KENT PUBLIC HEALTH OBSERVATORY

South Kent Coast CCG hub Profile Folkestone

October 2015

Kent County Council
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Contents

Key Findings

Demographics overview

- Approximately 70,750 persons are registered to the 11 GP practices located within the Folkestone hub. The hub has a predominantly younger population than that of South Kent Coast generally; more than 60% of the population are aged under 50.

Primary care context

- General practices in Folkestone hub have a relatively low number of full time equivalent general practitioners; five out of the eleven general practices have one general practitioner per practice.

GP Survey

- The ratings of 'very good' and 'fairly good' remain consistently higher than the other responses to the 'overall experience of GP surgery'.

Long term conditions prevalence

- In 2013/14, the general practice recorded prevalence was significantly higher than the CCG for mental health. Chronic kidney disease recorded prevalence has increased by 0.37% 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).
- Practices G82086, G82217 and G82760 had 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 percentage increase in activity between 2012/13 and 2014/15 for Folkestone patients is 3%; lower than both the South Kent Coast rate (5%) and the rate for the other CCGs in Kent (8%).
- The age profile of accident & emergency attendances over the three year period shows that young people aged 15-24 years are the most frequent of all attendances.

Outpatient activity

- Proportions of appointments cancelled by provider were similar in Folkestone, South Kent Coast CCG and Kent.
- First appointments accounted for 32,528 attendances within Folkestone general practices, after first attendance, 37.1% or 12,056 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 Folkestone (2.49).

Mortality and life expectancy

- The New Surgery, Guildhall Surgery, Folkestone East Family Practice, Manor Clinic and Park Farm Surgery all have significantly higher all age, all cause mortality rates in comparison with Folkestone hub, whilst The White House Surgery, The Surgery Lyminge and New Lyminge all have significantly lower rates.
- The Folkestone hub all age, all cause mortality rate for 2006 to 2014 (pooled) is significantly lower than South Kent Coast CCG, east Kent and Kent.
- The under 75 cancer mortality rate in Folkestone hub is lower than the CCG rate but greater than the Kent rate.
- Guildhall Surgery has a significantly higher under 75 circulatory disease rate than the Folkestone hub; however, no other significant differences are observed. The overall rate of decrease for the hub has been slower between 2006 and 2014 than the Kent rate of change; however, large fluctuations are observed.
- There are no significant differences in under 75 respiratory disease rate, although the hub rate has been higher than Kent for 2006 to 2014 (pooled). Between 2006 and 2014, there have been large fluctuations in the local rate.
- There is an 8.5 year gap in life expectancy between practices in the Folkestone hub. The hub has a significantly higher life expectancy in comparison with South Kent Coast CCG and east Kent.

Demographics Overview

Approximately 70,750 persons are registered to the 11 GP practices located within the Folkestone hub. The population structure can be seen in the chart below, predominantly a younger population than that of South Kent Coast generally, with more than 60% of the population aged under 50. There are slightly more females than males in the area (51.2% to 48.8% males).

Figure 1
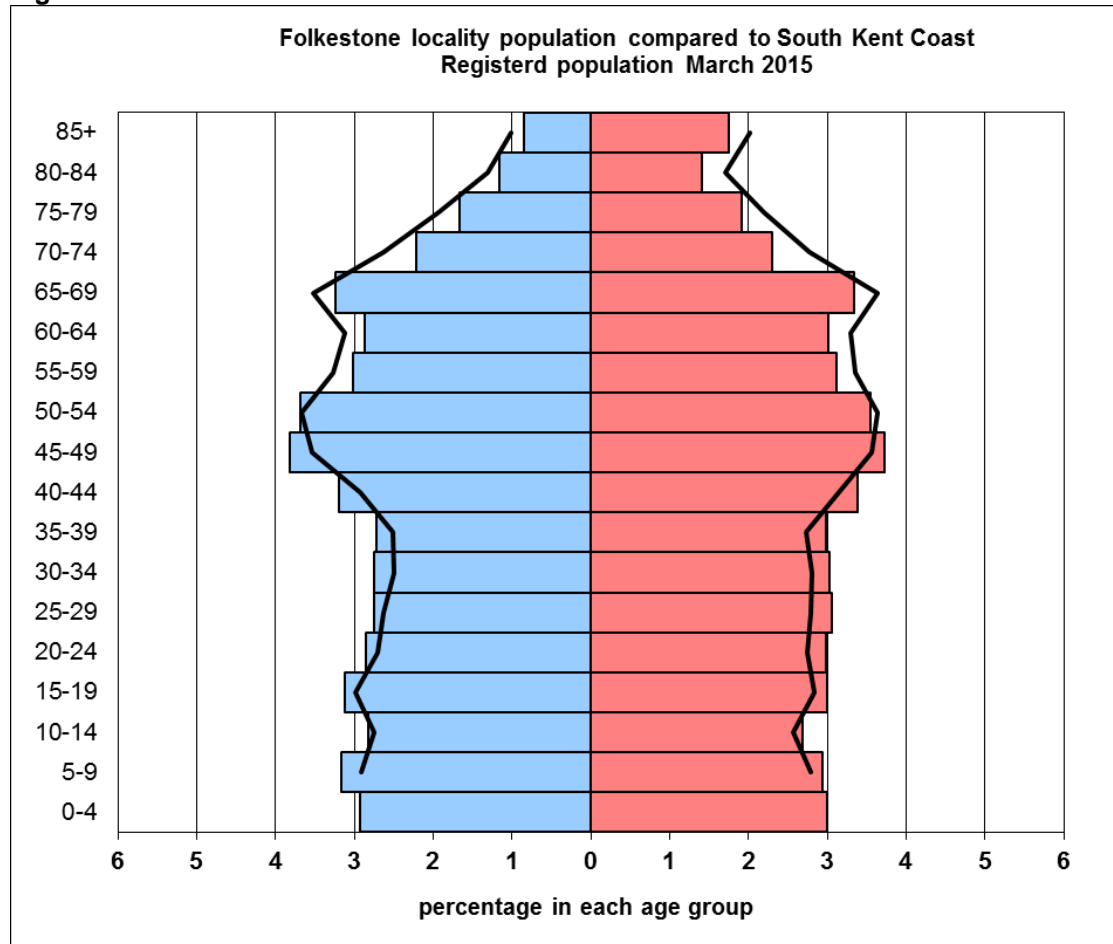
The overall population of South Kent Coast CCG is set to increase by 15% by the year 2025 from the current registered of 205,000 rising to around 215,000, with the greatest growth in the over 65 population (24%) up from 47,000 to 58,200 .

Figure 2

Folkestone locality registered population
- March 2015

Age band	Male	Female	Total
0-4	2,068	2,122	4,190
5-9	2,241	2,076	4,317
10-14	1,994	1,902	3,896
15-19	2,207	2,119	4,326
20-24	2,024	2,107	4,131
25-29	1,941	2,165	4,106
30-34	1,944	2,138	4,082
35-39	1,925	2,110	4,035
40-44	2,257	2,398	4,655
45-49	2,700	2,636	5,336
50-54	2,607	2,516	5,123
55-59	2,137	2,204	4,341
60-64	2,027	2,136	4,163
65-69	2,297	2,363	4,660
70-74	1,571	1,628	3,199
75-79	1,179	1,350	2,529
80-84	826	997	1,823
85+	602	1,238	1,840
Total	34,547	36,205	70,752

Figure 3

Indices of multiple deprivation in South Kent Coast CCG,
with general practices overlayed, 2015
Source: IMD (2015), PCIS
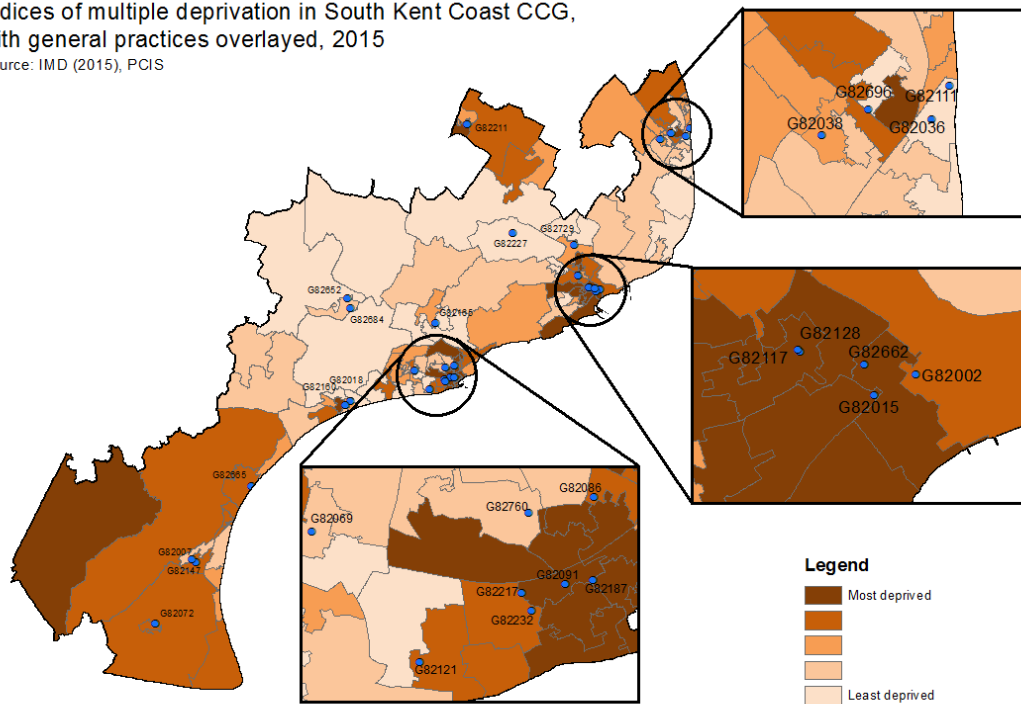
The most deprived fifth of LSOAs tend to centre around the towns; Dover and Folkestone.
The Romney Marsh area is also relatively deprived.

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.

- Five out of the eleven general practices have one general practitioner per practice whilst some of the others have as many as 6. The practitioner to population ratio is given below

Figure 4

General practitioner provider headcount, 2012-2014, Folkestone Hub
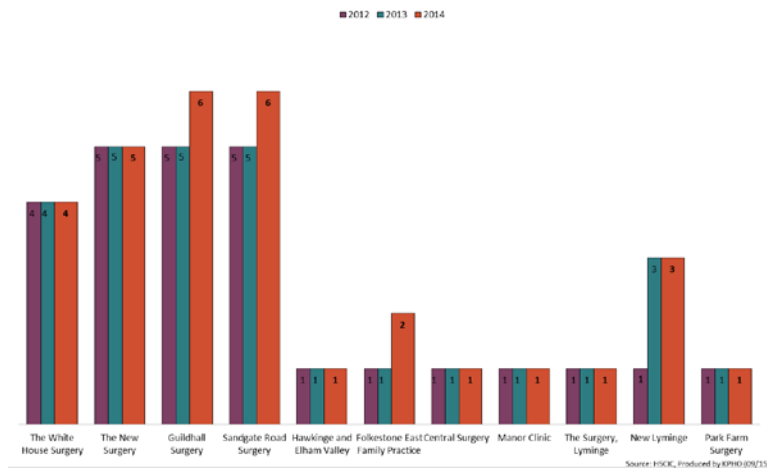
The majority of the general practices in the Folkestone hub have a lower FTE for general practitioners. General practices, Guildhall Surgery and Sandgate Road Surgery, are the only exceptions for 2014, each having a FTE of general practitioners at 5.8.

Figure 5

Full time eqivalent of general practitioner provider headcount, 2012-2014, Folkestone Hub

Total Nurses

The total nurses definition refers to advanced nurses, extended role nurses and practice nurses.
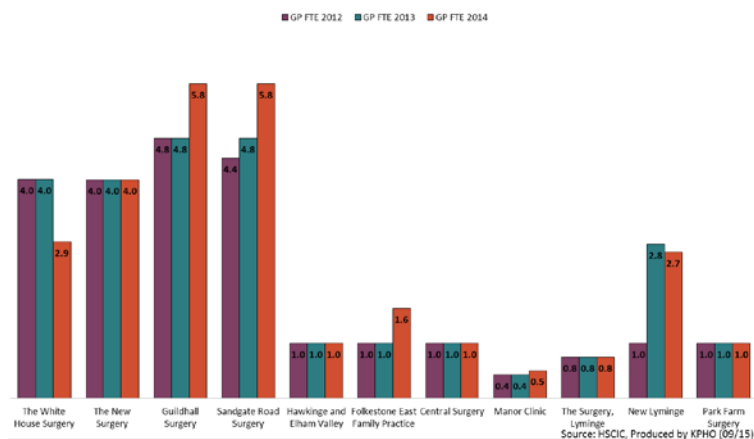
General practices in Folkestone have a higher headcount of nurses compared to general practitioners; the highest being for The White House Surgery who have seven nurses to four general practitioners (2014).

The number of advanced nurses has increased to eleven in 2014 from ten in 2013 and they are located at eight of out of eleven general practices in Folkestone hub. Extended nurse roles are located at seven general practices. The Sandgate Road Surgery has three extended nurse roles. There are no general practitioner specialisms.

Figure 6

Total headcount of nurses, 2013-2014, Folkestone Hub

■2013 ■2014

Source: HSCIC, Produced by KPHO (09/15)
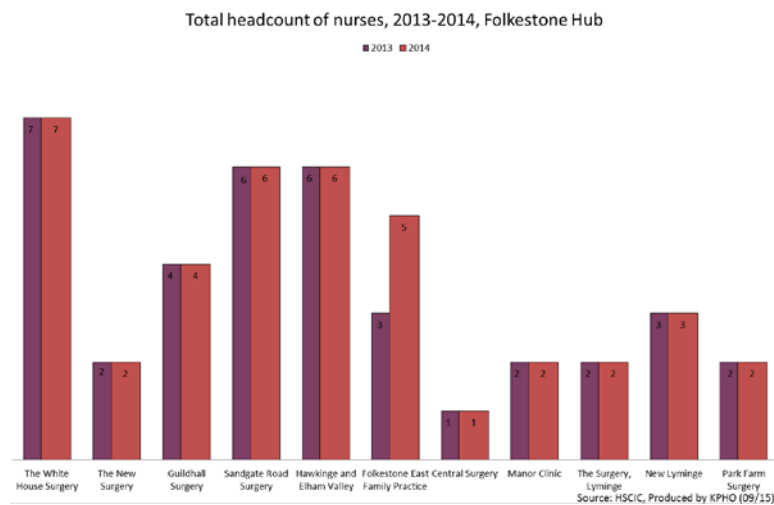
Practice Staff

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.

There is a higher headcount of practice staff at each general practice than general practitioners or nurses. There is an increase of practice staff in 2014 for seven out of the eleven general practices.

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Figure 7

Total headcount of practice staff, 2013-2014, Folkestone Hub
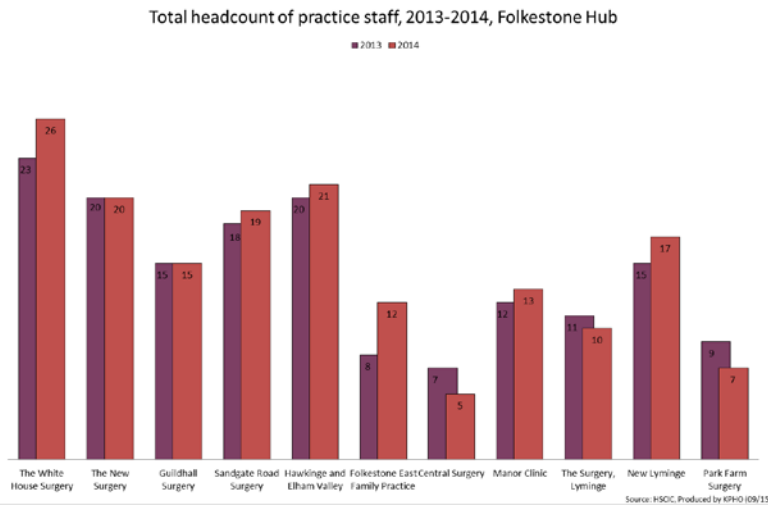
General Practitioner to Population Ratio

General practices, Guildhall Surgery and New Lyminge have the highest general practitioner ratio per 10,000 population for 2014. Hawkinge and Elham Valley surgery has the lowest general practitioner to population ratio at 1.1 general practitioners per 10,000 population.

Figure 8

The number of general practitioners (using provider headcount) per 10,000 population (using total patients per general practice), from 2013-2014, Folkestone Hub
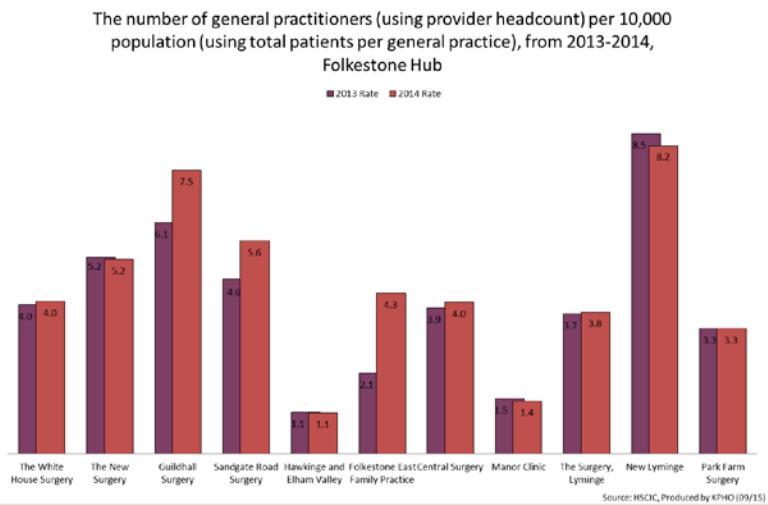
GP Survey

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

The percentage of ratings of 'very good' and 'fairly good' remain consistently higher than the other responses to the 'overall experience of GP surgery'.

Figure 5

Overall Response 2012	The White House Surgery	The New Surgery	Guildhall Surgery	Sandgate Road Surgery	Hawkinge and Elham Valley	Folkestone East Family Practice	Central Surgery	Manor Clinic	The Surgery (Lyminge)	New Lyminge	Park Farm Surgery
Overall experience of GP surgery	Percentage of answers (%)										
Very good	37	34	35	50	51	48	77	43	60	64	30
Fairly good	53	49	45	43	34	41	18	43	33	32	50
Neither good nor poor	6	10	14	5	11	11	3	12	7	4	15
Fairly poor	5	8	6	2	4	1	1	1	0	1	4
Very poor	0	0	0	0	0	0	1	1	0	0	1

Source: GP Patient Survey, January-September 2012

Overall Response 2013	The White House Surgery	The New Surgery	Guildhall Surgery	Sandgate Road Surgery	Hawkinge and Elham Valley	Folkestone East Family Practice	Central Surgery	Manor Clinic	The Surgery (Lyminge)	New Lyminge	Park Farm Surgery
Overall experience of GP surgery	Percentage of answers (%)										
Very good	38	32	40	47	44	50	80	35	55	57	38
Fairly good	51	50	40	45	37	30	15	52	36	35	46
Neither good nor poor	6	15	8	5	14	17	4	10	8	6	11
Fairly poor	5	3	11	2	3	3	0	2	0	2	4
Very poor	0	0	2	1	1	0	2	1	1	0	1

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

Overall Response 2014	The White House Surgery	The New Surgery	Guildhall Surgery	Sandgate Road Surgery	Hawkinge and Elham Valley	Folkestone East Family Practice	Central Surgery	Manor Clinic	The Surgery (Lyminge)	New Lyminge	Park Farm Surgery
Overall experience of GP surgery	Percentage of answers (%)										
Very good	38	32	30	45	48	47	81	31	67	68	43
Fairly good	51	41	53	51	44	36	14	42	30	24	39
Neither good nor poor	7	23	6	3	6	15	3	16	2	6	12
Fairly poor	4	2	10	*	1	2	0	11	1	2	5
Very poor	0	2	1	0	0	0	2	1	0	0	2

Source: Practice Report (GP Patient Survey), July-September 2013 and January-March 2014

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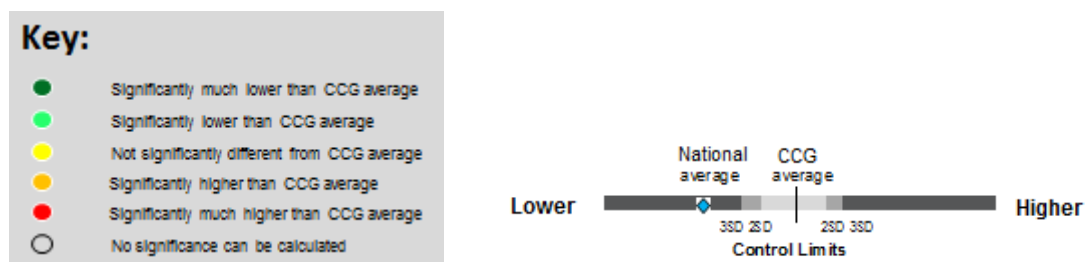
Trend analysis has been carried out to explore the general practice rate of change for long term condition recorded prevalence between 2006/07 to 2013/14. This has been compared with the National rate of change, as the most reliable estimate.

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.

G82069 - The White House Surgery

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

Figure 6:

Indicator	Practice		CCG			
	Number	Prevalence	Average	Low	Range	High
Asthma (%)	530	5.3	5.7	4.1		10.3
Atrial fibrillation (%)	163	1.6	2.2	1.2		3.6
Cancer (%)	162	1.6	2.5	0.8		4.0
Chronic Kidney Disease (%)	392	4.9	5.5	3.8		8.2
Chronic Obstructive Pulmonary Disease	140	1.4	2.3	1.1		4.3
Coronary Heart Disease (%)	318	3.2	3.8	2.7		5.7
Dementia (%)	24	0.2	0.6	0.1		1.0
Diabetes (%)	531	6.6	7.0	5.7		9.3
Epilepsy (%)	92	1.2	1.0	0.3		1.5
Heart Failure (%)	64	0.6	0.7	0.3		1.1
Hypertension (%)	1466	14.7	16.2	12.0		20.5
Hypothyroidism (%)	238	2.4	3.4	2.0		5.2
Learning Disabilities (%)	33	0.4	0.8	0.2		2.4
Mental Health (%)	32	0.3	0.7	0.3		1.5
Obesity (%)	696	8.5	10.4	3.8		20.2
Palliative Care (%)	12	0.1	0.2	0.0		0.4
Stroke (%)	171	1.7	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 7:

Rate of change in long term condition recorded prevalence: practice G82069, 2006/07 to 2013/14

* significance in comparison to national rate of change

Source: QOF

G82086 - The New Surgery

In 2013/14, the general practice recorded prevalence was not significantly higher than the CCG for any of the long term conditions.
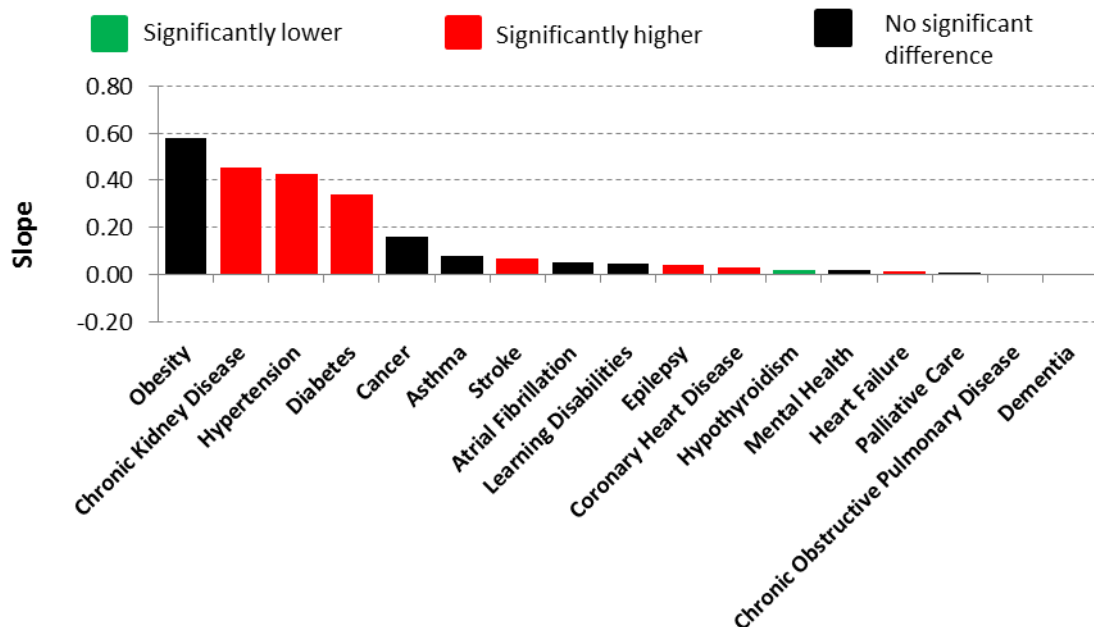
Figure 8:

Indicator	Practice		CCG			
	Number	Prevalence	Average	Low	Range	High
Asthma (%)	579	6.0	5.7	4.1		10.3
Atrial fibrillation (%)	154	1.6	2.2	1.2		3.6
Cancer (%)	188	1.9	2.5	0.8		4.0
Chronic Kidney Disease (%)	282	3.8	5.5	3.8		8.2
Chronic Obstructive Pulmonary Disease	252	2.6	2.3	1.1		4.3
Coronary Heart Disease (%)	297	3.1	3.8	2.7		5.7
Dementia (%)	47	0.5	0.6	0.1		1.0
Diabetes (%)	496	6.6	7.0	5.7		9.3
Epilepsy (%)	84	1.1	1.0	0.3		1.5
Heart Failure (%)	35	0.4	0.7	0.3		1.1
Hypertension (%)	1159	12.0	16.2	12.0		20.5
Hypothyroidism (%)	242	2.5	3.4	2.0		5.2
Learning Disabilities (%)	35	0.5	0.8	0.2		2.4
Mental Health (%)	81	0.8	0.7	0.3		1.5
Obesity (%)	824	10.8	10.4	3.8		20.2
Palliative Care (%)	7	0.1	0.2	0.0		0.4
Stroke (%)	133	1.4	2.0	1.2		3.3

Diabetes recorded prevalence has increased by 0.37% per year between 2006/07 and 2013/14. This was a significantly higher increase in comparison to the national trend.

Figure 9:

Rate of change in long term condition recorded prevalence: practice G82086, 2006/07 to 2013/14

* significance in comparison to national rate of change
Source: QOF

14

G82091 - Guildhall Surgery
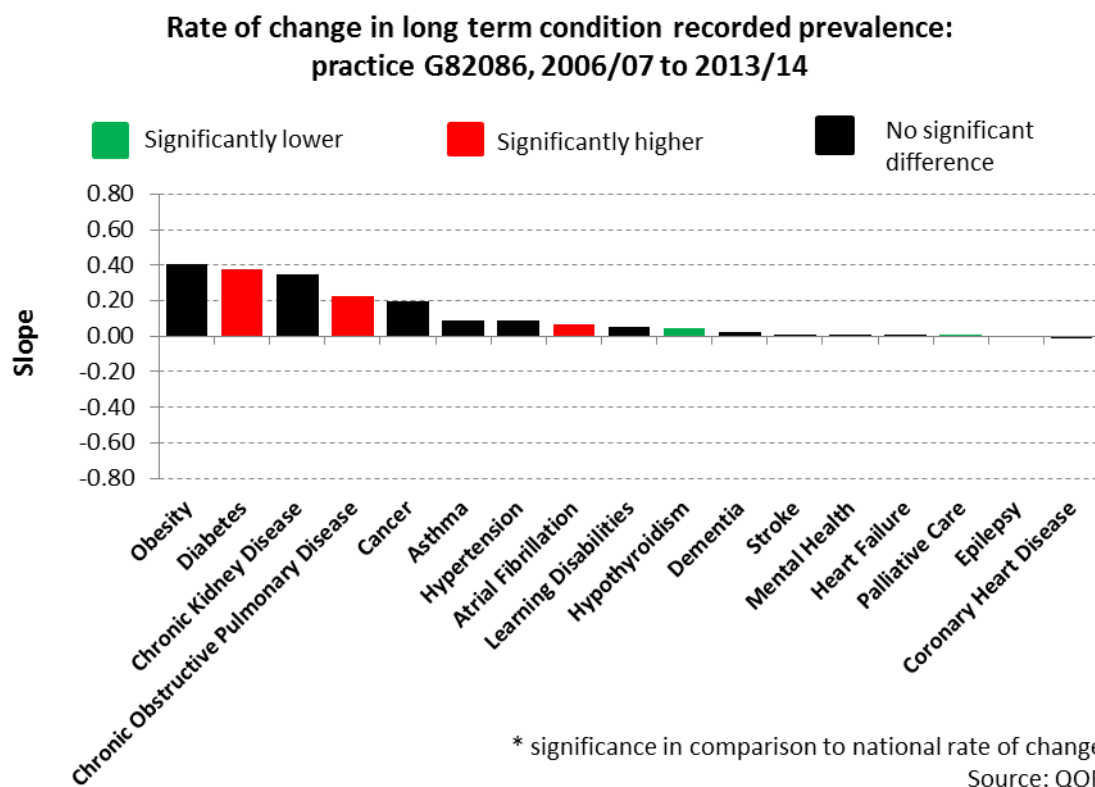
In 2013/14, the general practice recorded prevalence was significantly higher than the CCG for the long term conditions; mental health and obesity.

Figure 10:

Indicator	Practice		CCG			
	Number	Prevalence	Average	Low	Range	High
Asthma (%)	407	5.0	5.7	4.1		10.3
Atrial fibrillation (%)	99	1.2	2.2	1.2		3.6
Cancer (%)	147	1.8	2.5	0.8		4.0
Chronic Kidney Disease (%)	253	4.1	5.5	3.8		8.2
Chronic Obstructive Pulmonary Disease	137	1.7	2.3	1.1		4.3
Coronary Heart Disease (%)	231	2.8	3.8	2.7		5.7
Dementia (%)	20	0.2	0.6	0.1		1.0
Diabetes (%)	456	7.3	7.0	5.7		9.3
Epilepsy (%)	56	0.9	1.0	0.3		1.5
Heart Failure (%)	28	0.3	0.7	0.3		1.1
Hypertension (%)	1031	12.7	16.2	12.0		20.5
Hypothyroidism (%)	191	2.4	3.4	2.0		5.2
Learning Disabilities (%)	18	0.3	0.8	0.2		2.4
Mental Health (%)	122	1.5	0.7	0.3		1.5
Obesity (%)	838	13.2	10.4	3.8		20.2
Palliative Care (%)	7	0.1	0.2	0.0		0.4
Stroke (%)	142	1.8	2.0	1.2		3.3

Stroke recorded prevalence has increased by 0.06% per year between 2006/07 and 2013/14. This was a significantly higher increase in comparison to the national trend.

Figure 11:

Rate of change in long term condition recorded prevalence: practice G82091, 2006/07 to 2013/14

* significance in comparison to national rate of change
Source: QOF

15
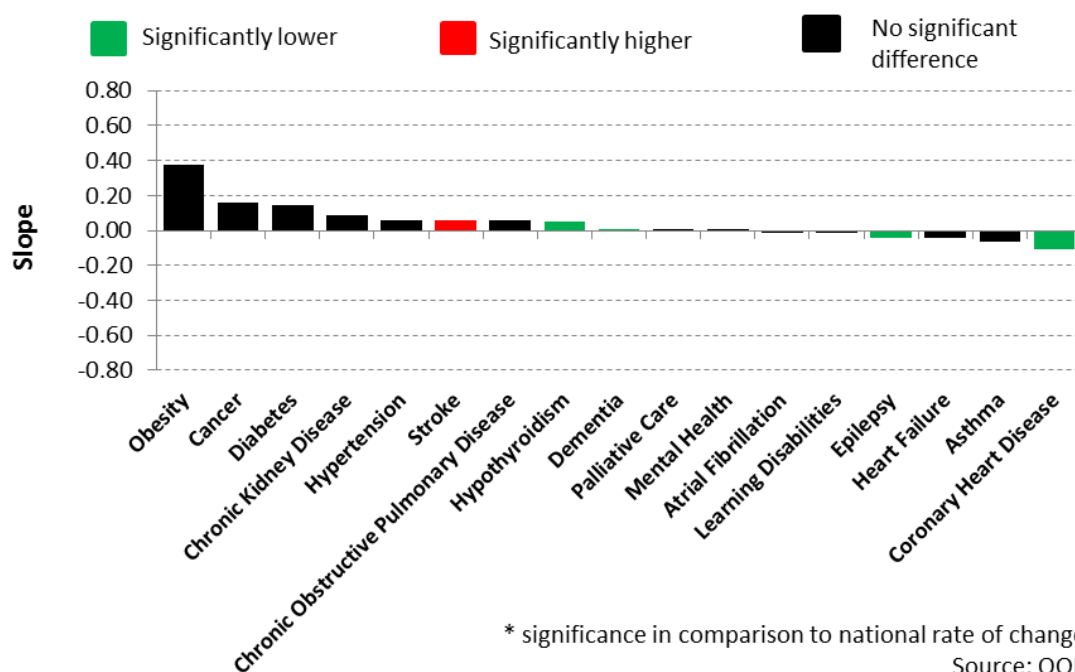
G82121 - Sandgate Road Surgery

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

Figure 12:

| Indicator | Practice | | CCG | | | |
	Number	Prevalence	Average	Low	Range	High
Asthma (%)	732	6.8	5.7	4.1		10.3
Atrial fibrillation (%)	297	2.8	2.2	1.2		3.6
Cancer (%)	313	2.9	2.5	0.8		4.0
Chronic Kidney Disease (%)	377	4.2	5.5	3.8		8.2
Chronic Obstructive Pulmonary Disease	206	1.9	2.3	1.1		4.3
Coronary Heart Disease (%)	377	3.5	3.8	2.7		5.7
Dementia (%)	88	0.8	0.6	0.1		1.0
Diabetes (%)	525	5.8	7.0	5.7		9.3
Epilepsy (%)	87	1.0	1.0	0.3		1.5
Heart Failure (%)	63	0.6	0.7	0.3		1.1
Hypertension (%)	1715	16.0	16.2	12.0		20.5
Hypothyroidism (%)	351	3.3	3.4	2.0		5.2
Learning Disabilities (%)	70	0.8	0.8	0.2		2.4
Mental Health (%)	124	1.2	0.7	0.3		1.5
Obesity (%)	540	5.9	10.4	3.8		20.2
Palliative Care (%)	18	0.2	0.2	0.0		0.4
Stroke (%)	239	2.2	2.0	1.2		3.3

Cancer recorded prevalence has increased by 0.23% per year between 2006/07 and 2013/14. This was a significantly higher increase in comparison to the national trend.

Figure 13:

Rate of change in long term condition recorded prevalence: practice G82121, 2006/07 to 2013/14

* significance in comparison to national rate of change
Source: QOF

16
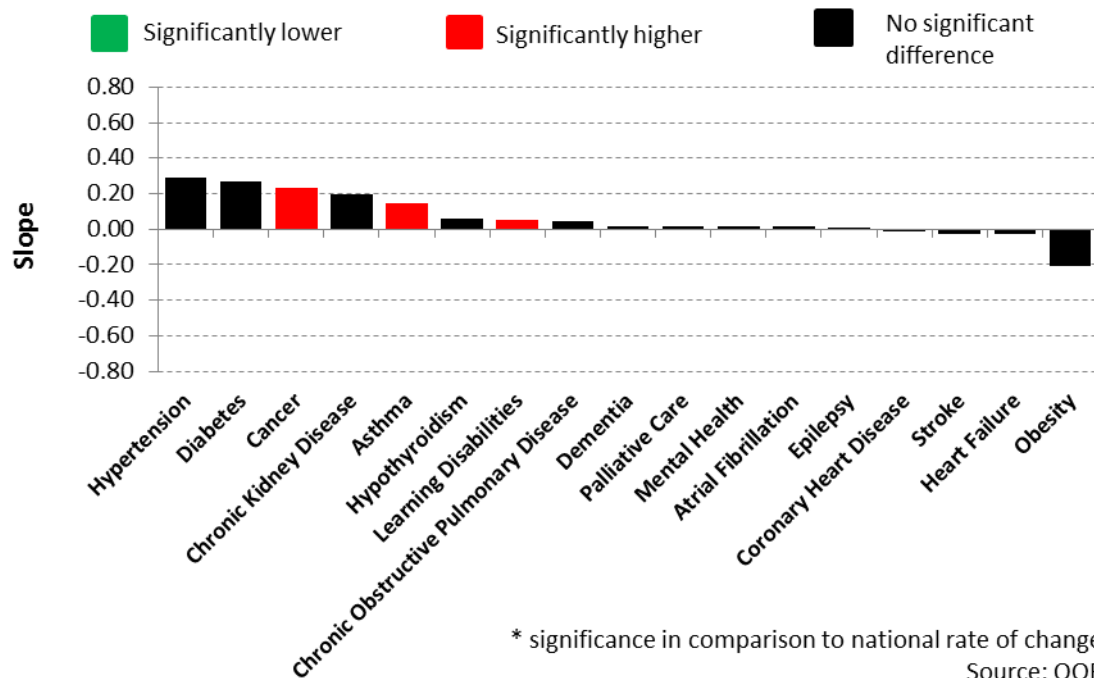
G82165 - Hawkinge and Elham Valley

In 2013/14, the general practice recorded prevalence was significantly higher than the CCG for none of the long term conditions.

Figure 14:

Indicator	Practice		CCG			
	Number	Prevalence	Average	Low	Range	High
Asthma (%)	507	5.5	5.7	4.1		10.3
Atrial fibrillation (%)	167	1.8	2.2	1.2		3.6
Cancer (%)	225	2.4	2.5	0.8		4.0
Chronic Kidney Disease (%)	417	5.9	5.5	3.8		8.2
Chronic Obstructive Pulmonary Disease	144	1.6	2.3	1.1		4.3
Coronary Heart Disease (%)	270	2.9	3.8	2.7		5.7
Dementia (%)	70	0.8	0.6	0.1		1.0
Diabetes (%)	454	6.3	7.0	5.7		9.3
Epilepsy (%)	63	0.9	1.0	0.3		1.5
Heart Failure (%)	62	0.7	0.7	0.3		1.1
Hypertension (%)	1484	16.2	16.2	12.0		20.5
Hypothyroidism (%)	292	3.2	3.4	2.0		5.2
Learning Disabilities (%)	53	0.7	0.8	0.2		2.4
Mental Health (%)	65	0.7	0.7	0.3		1.5
Obesity (%)	772	10.5	10.4	3.8		20.2
Palliative Care (%)	7	0.1	0.2	0.0		0.4
Stroke (%)	164	1.8	2.0	1.2		3.3

Chronic kidney disease recorded prevalence has increased by 0.49% per year between 2006/07 and 2013/14. This was a significantly higher increase in comparison to the national trend.

Figure 15:

Rate of change in long term condition recorded prevalence: practice G82165, 2006/07 to 2013/14

* significance in comparison to national rate of change
Source: QOF

17

G82187 - Folkestone East Family Practice

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

Figure 16:

| Indicator | Practice | | CCG | | | |
	Number	Prevalence	Average	Low	Range	High
Asthma (%)	298	6.3	5.7	4.1		10.3
Atrial fibrillation (%)	108	2.3	2.2	1.2		3.6
Cancer (%)	116	2.5	2.5	0.8		4.0
Chronic Kidney Disease (%)	215	5.9	5.5	3.8		8.2
Chronic Obstructive Pulmonary Disease	136	2.9	2.3	1.1		4.3
Coronary Heart Disease (%)	176	3.7	3.8	2.7		5.7
Dementia (%)	23	0.5	0.6	0.1		1.0
Diabetes (%)	270	7.2	7.0	5.7		9.3
Epilepsy (%)	46	1.3	1.0	0.3		1.5
Heart Failure (%)	27	0.6	0.7	0.3		1.1
Hypertension (%)	752	15.9	16.2	12.0		20.5
Hypothyroidism (%)	146	3.1	3.4	2.0		5.2
Learning Disabilities (%)	29	0.8	0.8	0.2		2.4
Mental Health (%)	53	1.1	0.7	0.3		1.5
Obesity (%)	324	8.5	10.4	3.8		20.2
Palliative Care (%)	14	0.3	0.2	0.0		0.4
Stroke (%)	76	1.6	2.0	1.2		3.3

Chronic obstructive pulmonary disease recorded prevalence has increased by 0.21% per year between 2006/07 and 2013/14. This was a significantly higher increase in comparison to the national trend.

Figure 17:

Rate of change in long term condition recorded prevalence: practice G82187, 2006/07 to 2013/14

* significance in comparison to national rate of change
Source: QOF

G82217 - Central Surgery

In 2013/14, the general practice recorded prevalence was significantly higher than the CCG for none of the long term conditions.

Figure 18:
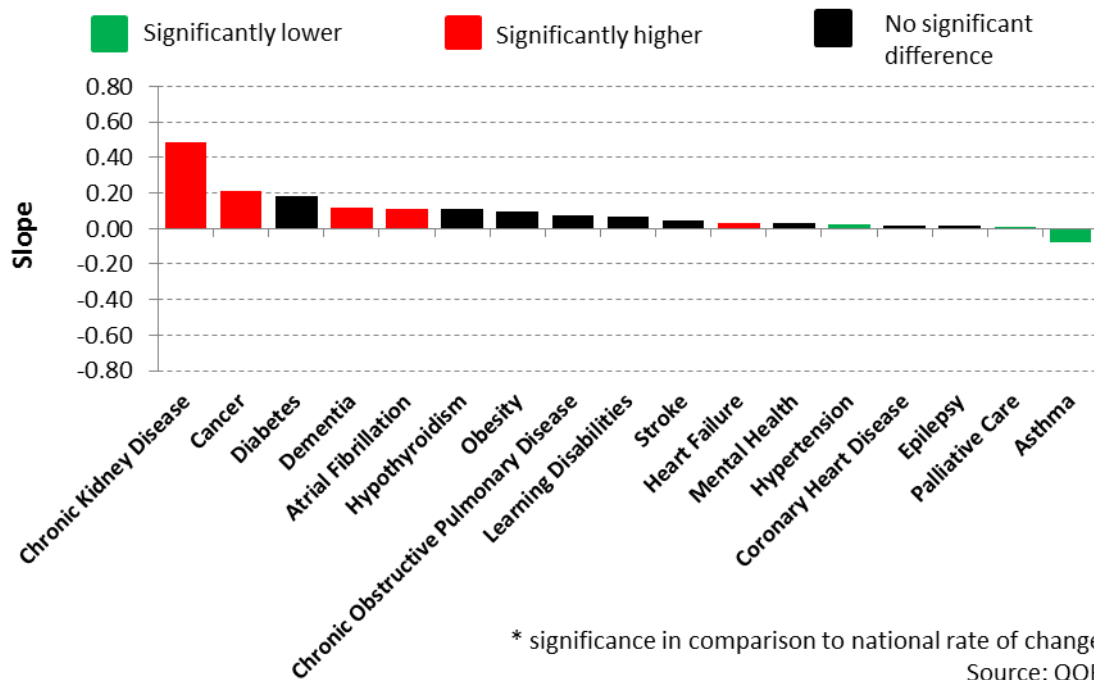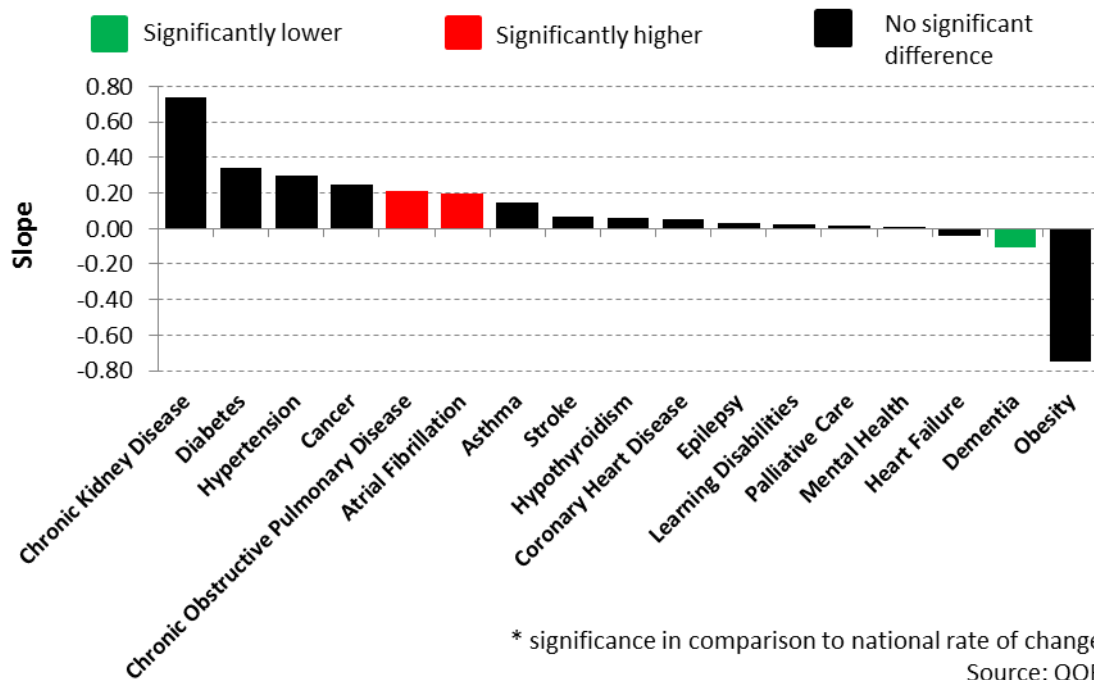
Indicator	Practice		CCG			
	Number	Prevalence	Average	Low	Range	High
Asthma (%)	106	4.2	5.7	4.1		10.3
Atrial fibrillation (%)	32	1.3	2.2	1.2		3.6
Cancer (%)	20	0.8	2.5	0.8		4.0
Chronic Kidney Disease (%)	92	4.4	5.5	3.8		8.2
Chronic Obstructive Pulmonary Disease	28	1.1	2.3	1.1		4.3
Coronary Heart Disease (%)	76	3.0	3.8	2.7		5.7
Diabetes (%)	142	6.8	7.0	5.7		9.3
Epilepsy (%)	19	0.9	1.0	0.3		1.5
Heart Failure (%)	18	0.7	0.7	0.3		1.1
Hypertension (%)	344	13.6	16.2	12.0		20.5
Hypothyroidism (%)	76	3.0	3.4	2.0		5.2
Mental Health (%)	7	0.3	0.7	0.3		1.5
Obesity (%)	80	3.8	10.4	3.8		20.2
Stroke (%)	30	1.2	2.0	1.2		3.3

Chronic kidney disease recorded prevalence has increased by 0.48% per year between 2006/07 and 2013/14. This was a significantly higher increase in comparison to the national trend.

Figure 19:

Rate of change in long term condition recorded prevalence: practice G82217, 2006/07 to 2013/14

* significance in comparison to national rate of change
Source: QOF

19
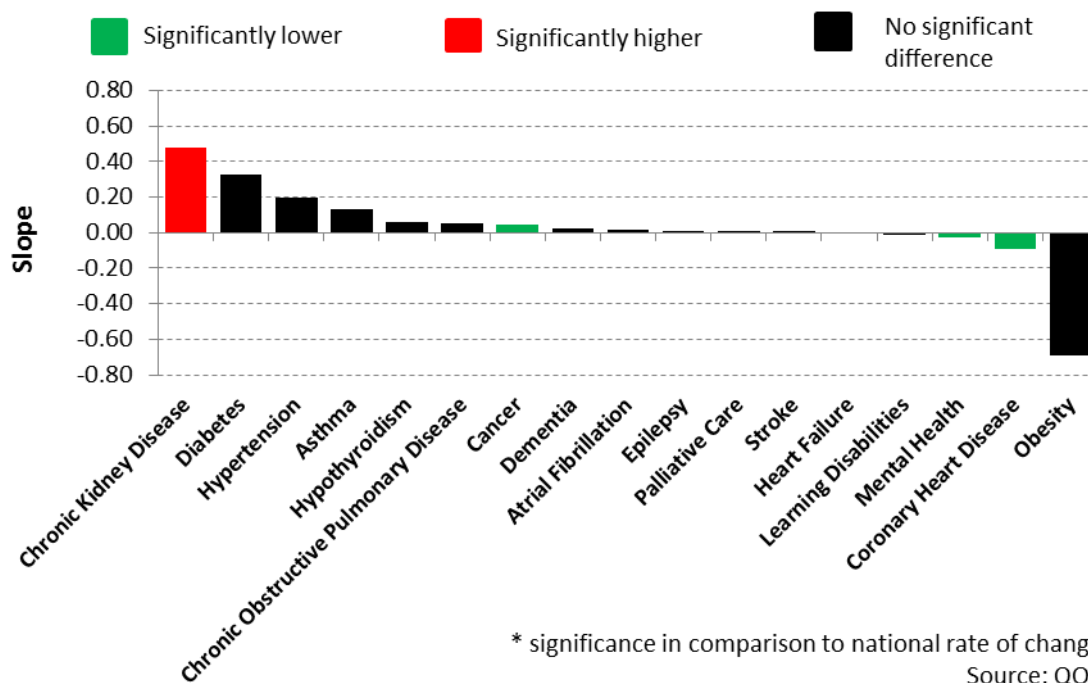
G82232 - Manor Clinic

In 2013/14, the general practice recorded prevalence was significantly higher than the CCG for learning disabilities and mental health.

Figure 20:
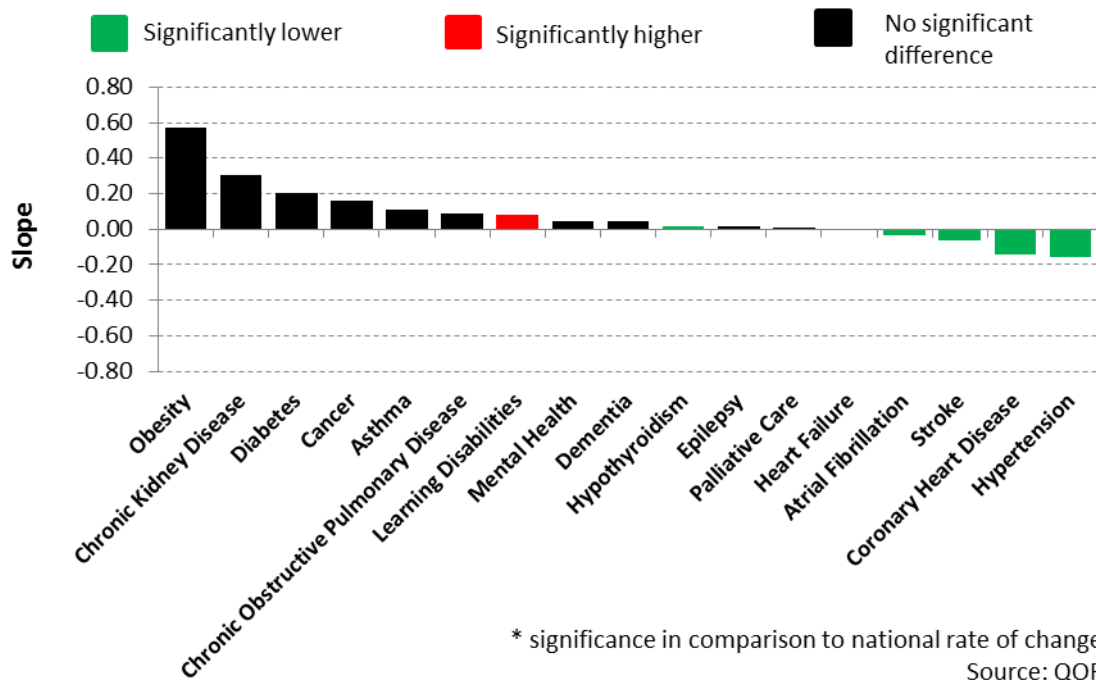
Indicator	Practice		CCG			
	Number	Prevalence	Average	Low	Range	High
Asthma (%)	404	5.7	5.7	4.1		10.3
Atrial fibrillation (%)	108	1.5	2.2	1.2		3.6
Cancer (%)	130	1.8	2.5	0.8		4.0
Chronic Kidney Disease (%)	304	5.4	5.5	3.8		8.2
Chronic Obstructive Pulmonary Disease	121	1.7	2.3	1.1		4.3
Coronary Heart Disease (%)	196	2.8	3.8	2.7		5.7
Dementia (%)	38	0.5	0.6	0.1		1.0
Diabetes (%)	354	6.2	7.0	5.7		9.3
Epilepsy (%)	52	0.9	1.0	0.3		1.5
Heart Failure (%)	29	0.4	0.7	0.3		1.1
Hypertension (%)	935	13.3	16.2	12.0		20.5
Hypothyroidism (%)	185	2.6	3.4	2.0		5.2
Learning Disabilities (%)	81	1.4	0.8	0.2		2.4
Mental Health (%)	79	1.1	0.7	0.3		1.5
Obesity (%)	454	7.8	10.4	3.8		20.2
Palliative Care (%)	11	0.2	0.2	0.0		0.4
Stroke (%)	104	1.5	2.0	1.2		3.3

Learning disabilities recorded prevalence has increased by 0.08% per year between 2006/07 and 2013/14. This was a significantly higher increase in comparison to the national trend.

Figure 21:

Rate of change in long term condition recorded prevalence: practice G82232, 2006/07 to 2013/14

* significance in comparison to national rate of change
Source: QOF

20

G82652 - The Surgery, Lyminge

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, coronary heart disease, hypertension, obesity and stroke.
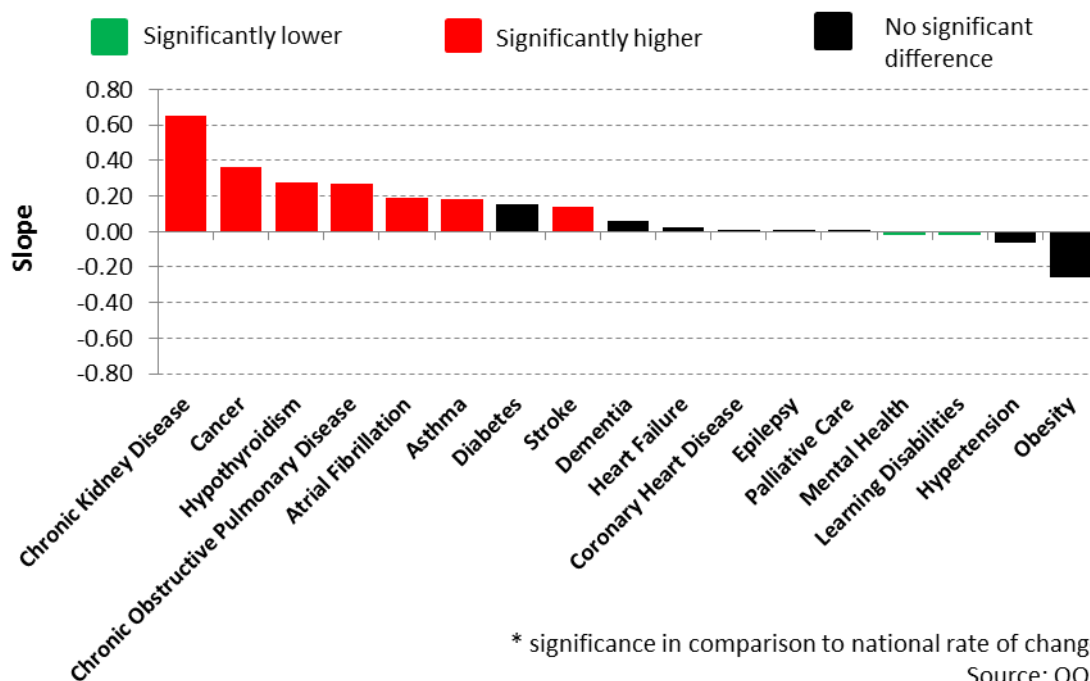
Figure 22:

	Practice		CCG			
Indicator	Number	Prevalence	Average	Low	Range	High
Asthma (%)	164	6.1	5.7	4.1		10.3
Atrial fibrillation (%)	98	3.6	2.2	1.2		3.6
Cancer (%)	95	3.5	2.5	0.8		4.0
Chronic Kidney Disease (%)	178	7.8	5.5	3.8		8.2
Chronic Obstructive Pulmonary Disease	80	3.0	2.3	1.1		4.3
Coronary Heart Disease (%)	129	4.8	3.8	2.7		5.7
Dementia (%)	18	0.7	0.6	0.1		1.0
Diabetes (%)	152	6.6	7.0	5.7		9.3
Epilepsy (%)	7	0.3	1.0	0.3		1.5
Heart Failure (%)	27	1.0	0.7	0.3		1.1
Hypertension (%)	518	19.1	16.2	12.0		20.5
Hypothyroidism (%)	105	3.9	3.4	2.0		5.2
Mental Health (%)	12	0.4	0.7	0.3		1.5
Obesity (%)	315	13.6	10.4	3.8		20.2
Stroke (%)	78	2.9	2.0	1.2		3.3

Chronic kidney disease recorded prevalence has increased by 0.65% per year between 2006/07 and 2013/14. This was a significantly higher increase in comparison to the national trend.

Figure 23:

Rate of change in long term condition recorded prevalence: practice G82652, 2006/07 to 2013/14

* significance in comparison to national rate of change
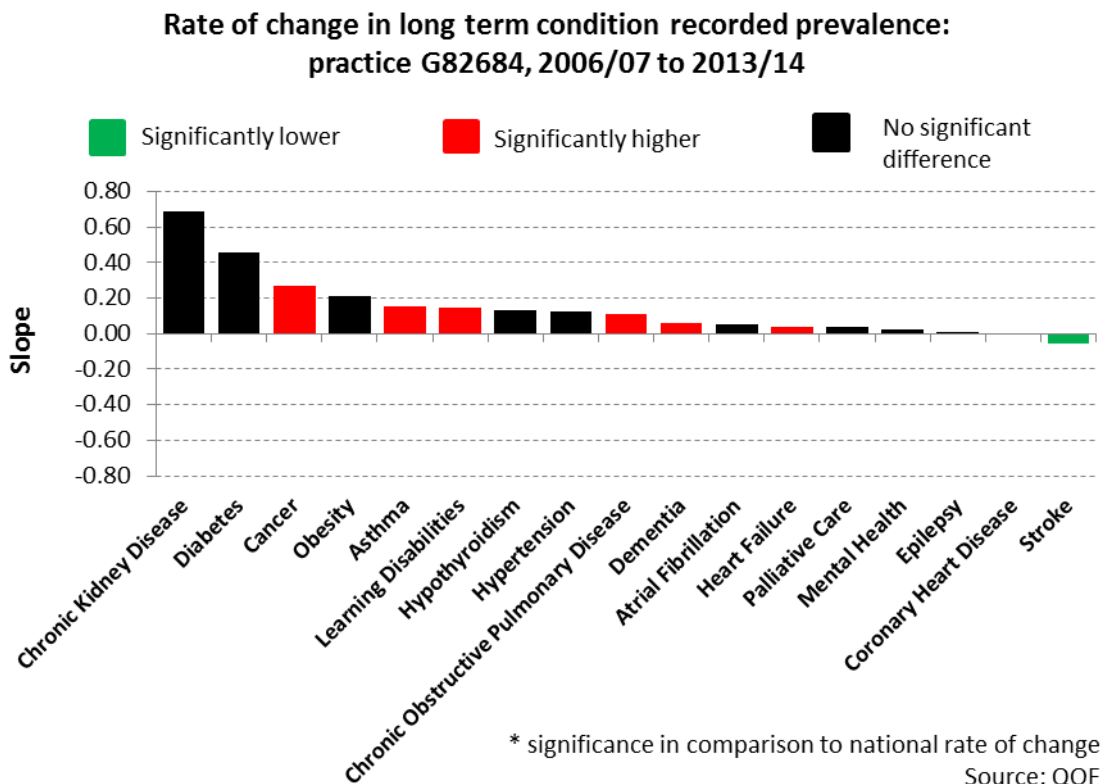Source: QOF

21

G82684 - New Lyminge

In 2013/14, the general practice recorded prevalence was significantly higher than the CCG for learning disabilities and mental health.

Figure 24:

Indicator	Practice		CCG			
	Number	Prevalence	Average	Low	Range	High
Asthma (%)	198	5.6	5.7	4.1		10.3
Atrial fibrillation (%)	68	1.9	2.2	1.2		3.6
Cancer (%)	88	2.5	2.5	0.8		4.0
Chronic Kidney Disease (%)	160	5.4	5.5	3.8		8.2
Chronic Obstructive Pulmonary Disease	48	1.3	2.3	1.1		4.3
Coronary Heart Disease (%)	113	3.2	3.8	2.7		5.7
Dementia (%)	18	0.5	0.6	0.1		1.0
Diabetes (%)	170	5.7	7.0	5.7		9.3
Epilepsy (%)	26	0.9	1.0	0.3		1.5
Heart Failure (%)	27	0.8	0.7	0.3		1.1
Hypertension (%)	614	17.2	16.2	12.0		20.5
Hypothyroidism (%)	128	3.6	3.4	2.0		5.2
Learning Disabilities (%)	72	2.4	0.8	0.2		2.4
Mental Health (%)	40	1.1	0.7	0.3		1.5
Obesity (%)	185	6.1	10.4	3.8		20.2
Palliative Care (%)	11	0.3	0.2	0.0		0.4
Stroke (%)	57	1.6	2.0	1.2		3.3

Cancer recorded prevalence has increased by 0.27% per year between 2006/07 and 2013/14. This was a significantly higher increase in comparison to the national trend.

Figure 25:

Rate of change in long term condition recorded prevalence: practice G82684, 2006/07 to 2013/14

* significance in comparison to national rate of change
Source: QOF

G82760 - Park Farm Surgery

In 2013/14, the general practice recorded prevalence was significantly higher than the CCG for none of the long term conditions.
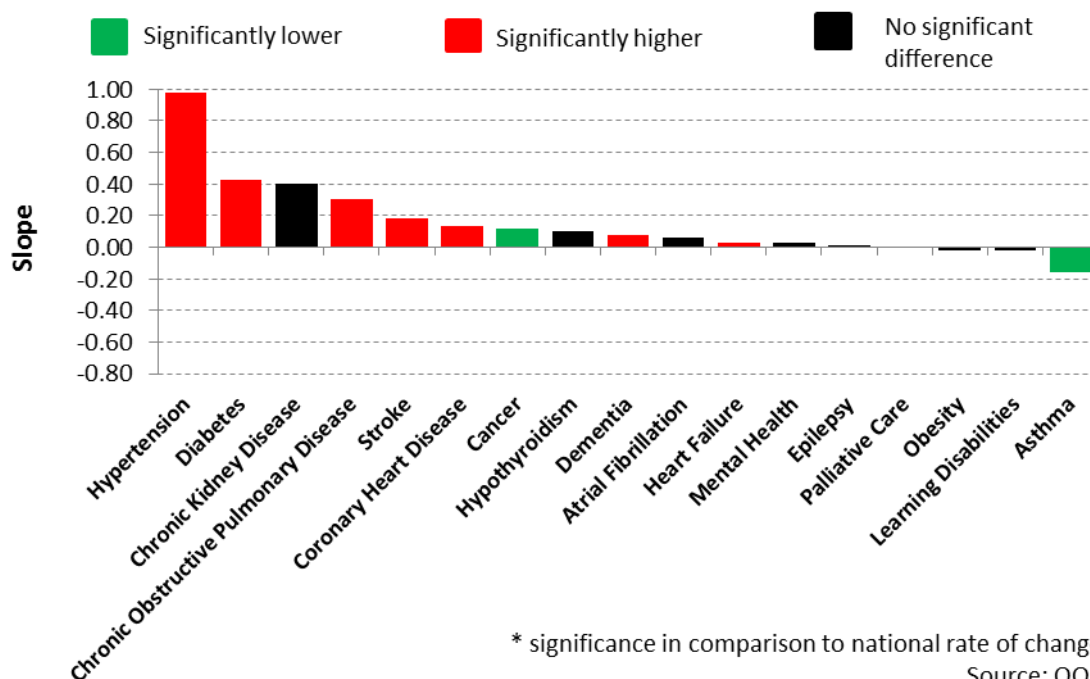
Figure 26:

Indicator	Practice		CCG			
	Number	Prevalence	Average	Low	Range	High
Asthma (%)	170	5.6	5.7	4.1		10.3
Atrial fibrillation (%)	40	1.3	2.2	1.2		3.6
Cancer (%)	44	1.5	2.5	0.8		4.0
Chronic Kidney Disease (%)	98	4.4	5.5	3.8		8.2
Chronic Obstructive Pulmonary Disease	77	2.6	2.3	1.1		4.3
Coronary Heart Disease (%)	85	2.8	3.8	2.7		5.7
Dementia (%)	20	0.7	0.6	0.1		1.0
Diabetes (%)	153	6.7	7.0	5.7		9.3
Epilepsy (%)	23	1.0	1.0	0.3		1.5
Heart Failure (%)	28	0.9	0.7	0.3		1.1
Hypertension (%)	455	15.1	16.2	12.0		20.5
Hypothyroidism (%)	89	3.0	3.4	2.0		5.2
Learning Disabilities (%)	26	1.2	0.8	0.2		2.4
Mental Health (%)	32	1.1	0.7	0.3		1.5
Obesity (%)	189	8.1	10.4	3.8		20.2
Stroke (%)	52	1.7	2.0	1.2		3.3

Hypertension recorded prevalence has increased by 0.98% per year between 2006/07 and 2013/14. This was a significantly higher increase in comparison to the national trend.

Figure 27:

Rate of change in long term condition recorded prevalence: practice G82760, 2006/07 to 2013/14

* significance in comparison to national rate of change
Source: QOF
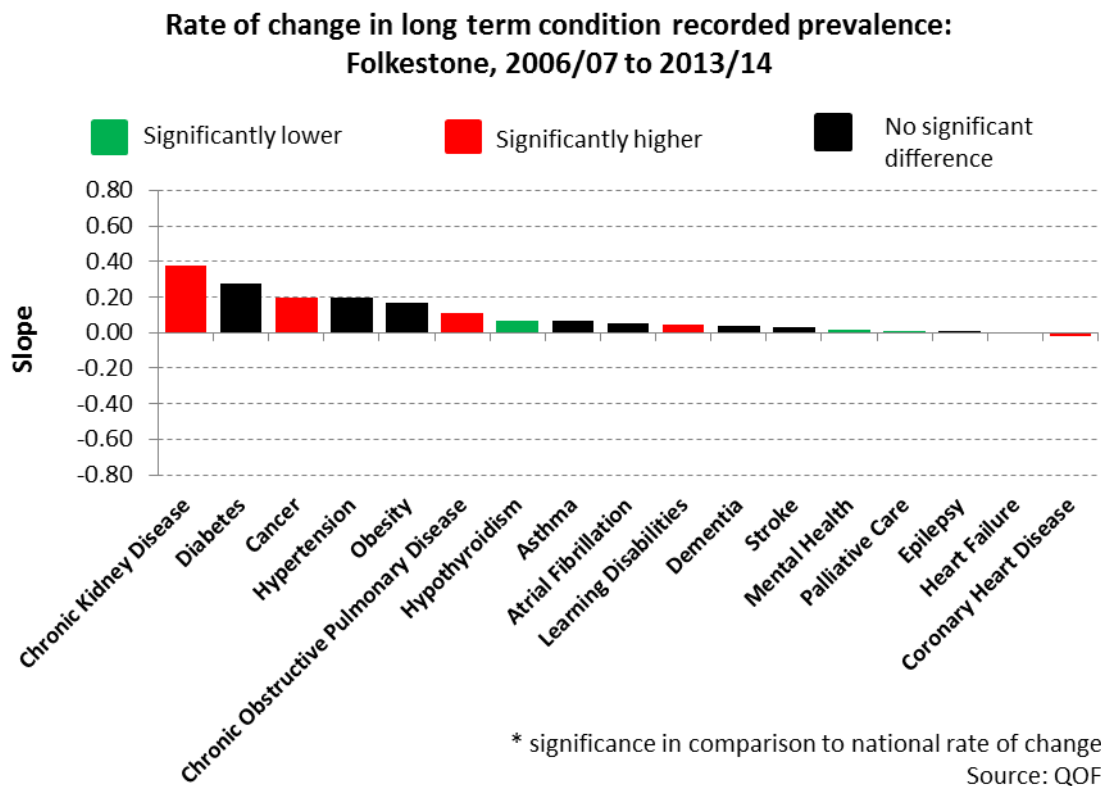
23

Folkestone Locality

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

Figure 28:

Indicator	Practice		CCG			
	Number	Prevalence	Average	Low	Range	High
Asthma (%)	4095	5.7	5.7	4.1		10.3
Atrial fibrillation (%)	1334	1.9	2.2	1.2		3.6
Cancer (%)	1528	2.1	2.5	0.8		4.0
Chronic Kidney Disease (%)	2768	4.9	5.5	3.8		8.2
Chronic Obstructive Pulmonary Disease	1369	1.9	2.3	1.1		4.3
Coronary Heart Disease (%)	2268	3.2	3.8	2.7		5.7
Dementia (%)	372	0.5	0.6	0.1		1.0
Diabetes (%)	3703	6.5	7.0	5.7		9.3
Epilepsy (%)	555	1.0	1.0	0.3		1.5
Heart Failure (%)	408	0.6	0.7	0.3		1.1
Hypertension (%)	10473	14.7	16.2	12.0		20.5
Hypothyroidism (%)	2043	2.9	3.4	2.0		5.2
Learning Disabilities (%)	428	0.8	0.8	0.2		2.4
Mental Health (%)	647	0.9	0.7	0.3		1.5
Obesity (%)	5217	9.0	10.4	3.8		20.2
Palliative Care (%)	98	0.1	0.2	0.0		0.4
Stroke (%)	1246	1.7	2.0	1.2		3.3

Chronic kidney disease recorded prevalence has increased by 0.37% per year between 2006/07 and 2013/14. This was a significantly higher increase in comparison to the national trend.

Figure 29: Dover

Rate of change in long term condition recorded prevalence: Folkestone, 2006/07 to 2013/14

* significance in comparison to national rate of change
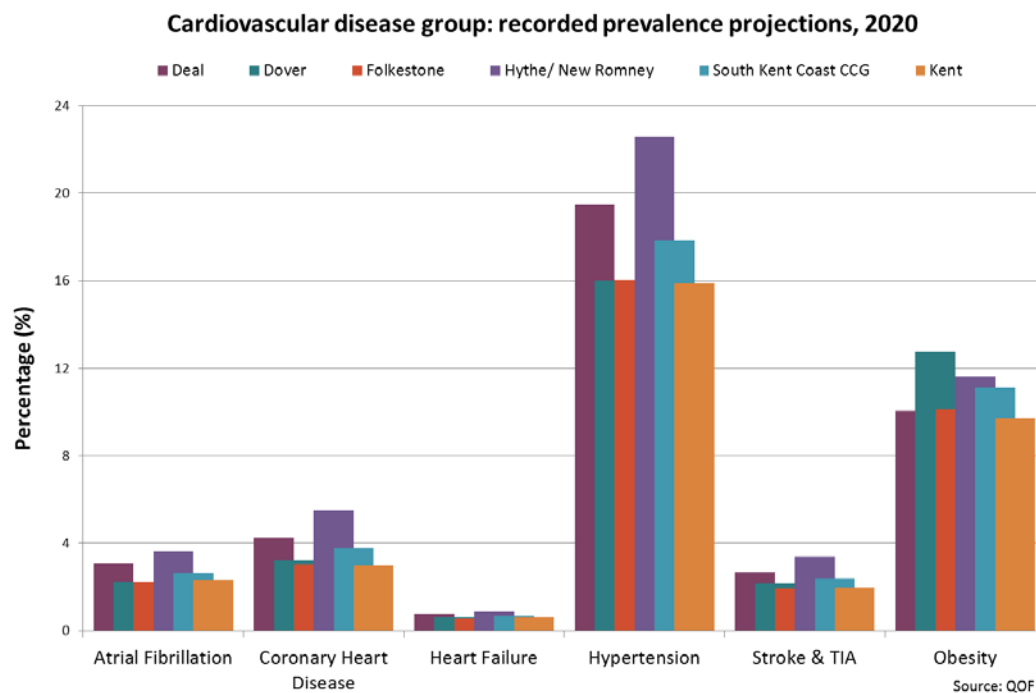Source: QOF

Cardiovascular disease

The Folkestone locality recorded prevalence has been projected to increase:

- Atrial fibrillation has been projected to increase to 2.24% in 2020: representing a 19.49% increase from 2013/14.

- Coronary heart disease has been projected to increase to 3.04% in 2020; representing a 4.42% decrease from 2013/14.

- Heart failure has been projected to increase to 0.56% in 2020; representing a 2.90% decrease from 2013/14.

- Hypertension has been projected to increase to 16.05% in 2020; this represents a 9.22% increase from 2013/14.

- Stroke & TIA has been projected to increase to 1.94% in 2020; this represents a 10.85% increase from 2013/14.

- Obesity has been projected to increase to 10.12% in 2020; this represents a 12.78% increase from 2013/14.

Figure 30

Cardiovascular disease group: recorded prevalence projections, 2020

Source: QOF

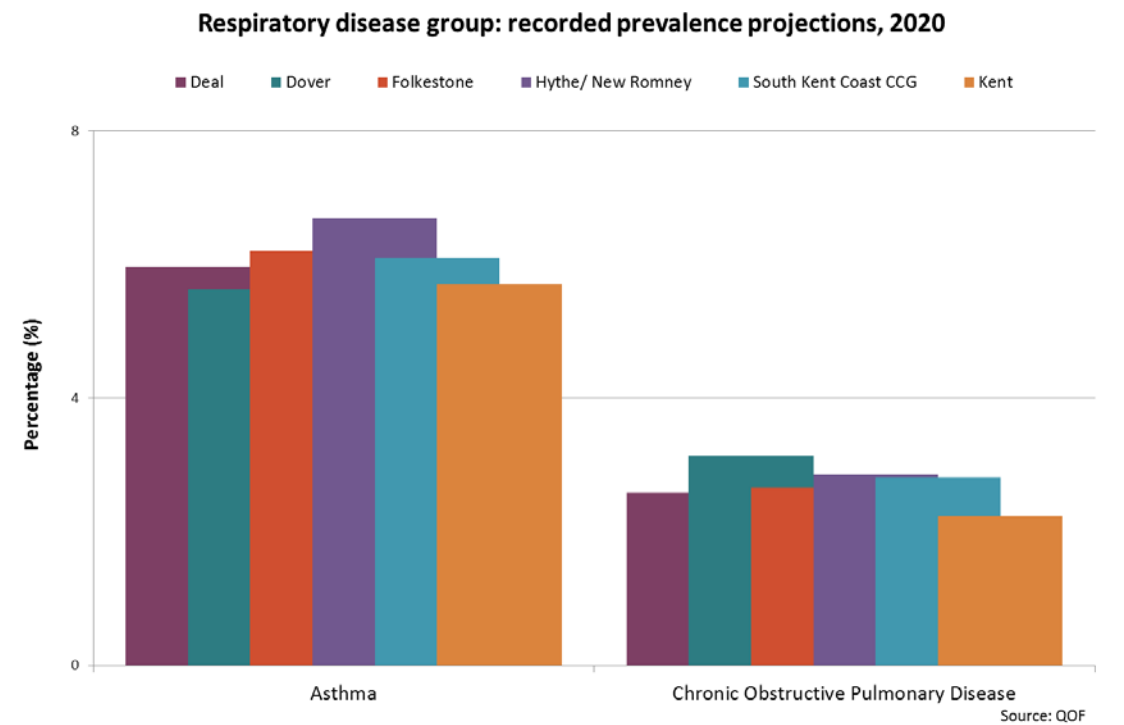**Respiratory disease**

The Folkestone locality recorded prevalence has been projected to increase:

- Asthma has been projected to increase to 6.20% in 2020; this represents a 7.97% increase from 2013/14.

- COPD has been projected to increase to 2.67% in 2020; this represents a 38.8% increase from 2013/14.

Figure 31

Respiratory disease group: recorded prevalence projections, 2020

Source: QOF

High Dependency

The Folkestone locality recorded prevalence has been projected to increase:

- Cancer has been projected to increase to 3.51% in 2020; this represents a 63.53% increase from 2013/14.

- Chronic kidney disease has been projected to increase to 7.54% in 2020; this represents a 53.37% increase from 2013/14.

- Diabetes has been projected to increase to 8.41% in 2020; this represents a 29.96% increase from 2013/14.

- Hypothyroidism has been projected to increase to 3.34% in 2020; this represents a 16.63% increase from 2013/14.

- Palliative care has been projected to increase to 0.20% in 2020; this represents a 43.82% increase from 2013/14.

Figure 32

High dependency group: recorded prevalence projections, 2020
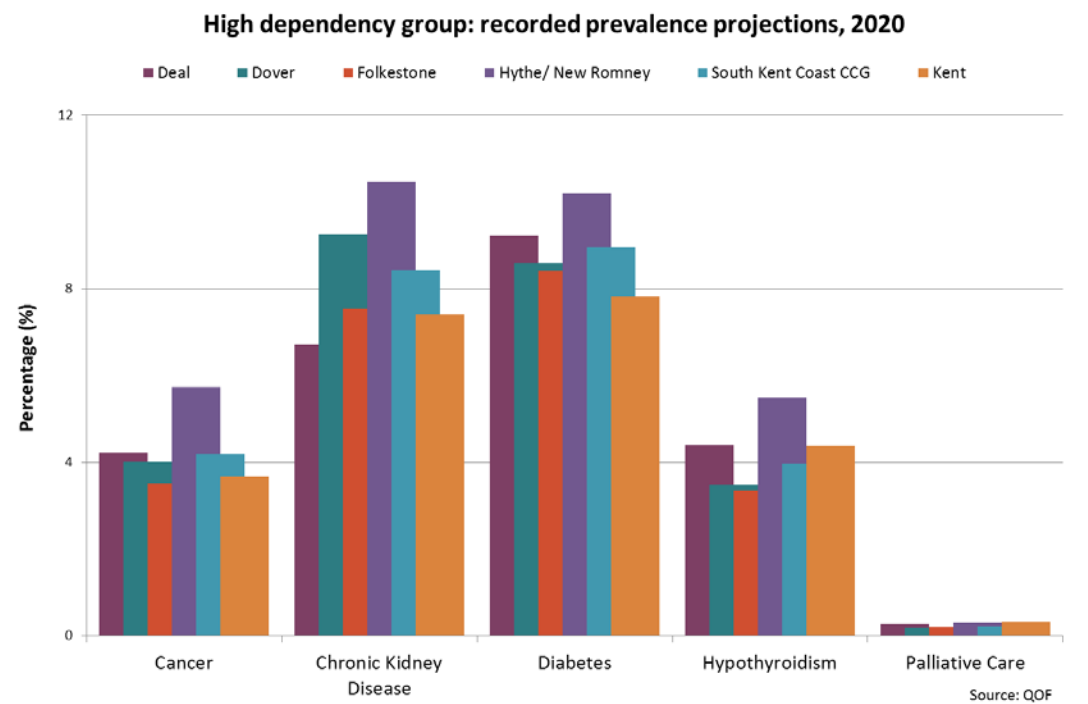
Source: QOF

Mental Health & Neurology

The Folkestone locality recorded prevalence has been projected to increase:

- Dementia has been projected to increase to 0.76% in 2020; this represents a 45.38% increase from 2013/14.

- Learning disabilities have been projected to increase to 1.06% in 2020; this represents a 39.34% increase from 2013/14.

- Mental health has been projected to increase to 1.02% in 2020; this represents a 12.89% increase from 2013/14
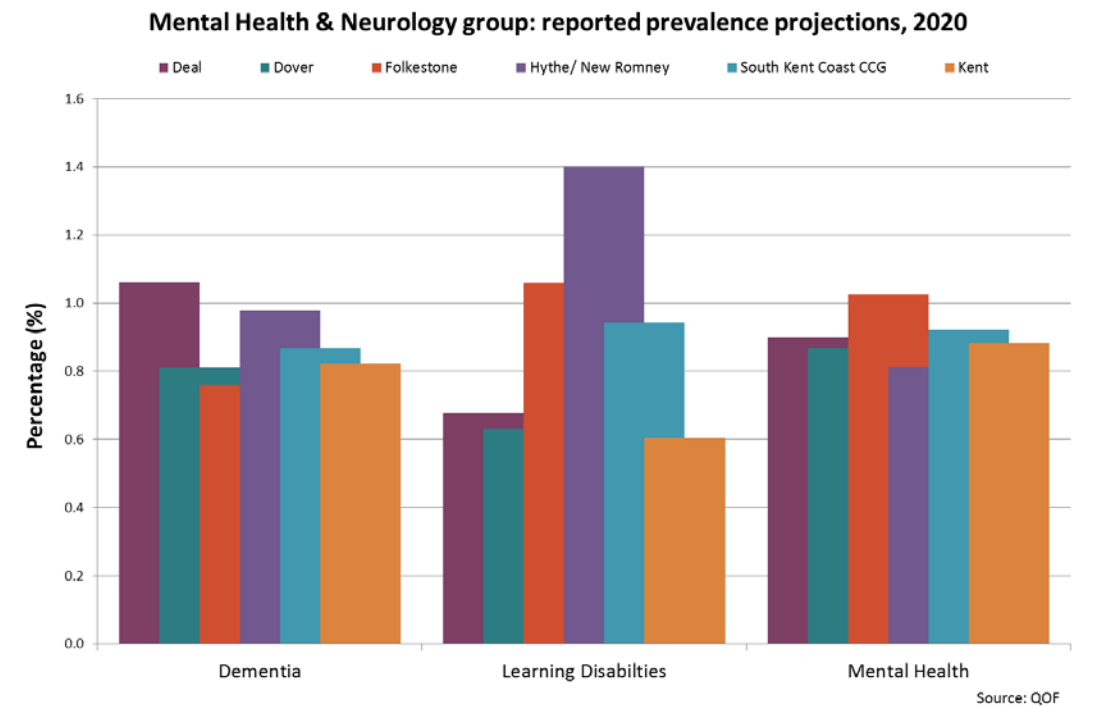
Figure 33

Mental Health & Neurology group: reported prevalence projections, 2020

Source: QOF

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.
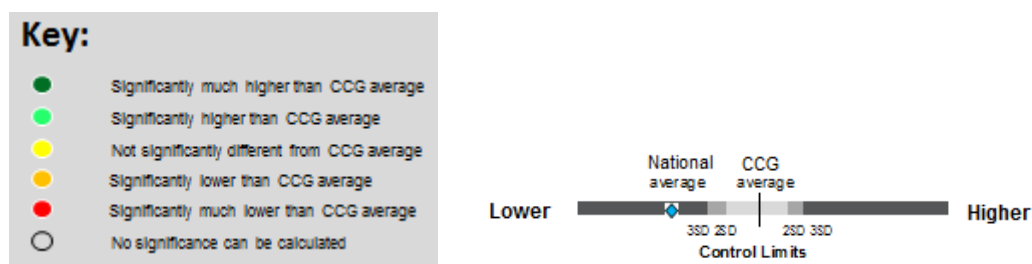
Confidence intervals for each indicator are calculated using the Wilson score method. Statistical significance is calculated relative to the mean for NHS South Kent Coast CCG at the 95% level. A practice is identified as significantly different from the CCG mean if the 95% confidence interval for the 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.

G82069 - The White House Surgery had significantly lower clinical achievement for the long term condition clinical achievement indicators;

- 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 whose notes record smoking status in the preceding 12 months.

Figure 34:

Indicator	Number	Performance	Average	Low	Range	High
	Practice		**CCG**			
Asthma 02	125	92.6	85.3	68.9		100.0
Asthma 03	370	69.8	70.7	47.0		93.3
Atrial Fibrillation 03	28	90.3	92.6	83.3		100.0
Atrial Fibrillation 04	81	71.7	72.8	60.3		93.3
Cancer 02	24	82.8	80.4	40.0		100.0
Chronic Kidney Disease 02	315	80.4	75.3	59.0		88.8
Chronic Kidney Disease 03	27	71.1	76.8	56.1		92.9
Chronic Obstructive Pulmonary Disease 03	125	89.3	81.3	63.8		95.0
Chronic Obstructive Pulmonary Disease 04	106	75.7	76.2	56.3		92.9
Dementia 02	22	91.7	78.3	44.4		100.0
Depression 02	37	51.4	63.0	36.6		93.3
Diabetes 03	411	77.4	73.8	40.8		89.5
Diabetes 07	386	72.7	64.6	52.5		76.0
Diabetes 09	458	86.3	82.6	72.9		90.1
Diabetes 14	37	84.1	75.7	20.0		100.0
Epilepsy 02	65	70.7	61.5	26.7		84.2
Hypertension 02	1274	86.9	80.5	66.2		88.7
Mental Health 02	13	46.4	74.4	29.2		100.0
Peripheral Artery Disease 02	36	87.8	86.3	73.6		100.0
Coronary Heart Disease 02	299	94.0	89.4	76.1		96.3
Coronary Heart Disease 06	30	76.9	71.4	33.3		100.0
Stroke & TIA 03	156	91.2	85.4	73.4		95.2
Blood Pressure 01	4401	83.3	89.9	80.9		95.9
Smoking 02	2101	92.6	94.4	88.9		99.2
Smoking 05	338	99.4	94.3	77.9		99.8
Cervical Screening 02	1811	78.2	77.8	71.1		85.5

Table 1:

	Exceptions	Exception rate
Asthma 03	26	4.91
Atrial Fibrillation 04	12	10.62
Chronic Kidney Disease 02	15	3.83
Chronic Kidney Disease 03	10	26.32
COPD 04	17	12.14
Depression 02	8	11.11
Diabetes 03	37	6.97
Diabetes 07	40	7.53
Diabetes 09	31	5.84
Epilepsy 02	8	8.70
Hypertension 02	46	3.14
Coronary Heart Disease 06	9	23.08
Stroke & TIA 03	8	4.68
Blood Pressure 01	35	0.66
Smoking 02	15	0.66
Cervical Screening 02	86	3.71

G82086 - The New 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 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 rheumatoid arthritis, on the register, who have had a face-to-face review in the preceding 12 months,

- 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 whose notes record smoking status in 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 35

Indicator	Practice		CCG			
	Number	Performance	Average	Low	Range	High
Asthma 02	60	82.2	85.3	68.9		100.0
Asthma 03	362	62.5	70.7	47.0		93.3
Atrial Fibrillation 03	48	90.6	92.6	83.3		100.0
Atrial Fibrillation 04	65	82.3	72.8	60.3		93.3
Cancer 02	30	85.7	80.4	40.0		100.0
Chronic Kidney Disease 02	174	61.7	75.3	59.0		88.8
Chronic Kidney Disease 03	14	87.5	76.8	56.1		92.9
Chronic Obstructive Pulmonary Disease 03	199	79.0	81.3	63.8		95.0
Chronic Obstructive Pulmonary Disease 04	201	79.8	76.2	56.3		92.9
Dementia 02	36	76.6	78.3	44.4		100.0
Depression 02	48	57.8	63.0	36.6		93.3
Diabetes 03	345	69.6	73.8	40.8		89.5
Diabetes 07	290	58.5	64.6	52.5		76.0
Diabetes 09	390	78.6	82.6	72.9		90.1
Diabetes 14	7	50.0	75.7	20.0		100.0
Epilepsy 02	43	51.2	61.5	26.7		84.2
Heart Failure 03	16	88.9	89.5	50.0		100.0
Hypertension 02	837	72.2	80.5	66.2		88.7
Mental Health 02	52	67.5	74.4	29.2		100.0
Peripheral Artery Disease 02	60	74.1	86.3	73.6		100.0
Rheumatoid Arthritis 02	42	53.2	78.4	6.2		100.0
Coronary Heart Disease 02	253	85.2	89.4	76.1		96.3
Coronary Heart Disease 06	12	54.5	71.4	33.3		100.0
Stroke & TIA 03	108	81.2	85.4	73.4		95.2
Blood Pressure 01	3778	80.9	89.9	80.9		95.9
Smoking 02	1880	88.9	94.4	88.9		99.2
Smoking 05	468	98.5	94.3	77.9		99.8
Cervical Screening 02	1682	72.6	77.8	71.1		85.5

Table 2:

	Exceptions	Exception rate
Asthma 03	83	14.34
Atrial Fibrillation 04	7	8.86
Chronic Kidney Disease 02	27	9.57
COPD 03	35	13.89
COPD 04	26	10.32
Depression 02	11	13.25
Diabetes 03	53	10.69
Diabetes 07	100	20.16
Diabetes 09	68	13.71
Diabetes 14	7	50.00
Epilepsy 02	14	16.67
Hypertension 02	84	7.25
Mental Health 02	13	16.88
Rheumatoid Arthritis 02	22	27.85
Coronary Heart Disease 02	14	4.71
Coronary Heart Disease 06	10	45.45
Blood Pressure 01	16	0.34
Smoking 02	9	0.43
Cervical Screening 02	260	11.22

G82091 - Guildhall Surgery had significantly lower clinical achievement for the long term condition clinical achievement indicators;

- 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 36

Indicator	Practice Number	Practice Performance	CCG Average	CCG Low	CCG Range	CCG High
Asthma 02	53	81.5	85.3	68.9		100.0
Asthma 03	301	74.0	70.7	47.0		93.3
Atrial Fibrillation 03	23	88.5	92.6	83.3		100.0
Atrial Fibrillation 04	46	78.0	72.8	60.3		93.3
Cancer 02	11	91.7	80.4	40.0		100.0
Chronic Kidney Disease 02	182	71.9	75.3	59.0		88.8
Chronic Kidney Disease 03	21	58.3	76.8	56.1		92.9
Chronic Obstructive Pulmonary Disease 03	115	83.9	81.3	63.8		95.0
Chronic Obstructive Pulmonary Disease 04	107	78.1	76.2	56.3		92.9
Dementia 02	14	70.0	78.3	44.4		100.0
Depression 02	24	72.7	63.0	36.6		93.3
Diabetes 03	357	78.3	73.8	40.8		89.5
Diabetes 07	303	66.4	64.6	52.5		76.0
Diabetes 09	384	84.2	82.6	72.9		90.1
Diabetes 14	11	52.4	75.7	20.0		100.0
Epilepsy 02	42	75.0	61.5	26.7		84.2
Heart Failure 03	9	81.8	89.5	50.0		100.0
Hypertension	819	79.4	80.5	66.2		88.7
Mental Health 02	78	74.3	74.4	29.2		100.0
Peripheral Artery Disease 02	30	81.1	86.3	73.6		100.0
Rheumatoid Arthritis 02	46	88.5	78.4	6.2		100.0
Coronary Heart Disease 02	207	89.6	89.4	76.1		96.3
Coronary Heart Disease 06	7	100.0	71.4	33.3		100.0
Stroke & TIA 03	120	84.5	85.4	73.4		95.2
Blood Pressure 01	3533	94.1	89.9	80.9		95.9
Smoking 02	1726	94.8	94.4	88.9		99.2
Smoking 05	419	88.6	94.3	77.9		99.8
Cervical Screening 02	1289	71.1	77.8	71.1		85.5

Table 3:

	Exceptions	Exception rate
Asthma 03	93	22.85
Chronic Kidney Disease 02	29	11.46
Chronic Kidney Disease 03	11	30.56
COPD 03	10	7.30
COPD 04	10	7.30
Diabetes 03	44	9.65
Diabetes 07	64	14.04
Diabetes 09	44	9.65
Diabetes 14	10	47.62
Hypertension 02	46	4.46
Mental Health 02	20	19.05
Coronary Heart Disease 02	15	6.49
Stroke & TIA 03	10	7.04
Smoking 02	45	2.47
Smoking 05	39	0.29
Cervical Screening 02	385	21.22

G82121 - Sandgate Road Surgery had significantly lower clinical achievement for the long term condition clinical achievement indicators;

- 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 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 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 diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less.
- 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 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 37

Indicator	Practice		CCG			
	Number	Performance	Average	Low	Range	High
Asthma 02	158	85.9	85.3	68.9		100.0
Asthma 03	518	70.8	70.7	47.0		93.3
Atrial Fibrillation 03	78	96.3	92.6	83.3		100.0
Atrial Fibrillation 04	109	64.5	72.8	60.3		93.3
Cancer 02	48	85.7	80.4	40.0		100.0
Chronic Kidney Disease 02	254	67.4	75.3	59.0		88.8
Chronic Kidney Disease 03	18	66.7	76.8	56.1		92.9
Chronic Obstructive Pulmonary Disease 03	151	73.3	81.3	63.8		95.0
Chronic Obstructive Pulmonary Disease 04	127	61.7	76.2	56.3		92.9
Dementia 02	60	68.2	78.3	44.4		100.0
Depression 02	51	45.5	63.0	36.6		93.3
Diabetes 03	350	66.7	73.8	40.8		89.5
Diabetes 07	354	67.4	64.6	52.5		76.0
Diabetes 09	443	84.4	82.6	72.9		90.1
Diabetes 14	11	78.6	75.7	20.0		100.0
Epilepsy 02	54	62.1	61.5	26.7		84.2
Heart Failure 03	10	83.3	89.5	50.0		100.0
Hypertension 02	1276	74.4	80.5	66.2		88.7
Mental Health 02	61	56.5	74.4	29.2		100.0
Osteoporosis 03	8	57.1	76.9	41.7		100.0
Peripheral Artery Disease 02	63	77.8	86.3	73.6		100.0
Rheumatoid Arthritis 02	70	82.4	78.4	6.2		100.0
Coronary Heart Disease 02	314	83.3	89.4	76.1		96.3
Coronary Heart Disease 06	20	50.0	71.4	33.3		100.0
Stroke & TIA 03	187	78.2	85.4	73.4		95.2
Blood Pressure 01	5588	88.1	89.9	80.9		95.9
Smoking 02	2652	93.9	94.4	88.9		99.2
Smoking 05	400	98.0	94.3	77.9		99.8
Cervical Screening 02	2104	82.3	77.8	71.1		85.5

Table 4: G82121

	Exceptions	Exception rate
Asthma 02	7	3.80
Asthma 03	31	4.23
Atrial Fibrillation 04	45	26.63
Chronic Kidney Disease 02	37	9.81
COPD 03	39	18.93
COPD 04	54	26.21
Dementia 02	8	9.09
Depression 02	49	43.75
Diabetes 03	75	14.29
Diabetes 07	62	11.81
Diabetes 09	41	7.81
Epilepsy 02	25	28.74
Hypertension 02	133	7.76
Mental Health 02	20	18.52
Peripheral Artery Disease 02	10	12.35
Rheumatoid Arthritis 02	11	12.94
Coronary Heart Disease 02	25	6.63
Coronary Heart Disease 06	20	50.00
Stroke & TIA 03	18	7.53
Blood Pressure 01	59	0.93
Smoking 02	32	1.13
Smoking 05	7	0.13
Cervical Screening 02	135	5.28

G82165 - Hawkinge and Elham Valley had significantly lower clinical achievement for the long term condition clinical achievement indicators;

- 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 38

Indicator	Practice		CCG			
	Number	Performance	Average	Low	Range	High
Asthma 02	72	85.7	85.3	68.9		100.0
Asthma 03	391	77.1	70.7	47.0		93.3
Atrial Fibrillation 03	29	96.7	92.6	83.3		100.0
Atrial Fibrillation 04	79	73.8	72.8	60.3		93.3
Cancer 02	27	73.0	80.4	40.0		100.0
Chronic Kidney Disease 02	331	79.4	75.3	59.0		88.8
Chronic Kidney Disease 03	36	76.6	76.8	56.1		92.9
Chronic Obstructive Pulmonary Disease 03	132	91.7	81.3	63.8		95.0
Chronic Obstructive Pulmonary Disease 04	106	73.6	76.2	56.3		92.9
Dementia 02	46	65.7	78.3	44.4		100.0
Depression 02	51	52.0	63.0	36.6		93.3
Diabetes 03	304	67.0	73.8	40.8		89.5
Diabetes 07	310	68.3	64.6	52.5		76.0
Diabetes 09	393	86.6	82.6	72.9		90.1
Diabetes 14	17	77.3	75.7	20.0		100.0
Epilepsy 02	41	65.1	61.5	26.7		84.2
Heart Failure 03	12	70.6	89.5	50.0		100.0
Hypertension 02	1168	78.7	80.5	66.2		88.7
Learning Disabilities 02	9	60.0	67.2	0.0		100.0
Mental Health 02	47	74.6	74.4	29.2		100.0
Peripheral Artery Disease 02	42	87.5	86.3	73.6		100.0
Rheumatoid Arthritis 02	64	77.1	78.4	6.2		100.0
Coronary Heart Disease 02	243	90.0	89.4	76.1		96.3
Coronary Heart Disease 06	22	71.0	71.4	33.3		100.0
Stroke & TIA 03	136	82.9	85.4	73.4		95.2
Blood Pressure 01	4513	89.3	89.9	80.9		95.9
Smoking 02	2118	95.6	94.4	88.9		99.2
Smoking 05	218	90.1	94.3	77.9		99.8
Cervical Screening 02	1830	82.6	77.8	71.1		85.5

Table 5:

	Exceptions	Exception rate
Asthma 02	11	13.10
Asthma 03	17	3.35
Atrial Fibrillation 04	17	15.89
Chronic Kidney Disease 02	12	2.88
Chronic Kidney Disease 03	10	21.28
COPD 03	8	5.56
COPD 04	32	22.22
Depression 02	30	30.61
Diabetes 03	31	6.83
Diabetes 07	24	5.29
Diabetes 09	13	2.86
Hypertension 02	48	3.23
Coronary Heart Disease 02	9	3.33
Coronary Heart Disease 06	9	29.03
Stroke & TIA 03	7	4.27
Blood Pressure 01	37	0.73
Smoking 02	21	0.95
Cervical Screening 02	59	2.66

G82187 - Folkestone East Family Practice had significantly lower clinical achievement for the long term condition clinical achievement indicators;

- 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.

Figure 39

	Practice		CCG			
Indicator	Number	Performance	Average	Low	Range	High
Asthma 02	52	86.7	85.3	68.9		100.0
Asthma 03	199	66.8	70.7	47.0		93.3
Atrial Fibrillation 03	26	96.3	92.6	83.3		100.0
Atrial Fibrillation 04	53	75.7	72.8	60.3		93.3
Cancer 02	14	87.5	80.4	40.0		100.0
Chronic Kidney Disease 02	179	83.3	75.3	59.0		88.8
Chronic Kidney Disease 03	13	92.9	76.8	56.1		92.9
Chronic Obstructive Pulmonary Disease 03	93	68.4	81.3	63.8		95.0
Chronic Obstructive Pulmonary Disease 04	85	62.5	76.2	56.3		92.9
Dementia 02	21	91.3	78.3	44.4		100.0
Depression 02	17	63.0	63.0	36.6		93.3
Diabetes 03	198	73.3	73.8	40.8		89.5
Diabetes 07	182	67.4	64.6	52.5		76.0
Diabetes 09	229	84.8	82.6	72.9		90.1
Epilepsy 02	25	54.3	61.5	26.7		84.2
Heart Failure 03	7	77.8	89.5	50.0		100.0
Hypertension 02	626	83.2	80.5	66.2		88.7
Mental Health 02	23	88.5	74.4	29.2		100.0
Peripheral Artery Disease 02	30	85.7	86.3	73.6		100.0
Rheumatoid Arthritis 02	25	78.1	78.4	6.2		100.0
Coronary Heart Disease 02	159	90.3	89.4	76.1		96.3
Coronary Heart Disease 06	15	60.0	71.4	33.3		100.0
Stroke & TIA 03	67	88.2	85.4	73.4		95.2
Blood Pressure 01	2115	89.9	89.9	80.9		95.9
Smoking 02	1192	96.5	94.4	88.9		99.2
Smoking 05	318	96.1	94.3	77.9		99.8
Cervical Screening 02	774	77.0	77.8	71.1		85.5

Table 6:

	Exceptions	Exception rate
Asthma 03	40	13.42
Atrial Fibrillation 04	8	11.43
Chronic Kidney Disease 02	18	8.37
COPD 03	16	11.76
COPD 04	25	18.38
Depression 02	10	37.04
Diabetes 03	39	14.44
Diabetes 07	38	14.07
Diabetes 09	19	7.04
Epilepsy 02	14	30.43
Hypertension 02	45	5.98
Coronary Heart Disease 02	11	6.25
Coronary Heart Disease 06	10	40.00
Blood Pressure 01	17	0.72
Smoking 02	9	0.73
Cervical Screening 02	175	17.41

G82217 - Central Surgery had significantly lower clinical achievement for the long term condition clinical achievement indicators;

- 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.

- 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.

Figure 40

Indicator	Number	Performance	Average	Low	Range	High
	Practice		**CCG**			
Asthma 02	41	95.3	85.3	68.9		100.0
Asthma 03	92	86.8	70.7	47.0		93.3
Atrial Fibrillation 03	8	100.0	92.6	83.3		100.0
Atrial Fibrillation 04	14	93.3	72.8	60.3		93.3
Chronic Kidney Disease 02	74	80.4	75.3	59.0		88.8
Chronic Kidney Disease 03	13	65.0	76.8	56.1		92.9
Chronic Obstructive Pulmonary Disease 03	26	92.9	81.3	63.8		95.0
Chronic Obstructive Pulmonary Disease 04	26	92.9	76.2	56.3		92.9
Depression 02	24	75.0	63.0	36.6		93.3
Diabetes 03	127	89.4	73.8	40.8		89.5
Diabetes 07	78	54.9	64.6	52.5		76.0
Diabetes 09	114	80.3	82.6	72.9		90.1
Epilepsy 02	16	84.2	61.5	26.7		84.2
Hypertension 02	297	86.3	80.5	66.2		88.7
Mental Health 02	7	100.0	74.4	29.2		100.0
Peripheral Artery Disease 02	13	86.7	86.3	73.6		100.0
Rheumatoid Arthritis 02	20	100.0	78.4	6.2		100.0
Coronary Heart Disease 02	73	96.1	89.4	76.1		96.3
Stroke & TIA 03	27	90.0	85.4	73.4		95.2
Blood Pressure 01	1241	91.1	89.9	80.9		95.9
Smoking 02	478	93.2	94.4	88.9		99.2
Smoking 05	116	88.5	94.3	77.9		99.8
Cervical Screening 02	485	80.8	77.8	71.1		85.5

Table 7:

	Exceptions	Exception rate
Diabetes 07	7	4.93
Cervical Screening 02	11	1.83

G82232 - Manor Clinic had significantly lower clinical achievement for the long term condition clinical achievement indicators;

- 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.

Figure 41

Indicator	Practice		CCG			
	Number	Performance	Average	Low	Range	High
Asthma 02	77	86.5	85.3	68.9		100.0
Asthma 03	306	75.7	70.7	47.0		93.3
Atrial Fibrillation 03	23	92.0	92.6	83.3		100.0
Atrial Fibrillation 04	40	61.5	72.8	60.3		93.3
Cancer 02	12	70.6	80.4	40.0		100.0
Chronic Kidney Disease 02	246	80.9	75.3	59.0		88.8
Chronic Kidney Disease 03	15	88.2	76.8	56.1		92.9
Chronic Obstructive Pulmonary Disease 03	107	88.4	81.3	63.8		95.0
Chronic Obstructive Pulmonary Disease 04	105	86.8	76.2	56.3		92.9
Dementia 02	28	73.7	78.3	44.4		100.0
Depression 02	33	80.5	63.0	36.6		93.3
Diabetes 03	305	86.2	73.8	40.8		89.5
Diabetes 07	200	56.5	64.6	52.5		76.0
Diabetes 09	274	77.4	82.6	72.9		90.1
Epilepsy 02	30	57.7	61.5	26.7		84.2
Heart Failure 03	10	90.9	89.5	50.0		100.0
Hypertension 02	787	84.2	80.5	66.2		88.7
Mental Health 02	69	89.6	74.4	29.2		100.0
Peripheral Artery Disease 02	35	89.7	86.3	73.6		100.0
Rheumatoid Arthritis 02	32	86.5	78.4	6.2		100.0
Coronary Heart Disease 02	183	93.4	89.4	76.1		96.3
Coronary Heart Disease 06	15	60.0	71.4	33.3		100.0
Stroke & TIA 03	99	95.2	85.4	73.4		95.2
Blood Pressure 01	3372	89.8	89.9	80.9		95.9
Smoking 02	1486	93.2	94.4	88.9		99.2
Smoking 05	340	90.2	94.3	77.9		99.8
Cervical Screening 02	1290	75.9	77.8	71.1		85.5

Table 8:

	Exceptions	Exception rate
Asthma 03	11	2.72
Atrial Fibrillation 04	22	33.85
Chronic Kidney Disease 02	36	11.84
COPD 03	10	8.26
COPD 04	12	9.92
Diabetes 03	11	3.11
Diabetes 07	28	7.91
Diabetes 09	22	6.21
Diabetes 14	7	58.33
Epilepsy 02	17	32.69
Hypertension 02	17	1.82
Coronary Heart Disease 02	9	4.59
Coronary Heart Disease 06	10	40.00
Blood Pressure 01	8	0.21
Smoking 02	38	2.38
Smoking 05	11	0.17
Cervical Screening 02	180	10.59

G82652 - The Surgery, Lyminge did not have significantly lower clinical achievement for any of the long term condition clinical achievement indicators.

Figure 42

Indicator	Practice		CCG			
	Number	Performance	Average	Low	Range	High
Asthma 02	42	100.0	85.3	68.9		100.0
Asthma 03	153	93.3	70.7	47.0		93.3
Atrial Fibrillation 03	14	100.0	92.6	83.3		100.0
Atrial Fibrillation 04	48	71.6	72.8	60.3		93.3
Cancer 02	12	85.7	80.4	40.0		100.0
Chronic Kidney Disease 02	157	88.2	75.3	59.0		88.8
Chronic Kidney Disease 03	8	80.0	76.8	56.1		92.9
Chronic Obstructive Pulmonary Disease 03	76	95.0	81.3	63.8		95.0
Chronic Obstructive Pulmonary Disease 04	70	87.5	76.2	56.3		92.9
Dementia 02	14	77.8	78.3	44.4		100.0
Depression 02	7	70.0	63.0	36.6		93.3
Diabetes 03	129	84.9	73.8	40.8		89.5
Diabetes 07	109	71.7	64.6	52.5		76.0
Diabetes 09	137	90.1	82.6	72.9		90.1
Diabetes 14	13	92.9	75.7	20.0		100.0
Heart Failure 03	13	92.9	89.5	50.0		100.0
Hypertension 02	448	86.5	80.5	66.2		88.7
Mental Health 02	10	83.3	74.4	29.2		100.0
Peripheral Artery Disease 02	23	95.8	86.3	73.6		100.0
Rheumatoid Arthritis 02	20	95.2	78.4	6.2		100.0
Coronary Heart Disease 02	123	95.3	89.4	76.1		96.3
Coronary Heart Disease 06	9	81.8	71.4	33.3		100.0
Stroke & TIA 03	73	93.6	85.4	73.4		95.2
Blood Pressure 01	1573	92.2	89.9	80.9		95.9
Smoking 02	799	97.4	94.4	88.9		99.2
Smoking 05	107	97.3	94.3	77.9		99.8
Cervical Screening 02	462	81.6	77.8	71.1		85.5

Table 9:

	Exceptions	Exception rate
Atrial Fibrillation 04	7	10.45
Hypertension 02	10	1.93
Cervical Screening 02	15	2.65

G82684 - **New Lyminge** 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 aged 40 or over and have a record of blood pressure in the preceding 5 years.

Figure 43

	Practice		CCG			
Indicator	Number	Performance	Average	Low	Range	High
Asthma 02	30	76.9	85.3	68.9		100.0
Asthma 03	116	58.6	70.7	47.0		93.3
Atrial Fibrillation 03	18	100.0	92.6	83.3		100.0
Atrial Fibrillation 04	32	82.1	72.8	60.3		93.3
Cancer 02	13	81.3	80.4	40.0		100.0
Chronic Kidney Disease 02	124	77.5	75.3	59.0		88.8
Chronic Kidney Disease 03	9	69.2	76.8	56.1		92.9
Chronic Obstructive Pulmonary Disease 03	39	81.3	81.3	63.8		95.0
Chronic Obstructive Pulmonary Disease 04	39	81.3	76.2	56.3		92.9
Dementia 02	16	88.9	78.3	44.4		100.0
Depression 02	25	78.1	63.0	36.6		93.3
Diabetes 03	139	81.8	73.8	40.8		89.5
Diabetes 07	115	67.6	64.6	52.5		76.0
Diabetes 09	148	87.1	82.6	72.9		90.1
Diabetes 14	9	100.0	75.7	20.0		100.0
Epilepsy 02	21	80.8	61.5	26.7		84.2
Heart Failure 03	8	88.9	89.5	50.0		100.0
Hypertension 02	490	79.8	80.5	66.2		88.7
Learning Disabilities 02	7	63.6	67.2	0.0		100.0
Mental Health 02	27	84.4	74.4	29.2		100.0
Peripheral Artery Disease 02	15	100.0	86.3	73.6		100.0
Rheumatoid Arthritis 02	31	91.2	78.4	6.2		100.0
Coronary Heart Disease 02	103	91.2	89.4	76.1		96.3
Stroke & TIA 03	49	86.0	85.4	73.4		95.2
Blood Pressure 01	1941	85.2	89.9	80.9		95.9
Smoking 02	904	95.3	94.4	88.9		99.2
Smoking 05	97	97.0	94.3	77.9		99.8
Cervical Screening 02	657	78.5	77.8	71.1		85.5

Table 10:

	Exceptions	Exception rate
Chronic Kidney Disease 02	16	10.00
Diabetes 03	8	4.71
Diabetes 07	7	4.12
Hypertension 02	29	4.72
Blood Pressure 01	11	0.48
Cervical Screening 02	23	2.75

G82760 - Park Farm Surgery did not have significantly lower clinical achievement for and of the long term condition clinical achievement indicators.

- 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.

Figure 44

	Practice		CCG			
Indicator	Number	Performance	Average	Low	Range	High
Asthma 02	39	90.7	85.3	68.9		100.0
Asthma 03	129	75.9	70.7	47.0		93.3
Atrial Fibrillation 03	9	100.0	92.6	83.3		100.0
Atrial Fibrillation 04	21	84.0	72.8	60.3		93.3
Chronic Kidney Disease 02	64	65.3	75.3	59.0		88.8
Chronic Kidney Disease 03	7	87.5	76.8	56.1		92.9
Chronic Obstructive Pulmonary Disease 03	69	89.6	81.3	63.8		95.0
Chronic Obstructive Pulmonary Disease 04	70	90.9	76.2	56.3		92.9
Dementia 02	18	90.0	78.3	44.4		100.0
Depression 02	26	76.5	63.0	36.6		93.3
Diabetes 03	117	76.5	73.8	40.8		89.5
Diabetes 07	109	71.2	64.6	52.5		76.0
Diabetes 09	127	83.0	82.6	72.9		90.1
Diabetes 14	13	86.7	75.7	20.0		100.0
Epilepsy 02	14	60.9	61.5	26.7		84.2
Hypertension 02	375	82.4	80.5	66.2		88.7
Mental Health 02	24	82.8	74.4	29.2		100.0
Peripheral Artery Disease 02	13	86.7	86.3	73.6		100.0
Rheumatoid Arthritis 02	21	91.3	78.4	6.2		100.0
Coronary Heart Disease 02	76	89.4	89.4	76.1		96.3
Stroke & TIA 03	46	88.5	85.4	73.4		95.2
Blood Pressure 01	1263	95.6	89.9	80.9		95.9
Smoking 02	680	95.4	94.4	88.9		99.2
Smoking 05	206	98.1	94.3	77.9		99.8
Cervical Screening 02	500	75.1	77.8	71.1		85.5

Table 11:

	Exceptions	Exception rate
Chronic Kidney Disease 02	23	23.47
Diabetes 03	15	9.80
Diabetes 07	14	9.15
Diabetes 09	11	7.19
Hypertension 02	24	5.27
Cervical Screening 02	20	3.00

Breastfeeding

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

Figure 45

South Kent Coast CCG, Folkestone Practices:
6-8 week breastfeeding (Q2-Q3 2014/15 pooled)

Source: Child Health Information System
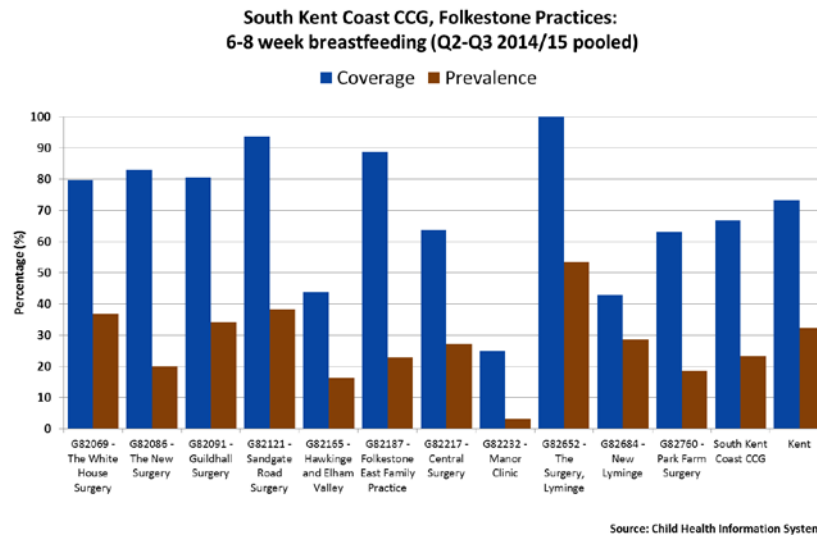
Coverage levels of 95% and greater have been recommended for the accurate assessment of breastfeeding prevalence.

The South Kent Coast coverage was 66.6% and within Folkestone practices ranged between 25 and 100% during the mid-part of 2014/15. Only the Surgery, Lymage had coverage higher than recommended levels and demonstrated a 53.3% prevalence of breastfeeding continuation at the 6-8 week check.

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 3,668 persons have been estimated to be eligible within Folkestone practices:

Table 12:

Practice	Eligible
G82069 - The White House Surgery	**512**
G82086 - The New Surgery	526
G82091 - Guildhall Surgery	363
G82121 - Sandgate Road Surgery	620
G82165 - Hawkinge and Elham Valley	408
G82187 - Folkestone East Family Practice	197
G82217 - Central Surgery	188
G82232 - Manor Clinic	353
G82652 - The Surgery, Lyminge	147
G82684 - New Lyminge	225
G82760 - Park Farm Surgery	129

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.

Practices G82086, G82217 and G82760 had performance that was significantly lower than the 95% or 99.8% control limits within Kent.

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

Figure 46

Health check performance, Folkestone, 2014/15

Source: KCHFT

45
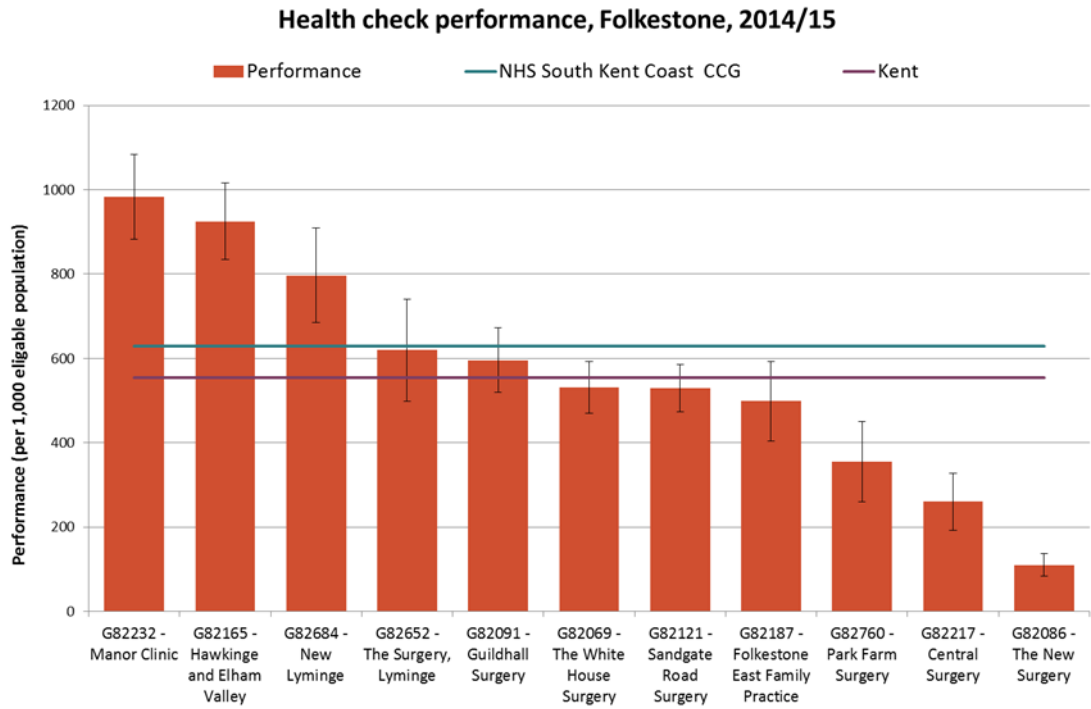
Cancer

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 G82069 and G82760 can be identified to have crude cancer incidence rates lower than South Kent Coast CCG.

Figure 47
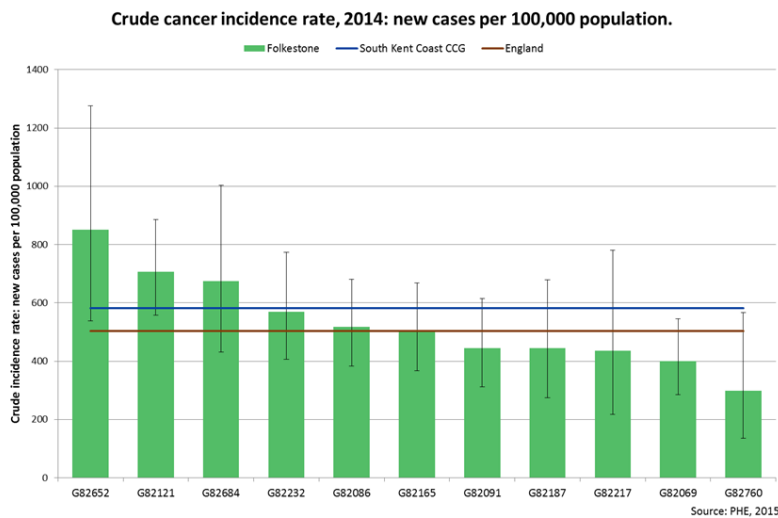
Prevalence

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 G82069, G82086, G82091, G82217, G82232 and G82760 can be identified to have prevalent cancer cases lower than South Kent Coast CCG.

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[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.

Figure 48

Prevalent cancer cases, 2014: proportion of practice population on cancer register.

Source: PHE, 2015
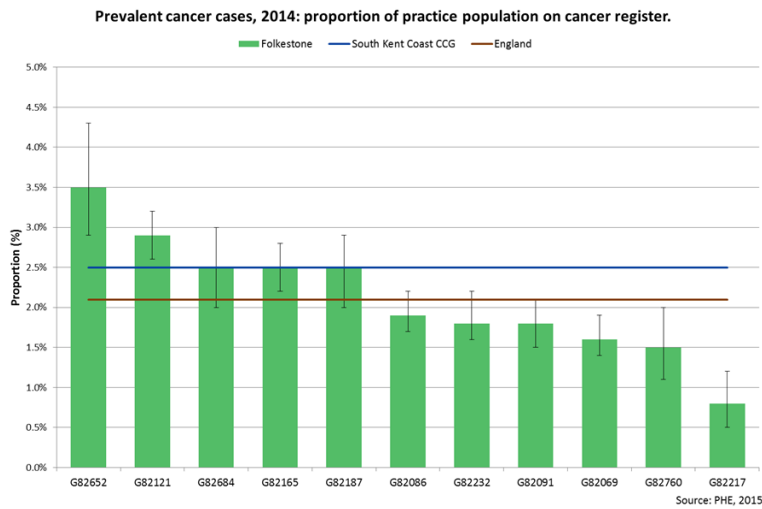
Breast Cancer

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

Figure 49

Females, 50-70 years, screened for breast cancer within last 36 months.

Source: PHE, 2015
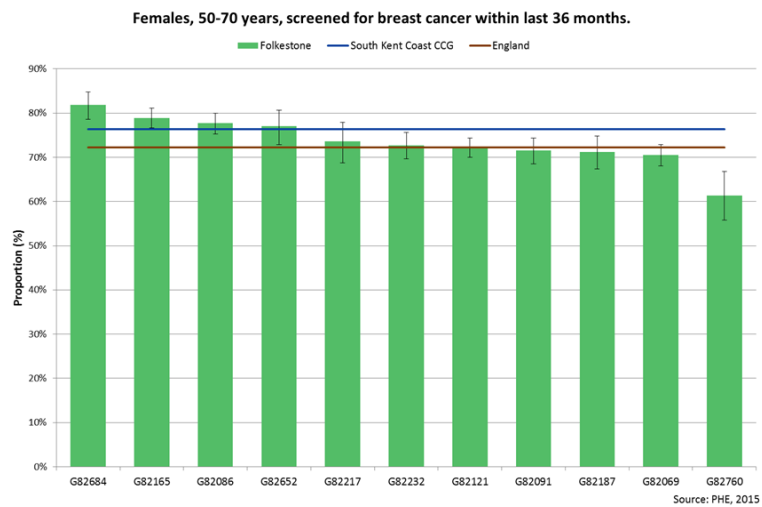
- Screening rates in G82069, G82091, G82121, G82187, G82232 and G82760 were significantly lower than South Kent Coast CCG.

Cervical Cancer

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

- Screening rates in G82086, G82091 and G82232 were significantly lower than South Kent Coast CCG.

Figure 50
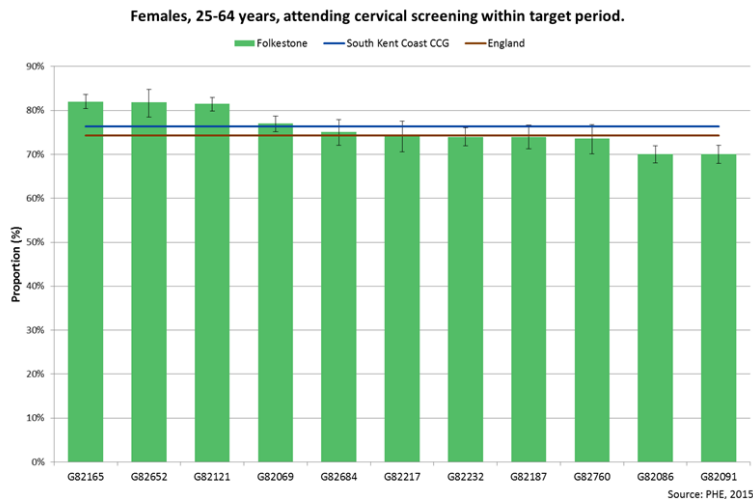
Bowel Cancer

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

- Screening rates in G82086, G82091, G82187, G82217, G82232 and G82760 were significantly lower than South Kent Coast CCG.

Figure 51
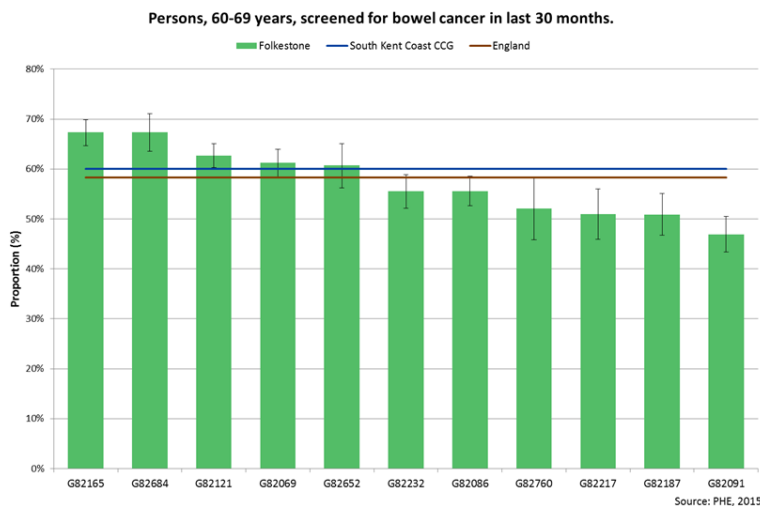
Lifestyles

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 52

Modelled adult obesity prevalence estimates

Source: ONS Lifestyle Estimates 2006-2008
Produced by: ZC, KPHO

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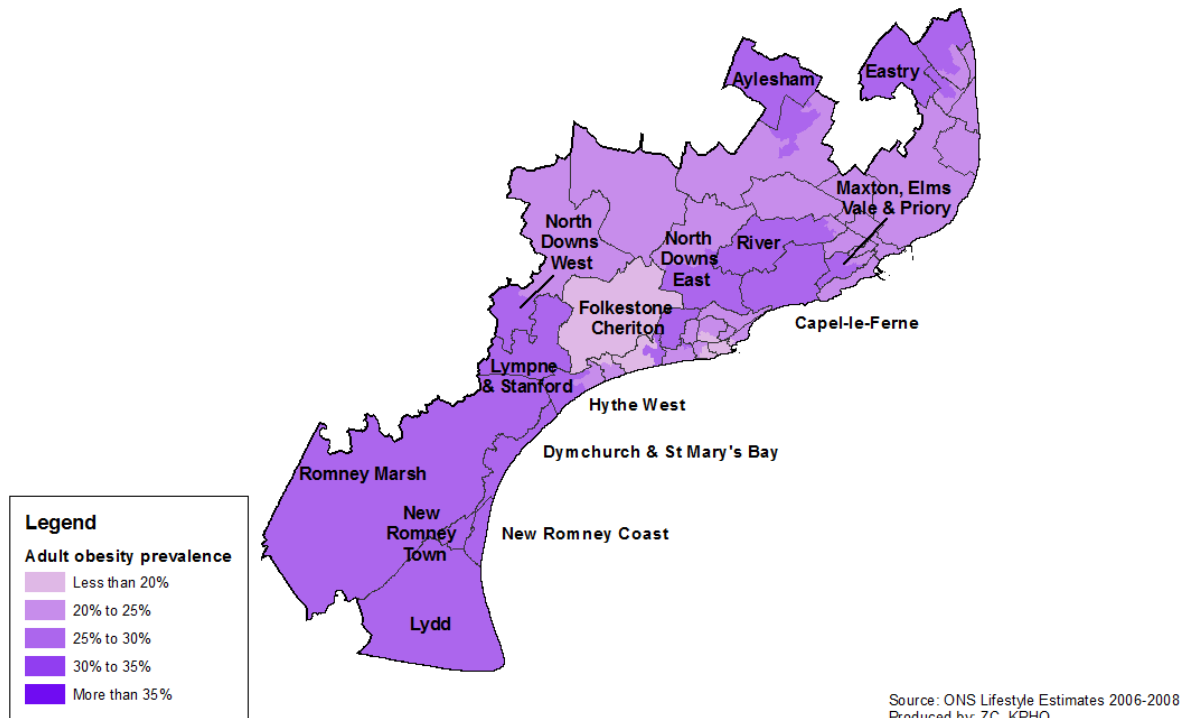
[5] MSOAs cover between 5,000 and 20,000 populations

Figure 53

Modelled smoking prevalence estimates

Legend

Smoking Prevalence

- Less than 20%
- 20% to 25%
- 25% to 30%
- 30% to 35%
- More than 35%

Source: ONS Lifestyle Estimates 2006-2008
Produced by: ZC, KPHO
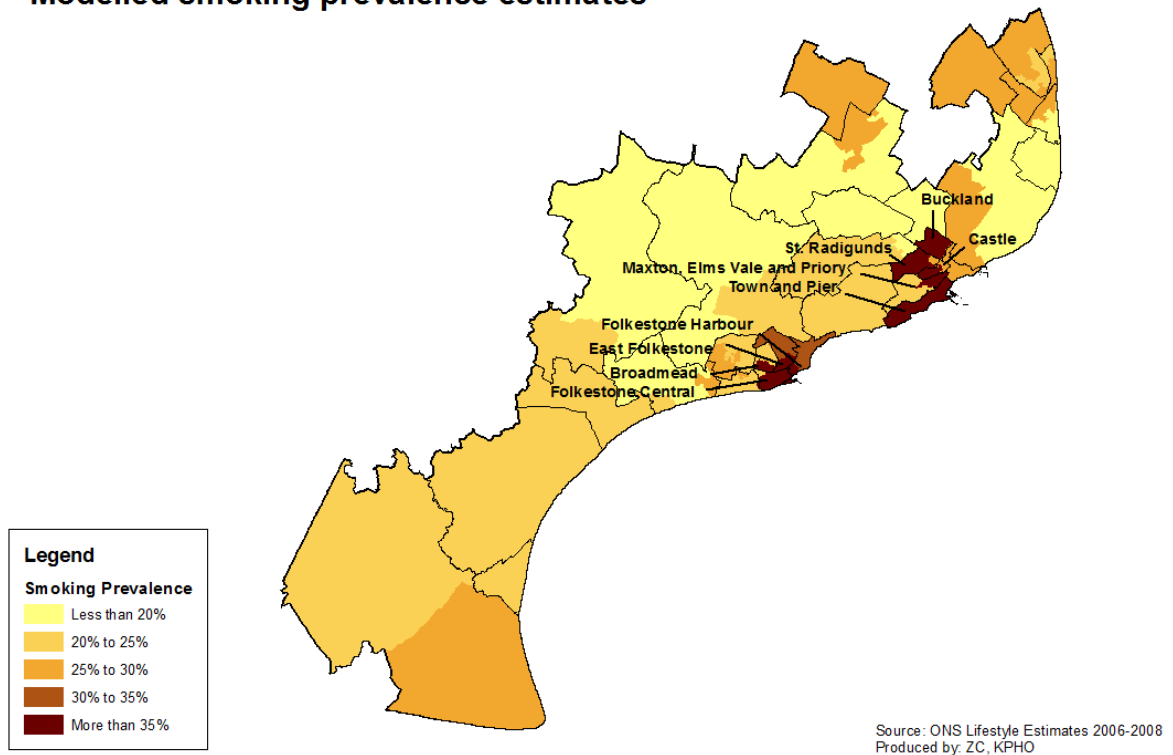
Accident and emergency activity

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 lower for patients registered with the Folkestone hub practices.

The percentage increase between 2012/13 and 2014/15 for Folkestone patients is just 3%, this is lower than both the South Kent Coast rate (5%) and the rate for the other CCGs in Kent (8%) and is the lowest of the four South Kent Coast CCG hub areas.

Figure 54
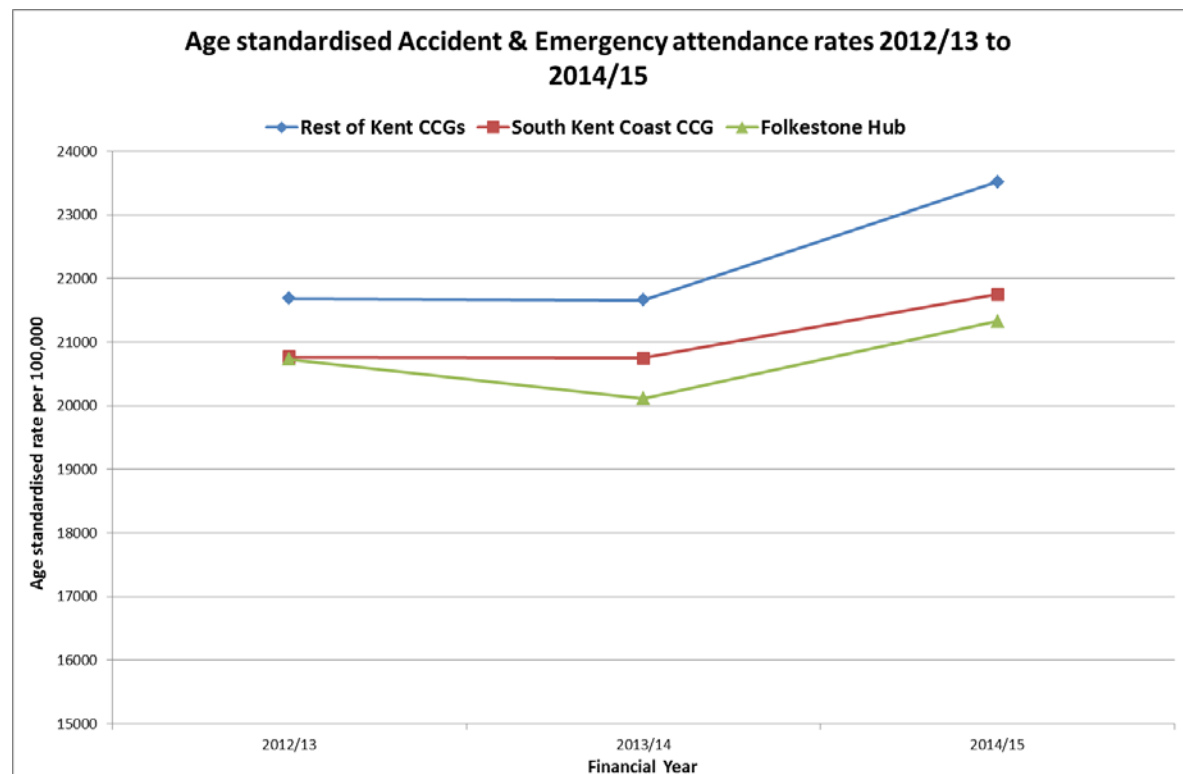
The age profile of accident & emergency attendances over the three year period shows that young people aged 15-24 years are the most frequent of all attendances. This pattern is reflected across South Kent Coast (14.5%) although the ratio is a little lower for patients registered with practices in Folkestone (14%).

The profile of attendances is very similar to that for South Kent Coast except for children aged 5-14 years, these make up 6% of the activity compared to South Kent Coast at 8% and Kent at 9%.

Figure 55

Age profile for Accident & Emergency attendances for Folkestone GPs Hub patients, 2012/13 to 2014/15 pooled data
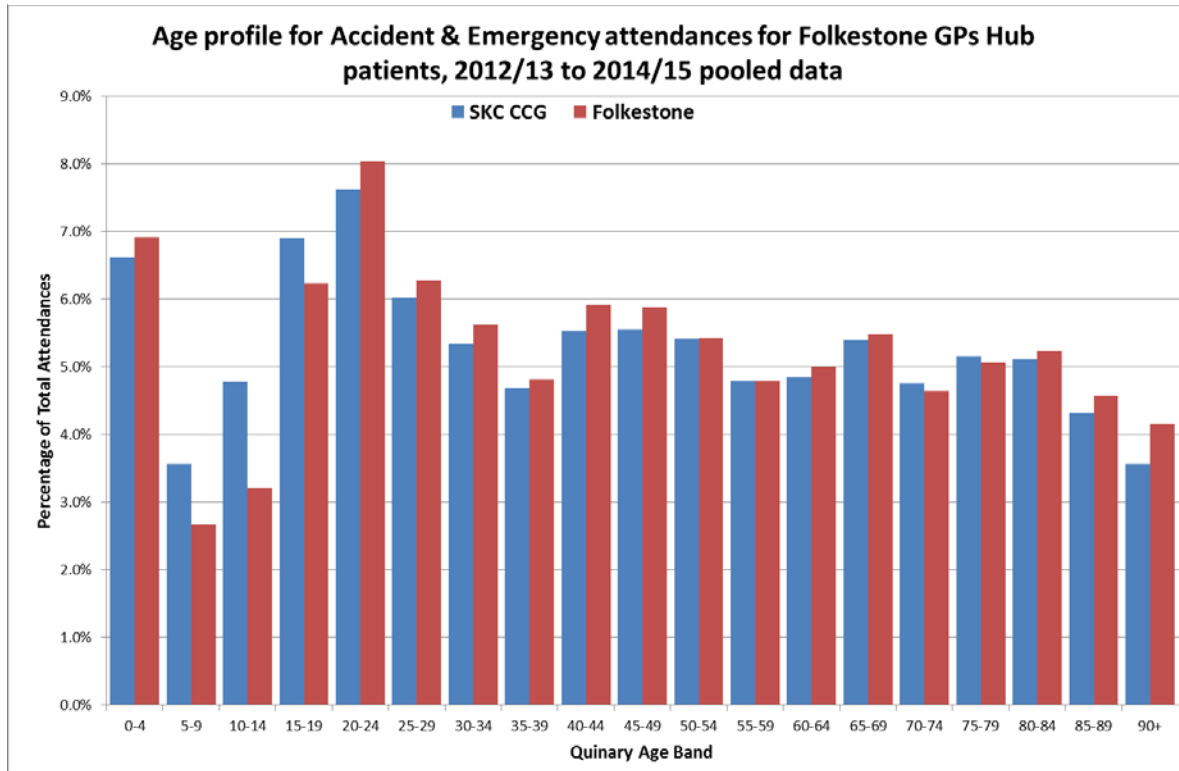
Outpatient activity

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 132,389 outpatient appointments for patients registered to Folkestone practices.

Figure 56

	Folkestone *n* (%)	South Kent Coast CCG *n* (%)	Kent *n* (%)
Not applicable	s (0.0)	8 (0.0)	627 (0.0)
Cancelled by patient	2,382 (1.8)	6547 (1.8)	97,978 (3.8)
Patient did not attend	9,372 (7.1)	23915 (6.4)	161,681 (6.2)
Appointment cancelled or postponed by Provider	1,571 (1.2)	4106 (1.1)	86567 (3.3)
Seen	118,678 (89.6)	336266 (90.3)	2,241,532 (86.0)
Arrived late and seen	248 (0.2)	853 (0.2)	3,233 (0.1)
Patient did not attend - arrived late and not seen	s (0.0)	86 (0.0)	637 (0.0)
Not known	0 (0.0)	0 (0.0)	0
Not coded	100 (0.1)	499 (0.1)	12,832 (0.5)

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

The proportion of appointments whereby the patient did not attend were lower within Folkestone, in comparison to South Kent Coast CCG and Kent. In 2014/15, within Folkestone, patient not attending appointment amounted to 2,630 appointments.

First appointments accounted for 32,528 attendances within Folkestone general practices. After first attendance, 37.1% or 12,056 were discharged from care.

Practice G82684 – New Lyminge had significantly greater proportions discharged than Folkestone, South Kent Coast CCG and Kent.

Figure 57
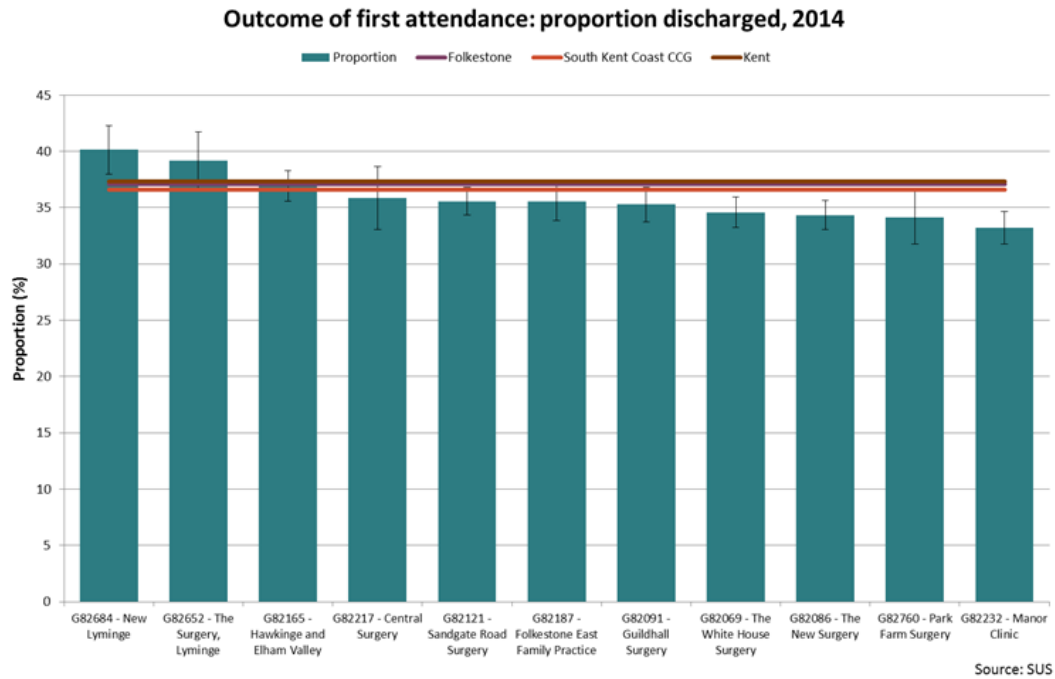
Outcome of first attendance: proportion discharged, 2014

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 Folkestone (2.49). The G82217 – Central Surgery showed the highest ratios (2.95) across Folkestone practices.

Figure 58

	First appointments	Follow-up appointments	Ratio
G82217 - Central Surgery	1110	3269	2.95
G82760 - Park Farm Surgery	1556	4208	2.70
G82165 - Hawkinge and Elham Valley	4783	12818	2.68
G82069 - The White House Surgery	4699	12574	2.68
G82086 - The New Surgery	5184	12924	2.49
G82652 - The Surgery, Lyminge	1403	3427	2.44
G82091 - Guildhall Surgery	3685	8992	2.44
G82232 - Manor Clinic	4020	9638	2.40
G82121 - Sandgate Road Surgery	5847	13932	2.38
G82684 - New Lyminge	1984	4716	2.38
G82187 - Folkestone East Family Practice	3088	6658	2.16
Folkestone	37359	93156	2.49
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. None of the practices had a significantly greater rate of change between 2010/11 and 2014/15 in comparison to Kent.

Figure 59

Rate of change in the ratio of follow-up appoinments for each first appointment, between 2010/11 to 2014/15: Folkestone

Source: SUS
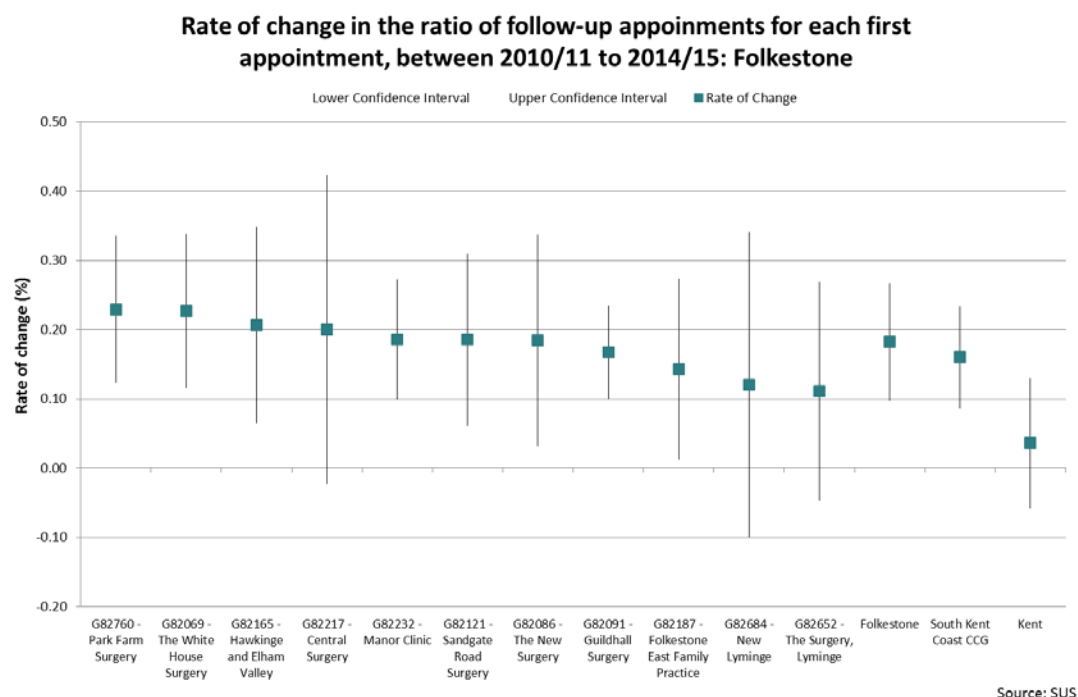
Mortality

All age, all cause mortality

There is considerable variation in all age, all cause mortality across the Folkestone hub, ranging from 551.4 deaths per 100,000 population at New Lyminge to 1020.9 at Park Farm Surgery. The New Surgery, Guildhall Surgery, Folkestone East Family Practice, Manor Clinic and Park Farm Surgery all have significantly higher mortality rates in comparison with Folkestone (807.3), whilst The White House Surgery, The Surgery Lyminge and New Lyminge all have significantly lower rates.

The Folkestone rate is significantly lower than South Kent Coast CCG (896.2), Kent (848.2) and the east Kent rate of 872.3.

Figure 60

In the Folkestone hub, the all age, all cause mortality decreased between 2006 and 2008, and since then the rate has fluctuated. The rate of decrease has been 5.7 deaths per 100,000 population annually, slower than the Kent (11.1) and South Kent Coast CCG (7.0) rate of decrease.

Figure 61

56
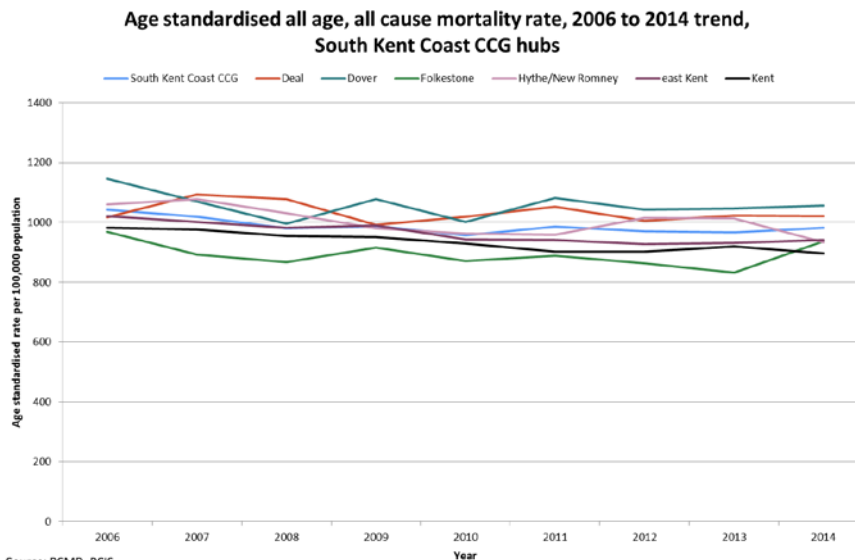
Cancer

Under 75 cancer mortality rates vary from 120.0 at The White House Surgery to 207.7 at Folkestone East Family Practice; however none of the practices have significantly different rates to Folkestone (142.0).

The Folkestone rate is not significantly different to either east Kent (142.7), Kent (137.6) and South Kent Coast CCG (144.5).

Figure 62

Cancer mortality rate, under 75 population, 2006 to 2014 pooled data

Source: PCMD, PCIS
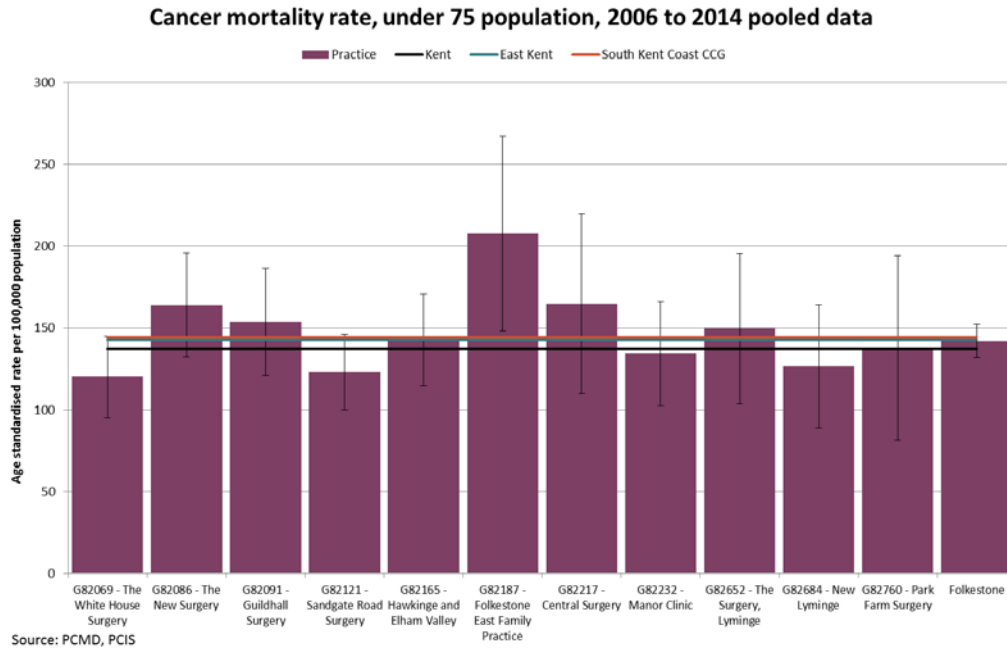
Across Kent, the under 75 mortality rate for cancer has reduced by 2.0 deaths per 100,000 population annually. In the Folkestone hub, there have been large fluctuations, with a peak at 151.9 deaths per 100,000 population in 2006. In 2014, the rate was 157.3, higher than the Kent rate of 130.5, but not significant.

Figure 63

Age standardised cancer mortality rate, under 75s, 2006 to 2014 trend, South Kent Coast CCG hubs

Source: PCMD, PCIS

57
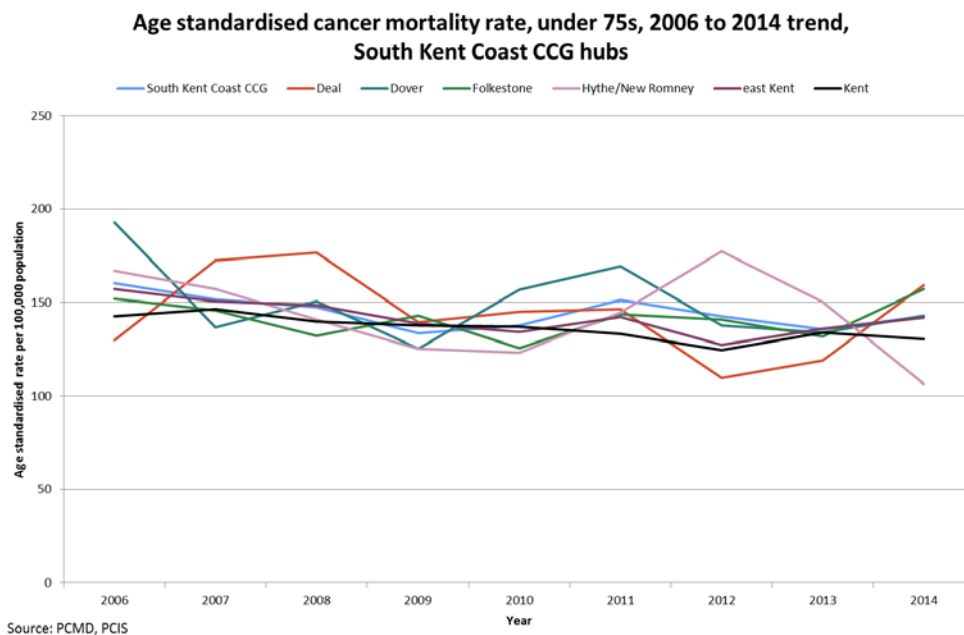
Circulatory Disease

Sandgate Road Surgery has the lowest mortality rate from circulatory disease in Folkestone hub at 52.8, whilst Central Surgery has the highest at 134.4 deaths per 100,000 population aged under 75. Folkestone hub has a rate of 85.0, and Guildhall Surgery has a significantly higher rate than the hub at 127.9.
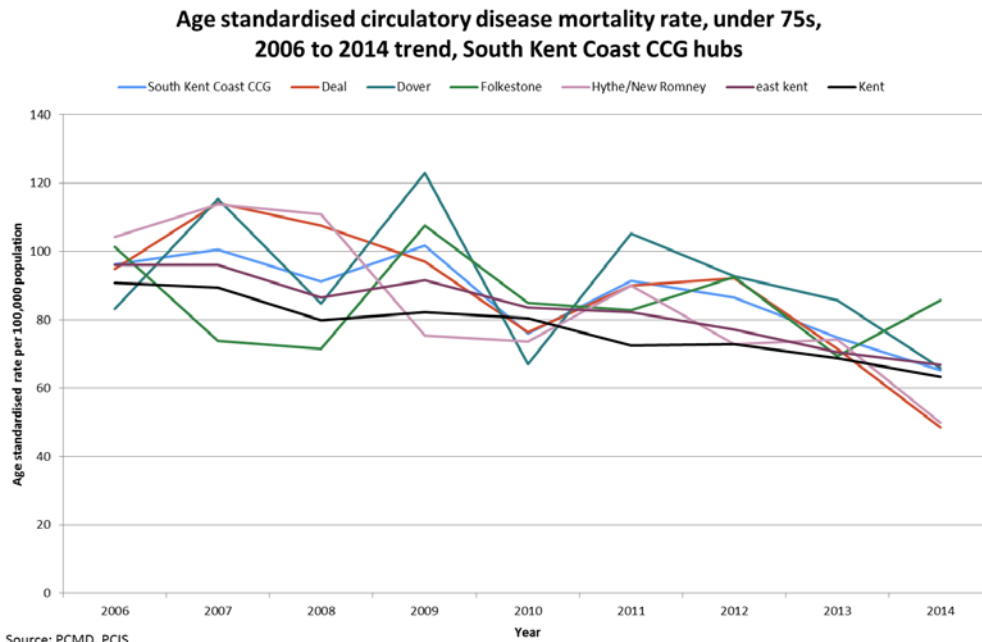
The Folkestone rate is not significantly different in comparison with South Kent Coast CCG (86.3), east Kent (82.8) or Kent (77.9).

Figure 64
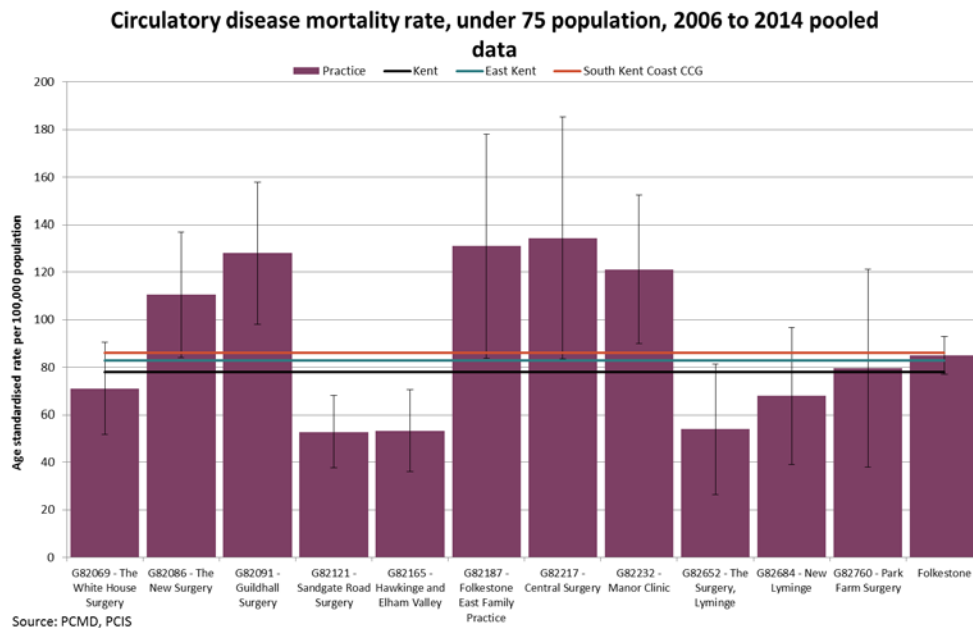
The rate of decrease has been slower in the Folkestone hub (1.0 deaths per 100,000) than in Kent (3.3); however, this difference is not significant. The rate has fluctuated substantially within the hub, peaking in 2009 at 107.5. The lowest recorded rate occurred in 2013 at 69.4; this is similar to the Kent (63.3), east Kent (66.8) and South Kent Coast CCG (65.3) rates.

58

Figure 65

Age standardised circulatory disease mortality rate, under 75s, 2006 to 2014 trend, South Kent Coast CCG hubs
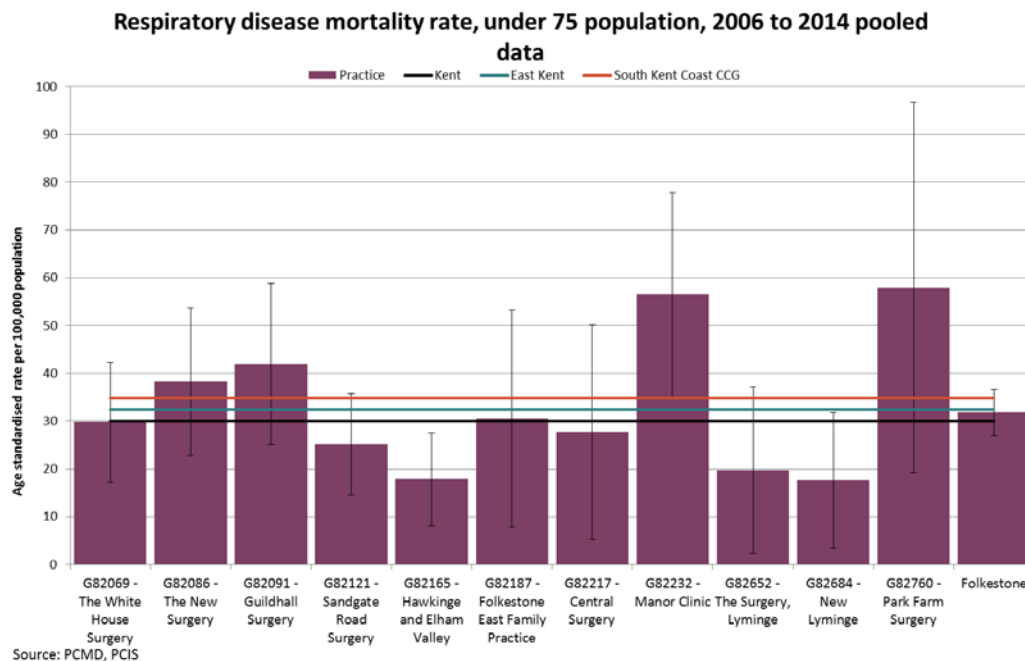
Respiratory Disease

Respiratory disease mortality rate ranges from 17.6 at New Lyminge to 58.0 at Park Farm Surgery; the Folkestone rate is 31.8. None of the practices have rates significantly different to that of Folkestone.

The Folkestone rate (31.8) is not significantly different to the South Kent Coast CCG (34.8), east Kent (32.4) or Kent (30.0) rates.

Figure 66

Respiratory disease mortality rate, under 75 population, 2006 to 2014 pooled data

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 decrease in the Folkestone hub is 0.2 with the lowest rate occurring in 2009 (24.8), increasing to a peak of 49.8 in 2011.

Figure 67

Age standardised respiratory disease mortality rate, under 75s, 2006 to 2014 trend, South Kent Coast CCG hubs
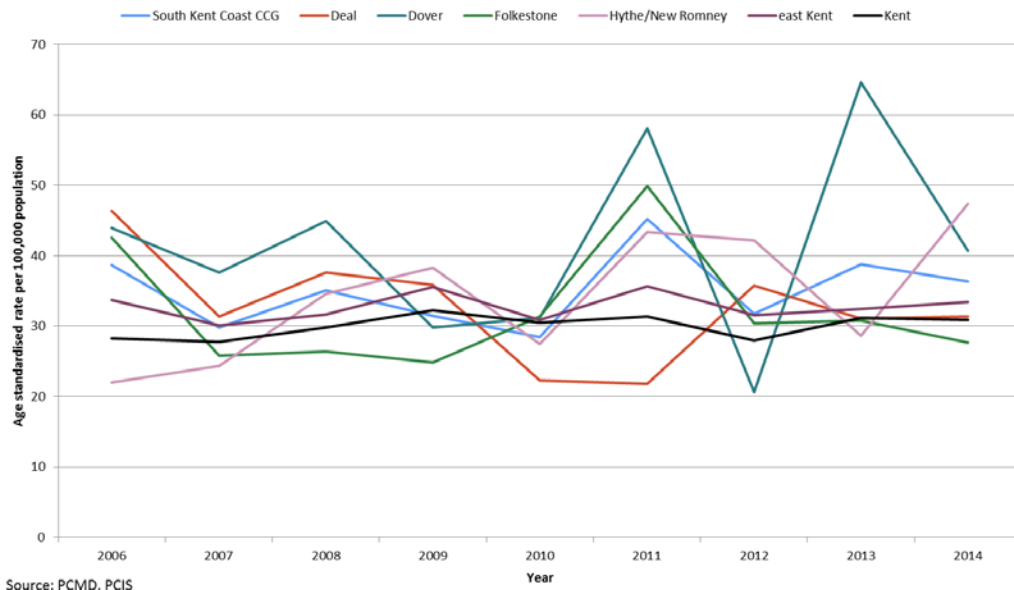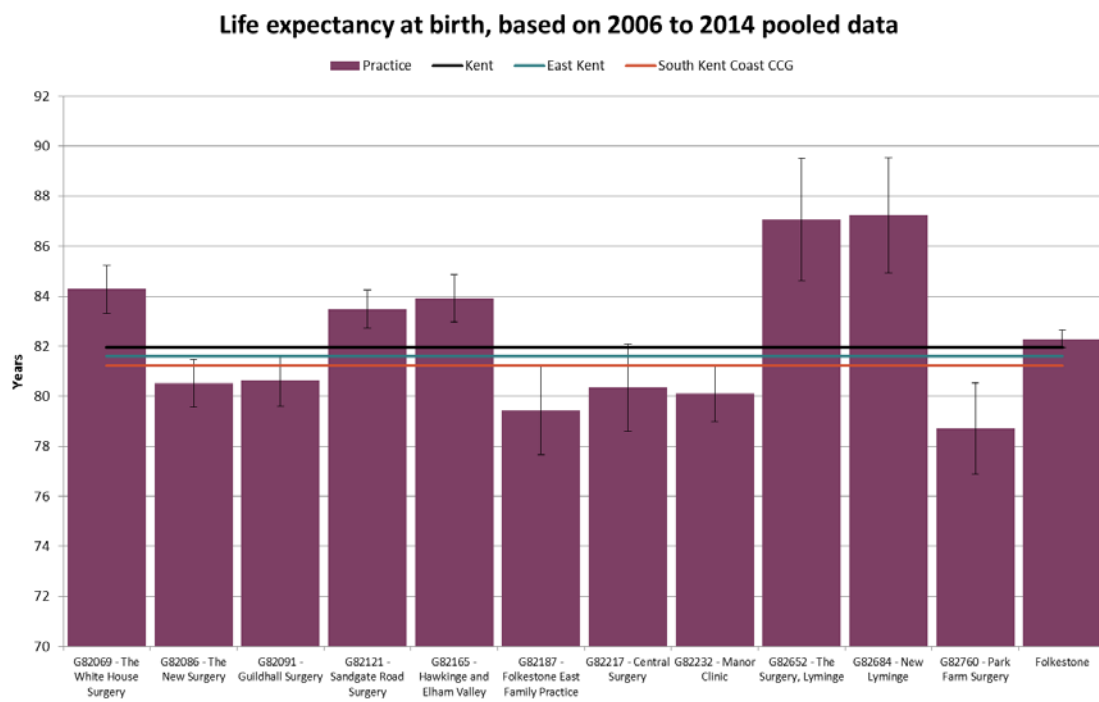
Source: PCMD, PCIS

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 an 8.5 year gap in life expectancy between practices in Folkestone; New Lyminge has the highest life expectancy ay 87.2 whilst the lowest is at Park Farm Surgery at 78.7. There is significant variation between a number of practices.

The Folkestone life expectancy (82.3) is significantly higher than both South Kent Coast CCG (81.2) and east Kent (81.6) but not significantly higher than Kent (82.0).
Figure 68

Life expectancy at birth, based on 2006 to 2014 pooled data

Source: PCMD, PCIS

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