Hertfordshire and
West Essex Integrated
Care System

PCN Insights Pack 2024

Lea Valley Health

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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

Lea Valley Health 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 Lea Valley Health areas of opportunity highlighted are :

- ***Childhood obesity in reception and Year 6***
- ***A&E attendance for asthma***
- ***Observed versus expected prevalence of LTC***
- ***Control of hypertension***
- ***Secondary prevention CVD who are on high intensity statins***
- ***8 care processes completed for people with diabetes***
- ***Admissions for Chronic Ambulatory Care Sensitive Conditions***
- ***Admissions for hip fractures in the over 75s***
- ***Identification of Dementia***

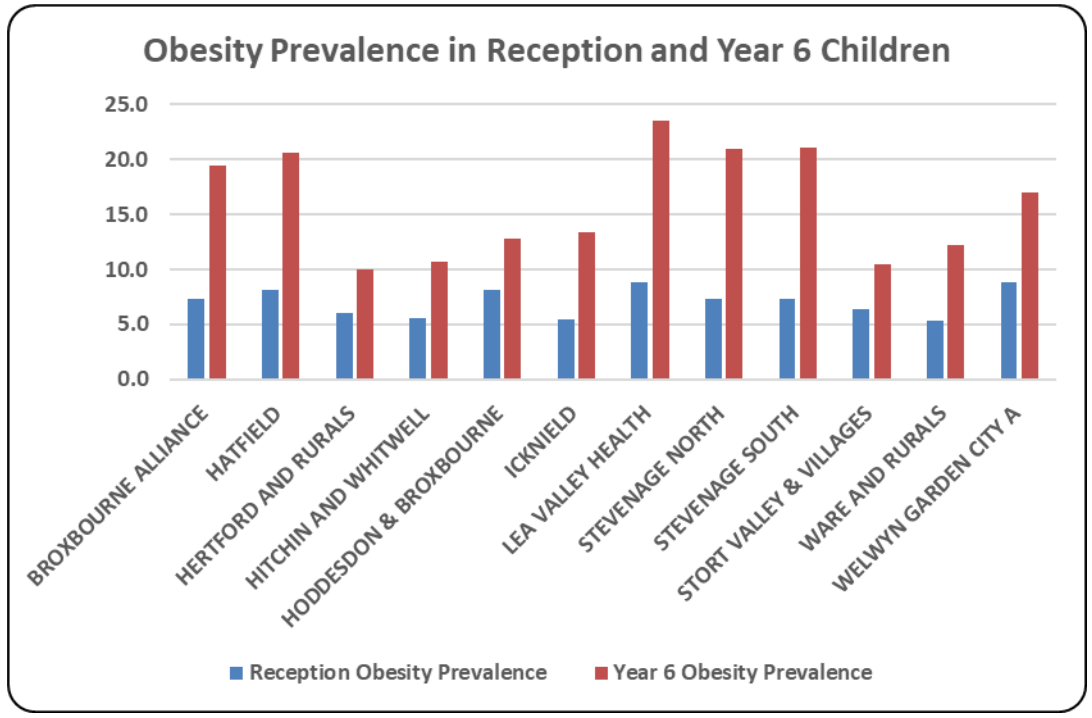
The following link takes you to Ardens Manager where there are reports. Here you will find the latest information on identification of LTCs and details of case finding Ardens searches available within EMIS and Systmone.
https://app.ardensmanager.com/login

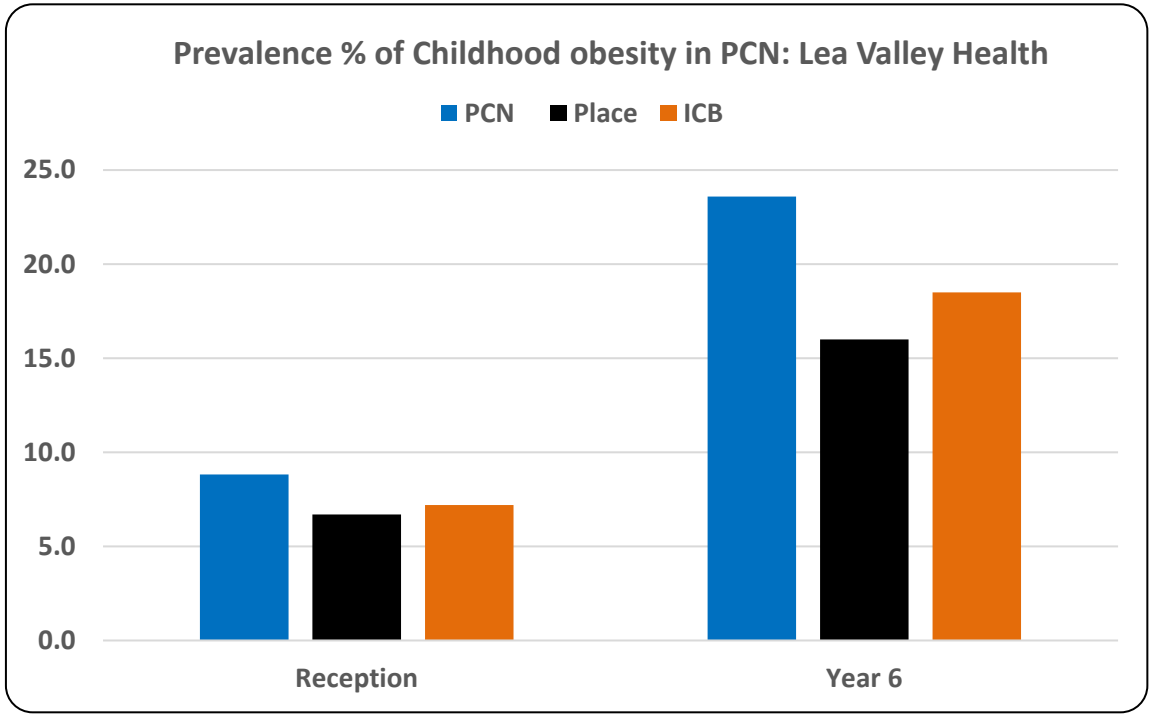
Clinical Priority	Metric	PCN compared to Place average	PCN compared to ICB average
Childhood obesity	% of children in Reception who are overweight	↑	↑
	% of children in Year 6 who are overweight	↑	↑
Reduce rates of emergency care for children and young people	A&E Attendances for Asthma (Children)	↑	↑
	Admissions for Asthma (Children)	↑	↓
	Admissions for Wheeze (Children)	↓	↓
	Admissions for Diabetes (Children)	↓	↓
	Admissions for Epilepsy (Children)	↓	↓
Prevention and health inequalities (Premature mortality for CVD)	Lifestyle risk factors: Smoking	↑	↑
	Observed versus expected prevalence	↓	↓
	Annual Reviews completed for LTCs	↔	↔
	% of people with AF treated with Anti Coagulant	↔	↔
	Control of hypertension	↓	↓
Preventative, Proactive care models for LTC	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 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	↓ **(Dem)**	↓ **(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 PCN rates for Childhood Obesity are higher for year 6 in comparison to reception children.
- Compared to the ICB and Place rate, Lea Valley Health PCN has a higher rate of Childhood Obesity for Children in Reception and Year 6.
- The data suggest that there is a deterioration from reception to Year 6 in childhood obesity in the PCN position against Place and ICB.





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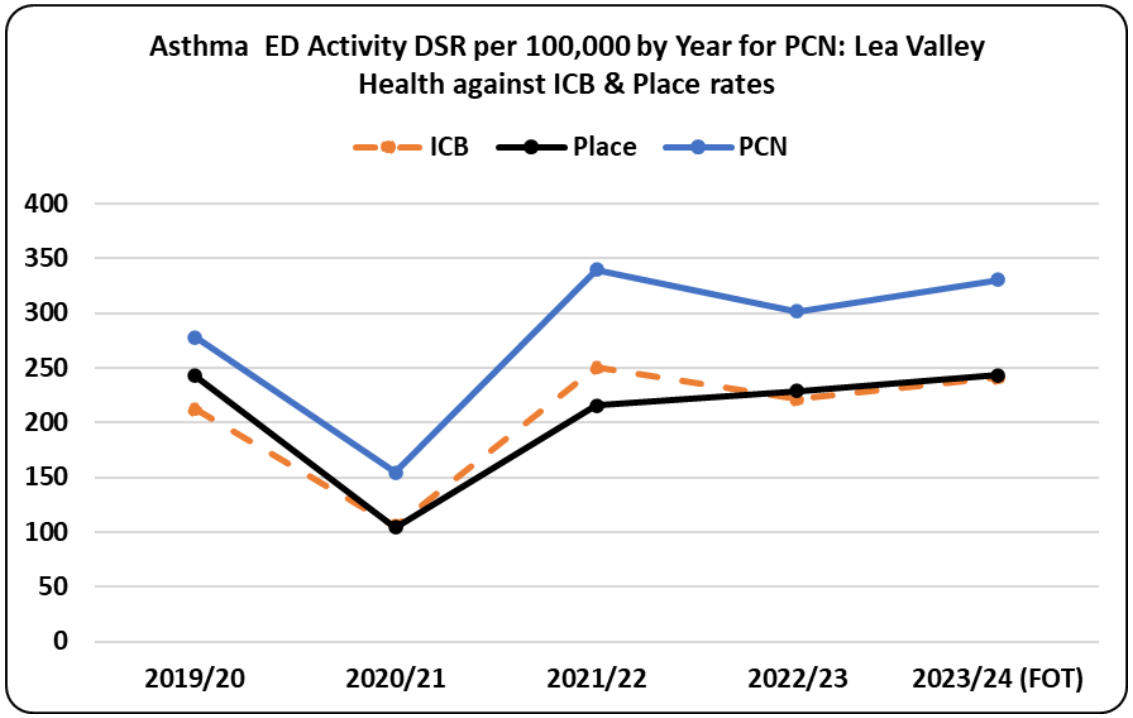
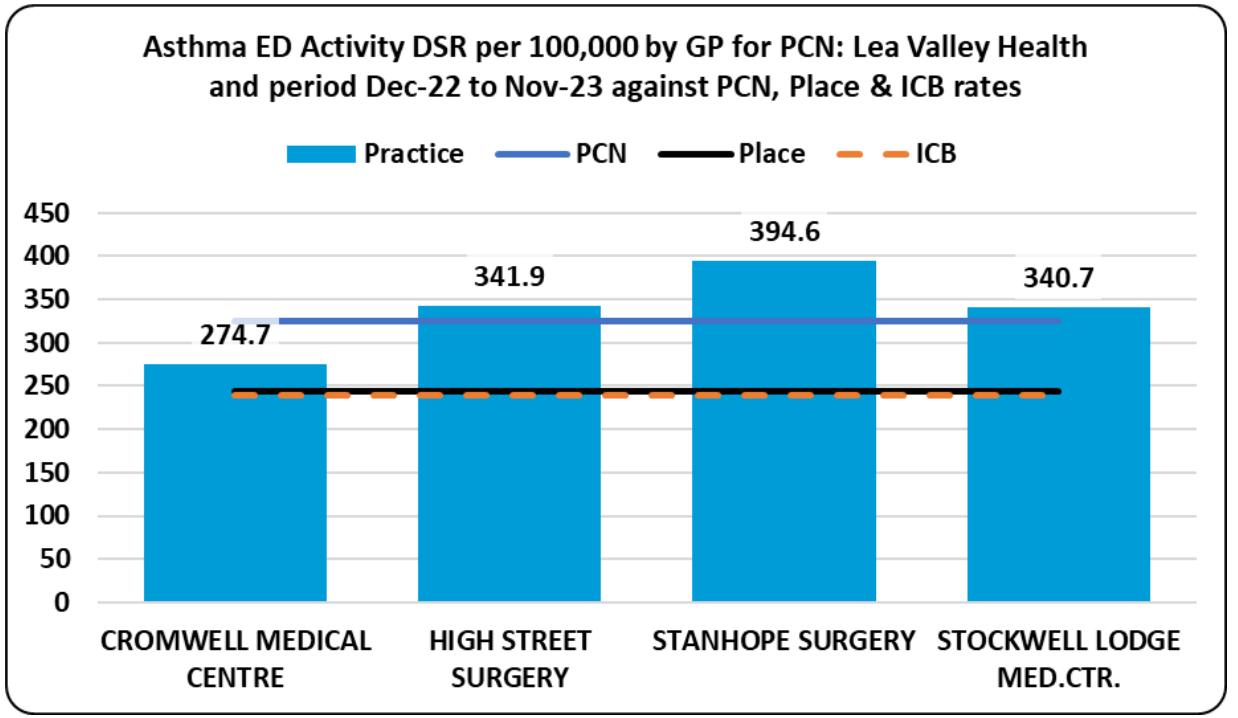
Source: NCMP and HES: 2022/23

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

- Compared to Place and the overall ICB, Lea Valley Health PCN has a higher rate of A&E attendances for Children and Young People with Asthma (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.





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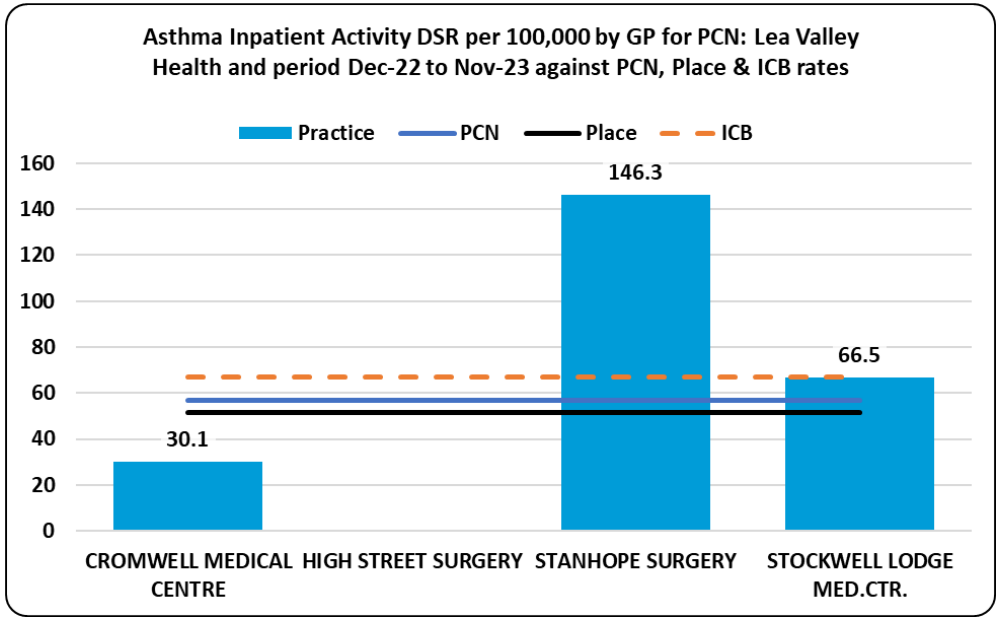
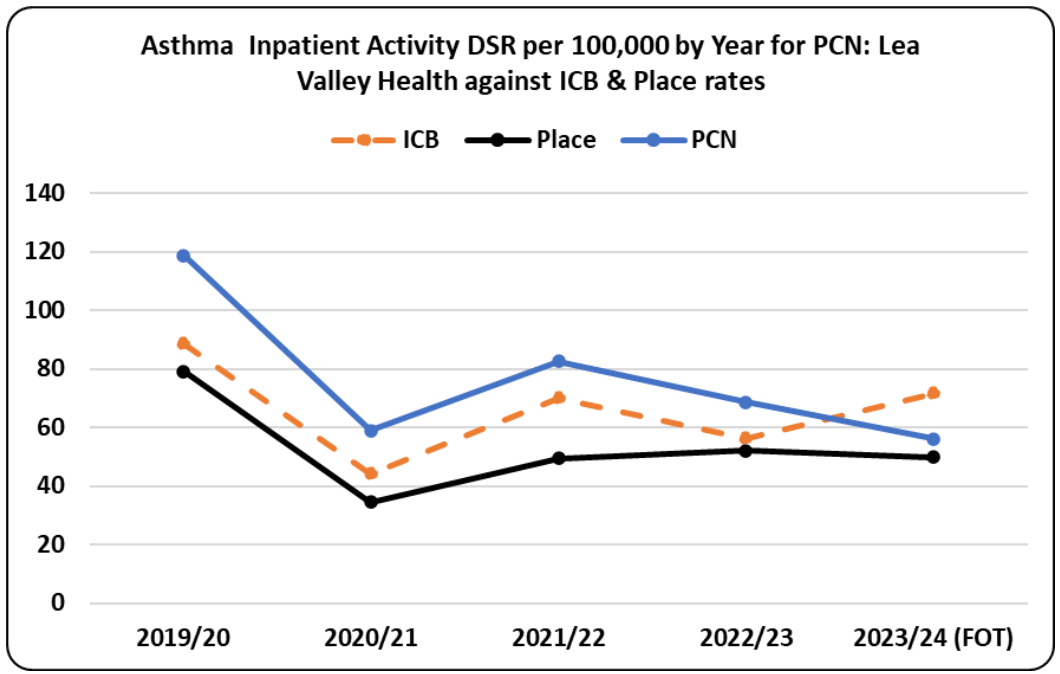
Source: SUS

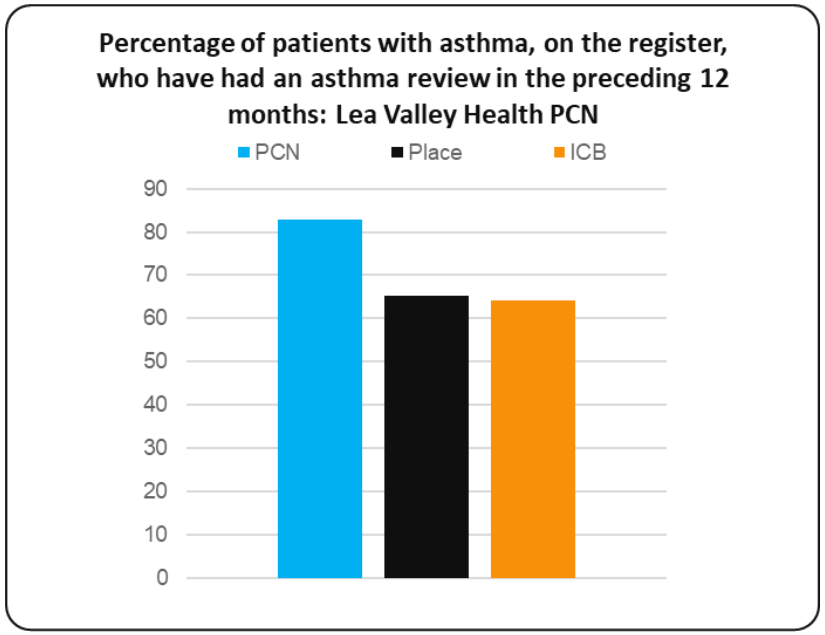
Admissions for Asthma (CYP)

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**

- Compared to Place, Lea Valley Health PCN has a higher rate of children's admissions for Asthma, but lower than the ICB (rolling years data on the right-hand side).
- The recent trend data shows a decreasing rate of admissions for Asthma for Lea Valley Health.
- Higher Proportion of Asthma Reviews are carried out within Lea Valley Health 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.





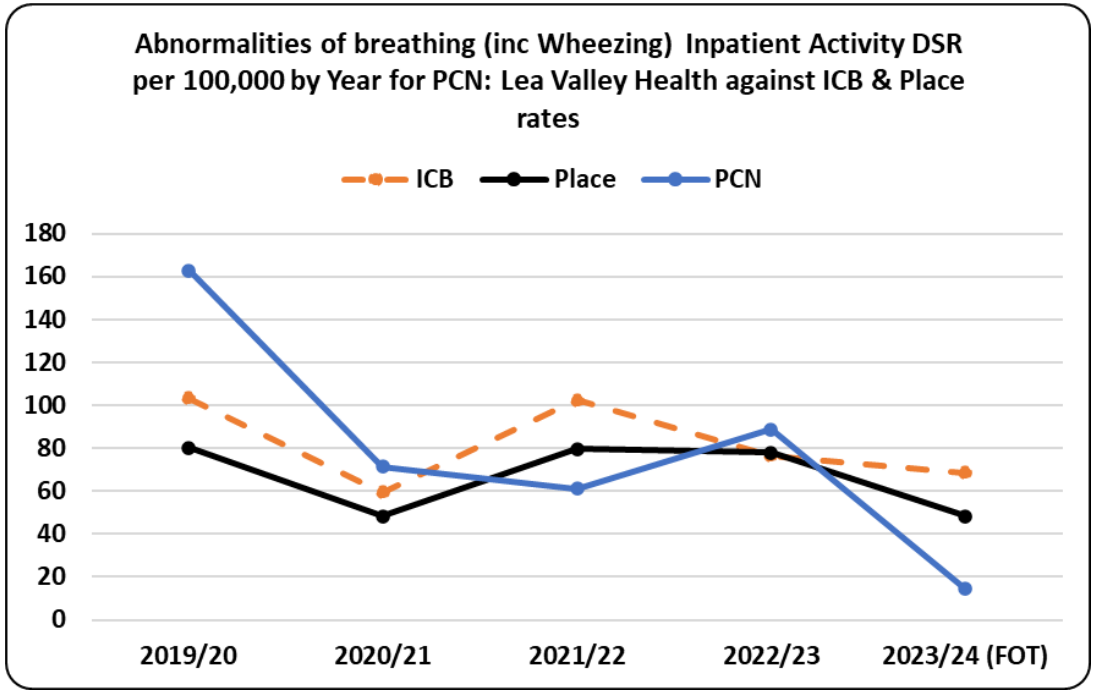


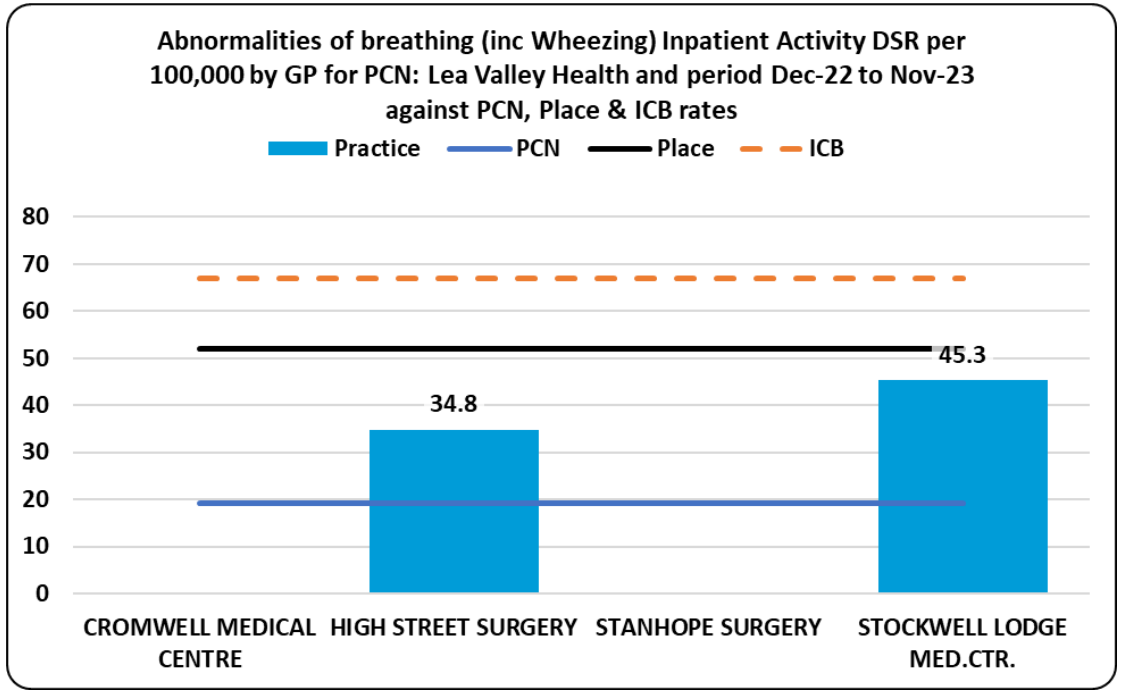
Source: SUS; QOF

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

- Lea Valley Health 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 a decrease on the previous year.
- When looking at the data by practice, two practices have rates of Children and Young People admitted to Hospital for Wheeze below Place and the ICB. Two practices have no admissions recorded for the year up to November 23.





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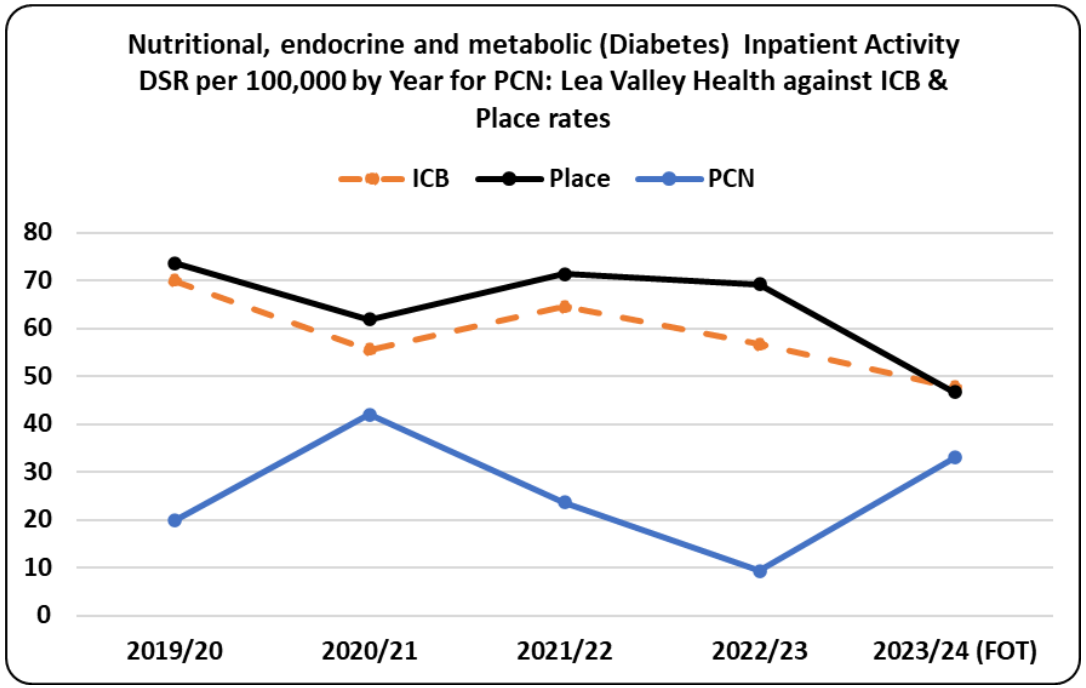
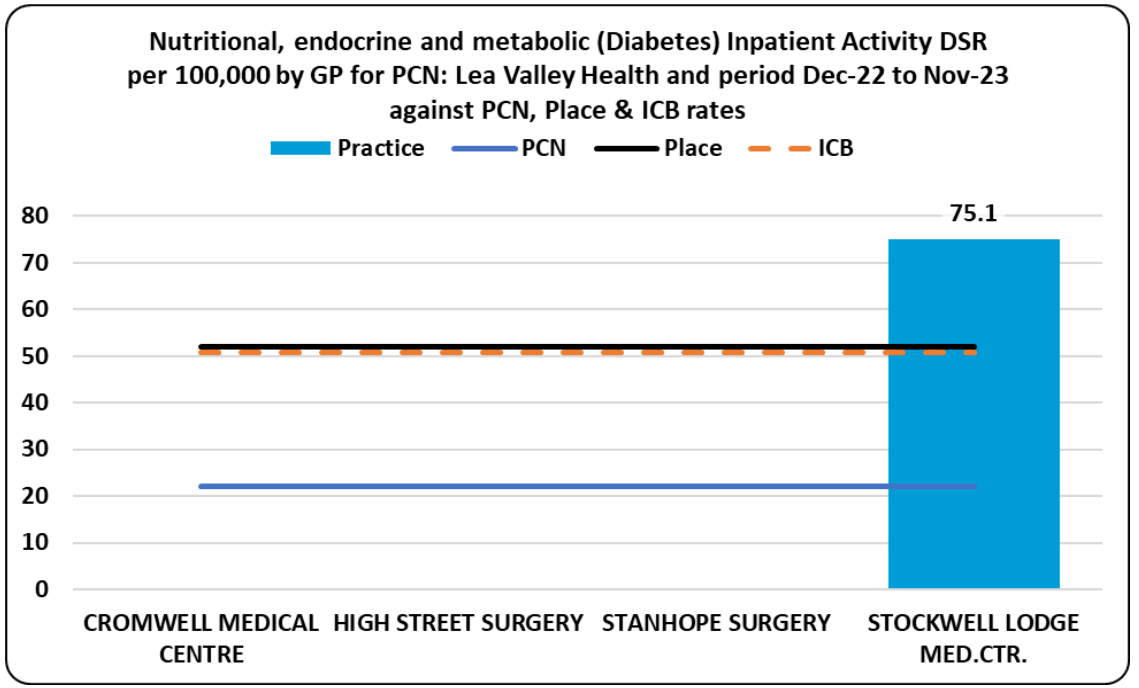
Source: SUS

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. PCN rates are lower than both ICB and 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.





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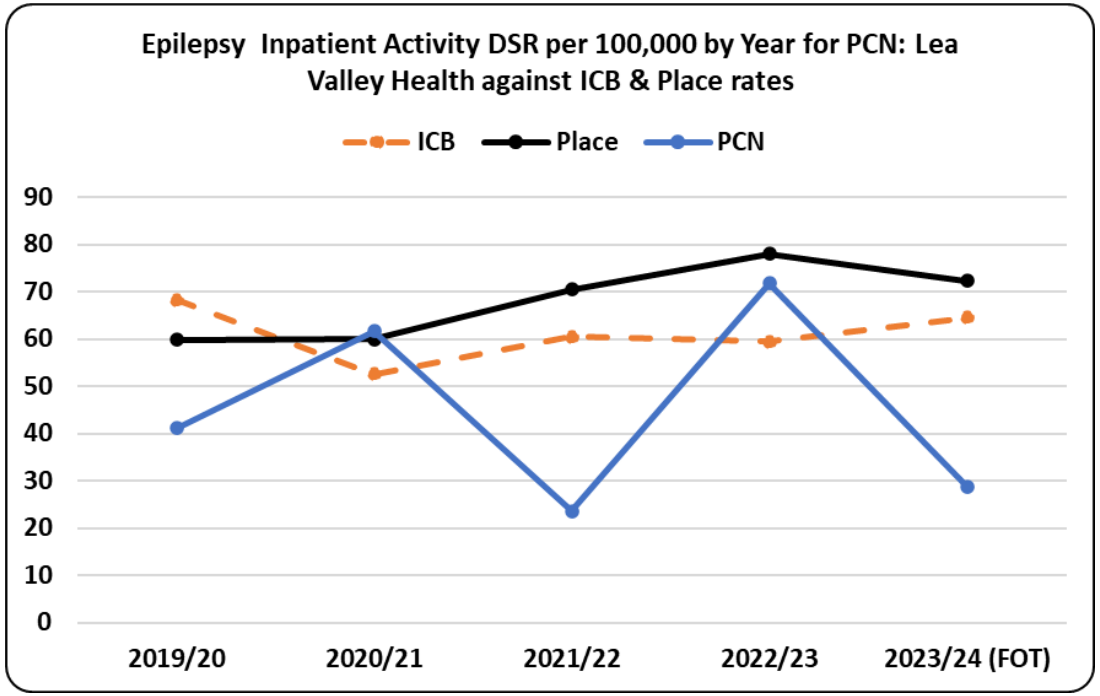
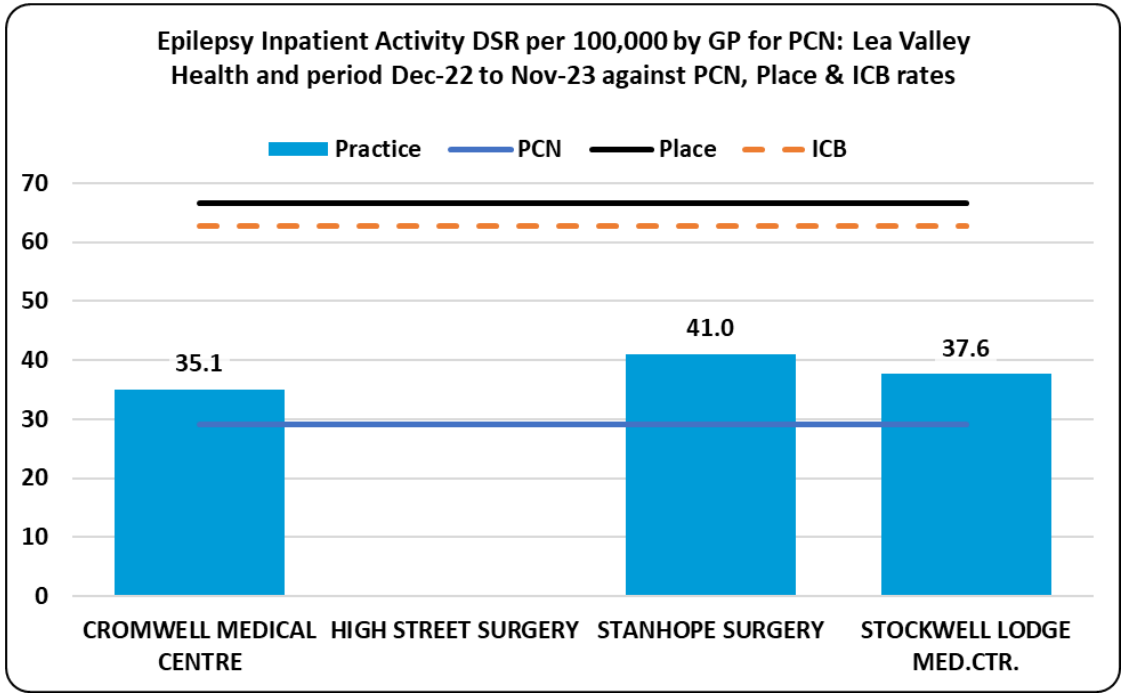
Source: SUS

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. PCN rates are lower than both ICB and place.
- The numbers of children admitted for epilepsy are small and therefore fluctuations in the trend are more prominent.
- 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.





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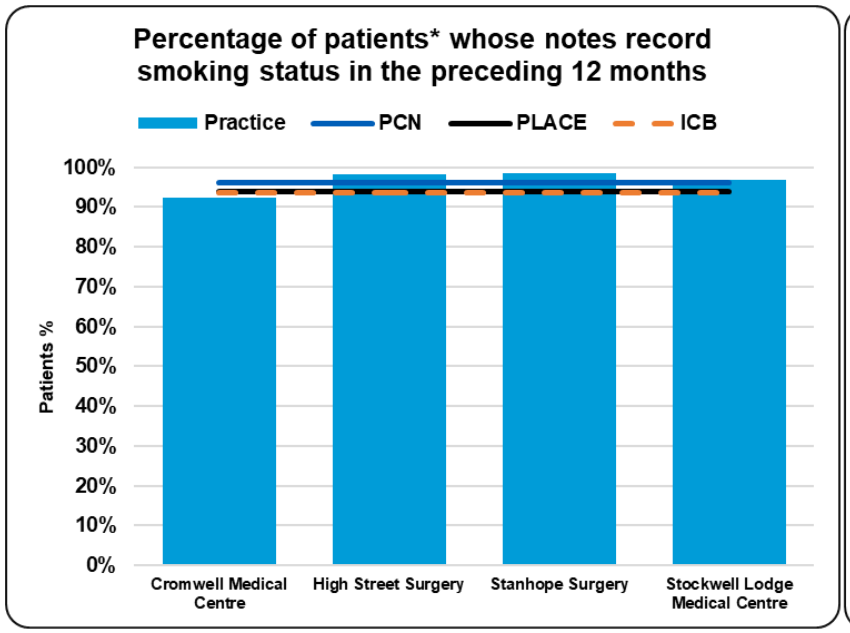
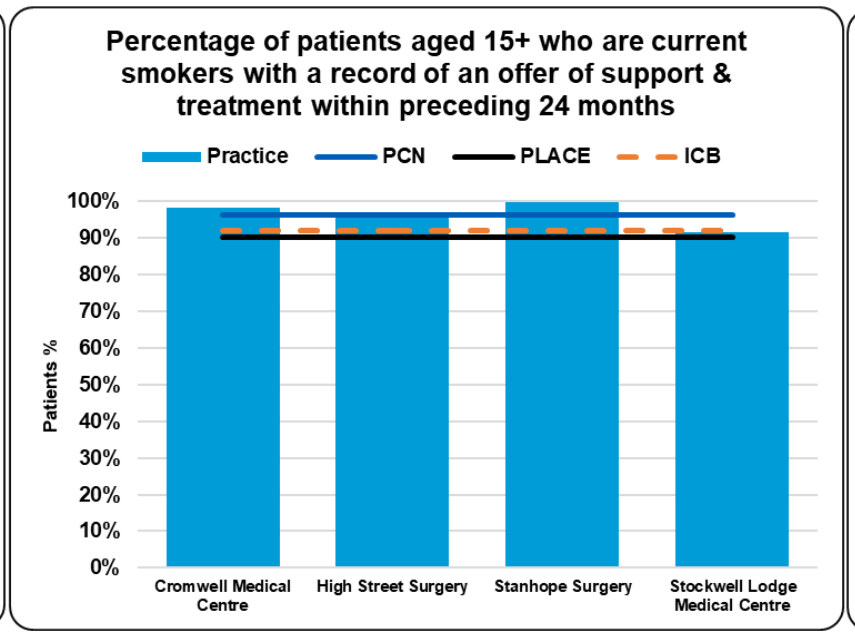
Source: SUS

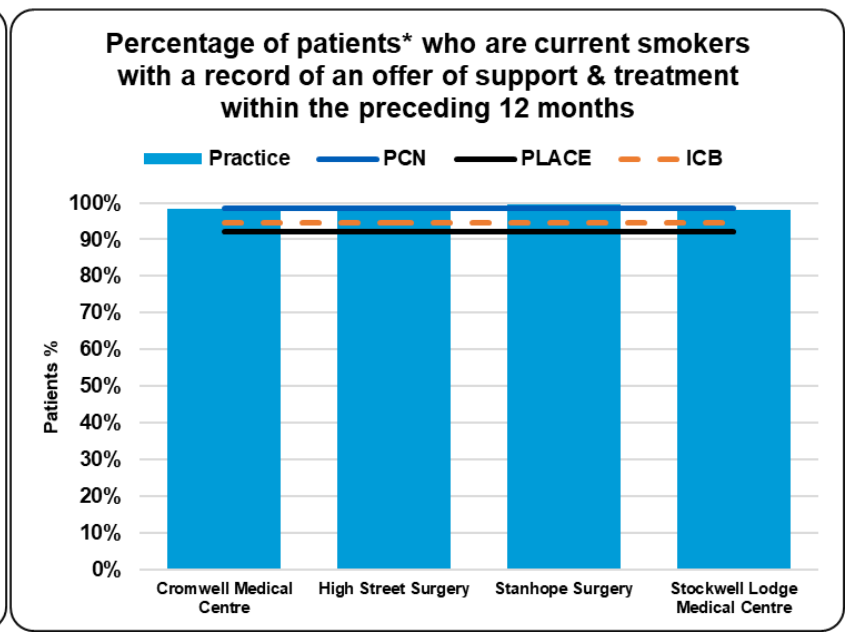
Prevention and health inequalities – Lifestyle factors - Smoking

- Lea Valley Health PCN data for smoking shows a slightly higher recording of smoking status compared to place and ICB.
- A higher proportion of have been offered treatment for smoking compared to 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
Cromwell and Wormley Med	30%	322	14%	686	0%	16
High Street Surgery	30%	138	8%	530	0%	11
Stanhope Surgery	28%	155	5%	441	0%	4
Stockwell Lodge Medical Cer	39%	658	19%	776	0%	19







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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

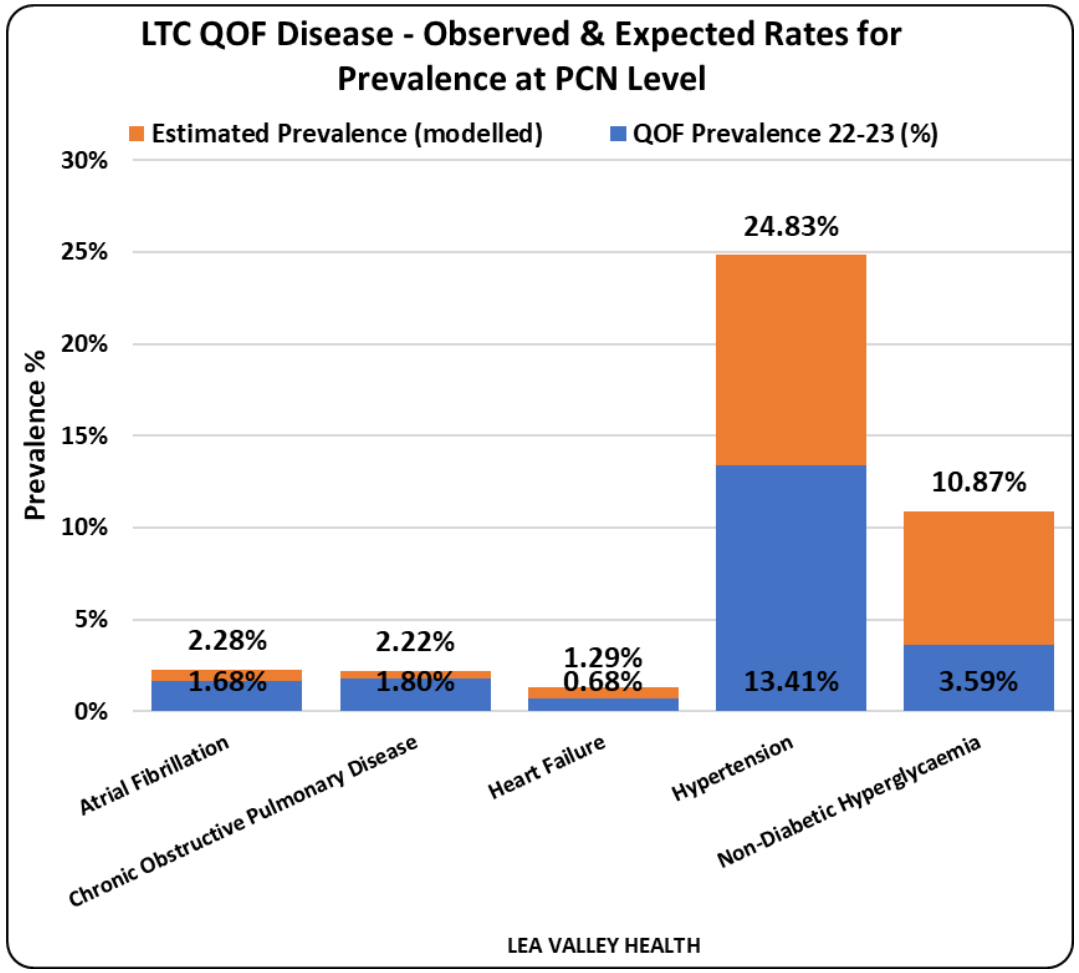
Prevention and health inequalities
Early Identification: Expected vs observed prevalence

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.

- Lea Valley Health 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 Detection Modelling for Lea Valley Health PCN - No. of New Diagnoses to Meet ICS & PLACE Rates - 2023/24	
Disease/ Condition	Number to meet ICS rate	Number to meet PLACE rate
Asthma	1905	176
Atrial Fibrillation	32	125
Chronic Kidney Disease	879	126
Chronic Obstructive Pulmonary Disease		12
Coronary Heart Disease	888	58
Diabetes Mellitus		
Epilepsy	183	19
Heart Failure		21
Hypertension	4522	120
Non-Diabetic Hyperglycaemia		459
Peripheral Arterial Disease	142	5
Stroke and Transient Ischaemic Attack	538	53



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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 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.

Lea Valley Health 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 %	CROMWELL MEDICAL CENTRE		STOCKWELL LODGE MED.CTR.		HIGH STREET SURGERY		STANHOPE SURGERY	
				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%	5.84%	6.62%		6.66%		4.62%		5.46%	
Atrial fibrillation	2.09%	2.12%	1.68%	1.78%		2.03%		1.49%		1.41%	
Chronic kidney disease	3.46%	2.94%	2.64%	2.46%		4.19%		1.62%		2.30%	
Chronic obstructive pulmonary disease (COPD)	1.49%	1.55%	1.80%	2.28%		1.93%		1.64%		1.34%	
Diabetes mellitus	6.63%	6.54%	7.48%	8.19%		7.48%		7.18%		7.08%	
Epilepsy	0.70%	0.73%	0.68%	0.74%		0.64%		0.76%		0.58%	
Heart Failure	0.80%	0.74%	0.68%	0.71%		0.75%		0.59%		0.67%	
Hypertension	13.84%	13.83%	13.41%	13.78%		14.09%		13.98%		11.78%	
Non-diabetic hyperglycaemia	6.42%	5.29%	3.59%	3.92%		6.34%		1.79%		2.30%	
Peripheral arterial disease	0.44%	0.45%	0.50%	0.57%		0.62%		0.46%		0.36%	
Secondary prevention of coronary heart disease	2.67%	2.63%	2.51%	2.79%		2.88%		2.42%		1.96%	
Stroke and transient ischaemic attack	1.63%	1.71%	1.53%	1.66%		1.74%		1.35%		1.38%	

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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

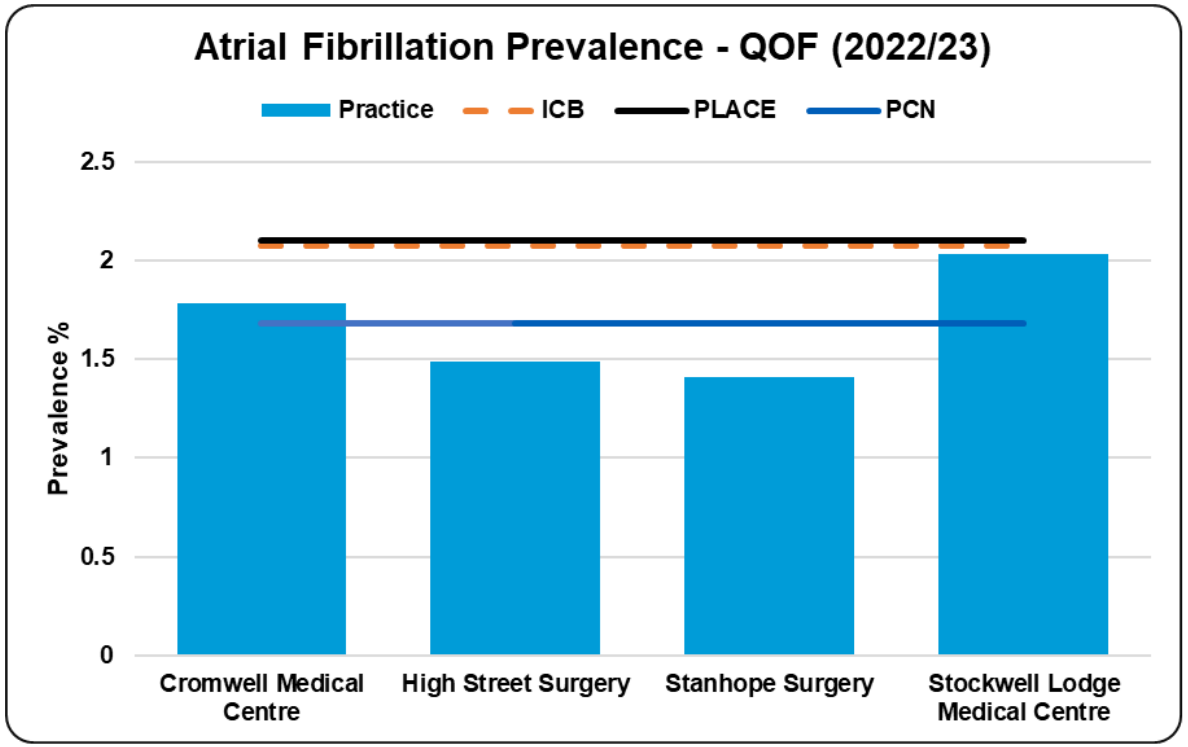
Development of more proactive, preventative care models for LTC : Annual Reviews

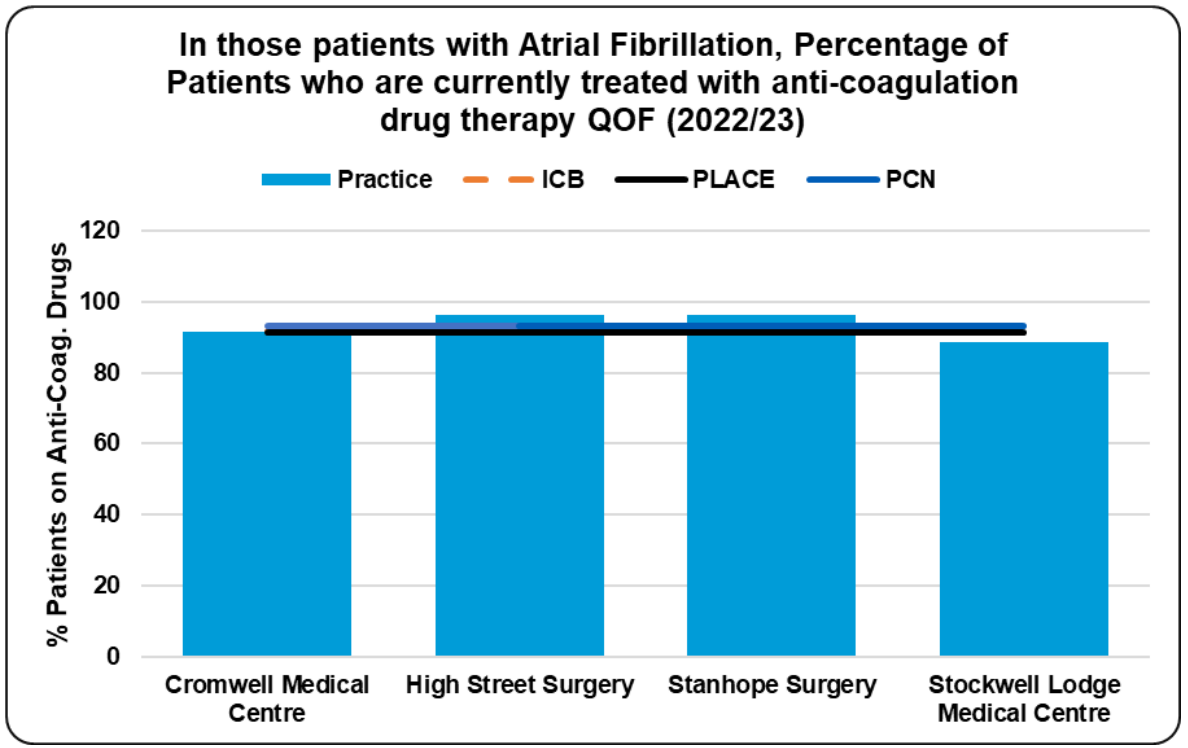
- The table on the right shows a summary of the percentage of patients receiving an annual review or risk assessment by condition.
- Where the cell is highlighted the percentage is lower than the Place value.
- Lea Valley Health PCN shows a higher percentage of patients receiving an annual reviews across all areas apart from Heart failure.
- 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	Lea Valley Health PCN	Cromwell Medical Centre	High Street Surgery	Stanhope Surgery	Stockwell Lodge Medical Centre
% of AF Patients with Stroke Risk Assessed in the last 12 months	92.9	91.8	93.4	95.9	92.5	**90.2**	93.6
The % of patients aged 45 or over who have a record of blood pressure in the preceding 5 years	85.7	85.9	90.1	89.4	93.3	89.9	89.0
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	**60.3**	**11.1**	88.1	86.4	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	82.7	73.8	95.0	94.8	78.5
The % of patients with COPD, on the register, who have had a review in the preceding 12 months	75.7	77.1	85.1	84.6	94.0	92.0	77.6
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	82.7	80.8	93.3	91.7	**72.8**
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	90.4	87.7	89.9	92.2	91.4

Prevention and health inequalities – Atrial Fibrillation

- Lea Valley Health 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, however there is variation between the practices.
- The data suggests there is further opportunity for identification of people with AF. Case finding Ardens searches are detailed within https://app.ardensmanager.com/login





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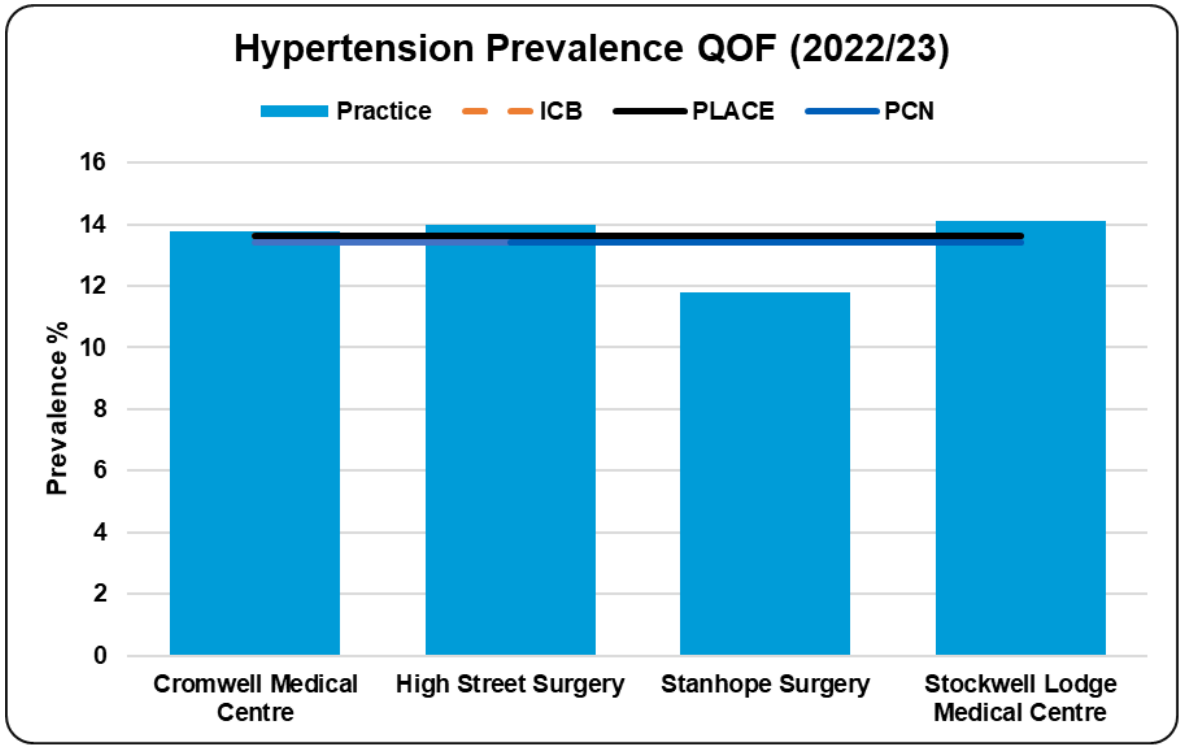
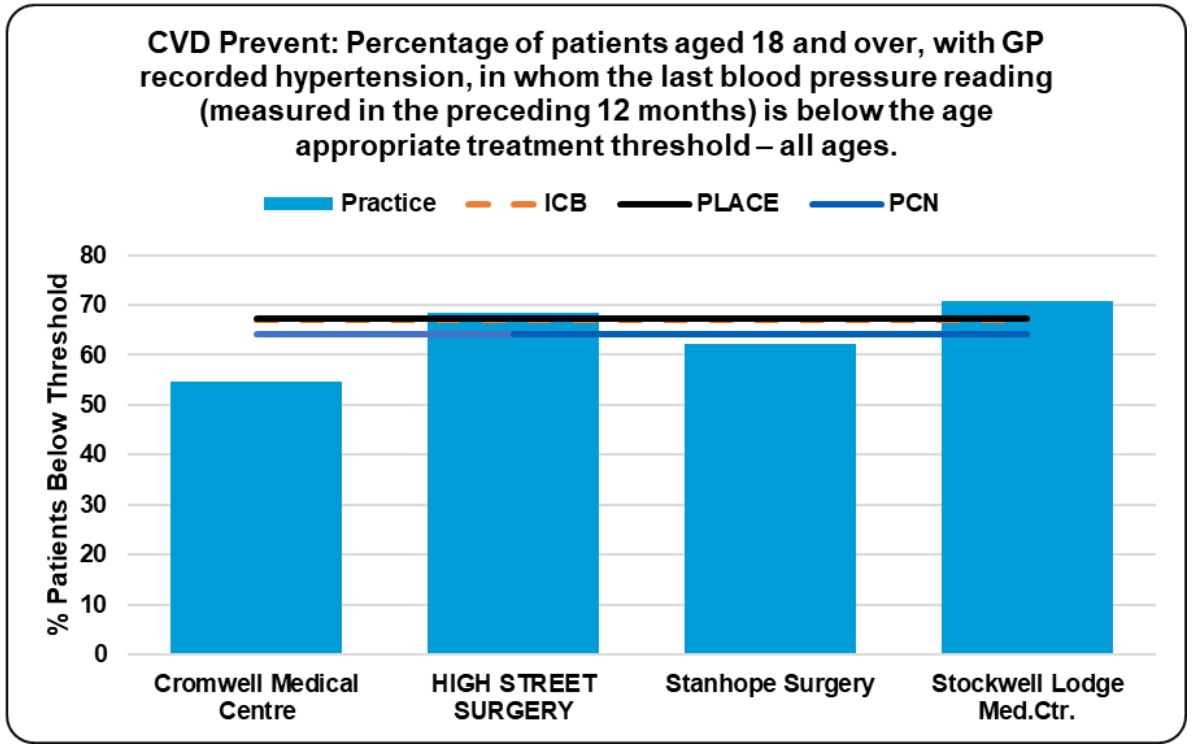
Source: NHS Digital QOF Data Sets Link: QOF Data Set

Prevention and health inequalities – Hypertension

- Lea Valley Health PCN recorded prevalence for hypertension is similar to 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 slightly lower than Place and ICB, however there is variation between the practices.
- The latest hypertension indicators can be found at https://app.ardensmanager.com/login





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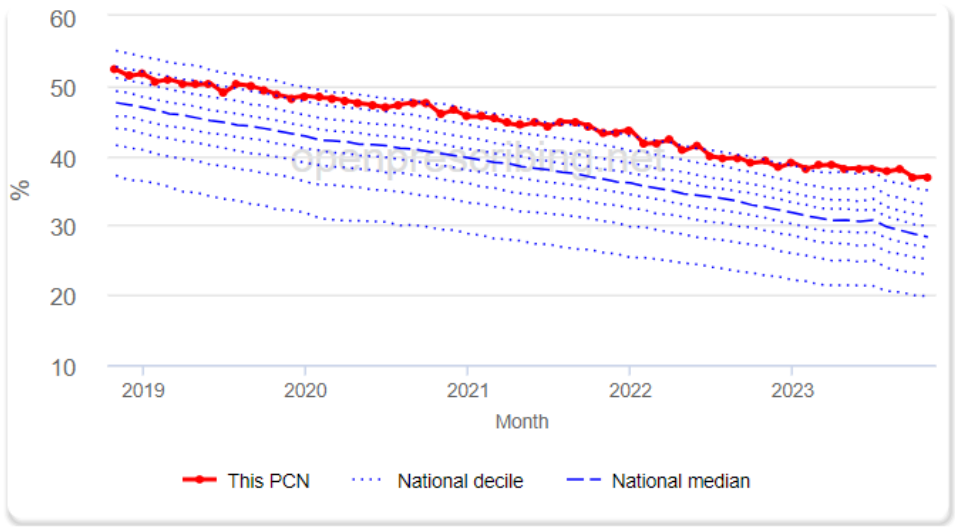
Source: NHS Digital QOF Data Sets Link: QOF Data Set & CVD Prevent Data Sets Link: CVD Prevent Data Explorer

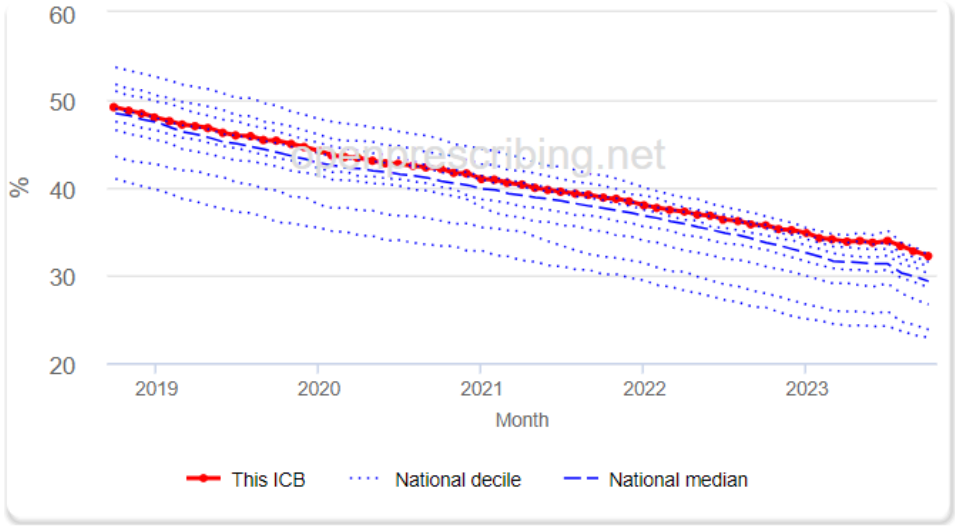
Lipid management: Percentage of people on lipid lowering therapy for secondary prevention who are on low and medium intensity statins

- 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 Lea Valley Health 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 95th percentile with 37% 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



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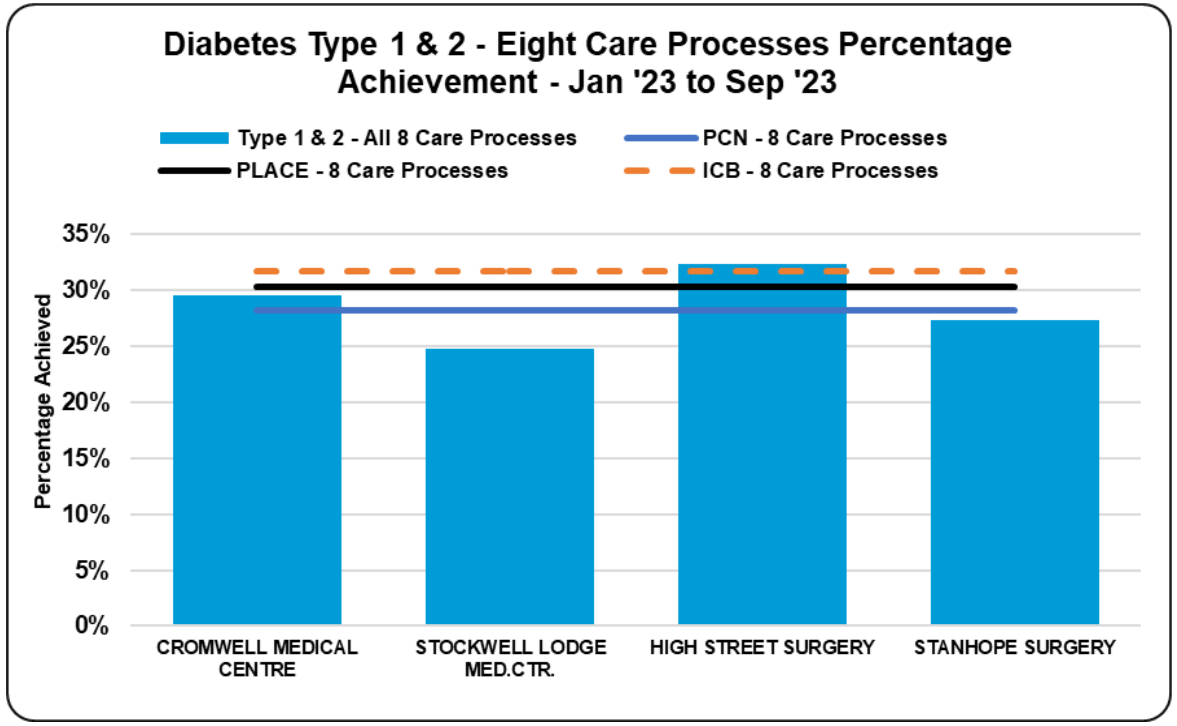
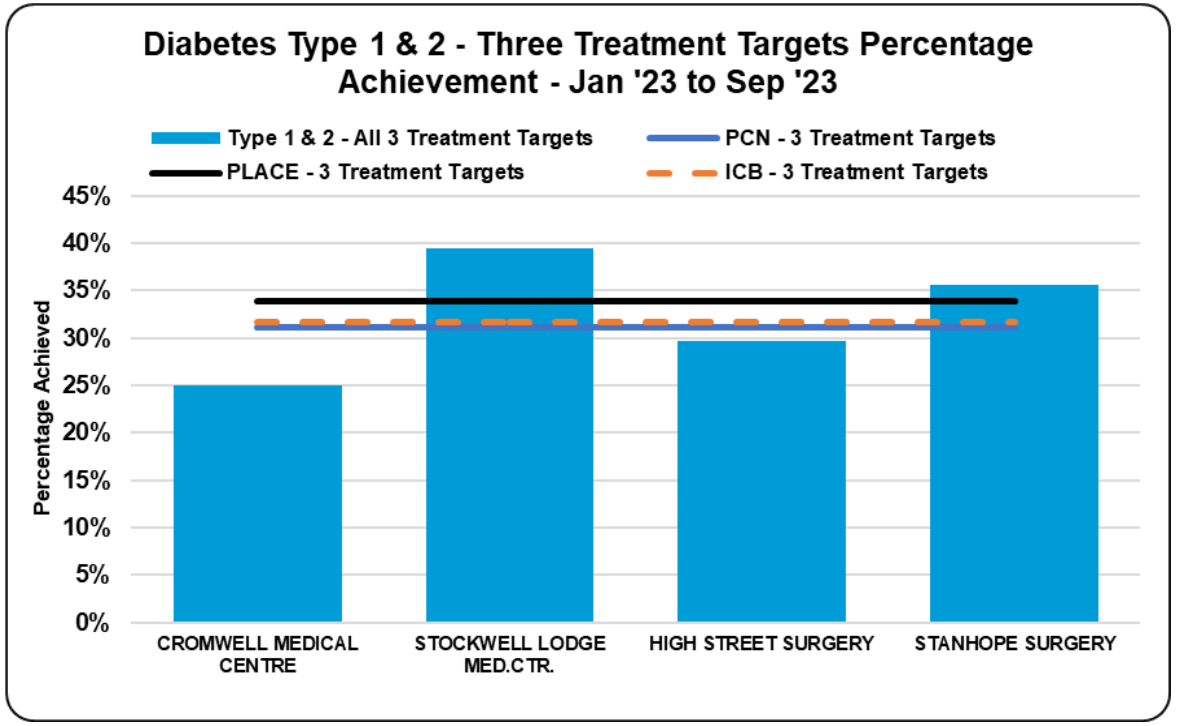
Source: OpenPrescribing.net – Link Here

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 Lea Valley Health PCN is lower than Place and the ICB. For the three treatment targets the PCN data shows a similar percentage to the ICB but lower than Place.
- The latest information can be found within Ardens Manager.





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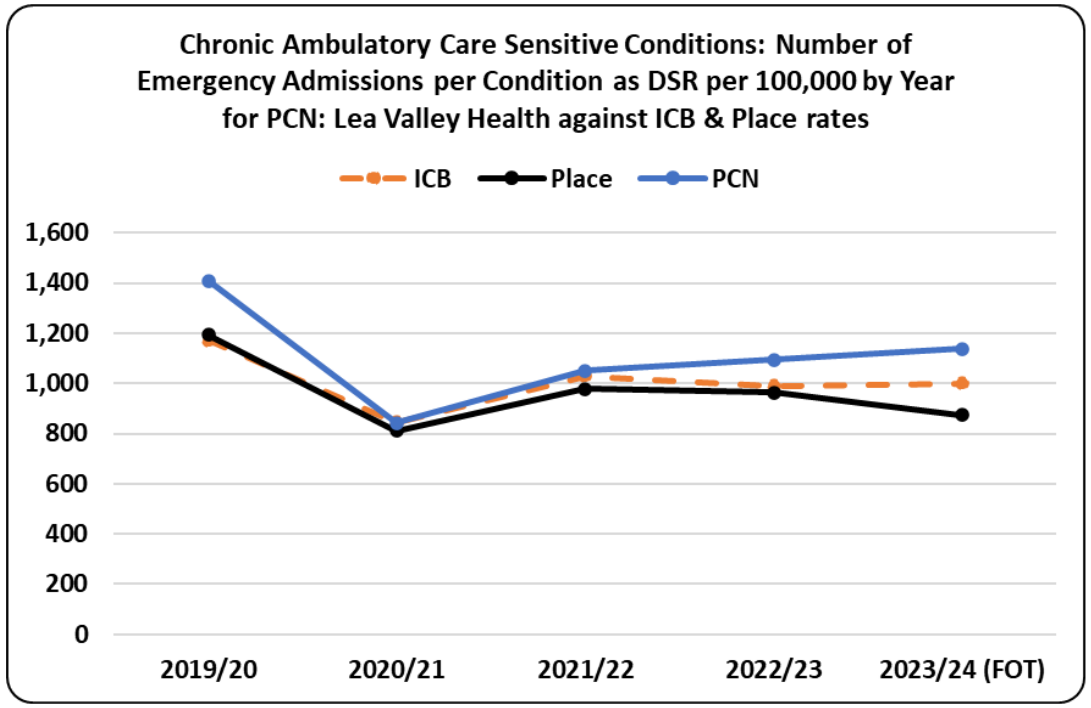
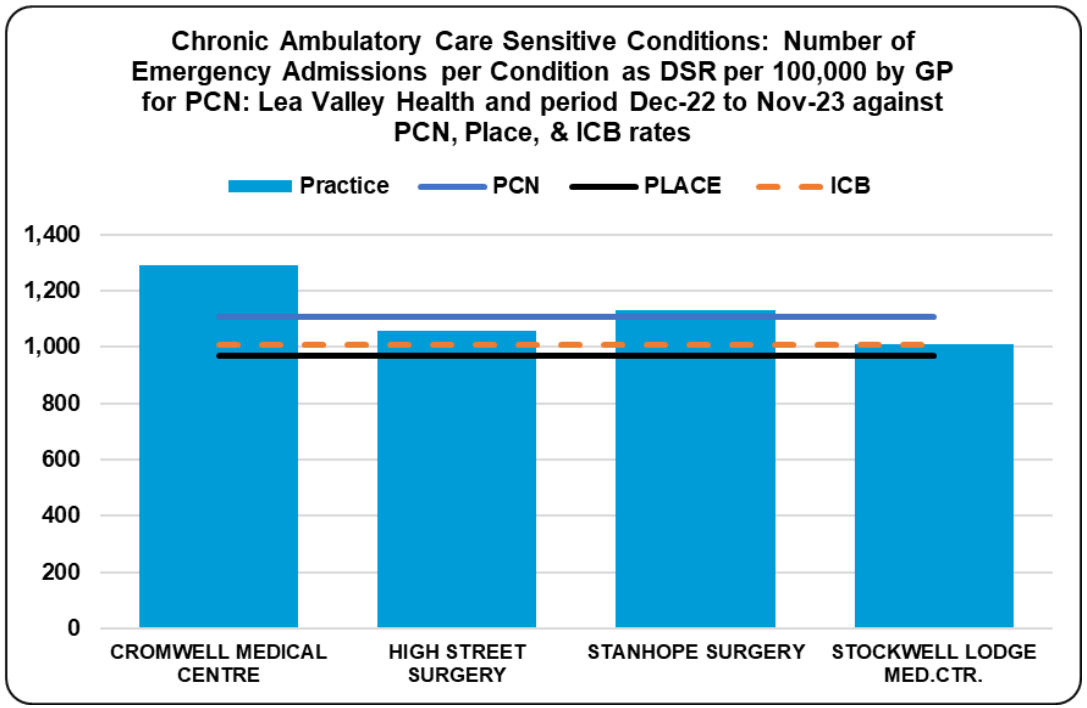
Source: National Diabetes Audit 2023-24 – Quarterly report January 2023 to September 2023, Link: NDA Quarterly Reports

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)
- Lea Valley Health PCN's admission rate for Chronic ACS conditions is higher than the ICB rate and the Place rate when looking at the 12 months data up to November 2023.
- Heart Failure and Diseases of the blood, are 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 of those with Coronary Heart Disease and Peripheral Arterial Disease

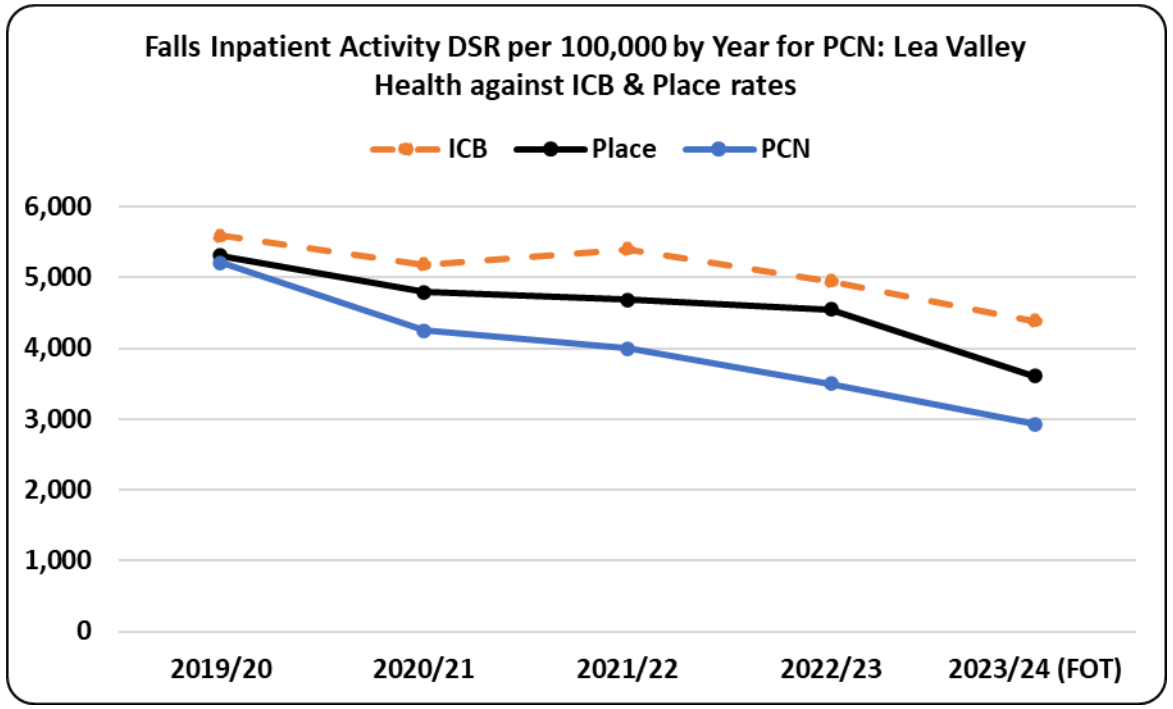
Source: SUS Link: Chronic ACS Conditions & NHSOF

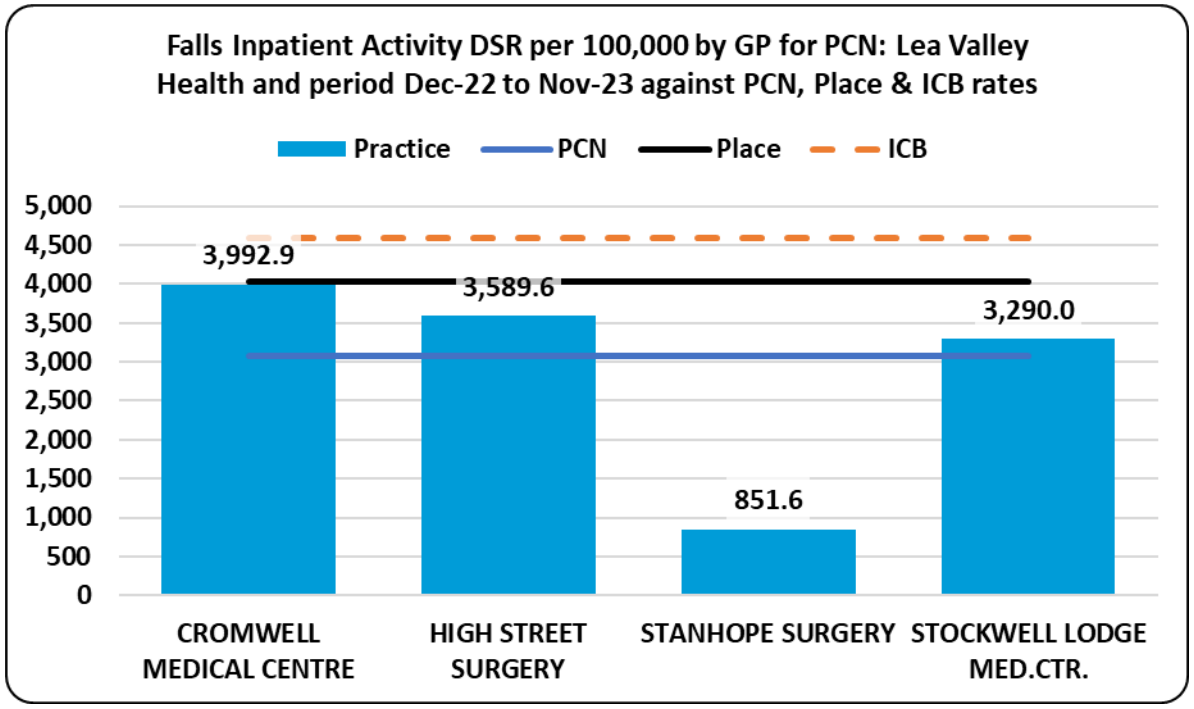
Chronic Ambulatory Care Sensitive Conditions for Lea Valley Health PCN	PCN Per 100,000 Rate Apr-23 to Nov-23	5 Year Trend	2024/25 Trajectory
Angina: Angina pectoris	85.12		UP
Asthma	65.93		UP
Atrial fibrillation and flutter	160.13		UP
COPD	160.83		UP
Congestive heart failure	216.26		UP
Diseases of the blood	359.07		UP
Epilepsy	27.98		UP
Hypertension	14.04		DOWN
Mental and behavioural disorders			
Nutritional, endocrine and metabolic	48.08		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 Lea Valley Health PCN has a lower 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.





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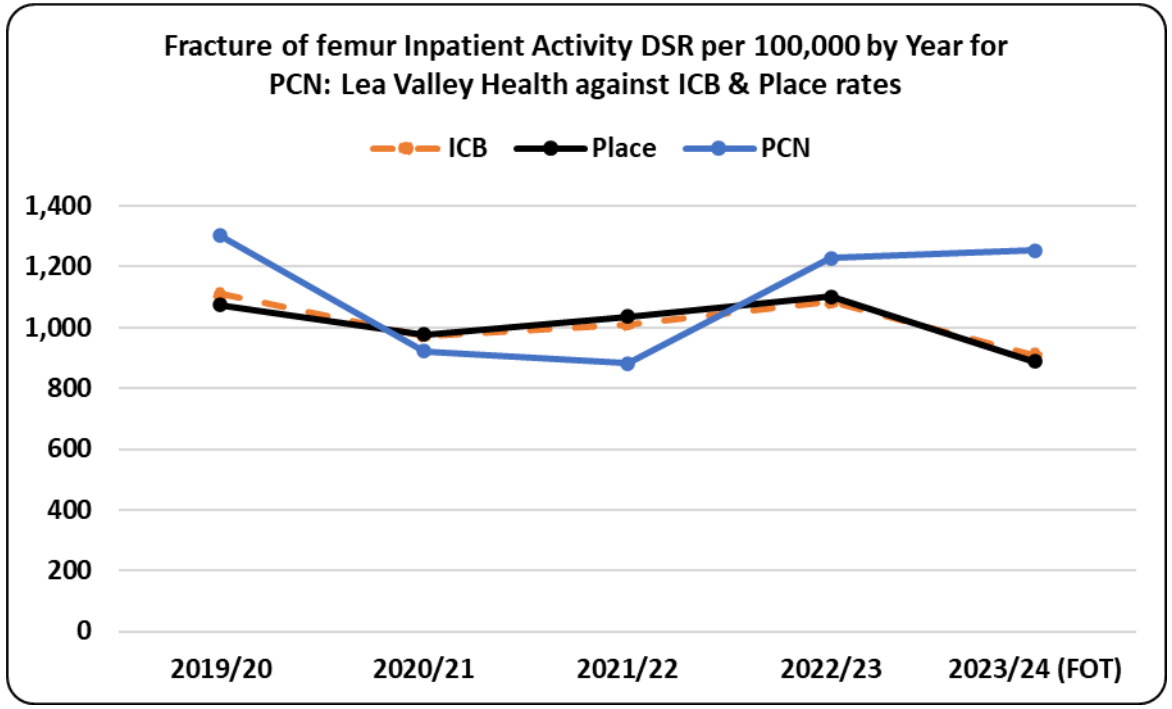
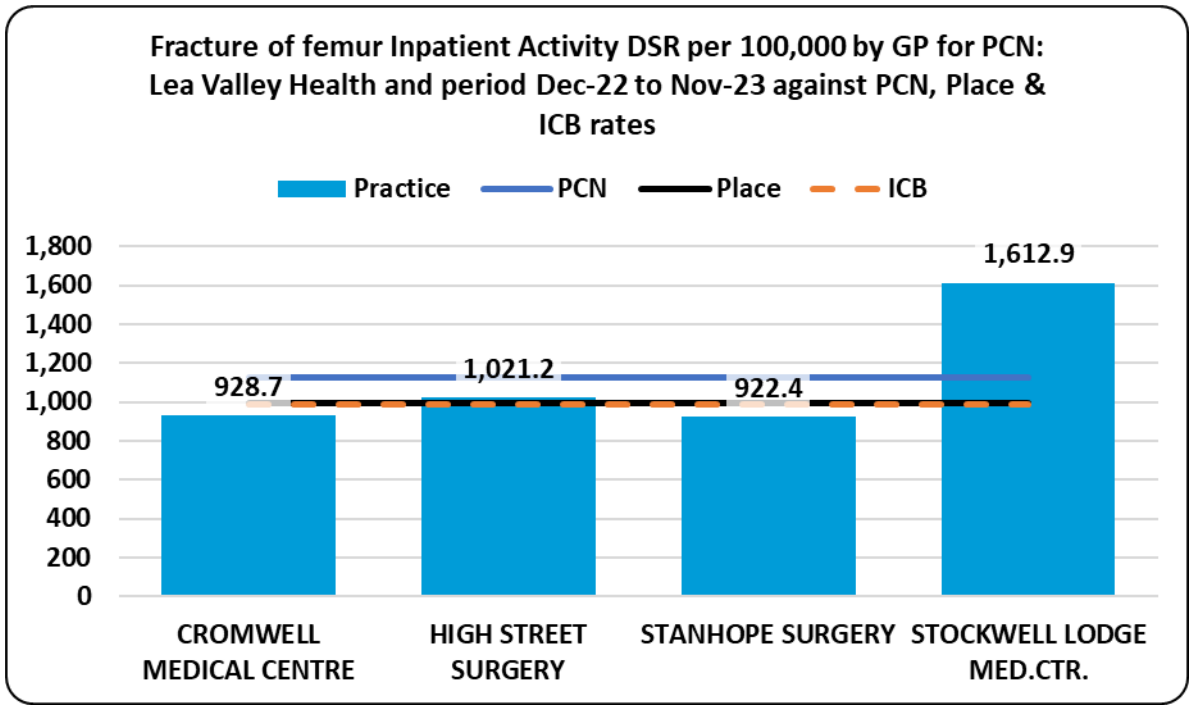
Source: SUS

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 the data shows that Lea Valley Health PCN has a higher 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 an increasing trend for the PCN.
- The ECF indicators on the next page shows potential areas of opportunity through benchmarking the PCN against Place and ICB.





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Source: SUS

ECF indicators for frailty and EOL

- The data shows that Lea Valley Health PCN has a higher percentage of falls frat scores completed, when compared to Place and ICB however the percentage of the population recorded as moderately or severely frail is lower than Place and ICB indicating a possible opportunity for further identification.
- The data contained within the table below is up to the end of December, the latest position can be found at Ardens Manager.

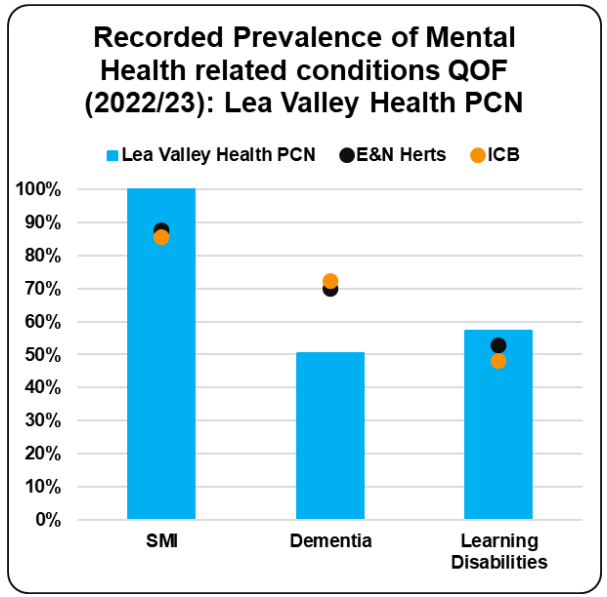
Lea Valley Health Enhanced Commissiong Framework (ECF) 2023-24 for the period 1 April 23 to 31 Dec 23

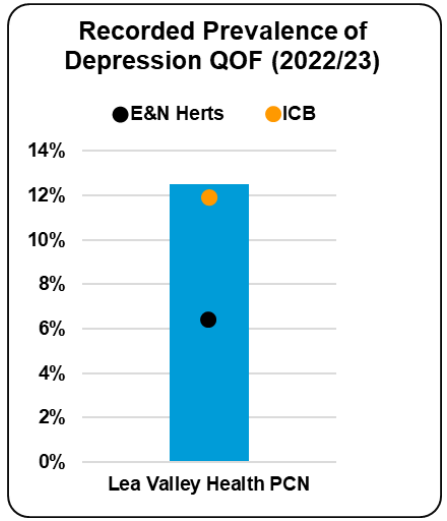
	Frailty			EOL						
	Mod/Sev + falls Frat score done %	Mod frailty + SMR or polypharmacy medication review %	% Mod/Sev frailty of population	% population on EOL register	GSF %	DNACPR %	ACP %	PPD %	PPC %	SCR Consent %
ICB	16.0%	19.5%	1.9%	0.7%	64.9%	53.3%	11.3%	37.3%	39.8%	34.8%
ENH	20.0%	11.7%	1.7%	0.8%	77.5%	48.6%	9.3%	35.1%	37.1%	48.0%
PCN	21.9%	0.0%	1.4%	0.6%	75.1%	32.7%	9.8%	21.5%	22.0%	65.4%
Cromwell Medical Centre	24.3%	0.0%	1.7%	0.6%	82.1%	33.9%	8.9%	23.2%	23.2%	39.3%
High Street Surgery	26.7%	0.0%	1.7%	0.3%	63.0%	33.3%	18.5%	22.2%	25.9%	70.4%
Stanhope Surgery	0.0%	0.0%	0.0%	1.2%	81.7%	22.0%	3.7%	7.3%	8.5%	70.7%
Stockwell Lodge Med.Ctr.	16.6%	0.0%	1.8%	0.4%	60.0%	52.5%	17.5%	47.5%	45.0%	87.5%

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 Lea Valley Health 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.





	Lea Valley Health PCN- Mental Health Conditions 2022-2023 QOF prevalence, with 3 year trend							
	Cromwell Medical Centre		High Street Surgery		Stanhope Surgery		Stockwell Logde Medical Centre	
	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
Dementia	0.7%		0.4%		0.4%		0.5%	
Depression	17.8%		12.9%		4.2%		15.1%	
Learning Disability	0.6%		0.5%		0.7%		0.6%	
SMI	1.3%		1.2%		1.3%		0.9%	

Mental Health QOF Indicators 22-23

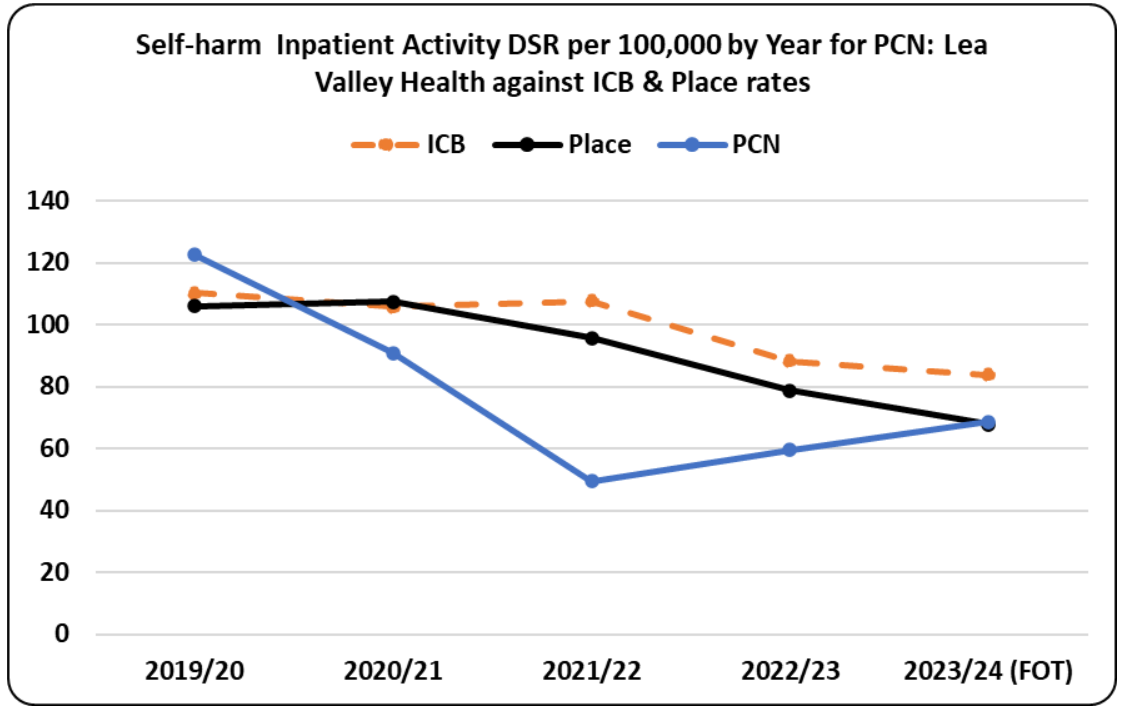
- The data her shows the latest Mental Health QOF metrics for 2022-23 for SMI and Depression in comparison to Place and the ICB.
- The data shows that Lea Valley Health PCN have lower recorded achievement for most areas compared to Place and ICB.
- The data contained within the table below is the latest QOF data, the latest in year position can be found at Ardens Manager.

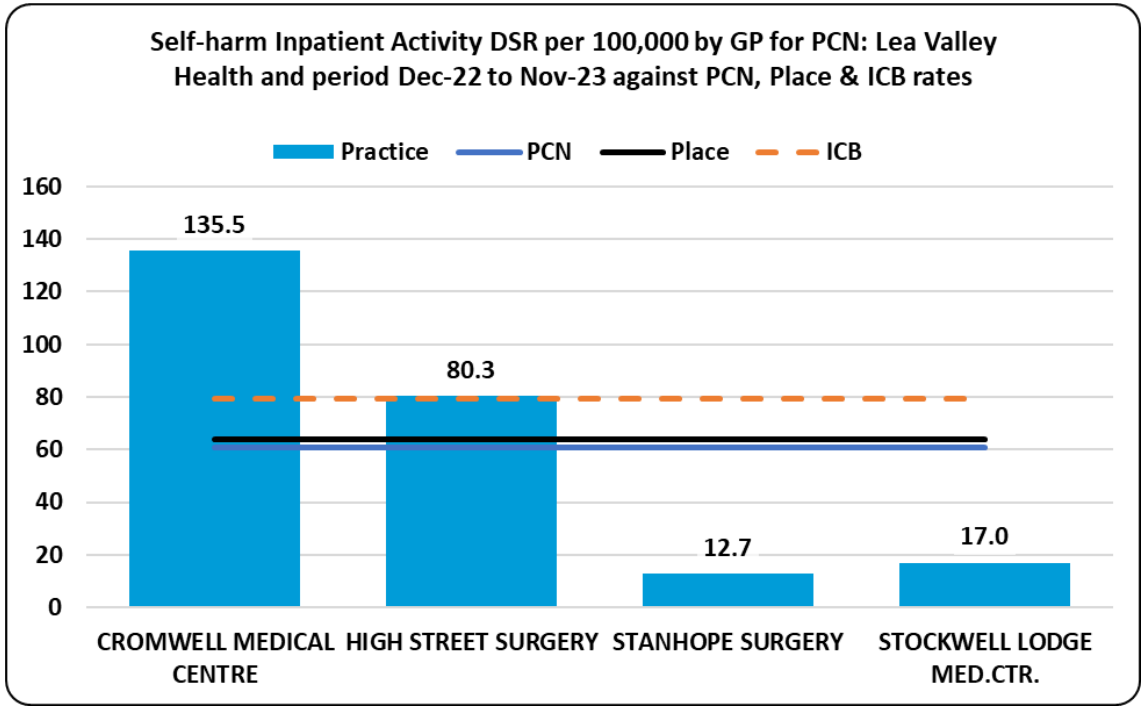
	SMI					Depression
	% of patients with SMI who have a care plan	% of patients with SMI who have a record of BMI in the preceding 12 months	% of patients with SMI who have a record of alcohol consumption in preceding 12 months	% of patients with SMI who have a record of a lipid profile in the preceding 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
E&N	79.8	88.3	89.0	81.5	81.5	82.0
Lea Valley Health PCN	64.3	84.4	89.6	68.0	66.4	81.3
Cromwell Medical Centre	51.0	78.6	79.6	55.4	57.5	78.0
High Street Surgery	70.9	98.2	93.1	82.1	80.0	80.0
Stanhope Surgery	81.3	91.4	97.1	77.6	75.9	83.3
Stockwell Lodge Medical Centre	62.8	75.6	93.6	65.8	60.3	86.5

Emergency Admissions Rates for Self – Harm

ICB overarching outcome of Improving Healthy life expectancy

- Lea Valley Health PCN has a similar rate of admissions for self-harm compared with Place, but lower than the 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.





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Source: SUS