Hertfordshire and West Essex Integrated Care System

PCN Insights Pack 2024

Central 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

Central 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 Central Watford PCN areas of opportunity highlighted are :

- ***Childhood obesity***
- ***Admissions for Asthma in children***
- ***Observed versus expected prevalence including hypertension***
- ***Long Term Condition Reviews***
- ***8 Care Processes for Diabetes***
- ***Admissions of ACS conditions***
- ***Admissions for falls (75+)***
- ***Admissions for sel-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 Systmone.

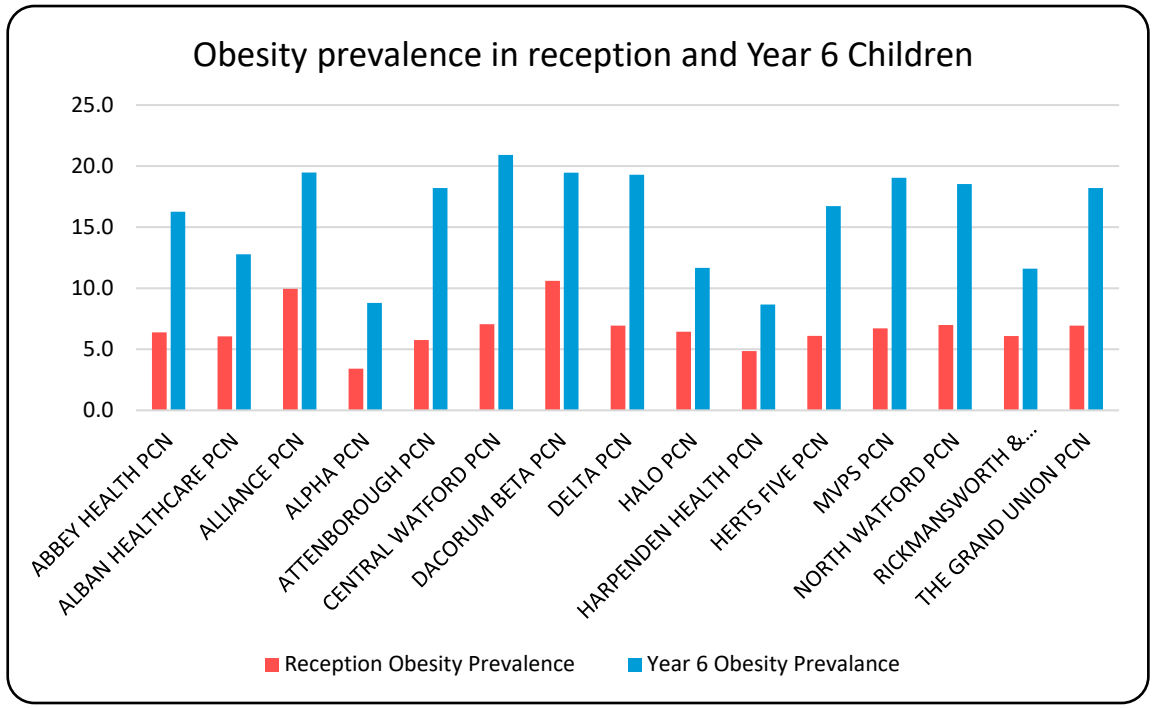
https://app.ardensmanager.com/login

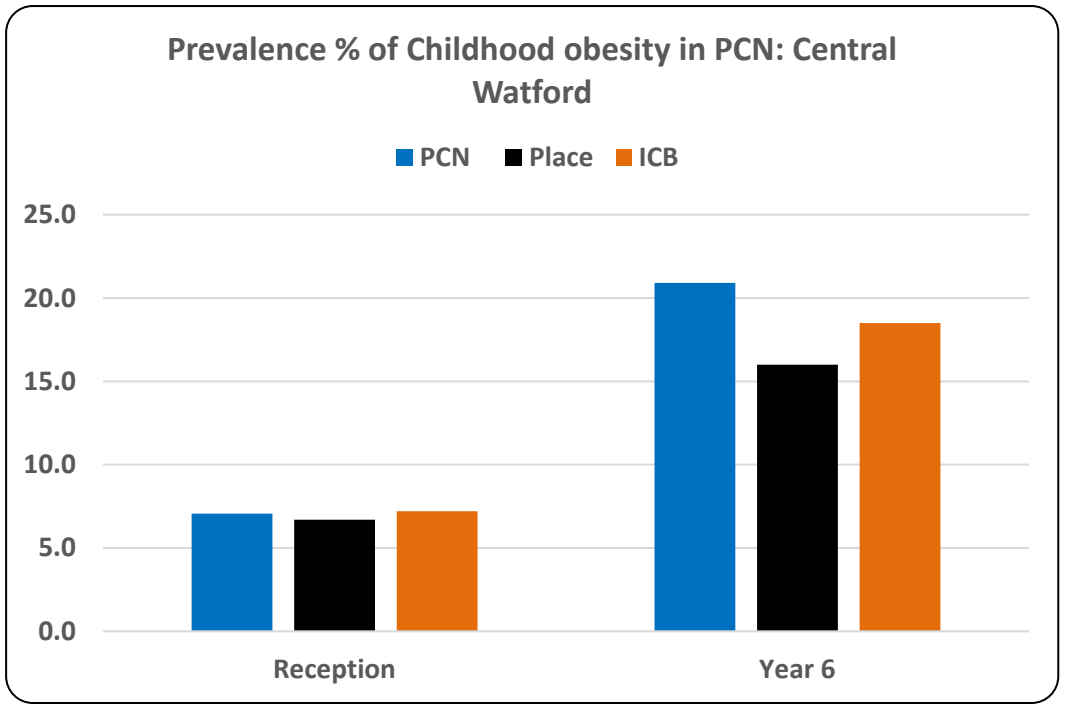
Clinical Priority	Metric	PCN compared to Place average	PCN compared to ICB average
Childhood obesity	% of children in Reception who are overweight	↑	↑
	% of children in Year 6 who are overweight	↑	↑
Reduce rates of emergency care for children and young people	A&E Attendances for Asthma (Children)	↑	↓
	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 low and medium intensity statins	↔	↔
	% of diabetics with all 8 care processes completed	↓	↓
	Admissions of 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

- Compared to the ICB and Place rate, Central Watford PCN has higher rates of Childhood Obesity for Children in Reception and year 6 compared to both place and ICB.
- In keeping with the national data, the PCN rates for Childhood Obesity are higher for year 6 in comparison to reception children.
- The data shows that there is a deterioration from reception to Year 6 in childhood obesity in the PCN position against Place and ICB.





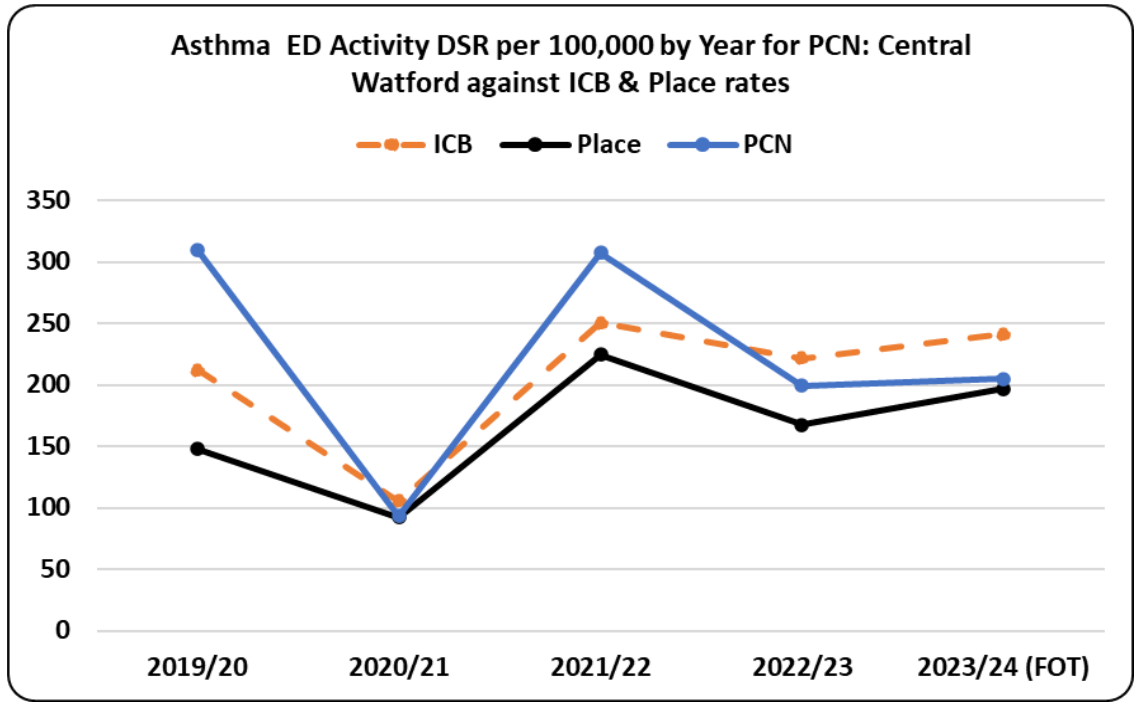
Hertfordshire and West Essex Integrated Care System

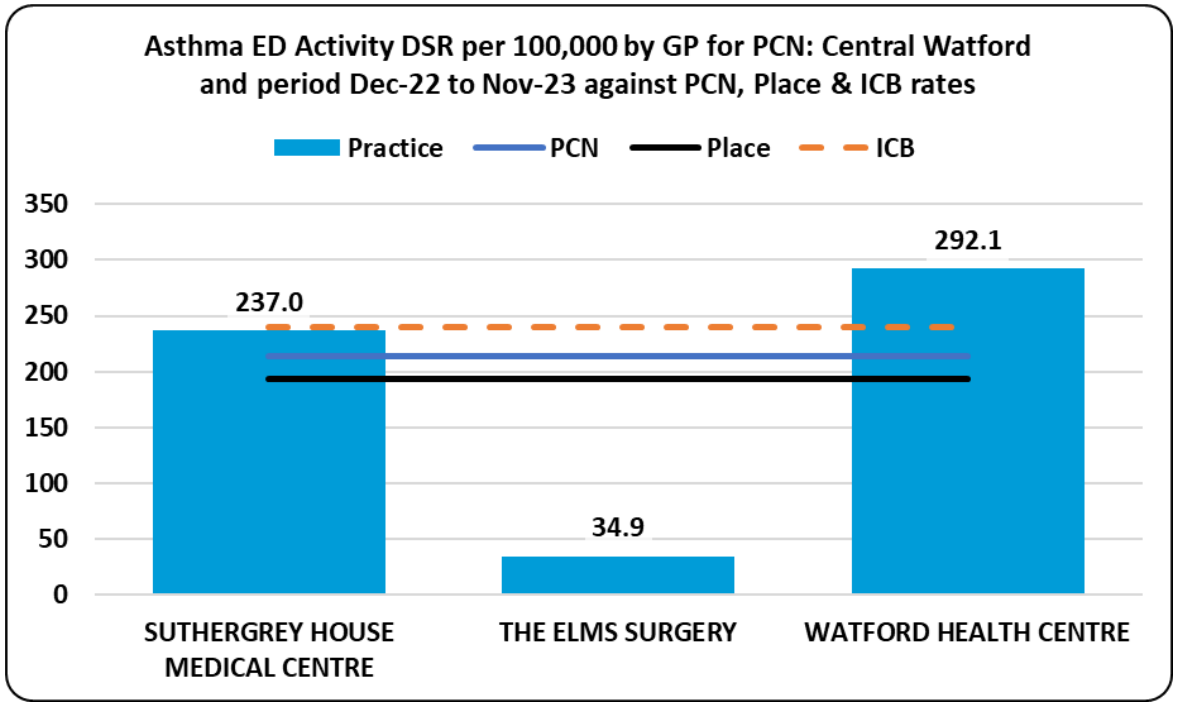
Source: NCMP and HES: 2022/23

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

- Central Watford PCN has a higher rate of A&E attendances for Children and Young People with Asthma (rolling years data on the right-hand side) compared with Place but lower than the ICB.
- 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 a similar level to the previous year.





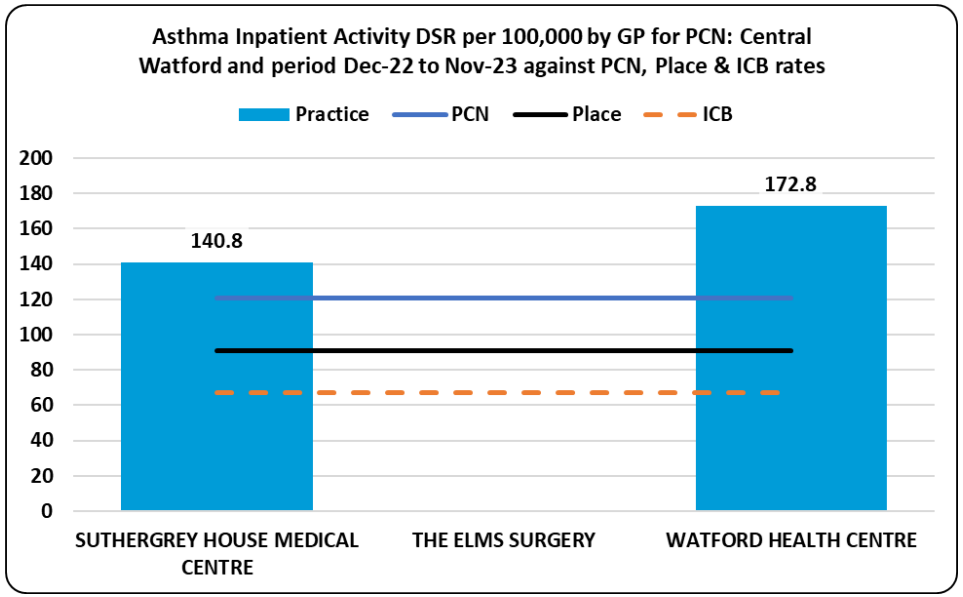
Hertfordshire and West Essex Integrated Care System

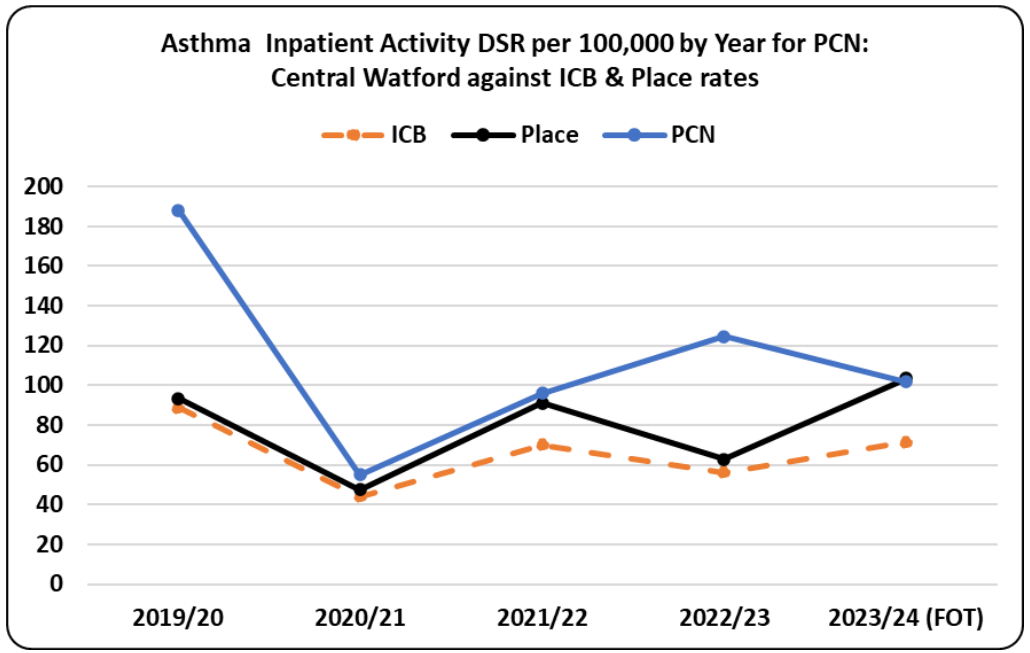
Source: SUS

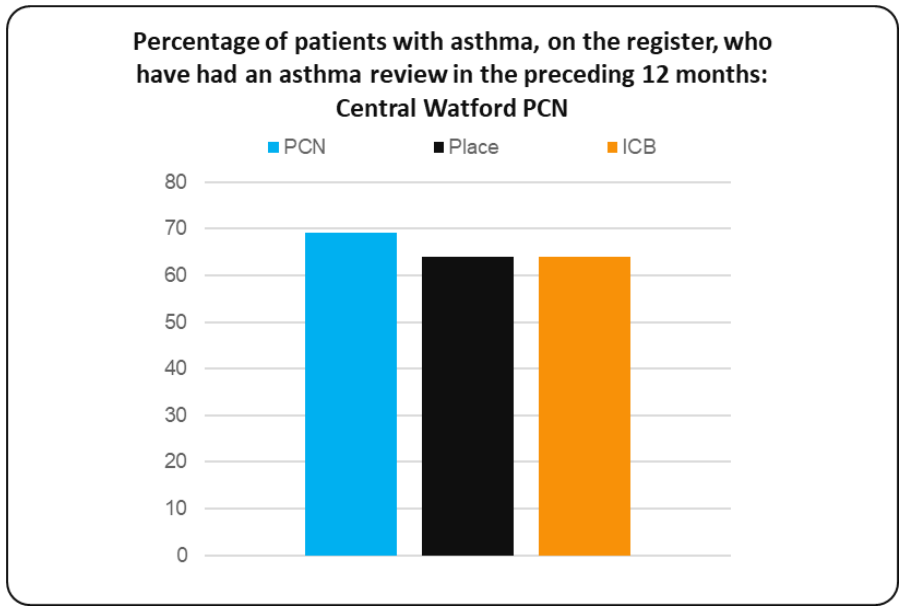
Admissions for Asthma (CYP)

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, Central Watford PCN has a higher rate of admissions for Asthma (rolling years data on the right-hand side).
- The trend data shows a higher rate of admissions for Asthma for Central Watford over the years, however the latest forecast outturn data from November shows a downward trend.
- Higher Proportion of Asthma Reviews are carried out within Central 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.
- The Children and Young Peoples programme can be contacted via hweicbenh.cypteam@nhs.net for details of current projects.





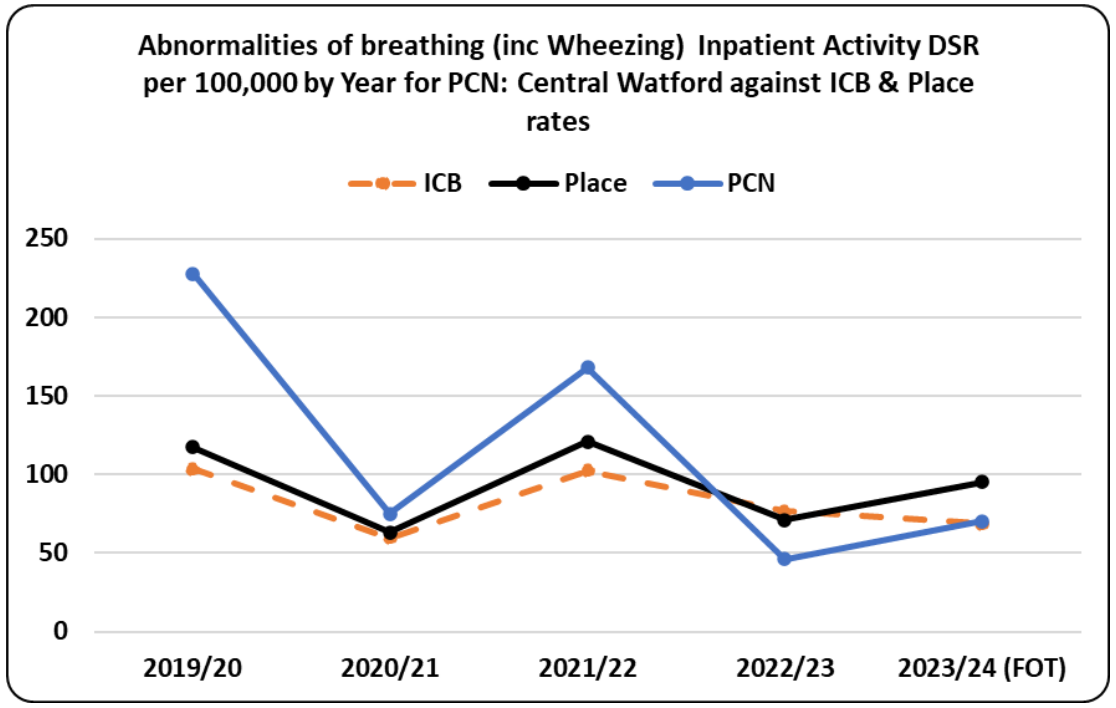


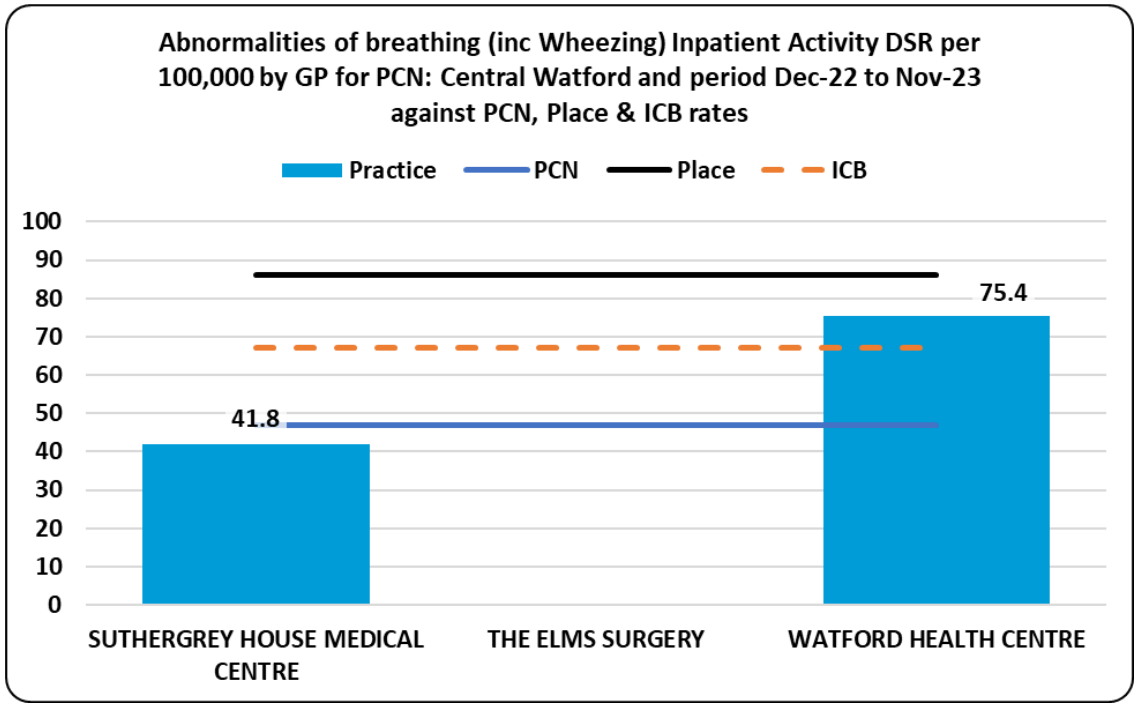
Source: SUS; QOF

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

- Central Watford PCN has a lower rate of Children and Young People admitted to hospital for abnormalities of breathing including wheeze compared to ICB and Place.
- Rates of Children and Young People admitted to Hospital for Wheeze fluctuate annually with the latest forecast outturn from November data showing an slight increase on the previous year.
- When looking at the data by practice there is variation.





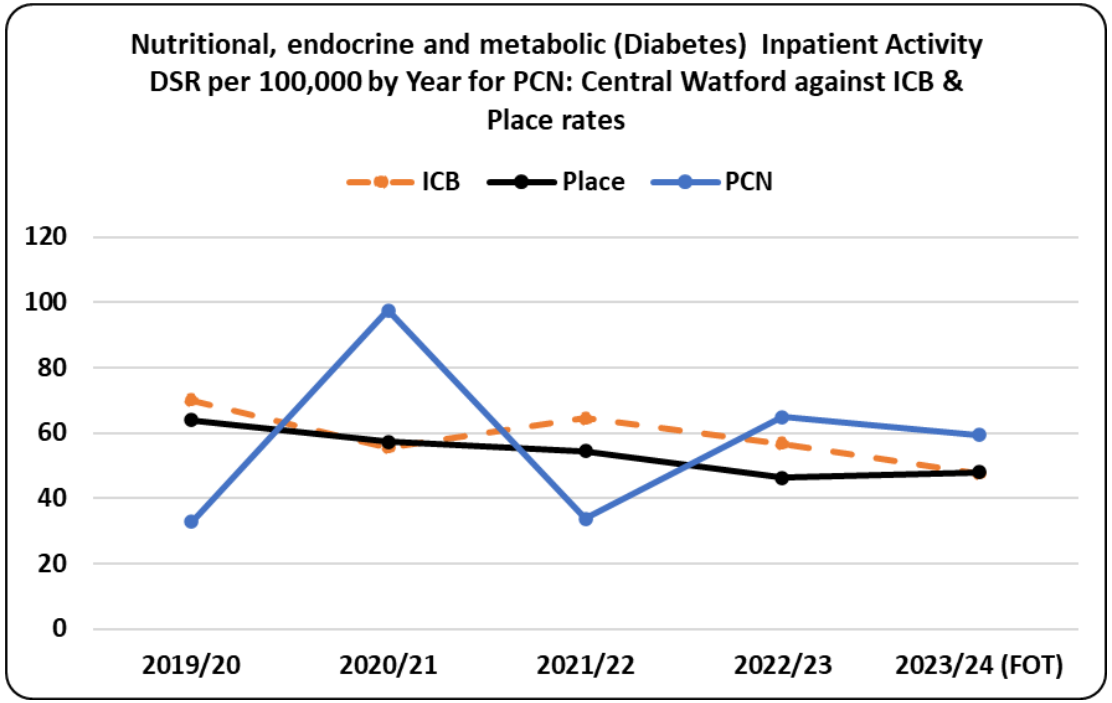
Hertfordshire and West Essex Integrated Care System

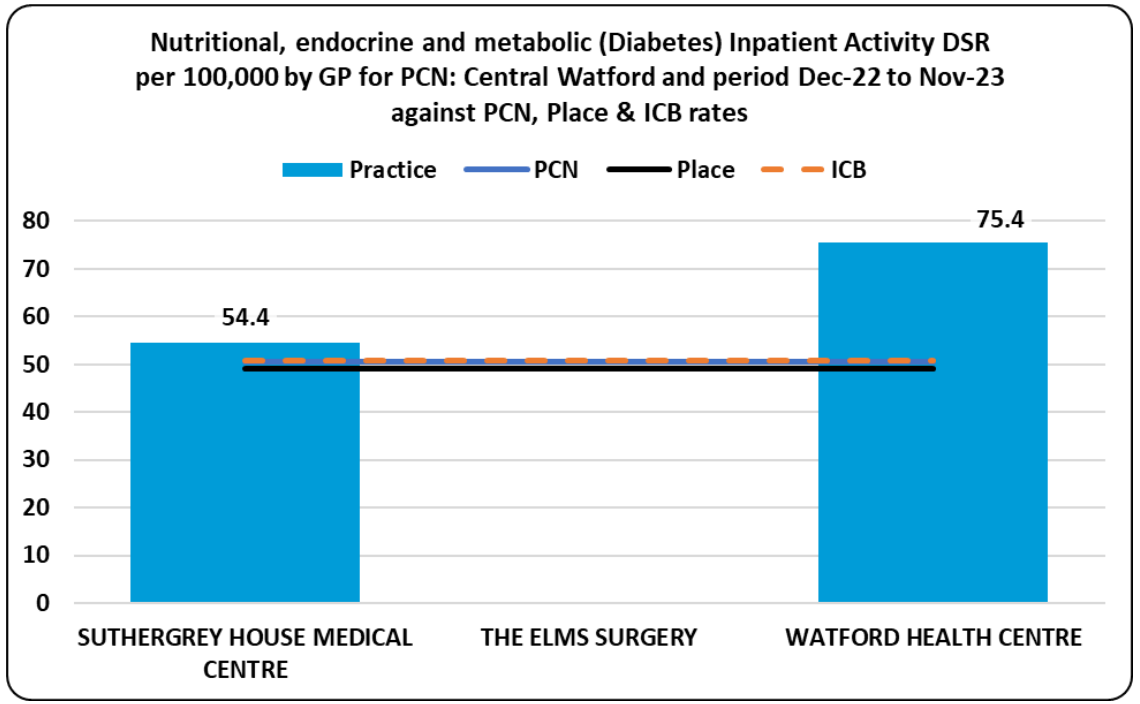
Source: SUS

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. The rate of admission for Central Watford PCN is similar to both place and ICB (latest 12 months data on the right hand side).
- 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.





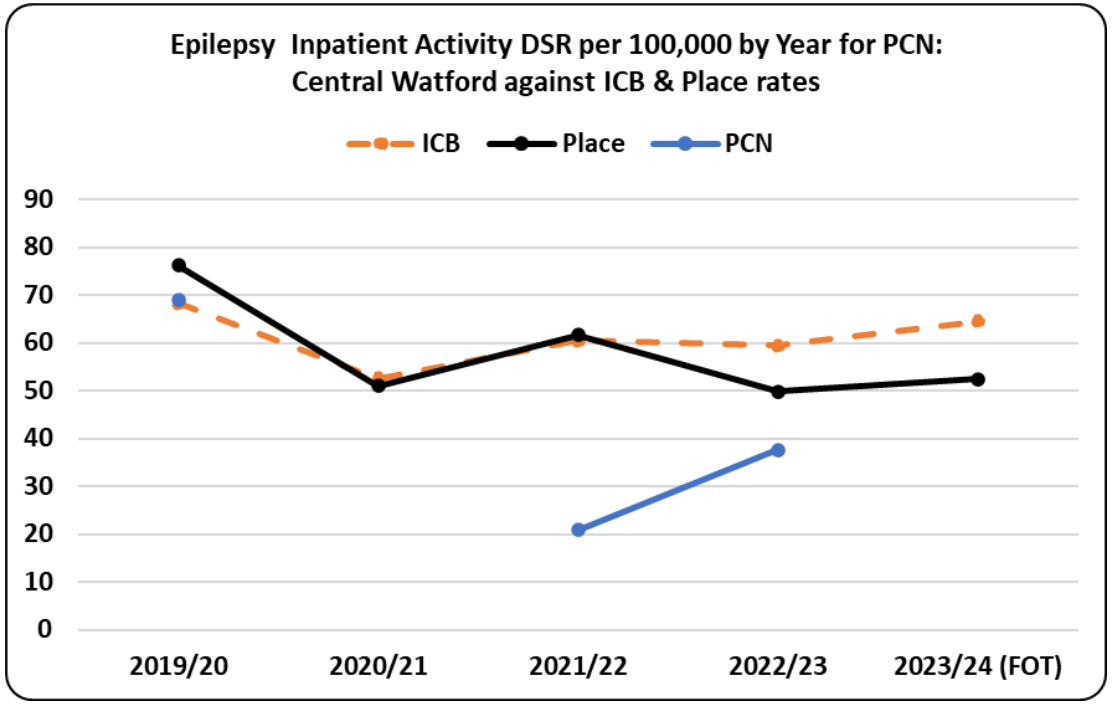
Hertfordshire and West Essex Integrated Care System

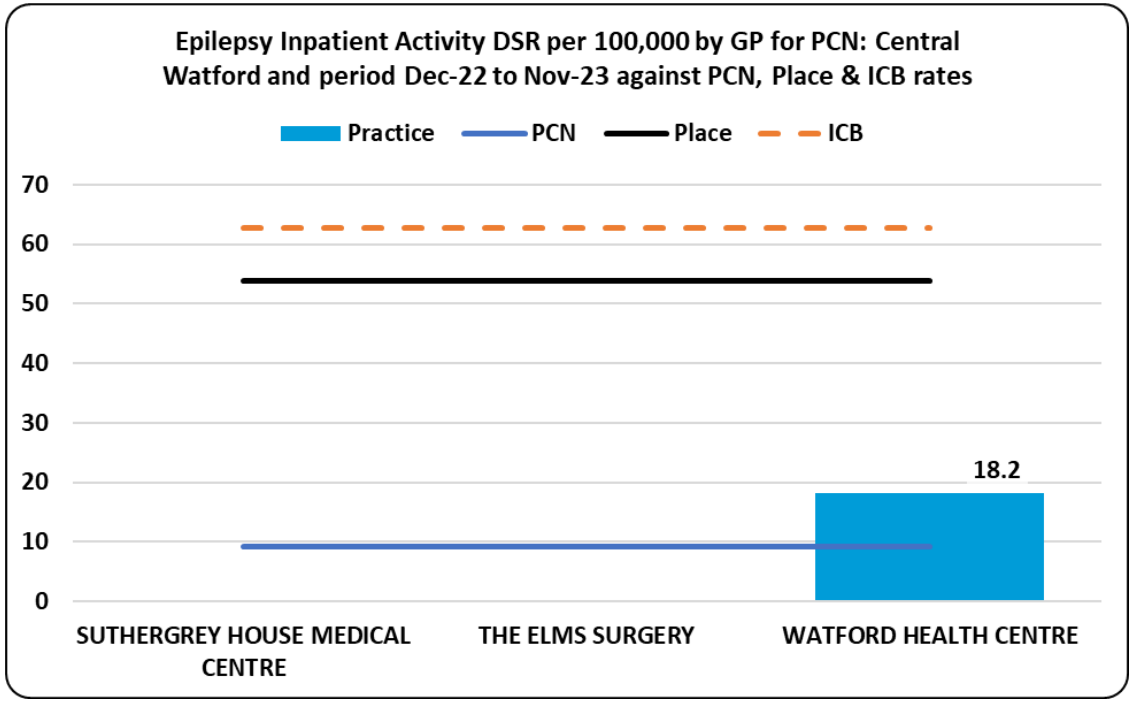
Source: SUS

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 rate of admission for Central Watford PCN is lower than both place and ICB (latest 12 months data on the right hand side).
- The numbers of children admitted for epilepsy are small and this should be considered when looking at the data. The data for epilepsy will continue to be monitored at wider HCP and ICB footprints.





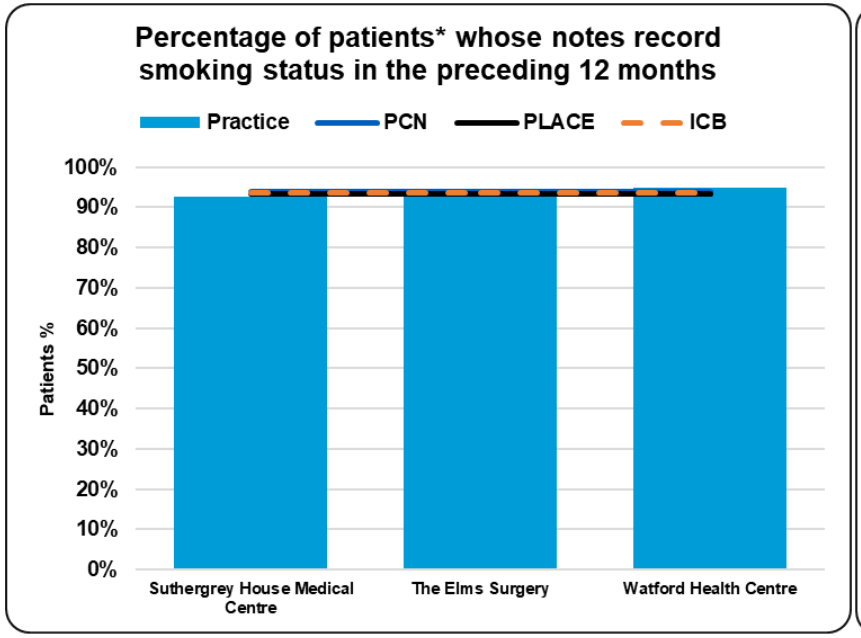
Hertfordshire and West Essex Integrated Care System

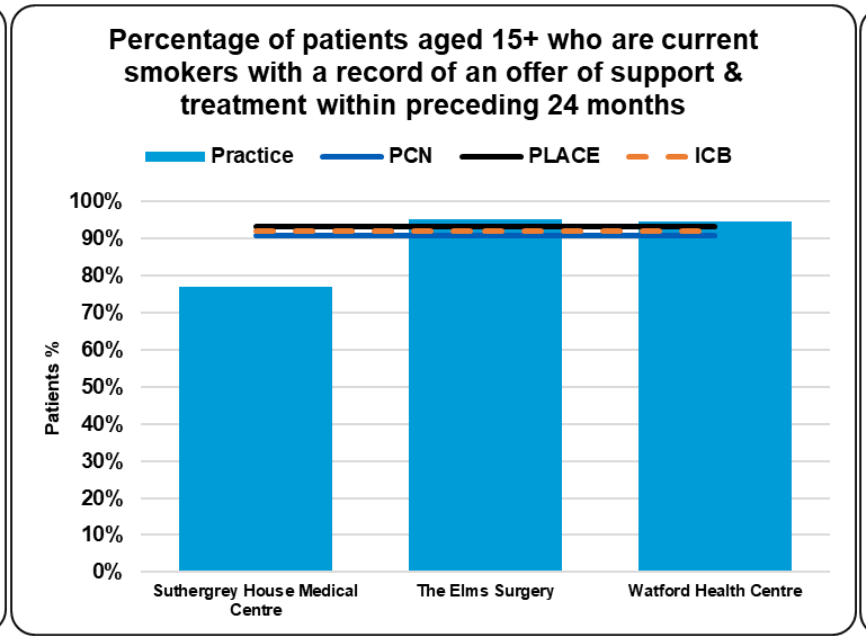
Source: SUS

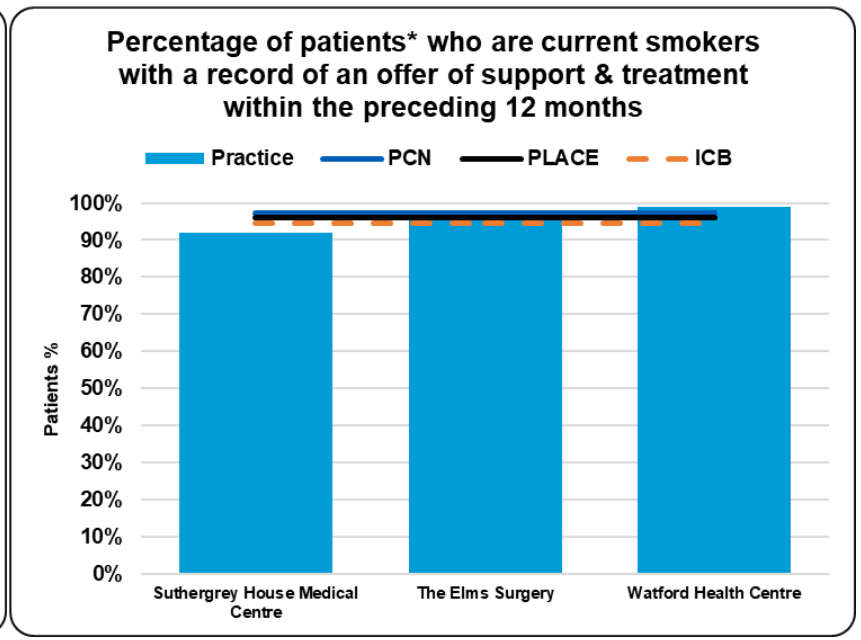
Prevention and health inequalities – Lifestyle factors - Smoking

- Central Watford PCN data for smoking shows a similar picture to the Place and ICB.
- 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
Suthergrey House MC	25%	905	15%	599	0%	5
The Elms Surgery	49%	472	39%	442	0%	4
Watford Health Centre	20%	1486	17%	1495	0%	11







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

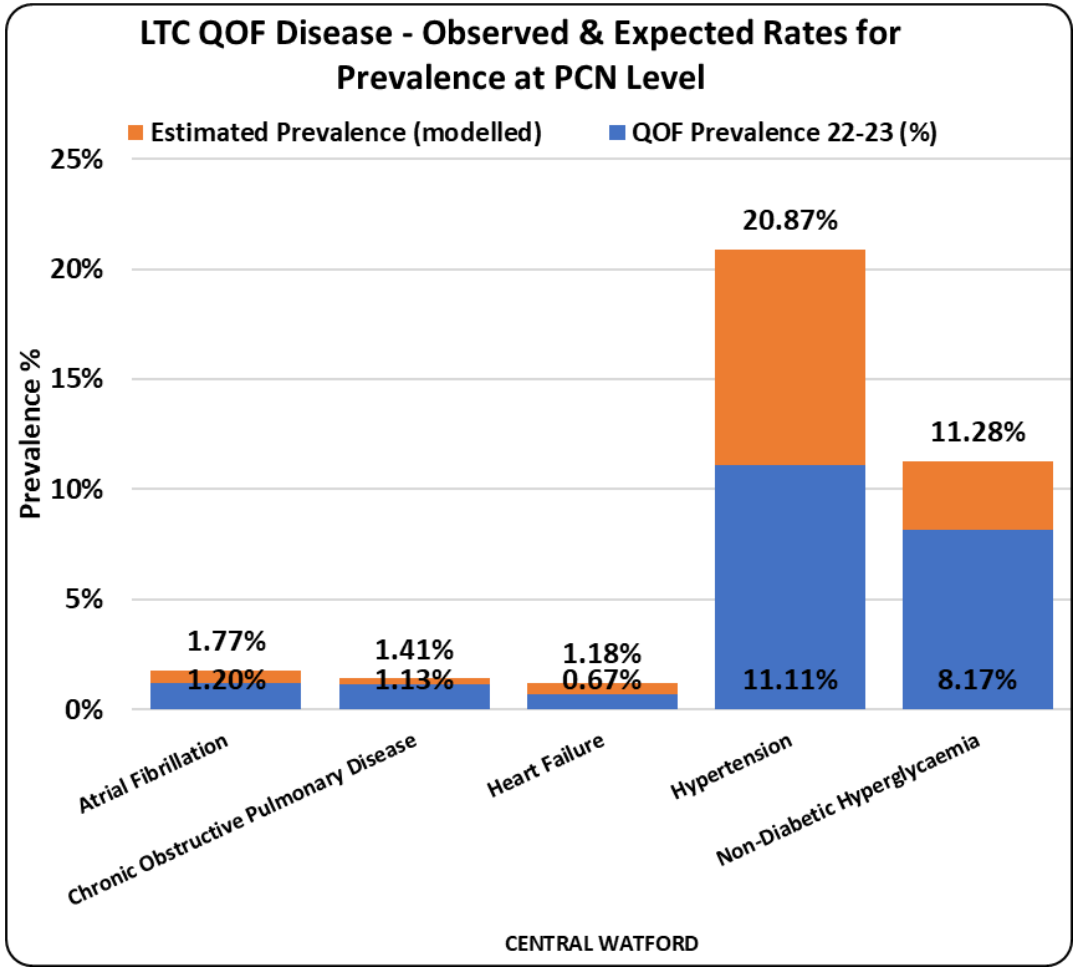
Prevention and health inequalities
Early Identification: Expected vs observed prevalence

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 this page shows the national modelled estimated prevalence for the PCN compared with the latest published QOF prevalence for the PCN.

- Central 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 Central Watford PCN - No. of New Diagnoses to Meet ICS & PLACE Rates - 2023/24	
	Number to meet ICS rate	Number to meet PLACE rate
Asthma	2101	403
Atrial Fibrillation	182	308
Chronic Kidney Disease	997	470
Chronic Obstructive Pulmonary Disease	51	64
Coronary Heart Disease	977	142
Diabetes Mellitus		19
Epilepsy	208	39
Heart Failure		28
Hypertension	4975	769
Non-Diabetic Hyperglycaemia		101
Peripheral Arterial Disease	157	36
Stroke and Transient Ischaemic Attack	592	140



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 this slide looks at the recorded prevalence by practice for the PCN compared with Place and ICB.
- The development of an ICB Data Platform will create a longitudinal record for our patients which will allow the data to be viewed by different characteristics such as deprivation, ethnicity, co-morbidities.
- For LTCs, QOF and ECF data can help us understand areas of opportunity for improving outcomes for our population living with LTCs.

Central Watford PCN - Long-Term Conditions 2022-23 QOF Prevalence, with 3 Year Trend.

QOF Disease/ Condition	QOF 22-23 - ICB %	QOF 22-23 - PLACE %	QOF 22-23 - PCN %	SUTHERGREY HOUSE MEDICAL CENTRE		WATFORD HEALTH CENTRE		THE ELMS SURGERY	
				QOF 2022-23	3 Year Trend	QOF 2022-23	3 Year Trend	QOF 2022-23	3 Year Trend
Asthma	6.16%	5.84%	4.73%	5.39%		4.52%		4.28%	
Atrial fibrillation	2.09%	2.01%	1.20%	1.77%		1.02%		0.82%	
Chronic kidney disease	3.46%	3.84%	2.09%	2.69%		2.40%		1.17%	
Chronic obstructive pulmonary disease (COPD)	1.49%	1.39%	1.13%	1.26%		1.50%		0.63%	
Diabetes mellitus	6.63%	6.56%	7.04%	6.72%		8.31%		6.09%	
Epilepsy	0.70%	0.70%	0.59%	0.79%		0.54%		0.44%	
Heart Failure	0.80%	0.72%	0.67%	0.81%		0.62%		0.59%	
Hypertension	13.84%	13.36%	11.11%	13.74%		11.22%		8.36%	
Non-diabetic hyperglycaemia	6.42%	7.43%	8.17%	9.90%		8.42%		6.20%	
Peripheral arterial disease	0.44%	0.41%	0.32%	0.41%		0.25%		0.30%	
Secondary prevention of coronary heart disease	2.67%	2.62%	2.24%	2.78%		2.22%		1.73%	
Stroke and transient ischaemic attack	1.63%	1.53%	1.26%	1.81%		1.03%		0.94%	

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

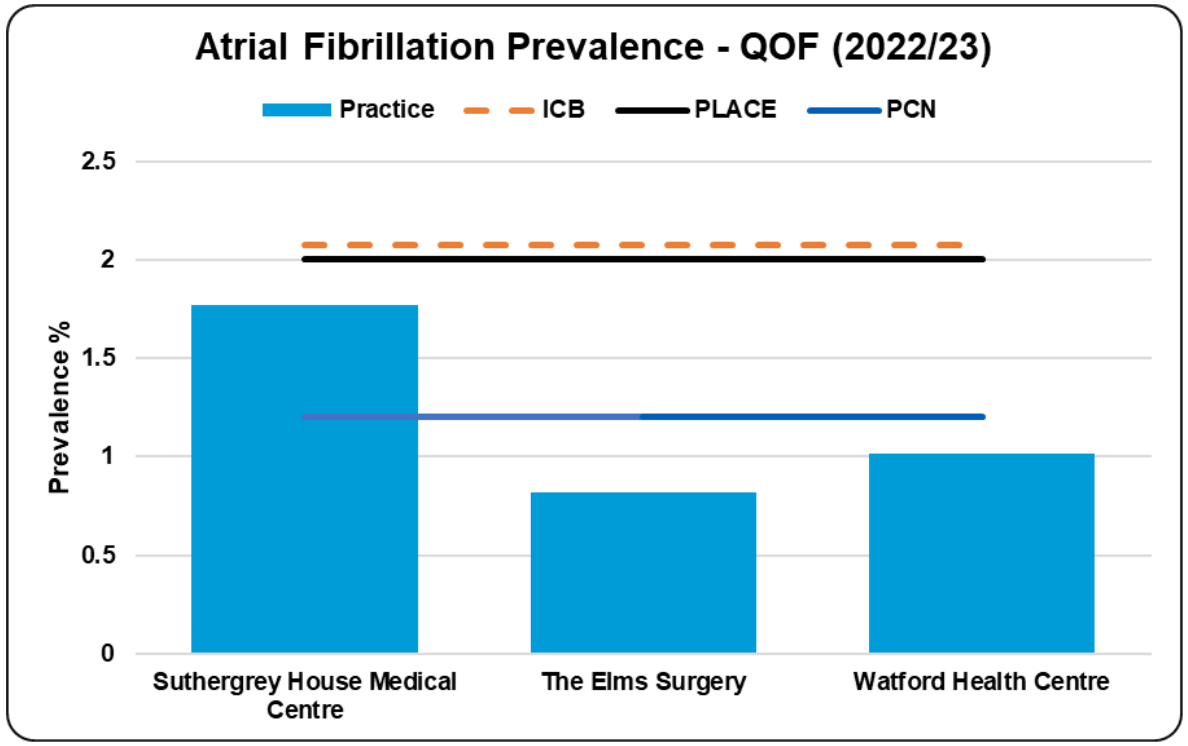
- The table on the right shows a summary of the percentage of patients receiving an annual review by condition.
- Where the cell is highlighted the percentage is lower than the place value.
- The data shows that all practices have lower percentages of recording of Blood Pressure in patients aged 45 and HbA1c for patients with non-diabetic hyperglycaemia.
- 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

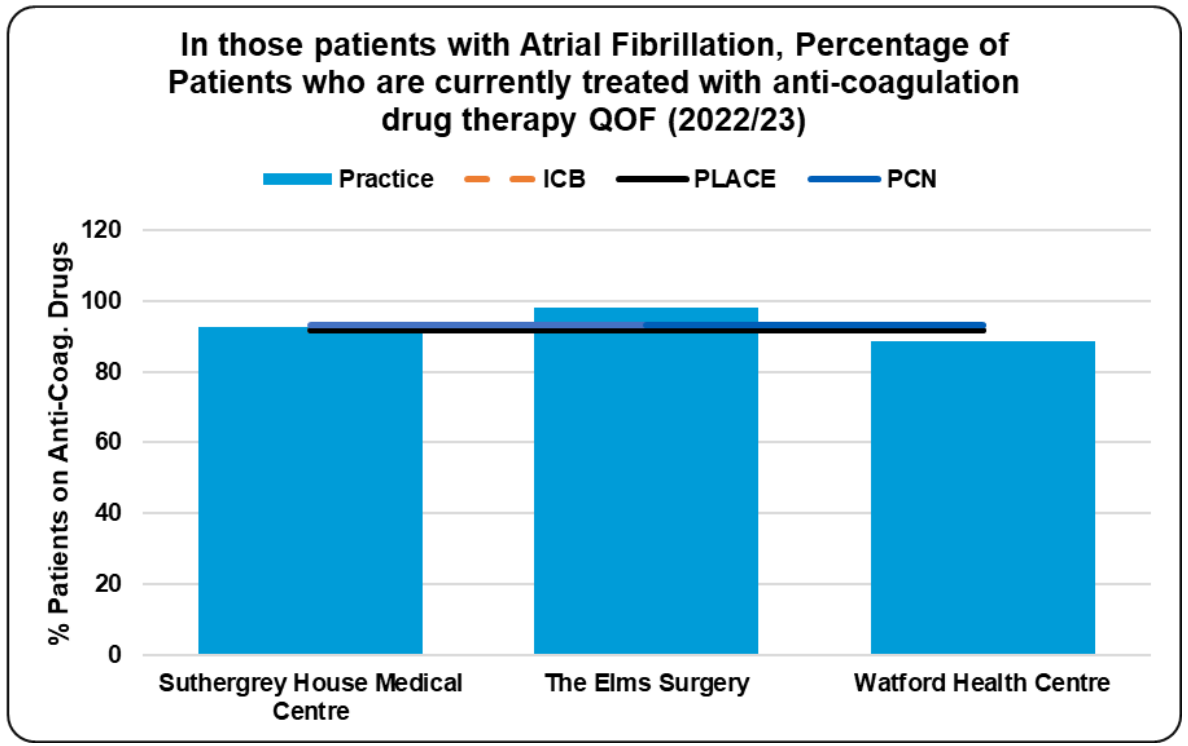
	ICB	SWH	Central Watford PCN	Suthergrey House Medical Centre	The Elms Surgery	Watford Health Centre
% of AF Patients with Stroke Risk Assessed in the last 12 months	92.9	94.2	97.7	99.3	100.0	96.2
The % of patients aged 45 or over who have a record of blood pressure in the preceding 5 years	85.7	85.1	**79.1**	**77.4**	**79.5**	**80.1**
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	**71.9**	**41.6**	91.5	83.9
The % of patients with asthma, on the register, who have had an asthma review in the preceding 12 months	64.0	64.1	69.2	**58.4**	69.1	75.8
The % of patients with COPD, on the register, who have had a review in the preceding 12 months	75.7	75.3	**71.9**	**34.2**	92.0	84.2
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	**74.1**	**60.5**	77.6	78.6
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	**80.3**	**78.5**	**80.4**	**81.4**

Prevention and health inequalities – Atrial Fibrillation

- Central 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 further opportunity for identification of people with AF. Latest information for AF indicators can be found within https://app.ardensmanager.com/login



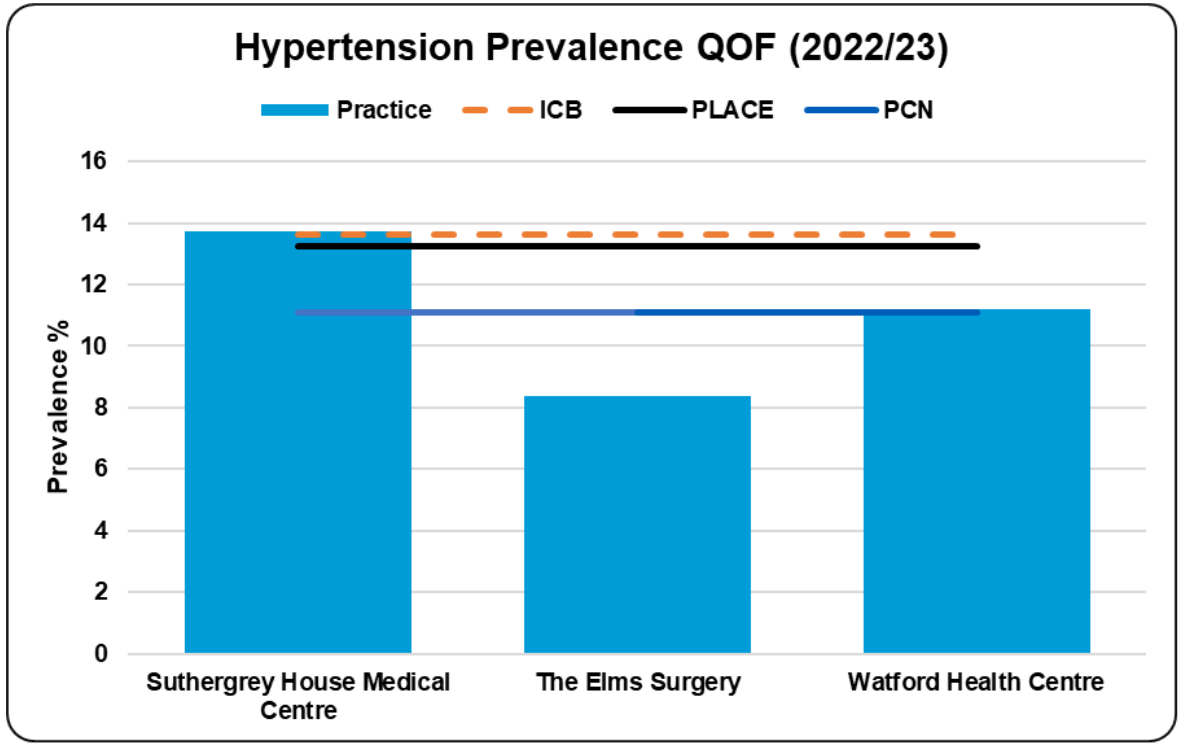


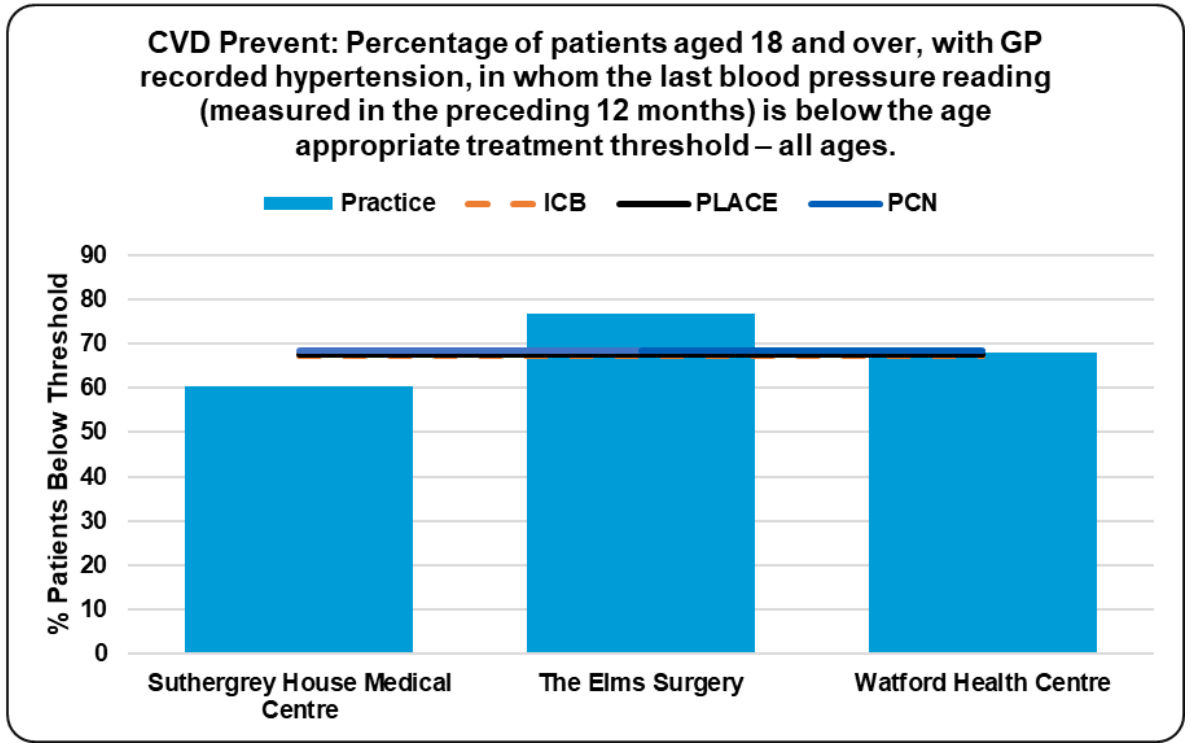
Hertfordshire and West Essex Integrated Care System

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

Prevention and health inequalities – Hypertension

- Central Watford PCN recorded prevalence for hypertension is lower 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 similar to both Place and ICB, however there is variation between the practices.
- The data suggests there is further opportunity for identification of people with hypertension.





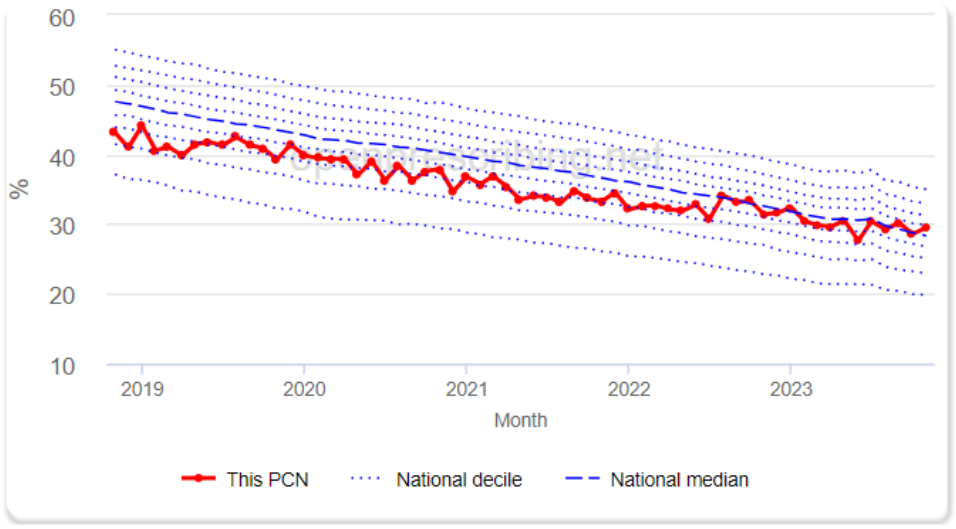
Hertfordshire and West Essex Integrated Care System

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

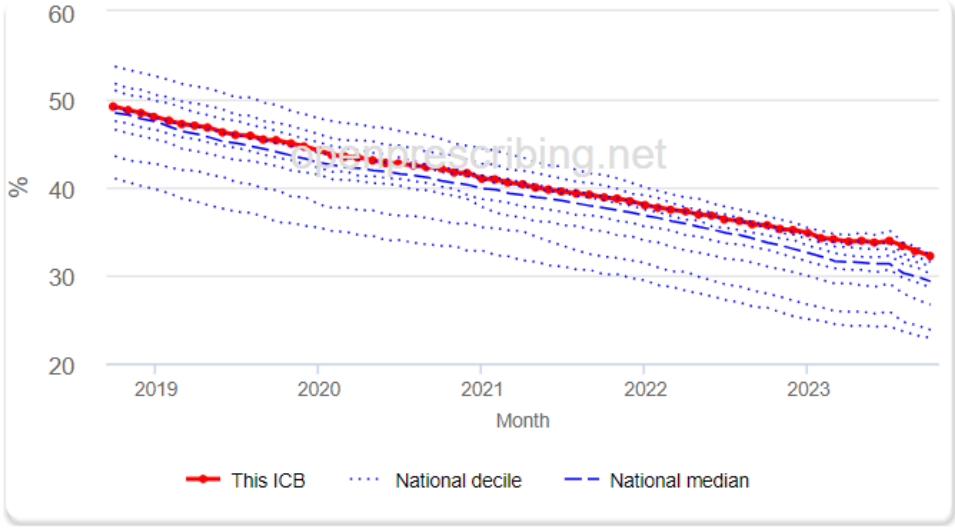
Lipid management : Percentage of people on lipid lowering therapy for secondary prevention who are on low and medium intensity statins

- 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 negative outlier in this area, with a high proportion of people not on a high intensity statin.
- The data for Central 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 57th percentile with 29.5% 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

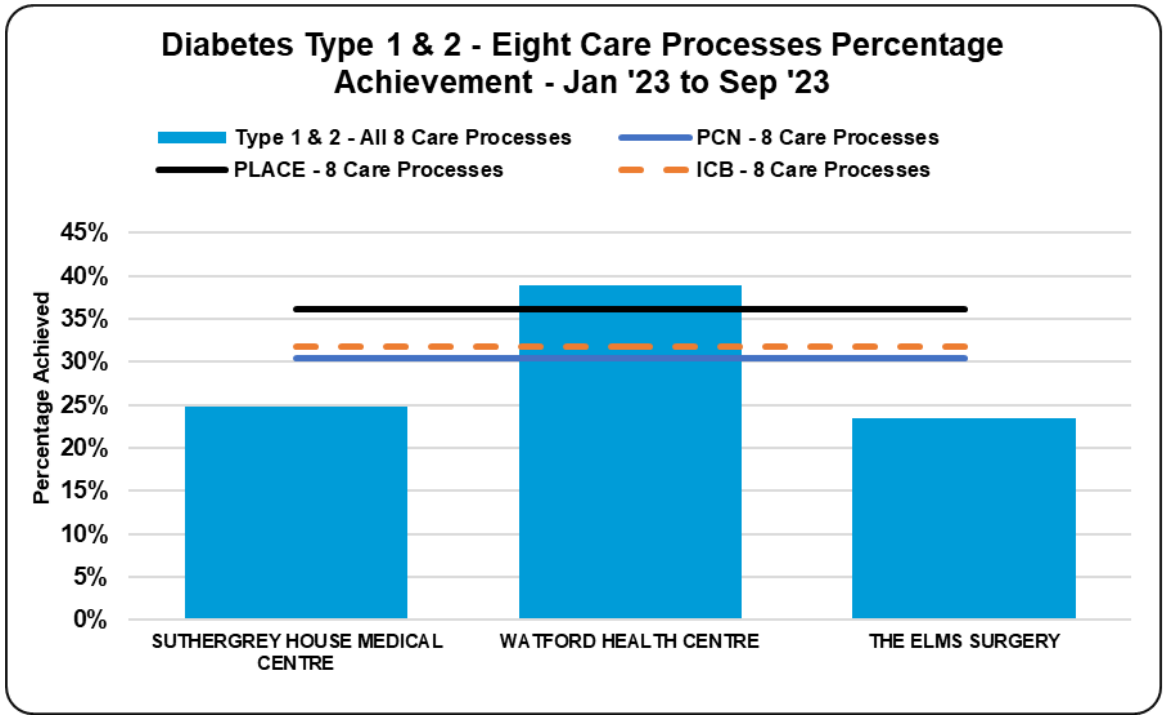


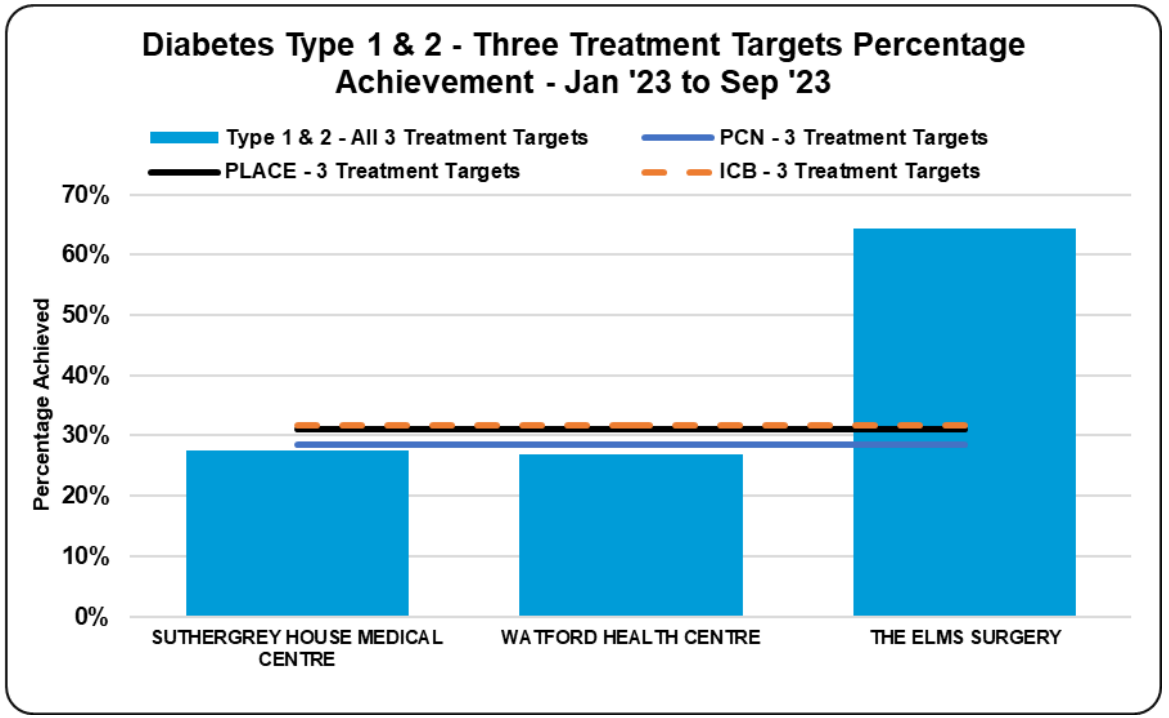
Hertfordshire and West Essex Integrated Care System

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 Central Watford PCN is lower than both place and ICB. The data shows a lower percentage for achievement of the three treatment targets compared with Place and ICB.
- The latest information for diabetes indicators can be found within Ardens Manager.



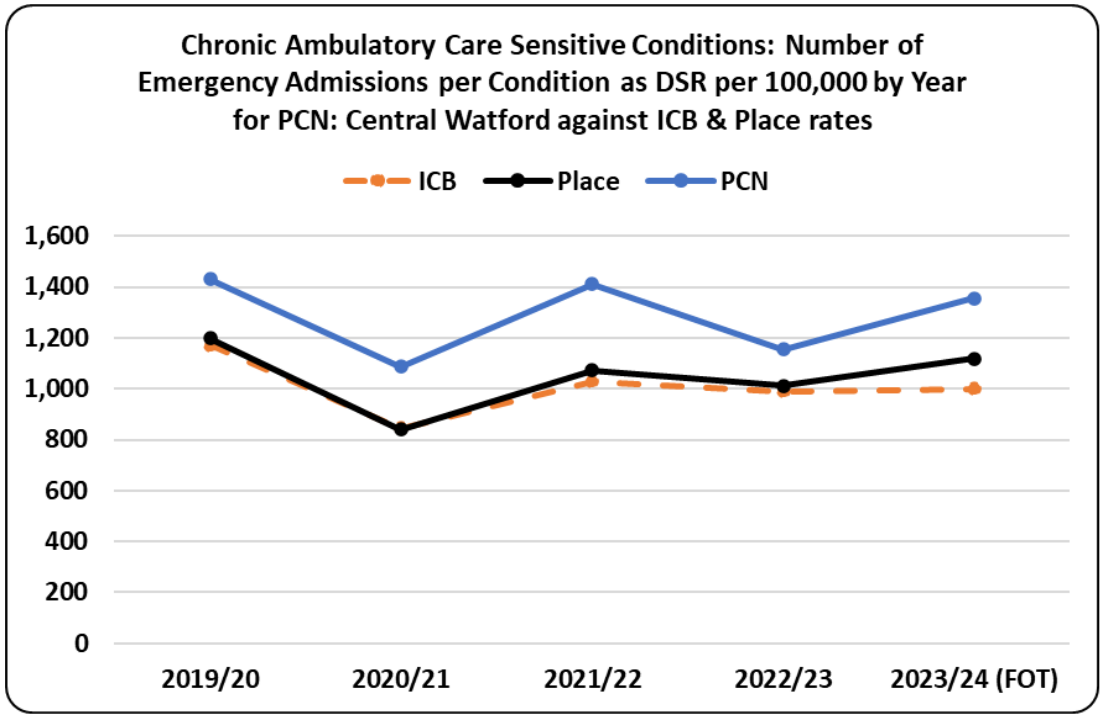


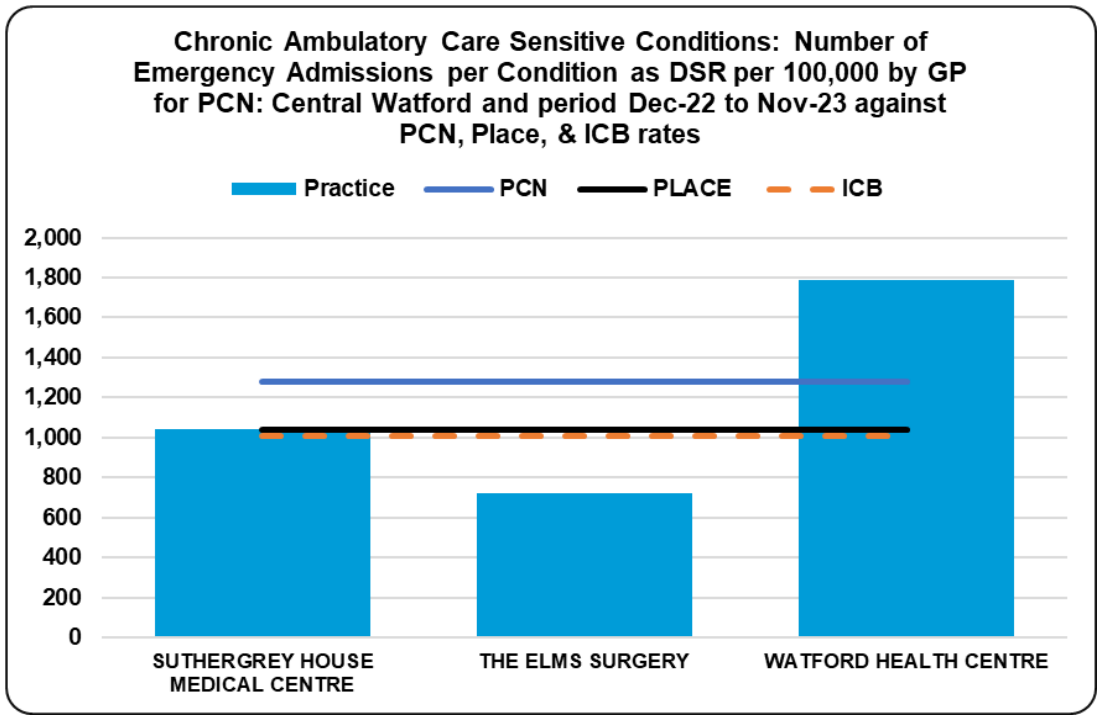
Hertfordshire and West Essex Integrated Care System

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)
- Central Watford PCN's admission rate for Chronic ACS conditions is higher than both the place and ICB when looking at the 12 months data up to November 2023.
- Diseases of the Blood and COPD are two of the conditions with the highest rate.

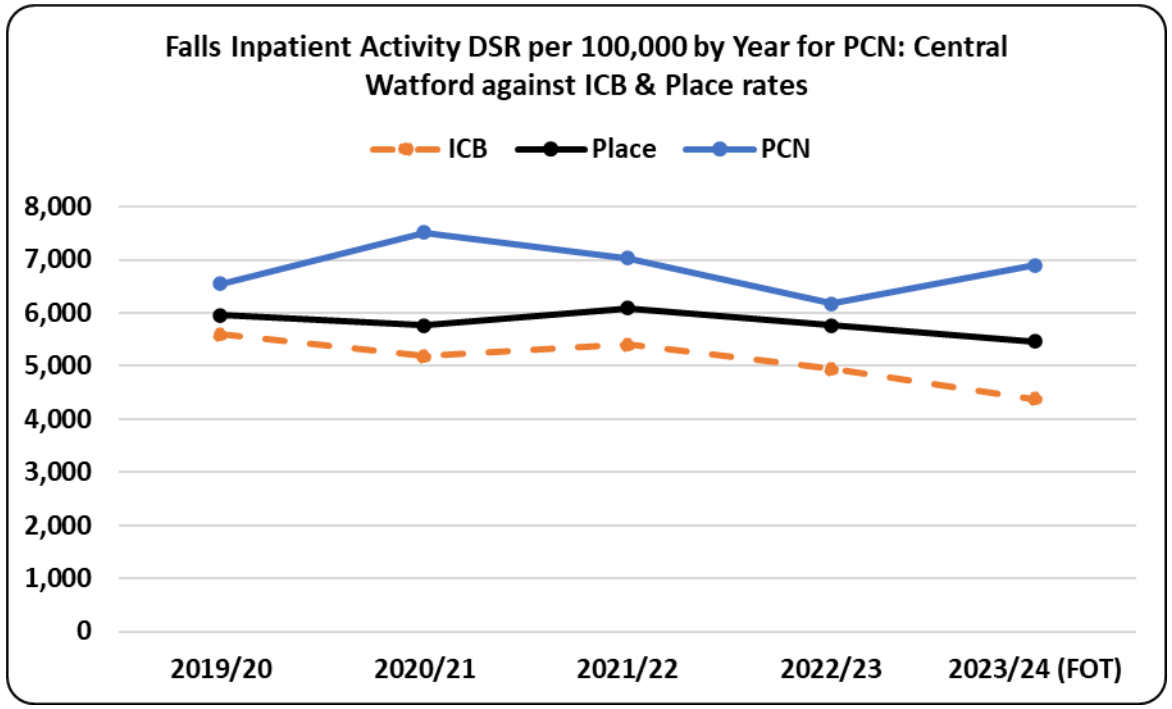
Chronic Ambulatory Care Sensitive Conditions for Central Watford PCN	PCN Per 100,000 Rate Apr-23 to Nov-23	5 Year Trend	2024/25 Trajectory
Angina: Angina pectoris	33.30		UP
Asthma	82.07		UP
Atrial fibrillation and flutter	191.11		UP
COPD	245.72		UP
Congestive heart failure	191.11		UP
Diseases of the blood	313.34		UP
Epilepsy	15.44		DOWN
Hypertension	88.03		UP
Mental and behavioural disorders	6.34		DOWN
Nutritional, endocrine and metabolic	188.42		UP

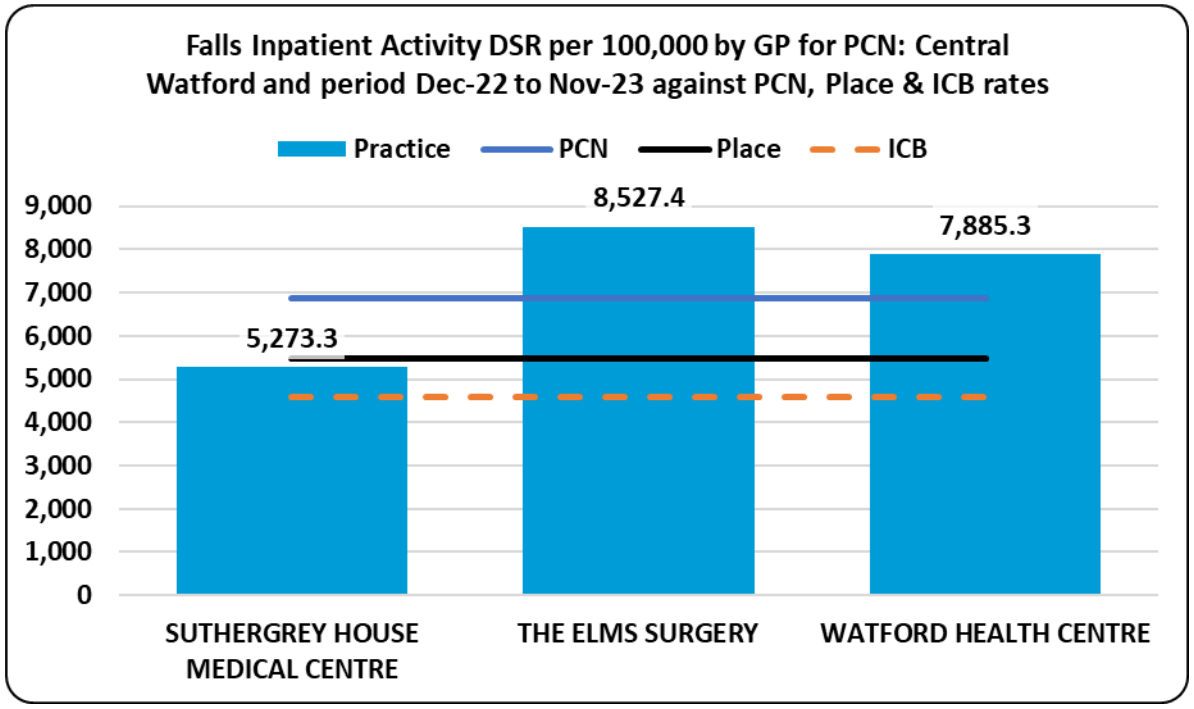
Source: SUS Link: Chronic ACS Conditions & NHSOF

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 Central Watford PCN has a higher rate of admissions for falls than Place and ICB.
- The trend information shows the rate for the PCN consistently higher than the place and ICB rate.
- 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.





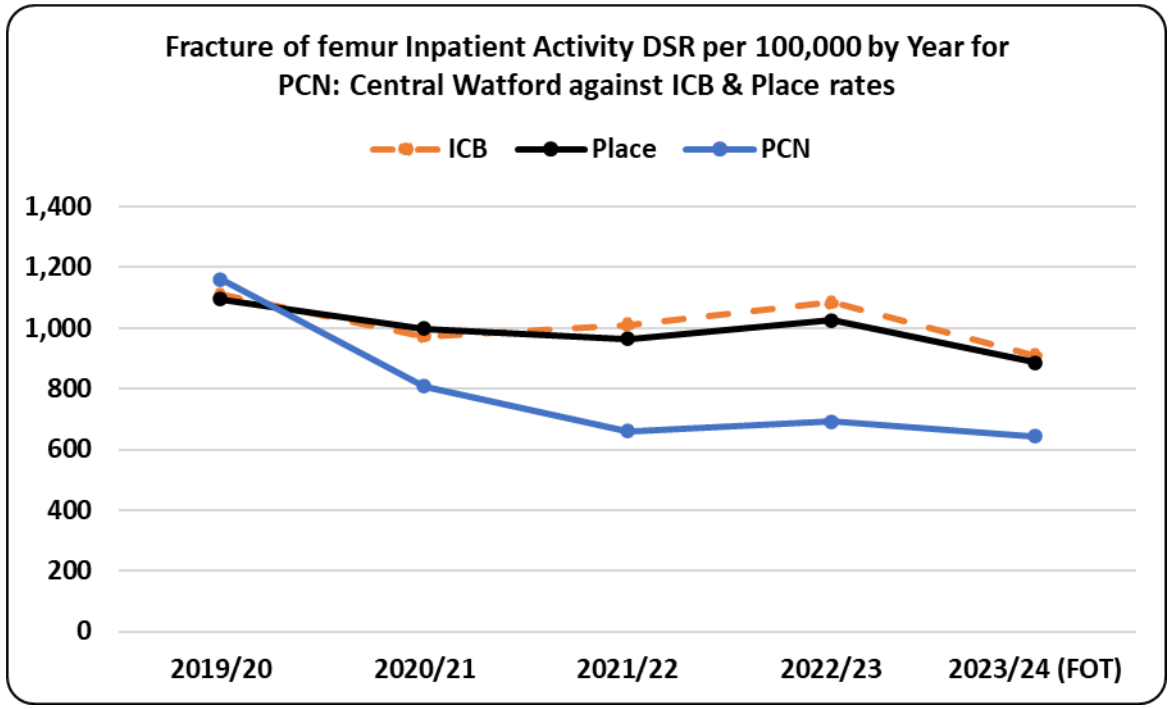
Hertfordshire and West Essex Integrated Care System

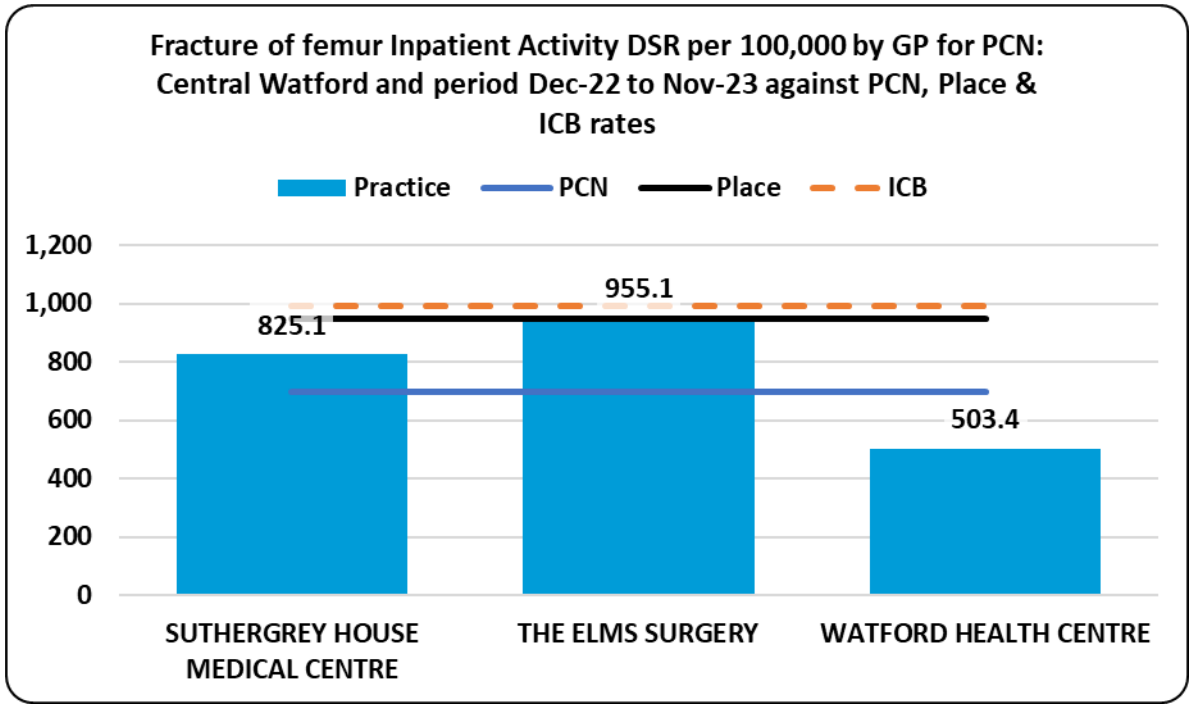
Source: SUS

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 data for hip fractures in the over 75s shows that Central Watford PCN has a lower rate than both the Place and the PCN.
- When looking at the data by PCN the small numbers will cause fluctuations over the years. The trend data shows a decreasing trend for the PCN.
- 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 Central Watford PCN has a high % of Frailty reviews completed, when compared to Place and ICB as at end Dec 23.
- The data contained within the table below is up to the end of December, the latest position can be found at Ardens Manager.

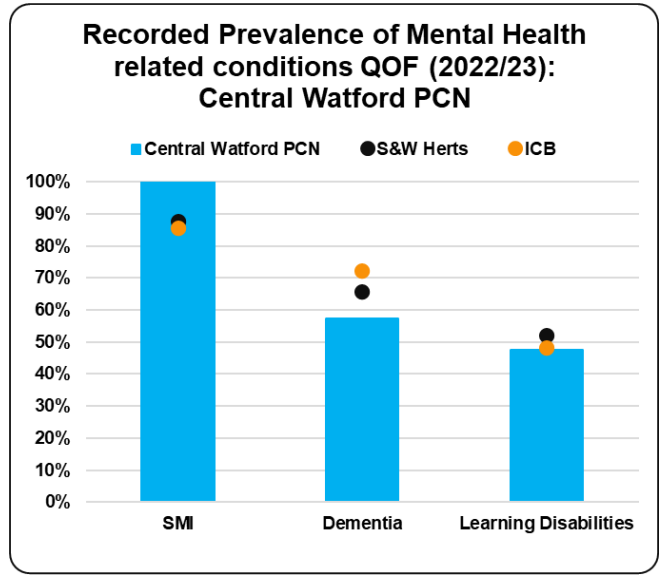
Central Watford Enhanced Commissiong Framework (ECF) 2023-24 for the period 1 April 23 to 31 Dec 23

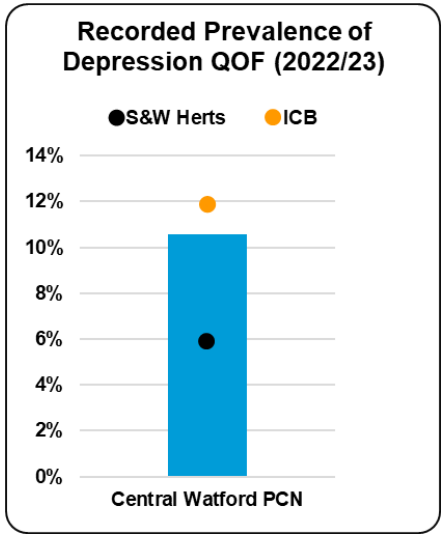
	Frailty			EOL						
	Mod/Sev + falls Frat score done %	Mod frail + SMR or polypharmacy medication review %	% Mod/Sev frailty of population	% population on EOL register	GSF %	DNACPR %	ACP %	PPD %	PPC %	SCR Consent %
ICB	16.0%	19.5%	1.9%	0.7%	64.9%	53.3%	11.3%	37.3%	39.8%	34.8%
SWH	15.9%	24.1%	1.9%	0.5%	42.8%	57.7%	18.6%	43.1%	44.2%	2.2%
PCN	18.5%	25.2%	2.4%	0.3%	20.8%	62.5%	30.8%	56.7%	59.2%	0.0%
Suthergrey House Medical Centre	9.2%	36.2%	1.5%	0.4%	8.1%	48.6%	13.5%	18.9%	18.9%	0.0%
The Elms Surgery	0.6%	1.8%	4.0%	0.1%	0.0%	66.7%	0.0%	66.7%	66.7%	0.0%
Watford Health Centre	36.9%	32.6%	2.1%	0.4%	29.7%	68.9%	43.2%	74.3%	78.4%	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 Central Watford PCN has a lower recorded prevalence for Dementia and Depression.
- 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.





	Central Watford- Mental Health Conditions 2022-2023 QOF prevalence, with 3 year trend					
	Suthergrey House Medical Centre		The Elms Surgery		Watford Health Centre	
	QOF Prevalence 22-23	3 year Trend	QOF Prevalence 22-23	3 year Trend	QOF Prevalence 22-23	3 year Trend
Dementia	0.5%		0.6%		0.6%	
Depression	11.5%		10.5%		9.7%	
Learning Disability	0.5%		0.4%		0.6%	
SMI	1.0%		0.8%		1.4%	

Mental Health QOF Indicators 22-23

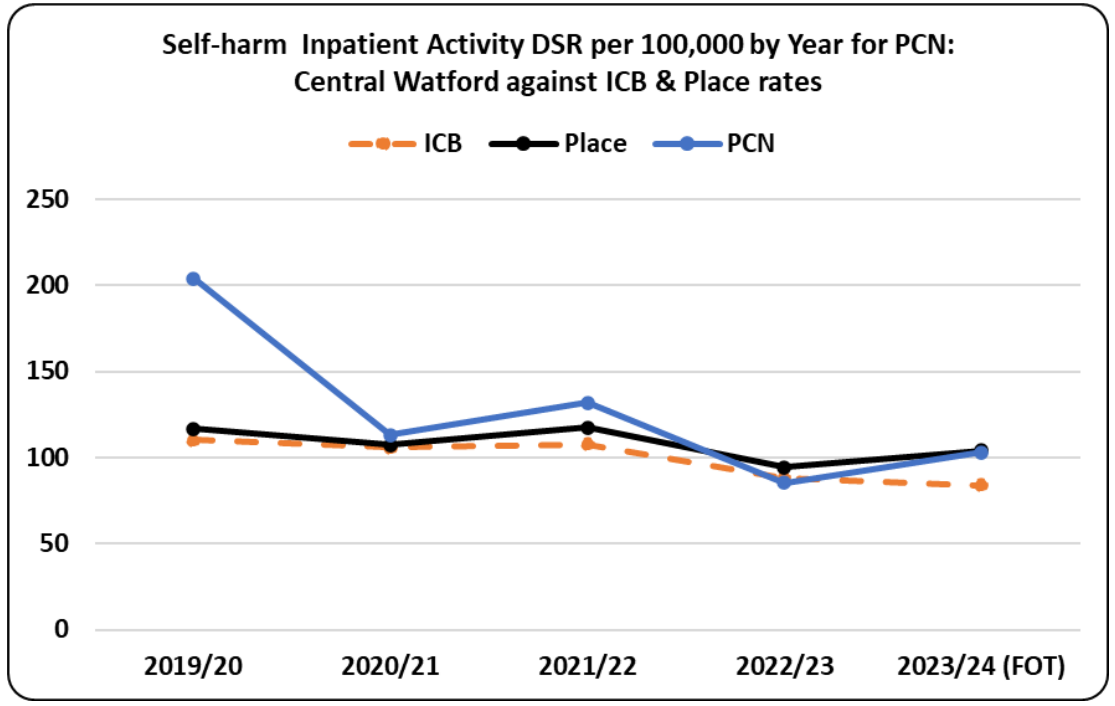
- Mental Health QOF metrics for 2022-23 show that Central Watford PCN have higher percentages of care plans and care processes recorded than both place and ICB across all measures.

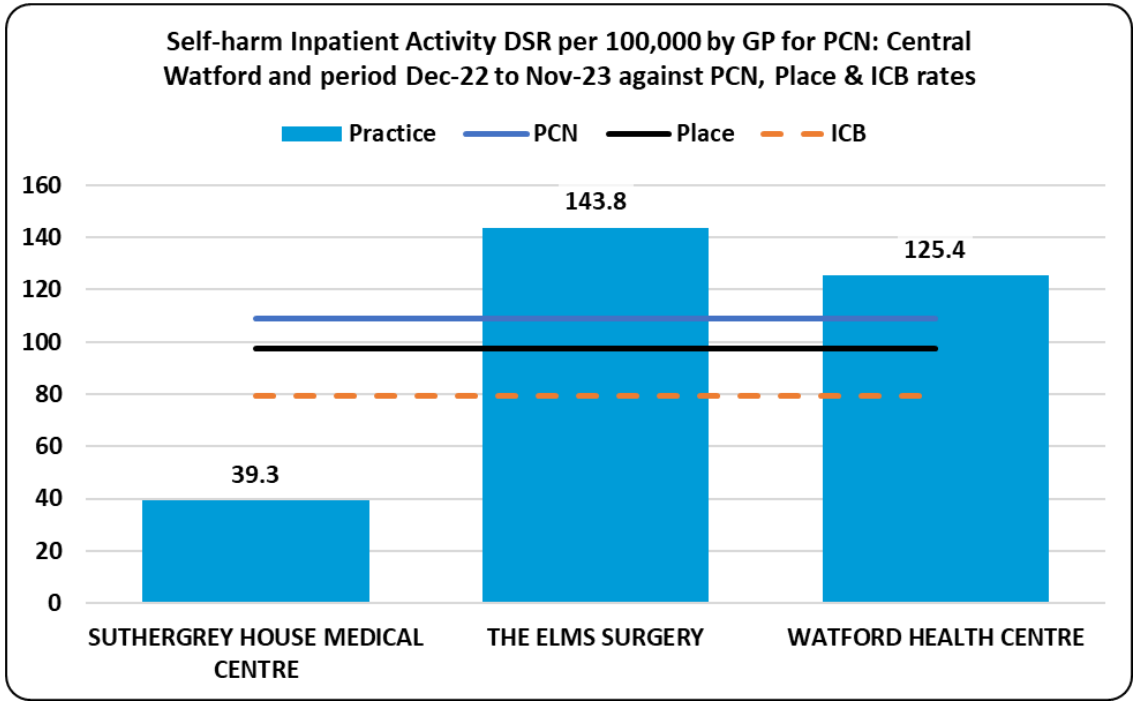
	SMI					Depression
	% of patients with SMI who have a care plan	% of patients with SMI who have a record of BMI in the preceding 12 months	% of patients with SMI who have a record of alcohol consumption in preceding 12 months	% of patients with SMI who have a record of a lipid profile in the preceding 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
Central Watford PCN	91.1	92.8	91.9	91.6	90.4	85.6
Suthergrey House Medical Centre	78.0	91.8	90.9	89.4	87.5	79.1
The Elms Surgery	100.0	96.0	93.9	88.6	88.2	87.7
Watford Health Centre	91.7	92.2	91.7	92.9	91.6	88.2

Emergency Admissions Rates for Self – Harm

ICB overarching outcome of Improving Healthy life expectancy

- Central 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, however the data shows a downward trend.
- The data will continue to be monitored at wider HCP and ICB footprints.





Hertfordshire and West Essex Integrated Care System

Source: SUS