Hertfordshire and West Essex Integrated Care System

PCN Insights Pack 2024

North Watford

Stefania Mistretta, PHM Champion
Hannes van der Merwe, PHM Champion
Jaron Inward, Snr PHM Champion

Working together
for a healthier future

Introduction

This latest version of the PCN pack has been developed around the ICB Clinical Priorities signed off by the ICB Board in March 23 and how they align to the population outcomes we are aiming to achieve. (See tables on the right hand side.)

The data contained within this pack compares the PCN data against Place and ICB. An overview table of all the data is available on the following page with areas of opportunity highlighted.

Some data will not be available at PCN level e.g. mortality rate for CVD. Where this is the case, proxy measures that will lead to improving this will be included e.g. early identification.

Where opportunities link with areas within the ECF or QOF a selection of related indicators have been shared alongside a link to Ardens Manager.

The data within this pack are shown at PCN level and are health focused. However to improve outcomes for our population, input from many partners is required. This pack can facilitate discussion within your Integrated Neighbourhood Teams as described within the Primary Care Strategy and also the wider HCP transformation spaces supported by your Primary Care Transformation leads.

Packs for other PCNs, Localities and Place can be found:

[Population health management – Hertfordshire and West Essex Integrated Care System (hertsandwestessexics.org.uk)]

Here you can also find previous PCN packs outlining the descriptive demographics for the PCNs.

Area	Clinical Priority
CYP	• Improved Readiness for school in children eligible for FSM • Reduce rates of Childhood obesity • Reduced unnecessary A&E attendances and admissions
Prevention and Health Inequalities	• Reduced premature mortality rate for CVD
LTC & Frailty	• Reduce attendance and admissions for falls, people with frailty and people in last year of life • Development of more proactive, preventative care models for management of LTC and Frailty
Mental Health	• Reducing suicide rates and attendances/ admission rates for self-harm • Reducing rates of A&E attendances involving substance misuse and violence

Outcome	Definition
Improve life expectancy	Average age at death for people who have died in the last 12 months
Improve healthy life expectancy	Average age of people who have left the 'healthy' segment in the last 12 months
Reduce the proportion of people living with advanced disease and complexity	Proportion of the registered population who are in the advanced disease and complexity segment (segment)
Reduce the rate of ambulatory care sensitive emergency hospital admissions	Rate of ambulatory care sensitive emergency admissions in the last 12 months
Reduce the overall spend on emergency hospital admissions	Spend on Emergency hospital admissions within a financial year

North Watford PCN at a Glance

The table on the right provides a summary of the data contained within this pack. It highlights how the PCN data compares with Place and ICB.

For North Watford PCN areas of opportunity highlighted are :

- ***Childhood obesity in Year 6 children***
- ***Observed versus expected prevalence***
- ***Control of Hypertension***
- ***Admissions for ACS conditions***
- ***Admissions for falls (75+)***
- ***Prevalence of mental health conditions – Dementia***
- ***Admissions for Self-harm***

The following link takes you to Ardens Manager where there are reports. Here you will find the latest information on identification of LTCs and details of case finding Ardens searches available within EMIS and System one.

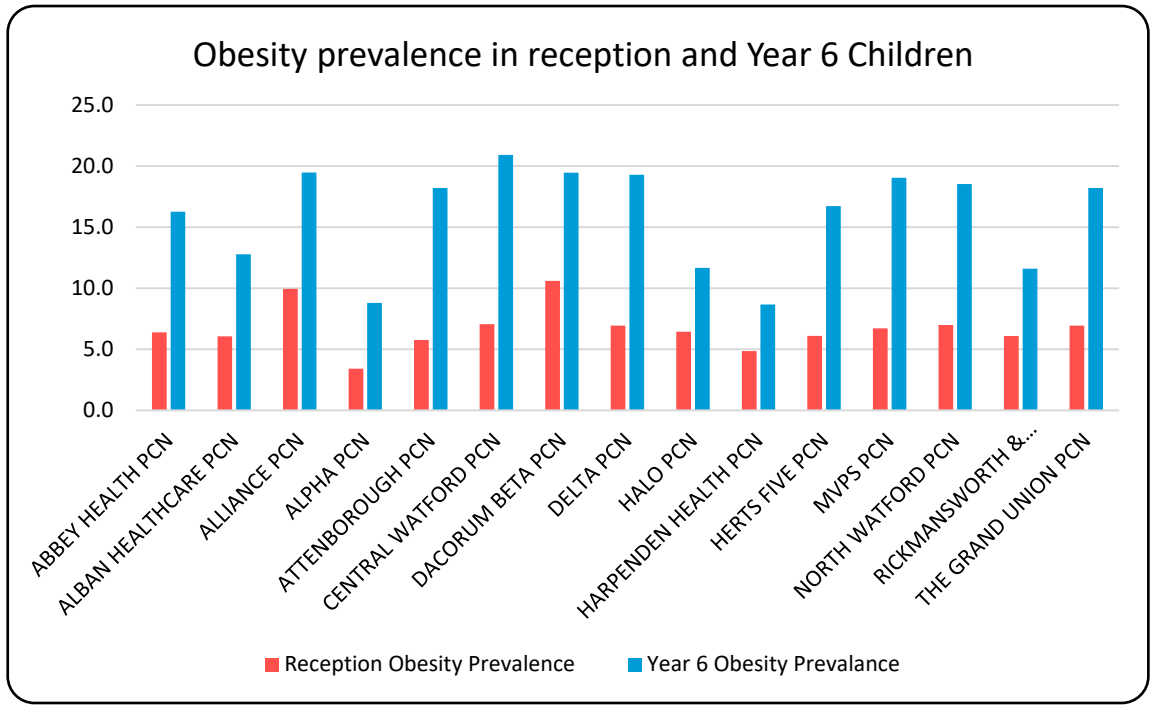
https://app.ardensmanager.com/login

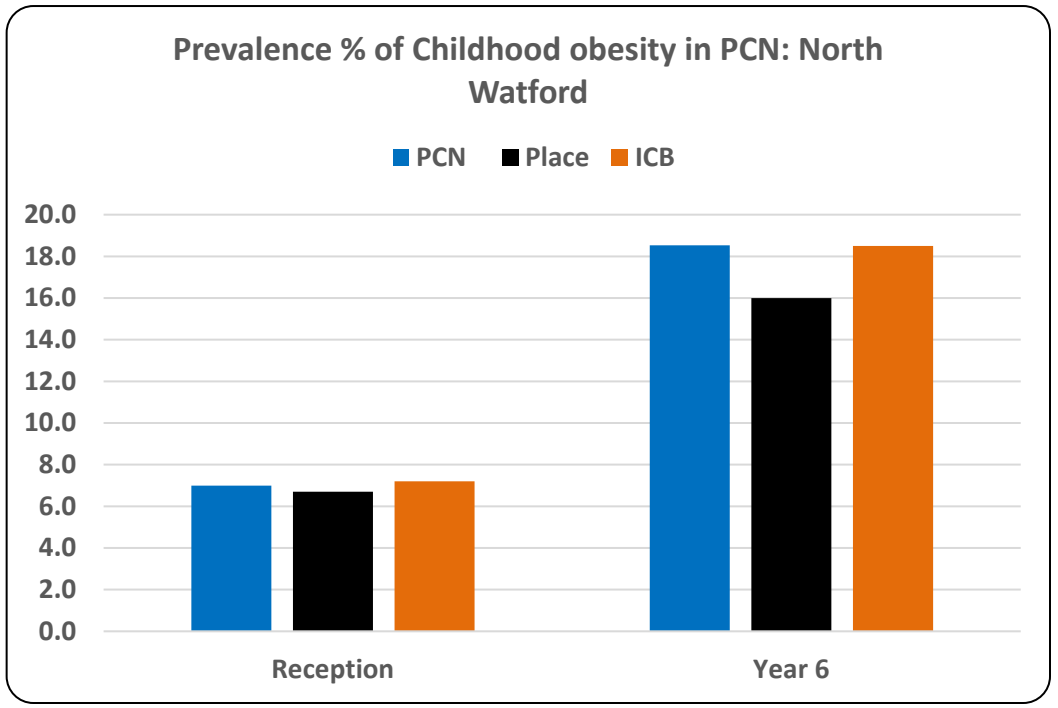
Clinical Priority	Metric	PCN compared to Place average	PCN compared to ICB average
Childhood obesity	% of children in Reception who are overweight	↑	↓
	% of children in Year 6 who are overweight	↑	↑
Reduce rates of emergency care for children and young people	A&E Attendances for Asthma (Children)	↓	↓
	Admissions for Asthma (Children)	↓	↓
	Admissions for Wheeze (Children)	↓	↑
	Admissions for Diabetes (Children)	↓	↑
	Admissions for Epilepsy (Children)	↓	↓
Prevention and health inequalities (Premature mortality for CVD) Preventative, Proactive care models for LTC	Lifestyle risk factors: Smoking	↑	↑
	Observed versus expected prevalence	↓	↓
	Annual Reviews completed for LTCs	↔	↔
	% of people with AF treated with Anti Coagulant	↔	↔
	Control of hypertension	↓	↓
	Identification of hypertension	↑	↑
	% of people for secondary prevention CVD who are on high intensity statins	↑	↑
	% of diabetics with all 8 care processes completed	↔	↑
	Admissions for ACS conditions	↑	↑
Preventative, Proactive care models for frailty and EOL	Admissions for falls (75+)	↑	↑
	Admissions for Hip Fractures (75+)	↓	↓
Mental Health	Prevalence of Mental Health Conditions including LD	↓ (Dementia)	↓ (Dementia)
	Admissions for Self-Harm	↑	↑

Rates of Childhood Obesity

CYP outcome – Every child will have the best start and live a healthy life → ICB overarching outcome of Improving Healthy life expectancy

- In keeping with the national data, the PCN rates for Childhood Obesity are higher for year 6 in comparison to reception children.
- Compared to the ICB and Place rate, North Watford PCN has lower rates of Childhood Obesity for Children in Reception. However, the rate of Childhood Obesity at Year 6 is higher when comparing with Place and the ICB.
- The data suggest that there is a deterioration from reception to Year 6 in childhood obesity in the PCN position against Place and ICB.





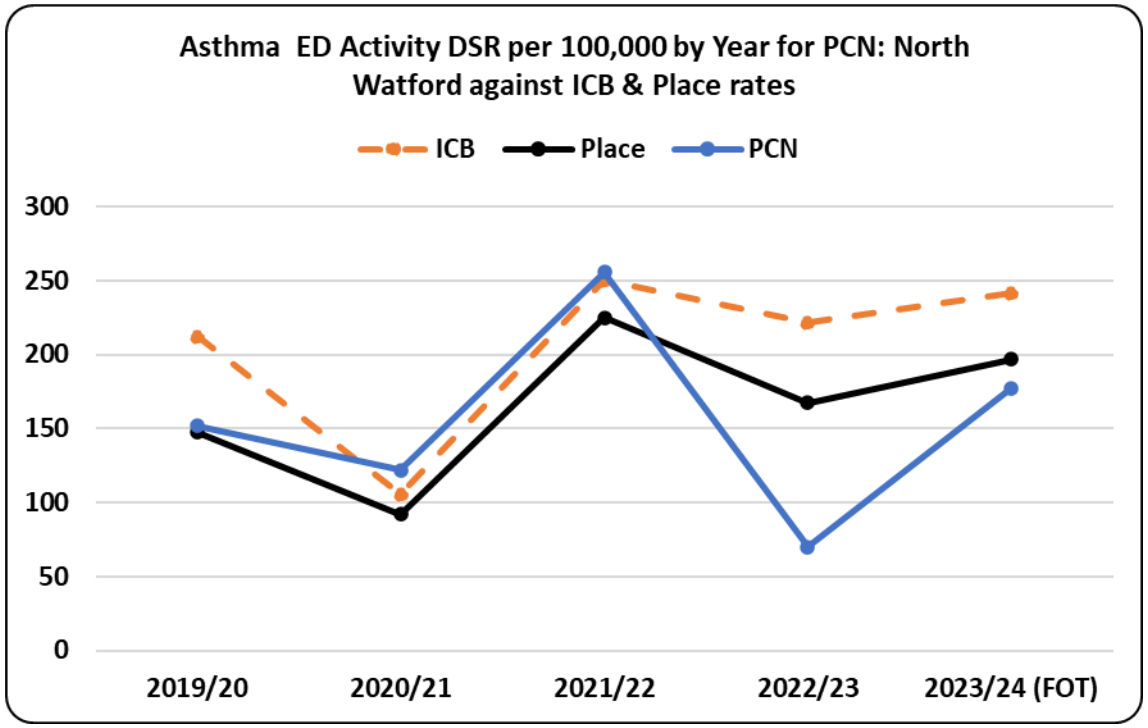
Hertfordshire and West Essex Integrated Care System

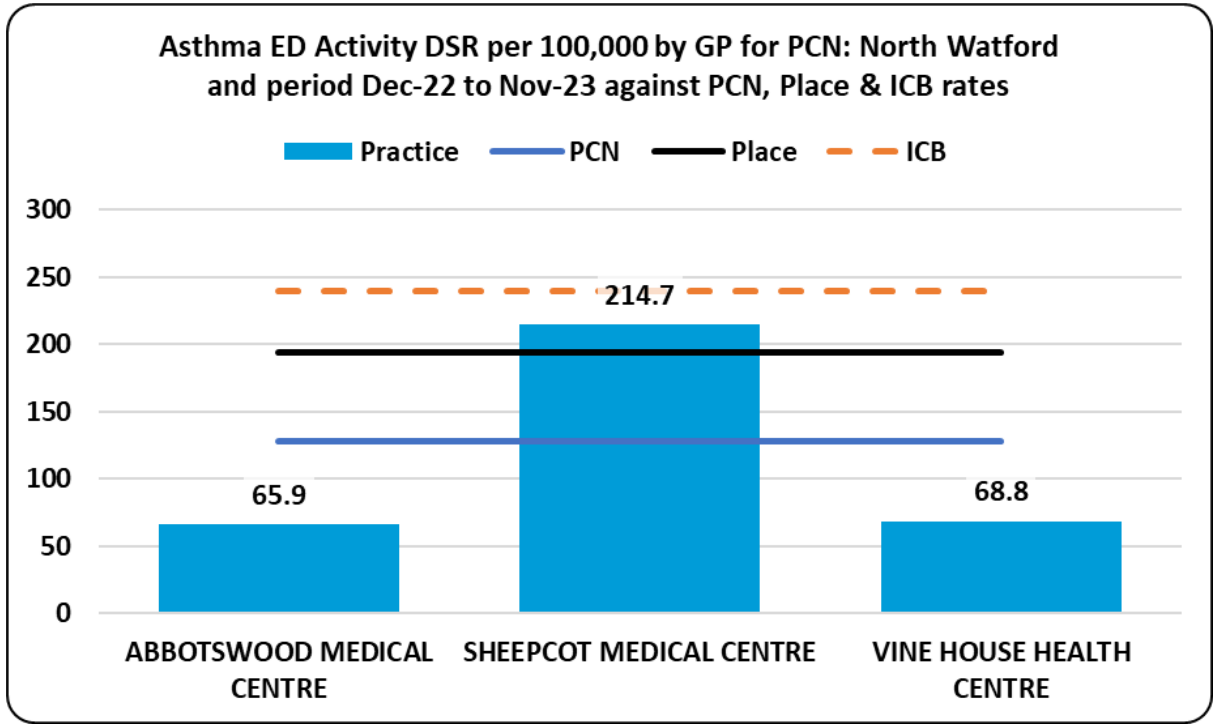
Source: NCMP and HES: 2022/23

A&E attendances for Asthma (CYP)

CYP outcome – Reduce the number of unplanned admissions for long term conditions → ICB overarching outcome of reduce the proportion of people living with advanced disease and complexity

- North Watford PCN has a lower rate of A&E attendances for Children and Young People with Asthma than Place and the ICB (rolling years data on the right-hand side).
- Rates of Children and Young People attending A&E for Asthma have increased since 2020/21 post covid. The rates fluctuate annually with the latest forecast outturn from November data showing an increase on the previous year.
- The Children and Young Peoples programme can be contacted via hweicbenh.cypteam@nhs.net for details of projects underway.





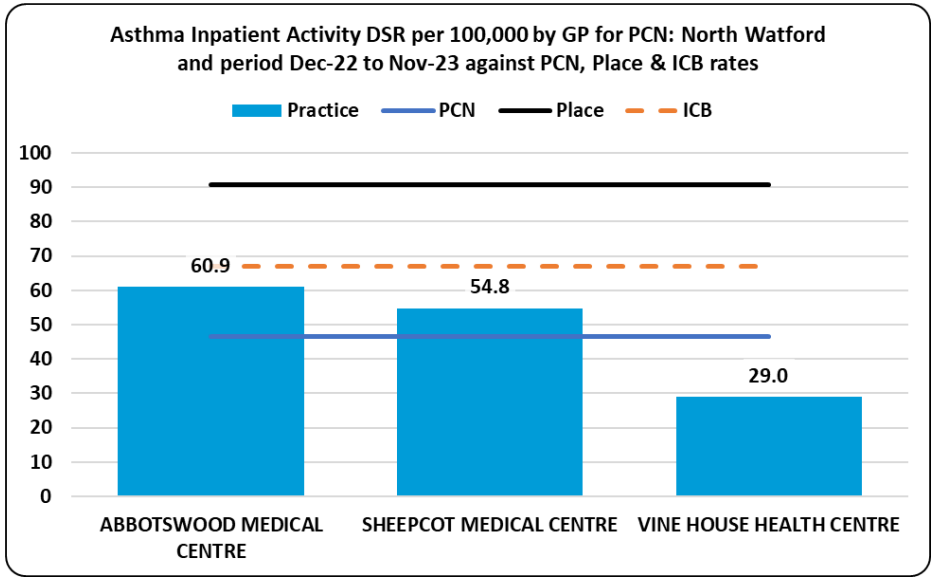
Hertfordshire and West Essex Integrated Care System

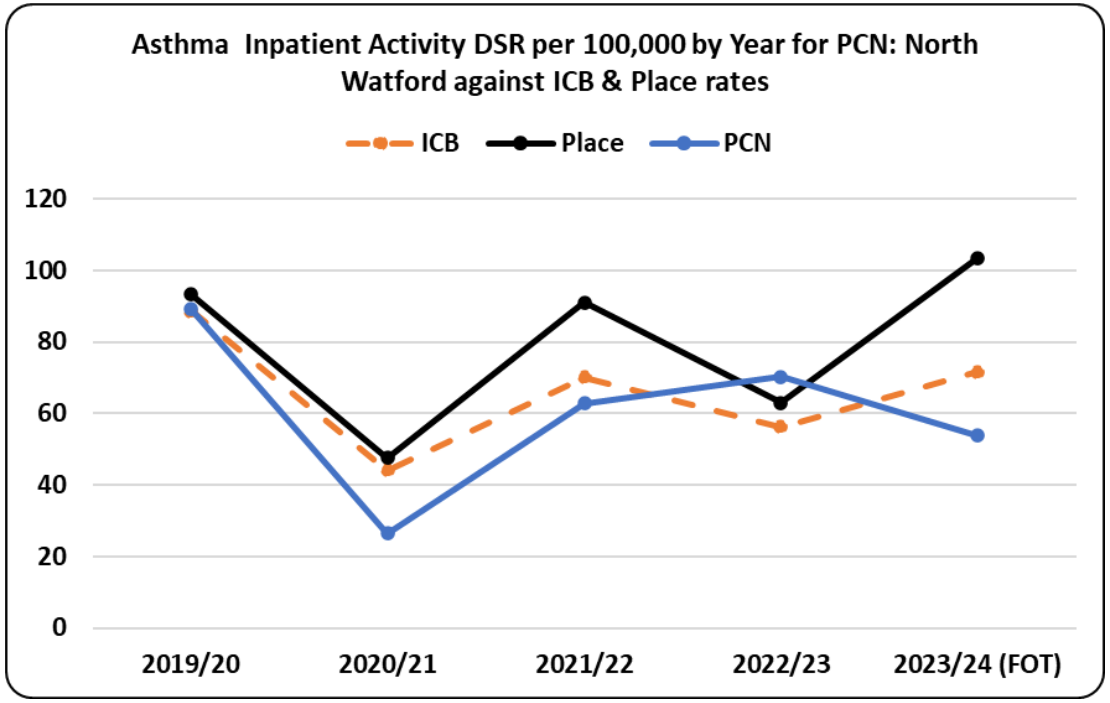
Source: SUS

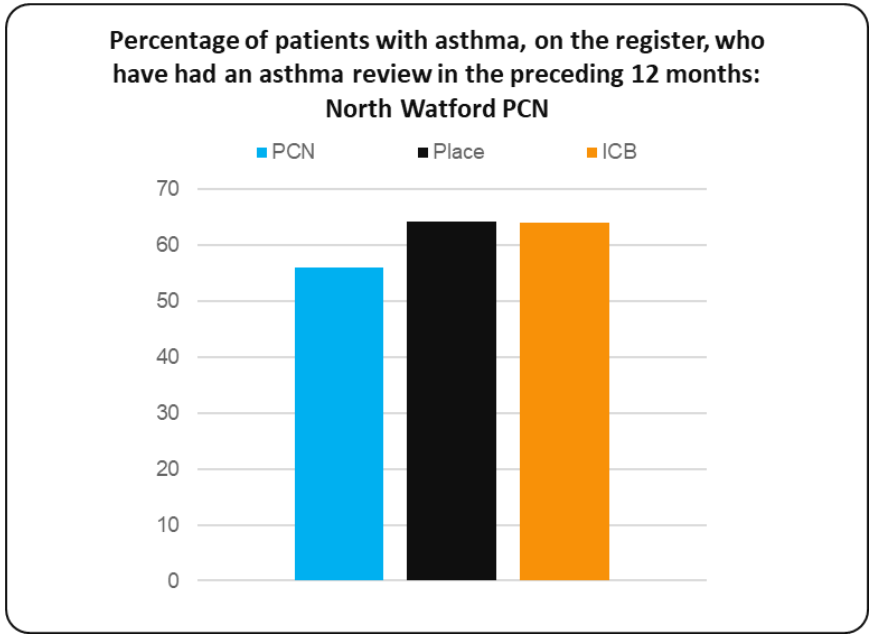
Admissions for Asthma (CYP)

CYP outcome – Reduce the number of unplanned admissions for long term conditions → ICB overarching outcome of reduce the proportion of people living with advanced disease and complexity

- Compared to Place and the ICB, North Watford PCN has a lower rate of children's admissions for Asthma (rolling years data on the right-hand side).
- The trend data showed an increasing rate of admissions for Asthma for North Watford PCN from 20/21, however the latest forecast outturn data from November show a decrease.
- Lower Proportion of Asthma Reviews are carried out within North Watford PCN in comparison to Place and the ICB. However, the QOF is for all ages and children specific reviews cannot be identified within the data.





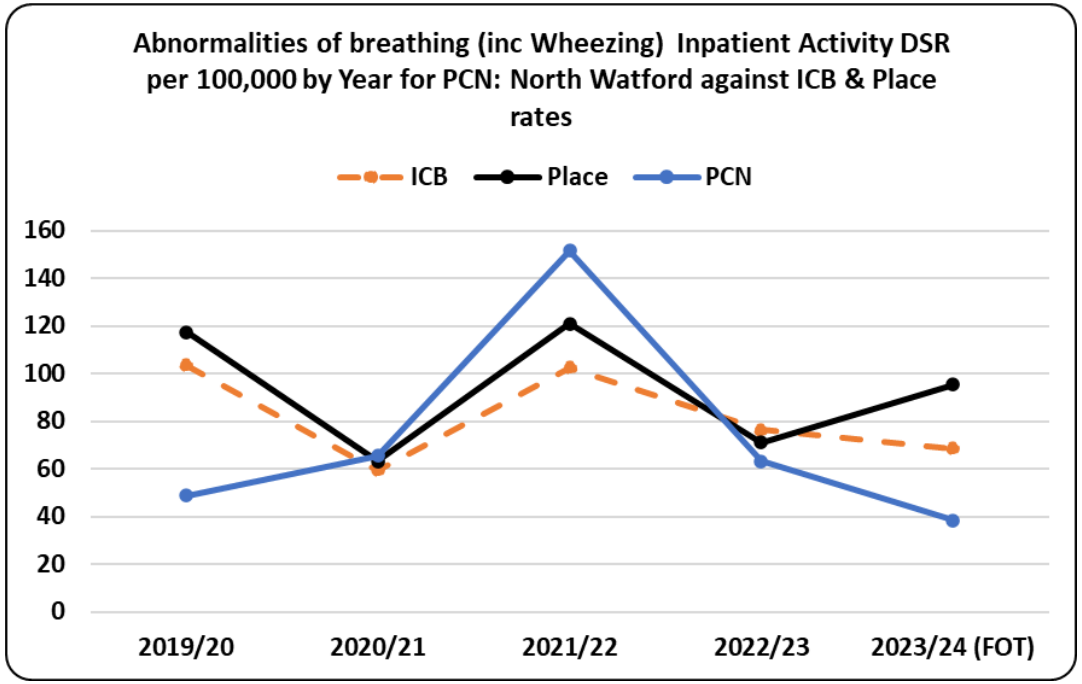


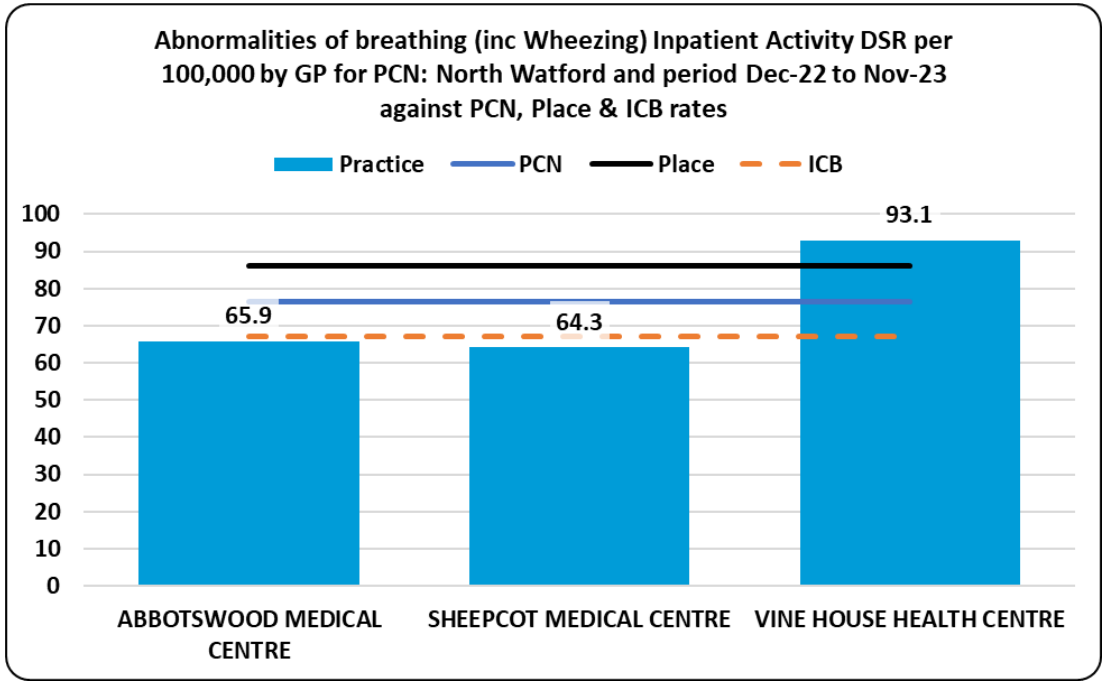
Source: SUS; QOF

Admissions for Wheeze (CYP)

CYP outcome – Reduce the number of unplanned admissions for long term conditions → **ICB overarching outcome of reduce the proportion of people living with advanced disease and complexity**

- North Watford PCN has a lower rates of Children and Young People admitted to hospital for abnormalities of breathing including wheeze compared to place but higher than ICB. Recent analysis of UEC data showed Wheeze as a significant reason for admission within young children across HWE.
- Rates of Children and Young People admitted to Hospital for Wheeze fluctuate annually with the latest forecast outturn from November data showing a decrease on the previous year.
- When looking at the data by practice there is variation between the practices.





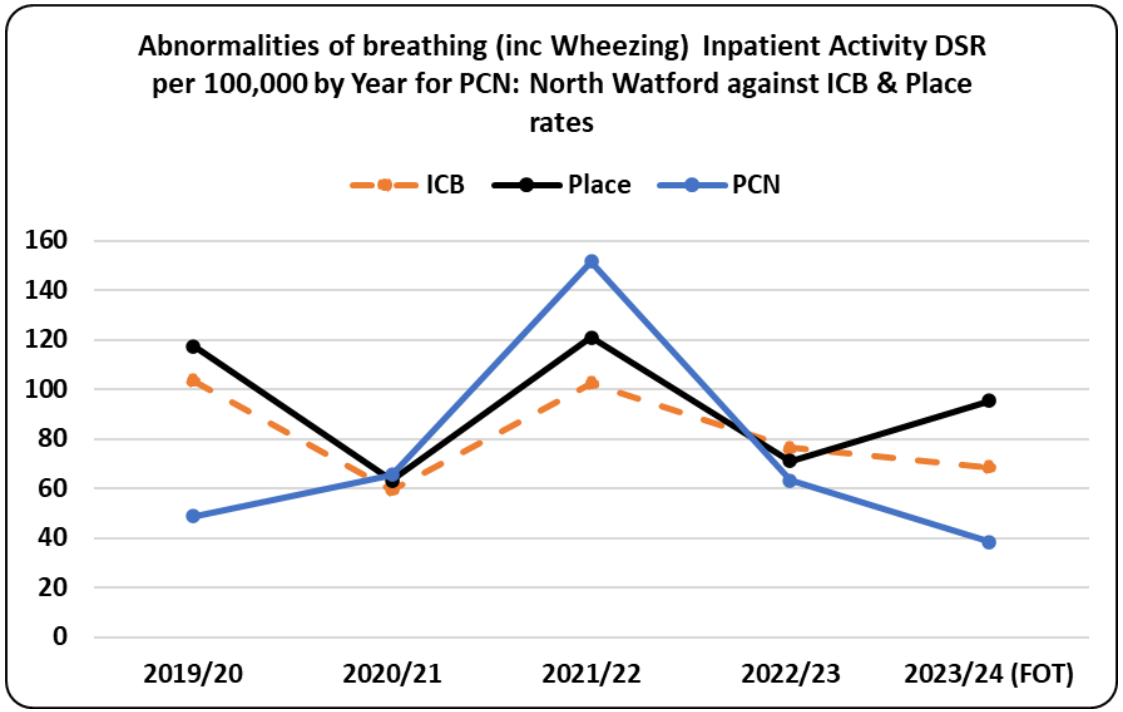
Hertfordshire and West Essex Integrated Care System

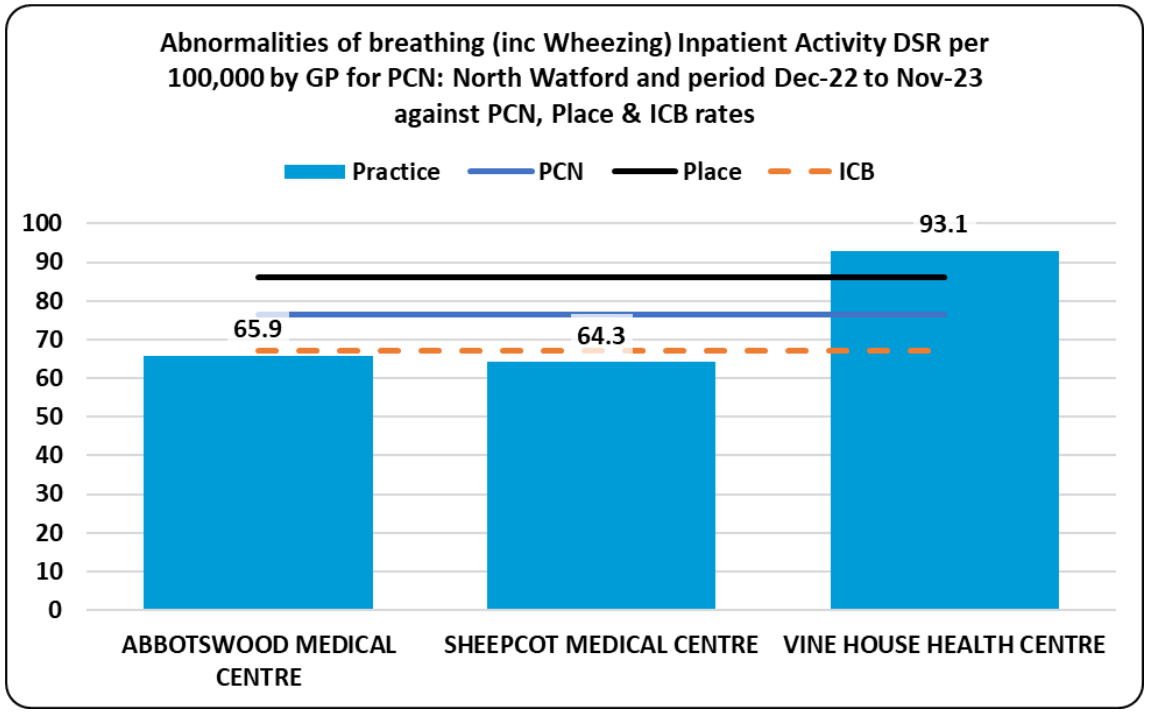
Source: SUS

Admissions for Diabetes (CYP)

CYP outcome – Reduce the number of unplanned admissions for long term conditions → ICB overarching outcome of reduce the proportion of people living with advanced disease and complexity

- Diabetes is identified as an area of focus within the Core 20 plus 5 for children. North Watford rates for the 12 month period up to November 23 are higher than ICB but lower than place.
- The numbers of children admitted for diabetes are small and this should be considered when looking at the data.
- The data for diabetes will continue to be monitored at wider HCP and ICB footprints.





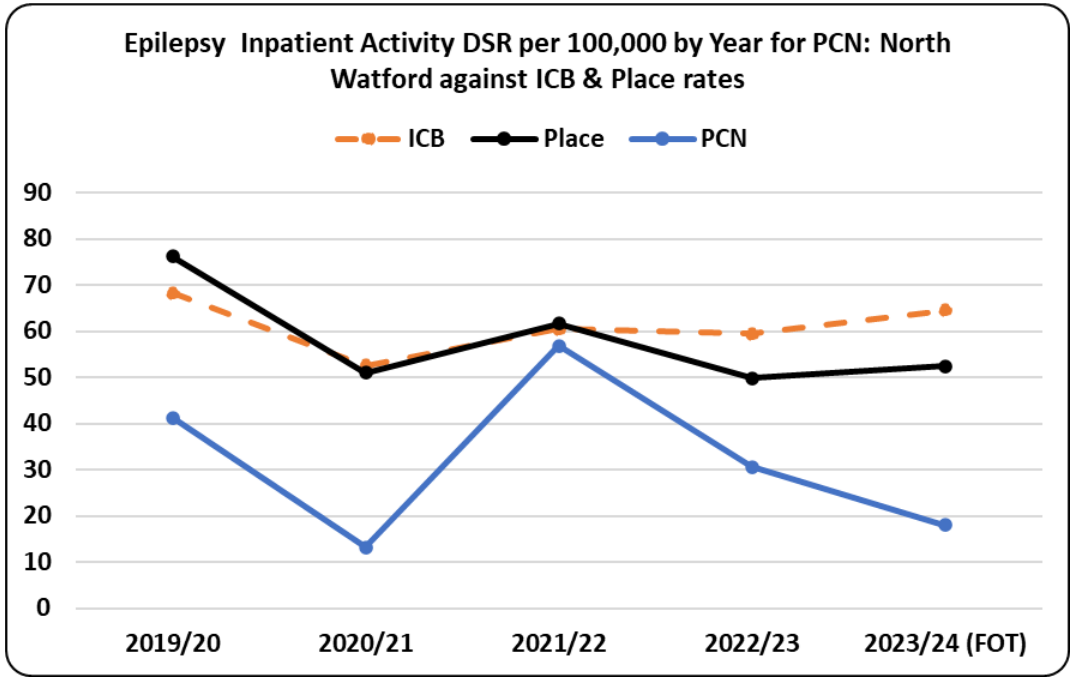
Hertfordshire and West Essex Integrated Care System

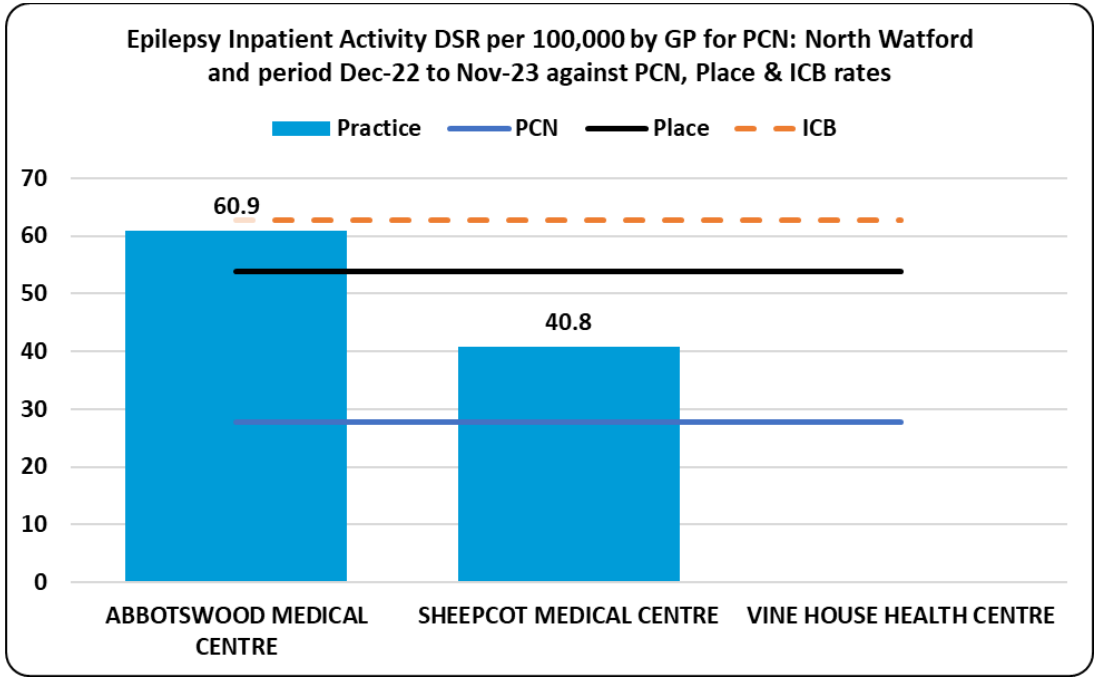
Source: SUS

Admissions for Epilepsy (CYP)

CYP outcome – Reduce the number of unplanned admissions for long term conditions → **ICB overarching outcome of reduce the proportion of people living with advanced disease and complexity**

- Epilepsy is identified as an area of focus within the Core 20 plus 5 for children. The data shows the PCN with a lower rate than both ICB and place.
- The numbers of children admitted for epilepsy are small and therefore fluctuations in the trend are more prominent. There were no admissions for Vine House Health Centre within the 12 months up to November 23.
- The data for epilepsy will continue to be monitored at wider HCP and ICB footprints. The Children and Young Peoples programme can be contacted via hweicbenh.cypteam@nhs.net for details of projects underway.





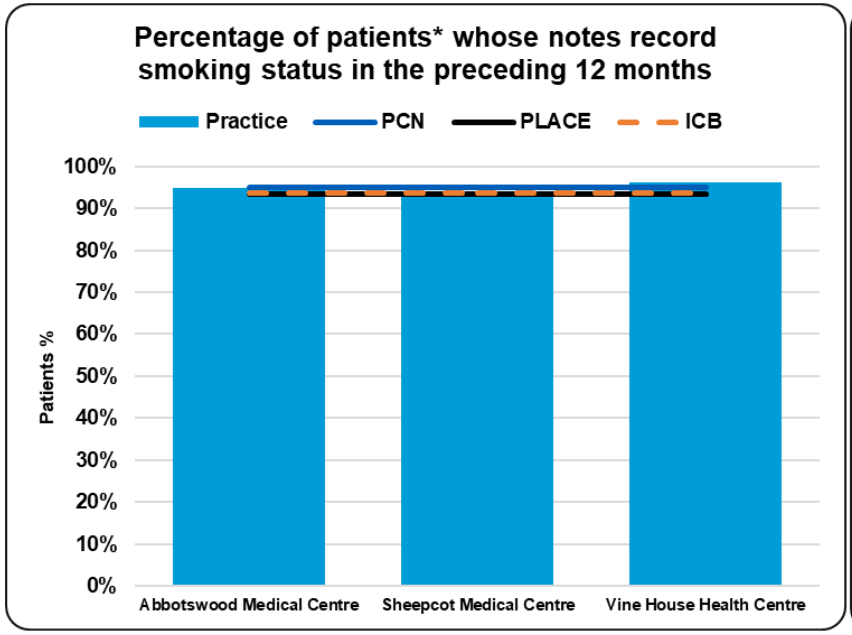
Hertfordshire and West Essex Integrated Care System

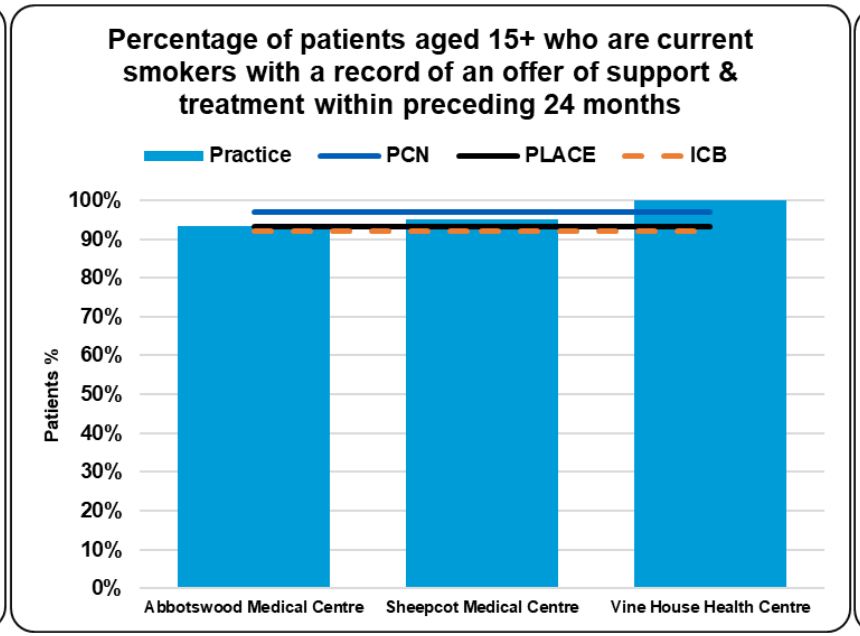
Source: SUS

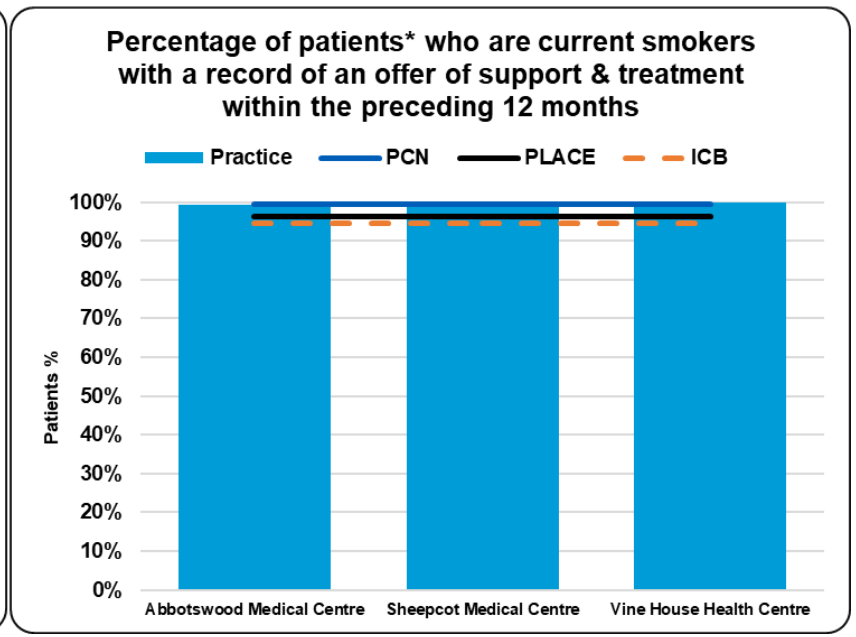
Prevention and health inequalities – Lifestyle factors - Smoking

- North Watford PCN data for smoking shows a similar picture to the Place and ICB for recording of smoking status.
- A higher proportion of patients have been offered treatment for smoking compared to ICB and place.
- The table to the right gives detail by condition of the opportunity for further recording of smoking status. This shows the position in January. The latest position can be found on https://app.ardensmanager.com/login

	ECF 2023-24 - Condition Section Under Smoker, Smoking Status, and Smoking Status Recorded - as of Jan. 2024					
	Pre-Diabetes		Diabetes		Atrial Fibrillation	
Practices	Remaining % of Population with a Smoking status	Smoking Available Patients - Number	Remaining % of Population with a Smoking status	Smoking Available Patients - Number	Remaining % of Population with a Smoking status	Smoking Available Patients - Number
Abbotswood Medical Centre	32%	421	20%	335	0%	4
Sheepcot Medical Centre	36%	783	23%	758	0%	6
Vine House Health Centre	42%	1181	23%	767	0%	15







Hertfordshire and West Essex Integrated Care System

* with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses

Source: Link: QOF Data Set & ECF Jan. 2024

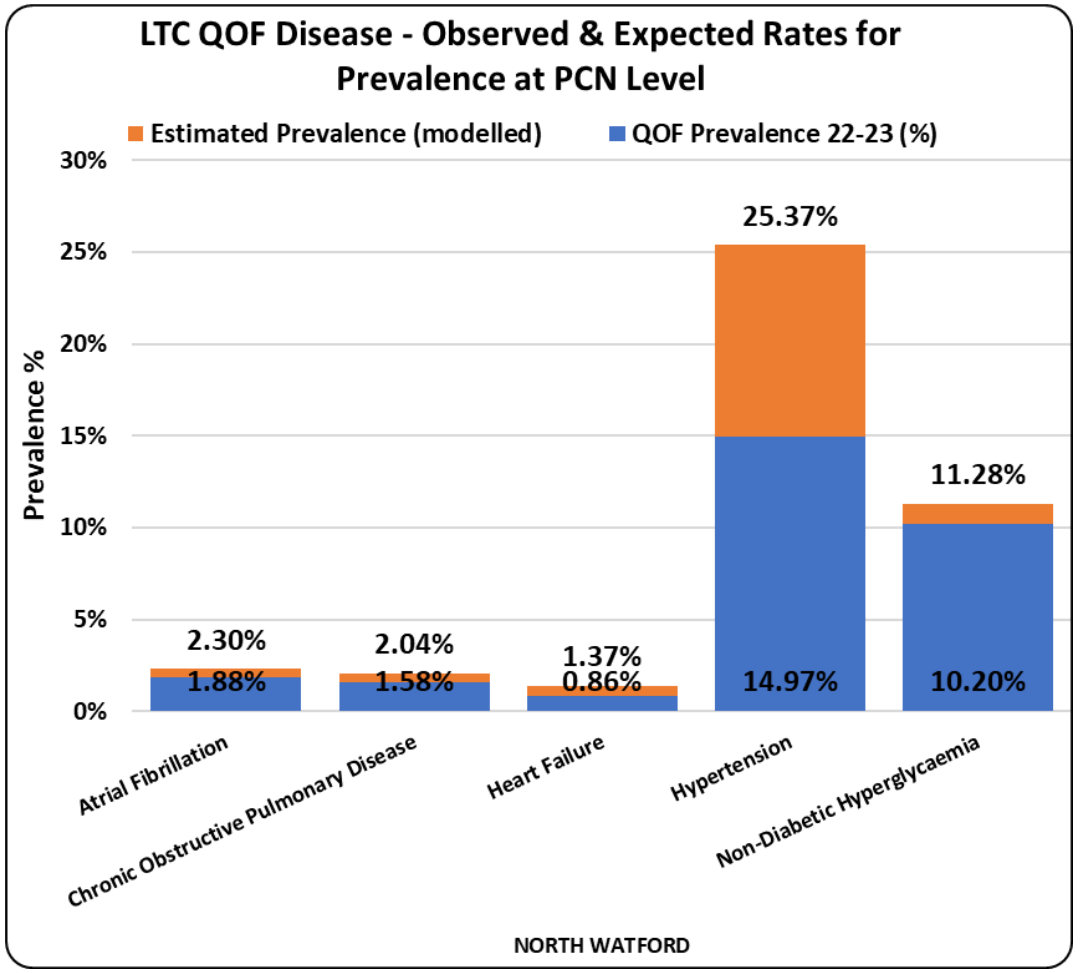
Prevention and health inequalities
Early Identification: Expected vs observed prevalence

LTC Outcome – Proportion of people with a long-term condition who feel able to manage their condition → **ICB overarching outcome of reduce the proportion of people living with advanced disease and complexity**

The data on here shows the national modelled estimated prevalence for the PCN compared with the latest published QOF prevalence for the PCN.

- North Watford PCN recorded prevalence compared with the modelled estimated prevalence for the PCN is lower across all conditions.
- The data shows an opportunity for further identification for these conditions. Case finding searches can be found within the Ardens Suite of searches: https://app.ardensmanager.com/login

Disease/ Condition	Disease Detection Modelling for North Watford PCN - No. of New Diagnoses to Meet ICS & PLACE Rates - 2023/24	
	Number to meet ICS rate	Number to meet PLACE rate
Asthma	1572	12
Atrial Fibrillation	8	71
Chronic Kidney Disease	721	129
Chronic Obstructive Pulmonary Disease		
Coronary Heart Disease	726	25
Diabetes Mellitus		
Epilepsy	150	4
Heart Failure		5
Hypertension	3699	
Non-Diabetic Hyperglycaemia		
Peripheral Arterial Disease	116	
Stroke and Transient Ischaemic Attack	440	19



Hertfordshire and West Essex Integrated Care System

Source: HWE PHM & Public Health Team, Fingertips & NHS Digital QOF Data Sets Link: QOF Data Set & Fingertips Data Set Example of Methodology in Estimating Prevalence: Fingertips & *Fingertips

Development of more proactive, preventative care models for LTC - Prevalence

LTC Outcome – Reduce the proportion of people with a long-term condition who are in the advanced disease & complexity or frailty & end of life segments → ICB overarching outcome of reduce the proportion of people living with advanced disease and complexity

- Following the expected and observed prevalence modelling in the previous slide, where there are opportunities for further identification, this slide looks at the recorded prevalence by practice for the PCN compared with Place and ICB.
- Following the expected and observed prevalence modelling in the previous slide, where there are opportunities for further identification, this slide looks at the recorded prevalence by practice for the PCN compared with Place and ICB.
- For LTCs, QOF and ECF data can help us understand areas of opportunity for improving outcomes for our population living with LTCs.

QOF Disease/ Condition	QOF 22-23 - ICB %	QOF 22-23 - PLACE %	QOF 22-23 - PCN %	North Watford PCN - Long-Term Conditions 2022-23 QOF Prevalence, with 3 Year Trend.					
				VINE HOUSE HEALTH CENTRE		SHEEPCOT MEDICAL CENTRE		ABBOTSWOOD MEDICAL CENTRE	
				QOF 2022-23	3 Year Trend	QOF 2022-23	3 Year Trend	QOF 2022-23	3 Year Trend
Asthma	6.16%	5.84%	6.38%	6.64%		6.86%		5.62%	
Atrial fibrillation	2.09%	2.01%	1.88%	2.61%		1.63%		1.40%	
Chronic kidney disease	3.46%	3.84%	4.80%	7.36%		2.30%		4.72%	
Chronic obstructive pulmonary disease (COPD)	1.49%	1.39%	1.58%	1.89%		1.45%		1.40%	
Diabetes mellitus	6.63%	6.56%	7.60%	7.31%		8.00%		7.48%	
Epilepsy	0.70%	0.70%	0.80%	0.78%		0.65%		0.97%	
Heart Failure	0.80%	0.72%	0.86%	1.16%		0.81%		0.61%	
Hypertension	13.84%	13.36%	14.97%	17.39%		13.95%		13.58%	
Non-diabetic hyperglycaemia	6.42%	7.43%	10.20%	12.26%		8.13%		10.22%	
Peripheral arterial disease	0.44%	0.41%	0.51%	0.51%		0.47%		0.54%	
Secondary prevention of coronary heart disease	2.67%	2.62%	2.80%	3.38%		2.96%		2.07%	
Stroke and transient ischaemic attack	1.63%	1.53%	1.56%	1.97%		1.59%		1.13%	

Hertfordshire and West Essex Integrated Care System

Source: HWE PHM & Public Health Team, Fingertips & NHS Digital QOF Data Sets Link: QOF Data Set & Fingertips Data Set Example of Methodology in Estimating Prevalence: Fingertips

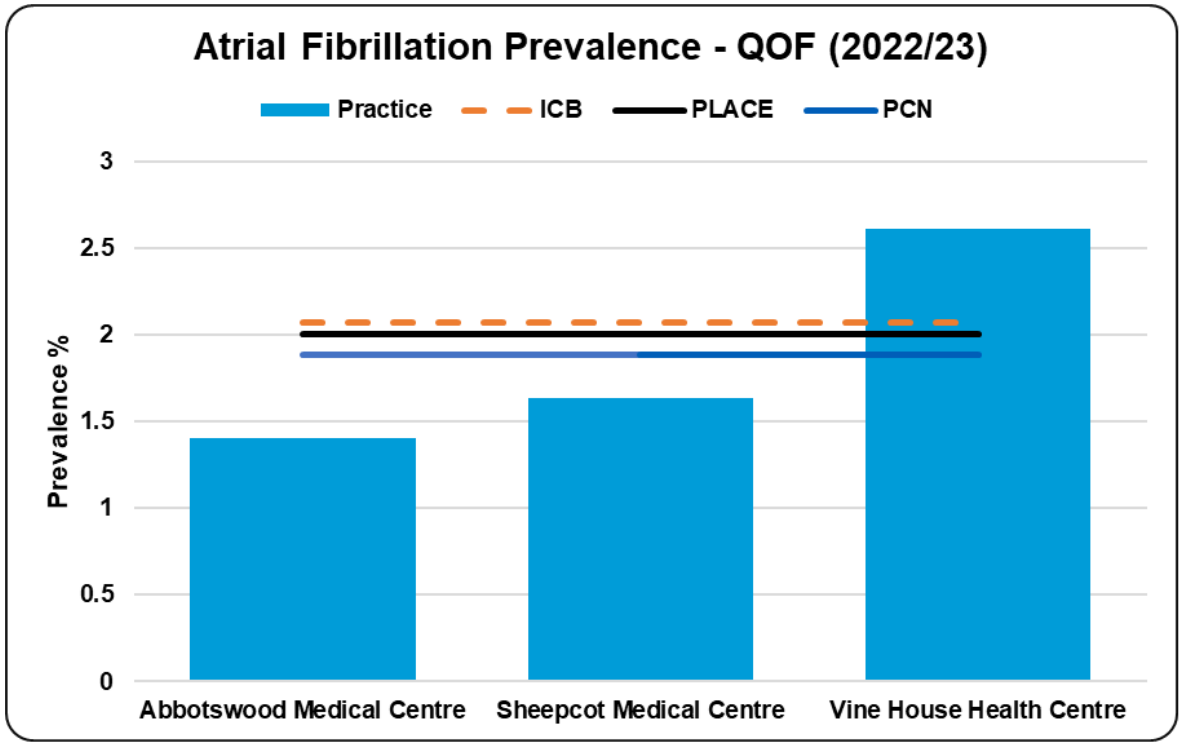
Development of more proactive, preventative care models for LTC : Annual Reviews

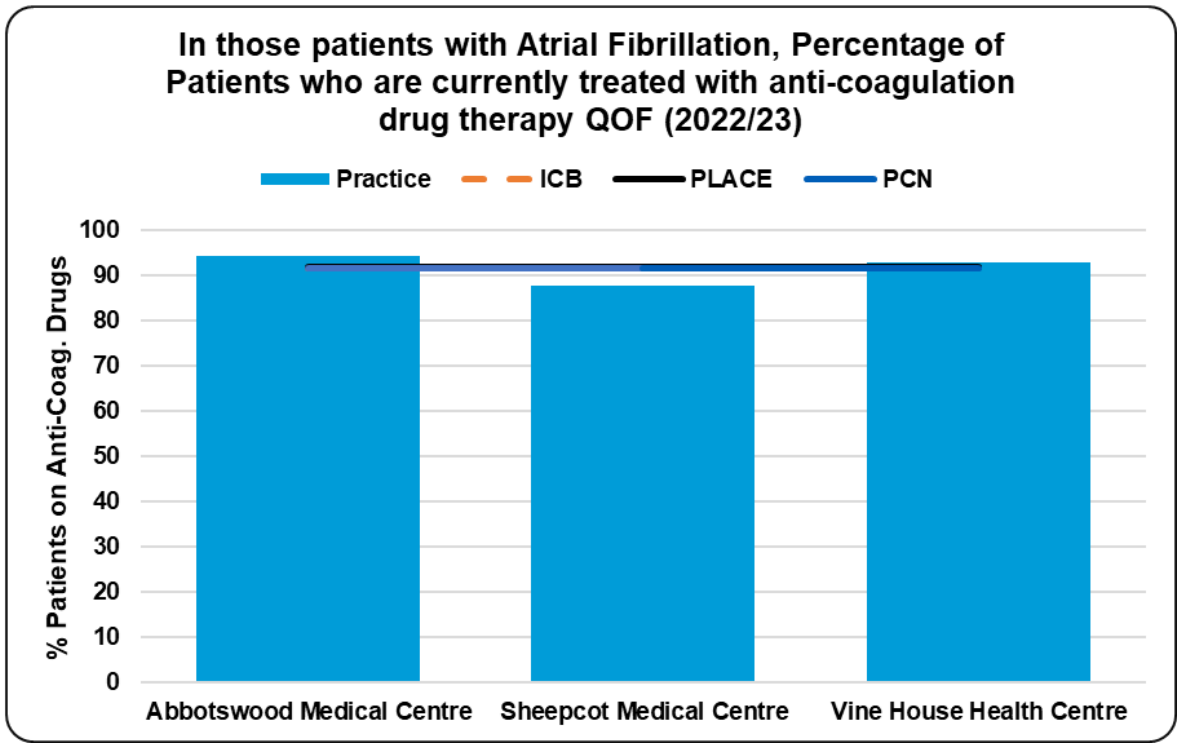
- The table on the right shows a summary of the percentage of patients receiving an annual review or risk assessment by condition.
- Where the cell is highlighted, the percentage is lower than the place value.
- The data shows that all practices have lower percentages for asthma and diabetes compared with place and ICB.
- North Watford PCN shows a higher percentage of patients with a recording of blood pressure than Place and ICB.
- The source of data in this table is QOF national reporting. More detailed information with the latest position is available to practices via https://app.ardensmanager.com/login

	ICB	SWH	North Watford PCN	Abbotswood Medical Centre	Sheepcot Medical Centre	Vine House Health Centre
% of AF Patients with Stroke Risk Assessed in the last 12 months	92.9	94.2	**92.2**	95.7	**81.1**	96.3
The % of patients aged 45 or over who have a record of blood pressure in the preceding 5 years	85.7	85.1	86.7	85.9	85.7	87.8
The % of patients with a diagnosis of heart failure on the register, who have had a review in the preceding 12 months	72.7	80.0	**53.6**	82.8	**46.6**	**51.9**
The % of patients with asthma, on the register, who have had an asthma review in the preceding 12 months	64.0	64.1	**56.1**	**54.0**	**59.9**	**53.0**
The % of patients with COPD, on the register, who have had a review in the preceding 12 months	75.7	75.3	**61.5**	76.1	**69.6**	**51.2**
The % of patients with diabetes, on the register, with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 12 months	75.5	76.1	**68.2**	**56.4**	**74.5**	**66.7**
The % of patients with non-diabetic hyperglycaemia who have had an HbA1c or fasting blood glucose performed in the preceding 12 months.	82.9	84.0	85.2	**77.6**	89.7	85.0

Prevention and health inequalities – Atrial Fibrillation

- North Watford PCN recorded prevalence for Atrial Fibrillation is lower than both Place and the ICB prevalence.
- Once identified the percentage of patients currently treated with anti-coagulant drug therapy is similar to the Place and ICB.
- The data suggests there is potential opportunity for identification of people with AF. Case finding Ardens searches are detailed within https://app.ardensmanager.com/login



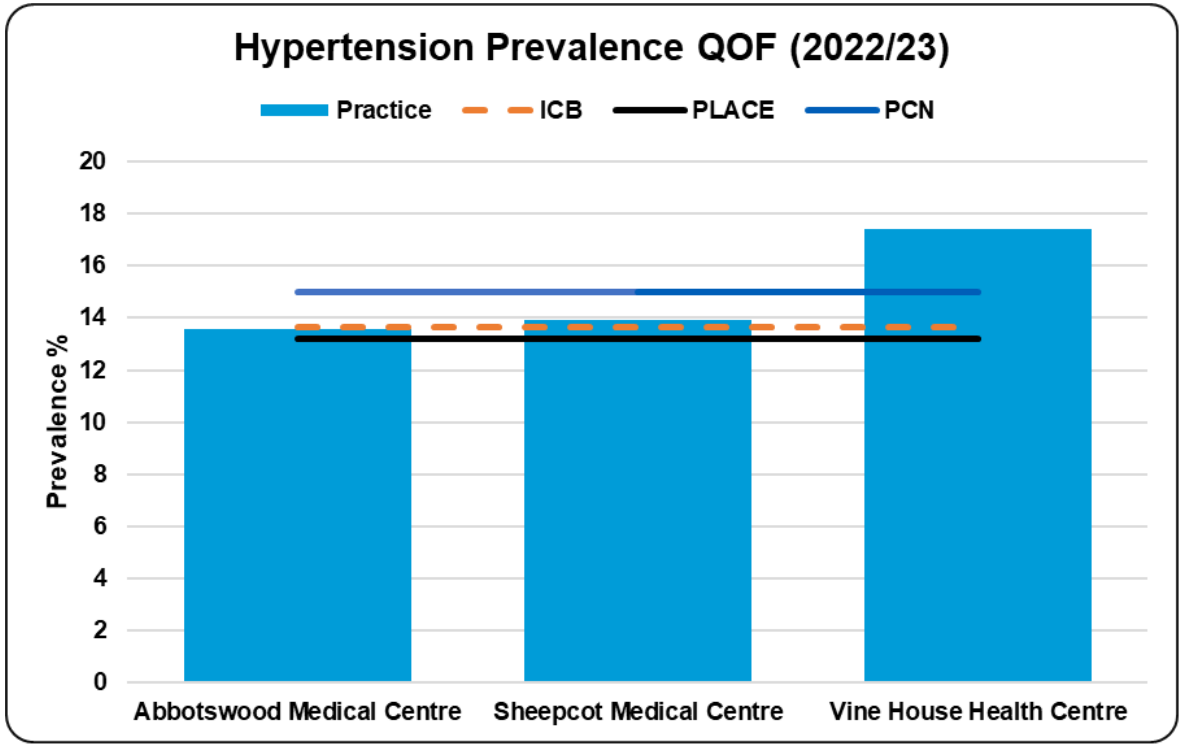


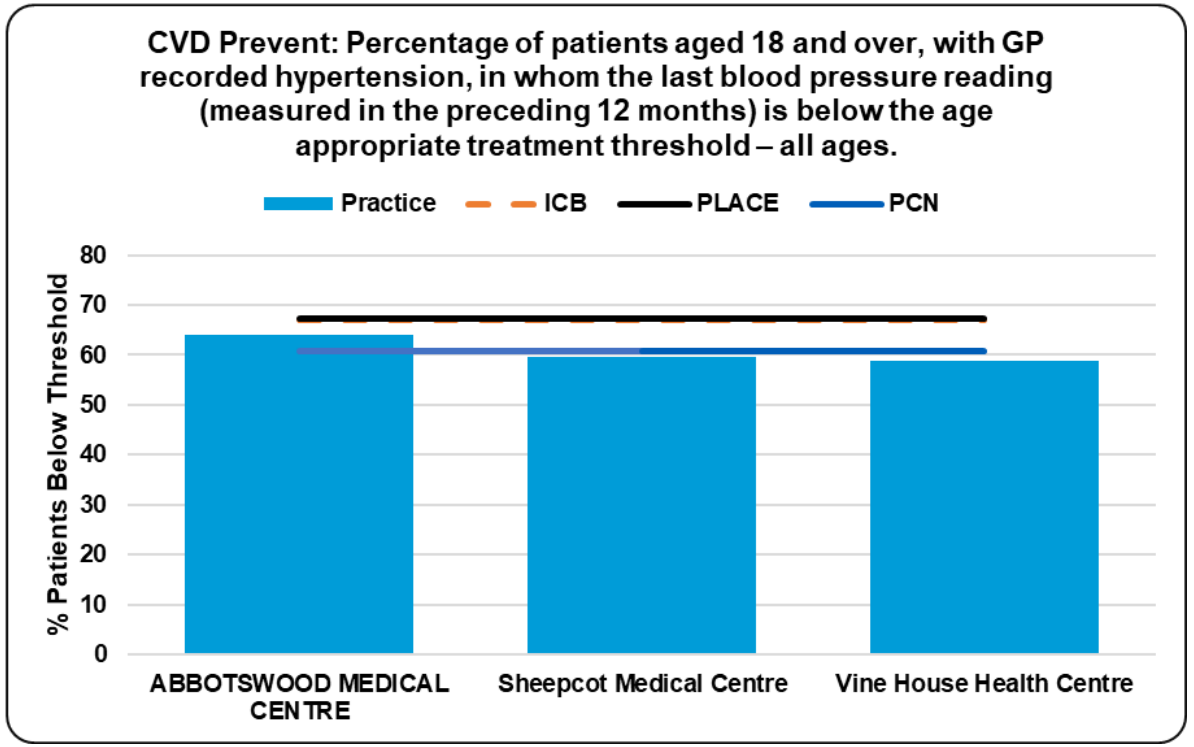
Hertfordshire and West Essex Integrated Care System

Source: NHS Digital QOF Data Sets Link: QOF Data Set

Prevention and health inequalities – Hypertension

- North Watford PCN recorded prevalence for hypertension is higher than both Place and the ICB prevalence.
- Once identified the data shows the percentage of patients in whom the latest BP reading is below the age-appropriate treatment threshold is lower than Place and ICB.
- The latest hypertension indicators are detailed within https://app.ardensmanager.com/login





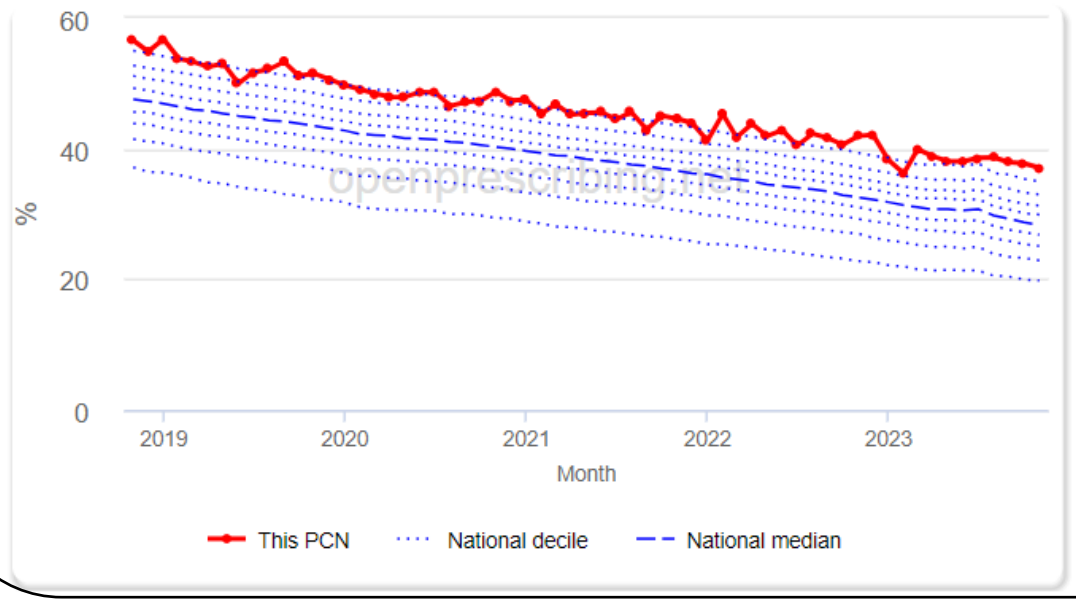
Hertfordshire and West Essex Integrated Care System

Source: NHS Digital QOF Data Sets Link: QOF Data Set & CVD Prevent Data Sets Link: CVD Prevent Data Explorer

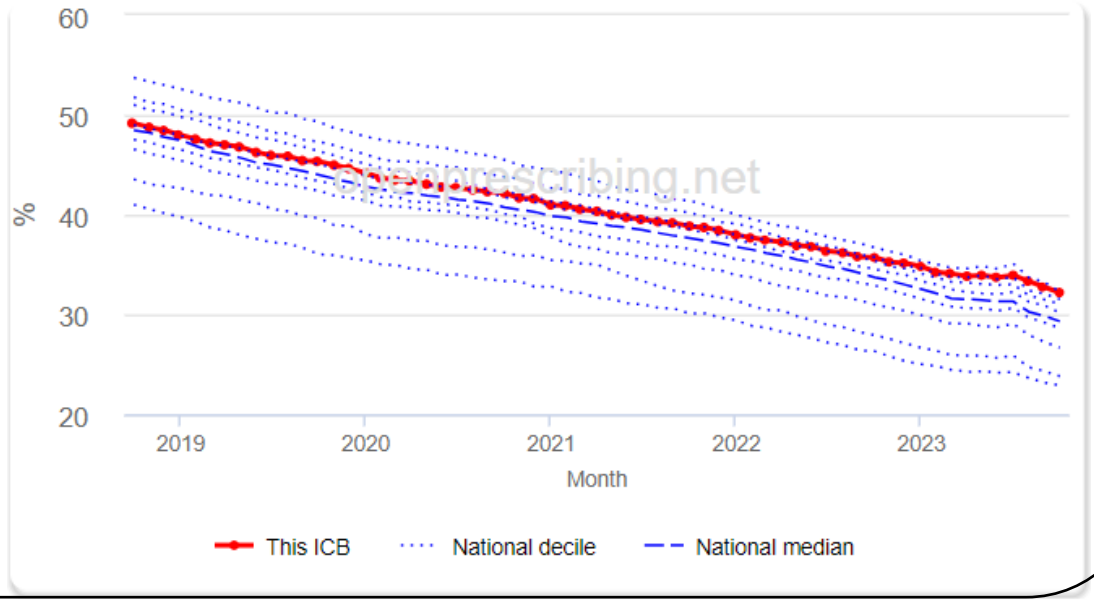
Lipid management : Percentage of people on lipid lowering therapy for secondary prevention who are on high intensity statins

- National lipid management pathways (Link to guidance) recommend the use of high intensity statins for all people with a history of Cardiovascular disease as well as where high dose statins are needed to control cholesterol. People on high intensity statins will see a greater reduction in c-LDL levels and reduce the risk of cardiovascular events.
- Data from OpenPrescribing provides information on the proportion of people who are on statins that are currently prescribed low or medium intensity doses. The ICS is a positive outlier in this area, with a high proportion of people on a high intensity statin.
- The data for North Watford PCN shows that there is an opportunity to improve statin treatment, prescribing a higher proportion of people onto high intensity statins. The PCN is in the 96th percentile with 37.1% of people not on high intensity statins. This compares to 28.3% nationally.

PCN – Items of Low and Medium Intensity Statins as a Percentage of Items of All Statins by Year



ICB – Items of Low and Medium Intensity Statins as a Percentage of Items of All Statins by Year

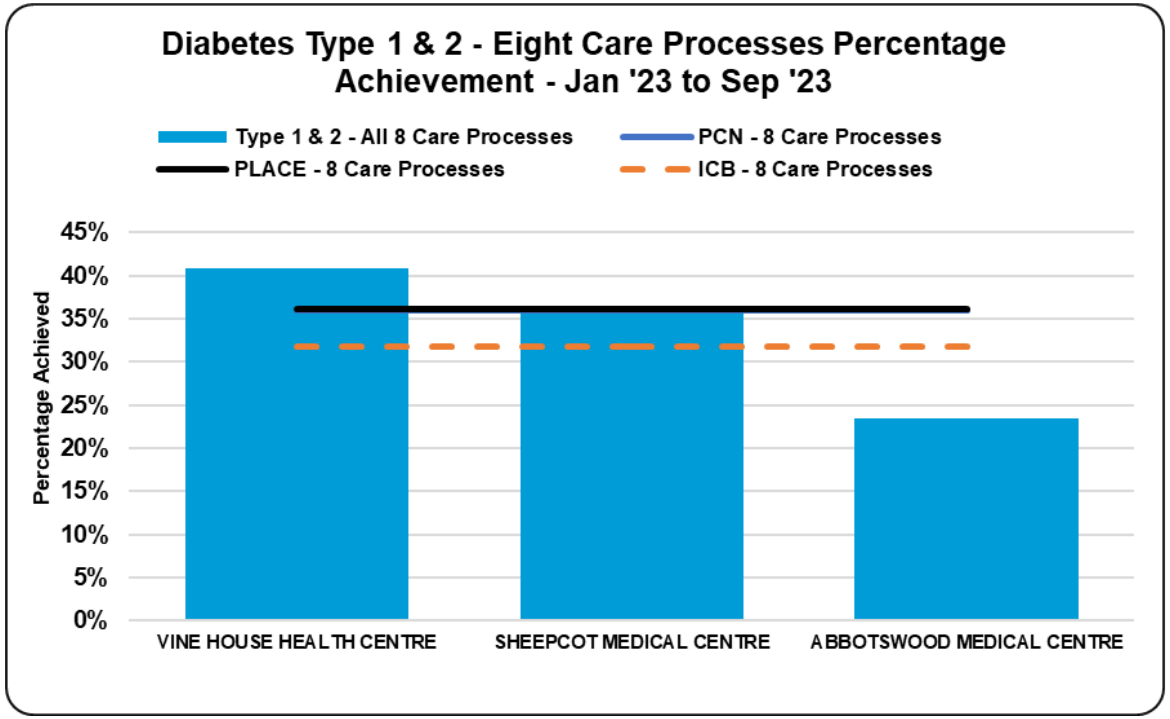


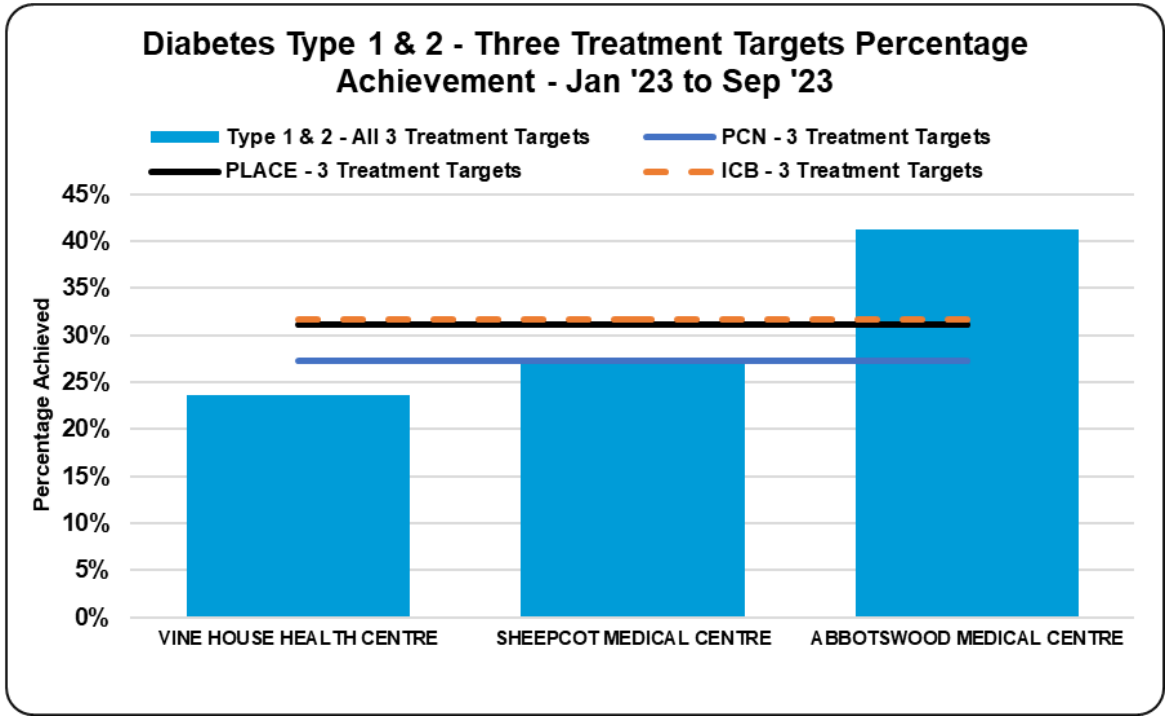
Hertfordshire and West Essex Integrated Care System

Source: OpenPrescribing.net – Link Here

Development of more proactive, preventative care models for LTC : 8 Care Processes & 3 treatment targets (all diabetes type 1 & 2)

- The percentage of people living with diabetes who have received the 8 care processes in North Watford PCN is similar to place but higher than ICB. However, for the three treatment targets the PCN data shows a lower percentage than Place and ICB.
- The latest information can be found within Ardens Manager.



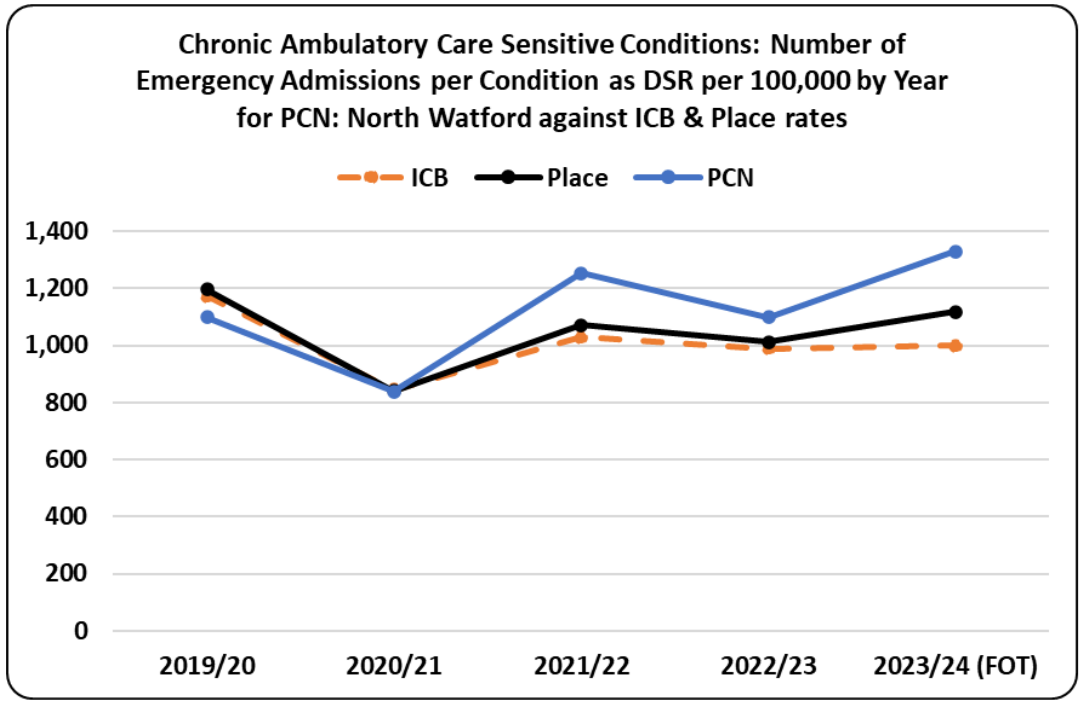


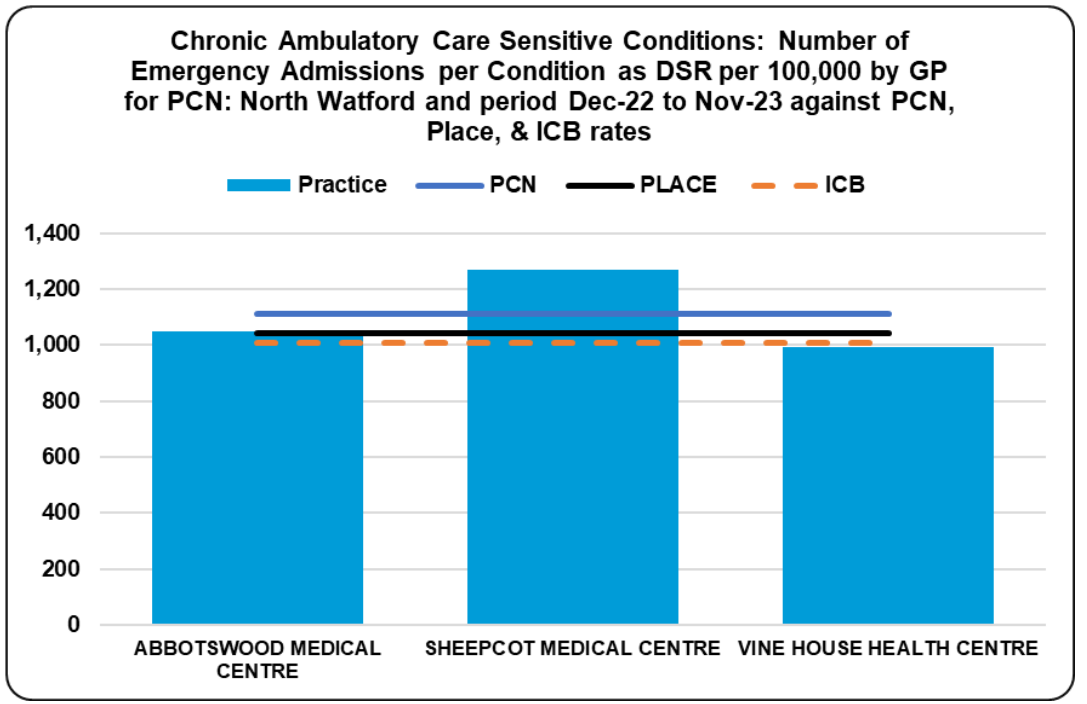
Hertfordshire and West Essex Integrated Care System

Source: National Diabetes Audit 2023-24 – Quarterly report January 2023 to September 2023, Link: NDA Quarterly Reports

Reduction in admissions rates of Chronic Ambulatory Care Sensitive (ACS) conditions

LTC Outcome – Reduce the rate of ambulatory care sensitive emergency hospital admissions → ICB overarching outcome of Reduce the rate of emergency admission for chronic ambulatory care sensitive conditions associated with LTCs





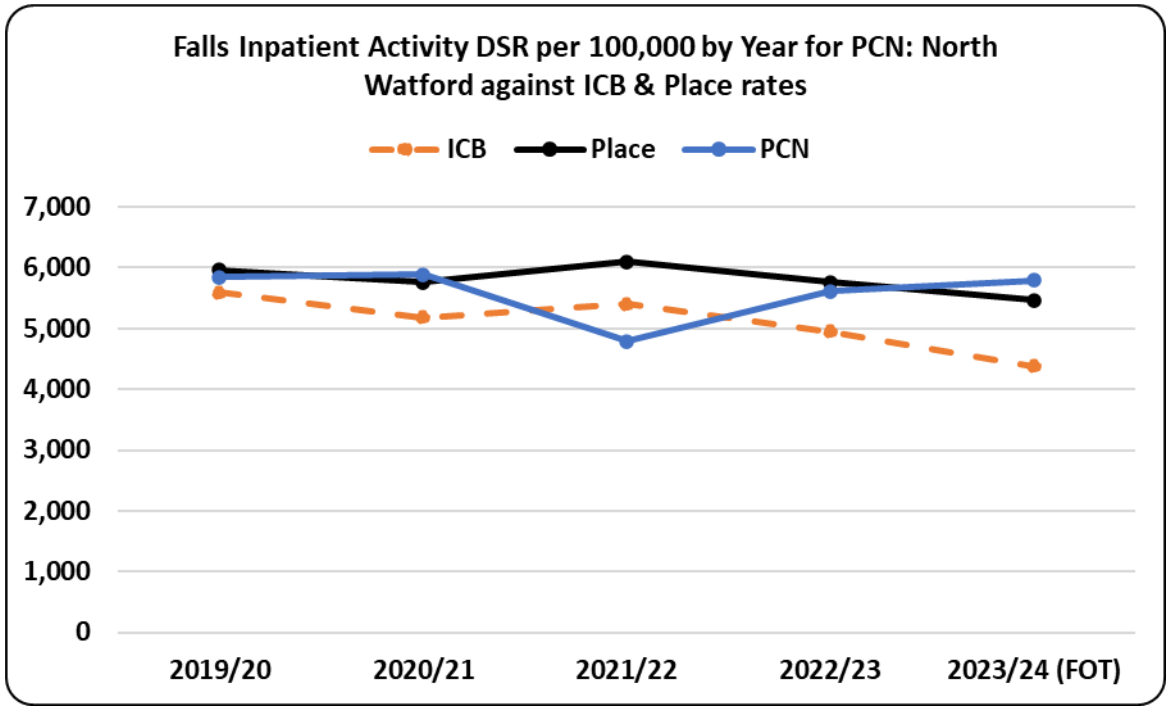
- Ambulatory care sensitive (ACS) conditions are conditions where effective community care and person-centred care can help prevent the need for hospital admission. (Nuffield Trust)
- North Watford PCN's admission rate for Chronic ACS conditions is higher than the ICB and Place rate when looking at the 12 months data up to November 2023.
- Atrial Fibrillation and flutter, Congestive heart failure and Diseases of the blood (includes diabetes), are the conditions with the highest volume and are also showing an upward trend.
- The data on page 11 looking at observed versus expected prevalence shows an opportunity for further identification.

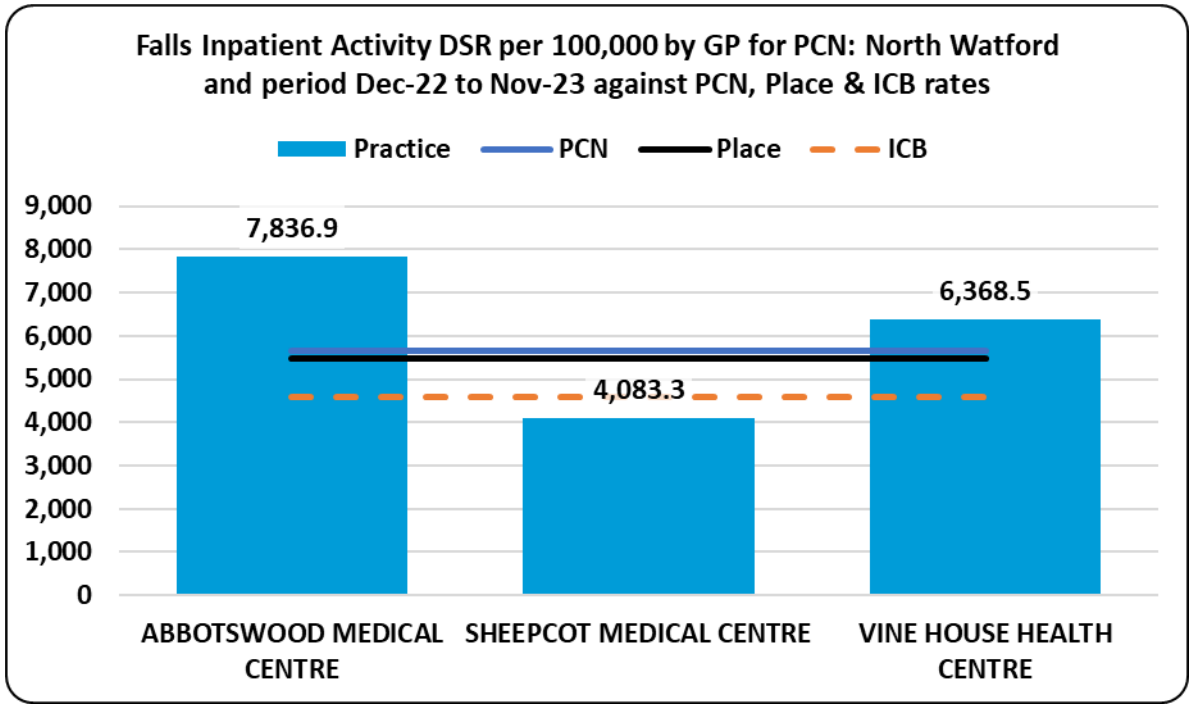
Chronic Ambulatory Care Sensitive Conditions for North Watford PCN	PCN Per 100,000 Rate Apr-23 to Nov-23	5 Year Trend	2024/25 Trajectory
Angina: Angina pectoris	32.60		UP
Asthma	87.99		UP
Atrial fibrillation and flutter	202.14		UP
COPD	133.92		UP
Congestive heart failure	204.32		UP
Diseases of the blood	382.31		UP
Epilepsy	35.73		DOWN
Hypertension	101.29		UP
Mental and behavioural disorders	5.75		UP
Nutritional, endocrine and metabolic	143.43		UP

Emergency Admission rates for Falls in persons aged +75

Frailty and EoL Outcome – Decrease rates of +75s emergency admissions for falls within the community → **ICB overarching outcome of Reduce the overall spend on emergency hospital admissions**

- When looking at the rolling 12 months up to November 2023 the data shows that North Watford PCN has a slightly higher rate of admissions for falls than Place and ICB.
- There is variation in the data for the practices within the PCN.
- Data in the following pages shows the data for the PCN compared with Place and PCN for areas within the ECF that aim to support reducing falls. Frailty Clinical Leads will be able to advise on current programmes of work within your area aimed at reducing falls.





Hertfordshire and West Essex Integrated Care System

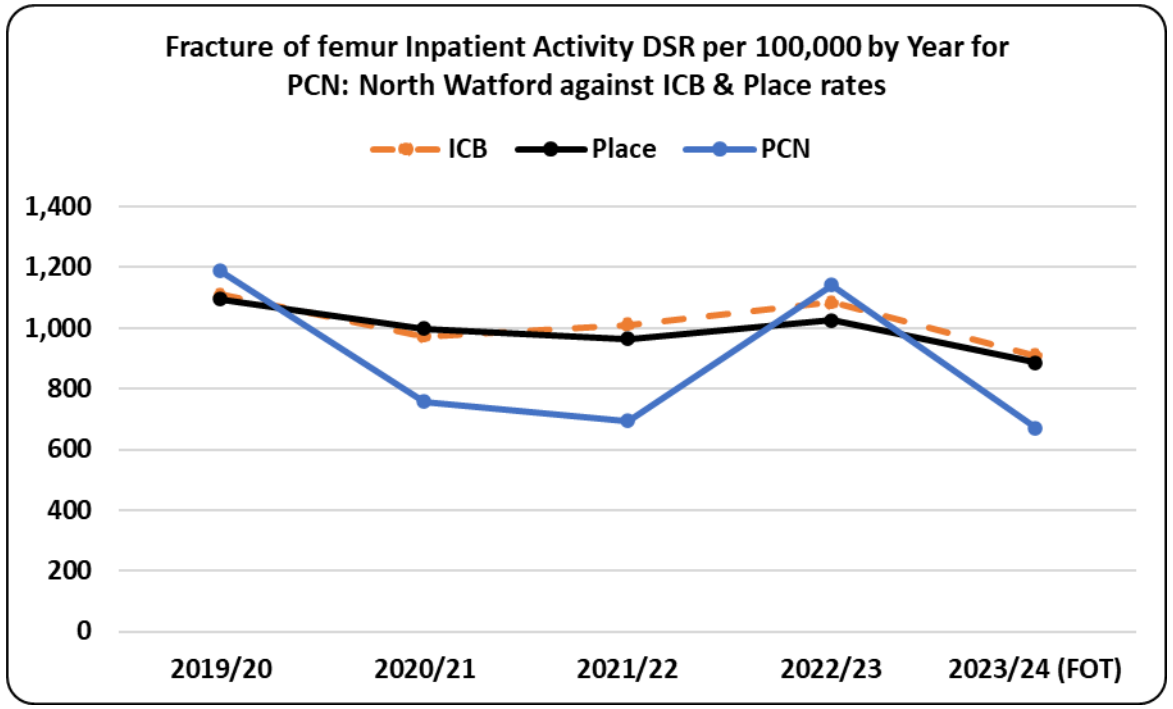
Source: SUS

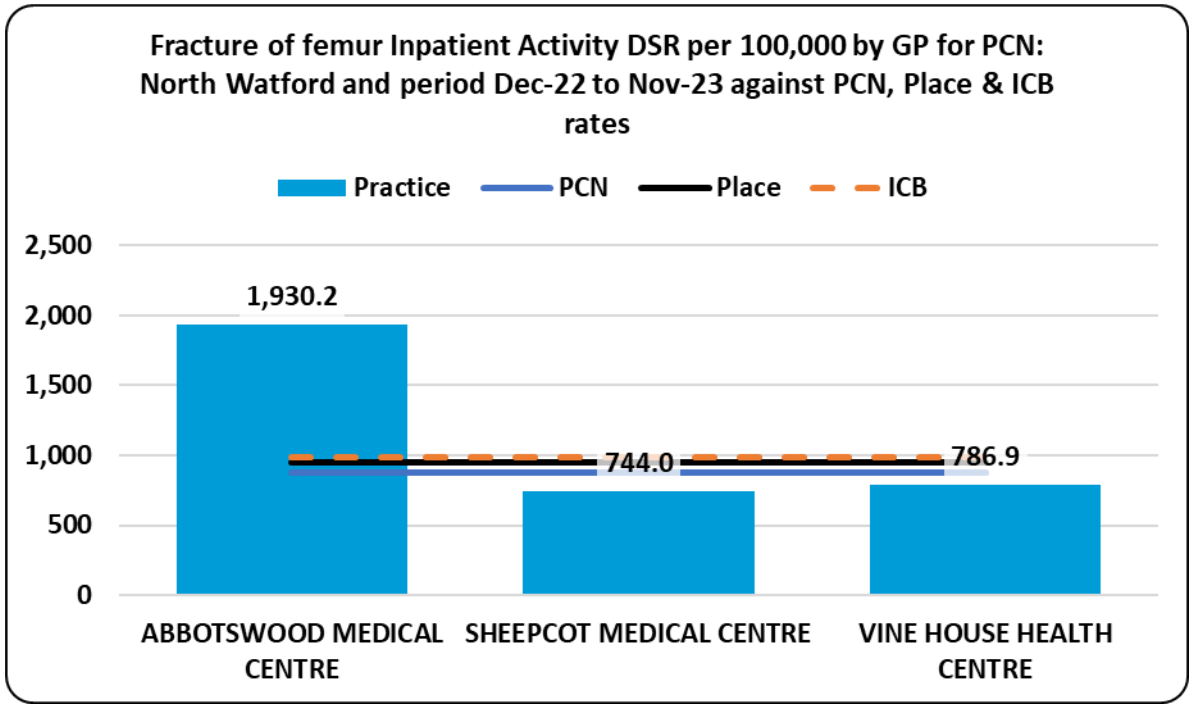
Emergency admission rates for Hip fractures in all over 75's

Frailty and EoL Outcome – Decrease rates of +75s emergency admissions for falls within the community

ICB overarching outcome of Reduce the overall spend on emergency hospital admissions

- The 12 months data up to November 2023 the data shows that North Watford PCN has a lower rate of admissions for hip fractures than Place and ICB.
- When looking at the data by PCN the small numbers will cause fluctuations over the years. The latest trend data shows a fall for the latest year against last year.
- The ECF indicators on the next page shows potential areas of opportunity through benchmarking the PCN against Place and ICB.





Hertfordshire and West Essex Integrated Care System

Source: SUS

ECF indicators for frailty and EOL

- The data shows that North Watford PCN has a lower percentage of falls frat scores completed, when compared to Place and ICB.
- The percentage of the population recorded as moderately or severely frail is higher than place and ICB.
- The data contained within the table below is up to the end of December, the latest position can be found at Ardens Manager.

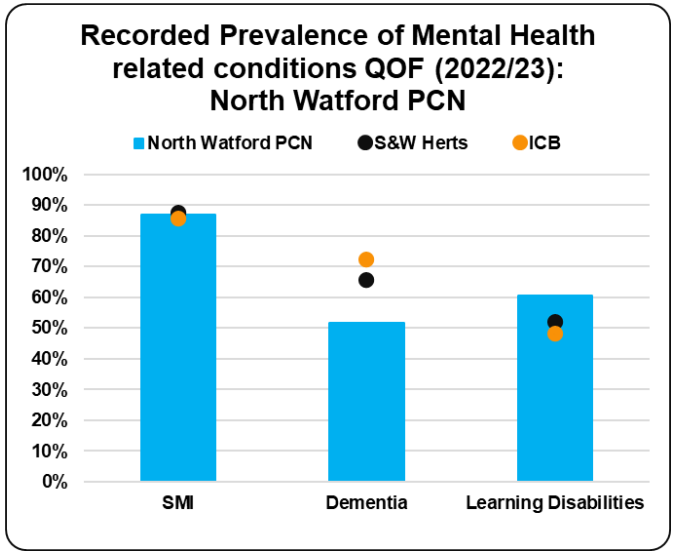
North Watford Enhanced Commissiong Framework (ECF) 2023-24 for the period 1 April 23 to 31 Dec 23

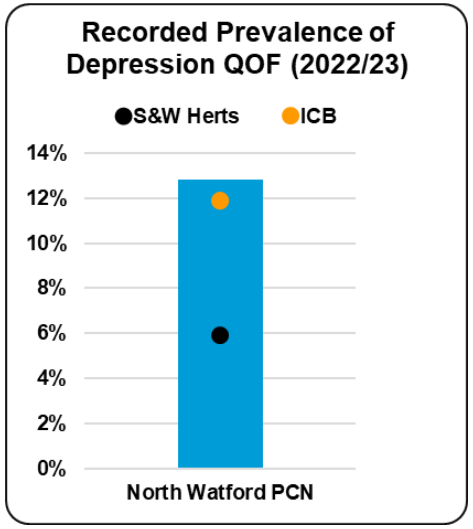
	Frailty			EOL						
	Mod/Sev + falls Frat score done %	Mod frailty + SMR or polypharmacy medication review %	% Mod/Sev frailty of population	% population on EOL register	GSF %	DNACPR %	ACP %	PPD %	PPC %	SCR Consent %
ICB	16.0%	19.5%	1.9%	0.7%	64.9%	53.3%	11.3%	37.3%	39.8%	34.8%
SWH	15.9%	24.1%	1.9%	0.5%	42.8%	57.7%	18.6%	43.1%	44.2%	2.2%
PCN	4.9%	9.8%	2.6%	0.3%	19.3%	64.8%	15.9%	33.0%	40.9%	0.0%
Abbotswood Medical Centre	0.0%	23.5%	2.0%	0.2%	0.0%	66.7%	11.1%	11.1%	33.3%	0.0%
Sheepcot Medical Centre	0.5%	6.9%	4.0%	0.2%	0.0%	63.0%	7.4%	25.9%	25.9%	0.0%
Vine House Health Centre	19.8%	9.8%	1.5%	0.5%	32.7%	65.4%	21.2%	40.4%	50.0%	0.0%

Prevalence of mental health conditions (QOF)

ICB overarching outcome of Improving Healthy life expectancy

- The data on this page looks at the recorded prevalence of conditions within the Mental Health section of QOF. It shows the PCN prevalence against the place and ICB. Future iterations will include comparisons against modelled expected prevalence.
- The data shows that North Watford PCN has a lower recorded prevalence for Dementia which may indicate an opportunity for further identification.
- The table below shows the trend over the last three years for each area.
- The following page looks at some of the wider QOF indicators around Mental Health.





North Watford PCN- Mental Health Conditions 2022-2023 QOF prevalence, with 3 year trend						
	Abbotswood Medical Centre		Sheepcot Medical Centre		Vine House Health Centre	
	QOF Prevalence 22-23	3 year Trend	QOF Prevalence 22-23	3 year Trend	QOF Prevalence 22-23	3 year Trend
Dementia	0.3%		0.6%		0.6%	
Depression	13.3%		10.5%		14.7%	
Learning Disability	0.6%		0.5%		0.7%	
SMI	1.1%		0.7%		0.7%	

Mental Health QOF Indicators 22-23

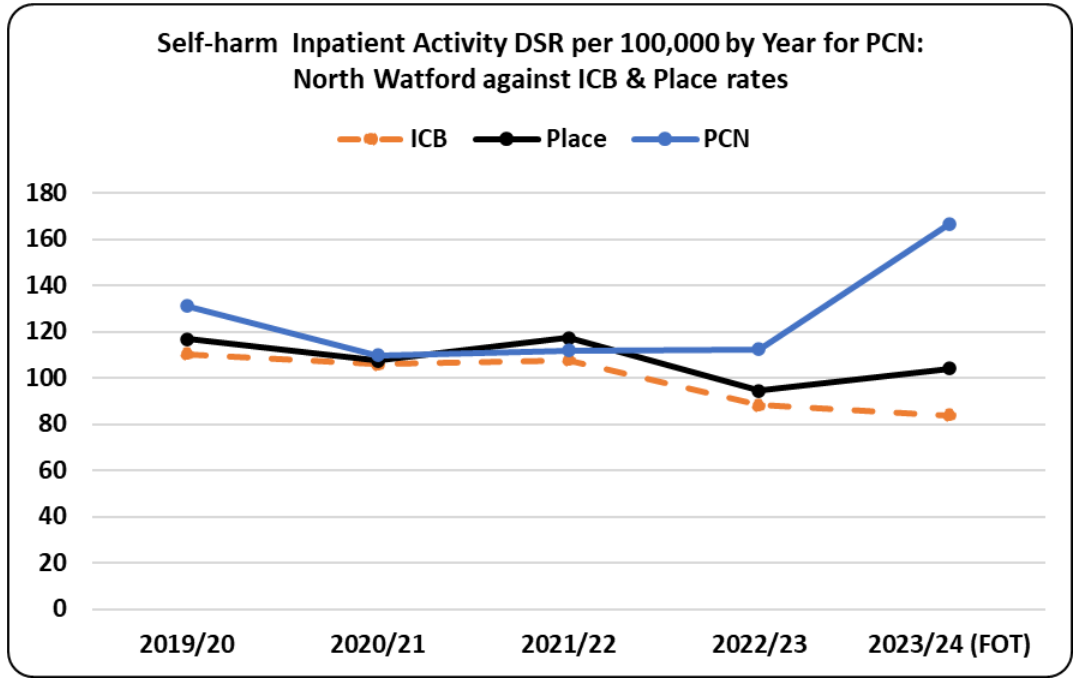
- Mental Health QOF metrics for 2022-23 show that North Watford PCN is achieving lower for metrics for SMI in comparison to Place and the ICB.
- The data contained within the table below is up to the end of December, the latest position can be found at Ardens Manager.

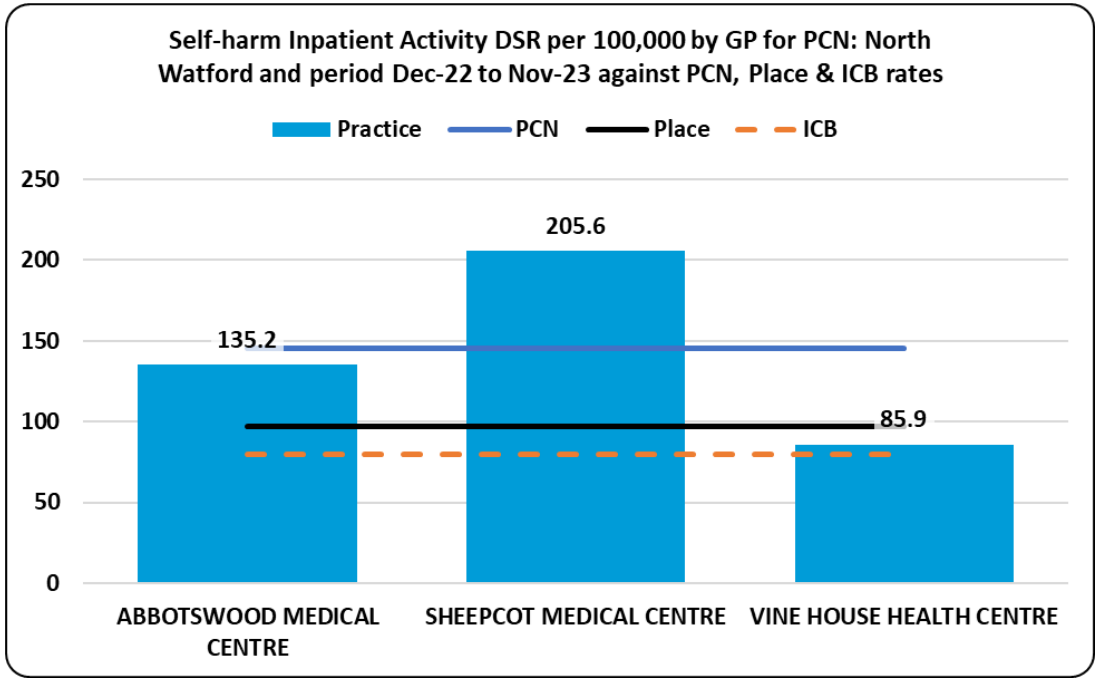
	SMI					Depression
	% of patients with SMI who have a care plan	% of patients with SMI who have a record of BMI in the preceding 12 months	% of patients with SMI who have a record of alcohol consumption in preceding 12 months	% of patients with SMI who have a record of a lipid profile in the preceding 12 months	% of patients with SMI who have a record of blood glucose of HbA1C in preceding 12 months	% of patients with a diagnosis of depression who have been reviewed within 10-56 days
ICB	82.6	88.7	89.3	83.1	83.0	83.0
SWH	87.2	90.0	90.4	84.8	84.4	84.9
North Watford PCN	81.9	86.6	97.2	83.2	80.6	88.1
Abbotswood Medical Centre	100.0	100.0	100.0	87.0	83.3	89.4
Sheepcot Medical Centre	96.4	91.4	93.8	94.4	92.6	89.2
Vine House Health Centre	67.9	77.8	98.0	74.1	72.9	86.2

Emergency Admissions Rates for Self – Harm

ICB overarching outcome of Improving Healthy life expectancy

- North Watford PCN has a higher rate of admissions for self-harm compared with both place and ICB.
- When looking at the data it should be noted that the numbers at PCN level are small and therefore more fluctuation between the years will be seen.
- The data will continue to be monitored at wider HCP and ICB footprints.





Hertfordshire and West Essex Integrated Care System

Source: SUS