Hertfordshire and
West Essex Integrated
Care System

Locality Insights Pack 2024

Upper Lea Valley

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Working together
for a healthier future

Introduction

This Locality 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 Locality data against place and ICB. An overview table of all the data is available on the following page with areas of opportunity highlighted.

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 Locality and 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 the individual PCNs, other 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

Upper Lea Valley at a Glance

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

For Upper Lea Valley 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***
- ***% of people living with diabetes with all 8 care processes completed***
- ***Identification of Dementia, SMI and Depression***

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 Systemone.

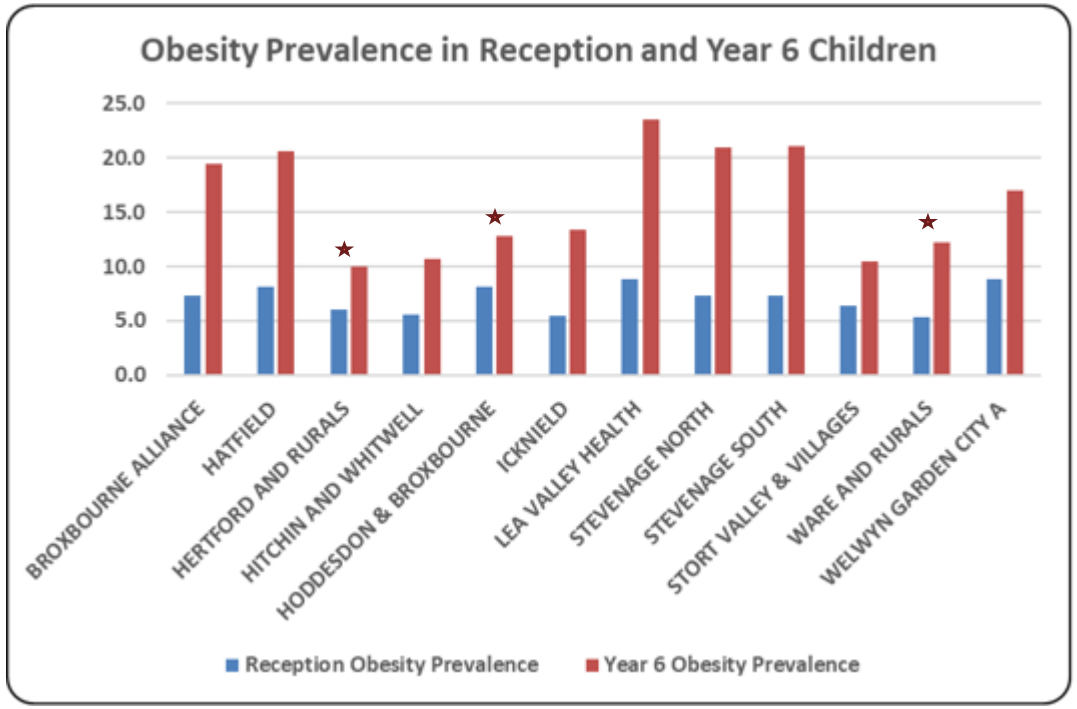
https://app.ardensmanager.com/login

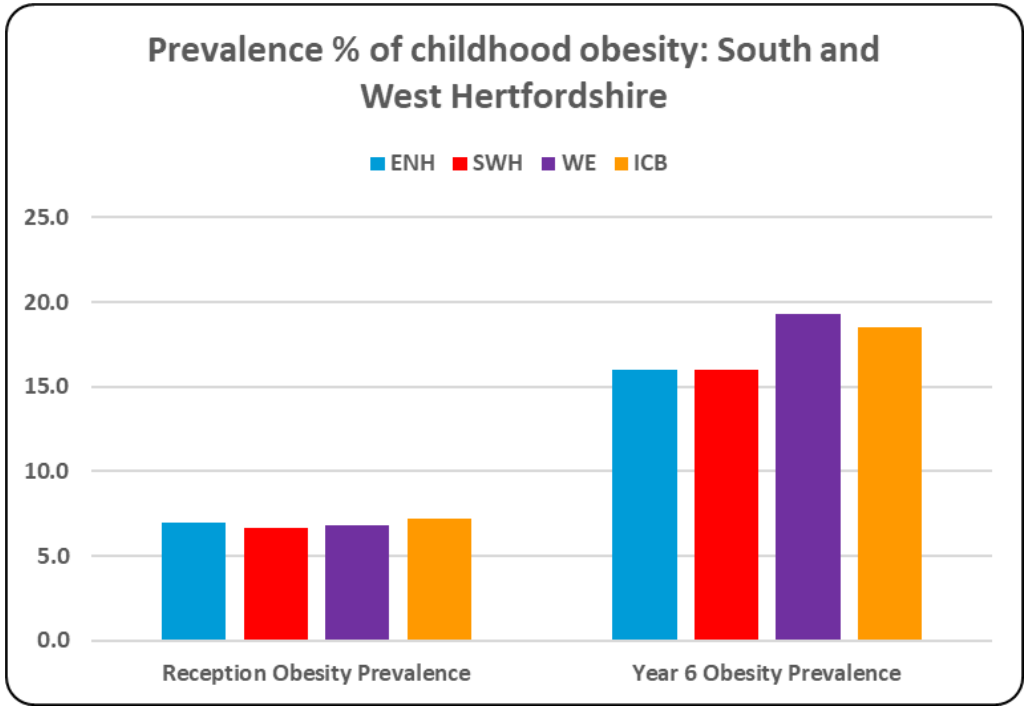
Clinical Priority	Metric	Locality compared to Place average	Locality compared to ICB average
Childhood obesity	% of children in Reception who are overweight	↓	↓
	% of children in Year 6 who are overweight	↓	↓
Reduce rates of emergency care for children and young people	A&E Attendances for Asthma (Children)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

- Rates of childhood obesity in East and North Herts Place follows the pattern of national data with a higher percentage of children recorded as obese in year 6 compared with reception.
- The Upper Lea Valley locality PCNs are highlighted by a star in the chart below, other geographies show greater opportunities around childhood obesity than Upper Lea Valley.





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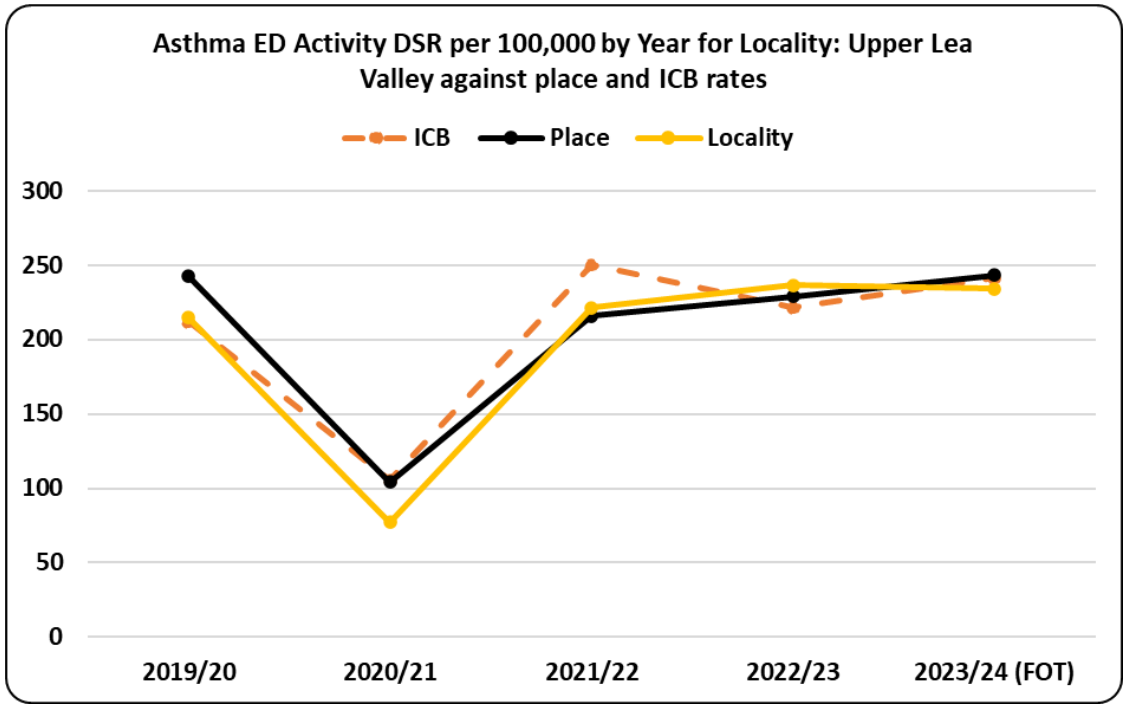
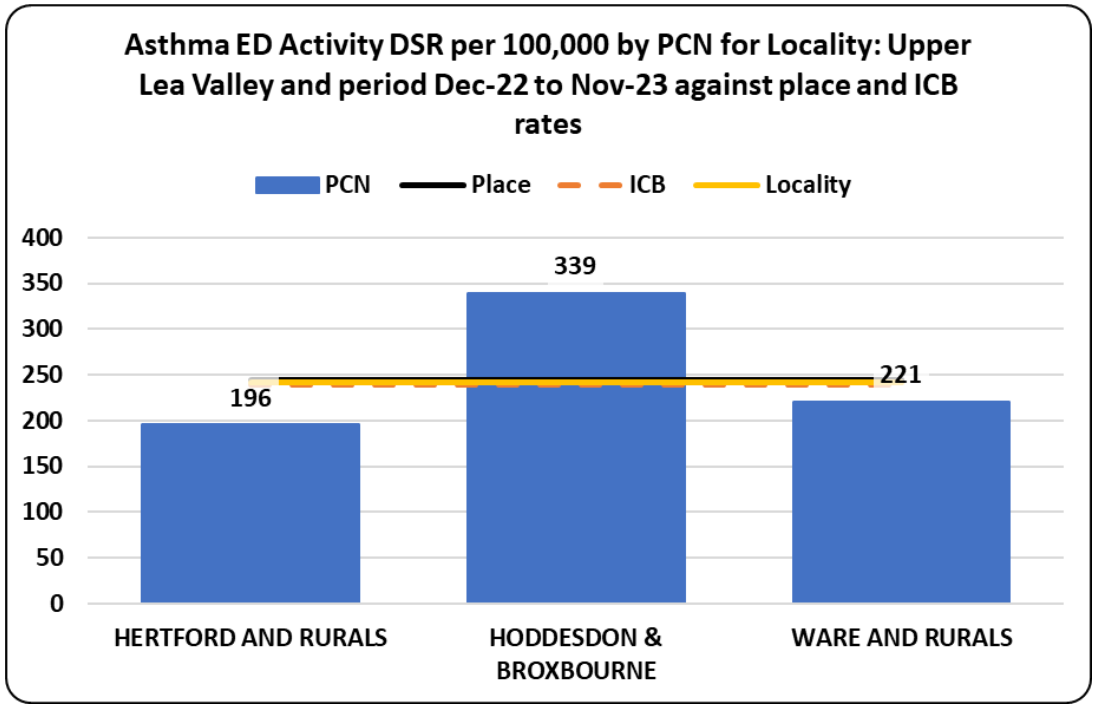
Source: NCMP and HES: 2022/23

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 Upper Lea Valley Place has a similar rate of A&E attendances for Children and Young People for Asthma (data on the right-hand side) compared with ICB and place.
- Rates of Children and Young People attending A&E for Asthma have increased since 2020/21 post covid with Upper Lea Valley rates returning to similar to ICB rates.
- There is variation between the PCNs with Hoddesdon and Broxbourne with higher rates.





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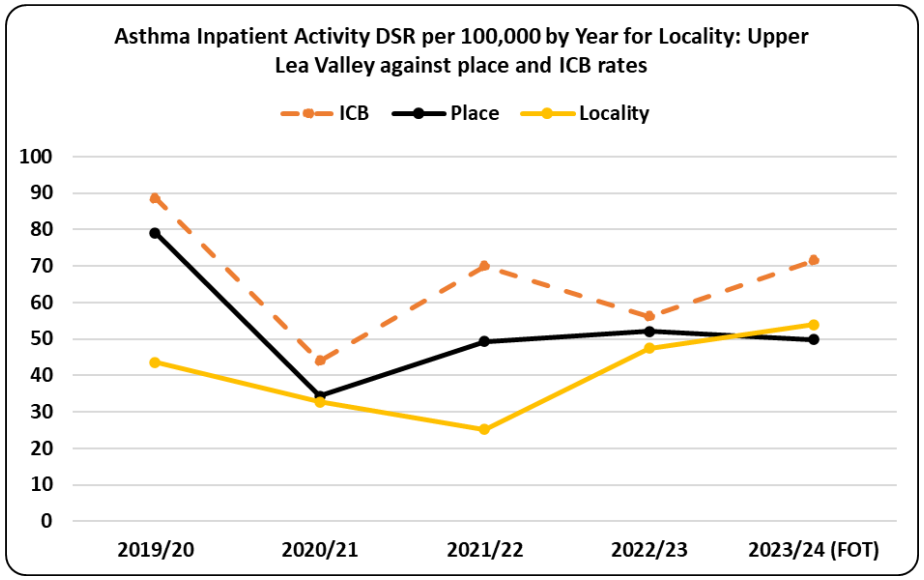
Source: SUS

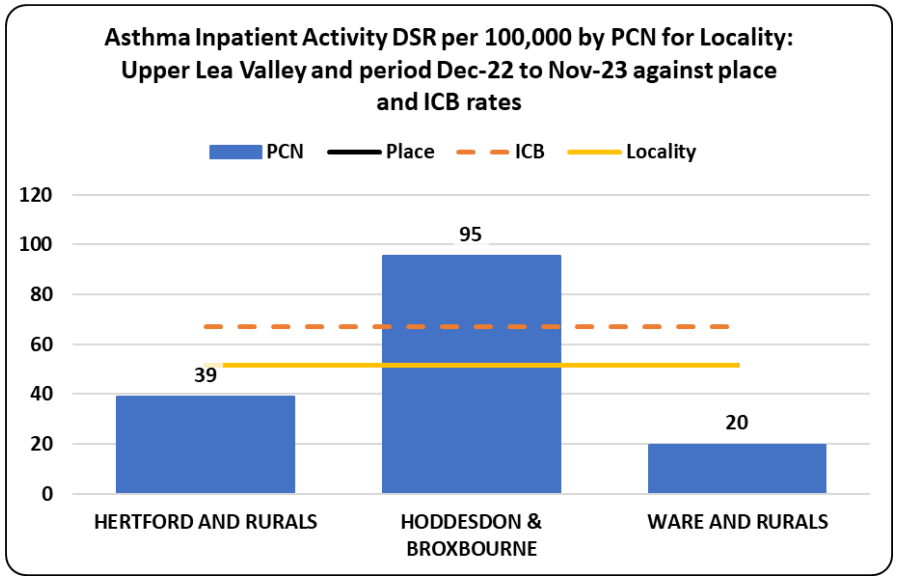
Admissions for Asthma (CYP)

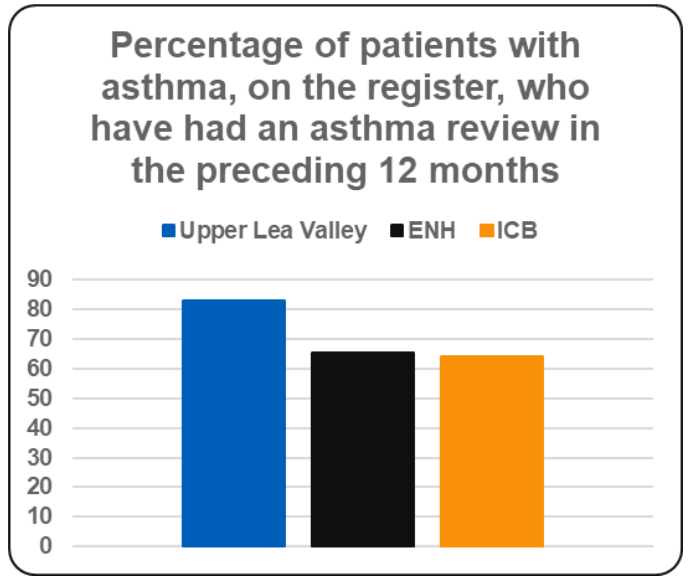
CYP outcome – Reduce the number of unplanned admissions for long term conditions

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

- Upper Lea Valley admission rates for asthma for Children is lower than the ICB and similar to place (rolling years data middle chart).
- The trend data shows an increasing trend in the latest data.
- Higher Proportion of Asthma Reviews are carried out within Upper Leave Valley in comparison to ENH place and the ICB. However, the QOF is for all ages and children specific reviews cannot be identified within the data.







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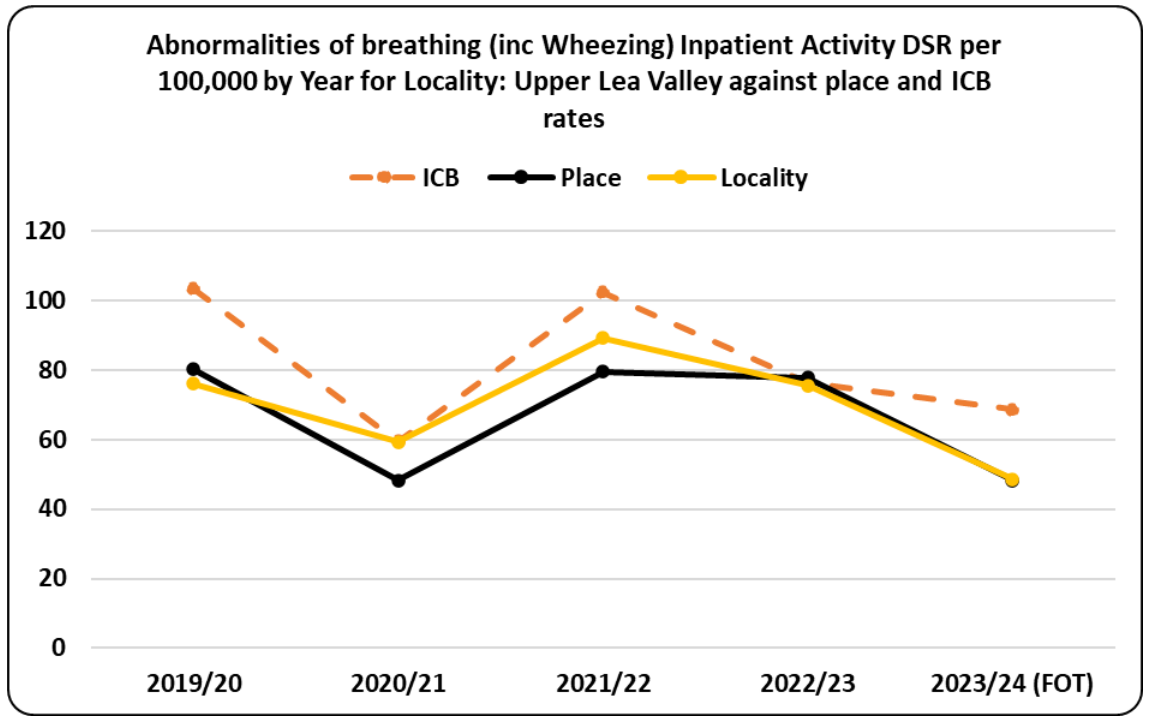
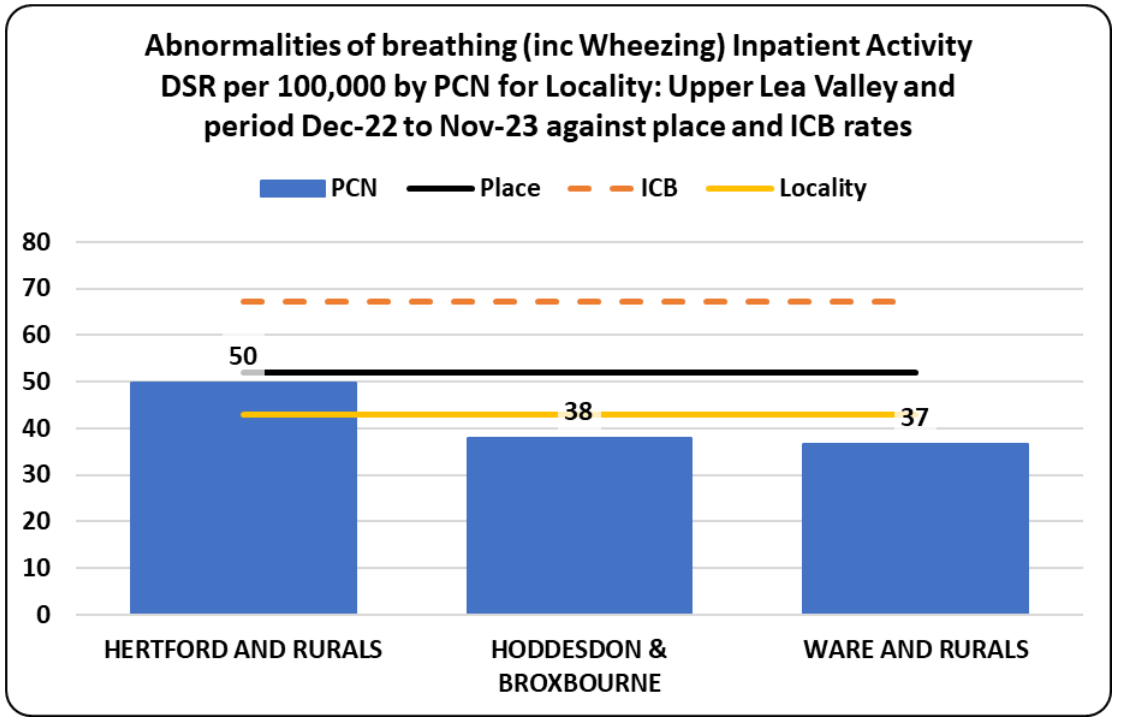
Admissions for Wheeze (CYP)

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

- Upper Lea Valley 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, Hertford and Rurals PCNs have higher rates of Children and Young People admitted to Hospital for Wheeze Upper Lea Valley.
- Detail by practice can be found within the PCN Packs.





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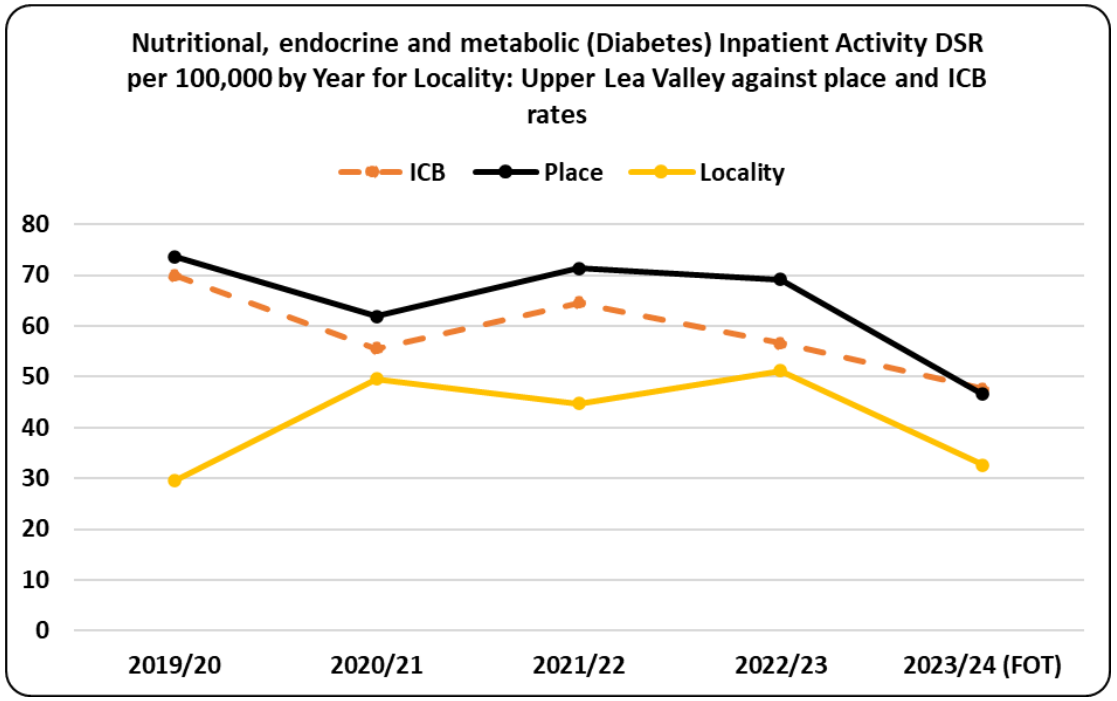
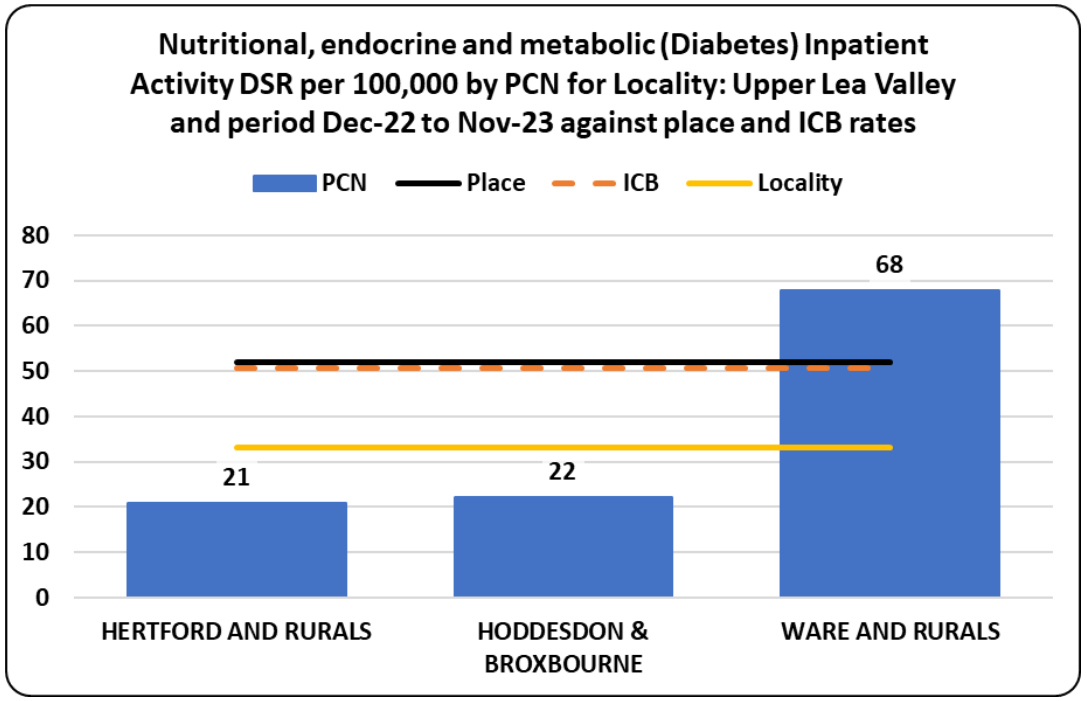
Source: SUS

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 Upper Lea Valley Locality rate of admission is lower compared to the 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 HCP and ICB footprints.





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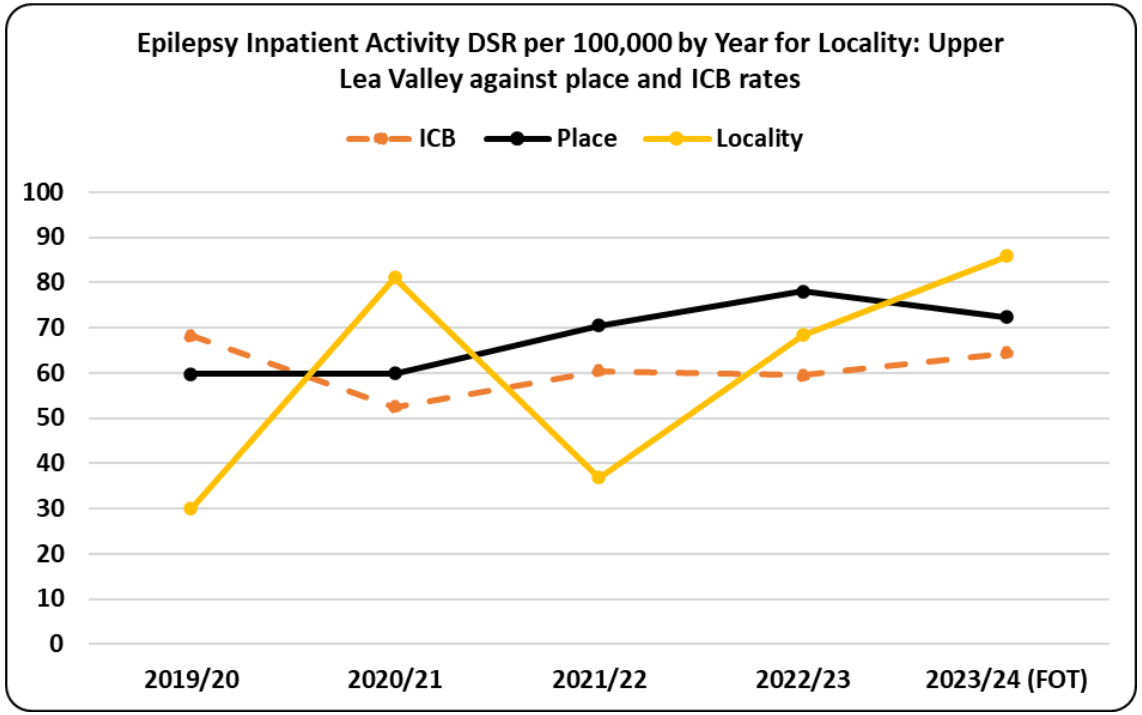
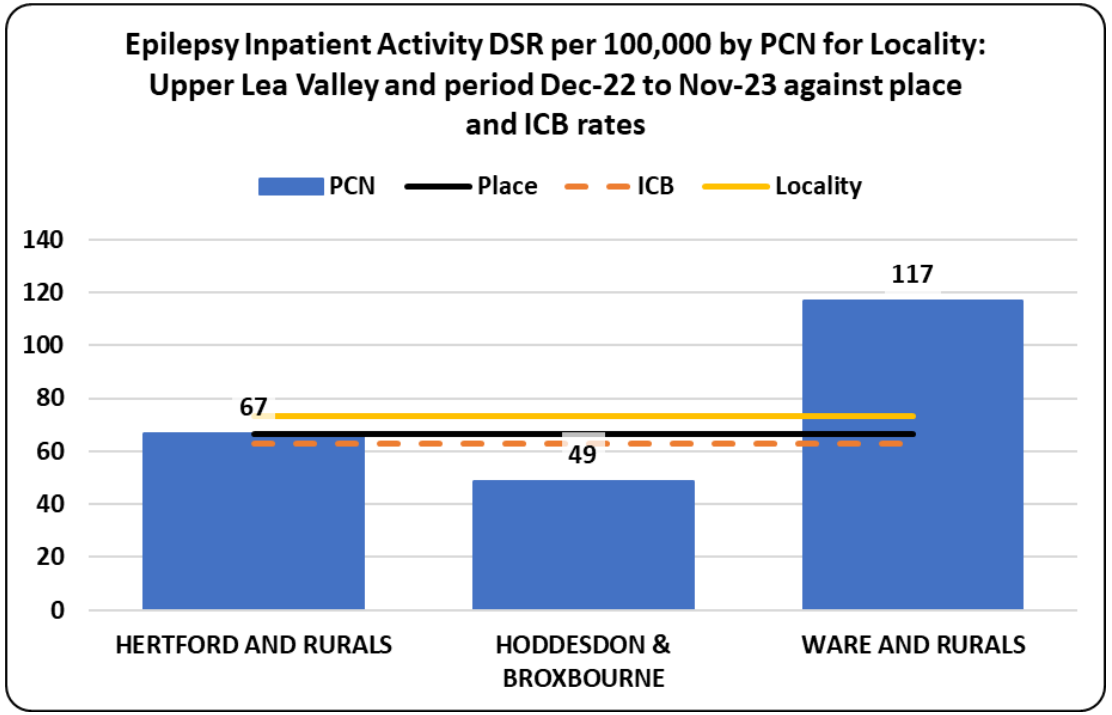
Source: SUS

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 Upper Lea Valley Locality rate of admission is higher compared to the 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.





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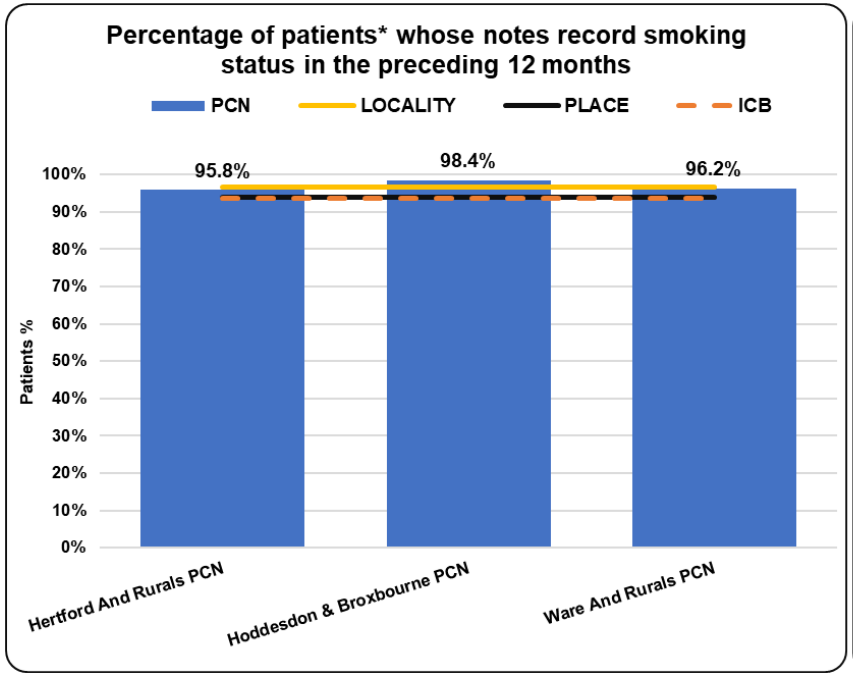
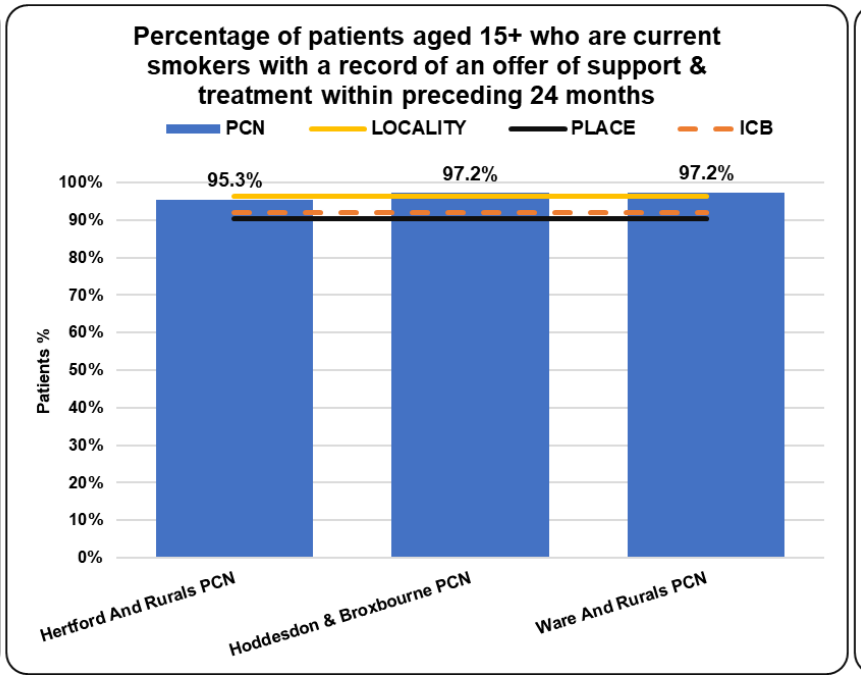
Source: SUS

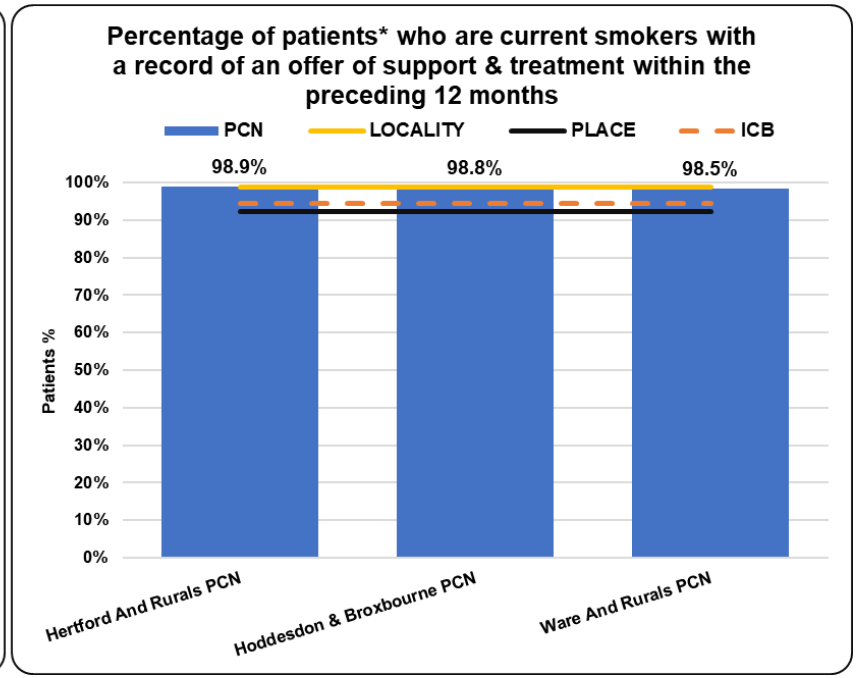
Prevention and health inequalities – Lifestyle factors - Smoking

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

	ECF 2023-24 - Condition Section Under Smoker, Smoking Status, and Smoking Status Recorded - as of Jan. 2024					
	Pre-Diabetes		Diabetes		Atrial Fibrillation	
Locality's PCNs	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
Hertford and Rurals PC	1.70%	2168	0.77%	2639	0%	60
Hoddesdon and Broxb	1.34%	2116	0.67%	2644	0%	48
Ware and Rurals PCN	0.65%	1779	0.28%	2127	0%	46







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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

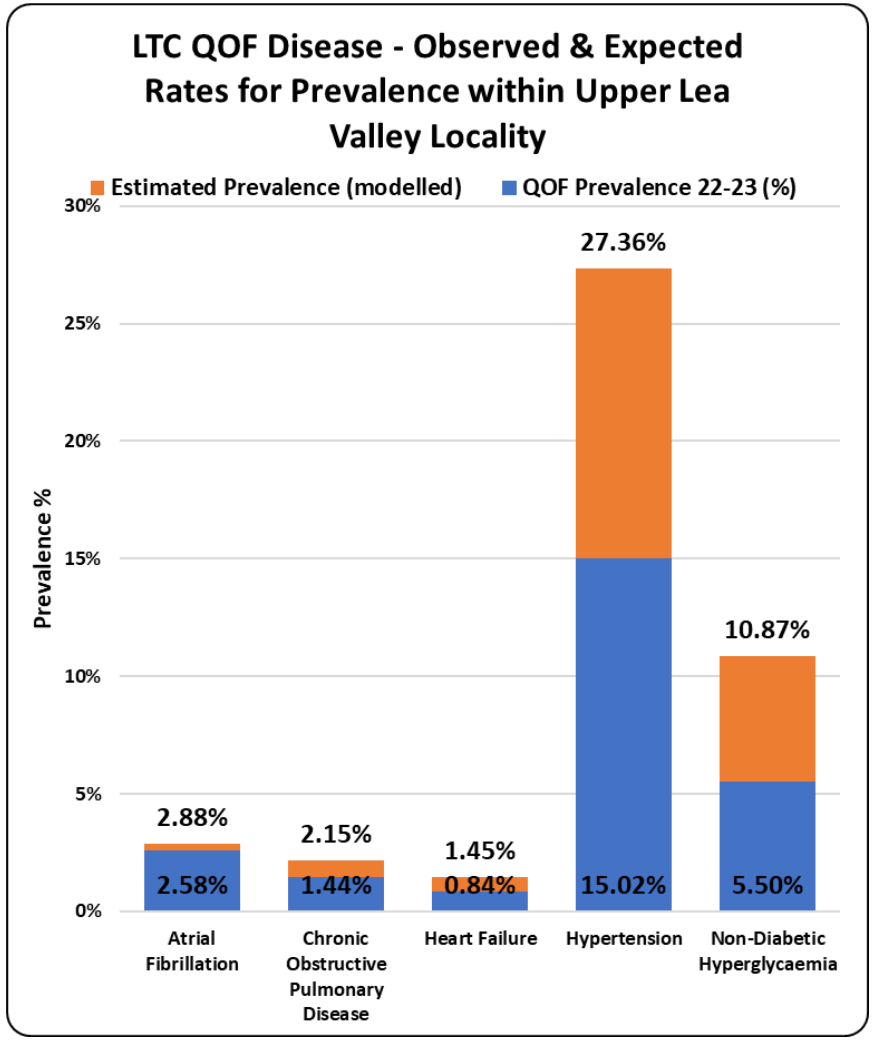
Prevention and health inequalities
Early Identification: Expected vs observed prevalence

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 Locality compared with the latest published QOF prevalence for the Place.

- Upper Lea Valley recorded prevalence compared with the modelled estimated prevalence for the Place 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
- The individual PCN details can be found here: https://hertsandwestessexics.org.uk/pcn-packs

Disease/ Condition	Disease Detection Modelling for Upper Lea Valley Locality - Total No. of New Diagnoses to Meet Locality & PLACE Rates - 2023/24	
	Total number to meet Locality rate	Total number to meet PLACE rate
Asthma	53	1968
Atrial Fibrillation	12	1319
Chronic Kidney Disease	189	1958
Chronic Obstructive Pulmonary Disease	240	903
Coronary Heart Disease	93	1219
Diabetes Mellitus	528	2075
Epilepsy	66	296
Heart Failure	91	492
Hypertension	83	4473
Non-Diabetic Hyperglycaemia	762	3918
Peripheral Arterial Disease	32	216
Stroke and Transient Ischaemic Attack	60	739



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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 Place compared with the 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.

	Upper Lea Valley Locality - 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 - LOCALITY %	HERTFORD AND RURALS		HODDESDON & BROXBOURNE		WARE AND RURALS	
				QOF 2022-23	3 Year Trend	QOF 2022-23	3 Year Trend	QOF 2022-23	3 Year Trend
Asthma	6.16%	6.40%	6.88%	6.92%		6.54%		7.44%	
Atrial fibrillation	2.09%	2.12%	2.58%	2.55%		2.65%		2.53%	
Chronic kidney disease	3.46%	2.94%	3.16%	3.35%		2.83%		3.37%	
Chronic obstructive pulmonary disease (COPD)	1.49%	1.55%	1.44%	1.27%		1.70%		1.37%	
Diabetes mellitus	6.63%	6.54%	6.14%	5.55%		6.77%		6.36%	
Epilepsy	0.70%	0.73%	0.74%	0.80%		0.66%		0.74%	
Heart Failure	0.80%	0.74%	0.84%	0.78%		0.90%		0.89%	
Hypertension	13.84%	13.83%	15.02%	15.06%		15.23%		14.49%	
Non-diabetic hyperglycaemia	6.42%	5.29%	5.50%	5.14%		5.68%		6.05%	
Peripheral arterial disease	0.44%	0.45%	0.48%	0.46%		0.46%		0.55%	
Secondary prevention of coronary heart disease	2.67%	2.63%	2.99%	2.73%		3.27%		3.11%	
Stroke and transient ischaemic attack	1.63%	1.71%	1.84%	1.82%		1.90%		1.77%	

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.
- Where the cell is highlighted the percentage is lower than the Place value.
- The data here is shown without exceptions removed in order to be able to view the percentage of people not receiving reviews.
- The data shows that the Locality has higher percentage of reviews than place and ICB across all areas.
- 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	Upper Lea Valley	Hertford And Rurals PCN	Hoddesdon & Broxbourne PCN	Ware And Rurals PCN
% of AF Patients with Stroke Risk Assessed in the last 12 months	92.9	91.8	95.2	94.3	95.2	97.1
The % of patients aged 45 or over who have a record of blood pressure in the preceding 5 years	85.7	85.9	87.0	87.4	88.9	84.0
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	81.7	78.4	84.6	83.2
The % of patients with asthma, on the register, who have had an asthma review in the preceding 12 months	64.0	65.3	67.7	59.6	74.1	75.0
The % of patients with COPD, on the register, who have had a review in the preceding 12 months	75.7	77.1	80.8	74.6	84.6	86.1
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	78.9	72.5	82.0	85.8
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	88.8	87.2	87.8	92.6

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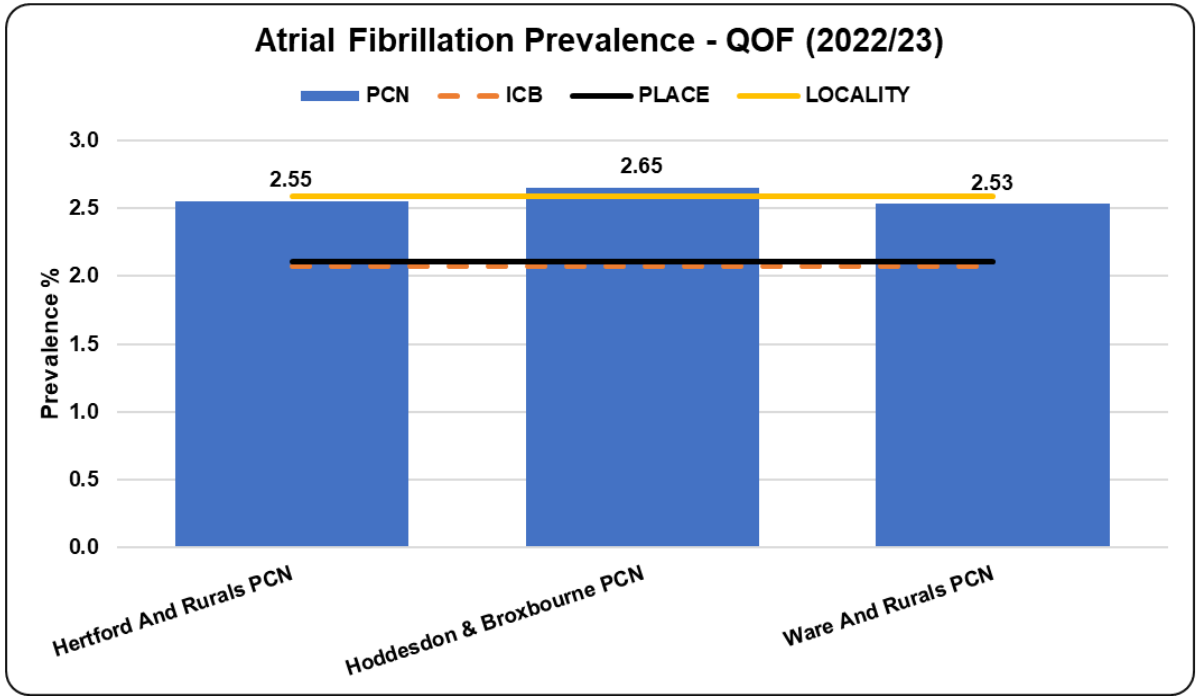
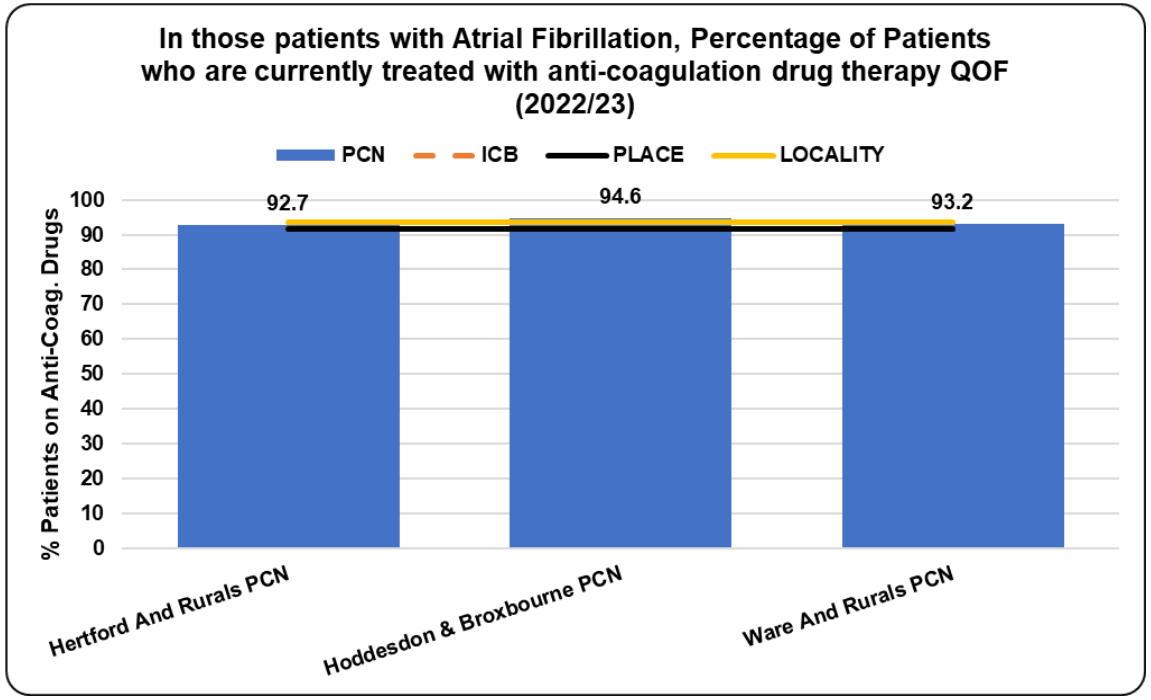
Source: NHS Digital QOF Data Sets Link: QOF Data Set

Prevention and health inequalities – Atrial Fibrillation

- Upper Lea Valley recorded prevalence for Atrial Fibrillation is higher than the ICB and Place prevalence.
- Once identified the percentage of patients currently treated with anti-coagulant drug therapy is similar to the ICB and Place.
- The latest AF indicator data is detailed within https://app.ardensmanager.com/login





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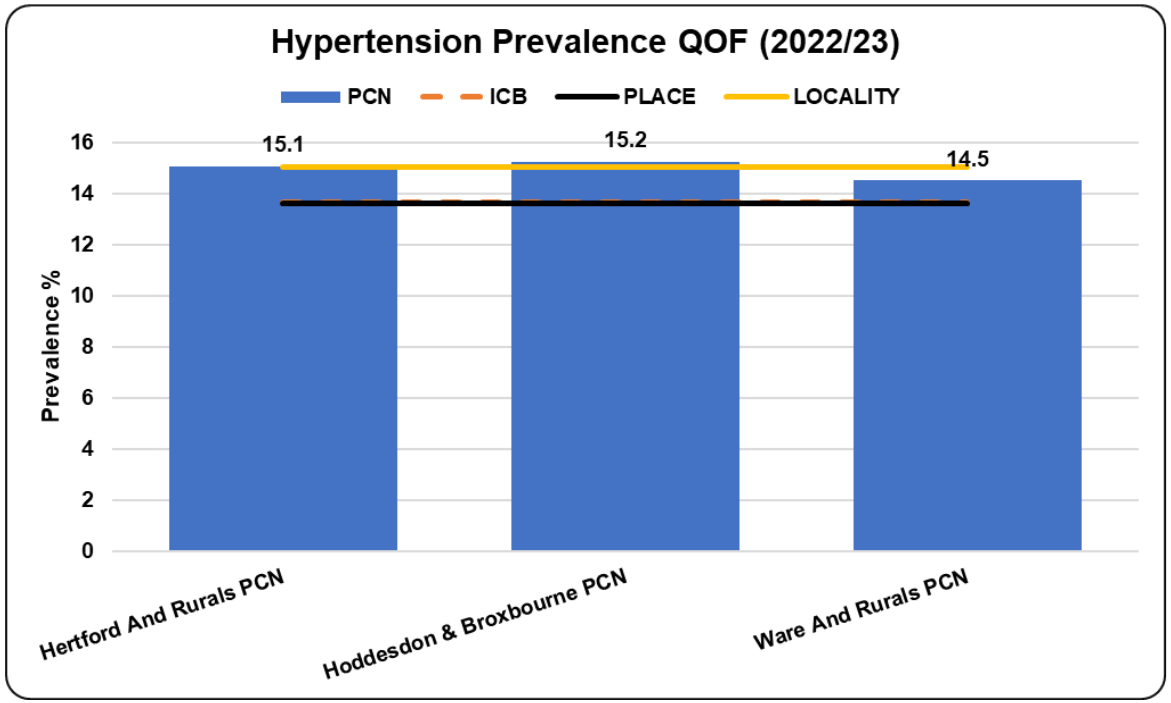
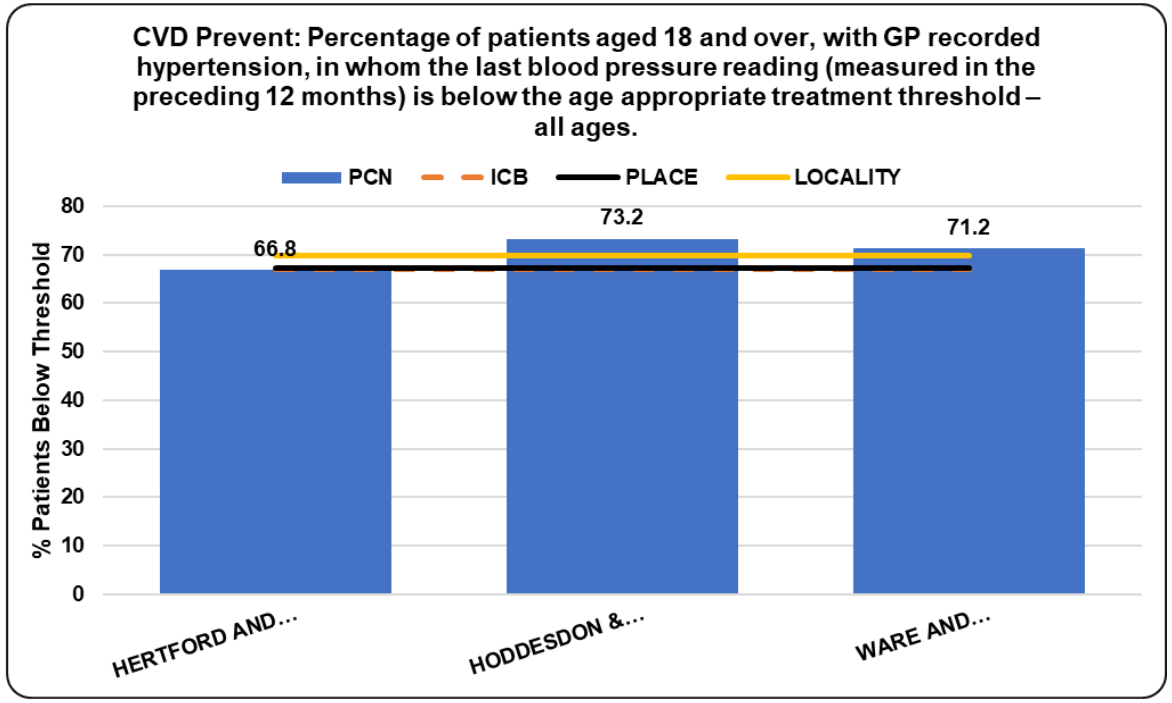
Source: NHS Digital QOF Data Sets Link: QOF Data Set

Prevention and health inequalities – Hypertension

- Upper Lea Valley recorded prevalence for hypertension is higher than the ICB and Place prevalences.
- Once identified the data shows the percentage of patients in whom the latest BP reading is below the age-appropriate treatment threshold is higher than the ICB and Place.
- The latest hypertension indicator data are detailed within https://app.ardensmanager.com/login





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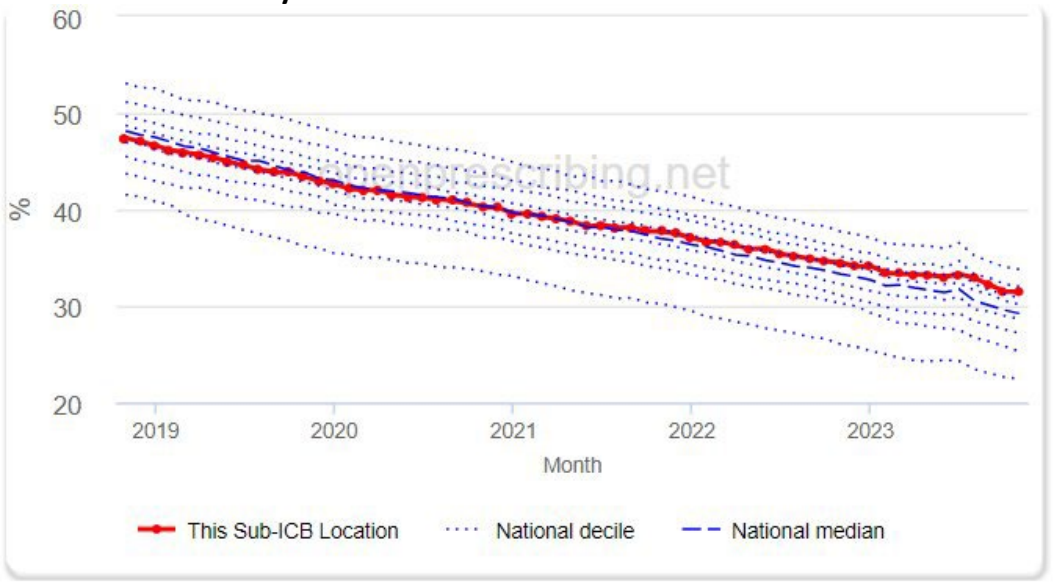
Source: NHS Digital QOF Data Sets Link: QOF Data Set & CVD Prevent Data Sets Link: CVD Prevent Data Explorer

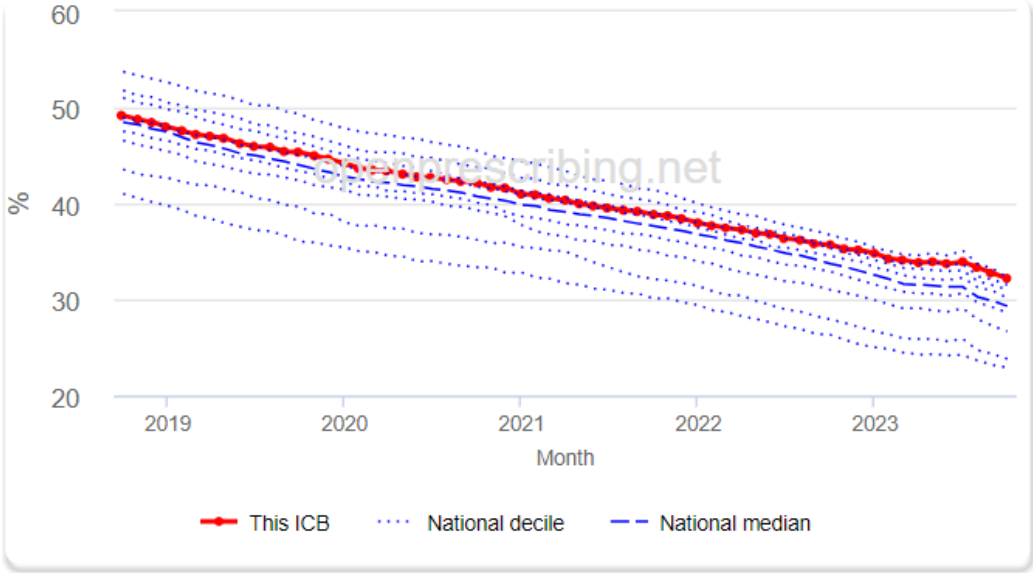
Lipid management : Percentage of people on lipid lowering therapy for secondary prevention who are on low and medium intensity statins

- 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 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. There is variation between the PCNs in the locality with opportunity to improve.

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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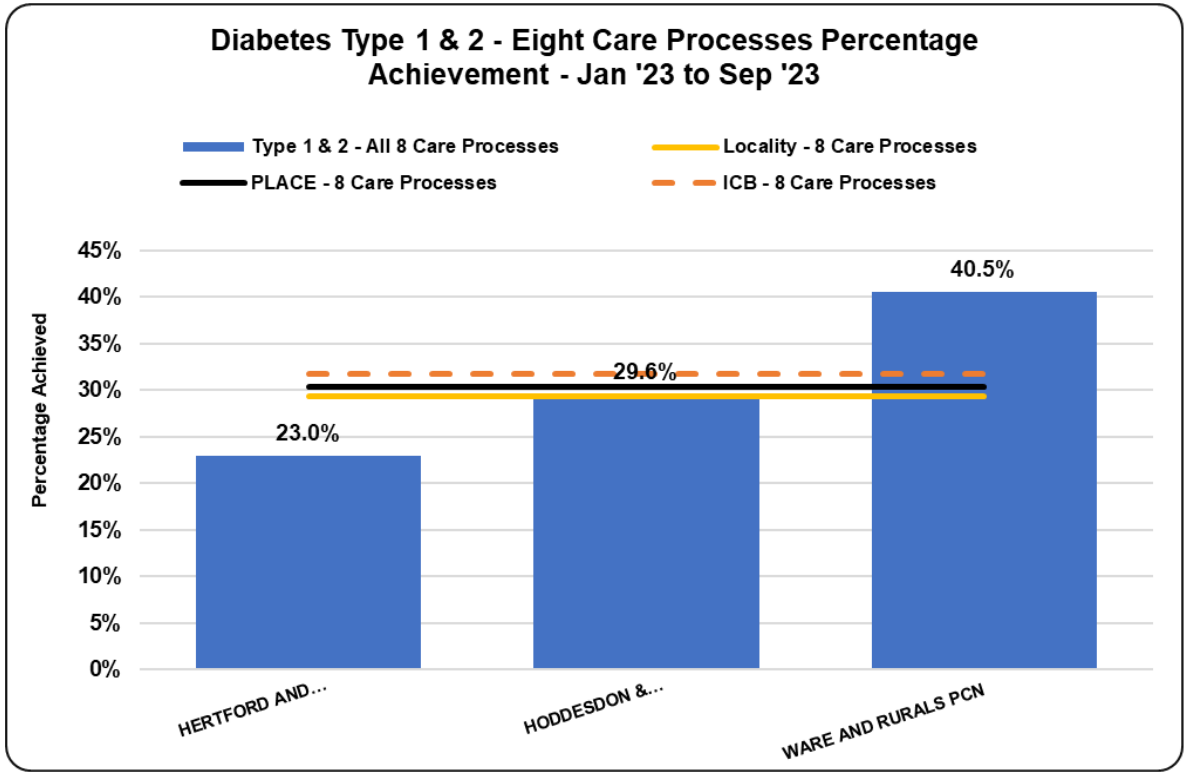
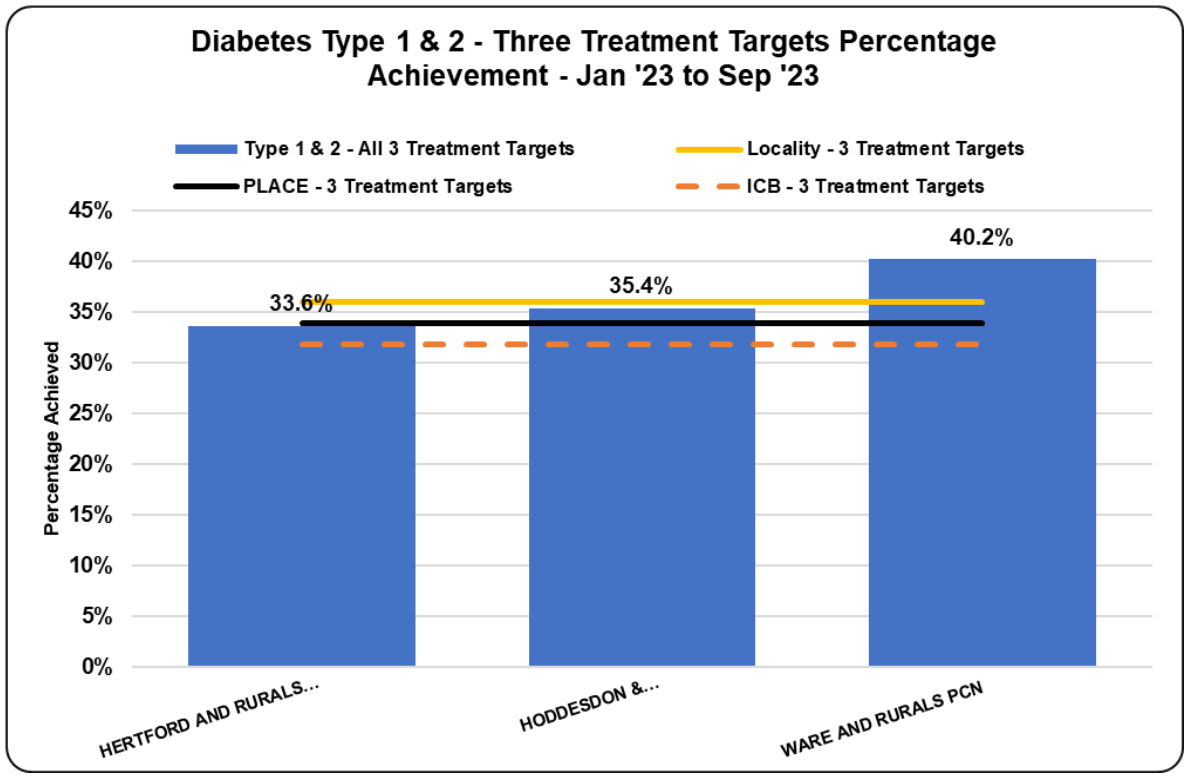
Source: OpenPrescribing.net – Link Here

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 Upper Lea Valley is slightly lower than the ICB and Place, but there is significant variation between the PCNs.
- For the three treatment targets Upper Lea Valley data shows a higher percentage than the ICB and Place.
- The latest information can be found within Ardens Manager.





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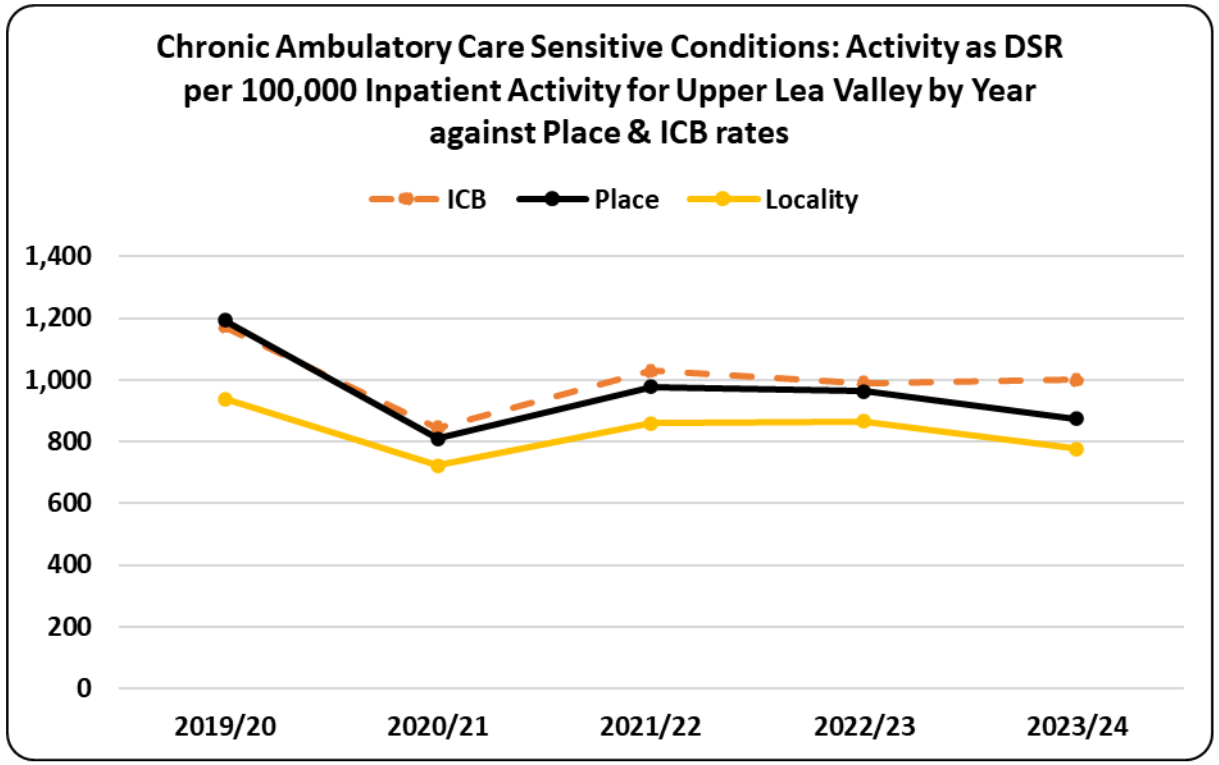
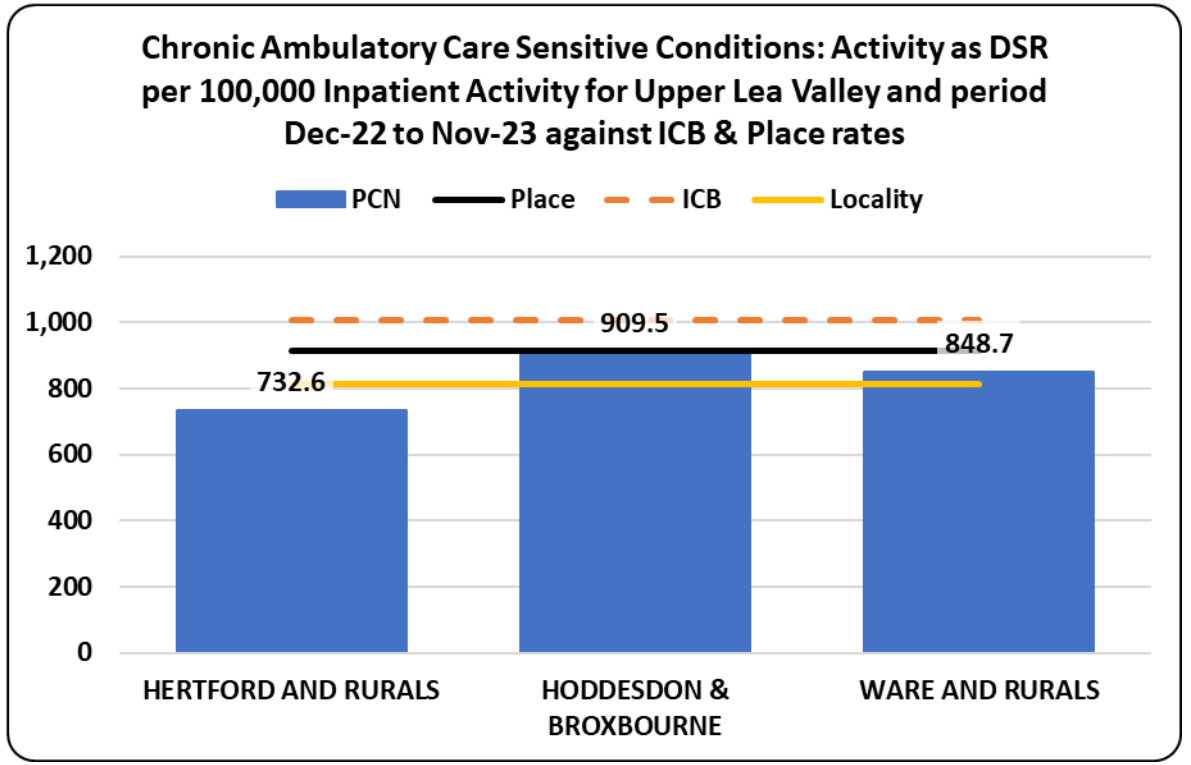
Source: National Diabetes Audit 2023-24 – Quarterly report January 2023 to September 2023, Link: NDA Quarterly Reports

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





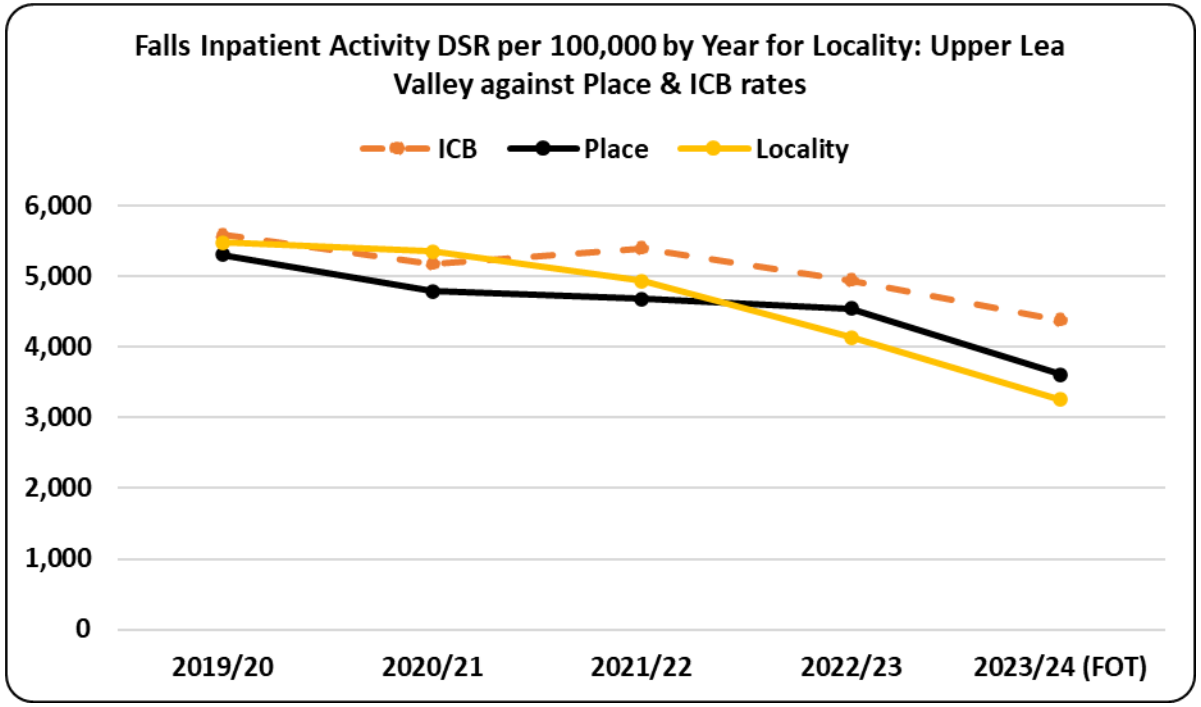
- Ambulatory care sensitive (ACS) conditions are conditions where effective community care and person-centred care can help prevent the need for hospital admission. (Nuffield Trust)
- Upper Lea Valley's admission rate for Chronic ACS conditions is lower than the ICB and Place rates when looking at the 12 months data up to November 2023.
- Upper Lea Valley Locality trend in activity follows a similar trajectory to ICB.

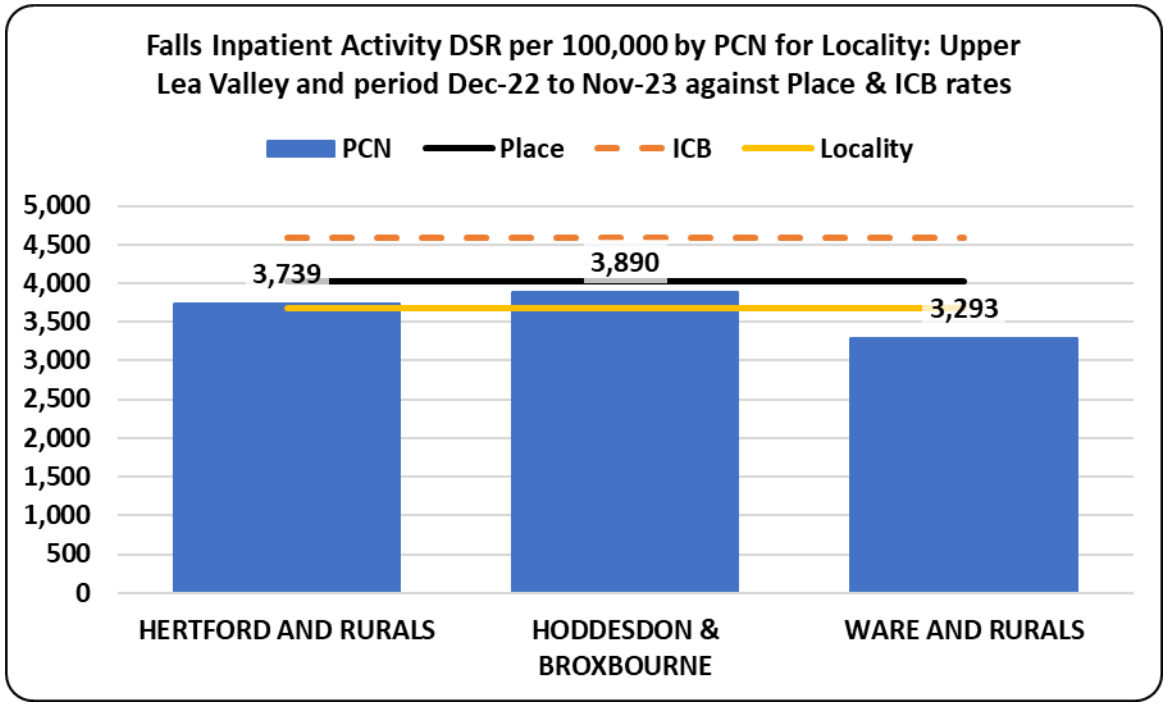
Source: SUS Link: Chronic ACS Conditions & NHSOF

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 Upper Lea Valley has a lower rate of admissions for falls than Place and the ICB.
- There is variation in the data for the PCNs within the Locality.
- Data in the following pages shows the data for the PCNs compared with Locality, Place and the ICB 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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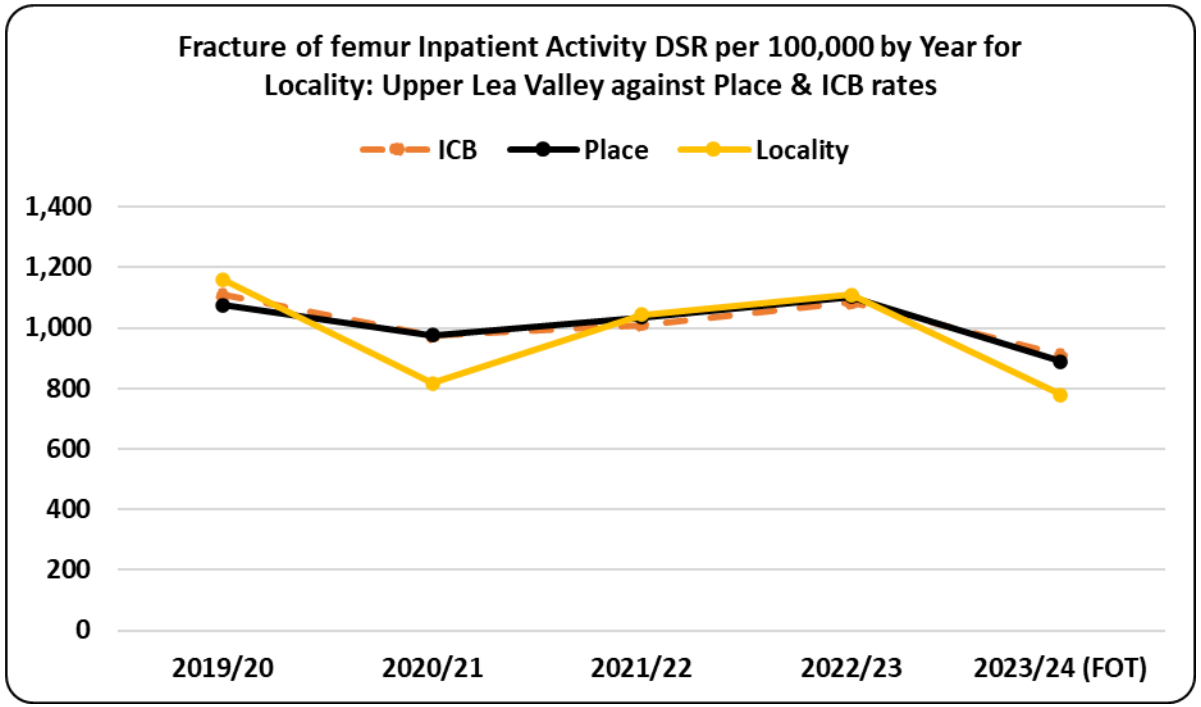
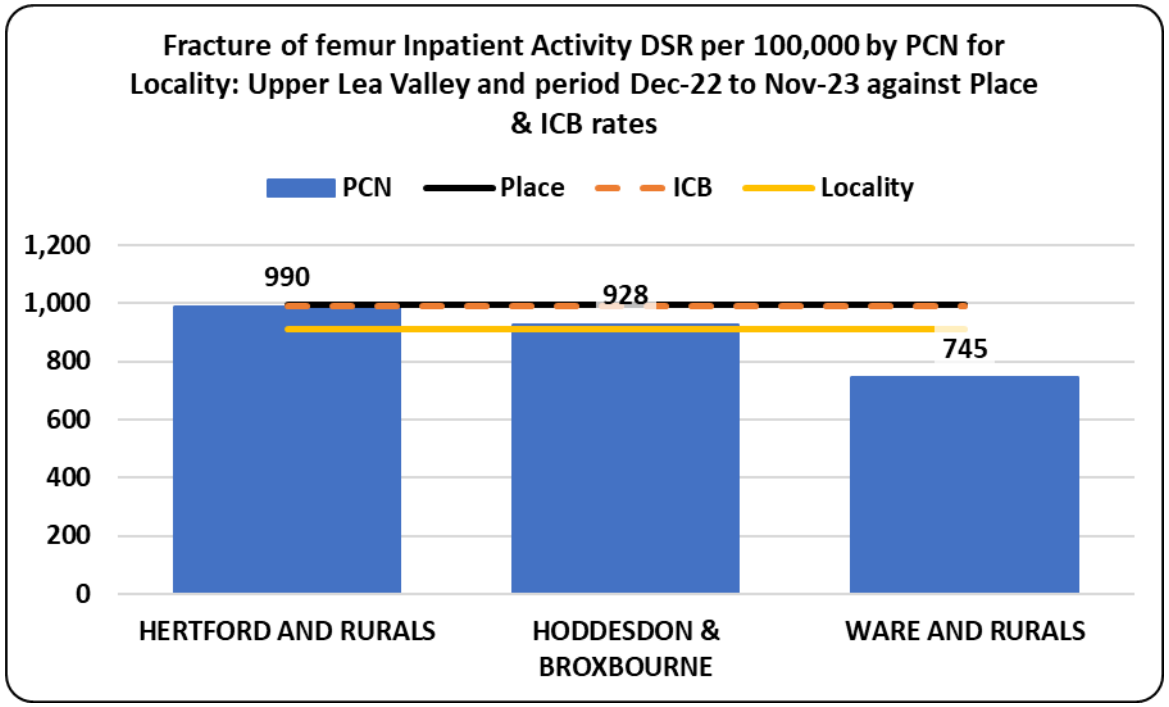
Source: SUS

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 Upper Lea Valley also has a lower rate of admissions for hip fractures than Place and the ICB.
- The latest trend data shows a fall for the latest year against last year.
- The ECF indicators on the next page shows potential areas of opportunity through benchmarking the PCNs against Locality, Place and ICB.





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Source: SUS

ECF indicators for frailty and EOL

- The data shows that Upper Lea Valley has a lower percentage of falls frat scores completed, when compared to Place and the ICB as at end Dec 23.
- The Locality percentage of the population recorded as moderately or severely frail is higher than Place and the ICB, however within the PCNs it is indicating further opportunity for identification.
- The data contained within the table below is up to the end of December, the latest position can be found at Ardens Manager.

ENH Locality, PCNs & ICB Enhanced Commissiong Framework (ECF) 2023-24 for the period 1 April 23 to 31 Dec 23

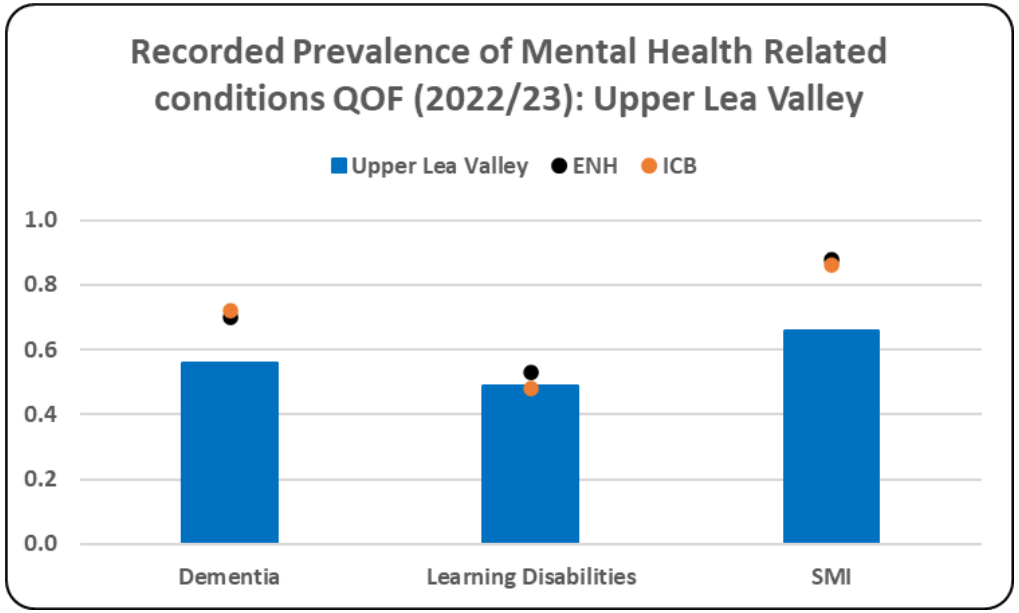
	Frailty			EOL						
	Mod/Sev + falls Frat score done %	Mod frail + SMR or polypharmacy medication review %	% Mod/Sev frailty of population	% population on EOL register	GSF %	DNACPR %	ACP %	PPD %	PPC %	SCR Consent %
ICB	16.0%	19.5%	1.9%	0.7%	64.9%	53.3%	11.3%	37.3%	39.8%	34.8%
ENH	20.0%	11.7%	1.7%	0.8%	77.5%	48.6%	9.3%	35.1%	37.1%	48.0%
Upper Lea Valley	14.9%	11.6%	2.4%	0.8%	78.1%	59.6%	11.7%	47.1%	47.1%	47.7%
Hertford And Rurals PCN	9.2%	18.5%	3.3%	0.7%	60.2%	71.0%	11.0%	61.3%	62.7%	42.5%
Hoddesdon & Broxbourne PCN	31.6%	0.0%	2.0%	0.8%	89.8%	47.1%	8.3%	33.5%	31.4%	44.9%
Ware And Rurals PCN	13.3%	1.4%	1.4%	1.1%	88.8%	57.0%	15.4%	41.9%	42.4%	56.3%

Source: Ardens Manager

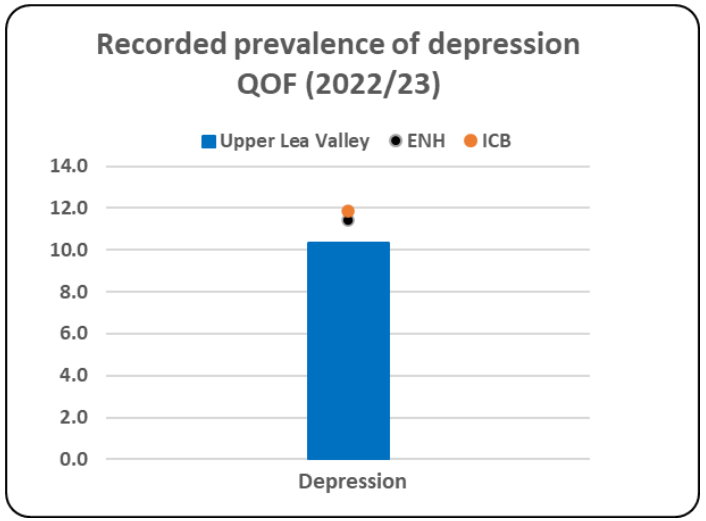
Prevalence of mental health conditions (QOF)

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 Upper Lea Valley prevalence compared with ENH and the ICB. Future iterations will include comparisons against modelled expected prevalence.
- The data shows that Upper Lea Valley has a lower recorded prevalence for Dementia, Depression and SMI compared to ICB and place which may indicate an opportunity for further identification. Details for individual PCNs can be found within their packs.
- 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.



	Upper Lea Valley 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	0.9%		11.9%		0.5%		0.9%	
ENH	0.7%		11.4%		0.5%		0.9%	
Upper Lea Valley	0.7%		11.3%		0.5%		0.7%	
Hertford and Rurals PCN	3.3%		57.6%		2.3%		3.5%	
Hoddesdon & Broxbourne PCN	3.2%		41.5%		2.3%		2.8%	
Ware and Rurals PCN	1.5%		25.3%		1.1%		1.5%	



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Source: QOF

Mental Health QOF Indicators 22-23

- Mental Health QOF metrics for 2022-23 show that Upper Lea Valley has higher achievement across all QOF metrics for SMI and Depression compared with ICB and place.
- 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
Upper Lea Valley	89.7	93.0	93.5	86.8	88.8	89.8
Hertford And Rurals PCN	95.2	95.5	96.0	87.2	89.3	93.6
Hoddesdon & Broxbourne PCN	81.7	88.6	88.9	78.8	83.7	85.1
Ware And Rurals PCN	89.5	93.9	94.3	95.8	93.9	89.1

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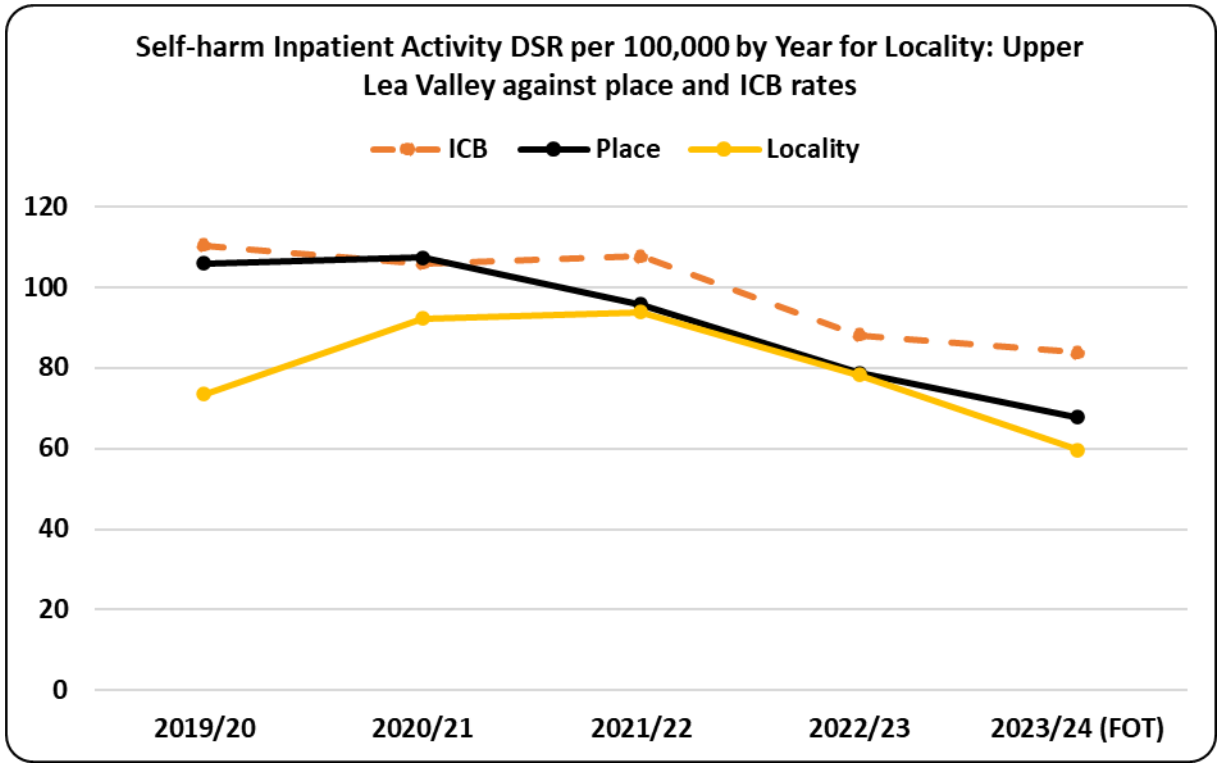
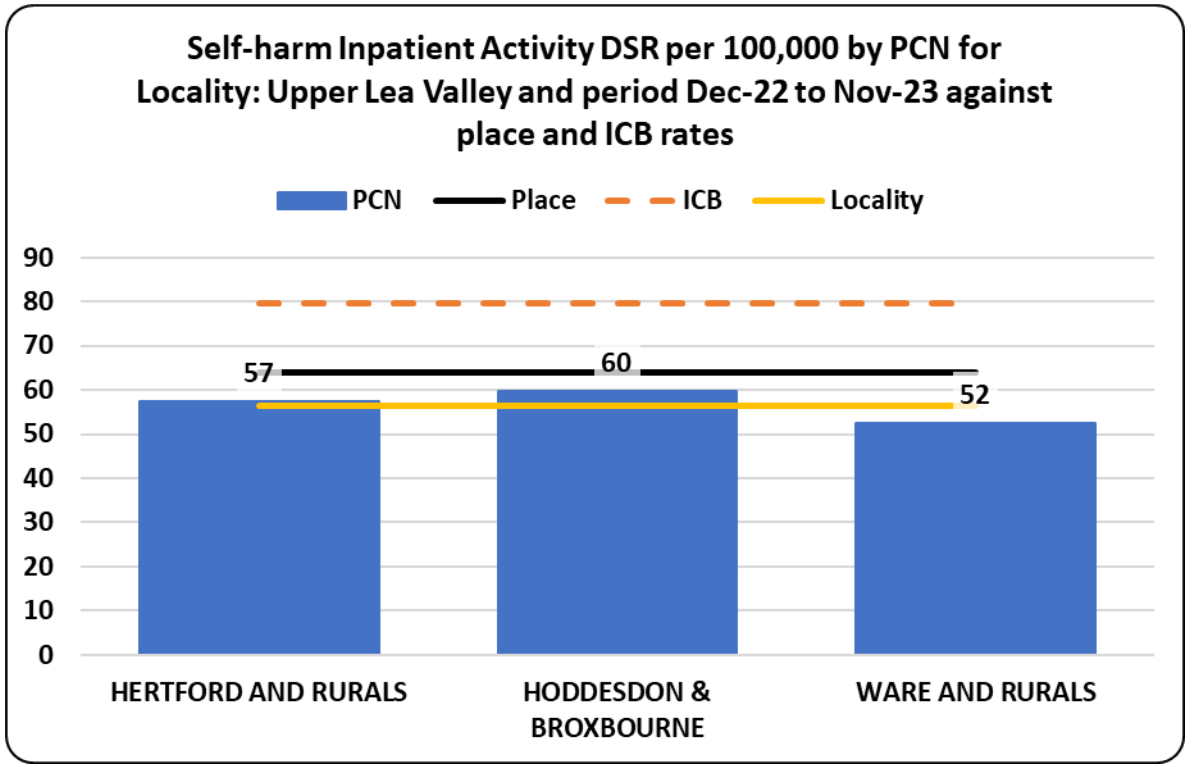
Source: QOF

Emergency Admissions Rates for Self – Harm

ICB overarching outcome of Improving Healthy life expectancy

- Upper Lea Valley has a lower rate of admissions for self-harm compared with the ICB.
- The trend data shows a decreasing trend for Upper Lea Valley.
- The data will continue to be monitored at wider HCP and ICB footprints.





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Source: SUS