Please note that full details on people’s health in Wandsworth is given in the Public Health Annual Report 2004.
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Executive Summary

There have been remarkable improvements in the health of the population in Wandsworth in the last decade. These improvements were associated with major demographic and social changes in the inner London Borough of Wandsworth. The bulk of the population are those between the ages of 20 to 44 years old.

Despite this progress, we continue to face many challenges which characterise inner cities, and in particular the rapidly developing ones.

- We still have small but significant pockets of deprivation.
- Some communities are isolated.
- The needs of specific communities and in particular the asylum seekers, the refugees and the homeless.
- Some of the ethnic minority groups continue to be disadvantaged (the high unemployment among young black people for example).
- Certain sectors and geographical areas (wards) are at higher risk of coronary heart disease, cancers and mental health problems. These are due to the high prevalence of risks to health such as smoking, obesity, lack of exercise and coping with the problems of daily living.
- Our life expectancy is still lower than the national average, although we expect rapid improvements due to the magnitude of the demographic changes.

Health improvements depend on the nature of our population, their willingness to make healthy choices about themselves and their children, our strategies and investments to enable them to make their own choices and our quality service provision for those who need help and support during illness.

We have credible plans and a good track record to enable this to happen. This document highlights the measures taken to tackle inequalities in Wandsworth. Our strategies are flexible and adaptable to the rapidly evolving needs of our versatile and highly mobile population.

More details and specifics are highlighted in the 2004 Director of Public Health Report on the Health of Wandsworth people.

Professor Salman Rawaf FRCP FFPHM
Director of Public Health
Wandsworth July 2004
The Greater London Authority is divided into three sub-regions; Central London, Inner London and Outer London. Wandsworth is part of Central London Sub Region. This is where a large number of the population work, socialise and spend a good deal of time in and around central parts of London. Furthermore, Wandsworth attracts a good proportion of tourists, with specific implications to health.

The three Localities within Wandsworth PCT

Primary Care Services within Wandsworth PCT are structured within three localities. Battersea, Wandsworth South, and Putney & Roehampton.
1. Introduction
1. Introduction

1.1 General

Wandsworth is the second largest Borough in Inner London in terms of population size, with only the Borough of Lambeth having a larger population. The number of residents in Wandsworth for 2001 was 260,380 (ONS census 2001). Studies have suggested that there has been an overall shortfall of around 190,000 men in the 2001 population estimates at national level, mainly young men aged 25 – 34. These re-calculations of the population age structure will be available by Sep/Oct 2004. We have been informed by ONS that the July 2004 adjustment will add about 5000 persons more to our population, mainly young adults. However, the Primary Care Trust is responsible for a registered population of 314,000 persons. Three practices in the south eastern part of the Borough (with an estimated population of 10,000 are part of Sutton and Merton PCT.

The Wandsworth population have one of the highest percentages of people with a qualification at degree level or higher with the 4th rank in the country (47% compared to 20% for England and Wales). We believe the figure would be higher if the additional 5000 identified by ONS since the 2001 census are taken into account.

Note: the data in the report that has the 2001 Census as it’s source, is using a count of 260,380 residents of Wandsworth, as this was the original result of the Census.

1.2 Age Structure

The population of Wandsworth has changed over the last 10 years. Figure 1a shows the age structure of the Wandsworth population and indicates how different it is to the UK average. A large proportion of the population of Wandsworth is aged between 20-44 years (53.7%). In comparison, 35.1% of the England and Wales population is in this age group and 42.8% of the London population. Likewise, Wandsworth has a much smaller proportion of older people and children aged 5-14 compared to the UK. While other London Boroughs do have a smaller older population than the UK average (figure 1b) and a slightly larger 20-44 year age group, it is not to the same extreme as Wandsworth. The high percentage of young adults in Wandsworth is mainly due to high mobility, the housing market, employment opportunities, and the new housing developments.

For the first time, at the national level there are now more people aged 60 and over than there are under 16. However, the London picture differs with more people under 16 than aged 60 and over and Wandsworth also follows this pattern – 16.3% of the Wandsworth population are under 16 years and 13.8% are aged 60 and over.
Figure 1: Population pyramids

a) Wandsworth

b) London

Source: Census 2001
### 1.3 Nature of the Wandsworth Population

#### Table 1: Percentage of people 16-49 by residential classification in Wandsworth

<table>
<thead>
<tr>
<th>Age Group</th>
<th>All people</th>
<th>Owner occupied</th>
<th>Rented from council</th>
<th>Other social rented</th>
<th>Private rented or living rent free</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>No. %</td>
<td>No. %</td>
<td>No. %</td>
<td>No. %</td>
</tr>
<tr>
<td>16 to 24</td>
<td>31498</td>
<td>9968 32%</td>
<td>4025 13%</td>
<td>2179 7%</td>
<td>15326 49%</td>
</tr>
<tr>
<td>25 to 34</td>
<td>74127</td>
<td>35272 48%</td>
<td>5252 7%</td>
<td>2884 4%</td>
<td>30719 41%</td>
</tr>
<tr>
<td>35 to 44</td>
<td>40713</td>
<td>24860 61%</td>
<td>5521 14%</td>
<td>3730 9%</td>
<td>6602 16%</td>
</tr>
<tr>
<td>45 to 49</td>
<td>11708</td>
<td>8199 70%</td>
<td>1535 13%</td>
<td>884 8%</td>
<td>1090 9%</td>
</tr>
<tr>
<td>All ages</td>
<td>255,974</td>
<td>135301 53%</td>
<td>37042 14%</td>
<td>19072 7%</td>
<td>64559 25%</td>
</tr>
</tbody>
</table>

Source: Census 2001

The majority of young people, between 16 and 24 either privately rent or live rent free (49%), in the next age group up 25 to 34 this percentage has dropped slightly to 41%, however the percentage living in owner occupied accommodation has increased to 48%. This trend continues through the next two age groups. The 25-34 age group has the lowest percentage of people renting from the council (7%). This perhaps reflects the fact that young people that have moved to the area already have employment.

#### Figure 2: Ethnic Composition of the 65+ population of Wandsworth (27,149 residents), 2001

Source: Census 2001

Figure 2 shows that amongst the 65+ population in Wandsworth, 74% categorise themselves as White, 5% White Other, 6% Irish and 15% Non-White. The largest Non White group in the 65+ age group are Black Caribbean at 6%.

Wandsworth has a resident population of people 65 and over of 27,149. This represents 10% of all residents of Wandsworth. For the population that is 65 and over, the non-white population accounts for 14.8%. The non-white section can be broken down into 7.5% of the older population being Black or Black British, and 5.1% being Asian or Asian British. The remainder of the older population falls within the Mixed, or Chinese/Other categories, which together account for the remaining 2.2% of the older population.
The highest percentage of lone pensioners appear to be in the Roehampton ward (18.8%) and the West Putney ward (16.8%). These form part of the Putney and Roehampton locality. The percentage of lone pensioners presented in this way may be due to the ability to live independently. We do not have information on social isolation resulting from this.

Table 2: Mortality- Causes of death for age 65+

(Top 5 causes of death)

<table>
<thead>
<tr>
<th>Diagnoses (ICD10 codes)</th>
<th>Frequency</th>
<th>% of pop</th>
</tr>
</thead>
<tbody>
<tr>
<td>J18- pneumonia, organism unspecified</td>
<td>162</td>
<td>9.5</td>
</tr>
<tr>
<td>I25- chronic ischaemic heart disease</td>
<td>157</td>
<td>9.2</td>
</tr>
<tr>
<td>I21- acute myocardial infarction</td>
<td>145</td>
<td>8.5</td>
</tr>
<tr>
<td>I64- stroke, not specified as haemorrhage or infarction</td>
<td>122</td>
<td>7.2</td>
</tr>
<tr>
<td>C34- malignant neoplasm of bronchus and lung</td>
<td>92</td>
<td>5.4</td>
</tr>
</tbody>
</table>

Source: Clearnet 2001

Table 2 shows the causes of death for ages 65+. A substantial proportion of mortality from Chronic Ischaemic heart disease occurs in the Asian ethnic group. Similarly, a considerable number of deaths that result from strokes occur in people of Afro Caribbean descent.
Figure 4 illustrates the number of asylum seekers who registered in Wandsworth in 2003. In this year the total number of asylum seekers in the Borough was 281. Earlsfield had the highest number of asylum seekers in Wandsworth (41) compared to Wandsworth Common, which only had one asylum seeker. The graph shows the wide variations between wards concerning the number of asylum seekers registered.
1.4 Ethnicity

Figure 5 shows the ethnic composition of the population of Wandsworth as described by the residents. Sixty-five per cent of the population of Wandsworth described themselves as White British. In England, as a whole, 87% classified themselves in this category and London 60%. Wandsworth has over 3 times the national (E&W) average of White Other residents and over twice the national average of White Irish.

The largest non-white ethnic group in Wandsworth was Black Caribbean (4.9%). In London 4.8% classified themselves in this group and England & Wales 1.1%. The largest non-white ethnic group for London was Indian (6.1%). Evidence suggests that there are particular health conditions that are more prevalent within these ethnic groups such as hypertension and diabetes (see section 4 (D)).

**Figure 5: Ethnic Composition of the Population of Wandsworth, 2001**

Due to the changes in the categories it is not possible to compare this data with that collected in the previous census (1991). However, population projections for 2001 from the Greater London Authority predicted that 25 per cent of the Wandsworth population would be non-white.

Source: Census 2001
Figure 6: Percentage of Asian or Asian British in Wandsworth Wards, 2001

Figure 6 illustrates that the wards Tooting and Gravency have the highest percentage of the ethnic group ‘Asian and Asian British’. The map shows that a large percentage of the Asian population occupy the South Eastern section of the Borough of Wandsworth. This gives some indication of where current and future health activities should be targeted that are appropriate to this group. (See Appendix 3.)
Figure 7 illustrates that the ward Latchmere has the highest percentage of the ethnic group ‘Black or Black British’. Queenstown and Furzedown also have a high percentage of this ethnic group. Again this shows areas of the Borough requiring culturally appropriate activities. (See Appendix 3.)
2. Standardised Mortality Ratios (SMR) and Life Expectancy
2. Standardised Mortality Ratios and Life Expectancy

2.1 General
For the years 1998-2002 the SMRs for all causes of deaths for the under 75 years old in Wandsworth is 115. Whilst it is the highest in the sector, it is ranked as the 6th lowest compared with the 14 Inner Boroughs of London (Figures 8 and 9).

Figure 8: Standardised mortality ratios for all causes, persons under 75, Inner London Boroughs 1998-2002

Source: ONS death registration data, 2001 Census populations

Further analysis of the data by wards shows wide variations between different wards within Wandsworth which reflects the level of deprivation (See Figures 10a, b, c). Lower life expectancy also reflects the level of ward deprivation.

Figure 9: Standardised mortality ratios for all causes, persons under 75, South West London sector 1998-2002

Source: ONS death registration data, 2001 Census populations
Figure 10a: SMRs by wards, all causes, persons, all ages, 1998-2002 for the Borough of Wandsworth

Standardised mortality ratios by wards, all causes, persons, all ages 1998-2002 for the Borough of Wandsworth

Source: ONS death registrations, 2001 Census Population
Figure 10b: Male life expectancy at birth by wards for the Borough of Wandsworth

Male life expectancy at birth by wards for the Borough of Wandsworth

- More than 2 years higher than London (3)
- 0-2 years higher than London (1)
- Not significantly different from London (2)
- 0-2 years lower than London (5)
- More than 2 years lower than London (2)

Source: ONS death registrations, 2001 Census Population
Figure 10c: Female life expectancy at birth by wards for the Borough of Wandsworth

Female life expectancy at birth by wards for the Borough of Wandsworth

- More than 2 years higher than London
- 0-2 years higher than London
- Not significantly different from London
- 0-2 years lower than London
- More than 2 years lower than London

Source: ONS death registrations, 2001 Census Population


2.2 Deprivation

Deprivation data published by the Office of the Deputy Prime Minister across London shows tremendous improvements in living standards in Wandsworth compared to other Boroughs in Inner London (See Figure 11).

Figure 11: Deprivation in London (Index of Multiple Deprivation, 2004)
The above map of the Borough shows those areas which fall within the worst 25% of "super output areas" (national clustering of a similar tenure). There are problems with this Index as we think it is skewed by the presence of large institutions, for example in the West Hill ward we have the Royal Hospital For Neuro Disability and in Queenstown ward there is Battersea PowerStation.
### Table 3: Rented housing in Wandsworth by ward, 2001

<table>
<thead>
<tr>
<th>WARD</th>
<th>RENTED FROM: COUNCIL (LOCAL AUTHORITY)</th>
<th>RENTED FROM: HOUSING ASSOCIATION/REGISTERED SOCIAL LANDLORD</th>
<th>RENTED FROM: PRIVATE LANDLORD OR LETTING AGENCY</th>
<th>RENTED FROM: OTHER</th>
<th>TOTAL</th>
<th>RATE/POPULATION PER 100</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queenstown</td>
<td>1,750</td>
<td>797</td>
<td>1,272</td>
<td>225</td>
<td>4,044</td>
<td>32.34</td>
</tr>
<tr>
<td>Latchmere</td>
<td>2,714</td>
<td>312</td>
<td>775</td>
<td>216</td>
<td>4,017</td>
<td>31.89</td>
</tr>
<tr>
<td>St. Mary's Park</td>
<td>1,250</td>
<td>505</td>
<td>1,313</td>
<td>200</td>
<td>3,268</td>
<td>26.37</td>
</tr>
<tr>
<td>Roehampton</td>
<td>2,337</td>
<td>247</td>
<td>563</td>
<td>194</td>
<td>3,341</td>
<td>25.68</td>
</tr>
<tr>
<td>Shaftesbury</td>
<td>452</td>
<td>1,136</td>
<td>1,280</td>
<td>167</td>
<td>3,035</td>
<td>24.35</td>
</tr>
<tr>
<td>Bedford</td>
<td>249</td>
<td>763</td>
<td>1,760</td>
<td>148</td>
<td>2,920</td>
<td>22.43</td>
</tr>
<tr>
<td>Fairfield</td>
<td>470</td>
<td>631</td>
<td>1,370</td>
<td>201</td>
<td>2,672</td>
<td>22.20</td>
</tr>
<tr>
<td>East Putney</td>
<td>585</td>
<td>288</td>
<td>1,671</td>
<td>280</td>
<td>2,824</td>
<td>21.40</td>
</tr>
<tr>
<td>Tooting</td>
<td>707</td>
<td>368</td>
<td>1,479</td>
<td>245</td>
<td>2,799</td>
<td>21.10</td>
</tr>
<tr>
<td>Earlsfield</td>
<td>683</td>
<td>457</td>
<td>1,239</td>
<td>278</td>
<td>2,657</td>
<td>20.59</td>
</tr>
<tr>
<td>Graveney</td>
<td>626</td>
<td>408</td>
<td>1,423</td>
<td>174</td>
<td>2,631</td>
<td>19.91</td>
</tr>
<tr>
<td>West Hill</td>
<td>1,458</td>
<td>156</td>
<td>1,064</td>
<td>166</td>
<td>2,844</td>
<td>19.81</td>
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<tr>
<td>West Putney</td>
<td>1,242</td>
<td>144</td>
<td>799</td>
<td>224</td>
<td>2,409</td>
<td>18.99</td>
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<tr>
<td>Nightingale</td>
<td>246</td>
<td>583</td>
<td>1,578</td>
<td>158</td>
<td>2,565</td>
<td>18.93</td>
</tr>
<tr>
<td>Thamesfield</td>
<td>324</td>
<td>221</td>
<td>1,553</td>
<td>178</td>
<td>2,276</td>
<td>18.44</td>
</tr>
<tr>
<td>Balham</td>
<td>403</td>
<td>398</td>
<td>1,361</td>
<td>178</td>
<td>2,340</td>
<td>18.22</td>
</tr>
<tr>
<td>Northcote</td>
<td>188</td>
<td>686</td>
<td>1,276</td>
<td>169</td>
<td>2,319</td>
<td>18.05</td>
</tr>
<tr>
<td>Southfields</td>
<td>642</td>
<td>342</td>
<td>1,267</td>
<td>141</td>
<td>2,392</td>
<td>17.01</td>
</tr>
<tr>
<td>Furzedown</td>
<td>523</td>
<td>507</td>
<td>1,070</td>
<td>172</td>
<td>2,272</td>
<td>16.78</td>
</tr>
<tr>
<td>Wandsworth Common</td>
<td>318</td>
<td>435</td>
<td>895</td>
<td>177</td>
<td>1,825</td>
<td>13.46</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>17,167</strong></td>
<td><strong>9,384</strong></td>
<td><strong>25,008</strong></td>
<td><strong>3,891</strong></td>
<td><strong>55,450</strong></td>
<td><strong>21.30</strong></td>
</tr>
</tbody>
</table>

Source: Census 2001

The wards Queenstown and Latchmere in the Battersea locality are located in high areas of deprivation and show a high rate of rented accommodation, similarly the Roehampton ward in the Putney and Roehampton locality.
2.3 Data Analysis

The data presented on SMRs and Life Expectancies are based on the aggregate of 1998 to 2002 death figures. Furthermore, our low life expectancy is based on comparisons within the sector (SW London) where all but Wandsworth are outer London and have a different population make-up in terms of structure, mobility, wealth and life-styles. When compared with other Inner London Boroughs, Wandsworth rank is totally different than that compared within SW London sector (see Figures 13, 14, 15 and 16).

Figure 13: Male life expectancy, Inner London Boroughs, 1998-2002

Source: ONS death registration data, 2001 Census populations

Figure 14: Male life expectancy, South West London sector, 1998-2002

Source: ONS death registration data, 2001 Census populations
Figure 15: Female life expectancy, Inner London Boroughs, 1998-2002

Source: ONS death registration data, 2001 Census populations

Figure 16: Female life expectancy, South West London sector, 1998-2002

Source: ONS death registration data, 2001 Census populations
3. Possible Explanations of Low Life Expectancy in Wandsworth
3. Possible Explanations

Taking into account the rapidly changing nature of our population living and working in Wandsworth the following may explain some of the possible reasons for the low life expectancies:

- The life expectancy calculation is based on the assumption that the current age specific mortality rate applied for the period 1998-2002 will continue, without taking into account a major population shift in particular:
  1) The young age group and especially those between 20-44 (53.7%)
  2) The high percentage of mobility (around 30% a year)
  3) The relatively high percentage of refugees and asylum seekers with health problems that reflect the country of origin.

- HMP Wandsworth is located in the Borough and is the second largest remand prison in London with a high percentage of turnover. In 2002, seven suicides were reported at the prison.

- The central location, housing market and the nature of our population (young, highly mobile, single and living alone) has an influence on who chooses to live in Wandsworth and their style of living.

- There are large variations with the number of registrations between GP’s. Residents make higher use of hospital accident emergency treatment and the Walk-In-Centre located at St George’s Healthcare Trust.

- In line with other Inner London areas, Wandsworth absorbs a relatively high percentage of refugees and asylum seekers which in turn causes high-risk behavioural factors and mental health needs due to the adaptation and simulation required by this vulnerable group.

- More than 22% of population are from mainly Asian and Black ethnic backgrounds with a relatively high prevalence of diabetes and hypertension; two major risk factors for CHD and Strokes.

- The high levels of smoking amongst young adults and the well documented resistance to change. (Please see smoking section)

- The high levels of social pressures and isolation will effect the mental well being of many individuals. This can then be compounded by constant relocation, instability and lack of continued support mechanisms which may result in depressive illnesses. This is the main cause of suicide and other mental health problems.

The changing needs of the Wandsworth population and the impacts to local services are highlighted in the Director of Public Health’s document “Changing Population, changing needs” (See www.wandsworth-pct.nhs.uk)
4. Measures to Tackle Health Inequalities in Wandsworth
4. Measures to tackle inequalities locally

All strategic and operational activities of the PCT for both commissioning and providing services are focused on improving health, reducing inequalities and securing health for the whole population. Wandsworth Primary Care Trust has a key role in representing the NHS in local strategic planning arrangements around health improvements and inequalities and the development of partnerships with key local agencies. This is articulated through local PCT strategic plans, as well as the active participation in Local Strategic Partnerships, including partnership arrangements in the formulation of the health chapters in the Community Strategy. Most of these activities are outlined in our delivery plans (see 2004/5 ADP [www.wandsworth-pct.nhs.uk](http://www.wandsworth-pct.nhs.uk)). Wandsworth Community Strategy and Wandsworth Neighbourhood Renewal Action Plan (see [www.wandsworth.gov.uk](http://www.wandsworth.gov.uk)) have incorporated many actions to address inequalities through tackling the wider determinants of health. The vision has been developed and endorsed by all members of the Local Strategic Partnership.

Works developed so far and those in progress include:

4.1 Strategy Development:

- Primary Care Strategy
- Smoking Cessation and Prevention Strategy
- Sexual Health Strategy (July 2004 first draft)
- CHD Plan of Actions
- Mental Health Promotion and Suicide Prevention Strategies
- Cervical and Breast Screening Programmes (SW London Cancer Network)
- Teenage Pregnancy Strategy
- Drug Action Plan (DAT)
- Physical Activity Strategy
- Food & Health Strategies
- Participatory Health Needs Implementation Plan
- Healthy Schools Action Plan
- Primary Care Commissioning Group
- WPCT Strategy Group
- Wandsworth Community Strategy
- Wandsworth Neighbourhood Renewal Plan
- Prison Health Plan
- WPCT 10 Year Strategy

4.2 Specific areas of Action

(a) Smoking prevalence/quit rates. (As part of a comprehensive Tobacco control plan in Wandsworth)

The 2003-2006 target for Wandsworth is 4,279; the target for 03/04 was 515. Figure 17 shows trajectory for 2003–2006

The trajectory shows that substantial improvement has taken place during the last year and is reflected in the last two quarter figures for 04/03 which have shown a doubling and trebling of quitters on previous quarters. See Table 4. Table 4 (b) shows that Wandsworth has achieved 63% of the 03/04 target.
Figure 17: Number of four-week quitters through Smoking Cessation Services

Table 4: Performance for 2003-2004

(a)

<table>
<thead>
<tr>
<th>PCT</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
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<tbody>
<tr>
<td>Wandsworth</td>
<td>46</td>
<td>33</td>
<td>64</td>
<td>181</td>
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</tbody>
</table>

(b)

<table>
<thead>
<tr>
<th>PCT</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
<th>2003-04</th>
<th>Target 2003/04</th>
<th>Performance against target</th>
<th>% of 2003-06 target achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sutton &amp; Merton</td>
<td>99</td>
<td>62</td>
<td>102</td>
<td>291</td>
<td>554</td>
<td>950</td>
<td>58%</td>
<td>10%</td>
</tr>
<tr>
<td>Wandsworth</td>
<td>46</td>
<td>33</td>
<td>64</td>
<td>181</td>
<td>324</td>
<td>515</td>
<td>63%</td>
<td>8%</td>
</tr>
</tbody>
</table>

Action Plans to Improve Quitting Rates

Specific plans are in place to improve the quit rates of our very diverse population, over seen by strategy group set up in July 03. An action plan is being developed as a working document to ensure that activities focusing on tackling smoking are mapped out, targeted and monitored. (Appendix 1.) Sub groups of the strategy group have also been developed to take forward aspects of the action plan. Current works include:

- Development of training courses.
- GP practice development to undertake smoking cessation as integral part of service.
- Pharmacist developmental work to undertake smoking cessation services (including refresher courses).
- Preparation for the Tobacco control conference in the autumn.
- Work with the media to increase public awareness in particular the availability of smoking cessation services.
Furthermore intensive work is invested in the following areas:

- Targeting those areas with high prevalence of smoking and high incidence of lung cancer and coronary heart disease, (these are outlined in earlier figures)
- Targeting secondary care services with particular emphasis on staff and opportunistic services for smokers visiting outpatient services or admitted to hospital. (The Department of Addictive Behaviour is running a project on providing smoking cessation services to patients admitted to Mental Health Hospitals.)
- Continue with the wider tobacco control agenda and build on the success with some workplaces and businesses to encourage a ban on smoking on their premises.
- We are grateful for the support of the local media in publishing targeted articles on the risk of smoking and other lifestyle behaviours.

Please refer to Appendix 1 for the draft “stop smoking action plan”.

**Smoking Cessation Advisors**

There has been an increase in stop smoking community advisors and a training programme is underway to further increase the numbers from 37 to 144 by 2005 and to 240 in the following year. The aim is to have stop smoking advisors in each GP practice and in other primary care services, such as pharmacists, dentists and family planning. This is to provide a range of access points at primary care level. Advisor training has taken place on the 6th and 7th June and 16th and 17th July. Training programmes area also being planned for August and September (this will initially target pharmacists but will also extend to the wider primary care team) and another planned for November/December, and in particular for advisers to target the entertainment industry (restaurants, pubs, clubs).

The revised targets have been set for 05/06 (see below). The 04/05 target is 2070. This provides a very challenging target for the PCT to meet. A summary of key actions on how the PCT aims to achieve this is with determination is outlined on page 34.

<table>
<thead>
<tr>
<th>PCT</th>
<th>Jun03</th>
<th>Sep03</th>
<th>Dec03</th>
<th>Mar04</th>
<th>Jun04</th>
<th>Sep04</th>
<th>Dec04</th>
<th>Mar05</th>
<th>Jun05</th>
<th>Sep05</th>
<th>Dec05</th>
<th>Mar06</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wands</td>
<td>83</td>
<td>191</td>
<td>332</td>
<td>515</td>
<td>647</td>
<td>966</td>
<td>1530</td>
<td>2395</td>
<td>2527</td>
<td>2847</td>
<td>3412</td>
<td>4279</td>
</tr>
</tbody>
</table>

**Source:** SWL SHA

Brief intervention training has already taken place within GP practices and others are scheduled during the summer. These will be targeted in practices with new advisors to ensure the quality of referrals and help to increase success rates. Brief intervention training targeting all primary care professionals, linked to motivational training and clinical governance is also proposed in the longer term. This will help to raise the awareness of the service and also ensure that smokers going through the service are ready to quit and will help to improve the success rate of the service. Brief intervention training for pharmacy counter assistants and receptionists is also being planned.

**Targeting high prevalence areas**

The numbers of stop smoking community advisors have been mapped across Wandsworth in order to match against deprivation and those areas with high rates of cancer and CHD, (see figure 18 and 19). This will enable the targeting of advisor training programme. (Community advisors attending training in June and July are to be added to the map). Additionally, practices in these areas will be encouraged and supported to offer smokers on their lists the help, advice and service they need. Discussions are taking place with the out patients cardiac departments at Queen Mary’s Hospital in Roehampton, who are keen to develop a smoking cessation clinic. Information on those eligible for free prescriptions are to be broken down by age, gender, ethnicity and postcode in order to give an overview of those in lower social class attending the service.
Figure 18: Location of Smoking Cessation Advisors in Wandsworth and Deprivation Scores

Source: MSW Smoking Cessation Service. Produced by: Belinda Myles, PHI, South West London
Figure 19: Cancer and CHD Standard Mortality Ratios and Deprivation Scores

Source: MSW Smoking Cessation Service. Produced by: Belinda Myles, PHI, South West London
Targeting Diverse Population

It is acknowledged that initiatives to target stop smoking activities must be appropriate to the diversity of Wandsworth population groups. For example the 20 – 44 year olds make up 53.7% of the population. Many in this group will not have a high attendance at GP practices. However pregnant women may be the exception to this. Those in this age group will require services that are quick and accessible and out of normal working hours. Therefore, wider public health measures are needed, to include targeting social venues eg pubs, restaurants and workplaces. Ramadan offers an excellent opportunity to link smoking cessation to the fasting period for Muslims. Smoking linked to chronic disease prevention and treatment pathways will have some impact on the encouragement of older smokers to quit. Strategies to tackle some of these issues will be posed at a stop smoking workshop scheduled for the autumn.

Visiting GP Practices

Practice visits and interviews have taken place with GPs and other practice staff to determine barriers and to encourage referrals. The interviews uncovered a poor understanding of the service, mixed understanding of the evidence base on smoking cessation and little up to date knowledge amongst those interviewed. The interviews also found that GPs wanted feedback on their patients seen by the service and that having an advisor based in the practice would make referrals simpler. A General Practitioner with Specialist Interest in smoking cessation is being appointed whose role will include the development of the evidence base for GPs and the wider primary care team, including training and development. This is outlined in the action plan to take place in the autumn. Work is also under way on the development of a local enhanced service targeting smoking cessation and a protocol for referral linked to the quality and outcomes framework.

New Database

A new database and monitoring system has been introduced which provides up to date information on the current picture. GPs will now be sent quarterly notification of patients seen by the service and a league table of practices by patients seen by the service will be put in place to give an overview of practice referrals and service take up by locality. Monthly monitoring sheets have been developed to provide regular updates to the management team, PEC and Board. The PCT has also employed Price Waterhouse Cooper to review the information systems within the service. This will hopefully identify ways in which the data and monitoring system can be improved. The service has experienced some problems with the late returns of client files and low activities amongst some stop smoking community advisors. New contracts have been introduced which states a minimum of 40 clients to been seen annually per advisor. The introduction of locality co-ordinators outlined below will help to ensure that stop smoking community advisor activities are monitored and client files returned in time.

Smokers Survey

A recent survey indicated that a good percentage of the population quit smoking either after one visit to their GP or through self-motivation without going through the counselling services. Unfortunately this additional data is not allowed by the DoH to be included in our statistics at the present time. This is simply because of the rigid definition of the four week quitters (i.e. they have to have completed the 4-6 counselling sessions) A local smoking survey is underway targeting the general public; results will be used to develop the service in line with local expressed need.

Smoking Action Plan

The WPCT PEC, Management Team, and Board have endorsed the stop smoking action plan, which includes the range of measures being taken to reduce smoking incidence and prevalence. These include a Patient Group Directive for pharmacists, which is in the process of being drafted. A pilot dental referral programme, a pilot stop smoking programme in Wandsworth prison, which will begin in
August. The implementation of stop smoking and physical exercise sessions, a stop smoking stakeholder workshop planned for the autumn, and the development of a tobacco plan are outlined below.

### Outline Tobacco Plan

- Health education to increase awareness in the general public, including targeting at risk groups, workplaces.
- Promote smoke free places e.g. bars pubs, clubs and restaurants.
- Target passive smoking and the development of health and safely guidelines for second hand smoke in the work place and enclosed spaces.
- Targeting young people including illegal sales of tobacco to minors, also work with schools and colleges on no smoking policies.
- Enforcing the law on advertising.
- Development of no smoking objectives in the development of new regeneration initiatives.
- Inclusion of no smoking policies in the provider/service contracts.
- Development of stop smoking advisor training programmes for statutory and non-statutory staff and for community members.
- Development of work place programme to support staff that wish to give up.

### Locality Co-ordinators

A stop smoking report was presented to the Management Team, PEC and Board in May 04. The report proposed the development of a locality structure, linked to the graded development of a Wandsworth managed service over the next two years. A locality approach to supporting smokers to stop smoking will compliment the service structure in Wandsworth. The employment of Locality Co-ordinators for each of the localities in Wandsworth will have a role to support and supervise the increase in stop smoking community advisors, also organise training and co-ordinate network meetings within their localities. This will help to ensure that recent improvements are sustained and improved further. Locality Co-ordinators will also have a role to oversee initiatives and work with the wider primary care team, overseeing and developing initiatives outlined in the action plan. Experienced stop smoking community advisors will be given the opportunity to apply for secondment to these posts. A job description has been drafted. It is hoped that posts will be filled by December. It is proposed that one of the current clinic counsellors provides a mentoring/supervisory role, depending upon the experience of the locality co-ordinators employed also to support the programme of development which focuses on the particular needs of Wandsworth’s population.

The action plan includes the development of group work skills for experienced community advisors. This will increase the numbers of group session run in Wandsworth, which have shown to have a higher success rate. In the short term more groups are to be targeted in each locality.

### Continuous Improvement

It is important that the development of a Wandsworth service does not jeopardise recent improvements. A time table will be put together to ensure systems, protocols and management structures are in place before there is any separation from the hosted service by Sutton and Merton PCT. The employment of Locality Co-ordinators is one step towards this process and to ensuring cessation activities are maintained during changes in the service management. Careful consideration
will be given to the change management for staff and the process followed. The human resources department in both PCTs are involved to ensure that staff needs are taken on board during changes.

**Smoking and pregnant women**

A 1% reduction year on year is the target set for smoking in pregnancy. The current figures are slightly lower than the target (Table 5). The present system does not collect or record data in a uniform way. Information is patchy and the smoking status of many women is not recorded. Thus, the true picture is not known.

**Table 5: Baseline information for smoking during pregnancy**

<table>
<thead>
<tr>
<th></th>
<th>2004 plan</th>
<th>2004 actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of maternities</td>
<td>3,761</td>
<td>2281</td>
</tr>
<tr>
<td>Number of women known to be smokers at the time of delivery</td>
<td>338</td>
<td>345</td>
</tr>
<tr>
<td>Percentage of women who continue to smoke throughout pregnancy</td>
<td>9.0%</td>
<td>15.1%</td>
</tr>
<tr>
<td>Annual percentage decrease (year on year change)</td>
<td>1.3%</td>
<td>-6.1%</td>
</tr>
<tr>
<td>Number of women with smoking status not known at time of delivery</td>
<td>354</td>
<td>8</td>
</tr>
<tr>
<td>Percentage of women whose smoking status was not known at time of delivery</td>
<td>9.4%</td>
<td>0.4%</td>
</tr>
</tbody>
</table>

Currently 0.5 FTE post covers 3 Boroughs and is insufficient to meet Wandsworth’s requirements. The stop smoking report presented to the Board recommended the employment a 0.5 FTE Wandsworth post, which includes an objective to improve data collection. A Wandsworth smoking in pregnancy post will help to highlight specific problems and facilitate a co-ordinated systematic method of data collection, which also includes breast-feeding, and teenage pregnancy information, as well as supporting women who smoke during pregnancy and mothers who smoke. Meetings have taken place with the St Georges Maternity Unit to discuss these issues. A draft job description has been put together for a public health nurse consultant for consideration. Contact will be made with St Georges hospital lead nursing team to discuss how they can encourage and support patients and staff to give up. The Public Health Department has also recently appointed an information analyst who will have a key role to lead on the development of common data sets between the Trusts and the PCT, for information on smoking in pregnancy, breast-feeding and teenage pregnancy. The birth notification sheet used by Croydon PCT will be used as an example of good practice. This piece of work will also feed into a PCT information group being developed.
**Achieving targets**

Below is a summary how the PCT aims to achieve the target set for 04/05. This is only a summary and should be considered in co-ordination with of a wider public health approach which includes the development of tobacco plan.

### Summary of key actions to meet targets

1. **Improve on the current quit rate by:**
   - Monitoring the individual success rate of community advisors and providing professional support to those under achieving.
   - Employ locality stop smoking advisors to support community advisors and practices and then develop a wider public health role.
   - Provide feedback to GPs on clients seen by the service and the outcome in order to encourage more referrals.
   - Provide refresher and support sessions for current community advisors.

2. **Raise awareness of smoking and health:**
   - Through the local media by using a segmented approach to target population groups and to encourage self referral.
   - Advertising local stop smoking community advisors in local papers.
   - Continue the targeting of brief intervention sessions in practices and with other professional groups.
   - Piloting brief intervention sessions with community members.

3. **Increasing access points for smokers by:**
   - Expanding the numbers of community advisors by approximately 25 per quarter = 100 new community advisors plus 40 current advisors giving a total of 140 by March 05.
   - Supporting and developing the skills of experienced community advisors e.g. providing group skills training. (6-8 clients per group).
   - Contract community advisors to see a minimum of 40 clients per annum. This will provide a potential capacity of 140*40=5,600 clients. *(Note this will be a graded increase as new advisors are trained).*
   - Target one, stop smoking group session in each of the three locality per quarter 25 - 50 clients.
   - Implement and monitor the prison stop smoking programme.
   - Implementation of stop smoking clinic at the cardiac out-patient department at Queen Mary’s hospital.

4. **Increase referrals by**
   - Developing a local enhanced service.
   - Developing a referral pathway linked to the Quality and Outcomes Framework.
   - Develop clinical referrals through secondary care.
   - Encourage self-referrals to the service as mentioned above.

5. **Focus on areas of deprivation and those with high CHD and lung cancer rates**
   - Target practices with advisors in high-risk areas to invite smokers to consider smoking cessation support.
   - Work with local Mosques to encourage smoking cessation during Ramadan.
   - Develop and target life style courses e.g. weight management exercise mental health and smoking.
a. Smoking is a major risk to health. The risk is much higher if it is associated with other risk factors (obesity, diabetes, high cholesterol, lack of exercise, high blood pressure). However, it is not a disease and smokers should not be labelled as such. They need “help” and support and the medical models (services etc) may not be suitable to deal with risks to health in healthy or apparently healthy individuals or populations.

b. While it is essential to achieve the national targets for the four week quitters by all means, it is essential to recognise that without a comprehensive and targeted tobacco control in Wandsworth, the gaps in the inequalities in health cannot be reduced. Hence, our commitment and energies will continue to escalate to tackle this major risk to health.

c. It is essential to re-iterate the assertion of the DPH that with the nature of our population (young adult, mobile, risk taking etc), general practice based services will NOT be the only solution to tackle the high prevalence of smoking. It is essential that we have diverse services that are available in all walks of young adult life in Wandsworth (workplaces, pubs, restaurants, clubs, train stations, and other public places).

d. Our aim is to achieve improvement in the health of the Wandsworth population. Participation of all partners is essential. Public wide measures are part of the processes to achieve this aim. Banning smoking in public places is one of these measures and it is an integral part of our tobacco control plan. It is fully supported by the majority of the public as evident in their responses to the choosing health public consultation document (please visit our website for more details on the wider public response www.wandsworth-pct.nhs.uk)
(b) Cancer

**Main Cancers**

The two main cancers in Wandsworth, which are higher than England and Wales averages, are cancer of the Lung and Colorectal cancers. The main risks for cancer are smoking and diet. Figure 20 shows the SMR’s by ward for all types of cancer plotted on a map showing wards. Activities outlined under tobacco control and smoking cessation will contribute to the reduction of inequalities in this area.

**Figure 20: Standardised Mortality Ratios by wards for all cancers, persons <75, 1998-2002 for the Borough of Wandsworth**

Figure 20 illustrates that Wandsworth Common, Nightingale and Graveney wards have the lowest number of deaths from cancer during the four-year period.

**Source: London Health Observatory**
Figure 21: Trends in Incidence of Breast Cancer, 1993-1999

Figure 21 shows that in the year 1995, Wandsworth had the highest standardised registration ratios (SRR) in comparison with London, England and Wales. Since then the SRR for Wandsworth has remained higher compared to London and the United Kingdom.

Figure 22: Trends in Incidence of Cervical Cancer in Females, 1993-1999

Figure 22 illustrates that since 1993 the SRR for cervical cancer in Wandsworth has been higher than the London figures, although it has been steadily decreasing with the exception of 1998.
Figure 23: Trends in Incidence of Lung Cancer, 1993-1999

Figure 23 illustrates that since 1993 the SRR for lung cancer in Wandsworth has been higher than the London and England figures.

Figure 24: Trends In Incidence of Prostate Cancer in Men, 1993-1999

Figure 24 illustrates that since 1996 the prostate cancer SRR has been gradually increasing in Wandsworth.
Figure 25: Trends In Incidence of Stomach Cancer, 1993-1999.

Figure 25 illustrates that since 1996 the SRR for stomach cancer in Wandsworth has been decreasing.

Table 6: Number of deaths from Malignant Neoplasms (ICD 10 C00-C97), Wandsworth, 2002

<table>
<thead>
<tr>
<th>MALIGNANT NEOPLASM (ICD 10 - C00 - C97)</th>
<th>NUMBER OF DEATHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Digestive organs</td>
<td>135</td>
</tr>
<tr>
<td>Respiratory and intrathoracic organs</td>
<td>122</td>
</tr>
<tr>
<td>Ill defined, secondary and unspecified sites</td>
<td>40</td>
</tr>
<tr>
<td>Lymphoid, haematopoietic &amp; related tissue</td>
<td>40</td>
</tr>
<tr>
<td>Breast</td>
<td>36</td>
</tr>
<tr>
<td>Male genital organs</td>
<td>30</td>
</tr>
<tr>
<td>Urinary tract</td>
<td>21</td>
</tr>
<tr>
<td>Female genital organs</td>
<td>20</td>
</tr>
<tr>
<td>Mesothelial and soft tissue</td>
<td>9</td>
</tr>
<tr>
<td>Eye, brain &amp; other parts of CNS</td>
<td>9</td>
</tr>
<tr>
<td>Lip, oral cavity and pharynx</td>
<td>6</td>
</tr>
<tr>
<td>Melanoma and other skin</td>
<td>5</td>
</tr>
<tr>
<td>Independent (primary) multiple sites</td>
<td>3</td>
</tr>
<tr>
<td>Bone and articular cartilage</td>
<td>1</td>
</tr>
<tr>
<td>Thyroid and other endocrine glands</td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>478</strong></td>
</tr>
</tbody>
</table>

Source: ONS 2002

The above table shows that the highest number of deaths occurring in Wandsworth are of the digestive organs and respiratory systems. Both these conditions will be influenced by lifestyle factors such as diet, alcohol intake, and smoking.
**Prevention**

Nutritional, physical activity and weight management initiatives have the potential to have a marked impact on cancer prevention. Information on local practical work relevant to cancer prevention is detailed within the CHD & Stroke section of this report (see later).

Wandsworth PCT provides Cervical & Breast Screening services based on the National guidelines. The Breast Screening Service is provided on a sector-wide basis. There is an identified screening commissioner and the sector group is working on extending the age range of women invited for screening subject to funding being available.

The sector also has an identified screening commissioner for cervical screening. Wandsworth PCT has recently set up a PCT Cervical Screening Committee to monitor the various strands of the programme. This committee is working towards changing the age band and frequency of screening and the introduction of Liquid Based Cytology as per the Pan London plan. It is our plan to target practices with low uptake of screening services. Both these services provide information in different languages to enable the local population to understand the services offered.

Funding has been obtained to develop a cervical screening video for Somali women, and the Public Health Department is taking this forward.

One of the localities is doing an audit of cervical screening and there are plans for the other localities to take part.

Figure 26 shows the cytology coverage for Wandsworth, 2003 - 2004. Only two practices have less than 50% uptake. The majority of the practices have more than 50% uptake. The locality staff are in the process of targeting practices that do not meet the 80% coverage required.
Figure 26: Cervical Cytology Coverage for Wandsworth, 2003 – 2004

Wandsworth Special Output Areas with Deprivation Levels based on 2001 Census Data

Source: Primary Care Agency, South West London Produced by: Belinda Myles, PHI, South West London
(e) Coronary Heart Disease and Stroke

**LDP Targets for Coronary Heart Disease**

The LDP targets are:

- Improve access to services across the patient pathway and increase patient choice by achieving the two week wait standard for Rapid Access Chest Pain Clinics;
- Setting local targets to make progress towards the NSF goal of a 3 month maximum wait for angiography; and delivering maximum waits of 3 months for revascularisation by March 2005, or sooner if possible
- Deliver a ten percentage increase per year in the proportion of people suffering from a heart attack who receive thrombolysis within 60 minutes of calling for professional help
- In primary care, update practice-based registers so that patients with CHD and diabetes continue to receive appropriate advice and treatment in line with NSF standards.
- By March 2006, ensure practice based registers and systematic treatment regimes, including appropriate advice on diet, physical activity and smoking, also cover the majority of patients at high risk of CHD, particularly those with hypertension, diabetes and a BMI greater than 30
- Improve the management of patients with heart failure in line with the NICE Clinical Guideline, and set local targets for the consequent reduction in patients admitted to hospital with a diagnosis of heart failure

**Profiling**

A Health Needs Assessment of CHD in Wandsworth is near completion. This exercise quantifies the magnitude of CHD on our population. Furthermore, data exists on the numbers of people on CHD disease registers in primary care. The PCT is looking at how data on clinical management can be extracted from practices across a range of clinical areas. The PCT will be piloting some work on this during the next two months. This will have an impact later on profiling information for CHD. In addition, the public health department are discussing with practices and localities how information can be collected on areas with the greatest numbers of people with CHD. This information could be mapped and compared, along with relevant prescribing data, to inform actions to target the most needy.

**Treatment**

As described above, data exists in primary care on the proportion of patients with established CHD receiving appropriate advice and treatment. How surgeries with a deprived catchment or a higher proportion of patients with established CHD treat their patients could also be further examined if the data becomes available. Data from one GP practice (anonymous) within a designated area of deprivation made available to the department records progress for patients on their CHD register on lifestyle risk factor management (Figure 27), as well as blood pressure and cholesterol management (Figure 28). This shows that records are being collected, however more analysis and investigation is needed to determine outcomes in patients health.
Figure 27: Lifestyle risk factor management within a selected surgery

Source: CHD Facilitators

Figure 28: Cholesterol & Blood Pressure Management within a selected surgery

Source: CHD Facilitators
Wandsworth PCT had the 9th lowest prescribing costs in the UK in 2003 (Prescription Pricing Authority annual report). The PCT spent £2.5 million on lipid lowering drugs in 2003/04, representing a 30% increase on the previous financial year. Comparison of Wandsworth’s spending on drugs relevant to the treatment of CHD showed that in the quarter to September 2003, Wandsworth was below the median for London Primary Care Trusts spending on Statins, ACE Inhibitors and Beta Blockers, but above the median for Calcium Channel Blockers. This comparison is however crude, as it does not account for the different population profiles of each PCT. The Borough of Hammersmith & Fulham is the only close match to Wandsworth for population age profile; the spending on Statins for the two PCTs for the quarter to September 2003 is similar.

Data on the prescribing of lipid lowering drugs and antihypertensives is available for each GP practice in Wandsworth. Further analysis could link this to the numbers of people on GP practice CHD disease registers should this data become available (see above), as well as deprivation and list size.

Prevention

Wandsworth PCT has systematically approached the aspirations set out in the CHD National Service Framework (NSF) for preventing CHD and Stroke. A Physical Activity Strategy and Food and Health Strategy have existed since April 2001, both of which are being updated this financial year (NSF Standard 1). An Obesity Strategy will be developed this year, along with a Green Travel Plan (NSF Standard 1). Action to reduce the prevalence of Smoking (Standard 2) is outlined earlier in this report. Although these strategies were stipulated within the CHD NSF, their implementation will have a broad impact on a range of areas linked to health, including the section on Cancer in this report.

A strategy to target those at high risk of CHD (10 year risk of CHD 30% or greater) through primary care has also been set out. This will enable people at high risk of CHD to join those with established CHD in receiving appropriate care, advice and interventions (Standards 3 & 4). Appropriate advice on diet, physical activity and weight management has been embedded within the PCT’s Angina Management, Hypertension and Hyperlipidaemia Guidelines.

The recording of blood pressure and treatment of high blood pressure is linked to several sections of the Quality & Outcomes Framework (QOF) within the new GP contract. This will enable accurate comparison of the proportion of the population receiving timely care, and those identified will be able to feed into the strategy for targeting people at high risk of CHD. Unfortunately the recording of BMI is only included within the QOF section covering the ongoing management of diabetes, so interrogation of individual GP Practice IT systems will be needed to provide data on recently recorded BMI.

Work is currently underway on a Health Needs Assessment for Coronary Heart Disease (CHD) to estimate the prevalence within the population by age, gender and ethnicity.

Lifestyle action in areas of deprivation

The PCT has two Healthy Living Initiatives (HLIs) targeting marked areas of deprivation in Wandsworth, both of which have programmes for promoting physical activity and healthy eating. Tooting HLI mainly focuses on the ward of Tooting, while Battersea HLI covers the 2001 census wards of Queenstown, Latchmere, St Mary’s Park, Shaftesbury and St John, as well as targeting the estates of Doddington, Winstanley, Surrey Lane and Patmore. 265 people benefited from Tooting HLI’s physical activity programme last year, of whom 88% were from Black and Minority Ethnic
(BME) Groups. Blood pressure support groups for the African and Caribbean community have been established, as well as weight management programmes for the general population. Cook and eat programmes have also been set up for the South Asian community. Physical activity, smoking cessation, healthy eating and weight management are some of the options within the locality’s *Footsteps to Healthy Living* initiative, which enables people to be referred through primary care to access a range of health information sessions – this approach has proved very popular. 587 people benefited from Battersea HLI’s physical activity programme last year, of whom 43% were from BME groups. Battersea HLI also supports a number of community groups offering “Healthy Eating” projects to very disadvantaged groups, complementing the existing “Hearty Eaters” group for those with established heart disease. The PCT was also awarded one of ten Local Exercise Action Pilots (LEAP), targeting deprived wards in Wandsworth to promote walking and cycling. Healthy eating projects are being developed within the two Sure Start projects.

**Specific Healthy Eating actions**
The PCT’s Nutrition and Dietetic Service offers an individual and group service for those referred by primary care staff. Referrals can include those who are obese, have hyperlipidaemia, diabetes and chronic diseases. The Heartbeat award is promoted locally to hospital and workplace canteens and schools to encourage the provision of a wide range of healthy choices for students and staff. The Contract for School meals will soon be re-tendered, providing an opportunity for healthier food in schools.

**Specific Physical Activity actions**
A three year British Heart Foundation Project is examining methods to promote physical activity effectively in primary care targeting people with CHD and diabetes. The project provides physical activity clinics for Battersea residents and 81 members of the primary health care team have been trained in promoting physical activity. The LEAP project is using similar methods to promote physical activity in primary care, but recipients are targeted on the basis of their physical inactivity rather than for their having established disease.

Community based cardiac exercise classes for those progressing from hospital-based rehabilitation programmes are run across the Borough. A specific project has been set up in Putney and Roehampton, creating closer links between the hospital and the community programme.

The PCT’s Older People and Exercise Programme runs a number of initiatives for those with a range of ability. Over 9 months last year there were 3201 attendances at Tai Chi sessions and a recent programme called “Keep on Moving” has proved to be very popular, targeting those aged 70+. Wandsworth Borough Council included two physical activity targets within their Local Public Sector Agreement. The first target focuses on promoting physical activity in schools, encouraging above national average participation in two or more hours of physical education. The second target focuses on promoting swimming and exercise opportunities for those aged over 50. One element of this target covers the implementation of an exercise referral scheme across the Borough which will enable those with specific health problems to have a specialised gym programme in local leisure centres at a subsidised rate. Another aspect will be to establish a network of affordable exercise classes across the Borough set up where older people live (eg sheltered housing) and/or gather (eg day and community centres).
**Combined healthy eating and physical activity actions**
A whole school approach to promoting healthy eating and physical activity is being promoted, through the National Healthy Schools scheme, the National Children’s Fund project and the “5 a day and Youth Sport Trust” being piloted in 10 deprived primary schools and nurseries as well as 6 parent toddler groups in Sure Start areas. A childhood obesity strategy will also be devised in the coming year. Primary care weight management guidelines are to be developed this year as part of the Obesity Strategy. The workplace will be targeted for combined health improvement initiatives.

**Specific Travel Actions**
A Travel plan co-ordinator has been recruited by the PCT to implement a green travel plan for Queen Mary’s Hospital during its redevelopment and to develop a travel plan for the PCT – recruitment of this post is a precedent for London PCTs. These travel plans will be relevant for staff, patients and visitors to NHS sites within Wandsworth. A travel plan is in place for the Borough Council and School Travel Plans are being developed across Wandsworth. Travel Plans have been stipulated within the redevelopments for St John’s Therapy Centre and the Putney Primary Care Centre. St George’s Hospital and Springfield Hospital are also developing travel plans for their sites.

Table 7 demonstrates that GP Practices in Wandsworth have active Disease Registers and regular twelve month reviews are being implemented. However more analysis is required to identify patient demographics.

**Table 7: 2003/2004 – Incidents of CHD recorded in the GP registered population of Wandsworth.**

<table>
<thead>
<tr>
<th>Sub-area</th>
<th>Description</th>
<th>Number</th>
<th>Quality</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>Number of patients with diagnosed CHD identified by practices in the PCT</td>
<td>5514</td>
<td>High</td>
<td>W. South: 2487 Battersea: 1661 P&amp;R: 1366</td>
</tr>
<tr>
<td>Primary Care</td>
<td>Number of patients on register of diagnosed CHD who have been called for review within the last 12 months</td>
<td>3522</td>
<td>High</td>
<td>W. South: 1476 reviewed Battersea: 1140 offered P&amp;R: 906 received or refused</td>
</tr>
<tr>
<td>Primary Care</td>
<td>Number of patients with diabetes identified by practices in the PCT</td>
<td>8636</td>
<td>High</td>
<td>W. South: 4532 Battersea: 2589 P&amp;R: 1515</td>
</tr>
<tr>
<td>Primary Care</td>
<td>Number of patients on register of diabetes who have been called for review within the last 12 months</td>
<td>6314</td>
<td>High</td>
<td>W. South: 3259 reviewed Battersea: 2040 offered P&amp;R: 1015</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>Non-elective FFCEs for heart failure (clinical code is 428 in ICD-9 and 150 in ICD-10)</td>
<td>323</td>
<td>Medium</td>
<td>ClearNet Data</td>
</tr>
<tr>
<td>Primary Care</td>
<td>Number of patients at risk of CHD identified by practices in the PCT</td>
<td>8636</td>
<td>Medium</td>
<td>It is not currently possible to identify all groups of patients at risk from CHD from practice systems. Diabetes figures used given that those with diabetes are part of “at risk” group.</td>
</tr>
<tr>
<td>Primary Care</td>
<td>Number of patients on register of CHD risk who have been called for review within the last 12 months</td>
<td>6314</td>
<td>Medium</td>
<td>As above</td>
</tr>
</tbody>
</table>

*Source: PCT Local Development Plan return (Quarter 4, 2003/04).*

*NB* data denoted as “Medium” quality has missing data (see comments column)
(d) Ethnic Minority Groups

A proportion of our population from ethnic minority background have diverse needs which reflect the diversity of their cultures and background. Various data presented in this report (with more analysis in the Director of Public Health Report 2004,) have illustrated the unequal burden of disease among these group. We have many targeted community intervention programmes to address their specific needs. A list of some of these programmes is given below.

Current Public Health Projects.

<table>
<thead>
<tr>
<th>Project Description</th>
<th>Programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 A Day and Youth Sport Trust Pilot</td>
<td>Implementation of Mental Health Promotion Strategy</td>
</tr>
<tr>
<td>African Caribbean Hypertension Project</td>
<td>Keep On Moving</td>
</tr>
<tr>
<td>African Community Involvement Association Joint Drug Awareness Project</td>
<td>Living &amp; Learning Mental Health Project</td>
</tr>
<tr>
<td>Association of Somali Women &amp; Children's Project</td>
<td>Local Exercise Action Pilot (LEAP) - Peer Mentoring</td>
</tr>
<tr>
<td>Battersea Healthy Living Initiative - Cook &amp; Eat</td>
<td>Accompanied Walking Programme</td>
</tr>
<tr>
<td>Battersea Public Involvement &amp; Carers Group</td>
<td>Local Public Service Agreement (LPSA)</td>
</tr>
<tr>
<td>Blood Pressure Support Group for African &amp; Caribbean Communities</td>
<td>Managing Diabetes During Ramadan</td>
</tr>
<tr>
<td>Chair-based Exercise Classes</td>
<td>Moving Forward, Moving On - Mental Health Prison Project</td>
</tr>
<tr>
<td>Children's Traffic Club</td>
<td>Primary Care Access Group</td>
</tr>
<tr>
<td>Choosing Health Consultation</td>
<td>Production of a Cervical Screening Video for Somali Women</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease (COPD)</td>
<td>Putney &amp; Roehampton Mental Health Promotion Forum</td>
</tr>
<tr>
<td>Community Development and Health Course</td>
<td>Putney &amp; Roehampton Phase IV Cardiac Rehabilitation Programme</td>
</tr>
<tr>
<td>Community Talk - Obesity Project</td>
<td>Roehampton Health Forum</td>
</tr>
<tr>
<td>Development of Action Plan for Sexual Health Strategy</td>
<td>Roshni House Cook &amp; Eat Programme</td>
</tr>
<tr>
<td>Falls and Injuries Prevention Exercise Service</td>
<td>Social Prescribing Project</td>
</tr>
<tr>
<td>Health Equity Audit</td>
<td>Social Skills Group - Imani Family Support Project</td>
</tr>
<tr>
<td>Health Information at Ashburton Community Festival</td>
<td>Sure Start - Battersea</td>
</tr>
<tr>
<td>Healthy Schools in Wandsworth</td>
<td>Tai Chi Classes</td>
</tr>
<tr>
<td>Heartbeat Award</td>
<td>Teenage Pregnancy Project</td>
</tr>
<tr>
<td>Hearty Eaters Group</td>
<td>Wandsworth Heart &amp; Stroke Study</td>
</tr>
<tr>
<td>Home Based Exercise Service</td>
<td>Weigh Management 'Taster Sessions' plus 12 Week Programme</td>
</tr>
<tr>
<td>Imani Volunteer Project</td>
<td>Well-being In Wandsworth Survey</td>
</tr>
<tr>
<td>Implementation - Suicide Prevention Strategy</td>
<td>Young People's Mental Health Video Project</td>
</tr>
</tbody>
</table>

While all these projects are addressing the needs of minority groups, some of these are specific to their identified needs.
(e) Primary Care

Better Services

The Wandsworth Primary Health Care strategy has been published and part funded. See Appendix 2 for the key aspects of the Primary Care Strategy for 2008. Improvements have been identified and are quantifiable which has resulted in an increase in the numbers of GPs, nurses and practices. Table 9 shows there has been both an increase in head count and WTE GPs in the past year of 8-9%. Table 10 highlights that Wandsworth has 63 GPs per 100,000 weighted population compared with the England average of 55.55 and it is the highest in the sector.

Table 9: Head count and WTE GP’s

<table>
<thead>
<tr>
<th></th>
<th>31st Mar 03</th>
<th>30th Jun 03</th>
<th>30th Sep 03</th>
<th>31st Dec 03</th>
<th>31st Mar 04</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wandsworth PCT</td>
<td>172</td>
<td>179</td>
<td>186</td>
<td>179</td>
<td>188</td>
</tr>
<tr>
<td>WTE</td>
<td>150</td>
<td>153.54</td>
<td>158.79</td>
<td>150.29</td>
<td>162.54</td>
</tr>
</tbody>
</table>

Table 10: GP’s and the Population

<table>
<thead>
<tr>
<th>PCT</th>
<th>Population</th>
<th>Age Index</th>
<th>Need Index</th>
<th>Population weighted for age &amp; need</th>
<th>Normalised</th>
<th>GP WTE serving population</th>
<th>GP per 100,000 PCT population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wandsworth</td>
<td>256440</td>
<td>0.92</td>
<td>1.03</td>
<td>242033</td>
<td>242365</td>
<td>153</td>
<td>63.0</td>
</tr>
<tr>
<td>Richmond and Twickenham</td>
<td>172801</td>
<td>0.98</td>
<td>0.93</td>
<td>157396</td>
<td>157611</td>
<td>96</td>
<td>61.0</td>
</tr>
<tr>
<td>Croydon</td>
<td>327382</td>
<td>0.96</td>
<td>0.97</td>
<td>303785</td>
<td>304201</td>
<td>178</td>
<td>58.4</td>
</tr>
<tr>
<td>Kingston</td>
<td>163204</td>
<td>0.97</td>
<td>0.92</td>
<td>146474</td>
<td>146674</td>
<td>84</td>
<td>57.6</td>
</tr>
<tr>
<td>Sutton and Merton</td>
<td>354184</td>
<td>0.97</td>
<td>0.96</td>
<td>330825</td>
<td>331277</td>
<td>181</td>
<td>54.8</td>
</tr>
<tr>
<td>South West London</td>
<td>1182128</td>
<td></td>
<td></td>
<td></td>
<td>692</td>
<td>58.6</td>
<td></td>
</tr>
<tr>
<td>England Total</td>
<td>48962968.7</td>
<td></td>
<td></td>
<td>48896091</td>
<td>48962968.7</td>
<td>27198</td>
<td>55.55</td>
</tr>
</tbody>
</table>

Better Access

The PCT has hit the target for 2003-2004. This has been achieved in two ways:

1. By practices providing access within 24/48 hours target
2. Some practices are able to refer into our extended primary care access pilot that is run by Primecare at the Bolingbroke. This scheme was made available to practices in January 2004; no referrals have yet been made. A number of practices were selected to be involved in the scheme. These practices were selected as they were the practices that needed to improve access to patients. Work is being undertaken to re-launch the scheme at the WIC

It should be noted that due to the nature of the population, a good number are not registered with GP practices and have not transferred registration into their new residency.

We have specific incentives operating in some practices as “local advanced services” in order to support refugees and asylum seekers (£85,000 being allocated for this activity). In addition, extended hours have been introduced to encourage people to register and access healthcare services in some surgeries and funding of £100,000 has been earmarked for this purpose.
Registrations

The PCA will shortly be commencing work on the National Duplicate Registration Initiative (NDRI) in conjunction with the PCT and the Audit Commission.

NDRI is the Audit Commission’s data matching exercise that looks at patient lists to identify inaccuracies in the data. Downloads were taken from the 88 ‘Exeter’ databases across England and Wales in March 2004. This data has been matched against the following.

<table>
<thead>
<tr>
<th>Match</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Itself</td>
<td>To identify possible duplicate patients on the same system</td>
</tr>
<tr>
<td>The other Exeter databases</td>
<td>To identify possible duplicate patients nationally</td>
</tr>
<tr>
<td>Department for Works and Pensions</td>
<td>To identify deceased patients still registered with a practice</td>
</tr>
<tr>
<td>Royal Mail – Re-directed mail records</td>
<td>To identify patients that have moved from the address held by the PCT/Agency</td>
</tr>
<tr>
<td>Home Office Removed Asylum Seeker records</td>
<td>To identify live registrations for unsuccessful asylum applicants that have been removed from the UK</td>
</tr>
</tbody>
</table>

As part of this exercise, the PCA are also required to confirm the registration status of

- Patients aged between 90 and 100
- Patients aged 100 and above
- Patients on their database with a dummy/query NHS number for more than a year

Nationally, this exercise has identified 80,000 duplicate NHS numbers, 500,000 matches on name and date of birth, 200,000 patients that have ‘gone away’ and 90,000 deaths. A high number of these ‘duplicates’ would have already been removed from the PCA and surgery databases since the initial download was taken and appeared only because of cross over registrations. I.e. where a patient had registered in a new area but the PCA had not yet received the deduction request. There will also be death removals that had not been processed and deaths since the data was downloaded from the Exeter systems included in these figures.

It is worth noting that a good number of “young adults” are not registered with GP practices; many did not transfer their registrations. This is a reflection of the population we serve. The percentage breakdown by age band is given in Table 11.
Commissioning Advanced Services

There is a specific primary care commissioning group addressing both the national and local advanced contracts to address specific issues relevant to the needs of the population, including the role of pharmacists (e.g. in smoking cessation and secondary prevention of CHD). The Primary Care Commissioning Steering Group has the following remit:

1. Mapping the need for providing/commissioning national enhanced services
   Taking into account patient need, the PEC recommended that the greatest priorities amongst the 12 national enhanced services for Wandsworth were “More specialised sexual health services” and “Enhanced care of the homeless”. Mapping work has begun on the former, linking with the PCT’s Sexual Health Implementation Group.

2. Developing local enhanced services in line with patient need
   A local enhanced service specification is being developed for GP practice-based smoking cessation services.

3. Reviewing any existing payment schemes
   Reviewing any existing schemes where payments are made to GP practices for services that do not fall under the definition of essential, additional, directed enhanced or national enhanced services since in time all such schemes should migrate to become local enhanced services.

    Two existing schemes that, if considered to be successful, would need to migrate to become local enhanced services, are being reviewed. These are:
    
    - The Wandsworth South Refugees and Asylum Seekers Scheme
    - The Wandsworth South Extended Opening Hours Scheme

Find A Doctor Scheme

Wandsworth PCT launched a new helpline in March 2004 for local residents looking for a NHS family doctor. The find-a-doctor helpline, run by the Wandsworth team at the Primary Care Agency, provides people with a list of surgeries in their local area that have open books. This will prevent people from having to make unnecessary phone calls to surgeries whose books are closed. To promote this service, posters and 40,000 bookmarks (see below) have been distributed throughout the Borough. Tooting Walk-in Centre and St George's Hospital A&E have also handed out this information to patients who are not registered with a GP. St George’s Hospital hand out 200 bookmarks a day in their A & E department. The scheme has been very popular with practice managers in particular, and was featured in the Wandsworth Guardian shortly after it was launched.
Flu Vaccine
The PCT is meeting the target of 70% uptake of ‘flu vaccination for those agreed 65 years and over. Current figures show that uptake is 70%.

Figure 29: Flu Immunisation Coverage for Wandsworth, 2003-2004
Table 11: Registered population by band, Wandsworth 2004

Numbers of registrations by age band in Wandsworth

<table>
<thead>
<tr>
<th>Age Band</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-19</td>
<td>58619</td>
</tr>
<tr>
<td>20-44</td>
<td>168779</td>
</tr>
<tr>
<td>45-64</td>
<td>56338</td>
</tr>
<tr>
<td>65-74</td>
<td>16052</td>
</tr>
<tr>
<td>75+</td>
<td>14153</td>
</tr>
<tr>
<td>Total</td>
<td>313941</td>
</tr>
</tbody>
</table>

20-44 as a % of total registrations 53.8 %

Source: Primary Care Agency 2004
**Health Equity Audit**

A self-assessment of the Health Equity audit has been completed. The areas identified as priority were CHD, lung cancer, breast cancer and access to primary care. Below is an outline action plan, key lead responsibilities and time frames are being discussed. This will be taken forward by a member of the Public Health team.

Table 8: Proposed Health Equity Audit Programme

<table>
<thead>
<tr>
<th>TASKS/ACTION</th>
<th>LEAD RESPONSIBILITY</th>
<th>DEADLINE/TIME-FRAME</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coronary Revascularisation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• A profile in relation to morbidity and deprivation data from 2001 census.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Availability and uptake of cardiac rehabilitation services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Plans / measures to target wards with highest CHD rates- details.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Use/ uptake of aspirin, statins and anti-hypertensives by patients with coronary heart disease-Prescribing data.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Health Promotion initiatives –(1).Physical Activity/Exercise- uptake and targets. (2). Obesiy (3). Diet and Nutrition.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SMOKING</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data on smoking cessation rates including:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- smoking in pregnancy rates.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 4 week quit rates</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Where are we on the trajectory for quit rates?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Comparison with national average quit rates.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### PRIMARY CARE

- Number of individuals registered with G.P.’s – relationship with morbidity and deprivation score data from 2001 Census.
- Primary care for disadvantaged groups- for example homeless and refugees.
- “Find a Doc” scheme.
- Number of Primary Care Professionals per 100,000 – comparison to national figures
- Any measures to increase primary care workforce?
- Waiting times for G.P. appointments. 24/48 hour target access rates- comparison to national figures. Any plans to increase these rates?
- Uptake of vaccination data- comparisons of childhood vaccinations as well as flu Vaccination for 65 and over age group with national targets.
- Access to dental care
- New GMS contract- potential for mapping health inequalities as well as addressing and redressing them

### CANCER- LUNG AND BREAST

- Lung and breast cancer data- classified according to age, gender, ethnic group, level of deprivation. Are there any social class gradients?
- Mortality rates.
- Comparison with national averages. Hospital episode statistics.
- Surgical out patient data for lung and breast cancers.
- Data on surgical operations and procedures- theatre data etc. Follow up / Management of cases.
- Is there targeted action to reduce prevalence of lung and breast cancers- especially in wards with highest rates.
- Breast screening programme- uptake rate; Cultural, language and religious sensitivity- e.g. Ethnic minority groups, Moslem women etc.
- Information on smoking and smoking cessation initiatives especially important- relationship with lung cancer.
(g) Partnerships

The targeting of action to reduce health inequalities demands effective partnerships from a range of stakeholders. The PCT has partnership at strategic, managerial operational levels and includes partnerships with the voluntary sector and local communities groups and forums.

Local Strategic Partnerships

Health inequalities are discussed with the SHA and the PCT is a key member of the Local Strategic Partnership (LSP). The PCT supports and contribute to LSP strategies that impact on health through the Community Strategy, which has six strategic priorities and includes action in reducing inequalities as part of the joint work. The PCT is also involved in activities and performance management of the Neighbourhood Renewal Action plan. Each of Wandsworth three localities has it’s own action plan and was updated in January 2004.

The PCT has a strong working relationship with the Local Authority in the implementation of the Teenage Pregnancy Strategy. The reduction of teenage pregnancy is a joint key objective and the PCT line manages the teenage pregnancy posts. There is representation on both the Steering and Reference Groups, which follow a multi agency approach.

The PCT is leading on and is working in partnership with the Local Authority, Traffic for London and the children’s Traffic Club in reducing the incidence of road traffic accidents for all 3-4 year olds. The scheme has been used for over ten years across the UK and has a proven record of success with a 12 % reduction in all road casualties where it is in operation. The PCT also supports the Healthy Schools programme by working close with education, by representation on the partnership group and the implementation of the school programme.

Partnerships and working alliances also exist in a range of other areas that impact on the reduction of health inequalities. These include crime, housing, education, Sure Start programmes, physical activity, mental health, promotion, sexual health, Drugs and alcohol, stop smoking and initiatives through healthy living programmes.

Community Development Programmes

A strong community development programme is in place, which targets areas of deprivation in the 3 localities and includes activities in many of the above areas. There are currently Public Health posts for Battersea and Tooting and a vacancy in Roehampton. These posts liaise and work with local community forums, community groups and with the voluntary sector. Their remit includes working with vulnerable groups and activities include work with older people, refugees and asylum seekers and families affected by domestic violence. A recent successful conference was organised to raise the issue locally. A community development and health course has just been completed by local residents with the aim of building local community capacity to engage in health issues. The course has been accredited by the London Open College Network. Other community-based work includes activities on mental health promotion, including challenging stigma of mental health issues. The Living and Learning project provides adult education classes in life management skills from sites in HMP Wandsworth (where it is known as Looking Forward: Moving On), Putney, Roehampton, and Tooting. It is planned to expand the programme to Battersea from September.
**Patient Participation**

Work in local GP practices has also taken place to encourage and support patient participation. Early findings from the recent Well-being in Wandsworth survey suggest that levels of common mental health problems are what would be expected among people attending GP surgeries - approximately 30%. Rates were slightly higher in the Putney and Roehampton and Battersea Localities, which also have higher levels of socio-economic deprivation. Similarly, a recent suicide audit found that the Putney and Roehampton Locality had a suicide rate above that of England and Wales. Both reports indicate that, in the general population, it is people aged 35-49 who have the poorest mental health. The Putney and Roehampton Mental Health Promotion Forum works to promote mental health among the population of Putney and Roehampton, and within organisations working in that Locality.

**Shared Priorities**

The PCT is taking full advantage of opportunities presented by the Shared Priority with local government and the new Comprehensive Performance assessment. There is joint partnership working with the Local Authority on many initiatives; DAT, Mental Health, Regeneration, Healthy Schools, Healthy Living Initiatives, Dealing with Domestic Violence, Travel Plans, Accident Prevention and other Life Style Programmes. We are developing a Wandsworth Compact with the Local Authority and other agencies.
5. Conclusion
5. Conclusion

Whilst we accept that life expectancy is low compared to the sector (SW London), Wandsworth is the only Inner London Borough in the South West sector. Despite significant improvements in the health of the population in Wandsworth, more efforts are needed through local strategic partnership to address the health inequalities through prevention and early interventions. In a rapidly changing and diverse population, needs are changing too but addressing the wider determinants of health (employment, housing, styles of living, crime and disorder etc) will have effective returns for good health in the medium and long term.

We have clear strategies to tackle inequalities and in particular in the following areas:

- **Tackling CHD:** Data shows that certain sectors of the population are at higher risk due to ethnic composition, e.g. there is a greater risk of our Asian population developing diabetes compared with the national average, coupled with a high prevalence of hypertension among the Afro-Caribbean community who make up 13% of our population.

- **Smoking Cession:** Cancer of the lung and CHD are prevalent in some wards in Wandsworth and we have developed a clear strategy to tackle this.

- **Sexual Health:** We are nearing completion of a Sexual Health plan of action that part meets the requirements of the national strategy for sexual health.

- **Primary Care Trust Information Group:** The group aims to agree on a collaborative approach to data collection and dissemination. The current focus is on Primary Care sources, and how to routinely employ this data into commissioning and public health cycles. Regular meetings are held that essentially cover three areas:
  1) Primary Care Information – practice based registers etc
  2) Commissioning – service utilization analyses
  3) Public Health – health service needs assessments

Within our strategies, we address the needs of vulnerable groups. We are also heavily involved in mental health promotion and have a strategy for suicide prevention. The mental health of prisoners in HMP Wandsworth is also an issue, as prisoners are known to be particularly vulnerable to mental health problems and suicide.

Cancer prevention measures are addressed through our breast and cervical screening services and our involvement in the cancer network.

Health improvement is dependent on the nature of the population and strategies are adapted to the rapidly evolving needs of our young, versatile and highly mobile population. (Please see Changing Population, Changing Needs www.wandsworth-pct.nhs.uk). We have credible plans to enable this to happen through our ADP and are supported by the PEC, Management Team and Board of Wandsworth PCT and Wandsworth Local Authority. Furthermore all issues are presented to a 10-year WPCT Strategy Group. This can be achieved by targeting improvements in the more disadvantaged communities where needs are highest. We have clearly defined programmes targeting disadvantaged communities, e.g. community development co-ordinators for specific localities, Afro-Caribbean blood pressure groups, Healthy Living initiatives and Sure Start programmes, just to name a few.
The forthcoming Wandsworth 10 year strategy for health will address all the inequality issues. It will concentrate on the areas of needs assessment, health improvement, service delivery, public/patient participation and partnership in full collaboration with all agencies serving the people of Wandsworth.
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- Chris Gillear
- Ros Lobo
- Fiona Marley
- Doug Middleton
- Christina Murphy
- Belinda Myles
- Asmat Nisa
- Kriel Ramcharitar
- Salman Rawaf
- Fiona Reid
- Ian Rickard
- Pam Shepherd
- Piers Simey
- John Thomas
- Sally Usher
- Helen Walley
- Stephen Warren
- Rhian Williams
- Primary Care Agency
- Office of National Statistics
- London Health Observatory
- Thames Cancer Registry
References

Annual Delivery Plan: www.wandsworth-pct.nhs.uk


Office of the Deputy Prime Minister, The English Indices of Deprivation, 2004


Glossary of terms

1. **LIFE EXPECTANCY - BASIC PRINCIPLES**

   “Life expectancy is traditionally defined as the average number of years of life remaining at a given age.” Life expectancy is a means of summarizing mortality, at different ages. It is arrived at by applying the prevailing sex and age-specific mortality rates to the individuals who survive to a given age.

   Healthy life expectancy is a somewhat less subjective measure that endeavours to incorporate both morbidity and mortality into one index. This index reflects the number of years of life left that is expected to be spared of serious disease. The occurrence of a serious disease with permanent sequelae—for example, a stroke with severe permanent residual effects—reduces the index as much as if the person who has the sequelae had perished from the disease.

   Changes in life expectancy have occurred for all age groups during the present century, but the most pronounced have been the increase in expectation of life at birth. Life expectancy at birth estimates the average life expectancy of a boy or girl born today if they experienced the current age- and sex-specific mortality for residents of a given area. It is influenced more by deaths that occur at a younger age than other summary health measures. It does not take account of changes in the incidence of disease or other causes of ill-health, migration, the availability of new treatments that may occur in the future nor changes in the composition of the population, for example ethnicity.

   In London, for the period 1998-2002, the average life expectancy was 75.4 years in men and 80.3 in women, a difference of 4.9 years. In Wandsworth, male and female life expectancy (based on 2000-2002 data) is in the bottom 20% for the country and significantly different from the England average.

   At both ward and Borough level, average life expectancy is closely related to the level of deprivation experienced. This association viz. between life expectancy and deprivation is stronger for males than for females.

   Social class is another factor strongly related to life expectancy. Recent data are not available for London but in 1997-99, life expectancy in England was 71.1 for men in Social Class V compared with 78.5 years for men in Social Class I; a stark difference of 7.4 years. For women, life expectancy in Social Class I was 82.8 years, compared with 77.1 in Social Class V; a difference of 5.7 years.

   One of the advantages of using life expectancy as a health inequality indicator is that it is an all-age summary measure of mortality, which does not require the use of a standard population. Hence, the output obtained is not reliant on which standard population is used. It is also useful as a comparison between areas, including other countries. In addition to these advantages, it is a measure of mortality that is comprehended by the general population.

2. **STANDARDISED MORTALITY RATIO - BASIC PRINCIPLES**

   The standardised mortality ratio (SMR) is the ratio of deaths observed, to those expected on the basis of the mortality rates from a reference population.

3. **STANDARDISED REGISTRATION RATIO**

   The standardised registration ratio (SRR) is the ratio of disease registrations observed, to those expected on the basis of disease rates from a reference population.
## Appendix 1

### STOP SMOKING ACTION PLAN – WORKING DRAFT

<table>
<thead>
<tr>
<th>Objective</th>
<th>Activities</th>
<th>Who should be Involved</th>
<th>Time Frame</th>
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</thead>
</table>
| Extend pool of Stop Smoking Advisors From 37 to approx 144 To achieve 04/05 4 week quit target of 2070 | • Invite all GP surgeries to identify/nominate practice based advisors  
• Target wider primary care team including family planning, health visitors and school nurses  
• Invite more pharmacists to become stop smoking advisor  
• Invited youth workers, and community members to become community advisors  
• Develop a rolling programme for community advisor training through out the year. e.g. training sessions each quarter)  
• Target stop smoking community advisors training at local community members | Primary Care Directorate/Public Health  
Lead pharmacist and Stop Smoking Service  
Local Authority and Public Health  
Stop Smoking Service Public health and Training department  
Public Health and Stop Smoking Service | May – Aug 04  
May – Aug 04  
August 04  
July 04 – Jan 05  
September – October 04 |
| Deliver a 1% reduction in the women who continue to smoke in pregnancy | • Deliver 5 no smoking in pregnancy training courses for midwives and health visitors  
• Continue work with Sure Start projects | Stop Smoking Service, St Georges Hospital and Primary care  
Stop Smoking Service, Primary care and Public | April 05  
April 05 |
### Appendix 1

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<th>Time Frame</th>
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<tbody>
<tr>
<td>Deliver a 1% reduction in the women who continue to smoke in pregnancy – Continued</td>
<td>• Appoint to a Wandsworth Pregnancy Advisor post</td>
<td>Public Health and St Georges and Stop Smoking Service</td>
<td>November 04</td>
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<tr>
<td></td>
<td>• Train 8 Community Stop Smoking Pregnancy Advisors</td>
<td>Stop Smoking Service</td>
<td>April 05</td>
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<td></td>
<td>• Develop a protocol and process to collect and collate information from St Georges and Primary Care</td>
<td>Stop Smoking Services, Public Health, Commissioning, Primary Care and St Georges</td>
<td>October 05</td>
</tr>
<tr>
<td>Brief Intervention Training</td>
<td>• Develop a rolling programme of brief intervention training for all primary care staff.</td>
<td>Stop Smoking Service, Primary Care and Training Department</td>
<td>Sep – Oct 04</td>
</tr>
<tr>
<td></td>
<td>• Identify accredited training to encourage GP attendance and other primary care staff</td>
<td>Stop Smoking Service/Public Health and Local Authority</td>
<td>August 04</td>
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<tr>
<td></td>
<td>• Offer brief intervention training to youth workers</td>
<td>Stop Smoking Service and Primary Care</td>
<td>September 04</td>
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<tr>
<td></td>
<td>• Offer brief intervention training to pharmacists and their assistants</td>
<td>Primary care Stop Smoking Service and Public Health</td>
<td>September – October 04</td>
</tr>
<tr>
<td></td>
<td>• Develop brief intervention project with Local dentists</td>
<td>Stop Smoking Service, Training Department and Primary Care</td>
<td>September 04</td>
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<td></td>
<td>• Begin discussions to introduce mandatory brief intervention training for new primary care staff. (Link to clinical governance)</td>
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<tr>
<td><strong>GP Feedback and Education Sessions</strong></td>
<td>• Develop Post for GP with specialist Interest in Smoking</td>
<td>Primary care and Public Health</td>
<td>July – August 04</td>
</tr>
<tr>
<td></td>
<td>• Development of GP educational (accredited) sessions</td>
<td>Stop Smoking Service Primary Care and Localities</td>
<td>September – October 04</td>
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<tr>
<td><strong>Training the Trainers</strong></td>
<td>• Stop Smoking Councillors to undertake training the trainers stop smoking programme</td>
<td>Stop Smoking</td>
<td>June – July 04</td>
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<tr>
<td><strong>GMS Contract</strong></td>
<td>• Develop a protocol for use in primary care</td>
<td>Primary Care and Public Health</td>
<td>June – July 04</td>
</tr>
<tr>
<td></td>
<td>• Identify Local Enhanced Service framework for stop smoking activities</td>
<td>Primary Care, Public Health</td>
<td>July – August 04</td>
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<td></td>
<td>• Develop a simplified referral system</td>
<td>Locality/Primary Care and Stop Smoking Service</td>
<td>August 04</td>
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<tr>
<td><strong>Monitoring</strong></td>
<td>• Regular feedback to GPs on referrals of smokers seen by the stop smoking services based on information from the new data base</td>
<td>Stop Smoking Service</td>
<td>July 04</td>
</tr>
<tr>
<td></td>
<td>• Also to the Board, Management Team and PEC</td>
<td>Stop Smoking Services/Public Health</td>
<td>June 04</td>
</tr>
<tr>
<td><strong>Update Service Level Agreement</strong></td>
<td>To include:</td>
<td>Public Health, Commissioning and Stop Smoking Service</td>
<td>June 04</td>
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<tr>
<td></td>
<td>• Provision of in house trainers and training within the Stop Smoking Services</td>
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</table>
| **Update Service Level Agreement – Continued** | • Work with Local Authority and local business  
• Identify a lead Stop Smoking Councillor for Wandsworth  
• Target the increase of community advisors to approx 144 in 04/05  
• Delivery of 4 community advisors training sessions annually (1 per quarter)  
• Monthly monitoring report  
• Follow up of clients through the service 6 and 12 monthly, including telephone lost to follow up  
• Evaluation of the service from the clients perspective | Local Authority/Public Health  
Public Health, Commissioning and Stop Smoking Service  
Public Health, Commissioning and Stop Smoking Service  
Public Health, Commissioning and Stop Smoking Service  
Public Health, Commissioning and Stop Smoking Service | June 04  
June 04  
June 04  
March 04 |
| **Extend and Increase Group Sessions** | • Introduce councillor out reach sessions targeting GP practices for hard to reach groups  
• Target group sessions in each locality one per quarter  
• Train experienced stop smoking community advisors in group skills | Stop Smoking Service  
Stop Smoking Service  
Stop Smoking Service | To be agreed  
To be agreed  
To be agreed |
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</table>
| **Wandsworth Stop Smoking Posts** | Develop Job descriptions for:-  
- Stop Smoking Locality Co-ordinators  
- Smoking in pregnancy post  
- To develop objectives with the Tooting Healthy Living Stop Smoking Co-ordinator | Public Health  
Public Health | June – July 04  
June – July 04  
June – July 04 |
| **Target Stop Smoking activities in areas of Greatest need** |  
- Identify practices in wards with high CHD and lung cancer rates  
- Identify practices with high number of smokers  
- Send invitation letters to smokers to attend a stop smoking service in the localities?  
- Target smoking and exercise class in community setting  
- Run stop smoking sessions in Wandsworth Prison  
- Developed work with local mosques  
- Develop smoking cessation programme with Battersea and Roehampton Sure Start | Primary Care and Public Health  
Primary Care and Public Health  
Stop Smoking Service and Primary Care  
Stop Smoking Service and Public Health  
Stop Smoking Service and Public Health  
Public Health and Tooting Health Living Initiative  
Stop Smoking Service | August – September 04  
August – September 04  
Sept - Oct 04  
July – August 04  
August 04  
August – September 04  
July – August 04 |
## Appendix 1

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<tr>
<td><strong>Target Stop Smoking activities in areas of Greatest need – Continued</strong></td>
<td>• Delivery of smoking cessation session as part of Wandsworth South Foot Steps programme</td>
<td>Stop Smoking Service</td>
<td>June 04</td>
</tr>
<tr>
<td><strong>Development of Targeted Initiatives</strong></td>
<td>• Develop Patient Group Directives for pharmacists</td>
<td>Primary Care, Pharmacist</td>
<td>Sept 04</td>
</tr>
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<td></td>
<td>• Develop pilot smokers referral scheme with selected dentists</td>
<td>Primary Care Stop Smoking services</td>
<td>Sept/Oct 04</td>
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<tr>
<td></td>
<td>• Set up stop smoking group session in localities</td>
<td>Primary Care Localities and Stop Smoking Service</td>
<td>August 04</td>
</tr>
<tr>
<td></td>
<td>• Support for a stop smoking clinic at Queen Mary’s</td>
<td>Stop Smoking Clinic</td>
<td>Aug/Sept 04</td>
</tr>
<tr>
<td><strong>Use of the Local Media to Promote the Service and Encourage Smoking Cessation in the General Population</strong></td>
<td>• Promotion of the service through the media including new year resolutions and National No Smoking day</td>
<td>Communications, Public Health and Stop Smoking Service</td>
<td>September 04</td>
</tr>
<tr>
<td></td>
<td>• Aim for an article per month I the local papers</td>
<td>Communication, Public Health and Stop Smoking Service</td>
<td>September 04</td>
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<tr>
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<td>• Incentive of prize draw of £100 for clients who go through the service and stop smoking</td>
<td>Communication and Public Health</td>
<td>September 04</td>
</tr>
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<td>• Stop smoking Information on PCT website</td>
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<tr>
<td><strong>Use of the Local Media to Promote the Service and Encourage Smoking Cessation in the General Population – Continued</strong></td>
<td>• Investigate joint publicity campaigns with neighbouring Stop Smoking Services</td>
<td>Stop Smoking Service and Communications</td>
<td>September 04</td>
</tr>
<tr>
<td><strong>Stop Smoking Collaborative</strong></td>
<td>• Develop an outline application for Stop Smoking Collaborative</td>
<td>Stop Smoking Service and Public Health</td>
<td>Aug 04</td>
</tr>
<tr>
<td><strong>Audit</strong></td>
<td>• Review the data monitoring systems</td>
<td>Public Health and Stop Smoking Service</td>
<td>July – August 04</td>
</tr>
</tbody>
</table>
| **Patient and Public Involvement** | Use the analysis of the: -  
• Smokers Survey  
• Work Place questionnaire  
• Choosing Health Consultation  
• Stop Smoking Services evaluation to develop local services | Primary Research Group, Public Health, Stop Smoking Service | August – September 04 |
| **Smoking Prevention and Cessation Workshop** | **Target key stakeholders in:** -  
• Primary and Secondary Care  
• Local Authority  
• Voluntary sector  
• Community  
To develop priority objectives for a prevention and cessation strategy | Strategy Group Members | Approx September – October 04 |
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</tr>
</thead>
</table>
| **Development of a Tobacco Control Plan** | Target:  
- Local business  
- Pubs  
- Restaurants  
- Leisure centres  
to promote smoking cessation and the Stop Smoking Service | Public Health and Local Authority | October 04 |
| **Support and Develop Young Persons Programme** |  
- Support community advisors to run school based programme for parents  
- Target Care Home helpers of Looked after Children | Public Health and Local Authority | September – October 04 |
| **Separation of Stop Smoking Service** |  
- Identify and put together a time table for sequential steps to put in place a Wandsworth managed Service for April 05 | Stop Smoking Service, Public Health and Primary Care | Approx September 04 – March 06 |
Appendix 2

Key aspects of the Primary Care Strategy to achieve the vision for 2008

The key aspects and characteristics of the vision identified from these events were as follows:

Creating healthy individuals and communities
- Requiring cultural change and the changing of attitudes and behaviour of patients & practitioners
- Providing holistic care e.g. health, housing, benefits, mental health, education
- WPCT with the lowest national rate for lung cancer and female suicide
- Smoking banned in all public buildings
- All residents receiving fluoridated water

Health Promotion
- More proactive health promotion e.g. screening every five years to address the fact that 80% of the population have unaddressed risk of illness
- Ongoing and proactive health education programmes
- Reduction in overall episode length
- More preventive work/advice/education
- Optimum user engagement/self management and diagnosis, and tackling health problems lower down the pyramid
- Wider access to exercise including exercise referral classes in practices/or leisure centres
- Training in brief intervention techniques to drive early intervention

Primary Care services that are patient centred
- A clear focus on the human element and the patient experience
- A service that values relationships and public involvement
- Informed empowered clients with access to their own integrated electronic health records and better access to information including the provision of access points for those without access to a computer
- Case managers to ensure proactive care for patients

Better access
- More access to diagnostics closer to home reducing the need for visits to secondary care - e.g. telemedicine, diagnostics centres in primary care, walk in centres, minor surgery, expansion of telephone triage and care, email consultations
- Enhanced access to primary care in terms of more hours, more ways, more places and no waiting times for appointments
  - Longer consultations with appropriate health professionals
  - A service able to meet a diversity of needs from the “quick fix” to long term care
  - One stop shop primary care centre services open at convenient times responsive to the needs of the local population and providing for medical, pharmacy, phlebotomy, dental and therapy services with a health professional always available with appropriate skills
  - Services that are accessible and responsive to reach at risk groups e.g. elderly, teenage mums, homeless, refugees, non English speaking ethnic minorities, including easily accessible, well publicised real time translation services and mobile health units
- Access to information hub via all media, web, digital TV, phone, etc for information on joining services and services offered, health education and promotion, for both patients and staff
- More access to NHS dentistry and integrated with other services
- Ability to pick up new prescriptions from the pharmacy at GP surgery and then get repeats from either local chemists or delivered to the patients home plus on line ordering of repeats
- 2 days for secondary care appointment if necessary and on line booking
Appendix 2

- Flexibility to see GP or appropriate health care professional anywhere in any practice/Walk in Centre, Primary Care Centre and be seen promptly, with access to patient records and ability to update them
- Employers sharing responsibility for education and provision of access to healthcare

Integrated care
- Better and more integrated chronic disease management and robust processes for monitoring
- More interagency work e.g. health and social care with the development of generic workers, proactive care of the elderly, high quality home helps, home visiting services and development towards a care trust
- Integrated skill mix teams across GP, health and social services
- Single assessment process embedded
- Improved communication and engagement within primary care and across the primary/secondary care interface plus well developed care pathways
- Total integrated clinical teams
- Pre-determined care pathways
- Emergency admission as short as possible & discharge well planned with primary care
- Secondary care: planned admission with primary care team and client for elective care
- Improved and integrated access to equipment loan services

Clearly this vision needs to tie in with the national agenda for primary care including the new GMS Contract so that local priorities are balanced with national targets sensibly applied to the local situation.

To deliver the vision as outlined there is a big agenda around developing the primary care infrastructure in the following areas, which can be viewed as characteristics of how the vision will be delivered:

Workforce
- The PCT as a place where people want to work, are treated well and where staff would recommend using the service to the public. This would include flexible hours and work from home via internet, telephone and videoconferencing
- Need to produce a competency list and skill mix map in primary care (practice, PCT, voluntary sector, complimentary medicine etc) and group together clusters of care to see what tasks can be performed by which staff
- The above would release capacity and funding by using the expertise of other professions, new roles in general practice e.g. primary care assistants, dentistry, pharmacy, optometry plus flexible use of money e.g. direct access to physios in GP practices
  - Improved work force planning
- Robust recruitment and retention strategies e.g. provision/access to childcare, staff encouraged to achieve a healthy work life balance, informing young people about career opportunities in the local NHS
- Training and development including organisational development to meet the strategic priorities
- General need for more clinical management
- Need to keep a balance between specialists & generalists
- Developing training and development strategies and developing the PCTs role as a Teaching PCT
- The PCT to Influence national training schemes and delivery of pre-graduate training to include public health role of PHCT and more balance between the medical and social models of care
- Confidence in the competence of other providers including validation/certification
- Dedicated computer room in GPs surgeries/PC Centres for research
Appendix 2

➢ Culture shift to break down barriers between different professionals and professionals and clients, benchmarking and sharing good practice, and communicating clearly to staff about the future direction of the PCT

IM&T
➢ Better information for patients
➢ Use of new technology e.g. Electronic Patient Record (EPR)
➢ Wherever patients go in the NHS, and at whatever time, their medical history & treatment is known
➢ Personal held records or patient held smart cards/health ID cards and patient access to EPR via internet
➢ Integration of records and systems to produce a seamless service
➢ IM&T work in partnership to promote IT standardisation and information sharing
   ➢ Paperless systems
➢ A long term IT Strategy is needed with specific goals, milestones/objectives

Premises
➢ Modern premises that are fit for purpose, accessible to all, clean, offering a pleasant environment for patients and staff and also potentially offering meeting space available to the community
➢ Designated children’s areas
➢ Premises adapted to accommodate all service changes and client needs
➢ Comfortable reception areas that are welcoming & pleasant

Additionally the following key values were identified, which need to underpin the vision:
➢ The PCT should be promoting health through flexible solutions without being over prescriptive
➢ Reward best practice and innovation
➢ The agenda needs to be widely shared and owned across the PCT and engage local people
➢ Short term actions must further long term aims
We need to learn from experience, use evidence and identify what works/doesn't work locally through regular monitoring and feedback.