Hertfordshire and West Essex Integrated Care System

Place Insights Pack 2024

East & North Herts

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Working together
for a healthier future

Introduction

This place pack has been developed around the ICB Clinical Priorities signed off by the ICB Board in March 23 and demonstrate 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 shows the East & North Herts compared with South West Herts, West Essex and the overall ICB.

The following pages show an overview table for East & North Herts and their PCNs.

The pack aims to provide details of where place is achieving better outcomes for its populations and where there are areas of opportunity. Where data allows, the variation between PCNs is shown to enable targeted interventions to improve outcomes. Further granular detail by practice can be found within the PCN Packs.

Data sources used within this pack include SUS, QOF, Ardens Manager and CVD Prevent.

PCN, Locality and other Places packs 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 and the recently updated Health Needs Analysis Refresh with comparative indicators.

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

ENH Place at a Glance

The table on the right provides a summary of the data contained within this pack. It highlights how East and North Herts compares with the ICB. On the following page is a summary by PCNs.

For ENH areas of opportunity highlighted are :

- ***Admissions for epilepsy in children***
- ***Observed versus expected prevalence of LTC***
- ***Secondary prevention CVD who are on high intensity statins***
- ***People living with diabetes with 8 care processes completed***
- ***Identification of dementia and depression***

For all areas there is variation between the PCNs and this is illustrated on the following page.

A practice breakdown of the PCNs can be found within the PCN packs published on the website.

Clinical Priority	Metric	Metric Ref	Place compared to ICB average
Childhood obesity	% of children in Reception who are overweight	**1**	↔
	% of children in Year 6 who are overweight	**2**	↓
Reduce rates of emergency care for children and young people	A&E Attendances for Asthma (Children)	**3**	↔
	Admissions for Asthma (Children)	**4**	↓
	Admissions for Wheeze (Children)	**5**	↓
	Admissions for Diabetes (Children)	**6**	↔
	Admissions for Epilepsy (Children)	**7**	↑
Prevention and health inequalities (Premature mortality for CVD)	Lifestyle risk factors: Smoking	**8**	↔
	Observed versus expected prevalence	**9**	↓
	Annual Reviews completed for LTCs	**10**	↔
	% of people with AF treated with Anti Coagulant	**11**	↔
	Control of hypertension	**12**	↔
	Identification of hypertension	**13**	↔
Preventative, Proactive care models for LTC	% of people for secondary prevention CVD who are on high intensity statins	**14**	↑
	% of people living with diabetes with all 8 care processes completed	**15**	↓
	Reduction in emergency admissions of ACS conditions	**16**	↓
Preventative, Proactive care models for frailty and EOL	Admissions for falls (75+)	**17**	↓
	Admissions for Hip Fractures (75+)	**18**	↔
Mental Health	Prevalence of Mental Health Conditions including LD	**19**	↓ **Dem, Dep**
	Admissions for Self-Harm	**20**	↓

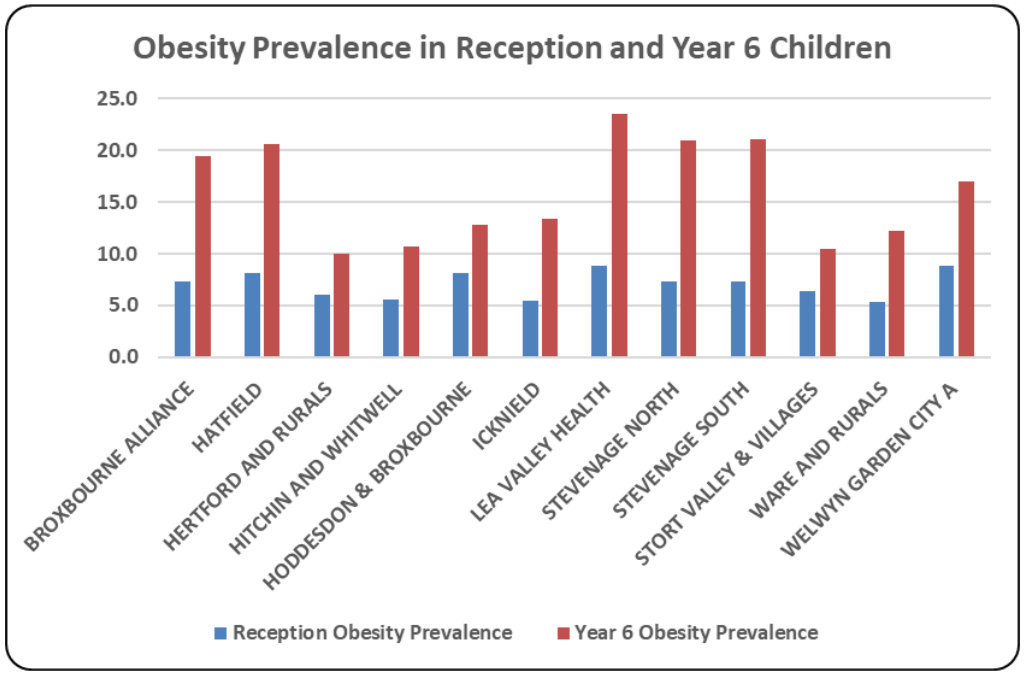
ENH Place PCNs at a Glance

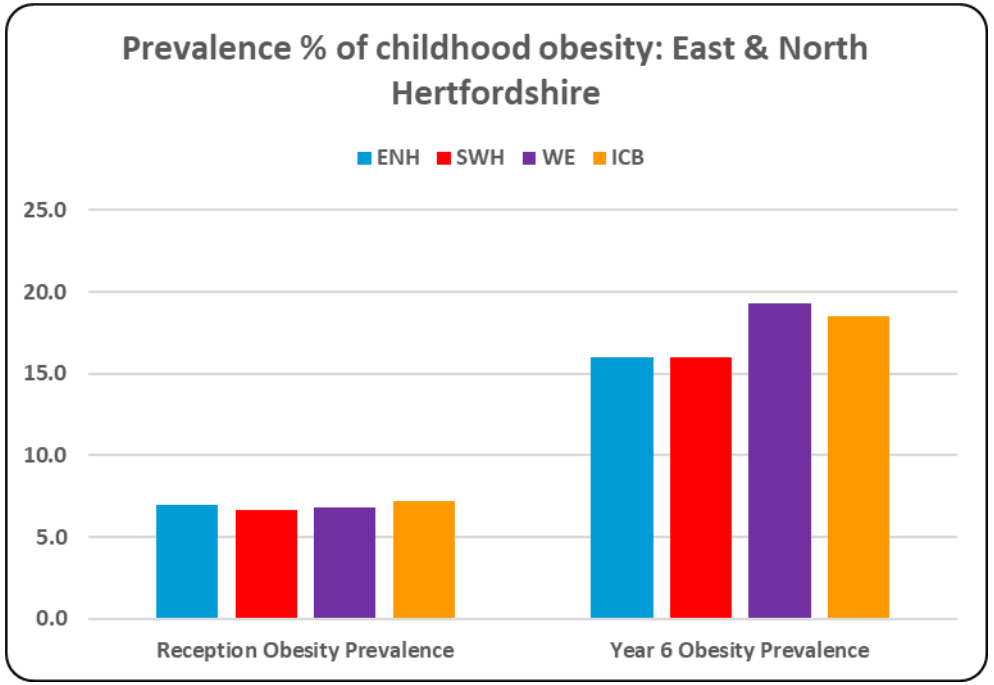
	PCNs compared to Place average											
Metric	Broxbourne Alliance	Hatfield	Hertford & Rurals	Hitchin & Whitwell	Hoddesdon & Broxbourne	Icknield	Lea Valley Health	Stevenage North	Stevenage South	Stort Valley & Villages	Ware & Rurals	Welwyn Garden City A
% of children in Reception who are overweight	↑	↑	↓	↓	↑	↓	↑	↔	↑	↓	↓	↑
% of children in Year 6 who are overweight	↑	↑	↓	↓	↓	↓	↑	↑	↑	↓	↓	↑
A&E Attendances for Asthma (Children)	↑	↓	↓	↔	↑	↓	↑	↑	↑	↓	↓	↓
Admissions for Asthma (Children)	↑	↓	↓	↑	↑	↓	↑	↑	↓	↓	↓	↑
Admissions for Wheeze (Children)	↔	↓	↓	↑	↓	↑	↓	↑	↑	↓	↓	↓
Admissions for Diabetes (Children)	↑	↔	↑	↑	↓	↑	↓	↑	↓	↑	↑	↔
Admissions for Epilepsy (Children)	↑	N/A	↔	↑	↓	↓	↓	↑	↔	↑	↑	↓
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 people living with diabetes with all 8 care processes completed	↔	↓	↓	↑	↔	↑	↓	↓	↑	↑	↑	↓
Reduction in emergency admissions of ACS conditions	↔	↑	↓	↓	↓	↓	↑	↑	↑	↓	↓	↑
Admissions for falls (75+)	↓	↑	↓	↑	↔	↓	↓	↑	↑	↔	↓	↔
Admissions for Hip Fractures (75+)	↔	↓	↔	↔	↓	↓	↑	↑	↑	↑	↓	↓
Prevalence of Mental Health Conditions including LD	↓ LD	↓ Dem	↓ SMI	↓ Dem,LD	↓ SMI	↔	↓ Dem	↑	↔	↓	↓ SMI	↓ Dem
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 trend, the Place rates for Childhood Obesity are higher for year 6 in comparison to reception children.
- The PCNs within E&N Herts with the highest prevalence of childhood obesity at year 6 are Lea Valley Health, Hatfield, Stevenage North, Stevenage South and Broxbourne Alliance. National data shows that areas with higher levels of deprivation have the highest rates of childhood obesity.





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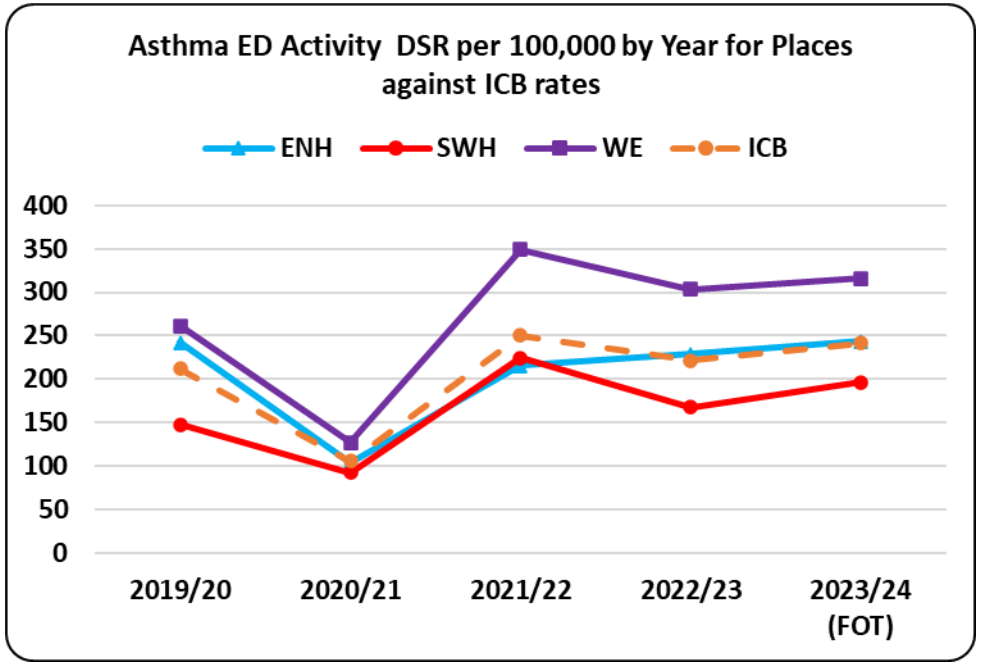
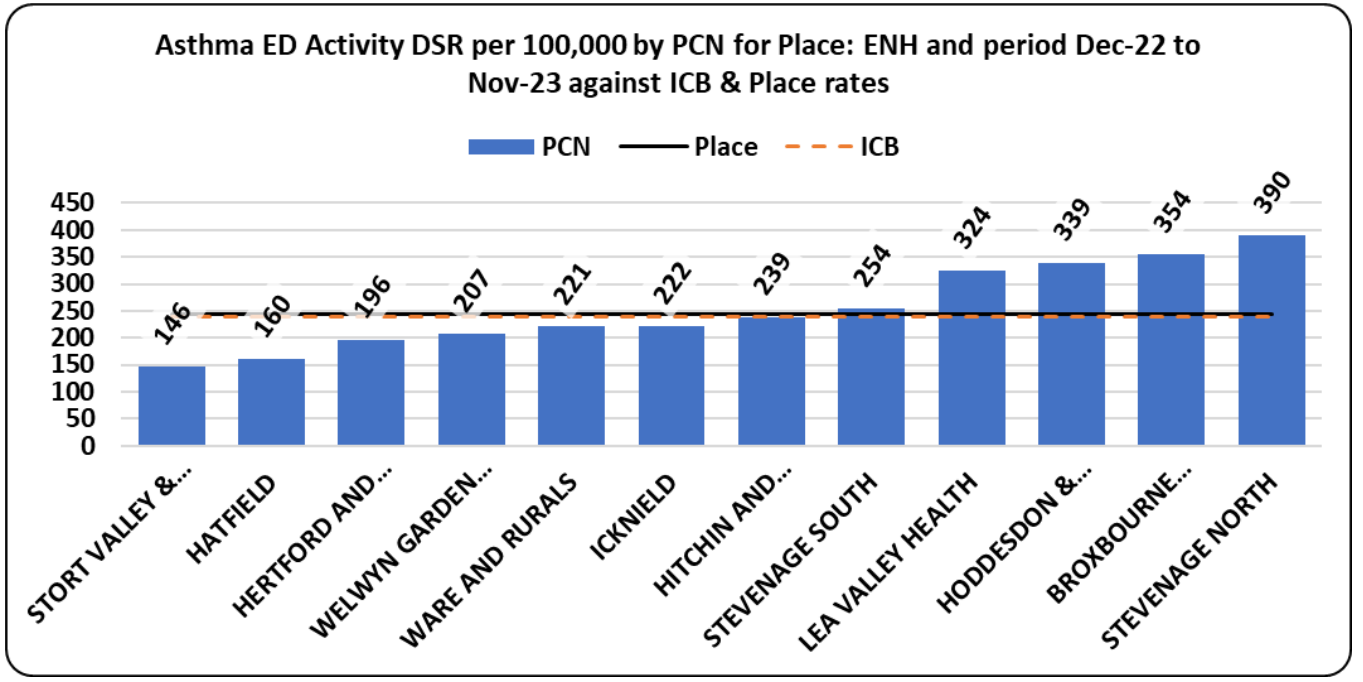
Source: NCMP and HES: 2022/23

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

- Data for the 12 months up to November 2023 shows ENH Place has a similar rate of A&E attendances for Children and Young People for Asthma (data on the right-hand side).
- Rates of Children and Young People attending A&E for Asthma have increased since 2020/21 post covid with ENH rates returning to similar to ICB rates.
- There is variation between the PCNs with Stevenage North, Broxbourne Alliance, Hoddesdon and Broxbourne and Lea Valley Health with the highest rates.





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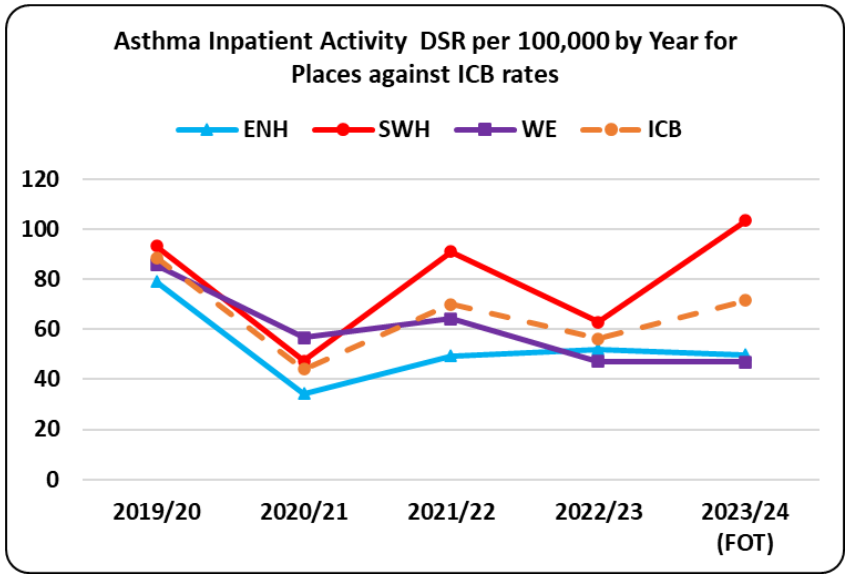
Source: SUS

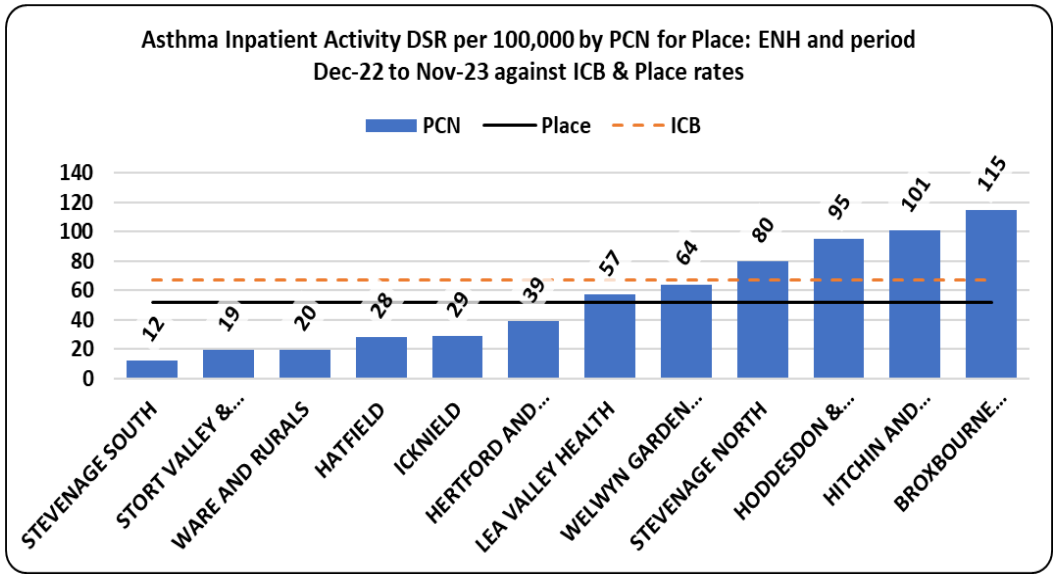
Admissions for Asthma (CYP)

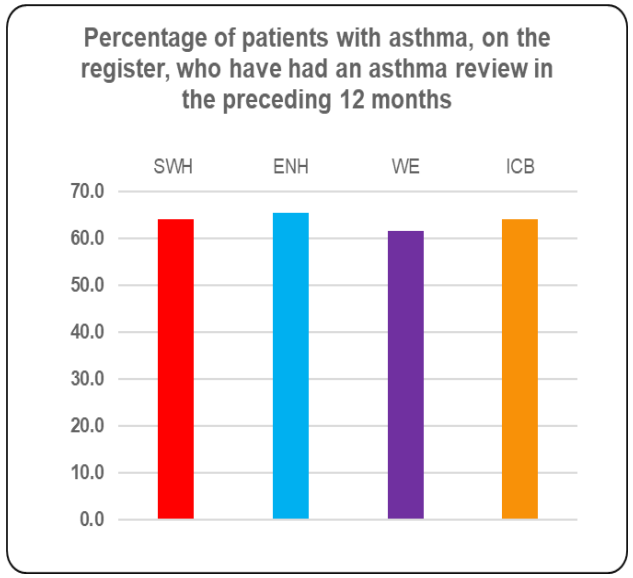
CYP outcome – Reduce the number of unplanned admissions for long term conditions

ICB overarching outcome of reduce the proportion of people living with advanced disease and complexity

- ENH A&E rates for asthma for Children is similar to the ICB, however ENH rates for admissions are lower than the ICB rate (rolling years data middle chart).
- The trend data shows admissions consistently lower than the ICB rate.
- Higher Proportion of Asthma Reviews are carried out within ENH Place in comparison to SWH, WE and the ICB. However, the QOF is for all ages and children specific reviews cannot be identified within the data.







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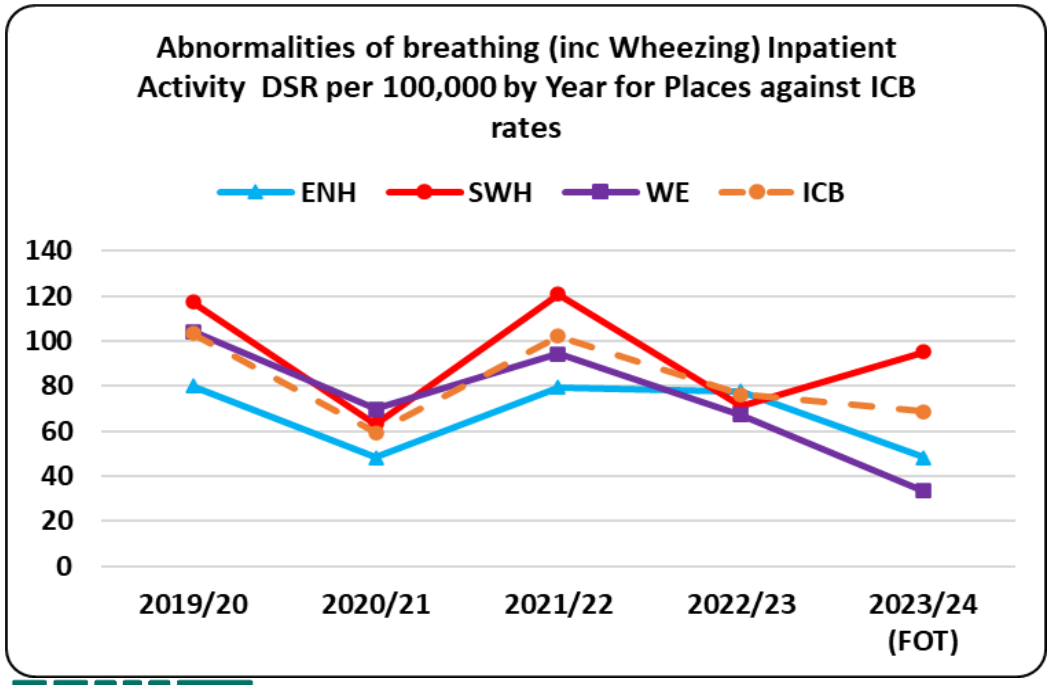
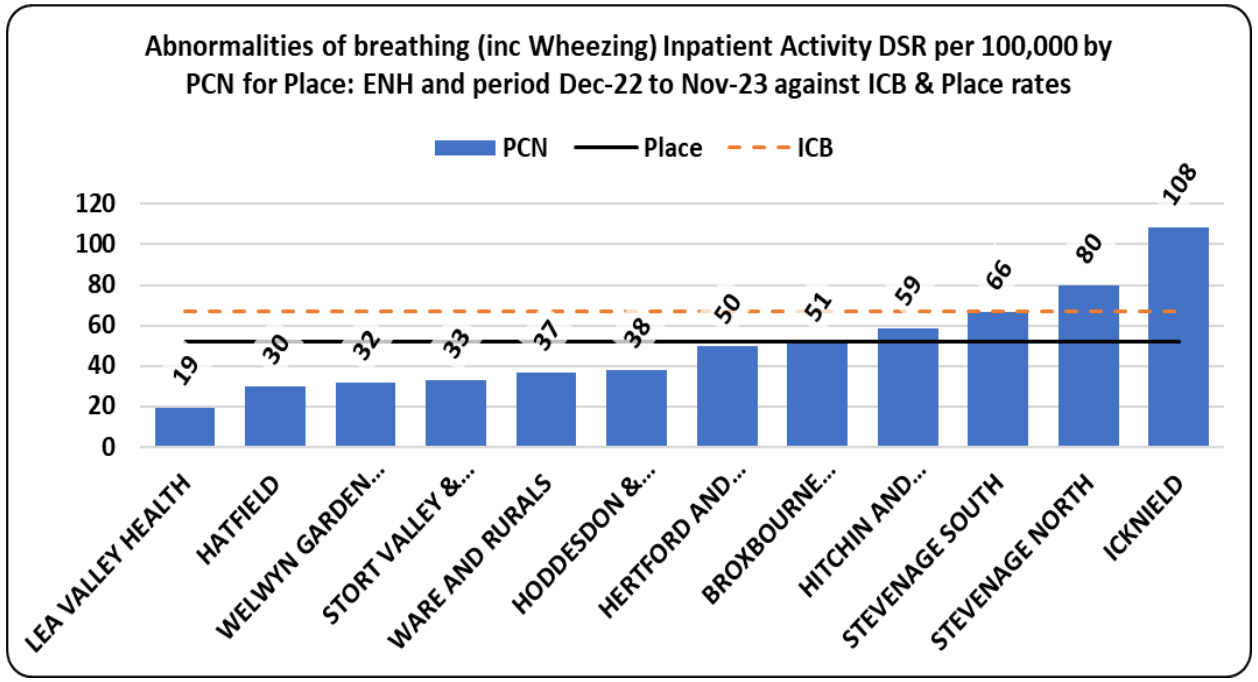
Admissions for Wheeze (CYP)

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**

- ENH Place has a lower rates of Children and Young People admitted to hospital for abnormalities of breathing including wheeze compared to the overall ICB. Recent analysis of UEC data showed Wheeze as a significant reason for admission within young children across HWE.
- When looking at the data by PCN, North Hertfordshire and Stevenage PCNs have the highest rates of Children and Young People admitted to Hospital for Wheeze within East and North Hertfordshire Place.





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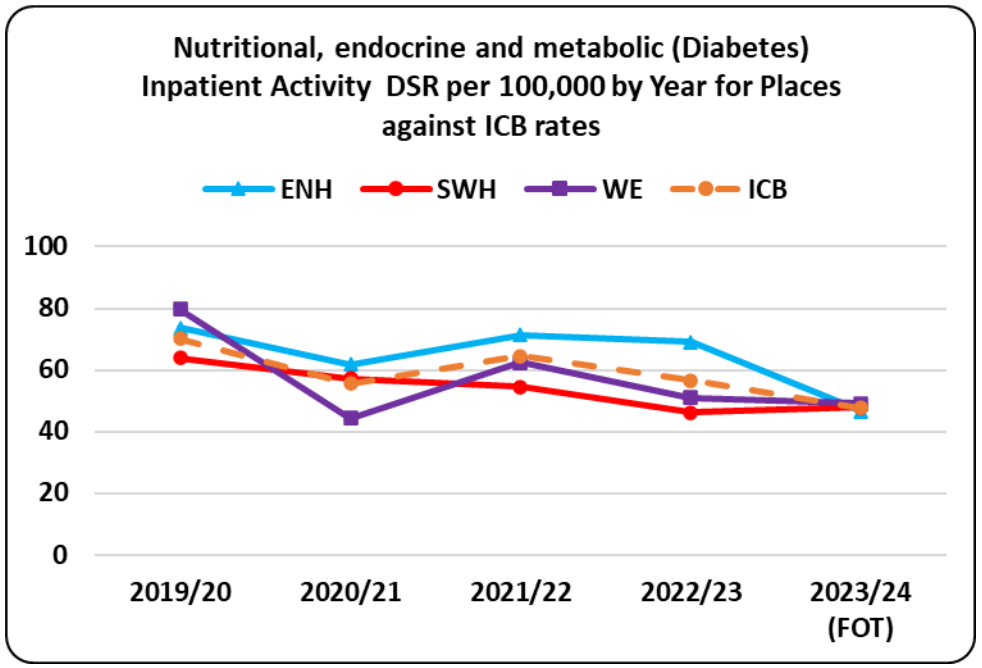
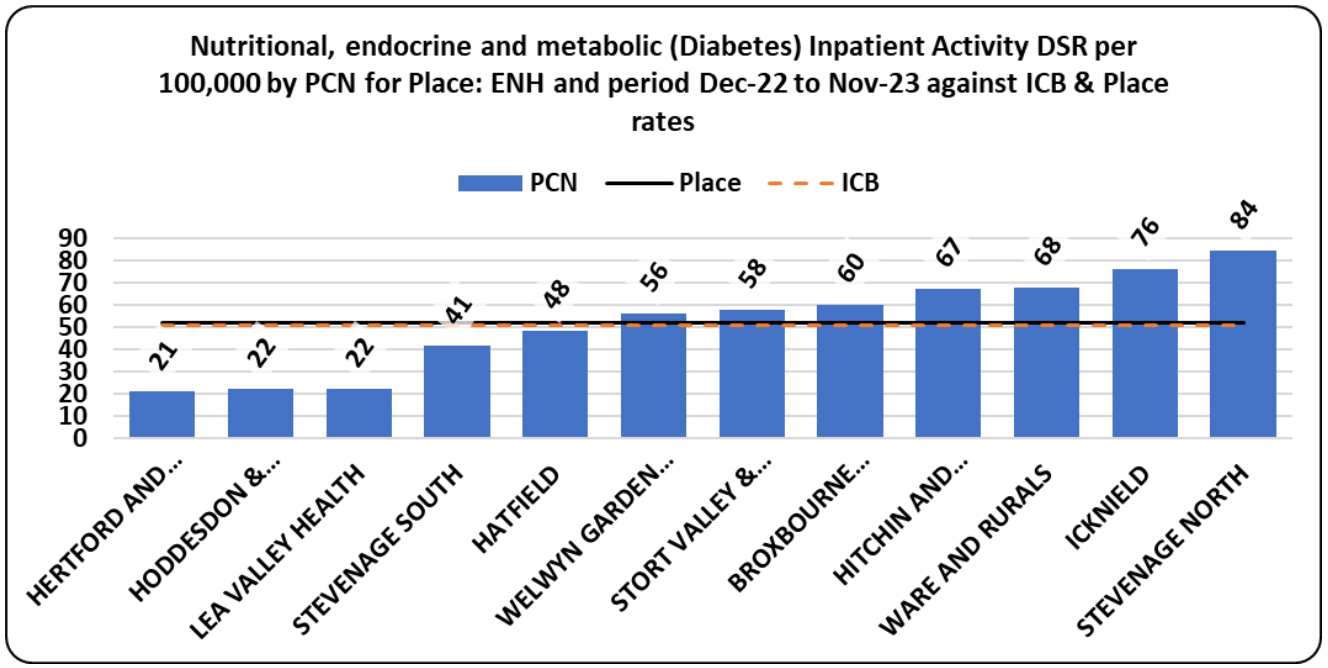
Source: SUS

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 latest data shows that the ENH rate of admission is similar to the ICB.
- The numbers of children admitted for diabetes are small and this should be considered when looking at the data. Stevenage North PCN has higher rates of admissions for diabetes when compared with other PCN's within ENH place.
- The data for diabetes will continue to be monitored at HCP and ICB footprints.





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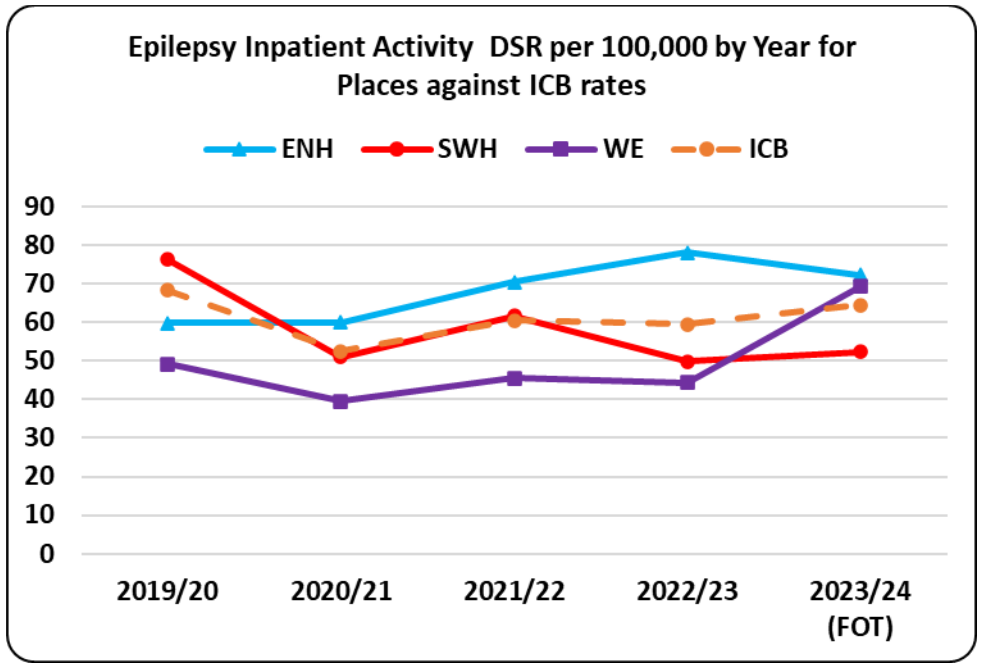
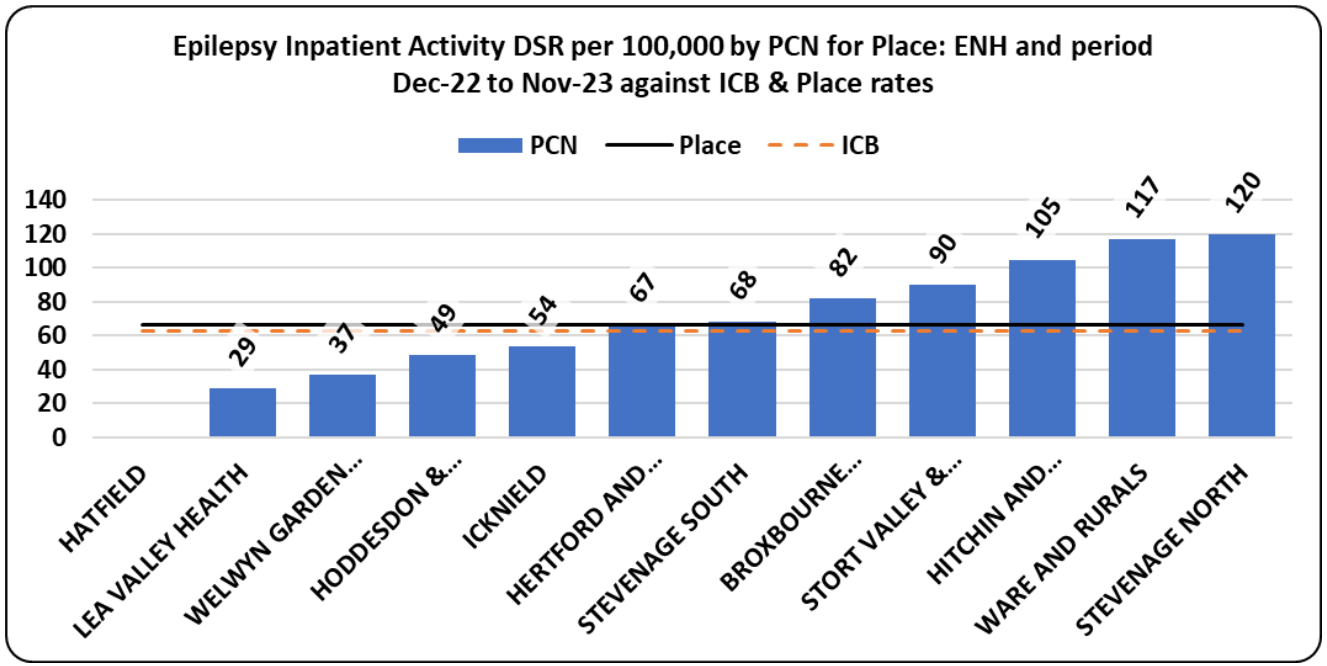
Source: SUS

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 latest data shows that the ENH rate of admission is similar to the ICB.
- The numbers of children admitted for epilepsy are small and therefore fluctuations in the trend are more prominent. When looking at the data by PCN there is variation between the PCNs in ENH place.
- The data for epilepsy will continue to be monitored at wider HCP and ICB footprints.





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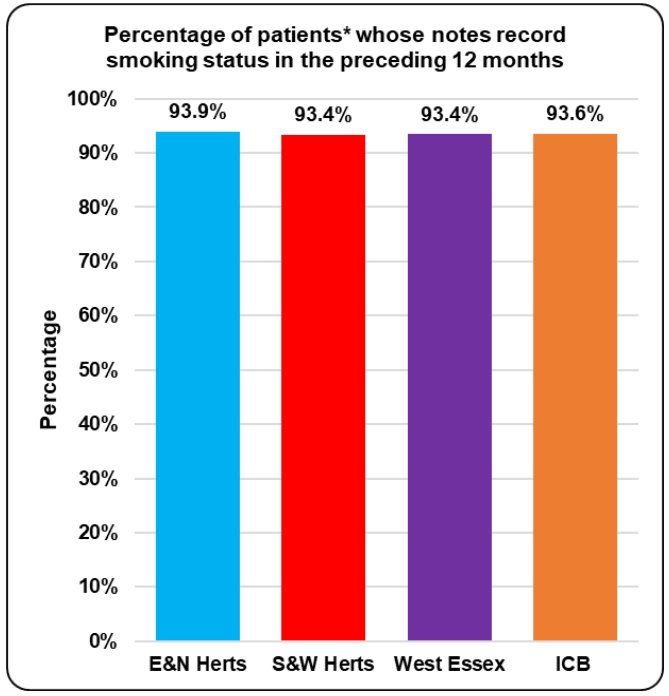
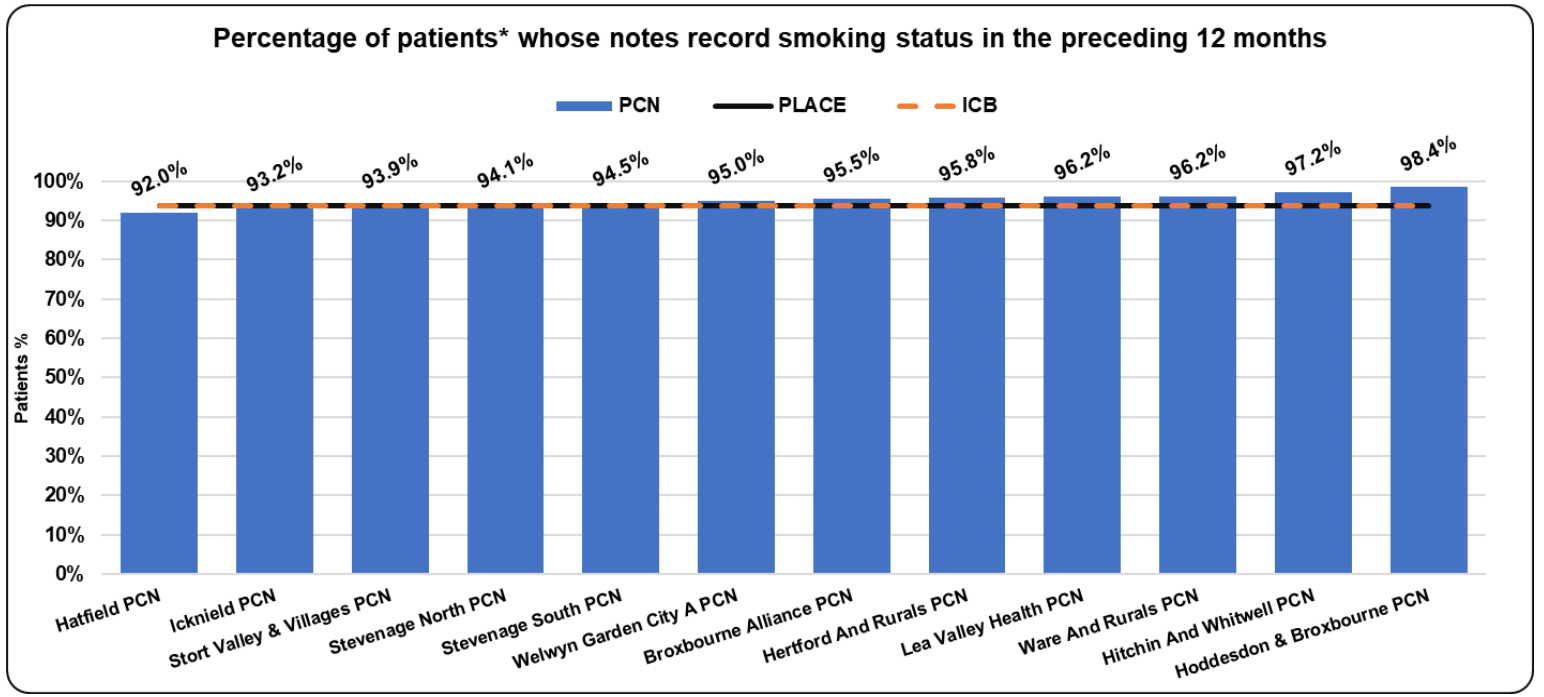
Source: SUS

Prevention and health inequalities – Lifestyle factors - Smoking

- ENH Place data for smoking shows a similar picture to the ICB, with 93.9% of patients with a smoking status recorded in the last 12 months. (QOF mar 23).
- The table to the right gives detail by condition of the opportunity for further recording of smoking status. This shows the position in January. Practices can access the latest position via https://app.ardensmanager.com/login

Practices	ECF 2023-24 - Condition Section Under Smoker, Smoking Status, and Smoking Status Recorded - as of Jan. 2024					
	Pre-Diabetes		Diabetes		Atrial Fibrillation	
	Remaining % of Population with a Smoking status	Smoking Available Patients - Total Number	Remaining % of Population with a Smoking status	Smoking Available Patients - Total Number	Remaining % of Population with a Smoking status	Smoking Available Patients - Total Number
ICB	16.30%	94566	8.47%	97582	0%	1800
East and North Herts	17.82%	28228	8.44%	36157	0%	712
South West Herts	20.53%	48680	11.26%	40592	0%	664
West Essex	10.54%	17658	5.69%	20833	0%	424





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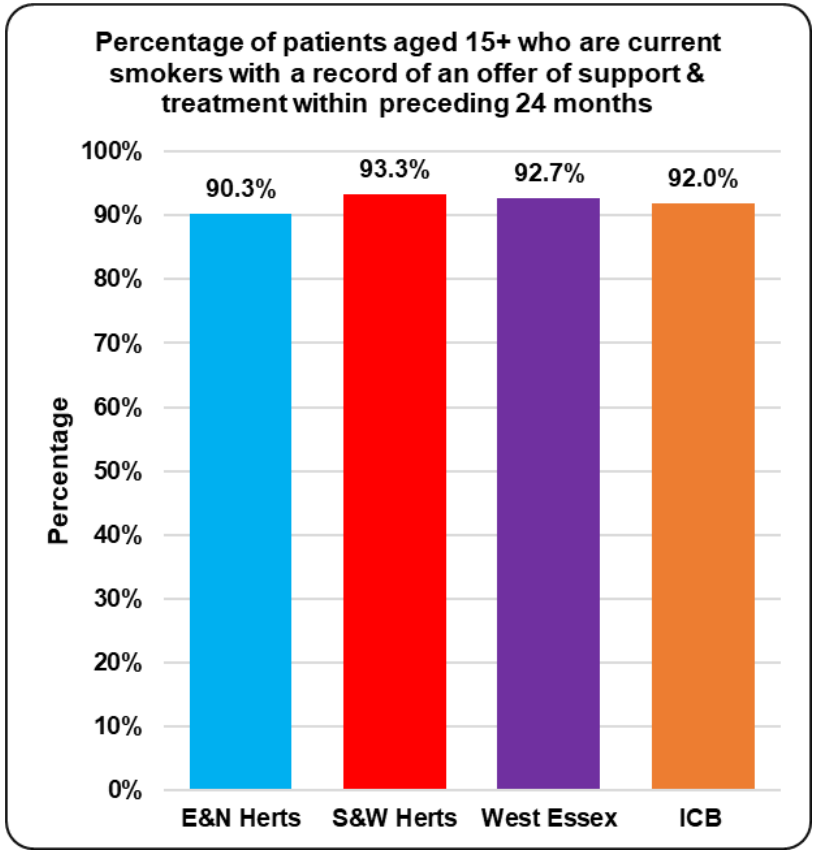
* with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses

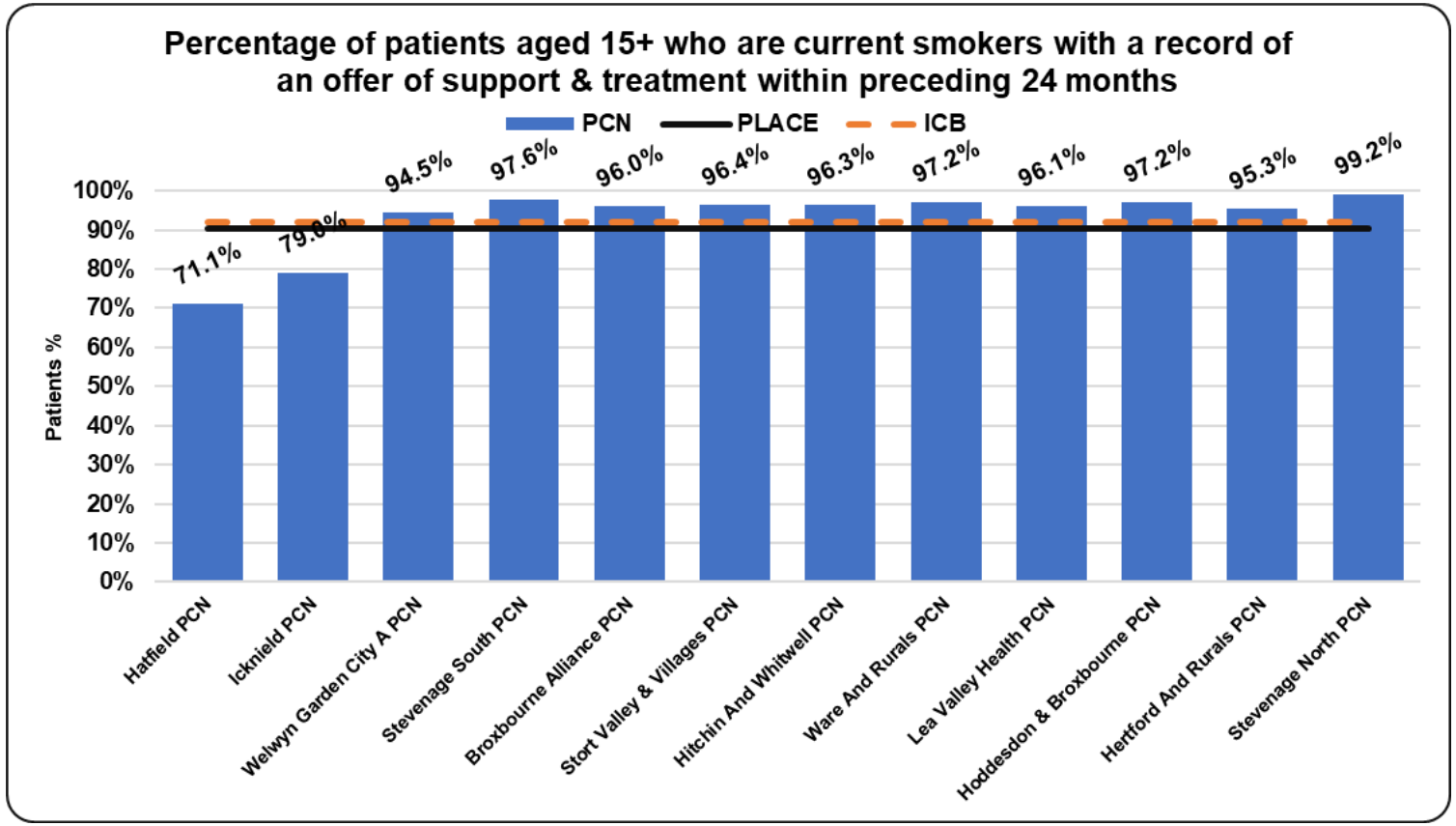
Source: Link: QOF Data Set & ECF Jan. 2024

Prevention and health inequalities – Lifestyle factors - Smoking

- Smoking is a significant cause of morbidity and mortality. The long-term risk of smoking to individuals has been quantified in a 50-year cohort study of British doctors. Observing deaths in smokers and non-smokers over a 50-year period, the study concluded that 'about half of all regular smokers will eventually be killed by their habit'. In Europe, about 20% of deaths from cardiovascular disease (CVD) in men and about 3% of deaths from CVD in women are due to smoking - Nice Advisory Paper NM39

- ENH Herts place has the highest recording of smoking status within the ICB. However ENH has the lowest percentage offered treatment. The chart on the right shows this detail by PCN.





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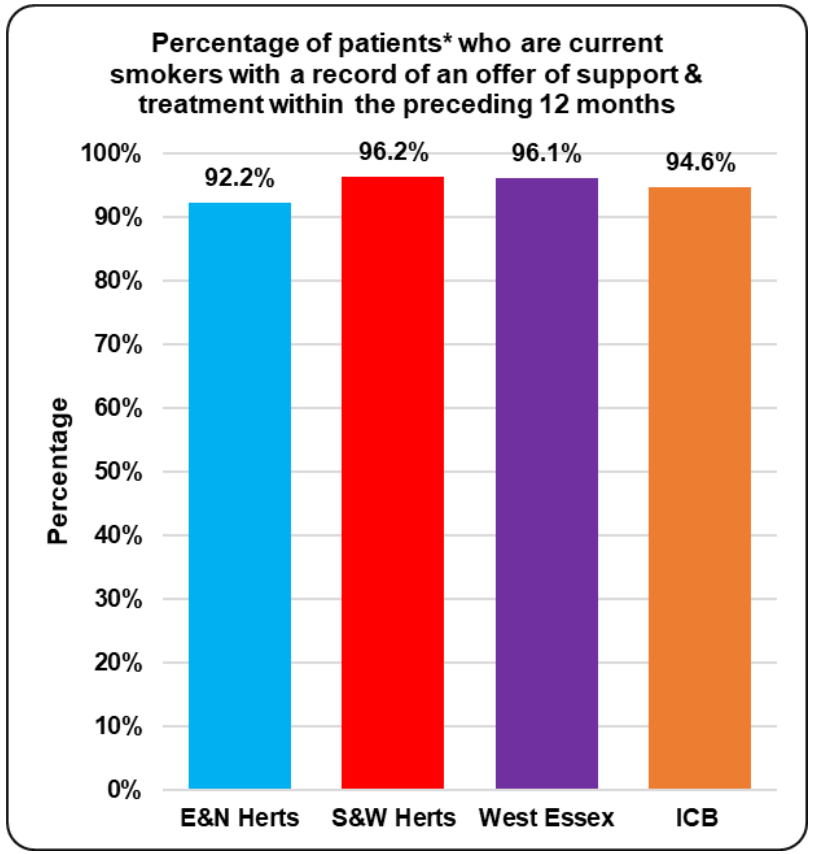
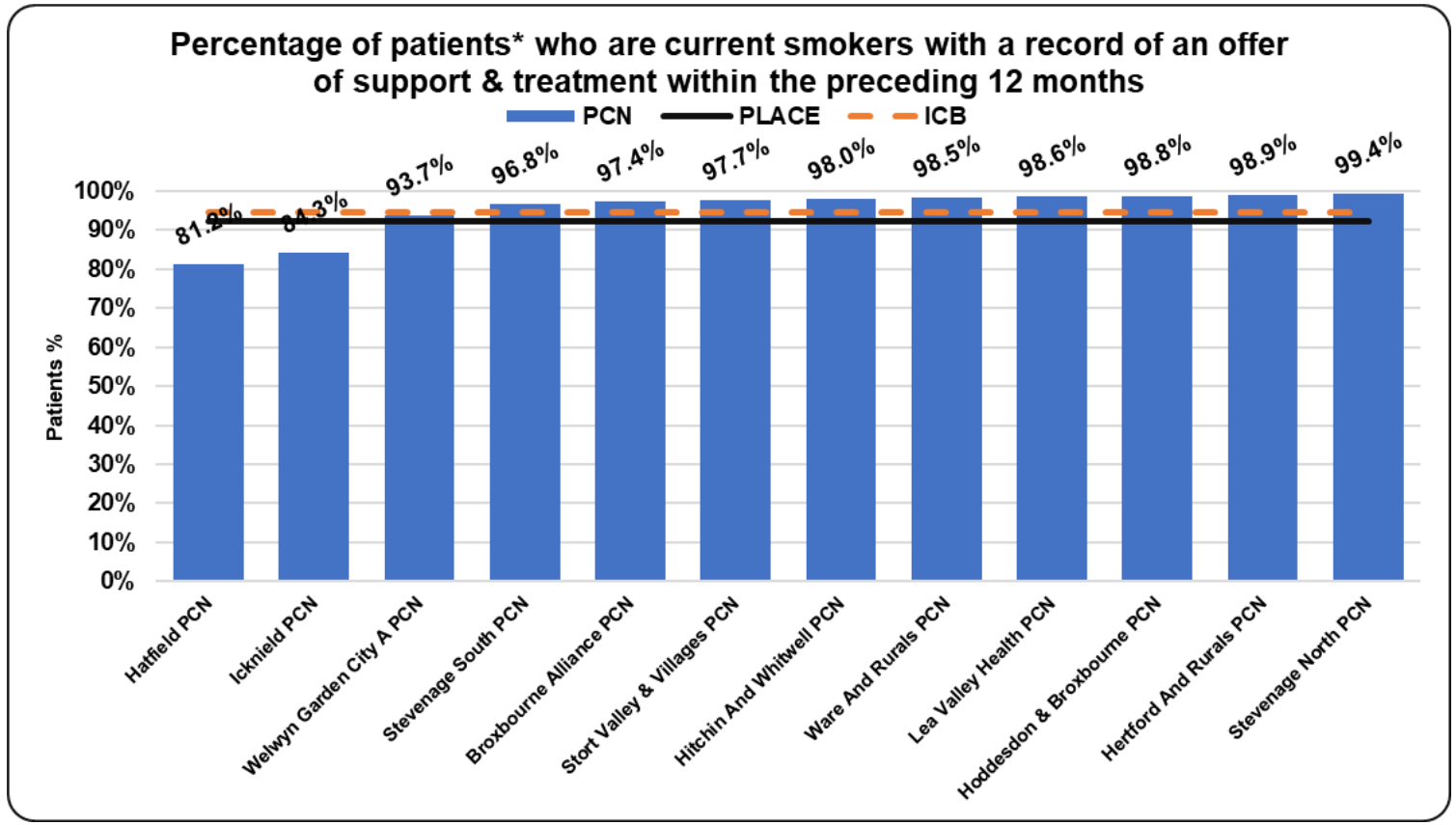
Prevention and health inequalities – Lifestyle factors - Smoking

- The health economic models for the NICE public health guidance PH10 on smoking cessation in primary care and the technology appraisal on bupropion and nicotine replacement therapy found smoking cessation interventions to be cost effective. The NICE costing report reported only the short-term additional cost of implementing the guidance by primary care trusts (PCTs). This is because the estimated longer-term improvements in health, and consequent reduction in expenditure in treating smoking-related diseases, was expected to be delivered over a much longer timeframe. These cost implications could therefore not be calculated directly in the implementation costs of the guideline - Nice Advisory Paper NM39

- As seen for people over the age of 15 offered treatment ENH also has a lower percentage of patients identified with conditions* offered treatment compared to the ICB.





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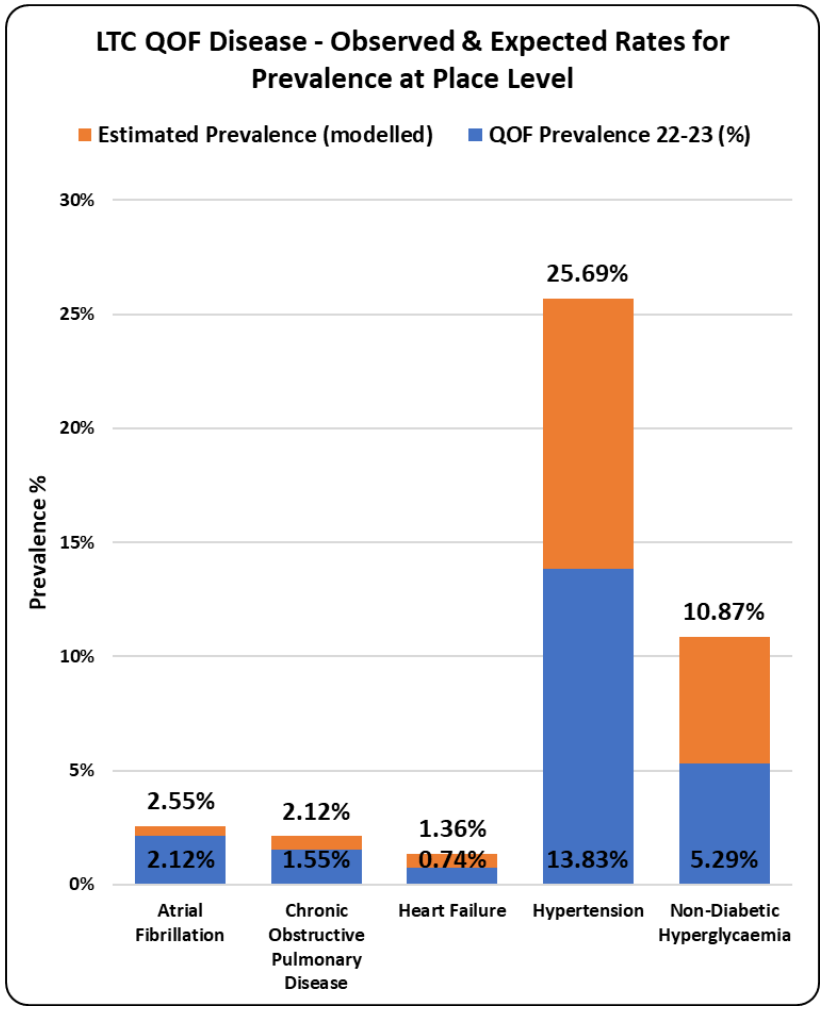
* with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses

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 here shows the national modelled estimated prevalence for East & North Herts compared with the latest published QOF prevalence for the Place.

- ENH Place recorded prevalence compared with the modelled estimated prevalence is lower across all conditions.
- The data shows an opportunity for further identification for these conditions. Practices can access case finding searches within the Ardens Suite of searches: https://app.ardensmanager.com/login
- Individual PCN details can be found within their packs here: https://hertsandwestessexics.org.uk/pcn-packs



	Disease Detection Modelling for Place - Total Number of New Diagnoses to Meet ICS & PLACE Rates - 2023/24					
	E&N Herts		S&W Herts		West Essex	
Disease/ Condition	Total number to meet ICS rate	Total number to meet PLACE rate	Total number to meet ICS rate	Total number to meet PLACE rate	Total number to meet ICS rate	Total number to meet PLACE rate
Asthma	36020	1968	38391	1511	18890	1099
Atrial Fibrillation	310	1319	446	1415	142	697
Chronic Kidney Disease	16769	1958	17679	3177	8756	1541
Chronic Obstructive Pulmonary Disease	148	903	57	991	15	479
Coronary Heart Disease	16685	1219	17800	1265	8792	604
Diabetes Mellitus		2075		3057		1381
Epilepsy	3498	296	3688	304	1826	139
Heart Failure	55	492		586		410
Hypertension	84970	4473	90647	5013	44775	2158
Non-Diabetic Hyperglycaemia		3918		5542		2223
Peripheral Arterial Disease	2675	216	2854	326	1410	135
Stroke and Transient Ischaemic Attack	10118	739	10794	783	5332	477

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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 PCN within East & North Hertfordshire.
- 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.

East & North Herts Place - Long-Term Conditions 2022-23 QOF Prevalence, with 3 Year Trend.

QOF Disease/ Condition	QOF 22-23 - ICB %	QOF 22-23 - PLACE %	BROXBOURNE ALLIANCE		HATFIELD		HERTFORD AND RURALS		HITCHIN AND WHITWELL		HODDESDON & BROXBOURNE		ICKNIELD		LEA VALLEY HEALTH		STEVENAGE NORTH		STEVENAGE SOUTH		STORT VALLEY & VILLAGES		WARE AND RURALS		WELWYN GARDEN CITY A	
			QOF 2022-23	3 Year Trend	QOF 2022-23	3 Year Trend	QOF 2022-23	3 Year Trend	QOF 2022-23	3 Year Trend	QOF 2022-23	3 Year Trend	QOF 2022-23	3 Year Trend	QOF 2022-23	3 Year Trend	QOF 2022-23	3 Year Trend	QOF 2022-23	3 Year Trend	QOF 2022-23	3 Year Trend	QOF 2022-23	3 Year Trend	QOF 2022-23	3 Year Trend
Asthma	6.16%	6.40%	6.04%		4.47%		6.92%		7.14%		6.54%		6.95%		5.84%		5.89%		6.43%		6.70%		7.44%		6.22%	
Atrial fibrillation	2.09%	2.12%	2.06%		1.53%		2.55%		2.34%		2.65%		2.33%		1.68%		1.56%		2.00%		2.09%		2.53%		1.81%	
Chronic kidney disease	3.46%	2.94%	3.55%		2.25%		3.35%		2.77%		2.83%		2.55%		2.64%		1.37%		3.25%		3.74%		3.37%		2.91%	
Chronic obstructive pulmonary disease (COPD)	1.49%	1.55%	1.66%		1.36%		1.27%		1.69%		1.70%		1.54%		1.80%		1.87%		1.78%		1.29%		1.37%		1.46%	
Diabetes mellitus	6.63%	6.54%	7.19%		6.02%		5.55%		6.12%		6.77%		7.07%		7.48%		7.70%		7.32%		5.44%		6.36%		6.23%	
Epilepsy	0.70%	0.73%	0.74%		0.61%		0.80%		0.65%		0.66%		0.78%		0.68%		0.88%		0.92%		0.61%		0.74%		0.77%	
Heart Failure	0.80%	0.74%	0.83%		0.55%		0.78%		0.66%		0.90%		0.67%		0.68%		0.63%		0.71%		0.96%		0.89%		0.64%	
Hypertension	13.84%	13.83%	14.93%		11.44%		15.06%		14.00%		15.23%		14.18%		13.41%		13.42%		13.83%		13.12%		14.49%		12.69%	
Non-diabetic hyperglycaemia	6.42%	5.29%	7.67%		5.30%		5.14%		3.51%		5.68%		6.08%		3.59%		3.25%		5.67%		3.78%		6.05%		7.13%	
Peripheral arterial disease	0.44%	0.45%	0.46%		0.43%		0.46%		0.38%		0.46%		0.43%		0.50%		0.42%		0.46%		0.44%		0.55%		0.39%	
Secondary prevention of coronary heart disease	2.67%	2.63%	2.69%		2.02%		2.73%		2.61%		3.27%		2.82%		2.51%		2.54%		2.59%		2.60%		3.11%		2.18%	
Stroke and transient ischaemic attack	1.63%	1.71%	1.81%		1.44%		1.82%		1.84%		1.90%		1.86%		1.53%		1.49%		1.75%		1.67%		1.77%		1.52%	

Hertfordshire and West Essex Integrated Care System

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

Development of more proactive, preventative care models for LTC : Annual Reviews (QOF 22/23)

- The table on the right shows a summary of the percentage of patients receiving an annual review or risk assessment by condition.
- The data here is shown without exceptions removed in order to be able to view the percentage of people not receiving reviews.
- Where the cell is highlighted the percentage is lower than the ICB value.
- Areas of opportunity for E&N Herts place are AF, Heart Failure and non-diabetic hyperglycaemia. The breakdown by PCN can be found on the following place.
- 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	E&N	SWH	WE
% of AF Patients with Stroke Risk Assessed in the last 12 months	92.9	91.8	94.2	93.0
The % of patients aged 45 or over who have a record of blood pressure in the preceding 5 years	85.7	85.9	85.1	86.4
The % of patients with a diagnosis of heart failure on the register, who have had a review in the preceding 12 months	72.7	67.0	80.0	70.0
The % of patients with asthma, on the register, who have had an asthma review in the preceding 12 months	64.0	65.3	64.1	61.4
The % of patients with COPD, on the register, who have had a review in the preceding 12 months	75.7	77.1	75.3	74.0
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	76.4	76.1	73.0
The % of patients with non-diabetic hyperglycaemia who have had an HbA1c or fasting blood glucose performed in the preceding 12 months.	82.9	82.9	84.0	80.5

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

Development of more proactive, preventative care models for LTC : Annual Reviews (QOF 22/23)

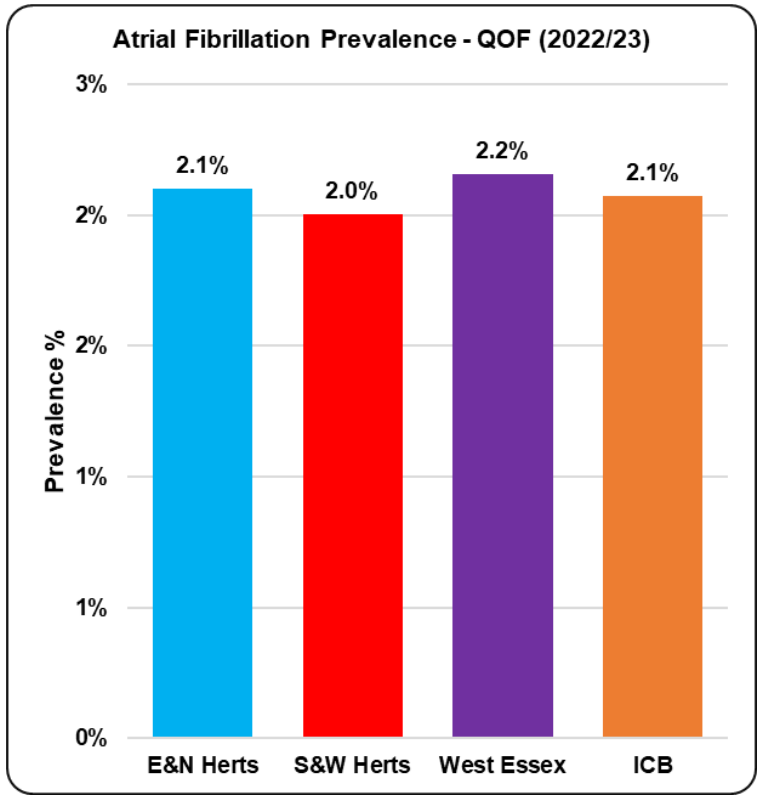
	E&N	Broxbourne Alliance PCN	Hatfield PCN	Hertford And Rurals PCN	Hitchin And Whitwell PCN	Hoddesdon & Broxbourne PCN	Icknield PCN	Lea Valley Health PCN	Stevenage North PCN	Stevenage South PCN	Stort Valley & Villages PCN	Ware And Rurals PCN	Welwyn Garden City A PCN
% of AF Patients with Stroke Risk Assessed in the last 12 months	91.8	94.9	94.7	94.3	90.1	95.2	79.0	93.4	88.6	87.4	88.5	97.1	94.2
The % of patients aged 45 or over who have a record of blood pressure in the preceding 5 years	85.9	85.7	81.8	87.4	85.9	88.9	83.7	90.1	87.9	84.4	86.2	84.0	84.6
The % of patients with a diagnosis of heart failure on the register, who have had a review in the preceding 12 months	67.0	79.6	64.4	78.4	68.4	84.6	45.5	60.3	34.6	69.0	61.7	83.2	85.1
The % of patients with asthma, on the register, who have had an asthma review in the preceding 12 months	65.3	59.4	52.9	59.6	63.0	74.1	65.0	82.7	63.3	60.8	65.8	75.0	68.8
The % of patients with COPD, on the register, who have had a review in the preceding 12 months	77.1	72.2	69.2	74.6	78.2	84.6	76.2	85.1	79.6	76.4	76.1	86.1	71.8
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	76.4	71.1	71.3	72.5	80.8	82.0	75.4	82.7	71.1	76.3	79.9	85.8	75.9
The % of patients with non-diabetic hyperglycaemia who have had an HbA1c or fasting blood glucose performed in the preceding 12 months.	82.9	81.2	77.7	87.2	87.0	87.8	78.0	90.4	75.3	80.9	82.7	92.6	85.0

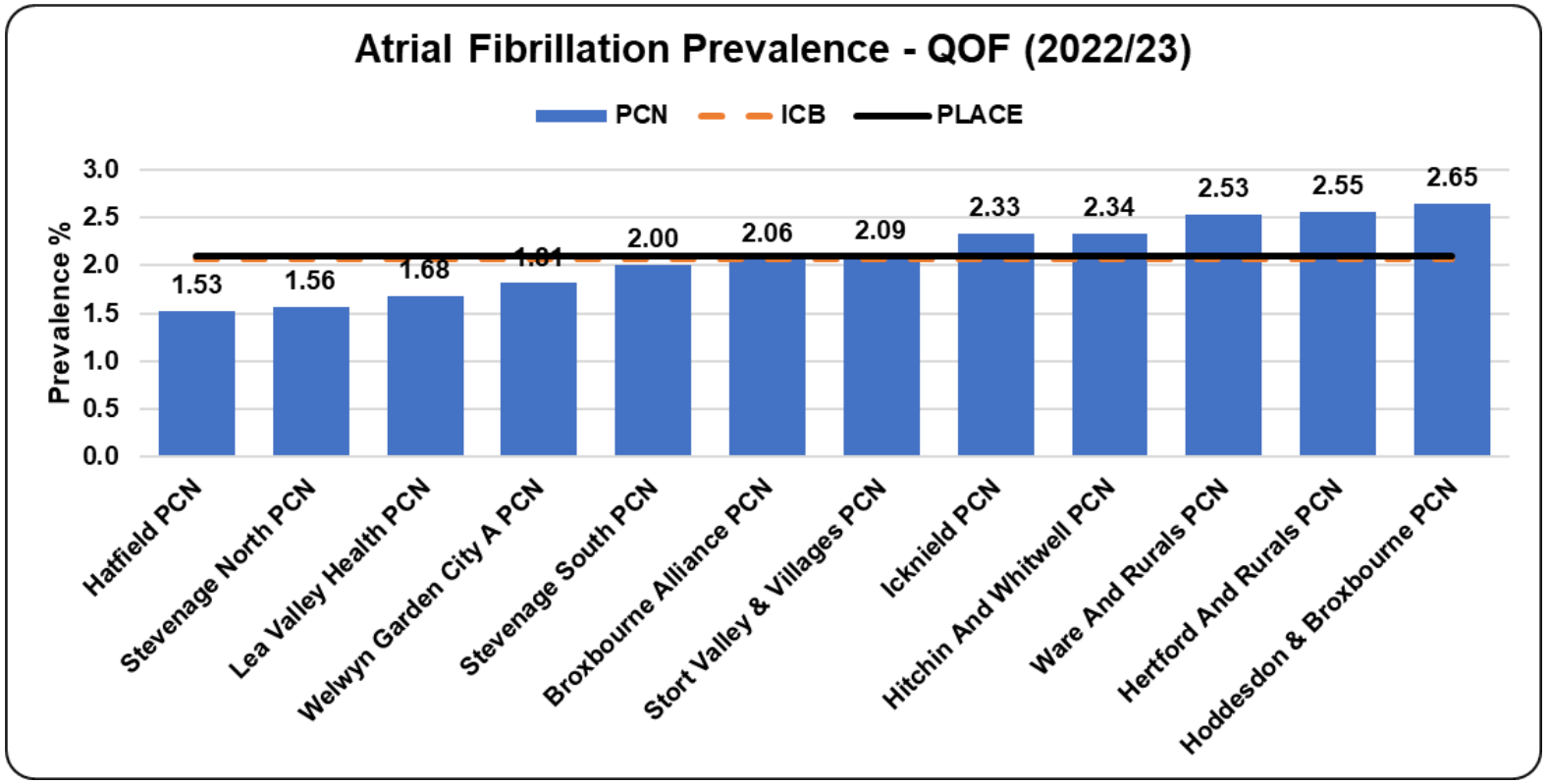
Hertfordshire and West Essex Integrated Care System

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

Prevention and health inequalities – Atrial Fibrillation

- ENH Place recorded prevalence for Atrial Fibrillation is similar to the ICB prevalence.
- There is variation between the prevalence by PCN with values ranging from 1.5% for Hatfield PCN to 2.65% for Hoddesdon & Broxbourne PCN.
- The data suggests there is further opportunity for identification of people with AF within some PCNs. Case finding Ardens searches are available to practices via https://app.ardensmanager.com/login





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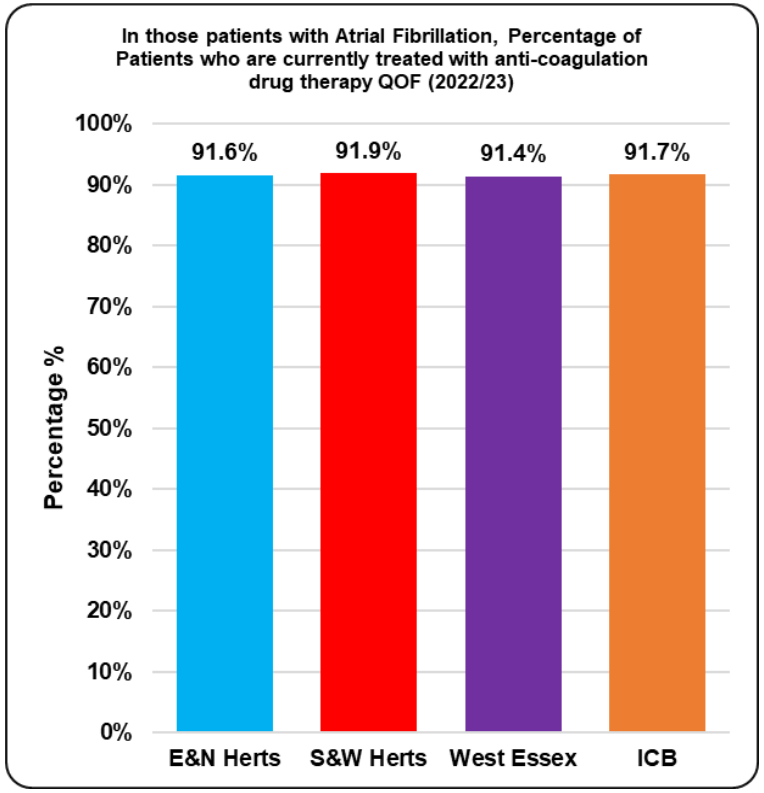
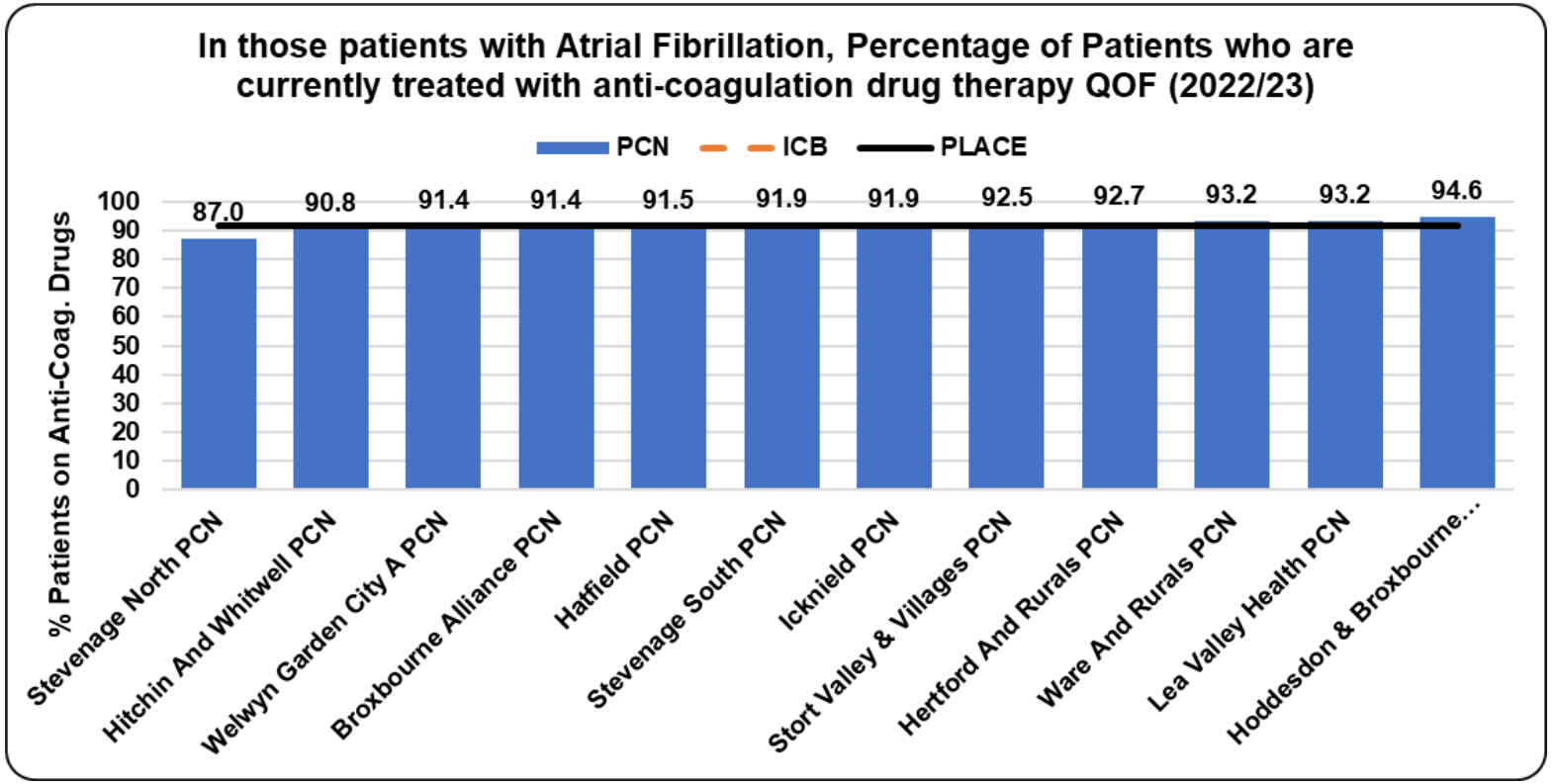
Source: NHS Digital QOF Data Sets Link: QOF Data Set

Prevention and health inequalities – Atrial Fibrillation

- Once identified with Atrial Fibrilation the percentage of patients who are currently treated with anti-coag drug therapy in East & North Herts is similar to the ICB.
- There is variation between the PCNs with Stevenage North PCN data showing 87% on anti-coag drug therapy compared to 91.6% for ENH.





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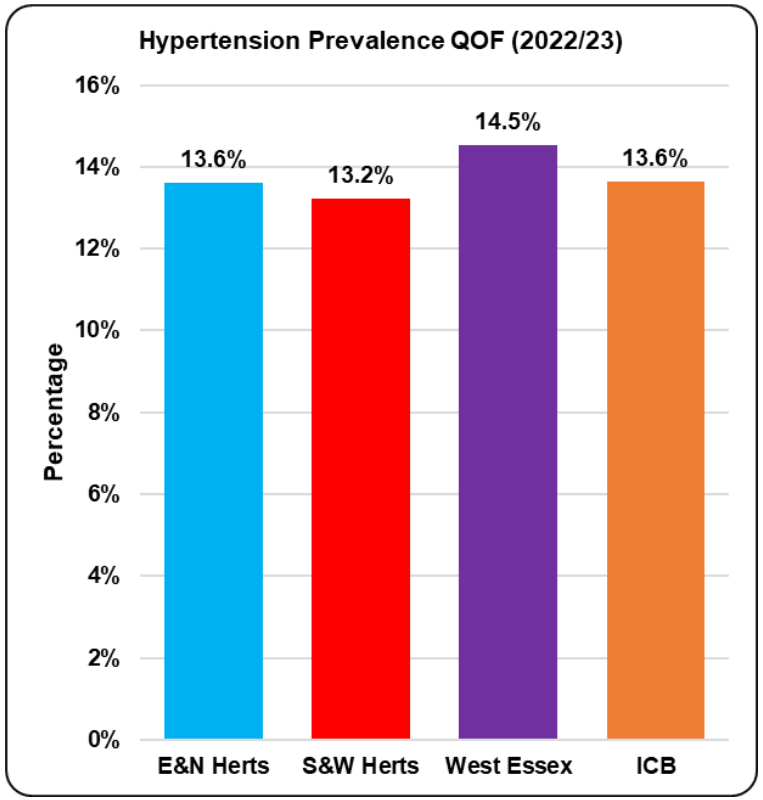
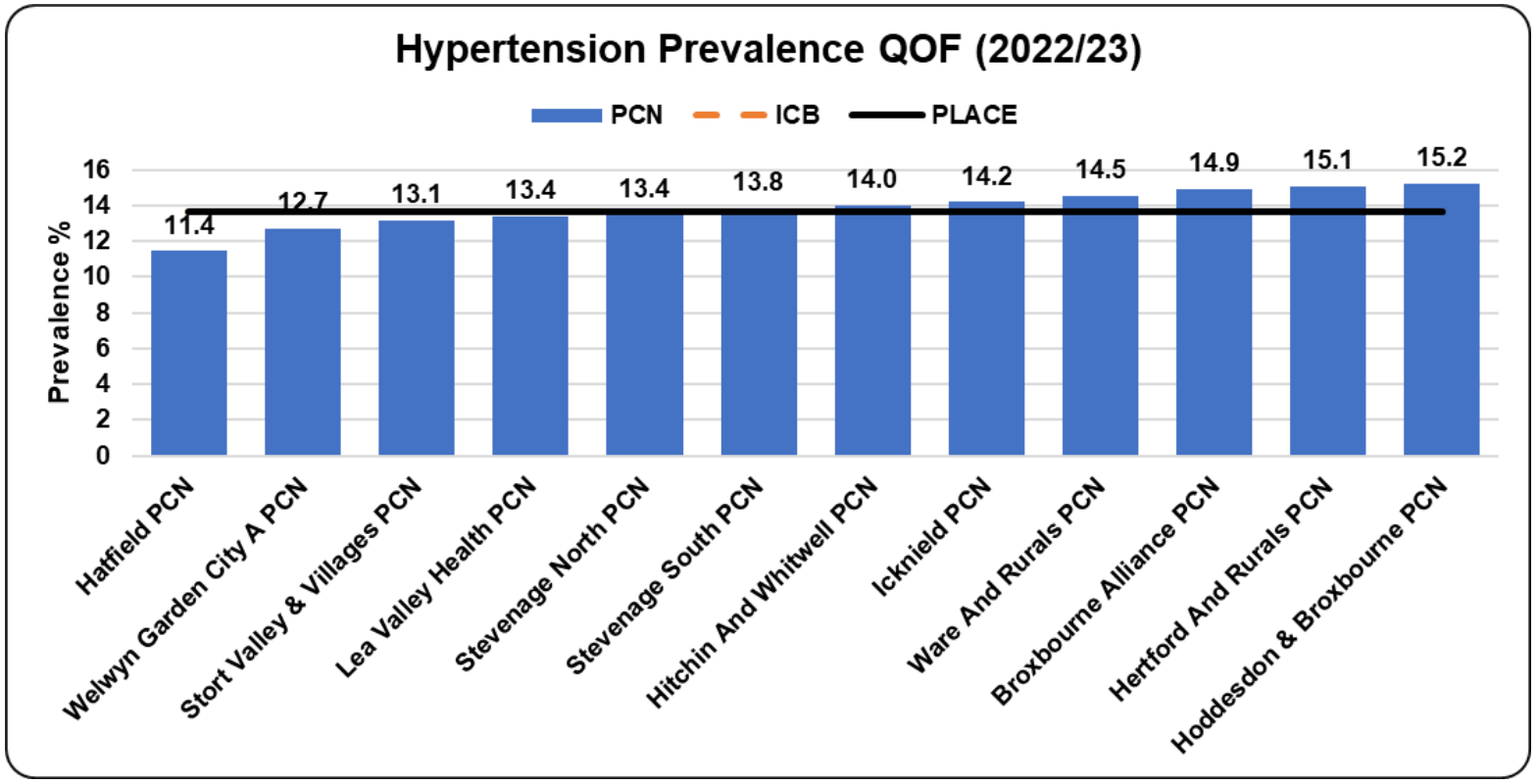
Prevention and health inequalities – Hypertension

- ENH Place recorded prevalence for hypertension is similar to the ICB prevalence.
- The data suggests there is further opportunity for identification of people with hypertension within some PCNs. Case finding Ardens searches are available to practices via https://app.ardensmanager.com/login





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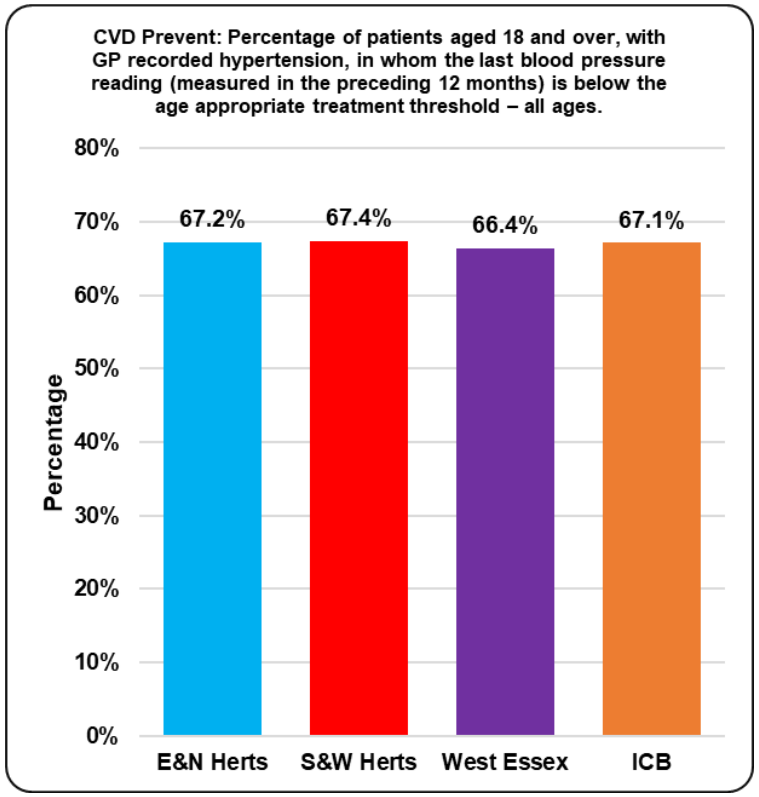
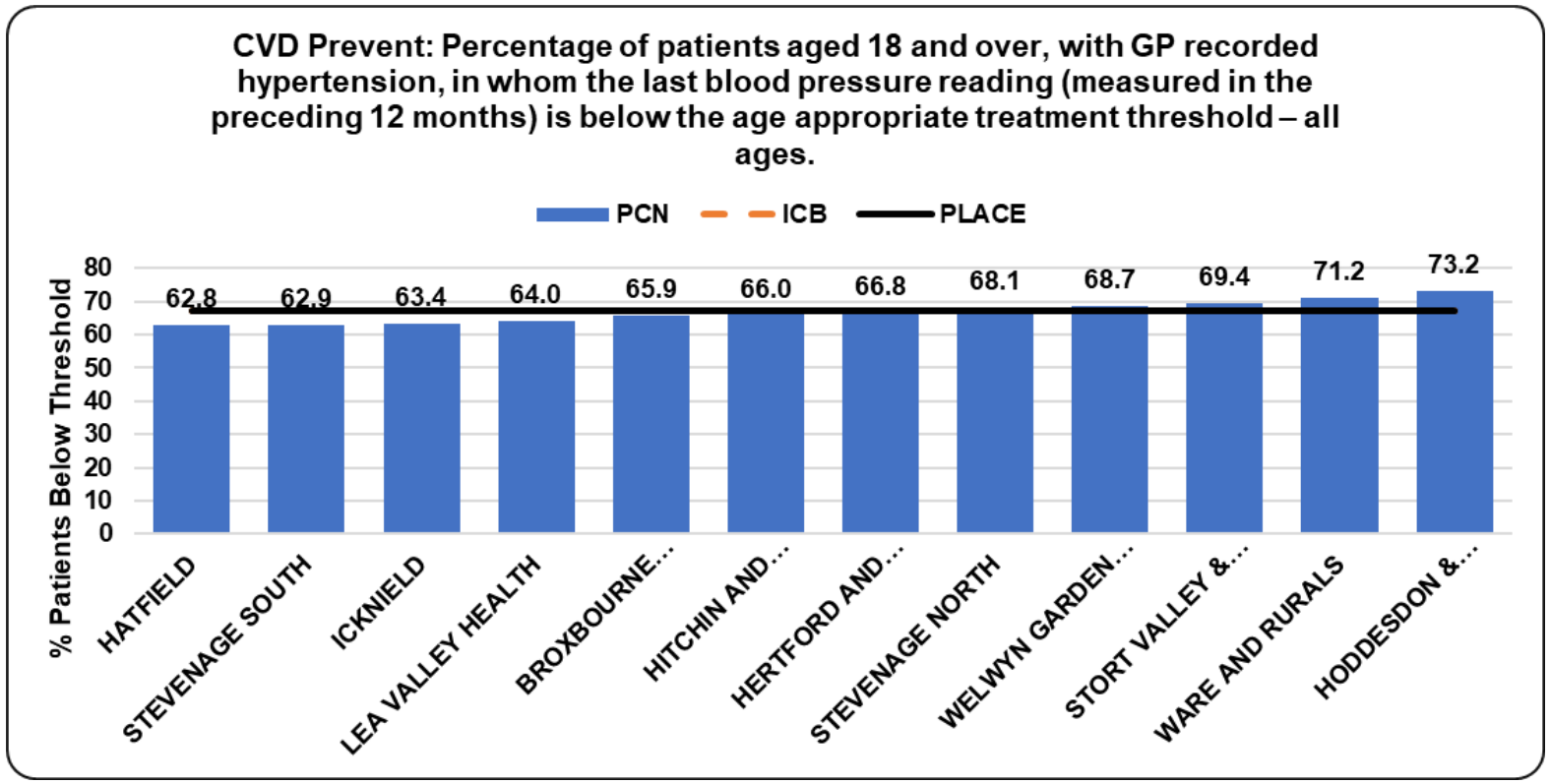
Source: NHS Digital QOF Data Sets Link: QOF Data Set & CVD Prevent Data Sets Link: CVD Prevent Data Explorer

Prevention and health inequalities – Hypertension

- 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 the ICB, however there is variation between the PCNs.
- The latest hypertension indicators can be found at https://app.ardensmanager.com/login





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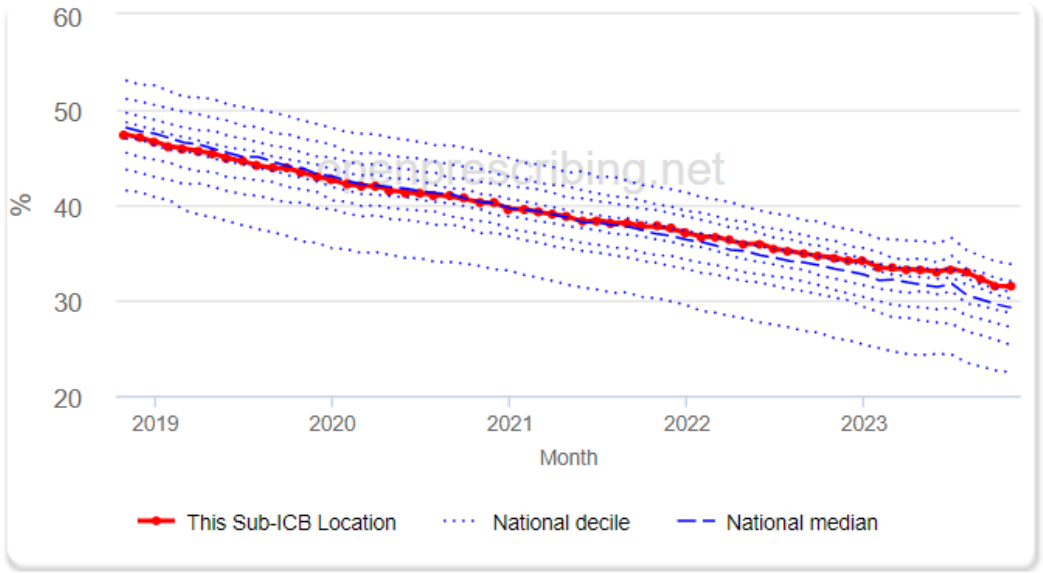
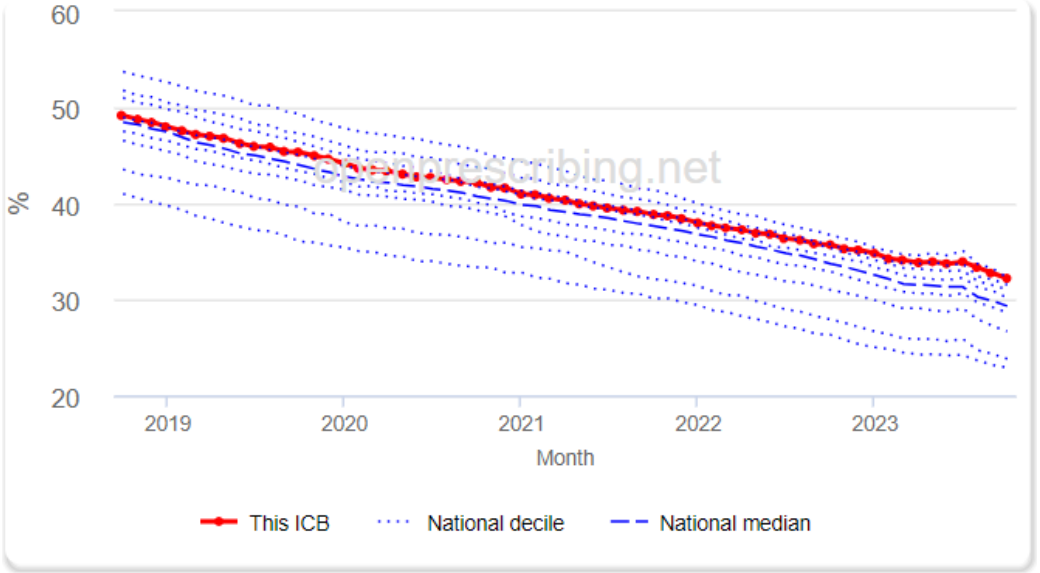
Lipid management : Percentage of people on lipid lowering therapy for secondary prevention who are on low and medium intensity statins

- 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 ENH Place shows that there is an opportunity to improve statin treatment, prescribing a higher proportion of people onto high intensity statins. The Place is in the 74th percentile with 31.5% of people not on high intensity statins. This compares to 28.3% nationally. Individual PCN data can be found within the PCN packs.

ENH Place – 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



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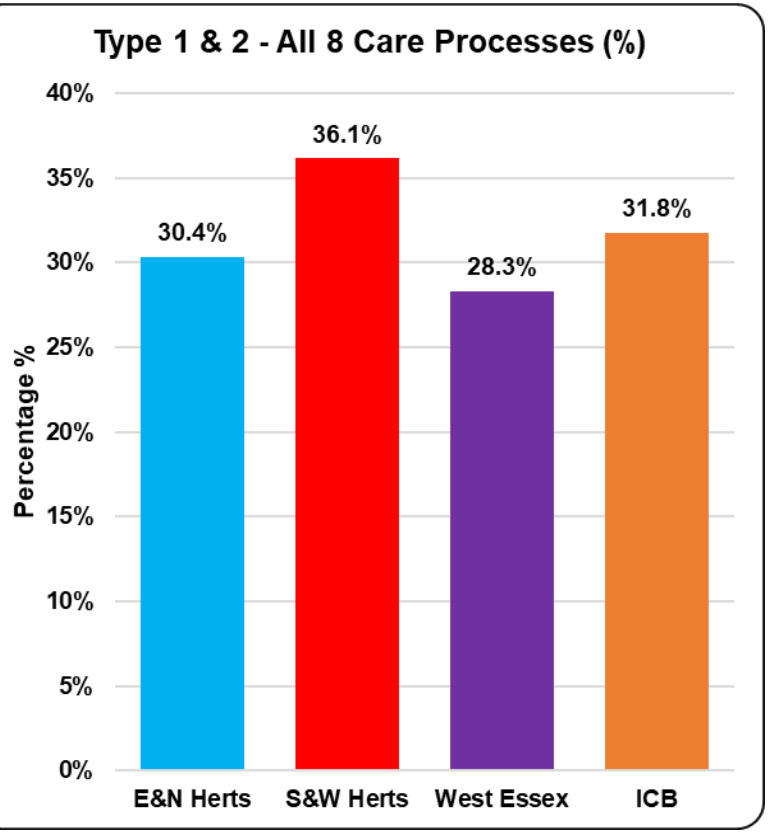
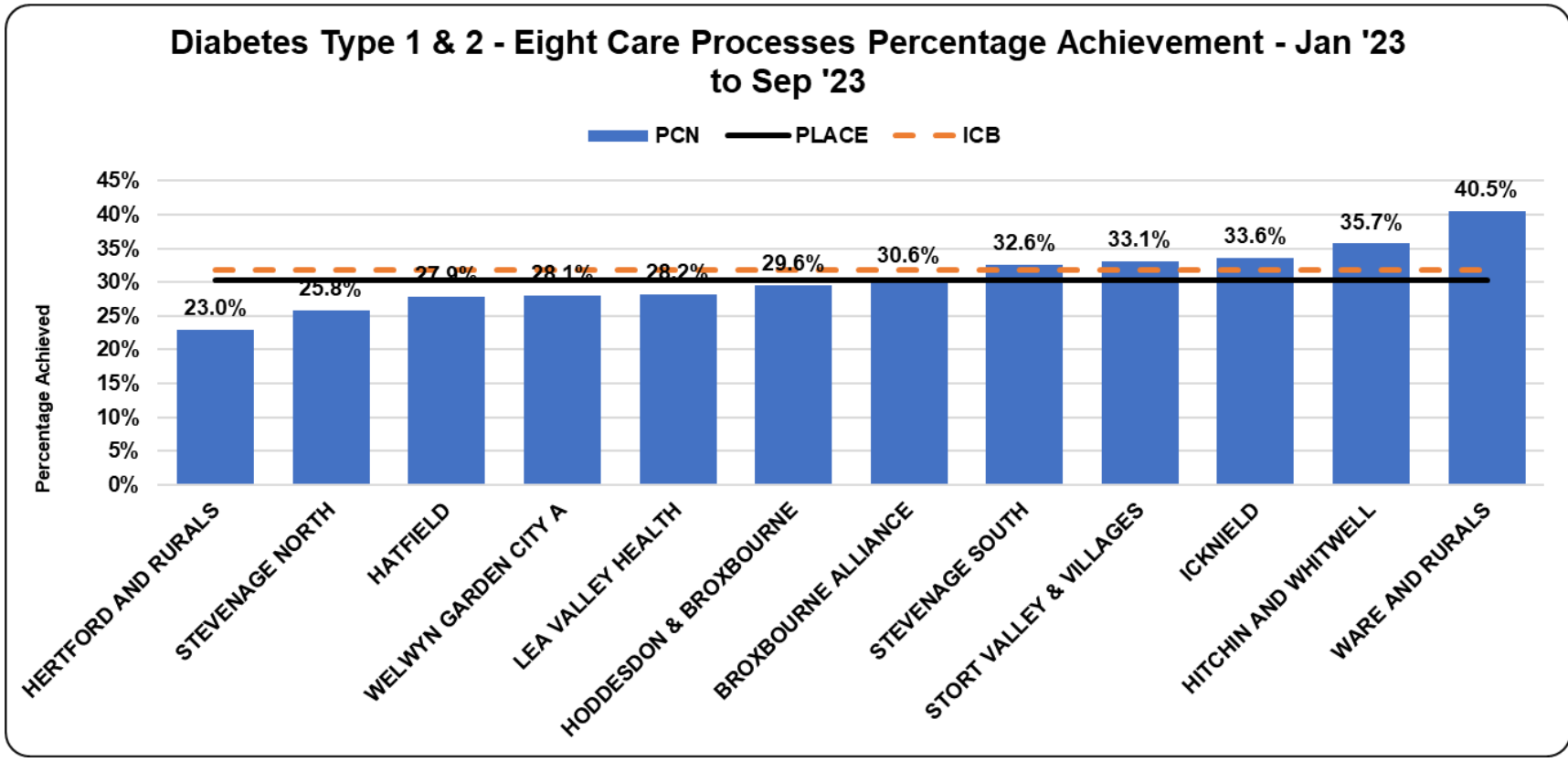
Source: OpenPrescribing.net – Link Here

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 ENH Place is lower than the ICB. There is wide variation between the PCNs.
- The information here is the published National Diabetes Audit. Practices can view their latest information within Ardens Manager where searches are also available to identify those who have not received all 8 care processes.





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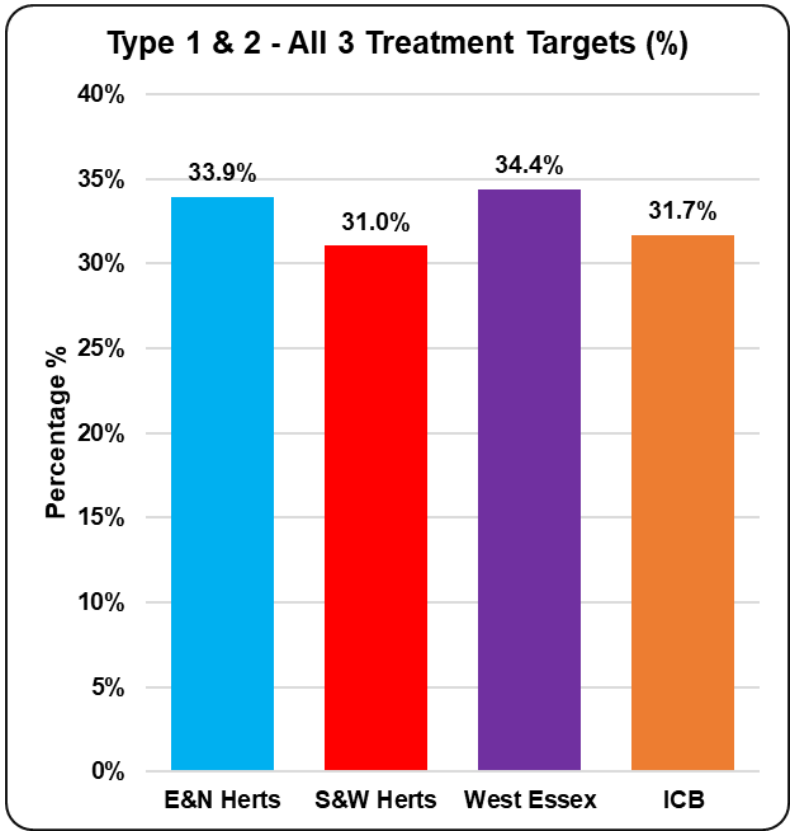
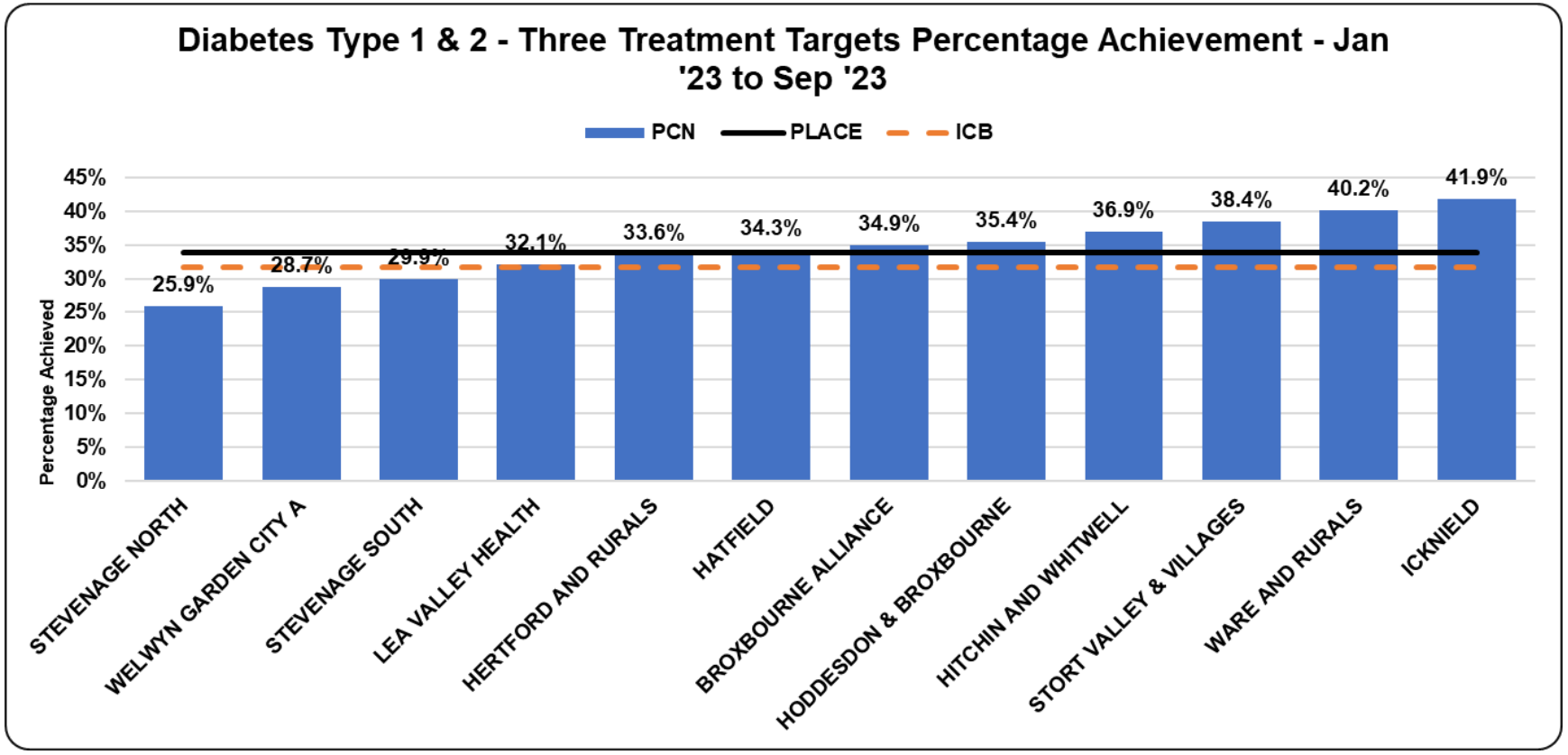
Source: National Diabetes Audit 2023-24 – Quarterly report January 2023 to September 2023, Link: NDA Quarterly Reports

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

- For the three treatment targets ENH Place data shows a higher percentage than the ICB. Similar to the 8 care processes there is variation between the PCNs.
- The information here is the published National Diabetes Audit. Practices can view their latest information within Ardens Manager where searches are also available to identify those who have not meeting the three treatment targets.





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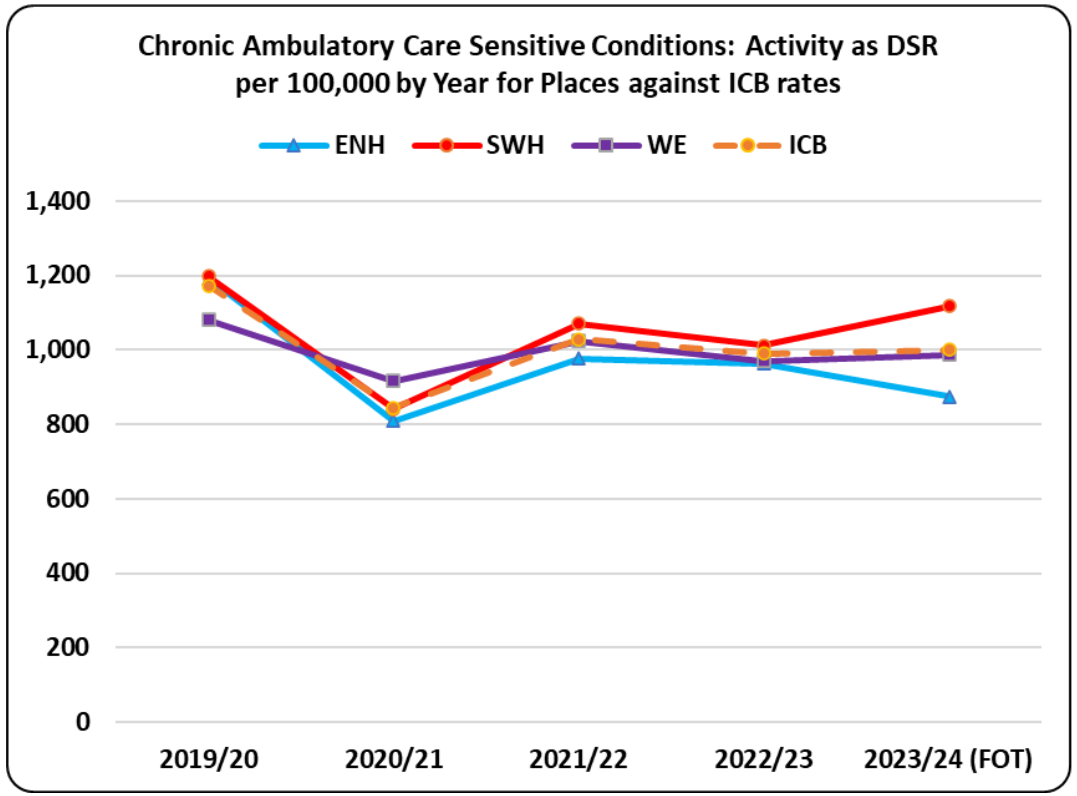
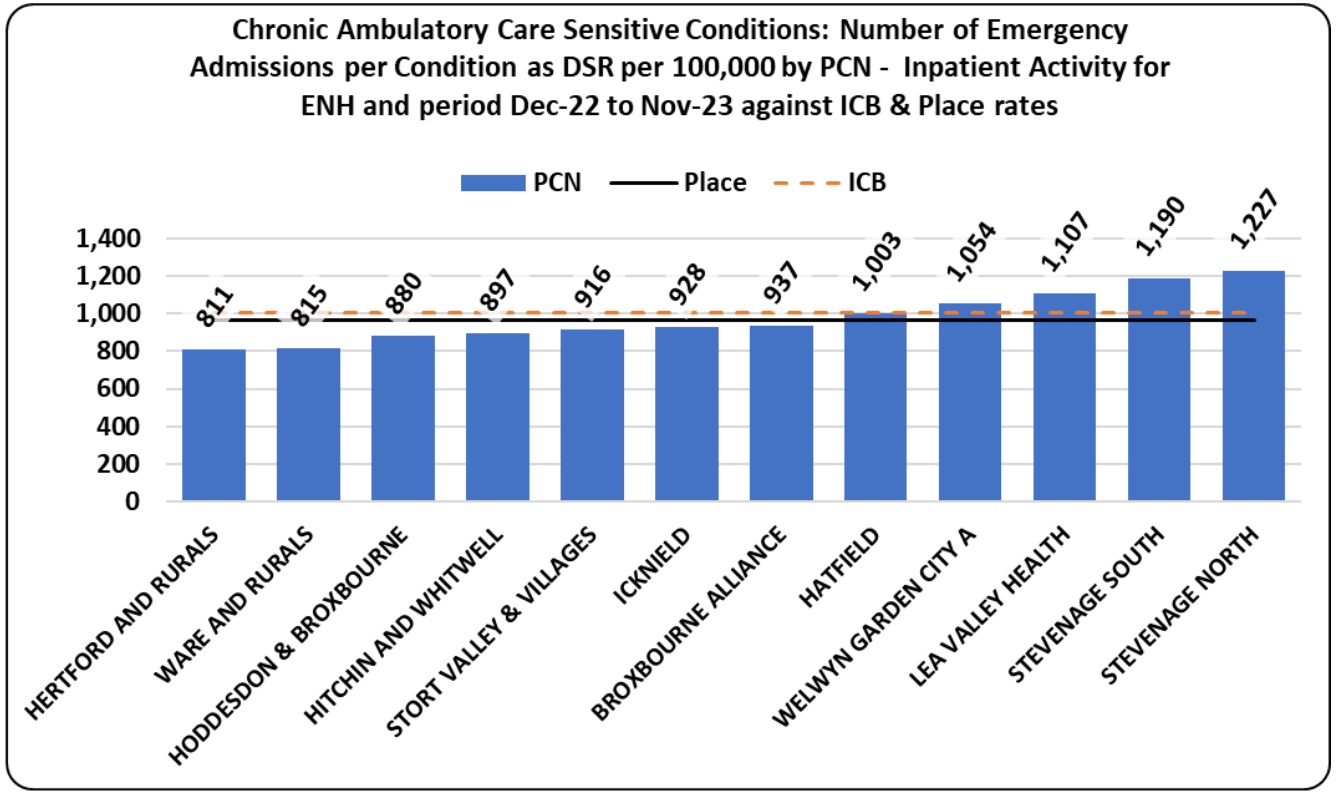
Reduction in admissions rates of Chronic Ambulatory Care Sensitive (ACS) conditions

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





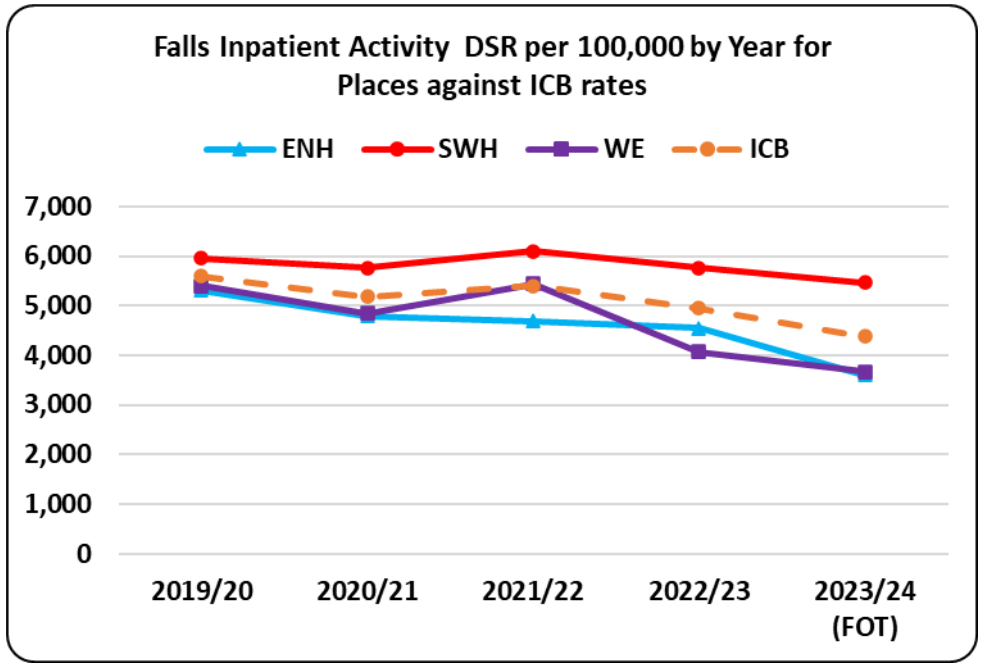
- Ambulatory care sensitive (ACS) conditions are conditions where effective community care and person-centred care can help prevent the need for hospital admission. (Nuffield Trust)
- ENH Place's admission rate for Chronic ACS conditions is slightly lower than the ICB rate when looking at the 12 months data up to November 2023.
- Details of the conditions with the highest volumes of admissions can be found within the PCN packs these include heart failure, COPD and Atrial Fibrillation.

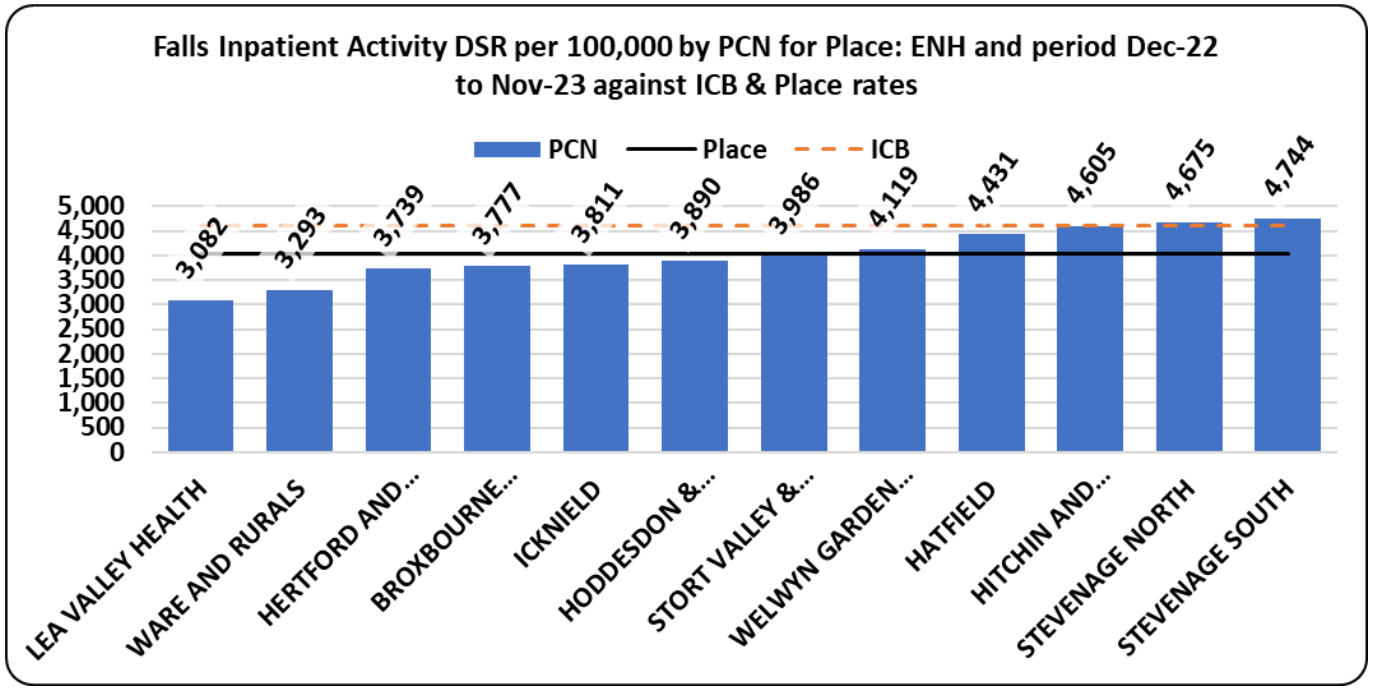
Source: SUS Link: Chronic ACS Conditions & NHSOF

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 shows ENH Place has a lower rate of admissions for falls than the ICB.
- There is variation in the data for the PCNs within the Place with Stevenage PCNs data showing the highest rates.
- Data in the following pages shows the data for the PCNs compared with Place and the ICB for areas within the ECF that aim to support reducing falls. Frailty Clinical Leads will be able to advise PCNs on current programmes of work within their area aimed at reducing falls.





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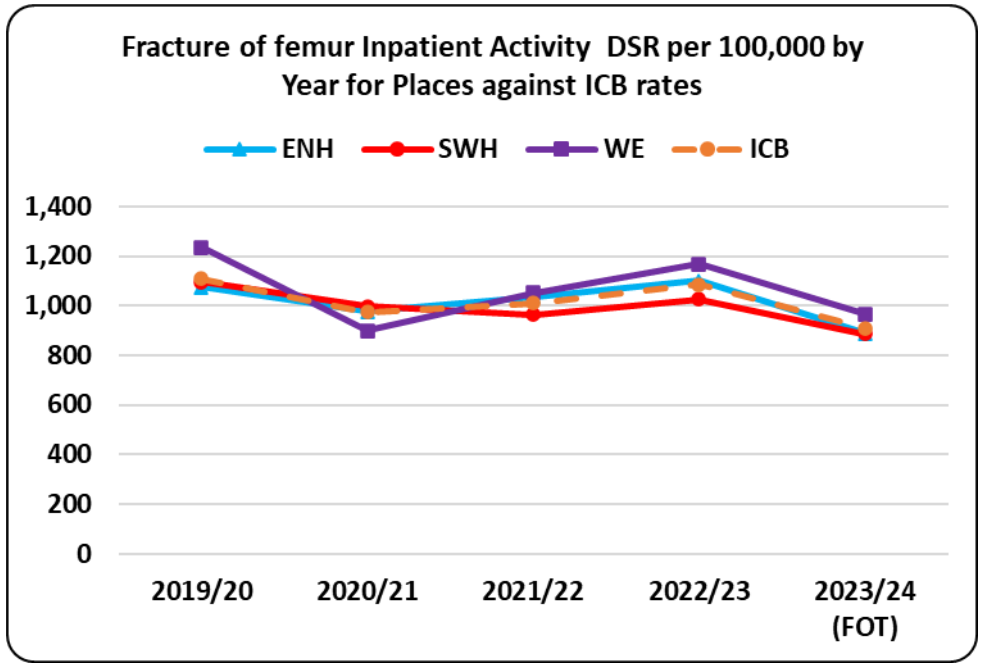
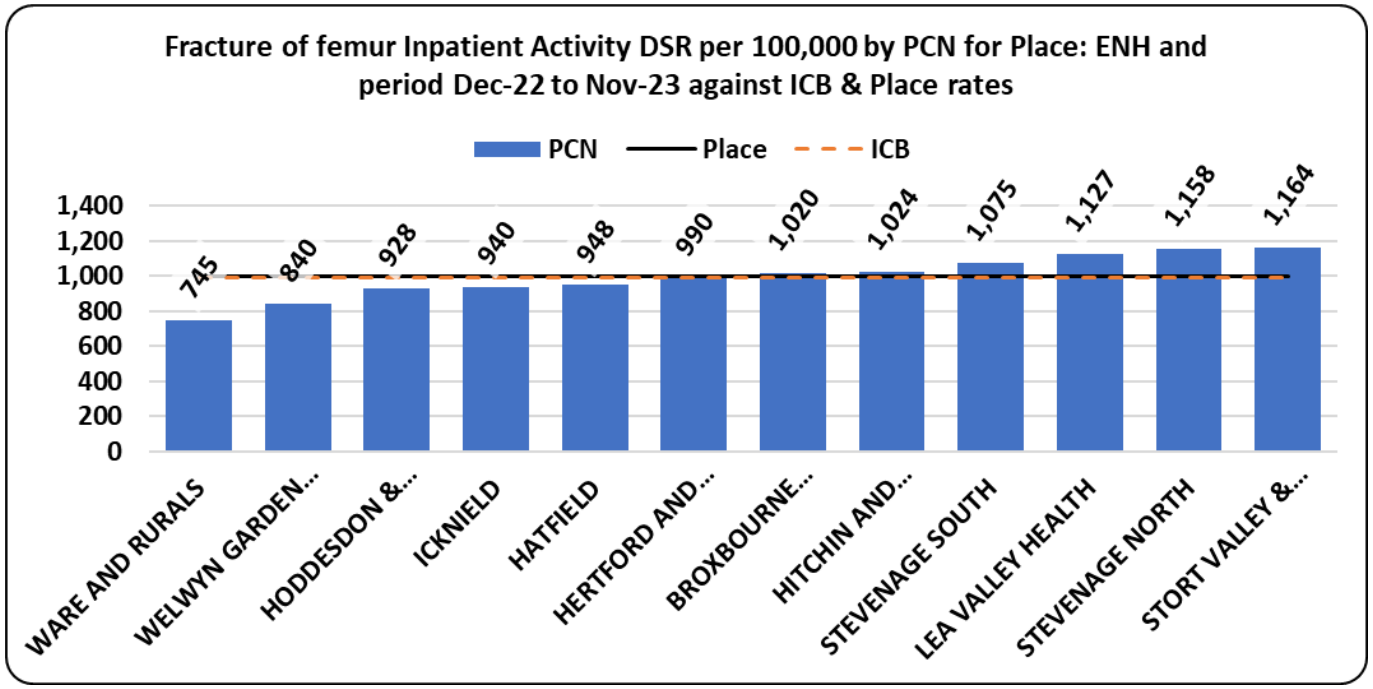
Source: SUS

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 shows ENH Place has a similar rate of admissions for hip fractures to the ICB.
- There is variation in the rates between PCNs.
- The ECF indicators on the next page shows potential areas of opportunity through benchmarking the PCNs against Place and ICB.





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Source: SUS

ECF indicators for frailty and EOL

- The data shows that ENH Place has a high percentage of falls Frat scores completed, when compared to the ICB as at end Dec 23, however there is variation between the PCNs.
- The ENH percentage of the population recorded as moderately or severely frail is slightly lower than the ICB with variation between the PCNs. This may indicate further opportunity for identification in some PCNs.
- The ENH percentage of the population recorded on the End of Life register is lower than the ICB with variation between the PCNs. This may indicate further opportunity for identification in some PCNs.
- The data contained within the table below is up to the end of December, the latest position can be found at Ardens Manager.

ENH PCNs & ICB 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%
ENH	20.0%	11.7%	1.7%	0.8%	77.5%	48.6%	9.3%	35.1%	37.1%	48.0%
Broxbourne Alliance PCN	28.2%	15.9%	1.9%	0.5%	59.9%	52.5%	9.7%	35.0%	35.5%	39.2%
Hatfield PCN	16.3%	16.0%	1.7%	0.5%	61.0%	56.1%	9.1%	41.7%	37.1%	48.7%
Hertford And Rurals PCN	9.2%	18.5%	3.3%	0.7%	60.2%	71.0%	11.0%	61.3%	62.7%	42.5%
Hitchin And Whitwell PCN	15.6%	0.0%	1.8%	1.7%	86.3%	32.1%	9.9%	21.4%	22.0%	38.3%
Hoddesdon & Broxbourne PCN	31.6%	0.0%	2.0%	0.8%	89.8%	47.1%	8.3%	33.5%	31.4%	44.9%
Icknield PCN	11.7%	0.6%	2.0%	0.8%	76.1%	55.9%	20.4%	42.0%	42.2%	35.6%
Lea Valley Health PCN	21.9%	0.0%	1.4%	0.6%	75.1%	32.7%	9.8%	21.5%	22.0%	65.4%
Stevenage North PCN	25.5%	31.7%	1.4%	1.3%	93.5%	46.9%	1.9%	44.0%	51.9%	56.3%
Stevenage South PCN	19.0%	0.0%	0.9%	0.7%	78.6%	54.0%	4.3%	29.9%	29.4%	44.5%
Stort Valley & Villages PCN	40.9%	30.0%	1.5%	0.5%	58.1%	45.6%	10.9%	27.6%	28.9%	65.4%
Ware And Rurals PCN	13.3%	1.4%	1.4%	1.1%	88.8%	57.0%	15.4%	41.9%	42.4%	56.3%
Welwyn Garden City A PCN	23.6%	0.0%	0.9%	0.7%	69.7%	43.4%	5.4%	20.3%	31.0%	55.5%

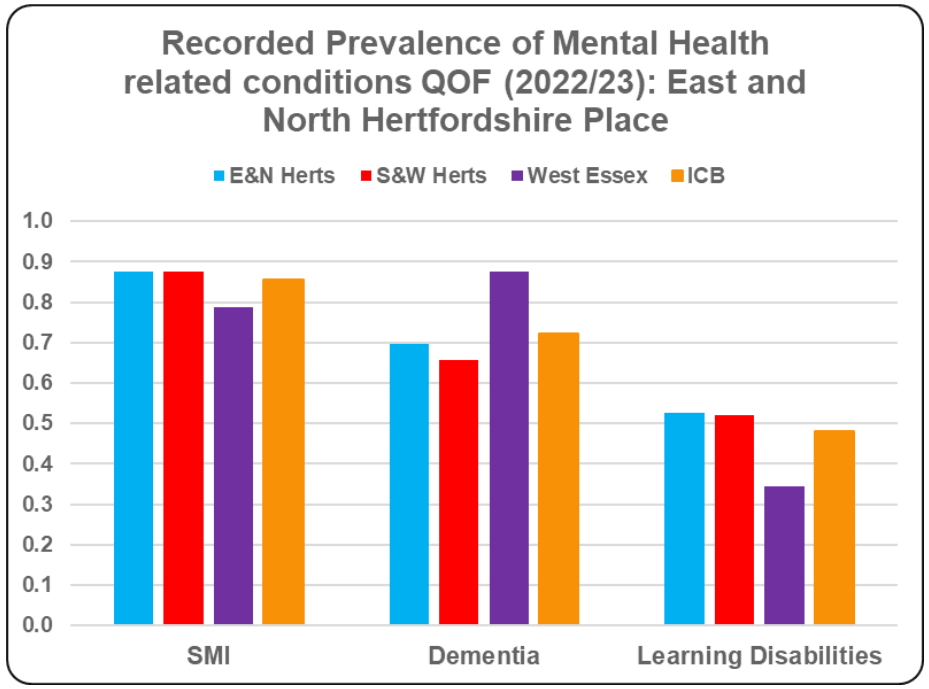
Hertfordshire and West Essex Integrated Care System

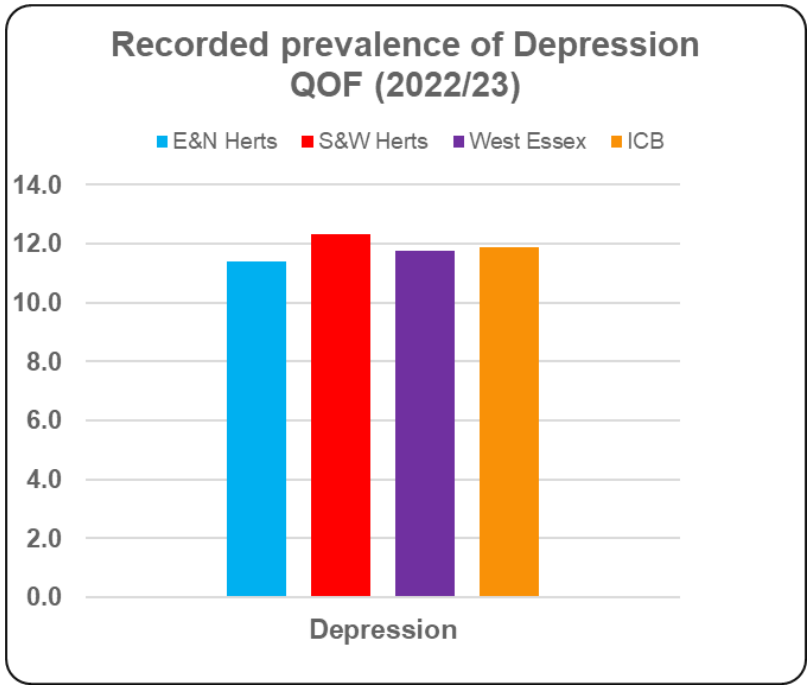
Source: Ardens Manager

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 East & North Herts prevalence compared with South West Herts, West Essex and the ICB. Future iterations will include comparisons against modelled expected prevalence.
- The data shows that ENH Place has a lower recorded prevalence for Dementia and Depression which may indicate an opportunity for further identification. Details for individual PCNs can be found within their packs.





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Source: QOF

Prevalence of mental health conditions (QOF)

- The table below shows the prevalence trend over the last three years for each of the recorded QOF mental health conditions.
- The following page looks at some of the wider QOF indicators for Mental Health.

	East and North Hertfordshire Place Mental Health Conditions 2022-2023 QOF prevalence, with 3 year trend							
	Dementia		Depression		Learning Disabilities		SMI	
	QOF Prevalence 22-23	3 year Trend	QOF Prevalence 22-23	3 year Trend	QOF Prevalence 22-23	3 year Trend	QOF Prevalence 22-23	3 year Trend
ICB	0.7%		11.9%		0.5%		0.9%	
ENH	0.7%		11.4%		0.5%		0.9%	
SWH	0.7%		12.3%		0.5%		0.9%	
WE	0.9%		11.8%		0.4%		0.8%	
Broxbourne Alliance PCN	2.5%		42.6%		2.0%		3.4%	
Hatfield PCN	2.4%		40.0%		1.9%		3.4%	
Hertford and Rurals PCN	3.4%		57.6%		2.3%		3.5%	
Hitchen and Whitwell PCN	3.2%		43.4%		1.6%		3.9%	
Hoddesdon and Broxbourne PCN	3.2%		41.3%		2.3%		2.8%	
Ickneild PCN	5.5%		60.9%		3.2%		6.3%	
Lea Valley North PCN	2.0%		50.0%		2.3%		4.7%	
Stevenage North PCN	1.6%		21.2%		1.6%		1.9%	
Stevenage South PCN	3.1%		52.0%		2.5%		3.5%	
Stort Valley and Villages PCN	2.8%		51.8%		2.4%		3.3%	
Ware and Rurals PCN	1.5%		25.3%		1.1%		1.5%	
Welwyn Garden City A PCN	2.4%		53.1%		2.1%		4.0%	

Mental Health QOF Indicators 22-23

- Mental Health QOF metrics for 2022-23 show that ENH place has a lower percentage of patients with SMI who have a care plan compared with ICB.
- Within this there is variation between the PCNs. The individual practices can be viewed within the PCN packs.
- Ardens searches are available to practices to identify those people with SMI without a care plan or recording of monitoring.

	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
E&N	79.8	88.3	89.0	81.5	81.5	82.0
Broxbourne Alliance PCN	97.4	94.3	95.1	84.2	85.6	83.4
Hatfield PCN	64.3	80.0	79.4	69.6	69.7	74.0
Hertford And Rurals PCN	104.8	100.9	99.3	92.5	92.8	119.2
Hitchin And Whitwell PCN	67.7	92.5	98.4	92.1	87.3	88.0
Hoddesdon & Broxbourne PCN	81.7	88.6	88.9	78.8	83.7	85.1
Icknield PCN	60.4	76.8	75.3	76.3	77.8	63.0
Lea Valley Health PCN	66.1	85.7	90.6	69.8	68.0	81.8
Stevenage North PCN	89.0	93.2	95.9	91.1	89.1	87.1
Stevenage South PCN	74.5	92.0	89.5	82.2	80.2	88.6
Ware And Rurals PCN	89.5	93.9	94.3	95.8	93.9	89.1
Welwyn Garden City A PCN	89.7	87.3	86.6	80.3	79.3	82.0

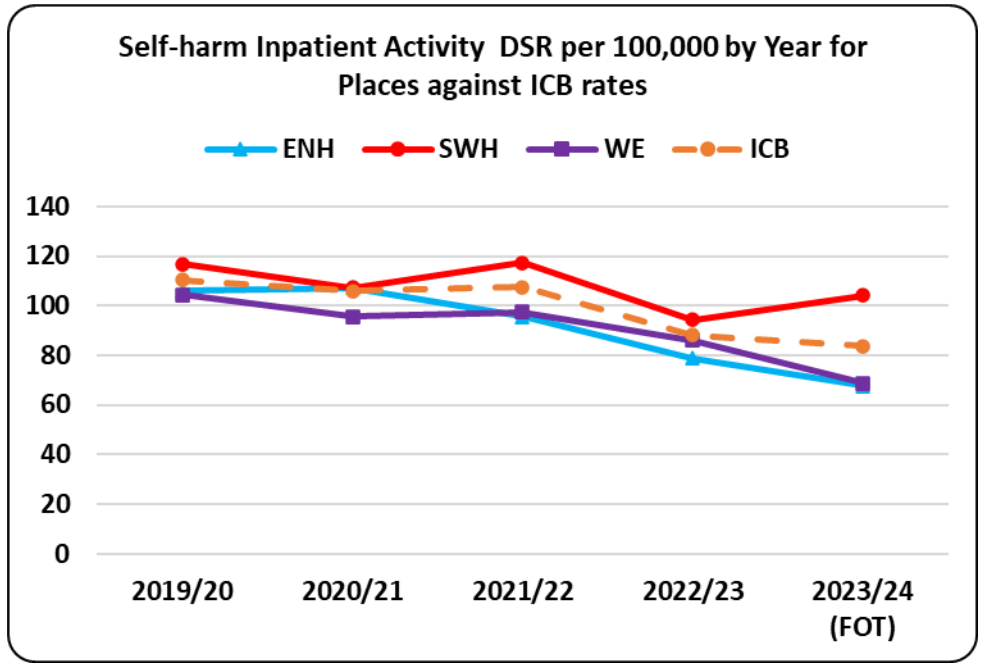
Hertfordshire and West Essex Integrated Care System

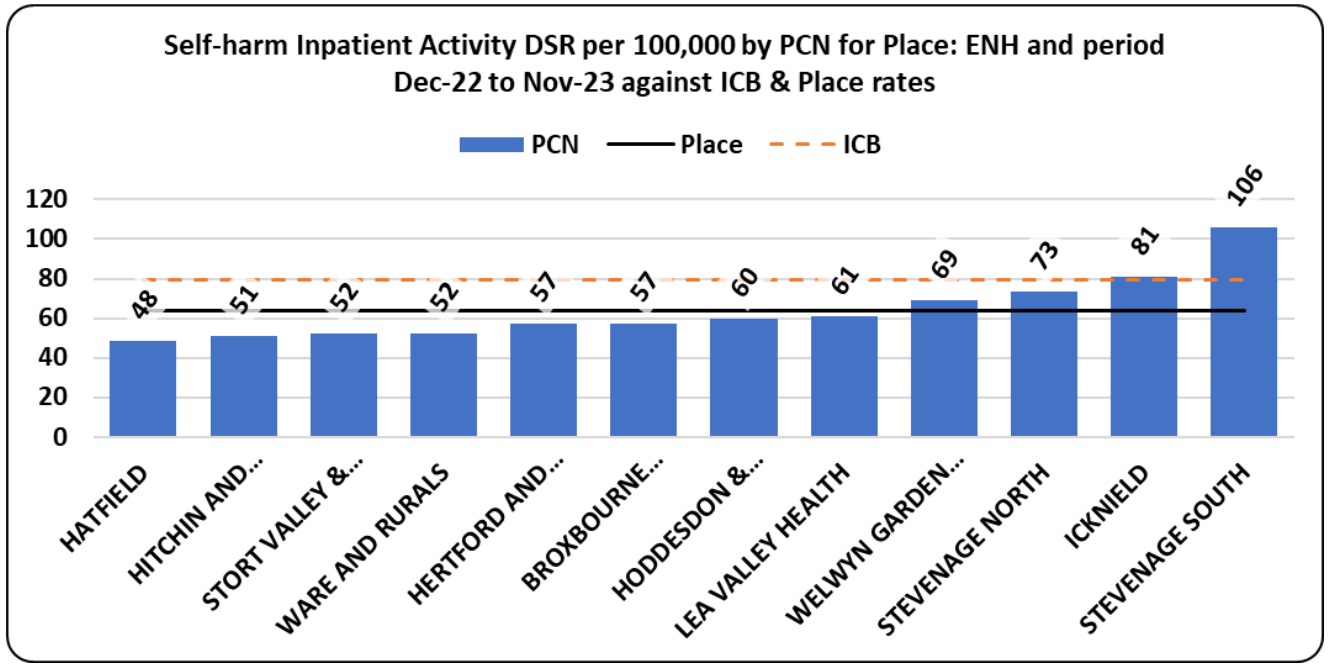
Source: QOF

Emergency Admissions Rates for Self – Harm

ICB overarching outcome of Improving Healthy life expectancy

- ENH Place has a lower rate of admissions for self-harm compared with the ICB.
- The trend data shows a decreasing trend for East and North Herts.
- The data will continue to be monitored at wider HCP and ICB footprints.





Hertfordshire and West Essex Integrated Care System

Source: SUS