NHS RightCare

Equality and Health Inequalities Pack

NHS South East Staffs and Seisdon Peninsular CCG

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Foreword

We are committed to ensuring that all those using the NHS have fair and equitable access to high quality services that are appropriate and in proportion to their needs. In addition we have a specific focus on those with protected characteristics (by reason of age, membership of disadvantaged groups or living in disadvantaged areas).

These NHS RightCare Equality and Health Inequality packs will help pinpoint areas of unwarranted variation and refocus resources on specific geographies, clinical areas and population groups. They will help the NHS to be fairer, as well as to improve quality and make best use of the tax payers' pound.

Matthew Swindells:	Deputy Chief Executive National Director Operations and Information NHS England
Professor Stephen Powis:	National Medical Director NHS England
Professor Jane Cummings:	Chief Nursing Officer England and Regional Director London NHS England

Executive Statistical Summary

Unplanned Hospitalisations for Chronic Ambulatory Care Sensitive Conditions and Urgent Care Sensitive Conditions for 2016/17

The Absolute Gradient of Inequality (AGI) - change over time

- Between 2015/16 and 2016/17, inequality decreased (but the change was not statistically significant)
- Between 2014/15 and 2016/17, inequality decreased (but the change was not statistically significant)

AGI - comparisons of CCG with Similar 10

- Your CCG has lower* inequality than 1 of your Similar 10
- Your CCG has similar inequality to 8 of your Similar 10 (6 lower, 2 higher, but the difference was not statistically significant)
- Your CCG has higher* inequality than 1 of your Similar 10

Protected characteristic groups - CCG compared with best 5 of Similar 10

- Your CCG had significantly lower* unplanned hospitalisations for 0 of the 19 groups
- Your CCG had similar unplanned hospitalisations for 8 of the 19 groups
  (lower for 0, higher for 8 but the difference was not statistically significant)
- Your CCG had significantly higher* unplanned hospitalisations for 11 of the 19 groups

Notes: *Statistically significant differences
The number of groups (sex, age and ethnic) shown for a CCG will vary, as groups with insufficient data are not counted.

Executive Statistical Summary

Improving Access to Psychological Therapies (IAPT) 2016/17 - CCG compared with best 5 of the Similar 10

Quintiles of deprivation - rate of referrals finishing treatment

- Your CCG had higher* referrals for 0 of the 5 quintiles
- Your CCG had similar referrals for 0 of the 5 quintiles (higher for 0, lower for 0, but the difference was not statistically significant)
- Your CCG had lower* referrals for 5 of the 5 quintiles

Quintiles of deprivation - percentage of referrals moving to recovery

- Your CCG had higher* recoveries for 0 of the 5 quintiles
- Your CCG had similar recoveries for 5 of the 5 quintiles (higher for 0, lower for 5, but the difference was not statistically significant)
- Your CCG had lower* recoveries for 0 of the 5 quintiles

Protected characteristics - rate of referrals finishing treatment

- Your CCG had higher* referrals for 0 of the 10 groups
- Your CCG had similar referrals for 3 of the 10 groups (higher for 0, lower for 3, but the difference was not statistically significant)
- Your CCG had lower* referrals for 7 of the 10 groups

Protected characteristics - percentage of referrals moving to recovery

- Your CCG had higher* recoveries for 0 of the 10 groups
- Your CCG had similar recoveries for 10 of the 10 groups (higher for 6, lower for 4, but the difference was not statistically significant)
- Your CCG had lower* recoveries for 0 of the 10 groups

Notes: *Statistically significant differences
The number of groups (sex, age and ethnic) shown for a CCG will vary, as groups with insufficient data are not counted. Similarly, the number of England quintiles shown will vary, as quintiles with insufficient data are not counted.

Executive Summary - Case Studies and Resources

This pack contains a range of case studies on interventions that can be used to help promote equality and reduce health inequalities. These are listed below under the area they relate to. More detail on the studies and explanation of how they might be used to support action planning is set out in the section ***Promoting Equality and Reducing Health Inequalities, from Data and Case Studies to Action Planning*** starting on page 44. This section also contains links to resources including ***NHS RightCare products, NHS Health Check Data***, the ***UCL's Institute of Health Equity's website***, ***York University's Centre for Health Economics' website*** and ***Public Health England's Health Profile for England***.

New Care Models
Community Outpatient Services (Sandwell and West Birmingham CCG)
Healthy Lives (Sandwell and West Birmingham CCG)
Digital
Doc Abode - workforce software to improve Urgent and Primary Care Access, Resilience & Scale
Emergency Care
Self Management (Flo Telehealth)
Social Prescribing (Rotherham CCG)
Falls Specialist Response Car (Queen's Hospital North East London)
GP Led Triage and Redirection (Care UK and St Georges Hospital)
Rapid Access Doctor (Sutton CCG)
Dedicated Community Nurse (Kingston CCG)
Non-clinical Navigators (City and Hackney CCG)
Rapid Response Service (Camden)
Primary Care
Disruptive Prevention (West Wakefield)
Improving Working Practices (Tower Hamlets)
Tool for Reducing Inequalities in Access to GP Services
Cancer
Prostate Cancer Diagnosis (UCLH Cancer Collaborative)
Catching More Cancers Early (Manchester)
Access to Cancer Screening (Kingston)
Learning Disability Network Cancer Screening (North East and Cumbria)
Psychological Therapies
Health and Justice – Liaison and Diversion services
Street Triage Scheme (Nottinghamshire Healthcare NHS Foundation Trust)
Cognitive Behavioural Therapy (CBT) in GP Surgeries (Islington)
Improving Access to Psychological Therapies (IAPT) for Older People (Yorkshire)
Community Perinatal Team (CPT) (Hertfordshire)
Hear Our Voice (Cornwall) - Self-care for Young People
Mother and Baby Unit (MBU) (South West)
Motiv8 (Havant) - Improving Confidence in Young People

Your Equality and Health Inequalities Pack

This pack contains data on a number of healthcare areas in your CCG to demonstrate where there are potential opportunities for addressing equality and tackling health inequalities. The information contained in this pack is specific to your CCG and should be used to support local discussions and inform a more in-depth analysis. Additionally, there is information on different interventions that may address these areas. CCGs should consider which interventions could be appropriate for their demographic and engage with other CCGs to seek out examples of successful implementation.

By using this information, together with other packs and local intelligence such as the joint strategic needs assessment, long-term conditions and focus packs, your local health economy will be able to ensure its plans focus on those opportunities which have the potential to provide the biggest improvements in health outcomes and resource allocations and the biggest reductions in health inequalities.

NHS England, Public Health England and CCGs have legal duties under the Equality Act 2010 with regard to eliminating discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic and those who do not share it. There are also legal duties under the Health and Social Care Act 2012 with regard to reducing health inequalities between patients in access to, and outcomes from healthcare services, and to ensure services are provided in an integrated way where this might reduce health inequalities. Commissioners should continue to use these packs and supporting tools to drive local action to reduce inequalities in access to services and in the health outcomes achieved.

The National Big Picture

Socioeconomic Status

People living in deprived areas on average have poorer health and shorter lives. Research shows that socioeconomic inequalities result in increased morbidity and decreased life expectancy. **The UCL Institute of Health Equity estimates 1.3 to 2.5 million potential years of life lost annually due to inequalities.**[10]

Protected Characteristics

These are individuals' characteristics protected by the Equality Act of 2010. Understanding these different characteristics can improve patient care in terms of health outcomes, access and experiences. There are 9 protected characteristics:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

The under 75 mortality rate from Cardiovascular Disease (CVD) is **almost five times higher** in the most deprived compared to the least deprived areas[1]

African-Caribbean and Asian females over 65 have **a higher risk** of cervical cancer[2]

Lesbian and bisexual women are **twice as likely** to have never had a cervical smear test, compared with women in general[3]

Older people report receiving **poorer levels of care** than younger people with the same conditions[4]

People with learning disabilities are **4 times as likely to die** of preventable causes[5]

South Asians are **up to 6 times more likely** to develop type 2 diabetes[6]

Suicide is currently the **biggest killer of men under 35** in the UK[7]

It is becoming **more common** for children to develop type 2 diabetes[8]

Muslim people report **worse health on average** compared to other religious groups[9]

Sources
1. NHS Outcomes Framework inequality indicators, NHS Digital (2016). **2.** Forman, D. "Cancer incidence and survival by major ethnic group, England, 2002–2006". *National Cancer Intelligence Network* (2009). **3.** Kerker, Bonnie D., Farzad Mostashari, and Lorna Thorpe. "Health care access and utilization among women who have sex with women: sexual behavior and identity". *Journal of Urban Health* 83.5 (2006): 970-979. **4.** Melzer, David, et al. "Health Care Quality for an Active Later Life". *Peninsula College of Medicine and Dentistry, University of Exeter* (2012). **5.** Rees S, Cullen C, Kavanagh S, Lelliott P. Chapter 17 Learning Disabilities. In: Stevens A, Raftery J, Mant J, Simpson S. (eds.) *Health Care Needs Assessment. First Series*. Second. Oxford: Radcliffe Publishing Ltd; 2004. pp451–540.
6. Khunti, Kamlesh. *Diabetes UK and South Asian Health Foundation recommendations on diabetes research priorities for British South Asians*. Diss. University of Warwick, 2009.
7. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2015registrations ONS, 2015.
8. Haines, Linda, et al. "Rising incidence of type 2 diabetes in children in the UK". *Diabetes care* 30.5 (2007): 1097-1101. **9.** 2011 Census data.
10. Marmot, M. "Fair society, healthy lives : the Marmot Review : strategic review of health inequalities in England post-2010" (2010).

Why Should Addressing Health Inequalities be a Priority for CCGs?

The NHS is dedicated to delivering better care for individuals, lowering per-capita cost and improving population health. Health inequalities are an important component of population health and one that should be a central priority for CCGs.

- **It is a moral imperative concerning social justice.** The issue should be of great importance to a caring and compassionate service.

- **It is a legal requirement.** The Health and Social Care Act (2012) placed responsibilities on CCGs (amongst others) to "demonstrably take account of inequalities in access to and outcomes of healthcare".

- **It makes good business sense.** The burden of ill health and disability, as well as premature mortality, is disproportionately focussed on the most deprived populations. These sections of society are least equipped and resourced to make best and most appropriate use of services. If the ‘unmet need’ for preventive services and those for early detection and management is not addressed in those at greatest risk, a large part of the growing burden and cost will persist.

What Contributes to the Development of Health Inequalities?

Figure 1 shows how social determinants of inequality ('Risk conditions' and 'Psycho-social risks'), resultant 'Behavioural risks' and the subsequent 'Physiological risks' are all linked. Strategies to impact on health inequalities as a whole need to include interventions addressing all levels.

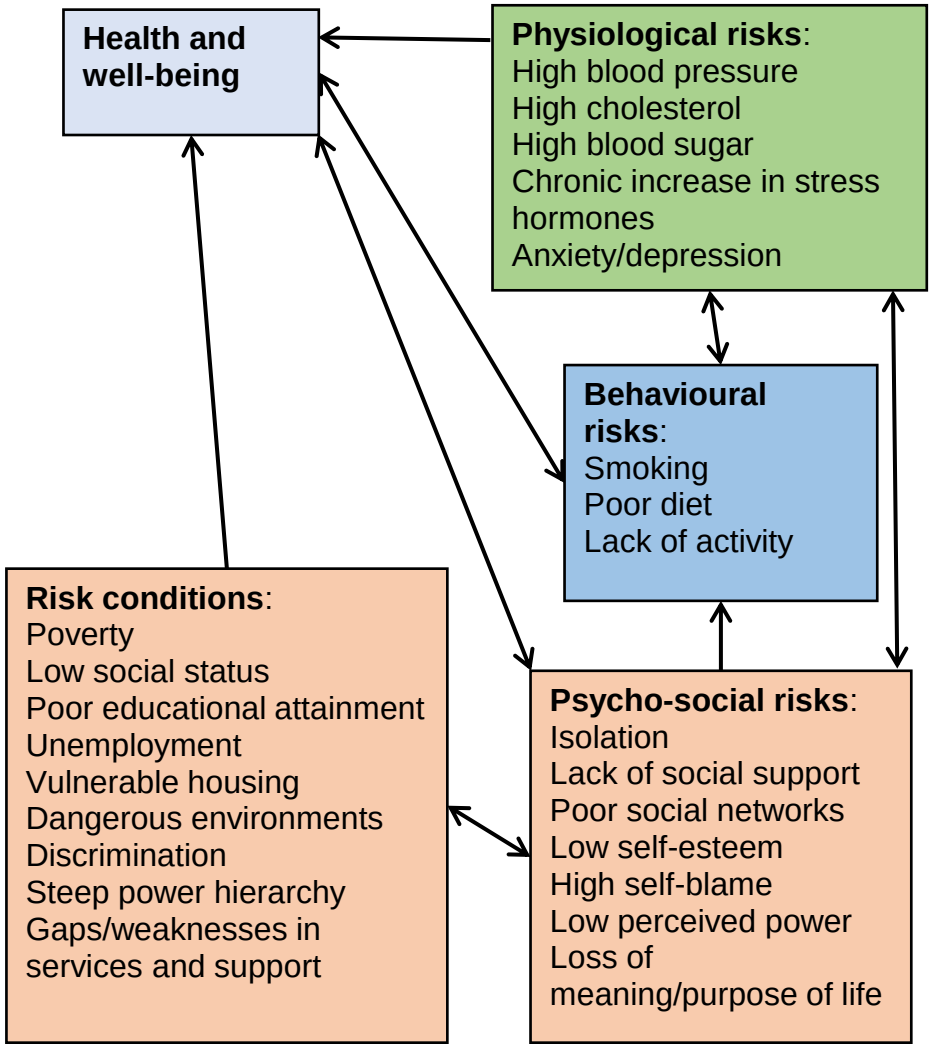
The CCG will have important partnership roles within the Health and Wellbeing Board and other place-based units of planning e.g. Integrated Care Systems and their contribution as commissioner or provider will differ across the three levels.

How can CCGs identify priorities and opportunities for improvement?

Working as a statutory partner in the Health and Wellbeing Board, the CCG will play their part, where possible, in addressing social determinants (Risk conditions and Psycho-social risks) through the Health and Wellbeing Strategy. These will include issues such as education and skills, joblessness, income and debt and housing.

To an extent, however, the NHSRightCare materials cluster CCGs with similar social determinants together, and then explore how effective similarly placed systems are being at addressing Behavioural risks and Physiological risks.

Figure 1: Pattern of risks affecting health and wellbeing



Your Most Similar CCGs

Your CCG is compared to the 10 most demographically similar CCGs. This is used to identify realistic opportunities to improve health and healthcare for your population. The analysis in this pack is based on a comparison with your most similar CCGs which are:

- NHS South Eastern Hampshire CCG
- NHS Redditch and Bromsgrove CCG
- NHS South Cheshire CCG
- NHS North Somerset CCG
- NHS Nottingham North and East CCG
- NHS Chorley and South Ribble CCG
- NHS Cannock Chase CCG
- NHS Warwickshire North CCG
- NHS Castle Point and Rochford CCG
- NHS Stafford and Surrounds CCG

To help you understand more about how your most Similar 10 CCGs are calculated, the Similar 10 Explorer Tool on the NHS England website is available here:

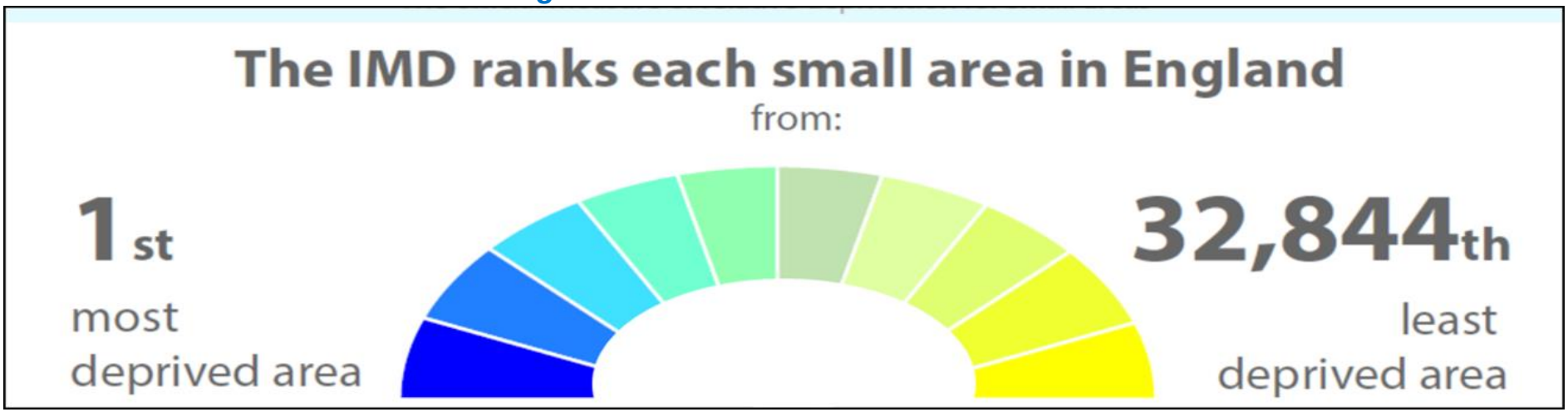
https://www.england.nhs.uk/publication/similar-10-ccg-explorer-tool/

This tool allows you to view similarity across all the individual demographics used to calculate your 10 most similar CCGs. You can also customise your Similar 10 group by weighting towards a desired demographic factor.

Measure of Deprivation

Ministry of Housing, Communities and Local Government's Index of Multiple Deprivation (IMD) for 2015

The IMD ranks each small area in England



IMD 2015 covers 7 domains of deprivation: income, employment, education, health, crime, barriers to housing and services and living environment and can be used for the following:

- Comparing small areas across England
- Identifying the most deprived small areas
- Exploring the domains (or types) of deprivation
- Comparing larger areas e.g. local authorities
- Looking at changes in relative deprivation between versions (i.e. changes in ranks)

IMD 2015 is used to construct key deprivation based inequality measures within these packs.

See the link below for more on IMD 2015

https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015

Your Data

This pack presents a variety of indicators. For each indicator, inequality within your CCG is measured, and then compared to your Similar 10 CCGs. Indicators for England are often included. This analysis is beneficial for showing current progress for CCGs, and forms one stage of a process. The aim is to shine a spotlight on variations in practice within and between CCGs, to help identify and share best practice in addressing equality and tackling health inequalities.

The indicators make the best use of available data. **However, data and analysis have limitations.**

The 2 areas covered are:

CCG Improvement and Assessment Framework (IAF) Health Inequalities Indicators

These are from the CCG IAF, based on methods developed by Richard Cookson, Miqdad Asaria and Shehzad Ali from the University of York, in a project funded by the National Institute for Health Research*. These are secondary care indicators that reflect on how well CCGs do overall in addressing inequalities in healthcare access and outcome between the most and least deprived members of the population.

CCG Indicators for Protected Characteristics for Increasing Access to Psychological Therapies (IAPT)

Equity indicators by socioeconomic status, sex, age and ethnicity groups have been constructed for IAPT services using ***rates of referral finishing a course of treatment*** (an access measure) and ***rates of movement to recovery for referrals finishing a course of treatment*** (an outcome measure).

Source

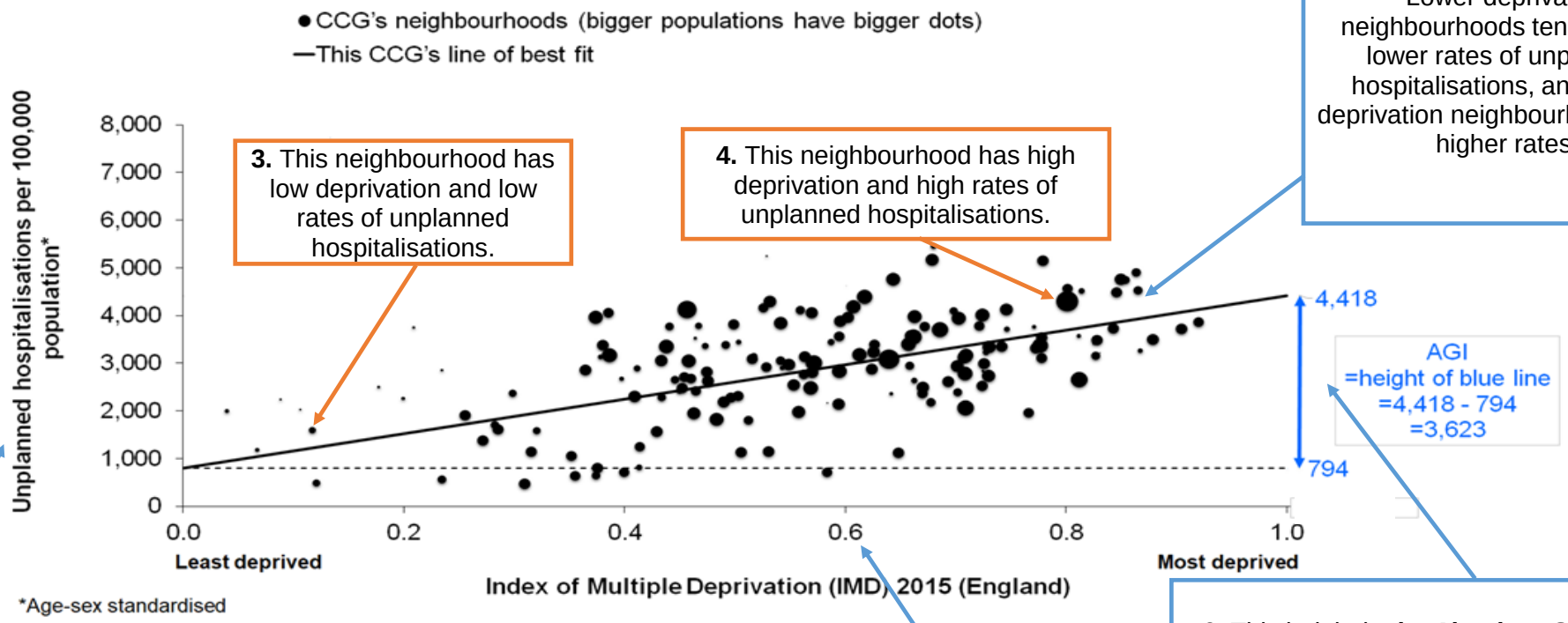
* Health Equity Indicators for the English NHS: a longitudinal whole-population study at the small-area level. Cookson et. al. HEALTH SERVICES AND DELIVERY RESEARCH 2016 VOL. 4 NO. 26. currently available at https://www.journalslibrary.nihr.ac.uk/hsdr/hsdr04260#/abstract

Inequalities in Unplanned Hospitalisations

This section relates to the CCG Improvement and Assessment Framework (IAF) Health Inequalities Indicator 106a: Inequality in Unplanned Hospitalisations for Chronic Ambulatory Care Sensitive and Urgent Care Sensitive Conditions for 2016/17

Explaining the AGI with an unspecified CCG

We will be using the Absolute Gradient of Inequality (AGI) as a measure of health inequalities within each CCG. Here, and in the next slide, we explain this measure.



3. This neighbourhood has low deprivation and low rates of unplanned hospitalisations.

4. This neighbourhood has high deprivation and high rates of unplanned hospitalisations.

5. The line is the general trend. Lower deprivation neighbourhoods tend to have lower rates of unplanned hospitalisations, and higher deprivation neighbourhoods have higher rates.

2. Each neighbourhood has a rate of unplanned hospitalisations.

1. The Index of Multiple Deprivation (IMD) is used to rank neighbourhoods from least deprived to most deprived.

6. This height is **the Absolute Gradient of Inequality (AGI).** This height and the gradient of the line both measure the AGI, because the steeper the gradient, the greater the height. The greater the inequality, the greater the gradient/height, and so the greater the AGI.

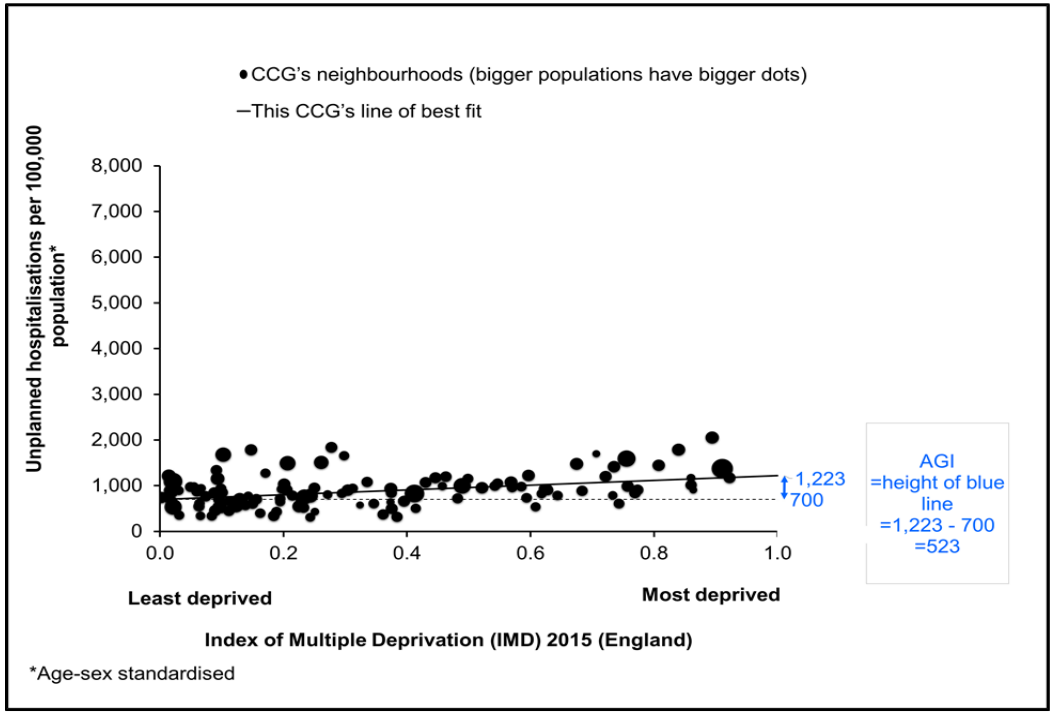
The Absolute Gradient of Inequality (AGI) for Unplanned Hospitalisations for Chronic Ambulatory Care Sensitive Conditions and Urgent Care Sensitive Conditions for 2016/17

Explaining the AGI with unspecified CCGs

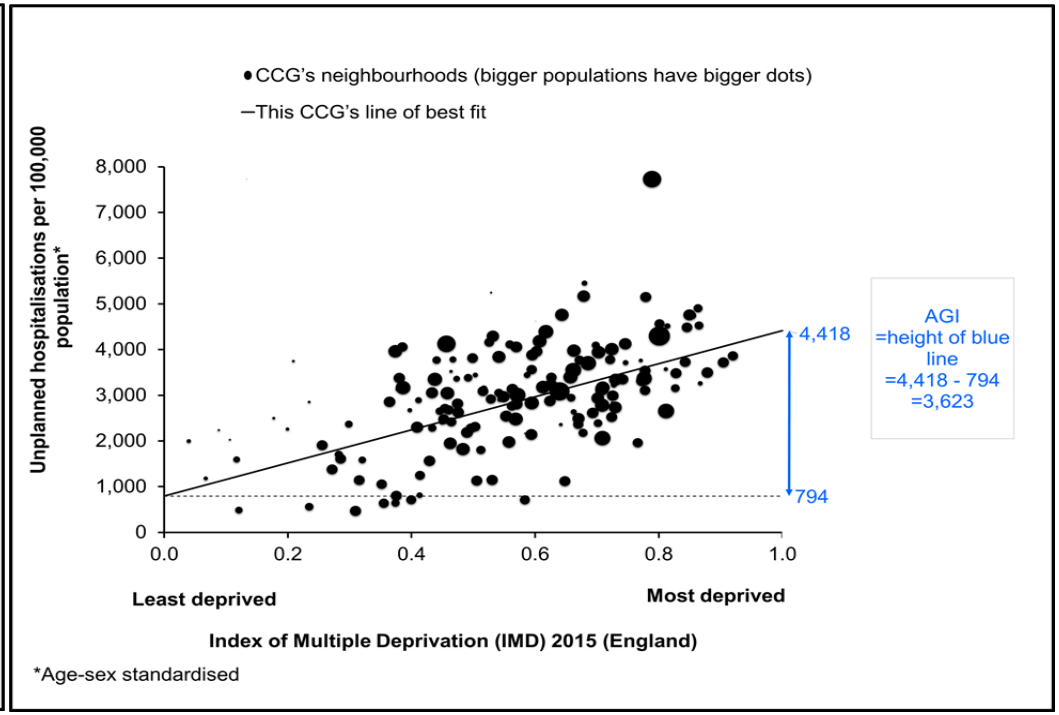
The charts below show how health inequalities, and therefore the AGI, can vary from CCG to CCG.

The steeper the gradient of the line of best fit, the greater the height of the blue line, the greater the AGI and so the greater the inequality.

A CCG with relatively low inequality - smaller AGI

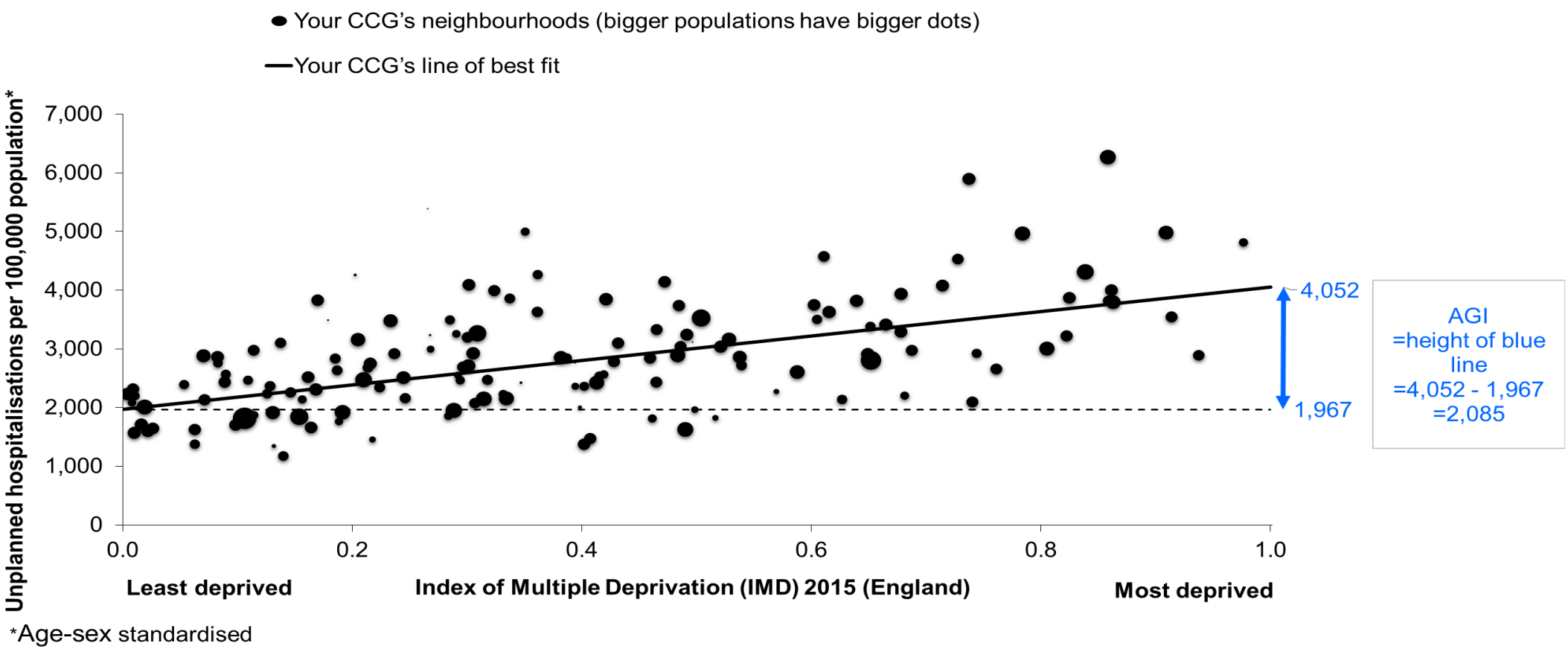


A CCG with relatively high inequality - larger AGI



The Absolute Gradient of Inequality (AGI) for your CCG

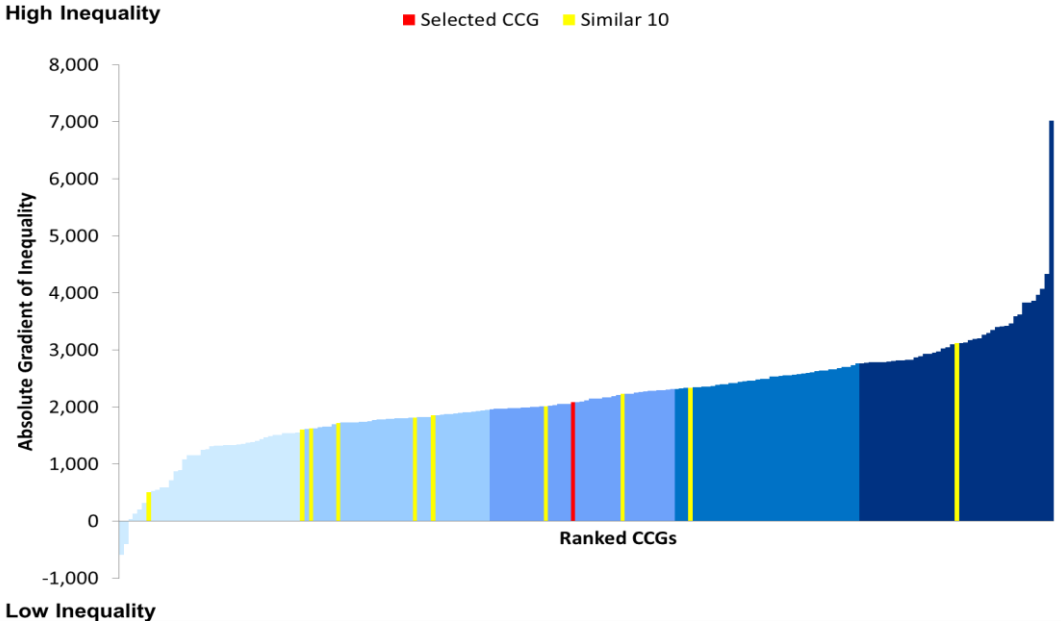
The chart below shows the AGI for your CCG. The steeper the gradient of the line of best fit, the greater the height of the blue line, the greater the AGI and so the greater the inequality. The chart shows neighbourhoods, which are also known as Lower Super Output Areas (LSOAs).

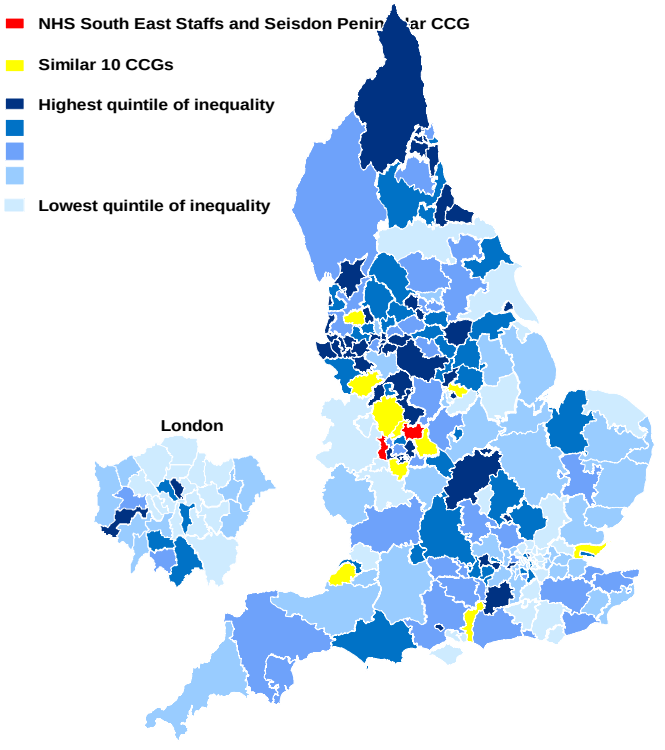


Sources: Unplanned hospitalisations: 2016-17 Secondary User Service (SUS), NHS Digital. Population data: CCG registered population for October 2016, NHS Digital.
Note: Numbers less than 6 have been suppressed when plotting neighbourhoods but have been included in overall calculations.

Inequality in your CCG compared with your Similar 10 and other CCGs in England

Each ranked bar on the chart represents the level of inequality in a CCG*. The red bar is your CCG and the yellow bars are the Similar 10 CCGs. These CCGs are also shown in the table below alongside their Absolute Gradient of Inequality (AGI) value, ranked from lowest (1) to highest (11) inequality. The CCGs in the highest quintile have the highest levels of inequality. The heatmap shows the geographical variation in levels of inequality across the country. The darkness of shades shows the CCGs' inequality with the darkest quintile having the highest inequality.





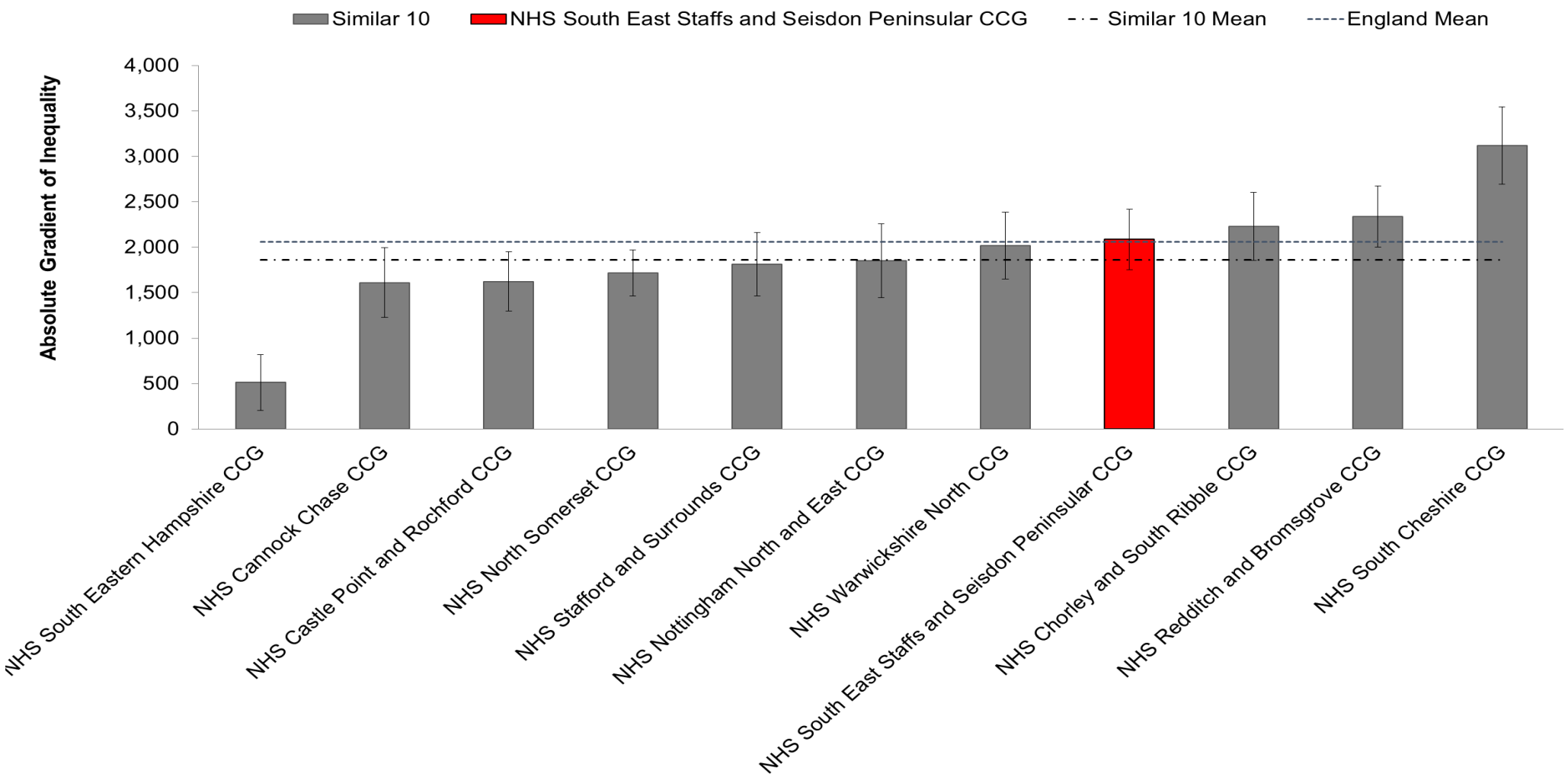
Rank	CCG Name	AGI
1	NHS South Eastern Hampshire CCG	512
2	NHS Cannock Chase CCG	1,609
3	NHS Castle Point and Rochford CCG	1,624
4	NHS North Somerset CCG	1,717
5	NHS Stafford and Surrounds CCG	1,814
6	NHS Nottingham North and East CCG	1,853
7	NHS Warwickshire North CCG	2,018
8	NHS South East Staffs and Seisdon Peninsular CCG	2,085
9	NHS Chorley and South Ribble CCG	2,230
10	NHS Redditch and Bromsgrove CCG	2,337
11	NHS South Cheshire CCG	3,117

Sources: Unplanned hospitalisations: SUS 2016/17, NHS Digital, population data - CCG registered population, October 2016, NHS Digital
Notes: * Difference in age sex standardised rates of unplanned hospitalisation per 100,000 population between the most and least deprived neighbourhoods in England if England had the same inequality as the CCG. See NHS England CCG Improvement and Assessment Framework Technical Annex for more details.

NHS England CCG Improvement and Assessment Framework Technical Annex

Inequality in your CCG compared with your Similar 10

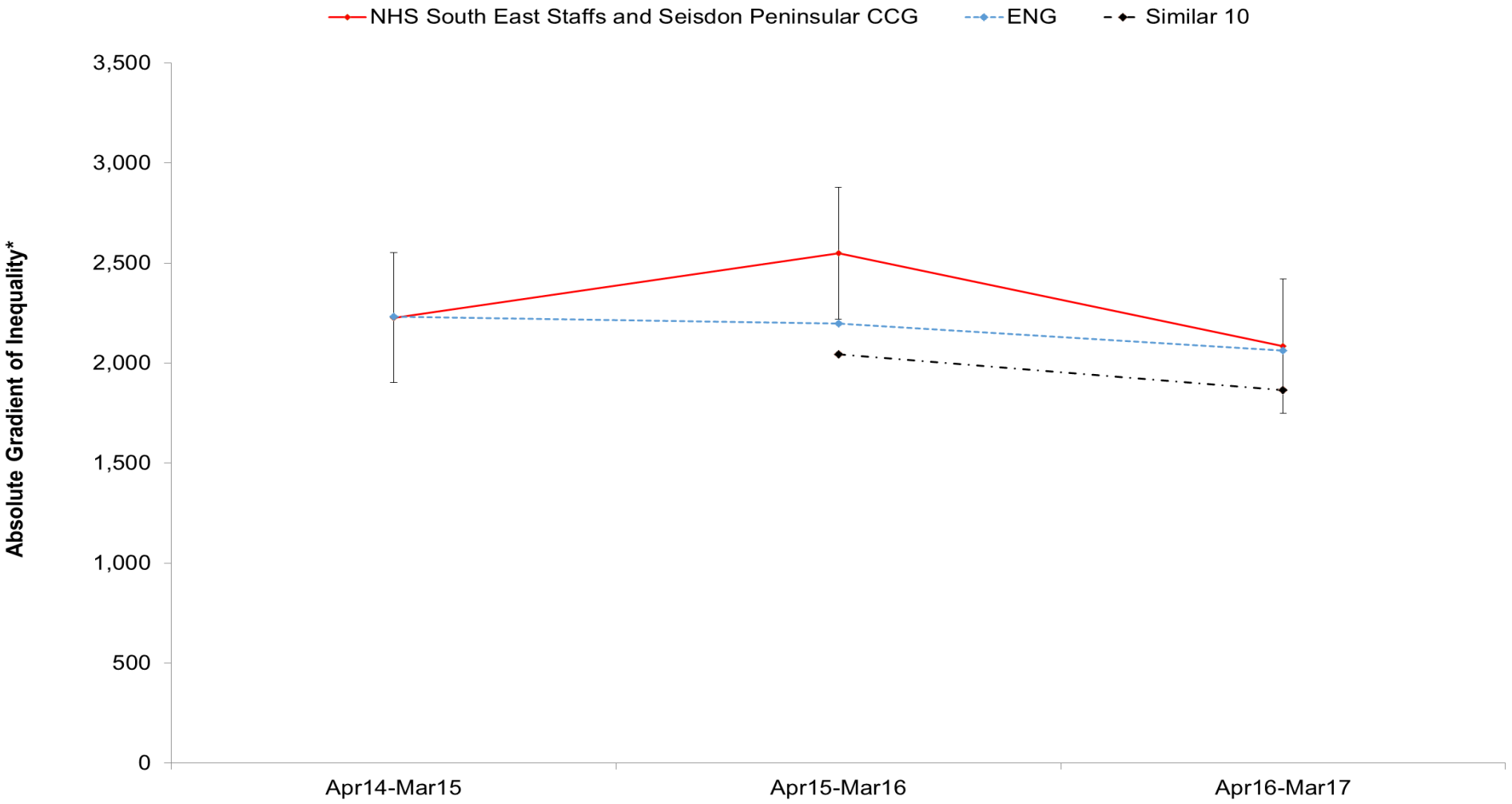
The current levels of inequality for your CCG and its Similar 10 CCGs are shown by the bars on the ranked chart. The 95% confidence interval error bars illustrate the uncertainty in the measure of inequality. Horizontal lines represent the mean of the Similar 10 as well as England. CCGs that are below the Similar 10 Mean have less inequality than its Similar 10 CCGs.



Sources: Unplanned hospitalisations - Secondary User Service (SUS) 2016/17, NHS Digital, population data - CCG registered population, October 2016, NHS Digital.

Time Series for your CCG's Inequality compared with your Similar 10 and England

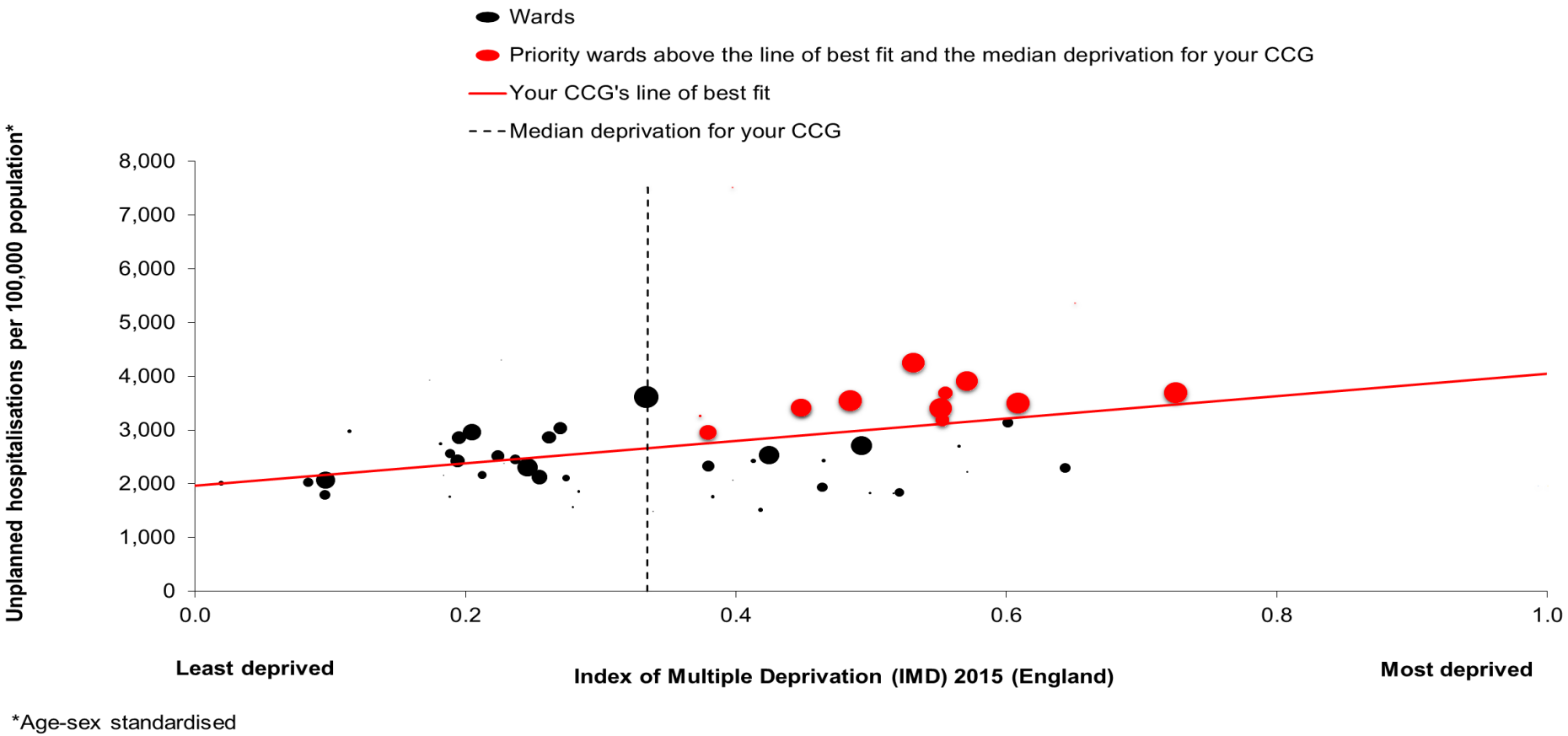
The current and previous levels of inequality for your CCG are shown by the solid line on the line chart. The 95% confidence interval error bars illustrate the uncertainty in the measure of inequality. The England average, and the average of the Similar 10 are also shown as benchmarks.



Sources: Unplanned hospitalisations - Secondary User Service (SUS) 2016/17, 2015/16, and 2014/15 (where available), NHS Digital, population data - CCG registered population, October 2016, NHS Digital.
Note: * Difference in age sex standardised rates of unplanned hospitalisation per 100,000 population between the most and least deprived neighbourhoods in England if England had the same inequality as the CCG.

Determining Priority Wards for Inequality for your CCG

This slide shows wards rather than neighbourhoods, because wards may be more familiar to CCGs and are around 4 times as large which helps to address statistical uncertainty. The dots on the chart represent the wards in your CCG. Dot sizes vary depending on the ward population. The red line shows the line of best fit for your CCG. The slope of the line shows the Absolute Gradient of Inequality (AGI). The steeper the line, the greater the level of inequality. The red priority wards are those in the most deprived half of your CCG (based upon the Index of Multiple Deprivation), that are above the red line. Priority wards are important because they are the wards associated with inequality.



*Age-sex standardised

Sources: Unplanned hospitalisations: 2016-17 Secondary User Service (SUS), NHS Digital. Population data: CCG registered population for October 2016, NHS Digital.
Note: Numbers less than 6 have been suppressed when plotting wards but have been included in determining the line of best fit.

Priority Wards for Inequality for your CCG

Up to 20 priority wards, with at least 50 hospitalisations, for your CCG are listed below. The final column shows the opportunity for saved hospitalisations if your CCG had no inequality. This is the number of hospitalisations that would be saved if expected rates for priority wards moved to the expected rate at median deprivation*.

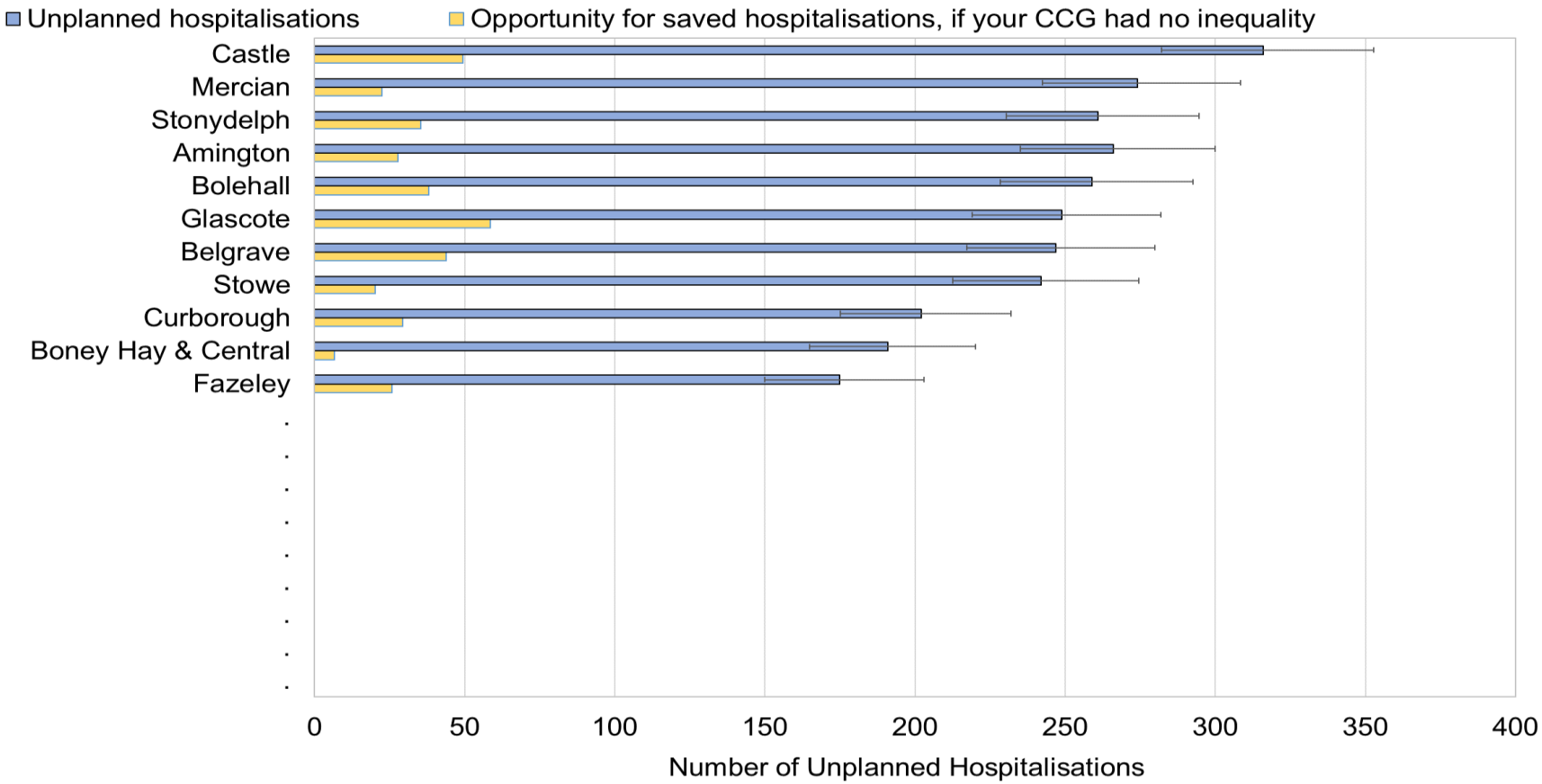
Rank	2015 ward	Population	Unplanned hospitalisations per 100,000 population**	Unplanned hospitalisations	Opportunity for saved hospitalisations, if your CCG had no inequality
1	Castle	7,624	3,909	316	49
2	Mercian	7,098	3,414	274	22
3	Stonydelph	7,869	4,253	261	35
4	Amington	8,165	3,549	266	28
5	Bolehall	7,969	3,402	259	38
6	Glascote	8,320	3,695	249	59
7	Belgrave	8,191	3,503	247	44
8	Stowe	5,292	3,393	242	20
9	Curborough	5,286	3,690	202	29
10	Boney Hay & Central	5,854	2,954	191	7
11	Fazeley	4,938	3,190	175	26
12	.	.	.	.	.
13	.	.	.	.	.
14	.	.	.	.	.
15	.	.	.	.	.
16	.	.	.	.	.
17	.	.	.	.	.
18	.	.	.	.	.
19	.	.	.	.	.
20	.	.	.	.	.
	.	.	.	.	.
	Total	**76,606**		**2,682**	**357**

Sources: Unplanned hospitalisations: 2016-17 Secondary User Service (SUS), NHS Digital. Population data: CCG registered population for October 2016, NHS Digital.

Notes:
Figures are taken from the Total (where 1 to 5 replaced with 3) column of the Top 10 conditions for priority wards table.
Numbers less than 6 have been suppressed.
*See Methodology Guide for further details
**Age-sex standardised

Priority Wards for Inequality and Uncertainty for your CCG

The chart below shows up to 20 priority wards, with at least 50 hospitalisations, for your CCG. The blue bars (with 95% confidence intervals to show uncertainty) show the number of unplanned hospitalisations. The yellow bars show the opportunity for saved hospitalisations, if your CCG had no inequality. This is the number of hospitalisations that would be saved if expected rates for priority wards moved to the expected rate at median deprivation*.



Sources: Unplanned hospitalisations: 2016-17 Secondary User Service (SUS), NHS Digital. Population data: CCG registered population for October 2016, NHS Digital.

Notes:
Figures are taken from the Total (where 1 to 5 replaced with 3) column of the Top 10 conditions for priority wards table. *See Methodology Guide for further details.

Top 10 Conditions for Inequality in all Priority Wards for your CCG

The table below shows the number of unplanned hospitalisations for all your CCG's priority wards with at least 50 hospitalisations combined. This is broken down by the top 10 conditions in your CCG. The opportunity for saved hospitalisations if your CCG had no inequality is also shown*.

Unplanned hospitalisations by condition

Pain in throat and chest	485
Abdominal and pelvic pain	380
Other disorders of urinary system	313
Other chronic obstructive pulmonary disease	241
Heart failure	140
Cellulitis	124
Atrial fibrillation and flutter	90
Asthma	125
Fracture of femur	67
Phlebitis and thrombophlebitis	43
Other	674
Total	**2,682**
Opportunity for saved hospitalisations, if your CCG had no inequality	***357***

Sources: Unplanned hospitalisations: 2016-17 Secondary User Service (SUS), NHS Digital. Population data: CCG registered population for October 2016, NHS Digital.

Notes:
Figures are taken from the Total (where 1 to 5 replaced with 3) row of the Top 10 conditions for priority wards table.
*This is the number of hospitalisations that would be saved if expected rates for priority wards moved to the expected rate at median deprivation. See Methodology Guide for further details.

Top 10 Conditions for Inequality for Priority Wards for your CCG

The table below shows up to 20 of your CCG's priority wards, with at least 50 hospitalisations, ranked by the total number of unplanned hospitalisations. This is broken down by the top 10 conditions in your CCG. The opportunity for saved hospitalisations, if your CCG had no inequality is also shown*.

Priority Wards	Unplanned hospitalisations by condition													
	Pain in throat and chest	Abdominal and pelvic pain	Other disorders of urinary system	Other chronic obstructive pulmonary disease	Heart failure	Cellulitis	Atrial fibrillation and flutter	Asthma	Fracture of femur	Phlebitis and thrombophlebitis	Other	**Total (where 1 to 5 suppressed)**	**Total (where 1 to 5 replaced with 3)**	Opportunity for saved hospitalisations, if your CCG had no inequality
Castle	35	32	53	37	12	16	11	8	12	6	94	**316**	**316**	***49***
Mercian	55	31	37	23	12	12	.	16	7	.	75	**268**	**274**	***22***
Stonydelph	60	52	25	21	16	.	.	15	.	.	60	**249**	**261**	***35***
Amington	62	47	28	11	15	16	6	12	.	7	59	**263**	**266**	***28***
Bolehall	51	41	28	22	9	12	10	15	.	.	65	**253**	**259**	***38***
Glascote	67	47	24	19	16	8	13	14	.	.	35	**243**	**249**	***59***
Belgrave	55	29	16	32	11	14	6	17	.	.	61	**241**	**247**	***44***
Stowe	33	18	36	28	15	10	8	9	12	.	70	**239**	**242**	***20***
Curborough	18	31	20	27	7	12	17	13	.	.	51	**196**	**202**	***29***
Boney Hay & Central	25	35	23	10	17	9	.	.	9	.	54	**182**	**191**	***7***
Fazeley	24	17	23	11	10	12	10	.	9	6	50	**172**	**175**	***26***
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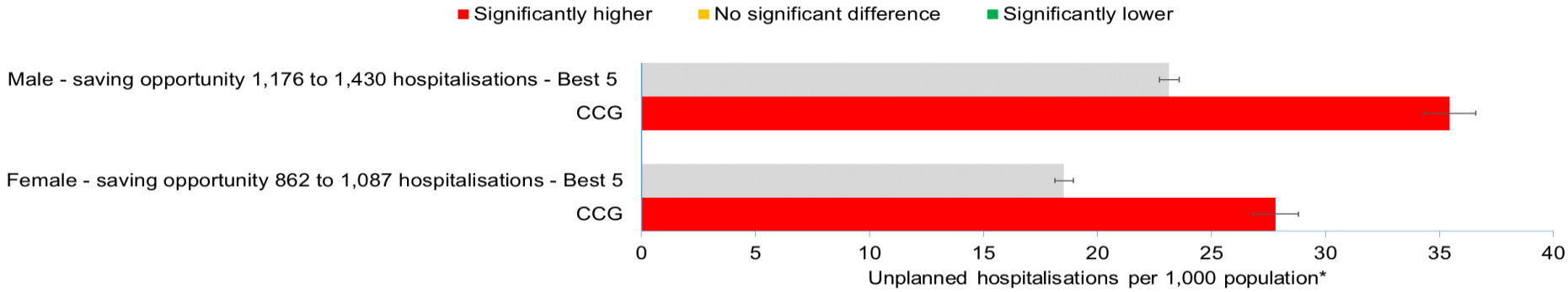
Total (where 1 to 5 suppressed)	**485**	**380**	**313**	**241**	**140**	**121**	**81**	**119**	**49**	**19**	**674**	**2,622**		**357**
Total (where 1 to 5 replaced with 3)	**485**	**380**	**313**	**241**	**140**	**124**	**90**	**125**	**67**	**43**	**674**		**2,682**	

Sources: Unplanned hospitalisations: 2016-17 Secondary User Service (SUS), NHS Digital. Population data: CCG registered population for October 2016, NHS Digital.

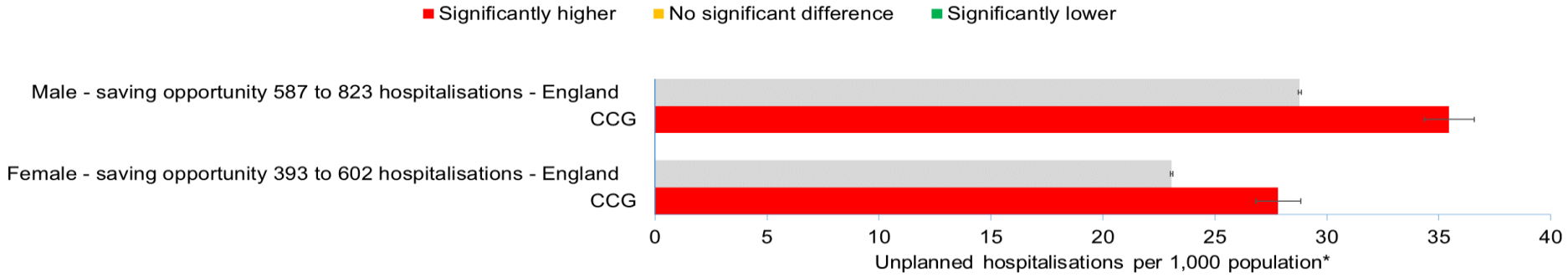
Notes:
Numbers between 1 and 5 have been suppressed or replaced with 3.
*This is the number of hospitalisations that would have been saved if expected rates for the priority wards moved to the expected rate at median deprivation. See Methodology Guide for further details.

Your CCG benchmarked by sex with the Best 5 of your Similar 10 CCGs and England

The charts below compare the rate of unplanned hospitalisations for your CCG with the rate for the average of the best (lowest) 5 in its Similar 10 and the rate for England by sex. These comparisons may reflect scope for improvement for your CCG. All bars show 95% confidence intervals to reflect statistical uncertainty. Where your CCG rate is statistically significantly higher than for the best 5 in its Similar 10 or England your CCG bar is coloured red. Numbers to the left of the red bars represent hospitalisations which could be saved if the CCG rate moved to the best 5 of its Similar 10 or England rate. A range is given to reflect statistical uncertainty.



Two charts are shown for the different benchmarks. The chart above compares your CCG with the average of the best (lowest) 5 of its Similar 10. The chart below compares your CCG with England.

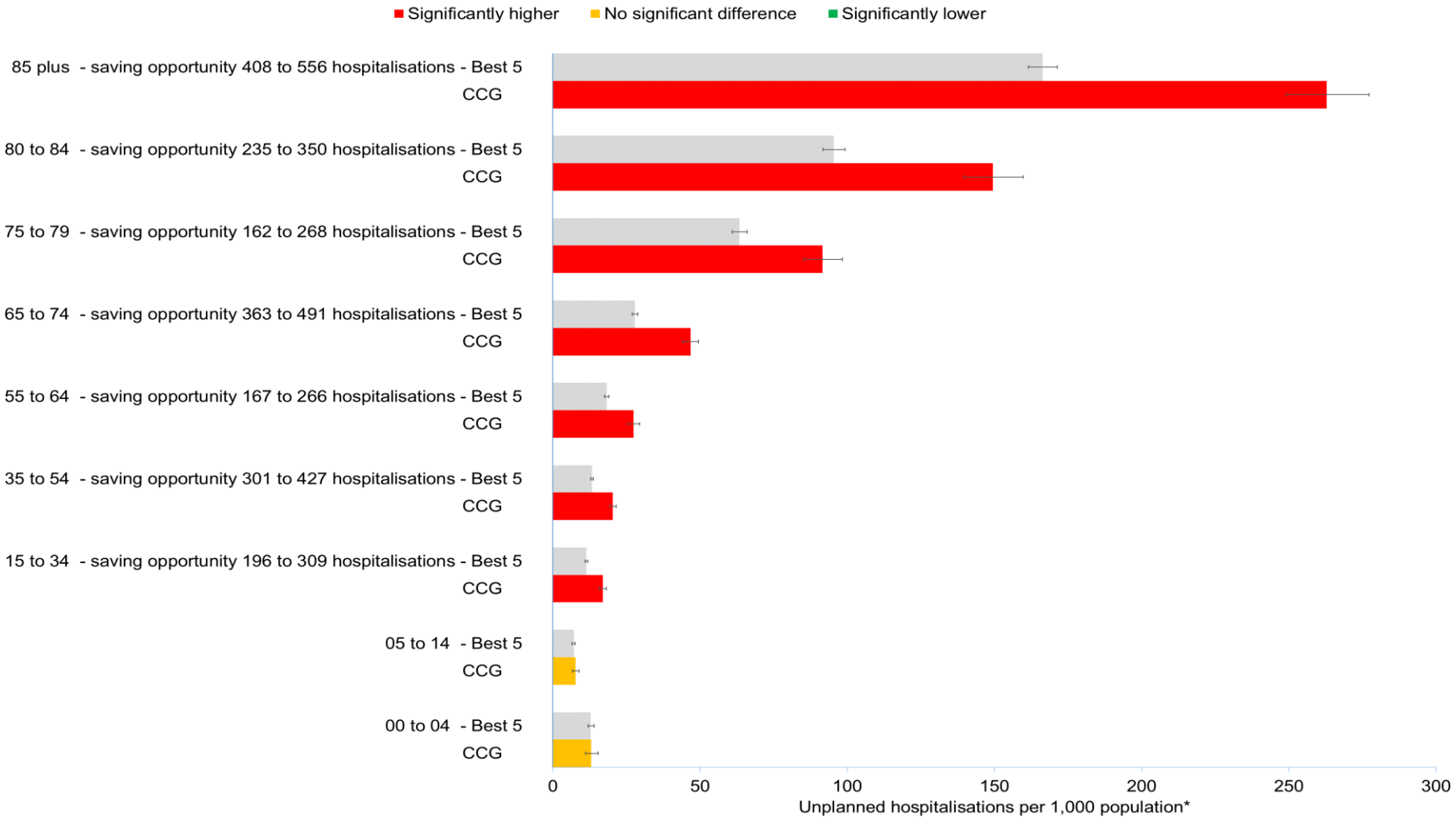


Sources: Unplanned hospitalisations - SUS 2016/17, population data - CCG registered population for October 2016, NHS Digital (2017).

Notes:
Numbers less than 6 have been suppressed.
*Data has been standardised for deprivation using indirect standardisation, deprivation has been measured using the Index of Multiple Deprivation for 2015. In addition data has also been standarised for age.
For more detail please see tables on pages 59 and 60.

Your CCG benchmarked by age with the Best 5 of your Similar 10 CCGs

The charts below compare the rate of unplanned hospitalisations for your CCG with the average of the best (lowest) 5 in its Similar 10 for various age groups. It is anticipated that different age groups within your CCG will have different rates because they reflect different life stages. However, for the same age group, differences between your CCG and the average of the best 5 in its Similar 10 CCGs may reflect scope for improvement. All bars show 95% confidence intervals to reflect uncertainty. Where your CCG rate is statistically significantly higher than for the best 5 in its Similar 10 your CCG bar is coloured red. Numbers to the left of the red bars represent hospitalisations which could be saved if the CCG rate moved to the best 5 of its Similar 10 rate. A range is shown to reflect statistical uncertainty.

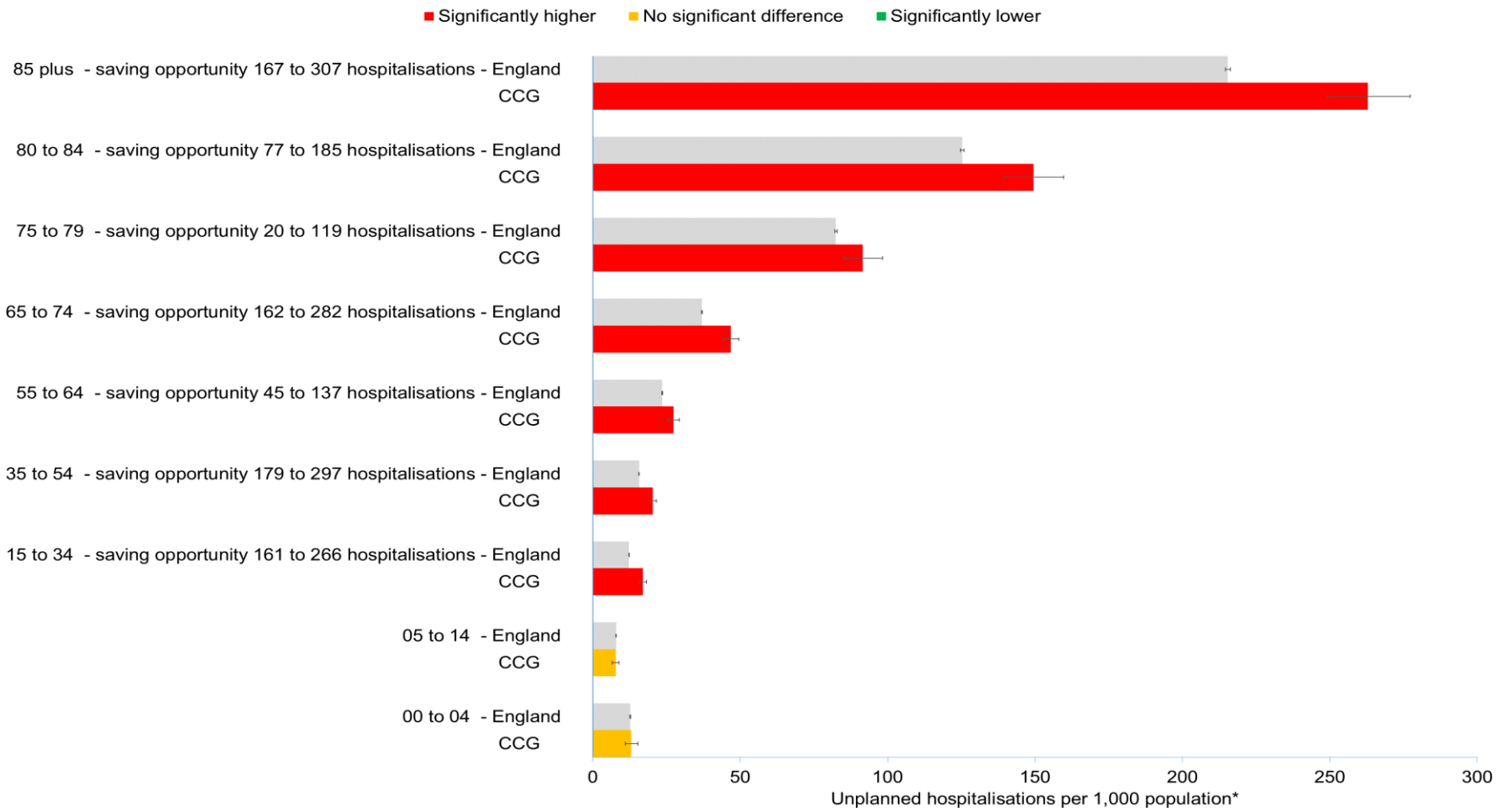


Sources: Unplanned hospitalisations - SUS 2016/17, population data - CCG registered population for October 2016, NHS Digital (2017).

Notes:
Numbers less than 6 have been suppressed.
*Data has been standardised for deprivation using indirect standardisation, deprivation has been measured using the Index of Multiple Deprivation for 2015. Data has also been standardised for sex.
For more detail please see tables on pages 59 and 60.

Your CCG benchmarked by age with England

The charts below compare the rate of unplanned hospitalisations for your CCG with the rate for England for various age groups. It is anticipated that different age groups within your CCG will have different rates because they reflect different life stages. However, for the same age group, differences between your CCG and England may reflect scope for improvement for your CCG. All bars show 95% confidence intervals to reflect statistical uncertainty. Where your CCG rate is statistically significantly higher than for England your CCG bar is coloured red. Numbers to the left of the red bars represent hospitalisations which could be saved if the CCG rate moved to the England rate. A range is shown to reflect statistical uncertainty.



Sources: Unplanned hospitalisations - SUS 2016/17, population data - CCG registered population for October 2016, NHS Digital (2017).

Notes:
Numbers less than 6 have been suppressed.
*Data has been standardised for deprivation using indirect standardisation, deprivation has been measured using the Index of Multiple Deprivation for 2015. Data has also been standardised for sex.
For more detail please see tables on pages 59 and 60.

Data limitations for constructing rates for ethnic groups for your CCG

The next two slides benchmark rates of unplanned hospitalisations by ethnic group for your CCG. This requires the ethnic group of the patient for each hospitalisation to be recorded. For some hospitalisations the ethnicity of the patient is recorded as unknown.

For your CCG 9.6% of hospitalisation records have an unknown ethnic group, compared to 6.6% for England and 10.9% for the best 5 of your Similar 10.

We do not know if hospitalisations where the ethnicity of the patient is unknown are split disproportionately across ethnic groups or if one ethnic group has a higher share of the hospitalisations of unknown ethnicity than another.

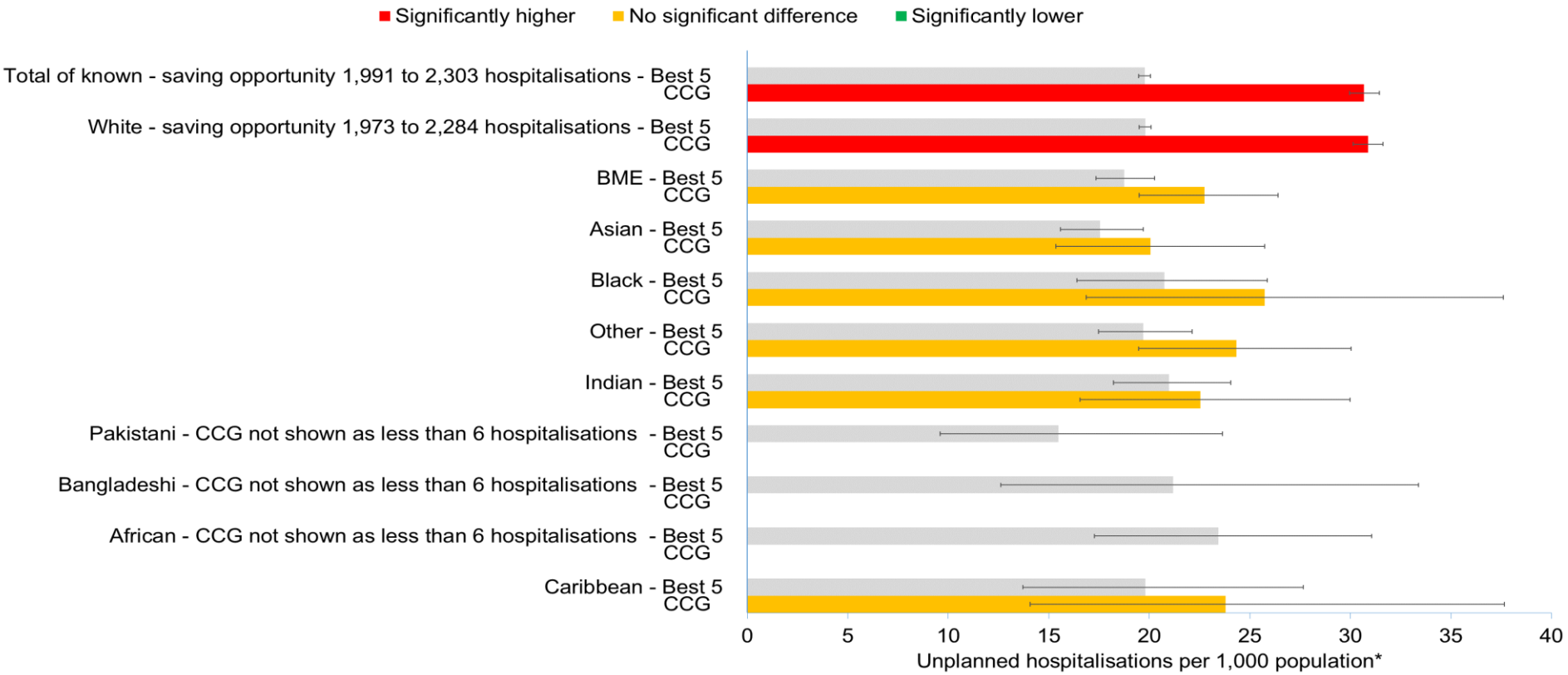
For each ethnic group, the comparability between your CCG rate and its benchmark rate will depend upon the proportion of hospitalisations of unknown ethnicity for your CCG and the proportion for its benchmark. For each ethnic group the more comparable the proportion unknown for your CCG and the proportion unknown for its benchmark, the more comparable will be the hospitalisations rates between your CCG and its benchmark.

A further limitation of hospitalisation rates by ethnic group is that they are constructed by dividing the number of unplanned hospitalisations by the population for each group and the population of each ethnic group has been estimated. Population estimates by ethnic group are derived by applying 2011 Census ethnic group splits at a detailed level to 2016/17 CCG registered population numbers.

Further detail is provided in slide 61 of the Annex.

Your CCG benchmarked by ethnicity with the Best 5 of your Similar 10 CCGs

The charts below compare the rate of unplanned hospitalisations for your CCG with the average of the best (lowest) 5 in its Similar 10 for various ethnic groups. It is important to note that rates have been standardised for deprivation as well as sex and age, so that benchmarking is more specifically for ethnicity. Differences between your CCG and the average of the best 5 in its Similar 10 CCGs may reflect scope for improvement. All bars show 95% confidence intervals to reflect uncertainty. Where your CCG rate is statistically significantly higher than for the best 5 in its Similar 10 your CCG bar is coloured red. Numbers to the left of the red bars represent hospitalisations which could be saved if the CCG rate moved to the best 5 of Similar 10 rate. A range is given to reflect statistical uncertainty.

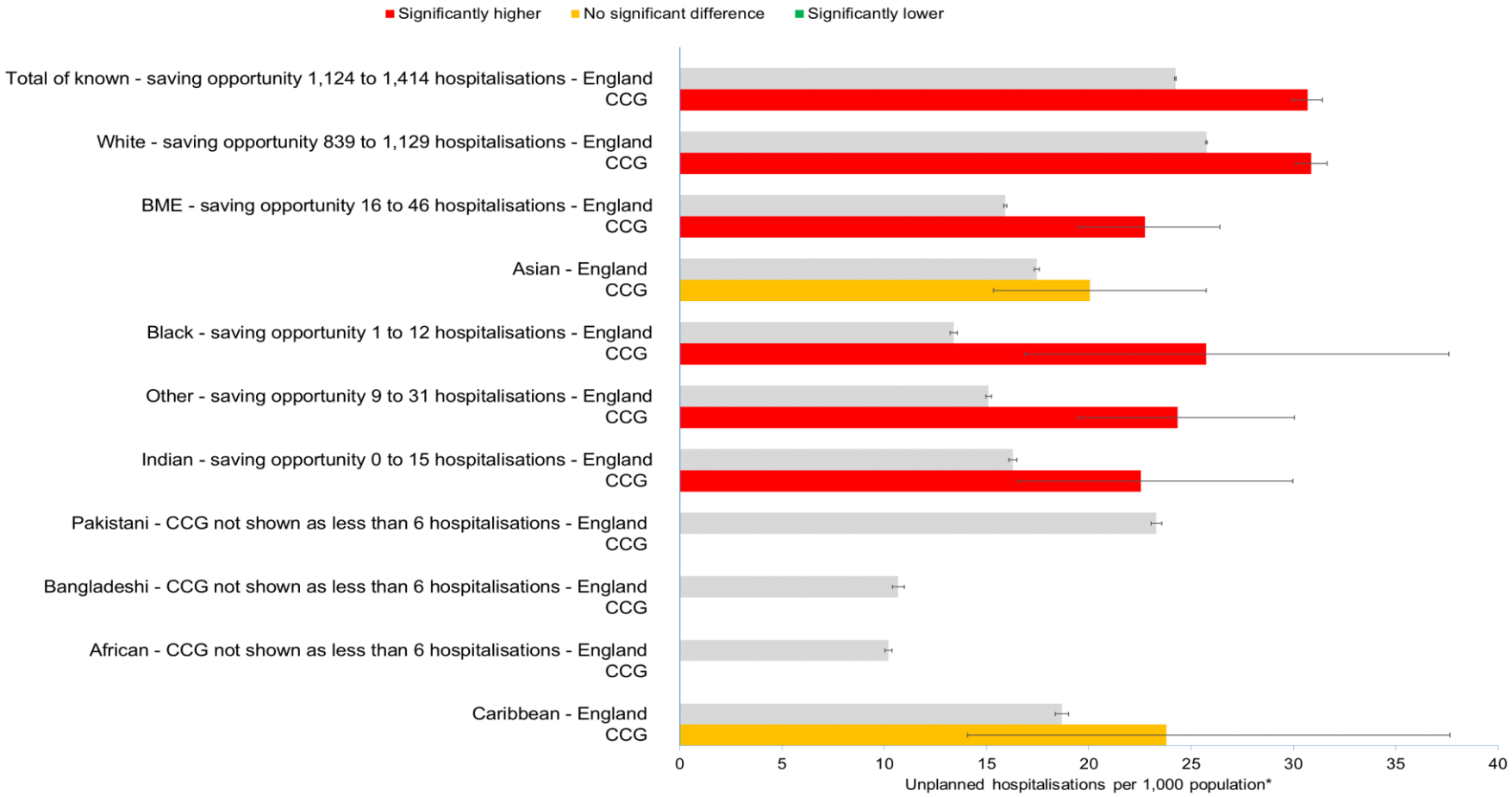


Sources: Unplanned hospitalisations SUS 2016/17, population data - CCG registered population for October 2016, NHS Digital (2017).

Notes:
Numbers less than 6 have been suppressed.
*Data has been standardised for sex, age and deprivation using indirect standardisation, deprivation has been measured using the Index of Multiple Deprivation for 2015.
For more detail please see table on page 62.

Your CCG benchmarked by ethnicity with England

The charts below compare the rate of unplanned hospitalisations for your CCG with England for various ethnic groups. It is important to note that rates have been standardised for deprivation as well as sex and age, so that benchmarking is more specifically for ethnicity. Differences between your CCG and England may reflect scope for improvement. All bars show 95% confidence intervals to reflect uncertainty. Where your CCG rate is statistically significantly higher than for England your CCG bar is coloured red. Numbers to the left of the red bars represent hospitalisations which could be saved if the CCG rate moved to the England rate. A range is given to reflect statistical uncertainty.



Sources: Unplanned hospitalisations - SUS 2016/17, population data - CCG registered population for October 2016, NHS Digital (2017).

Notes:
Numbers less than 6 have been suppressed.
*Data has been standardised for sex, age and deprivation using indirect standardisation, deprivation has been measured using the Index of Multiple Deprivation for 2015.
For more detail please see table on page 62.

Inequalities in Psychological Therapies

This section relates to CCG Indicators of Equity for Improving Access to Psychological Therapies (IAPT) for 2016/17

Inequality in Access to Psychological Therapies

Improving access to psychological therapies (IAPT) is an NHS programme in England that provides treatment approved by the National Institute for Health and Care Excellence (NICE) for anxiety disorders and depression. More than 900,000 people in England are accessing IAPT services each year, however there is scope for at least 1.5 million adults to access these services. CCGs should consider if those in the population with common mental health problems are not only able to access the service, but to get good outcomes. Reporting on the IAPT programme in general is based around referrals, waiting times and outcomes (see link below). In this pack the focus lies with outcomes - eligible referrals moving to recovery.

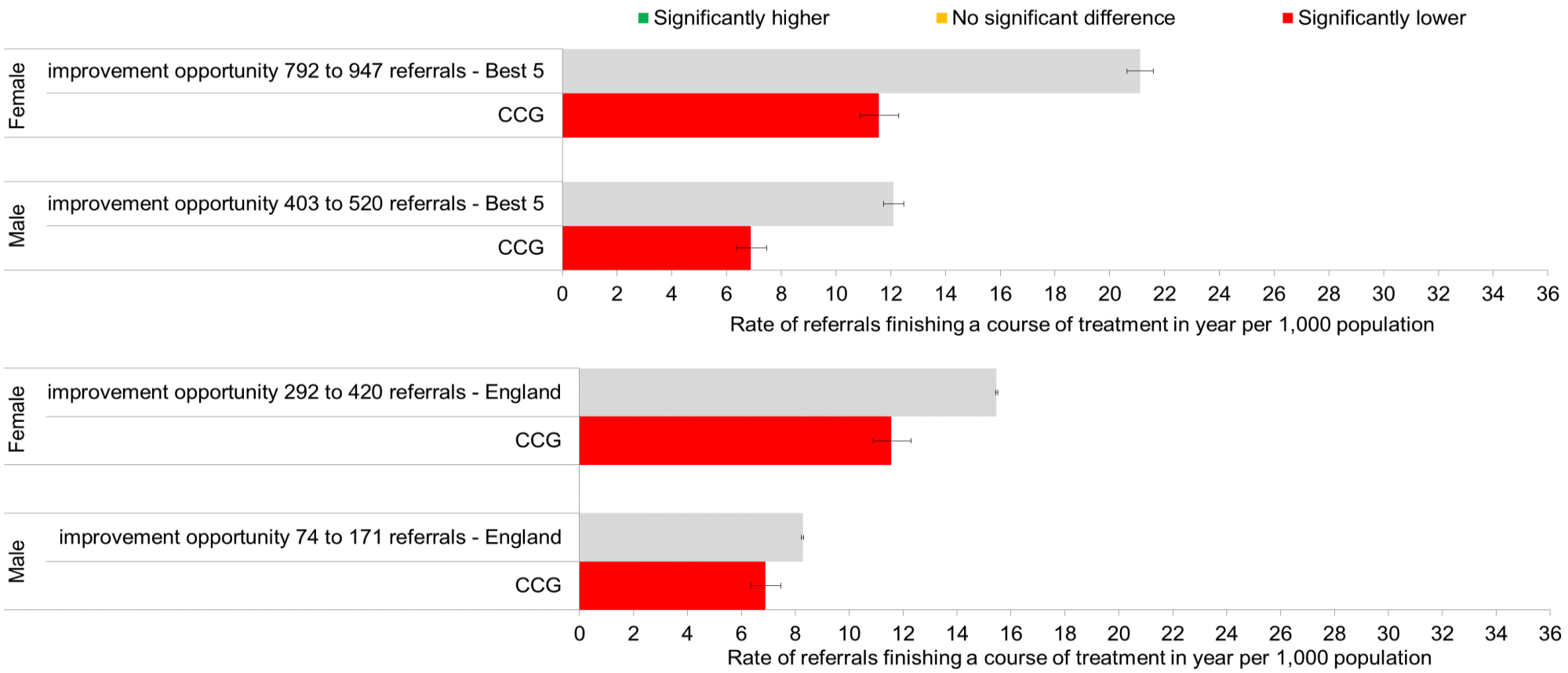
Outcomes
The Government target is that 50% of eligible referrals to IAPT services should move to recovery.

IAPT Report for 16-17

Your CCG benchmarked by sex with the Best 5 of your Similar 10 CCGs and England

The top chart compares the rate of referrals finishing a course of treatment in 2016/17 for your CCG with the best 5 of your Similar 10 average rate by sex. The bottom chart compares your CCG rate with the England rate.

The grey bars represent the benchmark rate whilst non-grey bars represent your CCG rate. Red bars indicate that your CCG is significantly lower than the benchmark. Amber bars indicate that there is no significant difference between your CCG and the benchmark. Green bars indicate that your CCG is significantly higher than the benchmark. Error bars use a 95% confidence level to show uncertainty. Numbers to the left of the red bars represent the number of referrals that could be made if the CCG rate moved to the benchmark rate. A range is given to reflect uncertainty.



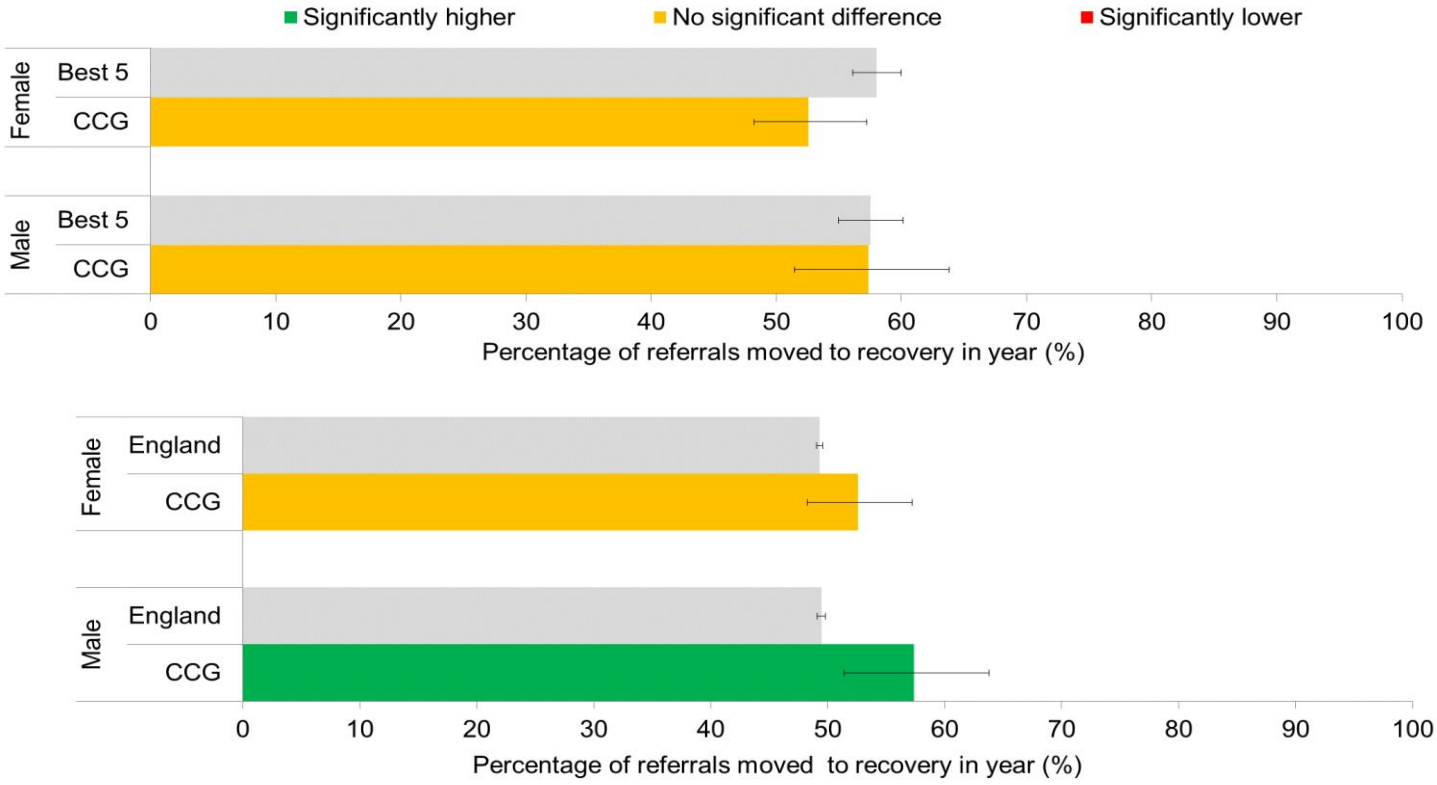
Sources: Psychological Therapies: Annual report on the use of IAPT services, NHS Digital (2018).
Note: Data points with values less than 5 have been suppressed, therefore, for these points, bars are not shown on the chart.

See page 63 for table by sex.

Your CCG benchmarked by sex with the Best 5 of your Similar 10 CCGs and England

The top chart compares the rate of referrals moving to recovery in 2016/17 for your CCG with the best 5 of your Similar 10 average rate by sex. The bottom chart compares your CCG rate with the England rate.

The grey bars represent the benchmark rate whilst non-grey bars represent your CCG rate. Red bars indicate that your CCG is performing significantly lower than the benchmark. Amber bars indicate that there is no significant difference between your CCG and the benchmark. Green bars indicate that your CCG is performing significantly higher than the benchmark. Error bars use a 95% confidence level to show uncertainty. Numbers to the left of the red bars represent the number of recoveries that could be made if the CCG rate moved to the benchmark rate. A range is given to reflect uncertainty.



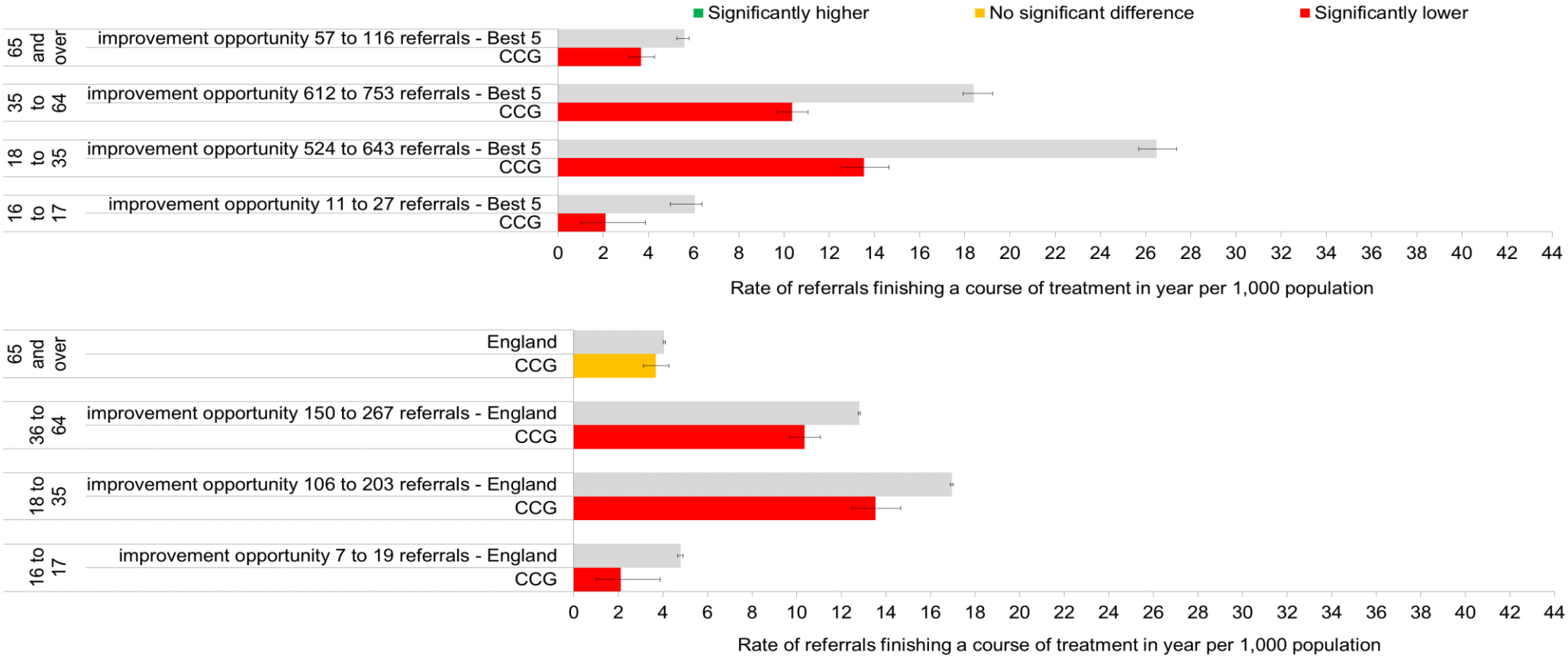
Sources: Psychological Therapies: Annual report on the use of IAPT services, NHS Digital (2018).
Note: Data points with values less than 5 have been suppressed, therefore, for these points, bars are not shown on the chart.

See page 63 for table by sex.

Your CCG benchmarked by age with the Best 5 of your Similar 10 CCGs and England

The top chart compares the rate of referrals finishing a course of treatment in 2016/17 for your CCG with the best 5 of your Similar 10 average rate by age. The bottom chart compares the CCG rate with the England rate.

The grey bars represent the benchmark rate whilst non-grey bars represent the CCG rate. Red bars indicate that your CCG is significantly lower than the benchmark. Amber bars indicate that there is no significant difference between your CCG and the benchmark. Green bars indicate that your CCG is significantly higher than the benchmark. Error bars use a 95% confidence level to show uncertainty. Numbers to the left of the red bars represent the number of referrals that could be made if the CCG rate moved to the benchmark rate. A range is given to reflect uncertainty.



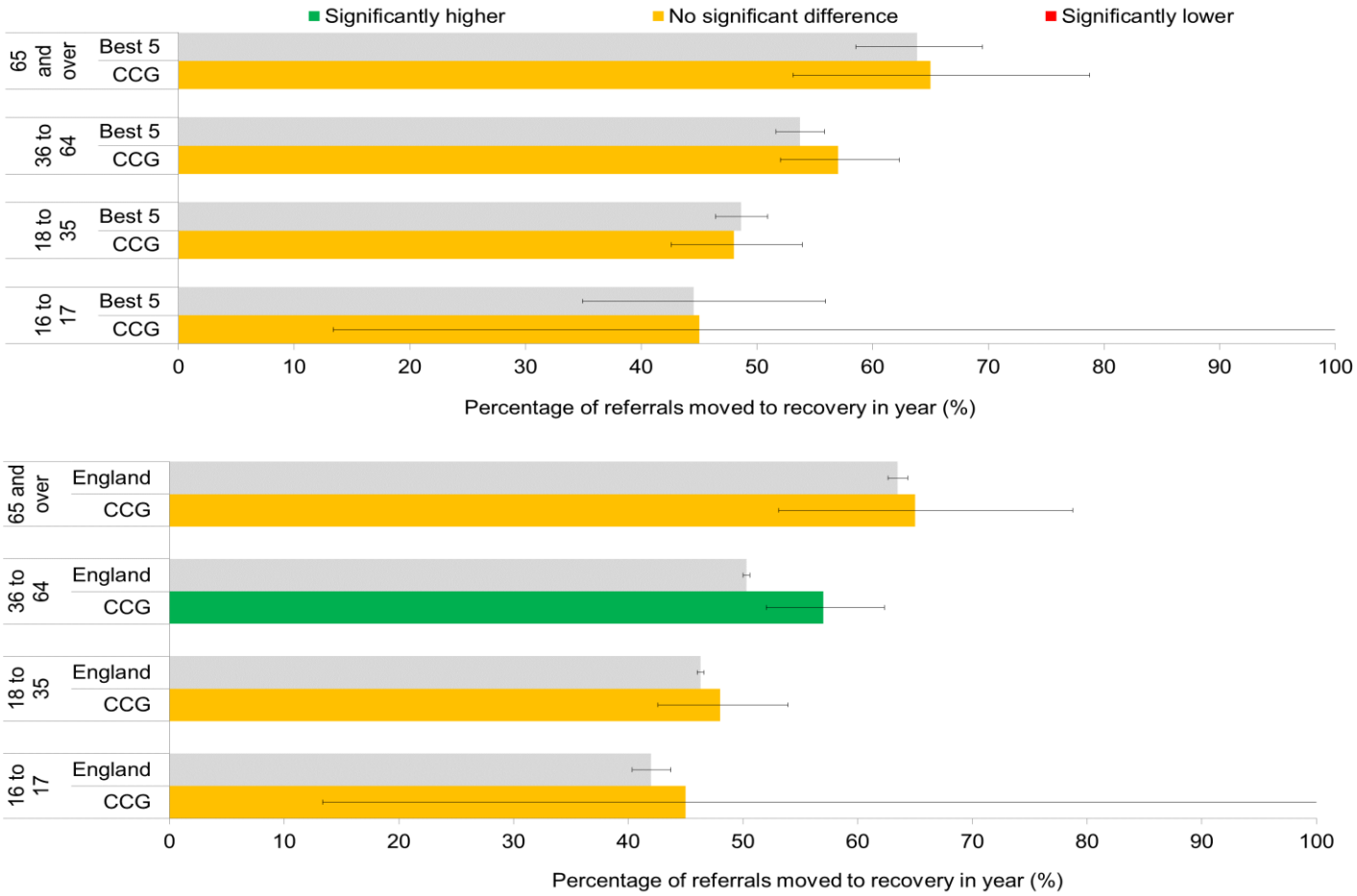
Sources: Psychological Therapies: Annual report on the use of IAPT services, NHS Digital (2018).
Note: Data points with values less than 5 have been suppressed, therefore, for these points, bars are not shown on the chart.

See page 64 for table by age

Your CCG benchmarked by age with the Best 5 of your Similar 10 CCGs and England

The top chart compares the rate of referrals moving to recovery in 2016/17 for your CCG with the best 5 of your Similar 10 average rate by age. The bottom chart compares your CCG rate with the England rate.

The grey bars represent the benchmark rate whilst non-grey bars represent your CCG rate. Red bars indicate that your CCG is significantly lower than the benchmark. Amber bars indicate that there is no significant difference between your CCG and the benchmark. Green bars indicate that your CCG is significantly higher than the benchmark. Error bars use a 95% confidence level to show uncertainty. Numbers to the left of the red bars represent the number of recoveries that could be made if the CCG rate moved to the benchmark rate. A range is given to reflect uncertainty.



Sources: Psychological Therapies: Annual report on the use of IAPT services, NHS Digital (2016)
Note: Data points with values less than 5 have been suppressed, therefore for these points, bars are not shown on the chart.

See page 64 for table by age

Data limitations for constructing rates for ethnic groups for your CCG

The next two slides benchmark IAPT rates of referrals finishing a course of treatment and moving to recovery by ethnic group for your CCG. This requires the ethnic group of the patient for each referral to be recorded. For some referrals the ethnicity of the patient is recorded as unknown.

For your CCG, 12.6% of referrals finishing a course of treatment have an unknown ethnic group, compared to 6.8% for England and 4.2% for the best 5 of your Similar 10.

Furthermore for your CCG , 13.1% of referrals moving to recovery have missing ethnicity, compared with 6.3% for England and 3.2% for the best 5 of your Similar 10.

We do not know if referrals (or movements to recovery) where the ethnicity of the patient is unknown are split disproportionately across ethnic groups or if one ethnic group has a higher share of the referrals (or movements to recovery) of unknown ethnicity than another.

For each ethnic group, the more comparable the proportion of referrals (or movements to recovery) of unknown ethicity for your CCG and the proportion of referrals (or movements to recovery) of unknown ethnicity for its benchmark, the more comparable will be the referral (or movement to recovery) rates between your CCG and its benchmark.

A further limitation of referral rates by ethnic group is that they are constructed by dividing the number of unplanned referrals by the population for each group and the population of each ethnic group has been estimated. Population estimates by ethnic group are derived by applying 2011 Census ethnic group splits at a detailed level to 2016/17 CCG registered population numbers.

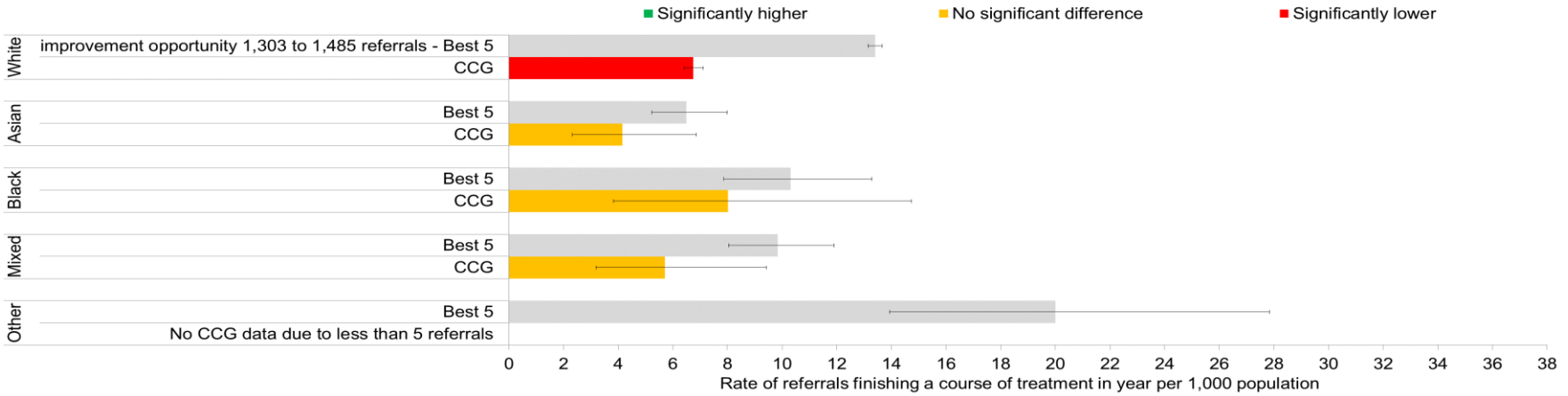
Further detail is provided in slide 66 of the Annex.

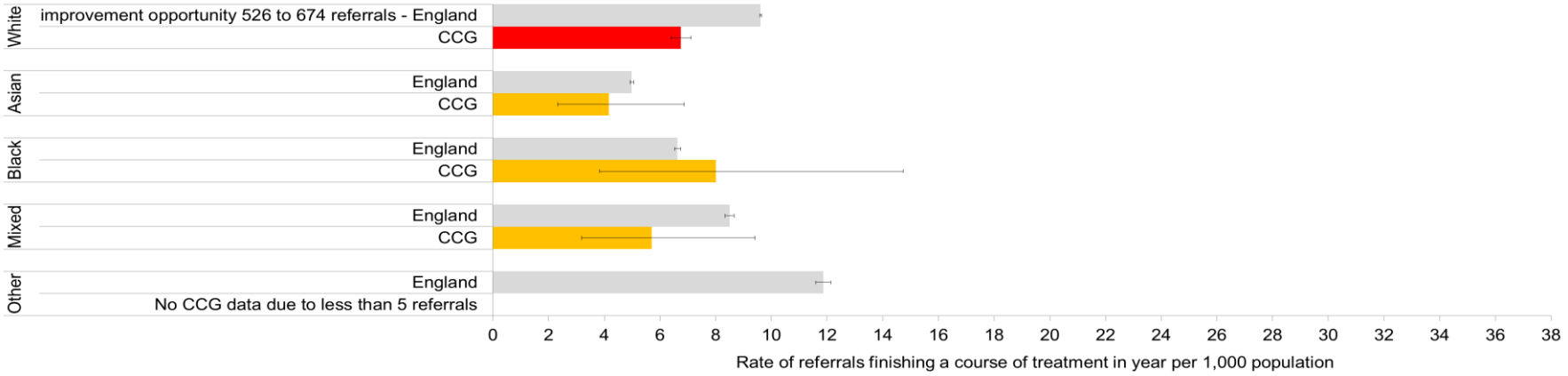
Note: * means missing data

Your CCG benchmarked by ethnicity with the Best 5 of your Similar 10 CCGs and England

The top chart compares the rate of referrals finishing a course of treatment in 2016/17 for your CCG with the best 5 of your Similar 10 average rate by ethnicity. The bottom chart compares your CCG rate with the England rate. It is important to note that rates have not been standardised for deprivation, sex or age, so the CCG will be more comparable with the best 5 of its Similar 10 than England.

The grey bars represent the benchmark rate whilst non-grey bars represent your CCG rate. Red bars indicate that your CCG is significantly lower than the benchmark. Amber bars indicate that there is no significant difference between your CCG and the benchmark. Green bars indicate that your CCG is significantly higher than the benchmark. Error bars use a 95% confidence level to show uncertainty. Numbers to the left of the red bars represent the number of referrals that could be made if the CCG rate moved to the benchmark rate. A range is given to reflect uncertainty.





Sources: Psychological Therapies: Annual report on the use of IAPT services, NHS Digital (2018).

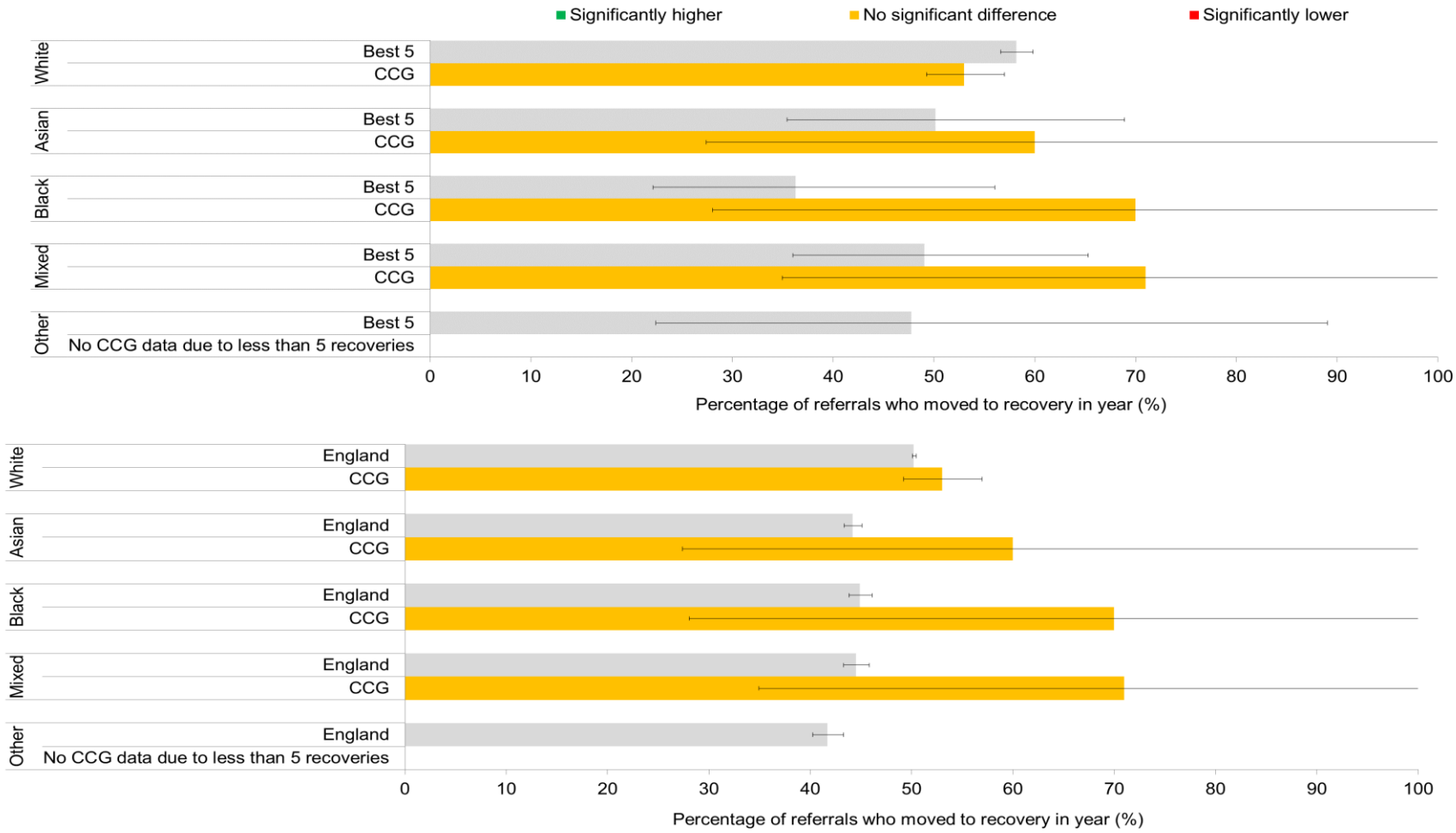
Notes:
Data points with values less than 5 have been suppressed, therefore for these points, bars are not shown on the chart.
A large rate for "Other" may reflect incorrect use of this category where ethnicity is unknown or unrecorded. This may result in con fidence intervals beyond the range shown on the chart.

See page 67 for table by ethnicity.

Your CCG benchmarked by ethnicity with the Best 5 of your Similar 10 CCGs and England

The top chart compares the rate of referrals moving to recovery in 2016/17 for your CCG with the best 5 of your Similar 10 average rate by ethnicity. The bottom chart compares your CCG rate with the England rate. It is important to note that rates have not been standardised for deprivation, sex or age, so the CCG will be more comparable with the best 5 of its Similar 10 than England.

The grey bars represent the benchmark rate whilst non-grey bars represent your CCG rate. Red bars indicate that your CCG is significantly lower than the benchmark. Amber bars indicate that there is no significant difference between your CCG and the benchmark. Green bars indicate that your CCG is significantly higher than the benchmark. Error bars use a 95% confidence level to show uncertainty. Numbers to the left of the red bars represent the number of recoveries that could be made if the CCG rate moved to the benchmark rate. A range is given to reflect uncertainty.



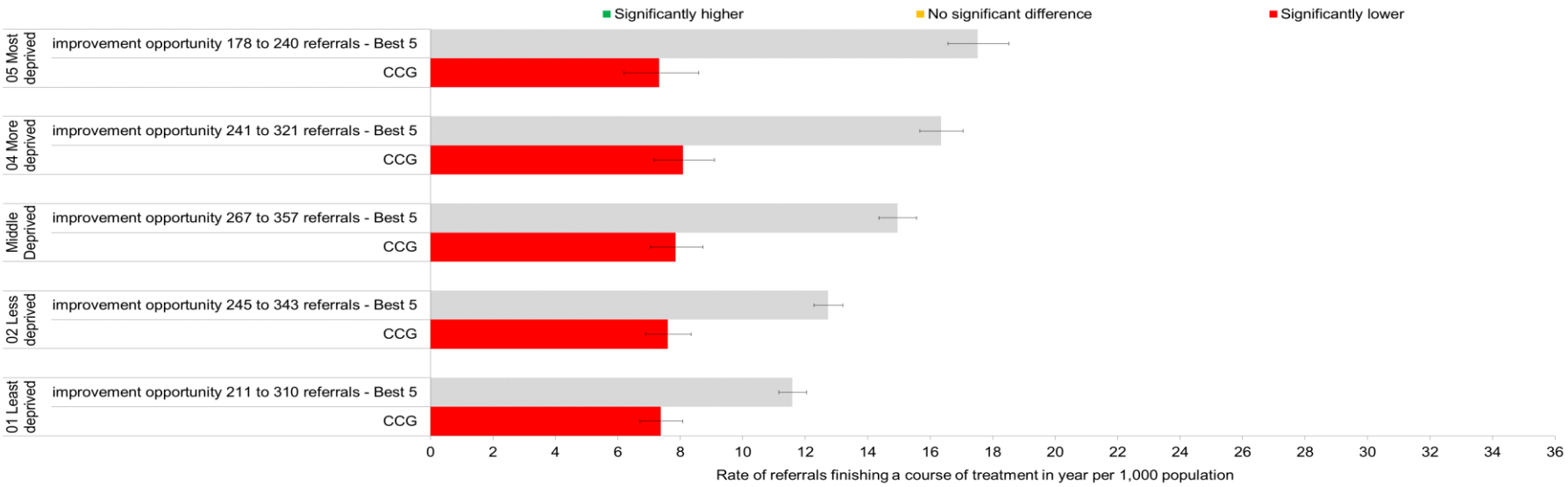
Sources: Psychological Therapies: Annual report on the use of IAPT services, NHS Digital (2018).
Note: Data points with values less than 5 have been suppressed, therefore for these points, bars are not shown on the chart. Where a benchmark is not shown, data are unavailable.

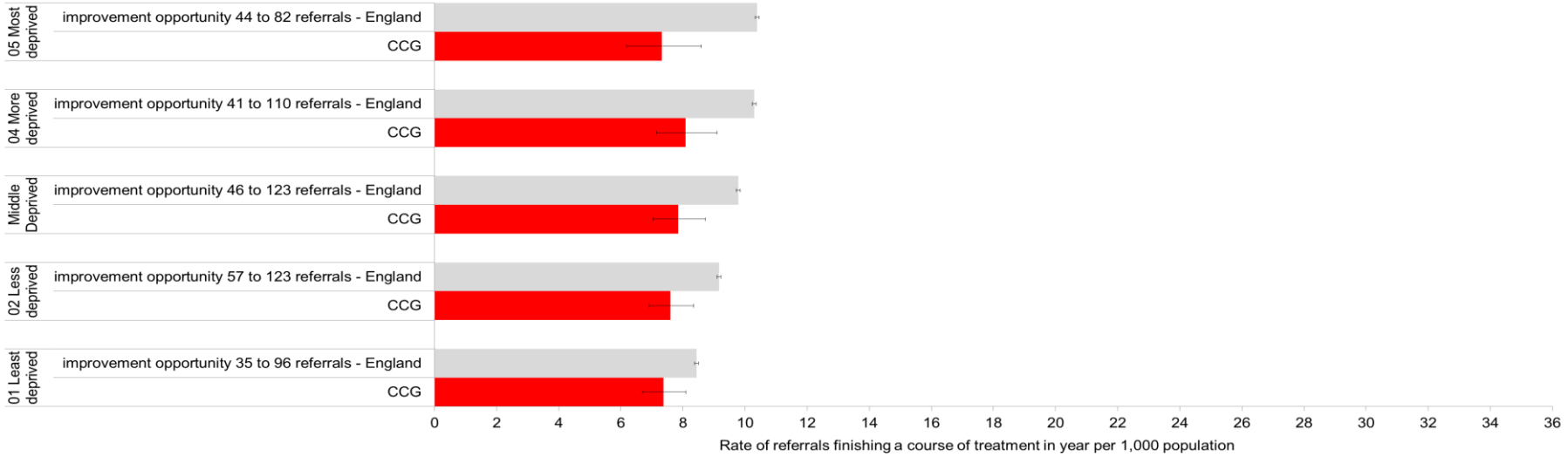
See page 67 for table by ethnicity

Your CCG benchmarked by deprivation with the Best 5 of your Similar 10 CCGs and England

The top chart compares the rate of referrals finishing a course of treatment in 2016/17 for the CCG with the best 5 of your Similar 10 average rate by deprivation. The bottom chart compares your CCG rate with the England rate.

The grey bars represent the benchmark rate whilst non-grey bars represent the CCG rate. Red bars indicate that your CCG is significantly lower than the benchmark. Amber bars indicate that there is no significant difference between your CCG and the benchmark. Green bars indicate that your CCG is performing higher than the benchmark. Error bars use a 95% confidence level to show uncertainty. Numbers to the left of the red bars represent the number of referrals that could be made if the CCG rate moved to the benchmark rate. A range is given to reflect uncertainty.





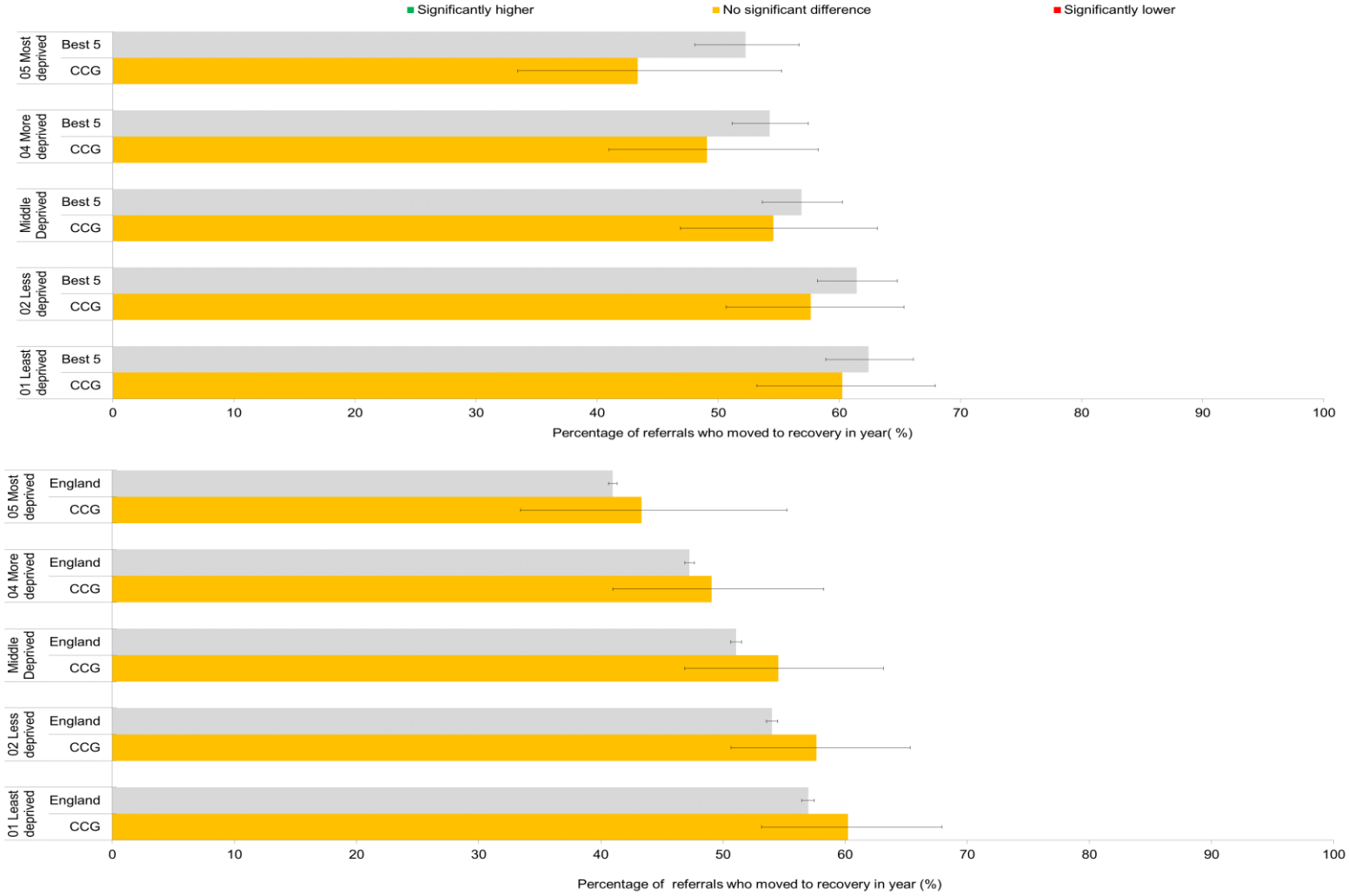
Sources: Psychological Therapies: Annual report on the use of IAPT services, NHS Digital (2018).
Note: Data points with values less than 5 have been suppressed, therefore for these points, bars are not shown on the chart.

See page 68 for table by deprivation.

Your CCG benchmarked by deprivation with the Best 5 of your Similar 10 CCGs and England

The top chart compares the rate of referrals moving to recovery in 2016/17 for your CCG with the best 5 of your Similar 10 average rate by deprivation. The bottom chart compares your CCG rate with the England rate.

The grey bars represent the benchmark rate whilst non-grey bars represent your CCG rate. Red bars indicate that your CCG is significantly lower than the benchmark. Amber bars indicate that there is no significant difference between your CCG and the benchmark. Green bars indicate that your CCG is significantly higher than the benchmark. Error bars use a 95% confidence level to show uncertainty. Numbers to the left of the red bars represent the number of recoveries that could be made if the CCG rate moved to the benchmark rate. A range is given to reflect uncertainty.



Sources: Psychological Therapies: Annual report on the use of IAPT services, NHS Digital (2018).
Note: Data points with values less than 5 have been suppressed, therefore for these points, bars are not shown on the chart.

See page 68 for table by deprivation.

Promoting Equality and Reducing Health Inequalities, from Data Analysis and Case Studies to Action Planning

This section contains good practice examples of interventions used to promote equality and reduce health inequalities and some key links to further resources. It also contains slides suggesting how the data analysis and case studies contained in these packs might be used to support action planning.

New Care Model Case Study

Community Outpatient Services (Sandwell and West Birmingham CCG)

This is an intervention in the Connected Care Partnership New Care Models vanguard in Sandwell and West Birmingham CCG for which evaluation evidence has been provided by the University of Birmingham.

The aim of this intervention is to deliver specialist outpatient services within a primary care context to improve access, reduce hospital waiting times and deliver more efficient outpatient care using one-stop clinics where patients receive their consultation and investigations during a single appointment. The range of specialist services has increased and these now include cardiology, dermatology, rheumatology, Ear, Nose and Throat (ENT), gynaecology, urology, x-ray, respiratory, pain management and anti-coagulation. Some of these services are being delivered via telemedicine as an alternative to face-to-face consultations.

Key Impacts

Compared with more usual hospital care there is evidence of improved patient experience (87% of patients were likely to recommend the services to friends and family), improved clinical quality, lower onward referral rates and shorter waiting times. Outpatient services were audited by consultants who looked at the service received by 10 patients per speciality. All services were rated 'good' or 'excellent'.

Example Services

- Cardiology service: Patients recognised an improvement in skill and competence of staff in primary care. This has meant fewer patient referrals to acute services for minor issues. The service is seeing an increased number of patients referred from local practices and Sandwell & West Birmingham Hospitals NHS Trust. GP training to increase their confidence to manage patients with no need for referral has been positively received. Some patients have received earlier interventions than they might otherwise have received and this has led to improved clinical outcomes.
- Urology service: The service started in July 2017. For urology in 2017/18, patients using community outpatient services show lower rates of new referrals per 1,000 patients compared with Sandwell and West Birmingham average. They also appear to have lower costs per 1,000 patients.

Inference

Compared with the treatment in a hospital, the shorter waiting times and improved quality community based care should result in fewer unplanned hospitalisations for patients using the services due to earlier intervention within the community.

For more information on outpatient services in Sandwell and West Birmingham, please contact:

Sapna Shannon

Mobile: 07976 683 446
Email: sapna.shannon@nhs.net
Address: Orsborn House, 55 Terrace Road, Birmingham, B19 1BP
Website: www.modalitypartnership.nhs.uk

New Care Model Case Study

Healthy Lives (Sandwell and West Birmingham CCG)

This is an intervention in the Connected Care Partnership New Care Models Vanguard in Sandwell and West Birmingham CCG. The aim of this intervention is to offer an extended appointment with a GP for motivational coaching to identify person centred goals for lifestyle changes such as weight loss and increased physical activity. The GP also completes a review to identify any medicines that no longer need to be taken.

Key impacts

The early analysis (6-9 months post programme) for participating patients showed a noticeable downward trend in A&E activity post intervention. Similarly, for participating patients, re-active GP and Advanced Nurse Practitioner appointments fell noticeably. All of the 32 patients who filled out pre and post evaluation questionnaires indicated an improvement in mobility, depression and pain management. The patients who filled out the programme satisfaction questionnaire would all recommend the service to others.

Example patient case studies

- Denise is 65, she lives alone and has had a very difficult past that included domestic abuse, bereavement, alcoholism and depression. Two years ago she developed poor mobility after suffering lower back pain. She has spinal stenosis, obesity, type 2 diabetes, asthma, hypertension, ischaemic heart disease, osteoarthritis and gout. She has a high level of primary care consultations. During her healthy lives appointment she was provided with advice and education about her health problems and how they affect her. Her plan of action was agreed and Denise felt extremely motivated to change her daily routine, starting with gentle movement and social interaction. She felt empowered and felt that her viewpoint was respected. A follow up telephone consultation suggested this change is likely to be sustainable.
- Jaswinder is 62, lives with his extended family and runs his own business. He had poorly controlled type 2 diabetes, obesity, and hypertension. He had frequent GP visits to manage his condition. He had a poor understanding of the benefit of improving weight, diabetes and hypertension to prevent future illness. As part of the healthy lives initiative, he was provided with a detailed explanation of his condition and a plan for making changes to his daily lifestyle to improve his health. A few weeks later, during his regular blood sugar check-up, his results showed an improvement in his diabetes control. He continues to attend the support group to sustain a healthy lifestyle.

For more information on healthy lives services please contact:

Dr. Mohanpal Singh Chandan
Email: m.chandan@nhs.net
Address: Orsborn House, 55 Terrace Road, Birmingham, B19 1BP
Website: www.modalitypartnership.nhs.uk

Doc Abode - Workforce Software to Improve Urgent and Primary Care Access, Resilience & Scale

The software was developed by Dr Taz Aldawoud, a GP with years of senior NHS management experience.
Doc Abode supports NHS healthcare providers to deliver more responsive, cost-effective care by safely connecting and matching a multi-disciplinary clinical workforce to NHS patient needs, in real-time, based on:

AVAILABILITY

PROXIMITY

EXPERTISE

Doc Abode

Why Doc Abode?

- Widens the network of a flexible workforce, improving operational resilience and efficiency
- Reduces risk and minimises unscheduled hospital attendances by matching clinical need to readily available expertise
- Takes into consideration the patient's first language when identifying the best possible match with available clinicians
- Platform enables healthcare providers to connect clinicians solely to NHS patients

Doc Abode has been trialled in Leeds and Huddersfield in 2017, with independent evaluation demonstrating a highly significant improvement in waiting times, releasing capacity in the system (email the address below to request the evaluation report).

Supported by

SBRI HEALTHCARE

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ACADEMIC HEALTH SCIENCE NETWORK

dhez
DIGITAL HEALTH ENTERPRISE ZONE

You can watch more about how Doc Abode works and testimonials on YouTube or via their website

How it works https://youtu.be/X91Rncxwcxs
Testimonials https://youtu.be/V4NsdPzz_ik

To find out more about Doc Abode and its vision to support the NHS through the use of innovations in digital health, visit www.docabode.com

Email:
info@docabode.com

Case Studies: Reducing Hospital Admissions

Self Management (Flo Telehealth)
Self-management is particularly useful for long-term conditions such as asthma and COPD. Self-management enables patients to understand how they are affected by their condition, and how they can cope with symptoms. Studies have found that the use of telehealth for COPD self-management has reduced visits to accident & emergency.

Flo telehealth is an interactive texting service for patients that gives prompts and advice to patients for managing their own health. It also collects patient readings. It is currently used by over 70 health and social care organisations. Flo increases levels of compliance through education and instilling good habits in patients.

Link to Self Management Case Study

Social Prescribing (Rotherham CCG)
Social prescribing encompasses various non-medical interventions including self-help groups, adult learning, gym-based activities and therapy.

Social prescribing is particularly useful for those with long-term conditions, which are more common for those living in deprived areas.

Rotherham CCG's use of social prescribing reduced demand for urgent hospital care with effective collaboration from voluntary and community organisations. Additionally the average number of A&E attendances reduced by 17%.

Link to Social Prescribing Case Study

Falls Specialist Response Car (Queen's Hospital North East London)
A Falls Specialist Response Car (call sign K466), provided by the London Ambulance Service (LAS), is staffed with a Community Treatment Team (CTT) nurse and a paramedic. LAS Control Centre identify the patient on a referral criteria, such as elderliness, and the service operates seven days a week between the hours of 07:00 and 19:00.

For this service, 66.5% of patients seen were treated within their own home, reducing unnecessary conveyances and emergency admissions for frail elderly fallers.

Link to Response Car Case Study

GP Led Triage and Redirection (Care UK and St Georges Hospital)

GPs and nurses based in triage identify ***patients who could be managed more effectively by being redirected to primary care*** when they enter the Emergency Department. The Redirection Team includes an administrator who ensures an appointment is booked the same day.

Of the patients identified as being able to be managed more effectively, 56% were redirected to their usual GPs, 32% to out of hours services and 10% to walk-in centres. The proportion of patients who were satisfied with the redirection service was 83%.

Link to Triage and Redirection Case Study

Case Studies: Reducing Hospital Admissions

Rapid Access Doctor (Sutton CCG)
The out of hours provider was commissioned to provide a GP with a driver in a non London Ambulance Service (LAS) vehicle. They responded to Green (C3-C4) category triaged calls from 999 and were dispatched from the LAS clinical decision making hub.

This operated every Friday, Saturday, Sunday and bank holidays between December 2014 and February 2015 from 15:00-00:00.

The objective was to assess, diagnose, prescribe and treat in the home and to improve patient access to appropriate support services within the community.

For patients using the service, 75% were treated in the home increasing capacity with the LAS, reducing non elective attendances and admissions at the acute trust.

Link to Rapid Access Doctor Case Study

Dedicated Community Nurse (Kingston CCG)
London Ambulance Service (LAS) and Your Healthcare Care Community Interest Company worked in partnership with Kingston CCG. The service worked with an LAS rapid dispatch car manned by a LAS Paramedic and Rapid Response Nurse.

The Nurse and Paramedic were able to treat those with complex needs at home and arrange medication and emergency equipment. They were also able to access community care services without delay, providing additional support at home which included community nursing, physiotherapy, occupational therapy, rehabilitation, the falls service and home care support.

The proportion of non conveyance rates with the LAS alone raised from 23.6% to 68.9% with the addition of a nurse practitioner.

Link to Community Nurse Case Study

Non-clinical Navigators (City and Hackney CCG)
City and Hackney CCG have especially high rates of A&E attendance.

At the time of the study too many primary care patients were attending A&E. To address this, 4 non-clinical patient navigators educated patients about sources of healthcare, encouraged GP registration and worked with frequent attenders to identify recurrent problems and signpost to other services.

This led to more joined up services with some patients being redirected to their GP and others being encouraged to care for themselves either at home or in the community. A significant proportion of patients registered with a GP for the first time.

Link to Non-clinical Navigators Case Study

Rapid Response Service (Camden)
The service offers short-term intensive care, including nursing and therapeutic assessments, referrals to other services and up to 10 days social care. It is provided at the patients' home, at a nursing home or in a care home.

The service is provided for adults living in Camden, registered with a Camden GP who require immediate intervention to prevent a possible hospital admission.

During the time of the case study, this led to a noticeable reduction in admissions, in particular form nursing homes and care homes.

Link to Rapid Response Service Case Study

Disruptive Prevention (West Wakefield)
Thousands of deaths could be avoided through changes to lifestyle, early diagnosis and better treatment.

West Wakefield believe that demands on primary care could be reduced through tackling avoidable illness.

They are targeting primary schools and trying to get new models of care for 9 or 10 years olds, to grow a healthy generation.

GPs' roles are also changing so that they can be released to do more in the community. Clinical leaders go out into the field and observe their communities first-hand so that they can make pragmatic solutions about where best to target resources.

Link to Disruptive Prevention Case Study

Improving Working Practices (Tower Hamlets)
Tower Hamlets Together vanguard introduced an Enabling Quality Improvement in Primary Care (EQUIP) programme to build a stronger workforce capable of delivering change. The initiative is designed to improve working practices, systems and structures.

In some cases, demand on GPs' call back lists reduced by 15% despite growth in list size of 5.2%.

They have reduced document workflow to GPs by 61% and have noticeably increased GP appointment capacity. They have also increased patient online use (by 38%) and reduced pressures on practice staff. This has potential to reduce spend on locums.

Link to Improving Working Practices Case Study

Tool for Reducing Inequalities in Access to GP Services
The resource pictured to the right is designed to help commissioners and providers of GP services understand whether any groups in their local community are experiencing barriers and address them.

Link to Tool for Reducing Inequalities in Access to GP Services

Case Studies: Cancer

Prostate Cancer Diagnosis (UCLH Cancer Collaborative)
UCLH Cancer Collaborative is helping to reduce waiting times by implementing a prostate cancer one stop clinic limiting the number of visits per patient from 5 to 2, and reducing the time to diagnosis from 6 weeks down to 1.

MRI scans identify fast-growing prostate cancers that need treatment which could potentially avoid biopsy. Those whose scans indicate cancer, go on to have a targeted biopsy virtually eliminating the risk of sepsis or infection. It doesn't cost any more and is better for patients.

One specific aim is to help the diagnosis of prostate cancer in black men in the UK as 1 in 4 develop prostate cancer in their lifetime which is double the lifetime risk for all men.

Link to Prostate Cancer Diagnosis Case Study

Catching More Cancers Early (Manchester)
Mobile scanners are detecting 4 out of 5 cases of lung cancer in the early stages. This is equivalent to 1 cancer detected for every 33 patients scanned over the course of a year. NHS England committed to expanding cancer screening to more than 4 million people in 2018.

A lung cancer pilot, offering smokers and ex-smokers free health checks and on-the-spot scans, has proved successful and quadrupled the early diagnosis rates for lung cancer in Manchester.

A more sensitive bowel cancer test could see as many as 1,500 more cancers in Manchester caught earlier every year.
A pilot programme that uses MRI scans is reducing average prostate cancer diagnosis time to just eight days and referral-to-treatment time to 20 days.

Link to Catching More Cancers Early Case Study

Access to Cancer Screening (Kingston)
The idea is to increase participation in cancer screening across those who do not respond to a traditional screening intervention or are not registered with a GP.

This initiative aims to promote equality of access to cancer screening across Kingston by employing a Community Department Worker (CDW). The role of the CDW is to raise awareness, encourage participation and work with GPs to capture trends in cancer screening engagement.

This pilot runs for a year (from January 2018) and will capture GP registrations, awareness session attendances and cancer screening appointments to evaluate its success.

Link to Access to Cancer Screening Case Study

Learning Disability Network Cancer Screening (North East and Cumbria)
The purpose of this initiative is to increase screening access for those with learning disabilities.

Research indicates those with learning disabilities have poorer general health. The purpose of this initiative is to increase bowel cancer screening accessibility and improve support to make informed screening decisions.

Learning disability staff also receive training in good bowel health and screening to enable them to encourage healthy habits, explain bowel screening and explain why it is important.

Link to Learning Disability Network Case Study

Case Studies: Mental Health

Health and Justice – Liaison and Diversion services
This case study is about functional development for police custody and the courts to recognise mental health problems and provide mental health assessments, advice and treatment.

The study recommends providers of criminal justice services and healthcare services should consider diverting people from standard courts to dedicated drug courts if the offence is linked to substance misuse and was non-violent.

It further recommends services should consider joint working arrangements between healthcare, social care and police services for managing mental health presentations. Three examples are:
1. Joint training for police, healthcare and social care staff;
2. Protocol for communication and joint working;
3. Agreed referral pathways for urgent and emergency care and routine care.

Link to Health and Justice – Liaison and Diversion services Case Study

Street Triage Scheme (Nottinghamshire Healthcare NHS Foundation Trust)
In this case study, the hospital trust uses 2 cars with 2 trained police officers and 2 community psychiatric nurses. These are available from 16:00 until 1:00. The team give advice to officers over the phone and support people with a mental health problem who have been in contact with the police by responding to them in person.

This scheme is intended to reduce the likelihood of patients being taken to a police cell (under section 136 of the Mental Health Act).

The scheme in Nottinghamshire is commissioned by 7 CCGs and offers a range of services. It has more than halved the annual rate of police custody for people in a mental health crisis.

Link to Street Triage Scheme Case Study

CBT in GP Surgeries (Islington)
This iCope scheme provides high quality CBT and other psychological approaches to treat anxiety and depression in GP surgeries.

The scheme increases capacity through specialists for step 2 and 3 of CBT treatment working alongside GPs.

Specialists who have completed their training are also given treatment in the form of an hour long recovery consultation to help prevent them suffering from mental health problems.

Referral rates quadrupled between 2011 and 2015 and recovery rates increased from 40.9% to 51% between September 2015 and September 2016 (exceeding the national target).

Link to CBT in GP Surgeries Case Study

IAPT for Older People (Yorkshire)
The service in Yorkshire was aware of decreasing referral rates for those aged 65+ in IAPT. Managers were also aware that national data showed older adults complete treatment with a better recovery rate than other age cohorts.

The older people's project started in June 2017. There have been a number of observable changes in the service such as increased confidence in Psychological Wellbeing Practitioner (PWP) clinicians working with older people and increased awareness of the importance of IAPT accessibility.

Link to IAPT for Older People Case Study

Case Studies: Mental Health

Community Perinatal Team (CPT) (Hertfordshire)
The scheme is joined up with regular antenatal clinics and outpatient clinics run in Hertfordshire. It offers individual assessments and medication in pregnancy, psychological therapies and support from nurses.

Most women with severe mental health illness during pregnancy/postnatally are struggling with depression or anxiety conditions. Two thirds of those referred were experiencing perinatal mental health problems for the first time, but around 74% had a history of other mental health problems.

While some women were signposted to other services, 72% of those identified as needing support from the CPT had their face to face assessment within six weeks, with emergency referrals usually being managed on the same day.

Link to Community Perinatal Team Case Study

Hear Our Voice (Cornwall) - Self-care for Young People
This initiative works with young people and provides training to teachers and parents.

Group programmes are based on the needs of the group and includes opportunities to build resilience, develop positive coping and self-care strategies and learn about mental health using 1 to 1 support.

The training aims to build understanding, confidence and skills among the workforce in schools, colleges and community groups.

Reports state 87% of young people improved their wellbeing, 75% improved their mental health and relationships and 70% gain a boost in confidence.

Link to Hear Our Voice Case Study

Mother and Baby Unit (MBU) (South West)
NHS England is investing £365 million in specialist perinatal mental health services as part of a five-year programme. This is aimed at increasing access to expert treatment and support for an extra 30,000 women each year. It does this by both increasing capacity and reducing travel times.

Devon has a well-established perinatal mental health team which works with health and social care professionals to identify women at risk of perinatal mental ill health. Specialist care and support is provided for them and their families.

As well as repurposing buildings, Devon Partnership NHS Trust received funding to build a brand new MBU, which is due to open in 2019 preventing people from having to travel further for such services.

Link to Mother and Baby Unit Case Study

Motiv8 (Havant) - Improving Confidence in Young People
This initiative gives support via individual 1 to 1s and small groups to young people who experience a range of emotional and behavioural issues including low confidence and self-esteem, raised anxiety and difficulty in relationships.

The main aims of the project are to create a positive outlook on life and set goals for the future.

Under this initiative, 80% of young people participating displayed an increase in confidence and self-esteem. All who gave feedback described themselves as having improved their emotional health and wellbeing.

Link to Motiv8 Case Study

Resources for Reducing Health Inequalities

Useful Public Health England (PHE) links:

The PHE Health Equity Collections page (first link below) brings together in one place evidence reviews, tools and guidance to help support national, regional and local areas to reduce health inequalities:

http://80.82.119.182/healthequitydashboard/

https://www.gov.uk/government/publications/health-profile-for-england-2018

Health Profile Blog with a summary of some of the key findings

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/641625/Reducing_health_inequalities_system_scale_and_sustainability.pdf

https://www.gov.uk/guidance/phe-data-and-analysis-tools

https://fingertips.phe.org.uk/

Other useful links to refer to:

Explore NHS Health Check Data

NHS RightCare
- Intelligence resources
- Intelligence tools and support

NHS England
- The Equality and Health Inequalities Hub

Equality and Health Inequalities Legal Duties

CCG Improvement and Assessment Framework (CCG IAF) Data

CCG IAF technical annex

York University Centre for Health Economics

UCL Institute of Health Equity

Institute of Health Equity New Care Models Report 2018

Unplanned Hospitalisations for Chronic Ambulatory Care Sensitive Conditions and Urgent Care Sensitive Conditions

Selecting case studies for areas of improvement - illustrative example from an undisclosed CCG

	Observations from data pack	Case Studies Selected		
		Emergency Care	Primary Care	Cancer
Inequality as measured by the Absolute Gradient of Inequality (AGI). Trend and benchmarked size	The AGI is in the upper quintile compared with other CCGs in England. When put alongside its Similar 10 CCGs, it has a relatively high AGI and ranks 8th out of 11. The trend shows improvement over time, but this is not statistically significant.	UH - 1 UH - 2 UH - 6	Digital 1 Primary Care - 1 Primary Care - 2 Primary Care - 3	Cancer - 1 Cancer - 3
Priority Wards	It has 17 Priority Wards with a total of 1,000 unplanned hospitalisations associated with health inequalities that might be saved.	UH - 1 UH - 2 UH - 6	Primary Care - 1 Primary Care - 2 Primary Care - 3	Cancer - 1 Cancer - 3
Top 10 Conditions for this CCG	Pain in throat and chest, abdominal and pelvic pain, other chronic pulmonary conditions, cellulitis, asthma, heart failure, atrial fibrillation, fracture of femur, angina pectoris among others.	UH - 1 UH - 2 UH - 6	Primary Care - 1 Primary Care - 2 Primary Care - 3	Cancer - 1 Cancer - 3
Groups with high rates compared with their Best 5 of Similar 10	The rate of unplanned hospitalisations is high for all protected characteristics shown in the pack. It is especially high for the older age groups and for Asian Pakistanis and Black Africans.	UH - 3	Primary Care - 1 Primary Care - 2 Primary Care - 3	Cancer - 1 Cancer - 3

List of case studies in this pack to choose from for the above table

Code to put in table above	Case Study
	New Care Models
NCM - 1	Community Outpatient Services (Sandwell and West Birmingham CCG)
NCM - 2	Healthy Lives (Sandwell and West Birmingham CCG)
	Digital
Digital - 1	Doc Abode - workforce software to improve Urgent and Primary Care Access, Resilience & Scale
	Emergency Care
UH - 1	Self Management (Flo Telehealth)
UH - 2	Social Prescribing (Rotherham CCG)
UH - 3	Falls Specialist Response Car (Queen's Hospital North East London)
UH - 4	GP Led Triage and Redirection (Care UK and St Georges Hospital)
UH - 5	Rapid Access Doctor (Sutton CCG)
UH - 6	Dedicated Community Nurse (Kingston CCG)
UH - 7	Non-clinical Navigators (City and Hackney CCG)
UH - 8	Rapid Response Service (Camden)
	Primary Care
Primary Care - 1	Disruptive Prevention (West Wakefield)
Primary Care - 2	Improving Working Practices (Tower Hamlets)
Primary Care - 3	Tool for Reducing Inequalities in Access to GP Services
	Cancer
Cancer - 1	Prostate Cancer Diagnosis (UCLH Cancer Collaborative)
Cancer - 2	Catching More Cancers Early (Manchester)
Cancer - 3	Access to Cancer Screening (Kingston)
Cancer - 4	Learning Disability Network (North East and Cumbria)

The ***Observations from the data pack*** section on this slide is based upon the analysis of ***Unplanned Hospitalisations for Ambulatory Care Sensitive and Urgent Care Sensitive Conditions*** contained in this pack.

The Emergency Care case studies listed to the left typically refer to interventions which are intended to save Emergency Admissions.

The term ***Unplanned Hospitalisations*** is often used interchangeably with the term ***Emergency Admissions***.

Selecting case studies for areas of improvement - illustrative example from an undisclosed CCG

	Observations from data pack	Case Studies Selected
Groups with low Rates of IAPT Referrals Finishing a Course of Treatment for CCG relative to Best 5 of Similar 10 CCGs	Compared with the best 5 of Similar 10, the CCG has relatively lower rates of referral for many groups. There are low rates across main IAPT age bands (<18 exception) especially 18-35 year olds. Also low rates among the white population and the most deprived quintile.	IAPT - 3 IAPT - 4
Groups with low Rates of IAPT Movements to Recovery for CCG relative to Best 5 of Similar 10 CCGs	Rates are comparable with the best 5 of Similar 10 across nearly all groups.	IAPT - 3 IAPT - 8

List of case studies in this pack to choose from for the above table

Code to put in table above	Case Study
	Psychological Therapies
IAPT - 1	Health and Justice – Liaison and Diversion Services
IAPT - 2	Street Triage Scheme (Nottinghamshire Healthcare NHS Foundation Trust)
IAPT - 3	CBT in GP Surgeries (Islington)
IAPT - 4	IAPT for Older People (Yorkshire)
IAPT - 5	Community Perinatal Team (CPT) (Hertfordshire)
IAPT - 6	Hear Our Voice (Cornwall) - Self-care for Young People
IAPT - 7	Mother and Baby Unit (MBU) (South West)
IAPT - 8	Motiv8 (Havant) - Improving Confidence in Young People

Illustrative Action Planning (based upon plans from Sheffield and Birmingham Cross City)

The table below shows how case studies taken from earlier slides in this pack (coloured red) might be used to support action planning to promote equality and reduce health inequalities. Example case studies from this pack are shown in red bold italic underlined font below.

Objectives	Actions	Milestones/performance measures	Outcomes	Timescales	Responsibility
Increase access to interventions preventing and treating major inequality conditions, focusing on practices with the highest CVD premature mortality.	Strengthen the pathway between Primary Care and community interventions by development of Enhanced Prevention in Communities (EPiC). Develop the Regional Innovations Fund Diabetes project utilising health trainers and champions. Implement NHS Health Checks if included in the new NHS strategy starting in the most at risk communities. ***Community Outpatient Services in Sandwell and West Birmingham CCG*** ***Healthy Lives Community Outpatient Services in Sandwell and West Birmingham CCG*** Deliver a social marketing project in BME communities. ***Doc Abode - workforce software to improve Urgent and Primary Care Access, Resilience & Scale***	Provision of information to target practices about community health activities in the Healthier Community areas. Run an initial pilot and undertake procurement. Health checks programme in place with social marketing project initiated. Pilot to be evaluated and linked to CLAHC stroke.	Earlier access to treatment in primary care settings. Narrow the gap which currently exists where more deprived and ethnic communities have poorer health and a higher risk of strokes.	Ongoing in NHS Sheffield	NHS Sheffield and the Director of Public Health
Work with local partners to improve health outcomes and support the voices of vulnerable and disadvantaged groups and communities to be heard.	Develop inclusive engagement structures to reflect the diversity of the CCG and localities including 'seldom heard' communities such as Gypsy Roma Travellers. Work on preventing ill health with third sector providers. Review the Accessible Information Standard in removing barriers to accessing information and communication support to disabled people. Develop a set of recommendations according to this review. Conduct patient experience visits addressing issues for specific groups in terms of patient experience. ***Tool for Reducing Inequalities in Access to GP Services***	The equality profile of patient representation forums/structures within CCGs and localities will be monitored. Measure the number of targeted engagements with protected and 'seldom heard' groups.	Will allow establishment of a climate for improvement and trust in the designing and commissioning of health care. 'Seldom heard' groups will have more of a voice due to initiatives improving equality and diversity which is also integral for understanding diversity across the region.	2018 - 2021	NHS Birmingham and Solihull CCG and their Quality and Safety Committee

http://democracy.sheffield.gov.uk/Data/Cabinet/20110323/Agenda/17%20Health%20Inequalities%20Action%20Plan.pdf
https://www.birminghamandsolihullccg.nhs.uk/about-us/publications/strategic/44-equality-objectives-health-inequalities-strategy-2018-2021/file

Annex of Detailed Tables

This annex contains tables providing numbers underpinning the charts in the main pack.
It also provides further analysis showing age-sex intersectionality in tabular form and more detail on the limitations of ethnicity analyses.

Your CCG benchmarked by sex and age with the Best 5 of your Similar 10 CCGs and England

The table below compares rates of unplanned hospitalisations for your CCG with the average of the best (lowest) 5 of its Similar 10 and the rate for England for various sex-age groups. It is anticipated that different sex-age groups within your CCG will have different rates because they reflect different life stages. However, for the same age sex group, variation by geography may reflect scope for improvement. A red traffic light indicates your CCG has a statistically significantly higher rate than its geographic comparator. For red traffic lights, the number of hospitalisations which could be saved if your CCG moved to the same rate as its geographic comparator are shown. A range is given to reflect statistical uncertainty.

Sex or Age	CCG		Rate per 1,000 population*			Rate comparisons				Opportunity for saved hospitalisations	
	Population	Hospitalisations	CCG	Best 5 of Similar 10	England	CCG & Similar 10	% Difference	CCG & England	% Difference	Best 5 of Similar 10	England
Male	107,863	2,919	28	19	23	R	+33%	R	+17%	862 to 1,087	393 to 602
Female	109,581	3,754	35	23	29	R	+35%	R	+19%	1,176 to 1,430	587 to 823
00 to 04	11,302	145	13	13	13	A	+1%	A	+3%	.	.
05 to 14	24,067	180	8	7	8	A	+9%	A	-2%	.	.
15 to 34	49,499	771	17	11	12	R	+33%	R	+28%	196 to 309	161 to 266
35 to 54	59,704	1,049	20	13	16	R	+35%	R	+23%	301 to 427	179 to 297
55 to 64	27,902	650	27	18	24	R	+33%	R	+14%	167 to 266	45 to 137
65 to 74	25,636	1,058	47	28	37	R	+40%	R	+21%	363 to 491	162 to 282
75 to 79	8,400	698	92	63	82	R	+31%	R	+10%	162 to 268	20 to 119
80 to 84	5,769	809	149	95	125	R	+36%	R	+16%	235 to 350	77 to 185
85 plus	5,165	1,313	263	166	215	R	+37%	R	+18%	408 to 556	167 to 307

R CCG is significantly higher
A CCG is not significantly different
G CCG is significantly lower

Sources: Unplanned hospitalisations - SUS 2016/17, population data - CCG registered population for October 2016, NHS Digital (2017).

Notes:
Numbers less than 6 have been suppressed.
*Data has been standardised for deprivation using indirect standardisation. Deprivation has been measured using the Index of Multiple Deprivation for 2015. In addition age is standarised for sex and sex for age.

Your CCG benchmarked by sex and age combined with the Best 5 of your Similar 10 CCGs and England

The table below compares rates of unplanned hospitalisations for your CCG with the average of the best (lowest) 5 of its Similar 10 and the rate for England for various sex-age groups. It is anticipated that different sex-age groups within your CCG will have different rates because they reflect different life stages. However, for the same age-sex group, variation by geography may reflect scope for improvement. A red traffic light indicates your CCG has a statistically significantly higher rate than its geographic comparator. For red traffic lights, the number of hospitalisations which could be saved if your CCG moved to the same rate as its geographic comparator are shown. A range is given to reflect statistical uncertainty.

Age	Sex	CCG		Rate per 1,000 population*			Rate comparisons					Opportunity for saved hospitalisations	
		Population	Hospitalisations	CCG	Best 5 of Similar 10	England	CCG & Best 5 of Similar 10		% Difference	CCG & England		% Difference	Best 5 of Similar 10	England
00 to 04	Male	5,740	82	15	13	13	A		+9%	A		+11%	.	.
	Female	5,562	63	11	13	12	A		-10%	A		-7%	.	.
05 to 14	Male	12,440	80	7	7	8	A		-1%	A		-15%	.	.
	Female	11,627	100	9	7	8	A		+17%	A		+9%	.	.
15 to 34	Male	25,126	235	10	7	8	R		+29%	R		+19%	38 to 99	16 to 73
	Female	24,373	536	24	15	16	R		+34%	R		+32%	137 to 231	125 to 213
35 to 54	Male	30,083	489	19	13	15	R		+34%	R		+22%	125 to 211	70 to 150
	Female	29,621	560	22	14	17	R		+35%	R		+23%	150 to 242	85 to 171
55 to 64	Male	13,729	345	30	20	25	R		+33%	R		+15%	79 to 151	20 to 87
	Female	14,173	305	25	17	22	R		+33%	R		+12%	68 to 136	6 to 69
65 to 74	Male	12,447	539	49	30	40	R		+38%	R		+19%	161 to 253	60 to 146
	Female	13,189	519	45	26	35	R		+42%	R		+23%	176 to 265	77 to 161
75 to 79	Male	3,938	323	91	68	82	R		+25%	A		+9%	45 to 118	.
	Female	4,462	375	92	60	83	R		+35%	R		+11%	94 to 171	4 to 77
80 to 84	Male	2,539	363	153	92	124	R		+40%	R		+19%	105 to 182	32 to 105
	Female	3,230	446	147	98	126	R		+33%	R		+14%	106 to 191	22 to 102
85 plus	Male	1,821	463	263	161	211	R		+39%	R		+20%	136 to 224	51 to 134
	Female	3,344	850	263	169	218	R		+36%	R		+17%	243 to 362	88 to 201

R CCG is significantly higher
A CCG is not significantly different
G CCG is significantly lower

Sources: Unplanned hospitalisations - SUS 2016/17, population data - CCG registered population for October 2016, NHS Digital (2017).

Notes:
Numbers less than 6 have been suppressed.
*Data has been standardised for deprivation using indirect standardisation. Deprivation has been measured using the Index of Multiple Deprivation for 2015.

Data limitations for constructing rates for ethnic groups for your CCG

For England, 6.6% of these unplanned hospitalisation are of unknown ethnicity. The extent to which unplanned hospitalisation are unknown will vary by CCG. The table below shows the extent of unknowns, comparing ethnicity splits for these unplanned hospitalisations and the population for your CCG, with its best 5 of Similar 10 and England.

Ethnicity	CCG		Best 5 of Similar 10		England	
	Population	Hospitalisations	Population	Hospitalisations	Population	Hospitalisations
Total of known	**217,444**	**6,034**	**898,430**	**17,157**	**57,944,525**	**1,404,138**
White	209,814	5,931	863,991	16,750	49,002,245	1,261,849
BME	7,630	103	34,439	407	8,942,280	142,289
Asian	3,052	37	16,253	185	4,403,512	76,883
Indian	2,082	26	9,754	122	1,625,591	26,465
Pakistani	.	.	1,361	18	1,310,950	30,548
Bangladeshi	.	.	863	7	514,569	5,497
Black	1,023	14	3,774	45	1,830,601	24,512
African	.	.	2,054	18	1,141,768	11,648
Caribbean	752	10	1,720	27	688,834	12,864
Other	3,554	52	14,412	177	2,708,166	40,894
Unknown	**0**	**639**	**0**	**2,103**	**0**	**99,339**
% Unknown	**0.0%**	**9.6%**	**0.0%**	**10.9%**	**0.0%**	**6.6%**

Sources: Unplanned hospitalisations - SUS 2016/17, NHS Digital, population data - CCG registered population, October 2016, NHS Digital.
Note: See Methodology Guide for further details.

Your CCG benchmarked by ethnicty with the Best 5 of your Similar 10 CCGs and England

The table below compares rates of unplanned hospitalisations for your CCG with the average of the best (lowest) 5 of its Similar 10 CCGs and the rate for England for various ethnic groups. It is important to note that rates have been standardised for deprivation as well as sex and age, so that benchmarking is more specifically for ethnicity. Variation by geography may reflect scope for improvement. A red traffic light indicates a CCG has a statistically significantly higher rate than its geographic comparator. For red traffic lights, the number of hospitalisations which could be saved if your CCG moved to the same rate as its geographic comparator are shown. A range is given to reflect uncertainty.

Ethnicity	CCG		Rate per 1,000 population*			Rate comparisons				Opportunity for saved Hospitalisations	
	Population	Hospitalisations	CCG	Best 5 of Similar	England	CCG & Best 5 of Similar 10	% Difference	CCG & England	% Difference	Best 5 of Similar 10	England
Total of known	217,444	6,034	30.7	19.8	24.2	R	36%	R	21%	1,991 to 2,303	1,124 to 1,414
White	209,814	5,931	30.9	19.8	25.8	R	36%	R	17%	1,973 to 2,284	839 to 1,129
BME	7,630	103	22.8	18.8	15.9	A	18%	R	30%	.	16 to 46
Asian**	3,052	37	20.0	17.5	17.5	A	12%	A	13%	.	.
Indian	2,082	26	22.5	21.0	16.3	A	7%	R	28%	.	0 to 15
Pakistani	.	.	.	.	.	.	.	.	.	.	.
Bangladeshi	.	.	.	.	.	.	.	.	.	.	.
Black**	1,023	14	25.7	20.7	13.4	A	19%	R	48%	.	1 to 12
African	.	.	.	.	.	.	.	.	.	.	.
Caribbean	752	10	23.8	19.8	18.7	A	17%	A	22%	.	.
Other	3,554	52	24.3	19.7	15.1	A	19%	R	38%	.	9 to 31

R CCG is significantly higher
A CCG is not significantly different
G CCG is significantly lower

Sources: Unplanned hospitalisations - SUS 2016/17, NHS Digital, population data - CCG registered population, October 2016, NHS Digital.

Notes:
*Data has been standardised for sex, age and deprivation using indirect standardisation, deprivation has been measured using the Index of Multiple Deprivation for 2015.
**The subgroups that follow these categories do not make up the category totals, other subgroups have been omitted because they would have large errors, see Methodology Guide for further details.
Ethnicity categories for population data is from October 2016 however the ethnicity categories for the admissions data are based on the 2001 Census.
Aggregate ethnicity groupings were therefore created to allow for greater accuracy when matching between the 2 datasets, given the population growth and movement between groups over the years.
Numbers less than 6 have been suppressed.

Your CCG benchmarked by sex with the Best 5 of your Similar 10 CCGs and England

The table below compares rates of referrals finishing a course of treatment and moving to recovery for your CCG with the average of the best 5 of its Similar 10 CCGs and the rate for England by sex. Variation by geography may reflect scope for improvement. A red traffic light indicates a CCG has a statistically significantly lower rate than its benchmark. Where a red traffic light is shown, an improvement opportunity is also shown. This represents how many more referrals/recoveries your CCG would need to have, to be equivalent to the average rate of the best 5 of the Similar 10 or England. A range is given to reflect uncertainty.

Sex	CCG		Rate per 1,000 population		England rate per 1,000 population	Rate comparisons		Opportunity for more referrals	
	Number of referrals finishing a course of treatment	Population	CCG	Best 5 of Simillar 10		CCG & Best 5 of Similar 10	CCG & England	Best 5 of Simillar 10	England
Male	610	88,527	6.9	12.1	8.3	🔴	🔴	403 to 520	74 to 171
Female	1,055	91,193	11.6	21.1	15.5	🔴	🔴	792 to 947	292 to 420

Sex	CCG		Percentage moved to recovery (%)		England percentage moved to recovery (%)	Rate comparisons		Opportunity for more recoveries	
	Number of referrals moved to recovery	Referrals finishing a course of treatment in the year who were initially at caseness	CCG	Best 5 of Similar 10		CCG & Best 5 of Similar 10	CCG & England	Best 5 of Similar 10	England
Male	341	595	57.4%	57.5%	49.5%	🟡	🟢	.	.
Female	536	1,020	52.6%	58.0%	49.3%	🟡	🟡	.	.

🟢 CCG is significantly higher
🟡 CCG is not significantly different
🔴 CCG is significantly lower

Sources: Psychological Therapies: Annual report on the use of IAPT services, NHS Digital (2018).
Note: Data points with values less than 5 have been suppressed.

IAPT Rates of Referrals Finishing a Course of Treatment and Moving to Recovery in 2016/17

Your CCG benchmarked by age with the Best 5 of your Similar 10 CCGs and England

The table below compares rates of referrals finishing a course of treatment and moving to recovery for your CCG with the average of the best 5 of its Similar 10 CCGs and the rate for England by age. Variation by geography may reflect scope for improvement. A red traffic light indicates a CCG has a statistically significantly lower rate than its benchmark. Where a red traffic light is shown, an improvement opportunity is also shown. This represents how many more referrals/recoveries your CCG would need to have, to be equivalent to the average rate of the best 5 of the Similar 10 or England. A range is given to reflect uncertainty.

Age	CCG		Rate per 1,000 population		England rate per 1,000 population	Rate comparisons		Opportunity for more referrals	
	Number of referrals finishing a course of treatment	Population	CCG	Best 5 of Similar 10		CCG & Best 5 of Similar 10	CCG & England	Best 5 of Similar 10	England
16 to 17	10	4,749	2.1	6.1	4.8	🔴	🔴	11 to 27	7 to 19
18 to 35	610	45,066	13.5	26.5	17.0	🔴	🔴	524 to 643	106 to 203
36 to 64	880	84,955	10.4	18.4	12.8	🔴	🔴	612 to 753	150 to 267
65 and over	165	44,951	3.7	5.6	4.1	🔴	🟡	57 to 116	.

Age	CCG		Percentage moved to recovery (%)		England percentage moved to recovery (%)	Rate comparisons		Opportunity for more recoveries	
	Number of referrals moved to recovery	Referrals finishing a course of treatment in the year who were initially at caseness	CCG	Best 5 of Similar 10		CCG & Best 5 of Similar 10	CCG & England	Best 5 of Similar 10	England
16 to 17	5	10	45.0%	44.5%	42.0%	🟡	🟡	.	.
18 to 35	286	595	48.0%	48.6%	46.3%	🟡	🟡	.	.
36 to 64	485	850	57.0%	53.7%	50.3%	🟡	🟢	.	.
65 and over	104	160	65.0%	63.9%	63.5%	🟡	🟡	.	.

Sources: Psychological Therapies: Annual report on the use of IAPT services, NHS Digital (2018).
Note: Data points with values less than 5 have been suppressed.

🟢 CCG is significantly higher
🟡 CCG is not significantly different
🔴 CCG is significantly lower

Your CCG benchmarked by sex and age combined with the Best 5 of your Similar 10 CCGs and England

The table below compares rates of referrals finishing a course of treatment and moving to recovery for your CCG with the average of the best 5 of its Similar 10 CCGs and the rate for England by age-sex. Variation by geography may reflect scope for improvement. A red traffic light indicates a CCG has a statistically significantly lower rate than its benchmark. Where a red traffic light is shown, an improvement opportunity is also shown. This represents how many more referrals/recoveries your CCG would need to have, to be equivalent to the average rate of the best 5 of the Similar 10 or England. A range is given to reflect uncertainty.

Sex	Age	CCG		Rate per 1,000 population		England rate per 1,000	Rate comparisons		Opportunity for more referrals	
		Number of referrals finishing a course of treatment	Population	CCG	Best 5 of Similar 10		Best 5 of Similar 10	CCG & England	Best 5 of Similar 10	England
Male	16 to 17	.	2,453	.	2.7	2.5	.	.	.	.
	18 to 35	200	22,852	8.8	17.3	10.9			162 to 230	21 to 76
	36 to 64	350	42,485	8.2	14.1	9.2			205 to 293	5 to 78
	65 and over	60	20,737	2.9	3.9	2.8			.	.
Female	16 to 17	5	2,296	2.2	8.9	7.1			9 to 22	7 to 16
	18 to 35	410	22,214	18.5	35.8	22.8			336 to 434	56 to 136
	36 to 64	535	42,470	12.6	22.7	16.4			374 to 484	115 to 206
	65 and over	105	24,213	4.3	7.1	5.0			44 to 91	.

Sex	Age	CCG		Percentage moved to recovery (%)		England percentage moved to recovery	Rate comparisons		Opportunity for more recoveries	
		Number of referrals moved to recovery	Referrals finishing a course of treatment in the year who were initially at caseness	CCG	Best 5 of Similar 10		CCG & Best 5 of Similar 10	CCG & England	Best 5 of Similar 10	England
Male	16 to 17	.	.	.	66.7%	48.5%	.	.	.	.
	18 to 35	105	195	54.0%	53.9%	46.5%			.	.
	36 to 64	201	340	59.0%	58.5%	50.0%			.	.
	65 and over	35	60	59.0%	70.8%	64.5%			.	.
Female	16 to 17	.	5	.	55.1%	39.9%	.	.	.	.
	18 to 35	180	400	45.0%	55.2%	46.2%			67 to 385	.
	36 to 64	288	515	56.0%	59.1%	50.5%			.	.
	65 and over	68	100	68.0%	68.6%	63.1%			.	.

CCG is significantly higher
CCG is not significantly different
CCG is significantly lower

Sources: Psychological Therapies: Annual report on the use of IAPT services, NHS Digital (2018).
Note: Data points with values less than 5 have been suppressed.

Data limitations for constructing rates for ethnic groups for your CCG

For England, 6.8% of referrals finishing a course of treatment, 6.3% of referrals moved to recovery and 6.6% of referrals finishing a course of treatment in the year who were initially at caseness are of unknown ethnicity and the extent to which data are unknown will vary by CCG. The table below compares ethnicity splits for your CCG, its best 5 of Similar 10 and England showing the extent of unknowns.

Ethnicity	CCG		Similar 10		England	
	Number of referrals finishing a course of treatment	Population	Number of referrals finishing a course of treatment	Population	Number of referrals finishing a course of treatment	Population
Total of known	**1,455**	**217,444**	**11,015**	**832,293**	**528,263**	**57,944,525**
White	1,415	209,584	10,725	800,200	470,964	48,986,265
Asian	15	3,605	90	13,850	24,081	4,827,990
Black	10	1,248	60	5,816	14,285	2,153,447
Mixed	15	2,628	105	10,677	11,424	1,343,769
Other	.	379	35	1,750	7,509	633,054
Unknown	**210**	**0**	**485**	**0**	**38,843**	**0**
% Unknown	**12.6%**	**0.0%**	**4.2%**	**0.0%**	**6.8%**	**0.0%**

Ethnicity	CCG		Best 5 of		England	
	Number of referrals moved to recovery	Referrals finishing a course of treatment in the year who were initially at caseness	Number of referrals moved to recovery	Referrals finishing a course of treatment in the year who were initially at caseness	Number of referrals moved to recovery	Referrals finishing a course of treatment in the year who were initially at caseness
Total of known	**763**	**1,430**	**5,173**	**8,940**	**242,659**	**489,127**
White	737	1,390	5,059	8,695	219,196	435,989
Asian	9	15	38	75	9,894	22,372
Black	7	10	20	55	5,941	13,211
Mixed	11	15	47	95	4,739	10,636
Other	.	.	10	20	2,889	6,919
Unknown	**115**	**190**	**170**	**335**	**16,229**	**34,603**
% Unknown	**13.1%**	**11.7%**	**3.2%**	**3.6%**	**6.3%**	**6.6%**

Sources: Psychological Therapies: Annual report on the use of IAPT services, NHS Digital (2018).

Note: See Methodology Guide for further details.

Your CCG benchmarked by ethnicity with the Best 5 of your Similar 10 CCGs and England

The table below compares rates of referrals finishing a course of treatment and moving to recovery for your CCG with the average of the best 5 of its Similar 10 CCGs and the rate for England by ethnicity. It is important to note that rates have not been standardised for deprivation, sex or age, so the CCG will be more comparable with the best 5 of its Similar 10 than England. Variation by geography may reflect scope for improvement. A red traffic light indicates a CCG has a statistically significantly lower rate than its benchmark. Where a red traffic light is shown, an improvement opportunity is also shown. This represents how many more referrals/recoveries your CCG would need to have, to be equivalent to the average rate of the best 5 of the Similar 10 or England. A range is given to reflect uncertainty.

Ethnicity	CCG		Rate per 1,000 population		England rate per 1,000 population	Rate comparisons		Opportunity for more referrals	
	Number of referrals finishing a course of treatment	Population	CCG	Best 5 of Similar 10		CCG & Best 5 of Similar 10	CCG & England	Best 5 of Similar 10	England
White	1,415	209,584	6.8	13.4	9.6			1,303 to 1,485	526 to 674
Asian	15	3,605	4.2	6.5	5.0			.	.
Black	10	1,248	8.0	10.3	6.6			.	.
Mixed	15	2,628	5.7	9.8	8.5			.	.
Other	.	379	.	20.0	11.9	.	.	.	.

Ethnicity	CCG		Percentage moved to recovery (%)		England percentage moved to recovery (%)	Rate comparisons		Opportunity for more recoveries	
	Number of referrals moved to recovery	Referrals finishing a course of treatment in the year who were initially at caseness	CCG	Best 5 of Similar 10		CCG & Best 5 of Similar 10	CCG & England	Best 5 of Similar 10	England
White	737	1,390	53.0%	58.2%	50.2%			.	.
Asian	9	15	60.0%	50.1%	44.2%			.	.
Black	7	10	70.0%	36.3%	44.9%			.	.
Mixed	11	15	71.0%	49.1%	44.5%			.	.
Other	.	.	.	47.8%	41.7%	.	.	.	.

CCG is significantly higher
CCG is not significantly different
CCG is significantly lower

Sources: Psychological Therapies: Annual report on the use of IAPT services, NHS Digital (2018).
Note: Data points with values less than 5 have been suppressed.

Your CCG benchmarked by deprivation with the Best 5 of your Similar 10 CCGs and England

The table below compares rates of referrals finishing a course of treatment and moving to recovery for your CCG with the average of the best 5 of its Similar 10 CCGs and the rate for England by deprivation. Variation by geography may reflect scope for improvement. A red traffic light indicates a CCG has a statistically significantly lower rate than its benchmark. Where a red traffic light is shown, an improvement opportunity is also shown. This represents how many more referrals/recoveries your CCG would need to have, to be equivalent to the average rate of the best 5 of the Similar 10 or England. A range is given to reflect uncertainty.

Deprivation	CCG		Rate per 1,000 population		England rate per 1,000 population	Rate Comparisons		Opportunity for more referrals	
	Number of referrals finishing a course of treatment	Population	CCG	Best 5 of Similar 10		Best 5 of Similar 10	CCG & England	Best 5 of Similar 10	England
01 Least deprived	455	61,698	7.4	11.6	8.4	🔴	🔴	211 to 310	35 to 96
02 Less deprived	435	57,267	7.6	12.7	9.2	🔴	🔴	245 to 343	57 to 123
Middle Deprived	345	43,959	7.8	15.0	9.8	🔴	🔴	267 to 357	46 to 123
04 More deprived	275	34,029	8.1	16.3	10.3	🔴	🔴	241 to 321	41 to 110
05 Most deprived	150	20,491	7.3	17.5	10.4	🔴	🔴	178 to 240	44 to 82

Deprivation	CCG		Percentage moved to recovery (%)		England percentage moved to recovery (%)	Rate Comparisons		Opportunity for more recoveries	
	Number of referrals moved to recovery	Referrals finishing a course of treatment in the year who were initially at caseness	CCG	Best 5 of Similar 10		CCG & Best 5 of Similar 10	CCG & England	Best 5 of Similar 10	England
01 Least deprived	265	440	60.2%	62.4%	57.0%	🟡	🟡	.	.
02 Less deprived	245	425	57.6%	61.4%	54.0%	🟡	🟡	.	.
Middle Deprived	180	330	54.5%	56.9%	51.1%	🟡	🟡	.	.
04 More deprived	130	265	49.1%	54.2%	47.3%	🟡	🟡	.	.
05 Most deprived	65	150	43.3%	52.3%	41.0%	🟡	🟡	.	.

🟢 CCG is significantly higher
🟡 CCG is not significantly different
🔴 CCG is significantly lower

Sources: Psychological Therapies: Annual report on the use of IAPT services, NHS Digital (2018).
Note: Data points with values less than 5 have been suppressed.