Harrow
JSNA Online

LONG TERM CONDITIONS - DATA UPDATE 2022

Introduction

This report updates some of the data and intelligence in several profiles previously published as part of the Harrow JSNA, relating to key Long Term Conditions (LTCs).

Contents

COST OF LONG TERM CONDITIONS IN HARROW

Introduction and backgrounds

This report includes the monthly cost of the 'Direct admissions' of the patients with Long-Term Conditions (LTC) in Harrow CCG for the last 3 financial years (2019/20 to 2021/22). In this report we are looking at the cost of: CVD, Diabetes, Hypertension, MSK, Neoplasm, Respiratory and Stroke. The source of data is Secondary Use Service (SUS) data, extracted by Harrow CCG. To identify the admissions for each of the LTC condition, the relevant 'Primary Diagnosis' code are used.

Data for March 2022 has not been provided; therefore, it has been estimated based on the available data (from the average proportion of the cost of LTC in March 2019/20 and 2020/21; and applying the calculated proportion to the cost of 11 month in 2021/22).

Abbreviations

LTC: Long Term Conditions

SUS: Secondary Use Services

PBR: Payment by Result

DC: Elective Day case

EL: Ordinary Elective

NULL & Other could be day/night attendances or uncoded (these are small numbers)

Summary

Overall, the annual cost of all seven conditions was lower in 2020/21 compared to the year before (2019/20) and after (2021/22). This could be for 2 reasons; the impact of the lock down caused by COVID-19 pandemic, reducing the use of the secondary care resources either by allocation of the resources to the COVID-19 patients or unwillingness of people with LTC to use the services to protect themselves from coronavirus. Secondly, the secondary care service users with a higher level of needs were targeted by the pandemic at the start, the first financial year (2020/21).

However, it is noticeable that the rate of cost for some LTC conditions has declined more than others at the start of the pandemic. In 2020/21 (the start of the Coronavirus pandemic) cost of all LTCs decreased with the highest decline for respiratory disease (57.5%) and lowest decline for stroke (0.2%). During the second year of the pandemic compared to the previous year (first year of the pandemic) the cost started to increase. The highest increase was for hypertension (57.4%) and the lowest was for diabetes (14.5%).

Comparing the 2nd year of the pandemic (2021/22) to the pre pandemic year (2019/20) the cost for most LTCs show lower, with lowest cost for respiratory (-29%) and the highest for Stroke (27.4%). It can confirm that those with some type of the LTC (such as respiratory disease) have been targeted by the pandemic, reducing the service users. But the pandemic has less impact on other LTC service users such as stroke, neoplasm, or hypertension (Illustrated in the summary table and figure below).

Summary Table Harrow rate of cost change for 7 main LTCs from 2020/21 and 2021/22 compared to the previous year also 2021/22 compared to 2 years before (pre-pandemic)

Harrow rate of cost change for 7 main LTCs from 2020/21 and 2021/22 compared to the previous year also 2021/22 compared to 2 years before (pre-pandemic)			
LTC	2020/21 to 2019/20	2021/22 to 2020/21	2021/22 to 2019/20
Respiratory	-57.5%	28.5%	-29.1%
MSK	-45.2%	29.5%	-15.7%
Hypertension	-42.1%	57.4%	15.3%
Diabetes	-32.8%	14.5%	-18.3%
CVD	-20.2%	22.4%	2.2%
Neoplasm	-18.0%	26.1%	8.1%
Stroke	-0.2%	27.7%	27.4%

Summary figure Harrow rate of cost change for 7 main LTCs from 2020/21 and 2021/22 compared to the previous year also 2021/22 compared to 2 years before (pre-pandemic)

Cardiovascular Disease (CVD): Primary Diagnosis ICD-10 I60 - I69 used

Figure 1 and Tables 1 to 3 show the cost of CVD in 2019/20 to 2021/22 broken down by 12 months. The figures show the cost of CVD in 2020/21 was lower than the year before and after.

Figure 1 Cost of CVD for Harrow by month, 2019/20 to 2021/22

Tables 1 – 3 show the cost of CVD in the last 3 financial years by month and type of admission.

Table 1 Cost of CVD, Harrow CCG, 2019/20

Row Labels	Column Labels Sum of Activity				Sum of PBR Cost				Total Sum of Activity	Total Sum of PBR Cost
	DC	EL	Other	NULL	DC	EL	Other	NULL		
2019 - 20	**3**	**22**	**412**	**30**	**£2,853**	**£92,328**	**£1,570,160**	**£162,191**	**467**	**£1,827,532**
Apr		2	33	5		£22,432	£130,949	£33,153	40	**£186,534**
May		3	33	2		£18,439	£141,434	£15,209	38	**£175,082**
Jun		3	33	1		£15,481	£202,421	£3,236	37	**£221,138**
Jul			40	3			£55,181	£26,051	43	**£81,232**
Aug		1	33			£0	£63,861		34	**£63,861**
Sep		1	34	4		£6,913	£117,422	£6,991	39	**£131,326**
Oct	2	2	50	2	£521	£4,204	£191,120	£1,388	56	**£197,233**
Nov	1	1	43	1	£2,332	£0	£186,513	£14,855	46	**£203,700**
Dec		2	34	3		£0	£154,616	£30,436	39	**£185,052**
Jan		3	27	4		£0	£72,473	£15,341	34	**£87,814**
Feb		2	25	3		£2,427	£116,803	£10,300	30	**£129,530**
Mar		2	27	2		£22,432	£137,367	£5,231	31	**£165,030**

Table 2 Cost of CVD, Harrow CCG, 2020/21

Row Labels	Column Labels Sum of Activity				Sum of PBR Cost				Total Sum of Activity	Total Sum of PBR Cost
	DC	EL	Other	NULL	DC	EL	Other	NULL		
2020 - 21		**6**	**361**	**23**		**£30,515**	**£1,344,441**	**£83,194**	**390**	**£1,458,150**
Apr			26	1			£64,878	£9,179	27	**£74,057**
May			23				£95,509		23	**£95,509**
Jun			31	4			£143,899	£19,036	35	**£162,935**
Jul			31	2			£120,442	£4,724	33	**£125,166**
Aug		2	25	2		£13,259	£97,896	£4,882	29	**£116,037**
Sep		1	27	2		£4,254	£85,616	£2,363	30	**£92,233**
Oct		1	24	2		£2,367	£88,517	£3,308	27	**£94,192**
Nov			37	4			£90,710	£27,248	41	**£117,958**
Dec		1	33	1		£2,367	£85,852	£0	35	**£88,219**
Jan			34	1			£135,270	£0	35	**£135,270**
Feb			39	3			£205,902	£12,454	42	**£218,356**
Mar		1	31	1		£8,268	£129,950	£0	33	**£138,218**

Table 3 Cost of CVD, Harrow CCG, 2021/22

Row Labels	Column Labels Sum of Activity				Sum of PBR Cost				Total Sum of Activity	Total Sum of PBR Cost
	DC	EL	Other	NULL	DC	EL	Other	NULL		
2021 - 22	**10**	**16**	**339**	**17**	**£17,725**	**£119,118**	**£1,500,918**	**£60,265**	**382**	**£1,698,026**
Apr	1	1	28	2	£2,386	£7,374	£102,365	£3,620	32	**£115,745**
May			37	3			£145,264	£31,119	40	**£176,383**
Jun	1	4	40	2	£2,386	£31,630	£112,363	£608	47	**£146,987**
Jul		1	28	1		£8,863	£151,026	£4,776	30	**£164,665**
Aug	1	4	21	1	£2,463	£20,853	£48,520	£0	27	**£71,836**
Sep	3	3	27	3	£6,859	£26,323	£131,570	£15,263	36	**£180,015**
Oct			47	1			£231,451	£0	48	**£231,451**
Nov	1		42		£2,427		£255,146		43	**£257,573**
Dec			33	2			£101,058	£4,879	35	**£105,937**
Jan	2	2	20	1	£602	£12,048	£128,665	£0	25	**£141,315**
Feb	1	1	16	1	£602	£12,027	£93,490	£0	19	**£106,119**

Diabetes Mellitus (DM): Primary Diagnosis ICD-10 E10 - E14 used

Figure 2 and Tables 4 to 6 show the cost of DM in 2019/20 to 2021/22 broken down by 12 months. The figures show the cost of DM in 2020/21 was lower than the year before and after.

Figure 2 Cost of Diabetes for Harrow by month, 2019/20 to 2021/22

Tables 4 – 6 show the cost of DM in the last 3 financial years by month and type of admission.

Table 4 Cost of Diabetes, Harrow CCG, 2019 /20

Row Labels	Column Labels Sum of Activity				Sum of PBR Cost				Total Sum of Activity	Total Sum of PBR Cost
	DC	EL	Other	NULL	DC	EL	Other	NULL		
2019 - 20	**46**	**3**	**168**		**£38,493**	**£3,513**	**£400,075**		**217**	**£442,081**
Apr	1		14		£337		£36,174		15	**£36,511**
May	1		21		£332		£45,920		22	**£46,252**
Jun			8				£27,547		8	**£27,547**
Jul	1		11		£337		£17,841		12	**£18,178**
Aug			22				£62,889		22	**£62,889**
Sep	28	2	14		£29,499	£2,011	£26,610		44	**£58,120**
Oct	2		17		£957		£33,871		19	**£34,828**
Nov	4	1	7		£2,104	£1,502	£16,163		12	**£19,769**
Dec	1		13		£406		£26,506		14	**£26,912**
Jan	1		16		£792		£38,241		17	**£39,033**
Feb	4		14		£1,808		£35,157		18	**£36,965**
Mar	3		11		£1,921		£33,156		14	**£35,077**

Table 5 Cost of Diabetes, Harrow CCG, 2020/21

Row Labels	Column Labels Sum of Activity				Sum of PBR Cost				Total Sum of Activity	Total Sum of PBR Cost
	DC	EL	Other	NULL	DC	EL	Other	NULL		
2020 - 21	**22**	**2**	**157**		**£12,426**	**£6,033**	**£278,746**		**181**	**£297,205**
Apr			4				£5,542		4	**£5,542**
May	3	1	11		£2,055	£6,033	£27,485		15	**£35,573**
Jun	1		6		£480		£12,372		7	**£12,852**
Jul	5		15		£2,976		£18,165		20	**£21,141**
Aug	4	1	11		£1,920	£0	£25,661		16	**£27,581**
Sep	1		13		£558		£28,952		14	**£29,510**
Oct	4		21		£2,338		£36,908		25	**£39,246**
Nov			18				£29,071		18	**£29,071**
Dec	1		18		£332		£23,535		19	**£23,867**
Jan	1		19		£332		£37,309		20	**£37,641**
Feb	2		10		£1,435		£19,614		12	**£21,049**
Mar			11				£14,132		11	**£14,132**

Table 6 Cost of Diabetes, Harrow CCG, 2021/22

Row Labels	Column Labels Sum of Activity				Sum of PBR Cost				Total Sum of Activity	Total Sum of PBR Cost
	DC	EL	Other	NULL	DC	EL	Other	NULL		
2021 - 22	**26**	**3**	**146**		**£24,038**	**£22,436**	**£291,832**		**175**	**£338,306**
Apr	1	1	14		£578	£5,493	£27,078		16	**£33,149**
May			11				£16,397		11	**£16,397**
Jun	3		12		£6,047		£20,814		15	**£26,861**
Jul	1		12		£335		£23,306		13	**£23,641**
Aug	2		7		£1,268		£11,179		9	**£12,447**
Sep	3		9		£2,017		£18,277		12	**£20,294**
Oct	3		25		£1,929		£47,640		28	**£49,569**
Nov	2	1	20		£1,065	£10,744	£50,044		23	**£61,853**
Dec	9	1	10		£9,126	£6,199	£16,672		20	**£31,997**
Jan	1		13		£506		£30,834		14	**£31,340**
Feb	1		13		£1,167		£29,591		14	**£30,758**

Hypertension: Primary Diagnosis ICD-10 I10 - I16 used

Figure 3 and Tables 7 to 9 show the cost of Hypertension in 2019/20 to 2021/22 broken down by 12 months. The figures show the cost of Hypertension in 2020/21 was lower than the year before and after.

Figure 3 Cost of Hypertension for Harrow by month, 2019/20 to 2021/22

Tables 7 – 9 show the cost of Hypertension in the last 3 financial years by month and type of admission.

Table 7 Cost of Hypertension, Harrow CCG, 2019/20

Row Labels	Column Labels Sum of Activity				Sum of PBR Cost				Total Sum of Activity	Total Sum of PBR Cost
	DC	EL	Other	NULL	DC	EL	Other	NULL		
2019 - 20	**28**		**122**		**£17,543**		**£107,153**		**150**	**£124,696**
Apr			12				£9,414		12	**£9,414**
May	2		15		£941		£11,290		17	**£12,231**
Jun	1		8		£2,180		£5,293		9	**£7,473**
Jul	4		9		£3,272		£8,120		13	**£11,392**
Aug			7				£4,333		7	**£4,333**
Sep	2		8		£1,116		£8,258		10	**£9,374**
Oct	8		14		£4,161		£16,145		22	**£20,306**
Nov	3		14		£1,674		£9,575		17	**£11,249**
Dec	1		5		£558		£3,429		6	**£3,987**
Jan	4		16		£1,929		£21,123		20	**£23,052**
Feb	1		8		£577		£4,973		9	**£5,550**
Mar	2		6		£1,135		£5,200		8	**£6,335**

Table 8 Cost of Hypertension, Harrow CCG, 2020/21

Row Labels	Column Labels Sum of Activity				Sum of PBR Cost				Total Sum of Activity	Total Sum of PBR Cost
	DC	EL	Other	NULL	DC	EL	Other	NULL		
2020 - 21	**12**		**83**		**£6,791**		**£65,427**		**95**	**£72,218**
Apr	3		1		£1,698		£968		4	**£2,666**
May			4				£2,502		4	**£2,502**
Jun	2		8		£1,132		£8,747		10	**£9,879**
Jul	1		4		£566		£2,855		5	**£3,421**
Aug	1		5		£566		£3,124		6	**£3,690**
Sep	1		6		£566		£6,005		7	**£6,571**
Oct	1		9		£566		£6,302		10	**£6,868**
Nov			7				£4,761		7	**£4,761**
Dec	2		14		£1,132		£13,954		16	**£15,086**
Jan			3				£2,095		3	**£2,095**
Feb			8				£5,672		8	**£5,672**
Mar	1		14		£565		£8,442		15	**£9,007**

Table 9 Cost of Hypertension, Harrow CCG, 2021/22

Row Labels	Column Labels Sum of Activity				Sum of PBR Cost				Total Sum of Activity	Total Sum of PBR Cost
	DC	EL	Other	NULL	DC	EL	Other	NULL		
2021 - 22	**19**	**3**	**129**		**£12,336**	**£4,307**	**£114,289**		**151**	**£130,932**
Apr	3		18		£1,731		£18,667		21	**£20,398**
May	1		14		£572		£8,980		15	**£9,552**
Jun	2		11		£1,144		£7,304		13	**£8,448**
Jul	4		12		£3,872		£8,005		16	**£11,877**
Aug			7				£4,452		7	**£4,452**
Sep	3	1	13		£1,716	£572	£17,544		17	**£19,832**
Oct			8				£5,162		8	**£5,162**
Nov	1	1	7		£376	£3,153	£4,505		9	**£8,034**
Dec	1	1	16		£582	£582	£13,211		18	**£14,375**
Jan	1		10		£582		£6,809		11	**£7,391**
Feb	3		13		£1,761		£19,650		16	**£21,411**

Musculoskeletal (MSK) Conditions: Treatment Function T&O, Rheumatology and Pain Management used

Figure 4 and Tables 10 to 12 show the cost of MSK in 2019/20 to 2021/22 broken down by 12 months. The figures show the cost of MSK in 2020/21 was lower than the year before and after.

Figure 4 Cost of MSK for Harrow by month, 2019/20 to 2021/22

Tables 10 – 12 show the cost of MSK in the last 3 financial years by month and type of admission.

Table 10 Cost of MSK, Harrow CCG, 2019/20

Row Labels	Column Labels Sum of Activity				Sum of PBR Cost				Total Sum of Activity	Total Sum of PBR Cost
	DC	EL	Other	NULL	DC	EL	Other	NULL		
2019 - 20	**3265**	**1039**	**771**	**86**	**£3,793,603**	**£5,893,440**	**£3,778,706**	**£40,667**	**5,161**	**£13,506,416**
Apr	305	71	54	4	£409,818	£395,543	£277,976	£0	434	**£1,083,337**
May	243	91	64	6	£304,421	£532,401	£272,963	£0	404	**£1,109,785**
Jun	290	95	66	11	£353,225	£518,761	£376,890	£15,503	462	**£1,264,379**
Jul	340	106	65	2	£389,645	£714,100	£357,043	£1,861	513	**£1,462,649**
Aug	308	101	61	7	£331,986	£590,802	£301,498	£3,734	477	**£1,228,020**
Sep	281	94	67	6	£297,592	£491,615	£303,730	£0	448	**£1,092,937**
Oct	292	85	60	11	£315,733	£441,775	£329,249	£0	448	**£1,086,757**
Nov	222	83	90	5	£267,490	£522,536	£416,140	£7,036	400	**£1,213,202**
Dec	237	75	76	12	£224,944	£432,857	£349,764	£4,255	400	**£1,011,820**
Jan	309	80	68	2	£374,821	£402,076	£370,627	£0	459	**£1,147,524**
Feb	279	97	54	6	£349,080	£534,008	£283,274	£8,278	436	**£1,174,640**
Mar	159	61	46	14	£174,848	£316,966	£139,552	£0	280	**£631,366**

Table 11 Cost of MSK, Harrow CCG, 2020/21

Row Labels	Column Labels Sum of Activity				Sum of PBR Cost				Total Sum of Activity	Total Sum of PBR Cost
	DC	EL	Other	NULL	DC	EL	Other	NULL		
2020 - 21	**1614**	**409**	**799**	**50**	**£1,625,195**	**£2,383,650**	**£3,341,629**	**£47,371**	**2,872**	**£7,397,845**
Apr	32	3	39	2	£22,472	£17,365	£145,530	£4,647	76	**£190,014**
May	46	7	54	4	£33,146	£15,119	£253,934	£0	111	**£302,199**
Jun	63	19	79	2	£42,829	£113,122	£337,407	£0	163	**£493,358**
Jul	126	18	71	7	£105,883	£103,447	£280,535	£0	222	**£489,865**
Aug	143	43	79	10	£142,460	£373,851	£344,292	£0	275	**£860,603**
Sep	210	46	93	3	£219,334	£250,448	£329,768	£17,602	352	**£817,152**
Oct	211	62	62	2	£236,626	£364,661	£289,457	£0	337	**£890,744**
Nov	201	71	59	7	£217,593	£402,606	£264,522	£1,262	338	**£885,983**
Dec	156	59	81	6	£142,678	£352,135	£314,306	£0	302	**£809,119**
Jan	111	11	61	5	£111,831	£62,341	£258,888	£23,860	188	**£456,920**
Feb	117	25	61		£118,499	£135,541	£250,969		203	**£505,009**
Mar	198	45	60	2	£231,844	£193,014	£272,021	£0	305	**£696,879**

Table 12 Cost of MSK, Harrow CCG, 2021/22

Row Labels	Column Labels Sum of Activity				Sum of PBR Cost				Total Sum of Activity	Total Sum of PBR Cost
	DC	EL	Other	NULL	DC	EL	Other	NULL		
2021 - 22	**2199**	**712**	**879**	**119**	**£2,717,304**	**£4,118,486**	**£3,709,161**	**£33,906**	**3,909**	**£10,578,857**
Apr	182	47	82	9	£232,325	£234,567	£369,911	£0	320	**£836,803**
May	205	77	78	8	£240,458	£504,424	£277,942	£0	368	**£1,022,824**
Jun	224	72	93	6	£283,165	£441,566	£391,697	£8,945	395	**£1,125,373**
Jul	233	72	97	16	£270,938	£394,491	£445,269	£0	418	**£1,110,698**
Aug	193	59	63	14	£220,089	£316,365	£253,250	£0	329	**£789,704**
Sep	199	74	82	16	£268,489	£415,791	£391,410	£5,089	371	**£1,080,779**
Oct	182	71	87	5	£229,594	£395,979	£395,233	£3,232	345	**£1,024,038**
Nov	225	78	85	12	£277,381	£455,052	£441,069	£0	400	**£1,173,502**
Dec	189	56	77	15	£237,164	£333,561	£309,777	£0	337	**£880,502**
Jan	169	46	62	12	£200,075	£288,127	£237,961	£16,640	289	**£742,803**
Feb	198	60	73	6	£257,626	£338,563	£195,642	£0	337	**£791,831**

Neoplasm: Primary Diagnosis ICD-10 C00 - D49 used

Figure 5 and Tables 13 to 15 show the cost of Neoplasm in 2019/20 to 2021/22 broken down by 12 months. The figures show the cost of Neoplasm in 2020/21 was lower than the year before and after.

Figure 5 Cost of Neoplasm for Harrow by month, 2019/20 to 2021/22

Tables 13 – 15 show the cost of Neoplasm in the last 3 financial years by month and type of admission.

Table 13 Cost of Neoplasm, Harrow CCG, 2019/20

Row Labels	Column Labels Sum of Activity				Sum of PBR Cost				Total Sum of Activity	Total Sum of PBR Cost
	DC	EL	Other	NULL	DC	EL	Other	NULL		
2019 - 20	**8366**	**910**	**591**	**531**	**£4,324,371**	**£3,787,926**	**£2,931,876**	**£136,691**	**10,398**	**£11,180,864**
Apr	667	72	41	37	£334,582	£241,578	£180,714	£17,363	817	**£774,237**
May	693	83	66	46	£370,261	£379,432	£288,313	£6,553	888	**£1,044,559**
Jun	680	73	43	36	£350,467	£237,310	£201,574	£20,075	832	**£809,426**
Jul	769	83	57	52	£443,048	£390,959	£276,782	£6,516	961	**£1,117,305**
Aug	698	67	51	55	£367,999	£369,805	£438,373	£6,131	871	**£1,182,308**
Sep	698	77	46	48	£363,464	£386,586	£231,467	£5,607	869	**£987,124**
Oct	759	66	42	47	£419,668	£238,978	£154,305	£7,801	914	**£820,752**
Nov	699	83	44	45	£367,882	£321,009	£276,728	£2,743	871	**£968,362**
Dec	679	57	46	49	£322,919	£248,861	£240,774	£31,695	831	**£844,249**
Jan	751	79	53	45	£386,156	£312,580	£219,938	£5,133	928	**£923,807**
Feb	671	94	60	45	£318,776	£376,061	£255,873	£23,512	870	**£974,222**
Mar	602	76	42	26	£279,149	£284,767	£167,035	£3,562	746	**£734,513**

Table 14 Cost of Neoplasm, Harrow CCG, 2020/21

Row Labels	Column Labels Sum of Activity				Sum of PBR Cost				Total Sum of Activity	Total Sum of PBR Cost
	DC	EL	Other	NULL	DC	EL	Other	NULL		
2020 - 21	**5583**	**720**	**637**	**311**	**£3,104,746**	**£3,381,896**	**£2,563,423**	**£122,128**	**7,251**	**£9,172,193**
Apr	302	34	40	30	£132,933	£147,528	£116,488	£23,716	406	**£420,665**
May	291	33	38	29	£128,792	£151,985	£166,040	£10,762	391	**£457,579**
Jun	425	56	53	23	£236,519	£347,316	£187,742	£10,094	557	**£781,671**
Jul	400	53	60	31	£225,025	£198,600	£214,553	£4,566	544	**£642,744**
Aug	441	48	52	26	£243,639	£251,996	£239,903	£19,607	567	**£755,145**
Sep	531	76	48	28	£315,303	£256,578	£195,748	£4,874	683	**£772,503**
Oct	499	84	87	24	£261,141	£426,663	£322,604	£13,150	694	**£1,023,558**
Nov	576	82	74	25	£319,440	£428,014	£314,571	£2,446	757	**£1,064,471**
Dec	556	66	51	23	£326,429	£321,855	£207,482	£1,144	696	**£856,910**
Jan	525	59	37	22	£335,987	£226,712	£148,431	£1,908	643	**£713,038**
Feb	487	64	45	21	£285,312	£317,385	£213,491	£12,652	617	**£828,840**
Mar	550	65	52	29	£294,226	£307,264	£236,370	£17,209	696	**£855,069**

Table 15 Cost of Neoplasm, Harrow CCG, 2021/22

Row Labels	Column Labels Sum of Activity				Sum of PBR Cost				Total Sum of Activity	Total Sum of PBR Cost
	DC	EL	Other	NULL	DC	EL	Other	NULL		
2021 - 22	**6737**	**858**	**718**	**296**	**£3,970,603**	**£4,099,541**	**£2,844,283**	**£212,909**	**8,609**	**£11,127,336**
Apr	635	69	56	18	£361,481	£356,450	£222,393	£1,536	778	**£941,860**
May	578	66	75	21	£340,820	£316,392	£232,032	£25,048	740	**£914,292**
Jun	670	76	83	13	£430,691	£313,598	£253,590	£1,346	842	**£999,225**
Jul	651	96	88	29	£404,335	£430,091	£360,407	£30,385	864	**£1,225,218**
Aug	576	76	57	16	£340,940	£391,494	£220,983	£4,168	725	**£957,585**
Sep	606	101	72	25	£328,176	£465,733	£298,706	£14,406	804	**£1,107,021**
Oct	591	89	72	30	£358,653	£364,911	£311,311	£41,710	782	**£1,076,585**
Nov	656	68	71	30	£380,167	£326,123	£356,022	£31,518	825	**£1,093,830**
Dec	667	76	61	37	£364,314	£468,027	£251,356	£17,648	841	**£1,101,345**
Jan	600	73	45	35	£364,273	£376,634	£185,288	£9,790	753	**£935,985**
Feb	507	68	38	42	£296,753	£290,088	£152,195	£35,354	655	**£774,390**

Respiratory Disease: Primary Diagnosis ICD-10 C00 - D49 used

Figure 6 and Tables 16 to 18 show the cost of respiratory disease in 2019/20 to 2021/22 broken down by 12 months. The figures show the cost of respiratory disease in 2020/21 was lower than the year before and after.

Figures show there has been a large decline in the cost of the respiratory disease, the conclusion could be that the death from COVID-19 has more been related to those cases who were subject to respiratory disease.

Figure 6 Cost of Respiratory Disease for Harrow by month, 2019/20 to 2021/22

Tables 16–18 show the cost of Respiratory Disease in the last 3 financial years by month and type of admission.

Table 16 Cost of Respiratory Disease, Harrow CCG, 2019/20

Row Labels	Column Labels Sum of Activity				Sum of PBR Cost				Total Sum of Activity	Total Sum of PBR Cost
	DC	EL	Other	NULL	DC	EL	Other	NULL		
2019 - 20	**841**	**200**	**3483**	**16**	**£958,521**	**£427,690**	**£9,132,836**	**£56,410**	**4,540**	**£10,575,457**
Apr	86	14	327	2	£88,033	£24,565	£845,585	£1,238	429	**£959,421**
May	76	17	302	2	£81,208	£21,364	£796,678	£6,412	397	**£905,662**
Jun	73	24	213		£104,269	£61,166	£609,629		310	**£775,064**
Jul	77	26	257	1	£82,111	£64,630	£642,366	£3,534	361	**£792,641**
Aug	69	12	208	2	£87,052	£29,723	£609,098	£14,648	291	**£740,521**
Sep	68	14	208		£72,423	£26,481	£577,485		290	**£676,389**
Oct	89	15	260	2	£95,751	£35,227	£665,836	£2,528	366	**£799,342**
Nov	57	20	338	3	£72,689	£52,886	£806,947	£18,616	418	**£951,138**
Dec	55	18	419	1	£52,925	£25,315	£1,050,654	£0	493	**£1,128,894**
Jan	103	14	419	1	£105,868	£34,617	£1,213,060	£9,434	537	**£1,362,979**
Feb	57	11	313		£65,016	£15,911	£827,731		381	**£908,658**
Mar	31	15	219	2	£51,176	£35,805	£487,767	£0	267	**£574,748**

Table 17 Cost of Respiratory Disease, Harrow CCG, 2020/21

Row Labels	Column Labels Sum of Activity				Sum of PBR Cost				Total Sum of Activity	Total Sum of PBR Cost
	DC	EL	Other	NULL	DC	EL	Other	NULL		
2020 - 21	**271**	**78**	**1281**	**8**	**£286,370**	**£241,346**	**£3,895,258**	**£68,133**	**1,638**	**£4,491,107**
Apr	2	4	66	3	£947	£18,318	£185,470	£11,637	75	**£216,372**
May	7		84	1	£7,380		£229,124	£11,303	92	**£247,807**
Jun	11	2	94		£8,412	£19,829	£262,132		107	**£290,373**
Jul	24	7	99	1	£31,869	£18,529	£326,727	£14,759	131	**£391,884**
Aug	25	7	88	1	£36,052	£26,673	£246,529	£7,364	121	**£316,618**
Sep	26	11	133	1	£27,355	£32,257	£355,144	£10,322	171	**£425,078**
Oct	12	9	169		£16,814	£13,594	£537,962		190	**£568,370**
Nov	40	8	137		£38,527	£20,871	£373,884		185	**£433,282**
Dec	42	14	103	1	£44,533	£50,038	£358,830	£12,748	160	**£466,149**
Jan	26	4	83		£20,412	£4,130	£254,600		113	**£279,142**
Feb	26	4	95		£25,662	£20,154	£328,557		125	**£374,373**
Mar	30	8	130		£28,407	£16,953	£436,299		168	**£481,659**

Table 18 Cost of Respiratory Disease, Harrow CCG, 2021/22

Row Labels	Column Labels Sum of Activity				Sum of PBR Cost				Total Sum of Activity	Total Sum of PBR Cost
	DC	EL	Other	NULL	DC	EL	Other	NULL		
2021 - 22	**487**	**144**	**1999**	**9**	**£644,906**	**£469,647**	**£5,695,823**	**£78,660**	**2,639**	**£6,889,036**
Apr	37	11	135		£49,578	£33,174	£453,320		183	**£536,072**
May	52	20	160		£58,882	£61,818	£323,376		232	**£444,076**
Jun	53	13	199	1	£60,978	£23,854	£511,687	£14,878	266	**£611,397**
Jul	36	15	192	3	£58,303	£22,737	£559,399	£41,720	246	**£682,159**
Aug	39	14	183		£43,912	£54,902	£594,783		236	**£693,597**
Sep	36	11	191		£45,210	£11,484	£578,784		238	**£635,478**
Oct	41	12	230		£53,156	£28,724	£704,501		283	**£786,381**
Nov	50	14	258	2	£77,127	£40,637	£700,599	£5,492	324	**£823,855**
Dec	50	5	211		£89,297	£9,922	£655,314		266	**£754,533**
Jan	36	11	117	2	£49,115	£86,038	£304,486	£15,961	166	**£455,600**
Feb	57	18	123	1	£59,348	£96,357	£309,574	£609	199	**£465,888**

Stroke: HRG AA35A, AA35B, AA35C, AA35D, AA35E, AA35F used

Figure 7 and Tables 19 to 21 show the cost of Stroke in 2019/20 to 2021/22 broken down by 12 months. The figures show the cost of Stroke in 2020/21 was lower than the year before and after.

Figure 7 Cost of Stroke for Harrow by month, 2019/20 to 2021/22

Tables 19 – 21 show the cost of Stroke in the last 3 financial years by month and type of admission.

Table 19 Cost of Stroke, Harrow CCG, 2019/20

Row Labels	Column Labels Sum of Activity				Sum of PBR Cost				Total Sum of Activity	Total Sum of PBR Cost
	DC	EL	Other	NULL	DC	EL	Other	NULL		
2019 - 20		**5**	**321**	**21**		**£6,913**	**£541,015**	**£157,978**	**347**	**£705,906**
Apr		1	26	3		£0	£68,229	£32,016	30	**£100,245**
May			28	2			£85,514	£15,209	30	**£100,723**
Jun			24	1			£58,756	£3,236	25	**£61,992**
Jul			36	3			£37,428	£26,051	39	**£63,479**
Aug		1	28			£0	£43,903		29	**£43,903**
Sep		1	26	3		£6,913	£45,901	£6,991	30	**£59,805**
Oct		1	36			£0	£23,897		37	**£23,897**
Nov			34	1			£45,970	£14,855	35	**£60,825**
Dec		1	26	3		£0	£46,564	£30,436	30	**£77,000**
Jan			21	2			£9,111	£14,855	23	**£23,966**
Feb			17	2			£28,107	£9,699	19	**£37,806**
Mar			19	1			£47,635	£4,630	20	**£52,265**

Table 20 Cost of Stroke, Harrow CCG, 2020/21

Row Labels	Column Labels Sum of Activity				Sum of PBR Cost				Total Sum of Activity	Total Sum of PBR Cost
	DC	EL	Other	NULL	DC	EL	Other	NULL		
2020 - 21			**288**	**10**			**£648,576**	**£55,788**	**298**	**£704,364**
Apr			21	1			£50,295	£9,179	22	**£59,474**
May			17				£62,641		17	**£62,641**
Jun			23	2			£64,036	£19,036	25	**£83,072**
Jul			23	1			£20,997	£4,724	24	**£25,721**
Aug			20				£54,912		20	**£54,912**
Sep			20	1			£20,413	£2,363	21	**£22,776**
Oct			21	2			£51,163	£3,308	23	**£54,471**
Nov			30	1			£44,616	£4,724	31	**£49,340**
Dec			27				£60,949		27	**£60,949**
Jan			28				£62,464		28	**£62,464**
Feb			34	2			£93,090	£12,454	36	**£105,544**
Mar			24				£63,000		24	**£63,000**

Table 21 Cost of Stroke, Harrow CCG, 2021/22

Row Labels	Column Labels Sum of Activity				Sum of PBR Cost				Total Sum of Activity	Total Sum of PBR Cost
	DC	EL	Other	NULL	DC	EL	Other	NULL		
2021 - 22		**3**	**268**	**7**		**£39,887**	**£726,751**	**£59,380**	**278**	**£826,018**
Apr			22	1			£70,706	£3,343	23	**£74,049**
May			30	2			£82,341	£31,119	32	**£113,460**
Jun		1	33			£15,057	£91,261		34	**£106,318**
Jul			21	1			£38,738	£4,776	22	**£43,514**
Aug			19				£19,251		19	**£19,251**
Sep		1	21	2		£15,209	£38,349	£15,263	24	**£68,821**
Oct			37				£115,699		37	**£115,699**
Nov			31				£112,158		31	**£112,158**
Dec			32	1			£99,552	£4,879	33	**£104,431**
Jan		1	11			£9,621	£31,966		12	**£41,587**
Feb			11				£26,730		11	**£26,730**

Total Cost of LTC Harrow CCG, 2019/20 - 2021/22

Figures 8, 9 and 10 below show the cost of each 7 LTC by actual (£) numbers. Overall, in the last 3 financial years, Neoplasm (£32,443,582) closely followed by MSK (£32,292,584) hold the highest cost between all LTCs in Harrow CCG. In the third-place cost of the Respiratory disease in the last 3 years was £22,567,352.

Figure 8 LTC cost grouped by year, Harrow CCG, 2019/20 - 2021/22

Figure 9 LTC cost grouped by main conditions, Harrow CCG, 2019/20 - 2021/22

Figure 9 LTC 3-Years cost by main conditions, Harrow CCG, 2019/20 - 2021/22

CARDIOVASCULAR DISEASE

Introduction

Broadly, hypertension, stroke, and atrial fibrillation (AF), diabetes, kidney disease, heart disease and heart failure can be classified as cardiovascular or cardiovascular disease related conditions. The data presented within this report and linked reports, compares Harrow CCG and its PCNs with a range of data and other areas including England, a group of similar CCGs and the North West London Sustainability and Transformation Partnership (STP).

The Office for Health Improvement and Disparities (OHID) have developed CVD profiles for Diabetes, Kidney Disease, Stroke and Heart Disease. These profiles are specific to NHS Harrow CCG using a range of data sources from 2020/21. The key findings from each of the reports can be found in appendix 1.

This report will focus on hypertension and AF, but also reference the key findings from each of the above reports to support the recommendations to address CVD in Harrow.

Summary

Hypertension

In 2020/21, there were 37,082 people who had been diagnosed with hypertension in NHS Harrow CCG. This equals 13.2 % of the population. This is significantly lower compared to the England average of 13.9% but holds the highest rate of hypertension prevalence between the North West London CCGs with average of 10.8%.

Prevalence of hypertension for Harrow CCG practices ranges from 18% (Kenton Clinic) to 6.5% (Streatfield Medical Centre).

There has been 0.3% increase in prevalence of hypertension for Harrow CCG From 2009/10 to 2020/21, which is a significant increase. During that time. Trend shows 0.2% decrease for NWL CCGs and 0.5% increases for England.

The estimated number of undiagnosed people with hypertension for Harrow CCG is 6,550. The estimated undiagnosed hypertension rate for GP Practices in Harrow CCG varies from 54.3% (The Pinner Road Surgery) to 94.8% (The Shaftsbury Medical Centre).

Overall, in Harrow CCG there are around 27,270 people with hypertension who are 'treated to target', 8,300 'not treated to target' and 1,500 on Personal Care Approach (PCA).

For Harrow CCG it is estimated that there are 2,370 patients with recorded hypertension whose blood pressure needs to be managed to target, to meet the PHE ambition.

Atrial Fibrillation (AF)

The estimated percentage of detected AF (2018/19) in Harrow was 67% compared to 80% for England. Cross the GP practices in Harrow it varies between 18% to 94%.

The percentage of 'Stroke risk of patients with AF assessed w. CHA2DS2-VASc' for Harrow in 2020/21 was 84.7% compared to 82% for NW London STP (not significantly higher) but significantly higher than the national average of 79%.

The percentage of 'Patients with AF who are treated w anti-coag. therapy (CHADS2DS2-VASc >=2)' for Harrow in 2020/21 was 84.3% (2,782 persons) compared with 85.8% for NW London STP (not significant lower) but significantly lower than the national average of 87.9%.

The estimated additional number of people with AF required to be diagnosed for Harrow CCG in 2018/19 was 1,210 people.

In Harrow CCG during 2018/19 there were 12 patients (38.7%) with AF and not on anticoagulation who had a stroke and their modified ranking scale (mRs=6) or 'Dead'. This rate for England for the same period was 24.9%.

In Harrow CCG the percentage of patients with AF in whom stroke risk has been assessed in the preceding 12 months, (NICE ID: NM81) in 2020/21 was 84.7% (847 patients), significantly higher than the England rate of 79%.

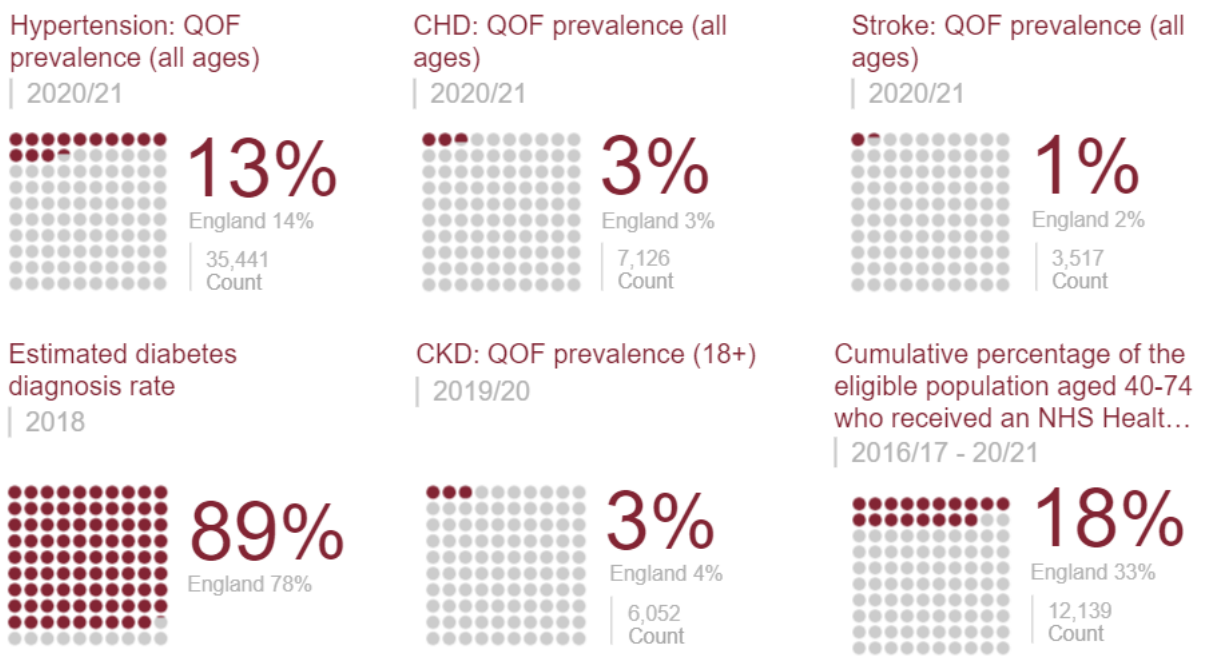
In Harrow CCG the percentage of 'Stroke admission with history of AF not prescribed anticoagulation prior to stroke' in 2019/20 was 59.3% (Count: 32), compared with 36% for England.

In Harrow CCG during 2019/20 the number of high-risk AF patients who were anticoagulated was 2,830, not anticoagulated was 260 and those who have had a Personalised Care Approach was 250.

In 2019/20 it was estimated that there are additional 200 high-risk AF patients in Harrow CCG who had to be anticoagulated to meet the PHE ambition.

Figure 1 shows a summary of CVD prevalence in Harrow compared with England.

Figure 1 Cardiovascular Disease Prevalence – Harrow compared with England



Source: Picture of Health - PBI

Disease Prevalence & Treatment

Hypertension

In 2020/21, there were 37,082 people who had been diagnosed with hypertension and included on GP registers in NHS Harrow CCG. This equals 13.2 % of the population. This is significantly lower compared to the England average of 13.9% but holds the highest rate of hypertension prevalence between the North West London CCGs with average of 10.8%. Figure 2 extracted from PHOF compares the hypertension rate for NW London CCGs and England.

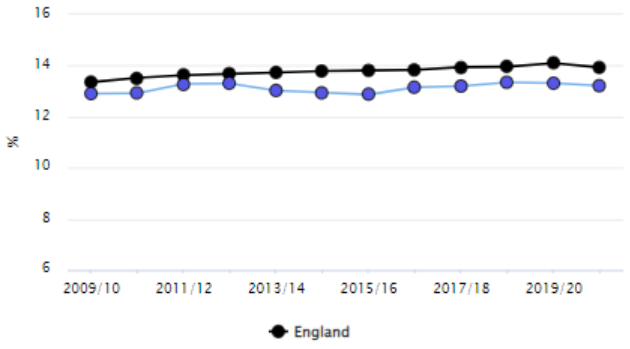
Figure 2 Hypertension: QOF Prevalence (all age) NW London CCGs and England, 2020/21

Area	Recent Trend	Count	Value	99.8% Lower CI	99.8% Upper CI
England	↑	8,457,600	13.9	13.9	13.9
NW London CCGs	–	284,896	10.8*	10.7	10.8
NHS Harrow CCG	→	37,082	13.2*	13.0	13.4
NHS Ealing CCG	↑	56,994	12.5*	12.4	12.7
NHS Hillingdon CCG	→	40,278	12.4*	12.2	12.6
NHS Hounslow CCG	→	38,546	11.5*	11.3	11.7
NHS Brent CCG	↓	46,797	11.5*	11.3	11.6
NHS West London (K&C & QPP) CCG	↓	23,318	8.7*	8.5	8.9
NHS Central London (Westminster) CCG	↓	18,829	7.5*	7.3	7.7
NHS Hammersmith And Fulham CCG	↓	23,052	7.1*	7.0	7.3

Source: Quality and Outcomes Framework (QOF), NHS Digital

Figure 3 shows the trend of hypertension prevalence in Harrow from 2009/10 to 2020/21. Graph shows 0.3% increase in prevalence for Harrow CCG during that time which is a significant increase. Trend shows 0.2% decrease for NWL CCGs and 0.5% increases for England.

Figure 3 Hypertension: QOF prevalence (all ages) in Harrow CCG (blue) compared to England, trend from 2009/10 to 2020/21



Recent trend: ➡ No significant change

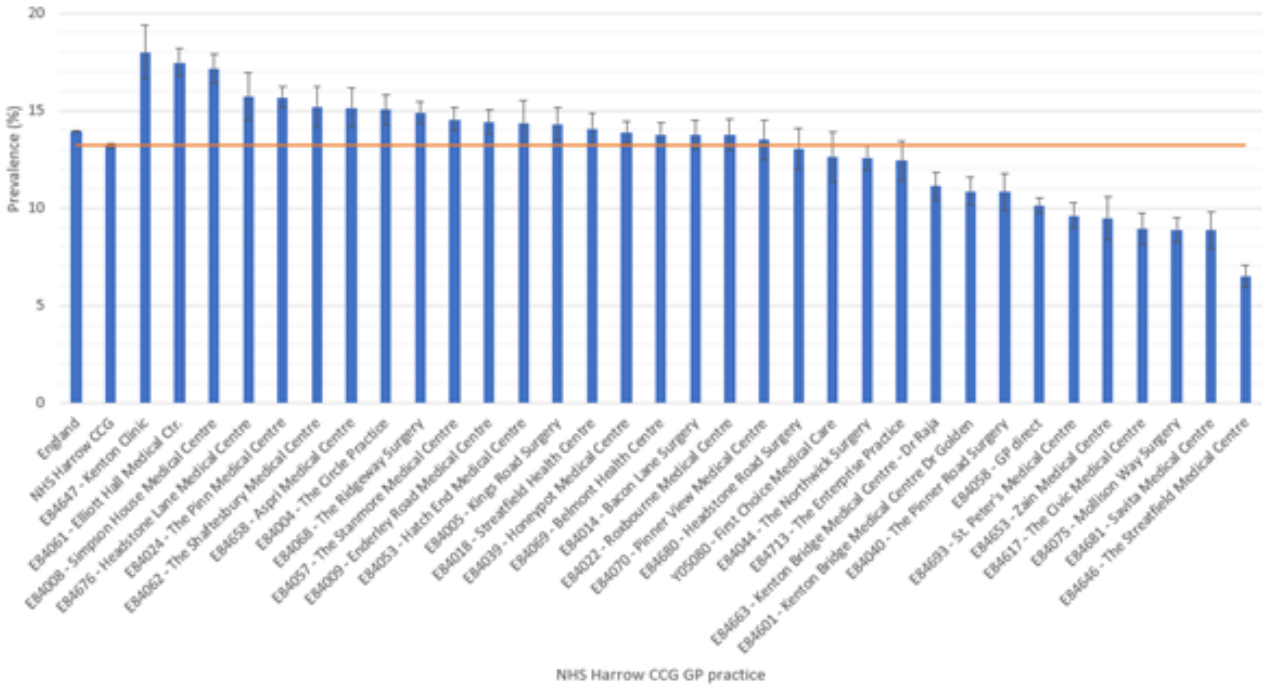
Period		NHS Harrow CCG Count	Value	95% Lower CI	95% Upper CI	NW London CCGs	England
2009/10	●	27,638	12.9%*	12.8%	13.0%	11.0%*	13.4%
2010/11	●	29,277	12.9%*	12.8%	13.1%	11.1%*	13.5%
2011/12	●	28,610	13.3%*	13.1%	13.4%	11.3%*	13.6%
2012/13	●	32,598	13.3%	13.2%	13.4%	11.2%*	13.7%
2013/14	●	32,715	13.0%	12.9%	13.2%	11.0%*	13.7%
2014/15	●	32,585	12.9%	12.8%	13.1%	11.1%*	13.8%
2015/16	●	33,536	12.9%	12.7%	13.0%	11.1%*	13.8%
2016/17	●	34,617	13.2%	13.0%	13.3%	11.4%*	13.8%
2017/18	●	35,192	13.2%	13.1%	13.3%	11.3%*	13.9%
2018/19	●	36,289	13.3%	13.2%	13.5%	11.2%*	14.0%*
2019/20	●	37,051	13.3%	13.2%	13.4%	11.0%*	14.1%
2020/21	●	37,082	13.2%*	13.1%	13.3%	10.8%*	13.9%

Source: Quality and Outcomes Framework (QOF), NHS Digital

Source: Quality and Outcomes Framework (QOF), NHS Digital

Figure 4 shows QOF prevalence of hypertension in all ages by GP practice in 2020/21. There are several GP practices that have a significantly higher or lower hypertension prevalence when comparing to Harrows and England's average. This ranges from 18% at Kenton Clinic to 6.5% at the Streatfield Medical Centre.

Figure 4 Hypertension QOF prevalence (%) in all ages by Harrow GP practices in 2020/21



Source: Quality Outcomes Framework

Figure 5 shows QOF prevalence of hypertension in all ages by GP practice in NW London CCGs and England average, 2020/21. Graph shows a significantly higher rate for Harrow compared to all other CCGs but lower than the England average

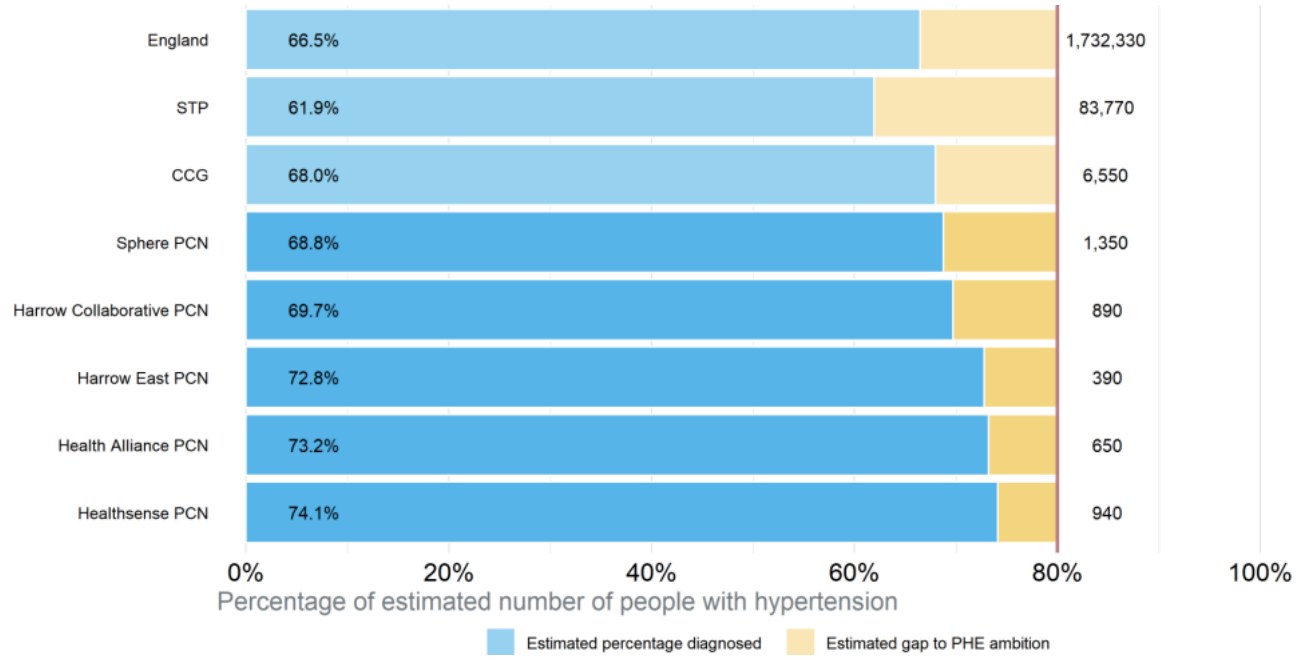
Figure 5 shows QOF prevalence of hypertension in all ages by GP practice in NW London CCGs, NW London STP and England average, 2020/21.

Area	Recent Trend	Count	Value	99.8% Lower CI	99.8% Upper CI
England	↑	8,457,600	13.9	13.9	13.9
NW London CCGs	–	284,896	10.8*	10.7	10.8
NHS Harrow CCG	→	37,082	13.2*	13.0	13.4
NHS Ealing CCG	↑	56,994	12.5*	12.4	12.7
NHS Hillingdon CCG	→	40,278	12.4*	12.2	12.6
NHS Hounslow CCG	→	38,546	11.5*	11.3	11.7
NHS Brent CCG	↓	46,797	11.5*	11.3	11.6
NHS West London (K&C & QPP) CCG	↓	23,318	8.7*	8.5	8.9
NHS Central London (Westminster) CCG	↓	18,829	7.5*	7.3	7.7
NHS Hammersmith And Fulham CCG	↓	23,052	7.1*	7.0	7.3

Source: Quality and Outcomes Framework (QOF), NHS Digital

Figure 6 shows QOF recorded Hypertension prevalence compared with estimated prevalence and estimated additional number of people with hypertension required to be diagnosed to meet the PHE ambition for Harrow PCNs, CCG, NW London STP and England, 2019/20. Estimated prevalence of Harrow CCG (68%) is higher than both STP and England average. The rate for PCNs varies from 68.8% to 74.1%. The estimated number of undiagnosed people with hypertension for Harrow CCG is 6,550.

Figure 6 shows Hypertension QOF recorded prevalence compared with estimated prevalence, 2019/20.



Source: Quality Outcomes Framework and the PHE CVD: Primary Care Intelligence Pack for NHS Harrow CCG[1]

[1] CVD Prevention Pack: Supporting data for NHS Harrow CCG available from: https://fingertips.phe.org.uk/profile/cardiovascular-disease-prevention/area-search-results/E38000074?place_name=NHS%20Harrow%20CCG&search_type=parent-area [accessed: 17-04-2022

The estimated undiagnosed hypertension rate for GP Practices in Harrow CCG varies from 54.3% (The Pinner Road Surgery) to 94.8% (The Shaftsbury Medical Centre). Similar information for all GP Practices within each CPN also can be found from the same source, can be accessed by clicking here (CVD Prevention Pack: Supporting data for NHS Harrow CCG).

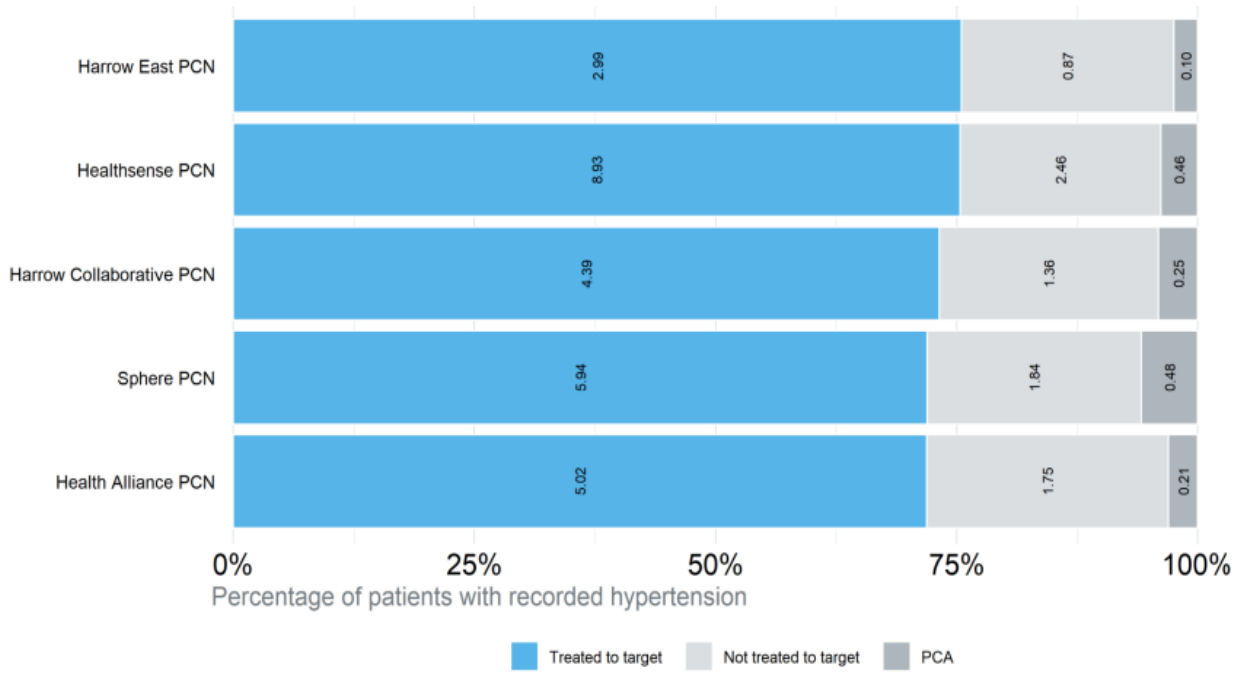
Hypertension Treatment

The PHE ambition refers to treating 80% of people diagnosed with hypertension to NICE guidance. The treatment levels for under and over 80-year-olds varies in the guidance. There is currently no single published measure available to track the progress against the NICE target.

QOF 2019/20 includes separate indicators for the two age groups; treated to 140/90 mmHg or less for patients aged 79 and under and treated to 150/90 mmHg or less for patients aged 80 and above. PHE have combined the data from these two indicators to create a measure looking at how well all patients diagnosed with hypertension are treated to NICE guidance.

Overall, in Harrow CCG there are around 27,270 people with hypertension who are 'treated to target', 8,300 'not treated to target' and 1,500 on Personal Care Approach (PCA).

Figure 7 Number of patients (in 1000s) with recorded hypertension whose blood pressure is managed to target, not managed to target and who have had a PCA

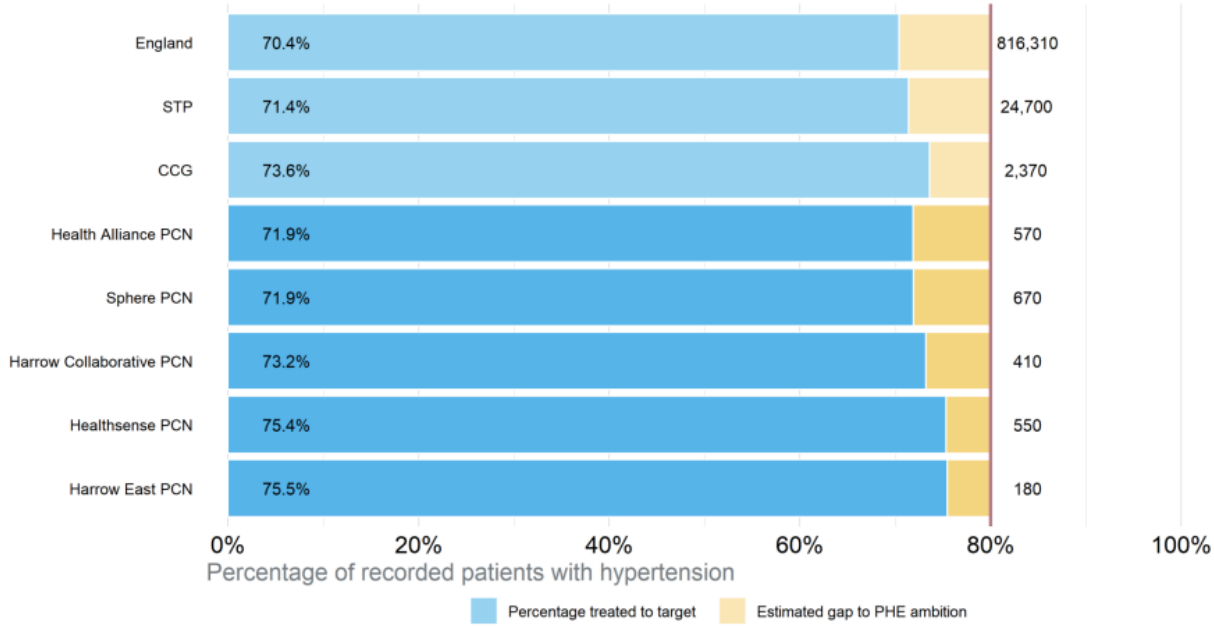


Source: QOF 2019/20 treatment figures. Numbers in thousands.

Estimated additional number of patients with recorded hypertension whose blood pressure needs to be managed to target, to meet the PHE ambition, England, STP, CCG and PCN level, 2019/20 is presented in Figure 8. For Harrow CCG it is estimated to be 2,370 patients but the sum of the additional number of patients in 5 Harrow PCNs is higher than the estimated number for Harrow

CCG which could be the result of overlapping the patient registration by GP surgeries from neighbouring CCGs.

Figure 8 Estimated additional number of patients with recorded hypertension whose blood pressure needs to be managed to target



Source: QOF 2019/20 treatment figures. Numbers rounded to the nearest 10.

Percentage of recorded hypertension patients for Harrow GP practices varies from 44.9% (Aspri Medical Centre) to 82.9% (Kenton Clinic). Further information related to the above two graphs at Harrow GP Practices level is available here: CVD Prevention Pack: Supporting data for NHS Harrow CCG.

NICE GUIDLINE: Hypertension in adults: diagnosis and treatment

Accessible from:

https://www.nice.org.uk/guidance/ng136

https://www.nice.org.uk/guidance/ng136/resources/visual-summary-pdf-6899919517

Also, a copy can be found at Appendix 2

Atrial Fibrillation (AF)

Background

According to the 'Sentinel Stroke National Audit Programme', only half of people with known Atrial Fibrillation (AF) who then suffer a Stroke have been anticoagulated before their stroke.

Atrial fibrillation increases the risk of stroke by a factor of 5, and strokes caused by AF are often more severe, with higher mortality and greater disability. Anticoagulation reduces the risk of stroke in people with AF by two thirds. Despite this, AF is underdiagnosed and under-treated: around a quarter of people with AF are unaware they have the condition and even when diagnosed inadequate treatment is common - large numbers do not receive anticoagulants or have poor anticoagulant control.

The latest available AF relevant indicators data (illustrated in Figure 9) from PHOF (Fingertips) show:

1) The latest available estimated percentage of detected AF (2018/19) in Harrow was 66.7% compared to 80% for England.

2) The percentage of 'Stroke risk of patients with AF assessed w. CHA2DS2-VASc' for Harrow in 2020/21 was 84.7% compared to 82% for NW London STP (not significantly higher) but significantly higher than the national average of 79%.

3) The percentage of 'Patients with AF who are treated w anti-coag. therapy (CHADS2DS2-VASc >=2)' for Harrow in 2020/21 was 84.3% compared with 85.8% for NW London STP (not significant lower) but significantly lower than the national average of 87.9%.

Figure 9 AF related indicators in PHOF

Indicator	Period	Harrow			STPs (from Apr 2020)	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Heart failure									
Estimated percentage of detected Atrial Fibrillation	2018/19	–	-	66.7%	-	80.0%	45.5%		100.0%
Stroke risk of patients with AF assessed w. CHA2DS2-VASc (denominator incl. PCAs)	2020/21	→	847	84.7%*	82.0%	79.0%	58.9%		90.5%
Patients with AF who are treated w anti-coag. therapy (CHADS2DS2-VASc >=2) (denominator incl. PCAs)	2020/21	↑	2,782	84.3%*	85.8%	87.9%	71.3%		92.9%

Estimated prevalence of AF

Figure 10 shows the estimated prevalence of AF in Harrow from 2009/10 to 2020/21. Graph shows a significant increase of the prevalence (detection of AF) for Harrow from 1% to 1.3% (0.3% increase) but this value for England has changed from 1.4% to 2% (0.6% increase).

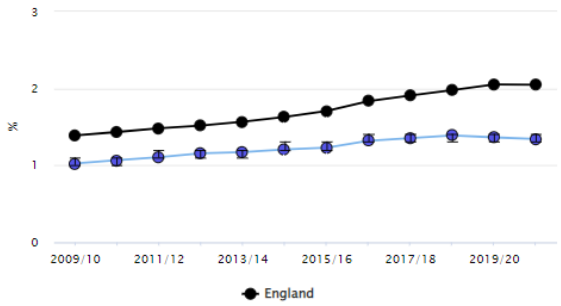
Figure 10 shows the estimated prevalence of AF in Harrow from 2009/10 to 2020/21

Atrial fibrillation: QOF prevalence

Proportion - %

Hide confidence intervals Show 99.8% CI values

More options



Recent trend: No significant change

Period		NHS Harrow CCG Count	Value	95% Lower CI	95% Upper CI	England
2009/10		2,194	1.0%*	1.0%	1.1%	1.4%
2010/11		2,418	1.1%*	1.0%	1.1%	1.4%
2011/12		2,381	1.1%*	1.1%	1.2%	1.5%
2012/13		2,835	1.2%	1.1%	1.2%	1.5%
2013/14		2,947	1.2%	1.1%	1.2%	1.6%
2014/15		3,038	1.2%	1.2%	1.3%	1.6%
2015/16		3,204	1.2%	1.2%	1.3%	1.7%
2016/17		3,470	1.3%	1.3%	1.4%	1.8%
2017/18		3,613	1.4%	1.3%	1.4%	1.9%
2018/19		3,780	1.4%	1.3%	1.4%	2.0%*
2019/20		3,798	1.4%	1.3%	1.4%	2.1%
2020/21		3,772	1.3%*	1.3%	1.4%	2.0%

Source: Quality and Outcomes Framework (QOF), NHS Digital

Figure 11 below illustrate the estimated prevalence of AF for NWL CCGs in 2021. Graph shows a significant higher rate for Harrow compared to the average of NWL CCGs but significantly lower than

Figure 11 Estimated prevalence of AF for NWL CCGs and England

Area	Recent Trend	Count	Value	99.8% Lower CI	99.8% Upper CI
England	↑	1,243,503	2.0	2.0	2.1
CCGs NWL	–	28,992	1.1*	1.1	1.1
NHS Hillingdon CCG	→	4,873	1.5*	1.4	1.6
NHS Harrow CCG	→	3,772	1.3*	1.3	1.4
NHS Ealing CCG	↑	5,247	1.2*	1.1	1.2
NHS West London (K&C & QPP) CCG	→	3,007	1.1*	1.1	1.2
NHS Hounslow CCG	→	3,572	1.1*	1.0	1.1
NHS Central London (Westminster) CCG	→	2,521	1.0*	0.9	1.1
NHS Brent CCG	→	3,478	0.9*	0.8	0.9
NHS Hammersmith And Fulham CCG	↓	2,522	0.8*	0.7	0.8

Source: Quality and Outcomes Framework (QOF), NHS Digital

Estimated prevelance of detected Atrial Fibrillation

Figure 12 and 13 show the 'Estimated percentage of detected Atrial Fibrillation' in Harrow CCG, NWL CCGs and England in 2018/19 (later data is not available). The ratio of those diagnosed with AF versus those expected to have AF in NHS Harrow CCG is 66.7% (suggesting that 2/3rd of people with AF in NHS Harrow CCG have been diagnosed). This compares to 80% for England.

Figure 12 shows the 'Estimated percentage of detected Atrial Fibrillation

Period		NHS Harrow CCG Count	Value	95% Lower CI	95% Upper CI	England
2015/16		3,204	58.5%	-	-	69.8%
2018/19		-	66.7%	-	-	80.0%

Source: QOF

Figure 13 North West London CCGs Estimated percentage of detected Atrial Fibrillation, 2018/19

Area	Recent Trend	Count	Value
England	–	-	80.0
CCGs NWL	–	-	-
NHS Hillingdon CCG	–	-	75.0
NHS Hammersmith And Fulham CCG	–	-	75.0
NHS Central London (Westminster) CCG	–	-	73.3
NHS West London (K&C & QPP) CCG	–	-	66.7
NHS Harrow CCG	–	-	66.7
NHS Hounslow CCG	–	-	64.7
NHS Ealing CCG	–	-	64.7
NHS Brent CCG	–	-	56.3

Source: Quality and Outcomes Framework, NHS Digital and Atrial fibrillation prevalence estimates for local populations, National Cardiovascular Intelligence Network, PHE

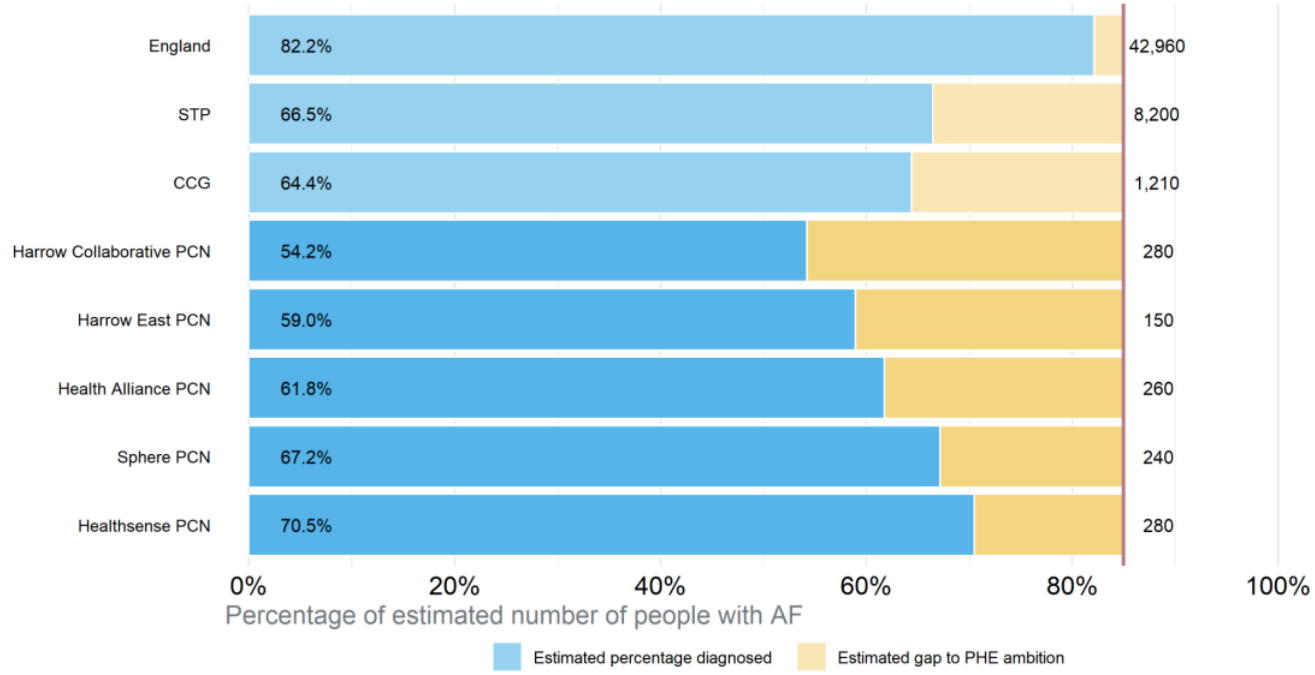
Figure 14 shows the 'Estimated percentage of detected Atrial Fibrillation' by Harrow GP Practices in 2018/19. Estimated percentage of detected Atrial Fibrillation for Harrow CCG is 67% and across GPs in NHS Harrow CCG varies between 18% to 94%.

Figure 14 Estimated percentage of detected AF, Harrow CCG and GP Practices - 2018/19.

Source: PHOF – QOF

Figure 15 below illustrates the AF QOF recorded prevalence compared with estimated prevalence and estimated additional number of people with AF required to be diagnosed to meet the PHE ambition for Harrow PCNs, Harrow CCG, NWL STP and England in 2019/20, reported in CVD Prevention Pack. The estimation is slightly lower than the 2018/19 rate but it includes the Harrow PCNs rate too. Graph below shows the additional estimated number for Harrow CCG is 1,210.

Figure 15 AF QOF recorded prevalence compared with estimated prevalence and estimated additional number of people with AF required to be diagnosed, 2018/19



Source: QOF 2019/20 recorded figures. Estimated prevalence from the NCVIN, 2020. Numbers rounded to the nearest 10.

Atrial Fibrillation Control

There is strong evidence that stroke risk can be substantially reduced by warfarin (approximately 66 per cent risk reduction) and less so by aspirin (approximately 22 per cent risk reduction) [1]. Warfarin in particular is under used for stroke prevention in AF. A NICE costing report accompanying the recommendations for AF treatment in 2006 estimated that nationally 355,312 patients with AF should be on warfarin (i.e., all of those assessed as high risk, half of those at moderate risk and none of those at low risk, using the NICE stroke risk stratification algorithm and if not contraindicated), or an additional 165,946 patients who were not receiving this treatment – almost 50 per cent of those estimated as requiring warfarin. Therefore, there is clearly a need to encourage the use of this treatment for AF patients at high risk of stroke. Furthermore, recent evidence from the BAFTA trial and the ACTIVE-W135 study suggests not only is warfarin much more effective than aspirin, but that it is not as unsafe – in terms of risk of serious haemorrhage – as previously thought (though it would be useful to ascertain if these findings are replicated elsewhere using an appropriate meta-analysis). Figure 16 illsustrates the trend of 'Patients with AF who are treated w anti-coag. therapy (CHADS2DS2-VASc >=2)' from 2015/16 to 2020/21. It shows there has been a steady increase of the

[1] Ajay Srivastava et.al. 2008, "Examining warfarin underutilization rates in patients with atrial fibrillation: Detailed chart review essential to capture contraindications to warfarin therapy", Thrombosis Journal volume 6, Article number: 6 (2008), Online available from: https://thrombosisjournal.biomedcentral.com/articles/10.1186/1477-9560-6-6 [Last accessed: 19/04/2022]

Also Fingertips, indicator definition and supporting information: https://fingertips.phe.org.uk/search/anti%20coag#page/6/gid/1/pat/15/par/E92000001/ati/166/are/E38000074/iid/92594/age/1/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/car-do-0

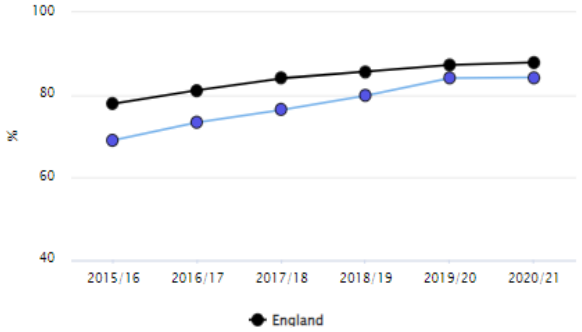
treatment rate up to 2019/20 but it has stopped in 2020/21. It could be an outcome of the Coronavirus pandemic on healthcare system.

Figure 16 Harrow Patients with AF who are treated w anti-coag. therapy (CHADS2DS2-VASc >=2), 2015/16-2020/21

Patients with AF who are treated w anti-coag. therapy (CHADS2DS2-VASc >=2) (denominator incl. PCAs)

Proportion - %

Show confidence intervals Show 99.8% CI values ▶ More options



Recent trend: Increasing

Period		NHS Harrow CCG Count	Value	95% Lower CI	95% Upper CI	England
2015/16		1,847	69.0%	67.2%	70.7%	77.9%
2016/17		2,172	73.4%	71.8%	74.9%	81.2%
2017/18		2,361	76.4%	74.9%	77.9%	84.0%
2018/19		2,643	79.8%	78.4%	81.2%	85.7%
2019/20		2,836	84.1%	82.8%	85.3%	87.3%
2020/21		2,782	84.3%*	83.0%	85.5%	87.9%

Source: Quality and Outcomes Framework (QOF), NHS Digital

Graph below compares the NWL CCGs' anti-coag. Therapy rate with the average rate of STP and England. Figure 17 shows the percentage of patients with AF with a CHA2DS2-VASc score of 2 or more, who were treated with anti-coag in 2020/21 in Harrow CCG was 84.3% was not significant different with North West London STP (85.8%), but it was significantly lower than the national rate of 87.8%.

Figure 17 Number and percentage of 'Patients with AF who are treated w anti-coag. therapy (CHADS2DS2-VASc >=2)', North West London CCGs and England - 2020/21

Area	Recent Trend	Count	Value	99.8% Lower CI	99.8% Upper CI
England		903,133	87.9	87.8	88.0
CCGs NWL	–	20,233	85.8*	85.0	86.4
NHS Ealing CCG		3,743	87.8*	86.2	89.3
NHS Hounslow CCG		2,500	87.6*	85.6	89.4
NHS Hillingdon CCG		3,553	86.1*	84.4	87.7
NHS Hammersmith And Fulham CCG		1,596	85.8*	83.1	88.1
NHS Central London (Westminster) CCG		1,682	85.4*	82.8	87.7
NHS Harrow CCG		2,782	84.3*	82.2	86.1
NHS Brent CCG		2,446	84.2*	82.0	86.2
NHS West London (K&C & QPP) CCG		1,931	83.3*	80.8	85.6

Source: Quality and Outcomes Framework (QOF), NHS Digital

There are 3,300 people with atrial fibrillation with a CHA2DS2-VASc score >= 2 in NHS Harrow CCG, 2,782 (84.3%) are currently treated with anti-coagulation therapy (PHOF, 2020/21).

Stroke admission with history of AF

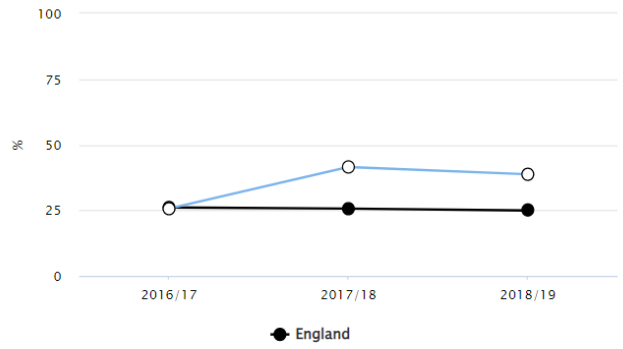
Stroke outcomes on discharge for patients with AF and not on anticoagulation (mRs = 6): Graph and table below shows the percentage (and number) of patients with AF and not on anticoagulation who had a stroke and their modified ranking scale (mRs) = Dead, 2018/19. Although the number is not big, but the data shows Harrow's rate is much higher than the national average (Figure 18).

Figure 18 Stroke outcomes on discharge for patients with AF and not on anti-coag (mRs = 6), 2018/19

Stroke outcomes on discharge for patients with AF and not on anticoagulation (mRs = 6)

Proportion - %

Show confidence intervals Show 99.8% CI values ▶ More options



Recent trend: Could not be calculated

Period		NHS Harrow CCG Count	Value	95% Lower CI	95% Upper CI	England
2016/17	○	10	25.6%	-	-	26.1%
2017/18	○	17	41.5%	-	-	25.6%
2018/19	○	12	38.7%	-	-	24.9%

Source: Sentinel Stroke National Audit Programme

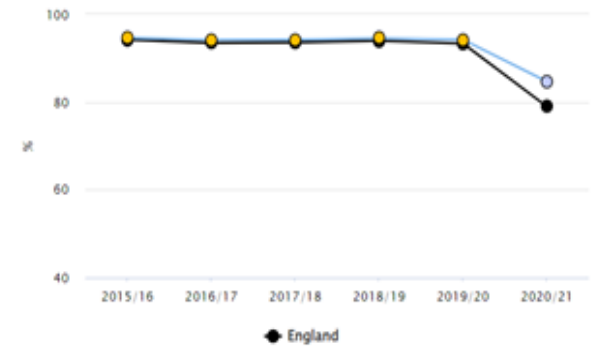
The modified Rankin scale (mRS), a clinician-reported measure of global disability, can be found in Appendix 3.

The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHADS2DS2-VASc score risk stratification scoring system in the preceding 12 months (excluding those patients with a previous CHADS2 or CHA2DS2-VASc score of 2 or more), (NICE ID: NM81) from 2015/16 to 2020/21 is presented below in Figure 19.

Figure X. shows there has been a significant (almost 10%) reduction in assessing the stroke risk of those patients with AF in 2020/21 (compared to 2019/20) which could be related to the impact of the Coronavirus pandemic reducing the stroke risk assessment.

Figure 19 Stroke risk of patients with AF assess w. CHA2DS2-VASc

Show confidence intervals Show 99.8% CI values ▶ More options



Recent trend: → No significant change

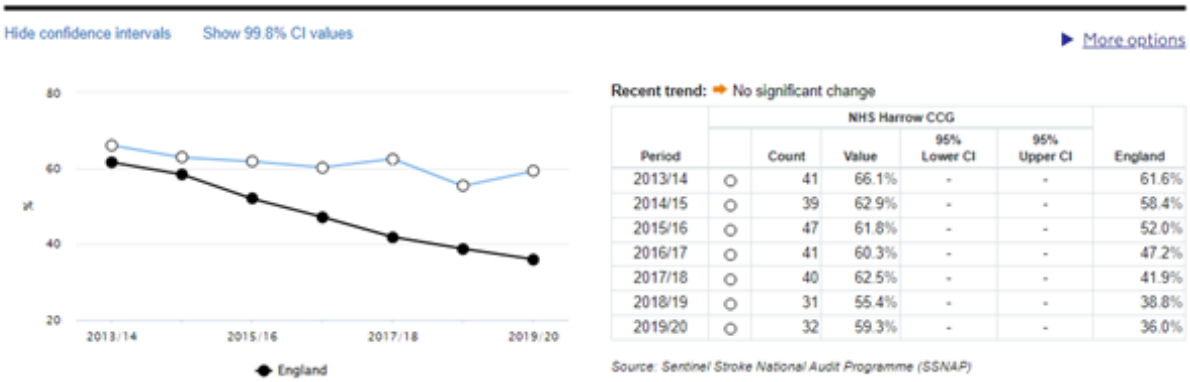
Period		NHS Harrow CCG Count	Value	95% Lower CI	95% Upper CI	England
2015/16		2,209	94.6%	93.7%	95.5%	94.2%
2016/17		1,142	94.2%	92.8%	95.4%	93.5%
2017/18		963	94.2%	92.6%	95.5%	93.6%
2018/19		1,340	94.6%	93.3%	95.6%	94.0%
2019/20		1,063	94.2%	92.7%	95.5%	93.3%
2020/21		847	84.7%*	82.3%	86.8%	79.0%

Source: Quality and Outcomes Framework (QOF), NHS Digital

Source: PHOF

Figures 20 below illustrates the percentage of 'Stroke admission with history of AF not prescribed anticoagulation prior to stroke' from 2013/14 to 2019/20 in Harrow CCG and England. Trend shows within 6 years there has been around 6% increase in prescribing for Harrow CCG but over 25% increase for England.

Figures 20 Percentage of 'Stroke admission with history of AF not prescribed anticoagulation prior to stroke' from 2013/14 to 2019/20



Figures 21 below illustrates the percentage of 'Stroke admission with history of AF not prescribed anticoagulation prior to stroke' in 2019/20 in North West London CCGs and England. It shows Harrow CCG holds the highest rate of mis prescribing, almost 3 times higher than Hammersmith and Fulham CCG (with the lowest rate).

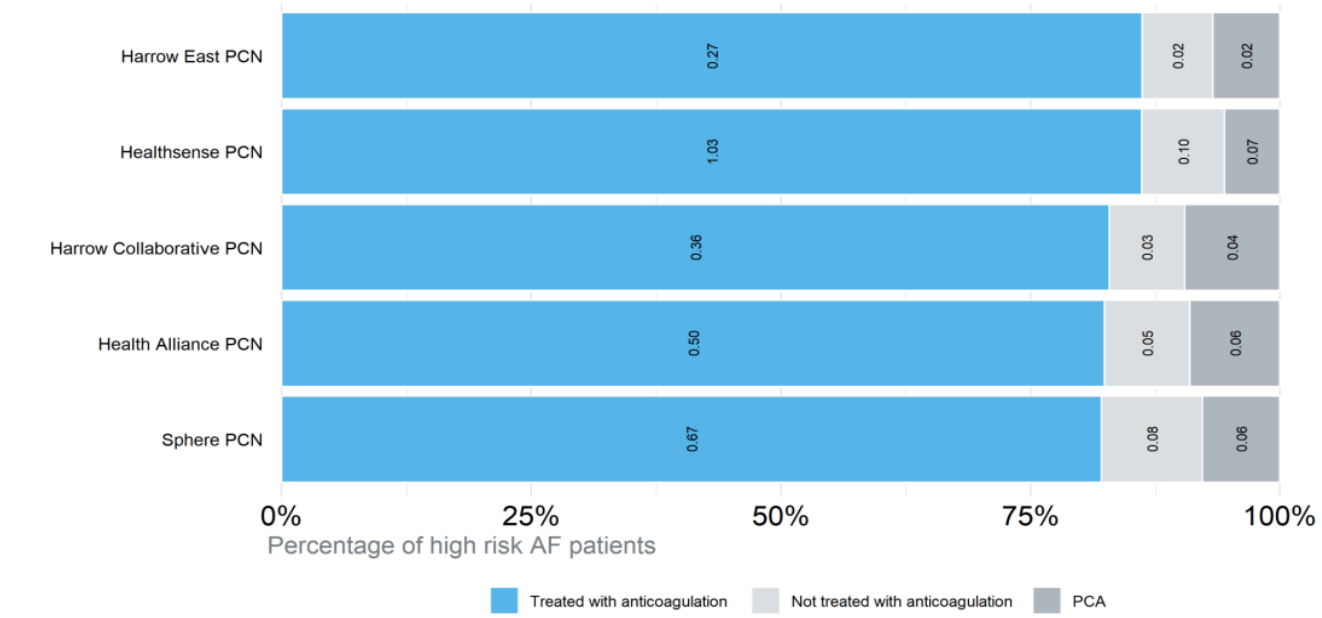
Figures 21 Percentage and number of 'Stroke admission with history of AF not prescribed anticoagulation prior to stroke' in North West London CCGs and England 2019/20

Area	Recent Trend	Count	Value
England	→	5,973	36.0
NW London CCGs	–	-	-
NHS Harrow CCG	→	32	59.3
NHS Brent CCG	→	24	54.5
NHS Hillingdon CCG	→	41	50.6
NHS Ealing CCG	→	30	40.5
NHS West London (K&C & QPP) CCG	→	19	36.5
NHS Hounslow CCG	→	12	34.3
NHS Central London (Westminster) CCG	→	10	29.4
NHS Hammersmith And Fulham CCG	→	11	21.6

Source: Sentinal Stroke National Audit Programme (SSNAP)

Figures 22 illustrates the Number (in 1000s) of high-risk AF patients who were anticoagulated (total of 2,830 patients for Harrow CCG), not anticoagulated (total of 260 patients for Harrow CCG), and who have had a Personalised Care Approach (total of 250 patients for Harrow CCG) recorded for Harrow PCNs in 2019/20.

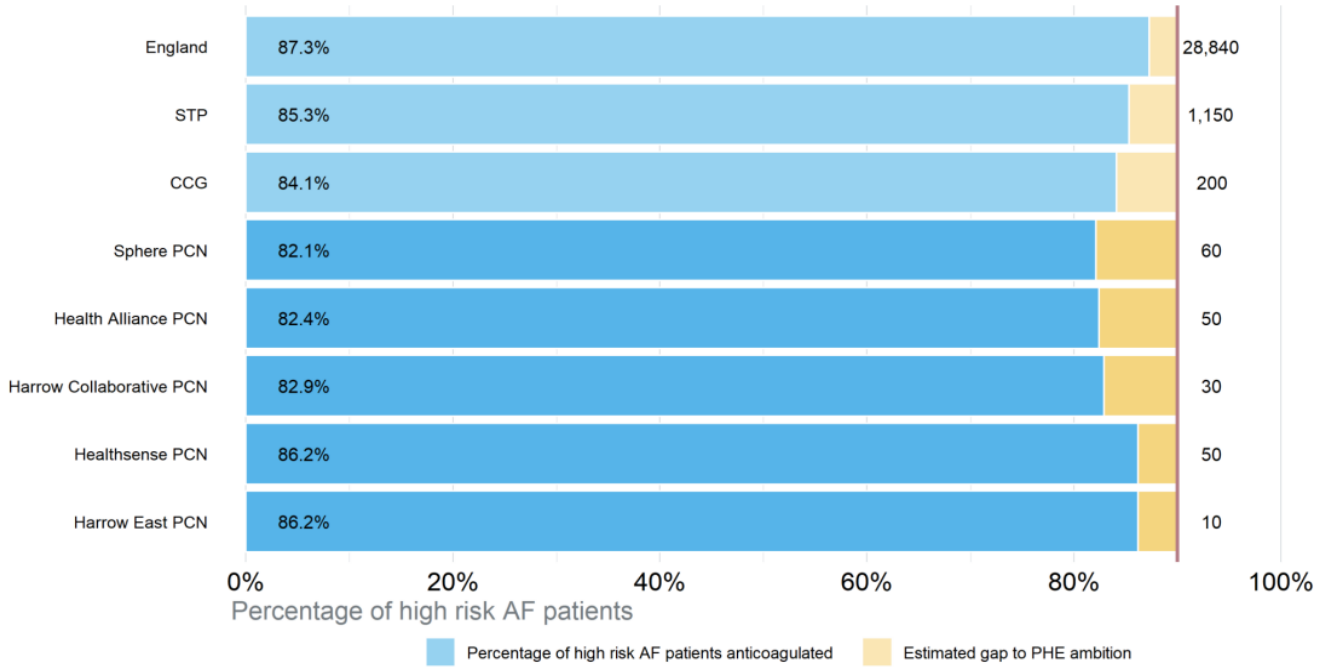
Figures 22 Number of high-risk AF patients who are anticoagulated, not anticoagulated, and who have had a Personalised Care Approach (PCA) recorded for this QOF indicator, by Harrow PCN, 2019/20.



Source: QOF 2019/20, treatment figures. Numbers in thousands.

Figure 23 shows the estimated additional number of high-risk AF patients who need to be anticoagulated to meet the PHE ambition for England for North West London STP (1,150), NHS Harrow CCG (200 Patients), and Harrow PCN level in 2019/20, written on the right of the graph against each area.

Figure 23 Estimated additional number of high-risk AF patients who need to be anticoagulated to meet the PHE ambition, England, STP, CCG, and PCN level, 2019/20



Source: QOF 2019/20, treatment figures. Numbers rounded to the nearest 10.

Atrial fibrillation ambitions (CVD Prevention Pack: Supporting data for NHS Harrow CCG)

Detection: 85% of the expected number of people with AF are diagnosed by 2029

Treatment: 90% of patients with AF who are known to be at high risk of a stroke to be adequately anticoagulated by 2029*

**The treatment charts and gaps to ambition are based on the number of patients recorded in QOF 2019/20 as being anticoagulated. Some of these individuals may not be adequately anticoagulated so the number required to achieve the target is therefore likely to be higher than indicated. Areas may choose to focus on ensuring known patients are adequately anticoagulated in the first instance.*

NICE GUIDLINE: diagnosis and management of Atrial Fibrillation

Accessible from:

https://www.nice.org.uk/guidance/ng196

A PDF version of the guidance is also available at:

https://www.nice.org.uk/guidance/ng196/resources/atrial-fibrillation-diagnosis-and-management-pdf-66142085507269

Future plan / Taking Action

We might need to add some information from this link:

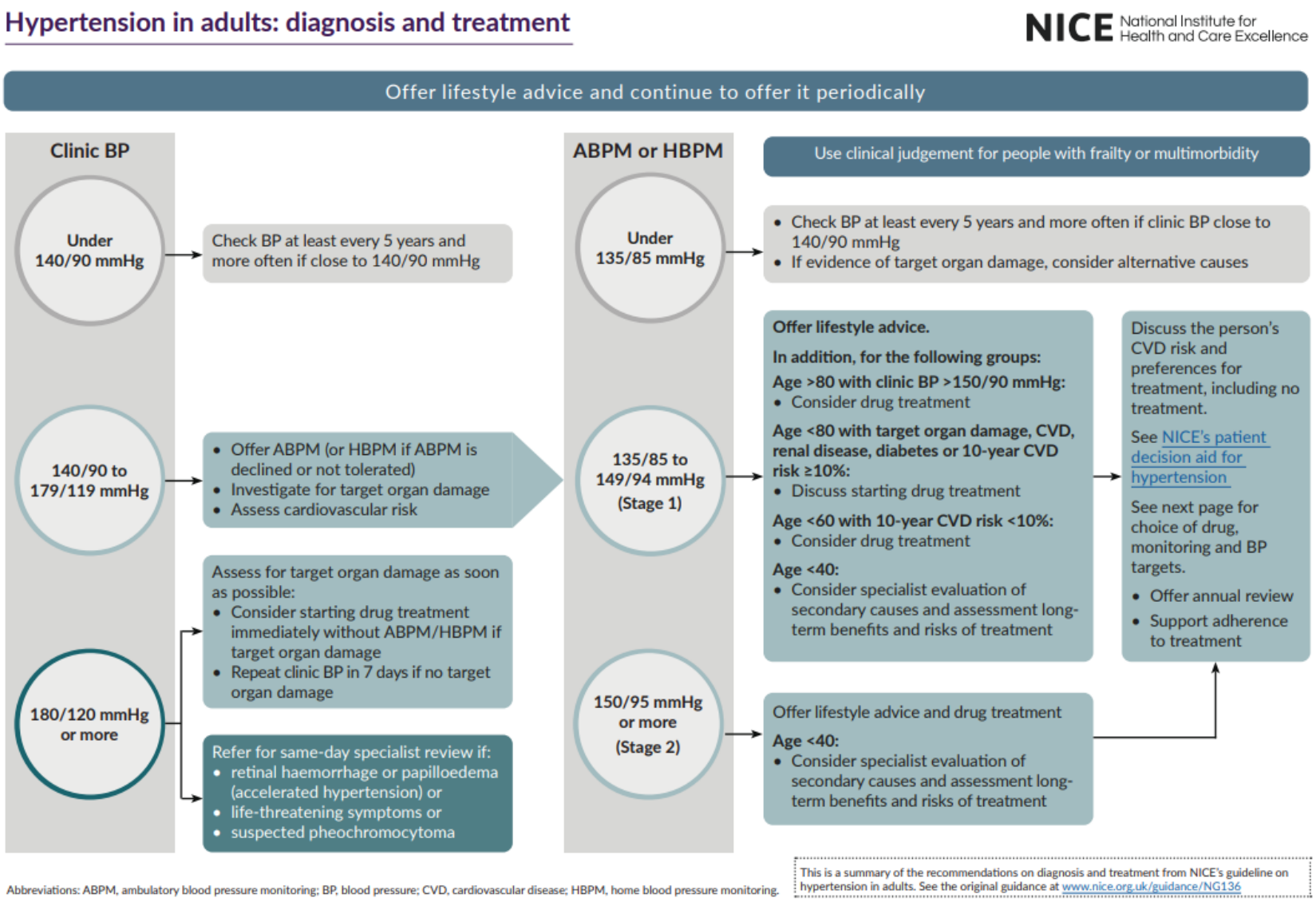
https://www.gov.uk/government/publications/cardiovascular-disease-prevention-applying-all-our-health/cardiovascular-disease-prevention-applying-all-our-health

Appendix 1 Key Findings from OHID CVD Profiles

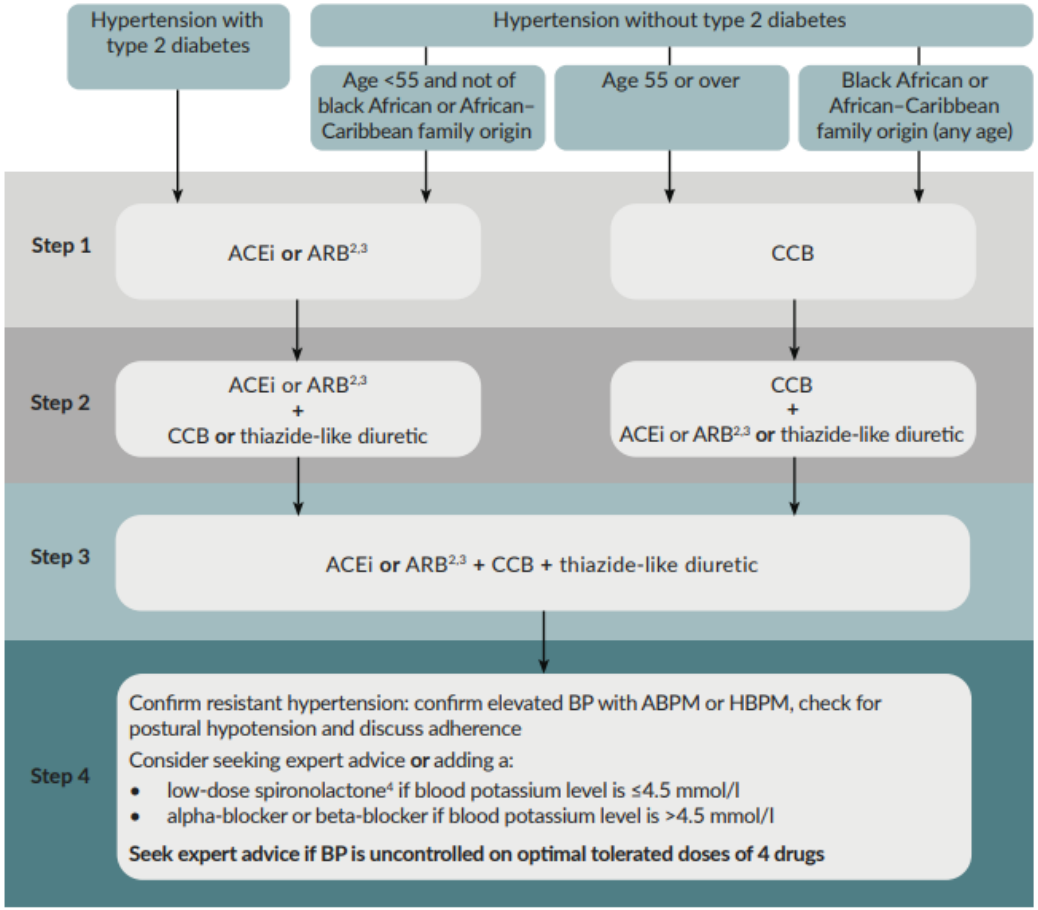
Key findings from OHID CVD profiles	
Diabetes	• In 2020/21 there were 22,367 people, aged 17 years or older, who had been diagnosed with diabetes and included on GP registers in NHS Harrow CCG. This equals 10.0% of the population. However, the total prevalence of people with diabetes, diagnosed and undiagnosed, is estimated to be 10.5%. • The percentage of people with type 1 diabetes who achieved the blood glucose target of ≤58 mmol/ml (7.5%) in this CCG was 30.0% compared to 31.6% in England. • The percentage of people with type 2 diabetes who achieved the blood glucose target of ≤58 mmol/ml (7.5%) in this CCG was 66.8% compared to 65.6% in England. • People with diabetes are at a higher risk of having a heart attack or stroke. In this area, people with diabetes were 100.5% more likely than people without diabetes to have a heart attack. This was higher than the figure for England which was 86.9%. People with diabetes were also 44.5% more likely to have a stroke. This was lower than the figure for England where there was a 58.5% greater risk.
Kidney Disease	• In 2020/21 There were 6,568 people aged 18 years and over who had been diagnosed with chronic kidney disease (CKD) in NHS Harrow CCG. This represents 3% of the registered population aged 18 or over. • The acceptance rate onto Renal Replacement Therapy (RRT) in 2013 to 2018 for NHS Harrow CCG is 168.1 per million population compared to the England rate of 116.2. • There were 419 NHS Harrow CCG residents receiving RRT in 2018. The change in the number of residents receiving RRT between 2013 and 2018 was 21.4%. • In NHS Harrow CCG during 2018 the percentage of people receiving RRT who had a renal transplant was 54.4%, a further 4.5% received home dialysis and 41.1% received hospital dialysis
Stroke	• In 2020/21 there were 3,701 people who have previously been diagnosed with a stroke in NHS Harrow CCG. In 2019/20 there were 353 admissions recorded on the Sentinel Stroke National Audit Programme (SSNAP).

	• The diagnosed prevalence of atrial fibrillation (AF) in this CCG is 1.3% and the estimated prevalence is 2.1%. There could be an additional 2125 people with undiagnosed atrial fibrillation in the CCG • In this CCG, 59.3% of stroke patients admitted who had a history of atrial fibrillation were not prescribed anticoagulation: this is higher than the England rate (36%). • In the SSNAP audit data for this CCG, 9.7% of people who had AF diagnosed prior to their stroke admission and were not on anticoagulation at admission were either completely independent or had no significant disability after their stroke: 38.7% of people died as a result of their stroke. • Early mortality rates (under 75 years of age) for stroke in NHS Harrow CCG were 7.3 per 100,000 people This was significantly lower than the England rate. • Later mortality rates (over 75 years of age) from stroke in NHS Harrow CCG were 304.4 per 100,000 people. This was significantly lower than the England rate (436.4).
Heart Disease	• Early mortality (under 75 years) rates from coronary heart disease are significantly lower than the England rate. • The CCG mortality rate has decreased by 51.4% since 2010. • In 2020, the early mortality rate for CHD in NHS Harrow CCG was 20.6 per 100,000 people. • In 2020/21 the admission rate for CHD in NHS Harrow CCG was 317.3 for every 100,000 people in the population (695 admissions). This is significantly lower than the England rate (368 per 100,000). • Getting treatment quickly is important for serious heart attack, where the coronary artery is blocked. In 2020/21, the London Ambulance Service Trust recorded 1,148 patients with a serious heart attack in 2020/21, who received appropriate primary PCI treatment (pPCI). The mean time to pPCI for these patients was 130 minutes, from the first call for help. In England this was 137.0 minutes. PCI is a procedure used to treat the narrowed or obstructed coronary arteries of the heart.

Appendix 2 NCIE guideline for diagnosis and treatment of Hypertension (*https://www.nice.org.uk/guidance/ng136*)



Choice of antihypertensive drug[1], monitoring treatment and BP targets



Monitoring treatment

Use clinic BP to monitor treatment.

Measure standing and sitting BP in people with:

- type 2 diabetes **or**
- symptoms of postural hypotension **or**
- aged 80 and over.

Advise people who want to self-monitor to use HBPM. Provide training and advice.

Consider ABPM or HBPM, in addition to clinic BP, for people with white-coat effect or masked hypertension.

BP targets

Reduce and maintain BP to the following targets:

Age <80 years:

- Clinic BP <140/90 mmHg
- ABPM/HBPM <135/85 mmHg

Age ≥80 years:

- Clinic BP <150/90 mmHg
- ABPM/HBPM <145/85 mmHg

Postural hypotension:

- Base target on standing BP

Frailty or multimorbidity:

- Use clinical judgement

[1] For women considering pregnancy or who are pregnant or breastfeeding, see NICE's guideline on hypertension in pregnancy. For people with chronic kidney disease, see NICE's guideline on chronic kidney disease. For people with heart failure, see NICE's guideline on chronic heart failure

[2] See MHRA drug safety updates on ACE inhibitors and angiotensin-II receptor antagonists: not for use in pregnancy, which states 'Use in women who are planning pregnancy should be avoided unless absolutely necessary, in which case the potential risks and benefits should be discussed', ACE inhibitors and angiotensin II receptor antagonists: use during breastfeeding and clarification: ACE inhibitors and angiotensin II receptor antagonists. See also NICE's guideline on hypertension in pregnancy.

[3] Consider an ARB, in preference to an ACE inhibitor in adults of African and Caribbean family origin.

[4] At the time of publication (August 2019), not all preparations of spironolactone have a UK marketing authorisation for this indication.

Abbreviations: ABPM, ambulatory blood pressure monitoring; ACEi, ACE inhibitor; ARB, angiotensin-II receptor blocker; BP, blood pressure; CCB, calcium-channel blocker; HBPM, home blood pressure monitoring.

BIHS British and Irish Hypertension Society
Committed to preventing cardiovascular disease

This visual summary builds on and updates previous work on treatment published by the BIHS (formerly BHS)

Published: August 2019

Appendix 3 Modified Rankin Scale

TABLE S.6 Modified Rankin Scale

Level	Level Description
Functional independence	
0	No symptoms
1	No significant disability despite symptoms; able to carry out all usual duties and activities
2	Slight disability; unable to carry out all previous activities, but able to look after own affairs without assistance
Functional dependence	
3	Moderate disability; requiring some help, but able to walk without assistance
4	Moderately severe disability; unable to walk without assistance and unable to attend to own bodily needs without assistance
5	Severe disability; bedridden, incontinent and requiring constant nursing care and attention
6	Dead

Source: Dromerick et al. 2003[94]

https://www.ncbi.nlm.nih.gov/books/NBK549071/table/sectiontwo.t5/?report=objectonly

RESPIRATORY DISEASE

Introduction

Respiratory disease continues to be a major cause of disability and premature mortality in the United Kingdom. It affects 1 in 5 people and is the third leading cause of death in England. Hospital admissions for lung disease have risen over the past seven years at three times the rate of all admissions generally. Respiratory disease has been identified as one of the disease priority areas in the '2020-2030 NHS Long Term Plan'[1] and Core20 Plus 5[2].

NHS Long Term Plan aims to improve the lives and outcomes of people with respiratory disease by diagnosing and treating conditions earlier and making sure that people with respiratory disease are receiving the right medication.

NHS plan is to increase access to respiratory rehabilitation services to support people living with a respiratory condition to be as independent as possible and experience improved quality of life by:

- Ensuring more patients have access to testing, such as spirometry testing, so that respiratory problems are diagnosed and treated earlier
- Ensuring patients with respiratory disease receive and use the right medication, including educating patients on the correct use of inhalers
- Expanding rehabilitation services, including pulmonary rehabilitation and digital tools so that more patients have access to them and have the support they need to best self-manage their condition and live as independently as possible
- Improving the treatment and care of people with pneumonia.

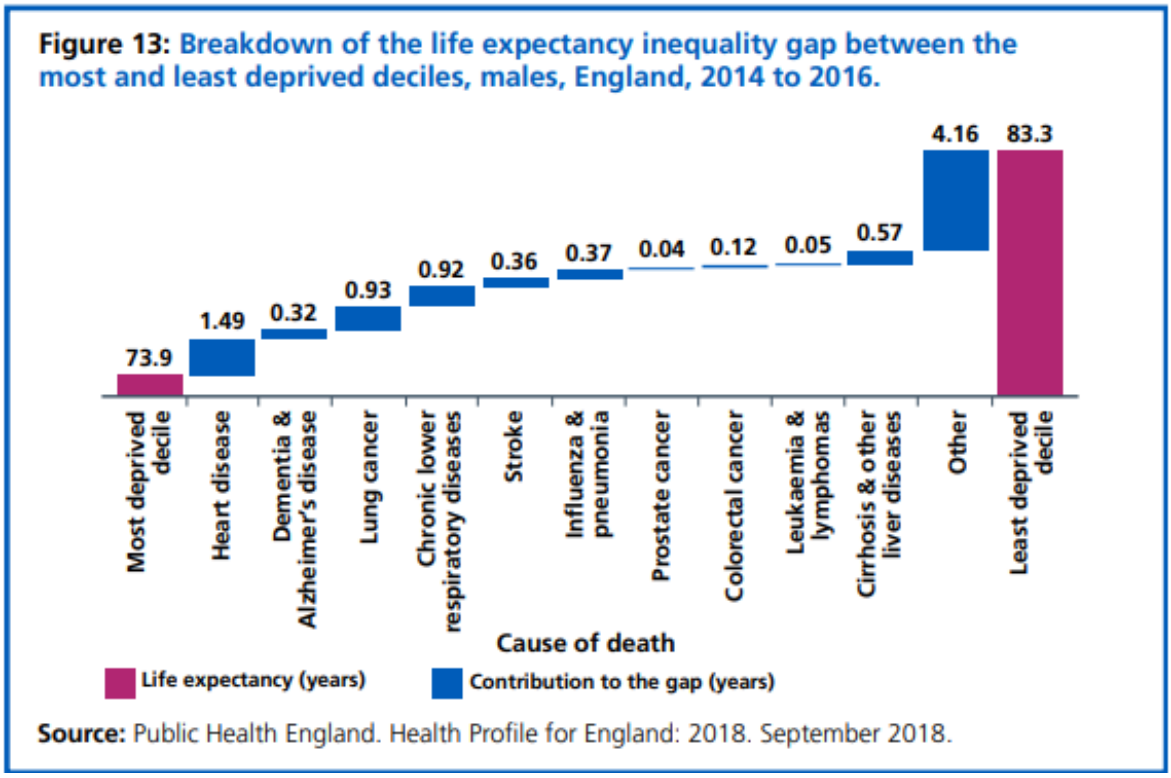
Incidence and mortality rates from respiratory disease are higher in disadvantaged groups and areas of social deprivation, with the gap widening and leading to worse health outcomes. Respiratory disease is one of the main contributors of the gap in Life Expectancy (LE) inequality, the 3rd after the 'heart disease' and 'Lung Cancer'. It contributes 1 out of the 10 years of the gap in LE between the 'Most' and the 'Least' Deprived Decile (Figure 1).

[1] NHS (2019) About the NHS long term plan, Online, Available from: https://www.longtermplan.nhs.uk/areas-of-work/respiratory-disease/#:~:text=Respiratory%20disease%20affects%201%20in,rate%20of%20all%20admissions%20generally. [Last accessed 11-05- 2022]

[2] NHS England, Core20 Plus 5, Online, Available from: https://www.england.nhs.uk/about/equality/equality-hub/core20plus5/ [Last accessed: 18-5-2022]

The most deprived communities have a higher incidence of smoking rates, exposure to higher levels of air pollution, poor housing conditions and exposure to occupational hazards. [1].

Figure 1 Main contributors to the Life Expectancy inequality, England, 2018



Source: NHS, Long Term Plan

The NHS Long Term Plan is aiming to support local planning and ensure national programmes are focused on health inequality reduction, and to set out specific, measurable goals for narrowing inequalities, including those relating to poverty, through the service improvements set out in this Long-Term Plan.

Chronic obstructive pulmonary disease (COPD) is the name for a group of lung conditions that cause breathing difficulties. It includes Emphysema (damage to the air sacs in lungs) and chronic bronchitis (long term inflammation of the airways). NHS RightCare Pathway for COPD[2] has been developed in collaboration with NHS England's National Clinical Director for

[1] Ibid

[2] NHS RightCareNHS RightCare Intelligence productsNHS RightCare PathwaysChronic Obstructive Pulmonary Disease (COPD) Pathway, Online available from: https://www.england.nhs.uk/rightcare/products/pathways/chronic-obstructive-pulmonary-disease-copd-pathway/ [Last accessed: 11-05-2022]

Respiratory Services, the British Lung Foundation, the British Thoracic Society, Respiratory Futures, the Primary Care Respiratory Society (PCRS-UK), and the National COPD Audit Programme.

The pathway provides a national case for change and a set of resources to support local health economies to concentrate their improvement efforts where there is greatest opportunity to address variation and improve population health. The resources in the Pathway also draw on a range of other national guidance and contain examples of best practice from across England to help make change on the ground. Here is a link to the RightCare Pathway: COPD

Tobacco control, immunisation, antimicrobial resistance, and supporting the Clean Air Strategy are all priorities for UK Health Security Agency (UKHSA, formerly PHE) as defined in the 2019/20 remit letter. The annual remit letter sets out government priorities and its role across the health and care system. 'All Our Health' is a resource for healthcare professionals to help them to maximise their impact on improving health outcomes and reducing health inequalities; these include a number of relevant prevention topics.[1]

The condition cannot be cured or reversed, but there is well established evidence that healthcare and public health interventions reduce disease progression and mortality in people with COPD. Long-term oxygen therapy in appropriate patients, increases in physical activity and smoking cessation all improve survival. Non-invasive ventilation (NIV) substantially reduces mortality during COPD exacerbations complicated by acute respiratory failure, whilst long term (home) NIV reduces the risk of readmission or death in selected patients. Invasive ventilation and management in intensive care plays a key role in some severe hospitalised exacerbations.

According to statistics from the British Lung Foundation, the UK is among the top 20 countries for COPD mortality worldwide. The UK has one of the highest rates across Europe (almost three times higher than France and twice higher than Italy), with a rate 50% higher than the average across the European Union[2].

Recommendation for commissioners

The RightCare Pathway – COPD contains a number of key messages for commissioners and to emphasise their importance when using this product, they are included below:

[1] PHE, The 2nd Atlas of variation in risk factors and healthcare for respiratory disease in England Online available from: file:///C:/Users/beh26/OneDrive/Desktop/2nd%20Atlas%20of%20Variation.pdf (Last accessed: 11-05-2022)

[2] Ibid

Commissioners responsible for **COPD** for their population should:

- focus on the key components for COPD care across a system:
  - Ensuring **early detection with accurate diagnosis**
  - **Optimising long-term management to reduce exacerbations, hospital admissions and premature mortality**
- work across the system to ensure that all **priorities to optimisation** are in place including the cross cutting themes:
  - **Multidisciplinary** supportive care approach
  - **Signposting** and care navigation
  - **Psychological support,** including for frightening breathlessness
  - **Community activation** to overcome social isolation and stay physically active, including peer support
  - **Self-management plan** supported by good information and patient training

Context (COPD and Asthma)

In addition to lung cancer and pneumonia, COPD is one of the 3 leading respiratory causes of death in England. COPD was responsible for more than 26,000 deaths in England in 2017. Of COPD deaths 86% are estimated to be attributable to smoking. Other causes of COPD include occupational exposure to fumes and dust, air pollution and genetics. In many people with COPD, the underlying cause of death is related to co-existing conditions such as cardiovascular disease and cancer as shown in Table 7.1 (adapted from PHE)[1].

Table 7.1: Underlying cause of death for which COPD was a contributory factor in England (2015-2017)[2]	Count	Percentage
Cancer	25,830	32.4%
Acute heart disease	16,930	21.2%
Other	12,721	16.0%
Dementia	6,025	7.6%
Digestive diseases	4,516	5.7%
Chronic heart disease	4,290	5.4%
Stroke	3,999	5.0%
Genitourinary diseases	1,836	2.3%
Infections	1,387	1.7%
Liver disease	1,197	1.5%
Musculoskeletal disorders	771	1.0%
Blood diseases	176	0.2%
Pneumonia	37	0.0%
Total	**79,715**	**100.0%**

Source: adapted from PHE, The 2nd Atlas of variation in risk factors and healthcare for respiratory disease in England[2]

[1] Ibid

[2] available from: file:///C:/Users/beh26/OneDrive/Desktop/Harrow/2ndRespiratoryAtlas_v1.0_20190923.pdf [Last accessed: 11-05-2022]

Asthma is an inflammatory disorder affecting the airways, characterised by breathlessness, wheezing and coughing particularly at night. The most common type of asthma is allergic asthma triggered by immunoglobulin E (IgE) antibodies generated in response to environmental allergens such as dust mites, pollen, and moulds. Consistent platelet-activating factor (PAF%) values from many studies suggest a median of 15% of asthma can be attributable to workplace exposures[1].

Deprivation, Asthma and COPD

It is estimated that in the UK around 550,000 respiratory diagnoses are made annually, of which around half are for asthma and COPD. Morbidity and mortality due to respiratory disease are not evenly distributed within the population but instead they are concentrated within deprived and other population groups. There is also a close association between high prevalence rates of respiratory conditions and current and past high rates of smoking[2].

COPD and Asthma Diagnosis

According to the PHE 2nd Atlas of variation in risk factors many people with COPD are unaware they have the condition. More than 1 million people in England are currently diagnosed with COPD on patient registers and a further 2 million are undiagnosed. Failure to diagnose is not confined to people with very mild disease: more than 50% of people with moderate COPD have not been detected and around 20% of undiagnosed people have severe or very severe disease[3].

In 2017/18, the prevalence of asthma in England, defined as receiving asthma treatment in the last year, and based on data from GP QOF registers, was 6.0%. It is generally accepted

[1] PHE, The 2nd Atlas of variation in risk factors and healthcare for respiratory disease in England Online available from: file:///C:/Users/beh26/OneDrive/Desktop/2nd%20Atlas%20of%20Variation.pdf (Last accessed: 11-05-2022)

[2] Ibid

[3] Ibid

that this is a conservative estimate based on known under reporting. The 2010 Health Survey for England indicated 9.5% of adults and children reported having asthma according to this definition, suggesting that many people with asthma are not included in GP registers.[1]

Economic Burden of Respiratory Diseases

The economic burden of respiratory diseases is substantial, excluding intangible costs. The annual economic burden of asthma and COPD on the NHS in the UK is estimated as £3 billion and £1.9 billion respectively. In total, all lung conditions (including lung cancer) directly cost the NHS in the UK £11billion annually[2].

[1] PHE, The 2nd Atlas of variation in risk factors and healthcare for respiratory disease in England Online available from: file:///C:/Users/beh26/OneDrive/Desktop/2nd%20Atlas%20of%20Variation.pdf (Last accessed: 11-05-2022)

[2] NHS England, Our work, Living well, ageing well and tackling premature mortality, Respiratory disease, Online, Available from: https://www.england.nhs.uk/ourwork/clinical-policy/respiratory-disease/ [Last accessed: 11-05-2022]

Local context (Harrow CCG)

Summary

Risk Factor: One of the main contributing risk factors associated with COPD is smoking. There is a direct correlation between smoking and COPD prevalence. QOF; 2020-21 data (reported by PHE-Fingertips) shows within Harrow it is estimated that 12.5% of the 15+ population are smokers (significantly lower than London rate of 15.5% and England with 15.9%). This associates to approximately 27,040 smokers. However, QOF 2017/18 recorded number of registered smokers in Harrow CCG was 28,361 (14.5%)[1] of adult population of 18+. Regardless of the changes in starting age (18+ to 15+), QOF shows around 5% decrease of smoking prevalence in Harrow.

Prevalence of COPD: Harrow CCG prevalence rate of COPD (0.9%, N=2,478) in 2020/21 was significantly lower than the North West London average (of 0.95%) and England average of 1.93%. Harrow's COPD rate was the 2nd lowest between the 10 most similar CCGs. Comparing the prevalence of the COPD for Harrow PCNs and Harrow CCG shows that the Healthsense PCN holds a significantly higher rate and Harrow East PCN has a significantly lower prevalence of COPD. All other 3 PCNs are lower than the Harrow average but not significantly. The COPD prevalence 2020/21 by GP practices within Harrow shows a large disparity between General Practices, varies from 0.28% to 1.93%. Eleven years trend in the prevalence of COPD in Harrow and England shows that there has been 0.1% increase for Harrow and around 0.3% increase nationally.

Harrow CCG Emergency Hospital admissions for COPD: Harrow's admission rate (of 305 per 100,000 population) in 2019/20 was the 4th lowest between its 10 most similar CCGs and significantly lower than 4 CCGs with the highest rate also national average.

Prevalence of Asthma: The QOF prevalence of asthma (6+ years old) in Harrow (among the GP practices' registered population), in 2020/21 was 5.3% (13,806 persons), the sixth highest prevalence between similar CCGs and significantly lower than England average of 6.4%. Compared with the Harrow CCG average prevalence of Asthma (5.29%), Sphere and Healthsense PCNs hold a significantly higher rate (5.96% and 5.72% respectively) and Harrow East and Harrow Collaborative PCNs have a significantly lower prevalence. Asthma prevalence 2020/21 within Harrow shows a large disparity between General Practices, varies from 2.4% to 7.5%. The prevalence of Asthma (all ages) from 2009/10 to 2019/20 in Harrow increased from 5.4% to 5.5% (0.1% increase) but for the same period of time, England rate increased from 5.9% to 6.5% (0.6% increase). Harrow's prevalence has always been significantly lower than the national average.

[1] Source: QOF and GLA projection of population.

Harrow CCG Hospital admissions for Asthma: Hospital admissions crude rate (per 100,000) for asthma (under 19 years old, 3-year range: 2017/18 - 19/20 was 162.6, the 3rd lowest rate between all 10 similar CCGs also significantly lower than 3 CCGs with highest rate but not significantly different from England average.

Mortality from Respiratory disease: The Indirectly Standardised Mortality Ratio (ISMR) with underlying cause respiratory disease in Harrow during 2015-19 was 70 (N=973), significantly lower than all 10 most similar CCGs to Harrow and England average. Death rate of populations aged 65+ in Harrow CCG during 2020 was 335.4 (N=147); except for the East Berkshire, Harrow rate was significantly lower than all other 10 similar CCGs and national average.

Respiratory Disease Cost for Harrow CCG: Overall, in the last 3 financial years, Neoplasm closely followed by MSK hold the highest cost between all LTCs in Harrow CCG. In the third-place cost of the respiratory disease was around £22,567,352.

Prevalence of COPD

Harrow CCG prevalence rate of COPD (0.9%, N=2,478) in 2020/21 was significantly lower than the North West London average (of 0.95%) and England average of 1.93%. Harrow's COPD rate was the 2nd lowest between the 10 most similar CCGs (Figure 2).

Figure 2 The percentage of patients with COPD, 10 most similar CCGs to NHS Harrow CCG, 2020/21

Area	Recent Trend	Neighbour Rank	Count	Value
England	↑	-	1,170,437	1.9
NHS Trafford CCG	→	6	4,911	2.0
NHS Havering CCG	→	7	4,901	1.7*
NHS Milton Keynes CCG	→	5	5,012	1.7*
NHS Brighton And Hove CCG	↑	9	4,861	1.5
NHS Luton CCG	→	10	3,135	1.3*
NHS Hillingdon CCG	→	1	4,024	1.2*
NHS East Berkshire CCG	→	3	5,284	1.1*
NHS Hounslow CCG	→	4	3,409	1.0*
NHS Ealing CCG	→	8	4,203	0.9*
NHS Harrow CCG	→	-	2,478	0.9*
NHS Redbridge CCG	→	2	2,621	0.8*

Source: Quality and Outcomes Framework (QOF), NHS Digital extracted from Fingertips PHE - OHID

Prevalence of COPD for Harrow PCNs and Harrow CCG average is illustrated in Figure 3. Graph shows that compared with the Harrow CCG average prevalence of COPD, Healthsense PCN holds a significantly higher rate and Harrow East PCN has a significantly lower prevalence of COPD. All other 3 PCNs are lower than the Harrow average but not significantly.

Figure 3 Prevalence (%), respiratory group, COPD, 2020-21, Harrow PCN and CCG, 2020/21

Source Data: NHS Digital, Quality and Outcome Framework, 2020/21, generated by PHI - Harrow

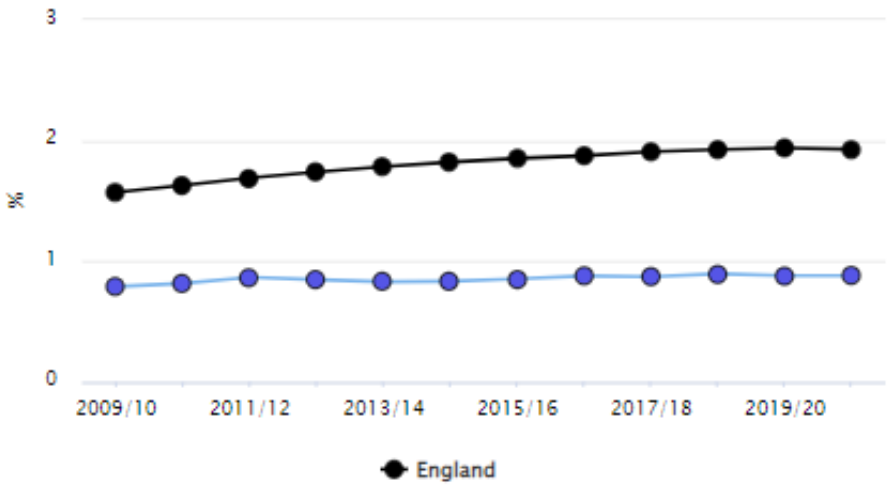
The COPD prevalence 2020/21 is further broken down by GP practices within Harrow that demonstrates a large disparity between General Practices, varies from 0.28% to 1.93% (Fig 4).

Fig 4 Prevalence Respiratory Group-COPD, Harrow practices; Harrow, NWL and England average, 2020/21

Source Data: NHS Digital, Quality and Outcome Framework, 2020/21, generated by PHI - Harrow

Eleven years trend in the prevalence of COPD in Harrow and England is presented in (Fig 5). Trend shows that there has been 0.1% increase for Harrow and around 0.3% increase nationally.

Fig 5 COPD trend: QOF prevalence (all ages) Harrow CCG, NN Average and England, 2009/10-2019/20



Source: Source: Quality and Outcomes Framework (QOF), NHS Digital, Extracted from Fingertips, PHE - OHID

Harrow CCG Emergency Hospital admissions for COPD

COPD is usually prevalent in adults over the age of 35. As many as 3 million people suffer from COPD in the UK, of which only around a third of cases have been diagnosed[1]. Figure 6 shows the 'Directly age-standardised' rate of emergency admissions to hospital for COPD in adults aged 35+ in 2019/20 for Harrow and its 10 most similar CCGs and England. Graph below shows Harrow's admission rate (305 per 100,000 population) is the 4th lowest between its 10 most similar CCGs and significantly lower than 4 CCGs with the highest rate and England's average. Figure 6 Directly age-standardised rate (per 100,000) of emergency admissions to hospital for COPD, adults aged 35+, Harrow and its 10 most similar CCGs and England, 2019/20

[1] PHE, Fingertips, OHID, Indicator Definitions and Supporting Information, Online available form: https://fingertips.phe.org.uk/search/hospital%20admission#page/6/gid/1938133225/pat/15/par/E92000001/ati/166/are/E38000074/iid/92302/age/202/sex/4/cat/-1/ctp/-1/yrr/1/nn/nn-9-E38000074/cid/4/tbm/1/page-options/car-do-0 [Last accessed: 15-05-2022]

Area	Recent Trend	Neighbour Rank	Count	Value
England	→	-	133,103	415
NHS Luton CCG	–	10	500	563
NHS Milton Keynes CCG	–	5	610	498
NHS Trafford CCG	–	6	585	451
NHS Hillingdon CCG	–	1	540	401
NHS Hounslow CCG	–	4	400	366
NHS Havering CCG	–	7	530	363
NHS Ealing CCG	–	8	530	357
NHS Harrow CCG	–	-	385	305
NHS Brighton And Hove CCG	–	9	335	271
NHS Redbridge CCG	–	2	330	266
NHS East Berkshire CCG	–	3	525	257

Source: HES data Extracted from Fingertips, PHE - OHID

Prevalence of Asthma

Asthma is a common condition which responds well to appropriate management, and which is principally managed in primary care. This indicator set was originally informed by the British Thoracic Society (BTS)/SIGN guidelines which were published in early 2003. In keeping with the other indicators, not all areas of management are included in the indicator set in an attempt to keep the data collection within manageable proportions. The indicator illustrated in Figure 7 presents the percentage of patients with asthma, excluding those who have been prescribed no asthma-related drugs in the previous twelve months, as recorded on practice disease registers from all registered patients[1].

Asthma QOF prevalence indicator for 'all age' has been retired since last year and the latest available data is for 2019/20 (5.5%). Since 2020/21 Fingertips-OHID only reports asthma prevalence for 6+ years old. Figure 7 shows the QOF prevalence of asthma (6+ years old) in Harrow (among the GP practices' registered population), in 2020/21 was 5.3% (13,806 persons), the sixth highest prevalence between similar CCGs and significantly lower than England average of 6.4%.

Figure 7 Asthma: QOF Prevalence (6+ years) in Harrow, 10 most similar CCGs to Harrow and England, 2020/21

[1] PHE, Fingertips, OHID, Indicator Definitions and Supporting Information, Online available form: https://fingertips.phe.org.uk/search/prevalence#page/6/gid/2000006/pat/15/par/E92000001/ati/166/are/E38000074/iid/285/age/1/sex/4/cat/-1/ctp/-1/yrr/1/nn/nn-9-E38000074/cid/4/tbm/1/page-options/car-do-0 [Last accessed: 15-05-2022]

Area	Recent Trend	Neighbour Rank	Count	Value
England	–	-	3,629,071	6.4
NHS Trafford CCG	–	6	16,952	7.4
NHS Milton Keynes CCG	–	5	16,681	5.9*
NHS Brighton And Hove CCG	–	9	17,769	5.7
NHS East Berkshire CCG	–	3	25,052	5.7*
NHS Luton CCG	–	10	12,223	5.5*
NHS Harrow CCG	–	-	13,806	5.3*
NHS Ealing CCG	–	8	22,373	5.3*
NHS Hillingdon CCG	–	1	15,861	5.3*
NHS Havering CCG	–	7	13,759	5.3*
NHS Redbridge CCG	–	2	15,632	5.0*
NHS Hounslow CCG	–	4	14,114	4.5*

Source: Quality and Outcomes Framework (QOF), NHS Digital extracted from Fingertips PHE - OHID

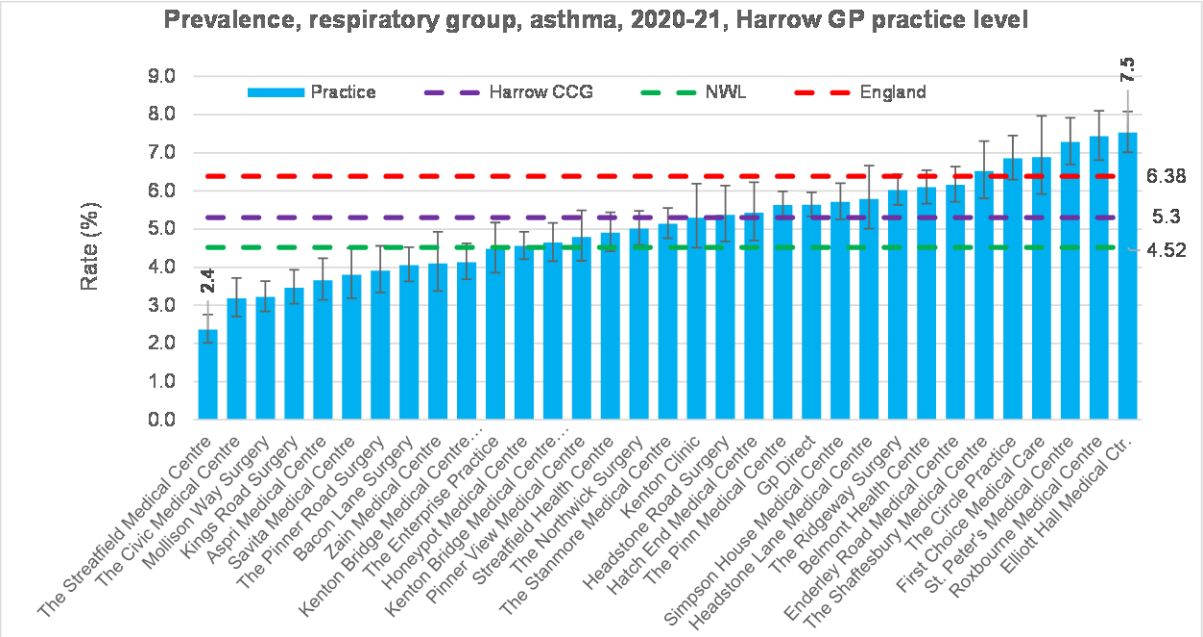
Prevalence of Asthma for Harrow PCNs and Harrow CCG average is illustrated in Figure 8. Graph below shows that compared with the Harrow CCG average prevalence of Asthma (5.29%), Sphere and Healthsense PCNs hold a significantly higher rate and Harrow East and Harrow Collaborative PCNs have a significantly lower prevalence. Prevalence of Asthma for Health Alliance PCNs is lower than the Harrow average but not significantly.

Figure 8 Prevalence (%), respiratory group, Asthma, 2020-21, Harrow PCN and CCG, 2020/21

Source Data: NHS Digital, Quality and Outcome Framework, 2020/21, generated by PHI - Harrow

Asthma prevalence 2020/21 is further broken down by GP practices within Harrow that demonstrates a large disparity between General Practices, varies from 2.4% to 7.5% (Fig 9).

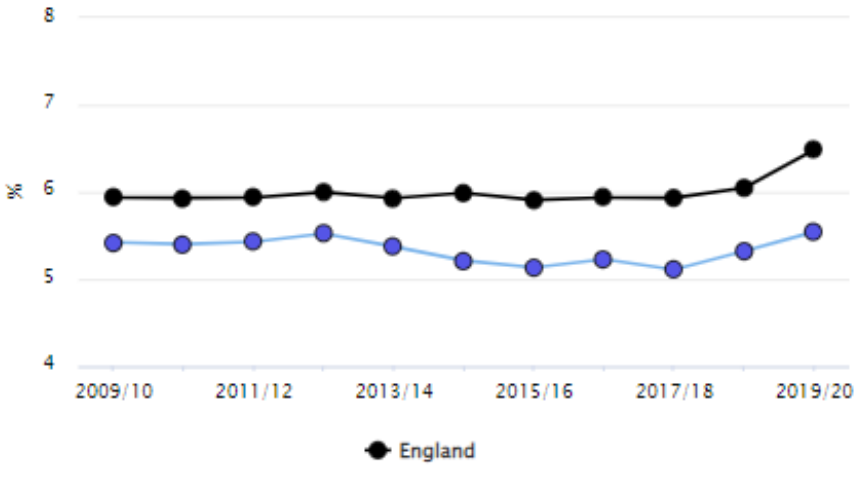
Fig 9 Prevalence Respiratory Group-Asthma, Harrow practices; Harrow, NWL and England average, 2020/21



Source Data: NHS Digital, Quality and Outcome Framework, 2020/21, generated by PHI - Harrow

Ten years trend in the prevalence of Asthma in Harrow and England is presented in Figure 10. The trend shows from 2009/10 to 2019/20 (10 years), Harrow's prevalence of Asthma (all ages) increased from 5.4% to 5.5% (0.1% increase) but for the same period of time, England rate increased from 5.9% to 6.5% (0.6% increase). Harrow's prevalence has always been significantly lower than the national average.

Fig 10 Asthma trend: QOF prevalence (all ages) Harrow CCG and England, 2009/10-2019/20



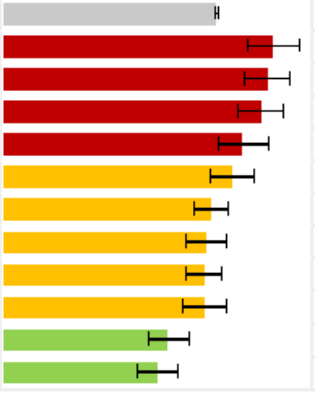
Source: Source: Quality and Outcomes Framework (QOF), NHS Digital, Extracted from Fingertips, PHE - OHID

Harrow CCG Hospital admissions for Asthma

Understanding local trends of emergency admissions of children and young people with long term conditions, and benchmarking against geographical and statistical neighbours will support service review and redesign. Figure 11 illustrates the Hospital admissions crude rate (per 100,000) for asthma (under 19 years old, 3 year range: 2017/18 - 19/20. The graph below shows Harrow's rate is 162.6, the 3rd lowest rate also significantly lower than 3 CCGs with highest rate but not significantly different from England average.

Figure 11 Hospital admissions for asthma (under 19 years) (3 year range), Crude rate - per 100,000, Harrow and its 10 most similar CCGs, England, 2017/18 - 19/20

Area	Recent Trend	Neighbour Rank	Count	Value
England	–	-	66,231	172.7
NHS Luton CCG	–	10	410	218.6
NHS Redbridge CCG	–	2	520	213.6
NHS Hillingdon CCG	–	1	465	208.4
NHS Trafford CCG	–	6	325	193.7
NHS Milton Keynes CCG	–	5	405	184.7
NHS East Berkshire CCG	–	3	565	168.2
NHS Hounslow CCG	–	4	355	164.1
NHS Ealing CCG	–	8	480	162.6
NHS Harrow CCG	–	-	295	162.6
NHS Havering CCG	–	7	250	133.2
NHS Brighton And Hove CCG	–	9	220	124.4



Source: HES data Extracted from Fingertips, PHE - OHID

Mortality from Respiratory disease

Respiratory diseases are a leading cause of death. Mortality is a direct measure of health care need indicating the overall respiratory disease burden on the population and reflecting both the incidence of disease and the ability to treat it. The Indirectly Standardised Mortality Ratio (ISMR) with underlying cause respiratory disease in Harrow during 2015-19 was 70 (N=973), significantly lower than all 10 most similar CCGs to Harrow and England average (Fig 12). Sufficient data for one and 3 year period wasn't available.

Fig 12 ISMR (per 100) for deaths from all respiratory disease (All ages, persons), Harrow, 10 most similar CCGs to NHS Harrow CCG and England, 2015-19

Area	Recent Trend	Neighbour Rank	Count	Value
England	–	-	344,055	100.0
NHS Luton CCG	–	10	1,053	111.6
NHS Milton Keynes CCG	–	5	1,310	108.8
NHS Havering CCG	–	7	1,753	102.1
NHS Hillingdon CCG	–	1	1,412	98.4
NHS Hounslow CCG	–	4	1,019	96.0
NHS Trafford CCG	–	6	1,380	94.1
NHS Redbridge CCG	–	2	1,269	92.7
NHS Brighton And Hove CCG	–	9	1,337	92.5
NHS East Berkshire CCG	–	3	1,983	91.6
NHS Ealing CCG	–	8	1,330	89.0
NHS Harrow CCG	–	-	973	70.0

Source: Office for Health Improvement and Disparities (based on ONS source data)

Respiratory disease is one of the major causes of death in the over 65's in England. Death rate of populations aged 65+ in Harrow CCG during 2020 was 335.4 (N=147); except for the East Berkshire, Harrow rate was significantly lower than all other similar CCGs and national average (Figure 13).

Figure 13 Mortality DS rate (per 100,000) from respiratory disease (Persons, 65+), Harrow, 10 most similar CCGs to NHS Harrow CCG and England, 2020

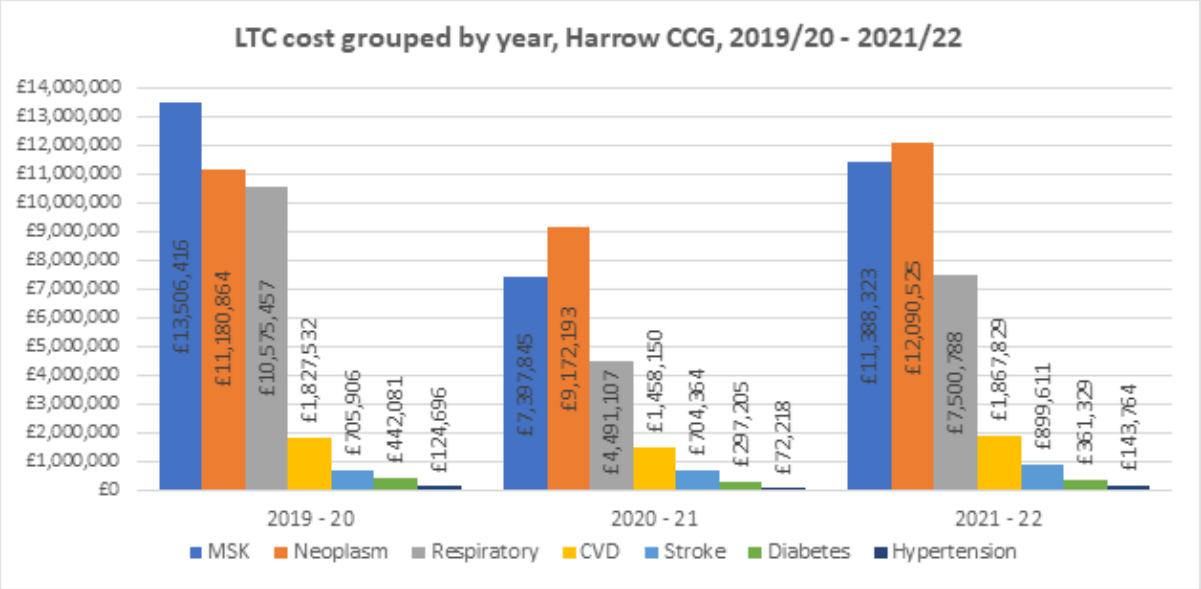
Area	Recent Trend	Neighbour Rank	Count	Value
England	↓	-	52,718	495.3
NHS Redbridge CCG	→	2	242	589.2
NHS Luton CCG	→	10	160	572.1
NHS Havering CCG	↓	7	279	536.0
NHS Hillingdon CCG	→	1	227	518.4
NHS Ealing CCG	→	8	234	507.1
NHS Brighton And Hove CCG	→	9	207	498.1
NHS Trafford CCG	→	6	221	492.2
NHS Milton Keynes CCG	↓	5	178	480.5
NHS Hounslow CCG	→	4	154	479.6
NHS East Berkshire CCG	↓	3	279	416.9
NHS Harrow CCG	→	-	148	335.4

Source: Office for Health Improvement and Disparities (based on ONS source data)

Respiratory Disease Cost for Harrow CCG

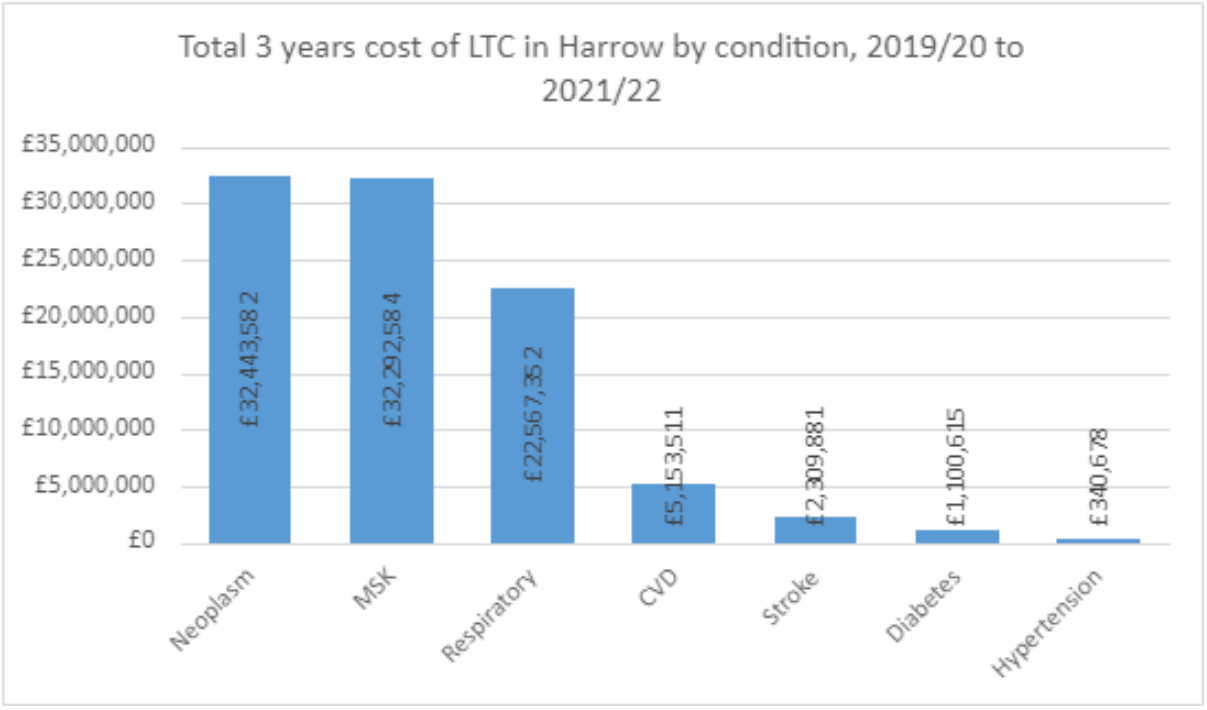
Figures 13 and 14 show the cost of 7 Long Term Conditions (LTC) by actual (£) numbers. Overall, in the last 3 financial years, Neoplasm (£32,443,582) closely followed by MSK (£32,292,584) hold the highest cost between all LTCs in Harrow CCG. In the third-place cost of the Respiratory Disease in the last 3 years was around £22,567,352.

Figure 13 LTC cost grouped by year, Harrow CCG, 2019/20 - 2021/22



Source: SUS Data provided by Harrow CCG, Generated by PHI - Harrow

Figure 14 LTCs 3 years total cost grouped by conditions, Harrow CCG, 2019/20 - 2021/22



Source: SUS Data provided by Harrow CCG, Generated by PHI - Harrow

The sum of 3 years cost of the Respiratory Disease in Harrow by type of admissions is illustrated in Figure 15.

Figure 15 Harrow CCG 3 years cost of Respiratory Disease by Sum of Payment by Result (PBR), 2019-20 to 2021/22

Source: SUS Data provided by Harrow CCG, Generated by PHI - Harrow

Notes: 1) NULL & Other could be day/night attendances or uncoded (these are small numbers). 2) Cost of March 2022 is estimated as 1/11th of the previous 11 month.

CANCER

Introduction

Our body's organs and tissues are made up of cells. These cells can receive signals from the body, which indicates to them when to grow and when to divide to make new cells[1] . This process enables our bodies to grow and heal. Some cells receive signals from the body to stop working, eventually these cells become old, damaged and die.

Unfortunately, some signals can go wrong eventually leading to the cell becoming abnormal. These abnormal cells may continue to divide resulting in more abnormal cells[1]. The product from this process is a lump, otherwise known as a tumour.

Now, not all tumours are cancerous. To examine whether the tumour is cancerous, doctors take a small sample of cells (known as a biopsy). This biopsy in examined visually under a microscope to observe for cancer cells. A benign tumour (non-cancerous tumour) is not able to spread to other parts of the body and usually only causes a problem if it grown and pushes up against on nearby organs. A malignant tumour (a cancerous tumour) is able to spread into other areas of the body from the primary site[1]. This type of tumour usually travels around the body through the lymphatic system. When these cancer cells reach other parts of the body, they may grow and from another tumour resulting in a secondary caner or a metastasis[1].

There are some forms of cancer which begin in the blood cell. These abnormal cells build up in the blood and sometimes the bone marrow (where blood cells are made). This is known as blood cancers.

There are more than 200 different types of cancer. The most common cancers are lung, breast (in women), prostate (in men) and bowel (otherwise known as colorectal cancer). These four types of cancers account for more than half of all cancer diagnosed in this country and in Harrow.

Cancer is the biggest cause of death in Harrow. According to Cancer Research UK, 1 in 2 people will develop cancer at some point in their lives[2]. As life expectancy is increasing

[1] Macmillan.org.uk. (2019). What is cancer? Available at: https://www.macmillan.org.uk/information-and-support/understanding-cancer/what-is-cancer.html [Last accessed 24 Oct. 2019].

globally, people are living for longer and consequently more people will be diagnosed with cancer in their lifetime. Because of this global transition there is an urgent need to strengthen health and social care services to collaborate to manage the needs of the growing population. Therefore, better methods of diagnosis, treatments and earlier diagnosis outlined in the National Cancer Strategy[1]. Prevention plays a critical role in the effort needed to reduce cancer in future.

The ability to positively influence cancer incidence and outcomes sits across health and social care domains, including public health, primary, community and secondary health care services, and social care.

Policy Context

The NHS Long Term Plan for Cancer[2] was published in January 2019. It sets out stretching ambitions and commitments to improve cancer outcomes and services in England over the next ten years.

The key ambitions in the NHS LTP for cancer are:

- by 2028, 55,000 more people each year will survive their cancer for five years or more; and
- by 2028, 75% of people with cancer will be diagnosed at an early stage (stage one or two).

The ambitions will be delivered in a way that:

- improves quality of life outcomes.
- improves patient experience outcomes.
- reduces variation; and
- reduces inequalities

Key Findings

- QOF prevalence in Harrow has consistently been lower than that of England but higher than London.
- The incidence of Cancer in Harrow is generally lower than that of England.
- Incidence of Prostate Cancer is the highest although still lower than England
- Mortality from Cancers in Harrow are generally lower than that of England
- Breast, Oral and Prostate cancers are the biggest concerns for Harrow.

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[2] Cancer Research UK. (2019). 1 in 2 people in the UK will get cancer. [online] Available at: https://www.cancerresearchuk.org/about-us/cancer-news/press-release/2015-02-04-1-in-2-people-in-the-uk-will-get-cancer [Accessed 24 Oct. 2019].

[1] Achieving World Class Cancer Outcomes: Taking the strategy forward May 2016 https://www.england.nhs.uk/wp-content/uploads/2016/05/cancer-strategy.pdf [Accessed 24 Oct. 2019].

[2] NHS England January 2019 National Long Term Ambitions for Cancer https://www.england.nhs.uk/wp-content/uploads/2016/05/cancer-strategy.pdf [Last accessed 24 Oct. 2019].

- Screening programmes in Harrow show low coverage.

Local Context

Prevalence

Cancer prevalence is a count of people still alive who have been diagnosed with cancer in the past. There are an estimated 1.9 million people living with or beyond cancer in the UK today. By 2030 it is estimated that there will be 3.1 million. At the end of 2015, around 6,586 people in Harrow CCG were living up to 21 years after a cancer diagnosis.

This could rise to an estimated 10,630 by 2030. Quality and Outcome Framework (QOF) reported prevalence of cancer all ages for Harrow in 2017/18 was 5,673 people (2.1% of the Harrow populations).

Harrow's cancer prevalence in 2020/21 was 2.5%, significantly lower than the England average of 3.2% (Figure 1).

The prevalence rate reflects trends in cancer incidence, mortality and survival, as well as advances in cancer treatment and detection.

Figure 1: Cancer QOF prevalence (%), all ages, Harrow and England, 2015/16 – 2020-21

Source: PHOF - https://fingertips.phe.org.uk/profile/cancerservices/

QOF cancer prevalence (persons, all ages), Harrow, ten Nearest Neighbours (NN), NN average, London and England 2017/18 is presented in Figure 2.

Figure 2: QOF prevalence (persons, all ages), Harrow, Most Similar CCGs and England 2020/21

Source: Quality and Outcomes Framework (QOF), NHS Digital

Figure 2 shows the percentage QOF prevalence for Harrow compared to England and the most similar CCGs in England. It confirms the numbers for Harrow and England in figure 1 confirming that Harrow has a lower rate than England (blue being lower and yellow being similar).

Incidence

Cancer incidence can be affected by the characteristics of a population.

According to the National Cancer Registration Service, there were 362 new cancer diagnoses in Harrow in 2020/21, less than the 9372 in 2017/18.

Figure 3 shows the crude incidence rate per 100,000 of populations in Harrow, its most similar CCGs and England in 2020/21. As can be seen, Harrow has a lower rate than England.

No confidence intervals were published for this data.

Figure 3: Cancer crude incidence rate (new cases per 100,000 population), persons, all ages, Harrow, Most Similar CCGs and England 2020/21

Area	Value
England	531
NHS Havering CCG	569
NHS Trafford CCG	531
NHS East Berkshire CCG	455
NHS Milton Keynes CCG	441
NHS Brighton And Hove CCG	428
NHS Hillingdon CCG	411
NHS Luton CCG	382
NHS Harrow CCG	362
NHS Hounslow CCG	340
NHS Redbridge CCG	336
NHS Ealing CCG	316

Source: National Cancer Registration Service. Each patient was traced to a GP Practice using the NHS Personal Demographics Service.

The above graph doesn't show a significant increase of cancer incident rate for Harrow CCG since 2009/10, but in the same period of time the cancer incident rate for England increased by 8%.

Figure 4: Cancer incidence (per 100,000) by type of cancer, Harrow and England 2014 to 2018

Source:https://fingertips.phe.org.uk/search/cancer#page/1/gid/1/pat/6/ati/402/are/E09000015/iid/1203/age/1/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1

Figure 4 shows standardised incidence ratios for the main cancers in the period 2014 to 2018. Harrow rates are indicated by the coloured circles with green being a good rate and yellow not so good.

The incidence of breast cancer is lower than that of England with a Harrow figure of 90.4 again the !00 England standard incidence ratio. It's a similar picture for colorectal cancer where the incidence ratio for Harrow is 83.5 again the England 100.

Lung cancer is also on a lower incidence ratio in Harrow with 68.5 compared to 100 for England.

Rates for Prostate Cancer need to be improved.

Survival

One year survival is a good indicator of whether cancer is diagnosed early and whether people have rapid access to optimal treatment. Figure 5 shows the 1-year cancer survival rate in Harrow has increased over the past decade for all cancers combined.

One-year cancer survival is 74.7% in Harrow. This is higher than the England rate of 72.8%.

Figure 5: One year cancer survival rate (%) 15-99 years old, Harrow and England, 2000 - 2015

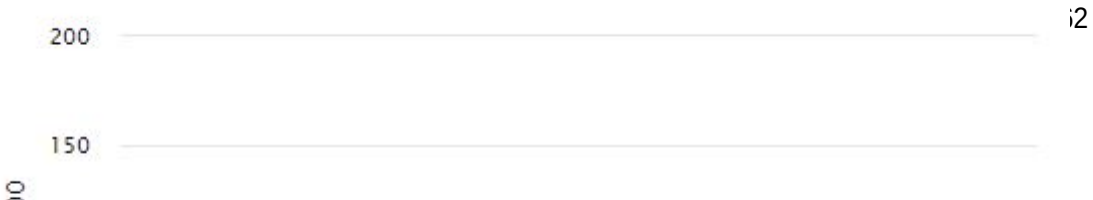
Source: Local Cancer Intelligence, NCIN & MacMillan Cancer Support *http://lci.cancertoolkit.co.uk/Prevalence*

Cancer mortality

The most recently published age standardised mortality rate from cancer is the April 2021 publication by Public Health England which shows mortality from Cancer.

Figure 7 shows that for Lung Cancer in all persons Harrow rates decreased from a 51.3 per 100,000, in 2001 to 30.1 rate in 2020 with the highest rate being 54.7 in 2003 (Harrow rates in green). Harrow rates have remained consistently below the England rates.

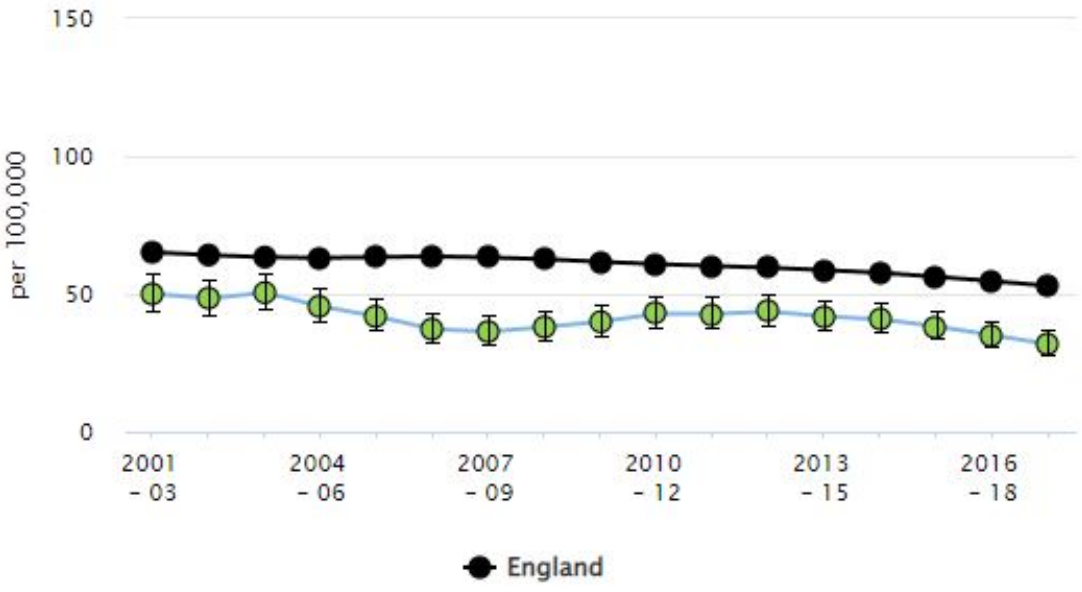
Figure 6: Cancer mortality directly standardised rate per 100,000 by mortality from Lung Cancer for all persons (one year range), Harrow and England (2001 to 2020)



Source: Calculated by OHID: Population Health Analysis (PHA) team from the Office for National Statistics (ONS) Annual Death Registrations Extract and ONS Mid-Year Population Estimates

Figure 6 did show a slight rise in 2020. The 95% confidence intervals shown have been calculated in and indicate that there is no significant change over time.

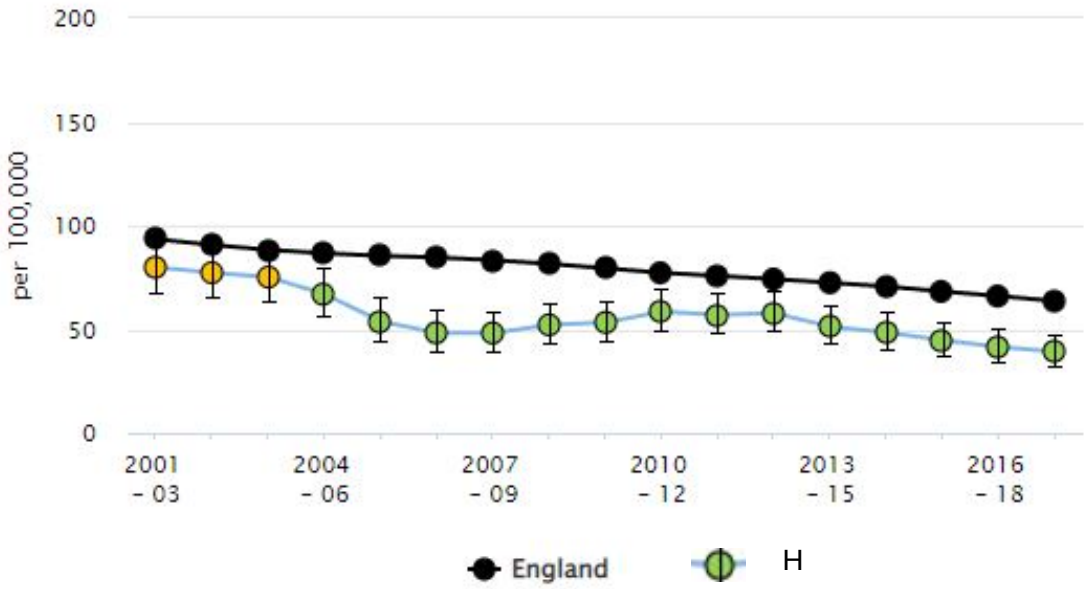
Figure 7: Cancer mortality directly standardised rate per 100,000 by mortality from Lung Cancer for all persons (three-year range), Harrow and England (2001 to 2020)



Source: Calculated by OHID: Population Health Analysis (PHA) team from the Office for National Statistics (ONS) Annual Death Registrations Extract and ONS Mid-Year Population Estimates

Figure 7 shows a standardised rate for a three-year range. The data for Harrow range from 50.1 in 2001/03 to 31.8 in 2017/19 with 95% confidence intervals.

Figure 8: Cancer mortality directly standardised rate per 100,000 by mortality from Lung Cancer for males (three-year range), Harrow and England (2001 to 2020).



Source: Calculated by OHID: Population Health Analysis (PHA) team from the Office for National Statistics (ONS) Annual Death Registrations Extract and ONS Mid-Year Population Estimates

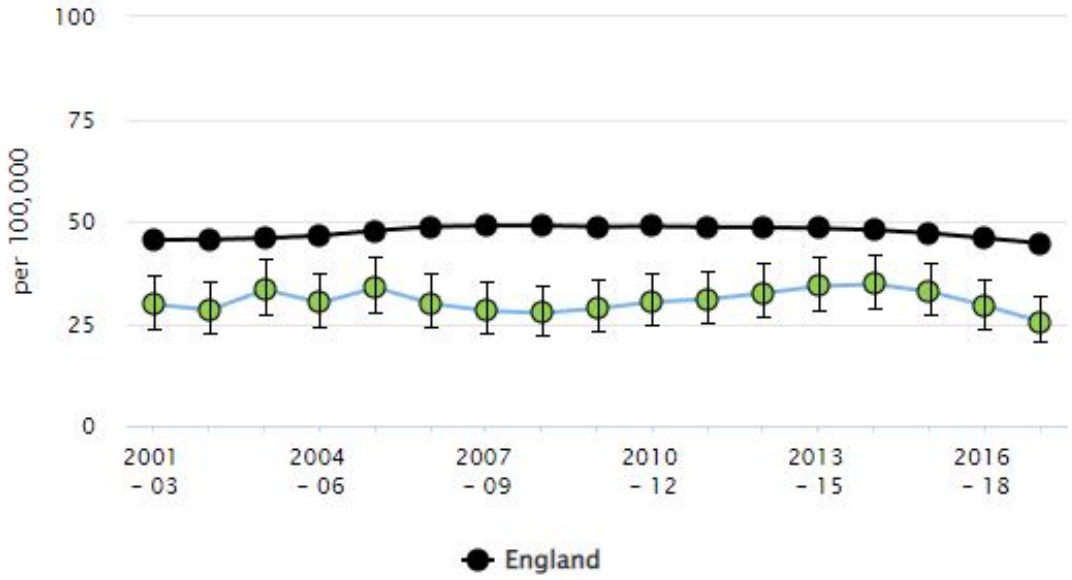
Figure 8 shows the same comparison for males on a three-year range and indicates that Harrow is showing a reduction in rates over the period in line with the reduction across England, but still remaining below the England rate. 95% confidence intervals are shown.

Harrow rates range from a highish 79.9 per 100,000 in 2011/03 to a 39.3 in 2017/19.

Figure 9 shows the three-year ranges for Lung Cancer in women and a trend that is downward for Harrow and lower consistently than England.

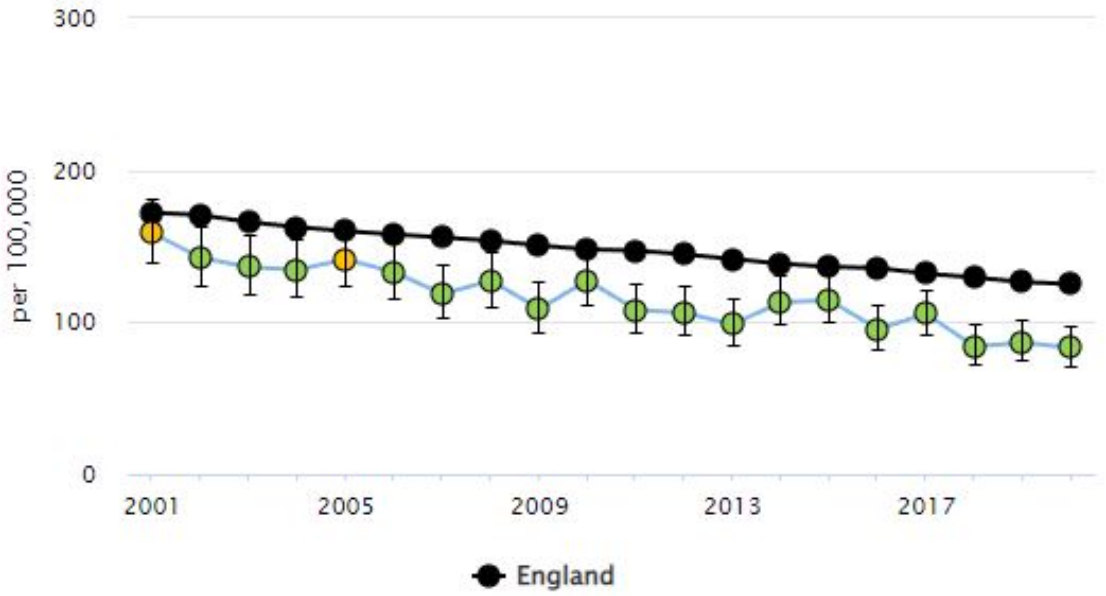
The rates range from a low 29,7 for the three-year range of 2001/03 to 25.5 in 2015/17 with a 33.3 rate peak in 2003/05.

Figure 9: Cancer mortality directly standardised rate per 100,000 by mortality from Lung Cancer for females (three-year range), Harrow and England (2001 to 2020).



Source: Calculated by OHID: Population Health Analysis (PHA) team from the Office for National Statistics (ONS) Annual Death Registrations Extract and ONS Mid-Year Population Estimates

Figure 10: Under 75 mortality rate from cancer (Persons, 1 year range)

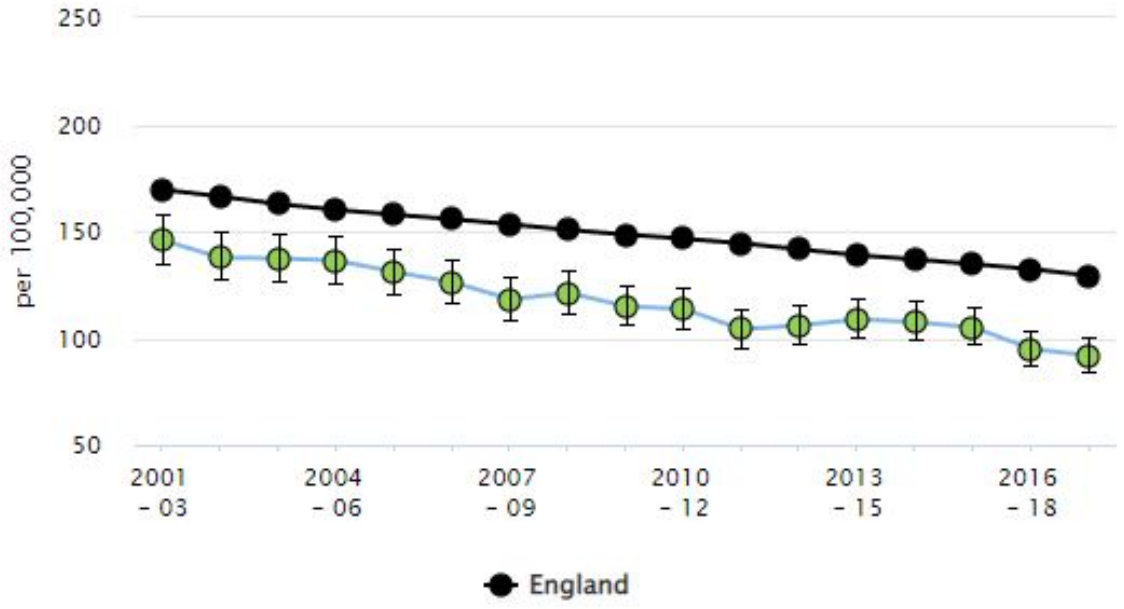


Source: Office for Health Improvement and Disparities (based on ONS source data)

Figure 10 shows that there has been a steady decline in mortality for all persons in Harrow since the 158.6 per 100,000 population in 2001 to 83.1 in 2020.

The rate in Harrow has always remained below that of England.

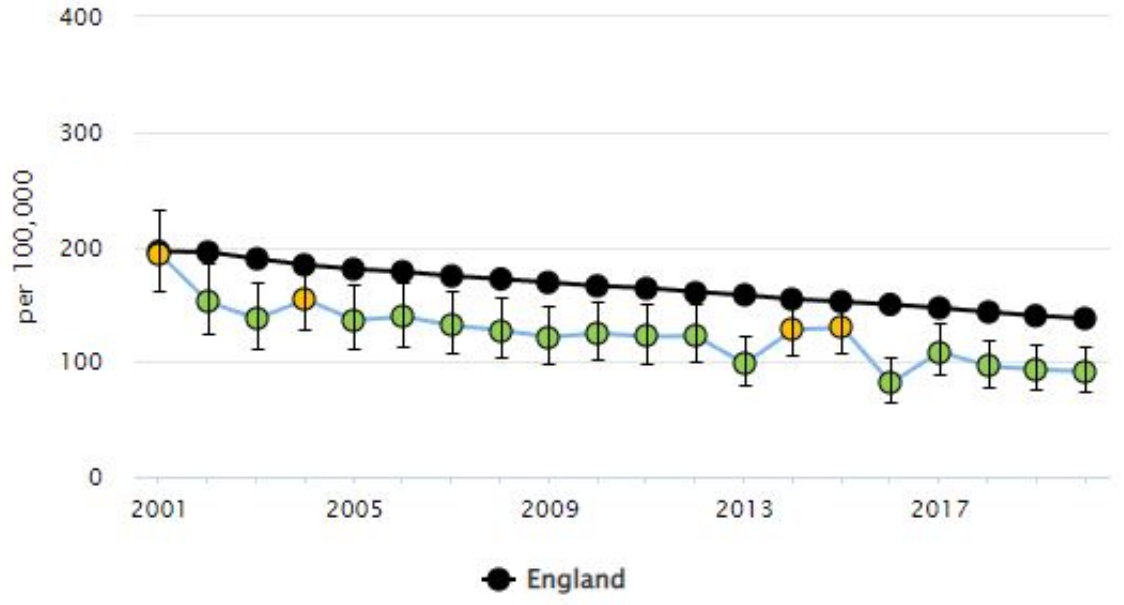
Figure 11: Under 75 mortality rate from cancer (Persons, 3 year range)



Source: Office for Health Improvement and Disparities (based on ONS source data)

Figure 11 shows an unsurprising similar trend as in figure 11 ranging from 145.6 in 2001/03 to 91.9 in 2017/19 with 95% confidence intervals.

Figure 12: Under 75 mortality rate from cancer (Males, 1 year range)

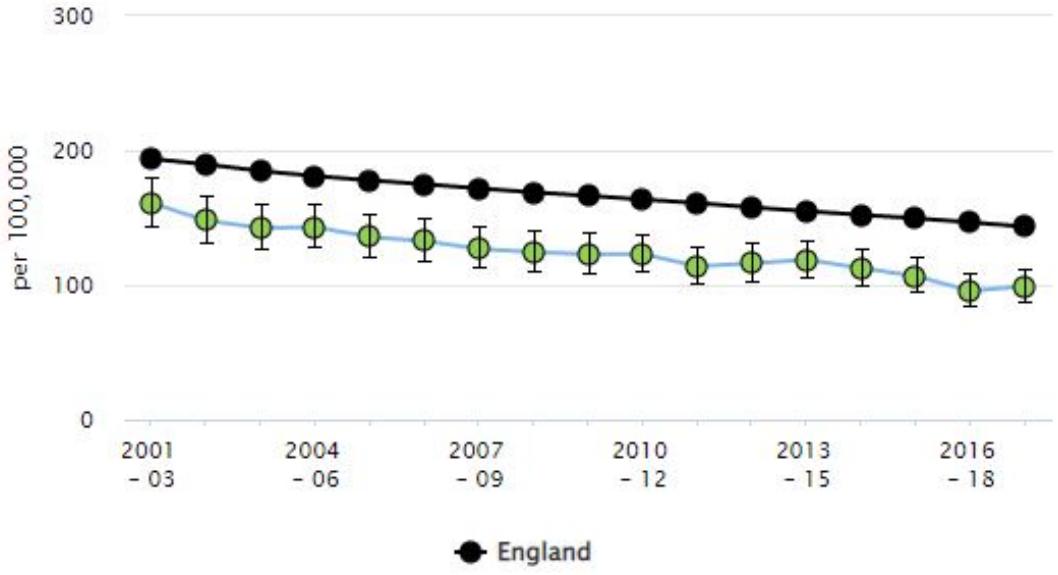


Source: Office for Health Improvement and Disparities (based on ONS source data)

Figure 12 tells us that the mortality rate for Under 75 males (on a single year range) has halved since the 193.9 rate in 2001 to the 91.6 rate in 2020 and has always been just below the England rates.

There was a significant spike in years 2014 and 2015.

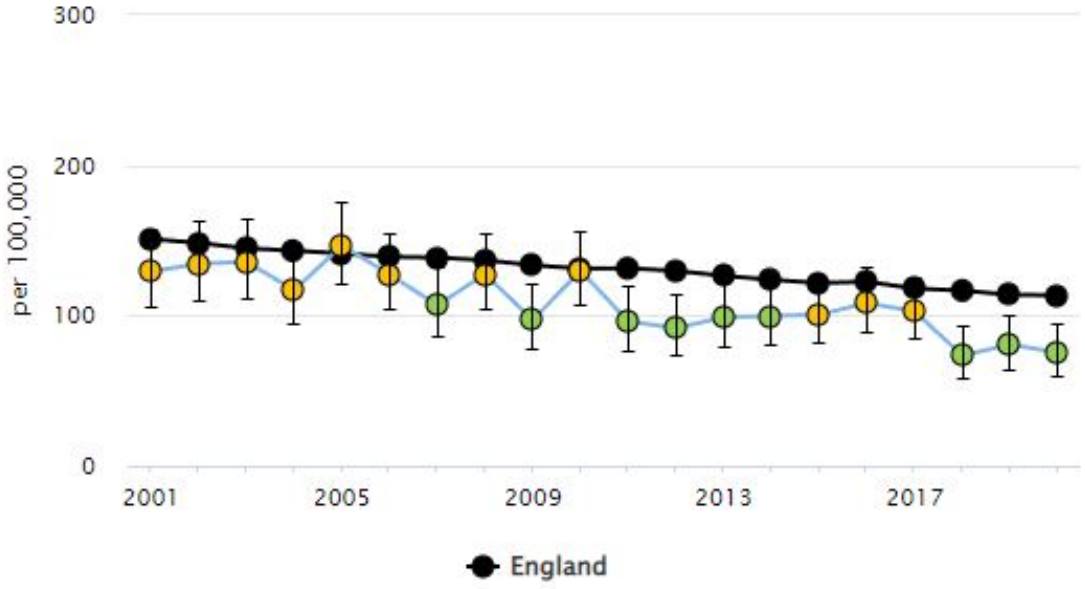
Figure 13: Under 75 mortality rate from cancer (Males, 3 year range)



Source: Office for Health Improvement and Disparities (based on ONS source data)

Figure 13 tells a similar story for the mortality rate for Under 75 males (on a three-year range) in that there is a downward trend since the figure of 160.8 in 201/03 to the latest 99.2 in 2017/19. This last figure is a rate rise since the 96.6 rate in 2016/18 but rates have always remained below that of England.

Figure 14: Under 75 mortality rate from cancer (Females, 1 year range)



Source: Office for Health Improvement and Disparities (based on ONS source data)

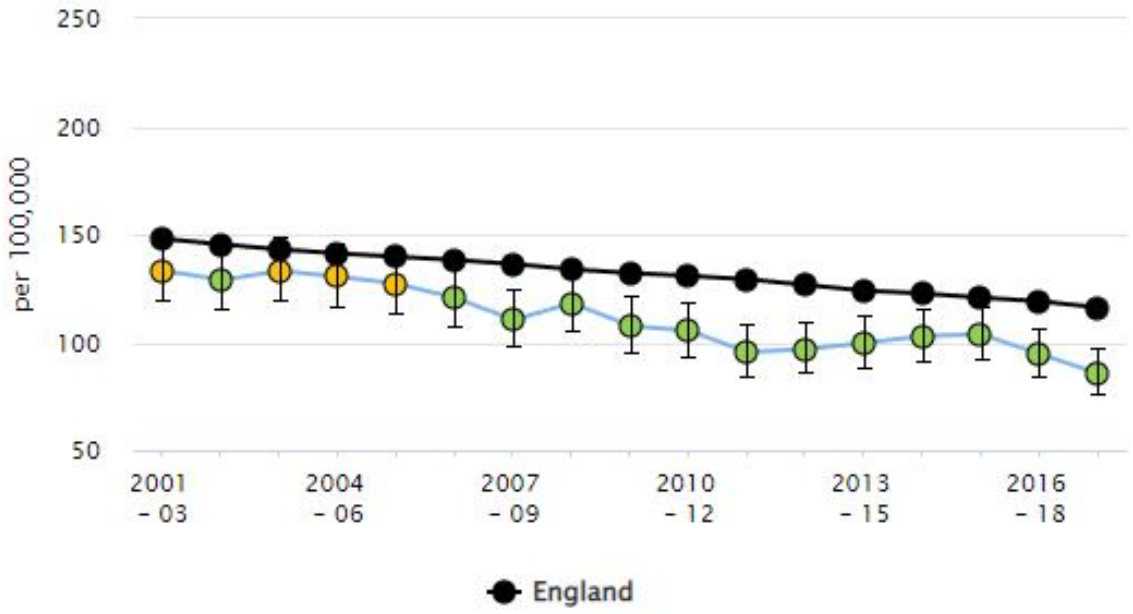
Figure 14, showing female Cancer mortality, tells a different story to that of males in Figures 13 and 14. It shows that rates for single years in women were 129.4 per 100,000 and rose for the next few years to 1 rate of 146.6 in 2005, a rate higher than England.

The rates fluctuated until 2011 when they fell to 96.1.

The rates did start to slowly rise increasing to 108.3 in 2016. There was a welcome rate fall to 73.4 in 2018 where some further fluctuating occurred giving a rate of 75.5 in 2020.

The data at 95% confidence intervals shows no significant change.

Figure 15: Under 75 mortality rate from cancer (Females, 3 year range)



Source: Office for Health Improvement and Disparities (based on ONS source data)

Figure 15, which shows Under 75 mortality rates from Cancer for women in a 3-year range, provides a slightly different view.

It tells a story of almost continual reduction since the high of 133.3 in 2001/03 to 85.5 in 2017/19 albeit with a few peaks along the way.

It is interesting to note that this final figure of 85.5 for 2017/19 is a higher rate than for the single year of 2020 of 75.5 shown in figure 15.

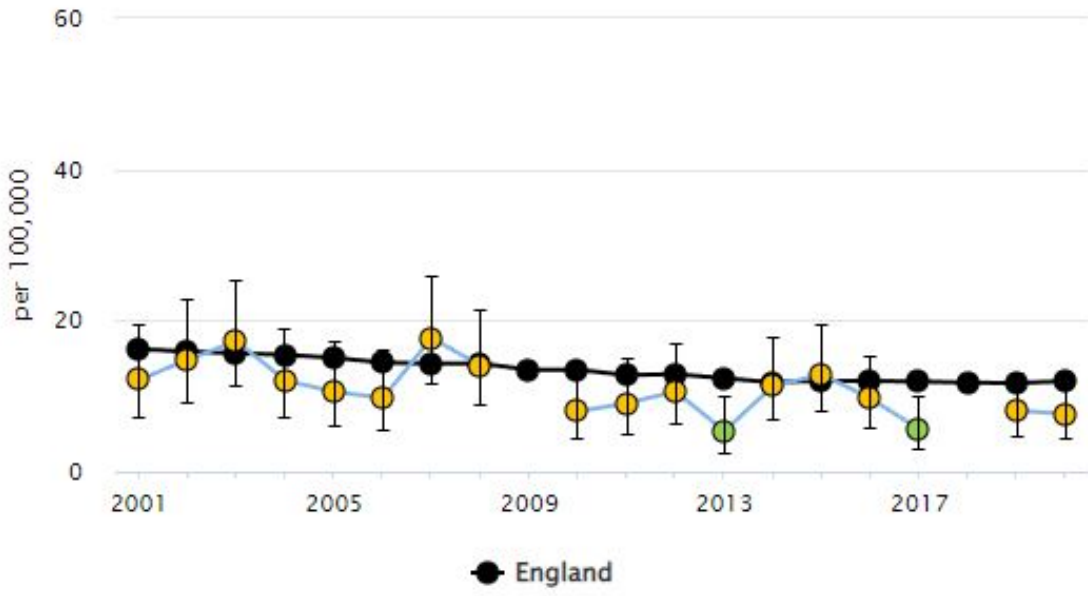
Figure 16 moves to Colorectal Cancer mortality for the under 75s for all persons one-year range.

Missing data is due to small numbers but the data there for the years since 2001 show that the rates in Harrow are comparatively and below that of England, apart from one year (2007 at 17.7 per 100,000 compared to England's 14.3).

Harrow ranges from 12.1 in 2001 to 7.6 in 2020.

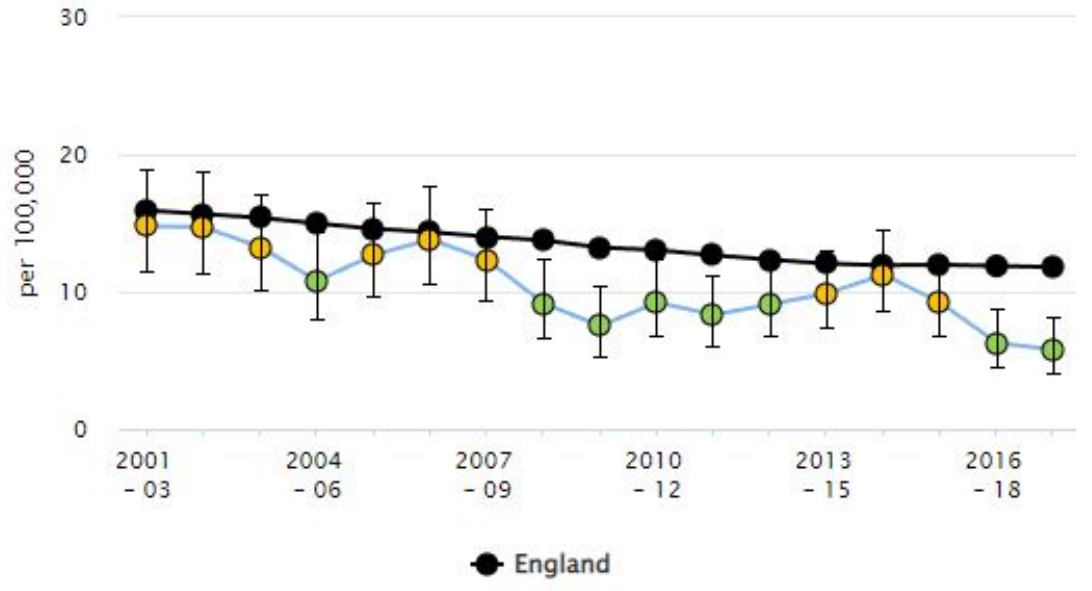
Counts are low for this indicator and so confidence intervals are wide.

Figure 16: Under 75 mortality rate from Colorectal cancer (All Persons, 1 year range)



Source: Office for Health Improvement and Disparities (based on ONS source data)

Figure 17: Under 75 mortality rate from Colorectal cancer (All Persons, 3 year range)

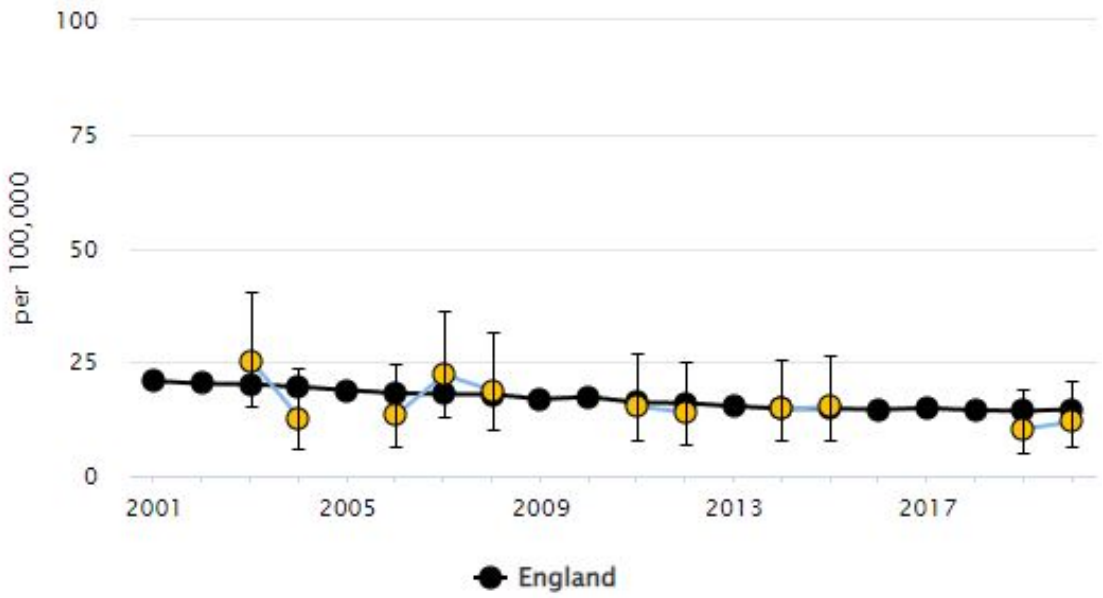


Source: Office for Health Improvement and Disparities (based on ONS source data)

Figure 17 provides a better view of all person's mortality with a 3-year range view of the data. Rates are relatively low with a start in 2001/03 of 14.8 per 100,000 (which was close the England average) to a most recent 5.8 for 2017/19 (well below that of England).

There are a few peaks in 2006/08 and 2014/16 but generally the mortality rate has been reducing over that time. Again, low numbers give wide confidence intervals.

Figure 18: Under 75 mortality rate from Colorectal cancer (Males, 1 year range)

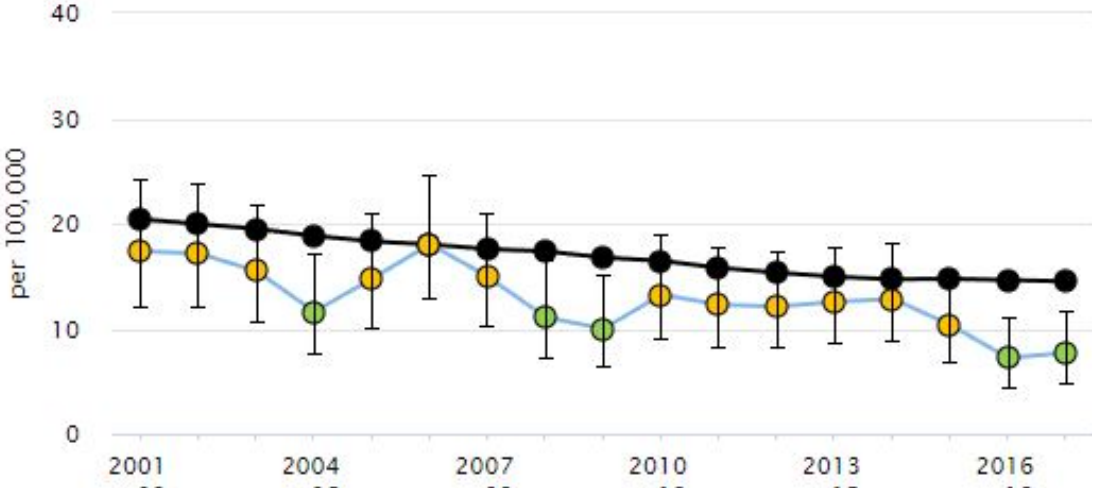


Source: Office for Health Improvement and Disparities (based on ONS source data)

Figure 18 shows Colorectal Cancer rates for males on a 1-year range and low numbers have caused some gaps in the data. Again, the chart shows low rate and Harrow has in the main remained similar to the England rates ranging from 25.3 in 2003 to 11.9 in 2020. Wide confidence intervals show that there are low numbers from which to calculate rates.

Figure 19 shows the rates on a 3-year range and gives a slightly different perspective.

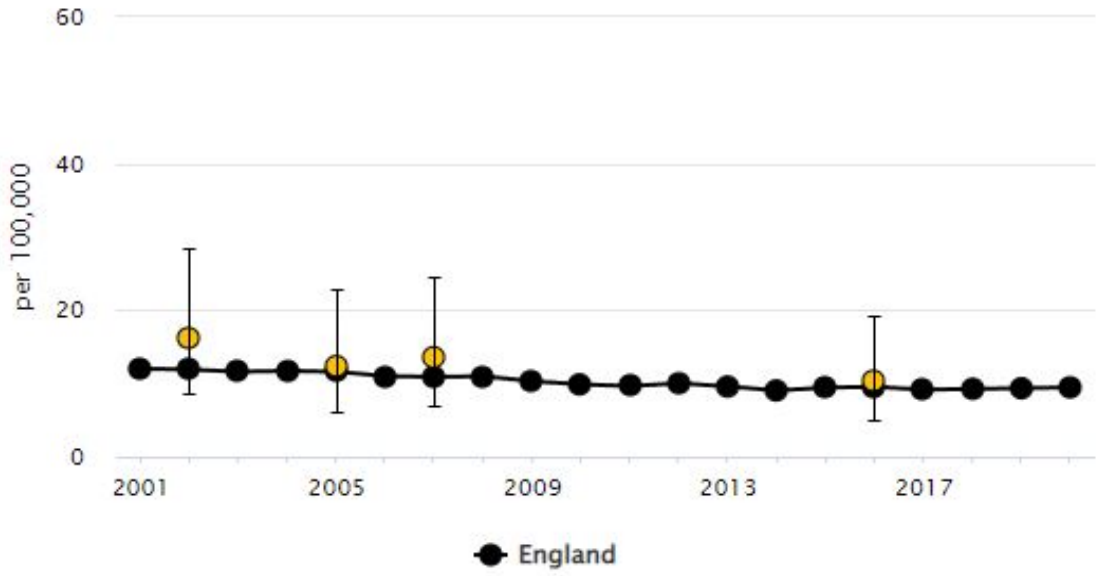
Figure 19: Under 75 mortality rate from Colorectal cancer (Males, 3 year range)



Source: Office for Health Improvement and Disparities (based on ONS source data)

It shows that Harrow has remained below the England rates on this 3 year range from 17.4 in 2001/03 to 7.7 in 2017/19. Again, lower numbers show wide confidence intervals.

Figure 20: Under 75 mortality rate from Colorectal cancer (Females, 1 year range)



Source: Office for Health Improvement and Disparities (based on ONS source data)

Figure 20 has little data, limited to only four years and has a first rate of 16.2 rate in 2002 which was above the England rate.

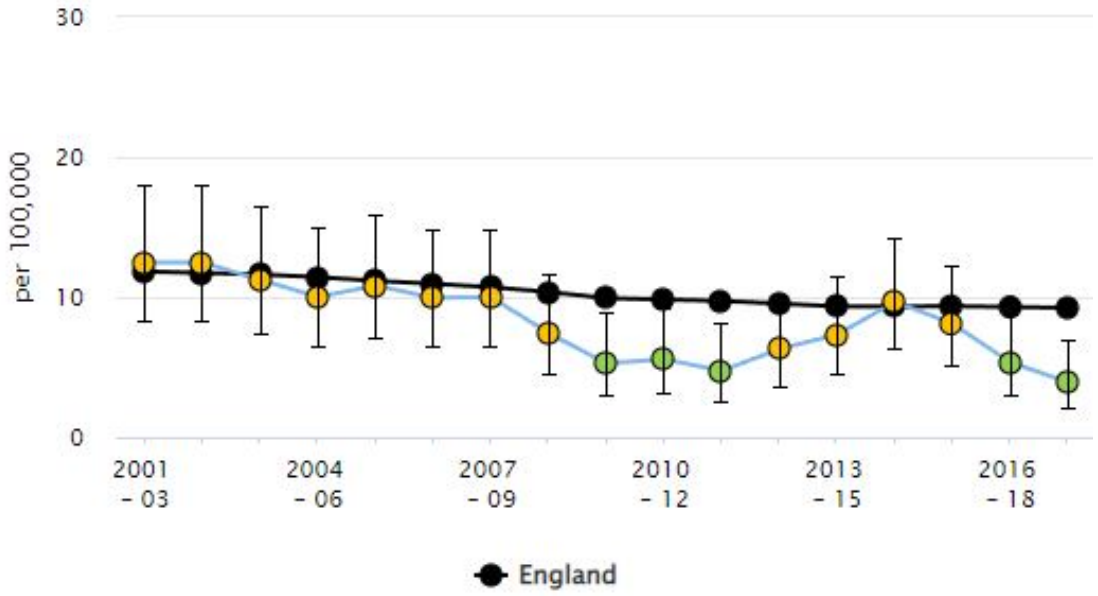
The other three rates are also slightly above England with the last Harrow rate being 10.4 slightly higher than England on 9.5 in 2016.

There are very low numbers for this indicator, with many years so low that calculations cannot be made. Confidence intervals are therefore high.

Figure 21 is a little more informative showing a starting rate above England of 12.5 for 2001/03 compared to England's 11.8. Its only in 2003/05 that Harrow comes below England's 11.6 with an 11.2 local rate.

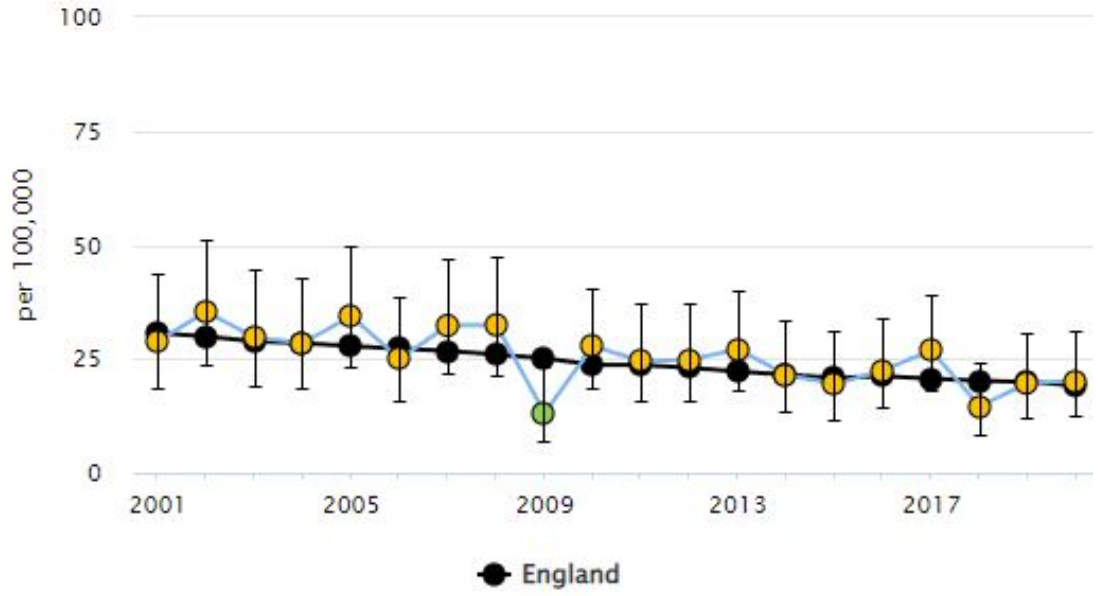
Harrows rates dip to a low of 4.9 compared to England's rate being 9.7. England's rate continued on a steady reduction until a 9.2 rate in 2017/19 compared to Harrows lowest rate of 3.9.

Figure 21: Under 75 mortality rate from Colorectal cancer (Females, 3 year range)



Source: Office for Health Improvement and Disparities (based on ONS source data)

Figure 22: Under 75 mortality rate from Breast cancer (1 year range)



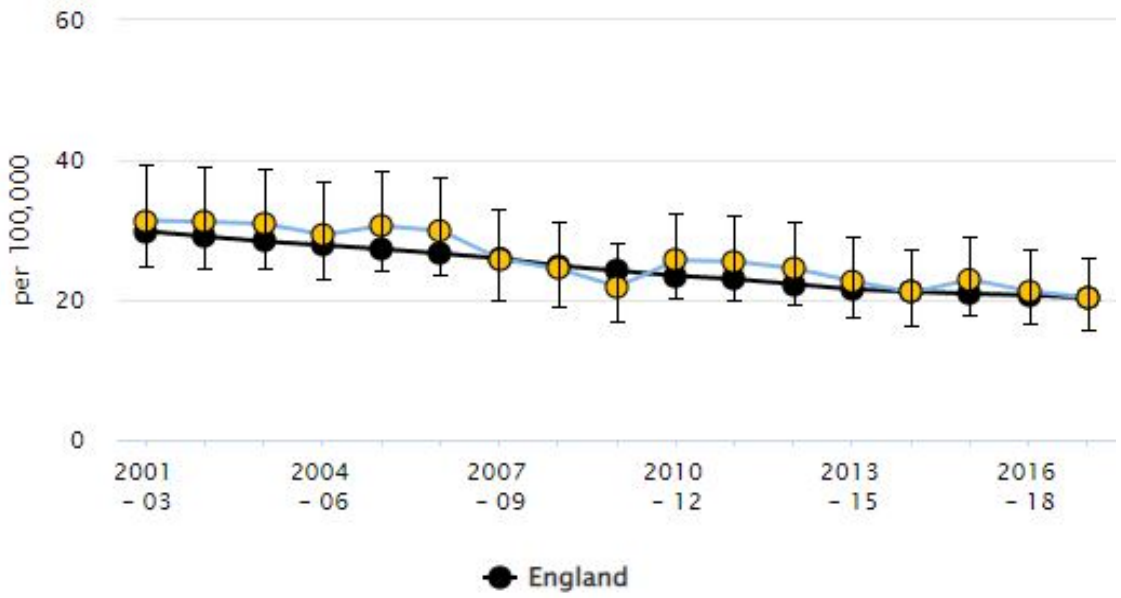
Source: Office for Health Improvement and Disparities (based on ONS source data)

Figure 22 shows the 1-year range for under 75 Breast Cancer and shows fluctuating rates from Harrows 28.9 rate per 100,000 population in 2001 (and lower than England's 30.7) to a most recent rate of 20.2 rate for 2020, slightly higher than England's 19.1.

Harrows lowest rate occurred in 2009 recording 13.1 when the England value was 25.1.

Low numbers again provide wide confidence intervals.

Figure 23: Under 75 mortality rate from Breast cancer (3 year range)



Source: Office for Health Improvement and Disparities (based on ONS source data)

Figure 23 shows the same information as Figure 3 but as a 3-year average rather than single years. The chart shows the same downward trend for both England and for Harrow but there are less traumatic fluctuations in the data trend line.

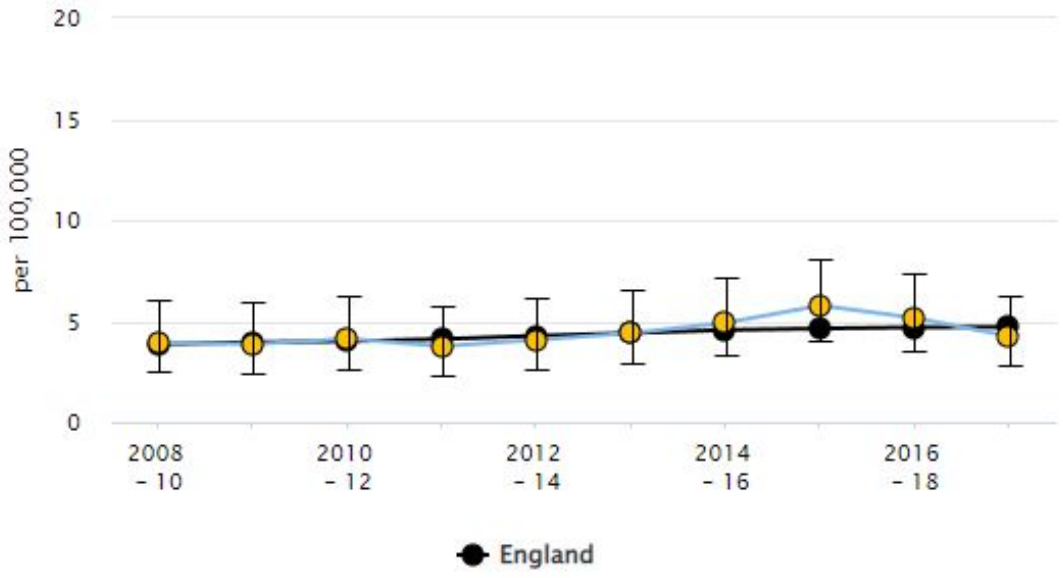
The rates for Harrow are above England in the earlier years but have a smoother trend line than for the single year. It shows that rates for Harrow have reduced from 31.3 in 2001/03 to 20.3 in 2017/19.

Figure 24: 65+ Cancer mortality rate

Source: Office for Health Improvement and Disparities (based on ONS source data)

Figure 24 shows that for the 65+ population mortality from Cancer is lower in Harrow compared to England. The single year data sets Harrow at a very high 1067.7 per 100,000 population although this is lower than the England rate of 1227.7. The most recent Harrow rate is 808.7 against an England value of 1050.5.

Figure 25: Oral Cancer mortality rate



Source: Calculated by OHID: Population Health Analysis (PHA) team from the Office for National Statistics (ONS) Annual Death Registrations Extract and ONS Mid-Year Population Estimates

Figure 25 shows the Oral Cancer mortality rate for the three-year trends from 2001/03. Harrow had a three-year trend rate of 3.9 per 100,000 population in 2001/03, the same as that of England. Rates for both Harrow and England increased slightly to 4.3 per 100,000 population in 2017/19 slightly lower than the England rate of 4.7.

There was a peak in Harrow in 2015/17 of 5.8.

Confidence intervals are high due to lower numbers.

Prevention

Prevention is a crucial component of both the London and national cancer strategies. More than 4 in 10 cases could be prevented through making certain lifestyle changes such as quitting smoking, maintaining a healthy body weight, reducing alcohol consumption, maintaining a healthy diet and engaging in physical activity[1]. Adapting to such changes could aid in preventing recurrence of cancer and in general improve health and wellbeing of individuals living with cancer and beyond.

A survey conducted by Cancer Research UK observed that only 3% of people they received results from knew that being overweight or obese could increase their risk of cancer[2]. Smoking is recognised as of the most significant risk factors for cancer, responsible for 19% - or around 64,500 cases – of all new cancer cases per year in the UK. Both the London and national cancer strategies have emphasised that the prevention of cancer is not only the responsibility of the NHS organisations, but is rather a shared responsibility across local government, employers and the wider community.

Detection

Diagnosing cancer at an early stage enables greater treatment option and an increase chance of full recovery. For example, over 93% of bowel cancer patients diagnosed with the earliest stage of disease survive at least five years compared with less than 7% of those diagnosed with the most advances stage disease. The pattern is true for lung cancer, breast cancer, and for many cancers, common or rare.

Detecting cancer at an early stage can be complex and this proved to be a challenge for both health professional and the wider public. Inequalities are unfortunately present, with some groups of patients associated with a higher likelihood of being diagnosed at a later stage.

The National Awareness and Early Diagnosis Initiative (NAEDI) reported that both Public Health and NHS have a role to play in tackling late diagnosis and their progress will be measured through indicators in their Outcome Frameworks[3].

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[1] Parkin DM, Boyd L and Walker LC. The fraction of cancer attributable to lifestyle and environmental factors in the UK in 2010. Summary and conclusions. British Journal of Cancer 2011

[2] Cancer Research UK. Perception of Risk Survey 2008 http://www.cancerresearchuk.org/prod_consump/groups/cr_common/@nre/@hea/documents/generalcontent/014219.pd [Last accessed 24 Oct. 2019].

[3] National Awareness and Early Diagnosis Initiative (NAEDI) http://www.cancerresearchuk.org/health-professional/early-diagnosis-activities/national-awareness-and-early-diagnosis-initiative-naedi [Last accessed 24 Oct. 2019].

Screening

Cancer screening is important in the early detection of cancer. The three national cancer screening programmes are based on internationally recognised principles of screening. Screening identifies individuals who may be at higher risk of a disease or condition amongst large populations of healthy people.

Once identified, those individuals can consider further tests, and healthcare providers can offer them interventions of benefit. A screening programme needs to offer more benefit than harm, at a reasonable cost to the NHS[1].

The cancer screening strategy for London identifies the need to (i) increase public awareness of screening, (ii) increase engagement with primary care and improve reliability of data, (iii) improve quality; capacity and patient experience of provider services to optimise coverage and uptake and (iv) to facilitate high quality research to further inform strategies to improve coverage and uptake in London.

Breast Screening for women aged 50-70 years

Breast screening can identify cancer before symptoms are noticed. It is one of the best methods to detect breast cancer earlier. Women have a higher likelihood of surviving breast cancer is it diagnosed at an early stage. The national minimum standard for coverage of women is 70% and national target is 80%.

Breast screening coverage (50-70 years) in Harrow Local Authority area is lower than England on 54.5% against the 61.3% of England but still not meeting than national standard (Figure 26).

Figure 26: Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %), Harrow, Most similar CCGs and England, 2020/21

[1] GOV.
https://\
Oct. 2019].

Source: Data was extracted from the NHAIS via the Open Exeter system. Data was collected by the NHS Cancer Screening Programme

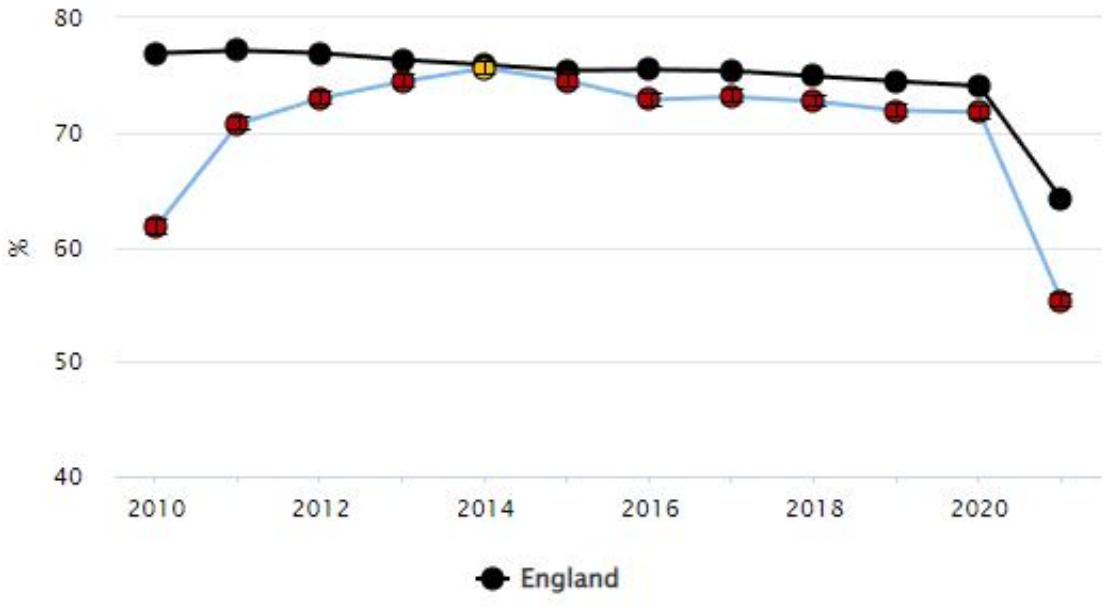
Figure 28 Trends in breast cancer screening from 2010 to 2014 were below the rate for England, but nevertheless saw a significant increase for Harrow from 61.8%in 2010 to 74.6% in 2014 where it was almost the same as that of England.

However there has been a dramatic decline in screening rates in Harrow to 55.3% in 2021 (Figure 27).

There has also been a decline in England rates during that time and a significant decline across England in 2021.

This may be due to pressures on the NHS system during the Covid 19 outbreak.

Figure 27: Breast Cancer screening coverage



Source: NHS Digital (Open Exeter) / Office for Health Improvement and Disparities

Cervical Cancer Screening in Women aged 25-64 years

Screening within target period 3.5- or 5.5-year coverage:

Cervical cancer screening detects changes in cells that may become cancer, so that they can be removed, and cancer prevented. Screening is estimates to save 4,500 lives in England each year.

The national coverage target for cervical screening is 80%[1]. Coverage in NHS Harrow CCG in 2017/18 was 62.5%, significantly lower than NNs, London and England average of 65.2%, 66.9% and 71.7% in that order (Figure 28).

Figure 29 illustrates the trend in cervical screening coverage in Harrow, NNs and England from 2009/10 to 2017/18. Graph below shows Harrow's cervical screening rate had 6% decline from 68.4% in 2009/10 to 62.4% in 2017/18, compared to 3.7% decline nationally.

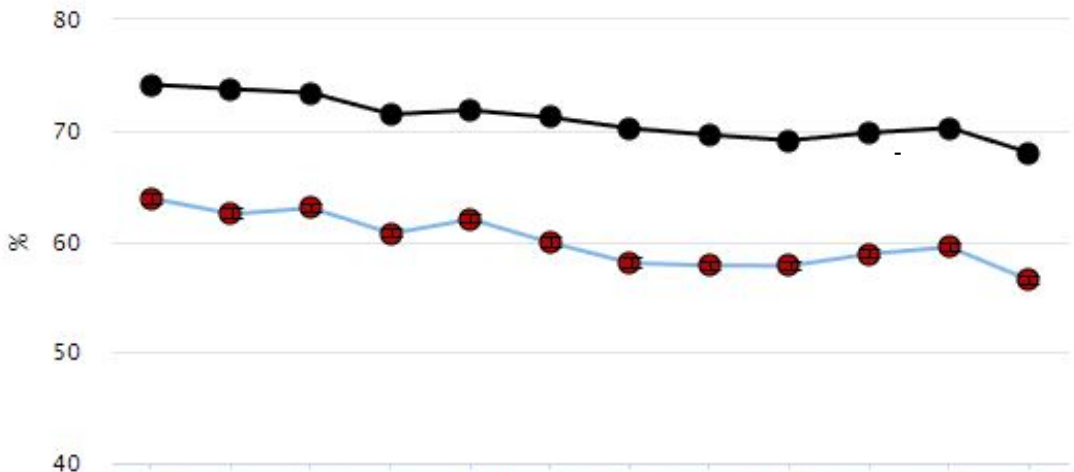
Figure 28: Females, 25-64, attending cervical screening within target period (3.5- or 5.5-year coverage, %), Harrow & NNs, NN Average, London and England, 2017/18

Source: PHOF - *https://fingertips.phe.org.uk/profile/cancerservices/*

Figure 29: Cervical screening coverage, women ages 25-64, Harrow, NNs and England, 2009/10 – 2017/18

Source: PHOF - *https://fingertips.phe.org.uk/profile/cancerservices/*

Figure 30: Cancer screening coverage - cervical cancer (aged 25 to 49)



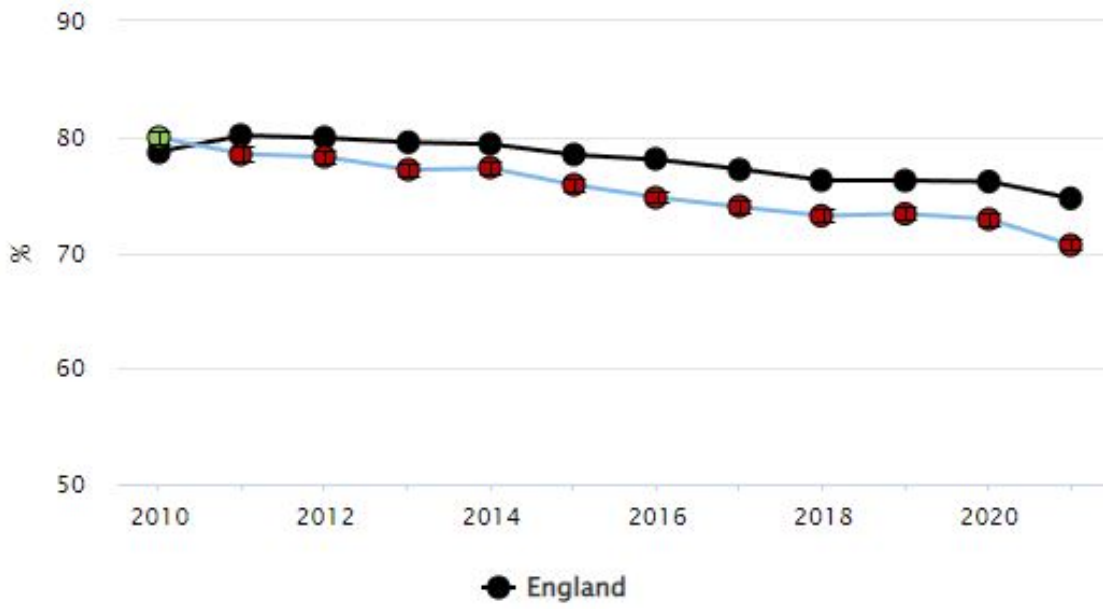
ıtters.
ealth-

Source: NHS Digital (Open Exeter) / Office for Health Improvement and Disparities

Figure 30 shows that Cancer screening for Cervical Cancer for the 25- to 49-year-olds is below the national rates with a figure of 56.5% in 2021 compared to 63.9% in 2010, a fall of around 7.4%.

Again, counts are high and so confidence intervals are significant. It is clear that coverage rates are decreasing and getting worse.

Figure 31: Cancer screening coverage - cervical cancer (aged 50 to 64)



Source: NHS Digital (Open Exeter) / Office for Health Improvement and Disparities

Figure 31 shows that cervical cancer screening for the 50- to 64-year-olds started in a good position in 2010 with 79.9% being screened compared to England's 78.7.

Unfortunately, this positive position has fallen dramatically in the 11 years to 2021 with 70.6% having been screened compared to 74.7 in England.

Again, rates are decreasing and getting worse.

Bowel Cancer screening for men and women aged 60-74 years

Bowel screening aims to prevent cancer developing by detecting and removing abnormal cells which have to potential to become cancerous over time. Screening is the best method to detect bowel cancer at an earlier stage. More than 9 out of 10 people with bowel cancer survive if it is diagnosed at an earlier stage. The national target of uptake of bowel screening is 60%[1].

The bowel screening coverage rate is NHS Harrow CCG in 2017/18 was 52.7%, higher than London average of 50.3% and lower than the England average of 59.6% (Figure 32).

Figure 32: Persons, 60-74, screened for bowel cancer in last 30 months (2.5-year coverage, %), Harrow, Most similar CCGs and England, 2020/21

Area	Value	Lower CI	Upper CI
England	66.8	-	-
NHS Havering CCG	67.5*	66.8	68.2
NHS Milton Keynes CCG	67.1*	66.4	67.8
NHS Trafford CCG	66.9	-	-
NHS Brighton And Hove CCG	65.9	-	-
NHS East Berkshire CCG	64.5*	63.9	65.1
NHS Hillingdon CCG	63.5*	62.7	64.3
NHS Harrow CCG	63.1*	62.3	63.9
NHS Hounslow CCG	61.9*	61.2	62.7
NHS Redbridge CCG	60.7*	59.9	61.5
NHS Ealing CCG	59.7*	59.0	60.4
NHS Luton CCG	58.3*	57.3	59.3

Source: Data was extracted from the Bowel Cancer Screening System (BCSS) via the Open Exeter system. Data was collected by the NHS Cancer Screening Programme

Figure 33 illustrates the trend in 'Screened for bowel cancer in last 30 months (2.5-year coverage, %), persons, 60-74' in Harrow, NNs and England from 2009/10 to 2017/18. The Graph shows Harrow's bowel screening rate increased from 44.3% in 2009/10 to 54% in 2013/14 but it has declined to 52.7% in 2017/18.

[1] The Nuffield Trust. (2019). Cancer screening. Available at: https://www.nuffieldtrust.org.uk/resource/breast-and-cervical-cancer-screening [Last accessed 24 Oct. 2019].

Figure 33: Bowel screening coverage trend in NHS Harrow CCG; persons aged 60-74; Harrow, NN Average and England, 2009/10—2017/18

Source: PHOF - https://fingertips.phe.org.uk/profile/cancerservices/

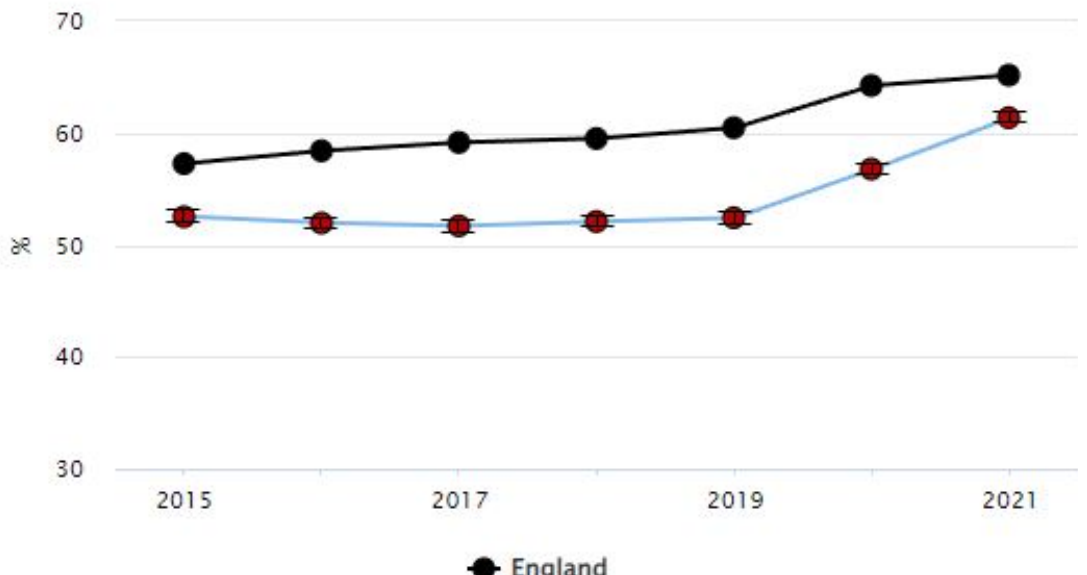
In 2020/21 62.9% of people aged 60-74 years old in Harrow were screened within 6 months of invitation, significantly lower than the England average of 70.7% (Figure 34).

Figure 34: Screening for bowel within 6 months of invitation, persons aged 60-74; Harrow, most similar CCGs and England, 2020/21

Area	Value	Lower CI	Upper CI
England	70.7	-	-
NHS Trafford CCG	70.4	-	-
NHS Brighton And Hove CCG	69.6	-	-
NHS Havering CCG	69.1*	68.1	70.0
NHS Milton Keynes CCG	68.9*	67.9	69.8
NHS East Berkshire CCG	68.3*	67.5	69.2
NHS Harrow CCG	64.0*	62.9	65.0
NHS Hillingdon CCG	63.9*	62.9	64.8
NHS Redbridge CCG	62.1*	61.0	63.2
NHS Hounslow CCG	61.6*	60.5	62.6
NHS Luton CCG	60.9*	59.6	62.2
NHS Ealing CCG	60.3*	59.3	61.2

Source: Data was extracted from the Bowel Cancer Screening System (BCSS) via the Open Exeter system. Data was collected by the NHS Cancer Screening Programme

Figure 35: Cancer screening coverage - bowel cancer



Source: NHS Digital (National Health Application and Infrastructure Services - NHAIS) / Office for Health Improvement and Disparities

Figure 35 adds data to 2021 and shows an improvement in screening in Harrow with the 2021 figure being 61.4% (England 65.2%). So, although Harrow is still below England, screening coverage is improving and closing the gap on England.

Counts are so high that confidence intervals are small and therefore significant.

Emergency Admissions

Patients who are diagnosed via emergency routes may display late diagnosis which may closely correlate with poor survival. Available data from 2009/10 to 2017/18 shows the number of emergency admissions with cancer (per 100,000) in Harrow has always been significantly lower than England. Emergency presentations have significantly reduced 1 year survival.

Figure 36 shows Harrow's rate of emergency admissions with cancer for all age. For Harrow there has been a reduction in rates from the 421 per 100,000 populations in 2017/18 to 341 in 2020/21. This is significantly lower than the National average rate of 540 per 100,000 populations in 2017/18 and 456 in 2020/21.

Figure 36: Number of emergency admissions with cancer (per 100,000 population), person, all a

Source: OHID - https://fingertips.phe.org.uk/profile/cancerservices/

Treatments

Treatment for cancer is most often comprised of a combination of chemotherapy, radiotherapy or surgery, or all three. In certain cases, it can involve hormone treatment or biological therapies. It is estimates that 4 in 10 cancers are cured due to radiotherapy[1] and 5 in 10 due to surgery[2].

Treatments are provided alongside social and psychological support as well as rehabilitation during and following treatment. The Cancer strategy for England 2015-20 states that "patients should have access to the best evidence-based treatments which will mean reducing variation across the country, upgrading radiotherapy technology, and using medicines in more stratified ways[3].

The case for change in London noted that variation in practice across the city is leading to variation in the quality of services offered to patients, and ultimately to care outcomes[4]. Cancer alliances aim to address variation by better coordination of resources and services.

Figure 38 shows the Two-Week Waiting (TWW) referrals rate resulting in a diagnosis of cancer for Harrow, NNs and England from 2009/10 to 2017/18 (5 years combined data). The graph below shows in this period of time there has been around 2% decline for comparing areas, with Harrow holding the lowest rate, significantly lower than NNs average and England.

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[1] Department of Health, Radiotherapy Services in England 2012. https://www.gov.uk/government/publications/radiotherapy-services-in-england-2012 [Last accessed 24 Oct. 2019].

[2] Price, P., Sikora, K. and Illidge, T. (eds.) (2008) Treatment of Cancer. London: Edward Arnold Ltd

[3] Achieving world-class cancer outcomes: a strategy for England 2015-2020 p23 Independent Cancer Taskforce http://www.cancerresearchuk.org/sites/default/files/achieving_world-class_cancer_outcomes_-_a_strategy_for_england_2015-2020.pdf [Last accessed 24 Oct. 2019].

[4] A Model of Care for Cancer Services p51 http://www.londonhp.nhs.uk/wp-content/uploads/2011/03/Cancer-model-of-care.pdf [Last accessed 24 Oct. 2019].

Figure 37: Two-week referrals resulting in a diagnosis of cancer (Conversion rate: as % of all TWW referrals), Five years combined data, Harrow, Similar CCGs and England 2020/21

Area	Value	Lower CI	Upper CI
England	7.1*	-	-
NHS Havering CCG	7.5*	7.1	7.8
NHS Luton CCG	7.2*	6.7	7.7
NHS Milton Keynes CCG	6.6*	6.3	7.0
NHS Hillingdon CCG	6.5*	6.2	6.9
NHS East Berkshire CCG	6.3*	6.1	6.6
NHS Trafford CCG	6.2*	-	-
NHS Brighton And Hove CCG	5.7*	-	-
NHS Redbridge CCG	5.0*	4.7	5.4
NHS Hounslow CCG	5.0*	4.7	5.4
NHS Harrow CCG	4.6*	4.3	4.9
NHS Ealing CCG	4.3*	4.1	4.6

Source: NHS England Cancer Waiting Times Database

The proportion of new cancer cases treated who were referred through the Two-Week Waiting referral route in Harrow, similar CCG's and England is presented in Figure 37.

The five years combined data shows Harrow on 4.3%, a reduction on the previous figure of 5.1 and an increase for England of 7.1 against the previous 4.6%.

Figure 38: Number of new cancer cases treated (Detection rate: % of which resulted from a TWW referral), Five years combined data, Harrow, Most similar CCGs and England 2016/17 to 2020/21

Source: NHS England Cancer Waiting Times Database

Figure 38 shows that has one of the highest detection rates within its similar CCGs grouping and higher than England with a local rate of 58.7% against England's 52.9%.

Sigmoidoscopy: Examination of the lower colon using a sigmoidoscope, inserted into the rectum. A sigmoidoscope is a thin, tube-like instrument with a light and a lens for viewing. It may also have a tool to remove tissue to be checked under a microscope for signs of disease, it is also called proctosigmoidoscopy. Figure 39 illustrates the In-patient or day-case sigmoidoscopy procedures (Number per 100,000 populations) performed on persons registered at the practices for Harrow, NNs average and England from 2009/10 to 2017/18. Graph below shows a sharp increase in sigmoidoscopy rate in Harrow from 2012/13.

Figure 39: In-patient or day-case sigmoidoscopy procedures (per 100,000 population), Harrow, NNs Average and England, 2009/10-2017/18

Source: PHOF - https://fingertips.phe.org.uk/profile/cancerservices/

Upper GI Endoscopy:

An endoscope is a long, thin, flexible tube that has a light source and camera at one end. Images of the inside of the patients' body are relayed to a television screen. An endoscopy can be used to investigate unusual symptoms also to help perform certain types of surgery.

The crude rate per 100,000 persons of endoscopies of the upper gastrointestinal tract performed on persons registered at the practice from 2009/10 to 2017/18 in Harrow, NNs and England is presented in Figure 40.

Graph below shows for Harrow between 2009/10 to 2017/18 there has been 37% increase in endoscopy rate (from 955 to 1302 per 100,000 of populations). Harrow's rate is significantly higher than NNs and England average.

Figure 40: In-patient or day-case upper GI endoscopy procedures (per 100,000 population), Harrow, NNs Average and England, 2009/10-2017/18

Source: PHOF - https://fingertips.phe.org.uk/profile/cancerservices/

Recommendations

1. ### Prevention
   Prevention is a crucial component of the Harrow Cancer Strategy. People should be supported to stop smoking, maintain a healthy body weight, eat a healthy diet and engage in physical activity. Focusing on these prevention strategies not only helps with cancer prevention, but numerous other medical conditions, such as hypertension and diabetes.
2. ### Public awareness
   The national 'Be clear on cancer' campaign has helped support increased awareness of cancer. The national cervical screening campaign, Cervical screening saves lives was launched earlier this year. Public Health England is currently evaluating the campaign. These national campaigns should be supported with local, tailored campaigns.
3. ### Screening programmes
   Harrow has introduced the primary Human Papilloma virus testing, which has higher sensitivity for detecting changes in the cervical cells compared with primary cytology (previous screening method). The new test will identify more women at risk of developing cervical cancer.

   Nevertheless, Harrow needs to improve the percentage of people being screened in their screening programmes.

   Screening reduces the risk of dying from Cancer. The NHS Bowel Cancer screening programme reduces the risk of dying from bowel cancer by detecting disease before symptoms develop. The introduction of the new home test kit will make the test simpler to complete and more accurate.

   These programmes should be supported and published locally to encourage participation.

4. ### Commissioning more effective Cancer Pathways
   Commissioning a pathway that allows straight to test for people referred with suspected gastrointestinal cancer avoids delays due to multiple appointments. Stratified follow-up for patients with prostate cancer.

5. ### Living with and Beyond Cancer
   Implementing the Recovery Package consisting of Holistic Needs Assessment, Treatment summary, Cancer care reviews, patient education and support. This package ensures that people are supported after their and beyond their cancer diagnosis.