KENT PUBLIC HEALTH OBSERVATORY

South Kent Coast CCG hub Profile
Dover

October 2015

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Key Findings

Demographic overview

- Approximately 57,100 persons are registered to the nine GP practices located within the Dover hub. The population structure can be seen in the chart below, predominantly a younger population than that of South Kent Coast generally, more than 60% of the population are aged under 50.

Primary care context

- All general practices have a general practitioner headcount of three or more practitioners with the exception of Aylesham Medical Practice, Buckland Medical Centre and White Cliffs Medical Centre in 2014.
- Pencester Health Centre has the lowest FTE of general practitioners at 0.7.

GP Survey

- The rating of 'neither good nor poor' for each GP surgery is slightly higher compared to other South Kent Coast CCG hubs. Pencester Surgery, has a larger response of 'neither good nor poor' than all surgeries (15% recorded in 2014).

Long term conditions prevalence

- In 2013/14, the general practice recorded prevalence was significantly higher than the CCG for chronic kidney disease, chronic obstructive pulmonary disease and obesity.
- Chronic kidney disease recorded prevalence has increased by 0.50% per year between 2006/07 and 2013/14. This was a significantly higher increase in comparison to the national trend.

Primary care performance

- General practices have been explored for significantly lower clinical achievement for the percentage of patients receiving the intervention for the range of long term conditions. Also, practices with exception rates that are outliers, greater than two standard deviations from the Kent mean have been highlighted.

Health Checks

- Performance describes the numbers of health checks delivered (within all settings) in comparison to the eligible population (one fifth of the five year eligible population).
- None of the Dover practices were identified to have performance that was significantly lower than the 95% or 99.8% control limits within Kent.

Cancer

- Across Kent it is known that there has been an increasing trend in cancer incidence. General practices have been explored for their prevalence, as well as, screening for breast, cervical and bowel cancer.

Lifestyles

- Modelled estimates for obesity and smoking prevalence have been presented for South Kent Coast CCG.

Accident and emergency activity

- The rate of increase for Dover patients is in line with the increase for all Kent patients (about 8%) but higher than the 5% for South Kent Coast.
- The age profile of all attendances does reflect the general profile of the population in Dover.

Outpatient activity

- The proportion of appointments whereby the patient did not attend were lower within Dover, in comparison to South Kent Coast CCG and Kent. In 2014/15, within Dover, patient not attending appointment amounted to 2,202 appointments.
- First appointments accounted for 36,167 attendances within Dover general practices. After first attendance, 36.5% or 13,208 were discharged from care.
- Within Kent, in 2014/15 there was a ratio of 2.25 follow-up appointments for each first appointment. A higher ratio can be seen for South Kent Coast CCG (2.49) and for Dover (2.67).

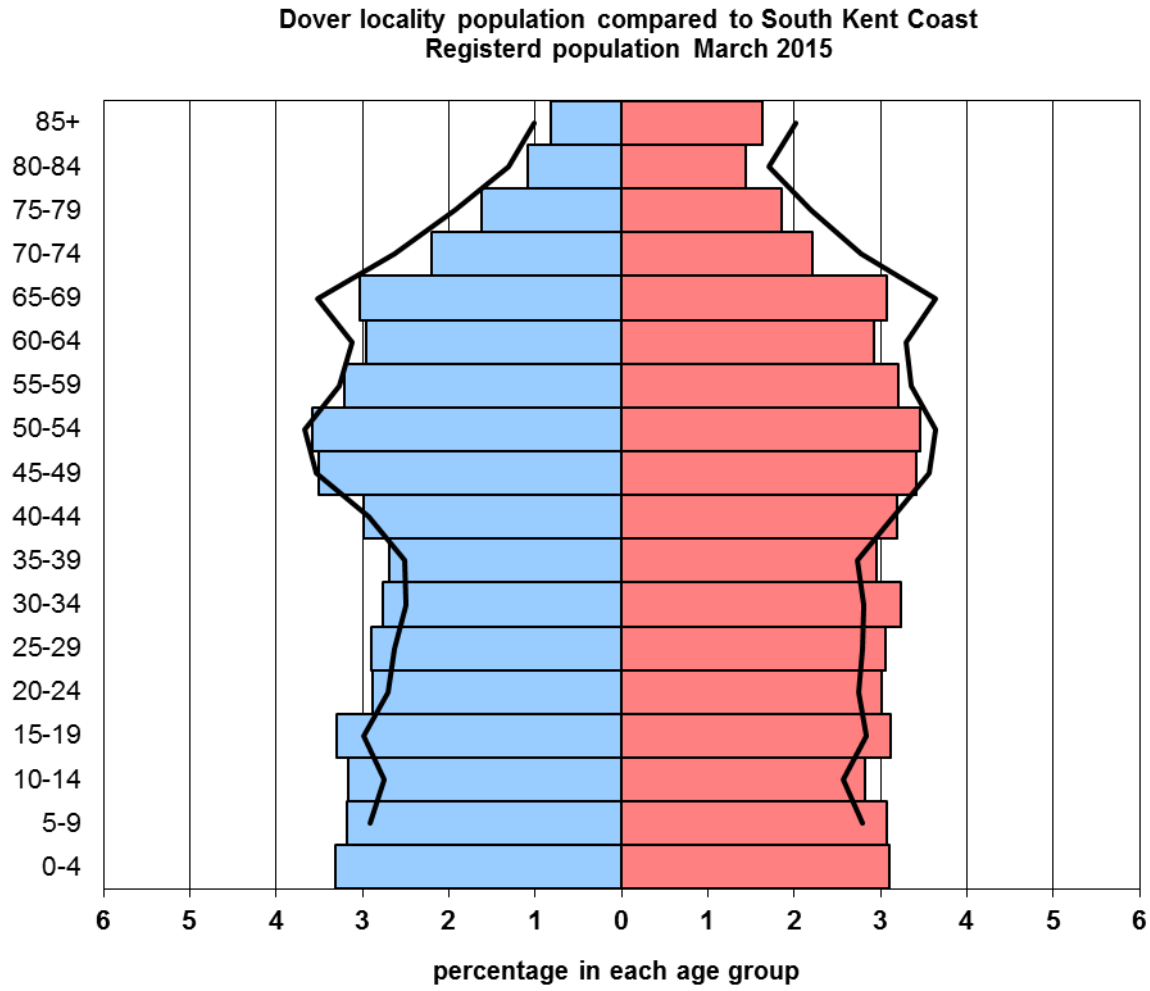
Mortality and life expectancy

- Dover has a significantly higher all age, all cause mortality rate than South Kent Coast CCG, east Kent and Kent for 2006 to 2014 (pooled). Within the hub, Buckland Medical Centre has a significantly lower rate than Dover hub. The rate of decrease between 2006 and 2014 has been slower in Dover than Kent and South Kent Coast CCG.
- Under 75 cancer mortality rates are similar for the Dover hub and comparator areas. There has been a faster rate of decrease in Dover, but there are large fluctuations in the rate.
- Dover hub has a significantly higher under 75 circulatory mortality rate than Kent for 2006 to 2014 (pooled). The rate of decrease has been slower since 2006 in comparison to Kent and east Kent; however, large fluctuations are observed.
- Whilst there are no significant differences between practices in the hub for under 75 respiratory disease mortality rates (2006 to 2014 pooled), the Dover hub rate is significantly higher than both east Kent and Kent.
- The gap in life expectancy between practices within the hub is 3.1 years, and the hub has a significantly lower life expectancy than South Kent Coast CCG, east Kent and Kent.

Demographics Overview

Approximately 57,100 persons are registered to the nine GP practices located within the Dover hub. The population structure can be seen in the chart below, predominantly a younger population than that of South Kent Coast generally, more than 60% of the population are aged under 50. There are slightly more females than males in the area (50.8% to 49.2% males).

Figure 1:



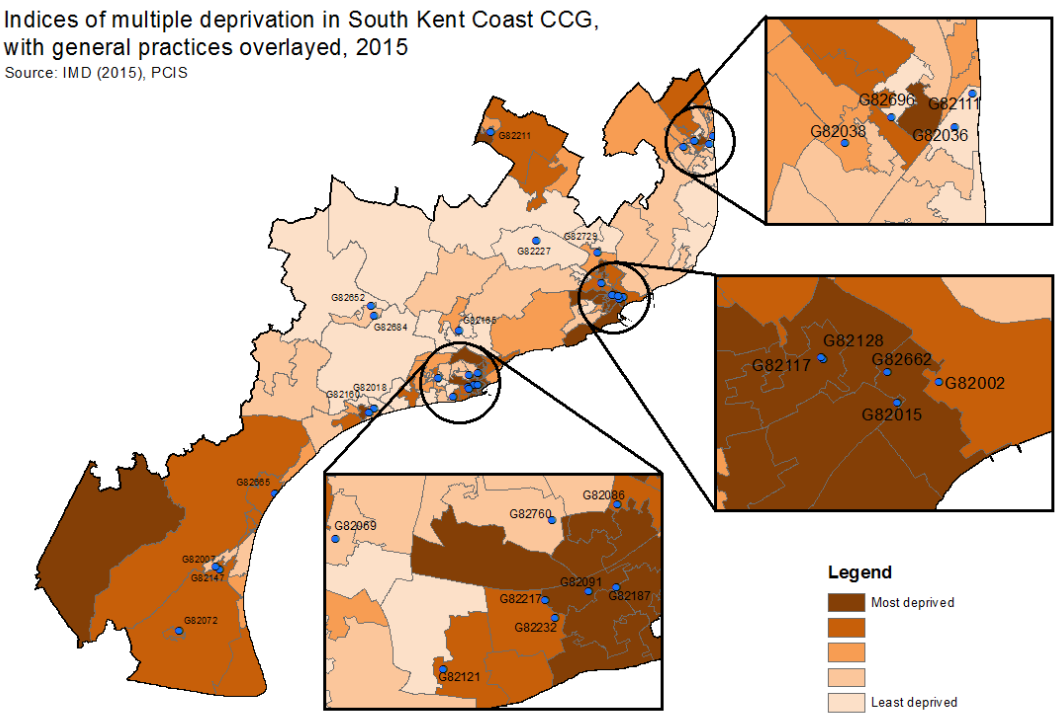
The overall population of South Kent Coast CCG is set to increase by 15% by the year 2025 from the current registered of 205,000 rising to around 215,000, with the greatest growth in the over 65 population (24%) up from 47,000 to 58,200 .

Table 1

Dover locality registered population - March 2015

Age band	Male	Female	Total
0-4	1,892	1,776	3,668
5-9	1,821	1,754	3,575
10-14	1,807	1,609	3,416
15-19	1,886	1,779	3,665
20-24	1,649	1,720	3,369
25-29	1,653	1,751	3,404
30-34	1,580	1,848	3,428
35-39	1,541	1,687	3,228
40-44	1,705	1,828	3,533
45-49	2,003	1,952	3,955
50-54	2,043	1,976	4,019
55-59	1,831	1,836	3,667
60-64	1,688	1,675	3,363
65-69	1,734	1,753	3,487
70-74	1,255	1,267	2,522
75-79	929	1,056	1,985
80-84	623	819	1,442
85+	470	933	1,403
Total	28,110	29,019	57,129

Figure 2



The most deprived fifth of LSOAs tend to centre around the towns; Dover and Folkestone. The Romney Marsh area is also relatively deprived.

Primary care context

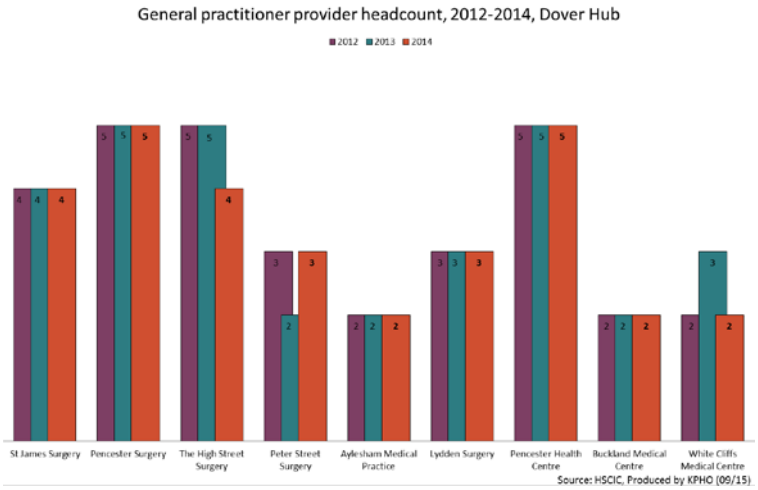
General Practitioners

The general practitioner providers have been referred to; this represents the practitioners who have entered into contracts to provide services. This indicator has been used as it enables comparison over time. This does not represent the salaried GPs who work within partnerships.

The general practice context: provider headcount, provider full time equivalent (FTE) and general practitioner provider to population ratio has been detailed below.

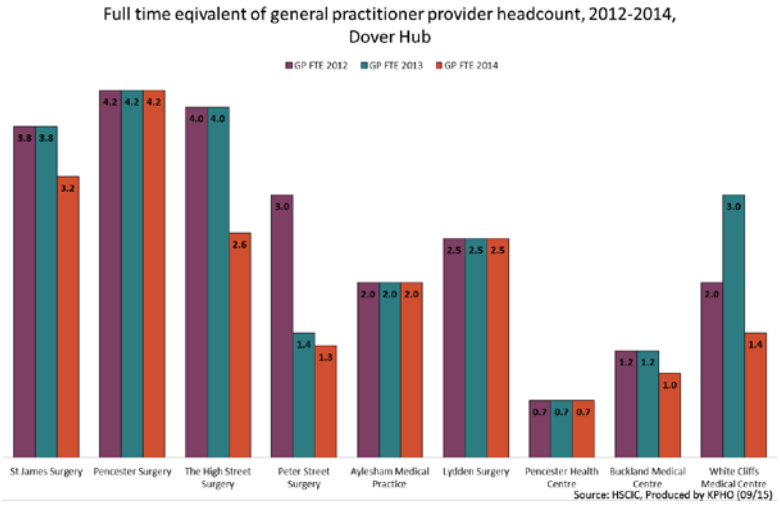
- All general practice surgeries have a general practitioner headcount of three or more practitioners with the exception of Aylesham Medical Practice, Buckland Medical Centre and White Cliffs Medical Centre in 2014.

Figure 3



Pencester Health Centre has the lowest FTE of general practitioners at 0.7; this has remained consistent since 2012. Five out of the nine general practices show a decrease of the FTE for general practitioners from 2013 to 2014.

Figure 4



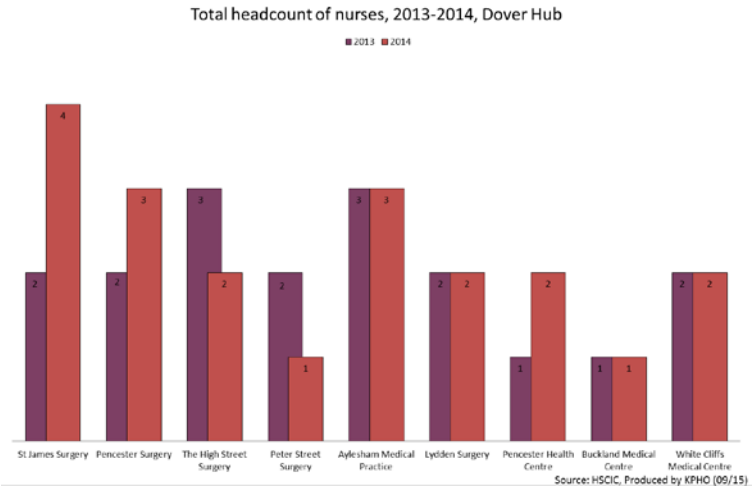
Total Nurses

The total nurses definition refers to advanced nurses, extended role nurses and practice nurses.

All Dover hub general practices have four or less nurses per practice. The lowest headcounts in 2014 for nurses are at Peter Street Surgery and Buckland Medical Centre, which both have one nurse per practice.

The number of advanced nurses in the Dover hub has increased to five in 2014 from three in 2013. The number of extended nurses has remained the same from 2013 to 2014 (currently five).

Figure 5

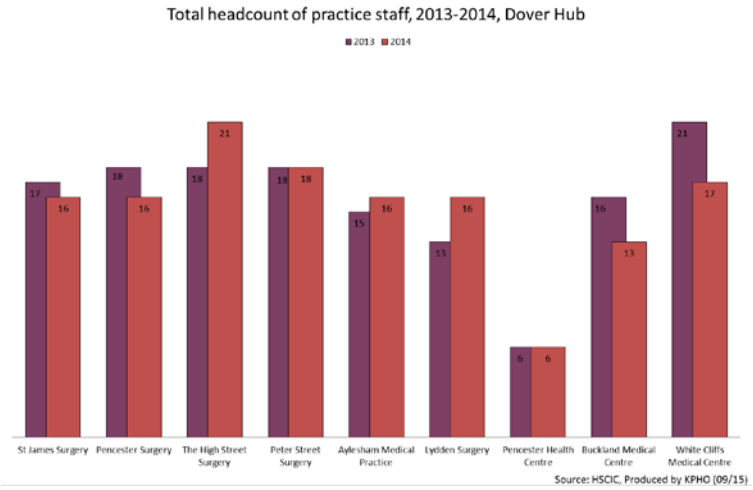


Practice Staff

The total practice staff indicator can be defined to exclude general practitioners, but includes; nurses, those involved within direct patient care or administration and other paid members of practice staff.

The headcount of practice staff is higher than the headcount of general practitioners and nurses. Pencester Health Centre is the only exception with a headcount of six practice staff from 2013 to 2014.

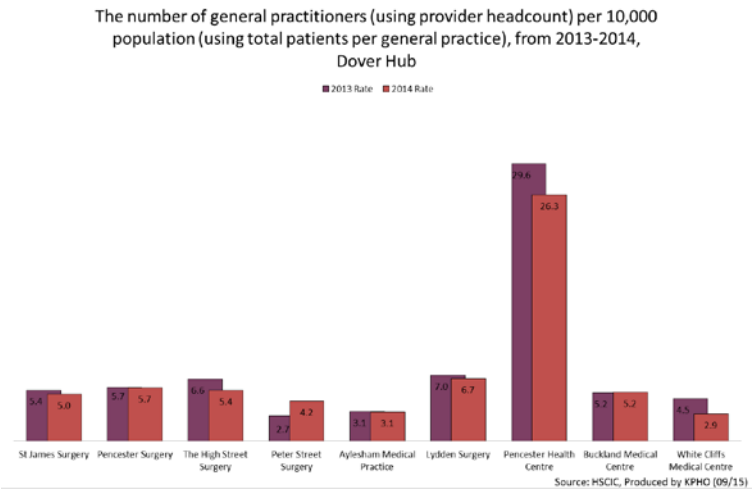
Figure 6



General Practitioner to Population Ratio

Pencester Health Centre has the highest general practitioner to population ratio at 26.3 per 10,000 population. All other general practices have a substantively lower practitioner to population ratio.

Figure 7



GP Survey

From the GP Survey, conducted for each year, the overall experience at a GP survey has been analysed from 2012 to 2014.

The rating of 'neither good nor poor' for each GP surgery is slightly higher compared to other South Kent Coast CCG hubs. GP Surgery, Pencester Surgery, has a larger response of 'neither good nor poor' than all surgeries (15% recorded in 2014).

Table 2

Overall Response 2012	St James Surgery	Pencester Surgery	The High Street Surgery	Peter Street Surgery	Aylesham Medical Practice	Lydden Surgery	Pencester Health Centre	Buckland Medical Centre	White Cliffs Medical Centre
Overall experience of GP surgery	Percentage of answers (%)								
Very good	42	31	37	42	42	64	59	37	53
Fairly good	41	49	50	46	46	33	31	51	39
Neither good nor poor	14	14	11	10	10	3	8	9	8
Fairly poor	1	5	0	1	1	0	1	3	0
Very poor	2	1	2	0	0	0	0	0	0

Source: GP Patient Survey, January-September 2012

Overall Response 2013	St James Surgery	Pencester Surgery	The High Street Surgery	Peter Street Surgery	Aylesham Medical Practice	Lydden Surgery	Pencester Health Centre	Buckland Medical Centre	White Cliffs Medical Centre
Overall experience of GP surgery	Percentage of answers (%)								
Very good	45	24	37	25	39	62	45	39	50
Fairly good	42	45	41	53	51	30	38	47	43
Neither good nor poor	9	25	14	17	8	4	14	11	5
Fairly poor	2	5	6	4	2	4	2	1	1
Very poor	2	1	2	1	1	0	0	2	1

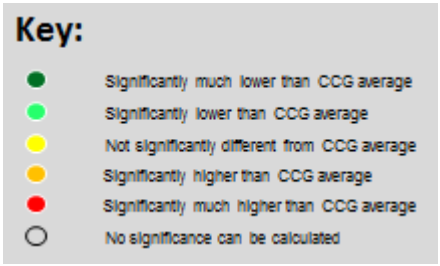
Source: Practice Report (GP Patient Survey), January-March 2013 and July-September 2013

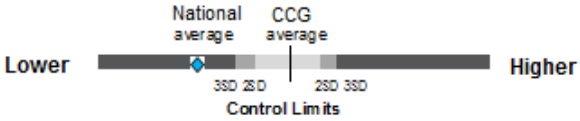
Overall Response 2014	St James Surgery	Pencester Surgery	The High Street Surgery	Peter Street Surgery	Aylesham Medical Practice	Lydden Surgery	Pencester Health Centre	Buckland Medical Centre	White Cliffs Medical Centre
Overall experience of GP surgery	Percentage of answers (%)								
Very good	45	22	43	22	41	58	36	36	50
Fairly good	44	54	41	54	41	33	54	54	41
Neither good nor poor	9	15	8	15	12	6	9	9	8
Fairly poor	1	7	5	7	4	2	1	1	0
Very poor	2	1	4	1	2	0	0	0	1

Long term conditions prevalence

Recorded Prevalence

Spine charts have been produced to compare the general practice recorded prevalence of long term conditions with the NHS South Kent Coast CCG recorded prevalence in 2013/14.





Trend analysis has been carried out to explore the general practice rate of change for long term condition recorded prevalence between 2006/07 to 2013/14. This has been compared with the National rate of change, as the most reliable estimate.

The QOF uses an extract of practice list sizes as of 1st January 2014 and disease registers as at 31st March 2014. Analysis has been based on practices open as at time of report publication.

Recorded prevalence for the most of long term conditions uses the total practice population. However, this differs for obesity (16 years and over), diabetes (17 years and over), as well as, learning disabilities, epilepsy and chronic kidney disease (18 years and over).

Limitations

A limitation of the QOF recorded prevalence is that analysis cannot differentiate between true prevalence and the effectiveness of case finding strategies between practices.

The projected recorded prevalence has not been adjusted for any other factors known to influence the risk of long term conditions, such as changes in deprivation and in the demographic patterns of at risk population groups (such as, age). It is likely therefore, that the prevalence projections shown in this section are likely to be conservative estimates.

*It should be noted that limitations have been identified with the QOF recorded prevalence of Chronic Kidney Disease. Coding issues have been reported that may lead to under reporting.

G82002 – St James Surgery

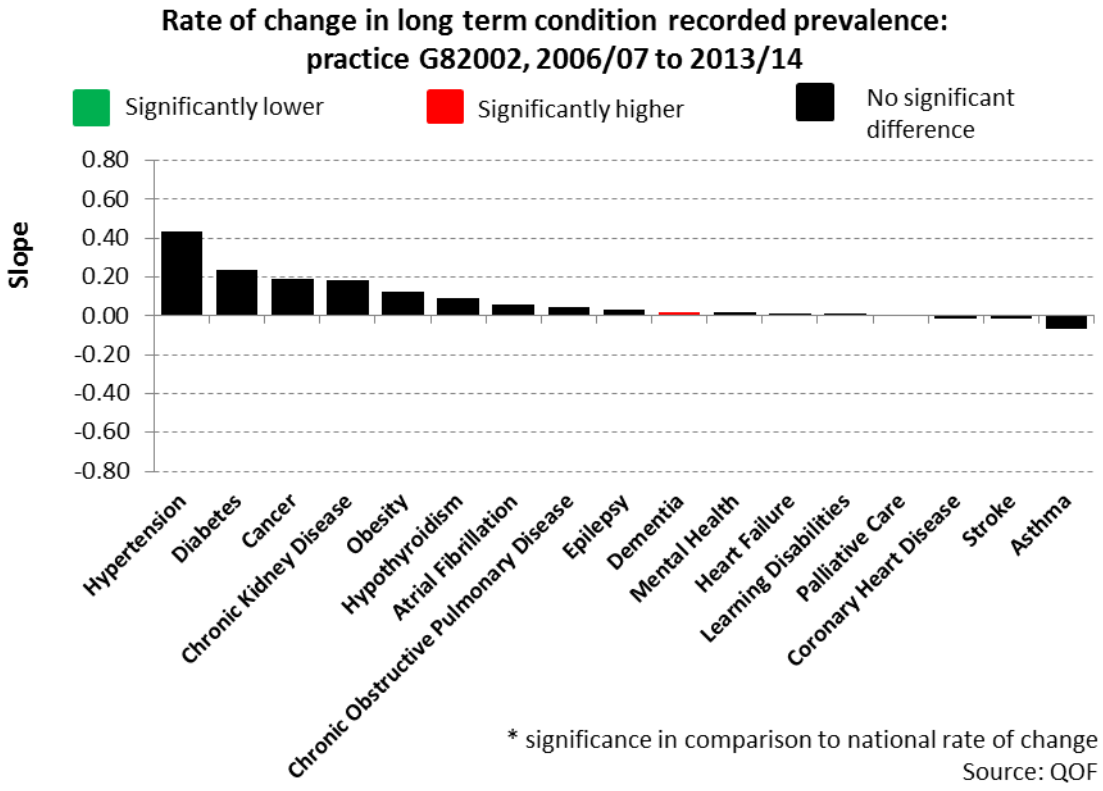
In 2013/14, the general practice recorded prevalence was not significantly higher than the CCG for any of the long term conditions.

Table 3

	Practice		CCG			
Indicator	**Number**	**Prevalence**	**Average**	**Low**	**Range**	**High**
Asthma (%)	456	5.8	5.7	4.1		10.3
Atrial fibrillation (%)	117	1.5	2.2	1.2		3.6
Cancer (%)	144	1.8	2.5	0.8		4.0
Chronic Kidney Disease (%)	264	4.4	5.5	3.8		8.2
Chronic Obstructive Pulmonary Disease	159	2.0	2.3	1.1		4.3
Coronary Heart Disease (%)	213	2.7	3.8	2.7		5.7
Dementia (%)	40	0.5	0.6	0.1		1.0
Diabetes (%)	399	6.5	7.0	5.7		9.3
Epilepsy (%)	62	1.0	1.0	0.3		1.5
Heart Failure (%)	31	0.4	0.7	0.3		1.1
Hypertension (%)	1040	13.1	16.2	12.0		20.5
Hypothyroidism (%)	197	2.5	3.4	2.0		5.2
Learning Disabilities (%)	41	0.7	0.8	0.2		2.4
Mental Health (%)	50	0.6	0.7	0.3		1.5
Obesity (%)	651	10.3	10.4	3.8		20.2
Stroke (%)	117	1.5	2.0	1.2		3.3

Epilepsy recorded prevalence has increased by 0.03% per year between 2006/07 and 2013/14. This was a significantly higher increase in comparison to the national trend.

Figure 4



G82015 - Pencester Surgery

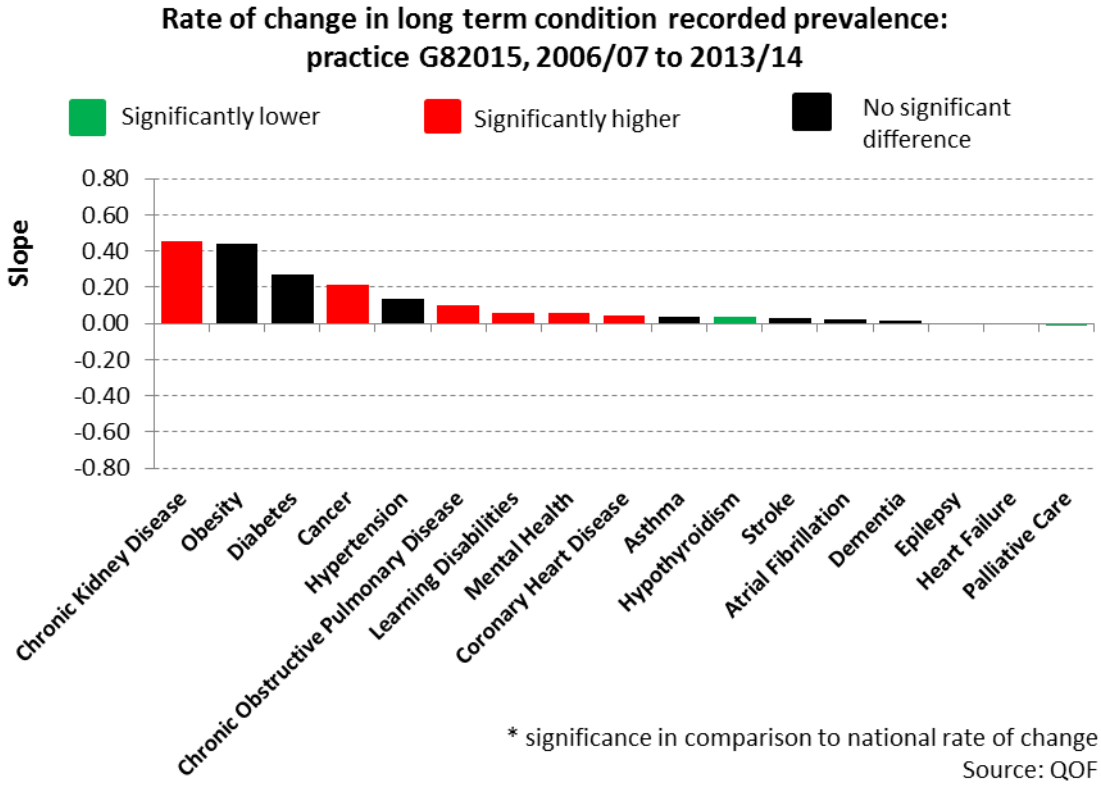
In 2013/14, the general practice recorded prevalence was not significantly higher than the CCG for any of the long term conditions.

Table 4

	Practice		CCG			
Indicator	**Number**	**Prevalence**	**Average**	**Low**	**Range**	**High**
Asthma (%)	532	6.1	5.7	4.1		10.3
Atrial fibrillation (%)	135	1.5	2.2	1.2		3.6
Cancer (%)	185	2.1	2.5	0.8		4.0
Chronic Kidney Disease (%)	272	4.0	5.5	3.8		8.2
Chronic Obstructive Pulmonary Disease	163	1.9	2.3	1.1		4.3
Coronary Heart Disease (%)	264	3.0	3.8	2.7		5.7
Dementia (%)	44	0.5	0.6	0.1		1.0
Diabetes (%)	439	6.3	7.0	5.7		9.3
Epilepsy (%)	68	1.0	1.0	0.3		1.5
Heart Failure (%)	41	0.5	0.7	0.3		1.1
Hypertension (%)	1137	13.0	16.2	12.0		20.5
Hypothyroidism (%)	226	2.6	3.4	2.0		5.2
Learning Disabilities (%)	37	0.5	0.8	0.2		2.4
Mental Health (%)	63	0.7	0.7	0.3		1.5
Obesity (%)	562	7.9	10.4	3.8		20.2
Stroke (%)	171	2.0	2.0	1.2		3.3

Chronic kidney disease recorded prevalence has increased by 0.45% per year between 2006/07 and 2013/14. This was a significantly higher increase in comparison to the national trend.

Figure 5



G82117 - The High Street Surgery

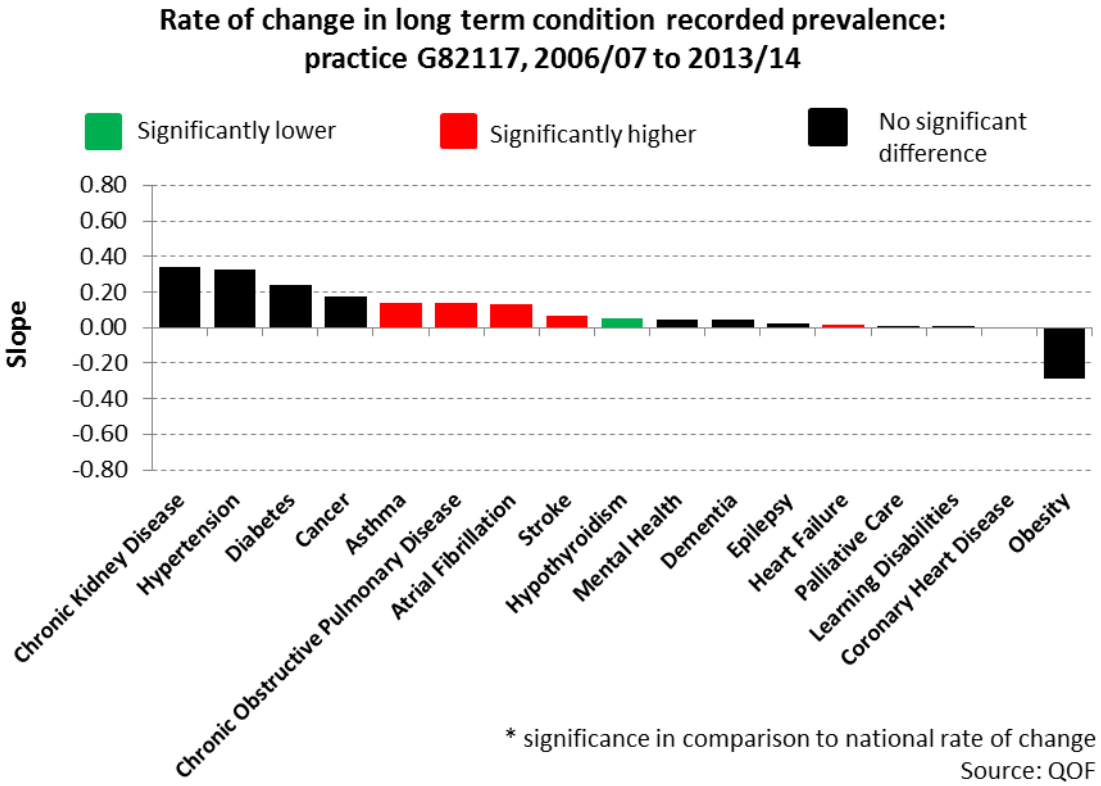
In 2013/14, the general practice recorded prevalence was not significantly higher than the CCG for any of the long term conditions.

Table 5

	Practice		CCG			
Indicator	**Number**	**Prevalence**	**Average**	**Low**	**Range**	**High**
Asthma (%)	386	5.3	5.7	4.1		10.3
Atrial fibrillation (%)	162	2.2	2.2	1.2		3.6
Cancer (%)	149	2.0	2.5	0.8		4.0
Chronic Kidney Disease (%)	310	5.4	5.5	3.8		8.2
Chronic Obstructive Pulmonary Disease	144	2.0	2.3	1.1		4.3
Coronary Heart Disease (%)	277	3.8	3.8	2.7		5.7
Dementia (%)	49	0.7	0.6	0.1		1.0
Diabetes (%)	406	7.0	7.0	5.7		9.3
Epilepsy (%)	60	1.0	1.0	0.3		1.5
Heart Failure (%)	34	0.5	0.7	0.3		1.1
Hypertension (%)	1128	15.4	16.2	12.0		20.5
Hypothyroidism (%)	241	3.3	3.4	2.0		5.2
Learning Disabilities (%)	28	0.5	0.8	0.2		2.4
Mental Health (%)	48	0.7	0.7	0.3		1.5
Obesity (%)	618	10.4	10.4	3.8		20.2
Palliative Care (%)	14	0.2	0.2	0.0		0.4
Stroke (%)	162	2.2	2.0	1.2		3.3

Asthma recorded prevalence has increased by 0.14% per year between 2006/07 and 2013/14. This was a significantly higher increase in comparison to the national trend.

Figure 6



G82128 - Peter Street Surgery

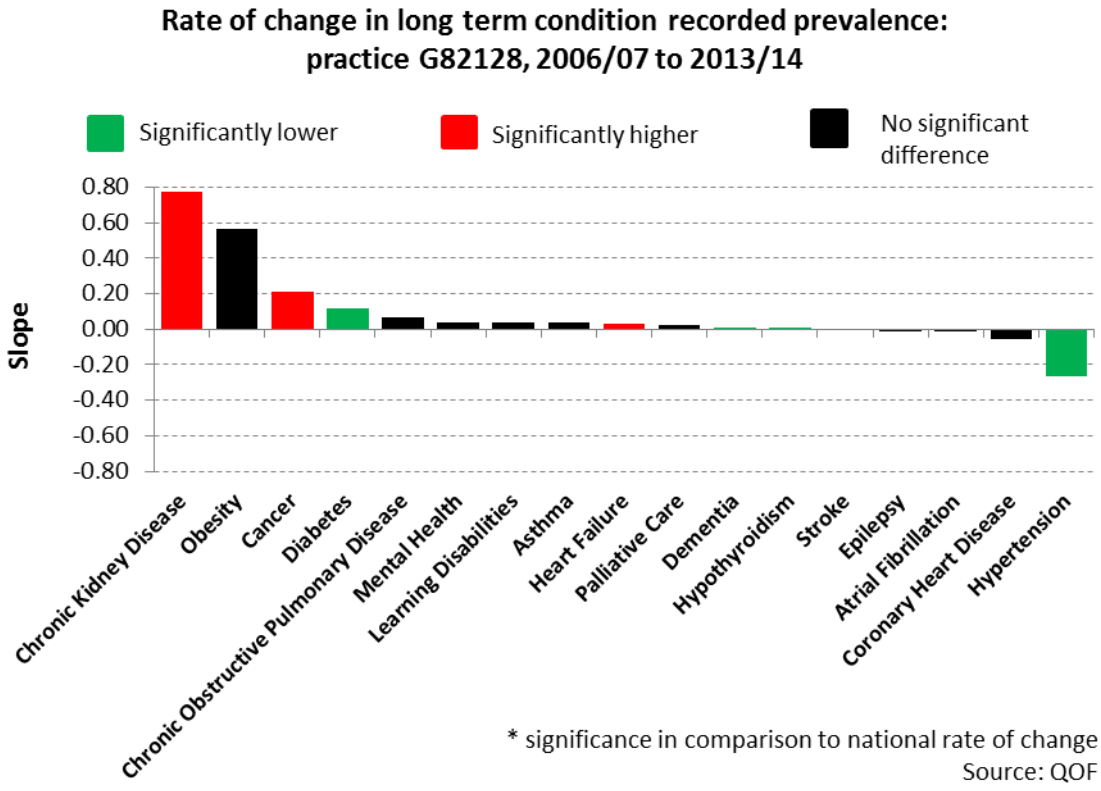
In 2013/14, the general practice recorded prevalence was significantly higher than the CCG for; chronic kidney disease and obesity.

Table 6

	Practice		CCG			
Indicator	**Number**	**Prevalence**	**Average**	**Low**	**Range**	**High**
Asthma (%)	408	5.6	5.7	4.1		10.3
Atrial fibrillation (%)	141	1.9	2.2	1.2		3.6
Cancer (%)	145	2.0	2.5	0.8		4.0
Chronic Kidney Disease (%)	367	6.4	5.5	3.8		8.2
Chronic Obstructive Pulmonary Disease	135	1.8	2.3	1.1		4.3
Coronary Heart Disease (%)	249	3.4	3.8	2.7		5.7
Dementia (%)	47	0.6	0.6	0.1		1.0
Diabetes (%)	387	6.6	7.0	5.7		9.3
Epilepsy (%)	70	1.2	1.0	0.3		1.5
Heart Failure (%)	48	0.7	0.7	0.3		1.1
Hypertension (%)	944	12.9	16.2	12.0		20.5
Hypothyroidism (%)	222	3.0	3.4	2.0		5.2
Learning Disabilities (%)	42	0.7	0.8	0.2		2.4
Mental Health (%)	56	0.8	0.7	0.3		1.5
Obesity (%)	764	12.9	10.4	3.8		20.2
Palliative Care (%)	13	0.2	0.2	0.0		0.4
Stroke (%)	152	2.1	2.0	1.2		3.3

Chronic kidney disease recorded prevalence has increased by 0.78% per year between 2006/07 and 2013/14. This was a significantly higher increase in comparison to the national trend.

Figure 7



G82211 - Aylesham Medical Practice

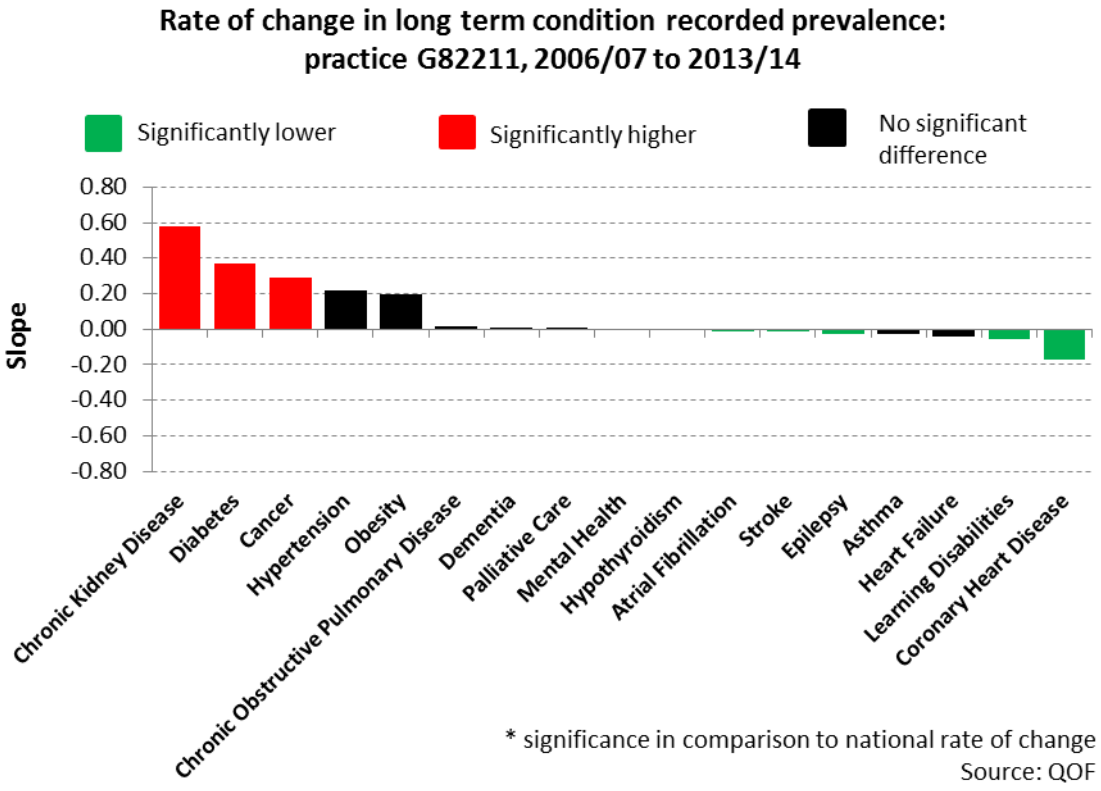
In 2013/14, the general practice recorded prevalence was significantly higher than the CCG for; chronic kidney disease, chronic obstructive pulmonary disease and obesity.

Table 7

	Practice		CCG			
Indicator	**Number**	**Prevalence**	**Average**	**Low**	**Range**	**High**
Asthma (%)	300	4.7	5.7	4.1		10.3
Atrial fibrillation (%)	106	1.7	2.2	1.2		3.6
Cancer (%)	177	2.8	2.5	0.8		4.0
Chronic Kidney Disease (%)	331	6.7	5.5	3.8		8.2
Chronic Obstructive Pulmonary Disease	264	4.1	2.3	1.1		4.3
Coronary Heart Disease (%)	210	3.3	3.8	2.7		5.7
Dementia (%)	29	0.5	0.6	0.1		1.0
Diabetes (%)	361	7.2	7.0	5.7		9.3
Epilepsy (%)	37	0.7	1.0	0.3		1.5
Heart Failure (%)	58	0.9	0.7	0.3		1.1
Hypertension (%)	884	13.8	16.2	12.0		20.5
Hypothyroidism (%)	234	3.6	3.4	2.0		5.2
Learning Disabilities (%)	32	0.6	0.8	0.2		2.4
Mental Health (%)	42	0.7	0.7	0.3		1.5
Obesity (%)	619	12.1	10.4	3.8		20.2
Palliative Care (%)	11	0.2	0.2	0.0		0.4
Stroke (%)	122	1.9	2.0	1.2		3.3

Chronic kidney disease recorded prevalence has increased by 0.58% per year between 2006/07 and 2013/14. This was a significantly higher increase in comparison to the national trend.

Figure 8



G82227 - Lydden Surgery

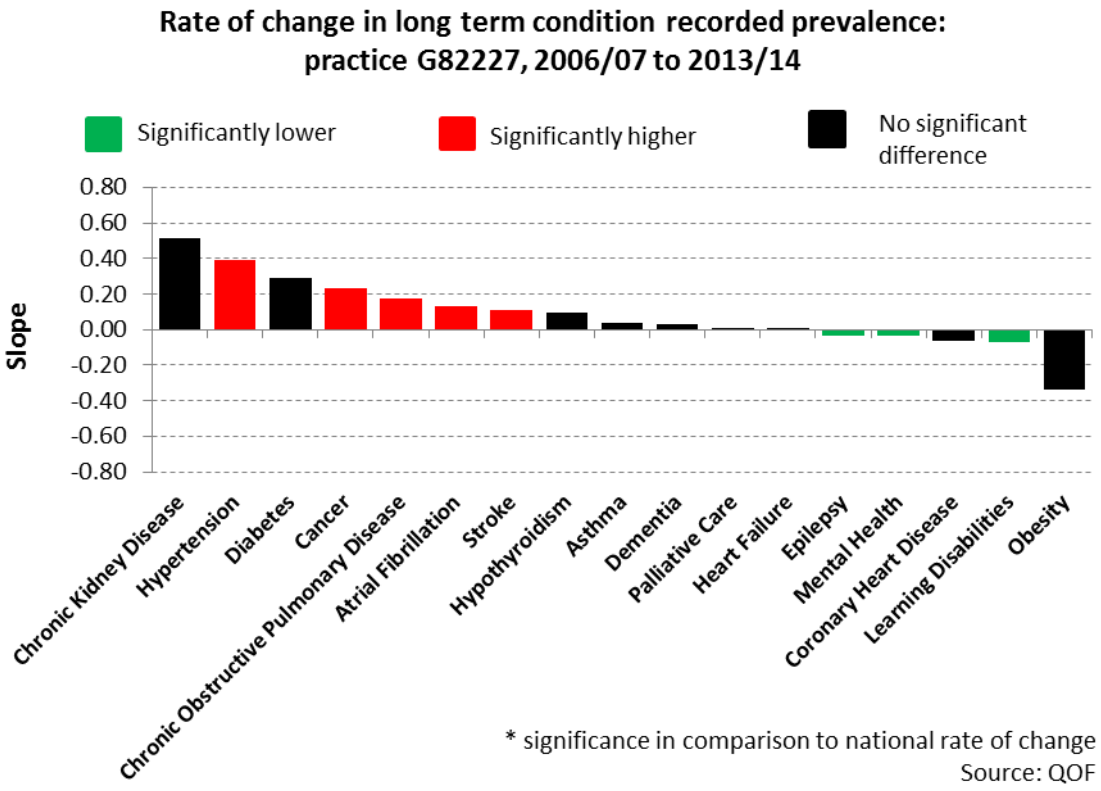
In 2013/14, the general practice recorded prevalence was significantly higher than the CCG for; asthma and hypertension.

Table 8

	Practice		CCG			
Indicator	**Number**	**Prevalence**	**Average**	**Low**	**Range**	**High**
Asthma (%)	304	7.0	5.7	4.1		10.3
Atrial fibrillation (%)	114	2.6	2.2	1.2		3.6
Cancer (%)	122	2.8	2.5	0.8		4.0
Chronic Kidney Disease (%)	239	6.6	5.5	3.8		8.2
Chronic Obstructive Pulmonary Disease	101	2.3	2.3	1.1		4.3
Coronary Heart Disease (%)	198	4.6	3.8	2.7		5.7
Dementia (%)	45	1.0	0.6	0.1		1.0
Diabetes (%)	238	6.5	7.0	5.7		9.3
Epilepsy (%)	22	0.6	1.0	0.3		1.5
Heart Failure (%)	37	0.9	0.7	0.3		1.1
Hypertension (%)	849	19.6	16.2	12.0		20.5
Hypothyroidism (%)	162	3.7	3.4	2.0		5.2
Learning Disabilities (%)	17	0.5	0.8	0.2		2.4
Mental Health (%)	15	0.3	0.7	0.3		1.5
Obesity (%)	258	7.0	10.4	3.8		20.2
Stroke (%)	94	2.2	2.0	1.2		3.3

Hypertension recorded prevalence has increased by 0.39% per year between 2006/07 and 2013/14. This was a significantly higher increase in comparison to the national trend.

Figure 9



G82662 - Pencester Health Centre

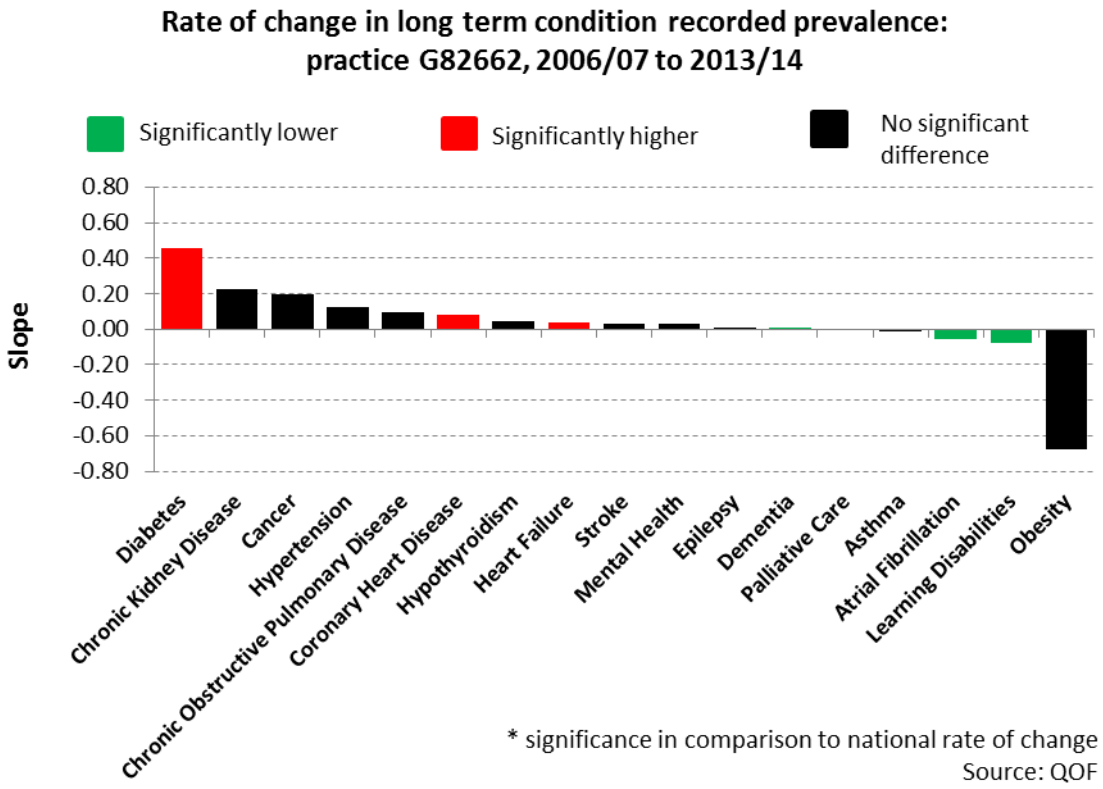
In 2013/14, the general practice recorded prevalence was significantly higher than the CCG for obesity.

Table 9

	Practice		CCG			
Indicator	**Number**	**Prevalence**	**Average**	**Low**	**Range**	**High**
Asthma (%)	76	4.2	5.7	4.1		10.3
Atrial fibrillation (%)	21	1.2	2.2	1.2		3.6
Cancer (%)	36	2.0	2.5	0.8		4.0
Chronic Kidney Disease (%)	53	3.9	5.5	3.8		8.2
Chronic Obstructive Pulmonary Disease	36	2.0	2.3	1.1		4.3
Coronary Heart Disease (%)	56	3.1	3.8	2.7		5.7
Diabetes (%)	101	7.2	7.0	5.7		9.3
Epilepsy (%)	13	0.9	1.0	0.3		1.5
Heart Failure (%)	7	0.4	0.7	0.3		1.1
Hypertension (%)	229	12.8	16.2	12.0		20.5
Hypothyroidism (%)	36	2.0	3.4	2.0		5.2
Mental Health (%)	10	0.6	0.7	0.3		1.5
Obesity (%)	184	13.0	10.4	3.8		20.2
Stroke (%)	21	1.2	2.0	1.2		3.3

Diabetes recorded prevalence has increased by 0.46% per year between 2006/07 and 2013/14. This was a significantly higher increase in comparison to the national trend.

Figure 10



G82700 - Buckland Medical Centre

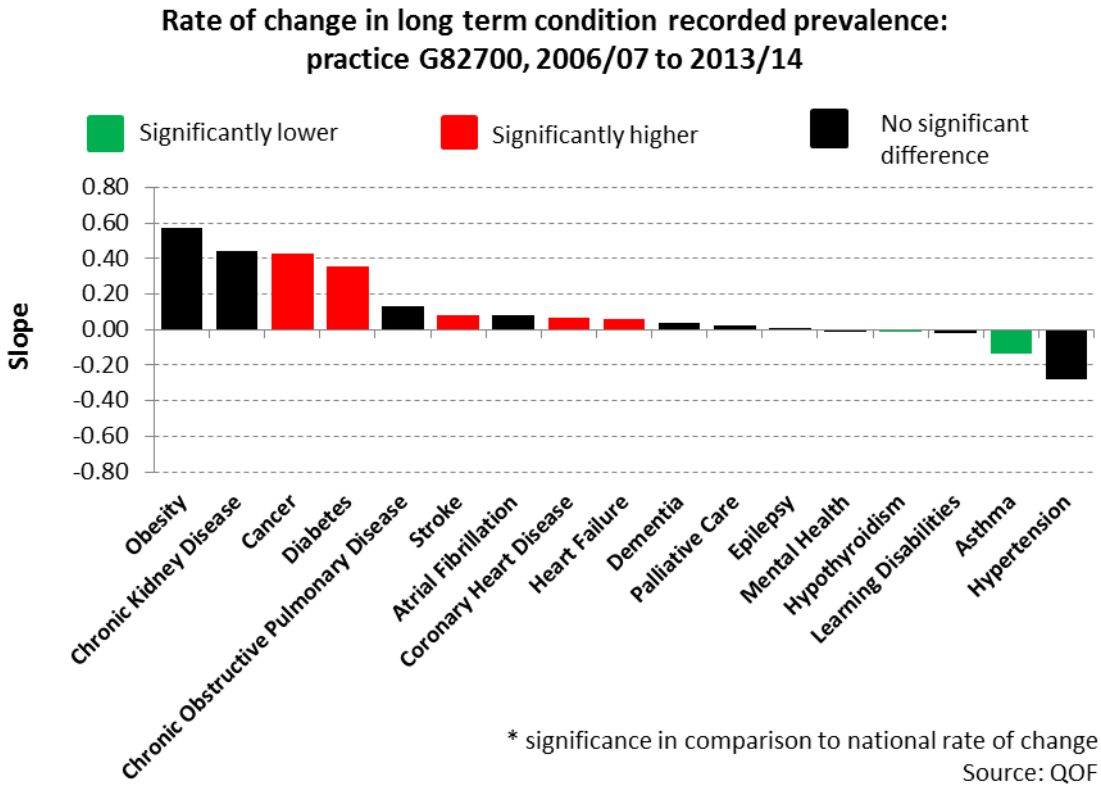
In 2013/14, the general practice recorded prevalence was significantly higher than the CCG for atrial fibrillation, cancer, chronic kidney disease, chronic obstructive pulmonary disease, obesity and stroke.

Table 10

	Practice		CCG			
Indicator	**Number**	**Prevalence**	**Average**	**Low**	**Range**	**High**
Asthma (%)	158	4.1	5.7	4.1		10.3
Atrial fibrillation (%)	120	3.1	2.2	1.2		3.6
Cancer (%)	155	4.0	2.5	0.8		4.0
Chronic Kidney Disease (%)	241	7.7	5.5	3.8		8.2
Chronic Obstructive Pulmonary Disease	167	4.3	2.3	1.1		4.3
Coronary Heart Disease (%)	160	4.2	3.8	2.7		5.7
Dementia (%)	28	0.7	0.6	0.1		1.0
Diabetes (%)	267	8.5	7.0	5.7		9.3
Epilepsy (%)	25	0.8	1.0	0.3		1.5
Heart Failure (%)	39	1.0	0.7	0.3		1.1
Hypertension (%)	681	17.7	16.2	12.0		20.5
Hypothyroidism (%)	157	4.1	3.4	2.0		5.2
Learning Disabilities (%)	20	0.6	0.8	0.2		2.4
Mental Health (%)	26	0.7	0.7	0.3		1.5
Obesity (%)	646	20.2	10.4	3.8		20.2
Palliative Care (%)	9	0.2	0.2	0.0		0.4
Stroke (%)	112	2.9	2.0	1.2		3.3

Cancer recorded prevalence has increased by 0.43% per year between 2006/07 and 2013/14. This was a significantly higher increase in comparison to the national trend.

Figure 11



G82729 - White Cliffs Medical Centre

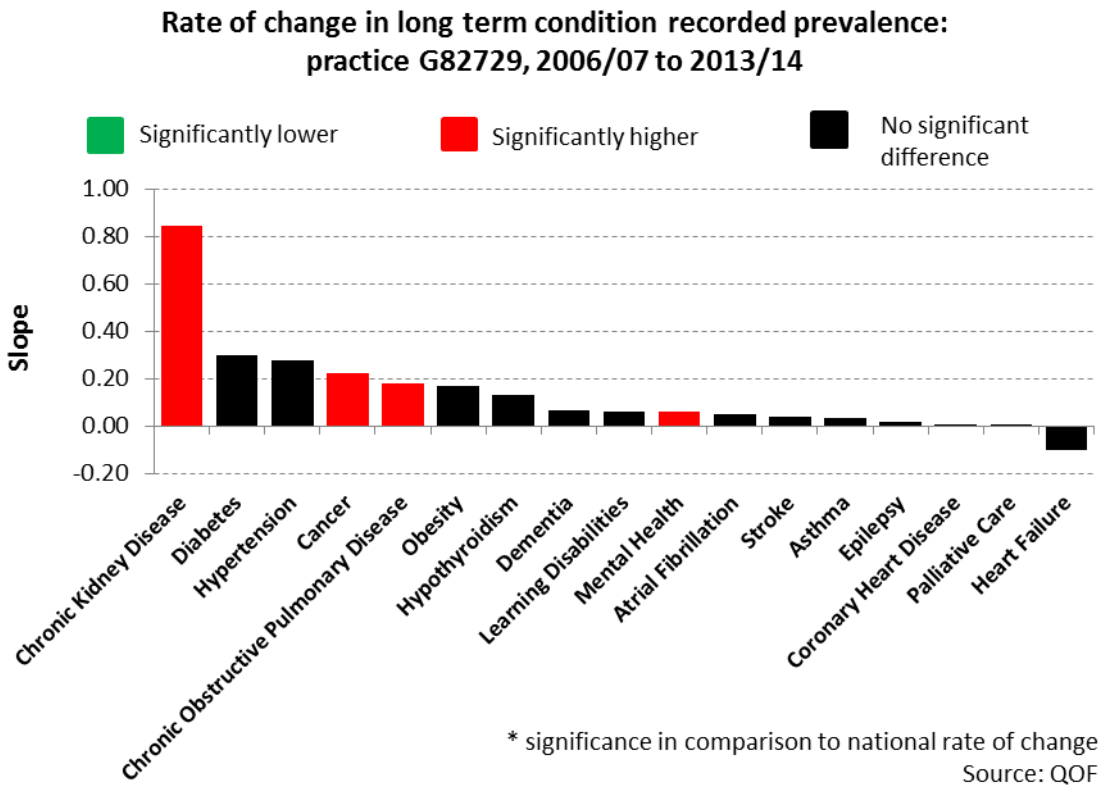
In 2013/14, the general practice recorded prevalence was significantly higher than the CCG for chronic kidney disease, hypertension and obesity.

Table 11

	Practice		CCG			
Indicator	**Number**	**Prevalence**	**Average**	**Low**	**Range**	**High**
Asthma (%)	384	5.6	5.7	4.1		10.3
Atrial fibrillation (%)	134	2.0	2.2	1.2		3.6
Cancer (%)	190	2.8	2.5	0.8		4.0
Chronic Kidney Disease (%)	389	7.2	5.5	3.8		8.2
Chronic Obstructive Pulmonary Disease	173	2.5	2.3	1.1		4.3
Coronary Heart Disease (%)	221	3.2	3.8	2.7		5.7
Dementia (%)	53	0.8	0.6	0.1		1.0
Diabetes (%)	339	6.1	7.0	5.7		9.3
Epilepsy (%)	46	0.8	1.0	0.3		1.5
Heart Failure (%)	42	0.6	0.7	0.3		1.1
Hypertension (%)	1210	17.8	16.2	12.0		20.5
Hypothyroidism (%)	240	3.5	3.4	2.0		5.2
Learning Disabilities (%)	23	0.4	0.8	0.2		2.4
Mental Health (%)	58	0.9	0.7	0.3		1.5
Obesity (%)	886	15.8	10.4	3.8		20.2
Palliative Care (%)	8	0.1	0.2	0.0		0.4
Stroke (%)	116	1.7	2.0	1.2		3.3

Chronic kidney disease recorded prevalence has increased by 0.85% per year between 2006/07 and 2013/14. This was a significantly higher increase in comparison to the national trend.

Figure 12



Dover Locality

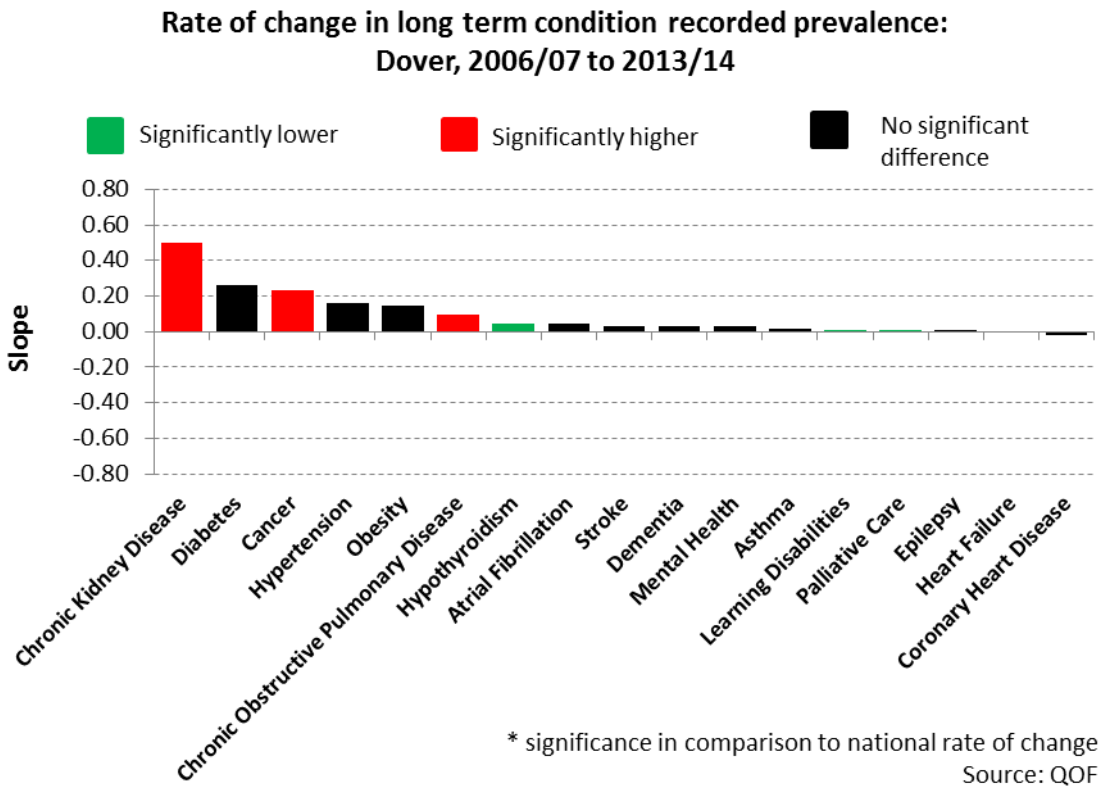
In 2013/14, the general practice recorded prevalence was significantly higher than the CCG for chronic kidney disease, chronic obstructive pulmonary disease and obesity.

Table 12

	Practice		CCG			
Indicator	**Number**	**Prevalence**	**Average**	**Low**	**Range**	**High**
Asthma (%)	3004	5.5	5.7	4.1		10.3
Atrial fibrillation (%)	1050	1.9	2.2	1.2		3.6
Cancer (%)	1303	2.4	2.5	0.8		4.0
Chronic Kidney Disease (%)	2466	5.8	5.5	3.8		8.2
Chronic Obstructive Pulmonary Disease	1342	2.5	2.3	1.1		4.3
Coronary Heart Disease (%)	1848	3.4	3.8	2.7		5.7
Dementia (%)	337	0.6	0.6	0.1		1.0
Diabetes (%)	2937	6.7	7.0	5.7		9.3
Epilepsy (%)	403	0.9	1.0	0.3		1.5
Heart Failure (%)	337	0.6	0.7	0.3		1.1
Hypertension (%)	8102	14.9	16.2	12.0		20.5
Hypothyroidism (%)	1715	3.1	3.4	2.0		5.2
Learning Disabilities (%)	246	0.6	0.8	0.2		2.4
Mental Health (%)	368	0.7	0.7	0.3		1.5
Obesity (%)	5188	11.7	10.4	3.8		20.2
Palliative Care (%)	69	0.1	0.2	0.0		0.4
Stroke (%)	1067	2.0	2.0	1.2		3.3

Chronic kidney disease recorded prevalence has increased by 0.50% per year between 2006/07 and 2013/14. This was a significantly higher increase in comparison to the national trend.

Figure 13

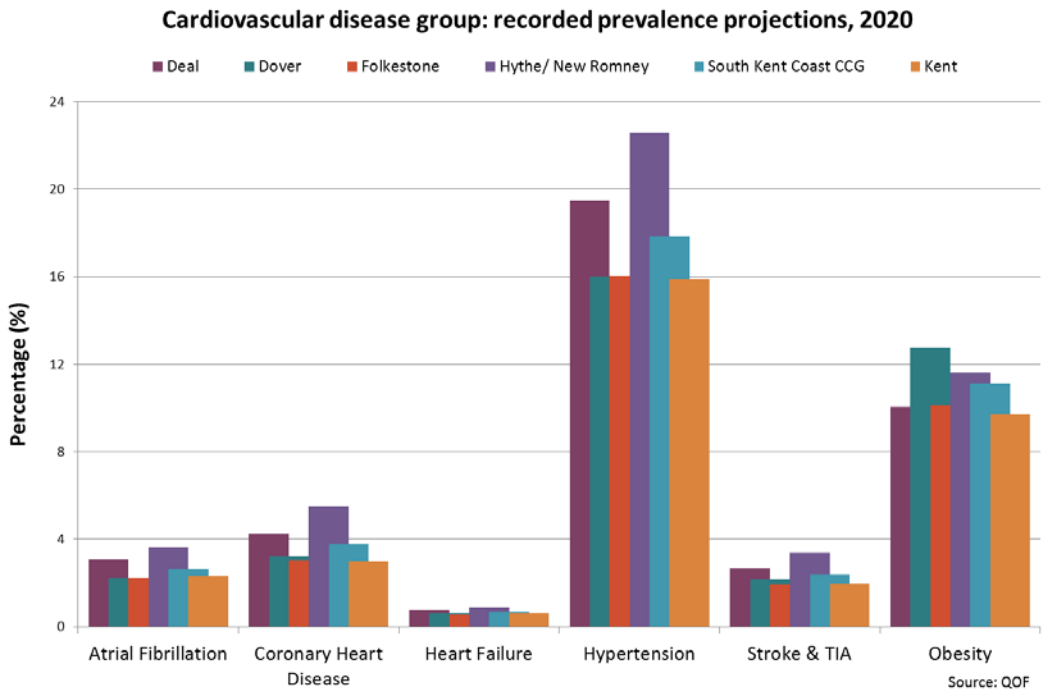


Cardiovascular disease

The Dover locality recorded prevalence has been projected to increase:

- Atrial fibrillation has been projected to increase to 2.24% in 2020: representing a 16.18% increase from 2013/14.
- Coronary heart disease has been projected to increase to 3.23% in 2020; representing a 4.61% decrease from 2013/14.
- Heart failure has been projected to increase to 0.6% in 2020; representing a 2.68% decrease from 2013/14.
- Hypertension has been projected to increase to 15.99% in 2020; this represents a 7.59% increase from 2013/14.
- Stroke & TIA has been projected to increase to 2.16% in 2020; this represents a 10.17% increase from 2013/14.
- Obesity has been projected to increase to 12.75% in 2020; this represents an 8.85% increase from 2013/14.

Figure 14

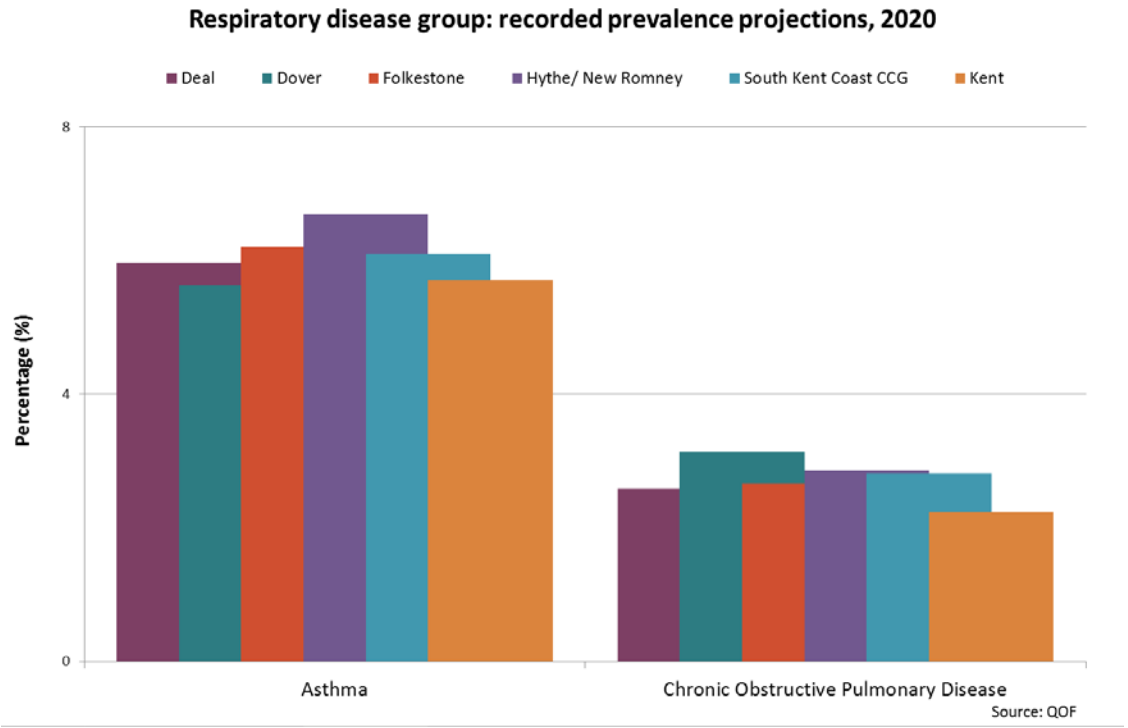


Respiratory disease

The Dover locality recorded prevalence has been projected to increase:

- Asthma has been projected to increase to 5.63% in 2020; this represents a 2.13% increase from 2013/14.
- COPD has been projected to increase to 3.14% in 2020; this represents a 27.54% increase from 2013/14.

Figure 15

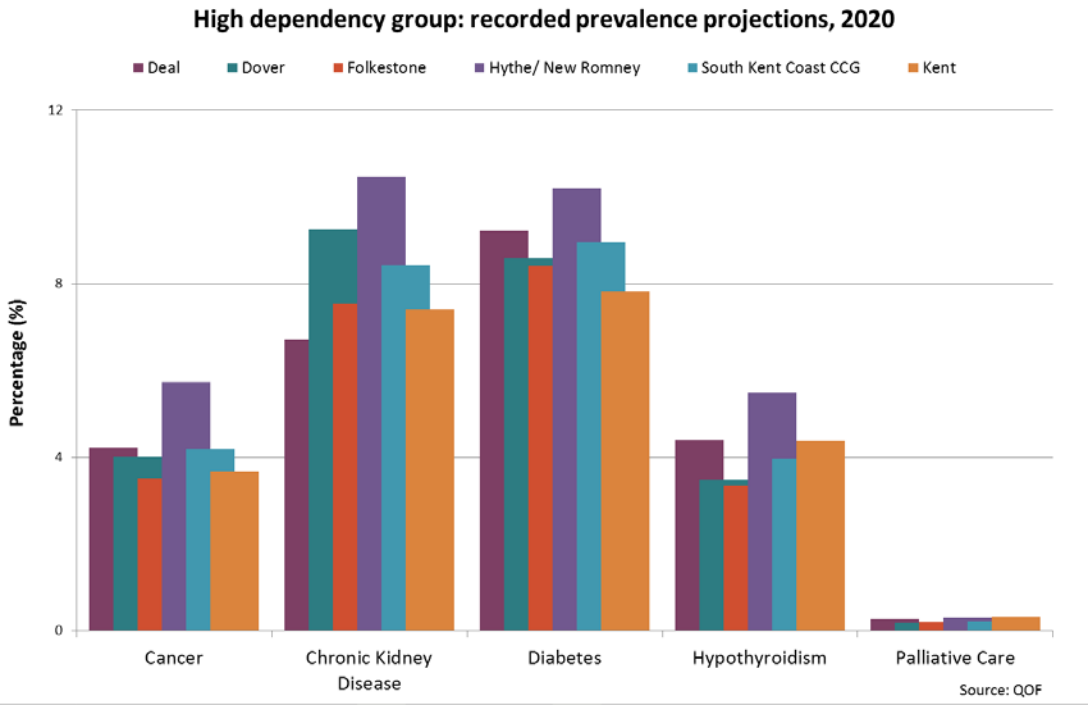


High Dependency

The Dover locality recorded prevalence has been projected to increase:

- Cancer has been projected to increase to 4.01% in 2020; this represents a 67.68% increase from 2013/14.
- Chronic kidney disease has been projected to increase to 9.26% in 2020; this represents a 60.64% increase from 2013/14.
- Diabetes has been projected to increase to 8.60% in 2020; this represents a 27.42% increase from 2013/14.
- Hypothyroidism has been projected to increase to 3.48% in 2020; this represents a 10.6% increase from 2013/14.
- Palliative care has been projected to increase to 0.18% in 2020; this represents a 41.03% increase from 2013/14.

Figure 16

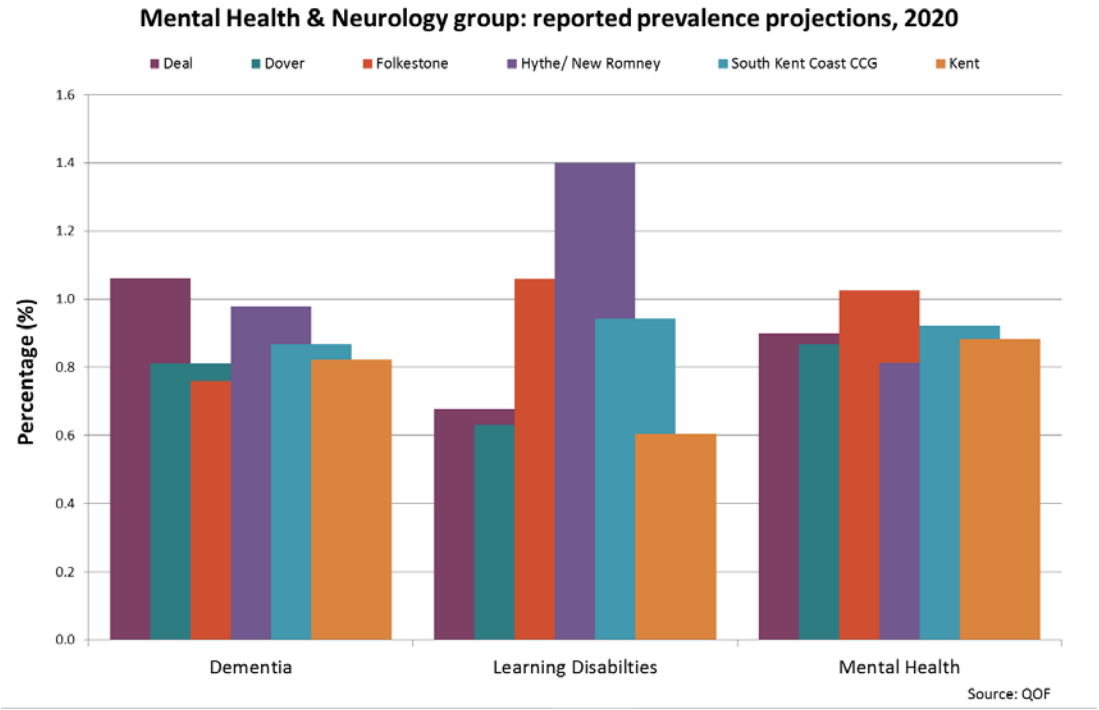


Mental Health & Neurology

The Dover locality recorded prevalence has been projected to increase:

- Dementia has been projected to increase to 0.81% in 2020; this represents a 31.12% increase from 2013/14.
- Learning disabilities have been projected to increase to 0.63% in 2020; this represents a 9.59% increase from 2013/14.
- Mental health has been projected to increase to 0.87% in 2020; this represents a 28.37% increase from 2013/14.

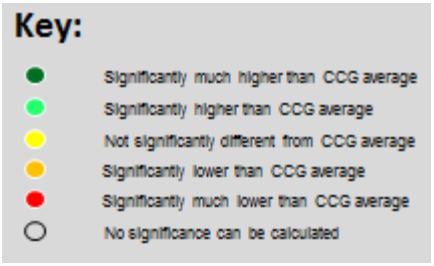
Figure 17

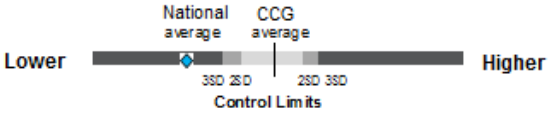


Primary care performance in the management of chronic conditions

Spine charts have been produced to compare the general practice percentage of patients receiving interventions for long term conditions with the NHS South Kent Coast CCG in 2013/14.

The indicator definitions have been included at the end of the chapter.





Confidence intervals for each indicator are calculated using the Wilson score method. Statistical significance is calculated relative to the mean for NHS South Kent Coast CCG at the 95% level. A practice is identified as significantly different from the CCG mean if the 95% confidence interval for the practice value does not overlap with the 95% confidence interval for the CCG mean.

The QOF uses an extract of practice list sizes as of 1st January 2014 and disease registers as at 31st March 2014. The NHS South Kent Coast CCG general practice percentage of patients receiving interventions for long term conditions for 2013/14 has been based on the combined data of open practices as at October, 2015.

General practice exceptions have been included within denominators to ensure performance is representative of the prevalent practice population for each of the long term conditions.

Exception rates represent the percentage of patients not receiving the intervention for each of the long term condition clinical achievement indicators. The criteria for exception reporting has been detailed below (see Notes).
The Kent 2013/14, general practice exception rates for the long term condition clinical achievement indicators were transformed to normalise the distribution for the better identification of outliers. Z-scores were then calculated using the Kent mean and standard deviation. The Z-score indicates how far away from the Kent average the general practice exception rates were. A Z-score greater than 2 was the cut-off used to identify outliers.

Exception rates for the indicators within Kent will be presented by practice. This will only be presented for the indicators with numbers of exceptions at 7 or greater. Outliers, greater than two standard deviations from the Kent mean have been highlighted.

G82002 - St James Surgery had significantly lower clinical achievement for the long term condition clinical achievement indicators;

- The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions.

- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate.

- The percentage of patients aged 40 or over who have a record of blood pressure in the preceding 5 years.

Figure 18

	Practice		CCG			
Indicator	**Number**	**Performance**	**Average**	**Low**	**Range**	**High**
Asthma 02	68	89.5	85.3	68.9		100.0
Asthma 03	275	60.3	70.7	47.0		93.3
Atrial Fibrillation 03	27	96.4	92.6	83.3		100.0
Atrial Fibrillation 04	46	70.8	72.8	60.3		93.3
Cancer 02	19	82.6	80.4	40.0		100.0
Chronic Kidney Disease 02	204	77.3	75.3	59.0		88.8
Chronic Kidney Disease 03	16	80.0	76.8	56.1		92.9
Chronic Obstructive Pulmonary Disease 03	137	86.2	81.3	63.8		95.0
Chronic Obstructive Pulmonary Disease 04	126	79.2	76.2	56.3		92.9
Dementia 02	34	85.0	78.3	44.4		100.0
Depression 02	33	71.7	63.0	36.6		93.3
Diabetes 03	310	77.7	73.8	40.8		89.5
Diabetes 07	252	63.2	64.6	52.5		76.0
Diabetes 09	325	81.5	82.6	72.9		90.1
Diabetes 14	22	88.0	75.7	20.0		100.0
Epilepsy 02	36	58.1	61.5	26.7		84.2
Hypertension 02	830	79.8	80.5	66.2		88.7
Mental Health 02	14	29.2	74.4	29.2		100.0
Peripheral Artery Disease 02	34	97.1	86.3	73.6		100.0
Rheumatoid Arthritis 02	29	80.6	78.4	6.2		100.0
Coronary Heart Disease 02	197	92.5	89.4	76.1		96.3
Coronary Heart Disease 06	21	72.4	71.4	33.3		100.0
Stroke & TIA 03	100	85.5	85.4	73.4		95.2
Blood Pressure 01	3456	87.7	89.9	80.9		95.9
Smoking 02	1568	93.2	94.4	88.9		99.2
Smoking 05	304	97.1	94.3	77.9		99.8
Cervical Screening 02	1386	79.3	77.8	71.1		85.5

Table 13

	Exceptions	Exception rate
Asthma 03	88	19.30
Chronic Kidney Disease 02	17	6.44
COPD 03	14	8.81
COPD 04	25	15.72
Diabetes 03	27	6.77
Diabetes 07	50	12.53
Diabetes 09	32	8.02
Hypertension 02	26	2.50
Mental Health 02	12	25.00
Rheumatoid Arthritis 02	7	19.44
Coronary Heart Disease 02	9	4.23
Coronary Heart Disease 06	8	27.59
Blood Pressure 01	23	0.58
Smoking 02	15	0.89
Cervical Screening 02	66	3.78

G82015 - Pencester Surgery had significantly lower clinical achievement for the long term condition clinical achievement indicators;

- The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions.

- The percentage of patients on the CKD register in whom the last blood pressure reading (measured in the preceding 12 months) is 140/85 mmHg or less.

- The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months.

- The percentage of patients with COPD with a record of FEV1 in the preceding 12 months.

- The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than 10 days after and not later than 35 days after the date of diagnosis.

- The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 9 months) is 150/90 mmHg or less.

- The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less.

- The percentage of patients aged 40 or over who have a record of blood pressure in the preceding 5 years.

- The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 12 months.

- The percentage of women aged 25 or over and who have not attained the age of 65 whose notes record that a cervical screening test has been performed in the preceding 5 years

Figure 19

	Practice		CCG			
Indicator	**Number**	**Performance**	**Average**	**Low**	**Range**	**High**
Asthma 02	88	84.6	85.3	68.9		100.0
Asthma 03	250	47.0	70.7	47.0		93.3
Atrial Fibrillation 03	34	91.9	92.6	83.3		100.0
Atrial Fibrillation 04	50	67.6	72.8	60.3		93.3
Cancer 02	17	58.6	80.4	40.0		100.0
Chronic Kidney Disease 02	176	64.7	75.3	59.0		88.8
Chronic Kidney Disease 03	24	66.7	76.8	56.1		92.9
Chronic Obstructive Pulmonary Disease 03	104	63.8	81.3	63.8		95.0
Chronic Obstructive Pulmonary Disease 04	105	64.4	76.2	56.3		92.9
Dementia 02	32	72.7	78.3	44.4		100.0
Depression 02	59	36.6	63.0	36.6		93.3
Diabetes 03	302	68.8	73.8	40.8		89.5
Diabetes 07	256	58.3	64.6	52.5		76.0
Diabetes 09	343	78.1	82.6	72.9		90.1
Diabetes 14	21	75.0	75.7	20.0		100.0
Epilepsy 02	34	50.0	61.5	26.7		84.2
Hypertension 02	857	75.4	80.5	66.2		88.7
Mental Health 02	51	83.6	74.4	29.2		100.0
Osteoporosis 03	12	85.7	76.9	41.7		100.0
Peripheral Artery Disease 02	39	73.6	86.3	73.6		100.0
Rheumatoid Arthritis 02	55	82.1	78.4	6.2		100.0
Coronary Heart Disease 02	216	81.8	89.4	76.1		96.3
Coronary Heart Disease 06	19	59.4	71.4	33.3		100.0
Stroke & TIA 03	143	83.6	85.4	73.4		95.2
Blood Pressure 01	3819	85.5	89.9	80.9		95.9
Smoking 02	1802	91.8	94.4	88.9		99.2
Smoking 05	372	85.1	94.3	77.9		99.8
Cervical Screening 02	1434	71.1	77.8	71.1		85.5

Table 14

	Exceptions	Exception rate
Asthma 03	154	28.95
Chronic Kidney Disease 02	26	9.56
COPD 03	13	7.98
COPD 04	12	7.36
Depression 02	31	19.25
Diabetes 03	21	4.78
Diabetes 07	25	5.69
Diabetes 09	16	3.64
Epilepsy 02	15	22.06
Hypertension 02	83	7.30
Coronary Heart Disease 06	12	37.50
Stroke & TIA 03	9	5.26
Blood Pressure 01	12	0.27
Smoking 02	12	0.61
Cervical Screening 02	44	2.18

G82117 - The High Street Surgery did not have significantly lower clinical achievement for any of the long term condition clinical achievement indicators.

Figure 20

	Practice		CCG			
Indicator	**Number**	**Performance**	**Average**	**Low**	**Range**	**High**
Asthma 02	61	78.2	85.3	68.9		100.0
Asthma 03	264	68.4	70.7	47.0		93.3
Atrial Fibrillation 03	38	90.5	92.6	83.3		100.0
Atrial Fibrillation 04	72	74.2	72.8	60.3		93.3
Cancer 02	18	81.8	80.4	40.0		100.0
Chronic Kidney Disease 02	261	84.2	75.3	59.0		88.8
Chronic Kidney Disease 03	38	88.4	76.8	56.1		92.9
Chronic Obstructive Pulmonary Disease 03	125	86.8	81.3	63.8		95.0
Chronic Obstructive Pulmonary Disease 04	106	73.6	76.2	56.3		92.9
Dementia 02	37	75.5	78.3	44.4		100.0
Depression 02	37	82.2	63.0	36.6		93.3
Diabetes 03	337	83.0	73.8	40.8		89.5
Diabetes 07	267	65.8	64.6	52.5		76.0
Diabetes 09	345	85.0	82.6	72.9		90.1
Diabetes 14	7	70.0	75.7	20.0		100.0
Epilepsy 02	35	58.3	61.5	26.7		84.2
Heart Failure 03	14	93.3	89.5	50.0		100.0
Hypertension 02	984	87.2	80.5	66.2		88.7
Mental Health 02	37	86.0	74.4	29.2		100.0
Osteoporosis 03	16	94.1	76.9	41.7		100.0
Peripheral Artery Disease 02	45	97.8	86.3	73.6		100.0
Rheumatoid Arthritis 02	38	88.4	78.4	6.2		100.0
Coronary Heart Disease 02	262	94.6	89.4	76.1		96.3
Stroke & TIA 03	142	87.7	85.4	73.4		95.2
Blood Pressure 01	3497	90.5	89.9	80.9		95.9
Smoking 02	1762	97.1	94.4	88.9		99.2
Smoking 05	275	97.9	94.3	77.9		99.8
Cervical Screening 02	1335	77.4	77.8	71.1		85.5

Table 15

	Exceptions	Exception rate
Asthma 03	18	4.66
Chronic Kidney Disease 02	16	5.16
COPD 03	8	5.56
COPD 04	19	13.19
Diabetes 03	22	5.42
Diabetes 07	60	14.78
Diabetes 09	42	10.34
Epilepsy 02	16	26.67
Hypertension 02	30	2.66
Coronary Heart Disease 02	7	2.53
Stroke & TIA 03	7	4.32
Blood Pressure 01	18	0.47
Smoking 02	11	0.61
Cervical Screening 02	218	12.64

G82128 - Peter Street Surgery had significantly lower clinical achievement for the long term condition clinical achievement indicators:

- The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 9 months) is 150/90 mmHg or less.

- The percentage of women aged 25 or over and who have not attained the age of 65 whose notes record that a cervical screening test has been performed in the preceding 5 years.

Figure 21

	Practice		CCG			
Indicator	**Number**	**Performance**	**Average**	**Low**	**Range**	**High**
Asthma 02	60	75.9	85.3	68.9		100.0
Asthma 03	307	75.2	70.7	47.0		93.3
Atrial Fibrillation 03	37	100.0	92.6	83.3		100.0
Atrial Fibrillation 04	50	64.1	72.8	60.3		93.3
Cancer 02	28	80.0	80.4	40.0		100.0
Chronic Kidney Disease 02	267	72.8	75.3	59.0		88.8
Chronic Kidney Disease 03	24	82.8	76.8	56.1		92.9
Chronic Obstructive Pulmonary Disease 03	118	87.4	81.3	63.8		95.0
Chronic Obstructive Pulmonary Disease 04	115	85.2	76.2	56.3		92.9
Dementia 02	35	74.5	78.3	44.4		100.0
Depression 02	25	62.5	63.0	36.6		93.3
Diabetes 03	301	77.8	73.8	40.8		89.5
Diabetes 07	250	64.6	64.6	52.5		76.0
Diabetes 09	303	78.3	82.6	72.9		90.1
Diabetes 14	17	94.4	75.7	20.0		100.0
Epilepsy 02	34	48.6	61.5	26.7		84.2
Hypertension 02	714	75.6	80.5	66.2		88.7
Mental Health 02	41	80.4	74.4	29.2		100.0
Peripheral Artery Disease 02	48	81.4	86.3	73.6		100.0
Rheumatoid Arthritis 02	52	88.1	78.4	6.2		100.0
Coronary Heart Disease 02	212	85.1	89.4	76.1		96.3
Stroke & TIA 03	126	82.9	85.4	73.4		95.2
Blood Pressure 01	3257	88.9	89.9	80.9		95.9
Smoking 02	1581	93.3	94.4	88.9		99.2
Smoking 05	280	89.2	94.3	77.9		99.8
Cervical Screening 02	1235	74.3	77.8	71.1		85.5

Table 16

	Exceptions	Exception rate
Asthma 03	8	1.96
Atrial Fibrillation 04	13	16.67
Chronic Kidney Disease 02	11	3.00
Depression 02	12	30.00
Diabetes 03	13	3.36
Diabetes 07	19	4.91
Diabetes 09	16	4.13
Epilepsy 02	9	12.86
Blood Pressure 01	14	0.38
Cervical Screening 02	94	5.66

G82211 - Aylesham Medical Practice had significantly lower clinical achievement for the long term condition clinical achievement indicators;

- The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 9 months) is 150/90 mmHg or less.

Figure 22

	Practice		CCG			
Indicator	**Number**	**Performance**	**Average**	**Low**	**Range**	**High**
Asthma 02	60	75.9	85.3	68.9		100.0
Asthma 03	227	75.7	70.7	47.0		93.3
Atrial Fibrillation 03	26	96.3	92.6	83.3		100.0
Atrial Fibrillation 04	44	77.2	72.8	60.3		93.3
Cancer 02	20	69.0	80.4	40.0		100.0
Chronic Kidney Disease 02	225	68.0	75.3	59.0		88.8
Chronic Kidney Disease 03	25	78.1	76.8	56.1		92.9
Chronic Obstructive Pulmonary Disease 03	206	78.0	81.3	63.8		95.0
Chronic Obstructive Pulmonary Disease 04	197	74.6	76.2	56.3		92.9
Dementia 02	24	82.8	78.3	44.4		100.0
Depression 02	25	59.5	63.0	36.6		93.3
Diabetes 03	246	68.1	73.8	40.8		89.5
Diabetes 07	246	68.1	64.6	52.5		76.0
Diabetes 09	301	83.4	82.6	72.9		90.1
Diabetes 14	11	61.1	75.7	20.0		100.0
Epilepsy 02	27	73.0	61.5	26.7		84.2
Heart Failure 03	9	90.0	89.5	50.0		100.0
Hypertension 02	656	74.2	80.5	66.2		88.7
Mental Health 02	37	92.5	74.4	29.2		100.0
Osteoporosis 03	7	100.0	76.9	41.7		100.0
Peripheral Artery Disease 02	36	78.3	86.3	73.6		100.0
Rheumatoid Arthritis 02	41	85.4	78.4	6.2		100.0
Coronary Heart Disease 02	174	82.9	89.4	76.1		96.3
Coronary Heart Disease 06	9	81.8	71.4	33.3		100.0
Stroke & TIA 03	96	78.7	85.4	73.4		95.2
Blood Pressure 01	2999	91.9	89.9	80.9		95.9
Smoking 02	1449	96.2	94.4	88.9		99.2
Smoking 05	285	93.8	94.3	77.9		99.8
Cervical Screening 02	1147	78.7	77.8	71.1		85.5

Table 17

	Exceptions	Exception rate
Asthma 03	22	7.33
Chronic Kidney Disease 02	13	3.93
Chronic Kidney Disease 03	7	21.88
COPD 03	26	9.85
COPD 04	29	10.98
Depression 02	15	35.71
Diabetes 03	25	6.93
Diabetes 07	26	7.20
Diabetes 09	17	4.71
Hypertension 02	29	3.28
Smoking 02	13	0.86
Smoking 05	11	0.19
Cervical Screening 02	54	3.70

G82227 - Lydden Surgery had significantly lower clinical achievement for the long term condition clinical achievement indicator;

- The percentage of patients with rheumatoid arthritis, on the register, who have had a face-to-face review in the preceding 12 months.

Figure 23

	Practice		CCG			
Indicator	**Number**	**Performance**	**Average**	**Low**	**Range**	**High**
Asthma 02	83	90.2	85.3	68.9		100.0
Asthma 03	243	79.9	70.7	47.0		93.3
Atrial Fibrillation 03	23	88.5	92.6	83.3		100.0
Atrial Fibrillation 04	49	71.0	72.8	60.3		93.3
Cancer 02	27	96.4	80.4	40.0		100.0
Chronic Kidney Disease 02	191	79.9	75.3	59.0		88.8
Chronic Kidney Disease 03	22	88.0	76.8	56.1		92.9
Chronic Obstructive Pulmonary Disease 03	88	87.1	81.3	63.8		95.0
Chronic Obstructive Pulmonary Disease 04	87	86.1	76.2	56.3		92.9
Dementia 02	31	68.9	78.3	44.4		100.0
Depression 02	27	79.4	63.0	36.6		93.3
Diabetes 03	191	80.3	73.8	40.8		89.5
Diabetes 07	159	66.8	64.6	52.5		76.0
Diabetes 09	195	81.9	82.6	72.9		90.1
Epilepsy 02	16	72.7	61.5	26.7		84.2
Hypertension 02	704	82.9	80.5	66.2		88.7
Mental Health 02	8	80.0	74.4	29.2		100.0
Osteoporosis 03	7	70.0	76.9	41.7		100.0
Peripheral Artery Disease 02	27	79.4	86.3	73.6		100.0
Rheumatoid Arthritis 02	30	93.8	78.4	6.2		100.0
Coronary Heart Disease 02	179	90.4	89.4	76.1		96.3
Coronary Heart Disease 06	7	63.6	71.4	33.3		100.0
Stroke & TIA 03	69	73.4	85.4	73.4		95.2

Table 18

	Exceptions	Exception rate
Asthma 03	26	8.55
Atrial Fibrillation 04	11	15.94
Chronic Kidney Disease 02	8	3.35
COPD 03	11	10.89
COPD 04	12	11.88
Dementia 02	7	15.56
Diabetes 03	19	7.98
Diabetes 07	38	15.97
Diabetes 09	28	11.76
Hypertension 02	31	3.65
Coronary Heart Disease 02	10	5.05
Stroke & TIA 03	11	11.70
Blood Pressure 01	26	0.92
Smoking 02	15	1.12
Cervical Screening 02	19	1.86

G82662 - Pencester Health Centre had significantly lower clinical achievement for the long term condition clinical achievement indicators;

- The percentage of women aged 25 or over and who have not attained the age of 65 whose notes record that a cervical screening test has been performed in the preceding 5 years.

Figure 24

	Practice		CCG			
Indicator	**Number**	**Performance**	**Average**	**Low**	**Range**	**High**
Asthma 02	12	80.0	85.3	68.9		100.0
Asthma 03	53	69.7	70.7	47.0		93.3
Atrial Fibrillation 03	8	88.9	92.6	83.3		100.0
Atrial Fibrillation 04	7	70.0	72.8	60.3		93.3
Cancer 02	7	100.0	80.4	40.0		100.0
Chronic Kidney Disease 02	42	79.2	75.3	59.0		88.8
Chronic Obstructive Pulmonary Disease 03	23	63.9	81.3	63.8		95.0
Chronic Obstructive Pulmonary Disease 04	22	61.1	76.2	56.3		92.9
Depression 02	12	41.4	63.0	36.6		93.3
Diabetes 03	77	76.2	73.8	40.8		89.5
Diabetes 07	53	52.5	64.6	52.5		76.0
Diabetes 09	79	78.2	82.6	72.9		90.1
Epilepsy 02	9	69.2	61.5	26.7		84.2
Hypertension 02	191	83.4	80.5	66.2		88.7
Peripheral Artery Disease 02	10	83.3	86.3	73.6		100.0
Rheumatoid Arthritis 02	7	63.6	78.4	6.2		100.0
Coronary Heart Disease 02	52	92.9	89.4	76.1		96.3
Coronary Heart Disease 06	8	80.0	71.4	33.3		100.0
Stroke & TIA 03	18	85.7	85.4	73.4		95.2
Blood Pressure 01	751	89.0	89.9	80.9		95.9
Smoking 02	361	95.3	94.4	88.9		99.2
Smoking 05	98	89.1	94.3	77.9		99.8
Cervical Screening 02	323	71.5	77.8	71.1		85.5

Table 19

	Exceptions	Exception rate
COPD 03	10	27.78
COPD 04	11	30.56
Diabetes 07	7	6.93
Hypertension 02	8	3.49
Cervical Screening 02	22	4.87

G82700 - Buckland Medical Centre did not have significantly lower clinical achievement for any of the long term condition clinical achievement indicators.

Figure 25

	Practice		CCG			
Indicator	**Number**	**Performance**	**Average**	**Low**	**Range**	**High**
Asthma 02	17	100.0	85.3	68.9		100.0
Asthma 03	131	82.9	70.7	47.0		93.3
Atrial Fibrillation 03	21	91.3	92.6	83.3		100.0
Atrial Fibrillation 04	56	70.0	72.8	60.3		93.3
Cancer 02	25	86.2	80.4	40.0		100.0
Chronic Kidney Disease 02	214	88.8	75.3	59.0		88.8
Chronic Kidney Disease 03	31	64.6	76.8	56.1		92.9
Chronic Obstructive Pulmonary Disease 03	151	90.4	81.3	63.8		95.0
Chronic Obstructive Pulmonary Disease 04	149	89.2	76.2	56.3		92.9
Dementia 02	25	89.3	78.3	44.4		100.0
Depression 02	31	86.1	63.0	36.6		93.3
Diabetes 03	239	89.5	73.8	40.8		89.5
Diabetes 07	203	76.0	64.6	52.5		76.0
Diabetes 09	238	89.1	82.6	72.9		90.1
Diabetes 14	13	92.9	75.7	20.0		100.0
Epilepsy 02	21	84.0	61.5	26.7		84.2
Hypertension 02	604	88.7	80.5	66.2		88.7
Mental Health 02	25	96.2	74.4	29.2		100.0
Osteoporosis 03	9	64.3	76.9	41.7		100.0
Peripheral Artery Disease 02	40	95.2	86.3	73.6		100.0
Rheumatoid Arthritis 02	38	95.0	78.4	6.2		100.0
Coronary Heart Disease 02	154	96.3	89.4	76.1		96.3
Stroke & TIA 03	105	93.8	85.4	73.4		95.2
Blood Pressure 01	2149	95.9	89.9	80.9		95.9
Smoking 02	1088	99.2	94.4	88.9		99.2
Smoking 05	145	98.0	94.3	77.9		99.8
Cervical Screening 02	640	80.8	77.8	71.1		85.5

Table 20

	Exceptions	Exception rate
Atrial Fibrillation 04	15	18.75
Chronic Kidney Disease 03	13	27.08
Diabetes 07	7	2.62
Cervical Screening 02	43	5.43

G82729 - White Cliffs Medical Centre had significantly lower clinical achievement for the long term condition clinical achievement indicators;

- The percentage of patients aged 8 or over with asthma (diagnosed on or after 1 April 2006), on the register, with measures of variability or reversibility recorded between 3 months before or any time after diagnosis.

- The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less.

Figure 26

	Practice		CCG			
Indicator	Number	Performance	Average	Low	Range	High
Asthma 02	84	68.9	85.3	68.9		100.0
Asthma 03	264	68.8	70.7	47.0		93.3
Atrial Fibrillation 03	29	85.3	92.6	83.3		100.0
Atrial Fibrillation 04	47	60.3	72.8	60.3		93.3
Cancer 02	36	85.7	80.4	40.0		100.0
Chronic Kidney Disease 02	266	68.4	75.3	59.0		88.8
Chronic Kidney Disease 03	79	80.6	76.8	56.1		92.9
Chronic Obstructive Pulmonary Disease 03	149	86.1	81.3	63.8		95.0
Chronic Obstructive Pulmonary Disease 04	114	65.9	76.2	56.3		92.9
Dementia 02	40	75.5	78.3	44.4		100.0
Diabetes 03	220	64.9	73.8	40.8		89.5
Diabetes 07	207	61.1	64.6	52.5		76.0
Diabetes 09	269	79.4	82.6	72.9		90.1
Diabetes 14	12	85.7	75.7	20.0		100.0
Epilepsy 02	35	76.1	61.5	26.7		84.2
Hypertension 02	948	78.3	80.5	66.2		88.7
Mental Health 02	50	89.3	74.4	29.2		100.0
Osteoporosis 03	17	54.8	76.9	41.7		100.0
Peripheral Artery Disease 02	20	90.9	86.3	73.6		100.0
Rheumatoid Arthritis 02	64	95.5	78.4	6.2		100.0
Coronary Heart Disease 02	191	86.4	89.4	76.1		96.3
Coronary Heart Disease 06	9	64.3	71.4	33.3		100.0
Stroke & TIA 03	104	89.7	85.4	73.4		95.2
Blood Pressure 01	3395	92.6	89.9	80.9		95.9
Smoking 02	1691	95.1	94.4	88.9		99.2
Smoking 05	294	95.1	94.3	77.9		99.8
Cervical Screening 02	1332	85.1	77.8	71.1		85.5

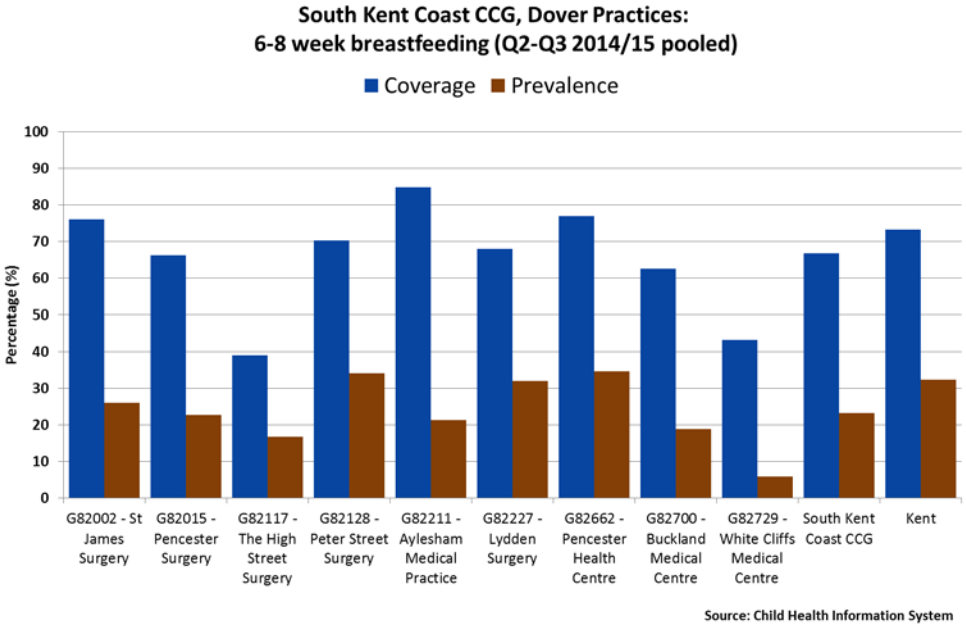
Table 21

	Exceptions	Exception rate
Asthma 02	23	18.85
Asthma 03	7	1.82
Atrial Fibrillation 04	16	20.51
Chronic Kidney Disease 02	16	4.11
COPD 03	10	5.78
COPD 04	35	20.23
Diabetes 03	19	5.60
Diabetes 07	22	6.49
Diabetes 09	14	4.13
Hypertension 02	34	2.81
Coronary Heart Disease 02	17	7.69
Blood Pressure 01	28	0.76
Cervical Screening 02	49	3.13

Breastfeeding

The following chart shows coverage and breastfeeding prevalence, which is recorded at the 6-8 week check.

Figure 27



Coverage levels of 95% and greater have been recommended for the accurate assessment of breastfeeding prevalence.

The South Kent Coast coverage was 66.6% and within Dover practices ranged between 38.9 and 84.9% during the mid-part of 2014/15. None of the practices had coverage higher than recommended levels.

Coverage rates below the recommended levels suggest that the prevalence indicators are less reliable and mask the true population prevalence with regard to breastfeeding continuation.

Health Checks

Data is available on the NHS Health Checks. [1] NHS Health Checks are available for adults aged 40-74 without a previous diagnosis of heart disease, stroke, diabetes, kidney disease or certain types of dementia. Eligible individuals are invited once every five years with the aim to assess risk and prevent disease.

Eligible Population

Within South Kent Coast CCG, the annual eligible population has been estimated to be 10,408 persons in 2014/15. A total of 2,554 persons have been estimated to be eligible within Dover practices:

Table 28

G82002 - St James Surgery	289
G82015 - Pencester Surgery	428
G82117 - The High Street Surgery	332
G82128 - Peter Street Surgery	341
G82211 - Aylesham Medical Practice	310
G82227 - Lydden Surgery	303
G82662 - Pencester Health Centre	86
G82700 - Buckland Medical Centre	149
G82729 - White Cliffs Medical Centre	316

Performance

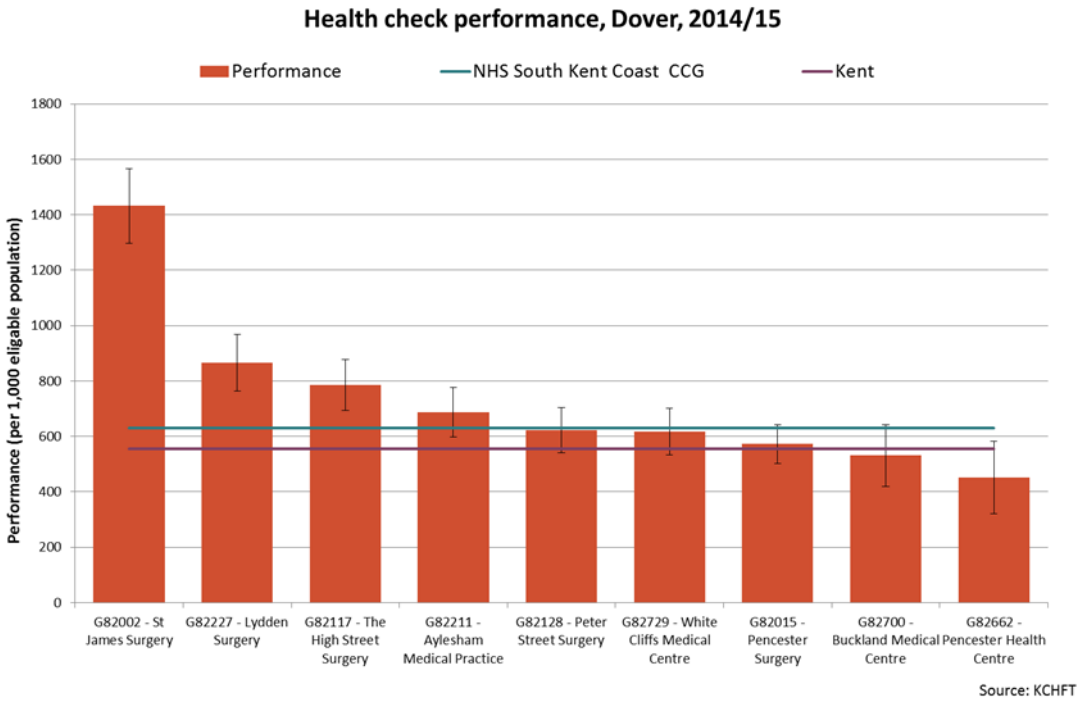
Performance describes the numbers of health checks delivered (within all settings) in comparison to the eligible population (one fifth of the five year eligible population).

A local analysis of health checks performance, practice level deprivation and list size has been completed.[2] This identified a weak and non-significant finding that practices with smaller list sizes had lower health check completion rates, as well as, lower patient satisfaction scores.

None of the Dover practices were identified to have performance that was significantly lower than the 95% or 99.8% control limits within Kent. Practices G82002, G82227, G82117 and G82211 had performance that was significantly higher than the Kent average performance.

[1] BMJ Informatica (2015) Health checks.
[2] KMPHO (2015) Health checks performance, practice level deprivation and list size.

Figure 29


Health check performance, Dover, 2014/15
Performance
NHS South Kent Coast CCG
Kent
Performance (per 1,000 eligable population)
1800
1600
1400
1200
1000
800
600
400
200
0
G82002 - St James Surgery
G82227 - Lydden Surgery
G82117 - The High Street Surgery
G82211 - Aylesham Medical Practice
G82128 - Peter Street Surgery
G82729 - White Cliffs Medical Centre
G82015 - Pencester Surgery
G82700 - Buckland Medical Centre
G82662 - Pencester Health Centre
Source: KCHFT

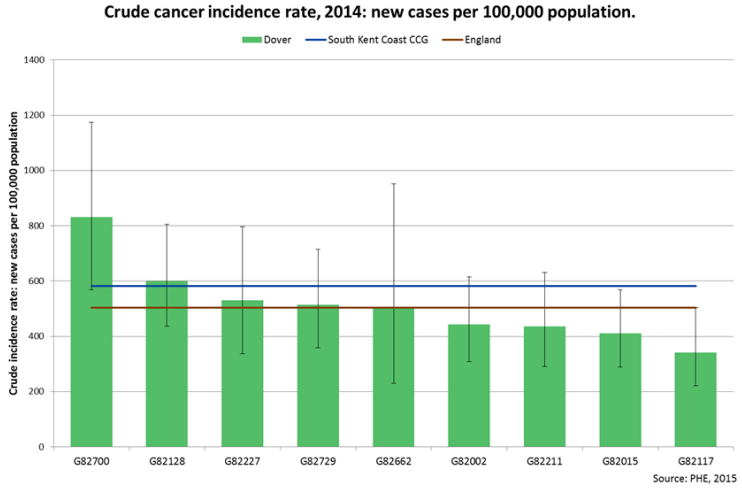
Cancer

Data is available on cancer care via the National Cancer Intelligence Network. [3] A local Cancer Equity Audit is also available for Kent.[4]

Incidence

Across Kent it is known that there has been an increasing trend in cancer incidence.[4] The crude incidence rate of cancer in 2014 (new cancer cases per 100,000 population) has been shown below. Practices G82015 and G82117 can be identified to have crude cancer incidence rates lower than South Kent Coast CCG.

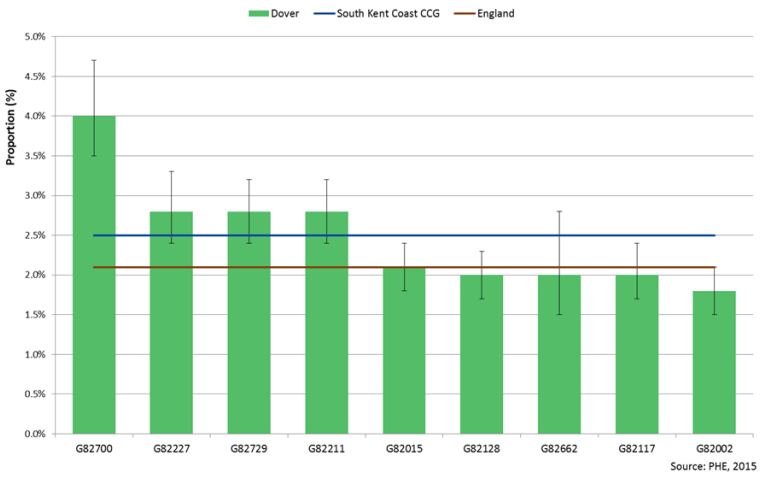
Figure 30



Prevalence

In 2014, the prevalence of cancer (% of practice population on practice cancer register) has been shown below. Practice G82000 can be identified to have cancer prevalence higher than South Kent Coast CCG. Practices G82002, G82015, G82117 and G82128 can be identified to have prevalent cancer cases lower than South Kent Coast CCG.

Figure 31



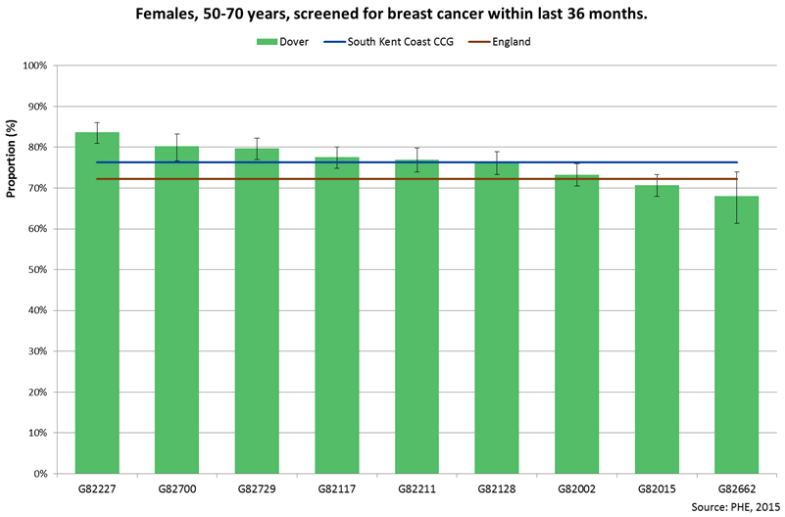
[3] Public Health England (2015) National Cancer Intelligence Network: Cancer Commissioning Toolkit. https://www.cancertoolkit.co.uk/Login

[4] Kent Public Health Observatory (2015) Cancer in Kent: equity review.

Breast Cancer

In 2014, the proportion of females screened for breast cancer (ages 50-70, in last 36 months) can be seen below:

Figure 32

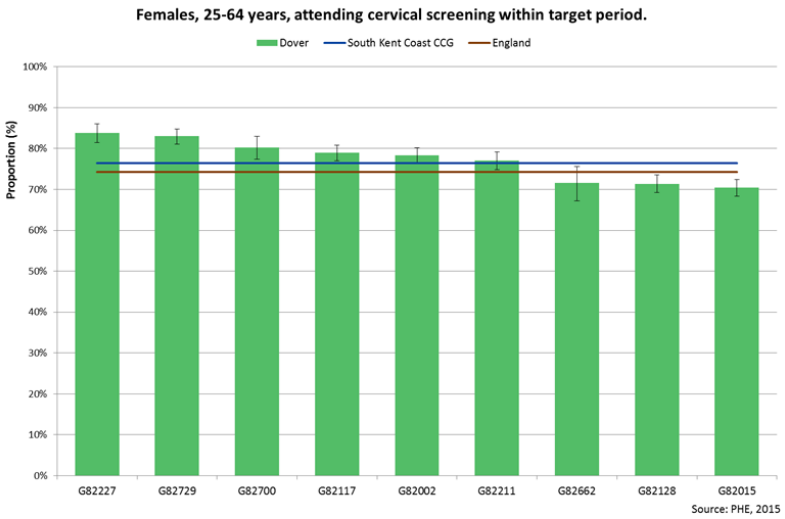


- Screening rates in G820002, G82015 and G82662 were significantly lower than South Kent Coast CCG.

Cervical Cancer

In 2014, the proportion of females attending cervical screening (ages 25-64, within target period) has been presented below:

Figure 33

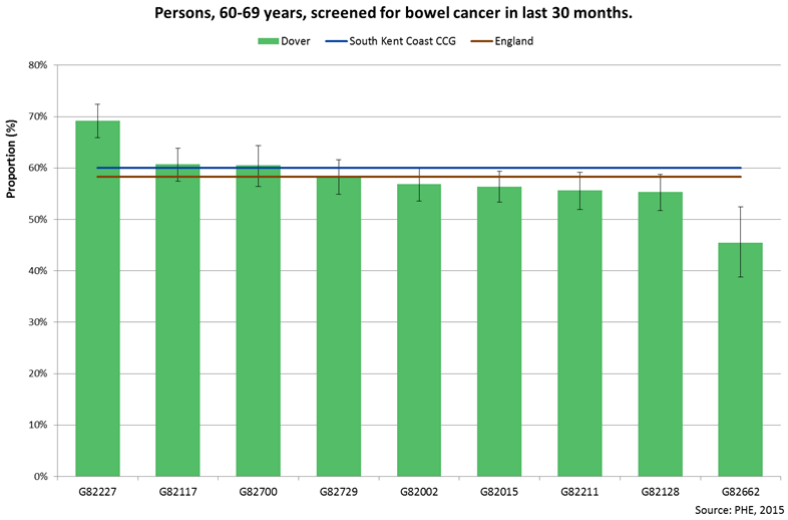


- Screening rates in G82015, G82128 and G82662 were significantly lower than South Kent Coast CCG.

Bowel Cancer

In 2014, the proportion of persons screened for bowel cancer (ages 60-69, within last 30 months) has been presented below:

Figure 34



Screening rates in G82015, G82128, G82211 and G82662 were significantly lower than South Kent Coast CCG

Lifestyles

The measuring of lifestyle factors is very difficult, we do not routinely weigh and measure adults for obesity prevalence, we do not regularly check on everyone's smoking status for population smoking prevalence. Estimates of population prevalence for these lifestyle factors are modelled from national surveys such as The Health Survey for England.

The following maps show modelled adult smoking and obesity prevalence estimates applied locally at a Mid Super Output Area[5] (MSOA) level with electoral wards overlaid for all of South Kent Coast CCG.

Whereas with adult obesity we have to rely on estimates modelled from national surveys – for children there is a National Child Measurement Programme. All children in reception year and year 6 schooling are routinely weighed and measured and whilst many debate the measure used to calculate Body Mass Index (BMI) we do have a defined and stable set of measures to calculate on a population scale.

Figure 35

Modelled adult obesity prevalence estimates

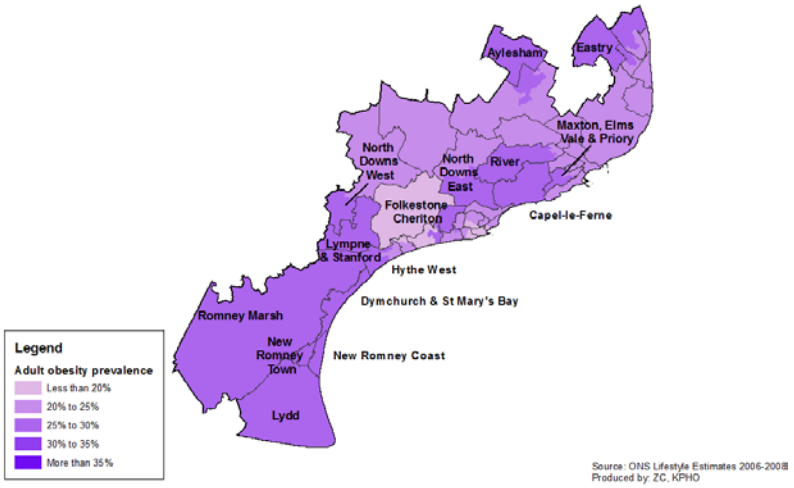
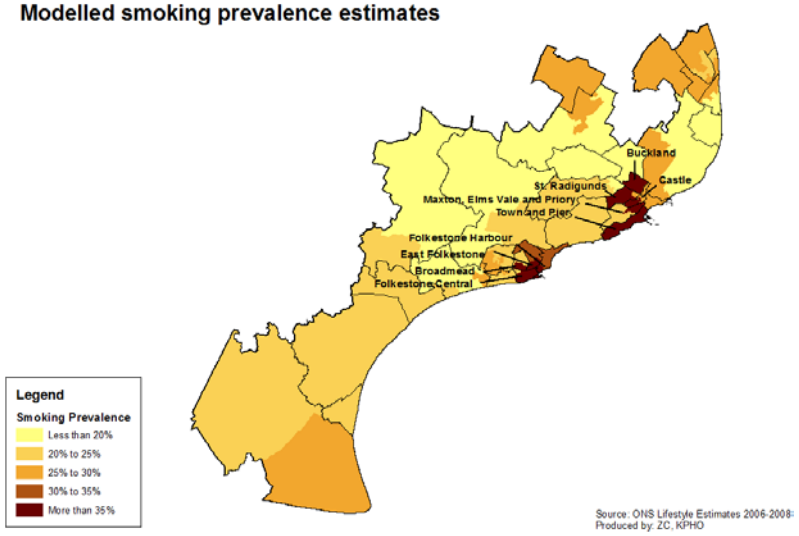


Figure 36

Modelled smoking prevalence estimates



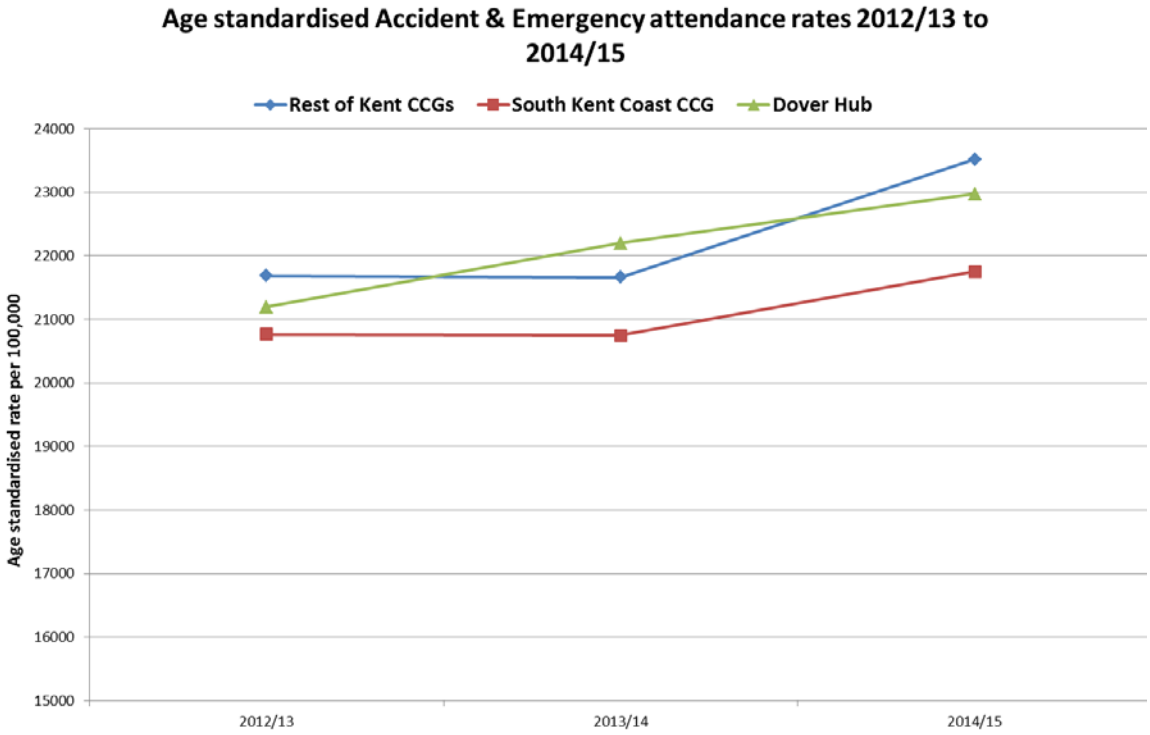
[5] MSOAs cover between 5,000 and 20,000 populations

Accident and emergency activity

Accident & Emergency attendances across Kent have been slowly increasing in recent years. This is also reflected in the attendance rates for South Kent Coast and each of its constituent hubs. Age standardised rates are higher for patients registered with the Dover hub practices.

The rate of increase for Dover patients is in line with the increase for all Kent patients (about 8%) but higher than the 5% for South Kent Coast.

Figure 37

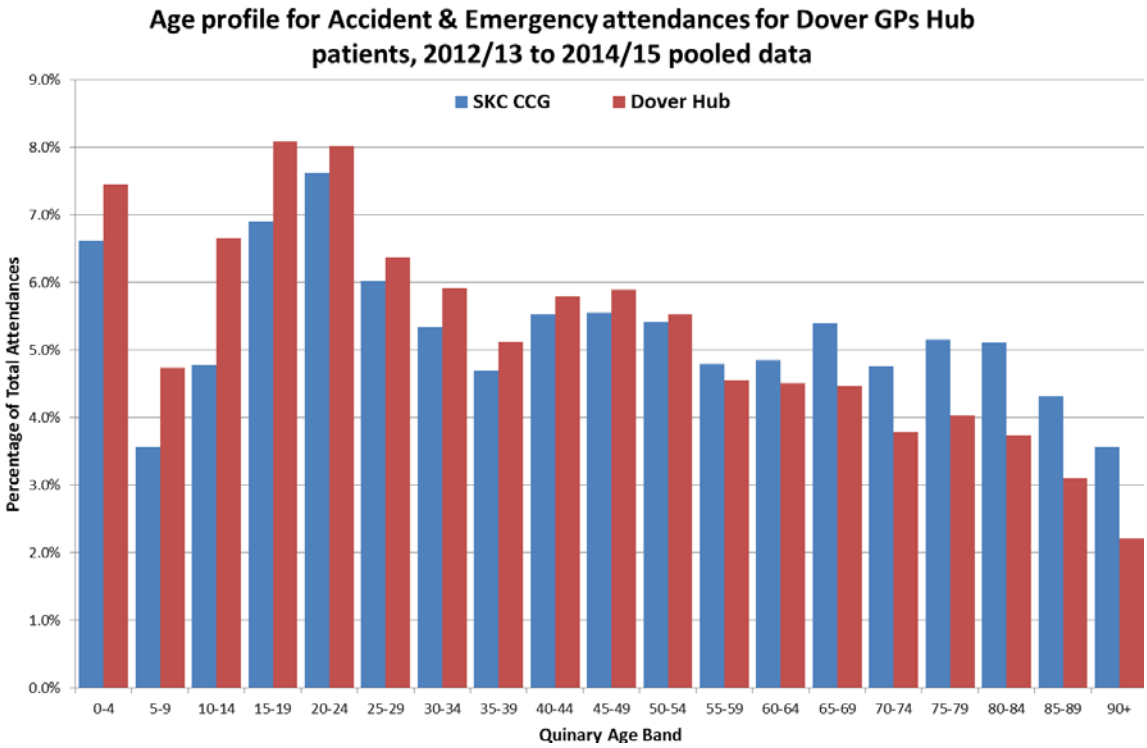


The age profile of accident & emergency attendances over the three year period shows that young people aged 10-24 years as well as the very young 0-4 years are the most frequent of all attendances. These sections of the population account for 30% of all attendances, this compares to 25% for South Kent Coast.

Overall there is a higher ratio of attendances for Dover patients for all ages up to age 55, compared to South Kent Coast.

The age profile of all attendances does reflect the general profile of the population in Dover.

Figure 38


Age profile for Accident & Emergency attendances for Dover GPs Hub patients, 2012/13 to 2014/15 pooled data
SKC CCG
Dover Hub
Percentage of Total Attendances
9.0%
8.0%
7.0%
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
0-4
5-9
10-14
15-19
20-24
25-29
30-34
35-39
40-44
45-49
50-54
55-59
60-64
65-69
70-74
75-79
80-84
85-89
90+
Quinary Age Band

Outpatient activity

In 2014/15, there were 2,605,087 outpatient appointments for the Kent registered population. Of these, 372,280 outpatient appointments were for the South Kent Coast CCG registered population.

In 2014/15, there were 104,754 outpatient appointments for patients registered to Dover practices.

Table 22

	Dover *n* (%)	South Kent Coast CCG *n* (%)	Kent *n* (%)
Not applicable	0	8 (0.0)	627 (0.0)
Cancelled by patient	1,833 (1.7)	6547 (1.8)	97,978 (3.8)
Patient did not attend	6,951 (6.6)	23915 (6.4)	161,681 (6.2)
Appointment cancelled or postponed by Provider	692 (0.7)	4106 (1.1)	86567 (3.3)
Seen	94,748 (90.4)	336266 (90.3)	2,241,532 (86.0)
Arrived late and seen	369 (0.4)	853 (0.2)	3,233 (0.1)
Patient did not attend - arrived late and not seen	29 (0.0)	86 (0.0)	637 (0.0)
Not known	0 (0.0)	0 (0.0)	0 (0.0)
Not coded	129 (0.1)	499 (0.1)	12,832 (0.5)

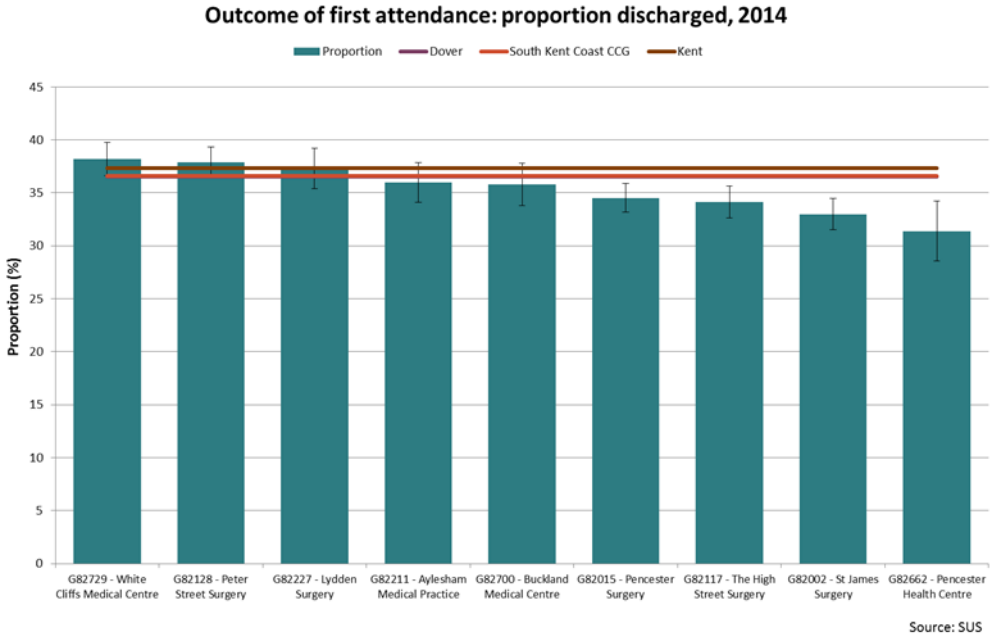
Proportions of appointments cancelled by provider were higher similar in Dover, South Kent Coast CCG and Kent.

The proportion of appointments whereby the patient did not attend were lower within Dover, in comparison to South Kent Coast CCG and Kent. In 2014/15, within Dover, patient not attending appointment amounted to 2,202 appointments.

First appointments accounted for 36,167 attendances within Dover general practices. After first attendance, 36.5% or 13,208 were discharged from care.

None of the practices were significantly greater than Dover, South Kent Coast CCG and Kent.

Figure 23



Within Kent, in 2014/15 there was a ratio of 2.25 follow-up appointments for each first appointment. A higher ratio can be seen for South Kent Coast CCG (2.49) and for Dover (2.67). The G82117 – The High Street Surgery and G82211 showed the highest ratios (2.87) across Dover practices.

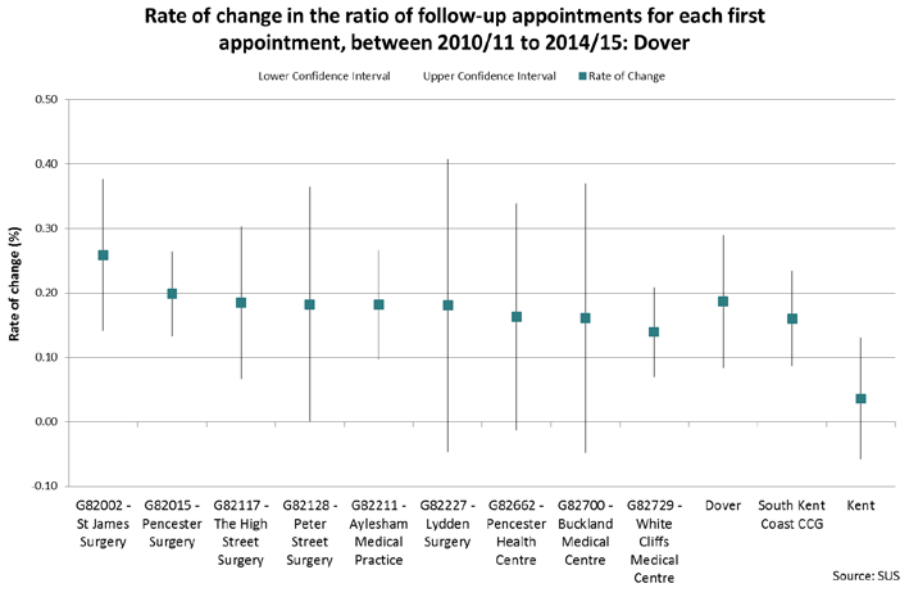
Table 24

	First appointments	Follow-up appointments	Ratio
G82117 - The High Street Surgery	3836	11008	2.87
G82211 - Aylesham Medical Practice	2537	7269	2.87
G82729 - White Cliffs Medical Centre	3610	9788	2.71
G82662 - Pencester Health Centre	1016	2727	2.68
G82015 - Pencester Surgery	4606	12241	2.66
G82002 - St James Surgery	3912	10325	2.64
G82227 - Lydden Surgery	2472	6473	2.62
G82128 - Peter Street Surgery	4115	10395	2.53
G82700 - Buckland Medical Centre	2196	5456	2.48
Dover	28300	75682	2.67
South Kent Coast CCG	105367	262361	2.49
Kent	793543	1789342	2.25

The rate of change in the ratio of follow-up appointments for each first appointment has been presented below. Only G82002 – St James Surgery and G82015 –

Pencester Surgery had a significantly greater rate of change between 2010/11 and 2014/15 in comparison to Kent.

Figure 39



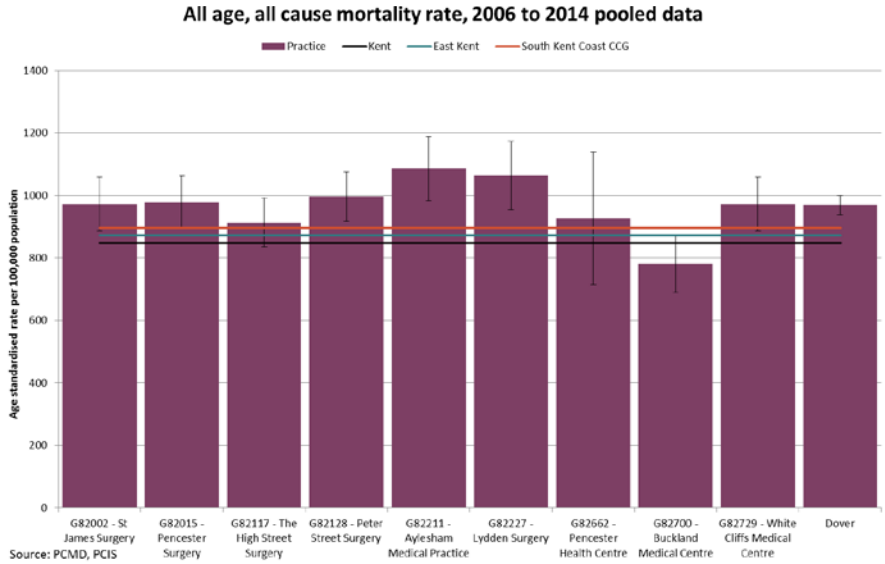
Mortality

All age, all cause mortality

There is a considerable range in all age, all cause mortality rates between practices varying from 780.5 per 100,000 population at Buckland Medical Centre to 1185.5 at Aylesham Medical Practice. The Buckland Medical Centre has a significantly lower rate than Dover (969.2); however, none of the other practices have significantly different rates.

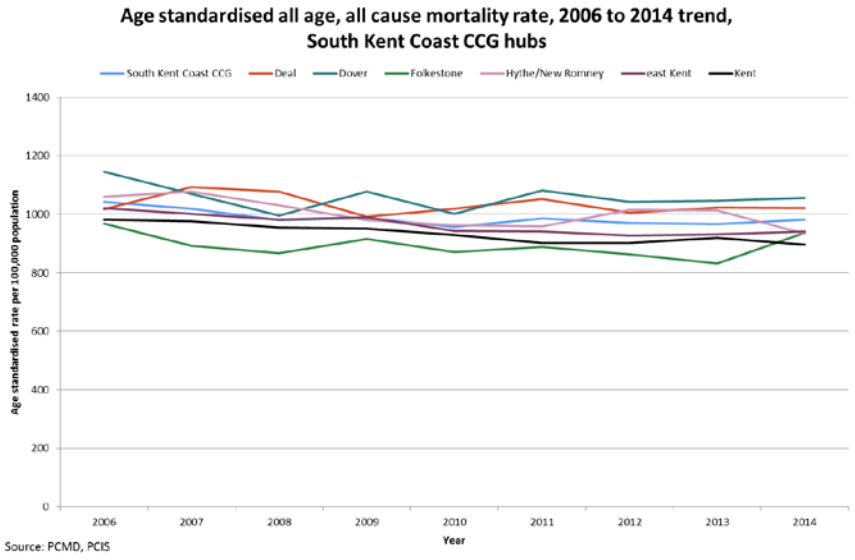
Dover has a significantly higher all age, all cause mortality rate than South Kent Coast CCG (896.2), east Kent (872.3) and Kent (848.2).

Figure 40



The rate of decrease in the Dover hub has been 5.6 deaths per 100,000 population annually, slower than the Kent (11.1) and South Kent Coast CCG (7.0) rate of decrease, although not significantly different.

Figure 41

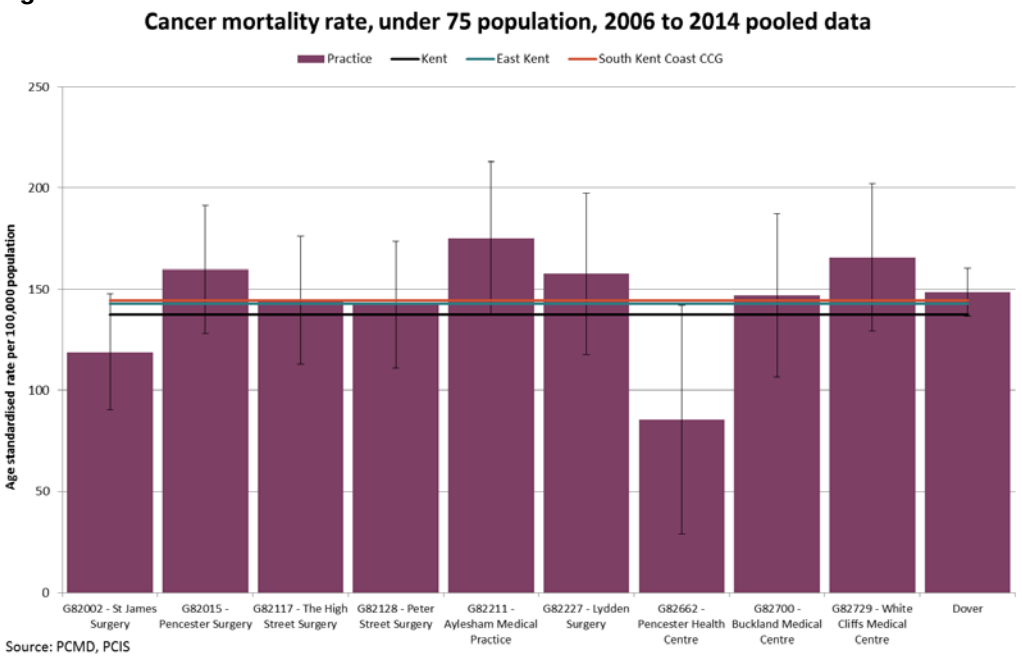


Cancer

Pencester Health Centre has the lowest cancer mortality rate per 100,000 population aged under 75, at 85.5 whilst Aylesham Medical Practice has the highest rate at 175.2; however none of the practices have rates significantly different to the Dover rate of 148.6.

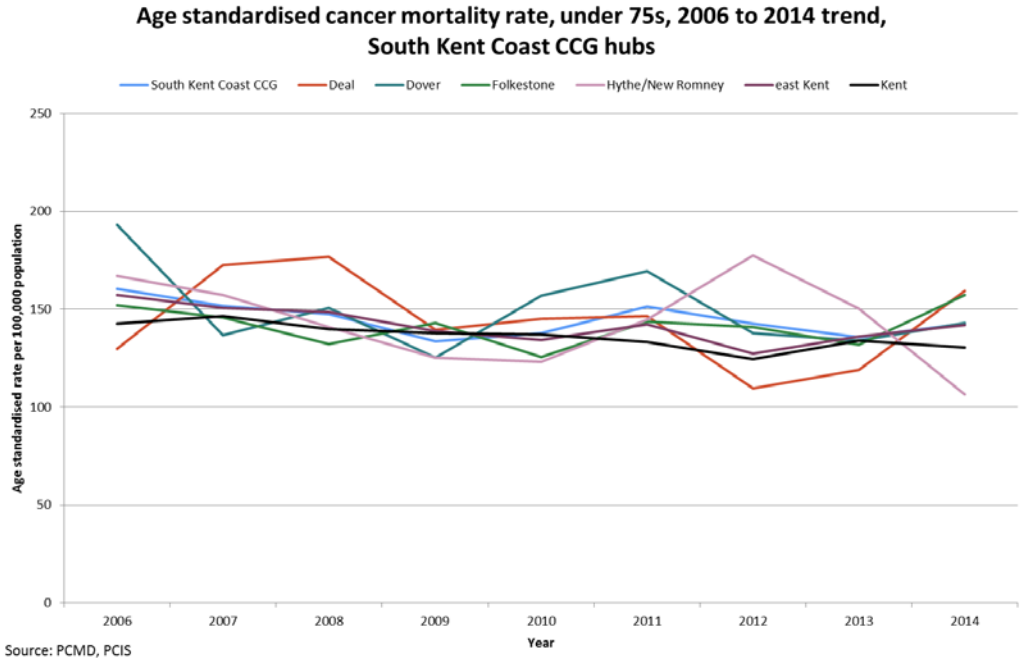
The Dover rate is not significantly different to South Kent Coast CCG (144.5), east Kent (142.7) or Kent (137.6).

Figure 42



Across Kent, the under 75 mortality rate for cancer has reduced by 2.0 deaths per 100,000 population annually. Overall in the Dover hub, the rate of decrease has been 3.2; however there have been large fluctuations, with a peak at 193.1 deaths per 100,000 population in 2006. In 2014, the rate was 143.0, higher than the Kent rate of 130.5, but not significant.

Figure 43

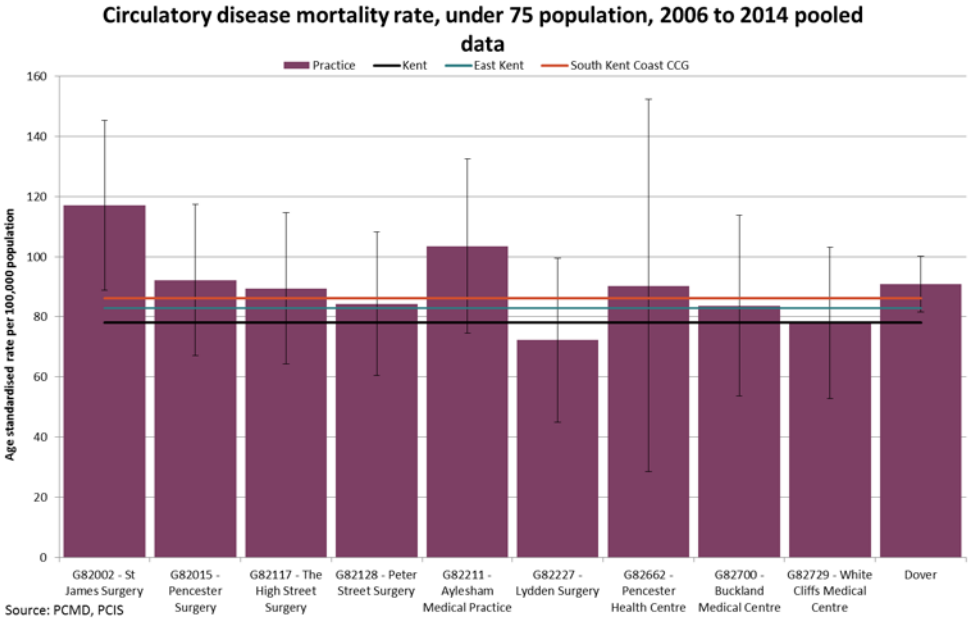


Circulatory Disease

The lowest under 75 circulatory disease mortality rate is at Lydden Surgery (72.2) whilst the highest is at St James Surgery (117.1); however none of these rates are significantly different.

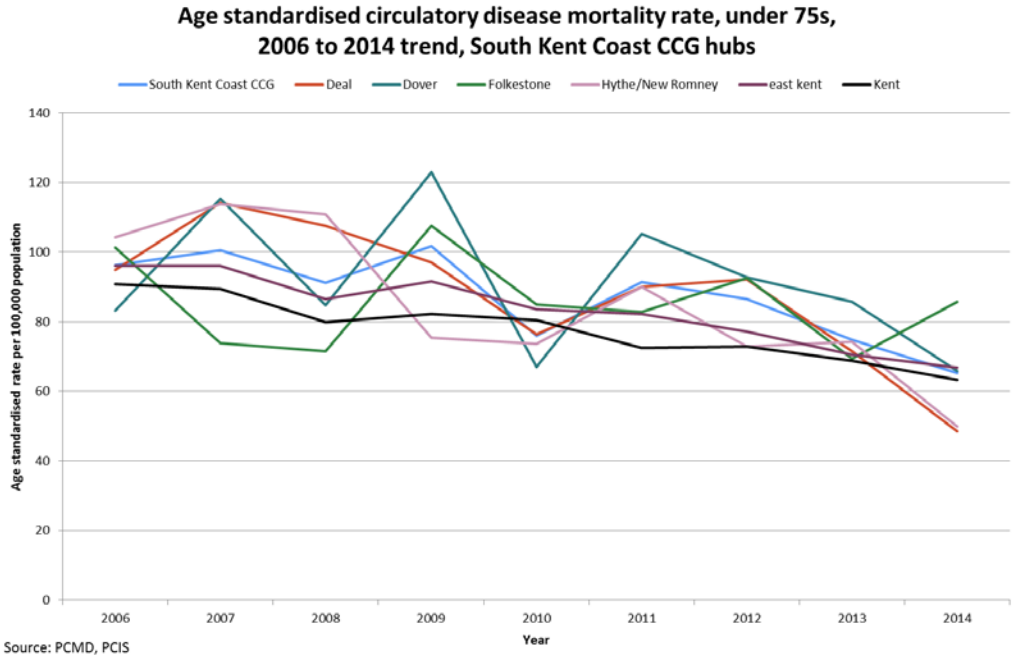
Whilst the Dover rate (90.9) is significantly higher than the Kent rate (77.9), it is not significantly different to either South Kent Coast CCG (86.3) or east Kent (82.8).

Figure 44



The rate of decrease has been slower in Dover hub (2.7 deaths per 100,000) than in Kent (3.3); however, this difference is not significant. The rate has fluctuated substantially within the hub, peaking in 2009 at 123.0. The lowest recorded rate occurred in 2014 at 65.8; this is similar to the Kent (63.3), east Kent (66.8) and South Kent Coast CCG (65.3) rates.

Figure 45

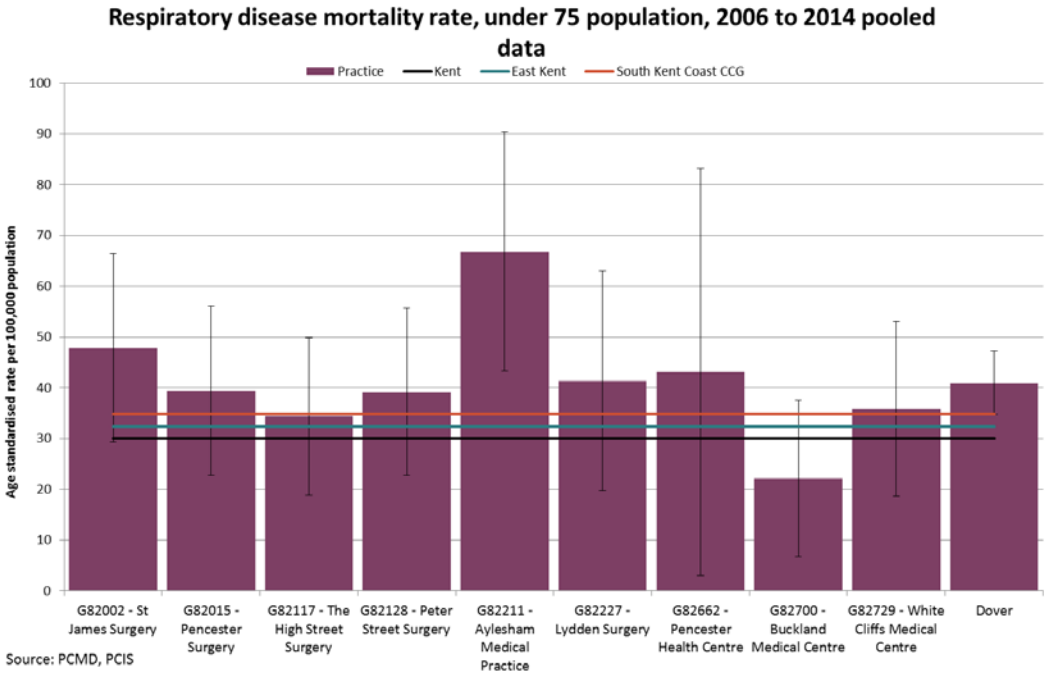


Respiratory Disease

The lowest under 75 mortality rate from respiratory disease in Dover hub is 22.2 deaths per 100,000 at Buckland Medical Centre whilst the higher rate is at Aylesham Medical Practice (66.8). None of the practices have rates significantly different to that of Dover (41.0).

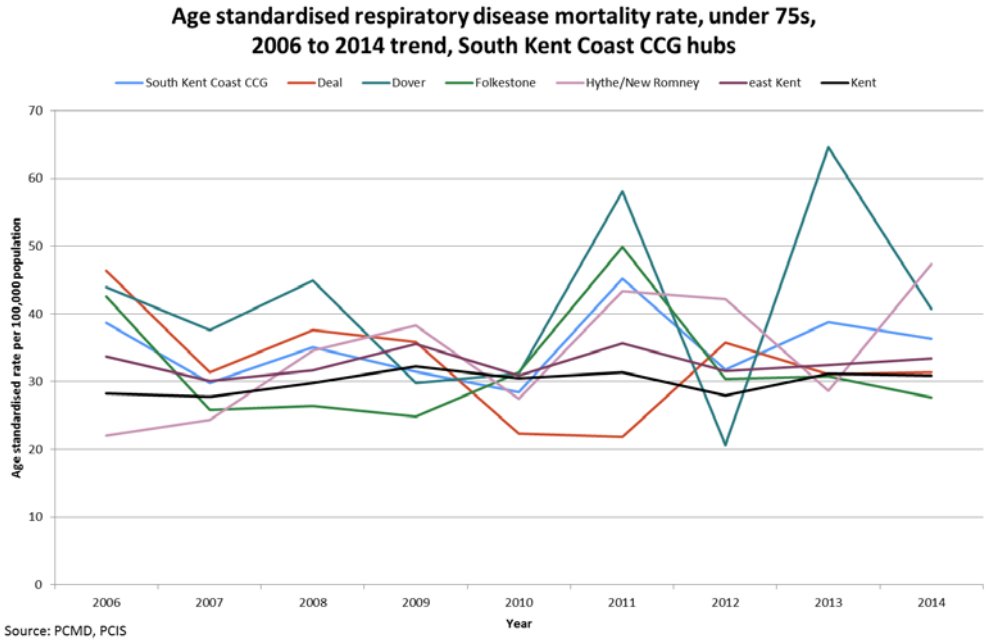
The Dover rate is not significantly different to the South Kent Coast CCG rate (34.8); however is significantly higher than both east Kent (32.4) and Kent (30.0).

Figure 46



There has been little change in under 75 mortality rates for respiratory disease across Kent, the rate of change has been 0.3 deaths per 100,000 population. Very large fluctuations are observed in mortality rate due to the small numbers of deaths involved. The rate of increase in the Dover hub is 0.8 with the lowest rate occurring in 2012 (20.7), increasing to a peak of 64.6 in 2013.

Figure 47



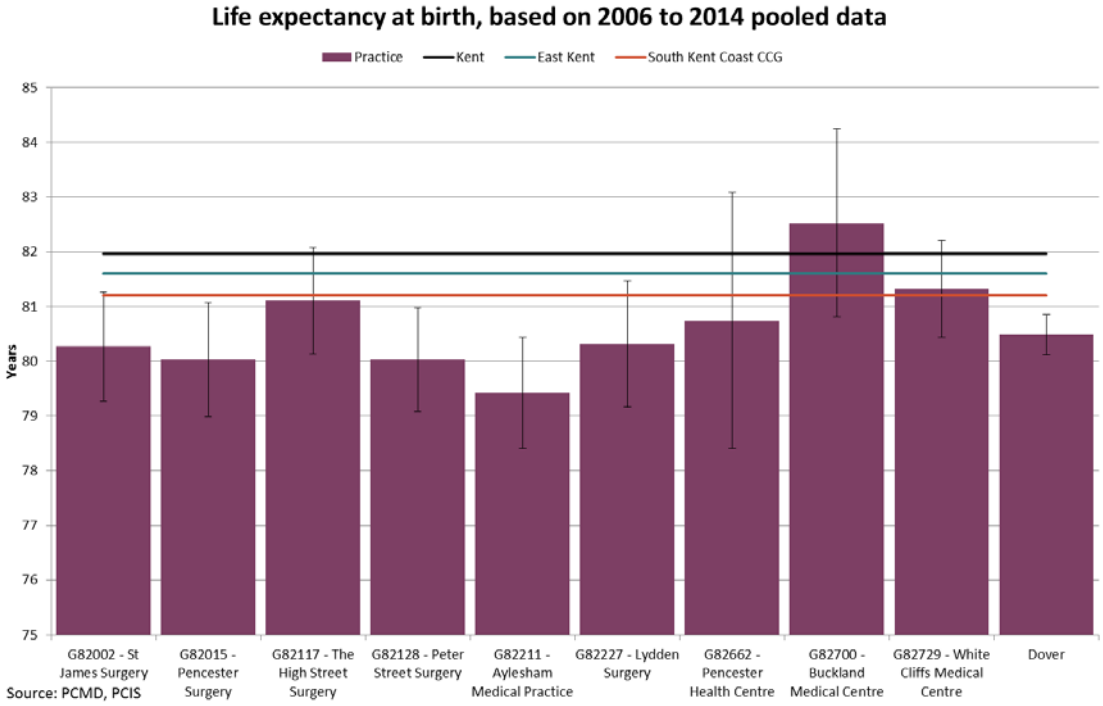
Life Expectancy

Life expectancy is defined by the South East Public Health Observatory as the 'average number of years a baby born in a particular area or population can be expected to live if it experiences the current age-specific mortality rates of that particular area or population throughout its life'.

There is a gap of 3.1 years between the practice with the highest life expectancy (Buckland Medical Centre, 82.5) and the practice with the lowest life expectancy (Aylesham Medical Practice.

The life expectancy in Dover (80.5) is significantly lower than that of South Kent Coast CCG (81.2), east Kent (81.6) and Kent (82.0).

Figure 48



Appendix

Indicator	Definition
Asthma 02	The percentage of patients aged 8 or over with asthma (diagnosed on or after 1 April 2006), on the register, with measures of variability or reversibility recorded between 3 months before or any time after diagnosis
Asthma 03	The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23
Atrial fibrillation 03	In those patients with atrial fibrillation in whom there is a record of a CHADS2 score of 1 (latest in the preceding 12 months), the percentage of patients who are currently treated with anti-coagulation drug therapy or anti-platelet therapy, NICE 2011 menu ID: NM45
Atrial fibrillation 04	In those patients with atrial fibrillation whose latest record of a CHADS2 score is greater than 1, the percentage of patients who are currently treated with anti-coagulation therapy, NICE 2011 menu ID: NM46
Cancer 02	The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 3 months of the contractor receiving confirmation of the diagnosis, NICE 2012 menu ID: NM62
Chronic Kidney Disease 02	The percentage of patients on the CKD register in whom the last blood pressure reading (measured in the preceding 12 months) is 140/85 mmHg or less
Chronic Kidney Disease 03	The percentage of patients on the CKD register with hypertension and proteinuria who are currently treated with an ACE-I or ARB
COPD 03	The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months
COPD 04	The percentage of patients with COPD with a record of FEV1 in the preceding 12 months
Dementia 02	The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 12 months
Depression 02	The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than 10 days after and not later than 35 days after the date of diagnosis, NICE 2012 menu ID: NM50
Diabetes 03	The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less, NICE 2010 menu ID: NM02
Diabetes 07	The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 12 months, NICE 2010 menu ID: NM14
Diabetes 09	The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months
Diabetes 14	The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register, NICE 2011 menu ID: NM27
Epilepsy 02	The percentage of patients aged 18 or over on drug treatment for epilepsy who have been seizure free for the last 12 months recorded in the preceding 12 months
Heart Failure 03	In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, the percentage of patients who are

Indicator	Definition
	currently treated with an ACE-I or ARB
Hypertension 02	The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 9 months) is 150/90 mmHg or less
Mental Health 02	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate
Osteoporosis 03	The percentage of patients aged 75 or over with a fragility fracture on or after 1 April 2012, who are currently treated with an appropriate bone-sparing agent, NICE 2011 menu ID: NM31
Peripheral Artery Disease 02	The percentage of patients with peripheral arterial disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less, NICE 2011 menu ID: NM34
Rheumatoid Arthritis 02	The percentage of patients with rheumatoid arthritis, on the register, who have had a face-to-face review in the preceding 12 months, NICE 2012 menu ID: NM58
Coronary Heart Disease 02	The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less
Coronary Heart Disease 06	The percentage of patients with a history of myocardial infarction (on or after 1 April 2011) currently treated with an ACE-I (or ARB if ACE-I intolerant), aspirin or an alternative anti-platelet therapy, beta-blocker and statin, NICE 2010 menu ID: NM07
Stroke & TIA 03	The percentage of patients with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less
Blood Pressure 01	The percentage of patients aged 40 or over who have a record of blood pressure in the preceding 5 years, NICE 2012 menu ID: NM61
Smoking 02	The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months, NICE 2011 menu ID: NM38
Smoking 05	The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 12 months, NICE 2011 menu ID: NM39
Cervical Screening 02	The percentage of women aged 25 or over and who have not attained the age of 65 whose notes record that a cervical screening test has been performed in the preceding 5 years