sharma). The level of exception reporting varied widely between Southwark practices, with three reporting more than a fifth of their stroke registered population as exceptions (Concordia Melbourne 36.2%, Princess Street 21.6% and Lister, Aru 20%).

**Blood pressure control**

Southwark practices achieved blood pressure control in 81% of registered stroke patients compared to 84% in London and England. Three practices achieved 100% for this target (Lister Hossain, The Surgery, Lee and Borough, Sharma) while the lowest performing practice was Concordia Parkside (66%). Thirty out of the 47 practices in Southwark had a lower proportion of their stroke patients with controlled blood pressure compared to the national average (Figure 6.15). It is important to note that the QOF audit level is easier to achieve than the optimal recommended control level of 130/80, for a group of people at high risk of a further stroke. There was variation in exception reporting, with two practices reporting more than 15% of their stroke population as exceptions (Surrey Docks and Princess Street).
Figure 6.14 The percentage of patients with TIA or stroke whose last measured total cholesterol is ≤5 mmol/l or less, 2009/2010

Source: QMMS database, 2009/10 data as at end of July 2010
The percentage of patients with a history of TIA or Stroke in whom the last blood pressure reading is 150/90 or less, 2009/2010

Again, modelling work has been carried out by the Health Inequalities National Support Team. The results shown earlier in this section indicated that an estimated 17 stroke deaths could be postponed by improving the medication of those not on optimal treatment (i.e. optimal prescribing of beta blocker, aspirin, ACE inhibitor and statins). A further 8 stroke
deaths could be averted by ensuring that all those aged over 65 with atrial fibrillation (a common heart condition that causes bouts of fast and irregular heartbeat) are on anticoagulant therapy (Table 6.3).

Table 6.3  Modelled results of improving anticoagulant therapy (warfarin) for people aged 65 and over with atrial fibrillation

<table>
<thead>
<tr>
<th>Intervention for people aged over 65 with atrial fibrillation</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated number of people with atrial fibrillation not on anticoagulant therapy</td>
<td>519</td>
</tr>
<tr>
<td>Maximum number of deaths postponed in one year</td>
<td>8</td>
</tr>
</tbody>
</table>

Source: Health Inequalities National Support Team, 2011
Note: See Appendix 1 for more information about this model

NICE recommends a risk based approach to prescribing rather than universal prescribing for all those aged over 65 ⁹. A readily available tool (GRASP-AF) can interrogate a GP practice list and identify which people with atrial fibrillation should be on this medication.

Emergency admissions
In 2009/10 there were 310 emergency admissions for stroke in Southwark. At 1.8 per 1,000, Southwark’s standardised emergency admission rate was significantly higher than the national average (1.5 per 1,000). There is variation between Southwark practices, although actual numbers are small (Figure 6.16). Two practices had admission rates significantly greater than the national average (Princess Street (2.7 per 1,000) and Lordship Lane (4.1 per 1,000).

Compared to the national average, a significantly higher proportion of people aged under 75 who have a stroke in Southwark were discharged home in 2009/10 ¹⁰. It is important that ongoing care for these people is comprehensive after discharge to enable as full a recovery as possible.
Figure 6.16  Stroke standardised emergency admission rate per 1,000 population for Southwark GP practices, 2009/2010

Source: NHS comparators
Recommendations:

- All patients who have had a stroke or a TIA should be on GP registers and therefore have the opportunity to be on optimal therapy.
- Variation in care for those on the stroke registers needs to be reduced.
- The GRASP-AF tool should be implemented in all Southwark practices to identify those with atrial fibrillation who are not currently on effective anti-coagulation therapy.

References

2. NICE. Stroke: diagnosis and initial management of acute stroke and transient ischaemic attack (TIA). NICE Guidelines. 2008
4. Health Survey for England 2004
9. NICE. Atrial Fibrillation: clinical guideline. 2006
10. SEPHO. Cardiovascular Disease Profiles
6.3 Hypertension

What is hypertension?
Hypertension is the medical term for chronically high blood pressure. It is a condition that is diagnosed by measuring an individual's blood pressure against a pre-determined threshold. Hypertension does not normally have symptoms but causes other serious problems including heart disease, stroke and kidney failure.

The impact of hypertension
Hypertension is a highly important risk factor for cardio-vascular disease and contributed to some 100,000 CHD deaths and 50,000 stroke deaths in 2000. NICE estimates that prescriptions for hypertension exceed 90 million per year in number and cost the NHS £480 million, which is nearly 15% of the total primary care bill for drugs.

Hypertension risk factors
Modifiable risk factors for hypertension include the following:
- diabetes,
- unhealthy diet, with high levels of saturated fat,
- high salt intake,
- being overweight or obese,
- physically inactivity.

There are a number of other risk factors that increase a person’s chances of developing hypertension. These include increasing age, ethnicity (particularly Asia, African or Caribbean ancestry) and other genetic factors associated with family history.

The role of Primary Care
Most people with hypertension are identified and managed by their GP. There are three key aspects to the management of hypertension:
- Identification by testing people’s blood pressure when they come to practice (especially those at high risk)
- Treatment: the initial intervention should be to offer lifestyle advice including advice on physical activity, weight loss, smoking and diet
- Drug therapy is important and, when correctly managed, will reduce deaths and disability associated with cardiovascular disease. An annual review is recommended to monitor patients’ progress on their treatment.

Hypertension prevalence
Hypertension has been recorded in approximately 10% of the GP registered population in Southwark. Local GP practices have an average of 656 patients recorded with hypertension, with a range from 72 patients (The Surgery, Lee) to 2672 patients (Aylesbury). Much hypertension is undiagnosed and less than half (48%) of the expected number of of local people with hypertension are actually recorded on GP registers in Southwark. This compares to 51% in London and 55% in England). Nine local practices had in excess of one thousand hypertension patients missing from the register when recorded patients are compared to the expected number (Figure 6.17).
Hypertension control outcome

The British Hypertension Society has recommended that QOF adopts a blood pressure audit standard of 150/90 mm Hg for those without other major cardiovascular diseases. Figure 6.18 shows that Southwark GP practices achieved this standard in 70% of patients on the hypertension register, compared to 75% in London and England.
The percentage of patients with hypertension in whom the last blood pressure reading (measured in the previous 9 months) is 150/90 or less, 2009/2010

Source: QM5 database, 2009/10 data as at end of July 2010

- blood pressure 150/90 or less
- blood pressure uncontrolled
- exceptions
Ten practices achieved a higher proportion than the national average and the best performance was by Lister Primary Care Centre – Dr Hossain (84%). The lowest five performing practices were Sir John Kirk close Surgery (58%), Maddock Way (60%), Falmouth Road (60%), Acorn (63%) and Hambleden (63%).

Modelling work examined how many deaths could be postponed if all people with hypertension who have not had a previous cardiovascular event were prescribed an additional hypertensive therapy and/or had statin treatment if they were at high risk of a CVD event. The model suggests that 34 deaths could be postponed through use of an additional hypertensive therapy and 15 deaths through use of statin therapy.

Table 6.4 Modelled results of improving hypertension therapy in Southwark

<table>
<thead>
<tr>
<th>Intervention for people with high blood pressure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary care initiative:</strong> all people with high blood pressure with no CVD history to have additional hypertensive therapy. Statin treatment for those with high CVD risk</td>
</tr>
<tr>
<td>Estimated Southwark eligible population</td>
</tr>
<tr>
<td><strong>Maximum number of deaths postponed in one year</strong></td>
</tr>
<tr>
<td>additional hypertensive therapy:</td>
</tr>
<tr>
<td>statin therapy:</td>
</tr>
</tbody>
</table>

Source: Health Inequalities National Support Team, 2011

Note: See Appendix 1 for more information about this model

Recommendations:

- It is important that primary care staff recognise hypertension and maintain timely and complete registers of patients with the condition.
- Implementation of NHS Health Checks in Southwark should help to systematically identify those people with as yet undiagnosed high blood pressure. All GP practices should be carrying out these health checks by March 2012.
- Risk factor assessment of those with hypertension should be used as an opportunity to find and treat people who may be vulnerable to other important causes of early death in Southwark.

References

1 NICE. Essential hypertension: managing adult patients in primary care [Internet]. 2006; available from: www.nice.org.uk/nicemedia/pdf/CG18background.pdf
2 Izzo J. Treating hypertension in the primary care population. Advanced studies in medicine. 2005; 5(6B): S531-6
6.4 Diabetes

What is diabetes?
Diabetes is a cluster of conditions with different causes, but with a common feature of abnormally high blood glucose. Most diabetes falls into two types:

- **Type 1 diabetes** accounts for 10% of all diabetes and often arises in childhood. It is caused by destruction of insulin producing cells and requires life-long insulin replacement in addition to life-style change.

- **Type 2 diabetes** is far more common (affecting 90% of people with diabetes). It is typically a disease of people older than 40 years, although it is becoming more common in younger people linked to rising levels of obesity. It is characterised by insulin insensitivity (insulin is secreted but it does not control blood glucose properly) and inadequate secretion of insulin (the body is unable to up-regulate insulin to compensate for high blood glucose).

The impact of diabetes
Diabetes is important as a cause of early death as it leads to serious health problems including heart disease, strokes and peripheral artery disease. For example, a person with diabetes and any previous cardiovascular event is at 10 times higher risk of a further event than the normal population\(^1\). High blood sugar levels can also lead to eye damage, kidney failure, and nerve damage. There has been a dramatic increase in the incidence of type 2 diabetes over the last two decades. As a result, diabetes is now associated with 4% of deaths in men and 8% of deaths in women in the UK\(^1\).

A number of factors contribute to the increasing cost of diabetes in the UK. As well as the greater number of people affected by the condition, there are costs associated with testing for blood sugar, the management of diabetic complications, and the cost of life-long drug treatment. Altogether, diabetes is estimated to cost around £2.8 billion annually (about 7-12% of total NHS expenditure)\(^2\). There are also additional costs to the economy through disability and early mortality, as well as the personal costs and other impacts on individual patients and families.

Risk factors for diabetes
The key modifiable risk factors for type 2 diabetes are as follows\(^3\):

- obesity (over 90% of type 2 diabetics are overweight),
- inadequate exercise,
- poor diet.

Risk factors which can not be changed include older age, family history and ethnicity (the condition is particularly common in Black and Asian ethnic groups). These factors are important in determining and interpreting individual risk.

The role of primary care
Most patients with diabetes are now managed exclusively or largely in primary care, where they are provided with education, regular reviews, treatment and ongoing management of complications\(^4\). Effective management of diabetes depends on reducing the level of blood sugar on a sliding scale of interventions. These range from diet and behavioural interventions, oral anti-hyperglycaemic drugs and, where necessary, tailored injectable insulin. GPs also have a pivotal role in the ongoing management of cardiovascular risk factors and the prevention and treatment of long term complications of diabetes.

Work in Southwark has focused on improving blood sugar control, ensuring that all those newly diagnosed are referred to structured education (DESMOND), and ‘repatriating’ people who have unnecessary continuous hospital based care back to their GP for ongoing care.

Diabetes prevalence
Figure 6.19 shows that the numbers of people with diabetes recorded on GP registers in Southwark has increased markedly since 2005/06. This may largely reflect efforts to identify the large numbers of people with undiagnosed diabetes in our population.

It is important to identify and treat people with diabetes before they start having serious symptoms. There are a number of approaches to this but one key method will be through the
NHS Health Checks Programme. This is aimed at people aged between 40 and 74 years old and will cover an increasing proportion of the target population as implementation continues. In the programme diabetes is detected through a blood test for people who have hypertension and/or are overweight. A long term aim will be to reduce diabetes prevalence once most of the people with undiagnosed diabetes have been identified.

Figure 6.19 Number of people on Southwark diabetes registers, 2005/2006 to 2009/2010

Although 10,945 people were recorded on Southwark diabetes registers in 2009/10, it has been estimated that a total of 19,530 people may have diabetes (uncertainty limit range: 9,379 – 35,911). This means that only around 56% of the estimated number of people with diabetes were actually on Southwark GP diabetes registers.

Figure 6.20 shows the number of people on diabetes registers compared to the expected number of diabetes people for each GP practice. On average, Southwark’s diabetes registers contained 233 patients. But there was a large range, from only 18 patients (The Surgery, Lee) up to 959 patients (Aylesbury). The proportion of the estimated practice prevalence recorded on registers varied between 22% (The Surgery, Lee) and 78% (Queens Road). Six practices had more than 300 patients ‘missing’ from the register: Acorn (404 patients), Camberwell Green (363), Forest Hill (494), Princess Street (351), Aylesbury Partnership (586) and Bermondsey & Lansdowne (334).
Figure 6.20  Diabetes prevalence and diabetes expected prevalence, 2009/2010)

Bermondsey & Rotherhithe Localisty
- Albion Street
- Avicenna
- Bermondsey & Lansdowne
- DMC Silverlock
- Falmouth Road
- Grange Road
- New Mill Street
- Park Medical
- Parkers Row
- St James Church
- Surrey Docks

Borough & Walworth Localisty
- Aylesbury Partnership
- Blackfriars
- Borough (Misra)
- Borough (Sharma)
- Maddock Way
- Manor Place
- Old Kent Road
- Penrose
- Princess Street
- Sir John Kirk Close
- The Surgery (East Street)
- The Surgery (Lee)
- Trafalgar
- Villa Street

Dulwich Localisty
- 3-Zero-6 MC
- Concordia Melbourne
- DMC CPR
- East Dulwich PCC
- Elm Lodge
- Forest Hill
- Hambledon
- Lordship Lane
- Nunhead
- The Gardens

Peckham & Camberwell Localisty
- Acorn
- Camberwell Green
- Concordia Parkside
- DMC Chadwick
- Lister (Aru)
- Lister (Hossain)
- Lister (Hurley Group)
- Lister (Ullah)
- Queens Road
- St Giles (Patel, Roseman & Vasant)
- St Giles (Vij & Begley)
- Sternhall Lane

Sources: actual prevalence – QMIS database, 2009/10 data as at end July 2010, expected prevalence – Assoc of Public Health Observatories Diabetes Prevalence Model with input from Southwark Diabetes Modernisation Initiative

Diabetes prescribing standards
Figure 6.21, compares the percentage of patients on the diabetic register with controlled blood sugar in each practice with the amount of metformin prescribed by the practice (metformin is the firstline treatment for controlling blood sugar in type 2 diabetics). This helps to assess the link between inputs (prescribing) and outcomes (controlled diabetes) at the population level.
There is very wide variation in prescribing volumes by different practices but no obvious relationship between prescribing and outcome in terms of the proportion of patients with controlled blood sugar. Nevertheless, this graph may help to identify practices that merit closer attention. These would fall into two quadrants in particular:

i) The bottom left quadrant contains practices that have relatively low prescribing activity and poor outcomes. These might be encouraged to explore whether prescribing is sufficient.

ii) The bottom right quadrant contains practices that have relatively high prescribing activity and poor outcomes. These might be encouraged to explore whether prescribing is cost effective.

The practices are colour coded by locality and there are some apparent geographical differences across the borough. For example practices in Borough and Walworth locality tend to have higher prescribing levels while those in Bermondsey and Rotherhithe are relatively low prescribers.

**Diabetes outcomes**

Cardiac risk associated with diabetes is dictated to a large extent by long term control of blood sugar. Average blood sugar levels over the previous three months can be estimated by measuring levels of HbA1c. This is an important diabetic clinical outcome.

Southwark GP practices achieved HbA1c levels of 8% or less in 63.5% of their diabetic patients, compared to 67.0% in London and 69.9% in England. The proportion of patients with HbA1c of 8% or less had a wide range, from 45% (Acorn) to 84% (Bermondsey & Lansdowne). Figure 6.22 shows that eight practices achieved better blood sugar control levels than the national average. Five practices had less than half of their diabetes patients with an HbA1c level under 8% (St James Church, Acorn, Concordia Parkside, Lister Aru and Lister Hosain). Four of these practices are in Peckham and Camberwell locality. Exception reporting again varied across practices, ranging from 2.2% (Borough, Sharma) to 37.5% (Concordia Parkside).

It is important to note that HbA1c control improved markedly for Southwark in 2010/11.
Figure 6.22 The percentage of patients with diabetes in whom the last HbA1c is 8 or less in the previous 15 months, 2009/2010

Source: QMAG database, 2009/10 data as at end of July 2010
The Health Inequalities National Support Team have modelled the impact of improving blood sugar control on deaths in Southwark. The estimate applies the age specific diabetes prevalence for the most deprived areas of England to the Southwark Local Authority population and assesses the potential for improving health outcomes based on national evidence. Table 6.5 shows that if all those with HbA1c over 7.5 in Southwark reduced their blood sugar levels by one unit, an estimated 9 deaths could be prevented in one year.

Table 6.5 Modelled results of improving blood sugar control in Southwark

<table>
<thead>
<tr>
<th>Intervention for people with high blood sugar (HbA1c &gt; 7.5)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care initiative: reduce HbA1c by one unit for all patients with measure &gt;7.5</td>
<td></td>
</tr>
<tr>
<td>Estimated number of people with HbA1c over 7.5</td>
<td>2,765</td>
</tr>
<tr>
<td>Maximum number of deaths postponed in one year</td>
<td>9</td>
</tr>
</tbody>
</table>

Source: Health Inequalities National Support Team, 2011
Note: See Appendix 1 for more information about this model

The eligible population identified by the model is likely to be a significant underestimate as:

- In addition to the 2,843 people with diabetes who had an HbA1c over 8 in Southwark during 2009/10, there were 1,150 exceptions for the target
- More than 8,500 people with diabetes may not yet be diagnosed\(^5\)
- There are more people registered with Southwark PCT than recorded as living in the Southwark Local Authority

More deaths could thus be prevented if all the above people are considered in the eligible population. But this estimate is a useful starting point for further work to model potential health gains more accurately.

**Recommendations**

- All Southwark GP Practices should be fully involved in NHS Health Checks by March 2012. This will help ensure that those with undiagnosed diabetes can be systematically identified in Southwark.
- All newly diagnosed diabetic patients should be referred to DESMOND structured education (part of the locality incentive scheme). Education should be reinforced where appropriate at annual reviews.
- Offer self-monitoring of plasma glucose to a person newly diagnosed with type 2 diabetes only as an integral part of his or her self-management education.
- When setting a target glycated haemoglobin the person should be involved in decisions about their individual HbA1c target level.

**References**

5. Diabetes Modernisation Initiative, using the APHO prevalence tool. This estimate does not include data from the Avicenna practice which does not participate in the QMS data retrieval programme

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6.5 COPD

What is COPD?
Chronic obstructive pulmonary disease (COPD) is a lung disease of progressive airflow obstruction. It causes breathlessness and predisposes people to lung infection. Damage to the lung largely results from long-term smoking, but may also be triggered by occupational exposure. The term COPD includes people who were diagnosed with emphysema and chronic bronchitis in the past. There is no single test for COPD. Diagnosis depends on clinical judgement and lung function tests.

The impact of COPD
COPD is important because it is common but can remain hidden. The condition develops slowly, and very significant disease may be present before an individual is aware of it. It is estimated that only a third of the 3 million people affected by COPD in the UK have been diagnosed. Approximately 30,000 deaths per year in the UK are attributed to COPD and the UK death rate is twice as high as the European average. This implies that improvements in COPD management can be made.

COPD is the second largest cause of emergency admission to hospital in the UK and is extremely costly. The direct cost of COPD was estimated to be more than £800 million in 2005, more than half of which was spent on acute hospital admissions. Preventing hospitalisation is a priority and will help to save lives and reduce costs. The indirect costs of COPD are also considerable and include the costs of disability, social care, lost working years and of early deaths. COPD is also a significant cause of co-morbidity in other smoking-related conditions, including lung cancer and CVD.

Figure 6.23 shows the standardised mortality ratio (SMR) for those aged under 75 years, and for all ages. Southwark has a high COPD death rate for both men and women. For men aged under 75, the local death rate is more than double the national average.

Figure 6.23 Standardised mortality ratios from COPD, all ages and under 75 years, 2006-08

![Graph showing SMR for COPD](image)

Source: The NHS Information Centre for Health and Social Care, NCHDD

COPD risk factors
Most COPD can be attributed to smoking and trends in the disease trends therefore follow historical patterns in smoking prevalence. Men are more likely to have COPD than women, although this gender gap is closing nationally as smoking has become more common among women. There is also a strong association between social deprivation and COPD. In fact men in unskilled manual occupations are 14-times more likely to die from COPD than those of equivalent age with professional occupations. Prevalence of COPD is also strongly correlated with urban dwelling.
Effective interventions in primary care
COPD diagnosed today will usually have been caused by decades of smoking. The role of primary care is critical in ensuring early diagnosis and managing cases effectively to minimise suffering, prolong life and prevent unnecessary hospital admissions. GPs therefore need to take a targeted approach to case-finding and maintain a high index of suspicion in smokers over the age of 35 with symptoms such as breathlessness or chronic cough. A COPD diagnosis should be confirmed by spirometry following administration of bronchodilators.

Smoking cessation is the most effective measure to reduce COPD risk, and is the most important aspect of disease management for patients. Beyond this, a symptomatic approach is increasingly encouraged in primary care, with emphasis on regular review and drug treatment to minimise breathlessness and exacerbations of infection. Evidence of effectiveness exists for symptom control but not disease modification for bronchodilators (including long acting oral drugs such as tiotropium) and for inhaled corticosteroids. Referral for pulmonary rehabilitation is important due to the strong evidence for improvement in quality of life, shortness of breath, exercise capacity, and reduced hospital admissions.

COPD prevalence

Figure 6.24 shows that the number of people on COPD registers in Southwark has increased every year since 2005/06. It should be noted that some of these people may be incorrectly recorded on the COPD register. Around a third of those with COPD referred to the STAR community clinics set up in Lambeth and Southwark were found not to have COPD. Efforts to find people as yet undiagnosed with COPD must ensure accurate diagnosis.

![Figure 6.24 Number of patients on Southwark COPD registers, 2005/06 to 2009/10](image)

The average Southwark GP practice has 77 patients on COPD registers, with a range from 2 (The Surgery, Lee) up to 378 (Aylesbury Partnership). However as we saw earlier there are many people with COPD who have not yet been diagnosed and it is estimated that Southwark GP practices have identified 52% of the people with COPD in the borough. There was very large variation in this measure of detection, from only 5% (The Lister, Ullah) up to 100% of expected patients registered (St James Church). Practice-level data are shown in Figure 6.25.
COPD outcomes

There are no clinical criteria within the quality and outcomes framework which are easily applied to measure COPD treatment success. However, NICE suggests that FEV1 (a measure of lung capacity) and inhaler technique should be assessed at least annually for people with COPD so that those with increasing severity can be identified and assessed for alternative treatment options.
Figure 6.26 The percentage of patients with COPD with a record of FeV1 in the previous 15 months, 2009/2010

Figure 6.26 shows the proportion of patients on COPD registers who have been assessed by spirometry within the previous 15 months. Overall, GPs in Southwark had achieved this goal in 74.2% of COPD patients, compared to 79.6% in London and 78.1% in England.
Figure 6.27  COPD Standardised emergency admission rate per 1000 population in Southwark GP practices, 2009/2010

Source: NHS comparators
17 practices had better recording than the London average. The range locally was from 100% (The Surgery, Lee) to 25% (Elm Lodge). Other practices performing in the bottom five were Lister Ullah (33%), Maddock Way (42%), Queens Road (52%) and Avicenna (53%). Four practices did not report any exceptions, while seven had more than a quarter of their COPD patients exception reported (New Mill Street, Concordia Melbourne, DMC CPR, Forest Hill, Lister Hossain, Lister Hurley Group, and Lister Ullah).

Emergency hospital admissions
The level of COPD emergency admission is associated with smoking and deprivation as well as the actual level of COPD prevalence itself. An association has also been shown between admission rates and undiagnosed COPD prevalence 8.

In 2009/10 there were 559 emergency admissions for COPD in Southwark. At 3.3 per 1,000 population, Southwark’s standardised admissions rate was the third highest in London and was significantly higher than the national average (1.8 per 1,000). The standardised admission rate has been in the highest three for London PCTs since 2005/06. The rate for each Southwark practice is shown in Figure 6.27.

Recommendations

▼ Practices should increase case finding and achieve accurate diagnosis and regular review of all COPD patients.

▼ There should be a focus on smoking cessation to slow lung function deterioration. All COPD patients who smoke should be encouraged to stop and offered advice at every opportunity.

▼ Improve FEV1 recording across Southwark GP practices.

▼ Ensure patients are on optimal treatment for their disease stage.

▼ Refer people who are disabled by their breathlessness for pulmonary rehabilitation.

▼ There should be further investigation of the variation in emergency admission rates.

References


2 British Lung Foundation. Invisible lives – Chronic Obstructive Pulmonary Disease (COPD) – finding the missing millions. 2007


6.6 HIV

What is HIV?
Human Immunodeficiency Virus (HIV) is a virus that causes a lifelong infection resulting in destruction of the immune system. This causes a progressive immune deficiency called Acquired Immunodeficiency Syndrome (AIDS) which makes sufferers susceptible to opportunistic infections. Without treatment HIV leads to death within an average of 10 years. However, HIV is now readily treatable with highly active antiretroviral therapy (HAART) and most people living with the virus will remain well on treatment with near-normal life expectancy, provided they are diagnosed early.

HIV in Primary Care
HIV infection is an important public health issue in the UK. This is particularly true in London, because around 44% of patients receiving HIV-related care are resident in the capital.

There are three aspects of HIV healthcare which are important in the context of primary care.

- Of those diagnosed with HIV in England in 2009 over half were identified at a late stage of infection [less than 350 CD4 cells per ml of blood], and one third at a very late stage [less than 200 CD4 cells per ml of blood]. Late diagnosis is associated with poorer quality of life, reduced life expectancy and greater cost than early diagnosis. Primary care has an important role in identifying patients with HIV at an early stage.
- 86,500 people are estimated to be living with HIV in the UK, of whom 25% are unaware of their status. Diagnosis can prevent onward transmission through treatment (which reduces infectivity) and through counselling which can lead to behaviour change. Primary care is an important setting in which new diagnoses can be made.
- There are significant co-morbidities associated with chronic infection, and treatment with HAART causes harmful effects including high cholesterol and liver disease. Shared care service models involve GPs providing management of co-morbidities. Disclosure of HIV infection to GPs is important to avoid potentially life-threatening drug interactions and allow shared care models to work effectively.

HIV in Southwark

Overall
HIV is very likely to be the fastest growing chronic condition in the borough. There were 2,197 people known to HIV services and living in Southwark in 2009, and the HIV-positive population has grown at an average of 6.7% per year since 2005. This means that some of Southwark’s larger GP practices will now have as many HIV patients on their lists as some smaller HIV centres.

Some key facts about HIV in Southwark:

- The overall prevalence of HIV in the borough was 10.4 per 1,000 residents aged 15-59.
- Southwark’s prevalence is seven times higher than the UK average.
- Most HIV infections were in men (73%).
- The male to female ratio of 2.7 has remained stable over recent years.
- The median number of HIV patients per GP practice is 25.5. The largest number of HIV patients in any one practice is 124 patients.
- It is estimated that 71% of HIV patients have disclosed their infection status to their GP.

Age
Age-specific HIV prevalence was highest for those aged 35-44 (in 2009). In this age group Southwark’s prevalence was 25.3 per 1,000 men and 10.4 per 1,000 women.

Ethnicity
There are striking differences in prevalence between ethnic groups and in the genders affected in each group. Two thirds (66%) of all male cases in Southwark were white, while almost three quarters (74%) of all cases in women were black African. In fact prevalence per
1,000 population was highest among black Africans for both genders (14.1 per 1000 for men and 27.0 per 1000 for women). In comparison, prevalence in white people was 11.5 and 0.7 per 1000 respectively, and in black Caribbean people was 10.4 per 1,000 for men and 3.7 for women.

**Route of infection**
The most common route of infection for people using HIV services in 2009 was through sex between men (52%), while heterosexual transmission accounted for 39% of cases. The infection route was not known in most of the remaining 9% of cases but some acquired their infection via transfusion of blood products (6 people), intravenous drug use (27 people), and mother to child transmission (52 people).

**Geographic distribution**
Figure 6.28 shows a map of age-standardised HIV prevalence rates in Southwark for those aged 15-59. Most of the people with HIV infection were concentrated in the north and west of the borough.

**Figure 6.28** Age-standardised HIV prevalence in Southwark in 2009

![HIV prevalence map](image)

Source: South East London Health Protection Unit

**Late diagnosis**
In 2009, half of newly diagnosed cases were diagnosed late and a quarter were diagnosed very late. This compares to a target of 15% set by NHS London. Those who acquired their infection through heterosexual sex were more likely to be diagnosed late than men who have sex with men.

**GP testing profiles**
HIV testing data from Guy’s and St Thomas’ Hospital Trust have been used to compare activity across Southwark and Lambeth GP practices. The rate of non-neonatal HIV tests varied very widely across the borough in 2009. The number of tests performed by each GP practice ranged from 2 to 252 in this period (equivalent to between 0.6 to 81.2 tests per 1,000 practice population). Importantly, although the prevalence of HIV is similar in Lambeth, the overall rate of HIV testing was significantly lower for Southwark GP practices.
**Recommendations:**

- HIV testing is recommended in primary care at new patient registration where the local HIV prevalence is greater than 2 per 1,000. This guideline is being piloted in six GP practices across Southwark. The practices involved are Aylesbury Partnership, Lister walk-in centre (Hurley), Manor Place, New Mill Street, Princess Street and Sir John Kirk.

- Opportunistic HIV testing should be performed in anyone presenting with significant risk factors (including tuberculosis, viral hepatitis and lymphoma) and/or suggestive symptoms.

- There is a need for effective HIV prevention, education and awareness raising.

- HIV is a long term condition. Shared care models between primary and secondary care need to be developed.

- Consideration of long term care management is important. These include drug interactions, side effects and co-morbidities associated with long term infection, as well as interventions to avoid new transmissions.

- Effective shared care models will require an environment where stigma against HIV infection is avoided and people feel able to disclose their infection.

**References**


6.7 Emergency admissions for ambulatory care sensitive conditions

What are ambulatory care sensitive conditions?
Ambulatory care sensitive (ACS) conditions are a group of 19 long or short-term illnesses for which hospital admissions can potentially be avoided through effective actions taken by primary care. They are relevant to this report as they may lead to early deaths in severe cases.

How many were there for Southwark PCT?
There were 3,754 hospital admissions due to ACS conditions for Southwark PCT in 2009/10. Southwark had the eighth highest standardised rate in London at 15.3 admissions per 1000 people. The local rate was significantly higher than the London and England averages (14.0 per 1000 and 14.5 per 1,000 respectively).

Figure 6.29 shows the number of admissions for each of the ambulatory care sensitive conditions for Southwark during 2009/10. The size of the blocks relates to the number of admissions for each specific condition. The Figure also shows how Southwark’s standardised admissions rate for a specific condition compared to the England average, through its colour scheme.

Southwark has a significantly higher standardised admission rate (in descending order) for chronic obstructive pulmonary disease, diabetic complications, congestive heart failure, pyelonephritis (kidney infection), iron deficiency anaemia, and perforated bleeding ulcer.
How did ambulatory care sensitive conditions vary by GP Practice?
Standardised hospital admission rates for all 19 ACS conditions were examined for our GP Practices. The rates take into account any age or gender differences between the populations registered with each practice and are shown in Figure 6.30.
Three practices in Bermondsey and Rotherhithe Locality (Grange Road, Park Medical, & St James Church) and four in Peckham and Camberwell Locality (Acorn, Camberwell Green, Concordia Parkside, and Queens Road) had significantly higher admission rates than the national and regional average.
Figure 6.30  Standardised admission rates per 1,000 for ambulatory care sensitive conditions, 2009/2010

Bermondsey & Rotherhithe Locality
- Albion Street
- Avicenna
- Bermondsey & Lansdowne
- DMC Silverlock
- Falmouth Road
- Grange Road
- New Mill Street
- Park Medical
- Parkers Row
- St James Church
- Surrey Docks

Borough & Walworth Locality
- Aylesbury Partnership
- Blackfriars
- Borough (Misra)
- Borough (Sharma)
- Maddock Way
- Manor Place
- Old Kent Road
- Penrose
- Princess Street
- Sir John Kirk Close
- The Surgery (East Street)
- The Surgery (Lee)
- Trafalgar
- Villa Street

Dulwich Locality
- 3-Zero-6 MC
- Concordia Melbourne
- DMC CPR
- East Dulwich PCC
- Elm Lodge
- Forest Hill
- Hambleden
- Lordship Lane
- Nunhead
- The Gardens

Peckham & Camberwell Locality
- Acorn
- Camberwell Green
- Concordia Parkside
- DMC Chadwick
- Lister (Arul)
- Lister (Hossain)
- Lister (Hurley Group)
- Lister (Utah)
- Queens Road
- St Giles (Patel, Roseman & Vasant)
- St Giles (Virji & Begley)
- Sternhall Lane

Source: NHS comparators
Seven practices had admissions rates that were significantly lower than the national average. These were spread across the localities (Falmouth Road, Old Kent Road, Trafalgar, DMC CPR, Elm Lodge, Forest Hill & St Giles – Patel, Roseman and Vasant).

**Recommendations**

- Further work is needed to identify the proportion of admissions that are avoidable and to ensure that evidence based interventions are in place to achieve reduced admissions.
- COPD and Diabetes are the chronic ambulatory conditions with the greatest number of admissions by Southwark residents. Section 6.5 (on COPD) and Section 6.4 (on Diabetes) examine care for these conditions in more depth and include specific recommendations.
- There will be three community based services for diabetes, heart failure and COPD working in Southwark during 2011/12. The impact of these services in reducing emergency admissions needs to be evaluated.
- Recommendations on influenza vaccination are set out in Section 5.2.2.
Appendix 1

Note on modelling health benefits

1 Introduction

This report has made use of a modelling tool developed by the Health Inequalities National Support Team, Department of Health (version 6.1, December 2010). The tool helps primary care trusts to quantify the effects of different interventions and thus illustrates the potential benefits of a more pro-active approach to preventing ill-health in primary care. All models rely on assumptions and are not intended to ‘predict’ the future. This brief note outlines the basics of how the model works and highlights possible next steps in Southwark.

2 Overall approach

The model uses a range of evidence to calculate the potential for health improvement. This varies according to the specific topic in question but is a combination of

a) national data such as the risk reduction associated with particular interventions,
b) data on the more socially deprived parts of the country (spearhead PCTs) such as the proportion of people who may be untreated or partially treated and
c) local Southwark data such as population figures and numbers of people estimated to have specific health problems. These various figures are then used to calculate the maximum possible number of people who would be ‘eligible’ to receive each particular intervention in Southwark and the scope for health improvement based on evidence of effectiveness (this is usually expressed as the number of deaths that would be postponed in one year).

3 Some caveats

Models are by nature a simplified version of reality but they can add real value by highlighting impacts that may be hidden in day to day life. Their assumptions can be altered to see ‘what if?’ different scenarios or to allow for uncertainties. Some of the main issues that need to be considered in the modelling used in this report are as follows:

- Population data in the model are ONS estimates for Southwark for the years 2006-2008. More recent data (and alternative sources such as the GLA) may yield different baseline figures
- Prevalence figures in Southwark may be different to those implied in the model because of local population factors and changes over time
- Coverage of the interventions would in practice be lower than the figures in the model (which often uses 100% of the eligible population to show the potential maximum). This may be due to people with the health condition not yet being diagnosed and/or on disease registers, differences in take-up of interventions by patients and differences in service provision across GP practices
- The actual health impact (ie deaths postponed) may differ locally from that found in national research data and may vary between different population groups for a number of different reasons
- There could be some ‘double-counting’ of patients as some people may have more than one condition
- The costs of each intervention are not specified in the model
- There may be other interventions which are equally effective but which are not covered by the model

4 Possible next steps

Modelling costs and effects will be increasingly important as commissioners seek value for money within limited resources. The interventions modelled in this report are all well established and proven treatments which are in place within Southwark. The question is thus about where to put special emphasis (and resources) in order to maximise health gain and to reduce inequalities in Southwark’s population. The main body of this report includes a recommendation to carry out further work tailored to local circumstances and using alternative assumptions. This should help to guide the preventative priorities in local commissioning plans.
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