Primary Care Network Data Pack

Mast Primary Care Network

Attain

Improving health and wellbeing

Primary Care Network (PCN) Data and Intelligence

These packs have been designed to support PCNs to meet the following criteria as set out by the National PCN Maturity Matrix:

- **Use existing readily available data to understand and address population needs and are identifying the improvements required for better population health.**
- **Analyse variation in outcomes and resource use between practices and PCNs.**

The intention is that in lieu of a Kirklees-wide Population Health Management process or the anticipated national PCN dashboard, these packs will enable PCNs to start working toward meeting these criteria. During engagement sessions with the PCNs the following key areas were identified as important in ensuring that the packs are 'useful' and 'useable' tools for the PCNs in their development and delivery:

- Better understanding existing priorities identified by the Network
- Ensuring those priorities are driven through variation of performance (data led priorities)
- Alignment with the new National Specifications PCN will be required to deliver as of April 2020.

How should this pack be used?

The first section aims to describe the Network demographics and population overviews; then listing Priority areas and how these have been identified. The latter section aims to offer intelligence and insight into what the data is telling us about the priority areas identified.

How has it been developed?

These packs have been developed in collaboration with the PCNs and Kirklees Council Public Health team. They represent a start on the journey towards Population Health Management in Kirklees and it is recognised that these tools will continue to develop in line with the PHM system and as the PCNs mature.

This pack will:

- Provide a level of **analysis and insight** about your PCN
- Offer **local system level context** and / or links to relevant programme leads within the system
- Where possible provide an **evidence base to support thinking about PCN priorities**
- Provide **links to data sources** for those who wish to interrogate further

Working within the wider System

Starting with outcomes enables us to step back from the things we are already doing or commissioning and explore what needs to be done, by whom and with whom to achieve improved outcomes for the citizens and places of Kirklees and the people who use our services. If we achieve the outcomes in Kirklees we will know that people are starting well, living well, and ageing well.

Improving population health and wellbeing through monitoring the delivery of these outcomes will be our focus. Alongside this, all the initiatives and changes across Kirklees to improve population health and wellbeing will be impact assessed for impact and improvements to:

- **Quality of services**
  (included achievement of local and national standards)
- **Cost and service efficiency**
- **Equality and equity**
  - ensuring service change does not discriminate or disadvantage people
- **Sustainability**

Seven Kirklees Outcomes:

Best start

Children have the **best start in life**

Well

People in Kirklees are **as well as possible** for as long as possible

Independent

People in Kirklees **live independently** and have control over their lives

Safe & Cohesive

People in Kirklees live in **cohesive communities, feel safe and** are **protected** from harm

Aspire & Achievement

People in Kirklees have aspiration and **achieve their ambitions** through education, training, employment and lifelong learning

Sustainable economy

Kirklees has **sustainable economic growth** and provides good employment for and with communities and businesses

Clean & Green

People in Kirklees experience a high quality, clean, and **green environment**

7 National PCN Specifications

During 2019 and 2020, NHSE and GPC England will develop seven service specifications. The service specifications will set out standard processes, metrics and intended quantified benefits for patients and will become key requirements of the Network Contract DES.

Structured Medications Reviews and Optimisation	PCN members will support direct tackling of the over-medication of patients, including inappropriate use of antibiotics, withdrawing medicines no longer needed and support medicines optimisation more widely.
Enhanced Health in Care Homes	The aim of this service will be to enable all care homes to be supported by a consistent multi-disciplinary team of healthcare professionals, delivering proactive and reactive care. This team will be led by named GP and nurse practitioners, organised by PCNs.
Anticipatory Care	PCN GP practices and other member providers will work collaboratively to introduce more proactive and intense care for patients assessed as being at high risk of unwarranted health outcomes, including patients receiving palliative care. The Anticipatory Care Service will need to be delivered by a fully integrated primary and community health team.
Supporting Early Cancer Diagnosis	PCNs will have responsibility for doing their part, alongside the Cancer Alliances and other local partners, and this will be reflected in the service specification.
Personalised Care	This model will be developed in full by PCNs under the Network Contract DES by 2023/24. The minimum national activity levels for all elements of the model will increase gradually over time in line with increases in capacity.
CVD Prevention and Diagnosis	PCNs will have a critical role in improving prevention, diagnosis and management of cardiovascular disease. The Testbed Programme will test the most promising approaches to detecting undiagnosed patients, including through local pharmacies, as well as managing patients with high risk conditions who are on suboptimal treatment.
Tackling Neighbourhood Inequalities	This service will be developed through the Testbed Programme and will seek to work out what practical approaches have the greatest impact at the 30,000 to 50,000 neighbourhood level and can be implemented in PCNs.

****Part of the wider programme of work to ensure all PCNs and the wider system are prepared with the correct information and intelligence to enable effective delivery and a coordinated approach.

Executive summary

- This pack represents the start of the process to help drive PCN development by :
  - providing high level priorities as to the direction of travel relating to population needs
  - providing links to key areas of work with the system
  - Offering ideas of shared practice to be adapted

- The five priority areas identified by this pack relate to:
  1. Cancer prevalence and emergency admissions
  2. Stroke prevalence
  3. Hypertension prevalence
  4. Diabetes
  5. Dementia prevalence

- Priorities have been identified based solely on the data contained in these the packs and as such may not represent the whole picture. As packs are further developed and additional sets of indicators are included, different insight may be generated which would potentially require a reprioritisation.

- Future emergent data led priorities will be developed as identified by network partners and population health management as well as other CCG and primary care initiatives. A piece of work identifying the capacity and need to inform system (ICS etc) response to needs will be required.

Mast PCN – An Overview

Place Overview

- **Volume of patients -** The Mast Network has five practices caring in total for c.35,000 patients. The average per practice (c.7,000) is below the national average (8,035) but above the local CCG average (6,721).

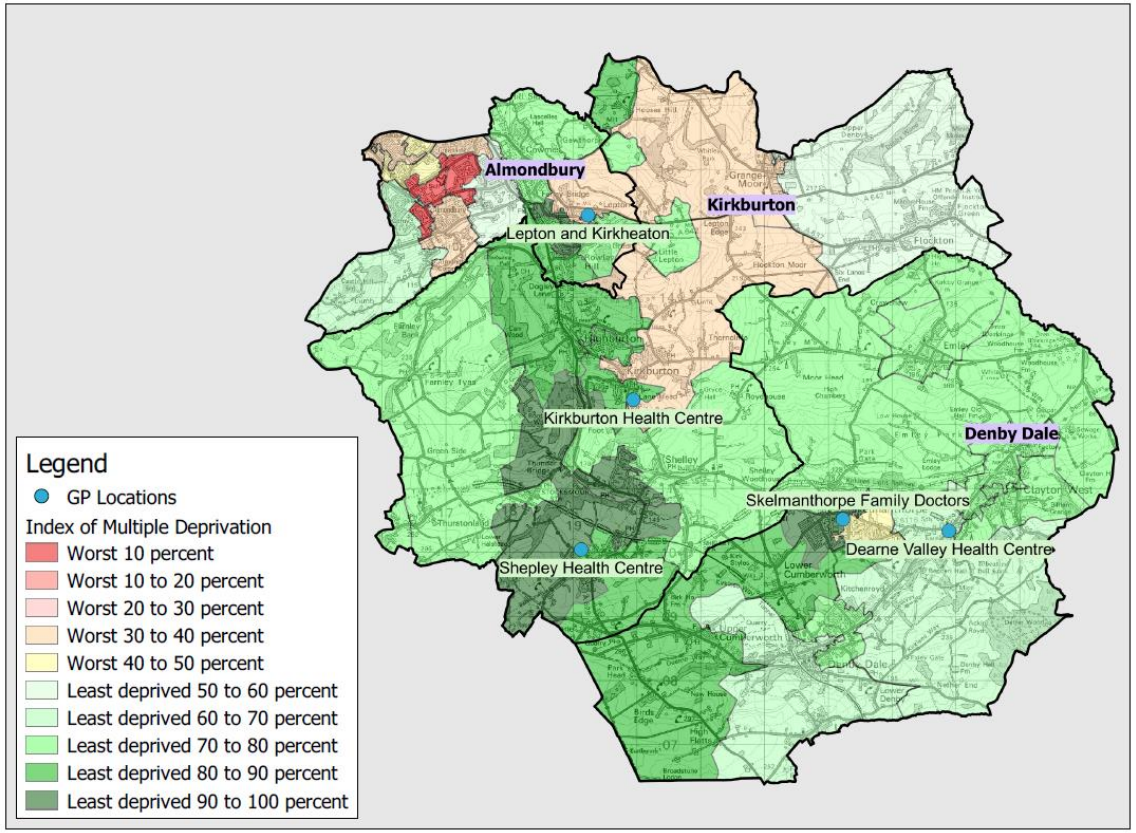
- **Ethnicity -** The network provides services for low levels of diverse ethic groups (I.e. mixed, Asian, black & other non-white). E.g. only c.5% of Lepton and Kirkheaton Surgery's patients are from mixed, Asian, black & other non-white groups which is the highest of the five network practices.

- **QOF -** Dearne Valley Health Centre is the only practice to have achieved is QOF targets, with the measure of positive patient experience ranging from 66.1% to 99.1%.

- **Life Expectancy –** Male life expectancy across the PCN is 80.7 years – above the CCG (78.1 years) and English averages (79.4 years) and the highest of any PCN in Kirklees.
- Female life expectancy is above the CCG average (82.5 years) and national average (83.1 years) at 83.7 years, the second highest of all the PCNs.

Network Practice Locations

The map below shows deprivation around Mast PCN – the five network practices are located in some of the least deprived areas.



See Slide 7 for practice breakdown

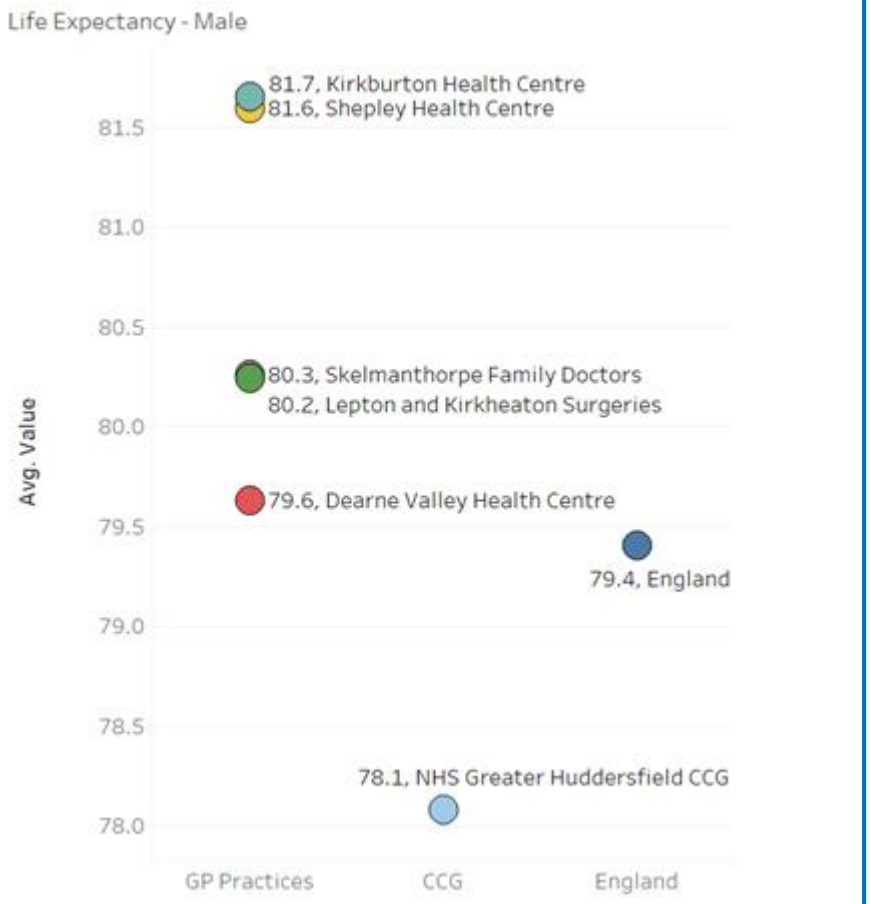
Place overview broken down by practice

		Dearne Valley Health Centre	Skelmanthorpe Family Doctors	Lepton and Kirkheaton	Kirkburton Health Centre	Shepley Health Centre
PCN Practice (England av. 8,035, GH 6,721)		3,908	9,450	7,128	8,134	6,493
Percentage of total PCN pop		11%	27%	20%	23%	18%
Life expectancy years (Male)		79.6	80.3	80.2	81.7	81.6
Life expectancy years (Female)		83.3	83.1	83.4	84.0	84.9
Deprivation		Second least deprived decile	Second least deprived decile	Third less deprived decile	Least deprived decile	Least deprived decile
Ethnicity Estimate	Mixed	0.0%	0.0%	2.0%	1.4%	0.0%
	Asian	0.0%	0.0%	2.0%	1.5%	0.0%
	Black	0.0%	0.0%	0.0%	0.0%	0.0%
	Other non-white	1.9%	1.5%	1.2%	0.0%	2.0%
QOF achievement % (out of 559 points)		588.9	553.2	518.5	537.7	547.0
Percentage with a +ve experience of practice		83.7%	83.9%	66.1%	91.0%	99.1%

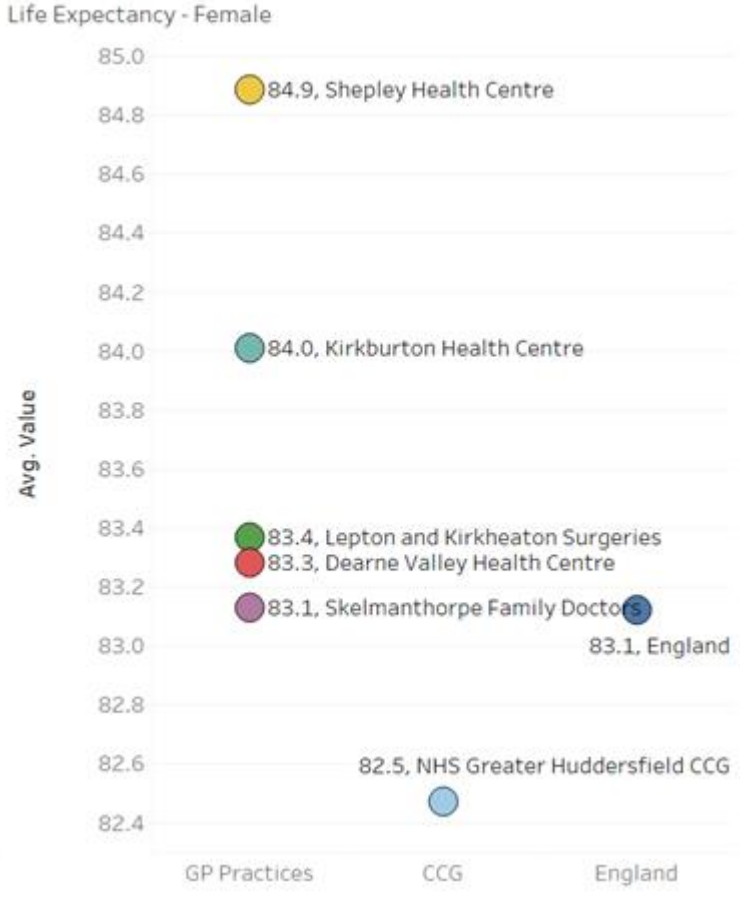
This chart refers to information summarised in slide 6

Life expectancies are higher than the CCG and national averages

Male life expectancy across the PCN is 80.7 years – above the CCG and English averages and the highest of any PCN in Kirklees.



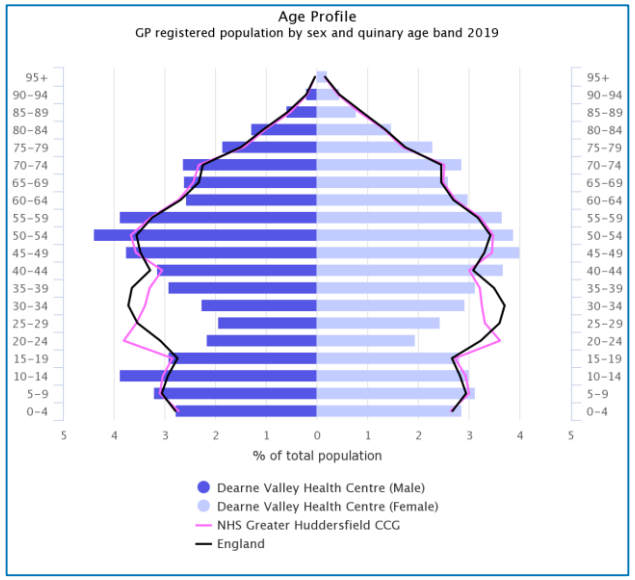
Female life expectancy is above the CCG average at 83.7 years, the second highest of all the PCNs

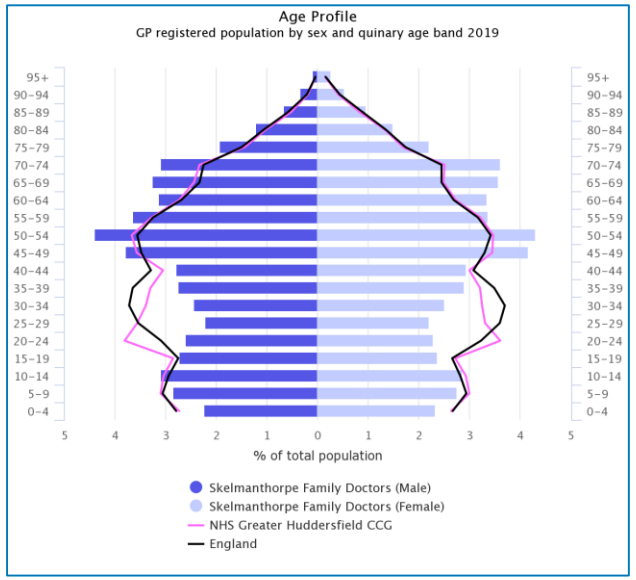


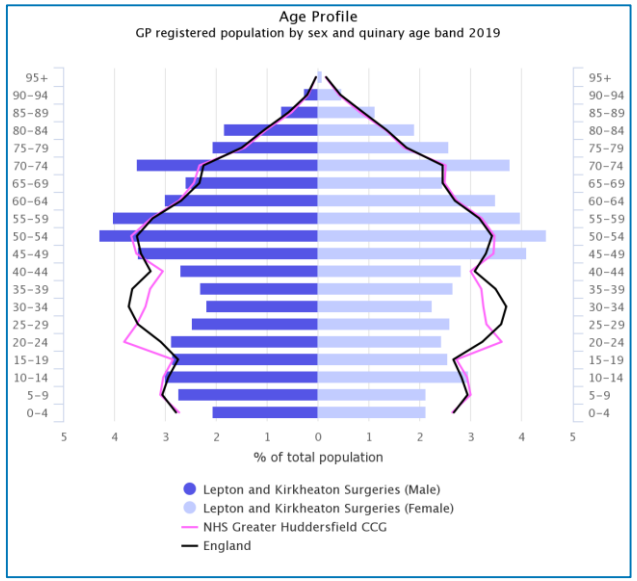
All GP practices have higher life expectancies for both men and women when compared to the CCG and to the national averages

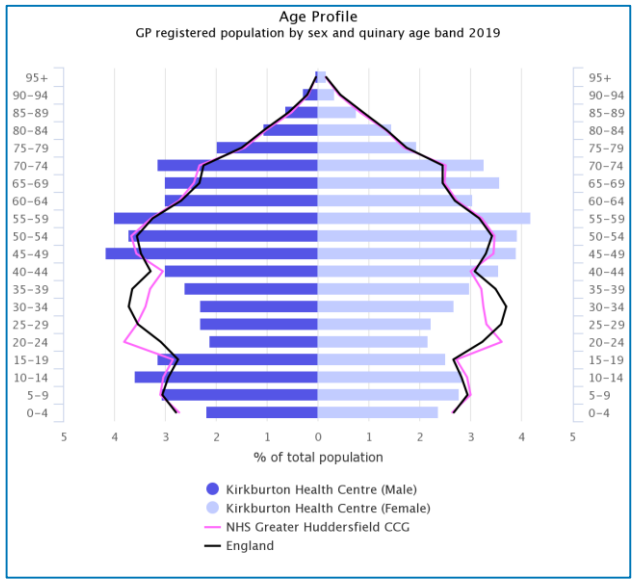
Male and female life expectancy across PCN practices, 2010-14 data

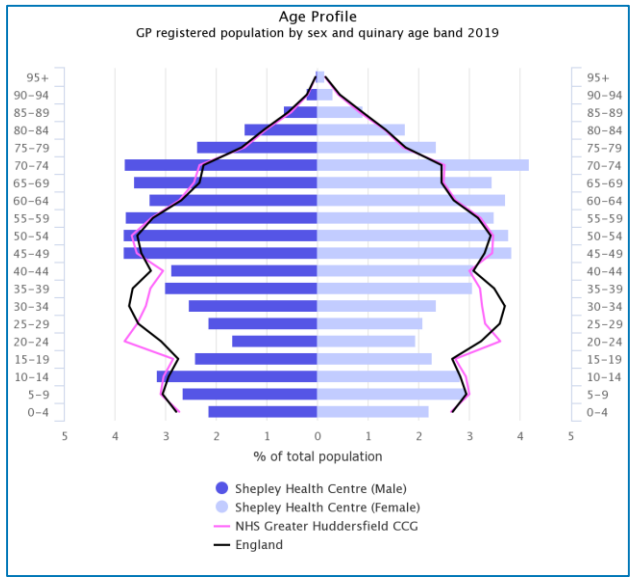
Age profile by practice



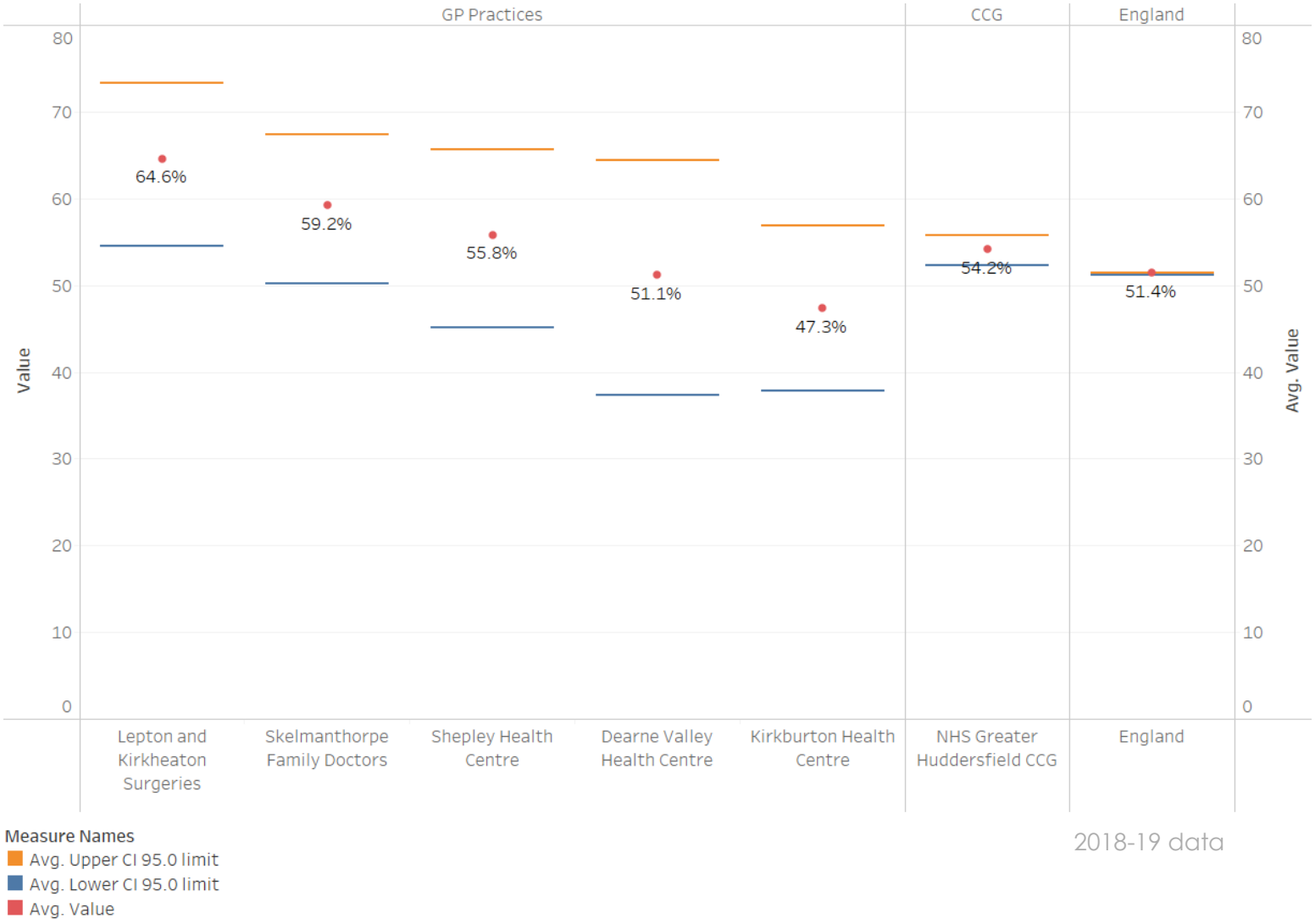








55.6% Of individuals live with a long-term condition



2018-19 data

- 55.6% of the Mast population (16+ years) live with a long-term condition, compared to 54.2% of the wider CCG. This equates to c.17k people. However, due to wide confidence intervals, these differences are not statistically significant.
- There has been limited change to this metric for the PCN over recent years, although this number is decreasing across England as a whole
- The most common long-term conditions at CCG level are mental health (35%), MSK
- 25% of working people in Greater Huddersfield have three or more long-term health conditions .
- Link to Supporting Data

Ambulatory care sensitive conditions

Data not publicly available at GP practice level

PCN Priority Areas

Priority areas: Criteria for prioritisation

- We used a range of approaches to develop the potential Mast PCN priorities. These included a review of:
  1. **Mast PCN stated priorities (taken from Networks Overview and other PCN communications)**
     - Maternity Service
     - MJOG
     - Phlebotomy
     - Diabetic Group Clinic
     - Network GP Hub

  2. **Variation in performance from CCG average (where data available)**
     - Significant variation from CCG average where a majority of practices lie outside the 95% confidence interval for a metric

  3. **Results of other analysis. e.g. deeper dive into 1 or 2 yields a new area of focus**

- Rightcare was used to validate this selection process and add to the short list as required. The Right care priorities for the CCG for 'Spend and Outcomes' are Mental Health, Endocrine and Respiratory; for 'Outcomes' is Cancer; and for 'Spend' are MSK, Circulation, Trauma & Injuries and Respiratory.

- Consideration is being given to the appropriate platforms to ensure PCNs have access to relevant data and insights on an ongoing basis.

Mast PCN priorities

Priorities focused on in this pack:

1. **Cancer prevalence and emergency admissions**
   - Four of five practices statistically higher prevalence than CCG
   - Emergency admissions higher than CCG average for all practices

2. **Stroke prevalence**
   - Variation from CCG average - Average stroke prevalence is higher in all PCN practices than is the CCG or national averages

3. **Hypertension prevalence**
   - Variation from CCG average - Four of five PCN practices has statistically higher hypertension prevalence than the wider CCG

4. **Diabetes**
   - PCN determined priority

5. **Dementia prevalence**
   - Variation from CCG average

Priority 1: Cancer prevalence and related emergency admissions

Cancer prevalence is higher than the CCG average

- **Why is this a priority?**
  - Cancer is the second most common cause of death in Kirklees, accounting for 26% of total deaths in the area.
  - A larger proportion of the population will be diagnosed with cancer at some point in their lives.
  - 40% of cancers are estimated to be preventable through lifestyle changes.

- **What does the data tell us?**
  - Overall cancer prevalence is significantly higher (3.53%) in four out of five Mast practices compared to CCG and English averages
  - Shepley Health Centre has a recorded cancer prevalence almost 2 percentage points higher than the CCG average

Cancer prevalence rates, 2017/18

Cancer emergency admissions are higher than CCG average

- **What does the data tell us (cont'd)?**
  - Further to high prevalence figures, the PCN sees higher than average levels of cancer related emergency admissions. Dues to wide confidence intervals, these are not statistically significant
  - Two week wait referrals for cancer show distinct variability between practices, that are not correlated to prevalence or emergency admissions
  - Practices with low two week wait referrals and high emergency admissions for cancer should consider reviewing their population's needs

Cancer related emergency admissions and 2 week wait referrals (per 100k ppl), 2017/18

Cancer screening levels are generally higher than the CCG average

PCN	GP Practice	Cervical Screening rate (Jun-2019)	Bowel Screening Rate (Feb-2019)	Breast Screening Rate (Feb-2019)
The Mast Healthcare Partnership	Dearne Valley Health Centre	86.1%	Not publicly available at GP practice level for 2019 – older data available via national GP profiles	
	Skelmanthorpe Family Doctors	79.7%		
	Lepton & Kirkheaton	81.2%		
	Kirkburton Health Centre	82.7%		
	Shepley Health Centre	84.1%		
CCG average		76.3%		
National average		71.1%		

Opportunity

- **What can be done?**
  - Take learnings from the Cancer Alliance Early Diagnosis Work Programmes
    - To increase the number of cancers diagnosed at stages 1 and 2 from 40% to 62% by the year 2020
    - To reduce the number of cancers that are diagnosed through emergency presentation from 20% to 10% by the year 2020
    - To reduce the variation in one-year survival rates between the Clinical Commissioning Group areas
    - To reduce the variation in reported patient experience
  - Review practices that have a higher than usual 2 week wait referral.
  - Reviewing cancer pathways to ensure that patients diagnosed with cancer have a treatment plan that will allow them to be cared outside of emergency services.
  - Promote cancer messages via several channel to increase awareness and promote ways of improving lifestyle.

- **What could this mean?**
  - Higher rates of cancer prevalence appear to be associated with higher screening rates which should hopefully in time represent a higher proportion of the population which can be cared for before worsening of health outcomes
- **Links and further reading**
  - Health and Wellbeing plan 2018-2023; KJSA re Cancer ; Cancer Prevalence; Number of emergency admissions with cancer ; Two-week wait referrals for suspected cancer
  - Early Diagnosis - West Yorkshire & Harrogate Cancer Alliance; Optimal Pathways - West Yorkshire & Harrogate Cancer Alliance

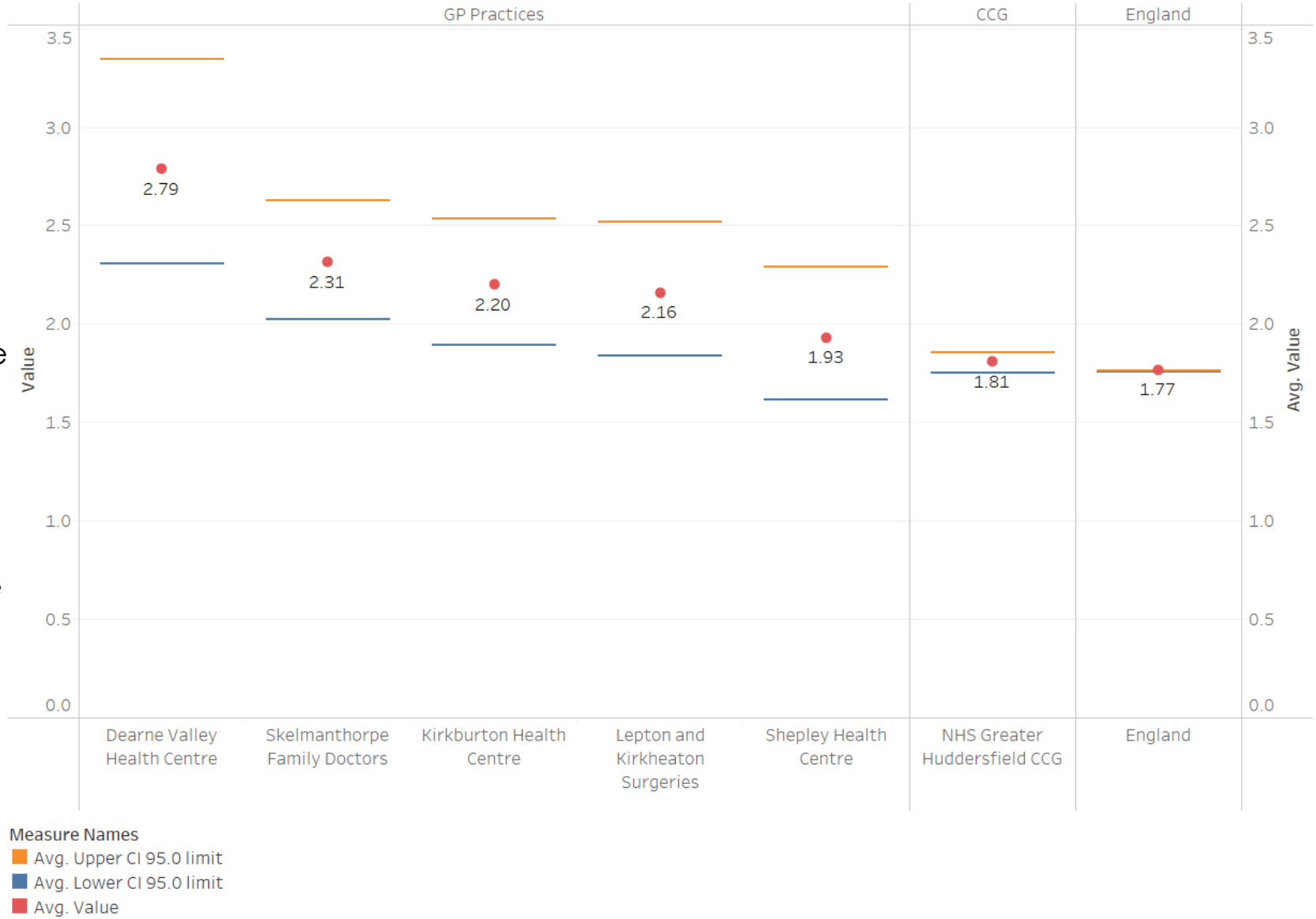
Priority 2: Stroke prevalence

Stroke prevalence is high across all practices

- **Why is this a priority?**
  - Strokes are the third largest causes of death and a one of the largest causes of long-term disability. Strokes can often be prevented through changes individuals' lifestyles including diet, exercise, smoking and alcohol consumption.
  - Due to its preventable nature and the scale of individuals it affects stroke prevention and management is one of the priority workstreams in West Yorkshire & Harrogate Integrated Care System.
  - Atrial fibrillation (AF) is the most common sustained cardiac arrhythmia[1] and its prevalence is increasing. A patient with atrial fibrillation has a 5-fold increase in the risk of stroke and 20–30% of all strokes are attributed to this arrhythmia.

- **What does the data tell us?**
  - Average stroke prevalence is higher in all PCN practices than is the CCG or national averages – this variation is significant in four of the five practices

Stroke prevalence, 2017/18



Stroke management meets CCG and national average

- **What does the data tell us (cont'd)?**
  - Looking at available metrics of stroke management (blood pressure reading) and medicine use, most practices are management their patients within the normal range for the CCG
  - Improvements can be made across some practices around blood pressure fore three practices
  - Further work is need to understand whether the higher rate of strokes is preventable and whether these individuals were part of the existing stroke management process
  - Between 76% and 86% of Mast AF patients are on anticoagulants – this compares favourably with other PCNs

	% of patients with Atrial Fibrillation who are on anticoagulation
Dearne Valley Health Centre	75.7
Skelmanthorpe Family Doctors	83.8
Lepton & Kirkheaton	81.3
Kirkburton Health Centre	77.8
Shepley Health Centre	86.0

(Figures for 2017/18)

BP reading and anti-platelet or anti-coagulant use, 2017/18

Opportunity

- **What can be done?**
  - Reviewing whether individuals at risk of developing a stroke have been identified and are being managed adequately.
  - Improve the detection and management of conditions such as Atrial Fibrillation which can lead to strokes.
  - Promote messages through varied channels to increase awareness and promote ways of improving lifestyle and reduce the incidence of strokes.
  - **West Yorkshire Harrogate Healthy Hearts**
    - The aim of West Yorkshire and Harrogate Healthy Hearts initiative is to reduce the impact of cardiovascular disease and to help prevent heart-related illnesses, including heart attacks and strokes, every year, across the whole region.

- **What could this mean?**
  - A reduction in the prevalence of strokes is likely to also help reduce the prevalence of other health burdens with which common risk factors are shared (e.g. diabetes, heart disease)

- **Links and further reading**
  - Health and Wellbeing plan 2018-2023; JSNA on cardiovascular diseases ; Greater Huddersfield stroke prevalence
  - Last BP reading is <=150/90 (den. incl. exc.); Record that an anti-platelet agent or an anti-coagulant is taken
  - West Yorkshire & Harrogate Healthy Hearts
  - https://www.nice.org.uk/sharedlearning/safe-and-effective-management-of-stroke-prevention-in-atrial-fibrillation

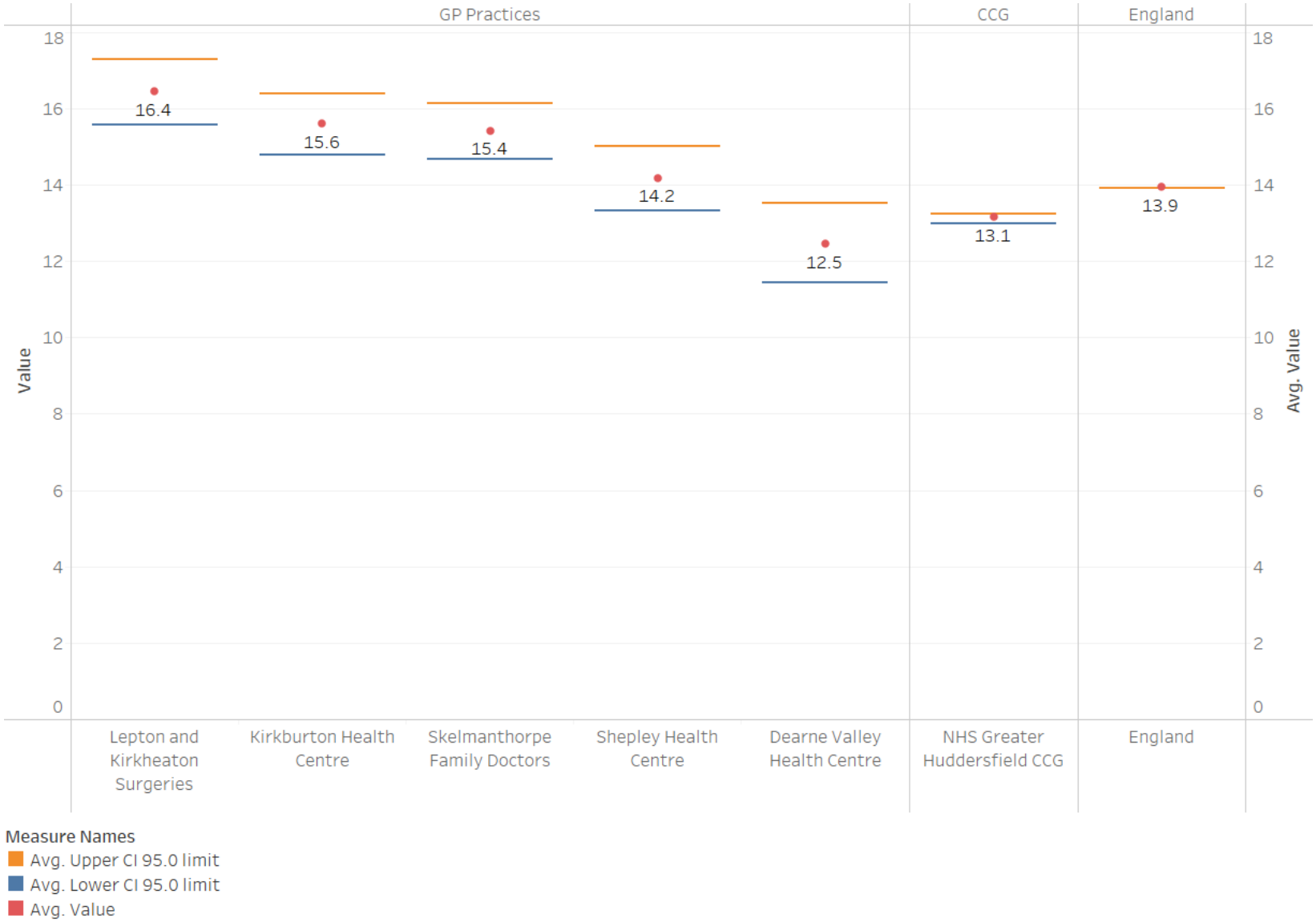
Priority 3: Hypertension prevalence

Hypertension prevalence is high

- **Why is this a priority?**
  - Hypertension can lead to the worsening of health outcomes. It is one of the causes of strokes, coronary heart diseases, general heart failure as well as the functioning of the kidneys.

- **What does the data tell us?**
  - Four of five PCN practices has statistically higher hypertension prevalence than the wider CCG. Only Dearne Valley Health Centre has below CCG average levels of hypertension

Hypertension prevalence (2017/18)



Primary prevention for hypertension is mostly above the CCG average

- **What does the data tell us (cont'd)?**
  - The prevalence of CVD primary prevention (see definition on the right hand side) is broadly similar to the CCG average, but shows that there is scope to improve the treatment of people with hypertension.
  - There are wide variations in primary prevention, with Deane Valley Health Centre and Skelmanthorpe Family Doctors having very low prevalence rates.

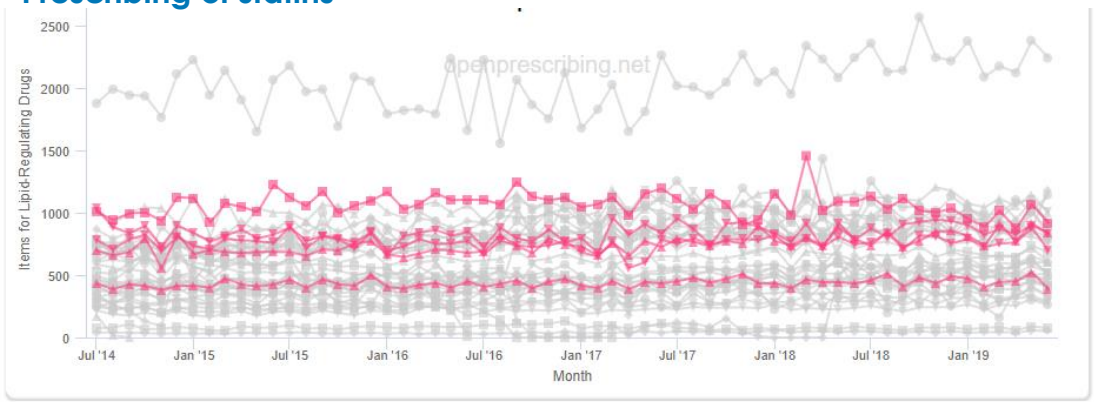
- **Statin prescribing**
  - Overall prescribing levels of lipid-regulating drugs were high for Mast PCN practices against the rest of the CCG

Prevalence of CVD primary prevention (ppl aged 30 to 74 treated with statins)

2018-19 data

Definition: In those patients with a new diagnosis of hypertension aged 30 or over and under the age of 75, recorded between the preceding 1 April to 31 March (excluding those with pre-existing CHD, diabetes, stroke and/or TIA), who have a recorded CVD risk assessment score (using an assessment tool agreed with the NHS CB) of ≥20% in the preceding 12 months: the percentage who are currently treated with statins

Prescribing of statins



Opportunity

- **What can be done?**
  - Ensure that individuals with hypertension are detected in order to better manage their condition by for example promoting the uptake of NHS Health Check.
  - Promote messages through varied channels to increase awareness and promote ways of improving lifestyle and reduce the incidence of high blood pressure.
  - Support initiatives that can help prevent hypertension such as smoking cessation and healthy eating.
  - Support self-monitoring and management programmes

- **What could this mean?**
  - At CCG level, estimated undiagnosed hypertension prevalence ranges from 9.4% to 4%. At GP level, it ranges from 3.8% to 20.4%. Potential for increased undiagnosed hypertension in line with the networks aging population.

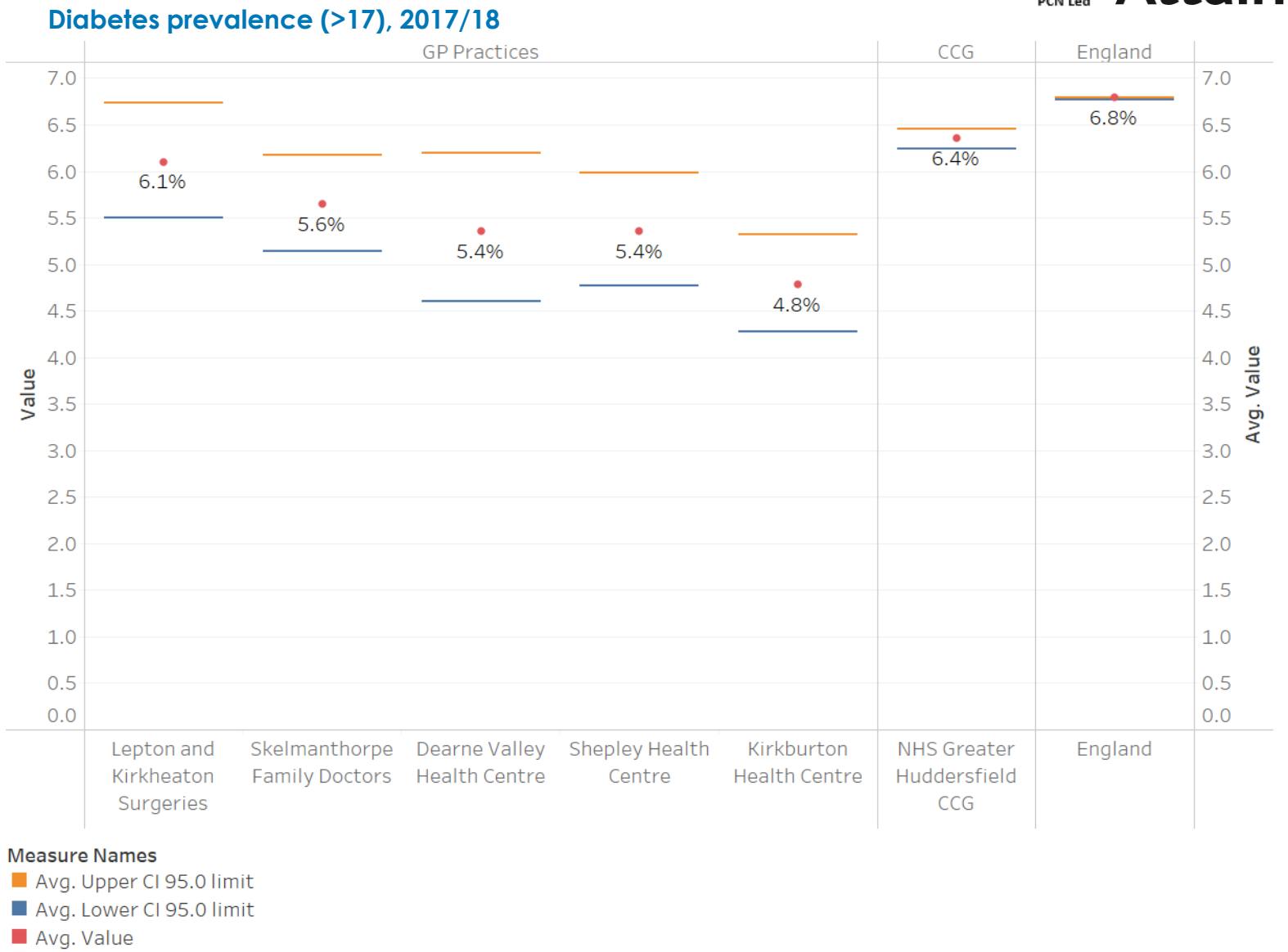
- **Links and further reading**
  - Health and Wellbeing plan 2018-2023
  - JSNA on cardiovascular diseases
  - Public Health England on high blood pressure
  - Hypertension Prevalence (all ages)
  - Prevalence of CVD primary prevention (ppl aged 30 to 74 treated with statins)

Priority 4: Diabetes

Diabetes prevalence is lower than the CCG average

- **Why is this a priority?**
  - Unmanaged diabetes can lead to the development of comorbidities (i.e. cardiovascular system, eyes, kidneys, nervous system) so a better management of the condition prevents worsening of individuals' health.

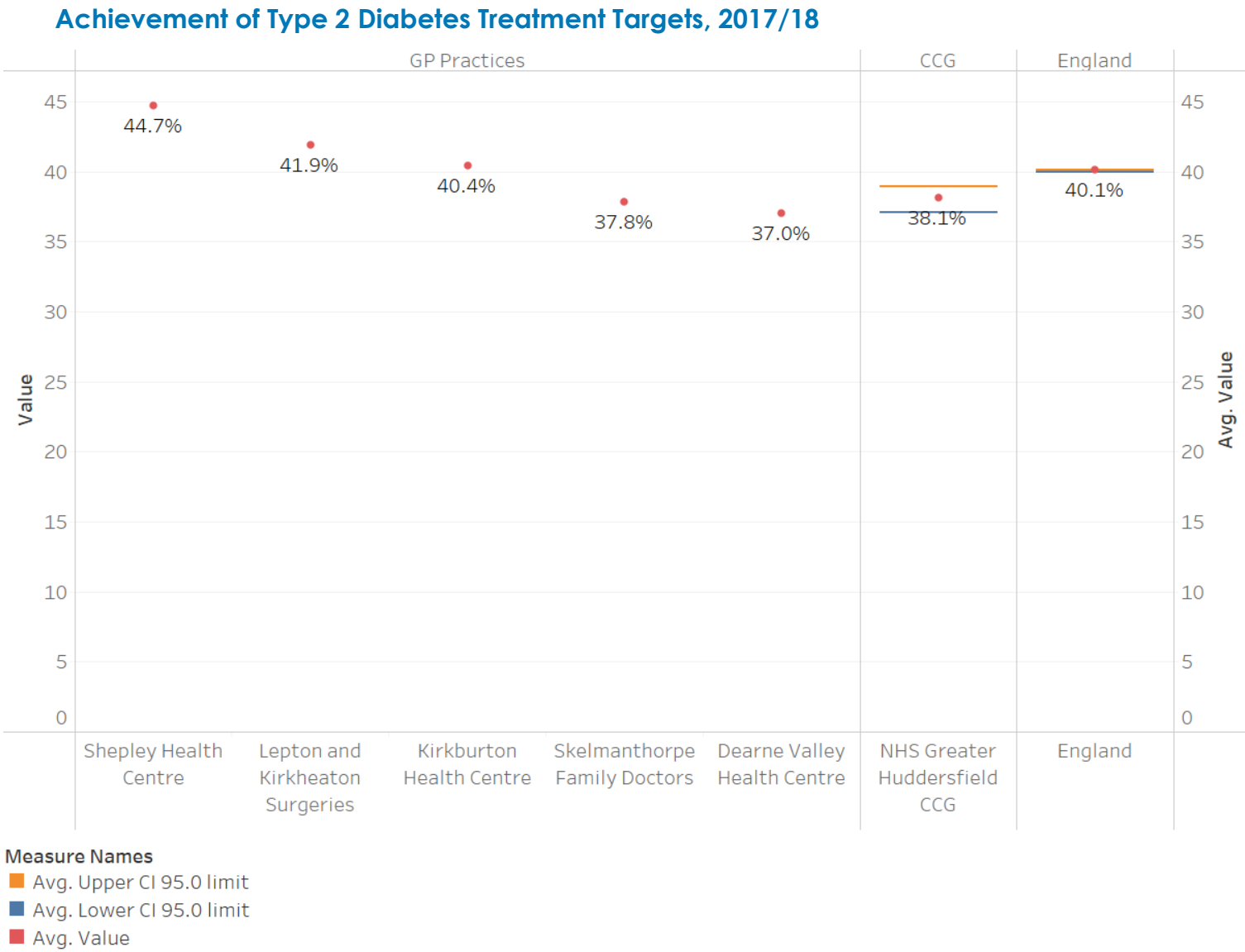
- **What does the data tell us?**
  - Despite the PCN selecting diabetes as a priority, the prevalence of diabetes is lower across all practices compared to the CCG and National averages



Diabetes treatment target achievement is also higher than CCG average

- **What does the data tell us (cont'd)?**
  - Furthermore, a higher share of type 2 diabetes patients (40.4%) achieved all three (HbA1c (blood sugar), cholesterol and blood pressure) treatment targets in 2017/18, compared to 38% for CCG as a whole
  - There is still scope to outperform the CCG average, focusing effort initially on Skelmanthorpe and Dearne Valley practices

- **Local context**
  - Deane Valley Health Centre had the lowest diabetes treatment achievement followed closely by Skelmanthorpe Family Doctors. Both of these practices had an average that was lower than the CCG average.



Opportunity

- **What can be done?**

  Suggestions include NHS Right Care Diabetes Pathways:

  - **NHS Diabetes prevention programmes (NDPP) -**
    - New contract across West Yorkshire and Harrogate commenced from the 1st of August 2019 and will run for 3 years – Funded by NHSE, provided by Reed Wellbeing
    - New contract framework includes less Face to face time and a digital option for the programme.
    - Will be sending out impact reports – October 2019 – offering practice visits
    - Information available on the intranet site
  - Protocol for diagnostic uncertainty
  - Education programmes (including personalised advice on nutrition and physical activity)
  - 9 recommended care processes and treatment targets
  - Type 1 Intensive specialist service
  - 1. Triage to specialist services 2. RCA for major amputations
  - Inpatient diabetes team, shared records, advice line

- **What could this mean?**
  - Continuing to improve diabetes prevention and treatment will ensure that fewer individuals live with long-term disabilities such as blindness, impotency, kidney failure. This will also decrease the cost associated to the care of those disabilities.
- **Links and further reading**
  - KJSA re Diabetes, Diabetes prevalence trend, Diabetes prevalence (17/18), Diabetes treatment target achievement

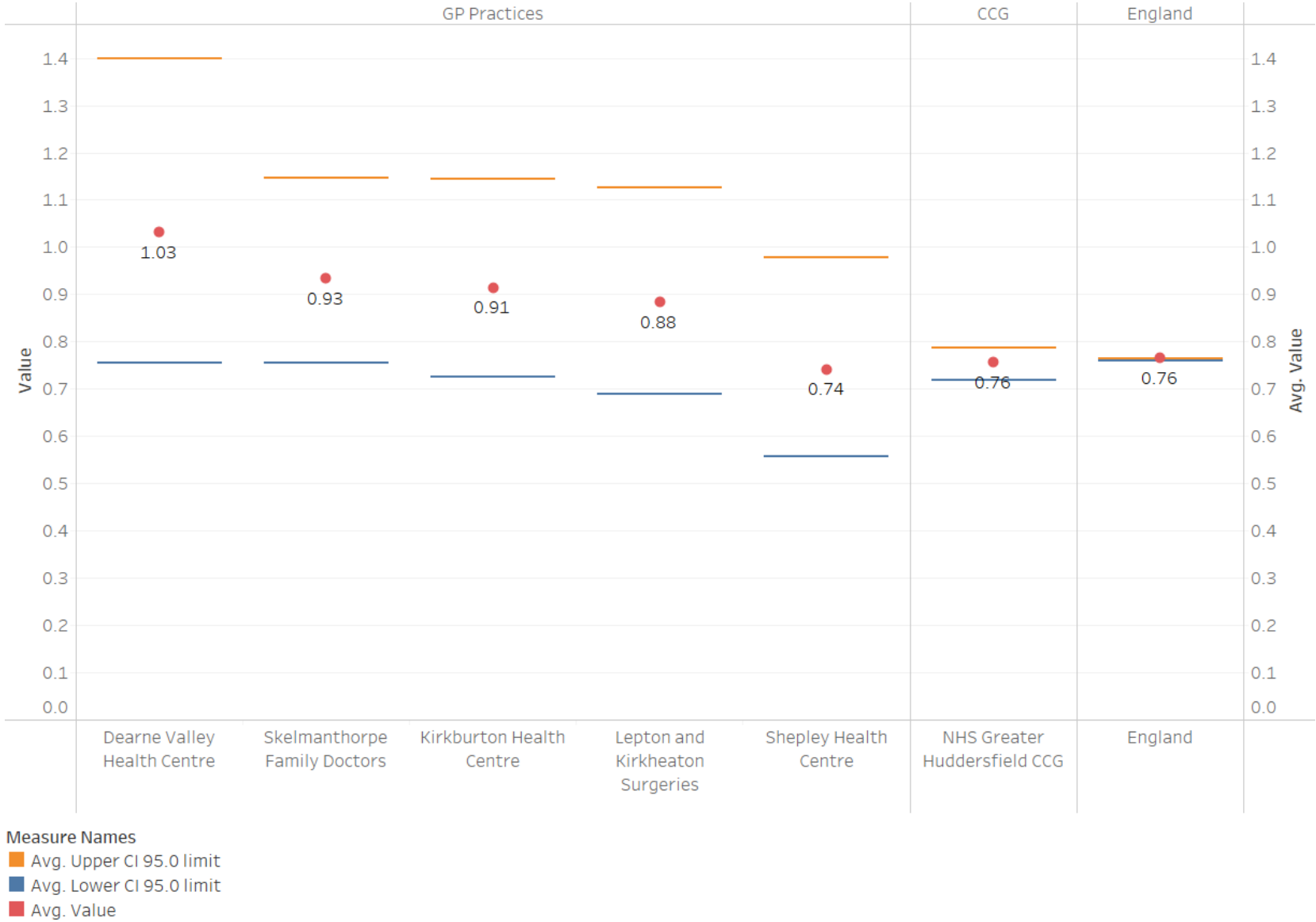
Priority 5: Dementia prevalence

Dementia prevalence is higher than CCG average

- **Why is this a priority?**
  - 10% Of deaths in men aged over 65 years, and 15% of deaths in women aged over 65 years are attributable to dementia. Depending on the stage of dementia, it can be a very debilitating condition which requires constant care.

- **What does the data tell us?**
  - Four of five practices have higher average prevalence (0.91%) of dementia compared to the CCG and national (0.76%) averages.

Dementia prevalence, 2017/18



Dementia management

- **What does the data tell us (cont'd)?**
  - There are opportunities for practices to review dementia care plans – three practices fall below CCG average.
  - There is also a mixed picture for the recording of dementia blood tests, with wide confidence intervals around all practices.
- **Local context**
  - Local awareness of dementia is very low and the development of the disease by a loved one remains the main trigger which raises greater awareness. This significantly impact how early individuals can obtain a diagnosis.

Dementia care plan and dementia blood tests, 2017/18

Opportunity

- **What can be done?**
  - Work to detect dementia as early as possible
  - Support the creation of a safe environment for patients (i.e. residential and nursing places, support for people able to remain safely at home).
  - Promote messages through varied channels to increase awareness and understanding of dementia to reduce the risk of stigma and encourage individuals and their families to seek diagnosis.
  - Specific target groups could benefit from personalised prevention (e.g. stroke patients for vascular dementia).

- **What could this mean?**
  - The prevalence of dementia is expected to reach 60% of the population over 65 by 2030, therefore a good detection and management of the condition now will help the system be more prepared for future rise in prevalence.

- **Links and further reading**
  - Dementia KJSA , Dementia All Our Health , Dementia prevalence, Dementia care plan has been reviewed last 12mths, Blood tests recorded

Appendix 1: Other areas of analysis

Supplementary Analytics

This section aims to offer additional analytics to provide support to networks in identifying population needs and areas of focus for potential service improvement.

The use of existing readily available data will provide a future reference point for networks and act as a useful starting point for further discussions with relevant stakeholders.

Useful links have been provided giving access to national, Kirklees, CCG and PCN level data and intelligence aiding insight into local needs, inequalities and assets available to the PCNs.

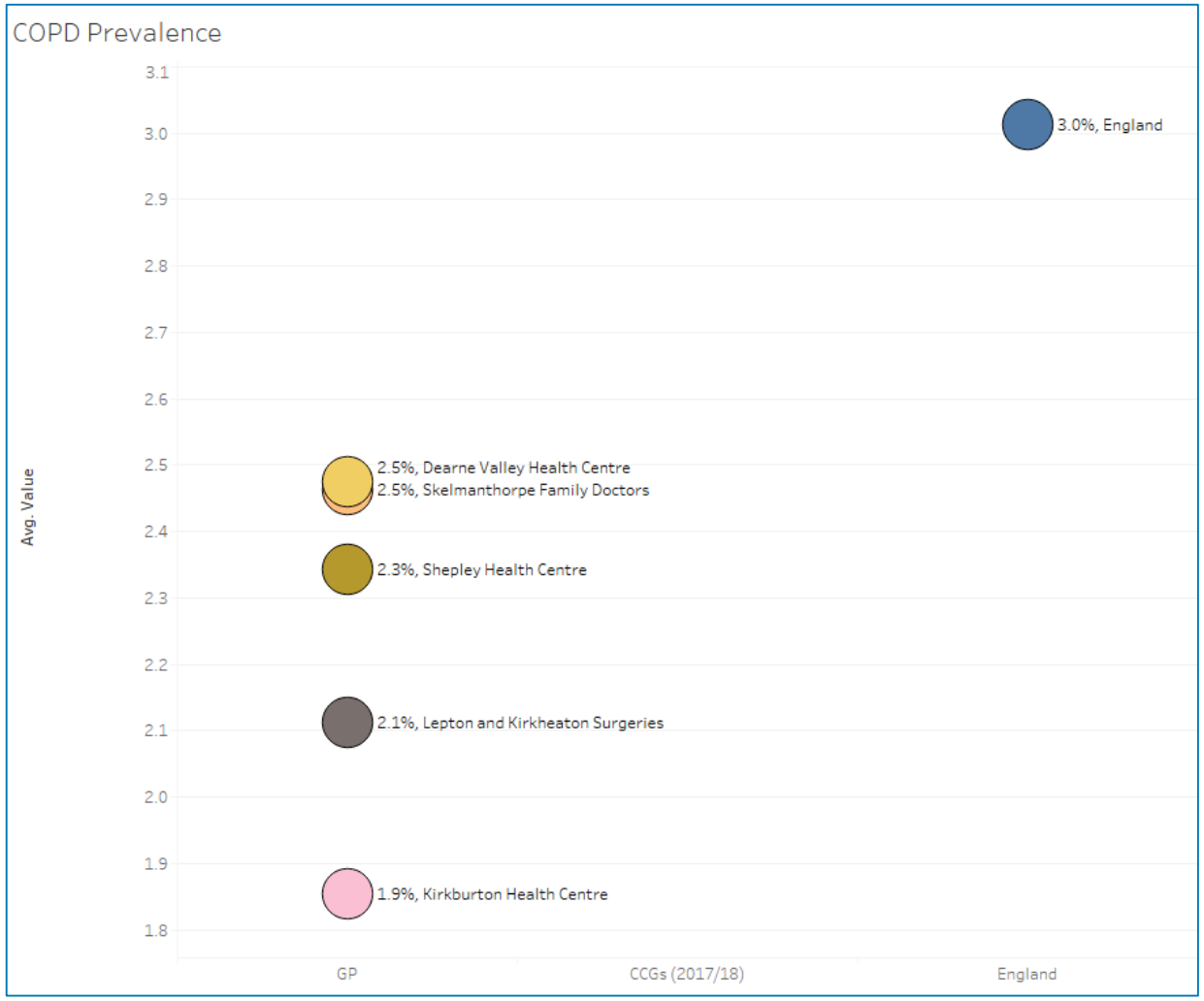
As previously mentioned, these packs have been developed in collaboration with the PCNs and Kirklees Council Public Health team.
They represent a start on the journey towards Population Health Management in Kirklees and it is recognised that these tools will continue to develop in line with the PHM system and as the PCNs mature.

Chart Contents

(List of chart contents & links in alphabetical order)

COPD Prevalence

COPD Prevalence (2017-18)



- The chart represents the percentage of patients with COPD, as recorded on practice disease registers.
- Most patients with COPD are managed by GPs and members of the primary healthcare team with onward referral to secondary care when required.
- The COPD Prevalence percentage for England is 3%.
- All five practices have lower COPD prevalence than the national average.
- Link to Supporting Data

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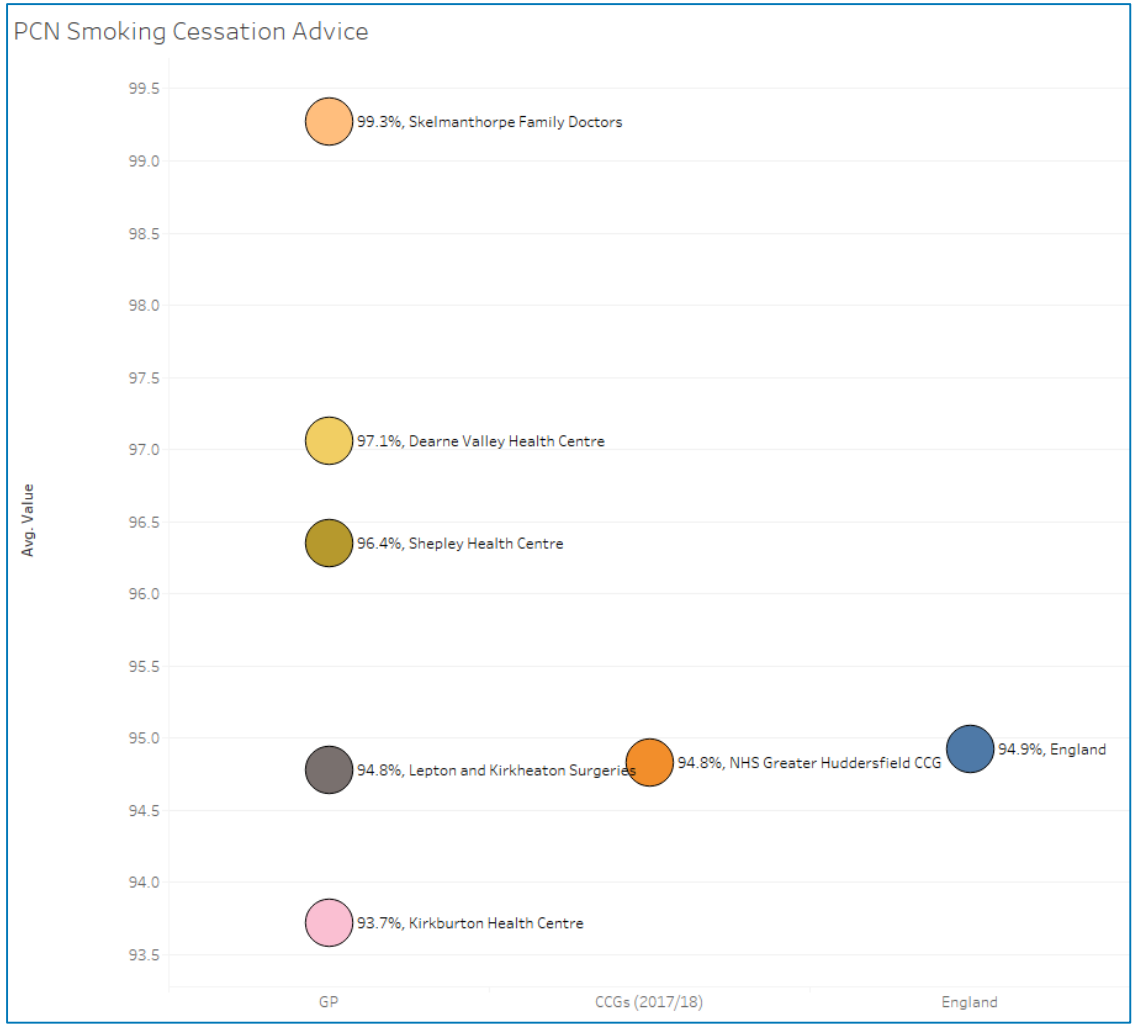
Smoking Cessation

Smoking Cessation (2017-18)



- The chart represents the percentage of patients with any or any combination of the following conditions: coronary heart disease, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who smoke whose notes contain a record of an offer of support and treatment within the preceding 12 months.
- The Smoking Cessation Advice percentage for England is 94.9%.
- The Smoking Cessation Advice percentage for NHS Greater Huddersfield is 94.8%.
- Three of the five practices are above the CCG and national average.
- Links to Supporting Data

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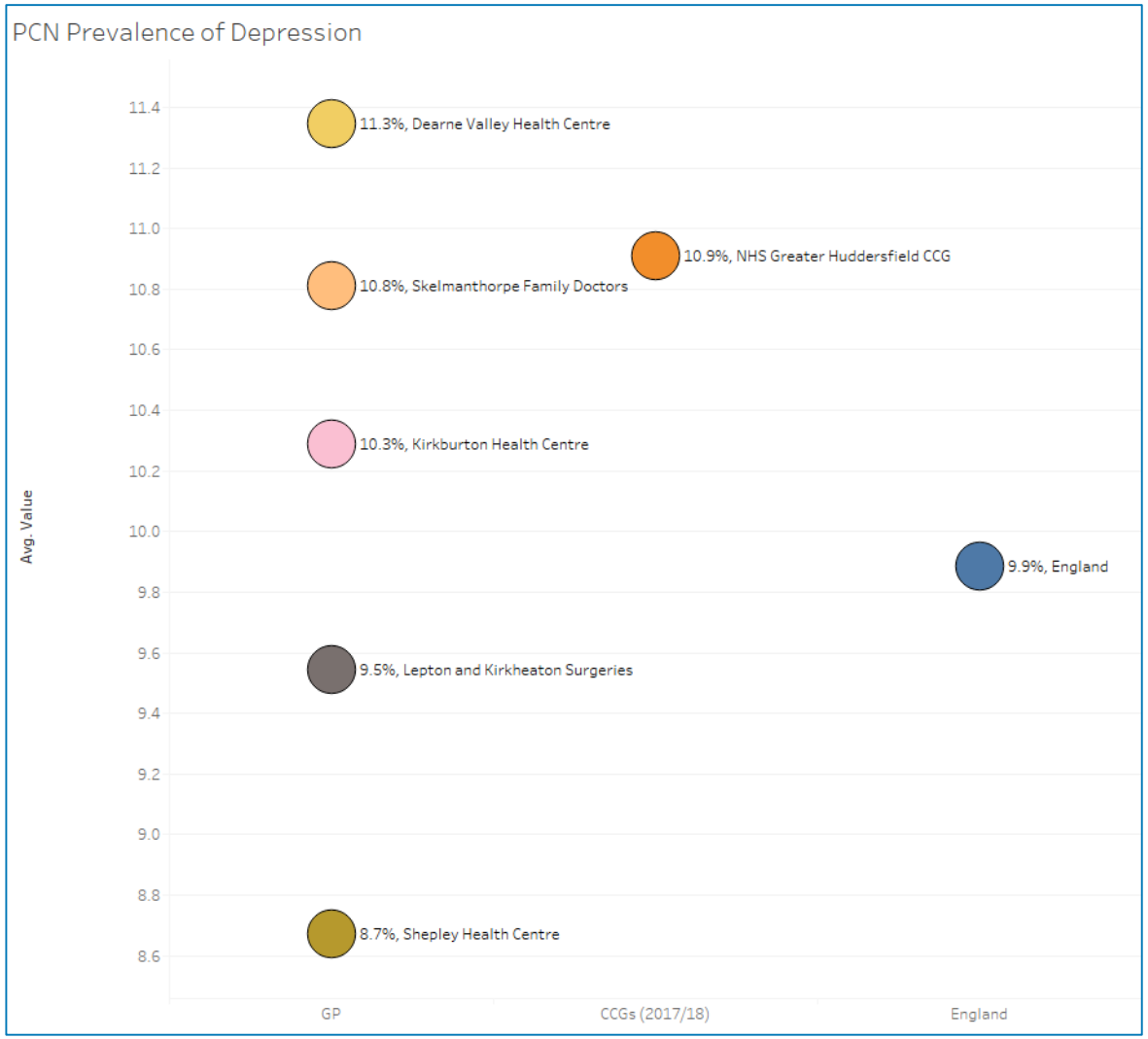
Depression

Prevalence of Depression (2017-18)



- The chart represents the percentage of patients aged 18 and over with depression, as recorded on practice disease registers.
- The Depression Prevalence percentage for England is 9.9%.
- The Depression Prevalence percentage for NHS Greater Huddersfield is 10.9%.
- Two of the five practices have prevalence rates below the CCG and national averages.
- Link to Supporting Data

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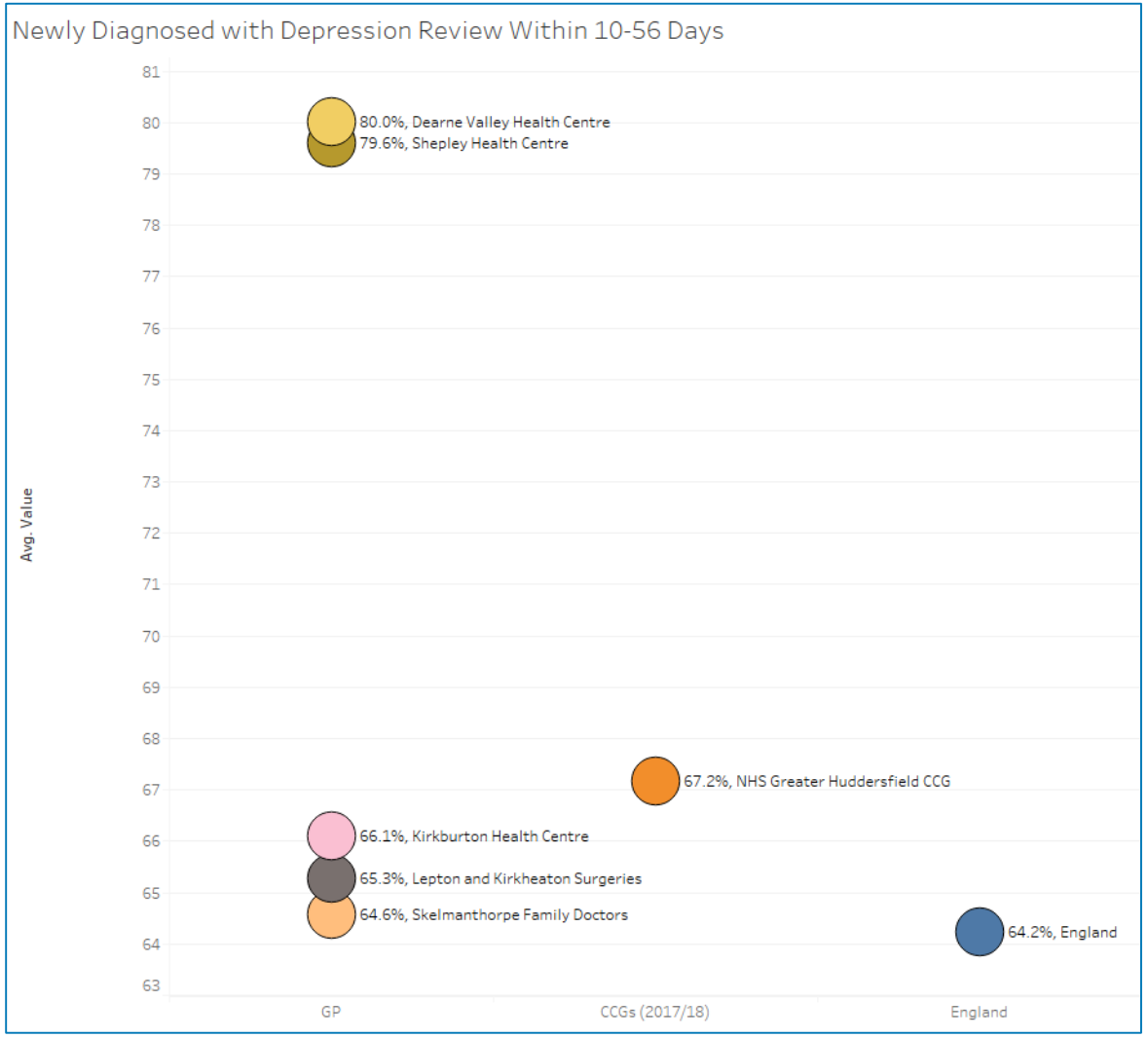
Depression Review within 10-56 Days

Newly Diagnosed with Depression Review within 10-56 Days (2017-18)



- The chart represents the percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than 10 days after and not later than 56 days after the date of diagnosis,
- The Newly Diagnosed with Depression Review within 10-56 Days percentage for England is 64.2%.
- The Newly Diagnosed with Depression Review within 10-56 Days percentage for NHS Greater Huddersfield is 67.2%.
- Dearne Valley and Shepley Health Centre are significantly above the CCG and national averages.
- Link to Supporting Data

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CHD Prevalence

CHD Prevalence (2017-18)

- The chart represents the percentage of patients with coronary heart disease, as recorded on practice disease registers.
- The CHD prevalence figure for England is 3.1%.
- The CHD prevalence figure for NHS Greater Huddersfield is 3.4%.
- All five PCN practices have CHD prevalence above the CCG and national average measures.
- Link to Supporting Data

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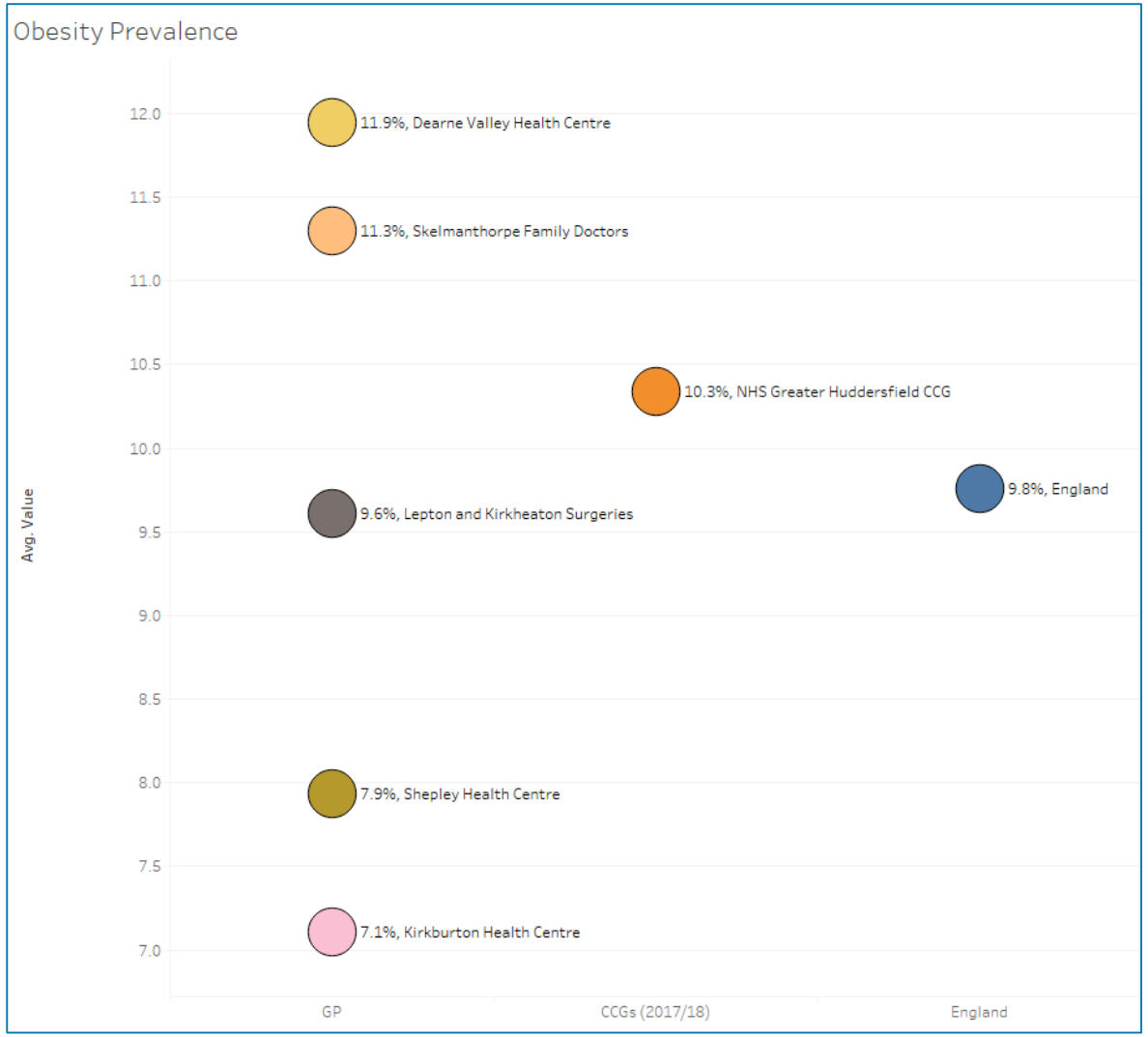
Obesity Prevalence

Obesity Prevalence (2017-18)



- There is a substantive evidence base on the epidemiology of obesity and its association with poor clinical outcomes.
- This measure is based upon the percentage of patients aged 18 and over with a BMI greater than or equal to 30 in the previous 12 months, as recorded on practice disease registers.
- The Obesity Prevalence percentage for England is 9.8%.
- The Obesity Prevalence percentage for NHS Greater Huddersfield is 10.3%.
- Kirkburton & Shepley health centres have lowest levels of obesity prevalence in the network.
- Link to Supporting Data

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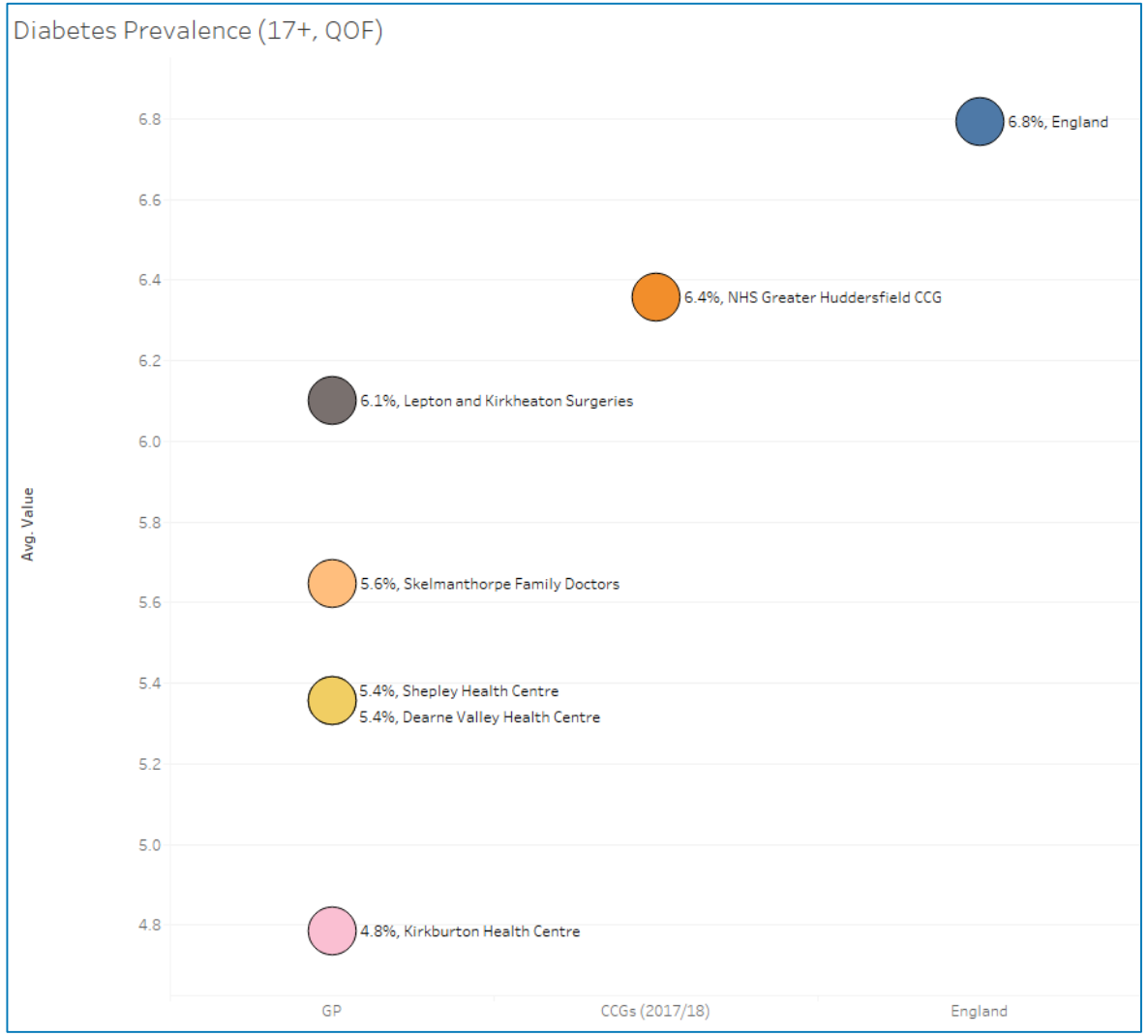
Diabetes Prevalence

Diabetes Prevalence (2017-18)



- The chart represents the percentage of patients aged 17 years and over with diabetes mellitus, as recorded on practice disease registers.
- The Diabetes prevalence figure for England is 6.8%.
- The Diabetes prevalence figure for NHS Greater Huddersfield is 6.4%.
- All five PCN practices are showing performance above national and regional average measures.
- Link to Supporting Data

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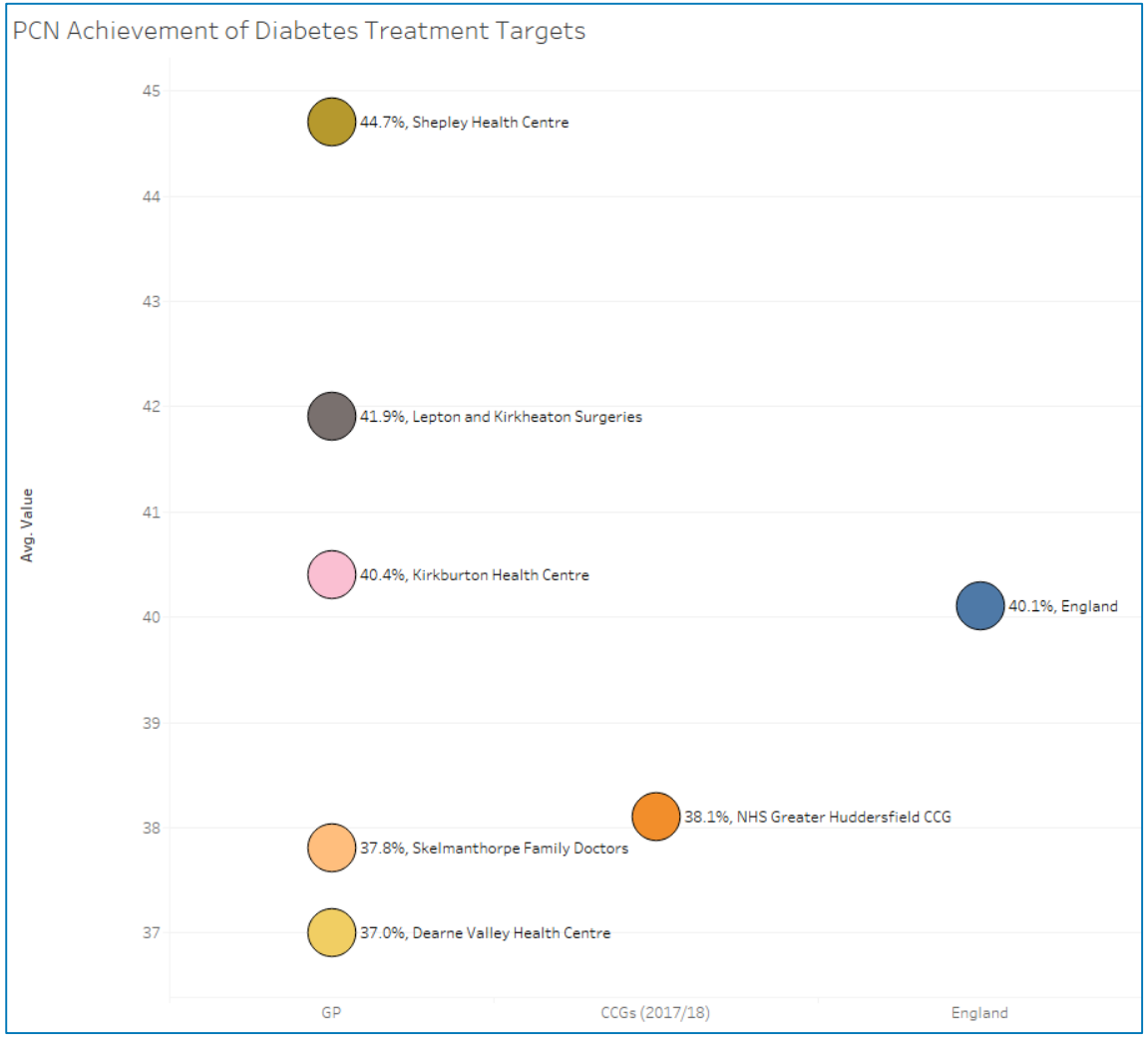
Achievement of Diabetes Treatment Targets

Achievement of Diabetes Treatment Targets (2017-18)



- The chart represents the percentage of people with type 2 diabetes who achieved all three treatment targets.
- The percentage of people with type 2 diabetes who achieved all three treatment targets for England is 40.1%.
- The percentage of people with type 2 diabetes who achieved all three treatment targets for NHS Greater Huddersfield is 38.1%.
- Three of the five PCN practices are showing performance above the national & CCG average measures.
- Link to Supporting Data

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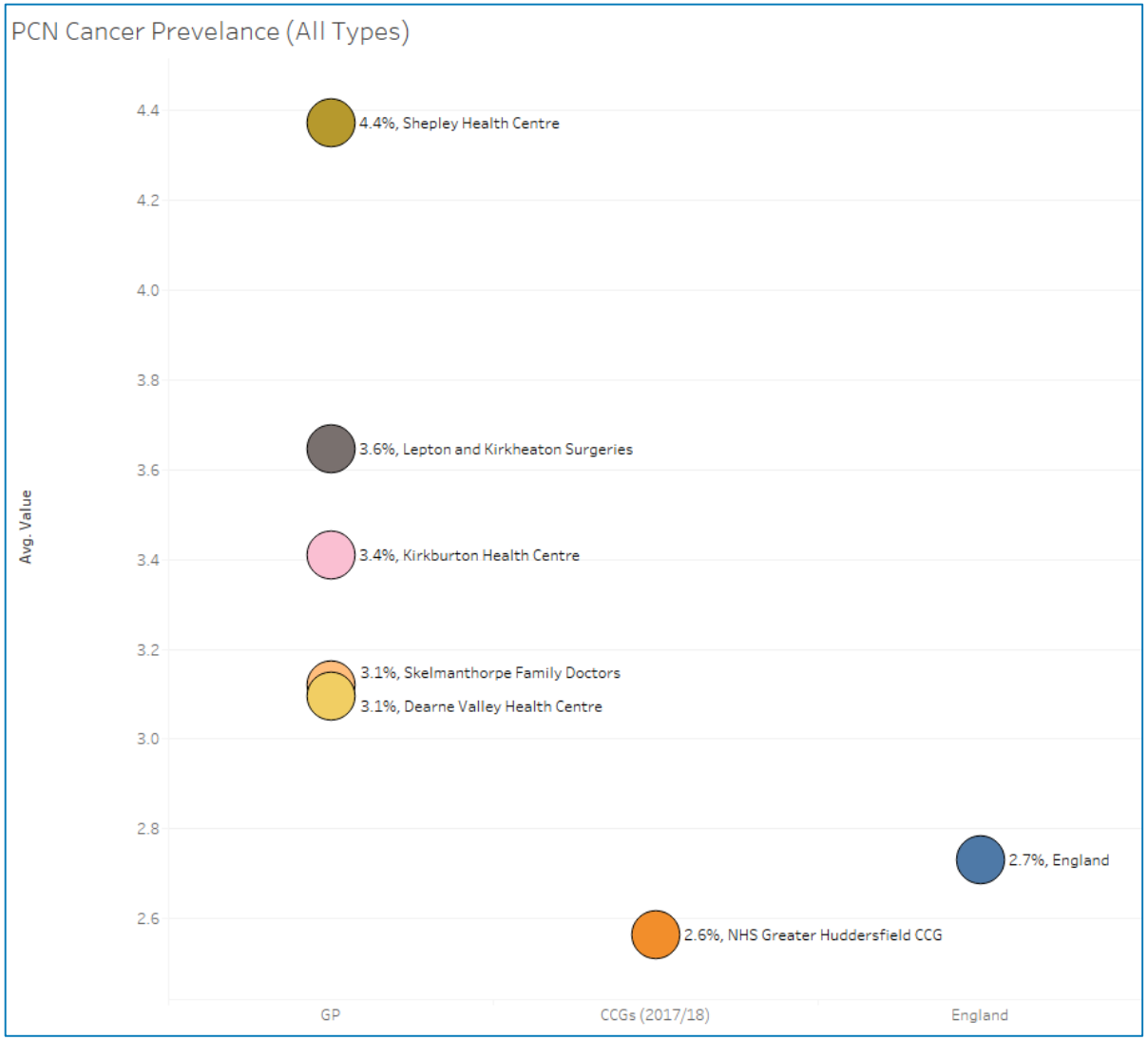
PCN Cancer Prevalence

PCN Cancer Prevalence (2017-18)



- The chart represents the percentage of patients with cancer, as recorded on practice disease registers
- The cancer prevalence percentage for England is 2.7%
- The cancer prevalence percentage for NHS Greater Huddersfield is 2.6%.
- All five PCN practices are showing prevalence figures above the national and CCG average measures.
- Link to Supporting Data

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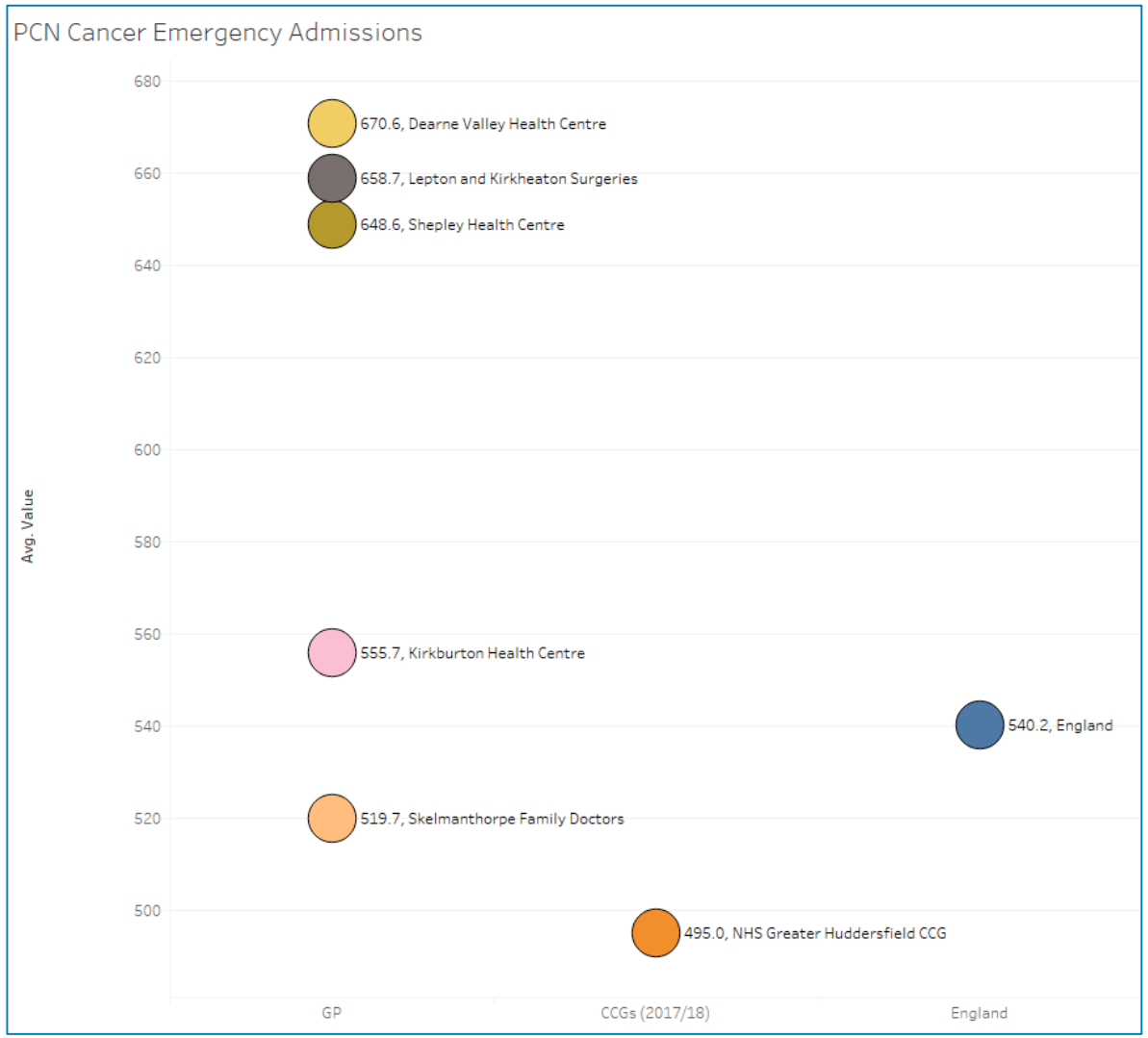
PCN Cancer Emergency Admissions

PCN Cancer Emergency Admissions (2017-18)



- The chart represents the rate per 100,000 persons of all emergency admissions with an invasive, in-situ, uncertain or unknown behaviour, or benign brain cancer present in any of the first three diagnostic fields (HES inpatient database) per patients on the practice register.
- The cancer emergency admissions rate figure for England is 540.2%
- The cancer emergency admissions rate figure for NHS Greater Huddersfield is 495.0%.
- Four of the five PCN practices are showing adverse figures in comparison to national and CCG average figures.
- Link to Supporting Data

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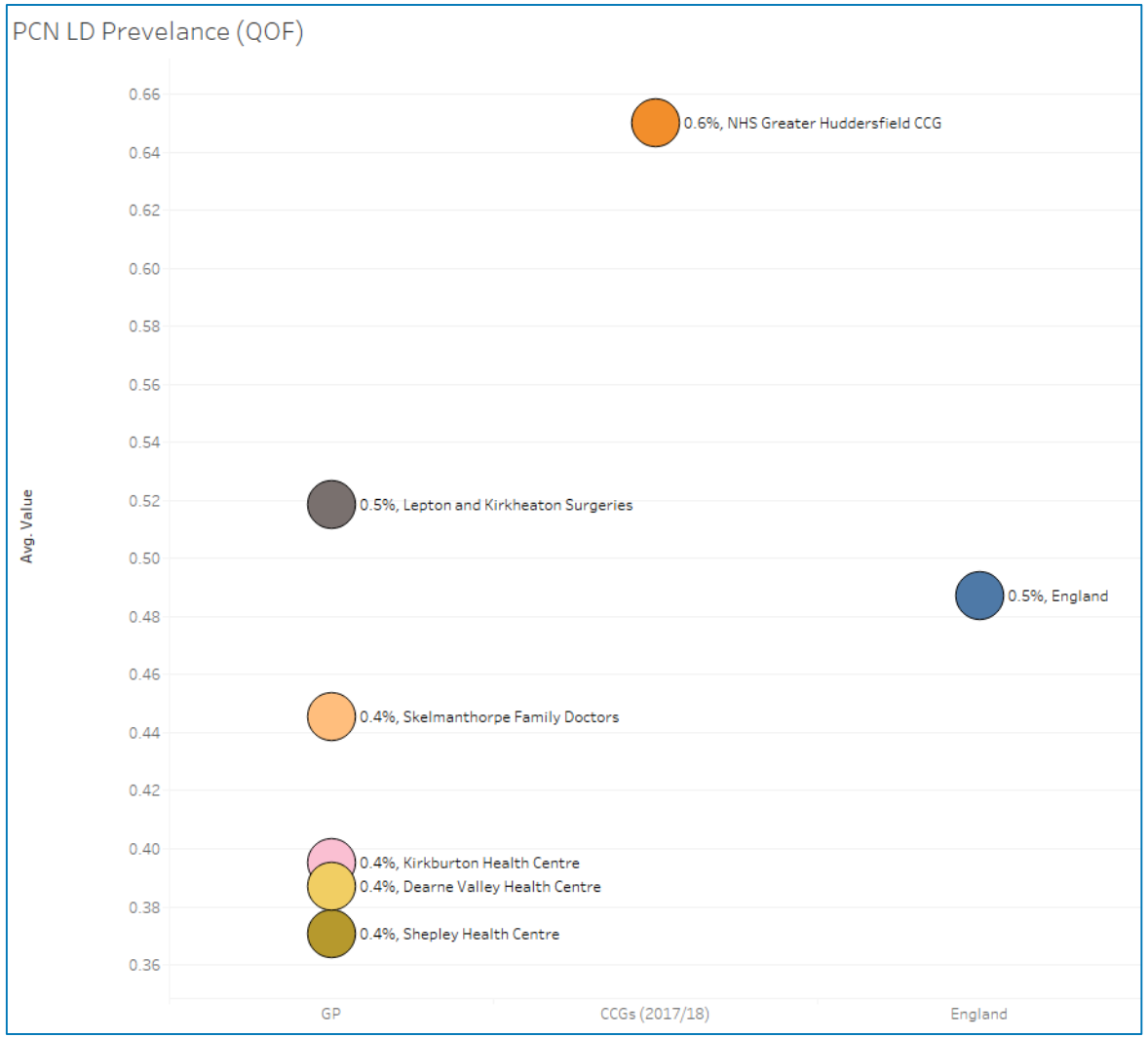
PCN Learning Difficulty Prevalence

PCN Learning Difficulty Prevalence (2017-18)



- The chart represents the percentage of patients with learning disabilities, as recorded on practice disease registers.
- The learning difficulties prevalence percentage for England is 0.5%
- The learning difficulties prevalence percentage for NHS Greater Huddersfield is 0.6%.
- Four of the five PCN practices are showing favourable figures in comparison to national figures. Lepton & Kirkheaton surgery is in line with the national average. All practices are favourable in comparison to CCG averages.
- Link to Supporting Data

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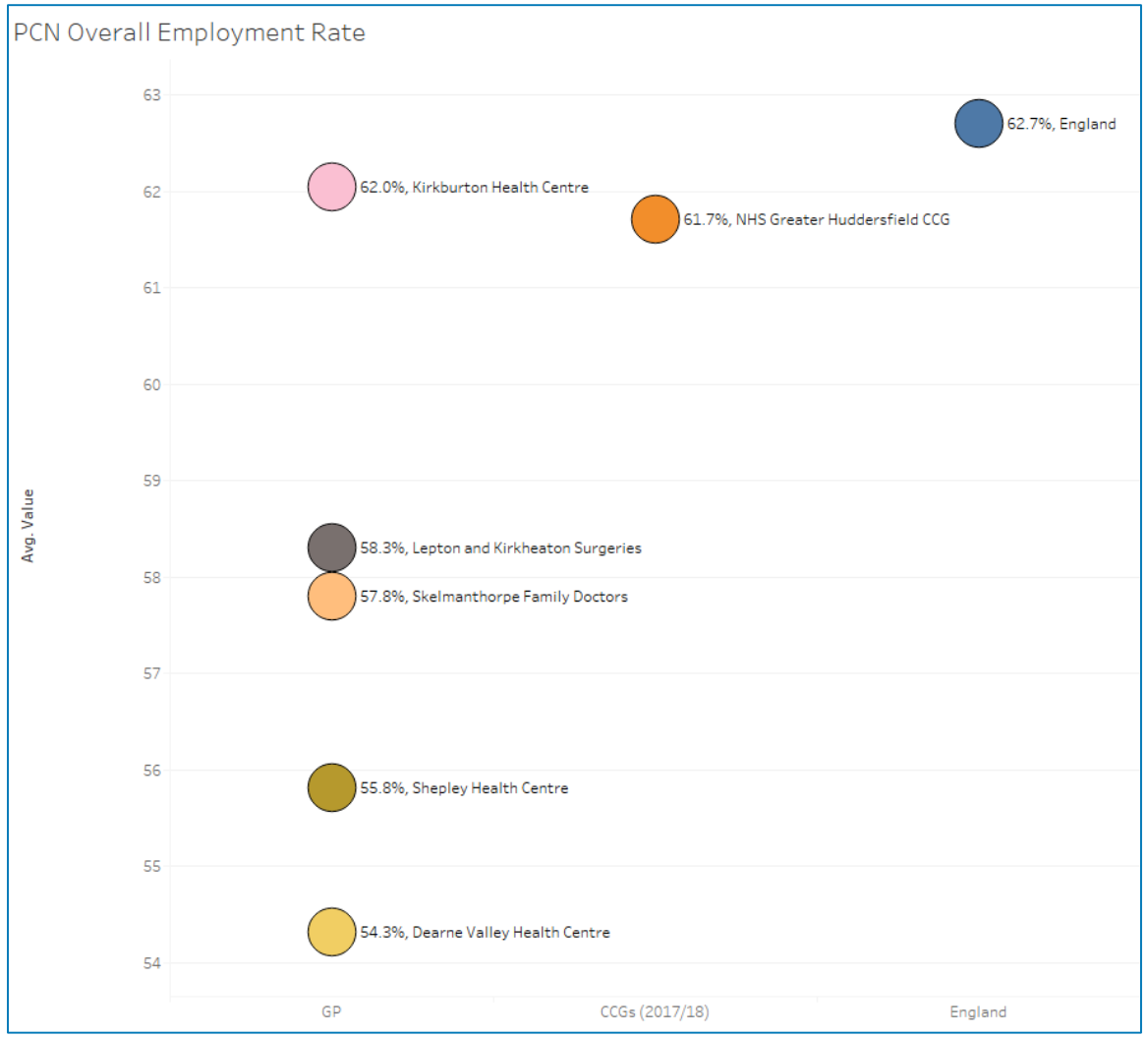
PCN Overall Employment Rate

PCN Overall Employment Rate (2017-18)



- The chart represents the percentage of all respondents to the question "Which of these best describes what you are doing at present?" who answered "Full-time paid work (30 hours or more each week)" or "Part-time paid work (under 30 hours each week)" or "Full-time education at school, college or university".
- The percentage with a full-time working status for England is 62.7%
- The percentage with a full-time working status for NHS Greater Huddersfield is 61.7%.
- Four of the five PCN practices are showing figures below national and CCG levels with Dearne Valley the lowest practice in the network.
- Link to Supporting Data

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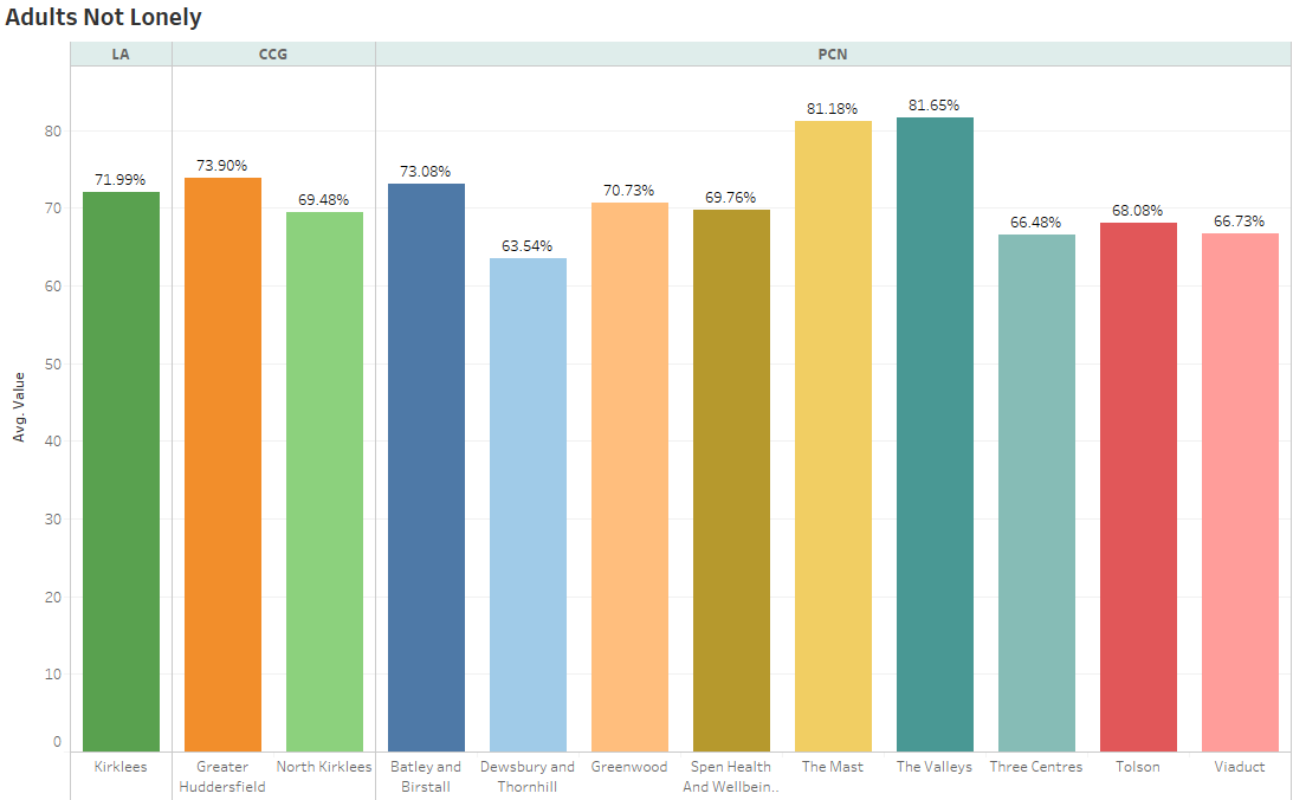
Adults Not Lonely

Adults Not Lonely (2016)



- The chart shows the average of value of adults recorded as not lonely at a PCN level, with comparisons to the regional Kirklees figure and the values for Greater Huddersfield CCG and North Kirklees CCG.
- The Valleys PCN has the highest percentage of adults recorded as not lonely

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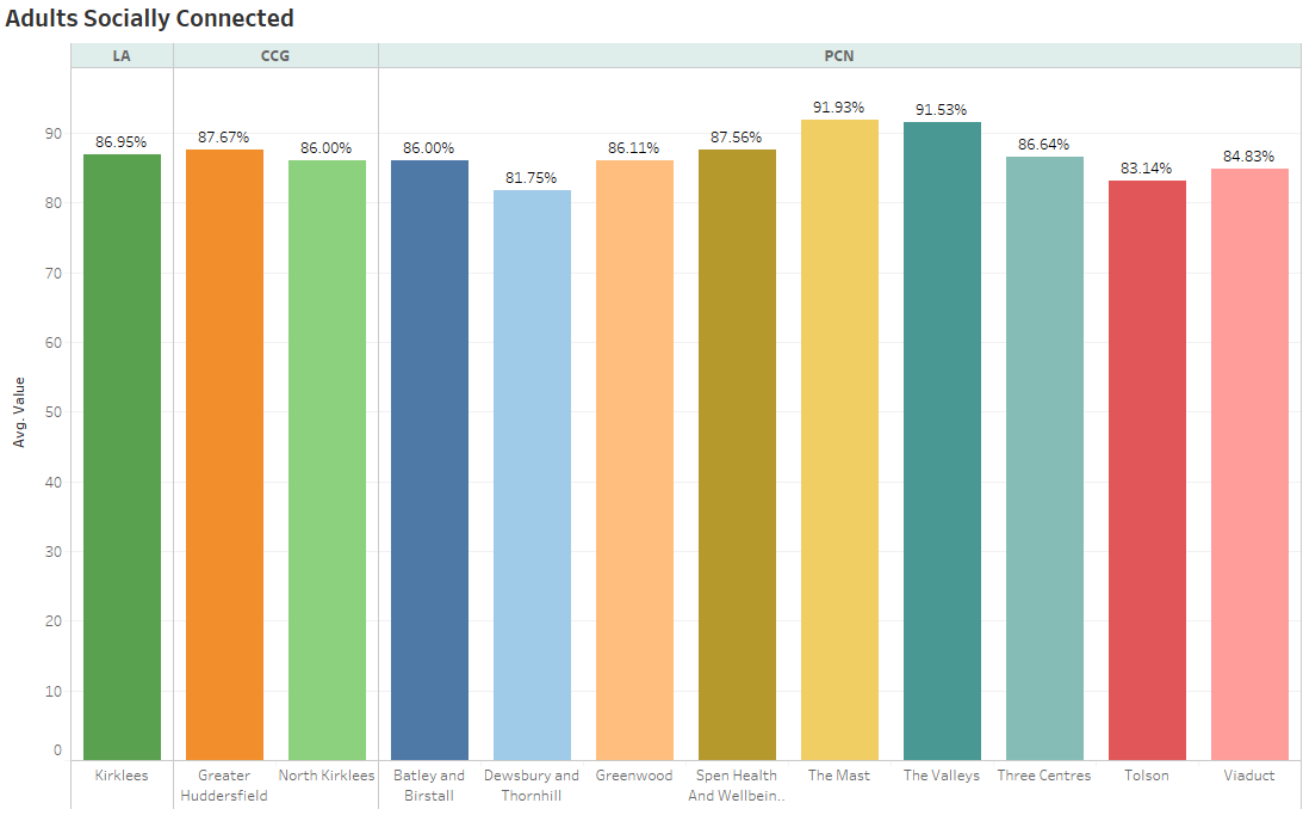
Adults Socially Connected

Adults Socially Connected (2016)



- The chart shows the average of value of adults recorded as socially connected at a PCN level, with comparisons to the regional Kirklees figure and the values for Greater Huddersfield CCG and North Kirklees CCG.
- The Mast PCN has the highest percentage of adults recorded as socially connected.

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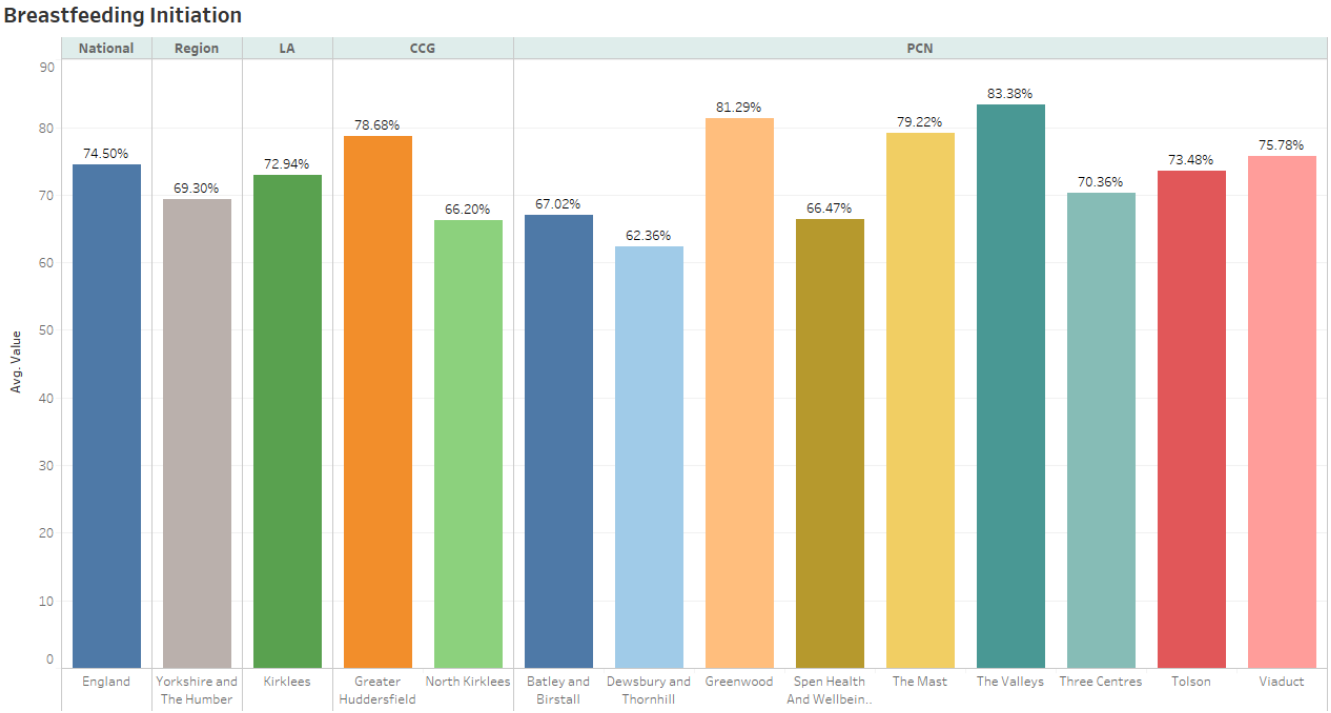
Breastfeeding Initiation

Breastfeeding Initiation (2016/17)



- The chart shows the average of value of breastfeeding initiation connected at a PCN level, with comparisons to the national, Yorkshire & Humber, regional Kirklees and the values for Greater Huddersfield CCG and North Kirklees CCG.
- The Valleys PCN has the highest percentage of breastfeeding initiation.

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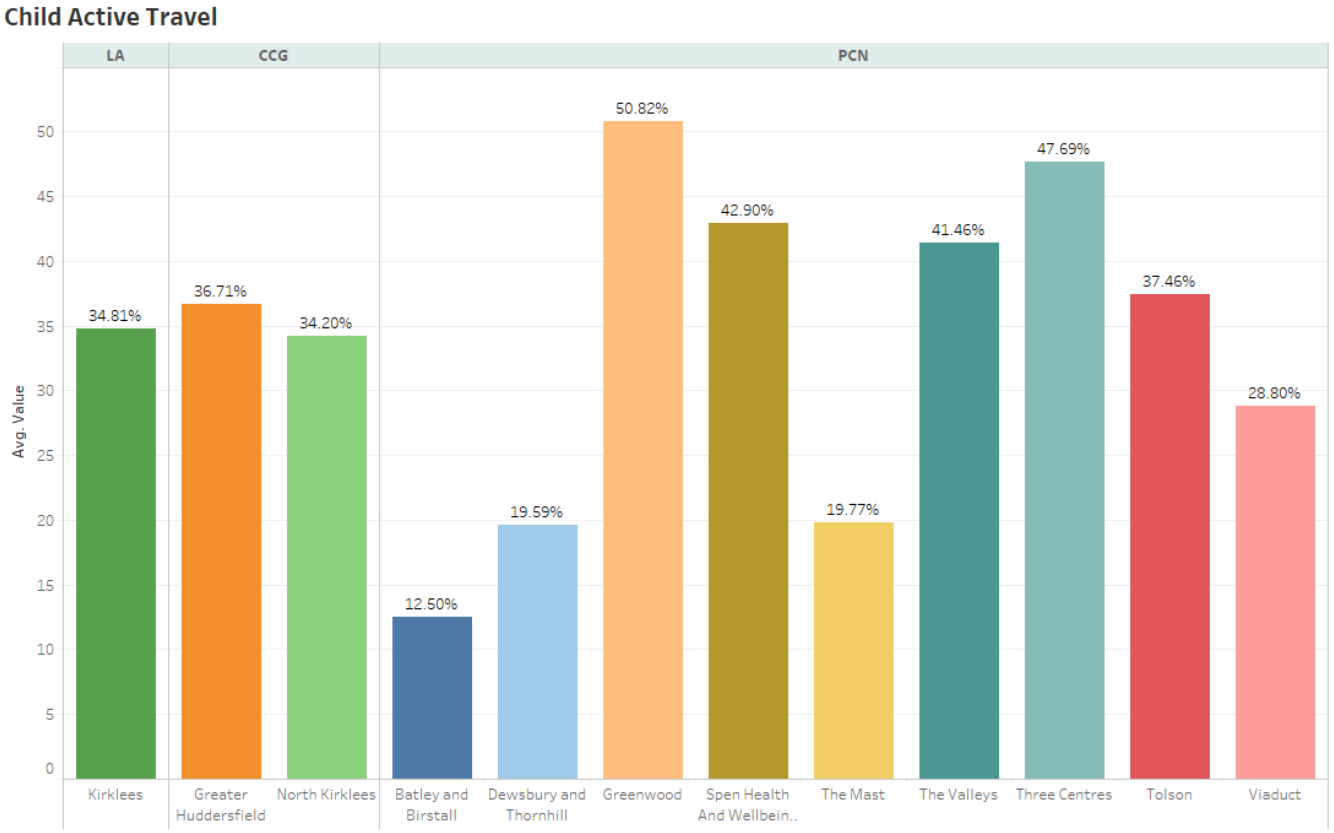
Child Active Travel

Child Active Travel (2019)



- The chart shows the average of value of children involved in active travel at a PCN level, with comparisons to the regional Kirklees figure and the values for Greater Huddersfield CCG and North Kirklees CCG.
- Lowest levels of child active travel is at the Bartley & Birstall PCN.

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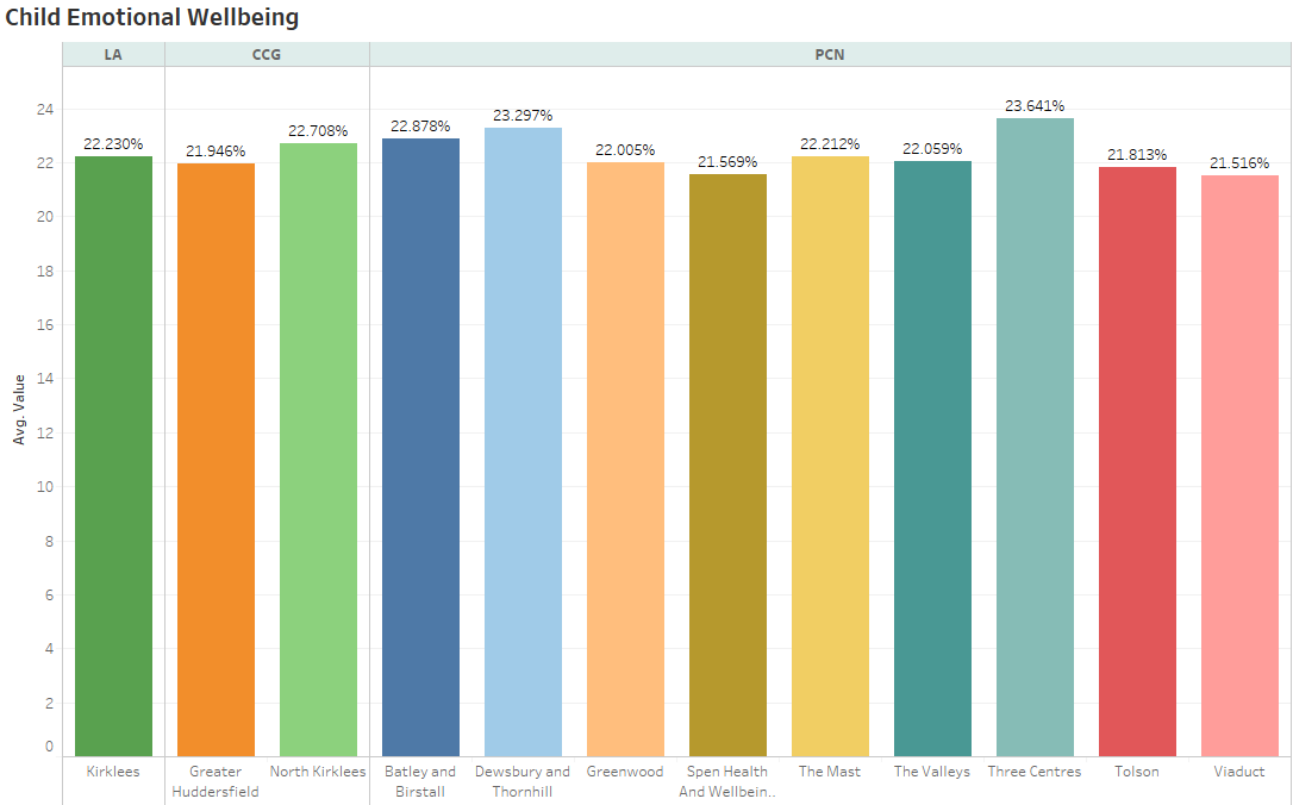
Child Emotional Wellbeing

Child Emotional Wellbeing (2019)



- The chart shows the average of value of child emotional wellbeing recorded at a PCN level, with comparisons to the regional Kirklees figure and the values for Greater Huddersfield CCG and North Kirklees CCG.
- The Three Centre PCN has the highest percentage score for child emotional wellbeing.

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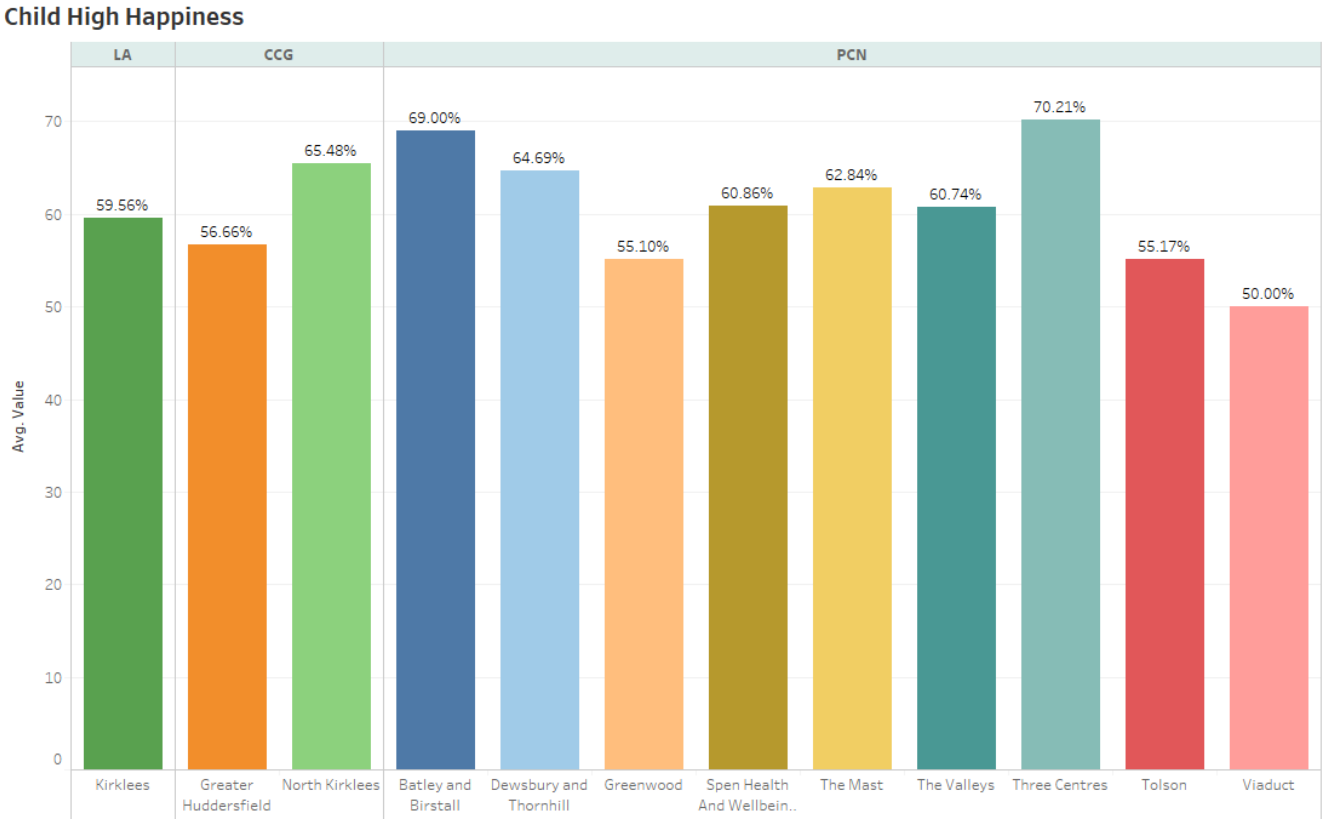
Child High Happiness

Child High Happiness (2019)



- The chart shows the average value of child high happiness recorded at a PCN level, with comparisons to the regional Kirklees figure and the values for Greater Huddersfield CCG and North Kirklees CCG.
- The Three Centre PCN has the highest percentage score for child high happiness.

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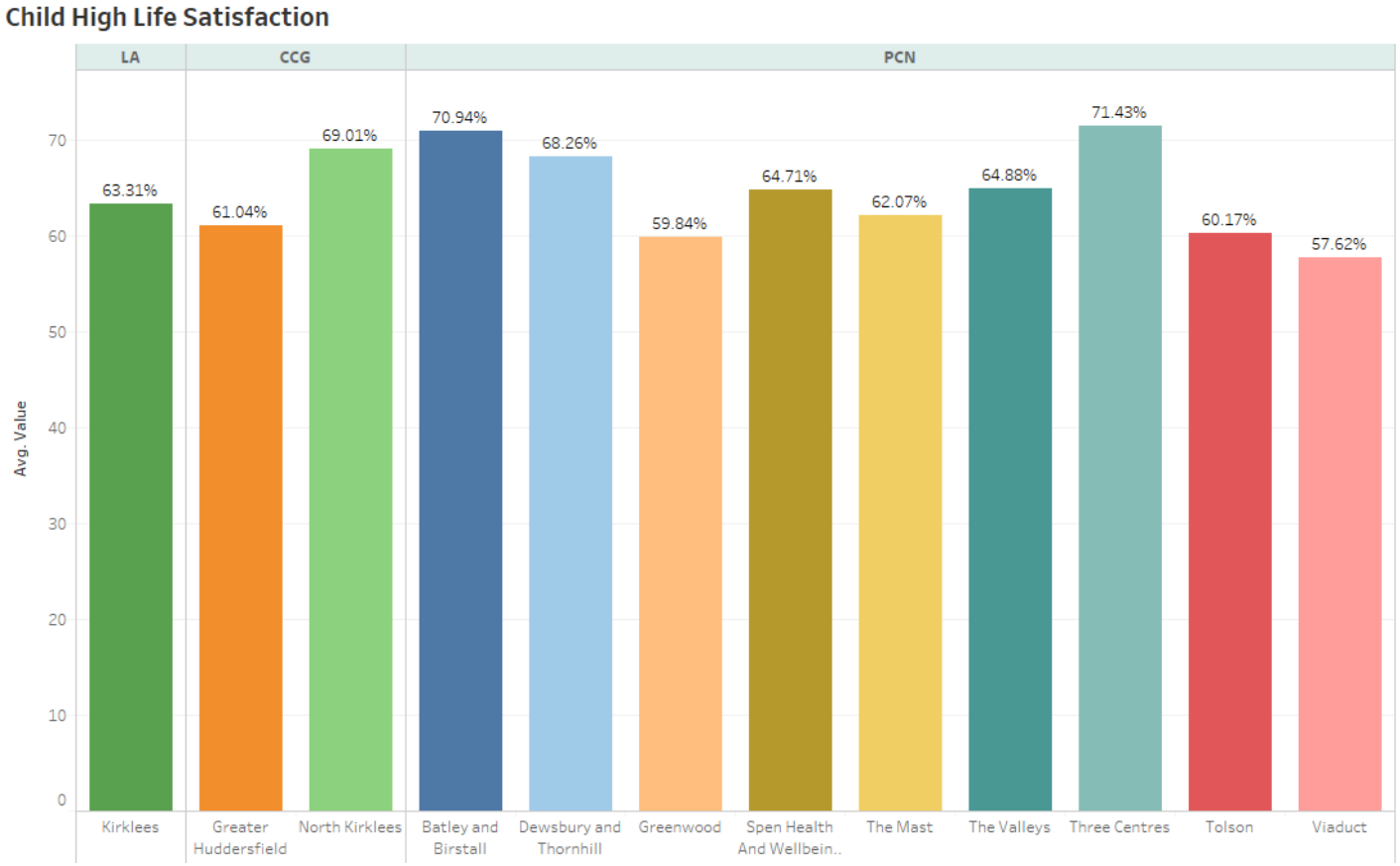
Child High Life Satisfaction

Child High Life Satisfaction (2019)



- The chart shows the average value of child high life satisfaction recorded at a PCN level, with comparisons to the regional Kirklees figure and the values for Greater Huddersfield CCG and North Kirklees CCG.
- The Three Centre PCN has the highest percentage score for child high life satisfaction.
- Subject Experience Contacts:

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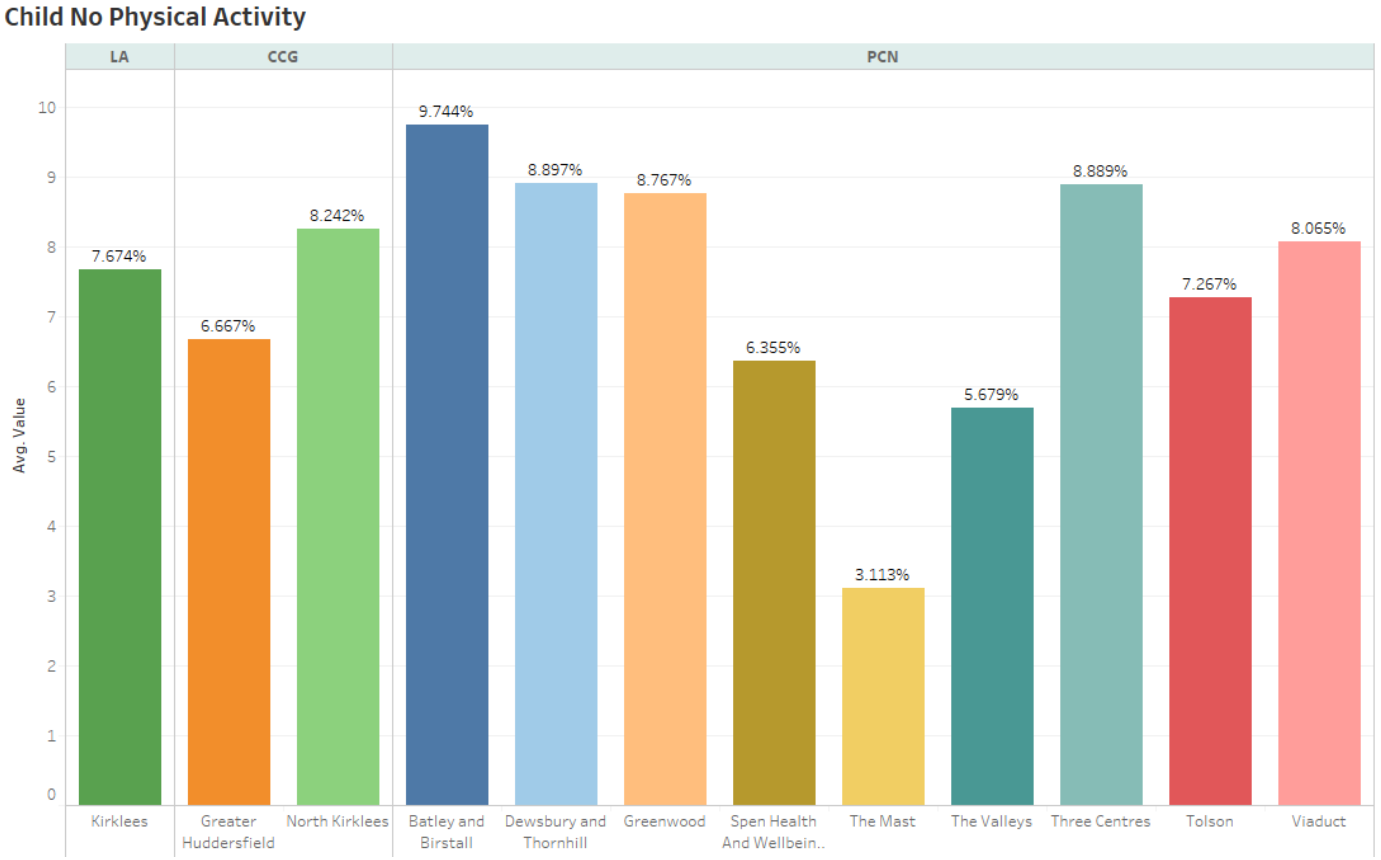
Child No Physical Activity

Child No Physical Activity (2019)



- The chart shows the average value of children with no physical activity recorded at a PCN level, with comparisons to the regional Kirklees figure and the values for Greater Huddersfield CCG and North Kirklees CCG.
- The Batley & Birstall PCN has the highest percentage score for child with no physical activity.

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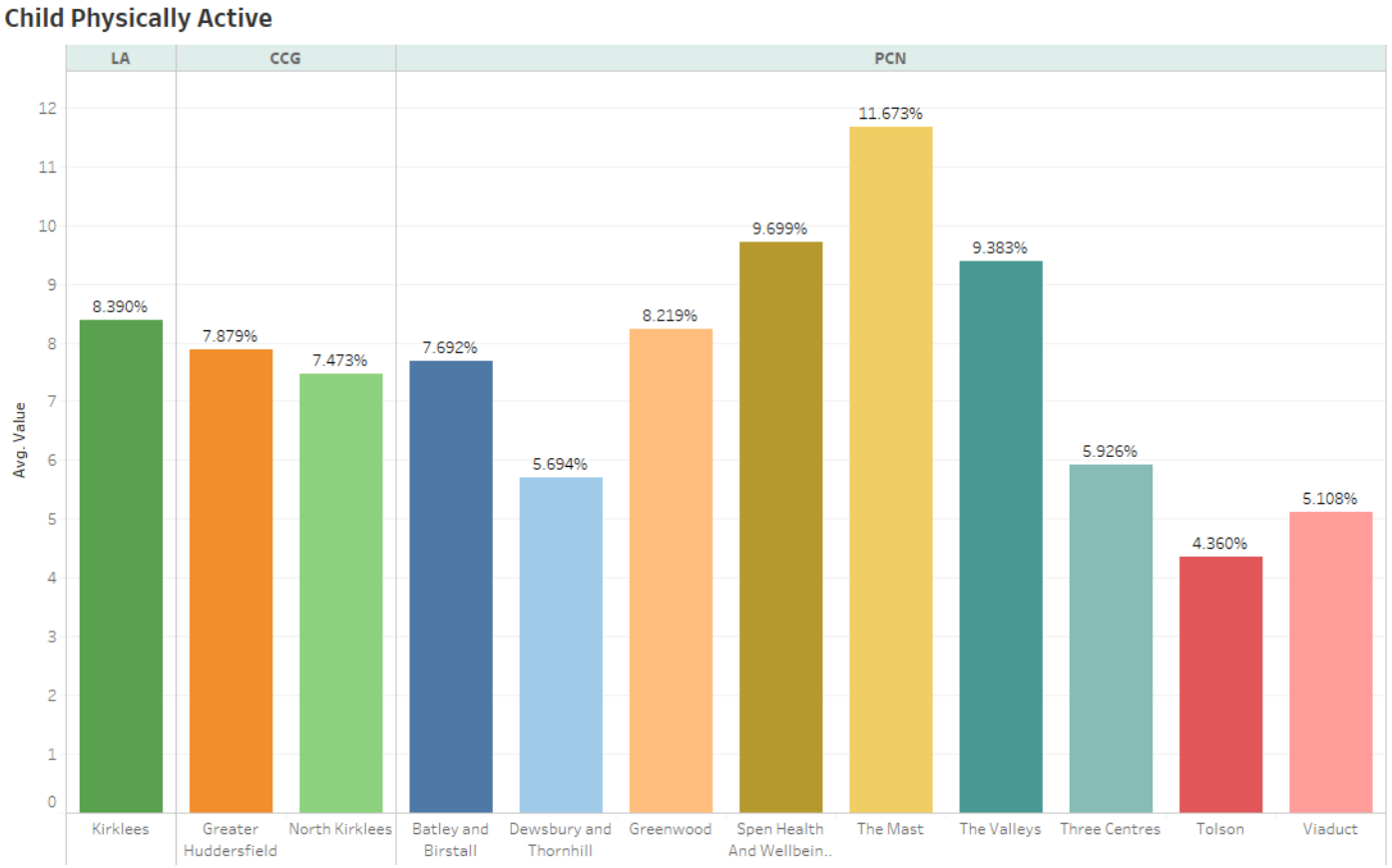
Child Physically Active

Child Physically Active (2019)



- The chart shows the average value of physically active children recorded at a PCN level, with comparisons to the regional Kirklees figure and the values for Greater Huddersfield CCG and North Kirklees CCG.
- The Mast PCN has the highest percentage score of physically active children.

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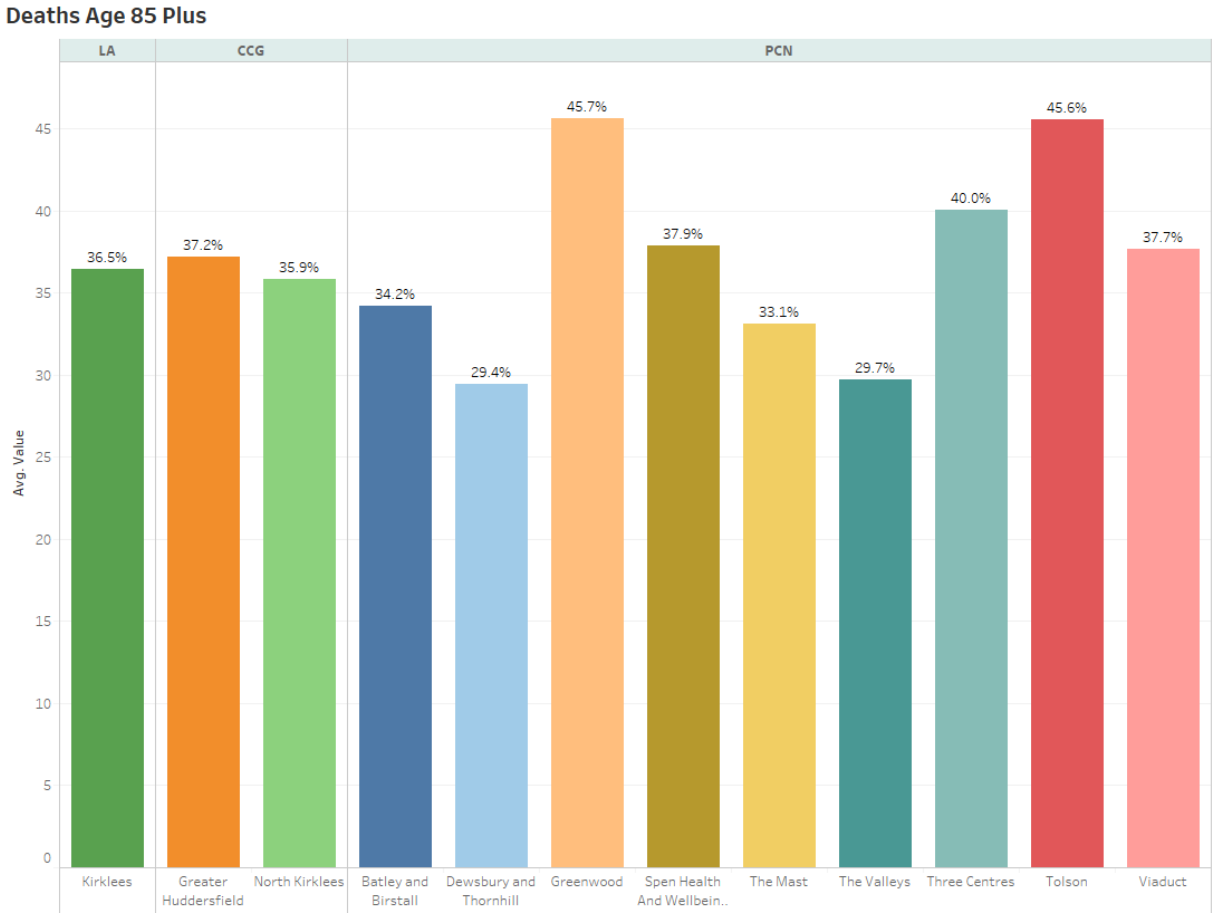
Deaths Age 85 Plus

Deaths Age 85 Plus (2015-17)



- The chart shows the average deaths over 85 years of age recorded at a PCN level, with comparisons to the regional Kirklees figure and the values for Greater Huddersfield CCG and North Kirklees CCG.
- Greenwood PCN has the highest percentage score for deaths over 85 years of age.

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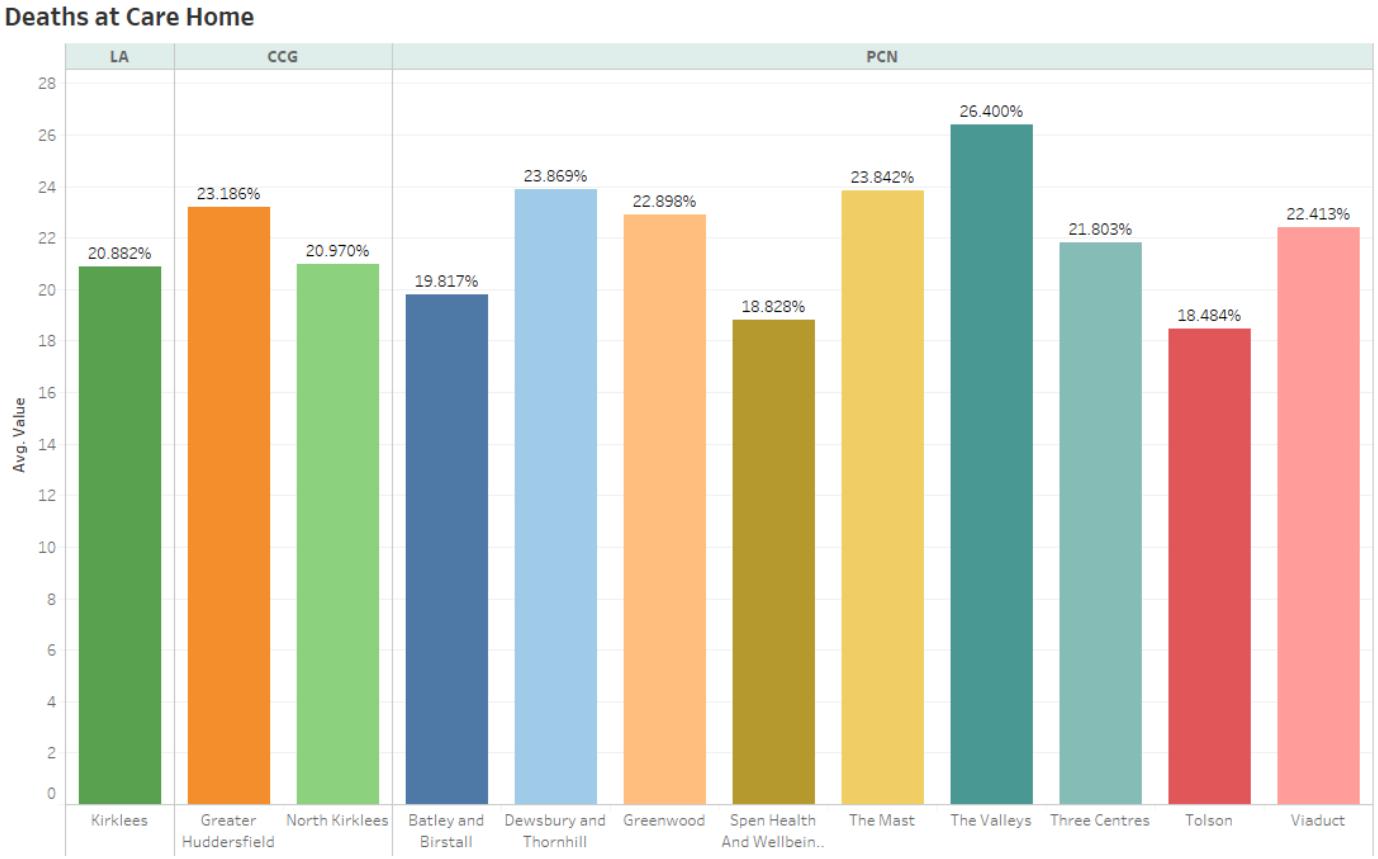
Deaths at Care Home

Deaths at Care Home (2015-17)



- The chart shows the average value of deaths at care homes recorded at a PCN level, with comparisons to the regional Kirklees figure and the values for Greater Huddersfield CCG and North Kirklees CCG.
- The Valleys PCN has the highest percentage score for deaths at care homes.

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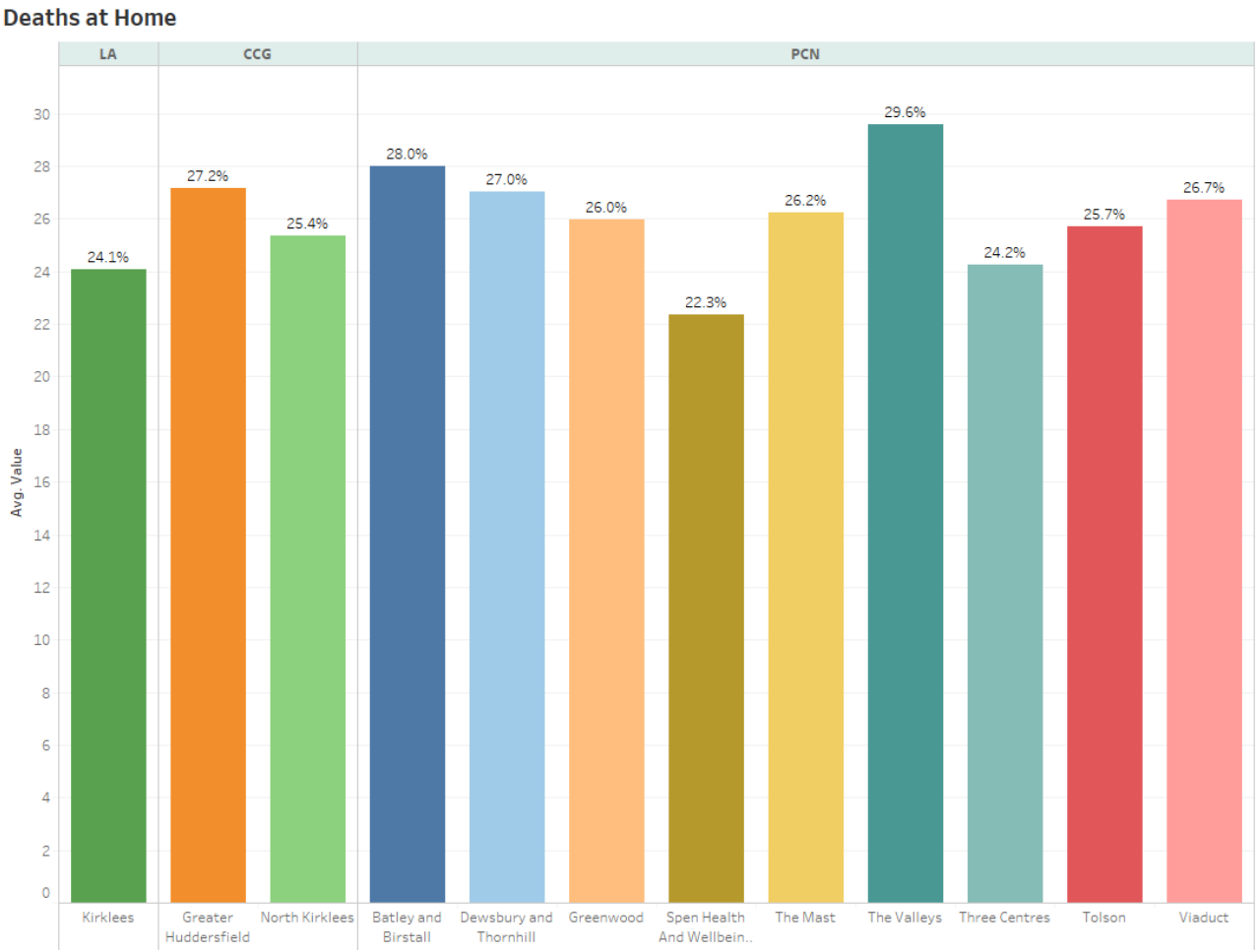
Deaths at Home

Deaths at Home (2015-17)



- The chart shows the average value of deaths at home recorded at a PCN level, with comparisons to the regional Kirklees figure and the values for Greater Huddersfield CCG and North Kirklees CCG.
- The Valleys PCN has the highest percentage score for deaths at home.

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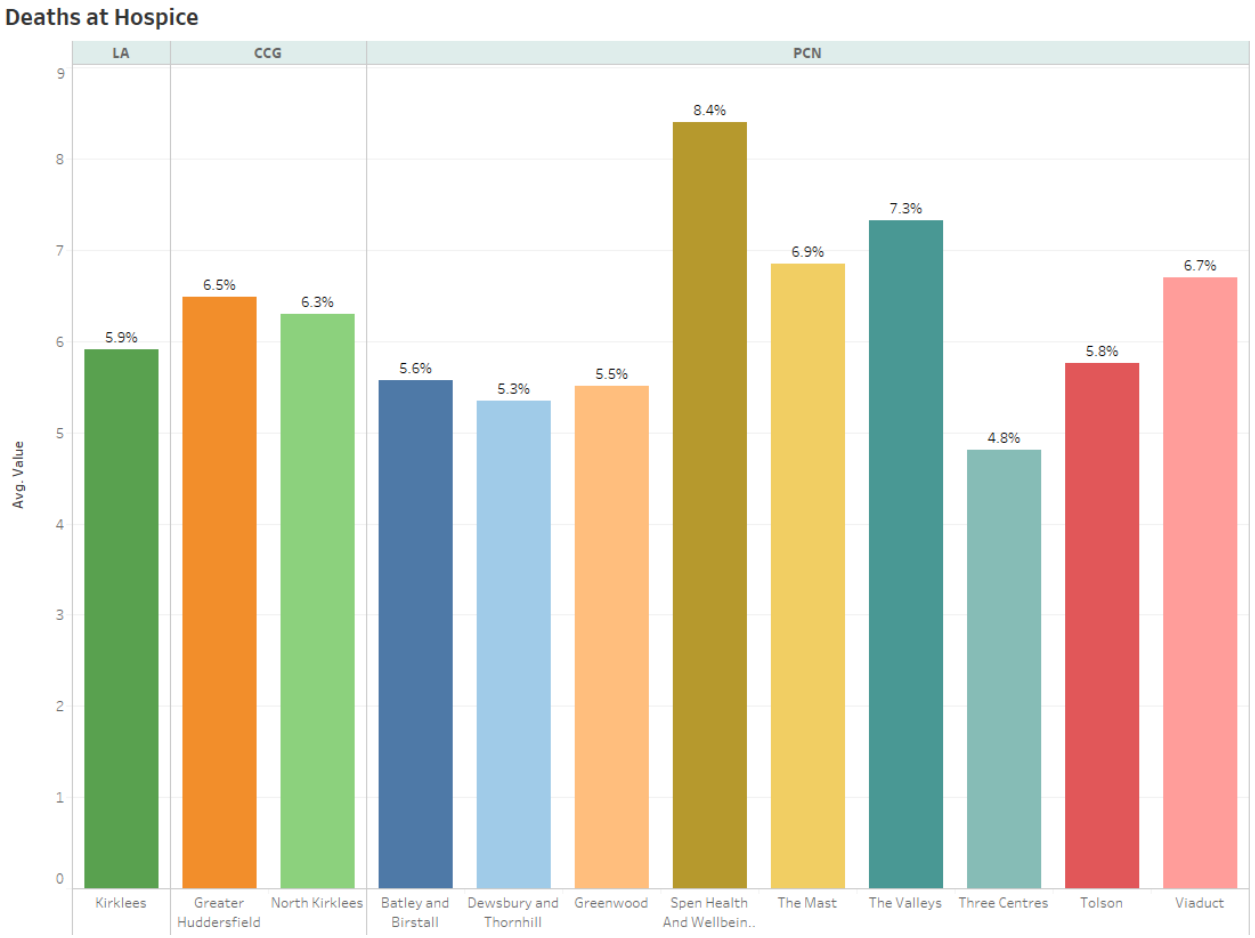
Deaths at Hospice

Deaths at Hospice (2015-17)



- The chart shows the average value of deaths at a hospice recorded at a PCN level, with comparisons to the regional Kirklees figure and the values for Greater Huddersfield CCG and North Kirklees CCG.
- Spen PCN has the highest percentage score for deaths at a hospice.

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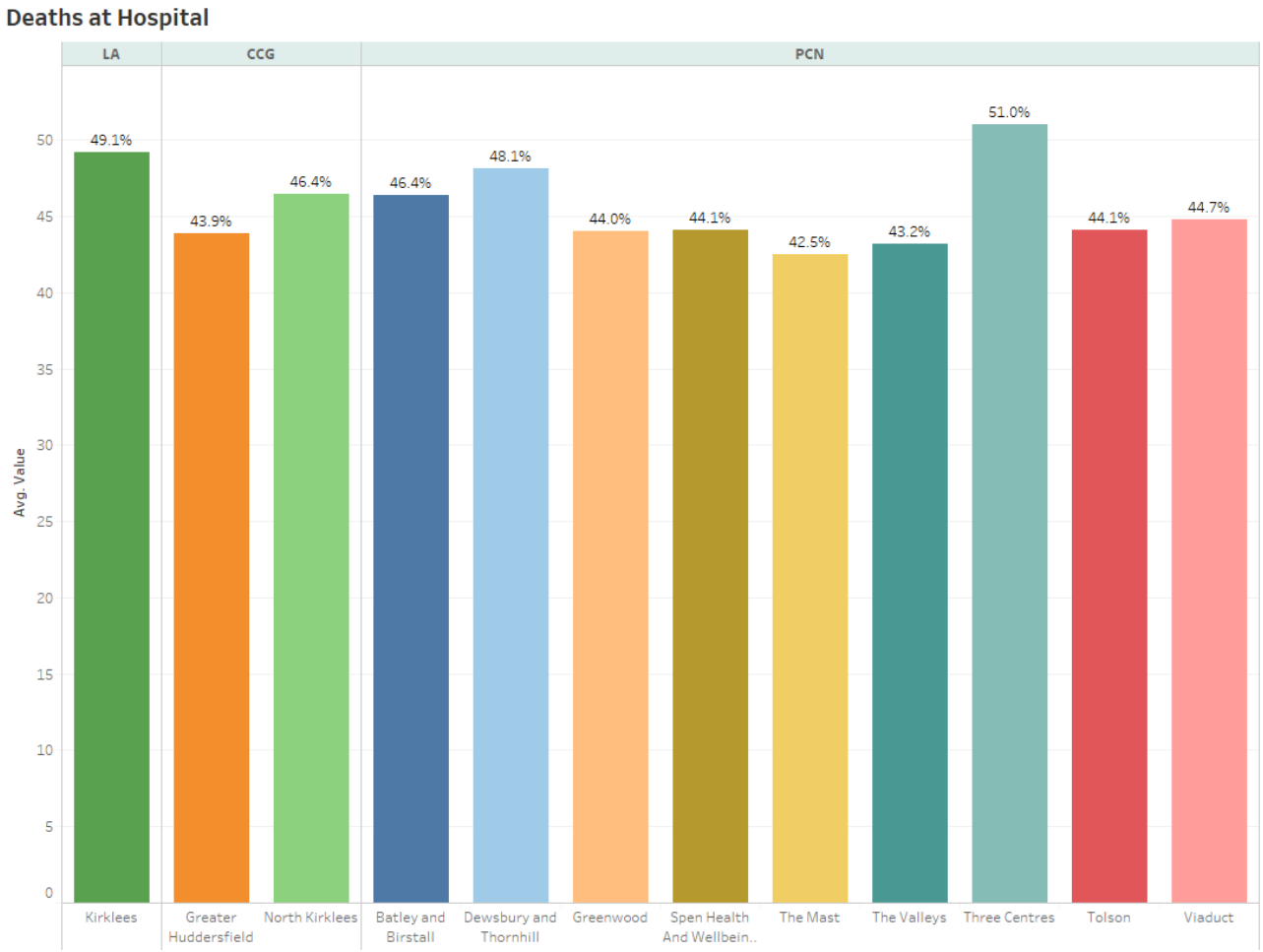
Deaths at Hospital

Deaths at Hospital (2015-17)



- The chart shows the average value of deaths at a hospital recorded at a PCN level, with comparisons to the regional Kirklees figure and the values for Greater Huddersfield CCG and North Kirklees CCG.
- 3 Centre PCN has the highest percentage score for deaths at a hospital.

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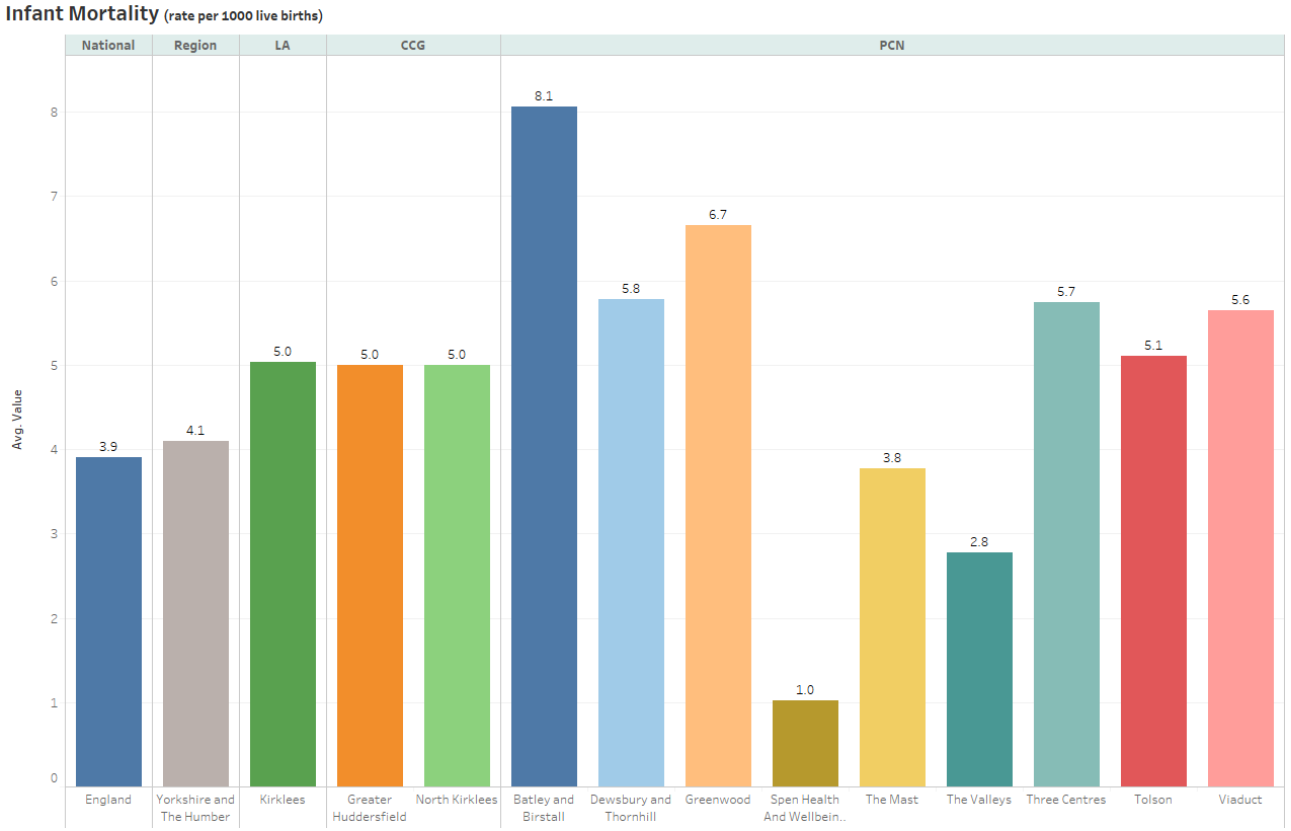
Infant Mortality

Infant Mortality (rate per 1,000 live births) (2015-17)



- The chart shows the average value of infant mortality recorded at a PCN level, with comparisons to the national, Yorkshire & Humber, regional Kirklees and the values for Greater Huddersfield CCG and North Kirklees CCG.
- Greenwood PCN has the second highest rate per thousand live births for infant mortality.

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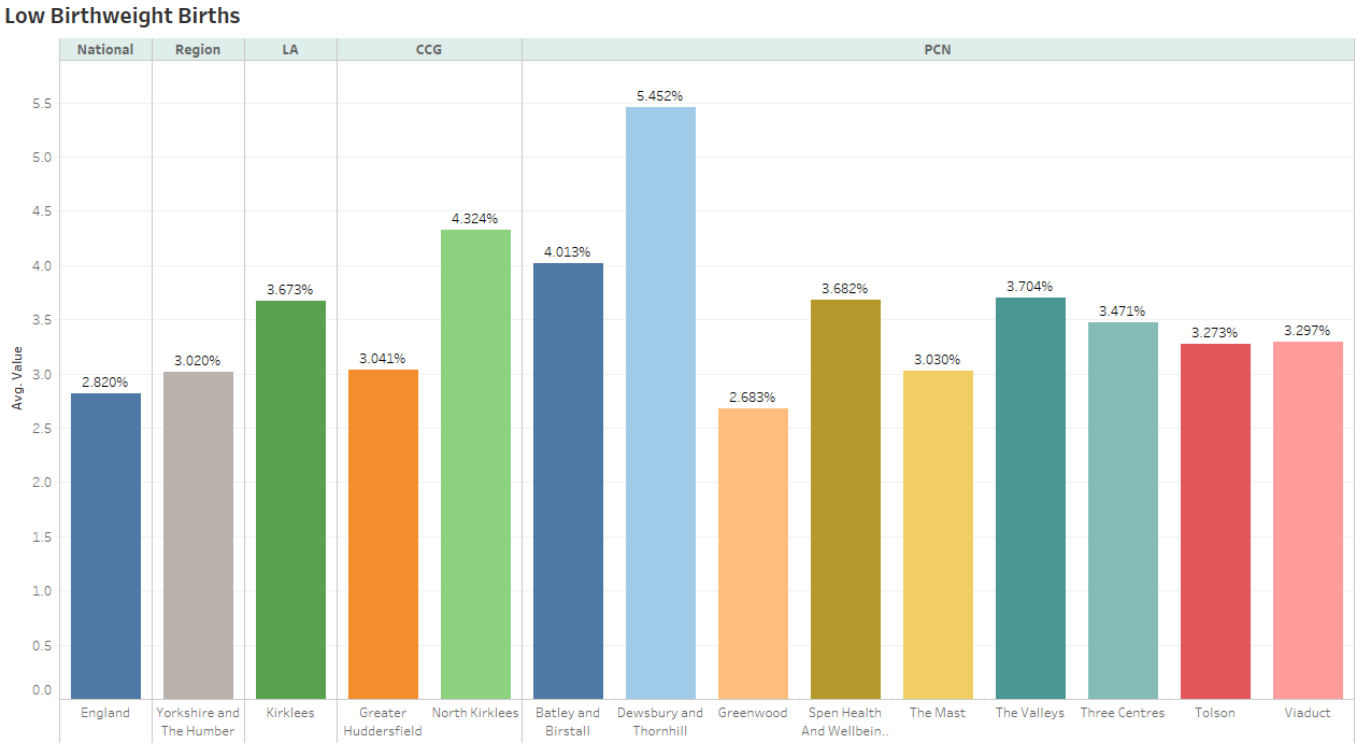
Low Birthweight Births

Low Birthweight Births (2017)



- The chart shows the average value of low birthweight births recorded at a PCN level, with comparisons to the national, Yorkshire & Humber, regional Kirklees and the values for Greater Huddersfield CCG and North Kirklees CCG.
- Dewsbury & Thornhill PCN has the highest percentage score of low birthweight births.

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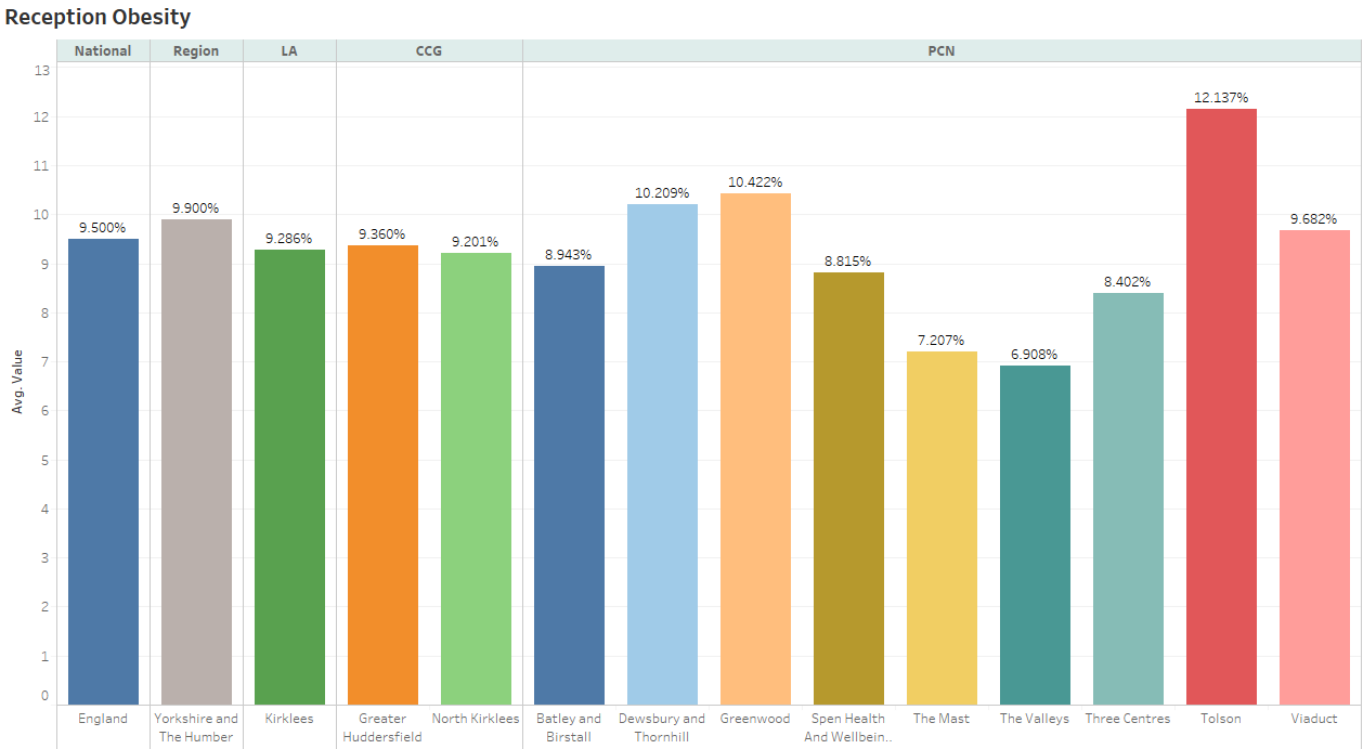
Reception Obesity

Reception Obesity (2017-18)



- The chart shows the average value of obesity at reception age at a PCN level, with comparisons to the national, Yorkshire & Humber, regional Kirklees and the values for Greater Huddersfield CCG and North Kirklees CCG.
- Tolson PCN has the highest percentage score for obesity at reception age.

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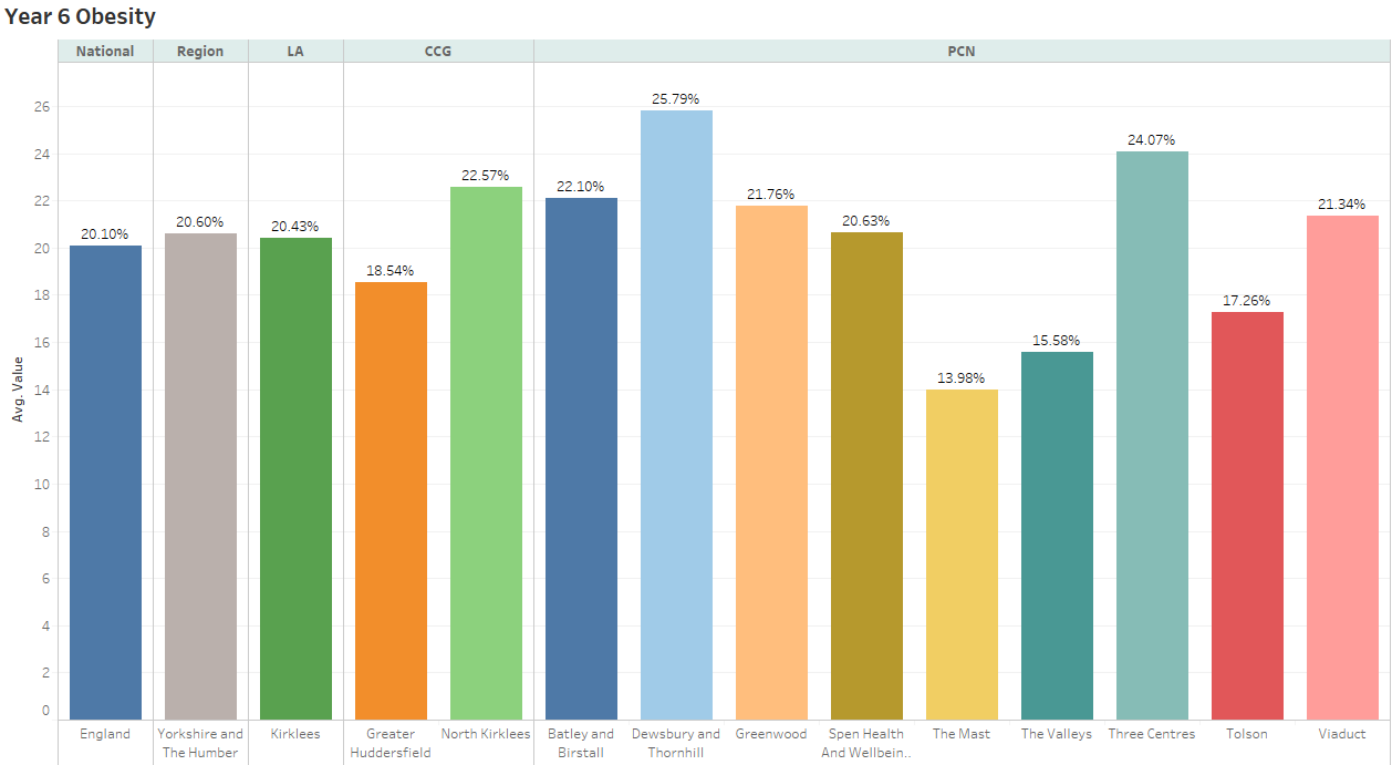
Year 6 Obesity

Year 6 Obesity (2017-18)



- The chart shows the average value of obesity at year 6 at a PCN level, with comparisons to the national, Yorkshire & Humber, regional Kirklees and the values for Greater Huddersfield CCG and North Kirklees CCG.
- Dewsbury & Thornhill PCN has the highest percentage score year 6 obesity levels.

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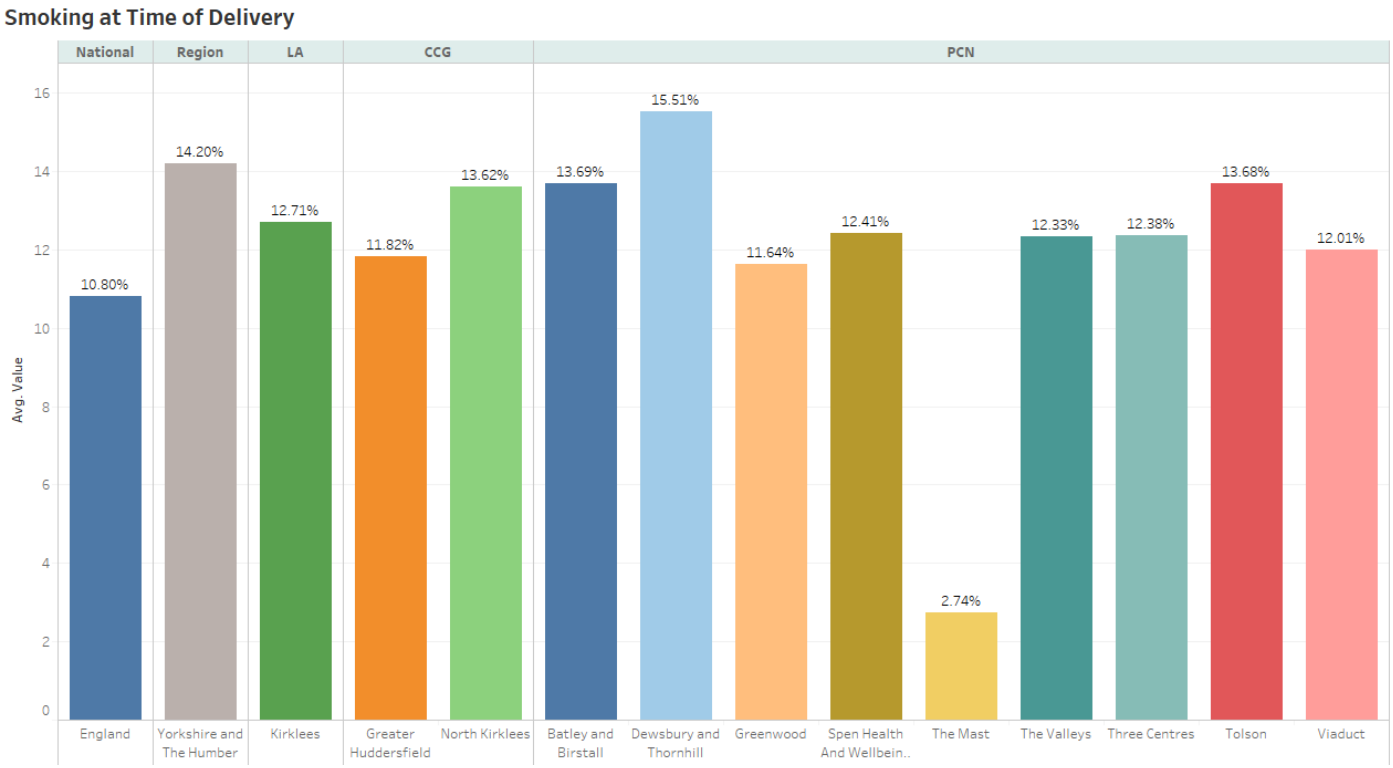
Smoking at Time of Delivery

Smoking at Time of Delivery (2018-19)



- The chart shows the average value of smoking at time of delivery at a PCN level, with comparisons to the national, Yorkshire & Humber, regional Kirklees and the values for Greater Huddersfield CCG and North Kirklees CCG.
- Dewsbury & Thornhill PCN has the highest percentage score for smoking at time of delivery.

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Information Sources & Useful Links

The following list of suggested links and information sources support further understanding and interrogation of primary care network performance.

Information Sources:

- Public Health England website – Public Health Profiles
- Thriving Kirklees Health and Wellbeing website
- Locala Community Partnerships
- Kirklees Council Director of Public Health Annual Report 17/18
- Kirklees Council Joint Strategic Assessment
- Ipsos MORI GP Patient Survey
- NHS Digital website - GP Registered Patient Dashboard
- NHS Digital website - General Practice Data Hub
- Public Health England website – National General Practice Profiles
- NHS RightCare
- NHS STP End of Life Publication for West Yorkshire
- NHS West Yorkshire & Harrogate Cancer Alliance
- Stroke Association partnership

Useful Links:

- Public Health England
- Thriving Kirklees
- Locala
- Kirklees Council Director of Public Health Annual Report 17/18
- Kirklees Observatory KJSA
- GP Patient Survey Results
- GP Registered Patient Dashboard
- General Practice Data Hub
- National General Practice Profiles
- Commissioning for Value Where to Look pack
- End of Life Care STP Support Tool
- Cancer Alliance
- Stroke information re Greater Huddersfield
- Appointments in General Practice
- West Yorkshire & Harrogate Healthy Hearts
- Dementia National Rates