

Chard, Crewkerne and Ilminster area

Federation profile

Part of the SOMERSET JOINT STRATEGIC NEEDS ASSESSMENT

Practices in Federation

Church View Surgery
Crewkerne Health Centre
Essex House Medical Centre
Springmead Surgery
Summervale Medical Centre
Tawstock Medical Centre
The Meadows Surgery (Ilminster)
West One Surgery (Crewkerne)



Introduction

This is the fifth Federation profile, produced to complement the eighth practice profiles. The document aims to provide an overview of demographic, health and service use data at a Federation level.

This document aims to aid Federations in the identification of health needs, priority areas and potential service interventions that could be commissioned or provided.

This year we have reorganised the order 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 Federation's performance compared to the rest of Somerset. This is followed by the Federation profile in more detail.

We have included additional explanation to the data pages to aid understanding and started to add some pages highlighting the interventions which can be adopted to improve performance on various outcomes. We aim to expand on these intervention summaries and would particularly welcome feedback on which additional areas would be useful. Another new addition for some outcomes is a practice level 'ski-slope' which enables variation of practices within the Federation to be seen more clearly. Again we would welcome feedback on whether you would like to see more (or less) of these. With all these exciting new developments, the length of the profiles has grown and we would also 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 Federation can then be used as a rudimentary health needs assessment and could be used to inform decisions within the Federation.

Feedback

To give feedback on any aspect of the Federation profile please contact Jacq Clarkson

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 Federation with the other Federations and with Somerset. Occasionally there is also a National comparison. The best, median and worst practice values across Somerset are shown.

Where possible an indication is made of whether the differences observed are due to chance or are potentially significant:

- Green highlighting indicates that the Federation value is statistically significantly better than the Somerset average
- Pink highlighting indicates that the Federation 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 Federation 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 Federation 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 Federation value falls in relation to the other Somerset Federations, which are shown as vertical lines.

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

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

Some indicators on the bar charts are shown comparing the chosen Federation (in blue) with the rest of the Federations (pale green) and Somerset (red) and England (dark red). Not all indicators are graphed in this way in order to limit the size of the pack.

Interpretation

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

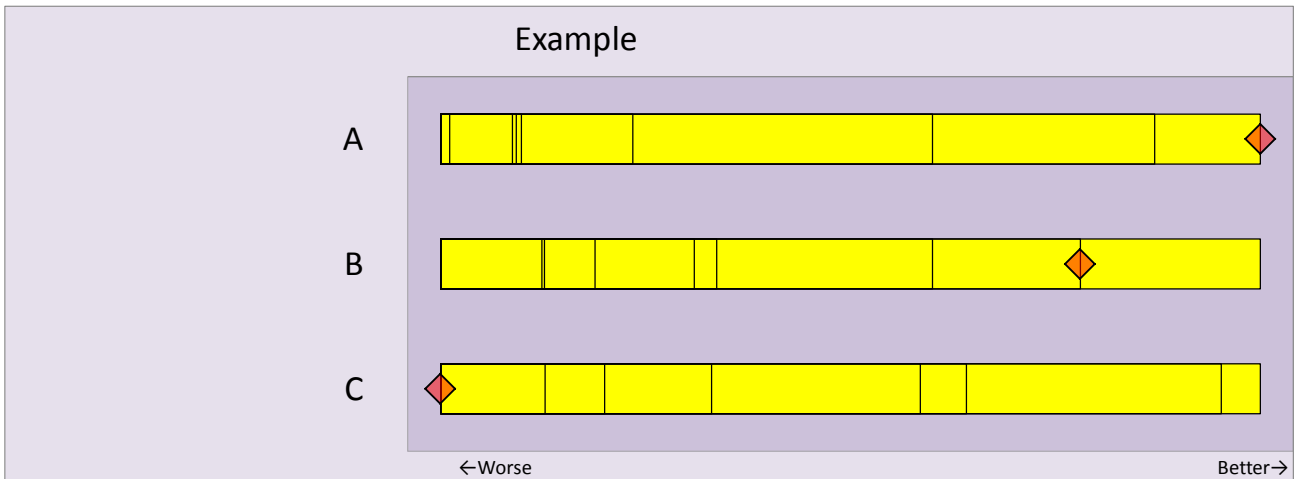
A value can be extreme (eg the "best" or "worst"; "highest" or "lowest") without necessarily being statistically significantly different to the Somerset average.

A statistically significant difference does not necessarily indicate the Federation 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	Federation 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



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 Federations in Somerset. Chard, Crewkerne and Ilminster area and its practices are highlighted.

Chard, Crewkerne and Ilminster Federation - Summary Public Health Profile 2014-15

Population & context for health

The Federation has a similar population age profile to the Somerset average. The Index of Multiple Deprivation for the local area is 15.0 compared to the value for Somerset of 16.9 and indicates comparatively low levels of deprivation compared to the rest of Somerset. More detail on the deprivation data is shown on p. 6.

Disease prevalence

Overviews of respiratory and cardiovascular health issues for CLICK Federation are shown on pp. 20 and 22 respectively.

Mortality, causes and places of death

The death blobs for mortality and years of life lost on pp.26-7 provide a visual indication of the key causes of death in CLICK. The proportion of deaths occurring before age 65 years is 11% which is lowest in the county, Somerset rate = 13%. Standardised mortality ratios for different conditions and age groups are shown on p.29.

Screening

In 2013-14, 100% of the eligible Federation population were invited to a Health Check, with 56% uptake. In the most deprived quintile, 35% of the population received a check. A full profile of this data is shown on p.34.

Although still high compared to other areas, bowel and breast screening rates have generally slipped compared to last year. Cervical screening rates for those aged 25-49 year old are the highest / best in the county. Practice based rates of chlamydia screening of eligible 15-24 year olds was 2.1%, lower than the Somerset average rate of 3.3%. This is one of the lowest rates in the county.

Immunisations

Immunisation rates for this year and last are shown on pp.44-5. MMR vaccination rates are below targets for herd immunity of 95%, with 93.1% vaccinated by age 2. Seasonal flu vaccination rates are generally high.

Childhood environment

Local breastfeeding initiation rates are 81% compared to 83% in Somerset. Continuation rates at 6-8 weeks are 50% compared to 49% in the county as a whole. A new paediatric health profile collates a number of risk factors and outcomes relating to children on p. 51.

Excess weight

According to the underlying model used to assess appropriate childhood weight, only 15% children should be of excess weight. Somerset rates are 23% with excess weight at age 4-5 years and 30% at age 10. For this Federation, estimated rates are 24% and 29% for each age group. The percentage of adults who are obese is 11%

which is about average for the county and compares to a Somerset average of 9.9%.

Smoking

The Federation has 17.8% of adults over age 16 recorded as smokers compared to a 15.4% Somerset average. This equates to an approximate 7,000 smokers across the Federation, although numbers may be slightly over estimated as smokers are more likely to visit their GP and thus have their status confirmed. Last year, a lower than average proportion of CLICK known smokers went through cessation services compared to other Federations. This is one of the higher rates of smoking in Somerset. At a county level, smoking in pregnancy continues to remain a challenge and despite great improvements last year, our county rates are still high compared to the rest of England. More detail on smoking related data is shown on pp. 57-8.

Drugs and Alcohol

Hospital admissions for drug and alcohol related reasons are similar to the Somerset average. Alcohol related admissions: CLICK 2,017 per 100,000; Somerset 2,068 per 100,000. Drug related admissions: CLICK 121 per 100,000; Somerset 120 per 100,000.

Hospital admission rates

The hospitalisation section pp.62-80, contains a wealth of data on reasons why the CLICK population access hospital services and whether on an emergency or elective basis. To focus on a few indications, the emergency admission rate for falls in the over 65s is 29 per 1000 as compared to the Somerset average of 31 per 1000. Self-harm admission rates are 202 per 100,000 which are lower than average for the county.

QIPP Prescribing

QIPP Prescribing indicators are shown on p. 82. These are designed to promote discussion on the variation, rather than provide targets or influence individual prescribing choices. In general, Somerset rates are similar or better than national levels, although the county has one of the lowest / worst rates for prescribing of low cost lipid modifying drugs, Somerset rate 71% items, England, 93% items. In this Federation, 83% of prescriptions for lipid modifying drugs are classified as low cost.

Suggested public health areas to prioritise

- Continue to increase numbers of smokers referred to stop smoking services
- Integrate offering chlamydia screening tests within general practice
- Continue focus on excess weight in children

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

Brief overview of Federation outcomes	ENGLAND	Somerset	Bridgwater Bay Health area	Central Mendip area	Chard, Crewkerne and Ilminster area	East Mendip area	North Sedgemoor area	South Somerset Healthcare area	Taunton Deane area	West Mendip area	West Somerset area
Proportion of population aged 0-14	18%	16%	17%	17%	15%	17%	15%	16%	17%	15%	12%
Proportion of population aged > 75	8%	10%	8%	9%	12%	8%	12%	10%	10%	11%	15%
Index of Multiple Deprivation	17.2	16.9	20.9	15.5	15.0	16.8	15.8	14.7	16.7	15.4	24.5
Proportion of population living in 10% most deprived neighbourhoods in Somerset*	27%	10%	26%	8%	0%	4%	8%	7%	10%	6%	16%
Proportion of population living in 20% most deprived neighbourhoods in Somerset*	37%	20%	36%	8%	9%	17%	15%	10%	21%	13%	65%
All cause mortality, all ages (SMR compared to Somerset)		100%	99%	106%	90%	96%	102%	100%	110%	94%	94%
Proportion of deaths occurring before 65	17%	13%	15%	13%	11%	13%	13%	12%	12%	13%	11%
Proportion of those dying at home (all causes)	22%	21%	25%	23%	23%	25%	19%	19%	19%	21%	22%
Health Checks % of eligible invited for check (annual target)		76%	67%	77%	100%	66%	68%	76%	67%	100%	38%
Health Checks undertaken as % of eligible (annual target)		40%	34%	44%	56%	27%	44%	39%	34%	62%	30%
Health Checks as % of eligible in most deprived population quintile		28%	27%	23%	35%	30%	28%	23%	27%	53%	21%
Cervical cancer screening (25-49)	71.5%	74.0%	73.5%	73.5%	76.6%	75.8%	74.4%	73.3%	75.6%	70.7%	69.0%
Chlamydia % screened of eligible (15-24 year olds)		3.3%	3.2%	4.4%	2.1%	4.5%	3.7%	4.4%	1.5%	4.1%	2.7%
MMR coverage by 2nd birthday	92.7%	93.8%	93.5%	93.0%	93.1%	93.0%	94.6%	95.4%	94.2%	89.8%	94.6%
Breastfeeding initiation		83%	79%	83%	81%	83%	84%	82%	85%	86%	85%
Breastfeeding prevalence at 6-8 weeks		49%	39%	52%	50%	54%	44%	48%	52%	54%	50%
Smoking rate adults 16+		15.4%	19.2%	20.1%	17.8%	14.1%	13.8%	13.8%	15.2%	13.7%	14.2%
Smoking ascertainment		73%	73%	73%	76%	68%	75%	72%	73%	69%	75%
Smokers going through cessation per 1000 recorded smokers		108	99	91	96	106	123	136	93	100	128
Excess weight in 4-5 year olds	23%	23%	26%	25%	24%	22%	23%	24%	20%	23%	23%
Excess weight in 10-11 year olds	33%	30%	33%	32%	29%	28%	30%	29%	29%	31%	30%
Obese adults (16+) (rate per 1000 - Standardised to Somerset)	119	99	131	99	110	81	100	97	85	92	105
Alcohol related admissions (rate per 100,000)	1,984	2,068	2,183	1,805	2,017	1,912	2,020	2,114	2,133	2,013	2,038
Drug related admissions (rate per 100,000)		120	137	88	121	96	84	121	143	106	117
Teenage deliveries (mother aged <19 at delivery) (rate per 1,000 females aged 15-17)		18.2	24.4	13.2	20.5	22.1	14.5	18.7	18.7	10.2	16.0
Self harm admissions (rate per 100,000)		223	218	197	202	245	139	243	254	209	207
Emergency admissions to hospital for Falls in people aged 65 and over (rate per 1000)		31	29	32	29	38	23	34	31	32	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 Federation

Multiple Deprivation Index

The Index of Multiple Deprivation measures multiple deprivation at small area level. The model of multiple deprivation underpinning this is based on the idea of distinct dimensions of deprivation, experienced by individuals living in an area which can be recognised and measured separately. People could be counted in one or more domains depending on the number of types of deprivation that they experience.

1. Income deprivation domain - relates to the proportion of the population living in low income families, which are those reliant on means tested benefits. The domain score is therefore the proportion of the population living in low-income families. The Income Deprivation Affecting Children Index and The Income Deprivation Affecting Older People Index are two age based summaries.
2. Employment deprivation domain - defined as involuntary exclusion of the working age population from work and includes elements of the "hidden unemployed" such as those out of work due to illness and disability.
3. Health deprivation and Disability domain - identifies areas with relatively high rates of people who die prematurely or whose quality of life is impaired by poor health or who are disabled.
4. Education, Skills and Training deprivation domain - consists of two sub-domains: one relating to the lack of educational attainment among children and young people and one relating to lack of qualifications in terms of skills among the working age population.
5. Barriers to Housing and Services domain - the purpose of this domain is to measure the barriers to housing and key local services (GP premises, supermarkets, primary schools and post offices). The indicators fall into two sub-domains "geographical barriers" and "wider barriers". The latter include issues relating to access to housing.
6. The Living Environment domain - consists of two sub-domains: the "indoors" living environment which measures the quality of housing and the "outdoors" living environment which includes measures of air quality and road traffic accidents.
7. The Crime domain - measures the rate of recorded crime for four key dimensions of crime. These are burglary, theft, criminal damage and violence as these are deemed to represent levels of personal and material victimisation at a small area level.

There are also two derived indices relating to Income deprivation in specific age groups.

- a. Income Deprivation Affecting Children Index - estimates the proportion of those aged under 16 who live in income deprived households
- b. Income Deprivation Affecting Older People Index - estimates the proportion of those aged 60 or more who live in income deprived households

Reproduced (and slightly extended) from Exeter City Council summary of Index of Multiple Deprivation Concepts and Definitions - for a more complete description and details of the variables used to construct the domains see the communities and local government website:

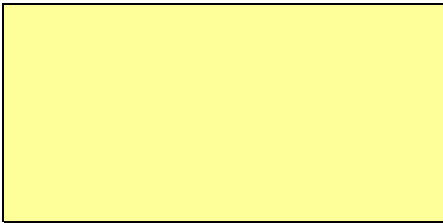
<https://www.gov.uk/government/statistics/english-indices-of-deprivation-2010-technical-report>

Chard, Crewkerne and Ilminster area

Population at April 2014 46,631

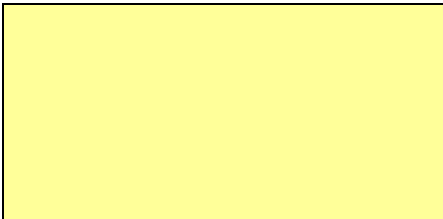
Chard, Crewkerne and Ilminster area

Age Group	Males	Females
00-04	1,178	1,136
05-14	2,446	2,374
15-24	2,378	2,350
25-34	2,334	2,251
35-44	2,609	2,584
45-54	3,356	3,248
55-64	3,025	3,158
65-74	3,174	3,431
75-84	1,807	2,026
85+	634	1,132



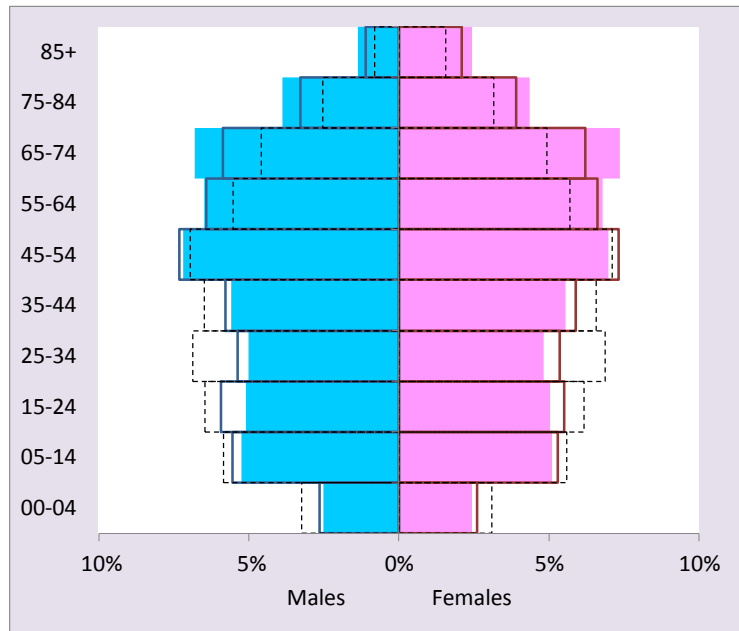
Somerset

Age Group	Males	Females
00-04	14,637	14,344
05-14	30,608	29,219
15-24	32,746	30,401
25-34	29,674	29,550
35-44	31,946	32,593
45-54	40,442	40,462
55-64	35,488	36,591
65-74	32,412	34,312
75-84	18,103	21,556
85+	6,124	11,555



Age/sex Population pyramid. Solid line represents Somerset as a whole, dotted line 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 Federation. 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.

The solid bars represent the population in your federation.

Proportion in age range	Federation	Somerset	England (mid 2014 projection)	Range of Practice values low / median / high
0-14	15%	16%	18%	9% / 16% / 23%
75+	12%	10%	8%	2% / 11% / 19%
Female 15-44	15%	17%	20%	11% / 16% / 32%



Chard, Crewkerne and Ilminster area

Deprivation

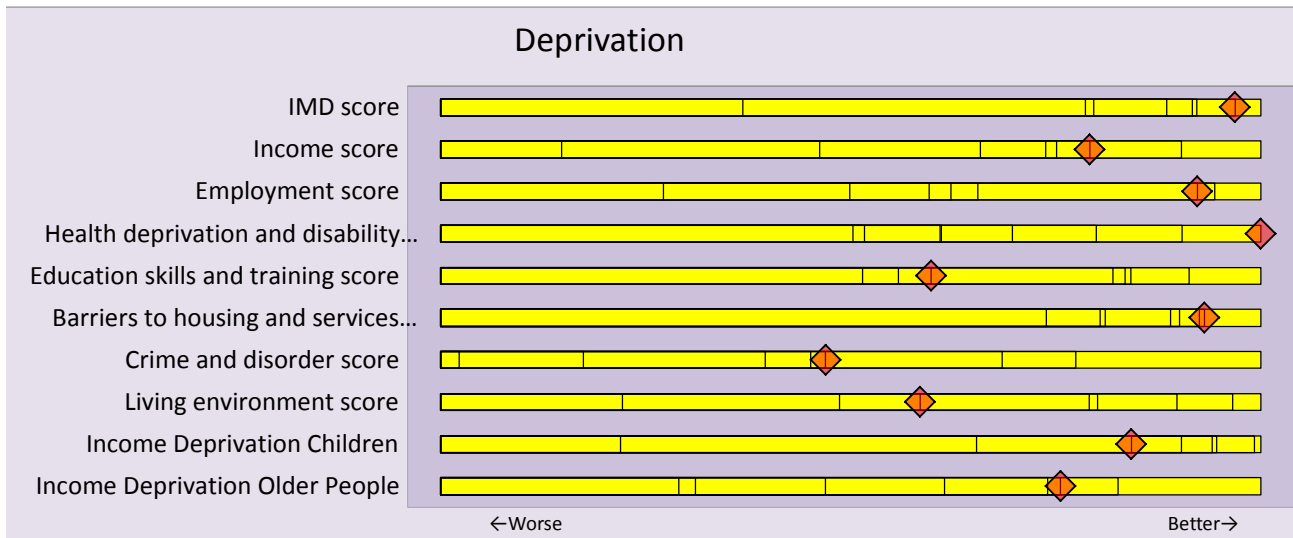
Index of Multiple Deprivation (IMD) 2010 and its domains.
 Calculated for Federation population in August 2014. All those with a known postcode are included even if they live outside Somerset.

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.

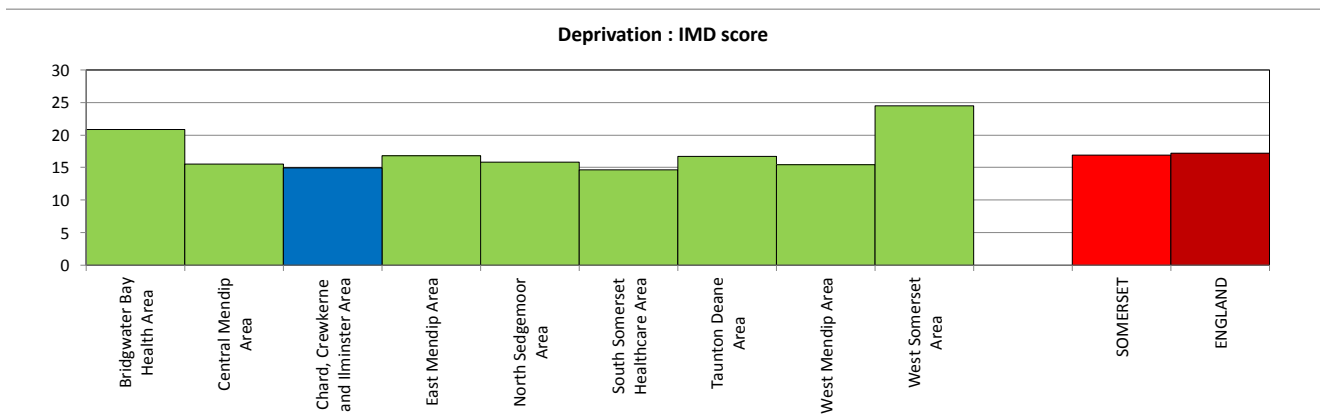
Score	Federation	Somerset	England (median LSOA* values)	Range of Practice values low / median / high
IMD score	15.0	16.9	17.2	9.6 / 15.8 / 27.4
Income score	0.10	0.11	0.11	0.06 / 0.10 / 0.17
Employment score	0.07	0.08	0.08	0.04 / 0.08 / 0.13
Health deprivation and disability score	-0.47	-0.21	-0.02	-0.81 / -0.26 / 0.46
Education skills and training score	21.0	19.6	16.1	5.9 / 17.8 / 44.1
Barriers to housing and services score	22.6	24.3	20.2	14.7 / 23.4 / 56.1
Crime and disorder score	-0.42	-0.37	0.01	-1.03 / -0.46 / 0.43
Living environment score	19.1	18.7	16.9	9.8 / 18.7 / 38.5
Income Deprivation Affecting Children Index	0.14	0.14	0.15	0.06 / 0.13 / 0.24
Income Deprivation Affecting Older People Index	0.14	0.15	0.17	0.09 / 0.14 / 0.21

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

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



The Federation has the best value in the county for:
 Health deprivation and disability score



Chard, Crewkerne and Ilminster area

People living in deprived areas

Proportion of Somerset patients registered with the practices in the Federation who live in one of the most deprived areas of Somerset and England. Deprivation measured using the Index of Multiple Deprivation 2010. Calculated for Federation populations in August 2014.

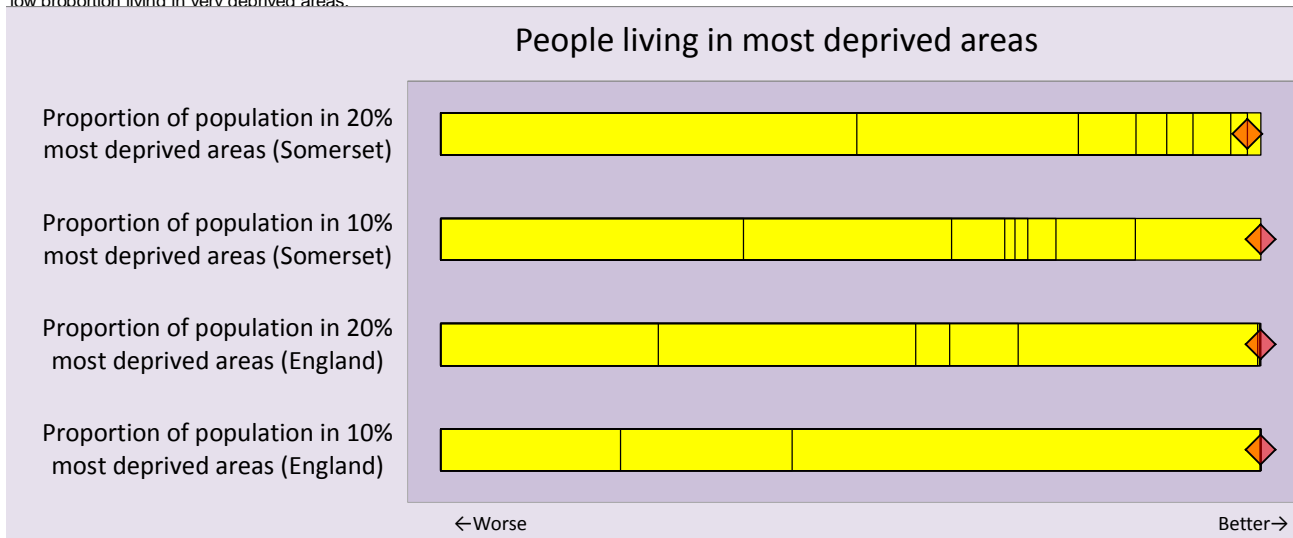
3.9% of this Federation's population is known to live outside Somerset, and they are excluded below.

Based on the IMD 2010 score, and calculated in August 2014, areas have been rated on their level of deprivation. This has been done for England as a whole and also just for Somerset. Somerset is less deprived than England therefore fewer people in Somerset live in a highly deprived area (ie only 4% of the Somerset population lives in the 20% most deprived areas of England and 2% in the 10% most deprived). The population within the Federation has then been classified by how many live in the 20% and 10% most deprived areas.

Federations with a higher proportion of their population living in highly deprived areas will have more challenges with regards to health interventions.

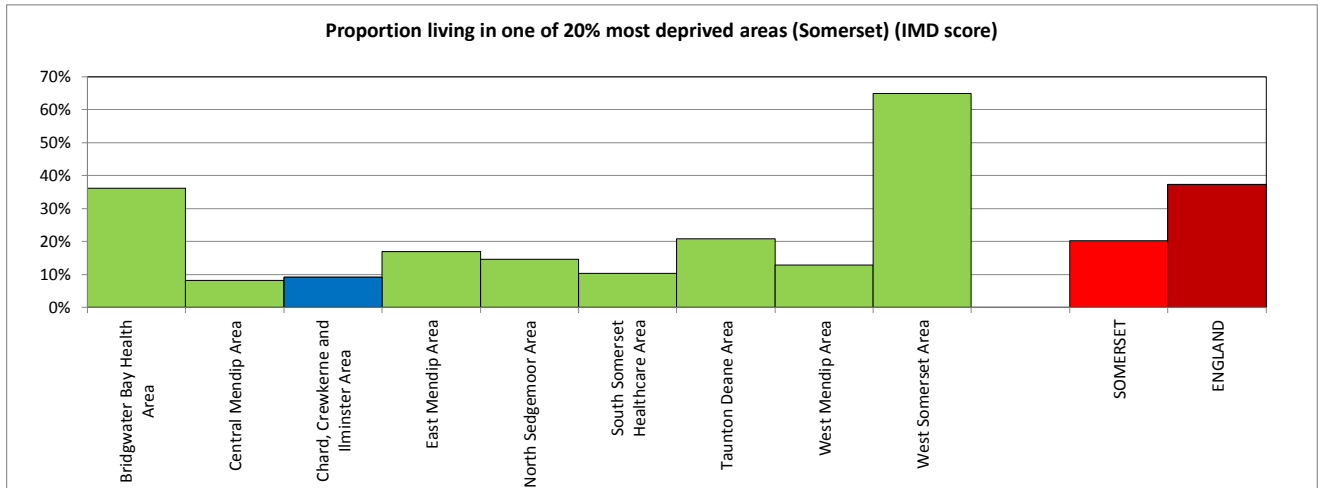
	Federation	Somerset	England	Range of Practice values low / median / high
Proportion of population in 20% most deprived areas (Somerset)	9%	20%	37%	0% / 12% / 80%
Proportion of population in 10% most deprived areas (Somerset)	0%	10%	27%	0% / 2% / 43%
Proportion of population in 20% most deprived areas (England)	0%	4%	20%	0% / 0% / 27%
Proportion of population in 10% most deprived areas (England)	0%	1%	10%	0% / 0% / 19%

This bar graph shows the proportion of the people in the Federation 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 Federation. Your Federation is highlighted with the red diamond. The worst performing Federation 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 Federation has the best value in the county for:

Proportion of population in 10% most deprived areas (Somerset) Proportion of population in 20% most deprived areas (England) Proportion of population in 10% most deprived areas (England)



Chard, Crewkerne and Ilminster area

Wider determinants of health

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

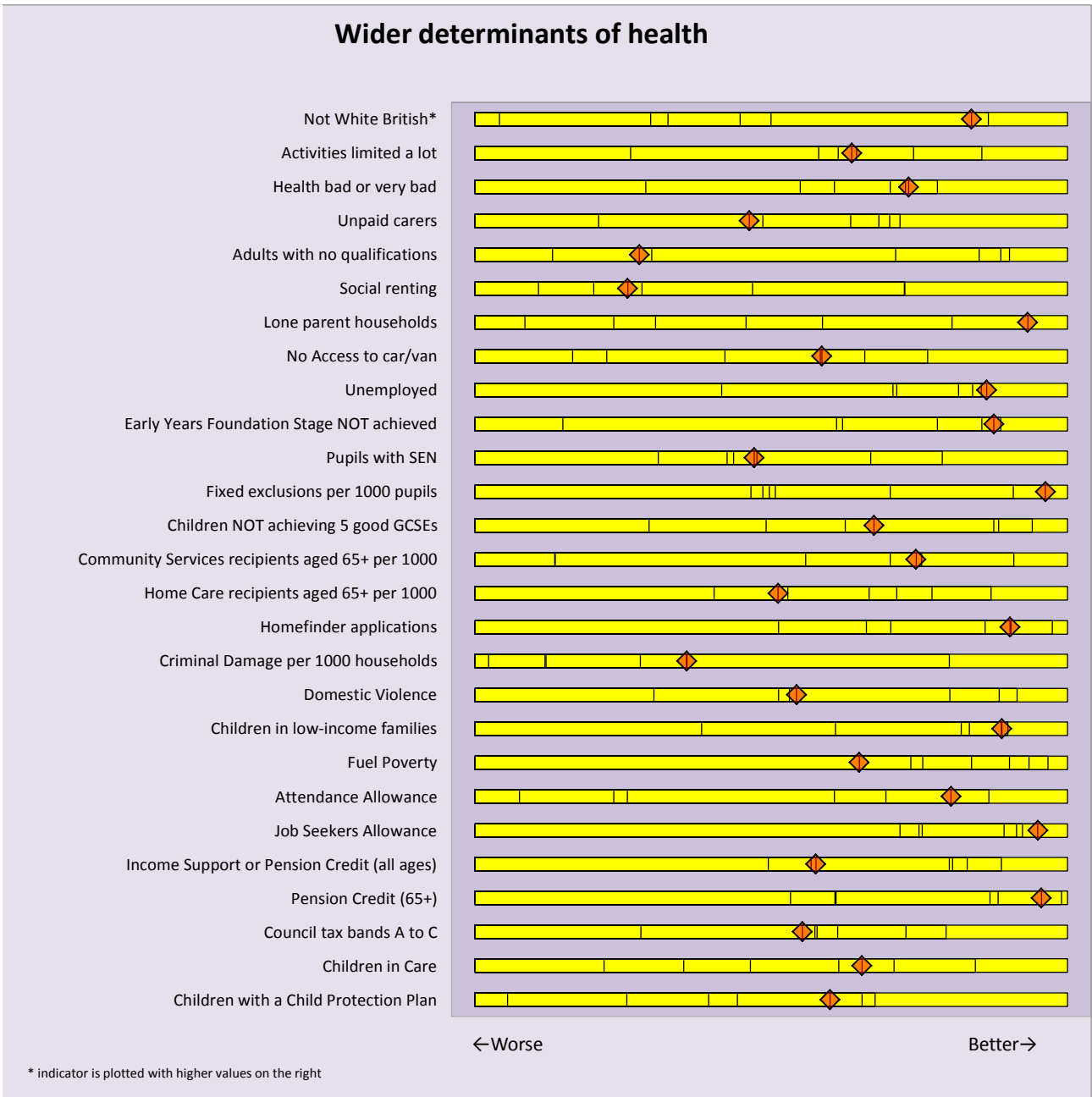
This set of data gives more clue as to the specific issues which affect the Federation population such as health status, proportion unemployed and benefits claimants. The data source and time period for each indicator is given in the table below and uses population weighted estimates of indicators available at Lower Super Output Area (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 Federation 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 pages.

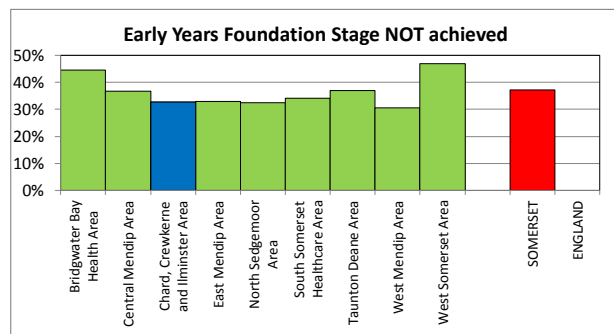
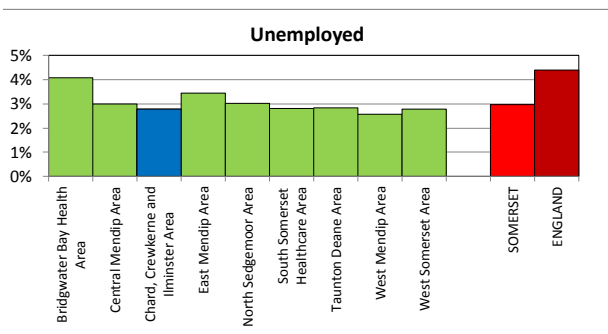
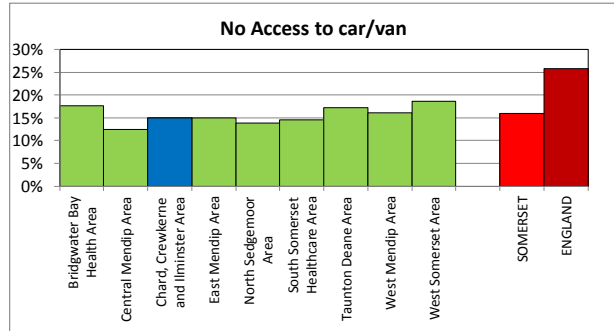
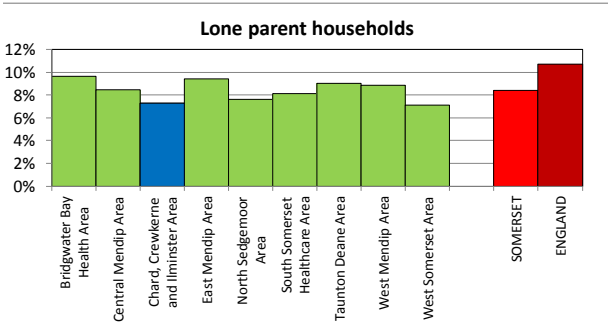
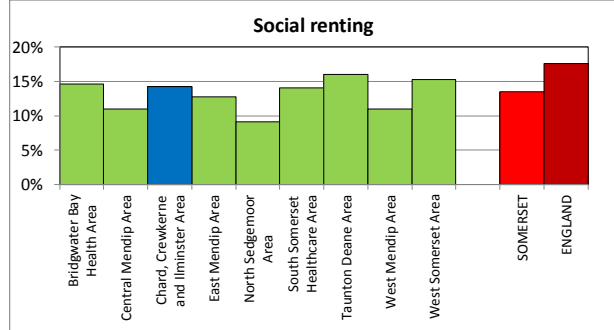
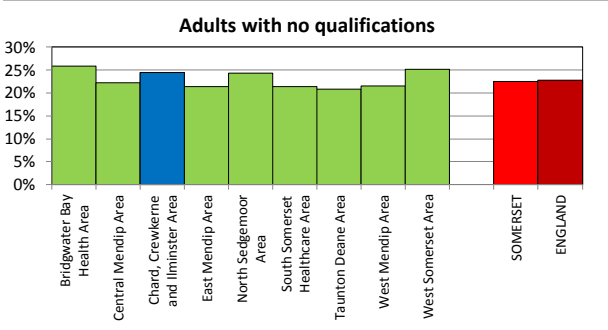
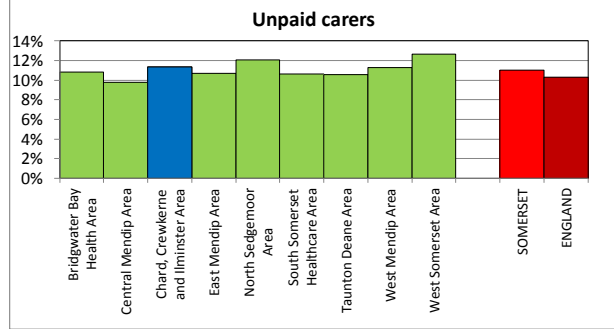
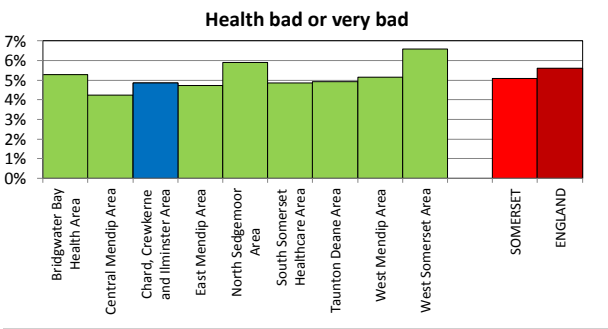
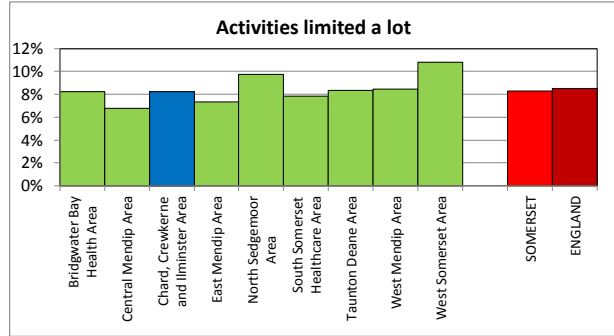
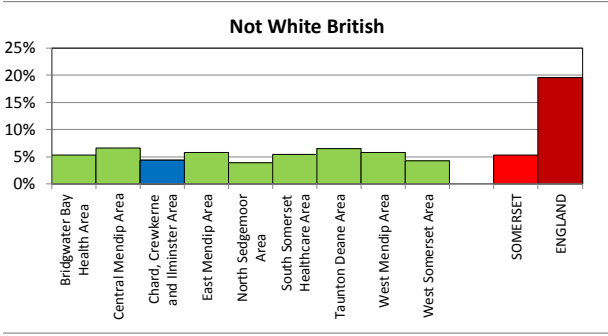
	Federation	Somerset	England	Range of Federation values
% of Residents that are not White British Census 2011	4%	5%	20%	4% to 7%
% of People whose day-to-day activities are limited a lot Census 2011	8%	8%	9%	7% to 11%
% of People whose health is bad or very bad Census 2011	5%	5%	6%	4% to 7%
% of People who provide unpaid care Census 2011	11%	11%	10%	10% to 13%
% of People aged 16 or over with no qualifications Census 2011	24%	22%	23%	21% to 26%
% of Households that are socially rented Census 2011	14%	14%	18%	9% to 16%
% of Households that are lone parent households Census 2011	7%	8%	11%	7% to 10%
% of Households with No Access to car/van Census 2011	15%	16%	26%	12% to 19%
% of Residents aged 16-74 who are Unemployed Census 2011	2.8%	3.0%	4.4%	2.6% to 4.1%
% of children not achieving Early Years Foundation Stage Somerset County Council 2012	33%	37%	n/a	31% to 47%
% of pupils with SEN Somerset County Council 2012	20%	19%	n/a	15% to 24%
Fixed exclusions per 1000 pupils Somerset County Council 2012	33	44	n/a	31 to 69
% of children not achieving 5 A*-C GCSEs including Maths and English Somerset County Council 2012	44%	44%	n/a	37% to 58%
Community Services recipients aged 65+ (rate per 1000 aged 65+) SCC Adult social care - Mar13	43	44	n/a	39 to 54
Home Care recipients aged 65+ (rate per 1000 aged 65+) SCC Adult social care - Mar13	26	24	n/a	21 to 31
Applications for housing on Homefinder SCC % of census households - Sep13	5%	6%	n/a	4% to 9%
Criminal Damage (rate per 100,000 population) Police ASPIRE 2012/13	914	912	n/a	703 to 1032
Domestic Violence Crimes (rate per 1000 census households) Police ASPIRE 2013	10.2	10.0	n/a	6.8 to 14.3
% of Children in low-income families Child Poverty Unit 2011	13%	14%	20%	12% to 19%
% of Households in Fuel Poverty DECC 2011	17%	16%	15%	14% to 21%
Attendance Allowance claimants (% of population aged 65+) NOMIS Feb14	13%	14%	15%	13% to 15%
Job Seekers Allowance (% of working population) NOMIS Sep14	1.2%	1.4%	2.5%	1.1% to 2.6%
Income Support or Pension Credit claimants (% of total population) NOMIS Feb14	5%	4%	5%	4% to 7%
Pension Credit claimants (% of population aged 65+) NOMIS Feb14	17%	17%	21%	16% to 21%
Council tax bands A to C (% of households) 2011	65%	65%	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 26/8/2014	28	33	60	17 to 47
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 26/8/2014	27	35	46	12 to 48

Chard, Crewkerne and Ilminster area

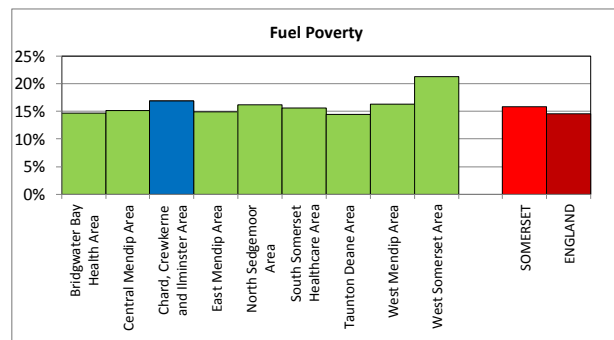
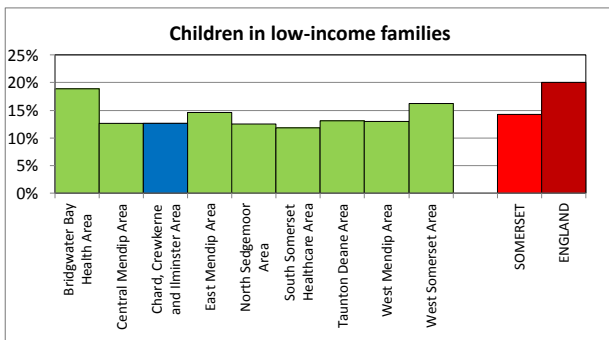
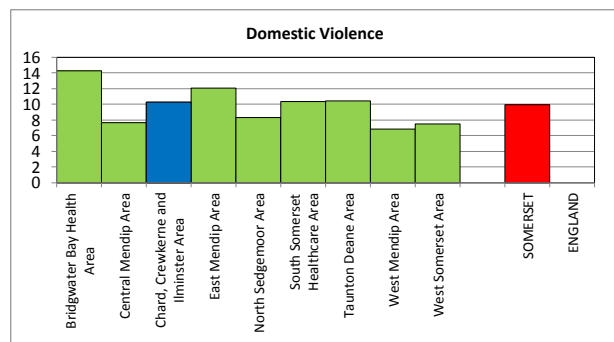
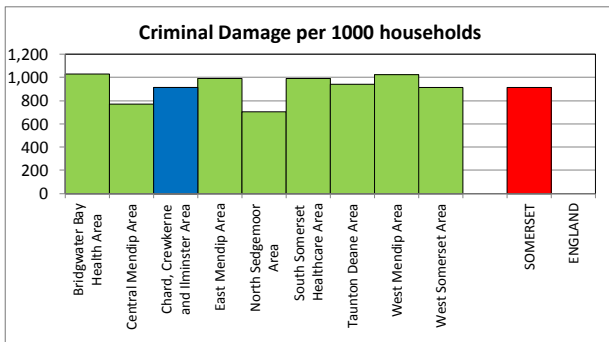
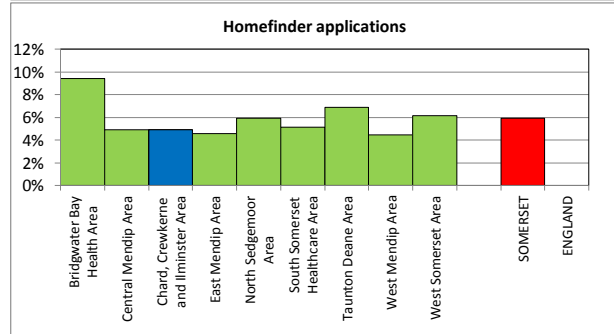
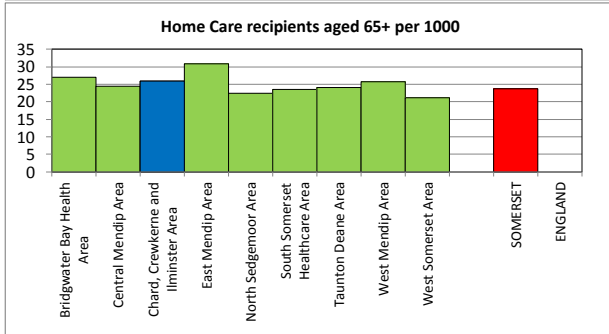
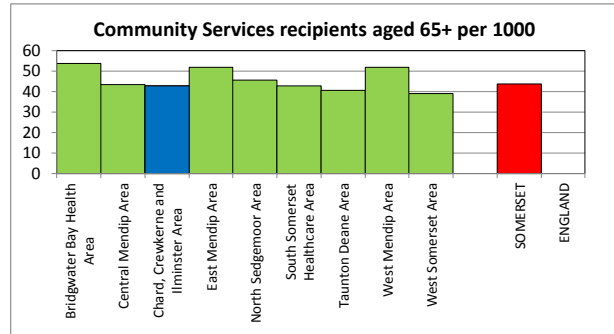
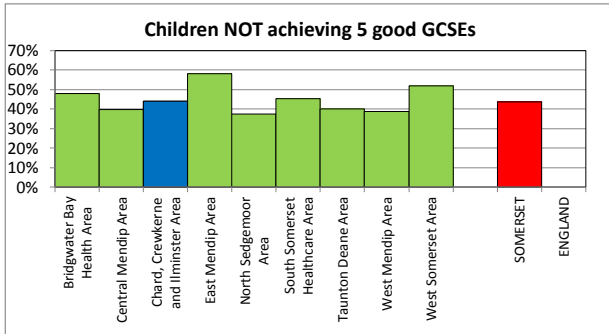
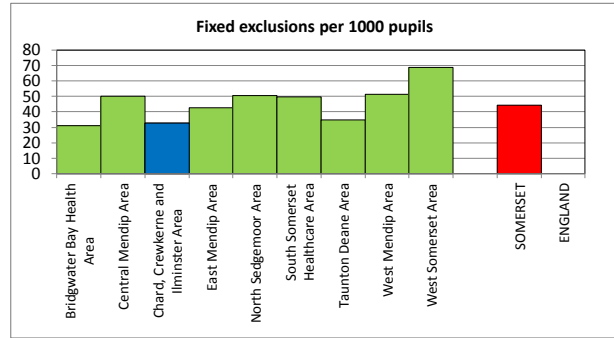
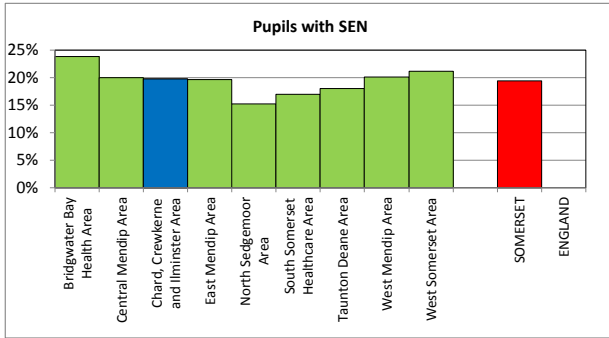
This bar graph shows where the Federation score is on the various indicators compared to the other Federations. Each vertical line on the yellow bar shows the position of a Federation. Your Federation is highlighted with the red diamond. The worst performing federation score is the extreme left and best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



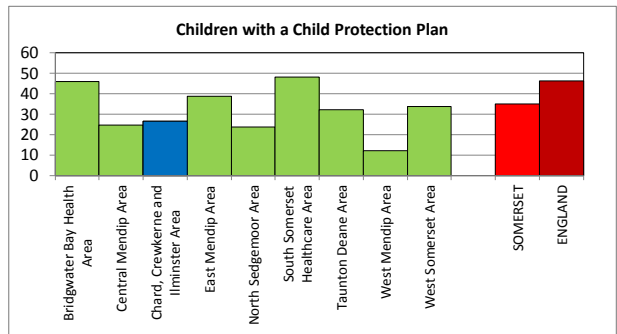
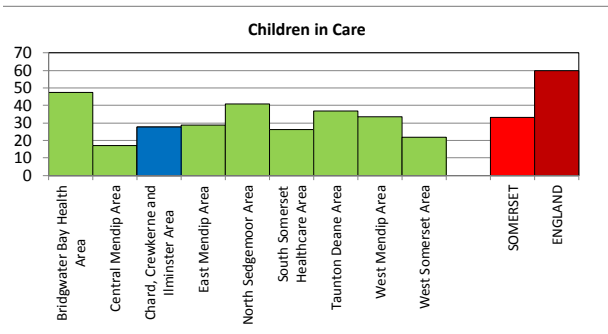
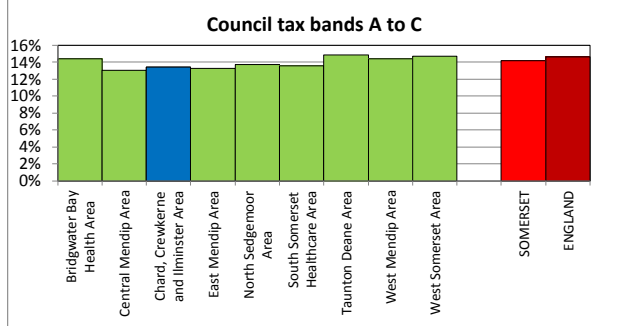
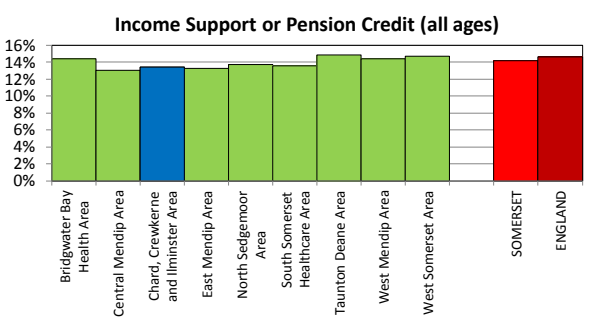
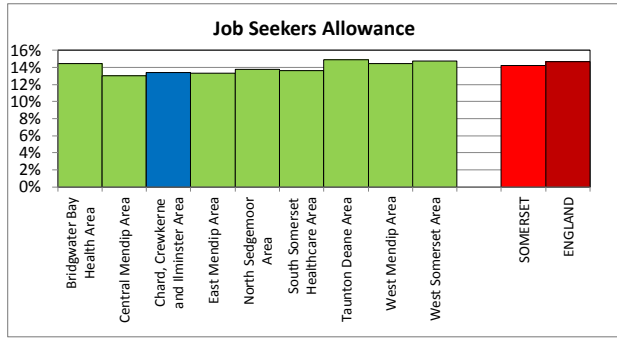
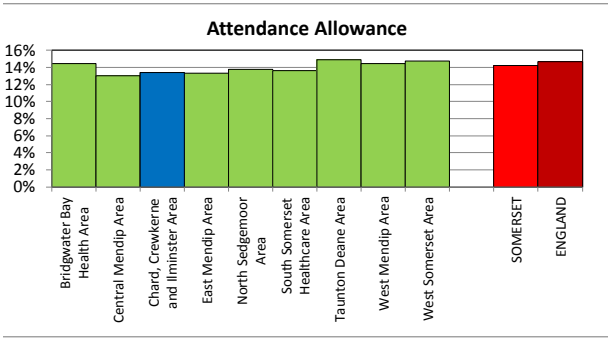
Chard, Crewkerne and Iminster area



Chard, Crewkerne and Iminster area



Chard, Crewkerne and Iminster area



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 Federation from practice clinical systems compared to expected numbers if the Federation 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 Federation and Somerset values of the number recorded with the condition as a proportion of the total population. The first method shown below is to improve upon this estimate by adjustments to allow for the extent to which the Federation 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 Federations 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 Federation has better than expected population health.

A comparison of the recorded prevalence to the modelled prevalence in the Federation is often used as an estimate of diagnosis completeness. Here we have focussed 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 last year 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
- 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 disease areas to cover. Please email JAClarkson@somerset.gov.uk

Chard, Crewkerne and Ilminster area

Prevalence rate (rate per 1000 population)

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

This data shows a comparison of the level of recorded disease in the Federation 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.

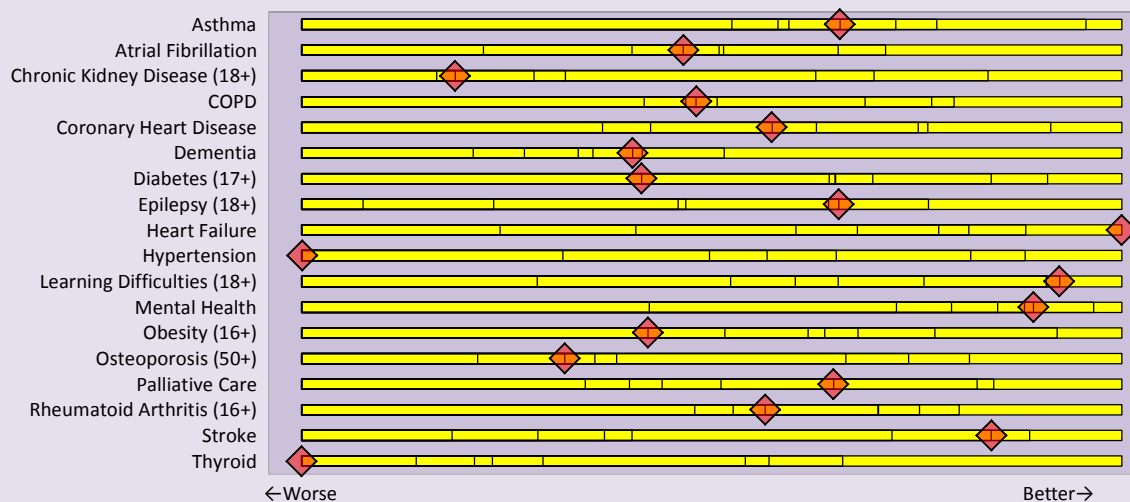
The level of disease /condition expected in the Federation has been calculated by taking the total Somerset recorded numbers and then partialling this out to the number expected in the Federation, making allowances for differences in the age and sex profile of the Federation compared to Somerset as a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

2014

Condition	Observed in Federation	Expected in Federation (based on Somerset rates)	Federation rate	Somerset rate	England rate (2013)	Range of Practice values low / median / high
Asthma	2,948	2,950	62.9	63.0	63.6	41.3 / 63.3 / 83.7
Atrial Fibrillation	1,184	1,174	22.2	22.0	21.1	12.9 / 22.3 / 29.8
Chronic Kidney Disease (18+)	2,401	2,163	55.9	50.3	56.9	27.6 / 48.9 / 87.5
COPD	1,111	1,057	21.2	20.2	23.1	9.7 / 19.3 / 41.7
Coronary Heart Disease	2,022	2,012	38.2	38.0	45.6	24.1 / 37.9 / 54.0
Dementia	417	438	7.7	8.1	8.3	2.6 / 7.4 / 15.2
Diabetes (17+)	2,764	2,645	65.9	63.0	74.3	46.6 / 62.4 / 89.2
Epilepsy (18+)	304	321	7.9	8.3	8.1	2.7 / 7.8 / 24.4
Heart Failure	381	428	7.1	8.0	10.0	3.2 / 8.0 / 17.1
Hypertension	9,064	8,300	175	160	178.8	122 / 160 / 234
Learning Difficulties (18+)	148	181	4.1	5.0	4.3	0.5 / 3.8 / 21.7
Mental Health	329	358	6.9	7.5	9.1	1.2 / 6.8 / 17.5
Obesity (16+)	4,447	4,018	110	99	118.8	55 / 99 / 188
Osteoporosis (50+)	679	623	16	15	0.0	0.0 / 14.8 / 33.1
Palliative Care	90	102	2.1	2.4	3.9	0.3 / 2.0 / 11.1
Rheumatoid Arthritis (16+)	353	343	8.6	8.3	0.0	4.2 / 8.0 / 13.3
Stroke	1,091	1,166	20.6	22.0	23.3	14.8 / 21.8 / 29.9
Thyroid	2,167	1,965	43.1	39.1	39.1	23.4 / 39.3 / 49.9

The bar chart shows how the Federation compares to other Federations in terms of their observed and expected numbers. Each vertical line on the yellow bar shows the position of a Federation. Your Federation is highlighted by the red diamond. Values to the left show more cases recorded than expected compared to other Federations 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.

Prevalence (Standardised to Somerset)



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

Chronic Kidney Disease (18+) Hypertension Obesity (16+) Thyroid

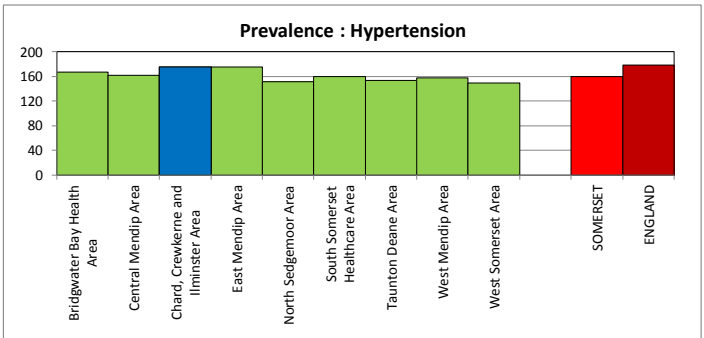
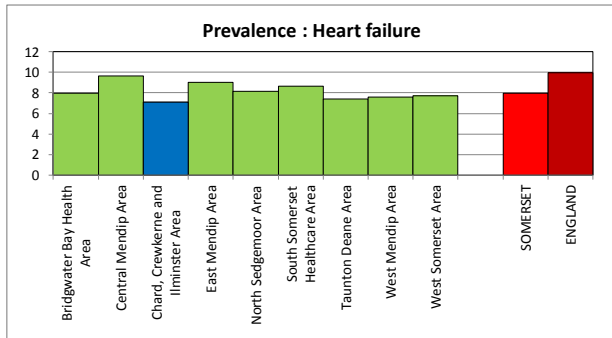
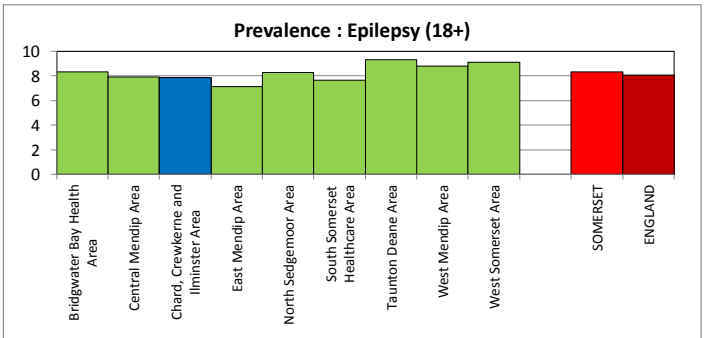
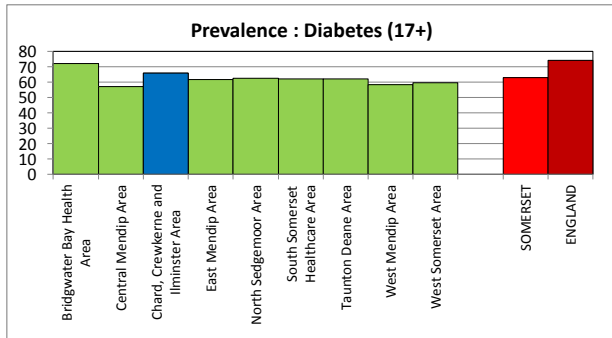
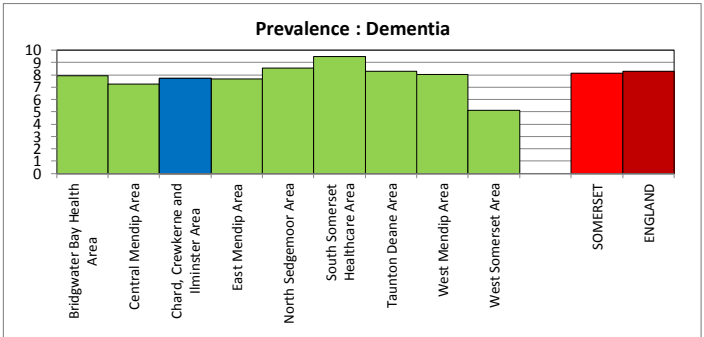
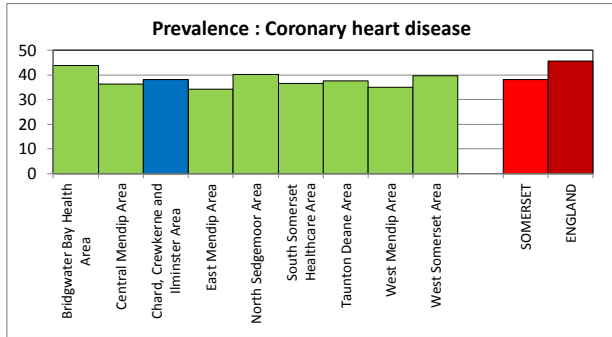
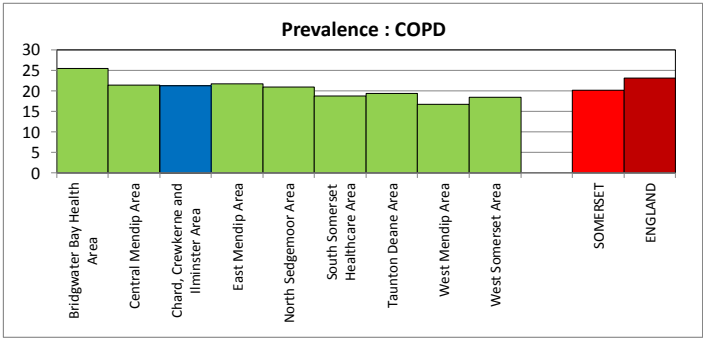
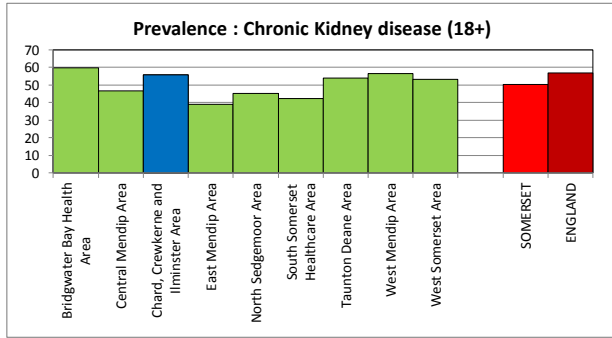
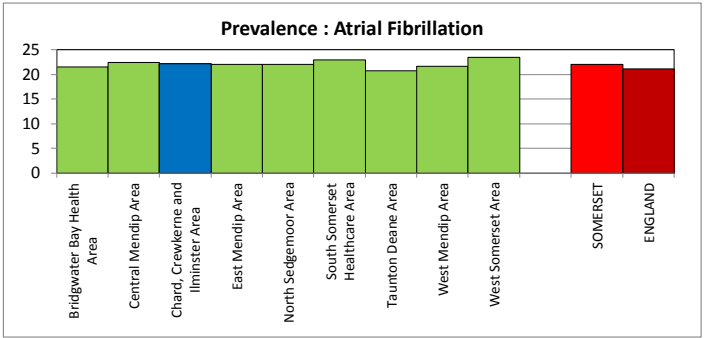
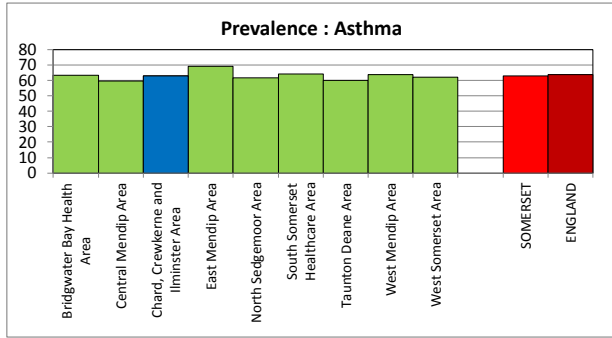
The Federation has the worst value (highest number compared to the expected based on county average) in the county for:

Thyroid

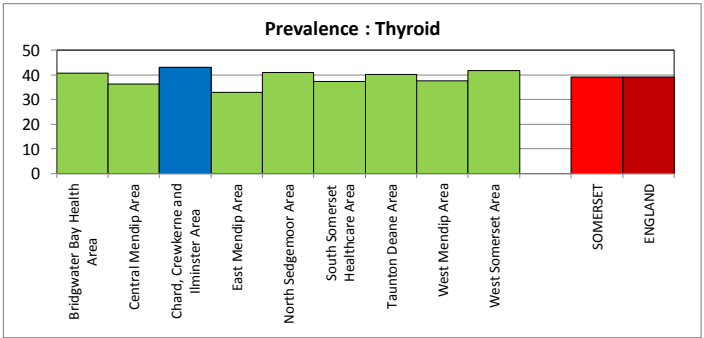
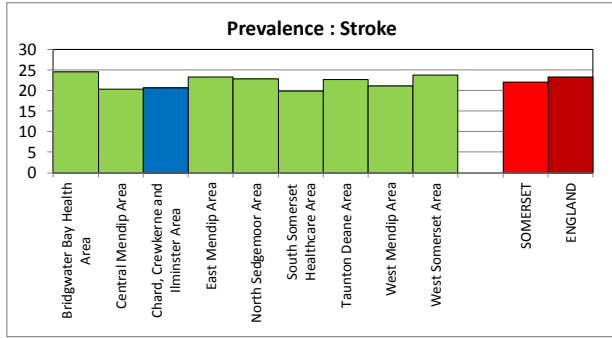
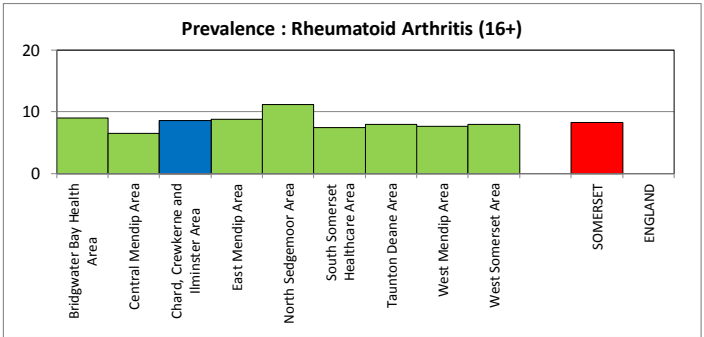
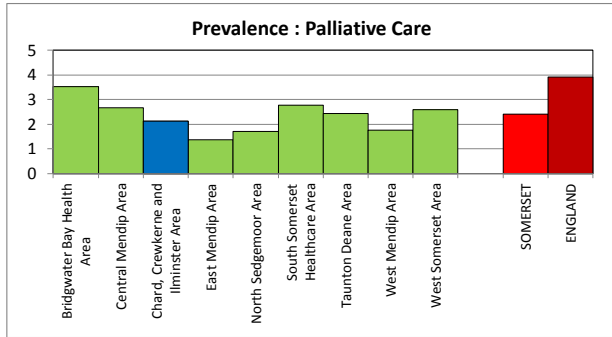
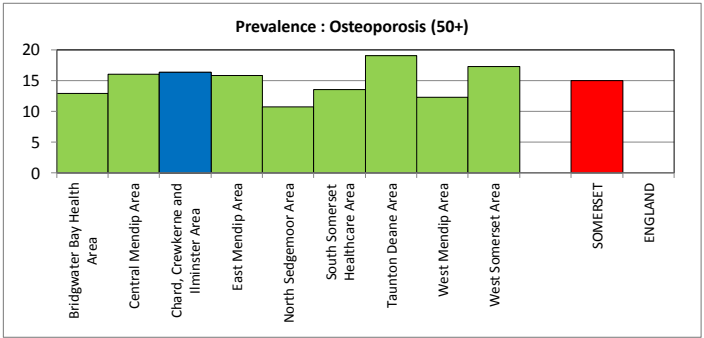
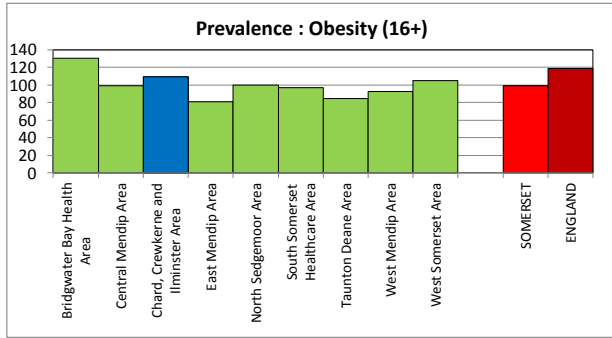
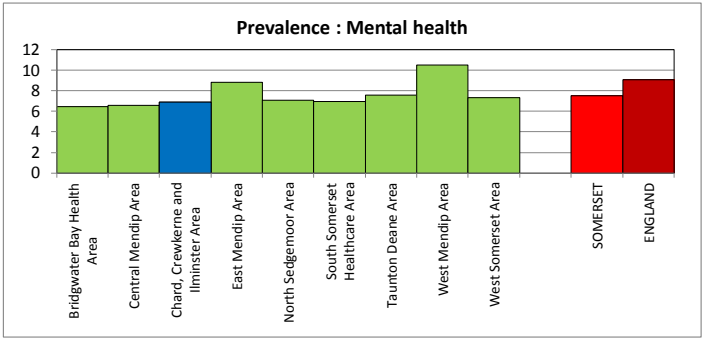
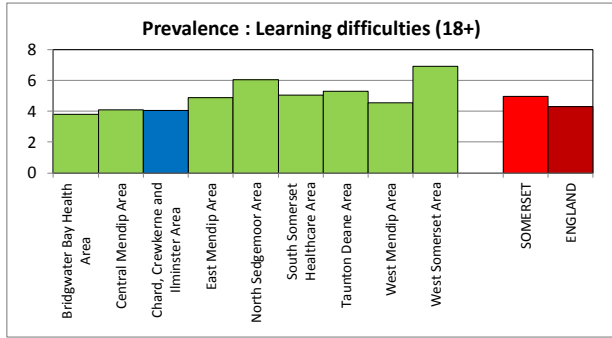
The Federation has the best value (lowest number compared to the expected based on county average) in the county for:

Heart Failure

Chard, Crewkerne and Iminster area



Chard, Crewkerne and Iminster area



England data is for 2013

Chard, Crewkerne and Ilminster area

Estimated proportion of people expected to have Dementia 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 .

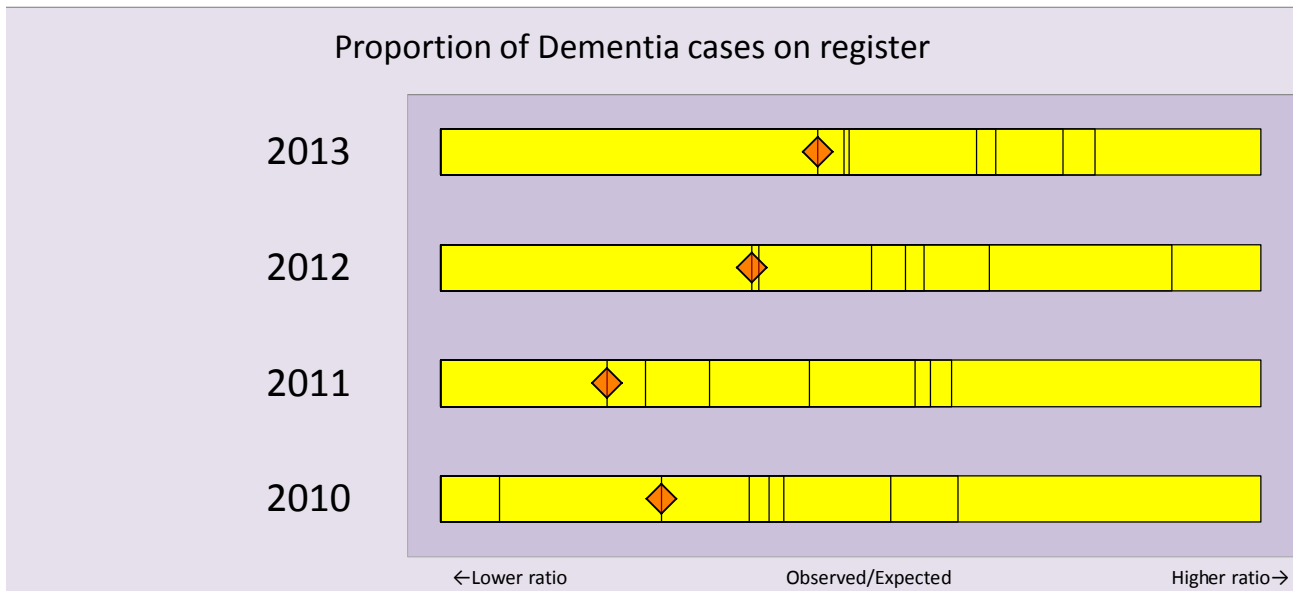
The expected values are based on the NHS Information Centre model as found on the NHS comparators website.

An observed value below that of the expected value may indicate there are undiagnosed patients with that condition within the Federation population. Conversely a higher number in the observed column may also warrant further investigation and may indicate are area 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.

		Federation	Somerset	England	Range of Practice values low / median / high
2013	Observed number on register	370	4,178	318,669	
	Expected number on register	843	8,618	647,786	
	Proportion of expected on register	43.9%	48.5%	49.2%	14.2% / 45.0% / 77.8%
2012	Observed number on register	317	3,681	293,738	
	Expected number on register	829	8,435	630,333	
	Proportion of expected on register	38.2%	43.6%	46.6%	16.0% / 42.8% / 83.9%
2011	Observed number on register	255	3,211	266,697	
	Expected number on register	803	8,224	642,741	
	Proportion of expected on register	31.8%	39.0%	41.5%	0.0% / 34.2% / 83.4%
2010	Observed number on register	253	2,892	249,463	
	Expected number on register	791	8,088	635,696	
	Proportion of expected on register	32.0%	35.8%	39.2%	0.0% / 33.1% / 70.1%

The bar chart shows how Federation performance compares to other Federations. Each vertical line on the yellow bar shows the position of a Federation. Your Federation 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.



Chard, Crewkerne and Ilminster area

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.

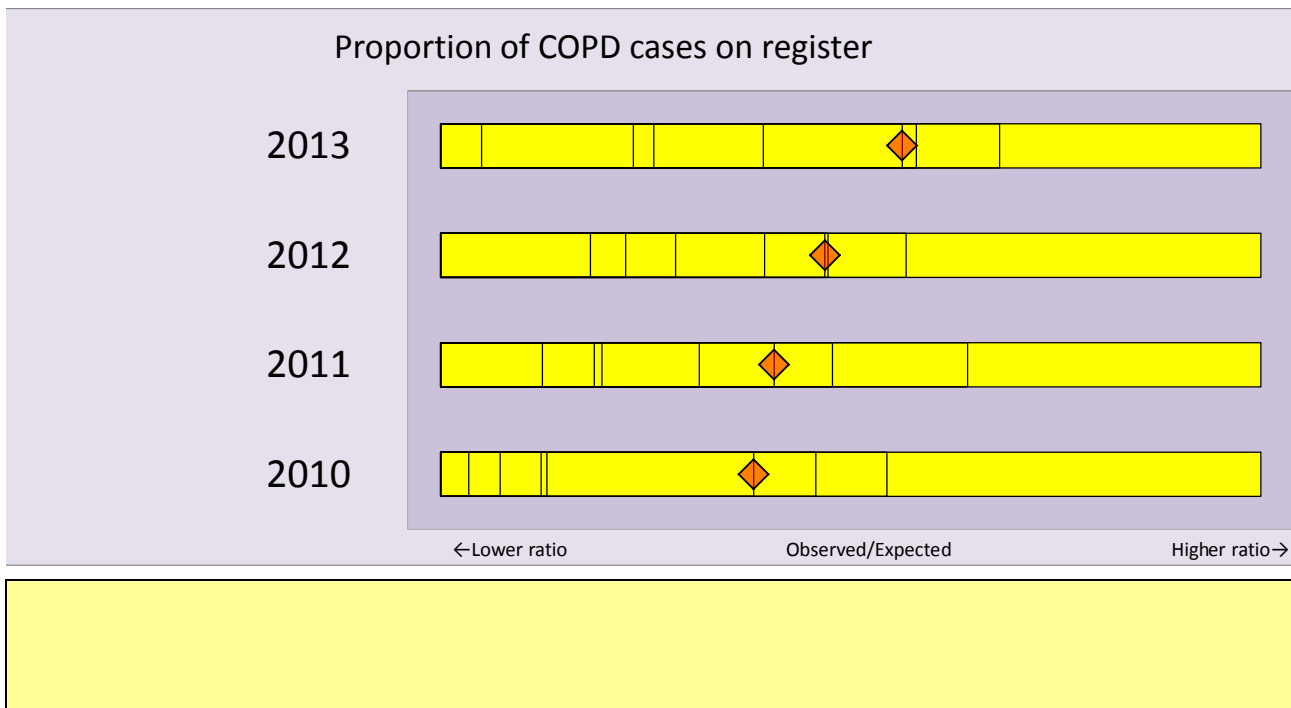
The expected values are based on NHS Information Centre models as found on the NHS comparators website, except for diabetes which uses the Yorkshire and Humberside Public Health Observatory Model.

An observed value below that of the expected value may indicate there are undiagnosed patients with that condition within the Federation population. Conversely a higher number in the observed column may also warrant further investigation and may indicate an area 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.

		Federation	Somerset	England	Range of Practice values low / median / high
2013	Observed number on register	1,024	10,507	1,870,395	
	Expected number on register	1,019	10,994	2,471,469	
	Proportion of expected on register	100.4%	95.6%	75.7%	50.4% / 93.5% / 162.9%
2012	Observed number on register	959	9,924	938,511	
	Expected number on register	998	10,751	907,873	
	Proportion of expected on register	96.0%	92.3%	103.4%	44.5% / 90.1% / 156.6%
2011	Observed number on register	899	9,487	898,989	
	Expected number on register	972	10,490	888,795	
	Proportion of expected on register	92.5%	90.4%	101.1%	40.5% / 86.9% / 166.5%
2010	Observed number on register	873	9,105	861,341	
	Expected number on register	959	10,345	916,143	
	Proportion of expected on register	91.1%	88.0%	94.0%	46.4% / 83.9% / 171.7%

The bar chart shows how Federation performance compares to other Federations. Each vertical line on the yellow bar shows the position of a Federation. Your Federation 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.

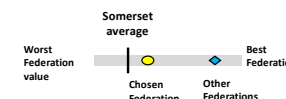




Respiratory data

Chard, Crewkerne and Ilminster

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



Significance	Indicator	Chard, Crewkerne and Ilminster number	Chard, Crewkerne and Ilminster value	Somerset average	Worst Federation value	Federation range		Best Federation value
						← Worse	Better →	
Prevalence	1 : Asthma	2,948	62.9	63.0	69.4	[Chart]		59.6
	2 : COPD	1,111	21.2	20.2	25.4	[Chart]		16.7
Mortality	3 : All respiratory disease	279	84%	100%	112%	[Chart]		74%
	4 : COPD	111	88%	100%	120%	[Chart]		68%
Flu vaccination	5 : 65 and over	9,088	74%	72%	67%	[Chart]		77%
	6 : All children aged 2 or 3	534	53%	44%	39%	[Chart]		53%
	7 : At risk 6 months to <65 years	2,385	55%	51%	44%	[Chart]		55%
	8 : Pregnant women	196	43%	35%	19%	[Chart]		47%
	9 : Carers	124	44%	40%	33%	[Chart]		44%
Smoking	10 : Current smokers (aged 16 and over)		18%	15%	20%	[Chart]		14%
	11 : 4 week smoking quit rate (all ages)		43%	42%	40%	[Chart]		47%
	12 : 4 week smoking quit rate (45-59)		42%	45%	42%	[Chart]		49%
	13 : Smokers going through cessation per 1000 recorded smokers		95.8	108.4	90.7	[Chart]		136.4
Emergency admissions	14 : Emergency admissions for Respiratory diseases (all ages)	498	10.0	10.6	12.7	[Chart]		10.0
	15 : Emergency admissions for COPD (all ages)	289	1.8	2.0	2.6	[Chart]		1.6
QOF 2013 ongoing management indicators	16 : ASTHMA 10. Patients with asthma aged 14 - 19 years with record of smoking status	204	90%	90%	89%	[Chart]		97%
	17 : ASTHMA 9. Had a review	2,136	74%	75%	73%	[Chart]		80%
	18 : COPD10. Record of FEV1	873	89%	91%	87%	[Chart]		96%
	19 : COPD13. Review including MRC dyspnoea score	891	91%	92%	91%	[Chart]		94%
	20 : COPD8. Had influenza immunisation	861	94%	93%	91%	[Chart]		97%

- Indicator Notes
- 1-2 MIQUEST (QOF) indirectly standardised prevalence rate within Somerset 2014
 - 3-4 Indirectly standardised mortality ratio (compared to Somerset) : ONS : 2009-13
 - 5-9 Uptake of Flu vaccination : PHE : Winter of 2013/14
 - 10-13 Smoking prevalence from MIQUEST query June 2014 and Somerset smoking cessation service data July 2010 to June 2014
 - 14-15 Indirectly standardised admission to hospital rate per 100,000 : Secondary Uses Service (SUS) : 2013/14 for All respiratory diseases, 2011/12 - 2013/14 for COPD. Respiratory diseases ICD10 codes: Chapter J
COPD ICD10 codes: J40-J44
 - 16-20 QOF ongoing management indicators : 2013

ASTHMA 10. The percentage of patients with asthma between the ages of 14 and 19 years in whom there is a record of smoking status in the preceding 15 months

ASTHMA 9. The percentage of patients with asthma who have had an asthma review in the preceding 15 months that includes an assessment of asthma control using the 3 RCP questions

COPD10. The percentage of patients with COPD with a record of FEV1 in the preceding 15 months

COPD13. The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the MRC dyspnoea score in the preceding 15 months

COPD8. 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 plan¹. 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 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 technique²
 - 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; Research³ 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 smoking quitters;
- 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^{2,3,4,5}. It is recommended¹ 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.

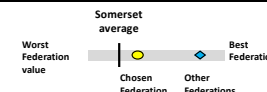
5] Jones CA, Mophew T, Clement LT, Kimia T, Dyer M, Li M, (2004) A school-based case identification process for identifying inner city children with asthma: the Breathmobile program. *Chest* 125(3) pp:924-34.

Cardiovascular data



Chard, Crewkerne and Ilminster

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



Significance	Indicator	Chard, Crewkerne and Ilminster number	Chard, Crewkerne and Ilminster value	Somerset average	Worst Federation value	Federation range	Best Federation value
						←Worse Better→	
Prevalence	1 : Coronary heart disease	2,022	38.2	38.0	43.8		34.1
	2 : Stroke/TIA	1,091	20.6	22.0	24.6		19.9
	3 : Heart failure	381	7.1	8.0	9.7		7.1
	4 : Atrial Fibrillation	1,184	22.2	22.0	23.5		20.7
	5 : Hypertension	9,064	175	160	175		149
	6 : Diabetes (ages 17 and over)	2,764	66	63	72		57
	7 : Obesity (ages 16 and over)	4,447	110	99	131		81
Smoking	8 : Current smokers (aged 16 and over)		0.2	0.2	0.2		0.1
	9 : 4 week smoking quit rate (all ages)		43%	42%	40%		47%
	10 : 4 week smoking quit rate (45-59)		42%	45%	42%		49%
Mortality	11 : Smokers going through cessation per 1000 recorded smokers		96	108	91		136
	12 : All circulatory disease	769	1.0	1.0	1.1		0.9
Admissions	13 : All circulatory disease <75	156	1.0	1.0	1.1		0.8
	14 : Emergency admissions for Circulatory diseases (all ages)	501	9.7	10.3	12.5		9.7
	15 : Elective admissions for Circulatory diseases (all ages)	448	8.9	8.7	10.0		5.5
	16 : Alcohol related admissions	5,133	2,017	2,068	2,183		1,805
NHS Health Checks	17 : Alcohol specific admissions	818	355	376	460		304
	18 : % of population eligible for NHS health check	2,959	67%	71%	73%		67%
	19 : % of eligible population invited	2,997	101%	76%	38%		130%
	20 : % of eligible population checked	1,657	56%	40%	27%		62%
QOF 2013 ongoing management indicators	21 : % of those invited who were checked	1,657	55%	53%	41%		79%
	22 : CHD6. BP is 150/90 or less	1,737	92%	91%	89%		93%
	23 : CHD8. Cholesterol is 5mmol/l or less	1,474	83%	82%	80%		85%
	24 : CHD9. Aspirin or alternative taken	1,775	94%	94%	93%		95%
	25 : CHD10. Treated with a beta-blocker	1,224	79%	77%	73%		81%
	26 : CHD12. Had influenza vaccination	1,635	95%	94%	92%		95%
	27 : CHD14. Treated with ACE inhibitor or alternative	69	88%	89%	85%		93%
	28 : STROKE 6. BP is 150/90 or less	956	91%	90%	88%		92%
	29 : STROKE 7. Have a record of cholesterol	983	94%	93%	91%		95%
	30 : STROKE 8. Cholesterol is 5mmol/l or less	810	82%	81%	78%		84%
	31 : STROKE 10. Had influenza vaccination	884	93%	91%	88%		94%
	32 : STROKE 12. Taking anti-platelet agent or an anti-coagulant	699	94%	93%	91%		94%
	33 : HF3. Treated with an ACE inhibitor or Angiotensin Receptor Blocker	167	91%	90%	87%		93%
	34 : HF4. Treated with ACE inhibitor/Angiotensin Receptor Blocker and also betablocker	109	90%	85%	81%		91%
	35 : AF5. Treated with anti-coagulation or anti-platelet therapy	1,055	99%	97%	93%		99%
	36 : AF6. Treated with anti-coagulation or anti-platelet therapy if CHAD2 score is 1	229	95%	95%	93%		96%
	37 : AF7. Treated with anti-coagulation or anti-platelet therapy if CHAD2 score is >1	485	89%	84%	76%		89%
	38 : BP4. BP recorded in the preceding nine months	8,233	93%	93%	91%		95%
	39 : BP5. BP is 150/90 or less	7,139	83%	83%	81%		85%

Indicator	Notes
1-7	MIQUEST (QOF) indirectly standardised prevalence rate within Somerset 2014
8-11	Smoking prevalence from MIQUEST query June 2014 and Somerset smoking cessation service data July 2010 to June 2014
12-13	Indirectly standardised mortality ratio (compared to Somerset) : ONS : 2009-13
14-17	Indirectly standardised admission to hospital rate per 100,000 : Secondary Uses Service (SUS) : 2013/14 for Circulatory diseases, 2009/10 - 2013/14 for Alcohol admissions. Circulatory diseases ICD10 codes: Chapter I 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 http://www.lape.org.uk/
18-21	Somerset NHS Health Checks : financial year 2013/14
22-39	QOF ongoing management indicators : 2013

AF5. The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHADS₂ risk stratification scoring system in the preceding 15 months

AF6. In those patients with atrial fibrillation in whom there is a record of a CHADS₂ score of 1 (latest in the preceding 15 months), the percentage of patients who are currently treated with anti-coagulation drug therapy or anti-platelet therapy

AF7. In those patients with atrial fibrillation whose latest record of a CHADS₂ score is greater than 1 who are currently treated with anti-coagulation therapy

BP4. The percentage of patients with hypertension in whom there is a record of the blood pressure in the preceding 9 months

BP5. The percentage of patients with hypertension in whom the last blood pressure (measured in the preceding 9 months) is 150/90 or less

CHD10. The percentage of patients with coronary heart disease who are currently treated with a beta-blocker

CHD12. The percentage of patients with coronary heart disease who have had influenza immunisation in the preceding 1 September to 31 March

CHD14. The percentage of patients with a history of myocardial infarction (from 1 April 2011) currently treated with, an ACE inhibitor (or ARB if ACE intolerant), alternative anti-platelet therapy

CHD6. The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 or less

CHD8. The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the preceding 15 months) is 5mmol/l or less

CHD9. The percentage of patients with coronary heart disease with a record in the preceding 15 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken

HF3. The percentage of patients with a current diagnosis of heart failure due to left ventricular dysfunction (LVD) who are currently treated with an ACE inhibitor or angiotensin receptor blocker (ARB), who can tolerate therapy and for whom there is no contraindication

HF4. The percentage of patients with a current diagnosis of heart failure due to LVD who are currently treated with an ACE inhibitor or angiotensin receptor blocker (ARB) who are additionally treated with a beta-blocker licensed for heart failure or recorded as intolerant to or having a contraindication to beta-blockers

STROKE 10. The percentage of patients with stroke or TIA who have had influenza immunisation in the preceding 1 September to 31 March

STROKE 12. The percentage of patients with a stroke shown to be non-haemorrhagic, who have a record that an anti-platelet agent (aspirin, dipyridamole or a combination), or an anti-coagulant is being taken

STROKE 6. The percentage of patients with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 or less

STROKE 7. The percentage of patients with stroke or TIA who have a record of total cholesterol in the preceding 15 months

STROKE 8. The percentage of patients with stroke or TIA whose last measured total cholesterol (measured in the preceding 15 months) is 5mmol/l or less

Cancer Commissioning Indicators

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

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

Chard, Crewkerne and Ilminster



Year	Indicator	Chard, Crewkerne and Ilminster number	Chard, Crewkerne and Ilminster value	Somerset CCG value	Lowest Federation value in Somerset	Chart	Highest Federation value in Somerset	Chard, Crewkerne and Ilminster compared to Somerset	Lowest practice value in Chard, Crewkerne and Ilminster	Highest practice value in Chard, Crewkerne and Ilminster
2013	1 Practice Population aged 65+ (% of population in this practice aged 65+)	11,841	26%	22%	18%		30%	Higher than Somerset	23%	35%
	2 New cancer cases (Crude incidence rate: new cases per 100,000 population)	264	571	603	534		790	Higher than Somerset	421	870
	3 Cancer deaths (Crude mortality rate: deaths per 100,000 population)	121	262	282	202		414	Higher than Somerset	0	417
	4 Prevalent cancer cases (% of practice population on practice cancer register)	1,322	3%	3%	2%		3%	Higher than Somerset	2%	4%
	5 Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %)	5,339	77%	76%	71%		79%	Higher than Somerset	64%	82%
	6 Females, 50-70, screened for breast cancer within 6 months of invitation (Uptake, %)	4,768	81%	79%	41%		81%	Higher than Somerset	69%	85%
	7 Females, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage, %)	7,985	78%	77%	73%		79%	Higher than Somerset	73%	84%
	8 Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)	4,405	64%	63%	61%		64%	Higher than Somerset	55%	68%
	9 Persons, 60-69, screened for bowel cancer within 6 months of invitation (Uptake, %)	2,091	66%	64%	63%		66%	Higher than Somerset	58%	70%
	10 Two-week wait referrals (Number per 100,000 population)	1,423	3,077	2,756	2,041		3,381	Higher than Somerset	2,007	3,807
	11 Two-week wait referrals (Indirectly age standardised referral ratio)	1,423	107%	103%	80%		110%	Higher than Somerset	71%	129%
	12 Two-week referrals with cancer (Conversion rate: % of all TWW referrals with cancer)	200	14%	11%	10%		14%	Higher than Somerset	9%	19%
	13 Number of new cancer cases treated (% of which are TWW referrals)	370	54%	49%	44%		55%	Higher than Somerset	40%	58%
	14 Two-week wait referrals with suspected breast cancer (Number per 100,000 population)	227	491	424	170		583	Higher than Somerset	308	637
	15 Two-week wait referrals with suspected lower GI cancer (Number per 100,000 population)	281	608	473	405		651	Higher than Somerset	261	863
	16 Two-week wait referrals with suspected lung cancer (Number per 100,000 population)	47	102	99	74		138	Higher than Somerset	21	308
	17 Two-week wait referrals with suspected skin cancer (Number per 100,000 population)	243	525	494	411		550	Higher than Somerset	386	660
	18 In-patient or day-case colonoscopy procedures (Number per 100,000 population)	331	716	676	534		859	Higher than Somerset	541	846
	19 In-patient or day-case sigmoidoscopy procedures (Number per 100,000 population)	382	826	664	347		942	Higher than Somerset	261	1,337
	20 In-patient or day-case upper GI endoscopy procedures (Number per 100,000 population)	554	1,198	1,158	1,019		1,261	Higher than Somerset	877	1,591
	21 Number of emergency admissions with cancer (Number per 100,000 population)	307	664	563	417		838	Higher than Somerset	485	1,003
	22 Number of emergency presentations with cancer (Number per 100,000 population)	50	108	86	47		111	Higher than Somerset	55	231
	23 Number of managed referral presentations with cancer (Number per 100,000 population)	187	404	351	259		441	Higher than Somerset	185	524

The following information is presented:

- Deaths – overview of causes of death 2009-2013 of Federation patients.
- Years of Life Lost – overview of causes of years of life lost due to death before age 75 2009-2013 in Federation 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 Federation 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.

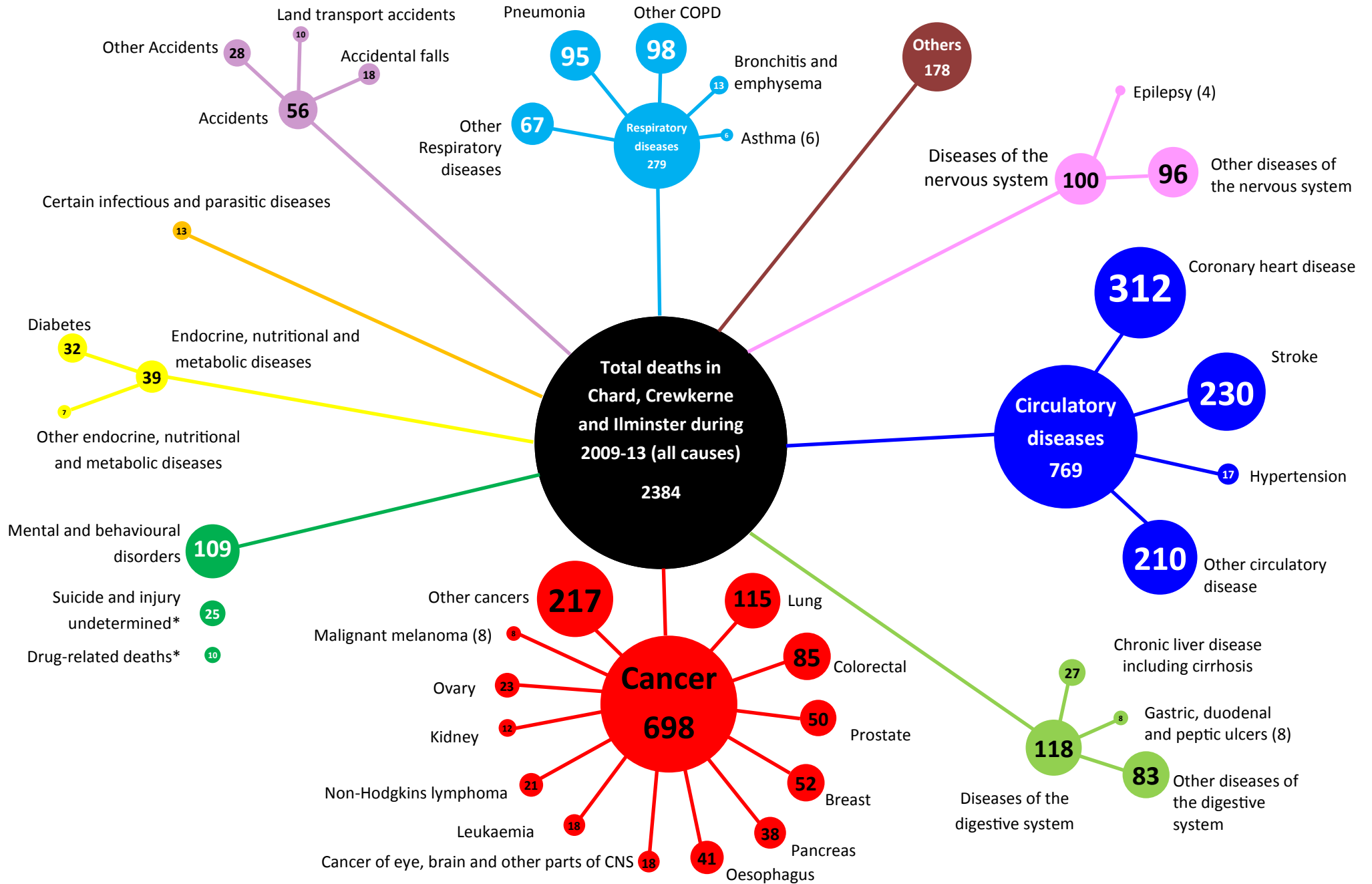
Possibly more important in terms of public health impact and valuable interventions is the corresponding diagram showing the conditions leading to years of life lost due to death before the age of 75. Whilst circulatory diseases cause approximately a third of deaths, they account for less than 20% of the years of life lost. With regard to years of life lost, 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 Federation followed the average Somerset age/sex specific death rates. They can highlight specific causes of death which may be more prevalent in this Federation. 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.

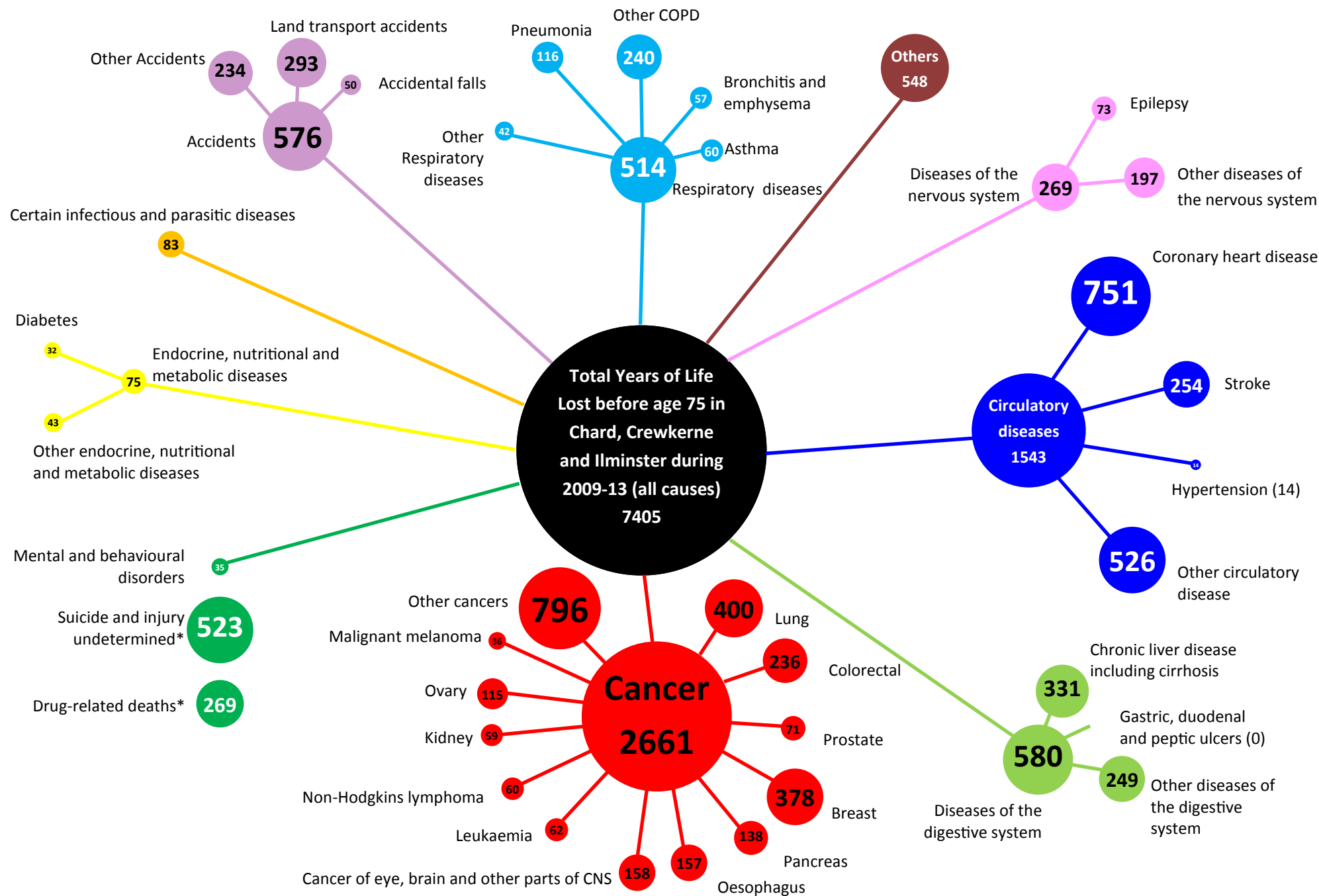
Where people die can give clues as to care available. Research has shown that many people with terminal conditions prefer to die at home if they have the choice and are appropriately supported. Numbers of those dying in nursing homes in part reflects location of nursing homes and any local barriers or 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.

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.

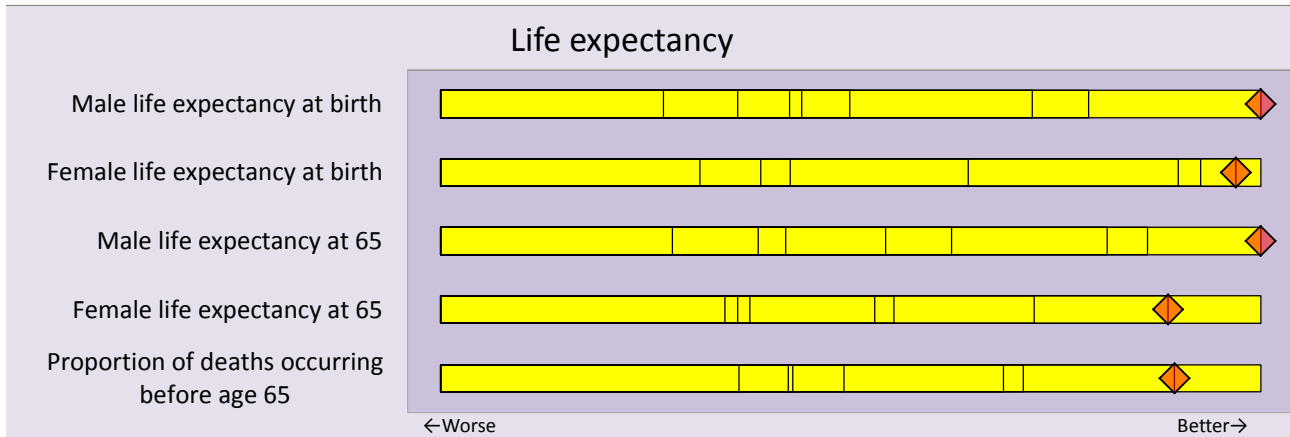
Chard, Crewkerne and Ilminster area

Life expectancy 2009-13

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

	Federation	Somerset	England (2010-12)	Range of Practice values low / median / high
Male life expectancy at birth	82.2	80.8	79.2	75.3 / 81.2 / 85.4
Female life expectancy at birth	85.2	84.3	83.0	81.0 / 84.7 / 91.1
Male life expectancy at 65	20.3	19.3	18.6	16.1 / 19.7 / 25.2
Female life expectancy at 65	22.8	21.8	21.1	18.8 / 22.3 / 28.7
Proportion of deaths occurring before age 65	11%	13%	17%	4% / 12% / 73%

The bar chart shows how the Federation compares to other Federations in terms of life expectancy of the resident population. Each vertical line on the yellow bar shows the position of a Federation. Your Federation is highlighted by the red diamond. Values to the left show shorter life expectancy compared to other federations, 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 other areas.

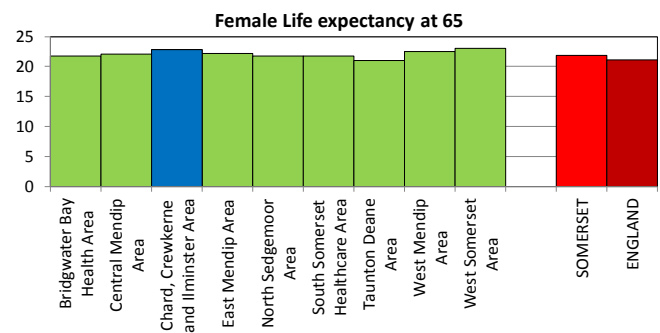
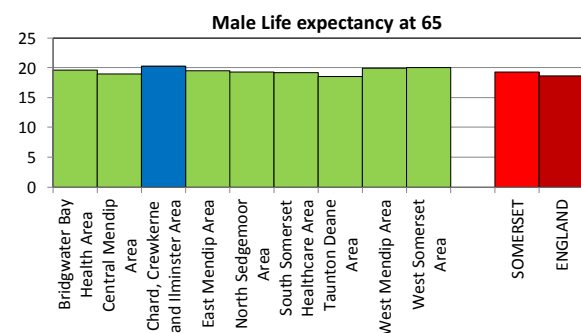
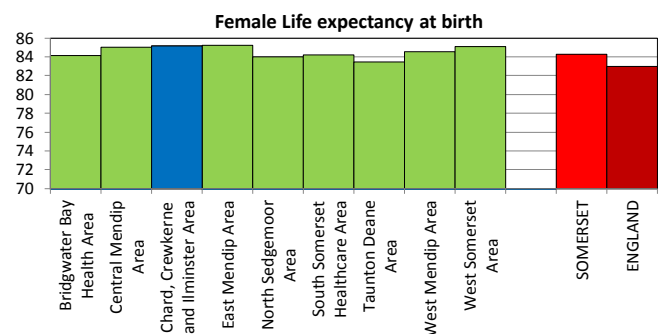
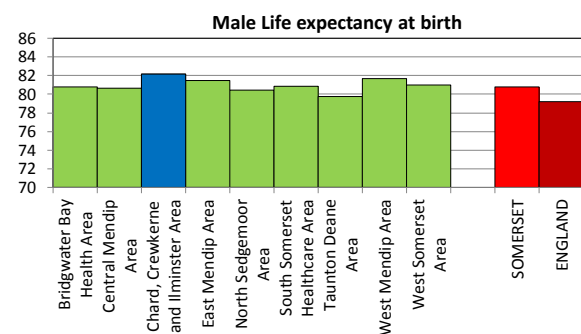


Significantly better than county average for:

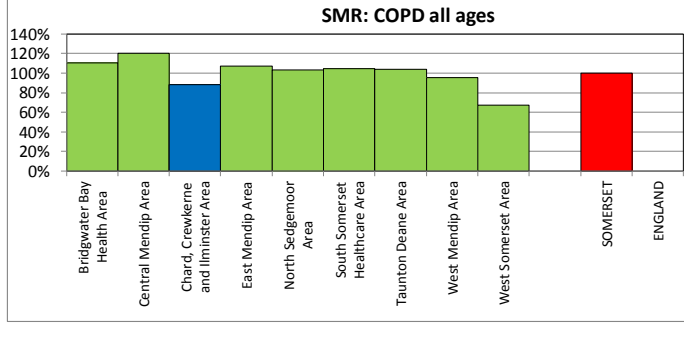
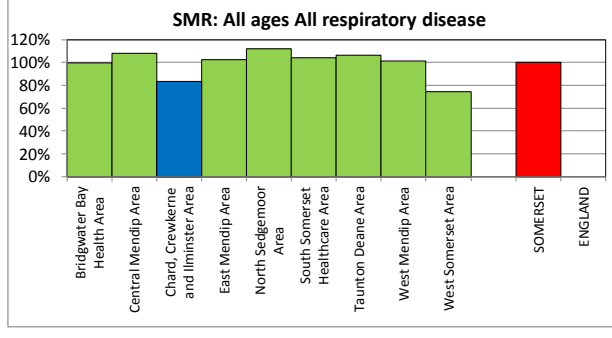
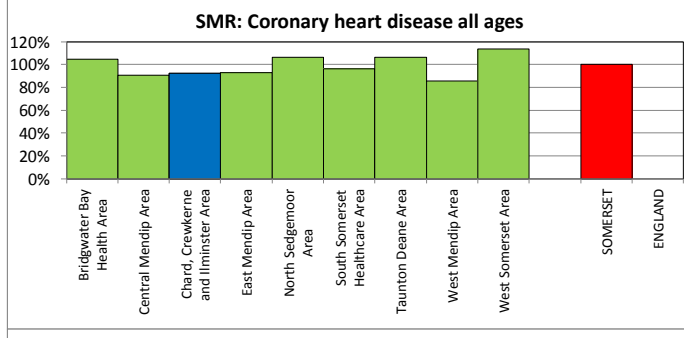
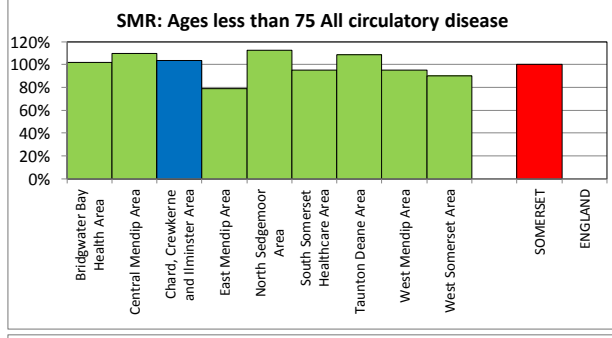
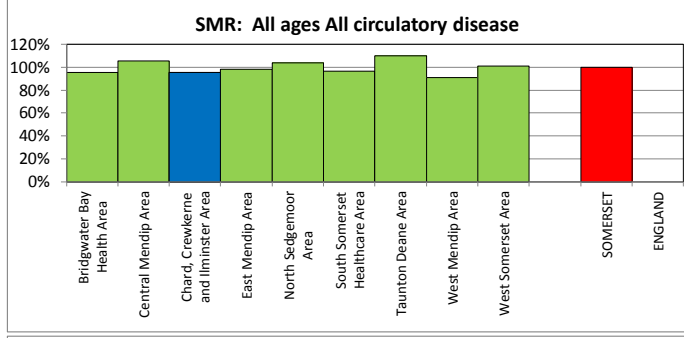
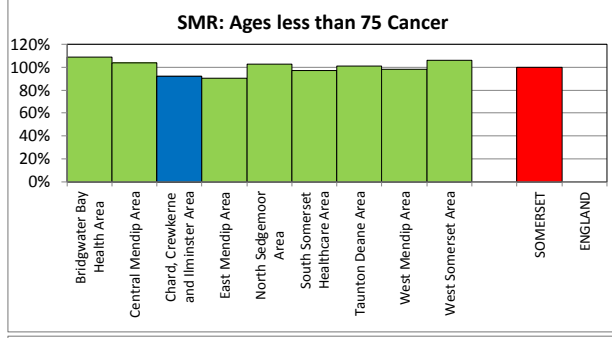
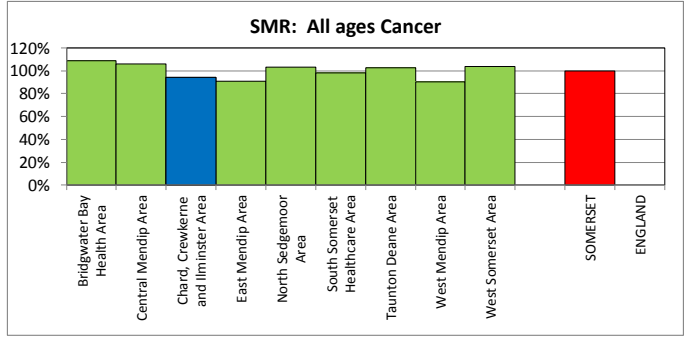
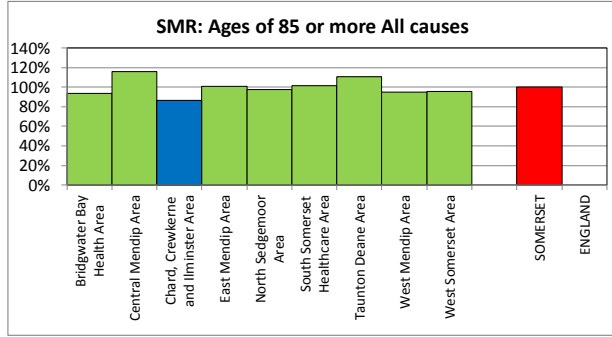
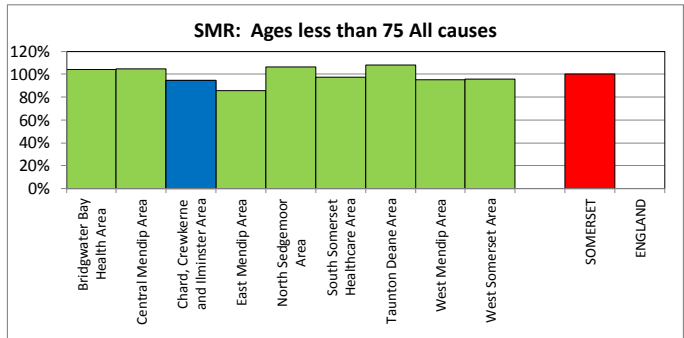
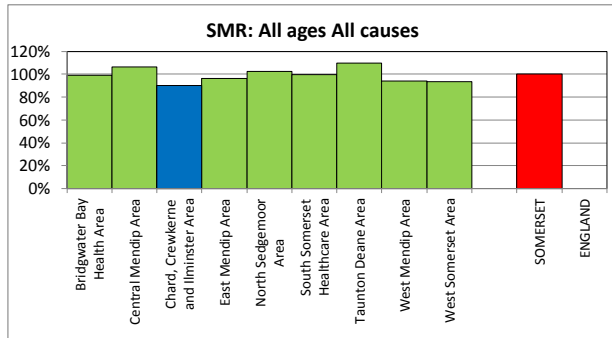
Male life expectancy at birth Male life expectancy at 65 Female life expectancy at 65

The Federation has the best value in the county for:

Male life expectancy at birth Male life expectancy at 65



Chard, Crewkerne and Ilminster area



Chard, Crewkerne and Ilminster area

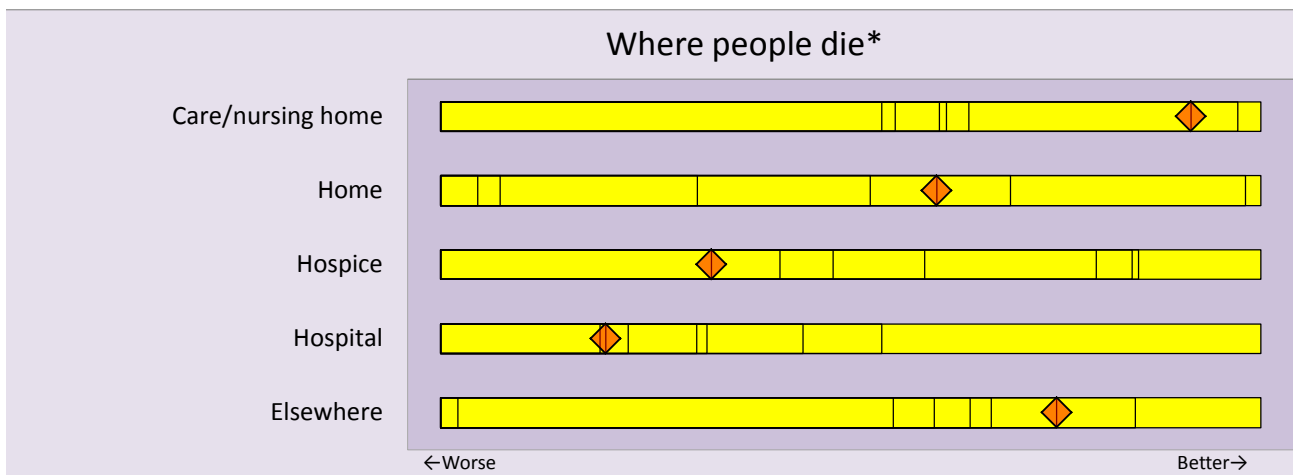
Where people die

Deaths registered between 2009 and 2013. ONS Primary Care Mortality Database.

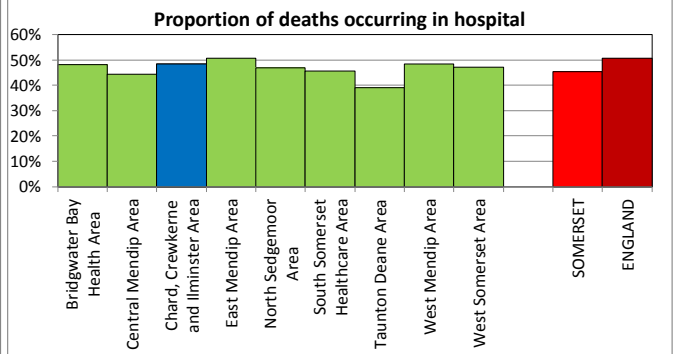
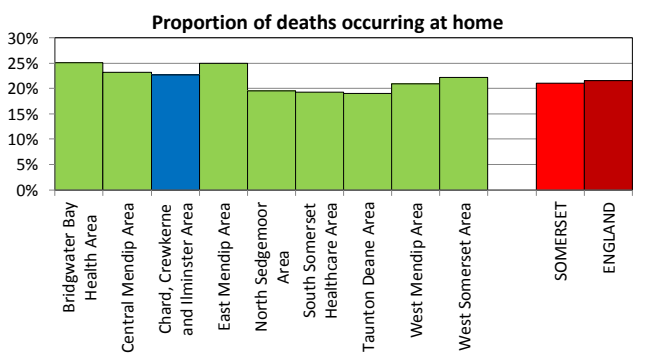
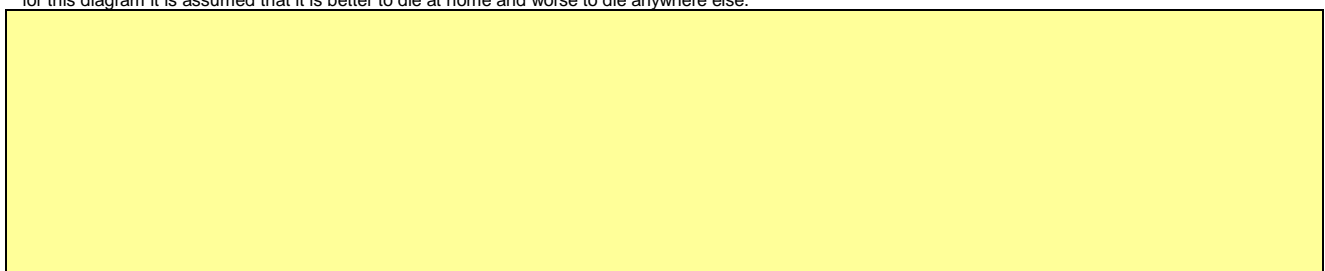
Where people die will reflect access to services as well as patterns of care. The category of Elsewhere covers everywhere not in the other categories and includes such places as other people's houses and roads.

	Federation %	Somerset %	England % (2010-12)	Range of Practice values low / median / high
Care/nursing home	21%	26%	20%	4% / 24% / 50%
Home	23%	21%	22%	10% / 22% / 39%
Hospice	6%	5%	6%	2% / 5% / 12%
Hospital	48%	45%	51%	31% / 46% / 59%
Elsewhere	2%	2%	2%	0% / 2% / 5%

The bar chart shows how the Federation compares to other Federations. 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 Federation. Your Federation 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 Federations.



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



Prevention

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

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 2013-14 this has been provided by GPs. More detail on this programme is provided in the health checks profiles for each Federation 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 43.

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 is a new addition for the 2014 profiles. This 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.

Chard, Crewkerne and Ilminster area

NHS Health Checks - notes to accompany activity snapshot

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 2013/14:

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

There are 2 snapshot versions available: by GP practice (distributed to the Practice Manager) and by Federation (here and also published on <http://extranet.somerset.gov.uk/health-checks/performance-reports/>)

OVERVIEW OF DATA REPORTED ON

The total number of Somerset NHS Health Checks analysed for 2013/2014 is 14,405 checks. This is comprised of 12,914 completed checks and 1,205 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. However, it is important to note that gaps continue to exist in the health checks records reported as follows:

Health Check Field	# records with missing data 2013/14	As % of total checks analysed
Smoking status	410	3%
Audit C Score	1,115	8%
AF Check	1,362	9%
BP	897	6%
GPPAQ	201	1%
BMI	114	1%
BMI &/or GPPAQ	264	2%
Chol/HDL Ratio	407	3%
Glucose	1,091	8%
Qrisk	17	0%

In addition to the fields with missing data identified above, it appears that some staff may not always be asking patients about "chest/calf pain on exertion" and/or "family history of CVD". Please ensure that **ALL** elements of the NHS Health Check are completed and accurately recorded.

CHART OF INVITES AND CHECKS BY ELIGIBLE POPULATION

These charts depict activity by GP Practice, Federation and 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. 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, for the GP Practice.
- 2) Indicates the checks completed as a percentage of the total eligible population in each quintile of deprivation, for the GP Practice.
- 3) Indicates the checks completed as a percentage of the total eligible population in each quintile of deprivation, for the Federation of the GP Practice.

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.

Target Activity: Practices should aim to invite a minimum of 25% of their eligible population each quarter for a health check to achieve the 100% target by year end. On reaching the 100% invite target, practices should then follow-up with those people who have not yet taken up their invitation.

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 practice has only completed a few checks. For this reason 25th and 75th percentile columns have been included to aid interpretation of the data. Averages and percentiles are based only on those practices that have done at least 1 check (ie practices with no checks are excluded).

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 ≥ 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).

Additional work is needed in this section to verify that all staff delivering health checks are recording referral activity on the patient's record.

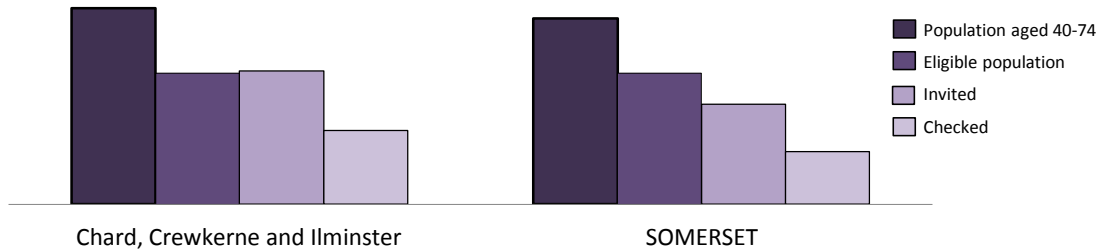
Practices should review this section in conjunction with the Referral Protocol Guideline that has been agreed within their practice.

Please note the following points:

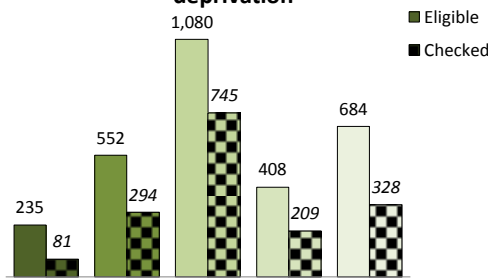
- ITEM 26: Indicates the number of people who confirmed chest/calf pain on exertion AND were recorded as referred to GP.
- ITEM 27: Indicates the number of people whose QRISK was calculated at $\geq 20\%$ AND were recorded as referred to GP.
- ITEM 31: Indicates the number of people whose BMI was calculated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

Chard, Crewkerne and Ilminster

The population/activity charts below provide a visual representation of NHS Health Check activity since April 2013 compared to the annual eligible population. This is by GP Federation and Somerset County. The data within this report includes 83 health checks that were excluded from payment to practices.¹

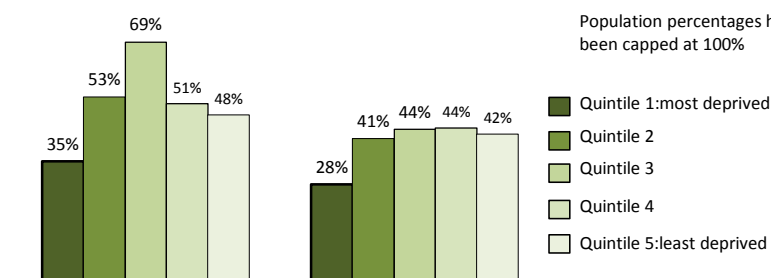


Numbers eligible and checked by deprivation



Chard, Crewkerne and Ilminster

Checks as % of eligible by deprivation



Chard, Crewkerne and Ilminster

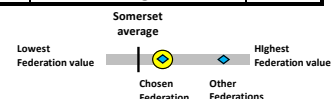
SOMERSET

Indicator	Federation Number	Federation Value	Somerset average	Lowest Federation	Range of Federation values	Highest Federation
Target activity						
1: % eligible for check	2,959	67%	71%	67%	67% - 100%	73%
2: % of eligible invited for check	2,997	100%	76%	38%	38% - 100%	100%
3: Checks as % of eligible	1,657	56%	40%	27%	27% - 79%	62%
4: Checks as % of invited	1,657	55%	53%	41%	41% - 79%	79%
Health Check Results						
5: Current Smoker	199	12%	12%	9%	9% - 28%	16%
6: Audit C >5	163	10%	12%	4%	4% - 28%	24%
7: Chest/Calf Pain indicated	46	3%	2%	0%	0% - 28%	4%
8: AF screening	17	1%	4%	1%	1% - 28%	11%
9: BP ≥140/90	464	28%	22%	17%	17% - 66%	28%
10: GPPAQ=Active	429	26%	33%	26%	26% - 61%	46%
11: GPPAQ = Moderately Active/Inactive	991	60%	48%	39%	39% - 61%	61%
12: GPPAQ=Inactive	227	14%	18%	8%	8% - 30%	30%
13: BMI ≥30	362	22%	20%	16%	16% - 26%	26%
14: BMI ≥30 and GPPAQ reported as Active	58	4%	5%	3%	3% - 7%	7%
15: Non-fasting Chol/HDL Ratio ≥6	144	9%	10%	9%	9% - 11%	11%
16: Non-fasting Glucose >6	284	17%	23%	10%	10% - 29%	29%
17: Family History of CHD	319	19%	20%	16%	16% - 28%	28%
18: Qrisk <10% (low risk)	935	56%	58%	47%	47% - 66%	66%
19: Qrisk ≥10% (moderate risk)	718	43%	41%	34%	34% - 53%	53%
20: Qrisk ≥20% (high risk)	244	15%	14%	8%	8% - 20%	20%
21: Qrisk ≥30% (very high risk)	72	4%	3%	1%	1% - 7%	7%
Lifestyle Counselling & Referrals						
22: Total receiving Lifestyle Counselling	1,561	94%	59%	44%	44% - 94%	94%
23: Smokers referred to smoking cessation	9	5%	13%	0%	0% - 31%	31%
24: Those with Audit C>5 referred to Alcohol team	0	0%	1%	0%	0% - 3%	3%
25: Total referred to GP	277	17%	9%	0%	0% - 17%	17%
26: Those with chest/calf pain indicated referred to GP	12	26%	23%	0%	0% - 29%	29%
27: Those with Qrisk≥20% referred to GP	155	64%	26%	0%	0% - 64%	64%
28: Total referred Physical Activity	5	0%	0%	0%	0% - 1%	1%
29: Total referred Weight Management	0	1%	2%	0%	0% - 5%	5%
30: Total referred Health Coaching	0	0%	1%	0%	0% - 3%	3%
31: Those with BMI≥30 referred to any of PA/WM/HC	13	4%	8%	0%	0% - 21%	21%
32: Patients with 1 referral	274	17%	11%	0%	0% - 17%	17%
33: Patients with 2+ Referrals	18	1%	1%	0%	0% - 2%	2%



1) We have included any 'excluded' records in order to provide a more complete picture of health issues identified within your practice population. Please note that health check records are excluded from payment if 4 or more data elements are missing or if QRisk is missing.

2) Federation level reports and supporting notes are available at: <http://extranet.somerset.gov.uk/health-checks/performance-reports/>
 3) Feedback should be directed to Sharon Ashton at seashton@somerset.gov.uk or NHSHealthChecks@somerset.gov.uk



Offer extended hours:

- Offer early morning appointments and/or evening appointments.
- Consider offering a number of Saturday appointments during the year.
- Target extended openings to those people who are least likely to attend during the day due to work commitments.
- Use "extended hours" for those in 40 to 55/60 age group who have not responded to initial invitation

Review your invite and follow-up:

- Ensure ALL 70-74 year olds have been invited (so they don't age out of programme)
- Review the invite letter (sample letters available on NHS Health Check support site).
 - Consider specific letters for different gender/age groups:
 - Men 40 to 60 (take charge message)
 - Women 40 to 60 (support)
 - General invite for all aged 60 to 74
 - Does it sufficiently explain what they are being invited for?
 - Does it emphasize importance of reducing risk of CVD?
 - Does it indicate the individual will receive "personalised" advice?
 - Does it emphasize that "small changes" in lifestyle can help reduce long-term risk of CVD?
- Follow-up of non-attenders:
 - How long do you wait before you follow-up?
 - Recommend 6 month window.
 - Focus on getting all initial invites out first, then go back and follow-up on those who did not respond.
 - Be sure you are accurately recording who was invited.
 - Do you follow-up by phone, letter or both?
 - Feedback suggests that phone calls late afternoon, early evening increase rates of attendance.
 - If you follow-up by letter review the wording. Strengthen the invite (ie "you are due a NHS Health Check" vs "we are inviting you")

Marketing the programme:

- Highlight NHS Health Check programme on your practice website
- Have posters in the waiting room
- Have a CVD bulletin board highlighting risk of obesity, diabetes etc (seen in one practice)
- Use of NHS Health Checks roll-up banner. Feedback is this resulted in increase in attendance for health checks.
- Use TV monitors in practice to raise awareness
- Utilise PPG to spread the word/raise awareness
- Consider local marketing/awareness strategies. Identify local areas where target population would see the message to take-up invite for a NHS Health Check.

Make use of resources on Somerset NHS Health Check Support website: <http://extranet.somerset.gov.uk/health-checks/>

Chard, Crewkerne and Ilminster area

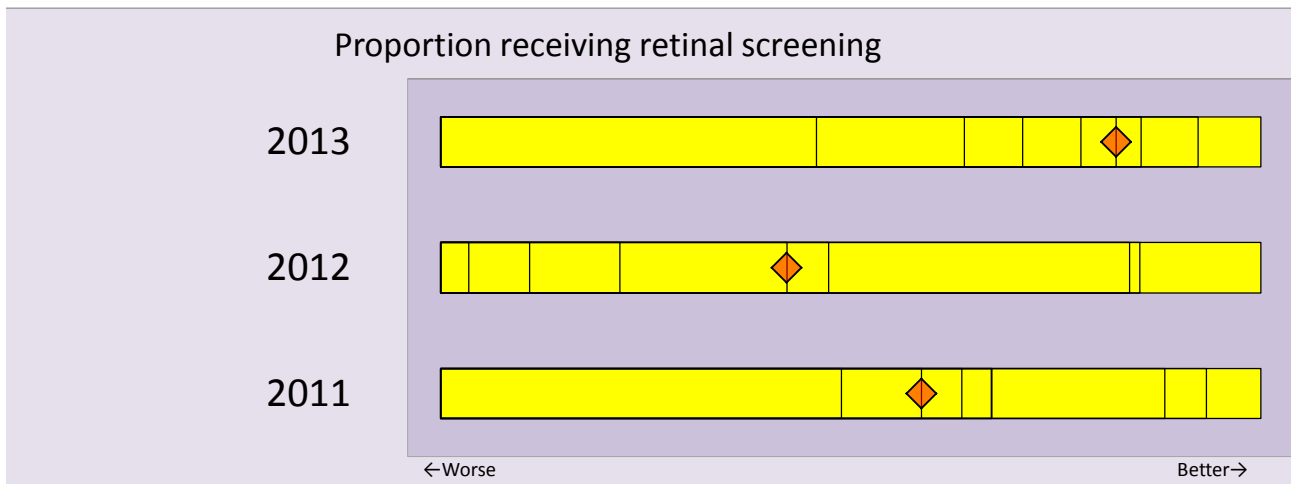
NHS Diabetic eye screening programme

Proportion of people on the QOF diabetes register receiving diabetic retinopathy screening in the previous 15 months

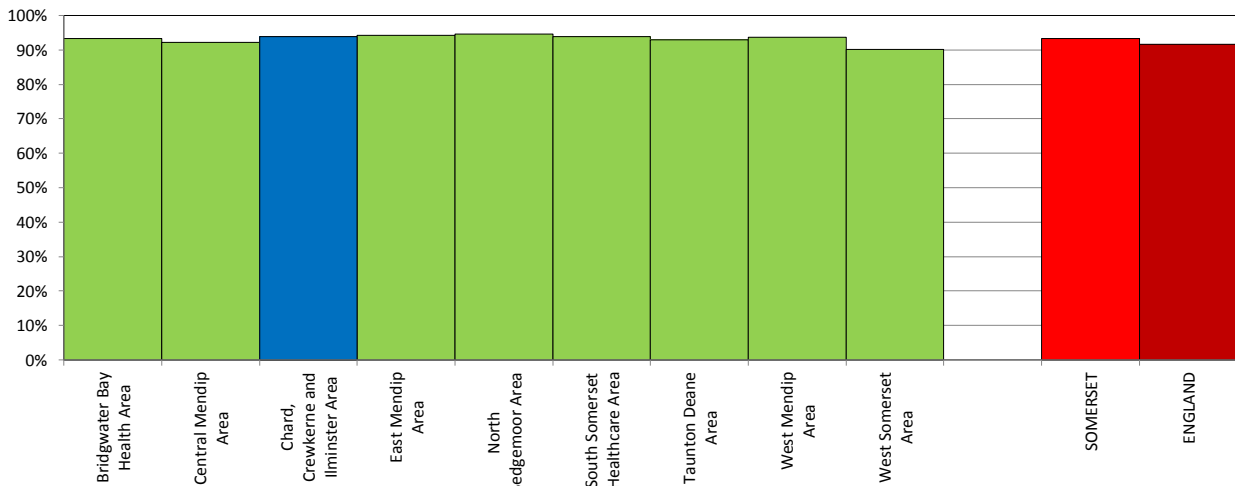
The Quality Outcome Framework indicators are reported annually through the Health and Social Care Information Centre website.

Condition		Federation	Somerset	England	Range of Practice values low / median / high
2013	Number receiving screening	2,229	23,510	2,292,786	
	Number of patients on diabetes register (excl. exceptions)	2,376	25,171	2,500,345	
	% screened	93.8%	93.4%	91.7%	83.6% / 93.1% / 98.2%
2012	Number receiving screening	2,131	22,576	2,193,364	
	Number of patients on diabetes register (excl. exceptions)	2,271	24,051	2,387,549	
	% screened	93.8%	93.9%	91.9%	88.6% / 93.4% / 98.8%
2011	Number receiving screening	2,011	21,377	2,087,997	
	Number of patients on diabetes register (excl. exceptions)	2,151	22,802	2,278,610	
	% screened	93.5%	93.8%	91.6%	87.3% / 94.0% / 98.1%

The bar chart shows how the Federation compares to other Federations 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 Federation. Your Federation 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.



Proportion of people on diabetes register receiving retinopathy screening 2013



Chard, Crewkerne and Ilminster area

Cancer screening

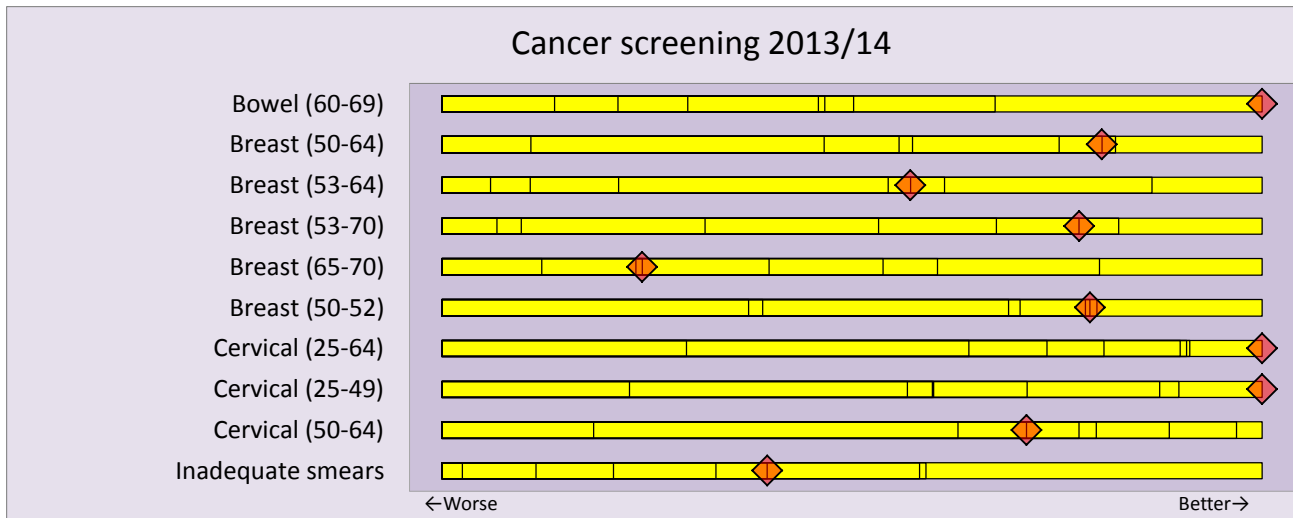
Breast cancer screening from KC63 report and Cervical cancer screening from KC53 report (Breast cancer data estimated using Q4 2013/14). Bowel cancer screening from NHS England.

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

2013/14

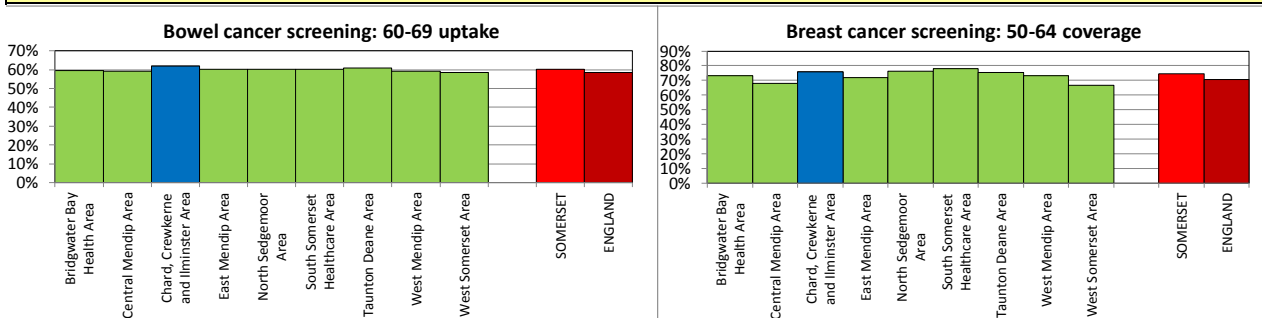
Condition	Federation	Somerset	England (2012/13 for breast and cervical)	Range of Practice values low / median / high
Bowel: 60-69 uptake of invitation to screen in year to October 2013	61.9%	60.2%	58.7%	42.7% / 60.4% / 69.5%
Breast: ages 50-64: coverage	76.0%	74.5%	70.5%	55.6% / 74.9% / 85.0%
Breast: ages 53-64: coverage	80.1%	79.8%	76.2%	53.8% / 79.6% / 87.0%
Breast: ages 53-70: coverage	80.8%	79.5%	76.4%	55.0% / 79.8% / 84.9%
Breast: ages 65-70: coverage	79.5%	80.6%	76.7%	64.5% / 80.9% / 87.8%
Breast: ages 50-52: coverage	59.7%	55.2%	51.6%	10.3% / 53.2% / 83.9%
Cervical: ages 25-64 coverage within 5 years	80.7%	79.1%	78.3%	68.6% / 80.0% / 87.0%
Cervical: ages 25-49 coverage within 3.5 years	76.6%	74.0%	71.5%	63.9% / 74.7% / 86.9%
Cervical: ages 50-64 coverage within 5 years	78.1%	78.0%	77.5%	62.1% / 78.3% / 87.9%
Cervical: Inadequate smears	2.2%	2.4%	2.2%	0.0% / 2.3% / 5.9%

The bar chart shows how the Federation compares to other Federations in terms of their coverage for cancer screening. Each vertical line on the yellow bar shows the position of a Federation. Your Federation 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.

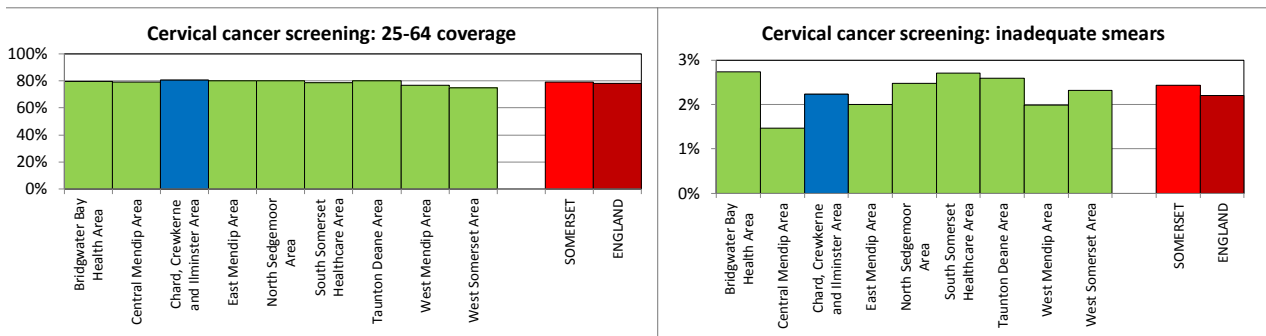


The Federation has the best value in the county for:

Bowel: 60-69 uptake of invitation to screen in year to October 2013 Cervical: ages 25-64 coverage within 5 years Cervical: ages 25-49 coverage within 3.5 years



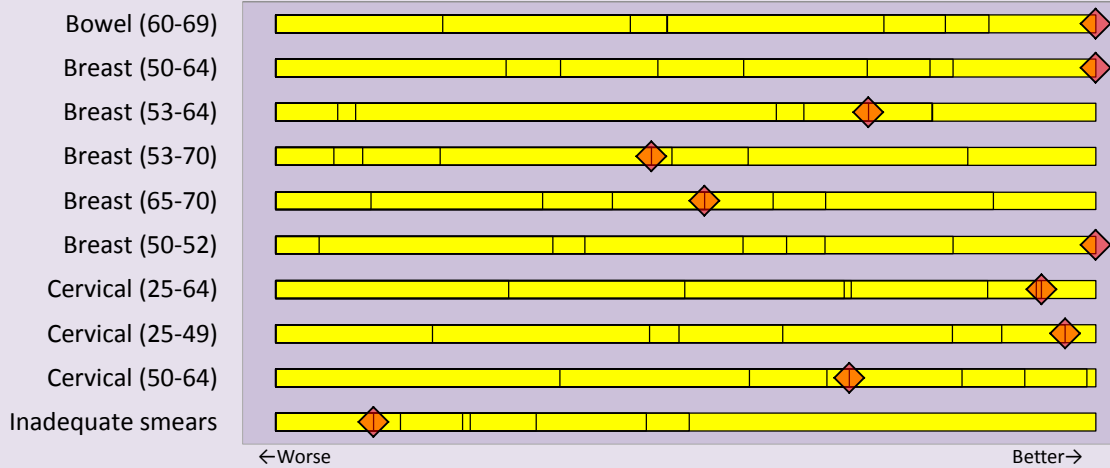
Chard, Crewkerne and Ilminster area



2012/13

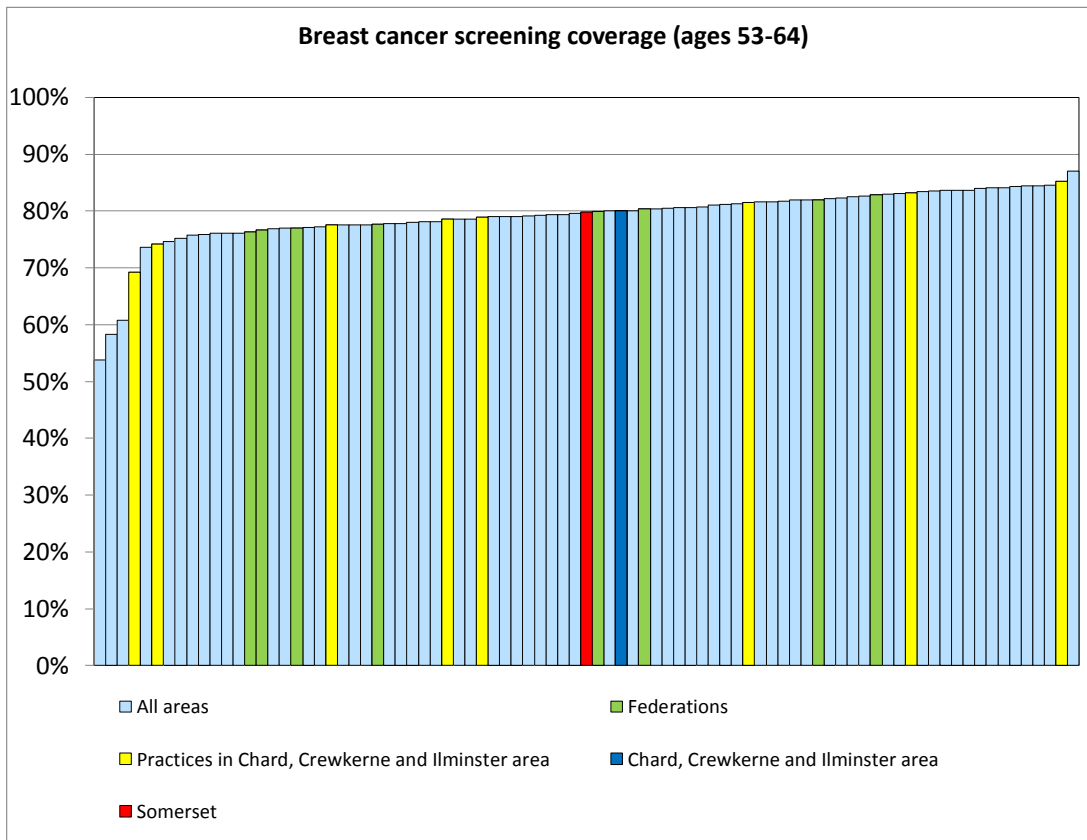
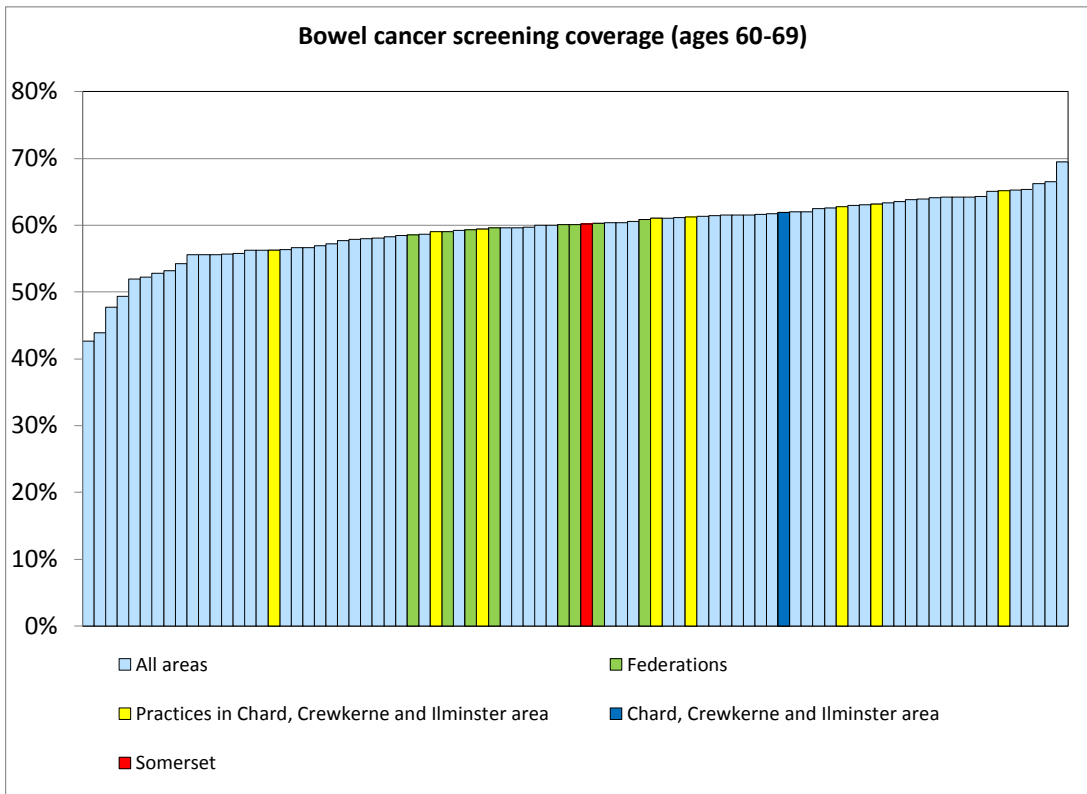
Condition	Federation	Somerset	England	Range of Practice values low / median / high
Bowel: 60-69 uptake of invitation to screen in year to January 2013	65.7%	64.3%	58.7%	46.9% / 63.8% / 75.0%
Breast: ages 50-64: coverage	79.9%	74.3%	70.5%	53.7% / 74.6% / 89.2%
Breast: ages 53-64: coverage	80.9%	80.0%	76.2%	55.7% / 80.4% / 88.2%
Breast: ages 53-70: coverage	79.9%	80.1%	76.4%	56.0% / 79.8% / 84.8%
Breast: ages 65-70: coverage	80.6%	80.7%	76.7%	60.0% / 80.7% / 91.6%
Breast: ages 50-52: coverage	76.2%	53.6%	51.6%	5.7% / 56.9% / 93.9%
Cervical: ages 25-64 coverage within 5 years	81.8%	80.4%	78.3%	67.7% / 80.8% / 88.6%
Cervical: ages 25-49 coverage within 3.5 years	76.6%	74.4%	71.5%	64.9% / 74.5% / 84.7%
Cervical: ages 50-64 coverage within 5 years	79.2%	79.2%	77.5%	61.2% / 79.6% / 89.4%
Cervical: Inadequate smears	2.1%	1.9%	2.2%	0.0% / 1.8% / 5.4%

Cancer screening 2012/13

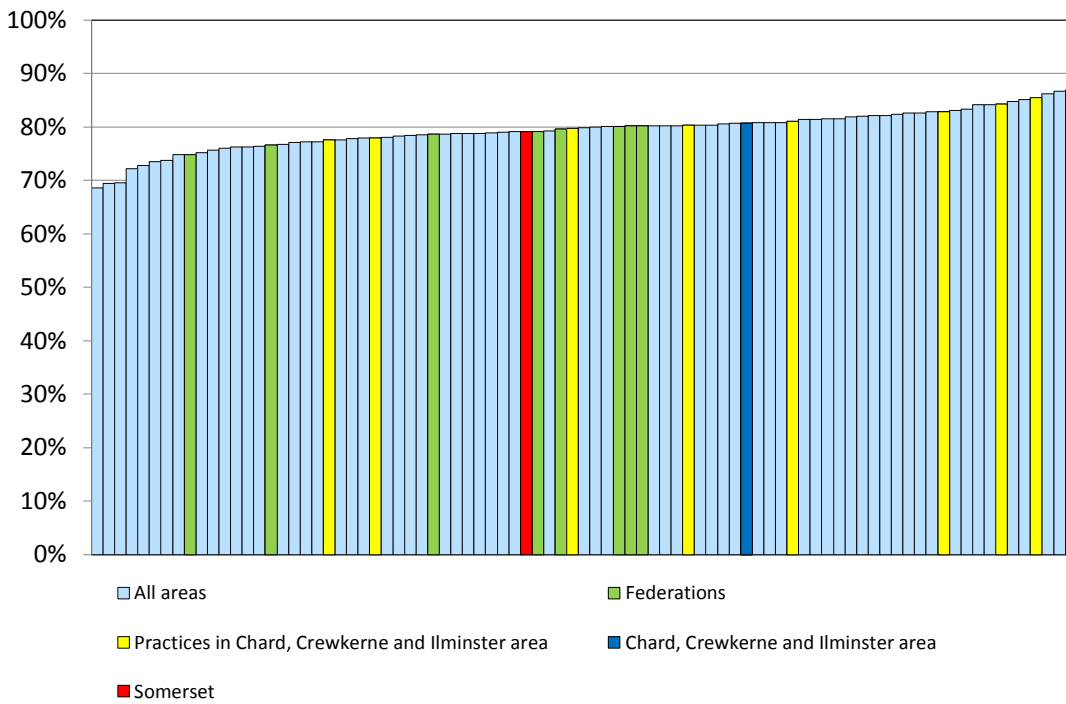


The Federation has the best value in the county for:

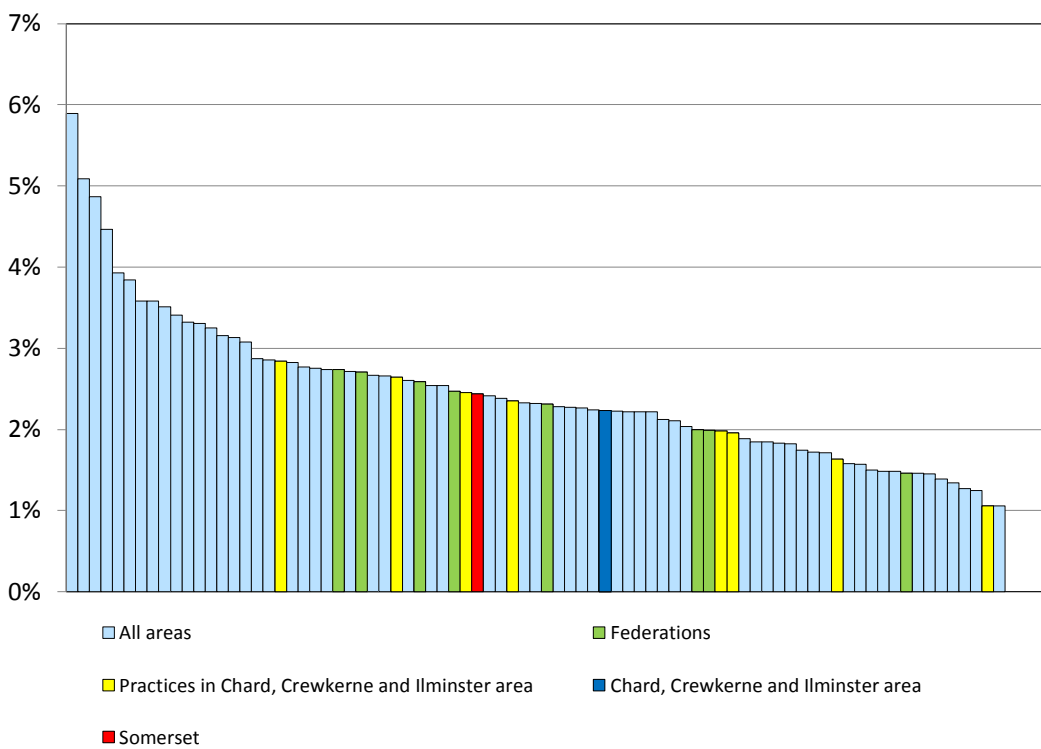
Breast: ages 50-64: coverage Breast: ages 50-52: coverage



Cervical cancer screening coverage (ages 25-64)



Cervical cancer screening inadequate smears (ages 25-64)



Chard, Crewkerne and Ilminster area

Chlamydia screening

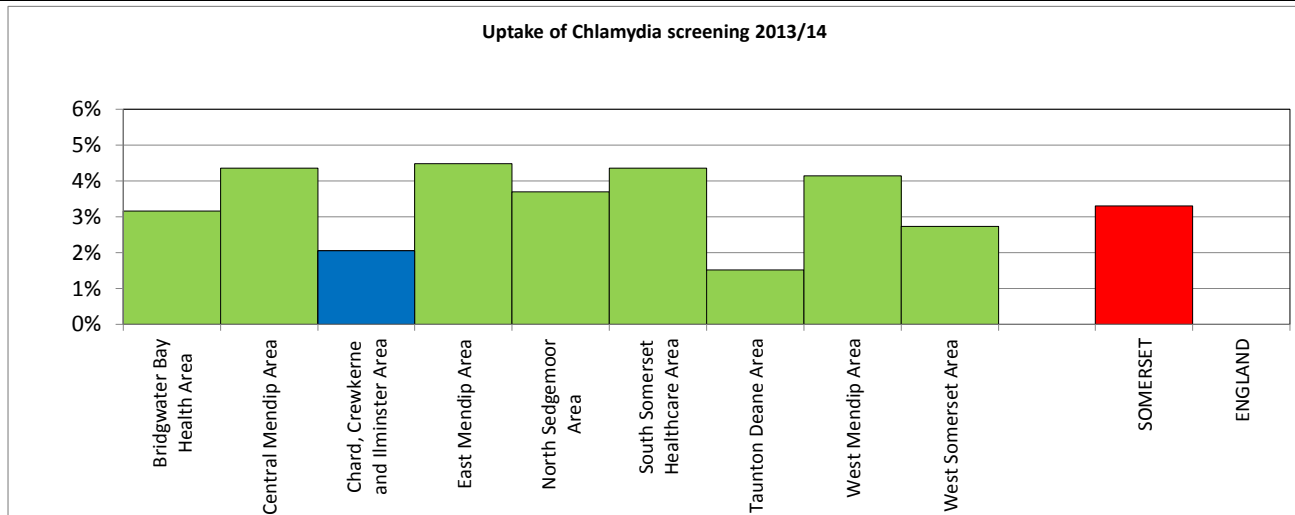
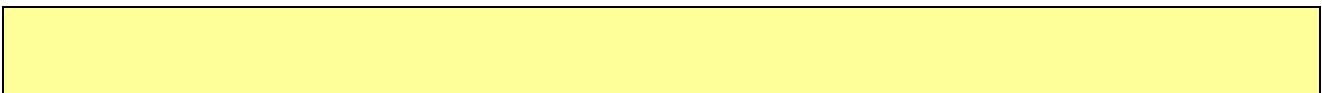
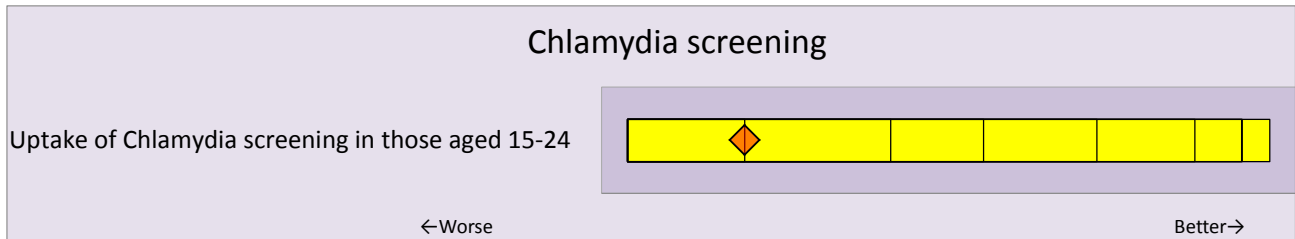
Uptake of Chlamydia screening 2013/14

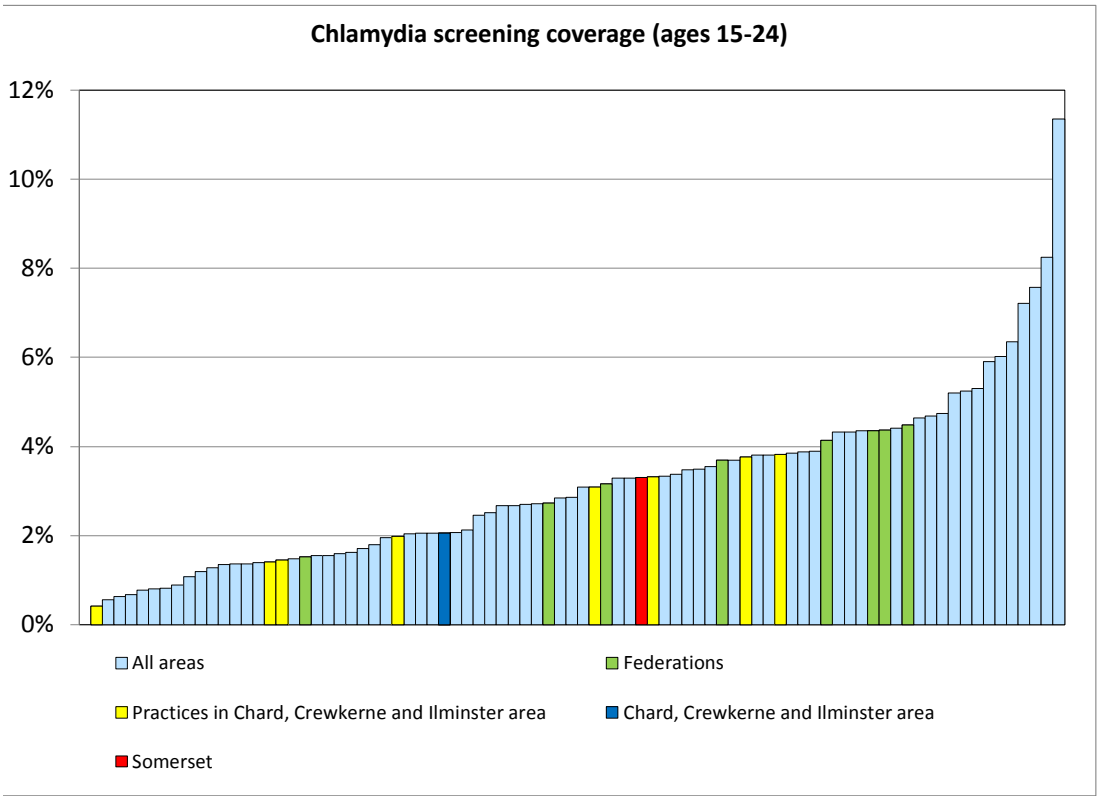
Chlamydia screening is provided at a number of locations around the county. The data shown is the proportion of eligible population aged 15-24 being screened for Chlamydia in practices.

2013/14

	Federation rate	Somerset rate	England	Range of Practice values low / median / high
Uptake of Chlamydia screening in those aged 15-24	2.1%	3.3%		0.0% / 2.7% / 11.4%

The bar chart shows how the Federation compares to other Federations in terms of their coverage for screening over the past three years. Each vertical line on the yellow bar shows the position of a Federation. Your Federation 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 (2013). 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 areas and treatment rooms and leave kits in grab bins in reception, resource areas 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'. The champion can ensure your surgery maximises every opportunity to promote chlamydia screening, monitor uptake and be your link to the Somerset Chlamydia Screening Office to ensure they receive support and access to helpful resources. 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 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

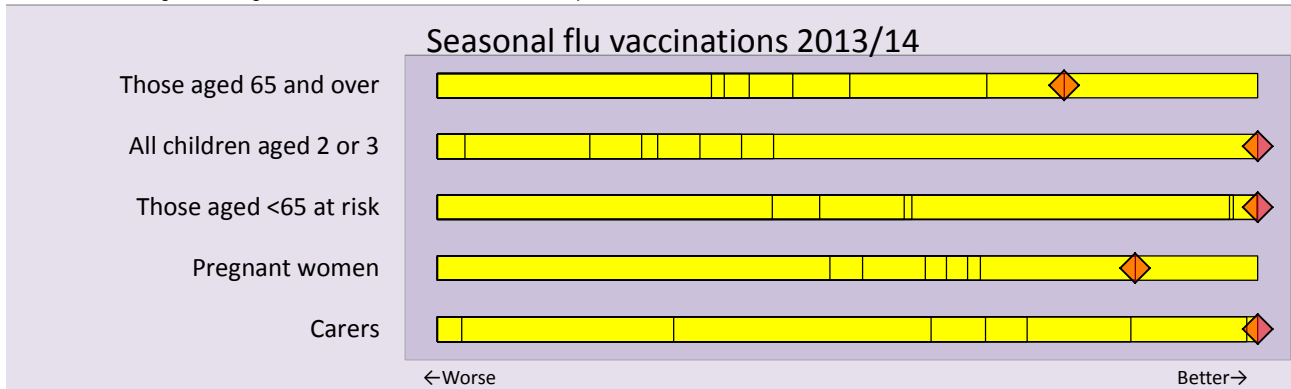
Chard, Crewkerne and Ilminster area

Seasonal flu vaccinations

Flu vaccination programme statistics. Winter 2013/14

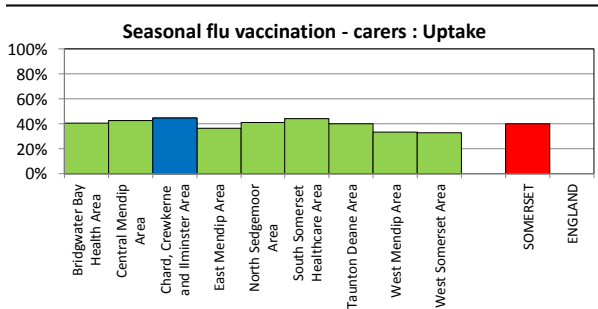
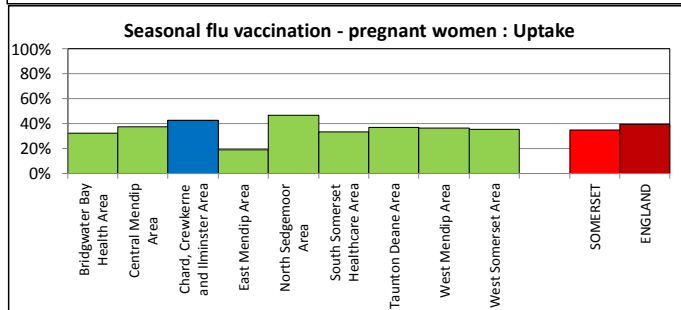
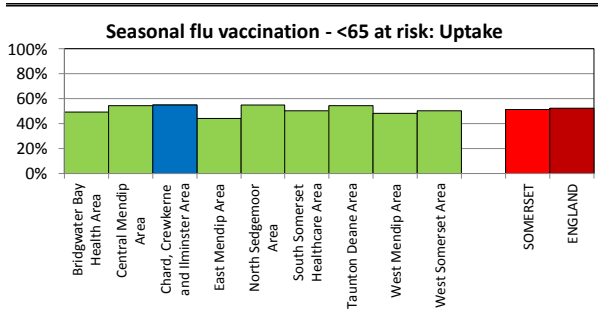
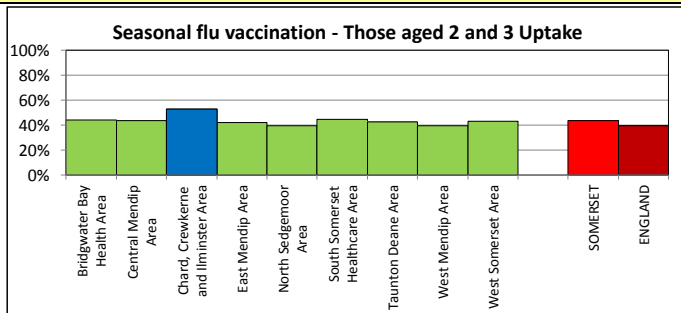
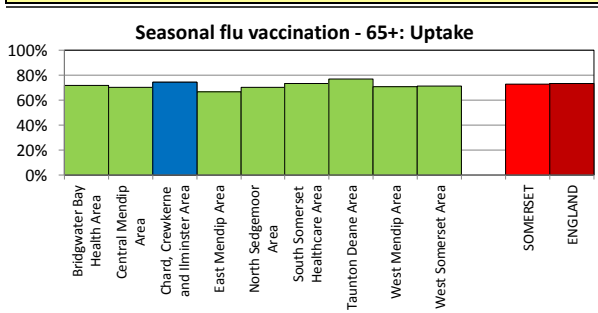
	Federation	Somerset	England	Range of Practice values low / median / high
Those aged 65 and over	74.2%	72.5%	73.2%	63.3% / 72.3% / 91.5%
All children aged 2 or 3	52.8%	43.6%	39.6%	3.8% / 44.2% / 95.6%
Those aged <65 at risk	54.9%	51.3%	52.3%	38.7% / 52.4% / 64.4%
Pregnant women	42.8%	35.1%	39.8%	16.9% / 36.4% / 58.8%
Carers	44.4%	40.2%	n/a	13.8% / 41.9% / 73.9%

The bar chart shows how the Federation compares to other Federations in terms of their immunisation outcomes. Each vertical line on the yellow bar shows the position of a Federation. Your Federation 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 Federation has the best value in the county for:

Those aged <65 at risk Carers



Chard, Crewkerne and Iminster area

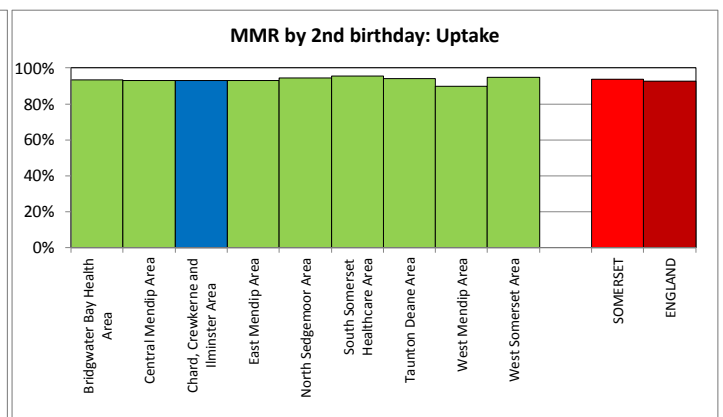
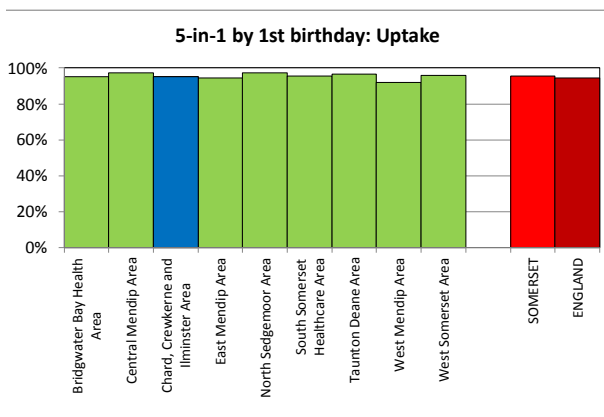
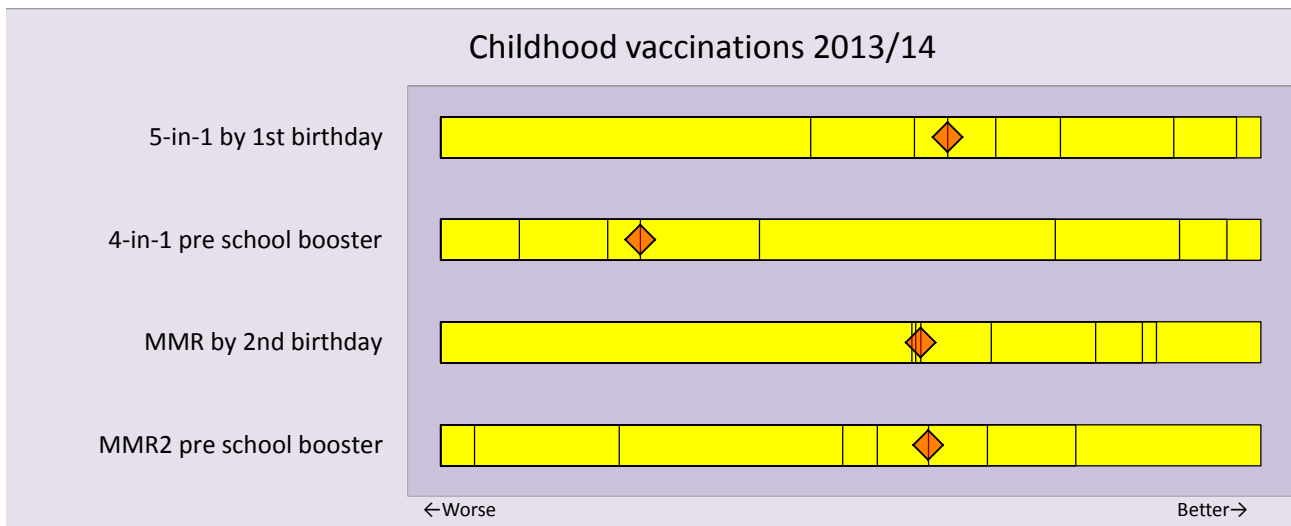
Childhood Immunisations

COVER statistics

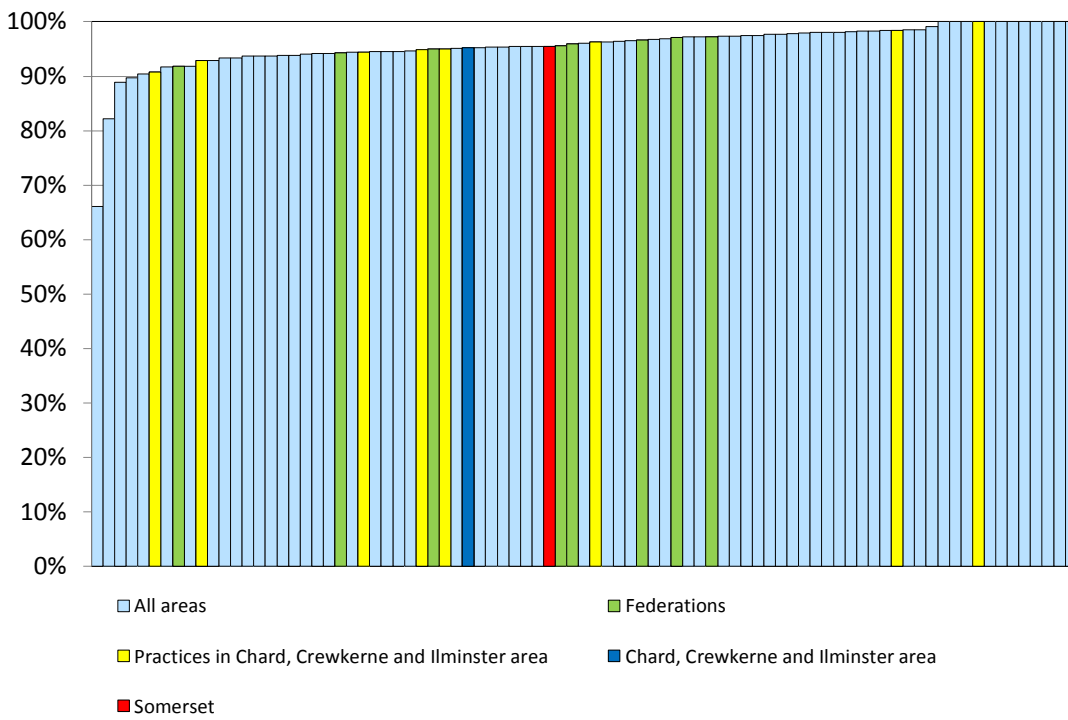
2013/14

	Federation	Somerset	England 2012/13	Range of Practice values low / median / high
5-in-1 by 1st birthday	95.2%	95.5%	94.3%	66.0% / 96.3% / 100.0%
4-in-1 pre school booster	91.2%	92.0%	88.8%	74.0% / 93.4% / 100.0%
MMR by 2nd birthday	93.1%	93.8%	92.7%	66.1% / 94.7% / 100.0%
MMR2 pre school booster	91.0%	90.8%	88.3%	76.0% / 91.7% / 100.0%

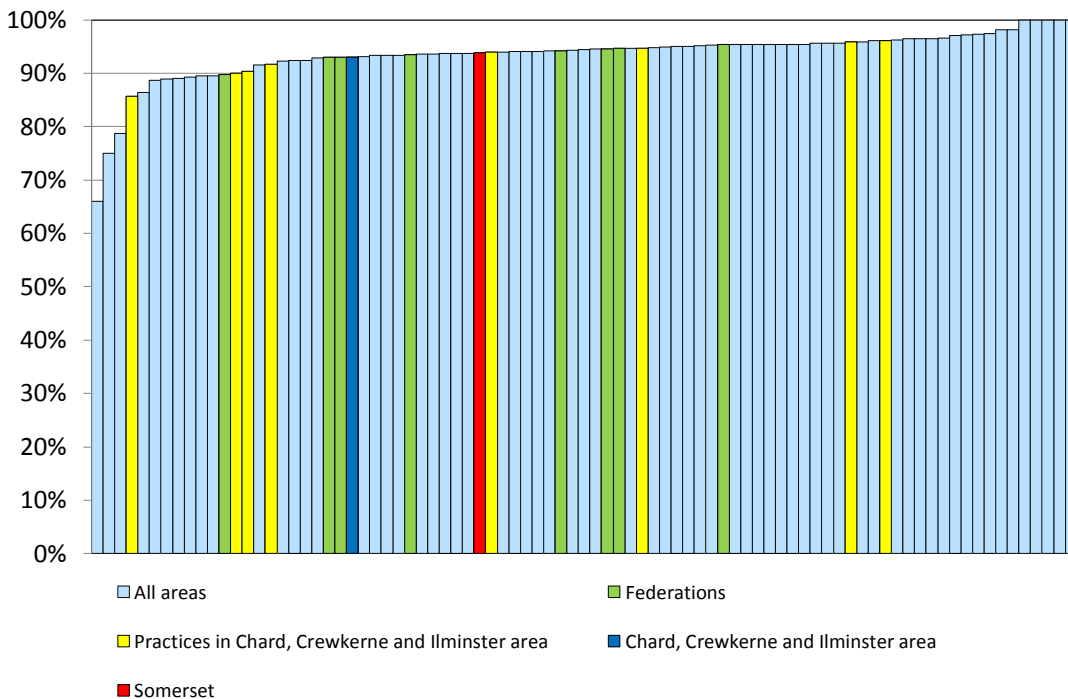
The bar chart shows how the Federation compares to other Federations in terms of their immunisation outcomes. Each vertical line on the yellow bar shows the position of a Federation. Your Federation is highlighted by the red diamond. Values to the left show lower relative levels of immunisation and so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



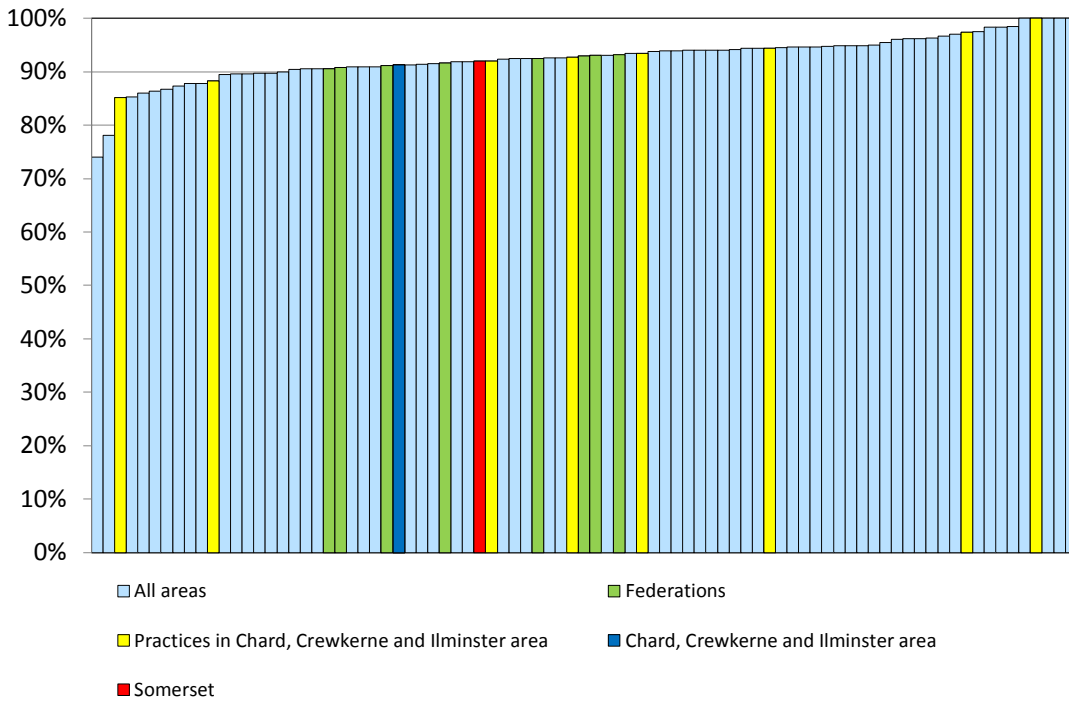
5-in-1 primary vaccination uptake by 1st birthday



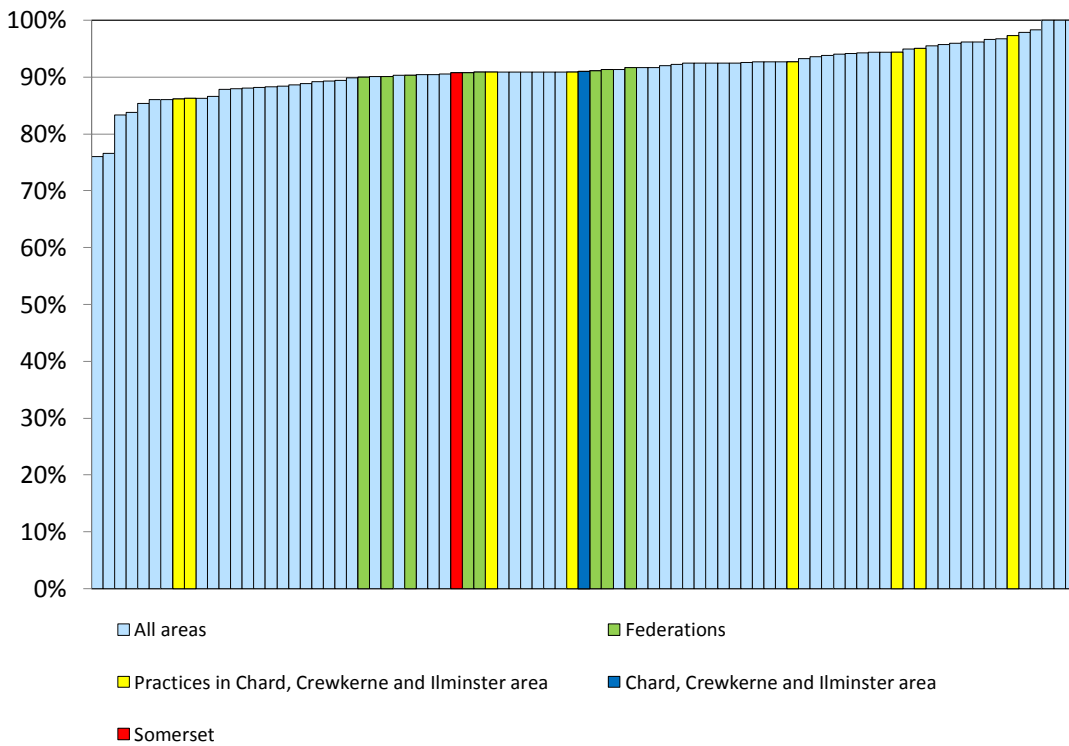
MMR primary vaccination uptake by 2nd birthday



4-in-1 booster vaccination uptake by 5th birthday



MMR2 booster vaccination uptake by 5th birthday



Chard, Crewkerne and Ilminster area

Breastfeeding initiation and prevalence at 6-8 weeks

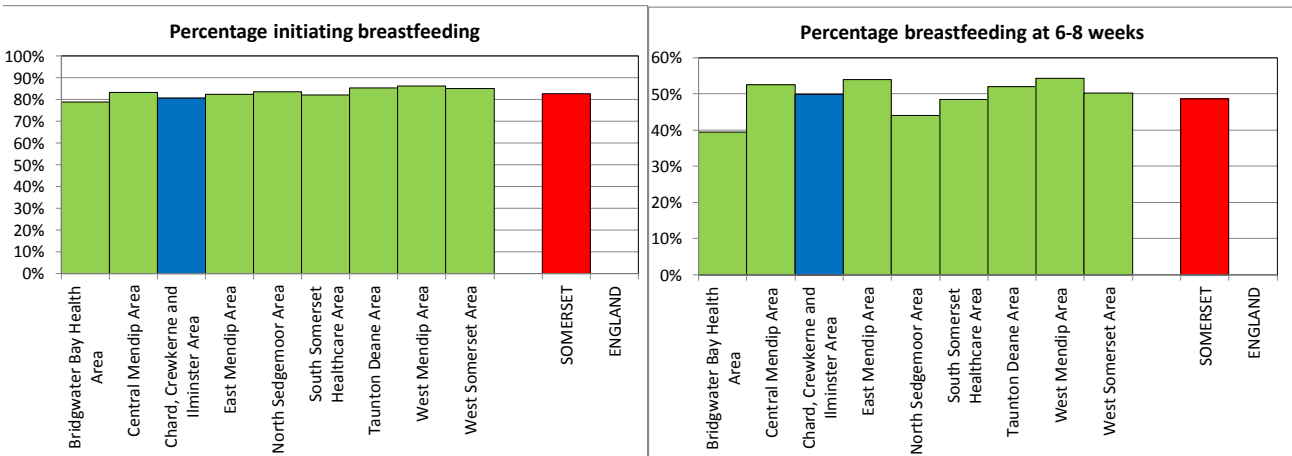
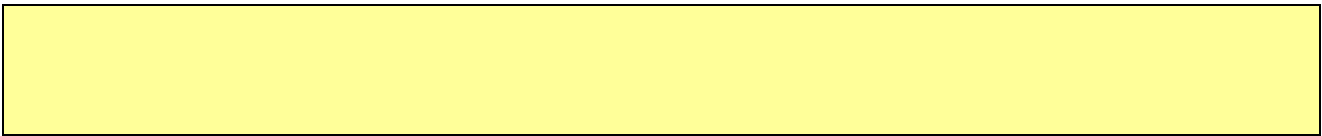
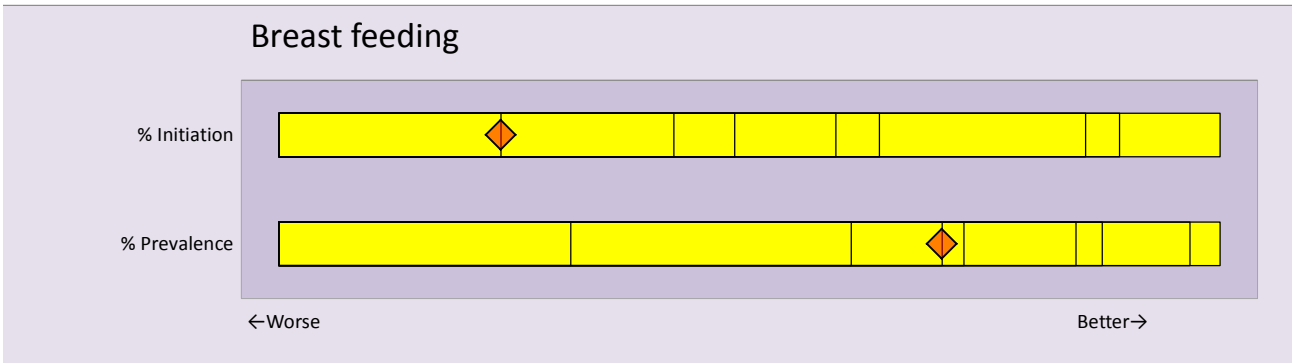
Breastfeeding initiation and prevalence at 6 to 8 weeks data from Analytical Services, NHS England Statistical Release Quarter 4, 2013/14 (data for whole year)

2013/14

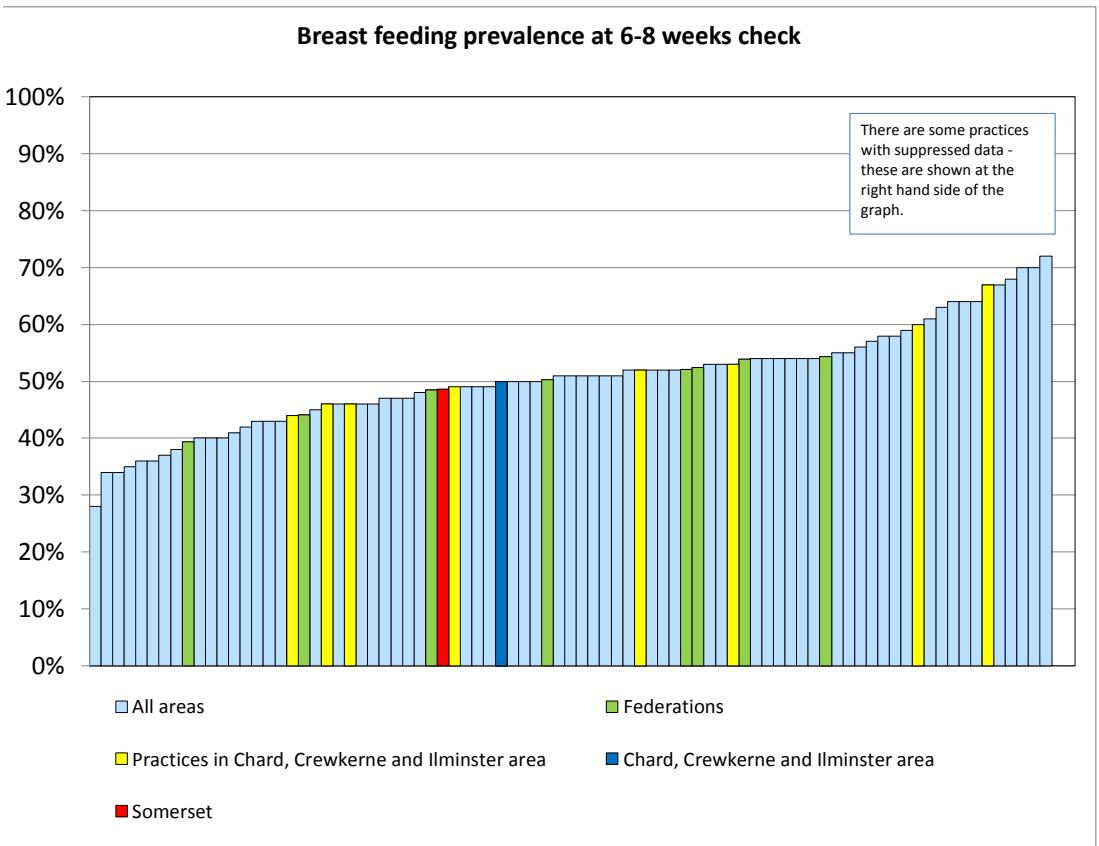
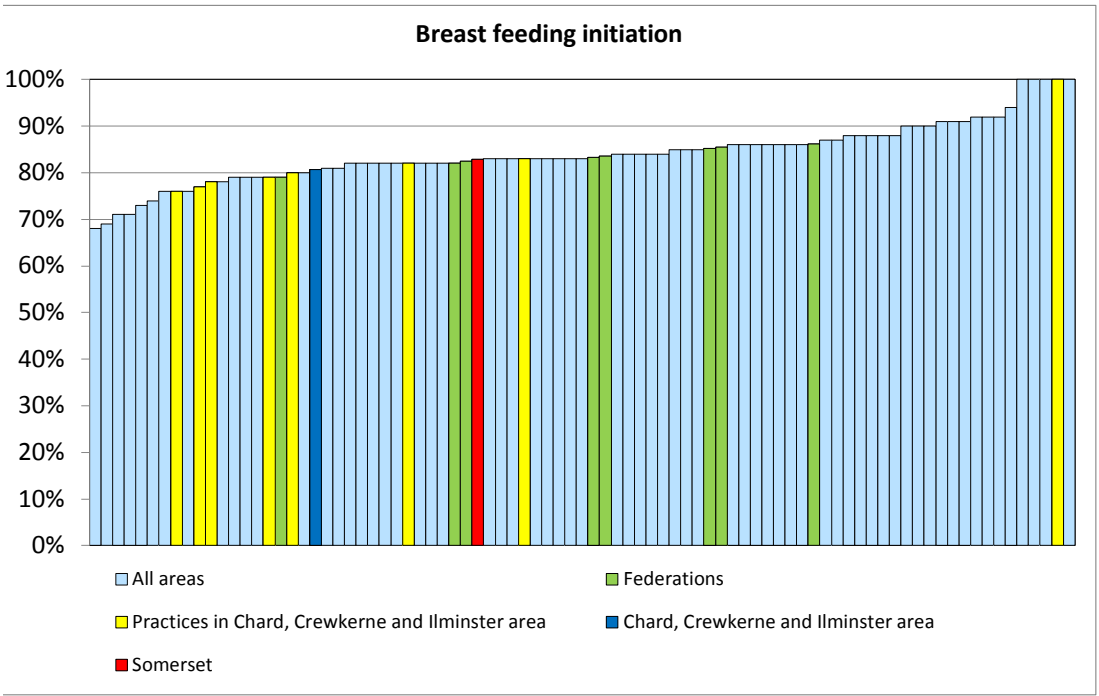
Condition	Federation	Somerset	England	Range of Practice values low / median / high
Number of maternities	417	5,334	n/a	
Percentage mothers initiating breastfeeding*	81%	83%	n/a	68% / 83% / 100%
Number of infants due a check at 6-8 weeks	419	5,343	n/a	
Percentage of infants being wholly or partially breastfed*	50%	49%	n/a	28% / 51% / 72%

* of those with known status

The bar chart shows how the Federation compares to other Federations in terms of their breastfeeding outcomes. Each vertical line on the yellow bar shows the position of a Federation. Your Federation 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.

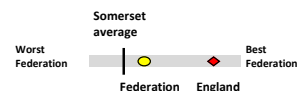


England rates not published because of low coverage in some areas (not Somerset)



Paediatric Indicators

Chard, Crewkerne and Ilminster area



Indicator	Chard, Crewkerne and Ilminster area number	Chard, Crewkerne and Ilminster area value	Somerset CCG value	Worst Federation value in Somerset	Chart	Best Federation value in Somerset	England value	Worst practice value in Somerset	Best practice value in Somerset
1 % of population aged 0-14 *	7,134	15%	16%	17%		12%	18%	23%	9%
2 Deprivation affecting Children Index		0.14	0.14	0.20		0.12	0.15	0.24	0.06
3 Breastfeeding initiation	336	81%	83%	79%		86%		68%	100%
4 Breastfeeding prevalence at 6-8 weeks	209	50%	49%	39%		54%		28%	72%
5 5-in-1 uptake by age 1	457	95%	95%	92%		97%	95%	66%	100%
6 4-in-1 booster uptake by age 5	436	91%	92%	91%		93%	89%	74%	100%
7 MMR uptake by age 2	429	93%	94%	90%		95%	92%	66%	100%
8 MMR booster uptake by age 5	435	91%	91%	90%		92%	88%	76%	100%
9 Flu vaccination uptake for 2 and 3yr olds	534	53%	44%	39%		53%	40%	4%	96%
10 % Obese in Reception		9%	9%	11%		8%	10%		
11 % Obese in Year 6		17%	16%	18%		15%	19%		
12 Teenage deliveries (age<19) in hospital per 1000 F15-17	113	20.5	18.2	24.4		10.2			
13 Emergency admission rate per 1000 for accidents (ages 0-17)	432	9.9	10.7	12.7		8.2			
14 Admissions for self-harm rate per 100,000 (ages 10-24)	129	358	467	599		213		2,588	0
15 Emergency admissions rate per 1000 (ages 0-17)	599	68	70	80		57		99	27
16 Elective admissions rate per 1000 (aged 0-17)	398	46	38	46		24		98	13
17 First outpatient attendances rate per 1000 (aged 0-17)	1,965	225	224	251		179		285	153
18 % lone parent households		7%	8%	10%		7%	11%		
19 % not achieving Early Years Foundation Status		33%	37%	47%		31%			
20 % Special Educational Needs		20%	19%	24%		15%			
21 Fixed exclusions per 1000 pupils		33	44	69		31			
22 % not achieving 5 A*-C GCSEs including Maths and English		44%	44%	58%		37%			
23 % of Children in low-income families		13%	14%	19%		12%	20%		
24 Children (0-17) currently in Care per 10,000	24	28	33	47		17	60		
25 Children (0-17) subject to a Child Protection Plan per 10,000	23	27	35	48		12	46		

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

Paediatric Indicators



Notes and Definitions

The values for the named Federation (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 Federation 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 Federations 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.

1. Proportion of population aged 0-14 as at August 2014 from Open Exeter GP registrations database.
2. Income deprivation affecting Children Index 2010 Department for Communities and Local Government. Federation value estimated using a weighted population average as at August 2014.
3. Breast feeding initiation 2013/14: Estimated proportion of maternities where breastfeeding was initiated. NHS England.
4. Breast feeding prevalence 2013/14: Estimated proportion of infants due checks who were reported as wholly or partially breastfed at 6-8 weeks. NHS England.
5. Uptake of 5-in-1 primary vaccination by 1st birthday 2013/14. COVER.
6. Uptake of 4-in-1 booster vaccination by 5th birthday 2013/14. COVER.
7. Uptake of MMR primary vaccination by 2nd birthday 2013/14. COVER.
8. Uptake of MMR booster vaccination by 5th birthday 2013/14. COVER.
9. Uptake of vaccination by those aged 2 and 3 during 2013/14 influenza season. Public Health England.
10. Proportion of children measured in Reception classes who had a Body Mass Index assessed as Obese for their age. 2013 National Child Measurement Programme.
11. Proportion of children measured in Year 6 classes who had a Body Mass Index assessed as Obese for their age. 2013 National Child Measurement Programme.
12. Number of deliveries in hospital to women aged less than 19, per 1000 females aged 15-17. April 2007 to March 2014 Secondary Uses Services (SUS) hospital activity data.
13. Emergency admissions for accidents per 1000 children aged 0-17. April 2009 to March 2014 Secondary Uses Services (SUS) hospital activity data.
14. Admissions for selfharm per 1000 children and young people aged 10-24. April 2009 to March 2014 Secondary Uses Services (SUS) hospital activity data.
15. Emergency admissions for any cause per 1000 children aged 0-17. April 2013 to March 2014 Secondary Uses Services (SUS) hospital activity data.
16. Elective (day case or inpatient) admissions for any cause per 1000 children aged 0-17. April 2013 to March 2014 Secondary Uses Services (SUS) hospital activity data.
17. First outpatient attendances (a proxy for referral) for any cause per 1000 children aged 0-17. April 2013 to March 2014 Secondary Uses Services (SUS) hospital activity data.
18. Proportion of households where there is a lone parent. Census 2011.
19. Proportion of children not achieving Early Years Foundation Status. 2012 Somerset County Council.
20. Proportion of children with Special Educational Needs. 2012 Somerset County Council.
21. Number of Fixed exclusions from school per 1000 pupils. 2012 Somerset County Council.
22. Proportion of children NOT achieving 5 A*-C GCSEs including Maths and English. 2012 Somerset County Council.
23. Proportion of children in low-income families. Child Poverty Unit 2011.
24. Children age 0-17 who are currently in Care and known to be living or placed in Somerset per 10,000. As at August 2014. Somerset County Council.
25. 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 2014. Somerset County Council.

Lifestyle factors

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 geographical areas where children live is used to estimate the rates in each Federation.

Adult obesity is assessed based on raw BMI, kg/m². 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 59.

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/>

Chard, Crewkerne and Ilminster area

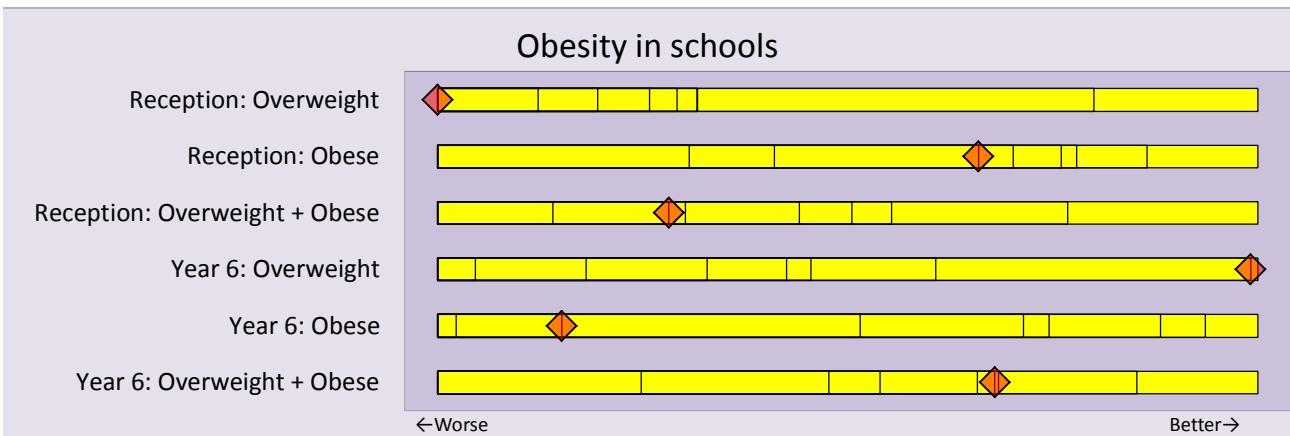
Obesity in schools

NCMP Reception and Year 6 measurements 2008/9 - 2012/13

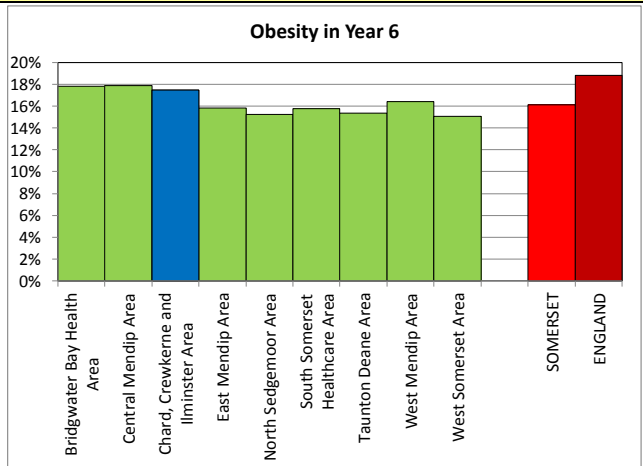
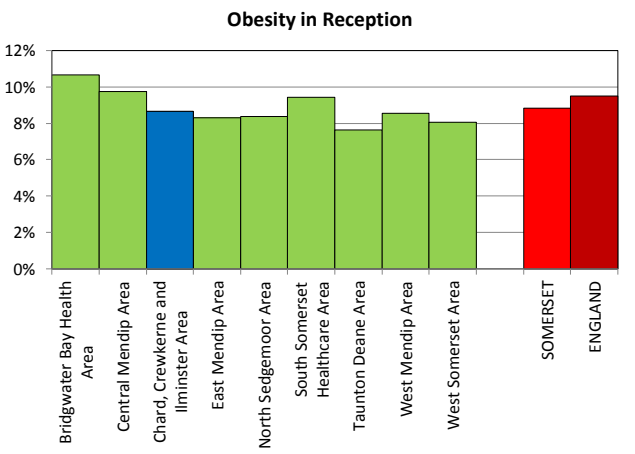
2008/9 - 2012/13

	Federation	Somerset	England	Range of Practice values low / median / high
Reception: Overweight	15%	14%	13%	
Reception: Obese	9%	9%	10%	
Reception: Overweight + Obese	24%	23%	23%	
Year 6: Overweight	12%	14%	14%	
Year 6: Obese	17%	16%	19%	
Year 6: Overweight + Obese	29%	30%	33%	

The bar chart shows how the Federation compares to other Federations. Each vertical line on the yellow bar shows the position of a Federation. Your Federation 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.



The Federation has the worst value in the county for:
Reception: Overweight



Chard, Crewkerne and Ilminster area

Obesity in adults

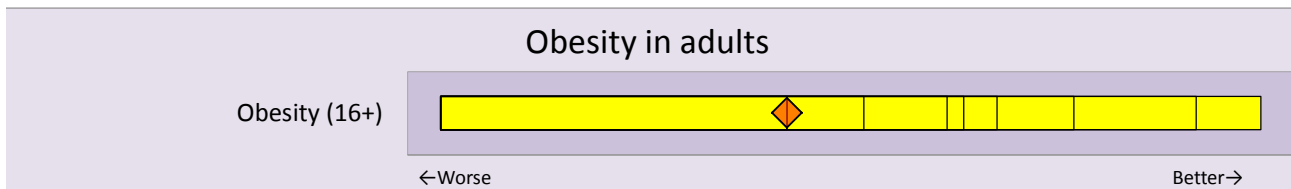
Age/sex standardised prevalence rates using Quality Outcome Framework crude prevalence, Exeter system population downloads and Somerset wide age/sex specific rates from MIQUEST.

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

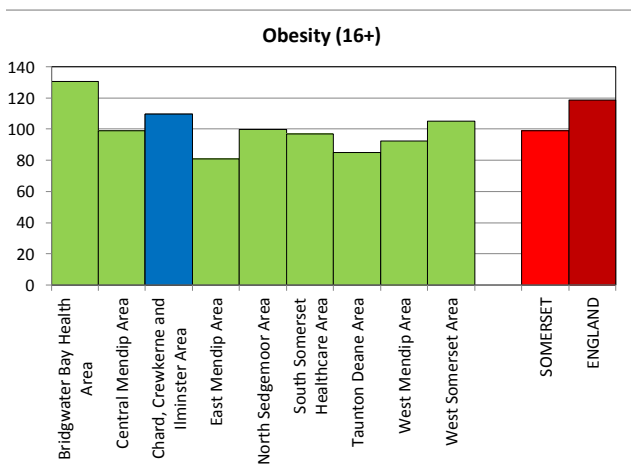
2014

Condition	Observed in Federation	Expected in Federation (based on Somerset rates)	Federation rate	Somerset rate	England rate	Range of Practice values low / median / high
Obesity (16+)	4,447	4,018	110	99	118.8	55 / 99 / 188

The bar chart shows how the Federation compares to other Federations. Each vertical line on the yellow bar shows the position of a Federation. Your Federation 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 worse than county average for:
Obesity (16+)





Chard, Crewkerne and Ilminster area

Smoking prevalence (%)

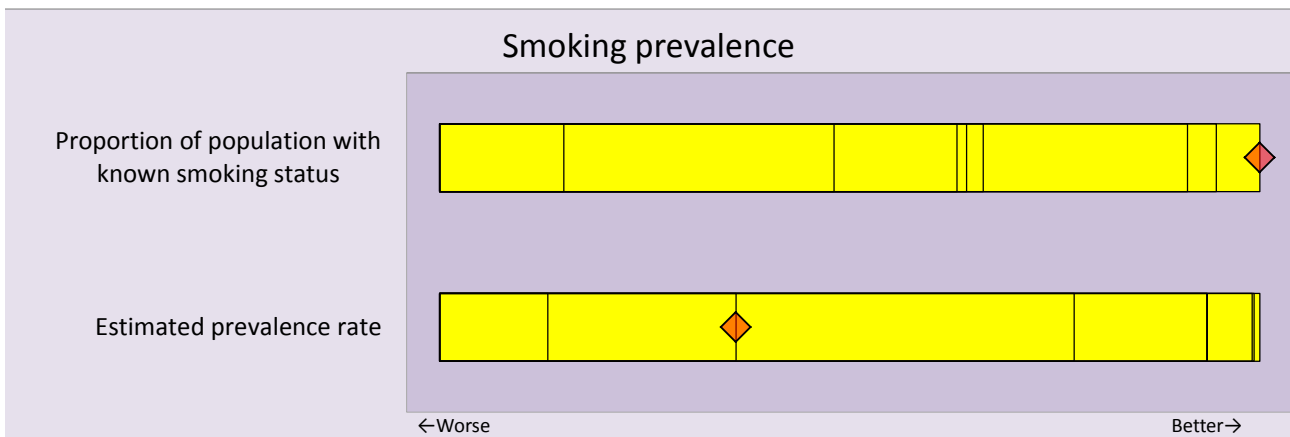
Smokers 16+ among those with a known smoking status in the last 15 months from MIQUEST queries on practice clinical systems.

The value given is the number smoking of those of known smoking status in the last 15 months. This estimate is likely to be an overestimate as those who smoke are more likely to visit their GP and are more likely to have their smoking status recorded.

Jun-14

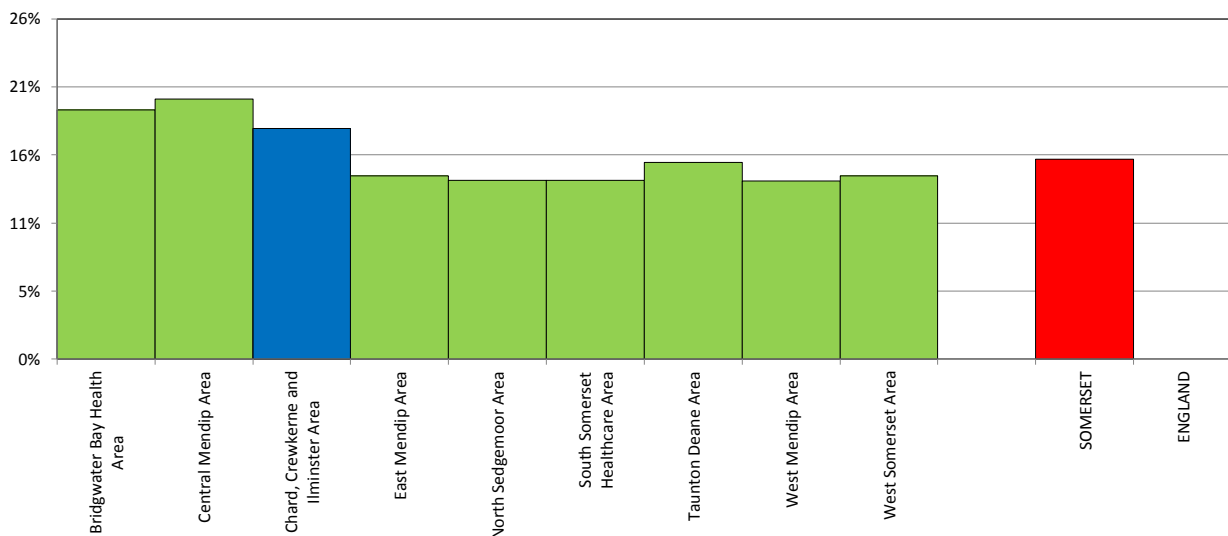
	Federation	Somerset	England	Range of Practice values low / median / high
Number with known smoking status (16+)	29,742	336,373		
Number smoking (16+)	5,292	51,881		
Population (16+)	39,267	462,844		
Proportion of population with known smoking status	76%	73%		60% / 73% / 83%
Estimated prevalence rate	17.8%	15.4%		6.5% / 14.0% / 33.3%

The bar chart shows how the Federation compares to other Federations. Each vertical line on the yellow bar shows the position of a Federation. Your Federation is highlighted by the red diamond. Values to the left show lower ascertainment or higher smoking rates and so worse performance.



The Federation has the best value in the county for:
Proportion of population with known smoking status

Smoking prevalence 16+



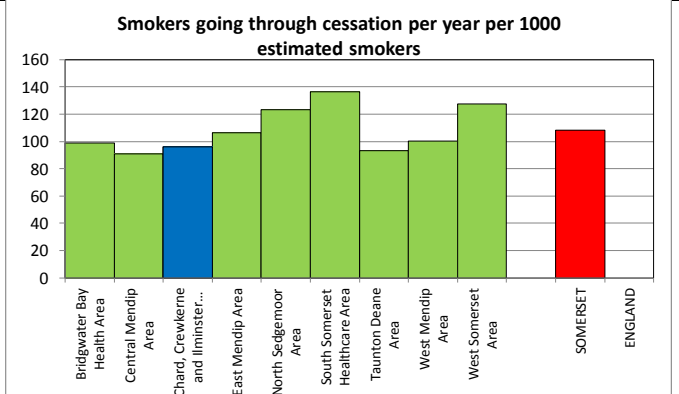
Chard, Crewkerne and Ilminster area

Stop smoking services provision July 2010 to June 2014

Smoking cessation services database

	Federation	Somerset	England	Range of Practice values low / median / high
Number going through a smoking cessation service	2,678	30,957		
Number going through a smoking cessation service per 1000 population per year	14.5	14.2		5.9 / 13.7 / 137.4
Number quit (4 week)	1,149	13,083		
Number not quit (4 week)	1,250	15,206		
Number unknown quit status (4 week)	279	2,668		
4 week quit rate	43%	42%		28% / 41% / 64%
% going through smoking cessation service run by Practice	82%	84%		0% / 90% / 97%
% going through Stop Smoking Services	14%	10%		1% / 6% / 87%
% using other smoking cessation services	4%	6%		0% / 4% / 24%
Quit rate for those aged 18-34	33%	35%		13% / 31% / 67%
Quit rate for those aged 35-44	47%	44%		22% / 42% / 69%
Quit rate for those aged 45-59	42%	45%		22% / 43% / 67%
Quit rate for those aged 60 and over	52%	50%		28% / 50% / 74%
Smokers going through cessation per year per 1000 estimated smokers	96	108		34 / 116 / 253

The bar chart shows how the Federation compares to other Federations. Each vertical line on the yellow bar shows the position of a Federation. Your Federation 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.



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 NCSCT/BMJ Learning Module. Note that many GPs are not up to date on current thinking, so should take this module to improve success rates. Qualifies for 1 hour CPD/CME.

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 a stop smoking service for support. 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 is adamant that they do not wish to be referred to a stop smoking practitioner, then it may be appropriate to prescribe, but other forms of support should be offered such as those available from the NHS Smokefree website, such as text, app and email. There is a strong evidence base for the effectiveness of the text support service.
- 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.
- Staff delivering NHS Health Checks should have very brief intervention training** as per 1 above, in order to refer effectively.
- 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, or if unwilling to do so, should be prescribed NRT (preferably 2 products, patch plus faster acting 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.** From 1st April 2015 there will be a new stop smoking service contract in place with a single provider. The provider will be seeking to work with all relevant stakeholders from early 2015 in preparation for the new contract. Federations and practices should work closely with the provider when approached to ensure that stop smoking services are available to patients, and that referral processes are effective."

In terms of support available, for the most part support is already available to practices for all the above from the Somerset NHS stop smoking service, which is currently commissioned to provide support at practice level. Public health can offer additional support if the federations wish to address any of the above at the Federation level. If you would like to work up any proposals please contact Stewart Brock, sbrock@somerset.gov.uk

Chard, Crewkerne and Ilminster area

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

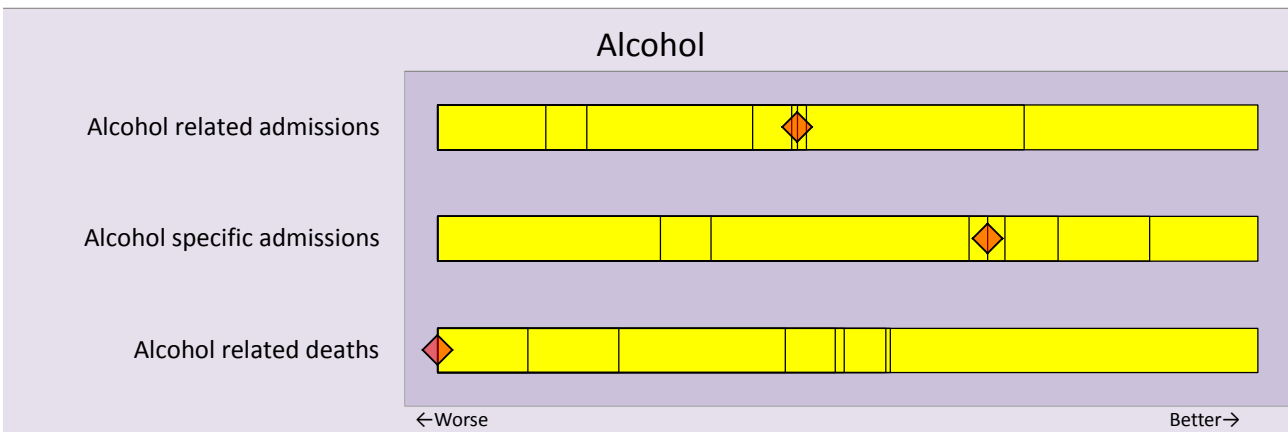
SUS Inpatient activity files April 2009 to March 2014 ONS Primary Care Mortality Database. Population files July 2009-July 2013. Admissions indirectly standardised rate by age/sex and Deaths indirectly standardised rate by age/sex.

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. 0.5% of admissions were excluded because of unknown age or gender.

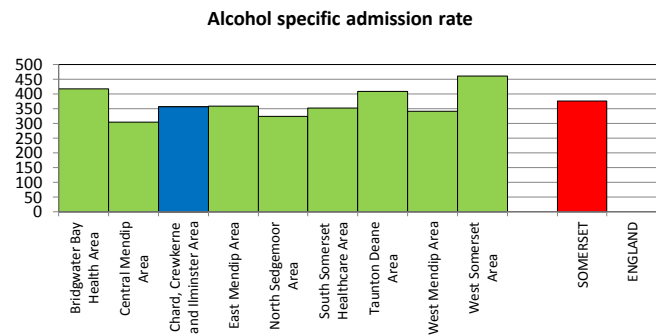
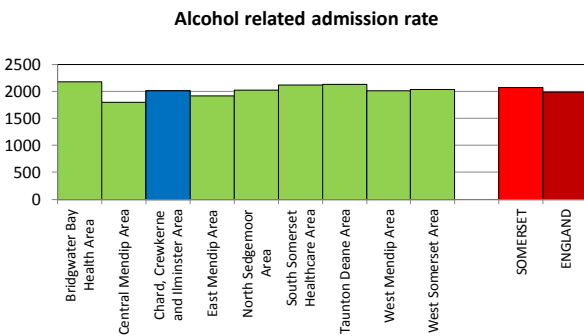
Alcohol specific conditions are a subset of alcohol related conditions that can directly be attributable to alcohol.

	Federation rate	Somerset rate	England (average annual value 2009/10 to 2013/14)	Range of Practice values low / median / high
Alcohol related admissions	2,017	2,068	1,984	1,314 / 1,999 / 5,828
Alcohol specific admissions	355	376		122 / 344 / 2,369
Alcohol related deaths	32	29		

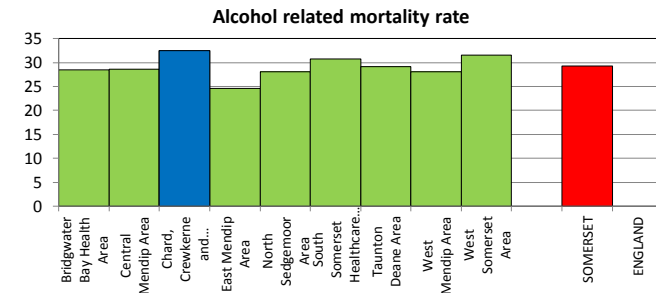
The bar chart shows how the Federation compares to other Federations. Each vertical line on the yellow bar shows the position of a Federation. Your Federation is highlighted by the red diamond. Values to the left show higher rates of harm and so worse performance.



The Federation has the worst value in the county for:
Alcohol related deaths



England figure is average annual value 2009/10 to 2013/14



Chard, Crewkerne and Ilminster area

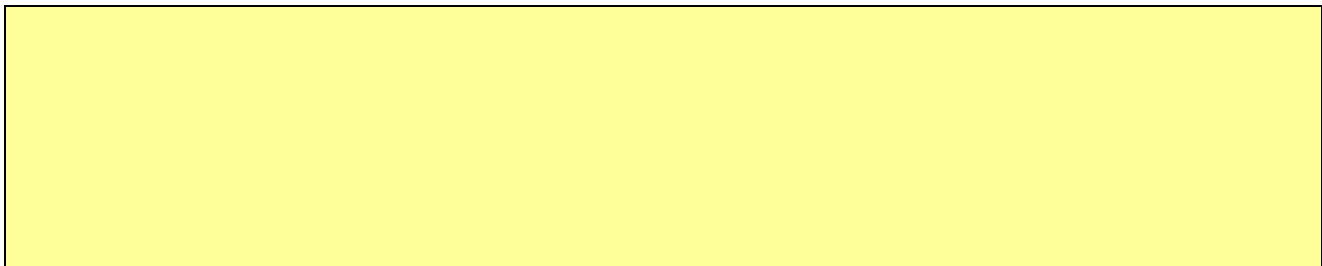
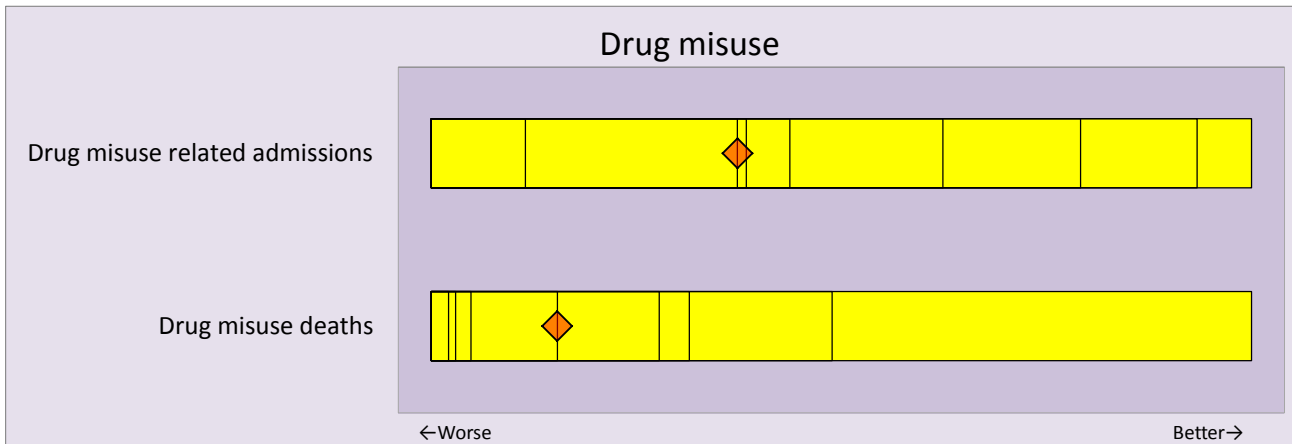
Standardised admission and mortality rates for drug misuse per 100,000 population per year

SUS Inpatient activity files April 2008 to March 2014 and ONS Primary Care Mortality Database. Population files July 2008-July 2014. Indirectly standardised rate by age/sex.

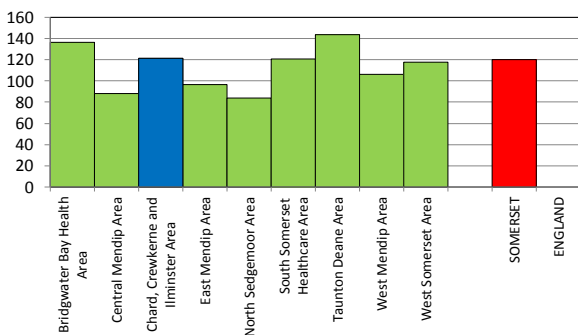
Drug related harms is represented according to the number of admissions which are judged as being related to drugs or deaths related to drug misuse. The National Treatment Agency for Substance Misuse guidance, Undertaking Needs Assessment – Drug Treatment (2009) recommended the following ICD10 codes: 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 indicators. 3% of admissions were excluded because of unknown age or gender.

	Federation rate	Somerset rate	England	Range of Practice values low / median / high
Drug misuse related admissions	121	120		21 / 91 / 647
Drug misuse deaths	3.6	3.2		

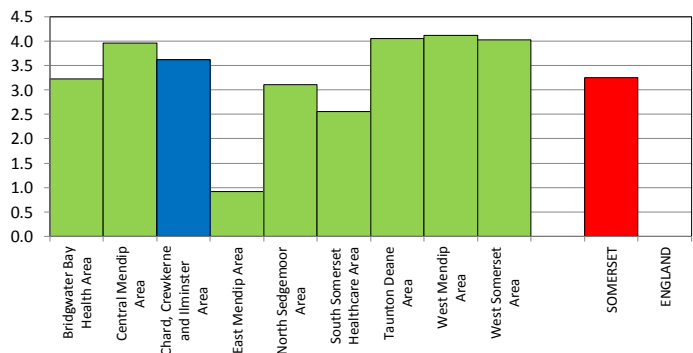
The bar chart shows how the Federation compares to other Federations. Each vertical line on the yellow bar shows the position of a Federation. Your Federation is highlighted by the red diamond. Values to the left show higher rates of harm and so worse performance.



Drug misuse related admission rate



Drug misuse mortality rate



Hospitalisations

The profile contains information on aspects relating to hospitalisation:

- Admission rates for specific conditions of interest: Self-harm and Mental and Behavioural disorders, falls, teenage deliveries
- Standardised emergency admission rates and rates by age and sex of patient
- Emergency admissions by reason for admission
- Emergency admission rates for specific conditions of interest: CHD, CVD, COPD and Asthma
- Elective admissions rates and rates by age and sex of patient
- Out patient attendances rates, rates by age and sex of patient and by reason

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	
Vaccine-preventable	Acute
1. Influenza and pneumonia	11. Dehydration and gastroenteritis
2. Other vaccine-preventable conditions	12. Pyelonephritis
	13. Perforated/bleeding ulcer
Chronic	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-in-primary-care-overview>.

Chard, Crewkerne and Ilminster area

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

SUS Inpatient activity files April 2008 to March 2014 and ONS Primary Care Mortality Database. Population files July 2008-July 2013. Indirectly standardised rate by age/sex.

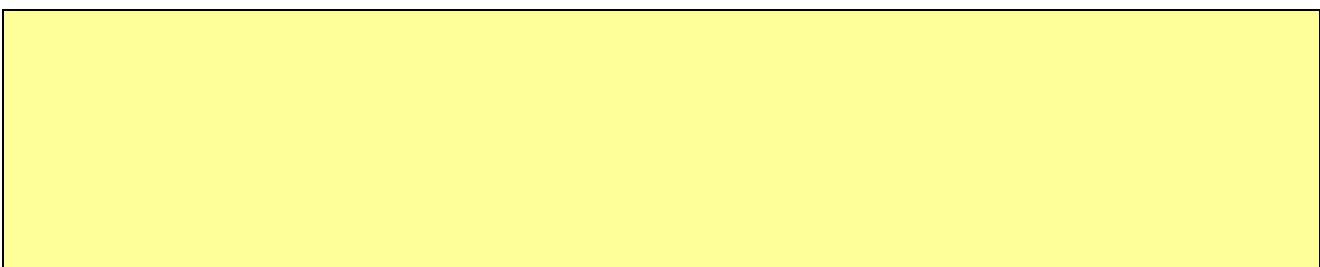
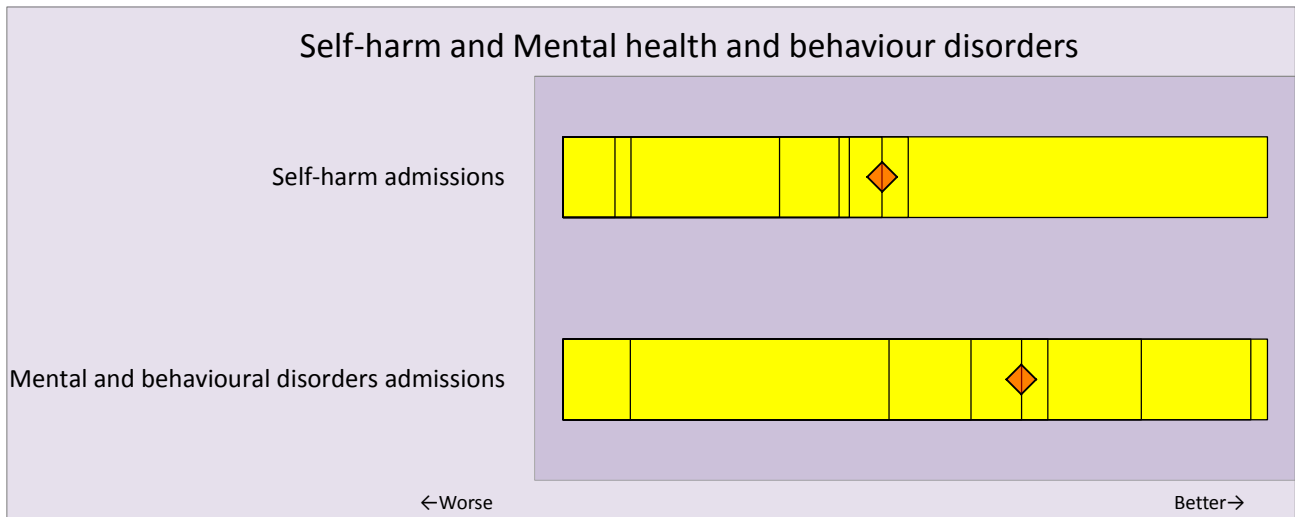
Admissions to hospital with any diagnosis of self-harm or self-injury of undetermined intent.

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

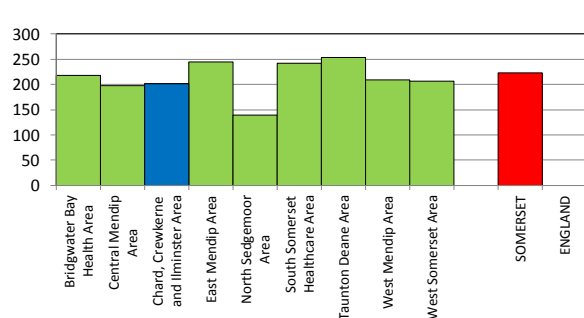
0.6% of self-harm admissions and 0.1% of mental and behavioural disorder admissions were excluded because of unknown age or gender.

April 2008 to March 2014

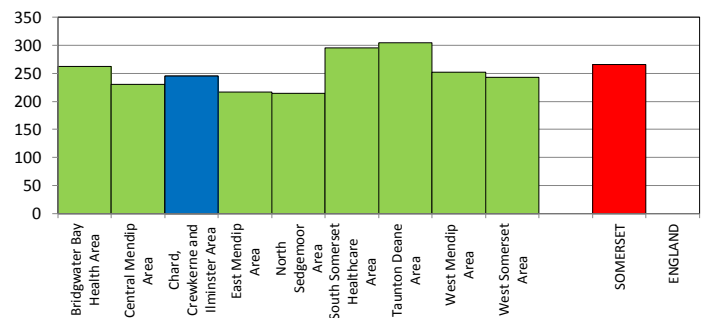
	Federation rate	Somerset rate	England	Range of Practice values low / median / high
Self-harm admissions	202	223		72 / 204 / 1,041
Mental and behavioural disorders admissions	246	266		100 / 237 / 1,401



Self-harm admission rate



Mental and Behavioural Disorders admission rate



Chard, Crewkerne and Ilminster area

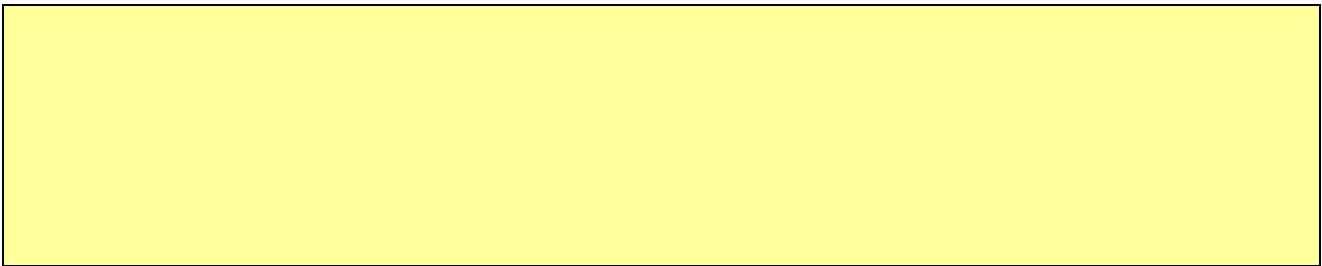
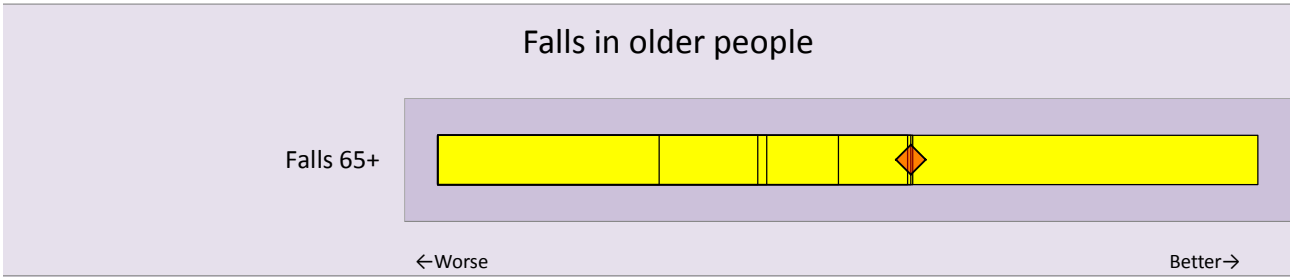
Standardised admission rates for Falls per 1000 population aged 65 and over per year

SUS Inpatient activity files April 2011 to March 2014 and ONS Primary Care Mortality Database. Population files July 2011-July 2013. Indirectly standardised rate by age/sex.

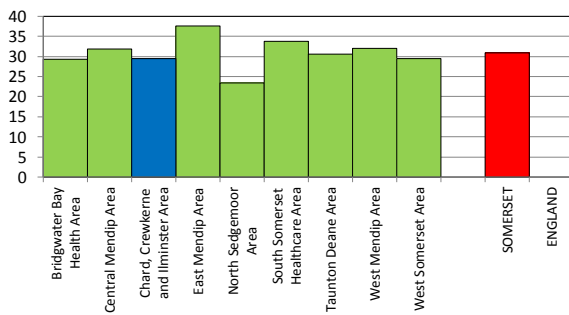
Admissions to hospital with any diagnosis indicating a fall, for those aged 65 and over.
No admissions were excluded because of unknown gender

April 2011 to March 2014

	Federation rate	Somerset rate	England	Range of Practice values low / median / high
Falls 65+	29	31		15 / 30 / 64



Falls 65+ admission rate



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 and help people maintain their bone health into older age. In Somerset in 2013 approximately 4000 people aged 65 and over were admitted to hospital as a result of a fall and with our increasingly ageing population this is likely to continue to rise. Evidence shows each hip fracture costs the NHS £10,000 with additional social care costs and in Somerset 737 people fractured a hip during 2012/13 which highlights the importance of reducing falls and maintaining bone health. Over the past few years several national initiatives have been introduced and there are many ways to help address falls and bone health at a GP Federation level.

1) Primary diagnosis of osteoporosis

It is imperative we identify those with osteoporosis who are at risk of fragility fracture early on. NICE Clinical Guidance CG 146 (2012) provides a means of assessing fragility fracture risk and incorporates an osteoporosis pathway to assist with this <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, this would include a DXA scan where appropriate

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 Falls Risk Assessment Tool (FRAT) can help identify specific risk factors and is used as a trigger to refer to the Somerset Falls Service. This assessment asks about:

- 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?

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

4) Importance of physical activity

The evidence highlights that exercise programmes 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. Evidence suggests this is most effective in those aged 70 years and above.

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, and the Falls Service 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 support falls reductions and subsequent fractures is secondary prevention of a second fragility fracture, as often the initial fragility fracture is fairly minor and can be considered as a warning sign for a more severe fracture and associated morbidity and potential mortality. In up to 50% of hip fracture cases there is opportunity for intervention, as studies have shown about half of those who experience a hip fracture have had a previous fragility fracture. Therefore ensuring those with minor fractures are appropriately assessed for osteoporosis is key, Fracture Liaison Services (currently only in place at Yeovil District Hospital) have a vital role in this, however action often rests with GPs to action recommendations relating to prescribing.

Chard, Crewkerne and Ilminster area

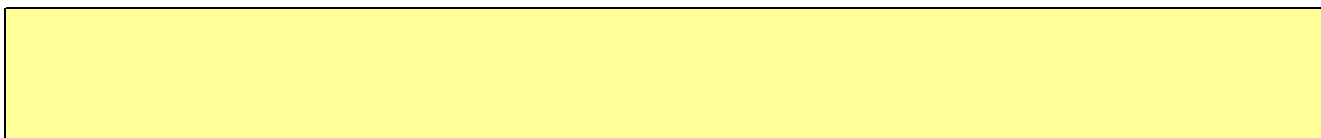
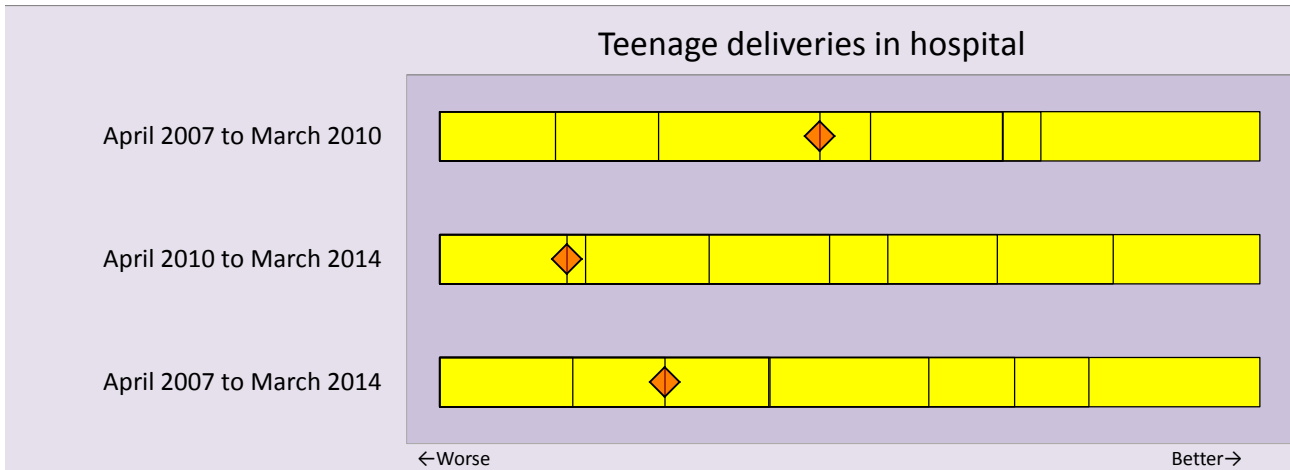
Teenage deliveries in hospital

SUS Inpatient activity files April 2007 to March 2014. GP population files July 2007-July 2013.
Rate per 1000 females aged 15-17 per year.

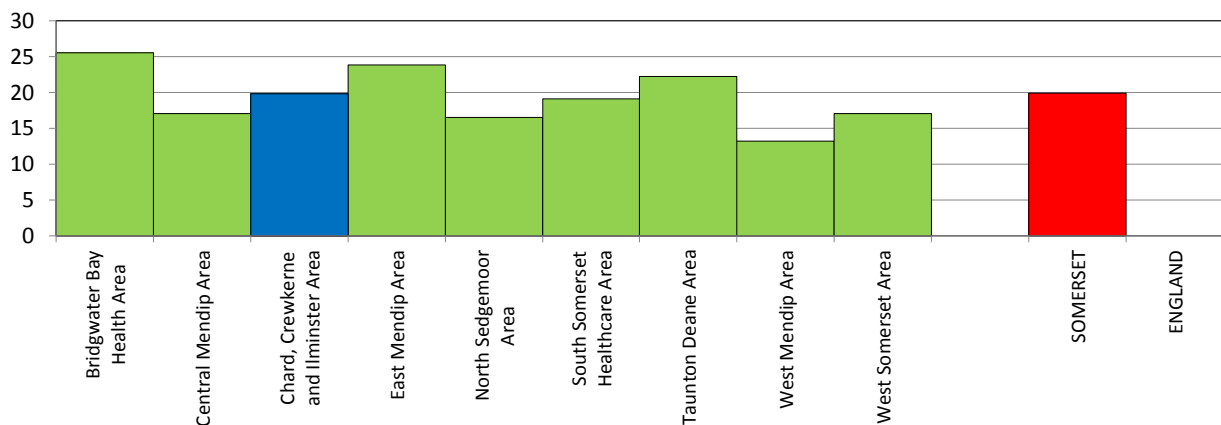
Numbers of deliveries in hospital where the age of the mother is less than 19 at delivery. This will not include home deliveries.

April 2007 to March 2014

	Federation rate	Somerset rate	England	Range of Practice values low / median / high
April 2007 to March 2010	19.8	19.9		
April 2010 to March 2014	21.2	16.9		
April 2007 to March 2014	20.5	18.2		



Teenage deliveries in hospital per 1000 females aged 15-17 per year April 2007 - March 2014



Chard, Crewkerne and Ilminster area

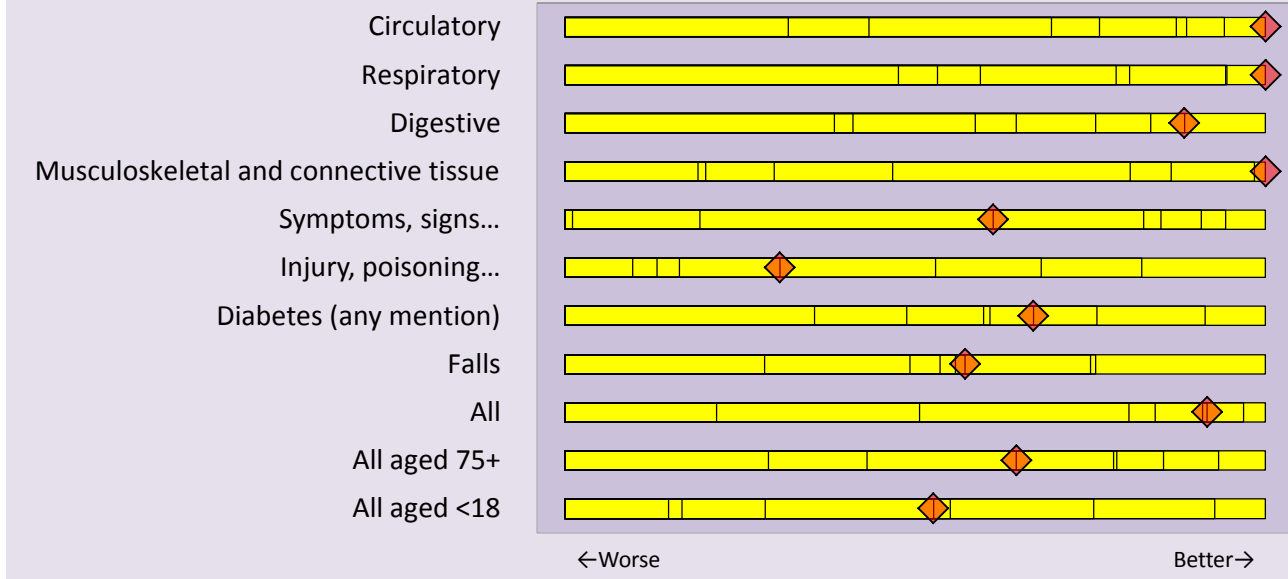
Standardised emergency admission rate to hospital per 1000 population (ICD grouping)

SUS Inpatient activity files 2013/14. Population file July 2013. Emergency admissions. Standardised by age and sex.

0.1% 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)	Federation rate	Somerset rate	England	Range of Practice values low / median / high
Diseases of the circulatory system	501	535	9.7	10.3		6.0 / 10.4 / 17.1
Diseases of the respiratory system	498	531	10.0	10.6		5.5 / 10.5 / 17.7
Diseases of the digestive system	390	414	8.0	8.5		3.9 / 8.1 / 13.0
Diseases of musculoskeletal system and connective tissue	176	195	3.5	3.9		1.3 / 3.7 / 6.6
Symptoms, signs and abnormal clinical and laboratory findings	1,073	1,107	22.0	22.7		14.7 / 21.7 / 41.6
Injury, poisoning and other external causes	796	798	16.4	16.5		11.4 / 16.1 / 40.2
Diabetes (any mention of diabetes for the admission)	635	666	12.3	12.9		6.6 / 12.3 / 22.8
Falls (any mention of a fall for the admission)	447	458	8.7	8.9		3.5 / 8.7 / 25.6
All	4,766	4,944	97.3	100.9		71.1 / 100.5 / 188.6
All aged 75+	1,700	1,658	410.3	400.1		40.4 / 393.1 / 603.9
All aged <18	599	615	68.1	70.0		27.4 / 70.0 / 98.7

Emergency admissions to hospital 2013/14

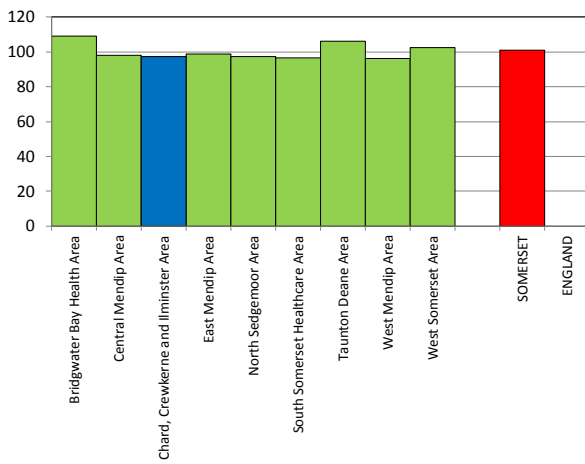


Chard, Crewkerne and Ilminster area

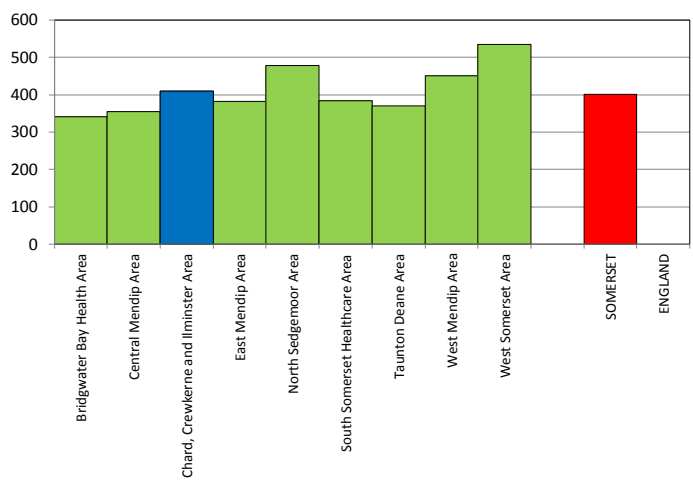
The Federation has the best value in the county for:

Diseases of the circulatory system Diseases of the respiratory system Diseases of musculoskeletal system and connective tissue

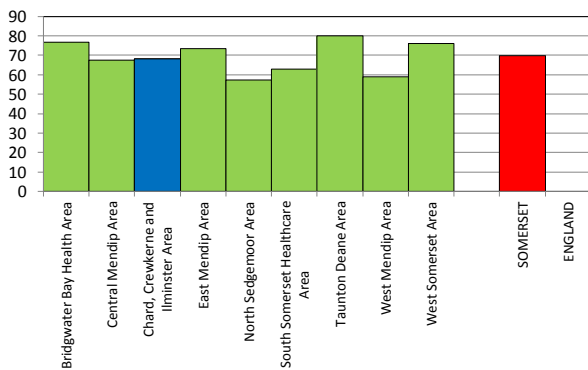
Emergency admission rate: All ages all causes



Emergency admission rate: those aged 75 and over all causes



Emergency admission rate: those aged <18 all causes



Chard, Crewkerne and Ilminster area

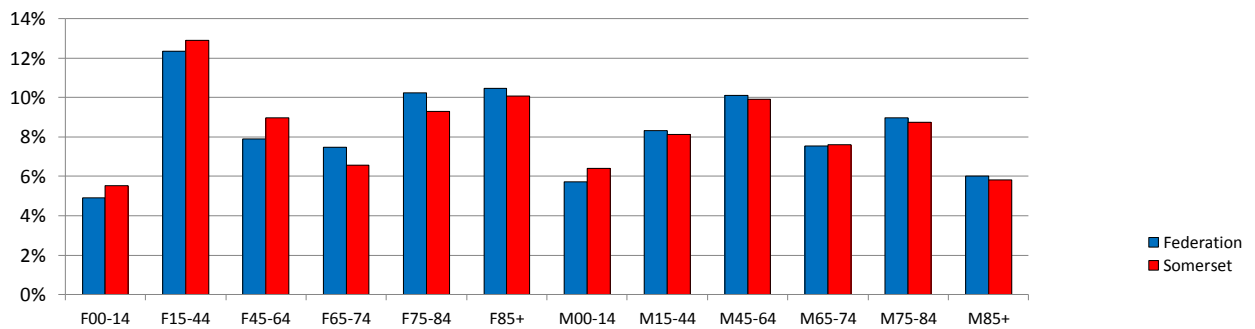
Emergency admission numbers by age and sex of patient

SUS Inpatient activity files 2013/14. Population file July 2013.

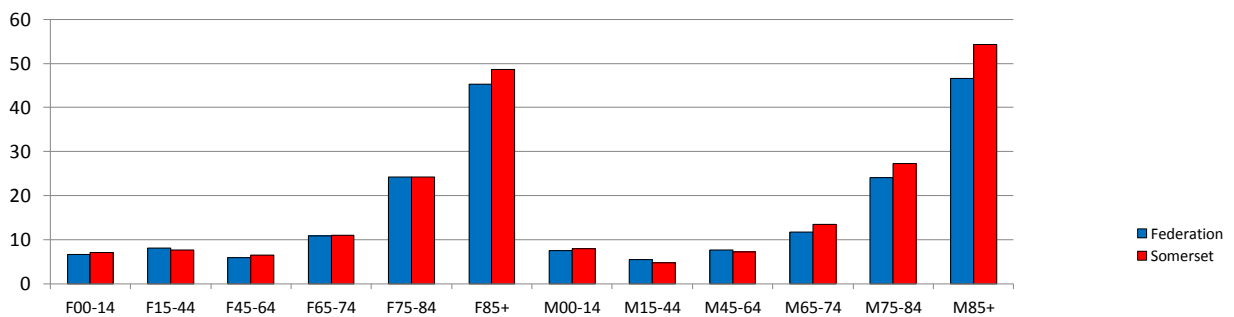
The crude rate shown is the number of admissions per population in the age/sex group. There can be multiple admissions for patients. 0.1% of admissions are not included in the table below because the patient was of unknown age or sex.

age/sex group	Federation			Somerset		
	no.	% of total	Crude rate per	no.	% of total	Crude rate per 100
F00-14	234	5%	6.6	3,067	6%	7.1
F15-44	588	12%	8.1	7,166	13%	7.7
F45-64	376	8%	5.9	4,982	9%	6.5
F65-74	356	7%	10.8	3,651	7%	11.0
F75-84	488	10%	24.2	5,152	9%	24.2
F85+	499	10%	45.3	5,591	10%	48.6
M00-14	273	6%	7.5	3,560	6%	7.9
M15-44	397	8%	5.4	4,507	8%	4.8
M45-64	482	10%	7.6	5,501	10%	7.3
M65-74	360	8%	11.7	4,228	8%	13.4
M75-84	427	9%	24.0	4,847	9%	27.3
M85+	286	6%	46.7	3,238	6%	54.3
Total	4,766	100%		55,490	100%	

Proportion of all emergency admissions



Crude rate per 100 population



Chard, Crewkerne and Ilminster area

Emergency admission numbers by reason for admission

SUS Inpatient activity files 2013/14

The total is the sum of the ICD groupings above the thick black line. Those below are subsets of groupings above.

ALL AGES

This table only includes those with known diagnosis.

ICD groupings	Federation		Somerset	
	no.	%	no.	%
Infectious and parasitic diseases	197	4%	2,492	4%
Cancer	106	2%	1,086	2%
In situ and benign neoplasms and neoplasms of unknown or uncertain behaviour	13	0%	130	0%
Diseases of blood and blood forming organs	52	1%	485	1%
Endocrine, nutritional and metabolic diseases	101	2%	1,129	2%
Mental and behavioural disorders	120	3%	1,410	3%
Diseases of the nervous system	132	3%	1,389	3%
Diseases of eye and adnexa	24	1%	271	0%
Diseases of Ear and Mastoid process	12	0%	152	0%
Diseases of the circulatory system	501	11%	5,690	10%
Diseases of the respiratory system	498	10%	5,844	11%
Diseases of the digestive system	390	8%	4,662	8%
Diseases of skin and subcutaneous tissue	145	3%	1,645	3%
Diseases of musculoskeletal system and connective tissue	176	4%	2,160	4%
Diseases of genitourinary system	270	6%	3,261	6%
Pregnancy, childbirth and puerperium	83	2%	1,180	2%
Certain conditions originating in perinatal period	28	1%	394	1%
Congenital malformations, deformations and chromosomal abnormalities	7	0%	100	0%
Symptoms, signs and abnormal clinical and laboratory findings	1,073	23%	12,491	23%
Injury, poisoning and other external causes	796	17%	9,056	16%
Factors influencing health status and contact with health services	41	1%	458	1%
Coronary Heart Disease	105	2%	1,274	2%
Cerebrovascular disease	115	2%	1,228	2%
COPD	93	2%	1,107	2%
Asthma	31	1%	403	1%
Diabetes (as the main reason for admission)	39	1%	449	1%
Diabetes (any mention of diabetes for the admission)	635	13%	7,120	13%
Falls (any mention of a fall for the admission)	447	9%	4,901	9%
Total	4,765	100%	55,485	100%

Chard, Crewkerne and Ilminster area

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

SUS Inpatient activity files 2011/12 - 2013/14. Population file July 2011, July 2012 and July 2013. Emergency admissions. Standardised by age and sex.

0.3% of admissions are not included because of unknown age or sex.

ICD groupings	Observed	Expected (based on Somerset rates)	Federation rate	Somerset rate	England	Range of Practice values low / median / high
Coronary heart disease	338	401	2.2	2.6		1.3 / 2.6 / 4.4
Cerebrovascular disease	295	319	1.9	2.0		0.6 / 2.0 / 6.0
COPD	289	319	1.8	2.0		0.0 / 1.8 / 10.2
Asthma	93	110	0.7	0.8		0.1 / 0.8 / 1.7

Emergency admissions to hospital 2011/12 - 2013/14

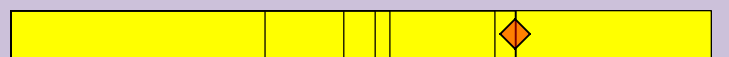
Coronary heart disease



Cerebrovascular disease



COPD



Asthma



←Worse

Better→

Significantly better than county average for:

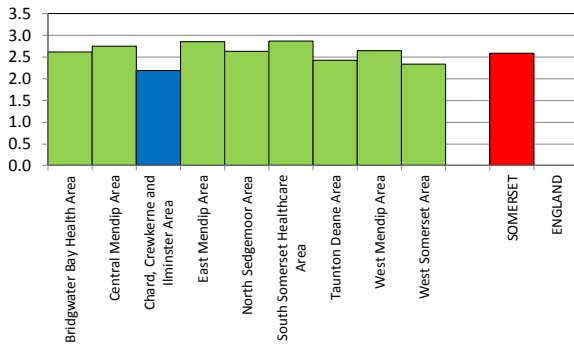
Coronary heart disease

The Federation has the best value in the county for:

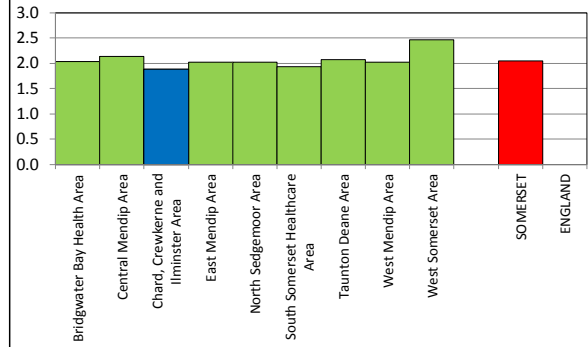
Coronary heart disease Cerebrovascular disease Asthma

Chard, Crewkerne and Iminster area

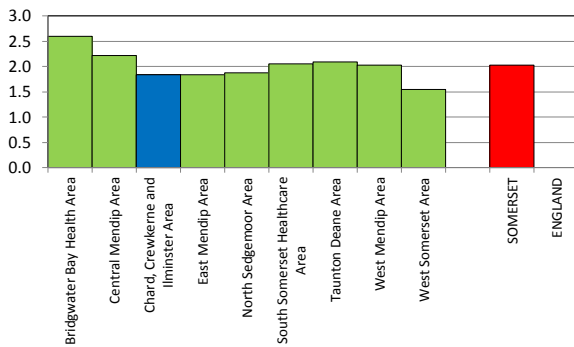
Emergency admission rate: Coronary heart disease



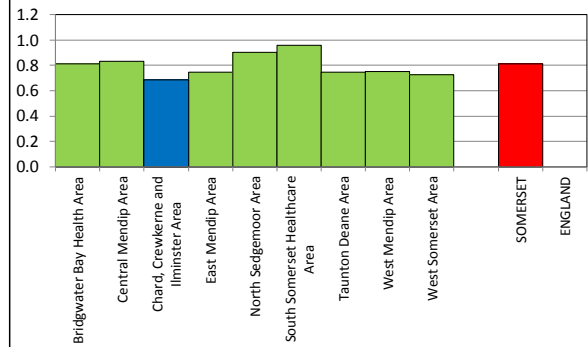
Emergency admission rate: Cerebrovascular disease



Emergency admission rate: COPD



Emergency admission rate: Asthma



Chard, Crewkerne and Ilminster area

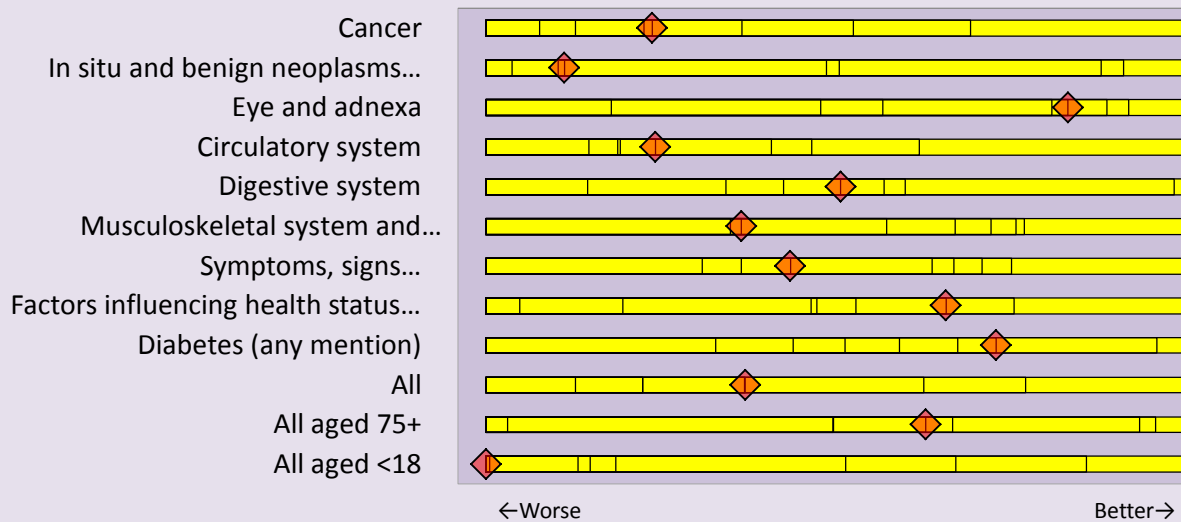
Standardised elective admission rate to hospital per 1000 population (ICD grouping)

SUS Inpatient activity files 2013/14. Population file July 2013. Elective and Day cases. Standardised by age and sex.

Fewer than 0.5% 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)	Federation rate	Somerset rate	England rate	Range of Practice values low / median / high
Cancer	1,752	1,654	34.5	32.5		10.7 / 32.0 / 65.2
In situ and benign neoplasms and neoplasms of unknown or uncertain behaviour	354	332	7.1	6.7		2.2 / 6.3 / 11.6
Diseases of eye and adnexa	634	704	12.1	13.5		8.0 / 13.2 / 31.6
Diseases of the circulatory system	448	438	8.9	8.7		4.9 / 8.7 / 20.0
Diseases of the digestive system	1,193	1,185	24.6	24.5		15.0 / 24.4 / 45.8
Diseases of musculoskeletal system and connective tissue	897	857	18.3	17.5		10.8 / 17.4 / 27.9
Symptoms, signs and abnormal clinical and laboratory findings	449	437	9.2	8.9		5.4 / 8.7 / 14.7
Factors influencing health status and contact with health services	351	409	7.1	8.3		4.3 / 8.2 / 14.7
Diabetes (any mention of diabetes for the admission)	703	782	13.6	15.2		8.6 / 14.8 / 23.4
All	7,611	7,657	154.1	155.0		125.9 / 156.6 / 217.8
All aged 75+	1,702	1,738	402.2	410.8		49.2 / 416.4 / 778.5
All aged <18	398	330	45.9	38.1		13.1 / 36.0 / 98.3

Elective (inpatient and day cases) admissions to hospital 2013/14



Chard, Crewkerne and Iminster area

Significantly worse than county average for:

All aged <18

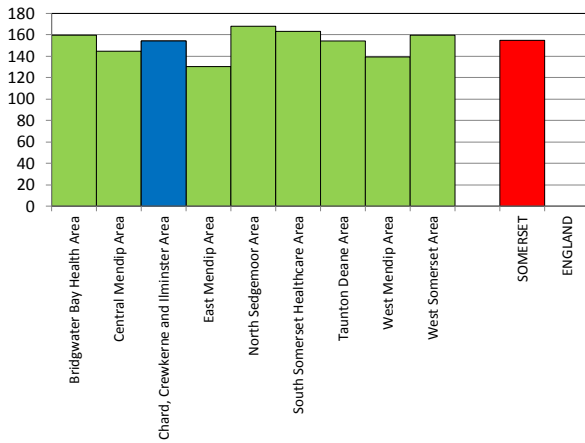
The Federation has the worst value in the county for:

All aged <18

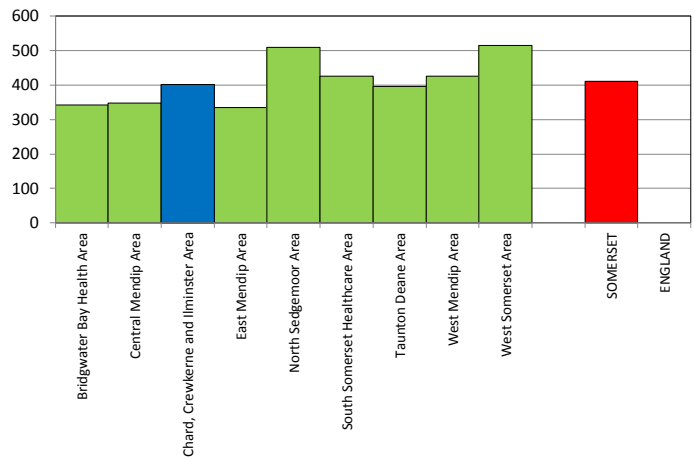
Significantly better than county average for:

Diseases of eye and adnexa Factors influencing health status and contact with health services Diabetes (any mention of diabetes for the admission)

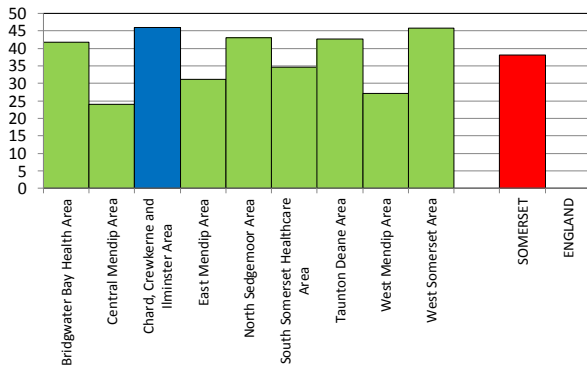
Elective admission rate: All ages all causes



Elective admission rate: those aged 75 and over all causes



Elective admission rate: those aged <18 all causes



Chard, Crewkerne and Ilminster area

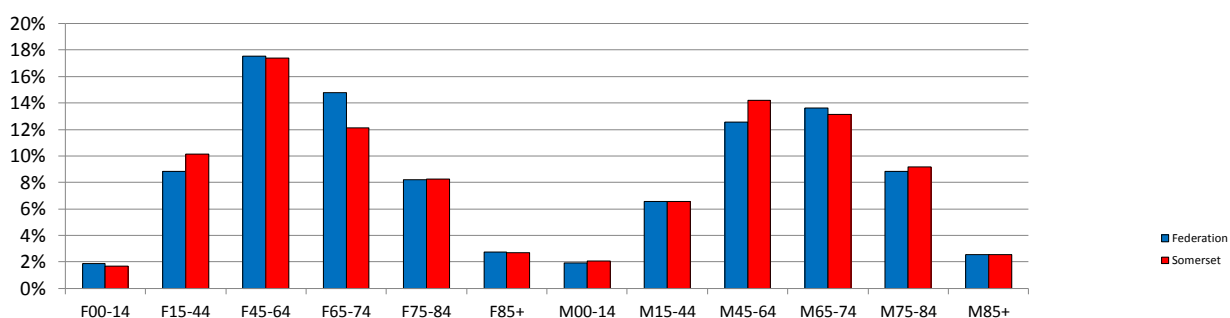
Elective admission numbers by age and sex of patient

SUS Inpatient activity files 2013/14. Population file July 2013. Elective and Day cases.

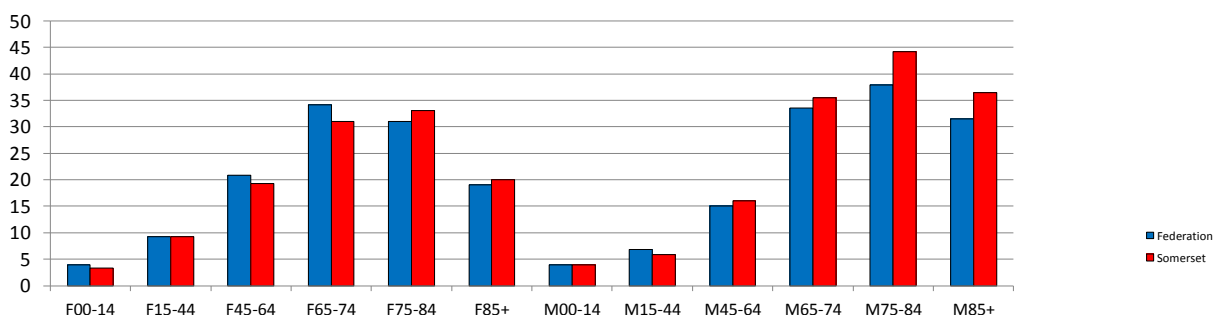
The crude rate shown is the number of admissions per population in the age/sex group. There can be multiple admissions for patients. Fewer than 0.5% of admissions are not included in the table below because the patient was of unknown age or sex.

age/sex group	Federation			Somerset		
	no.	% of total	Crude rate per	no.	% of total	Crude rate per 100
F00-14	141	2%	4.0	1,446	2%	3.3
F15-44	672	9%	9.2	8,666	10%	9.3
F45-64	1,334	18%	20.9	14,821	17%	19.3
F65-74	1,124	15%	34.1	10,320	12%	31.0
F75-84	625	8%	31.0	7,029	8%	33.0
F85+	210	3%	19.1	2,298	3%	20.0
M00-14	146	2%	4.0	1,777	2%	3.9
M15-44	499	7%	6.8	5,579	7%	5.9
M45-64	955	13%	15.0	12,103	14%	16.0
M65-74	1,038	14%	33.6	11,211	13%	35.5
M75-84	674	9%	37.9	7,830	9%	44.1
M85+	193	3%	31.5	2,176	3%	36.5
Total	7,611	100%		85,256	100%	

Proportion of all elective admissions



Crude rate per 100 population



Chard, Crewkerne and Ilminster area

Elective admission numbers by reason for admission

SUS Inpatient activity files 2013/14

The total is the sum of the ICD groupings above the thick black line. Those below are subsets of groupings above.

ALL AGES

This table only includes those with known diagnosis.

ICD groupings	Federation		Somerset	
	no.	%	no.	%
Infectious and parasitic diseases	39	1%	434	1%
Cancer	1,752	23%	17,902	21%
In situ and benign neoplasms and neoplasms of unknown or uncertain behaviour	354	5%	3,681	4%
Diseases of blood and blood forming organs	188	2%	2,389	3%
Endocrine, nutritional and metabolic diseases	65	1%	844	1%
Mental and behavioural disorders	15	0%	186	0%
Diseases of the nervous system	191	3%	2,390	3%
Diseases of eye and adnexa	634	8%	7,400	9%
Diseases of Ear and Mastoid process	62	1%	989	1%
Diseases of the circulatory system	448	6%	4,780	6%
Diseases of the respiratory system	134	2%	1,635	2%
Diseases of the digestive system	1,193	16%	13,461	16%
Diseases of skin and subcutaneous tissue	131	2%	1,645	2%
Diseases of musculoskeletal system and connective tissue	897	12%	9,638	11%
Diseases of genitourinary system	399	5%	4,963	6%
Pregnancy, childbirth and puerperium	83	1%	951	1%
Certain conditions originating in perinatal period	0	0%	25	0%
Congenital malformations, deformations and chromosomal abnormalities	67	1%	647	1%
Symptoms, signs and abnormal clinical and laboratory findings	449	6%	4,919	6%
Injury, poisoning and other external causes	159	2%	1,833	2%
Factors influencing health status and contact with health services	351	5%	4,544	5%
Coronary Heart Disease	131	2%	1,315	2%
Diabetes (any mention of diabetes for the admission)	703	9%	8,352	10%
Total	7,611	100%	85,256	100%

Chard, Crewkerne and Ilminster area

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

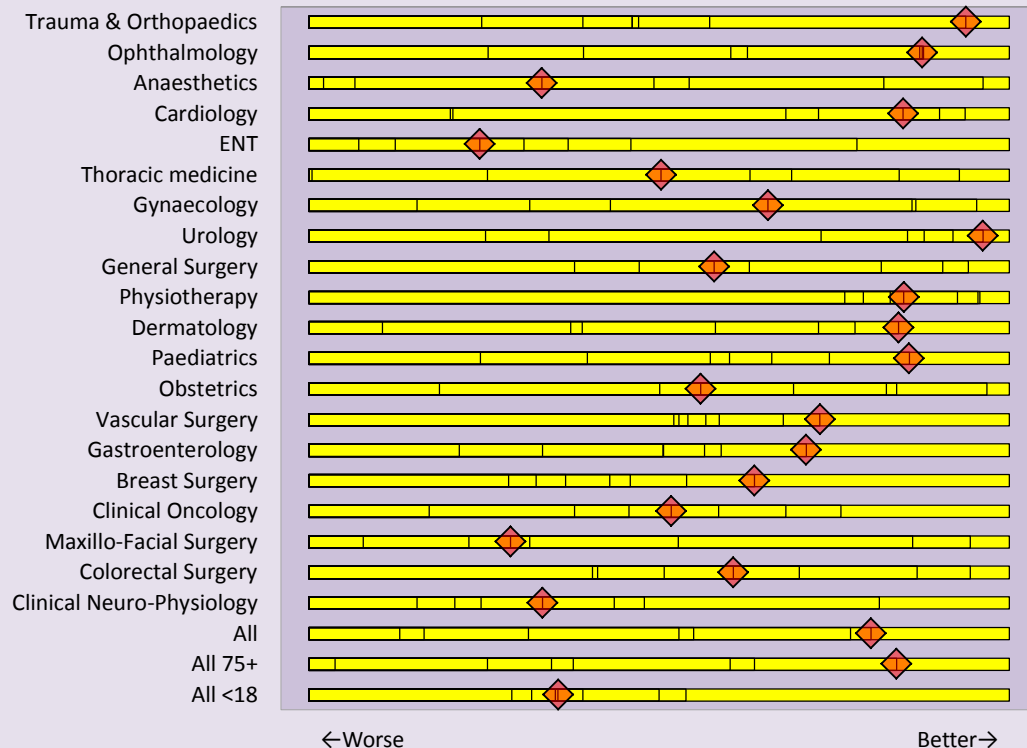
SUS Outpatient activity files 2013/14. Population file July 2013. Standardised by age and sex.

Treatment function code is used rather than Specialty. The treatment function code reflects what the patient is treated for rather than the main speciality of the consultant under whose care the patient is. Not all treatment functions are listed. Some activity is only shown for Federations. 1% of first attendances are not included in the table below because the patient was of unknown age or sex.

2013/14

Treatment Function	Observed	Expected (based on Somerset rates)	Federation rate	Somerset rate	England rate	Range of Practice values low / median / high
Trauma & Orthopaedics	2,690	3,410	56.3	71.3		40.7 / 69.9 / 102.9
Ophthalmology	1,643	1,769	32.7	35.3		24.9 / 35.5 / 53.7
Anaesthetics	1,185	1,031	24.6	21.4		0.4 / 23.6 / 44.5
Cardiology	827	1,082	16.5	21.6		6.1 / 16.8 / 53.8
ENT	1,055	1,049	22.2	22.0		13.4 / 21.6 / 47.8
Thoracic medicine	948	953	19.2	19.3		3.4 / 18.7 / 39.1
Gynaecology	729	764	32.2	33.7		16.9 / 30.9 / 67.8
Urology	747	894	15.0	17.9		9.9 / 16.2 / 37.6
General Surgery	734	701	15.2	14.5		4.6 / 11.7 / 34.3
Physiotherapy	426	716	9.0	15.1		1.1 / 9.1 / 73.4
Dermatology	613	693	12.6	14.2		5.5 / 13.7 / 24.8
Paediatrics	222	258	26.5	30.8		12.7 / 30.8 / 52.2
Obstetrics	358	354	50.1	49.5		14.4 / 42.3 / 142.8
Vascular Surgery	332	396	6.5	7.7		
Gastroenterology	340	366	7.0	7.6		
Breast Surgery	313	389	6.8	8.4		
Clinical Oncology	367	343	7.2	6.7		
Maxillo-Facial Surgery	340	281	7.2	5.9		
Colorectal Surgery	259	260	5.3	5.3		
Clinical Neuro-Physiology	286	278	6.0	5.8		
All	18,157	20,132	378.1	419.2		283.5 / 417.7 / 575.9
All 75+	3,566	4,090	646.3	741.2		405.9 / 746.5 / 1060.5
All <18	1,965	1,954	225.4	224.1		152.5 / 226.2 / 285.5

First Outpatient attendances 2013/14



Chard, Crewkerne and Iminster area

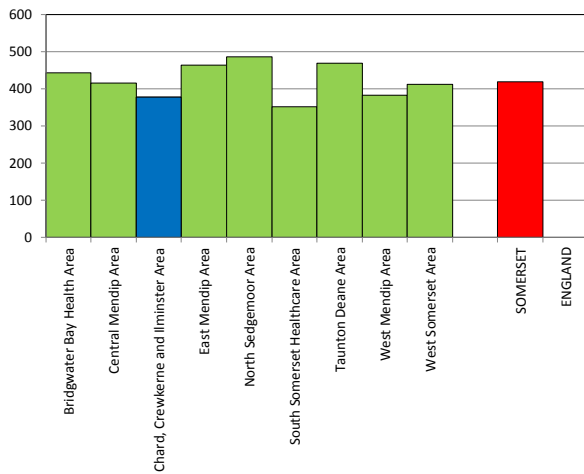
Significantly worse than county average for:

Anaesthetics Maxillo-Facial Surgery

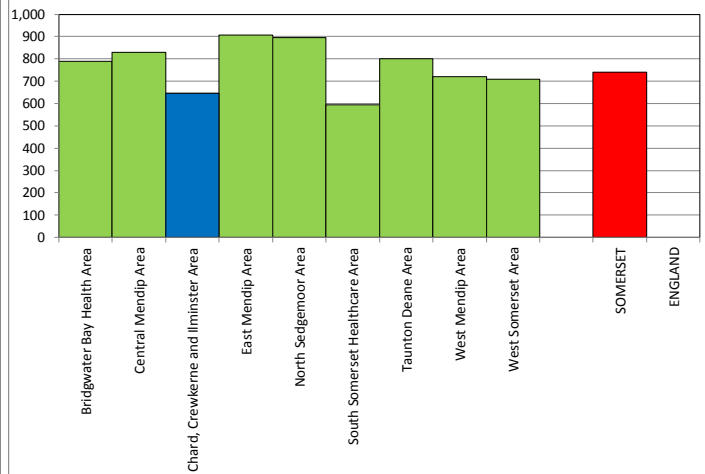
Significantly better than county average for:

Trauma & Orthopaedics Ophthalmology Cardiology Urology Physiotherapy Dermatology Vascular Surgery Breast Surgery All All 75+

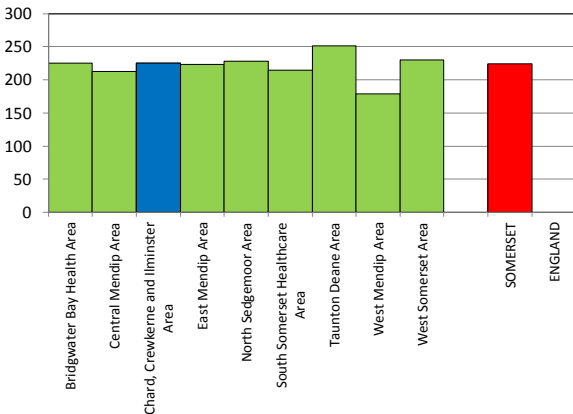
First Outpatient attendance rate: All ages All causes



First Outpatient attendance rate: 75+ All causes



First Outpatient attendance rate: <18 All causes



Chard, Crewkerne and Ilminster area

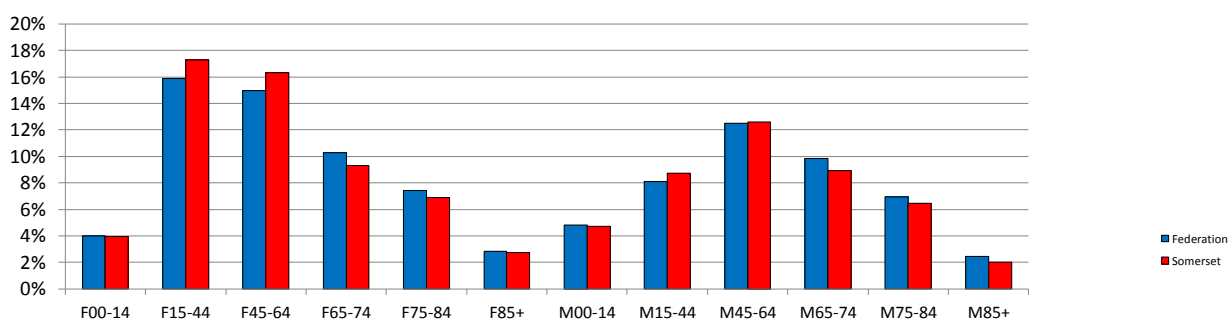
First Outpatient attendances by age and sex of patient

SUS Outpatient activity file 2013/14. Population file July 2013.

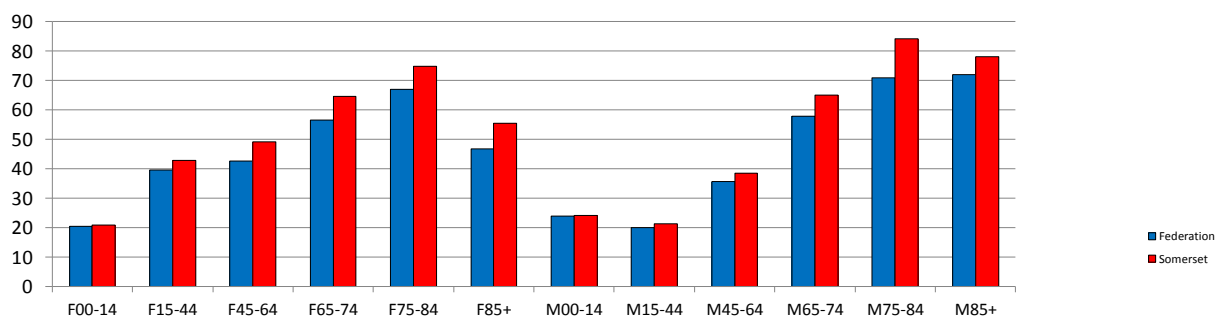
The crude rate shown is the number of first attendances per population in the age/sex group. There can be multiple first attendances for patients. 1% of admissions are not included in the table below because the patient was of unknown age or sex.

age/sex group	Federation			Somerset		
	no.	% of total	Crude rate per	no.	% of total	Crude rate per 100
F00-14	726	4%	20.5	9,089	4%	20.9
F15-44	2,881	16%	39.6	39,810	17%	42.8
F45-64	2,722	15%	42.7	37,640	16%	49.1
F65-74	1,865	10%	56.6	21,511	9%	64.6
F75-84	1,349	7%	67.0	15,924	7%	74.8
F85+	516	3%	46.9	6,369	3%	55.4
M00-14	874	5%	23.9	10,857	5%	24.1
M15-44	1,470	8%	20.0	20,116	9%	21.2
M45-64	2,267	12%	35.7	29,108	13%	38.5
M65-74	1,786	10%	57.8	20,546	9%	65.1
M75-84	1,260	7%	70.9	14,923	6%	84.1
M85+	441	2%	71.9	4,656	2%	78.1
Total	18,157	100%		230,549	100%	

Proportion of all first outpatient attendances



Crude rate per 100 population



Chard, Crewkerne and Ilminster area

First Outpatient attendances by reason for attendance

SUS Outpatient activity file 2013/14

The total contains more than the sum of the lines above. 1% of admissions are not included in the table below because the patient was of unknown age or sex.

ALL AGES

This table only includes those with known treatment function code.

Treatment Function	Federation		Somerset	
	no.	%	no.	%
Trauma & Orthopaedics	2,690	15%	39,240	17%
Ophthalmology	1,643	9%	19,396	8%
Anaesthetics	1,185	7%	11,755	5%
Cardiology	827	5%	11,882	5%
ENT	1,055	6%	12,119	5%
Thoracic Medicine	948	5%	10,629	5%
Gynaecology	729	4%	9,410	4%
Urology	747	4%	9,858	4%
General Surgery	734	4%	7,986	3%
Physiotherapy	426	2%	8,326	4%
Dermatology	613	3%	7,814	3%
Paediatrics	222	1%	3,165	1%
Obstetrics	358	2%	4,610	2%
All treatment functions (not all shown above)	18,157		230,549	

Chard, Crewkerne and Ilminster area

Prescribing

The QIPP Prescribing indicators set:

Key therapeutic topic	Comparator	Comparator description and history
Laxatives	Laxatives ADQ/STAR PU	Number of average daily quantities (ADQs) for laxatives per Laxatives (BNF 1.6) COST based STAR-PU. Introduced February 2012. Amended to current comparator in May 2012.
Renin-angiotensin system drugs	ACE inhibitor % items	Number of prescription items for angiotensin converting enzyme (ACE) inhibitors as a percentage of the total number of prescription items for all drugs affecting the renin-angiotensin system excluding aliskiren. Introduced March 2011.
Lipid lowering drugs including ezetimibe	Low cost lipid modifying drugs	Number of prescription items for generic statin preparations listed under category M in part VIII of the Drug Tariff as a percentage of the total number of prescription items for all statins, plus the total number of prescription items for combination of simvastatin/ezetimibe, plus total number of prescription items for ezetimibe alone. Introduced March 2011. Amended August 2013.
	Lipid modifying drugs: Ezetimibe % items	Number of items for ezetimibe and ezetimibe/simvastatin combinations as a percentage of the total number of prescription items for all statins, plus the total number of prescription items for combination of simvastatin/ezetimibe, plus total number of prescription items for ezetimibe alone. Introduced February 2012.
Omega-3 fatty acid supplements	Omega-3 ADQ/STAR PU	Number of ADQs for omega-3 fatty acid compounds per Omega-3 fatty acid compounds (BNF 2.12 sub-set) ADQ based STAR-PU. Comparator introduced August 2013.
Hypnotics	Hypnotics ADQ/STAR PU (ADQ based)	Number of average daily quantities (ADQs) for benzodiazepines (indicated for use as hypnotics) and "Z" drugs per Hypnotics (BNF 4.1.1 sub-set) ADQ based STAR-PU. Introduced March 2011. Amended August 2013.
First choice anti-depressant use in adults with depression or anxiety disorder	Antidepressant (selected): ADQ/STAR PU (ADQ based)	Number of average daily quantities (ADQs) for selected antidepressant prescribing per Antidepressants (BNF 4.3 sub-set) ADQ based STAR-PU. Introduced February 2012. Amended August 2013.
	Antidepressants: First choice % items	Number of prescription items for „1st choice“ generic SSRIs as a percentage of the total number of prescription items for selected „other antidepressants“. Introduced August 2012.
Antibiotic prescribing - especially quinolones and cephalosporins	Antibacterial items/STAR PU	Number of prescription items for antibacterial drugs (BNF 5.1) per Oral antibacterials (BNF 5.1 sub-set) ITEM based STAR-PU. Introduced March 2011.
	Cephalosporins & quinolones % items	Number of prescription items for cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1). Introduced March 2011.
Three-day courses of trimethoprim for uncomplicated urinary tract infection	3 days trimethoprim ADQ/item	Number of average daily quantities (ADQs) per item for trimethoprim 200mg tablets. Introduced February 2012.
Minocycline	Minocycline ADQ/1000 patients	Number of average daily quantities (ADQs) for minocycline per 1000 patients. Introduced February 2012. Amended to current title and description in May 2012.
Type 2 diabetes mellitus	Hypoglycaemic drugs	Number of prescription items for metformin and sulfonylureas as a percentage of the total number of prescription items for all antidiabetic drugs. Introduced March 2011.
	Long-acting insulin analogues	Number of prescription items for long-acting human analogue insulins as a percentage of the total number of prescription items for all long- acting and intermediate acting insulins excluding biphasic insulins. Introduced March 2011. Amended August 2013.
Non-steroidal anti-inflammatory drugs (NSAIDs)	NSAIDs: Ibuprofen & naproxen % items	Number of prescription items for ibuprofen and naproxen as a percentage of the total number of prescription items for all NSAIDs. Introduced March 2011.
	NSAIDs ADQ/STAR PU	Number of average daily quantities (ADQs) for all NSAIDs (BNF 10.1.1) per Oral NSAID (BNF 10.1.1 sub-set) COST based STAR-PU. Introduced March 2011.
Wound care products	Wound care products: NIC/item	Cost (NIC) per item for wound care products. Introduced August 2012.

The aim of the 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 QIPP. More detail on the prescribing measures is available at <http://www.hscic.gov.uk/prescribing/measures> and the following taken from their website:

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 therapeutic areas, 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.

Chard, Crewkerne and Ilminster area

QIPP Prescribing indicators

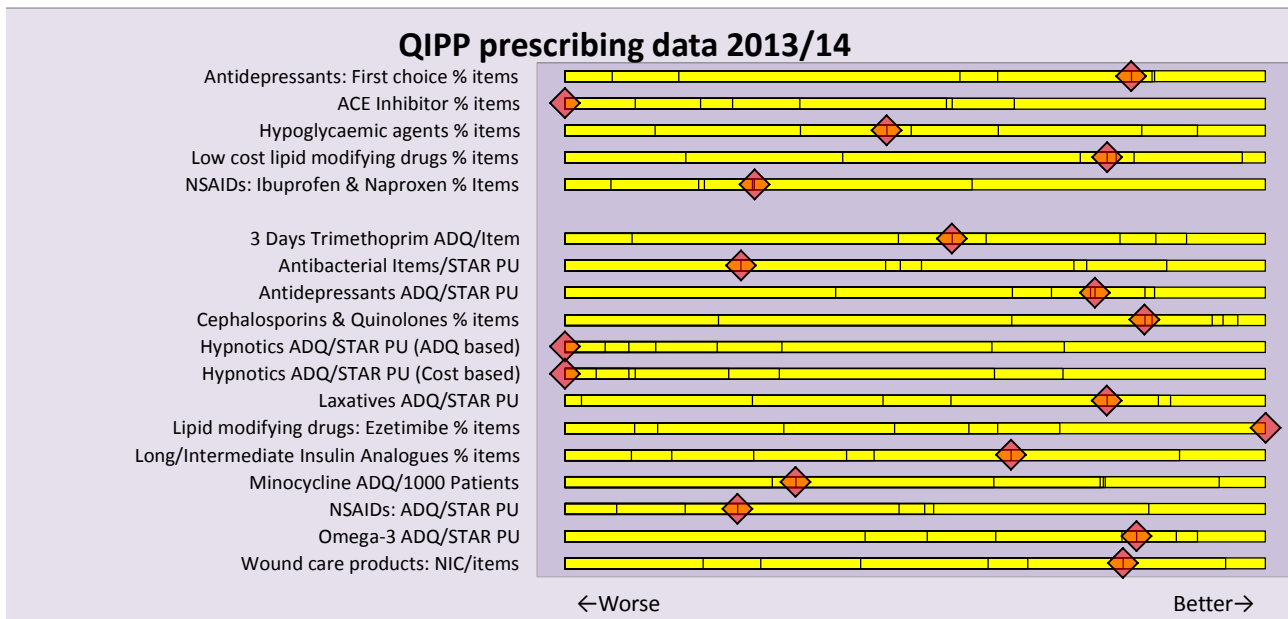
NHSBSA reports 2014

Definitions of indicators have changed and so a comparison with previous year is not meaningful.

2013/14

Indicator	Numerator	Denominator	Federation rate	Somerset rate	England rate	Range of Practice values
Antidepressants: First choice % items	20,169	32,931	61.2	56.4	63.5	24.3 / 60.3 / 76.0
ACE Inhibitor % items	49,426	69,775	70.8	73.6	70.7	62.5 / 73.8 / 82.2
Hypoglycaemic agents % items	21,821	26,166	83.4	83.6	83.8	74.6 / 85.1 / 91.6
Low cost lipid modifying drugs % items	55,323	66,749	82.9	71.0	93.2	20.1 / 89.4 / 98.5
NSAIDs: Ibuprofen & Naproxen % Items	10,598	14,254	74.4	74.6	71.5	54.2 / 75.8 / 90.8
3 Days Trimethoprim ADQ/Item	18,221	3,069	5.9	5.8	6.0	4.0 / 5.8 / 8.0
Antibacterial Items/STAR PU	32,718	28,359	1.2	1.1	1.2	0.6 / 1.1 / 4.5
Antidepressants ADQ/STAR PU	1,177,995	1,071,646	1.1	1.1	1.2	0.7 / 1.1 / 1.8
Cephalosporins & Quinolones % items	1,472	32,539	4.5	4.6	5.5	2.0 / 4.4 / 10.1
Hypnotics ADQ/STAR PU (ADQ based)	161,964	151,283	1.1	0.9	1.2	0.1 / 0.8 / 2.5
Hypnotics ADQ/STAR PU (Cost based)	161,964	24,343	6.7	5.9	7.2	0.9 / 5.1 / 15.3
Laxatives ADQ/STAR PU	344,818	62,818	5.5	5.9	7.2	2.9 / 5.6 / 9.4
Lipid modifying drugs: Ezetimibe % items	681	66,749	1.0	1.7	2.8	0.2 / 1.6 / 4.6
Long/Intermediate Insulin Analogues % items	1,526	2,253	67.7	73.6	81.7	43.2 / 72.8 / 94.3
Minocycline ADQ/1000 Patients	1,526	47	32.7	22.9	65.3	0.0 / 3.9 / 721.9
NSAIDs: ADQ/STAR PU	460,195	69,375	6.6	6.3	6.2	2.8 / 6.2 / 16.7
Omega-3 ADQ/STAR PU	11,648	17,841	0.7	0.8	1.4	0.0 / 0.6 / 5.2
Wound care products: NIC/items	72,840	5,088	14.3	16.0	24.4	7.8 / 15.4 / 53.8

For the first 5 indicators a higher rate is better. For the rest a lower rate is better.



The Federation has the worst value in the county for:

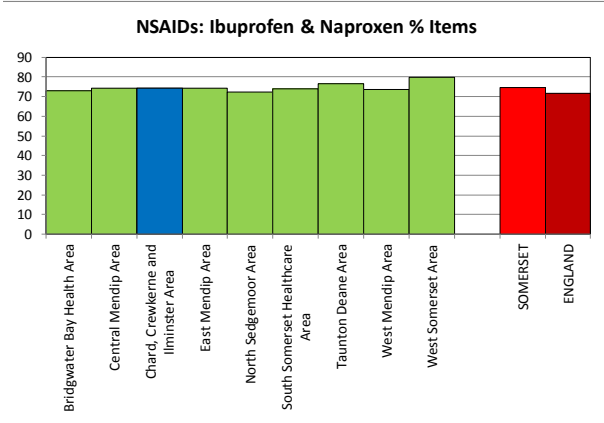
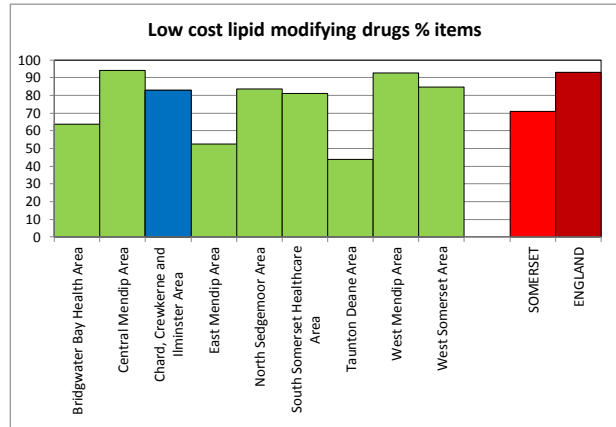
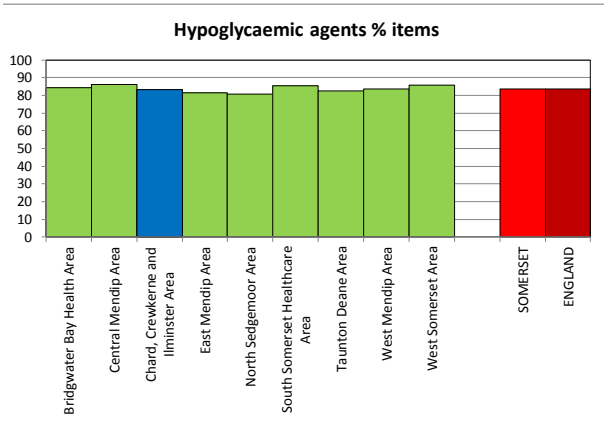
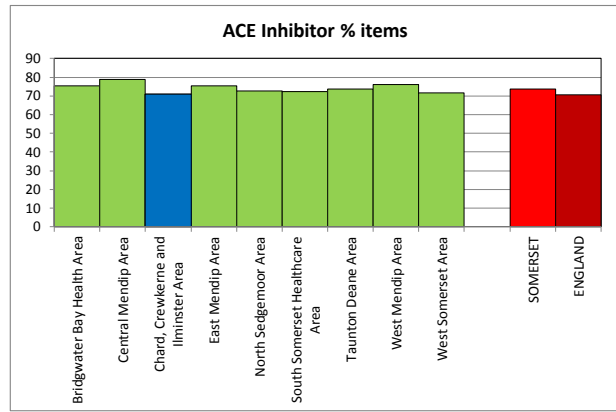
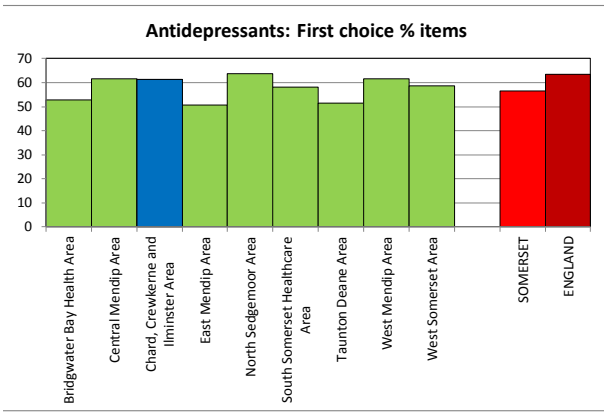
ACE Inhibitor % items Hypnotics ADQ/STAR PU (ADQ based)

The Federation has the best value in the county for:

Lipid modifying drugs: Ezetimibe % items

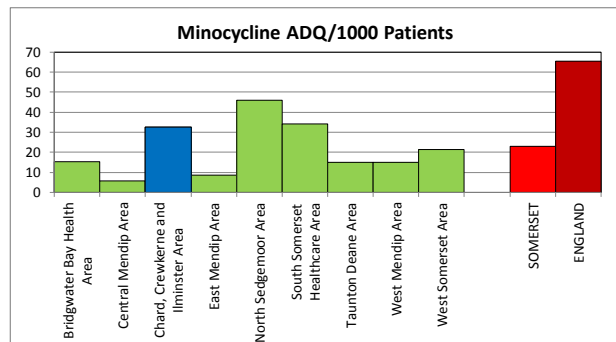
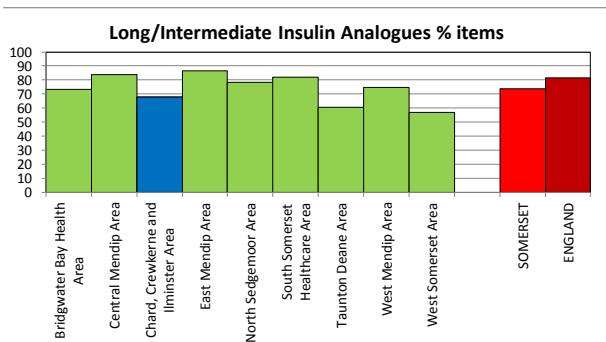
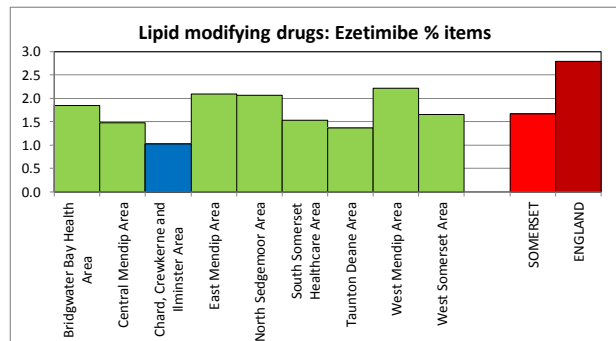
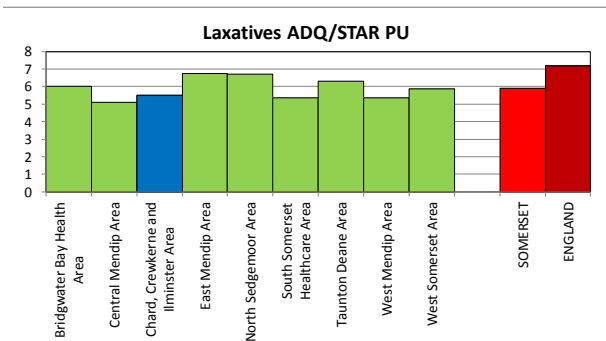
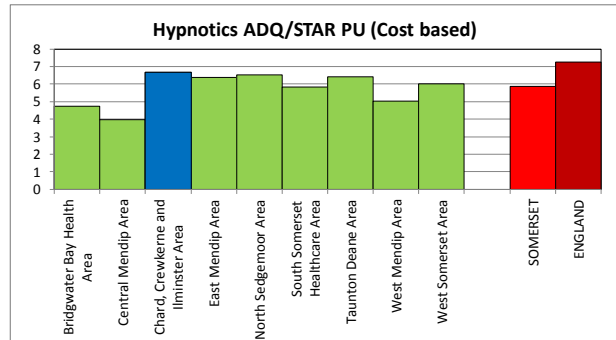
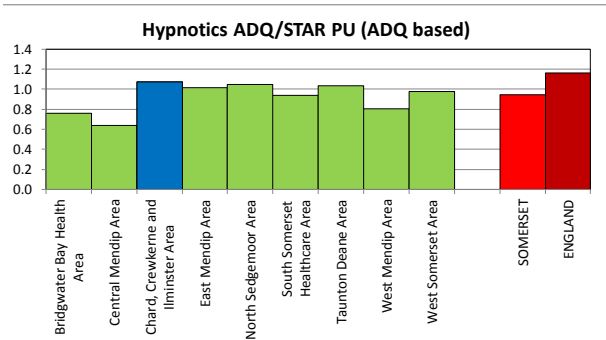
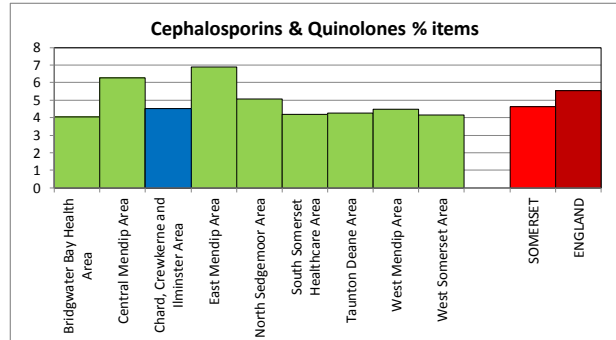
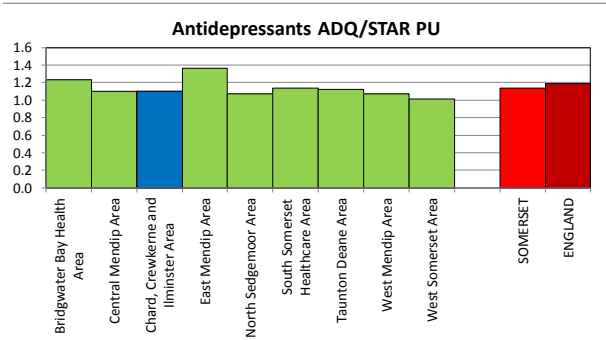
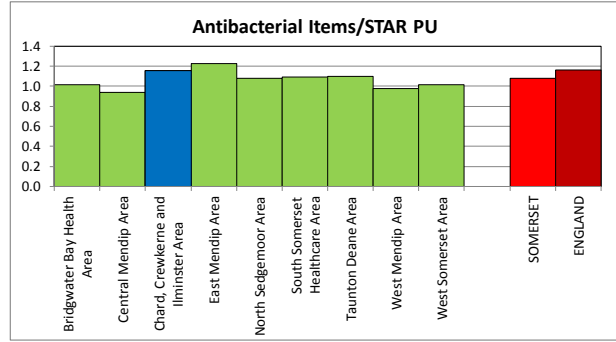
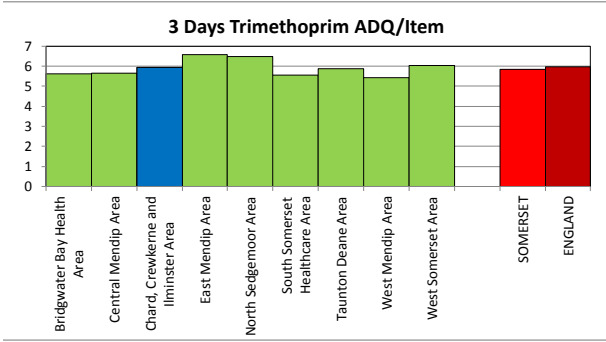
Chard, Crewkerne and Iminster area

Indicators where a higher rate is better

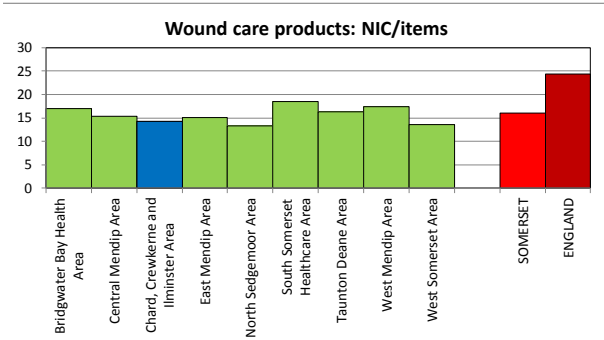
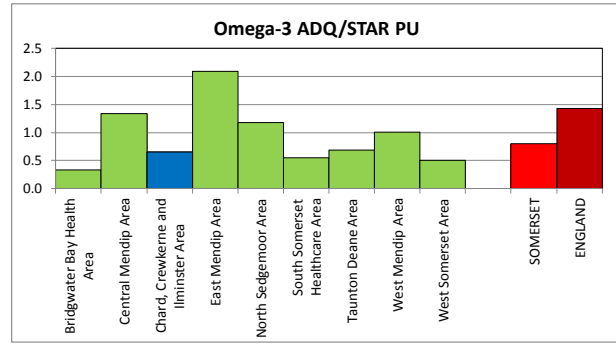
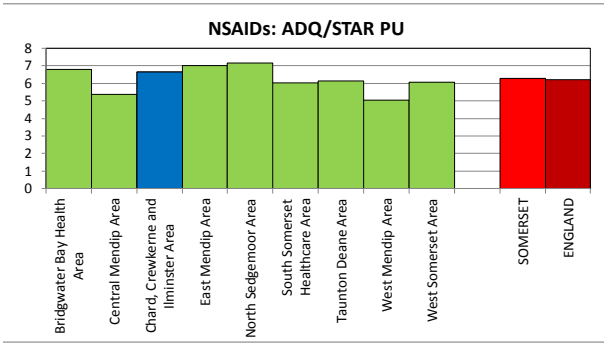


Chard, Crewkerne and Iminster area

Indicators where a lower rate is better



Chard, Crewkerne and Iminster area



Chard, Crewkerne and Ilminster area

ASTRO-PUs at April 2014 **348,135**

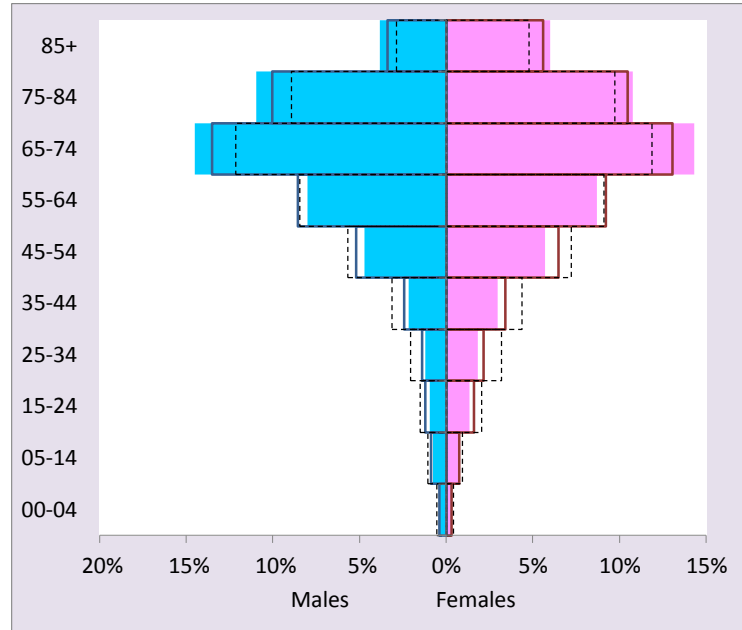
Age/Sex ASTRO-PU pyramid
 Solid line represents Somerset as a whole, dotted line represents England.
 Data from Exeter system download of GP registered patients.

ASTRO-PUs here are units based on the population at a Federation 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.

Chard, Crewkerne and Ilminster area

Age Group	Males	Females
00-04	1,178	909
05-14	2,691	2,374
15-24	3,329	4,700
25-34	4,201	6,303
35-44	7,566	10,336
45-54	16,444	19,813
55-64	27,830	30,317
65-74	50,467	49,750
75-84	38,128	37,481
85+	13,377	20,942

The ASTRO-PU distribution reflects the Federation population profile.



Somerset

Age Group	Males	Females
00-04	14,637	11,475
05-14	33,669	29,219
15-24	45,844	60,802
25-34	53,413	82,740
35-44	92,643	130,372
45-54	198,166	246,818
55-64	326,490	351,274
65-74	515,351	497,524
75-84	381,973	398,786
85+	129,216	213,768