

# Central Mendip

## Commissioning Locality profile

Part of the **SOMERSET JOINT STRATEGIC NEEDS  
ASSESSMENT**

## Practices in Commissioning Locality

Grove House Surgery  
Oakhill Surgery  
Park Medical Practice



## Introduction

This is the sixth Commissioning Locality profile, produced to complement the ninth edition of practice profiles. The document aims to provide an overview of demographic, health and service use data at a Commissioning Locality level.

This document aims to aid Commissioning Localities in the identification of health needs, priorities and potential service interventions that could be commissioned or provided.

This year we have again reorganised the content of information slightly, made clearer the categories of information provided and integrated some of the new information added in recent years. A summary of some of the key outcomes is presented first, highlighting the Commissioning Locality's performance compared to the rest of Somerset. This is followed by the Commissioning Locality profile in more detail.

We aim to expand on the intervention summaries highlighting the interventions which can be adopted to improve performance on various outcomes and would particularly welcome feedback on which additional areas would be useful. There are more practice level 'ski-slopes' which show the variation of practices within the Commissioning Locality more clearly. Again we would welcome feedback on whether you would like to see more (or fewer) of these. An attempt has been made to reduce the length of the profile (mainly by reducing the tables showing hospital activity which should be available elsewhere in the CCG) but there are some new additions around diabetes. We would be receptive to feedback on any material you feel is less useful and we could consider removing.

The information, together with other data held within the Commissioning Locality can then be used as a rudimentary health needs assessment and could be used to inform decisions within the Commissioning Locality.

## Feedback

To give feedback on any aspect of the Commissioning Locality profile please contact Jacq Clarkson  
[JAClarkson@somerset.gov.uk](mailto:JAClarkson@somerset.gov.uk)

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## Presentation of data

Data are presented in tables and graphs.

### Tables

Tables vary in content, but all contain a comparison of the Commissioning Locality with the other Commissioning Localities and with Somerset. Occasionally there is also a National comparison. The best, median and worst practice values across Somerset are shown where available. Where possible an indication is made of whether the differences observed are due to chance or are potentially significant:

Green highlighting indicates that the Commissioning Locality value is statistically significantly better than the Somerset average  
 Pink highlighting indicates that the Commissioning Locality value is statistically significantly worse than the Somerset average

Occasionally it is not possible to say whether a high value is good or bad; in these instances higher/ lower are used instead of better/worse.

### Graphs

The absolute levels of indicators can be on very different scales. In order to show a group of indicators on the same graph the values have been "Normalised" and the plotted value will lie between 0 and 1 - with 0 being the worst and 1 the best (or in some instances lowest and highest)

Normalised score = the difference between the value and the worst value expressed as a percentage of the range of Commissioning Locality values in Somerset

For example if for indicator X the worst value in Somerset is 6 and the best is 11, then the range in Somerset is 5. If the Commissioning Locality has a value of 7 then the normalised score is  $(7 - 6)/(11 - 6) = 0.2$

The position of the red diamond indicates where the Commissioning Locality value falls in relation to the other Somerset Commissioning Localities, which are shown as vertical lines.

If the Commissioning Locality markers are not equally spread it means that the distribution of values is not symmetric.

Comments about the Commissioning Locality values will be written in the yellow boxes following the graphs if the Commissioning Locality has an extreme value or if it is significantly higher or lower than the Somerset average.

For some indicators a 'ski slope' of values is shown. This shows the rates, ordered from worst to best, for the county and all of the practices and Commissioning Localities in Somerset. Central Mendip and its practices are highlighted. For some other indicators a comparison across the Localities is shown.

### Interpretation

When assessing whether a finding needs further investigation it is worth remembering that:

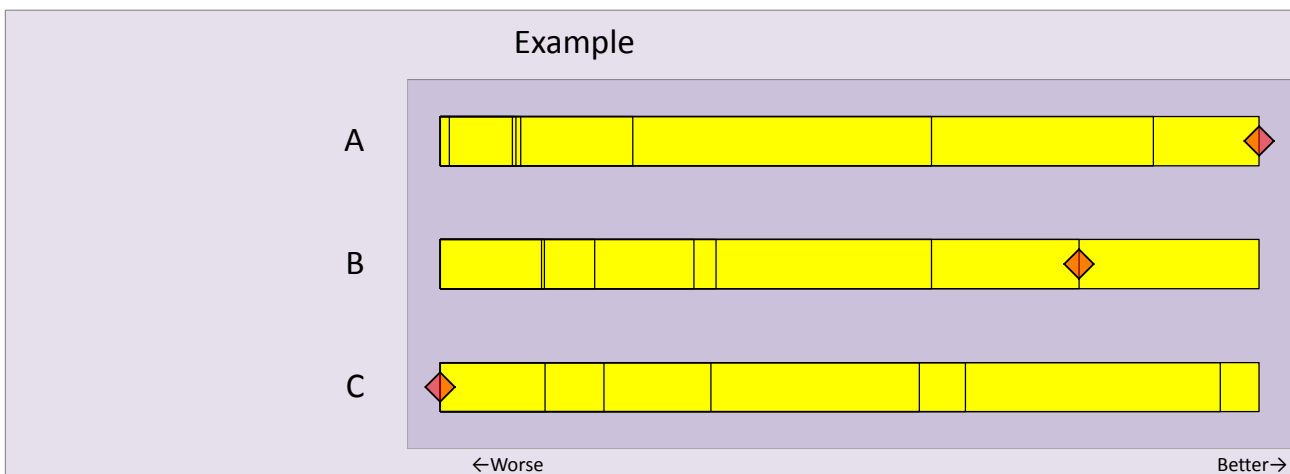
A value can be extreme (eg the "best" or "worst"; "highest" or "lowest") without necessarily being statistically significantly different to the Somerset average.

A statistically significant difference does not necessarily indicate the Commissioning Locality has an extreme value (best or worst; highest or lowest value).

A statistically significant difference might not be a clinically significant difference.

Example	Position of red marker	Commissioning Locality value is...
A	At right hand end	The best (or, for some indicators, the highest)
B	Between the ends	An intermediate value
C	At left hand end	The worst (or, for some indicators, the lowest)

### Example



# Central Mendip Commissioning Locality Summary Public Health Profile 2015-16

## Population & context for health

The area has a smaller proportion of older people compared to the Somerset average. Using the new 2015 data the Index of Multiple Deprivation for the local area is 16.3 representing similar levels of deprivation compared to the Somerset average of 18.4. More detail on the deprivation data is shown on pp.7-8 with wider determinants of health on pp.9-10.

## Disease prevalence

Overviews of respiratory, cardiovascular, diabetes and cancer health issues are shown on pp.16, 18, 20 and 21 respectively.

## Mortality, causes and places of death

The death blobs for mortality and years of life lost on pp.23-24 provide a visual indication of the key causes of death in Central Mendip Locality. The proportion of deaths occurring before age 65 years is 14.9% and is the highest in the county, the Somerset rate being 12.5%. Standardised mortality ratios for different conditions and age groups are shown on p.26.

## Screening

Although commissioning arrangements have changed for the NHS Health Checks programme, we felt it important to include data on the 2014-15 primary care driven performance. Last year, 59.8% of the eligible Commissioning Locality population were invited to a Health Check, with 40.8% uptake. In the most deprived quintile, 37.8% of the population received a check. A full profile of this data is shown on p.30-31.

Breast screening rates are generally the worst in the county. The cervical screening rate for those aged 25-49 years old, at 72.5%, is similar to the county average of 73.1%. The practice based rate of chlamydia screening of eligible 15-24 year olds was 3.4%, similar to the Somerset rate of 2.9%

## Immunisations

Immunisation rates for this year and last are shown on pp.39-40. MMR vaccination rates are close to the target for herd immunity of 95%, with 94.8% vaccinated by age 2.

## Childhood environment

The local breastfeeding initiation rate is 83.3% compared to 80.7% in Somerset. The prevalence rate at 6-8 weeks is 49.3% compared to 49.4% in the county as a whole. The paediatric health profile collates a number of risk factors and outcomes relating to children on p.42.

## Excess weight

According to the underlying model used to assess appropriate childhood weight, 15% of children would be expected to have excess weight. Somerset rates are 23.3% at age 4-5 years and 30.4% at age 10. For this

Commissioning Locality, estimated rates are 23.7% and 30.8% respectively. The percentage of adults in the area who are obese is 7.4% which is lower than average for the county.

## Smoking

Despite a general reduction in smoking rates for adults in Somerset, smoking remains our greatest public health challenge. The Commissioning Locality has 16.6% of adults over age 16 recorded as smokers compared to a 14.0% Somerset average. This is still one of the higher rates of smoking in Somerset but is much improved compared to last year. In 2014/15, only 79 per 1000 recorded smokers in Central Mendip went through cessation services compared to 91 per 1000 in 2013/14. This is a lower than average proportion compared to other Commissioning Localities and this number is dramatically down in absolute terms. Smoking in pregnancy remains a challenge and our county rates are still high compared to the rest of England. More detail on smoking related data is shown on pp.46-7.

## Drugs and Alcohol

Hospital admissions for drug and alcohol related reasons are some of the lowest in Somerset. Alcohol related admissions: Central Mendip 1,595 per 100,000; Somerset 1,862 per 100,000. Drug related admissions: Central Mendip 95 per 100,000; Somerset 134 per 100,000.

## Hospital admission rates

The newly slim-lined hospitalisation section on pp.51-60, contains a wealth of data on reasons why the Central Mendip population access hospital services and whether on an emergency or elective basis. To focus on a few indicators, the emergency admission rate for falls in the over 65s is 33 per 1000 as compared to the Somerset average of 31 per 1000. The self-harm admission rate is 203 per 100,000 which is lower than average for the county.

## Medicines Optimisation Key Therapeutic Topics

Performance on the new and revised MOKTT indicators (formerly QIPP indicators) is shown on pp.62-63. These are designed to promote discussion on the variation, rather than provide targets or influence individual prescribing choices.

## Suggested public health areas to prioritise

- Increase numbers of smokers referred to stop smoking services
- Improve breast cancer screening rates
- Continue focus on childhood excess weight

Please contact the public health team at the council if you would like to discuss further any aspect of your profile or related actions - [JAClarkson@Somerset.gov.uk](mailto:JAClarkson@Somerset.gov.uk)

Brief overview of Commissioning Locality outcomes		ENGLAND	Somerset	Commissioning Localities								
				Bridgwater	Central Mendip	Crewkerne, Chard and Ilminster	East Mendip	North Sedgemoor	South Somerset	Taunton	West Mendip	West Somerset
Population and context	Proportion of population aged 0-14	18%	16%	18%	16%	15%	17%	15%	16%	17%	15%	12%
	Proportion of population aged > 75	8%	10%	9%	8%	12%	9%	12%	11%	10%	11%	15%
	Index of Multiple Deprivation	17.4	18.4	22.7	16.3	17.7	16.9	15.8	17.4	17.7	17.0	22.7
	Proportion of population living in 10% most deprived neighbourhoods in Somerset*	25%	12%	27%	6%	4%	3%	7%	11%	14%	3%	8%
	Proportion of population living in 20% most deprived neighbourhoods in Somerset*	37%	22%	36%	6%	19%	20%	13%	19%	20%	14%	35%
Death	All cause mortality, all ages (SMR compared to Somerset)		100%	99%	103%	89%	98%	102%	99%	110%	97%	93%
	Proportion of deaths occurring before 65	16%	13%	15%	15%	12%	13%	13%	12%	12%	12%	11%
	Proportion of those dying at home (all causes)	22%	22%	25%	27%	26%	20%	21%	19%	21%	23%	23%
Prevention	Health Checks % of eligible invited for check (annual target)		59%	54%	60%	97%	81%	62%	39%	56%	94%	34%
	Health Checks undertaken as % of eligible (annual target)		36%	32%	41%	48%	52%	41%	22%	35%	59%	22%
	Health Checks as % of eligible in most deprived population quintile		27%	24%	38%	53%	53%	30%	21%	26%	48%	14%
	Cervical cancer screening (25-49)	71.3%	73.1%	73.0%	72.5%	76.6%	74.2%	73.6%	72.5%	74.8%	70.1%	67.9%
	Chlamydia % screened of eligible (15-24 year olds)		2.9%	3.1%	3.4%	1.5%	4.9%	2.3%	3.9%	1.4%	3.1%	2.3%
	MMR coverage by 2nd birthday	92.3%	94.9%	94.7%	94.8%	95.1%	95.2%	95.6%	95.1%	95.2%	91.8%	96.0%
	Breastfeeding initiation		81%	75%	83%	84%	82%	81%	79%	82%	86%	88%
	Breastfeeding prevalence at 6-8 weeks		49%	40%	49%	45%	54%	43%	51%	54%	53%	52%
Lifestyle factors	Smoking rate adults 16+		14.0%	18.9%	16.6%	16.2%	13.2%	13.1%	12.7%	12.5%	11.9%	14.4%
	Smoking ascertainment		66%	69%	66%	69%	63%	69%	65%	64%	62%	70%
	Smokers going through cessation per 1000 recorded smokers		85	65	79	90	66	93	109	89	71	81
	Excess weight in 4-5 year olds	23%	23%	25%	24%	27%	22%	24%	24%	20%	23%	24%
	Excess weight in 10-11 year olds	33%	30%	33%	31%	32%	29%	31%	31%	28%	30%	29%
	Obese adults (16+) (rate per 1000 - Standardised to Somerset)	104	84	127	74	85	70	83	74	78	74	88
	Alcohol related admissions (rate per 100,000)	2,056	1,862	2,033	1,595	1,879	1,769	1,766	1,887	1,920	1,749	1,802
	Drug related admissions (rate per 100,000)		134	158	95	148	112	88	126	158	125	138
Hospital activity	Teenage deliveries (mother aged <19 at delivery) (rate per 1,000 females aged 15-17)		15.8	22.1	10.4	17.8	19.5	12.9	17.8	14.8	7.6	13.1
	Self harm admissions (rate per 100,000)		228	222	203	204	261	138	249	249	216	217
	Emergency admissions to hospital for Falls in people aged 65 and over (rate per 1000)		31	29	33	28	40	24	34	29	32	26

\*England data shows what proportion of England's population are in areas with IMD above the Somerset critical value for being in the most deprived 10% or 20%

Red = 'Worst' (most worthy of attention)  
Green = 'Best' (least worthy of attention)

Brief overview of Commissioning Locality outcomes		ENGLAND	Somerset	Rurality		Deprivation quintile of practices (IMD 2015)					
				Urban	Rural	1 most deprived	2	3	4	5 least deprived	Worse at left
Population and context	Proportion of population aged 0-14	18%	16%	17%	15%	17%	15%	16%	16%	16%	
	Proportion of population aged > 75	8%	10%	10%	11%	8%	11%	10%	11%	12%	
	Index of Multiple Deprivation	17.4	18.4	19.7	18.4	23.9	19.5	17.1	15.4	13.0	
	Proportion of population living in 10% most deprived neighbourhoods in Somerset*	25%	12%	16%	3%	28%	13%	8%	2%	1%	
	Proportion of population living in 20% most deprived neighbourhoods in Somerset*	37%	22%	27%	11%	42%	27%	15%	9%	3%	
Death	All cause mortality, all ages (SMR compared to Somerset)		100%	106%	91%	102%	105%	99%	100%	91%	
	Proportion of deaths occurring before 65	16%	13%	13%	11%	15%	13%	13%	10%	11%	
	Proportion of those dying at home (all causes)	22%	22%	31%	31%	23%	19%	24%	22%	21%	
Prevention	Health Checks % of eligible invited for check (annual target)		59%	64%	52%	49%	54%	80%	59%	46%	
	Health Checks undertaken as % of eligible (annual target)		36%	40%	29%	30%	34%	49%	34%	28%	
	Health Checks as % of eligible in most deprived population quintile		27%	25%	36%	20%	20%	48%	30%	27%	
	Cervical cancer screening (25-49)	71.3%	73.1%	72.3%	74.3%	70.8%	71.7%	74.5%	73.3%	75.5%	
	Chlamydia % screened of eligible (15-24 year olds)		2.9%	3.0%	2.8%	4%	2%	3%	3%	2%	
	MMR coverage by 2nd birthday	92.3%	94.9%	95.0%	94.7%	94.5%	94.2%	95.0%	94.9%	96.5%	
	Breastfeeding initiation		81%	80%	82%	75%	81%	82%	84%	82%	
	Breastfeeding prevalence at 6-8 weeks		49%	48%	52%	41%	48%	51%	55%	53%	
Lifestyle factors	Smoking rate adults 16+		14.0%	15.0%	12.4%	20%	14%	15%	12%	10%	
	Smoking ascertainment		66%	66%	65%	69%	66%	65%	65%	66%	
	Smokers going through cessation per 1000 recorded smokers		85	85	86	83	86	77	84	108	
	Excess weight in 4-5 year olds	23%	23%	23%	24%	24%	24%	22%	24%	23%	
	Excess weight in 10-11 year olds	33%	30%	31%	29%	32%	32%	30%	30%	27%	
	Obese adults (16+) (rate per 1000 - Standardised to Somerset)	104	84	91	73	127	77	74	71	81	
	Alcohol related admissions (rate per 100,000)	2,056	1,862	1,978	1,681	2,179	1,982	1,823	1,706	1,601	
	Drug related admissions (rate per 100,000)		134	162	84	198	165	128	93	64	
Hospital activity	Teenage deliveries (mother aged <19 at delivery) (rate per 1,000 females aged 15-17)		15.8	19.2	10.4	26.1	18.3	15.6	9.4	9.8	
	Self harm admissions (rate per 100,000)		228	261	171	273	260	232	206	141	
	Emergency admissions to hospital for Falls in people aged 65 and over (rate per 1000)		31	31	29	30	30	32	30	29	

\*England data shows what proportion of England's population are in areas with IMD above the Somerset critical value for being in the most deprived 10% or 20%

Red = 'Worst' (most worthy of attention)

Green = 'Best' (least worthy of attention)

### Population & context for health

The profile contains information on the following aspects of the local population and context for health. These considerations set the scene for health activities within the area and although they don't change much year on year, seeing this background can be helpful in understanding need and planning interventions.

The following information is presented:

- Population pyramid
- Deprivation - as measured using the Index of Multiple Deprivation, see below for an explanation of the seven sub domains which make up this index and the Income Deprivation Affecting Children Index and The Income Deprivation Affecting Older People Index
- People living in highly deprived areas, based on Index of Multiple Deprivation
- Wider context for health – a variety of other indicators such as estimated number of benefits claimants, percentage unemployment and educational attainment within the Commissioning Locality

#### Index of Multiple Deprivation

The Index of Multiple Deprivation (IMD) combines information from the seven domains to produce an overall relative measure of deprivation. The domains are combined using the following weights:

- Income Deprivation (22.5%)
- Employment Deprivation (22.5%)
- Education, Skills and Training Deprivation (13.5%)
- Health Deprivation and Disability (13.5%)
- Crime (9.3%)
- Barriers to Housing and Services (9.3%)
- Living Environment Deprivation (9.3%)

The weights were derived from consideration of the academic literature on poverty and deprivation, as well as consideration of the levels of robustness of the indicators.

#### Income Deprivation Domain

The Income Deprivation Domain measures the proportion of the population experiencing deprivation relating to low income. The definition of low income used includes both those people that are out-of-work, and those that are in work but who have low earnings (and who satisfy the respective means tests).

#### Employment Deprivation Domain

The Employment Deprivation Domain measures the proportion of the working age population in an area involuntarily excluded from the labour market. This includes people who would like to work but are unable to do so due to unemployment, sickness or disability, or caring responsibilities.

#### Education, Skills and Training Deprivation Domain

The Education, Skills and Training Deprivation Domain measures the lack of attainment and skills in the local population. The indicators fall into two sub-domains: one relating to children and young people and one relating to adult skills.

#### Health Deprivation and Disability Domain

The Health Deprivation and Disability Domain measures the risk of premature death and the impairment of quality of life through poor physical or mental health. The domain measures morbidity, disability and premature mortality but not aspects of behaviour or environment that may be predictive of future health deprivation.

#### Crime Domain

The Crime Domain measures the risk of personal and material victimisation at local level.

#### Barriers to Housing and Services Domain

The Barriers to Housing and Services Domain measures the physical and financial accessibility of housing and local services. The indicators fall into two sub-domains: 'geographical barriers', which relate to the physical proximity of local services, and 'wider barriers' which includes issues relating to access to housing such as affordability and homelessness.

#### Living Environment Deprivation Domain

The Living Environment Deprivation Domain measures the quality of the local environment. The indicators fall into two sub-domains. The 'indoors' living environment measures the quality of housing; while the 'outdoors' living environment contains measures of air quality and road traffic accidents.

#### Income Deprivation Affecting Children Index

The Income Deprivation Affecting Children Index (IDACI) measures the proportion of all children aged 0 to 15 living in income deprived families. This is one of two supplementary indices and is a sub-set of the Income Deprivation Domain.

#### Income Deprivation Affecting Older People Index

The Income Deprivation Affecting Older People Index (IDAOPI) measures the proportion of all those aged 60 or over who experience income deprivation. This is one of two supplementary indices and is a sub-set of the Income Deprivation Domain.



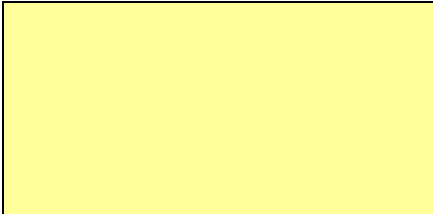
## Central Mendip

Population at April 2015

19,625

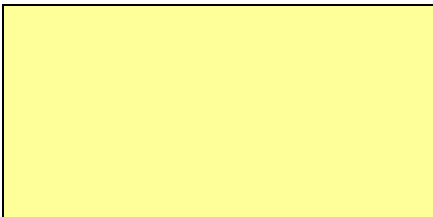
### Central Mendip

Age Group	Males	Females
00-04	541	528
05-14	1,153	1,006
15-24	1,284	1,173
25-34	1,164	1,126
35-44	1,155	1,133
45-54	1,607	1,511
55-64	1,254	1,205
65-74	1,033	1,087
75-84	564	635
85+	168	298

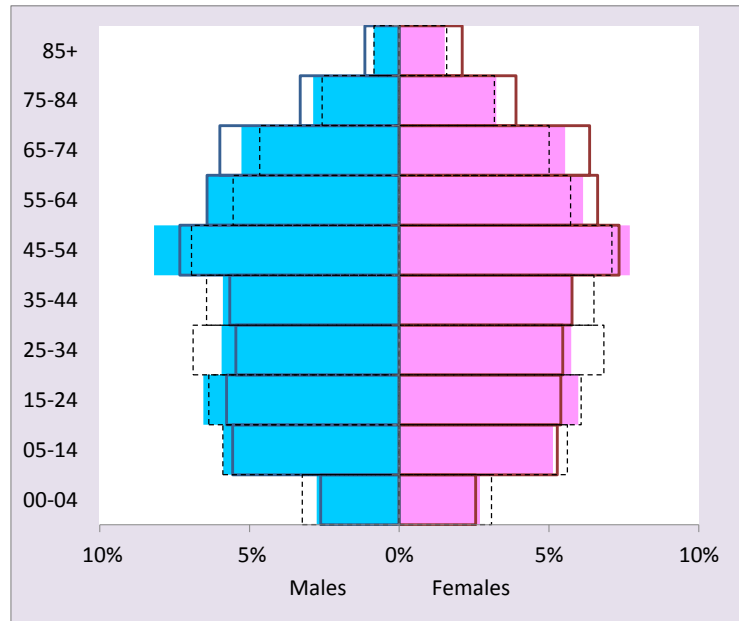


### Somerset

Age Group	Males	Females
00-04	14,645	14,198
05-14	30,994	29,414
15-24	32,126	30,071
25-34	30,381	30,415
35-44	31,522	32,158
45-54	40,824	40,889
55-64	35,765	36,898
65-74	33,396	35,400
75-84	18,413	21,685
85+	6,371	11,717



Age/sex Population pyramid. The solid bars represent the population in your Commissioning Locality; solid lines represents Somerset as a whole, dotted lines represents England. Data from Exeter system download of GP registered patients.



The population pyramid shows the percentage of the population at each age group. Conventionally males are shown on the left and females on the right. Each bar represents an age group ordered from youngest at the bottom to oldest at the top.

This data is drawn from the Exeter system download of GP registered patients and the pyramid above shows data for England, Somerset and your Commissioning Locality. The tables to the left show the population numbers in each cohort.

The dotted line represents the population of England as a whole. Due to low death rates in younger years, our population pyramid shows fairly stable proportions in each age cohort (NB the youngest category covers only 5 years). Year on year the pyramid shape can shift due to migration as well as mortality and births.

The solid line for Somerset highlights the greater proportion of people in older age groups.

Proportion in age range	Commissioning Locality	Somerset	England (mid 2015 projection)	Range of Practice values low / median / high
0-14	16%	16%	18%	9% / 16% / 24%
75+	8%	10%	8%	2% / 11% / 20%
Female 15-44	17%	17%	19%	11% / 16% / 31%

The Commissioning Locality has the lowest value in the county for:  
75+

# Central Mendip

## Deprivation

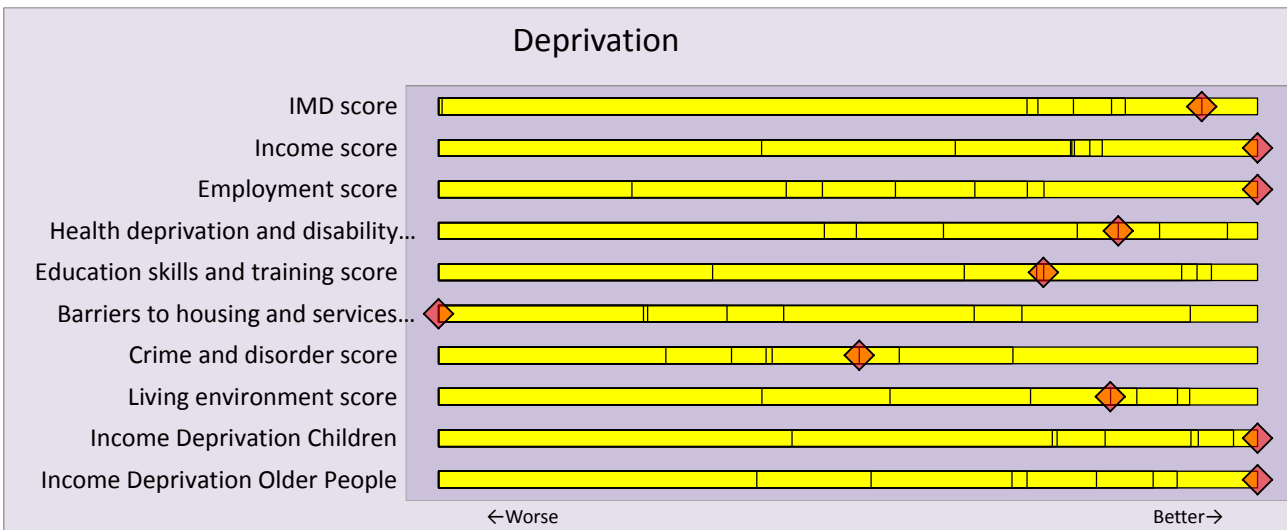
Index of Multiple Deprivation (IMD) 2015 and its domains.  
 Calculated for Commissioning Locality population in July 2015. All those with a known postcode are included even if they live outside Somerset.

For the IMD score and all of its domains and indices a higher score (and points towards the left of the normalised score graph) indicate a worse situation and more deprivation.

Score	Commissioning Locality	Somerset	England (median LSOA* values)	Range of Practice values low / median / high
IMD score	16.3	18.4	17.4	10.4 / 16.7 / 25.9
Income score	0.10	0.12	0.11	0.06 / 0.10 / 0.17
Employment score	0.08	0.10	0.10	0.05 / 0.09 / 0.14
Health deprivation and disability score	-0.32	-0.21	16.29	-0.94 / -0.32 / 0.25
Education skills and training score	20.0	20.9	0.0	6.8 / 19.0 / 36.2
Barriers to housing and services score	31.5	25.3	0.0	19.7 / 26.2 / 41.2
Crime and disorder score	-0.40	-0.34	20.29	-1.33 / -0.41 / 0.14
Living environment score	22.1	24.3	17.6	13.7 / 23.5 / 56.2
Income Deprivation Affecting Children Index	0.12	0.15	0.15	0.07 / 0.13 / 0.25
Income Deprivation Affecting Older People Index	0.12	0.13	0.15	0.08 / 0.12 / 0.18

\*A Lower Super Output Area is a geographical area of about 1500 people.

This bar graph shows where the Commissioning Locality score is on the various deprivation indices compared to the other Commissioning Localities. Each vertical line on the yellow bar shows the position of a Commissioning Locality. The worst performing Commissioning Locality score is the extreme left and best extreme right. Your Commissioning Locality is highlighted with the red diamond. A diamond positioned to the left shows a worse performance.

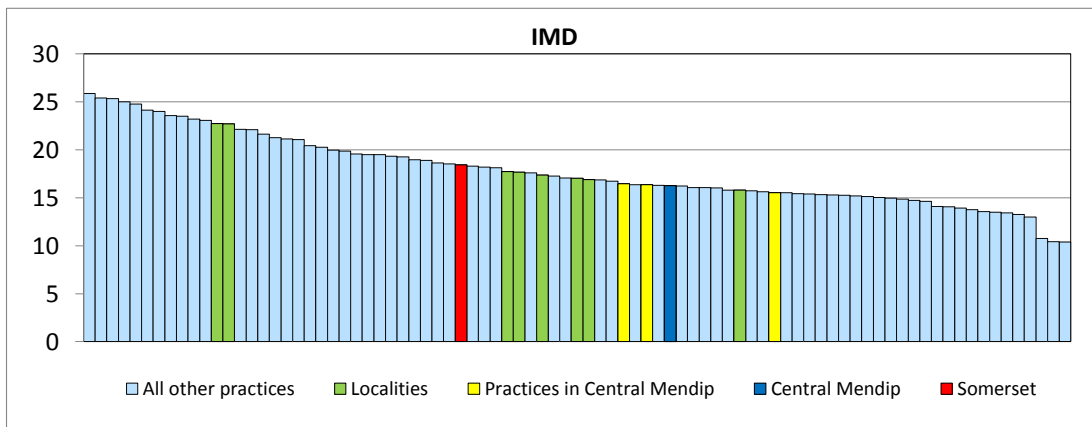


**The Commissioning Locality has the worst value in the county for:**

Barriers to housing and services score

**The Commissioning Locality has the best value in the county for:**

Income score    Employment score    Income Deprivation Affecting Children Index    Income Deprivation Affecting Older People Index



# Central Mendip

## People living in deprived areas

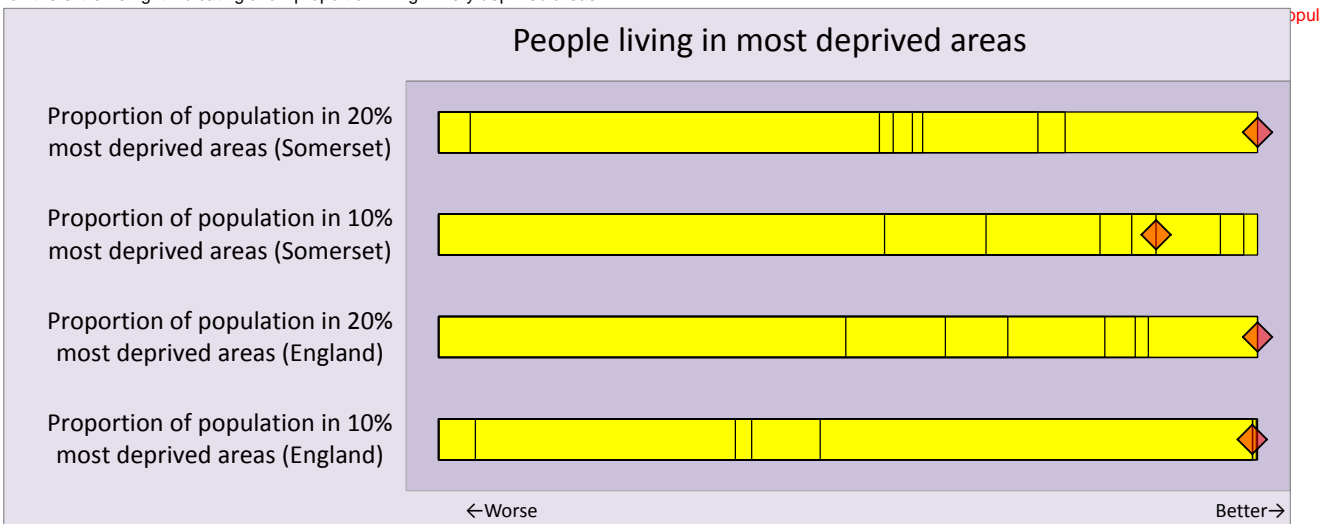
Proportion of Somerset patients registered with the practices in the Commissioning Locality who live in one of the most deprived areas of Somerset and England. Deprivation measured using the Index of Multiple Deprivation 2015. Calculated for Commissioning Locality populations in July 2015.

0.1% of this Locality's population is known to live outside Somerset, and they are excluded below.

Based on the IMD 2015 score, small areas (Lower Super Output Areas - LSOAs) have been rated on their level of deprivation. This has been done for England as a whole and areas grouped into deciles. A grouping has also been done just within Somerset. Somerset is less deprived than England therefore fewer people in Somerset live in a highly deprived area (ie only 9% of the Somerset population lives in the 20% most deprived areas of England and 3% in the 10% most deprived). The population within the Commissioning Locality has been classified by how many live in the 20% and 10% most deprived geographical areas. Note that the number of people living in an LSOA varies and for instance the 20% most deprived areas in Somerset contain 22% of the people. Commissioning Localities with a higher proportion of their population living in highly deprived areas will have more challenges with regards to health interventions.

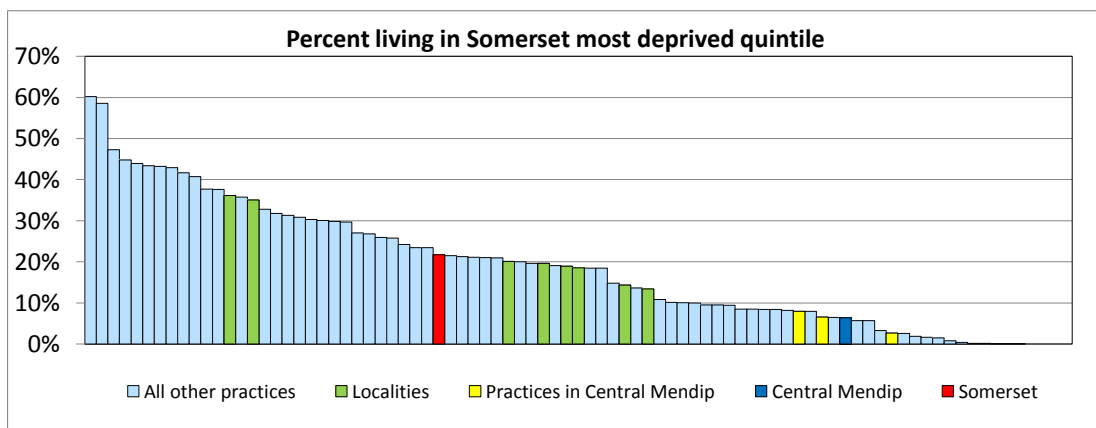
	Commissioning Locality	Somerset	England	Range of Practice values low / median / high
Proportion of population in 20% most deprived areas (Somerset)	6%	22%	37%	0% / 18% / 60%
Proportion of population in 10% most deprived areas (Somerset)	6%	12%	25%	0% / 5% / 36%
Proportion of population in 20% most deprived areas (England)	0%	9%	20%	0% / 2% / 32%
Proportion of population in 10% most deprived areas (England)	0%	3%	10%	0% / 0% / 15%

This bar graph shows the proportion of the people in the Commissioning Locality who live in the areas rated in the 10% and 20% most deprived areas of England and/or Somerset. Each vertical line on the yellow bar shows the position of a Commissioning Locality. Your Commissioning Locality is highlighted with the red diamond. The worst performing Commissioning Locality score is the extreme left and indicates a higher proportion of the population living in very deprived areas and the best is on the extreme right indicating a low proportion living in very deprived areas.



**The Commissioning Locality has the best value in the county for:**

Proportion of population in 20% most deprived areas (Somerset)    Proportion of population in 20% most deprived areas (England)



## Central Mendip

### Wider determinants of health

Population weighted estimates of indicators available at Lower Super Output level except for the final two indicators which are by Commissioning Locality geographical area

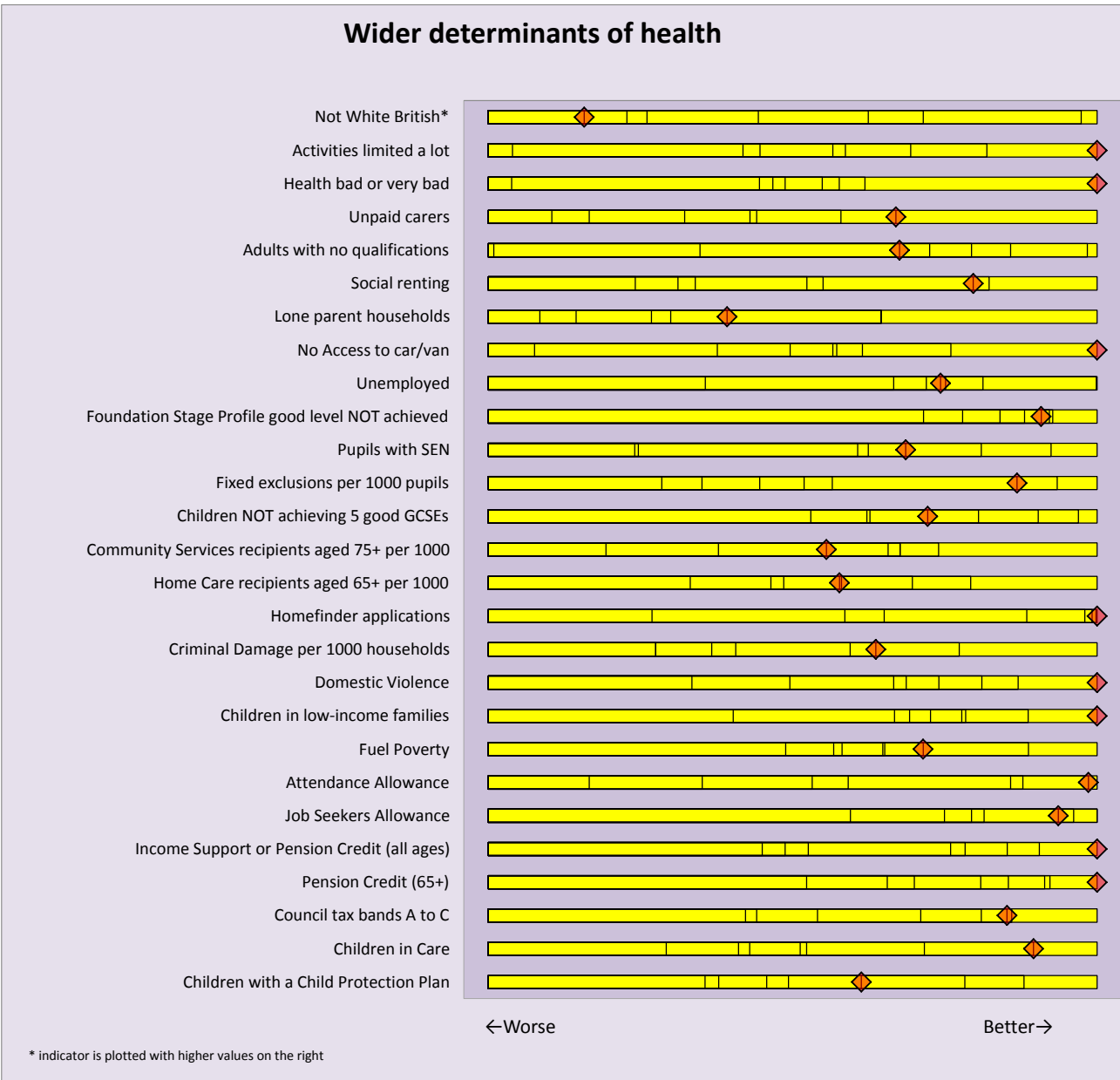
This set of data gives more clue as to the specific issues which affect the Commissioning Locality population such as health status, proportion unemployed and benefits claimants. The data source and time period for each indicator is given in the table below and uses population weighted estimates of indicators available at Lower Super Output (LSOA) level, a small grouping of about 1500 people. England figures are not available for all indicators and some may not be for exactly the same time period.

To calculate the Commissioning Locality value, each registered patient is assumed to have the same pattern of experience as the whole LSOA in which they live, thus they are not exact measures but based on averages. The indicators are summarised graphically on the following page.

	Commissioning Locality	Somerset	England	Range of Commissioning Locality values
% of Residents that are not White British Census 2011	6%	5%	20%	4% to 6%
% of People whose day-to-day activities are limited a lot Census 2011	7%	8%	9%	7% to 9%
% of People whose health is bad or very bad Census 2011	4%	5%	6%	4% to 5%
% of People who provide unpaid care Census 2011	10%	10%	10%	10% to 11%
% of People aged 16 or over with no qualifications Census 2011	22%	22%	23%	21% to 24%
% of Households that are socially rented Census 2011	10%	14%	18%	9% to 16%
% of Households that are lone parent households Census 2011	8%	8%	11%	6% to 9%
% of Households with No Access to car/van Census 2011	12%	16%	26%	12% to 18%
% of Residents aged 16-74 who are Unemployed Census 2011	2.8%	2.9%	4.4%	2.4% to 3.8%
Foundation Stage Profile (FSP) % students NOT achieving a good level of development Somerset County Council 2014	34%	38%	40%	32% to 60%
% of pupils with SEN Somerset County Council 2014	17%	18%	18%	15% to 21%
Fixed exclusions per 1000 pupils Somerset County Council 2014	28	35	35	26 to 43
% of children not achieving 5 A*-C GCSEs including Maths and English Somerset County Council 2014	42%	42%	47%	36% to 58%
Community Services recipients aged 75+ (rate per 1000 aged 75+) SCC Adult social care - Mar15	76	76	n/a	57 to 100
Home Care recipients aged 65+ (rate per 1000 aged 65+) SCC Adult social care - Mar15	21	21	n/a	15 to 28
Applications for housing on Homefinder SCC % of census households - Sep13	2%	5%	n/a	2% to 8%
Criminal Damage (rate per 100,000 population) Home Office 2014/15	664	769	n/a	524 to 908
Domestic Violence Crimes (rate per 1000 census households) Home Office 2014/15	7.2	11.4	15.1	7.2 to 15.1
% of Children in low-income families Child Poverty Unit 2013	11%	13%	19%	11% to 18%
% of Households in Fuel Poverty DECC 2013	11%	11%	10%	10% to 13%
Attendance Allowance claimants (% of population aged 65+) NOMIS Feb15	12%	13%	14%	12% to 14%
Job Seekers Allowance (% of working population) NOMIS Feb15	0.7%	1.0%	1.6%	0.6% to 1.7%
Income Support or Pension Credit claimants (% of total population) NOMIS Feb15	4%	4%	5%	4% to 6%
Pension Credit claimants (% of population aged 65+) NOMIS Feb15	14%	16%	19%	14% to 19%
Council tax bands A to C (% of households) 2011	60%	66%	66%	57% to 75%
Children 0-17 currently in care known to be living or placed in Somerset (rate per 10,000) Somerset County Council as at August 2015	24	33	60	22 to 43
Children 0-17 subject to a Child Protection Plan known to be living or placed in Somerset (rate per 10,000) Somerset County Council as at August 2015	29	35	38	13 to 55

# Central Mendip

This bar graph shows where the Commissioning Locality score is on the various indicators compared to the other Commissioning Localities. Each vertical line on the yellow bar shows the position of a Commissioning Locality. Your Commissioning Locality is highlighted with the red diamond. The worst performing Commissioning Locality score is the extreme left and best extreme right. A diamond positioned to the left shows a worse performance.



**The Commissioning Locality has the best/lowest value in the county for:**  
 Activities limited a lot    Health bad or very bad    No Access to car/van    Homefinder applications    Domestic Violence    Children in low-income families  
 Income Support or Pension Credit (all ages)    Pension Credit (65+)

### Disease prevalence

The profile contains information on the following aspects of the local population and their level of disease. Dependent on the data this information can give an indication of need within the population and success of case finding programmes.

The following information is presented:

- Prevalence numbers in the Commissioning Locality from practice clinical systems compared to expected numbers if the Commissioning Locality prevalence mirrored the average recorded rates over Somerset (adjusted for age and sex differences)
- Change over time in observed numbers of people on the disease registers compared to modelled expected numbers: diabetes, dementia & COPD
- Disease profiles, an overview of factors contributing to disease levels, see below

Presentation of actual disease prevalence is based on MIQUEST and can inform commissioning plans to cover the number of people with the condition. However when calculating level of disease it is useful to know how this compares to average levels which might be expected to expose possible undiagnosed cases and/or particular health needs in the area. There are two methods of calculating expected prevalence of disease used in this profile.

The crude prevalence rate (such as appeared in QOF rates) is calculated by comparing the Commissioning Locality and Somerset values of the number recorded with the condition as a proportion of the total population. The first method shown on the next page is to improve upon this estimate by adjustments to allow for the extent to which the Commissioning Locality has a different age and sex profile to Somerset as a whole. This is important where the disease has a clear variation by age or gender, for example in dementia. Using this approach, some Commissioning Localities will always be under diagnosing whereas others will always be over diagnosing relative to the Somerset average.

The second method of estimating prevalence comes from assumptions about the true prevalence of disease. Using this second approach it would be possible for the whole of Somerset to be over or under diagnosing. Levels of prevalence below expected levels may indicate undiagnosed cases or it could indicate an area in which the Commissioning Locality has better than expected population health.

A comparison of the recorded prevalence to the modelled prevalence in the Commissioning Locality is often used as an estimate of diagnosis completeness. Here we have focused on three conditions - diabetes, dementia and COPD - and shown how the estimated diagnosis levels have changed over time.

It is important to note that the assumptions made by the model are critical and revisions to the model may affect quite dramatically the expected numbers and thus diagnosis levels.

Disease profiles were introduced to provide a useful collation of a range of data on a particular area. The aim is to enable a more holistic picture to be built up of the most appropriate actions along the disease pathway to improve health.

The profiles are designed to provide information on:

- Prevalence of relevant conditions
- Mortality rates
- Preventative intervention
- Risk factors
- Admissions to hospital
- QOF On-going management indicators

Profiles have been produced on:

- Respiratory disease
- Cardiovascular disease
- Diabetes
- Cancer Commissioning Toolkit indicators

We would particularly welcome feedback on these profiles, whether they are useful, what you like, aspects which may be less clear and suggestions for additional indicators to include or diseases to cover. Please email [JAClarkson@somerset.gov.uk](mailto:JAClarkson@somerset.gov.uk)

## Central Mendip

### Prevalence rate (rate per 1000 population)

Age/sex standardised prevalence rates using Somerset wide age/sex specific rates from MIQUEST (using the Quality Outcome Framework definitions) and Exeter system population downloads .

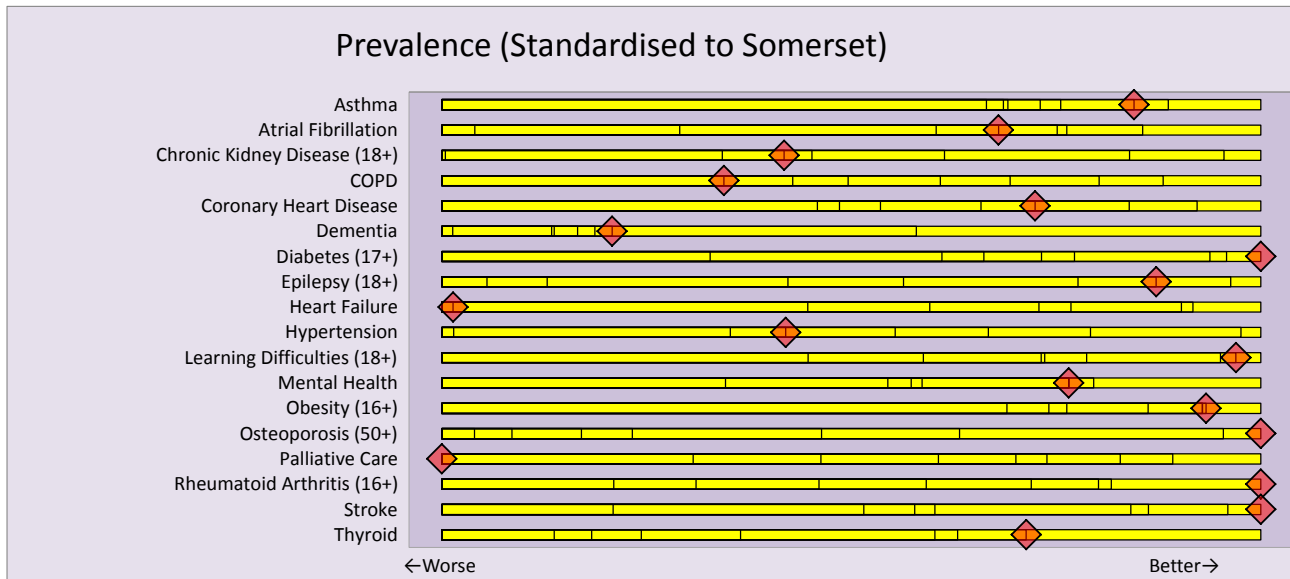
This data shows a comparison of the level of recorded disease in the Commissioning Locality compared to the level in the totality of Somerset practices. The numbers of patients with recorded disease at the practice level has been derived from the Quality Outcome Framework submissions, reported annually through the Information Centre website. This is then converted to a rate per 1000 of the population based on Exeter system population size and composition for each practice which has been retrieved by MIQUEST. MIQUEST is a locally used interrogation tool that retrieves data from practice clinical systems.

The level of disease /condition expected in the Commissioning Locality has been calculated by taking the total Somerset recorded numbers and then partialling this out to the number expected in the Commissioning Locality, making allowances for differences in the age and sex profile of the Commissioning Locality compared to Somerset as a whole. This adjustment is particularly important where conditions are more common in specific age groups or by gender.

2015

Condition	Observed in Locality	Expected in Locality	Commissioning Locality rate	Somerset rate	England rate (2013)	Range of Practice values low / median / high
Asthma	1,247	1,270	63.3	64.4	62.9	44.4 / 65.5 / 84.3
Atrial Fibrillation	398	404	23.6	23.9	21.3	15.9 / 24.1 / 30.9
Chronic Kidney Disease (18+)	675	639	50.4	47.7	54.4	26.8 / 46.9 / 84.4
COPD	404	364	23.0	20.7	23.6	10.4 / 20.3 / 42.4
Coronary Heart Disease	641	654	37.1	37.8	44.1	26.1 / 37.3 / 54.9
Dementia	152	152	9.5	9.5	8.9	3.8 / 8.9 / 17.3
Diabetes (17+)	889	967	59.7	65.0	76.6	47.1 / 64.6 / 92.8
Epilepsy (18+)	125	139	7.9	8.8	8.2	4.0 / 8.2 / 27.1
Heart Failure	165	141	9.9	8.5	9.8	4.6 / 8.4 / 17.1
Hypertension	2,908	2,831	165	160	179.0	123 / 160 / 231
Learning Difficulties (18+)	68	84	4.1	5.1	4.4	0.5 / 3.8 / 24.0
Mental Health	126	137	6.4	7.0	9.2	1.9 / 6.5 / 15.7
Obesity (16+)	1,173	1,331	74	84	104.1	35 / 76 / 412
Osteoporosis (50+)	2	12	0	2	4.4	0.0 / 1.1 / 9.5
Palliative Care	81	45	5.9	3.3	4.5	0.0 / 3.0 / 13.1
Rheumatoid Arthritis (16+)	106	126	7.1	8.4	9.0	2.7 / 8.1 / 12.4
Stroke	427	463	24.9	27.1	23.1	16.3 / 26.8 / 34.8
Thyroid	679	722	37.6	40.0	39.8	24.5 / 40.4 / 51.6

The bar chart shows how the Commissioning Locality compares to other Commissioning Localities in terms of their observed and expected numbers. Each vertical line on the yellow bar shows the position of a Commissioning Locality. Your Commissioning Locality is highlighted by the red diamond. Values to the left show more cases recorded than expected compared to other Commissioning Localities and values to the right show much fewer cases recorded than expected. Values to the left may indicate an increased burden of disease whereas values to the right may indicate under-diagnosis and where case finding efforts may need to be increased.



**Significantly worse (higher number than expected compared to the county average) for:**

Palliative Care

**The Commissioning Locality has the worst value (highest number compared to the expected based on county average) in the county for:**

Palliative Care

**Significantly better (lower number than expected compared to the county average) for:**

Diabetes (17+) Obesity (16+) Osteoporosis (50+)

**The Commissioning Locality has the best value (lowest number compared to the expected based on county average) in the county for:**

Diabetes (17+) Osteoporosis (50+) Rheumatoid Arthritis (16+) Stroke

## Central Mendip

### Estimated proportion of people expected to have Diabetes who are on register

Register data compared with modelled Type1 and Type 2 prevalence. Data based on Yorkshire and Humberside Public Health Observatory model.

This data shows a comparison of the actual level of disease with the "true" level of the condition estimated to be in the population. The numbers of patients with recorded disease at the practice level has been derived from the Quality Outcome Framework submissions, reported annually through the Information Centre website. Note that these numbers vary slightly from those from local MIQUEST queries used in the Prevalence section and Cardiovascular and Diabetes profiles.

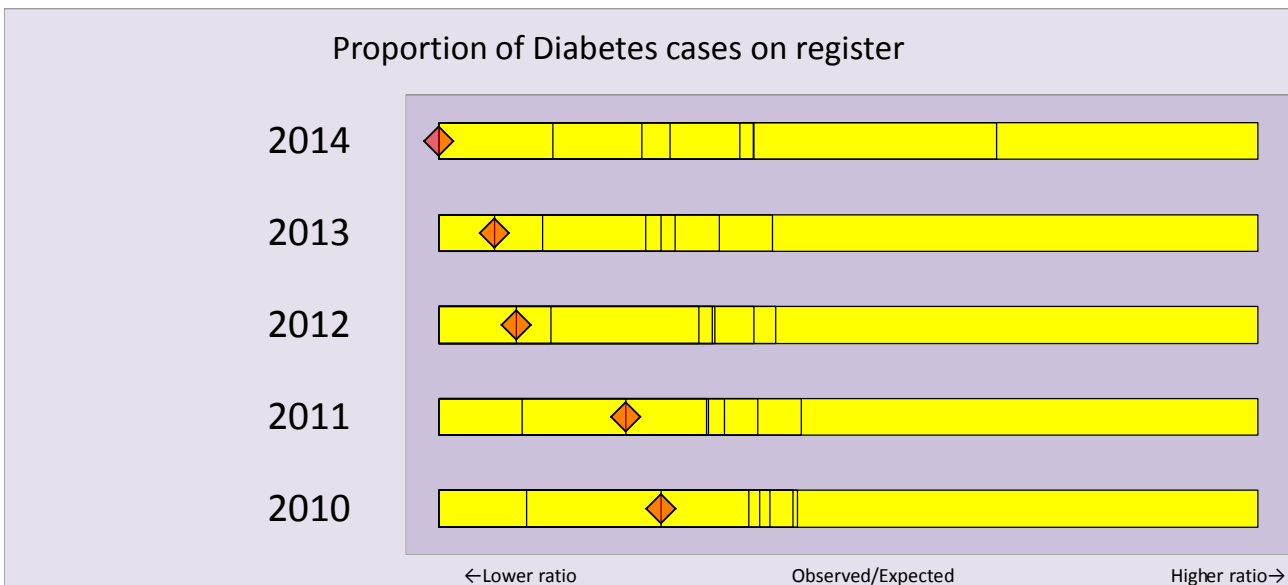
The expected values are based on the Yorkshire and Humberside Public Health Observatory Model

An observed value below that of the expected value may indicate there are undiagnosed patients with that condition within the Commissioning Locality population. Conversely a higher number in the observed column may also warrant further investigation and may indicate are of high prevalence or possibly over diagnosis.

The ratio can be greater than 100% as it is the comparison of the actual number on the register compared to a modelled expected number.

		Commissioning Locality	Somerset	England	Range of Practice values low / median / high
2014	Observed number on register	843	28,516	2,703,044	
	Expected number on register	1,182	36,265	3,321,750	
	Proportion of expected on register	71.3%	78.6%	81.4%	56.4% / 78.5% / 109.7%
2013	Observed number on register	828	27,046	2,703,044	
	Expected number on register	1,141	35,248	3,321,750	
	Proportion of expected on register	72.6%	76.7%	81.4%	53.4% / 76.0% / 108.6%
2012	Observed number on register	776	25,624	2,566,436	
	Expected number on register	1,128	34,845	3,245,432	
	Proportion of expected on register	68.8%	73.5%	79.1%	51.5% / 72.4% / 106.6%
2011	Observed number on register	763	24,405	2,455,937	
	Expected number on register	1,091	33,771	3,166,556	
	Proportion of expected on register	69.9%	72.3%	77.6%	50.8% / 71.1% / 118.4%
2010	Observed number on register	718	23,099	2,338,813	
	Expected number on register	1,076	33,440	3,099,853	
	Proportion of expected on register	66.7%	69.1%	75.4%	49.1% / 67.0% / 105.2%

The bar chart shows how Commissioning Locality performance compares to other Commissioning Localities. Each vertical line on the yellow bar shows the position of a Commissioning Locality. Your Commissioning Locality is highlighted by the red diamond. Values to the left show a lower ratio of observed to expected cases, in general indicating under-diagnosis compared to the model. Values to the right show a higher ratio of observed to expected cases although this may still indicate a picture of some under-diagnosis.



The Commissioning Locality has the lowest value in the county for:  
2014





## Central Mendip

### Estimated proportion of people expected to have COPD who are on register

Register data compared with modelled prevalence using models from the NHS Comparators website.

This data shows a comparison of the actual level of disease with the "true" level of the condition estimated to be in the population. The numbers of patients with recorded disease at the practice level has been derived from the Quality Outcome Framework submissions, reported annually through the Information Centre website. Note that these numbers vary slightly from those from local MIQUEST queries used in the Prevalence section and in the Respiratory profile.

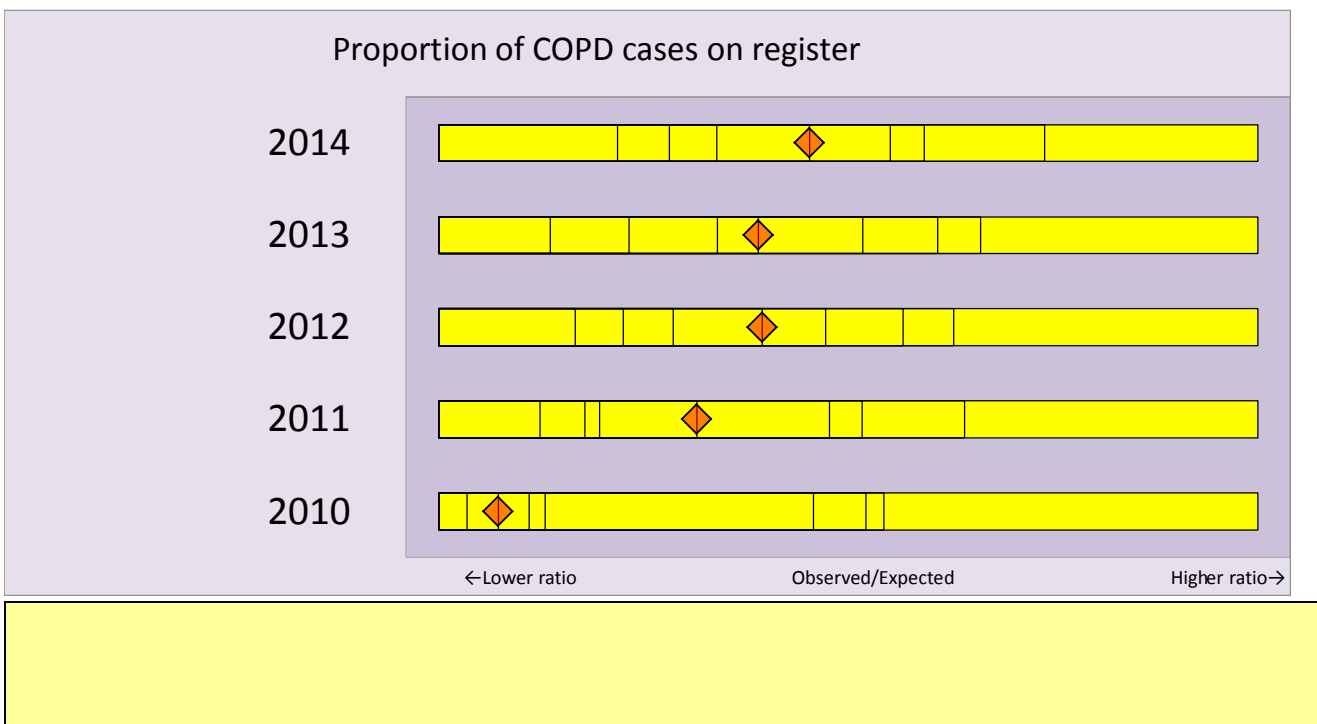
The expected values are based on NHS Information Centre models as found on the NHS comparators website, except for diabetes which uses the Yorkshire and Humberside Public Health Observatory Model.

An observed value below that of the expected value may indicate there are undiagnosed patients with that condition within the Commissioning Locality population. Conversely a higher number in the observed column may also warrant further investigation and may indicate are of high prevalence or possibly over diagnosis.

The ratio can be greater than 100% as it is the comparison of the actual number on the register compared to a modelled expected number.

		Commissioning Locality	Somerset	England	Range of Practice values low / median / high
2014	Observed number on register	359	11,029	1,004,920	
	Expected number on register	362	11,284	940,097	
	Proportion of expected on register	99.1%	97.7%	106.9%	42.0% / 93.8% / 167.9%
2013	Observed number on register	337	10,507	974,999	
	Expected number on register	351	10,994	926,224	
	Proportion of expected on register	96.1%	95.6%	105.3%	50.4% / 93.5% / 162.9%
2012	Observed number on register	319	9,924	938,511	
	Expected number on register	342	10,751	907,873	
	Proportion of expected on register	93.2%	92.3%	103.4%	44.5% / 90.1% / 156.6%
2011	Observed number on register	297	9,487	898,989	
	Expected number on register	334	10,490	888,795	
	Proportion of expected on register	89.0%	90.4%	101.1%	40.5% / 86.9% / 166.5%
2010	Observed number on register	261	9,105	861,341	
	Expected number on register	327	10,345	916,143	
	Proportion of expected on register	79.8%	88.0%	94.0%	46.4% / 83.9% / 171.7%

The bar chart shows how Commissioning Locality performance compares to other Commissioning Localities. Each vertical line on the yellow bar shows the position of a Commissioning Locality. Your Commissioning Locality is highlighted by the red diamond. Values to the left show a lower ratio of observed to expected cases, in general indicating under-diagnosis compared to the model. Values to the right show a higher ratio of observed to expected cases although this may still indicate a picture of some under-diagnosis

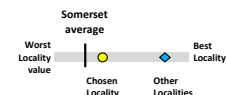


# Respiratory data



## Central Mendip

	Significantly better than Somerset average
	Not significantly different to Somerset average
	Significantly worse than Somerset average
	Difference not assessed



	Improved
	Worsened

Significance	Indicator	Central Mendip number	Central Mendip value	Somerset average	Worst Locality value	Locality range	Best Locality value	Central Mendip value 2014	Direction of change
	1: Asthma	1,247	63.3	64.4	71.5	←Worse Better→	61.8	59.6	
Prevalence	2: COPD	404	23.0	20.7	25.6		18.0	21.3	
	3: COPD estimated proportion of cases on register	362	99%	98%	82%		120%	96%	
Mortality	4: All respiratory disease	110	116%	100%	116%		76%	108%	
	5: COPD	44	117%	100%	120%		70%	120%	
	6: 65 and over	2,698	71%	71%	66%		74%	70%	
Flu vaccination	7: All children aged 2,3 or 4	303	45%	42%	37%		47%	New indicator	
	8: At risk 6 months to <65 years	1,028	51%	48%	40%		53%	55%	
	9: Pregnant women	94	44%	37%	25%		44%	38%	
	10: Carers	59	33%	37%	29%		43%	43%	
Smoking	11: Current smokers (aged 16 and over)		17%	14%	19%		12%	20%	
	12: 4 week smoking quit rate (all ages)		38%	42%	37%		47%	40%	
	13: 4 week smoking quit rate (45-59)		36%	40%	35%		49%	43%	
	14: Smokers going through cessation per 1000 recorded smokers		78.7	85.1	64.7		108.5	90.7	
Emergency admissions	15: Emergency admissions for Respiratory diseases (all ages)	261	14.8	12.1	14.8		9.5	12.7	
	16: Emergency admissions for COPD (all ages)	124	2.4	2.1	2.6		1.6	2.2	
	17: Emergency admissions for Respiratory diseases (aged <18)	309	12.9	13.0	15.2		11.1	New indicators	
	18: Emergency admissions for Asthma (aged <18)	44	1.8	1.7	2.2		1.4	New indicators	
QOF 2014 ongoing management indicators	19: AST004. Patients with asthma aged 14 - 19 years with record of smoking status	87	87%	77%	60%		88%	Indicators changed from within 15 months to within 12 months so values not comparable	
	20: AST003. Had a review	893	78%	62%	58%		78%	Indicators changed from within 15 months to within 12 months so values not comparable	
	21: COPD004. Record of FEV1	299	85%	76%	70%		85%	Indicators changed from within 15 months to within 12 months so values not comparable	
	22: COPD003. Review including MRC dyspnoea score	264	75%	75%	72%		84%	Indicators changed from within 15 months to within 12 months so values not comparable	
	23: COPD005. MRC dyspnoea grade ≥3, with a record of oxygen saturation value	117	89%	86%	59%		97%	New indicator	
	24: COPD006. Had influenza immunisation	284	93%	90%	84%		94%	91%	

Indicator	Notes
1-2	MIQUEST (QOF) indirectly standardised prevalence rate within Somerset 2015
3	Modelled true prevalence using Doncaster models compared to QOF reported cases 2014
4-5	Indirectly standardised mortality ratio (compared to Somerset) : ONS : 2010-14
6-10	Uptake of Flu vaccination : PHE : Winter of 2014/15
11-14	Smoking prevalence from MIQUEST query March 2015 and Somerset smoking cessation service data April 2013 to March 2015
15-18	Indirectly standardised admission to hospital : Secondary Uses Service (SUS) : 2014/15 for All respiratory diseases (all ages), 2012/13 - 2014/15 for COPD, 2009/10 - 2014/15 for those aged <18. Respiratory diseases ICD10 codes: Chapter J; Asthma ICD10 codes: J45 or J46; COPD ICD10 codes: J40-J44
	Rate per 100,000 for all ages and per 1000 for those aged <18
19-24	QOF ongoing management indicators : 2014

AST004: The percentage of patients with asthma aged 14 or over and who have not attained the age of 20, on the register, in whom there is a record of smoking status in the preceding 12 months  
 AST003: The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23  
 COPD004: The percentage of patients with COPD with a record of FEV1 in the preceding 12 months  
 COPD003: The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months  
 COPD005: The percentage of patients with COPD and Medical Research Council dyspnoea grade ≥3 at any time in the preceding 12 months, with a record of oxygen saturation value within the preceding 12 months, NICE 2012 menu ID: NM63  
 COPD006: The percentage of patients with COPD who have had influenza immunisation in the preceding 1 September to 31 March

### Interventions to improve respiratory health

Respiratory disease is one of the key contributing factors to reduced life expectancy in Somerset and there are variations and inequalities in the experience of respiratory illness across the county with a clear relationship between deprivation and poor respiratory health.

#### Priorities to be considered for respiratory services:

Respiratory disease has a number of risk factors that can be minimised and approaches that can add to the effective management of the disease. Overall aims of respiratory services should look to:

- Increase the number of people with long term conditions living independently and in control of their condition e.g. COPD through managed self-care. People with COPD/asthma should be reviewed regularly by a nurse/doctor with appropriate training in respiratory disease management. Review should incorporate a written action plan<sup>1</sup>. Further review(s) can take place opportunistically:
  - An acute consultation offers opportunity to determine what action the patient has already taken to deal with the exacerbation. Their self-management strategy may be reinforced or refined and the need for consolidation at a routine follow up considered.
  - A consultation for an upper respiratory tract infection is an opportunity to rehearse self-management in the event of their condition deteriorating.
- Encourage compliance with prescribed medications, with information and support on use and effectiveness, for example;
  - Prescribe inhalers only after patients have received training in the use of the device and have demonstrated satisfactory technique<sup>2</sup>
  - If the patient is unable to use a device satisfactorily an alternative should be found.
  - The patient should have their ability to use an inhaler device assessed by a competent healthcare professional.
  - The medication needs to be titrated against clinical response to ensure optimum efficacy.
  - Reassess inhaler technique as part of structured clinical review
- Increase rates of immunisation against seasonal flu, pandemic flu and pneumonia amongst eligible groups; Research<sup>3</sup> has shown the following approaches effective:
  - Having a lead member of staff to oversee the vaccination programme;
  - Ordering sufficient vaccine for 75% uptake among eligible groups;
  - Tailor call-recall process: Personal invitations (particularly effective for the over 65s) and repeats/reminders (particularly effective for under 65s);
  - Using in house IT search to identify eligible patients;
  - Community midwives administering vaccine to pregnant women;
  - Production of report reviewing annual vaccination rates, including detail of rationale to end each annual campaign.
- Increase number of patients referred for stop smoking support to Smokefreelife Somerset <http://www.smokefreelivesomerset.co.uk/> and encouragement to patients not ready to quit to have a Smokefree home, especially parents of young children,
- Increase awareness in the population of signs and symptoms of respiratory disease and when to seek medical advice, seeking to minimise emergency admissions, particularly amongst children and the most deprived groups.
  - Case detection studies have used symptom questionnaires to screen for asthma in school-age children<sup>2,3,4,5</sup>. It is recommended<sup>1</sup> to focus the initial assessment in children suspected of having asthma on:
    - Presence of key features in the history and examination
    - Careful consideration of alternative diagnoses

1]Galant SP, Crawford LJ, Mophew T, Jones CA, Bassin S. (2004) Predictive value of a cross-cultural asthma case-detection tool in an elementary school population. *Pediatrics* 114(3) pp: 307-16.

2] Healthcare Improvement Scotland (2012) British Guidelines on the Management of Asthma. Scottish Intercollegiate Guidelines Network. Available from <http://www.brit-thoracic.org.uk/Portals/0/Guidelines/AsthmaGuidelines/sign101%20Jan%202012.pdf>

3] Dexter, L. J., Teare, M. D., Dexter, M., Siriwardena, A. N. and Read, R. C. (2012) Strategies to increase influenza vaccination rates: outcomes of a nationwide cross sectional survey of UK general practice. *British Medical Journal* [online] 2(3) Available from: <http://bmjopen.bmj.com/content/2/3/e000851.full>

4] Gerald LB, Grad R, Turner-Henson A, Hains C, Tang S, Feinstein R, (2004) Validation of a multistage asthma case-detection procedure for elementary school children. *Pediatrics*.114(4) pp:459-68.

5] Jones CA, Mophew T, Clement LT, Kimia T, Dyer M, Li M, (2004) A school-based case identification process for identifying inner city children with asthma: the Breathmobile program. *Chest* 125(3) pp:924-34.

# Cardiovascular data



## Central Mendip

	Significantly better than Somerset average
	Not significantly different to Somerset average
	Significantly worse than Somerset average
	Difference not assessed



Significance	Indicator	Central Mendip number	Central Mendip value	Somerset average	Worst Locality value	Locality range ←Worse Better→	Best Locality value	Central Mendip value 2014	Direction of change
Prevalence	1 : Coronary heart disease	641	37.1	37.8	43.0		34.8	36.4	
	2 : Stroke/TIA	427	24.9	27.1	30.7		24.9	20.4	
	3 : Heart failure	165	9.9	8.5	10.0		7.8	9.7	
	4 : Atrial Fibrillation	398	23.6	23.9	25.2		22.8	22.4	
	5 : Hypertension	2,908	165	160	176		149	162	
	6 : Diabetes (ages 17 and over)	889	60	65	74		60	57	
	7 : Obesity (ages 16 and over)	1,173	74	84	127		70	99	
Smoking	8 : Current smokers (aged 16 and over)		0.2	0.1	0.2		0.1	0.2	
	9 : 4 week smoking quit rate (all ages)		38%	42%	40%		47%	40%	
	10 : 4 week smoking quit rate (45-59)		36%	40%	35%		49%	43%	
Mortality	11 : Smokers going through cessation per 1000 recorded smokers		79	85	65		109	91	
	12 : All circulatory disease	233	1.0	1.0	1.1		0.9	1.1	
Admissions	13 : All circulatory disease <75	55	1.1	1.0	1.2		0.9	1.1	
	14 : Emergency admissions for Circulatory diseases (all ages)	211	12.4	10.2	12.4		9.0	12.5	
	15 : Elective admissions for Circulatory diseases (all ages)	134	7.4	8.5	9.6		7.2	7.2	
	16 : Alcohol related admissions	1,462	1,595	1,862	2,033		1,595	1,805	
	17 : Alcohol specific admissions	325	340	435	515		340	304	
NHS Health Checks	18 : % of population eligible for NHS health check	1,301	72%	71%	73%		67%	72%	
	19 : % of eligible population invited	778	60%	59%	34%		97%	77%	
	20 : % of eligible population checked	531	41%	36%	22%		59%	44%	
	21 : % of those invited who were checked	531	68%	61%	49%		68%	58%	
QOF 2014 ongoing management indicators	22 : CHD002: BP is 150/90 mmHg or less	582	90%	86%	79%		90%		Changed definition
	23 : CHD003: Total cholesterol is 5 mmol/l or less	466	79%	75%	65%		81%		
	24 : CHD004: Had influenza immunisation	549	92%	89%	81%		92%		93%
	25 : CHD005: Aspirin or an alternative taken	600	93%	91%	91%		93%		
	26 : CHD006: Treated as recommended by NICE	34	76%	78%	70%		91%		Changed definition
	27 : HYP002: BP is 150/90 mmHg or less	2,183	79%	76%	68%		82%		81%
	28 : HYP003: Treated recommended by NICE (age <80)	1,499	70%	65%	57%		71%		
	29 : HYP004: Had assessment of physical activity (age 16-74)	1,476	81%	63%	50%		83%		
	30 : HYP005: 'less than active' who have had a brief intervention (age 16-74)	1,103	92%	82%	75%		92%		
	31 : PAD002: BP is 150/90 mmHg or less	106	95%	82%	72%		95%		New indicators
	32 : PAD003: Total cholesterol is 5 mmol/l or less	84	80%	71%	62%		80%		
	33 : PAD004: Treated as recommended by NICE	85	90%	86%	84%		90%		
	34 : CVD-PP002: Given lifestyle advice	413	67%	64%	51%		85%		
	35 : HF003: Treated with an ACE-I or ARB	34	97%	90%	88%		97%		
	36 : HF004: Of those treated with an ACE-I or ARB, also treated with beta-blocker	26	90%	87%	81%		95%		
	37 : STIA003: BP is 150/90 mmHg or less	296	88%	85%	78%		88%		Changed definition
	38 : STIA004: Have a record of total cholesterol	295	87%	81%	70%		89%		
	39 : STIA005: Total cholesterol is 5 mmol/l or less	161	74%	71%	65%		75%		
	40 : STIA006: Had influenza immunisation	261	88%	87%	80%		92%		94%
	41 : STIA007: Taking anti-platelet agent or an anti-coagulant	215	92%	91%	90%		95%		Changed definition
42 : BP001: BP recorded (age 40+)	9,190	88%	87%	83%		91%		New indicator	
43 : AF002: CHADS2 score measured	314	99%	85%	75%		99%			
44 : AF003: Treated with anti-coagulation or anti-platelet therapy if CHAD2 score is 1	73	95%	93%	91%		95%		Changed definition	
45 : AF004: Treated with anti-coagulation or anti-platelet therapy if CHAD2 score is >1	162	81%	82%	78%		86%		89%	

Indicator	Notes
1-7	MIQUEST (QOF) indirectly standardised prevalence rate within Somerset 2015
8-11	Smoking prevalence from MIQUEST query March 2015 and Somerset smoking cessation service data April 2013 to March 2015
12-13	Indirectly standardised mortality ratio (compared to Somerset) : ONS : 2010-14
14-17	Indirectly standardised admission to hospital rate per 100,000 : Secondary Uses Service (SUS) : 2014/15 for Circulatory diseases, 2010/11 - 2014/15 for Alcohol admissions. Circulatory diseases ICD10 codes: Chapter I
18-21	Alcohol related and alcohol specific causes as listed in work by North West Public Health Observatory and released through the Local Alcohol Profiles for England <a href="http://www.lape.org.uk/">http://www.lape.org.uk/</a>
22-45	Somerset NHS Health Checks : financial year 2014/15 QOF ongoing management indicators : 2014

CHD002: The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less

CHD003: The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the preceding 12 months) is 5 mmol/l or less

CHD004: The percentage of patients with coronary heart disease who have had influenza immunisation in the preceding 1 September to 31 March

CHD005: The percentage of patients with coronary heart disease with a record in the preceding 12 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken

CHD006: The percentage of patients with a history of myocardial infarction (on or after 1 April 2011) currently treated with an ACE-I (or ARB if ACE-I intolerant), aspirin or an alternative anti-platelet therapy, beta-blocker and statin, NICE 2010 menu ID: NM07

HYP002: The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 9 months) is 150/90 mmHg or less

HYP003: The percentage of patients aged 79 or under with hypertension in whom the last blood pressure reading (measured in the preceding 9 months) is 140/90 mmHg or less, NICE 2012 menu ID: NM53

HYP004: The percentage of patients with hypertension aged 16 or over and who have not attained the age of 75 in whom there is an assessment of physical activity, using GPPAQ, in the preceding 12 months, NICE 2011 menu ID: NM36

HYP005: The percentage of patients with hypertension aged 16 or over and who have not attained the age of 75 who score 'less than active' on GPPAQ in the preceding 12 months, who also have a record of a brief intervention in the preceding 12 months, NICE 2011 menu ID: NM37

PAD002: The percentage of patients with peripheral arterial disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less, NICE 2011 menu ID: NM34

PAD003: The percentage of patients with peripheral arterial disease in whom the last measured total cholesterol (measured in the preceding 12 months) is 5 mmol/l or less, NICE 2011 menu ID: NM35

PAD004: The percentage of patients with peripheral arterial disease with a record in the preceding 12 months that aspirin or an alternative anti-platelet is being taken, NICE 2011 menu ID: NM33

CVD-PP002: The percentage of patients diagnosed with hypertension (diagnosed on or after 1 April 2009) who are given lifestyle advice in the preceding 12 months for: smoking cessation, safe alcohol consumption and healthy diet

HF003: In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, the percentage of patients who are currently treated with an ACE-I or ARB

HF004: In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction who are currently treated with an ACE-I or ARB, the percentage of patients who are additionally currently treated with a beta-blocker licensed for heart failure

STIA003: The percentage of patients with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less

STIA004: The percentage of patients with stroke or TIA who have a record of total cholesterol in the preceding 12 months

STIA005: The percentage of patients with stroke shown to be non-haemorrhagic, or a history of TIA, whose last measured total cholesterol (measured in the preceding 12 months) is 5 mmol/l or less, NICE 2012 menu ID: NM60

STIA006: The percentage of patients with stroke or TIA who have had influenza immunisation in the preceding 1 September to 31 March

STIA007: The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record in the preceding 12 months that an anti-platelet agent, or an anti-coagulant is being taken

BP001: The percentage of patients aged 40 or over who have a record of blood pressure in the preceding 5 years, NICE 2012 menu ID: NM61

AF002: The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHADS2 risk stratification scoring system in the preceding 12 months (excluding those whose previous CHADS2 score is greater than 1), NICE 2011 menu ID: NM24

AF003: In those patients with atrial fibrillation in whom there is a record of a CHADS2 score of 1 (latest in the preceding 12 months), the percentage of patients who are currently treated with anti-coagulation drug therapy or anti-platelet therapy, NICE 2011 menu ID: NM45

AF004: In those patients with atrial fibrillation whose latest record of a CHADS2 score is greater than 1, the percentage of patients who are currently treated with anti-coagulation therapy, NICE 2011 menu ID: NM46

# Diabetes profile



## Central Mendip

	Significantly better than Somerset average
	Not significantly different to Somerset average
	Significantly worse than Somerset average
	Difference not assessed



	Significance	Indicator	Central Mendip number	Central Mendip value	Somerset average	Worst Locality value	Locality range ← Worse      Better →	Best Locality value
Prevalence		1 Diabetes (ages 17 and over) standardised rate	889	60	65	74		60
		2 Diabetes (ages 17 and over) crude rate	843	54	63	71		54
		3 % of diabetes cases on register	843	71%	79%	89%		71%
		4 Obesity (ages 16 and over)	1,173	73.7	83.7	126.6		69.9
		5 Excess weight (ages 4-5)	n/a	24%	23%	27%		20%
		6 Excess weight (ages 10-11)	n/a	14%	14%	15%		13%
Deaths		7 Diabetes as underlying cause	16	0.17	0.13	0.18		0.09
NHS Health Checks		8 % of eligible invited for check	n/a	60%	59%	34%		97%
		9 % of eligible checked	n/a	41%	36%	22%		59%
		10 % of eligible in most deprived quintile checked (capped at 100%)	n/a	38%	27%	14%		53%
Prescribing		11 Blood glucose lowering drugs	5,894	83.4	81.7	79.3		84.3
		12 Long/Intermediate Insulin Analogues	697	80.5	70.8	84.2		54.5
Admissions		13 Emergency admissions for Diabetes (all ages) main dx	106	0.96	1.08	1.40		0.80
		14 Emergency admissions (all ages) for someone with diabetes	205	11.9	14.0	17.0		11.9
		15 Elective admissions (all ages) for someone with diabetes	213	12.1	15.9	19.8		12.1
		16 Admissions (all ages) for lower limb amputation	21	0.21	0.21	0.29		0.16
		17 Admissions (all ages) for DKA/coma	27	0.23	0.27	0.45		0.17
QOF 2014 care indicators		18 DM002: BP<=150/90 mmHg	763	91%	88%	84%		92%
		19 DM003: BP<=140/80 mmHg	611	74%	73%	63%		80%
		20 DM004: Total cholesterol <=5 mmol/l	610	77%	80%	77%		83%
		21 DM005: Record of an albumin:creatinine ratio test	692	83%	75%	71%		83%
		22 DM006: Patients with nephropathy/microalbuminuria given ACE	76	88%	84%	82%		88%
		23 DM007: IFCC-HbA1c is <=59 mmol/mol	537	65%	64%	60%		69%
		24 DM008: IFCC-HbA1c is <=64 mmol/mol	619	75%	72%	70%		77%
		25 DM009: IFCC-HbA1c is <=75 mmol/mol	706	85%	82%	80%		85%
		26 DM010: Had Flu vaccination	677	90%	88%	82%		92%
		27 DM011: Had retinal screening	685	83%	87%	81%		93%
		28 DM012: Had foot examination and risk classification	691	84%	82%	79%		86%
		29 DM013: Had dietary review	701	84%	79%	73%		87%
		30 DM014: Been referred to a structured education programme	29	91%	90%	76%		97%
		31 DM015: Male patients asked about erectile dysfunction	378	78%	73%	64%		79%
		32 DM016: Male patients with erectile dysfunction with advice	138	95%	83%	77%		95%

- Indicator Notes
- 1, 4 MIQUEST (QOF) indirectly standardised prevalence rate per 1000 within Somerset 2015
  - 2 QOF crude prevalence rate per 1000: 2014
  - 3 Modelled true prevalence using York and Humber PHO models compared to QOF reported cases 2014
  - 5-6 National Child Measurement Programme 2009/10 - 2013/14: LSOA weighted averaging population as at July 2015
  - 7 Indirectly standardised mortality ratio (compared to Somerset) : ONS : 2010-14
  - 8-10 Somerset NHS Health Checks : financial year 2014/15
  - 11-12 MO KTT prescribing indicators: NHS Business Authority report 2014/15
  - 13-17 Indirectly standardised admission to hospital (rate per 1000) : Secondary Uses Service (SUS) : 2014/15 for All emergency/elective admissions for those with diabetes; 2009/10 - 2014/15 for Diabetes as main reason for emergency admission, Lower limb amputations and DKA/coma admissions. Diabetes ICD10 codes: E10-E14; Lower limb amputations ICD10 codes E10-E14 AND OPCS4 codes X9-X11; DKA/Coma ICD10 codes E10.0, E10.1, E11.0, E11.1, E12.0, E12.1, E13.0, E13.1, E14.0, E14.1
  - 18-32 QOF ongoing management indicators : 2014

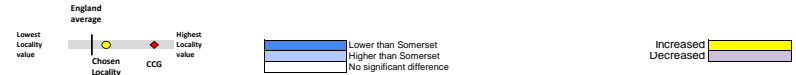
DM002: The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less, NICE 2010 menu ID: NM01  
 DM003: The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less, NICE 2010 menu ID: NM02  
 DM004: The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less  
 DM005: The percentage of patients with diabetes, on the register, who have a record of an albumin:creatinine ratio test in the preceding 12 months, NICE 2012 menu ID: NM59  
 DM006: The percentage of patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are currently treated with an ACE-I (or ARBs)  
 DM007: The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 12 months, NICE 2010 menu ID: NM14  
 DM008: The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months  
 DM009: The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months  
 DM010: The percentage of patients with diabetes, on the register, who have had influenza immunisation in the preceding 1 September to 31 March  
 DM011: The percentage of patients with diabetes, on the register, who have a record of retinal screening in the preceding 12 months  
 DM012: The percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 12 months, NICE 2010 menu ID: NM13  
 DM013: The percentage of patients with diabetes, on the register, who have a record of a dietary review by a suitably competent professional in the preceding 12 months, NICE 2011 menu ID: NM28  
 DM014: The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register, NICE 2011 menu ID: NM27  
 DM015: The percentage of male patients with diabetes, on the register, with a record of being asked about erectile dysfunction in the preceding 12 months, NICE 2012 menu ID: NM51  
 DM016: The percentage of male patients with diabetes, on the register, who have a record of erectile dysfunction with a record of advice and assessment of contributory factors and treatment options in the preceding 12 months, NICE

# Cancer Commissioning Indicators

Collated and calculated from the practice level data available on the Cancer Commissioning Toolkit website

<https://www.cancertoolkit.co.uk>

## Central Mendip



Indicator	Central Mendip number	Central Mendip value	Somerset CCG value	Lowest Locality value in Somerset	Chart	Highest Locality value in Somerset	Central Mendip compared to Somerset	Lowest practice value in Central Mendip	Highest practice value in Central Mendip	Urban	Rural	Central Mendip 2014 profile	Direction of change
1 Practice Population aged 65+ (% of population in this practice aged 65+)	3,701	19%	22%	19%		31%	Higher than Somerset	16%	20%	Higher than Somerset		18%	Decreased
2 New cancer cases (Crude incidence rate: new cases per 100,000 population)	95	488	630	488		749	Higher than Somerset	402	630	Higher than Somerset		534	Increased
3 Cancer deaths (Crude mortality rate: deaths per 100,000 population)	39	200	274	200		415	Higher than Somerset	148	246			Deaths not updated	
4 Prevalent cancer cases (% of practice population on practice cancer register)	468	2%	3%	2%		4%	Higher than Somerset	2%	3%	Higher than Somerset		2%	Decreased
5 Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %)	1,742	66%	75%	66%		80%	Higher than Somerset	65%	67%			71%	Increased
6 Females, 50-70, screened for breast cancer within 6 months of invitation (Uptake, %)	164	6%	21%	1%		78%	Higher than Somerset	24%	58%			43%	Increased
7 Females, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage, %)	3,449	70%	70%	66%		73%	Higher than Somerset	75%	85%	Higher than Somerset		77%	Increased
8 Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)	1,438	60%	62%	60%		63%	Higher than Somerset	60%	61%	Higher than Somerset		61%	Increased
9 Persons, 60-69, screened for bowel cancer within 6 months of invitation (Uptake, %)	682	28%	29%	28%		30%	Higher than Somerset	53%	58%			64%	Increased
10 Two-week wait referrals (Number per 100,000 population)	505	2,592	2,864	2,320		3,396	Higher than Somerset	1,855	3,444		Higher than Somerset	2,271	Decreased
11 Two-week wait referrals (Indirectly age standardised referral ratio)	505	98%	100%	85%		110%	Higher than Somerset	79%	128%			92%	Decreased
12 Two-week referrals with cancer (Conversion rate: % of all TWW referrals with cancer)	50	10%	12%	10%		13%	Higher than Somerset	8%	12%			10%	Increased
13 Number of new cancer cases treated (% of which are TWW referrals)	98	51%	53%	46%		62%	Higher than Somerset	44%	56%			44%	Decreased
14 Two-week wait referrals with suspected breast cancer (Number per 100,000 population)	83	426	464	412		585	Higher than Somerset	222	553			264	Decreased
15 Two-week wait referrals with suspected lower GI cancer (Number per 100,000 population)	72	370	420	350		542	Higher than Somerset	222	553		Higher than Somerset	430	Increased
16 Two-week wait referrals with suspected lung cancer (Number per 100,000 population)	20	103	97	65		137	Higher than Somerset	46	137			119	Increased
17 Two-week wait referrals with suspected skin cancer (Number per 100,000 population)	106	544	558	445		674	Higher than Somerset	401	830			425	Decreased
18 In-patient or day-case colonoscopy procedures (Number per 100,000 population)	237	1,217	1,222	1,016		1,458	Higher than Somerset	965	1,568			850	Decreased
19 In-patient or day-case sigmoidoscopy procedures (Number per 100,000 population)	90	462	641	357		878	Higher than Somerset	334	507		Higher than Somerset	446	Decreased
20 In-patient or day-case upper GI endoscopy procedures (Number per 100,000 population)	237	1,217	1,222	1,016		1,458	Higher than Somerset	965	1,568			1,229	Increased
21 Number of emergency admissions with cancer (Number per 100,000 population)	81	416	559	416		764	Higher than Somerset	372	482			446	Increased



The following information is presented:

- Deaths – overview of causes of death 2009-2013 of Commissioning Locality patients.
- Years of Life Lost – overview of causes of years of life lost due to death before age 75 2009-2013 in Commissioning Locality patients.
- Life expectancy
- Standardised Mortality Ratios
- Where people die

The 'blobs' diagrams were first introduced in the Somerset 2013 profiles and provide an at a glance indication of the main causes of death 2009-2013 in Commissioning Locality registered patients. Different colours represent different disease/condition groups and lines indicate how more specific conditions are included within a larger grouping. The two 'blobs' with no lines have overlapping content with other 'blobs' but are not strict subgroups. They are placed beside the mental and behavioural disorders as they are, at least in part, mental health issues.

Possibly more important in terms of public health impact and valuable interventions is the corresponding diagram showing the conditions leading to years of life lost due to death before the age of 75. Whilst circulatory diseases cause approximately a third of deaths, they account for less than 20% of the years of life lost. With regard to years of life lost (YLL), cancer is the main cause and justifiably receives a lot of attention, with lung cancer being of particular concern. Other cancers which result in a high proportion of years lost have corresponding screening programmes – breast cancer, colorectal cancer and if YLL are high it is important to ensure that screening programmes are working as effectively as possible. Within Somerset, although the number of years lost to malignant melanoma is one of the smaller values, we know our local performance is worse than in the rest of England.

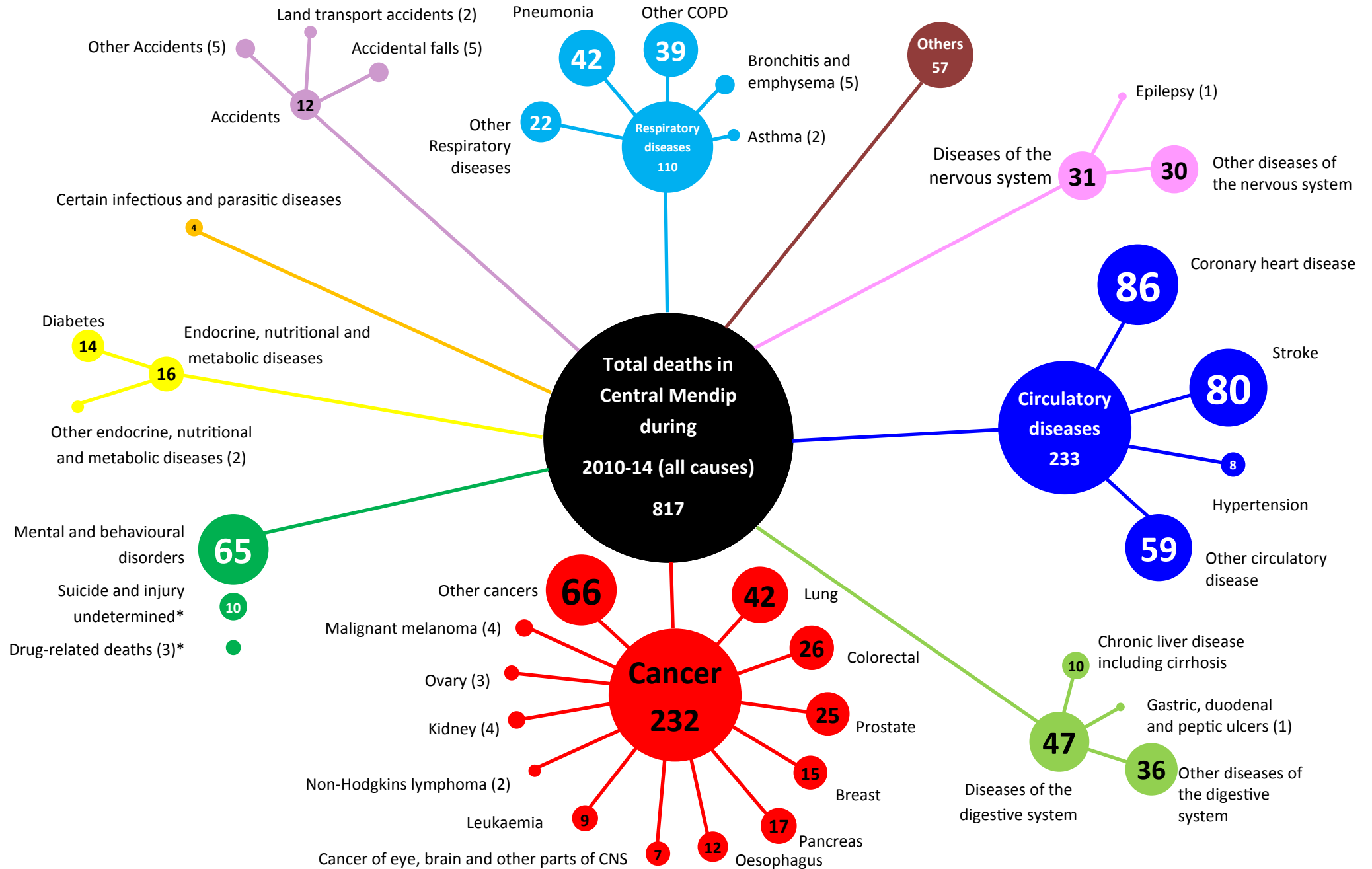
Life expectancy is presented at birth and also additional life expectancy at age 65. On the whole Somerset life expectancy is longer than England as a whole. Another index of preventable deaths is the proportion of deaths occurring before the age of 65 and Somerset is also shown to be better than the national average.

Standardised mortality ratios look at the number of deaths compared to the number expected if the Commissioning Locality followed the average Somerset age/sex specific death rates. They can highlight specific causes of death which may be more prevalent in this Commissioning Locality. Of particular concern are the causes of death occurring at young ages and robbing people of many valuable years of life. 75 years is often used as an arbitrary age to highlight the issue of premature deaths, without implying that years of life lived after that age are in any way less valuable.

Where people die can give clues as to care available. Research has shown that many people with terminal conditions prefer to die at home if they have the choice and are appropriately supported. Numbers of those dying in nursing homes in part reflects location of nursing homes and any local barriers or enablers to access. Lower rates of people dying in hospices could also reflect access issues. High numbers of those dying in hospital could be due to emergency admissions for disease that has not been well managed. More detail on hospitalisations is given in the later section on admissions.

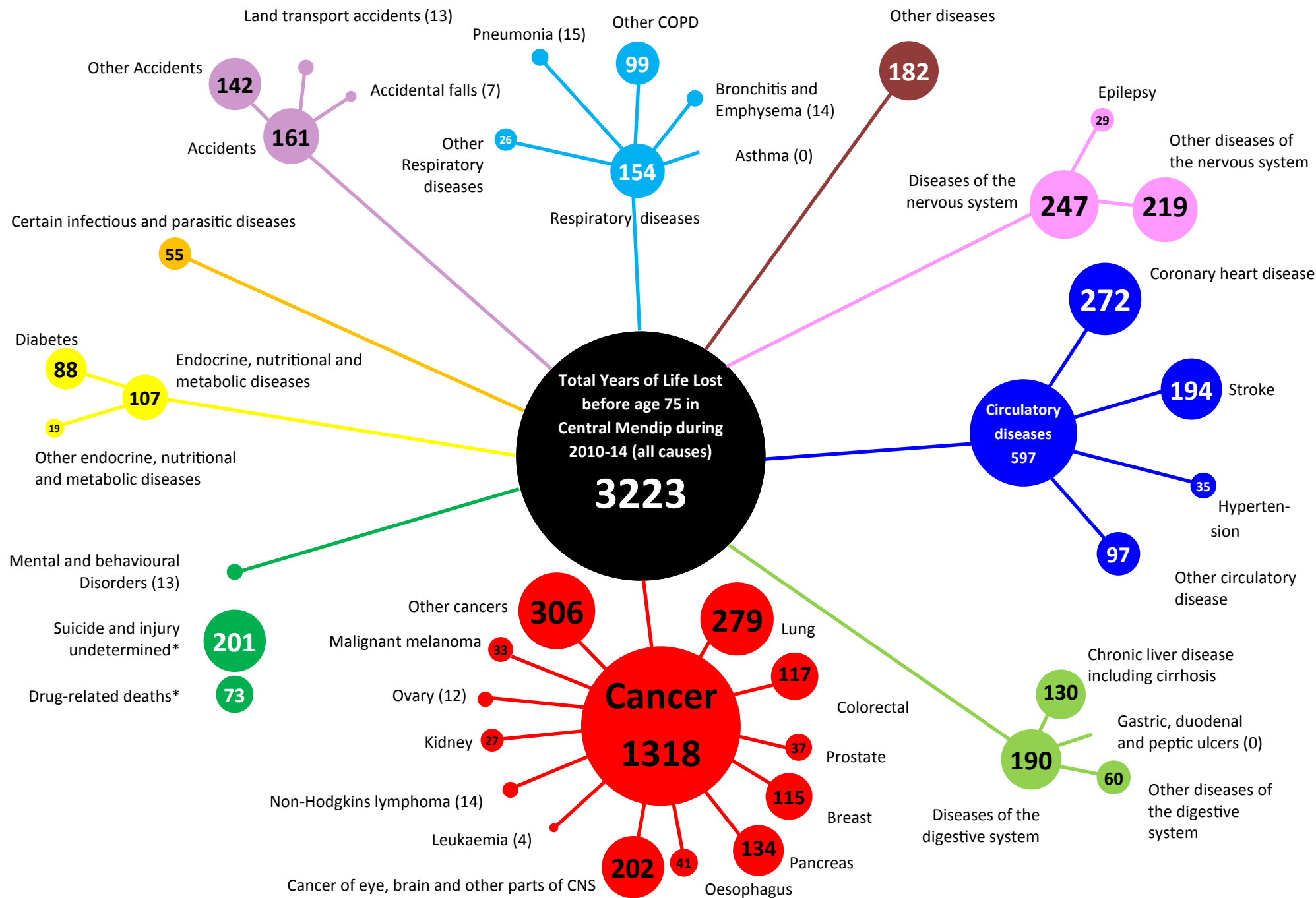
It is worth noting that ONS have revised mortality coding twice in the time period covered by these statistics - in 2011 and in 2014 - to be in line with how cause of death is coded internationally. This has had some impact on the proportion of deaths coded to certain conditions, notably dementia and diabetes. Further details of the effects can be found at [http://www.ons.gov.uk/ons/dcp171778\\_373602.pdf](http://www.ons.gov.uk/ons/dcp171778_373602.pdf).

# DEATHS



\*There is some overlap between Drug related deaths and Mental and behavioural disorders and also between Drug related deaths and Suicide and injury undetermined deaths. There is a further overlap between Drug related deaths and Accidents.

# YEARS OF LIFE LOST BEFORE THE AGE OF 75



\*There is some overlap between Drug related deaths and Mental and behavioural disorders and also between Drug related deaths and Suicide and injury undetermined deaths. There is a further overlap between Drug related deaths and Accidents.

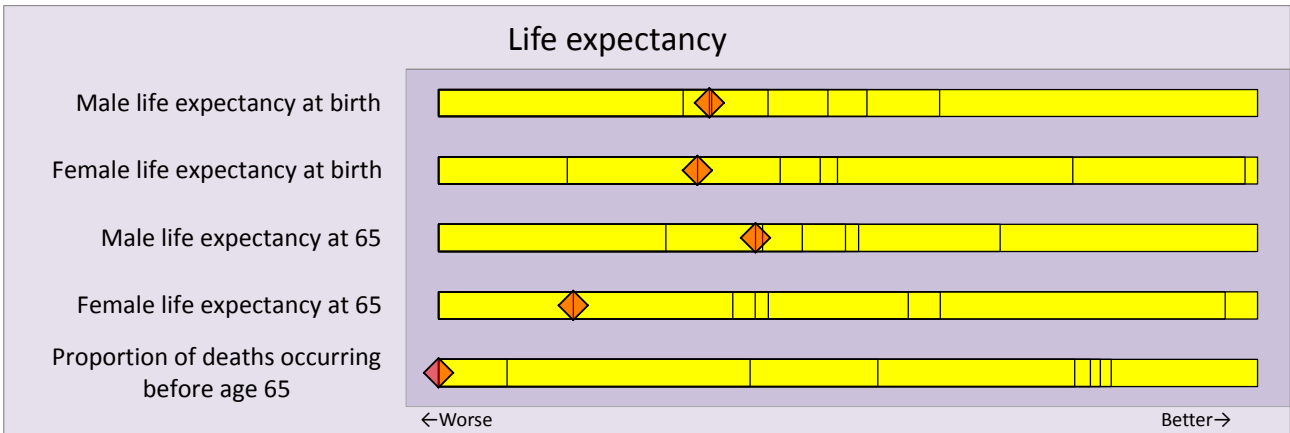
# Central Mendip

## Life expectancy 2010-14

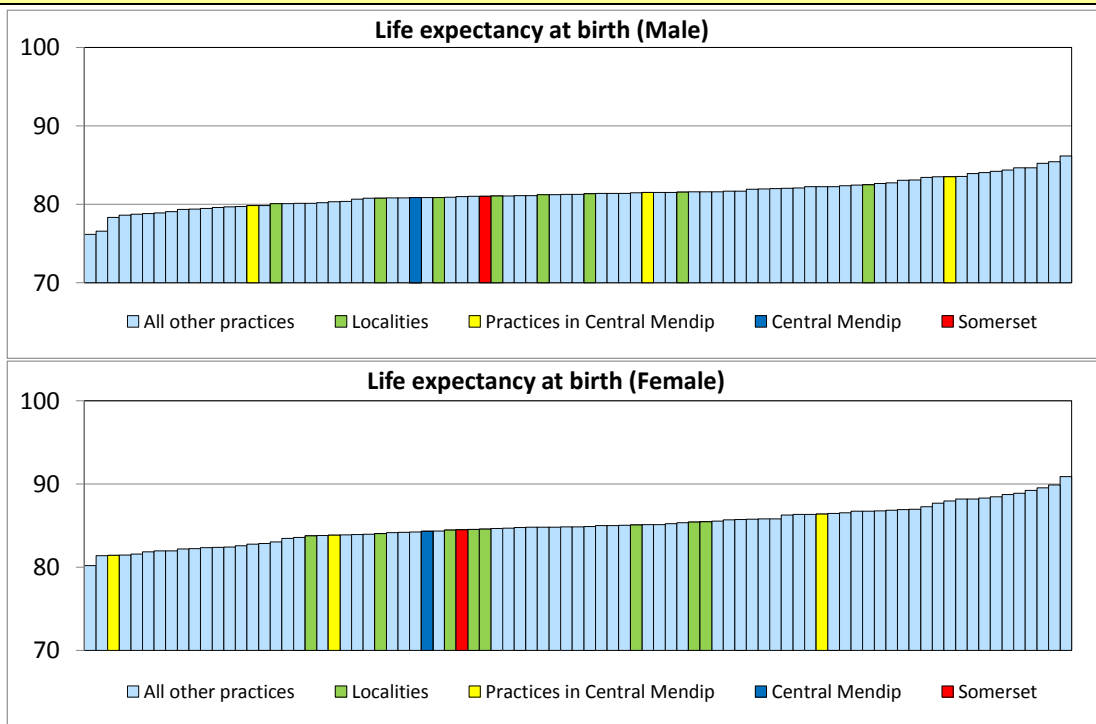
Life expectancy based on deaths from ONS Primary Care Mortality Database and population estimates from the Exeter system

	Commissioning Locality	Somerset	England (2011-13)	Range of Practice values low / median / high
Male life expectancy at birth	80.9	81.0	79.4	76.2 / 81.4 / 86.2
Female life expectancy at birth	84.3	84.5	83.1	80.2 / 85.0 / 90.9
Male life expectancy at 65	19.5	19.5	18.7	16.4 / 19.9 / 24.1
Female life expectancy at 65	21.5	22.0	21.1	18.7 / 22.4 / 27.9
Proportion of deaths occurring before age 65	15%	13%	16%	4% / 13% / 68%

The bar chart shows how the Commissioning Locality compares to other Commissioning Localities in terms of life expectancy of the resident population. Each vertical line on the yellow bar shows the position of a Commissioning Locality. Your Commissioning Locality is highlighted by the red diamond. Values to the left show shorter life expectancy compared to other Commissioning Localities, values to the right show longer life expectancy and so better performance. For the proportion of deaths occurring before 65 a score to the left indicates more deaths prior to age 65 compared to others.



**The Commissioning Locality has the worst value in the county for:**  
Proportion of deaths occurring before age 65



## Central Mendip

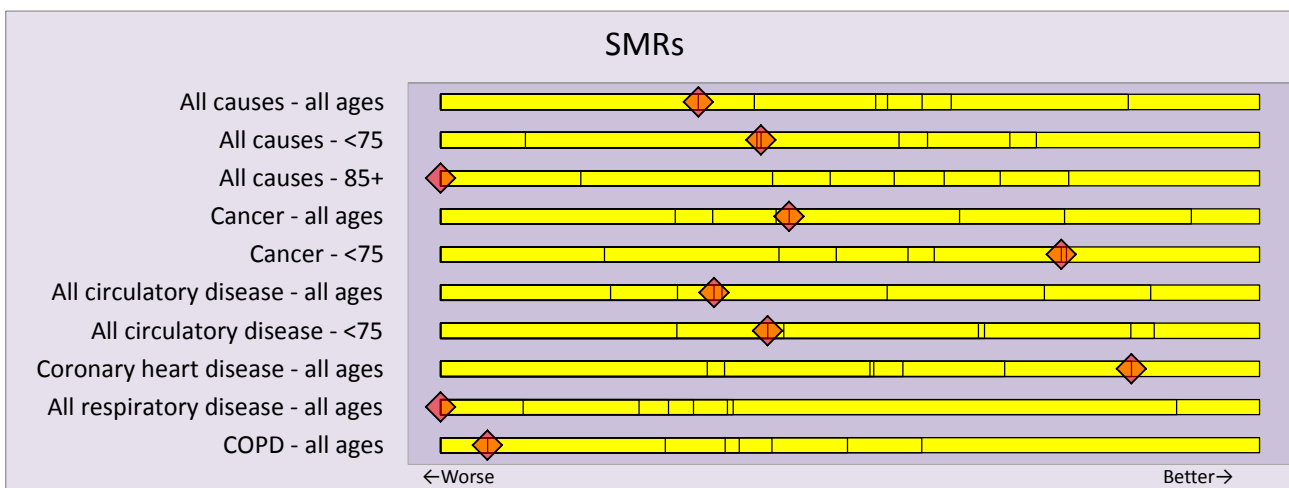
### Standardised mortality ratios

Deaths registered between 2010 and 2014, age and sex standardised to Somerset as a whole (a value of 100% is the Somerset average). ONS Primary Care Mortality Database.

The standardised mortality ratio (SMR) describes the mortality rate in the adjusting for differences between Commissioning Localities in their age and sex profile and compared to the overall mortality in Somerset. A ratio greater than 100% indicates higher rates of death than expected, a ratio of 110% indicates death rates 10% higher than in Somerset as a whole. Where the all causes, all ages SMR is high, the other SMRs presented for more specific ages and/ or causes may indicate the root of the imbalance or specific issues which may be masked in the overall SMR.

Condition	Observed	Expected	Commissioning Locality SMR	Somerset SMR	England	Range of Practice values low / median / high
All causes - all ages	817	791	103%	100%		68% / 97% / 141%
All causes - <75	245	243	101%	100%		64% / 98% / 178%
All causes - 85+	366	320	114%	100%		32% / 97% / 159%
Cancer - all ages	232	229	101%	100%		74% / 100% / 148%
Cancer - <75	104	109	95%	100%		60% / 100% / 200%
All circulatory disease - all ages	233	228	102%	100%		63% / 96% / 163%
All circulatory disease - <75	55	52	105%	100%		47% / 100% / 246%
Coronary heart disease - all ages	86	97	89%	100%		59% / 101% / 237%
All respiratory disease - all ages	110	95	116%	100%		38% / 98% / 151%
COPD - all ages	44	38	117%	100%		27% / 98% / 171%

The bar chart shows how the Commissioning Locality compares to other Commissioning Localities in terms of SMRs. Each vertical line on the yellow bar shows the position of a Commissioning Locality. Your Commissioning Locality is highlighted by the red diamond. For consistency with previous graphs, values to the left show a worse position, which equates to a greater SMR. Values to the right show lower SMRs compared to other Commissioning Localities.

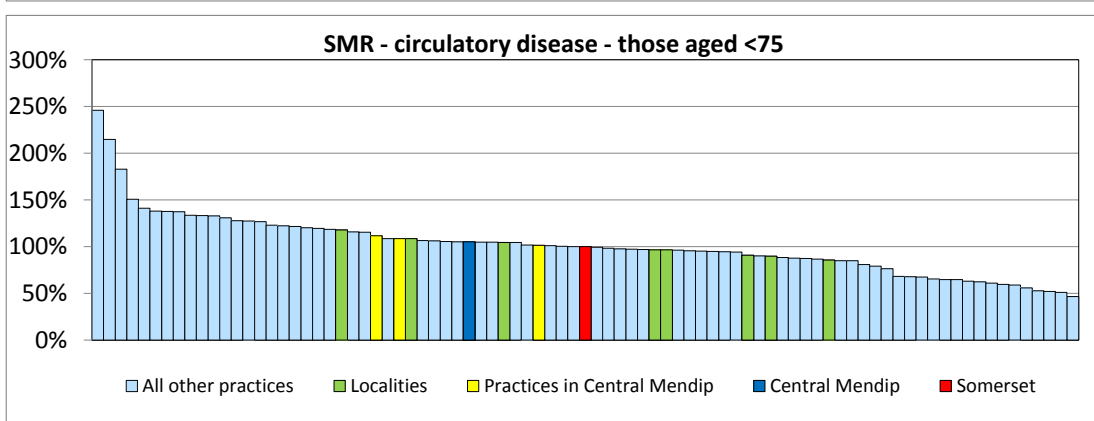
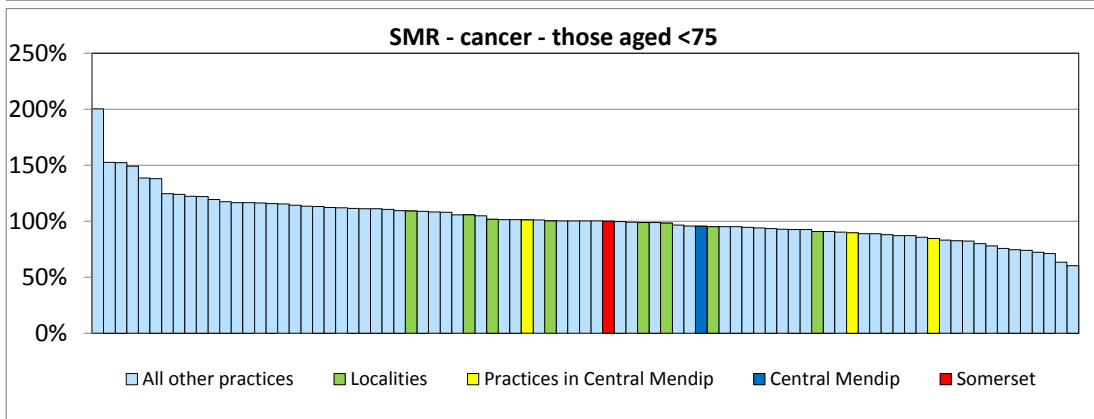
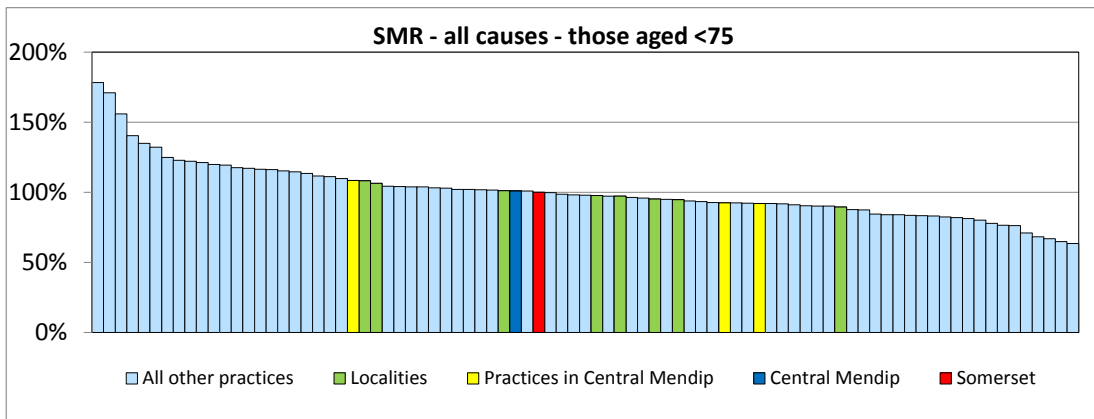
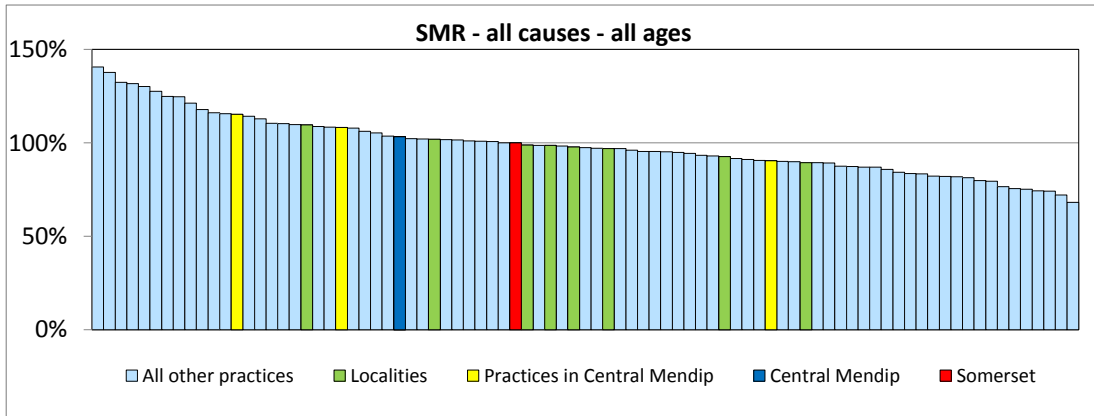


#### Significantly worse than county average for:

All causes - 85+

#### The Commissioning Locality has the worst value in the county for:

All causes - 85+ All respiratory disease - all ages



# Central Mendip

## Where people die

Deaths registered between 2010 and 2014. ONS Primary Care Mortality Database.

Where people die will reflect access to services as well as patterns of care. The category of Anywhere else covers everywhere not in the other categories and includes such places as other people's houses and roads.

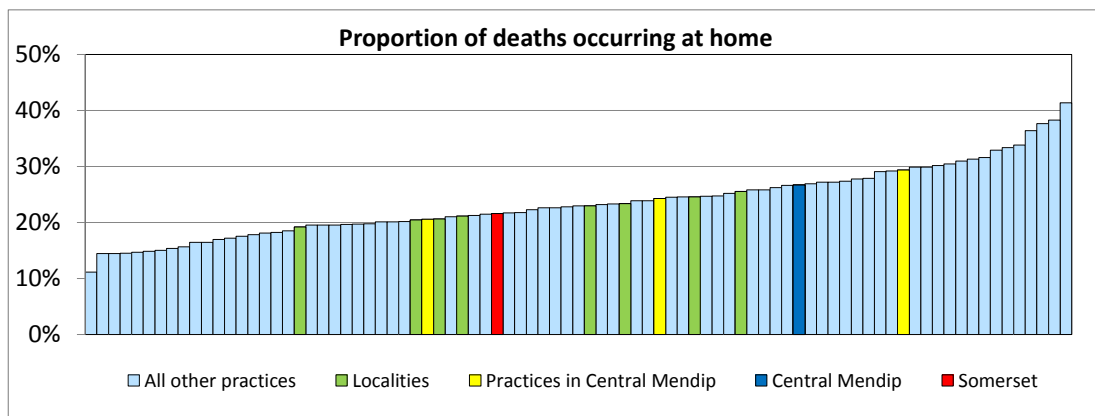
	Commissioning Locality %	Somerset %	England % (2010-12)	Range of Practice values low / median / high
Home	27%	22%	22%	11% / 23% / 41%
Care/nursing home	27%	28%	21%	3% / 25% / 51%
Hospital	41%	43%	49%	29% / 45% / 54%
Anywhere else	6%	7%	8%	3% / 8% / 17%

The bar chart shows how the Commissioning Locality compares to other Commissioning Localities. For the purposes of this data, it is assumed that it is better to die at home and worse to die anywhere else. Each vertical line on the yellow bar shows the position of a Commissioning Locality. Your Commissioning Locality is highlighted by the red diamond. Values to the left show a worse position and values to the right show a better position compared to other Commissioning Localities.



\* for this diagram it is assumed that it is better to die at home and worse to die anywhere else.

The Commissioning Locality has the worst value in the county for:  
Home



The profile contains information on the following preventative health aspects which may impact on the local Commissioning Locality.

The following information is presented:

- Screening, health checks, retinopathy, cancer screening, chlamydia
- Immunisations, childhood and seasonal influenza
- Breastfeeding – initiation rates and continuation at 6-8 weeks

The county council commissions the local NHS Health Checks programme and in 2014 -15 this was provided by GPs. More detail on this programme is provided in the health checks profiles for each Commissioning Locality which highlights invitations issued, taken up and the coverage by socioeconomic indicators as well as outcomes.

The Diabetic Eye screening programme aims to detect retinopathy, maculopathy and other eye defects at an early stage. The aim is to screen all people with diabetes aged over 12 years old at least once per year. The local service is provided by Somerset Partnership NHS Foundation Trust. GPs can support the process through encouragement of patients to attend screening and, if necessary, treatment, explaining the issues.

The outcomes of three cancer screening programmes are shown: bowel cancer, breast cancer, and cervical screening. Data is shown for the current year and previous year. For the cervical screening programme, the rate of inadequate smears is also provided.

Chlamydia screening is provided at a number of locations within the county so overall rates of screening are higher than just those screened via the GP. However local research suggests that young people are very receptive to screening provided routinely in general practice so the overall low screening rates probably represent a missed opportunity to improve health. More detail on interventions which can support increased chlamydia screening is provided on page 37.

The goal is for coverage for all antigens in the childhood vaccination schedule to be at 95% as this is a level which guarantees herd immunity. A selection of childhood vaccinations is presented. In general Somerset childhood immunisation rates are similar to or better than those seen in the rest of England.

Breastfeeding initiation rates in Somerset are, in general, better than those seen in the rest of England although there can be quite striking variation by practice. Whilst GPs may not be so close to the routine support provided to mothers on breastfeeding, they may be consulted about problems which may lead to earlier cessation of breastfeeding than mothers may ideally choose.

The paediatric profile provides an overview of many issues which may impact on the health of children, including breastfeeding, immunisation, childhood obesity, teenage deliveries, youth admission rates and wider determinants of health. This profile was developed to support a Somerset CCG study day raising the profile of child health needs and highlighting the role of GPs in this - for example promoting healthy weight and being aware of the health impact of children living in households with a low income. The aim is to provide a more holistic approach to childhood health.



NHS Health Checks programme is a 5-year rolling call/recall programme. Eligible population refers to the 20% of the total eligible population to be invited during the current year.

Targets for NHS Health Checks are as follows for 2014/15

	Department of Health	Somerset County Council
Eligible individuals invited	100%	100%
Take-up rate (completed)	→ →75%	60% - 75%

### OVERVIEW OF DATA REPORTED ON

The total number of Somerset NHS Health Checks analysed for 2014/15 is 13,119 checks. This is comprised of 12,823 completed checks and 296 excluded checks. We have incorporated the excluded data (which has been excluded from payment to practices and from national reports) in the analysis to ensure that as much detail as possible is being reported.

### CHART OF INVITES AND CHECKS BY ELIGIBLE POPULATION

These charts depict activity by Commissioning Locality and for Somerset County and identifies;

- 1) 20% of the total population aged 40-74 on GP list(s).
- 2) Number of individuals aged 40 to 74 (from item 1 above) who are not currently managed by their GP for a pre-existing condition and are eligible for a health check.
- 3) Number of eligible individuals (from item 2 above) who have received at least one invitation for a check. This should grow incrementally each quarter to achieve the 100% year-end target with roughly a quarter of the eligible being invited in each quarter. In year activity could be above equal increments if:
  - a. the number of eligible individuals on practice lists has increased, or
  - b. the practice is pushing to invite their eligible population and complete the checks early in the year.

Once 100% of eligible people have been invited the focus should shift to people who have not yet taken up the offer of a health check.
- 4) Checks completed requires 100% of results to be recorded on the patient's record for payment and reporting to the national team.

### CHART OF COMPLETED CHECKS BY DEPRIVATION QUINTILES

These charts depict health check activity within each deprivation quintile.

- 1) Indicates the number of people in each quintile eligible for a check and the number of checks completed in that quintile
- 2) Indicates the checks completed as a percentage of the total eligible population in each quintile of deprivation
- 3) Indicates the checks completed as a percentage of the total eligible population in each quintile of deprivation, for the Commissioning Locality

### TABLE OF NHS HEALTH CHECKS ACTIVITY

The NHS Health Check data is reported by Target Activity, Health Check Results and Referrals. Notes have been included for certain data items where it was felt further explanation would be useful.

**Health Check Results:** This section indicates the findings from completed health checks. **All health check results fields must be completed for checks to be eligible for payment.** The only exceptions to this are ITEMS #7 and #17 where a field left blank is interpreted as "No" as there is no appropriate Read code to record "No".

**Columns marked Somerset Lowest & Somerset Highest:** Values of 0% or 100% may appear within these 2 categories where a Commissioning Locality has only completed a few checks. For this reason 25<sup>th</sup> and 75<sup>th</sup> percentile columns have been included to aid interpretation of the data.

#### Please note the following points:

- ITEM 8: AF Screening: Indicates that an irregular pulse was detected.
- ITEMS 10 to 12: GPPAQ: Reported levels of physical activity have been categorised.
- ITEM 14: Highlights anomaly between recorded BMI  $\geq 30$  and GPPAQ recorded as active. Indicates that GPPAQ questionnaire is not being used to identify correct levels of physical activity.
- ITEMS 18 to 21: QRISK grouped into 4 levels of risk.

#### Referrals

This section indicates where a referral has been made either to a GP for further investigation or to a support service. Referral activity percentages are calculated against total checks completed EXCEPT where the referral is based on a specific health check result (eg number of smokers identified who were referred to smoking cessation).

#### Please note the following points:

- ITEM 26: Indicates the number of people who confirmed chest/calf pain on exertion AND were recorded as referred to GP.
- ITEM 27: Indicates the number of people whose QRISK was calculated at  $\geq 20\%$  AND were recorded as referred to GP.
- ITEM 31: Indicates the number of people whose BMI was calculated at  $\geq 30$  and were recorded as being referred to one or more of these support services (physical activity, weight management or health coaching).



# Central Mendip

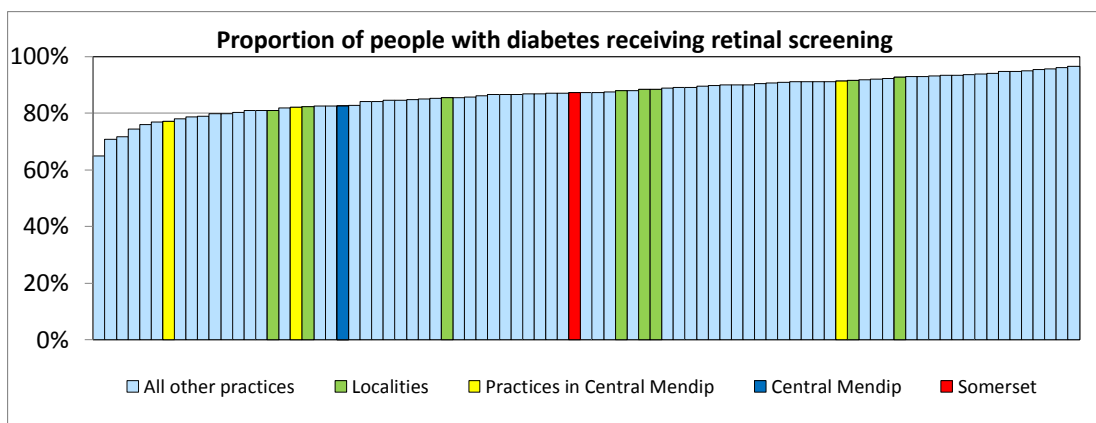
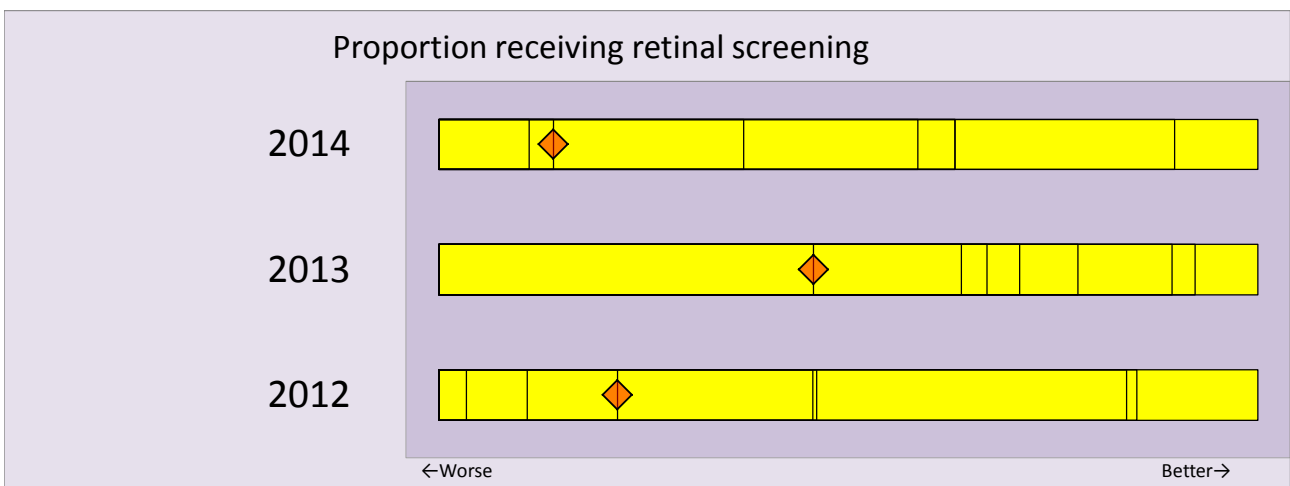
## NHS Diabetic eye screening programme

Proportion of people on the Quality Outcome Framework (QOF) diabetes register receiving diabetic retinopathy screening in the previous 12 or 15 months. This is a shorter period in 2013/14 compared to previous years.

The Quality Outcome Framework indicators are reported annually through the Health and Social Care Information Centre website. Note the time period has changed.

Condition		Commissioning Locality	Somerset	England	Range of Practice values low / median / high
2014	Number receiving screening within last 12 months	685	23,640	2,323,911	
	Number of patients on diabetes register (excl. exceptions)	829	27,073	2,580,886	
	% screened	82.6%	87.3%	90.0%	65.0% / 87.3% / 96.6%
2013	Number receiving screening within last 15 months	711	23,510	2,292,786	
	Number of patients on diabetes register (excl. exceptions)	771	25,171	2,500,345	
	% screened	92.2%	93.4%	91.7%	83.6% / 93.1% / 98.2%
2012	Number receiving screening within last 15 months	698	22,576	2,193,364	
	Number of patients on diabetes register (excl. exceptions)	746	24,051	2,387,549	
	% screened	93.6%	93.9%	91.9%	88.6% / 93.4% / 98.8%

The bar chart shows how the Commissioning Locality compares to other Commissioning Localities in terms of their coverage for diabetic eye screening over the past three years. Each vertical line on the yellow bar shows the position of a Commissioning Locality. Your Commissioning Locality is highlighted by the red diamond. Values to the left show lower levels of screening and worse performance and values to the right show higher rates of screening and better performance.



**Cancer screening**

Breast cancer screening from KC63 report and Cervical cancer screening from KC53 report . Bowel cancer screening from NHS England. All provided by the CSU.

Of note is the often wide variation in screening rates at practice level and to aid further work within the Locality we have highlighted where the practices rank.

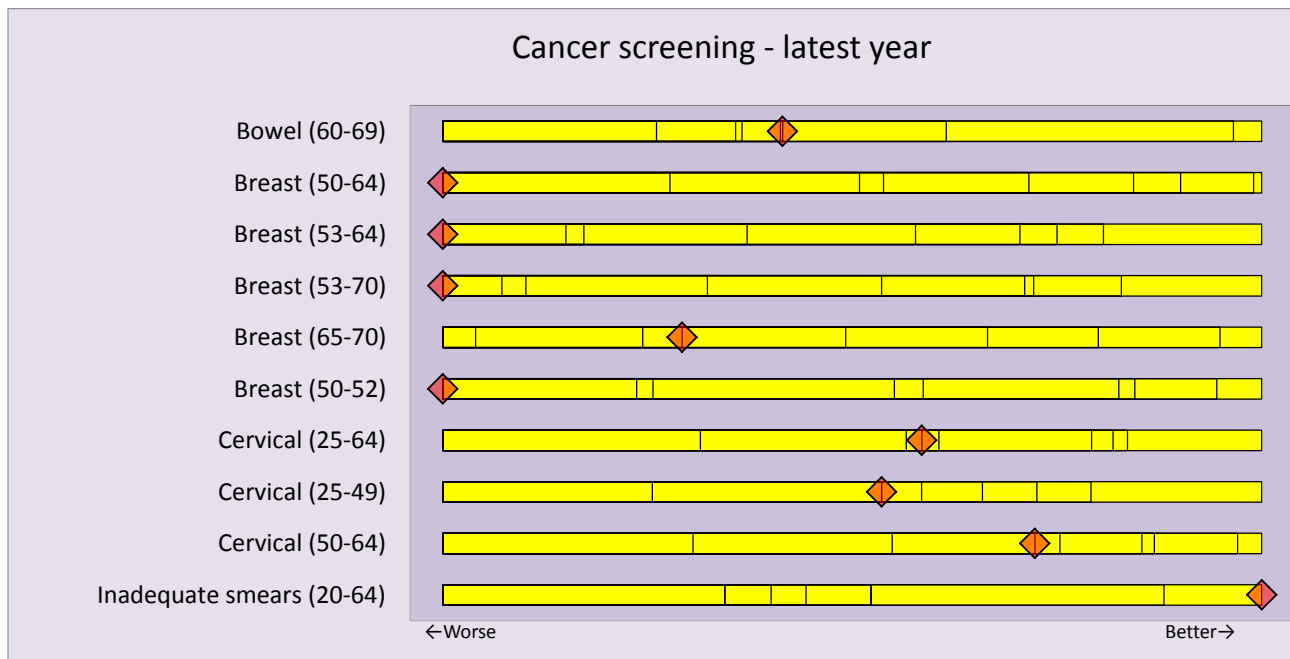
**Bowel and Cervical 2014/15, Breast 2013/14**

Condition	Commissioning Locality	Somerset	England (2013/14 for breast)	Range of Practice values low / median / high
Bowel: 60-69 uptake of invitation to screen in year	61.9%	62.0%	55.4%	40.4% / 62.2% / 68.1%
Breast: ages 50-64: coverage	61.3%	73.7%	71.7%	49.9% / 74.9% / 84.5%
Breast: ages 53-64: coverage	74.5%	79.1%	75.7%	53.8% / 79.7% / 87.6%
Breast: ages 53-70: coverage	76.1%	79.5%	75.9%	55.0% / 79.8% / 84.9%
Breast: ages 65-70: coverage	79.3%	80.3%	76.4%	59.1% / 80.4% / 88.5%
Breast: ages 50-52: coverage	18.3%	54.6%	54.6%	16.7% / 66.5% / 92.0%
Cervical: ages 25-64 coverage within 5 years	78.0%	78.4%	77.2%	67.0% / 79.2% / 86.8%
Cervical: ages 25-49 coverage within 3.5 years	72.5%	73.1%	71.3%	61.2% / 73.5% / 83.5%
Cervical: ages 50-64 coverage within 5 years	77.7%	77.4%	76.5%	62.9% / 77.5% / 87.7%
Cervical: Inadequate smears (ages 20-64)	0.8%	2.9%	2.4%	0.0% / 2.9% / 6.6%

The bar chart shows how the Commissioning Locality compares to other Commissioning Localities in terms of their coverage for cancer screening. Each vertical line on the yellow bar shows the position of a Commissioning Locality. Your Commissioning Locality is highlighted by the red diamond.

For screening uptake indicators, values to the left show lower levels of screening and worse performance and values to the right show higher rates of screening and better performance.

For the inadequate smears indicator, values to the left indicate higher than average rates of inadequate smear tests and thus worse performance. Values to the right indicate lower relative rates of inadequate smears and better performance.



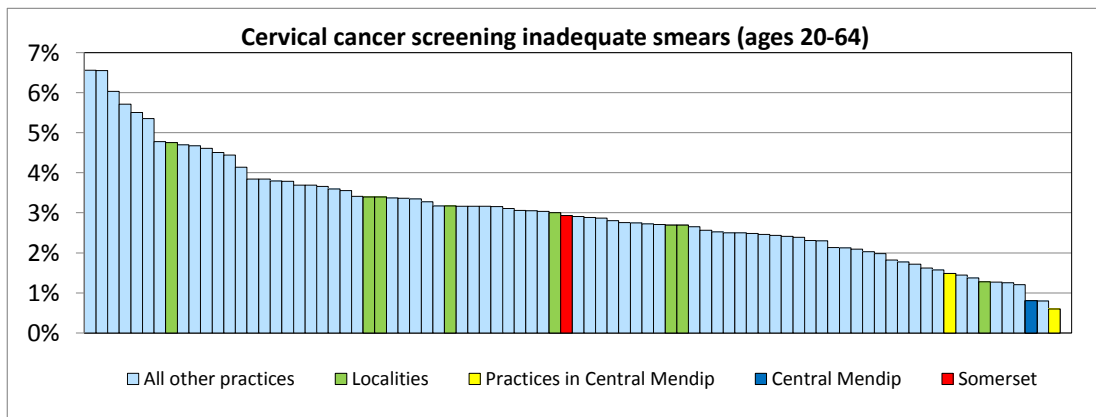
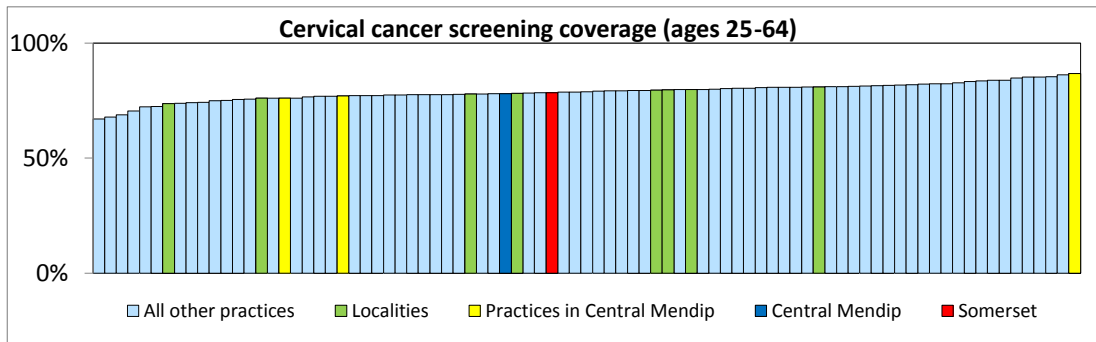
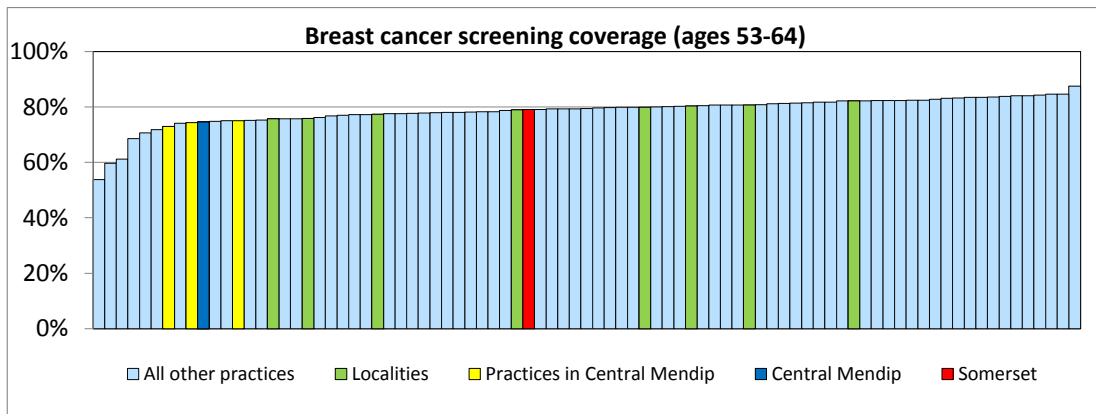
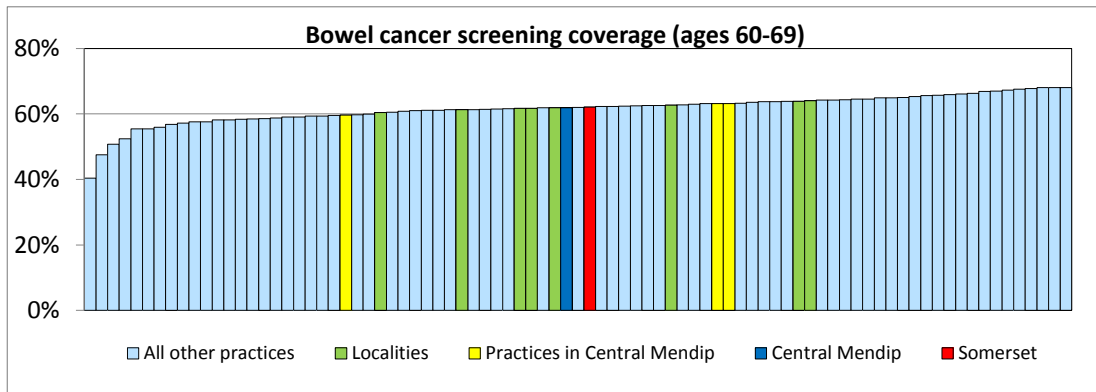
**The Commissioning Locality has the best value in the county for:**

Cervical: Inadequate smears (ages 20-64)

**The Commissioning Locality has the worst value in the county for:**

Breast: ages 50-64: coverage    Breast: ages 53-64: coverage    Breast: ages 53-70: coverage    Breast: ages 50-52: coverage





# Central Mendip

## Chlamydia screening

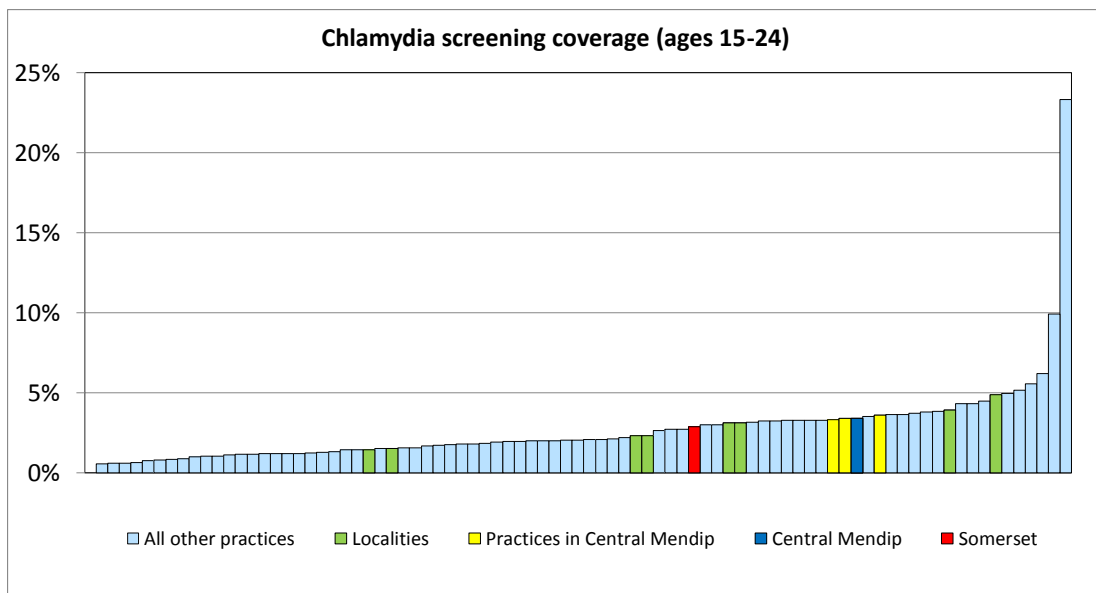
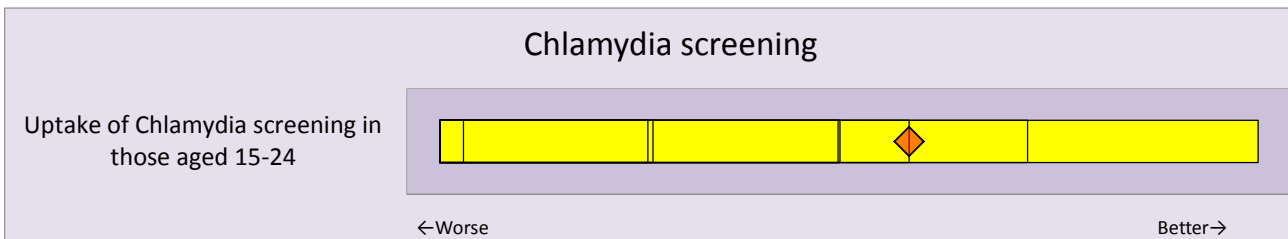
Uptake of Chlamydia screening 2014/15

Chlamydia screening is provided at a number of locations around the county. The data shown is the proportion of eligible population aged 15-24 being screened for Chlamydia in practices.

2014/15

	Commissioning Locality rate	Somerset rate	England	Range of Practice values low / median / high
Uptake of Chlamydia screening in those aged 15-24	3.4%	2.9%		0% / 2% / 23%

The bar chart shows how the Commissioning Locality compares to other Commissioning Localities in terms of their coverage for screening over the past three years . Each vertical line on the yellow bar shows the position of a Commissioning Locality. Your Commissioning Locality is highlighted by the red diamond. Values to the left show lower levels of screening and worse performance and values to the right show higher rates of screening and better performance.





General practice is essential for ensuring young people aged 15-24 years have access to chlamydia screening, particularly in a rural county like Somerset. Consultations with young people in Somerset show that the many would like to be able to access sexual health services via general practice; a local survey showed that 50% would prefer to go to their surgery for a chlamydia test and that general practice was the most popular place for them to accept testing when offered

The numbers of young people testing for chlamydia in Somerset has been declining across all services, but particularly in general practice which is where the majority of tests come from. Somerset now has the second lowest chlamydia detection rate in the South West region (2014). The routine availability of chlamydia screening in general practice is an essential component of the strategy to reduce sexually transmitted infections in young people who carry one of the highest burdens of sexual ill health in Somerset.

Below are some of the tried and tested interventions in general practice known to improve the offer and uptake of chlamydia screening by young people:

- Make it normal, advise it is something that is routinely offered to young people as part of keeping them healthy and link with other health promotion messages
- Ensure that young people are clear that the test is simple, DIY and confidential
- Introduce opportunities not requiring direct nurse/doctor involvement – ensure posters and leaflets are displayed in waiting and treatment rooms and leave kits in grab bins in reception, resources or toilets
- Advise that all young people should have a chlamydia test once a year and with every new partner
- Identify a member of staff as your 'chlamydia screening champion'.
- 76% of practices now have a designated 'chlamydia champion' who is the link person for the chlamydia screening service, updates and alerts are regularly sent along with giving access to helpful resources
- The champion can ensure your surgery maximises every opportunity to promote chlamydia screening. Previous evidence from Somerset shows that those surgeries that nominated a champion saw a significant increase in their test returns e.g. one surgery has increased their screens from 37 a year to consistently achieving well over a hundred screens per year for the past 3 years
- Have a 'whole team' approach and make greater use of all staff in the surgery. This could include reception staff giving out information leaflets or test kits before the young person sees their clinician or the use of health care assistants who can see young people before or after their appointment
- Every time a young person visits their general practice is an opportunity to offer a chlamydia screen
- Tack the offer of a test onto specific clinics e.g. all sexual health and contraceptive clinics, new patient health checks and travel clinics
- Use a 'pop-up' on EMIS for everyone aged 15-24. It is useful to do this for all contraceptive appointments but including everyone ensures that young men are offered the test
- Put the emphasis on 'on site' completion of the test and immediate return – less chance of 'losing it', more chance of 'getting round' to it
- If a young person is with friends offer them all a test
- Make kits available to the partners of young people particularly if they have tested positive through their GP service

Please contact the Somerset Chlamydia Screening Office on 01749 836704 or [Somersetcs@sompar.nhs.uk](mailto:Somersetcs@sompar.nhs.uk) for

- more information on the Somerset Chlamydia Screening programme
- ordering resources such as kits, grab bins, posters, leaflets and window stickers
- arranging a visit by one of the team to advise on how to improve your offer of chlamydia screening



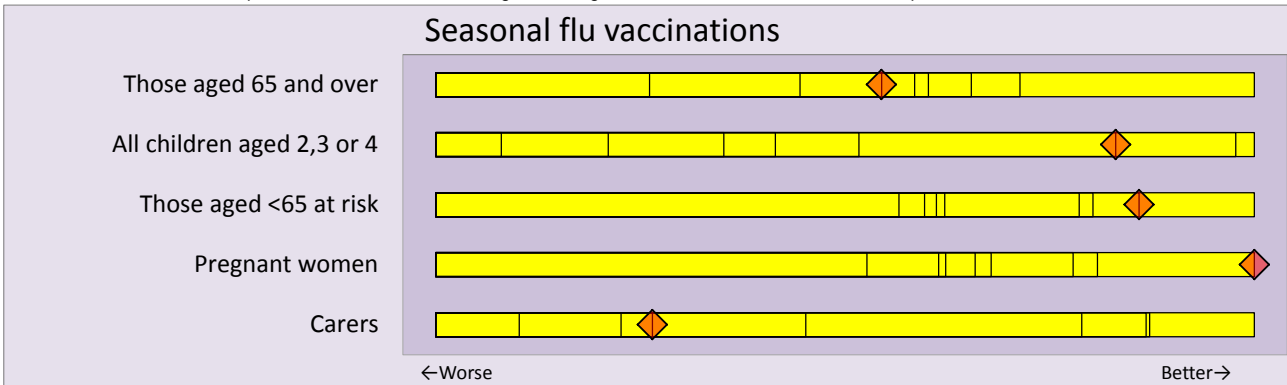
# Central Mendip

## Seasonal flu vaccinations

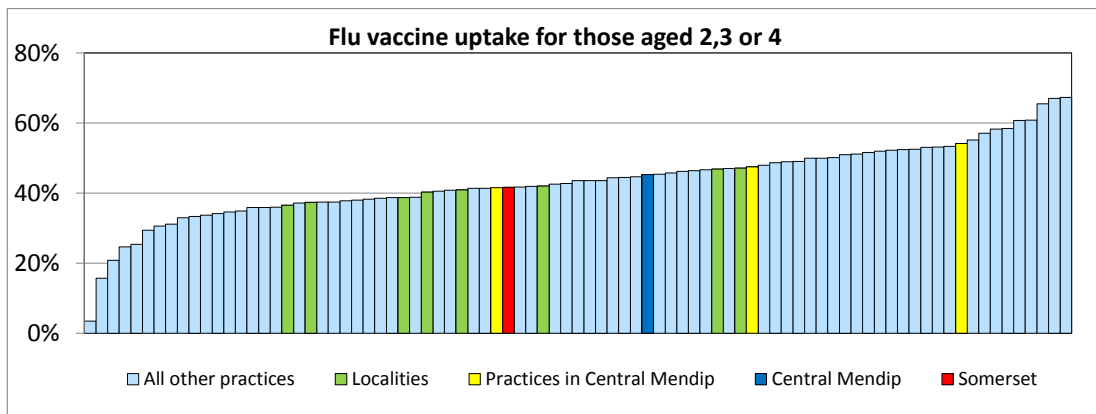
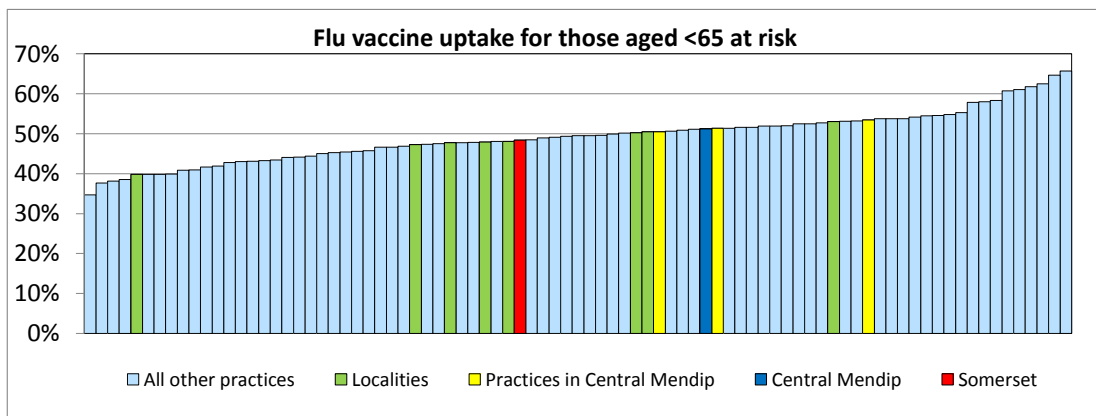
Flu vaccination programme statistics. Winter 2014/15

	Commissioning Locality	Somerset	England	Range of Practice values low / median / high
Those aged 65 and over	70.8%	71.3%	72.7%	62.8% / 71.2% / 81.2%
All children aged 2,3 or 4	45.4%	41.7%	36.9%	3.4% / 43.6% / 67.3%
Those aged <65 at risk	51.2%	48.4%	50.3%	34.7% / 49.5% / 65.7%
Pregnant women	43.5%	37.0%	44.1%	0.0% / 38.5% / 60.0%
Carers	33.1%	36.9%	n/a	12.9% / 37.5% / 66.7%

The bar chart shows how the Commissioning Locality compares to other Commissioning Localities in terms of their immunisation outcomes. Each vertical line on the yellow bar shows the position of a Commissioning Locality. Your Commissioning Locality is highlighted by the red diamond. Values to the left show lower relative levels of immunisation and so worse performance and values to the right show higher rates of immunisation and so better performance.



The Commissioning Locality has the best value in the county for:  
Pregnant women



## Central Mendip

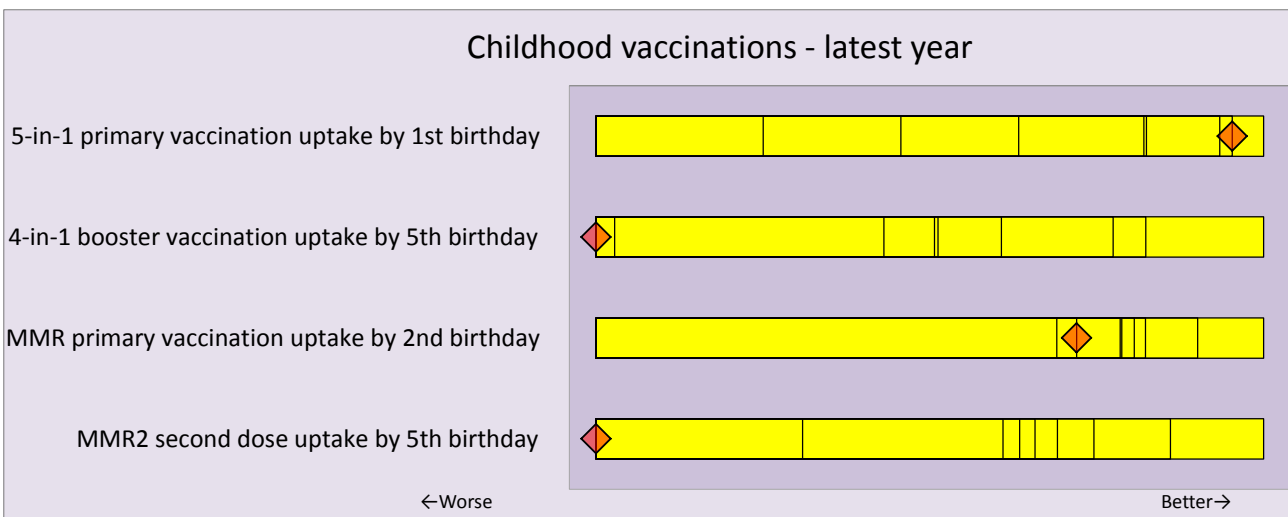
### Childhood Immunisations

Data from NHS England : Child Immunisation Collection 2014/15 outturn - this may not be exactly the same as COVER

2014/15

	Commissioning Locality	Somerset	England	Range of Practice values low / median / high
5-in-1 primary vaccination uptake by 1st birthday	96.6%	95.5%	94.2%	78.2% / 96.1% / 100.0%
4-in-1 booster vaccination uptake by 5th birthday	91.3%	93.8%	88.5%	73.8% / 94.6% / 100.0%
MMR primary vaccination uptake by 2nd birthday	94.8%	94.9%	92.3%	72.9% / 95.0% / 100.0%
MMR2 second dose uptake by 5th birthday	89.4%	92.9%	88.6%	73.8% / 93.3% / 100.0%

The bar chart shows how the Commissioning Locality compares to other Commissioning Localities in terms of their immunisation outcomes. Each vertical line on the yellow bar shows the position of a Commissioning Locality. Your Commissioning Locality is highlighted by the red diamond. Values to the left show lower relative levels of immunisation and so worse performance and values to the right show higher rates of immunisation and so better performance.

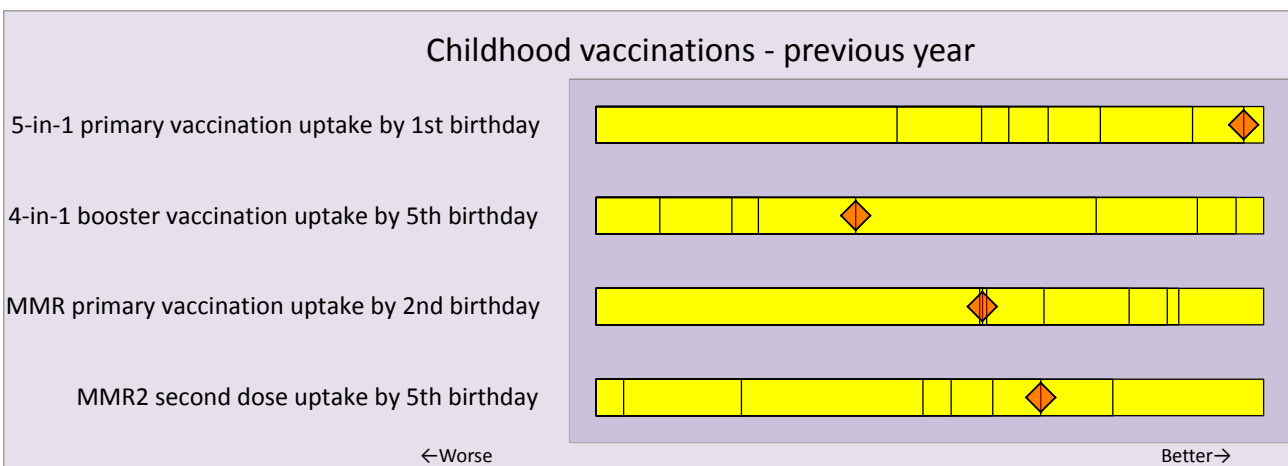


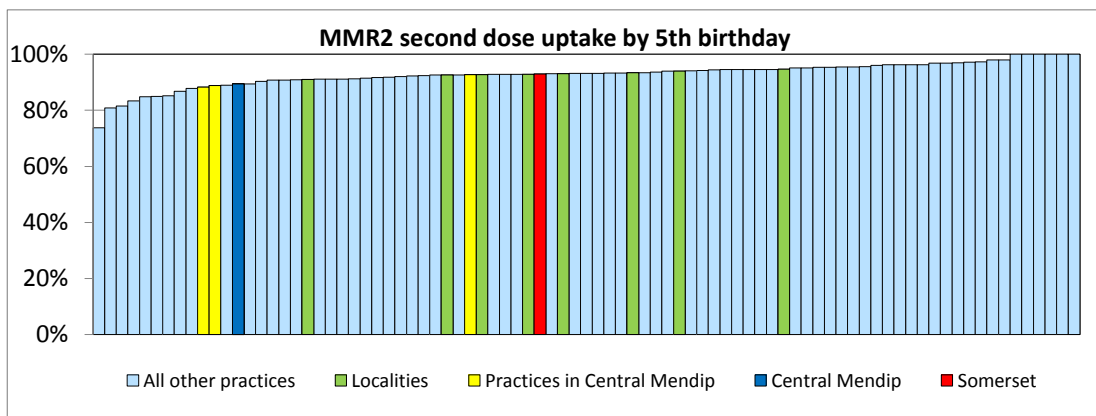
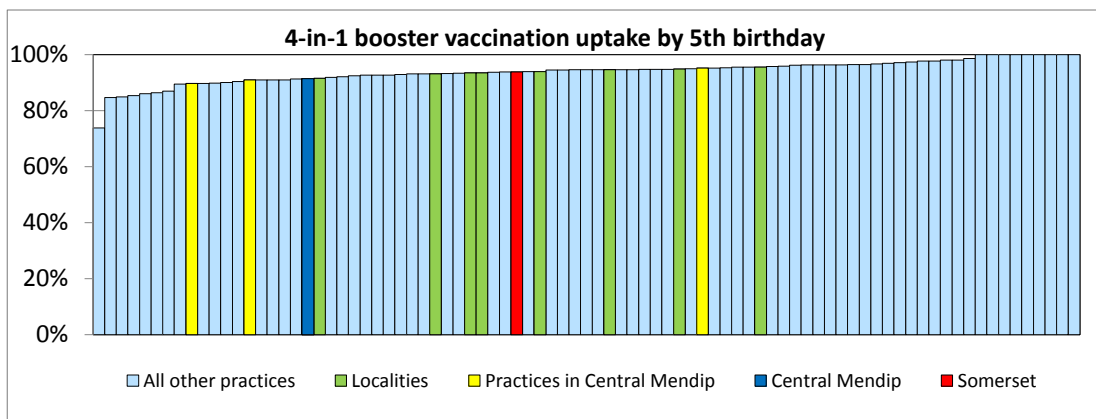
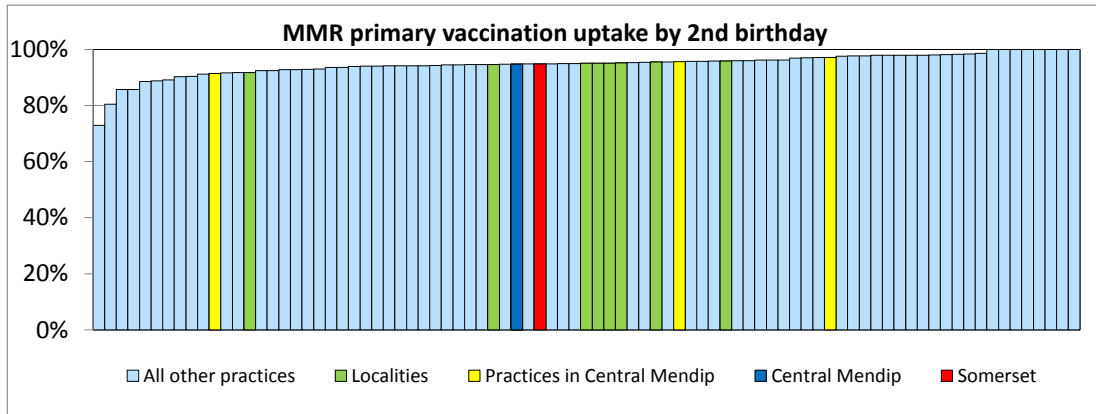
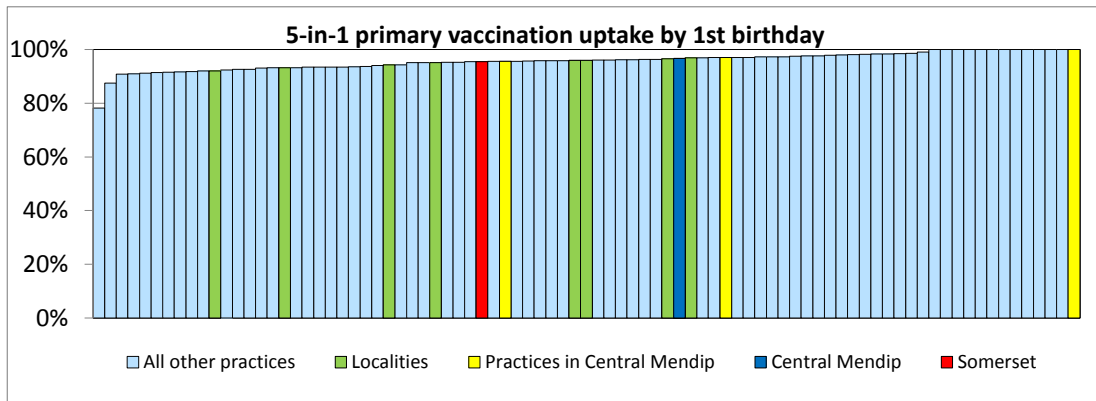
The Commissioning Locality has the worst value in the county for:

4-in-1 booster vaccination uptake by 5th birthday    MMR2 second dose uptake by 5th birthday

2013/14

	Commissioning Locality	Somerset	England	Range of Practice values low / median / high
5-in-1 primary vaccination uptake by 1st birthday	97.1%	95.5%	94.3%	66.0% / 96.3% / 100.0%
4-in-1 booster vaccination uptake by 5th birthday	91.6%	92.0%	88.7%	74.0% / 93.4% / 100.0%
MMR primary vaccination uptake by 2nd birthday	93.0%	93.8%	92.7%	66.1% / 94.7% / 100.0%
MMR2 second dose uptake by 5th birthday	91.1%	90.8%	88.3%	76.0% / 91.7% / 100.0%





# Central Mendip

## Breastfeeding initiation and prevalence at 6-8 weeks

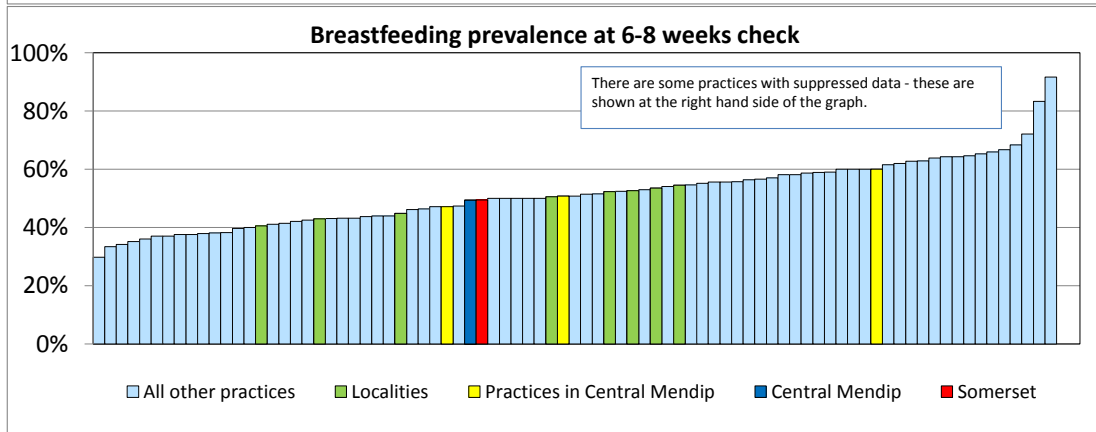
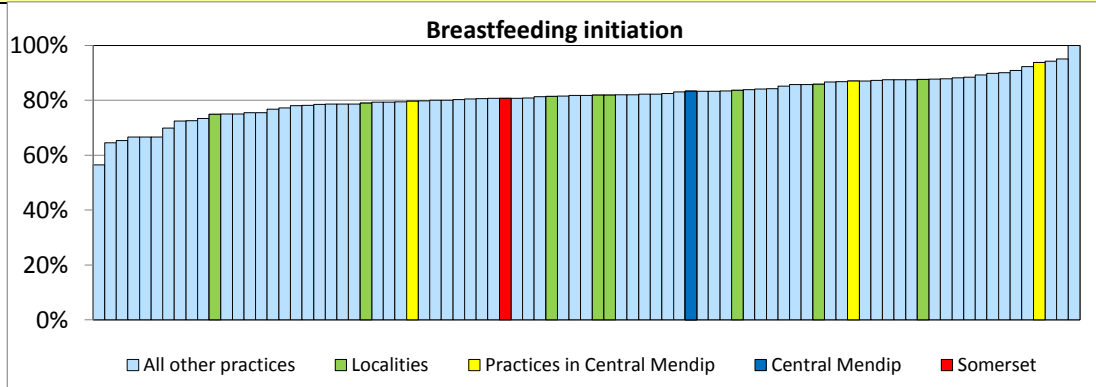
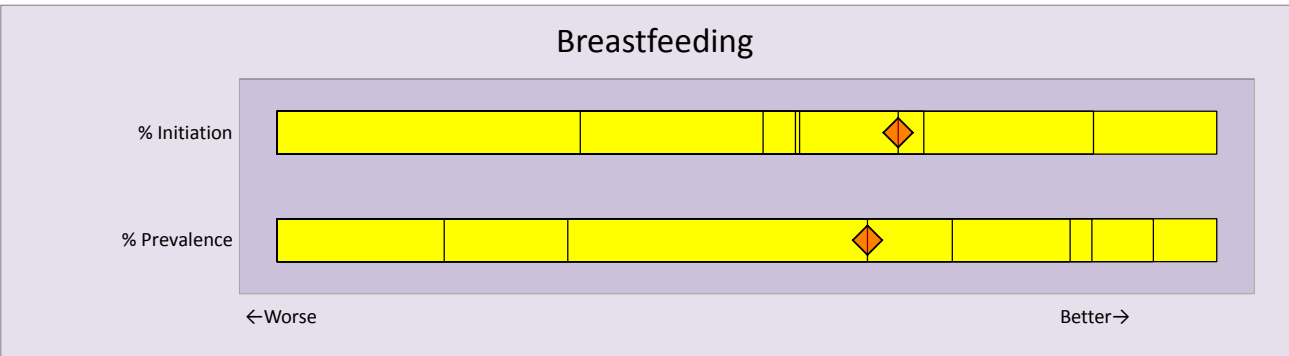
Breastfeeding initiation and prevalence at 6 to 8 weeks data from NHS England  
 Statistical Release: 12 week Maternal Assessment, Breastfeeding Initiation & Breastfeeding prevalence 6-8 weeks at Practice level  
 OT 2014/15

2014/15

Condition	Commissioning Locality	Somerset	England	Range of Practice values low / median / high
Number of maternities	203	5,431	634,378	
Percentage mothers initiating breastfeeding*	83%	81%	74%	57% / 82% / 100%
Number of infants due a check at 6-8 weeks	203	5,281	631,353	
Percentage of infants being wholly or partially breastfed*	49%	49%	44%	30% / 51% / 92%

\* of those with known status

The bar chart shows how the Commissioning Locality compares to other Commissioning Localities in terms of their breastfeeding outcomes. Each vertical line on the yellow bar shows the position of a Commissioning Locality. Your Commissioning Locality is highlighted by the red diamond. Values to the left show lower levels of breastfeeding and worse performance and values to the right show higher rates of breastfeeding and better performance.



# Paediatric Profile



## Central Mendip



Indicator	Central Mendip number	Central Mendip value	Somerset CCG value	Worst Locality value in Somerset	Chart	Best Locality value in Somerset	England value	Worst practice value in Somerset	Best practice value in Somerset	Central Mendip value 2014	Direction of change
1 % of population aged 0-14 *	3,228	20%	19%	20%		15%	21%	26%	11%	17%	Higher
2 Income deprivation affecting Children Index		0.12	0.15	0.20		0.12	0.15	0.25	0.07	0.12	Lower
3 Breastfeeding initiation	169	83%	81%	75%		88%	74%	57%	100%	83%	Improved
4 Breastfeeding prevalence at 6-8 weeks	100	49%	49%	40%		54%		30%	92%	53%	Worsened
5 5-in-1 uptake by age 1	199	97%	95%	92%		97%	94%	78%	100%	97%	Improved
6 4-in-1 booster uptake by age 5	190	91%	94%	91%		96%	89%	74%	100%	92%	Improved
7 MMR uptake by age 2	201	95%	95%	92%		96%	92%	73%	100%	93%	Improved
8 MMR booster uptake by age 5	186	89%	93%	89%		95%	89%	74%	100%	91%	Improved
9 Flu vaccination uptake for 2, 3 and 4yr olds	303	45%	42%	37%		47%	37%	3%	67%	Indicator changed	Indicator changed
10 % Obese in Reception		10%	9%	11%		8%	10%			10%	Worsened
11 % Obese in Year 6		17%	16%	18%		15%	19%			18%	Worsened
12 Teenage deliveries (age<19) in hospital per 1000 F15-17	25	10.4	15.8	22.1		7.6				13.2	Worsened
13 Emergency admission rate per 1000 for accidents (ages 0-17)	209	8.4	9.1	10.7		6.9				9.7	Worsened
14 Admissions for self-harm rate per 1000 (ages 10-24)	78	359.2	493.9	674.8		221.5		2221.3	41.4	308.1	Worsened
15 Emergency admissions rate per 1000 (ages 0-17)	305	76	69	76		60		117	31	68	Worsened
16 Elective admissions rate per 1000 (aged 0-17)	110	27	38	46		27		98	16	24	Worsened
17 First outpatient attendances rate per 1000 (aged 0-17)	904	223	231	250		199		358	158	212	Worsened
18 % lone parent households		8%	8%	9%		6%	11%			8%	Worsened
19 Foundation Stage Profile (FSP) % students NOT achieving a good level of development		34%	38%	60%		32%				Indicator changed	Indicator changed
20 % of pupils with SEN		17%	18%	21%		15%				20%	Worsened
21 Fixed Exclusions per 1000 pupils		28	35	43		26				50	Worsened
22 % Students NOT achieving 5 A*-C GCSEs inc Maths & English		42%	42%	58%		36%				40%	Worsened
23 % of children in low-income families Child Poverty Unit 2013		11%	13%	18%		11%	19%			13%	Worsened
24 Children (0-17) currently in Care per 10,000**	10	24	33	43		22	60			17	Worsened
25 Children (0-17) subject to a Child Protection Plan per 10,000**	12	29	35	55		13	38			25	Worsened

\* This indicator is arbitrarily drawn with a higher proportion shown on the left of the spine chart.

\*\* These indicators are based on the previous configuration of practices in the old Federations.

### Notes and Definitions

The values for the named Commissioning Locality (yellow circles) are compared with the Somerset averages (vertical line). Also shown (where data is available) is the England average (red diamonds). The range of Commissioning Locality values are shown by the grey bars. Better values are plotted to the right.

Some indicators are based on population weighted estimates and so do not have an actual number to show for Commissioning Localities or practices. Other practice data is missing where rates would have been based on very few events. England data is not available for locally calculated rates and some national data was not published because data was not complete.

- Proportion of population aged 0-14 as at April 2015 from Open Exeter GP registrations database.
- Income deprivation affecting Children Index 2015 Department for Communities and Local Government. Commissioning Locality value estimated using a weighted population average as at July 2015.
- Breast feeding initiation 2014/15: Estimated proportion of maternities where breastfeeding was initiated. NHS England.
- Breast feeding prevalence 2014/15: Estimated proportion of infants due checks who were reported as wholly or partially breastfed at 6-8 weeks. NHS England.
- Uptake of 5-in-1 primary vaccination by 1st birthday 2014/15 NHS England
- Uptake of 4-in-1 booster vaccination by 5th birthday 2014/15 NHS England
- Uptake of MMR primary vaccination by 2nd birthday 2014/15 NHS England
- Uptake of MMR booster vaccination by 5th birthday 2014/15 NHS England
- Uptake of vaccination by those aged 2, 3 and 4 during 2014/15 influenza season. NHS England.
- Proportion of children measured in Reception classes who had a Body Mass Index assessed as Obese for their age. 2009/10 - 2013/14 National Child Measurement Programme.
- Proportion of children measured in Year 6 classes who had a Body Mass Index assessed as Obese for their age. 2009/10 - 2013/14 National Child Measurement Programme.
- Number of deliveries in hospital to women aged less than 19, per 1000 females aged 15-17. April 2009 to March 2015 Secondary Uses Services (SUS) hospital activity data.
- Emergency admissions for accidents per 1000 children aged 0-17. April 2009 to March 2015 Secondary Uses Services (SUS) hospital activity data.
- Admissions for self-harm per 100,000 children and young people aged 10-24. April 2009 to March 2015 Secondary Uses Services (SUS) hospital activity data.
- Emergency admissions for any cause per 1000 children aged 0-17. April 2014 to March 2015 Secondary Uses Services (SUS) hospital activity data.
- Elective (day case or inpatient) admissions for any cause per 1000 children aged 0-17. April 2014 to March 2015 Secondary Uses Services (SUS) hospital activity data.
- First outpatient attendances (a proxy for referral) for any cause per 1000 children aged 0-17. April 2014 to March 2015 Secondary Uses Services (SUS) hospital activity data.
- Proportion of households where there is a lone parent. Census 2011.
- Proportion of children not achieving a good level of development, Foundation Stage Profile (FSP). 2014 Somerset County Council.
- Proportion of children with Special Educational Needs. 2014 Somerset County Council.
- Number of Fixed exclusions from school per 1000 pupils. 2014 Somerset County Council.
- Proportion of children NOT achieving 5 A\*-C GCSEs including Maths and English. 2014 Somerset County Council.
- Proportion of children in low-income families. Child Poverty Unit 2013.
- Children age 0-17 who are currently in Care and known to be living or placed in Somerset per 10,000. As at August 2015. Somerset County Council.
- Children age 0-17 who are subject to a Child Protection Plan and known to be living or placed in Somerset per 10,000. As at August 2015. Somerset County Council.

The profile contains information on the following lifestyle aspects of the local population:

- Obesity as assessed by the National Child Measurement Programme
- Obesity in adults
- Smoking prevalence
- Smoking cessation statistics
- Alcohol standardised admissions and mortality
- Drug misuse standardised admissions and mortality

Childhood obesity affects the ability to study, take part in physical activity and social activities. The National Child Measurement Programme (NCMP) measures the weight and height of children in reception class (aged 4 to 5 years) and year 6 (aged 10 to 11 years) to assess overweight children and obesity levels within primary schools. The measurement process is overseen by trained healthcare professionals in schools. The county council is responsible for the organisation of the local programme. Children's heights and weights are measured and used to calculate a Body Mass Index (BMI) centile based on the UK90 reference population. For population monitoring purposes, children above 85th centile are classified as overweight and above 95th centile as obese. Rates across England and Somerset show more children falling into the overweight and obese categories than might be expected. Population weighted averages of the rates in the areas where children live is used to estimate the rates in each Commissioning Locality.

Adult obesity is assessed based on raw BMI, kg/m<sup>2</sup>. This data is taken from practice clinical records via the MIQUEST tool and looks at people measured as obese in the previous 15 months and so might not include all obese patients.

Smoking is the lifestyle feature which has the largest impact on individual health. Smoking ascertainment and prevalence are presented along with a range of statistics which highlight how well the smoking cessation process is operating. Somerset in general has lower rates of smoking than England but, despite recent improvements, still has much higher than average rates of smoking during pregnancy as assessed at time of delivery. More detail on local evidence based interventions to improve smokers' health is given on page 48.

Alcohol related admissions are more of a problem in Somerset than England as a whole and young people in particular show increased needs. There is increasing recognition of the damage that chronic excessive social drinking can cause. Although drug misuse affects a small proportion of the population than other lifestyle behaviours, the scale of impact can be far greater and it causes a disproportionate amount of human misery and takes a disproportionate amount of funding. Somerset Drug and Alcohol Service website provides a range of resources for professionals and the public to support healthier behaviour change <http://www.somersetdap.org.uk/>

# Central Mendip

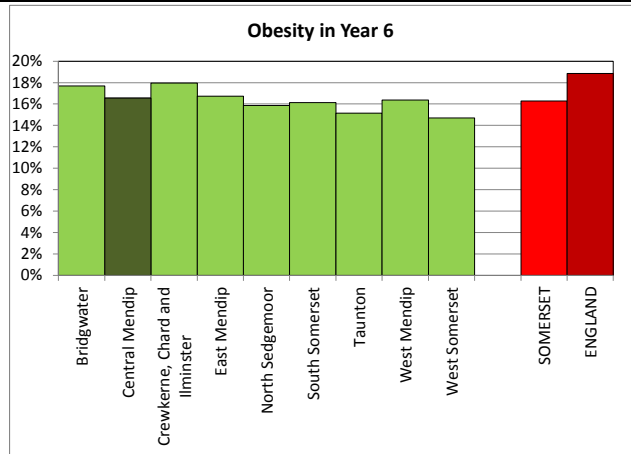
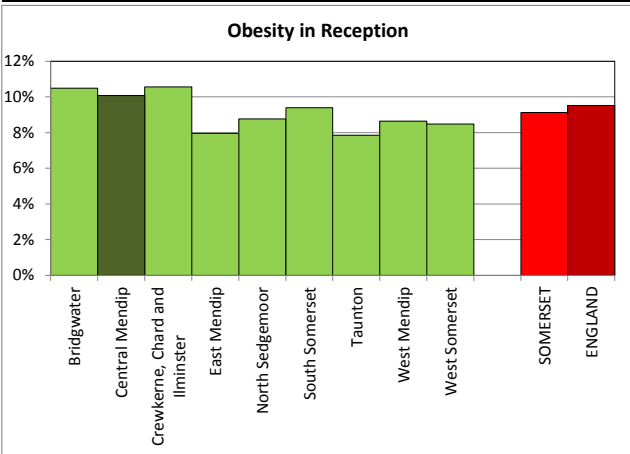
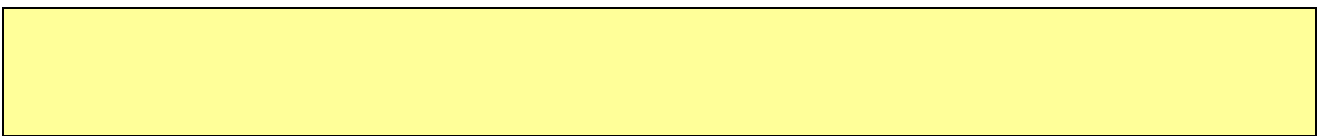
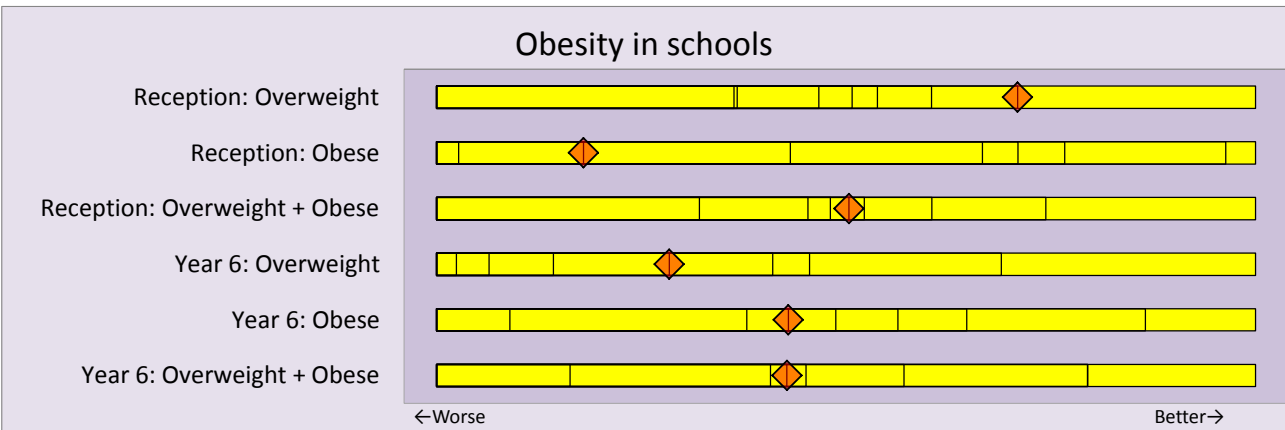
## Obesity in schools

National Child Measurement Programme (NCMP) Reception and Year 6 measurements 2009/10 - 2013/14

2009/10 - 2013/14

	Commissioning Locality	Somerset	England	Range of Practice values low / median / high
Reception: Overweight	14%	14%	13%	
Reception: Obese	10%	9%	10%	
Reception: Overweight + Obese	24%	23%	23%	
Year 6: Overweight	14%	14%	14%	
Year 6: Obese	17%	16%	19%	
Year 6: Overweight + Obese	31%	30%	33%	

The bar chart shows how the Commissioning Locality compares to other Commissioning Localities. Each vertical line on the yellow bar shows the position of a Commissioning Locality. Your Commissioning Locality is highlighted by the red diamond. Values to the left show higher relative levels of overweight and obesity and so worse performance and values to the right show lower rates and so better performance.



## Central Mendip

### Obesity in adults (rate per 1000)

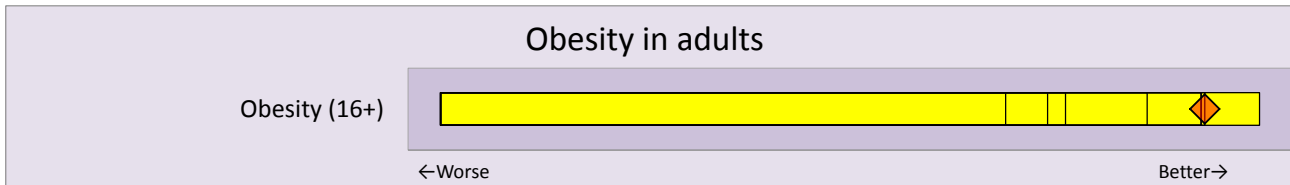
Age/sex standardised prevalence rates using Quality Outcome Framework crude prevalence, Exeter system population downloads and Somerset wide age/sex specific rates from MIQUEST queries run by the CSU.

The Quality Outcome Framework indicators are reported annually through the Health and Social Care Information Centre website.

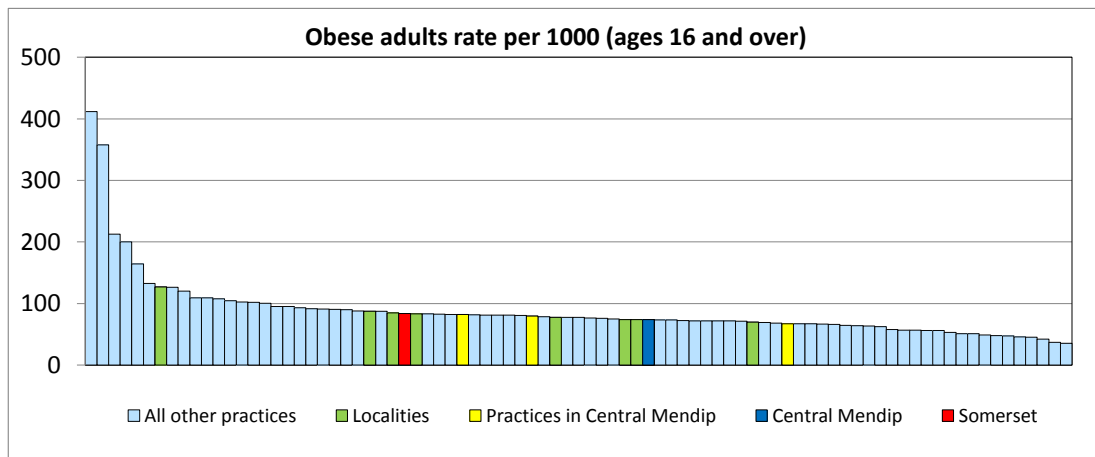
2015

Condition	Observed in Commissioning Locality	Expected in Commissioning Locality (based on Somerset rates)	Commissioning Locality rate	Somerset rate	England rate	Range of Practice values low / median / high
Obesity (16+)	1,173	1,331	74	84	104	35 / 76 / 412

The bar chart shows how the Commissioning Locality compares to other Commissioning Localities. Each vertical line on the yellow bar shows the position of a Commissioning Locality. Your Commissioning Locality is highlighted by the red diamond. Values to the left show higher relative levels of overweight and obesity and so worse performance and values to the right show lower rates and so better performance.



**Significantly better than county average for:**  
Obesity (16+)





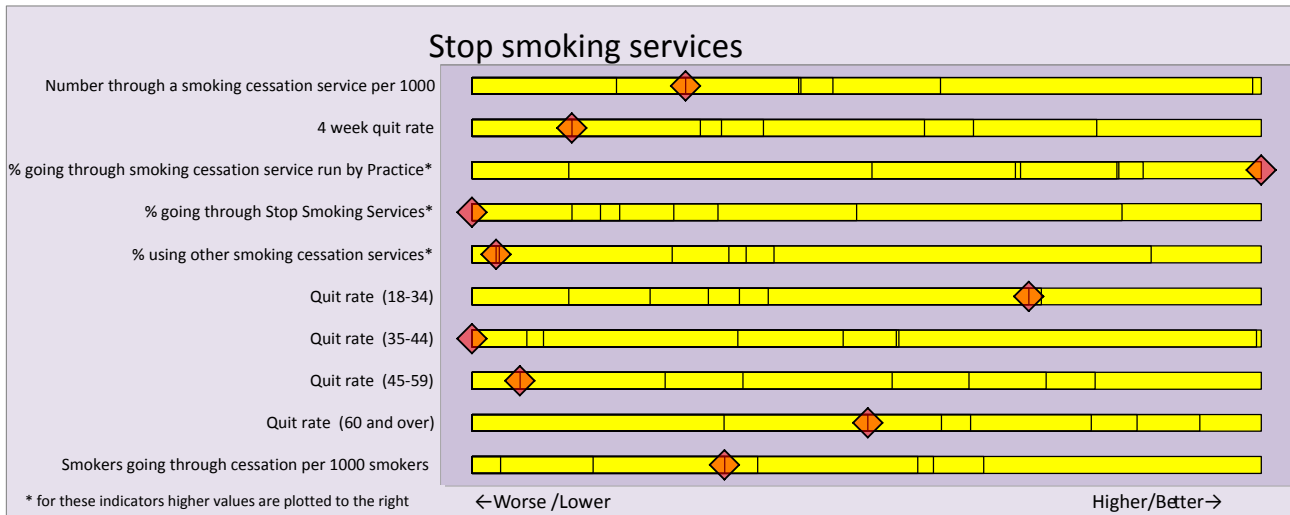


**Stop smoking services provision April 2013 to March 2015**

Smoking cessation services database

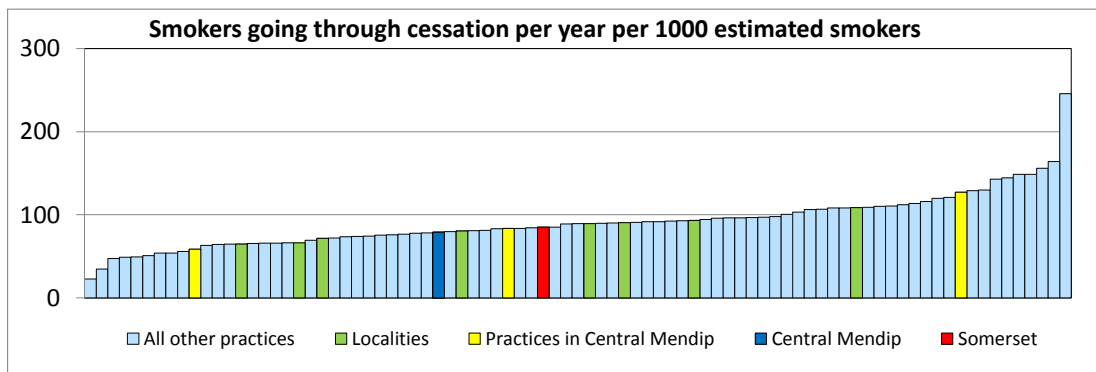
	Commissioning Locality	Somerset	England	Range of Practice values low / median / high
Number going through a smoking cessation service	428	11,161		
Number going through a smoking cessation service per 1000 population per year	11.1	10.0		2.9 / 9.7 / 72.8
Number quit (4 week)	164	4,709		
Number not quit (4 week)	224	5,319		
Number unknown quit status (4 week)	40	1,133		
4 week quit rate	38%	42%		29% / 41% / 63%
% going through smoking cessation service run by Practice	93%	79%		0% / 86% / 98%
% going through Stop Smoking Services	6%	19%		1% / 12% / 97%
% using other smoking cessation services	0%	2%		0% / 1% / 29%
Quit rate for those aged 18-34	39%	37%		14% / 36% / 100%
Quit rate for those aged 35-44	38%	44%		16% / 43% / 75%
Quit rate for those aged 45-59	36%	42%		23% / 43% / 73%
Quit rate for those aged 60 and over	48%	51%		10% / 50% / 86%
Smokers going through cessation per year per 1000 estimated smokers	79	85		23 / 90 / 246

The bar chart shows how the Commissioning Locality compares to other Commissioning Localities. Each vertical line on the yellow bar shows the position of a Commissioning Locality. Your Commissioning Locality is highlighted by the red diamond. For consistency, values to the left show worse performance and to the right better performance which may be higher or lower absolute values.



**The Commissioning Locality has the best/highest value in the county for:**  
 % going through smoking cessation service run by Practice

**The Commissioning Locality has the worst/lowest value in the county for:**  
 % going through Stop Smoking Services    Quit rate for those aged 35-44



Smoking evidence based interventions

- GPs to deliver brief or very brief interventions to identified smokers**, offering referral to those who express an interest in quitting, and offering help in the future for those who not ready to quit in the short term. VBI should be based on the NCST/BMJ Learning Module. Qualifies for 1 hour CPD/CME.

[http://learning.bmj.com/learning/module-intro/advice-smoking.html?moduleId=10032720&locale=en\\_GB](http://learning.bmj.com/learning/module-intro/advice-smoking.html?moduleId=10032720&locale=en_GB)

Note that brief advice, alone, is significantly more effective than many standard medical treatments as shown in the table below, emphasising the importance of delivering this intervention well.

Intervention	Outcome	NNT
Statins	Prevent one death over five years	107
Antihypertensive therapy	Prevent one stroke, MI, death over one year	700
Cervical cancer screening	Prevent one death over ten years	1140
GP brief advice to stop smoking (five minutes)	Prevent one premature death	80

- Referral of smokers to stop smoking services.** Smokers who express an interest in quitting in the near future should be referred to the Smokefreelife Somerset service for support <http://www.smokefreelifesomerset.co.uk/>. Smokers attending a NHS stop smoking service are up to 5 times more likely to quit than people quitting cold turkey or using OTC NRT. GPs should not normally prescribe stop smoking meds without behavioural support. If a smoker does not wish to be referred to a stop smoking practitioner, then it may be appropriate to provide a prescription, but other forms of support should be offered such as those available from the NHS Smokefree website, such as text, app and email. Repeat prescriptions should not be offered, with the patient referred to Smokefreelife Somerset to discuss options. There is a strong evidence base for the effectiveness of the text support service. Patients wishing to quit using electronic cigarettes/vaporisers will need to supply their own device, but are otherwise fully able to access Smokefreelife Somerset services.
- Practice records should be used to identify chronic disease patient groups for intervention.** In particular, patients with COPD who are continuing smokers should be a priority. Stop smoking groups specifically for COPD patients have been successful elsewhere, and would be worth trying in communities where there is sufficient interest. Smokefreelife Somerset should be contacted regarding facilitating such groups.
- Support for those likely to be hospitalised to quit smoking.** For patients likely to be admitted to hospital, GPs should ensure that patients are aware that hospitals are non-smoking sites (buildings and grounds) and that they will NOT be permitted to smoke anywhere on the site. They should then be offered support, either to quit prior to admission via Smokefreelife Somerset, or if unwilling to do so, should be prescribed NRT (preferably 2 products, patch plus a faster acting product such as lozenge) to enable temporary abstinence while in hospital, which they should start using a few days before admission.
- Engagement with the Stop Smoking Service provider.** Commissioning Localities and practices should work closely with Smokefreelife Somerset to ensure that stop smoking services are available to patients, and that referral processes are effective. The service has a GP and Pharmacy Co-ordinator, Sarah Westlake, who can be contacted via 01823 765006,

For the most part support is already available to practices for all the above from Smokefreelife Somerset. Public health can offer additional support if the Commissioning Localities wish to address any of the above at the larger geographic level. If you would like to work up any proposals please contact Stewart Brock, [sbrock@somerset.gov.uk](mailto:sbrock@somerset.gov.uk)

## Central Mendip

**Standardised admission and mortality rates for alcohol related conditions and drug misuse per 100,000 population per year**

SUS Inpatient activity files April 2010 to March 2015 ONS Primary Care Mortality Database 2010-14. Population files July 2010-July 2014. Admissions indirectly standardised rate by age/sex and Deaths indirectly standardised rate by age/sex.

**Alcohol:** The North West Public Health Observatory has produced a list of conditions that they consider could have an alcohol related component. Each condition is allocated an Attributable Fraction, which is dependent on age and sex, that describes what proportion of admissions from that cause could be attributable to alcohol. These rates have been increasing year on year throughout the country. A very small percentage of admissions were excluded because of unknown age or gender.

Alcohol specific conditions are a subset of alcohol related conditions that can directly be attributable to alcohol.

**Drug related harm:** is represented according to the number of admissions which are judged as being related to drugs or deaths related to drug misuse. The National Treatment Agency for Substance Misuse guidance, Undertaking Needs Assessment – Drug Treatment (2009) recommended the following ICD10 codes: F10-F16, F18-F19, X42, X62 or Y12 in either the main diagnosis field or a secondary diagnosis field to identify substance misuse. **F10** relates to alcohol and is the major contributing code to substance misuse it is **excluded** in the following drug misuse indicators.

A small number of admissions were excluded because of unknown age or gender.

	Commissioning Locality rate	Somerset rate	England (average annual value 2010/11 to 2014/15)	Range of Practice values low / median / high
Alcohol related admissions	1,595	1,862	2,056	1214 / 1775 / 4622
Alcohol specific admissions	340	435		104 / 403 / 2154
Admissions for Alcoholic liver disease (K70)	55	81		0 / 67 / 344
Admissions for Alcoholic cirrhosis of liver (K703)	19	41		0 / 29 / 278
People admitted for Alcohol related conditions	809	844		634 / 829 / 2181
People admitted for Alcohol specific conditions	226	243		96 / 227 / 1130
People admitted for Alcoholic liver disease (K70)	29	30		0 / 29 / 88
People admitted for Alcoholic cirrhosis of liver (K703)	10	16		0 / 15 / 49
Alcohol related deaths	32	29		
Drug misuse related admissions	95	134		22 / 101 / 606
Drug misuse deaths	2	3		
Alcohol specific OR drug misuse deaths	16	15		

The bar chart shows how the Commissioning Locality compares to other Commissioning Localities. Each vertical line on the yellow bar shows the position of a Commissioning Locality. Your Commissioning Locality is highlighted by the red diamond. Values to the left show higher rates of harm and so worse performance.



**The Commissioning Locality has the worst value in the county for:**

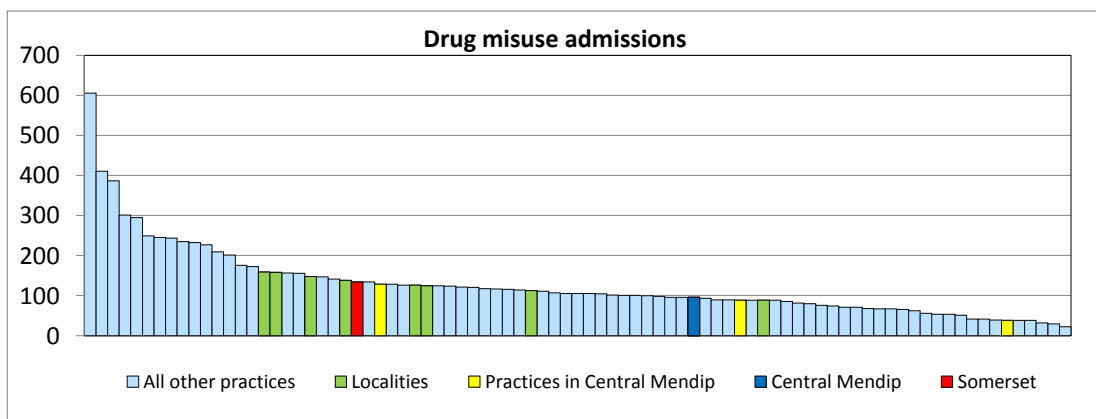
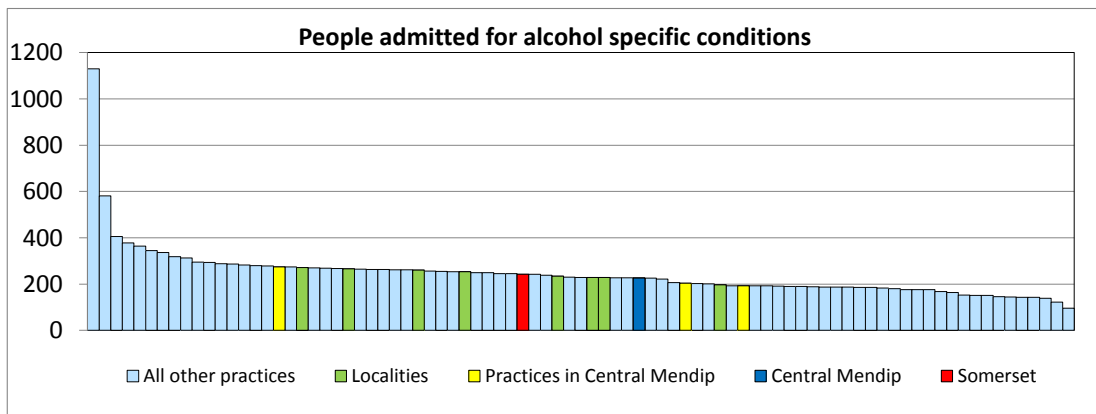
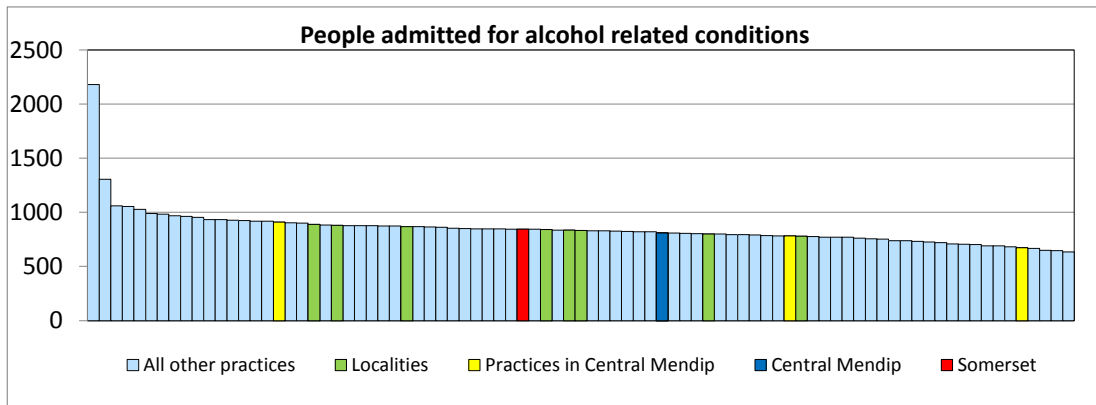
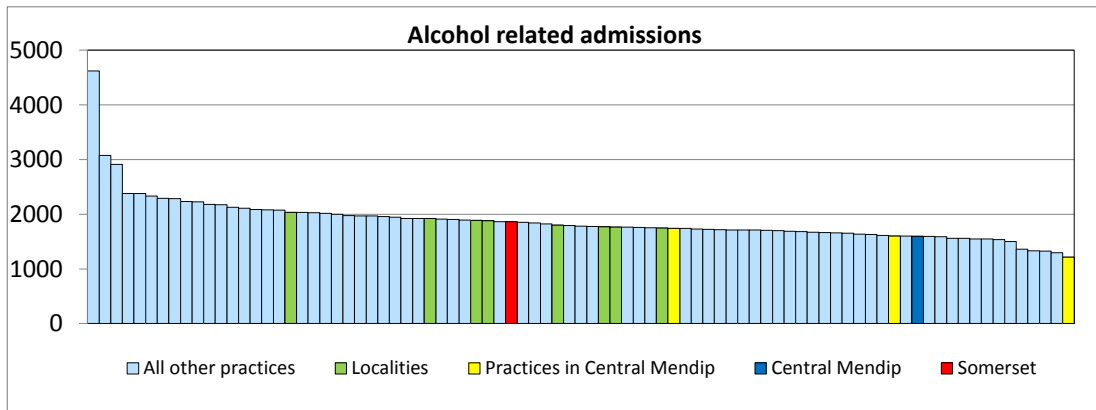
Alcohol related deaths

**Significantly better than county average for:**

Alcohol related admissions    Alcohol specific admissions    Admissions for Alcoholic liver disease (K70)    Admissions for Alcoholic cirrhosis of liver (K703)    Drug misuse related admissions

**The Commissioning Locality has the best value in the county for:**

Alcohol related admissions    Alcohol specific admissions    Admissions for Alcoholic liver disease (K70)    Admissions for Alcoholic cirrhosis of liver (K703)    People admitted for Alcoholic cirrhosis of liver (K703)



The profile contains information on aspects relating to hospitalisation:

- Admission rates for specific conditions of interest: Self-harm and Mental and Behavioural disorders, falls, accidents to children, teenage deliveries
- Emergency admission rates
- Emergency admission rates for specific conditions of interest: CHD , CVD, COPD, Asthma and Diabetes
- Elective admissions rates
- Out patient attendances rates

This data enables scrutiny at a more local level of causes for emergency admissions. Emergency admissions – that is, admissions that are not predicted and happen at short notice because of perceived clinical need (NHS Connecting for Health 2010) – represent around 65 per cent of hospital bed days in England. In 2012-13, over a quarter of all patients attending major A&E departments were admitted, up from 19 per cent in 2003-04. This resulted in 5.3m emergency admissions at a cost of £12.5bn.

Whilst many admissions may be unavoidable, avoiding unnecessary emergency hospital admissions is a major concern for the NHS, not only because of the high and rising costs of emergency admission compared with other forms of care, but also because of the disruption it causes to elective health care – most notably inpatient waiting lists – and to the individuals admitted (Audit Commission 2009). It is recognised that a lack of alignment between hospitals and community and local services in the hours they are open compromises efforts to avoid out-of- hours hospital admissions and prolongs the length of stay of inpatients.

Rates of emergency admissions may indicate poorer patient management which has led up to a crisis point and thus indicate where improvements in primary care could be targeted to good effect. It is recommended that clinical commissioning groups to use data on variations in emergency admissions from ACSCs by constituent practices to understand variations in the quality of general practice as one of the causes. A recent NAO report (<http://www.nao.org.uk/wp-content/uploads/2013/10/10288-001-Executive-Summary.pdf>) estimates that 20% of admissions could be managed effectively in the community. Ambulatory care sensitive conditions (ACSCs) have been defined as chronic conditions for which it is possible to prevent acute exacerbations and reduce the need for hospital admission through active management, such as vaccination; better self-management, disease management or case management; or lifestyle interventions. Examples include congestive heart failure, diabetes, asthma, angina, epilepsy and hypertension. Focus on these conditions is one of the key proposed interventions to reduce overall emergency admissions. A 2012 Kings Fund briefing suggested that emergency admissions for ACSCs could be reduced by between 8 and 18 per cent resulting in savings of between £96 million and £238 million per year. Influenza, pneumonia, COPD, congestive heart failure, dehydration and gastroenteritis account for more than half (53 per cent) of the cost of emergency ACSCs admissions.

The 19 ambulatory care-sensitive conditions - NHS Institute for Innovation and Improvement	
<b>Vaccine-preventable</b>	<b>Acute</b>
1. Influenza and pneumonia	11. Dehydration and gastroenteritis
2. Other vaccine-preventable conditions	12. Pyelonephritis
	13. Perforated/bleeding ulcer
<b>Chronic</b>	14. Cellulitis
3. Asthma	15. Pelvic inflammatory disease
4. Congestive heart failure	16. Ear, nose and throat infections
5. Diabetes complications	17. Dental conditions
6. Chronic obstructive pulmonary disease (COPD)	18. Convulsions and epilepsy
7. Angina	19. Gangrene
8. Iron-deficiency anaemia	
9. Hypertension	
10. Nutritional deficiencies	

For Somerset other indications are of relevance and interest such as rates of admissions for falls, especially rates in older people given the local population structure. Somerset has significantly higher rates of hospital admissions for self-harm than the rest of England. Guidance from NICE on common mental health disorders in primary care has been released at <http://pathways.nice.org.uk/pathways/common-mental-health-disorders-in-primary-care/common-mental-health-disorders-inprimary-care-overview>.

## Central Mendip

### Standardised admission rates for self-harm and Mental and Behavioural disorders per 100,000 population per year

SUS Inpatient activity files April 2009 to March 2015 and ONS Population files July 2009-July 2014. Indirectly standardised rates by age/sex.

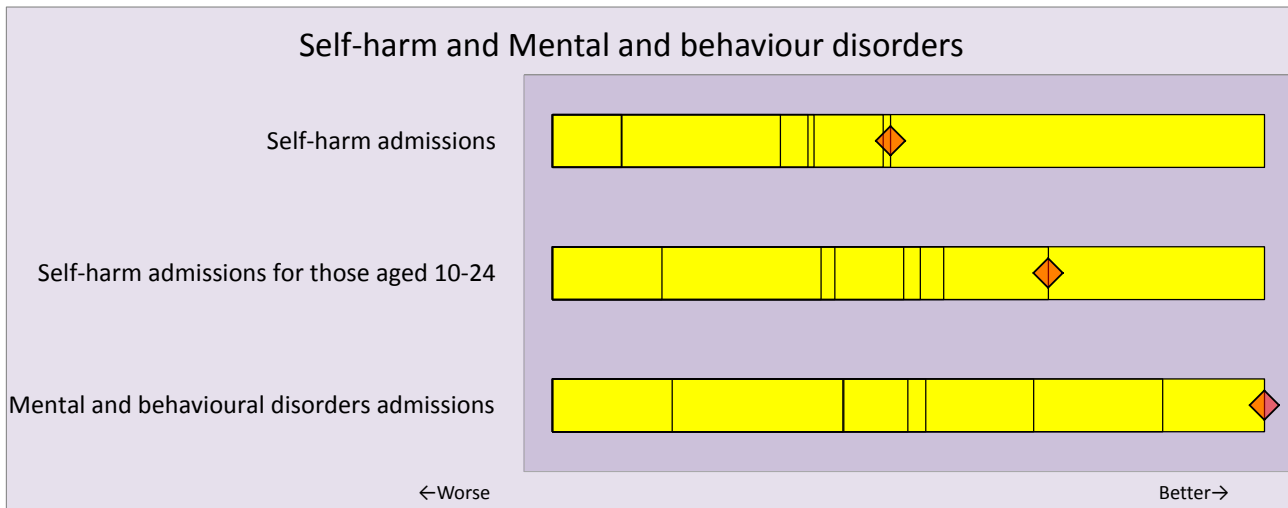
Admissions to hospital with any diagnosis of self-harm or self-injury of undetermined intent.

Admissions with a primary diagnosis in the Mental and Behavioural Disorders chapter of the International Classification of Diseases.

A very small percentage of self-harm admissions and mental and behavioural disorder admissions were excluded because of unknown age or gender.

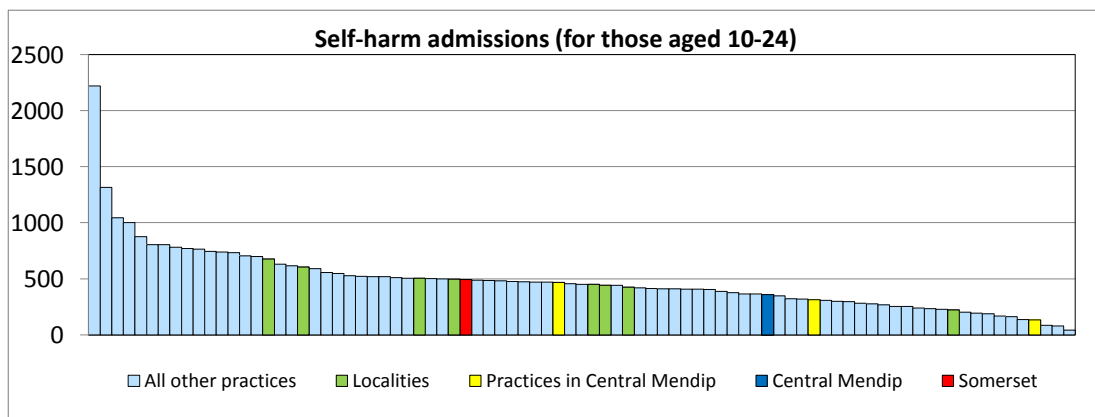
2009/10 - 2014/15

	Commissioning Locality rate	Somerset rate	England	Range of Practice values low / median / high
Self-harm admissions	203	228		68 / 219 / 883
Self-harm admissions for those aged 10-24	359	494		41 / 451 / 2,221
Mental and behavioural disorders admissions	196	259		115 / 229 / 1,166



**Significantly better than county average for:**  
Mental and behavioural disorders admissions

**The Commissioning Locality has the best value in the county for:**  
Mental and behavioural disorders admissions



# Central Mendip

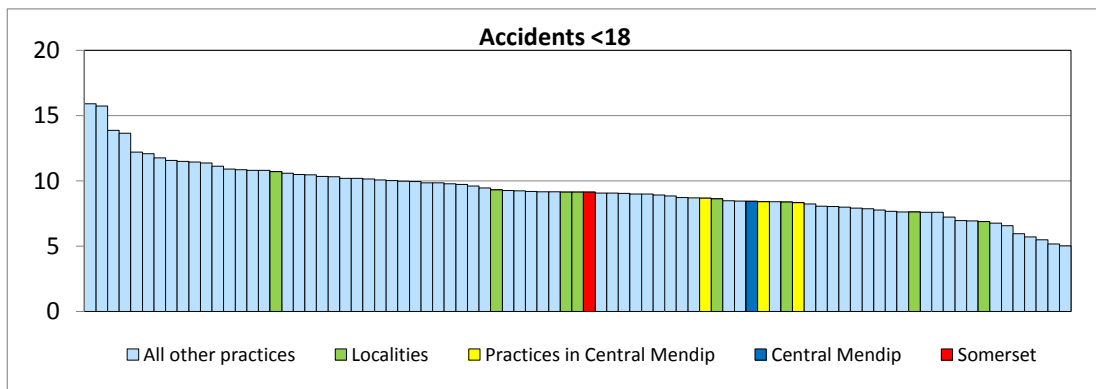
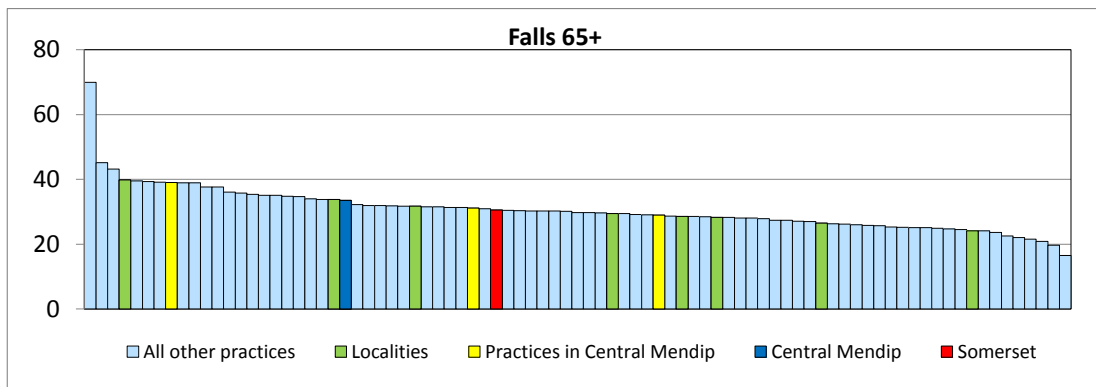
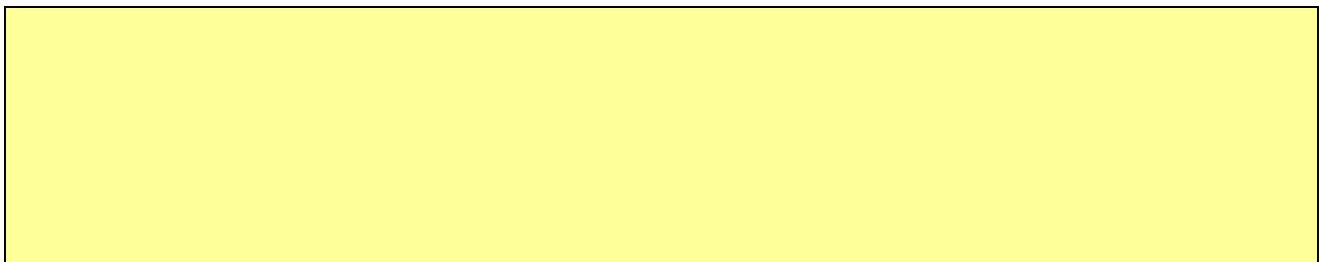
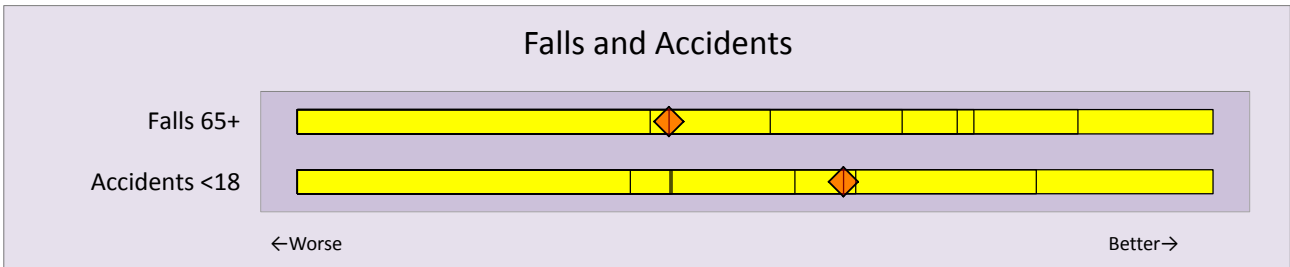
**Standardised emergency admission rates for Falls per 1000 population aged 65 and over and for accidents per 1000 population aged <18**

SUS Inpatient activity files April 2010 to March 2015 and ONS Population files July 2010-July 2014. Indirectly standardised rate by age/sex.

Admissions to hospital with any diagnosis indicating a fall, for those aged 65 and over and any diagnosis indicating an Accident for those aged <18. No admissions were excluded because of unknown gender.

April 2012 to March 2015

	Commissioning Locality rate	Somerset rate	England	Range of Practice values low / median / high
Falls 65+	33	31		17 / 30 / 70
Accidents <18	8.4	9.1		5.0 / 9.2 / 15.9





### Falls and Bone Health evidence based interventions

Falls are a major cause of injury, disability and mortality among older people, however there are many opportunities to reduce the risk of falls. It is also essential we support individuals to build and maintain optimum bone strength across the life course, assisting with maintenance of bone density into older age. During 2014/15 in Somerset approximately 4200 people aged 65 and over were admitted to hospital as a result of a fall and with our increasingly ageing population these numbers are set to continue to rise, we know that over 70% of falls go unreported placing an older person at risk of a more serious fall.

Hip fractures are costly both to the NHS and individuals. In Somerset each hip fracture costs the NHS over £6300 (2015) with additional substantial community hospital and social care costs, with 855 hip fractures during 2014/15 this amounts to approximately £5.4 million. In addition research has shown that up to 30% of people die within a year following a hip fracture and a further 20% have reduced capacity to live independently.

Alongside emphasis on falls reduction, diagnosing and treating osteoporosis is essential as 40-50% of women over 50 will experience a fragility fracture and 13-22% of men. Research also shows up to 50% of people who fracture a hip have sustained a previous fracture and a missed opportunity of diagnosis. In Somerset it is predicted 15,966 (12.6%) women have osteoporosis without a prior fracture and 14,949 (11.8%) women have osteoporosis with clinically apparent osteoporotic fragility fractures (2015).

Over the past few years national initiatives have been introduced and Somerset now has Bone Health and Falls pathways to provide comprehensive information and guidance for health professionals and other organisations. These are available on the Somerset Pathway Navigator App. The Bone Health pathway has sections on Healthy living for stronger bones; Who is at risk of osteoporosis; After fracture and End of life.

#### 1) Primary diagnosis of osteoporosis

It is imperative we identify those with osteoporosis who are at risk of fragility fracture early on. Visit Somerset Bone Health pathway 'Who is at risk of osteoporosis' section via Navigator, this is supported by NICE Clinical Guidance CG 146 (2012) <http://publications.nice.org.uk/osteoporosis-assessing-the-risk-of-fragility-fracture-cg146>. The pathway suggests considering assessment in all women over 65 and men over 75, or younger if specific risk factors are present (including some health conditions/diseases – secondary causes, family history of osteoporosis, use of glucocorticoids, low BMI, smoking and more than 3 units of alcohol daily), using FRAX [www.shef.ac.uk/FRAX/tool.jsp?country=1](http://www.shef.ac.uk/FRAX/tool.jsp?country=1) to assess fracture risk, and a DXA scan where indicated.

#### 2) Interventions including medication

When osteoporosis is diagnosed appropriate medication should be prescribed, as per NICE technology appraisals TA160 (2011) and TA204 (2010). Adherence to treatment regimens should be regularly reviewed. These guidelines also highlight the importance of a balanced diet with adequate levels of calcium and vitamin D and if people are not receiving an adequate amount of these nutrients through their diet prescribe vitamin D and calcium supplements. Safe exposure to sunlight is also important and should be recommended.

#### 3) Physical function and health issues

The Somerset Falls Pathway and Falls Risk Assessment Tool in Somerset (FRATiS) (visit Somerset Pathway Navigator App) assist in identifying specific risk factors and is used as a trigger for appropriate onward referral. This asks:

- Is there a history of any fall in the previous year?
- Is the patient/client on four or more medications per day?
- Does the patient/client have a diagnosis of stroke or Parkinson's Disease?
- Does the patient/client report any problems with his/her balance?
- Is the patient/client unable to rise from a chair of knee height (without assisting themselves)?
- It also includes a safe at home hazard assessment.

A positive response to three or more of the questions would indicate increased risk and a need for referral or other intervention.

#### 4) Importance of physical activity

Evidence highlights that exercise programmes focusing on improving balance targeted at older high risk fallers, particularly those who have a history of falling, or a fear of falling are most effective in reducing falls and moderate injuries. A Cochrane review (2011) considered the evidence of exercise to improve bone health in postmenopausal women and found less BMD loss at the spine and neck of femur for those who were most active. Exercise also improves balance and maintains muscle strength. There are a range of exercise opportunities for individuals ranging from specialist Balance and Safety classes at Community Hospitals to community based modified tai chi and exercise for improving balance. The Zing website has details [www.zingsomerset.co.uk](http://www.zingsomerset.co.uk).

#### 5) Psychological aspects

It is widely recognised that psychological function has an impact on falls, this can be linked to specific cognitive problems but also to anxiety and a fear of falling, this can lead to avoidance of activity, further muscle and balance deterioration and reduced quality of life. It is important to break the cycle of anxiety; rehabilitation services can assist with confidence and increased mobility to help reduce the risk of social isolation and further deterioration.

#### 6) Secondary prevention

Of vital importance to reduce hip fractures and other fragility fractures is diagnosis, management, and treatment of osteoporosis (see Somerset Bone Health Pathway in the Pathway Navigator App). Fracture Liaison Services (FLS) are now in place across Somerset and will identify all fractures in people over 50 and provide interventions, signposting, recommendations to GPs, and follow up where appropriate for a year after the fracture. Around fifty percent of people who fracture their hip have previously had a fragility fracture of some sort. This first, often relatively minor fracture (in terms of effect on morbidity and mortality) should be considered a warning sign of impending further fracture risk and trigger a comprehensive bone health and falls risk assessment. GPs are asked to action recommendations relating to prescribing and, after the first year on treatment, monitor patient medication adherence and suitability: seeking advice from the Bone Health Pathway; Falls Pathway; and/or FLS staff as appropriate.



## Central Mendip

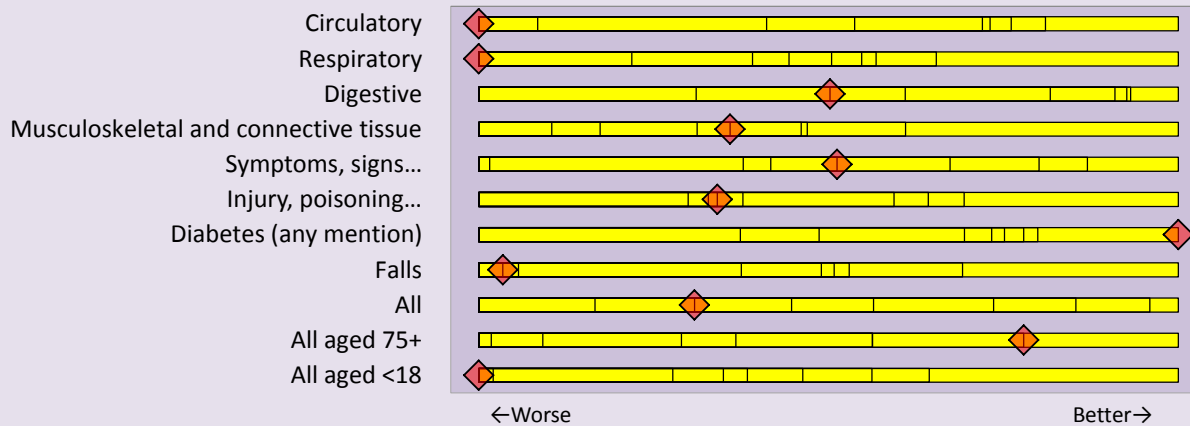
### Standardised emergency admission rate to hospital per 1000 population (ICD grouping)

SUS Inpatient activity files 2014/15. Population file July 2014. Emergency admissions. Standardised by age and sex.

A very small percentage of admissions are not included in the table below because the patient was of unknown age or sex.

ICD groupings	Observed	Expected (based on Somerset rates)	Commissioning Locality rate	Somerset rate	England	Range of Practice values low / median / high
Diseases of the circulatory system	211	174	12.4	10.2		4.7 / 10.0 / 21.2
Diseases of the respiratory system	261	214	14.8	12.1		5.2 / 11.9 / 16.9
Diseases of the digestive system	158	150	8.6	8.2		4.9 / 8.1 / 13.0
Diseases of musculoskeletal system and connective tissue	75	76	4.2	4.2		1.6 / 4.1 / 7.9
Symptoms, signs and abnormal clinical and laboratory findings	429	435	23.4	23.7		12.0 / 23.1 / 49.2
Injury, poisoning and other external causes	304	301	16.7	16.5		11.1 / 16.4 / 36.7
Diabetes (any mention of diabetes for the admission)	205	241	11.9	14.0		7.2 / 14.3 / 25.6
Falls (any mention of a fall for the admission)	179	159	10.7	9.5		3.8 / 9.0 / 19.7
<b>All</b>	<b>1,952</b>	<b>1,894</b>	<b>107.7</b>	<b>104.5</b>		<b>70.8 / 102.0 / 181.2</b>
<b>All aged 75+</b>	<b>660</b>	<b>724</b>	<b>393.8</b>	<b>431.9</b>		<b>49.2 / 434.2 / 673.0</b>
<b>All aged &lt;18</b>	<b>305</b>	<b>278</b>	<b>76.0</b>	<b>69.3</b>		<b>31.0 / 66.5 / 116.7</b>

### Emergency admissions to hospital



#### Significantly worse than county average for:

Diseases of the circulatory system    Diseases of the respiratory system

#### The Commissioning Locality has the worst value in the county for:

Diseases of the circulatory system    Diseases of the respiratory system    All aged <18

#### Significantly better than county average for:

Diabetes (any mention of diabetes for the admission)    All aged 75+

#### The Commissioning Locality has the best value in the county for:

Diabetes (any mention of diabetes for the admission)

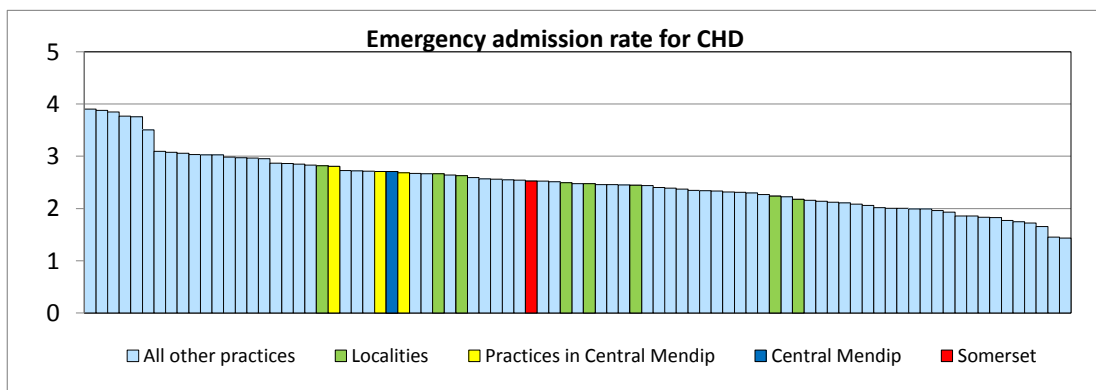
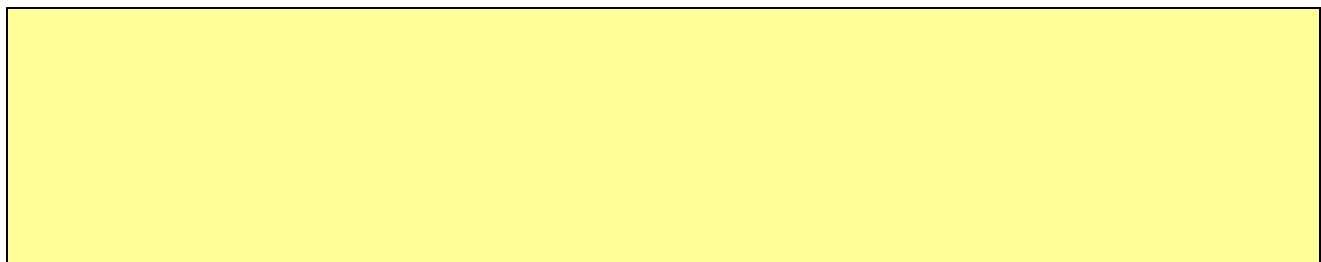
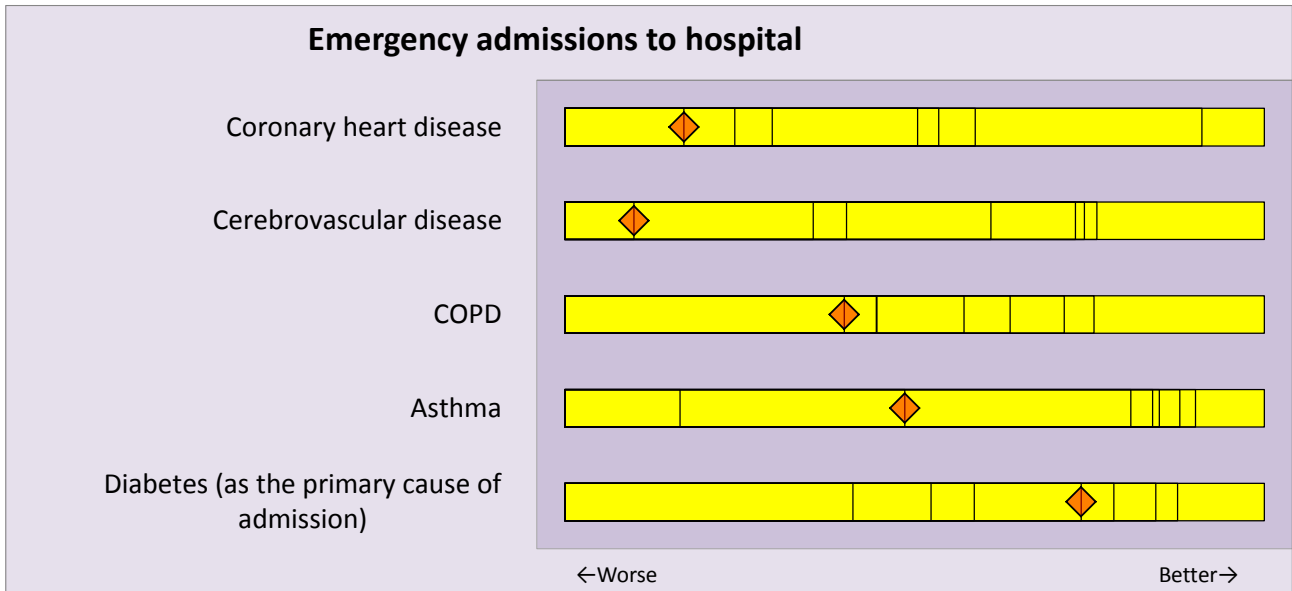
# Central Mendip

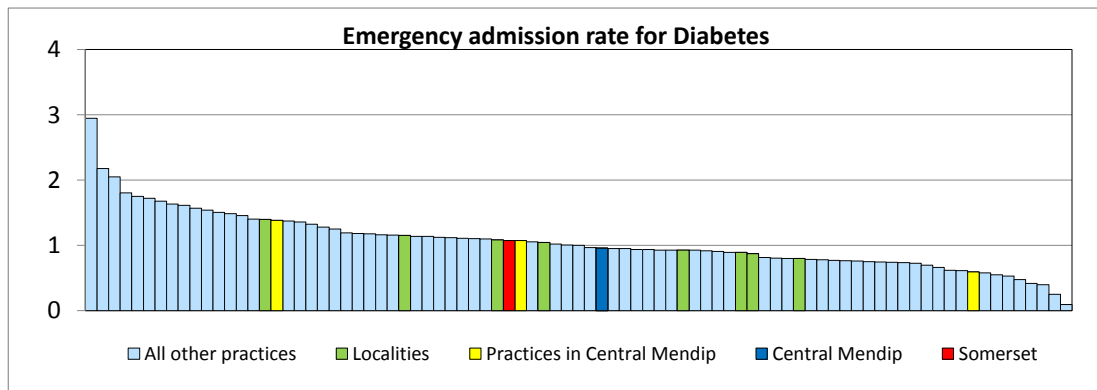
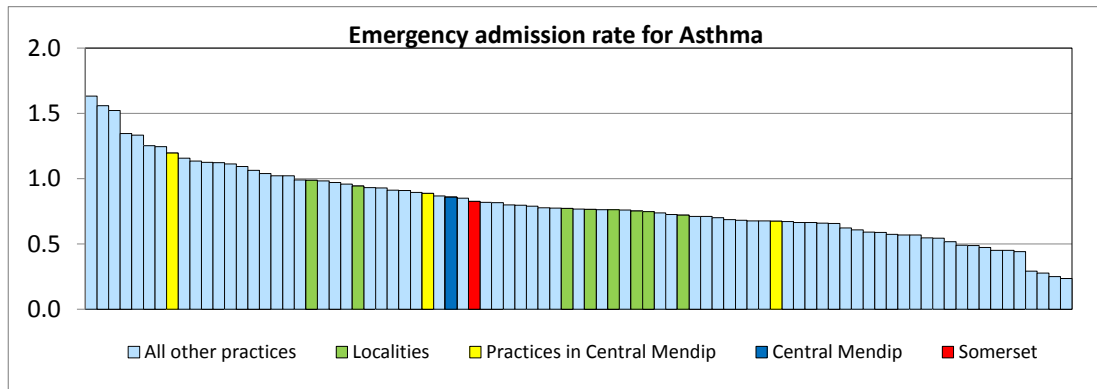
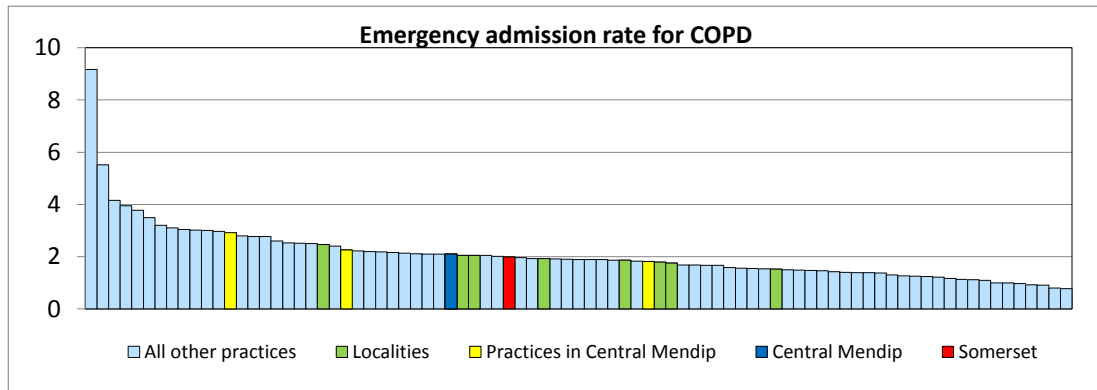
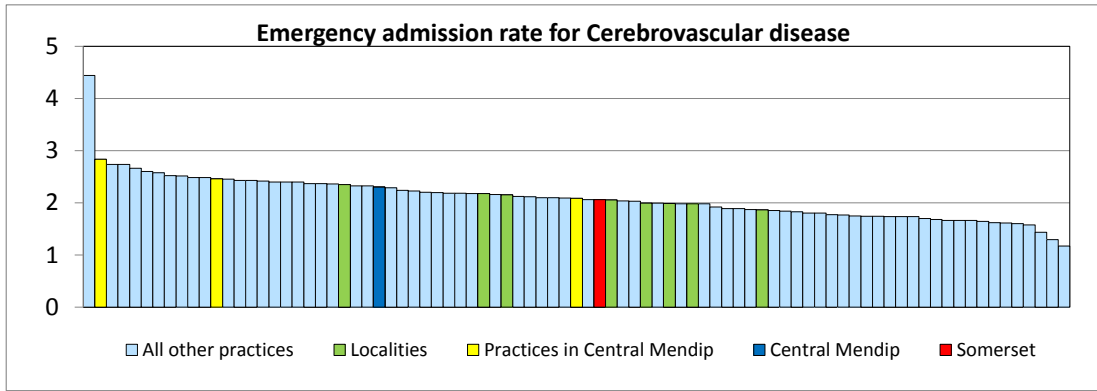
**Standardised emergency admission rate to hospital per 1000 population (CHD, CVD, COPD, Asthma, Diabetes)**

SUS Inpatient activity files 2009/10 to 2014/15. Population file July 2009-July 2014. Emergency admissions. Standardised by age and sex.

A very small percentage of admissions are not included because of unknown age or sex.

ICD groupings	Observed	Commissioning Locality rate	Somerset rate	England	Range of Practice values low / median / high
Coronary heart disease	273	2.7	2.5		1.4 / 2.5 / 3.9
Cerebrovascular disease	222	2.3	2.1		1.2 / 2.1 / 4.4
COPD	205	2.1	2.0		0.8 / 1.9 / 9.2
Asthma	100	0.9	0.8		0.2 / 0.8 / 1.6
Diabetes (as the primary cause of admission)	106	1.0	1.1		0.1 / 1.0 / 2.9





## Central Mendip

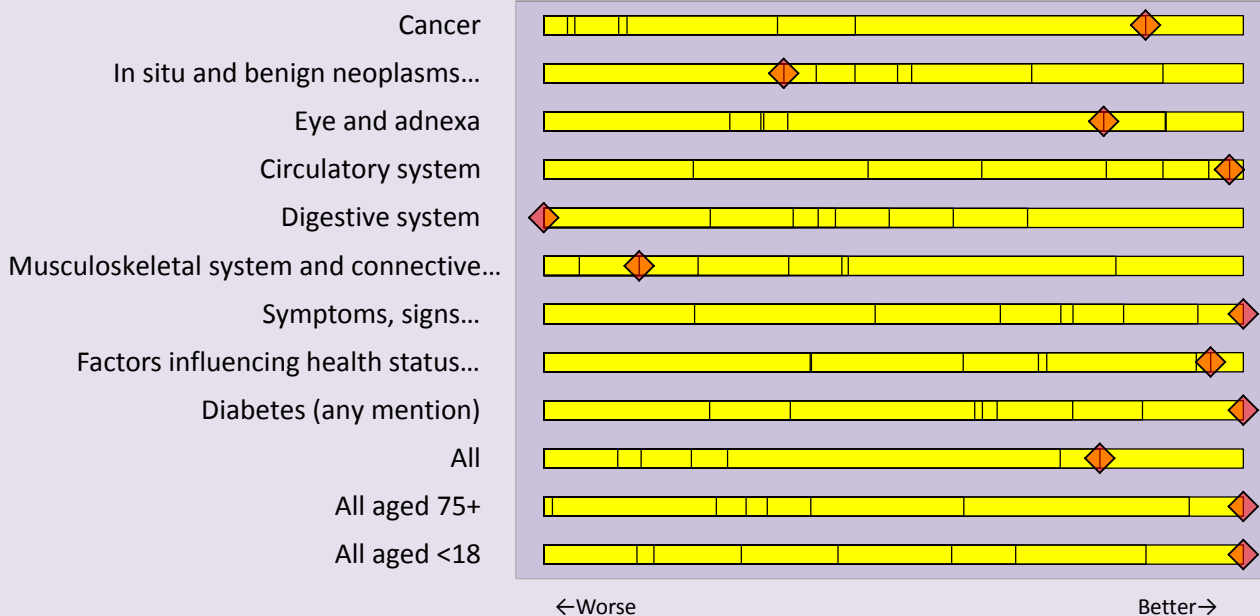
**Standardised elective admission rate to hospital per 1000 population (ICD grouping)**

SUS Inpatient activity files 2014/15. Population file July 2014. Elective and Day cases. Standardised by age and sex.

A very small percentage of admissions are not included in the table below because the patient was of unknown age or sex.

ICD groupings	Observed	Expected (based on Somerset rates)	Commissioning Locality rate	Somerset rate	England rate	Range of Practice values low / median / high
Cancer	379	614	21.3	34.4		16.2 / 35.5 / 73.7
In situ and benign neoplasms and neoplasms of unknown or uncertain behaviour	138	133	7.6	7.3		3.0 / 7.0 / 13.8
Diseases of eye and adnexa	213	240	12.6	14.2		9.4 / 14.2 / 24.8
Diseases of the circulatory system	134	156	7.4	8.6		3.9 / 8.6 / 20.1
Diseases of the digestive system	515	469	27.4	24.9		17.3 / 24.9 / 36.1
Diseases of musculoskeletal system and connective tissue	346	326	18.6	17.6		11.5 / 17.3 / 32.9
Symptoms, signs and abnormal clinical and laboratory findings	153	192	8.3	10.4		5.5 / 10.3 / 17.8
Factors influencing health status and contact with health services	115	168	6.3	9.2		4.6 / 9.0 / 16.1
Diabetes (any mention of diabetes for the admission)	213	280	12.1	15.9		7.9 / 15.6 / 34.5
<b>All</b>	<b>2,640</b>	<b>2,956</b>	<b>144.1</b>	<b>161.4</b>		<b>126.6 / 164.3 / 216.9</b>
<b>All aged 75+</b>	<b>467</b>	<b>692</b>	<b>283.6</b>	<b>420.4</b>		<b>77.6 / 432.9 / 802.3</b>
<b>All aged &lt;18</b>	<b>110</b>	<b>155</b>	<b>27.1</b>	<b>38.1</b>		<b>16.0 / 37.1 / 98.2</b>

### Elective (inpatient and day cases) admissions to hospital



**The Commissioning Locality has the worst value in the county for:**  
Diseases of the digestive system

**Significantly better than county average for:**

Cancer Symptoms, signs and abnormal clinical and laboratory findings Factors influencing health status and contact with health services Diabetes (any mention of diabetes for the admission) All All aged 75+ All aged <18

**The Commissioning Locality has the best value in the county for:**

Symptoms, signs and abnormal clinical and laboratory findings Diabetes (any mention of diabetes for the admission) All aged 75+ All aged <18

**Standardised first outpatient attendance rate per 1000 population (proxy for referral)**

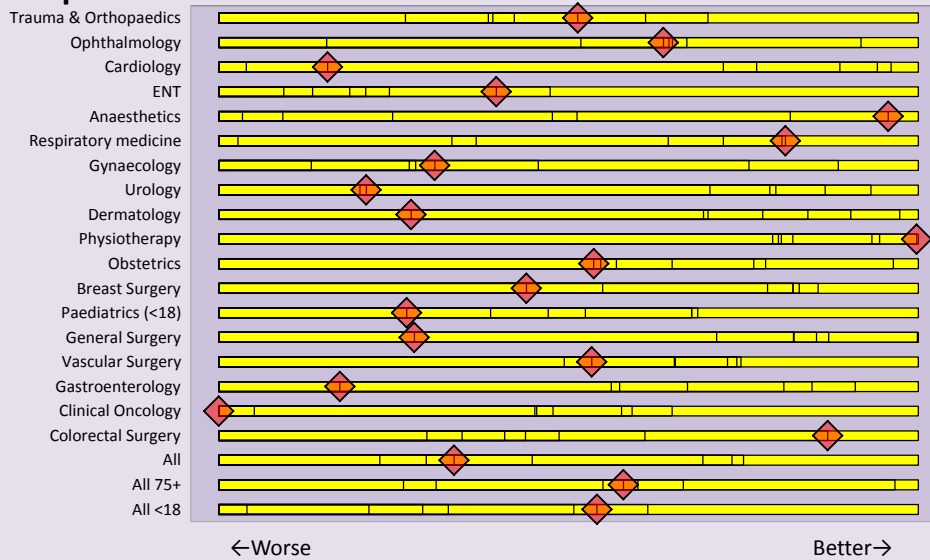
SUS Outpatient activity files 2014/15. Population file July 2014. Standardised by age and sex.

Treatment function code is used rather than Specialty. The treatment function code reflects what the patient is treated for rather than the main specialty of the consultant under whose care the patient is. Not all treatment functions are listed. Some activity is only shown for Commissioning Localities. A small percentage of first attendances is not included in the table below because the patient was of unknown age or sex. Appropriate age and sex populations are used as the base for the rates.

2014/15

Treatment Function	Observed	Expected (based on Somerset rates)	Commissioning Locality rate	Somerset rate	England rate	Range of Practice values low / median / high
Trauma & Orthopaedics	1,342	1,332	70.8	70.3		43.3 / 69.1 / 99.0
Ophthalmology	629	647	35.2	36.2		24.0 / 36.0 / 55.7
Cardiology	823	448	45.7	24.8		8.0 / 18.5 / 60.4
ENT	432	457	22.7	24.0		13.6 / 23.2 / 40.4
Anaesthetics	36	406	1.9	21.8		0.2 / 25.3 / 42.8
Respiratory medicine	249	383	13.5	20.7		3.4 / 19.8 / 42.3
Gynaecology	242	237	26.2	25.7		13.0 / 25.3 / 49.6
Urology	414	320	22.5	17.4		9.8 / 15.9 / 30.9
Dermatology	379	285	20.5	15.4		6.3 / 14.6 / 27.2
Physiotherapy	65	280	3.4	14.7		1.0 / 9.6 / 65.6
Obstetrics	252	247	73.9	72.5		18.2 / 64.9 / 181.5
Breast Surgery	264	230	13.8	12.0		6.7 / 11.8 / 17.3
Paediatrics (<18)	253	221	63.7	55.6		24.1 / 53.6 / 95.5
General Surgery	278	174	14.8	9.3		5.2 / 8.4 / 18.4
Vascular Surgery	185	155	10.5	8.9		2.3 / 8.9 / 22.2
Gastroenterology	172	143	9.2	7.6		3.8 / 7.4 / 16.8
Clinical Oncology	207	129	11.7	7.3		2.1 / 7.0 / 17.7
Colorectal Surgery	68	132	3.7	7.2		1.8 / 7.4 / 15.2
<b>All</b>	<b>8,917</b>	<b>8,246</b>	<b>475.2</b>	<b>439.4</b>		<b>299.2 / 427.7 / 565.1</b>
<b>All 75+</b>	<b>1,629</b>	<b>1,573</b>	<b>981.7</b>	<b>947.9</b>		<b>171.9 / 977.4 / 1527.5</b>
<b>All &lt;18</b>	<b>904</b>	<b>939</b>	<b>222.7</b>	<b>231.2</b>		<b>157.8 / 231.1 / 358.0</b>

**First Outpatient attendances**



**Significantly worse than county average for:**  
 Urology   Dermatology   General Surgery   Gastroenterology   Clinical Oncology   All

**The Commissioning Locality has the worst value in the county for:**  
 Clinical Oncology

**Significantly better than county average for:**  
 Anaesthetics   Respiratory medicine   Physiotherapy   Colorectal Surgery

The aim of the Medicines Optimisation Key Therapeutic Topics Comparators (formerly QIPP Prescribing Comparators) is to support organisations and prescribers to review the appropriateness of current prescribing, revise prescribing where appropriate and monitor implementation. The comparators are not intended to be used as targets or performance tables but rather highlight variation and support local discussion and decisions regarding MO KTT. More detail on the prescribing measures is available at <http://www.hscic.gov.uk/prescribing/measures> and the following data was taken from the website <https://apps.nhsbsa.nhs.uk/infosystems/welcome>:

#### ASTRO-PU weightings

ASTRO-PU stands for Age, Sex and Temporary Resident Originated Prescribing Units. This weighting is designed to weight individual practice or organisation populations for age and sex to allow for better comparison of prescribing patterns. These figures are based on the cost or volume of prescribing across all therapeutics, and these weightings should be used only when considering all prescribing. The number of temporary residents attending practices is no longer captured or included in funding allocations. The cost based weightings are standardised (based on a male child under 4 years being 1) as they are used in national resource allocation formulae. The item based weightings are not standardised, as this more clearly shows relative use across different demographic groups.





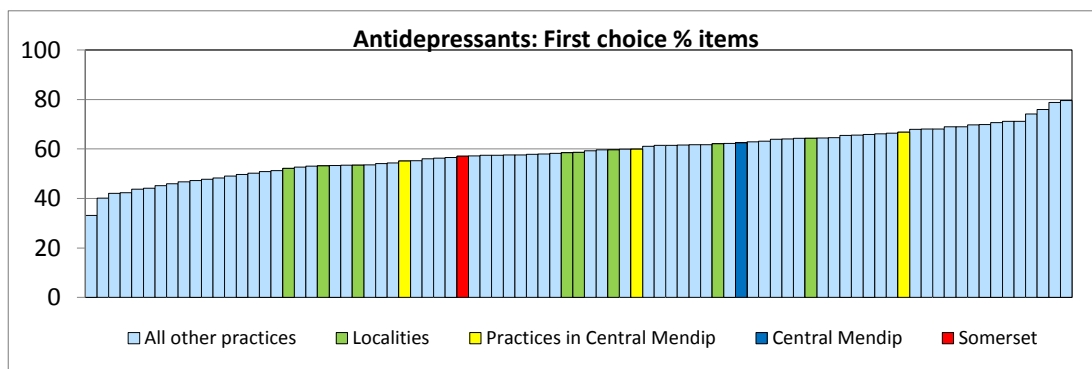
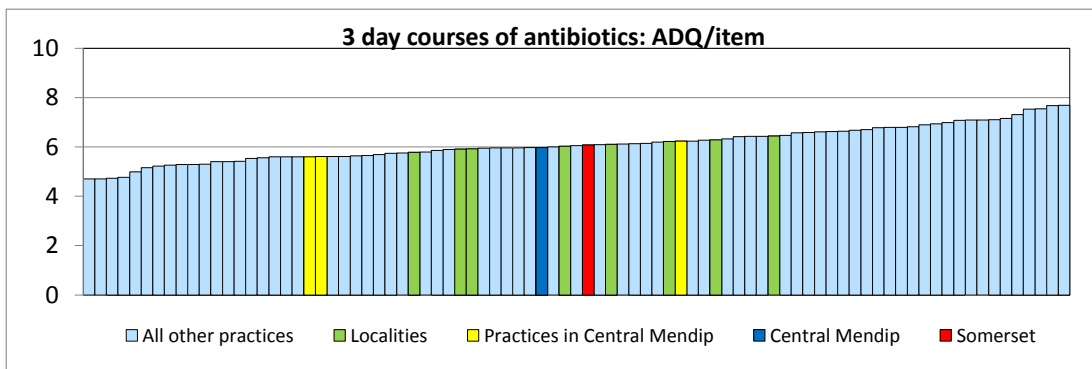
## Central Mendip

The Commissioning Locality has the worst value in the county for:

Omega-3 ADQ/STAR PU Wound care products: NIC/item

The Commissioning Locality has the best value in the county for:

ACE Inhibitor % items Low cost lipid modifying drugs Antibacterial Items/STAR PU Hypnotics ADQ/STAR PU (ADQ based) Laxatives ADQ/STAR PU



2013/14

Indicator	Numerator	Denominator	Commissioning Locality rate	Somerset rate	England rate	Range of Practice values low / median / high
Antidepressants: First choice % items	7,486	12,137	61.7	56.4	63.5	24.3 / 60.3 / 76.0
ACE Inhibitor % items	14,155	17,912	79.0	73.6	70.7	62.5 / 73.8 / 82.2
Low cost lipid modifying drugs	18,058	19,158	94.3	71.0	93.2	20.1 / 89.4 / 98.5
NSAIDs: Ibuprofen & Naproxen % Items	3,425	4,608	74.3	74.6	71.5	54.2 / 75.8 / 90.8
3 Days Trimethoprim ADQ/Item	6,220	1,099	5.7	5.8	6.0	4.0 / 5.8 / 8.0
Antibacterial Items/STAR PU	10,264	10,950	0.9	1.1	1.2	0.6 / 1.1 / 4.5
Antidepressants ADQ/STAR PU	469,828	426,527	1.1	1.1	1.2	0.7 / 1.1 / 1.8
Cephalosporins & Quinolones % items	640	10,207	6.3	4.6	5.5	2.0 / 4.4 / 10.1
Hypnotics ADQ/STAR PU (ADQ based)	33,617	52,936	0.6	0.9	1.2	0.1 / 0.8 / 2.5
Laxatives ADQ/STAR PU	112,067	21,898	5.1	5.9	7.2	2.9 / 5.6 / 9.4
Lipid modifying drugs: Ezetimibe % items	283	19,158	1.5	1.7	2.8	0.2 / 1.6 / 4.6
Long/Intermediate Insulin Analogues	735	878	83.7	73.6	81.7	43.2 / 72.8 / 94.3
Minocycline ADQ/1000 Patients	112	19	5.8	22.9	65.3	0.0 / 3.9 / 721.9
NSAIDs: ADQ/STAR PU	139,713	25,930	5.4	6.3	6.2	2.8 / 6.2 / 16.7
Omega-3 ADQ/STAR PU	8,452	6,342	1.3	0.8	1.4	0.0 / 0.6 / 5.2
Wound care products: NIC/item	58,088	3,793	15.3	16.0	24.4	7.8 / 15.4 / 53.8

## Central Mendip

**ASTRO-PUs at April 2015**      **125,599**

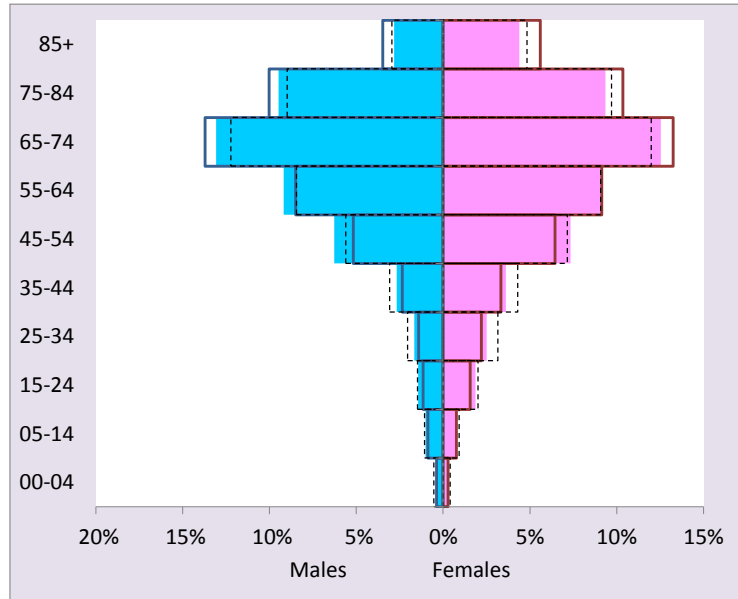
Age/Sex ASTRO-PU pyramid  
 Solid line represents Somerset as a whole, dotted line represents England.  
 Data from Exeter system download of GP registered patients.

ASTRO-PUs here are units based on the population at a Commissioning Locality and are used to help with prescribing budgets. Weighting of the population is higher for the sections of the population expected to need more prescribing spend.

### Central Mendip

Age Group	Males	Females
00-04	541	422
05-14	1,268	1,006
15-24	1,798	2,346
25-34	2,095	3,153
35-44	3,350	4,532
45-54	7,874	9,217
55-64	11,537	11,568
65-74	16,425	15,762
75-84	11,900	11,748
85+	3,545	5,513

The ASTRO-PU distribution reflects the Commissioning Locality population profile.



### Somerset

Age Group	Males	Females
00-04	14,645	11,358
05-14	34,093	29,414
15-24	44,976	60,142
25-34	54,686	85,162
35-44	91,414	128,632
45-54	200,038	249,423
55-64	329,038	354,221
65-74	530,996	513,300
75-84	388,514	401,173
85+	134,428	216,765