Preventing premature deaths in Lewisham: the contribution of primary care

Annual Report of the Director of Public Health 2009
I am very pleased to present this annual report of the Lewisham Director of Public Health for 2008/9. Public health reports can be very broad or very narrow in their scope; this report is a focused, in-depth, assessment of the contribution that General Practice can make to reducing avoidable deaths in Lewisham. The main audience for this year’s report is the 187 GPs and their teams who deliver primary care in our borough.

Why have we chosen to do this? Whilst I would be the first to say that the biggest impact on life expectancy and health inequalities in Lewisham over the long term will be made by tackling poverty and changing lifestyles to reduce smoking, obesity and alcohol misuse, we believe that Lewisham’s General Practices can make the single greatest contribution to preventing avoidable deaths in the next one to five years.

All of our General Practices work extremely hard to improve and maintain the health of their patients. They are the backbone of our local health service, and they provide clinical care across a huge range of illnesses and health problems. They also make an invaluable contribution to preventing illness and promoting good health.

The challenge for General Practices now, as they take on far greater responsibility for the whole health care system, is to step back from the individual patient in the surgery and look at how they can improve the systems and processes in their practices that ensure that people with life threatening diseases are diagnosed as early as possible, properly treated and regularly reviewed. This report is intended to help practices achieve these aims. The report identifies, for each practice, exactly where diagnosis and treatment of key diseases can be improved so that they can achieve at least the performance standards of the average English practice; at present the majority of Lewisham practices perform below the national average on the key clinical indicators. Our report shows that this is possible for all Lewisham practices, regardless of the deprivation levels or numbers of older patients in their catchment population. Our analysis shows that there is no correlation between clinical quality, deprivation and age, although ethnic differences might explain some practice variation; some of our practices in the most deprived parts of Lewisham, with the highest proportion of older patients, achieve the best outcomes.

It is my sincere hope that Lewisham General Practices will be even more ambitious than simply to strive for the national average. I hope that, inspired (and supported) by those Lewisham practices who already far outperform the national average, they will strive to be the best in the country at identifying and treating patients with high blood pressure, high cholesterol, diabetes, and chronic lung disease. Whilst the PCT is still in existence (it will cease to exist by 2013), it will do all it can to support practices in this aim, and will be supported by Lewisham Hospital, the council, and the voluntary sector. Together, with Lewisham general practices at the vanguard, we can find the missing thousands of undiagnosed patients and avoid hundreds of unnecessary deaths every year.

Dr Danny Ruta
Director of Public Health for Lewisham
Executive Summary

This Annual Public Health Report (2008/09) focuses on primary care, in recognition of the potential impact these services can make to the health of the population, particularly in increasing life expectancy and reducing health inequalities in Lewisham. Around 90% of NHS activity takes place in primary care, and for most people this is their first point of contact with the NHS. Primary care also acts as gatekeeper to other NHS services such as those provided by community health services and more specialised services in hospitals.

This report profiles the prevalence of a number of chronic diseases in primary care and looks at the clinical outcomes achieved using the data recorded by GP practices as part of the Quality and Outcomes Framework (QOF). The data are for the financial year 2008/09. The report focuses on those diseases and selected relevant clinical outcomes that contribute most to the gap in life expectancy in males and females in Lewisham compared to England.

Under the new NHS reforms, GPs are to take on most of the commissioning of local services, and at the same time there is a need to reduce the reliance on hospital-based care. Therefore this is a good opportunity to examine the robustness of the local data and to understand local population needs. More importantly, the report identifies practices where more can be done to save lives through improvements in the identification and management of disease and risk factors in primary care.

Population

Lewisham has an estimated population of 265,000, and has a younger population profile than the national average, with fewer people aged 65 and over and a larger younger working population in the 25-45 age band. It is ranked the 39th most deprived borough in England. It is culturally diverse with approximately 40% of the overall population from Black and minority ethnic groups, rising to 65% of school age children.

Organisation of general practice

In 2008/09 there were 48 GP Practices in Lewisham. Of these practices, 15 were commissioned via a General Medical Services Contract (GMS) and 33 by a Personal Medical Services Contract (PMS). There were a total of 187 GPs. There were ten single handed practices.

Lewisham’s 48 General Practices are organised into four Practice Based Commissioning Clusters (now known as clinical commissioning clusters). Clusters are GP Practice consortia which work together to plan, commission, re-design and develop new services for their registered populations.

More detail about the location and population of the 4 clusters can be found in the main report.

Quality and Outcomes Framework

The Quality and Outcomes Framework (QOF) was introduced nationally as part of the new General Medical Services (GMS) contract in 2004. It required practices to maintain registers of patients with certain conditions and report on clinical management and a number of related clinical outcomes.

Whilst acknowledging that QOF provides extremely valuable data, it is important to recognise that there are limitations to the data which may be relevant in explaining variations between practices and across different parts of the borough, as well as overall performance.

When compared to national performance across a range of QOF indicators, Lewisham as a whole compares poorly, falling into the lower 10-25%. Lewisham is ranked second from the bottom when overall QOF performance is compared with other Spearhead PCTs (deprived areas). However, it should be noted that Lewisham has undertaken a very active approach to QOF data validation and reviews of exception reporting every year since its inception in 2004. It is known that this has reduced the overall QOF scores but will reflect a more accurate position.

Since the introduction of the QOF, the numbers of patients on Lewisham GP disease registers has increased year on year with the exception of CHD, where the number has decreased slightly over a four year period. The increased number of patients on registers is a positive indication that diagnosis of chronic disease is improving, although the increased numbers may present a challenge to practices in managing their patients. There has been little year on year improvement in the achievement of the QOF clinical outcomes since 2006/07.

Circulatory Diseases

There were 5,509 patients on CHD registers, a prevalence of 1.9%. All Lewisham practices record lower prevalence of CHD than would be expected based on the national prevalence models. This equates to an estimated 3,599 ‘missing patients.’ Cluster 1 performs particularly poorly with less than 50% of the expected number of people with CHD recorded on disease registers. Cluster 3 performs the best, but

1 DH 2008 NHS Next Stage Review: Our vision for primary and community care
still falls short of the London and England achievement for identifying the expected number of cases.

All four Lewisham clusters record a lower percentage of CHD patients with a cholesterol of equal or less than 5mmol/l than the England average of 82.1%. However, eight practices do perform well and exceed the England average.

Prescribing rates for beta blockers for patients following a heart attack are similar to the England average (72.9%) across all four clusters, although five practices recorded rates above 85%. Two practices recorded prescribing rates below 60%.

### Stroke and TIA

There were 3,033 patients recorded as having had a stroke. This equates to a prevalence of 1%. There appears to be considerable under-recording of stroke on GP registers based on the expected prevalence. There are estimated to be an additional 1,664 patients who have had a stroke or TIA but are not recorded on the disease register. Given that stroke is more common in Black and minority ethnic groups, it would be reasonable to expect Lewisham to have a higher number of patients with stroke. Only one practice in Cluster 2 recorded a higher number of patients with stroke/TIA than expected based on the national prevalence models.

### Hypertension

There were 30,669 patients on GP registers with hypertension, equating to a prevalence of 10.3%. Lewisham practices record less than half the expected prevalence of hypertension (46%), indicating that there are an additional 31,905 patients with hypertension not on GP disease registers. London's rate is 51%, and England's 55%. The proportion of patients in Lewisham whose blood pressure is controlled at 150/90 or lower is 74%. All four clusters have a lower achievement than the England average of 78.6%. Seven practices achieved levels of control higher than the England average.

### Heart Failure

There were 1,454 patients with heart failure recorded, a prevalence of 0.5%. Fifty percent of Lewisham's expected number of heart failure cases are recorded on GP registers. Lewisham recording of heart failure is similar to London (51%), but lower than for England (55%). Cluster 1 records the lowest proportion of cases. Cluster 3 records a higher prevalence than London; Clusters 2 and 4 record higher proportions than both London and England.

### Atrial fibrillation

There were 1,923 patients recorded with atrial fibrillation, a prevalence of 0.7%. Eighty-six percent of the number of Lewisham's expected cases are recorded on GP registers. The figure for London is 88%, and that for England is 106%. Cluster 1 records the lowest proportion of cases. Cluster 4 records a higher prevalence than London. Two practices record higher levels of atrial fibrillation than expected.

### Respiratory Disease

#### Asthma

There were 15,416 patients registered as having asthma. This is a prevalence of 5.2%. Fifty-three percent of the expected number of asthma cases in Lewisham's are recorded on GP registers. London's figure is 58%, and England's is 64%. Cluster 1 recorded the lowest proportion of cases. Cluster 4 recorded higher rates than England.

#### Chronic Obstructive Pulmonary Disease (COPD)

Fifty percent of the expected number of COPD cases in Lewisham were recorded on GP registers. This is higher than London's figure of 37%. The figure for England is 56%. Recording of Forced Expiratory Volume (FEV1) varies across clusters in Lewisham from 76.9% to 81.4%. All four clusters are lower than the England average of 82.5%. However, nineteen practices achieved a FEV1 recording above the England average. It should be noted that some of these practices had very small numbers of COPD patients; for example, one practice only recorded two patients with COPD.

#### Dementia

Lewisham has a lower prevalence of dementia (1.2% of the population over 30 years old or approximately 1,781 people) than the London average, with very small numbers (48) of early onset dementia for over 30’s. Forty percent of the expected number of dementia cases in Lewisham were recorded on GP registers. The figure for London and England is 39%. Cluster 1 recorded the lowest proportion of cases in Lewisham.

#### Diabetes

Lewisham's GP registers recorded 110% of the expected number of cases of diabetes. The figure for London was 104%, and that for England was 88%. Every cluster in Lewisham recorded higher rates than England. The model to predict expected prevalence of diabetes is no longer considered robust and thus these results should be used for crude benchmarking purposes only. Achievement of HbA1c levels of 7.5 or less in patients with diabetes varied across clusters in Lewisham from 57.5% to 65.7%. All four clusters were lower than the England average of 66.3%. Twelve practices exceeded the England average for HbA1c outcome.
Achievement on key disease prevalence and clinical outcomes most likely to impact on life expectancy and health inequalities

Through the Quality & Outcomes framework (QOF) clinical data has been collected nationally, from all practices in England. This data looks at achievements against clinical indicators and expected prevalence of various diseases. In order to assess overall performance in contributing to life expectancy and reducing health inequalities, each GP Practice in Lewisham has been classified by its quintile position on key outcome indicators in the overall spectrum for England (Quintile 1 being the practices in England having the lowest values for the indicator, Quintile 5 being those with the highest values). Table 1 includes the results from 11 key areas, these results have then been ranked by the sum of the quintile scores in order to provide an overall assessment of performance in diagnosing and managing patients most at risk of premature death. (Best score would be 55 worst score would be 11). In each case, practice data are represented by the average deprivation for the practice’s registered patients (calculated from the IMD 2007 figure for the Lower Super Output Areas corresponding to the patients’ postcodes) and the percentage of the registered population aged under 5 or over 65 years old. There was no significant correlation between the indicators and either deprivation or proportion of patients in these age groups. QOF achievements are calculated using observed numbers of patients (i.e, those recorded on the practice disease registers). These can be misleading when there are very small numbers of observed patients: a practice may have good outcomes, but have identified only a small fraction of its expected cases. Table 1 shows the clinical achievement indicators calculated using the number of patients with the specified clinical outcome as numerators, with the expected numbers as denominators, for blood pressure control in hypertension, cholesterol control and beta blocker prescription in coronary heart disease and forced expiratory volume in chronic obstructive pulmonary disease. HbA1c control in diabetes is also presented but, due to the limitations of the diabetes model, the actual prevalence is used as the denominator. The models for calculating expected numbers of patients have their limitations and do not fully take into account factors such age and ethnicity of individual practice populations; this is equally so for all practices nationally. This may account for some of the variance between Lewisham practices and the national position. It should also be noted that some practices have undertaken significant development work since 2008/9, and the outcomes will not be seen until the 2009/10 data are analysed. However, we believe this current analysis will prove invaluable for Lewisham practices seeking to take stock of their systems and processes.
### Table 1 A summary of achievement based on 2008/09 QOF data, against the key disease prevalence and clinical outcomes that are most likely to impact on life expectancy and health outcomes

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It is clear from this exercise that the majority of practices in Lewisham achieved better than the national average on at least one indicator and a small number of practices that achieved this across a number of indicators. However, there were also a very small number of practices that, for the majority of the indicators explored, achieve below the national average.

Prescribing and clinical achievement

Pharmacological treatment is key to the outcome of many long-term conditions. Two QOF clinical outcomes, achievement of cholesterol levels and HbA1c and prescribing volumes at practice level, were explored to assess the effectiveness of prescribing at a population level.

There was marked variation in prescribing volumes of lipid lowering drugs and the percentage of patients on practice CHD registers with cholesterol levels within the accepted range (less than 5mmol/l) to reduce risk of heart disease. There were a number of practices that appear to have high volume prescribing but were not achieving better outcomes than their peers. There were also a number of practices that prescribed lower volumes but achieved worse clinical outcomes compared to their peers, suggesting that they could prescribe more appropriately and improve patient outcomes.

Oral diabetic hypoglycaemic prescribing volumes were similar across the majority of practices in Lewisham. However, the percentage of patients on the diabetes register in whom the last HbA1c is 7.5 or less in the previous 15 months (QOF Indicator 2008/09) varied considerably across practices. This would suggest that clinicians were prescribing in a similar manner. One hypothesis for the variation may be that there is a difference in practice populations resulting in a difference in patients’ understanding of their therapy and their subsequent concordance.

Emergency Admissions

Overall, Lewisham’s standardised rate of emergency admissions was 83.5 per 1,000 registered patients, which was lower than London at 85.6, but higher than England’s 78.0. However, there was much variation between practices. Two practices had significantly lower admission rates than England.

Cancer Screening

Breast screening coverage is defined as the percentage of 53 to 64 year old eligible women who have been screened in the last 3 years. The national target is currently 70% coverage. In 2008/09 Lewisham did not reach this target. No practice list in Lewisham reached the 70% target.

The Cervical Screening Programme target for five-year coverage is 80%. The national coverage rate dropped from 80.6% to 78.6% between 2003/04 and 2008/09. In Lewisham the coverage rate dropped in the same period from 75.5% to 74.5%. Coverage varied considerably by GP practice; in 2008/09, five practices achieved coverage of 80%, nineteen practices coverage of between 75% and 79% and one practice had the lowest coverage of 55%.

The National Bowel Screening programme was launched in Lewisham in January 2008. The national target for bowel screening is 60% uptake. At a national level, the uptake at end of December 2009 was 53%, for London 40%. At the end of December 2009 nearly 20,000 invitations had been sent out and 7,820 kits returned, resulting in an uptake of 39%. Uptake by GP practice is not available for this period.

Childhood Immunisation

In Lewisham the recorded uptake of key immunisations between March 2005 and the end of June 2009 increased, and by the end of this period was line with the London average. Uptake of the second dose of MMR and the preschool booster also improved to 59.6% (MMR2) and 59.9% (preschool booster), but was still below the London average of 69% (MMR2) and 68% (preschool booster) at the end of the period.

Within Lewisham, there was considerable variation between GP practices in the proportion of their registered children who have been vaccinated.

Smoking

The ‘GP recorded Smoking Prevalence’ data collection is designed to provide a measure of the prevalence of smoking at a local level. However, the data were incomplete and it is thought that some smokers are reluctant to inform their GPs that they continue to smoke. The smoking prevalence for 2008/9 ranged from 17% to 24% for the Lewisham registered practice population aged 16 and above. The average was 18%, with an estimated prevalence of 26.8%. In 2008/9, 70% of smokers who set quit dates with the Stop Smoking Services set them in a primary care and 17% in pharmacies. In 2008/9, the Stop Smoking Service achieved 1584 quits in total. Sixty-one pregnant women smokers used the service to stop, three times the number in 2007/8. Six percent of Lewisham’s estimated 56,000 smokers set a quit date in 2008/9, more than the NICE guidance minimum standard of 5%. However, eighteen practices did not provide a Stop Smoking Service or actively refer to the Stop Smoking Service.

Conclusions

Delivering health services to the population in Lewisham can be challenging. High population turnover and patient turnover in primary care can make it particularly challenging to establish the type of clinical relationship required for optimal management of many long term conditions.

When considering disease prevalence, it has been estimated that there may be over 55,000 people in Lewisham with undiagnosed disease. If the figure is an overestimate, it does indicate that there is still much to do to identify people with disease. The implementation of the NHS Health Checks will help identify some of the undiagnosed. There was variation across the four clinical commissioning clusters in Lewisham in terms of expected disease prevalence versus recorded prevalence. For example, for COPD, Cluster 3 had a higher recorded prevalence than those of the other three clusters. This may be a result of the active case-finding initiative, part of the community spirometry pilot that operated in this cluster in 2008.
It is interesting to note that for those diseases where the clinical outcome indicators have been explored (cholesterol control, prescribing of beta blockers, blood pressure measurement, FEV1 measurement recorded, and control of HbA1c), there was little variation between the clusters. Overall, Lewisham practices were less successful than practices elsewhere in England in managing some key clinical indicators. However, for each indicator considered, there were a number of Lewisham practices that performed as well as, or exceeded, the English average on one or more indicators. In some cases performance on clinical outcomes also reflected performance across the whole pathway, reflecting activity in both primary and secondary care. For example, appropriate prescribing may be initiated in secondary care rather than primary care, but would contribute to a practice’s QOF performance. Equally, failures across the system occur where patients do not have adequate management plans or do not receive optimal treatment in either or both settings.

A National Audit Office report has stated “it is too early to say conclusively if the QOF has led to improved outcomes for patients, but some evidence exists to suggest that modest improvements have been made in controlling asthma and diabetes”. In Lewisham in the past three years, there has been a slight improvement in achievement represented by the clinical indicators examined in this report. However, QOF in its current form does not appear to be driving further improvement and in many cases opportunities are being missed to improve outcomes at a population level.

It should be recognised also that 70% achievement in QOF also means 30% failure. It is likely that the large proportion of vulnerable and complex patients will be concentrated in this final 30%. This will include, for example, people from black and minority ethnic groups and vulnerable groups such as those with learning disabilities, enduring mental health problems and those with chaotic lives. For such groups it will require disproportionate effort and resources to achieve the same outcomes.

There is strong evidence that primary care has a crucial role in the promotion of the uptake and, where appropriate, the delivery of immunisation and screening and the delivery of brief interventions to reduce lifestyle risks such as smoking. Benchmarking performance both within clusters, across Lewisham practices and to external national benchmarks is important when trying to explain variation in quality and ‘raising the bar’. The cause of any variation may be multifactorial. Key to reducing it is the implementation of a common systematic management approach to long-term conditions that includes: the establishment of registers; the recall and review of patients as appropriate, and adherence to recognised protocols. The sharing of experiences by the best performing practices could greatly help to drive up performance.

Primary care performance needs to be seen in the context of population health. The effective management of conditions such as hypertension, diabetes and CHD has the potential to make a real contribution to the life expectancy of the overall population. Conversely, failure to effectively identify, treat and manage these and other conditions leads to many avoidable deaths and considerable disability.

Many patients may not be aware of the seriousness of their symptoms or that treatment is available to reduce risk of further disease. Benefits of screening and signs and symptoms that should prompt self referral to primary care should be widely publicised to patients.

Recommendations

- Performance should be benchmarked across all Lewisham practices and action taken to improve performance in the worst performing practices with peer support from best performing practices.
- QOF targets need to be supplemented by local targets and reviewed nationally in order to drive up and continuously improve performance rather than allowing it to plateau.
- Incentives should actively encourage case finding. Having identified the patients, practices should be given guidance and best practice advice to enable them to manage these patients effectively. Practices that are successful in actively finding and managing patients should be congratulated and encouraged to maintain their success and share best practice with others.
- Effective pharmacological (drug) management of many long term conditions needs to be supported by both clear clinical advice to clinicians on current best treatments (supported by audits) and appropriate advice to patients on their concordance (over many years) with the therapies prescribed.
- Case finding of the ‘missing’ patients should be actively promoted within primary care and with the general public. Many patients may not be aware of the seriousness of their symptoms or that treatment is available to reduce risk of further disease. Benefits of screening and signs and symptoms that should prompt self referral to primary care should be widely publicised to patients.
- Primary care clusters should encourage practices to adopt robust and systematic clinical and management processes, particularly around immunisation, chronic disease management and screening, to help drive up performance.
- Primary care has an important public health role in relation to lifestyle interventions and, whilst these are not well captured within QOF, it is essential that they are not overlooked. In Lewisham, Enhanced Services have been introduced to support these areas. In particular, brief interventions around smoking, exercise, weight management and alcohol are ideal for delivery in a primary care setting. Referral to health trainers can support practices in the delivery of these interventions. Consideration as to how these types of interventions can be systematically embedded into primary care practice and monitored robustly is required.
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1 Introduction

Lewisham is a diverse and vibrant inner London borough characterised by a large Black and ethnic minority population, a young population and considerable mobility in and out of the borough. The National Health Service (NHS) in Lewisham faces many challenges in the delivery of healthcare to its population, including high patient turnover within GP practices, a young mobile population that is less likely to engage with health issues, cultural and language barriers for many residents as well as high demand for services. There are significant health inequalities across the borough which means that health outcomes for Lewisham residents are poor compared to England. This Annual Public Health Report focuses on those diseases (cardiovascular disease, diabetes and respiratory disease) and selected relevant clinical outcomes that contribute to the gap in life expectancy in males and females in Lewisham compared to England, and how they are managed in primary care.

1.1 Why focus on primary care?

Primary care services are those provided by General Practitioners (GPs), practice nurses, pharmacists, dentists and optometrists. For the purpose of this report we have used the term primary care to describe the care provided by GPs and their primary health care teams. Around 90% of NHS activity takes place in primary care and for most people this is their first point of contact with the NHS. General practice is therefore a unique setting that offers an unrivalled opportunity for working with the majority of the local population to improve their health and to manage their health problems.

Primary care also acts as gatekeeper to other NHS services such as those provided by community health services and more specialised services in hospitals. For this reason the role of primary care is vital in managing demand for other NHS services both through managing patients within the practice and referring on where appropriate. In addition to making referrals, primary care plays a key role in ensuring that patients are seen in the most appropriate setting. Due to increasing demand and limited resources, the need to maximise the effective use of services is very important. Increasingly referrals are likely to be to more specialised community services or specialist GP services, rather than to hospitals.

This report profiles the prevalence of a number of chronic diseases in primary care using the data recorded in GP practices as part of the Quality and Outcomes Framework (QOF). The availability of this information gives primary care organisations and clinical commissioners the opportunity to consider how local prevalence may reflect the need for health care, opportunities for prevention of certain conditions and the overall quality of the care provided. Because it is likely in the future that more community services will be commissioned by primary care under clinical commissioning arrangements, this is a good opportunity to examine the robustness of the local data and help clinical commissioners understand local population needs.

As NHS resources become squeezed by rising costs and increased demands, the role of primary care professionals in commissioning services and as gatekeepers will become more important than ever.

1.2 Long term conditions

Over the past five to ten years there has been considerable emphasis on the management of long term conditions or chronic diseases. In addition to improving the health, well being and independence of people with long term conditions, effective management within primary care can also prevent emergency hospital admissions and reduce the time people spend in hospital. It is estimated that long term conditions account for 70% of total health and social care expenditure, 50% of GP consultations, 65% of outpatient appointments and 70% of inpatient bed days. There is good evidence that support for self care can reduce consultations in primary care and improve a patient’s ability to manage their condition, improving outcomes.

The NHS and Social Care Long Term Conditions Model has three levels of care for patients: Level 1 is supported self care - these are patients who are generally managed in primary care with minimal intervention; Level 2 is disease management, which is active management of the patient’s condition, generally in primary care but perhaps with some specialist input; Level 3 is case management, which involves patients who are heavy users of hospital services, at high risk of admission and may have multiple conditions and complex needs. These cases are managed by community matrons with support from GPs and hospital specialists. The shift of patients from acute hospital settings to community and primary care settings in relation to long term conditions has potentially increased the workload of primary care. There has been an increase in the average number of consultations per patient per year across England since 2000. In 2000, the crude primary care consultation rate was 4.23 per year, and by 2008 it was 5.25 per year. It is suggested that much of this increase is due to an increase in patients seen by practice nurses.
1.3 Links to Joint Strategic Needs Assessment

Each year, the London Borough of Lewisham and NHS Lewisham produce a Joint Strategic Needs Assessment (JSNA)\(^\text{12}\). This provides a basis for determining which services are priorities for Lewisham and how they should be commissioned. The NHS Lewisham Commissioning Strategy Plan (CSP) then articulates how they will be commissioned. From 2011 onwards it is anticipated that the JSNA will be a ‘live’ and on-going ‘process’, and its analyses and recommendations will be available on the internet and constantly updated. The JSNA provides a comprehensive overview of local needs and can be referred to for more detail about the local population.

1.4 Structure of the report

The report gives an overview of primary care by individual GP practices in Lewisham and by GP clusters. Chapters 3 & 4 describe the delivery of primary care and the QOF data. This builds a picture of local need and performance and allows comparisons between practices and clusters of GP practices. The difference between the expected prevalence of disease versus that recorded in primary care in Lewisham, London and England is presented. Chapters 6, 7 and 8 specifically review the contribution made by Primary Care towards the Public Health needs of the population in relation to screening, smoking and immunisation. Finally, some conclusions and recommendations are presented.

2 Overview of Lewisham

Lewisham stretches from the banks of the Thames in the north to the borders of Bromley in the south, with a total area of 13.4 square miles. Lewisham is one of the greenest parts of south-east London: over a fifth of the borough is parkland or open spaces, and this combines with Lewisham’s residential neighbourhoods and waterway network to create a pleasant environment in the midst of bustling city life. The small stretch of Deptford riverside, now known as Convoy’s Wharf (formerly The King’s Yard), was the site of the first Royal Dockyard, established by Henry VIII in 1513. Francis Drake was knighted here, and Raleigh, Frobisher, and later Captain Cook, embarked on voyages of exploration from Deptford.

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\(^{12}\) The most recent JSNA was updated in January 2010. Available at: [www.lewishampct.nhs.uk/index.php?assetId=2331&assetGroupId=2330](http://www.lewishampct.nhs.uk/index.php?assetId=2331&assetGroupId=2330)
2.1 Lewisham’s Wards

There are eighteen electoral and statistical wards in Lewisham\textsuperscript{14} (see figure 2.2).

Figure 2.2 Map of Lewisham electoral wards

2.2 Population

At the 2001 census\textsuperscript{15}, Lewisham had a population of just below 250,000 people. The best current estimate is about 265,000\textsuperscript{16}. The population is relatively young. Twenty five percent of residents are aged under 19 years, which is similar to the position in England as a whole, but the population aged 60 years and over is smaller, at about 14% compared with more than 20% in England\textsuperscript{17}. Lewisham’s population has particularly high proportions in the younger working age population groups. Overall, Lewisham’s population is expected to rise by about 20,000 (7.6%) people in the period from 2009 to 2015. The greatest increase will be in the school-age (5 -14) group, which is expected to increase by 14%, while the smallest increase is expected in the elderly population (4% in the 65-84 band, and 1.4% in the over 85s). The largest contributor to this increase is expected to be Evelyn Ward. This includes the Convoy’s Wharf area, parts of which are expected to be developed under the Thames Gateway urban regeneration scheme. Other major developments include the Lewisham Gateway, in Lewisham Central.

2.2 Diversity

Lewisham has a very diverse community. Over 170 languages are spoken, and two out of every five residents come from a Black or minority ethnic (BME) background. The largest BME groups are Black African and Black Caribbean; Black ethnic groups are estimated to comprise 30% of the total population of Lewisham. The age profile of the BME groups is younger than that of the White groups, and 65% of school pupils in Lewisham are from BME groups. The Lewisham population is likely to grow and will become increasingly diverse, with a higher proportion of residents from BME backgrounds and new communities arriving from the European Union and beyond.

Figure 2.4 shows the estimated breakdown of Lewisham’s population, by major ethnic group.

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\textsuperscript{14} Electoral ward are those for which councillors are elected. Statistical wards are units that the Office of National Statistics use for release of Census and other data. In Lewisham, they are the same.

\textsuperscript{15} Office of National Statistics, Census 2001

\textsuperscript{16} GLA Round 2008 PLP Low population projections

\textsuperscript{17} Office of National Statistic population estimates mid-2008, and GLA Round 2008 PLP Low population projections.

\textsuperscript{18} GLA Round 2007 PLP Low population projections
2.3 Births

Between April 2008 and March 2009 there were over 4870 live births\(^{19}\) to Lewisham residents. Around 30% of births were to women from Black ethnic groups, and 5% were from Asian ethnic groups, reflecting their proportions of the population. Around 43% of births were to women in the White ethnic groups, very much lower than their proportion of the population, reflecting the different age demographic in this group. Other ethnic groups made up 10% of women giving birth, much higher than their proportion of the population, and 9% of births did not have the mother’s ethnicity recorded. Ten percent of births were to women aged under 20 years and 10% of births were to women aged over 40 years. Since 2002, births in Lewisham have increased by 29%\(^{20}\). This trend is expected to continue until at least 2015\(^{21}\).

2.4 Deaths

In the period 2005-2008 there were approximately 1800 deaths of Lewisham residents per annum. Of these, 63% took place in hospitals, 17% at home, 12% in nursing homes, 6% in hospices, and 2% elsewhere.

One third of all deaths are due to circulatory diseases (cardio-vascular disease and stroke). A quarter of deaths are from cancer. Respiratory diseases account for 15% of deaths in Lewisham.

2.5 Living Arrangements

In 2007\(^{22}\), one household in five was a single person. Half of these were pensioners living alone. Pensioner couples made up one household in twenty. Single parents made up one household in seven.

Between 2001 and 2007 the proportion of households in private rented accommodation more than doubled, from 14% to 30%. There were significant reductions in proportions of both social rented housing and owner-occupiers with mortgages. In 2007, 10% of households were overcrowded. For BME groups, 20% of households were overcrowded.

2.6 Employment and income

At December 2008, the employment rate was 72%, the highest this century\(^{23}\). In the year to December 2008, the number of unemployed people fell from 12,500 to 10,800. Average incomes in Lewisham are about 10% below the London average. Females earn about 7% less than the London average and males earn about 13% less than the London average.

2.7 Education

Whilst attainment at key stages 1, 2 and 3 is generally below attainment across London, in 2008 Lewisham ranked equal 2\(^{nd}\) for 5 + A* - C grades including English and Maths, out of 8 statistical neighbour London boroughs who submitted results. At 60%, Lewisham is just 2% below the national average.

Lewisham’s vulnerable groups continue to improve and to outperform set targets for their GCSEs 5+ A* - C achievement in 2008. The achievement of ‘looked-after children’ has increased to 10% which is above the 2008 target of 5.3%. Black Caribbean boys receiving free school meals (FSM) increased their overall achievement by 24% to 40% from 2003 to 2008, as have White British boys receiving FSM. The gap between those receiving FSM and those not receiving FSM is narrowing and now stands at 18%, a reduction of 28% over the last three years.

2.8 Deprivation

In the most recent set of the English indices of deprivation, the Index of Multiple Deprivation (2007) (IMD)\(^{24}\) ranked Lewisham as the 39\(^{th}\) most deprived of the 354 local authorities in England. Deprivation varies across the borough. The lowest geographical level for which it is calculated is the Lower Super Output Area (LSOA)\(^{25}\). Deprivation scores have also been calculated for wards. Deprivation is strongly correlated with a range of health problems and outcomes.

Figure 2.5 shows the distribution of IMD scores across Lewisham by ward. The higher the IMD score, the more deprived the wards. The most deprived ward is Evelyn at the extreme north of borough, followed by Bellingham and Downham in the south of the borough. The least deprived is Catford South.

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\(^{19}\) Source: ONS

\(^{20}\) Source: ONS Public Health Birth Files

\(^{21}\) GLA Round 2008 PLP (Low) population projections

\(^{22}\) Lewisham Household Survey 2007

\(^{23}\) Source: nomisweb.co.uk

\(^{24}\) Source: Communities and Local Government, 2007

\(^{25}\) SOAs were defined for presenting 2001 census information. They have an average of about 1,500 persons residents
Figure 2.6 shows the distribution by Lower Super Output Area (LSOA).

No LSOA in Lewisham is in the least deprived 10% of the country, and only two of the 166 LSOAs in the borough are in the least deprived 20% of the country.

3 The Organisation of General Practice in Lewisham

3.1 GP Practices - GPs as providers of care

In 2008/09 there were 48 GP practices in Lewisham. Of these, 15 were commissioned via a General Medical Services Contract (GMS) and 33 by a Personal Medical Services Contract (PMS). There were a total of 187 GPs. There were ten single handed practices.

In future years we would expect to see a reduction in the number of practices as we anticipate that some to ‘join’ in various ways, resulting in larger organisations. Alongside this we would expect to see more Alternative Personal Medical Services Contracts (APMS), which are time-limited contracts that are potentially more flexible and responsive.

In addition to the core primary care contracts, the PCT commissions a range of enhanced and extended services from individual practices. Enhanced services cover a range of areas including access, immunisation/vaccinations, stop smoking, minor surgery and extended services such more complex aspects of diabetes care.

3.2 Practice Based Commissioning (Clinical Commissioning) - GPs as commissioners of care

Practice based commissioning (PBC) has been a major element of NHS policy since 2005, and gives front-line clinicians more control over commissioning arrangements for local health services. Whilst called ‘practice based’ commissioning, in reality the economies of scale required to commission NHS services mean the practices are organised into consortia or, in Lewisham, into ‘clusters’, so that they cover populations which are large enough to make real changes to commissioning arrangements. PBC has had a chequered history and it has been difficult to engage clinicians at national and local levels. A 2009 survey by the King’s Fund found that 52% of clinicians reported being not at all engaged or not very engaged with PBC. The reasons for this are complex, but include the fact that budgets were not clearly...
defined, the length of time taken to make and action decisions in relation to business cases put forward through PBC, the lack of capacity within the consortia or PCTs to provide the necessary support in terms of data and administration and management support, and the level of commitment and buy-in from all clinicians within a cluster to change services, which needs to be substantial and may include a degree of risk.

Lewisham’s 48 general practices are organised into four Practice Based Commissioning Clusters. Clusters are GP Practice consortia that work together to plan, commission, re-design and develop new services for their registered populations. Membership of clusters is fairly stable; practices may move between clusters, but this is infrequent.

Practice based commissioning, now known as clinical commissioning, recognises the central role of primary care clinicians - through the hundreds of thousands of treatment and referral decisions they make each day - in using NHS resources to deliver high-quality care for all. Clinical commissioning gives local clinicians much greater power and influence, working in partnership with PCTs, to shape how these resources are invested so that they deliver better health, better care and better value for local practice populations and for taxpayers.

3.3 Practice demographics

It is not possible to precisely define a fixed border for each cluster’s area, because the location of patients registered with GP practices is fluid, and the practices’ preferred catchment areas overlap and do not follow any administrative boundaries. However, practices within a cluster tend to be located close to each other, as the map in Figure 3.1 shows. The list of the practice names by their position on the map can be found in Appendix I (Table AI.I).

Cluster 1 serves the North and North East of the borough.
Cluster 2 serves the central bands and North West of the borough.
Cluster 3 serves the South East of the borough.
Cluster 4 serves the South West of the borough.

3.4 GP practice and cluster populations

Lewisham experiences high patient turnover. At the 2001 Census, 15% of respondents in the borough reported changing address in the previous twelve months. Analysis of registrations of patients with GP practices in Lewisham confirms an average turnover of about 15% per annum. The actual population turnover is thought to be rather higher, in the region of 25% per annum. Lewisham residents include large numbers of transient young people who may never contact the health services during their period of residence.

Practice populations extend across the borough’s boundaries. Some of Lewisham’s GP registered population live in neighbouring boroughs, and some residents of Lewisham are registered with GP practices outside Lewisham.

Table 3.1 shows the registered populations for clusters in Lewisham as at 31 March 2009, the age profile of the clusters, and the deprivation score (from the Index of Multiple Deprivation (IMD) 2007, based on the SOA of patients’ residence). Figure 3.2 shows the age band breakdown by cluster, and percentage of the cluster total. Deprivation is well known to be closely linked to health status and health outcomes; therefore the deprivation score is an indicator of relative levels of expected need for health care. The higher the deprivation score, the higher the level of deprivation.

Table 3.1 Cluster Populations and Deprivation

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</tr>
</tbody>
</table>

A breakdown of IMD by practice with the registered practice population is available in Appendix I (Table AI.II).

Figure 3.2 Age Band Structure of Lewisham GP Cluster Patients

Cluster 1 has the lowest proportion of children (<15) and of the elderly in each of the three 65+ age bands. It has the highest proportion of younger working-age (15-44) people.
Cluster 3 has the highest proportion of children and of the elderly in each of the three 65+ age bands. It has the lowest proportion of younger working-age (15-44) people.

Clusters 2 and 4 have very similar population structures.

Cluster 1 is overall the most deprived. Cluster 2 is the least deprived. However, there is considerable variation between practices within the clusters. Figure 3.3 shows the spread of deprivation by practice, within cluster. Full details of deprivation score and practice population size are given in Table AI.II in the Appendix.

The total number of GP-registered patients is some 30,000 (~12%) higher than the estimated number of residents of Lewisham. Nationally, it is estimated that there is a 7% discrepancy between registered patient lists and population estimates.

When NHS patients move and register with a new GP practice, the patients are automatically removed from the old practice’s list. However, if they move out of the borough and do not register with a new GP, they will remain on the practice list unless a decision is taken to remove them. Patients who leave the country do not always notify their GPs, and may remain on lists until the lists are systematically cleaned. However, it is unlikely that this will account for a discrepancy of this magnitude. Official population estimates are ultimately derived from the most recent census and in 2001, certain sections of the population were known to have been under-counted. In inner London it is widely believed that the population estimates are lower than the actual numbers of residents.

All the expected prevalence for health conditions used in the subsequent sections of this report were derived from the registered practice populations.

3.5 Lewisham’s health priorities and management in Primary Care

Lewisham’s health priorities are set out in the NHS Lewisham Commissioning Strategy Plan. Of these, the following may be particularly influenced by improved management in primary care:

- to increase life expectancy in Lewisham and reduce premature mortality in the borough by earlier diagnosis and effective intervention in conditions which are the major causes of death in the borough in particular cardiovascular disease and cancer
- to improve end of life care
- to improve care of people with long term conditions
- to improve care for people with dementia
- to increase uptake of immunisation in children

3.6 Main Causes of Death in Lewisham

The main causes of death in Lewisham are circulatory diseases, followed by cancer, and respiratory disease. This reflects national data for England and Wales. The exact proportions vary from year to year, but around one death in three is from circulatory disease, one death in four is from cancer, and one death in seven is from respiratory diseases. Figure 3.4 shows a more detailed breakdown for the most recent data available.

![Figure 3.4 Main underlying causes of death, 2008/9](image)

More details of mortality rates can be found in Lewisham’s Joint Strategic Needs Assessment.
4 Quality and Outcomes Framework

The Quality and Outcomes Framework (QOF) was introduced nationally as part of the new General Medical Services (GMS) contract in 2004. Participation in QOF is voluntary for practices but all 48 Lewisham practices have participated every year. This framework created a system which remunerated general practices for providing quality care, and the ability to measure the level of this care, to their patients. The funding realised from achievements in QOF can be used by individual practices however they wish, but it was hoped that many would use this to fund further improvements to the quality of healthcare delivered in the practice. Linking resources with QOF outcomes aims to ensure that the work undertaken in general practice is adequately resourced, standards are consistent across the country, and a practice’s achievements are recognised. QOF is made up of a range of criteria, often referred to as indicators, which are grouped into four domains: clinical, organisational, patient experience and additional services. Achievement is measured against a set of evidenced based indicators, where points and payments are awarded according to the level of achievement. Importantly, the majority of points available within QOF are derived from the clinical domains and relate to the care provided to patients in disease specific groups, such as diabetes or asthma. The annual QOF performance results are publically available for all practices in England.

The 2004 UK GP contract is unique in international terms, providing an unprecedented empirical benchmark on the quality of healthcare delivered within primary care, but it has also supplied valuable new information on the prevalence of chronic disease in the UK population. Nationally, there is an increasing body of evidence which highlights the positive impact that the QOF is already having upon chronic disease, both in terms of the quality of healthcare delivered and the outcomes experienced by patients themselves. There is also very encouraging evidence that QOF is reducing the inequity in healthcare.

4.1 Exception reporting

The Quality and Outcomes Framework includes the concept of exception reporting. This has been introduced to allow practices to pursue the quality improvement agenda and not be penalised where, for example, patients do not attend for review, or where a medication cannot be prescribed due to a contraindication or side-effect. The GMS contract sets out the criteria that allow practices to participate in QOF but not to be penalised where exception reporting occurs. Lewisham PCT has, like many other PCTs, actively reviewed the level of exception reporting to ensure that the correct process has been followed. This is important, as any patients who are exception reported may, if the criteria have not been followed correctly, be excluded from receiving care that they need. In 2008/09, the overall exception rate across all clinical indicators for England was 4.87%. The overall exception rate for London was 4.66% and in Lewisham it was 4.44% which suggests that inappropriate exception reporting is unlikely.

4.2 Limitations of QOF data

Whilst acknowledging that QOF provides a tremendous amount of extremely valuable data, it is important to recognise that, in the next section, that there may be some variables that cannot be compared on a like for like basis. The list below highlights some of the factors that may have an impact on individual practice’s QOF achievement and thus need to be considered when reviewing QOF information.

The apparent outcome of performance relating to QOF clinical indicators may be affected by:

- High levels of patient turnover
- A very small or very large practice list size e.g. if there are only two patients eligible to be considered under a specific indicator – taking action for those two patients will give a 100% success rate
- High levels of exception reporting
- High numbers of patients with similar clinical issues registering with certain practices who can offer specialist advice which may skew the expected prevalence figures in a specific clinical area
- Practices registering high number of younger patients / older people, e.g. university or nursing home in their catchment area.
- Practices registering high numbers of patients from a specific ethnic group, with higher risk of disease or specific language requirements
- Poor recording of information on GP clinical systems e.g. using free text rather than Read codes.

Practices may excel in one clinical area rather than another, so looking at the picture across all areas for an individual practice is important.

32 Bland, D 2008 The New General Practitioners (GP) contract: improving the way healthcare is delivered in the UK. BMA.
33 Read codes are the recommended national standard coding system in General Practice. The codes facilitate the access of information within patient records to enable reporting, auditing, research, automation of repetitive tasks, electronic communication and decision support.
The impact of deprivation, age, sex and ethnicity may mean that areas within the borough vary significantly from each other.

In comparing results with other practices across England, it is important to take into account the PCT’s approach to actively monitoring the QOF results. A PCT that undertakes rigorous tests of the data is likely to result in lower individual practice performance achievement because inaccurate data are rejected. Where a PCT undertakes this approach, there is a level of validation of the information which should result in improved quality of care.

When a practice achieves the targets set out in QOF these are set at levels of less than 100%. E.g. a target achievement of 70% on a register of 100 patients will mean that 30% have not received the optimum treatment required to meet the target. A recent DH National Support Team visit recommended that PCTs and practices alike should be ambitious and work on reducing the number of patients not receiving optimum care.

4.3 An overview of performance in Primary Care in Lewisham.

The QOF can be expressed as a set of indicators that show how practices are performing relative to other practices in Lewisham, London and England. For clinical aspects, the indicators are expressed in terms of percentages, where the denominator is the number of patients recorded as having a specified condition, and the numerator is the number with the condition who have achieved a set clinical outcome.

Figure 4.1 shows the overall Lewisham average achievement for QOF clinical indicators and achievement for the major clinical conditions that are priorities for Lewisham. It also provides information about Lewisham’s position within the national range for the 152 PCTs in England. A full description of each indicator is available in the appendix (Table AI.III).

4.4 Disease Prevalence Definitions

In order to identify the population who will benefit from improved clinical management, it is necessary to understand how many people in the borough, and registered with each GP practice, can expect to have the identified long-term conditions. The term for this is prevalence. The word has technical meanings: point prevalence is the proportion of the population having a condition at a particular time, and period prevalence is the proportion of the population experiencing a condition during a specified period. In this context the interpretation is wider:

- for long term conditions, such as diabetes and COPD which, once identified, may be managed but not cured, the point prevalence is used.
- for certain high risk conditions, such as stroke, where a single occurrence means that a patient will need continuing monitoring and possible intervention even if the condition appears to have been cured or to have resolved itself, the prevalence is considered to be all those who have ever had the condition.

The true prevalence of any condition is unavailable, but certain risk factors are known for each condition. For each of the conditions for which practices maintain disease registers, national prevalence models have been developed that predict how many cases we would expect to be identified (on the basis of England-wide survey data) from each practice’s registered population. Therefore, it is possible to compare the number of cases actually identified with the number that would be expected for that population, and to make an estimate of unmet need. Data relate to the year 2008/9.

The estimates for the expected number of patients are based on an age and sex adjusted models. The model for CHD, hypertension, stroke and COPD also adjusts for ethnicity, deprivation and smoking status. However certain assumptions in the modelling process have been made. These include the following:

- The distribution of the ethnic groups within each age-sex group is the same as the overall distribution of the ethnicity for the practice.
- Smoking prevalence is the same across ethnic groups.
- Ex smoking prevalence by age group and sex is the same in all practices
- Disease prevalence in the population aged under 16 is 0%.

For some practices with a large BME population, these assumptions may not hold and the model may not be an accurate reflection of the true prevalence. For some conditions where ethnic group is a risk factor for disease, the expected number of cases may be disproportionately low.

<table>
<thead>
<tr>
<th>Table 4.1 Spearhead QOF Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spearhead QOF average</td>
</tr>
<tr>
<td>Minimum</td>
</tr>
<tr>
<td>Maximum</td>
</tr>
<tr>
<td>Lewisham</td>
</tr>
</tbody>
</table>

As the table shows, general practitioners in Lewisham have been much less successful in controlling blood pressure, cholesterol, and HbA1c than GPs elsewhere England. When overall QOF performance by Lewisham practices, as measured by the average QOF score, is compared to PCTs in other deprived areas (Spearhead PCTs), Lewisham is ranked second from the bottom.

34 DH Health Inequalities, National Support Team: Feedback, Systematic Delivery of Population Interventions
35 Calculated by NHS Primary Care Commissioning, http://www.pcc.nhs.uk/572
36 This statement assumes that all PCTs are taking the same rigorous approach to exception reporting and other checks that NHS Lewisham is undertaking.
37 NHS Primary Care Commissioning, http://www.pcc.nhs.uk/572
38 www.apho.org.uk
These models have been endorsed by the Association of Public Health Observatories. The models use data from the Health Survey for England (an annual study of a random sample of the national population) and a range of other data sources. They have been applied (by the NHS Comparators service) to each GP practice’s registered population, to arrive at expected numbers of patients with the various conditions.

The estimates produced by the Diabetes Prevalence model are no longer considered to provide the most robust data on diabetes prevalence. Whilst some of the assumptions included in the model were based on the best available evidence at the time of development, the progression of diabetes information, and diabetes prevalence data in particular, means that these assumptions may no longer be appropriate. Thus, expected prevalence figures for diabetes come with the caveat that they are only to be used for crude benchmarking purposes.

The observed and expected prevalence rates are presented by GP practice and cluster for the following conditions:

**Circulatory diseases**
- Coronary Heart Disease
- Stroke and Transient Ischaemic Attack
- Hypertension
- Heart Failure
- Atrial Fibrillation

**Long term Conditions**
- Asthma
- Chronic Obstructive Pulmonary Disease
- Dementia
- Diabetes

### 4.5 Circulatory Diseases

Diseases of the circulatory system collectively cause the largest number of deaths in Lewisham. Sometimes referred to as cardiovascular (CVD), they include Coronary Heart disease (CHD), ischaemic heart disease, stroke (cerebro-vascular accident), heart failure, and hypertensive disease (high blood pressure).

General practices maintain registers of patients known to have, or to have experienced, CHD, stroke and transient ischaemic attack (TIA), heart failure, hypertension, and atrial fibrillation.

The incidence of most circulatory diseases is closely linked to smoking. Diet, physical activity and family history also play a significant role. Most of these are matters general practitioners are well placed to influence.

The identification of people with risk factors, or showing early signs of circulatory disease, can enable general practitioners to work with patients to reduce the risk of having a myocardial infarction (heart attack) and/or stroke.

Lewisham has high premature mortality from circulatory diseases. There are considerable differences in mortality rates across the borough, though each cluster serves at least one area that has significantly higher premature mortality than England for one or both sexes. Absolute numbers of deaths are too low in the sub-categories of CHD for sensible calculation of mortality at small area level.

For every circulatory condition covered by primary care registers, Lewisham records a lower proportion of cases than England. Within Lewisham, Cluster 1, serving the North and North East of the borough, records the smallest number of cases relative to those expected based on national prevalence rates. There is considerable variation in performance among GP practices and a significant proportion of practices are below the England average.

There are also significant differences in mortality at ward level. For the years 2003-2007, standardised mortality rates (SMR) for cardiovascular disease ranged from 81 in Crofton Park ward to 172 in Ladywell ward (100 = England). There is no clear correlation between hospital admission rates and premature mortality, although admission rates are the lowest in the three wards with high premature CVD mortality.

The secondary prevention of circulatory disease is largely undertaken in the primary care setting. The performance of primary care in relation to secondary prevention can be assessed via the Quality and Outcomes Framework (QOF).

**Coronary Heart Disease**

Coronary heart disease (CHD) develops when the artery supplying blood to the heart becomes partially or wholly blocked. CHD can result in a heart attack. Once established, CHD can be managed but not cured, so focus on prevention of these conditions is of great importance.

**Risk factors for CHD include:**
- Smoking
- Hypertension
- High blood cholesterol
- Obesity
- Diabetes
- Lack of physical exercise
- South Asian ethnicity

Many of these risk factors can be managed in primary care. Figures 4.2 – 4.5 show the expected number of patients with CHD for each practice by cluster and the actual number recorded by the practice. Figure 4.6 shows the ratio of the recorded to expected numbers of patients on the register, together with the PCT as a whole, with comparative levels for London and England.

In Lewisham, 60% of the expected number of cases are recorded on GP registers. In London, the figure is 67%, and for England, 80%. Cluster 1 has the lowest proportion of diagnosed cases.

40 http://www.nhs.uk/Pathways/coronaryheartdisease/Pages/Landing.aspx
The trend shows that the number of patients on the CHD register has actually reduced over time. The decrease in the CHD register numbers is due to a number of factors including the introduction of the atrial fibrillation register and the restructuring of QOF points for CHD and, in particular, the implementation of QOF points for hypertension.

**Cholesterol Control**

A major risk factor for heart disease is a raised cholesterol level. This should be regularly monitored, and the desired level is a cholesterol concentration of 5mmol/l or less. Figures 4.8 – 4.12 show the percentage of patients recorded with CHD whose last cholesterol measurement, recorded in the previous 15 months, was equal to or below 5mmol/l, by GP practice and cluster.
Rates of recorded cholesterol within the target range vary across clusters in Lewisham, from 72.5% to 77.6%. All are lower than the England average of 82.1%.

The following practices have higher numbers of CHD patients with cholesterol <= 5 mmol/l recorded in the last 15 months than the England average:

- **In Cluster 1:** Dr Charmantas, Drs Singh/Irvine and Dr Mohamedali
- **In Cluster 2:** Dr Abraham, Dr Uduku and Dr Kawooya
- **In Cluster 3:** Dr Lingarajah and Dr Arora

No practice in Cluster 4 exceeds the rate for England.

Figure 4.13 shows the trend over time in the proportion of patients on the CHD register whose measurement of blood cholesterol was within the target range.
Prescription of Beta Blockers

Beta blockers are a class of drug treatment that are prescribed for all patients who have had an acute myocardial infarction, and are strongly indicated for a range of other cardiac conditions (unless a specific clinical contra-indication is present). Figures 4.14 – 4.18 show the percentage of patients recorded with CHD who were being treated with a beta blocker, by GP practice / cluster.
4.6 Stroke and Transient Ischaemic Attack (TIA)

A stroke happens when the blood supply to the brain is disturbed. The chances of having a stroke can be reduced by management of risk factors.

Transient ischaemic attack (TIA) or ‘mini-stroke’ has similar symptoms to stroke but they resolve spontaneously. The TIA may be a warning sign of a more serious stroke and requires further immediate medical attention\(^\text{41}\). However, it is thought that many cases of TIA are not reported to GPs. Factors such as patients’ lack of understanding of the severity of the condition and waiting times for appointments may impact on the number of patients who actually present to NHS services.

Stroke continues to be the major cause of adult disability and the third most common cause of death in Britain. In London, stroke is the second most common cause of death. The development of rapid treatment within three hours of acute ischaemic stroke with thrombolysis and the recognition that people who suffer a stroke have improved outcomes when given co-ordinated high quality specialist care, were highlighted in the National Stroke Strategy\(^\text{42}\) (2007) and the Healthcare for London Stroke Strategy\(^\text{43}\) (2009).

Risk factors for stroke include:

- Smoking
- Hypertension
- High blood cholesterol
- Obesity
- Diabetes
- Atrial fibrillation
- Lack of physical exercise
- High alcohol consumption
- South Asian, African or Caribbean ethnicity
- Age
- Family history
- Previous medical history

The most recent research suggests that age remains the strongest predictor of stroke and that area deprivation scores are not strongly associated with the incidence of stroke. Black African and Black Caribbean populations have a 60% greater incidence of stroke that occurs up to ten years earlier than amongst the White British population\(^\text{44}\). These findings suggest that Lewisham will have a larger group of younger stroke survivors who are likely to live for longer with the consequences of stroke, and who have specific health and social care needs, than those reflected in nationally representative data.

Figures 4.20 – 4.23 show the number of patients expected to have had stroke or TIA for each practice by cluster and the actual number recorded by each practice. Figure 4.24 shows the ratio of the recorded to expected numbers of patients on the register, together with the PCT as a whole, with comparative levels for London and England.

\(^\text{41}\) http://www.nhs.uk/pathways/stroke/Pages/Landing.aspx
\(^\text{42}\) Department of health. National Stroke Strategy (2007)

---

Figure 4.19 Patients with CHD currently treated with beta blockers

<table>
<thead>
<tr>
<th>Cluster</th>
<th>2004/5</th>
<th>2005/6</th>
<th>2006/7</th>
<th>2007/8</th>
<th>2008/9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lewisham</td>
<td>67.9%</td>
<td>68.6%</td>
<td>69.9%</td>
<td>71.3%</td>
<td>72.9%</td>
</tr>
</tbody>
</table>

---

Figure 4.20 Cluster 1 - Stroke and TIA prevalence

<table>
<thead>
<tr>
<th>Patients</th>
<th>Recorded</th>
<th>Expected</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004/5</td>
<td>150</td>
<td>100</td>
</tr>
<tr>
<td>2005/6</td>
<td>120</td>
<td>80</td>
</tr>
<tr>
<td>2006/7</td>
<td>100</td>
<td>60</td>
</tr>
<tr>
<td>2007/8</td>
<td>80</td>
<td>40</td>
</tr>
<tr>
<td>2008/9</td>
<td>60</td>
<td>30</td>
</tr>
</tbody>
</table>

---

Figure 4.18 Inter-cluster comparison Patients with CHD currently treated with a beta blocker

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Recorded</th>
<th>Expected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cluster 1</td>
<td>90%</td>
<td>80%</td>
</tr>
<tr>
<td>Cluster 2</td>
<td>70%</td>
<td>60%</td>
</tr>
<tr>
<td>Cluster 3</td>
<td>50%</td>
<td>40%</td>
</tr>
<tr>
<td>Cluster 4</td>
<td>30%</td>
<td>20%</td>
</tr>
</tbody>
</table>
There appears to be considerable under-recording of stroke on GP registers based on the expected prevalence compared to England, although the Lewisham ratio of observed to expected stroke and TIA is similar to that of London. Dr Lumb’s practice in Cluster 2 recorded a higher number of patients with stroke/TIA than expected based on the national prevalence models. This could be due to a larger population of patients from BME groups than is assumed in the prevalence prediction model (although the practice is not known to have a high proportion of BME groups), or a higher frequency of risk factors for stroke in the practice population than expected.

4.7 Hypertension

Hypertension is a chronic medical condition in which the blood pressure is persistently higher than the recommended level. It is also referred to as high blood pressure. Hypertension can be classified as either essential (primary) or secondary to another condition. The majority of cases are of essential hypertension. Most cases of hypertension are asymptomatic, but hypertension is an important risk factor for strokes, heart attacks, heart failure, arterial aneurysm and chronic renal failure. Even moderately high blood pressure can lead to shortened life expectancy.45 Hypertension may be detected by direct measurement of blood pressure in primary care.

Risk factors for hypertension include:
- Salt intake
- Obesity
- Inactive life-style
- High alcohol intake
- Poor diet
- Diabetes
- South Asian, African or Caribbean ethnicity
- Family history
- Age

Figures 4.25 - 4.28 show the number of patients expected to have persistent hypertension for each practice by cluster and the actual number recorded by each practice. Figure 4.29 shows the ratio of the recorded to expected numbers of patients on the register, together with the PCT as a whole, with comparative levels for London and England.

45 http://www.patient.co.uk/health/High-Blood-Pressure-(Hypertension).htm
Forty-six percent of expected cases of hypertension in Lewisham are recorded on GP registers. London’s rate is 51%, and England’s, 55%. Cluster 1 records the lowest proportion of diagnosed cases. Cluster 4 records a higher proportion than London, although less than England.

**Figure 4.25 Cluster 1 - Hypertension prevalence**

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Recorded</th>
<th>Expected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cl1</td>
<td>28,586</td>
<td>30,669</td>
</tr>
<tr>
<td>Cl2</td>
<td>29,552</td>
<td>30,945</td>
</tr>
<tr>
<td>Cl3</td>
<td>29,939</td>
<td>30,945</td>
</tr>
<tr>
<td>Cl4</td>
<td>30,669</td>
<td>30,945</td>
</tr>
</tbody>
</table>

**Figure 4.26 Cluster 2 – Hypertension prevalence**

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Recorded</th>
<th>Expected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cl1</td>
<td>28,586</td>
<td>30,669</td>
</tr>
<tr>
<td>Cl2</td>
<td>29,552</td>
<td>30,945</td>
</tr>
<tr>
<td>Cl3</td>
<td>29,939</td>
<td>30,945</td>
</tr>
<tr>
<td>Cl4</td>
<td>30,669</td>
<td>30,945</td>
</tr>
</tbody>
</table>

**Figure 4.27 Cluster 3- Hypertension prevalence**

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Recorded</th>
<th>Expected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cl1</td>
<td>28,586</td>
<td>30,669</td>
</tr>
<tr>
<td>Cl2</td>
<td>29,552</td>
<td>30,945</td>
</tr>
<tr>
<td>Cl3</td>
<td>29,939</td>
<td>30,945</td>
</tr>
<tr>
<td>Cl4</td>
<td>30,669</td>
<td>30,945</td>
</tr>
</tbody>
</table>

The time trend below indicates that the number of patients on hypertension registers has increased over time.

**Figure 4.28 Cluster 4 – Hypertension prevalence**

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Recorded</th>
<th>Expected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cl1</td>
<td>28,586</td>
<td>30,669</td>
</tr>
<tr>
<td>Cl2</td>
<td>29,552</td>
<td>30,945</td>
</tr>
<tr>
<td>Cl3</td>
<td>29,939</td>
<td>30,945</td>
</tr>
<tr>
<td>Cl4</td>
<td>30,669</td>
<td>30,945</td>
</tr>
</tbody>
</table>

**Figure 4.29 Intercluster comparisions - Hypertension ratio recorded/expected prevalence**

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Recorded/Expected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cl1</td>
<td>0.5</td>
</tr>
<tr>
<td>Cl2</td>
<td>0.5</td>
</tr>
<tr>
<td>Cl3</td>
<td>0.5</td>
</tr>
<tr>
<td>Cl4</td>
<td>0.5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Country</th>
<th>Recorded/Expected</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>0.5</td>
</tr>
<tr>
<td>London</td>
<td>0.5</td>
</tr>
<tr>
<td>Lewisham</td>
<td>0.5</td>
</tr>
</tbody>
</table>

**Figure 4.30 Number of patients recorded on hypertension disease registers**

<table>
<thead>
<tr>
<th>Year</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005/06</td>
<td>28,586</td>
</tr>
<tr>
<td>2006/07</td>
<td>29,552</td>
</tr>
<tr>
<td>2007/08</td>
<td>29,939</td>
</tr>
<tr>
<td>2008/09</td>
<td>30,669</td>
</tr>
</tbody>
</table>
4.8 Control of Blood Pressure in Primary Care

Figures 4.31 – 4.34 show the percentage of patients recorded on the hypertension register whose last recorded blood pressure measurement (within the previous 9 months) was 150/90 or lower, by GP practice and cluster. For most patients, a target of 140/85 is recommended. However, the British Hypertension Society suggests an audit standard of 150/90, which has been adopted for the NHS Quality and Outcomes Framework.

Figure 4.31 Cluster 1 – Patients with hypertension with blood pressure ≤150/90

Patients on the Hypertension Register with Blood Pressure < 150/90, Cluster 1

Figure 4.32 Cluster 2 – Patients with hypertension with blood pressure ≤150/90

Patients on the Hypertension Register with Blood Pressure < 150/90, Cluster 2

Figure 4.33 Cluster 3 – Patients with hypertension with blood pressure ≤150/90

Patients on the Hypertension Register with Blood Pressure < 150/90, Cluster 3

Figure 4.34 Cluster 4 – Patients with hypertension with blood pressure ≤150/90

Patients on the Hypertension Register with Blood Pressure < 150/90, Cluster 4

Figure 4.35 Inter-cluster comparison – Patients with hypertension with blood pressure ≤150/90

Patients on the Hypertension Register with Blood Pressure < 150/90, Inter-cluster comparison

All clusters in Lewisham have very similar percentages of their patients on the hypertension register whose blood pressure is under control (72.4% to 74%). All are lower than the England average of 78.6%.

The following practices have higher rates of controlled patients than the England average:

In Cluster 1: Dr Berman, Dr Charmantas and Dr Krishnapalasuyar
In Cluster 2: Dr Lettington
In Cluster 3: Dr Lingarajah; Dr U Israel and Dr Sarker

No practice in Cluster 4 exceeds the rate for England.

Figure 4.36 shows the time trend for patients on hypertension registers whose most recent blood pressure was less than 150/90. There has not been much improvement in the proportion of patients who have blood pressure control since 2006/07.

4.9 Heart Failure

Heart failure occurs when the heart can no longer effectively pump blood around the body\(^4\). Chronic heart failure is a long term condition, and may be caused by a previous heart attack, disease of the heart muscle (cardiomyopathy) or of the heart valves, as a result of some genetic conditions, or certain infections.

Other risk factors include:
- High long term consumption of alcohol
- Smoking
- Lack of physical activity
- Age

There is usually no cure for chronic heart failure, and management concentrates on relief of symptoms and stopping progress of the disease.

Figures 4.37 – 4.40 show the number of patients expected to have heart failure for each practice by cluster and the actual number recorded by the practice. Figure 4.41 shows the ratio of the recorded to expected numbers of patients on the register, together with the PCT as a whole, with comparative levels for London and England.

Fifty percent of Lewisham’s expected number of heart failure cases are recorded on GP registers. The figure for London is 51%, and for England, 55%. Cluster 1 records the lowest proportion of cases. Cluster 3 records a higher prevalence than London; clusters 2 and 4 record higher proportions than London and England.

47 http://www.nhs.uk/Conditions/Heart-failure/Pages/Introduction.aspx
4.10 Atrial Fibrillation

Atrial fibrillation is one of the most common abnormal heart rhythms. It presents as a fast and irregular heartbeat, usually over 140 beats per minute, but some people with atrial fibrillation have no symptoms and the condition is only discovered during routine tests or investigations for another condition. Atrial fibrillation reduces the heart’s efficiency and performance. This can result in low blood pressure and heart failure. It affects less than 1% of people under 60 years old, and over 5% of those over 60.

Atrial fibrillation is common in people with other heart conditions, and may also be associated with respiratory diseases, lung cancer and diabetes.

Management may involve investigation and treatment of the causal condition, medicines to control the atrial fibrillation itself, medicines to reduce the risk of stroke, or specialist invasive cardiac intervention that requires secondary referral.

Figures 4.42 – 4.45 show the number of patients expected to suffer with atrial fibrillation for each practice by cluster and the actual number recorded by each practice. Figure 4.46 shows the ratio of the recorded to expected numbers of patients on the register, together with the PCT as a whole, with comparative levels for London and England.
4.11 Asthma

Asthma causes the airways of the lungs (the bronchi) to become inflamed and swollen, making it difficult to breathe and causing wheezing and coughing. The severity of the symptoms of asthma varies from mild to severe. The narrowing of the airways is usually reversible, either naturally or through the use of medicines. However, for some people with chronic (long-lasting) asthma, the inflammation may lead to an irreversible obstruction of the airways\(^48\). Severe asthma attacks can be life-threatening and may require hospital treatment.

Asthma is common, affecting over 5 million people in the UK, about one in twelve of the population. More adult women are affected than men. The cause of asthma is not fully understood, but it is thought to be a combination of genetic and environmental factors. Asthma often runs in families and an attack may be triggered by certain factors in the environment.

Potential triggers include air pollutants and allergens, including cigarette smoke, pollen, animal fur, viral infections, exposure to industrial chemicals and repeated exposure at work to specific substances which are not normally considered harmful. It may also be triggered by physical exercise.

There is no cure for asthma, but the condition can be managed by a combination of:
1. medical treatment such as inhalers for symptomatic relief,
2. medication to prevent future symptoms from developing,
3. identifying particular triggers and avoiding them.

Overall prevalence figures for asthma are not available at borough or PCT level, but in 2007/8 the national prevalence rate was 5.75%, while London had the lowest prevalence (4.6%) of all Government Office Regions\(^49\).

Figures 4.47 – 4.50 show the expected number of patients with asthma for each practice by practice and the actual number recorded by each practice. Figure Figure 4.51 shows the ratio of the recorded to expected numbers of patients on the register, together with the PCT as a whole, with comparative levels for London and England.

Fifty-three percent of the expected number of asthma cases in Lewisham are recorded on GP registers. London’s figure is 58%, and England’s is 64%. Cluster 1 recorded the lowest proportion of cases. Cluster 4 recorded higher rates than England.

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\(^48\) http://www.nhs.uk/conditions/asthma/Pages/Introduction.aspx
\(^49\) National Centre for Health Outcomes Development Compendium of Public Health Information, http://nww.nchod.nhs.uk , worksheet 23C_649PC_08_V1.xls
4.12 Chronic Obstructive Pulmonary Disease (COPD)

Chronic obstructive pulmonary disease (COPD) is the name for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive Airways disease. The main symptom of COPD is an inability to breathe in and out properly. This is also referred to as airflow obstruction. Airflow obstruction is caused by long-term damage to the lungs, usually as a result of smoking, which is the main cause of COPD. The likelihood of developing the condition increases with the duration and intensity of smoking, and the condition generally manifests after the age of 40. As the condition progresses, breathing in and out becomes increasingly difficult, and the patient's physical ability to carry out normal tasks may be diminished. COPD is a predisposing condition for heart failure. Symptoms can be exacerbated by air pollution, extremes of temperature, and viral or bacterial infections.

There is no cure for COPD, and treatment concentrates on relieving the symptoms. Those with the condition receive annual seasonal flu immunisations.

In Lewisham, COPD is the third leading cause of disease burden: the third leading cause of death among males and eighth among females. COPD contributes to the gap in life expectancy between England and Lewisham as smoking rates are highest in lower socio-economic groups and the number of cigarettes smoked per day is also higher in this group. The Department of Health estimates that the routine and manual occupational groups represent almost half of the people with diagnosed and undiagnosed COPD in England.

Figures 4.52 – 4.55 show the number of patients expected to have COPD for each practice by cluster and the actual number recorded by each practice. Figure Figure 4.56 shows the ratio of the recorded to expected numbers of patients on the register, together with the PCT as a whole, with comparative levels for London and England.

In 2008/2009, there were 2,967 people on GP registers with COPD. This is likely to be a significant underestimation of the actual number of people with COPD. Only 40% of the expected number of COPD cases in Lewisham are recorded on GP registers. This is higher than London’s figure of 37%. The figure for England is 56%.

Cluster 1 and cluster 2 recorded lower rates than London, while cluster 3 recorded the highest rates. This could be due to the impact of the community spirometry pilot which was undertaken in cluster 3 in 2008/09.

The number of patients on COPD registers has increased year on year, although the increases are relatively modest.

Lung Capacity Measurement in COPD Patients in Primary Care

Spirometry is fundamental to making a diagnosis of COPD and NICE guidelines (2004) recommend that spirometry is carried out at diagnosis. Primary care physicians are in an ideal position to be able to detect COPD in its early stages and perform spirometry to confirm the diagnosis. NICE supports opportunistic COPD case finding in primary care as a relatively cost effective strategy.

The QOF (2004) identified that, in the first instance, a practice should have a register of patients with COPD and, secondly, all new patients should have the diagnosis confirmed with spirometry including reversibility testing; spirometry then needs to be repeated once every two years. In response to this guidance, the initial demand for spirometry was expected to be high; Lewisham PCT therefore purchased spirometers and training sessions for every GP practice across Lewisham. However, there was a large variation of the use of the spirometers across Lewisham practices consistent with

52 Thorax 2004;59;i175-i190 Appendix B: The cost effectiveness of opportunistic case finding in primary care
the experience at a national level. Only 14 of the 27 practices responding to a GP survey in 2007 provided spirometry at the practice, and staff from 22 of the 27 practices reported that they needed spirometry training. The majority of patients continued to be referred to University Hospital Lewisham (UHL).

The local QOF data indicates that 79.4% of patients with a recorded diagnosis of COPD have had their Forced Expiratory Volume (FEV1) recorded in the previous 15 months. This can be used as a proxy for access to spirometry, although it should be noted that much of this may have been provided in secondary care through referral to the Respiratory Consultants.

Figures 4.58 – 4.62 show the percentage of patients recorded on the COPD Register who have an FEV1 measurement recorded in the previous 15 months, by GP practice and cluster.

Recording of FEV1 varies across clusters in Lewisham from 76.9% to 81.4%. All are lower than the England average of 82.5%.

53 Survey of Lewisham GP Practices April 2007 - 27 of 51 (52%) surgeries responded
A number of practices had a higher percentage of COPD patients with an FEV1 recorded in the last 15 months than the England average. However, many of these recorded very low levels of prevalence compared to those expected. The practices below all have a higher percentage of patients with FEV1 recorded than the England average, although those underlined have a much lower number of patients in their practice than would be expected, suggesting there are significant numbers of undiagnosed patients in the practice. For example, two practices record 100% achievement on the FEV1 measure but of these two, Dr Charmantas records only 2 patients with COPD out of an expected 98 and Dr Das records only 11 out of an expected 104.

In Cluster 1: Dr Berman, Dr Charmantas, Dr Singh/Irvine, Dr Sarder, Dr Mohamedali and Dr Krishnapalasuyar

In Cluster 2: Dr Holloway, Dr Chen, Dr Abraham, Dr Uduku, Dr Lumb and Dr Parker

In Cluster 3: Dr Lingarajah; Dr U Israel, Dr Das, Dr Selvanathan and Dr Pavar

In Cluster 4: Dr Misselbrook and Dr Rowland

While Lewisham as a PCT performs reasonably well on the COPD QOF indicators, the recorded prevalence is much lower than expected in some practices.

Figure 4.63 shows the proportion of patients on COPD registers with a record of a forced expiratory volume measurement within the last 15 months. Since this indicator was introduced in 2006/7, the proportion has increased steadily over the three years.

4.13 Dementia

Dementia is a syndrome (a group of related symptoms) that is associated with an ongoing decline of the brain and its abilities. These include thinking, language, memory, understanding and judgement. People with dementia may also have problems controlling their emotions or behaving appropriately in social situations. Aspects of their personality may change. Most cases of dementia are caused by damage to the structure of the brain. The most common types of dementia are Alzheimer’s disease and vascular (which includes multi-infarct) dementia. There is also dementia with Lewy bodies, where abnormal structures develop inside the brain, and Frontotemporal dementia, where the frontal and temporal lobes of the brain begin to shrink.

Frontotemporal dementia, which is rare, usually develops in people who are under 65. The other forms of dementia are strongly linked with age. About 1.5% of people aged 65-69 have dementia, rising to about one in five men and over one in four women aged over 85. A higher proportion of women than men experience dementia.

There is no cure for dementia and cases progress in severity over time. There are some experimental medicines that can improve the condition of some cases of Alzheimer’s disease, although these do not work for all patients; their efficacy has been questioned and their side effects can be undesirable. There is a range of psychological treatments that can be used.

Care planning for dementia should be done early in the disease, as in later stages the patient may not be able to give or withhold informed consent for any intervention. It is important to ensure a smooth transition into planning for end-of-life care.

Figures 4.64 – 4.67 show the expected number of patients with dementia for each practice by cluster and the actual number recorded by the practice. Figure 4.68 shows the ratio of the recorded to expected numbers of patients on the register, together with the PCT as a whole, with comparative levels for London and England.

Lewisham has lower levels of dementia (1.2% of the population over 30 years old or approximately 1,781 people) than the London average, with a very small number (48) of early onset dementia for over 30’s. 4.14 Forty percent of the expected number of dementia cases in Lewisham is recorded on GP registers. The figure for London and England is 39%. Cluster 1 records the lowest proportion of cases.

54 Healthcare for London 2009 Dementia Needs Assessment
There is considerable variation between practices and clusters in the proportion of recorded to expected patients with dementia. It is likely that case ascertainment is higher where a practice provides services to a nursing home. Due to the population structure of Lewisham, which is younger than the England average, based on population projections there is a relatively stable older adult population with dementia expected up until 2021. However, there will be an increase of BME elders requiring dementia services. The general rise of 33.3% in the Lewisham BME population over 20 years estimates an additional 347 additional BME clients will require dementia services. Estimates suggest that a total of 582 BME clients will require dementia services by 2021. Lewisham may need to re-design services so that they cater for the changing BME elder population.

4.14 Diabetes

Diabetes is a common life-long condition where the amount of glucose in the blood is too high as the body cannot use it properly. This is because the pancreas does not produce any or enough insulin, or the insulin that is produced does not work properly (known as insulin resistance)\(^\text{55}\). There are two main types of diabetes:

- Type 1 diabetes develops when the insulin-producing cells have been destroyed and the body is unable to produce any insulin. Usually it appears before the age of 40, and especially in childhood. It is treated with insulin either by injection or pump, a healthy diet and regular physical activity.

- Type 2 diabetes develops when the body does not produce enough insulin or the insulin that is produced doesn’t work properly. Usually it appears in people aged over 40, although in South Asian and Black people it can appear from the age of 25. It is becoming more common in children and young people of all ethnicities. Type 2 diabetes is treated with a healthy diet and regular physical activity, but it is a progressive disease, and medication and/or insulin often become required.

Between 85% and 90% of people with diabetes have Type 2 Diabetes.
Between two and seven percent of pregnant women develop gestational diabetes, which usually resolves after childbirth. However, women who develop gestational diabetes are at higher risk of developing Type 2 diabetes later in life\(^\text{56}\).

The cause of Type 1 diabetes is unknown, but it is thought to be auto-immune, perhaps in response to an infection\(^\text{57}\). The exact cause of Type 2 diabetes is unknown but risk factors include:

- Family history of the disease
- Overweight and obesity
- Heart disease
- Asian, African, or Caribbean ethnicity
- History of gestational diabetes or polycystic ovary syndrome
- Age

Figures 4.69 – 4.72 show the expected number of patients with diabetes for each practice by cluster and the actual number recorded by the practice. Figure 4.73 shows the ratio of the recorded to expected numbers of patients on the register, together with the PCT as a whole, with comparative levels for London and England.

Lewisham’s GP registers recorded 110% of the expected number of cases. The figure for London was 104%, and that for England was 88%. Every cluster in Lewisham records higher rates than England. As noted in section 4.4, the model used to predict expected prevalence of diabetes is no longer considered robust and therefore these results should only be used for crude benchmarking purposes.

The National Diabetes Audit executive summary (2005-06) suggests that as many as 750,000 undiagnosed cases of diabetes exist nationally (making up over one third of all predicted cases). If the same were true of Lewisham, then there could be over 4,000 undiagnosed cases of diabetes.

Ethnic projections by the Greater London Authority (GLA) show increases in the BME groups in Lewisham, especially those of Black ethnic origin. In addition, incidence of diabetes type 2 is known to be linked to obesity and, in common with the rest of the country, obesity rates are rising in Lewisham. Thus, the burden of diabetes is predicted to increase and it will remain an ongoing and increasing priority for Lewisham. People in BME ethnic groups tend to present late, with complications\(^\text{58}\). There needs to be increased emphasis on early detection and appropriate management of the disease in primary care.

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\(^{56}\) [Webpage](http://www.nhs.uk/Conditions/Diabetes-type2/Pages/Introduction.aspx)

\(^{57}\) [Website](http://www.diabetes.org.uk/Guide-to-diabetes/Introduction-to-diabetes/Causes_and_Risk_Factors/)

The number of patients with diabetes has increased over time, with relatively large year-on-year increases in the number of patients appearing on practice diabetes disease registers (Figure 4.74).

Control of HbA1c in Patients with Diabetes in Primary Care

People with poorly controlled HbA1c are more likely to suffer macro-vascular and micro-vascular complications of diabetes, resulting in ischaemic heart disease, stroke, blindness, peripheral vascular disease, renal failure, and other complications. Optimal diabetes management is to bring the patient’s HbA1c level as close to the normal range as possible, and to keep it there. HbA1c is a test that measures the amount of glycated haemoglobin in the blood. Glycated haemoglobin is a substance in red blood cells that is formed when blood sugar (glucose) attaches to haemoglobin. An HbA1c of 6% or less is normal. For people with diabetes, the target is to reduce HbA1c to 7.5% or less (based on 2008/09 QOF target). Abnormal results mean that the blood glucose level has been above normal over a period of weeks to months, and diabetes control may not be as good as it should be. Reducing HbA1c reduces the risk of stroke and of eye, heart, kidney and nerve complications of diabetes.

Figures 4.75 – 4.78 show the percentage of patients with diabetes whose last HbA1c measurement, recorded in the previous 15 months, was equal to or below 7.5%, by GP practice and cluster.

Achievement of HbA1c levels of 7.5 or less in diabetic patients varies across clusters in Lewisham, from 57.5% to 65.7%. All are lower than the England average of 66.3%.

The following practices had higher rates of patients’ Hb1Ac below 7.5% recorded in the last 15 months than the England average:

In Cluster 1: Dr Berman, Dr Charmantas, Dr Neal, Dr Singh/Irvine, Dr Sarder and Dr Mohamedali
In Cluster 2: Dr Lumb, Dr Khan/Malde, Dr Abraham, Dr Macdonagh and Dr Neal
In Cluster 3: Dr Fagbohungbe
In Cluster 4: No practice in cluster 4 had higher rates than the England average

The practices of Dr Sarder in Cluster 1 and Dr Sarker in Cluster 3 recorded rates below 50% of patients.

Figure 4.80 shows the proportion of patients on diabetes registers whose Hb1Ac is at or below the target level. The target for this changed in 2006/7 from an upper threshold of 7.4 to 7.5.

Since the introduction of the QOF disease registers, the numbers of patients recorded in primary care on each register has increased with the exception of CHD, where the number has decreased slightly over a four year period. The increased number of patients on registers is an indication that detection of conditions is improving, but may present management problems for practices as they have more patients to see to meet their outcome and management targets.

Table 4.4 shows the numerical differences by cluster between the expected numbers of patients with a particular condition and the numbers actually recorded on the disease register. The negative value by the diabetes data reflects the fact that the diabetes model is no longer thought to be robust and therefore underestimates the expected prevalence.
For most conditions, there is an under-identification of cases, and this could be due to a number of factors. Some patients have not been diagnosed and therefore do not appear on the register, other patients may have been diagnosed but not put onto the disease register, and in some areas the estimates may be incorrect.

Targeting of resources to identify undiagnosed disease can improve outcomes for patients once they are diagnosed and given advice and treatment for the management of their condition. The Vascular Checks Programme will target over-40 year olds with risk factors for cardio-vascular disease, and spirometry in primary care targets smokers and ex-smokers who may be a risk of COPD. Early detection of disease allows individuals to take action to modify their risk factors and access treatment to prevent further complications of their condition. This can have a real impact on preventing early mortality and morbidity, particularly from circulatory and respiratory disease.

### Table 4.3 Differences in the number of patients recorded and expected on disease registers, 2008/09

<table>
<thead>
<tr>
<th>Circulatory Diseases</th>
<th>Cluster</th>
<th>Lewisham</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>896</td>
<td>1082</td>
</tr>
<tr>
<td>Stroke</td>
<td>438</td>
<td>495</td>
</tr>
<tr>
<td>Hypertension</td>
<td>6700</td>
<td>11699</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>195</td>
<td>388</td>
</tr>
<tr>
<td>Atrial Fibrillation</td>
<td>158</td>
<td>224</td>
</tr>
<tr>
<td>Long Term Conditions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td>2855</td>
<td>4006</td>
</tr>
<tr>
<td>COPD</td>
<td>871</td>
<td>1732</td>
</tr>
<tr>
<td>Dementia</td>
<td>199</td>
<td>394</td>
</tr>
<tr>
<td>Diabetes -</td>
<td>-306</td>
<td>-170</td>
</tr>
</tbody>
</table>

The axes cross at the median values for Lewisham's GP practices. A practice’s position in the quadrant diagram is relative to the Lewisham average, not to any external comparator.

Figure 4.81 shows that there is marked variation in prescribing volumes of lipid lowering drugs and the percentage of patients on practice CHD registers with cholesterol levels defined as accepted good clinical practice. There are a number of practices that appear to have high volume prescribing but are not achieving as high a percentage of the patients with cholesterol ≤5 as their peers. There are also a number of practices that are prescribing lower volumes and achieving lower percentages of patients compared to their peers. These variations require further exploration.

### 4.16 Prescribing and clinical achievement

The QOF was intended to help drive improvement in the clinical management of patients in primary care. To ascertain whether there is any relationship between activity and outcomes, two QOF indicators are examined by treatment (prescribing) and outcome. It should be noted that these are relatively crude measures and may mask complexities in the management of individual patients.

QOF indicator CH8, which relates to the percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the previous 15 months) is 5 mmol/l or less; and QOF indicator DM20, which is the percentage of patients with diabetes in whom the last HbA1c is 7.5 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months, have both been linked to ADQ/star PU prescribing data.

Figure 4.81 presents information for CHD lipid-lowering drugs (statins) and percentage of patients on practice CHD registers with cholesterol levels defined as accepted good clinical practice. There are a number of practices that appear to have high volume prescribing but are not achieving as high a percentage of the patients with cholesterol ≤5 as their peers. There are also a number of practices that are prescribing lower volumes and achieving lower percentages of patients compared to their peers. These variations require further exploration.

Figure 4.82 presents information on prescribing volumes for oral diabetic hypoglycaemic drugs and the percentage of patients on the diabetes register with Hb1Ac within the target range (equal to or below 7.5) by GP practice and cluster.
Figure 4.82 HbA1c Control and Oral Diabetic Drug Prescribing in Lewisham 2008-9

The axes cross at the median values for Lewisham’s GP practices. A practice’s position in the quadrant diagram is relative to the Lewisham average, not to any external comparator.

For the majority of practices in Lewisham, oral diabetic hypoglycaemic prescribing is quite similar. However, the percentage of patients on registers with HbA1c =<7.5 as displayed on the vertical axis varies considerably. This would suggest that clinicians are prescribing in a similar manner but getting different clinical outcomes. One hypothesis for the variation maybe that there is a difference in the practice populations, and this may result in a difference in their understanding of their therapy and subsequent concordance. This variation in outcome would require further investigation before any firm conclusions can be drawn.

5 Emergency Admissions

Reviewing other activity such as emergency admissions to hospital may be an additional indicator of the quality of access to primary care and management of long term conditions in primary care. Emergency admissions to hospitals may arise as a result of attendance at Accident and Emergency (A&E) departments, by a request from a GP, from an attendance at a consultant outpatient appointment, from a domiciliary visit, or via a bed bureau.

Emergency admission is appropriate in cases of serious injury and sudden onset or exacerbation of illness, but unusually high rates at a local level may be indicative of inappropriate referrals from GP practices, ineffective management of conditions in primary care, or poor access to or provision of NHS community services. Where there is a high rate of emergency admissions through A&E, this may be indicative of difficulty in accessing services in primary care, especially where many of the admissions do not result in an overnight stay in hospital and the patient is discharged on the day of admission. Where rates of emergency admission are low, this could indicate effective management in primary care, good NHS community care provision, good access to primary care services, or low levels of inappropriate referrals.

Figures 5.1 – 5.4 show the standardised rates62 of emergency admission per thousand patients in 2008/9, by practice within clusters. Each includes the Lewisham average, London, and England rates as calculated by the NHS Information Centre.63 (The data do not enable cluster averages to be calculated.)

Overall, Lewisham’s standardised rate of emergency admissions was 83.5 per 1000 registered patients, lower compared with London which was 85.6, but higher than England’s, which was 78.0. However, there is much variation between practices. Further work is required to understand this variation.

In Cluster 1, Dr Batra’s practice is significantly high compared with England and Dr Kandavel’s practice is significantly high compared with London. The practices of Dr Jain, Dr Jamil, Dr Charmantas, Dr Mohamedali, Drs Irvine/Singh, and Dr Sarder, respectively, are significantly low compared with London.

In Cluster 2, Dr Chen’s practice is significantly high compared with England, and Dr Macdonagh’s practice is significantly high compared with London. Dr Lumb’s practice is significantly very low compared with London, Dr Holloway’s practice is significantly low compared with Lewisham, and both Dr Abraham’s and Dr Parker’s respective practices were significantly low compared with England.

In Cluster 3, Dr Lingarajah, Dr Ismail, Dr Fagbohungbe and Dr U Israel are significantly high compared with England.

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62 Standardisation is a technique that enables rates to be compared taking into account differences between age and sex structure of populations
63 https://www.nhscomparators.nhs.uk
The practices led by Dr Mani-Babu and Dr Selvanathan were significantly low compared with London.

In Cluster 4, Dr Misselbrook's practice was significantly high compared with England.

The following practices: Dr Rowland, Dr Platman and Dr Entwistle were significantly low compared with Lewisham.

**Figure 5.1 Cluster 1 – Emergency hospital admissions**

*Emergency Admissions 2008-9, Cluster 1*

**Figure 5.2 Cluster 2 – Emergency hospital admissions**

*Emergency Admissions 2008-9, Cluster 2*

**Figure 5.3 Cluster 3 – Emergency hospital admissions**

*Emergency Admissions 2008-9, Cluster 3*

**Figure 5.4 Cluster 4 – Emergency hospital admissions**

*Emergency Admissions 2008-9, Cluster 4*
Screening programmes are important public health interventions to prevent premature mortality and morbidity by early detection of asymptomatic disease. NHS screening programmes are delivered in a variety of ways. Some have centrally managed call and recall systems such as breast screening and cervical cancer screening, although the screen itself may happen at a primary care, community or hospital setting. Others, such as neonatal hearing screening, are delivered through hospital settings or, in the case of the chlamydia screening programme, through opportunistic screening in a variety of different settings. Screening programmes must meet certain criteria set by the National Screening Committee before they are rolled out in the NHS. In this chapter, information is presented on three cancer screening programmes. However, it should be noted that primary care is also involved in other screening programmes, such as chlamydia screening and, more recently, the vascular checks programme, not reported here.

6.1 Breast cancer

Breast cancer accounts for 31% of all female cancers. Despite being rare in men, it is also the commonest of all UK cancers. Since the 1970’s, incidence has been rising. Lifetime risk for UK women is now 1 in 9. This is likely due to known risk factors such as increasing population age; increased use of hormone replacement therapy and oral contraceptives; having no or few children; having children late (especially >30 years), not breastfeeding long term; early puberty; later menopause; and obesity (for post-menopausal women only).

In the latest (2007) report from the Thames Cancer Registry, 912 cases of breast cancer were registered in the South East Cancer Network (of which Lewisham is part, along with Bexley, Bromley, Greenwich, Lambeth & Southwark). Despite the increase in numbers diagnosed, mortality from breast cancer is slowly decreasing.

The NHS Breast Screening Programme (NHSBSP) is a national initiative started in 1988. It aims to reduce morbidity and mortality by detecting breast cancer at an earlier stage of disease, when outcomes are better. Women aged 50-70 years are invited for screening every 3 years (round length). Screening for women aged >70 is available on request. The government recently announced an age extension to the core programme to include all women aged 47 to 73 years by 2012.

NHSBSP for Lewisham is run from King’s College Hospital. The programme also provides for the other five PCTs of the South East London Cancer Network. Eligible women are identified from GP Exeter databases. In Lewisham, women are invited for screening by postcode of residence. Screening is by mammogram, with further referrals as clinically indicated.

Coverage

Figure 6.1 shows the screening coverage from March 2003 to March 2009 for Lewisham and the neighbouring PCTs of Lambeth and Southwark.

This is the key performance indicator for NHSBSP. It is defined as the percentage of 53 to 64 year old eligible women who have been screened in the last 3 years. The national target is currently 70% coverage. Current performance does not reach this target. When analysed by GP practice list, there is large variation in coverage, though no practice list in Lewisham reaches the 70% target.

6.2 Cervical Screening

Cancer of the cervix is the second most common cause of cancer among women globally. In England it is the thirteenth, mainly as a result of the effectiveness of the NHS Cervical Screening Programme (NHSCSP).

Nationally, cervical cancer incidence is 8.4 per 100,000 females and has declined over the past decade. Similarly, the national mortality rate from cervical cancer has also declined and is now 2.6 deaths per 100,000. However, local
incidence and mortality of cervical cancer is high (Table 6.1). Whilst Lewisham is close to the England figure for incidence and mortality, both Lambeth and Southwark are considerably higher.

### Table 6.1 Incidence and mortality from cervical cancer for England, London, Lambeth, Southwark and Lewisham

<table>
<thead>
<tr>
<th>Age group (years)</th>
<th>Incidence per 100,000 female population</th>
<th>Mortality per 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lambeth</td>
<td>Southwark</td>
</tr>
<tr>
<td>25</td>
<td>10.8</td>
<td>11.0</td>
</tr>
<tr>
<td>25 - 49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>50 - 64</td>
<td></td>
<td></td>
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<tr>
<td>65+</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Cervical screening is not a test for cancer. It is a method of preventing cancer by detecting and treating early abnormalities which, if left untreated, could lead to cancer in a woman’s cervix (the neck of the womb).

### Cervical Screening performance

The effectiveness of the cervical screening programme is judged by its coverage. Coverage is defined as the percentage of eligible women between the ages of 25 and 64 who have had an adequate test result in the last five years.

The target for five-year coverage is 80%. The national coverage rate dropped from 80.6% to 78.6% between 2003-04 and 2008-09. In Lewisham, the coverage rate has dropped in the same period, from 75.5% to 74.5%.

Coverage varies considerably by GP practice. In 2008-09:
- 5 (10%) out of 49 practices achieved coverage of 80%.
- 19 (38%) practices with coverage of between 75% and 79%.
- One practice had the lowest coverage (55%).

#### 6.3 Bowel Cancer Screening

The National Bowel Cancer Screening Programme was introduced in England in 2006. It offers screening every two years to all men and women aged 60-69 years. People over 70 can request a screening kit. Invitations are sent by the London Programme Hub to patients registered with a GP. This is followed by a guaiac-based Faecal Occult Blood testing kit.

The programme is to be extended to include people aged up to 75. In Lewisham, it is expected the extension will start in 2010.

#### Bowel Cancer Screening Performance

The national target for bowel screening is 60% uptake. At a national level the uptake at end of December 2009 was 53%; for London, 40.3%.

In Lewisham, the programme was launched in January 2008. At the end of December 2009 there were nearly 20,000 invites sent out and 7,820 kits returned, resulting in an uptake of 39.2%. Uptake by GP practice is not available for this period.

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64 P Sasieni, J Adams and J Cuzick, Benefits of cervical screening at different ages: evidence from the UK audit of screening histories, British Journal of Cancer, July 2003
Immunisation is the process whereby a person is made immune or resistant to an infectious disease, typically by the administration of a vaccine. Vaccines stimulate the body’s own immune system to protect the person against subsequent infection or disease.

Immunisation is a proven tool for controlling and eliminating life-threatening infectious diseases, and globally is estimated to avert over two million deaths each year (WHO, 2009). In addition, it has long been recognised as one of the most cost-effective health interventions.

In Lewisham, the standard childhood immunisation schedule sets out when different vaccines should be administered. This schedule is in line with national recommendations, and is designed to ensure that children have every chance to have the full course of MMR vaccine (two doses) and are fully immunised before they attend school. In response to local outbreaks of measles, the schedule has recently been amended so that children are offered the second dose of MMR three months after the first, and should be offered their pre-school booster from the age of three years and four months onwards.

Most children are immunised by their GP practice. Health visitors also immunise a significant number of children, mainly in community clinics.

The proportion of children who have been vaccinated is reported through quarterly reports to the COVER (Coverage of Vaccinations Evaluated Rapidly) programme, which is managed by the Health Protection Agency.

The recorded uptake of key immunisations between March 2005 and the end of June 2009 increased, and by the end of this period was in line with the London average (Figure 7.1). Uptake of the second dose of MMR and the preschool booster also improved to 59.6% (MMR2) and 59.9% (preschool booster), but was still below the London average of 69% (MMR2) and 68% (preschool booster) at the end of the period.

Within Lewisham, there is considerable variation between GP practices in the proportion of their registered children who have been vaccinated (Figure 7.2).
7.1 HPV Immunisation

The HPV vaccine Cervarix, used in the UK, protects against Human Papilloma Virus (HPV) types 16 and 18 which together cause about 70% of cases of invasive cervical cancer. The vaccine is given in three injections over six months.

The national HPV vaccination programme began in September 2008. The plan is that by 2011, all girls between the ages of 12 and 18 in Britain will have been offered the vaccine. This plan includes a catch-up programme, also started in September 2008, that offers the vaccine to older girls up to the age of 18.

The HPV vaccination programme began in Lewisham in October 2008. The vaccination was offered to the year 8 cohort of 1183 female students in 20 secondary schools and specialist units. Catch-up clinics were delivered in schools and community health clinics to increase uptake. Seventy-two percent of the 1183 eligible girls had the third dose of the vaccination, thereby achieving a 70% target. Parents who refused their consent were contacted in a resource-intensive effort to promote the programme, but this resulted in only 10% of non-consenters changing their mind.

7.2 Challenges

Over the past few years, uptake of immunisation in Lewisham has been below that of London (which is turn historically lower than England as a whole). While improvements have been seen, particularly in uptake at one and two years of age, the challenge is to sustain and further extend this improvement in line with the rest of London, and to significantly improve uptake of vaccination at 5 years old (specifically MMR2 and the pre-school booster).

Current levels of MMR uptake in Lewisham are below the level needed to control transmission and prevent outbreaks of communicable disease. In 2008, an unprecedented number of cases of measles occurred in South East London and in England and Wales as a whole. The Health Protection Agency has published data reporting a total of 1370 confirmed cases in England and Wales, of which 331 occurred in SE London – almost a quarter of the total. A total of 157 of these confirmed cases in 2008 occurred in Lewisham residents. Although the peak of the outbreak had passed by the end of 2008, a continuous trickle of cases have been reported since. Uptake of MMR must increase if a repeat of this outbreak is to be avoided.

7.3 Future plans

The PCT has agreed a comprehensive action plan with NHS London to identify and address outstanding areas for improvement. Major developments include the appointment of a GP facilitator, implementation of an immunisation care pathway, and further improvements in information and data flows, including electronic reporting. Another objective is to work with schools to raise the profile of the HPV vaccination programme as a core function of the School Age Nursing Service.
8 Smoking

Tobacco use is the biggest single factor contributing to the gap in healthy life expectancy between Lewisham and England.

Cigarette smoking is lower among households classified as professional and managerial (15 per cent) than those classified as routine and manual (26 per cent). Smoking prevalence is high in lower socio-economic groups and the number of cigarettes smoked per day is also high in this group. Smoking prevalence among low income groups is declining at a slower rate than the general population of smokers.

Smoking fell to its lowest recorded level in 2007: 21 per cent of the population of England aged 16 and over. Twenty two per cent of men and 20 per cent of women were cigarette smokers. In 2007, smoking was highest in the 20-24 age group (31 per cent) and lowest among those aged 60 and over (12 per cent).

The estimated smoking prevalence in Lewisham is significantly higher than England. There are two main sources of information about smoking prevalence in Lewisham. The first is the model-based estimate by the National Centre for Social Research, derived from the General Household Survey. The estimated smoking prevalence in 2006 in Lewisham was 26.8% - seventh highest in London – compared with an England prevalence of 24.1%. There is wide variation within Lewisham, with an estimated smoking prevalence of 33% in the most deprived wards in 2006.

The second source of information about smoking prevalence is the ‘GP-recorded smoking prevalence’ data collection. It is designed to provide a measure of the prevalence of smoking at a local level. However, it currently does not provide an accurate picture due to incomplete data and some smokers being reluctant to inform their GPs that they continue to smoke. The smoking prevalence for 2008/9 ranged from 17% to 24% for the Lewisham registered practice population aged 16 and above.

Table 8.1 looks at the ratio of smoking indicators for the most and least deprived practices compared with Lewisham as a whole. A ratio of 1.00 indicates a similar profile to Lewisham, above 1.00 is higher than Lewisham and below 1.00 is lower than the Lewisham average. As would be expected, high IMD scores correlate with high smoking prevalence.

### Table 8.1 Ratio of smoking indicators compared to top most deprived practices and the least deprived practices by IMD score

<table>
<thead>
<tr>
<th>Practice Name</th>
<th>IMD Ratio</th>
<th>% 0-24 years ratio</th>
<th>% 75 years + ratio</th>
<th>Smoking Prevalence ratio</th>
<th>Smoking recorded in last 15 months ratio</th>
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<tr>
<td>Lee Road Surgery</td>
<td>0.66</td>
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<td>1.03</td>
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<tr>
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<td>1.12</td>
<td>0.33</td>
<td>1.01</td>
<td>1.00</td>
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<td>Jamil (Waldron)</td>
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<td>1.07</td>
<td>0.49</td>
<td>1.01</td>
<td>1.03</td>
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<td>0.5</td>
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<td>1.04</td>
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<td>Bellingham Green</td>
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<td>1.17</td>
<td>0.57</td>
<td>1.24</td>
<td>1.02</td>
</tr>
</tbody>
</table>

8.1 Mental health and smoking

Smoking rates are much higher among people with mental illness than in the general population. Over 70% of psychiatric inpatients smoke, 50% of them heavily, and 76% of people with first episode psychosis smoke. More than 40% of total tobacco consumption is by those with mental illness. Over 50% of smokers with mental illness say they would like to stop but are less likely to be offered help to do so.

Those with severe mental illness die on average 25 years earlier than the general population and are ten times more likely to die from respiratory disease. Most of this increased mortality can be attributed to higher rates and levels of smoking. Doses of many psychiatric medications can be reduced by up to 50% if a mental health service user stops smoking, with a reduction in side effects.

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65 ONS Smoking and drinking among adults, 2007 General Household Survey 2007  
66 APHO and Department of Health, 2008 Health Profile for Lewisham  
67 The NHS Information centre for Health and Social Care, Healthy lifestyle Behaviours: model Based Estimates
8.2 Physical health and smoking

Smoking is a major contributor to ill health, including circulatory disease, cancer and chronic obstructive pulmonary disease (COPD). Eighty-five percent of COPD is caused by smoking.

Half of all smokers lose an average of 20 years of life. The number of smoking-related deaths in Lewisham is significantly higher than England. In the period 2005-07, the rate of deaths attributable to smoking for those aged 35 years and over in Lewisham (265.2 per 100,000 population) was significantly higher than that of England8, although lower than the 284.5 rate for 2004-06.

Sixty-six percent of smokers say they want to give up. Health concerns are the most commonly mentioned reason for quitting, with 86% of people who want to give up mentioning at least one health reason. After health, the next most commonly mentioned reasons are cost (27%), family pressure (20%) and the effect on children (15%).

8.3 Lewisham Stop Smoking Service

The Stop Smoking Service offers the recommended evidence-based NHS intervention: medication, to reduce the impact of nicotine withdrawal symptoms, together with behavioural support to help people change their smoking habits.

In Lewisham this support is provided in one to one consultations by:-
- trained advisors in 30 GP practices, through enhanced service SLAs
- trained advisors in 30 pharmacies, through enhanced service SLAs
- a part time specialist advisor for pregnant women, partners and parents of under 5s linked to each Children’s Centre
- weekly stop smoking sessions at
  - Waldron Health Centre
  - Downham Health and Leisure Centre
  - Bellingham Leisure Centre
  - Lee Health Centre
  - 6 GP practices with no advisor or insufficient capacity to meet demand

There is also a 7-week structured group programme at Lewisham Hospital on Monday evenings.

In 2008/9, the service aimed to increase the number of people supported to stop smoking and to improve services, targeting Lewisham’s most deprived areas and groups at people supported to stop smoking and to improve services.

In 2008/9, the service achieved 1584 quits, 28% above its target of 1250 quits. Sixty-one pregnant women smokers used the service to stop, three times the number in 2007/8.

In 2008/9, there was considerable variation among wards in the numbers of smokers quitting at four weeks through the Lewisham Stop Smoking Service. The highest number of smoking quitters lived in Bellingham, Perry Vale, Crofton Park and Lewisham Central. The lowest number of quitters lived in Carford South, Lee Green and Blackheath. As part of the North Lewisham Health Improvement Programme, 60% more residents in New Cross ward and 49% more residents in Evelyn ward were supported to quit compared with 2007/8.

8.5 Performance of GP practices 2008/9 by cluster

Only 30 of the 48 GP practices in Lewisham are commissioned to provide a Stop Smoking service. The table below summarises performance for those practices in 2008/9.

8.6 Challenges for the future

A three-pronged approach is needed to contribute to achieving the strategic aims of ‘A Smokefree Future: Tobacco Control Strategy for England’.
- Reduce the inflow of young people who start smoking
- Motivate every smoker to quit and help them to do so
- Protect families and communities from harm

In order to motivate every smoker to quit, the stop smoking service has to increase its scale of intervention overall, in addition to targeting groups most at risk of poor health and premature mortality linked to smoking.

There are currently 18 GP practices which do not provide a stop smoking service, as described above, to their practice population.
Delivering health services to the population in Lewisham can be challenging. In particular, high population turnover in primary care can make it challenging to establish the type of clinical relationship required for optimal management of many long term conditions.

When considering disease prevalence, it has been estimated that there may be over fifty-five thousand people in Lewisham with undiagnosed disease. Even if this figure is an overestimate, it does indicate that there is still much to do to identify people with disease.

Although overall Lewisham practices were less successful than practices elsewhere in England in managing some key clinical indicators, for each indicator considered there were a number of Lewisham practices that performed as well as, or exceeded, the English average on one or more indicators. In some cases, performance on clinical outcomes also reflects performance across the whole pathway, reflecting activity in both primary and secondary care. For example, appropriate prescribing may be initiated in secondary care rather than primary care, but would contribute to a practice’s QOF performance. Equally, failures across the system occur where patients do not have an adequate management plan or do not receive optimal treatment in either or both settings.

A National Audit Office report has stated “it is too early to say conclusively if the QOF has led to improved outcomes for patients but some evidence exists to suggest that modest improvement has been made in controlling asthma and diabetes”69. In Lewisham in the past three years, there has been a slight improvement in achievement in the clinical indicators examined in this report. However, it appears that QOF in its current form is not driving further improvement and that, in many cases, opportunities are being missed to improve outcomes at a population level.

It should be recognised also that 70% achievement in QOF means 30% failure. It is likely that the large proportion of vulnerable and complex patients will be concentrated in this final 30 percent. This will include, for example, people from black and minority ethnic groups and vulnerable groups such as those with learning disabilities, enduring mental health problems, and those with chaotic lives. For such groups, it will require disproportionate effort and resources to achieve the same outcomes.

There is strong evidence that primary care has a crucial role in the promotion of the uptake and, where appropriate, the delivery of immunisation and screening, as well as the delivery of brief interventions to reduce lifestyle risks such as smoking70,71,72.

Benchmarking performance both within clusters, across Lewisham practices and to external national benchmarks is important when trying to explain variation in quality and ‘raising the bar’. The cause of the variation may be multifactorial. Key to reducing it is the implementation of a common systematic management approach to long-term conditions that includes: the establishment of registers; the recall and review of patients as appropriate; and adherence to recognised protocols. The sharing of experiences by the best performing practices could greatly help to drive up performance.

Primary care performance needs to be seen in the context of population health. The effective management of conditions such as hypertension, diabetes and CHD has the potential to make a real contribution to the life expectancy of the overall population. Conversely, failure to effectively identify, treat and manage these and other conditions causes many avoidable deaths and disability. For example; assuming all the CHD and stroke patients are identified in Lewisham, and that GPs achieve similar treatment outcomes for the newly identified patients as for the GPs’ existing patients on disease registers, effective treatment would be expected to prevent 48 cardiovascular disease events per year; 14 heart attacks, 11 strokes/ TIAs, 19 episodes of angina, and 4 deaths. If all practices in Lewisham were to achieve the performance standards of the best, then many more deaths would be avoided.

Fundamental to understanding the scale of the challenges in primary care is having as accurate an estimate of practice populations as possible. This will become increasingly important when commissioning services for cluster populations. It is impossible to be 100% accurate but regular list cleansing to reduce list inflation is important.

70 Dr J Mortell, Dr S McCluskey, S Lui, Prof A Topping (2009) Effectiveness of interventions to improve the uptake of immunization in primary care, with specific focus on Mumps, Measles and Rubella (MMR).
• Performance should be benchmarked across all Lewisham practices and action taken to improve performance in the worst performing practices with peer support from best performing practices.

• QOF targets need to be supplemented by local targets or reviewed centrally in order to drive up and continuously improve performance rather than allowing it to plateau.

• Incentives should actively encourage case finding. Having identified the patients, practices should be given guidance and best practice advice to enable them to manage these patients effectively. Practices that are successful in actively finding and managing patients should be congratulated and encouraged to maintain their success and share best practice with others;

• Effective pharmacological (drug) management of many long term conditions needs to be supported by both clear clinical advice on current best treatments to clinicians (support with audits) and appropriate advice to patients on their concordance (over many years) with the therapies prescribed.

• Case finding of the ‘missing’ patients should be actively promoted within primary care and with the general public. Many patients may not be aware of the seriousness of their symptoms or that treatment is available to reduce risk of further disease. Benefits of screening and signs and symptoms which should prompt self referral to primary care should be well publicised to patients.

• Primary care clusters should encourage practices to adopt robust and systematic clinical and management processes, particularly around immunisation, chronic disease management and screening to help drive up performance.

• Primary care has an important public health role in relation to lifestyle interventions, and whilst these are not well captured within QOF, it is essential that they are not overlooked. In Lewisham, enhanced services have been introduced to support these areas. In particular, brief interventions around smoking, exercise, weight management and alcohol are ideal for delivery in a primary care setting. Referral to health trainers can support practices in the delivery of these interventions. Consideration as to how these types of interventions can be systematically embedded into primary care practice and monitored robustly is required.
Table AI.I Key to GP Cluster Map Figure 3.1

<table>
<thead>
<tr>
<th>Site No.</th>
<th>Senior Partner</th>
<th>Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Krishnapalasuyar</td>
<td>Mornington Surgery</td>
</tr>
<tr>
<td>2</td>
<td>Rodrigues</td>
<td>Queens Road Practice</td>
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<td>3</td>
<td>Jain</td>
<td>Kingfisher Medical Centre</td>
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<td>4</td>
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* Dr Neal successfully won a tender for a second practice. One appears in Cluster 1 and one appears in Cluster 2. By 2009/10 they are amalgamated for future reference.

Table AI.II Registered Population and Deprivation by GP Practice

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<tr>
<th>Senior Partner</th>
<th>IMD</th>
<th>Patients</th>
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</table>

Table AI.II shows the registered populations for GP practices in Lewisham as at 31 March 2009, and the practices’ deprivation scores. The IMD is issued at Lower Super Output Area (LSOA) level, and the practice scores were calculated as the weighted average score for registered patients’ LSOA of residence. Deprivation is well known to be closely linked to health status and health outcomes: the practice deprivation score is an indicator of relative levels of expected need for health care. The higher the deprivation score, the more deprived the population.
<table>
<thead>
<tr>
<th>Indicator Short Name</th>
<th>Indicator description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Average QOF score</strong></td>
<td><strong>Average QOF score</strong></td>
</tr>
<tr>
<td><strong>Circulatory disease</strong></td>
<td></td>
</tr>
<tr>
<td>CHD, BP &lt;= 150/90</td>
<td>% patients with CHD in whom last BP is 150/90 or less</td>
</tr>
<tr>
<td>CHD, cholesterol &lt;= 5</td>
<td>% patients with CHD in whom last measured total cholesterol is 5 or less</td>
</tr>
<tr>
<td>heart failure confirmed</td>
<td>% patients with a diagnosis of heart failure which has been confirmed by an echo or specialist</td>
</tr>
<tr>
<td>strokes referred</td>
<td>% new patients with a stroke who have been referred for further investigation</td>
</tr>
<tr>
<td>stroke/TIA, last BP &lt;= 150/90</td>
<td>% patients with a history of TIA or stroke in whom last BP is 150/90 or less</td>
</tr>
<tr>
<td>stroke, cholesterol &lt;= 5</td>
<td>% patients with TIA or stroke whose last measured total cholesterol is 5 or less</td>
</tr>
<tr>
<td>hypertension BP &lt;= 150/90</td>
<td>% patients with hypertension in whom last BP is 150/90 or less</td>
</tr>
<tr>
<td>Atr Fib confirmed</td>
<td>% patients with Atrial Fibrilation diagnosed after 1 April 2006 with ECG or specialist confirmed diagnosis</td>
</tr>
<tr>
<td><strong>Other long term conditions</strong></td>
<td></td>
</tr>
<tr>
<td>diabetes, HbA1c &lt;= 7.5</td>
<td>% patients with diabetes in whom last HbA1c is 7.5 or less</td>
</tr>
<tr>
<td>diabetes, HbA1c &lt;= 10</td>
<td>% patients with diabetes in whom last HbA1c is 10 or less</td>
</tr>
<tr>
<td>diabetes BP &lt;= 145/85</td>
<td>% patients with diabetes in whom last BP is 145/85 or less</td>
</tr>
<tr>
<td>diabetes, cholesterol &lt;= 5</td>
<td>% patients with diabetes whose last measured total cholesterol is 5 or less</td>
</tr>
<tr>
<td>epilepsy, seizure free year</td>
<td>% patients over 18 on drug treatment for epilepsy who have been seizure free for the last 12 months</td>
</tr>
<tr>
<td>asthma var and revers</td>
<td>% patients aged 8 and over diagnosed with having asthma from 1 April 2006 with measures of variability and reversibility</td>
</tr>
</tbody>
</table>
Department of Public Health,
NHS Lewisham

Cantilever House
Eltham Road
London SE12 8RN

Further copies of this report are available from the above address or the NHS Lewisham website:
www.lewishampct.nhs.uk