

# East Mendip

## Commissioning Locality profile

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

## Practices in Commissioning Locality

Beckington Family Practice  
Frome Medical Practice  
Mendip Country Practice, Radstock



## Introduction

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

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

A summary of some of the key outcomes is presented first, highlighting the Commissioning Locality's performance compared to the rest of Somerset. This is followed by the Commissioning Locality profile in more detail.

We aim to expand on the intervention summaries highlighting the interventions which can be adopted to improve performance on various outcomes and would particularly welcome feedback on which additional areas would be useful. There are practice level 'ski-slopes' which show the variation of practices within the Commissioning Locality more clearly and again we would welcome feedback on whether you would like to see more (or fewer) of these. Diabetic retinopathy screening data is no longer available to us and there are some changes in definitions and sources of some indicators, otherwise the contents are as in the previous profile. We would be receptive to feedback on any material you feel is less useful and we could consider removing.

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

## Feedback

To give feedback on any aspect of the Commissioning Locality profile please contact the Public Health team.  
[PublicHealth@somerset.gov.uk](mailto:PublicHealth@somerset.gov.uk)

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## Presentation of data

Data are presented in tables and graphs.

### Tables

Tables vary in content, but all contain a comparison of the Commissioning Locality with the other Commissioning Localities and with Somerset. Occasionally there is also a National comparison. The best, median and worst practice values across Somerset are shown where available.

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

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

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

### Graphs

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

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

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

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

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

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

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

### Interpretation

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

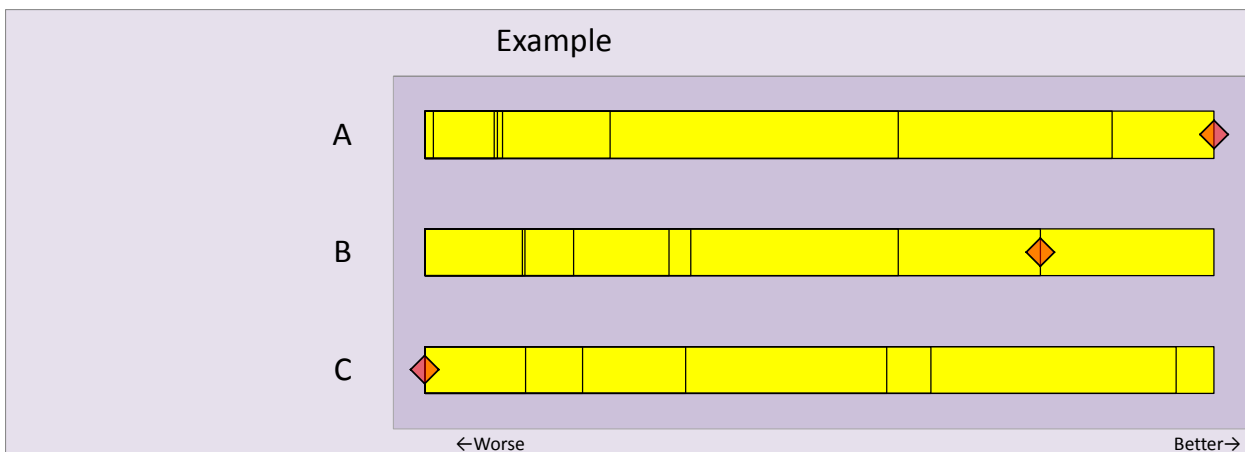
A value can be extreme (eg the "best" or "worst"; "highest" or "lowest") without necessarily being statistically significantly different to the Somerset average.

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

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

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

### Example



# East Mendip Commissioning Locality - Summary Public Health Profile 2016

## Population & context for health

The area has slightly more younger people compared to the Somerset average and fewer older people. The Index of Multiple Deprivation for the local area is 17.8 representing similar levels of deprivation compared to the Somerset average of 18.1. More detail on the deprivation data is shown on pp. 7-8 with wider determinants on pp. 9-10.

## Disease prevalence

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

## Mortality, causes and places of death

The death blobs for mortality and years of life lost on pp.23-4 provide a visual indication of the key causes of death in East Mendip Locality. The proportion of deaths occurring before age 65 years is 12.5% which is similar to the rest of the county, the Somerset rate being 12.0%. Standardised mortality ratios for different conditions and age groups are shown on p.26.

## Screening

The commissioning arrangements have changed for the NHS Health Checks programme. Of those eligible, 35.6% received a health check. In the most deprived quintile, 43.9% of the population received a check. A full profile of this data is shown on pp.30-31.

Cervical screening rates for those aged 25-49 years old, at 73.0%, are similar to the county average of 72.3%. Practice based rates of chlamydia screening of eligible 15-24 year olds was 4.6%, much higher than the Somerset average rate of 3.0%. As last year, this is the best rate in the county.

## Immunisations

Immunisation rates for this year and last are shown on pp.44-5. MMR vaccination rates are far below the target for herd immunity of 95%, with 91.9% vaccinated by age 2.

## Childhood environment

Local breastfeeding initiation rates are 81.9% compared to 80.7% in Somerset. Continuation rates at 6-8 weeks are 53.5% compared to 49.4% in the county as a whole. The paediatric health profile collates a number of risk factors and outcomes relating to children on p. 41.

## Excess weight

According to the underlying model used to assess appropriate childhood weight, only 15% children should be of excess weight. Somerset rates are 22.4% at age 4-5 years and 30.4% at age 10. For this Commissioning

Locality, estimated rates are 21.4% and 28.6% for each age group. The percentage of adults in the area who are obese is 7.3% which is the lowest rate in the county.

## Smoking

Despite a general reduction in smoking rates in adults in Somerset this remains our greatest public health challenge. The Commissioning Locality has 12.1% of adults over age 16 recorded as smokers compared to a 12.8% Somerset average. This is a low rate of smokers but the smoking ascertainment rate is poor and has declined again since last year so some problems may be masked. In 2015/16, only 46 per 1000 recorded smokers in East Mendip went through cessation services compared to 66 per 1000 in 2013-15. This is a higher than average proportion compared to other Commissioning Localities but this number is dramatically down in absolute terms. Smoking in pregnancy remains a challenge and our county rates are still high compared to the rest of England. More detail on smoking related data is shown on pp. 45-6.

## Drugs and Alcohol

Hospital admissions for drug and alcohol related reasons are lower than the Somerset average. Alcohol related admissions: East Mendip 1,840 per 100,000; Somerset 1,894 per 100,000. Drug related admissions: East Mendip 119 per 100,000; Somerset 137 per 100,000.

## Hospital admission rates

The hospitalisation section on pp.50-9, contains a wealth of data on reasons why the East Mendip population access hospital services and whether on an emergency or elective basis. To focus on a few indicators, the emergency admission rate for falls in the over 65s is 38 per 1000 as compared to the Somerset average of 31 per 1000. The self-harm admission rate is 263 per 100,000 which is the highest for the county.

## Medicines Optimisation Key Therapeutic Topics

Performance on the new and revised MOKTT indicators (formerly QIPP indicators) is shown on pp. 61-2. These are designed to promote discussion on the variation, rather than provide targets or influence individual prescribing choices.

## Suggested public health areas to prioritise

- Increase numbers of smokers referred to stop smoking services
- Increase seasonal flu vaccination rates.
- Reduce rates of admissions for falls.

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

Brief overview of Commissioning Locality outcomes		ENGLAND	Somerset	Commissioning Localities								
				Bridgwater	Central Mendip	Crewkerne, Chard and Ilminster	East Mendip	North Sedgemoor	South Somerset	Taunton	West Mendip	West Somerset
Population and context	Proportion of population aged 0-14	18%	16%	18%	16%	15%	17%	14%	16%	17%	15%	12%
	Proportion of population aged > 75	8%	10%	9%	8%	12%	8%	12%	10%	10%	11%	15%
	Index of Multiple Deprivation	17.4	18.1	22.4	16.6	17.3	17.8	16.2	16.9	16.8	17.2	23.2
	Proportion of population living in 10% most deprived neighbourhoods in Somerset*	24%	10%	24%	8%	3%	4%	8%	9%	11%	4%	12%
	Proportion of population living in 20% most deprived neighbourhoods in Somerset*	35%	20%	36%	8%	16%	25%	15%	16%	15%	15%	37%
Death	All cause mortality, all ages (SMR compared to Somerset)		100%	98%	103%	92%	99%	100%	98%	109%	100%	93%
	Proportion of deaths occurring before 65	16%	12%	14%	14%	10%	12%	12%	13%	11%	12%	11%
	Proportion of those dying at home (all causes)	22%	22%	24%	26%	24%	26%	22%	21%	19%	22%	24%
Prevention	Health Checks undertaken as % of eligible (annual target)		17%	11%	10%	19%	36%	26%	8%	16%	24%	11%
	Health Checks as % of eligible in most deprived population quintile		14%	9%	5%	24%	44%	21%	8%	10%	28%	6%
	Cervical cancer screening (25-49)	70.3%	72.3%	72.8%	71.3%	75.4%	73.0%	74.4%	70.6%	73.8%	69.5%	66.5%
	Chlamydia % screened of eligible (15-24 year olds)		3.0%	2.5%	4.1%	4.3%	4.6%	3.2%	3.6%	1.8%	3.0%	2.1%
	MMR coverage by 2nd birthday	91.9%	95.0%	95.7%	93.4%	95.2%	91.9%	95.5%	95.8%	95.6%	92.3%	95.0%
	Breastfeeding initiation		81%	75%	83%	83%	82%	81%	79%	82%	86%	88%
Lifestyle factors	Breastfeeding prevalence at 6-8 weeks		49%	40%	49%	50%	54%	43%	49%	54%	53%	52%
	Smoking rate adults 16+		12.8%	17.8%	14.3%	13.9%	12.1%	12.6%	11.5%	11.1%	10.4%	13.2%
	Smoking ascertainment		63%	67%	62%	63%	60%	67%	64%	61%	58%	67%
	Smokers going through cessation per 1000 recorded smokers		40	31	40	30	46	38	42	54	40	35
	Excess weight in 4-5 year olds	23%	22%	24%	23%	26%	21%	25%	23%	20%	20%	22%
	Excess weight in 10-11 year olds	38%	30%	32%	31%	32%	29%	31%	31%	28%	31%	30%
	Obese adults (16+) (rate per 1000 - Standardised to Somerset)	104	88	101	78	94	73	89	86	87	75	105
	Alcohol related admissions (rate per 100,000)	2,056	1,894	2,062	1,685	1,842	1,840	1,794	1,946	1,942	1,760	1,833
Hospital activity	Drug related admissions (rate per 100,000)		137	157	103	143	119	90	128	161	131	140
	Teenage deliveries (mother aged <19 at delivery) (rate per 1,000 females aged 15-17)		14.7	21.5	11.1	12.7	20.3	10.5	17.6	13.5	6.4	12.6
	Self harm admissions (rate per 100,000)		221	208	199	191	263	135	247	238	218	206
	Emergency admissions to hospital for Falls in people aged 65 and over (rate per 1000)		31	30	34	28	38	24	34	31	31	26

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

Red = 'Worst' (most worthy of attention)

Green = 'Best' (least worthy of attention)

Brief overview of Commissioning Locality outcomes		ENGLAND	Somerset	Rurality		Deprivation quintile of practices					
				Urban	Rural	1 most deprived	2	3	4	5 least deprived	Worse at left
Population and context	Proportion of population aged 0-14	18%	16%	17%	15%	17%	16%	16%	15%	16%	
	Proportion of population aged > 75	8%	10%	10%	11%	8%	11%	10%	12%	12%	
	Index of Multiple Deprivation	17.4	18.1	19.4	15.9	24.4	19.3	16.6	15.2	12.2	
	Proportion of population living in 10% most deprived neighbourhoods in Somerset*	24%	10%	14%	3%	28%	9%	7%	0%	1%	
	Proportion of population living in 20% most deprived neighbourhoods in Somerset*	35%	20%	26%	10%	44%	27%	10%	7%	2%	
Death	All cause mortality, all ages (SMR compared to Somerset)		100%	107%	90%	103%	107%	104%	91%	90%	
	Proportion of deaths occurring before 65	16%	12%	12%	11%	16%	12%	12%	10%	10%	
	Proportion of those dying at home (all causes)	22%	22%	20%	25%	23%	20%	22%	24%	22%	
Prevention	Health Checks undertaken as % of eligible (annual target)		17%	19%	14%	11%	20%	21%	15%	14%	
	Health Checks as % of eligible in most deprived population quintile		14%	14%	14%	9%	16%	24%	8%	22%	
	Cervical cancer screening (25-49)	70.3%	72.3%	71.1%	74.5%	70.1%	70.5%	73.5%	73.5%	75.8%	
	Chlamydia % screened of eligible (15-24 year olds)		3.0%	3.1%	3.0%	4%	3%	3%	3%	2%	
	MMR coverage by 2nd birthday	91.9%	95.0%	95.1%	94.8%	94.9%	94.2%	95.4%	96.0%	95.0%	
	Breastfeeding initiation		81%	80%	83%	76%	80%	82%	84%	84%	
	Breastfeeding prevalence at 6-8 weeks		49%	47%	56%	43%	45%	53%	56%	58%	
Lifestyle factors	Smoking rate adults 16+		12.8%	13.8%	11.2%	18%	12%	12%	11%	9%	
	Smoking ascertainment		63%	63%	63%	64%	64%	63%	61%	64%	
	Smokers going through cessation per 1000 recorded smokers		40	44	32	37	47	46	31	39	
	Excess weight in 4-5 year olds	23%	22%	22%	23%	24%	22%	22%	22%	21%	
	Excess weight in 10-11 year olds	38%	30%	32%	29%	33%	32%	29%	29%	27%	
	Obese adults (16+) (rate per 1000 - Standardised to Somerset)	104	88	92	82	104	87	79	74	95	
	Alcohol related admissions (rate per 100,000)	2,056	1,894	2,010	1,712	2179	1966	1851	1724	1625	
	Drug related admissions (rate per 100,000)		137	165	87	199	149	135	96	63	
Hospital activity	Teenage deliveries (mother aged <19 at delivery) (rate per 1,000 females aged 15-17)		14.7	17.9	9.6	24.1	17.1	14.4	6.5	8.2	
	Self harm admissions (rate per 100,000)		221	250	169	259	249	226	185	142	
	Emergency admissions to hospital for Falls in people aged 65 and over (rate per 1000)		31	31	29	31	32	31	29	29	

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

Red = 'Worst' (most worthy of attention)

Green = 'Best' (least worthy of attention)

### Population & context for health

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

The following information is presented:

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

#### Index of Multiple Deprivation

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

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

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

#### Income Deprivation Domain

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

#### Employment Deprivation Domain

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

#### Education, Skills and Training Deprivation Domain

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

#### Health Deprivation and Disability Domain

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

#### Crime Domain

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

#### Barriers to Housing and Services Domain

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

#### Living Environment Deprivation Domain

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

#### Income Deprivation Affecting Children Index

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

#### Income Deprivation Affecting Older People Index

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



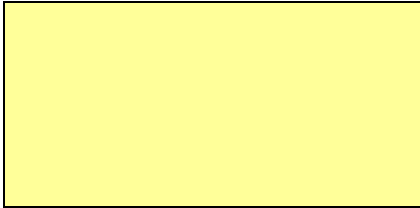
## East Mendip

Population at April 2016

43,837

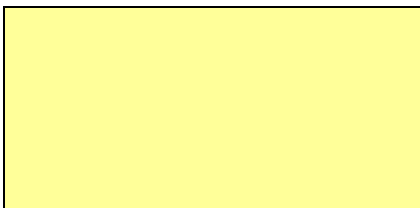
### East Mendip

Age Group	Males	Females
00-04	1,211	1,253
05-14	2,715	2,446
15-24	2,377	2,165
25-34	2,454	2,439
35-44	2,631	2,816
45-54	3,420	3,417
55-64	2,692	2,846
65-74	2,545	2,684
75-84	1,225	1,417
85+	393	691

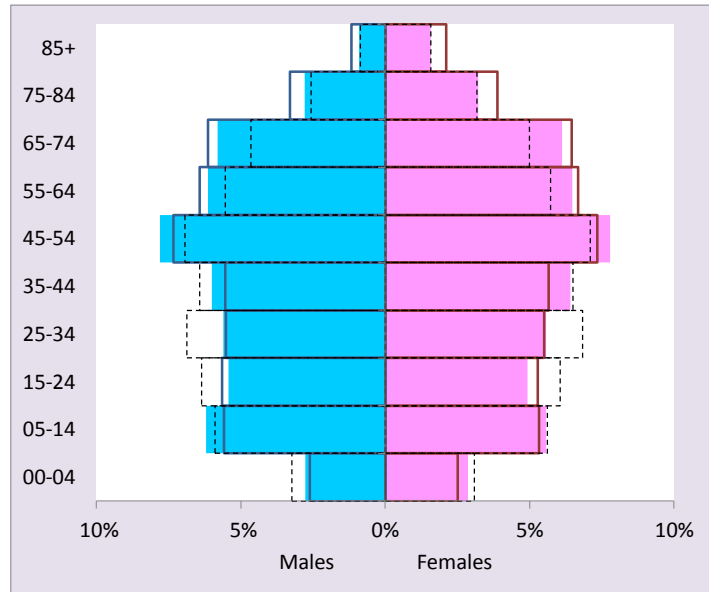


### Somerset

Age Group	Males	Females
00-04	14,717	14,121
05-14	31,431	30,024
15-24	31,828	29,796
25-34	31,065	31,002
35-44	31,179	31,952
45-54	41,258	41,331
55-64	36,184	37,582
65-74	34,633	36,370
75-84	18,529	21,851
85+	6,620	11,869



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



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

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

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

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

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



# East Mendip

## Deprivation

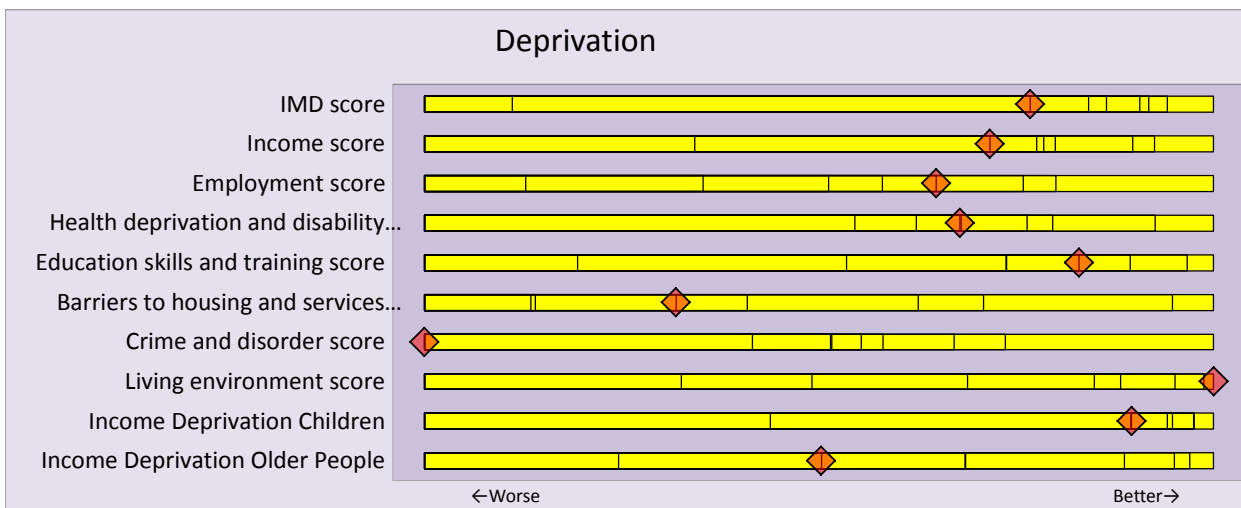
Index of Multiple Deprivation (IMD) 2015 and its domains.  
 Calculated for Commissioning Locality population in April 2016. All those with a known postcode are included even if they live outside Somerset.

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

Score	Commissioning Locality	Somerset	England (median LSOA* values)	Range of Practice values low / median / high
IMD score	17.8	18.1	17.4	9.5 / 16.6 / 26.8
Income score	0.11	0.12	0.11	0.06 / 0.10 / 0.18
Employment score	0.10	0.10	0.10	0.05 / 0.09 / 0.15
Health deprivation and disability score	-0.24	-0.25	16.29	-1.00 / -0.28 / 0.41
Education skills and training score	18.6	20.4	0.0	6.5 / 19.2 / 40.6
Barriers to housing and services score	27.4	25.2	0.0	18.4 / 25.2 / 42.6
Crime and disorder score	-0.01	-0.37	20.29	-1.41 / -0.41 / 0.35
Living environment score	19.0	24.1	17.6	11.0 / 24.8 / 58.6
Income Deprivation Affecting Children Index	0.14	0.14	0.15	0.06 / 0.14 / 0.26
Income Deprivation Affecting Older People Index	0.14	0.13	0.15	0.08 / 0.13 / 0.19

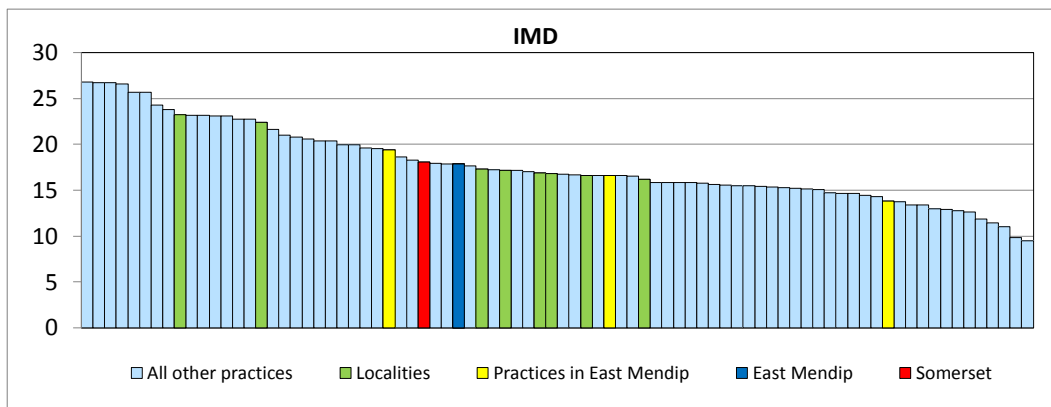
\*A Lower Super Output Area is a geographical area of about 1500 people.

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



**The Commissioning Locality has the worst value in the county for:**  
 Crime and disorder score

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



## People living in deprived areas

Proportion of Somerset patients registered with the practices in the Commissioning Locality who live in one of the most deprived areas of Somerset and England. Deprivation is measured using the Index of Multiple Deprivation 2015 and calculated for Commissioning Locality populations in April 2016.

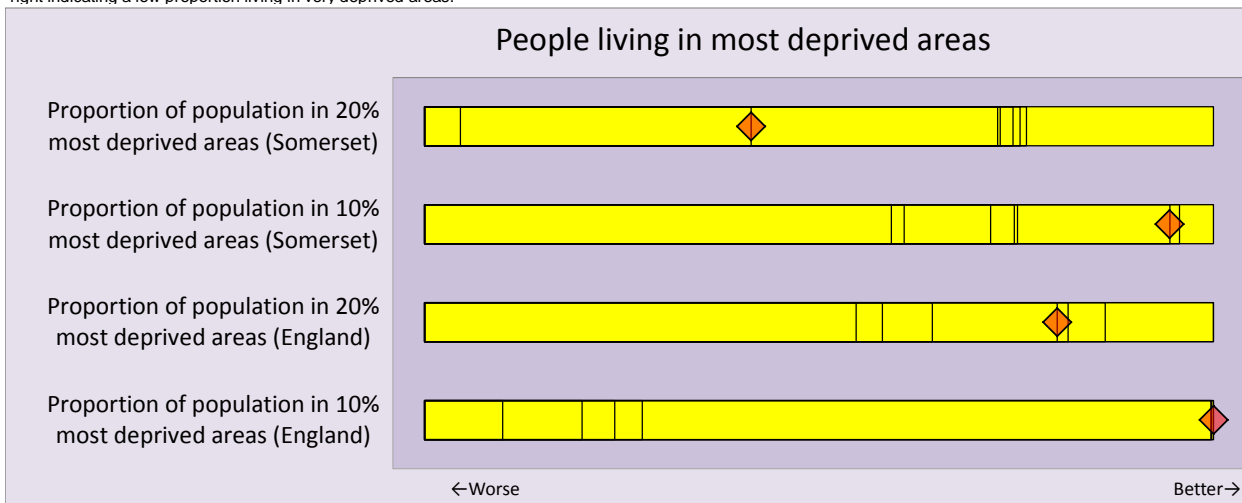
Based on the IMD 2015 score, small areas (Lower Super Output Areas - LSOAs) have been rated on their level of deprivation. This has been done for England as a whole and areas grouped into deciles. A grouping has also been done just within Somerset. Somerset is less deprived than England therefore fewer people in Somerset live in a highly deprived area (ie only 8% of the Somerset population lives in the 20% most deprived areas of England and 3% in the 10% most deprived). The population within the Commissioning Locality has been classified by how many live in the 20% and 10% most deprived geographical areas. Differing LSOAs will be in the quintiles and deciles for Somerset and England and may give rise to seemingly contradictory messages in the yellow box below.

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

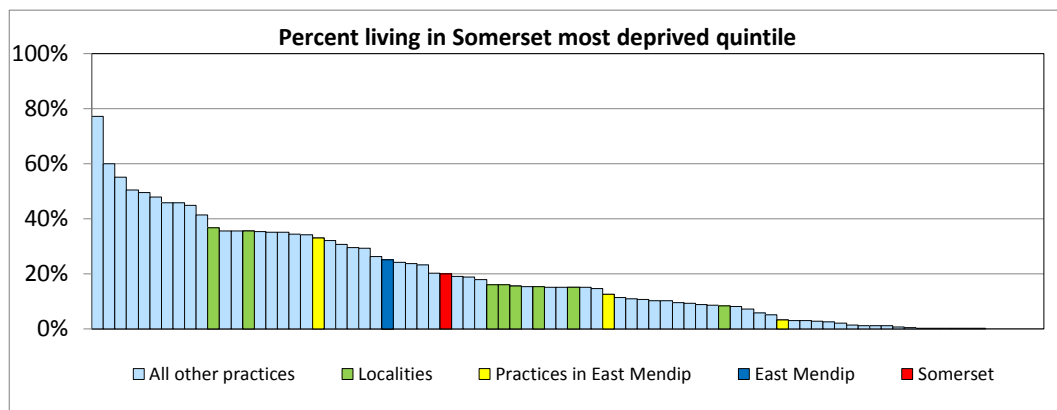
All patients with a known LSOA are included below (if they are living outside Somerset their IMD score is compared with the Somerset deprivation quintiles for the first two indicators)

	Commissioning Locality	Somerset	England	Range of Practice values low / median / high
Proportion of population in 20% most deprived areas (Somerset)	25%	20%	35%	0% / 12% / 77%
Proportion of population in 10% most deprived areas (Somerset)	4%	10%	24%	0% / 2% / 40%
Proportion of population in 20% most deprived areas (England)	4%	8%	20%	0% / 1% / 37%
Proportion of population in 10% most deprived areas (England)	0%	3%	10%	0% / 0% / 17%

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



The Commissioning Locality has the best value in the county for:  
Proportion of population in 10% most deprived areas (England)



## Wider determinants of health

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

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

To calculate the Commissioning Locality value, each registered patient is assumed to have the same pattern of experience as the whole LSOA in which they live, thus they are not exact measures but based on averages. As the populations of the localities have changed the value shown for indicators from the Census will have changed since the last profile was published. The indicators are summarised graphically on the following page.

	Commissioning Locality	Somerset	England	Range of Commissioning Locality values
% of Residents that are not White British Census 2011	6%	5%	20%	4% to 7%
% of People whose day-to-day activities are limited a lot Census 2011	7%	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	21%	23%	23%	21% to 26%
% of Households that are socially rented Census 2011	13%	14%	18%	9% to 16%
% of Households that are lone parent households Census 2011	9%	9%	11%	7% to 10%
% of Households with No Access to car/van Census 2011	15%	16%	26%	13% to 19%
% of Residents aged 16-74 who are Unemployed Census 2011	3.4%	3.0%	4.4%	2.6% to 4.1%
Foundation Stage Profile (FSP) % students NOT achieving a good level of development Somerset County Council 2015	30%	33%	n/a	28% to 50%
% of pupils with SEN Somerset County Council 2015	17%	15%	n/a	12% to 17%
Fixed exclusions per 1000 pupils Somerset County Council 2015	48	46	n/a	31 to 52
% of children not achieving 5 A*-C GCSEs including Maths and English Somerset County Council 2015	44%	41%	n/a	36% to 50%
Community Services recipients aged 75+ (rate per 1000 aged 75+) SCC Adult social care - Mar16	51	33	n/a	24 to 51
Home Care recipients aged 65+ (rate per 1000 aged 65+) SCC Adult social care - Mar16	24	18	n/a	14 to 24
Applications for housing on Homefinder SCC % of census households - Mar16	3%	3%	n/a	3% to 5%
Criminal Damage (rate per 100,000 population) Home Office 2015/16	764	712	n/a	523 to 959
Violence and Sexual offences (rate per 1000 census households) Home Office 2015/16	31.0	36.9	n/a	28.2 to 55.0
% of Children in low-income families Child Poverty Unit 2014	16%	15%	20%	13% to 18%
% of Households in Fuel Poverty DECC 2014	14%	13%	11%	11% to 14%
Attendance Allowance claimants (% of population aged 65+) NOMIS Feb16	11%	13%	14%	11% to 14%
Job Seekers Allowance (% of working population) NOMIS Feb16	0.8%	0.8%	1.5%	0.5% to 1.1%
Income Support or Pension Credit claimants (% of total population) NOMIS Feb16	4%	4%	4%	3% to 5%
Pension Credit claimants (% of population aged 65+) NOMIS Feb16	14%	14%	17%	12% to 17%
Council tax bands A to C (% of households) 2016	72%	66%	66%	59% 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 Jun16	23	35	60	19 to 44
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 Jun16	29	30	43	7 to 61



### Disease prevalence

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

The following information is presented:

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

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

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

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

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

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

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

The profiles are designed to provide information on:

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

Profiles have been produced on:

- Respiratory disease
- Cardiovascular disease
- Diabetes
- Cancer

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

## East Mendip

### Prevalence rate (rate per 1000 population)

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

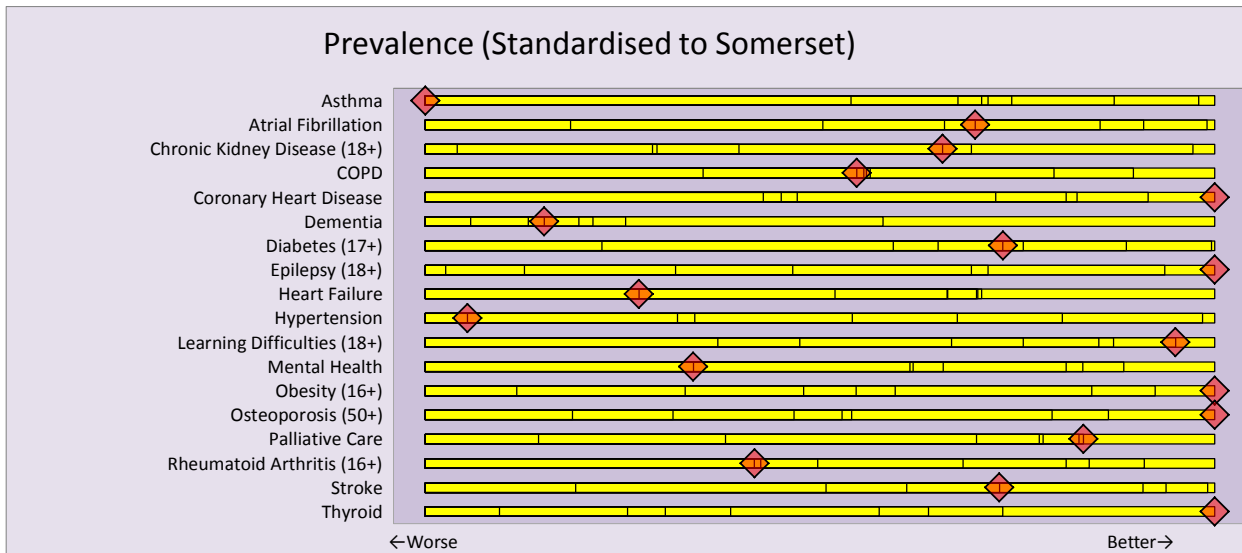
This data shows a comparison of the level of recorded disease in the Commissioning Locality compared to the level in the totality of Somerset practices. The numbers of patients with recorded disease at the practice level has been derived from the Quality Outcome Framework submissions, reported annually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

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

2016

Condition	Observed in Locality	Expected in Locality	Commissioning Locality rate	Somerset rate	England rate (2015)	Range of Practice values low / median / high
Asthma	3,104	2,820	70.9	64.5	63.8	46 / 66 / 77
Atrial Fibrillation	927	933	24.5	24.6	24.4	16 / 25 / 31
Chronic Kidney Disease (18+)	1,367	1,422	44.9	46.7	57.6	25 / 44 / 80
COPD	883	859	22.1	21.5	25.2	10 / 21 / 38
Coronary Heart Disease	1,354	1,464	34.8	37.6	44.7	22 / 37 / 55
Dementia	356	340	10.0	9.5	11.4	4 / 9 / 18
Diabetes (17+)	2,176	2,223	64.5	65.9	82.6	48 / 65 / 95
Epilepsy (18+)	260	305	7.4	8.7	8.7	4 / 8 / 18
Heart Failure	357	329	9.6	8.8	11.0	5 / 9 / 19
Hypertension	7,013	6,465	175	161	184.8	130 / 161 / 228
Learning Difficulties (18+)	150	186	4.1	5.1	5.5	0 / 4 / 19
Mental Health	378	315	8.6	7.2	9.8	3 / 6 / 17
Obesity (16+)	2,601	3,144	73	88	103.7	33 / 81 / 235
Osteoporosis (50+)	8	51	0	3	3.6	0 / 2 / 15
Palliative Care	87	104	2.8	3.3	5.9	0 / 3 / 14
Rheumatoid Arthritis (16+)	317	294	9.2	8.6	9.2	4 / 8 / 12
Stroke	1,044	1,056	27.0	27.3	24.1	20 / 27 / 34
Thyroid	1,455	1,643	35.1	39.6	n/a	22 / 40 / 51

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



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

Asthma Hypertension Mental Health

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

Asthma

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

Coronary Heart Disease Epilepsy (18+) Learning Difficulties (18+) Obesity (16+) Osteoporosis (50+) Thyroid

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

Coronary Heart Disease Epilepsy (18+) Obesity (16+) Osteoporosis (50+) Thyroid







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

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

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

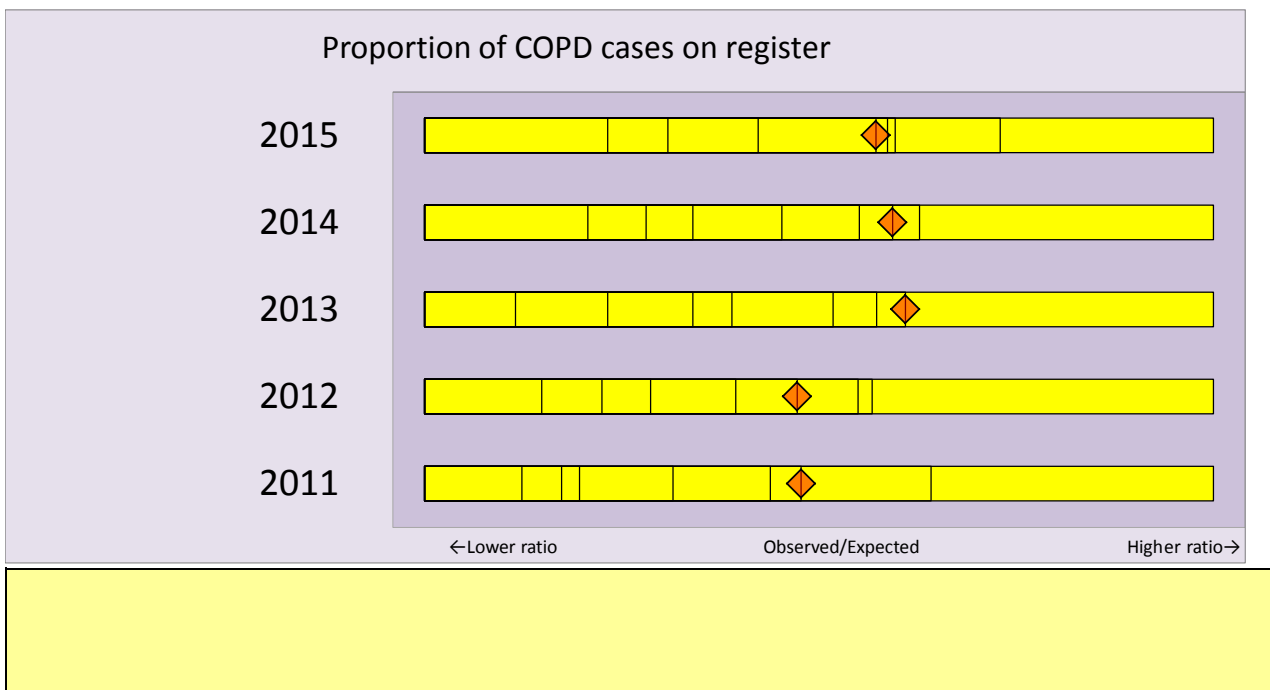
The expected values are based on NHS Information Centre models as found on the NHS comparators website, except for diabetes which uses the Yorkshire and Humber Public Health Observatory Model.

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

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

		Commissioning Locality	Somerset	England	Range of Practice values low / median / high
2015	Observed number on register	859	11,351	1,034,578	
	Expected number on register	835	11,487	955,221	
	Proportion of expected on register	102.9%	98.8%	108.3%	49% / 96% / 163%
2014	Observed number on register	858	11,029	1,004,920	
	Expected number on register	822	11,284	940,097	
	Proportion of expected on register	104.4%	97.7%	106.9%	42% / 93% / 168%
2013	Observed number on register	835	10,507	974,999	
	Expected number on register	798	10,994	926,224	
	Proportion of expected on register	104.6%	95.6%	105.3%	50% / 93% / 157%
2012	Observed number on register	753	9,924	938,511	
	Expected number on register	783	10,751	907,873	
	Proportion of expected on register	96.2%	92.3%	103.4%	52% / 86% / 167%
2011	Observed number on register	727	9,487	898,989	
	Expected number on register	764	10,490	888,795	
	Proportion of expected on register	95.2%	90.4%	101.1%	52% / 86% / 167%

The bar chart shows how Commissioning Locality performance compares to other Commissioning Localities. Each vertical line on the yellow bar shows the position of a Commissioning Locality. Your Commissioning Locality is highlighted by the red diamond. Values to the left show a lower ratio of observed to expected cases, in general indicating under-diagnosis compared to the model. Values to the right show a higher ratio of observed to expected cases although even so this does not exclude the possibility of some under reporting.

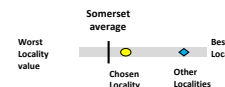


# Respiratory data



## East Mendip

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



	Improved
	Worsened

	Significance	Indicator	East Mendip number	East Mendip value	Somerset average	Worst Locality value	Locality range ←Worse Better→	Best Locality value	East Mendip value 2015	Direction of change
Prevalence		1 : Asthma	3,104	70.9	64.5	70.9		61.6	71.5	
		2 : COPD	883	22.1	21.5	26.2		18.6	21.8	
		3 : COPD estimated proportion of cases on register	859	103%	99%	85%		116%	104%	
Mortality		4 : All respiratory disease	228	103%	100%	123%		77%	105%	
		5 : COPD	87	96%	100%	118%		71%	106%	
Flu vaccination		6 : 65 and over	6,094	68%	70%	65%		74%	66%	
		7 : All children aged 2-4	728	47%	42%	32%		47%	37%	
		8 : At risk 6 months to <65 years	2,286	44%	46%	42%		48%	40%	
		9 : Pregnant women	200	37%	43%	33%		55%	25%	
Smoking		10 : Carers	190	37%	37%	25%		44%	29%	
		11 : Current smokers (aged 16 and over)		12%	13%	18%		10%	13%	
		12 : 4 week smoking quit rate (all ages)		45%	49%	40%		60%	41%	
		4 week smoking CO confirmed quit rate (all ages)		31%	37%	29%		53%		New indicator
		14 : 4 week smoking quit rate (45-64)		50%	45%	30%		66%	42%	
Emergency admissions		15 : Smokers going through cessation per 1000 recorded smokers		46.4	40.2	30.3		54.3	66.3	
		16 : Emergency admissions for Respiratory diseases (all ages)	583	14.2	13.6	15.0		12.0	13.6	
		17 : Emergency admissions for Respiratory diseases (<18)	827	14.7	13.4	15.4		10.9	13.9	
		18 : Emergency admissions for COPD (all ages)	185	1.6	2.2	2.6		1.6	1.8	
		19 : Emergency admissions for Asthma (all ages)	90	0.7	0.8	0.9		0.6	0.7	
QOF 2015 ongoing management indicators		20 : Emergency admissions for Asthma (<18)	83	1.5	1.5	1.9		1.3	1.5	
		21 : AST004. Patients with asthma aged 14 - 19 years with record of smoking status	185	58%	68%	57%		88%	60%	
		22 : AST003. Had a review	90	67%	78%	50%		77%	61%	
		23 : COPD004. Record of FEV1	83	149%	155%	65%		89%	70%	
		24 : COPD003. Review including MRC dyspnoea score	130	58%	68%	64%		94%	72%	
		25 : COPD005. MRC dyspnoea grade ≥3, with a record of oxygen saturation value	1,570	55%	59%	74%		97%	83%	
		26 : COPD007. Had influenza immunisation	535	70%	74%	87%		99%	84%	

- Indicator Notes
- 1-2 MIQUEST (QOF) indirectly standardised prevalence rate within Somerset 2016
  - 3 Modelled true prevalence using Doncaster models compared to QOF reported cases 2015
  - 4-5 Indirectly standardised mortality ratio (compared to Somerset) : ONS : 2011-15
  - 6-10 Uptake of Flu vaccination : PHE : Winter of 2015/16
  - 11-15 Smoking prevalence from MIQUEST query March 2016 and SmokefreeLife Somerset service data April 2015 to March 2016
  - 16-20 Indirectly standardised admission to hospital rate per 100,000 : Secondary Uses Service (SUS) : 2015/16 for Respiratory (all ages) and Asthma (all ages), 2013/14 - 2015/16 for COPD (all ages) and Asthma (<18).  
Respiratory diseases ICD10 codes: Chapter J  
COPD ICD10 codes: J40-J44  
Asthma ICD10 code J45, J46
  - 17-22 QOF ongoing management indicators : 2015

AST004: The percentage of patients with asthma aged 14 or over and who have not attained the age of 20, on the register, in whom there is a record of smoking status in the preceding 12 months  
 AST003: The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23  
 COPD004: The percentage of patients with COPD with a record of FEV1 in the preceding 12 months  
 COPD003: The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months  
 COPD005: The percentage of patients with COPD and Medical Research Council dyspnoea grade ≥3 at any time in the preceding 12 months, with a record of oxygen saturation value within the preceding 12 months, NICE 2012 menu ID: NM63  
 COPD007: The percentage of patients with COPD who have had influenza immunisation in the preceding 1 August 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:

- Increase number of patients referred for stop smoking support to Smokefree Somerset <http://www.smokefreeifesomerset.co.uk/> and encouragement to patients not ready to quit to have a smokefree home, especially parents of young children.
- For patients not ready to quit signpost to the NHS Smokefree website <https://www.nhs.uk/smokefree/>. Patients interested in vaping instead of smoking should not be discouraged as the risks are substantially lower <https://www.gov.uk/government/news/e-cigarettes-around-95-less-harmful-than-tobacco-estimates-landmark-review>.

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

- Increase the number of people with long term conditions living independently and in control of their condition e.g. COPD through managed self-care. People with COPD/asthma should be reviewed regularly by a nurse/doctor with appropriate training in respiratory disease management. Review should incorporate a written action plan<sup>1</sup>. Further review(s) can take place opportunistically:
  - An acute consultation offers opportunity to determine what action the patient has already taken to deal with the exacerbation. Their self-management strategy may be reinforced or refined and the need for consolidation at a routine follow up considered.
  - A consultation for an upper respiratory tract infection is an opportunity to rehearse self-management in the event of their condition deteriorating.
- Encourage compliance with prescribed medications, with information and support on use and effectiveness, for example;
  - Prescribe inhalers only after patients have received training in the use of the device and have demonstrated satisfactory technique<sup>2</sup>
  - If the patient is unable to use a device satisfactorily an alternative should be found.
  - The patient should have their ability to use an inhaler device assessed by a competent healthcare professional.
  - The medication needs to be titrated against clinical response to ensure optimum efficacy.
  - Reassess inhaler technique as part of structured clinical review
- Increase rates of immunisation against seasonal flu and pneumonia amongst eligible groups; Research<sup>3</sup> has shown the following approaches effective:
  - Having a lead member of staff to oversee the vaccination programme;
  - Ordering sufficient vaccine for 75% uptake among eligible groups;
  - Tailor call-recall process: Personal invitations (particularly effective for the over 65s) and repeats/reminders (particularly effective for under 65s);
  - Using in house IT search to identify eligible patients;
  - Community midwives administering vaccine to pregnant women;
  - Production of report reviewing annual vaccination rates, including detail of rationale to end each annual campaign.
- Increase awareness in the population of signs and symptoms of respiratory disease and when to seek medical advice, seeking to minimise emergency admissions, particularly amongst children and the most deprived groups.
  - Case detection studies have used symptom questionnaires to screen for asthma in school-age children<sup>2,3,4,5</sup>. It is recommended<sup>1</sup> to focus the initial assessment in children suspected of having asthma on:
    - Presence of key features in the history and examination
    - Careful consideration of alternative diagnoses

1] Galant SP, Crawford LJ, Morpew 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, Morpew 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



## East Mendip



Significance	Indicator	East Mendip number	East Mendip value	Somerset average	Worst Locality value	Locality range		Best Locality value	East Mendip value 2015	Direction of change
						<-Worse	Better->			
Prevalence	1 : Coronary heart disease	1,354	34.8	37.6	42.8			34.8	34.8	
	2 : Stroke/TIA	1,044	27.0	27.3	30.9			25.5	27.4	
	3 : Heart failure	357	9.6	8.8	10.1			8.0	10.0	
	4 : Atrial Fibrillation	927	24.5	24.6	26.1			23.8	24.5	
	5 : Hypertension	7,013	175	161	176			150	176	
	6 : Diabetes (ages 17 and over)	2,176	65	66	75			61	63	
	7 : Obesity (ages 16 and over)	2,601	73	88	105			73	70	
Smoking	8 : Current smokers (aged 16 and over)		12.1%	12.8%	17.8%			10.4%	13.2%	
	9 : 4 week smoking quit rate (all ages)		45%	49%	40%			60%	41%	
	10 : 4 week smoking quit rate (45-64)		50%	45%	30%			66%	42%	
Mortality	11 : Smokers going through cessation per 1000 recorded smokers		46	40	30			54	66	
	12 : All circulatory disease	527	102%	100%	110%			92%	103%	
Admissions	13 : All circulatory disease <75	96	78%	100%	124%			78%	86%	
	14 : Emergency admissions for Circulatory diseases (all ages)	416	10.7	10.9	11.4			9.4	12.1	
	15 : Elective admissions for Circulatory diseases (all ages)	284	6.9	8.5	9.3			6.9	7.3	
	16 : Emergency admissions for CHD	308	2.6	2.3	2.6			2.0	2.9	
	17 : Emergency admissions for CVD	206	1.8	2.1	2.5			1.8	1.9	
	18 : Alcohol related admissions	3,882	1,840	1,894	2,062			1,685	1,769	
	19 : Alcohol specific admissions	985	464	445	548			370	436	
NHS Health Checks	20 : % of eligible population checked	1,036	36%	17%	8%			36%	52%	
	21 : % of eligible population checked in most deprived quintile	263	44%	14%	5%			44%	53%	
QOF 2015 ongoing management indicators	22 : AF patients with CHA2DS2-VASc score measured	670	87%	84%	71%			97%		New indicators
	23 : Anti-coagulation drug therapy in those AF patients with CHA2DS2-VASc score ≥ 2	555	87%	84%	80%			90%		
	24 : BP measured in patients ≥ 45	18,385	87%	89%	87%			92%		
	25 : CHD patients with 150/90 mmHg or less	1,057	83%	85%	78%			95%	79%	
	26 : CHD patients with Aspirin or alternative taken	1,215	93%	91%	88%			97%		New indicator
	27 : CHD patients had influenza immunisation	1,012	84%	89%	84%			98%	81%	
	28 : HF patients currently treated with ACE-I or ARB	41	80%	87%	80%			100%	88%	
	29 : HF patients currently treated with ACE-I or ARB also treated with beta-blocker	31	84%	86%	80%			94%	91%	
	30 : Hypertension patients with 150/90 mmHg or less	4,910	75%	77%	72%			86%		New indicators
	31 : PAD patients with 150/90 mmHg or less	222	74%	79%	74%			92%		
	32 : PAD patients with Aspirin or alternative taken	204	87%	84%	79%			94%		
	33 : Stroke/TIA patients with 150/90 mmHg or less	650	80%	80%	76%			87%	78%	
	34 : NH Stroke/history of TIA patients taking antiplatelet agent or anti-coagulant	494	93%	91%	88%			98%	90%	
	35 : Stroke/TIA patients had influenza immunisation	625	81%	88%	81%			97%	80%	

Indicator	Notes
1-7	MIQUEST (QOF) indirectly standardised prevalence rate within Somerset 2015
8-11	Smoking prevalence from MIQUEST query March 2016 and SmokefreeLife Somerset service data April 2015 to March 2016
12-13	Indirectly standardised mortality ratio (compared to Somerset) : ONS : 2011-15
14-19	Indirectly standardised admission to hospital rate per 100,000 : Secondary Uses Service (SUS) : 2015/16 for Circulatory diseases, 2013/14 - 2015/16 for CHD and CVD, 2011/12 - 2015/16 for Alcohol admissions. Circulatory diseases ICD10 codes: Chapter I CHD ICD10 codes: I20-I25 CVD ICD10 codes: I6*
20-21	Alcohol related and alcohol specific causes as listed in work by North West Public Health Observatory and released through the Local Alcohol Profiles for England <a href="http://www.lape.org.uk/">http://www.lape.org.uk/</a>
22-35	Somerset NHS Health Checks : financial year 2015/16 QOF ongoing management indicators : 2015

AF006: The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHA2DS2-VASc score risk stratification scoring system in the preceding 12 months (excluding those patients with a previous CHADS2 or CHA2DS2-VASc score of 2 or more)

AF007: In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy

BP002: The percentage of patients aged 45 or over who have a record of blood pressure in the preceding 5 years

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

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

CHD007: The percentage of patients with coronary heart disease who have had influenza immunisation in the preceding 1 August to 31 March

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

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

HYP006: The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less

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

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

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

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

STIA009: The percentage of patients with stroke or TIA who have had influenza immunisation in the preceding 1 August to 31 March

# Diabetes profile



## East Mendip

<span style="background-color: #c8e6c9; border: 1px solid black; display: inline-block; width: 15px; height: 10px;"></span> Significantly better than Somerset average	<span style="background-color: #fff9c4; border: 1px solid black; display: inline-block; width: 15px; height: 10px;"></span> Not significantly different to Somerset average	<span style="background-color: #ffcdd2; border: 1px solid black; display: inline-block; width: 15px; height: 10px;"></span> Significantly worse than Somerset average	<span style="background-color: #e0e0e0; border: 1px solid black; display: inline-block; width: 15px; height: 10px;"></span> Difference not assessed		<span style="background-color: #c8e6c9; border: 1px solid black; display: inline-block; width: 15px; height: 10px;"></span> Improved	<span style="background-color: #ffcdd2; border: 1px solid black; display: inline-block; width: 15px; height: 10px;"></span> Worsened
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Significance	Indicator	East Mendip number	East Mendip value	Somerset average	Worst Locality value	Locality range ←Worse Better→	Best Locality value	East Mendip value 2015	Direction of change
Prevalence	1 Diabetes (ages 17 and over) standardised rate	2,176	65	66	75		61	63	
	2 Diabetes (ages 17 and over) crude rate	2,168	62	67	76		58	59	
	3 % of diabetes cases on register	2,101	63%	65%	73%		59%	76%	
	4 Obesity (ages 16 and over)	2,601	72.7	87.8	104.6		72.7	69.9	
	5 Excess weight (ages 4-5)	n/a	21%	22%	26%		20%	22%	
	6 Excess weight (ages 10-11)	n/a	29%	30%	32%		28%	29%	
Deaths	7 Diabetes as underlying cause	23	0.13	0.11	0.18		0.09	0.10	
Health Checks	8 % of eligible checked	n/a	36%	17%	8%		36%	52%	
	9 % of eligible in most deprived quintile checked (capped at 100%)	n/a	44%	14%	5%		44%	53%	
Prescribing	10 Blood glucose lowering drugs	24,276	77.8	79.7	77.4		83.5	79.9	
	11 Long/Intermediate Insulin Analogues	1,637	83.4	67.7	83.4		53.6	84.2	
Admissions	12 Emergency admissions for Diabetes (all ages) main dx	198	0.74	0.95	1.21		0.74	0.80	
	13 Emergency admissions (all ages) for someone with diabetes	483	12.4	14.9	19.6		10.8	13.3	
	14 Elective admissions (all ages) for someone with diabetes	551	13.7	16.4	20.1		12.6	13.2	
	15 Admissions (all ages) for lower limb amputation	32	0.14	0.18	0.26		0.14	0.16	
	16 Admissions (all ages) for DKA/coma	48	0.19	0.26	0.55		0.19	0.17	
QOF 2015 care indicators	17 DM002: BP<=150/90 mmHg	1,676	85%	86%	80%		95%	84%	
	18 DM003: BP<=140/80 mmHg	1,246	66%	70%	58%		83%	67%	
	19 DM004: Total cholesterol <=5 mmol/l	1,445	79%	79%	76%		85%	77%	
	20 DM006: Patients with nephropathy/microalbuminuria given ACE	130	86%	84%	78%		99%	87%	
	21 DM007: IFCC-HbA1c is <=59 mmol/mol	1,173	62%	64%	55%		74%	69%	
	22 DM008: IFCC-HbA1c is <=64 mmol/mol	1,383	71%	73%	66%		82%	77%	
	23 DM009: IFCC-HbA1c is <=75 mmol/mol	1,642	83%	84%	79%		91%	84%	
	24 DM012: Had foot examination and risk classification	1,574	81%	81%	73%		92%	79%	
	25 DM014: Been referred to a structured education programme	121	80%	74%	54%		99%	89%	
	26 DM018: Had Flu vaccination	1,556	84%	89%	84%		98%	82%	

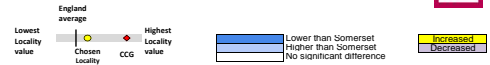
- Indicator Notes
- 1, 4 MICEST (QOF) indirectly standardised prevalence rate per 1000 within Somerset 2016
  - 2 QOF crude prevalence rate per 1000, 2015
  - 3 Modelled true prevalence using York and Humber PHO models compared to QOF reported cases 2015
  - 5-6 National Child Measurement Programme 2010/11 - 2015/16: LSOA weighted average using population as at April 2016
  - 7 Indirectly standardised mortality ratio (compared to Somerset) : ONS : 2011-15
  - 8-9 Somerset NHS Health Checks : financial year 2015/16
  - 10-11 MO KTT prescribing indicators: NHS Business Authority report 2015/16
  - 12-16 Indirectly standardised admission to hospital (rate per 1000) : Secondary Uses Service (SUS) : 2015/16 for All emergency/elective admissions for those with diabetes; 2010/11 - 2015/16 for Diabetes as main reason for emergency admission, Lower limb amputations and DKA/coma admissions, Diabetes ICD10 codes: E10-E14; Lower limb amputations ICD10 codes E10-E14 AND OPCS4 codes X9-X11; DKA/Coma ICD10 codes E10.0, E10.1, E11.0, E11.1, E12.0, E12.1, E13.0, E13.1, E14.0, E14.1
  - 17-26 QOF ongoing management indicators : 2015

DM002: The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less, NICE 2010 menu ID: NM01  
 DM003: The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less, NICE 2010 menu ID: NM02  
 DM004: The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less  
 DM006: The percentage of patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are currently treated with an ACE-I (or ARBs)  
 DM007: The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 12 months, NICE 2010 menu ID: NM14  
 DM008: The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months  
 DM009: The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months  
 DM012: The percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 12 months, NICE 2010 menu ID: NM13  
 DM010: The percentage of patients with diabetes, on the register, who have had influenza immunisation in the preceding 1 September to 31 March  
 DM014: The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register, NICE 2011 menu ID: NM27  
 DM018: The percentage of patients with diabetes, on the register, who have had influenza immunisation in the preceding 1 August to 31 March (the comparative data for previous year is the same but from September to March)

# Cancer Profile



## East Mendip



Indicator	East Mendip number	East Mendip value	Somerset CCG value	Lowest Locality value in Somerset	Chart	Highest Locality value in Somerset	East Mendip compared to Somerset	England value	East Mendip previous time period	Direction of change
1 Cancer: QOF prevalence (all ages) (%)	1,262	2.9	3.2	2.7		4.4	Lower than Somerset	2.4	2.8	Increased
2 New cancer cases (Crude incidence rate: new cases per 100,000 population)	220	511	602	511		821	Higher than Somerset	515	450	Decreased
3 % reporting cancer in the last 5 years	17	2.9	3.7	2.9		4.6	Higher than Somerset	3.2	2.2	Increased
4 CAN003: review within 6 mths of diagnosis (%)	132	67	46	31		71	Higher than Somerset	71	80	Decreased
5 CS002: Women, aged 25-64, with a record of cervical screening (last 5 yrs) (%)	8,381	77	76	71		79	Higher than Somerset	76	79	Decreased
6 Females, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage, %)	8,193	76	75	71		78	Higher than Somerset	74	78	Decreased
7 Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %)	4,599	73	75	69		78	Higher than Somerset	73	74	Decreased
8 Females, 50-70, screened for breast cancer within 6 months of invitation (Uptake, %)	55	49	76	41		80	Higher than Somerset	74	74	Decreased
9 Persons, 60-69, screened for bowel cancer within 6 months of invitation (Uptake, %)	1,781	64	63	61		65	Higher than Somerset	58	58	Increased
10 Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)	3,465	62	62	60		64	Higher than Somerset	58	62	Decreased
11 In-patient or day-case colonoscopy procedures (Number per 100,000 population)	310	708	640	572		743	Higher than Somerset	733	830	Decreased
12 In-patient or day-case sigmoidoscopy procedures (Number per 100,000 population)	183	418	816	418		1,025	Higher than Somerset	478	454	Decreased
13 In-patient or day-case upper GI endoscopy procedures (Number per 100,000 population)	633	1,445	1,338	1,164		1,539	Higher than Somerset	1,302	1,333	Decreased
14 Number of emergency admissions with cancer (Number per 100,000 population)	264	603	667	575		953	Higher than Somerset	538	629	Decreased
15 Number of emergency presentations (Number per 100,000 population)	42	96	116	96		186	Higher than Somerset	89	115	Decreased
16 Number of other presentations (Number per 100,000 population)	154	351	422	321		560	Higher than Somerset	361	468	Decreased
17 Two-week wait referrals for suspected cancer (Number per 100,000 population)	1,399	3,193	3,394	2,925		3,842	Higher than Somerset	2,975	2,488	Decreased
18 Two-week wait referrals (Indirectly age-sex standardised referral ratio)	1,399	98	99	92		105	Higher than Somerset	100	84	Increased
19 Two-week referrals resulting in a diagnosis of cancer (Conversion rate: as % of all TWW referrals).	133	9.5	10.0	7.7		12.5	Higher than Somerset	7.8	8.8	Decreased
20 Number of new cancer cases treated (Detection rate: % of which resulted from a TWW referral)	126	55	53	47		64	Higher than Somerset	50	38	Increased
21 Two-week wait referrals for suspected breast cancer (Number per 100,000 population)	223	509	535	396		723	Higher than Somerset	541	360	Decreased
22 Two-week wait referrals for suspected lower GI cancers (Number per 100,000 population)	234	534	502	426		613	Higher than Somerset	453	406	Decreased
23 Two-week wait referrals for suspected lung cancer (Number per 100,000 population)	40	91	107	81		154	Higher than Somerset	103	85	Decreased
24 Two-week wait referrals for suspected skin cancer (Number per 100,000 population)	342	781	735	572		869	Higher than Somerset	572	604	Decreased
25 Two-week wait referrals for suspected cancer (Number per 100,000 population). Five years combined data.	5,254	11,992	14,381	11,992		16,450	Higher than Somerset	11,860	10,749	Decreased
26 Two-week wait referrals (Indirectly age-sex standardised referral ratio). Five years combined data.	5,254	91	105	91		113	Higher than Somerset	100	90	Increased
27 Two-week referrals resulting in a diagnosis of cancer (Conversion rate: as % of all TWW referrals). Five years combined data.	493	9.4	10.8	8.1		12.1	Higher than Somerset	8.8	9.9	Decreased
28 Number of new cancer cases treated (Detection rate: % of which resulted from a TWW referral). Five years combined data.	486	44	52	43		54	Higher than Somerset	48	42	Increased
29 Two-week wait referrals for suspected breast cancer (Number per 100,000 population). Five years combined data.	777	1,773	2,252	1,636		2,966	Higher than Somerset	2,161	1,547	Decreased
30 Two-week wait referrals for suspected lower GI cancers (Number per 100,000 population). Five years combined data.	900	2,054	2,280	1,987		2,943	Higher than Somerset	1,897	1,828	Decreased
31 Two-week wait referrals for suspected lung cancer (Number per 100,000 population). Five years combined data.	188	429	477	390		605	Higher than Somerset	449	397	Decreased
32 Two-week wait referrals for suspected skin cancer (Number per 100,000 population). Five years combined data.	1,175	2,682	2,828	2,395		3,358	Higher than Somerset	2,170	2,370	Decreased

Notes

- (1) Current data is for time periods ending in 2015/16 and previous data is for time periods ending in 2014/15
- (2) Data from PHE National General Practice Profiles <https://fingertips.phe.org.uk/profile/general-practice/data#mod.2.ovr.2016.nat.19.par.E38000150.ave.1.85055.sid1.2000005.ind1.-.sid2.-.ind2.->



The following information is presented:

- Deaths – overview of causes of death 2011-2015 of Commissioning Locality patients.
- Years of Life Lost – overview of causes of years of life lost due to death before age 75 2011-2015 in Commissioning Locality patients.
- Life expectancy
- Standardised Mortality Ratios
- Where people die

The 'blobs' diagrams were first introduced in the Somerset 2013 profiles and provide an at a glance indication of the main causes of death 2011-2015 in Commissioning Locality registered patients. Different colours represent different disease/condition groups and lines indicate how more specific conditions are included within a larger grouping. The two 'blobs' with no lines have overlapping content with other 'blobs' but are not strict subgroups. They are placed beside the mental and behavioural disorders as they are, at least in part, mental health issues.

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

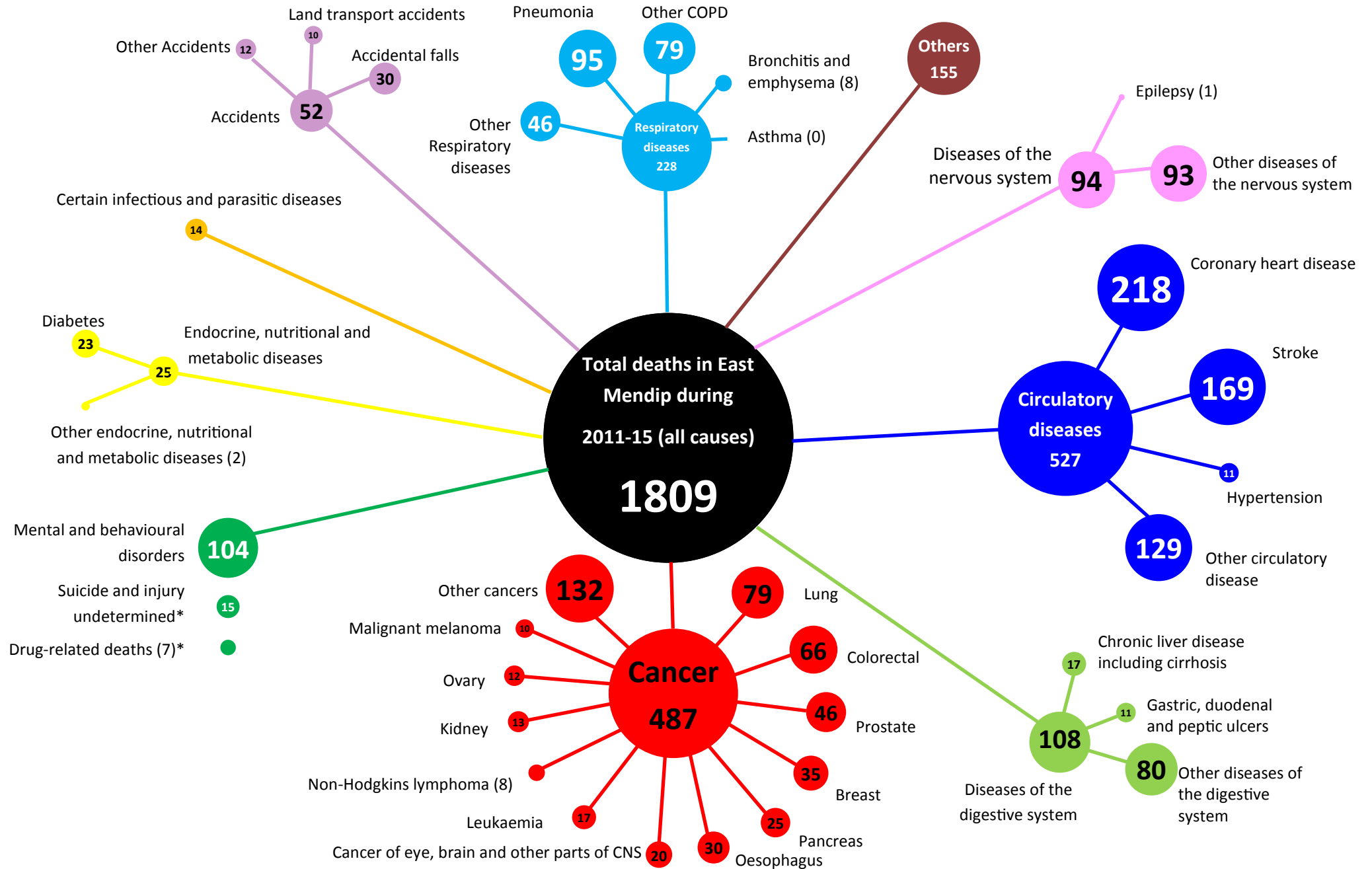
Life expectancy is presented at birth and also additional life expectancy at age 65. On the whole Somerset life expectancy is longer than England as a whole. Another index of preventable deaths is the proportion of deaths occurring before the age of 65 and Somerset is also shown to be better than the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

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

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

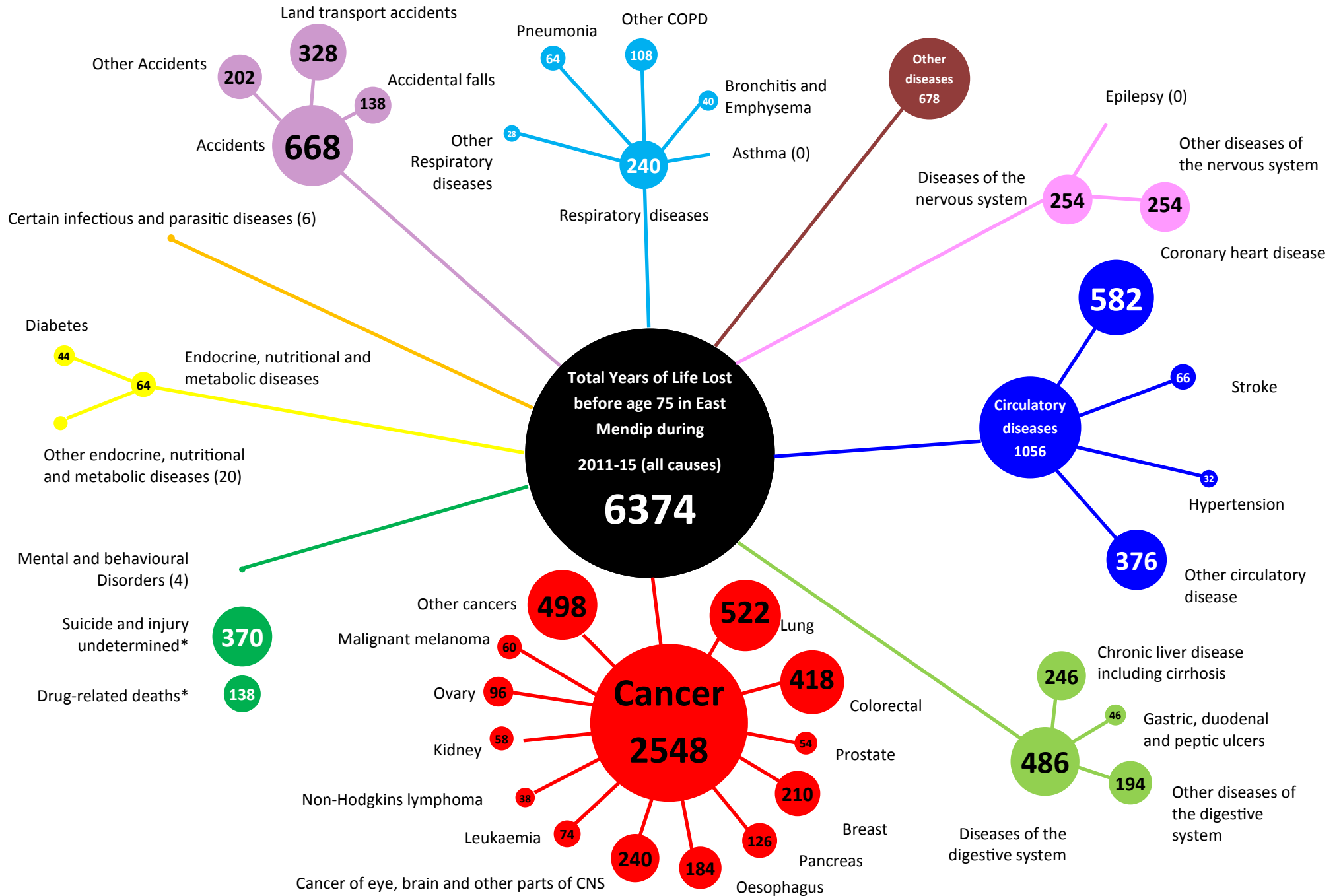
It is worth noting that ONS have revised mortality coding twice in the time period covered by these statistics - in 2011 and in 2014 - to be in line with how cause of death is coded internationally. This has had some impact on the proportion of deaths coded to certain conditions, notably dementia and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

# DEATHS



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

# YEARS OF LIFE LOST BEFORE THE AGE OF 75



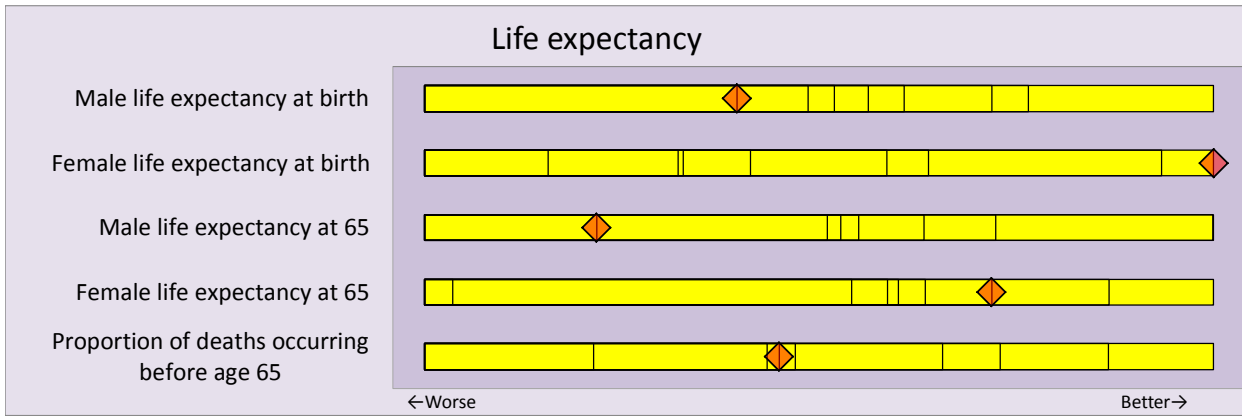
\*There is some overlap between Drug related deaths and Mental and behavioural disorders and also between Drug related deaths and Suicide and injury undetermined deaths. There is a further overlap between Drug related deaths and Accidents.

Life expectancy 2011-15

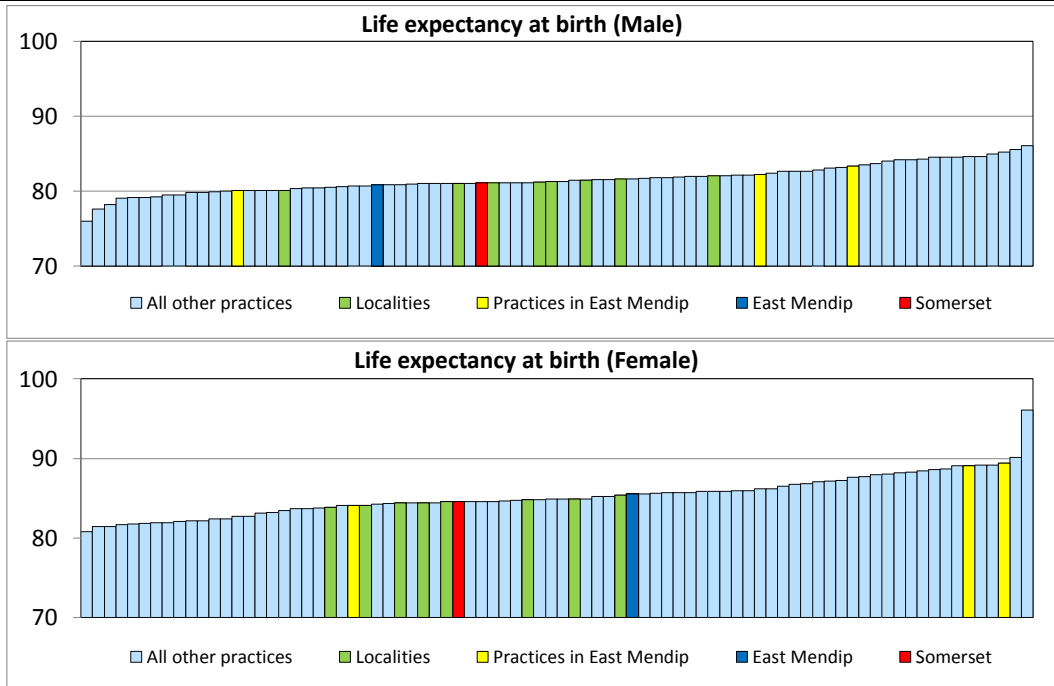
Life expectancy based on deaths from ONS Primary Care Mortality Database and population estimates from the Exeter system

	Commissioning Locality	Somerset	England (2012-14)	Range of Practice values low / median / high
Male life expectancy at birth	80.9	81.1	79.5	76.0 / 81.5 / 86.1
Female life expectancy at birth	85.5	84.5	83.2	80.8 / 85.1 / 96.1
Male life expectancy at 65	19.1	19.6	79.5	15.4 / 19.9 / 31.0
Female life expectancy at 65	22.3	22.0	83.2	18.8 / 22.4 / 33.8
Proportion of deaths occurring before age 65	12.5%	12.0%	15.9%	5.9% / 12.0% / 66.0%

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



The Commissioning Locality has the best value in the county for:  
Female life expectancy at birth



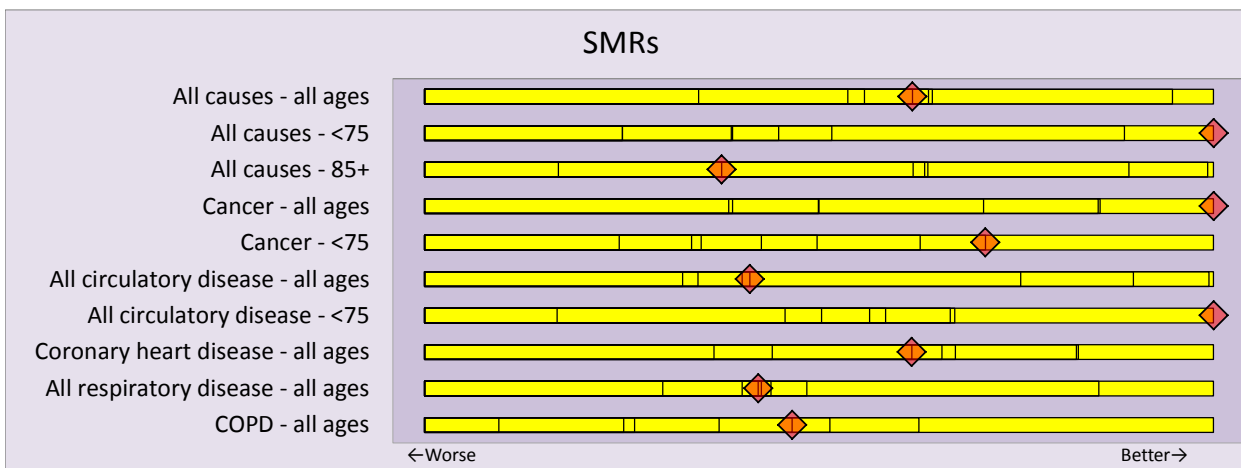
## Standardised mortality ratios

Deaths registered between 2011 and 2015, age and sex standardised to Somerset as a whole (a value of 100% is the Somerset average). ONS Primary Care Mortality Database.

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

Condition	Observed	Expected	Commissioning Locality SMR	Somerset SMR	England	Range of Practice values low / median / high
All causes - all ages	1,809	1,834	99%	100%		71% / 97% / 142%
All causes - <75	505	568	89%	100%		59% / 97% / 187%
All causes - 85+	789	752	105%	100%		29% / 96% / 156%
Cancer - all ages	487	530	92%	100%		73% / 101% / 156%
Cancer - <75	234	255	92%	100%		67% / 102% / 208%
All circulatory disease - all ages	527	514	102%	100%		56% / 95% / 147%
All circulatory disease - <75	96	123	78%	100%		39% / 95% / 209%
Coronary heart disease - all ages	218	220	99%	100%		51% / 95% / 194%
All respiratory disease - all ages	228	220	103%	100%		53% / 96% / 141%
COPD - all ages	87	91	96%	100%		42% / 101% / 305%

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

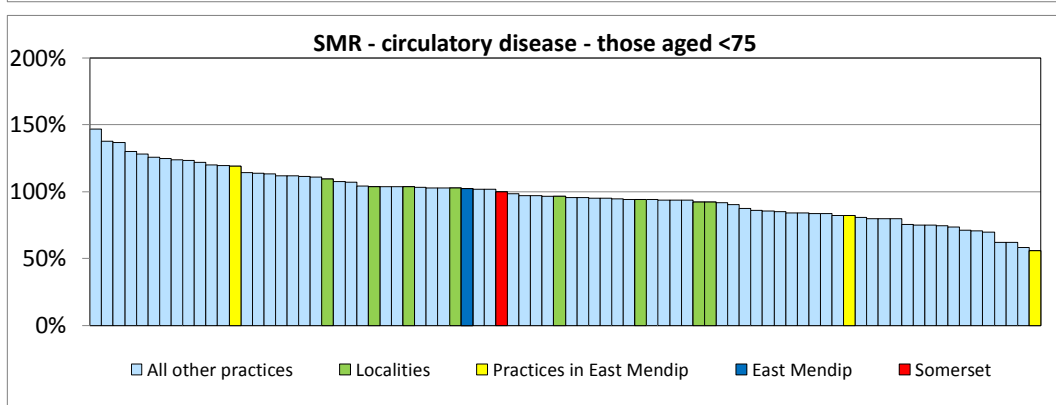
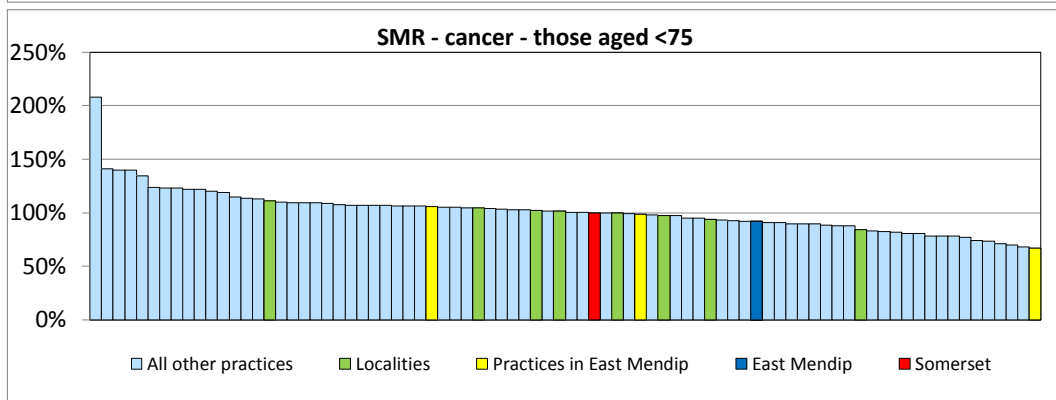
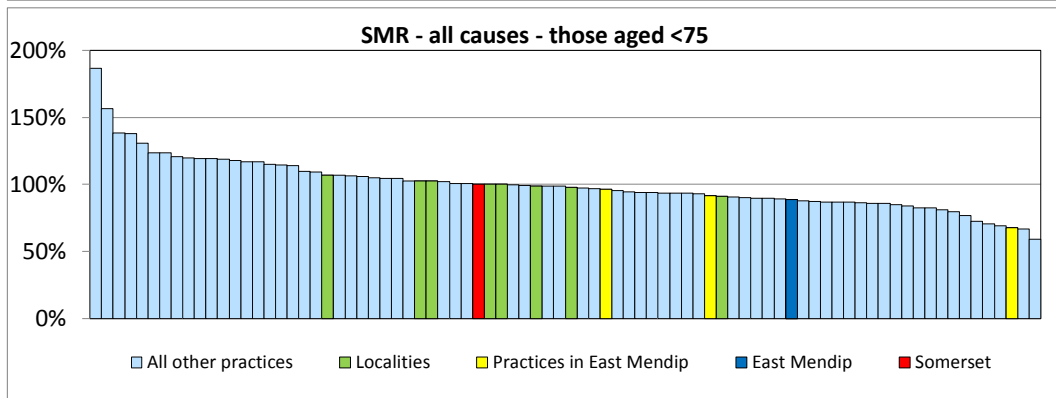
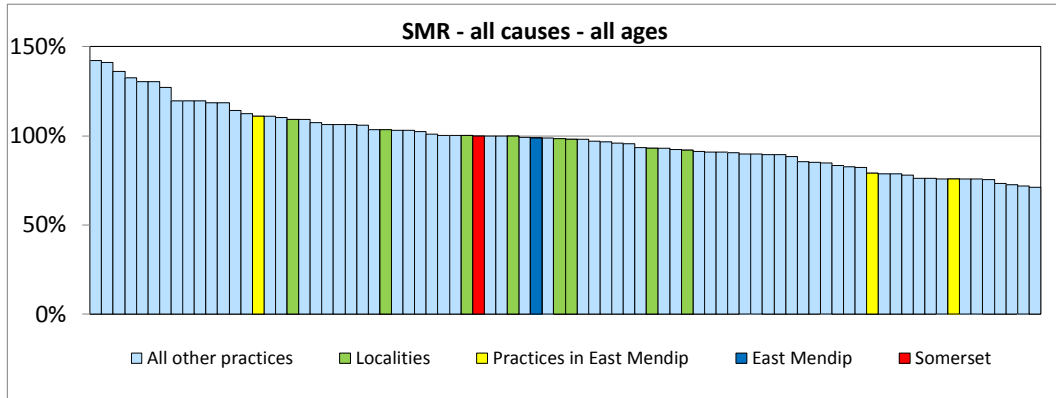


### Significantly better than county average for:

All causes - <75

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

All causes - <75    Cancer - all ages    All circulatory disease - <75





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

The following information is presented:

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

The Somerset NHS Health Check programme was recommissioned by Somerset County Council in April 2015. The health checks are delivered through GP practices, pharmacies, workplaces, community venues and through the use of a mobile van. More detail on this programme is provided in the health checks profiles for each Commissioning Locality which highlights checks taken up and the coverage by socioeconomic indicators as well as outcomes.

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 36.

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.

A new Children and Young People's Health Services (CYPHS) dataset was introduced in April 2015 but only contains data from September 2015. Currently there is not a full year's robust data for breastfeeding, so data has been presented for 2014/15 in this profile. The initiation rates in Somerset are, in general, better than those seen in the rest of England although there can be quite striking variation by practice. Whilst GPs may not be so close to the routine support provided to mothers on breastfeeding, they may be consulted about problems which may lead to earlier cessation of breastfeeding than mothers may ideally choose.

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



### NHS Health Checks - notes to accompany activity snapshot

Local Authorities have a statutory duty to invite their eligible population for a NHS Health Check once every 5 years as part of the 5-year call/recall. In addition, local authorities have a legal duty to seek continuous improvement in the percentage of eligible individuals taking up their offer of a NHS Health Check as part of their statutory duties. As of January 2016, there were 261,000 people in Somerset aged 40 to 74 of whom 185,325 (71%) were eligible for a NHS Health Check every 5 years.

The Somerset NHS Health Check programme was recommissioned by Somerset County Council in April 2015. The health checks are delivered through GP practices, pharmacies, workplaces, community venues and through the use of a mobile van.

#### **CHART OF ELIGIBLE POPULATION & HEALTH CHECKS COMPLETED**

The charts indicate levels of population activity by Commissioning Locality and by County level:

- 1) The proportion of the total population aged 40-74 registered with a GP Practice during the current year (20%).
- 2) The proportion of individuals aged 40 to 74 (from item 1 above) who are eligible for a health check as they have not been diagnosed by their GP with a pre-existing condition.
- 3) The proportion of eligible individuals (from item 2 above) who have received a NHS Health Check

#### **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 Commissioning Locality.
- 2) Indicates the checks completed as a percentage of the total eligible population in each quintile of deprivation, for the Commissioning Locality.
- 3) Indicates the checks completed as a percentage of the total eligible population in each quintile of deprivation, for the Commissioning Locality.

#### **TABLE OF NHS HEALTH CHECKS ACTIVITY**

The NHS Health Check data is categorised by Activity, Health Check Results and Referrals.

Columns marked Locality Lowest & Locality Highest: Values of 0% or 100% may appear within these 2 categories where only a few checks have been completed for the Commissioning Locality.

**TARGET ACTIVITY:** Indicates the number and percentage of people eligible for a health check and who received a health check.

**HEALTH CHECK RESULTS:** This section indicates the findings from completed health checks. The following criteria are new to the Somerset NHS Health Check programme:

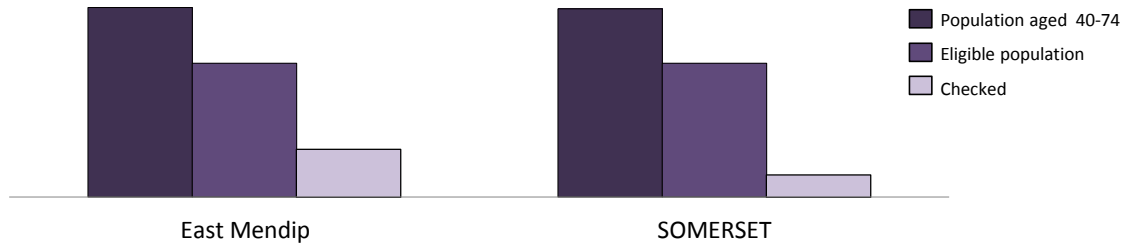
- Item 13 Diabetes Filter triggered: Where a person's BP is recorded as  $\geq 140/90$  and/or their BMI is  $\geq 30$ , this indicates the possibility of a risk of diabetes.
- Item 14 raised HbA1c: HbA1c test was available for health checks delivered in workplaces or community locations.
- Item 15 Family History of CVD: This is recorded when the person indicates this is the case for a family member in the 1<sup>st</sup> degree.
- Item 16 Depression Assessment.

**LIFESTYLE COUNSELLING AND REFERRALS:** This section indicates where there was a recommendation that the user should follow up with their GP or where the user requested referral to a lifestyle support service.

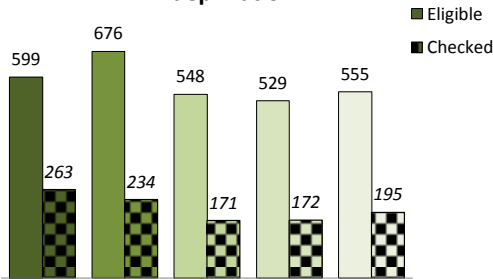
Referral activity percentages are calculated against total checks completed EXCEPT where the referral is based on a specific health check result (eg number of smokers identified who requested a referral to the stop smoking service).

East Mendip

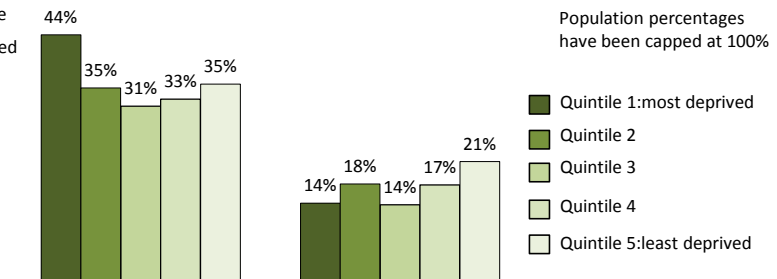
The population/activity charts below provide a visual representation of NHS Health Check activity compared to the annual eligible population. This is by Commissioning Locality as at 2016 and Somerset County.



Numbers eligible and checked by deprivation



Checks as % of eligible by deprivation



East Mendip

East Mendip

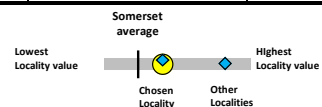
SOMERSET

Indicator	Locality Number	Locality Value	Somerset average	Lowest Locality	Range of Locality values	Highest Locality
1: % eligible for check	2,906	71%	71%	68%		74%
2: Checks as % of eligible	1,036	36%	17%	8%		36%
3: Current Smoker	153	15%	11%	7%		16%
4: Very High Alcohol score	5	0.5%	0.3%	0.0%		0.5%
5: Chest/Calf Pain indicated*	21	2.0%	2.2%	1.2%		5.1%
6: AF screening / Irregular pulse*	16	1.5%	1.8%	0.4%		3.0%
7: BP Raised (≥ 140/90 and <160/100)*	247	24%	23%	19%		30%
8: BP High (≥160/100)*	67	6.5%	7.4%	5.2%		10.3%
9: GPPAQ = Moderately Inactive	160	15%	17%	13%		21%
10: GPPAQ = Inactive	309	30%	28%	25%		37%
11: Obese or morbidly obese (BMI ≥30)	206	20%	20%	17%		26%
12: Non-fasting Chol/HDL Ratio ≥7*	46	4.4%	3.8%	2.8%		4.8%
13: Diabetes Filter triggered*	404	39%	39%	32%		44%
14: HbA1c (Outreach**) Raised (≥42 mmol/mol)*	4	17%	12%	8%		17%
15: Family History of CVD	397	38%	38%	37%		42%
16: Depression (PRIME-MD)	113	11%	12%	9%		17%
17: Qrisk ≥20 (high & very high risk)*	64	6.2%	6.3%	4.5%		12%
18: All GP Referrals	484	47%	48%	41%		54%
19: Smokers referred to smoking cessation	32	21%	14%	5%		21%
20: Referrals for Very High Alcohol score	2	40%	29%	0%		100%
21: Referral for mental wellbeing	35	31%	39%	28%		45%
22: Qrisk ≥20 (high & very high risk)	64	6.2%	6.3%	4.5%		12%
23: Total Referred PA GPPAQ = Moderately Inactive	2	1.3%	6.7%	1.3%		14%
24: Total Referred PA GPPAQ = Inactive	8	2.6%	8.3%	2.6%		16%
25: Referral for Weight Management	96	47%	32%	20%		47%



\* Requires referral to GP (NICE Guidance)  
 \*\* Outreach includes Community and Workplace locations  
 All people receive lifestyle counselling

Feedback should be directed to Sharon Ashton at [seashton@somerset.gov.uk](mailto:seashton@somerset.gov.uk)



Cancer screening

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

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

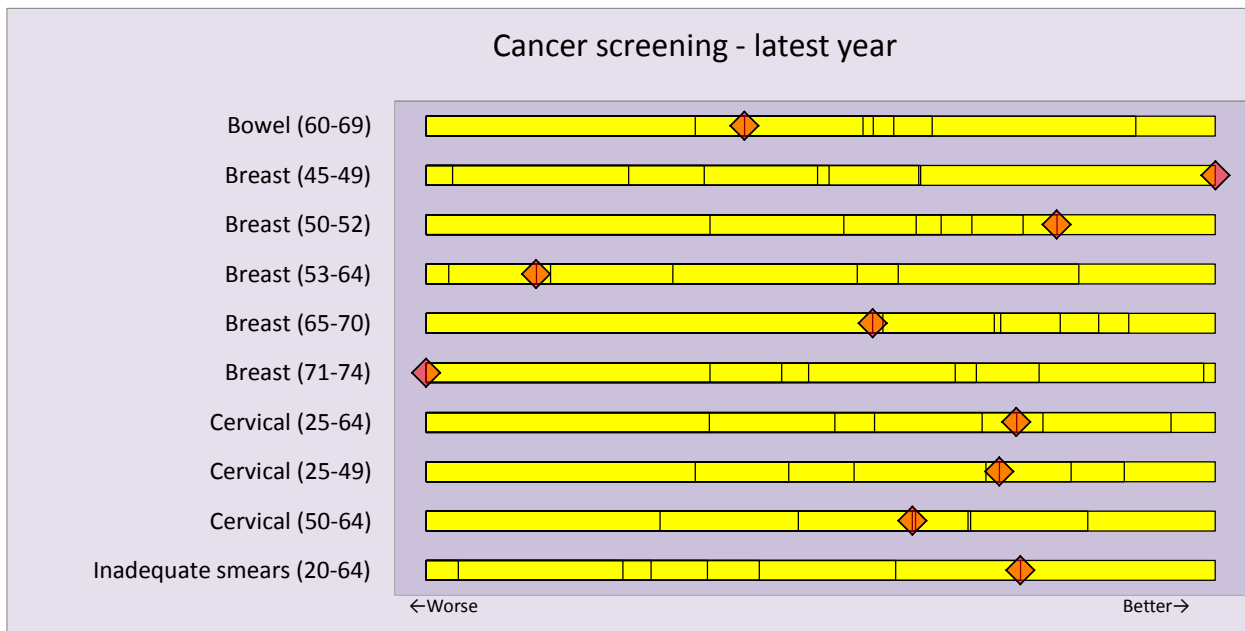
Bowel and Cervical 2015/16, Breast 2014/15

Condition	Commissioning Locality	Somerset	England (2015 - ages 60-74 - for bowel)	Range of Practice values low / median / high
Bowel: 60-69 uptake of invitation to screen in year	56.9%	58.2%	57.1%	41% / 58% / 66%
Breast: ages 45-49: coverage	27.1%	12.6%	66.7%	0% / 3% / 43%
Breast: ages 50-52: coverage	67.2%	57.5%	69.0%	14% / 64% / 89%
Breast: ages 53-64: coverage	74.9%	77.3%	71.3%	39% / 79% / 85%
Breast: ages 65-70: coverage	77.1%	77.8%	72.9%	15% / 80% / 88%
Breast: ages 71-74: coverage	30.3%	51.9%	68.4%	7% / 56% / 82%
Cervical: ages 25-64 coverage within 5 years	78.4%	77.6%	76.5%	66% / 78% / 88%
Cervical: ages 25-49 coverage within 3.5 years	73.0%	72.3%	70.3%	60% / 73% / 81%
Cervical: ages 50-64 coverage within 5 years	76.2%	76.0%	75.7%	60% / 76% / 88%
Cervical: Inadequate smears (ages 20-64)	1.3%	2.1%	2.5%	0% / 2% / 7%

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

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

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



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

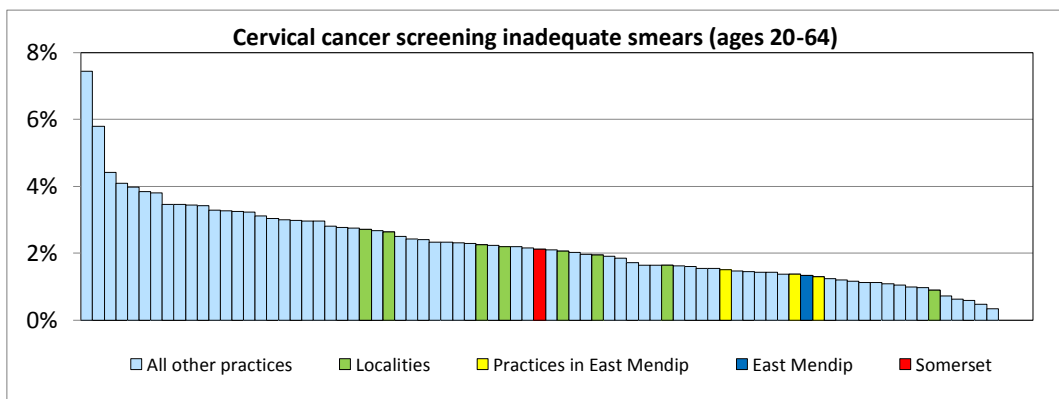
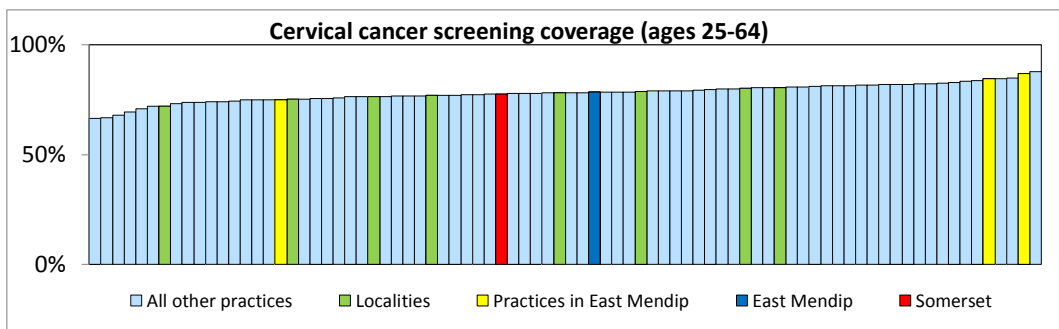
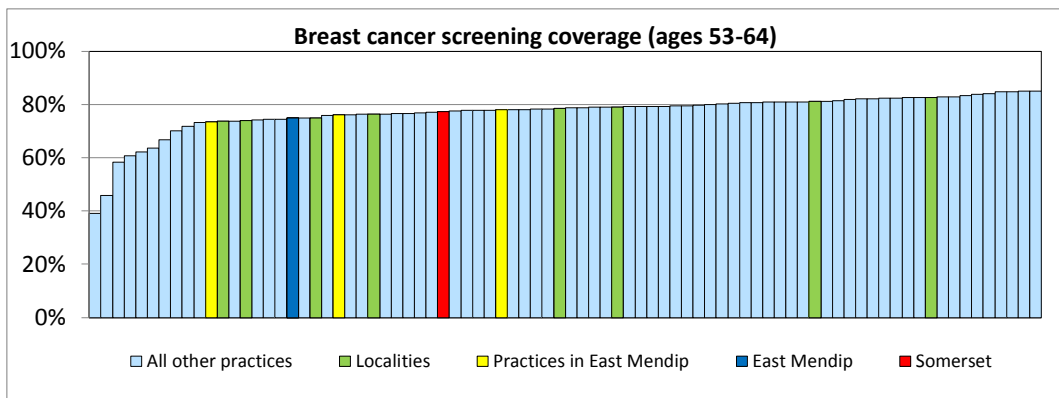
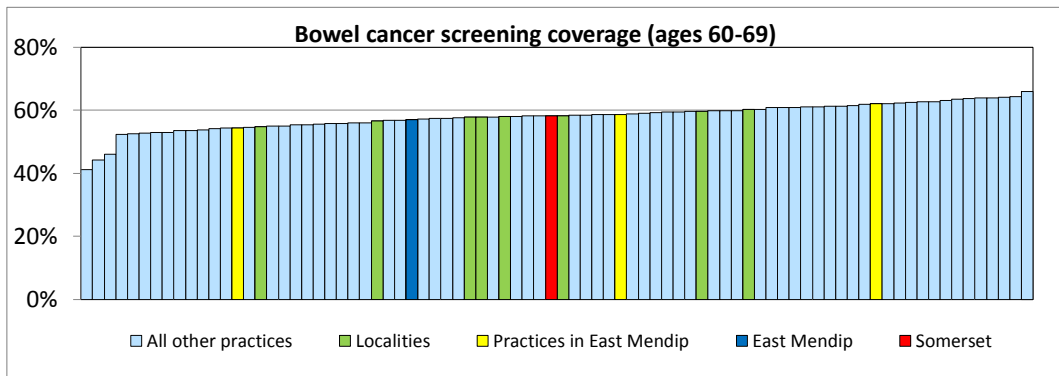
Breast: ages 45-49: coverage

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

Breast: ages 71-74: coverage



Cancer screening - latest year



**Chlamydia screening**

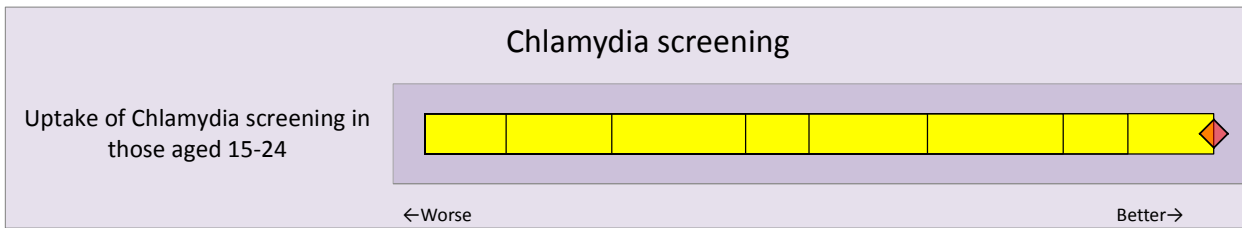
Uptake of Chlamydia screening 2015/16

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.

2015/16

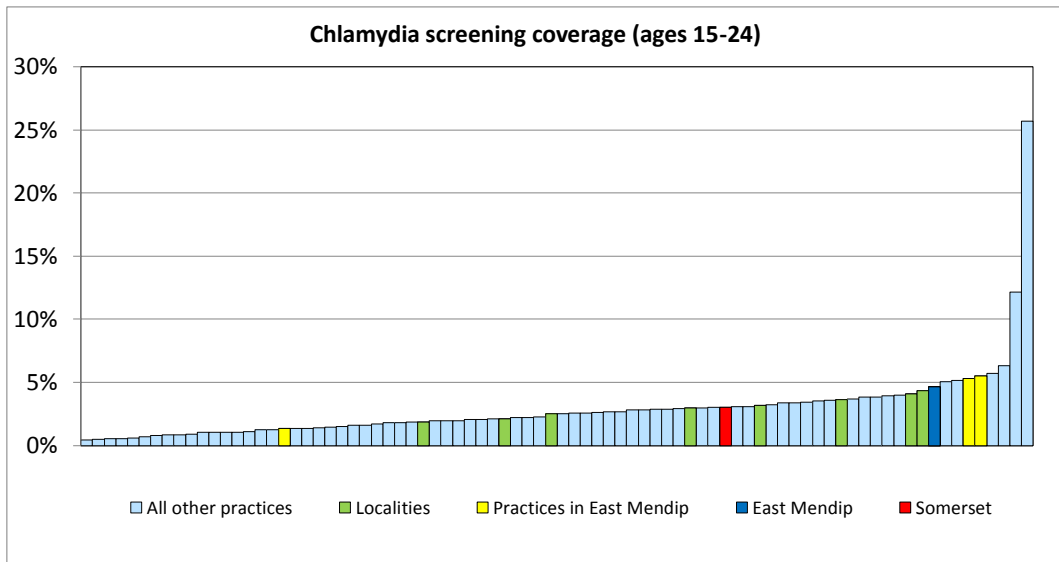
	Commissioning Locality rate	Somerset rate	England	Range of Practice values low / median / high
Uptake of Chlamydia screening in those aged 15-24	4.6%	3.0%		0% / 2% / 26%

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



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

Uptake of Chlamydia screening in those aged 15-24





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

Somerset-wide Integrated Sexual Health (SWISH) services alongside the Somerset Chlamydia Screening Programme strive to increase the detection rate of Chlamydia in the region. 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 easy to do, self-taken, not invasive and confidential
- Introduce opportunities not requiring direct nurse/doctor involvement – ensure posters and leaflets are displayed in waiting rooms and treatment rooms and leave kits in grab bins in reception, resources or toilets
- Advise that all young people should have a chlamydia test once a year and with every new partner
- Identify a member of staff as your 'chlamydia screening champion'
- The champion can ensure your surgery maximises every opportunity to promote chlamydia screening. Previous evidence from Somerset shows that those surgeries that nominated a champion saw a significant increase in their test returns e.g. one surgery has increased their screens from 37 a year to consistently achieving well over a hundred screens per year for the past 3 years
- Have a 'whole team' approach and make greater use of all staff in the surgery. This could include reception staff giving out information leaflets or test kits before the young person sees their clinician or the use of health care assistants who can see young people before or after their appointment
- Every time a young person visits their general practice is an opportunity to offer a chlamydia screen
- Tack the offer of a test onto specific clinics e.g. all sexual health and contraceptive clinics, new patient health checks and travel clinics
- Use a 'pop-up' on EMIS for everyone aged 15-24. It is useful to do this for all contraceptive appointments but including everyone ensures that young men are offered the test
- Put the emphasis on 'on site' completion of the test and immediate return – less chance of 'losing it', more chance of 'getting round' to it
- If a young person is with friends offer them all a test
- Make kits available to the partners of young people particularly if they have tested positive through their GP service

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

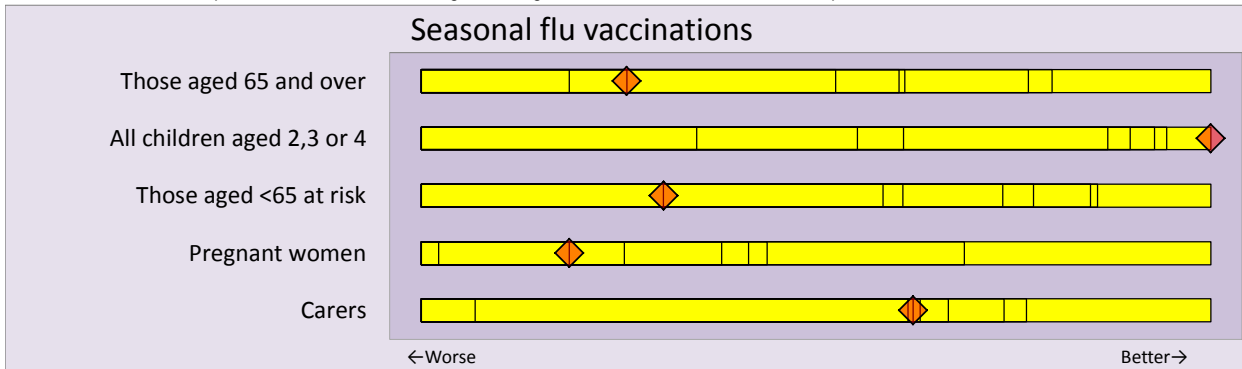
- more information on the Somerset Chlamydia Screening programme
- ordering resources such as kits, grab bins, posters, leaflets and window stickers
- arranging a visit by one of the team to advise on how to improve your offer of chlamydia screening

Seasonal flu vaccinations

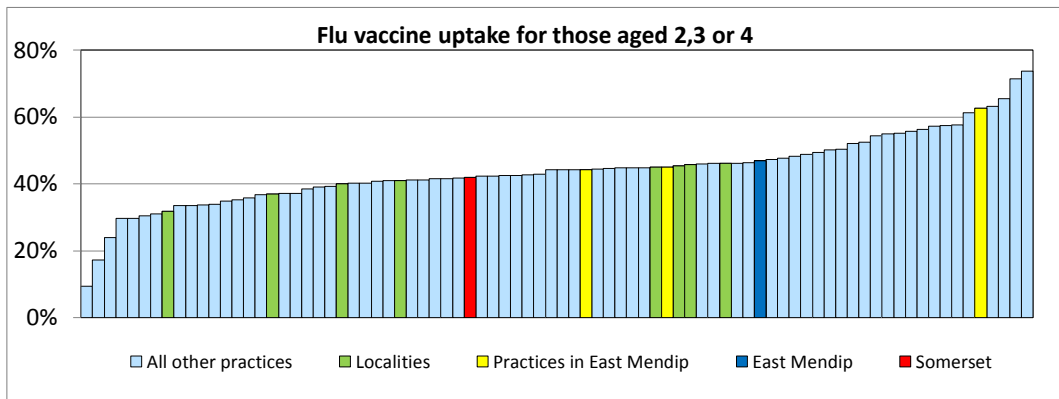
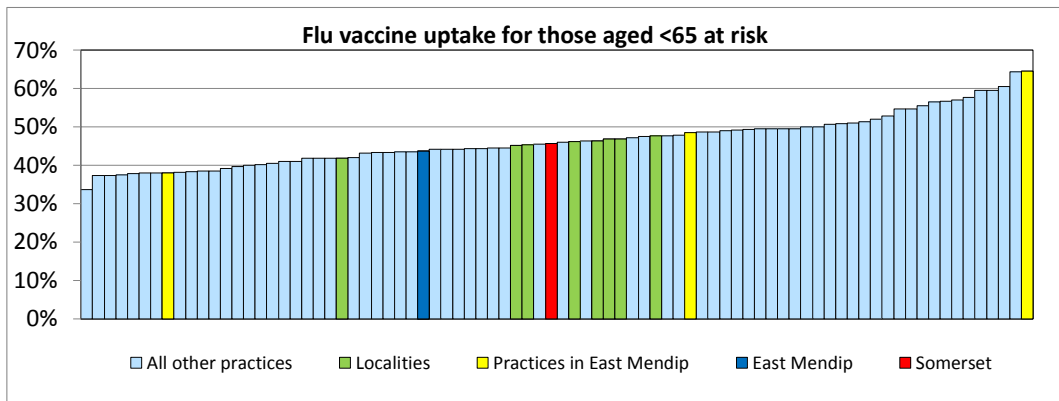
Flu vaccination programme statistics. Winter 2015/16

	Commissioning Locality	Somerset	England	Range of Practice values low / median / high
Those aged 65 and over	68%	70%	71%	59% / 70% / 82%
All children aged 2,3 or 4	47%	42%	34%	9% / 44% / 74%
Those aged <65 at risk	44%	46%	45%	34% / 46% / 64%
Pregnant women	37%	43%	42%	20% / 42% / 68%
Carers	37%	37%	n/a	13% / 39% / 70%

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



The Commissioning Locality has the best value in the county for:  
All children aged 2,3 or 4





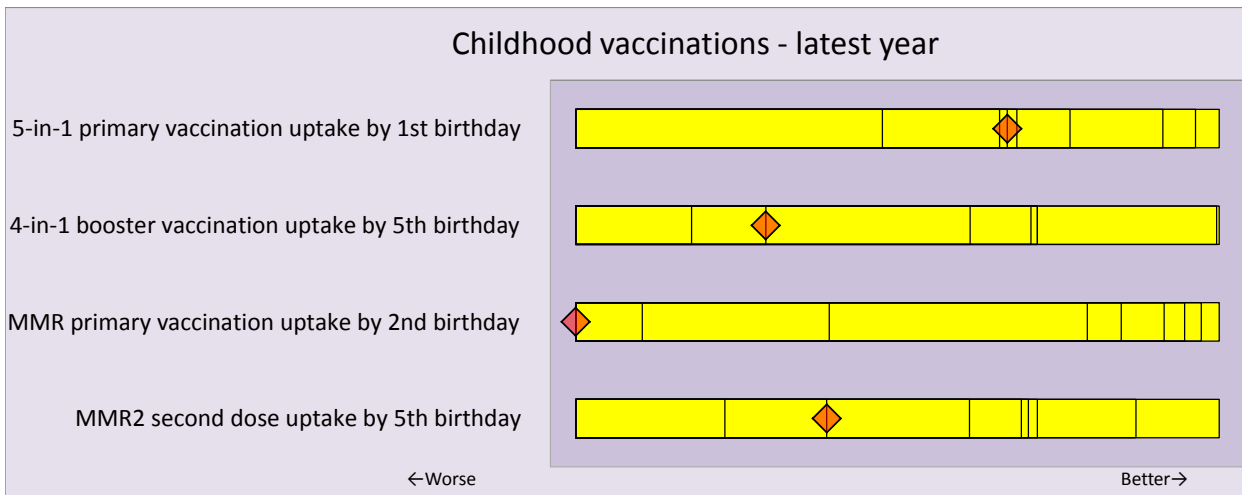
Childhood Immunisations

Data from NHS England : Child Immunisation Collection 2015/16 outturn - this is management information and may not be exactly the same as COVER

2015/16

	Commissioning Locality	Somerset	England	Range of Practice values low / median / high
5-in-1 primary vaccination uptake by 1st birthday	95.5%	95.3%	93.6%	81% / 96% / 100%
4-in-1 booster vaccination uptake by 5th birthday	92.6%	94.1%	86.3%	75% / 95% / 100%
MMR primary vaccination uptake by 2nd birthday	91.9%	95.0%	91.9%	73% / 96% / 100%
MMR2 second dose uptake by 5th birthday	91.5%	92.7%	88.2%	67% / 94% / 100%

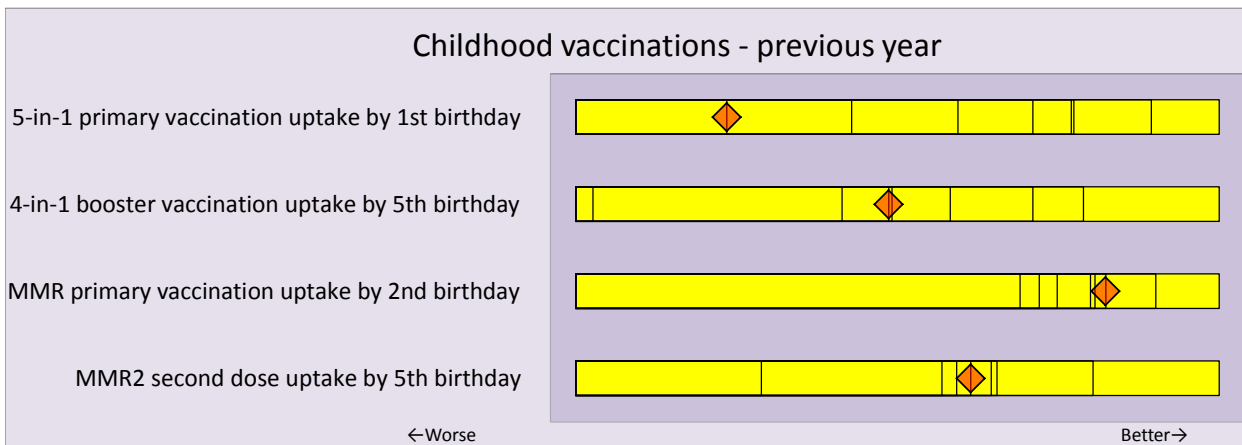
The bar chart shows how the Commissioning Locality compares to other Commissioning Localities in terms of their immunisation outcomes. Each vertical line on the yellow bar shows the position of a Commissioning Locality. Your Commissioning Locality is highlighted by the red diamond. Values to the left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



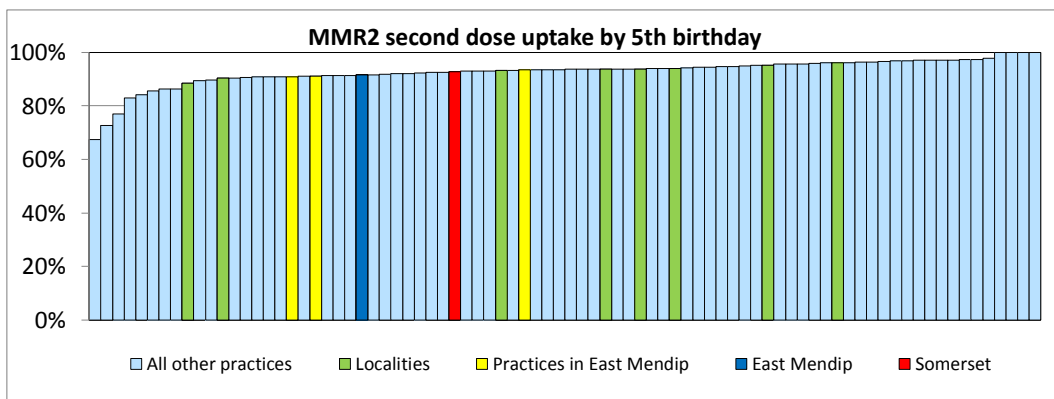
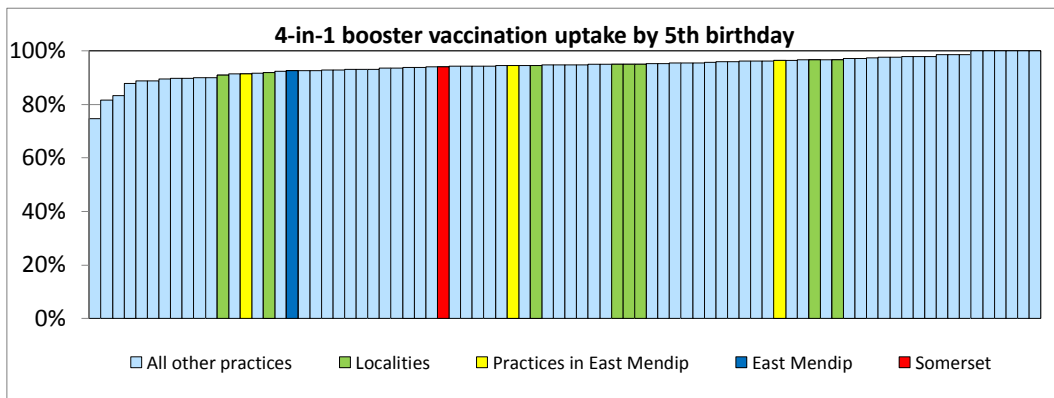
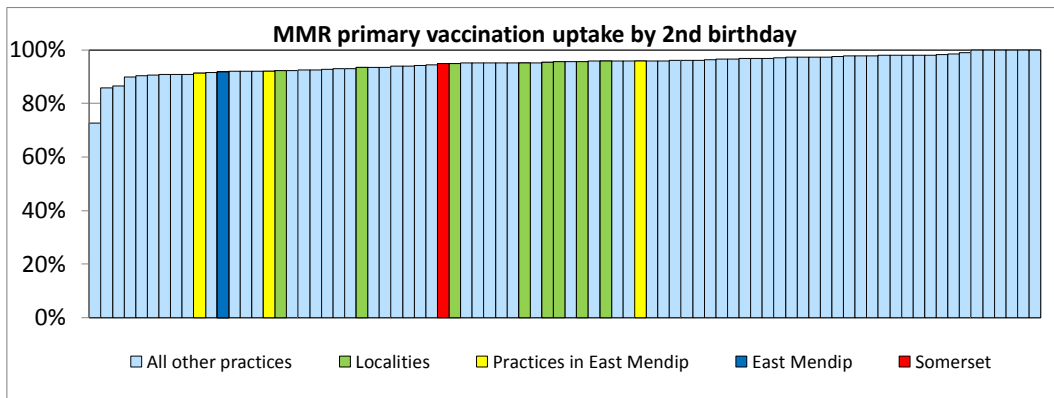
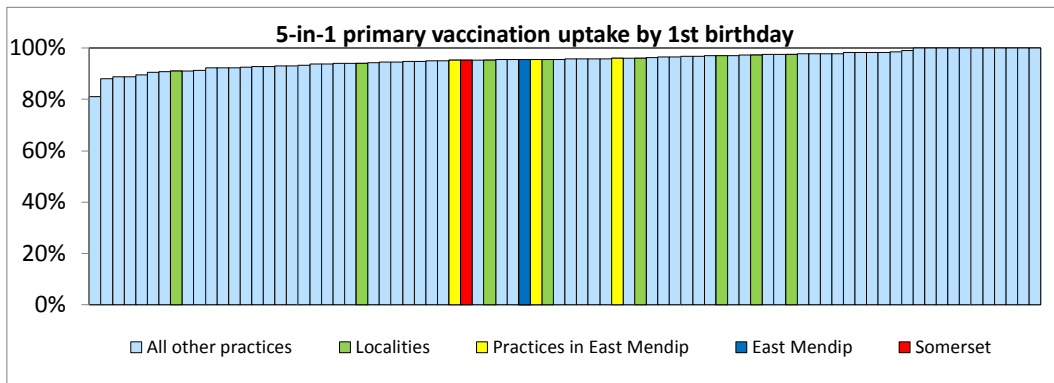
The Commissioning Locality has the worst value in the county for:  
MMR primary vaccination uptake by 2nd birthday

previous year

	Commissioning Locality	Somerset	England	Range of Practice values low / median / high
5-in-1 primary vaccination uptake by 1st birthday	93.2%	95.5%	94.2%	78% / 96% / 100%
4-in-1 booster vaccination uptake by 5th birthday	93.5%	93.8%	88.5%	74% / 95% / 100%
MMR primary vaccination uptake by 2nd birthday	95.2%	94.9%	92.3%	73% / 95% / 100%
MMR2 second dose uptake by 5th birthday	92.9%	92.9%	88.6%	74% / 93% / 100%



Childhood immunisations - latest year



# East Mendip

## Breastfeeding initiation and prevalence at 6-8 weeks

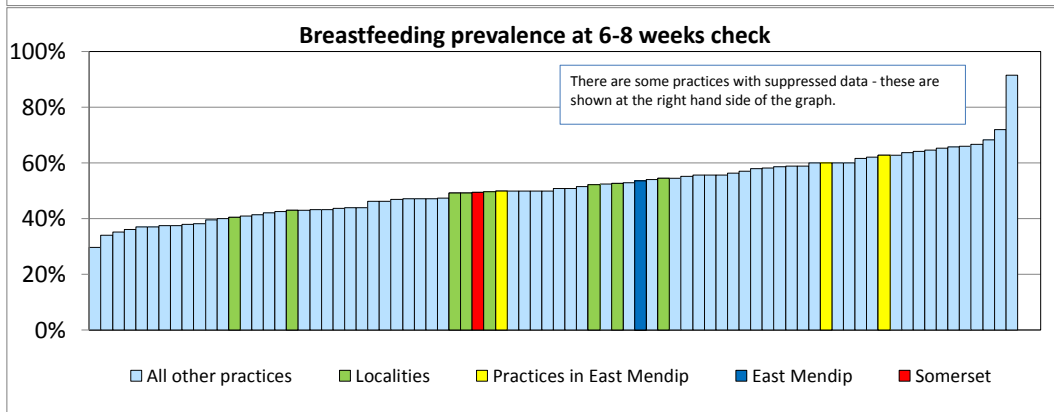
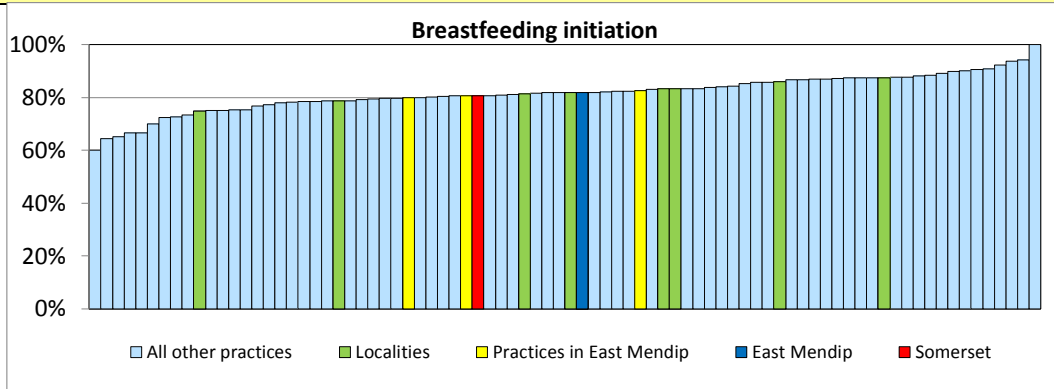
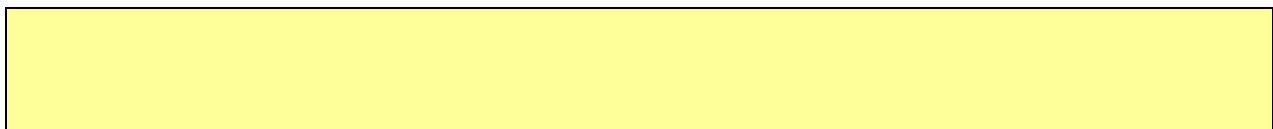
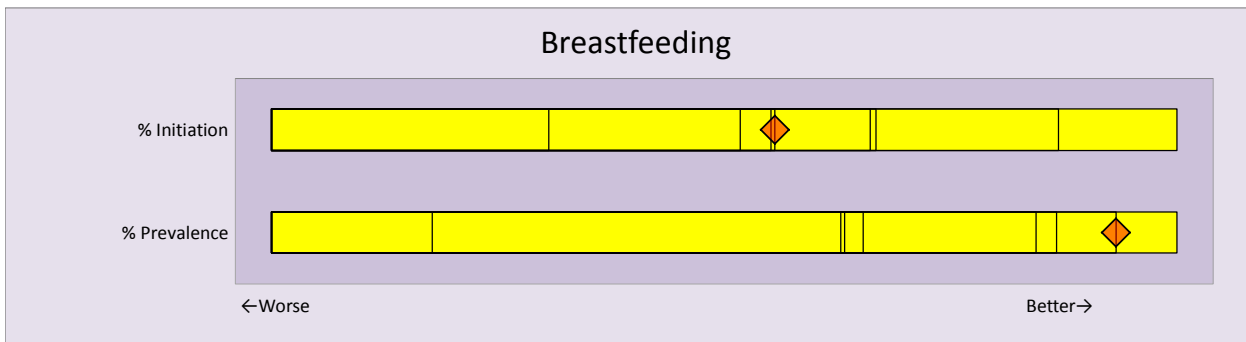
During transition to new maternity dataset the Breastfeeding data available is not currently robust. 2014/15 data only is shown below. Breastfeeding initiation and prevalence at 6 to 8 weeks data from NHS England Statistical Release: 12 week Maternal Assessment, Breastfeeding Initiation & Breastfeeding prevalence 6-8 weeks at Practice level OT 2014/15

2014/15

Condition	Commissioning Locality	Somerset	England	Range of Practice values low / median / high
Number of maternities	459	5,431	634,378	
Percentage mothers initiating breastfeeding*	82%	81%	74%	60% / 82% / 100%
Number of infants due a check at 6-8 weeks	456	5,281	631,353	
Percentage of infants being wholly or partially breastfed*	54%	49%	44%	30% / 50% / 92%

\* of those with known status

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



# Paediatric Profile



## East Mendip



Indicator	East Mendip number	East Mendip value	Somerset CCG value	Worst Locality value in Somerset	Chart	Best Locality value in Somerset	England value	Worst practice value in Somerset	Best practice value in Somerset	East Mendip value 2015	Direction of change
1 % of population aged 0-14 *	7,625	17%	16%	18%		12%	18%	24%	9%	17%	Higher
2 Income deprivation affecting Children Index		0.14	0.14	0.20		0.13	0.15	0.26	0.06	0.13	Lower
3 Breastfeeding initiation	376	82%	81%	75%		88%	74%	60%	100%	82%	Improved
4 Breastfeeding prevalence at 6-8 weeks	244	54%	49%	40%		54%		30%	92%	54%	Improved
5 5-in-1 uptake by age 1	442	95%	95%	91%		98%	94%	81%	100%	93%	Improved
6 4-in-1 booster uptake by age 5	489	93%	94%	91%		97%	86%	75%	100%	93%	Improved
7 MMR uptake by age 2	430	92%	95%	92%		96%	92%	73%	100%	95%	Improved
8 MMR booster uptake by age 5	483	91%	93%	89%		96%	88%	67%	100%	93%	Improved
9 Flu vaccination uptake for 2, 3 and 4yr olds	728	47%	42%	32%		47%	34%	9%	74%	37%	Worsened
10 % Obese in Reception		8%	9%	10%		7%	10%			8%	Lower
11 % Obese in Year 6		16%	16%	18%		15%	23%			17%	Lower
12 Teenage deliveries (age<19) in hospital per 1000 F15-17	91	20.3	14.7	21.5		6.4				19.5	Lower
13 Emergency admission rate per 1000 for accidents (ages 0-17)	450	8.2	9.3	10.9		6.6				7.6	Lower
14 Admissions for self-harm rate per 1000 (ages 10-24)	327	733.9	551.5	733.9		242.5		4421.2	61.7	674.8	Lower
15 Emergency admissions rate per 1000 (ages 0-17)	797	87	84	97		64		129	36	70	Lower
16 Elective admissions rate per 1000 (aged 0-17)	312	35	38	43		27		144	14	33	Lower
17 First outpatient attendances rate per 1000 (aged 0-17)	2,077	230	235	256		201		477	162	233	Lower
18 % lone parent households		9%	9%	10%		7%	11%			9%	Lower
19 Foundation Stage Profile (FSP) % students NOT achieving a good level of development		30%	33%	50%		28%				36%	Lower
20 % of pupils with SEN		17%	15%	17%		12%				20%	Lower
21 Fixed Exclusions per 1000 pupils		48	46	52		31				35	Lower
22 % Students NOT achieving 5 A*-C GCSEs inc Maths & English		44%	41%	50%		36%				45%	Lower
23 % of children in low-income families Child Poverty Unit 2014		16%	15%	18%		13%	20%			13%	Lower
24 Children (0-17) currently in Care per 10,000**	21	23	35	44		19	60			22	Lower
25 Children (0-17) subject to a Child Protection Plan per 10,000**	26	29	30	61		7	43			22	Lower

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

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

### Notes and Definitions

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

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

- Proportion of population aged 0-14 as at April 2016 from Open Exeter GP registrations database.
- Income deprivation affecting Children Index 2015 Department for Communities and Local Government. Commissioning Locality value estimated using a weighted population average as at April 2016.
- Breast feeding initiation 2014/15. Estimated proportion of maternities where breastfeeding was initiated. NHS England.
- Breast feeding prevalence 2014/15. Estimated proportion of infants due checks who were reported as wholly or partially breastfed at 6-8 weeks. NHS England.
- Uptake of 5-in-1 primary vaccination by 1st birthday 2015/16 NHS England
- Uptake of 4-in-1 booster vaccination by 5th birthday 2015/16 NHS England
- Uptake of MMR primary vaccination by 2nd birthday 2015/16 NHS England
- Uptake of MMR booster vaccination by 5th birthday 2015/16 NHS England
- Uptake of vaccination by those aged 2, 3 and 4 during 2015/16 influenza season. NHS England.
- Proportion of children measured in Reception classes who had a Body Mass Index assessed as Obese for their age. 2010/11 - 2014/15 National Child Measurement Programme.
- Proportion of children measured in Year 6 classes who had a Body Mass Index assessed as Obese for their age. 2010/11 - 2014/15 National Child Measurement Programme.
- Number of deliveries in hospital to women aged less than 19, per 1000 females aged 15-17. April 2010 to March 2016 Secondary Uses Services (SUS) hospital activity data.
- Emergency admissions for accidents per 1000 children aged 0-17. April 2010 to March 2016 Secondary Uses Services (SUS) hospital activity data.
- Admissions for self-harm per 1000 children and young people aged 10-24. April 2010 to March 2016 Secondary Uses Services (SUS) hospital activity data.
- Emergency admissions for any cause per 1000 children aged 0-17. April 2015 to March 2016 Secondary Uses Services (SUS) hospital activity data.
- Elective (day case or inpatient) admissions for any cause per 1000 children aged 0-17. April 2015 to March 2016 Secondary Uses Services (SUS) hospital activity data.
- First outpatient attendances (a proxy for referral) for any cause per 1000 children aged 0-17. April 2015 to March 2016 Secondary Uses Services (SUS) hospital activity data.
- Proportion of households where there is a lone parent. Census 2011.
- Proportion of children not achieving a good level of development, Foundation Stage Profile (FSP). 2015 Somerset County Council.
- Proportion of children with Special Educational Needs. 2015 Somerset County Council.
- Number of Fixed exclusions from school per 1000 pupils. 2015 Somerset County Council.
- Proportion of children NOT achieving 5 A\*-C GCSEs including Maths and English. 2015 Somerset County Council.
- Proportion of children in low-income families. Child Poverty Unit 2014.
- Children age 0-17 who are currently in Care and known to be living or placed in Somerset per 10,000. As at June 2016. Somerset County Council.
- Children age 0-17 who are subject to a Child Protection Plan and known to be living or placed in Somerset per 10,000. As at June 2016. Somerset County Council.

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

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

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

Following the measurement programme parents are sent a feedback letter informing them of their child's weight and weight category (underweight, healthy weight, overweight and very overweight). The letters include links to web-based advice and support, contact numbers for local health teams and details of Somerset's children and families weight management programme. Copies of the feedback letters are also sent to GP practices.

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

Smoking is the lifestyle feature which has the largest impact on individual health. Smoking ascertainment and prevalence are presented along with a range of statistics which highlight how well the smoking cessation process is operating. Somerset in general has lower rates of smoking than England but, despite recent improvements, still has much higher than average rates of smoking during pregnancy as assessed at time of delivery. More detail on local evidence based interventions to improve smokers' health is given on page 47.

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/>

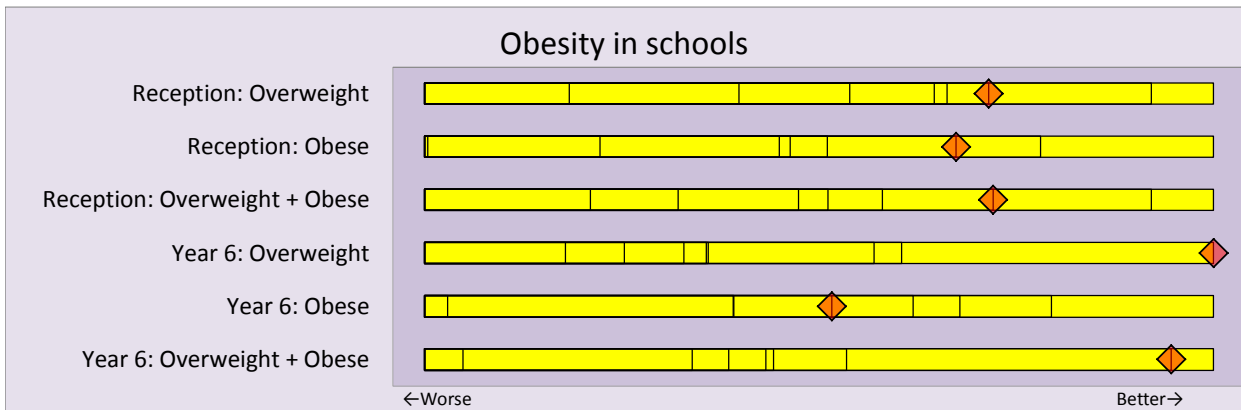
# East Mendip

## Obesity in schools

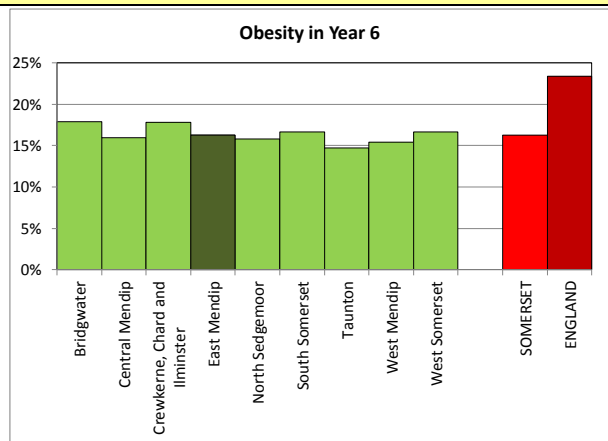
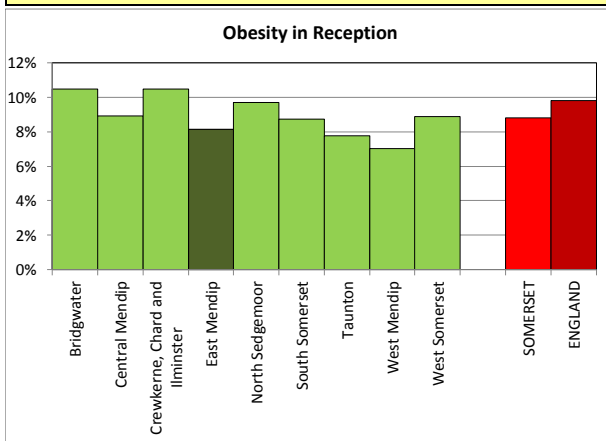
National Child Measurement Programme (NCMP) Reception and Year 6 measurements 2011/12 - 2015/16

	Commissioning Locality	Somerset	England	Range of Practice values low / median / high
Reception: Overweight	13%	14%	13%	
Reception: Obese	8%	9%	10%	
Reception: Overweight + Obese	21%	22%	23%	
Year 6: Overweight	12%	14%	14%	
Year 6: Obese	16%	16%	23%	
Year 6: Overweight + Obese	29%	30%	38%	

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



The Commissioning Locality has the best value in the county for:  
Year 6: Overweight



## East Mendip

### Obesity in adults (rate per 1000)

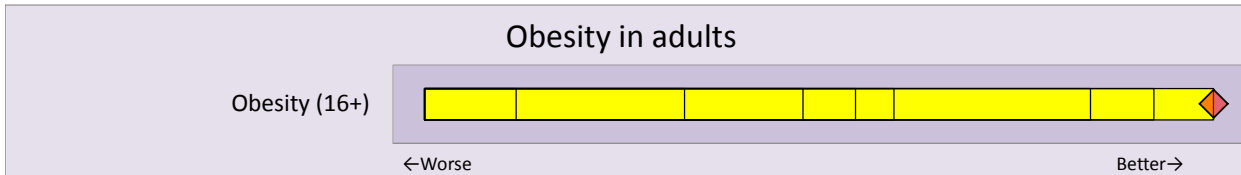
Age/sex standardised prevalence rates using Quality Outcome Framework crude prevalence, Exeter system population downloads and Somerset wide age/sex specific rates from MIQUEST queries run by the CSU.

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

2016

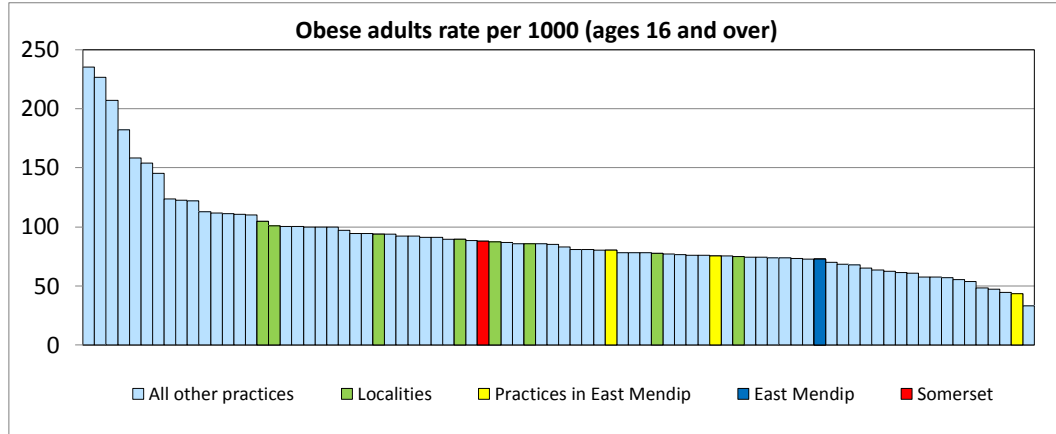
Condition	Observed in Commissioning Locality	Expected in Commissioning Locality (based on Somerset rates)	Commissioning Locality rate	Somerset rate	England rate	Range of Practice values low / median / high
Obesity (16+)	2,601	3,144	73	88	104	33 / 81 / 235

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



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

**The Commissioning Locality has the best value in the county for:**  
Obesity (16+)



# East Mendip

## Smoking prevalence (%)

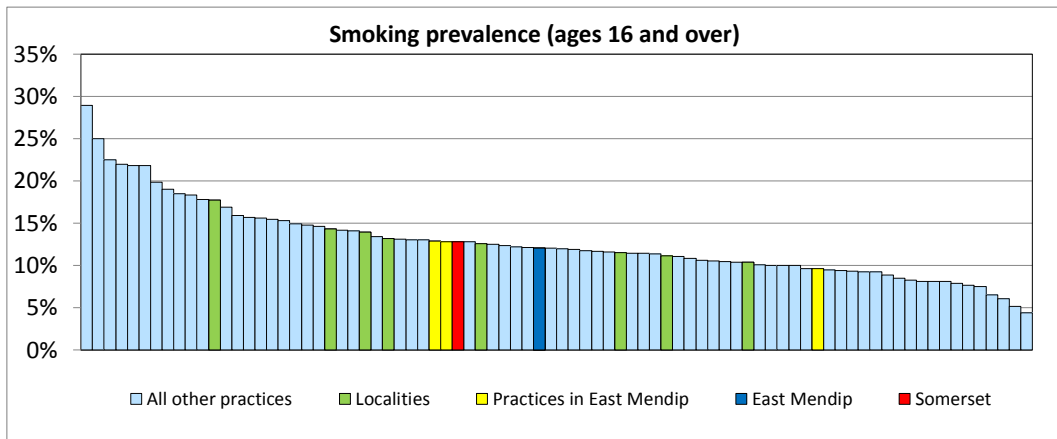
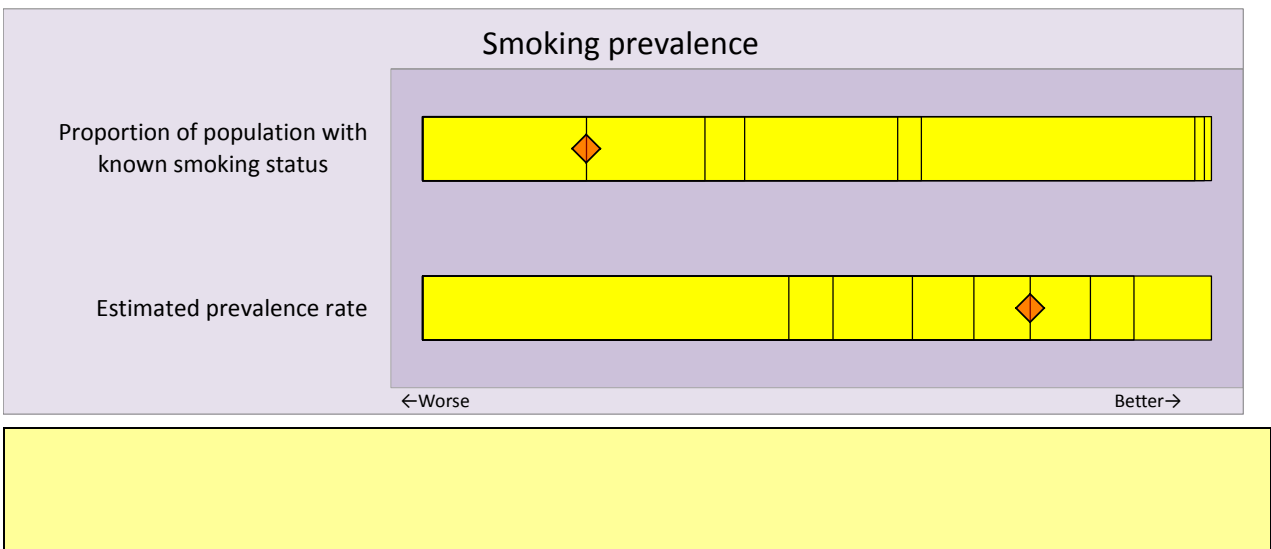
Smokers 16+ among those with a known smoking status in the last 15 months from MIQUEST queries on practice clinical systems run by the CSU.

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.

Mar-16

	Commissioning Locality	Somerset	England	Range of Practice values low / median / high
Number with known smoking status (16+)	21,575	299,032		
Number smoking (16+)	2,607	38,234		
Population (16+)	36,185	473,432		
Proportion of population with known smoking status	60%	63%		49% / 63% / 74%
Estimated prevalence rate	12.1%	12.8%		4% / 12% / 29%

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







Smoking evidence based interventions

1. **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. Qualifies for 1 hour CPD/CME.

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

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

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

2. **Referral of smokers to stop smoking services.** Smokers who express an interest in quitting in the near future should be referred to the Smokefreelife Somerset service for support <http://www.smokefreelivesomerset.co.uk/>. In addition to group and 1-1 support, this service now includes telephone and video 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 does not wish to be referred to a stop smoking practitioner, then it may be appropriate to provide a prescription, but other forms of support should be offered such as those available from the NHS Smokefree website, such as text, app and email. Repeat prescriptions should not be offered, with the patient referred to Smokefreelife Somerset to discuss options. There is a strong evidence base for the effectiveness of the text support service. Patients wishing to quit using electronic cigarettes/vaporisers will need to supply their own device, but are otherwise fully able to access Smokefreelife Somerset services.
3. **Practice records should be used to identify chronic disease patient groups for intervention.** In particular, patients with COPD who are continuing smokers should be a priority. Stop smoking groups specifically for COPD patients have been successful elsewhere, and would be worth trying in communities where there is sufficient interest. Smokefreelife Somerset should be contacted regarding facilitating such groups.
4. **Support for those likely to be hospitalised to quit smoking.** For patients likely to be admitted to hospital, GPs should ensure that patients are aware that hospitals are non-smoking sites (buildings and grounds) and that they will NOT be permitted to smoke anywhere on the site. They should then be offered support, either to quit prior to admission via Smokefreelife Somerset, or if unwilling to do so, should be prescribed NRT (preferably 2 products, patch plus a faster acting product such as lozenge) to enable temporary abstinence while in hospital, which they should start using a few days before admission.
5. **Engagement with the Stop Smoking Service provider.** Commissioning Localities and practices should work closely with Smokefreelife Somerset to ensure that stop smoking services are available to patients, and that referral processes are effective. The service has a GP and Pharmacy Co-ordinator, Sarah Westlake, who can be contacted via 01823 765006,

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

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

SUS Inpatient activity files April 2011 to March 2016 ONS Primary Care Mortality Database 2011-15. Population files July 2011-July 2015. Admissions indirectly standardised rate by age/sex and Deaths indirectly standardised rate by age/sex.

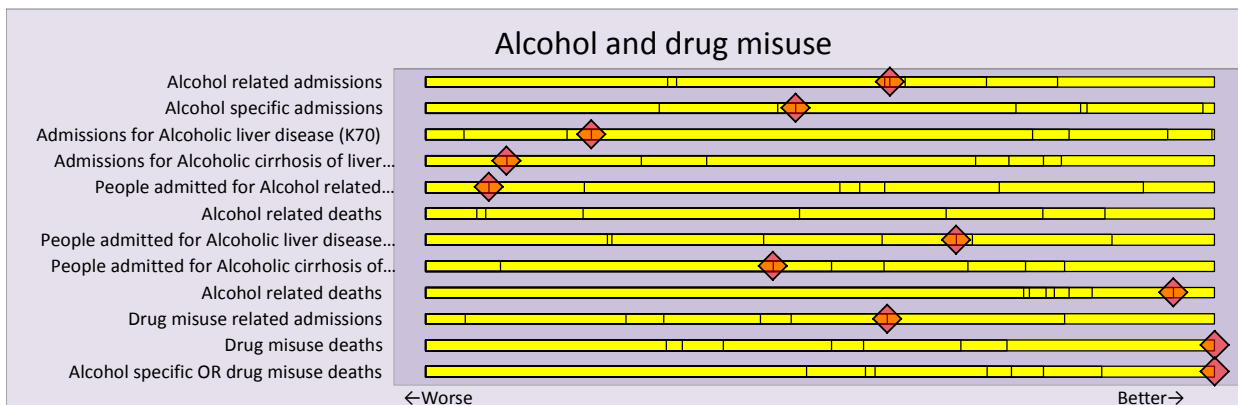
**Alcohol:** The North West Public Health Observatory has produced a list of conditions that they consider could have an alcohol related component. Each condition is allocated an Attributable Fraction, which is dependent on age and sex, that describes what proportion of admissions from that cause could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

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

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

	Commissioning Locality rate	Somerset rate	England (average annual value 2010/11 to 2014/15)	Range of Practice values low / median / high
Alcohol related admissions	1,840	1,894	2,056	1,326 / 1,810 / 3,950
Alcohol specific admissions	464	445		105 / 404 / 1,680
Admissions for Alcoholic liver disease (K70)	102	84		
Admissions for Alcoholic cirrhosis of liver (K703)	68	44		
People admitted for Alcohol related conditions	894	852		636 / 824 / 1,853
People admitted for Alcohol specific conditions	263	248		100 / 222 / 895
People admitted for Alcoholic liver disease (K70)	30	31		
People admitted for Alcoholic cirrhosis of liver (K703)	19	16		
Alcohol related deaths	1	6		
Drug misuse related admissions	119	137		20 / 109 / 488
Drug misuse deaths	1	3		
Alcohol specific OR drug misuse deaths	26	31		

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

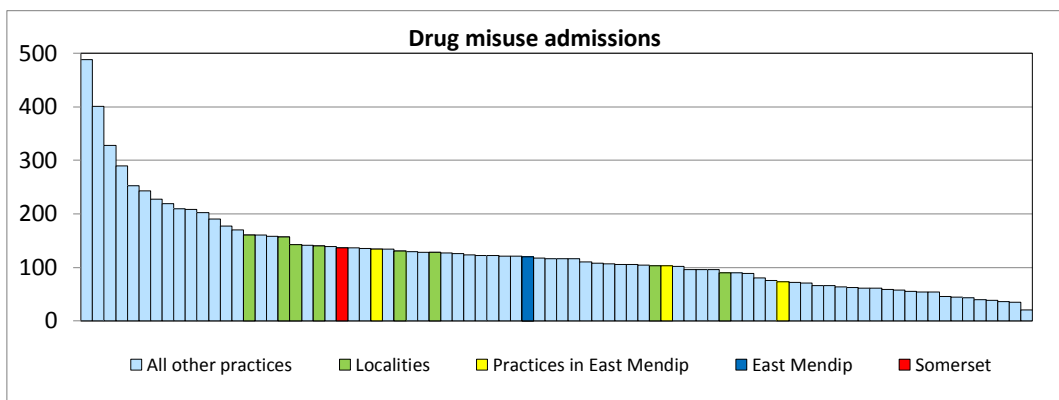
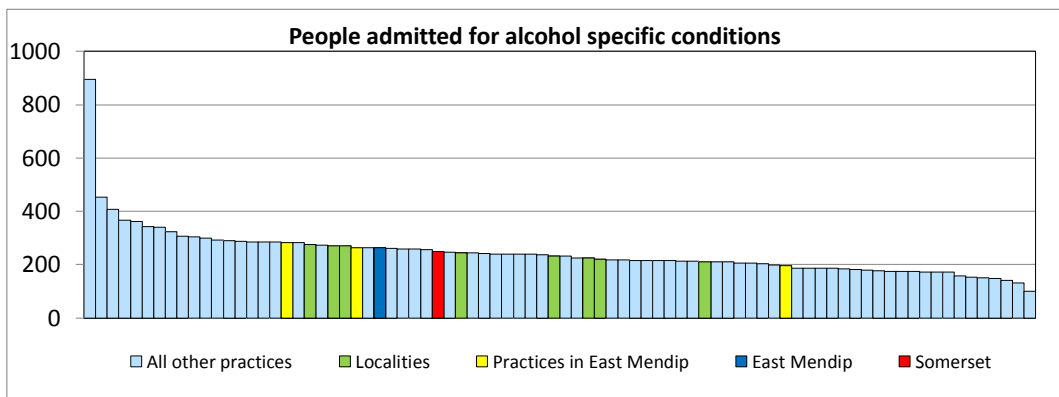
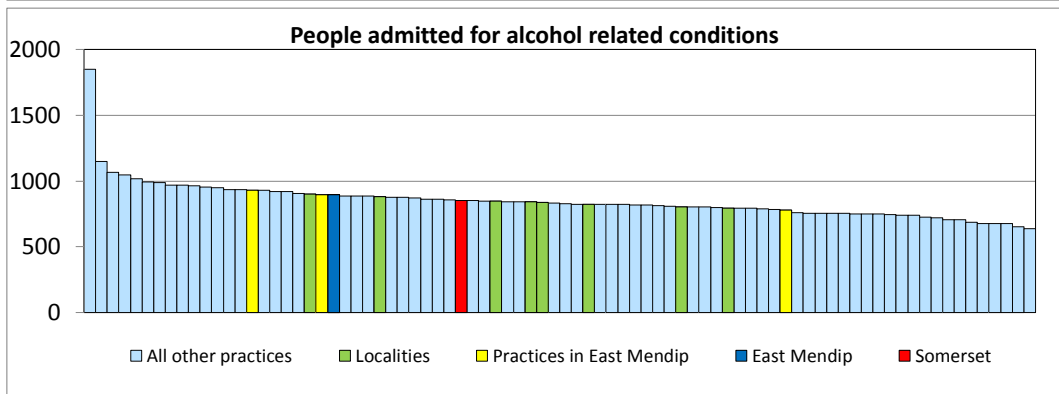
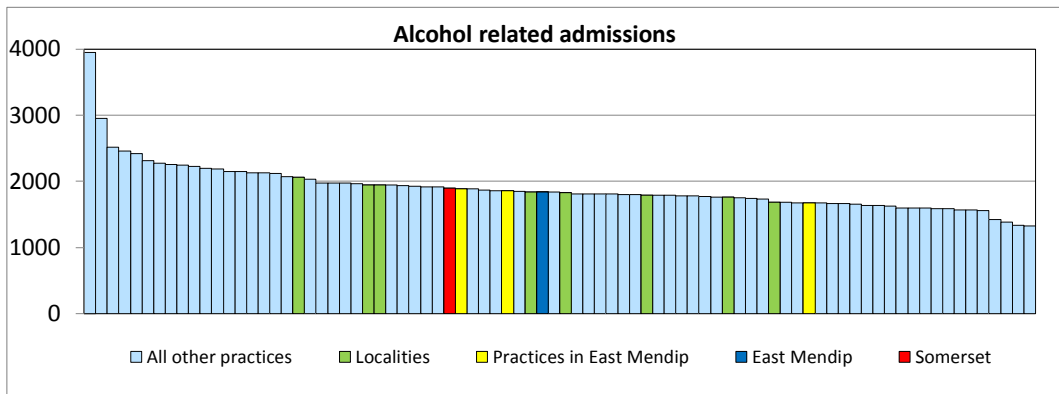


**Significantly worse than county average for:**  
Admissions for Alcoholic cirrhosis of liver (K703)

**Significantly better than county average for:**  
Drug misuse related admissions

**The Commissioning Locality has the best value in the county for:**  
Drug misuse deaths    Alcohol specific OR drug misuse deaths

Alcohol and drug misuse



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, accidents to children, teenage deliveries
- Emergency admission rates
- Emergency admission rates for specific conditions of interest: CHD , CVD, COPD, Asthma and Diabetes
- Elective admissions rates
- Out patient attendances rates

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

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

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

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

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

## East Mendip

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

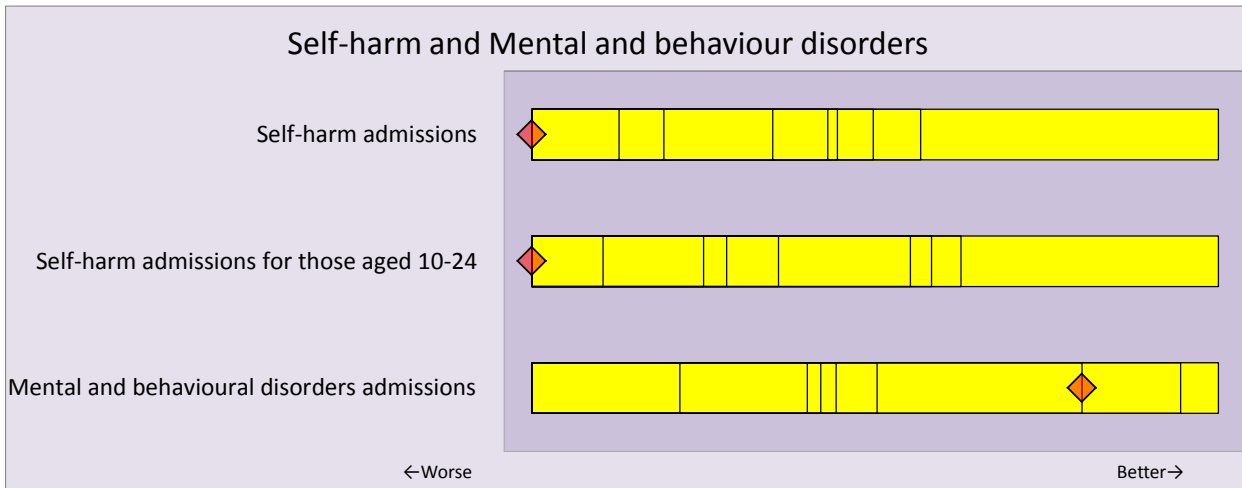
SUS Inpatient activity files April 2010 to March 2016 and ONS Population files July 2011-July 2015. Indirectly standardised rates by age/sex.

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

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

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

	Commissioning Locality rate	Somerset rate	England	Range of Practice values low / median / high
Self-harm admissions	263	221		76 / 200 / 736
Self-harm admissions for those aged 10-24	734	551		62 / 513 / 4,421
Mental and behavioural disorders admissions	218	258		105 / 235 / 829



#### Significantly worse than county average for:

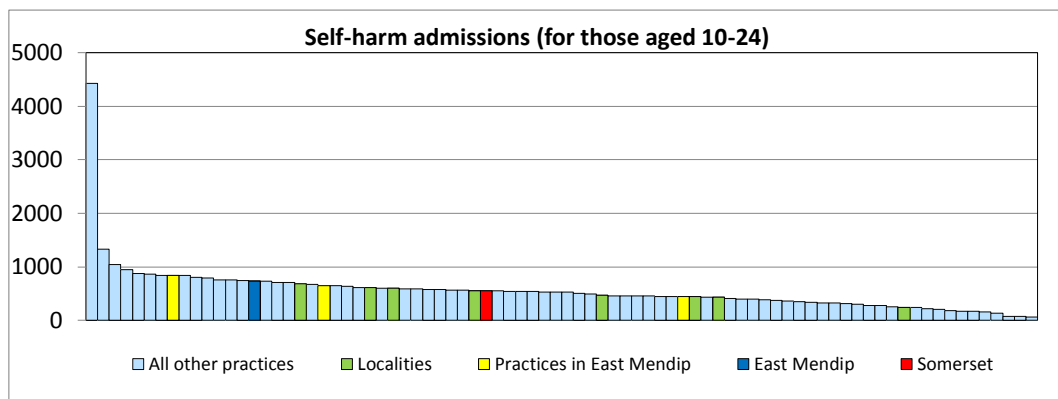
Self-harm admissions    Self-harm admissions for those aged 10-24

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

Self-harm admissions    Self-harm admissions for those aged 10-24

#### Significantly better than county average for:

Mental and behavioural disorders admissions



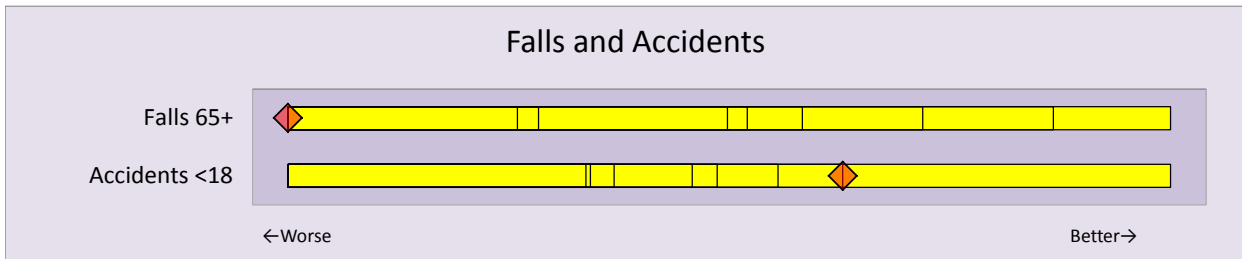
# East Mendip

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

SUS Inpatient activity files April 2013 to March 2016 and ONS Population files July 2013-July 2015. Indirectly standardised rates by age/sex.

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

	Commissioning Locality rate	Somerset rate	England	Range of Practice values low / median / high
Falls 65+	38	31		14 / 30 / 60
Accidents <18	8.2	9.3		4.2 / 9.2 / 14.7



**Significantly worse than county average for:**

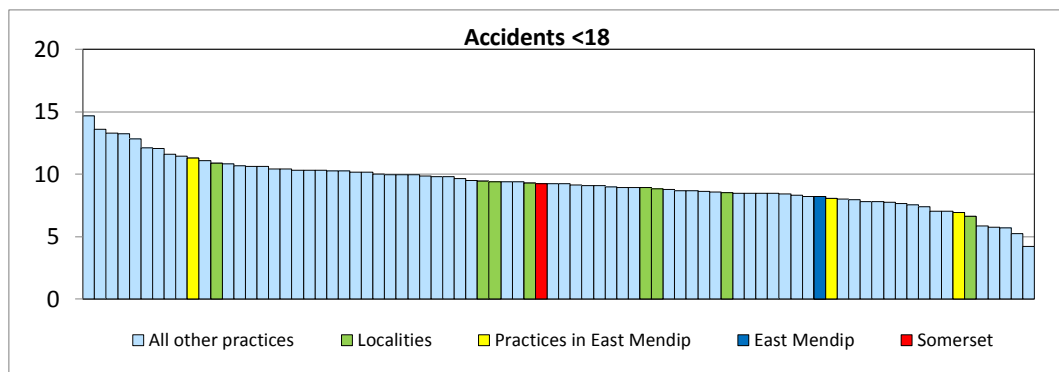
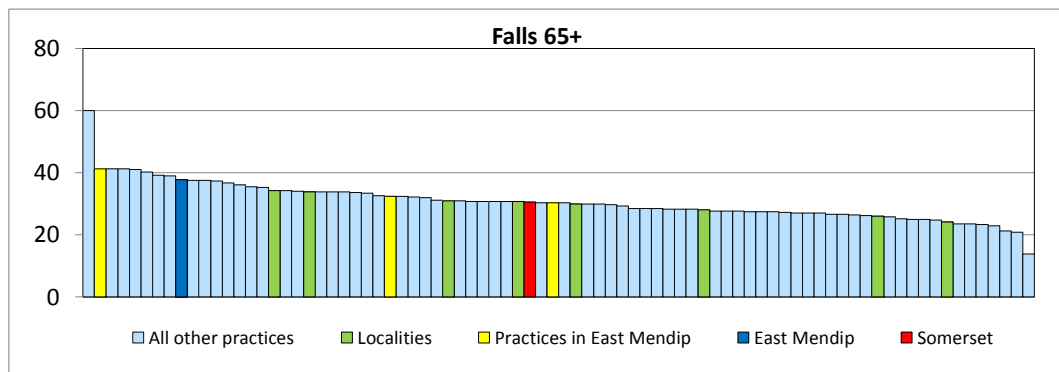
Falls 65+

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

Falls 65+

**Significantly better than county average for:**

Accidents <18



### Falls and Bone Health evidence based interventions

Falls are a major cause of injury, disability and mortality among older people, however there are many opportunities to reduce the risk of falls. It is also essential we support individuals to build and maintain optimum bone strength across the life course, assisting with maintenance of bone density into older age. During 2015/16 in Somerset approximately 4170 people aged 65 and over were admitted to hospital as a result of a fall and with our increasingly ageing population these numbers are set to continue to rise, we know that over 70% of falls go unreported placing an older person at risk of a more serious fall.

Hip fractures are costly both to the NHS and individuals. In Somerset we estimate each hip fracture costs the NHS £39,500 (2016) with additional substantial community hospital and social care costs, with 1430 hip fractures during 2015/16 this amounts to over £56.5 million for the NHS and £3 million for social care. In addition research has shown that up to 30% of people die within a year following a hip fracture and a further 20% have reduced capacity to live independently.

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

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

#### 1) Primary diagnosis of osteoporosis

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

#### 2) Interventions including medication

When osteoporosis is diagnosed appropriate medication should be prescribed, as per NICE technology appraisals TA160 (2011) and TA204 (2010). Adherence to treatment regimens should be regularly reviewed. These guidelines also highlight the importance of a balanced diet with adequate levels of calcium and vitamin D and if people are not receiving an adequate amount of these nutrients through their diet prescribe vitamin D and calcium supplements. Further guidelines (2016) recommend adults in at risk groups take a vitamin D supplement of 10mcg per day particularly in the winter months. Safe exposure to sunlight is extremely important for the absorption of vitamin D and should be recommended in line with guidance.

#### 3) Physical function and health issues

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

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

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

#### 4) Importance of physical activity

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

#### 5) Psychological aspects

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

#### 6) Secondary prevention

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



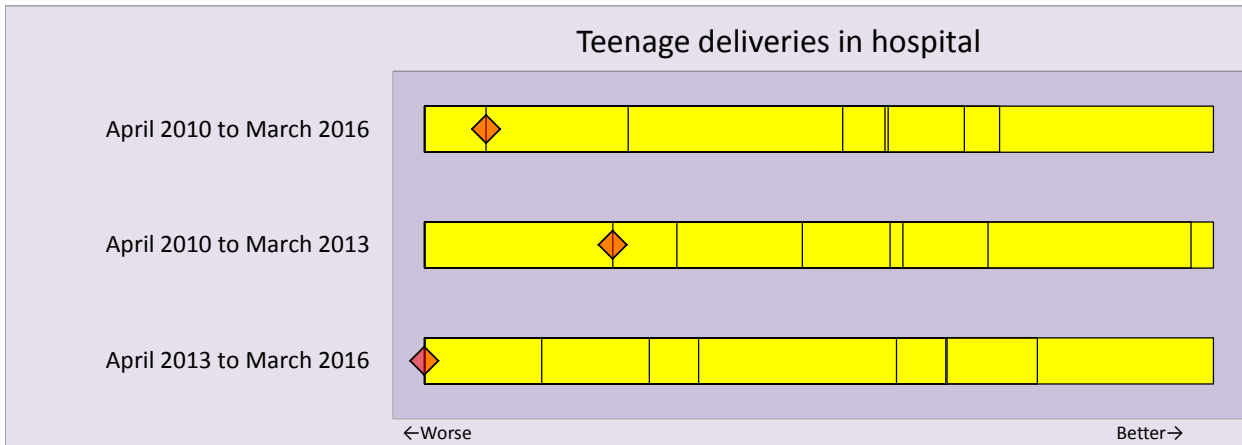
## East Mendip

### Teenage deliveries in hospital

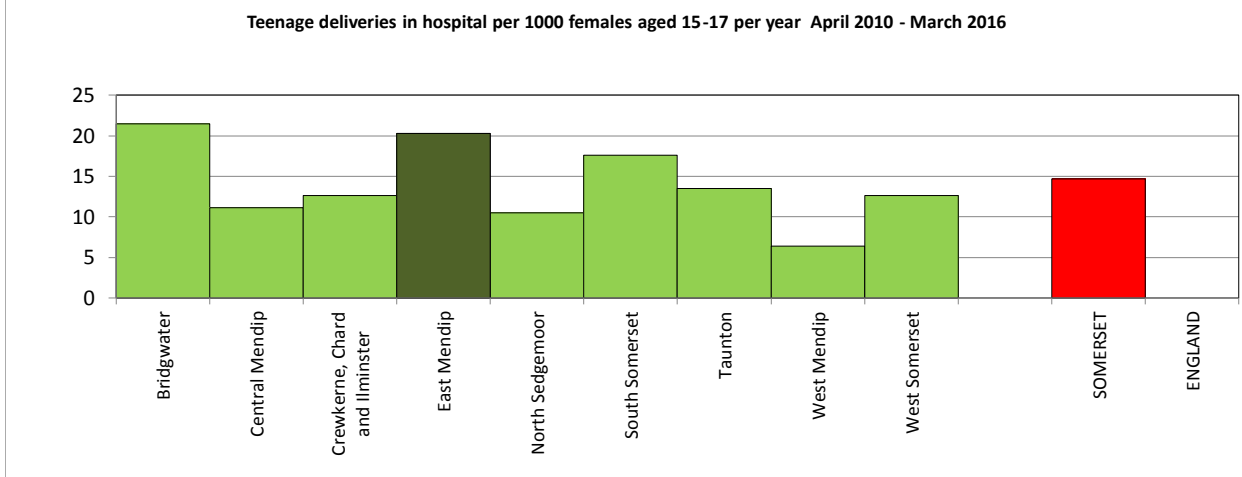
SUS Inpatient activity files April 2010 to March 2016. GP population files July 2010-July 2015. Rate per 1000 females aged 15-17 per year.

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

	Commissioning Locality rate	Somerset rate	England	Range of Practice values low / median / high
April 2010 to March 2016	20.3	14.7		
April 2010 to March 2013	22.5	18.2		
April 2013 to March 2016	17.9	11.0		



**The Commissioning Locality has the worst value in the county for:**  
April 2013 to March 2016



## East Mendip

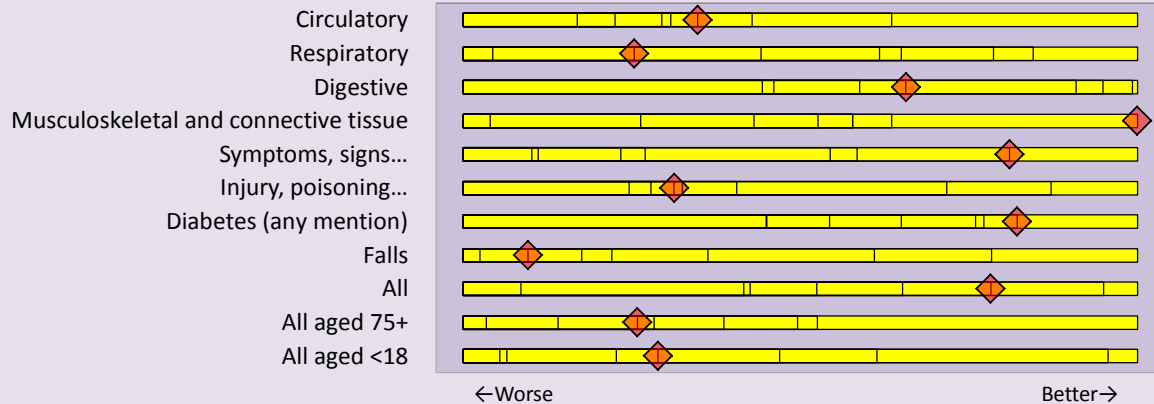
### Standardised emergency admission rate to hospital per 1000 population (ICD grouping)

SUS Inpatient activity files 2015/16. Population file July 2015. Emergency admissions. Standardised by age and sex.

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

ICD groupings	Observed	Expected (based on Somerset rates)	Commissioning Locality rate	Somerset rate	England	Range of Practice values low / median / high
Diseases of the circulatory system	416	422	10.7	10.9		7.4 / 10.5 / 23.9
Diseases of the respiratory system	583	558	14.2	13.6		6.5 / 13.3 / 23.0
Diseases of the digestive system	380	379	9.2	9.2		4.0 / 9.2 / 13.5
Diseases of musculoskeletal system and connective tissue	126	196	3.1	4.9		2.6 / 4.7 / 10.4
Symptoms, signs and abnormal clinical and laboratory findings	770	984	18.7	23.9		13.6 / 23.1 / 51.7
Injury, poisoning and other external causes	693	686	17.1	16.9		10.7 / 16.8 / 28.9
Diabetes (any mention of diabetes for the admission)	483	582	12.4	14.9		6.2 / 14.1 / 29.6
Falls (any mention of a fall for the admission)	380	355	10.1	9.4		5.2 / 9.3 / 14.8
<b>All</b>	<b>4,244</b>	<b>4,595</b>	<b>103.6</b>	<b>112.2</b>		<b>79 / 111 / 190</b>
<b>All aged 75+</b>	<b>1,349</b>	<b>1,344</b>	<b>371.6</b>	<b>370.1</b>		<b>265 / 372 / 596</b>
<b>All aged &lt;18</b>	<b>797</b>	<b>767</b>	<b>87.5</b>	<b>84.2</b>		<b>36 / 82 / 129</b>

### Emergency admissions to hospital



#### Significantly better than county average for:

Diseases of musculoskeletal system and connective tissue    Symptoms, signs and abnormal clinical and laboratory findings    Diabetes (any mention of diabetes for the admission)    All

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

Diseases of musculoskeletal system and connective tissue

## East Mendip

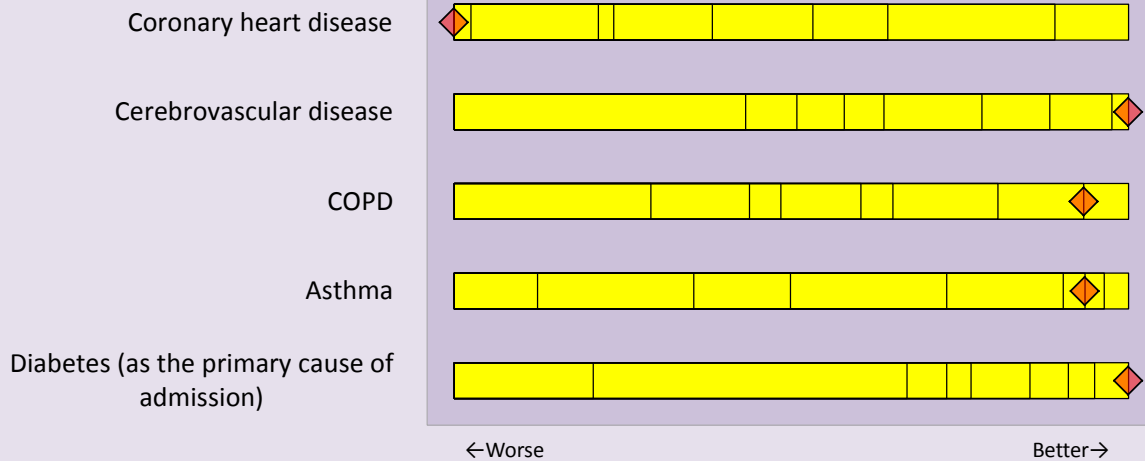
**Standardised emergency admission rate to hospital per 1000 population (CHD, CVD, COPD, Asthma, Diabetes)**

SUS Inpatient activity files 2010/11 to 2015/16. Population file July 2010-July 2015. Emergency admissions. Standardised by age and sex.

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

ICD groupings	Observed	Commissioning Locality rate	Somerset rate	England	Range of Practice values low / median / high
Coronary heart disease	648	2.6	2.3		1.5 / 2.2 / 3.9
Cerebrovascular disease	427	1.8	1.9		1.3 / 1.9 / 4.2
COPD	401	1.6	1.9		0.8 / 1.8 / 7.6
Asthma	189	0.7	0.8		0.2 / 0.7 / 1.5
Diabetes (as the primary cause of admission)	198	0.7	0.9		0.2 / 0.9 / 2.4

### Emergency admissions to hospital



**Significantly worse than county average for:**

Coronary heart disease

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

Coronary heart disease

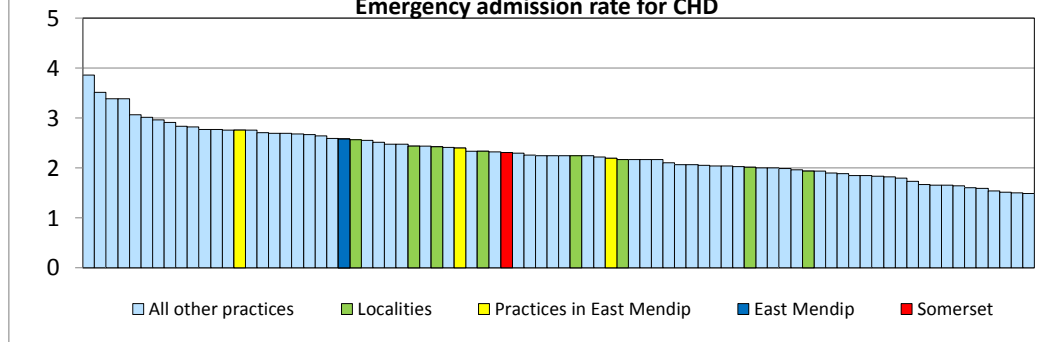
**Significantly better than county average for:**

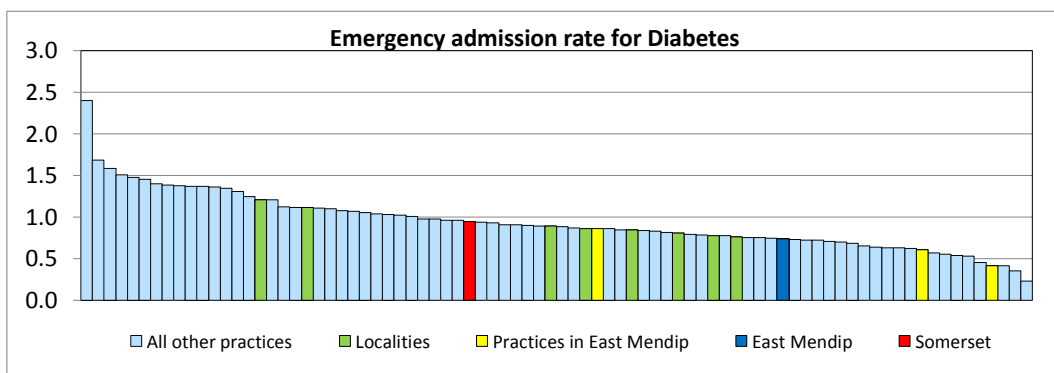
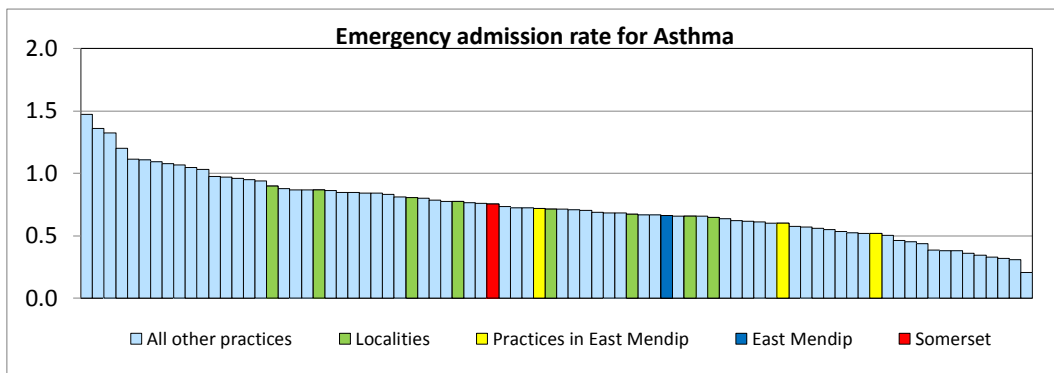
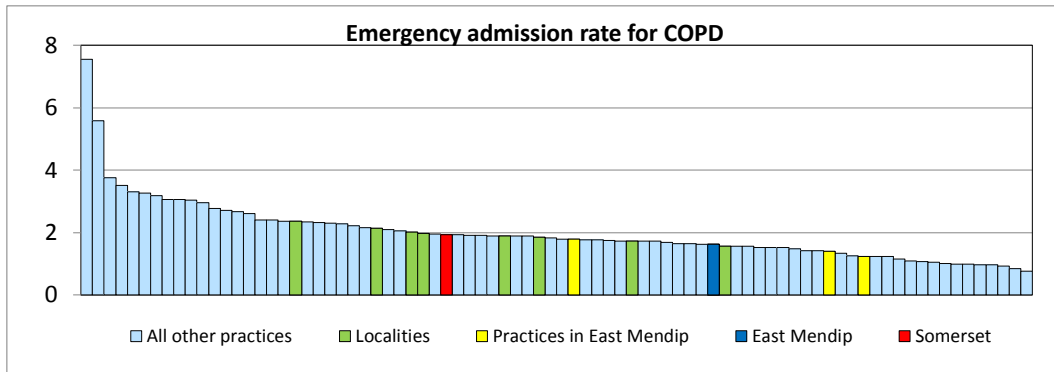
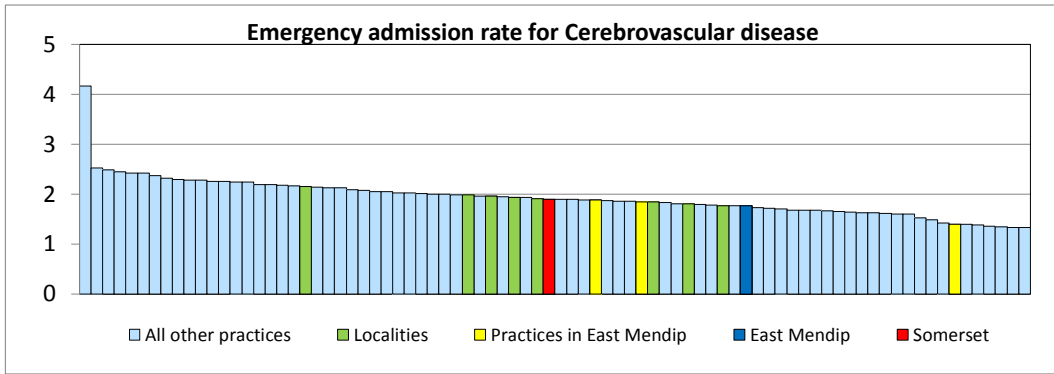
COPD Diabetes (as the primary cause of admission)

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

Cerebrovascular disease Diabetes (as the primary cause of admission)

### Emergency admission rate for CHD





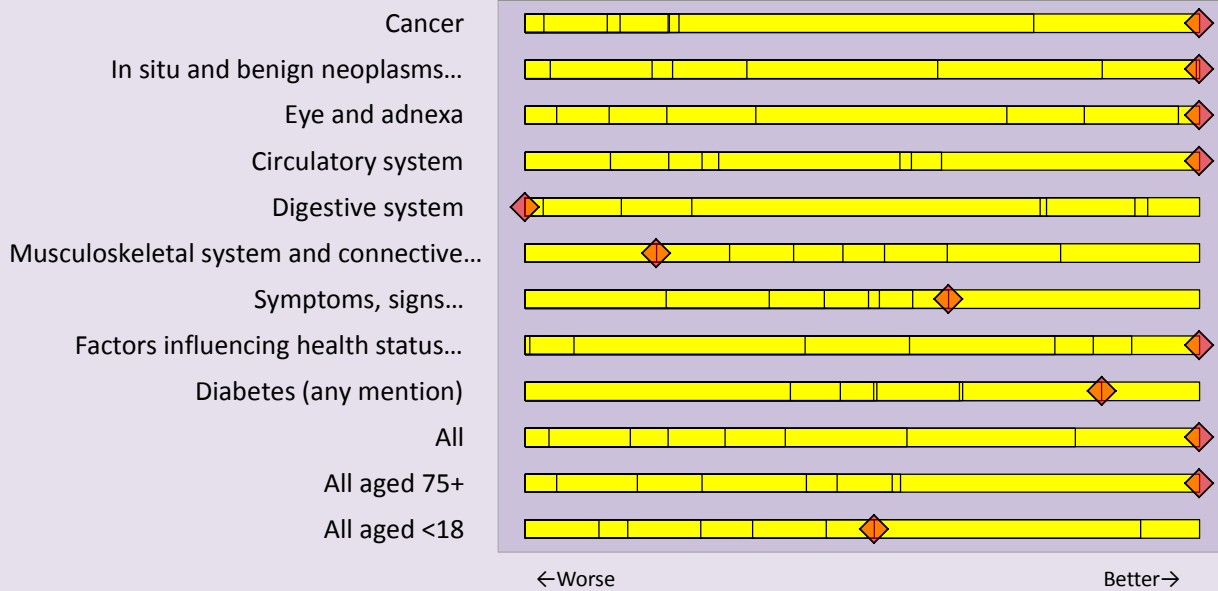
**Standardised elective admission rate to hospital per 1000 population (ICD grouping)**

SUS Inpatient activity files 2015/16. Population file July 2015. Elective and Day cases. Standardised by age and sex.

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

ICD groupings	Observed	Expected (based on Somerset rates)	Commissioning Locality rate	Somerset rate	England rate	Range of Practice values low / median / high
Cancer	721	1,397	17.5	34.0		15.7 / 34.3 / 61.0
In situ and benign neoplasms and neoplasms of unknown or uncertain behaviour	236	312	5.7	7.5		3.4 / 6.8 / 16.2
Diseases of eye and adnexa	440	510	11.4	13.2		6.0 / 13.5 / 19.8
Diseases of the circulatory system	284	353	6.9	8.5		3.7 / 8.5 / 16.3
Diseases of the digestive system	1,196	1,100	28.0	25.8		17.9 / 25.7 / 33.5
Diseases of musculoskeletal system and connective tissue	830	764	19.7	18.1		12.0 / 18.1 / 25.8
Symptoms, signs and abnormal clinical and laboratory findings	362	423	8.6	10.0		5.2 / 9.7 / 15.1
Factors influencing health status and contact with health services	193	341	4.6	8.1		3.8 / 7.7 / 13.5
Diabetes (any mention of diabetes for the admission)	551	660	13.7	16.4		9.2 / 16.0 / 27.7
<b>All</b>	<b>5,615</b>	<b>6,721</b>	<b>134.3</b>	<b>160.8</b>		<b>128 / 163 / 193</b>
<b>All aged 75+</b>	<b>1,107</b>	<b>1,314</b>	<b>295.4</b>	<b>350.5</b>		<b>204 / 351 / 507</b>
<b>All aged &lt;18</b>	<b>312</b>	<b>339</b>	<b>34.6</b>	<b>37.6</b>		<b>14 / 37 / 144</b>

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



**Significantly worse than county average for:**

Diseases of the digestive system

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

Diseases of the digestive system

**Significantly better than county average for:**

Cancer In situ and benign neoplasms and neoplasms of unknown or uncertain behaviour Diseases of eye and adnexa Diseases of the circulatory system

Symptoms, signs and abnormal clinical and laboratory findings Factors influencing health status and contact with health services Diabetes (any mention of diabetes for the admission)

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

Cancer In situ and benign neoplasms and neoplasms of unknown or uncertain behaviour Diseases of eye and adnexa Diseases of the circulatory system Factors influencing health status and contact with health services All All aged 75+

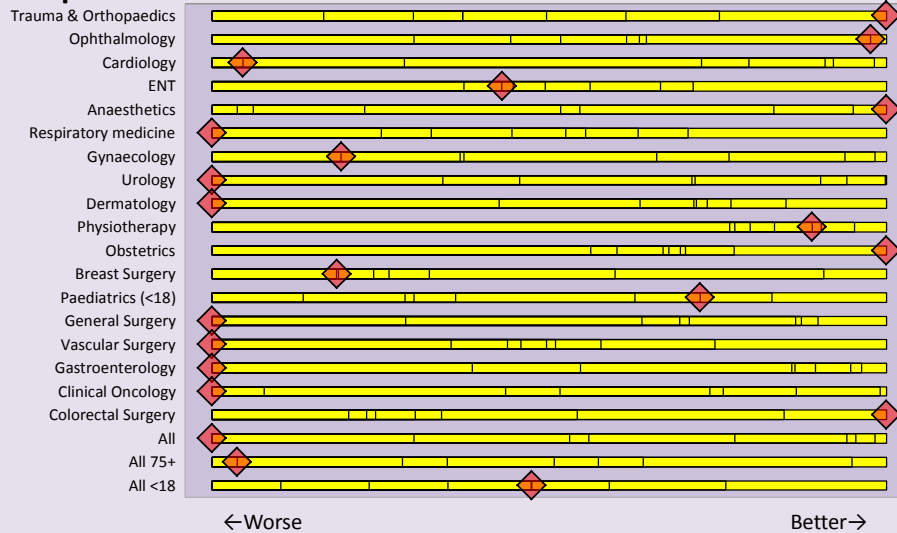
**Standardised first outpatient attendance rate per 1000 population (proxy for referral)**

SUS Outpatient activity files 2015/16. Population file July 2015. Standardised by age and sex.

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

Treatment Function	Observed	Expected (based on Somerset rates)	Commissioning Locality rate	Somerset rate	England rate	Range of Practice values low / median / high
Trauma & Orthopaedics	1,835	2,138	42.8	49.8		40.5 / 49.7 / 63.7
Ophthalmology	1,314	1,464	32.3	36.0		26.4 / 35.4 / 49.3
Cardiology	1,971	956	48.1	23.3		8.0 / 17.6 / 85.0
ENT	1,028	1,025	23.9	23.8		14.7 / 23.7 / 37.0
Anaesthetics	20	789	0.5	18.6		0.2 / 20.2 / 34.9
Respiratory medicine	545	383	13.1	9.2		3.2 / 9.2 / 19.7
Gynaecology	965	771	42.9	34.3		17.1 / 31.0 / 71.3
Urology	1,012	686	24.4	16.6		6.3 / 15.7 / 25.1
Dermatology	816	558	19.7	13.5		6.4 / 12.7 / 23.7
Physiotherapy	329	640	7.7	14.9		0.8 / 9.4 / 64.0
Obstetrics	38	531	5.2	72.4		5.0 / 56.9 / 225.1
Breast Surgery	615	599	14.0	13.6		8.7 / 13.4 / 18.4
Paediatrics (<18)	458	513	49.8	55.8		29.9 / 53.8 / 94.8
General Surgery	768	372	18.0	8.7		4.0 / 8.0 / 21.4
Vascular Surgery	583	361	14.6	9.0		2.0 / 8.5 / 17.2
Gastroenterology	472	303	11.2	7.2		2.7 / 6.6 / 15.0
Clinical Oncology	379	264	9.3	6.5		1.6 / 6.4 / 13.8
Colorectal Surgery	109	311	2.6	7.5		2.2 / 7.4 / 11.9
<b>All</b>	<b>19,833</b>	<b>16,895</b>	<b>466.5</b>	<b>397.4</b>		<b>308 / 389 / 524</b>
<b>All 75+</b>	<b>3,907</b>	<b>3,180</b>	<b>945.5</b>	<b>769.6</b>		<b>134 / 778 / 1361</b>
<b>All &lt;18</b>	<b>2,077</b>	<b>2,122</b>	<b>230.0</b>	<b>234.9</b>		<b>162 / 234 / 307</b>

**First Outpatient attendances**



**Significantly worse than county average for:**

Cardiology Respiratory medicine Gynaecology Urology Dermatology General Surgery Vascular Surgery Gastroenterology Clinical Oncology All All 75+

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

Respiratory medicine Urology Dermatology General Surgery Vascular Surgery Gastroenterology Clinical Oncology All

**Significantly better than county average for:**

Trauma & Orthopaedics Ophthalmology Anaesthetics Physiotherapy Obstetrics Colorectal Surgery

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

Trauma & Orthopaedics Anaesthetics Obstetrics Colorectal Surgery

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

#### ASTRO-PU weightings

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

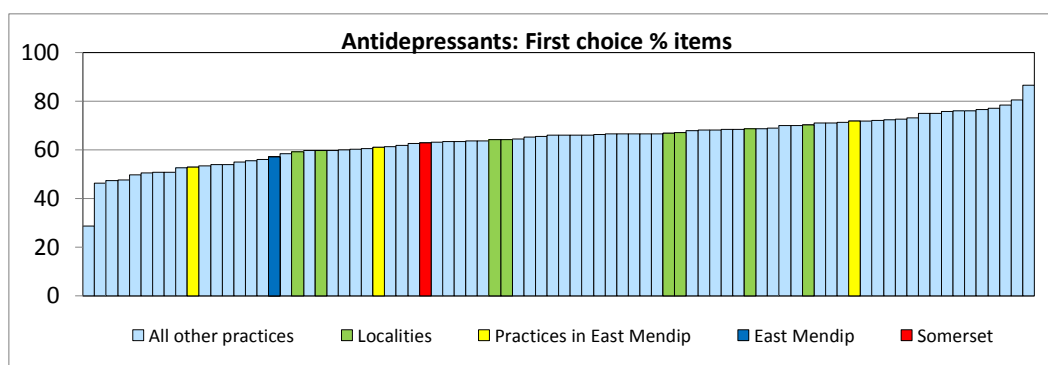
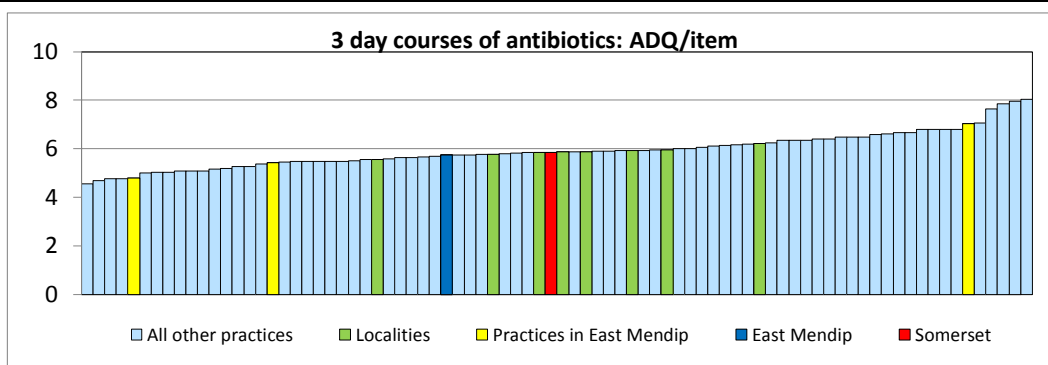




## East Mendip

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

Antidepressants: First choice % items    Antibacterial Items/STAR PU    Antidepressants ADQ/STAR PU    Co-Amoxiclav, Cephalosporins and Quinolones: % Items  
 Long/Intermediate Insulin Analogues    Other Lipid Modifying Drugs: % items



2014/15

Indicator	Numerator	Denominator	Commissioning Locality rate	Somerset rate	England rate	Range of Practice values low / median / high
3 day courses of antibiotics: ADQ/item	24,282	4,203	5.8	6.1	6.0	4.7 / 6.1 / 7.7
Antidepressants: First choice % items	23,788	45,589	52.2	57.1	63.7	33 / 59 / 80
Blood glucose lowering drugs	22,704	28,432	79.9	81.7	82.5	69 / 83 / 90
NSAIDs: Ibuprofen & Naproxen % Items	10,486	13,449	78.0	77.7	76.2	59 / 79 / 91
Antibacterial Items/STAR PU	29,640	24,902	1.2	1.1	1.2	0.8 / 1.0 / 3.5
Antidepressants ADQ/STAR PU	1,382,628	976,241	1.4	1.2	1.3	0.8 / 1.2 / 1.8
Co-Amoxiclav, Cephalosporins and Quinolones: % Items	4,114	29,520	13.9	9.0	10.7	3.9 / 8.4 / 17.0
Dosulepin: % items	1,024	45,589	2.2	1.8	2.6	0.0 / 1.5 / 6.7
Hypnotics ADQ/STAR PU (ADQ based)	117,144	122,541	1.0	0.9	1.1	0.2 / 0.8 / 2.6
Long/Intermediate Insulin Analogues	1,639	1,947	84.2	70.8	80.0	41 / 71 / 94
Minocycline ADQ/1000 Patients	1,092	44	25.1	20.9	50.9	0 / 1 / 468
NSAIDs: ADQ/STAR PU	384,489	60,123	6.4	6.0	5.9	3.0 / 6.0 / 14.7
Other Lipid Modifying Drugs: % items	3,372	74,576	4.5	2.0	2.4	0.5 / 1.7 / 4.9

## East Mendip

**ASTRO-PUs at April 2016**

**287,655**

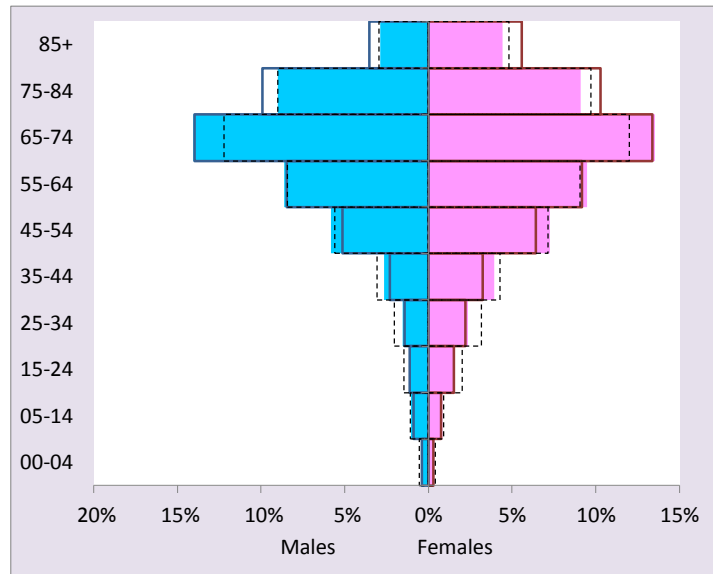
Age/Sex ASTRO-PU pyramid  
 Solid line represents Somerset as a whole, dotted line represents England.  
 Data from Exeter system download of GP registered patients.

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

### East Mendip

Age Group	Males	Females
00-04	1,211	1,002
05-14	2,987	2,446
15-24	3,328	4,330
25-34	4,417	6,829
35-44	7,630	11,264
45-54	16,758	20,844
55-64	24,766	27,322
65-74	40,466	38,918
75-84	25,848	26,215
85+	8,292	12,784

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



### Somerset

Age Group	Males	Females
00-04	14,717	11,297
05-14	34,574	30,024
15-24	44,559	59,592
25-34	55,917	86,806
35-44	90,419	127,808
45-54	202,164	252,119
55-64	332,893	360,787
65-74	550,665	527,365
75-84	390,962	404,244
85+	139,682	219,577