Public Health Services for Berkshire

Working together for health and wellbeing
Title: Wokingham Clinical Commissioning Group: Locality Profile 2017

Purpose of Document: To provide information about the health needs of the local population to support GP commissioners to develop their commissioning priorities. This has been produced as part of the Joint Strategic Needs Assessment process for Berkshire and is the 5th edition of this Profile.

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1. **Introduction**

The Clinical Commissioning Group (CCG) Locality Profile has been produced to provide information about the health needs of the local population, as part of the Joint Strategic Needs Assessments for Wokingham Borough Council. This will support GP commissioners to identify the priorities for the local area and develop their commissioning priorities accordingly.

The profile incorporates information from a variety of different national and local sources to:

- illustrate the demography of the area
- summarise key aspects of health
- assess variations in health needs between GP practices in the locality
- benchmark Wokingham CCG against national figures and other CCGs

1.1 **What’s new in the 2017 Locality Profile?**

The first CCG Locality Profile was published in July 2013, as part of Public Health’s core offer to CCGs. This has been developed further, based on feedback from the 7 CCGs and the Local Authority Public Health Teams in Berkshire. The data included in this Profile is the latest publicly available in December 2017. Unfortunately the publication of several key CCG Outcomes Indicators was delayed by NHS England, as the methodology for these is currently under review. This means that data around mortality and Potential Years of Life Lost (PYLL) could not be updated for the Locality Profiles.

This Profile uses national and comparator group data to provide a benchmark for Wokingham CCG, The ‘similar CCGs’ comparator group has been taken from the Commissioning for Value model, which uses a variety of population, health and deprivation indices to identify the 10 CCGs that are most similar to Wokingham CCG. The full data and methodology used to calculate ‘similar CCGs’ is available on the NHS RightCare website.

Wokingham CCG’s ‘10 most similar CCGs’ benchmarking group includes Bracknell & Ascot CCG, Surrey Heath CCG, North East Hampshire & Farnham CCG, Surrey Downs CCG, North Hampshire CCG, Horsham and Mid Sussex CCG, East Surrey CCG, South Gloucestershire CCG, Windsor, Ascot and Maidenhead CCG and Chiltern CCG.
1.2 Who is included in the Wokingham CCG profile?

This profile will include information about people who are:

- **Registered** with one of the 13 GP practices who belong to the CCG group (164,002 people at 1st October 2017)
  - Brookside Group Practice
  - New Wokingham Road Surgery
  - Wargrave Surgery
  - Woosehill Surgery
  - Burma Hills Surgery
  - Parkside Family Practice
  - Wilderness Road Surgery
  - Finchampstead Surgery
  - Swallowfield Medical Practice
  - Wokingham Medical Centre
  - Loddon Vale Practice
  - Twyford Surgery
  - Woodley Centre Surgery

- **Resident** within the Wokingham CCG boundary (approximately 161,878 people from 2016 mid-year estimates)
  - This resident group includes everyone who lives in the Wokingham Borough Council boundary.

A large proportion of people will be included in both the ‘registered’ and ‘resident’ population groups, as shown in the diagram to the right. However, there will be a number of people who live inside the geographical boundary covered by the CCG who are not registered to a Wokingham GP, as well as those who are registered with a Wokingham GP who are not resident in the area.

Wherever possible the ‘registered’ population information will be used in this profile, as this will directly link to the people who are being supported by Wokingham CCG. However, some information may not be available at this level, so the resident population will be used instead. Each data source and table/chart included in this profile will be clearly labelled to show what population group is being used.
2. **Summary**

**Population**
- The resident population is 161,878 and the registered population is 164,002.
- The population profile differs from the national picture with a larger proportion of children aged 5 to 14, but smaller proportion of younger adults (aged 20 to 34). There is also a larger proportion of adults aged 35 to 54 in comparison to England and Wales.
- The CCG’s resident population is estimated to increase to 183,600 people by 2039, which is a 15% percentage increase. The most significant population change is in older adults aged 85 and over.
- The most deprived areas are in parts of Wokingham Without and Norreys wards. However, there are no LSOAs in the CCG boundary that are in the 20% most deprived in Berkshire or in England.

**Life expectancy at birth**
- Life expectancy at birth for men is 81.6 years, which is significantly better than the national figure of 79.2 years
- Life expectancy at birth for women is 84.5 years, which is significantly better than the national figure of 83.0 years.

**Health Behaviour**
- Smoking: 8.8% of Wokingham adult residents are estimated to smoke, which is significantly better than the national rate of 15.5%.
- Obesity and being overweight: 6.6% of people aged 18 and over are estimated to be obese in the CCG, which is lower than the national prevalence rate. The proportion of the population estimated to be overweight or obese in Wokingham is significantly lower than the national prevalence at 53%.
- Physical inactivity: 18.3% of Wokingham’s residents aged 16 and over are ‘physically inactive’, which is a lower rate than the national figure.
- Alcohol: Estimates for Wokingham CCG indicate that 22,856 people are drinking above the recommended levels. The alcohol-related hospital admissions in Wokingham are lower than the national figure.

**Children & Young People**
- 24% of the CCG’s total registered population are under 19.
- There were 1,787 live births in the CCG in 2015.
- 2 CCG Outcome Framework indicators measure emergency hospital admissions for children. The CCG has a lower rate for both of these compared to the national average (2344 emergency admissions per 100,000 population for lower respiratory tract infection in 2016/17; 158 unplanned admissions per 100,000 population for asthma, diabetes and epilepsy in 2016/17).
- 1,021 pre-school children (aged 2 to 5) and 1,710 children school-age children (aged 5-16) are estimated to have a mental health disorder.
- 955 young people (aged 16 to 19) are estimated to have a neurotic disorder.
Adult Profile

- The prevalence of cardiovascular diseases, cancer, respiratory diseases, diabetes, chronic kidney disease, mental health disorders and dementia is lower than the national prevalence rates and comparator CCG group. The prevalence of depression is higher.

- 3 CCG Outcome Framework indicators measure emergency hospital admissions for the whole population. The CCG’s rate of emergency admissions for acute conditions that should not require admission was significantly better than the nation and comparator group rates in 2016/17. Unplanned admissions for chronic ambulatory care sensitive conditions and emergency admissions for alcohol-related liver disease were similar to the comparator group.

- The CCG had 7,658 potential years of life lost (PYLL) considered amenable to healthcare on 2012-14. This is a rate of 1,567 PYLL per 100,000 registered population, which is significantly lower than the national rate.

- Neoplasms are the main cause of PYLL in the CCG at 39.0% in 2012-14.

- In 2015, 1,184 people died in the CCG, which was a rate of 867 per 100,000 population. This was significantly lower than the national rate of 1,001 per 100,000 population. Cancer was the main cause of death for all age groups, apart from those aged 85 and over.

- In 2015, 45% of people who died in the CCG were in hospital and 24% died at home. 46% of people died in their Usual Place of Residence in the CCG, such as their own home, care home or religious establishment.

Patient Satisfaction (GP Patient Survey 2016/17)

- Accessing GP Services – the 2016/17 GP Survey showed that 88% of respondents found their GP surgery receptionist helpful and 68% found it easy to get through on the telephone. These scores were both similar to the comparator group and national averages. 65% of respondents saw their preferred GP always, almost always or a lot of the time, which was the highest level in the comparator group.

- Making an appointment – 83% of the CCG’s respondents found the overall experience of making an appointment good at their GP surgery, which was similar to the comparator group and national averages. This was also a significant improvement on the previous years.

- GP/Nurse appointment – The CCG’s respondents gave similar ratings for their last GP and nurse appointment, compared to the national and comparator group averages. The only exception to this was the rating of GPs explaining tests and treatments, which was the lowest rating in the comparator group at 78%. This was also a significant decrease on the previous year’s figure.

- Opening Hours – 76% of respondents were satisfied with their GP opening hours and 75% also thought that their GP Surgery was open at times that were convenient. The majority of patients that did not find their GP Surgery opening hours convenient said that they would find Saturday (74%) or after 6:30pm appointments (72%) easier.

- Overall Experience – 85% of patients stated that their overall experience of their GP surgery was very good/ good in the CCG, which was similar to the comparator group.

- Out of Hours - 67% of respondents rated their overall experience of out-of-hours GP services as good, which is similar to the comparator group and significantly better than the national figures.
3. **Place**

3.1 **Population profile**

The 2016 mid-year estimates indicate that the resident population for the Wokingham CCG locality was 161,878. The latest registered population figure for Wokingham CCG was higher at 164,002. This discrepancy will be made up of people who live outside of the CCG boundary and also a percentage of people on GP patient lists that no longer live in the area. Figure 1 shows the registered population profile of Wokingham CCG compared with the national profile. The population profile differs from the national picture with a larger proportion of children aged 5 to 14, but smaller proportion of younger adults (aged 20 to 34). There is also a larger proportion of adults aged 35 to 54 in comparison to England and Wales.

*Figure 1: Registered population pyramid for Wokingham CCG compared with England and Wales at 1-Oct-17*

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Male</th>
<th>Female</th>
<th>People</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>4,856</td>
<td>4,547</td>
<td>9,403</td>
</tr>
<tr>
<td>5-9</td>
<td>5,753</td>
<td>5,480</td>
<td>11,233</td>
</tr>
<tr>
<td>10-14</td>
<td>5,326</td>
<td>5,008</td>
<td>10,334</td>
</tr>
<tr>
<td>15-19</td>
<td>4,581</td>
<td>4,187</td>
<td>8,768</td>
</tr>
<tr>
<td>20-24</td>
<td>3,773</td>
<td>3,817</td>
<td>7,591</td>
</tr>
<tr>
<td>25-29</td>
<td>4,439</td>
<td>4,467</td>
<td>8,906</td>
</tr>
<tr>
<td>30-34</td>
<td>4,674</td>
<td>5,054</td>
<td>9,728</td>
</tr>
<tr>
<td>35-39</td>
<td>5,759</td>
<td>6,100</td>
<td>11,859</td>
</tr>
<tr>
<td>40-44</td>
<td>6,361</td>
<td>6,155</td>
<td>12,516</td>
</tr>
<tr>
<td>45-49</td>
<td>6,618</td>
<td>6,273</td>
<td>12,891</td>
</tr>
<tr>
<td>50-54</td>
<td>6,364</td>
<td>6,159</td>
<td>12,523</td>
</tr>
<tr>
<td>55-59</td>
<td>5,572</td>
<td>5,298</td>
<td>10,870</td>
</tr>
<tr>
<td>60-64</td>
<td>4,422</td>
<td>4,299</td>
<td>8,721</td>
</tr>
<tr>
<td>65-69</td>
<td>3,871</td>
<td>4,245</td>
<td>8,116</td>
</tr>
<tr>
<td>70-74</td>
<td>3,627</td>
<td>4,010</td>
<td>7,637</td>
</tr>
<tr>
<td>75-79</td>
<td>2,418</td>
<td>2,782</td>
<td>5,200</td>
</tr>
<tr>
<td>80-84</td>
<td>1,777</td>
<td>2,187</td>
<td>3,964</td>
</tr>
<tr>
<td>85-89</td>
<td>1,012</td>
<td>1,460</td>
<td>2,472</td>
</tr>
<tr>
<td>90-94</td>
<td>326</td>
<td>650</td>
<td>976</td>
</tr>
<tr>
<td>95+</td>
<td>73</td>
<td>221</td>
<td>294</td>
</tr>
<tr>
<td>Total</td>
<td>81,602</td>
<td>82,400</td>
<td>164,002</td>
</tr>
</tbody>
</table>

*Source: NHS Digital (November 2017)*
Figure 2: Registered population by GP practice at 1-Oct-17 with an age group breakdown

Source: NHS Digital (November 2017)
3.11 Population projection

The Office for National Statistics has produced population projections for people resident in CCG boundaries. These are trend-based projections, which use previous year’s births, deaths and migration figures to estimate how the population will change in the next 25 years. The figures based on the 2014 mid-year population estimates indicate that Wokingham CCG’s resident population will increase to 183,600 people by 2039, which is a 15% percentage increase. Figure 3 shows this population change by age group and shows that the most significant population change is in older adults aged 85 and over.

Figure 3: Percentage change in Wokingham CCG’s resident population 2014 to 2039 by age group

<table>
<thead>
<tr>
<th>Age Group</th>
<th>2014</th>
<th>2019</th>
<th>2024</th>
<th>2029</th>
<th>2034</th>
<th>2039</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 18</td>
<td>38,600</td>
<td>40,660</td>
<td>42,220</td>
<td>42,460</td>
<td>42,020</td>
<td>41,800</td>
</tr>
<tr>
<td>18 to 64</td>
<td>93,600</td>
<td>95,240</td>
<td>95,980</td>
<td>95,740</td>
<td>95,780</td>
<td>96,100</td>
</tr>
<tr>
<td>65 to 84</td>
<td>23,800</td>
<td>26,100</td>
<td>28,400</td>
<td>31,500</td>
<td>33,600</td>
<td>35,900</td>
</tr>
<tr>
<td>85 and over</td>
<td>3,400</td>
<td>4,200</td>
<td>5,400</td>
<td>6,500</td>
<td>8,700</td>
<td>9,800</td>
</tr>
<tr>
<td>All ages</td>
<td>159,400</td>
<td>166,200</td>
<td>172,000</td>
<td>176,200</td>
<td>180,100</td>
<td>183,600</td>
</tr>
</tbody>
</table>

Estimated population change

<table>
<thead>
<tr>
<th>Age Group</th>
<th>2014</th>
<th>2019</th>
<th>2024</th>
<th>2029</th>
<th>2034</th>
<th>2039</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 18</td>
<td>-</td>
<td>5.3%</td>
<td>9.4%</td>
<td>10.0%</td>
<td>8.9%</td>
<td>8.3%</td>
</tr>
<tr>
<td>18 to 64</td>
<td>-</td>
<td>1.8%</td>
<td>2.5%</td>
<td>2.3%</td>
<td>2.3%</td>
<td>2.7%</td>
</tr>
<tr>
<td>65 to 84</td>
<td>-</td>
<td>9.7%</td>
<td>19.3%</td>
<td>32.4%</td>
<td>41.2%</td>
<td>50.8%</td>
</tr>
<tr>
<td>85 and over</td>
<td>-</td>
<td>23.5%</td>
<td>58.8%</td>
<td>91.2%</td>
<td>155.9%</td>
<td>188.2%</td>
</tr>
<tr>
<td>All ages</td>
<td>-</td>
<td>4.3%</td>
<td>8.1%</td>
<td>10.9%</td>
<td>13.2%</td>
<td>15.4%</td>
</tr>
</tbody>
</table>

Source: Office for National Statistics (May 2016)
3.2 Demography profile

Most of the demographic data included in the 2013 CCG Locality Profile has not been updated, as this came from the 2011 Census. This page provides a summary of the key demographic details from 2011.

- 11.6% of population from Black and Minority Ethnic (BME) background
- 4.8% of population from a White non-British background
- 9% of the population are carers (13,902 people)
- 1.5% of population provide over 50 hours of unpaid care a week.
- 857 people cannot speak English well or at all
- 60,332 households in CCG boundary
- 23% are occupied by people who live alone.
- 26% of people aged 65 and over live on their own
- 7,325 people feel that their day to day activities are limited a lot by their health (4.9% population)
- 3,394 people say that they have a bad state of health (2.2% population)
- 963 people say that they have a very bad state of health (0.6% population)
- 655 people cannot speak English well or at all
- 3,394 people say that they have a bad state of health (2.2% population)
- 70% of population are in employment (aged 16-74)
- 1.6% of population are not in employment due to being long-term sick or disabled (1,742 people)
- 70% of population are in employment (aged 16-74)
- 1.6% of population are not in employment due to being long-term sick or disabled (1,742 people)
- 35% of unemployed people are 'long term unemployed'
- 70% of population are in employment (aged 16-74)
- 1.6% of population are not in employment due to being long-term sick or disabled (1,742 people)
- 35% of unemployed people are 'long term unemployed'
3.21 Employment and benefits

The Office for National Statistics and the Department for Work and Pensions publish employment and benefit claimant information at a local authority level. The information included in this profile focuses on working aged people (aged 16 to 64) in Wokingham Borough.

From July 2016 to June 2017, 80% of people aged 16 to 64 in Wokingham Borough were in employment. This compares to 78% in the South East. Figure 4 shows the economic status for working aged people not in employment.

**Figure 4: Economic status of working aged people not in employment (July 2016 to June 2017)**

![Economic status chart]

Source: Office for National Statistics (2017)

3.2% of the South East's total working age population were long-term sick from July 2016 to June 2017. The figure for Wokingham is unreported, as the numbers were too small to publish. Figure 5 shows how the number of people who are long-term sick has changed in Wokingham since 2004-2005. From July 2016 to June 2017, 6.1% of the economically inactive working age population in Wokingham were long-term sick.
In November 2016, 4.7% of Wokingham Borough’s working-age population were claiming benefits. 68% of claimants received an out of work benefit, such as Job Seekers, Employment Support Allowance/ Incapacity Benefit and Lone Parent Benefits. Figure 6 shows the types of benefits claimed in Wokingham Borough in November 2016.

The percentage of the working-aged population who receive Employment Support Allowance/ Incapacity Benefit has remained static over the last 8 years in Wokingham. Figure 7 shows that in November 2016, 2.3% of people in Wokingham received these benefits, which was lower than the South East figure of 4.4%.
**Figure 6: Type of benefits claimed by working-aged people not in employment (November 2016)**

- **Total Claimants**: 4,640
- **Job Seekers**: 440
- **ESA and Incapacity Benefits**: 2,270
- **Lone Parents**: 410
- **Others Income Related Benefits**: 50
- **Carers**: 720
- **Disabled**: 550
- **Bereaved**: 190

Source: Office for National Statistics (2017)

**Figure 7: Percentage of working-aged people receiving Employment Support Allowance/Incapacity Benefits (November 1999 to November 2016)**

Source: Office for National Statistics (2017)
3.3 Geodemographic classification profile

Geodemographic classification uses Census and lifestyle data to classify people by where they live. Wokingham CCG’s lifestyle distribution is shown in Figure 8, and uses classifications defined by Beacon Dodsworth. More information about these classifications can be found on their [website](http://www.beacondodsworth.com).

8 out of 14 primary classifications are represented within the CCG boundary.

52% of the CCG’s resident population are defined as Mature Oaks. These are generally middle-aged and older people, with many aged 45 to 64 and past retirement age. The majority are married couples with teenage children still living with them, or grown up children who have left home. These make up 12.7% of the UK population.

28% of the CCG’s resident population are defined as Blossoming Families, which is a significantly higher proportion than the national average. This group are mainly made up of families, often aged 25 to 54 who are either married or cohabiting. There are many infants and young children and some teenagers. These make up 8.3% of the UK population.

10% of the resident population are Qualified Metropolitans, which is also a significantly higher proportion than the national average. This group is mainly made up of young adults, aged 16 to 35 who are cohabiting and do not have children. A large number are students and there are some single person households. There is also a multicultural population. These make up 5.0% of the UK population.
3.4 Deprivation profile

The Index of Multiple Deprivation (IMD) combines a number of indicators to measure the level of deprivation in an area. These cover seven different domains, including crime, health and disability, employment, education, skills and training, barriers to housing and services and living environment. The IMD enables neighbourhoods, or Super Output Areas (LSOAs), to be ranked against each other according to their level of deprivation. Each LSOA covers a population of 1,000-3,000 people and an area with a higher IMD score will be more deprived than another. The IMD was updated in 2015, having previously been published in 2010.

The Wokingham CCG area is made up of 99 LSOAs. 82 (83%) of these are in the 20% least deprived areas in England and none of them are in the 20% most deprived nationally.

The most deprived areas in the CCG are neighbourhoods within Wokingham Without and Norreys wards. However, neither of these are in the 20% most deprived LSOAs in Berkshire. 78 (79%) of Wokingham CCG’s LSOAs are in the 20% least deprived areas in Berkshire.

Figure 9 shows the level of deprivation in Wokingham CCG. Areas of higher deprivation are shown in darker purple.
Health deprivation and disability indicators are included in the Index of Multiple Deprivation (IMD). This uses measures of premature death, morbidity, disability and the rate of adults suffering from mood and anxiety disorders to determine the levels of deprivation in an area.

The areas with the highest level of health and disability deprivation in Wokingham CCG include specific neighbourhoods in Wokingham Without and Loddon wards. However, these are both not in the 20% most health deprived areas in Berkshire or England. Almost 95% of the wards in Wokingham CCG are in the 20% least health deprived in England.
4. **Lifestyle and Health Behaviour**

Lifestyle and the personal choices that people make significantly impact on their health.

Modelling from the most recent Global Burden of Disease study (2015) showed that behavioural patterns contribute to approximately 40% of premature deaths in England. This is the largest contributor, above genetic predisposition (30%), social circumstances (15%) and healthcare (10%). While there are a large number of causes of death and ill-health, many of the risk factors for these are the same. Just under half of the disability adjusted life years (DALYs) lost in England are attributable to smoking, diet, high blood pressure, being overweight, alcohol and drug use. Figure 10 shows the 5 main risk factors for death and DALYs in South East England.

![Figure 10: Key risks attributed to deaths and DALYS in South East England (2013)](image)

*What is a Disability Adjusted Life Year (DALY)?*

Burden of disease can be measured by disability-adjusted life years (DALYs), which combine the years of life lost to premature mortality and those lived with disability, illness or injury.

While people are living longer, they are spending more years in ill health. **There is therefore an increase in DALY, which will impact on health and social care systems.**

The Government’s (2010) **Strategy for Public Health** states that “many lifestyle-driven health problems seen today are already at alarming levels”. Britain is the most obese nation in Europe; has amongst the worst rates of sexually-transmitted infections; a relatively large population of problem drug users; rising levels of harm from alcohol and approximately 20% of the adult population who still smoke.

While it’s clear that unhealthy behaviours, such as smoking and being overweight, increase the risk of dying prematurely and also impact on an individual’s quality of life, it is important to note that healthy behaviours, such as being physically active, can help to improve quality of life and also reduce the risks of dying prematurely.

This section of the Locality Profile looks at the impact of lifestyle and health behaviours in Wokingham CCG. Additional information about health behaviours in children and young people is included later on in the Profile (section 5.34).
4.1 Smoking

According to the National Institute for Health and Care Excellence (NICE), smoking is the single most important cause of preventable morbidity and premature death in England, as well as the primary reason for the gap in healthy life expectancy between rich and poor. The Global Burden of Disease (2015) showed that smoking was the biggest single cause of deaths and disability adjusted life years (DALYs) in South East England, at 15.6% and 9.1% respectively. A wide range of diseases and conditions are caused by smoking, such as cancers, respiratory diseases and cardiovascular diseases.

The Government’s latest Tobacco Control Plan for England was published in July 2017. This built on the 2013 Plan and set out a strategy to reduce smoking prevalence further, including a number of new targets to be achieved by 2022.

4.11 Smoking prevalence in adults

The Government aims to reduce smoking prevalence in adults from 15.5% in 2016 to 12% or less by 2022. The Annual Population Survey for 2016 indicated that Wokingham Borough’s prevalence rate was significantly better than the national rate at 8.8%.

The latest GP Patient Survey (2017) asked people to comment on their smoking habits. This survey was completed by 1,510 patients from Wokingham CCG. Figure 11 shows that 63% of people who responded to the survey in Wokingham CCG said that they never smoked, while 10% were either occasional or regular smokers.

*Figure 11: Smoking habits of people in Wokingham CCG compared with the national and comparator group*

Smoking is also included in the GP Quality and Outcomes Framework (QOF). In March 2017, 11.5% of people aged 15 and over registered with a Wokingham CCG GP Practice were recorded as current smokers. This was 15,146 people in total. Additional QOF information about smoking can be found in the condition specific sections of the Adult Profile chapter.

4.12 Smoking prevalence in pregnancy

The Government aims to reduce smoking prevalence in pregnancy to 6% or less by the end of 2022. In 2016/17, the percentage of women in England known to be smokers at the time of delivery was 10.5%, which was a reduction from 15.1% in 2006/07.

An indicator to monitor the percentage of women who are smokers at the time of delivery is included in the CCG Outcomes Indicator Set. This data has been reported since April 2013 and is published quarterly. Figure 12 shows that Wokingham CCG’s smoking prevalence is significantly better than the comparator group and national prevalence rates. Caution needs to be applied to this data, as it is based on self-reported information.

Wokingham CCG had 1,629 maternities in 2016/17. 62 of these mothers were smokers at the point of delivery, which is 3.8% of all maternities.

4.13 Smoking prevalence in 15-year-olds

The Government aims to reduce rates of regular smoking among 15 year olds from 8% in 2016 to 3% or less by the end of 2022. The What About YOUth (WAY) survey in 2014/15 provided this data at a local authority level and estimated that 4.9% of 15 year olds in Wokingham were current smokers, which was significantly better than the England figures of 8.2%. Additional data for smoking in young people is included in section 5.34 of this Profile - ‘Lifestyle and Health Behaviours in Children and Young People’.

Figure 12: CCG 1.14: Percentage of mothers who were smokers at the point of delivery (2013/14 Q1 – 2016/17 Q4)

Source: NHS Digital (2017)
4.14 Smoking prevalence for people with Mental Health problems

While the number of people smoking has decreased in the general population over the last 20 years, the prevalence for people with a mental health condition has remained constant at around 40%. A third of all tobacco now smoked in England is by someone with a mental health condition. The Tobacco Control Plan did not include a prevalence target for people suffering from mental health problems, although it did acknowledge that the smoking prevalence in this population was significantly higher than the general population.

In 2014/15, 31.2% (199) of people with a serious mental illness were recorded as smokers in Wokingham CCG. This is lower than the national rate of 41%, but a much higher prevalence rate than the CCG’s general population.
4.2 Being obese or overweight

Obesity is indicated when an individual’s Body Mass Index (BMI) is over 30. It increases the risk of heart disease, diabetes, stroke, depression, bone disease and joint problems and decreases life expectancy by up to nine years. The Global Burden of Disease (2015) showed that a high BMI attributed to 9% of deaths and disability adjusted life years in South East England and that this was the 2\textsuperscript{nd} biggest single cause of deaths and DALYs in the region.

Wokingham CCG has an obesity prevalence rate of 6.6\% in the registered population aged 18 and over. This is approximately 8,350 people. This prevalence rate is lower than both the comparator CCG average of 7.3\% and the national prevalence rate of 9.7\%.

\textit{Figure 13: Prevalence of Obesity at a GP Practice level in 2015/16 and 2016/17}

![Graph showing prevalence of obesity at different GP practices in 2015/16 and 2016/17.]

Source: NHS Digital (2017); Quality and Outcomes Framework

Adults with a Body Mass Index over 25 are defined as being overweight. Figures collected through the Active Lives Survey (2015/16) estimate that 61.3\% of adults living in England are overweight or obese. Wokingham Borough has a significantly lower proportion of adults with excess weight at 53.0\%. 
The National Child Measurement Programme (NCMP) measures the prevalence of obesity in 4-5 year olds (Reception) and 10-11 year olds (Year 6). Figure 14 shows that Wokingham Borough has a lower level of overweight and obese children than the England average for both age-groups.

Figure 14: Prevalence of Obesity and Overweight children (2016/17)

<table>
<thead>
<tr>
<th></th>
<th>Wokingham Prevalence</th>
<th>England Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reception (aged 4 to 5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overweight (including obesity)</td>
<td>18.0%</td>
<td>22.6%</td>
</tr>
<tr>
<td>Obesity</td>
<td>6.2%</td>
<td>9.6%</td>
</tr>
<tr>
<td>Year 6 (aged 10 to 11)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overweight (including obesity)</td>
<td>27.1%</td>
<td>34.2%</td>
</tr>
<tr>
<td>Obesity</td>
<td>14.3%</td>
<td>20.0%</td>
</tr>
</tbody>
</table>

Source: NHS Digital (2017); National Child Measurement Programme

3-year pooled figures have been published at a CCG level and show that children living within Wokingham CCG have lower levels of obesity and excess weight than the national average.

Figure 15: Prevalence of obesity and excess weight for children in Reception and Year 6 (2013/14 to 2015/16)

Source: Public Health England (2017); Child obesity and excess weight: small area level data
4.3 Physical Activity and Inactivity

People who have a physically active lifestyle have a 20-35% lower risk of cardiovascular disease, coronary heart disease and stroke compared to those with a sedentary lifestyle. Physical activity is also associated with improved mental health and wellbeing. In contrast, physical inactivity is directly accountable for 5% of deaths in South East England and is the fourth leading risk factor for global mortality.

The Active Lives Survey (2016/17) asked people how much physical activity they did. The results indicated that Wokingham has a higher proportion of physically active adults than the national average (doing at least 150 minutes of moderate physical activity per week), and a lower proportion or physically inactive adults (doing less than 30 minutes of moderate physical activity a week).

4.4 Diet

Unhealthy diet is attributable to 9.6% of the total disease burden in England. A diet rich in fruit and vegetables can help to protect against the development of heart disease and certain cancers. It is estimated that eating at least 5 portions of a variety of fruit and vegetables each day could reduce the risk of death from chronic diseases by up to 20%.

The Active Lives Survey (2015/16) asked people aged 16 and over about the amount of fruit and vegetables they ate the day before. 56.8% of people in England said that they ate the recommended '5 a day' and Wokingham’s figure was similar to the national average at 60.1%. In Wokingham, the average person ate 2.7 portions of fruit and 2.8 portions of vegetables.
4.5 Alcohol

Harmful drinking is a significant public health problem in the UK and is associated with a wide range of health problems, including brain damage, alcohol poisoning, chronic liver disease, breast cancer, skeletal muscle damage and poor mental health. Nearly 4% of all deaths and disability adjusted life years are attributed to alcohol in South East England. Alcohol can also play a role in accidents, acts of violence, criminal behaviour and other social problems.

The Alcohol Concern Alcohol Harm Map indicates that 20% of people in South East England drink at a level which increases the risk of damaging their health. Estimates for Wokingham CCG indicate that 22,856 people are drinking above the recommended levels, which will increase the risk of damaging their health. 6,786 of these are higher risk drinkers, who drink at a very heavy level which significantly increases the risk of damaging their health and may have already caused some harm to their health.

In 2015/16 there were nearly 340,000 alcohol-related hospital admissions in England, which equates to 647 admissions per 100,000 population. Wokingham’s admission rate was significantly better at 410 per 100,000 population. Wokingham’s rates have been consistently lower than the national average from 2008/09 to 2015/16, although they have slightly increased over this time.

More men have alcohol-related hospital admissions than women. In England, the rate for men was 830 per 100,000 compared to 483 per 100,000 for women. 58% of Wokingham’s admissions were for men in 2015/16. Wokingham’s rates were significantly better than England’s for men and women.

Additional information on the number of emergency admissions for alcohol-related liver disease is included in the Liver Disease section of the Adult Profile (6.62). More information can also be found in the Local Alcohol Profiles for England.
4.6 Sexual Health

Sexual health covers the provision of advice and services around contraception, relationships, sexually transmitted infections (STIs) and abortion. While sexual relationships are essentially a private matter, good sexual health is important to individuals and to society as a whole. Public Health England (2015) state that the success of sexual and reproductive health services “depends on the whole system working together to make these services as responsive, relevant and as easy to use as possible and ultimately to improve the public’s health”.

Public Health England’s Sexual and Reproductive Health Profiles provide detailed information at a Local Authority level. The key indicators for Wokingham are shown at Figure 18.

**Figure 18: Key indicators of Sexual and Reproductive Health**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Latest data</th>
<th>Wokingham</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Syphilis diagnosis rate per 100,000 population</td>
<td>2016</td>
<td>4 2.5</td>
<td>Significantly better</td>
</tr>
<tr>
<td>Gonorrhoea diagnosis rate per 100,000 population</td>
<td>2016</td>
<td>38 23.7</td>
<td>Significantly better</td>
</tr>
<tr>
<td>Chlamydia detection rate per 100,000 population aged 15-24</td>
<td>2016</td>
<td>141 854</td>
<td>Significantly worse</td>
</tr>
<tr>
<td>Proportion of 15-24 year olds screened for chlamydia</td>
<td>2016</td>
<td>2,501 15.1%</td>
<td>Significantly worse</td>
</tr>
<tr>
<td>All new STI diagnoses (exc. chlamydia) per 100,000 population</td>
<td>2016</td>
<td>497 490</td>
<td>Significantly better</td>
</tr>
<tr>
<td>HIV testing coverage</td>
<td>2016</td>
<td>2,664 67.8%</td>
<td>Similar</td>
</tr>
<tr>
<td>HIV late diagnoses</td>
<td>2014-16</td>
<td>5 38.5%</td>
<td>Similar</td>
</tr>
<tr>
<td>New HIV diagnosis rate per 100,000 population aged 15+</td>
<td>2016</td>
<td>4 3.1</td>
<td>Significantly better</td>
</tr>
<tr>
<td>HIV diagnoses prevalence rate per 1,000 aged 15-59</td>
<td>2016</td>
<td>102 1.10</td>
<td>Significantly better</td>
</tr>
<tr>
<td>HPV vaccination coverage - % of girls aged 12-13 who have received 1 dose of vaccine</td>
<td>2015/16</td>
<td>835 91.0%</td>
<td>Significantly better</td>
</tr>
</tbody>
</table>
### Indicator

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Latest data</th>
<th>Wokingham</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortions - % of abortions under 10 weeks</td>
<td>2016</td>
<td>323</td>
<td>85.0%</td>
</tr>
<tr>
<td>Abortions - % of repeat abortions in under 25s</td>
<td>2016</td>
<td>36</td>
<td>24.3%</td>
</tr>
<tr>
<td>Total prescribed long acting reversible contraception (LARC) per 1,000 population</td>
<td>2016</td>
<td>1,082</td>
<td>37.3</td>
</tr>
</tbody>
</table>


Additional information on teenage pregnancy and chlamydia screening is also included in the Young People’s Sexual Health section of this Profile (5.345).
5. **Child & Young People Health Profile**

In October 2017, Wokingham CCG had 39,738 registered patients aged under 19. This is 24% of the CCG's total registered population. The CCG’s population profile (Figure 1) shows a higher percentage of children and young people (aged 5 to 14) compared to the national picture.

This section of the Locality Profile focuses on the health of children and young people in Wokingham CCG, from conception to adulthood. Data is shown at a CCG level where available, but is also supplemented with Local Authority data to provide a more detailed picture on the wider factors impacting on children’s health in the CCG.

Additional information about Children and Young People’s Health can be found on a number of different Public Health England Profiles, such as the [Child and Maternal Health Fingertips Profile](#) and [Child and Maternal Health Intelligence Network](#).

### 5.1 Maternity and Birth

#### 5.11 Birth and fertility rates

In 2015 there were 1,787 live births in Wokingham CCG, which is a general fertility rate of 61.4 per 1,000 female population (aged 15 to 44). This is similar to the national rate of 62.5. In the same year, there were 10 stillbirths in Wokingham CCG, which was 0.56% of all births. Nationally, 0.44% of births were still births.

28% of births to Wokingham CCG mothers were delivered by caesarean section in 2015/16. This was similar to the national proportion of 27%. 14.6% of deliveries were to mothers from Black and Minority Ethnic groups and 32.4% were to women aged 35 and over.

#### 5.12 Low birth weight

A baby is defined as being a low birth weight if they are under 2,500g and a gestational age of at least 37 complete weeks. Low birth weight increases the risk of childhood mortality, developmental problems in childhood and also indicates a risk of poorer health in later life. In 2015, 2.8% of term babies born in England had a low birth weight. Wokingham CCG’s percentage of low birth weight babies was lower at 1.7% (27 babies).
5.13 Infant mortality (deaths in infants under 1 year)

Infant mortality rates reflect the health and care of mothers and newborns, as well as being an indicator of the general health of an entire population. Rates of infant mortality are higher in areas of greater deprivation and the Government’s Public Health Strategy (2010) aims to reduce this gap.

From 2014-16, 20 infants aged under 1 who were resident in Wokingham CCG died.

Figure 19 shows the infant mortality rate in Wokingham since 2001. In 2014-16, the rate of infant mortality for Wokingham was 3.7 per 1,000 live births, which was similar to the national rate of 3.9.

Figure 19: Rate of deaths in infants aged under 1 year in Wokingham and England (2001-03 to 2014-16)

5.14 Breastfeeding

Breastfeeding has health benefits for both mother and baby. Babies who are breast-fed experience lower levels of gastrointestinal and respiratory infection and evidence also suggests that they will have lower levels of child obesity. Benefits for mothers include reduced risk of breast and ovarian cancer, as well as a faster return to pre-pregnancy weight. Current national and international guidance recommends exclusive breastfeeding for newborns for at least six months.

Breastfeeding rates are measured at 48 hours after birth (initiation) and 6-8 weeks after birth (prevalence).

In 2016/17, 44.4% of infants were totally or partially breastfed at 6-8 weeks in England. Figure 20 provides a breakdown of breastfeeding prevalence and shows that Wokingham's breastfeeding prevalence rate is higher than England’s.

(This indicator has now been retired from the CCG Outcomes Indicator Set, as it is collected at a local authority level through Public Health England.)
5.2 Children and Young People with long-term conditions

This section of the Child and Young People Health Profile focuses on children with long-term conditions. The information included looks at the local prevalence of specific conditions in childhood and hospital activity for these conditions. A more detailed analysis of long-term conditions and diseases is included in the Adult Profile, including risk factors for disease and local GP management of long term conditions.

5.21 Respiratory disease

5.21.1 Prevalence

The Quality and Outcomes Framework (QOF) uses GP Registers to estimate the prevalence of disease or long-term conditions for adults. Prevalence of disease for children is not included in the QOF, so national models need to be used to estimate the level of disease in local child populations. These agreed disease prevalence models have been taken from Public Health England, but it is important to note that they do not take local demographics or deprivation levels into account and can only be a guide to the level of childhood disease in a local area.

Asthma

6.3% of Wokingham CCG’s population have asthma recorded on a GP register (QOF 2016/17). Modelled estimates indicate that 10.9% of under 19s in the CCG have asthma, which is approximately 4,313 children. Figure 21 provides a breakdown by age and sex.

Figure 21: Modelled prevalence of asthma in Wokingham CCG based on October 2017 registered population

<table>
<thead>
<tr>
<th></th>
<th>Aged 0-4</th>
<th>Aged 5-9</th>
<th>Aged 10-14</th>
<th>Aged 15-19</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boys</td>
<td>448</td>
<td>801</td>
<td>742</td>
<td>416</td>
<td>2,408</td>
</tr>
<tr>
<td>Girls</td>
<td>257</td>
<td>621</td>
<td>567</td>
<td>461</td>
<td>1,906</td>
</tr>
<tr>
<td>Total</td>
<td>705</td>
<td>1,422</td>
<td>1,309</td>
<td>877</td>
<td>4,313</td>
</tr>
</tbody>
</table>

Source: Public Health England disease prevalence models; Modelled on NHS Digital (2017) registered population figures
Chronic Obstructive Pulmonary Disease (COPD)

1.0% of Wokingham CCG’s population have COPD recorded on a GP register, although 2.4% are actually estimated to have the condition (QOF 2016/17). Modelled estimates indicate that 0.41% of under 19s in the CCG have COPD, which is approximately 164 children. Figure 22 provides a breakdown by age and sex.

Figure 22: Modelled prevalence of COPD in Wokingham CCG based on October 2017 registered population

<table>
<thead>
<tr>
<th></th>
<th>Aged 0-4</th>
<th>Aged 5-9</th>
<th>Aged 10-14</th>
<th>Aged 15-19</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boys</td>
<td>53</td>
<td>12</td>
<td>11</td>
<td>14</td>
<td>89</td>
</tr>
<tr>
<td>Girls</td>
<td>41</td>
<td>11</td>
<td>10</td>
<td>13</td>
<td>74</td>
</tr>
<tr>
<td>Total</td>
<td>94</td>
<td>22</td>
<td>21</td>
<td>26</td>
<td>164</td>
</tr>
</tbody>
</table>

Source: Public Health England disease prevalence models; Modelled on NHS Digital (2017) registered population figures

5.212 Hospital admissions

In 2015/16, Wokingham CCG had 64 emergency admissions for asthma in under 19 year olds at a rate of 173 per 100,000 population. Figure 23 shows the trend for emergency admissions over the last seven years. Wokingham CCG’s admission rate has increased over the last two years and is now similar to the national rate.

Figure 23: Emergency admissions for asthma in under 19 year olds in Wokingham CCG (2009/10-2015/16)

Source: Public Health England (2017); Child Health Profiles
The rate of emergency admissions for children with lower respiratory tract infection is included in both the CCG and NHS Outcome Frameworks. In 2016/17, there were 112 emergency admissions in Wokingham CCG, which was a rate of 344 per 100,000 population. The CCG’s rate continued to be significantly lower than the national rate.

**Figure 24: Emergency admissions for children with lower respiratory tract infection in Wokingham CCG – all persons (2010/11-2015/16)**

![Graph showing emergency admissions for children with lower respiratory tract infection in Wokingham CCG – all persons (2010/11-2015/16)](source: NHS Digital (2017))

**Figure 25: Emergency admissions for children with lower respiratory tract infection in Wokingham CCG – male and female (2010/11-2016/17)**

![Graph showing emergency admissions for children with lower respiratory tract infection in Wokingham CCG – male and female (2010/11-2016/17)](source: NHS Digital (2017))
5.22 Epilepsy

5.221 Prevalence

Approximately 0.7% of adults in Wokingham CCG have epilepsy (QOF 2016/17). Modelled estimates indicate that 0.41% of under 19s in the CCG have epilepsy, which is approximately 164 children. Figure 26 provides a breakdown by age and sex.

**Figure 26: Modelled prevalence of epilepsy in Wokingham CCG based on October 2017 registered population (rounded)**

<table>
<thead>
<tr>
<th>Aged</th>
<th>Aged</th>
<th>Aged</th>
<th>Aged</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0-4</td>
<td>5-9</td>
<td>10-14</td>
<td>15-19</td>
</tr>
<tr>
<td>Boys</td>
<td>9</td>
<td>25</td>
<td>23</td>
<td>28</td>
</tr>
<tr>
<td>Girls</td>
<td>8</td>
<td>22</td>
<td>21</td>
<td>27</td>
</tr>
<tr>
<td>Total</td>
<td>17</td>
<td>48</td>
<td>44</td>
<td>55</td>
</tr>
</tbody>
</table>

Source: Public Health England disease prevalence models; Modelled on NHS Digital (2017) registered population figures

5.222 Hospital admissions

In 2014/15, Wokingham CCG had 137 emergency admissions for epilepsy in under 19 year olds. This was a rate of 47 per 100,000 population, compared to 75 per 100,000 population nationally. Figure 27 shows the trend for emergency admissions over the last six years.

**Figure 27: Emergency admissions for epilepsy in under 19 year olds in Wokingham CCG (2009/10-2014/15)**

Source: Public Health England (2017); Child Health Profiles
5.23 Diabetes

5.23.1 Prevalence

Approximately 7.3% of adults in Wokingham CCG have diabetes, although only 4.9% are actually diagnosed with the condition (QOF 2016/17). Modelled estimates indicate that 0.34% of under 19s in the CCG have diabetes, which is approximately 135 children. Figure 28 provides a breakdown by age and sex.

**Figure 28: Modelled prevalence of diabetes in Wokingham CCG based on October 2017 registered population**

<table>
<thead>
<tr>
<th></th>
<th>Aged 0-4</th>
<th>Aged 5-9</th>
<th>Aged 10-14</th>
<th>Aged 15-19</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boys</td>
<td>17</td>
<td>20</td>
<td>18</td>
<td>16</td>
<td>70</td>
</tr>
<tr>
<td>Girls</td>
<td>15</td>
<td>19</td>
<td>17</td>
<td>14</td>
<td>65</td>
</tr>
<tr>
<td>Total</td>
<td>32</td>
<td>38</td>
<td>35</td>
<td>30</td>
<td>135</td>
</tr>
</tbody>
</table>

Source: Public Health England disease prevalence models; Modelled on NHS Digital (2017) registered population figures

5.23.2 Hospital admissions

In 2014/15, Wokingham CCG had 13 emergency admissions for diabetes in under 19 year olds. This was a rate of 36 per 100,000 population, compared to 56 per 100,000 in England. Figure 29 shows the trend for emergency admissions over the last six years.

**Figure 29: Emergency admissions for diabetes in under 19 year olds in Wokingham CCG (2009/10-2014/15)**

Source: Public Health England (2017); Child Health Profiles
5.24 Unplanned hospitalisation for asthma, diabetes and epilepsy

The CCG Outcomes Indicator Set includes five indicators that focus on emergency admission to hospital. This section has already included an analysis of CCG Indicator 3.4, which looks at the rate of admissions for lower respiratory tract infection in under 19s. An additional indicator for under 19s combines unplanned admissions for asthma, diabetes and epilepsy.

In 2016/17, Wokingham CCG had 60 unplanned admissions for under 19s at a rate of 158 per 100,000 population. This has remained below the England figure, as shown in Figure 30.

Figure 30: Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s - all persons (2010/11-2016/17)

Source: NHS Digital (2017)

50% of the unplanned admissions in Wokingham CCG were for males from 2010/11 to 2016/17.
5.3 Health of all children and young people

5.31 General indicators of health and healthcare

5.311 Child mortality (aged 1 to 17 years)

The rate of child mortality is low in Wokingham CCG with 8 deaths recorded for residents of the CCG in the last 3-years (2014-16).

5.312 Tooth decay

In 2014/15, 25% of 5-year-old children had observable dental decay in England despite this being a predominately preventable disease. In Wokingham, 14.8% of 5-year-olds had dental decay, which was significantly better than the England figure.

Children aged 1 to 4 years old in Wokingham CCG did not have any hospital admissions for dental caries from 2013/14 to 2015/16.

5.313 A&E attendances

In 2015/16, 25% of all A&E attendances in England were for children and young people aged 18 and under. This was a higher percentage than those aged 65 and over (NHS Digital 2017). A&E attendances for children, specifically those aged under 5, are commonly caused by accidental injury or by minor illnesses. The Royal College of Paediatrics and Child Health (2014) estimated that up to 16% of children who arrive in A&E could have attended primary care, or other forms of healthcare outside of the hospital. However, it is important to note that unintentional injuries do form a major burden of disease in children and young people and are a major cause of inequality. Unintentional injuries in and around the home are also a leading reason for preventable death in children under five years and are a major cause of ill health and serious disability.

There were 14,615 A&E attendances for children and young people aged 0 to 19 years old in Wokingham CCG in 2015/16. This was a rate of 378 per 1,000 population, which was similar to the national rate of 408 per 1,000 population. Figure 31 shows that Wokingham CCG’s admission rate has increased over the last five years.

Figures 31 to 33 provide more detailed information on Wokingham CCG’s A&E attendances for children and young people.
Figure 31: A&E attendances for children and young people per 1,000 population (2010/11-2015/16)

Source: Public Health England (2017); Child Health Profile

Figure 32 shows the rate of A&E attendances for each 5-year age group for children and young people in 2015/16. Wokingham CCG’s rates were significantly lower than the national rates for children aged 5 and over, however admission rates for those aged 0-4 were similar.

Figure 33 shows that 40% of all A&E attendances for children and young people in Wokingham CCG were for those aged under 5. The remaining 60% were evenly spread between the other 3 age groups (5-9 year olds, 10-14 year olds and 15-19 year olds.

Source: Public Health England (2017); Child Health Profile
5.314 Hospital admissions

In 2015/16, there were 3,242 hospital admissions for children and young people in Wokingham CCG. 63% (2,051) of these were emergency admissions. The rate of emergency admissions in Wokingham CCG remained significantly lower than England’s in 2015/16 at 53 per 1,000 population, compared to 74 per 1,000 population nationally. 52% of the emergency admissions in Wokingham CCG were for children aged under 5.

Figure 34: Emergency hospital admissions for children and young people per 1,000 population (2010/11-2015/16)

![Graph showing emergency hospital admissions from 2010/11 to 2015/16 in Wokingham CCG, Comparator CCGs, and England.](image)

Source: Public Health England (2017); Child Health Profile

447 of Wokingham CCG’s emergency hospital admissions for children and young people (aged 0 to 24) in 2015/16 were due to unintentional or deliberate injury. Figure 36 shows that the rates of hospital admissions for injury in the CCG were lower than the national rates for children aged 0-14 years old, and were similar for those aged 15 to 24. These indicators are monitored in Public Health England’s [Child Health Profile](#).
In 2015/16, there were 1,191 elective hospital admissions for children and young people in Wokingham CCG. This was a rate of 31 per 1,000 population, compared to 49 per 1,000 population nationally.
5.32 Wider determinants of health for Children and Young People

The Public Health Outcomes Framework and Child Health Profile include a number of indicators that do not directly measure the health of children and young people, but focus on aspects of life that could impact on their health. These wider determinants of health are measured at a local authority level and the latest information for Wokingham Borough Council has been included at Figure 39.

**Figure 39: Wider determinants of health for Children and Young People**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Latest data</th>
<th>Wokingham</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children in low income families (under 16s)</td>
<td>2014</td>
<td>2,065</td>
<td>7.0%</td>
</tr>
<tr>
<td>Family homelessness - statutory homeless households with dependent children or pregnant women per 1,000 households</td>
<td>2016/17</td>
<td>89</td>
<td>1.4%</td>
</tr>
<tr>
<td>Children in care per 10,000 population</td>
<td>2017</td>
<td>75</td>
<td>20%</td>
</tr>
<tr>
<td>Children achieving a good level of development at the end of reception</td>
<td>2016/17</td>
<td>1,735</td>
<td>76.2%</td>
</tr>
<tr>
<td>Children with free school meal status achieving a good level of development at end of reception</td>
<td>2016/17</td>
<td>57</td>
<td>52.3%</td>
</tr>
<tr>
<td>Year 1 pupils achieving the expected level in the phonics screening check</td>
<td>2016/17</td>
<td>1,808</td>
<td>82.8%</td>
</tr>
<tr>
<td>Year 1 pupils with free school meal status achieving the expected level in the phonics screening check</td>
<td>2016/17</td>
<td>57</td>
<td>58.8%</td>
</tr>
<tr>
<td>GCSE results (% achieving 5A*-C inc. English and Maths)</td>
<td>2015/16</td>
<td>1,160</td>
<td>70.9%</td>
</tr>
<tr>
<td>Pupil absence</td>
<td>2015/16</td>
<td>4.10%</td>
<td>4.57%</td>
</tr>
<tr>
<td>First time entrants to the youth justice system per 100,000 population</td>
<td>2016</td>
<td>33</td>
<td>205</td>
</tr>
<tr>
<td>16-17 year olds not in education, employment or training or whose activity is not known</td>
<td>2016</td>
<td>140</td>
<td>4.4%</td>
</tr>
<tr>
<td>Children killed or seriously injured in road traffic accidents per 100,000 population</td>
<td>2014-16</td>
<td>16</td>
<td>16.0%</td>
</tr>
</tbody>
</table>

*Source: Public Health England (2017); Public Health Outcomes Framework and Child Health Profile*
5.33 Mental Health and Wellbeing

5.33.1 Prevalence of mental health disorders

The Child and Maternal Health Intelligence Network (CHIMAT) has produced a series of prevalence estimates for mental health disorders in children. These combine the findings from different national and international studies to provide modelled estimates at a local level. Wokingham CCG’s CAMHS Needs Assessment has been summarised below and is based on 2014 registered population information. The full report can be found on the CHIMAT website.

**Pre School children**

1,021 children aged 2-5 have a mental health disorder (based on modelled prevalence of 19.6%)

**School-age children**

The prevalence of mental health disorders in school-age children vary by age and sex, with boys more likely (11.4%) to have experienced or be experiencing mental health problems than girls (7.8%). Children aged 11 to 16 years olds are also more likely (11.5%) than 5 to 10 year olds (7.7%) to experience mental health problems. In 2012, 1,710 children aged 5-16 were estimated to have a mental health disorder in the CCG.

*Figure 40: Estimated number of children with mental health disorders in Wokingham CCG by age group and sex*

<table>
<thead>
<tr>
<th>All mental health disorders</th>
<th>5 to 10 year olds</th>
<th>11 to 16 year olds</th>
<th>Total number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Boys</strong></td>
<td>480</td>
<td>575</td>
<td>1,055</td>
</tr>
<tr>
<td><strong>Girls</strong></td>
<td>230</td>
<td>425</td>
<td>655</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>710</td>
<td>1,000</td>
<td>1,710</td>
</tr>
</tbody>
</table>
**Figure 41: Estimated number of children with specific mental health disorders in Wokingham CCG by age group and sex**

<table>
<thead>
<tr>
<th>Conduct disorders</th>
<th>5 to 10 year olds</th>
<th>11 to 16 year olds</th>
<th>Total number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boys</td>
<td>330</td>
<td>330</td>
<td>660</td>
</tr>
<tr>
<td>Girls</td>
<td>120</td>
<td>190</td>
<td>310</td>
</tr>
<tr>
<td>Total</td>
<td>450</td>
<td>520</td>
<td>970</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emotional disorders</th>
<th>5 to 10 year olds</th>
<th>11 to 16 year olds</th>
<th>Total number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boys</td>
<td>100</td>
<td>205</td>
<td>305</td>
</tr>
<tr>
<td>Girls</td>
<td>110</td>
<td>265</td>
<td>375</td>
</tr>
<tr>
<td>Total</td>
<td>210</td>
<td>470</td>
<td>680</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hyperkinetic disorders</th>
<th>5 to 10 year olds</th>
<th>11 to 16 year olds</th>
<th>Total number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boys</td>
<td>125</td>
<td>95</td>
<td>220</td>
</tr>
<tr>
<td>Girls</td>
<td>30</td>
<td>30</td>
<td>60</td>
</tr>
<tr>
<td>Total</td>
<td>155</td>
<td>125</td>
<td>280</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Less common disorders</th>
<th>5 to 10 year olds</th>
<th>11 to 16 year olds</th>
<th>Total number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boys</td>
<td>110</td>
<td>90</td>
<td>200</td>
</tr>
<tr>
<td>Girls</td>
<td>50</td>
<td>40</td>
<td>90</td>
</tr>
<tr>
<td>Total</td>
<td>160</td>
<td>130</td>
<td>290</td>
</tr>
</tbody>
</table>

**Young people**

The prevalence of neurotic disorders in young people aged 16-19 is shown in Figure 42.

**Figure 42: Estimated number of young people aged 16-19 with neurotic disorders in Wokingham CCG**

<table>
<thead>
<tr>
<th>Neurotic disorders</th>
<th>Mixed anxiety and depressive disorder</th>
<th>Generalised anxiety disorder</th>
<th>Depressive episode</th>
<th>All phobias</th>
<th>Obsessive compulsive disorder</th>
<th>Panic disorder</th>
<th>Any neurotic disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>185</td>
<td>60</td>
<td>35</td>
<td>25</td>
<td>35</td>
<td>20</td>
<td>310</td>
</tr>
<tr>
<td>Females</td>
<td>420</td>
<td>40</td>
<td>95</td>
<td>75</td>
<td>35</td>
<td>25</td>
<td>645</td>
</tr>
<tr>
<td>Total</td>
<td>605</td>
<td>100</td>
<td>130</td>
<td>100</td>
<td>70</td>
<td>45</td>
<td>955</td>
</tr>
</tbody>
</table>
Children requiring support from Child & Adolescent Mental Health Services (CAMHS)

CHIMAT’s Needs Assessment for Wokingham CCG estimates that 8,360 children and young people may require support from CAMHS. This has been broken down for each of the CAMHS Tiers:

- CAMHS Tier 1: 5,235 children and young people. 
  (Service provided by professionals whose main role and training is not in mental health. These include GPs, health visitors, school nurses, social services, voluntary agencies, teachers, residential social workers and juvenile justice workers.)

- CAMHS Tier 2: 2,445 children and young people. 
  (Provided by specialist trained mental health professionals. They work primarily on their own but may provide specialist input to multiagency teams. Roles include clinical child psychologists, paediatricians, educational psychologists, child psychiatrists and community child psychiatric nurses.)

- CAMHS Tier 3: 650 children and young people. 
  (Aimed at young people with more complex mental health problems than those seen in Tier 2. This service is provided by a multidisciplinary team, including child and adolescent psychiatrists, social workers, clinical psychologists, community psychiatric nurses, child psychotherapists, occupational therapists and are, drama and music therapists.)

- CAMHS Tier 4: 30 children and young people. 
  (Aimed at children and adolescents with severe and/or complex problems. These specialised services may be offered in residential, day patient or out-patient settings. These services include in-patient units, secure forensic adolescent units, eating disorder units, specialised teams for sexual abuse and specialist teams for neuropsychiatric problems.)

Children with a learning disability

Approximately 560 children aged 5 to 19 have a learning disability in Wokingham CCG. This figure increases by age group:

- 5 to 9 year olds: 100
- 10 to 14 year olds: 220
- 15 to 19 year olds: 240

Approximately 225 children aged 5 to 19 have a learning disability with mental health problems in Wokingham CCG. This figure also increases by age group:

- 5 to 9 year olds: 40
- 10 to 14 year olds: 90
- 15 to 19 year olds: 95
5.332 Hospital admissions for mental ill-health in children and young people

In 2015/16, children aged 0 to 17 had 41 hospital admissions for mental health disorders in Wokingham CCG. This was a rate of 116 per 100,000 population, which was significantly higher than the national rate of 85 per 100,000 population.

Self-harming is much more common in children and young people who have mental health disorders, with approximately 10% of 15-16 year olds having self-harmed. In 2015/16, there were 126 hospital admissions for self-harm in Wokingham CCG at a rate of 485 per 100,000 population. This was similar to the England rate of 423 per 100,000 population. It is important to note that hospital admissions do not show the full extent of self harm. The majority of young people who do self-harm will either not harm themselves in a way that needs medical treatment or they will deal with it themselves.

Trend data is not available at a CCG level for both of these indicators, as they were first published in 2014/15. Figures 43 and 44 provide national trend data for information only.

**Figure 43: Hospital admissions for mental health conditions per 100,000 population aged 0 to 17 (2010/11 to 2015/16)**

**Figure 44: Hospital admissions as a result of self harm per 100,000 population aged 10 to 24 – directly standardised rate (2012/13 to 2015/16)**

*Source: Public Health England (2017); Child & Young People’s Health Benchmarking Tool*
5.333 Wellbeing

The 2014/15 What About YOUth (WAY) survey asked a sample of 15 year olds about their health and lifestyle behaviours. Within this survey, respondents were asked questions about their wellbeing using the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS). This scale is formed of 14 statements covering a range or feelings and attitudes towards life and respondents are asked to rate themselves against these to create an overall score of wellbeing. The score can go from 14 to 70, with 70 being the highest score of wellbeing. Nationally, the average wellbeing score for 15-year olds was 47.6 out of 70, and this was same score for 15-year olds in Wokingham.

10.5% of Wokingham respondents stated that they had low life satisfaction, which was significantly lower than the national response of 13.7%.

The WAY Survey also asked respondents about bullying. 49.9% of Wokingham respondents stated that they had been bullied in past couple of months, which was significantly below the national figure of 55.0%. 9.2% of Wokingham respondents stated that they had bullied others in the past couple of months, compared to 10.1% nationally.
5.34  Lifestyle and Health Behaviours in Children and Young People

Lifestyle and health behaviours have already been included in this Locality Profile at a general population level. This section provides a focus on specific health behaviours in children and young people. National prevalence information has been used to provide modelled estimates for Wokingham CCG, where applicable. These are only a guide and do not take the demography of an area into account.

5.341  Smoking

The Government’s Tobacco Control Plan for England aims to reduce rates of regular smoking among 15 year olds from 8% in 2016 to 3% or less by the end of 2022. The 2014 Smoking, Drinking and Drug Use Among Young People in England Survey showed that 8% of 15 year olds were regular smokers and provided some additional information about young peoples smoking habits.

In 2014, 3% of 11 to 15 year olds in England smoked at least one cigarette a week. This is a reduction from 9% in 2003.

18% of 11 to 15 year olds said that they had tried smoking, compared to 42% of young people in 2003. 26% thought it was OK for a young person to try smoking.

In 2014, 88% of 11 to 15 year olds in England said that they were aware of e-cigarettes. 22% said that they have tried an e-cigarette and 1% had at least one a week.

5.342  Alcohol

The 2014 Smoking, Drinking and Drug Use Among Young People in England Survey indicated that 38% of 11 to 15 year-olds had drunk alcohol at least once. 48% thought that it was OK for someone their age to try drinking alcohol and 18% thought that it was OK to try getting drunk to see what it was like.

8% of 11 to 15 year-olds had drunk alcohol in the last week, compared to 25% in 2003.

The number of young people admitted to hospital for alcohol-specific conditions is significantly lower in Wokingham CCG, compared to the national figures. The trend from 2007/08 to 2014/15 is shown in Figure 45. From 2012/13 to 2014/15, there were 22 admissions for young people in Wokingham CCG, which was a rate of 20 per 100,000 population (aged 0 -17).
5.343 Substance Misuse

The 2014 Smoking, Drinking and Drug Use Among Young People in England Survey indicated that:

- 15% of 11 to 15 year-olds had taken drugs
- 10% had taken drugs in the last year
- 6% had taken drugs in the last month

26% of pupils aged 11 to 15 reported that they had been offered drugs in the past.

In 2014, 51% of 11 to 15 year olds in England said that they were aware of legal highs. 6% said that they had been offered legal highs and 2.5% had taken them at least once.

From 2013/14 to 2015/16, 18 young people (aged 15 to 24) were admitted to hospital due to substance misuse in Wokingham CCG. This was a rate of 37 per 100,000 population, which was significantly better than the national rate of 94 per 100,000 population.

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**Figure 45: Hospital admissions for alcohol-specific conditions per 100,000 population aged 0 to 17 (2007/08 to 2014/15)**

![Graph showing hospital admissions for alcohol-specific conditions per 100,000 population aged 0 to 17 (2007/08 to 2014/15)](image)

**Source:** Public Health England (2017); Healthcare use Profile

*Modelled estimates for Wokingham CCG using registered population figures for Oct-17:*

- 1,363 young people (aged 11-15) have taken drugs
- 908 young people have taken drugs in the last year
- 545 young people have taken drugs in the last month
- 2,362 young people have been offered drugs
- 545 young people have been offered legal highs
5.344  Obesity, Physical Activity and Diet

The prevalence of obesity in children is measured through the National Child Measurement Programme. Figures from 2015/16 show that the prevalence of obesity in Wokingham is lower than the national average for both age-groups. Detailed information is shown in the main Lifestyle section of this Locality Profile (4.2).

The 2014/15 What About YOUth (WAY) survey asked a sample of 15 year olds about their health and lifestyle behaviours in. Within this survey, respondents were asked to state how many portions of fruit and vegetables they had eaten the day before. 63.1% of respondents in Wokingham had eaten 5 portions of fruit or vegetables the day before, compared to 52.4% nationally.

15 year olds were also asked about their levels of physical activity in the WAY survey. 15.5% of Wokingham respondents stated that they had been physically active for at least one hour per day in the previous week, which was similar to the national figure of 13.9%. 62.9% of Wokingham respondents stated that they had a mean daily sedentary time of 7 hours per day in the last week, which was also significantly better than the national proportion of 70.1%.

5.345  Young People’s Sexual Health

Public Health England’s Sexual and Reproductive Health Profiles provide key information about sexual health for local authorities. This data is not currently available at a CCG level, so this section focuses on the latest figures and trends for the Wokingham Borough. Additional information about sexual health can also be found in the Lifestyle and Health Behaviour section of this profile (4.6).

5.3451 Teenage pregnancy

Most teenage pregnancies are unplanned and around half end in an abortion. Longitudinal studies show that teenage pregnancy is associated with poorer outcomes for both young parents and their children. Teenage mothers are less likely to finish their education, are more likely to bring up their child alone and in poverty and have a higher risk of poor mental health than older mothers. Infant mortality rates for babies born to teenage mothers are around 60% higher than for babies born to older mothers. The children of teenage mothers have an increased risk of living in poverty and poor quality housing and are more likely to have accidents and behavioural problems.

Teenage conception rates in Wokingham are lower than the national rate, as highlighted in Figures 46 and 47. Data is not shown for some years, as some the numbers are too small to publish.
In 2015, 23 females aged 15 to 17 and 9 females aged 13 to 15 had a pregnancy that either led to a birth or legal abortion in Wokingham. 57% of under 18 conceptions led to an abortion (13 in total).

Over a quarter of abortions in England are repeat abortions for women aged under 25. In 2016, 26.7% of abortions in this age group were repeat abortions. Wokingham’s figure was similar at 24.3%.
5.3452 Chlamydia

Chlamydia is the most commonly diagnosed sexually transmitted infection. It causes avoidable sexual and reproductive ill-health, including symptomatic acute infections and complications such as pelvic inflammatory disease (PID), ectopic pregnancy and tubal-factor infertility. Chlamydia screening is recommended for all sexually active people under 25 and on partner change. Public Health England recommends that local authorities should be working towards achieving a diagnosis rate of at least 2,300 per 100,000 population.

Wokingham’s screening and diagnoses rates are significantly lower than the England rates, as shown in Figures 48 to 50.

**Figure 48: Chlamydia screening for 15 to 24 year olds (Jan-Dec 2016)**

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>Chlamydia Screens</th>
<th>% of population tested</th>
<th>Diagnoses rate per 100,000</th>
<th>Positive Tests</th>
<th>% of tests that were positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wokingham</td>
<td>2,501</td>
<td>15.1%</td>
<td>854</td>
<td>141</td>
<td>5.6</td>
</tr>
</tbody>
</table>

**Figure 49: Percentage of population aged 15 to 24 who were screened for chlamydia and who had a positive test result (2016)**

**Figure 50: Chlamydia detection rate per 100,000 population aged 15 to 24 (2012 to 2016)**

Source: Public Health England (2017); NHS National Chlamydia Screening Programme
5.35 Childhood immunisations

The overall aim of the childhood immunisation programme in the UK is to protect all children against preventable childhood infections or diseases. The national target for childhood immunisations is 95% for each of the six vaccines of the under-fives childhood immunisation schedule and 90% coverage for HPV in school-aged girls.

5.351 Children immunised by their first birthday

One of the first vaccines that a baby will have is the 5-in-1 vaccine, also known as the DTaP/IPV/Hib vaccine, which protects against five serious childhood diseases of diphtheria, tetanus, whooping cough, polio and haemophilus influenzae type b.

In 2016/17, 1,751 children were immunised with this vaccine by their first birthday in the Wokingham CCG area. This is 95.6% of the eligible population, which is above the national target of 95%.

Figure 51 shows the immunisation coverage at a GP practice level. 9 Wokingham CCG Practices met the target of 95%.

<table>
<thead>
<tr>
<th>Eligible children</th>
<th>Dtap/IPV/Hib</th>
<th>% coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wokingham CCG</td>
<td>1,831</td>
<td>1,751</td>
</tr>
<tr>
<td>Brookside Group Practice</td>
<td>265</td>
<td>250</td>
</tr>
<tr>
<td>Burma Hills Surgery</td>
<td>38</td>
<td>37</td>
</tr>
<tr>
<td>Finchampstead Practice</td>
<td>135</td>
<td>125</td>
</tr>
<tr>
<td>Loddon Vale Practice</td>
<td>161</td>
<td>159</td>
</tr>
<tr>
<td>New Wokingham Road Surgery</td>
<td>71</td>
<td>69</td>
</tr>
<tr>
<td>Parkside Practice</td>
<td>164</td>
<td>152</td>
</tr>
<tr>
<td>Swallowfield Medical Practice</td>
<td>168</td>
<td>160</td>
</tr>
<tr>
<td>Twyford Surgery</td>
<td>157</td>
<td>150</td>
</tr>
<tr>
<td>Wargrave Surgery</td>
<td>60</td>
<td>58</td>
</tr>
<tr>
<td>Wilderness Road Surgery</td>
<td>27</td>
<td>25</td>
</tr>
<tr>
<td>Wokingham Medical Centre</td>
<td>254</td>
<td>247</td>
</tr>
<tr>
<td>Woodley Centre Surgery</td>
<td>189</td>
<td>180</td>
</tr>
<tr>
<td>Woosehill Surgery</td>
<td>142</td>
<td>139</td>
</tr>
</tbody>
</table>

Source: NHS England (2017); Child Immunisation at Practice Level OT 2016/17
5.352 Children immunised by their second birthday

Three vaccines are generally given to children when they are 12 to 13 months old and these include the Hib/ Meningitis C booster, MMR vaccine for measles, mumps and rubella and the third dose of the PCV vaccine.

The table below shows the number and percentage of children vaccinated in Wokingham CCG before their second birthday in 2016/17. The CCG did not meet the 95% national target for any of these immunisations.

Figure 52 shows immunisation coverage at a GP practice level. 2 Wokingham CCG Practices met the 95% target for all 3 immunisations.

*Figure 52: Child immunisations for children aged under 24 months – GP Practice level (2016/17)*

<table>
<thead>
<tr>
<th>Eligible children</th>
<th>MMR – 1st dose</th>
<th>Hib/Men C Booster</th>
<th>PCV Booster</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number vaccinated</td>
<td>% coverage</td>
<td>Number vaccinated</td>
</tr>
<tr>
<td>Wokingham CCG</td>
<td>1,854</td>
<td>1,712</td>
<td>92.3%</td>
</tr>
<tr>
<td>Brookside Group Practice</td>
<td>276</td>
<td>259</td>
<td>93.8%</td>
</tr>
<tr>
<td>Burma Hills Surgery</td>
<td>48</td>
<td>47</td>
<td>97.9%</td>
</tr>
<tr>
<td>Finchampstead Practice</td>
<td>149</td>
<td>139</td>
<td>93.3%</td>
</tr>
<tr>
<td>Loddon Vale Practice</td>
<td>161</td>
<td>155</td>
<td>96.3%</td>
</tr>
<tr>
<td>New Wokingham Road Surgery</td>
<td>66</td>
<td>58</td>
<td>87.9%</td>
</tr>
<tr>
<td>Parkside Practice</td>
<td>178</td>
<td>162</td>
<td>91.0%</td>
</tr>
<tr>
<td>Swallowfield Medical Practice</td>
<td>159</td>
<td>151</td>
<td>95.0%</td>
</tr>
<tr>
<td>Twyford Surgery</td>
<td>150</td>
<td>118</td>
<td>78.7%</td>
</tr>
<tr>
<td>Wargrave Surgery</td>
<td>70</td>
<td>63</td>
<td>90.0%</td>
</tr>
<tr>
<td>Wilderness Road Surgery</td>
<td>14</td>
<td>12</td>
<td>85.7%</td>
</tr>
<tr>
<td>Wokingham Medical Centre</td>
<td>257</td>
<td>243</td>
<td>94.6%</td>
</tr>
<tr>
<td>Woodley Centre Surgery</td>
<td>183</td>
<td>172</td>
<td>94.0%</td>
</tr>
<tr>
<td>Wooschild Surgery</td>
<td>143</td>
<td>133</td>
<td>93.0%</td>
</tr>
</tbody>
</table>

Source: NHS England (2017); Child Immunisation at Practice Level OT 2016/17
5.353 Children immunised by their fifth birthday

Two vaccines are given to children when they are aged 3 years and 4 months. These are the second dose of the MMR vaccine and the 4-in-1 pre school booster which contains vaccines against diphtheria, tetanus, whooping cough and polio.

Figure 53 shows the number and percentage of children vaccinated in Wokingham CCG before their fifth birthday in 2016/17. The CCG did not meet the target of 95% for either of these immunisations. No Wokingham CCG Practices met the 95% target for these immunisations.

**Figure 53: Child immunisations for children aged under 5 years – GP Practice level (2016/17)**

<table>
<thead>
<tr>
<th></th>
<th>Eligible children</th>
<th>Dtap/IPV Booster</th>
<th>MMR – 2nd dose</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Number vaccinated</td>
<td>% coverage</td>
</tr>
<tr>
<td><strong>Wokingham CCG</strong></td>
<td>2,197</td>
<td>1,939</td>
<td>88.3%</td>
</tr>
<tr>
<td>Brookside Group Practice</td>
<td>415</td>
<td>373</td>
<td>89.9%</td>
</tr>
<tr>
<td>Burma Hills Surgery</td>
<td>52</td>
<td>51</td>
<td>98.1%</td>
</tr>
<tr>
<td>Finchampstead Practice</td>
<td>173</td>
<td>152</td>
<td>87.9%</td>
</tr>
<tr>
<td>Loddon Vale Practice</td>
<td>165</td>
<td>151</td>
<td>91.5%</td>
</tr>
<tr>
<td>New Wokingham Road Surgery</td>
<td>81</td>
<td>69</td>
<td>85.2%</td>
</tr>
<tr>
<td>Parkside Practice</td>
<td>173</td>
<td>148</td>
<td>85.5%</td>
</tr>
<tr>
<td>Swallowfield Medical Practice</td>
<td>183</td>
<td>160</td>
<td>87.4%</td>
</tr>
<tr>
<td>Twyford Surgery</td>
<td>180</td>
<td>146</td>
<td>81.1%</td>
</tr>
<tr>
<td>Wargrave Surgery</td>
<td>70</td>
<td>63</td>
<td>90.0%</td>
</tr>
<tr>
<td>Wilderness Road Surgery</td>
<td>26</td>
<td>24</td>
<td>92.3%</td>
</tr>
<tr>
<td>Wokingham Medical Centre</td>
<td>327</td>
<td>286</td>
<td>87.5%</td>
</tr>
<tr>
<td>Woodley Centre Surgery</td>
<td>179</td>
<td>161</td>
<td>89.9%</td>
</tr>
<tr>
<td>Wooseshill Surgery</td>
<td>173</td>
<td>155</td>
<td>89.6%</td>
</tr>
</tbody>
</table>

*Source: NHS England (2017); Child Immunisation at Practice Level OT 2016/17*
6. **Adult Health Profile**

### 6.1 Cardiovascular Disease (CVD)

Cardiovascular disease (CVD) is not a single condition, but an umbrella term that describes all diseases of the heart and circulation. This includes coronary heart disease, heart failure, stroke, atrial fibrillation and hypertension. Cardiovascular disease was the second largest cause of death in England and Wales in 2016, accounting for 25.5% of all deaths. However, the mortality rate for cardiovascular disease has reduced significantly over the last 10 years for both men and women.

Many deaths caused by cardiovascular disease are premature and could be prevented by making lifestyle changes. Factors that can increase a person’s risk of cardiovascular disease include smoking, being overweight or obese, not taking regular exercise or eating an unhealthy diet (high in salt and saturated fat). Having other conditions or diseases, such as diabetes, kidney disease and mental health problems, can also increase a person’s chances of developing a cardiovascular disease. A person’s sex, age, ethnic origin and socio-economic group will also have an impact on the risks of developing and dying from cardiovascular disease.

Public Health England’s National Cardiovascular Intelligence Network (NCVIN) has published Cardiovascular Disease Profiles at a CCG level, which provide a wide range of data on cardiovascular diseases at a local population level. In addition, NHS RightCare has also published Cardiovascular Disease Commissioning for Value focus packs, which were updated in April 2016. These packs provide detailed information at a CCG level and indicate potential areas for improvement in primary and secondary care, as well as prevention programmes. To best inform local commissioning, the Wokingham CCG focus pack should be looked at alongside the information included in this Locality Profile.

#### 6.11 Cardiovascular Disease prevalence profile for Wokingham CCG

Prevalence is a measure of the burden of a disease in the population at a particular point in time. This section provides information about the recorded prevalence of different Cardiovascular diseases in the CCG area, which have been taken from the Quality and Outcomes Framework. These have been compared with the prevalence rates of similar CCGs and also the national rate.

It is important to note that looking at the numbers of people currently being treated for a disease does not show the true prevalence and impact on a population’s health. There will also be many people who have a disease or condition that are not aware of it and have not been diagnosed. This section will also include estimated prevalence figures, where available, which have been developed by using population statistics and research on the risks factors for each disease to derive an estimation of the true number of people suffering from it. The source of these estimations will be shown under each condition.
6.111 Coronary Heart Disease (CHD) Prevalence

The estimated prevalence for Coronary Heart Disease in Wokingham CCG is 3.4%. This means that there were 1,664 people “missing” from GP registers in 2016/17. These estimations come from Public Health England’s Disease and Risk Factor Prevalence Profile using the Eastern Region Public Health Observatory’s model developed from the 2003-2004 Health Surveys for England.

Figure 54: Prevalence of Coronary Heart Disease at a GP Practice level in 2015/16 and 2016/17

Source: NHS Digital (2017); Quality and Outcomes Framework
6.112 Heart Failure Prevalence

The estimated prevalence for Heart Failure in Wokingham CCG is 1.6%. This means that there were 1,606 people “missing” from GP registers in 2016/17. These estimations come from the NHS Comparators website and are based on October 2017 GP population figures. This national model has not been disaggregated to a local level, so will show under or over estimations in local regions depending on the demographics of that region.

Figure 55: Prevalence of Heart Failure at a GP Practice level in 2015/16 and 2016/17

The CCG’s 2016/17 prevalence rate was higher than the 2015/16 rate of 0.56%.

Source: NHS Digital (2017); Quality and Outcomes Framework
**6.113 Atrial Fibrillation Prevalence**

Number of people on Atrial Fibrillation Register:
- 2,869 people

Recorded prevalence in CCG area:
- 1.77%

Comparison of prevalence:
- ↓ than the Comparator CCG rate of 1.97%
- ↓ than the national rate of 1.84%

The CCG’s 2016/17 prevalence rate was higher than the 2015/16 rate of 1.63%.

The estimated prevalence for Atrial Fibrillation in Wokingham CCG is 2.46%. This means that there were 1,129 people “missing” from GP registers in 2016/17. These estimations come from Public Health England’s *Atrial Fibrillation prevalence estimates for local populations*, which was updated in September 2017.

**Figure 56: Prevalence of Atrial Fibrillation at a GP Practice level in 2015/16 and 2016/17**

Source: *NHS Digital (2017); Quality and Outcomes Framework*
6.114 Stroke or Transient Ischaemic Attacks (TIA) Prevalence

The estimated prevalence for Stroke or Transient Ischaemic Attacks (TIA) in Wokingham CCG is 1.53%. This means that there were 159 people “missing” from GP registers in 2016/17. These estimations come from Public Health England’s Disease and Risk Factor Prevalence Profile using the Eastern Region Public Health Observatory’s model developed from the 2003-2004 Health Surveys for England.

**Figure 57: Prevalence of Stroke or TIA at a GP Practice level in 2015/16 and 2016/17**

Source: NHS Digital (2017); Quality and Outcomes Framework
6.115 Hypertension Prevalence

The estimated prevalence for Hypertension in Wokingham CCG is 22.9%. This means that there were 17,021 people “missing” from GP registers in 2016/17. These estimations come from the National Cardiovascular Intelligence Network Profiles for England.

Figure 58: Prevalence of Hypertension at a GP Practice level in 2015/16 and 2016/17

Source: NHS Digital (2017); Quality and Outcomes Framework
6.12 Quality of Care

This section of the Profile provides a summary of indicators that are used to monitor care for cardiovascular disease from the CCG Outcomes Indicator Set (CCG OIS) and the GP Quality and Outcomes Framework (QOF):

- CCG Outcomes Indicator Set – the indicators included in the CCG OIS contribute to the five domains of the NHS Outcomes Framework. This provides clear, comparative information for CCGs about the quality of health services and the associated health outcomes.

- Quality and Outcomes Framework (QOF) – the QOF is the annual reward and incentive programme detailing GP practice achievement results. This rewards practices for the provision of quality care and helps standardise improvement in the delivery of primary medical services.

These indicators compare Wokingham CCG’s performance against the national average and the CCG Comparator Group. The Comparator Group includes the 10 CCGs that are “most similar” to Wokingham CCG, as defined in the Commissioning for Value packs. The Direction of Travel (DOT) is also shown to indicate whether the CCG’s performance was significantly better, significantly worse or similar to the previous year’s outturn.

Where Wokingham CCG have performed significantly worse than the Comparator Group average in the Quality and Outcomes Framework, an additional graph has been included to show a breakdown by GP.

<table>
<thead>
<tr>
<th>Key for spine charts:</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Significantly better than similar CCG average" /></td>
</tr>
<tr>
<td><img src="image" alt="Significantly worse than the similar CCG average" /></td>
</tr>
<tr>
<td><img src="image" alt="Not significantly different to the similar CCG average" /></td>
</tr>
<tr>
<td><img src="image" alt="National average" /></td>
</tr>
</tbody>
</table>
## 6.121 CCG Outcomes Indicator Set summary for cardiovascular diseases

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Latest outcome</th>
<th>CCG value</th>
<th>CCG Comp Group Avg</th>
<th>England Avg</th>
<th>CCG Comp Group Worst</th>
<th>CCG Comparator Group Range</th>
<th>CCG Comp Group Best</th>
<th>Previous outcome</th>
<th>DOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCG 1.1a PYLL for causes considered amenable to healthcare - Cerebrovascular diseases</td>
<td>2012-14</td>
<td>195.0</td>
<td>190.7</td>
<td>231.5</td>
<td>243.0</td>
<td><img src="image" alt="Indicator" /></td>
<td><img src="image" alt="Indicator" /></td>
<td>153.7</td>
<td>199.3</td>
</tr>
<tr>
<td>CCG 1.1b PYLL for causes considered amenable to healthcare - Ischaemic heart diseases</td>
<td>2012-14</td>
<td>445.3</td>
<td>467.2</td>
<td>667.5</td>
<td>562.4</td>
<td><img src="image" alt="Indicator" /></td>
<td><img src="image" alt="Indicator" /></td>
<td>410.3</td>
<td>448.7</td>
</tr>
<tr>
<td>CCG 1.2 Under 75 mortality rate from cardiovascular disease</td>
<td>2015</td>
<td>41.7</td>
<td>47.2</td>
<td>64.0</td>
<td>58.8</td>
<td><img src="image" alt="Indicator" /></td>
<td><img src="image" alt="Indicator" /></td>
<td>38.7</td>
<td>44.5</td>
</tr>
<tr>
<td>CCG 1.3 Completion of cardiac rehabilitation following an admission for CHD</td>
<td>2013/14</td>
<td>66.7%</td>
<td>52.9%</td>
<td>38.0%</td>
<td>34.7%</td>
<td><img src="image" alt="Indicator" /></td>
<td><img src="image" alt="Indicator" /></td>
<td>67.5%</td>
<td>56.6%</td>
</tr>
<tr>
<td>CCG 1.5 Mortality within 30 days of hospital admission for stroke</td>
<td>2015/16</td>
<td>0.66</td>
<td>0.97</td>
<td>1.00</td>
<td>1.21</td>
<td><img src="image" alt="Indicator" /></td>
<td><img src="image" alt="Indicator" /></td>
<td>0.66</td>
<td>0.82</td>
</tr>
<tr>
<td>CCG 1.21 All-cause mortality - 12 months following first emergency admissions to hospital for heart failure in people aged 16+</td>
<td>Apr-12 to Mar-15</td>
<td>92.4</td>
<td>92.8</td>
<td>100.0</td>
<td>106.0</td>
<td><img src="image" alt="Indicator" /></td>
<td><img src="image" alt="Indicator" /></td>
<td>84.7</td>
<td>89.0</td>
</tr>
<tr>
<td>CCG 1.24 Referrals to cardiac rehabilitation within 5 days of an admission for coronary heart disease</td>
<td>2014/15</td>
<td>20.2%</td>
<td>22.2%</td>
<td>14.1%</td>
<td>6.6%</td>
<td><img src="image" alt="Indicator" /></td>
<td><img src="image" alt="Indicator" /></td>
<td>41.9%</td>
<td>17.6%</td>
</tr>
<tr>
<td>CCG 2.1 Improved health-related quality of life for people with LTCs</td>
<td>2016/17</td>
<td>0.80</td>
<td>0.78</td>
<td>0.74</td>
<td>0.77</td>
<td><img src="image" alt="Indicator" /></td>
<td><img src="image" alt="Indicator" /></td>
<td>0.80</td>
<td>0.82</td>
</tr>
<tr>
<td>CCG 2.2 % of people feeling supported to manage their conditions</td>
<td>2016/17</td>
<td>70.2%</td>
<td>65.6%</td>
<td>64.0%</td>
<td>61.2%</td>
<td><img src="image" alt="Indicator" /></td>
<td><img src="image" alt="Indicator" /></td>
<td>70.2%</td>
<td>71.2%</td>
</tr>
<tr>
<td>CCG 2.6 Unplanned hospitalisation for chronic ambulatory care sensitive (ACS) conditions</td>
<td>2016/17</td>
<td>585.9</td>
<td>573.2</td>
<td>821.2</td>
<td>770.7</td>
<td><img src="image" alt="Indicator" /></td>
<td><img src="image" alt="Indicator" /></td>
<td>107.7</td>
<td>566.1</td>
</tr>
<tr>
<td>CCG 3.1 Emergency admissions for acute conditions that should not usually require hospital admission</td>
<td>2016/17</td>
<td>983</td>
<td>1,064</td>
<td>1,357</td>
<td>1,444</td>
<td><img src="image" alt="Indicator" /></td>
<td><img src="image" alt="Indicator" /></td>
<td>253</td>
<td>977</td>
</tr>
<tr>
<td>CCG 3.2 Emergency readmissions within 30 days of discharge from hospital</td>
<td>2011/12</td>
<td>10.3%</td>
<td>11.5%</td>
<td>11.8%</td>
<td>13.1%</td>
<td><img src="image" alt="Indicator" /></td>
<td><img src="image" alt="Indicator" /></td>
<td>10.3%</td>
<td>10.2%</td>
</tr>
<tr>
<td>CCG 3.5 Stroke: People admitted to an acute stroke unit within 4 hours of arrival in hospital</td>
<td>2016/17</td>
<td>60.8%</td>
<td>63.2%</td>
<td>58.7%</td>
<td>47.0%</td>
<td><img src="image" alt="Indicator" /></td>
<td><img src="image" alt="Indicator" /></td>
<td>73.9%</td>
<td>66.0%</td>
</tr>
<tr>
<td>CCG 3.6 Stroke: People who receive thrombolysis following an acute stroke</td>
<td>2016/17</td>
<td>27.6%</td>
<td>13.2%</td>
<td>11.5%</td>
<td>7.9%</td>
<td><img src="image" alt="Indicator" /></td>
<td><img src="image" alt="Indicator" /></td>
<td>27.6%</td>
<td>21.4%</td>
</tr>
<tr>
<td>CCG 3.7 Stroke: People discharged from hospital with a joint health and social care plan</td>
<td>2016/17</td>
<td>100.0%</td>
<td>93.6%</td>
<td>90.5%</td>
<td>77.8%</td>
<td><img src="image" alt="Indicator" /></td>
<td><img src="image" alt="Indicator" /></td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>CCG 3.8 Stroke: People who receive a follow up assessment between 4-8 months after initial admission</td>
<td>2016/17</td>
<td>63.6%</td>
<td>15.1%</td>
<td>31.6%</td>
<td>0.0%</td>
<td><img src="image" alt="Indicator" /></td>
<td><img src="image" alt="Indicator" /></td>
<td>63.6%</td>
<td>64.3%</td>
</tr>
<tr>
<td>CCG 3.9 Stroke: Patients who have had an acute stroke who spend 90% or more of their stay on a stroke unit</td>
<td>2016/17</td>
<td>79.1%</td>
<td>84.8%</td>
<td>84.3%</td>
<td>73.4%</td>
<td><img src="image" alt="Indicator" /></td>
<td><img src="image" alt="Indicator" /></td>
<td>94.9%</td>
<td>80.4%</td>
</tr>
</tbody>
</table>
67% of people who were admitted for coronary heart disease in Wokingham CCG in 2013/14 completed cardiac rehabilitation. This was significantly better than both the CCG comparator Group and national figures.

In 2016/17, Wokingham CCG’s unplanned hospitalisation for chronic ambulatory care sensitive conditions (CCG 2.6) was similar to the CCG comparator group. Emergency admissions for conditions that should not usually require hospital admission (CCG 3.1) were significantly better than the comparator group. Additional trend information for both of these indicators can be found in the ‘General healthcare and hospital activity’ section of the Profile (6.9).

Wokingham CCG had one of the highest average health-status score for people with long-term conditions in the comparator group. This is collected through the GP Patient Survey, where each survey respondent answers a series of questions from which a health status score can be calculated. The measure seeks to assess whether health-related quality of life is increasing over time for the population with long-term conditions, while adjusting for measurable factors that the NHS does not have control over, such as age and sex. The GP Patient Survey also indicated that the CCG had the highest percentage of people with long-term conditions who felt that they were supported to manage their condition in the comparator group. More information about the GP Patient Survey can be found in section 7 of this Profile.

Wokingham CCG performance was the best in the comparator group for three of the stroke indicators in 2016/17. Over 27% of people received thrombolysis following an acute stroke, 100% had a joint health and social care plan and 64% received a follow up assessment between 4-8 months after initial admission. However, the percentage of patients who spend 90% or more of their stay on a stroke unit was significantly lower than the comparator group at 79%.

### 6.122 Quality and Outcomes Framework - Coronary Heart Disease

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Wok CCG Value</th>
<th>CCG Comparator Group Avg</th>
<th>CCG Comparator Group Worst</th>
<th>CCG Comparator Group Range</th>
<th>CCG Comparator Group Best</th>
<th>Wok CCG in 15/16</th>
<th>DOT for Wok CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD02</td>
<td>% patients with CHD who have last BP reading in the previous 12 months of 150/90 or less</td>
<td>93%</td>
<td>92%</td>
<td>92%</td>
<td>90%</td>
<td>94%</td>
<td>92% ↑</td>
</tr>
<tr>
<td>CHD05</td>
<td>% patients with CHD with a record in the previous 12 months that aspirin, alternative anti-platelet therapy or an anti-coagulant is being taken</td>
<td>97%</td>
<td>97%</td>
<td>96%</td>
<td>95%</td>
<td>98%</td>
<td>97% ↔</td>
</tr>
<tr>
<td>CHD07</td>
<td>% patients with CHD who have had flu immunisation in the preceding 1st August to 31st March</td>
<td>97%</td>
<td>96%</td>
<td>96%</td>
<td>94%</td>
<td>98%</td>
<td>96% ↑</td>
</tr>
</tbody>
</table>
### 6.123 Quality and Outcomes Framework - Heart Failure

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
<th>Wok CCG Value</th>
<th>CCG Comparator Group Avg</th>
<th>CCG Comparator Group Worst</th>
<th>CCG Comparator Group Range</th>
<th>CCG Comparator Group Best</th>
<th>Wok CCG in 15/16</th>
<th>DOT for Wok CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>HF02</td>
<td>% patients with diagnosis of heart failure which has been confirmed by an ECG or by specialist assessment</td>
<td>96%</td>
<td>95%</td>
<td>95%</td>
<td>94%</td>
<td>96%</td>
<td>94%</td>
<td>↑</td>
</tr>
<tr>
<td>HF03</td>
<td>% patients with diagnosis of heart failure due to LVD - currently treated with ACE-I/ARB</td>
<td>100%</td>
<td>100%</td>
<td>99%</td>
<td>99%</td>
<td>100%</td>
<td>100%</td>
<td>↔</td>
</tr>
<tr>
<td>HF04</td>
<td>% patients with diagnosis of heart failure due to LVD treated with an ACE-I or ARB, who are also treated with beta-blocker licensed for heart failure</td>
<td>91%</td>
<td>92%</td>
<td>93%</td>
<td>89%</td>
<td>95%</td>
<td>92%</td>
<td>↔</td>
</tr>
</tbody>
</table>

### 6.124 Quality and Outcomes Framework - Atrial Fibrillation

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
<th>Wok CCG Value</th>
<th>CCG Comparator Group Avg</th>
<th>CCG Comparator Group Worst</th>
<th>CCG Comparator Group Range</th>
<th>CCG Comparator Group Best</th>
<th>Wok CCG in 15/16</th>
<th>DOT for Wok CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>AF06</td>
<td>% patients with AF who have stroke risk assessed using the CHA2DS2-VASc score risk stratification scoring system in the previous 12 months</td>
<td>96%</td>
<td>97%</td>
<td>97%</td>
<td>96%</td>
<td>99%</td>
<td>96%</td>
<td>↔</td>
</tr>
<tr>
<td>AF07</td>
<td>% patients with AF who have CHA2DS2-VASc score of 2 or more who are currently treated with anti-coagulation drug therapy</td>
<td>92%</td>
<td>90%</td>
<td>88%</td>
<td>86%</td>
<td>93%</td>
<td>86%</td>
<td>↑</td>
</tr>
</tbody>
</table>
Figure 59: GP Practice performance for AF06: % patients with AF who have stroke risk assessed in the past 12 months

Source: NHS Digital (2017); Quality and Outcomes Framework

6.125 Quality and Outcomes Framework - Stroke or TIA

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
<th>Wok CCG Value</th>
<th>CCG Comparator Group Avg</th>
<th>CCG Comparator Group Worst</th>
<th>CCG Comparator Group Range</th>
<th>CCG Comparator Group Best</th>
<th>Wok CCG in 15/16</th>
<th>DOT for Wok CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>STIA03</td>
<td>% patients with history of Stoke or TIA who have last BP reading in the previous 12 months of 150/90 or less</td>
<td>87%</td>
<td>88%</td>
<td>88%</td>
<td>86%</td>
<td>89%</td>
<td>86%</td>
<td>↔</td>
</tr>
<tr>
<td>STIA07</td>
<td>% patients with stroke shown to be non-haemorrhagic, or a history of TIA, who have a record that an anti-platelet agent or anti-coagulant is being taken</td>
<td>98%</td>
<td>98%</td>
<td>97%</td>
<td>96%</td>
<td>99%</td>
<td>98%</td>
<td>↔</td>
</tr>
<tr>
<td>STIA08</td>
<td>% patients with history of Stroke or TIA who have referral for further investigation 3 mths before or 1 mth after date of latest stroke or first TIA</td>
<td>90%</td>
<td>89%</td>
<td>89%</td>
<td>86%</td>
<td>91%</td>
<td>89%</td>
<td>↔</td>
</tr>
<tr>
<td>STIA09</td>
<td>% patients with stroke or TIA who have had flu immunisation in the preceding 1st August to 31st March</td>
<td>96%</td>
<td>95%</td>
<td>95%</td>
<td>93%</td>
<td>97%</td>
<td>95%</td>
<td>↑</td>
</tr>
</tbody>
</table>
### 6.126 Quality and Outcomes Framework - Peripheral Arterial Disease (PAD)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
<th>Wok CCG Value</th>
<th>CCG Comp Group Avg</th>
<th>CCG Comp Group Eng Avg</th>
<th>CCG Comp Group Worst</th>
<th>CCG Comparator Group Range</th>
<th>CCG Comparator Group Wok CCG in 15/16 DOT for Wok CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAD02</td>
<td>% patients with PAD who have last BP reading in the previous 12 months of 150/90 or less</td>
<td>94%</td>
<td>92%</td>
<td>91%</td>
<td>89%</td>
<td>![Diagram]</td>
<td>94% 89% ↑</td>
</tr>
<tr>
<td>PAD04</td>
<td>% patients with PAD who have a record in the previous 12 months that aspirin or an alternative anti-platelet is being taken</td>
<td>95%</td>
<td>94%</td>
<td>93%</td>
<td>91%</td>
<td>![Diagram]</td>
<td>97% 94% ↔</td>
</tr>
</tbody>
</table>

### 6.127 Quality and Outcomes Framework - Hypertension

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
<th>Wok CCG Value</th>
<th>CCG Comp Group Avg</th>
<th>CCG Comp Group Eng Avg</th>
<th>CCG Comp Group Worst</th>
<th>CCG Comparator Group Range</th>
<th>CCG Comparator Group Wok CCG in 15/16 DOT for Wok CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>HYP06</td>
<td>% patients with hypertension who have last BP reading in the previous 12 months of 150/90 or less</td>
<td>84%</td>
<td>83%</td>
<td>83%</td>
<td>80%</td>
<td>![Diagram]</td>
<td>84% 83% ↑</td>
</tr>
</tbody>
</table>

### 6.128 Quality and Outcomes Framework – Risk factors of cardiovascular diseases

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
<th>Wok CCG Value</th>
<th>CCG Comp Group Avg</th>
<th>CCG Comp Group Eng Avg</th>
<th>CCG Comp Group Worst</th>
<th>CCG Comparator Group Range</th>
<th>CCG Comparator Group Wok CCG in 15/16 DOT for Wok CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>CVDPP01</td>
<td>% patients with new diagnosis of hypertension that have a recorded CVD risk assessment score who are currently treated with statins</td>
<td>100%</td>
<td>99%</td>
<td>97%</td>
<td>97%</td>
<td>![Diagram]</td>
<td>100% 100% ↔</td>
</tr>
<tr>
<td>BP02</td>
<td>% patients aged 45 or over who have a record of blood pressure in the preceding 5 years</td>
<td>87%</td>
<td>89%</td>
<td>91%</td>
<td>87%</td>
<td>![Diagram]</td>
<td>91% 87% ↔</td>
</tr>
<tr>
<td>SMOK02</td>
<td>% patients with LTCS whose notes record smoking status in last 12 months</td>
<td>94%</td>
<td>95%</td>
<td>95%</td>
<td>93%</td>
<td>![Diagram]</td>
<td>96% 94% ↑</td>
</tr>
<tr>
<td>SMOK04</td>
<td>% of patients aged 15+ who are recorded as current smokers who have a record of an offer of support and treatment within the previous 24 months</td>
<td>87%</td>
<td>91%</td>
<td>90%</td>
<td>87%</td>
<td>![Diagram]</td>
<td>96% 87% ↑</td>
</tr>
<tr>
<td>SMOK05</td>
<td>% of patients with LTCS who are recorded as current smokers who have a record of an offer of support and treatment within the previous 12 months</td>
<td>99%</td>
<td>98%</td>
<td>97%</td>
<td>96%</td>
<td>![Diagram]</td>
<td>99% 96% ↑</td>
</tr>
</tbody>
</table>
Introduction

Summary

Place

Lifestyle

Child Profile

Adult Profile

GP Survey

Wokingham CCG Locality Profile 2017

Figure 60: GP Practice performance for BP02: % patients aged 45 or over who have a record of blood pressure in the preceding 5 years

Source: NHS Digital (2016); Quality and Outcomes Framework

Figure 61: GP Practice performance for SMOK02: % patients with LTCs whose notes record smoking status in last 12 months

Source: NHS Digital (2016); Quality and Outcomes Framework
Figure 62: GP Practice performance for SMOK04: % patients aged 15+ who are recorded as current smokers who have a record of an offer of support and treatment within the previous 24 months

<table>
<thead>
<tr>
<th>Practice</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brookside Group Practice</td>
<td>99.0%</td>
</tr>
<tr>
<td>Burma Hills Surgery</td>
<td>90.1%</td>
</tr>
<tr>
<td>Finchampstead Practice</td>
<td>90.4%</td>
</tr>
<tr>
<td>Loddon Vale Practice</td>
<td>55.5%</td>
</tr>
<tr>
<td>New Wokingham Road Surgery</td>
<td>91.2%</td>
</tr>
<tr>
<td>Parkside Practice</td>
<td>90.3%</td>
</tr>
<tr>
<td>Swallowfield Medical Practice</td>
<td>81.7%</td>
</tr>
<tr>
<td>Twyford Surgery</td>
<td>52.2%</td>
</tr>
<tr>
<td>Wargrave Surgery</td>
<td>92.1%</td>
</tr>
<tr>
<td>Wilderness Road Surgery</td>
<td>94.7%</td>
</tr>
<tr>
<td>Wokingham Medical Centre</td>
<td>90.1%</td>
</tr>
<tr>
<td>Woodley Centre Surgery</td>
<td>91.3%</td>
</tr>
</tbody>
</table>

Source: NHS Digital (2017); Quality and Outcomes Framework
6.13 Hospital Admissions and Activity

In 2015/16, there were 553 admissions for coronary heart disease in Wokingham CCG. This was a rate of 381 per 100,000 population, which was significantly lower than the national rate and comparator group rates.

*Figure 6.3: Rate of admissions to hospital for Coronary Heart Disease for all ages (2002/03 to 2015/16)*

Source: Public Health England (2017); Cardiovascular Disease Profiles
In 2015/16, there were 171 admissions for heart failure in Wokingham CCG. This was a rate of 120 per 100,000 population, which was significantly better than the national rate and similar to the comparator group.

*Figure 64: Rate of admissions to hospital for Heart Failure for all ages (2002/03 to 2015/16)*

In 2015/16, there were 226 admissions for stroke in Wokingham CCG. This was a rate of 158 per 100,000 population, which was similar to the comparator group and national rates.

*Figure 65: Rate of admissions to hospital for Stroke for all ages (2003/04 to 2015/16)*
6.14 Mortality

In 2015, 62 people aged under 75 died from a cardiovascular disease in Wokingham CCG. The graphs below show the mortality rate for men and women from 2009 to 2015.

Figure 66: Under 75 mortality for cardiovascular disease per 100,000 population – directly standardised rate (2009-2015)

From 2009-2015, 58% of people aged under 75 who died from a cardiovascular disease in Wokingham CCG were male. The mortality rate for men remained at a similar level in the CCG over this period at around 46 deaths each year, although there has been a decrease since 2013. This rate has stayed below the national average and similar to the comparator group average over this time.

The mortality rate for women in Wokingham CCG has remained at around 23 deaths each year. This is similar to the national and comparator group averages.

Source: NHS Digital (2016)
6.15 NHS Health Check Programme

The NHS Health Check Programme aims to prevent cardiovascular disease, as well as diabetes and kidney disease. People aged 40 to 74, who have no pre-existing condition, are invited to a health check every 5 years to have their circulatory and vascular health assessed. Individuals then receive advice and support to maintain or improve their health, such as making lifestyle changes or being referred on for further tests.

Local authorities have been responsible for the delivery of the NHS Health Check Programme since April 2013. GPs are the main providers of Health Checks in Wokingham Borough.

**Wokingham Borough**

Eligible population in 2015/16: 49,500

<table>
<thead>
<tr>
<th>Number</th>
<th>% of eligible population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health checks offered (1/4/13 to 31/3/17)</td>
<td>24,219</td>
</tr>
<tr>
<td>Health checks completed (1/4/13 to 31/3/17)</td>
<td>10,502</td>
</tr>
</tbody>
</table>


At the end of 2016/17, 36.2% of the eligible population in England had received an NHS health check. Wokingham Borough’s figure of 21.2% was significantly worse than this.
6.2 Cancer

There are more than 200 types of cancer, with different causes, symptoms and treatments. In the UK the most common types of cancer are breast, prostate, lung, bowel, bladder and uterine (womb). Cancer incidence rates have increased by more than one-third since the mid 1970s, with approximately 910 people being diagnosed with cancer every day. Although more than 1 in 3 people in the UK will now develop some form of cancer in their lifetime, the mortality rate for cancer has actually decreased. Over half of people diagnosed with cancer in the UK will survive 10 or more years after diagnosis.

Cancer is the biggest cause of death in England and Wales, accounting for 28.5% of deaths in 2016. More than half of these deaths occur in people aged 75 and over. Lung cancer is the most common cause of cancer death for both men and women, with more than 1 in 5 of all cancer deaths being from lung cancer.

A person’s risk of developing cancer is dependent on a number of factors, including their age and genetics. Lifestyle also has a significant impact on a person’s chances of developing cancer, such as smoking, drinking alcohol, being overweight, being physically inactive and certain occupations. Cancer Research UK states that over 40% of cancers could be prevented by lifestyle changes.

Public Health England’s Cancer Services Profiles provide additional local information about cancer demographics, screening, diagnostics and two week wait referrals.
6.21 Cancer prevalence and incidence profile for Wokingham CCG

Prevalence is a measure of the burden of a disease in the population at a particular point in time. This section provides information about the recorded prevalence of Cancer in the CCG area, which has been taken from the Quality and Outcomes Framework. This has been compared with the prevalence rates of similar CCGs and also the national rate.

Number of people on Cancer Registers: 4,445
Recorded prevalence in CCG area: 2.74%
Comparison of prevalence:
- Less than the Comparator CCG rate of 2.85%
- Less than the national rate of 2.58%

The CCG’s 2016/17 prevalence rate was higher than the 2015/16 rate of 2.58%.

Figure 67: Prevalence of Cancer at a GP Practice level in 2015/16 and 2016/17

Source: NHS Digital (2017); Quality and Outcomes Framework
6.211 Cancer incidence

Cancer incidence rates have increased by more than one-third since the mid 1970s, with approximately 910 people being diagnosed with cancer every day. Although more than 1 in 3 people in the UK will now develop some form of cancer in their lifetime, the mortality rate for cancer has actually decreased.

4,034 new cases of cancer were recorded in Wokingham CCG from 2011 to 2015 at an age-standardised rate of 583 per 100,000 population. This compares to 614 per 100,000 population in England. 19% of all new diagnoses in Wokingham CCG were for breast cancer, 16% were for prostate cancer, 12% were for colorectal cancer and 8% were for lung cancer (Public Health England, Local Health, 2017).

6.22 Quality of Care

This section of the Profile provides a summary of indicators that are used to monitor care for cancer from the CCG Outcomes Indicator Set (CCG OIS) and the GP Quality and Outcomes Framework (QOF):

- CCG Outcomes Indicator Set – the indicators included in the CCG OIS contribute to the five domains of the NHS Outcomes Framework. This provides clear, comparative information for CCGs about the quality of health services and the associated health outcomes.

- Quality and Outcomes Framework (QOF) – the QOF is the annual reward and incentive programme detailing GP practice achievement results. This rewards practices for the provision of quality care and helps standardise improvement in the delivery of primary medical services.

These indicators compare Wokingham CCG’s performance against the national average and the CCG Comparator Group. The Comparator Group includes the 10 CCGs that are “most similar” to Wokingham CCG, as defined in the Commissioning for Value packs. The Direction of Travel (DOT) is also shown to indicate whether the CCG’s performance was significantly better, significantly worse or similar to the previous year’s outturn.

Where Wokingham CCG have performed significantly worse than the Comparator Group average in the Quality and Outcomes Framework, an additional graph has been included to show a breakdown by GP.
6.221 CCG Outcomes Indicator Set summary for cancer

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Latest outturn CCG value</th>
<th>CCG Comp Group Avg</th>
<th>England Avg</th>
<th>CCG Comp Group Worst</th>
<th>CCG Comparator Group Range</th>
<th>Previous outturn CCG value</th>
<th>Pre DOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCG 1.1c PYLL for causes considered amenable to healthcare - neoplasms</td>
<td>2012-14 608.4 566.9 620.5 639.7</td>
<td>472.1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>CCG 1.9 Under 75 mortality rate from cancer</td>
<td>2015 97.9 103.2 119.5 125.2</td>
<td>93.2</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>CCG 1.10 One year survival from all cancers</td>
<td>2014 70.0% 72.0% 70.4% 70.0%</td>
<td>73.8%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>CCG 1.14 Maternal smoking at delivery</td>
<td>2016/17 Q4 3.8% 6.5% 10.8% 8.4%</td>
<td>3.8%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>CCG 1.17 Cancer: % of new cases for which a valid stage is recorded</td>
<td>2015 75.4% 76.4% 79.6% 72.5%</td>
<td>79.8%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>CCG 1.18 Cancer: % of new cases diagnosed at stage 1 or 2</td>
<td>2015 55.4% 52.8% 52.4% 48.3%</td>
<td>55.7%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>CCG 1.19 Record of lung cancer stage at decision to treat</td>
<td>2015 98.3% 91.6% 92.5% 85.6%</td>
<td>98.3%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>CCG 1.20 Mortality rate from breast cancer</td>
<td>2013-15 35.8 34.5 34.3 41.0</td>
<td>29.8</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>CCG 2.1 Improved health-related quality of life for people with LTCs</td>
<td>2016/17 0.80 0.78 0.74 0.77</td>
<td>0.80</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>CCG 2.2 % of people feeling supported to manage their conditions</td>
<td>2016/17 70.2% 65.6% 64.0% 61.2%</td>
<td>70.2%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Wokingham CCG’s one-year survival from all cancers was significantly lower in 2014, compared to the CCG Comparator Group.

In 2015, 75% of new cases of cancer had a valid stage recorded in Wokingham CCG. This was a significant improvement on 2014’s figure, however it continued to be below the national average. This indicator is included in the CCG OIS, as tumour stage diagnoses is a major determinant of cancer outcomes. Improving the recording of cancer stage at diagnosis allows more detailed and actionable analyses of outcomes by treatment type, patient pathway and case mix. In Wokingham CCG, 98% of lung cancer cases had a cancer stage recorded at the decision to treat, which was a significant improvement on the previous year’s figures and also the highest proportion in the comparator group.

55% of new cancer cases were diagnosed at stage 1 or 2 in Wokingham CCG in 2015. This was significantly better than the previous year’s outturn and one of the highest proportions in the comparator group. Diagnosing cancer at an early stage improves the chance of survival. Specific public health interventions, such as screening programmes and information campaigns, aim to improve rates or early diagnosis.
6.222 Quality and Outcomes Framework – Cancer

<table>
<thead>
<tr>
<th>Indicator</th>
<th>CAN03</th>
<th>SMOK04</th>
<th>SMOK05</th>
<th>CS02</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% patients with cancer, diagnosed in the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis</td>
<td>% of patients aged 15+ who are recorded as current smokers who have a record of an offer of support and treatment within the previous 24 months</td>
<td>% of patients with LTCs who are recorded as current smokers who have a record of an offer of support and treatment within the previous 12 months</td>
<td>% of women aged 25-64 whose notes record that a cervical screening test has been performed in the preceding 5 years</td>
</tr>
<tr>
<td>Wok Value</td>
<td>95%</td>
<td>87%</td>
<td>99%</td>
<td>83%</td>
</tr>
<tr>
<td>CCG Comp Avg</td>
<td>95%</td>
<td>91%</td>
<td>98%</td>
<td>82%</td>
</tr>
<tr>
<td>Eng Avg</td>
<td>94%</td>
<td>90%</td>
<td>97%</td>
<td>81%</td>
</tr>
<tr>
<td>CCG Comp Worst</td>
<td>88%</td>
<td>87%</td>
<td>96%</td>
<td>80%</td>
</tr>
<tr>
<td>CCG Comparator Group Range</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCG Comp Best</td>
<td>97%</td>
<td>96%</td>
<td>99%</td>
<td>83%</td>
</tr>
<tr>
<td>Dobots</td>
<td>95%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DOT for Wok CCG</td>
<td>95%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A graph for SMOK04 is included in the ‘Risk factors for cardiovascular disease’ section of this Profile (6.128).

6.23 Diagnosis

6.231 Routes to diagnosis

The route to a cancer diagnosis ultimately impacts on patient survival. Different cancer types show substantial differences between the proportion of cases that present by each route. Patients presenting via emergency routes have significantly lower one-year survival rates than those diagnosed through other routes. Figure 68 shows the route to diagnosis for Wokingham CCG in 2006-2014. These focus on breast, colorectal, lung and prostate cancer. The majority of cases are diagnosed via the managed route in Wokingham CCG, which include GP referrals, 2 week waits and hospital referrals. Wokingham CCG’s rate of diagnoses through ‘other’ routes are significantly higher than the England average for female breast cancer, colorectal cancer and prostate cancer. Other routes include diagnosis after death or if diagnosis route is unknown.
Figure 68: Routes to diagnoses by cancer type in Wokingham CCG (2006-2014)

<table>
<thead>
<tr>
<th>Cancer type</th>
<th>Number of cases</th>
<th>Directly age-standardised rate per 100,000 population by route</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Screen detected</td>
</tr>
<tr>
<td>Female breast cancer</td>
<td>1,242</td>
<td>59.0</td>
</tr>
<tr>
<td>Colorectal cancer</td>
<td>835</td>
<td>5.7</td>
</tr>
<tr>
<td>Lung cancer</td>
<td>550</td>
<td>-</td>
</tr>
<tr>
<td>Prostate cancer</td>
<td>1,018</td>
<td>-</td>
</tr>
</tbody>
</table>

Source: National Cancer Intelligence Network (2016); Routes to diagnoses 2006 – 2014 workbook

Figure 69: Percentage of cancer diagnoses by route for Wokingham CCG and England (2006-2014)

Source: National Cancer Intelligence Network (2016); Routes to diagnoses 2006 – 2014 workbook
6.232 Two Week Wait Referrals

In 2015/16, there were 5,279 two week wait referrals for suspected cancer in Wokingham CCG. This was a rate of 3,246 per 100,000 population and similar to the national figure of 3,164 per 100,000. 8.2% of the CCG’s referrals resulted in a diagnosis of cancer.

*Figure 70: Two week wait referrals for suspected cancer by cancer type (2016/17)*

<table>
<thead>
<tr>
<th>Cancer type</th>
<th>Wokingham CCG</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Rate per 100,000 population</td>
</tr>
<tr>
<td>All cancers</td>
<td>5,279</td>
<td>3,246</td>
</tr>
<tr>
<td>Breast cancer</td>
<td>971</td>
<td>597</td>
</tr>
<tr>
<td>Lower GI cancer</td>
<td>683</td>
<td>420</td>
</tr>
<tr>
<td>Lung cancer</td>
<td>109</td>
<td>67</td>
</tr>
<tr>
<td>Skin cancer</td>
<td>1,331</td>
<td>819</td>
</tr>
</tbody>
</table>

*Source: Public Health England (2017); Cancer Services*

6.24 Cancer Screening

6.241 Breast Screening

The Department of Health's (2011) *Improving Outcomes: A Strategy for Cancer* recognised that cancer screening was an important way to detect cancer early and that around a third of breast cancers are now diagnosed through screening. The NHS Breast Screening Programme invites women between the ages of 50 and 70 for breast screening every three years. The first step involves a mammogram of each breast. The mammogram can detect small changes in breast tissue which may indicate cancers which are too small to be felt either by the woman herself or by a doctor.

In 2015/16, over 2 million women aged 45 and over were screened by the National Breast Screening Programme in England. Overall, the breast screening programme finds cancer in about 8 out of every 1,000 women having screening. Current evidence suggests that breast screening reduces the number of deaths from breast cancer by about 1,300 a year in the UK (NHS Digital, 2016).
At 31st March 2017, Wokingham CCG’s breast screening coverage was 77.5%, which was lower than the national target of 80%. 16,238 eligible women received screening in the 3 years prior to this date. Figure 71 shows that the coverage rates varied across GP practices in the CCG, with 4 practices achieving the national target of 80% and 3 not meeting the minimum standard of 70%. The remaining 6 practices coverage rates fell between 70 and 80%.

Figure 71: Breast screening coverage in Wokingham CCG at 31st March 2017 (3 year coverage)

Source: Public Health England (2017); Cancer Services
6.242 Cervical Screening

Cervical screening is not a test for cancer. It is a method of preventing cancer by detecting and treating early abnormalities which, if left untreated, could lead to cancer in a woman's cervix. The screening involves taking a sample of cells from the cervix for analysis. The NHS Cervical Screening Programme invites all women between the ages of 25 and 64 for free screening test every three to five years. The screening intervals are different for particular age groups (25-49: 3 yearly; 50-64: 5 yearly). In 2016/17, over 3 million women aged 25 to 64 were screened by the National Programme in England (NHS Digital, 2017).

It is estimated that cervical screening saves around 4,500 lives each year in the UK. Women screened between the ages of 35 to 64 are thought to have a 60 to 80% lower risk of being diagnosed with cervical cancer in the 5 years following the test compared to women who haven’t been screened. The benefit of screening also increases with age. Since cervical screening started in the 1980s in Great Britain, rates of cervical cancer have almost halved.

At 31st March 2017, Wokingham CCG’s cervical screening coverage was 76.3%, which was below the national target of 80%. 31,906 eligible women received screening in the age-appropriate time period (3 to 5 years). The coverage rates varied across the GP practices in the CCG with one meeting the national target.

Figure 72: Cervical screening coverage in Wokingham CCG at 31st March 2017 (within age appropriate target period – 3 to 5 year coverage)
6.243 Bowel Screening

About 1 in 20 people in the UK will develop bowel cancer during their lifetime. It is the third most common cancer in the UK, and the second leading cause of cancer deaths, with over 16,000 people dying from it each year.

Regular bowel cancer screening has been shown to reduce the risk of dying from bowel cancer by 16%. Bowel cancer screening aims to detect bowel cancer at an early stage when patients may be asymptomatic. At this early stage treatment is more likely to be effective.

The NHS Bowel Cancer Screening Programme offers screening every two years to all men and women aged 60 to 74. The screening is done by faecal occult blood test kits. At 31st March 2017, Wokingham CCG’s bowel screening coverage was 67.1%. 16,157 eligible people received an adequate screening result from these tests in the 2 years previous. No national target or minimum standard is currently set for this screening programme.

*Figure 73: Bowel screening coverage in Wokingham CCG at 31st March 2017 (2 ½ year coverage)*

Source: Public Health England (2017); Cancer Services
6.25 Hospital Admissions and Activity

In 2015/16, there were 436 emergency admissions in Wokingham CCG which had a diagnostic code of cancer. This was a rate of 272 per 100,000 population, which was significantly lower than the comparator group and national figures.

Figure 74: Rate of emergency admissions to hospital with a diagnostic code of cancer (2009/10 to 2015/16)

Source: Public Health England (2017); Cancer Services
6.26 Mortality

In 2015, 146 people aged under 75 died from cancer in Wokingham CCG. This is a rate of 98 per 100,000 population. The graphs below show the mortality rate for men and women from 2009 to 2015.

**Figure 75: Under 75 mortality for cancer per 100,000 population – directly standardised rate (2009-2015)**

In 2015, 84 men aged under 75 died from cancer in Wokingham CCG, which is a rate of 112 per 100,000 population. This is similar to both the national and comparator group figures. From 2009 to 2015, men accounted for 57% of cancer deaths in people aged under 75 in Wokingham CCG.

In 2015, 62 women aged under 75 died from cancer in the CCG, which is a rate of 84 per 100,000 population. The rate dropped in 2015, having previously increased from 2012 to 2015.

Source: NHS Digital (2016)
6.3 Respiratory Disease

Chronic Obstructive Pulmonary Disease (COPD) is the name for a collection of lung diseases, such as chronic bronchitis, emphysema and chronic obstructive airways disease. COPD usually affects people over the age of 35, although most people are not diagnosed until they are in their fifties. It is thought there are over 3 million people living with the disease in the UK, of which only about 900,000 have been diagnosed. COPD is the fifth largest cause of death in the UK, killing approximately 25,000 people each year.

The prevalence of asthma in England is amongst the highest in the world. Asthma is responsible for a large number of emergency admissions to hospital each year. Deaths from asthma have remained at 1,000-1,200 each year since 2000, but it is estimated that 90% of these are associated with preventable factors.

Respiratory diseases are the 3rd main cause of death in England, behind cancer and circulatory diseases. In 2016, 13.7% of all registered deaths in England were caused by respiratory diseases.

6.31 Respiratory Disease prevalence profile for Wokingham CCG

Prevalence is a measure of the burden of a disease in the population at a particular point in time. This section provides information about the recorded prevalence of different Respiratory diseases in the CCG area, which have been taken from the Quality and Outcomes Framework. These have been compared with the prevalence rates of similar CCGs and also the national rate.

It is important to note that looking at the numbers of people currently being treated for a disease does not show the true prevalence and impact on a population’s health. There will also be many people who have a disease or condition that are not aware of it and have not been diagnosed. This section will also include estimated prevalence figures, where available, which have been developed by using population statistics and scientific research on the risks factors for each disease to derive an estimation of the true number of people suffering from it. The source of these estimations will be shown under each condition.
6.311 Chronic Obstructive Pulmonary Disease (COPD) Prevalence

Number of people on COPD Register: 1,698
Recorded prevalence in CCG area: 1.04%
Comparison of prevalence:
- ↓ than the Comparator CCG rate of 1.31%
- ↓ than the national rate of 1.87%

The CCG’s 2016/17 prevalence rate was similar to the 2015/16 rate of 1.04%.

The estimated prevalence for Chronic Obstructive Pulmonary Disease in Wokingham CCG is 2.4%. This means that there were 2,202 people “missing” from GP registers in 2016/17. These estimations come from Public Health England’s Inhale Profile developed by the Department of Primary Care and Social Medicine, Imperial College and are based on October 2017 GP population figures.

Figure 76: Prevalence of Chronic Obstructive Pulmonary Disease at a GP Practice level in 2015/16 and 2016/17

Source: NHS Digital (2017); Quality and Outcomes Framework
### 6.312 Asthma Prevalence

The estimated prevalence for Asthma in Wokingham CCG is 9.2%. This means that there were 4,675 people “missing” from GP registers in 2016/17. These estimations come from Public Health England’s Inhale Profile developed by the Department of Primary Care and Social Medicine, Imperial College and are based on October 2017 GP population figures.

The CCG’s 2016/17 prevalence rate was the same as the 2015/16 rate.

**Figure 77: Prevalence of Asthma at a GP Practice level in 2015/16 and 2016/17**

**Number of people on Asthma Register:** 10,277

- **Recorded prevalence in CCG area:** 6.3%
- **Comparison of prevalence:**
  - ‣ than the Comparator CCG rate of 5.8%
  - ‣ than the national rate of 5.9%

The estimated prevalence for Asthma in Wokingham CCG is 9.2%. This means that there were 4,675 people “missing” from GP registers in 2016/17. These estimations come from Public Health England’s Inhale Profile developed by the Department of Primary Care and Social Medicine, Imperial College and are based on October 2017 GP population figures.

The estimated prevalence for Asthma in Wokingham CCG is 9.2%. This means that there were 4,675 people “missing” from GP registers in 2016/17. These estimations come from Public Health England’s Inhale Profile developed by the Department of Primary Care and Social Medicine, Imperial College and are based on October 2017 GP population figures.

**Figure 77: Prevalence of Asthma at a GP Practice level in 2015/16 and 2016/17**

**Number of people on Asthma Register:** 10,277

- **Recorded prevalence in CCG area:** 6.3%
- **Comparison of prevalence:**
  - ‣ than the Comparator CCG rate of 5.8%
  - ‣ than the national rate of 5.9%

The CCG’s 2016/17 prevalence rate was the same as the 2015/16 rate.

**Figure 77: Prevalence of Asthma at a GP Practice level in 2015/16 and 2016/17**

**Number of people on Asthma Register:** 10,277

- **Recorded prevalence in CCG area:** 6.3%
- **Comparison of prevalence:**
  - ‣ than the Comparator CCG rate of 5.8%
  - ‣ than the national rate of 5.9%

The CCG’s 2016/17 prevalence rate was the same as the 2015/16 rate.
6.32 Quality of Care

This section of the Profile provides a summary of indicators that are used to monitor care for respiratory disease from the CCG Outcomes Indicator Set (CCG OIS) and the GP Quality and Outcomes Framework (QOF):

- CCG Outcomes Indicator Set – the indicators included in the CCG OIS contribute to the five domains of the NHS Outcomes Framework. This provides clear, comparative information for CCGs about the quality of health services and the associated health outcomes.

- Quality and Outcomes Framework (QOF) – the QOF is the annual reward and incentive programme detailing GP practice achievement results. This rewards practices for the provision of quality care and helps standardise improvement in the delivery of primary medical services.

These indicators compare Wokingham CCG’s performance against the national average and the CCG Comparator Group. The Comparator Group includes the 10 CCGs that are “most similar” to Wokingham CCG, as defined in the Commissioning for Value packs. The Direction of Travel (DOT) is also shown to indicate whether the CCG’s performance was significantly better, significantly worse or similar to the previous year’s outcome.

Where Wokingham CCG have performed significantly worse than the Comparator Group average in the Quality and Outcomes Framework, an additional graph has been included to show a breakdown by GP.

**Key for spine charts:**
- Green: Significantly better than similar CCG average
- Red: Significantly worse than the similar CCG average
- Black: Not significantly different to the similar CCG average
- Diamond: National average
6.321 CCG Outcomes Indicator Set summary for respiratory diseases

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Latest outturn</th>
<th>CCG value</th>
<th>CCG Comp Group Avg</th>
<th>England Avg</th>
<th>CCG Comp Group Worst</th>
<th>CCG Comparator Group Range</th>
<th>CCG Comp Group Average</th>
<th>Previous outturn</th>
<th>DOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCG 1.1d PYLL for causes considered amenable to healthcare - Respiratory diseases</td>
<td>2012-14</td>
<td>110.6</td>
<td>115.9</td>
<td>140.7</td>
<td>177.7</td>
<td>[73.6]</td>
<td>[131.7]</td>
<td>113.7</td>
<td>↑</td>
</tr>
<tr>
<td>CCG 1.6 Under 75 mortality rate from respiratory disease</td>
<td>2015</td>
<td>14.8</td>
<td>19.6</td>
<td>29.4</td>
<td>27.0</td>
<td>[13.6]</td>
<td>[11.0]</td>
<td>110.0</td>
<td>⇩</td>
</tr>
<tr>
<td>CCG 2.1 Improved health-related quality of life for people with LTCs</td>
<td>2016/17</td>
<td>0.80</td>
<td>0.78</td>
<td>0.74</td>
<td>0.77</td>
<td>[0.80]</td>
<td>[0.82]</td>
<td>[71.2%]</td>
<td>⇩</td>
</tr>
<tr>
<td>CCG 2.2 % of people feeling supported to manage their conditions</td>
<td>2016/17</td>
<td>70.2%</td>
<td>65.6%</td>
<td>64.0%</td>
<td>61.2%</td>
<td>[70.2%]</td>
<td>[71.2%]</td>
<td>71.2%</td>
<td>⇩</td>
</tr>
<tr>
<td>CCG 2.3 % of people with COPD and MRC Dyspnoea Scale &gt;3 referred to a pulmonary rehabilitation programme</td>
<td>2014/15</td>
<td>21.4%</td>
<td>15.1%</td>
<td>18.8%</td>
<td>4.6%</td>
<td>[32.1%]</td>
<td>[20.7%]</td>
<td>[20.7%]</td>
<td>⇩</td>
</tr>
<tr>
<td>CCG 2.6 Unplanned hospitalisation for chronic ambulatory care sensitive (ACS) conditions</td>
<td>2016/17</td>
<td>585.9</td>
<td>573.2</td>
<td>821.2</td>
<td>770.7</td>
<td>[107.7]</td>
<td>[566.1]</td>
<td>226.7</td>
<td>↑</td>
</tr>
<tr>
<td>CCG 2.7 Unplanned hospitalisation for asthma, diabetes and epilepsy (under 19s)</td>
<td>2016/17</td>
<td>158.3</td>
<td>215.8</td>
<td>304.1</td>
<td>378.4</td>
<td>[92.9]</td>
<td>[226.7]</td>
<td>226.7</td>
<td>↑</td>
</tr>
<tr>
<td>CCG 3.1 Emergency admissions for acute conditions that should not usually require hospital admission</td>
<td>2016/17</td>
<td>983</td>
<td>1064</td>
<td>1357</td>
<td>1444</td>
<td>[253]</td>
<td>[977]</td>
<td>977</td>
<td>⇩</td>
</tr>
<tr>
<td>CCG 3.2 Emergency readmissions within 30 days of discharge from hospital</td>
<td>2011/12</td>
<td>10.3%</td>
<td>11.5%</td>
<td>11.8%</td>
<td>13.1%</td>
<td>[10.3%]</td>
<td>[10.2%]</td>
<td>10.2%</td>
<td>⇩</td>
</tr>
<tr>
<td>CCG 3.4 Emergency admissions for children with LRTIs</td>
<td>2016/17</td>
<td>344.3</td>
<td>432.6</td>
<td>459.0</td>
<td>748.2</td>
<td>[267.4]</td>
<td>[332.7]</td>
<td>332.7</td>
<td>⇩</td>
</tr>
</tbody>
</table>

In 2014/15, 21% of people with COPD and a diagnosis of >3 on the Medical Research Council Dyspnoea Scale were referred to a pulmonary rehabilitation programme in Wokingham CCG. This was a significantly better referral rate than the CCG comparator group average.

Wokingham CCG had one of the highest average health-status score for people with long-term conditions in the comparator group. This is collected through the GP Patient Survey, where each survey respondent answers a series of questions from which a health status score can be calculated. The measure seeks to assess whether health-related quality of life is increasing over time for the population with long-term conditions, while adjusting for measureable factors that the NHS does not have control over, such as age and sex. The GP Patient Survey also indicated that the CCG had the highest percentage of people with long-term conditions who felt that they were supported to manage their condition in the comparator group. More information about the GP Patient Survey can be found in section 7 of this Profile.
In 2016/17, Wokingham CCG’s unplanned hospitalisation for chronic ambulatory care sensitive conditions (CCG 2.6) was similar to the CCG comparator group. Emergency admissions for conditions that should not usually require hospital admission (CCG 3.1) were significantly better than the comparator group. Additional trend information for both of these indicators can be found in the ‘General healthcare and hospital activity’ section of the Profile (6.9).

6.322 Quality and Outcomes Framework – Chronic Obstructive Pulmonary Disease

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Wok CCG Value</th>
<th>CCG Comparator Group Avg</th>
<th>CCG Comparator Group Worst</th>
<th>CCG Comparator Group Range</th>
<th>CCG Comparator Group Best</th>
<th>Wok CCG in 15/16 DOT for Wok CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>COPD02 % patients with COPD diagnosed after 1-Apr-11 whose diagnosis has been confirmed by post bronchodilator spirometry</td>
<td>89%</td>
<td>88%</td>
<td>89%</td>
<td>85%</td>
<td>91%</td>
<td>87%</td>
</tr>
<tr>
<td>COPD03 % patients with COPD who have had a review, including an assessment of breathlessness using the MRC dyspnoea scale in the in the last 12 months</td>
<td>92%</td>
<td>92%</td>
<td>90%</td>
<td>90%</td>
<td>94%</td>
<td>92%</td>
</tr>
<tr>
<td>COPD04 % patients with COPD with a record of FEV1 in the last 12 months</td>
<td>89%</td>
<td>88%</td>
<td>87%</td>
<td>84%</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>COPD05 % patients with COPD and MRC dyspnoea grade ≤3 at any time in last 12 months, with a record of oxygen saturation value within last 12 months</td>
<td>98%</td>
<td>97%</td>
<td>97%</td>
<td>95%</td>
<td>98%</td>
<td>97%</td>
</tr>
<tr>
<td>COPD07 % patients with COPD who have had flu immunisation in the preceding 1st August to 31st March</td>
<td>99%</td>
<td>98%</td>
<td>97%</td>
<td>97%</td>
<td>99%</td>
<td>98%</td>
</tr>
</tbody>
</table>

6.323 Quality and Outcomes Framework – Asthma

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Wok CCG Value</th>
<th>CCG Comparator Group Avg</th>
<th>CCG Comparator Group Worst</th>
<th>CCG Comparator Group Range</th>
<th>CCG Comparator Group Best</th>
<th>Wok CCG in 15/16 DOT for Wok CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>AST02 % patients aged 8 yrs and over diagnosed as having asthma from 1 Apr 2006 with measures of variability or reversibility recorded</td>
<td>85%</td>
<td>87%</td>
<td>89%</td>
<td>84%</td>
<td>89%</td>
<td>85%</td>
</tr>
<tr>
<td>AST03 % patients with asthma who have had an asthma review in the last 12 months that includes an assessment of asthma control using the 3 RCP questions</td>
<td>76%</td>
<td>76%</td>
<td>76%</td>
<td>73%</td>
<td>78%</td>
<td>74%</td>
</tr>
<tr>
<td>AST04 % patients with asthma between the ages of 14-19 who have a record of smoking status in the last 12 months</td>
<td>87%</td>
<td>88%</td>
<td>89%</td>
<td>85%</td>
<td>91%</td>
<td>85%</td>
</tr>
</tbody>
</table>
Figure 78: GP Practice performance for AST02: % patients aged 8 and over diagnosed as having asthma from 1 Apr 2006 with measures of variability or reversibility recorded

Source: NHS Digital (2017); Quality and Outcomes Framework

6.324 Quality and Outcomes Framework – Risk factors for Respiratory Disease

<table>
<thead>
<tr>
<th>Indicator</th>
<th>CCG Comparator Group Range</th>
<th>Wok CCG in 15/16</th>
<th>DOT for Wok CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>SMOK02</td>
<td>Wok CCG Value</td>
<td>CCG Comp Group Avg</td>
<td>Eng Avg</td>
</tr>
<tr>
<td>% patients with LTCs whose notes record smoking status in last 12 months</td>
<td>94%</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>SMOK04</td>
<td>% of patients aged 15+ who are recorded as current smokers who have a record of an offer of support and treatment within the previous 24 months</td>
<td>87%</td>
<td>91%</td>
</tr>
<tr>
<td>SMOK05</td>
<td>% of patients with LTCs who are recorded as current smokers who have a record of an offer of support and treatment within the previous 12 months</td>
<td>99%</td>
<td>98%</td>
</tr>
</tbody>
</table>

Graphs for SMOK02 and SMOK04 are included in the ‘Risk factors for cardiovascular disease’ section of this Profile (6.128).
6.33 Mortality

In 2015, 22 people aged under 75 died from a respiratory disease in Wokingham CCG, which is a rate of 15 per 100,000 population. The graphs below show the mortality rate for men and women from 2009 to 2015.

Figure 79: Under 75 mortality for respiratory disease per 100,000 population – directly standardised rate (2009-2015)

In 2009-2015, 57% of people aged under 75 who died from a respiratory disease in Wokingham CCG were male. This is similar to the national figures.

The mortality rates for men and women have generally been lower than the national rates over this time period, and were both significantly lower in 2015. Single year figures can be affected by short-term fluctuations in data, rather than a genuine increase or decrease in deaths, so it is important to look at the overall trends rather than yearly figures.

Source: NHS Digital (2016)
### 6.4 Diabetes

Diabetes is a lifelong condition that causes a person’s blood sugar level to become too high. In the UK, diabetes affects 2.8 million people and there are estimated to be an additional 980,000 people with diabetes who are undiagnosed.

Diabetes is one of the key local priorities for Berkshire CCGs and Public Health teams, as it is a long-term disease with significant effects on morbidity and mortality. People with diabetes are more likely to have a heart attack, stroke or emergency admission related to heart failure than the general population. They are also more likely to develop kidney disease, go blind and have complications in pregnancy, compared to people without the disease. Diabetes UK estimates that the life expectancy of someone with type 2 diabetes is likely to be reduced by 10 years, as a result of the condition.

Public Health England have published a Diabetes Profile for CCGs and local authorities, as part of the Fingertips suite of tools, and this provides additional information on care processes, treatment targets, complications, prevalence and risk.

#### 6.4.1 Diabetes prevalence profile for Wokingham CCG

Prevalence is a measure of the burden of a disease in the population at a particular point in time. This section provides information about the recorded prevalence of Diabetes in the CCG area, which has been taken from the Quality and Outcomes Framework. These have been compared with the prevalence rates of similar CCGs and also the national rate.

It is important to note that looking at the numbers of people currently being treated for a disease does not show the true prevalence and impact on a population’s health. There will also be many people who have a disease or condition that are not aware of it and have not been diagnosed. This section will also include estimated prevalence figures, where available, which have been developed by using population statistics and scientific research on the risks factors for each disease to derive an estimation of the true number of people suffering from it.
The estimated prevalence for Diabetes in Wokingham CCG is 7.3%. This means that there were 3,142 people “missing” from GP registers in 2016/17. These estimations come from the refreshed Diabetes Prevalence Model developed by Public Health England’s National Cardiovascular Intelligence Network.

**Figure 80: Prevalence of Diabetes at a GP Practice level in 2015/16 and 2016/17**

Source: NHS Digital (2017); Quality and Outcomes Framework
The prevalence of diabetes is expected to increase in Wokingham CCG over the next 20 years. Figure 81 shows the projections, which have been developed by Public Health England’s National Cardiovascular Intelligence Network. These are based on GP Practice Populations for April 2015 and have been adjusted for age, sex, ethnic group and deprivation.

By 2035, 8.2% of Wokingham CCG’s population aged 16 and over are expected to have diabetes, which is 11,977 people.

*Figure 81: Projected prevalence of diabetes in Wokingham CCG (2015 to 2035)*

Source: Public Health England (2016), Diabetes prevalence model for local authorities and CCGs
6.42 Quality of Care

This section of the Profile provides a summary of indicators that are used to monitor care for diabetes:

- **CCG Outcomes Indicator Set** – the indicators included in the CCG OIS contribute to the five domains of the NHS Outcomes Framework. This provides clear, comparative information for CCGs about the quality of health services and the associated health outcomes.

- **Quality and Outcomes Framework (QOF)** – the QOF is the annual reward and incentive programme detailing GP practice achievement results. This rewards practices for the provision of quality care and helps standardise improvement in the delivery of primary medical services.

- **National Diabetes Audit (NDA)** – The NDA is a major national clinical audit, which measures the effectiveness of diabetes healthcare against NICE Clinical Guidelines and NICE Quality Standards in England and Wales. All people with diabetes aged 12 years and over should annually receive nine NICE recommended care processes and attend a structured education program when diagnosed. Some of the results from the NDA are included in the CCG OIS and QOF to assess diabetes care locally.

The CCG OIS and QOF indicators included compare Wokingham CCG’s performance against the national average and the CCG Comparator Group. The Comparator Group includes the 10 CCGs that are “most similar” to Wokingham CCG, as defined in the Commissioning for Value packs. The Direction of Travel (DOT) is also shown to indicate whether the CCG’s performance was significantly better, significantly worse or similar to the previous year’s outturn.

Where Wokingham CCG have performed significantly worse than the Comparator Group average in the Quality and Outcomes Framework, an additional graph has been included to show a breakdown by GP.
6.421 CCG Outcomes Indicator Set summary for diabetes

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Latest outturn</th>
<th>CCG value</th>
<th>CCG Comp Group Avg</th>
<th>CCG Comp Group Worst</th>
<th>CCG Comparator Group Range</th>
<th>CCG Comp Group Best</th>
<th>Previous outturn</th>
<th>DOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCG 1.4 Ratio of MI, stroke &amp; stage 5 CKD in people with diabetes</td>
<td>2015/16</td>
<td>73.5</td>
<td>77.8</td>
<td>100.0</td>
<td>96.8</td>
<td>54.2</td>
<td>79.1</td>
<td>↘</td>
</tr>
<tr>
<td>CCG 2.1 Improved health-related quality of life for people with LTCs</td>
<td>2016/17</td>
<td>0.80</td>
<td>0.78</td>
<td>0.74</td>
<td>0.77</td>
<td>0.80</td>
<td>0.82</td>
<td>↘</td>
</tr>
<tr>
<td>CCG 2.2 % of people feeling supported to manage their conditions</td>
<td>2016/17</td>
<td>70.2%</td>
<td>65.6%</td>
<td>64.0%</td>
<td>61.2%</td>
<td>70.2%</td>
<td>71.2%</td>
<td>↘</td>
</tr>
<tr>
<td>CCG 2.4 People with diabetes who have received nine care processes</td>
<td>2015/16</td>
<td>62.8%</td>
<td>50.8%</td>
<td>52.6%</td>
<td>35.5%</td>
<td>62.8%</td>
<td>63.6%</td>
<td>↘</td>
</tr>
<tr>
<td>CCG 2.5 Diabetes: People diagnosed less than a year who are referred to</td>
<td>2014/15</td>
<td>78.7%</td>
<td>78.0%</td>
<td>75.8%</td>
<td>66.1%</td>
<td>87.6%</td>
<td>67.4%</td>
<td>↑</td>
</tr>
<tr>
<td>structured education</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCG 2.6 Unplanned hospitalisation for chronic ambulatory care sensitive</td>
<td>2016/17</td>
<td>585.9</td>
<td>573.2</td>
<td>821.2</td>
<td>770.7</td>
<td>107.7</td>
<td>566.1</td>
<td>⇧</td>
</tr>
<tr>
<td>(ACS) conditions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCG 2.7 Unplanned hospitalisation for asthma, diabetes and epilepsy</td>
<td>2016/17</td>
<td>158.3</td>
<td>215.8</td>
<td>304.1</td>
<td>378.4</td>
<td>92.9</td>
<td>226.7</td>
<td>↑</td>
</tr>
<tr>
<td>(under 19s)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCG 2.8 Diabetes: Ratio of complications associated with diabetes</td>
<td>2015/16</td>
<td>77.1</td>
<td>81.3</td>
<td>100.0</td>
<td>105.7</td>
<td>64.8</td>
<td>77.1</td>
<td>⇧</td>
</tr>
<tr>
<td>CCG 3.1 Emergency admissions for acute conditions that should not</td>
<td>2016/17</td>
<td>983</td>
<td>1,064</td>
<td>1,357</td>
<td>1,444</td>
<td>253</td>
<td>977</td>
<td>⇧</td>
</tr>
<tr>
<td>usually require hospital admission</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCG 3.2 Emergency readmissions within 30 days of discharge from hospital</td>
<td>2011/12</td>
<td>10.3%</td>
<td>11.5%</td>
<td>11.8%</td>
<td>13.1%</td>
<td>10.3%</td>
<td>10.2%</td>
<td>⇧</td>
</tr>
</tbody>
</table>

A number of indicators included in the CCG Outcomes Indicator Set are based on findings from the National Diabetes Audit.

**CCG 1.4: Myocardial infarction, stroke and stage 5 chronic kidney disease in people with diabetes**

This indicator measures the proportion of people with diabetes who develop long-term conditions or complications which may be exacerbated by poor management of diabetes. Some complications may be avoidable with high quality management of diabetes in primary care and this indicator can therefore be used as a proxy for outcomes of care. In 2015/16, 103 people with diabetes in Wokingham CCG had an admission to hospital for myocardial infarction, stroke or stage 5 chronic kidney disease. This is an indirectly standardised ratio of 73.5, which is lower than the England standard of 100.
CCG 2.5: People with diabetes diagnosed less than a year who are referred to structured education
This indicator measures the percentage of people with diabetes diagnosed for less than one year who have a record of a referral for structured education. This is a key aspect of high-quality care, which is included in the NICE Quality Standard for Diabetes. In 2014/15, 461 people were newly diagnosed with diabetes in Wokingham CCG and 79% of these were referred to structured education. Nationally, 76% of newly diagnosed people were referred.

CCG 2.8: Ratio of complications associated with diabetes
This indicator measures the rates of complications associated with diabetes, including admissions for myocardial infarction, stroke and stage 5 chronic kidney disease, diabetic ketoacidosis, angina, heart failure, renal replacement therapy, retinopathy treatments and lower limb amputation. Some complications associated with diabetes are avoidable with high-quality diabetes management in primary care. This indicator is used as a proxy for outcomes of care.

In 2015/16, 341 people with diabetes in Wokingham CCG had an admission to hospital for one of these complications. This is an indirectly standardised ratio of 77.1, which is lower than the England standard of 100.

In 2016/17, Wokingham CCG’s unplanned hospitalisation for chronic ambulatory care sensitive conditions (CCG 2.6) was similar to the CCG comparator group. Emergency admissions for conditions that should not usually require hospital admission (CCG 3.1) were significantly better than the comparator group. Additional trend information for both of these indicators can be found in the ‘General healthcare and hospital activity’ section of the Profile (6.9).
### 6.422 Quality and Outcomes Framework – Diabetes

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Wok CCG Value</th>
<th>CCG Comparator Group Avg</th>
<th>CCG Comparator Group Worst</th>
<th>CCG Comparator Group Range</th>
<th>CCG Comparator Group Best</th>
<th>Wok CCG in 15/16</th>
<th>DOT for Wok CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>DM02 % patients with diabetes who have last BP reading in the previous 12 months of 150/90 or less</td>
<td>93%</td>
<td>92%</td>
<td>92%</td>
<td>90%</td>
<td>95%</td>
<td>92%</td>
<td>↑</td>
</tr>
<tr>
<td>DM03 % patients with diabetes who have last BP reading in the previous 12 months of 140/80 or less</td>
<td>79%</td>
<td>78%</td>
<td>78%</td>
<td>74%</td>
<td>84%</td>
<td>78%</td>
<td>⇣</td>
</tr>
<tr>
<td>DM04 % patients with diabetes whose last measured total cholesterol within the last 12 months is 5mmol/l or less</td>
<td>81%</td>
<td>81%</td>
<td>80%</td>
<td>78%</td>
<td>83%</td>
<td>81%</td>
<td>⇣</td>
</tr>
<tr>
<td>DM06 % patients with diabetes with a diagnosis of nephropathy or microalbuminuria who are currently treated with ACE-I or ARBs</td>
<td>99%</td>
<td>96%</td>
<td>93%</td>
<td>91%</td>
<td>99%</td>
<td>95%</td>
<td>↑</td>
</tr>
<tr>
<td>DM07 % patients with diabetes in whom the last IFCC-HbA1c is 59 mmol/mol or less in the last 12 months</td>
<td>69%</td>
<td>74%</td>
<td>72%</td>
<td>69%</td>
<td>75%</td>
<td>65%</td>
<td>↑</td>
</tr>
<tr>
<td>DM08 % patients with diabetes in whom the last IFCC-HbA1c is 64 mmol/mol or less in the last 12 months</td>
<td>77%</td>
<td>81%</td>
<td>79%</td>
<td>77%</td>
<td>83%</td>
<td>74%</td>
<td>↑</td>
</tr>
<tr>
<td>DM09 % patients with diabetes in whom the last IFCC-HbA1c is 75 mmol/mol or less in the last 12 months</td>
<td>88%</td>
<td>90%</td>
<td>88%</td>
<td>88%</td>
<td>92%</td>
<td>86%</td>
<td>↑</td>
</tr>
<tr>
<td>DM12 % patients with diabetes with record of a foot examination and risk classification in the last 12 months</td>
<td>93%</td>
<td>91%</td>
<td>90%</td>
<td>85%</td>
<td>93%</td>
<td>92%</td>
<td>↑</td>
</tr>
<tr>
<td>DM14 % patients newly diagnosed with diabetes in preceding 1-Apr to 31-Mar who have a record of being referred to a structured education programme</td>
<td>93%</td>
<td>95%</td>
<td>93%</td>
<td>93%</td>
<td>97%</td>
<td>95%</td>
<td>⇣</td>
</tr>
<tr>
<td>DM18 % patients with diabetes who have had flu immunisation in the preceding 1st August to 31st March</td>
<td>96%</td>
<td>96%</td>
<td>95%</td>
<td>93%</td>
<td>98%</td>
<td>95%</td>
<td>↑</td>
</tr>
</tbody>
</table>
Figure 82: GP Practice performance for DM07: % patients with diabetes in whom the last IFCC-HbA1c is 59 mmol/mol or less in the last 12 months

Source: NHS Digital (2017); Quality and Outcomes Framework

Figure 83: GP Practice performance for DM08: % patients with diabetes in whom the last IFCC-HbA1c is 64 mmol/mol or less in the last 12 months

Source: NHS Digital (2017); Quality and Outcomes Framework
Figure 84: GP Practice performance for DM09: % patients with diabetes in whom the last IFCC-HbA1c is 75 mmol/mol or less in the last 12 months

The National Diabetes Audit (NDA) indicated that 6,100 people were registered as having diabetes in Wokingham CCG in 2016/17. 90% of these were registered as having Type 2 diabetes (5,470 people). The Audit provides a summary by gender, age, ethnicity and deprivation quintile, as shown below:

**Gender**
59% of people registered with diabetes in Wokingham CCG were men (same for both types of diabetes).

**Age**
As expected, the age profile of people diagnosed with diabetes differed between Type 1 and Type 2. 40% of people diagnosed with Type 1 diabetes were aged under 40, compared to only 3% of people with Type 2 diabetes.
Figure 85: Age group of people registered with diagnosed diabetes in Wokingham CCG (2016/17)

Source: NHS Digital (2017); National Diabetes Audit 2016-17 Interactive report

Ethnicity

33% of people with diabetes do not have an ethnicity recorded in Wokingham CCG, so the validity of this data is weak. However, it is possible to see that in the CCG, the proportion of people from a minority ethnic origin who have diabetes is higher than the BME population as a whole.

Figure 86: Ethnicity of people registered with diagnosed diabetes in Wokingham CCG (2016/17)

Source: NHS Digital (2017); National Diabetes Audit 2016-17 Interactive report
**Deprivation**

Figure 87 shows the deprivation quintile that people diagnosed with diabetes in Wokingham CCG live in. This indicates that there are a higher proportion of people diagnosed with diabetes from more deprived quintiles, compared to the total population.

*Figure 87: IMD deprivation quintile of people registered with diagnosed diabetes in Wokingham CCG (2016/17)*

All people with diabetes aged 12 years and over should annually receive 8 NICE recommended care processes and attend a structured education program when diagnosed. Figure 88 shows the percentage of people with diabetes who received the NICE recommended care processes in 2016/17. This shows that people with Type 1 diabetes are less likely to receive all 8 of the care processes both nationally and locally when compared with people with Type 2 diabetes. In 2016/17, 49% of people with Type 1 diabetes in Wokingham CCG and 66% of people with Type 2 diabetes received all 8 care processes in the year. These are both higher than the national figures.
In 2015, 25 people were newly diagnosed with Type 1 diabetes in Wokingham CCG. 40% were offered structured education within a year of their diagnosis and none of them attended. 365 people were newly diagnosed with Type 2 diabetes in the same year and 85% were offered structured education within a year of diagnosis. However, only 30 people (8.2%) attended.

NICE recommends treatment targets for HbA1c (glucose control), blood pressure and serum cholesterol
- Target HbA1c reduces the risk of all diabetic complications
- Target blood pressure reduces the risk of vascular complications and reduces the progression of eye disease and kidney failure.
- Target cholesterol reduces the risk of vascular complications

Figure 89 shows that 22.1% of people with Type 1 diabetes in Wokingham CCG and 41.6% of people with Type 2 diabetes achieved all 3 treatment targets in 2016/17. These were higher than the England figures.
**Figure 89: Treatment target achievement for people with diabetes in Wokingham CCG and England (2016/17)**

<table>
<thead>
<tr>
<th>Treatment targets</th>
<th>Type 1 Diabetes</th>
<th>Type 2 Diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Wokingham CCG</td>
<td>England</td>
</tr>
<tr>
<td>HBA1c &lt;= 58mmol (7.5%)</td>
<td>34.9%</td>
<td>30.4%</td>
</tr>
<tr>
<td>Blood Pressure &lt;= 140/80</td>
<td>85.0%</td>
<td>76.0%</td>
</tr>
<tr>
<td>Cholesterol &lt; 5 mmol/l</td>
<td>72.4%</td>
<td>69.4%</td>
</tr>
<tr>
<td>All 3 Treatment targets</td>
<td>22.1%</td>
<td>19.0%</td>
</tr>
</tbody>
</table>

*Source: NHS Digital (2017); National Diabetes Audit 2016-17 Interactive report*
6.5 Chronic Kidney Disease (CKD)

People with Chronic Kidney Disease will have the presence of kidney damage or decreased kidney function for 3 months or more. The severity of Chronic Kidney Disease varies from Stage 1 (mild) to Stage 5 (end-stage kidney failure). The majority of people with CKD will have a mild to moderate disease (Stage 1 to 3), which will not lead to kidney failure or the need for kidney dialysis and transplant. However, people with any stage of CKD have an increased risk of developing heart disease or a stroke, due to changes that occur to their circulation, so it is important to detect even mild CKD. Treatment and changes to lifestyle can slow down the progression of the disease and reduce the risk of heart disease and stroke.

A number of conditions can cause permanent kidney damage and affect the function of the kidneys, such as diabetes, high blood pressure and ageing. These causes account for 75% of cases in adults. CKD is commonly associated with ageing, and the older you get the more likely you are to have some degree of kidney damage. CKD is also more common in people from South Asia, due to the higher levels of diabetes in this population, as well as people from Black African/Caribbean populations who have a higher risk of high blood pressure.

NHS Choices note that the main way to reduce the chances of CKD developing is to ensure that existing conditions are carefully managed, such as diabetes and high blood pressure. Having a healthy diet, exercising regularly and avoiding drinking excessive amounts of alcohol will also reduce the risk of CKD developing.
6.51 Chronic Kidney Disease prevalence profile for Wokingham CCG

Prevalence is a measure of the burden of a disease in the population at a particular point in time. This section provides information about the recorded prevalence of Chronic Kidney Disease in the CCG area, which has been taken from the QOF.

Number of people on CKD Register: 4,833
Recorded prevalence in CCG area: 3.83%
Comparison of prevalence: ↓ than the Comparator CCG rate of 3.90%
↓ than the national rate of 4.09%

The CCG’s 2016/17 prevalence rate was similar to the 2015/16 rate of 3.82%.

It is important to note that looking at the numbers of people currently being treated for a disease does not show the true prevalence and impact on a population’s health. There will also be many people who have a disease or condition that are not aware of it and have not been diagnosed. The estimated prevalence for Chronic Kidney Disease in Wokingham CCG is 6.1%. This means that there were 2,864 people “missing” from GP registers in 2016/17. These estimations come from Public Health England’s Chronic Kidney Disease prevalence model and have been updated using the CCG’s population age profile from October 2017.

**Figure 90: Prevalence of Chronic Kidney Disease at a GP Practice level in 2015/16 and 2016/17**

Source: NHS Digital (2017); Quality and Outcomes Framework
6.52 Mortality

Only a small number of people with Chronic Kidney Disease progress to end-stage kidney failure (Stage 5 CKD) that requires kidney dialysis or kidney transplant. People who have CKD have an increased risk of developing cardiovascular disease and are more likely to die from cardiovascular-related problems than from kidney failure.

In 2012-2014, 9 people died from chronic renal failure in Wokingham Borough at a rate of 2.4 per 100,000 population. This compares to the national rate of 3.3 per 100,000 population.
6.6 Liver Disease

Liver disease is the fifth ‘biggest killer’ nationally. From 1995 to 2013, there was a 42% rise in the age-standardised mortality rate for chronic liver disease in England. This has largely been attributed to lifestyle factors, such as alcohol, obesity and drug taking.

There are over 100 types of liver disease, which affect approximately 2 million people in the UK. These include alcohol-related liver disease, which can lead to cirrhosis, non-alcoholic fatty liver disease and hepatitis. Liver disease can go unnoticed for a long time, as signs and symptoms often do not manifest until the disease reaches a relatively late stage. In the most serious cases, where the liver loses its ability to function, an individual will have liver failure. A liver transplant is currently the only way to cure irreversible liver failure and approximately 600 people per year in England and Wales receive a liver transplant.

The British Liver Trust note that "it is important to remember that as people can survive with 70% liver damage, there is a substantial burden of morbidity from liver disease, a high cost to the NHS and a huge economic and human cost from liver-related ill health”.

NHS RightCare has produced a detailed NHS Atlas of Variation in Healthcare for people with Liver Disease which provides local information about the extent of variations in services and outcomes for people with liver disease. Public Health England have published a Liver Disease Profile for local authorities, as part of the Fingertips suite of tools, and this provides additional information on care processes, treatment targets, complications, prevalence and risk. This can be used alongside the data included in this Locality Profile to aid commissioning in Wokingham CCG.

6.61 Liver Disease prevalence profile for Wokingham CCG

Liver Disease is not currently monitored through the Quality and Outcomes Framework, so we do not know how many people are treated for or live with this condition within Wokingham CCG. An All-Party Parliamentary Group that looked at improving outcomes in liver disease stated in their 2014 report, Liver Disease: Today’s Complacency, Tomorrow’s Catastrophe, that GPs should be incentivised through the QOF to pick up cases of liver disease earlier.

NHS RightCare (2013) states that 10-20% of the population are potentially at risk of developing liver damage in the UK, and that between 600,000 and 700,000 people already have a significant degree of damage. There are regional variations to these figures, largely associated with deprivation, so these figures cannot be modelled on the local population of Wokingham CCG.
6.62 Quality of Care

This section of the Profile provides a summary of indicators that are used to monitor care for liver disease from the CCG Outcomes Indicator Set (CCG OIS). The indicators included in the CCG OIS contribute to the five domains of the NHS Outcomes Framework and provide clear, comparative information for CCGs about the quality of health services and the associated health outcomes.

Wokingham CCG’s performance is shown against the national average and the CCG Comparator Group. The Comparator Group includes the 10 CCGs that are “most similar” to Wokingham CCG, as defined in the Commissioning for Value packs. The Direction of Travel (DOT) is also shown to indicate whether the CCG’s performance was significantly better, significantly worse or similar to the previous year’s outturn.

Key for spine charts:
- Significantly better than similar CCG average
- Significantly worse than the similar CCG average
- Not significantly different to the similar CCG average
- National average

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Latest outturn</th>
<th>CCG value</th>
<th>CCG Comp Group Avg</th>
<th>England Avg</th>
<th>CCG Comp Group Worst</th>
<th>CCG Comparator Group Range</th>
<th>CCG Comp Group Best</th>
<th>Previous outturn</th>
<th>DOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCG 1.7</td>
<td>2015</td>
<td>13.9</td>
<td>11.5</td>
<td>16.1</td>
<td>13.9</td>
<td></td>
<td></td>
<td>8.0</td>
<td>10.7</td>
</tr>
<tr>
<td>CCG 1.8</td>
<td>2016/17</td>
<td>16.7</td>
<td>15.0</td>
<td>27.7</td>
<td>26.8</td>
<td></td>
<td></td>
<td>4.7</td>
<td>13.4</td>
</tr>
<tr>
<td>CCG 2.1</td>
<td>2016/17</td>
<td>0.80</td>
<td>0.78</td>
<td>0.74</td>
<td>0.77</td>
<td></td>
<td></td>
<td>0.80</td>
<td>0.82</td>
</tr>
<tr>
<td>CCG 2.2</td>
<td>2016/17</td>
<td>70.2%</td>
<td>65.6%</td>
<td>64.0%</td>
<td>61.2%</td>
<td></td>
<td></td>
<td>70.2%</td>
<td>71.2%</td>
</tr>
<tr>
<td>CCG 3.14</td>
<td>2016/17</td>
<td>62.7</td>
<td>68.4</td>
<td>110.2</td>
<td>116.3</td>
<td></td>
<td></td>
<td>28.1</td>
<td>67.2</td>
</tr>
<tr>
<td>CCG 3.15</td>
<td>2014-17</td>
<td>93.5</td>
<td>115.9</td>
<td>100.0</td>
<td>187.1</td>
<td></td>
<td></td>
<td>70.1</td>
<td>80.0</td>
</tr>
</tbody>
</table>
6.63 Hospital Admissions and Activity

The number of emergency admissions for alcohol related liver disease is included in the CCG Outcomes Indicator Set. In 2016/17, there were 23 emergency admissions for alcohol-related liver disease in Wokingham CCG, which was a rate of 17 per 100,000 population. Figure 91 shows that the rate of admissions in Wokingham CCG has consistently been lower than the national rate. However, it is important to note that this trend is based on relatively small figures and are therefore not statistically significant.

Figure 91: Emergency admissions for alcohol related liver disease per 100,000 population – directly standardised rate (2010/11-2016/17)

Source: NHS Digital (2017)
6.64 Mortality

In 2015, 21 people aged under 75 died from liver disease in Wokingham CCG, which was a rate of 14 per 100,000 population. The graph below shows the mortality rate from 2009 to 2015 for all people aged under 75.

Figure 92: Under 75 mortality for liver disease per 100,000 population – directly standardised rate (2009-2015)

Source: NHS Digital (2016)

NHS RightCare (2013) notes that there was an 88% rise in age standardised mortality rates from chronic liver disease between 1993 and 2010. While this significant rise has plateaued slightly in recent years, liver disease is the only major cause of death that is increasing year on year.
6.7  Mental Health

Mental illness is the single largest cause of disability in the UK. At least one in four people will experience a mental health problem at some point in their life and one in six adults have a mental health problem at any one time. Approximately 1% of the UK population has a severe mental health problem and many will have begun to suffer from this in their teens or early twenties.

According to the Alzheimer’s Society, there are around 800,000 people in the UK with dementia. One in three people over 65 will develop dementia and two-thirds of people with dementia are women. The number of people with dementia is increasing because people are living longer. It is estimated that by 2021, the number of people with dementia in the UK will have increased to around 1 million.

An independent Mental Health Taskforce published The Five Year Forward View for Mental Health for NHS England in February 2016. The Strategy set out the current state of mental health service provision in England and made recommendations to transform services. Some recommendations were specific to the NHS in achieving parity of esteem between mental health and physical health across all age groups. Other recommendations were made for a cross-government approach, as mental health impacts on and is affected by other wider determinants of health, such as housing, employment opportunities, education, community involvement and personal relationships. NHS England accepted all the recommendations in the report for which it held responsibility and it was agreed that to support this transformation, mental health services would benefit from additional investment of £1bn per year by 2020/21.

Public Health England regularly refreshes the Mental Health Dementia and Neurology Profiles. These Profiles provide information about the levels of mental illness at a local level, as well as treatment and outcomes indicators. The PHE Profiles can be looked at alongside this Locality Profile to inform commissioning in Wokingham CCG.

6.71  Mental Health prevalence profile for Wokingham CCG

Prevalence is a measure of the burden of a disease in the population at a particular point in time. This section provides information about the recorded prevalence of different Mental Health conditions in the CCG area, which have been taken from the Quality and Outcomes Framework. These have been compared with the prevalence rates of similar CCGs and also the national rate.

It is important to note that looking at the numbers of people currently being treated for a disease or condition does not show the true prevalence and impact on a population’s health. There will also be many people who have a disease or condition that are not aware of it and/or have not been diagnosed. This section will also include estimated prevalence figures, where available, which have been developed by using population statistics and scientific research on the risks factors for each disease to derive an estimation of the true number of people suffering from it. The source of these estimations will be shown under each condition.
6.711 Prevalence of schizophrenia, bipolar affective disorder and other psychoses

Number of people on Mental Health Register: 892
Recorded prevalence in CCG area: 0.55%
Comparison of prevalence:
– lower than the Comparator CCG rate of 0.70%
– lower than the national rate of 0.92%

The CCG’s 2016/17 prevalence rate was higher than the 2015/16 rate of 0.52%.

The GP Mental Health Register records the number of people who have schizophrenia, bipolar affective disorder or other psychoses.

**Figure 93: Prevalence of Mental Health at a GP Practice level in 2015/16 and 2016/17**

Source: NHS Digital (2017); Quality and Outcomes Framework
6.712 Dementia Prevalence

Number of people on Dementia Register: 1,182
Recorded prevalence in CCG area: 0.73%
Comparison of prevalence:

- Lower than the Comparator CCG rate of 0.80%
- Lower than the national rate of 0.76%

The CCG’s 2016/17 prevalence rate was similar to the 2015/16 rate of 0.74%

The estimated prevalence for Dementia in Wokingham CCG is 1.2%. This means that there were 768 people “missing” from GP registers in 2016/17. These estimations come from the national prevalence model developed by Knapp and Prince (2007). It is important to note that these estimations have not been disaggregated to a local level. This model will therefore show under or over estimations in local regions, depending on the demographics of that region.

Figure 94: Prevalence of Dementia at a GP Practice level in 2015/16 and 2016/17

Source: NHS Digital (2017); Quality and Outcomes Framework
6.713 Depression Prevalence

Number of people on Depression Register: 9,642
Recorded prevalence in CCG area: 7.6%
Comparison of prevalence: ‹ than the Comparator CCG rate of 9.0%
† than the national rate of 9.1%

The CCG’s 2016/17 prevalence rate was higher than the 2015/16 rate of 7.0%.

Figure 95: Prevalence of Depression at a GP Practice level in 2015/16 and 2016/17

Source: NHS Digital (2017); Quality and Outcomes Framework
6.72 Quality of Care

This section of the Profile provides a summary of indicators that are used to monitor care for mental health from the CCG Outcomes Indicator Set (CCG OIS) and the GP Quality and Outcomes Framework (QOF):

- CCG Outcomes Indicator Set – the indicators included in the CCG OIS contribute to the five domains of the NHS Outcomes Framework. This provides clear, comparative information for CCGs about the quality of health services and the associated health outcomes.

- Quality and Outcomes Framework (QOF) – the QOF is the annual reward and incentive programme detailing GP practice achievement results. This rewards practices for the provision of quality care and helps standardise improvement in the delivery of primary medical services.

These indicators compare Wokingham CCG’s performance against the national average and the CCG Comparator Group. The Comparator Group includes the 10 CCGs that are “most similar” to Wokingham CCG, as defined in the Commissioning for Value packs. The Direction of Travel (DOT) is also shown to indicate whether the CCG’s performance was significantly better, significantly worse or similar to the previous year’s outturn.

Where Wokingham CCG have performed significantly worse than the Comparator Group average in the Quality and Outcomes Framework, an additional graph has been included to show a breakdown by GP.

Key for spine charts:

- ▶️ Significantly better than similar CCG average
- 🔴 Significantly worse than the similar CCG average
- ⬤ Not significantly different to the similar CCG average
- ◊ National average
6.721 CCG Outcomes Indicator Set summary for mental health

Wokingham CCG performed significantly better than the comparator group for the indicators about Improving Access to Psychological Therapies (IAPT) in 2014/15. IAPT aims to encourage improved access to talking therapies for people with common mental health problems such as depression and anxiety disorders. These indicators look at the completion of treatment (2.11a) and improvement following completion of treatment (2.11b).

2 indicators in the CCG Outcomes Indicator Set look at access to mental health services by people from Black and Minority Ethnic (BME) Groups. In 2014/15, 300 people from a BME group accessed community mental health services in Wokingham CCG. This was a rate of 1,680 people per 100,000. In 2015/16, 210 people from a BME group accessed psychological therapies in the CCG, which was a rate of 1,165 per 100,000 population. These indicators were both similar to the national and comparator group figures.
### 6.722 Quality and Outcomes Framework – Mental Health (patients with schizophrenia, bipolar affective disorder and other psychoses)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Wok CCG Value</th>
<th>CCG Comp Group Avg</th>
<th>CCG Comp Group Worst</th>
<th>CCG Comparator Group Range</th>
<th>CCG Comp Group Best</th>
<th>Wok CCG in 15/16</th>
<th>DOT for Wok CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH02</td>
<td>% patients on the register who have a care plan documented in the last 12 months, agreed between individuals, family and carers as appropriate</td>
<td>93%</td>
<td>93%</td>
<td>90%</td>
<td>91%</td>
<td>95%</td>
<td>89% ↑</td>
</tr>
<tr>
<td>MH03</td>
<td>% patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of a blood pressure reading in the last 12 months</td>
<td>91%</td>
<td>91%</td>
<td>90%</td>
<td>89%</td>
<td>94%</td>
<td>90% ↔</td>
</tr>
<tr>
<td>MH07</td>
<td>% patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the last 12 months</td>
<td>93%</td>
<td>92%</td>
<td>91%</td>
<td>89%</td>
<td>95%</td>
<td>89% ↑</td>
</tr>
<tr>
<td>MH08</td>
<td>% women with schizophrenia, bipolar affective disorder and other psychoses whose notes record a cervical screening test in the last 5 years</td>
<td>91%</td>
<td>89%</td>
<td>88%</td>
<td>87%</td>
<td>92%</td>
<td>87% ↑</td>
</tr>
<tr>
<td>MH09</td>
<td>% patients on lithium therapy with a record of serum creatinine and TSH in the last 9 months</td>
<td>99%</td>
<td>98%</td>
<td>97%</td>
<td>95%</td>
<td>100%</td>
<td>99% ↔</td>
</tr>
<tr>
<td>MH10</td>
<td>% patients on lithium therapy with a record of lithium levels in the therapeutic range in the last 4 months</td>
<td>93%</td>
<td>93%</td>
<td>91%</td>
<td>90%</td>
<td>98%</td>
<td>96% ↔</td>
</tr>
</tbody>
</table>

### 6.723 Quality and Outcomes Framework – Dementia

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Wok CCG Value</th>
<th>CCG Comp Group Avg</th>
<th>CCG Comp Group Worst</th>
<th>CCG Comparator Group Range</th>
<th>CCG Comp Group Best</th>
<th>Wok CCG in 15/16</th>
<th>DOT for Wok CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEM04</td>
<td>% patients diagnosed with dementia whose care has been reviewed in a face to face review in the last 12 months</td>
<td>87%</td>
<td>85%</td>
<td>84%</td>
<td>81%</td>
<td>88%</td>
<td>82% ↑</td>
</tr>
<tr>
<td>DEM05</td>
<td>% patients with new diagnosis of dementia with a record of tests recorded 12 months before or 6 months after entering on to the register</td>
<td>89%</td>
<td>89%</td>
<td>88%</td>
<td>84%</td>
<td>92%</td>
<td>84% ↑</td>
</tr>
</tbody>
</table>

### 6.724 Quality and Outcomes Framework – Depression

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Wok CCG Value</th>
<th>CCG Comp Group Avg</th>
<th>CCG Comp Group Worst</th>
<th>CCG Comparator Group Range</th>
<th>CCG Comp Group Best</th>
<th>Wok CCG in 15/16</th>
<th>DOT for Wok CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEP03</td>
<td>% patients with new diagnosis of depression in the previous 1-Apr to 31-Mar, who have been reviewed in the specified timescale</td>
<td>86%</td>
<td>86%</td>
<td>84%</td>
<td>83%</td>
<td>89%</td>
<td>84% ↑</td>
</tr>
</tbody>
</table>
### 6.725 Quality and Outcomes Framework – Risk factors for mental health

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
<th>Wok CCG Value</th>
<th>CCG Comparator Group Avg</th>
<th>CCG Comparator Group Worst</th>
<th>CCG Comparator Group Range</th>
<th>Wok CCG in 15/16</th>
<th>DOT for Wok CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>SMOK02</td>
<td>% patients with LTCs whose notes record smoking status in last 12 months</td>
<td>94%</td>
<td>95%</td>
<td>95%</td>
<td>93%</td>
<td>96%</td>
<td>94%</td>
</tr>
<tr>
<td>SMOK04</td>
<td>% of patients aged 15+ who are recorded as current smokers who have a record of an offer of support and treatment within the previous 24 months</td>
<td>87%</td>
<td>91%</td>
<td>90%</td>
<td>87%</td>
<td>96%</td>
<td>87%</td>
</tr>
<tr>
<td>SMOK05</td>
<td>% of patients with LTCs who are recorded as current smokers who have a record of an offer of support and treatment within the previous 12 months</td>
<td>99%</td>
<td>98%</td>
<td>97%</td>
<td>96%</td>
<td>99%</td>
<td>96%</td>
</tr>
</tbody>
</table>

Graphs for SMOK02 and SMOK04 are included in the ‘Risk factors for cardiovascular disease’ section of this Profile (6.128).
6.73 Mortality

The NHS Outcomes Framework includes a measure of the extent to which adults with a serious mental illness die younger than adults in the general population. This is not available at a CCG level, so the information shown below is for Wokingham Borough.

In 2014/15, the under 75 mortality rate in Wokingham was 299 per 100,000 for the whole population, compared with a much higher rate of 1,730 per 100,000 for the adult population with serious mental illness. The excess under 75 mortality rate for people with severe mental illness was 426%.

*Figure 96: Excess under 75 mortality rate in adults with severe mental illness – standardised mortality ratio (2009/10-2014/15)*

National data for this indicator also shows a more detailed breakdown by age group, gender and condition. These graphs are shown on the following page and indicate that the excess mortality ratio for people with severe mental illness is similar for men and women. Those aged 30 to 39 also have the greatest ratio of excess deaths compared with people in other age groups.
Figure 97: Excess under 75 mortality rate in adults with severe mental illness by age group and gender (England, 2014/15)

Source: NHS Digital (2016)

Figure 98 shows the excess under 75 mortality rate by condition. Liver disease and respiratory disease had the highest excess death ratios, which show that proportionately more people with severe mental illness died from these conditions compared to the population as a whole.

Figure 98: Excess under 75 mortality rate in adults with severe mental illness by condition (England, 2014/15)

Source: NHS Digital (2016)
In 2014, there were 207 deaths for people aged 65 and over in Wokingham CCG that had a recorded mention of dementia. This was a rate of 792 per 100,000, which was similar to the national rate of 750 per 100,000 population.

### 6.731 Suicide and self harm

Around 4,400 people end their own lives in England each year and at least 10 times that number attempt suicide. Many factors are associated with increased risk of suicide, such as drug and alcohol misuse, unemployment, poverty and domestic violence. Approximately 90% of suicide victims suffer from a psychiatric disorder at the time of their death.

In 2014-16, there were 31 suicides in Wokingham at a directly standardised rate of 7.3 per 100,000 population. This was similar to the national rate of 9.9 per 100,000 population.

In contrast to the trends in suicide, the incidence of self-harm has continued to rise in the UK over the past 20 years and, for young people at least, is said to be among the highest in Europe. The Government’s Report (2015) Preventing suicide in England: Two Years on states that suicide risk is raised 49-fold in the year after self harm and this risk increases with age. In 2015/16, there were 276 emergency admissions for intentional self harm in Wokingham, at a directly standardised rate of 176.3 per 100,000 population. This is similar to the national rate of 196.5 per 100,000 population. However, it is important to note that hospital admissions do not show the full extent of self harm, as the majority of people who self harm will either not harm themselves in a way that needs medical treatment or will deal with it themselves.
6.8 Tuberculosis

The incidence of tuberculosis in England is higher than most other Western European countries. There are significant differences in the geographical and socioeconomic distribution of TB cases in England with much higher rates in large urban centres, such as London, Leicester and Birmingham. Other specific areas have higher incidences of TB with rates (40 or more cases per 100,000 population) and these include Slough and Reading. Almost 75% of TB cases occur in those born abroad and the vast majority of these are among settled migrants who have been in the country for more than 2 years, rather than in new entrants.

Reducing TB incidence is a key ambition of the Collaborative Tuberculosis Strategy for England: 2015 to 2020. To achieve this aim and deliver significant improvements in TB control, the national strategy set out ten key areas for action as shown in Figure 99. Regional TB Control Boards were set up to take the strategy forward and to work closely with TB networks to deliver it locally. The Thames Valley TB Network, which covers Berkshire, Oxfordshire and Buckinghamshire, reports into the South TB Control Board.

A multiagency Berkshire TB Strategy Group was established in 2015 and links into the Thames Valley TB Network. The local Strategy Group used the ten key areas of the national strategy to develop local priorities, which were incorporated into the Berkshire TB Action Plan for 2017-2019. This Action Plan continues to be monitored to ascertain progress in the reduction of TB locally.

In 2014-16 there were 17,863 new cases of TB notified in England at a rate of 11 per 100,000 population. Wokingham CCG’s incidence rate was similar at 10.8 per 100,000, with 52 notifiable cases over the 3 year period.
As Wokingham CCG’s number of TB cases are lower than 20 per year, local information for other indicators included in the TB Strategy are suppressed to avoid disclosure. The following information is therefore shown at a national level only. More information can be found at Public Health England’s TB Strategy Monitoring Indicators Profile.

Late diagnosis of TB can result in a more advanced and complex disease with greater morbidity, mortality, cost and onward transmission. This can also reinforce pre-existing health and social inequalities, which will affect under-served populations to a greater degree. Reducing the diagnosis delay and the start of treatment for TB is therefore another key indicator in the Collaborative Tuberculosis Strategy. In 2016, 39% of pulmonary TB cases started treatment within 2 months of symptom onset nationally and 69% started within 4 months of onset.

76% of pulmonary TB cases were culture confirmed in England in 2016, which is lower than the 80% target set by the European Centre for Disease Prevention and Control. Timely drug susceptibility testing is crucial to ensure appropriate treatment and reduce the period of infectiousness to protect others.

In 2015, 83% of drug sensitive TB cases completed a full course of treatment within 12 months nationally. Without treatment TB can be fatal, while those who survive without treatment can experience long-term health problems and remain infectious. A high treatment quality standard and treatment completion rate therefore needs to be ensured to avoid the development of drug-resistant TB and to improve TB control.
6.9 General healthcare and hospital activity

6.91 Potential Years of Life Lost

Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare is one of the key outcomes measures included in both the CCG and NHS Outcome Frameworks. This indicator of premature mortality shows the number of years not lived by an individual from birth to 75. A death is considered amenable (treatable) if, in the light of medical knowledge and technology at the time of death, all or most deaths from that cause could be avoided through good quality healthcare. Examples of these conditions include coronary heart disease, stroke, treatable cancers, diabetes and TB.

In 2012-14, Wokingham CCG had 7,568 PYLL considered amenable to healthcare. This is a rate of 1,567 PYLL per 100,000 registered population, which is significantly lower than the England PYLL of 2,032 per 100,000.

Wokingham CCG’s PYLL for cerebrovascular disease, ischaemic heart disease, neoplasms and respiratory disease were all lower than the England average.

Neoplasms are the main cause of PYLL in Wokingham CCG at 39.0% in 2012-14. Ischaemic heart disease is the second main cause at 28.7% on 2012-14.
6.92 Mortality and End of Life Care

Public Health England’s National End of Life Care Intelligence Network has developed End of Life Care Profiles, as part of the Fingertips suite of tools. The Profile provides data at a CCG and local authority level to help with the planning and delivery of local services that impact on end of life care.

In 2015, 1,184 people died in Wokingham CCG at a rate of 867 per 100,000 population. This was significantly lower than the national rate of 1,001 per 100,000 population.

Figure 103 shows the underlying cause of death by age group in Wokingham CCG. Cancer was the main cause of death for all age groups, apart from those aged 85 and over.

46% of people died in their Usual Place of Residence in Wokingham CCG, such as their own home, care home or religious establishment. This was the same as the national figure. This did vary according to the underlying cause of death, as 39% of people who died of circulatory disease in Wokingham CCG were in their Usual Place of Residence, compared to 73% of deaths from dementia and Alzheimer’s disease.

Figure 104 shows the place of death by age group in Wokingham CCG. 45% of all people died in hospital and 24% died at home.
6.93 Emergency hospital admissions – CCG Outcomes Indicator Set

The CCG Outcomes Indicator Set includes 5 indicators that focus on emergency admission to hospital. These are used as a measure of co-ordination between different elements of the healthcare system.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Latest outturn</th>
<th>CCG value</th>
<th>CCG Comp Group Avg</th>
<th>England Avg</th>
<th>CCG Comp Group Worst</th>
<th>CCG Comparator Group Range</th>
<th>CCG Comp Group Worst</th>
<th>Previous outturn</th>
<th>DOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCG 1.8: Emergency admissions for alcohol-related liver disease</td>
<td>2016/17</td>
<td>16.7</td>
<td>15.0</td>
<td>27.7</td>
<td>26.8</td>
<td>4.7</td>
<td>13.4</td>
<td>↔</td>
<td></td>
</tr>
<tr>
<td>CCG 2.6: Unplanned hospitalisation for chronic ambulatory care sensitive (ACS) conditions</td>
<td>2016/17</td>
<td>585.9</td>
<td>573.2</td>
<td>821.2</td>
<td>770.7</td>
<td>107.7</td>
<td>566.1</td>
<td>↔</td>
<td></td>
</tr>
<tr>
<td>CCG 2.7: Unplanned hospitalisation for asthma, diabetes and epilepsy (under 19s)</td>
<td>2016/17</td>
<td>158.3</td>
<td>215.8</td>
<td>304.1</td>
<td>378.4</td>
<td>92.9</td>
<td>226.7</td>
<td>↑</td>
<td></td>
</tr>
<tr>
<td>CCG 3.1: Emergency admissions for acute conditions that should not usually require hospital admission</td>
<td>2016/17</td>
<td>983</td>
<td>1,064</td>
<td>1,357</td>
<td>1,444</td>
<td>253</td>
<td>977</td>
<td>↔</td>
<td></td>
</tr>
<tr>
<td>CCG 3.4: Emergency admissions for children with LRTIs</td>
<td>2016/17</td>
<td>344.3</td>
<td>432.6</td>
<td>459.0</td>
<td>748.2</td>
<td>267.4</td>
<td>332.7</td>
<td>↔</td>
<td></td>
</tr>
</tbody>
</table>

**CCG 1.8: Emergency admissions for alcohol-related liver disease**

In 2016/17, there were 23 emergency admissions for alcohol-related liver disease in Wokingham CCG, which was a rate of 16.7 per 100,000 population. This rate has consistently been lower than the national rate. A graph for this indicator is included in the Liver Disease section of this Profile (6.63).

**CCG 2.6: Unplanned hospitalisation for chronic ambulatory care sensitive conditions (ACSCs)**

Unplanned hospitalisation for chronic ACSCs include admissions for long-term conditions such as asthma, diabetes, epilepsy, hypertensive disease, dementia and heart failure. These are admissions which could be prevented by effective community care and case-management.

In 2016/17, Wokingham CCG had 911 unplanned admissions for ACSCs. This was 586 admissions per 100,000 population. The rate of admissions in the CCG continues to be significantly lower than the national rate, however it has been significantly higher than the comparator CCG group since 2012/13.
**Figure 105: Unplanned hospitalisation for chronic ambulatory care sensitive conditions – all persons (2010/11-2016/17)**

![Graph showing unstandardised rates per 100,000 population from 2010/11 to 2016/17 for Wokingham CCG, Comparator CCGs, and England.]

Source: NHS Digital (2017)

**CCG 2.7: Unplanned hospitalisation for asthma, diabetes and epilepsy (under 19s)**

In 2016/17, Wokingham CCG had 60 unplanned admissions for under 19s at a rate of 158 per 100,000 population, which remained below the England figure. A graph for this indicator is included in the ‘Child and young people with long-term conditions’ section of this Profile (5.24).

**CCG 3.1: Emergency admissions for acute conditions that should not require hospital admission**

Emergency admissions for acute conditions that should not usually require hospital admission include disease such as influenza, pneumonia, urinary tract infections and cellulitis. These should be managed without the patient needing to be admitted to hospital.

In 2016/17, Wokingham CCG had 1,516 emergency admissions for acute conditions that should not require admission. This was 983 admissions per 100,000 population. The rate of admissions in the CCG continued to be significantly lower than the national rate.
**CCG 3.4: Emergency admissions for children with Lower Tract Respiratory Infections (under 19s)**

In 2016/17, there were 112 emergency admissions in Wokingham CCG, which was a rate of 344 per 100,000 population. The CCG’s rate continued to be significantly lower than the national rate. Additional information for this indicator is included in the ‘Child and young people with long-term conditions’ section of this Profile (5.212).
6.94 Antimicrobial Resistance (AMR)

Antimicrobial Resistance (AMR) is the resistance of a microorganism to a drug that was originally effective for the treatment of the infections that it caused. Resistant microorganisms, such as bacteria, fungi, viruses and parasites, are able to withstand attack from standard antimicrobial drugs, so treatment becomes ineffective and infections persist. The cost of health care for patients with resistant infections is therefore higher, due to the longer duration of illness, the additional tests required and the use of more expensive, alternative medication. The World Health Organisation (2016) explains that AMR is an increasingly serious threat to global public health that requires action across all government sectors and society. Without effective antimicrobials for prevention and treatment of infections, medical procedures such as organ transplants, cancer chemotherapy, diabetes management and major surgery become very high risk.

Antibiotic misuse contributes to AMR in a number of ways, such as a patient’s failure to complete a course of antibiotics or the inappropriate prescription of antibiotics for non-bacterial infections. A key aim of the Department of Health (2013) UK Five Year Antimicrobial Resistance Strategy 2013 to 2018 is the reduction of antibiotic prescriptions.

From Sep-16 to Sep-17, nearly 93,000 antibiotic items were prescribed in a Wokingham CCG primary care setting. Levels of prescribing are influenced by the demographic characteristics of a population, so STAR-PU data is used to compare prescribing for different geographical areas. This is adjusted for both age and sex. Wokingham CCG’s STAR-PU score has decreased over time, indicating lower levels of prescribing locally. Prior to July 2016, Wokingham’s STAR-PU score was higher than England’s, however it has consistently remained lower than this date.

A Berkshire AMR Stewardship Network was established in 2016, with representatives from all the main Trusts in primary and secondary care. The aims of the group are to concentrate and amalgamate efforts to comply with the national SMR strategies, as well as improve the local understanding and awareness of AMR. One example of this is through the Antibiotic Guardian campaign. This campaign is led by Public Health England to encourage improved behaviours and engagement on the prudent use and prescription of antibiotics with members of the public and healthcare professionals. Antibiotic Guardians sign up online and choose a pledge about how they can personally prevent infections or make better use of antibiotics. In 2016, Wokingham CCG had 29 Antibiotic Guardians at 18.1 per 100,000 population. This was similar to the national rate.

The Berkshire AMR Stewardship Network reviews a selection of indicators on a quarterly basis, which are taken from Public Health England’s AMR Local Indicators Profile. Healthcare Associated Infections (HCAI) are one focus area, as these can be used to monitor AMR locally.
6.941 Healthcare Associated Infections (HCAI)

The UK government has a zero-tolerance approach to avoidable healthcare associated infections and national guidance has been issued for the control of Meticillin Resistant Staphylococcus aureus (MRSA) and Clostridium difficile infection (C. difficile). These involve undertaking a root cause analysis review to identify how a case occurred, agree actions by healthcare teams that will prevent a reoccurrence and identify the organisation best places to ensure improvements are made.

In 2016/17, Wokingham CCG had 2 cases of MRSA. Figure 106 shows how the number of cases has fluctuated since 2009/10, but it is important to note that these are based on small figures with a peak in 2013/14 of 3 cases of MRSA for the CCG. Also, this indicator includes all cases of MRSA-positive blood cultures reported by the Trust whose laboratory processes the specimen and does not always reflect where the bacteraemia was acquired.

Figure 107: Rate of MRSA bacteraemia per 100,000 population (2009/10 to 2016/17)

![Graph showing rate of MRSA bacteraemia per 100,000 population (2009/10 to 2016/17)]

Source: Public Health England (2017); AMR local indicators

In 2016/17, Wokingham CCG had 18 cases of C. difficile at 11 per 100,000 population. Figure 107 shows that the CCG’s rates have similar to the national and comparator group rates, apart from a slight increase on 2011/12. As with the MRSA indicator, this measure includes all cases of C. difficile reported by the Trust whose laboratory processes the specimen and does not always reflect where the bacteraemia was acquired.

NHS England has set targets at a CCG-level for C. difficile cases in 2018/19. Wokingham CCG merges with the other Berkshire West CCGs on 1st April 2018, so the target has been set for the whole of Berkshire West CCG at 92 cases or less (19.1 per 100,000 population).
In 2016/17, Wokingham CCG had 91 cases of E.coli bacteraemia at 56.6 per 100,000 population. Figure 108 shows that the CCG’s rates have remained below the national ones since 2012/13. As with the other HCAI indicators, this measure includes all cases of E.coli reported by the Trust whose laboratory processes the specimen and does not always reflect where the bacteraemia was acquired.

E.coli bacteraemia is included in the Quality Premiums for 2017/18 onwards. The required performance in 2017/18 is a 10% reduction of E.coli bacteraemia cases, based on 2015/16 performance. For Wokingham CCG the 2017/18 target is 76 cases or less.
7. GP Patient Survey

The GP Survey is sent out annually and is used to assess patient’s experience of the quality of care that they receive from their local GP, as well as how easy it is to access services. In 2016/17, 1,510 patients from Wokingham CCG responded to the survey.

The tables below provide a summary of the 2016/17 GP Survey results for Wokingham CCG, which were sent out from January to March 2017. These are compared with the CCG Comparator Group average and national average. The Comparator Group is made up of the 10 CCGs that are the “most similar” to Wokingham CCG, as defined in the Commissioning for Value packs. Additional graphs are included for indicators where Wokingham CCG’s performance is significantly lower than the CCG comparator group.

- Significantly better than similar CCG average
- Significantly worse than the similar CCG average
- Not significantly different to the similar CCG average
- National average

The Direction of Travel (DOT) column indicates whether the CCG’s 2016/17 performance was significantly better, significantly worse or similar to the 2015/16 outturn.

### 7.1 Accessing GP Services

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Wok CCG Value</th>
<th>CCG Comp Group Avg</th>
<th>Eng Avg</th>
<th>CCG Comp Group Worst</th>
<th>CCG Comparator Group Range</th>
<th>CCG Comp Group Best</th>
<th>Wok CCG in 15/16</th>
<th>DOT for Wok CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPS03 Ease of getting through to someone at GP surgery - Easy (total)</td>
<td>68%</td>
<td>69%</td>
<td>68%</td>
<td>62%</td>
<td></td>
<td></td>
<td>76%</td>
<td>74%</td>
</tr>
<tr>
<td>GPS04 Helpfulness of receptionists at GP surgery - Helpful (total)</td>
<td>88%</td>
<td>87%</td>
<td>87%</td>
<td>84%</td>
<td></td>
<td></td>
<td>90%</td>
<td>88%</td>
</tr>
<tr>
<td>GPS09 Frequency of seeing preferred GP - always, almost always or a lot of the time (total)</td>
<td>65%</td>
<td>58%</td>
<td>56%</td>
<td>48%</td>
<td></td>
<td></td>
<td>65%</td>
<td>66%</td>
</tr>
</tbody>
</table>
50% of Wokingham CCG respondents had seen/spoken to a GP from their surgery in the last 3 months. 17% had not seen/spoken to a GP in over a year.

Patients were asked about how they booked their GP appointments and were able to pick more than one method. 89% of patients in the CCG normally book their appointments at the surgery by phone, 21% do so in person and 8% book online. 42% of respondents said that they were aware they could book appointments online, although 41% stated that they did not know what online services were offered by their GP Practice.

65% of Wokingham CG respondents saw their preferred GP always, almost always or a lot of the time, which was the highest level in the comparator group.

### 7.2 Making an appointment

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Wok CCG Value</th>
<th>CCG Comp Group Avg</th>
<th>CCG Comp Group Worst</th>
<th>CCG Comparator Group Range</th>
<th>Wok CCG in 15/16</th>
<th>DOT for Wok CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPS12</td>
<td>Able to get an appointment to see or speak to someone - Yes (total)</td>
<td>86%</td>
<td>86%</td>
<td>84%</td>
<td>84%</td>
<td>90%</td>
</tr>
<tr>
<td>GPS15</td>
<td>Convenience of appointment - Convenient (total)</td>
<td>92%</td>
<td>92%</td>
<td>92%</td>
<td>90%</td>
<td>94%</td>
</tr>
<tr>
<td>GPS18</td>
<td>Overall experience of making an appointment - Good (total)</td>
<td>83%</td>
<td>82%</td>
<td>81%</td>
<td>79%</td>
<td>87%</td>
</tr>
</tbody>
</table>

86% of patients said that the last GP/Nurse appointment they were offered was convenient for them. For those that did not find it convenient, the main reason was because they could not see or speak to someone on the day that they wanted (43%).

For the patients that felt the appointment offered was inconvenient
- 39% still took the appointment offered
- 18% got appointment for a different day
- 18% decided to ring the surgery another time
- 16% had consultation over the phone
- 6% didn’t speak to anyone about their concerns
- 3% used another NHS service
- 2% went to A&E
- 1% saw pharmacists instead
### 7.3 Last GP or Nurse appointment

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Wok CCG Value</th>
<th>CCG Comparator Group Range</th>
<th>Wok CCG in 15/16</th>
<th>DOT for Wok CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPS21a</td>
<td>85% 85% 85% 84% 82%</td>
<td>88% 84% 84% 83% 84%</td>
<td>84% 84% 84% 84% 84%</td>
<td>84% 84% 84% 84% 84%</td>
</tr>
<tr>
<td>GPS21b</td>
<td>88% 88% 88% 87% 85%</td>
<td>91% 91% 91% 90% 88%</td>
<td>91% 91% 91% 90% 90%</td>
<td>89% 91% 91% 90% 90%</td>
</tr>
<tr>
<td>GPS21c</td>
<td>78% 81% 81% 78% 78%</td>
<td>84% 84% 84% 83% 83%</td>
<td>84% 84% 84% 83% 83%</td>
<td>83% 83% 83% 83% 83%</td>
</tr>
<tr>
<td>GPS21d</td>
<td>72% 74% 74% 70% 70%</td>
<td>76% 76% 76% 75% 75%</td>
<td>76% 76% 76% 75% 75%</td>
<td>75% 75% 75% 75% 75%</td>
</tr>
<tr>
<td>GPS21e</td>
<td>83% 84% 83% 78% 78%</td>
<td>86% 86% 86% 85% 85%</td>
<td>86% 86% 86% 85% 85%</td>
<td>82% 82% 82% 82% 82%</td>
</tr>
<tr>
<td>GPS22</td>
<td>93% 93% 92% 90% 89%</td>
<td>96% 96% 96% 95% 95%</td>
<td>96% 96% 96% 95% 95%</td>
<td>94% 94% 94% 94% 94%</td>
</tr>
<tr>
<td>GPS23a</td>
<td>80% 79% 80% 75% 75%</td>
<td>84% 84% 84% 83% 83%</td>
<td>84% 84% 84% 83% 83%</td>
<td>80% 80% 80% 80% 80%</td>
</tr>
<tr>
<td>GPS23b</td>
<td>79% 77% 79% 74% 74%</td>
<td>82% 82% 82% 81% 81%</td>
<td>82% 82% 82% 81% 81%</td>
<td>79% 79% 79% 79% 79%</td>
</tr>
<tr>
<td>GPS23c</td>
<td>76% 75% 76% 70% 70%</td>
<td>79% 79% 79% 78% 78%</td>
<td>79% 79% 79% 78% 78%</td>
<td>75% 75% 75% 75% 75%</td>
</tr>
<tr>
<td>GPS23d</td>
<td>63% 62% 66% 58% 58%</td>
<td>65% 65% 65% 64% 64%</td>
<td>65% 65% 65% 64% 64%</td>
<td>62% 62% 62% 62% 62%</td>
</tr>
<tr>
<td>GPS23e</td>
<td>79% 77% 78% 74% 74%</td>
<td>81% 81% 81% 80% 80%</td>
<td>81% 81% 81% 80% 80%</td>
<td>79% 79% 79% 79% 79%</td>
</tr>
<tr>
<td>GPS24</td>
<td>86% 84% 84% 81% 81%</td>
<td>88% 88% 88% 87% 87%</td>
<td>88% 88% 88% 87% 87%</td>
<td>87% 87% 87% 87% 87%</td>
</tr>
</tbody>
</table>

Wokingham CCG’s survey respondents gave similar ratings for their last GP and nurse appointment, compared to the national and comparator group averages. The only exception to this was the rating of GPs explaining tests and treatments, which was the lowest rating in the comparator group at 78%. This was also a significant decrease on the previous year’s figure.
7.4 Opening Hours

76% of respondents in Wokingham CCG were satisfied with their GP opening hours in 2016/17. The majority of patients that did not find their GP Surgery opening hours convenient said that they would find appointments on Saturdays (74%) or after 6:30pm (72%) or easier.
7.5 Overall Experience

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Wok CCG Value</th>
<th>CCG Comp Group Avg</th>
<th>Eng Avg</th>
<th>CCG Comp Group Worst</th>
<th>CCG Comparator Group Range</th>
<th>CCG Comp Group Best</th>
<th>Wok CCG in 15/16</th>
<th>DOT for Wok CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPS28 Overall experience of GP surgery - Good (total)</td>
<td>85%</td>
<td>86%</td>
<td>85%</td>
<td>83%</td>
<td></td>
<td></td>
<td>90%</td>
<td>88%</td>
</tr>
<tr>
<td>GPS29 Recommending GP surgery to someone who has just moved to the local area - Yes (total)</td>
<td>80%</td>
<td>79%</td>
<td>77%</td>
<td>75%</td>
<td></td>
<td></td>
<td>85%</td>
<td>83%</td>
</tr>
</tbody>
</table>

The percentage of patients who stated that their overall experience of their GP surgery was very good or good in Wokingham CCG was similar to the national and comparator group responses. The percentage of patients that would recommend their surgery to someone moving into the local area was also similar.

7.6 Managing your health and state of health today

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Wok CCG Value</th>
<th>CCG Comp Group Avg</th>
<th>Eng Avg</th>
<th>CCG Comp Group Worst</th>
<th>CCG Comparator Group Range</th>
<th>CCG Comp Group Best</th>
<th>Wok CCG in 15/16</th>
<th>DOT for Wok CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPS32 Last 6 months, enough support from local services/organisations to help manage long-term conditions - Yes (total)</td>
<td>66%</td>
<td>62%</td>
<td>63%</td>
<td>58%</td>
<td></td>
<td></td>
<td>66%</td>
<td>65%</td>
</tr>
<tr>
<td>GPS33 Confidence in managing own health - Confident (total)</td>
<td>94%</td>
<td>94%</td>
<td>92%</td>
<td>93%</td>
<td></td>
<td></td>
<td>96%</td>
<td>95%</td>
</tr>
</tbody>
</table>

51% of Wokingham CCG’s survey respondents said that they had a long-standing health condition.

When asked about the state of their health at the point of completing the survey:
- 19% had mobility problems (from slight problems to inability to walk about)
- 5% had problems washing and dressing (from slight problems to being unable to wash and dress themselves)
- 20% had problems completing usual activities, such as work, studying, family or leisure activities (from slight to unable to complete)
- 42% had pain or discomfort (from slight to extreme pain and discomfort)
- 28% were anxious or depressed (from slightly to extremely anxious or depressed)
66% of respondents from Wokingham CCG felt supported to manage their long term condition in the last 6 months, which was the highest rate in the comparator group.

7.7 Out of Hours

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Wok CCG Value</th>
<th>CCG Comp Group Avg</th>
<th>CCG Comp Group Worst</th>
<th>CCG Comparator Group Range</th>
<th>CCG Comp Group Best</th>
<th>Wok CCG in 15/16</th>
<th>DOT for Wok CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPS42</td>
<td>59%</td>
<td>65%</td>
<td>61%</td>
<td>59%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GPS43</td>
<td>87%</td>
<td>84%</td>
<td>61%</td>
<td>60%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GPS44</td>
<td>67%</td>
<td>69%</td>
<td>66%</td>
<td>63%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CCG Outcomes Indicator Set indicator 4.1 measures the overall experience of Out of Hours in GP services. 67% of respondents in Wokingham CCG felt that their experience was good, which was similar to the national and comparator group averages.

References
The information and data sources used in the Wokingham CCG Locality Profile have been referenced throughout this document. Some of the data has come from Health Information Systems that have restricted access, such as Open Exeter, Hospital Episode Statistics and CancerStats website. Government strategies and policies have also been hyperlinked when cited.

Data sources that are available online have been added below for your information.

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Child and Maternal Health Intelligence Network (2015); Disease Management Information Toolkit (restricted access)

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Public Health England (2017); Local Health
Public Health England (2017); Local Tobacco Control Profiles
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Public Health England (2017); National Chlamydia Screening Programme (CTAD) – data tables
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Public Health England (2017); Public Health Outcomes Framework Profiles
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Public Health England (2017), Strategic Health Asset Planning and Evaluation (SHAPE) (restricted access)
Public Health England (2017), TB Strategy Monitoring Indicators
Public Health England (2015); Chronic Kidney Disease Prevalence Estimates
Sport England (2017); Active Lives Adult Survey