Primary Care Network Data Pack

Spen Health And Wellbeing (Primary Care) Network (SHAWN)

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. Diabetes management
  2. End of life care
  3. Cancer emergency admissions
  4. Obesity prevalence
  5. Stroke 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 and/or tools 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.

Spen Health and Wellbeing PCN – An Overview

Place Overview

- **Volume of patients -** The Spen Health and Wellbeing Network has seven practices caring in total for c.52,500 patients. The average per practice (c.7,500) is below the national average (8,035) but above the local CCG average (7,166).

- **Ethnicity -** The network provides services for diverse ethic groups (I.e. mixed and Asian). E.g. c.30% of Cook Lane Centre's patients are from mixed and Asian groups.

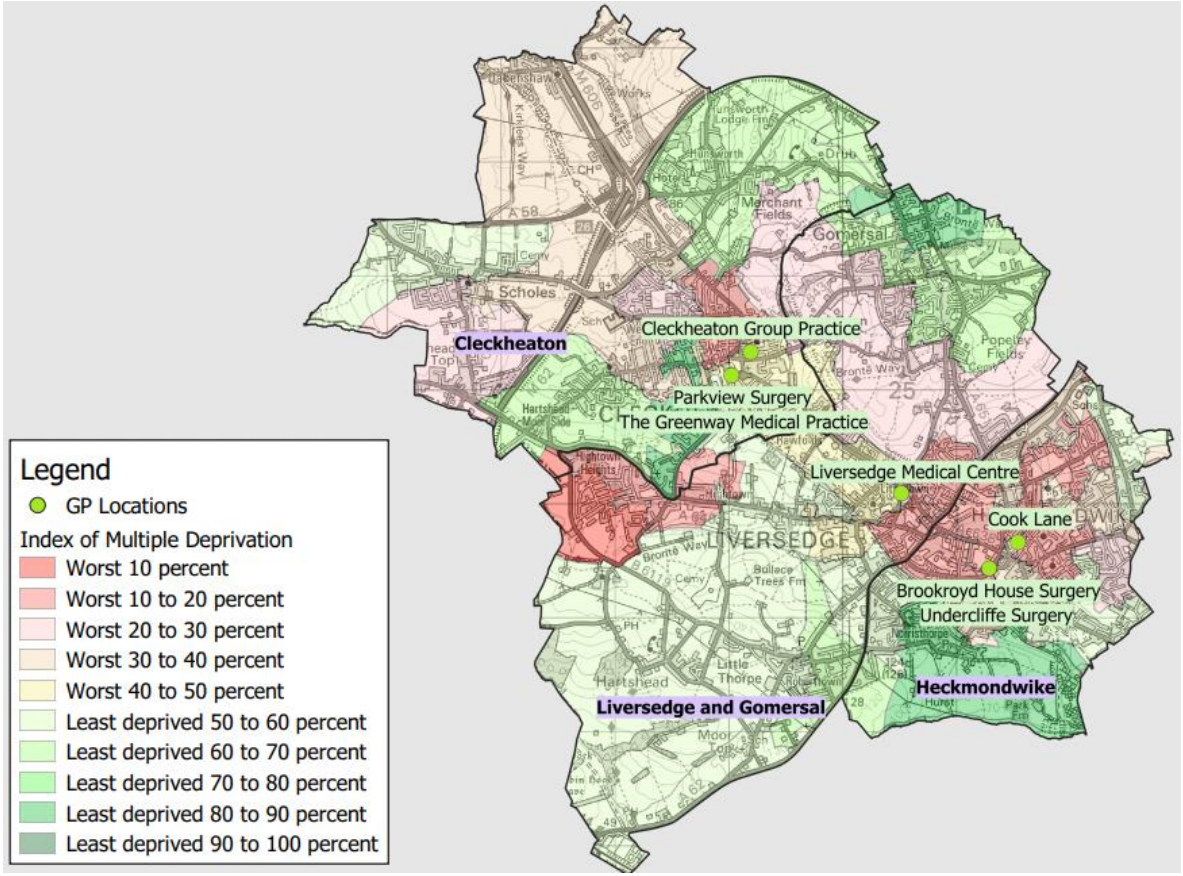
- **QOF -** QOF has not been achieved by any of the seven practices, with the measure of positive patient experience ranging from 60.4% to 85.4%.

- **Green spaces –** 92% of people have access to green spaces within a mile of their home, although their utilisation is lower locally than in Kirklees overall (61% vs 66% respectively utilise green spaces at least once a month). Usage reduces with age, with 63% of under 65 year olds utilising them compared to 56% for over 65 year olds.

- **Satisfaction with living in local area –** The area has a slightly lower satisfaction rate than Kirklees overall (76% vs 79%). It increases with age, rising from 57% in those aged 18-24 years to 87% in those aged over 75 years.

Network Practice Locations

The map below shows deprivation around Spen PCN – the most deprived areas are in the East and South of Hartshead Moorside.



See Slide 7 for practice breakdown

Place overview broken down by practice

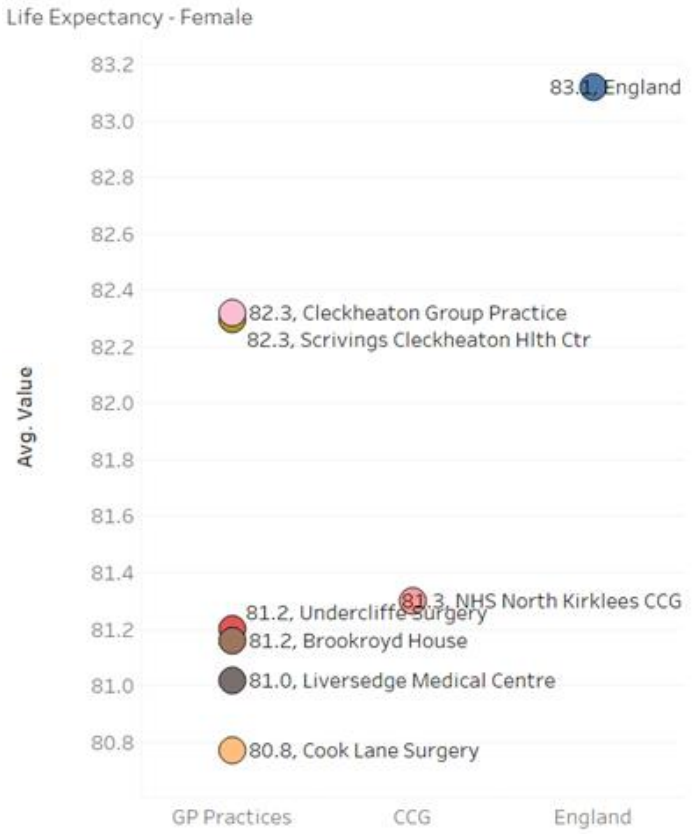
		Cleckheaton Group Practice	Cook Lane (Albion St)	Liversedge Medical Centre	Parkview Surgery	The Greenway Medical Practice	Brookroyd House Surgery	Undercliffe Surgery
PCN Practice (England av. 8,035, NK 7,166)		9,736	2,841	3,469	7,635	8,298	9,610	10,986
Percentage of total PCN pop		19%	5%	7%	15%	16%	18%	21%
Life expectancy years (Male)		78.7	78.4	78.3		78.6	78.7	78.5
Life expectancy years (Female)		82.3	80.8	81.0		82.3	81.2	81.2
Deprivation		Fifth less deprived decile	Fourth more deprived decile	Fifth more deprived decile	Fifth less deprived decile	Fifth less deprived decile	Fifth more deprived decile	Fourth more deprived decile
Ethnicity Estimate	Mixed	1.1%	1.4%	1.3%	1.1%	1.1%	1.3%	1.5%
	Asian	2.9%	28.6%	11.0%	3.0%	3.0%	12.2%	20.6%
	Black	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Other non-white	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
QOF achievement % (out of 559 points)		555.6	539.1	536.4	542.4	527.9	517.3	549.0
Percentage with a +ve experience of practice		76.0%	60.4%	77.7%	85.4%	82.5%	84.6%	84.1%

This chart refers to information summarised in slide 6

Life expectancy is above the CCG average for men but below the average for women

Male life expectancy across the PCN is above the CCG average for all practices, but still below the English average

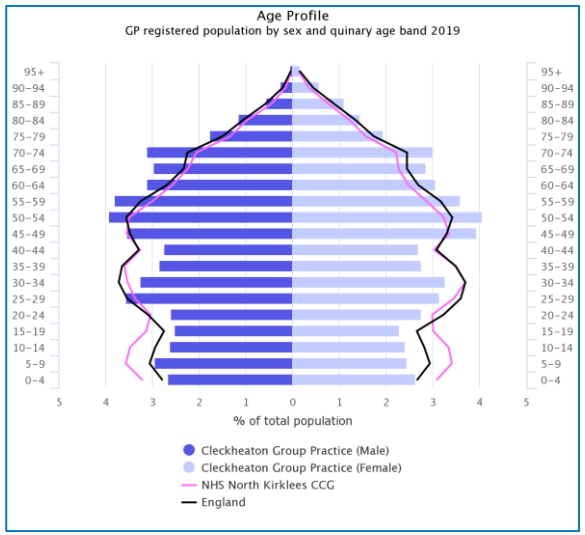
Female life expectancy is below the CCG average in four practices and also below the English average

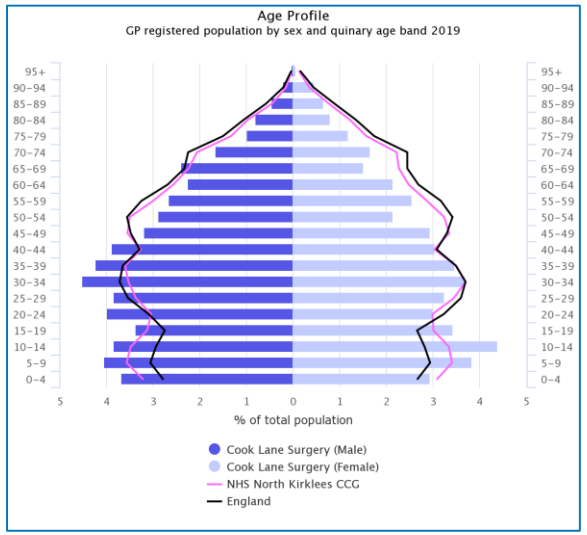


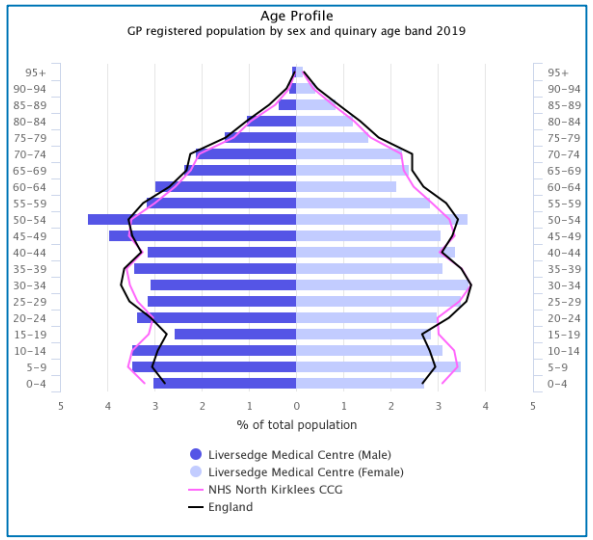
- Although women still appear to live longer, their local life expectancy is below the CCG average as opposed to the men's one which is above average.
- This local gender disparity could provide an opportunity to review the gender discrepancies in the provision of care.

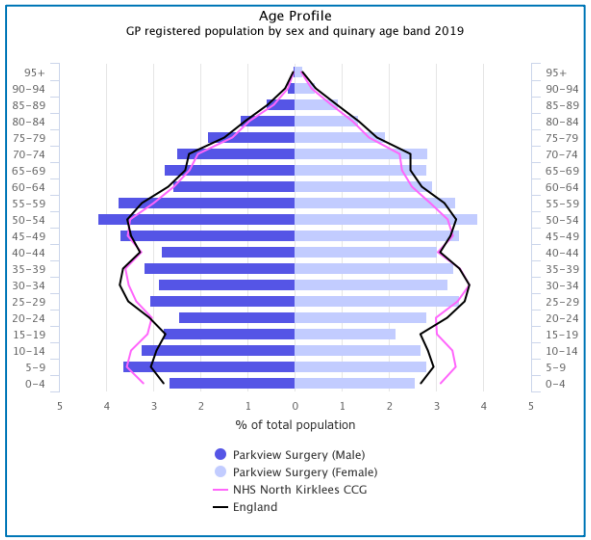
Male and female life expectancy across PCN practices, 2010-14 data

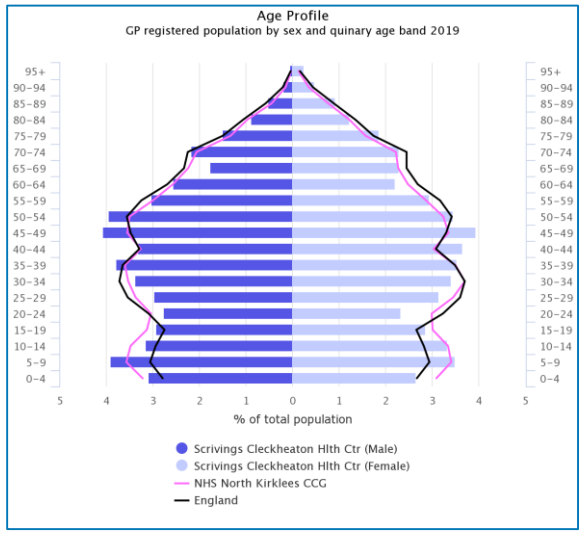
Age profile by practice

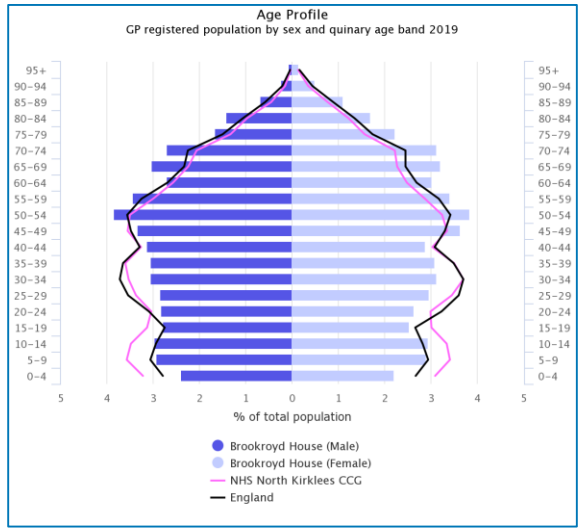




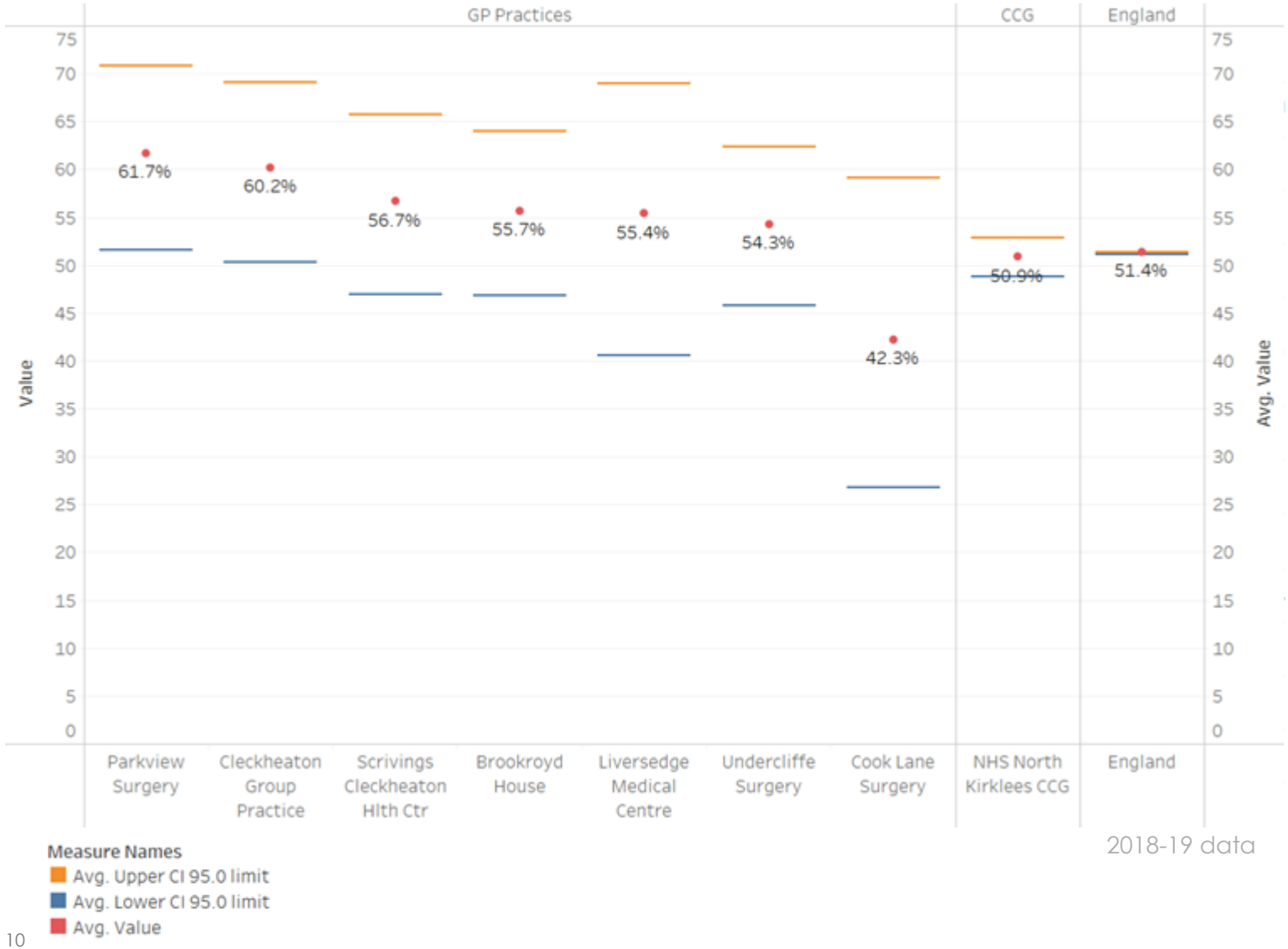








55% of the local population lives with a long-term condition



2018-19 data

- 55.2% of people in the PCN (16+ years) are living with an LTC. This equates to c.26k people.
- Six of seven practices show average % of people with LTCs higher than the CCG average. However, due to wide confidence intervals, these differences are not statistically significant. This trend has remained relatively stable over recent years.
- A significantly higher rate of 3+ LTCs is observed in those of Asian ethnicity and those living in the most deprived areas.
- The leading long-term conditions for the area include mental health problems (circa 1 in 3); back pain (circa 1 in 6); Long-term pain (circa 1 in 7); high blood pressure (circa 1 in 7) and dermatological problems (circa 1 in 7).

Source : Kirklees JSNA

- Link to supporting data

PCN Priority Areas

Priority areas: Criteria for prioritisation

- We used a range of approaches to develop the potential Spen PCN priorities. These included a review of:

1. **Spen PCN stated priorities (taken from Networks Overview and other PCN communications)**
   - Focus on End of Life Care
   - Patient stakeholder involvement
   - PCN management
   - Development and engagement

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

3. **Results of other analysis.** e.g. disparity in women's life expectancy

- Rightcare was used to validate this selection process and add to the short list as required. The Rightcare priorities for the CCG for 'Spend and Outcomes' include Mental Health, Endocrine and Respiratory; for 'Outcomes' Cancer; and for 'Spend' 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, with a National PCN Dashboard potentially being launched April 2020

Spen PCN priorities

Priorities focused on in this pack:

1. **Diabetes management**
   - Outlier compared to CCG - aall PCN practices are below the CCG average

2. **End of life care**
   - PCN stated priority

3. **Cancer emergency admissions**
   - One practice has double the CCG rate and is a statistically significant outlier.
   - Six of seven practices have average rate higher than the CCG (although not significant)

4. **Obesity prevalence**
   - Two practices have statistically higher obesity prevalence than the CCG.
   - Four of seven practices have average rate higher than the CCG (although not significant)

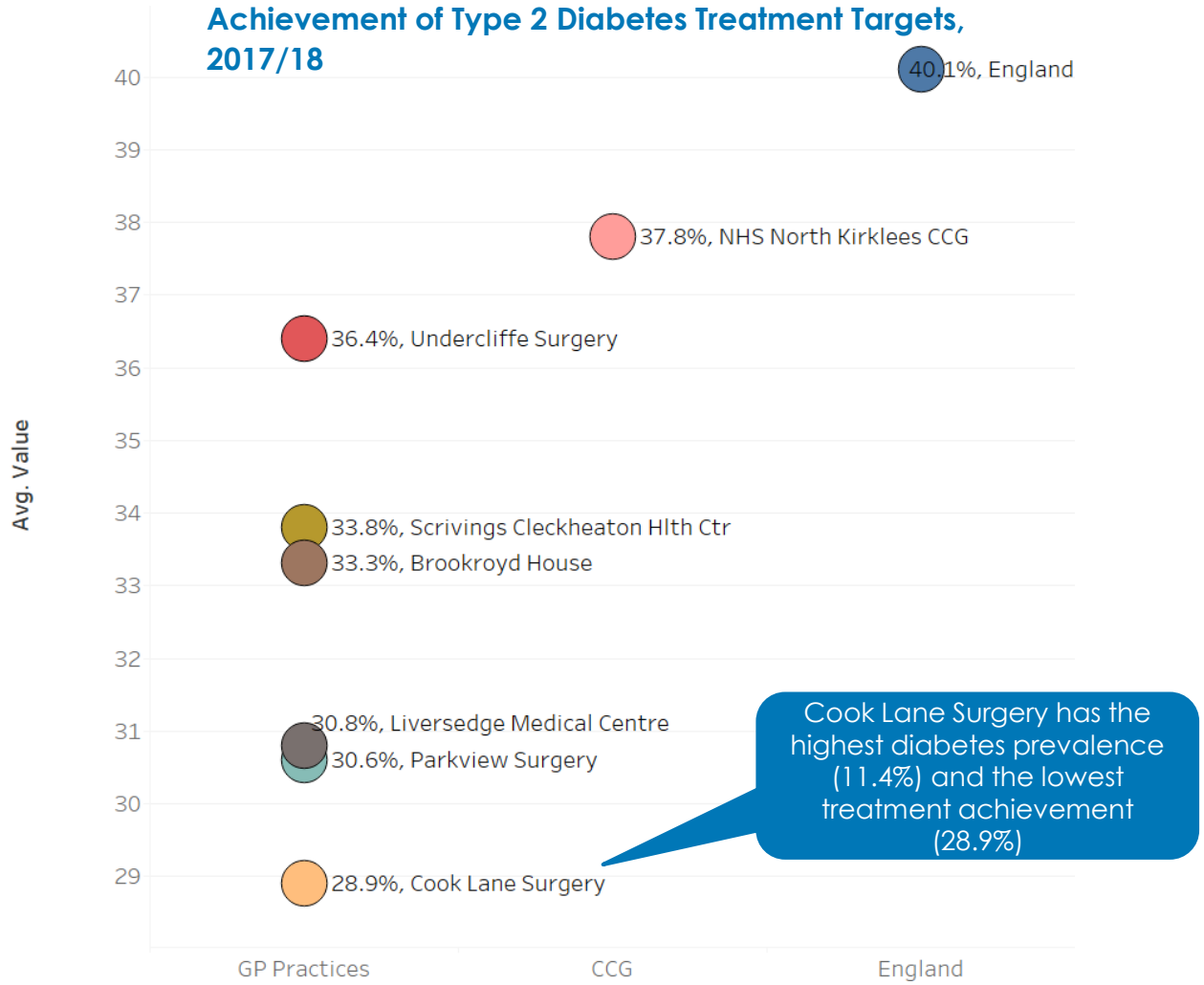
5. **Stroke prevalence**
   - Two practices have statistically higher stroke prevalence than the CCG.
   - Six of seven practices have average rate higher than the CCG (although not significant)

Priority 1: Management of diabetes

Local treatment achievement is low

- **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.
  - Type 2 diabetes is up to six times more likely in people of South Asian descent meaning some practices in the PCN will be disproportionately affected.

- **What does the data tell us?**
  - All practices in the PCN fall below the CCG and England average in terms of treatment achievement.
  - On average 33% of type 2 diabetes patients achieved all three (HbA1c (blood sugar), cholesterol and blood pressure) treatment targets in 2017/18, compared to 38% for CCG as a whole.

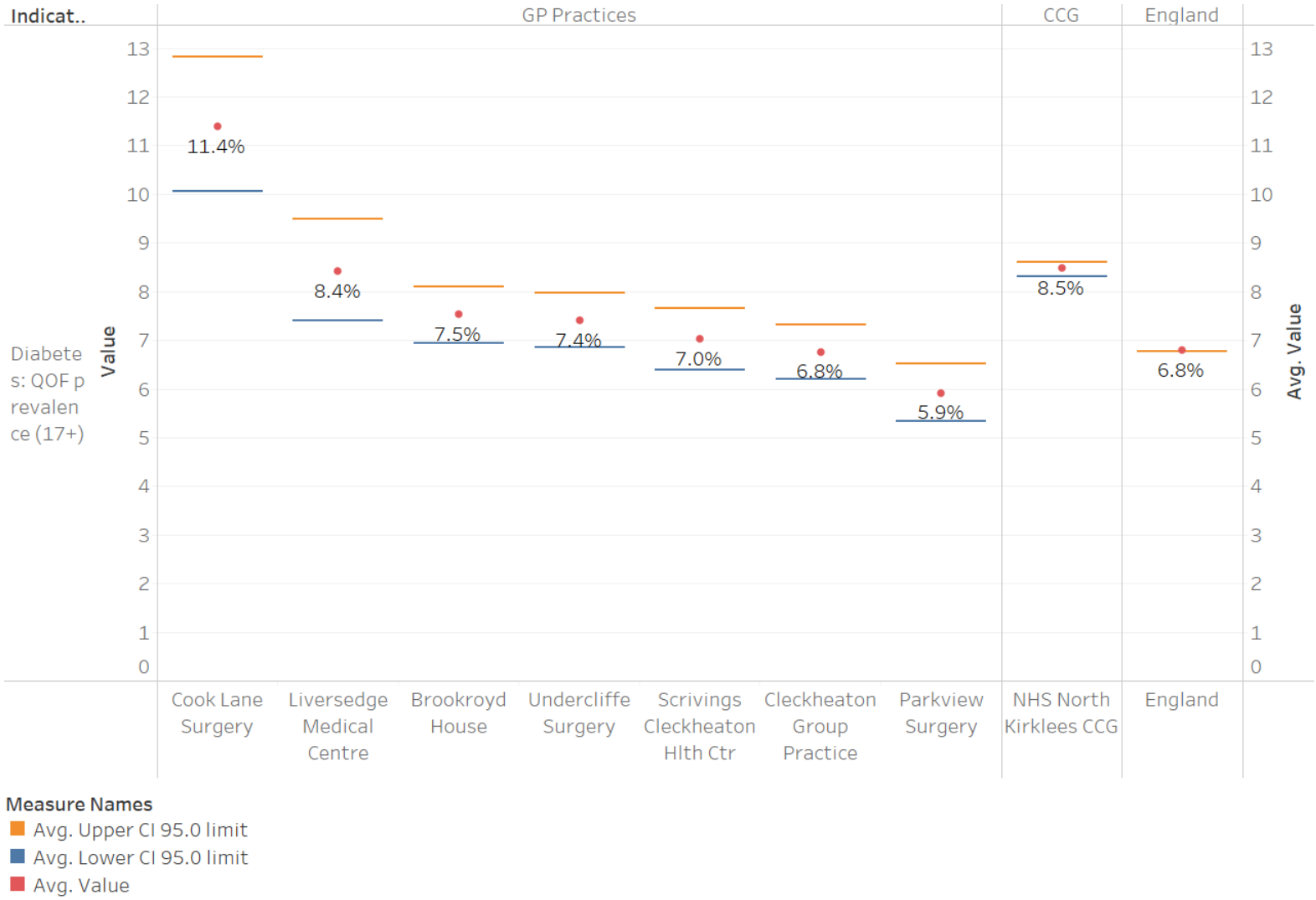


Local diabetes prevalence is low but increasing

- **What does the data tell us?**
  - Whilst treatment achievement is low, prevalence is also low (7.4%) compared to the CCG (8.5%). However, prevalence is increasing.
  - This suggests the need for a service improvement rather than an intervention focused on prevention.

- **Local context**
  - The Cook Lane Surgery patient profile has the highest proportion of Asian patients at 28.6% (the next highest is Undercliffe with 20.6%)
  - Locally the number of people with diabetes is expected to increase due to rising obesity levels, an ageing population and a growing population of south Asian origin.

Diabetes prevalence, 2017/18



Diabetes prevalence trend by practice (vs English average)

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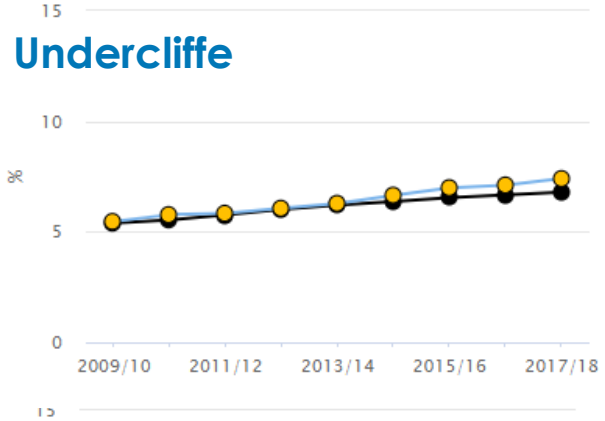
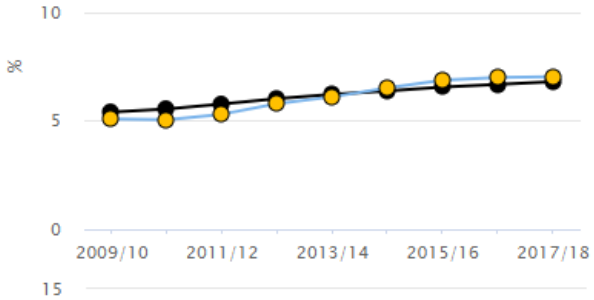
LOWER PREVALENCE

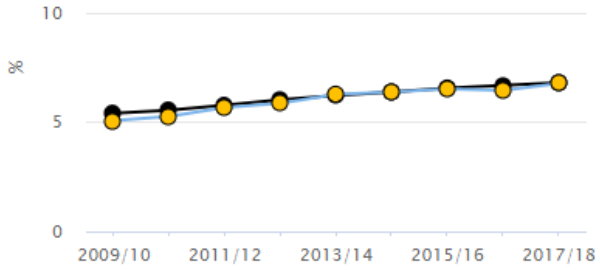
Undercliffe



Scrivings

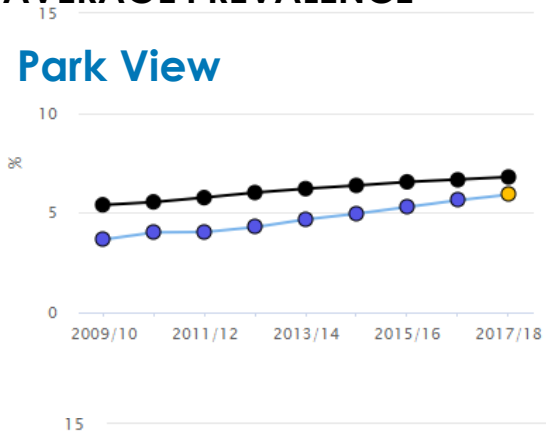


Cleckheaton

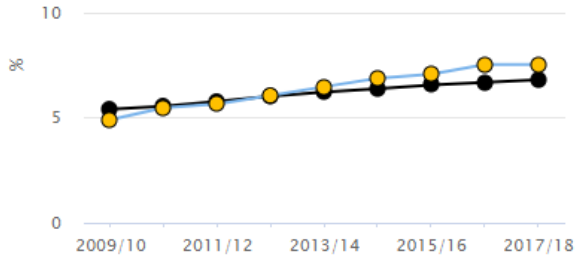


AVERAGE PREVALENCE

Park View

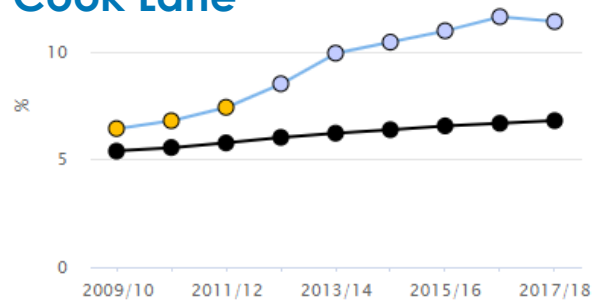


Brookroyd

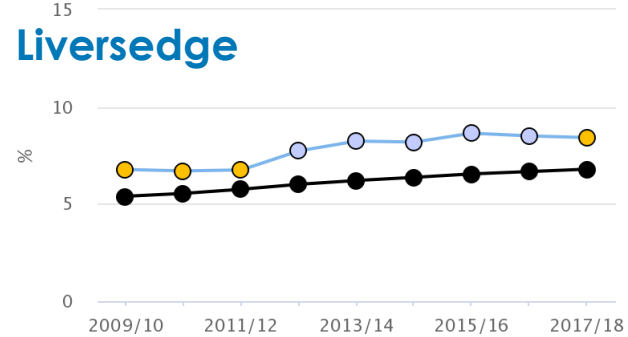


HIGHER PREVALENCE

Cook Lane



Liversedge



Cook Lane Practice has a diabetes prevalence trend significantly above the national average with a slight downturn in experienced in 2017/18. Cook Lane has the highest proportion of mixed and Asian patients (circa 30%) and exists in the fourth most deprived decile.

The increase in part is due to rising obesity levels, an ageing population and a growing population of south Asian origin. People from south Asian and black ethnic groups have a greater chance of developing Type 2 diabetes than people from white ethnic groups.

Opportunities

- **What can be done?**
- Suggestions include NHS Rightcare 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)
  - Nine 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?**
  - Each 2% increase in diabetes treatment is a further c. 80 people treated

- **Links and further reading**
  - KJSA re Diabetes
  - Diabetes prevalence trend
  - Link to supporting treatment data
  - Link to supporting prevalence data
  - https://www.diabetes.org.uk/resources-s3/2017-11/south_asian_report.pdf

Priority 2: End of life care

Improving end of life care

- **Why is this a priority?**
  - If recent mortality trends continue, 160,000 more people in England and Wales will need palliative care by 2040.
  - If access to community-based EoLC improved, £104 million could be redistributed to meet people's preferences for place of care by reducing emergency hospital admissions by 10% and the average length of stay following admission by three days.

- **What does the data tell us?**
  - As of August 2019, there were 238 people on the EOL register across the Spen PCN. One in four of these people had a care plan, up from one in five across the CCG.

EOL care – number of patients on the EOL register and presence of advanced care planning (ACP)

GP practice name	Practice list size Weighted	Number patients over 65 years of age	% of patients on the Palliative Care Register	Number of people on the Palliative Care Register	% of patients on the palliative care register with a recorded discussion about ACP	Number of patients on the palliative care register with a recorded discussion about ACP
Parkview Surgery	7,694	1,491	0.3%	25	Not publicly available at GP practice level	
Undercliffe Surgery	10,994	1,780	0.4%	49		
Brookroyd House Surgery	10,029	2,101	0.4%	41		
Cleckheaton Group Practice	10,170	2,077	0.5%	51		
The Greenway Medical Practice	7,923	1,341	0.6%	46		
Liversedge Medical Centre	3,285	568	0.3%	9		
Cook Lane (Albion Street) Surgery	2,651	372	0.6%	17		
Total	52,747	9,730	0.5%	238		
CCG average (where applicable)	7,059	1144	0.4%	30	20.3%	6.0

- EPaCCS also captures whether an Advance Care Plan is in place. Not all patients with an EPaCCS will have an Advance Care Planning (ACP) discussion.
- Advance Care planning is key means of improving care for people nearing the end of life and of enabling better planning and provision of care, to help them live well and die well in the place and the manner of their choosing.
- The formation of Primary Care Networks provides a real opportunity to influence and improve the care and support provided to people with a life limiting illness within Kirklees.

Opportunities

- **What can be done?**
  - Advance Care Planning (ACP) improves EoLC and patient and family satisfaction and reduces care home admissions, stress, anxiety and depression in surviving relatives.
  - Hospital improvement programme enablers can be adopted to improve recognising and managing uncertain recovery, discharge to home, care co-ordination, Advance Care Planning ACP), and improve care of the dying adult.
  - Best practice is identified and shared through national and local networks and communication mechanisms.
- **What could this mean?**
  - If recent mortality trends continue, 160,000 more people in England and Wales will need palliative care by 2040.
  - If access to community-based EoLC improved, £104 million could be redistributed to meet people's preferences for place of care by reducing emergency hospital admissions by 10% and the average length of stay following admission by three days.
- **Links and further reading**

  End of Life Care CCG Project Lead– Ruth Devine Ruth.Devine@northkirkleesccg.nhs.uk
  - End of Life Care STP Support Tool
  - KJSA Dying & Bereavement
  - North Kirklees End of Life Trend Analysis
    - Percentage of deaths that occur in hospital (All ages)
    - Percentage of deaths that occur in care homes (All ages)
    - Percentage of deaths that occur at home (All ages)
    - Percentage of deaths that occur in 'other places' (All ages)
    - Percentage of deaths that occur in hospice (All ages)
- **In summary, so what?**
  - PCN Pilot work is underway with PCNs across Kirklees, with developing good practice and training in partnership with Kirkwood Hospice. These pilot projects are being developed so as to be replicated across networks with localisation.

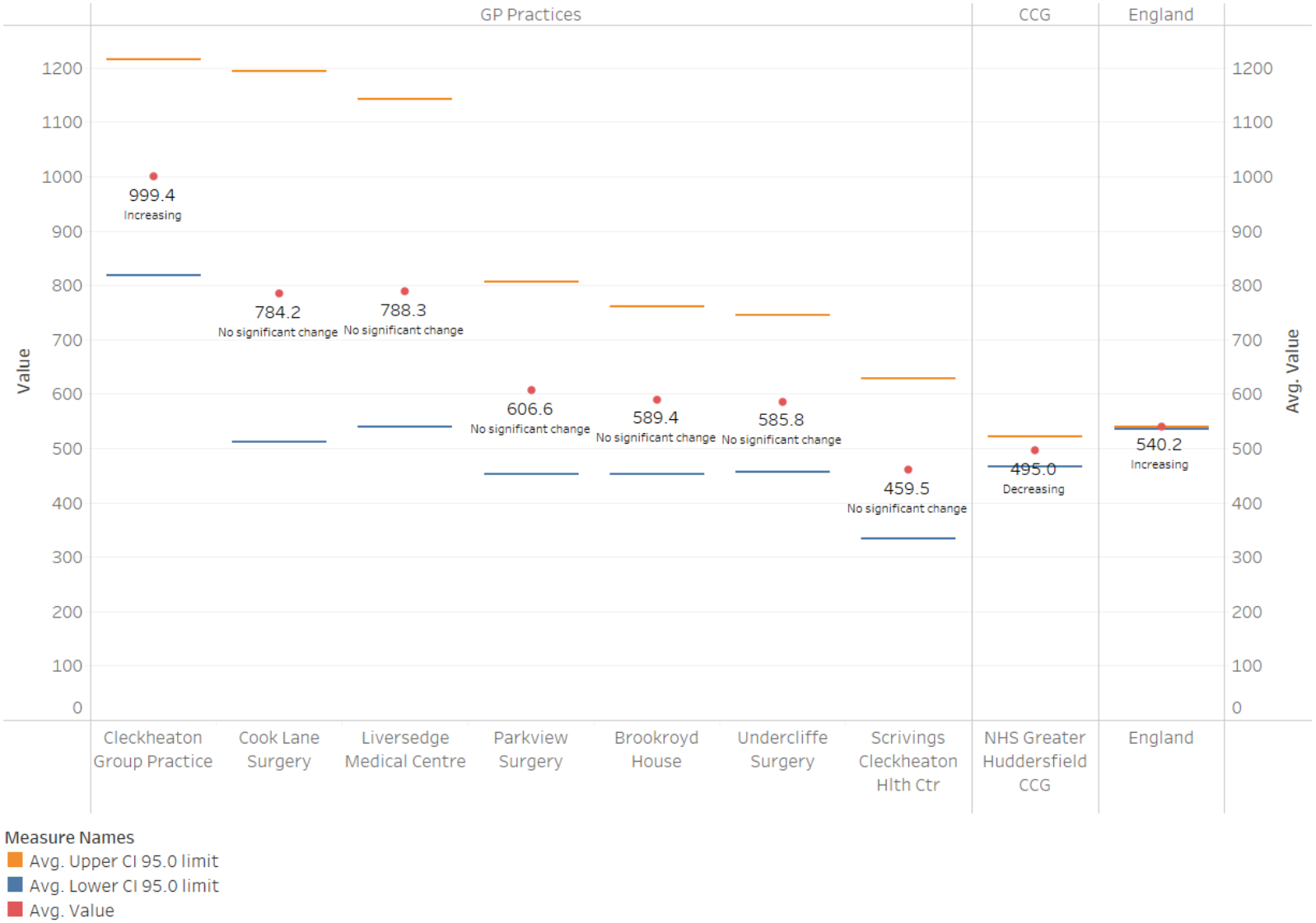
Priority 3: Cancer emergency admissions

High volumes of emergency admissions

- **Why is this a priority?**
  - Emergency admissions for cancer can mean that patients are being diagnosed too late, and as a consequence their health outcomes are likely to be poorer.
  - Coronary heart disease (CHD) and stroke, collectively cardiovascular disease (CVD), South Asians have high susceptibility to these diseases.

- **What does the data tell us?**
  - One practice (Cleckheaton) has double the CCG rate of admissions and is a statistically significant outlier. Six of seven practices have average rate higher than the CCG (although not significant).
  - In terms of trends, most practices are not changing. However Cleckheaton's high rates of activity are increasing. This is against a CCG backdrop of decreasing activity.

Emergency admissions related to cancer (per 100k people) 2017/18



Prevalence, referrals and emergency admissions

- **What does the data tell us (cont'd)?**
  - **Cleckheaton** practice does have higher cancer prevalence than other practices as well as higher 2WW referrals, but there are other practices that have either similarly high prevalence or similarly high referrals , without the associated emergency admissions.
  - **Cook Lane** has high cancer related emergency admissions, but a low recorded prevalence and 2WW referral count, suggesting that under diagnosis may be occurring. Cook Lane also saw the lowest levels of cancer screening.
  - **Liversedge** practice has similar prevalence and 2WW data to the overall CCG, but much higher emergency admissions suggesting further exploration of the drivers of this behaviour. Liversedge saw the second lowest levels of cancer screening.

Cancer 2WW referrals, cancer related emergency admissions and cancer prevalence, 2017/18

Area Type	Area Name	Prevalence	Average 2WW referrals	Emergency admissions
CCG	NHS North Kirklees CCG	2.5%	2879.8	512.7
England	England	2.7%	3262.9	540.2
GP Practices	Brookroyd House	3.1%	2698.8	589.4
	Cleckheaton Group Practice	3.3%	3554.5	999.4
	Cook Lane Surgery	2.0%	1717.7	784.2
	Liversedge Medical Centre	2.5%	2423.4	788.3
	Parkview Surgery	3.2%	3230.9	606.6
	Scrivings Cleckheaton Hlth Ctr	2.5%	2999.2	459.5
	Undercliffe Surgery	2.5%	3899.0	585.8

Cancer screening rates by site, 2019

PCN	GP Practice	Cervical Screening rate (Jun-2019)	Bowel Screening Rate (Feb-2019)	Breast Screening Rate (Feb-2019)
Spen Health and Wellbeing Network (SHAWN)	Parkview Surgery	80.8%	Not publicly available at GP practice level for 2019 – older data available via national GP profiles	
	Undercliffe Surgery	77.1%		
	Brookroyd House Surgery	77.8%		
	Cleckheaton Group Practice	78.3%		
	The Greenway Medical Practice	77.3%		
	Liversedge Medical Centre	70.8%		
	Cook Lane (Albion Street) Surgery	65.1%		

Opportunities

- **What can be done?**
  - 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
  - Speeding up diagnosis - cancer or otherwise - for those patients who present with vague but concerning symptoms.

- **What could this mean?**
  - Currently, 40% of cancers are diagnosed at curative stage - i.e. stages 1 and 2. If we achieved - for lung and colorectal cancer alone - the stage at diagnosis currently achieved by the best CCG in England, an additional 156 people would survive their cancer diagnosis for at least one year.

- **Links and further reading**
  - Early Diagnosis - West Yorkshire & Harrogate Cancer Alliance, KJSA re Cancer, Optimal Pathways - West Yorkshire & Harrogate Cancer Alliance, Trend re number of emergency admissions with cancer (Number per 100,000 population)
  - https://www.sahf.org.uk/our-work - South Asian Health Foundation (SAHF) is a registered charity founded in 1999 to promote good health in the UK's South Asian communities. The website provides examples and potential resources

Priority 4: Obesity prevalence

Obesity prevalence is high in some practices

- **Why is this a priority?**
  - Obesity is a risk factor for diabetes, cardiovascular disease (including heart attacks and stroke) and some cancers, so rising levels of obesity are a key concern. Less than half of the local working age population are a healthy weight (42%). Overweight and obesity levels locally are similar to the Kirklees average amongst working age adults overall and women of childbearing age. The proportion of people who are overweight has increased locally and in Kirklees overall since 2012. Whilst almost one in four (23%) working age adults in the area are obese, obesity rates are highest amongst older adults with almost one in three (29%) 55-64-year olds being obese.

- **What does the data tell us?**
  - Two practices have statistically higher obesity prevalence than the CCG. Four of seven practices have average rate higher than the CCG (although not significant).
  - All but one practice have statistically higher prevalence than the English average.
  - Cleckheaton practice is significantly lower than the other practices and the CCG/English averages.

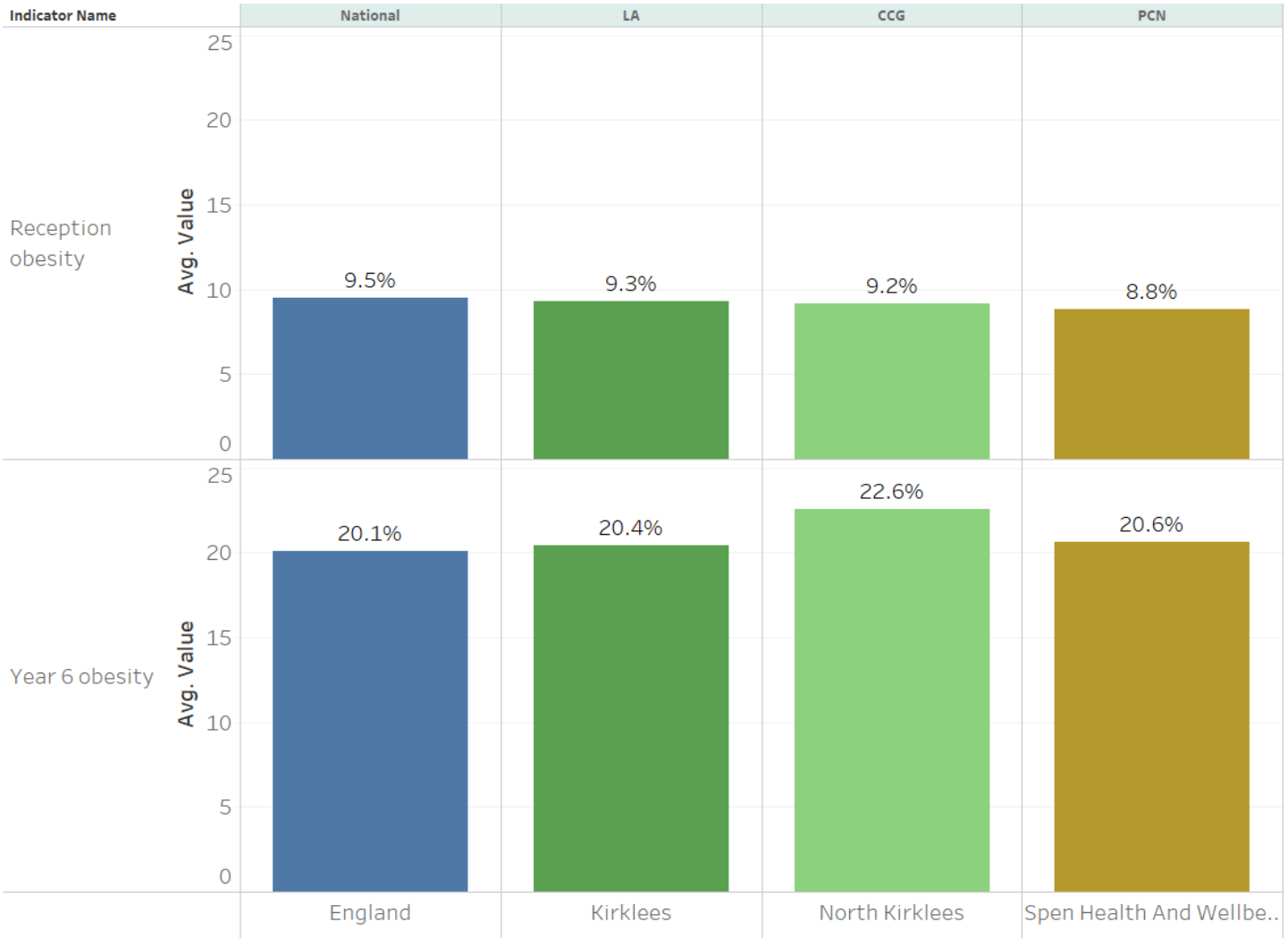
Obesity prevalence 2017/18

Relatively low prevalence in child obesity

- **What does the data tell us (cont'd)?**
  - Reception and Year 6 (last year of primary school) child obesity is lower than CCG average suggesting that obesity is not exclusively starting in early life.

- A life course perspective can increase our understanding of obesity. There is now strong evidence that pre -and early life factors are involved in the development of obesity, and that it begins early in life.

Reception and Year 6 obesity prevalence 2017/18



Opportunities

- **What can be done?**
  - Innovative approaches to education and raising awareness are needed to motivate the target groups.
  - Key partners and service planners should maximise opportunities to deliver key messages to encourage the public to take personal action and highlight the effective help available to support them.
  - These include national campaigns such as the Change4Life movement and local initiatives such as the Healthyweight Kirklees website and network which provide advice, support and links to local services.
  - **An Integrated Wellness Model (IWM)** is being implemented in Kirklees, to be launched September 2019. If you need further information about the new service, please contact the Service Lead, Patrick Boosey – Patrick.boosey@kirklees.gov.uk

- **What could this mean?**
  - Reduction in obesity prevalence will mitigate pressures on diabetes, cardiovascular and cancer services in the areas and facilitate improved mental health measures for the region.

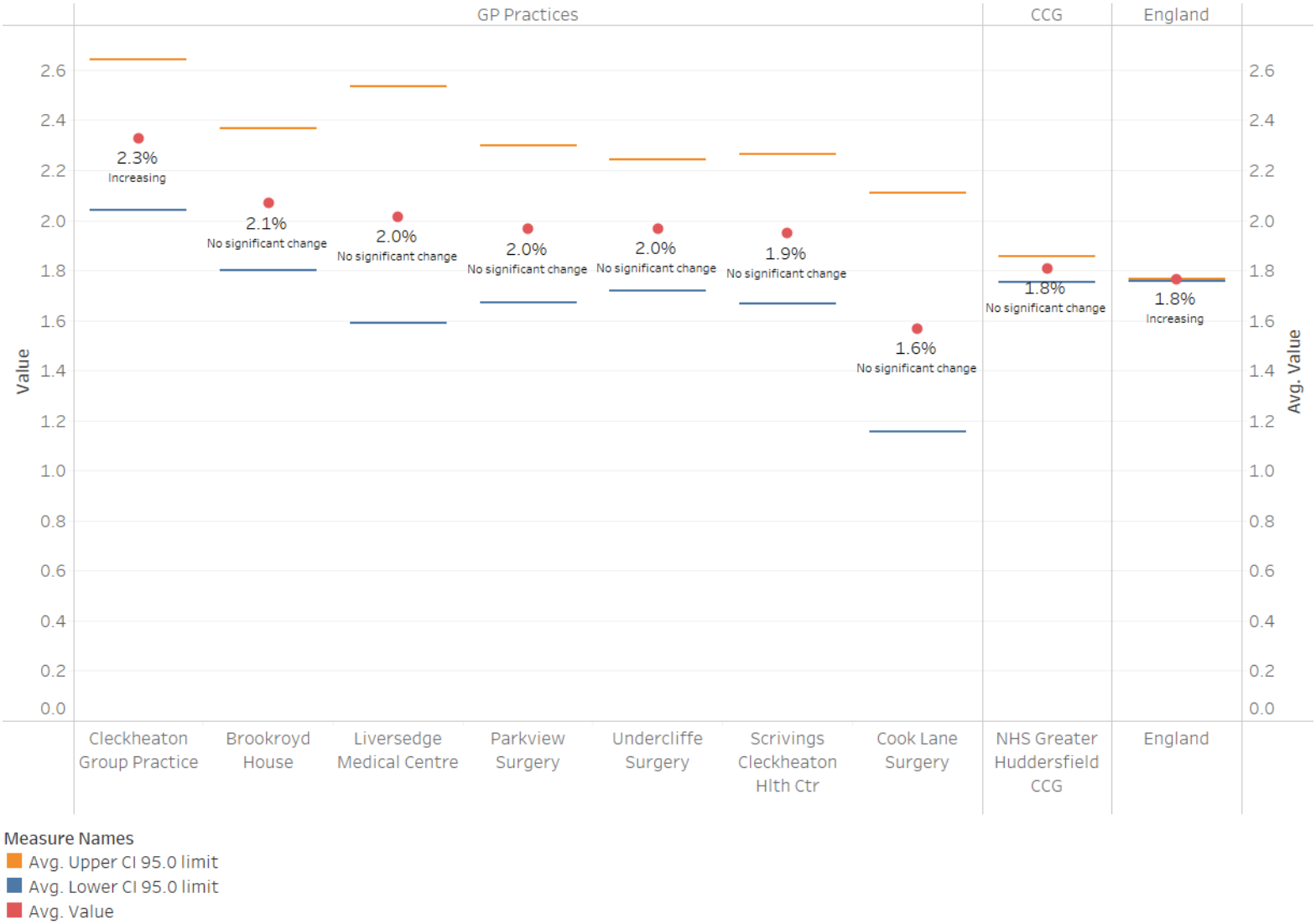
- **Links and further reading**
  - KJSA re Obesity
  - Link to supporting data
  - Government publication, "Healthy lives, healthy people: a call to action on obesity in England
  - North Kirklees Obesity Prevalence trend re Obesity: QOF prevalence (18+)
  - Kirklees Wellness Service Update Communications

Priority 5: Stroke prevalence

Prevalence and stroke rate

- **Why is this a priority?**
  - Structured clinical audit by experienced clinicians can support primary care to identify, review and where appropriate intervene to ensure quality care for all.
  - Safe and effective management of stroke prevention in atrial fibrillation NICE Programme
- **What does the data tell us?**
  - Two practices have statistically higher stroke prevalence than the CCG. Six of seven practices have average rate higher than the CCG (although not significant).
  - No significant changes were seen in all practices apart from Cleckheaton.
  - The difference between a stroke rate of 1.7% and 2% across the whole PCN is c. 2000 strokes.
  - Records of antiplatelet or anti-coagulant use are universally high.

Stroke prevalence, 2017/18



Stroke prevalence

- **What does the data tell us (cont'd)?**
  - Looking at available metrics of stroke management (blood pressure reading) and medicine use, most practices are managing their patients within the normal when compared to CCG average.
  - Improvements can be made across some practices around blood pressure for 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.
  - 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.

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

% of patients with Atrial Fibrillation who are on anticoagulation	71%	85%	81%	74%	79%	89%	74%

Opportunities

- **What can be done?**
  - Adoption of best practice approach to help identify and improve the management of patients with AF.
  - Examine the level of variation in detection rates between network practices.
  - Support practices to audit and improve case finding using local solutions as developed in Bradford for example, or off the shelf tools such as GRASP-AF.
  - Add pulse checking to local enhanced service specifications where appropriate.
  - **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?**
  - Almost a quarter of people with AF are undiagnosed. They are therefore untreated and at a high risk of premature death and disability.

- **Links and further reading**
  - North Kirklees Stroke Prevalence
  - Stroke or TIA in whom the last blood pressure reading (last 12 months) is 150/90 mmHg or less.
  - Record that an anti-platelet agent or an anti-coagulant is taken
  - New stroke patients referred for further investigation
  - North Kirklees CCG CVD intelligence pack
  - West Yorkshire & Harrogate Healthy Hearts
  - https://www.nice.org.uk/sharedlearning/safe-and-effective-management-of-stroke-prevention-in-atrial-fibrillation

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, Kirklees Council Public Health team and the CCG Primary Care team

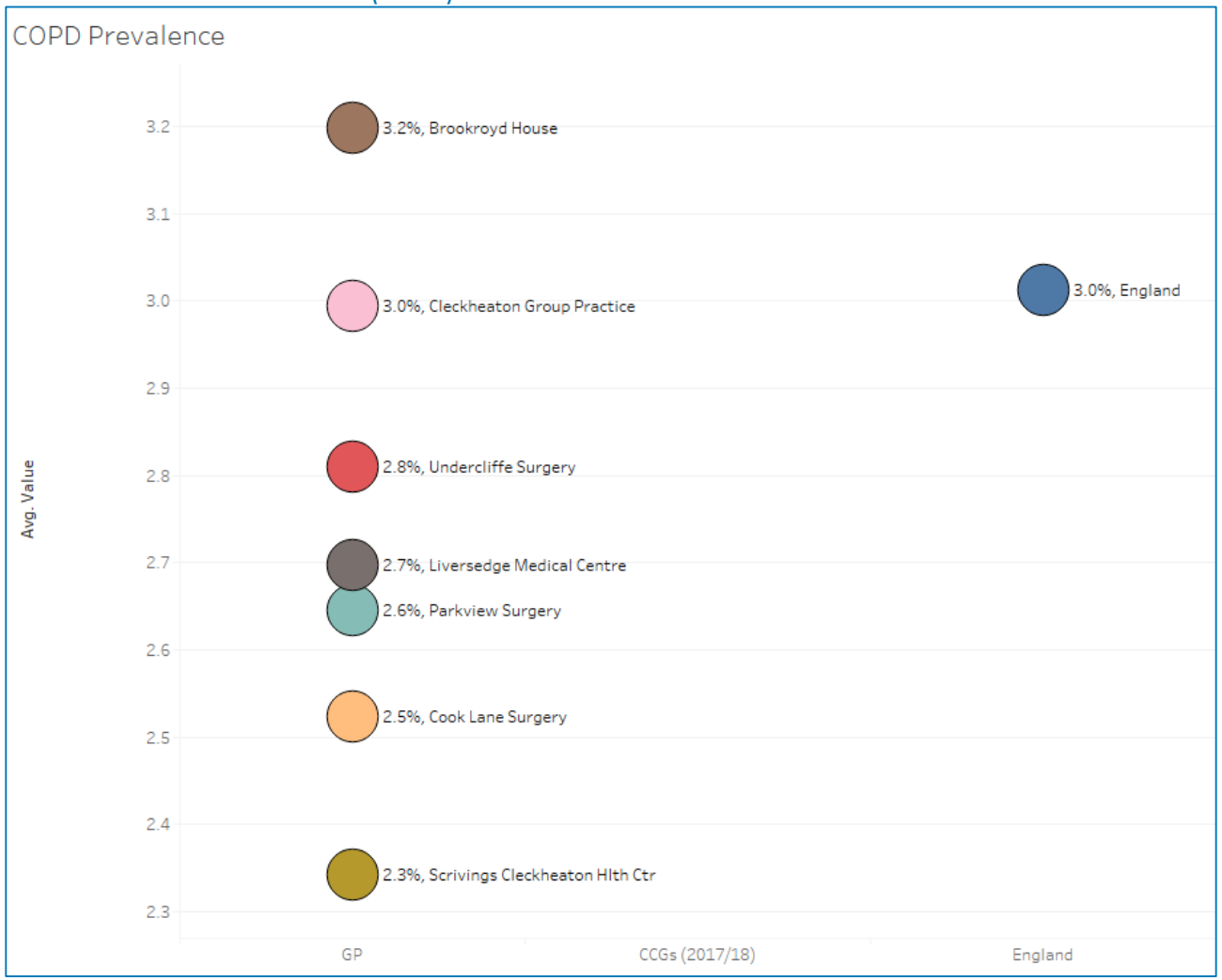
They represent a start on the journey towards Population Health Management in Kirklees and it is recognised that these tools will continue to develop in line with the PHM system and as the PCNs mature.

Chart Contents

(List of chart contents & links in alphabetical order)

COPD prevalence

COPD Prevalence (2015)



- 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%.
- Five of the seven practices have COPD prevalence rates lower than the national average.
- Link to Supporting Data

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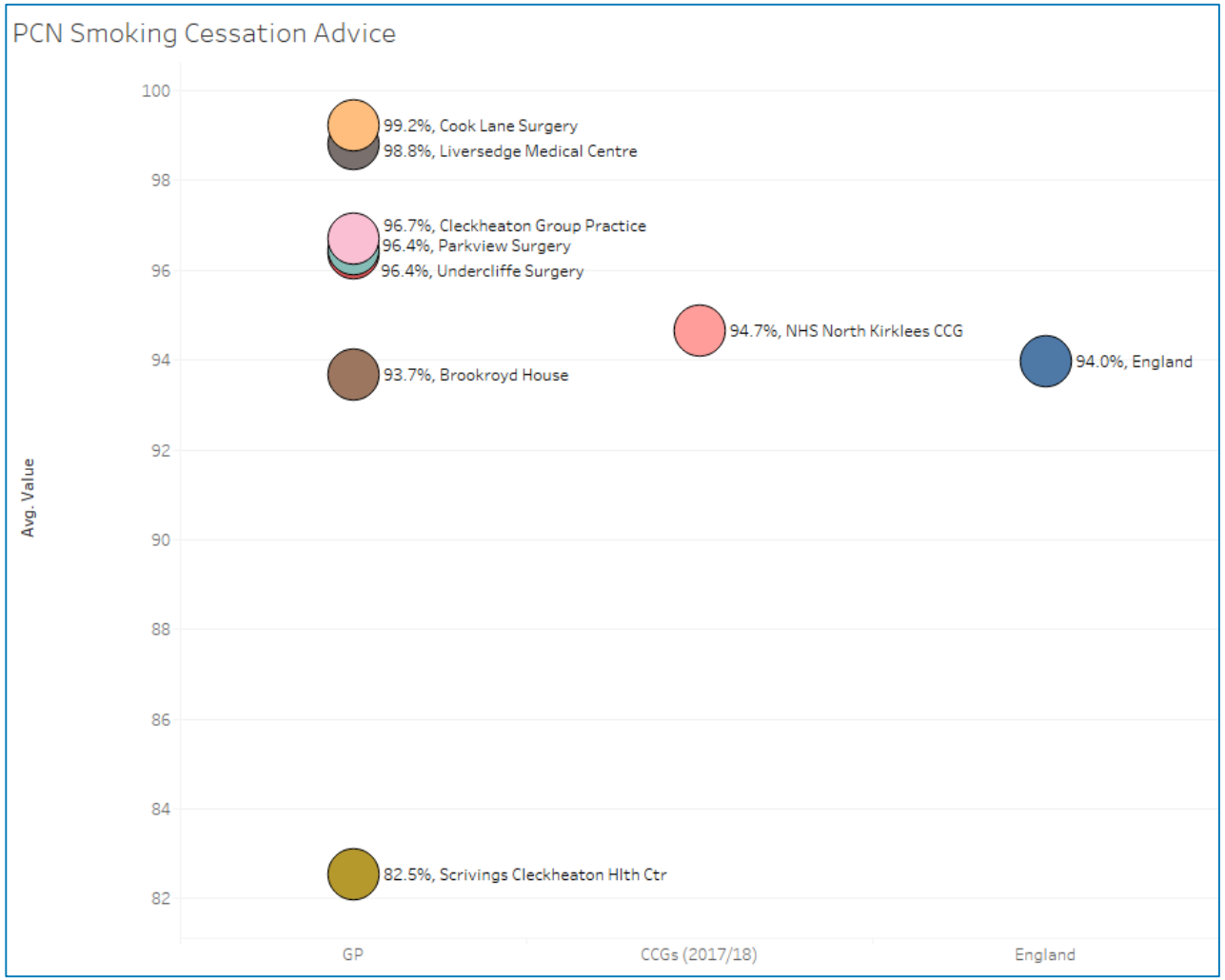
Smoking Cessation

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%.
- The Smoking Cessation Advice percentage for NHS North Kirklees is 94.7%.
- The Scrivings Practice is significantly below the national and regional average measures.
- Links to Supporting Data

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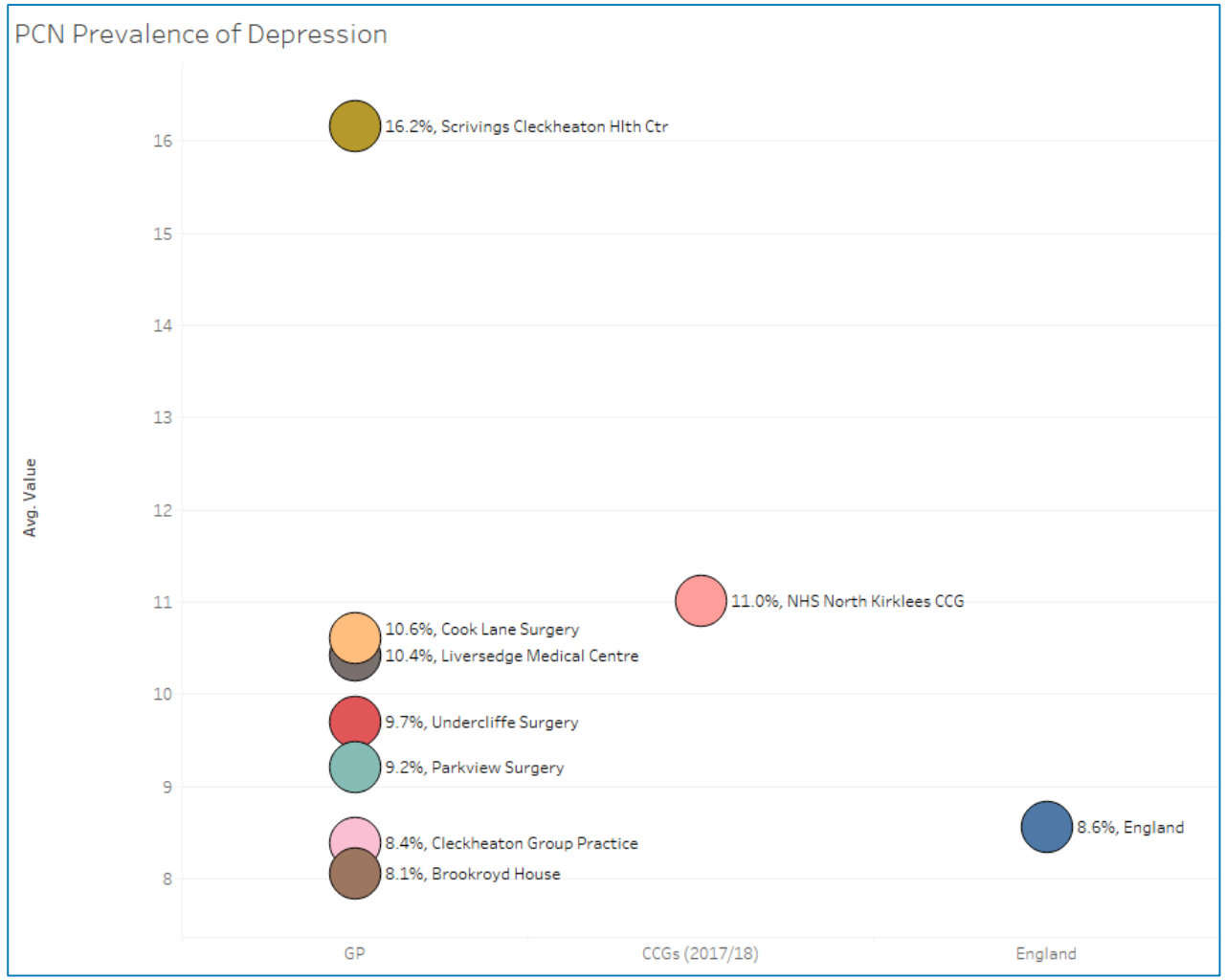
Depression

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 8.6%.
- The Depression Prevalence percentage for NHS North Kirklees is 11.0%.
- Only the Scrivings Practice has prevalence rates above the national and regional average measures.
- Link to Supporting Data

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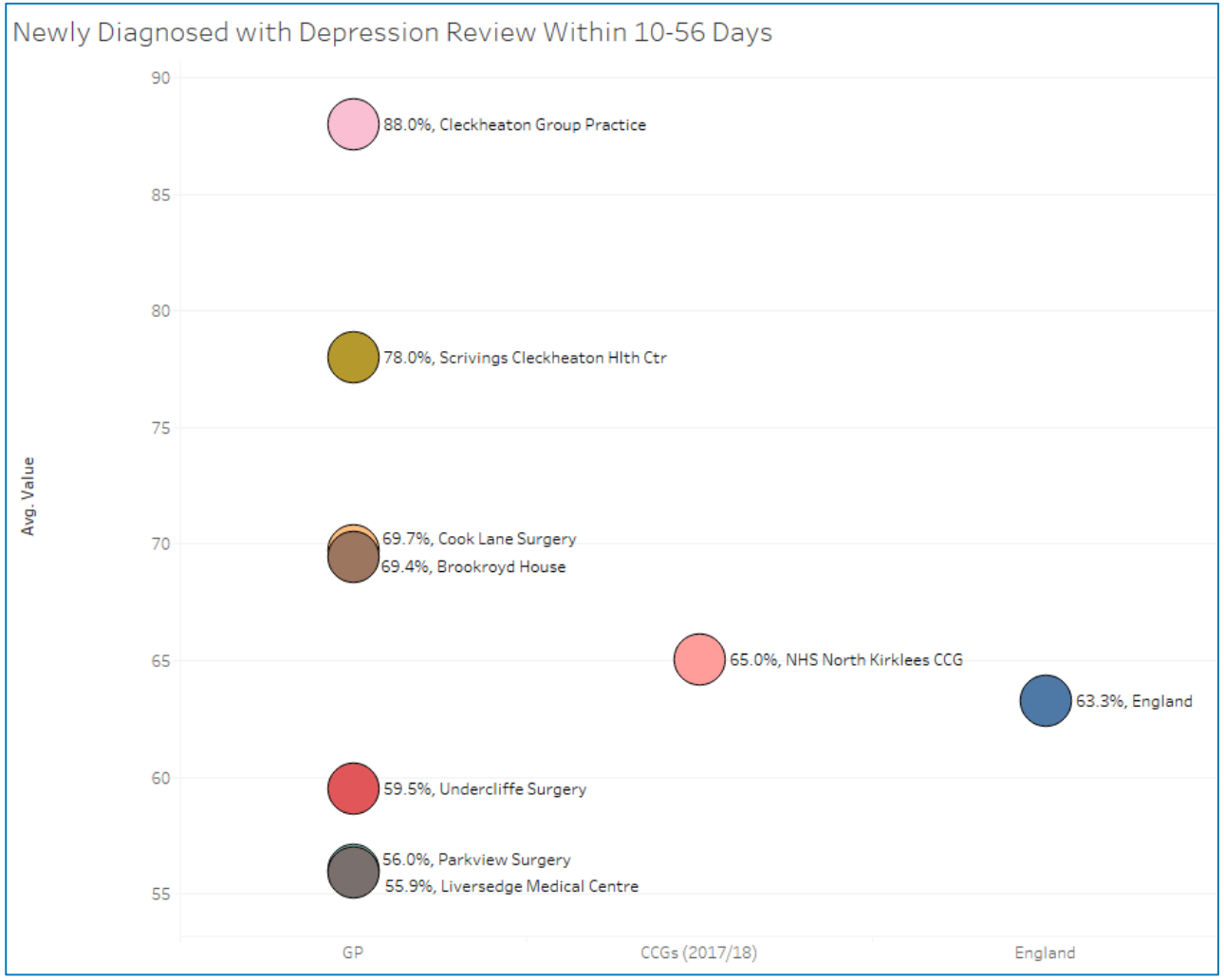
Depression Review within 10-56 Days

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 63.3%.
- The Newly Diagnosed with Depression Review within 10-56 Days percentage for NHS North Kirklees is 65.0%.
- Three of the seven practices fall below the national and regional average position.
- 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 3.2%.
- The CHD prevalence figure for NHS North Kirklees is 3.6%.
- Five of the seven PCN practices have CHD prevalence measures above the national and regional averages.
- Link to Supporting Data

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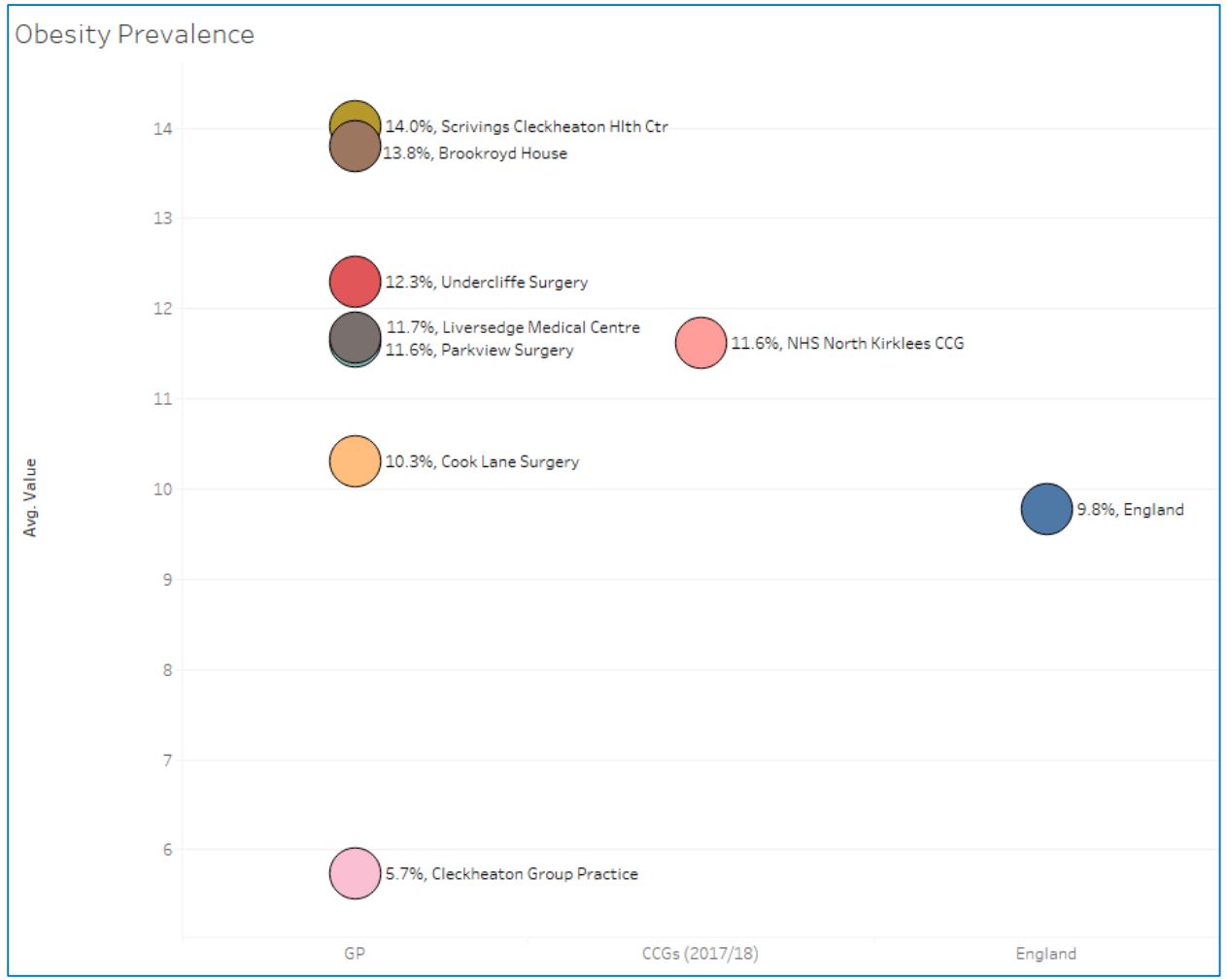
Obesity Prevalence

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 North Kirklees is 11.6%.
- Four of the seven practices have obesity prevalence rates above the national and regional measures.
- Link to Supporting Data

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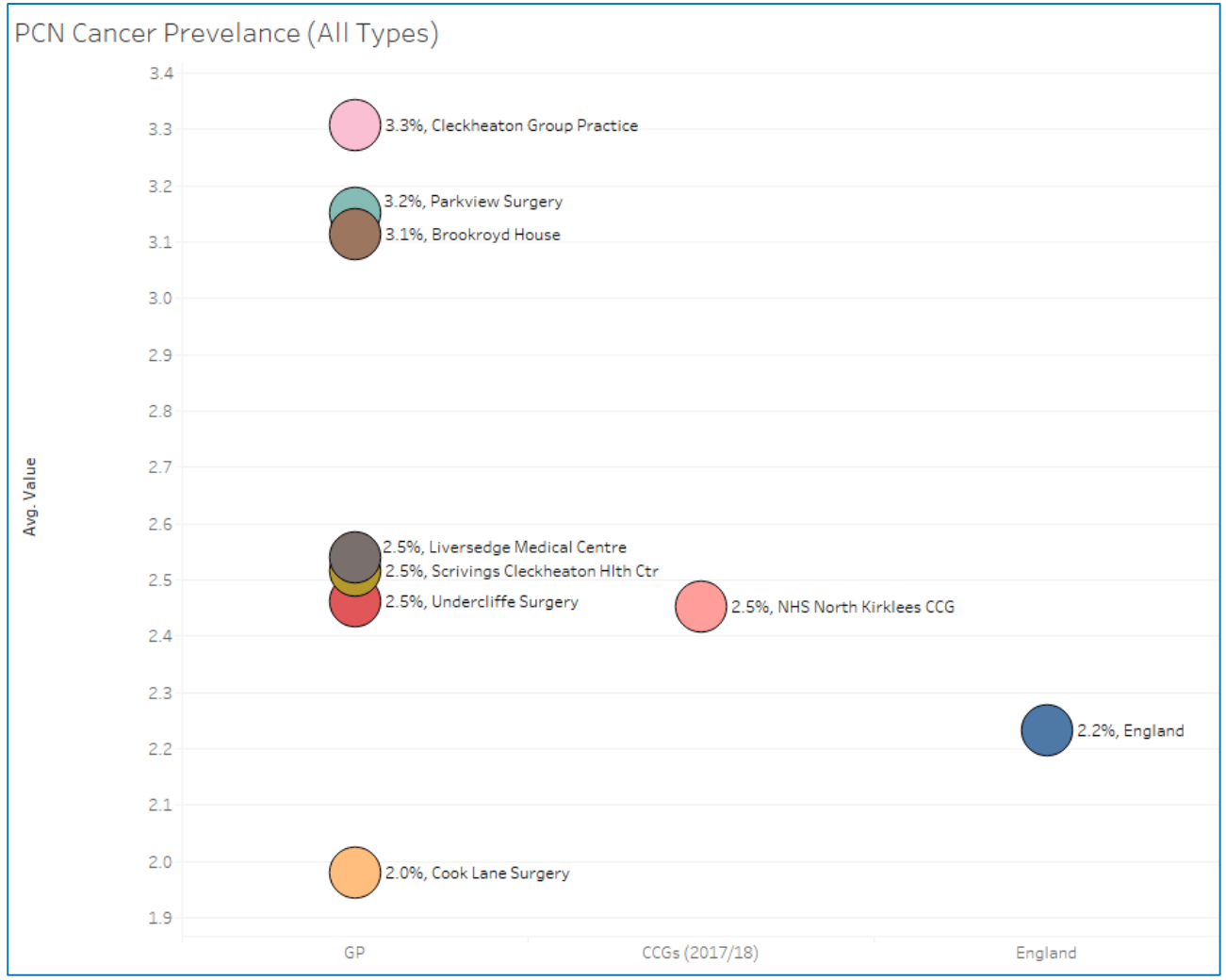
PCN Cancer Prevalence

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 2.2%
- The cancer prevalence percentage for NHS North Kirklees is 2.5%.
- Six of the seven practices have prevalence rates above the national and regional measures.
- Only Cook Lane Surgery is lower than the national and regional measures.
- Link to Supporting Data

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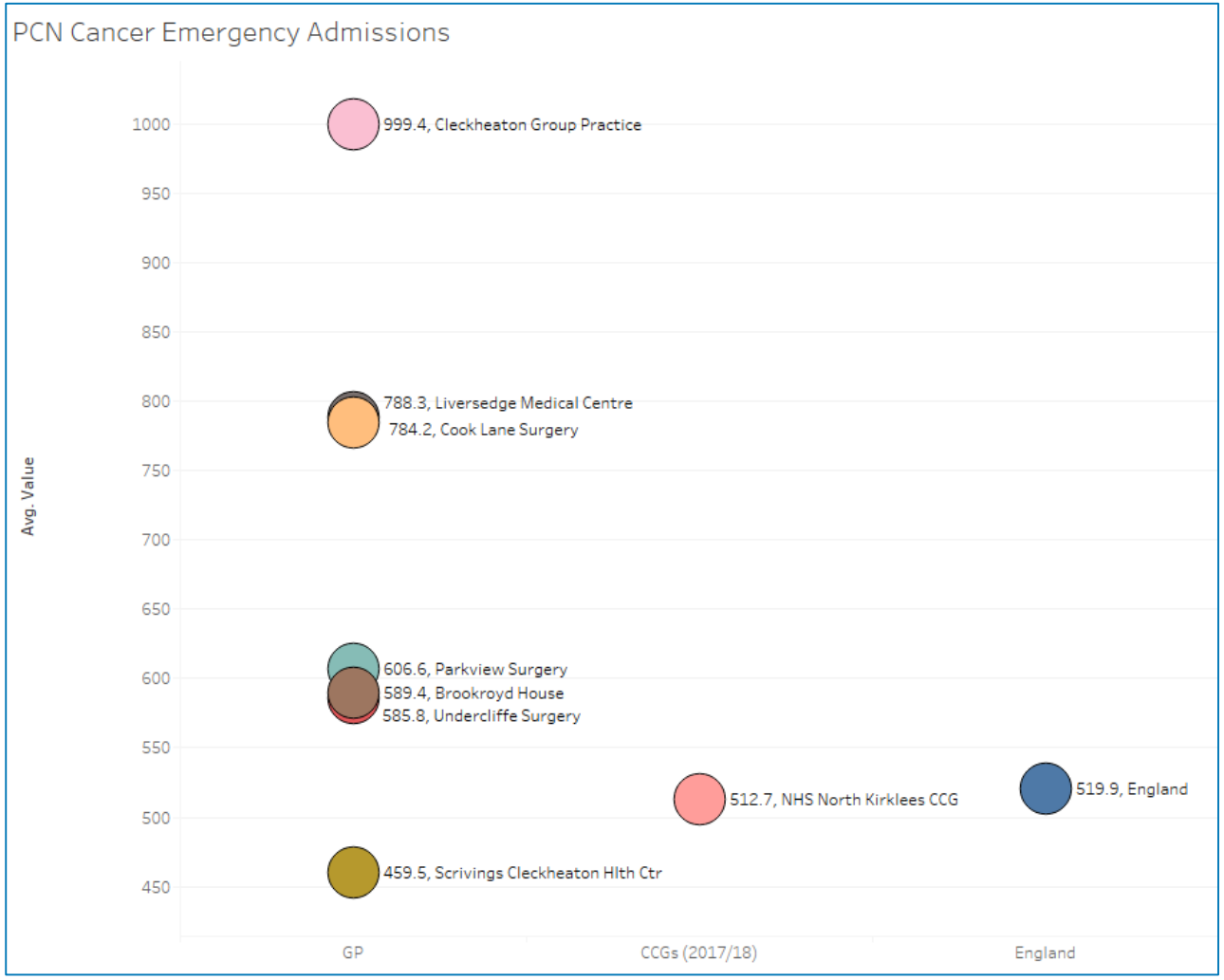
PCN Cancer Emergency Admissions

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 519.8
- The cancer emergency admissions rate figure for NHS North Kirklees is 512.7
- Six out of the seven practices are above both regional and national measures. Only Scrivings Health Centre is lower than regional and national measures.
- Link to Supporting Data

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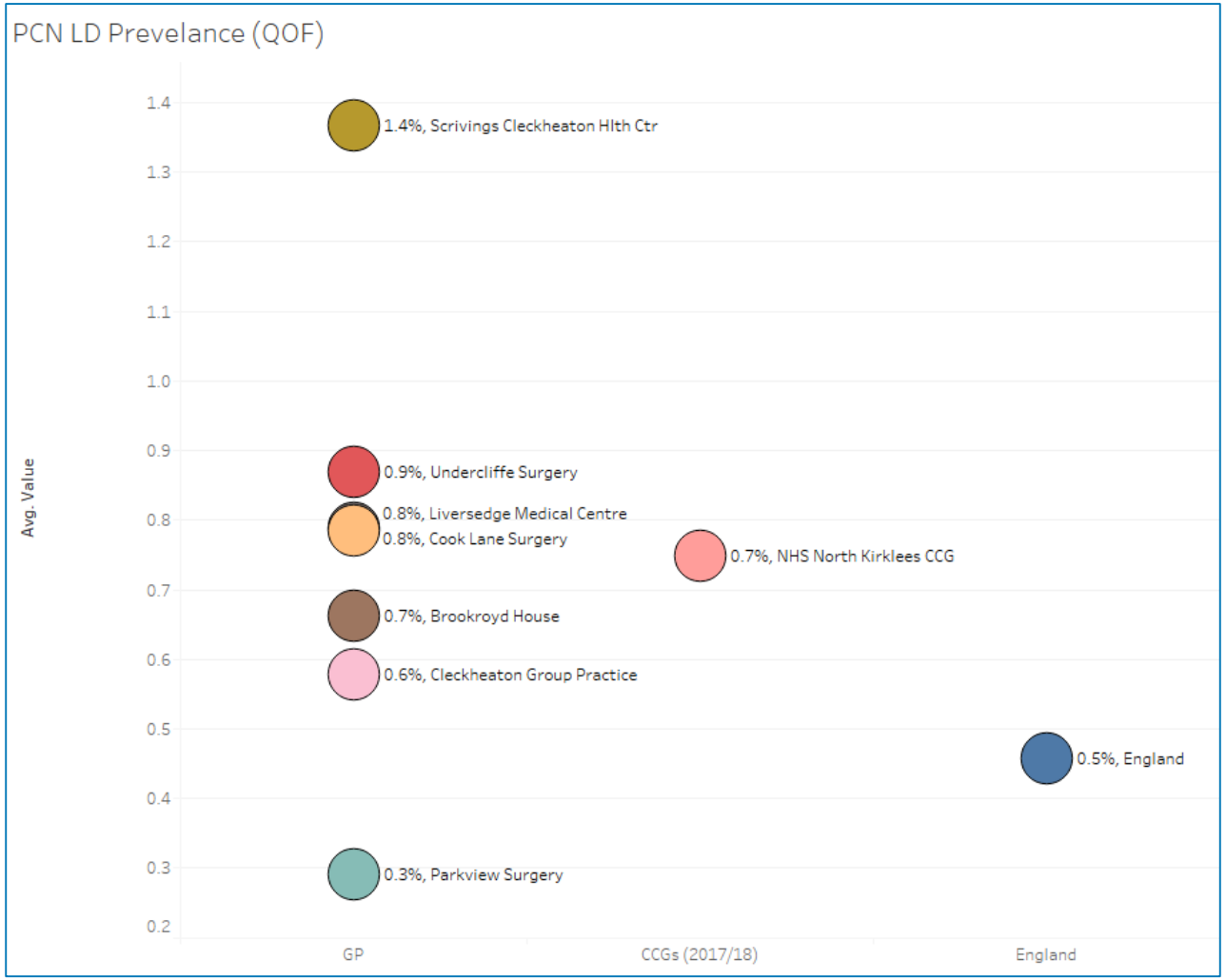
PCN Learning Difficulty Prevalence

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 North Kirklees is 0.7%.
- Four of the seven PCN practices have LD prevalence rates above the regional and national measures.
- Only Parkview Surgery has LD prevalence rates below both the regional and national measures.
- Link to Supporting Data

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PCN % People on Palliative Care Register

PCN % People on Palliative Care Register (2017-18)

- The chart represents the percentage of patients in need of palliative care/support, as recorded on practice disease registers, irrespective of age.
- The percentage of people on the palliative care register for England is 0.3%
- The percentage of people on the palliative care register for NHS North Kirklees is 0.4%.
- Four of the seven practices are above the regional and national measures.
- Only Parkview Surgery measures below both the regional and national percentages.
- Link to Supporting Data

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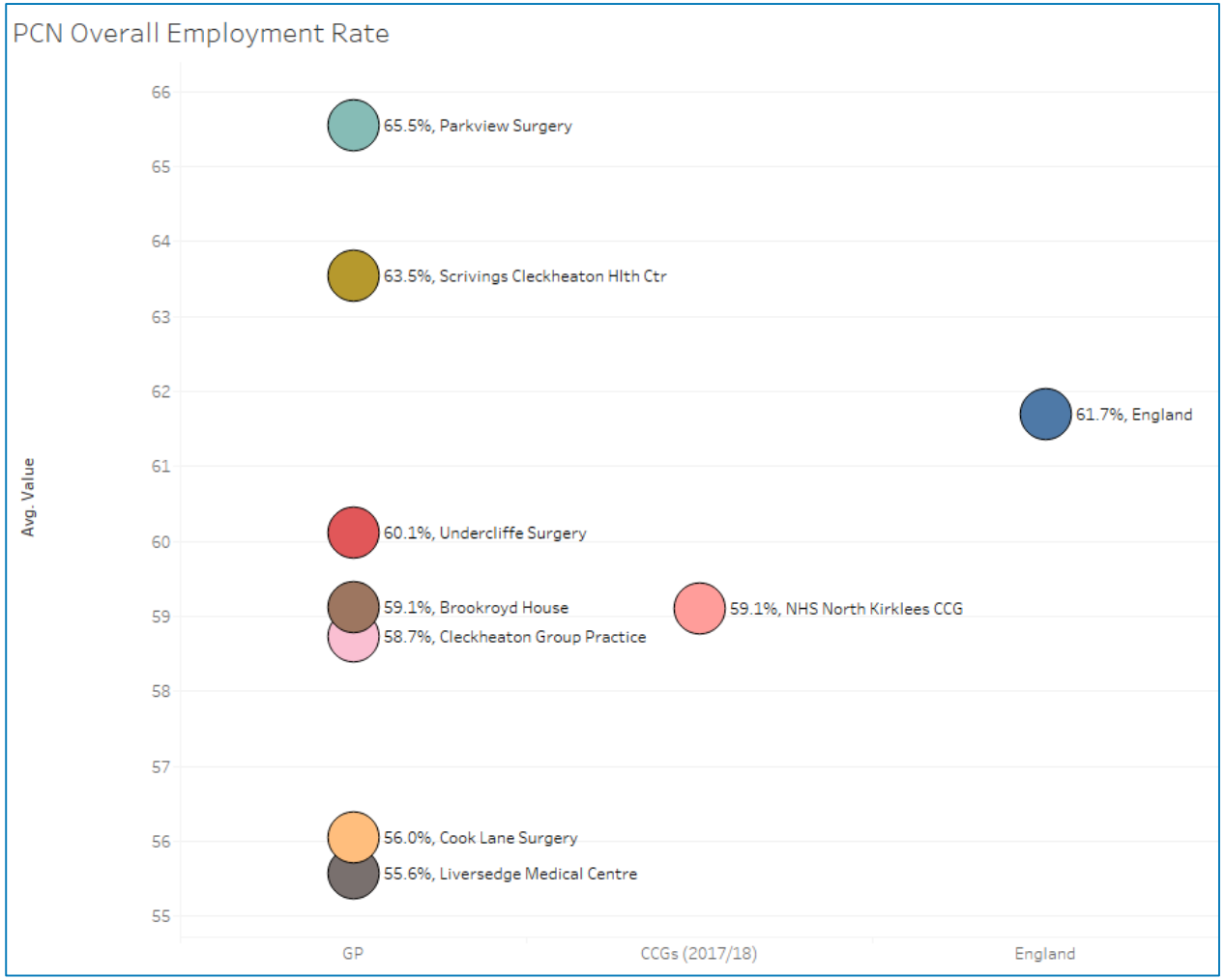
PCN Overall Employment Rate

PCN Overall Employment Rate (2018)



- 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 61.7%
- The percentage with a full-time working status for NHS North Kirklees is 59.1%.
- Three of the seven PCN practices are showing figures below national and regional levels.
- Link to Supporting Data

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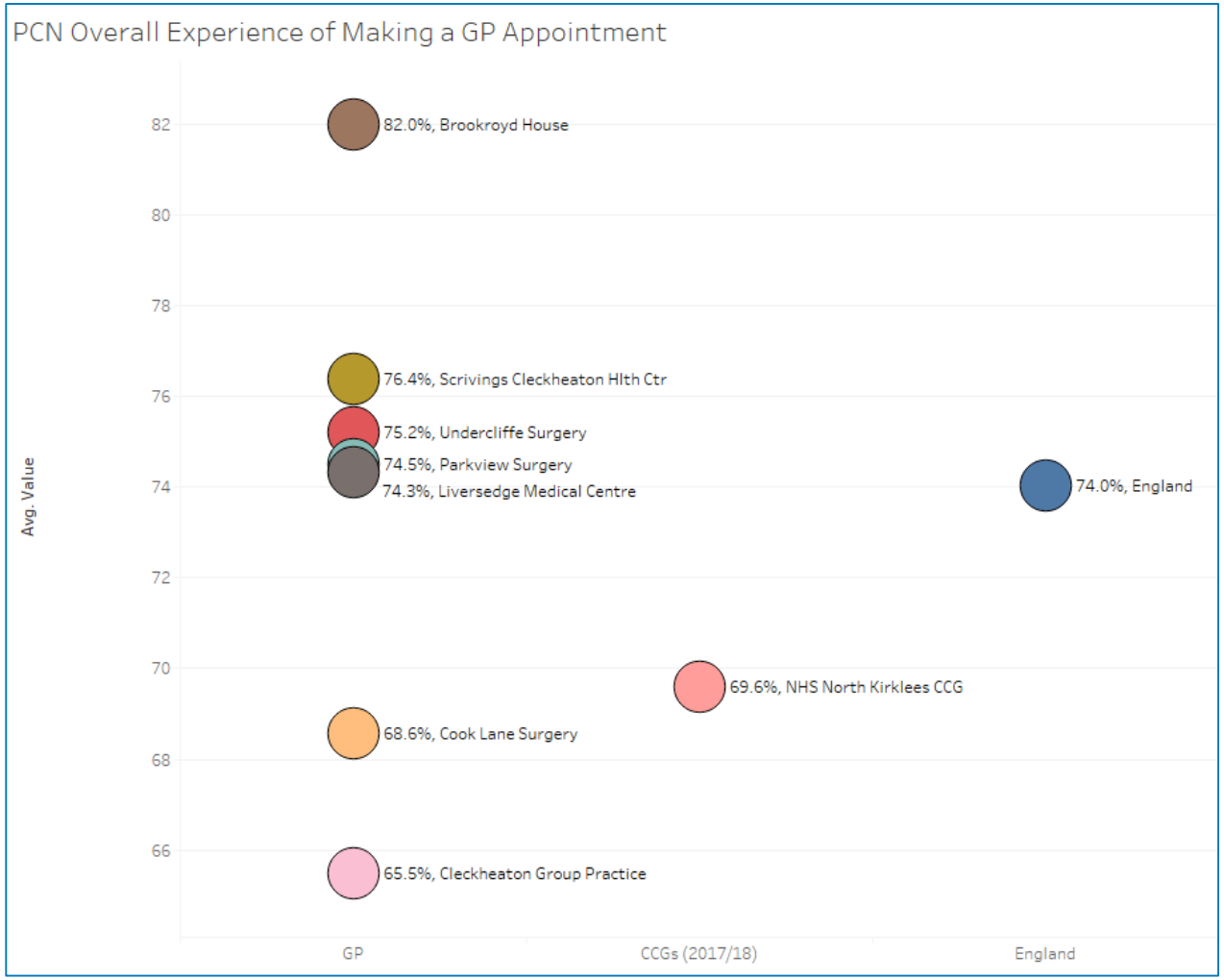
PCN Overall Experience of Making a GP Appointment

PCN Overall Experience of Making a GP Appointment (2018)



- The chart represents the response to the question: "Overall, how would you describe your experience of making an appointment?".
- The indicator value is the percentage of people who answered this question with either "Very good" or "Fairly good" from all respondents to this question.
- The percentage with a positive experience in England is 74.0%
- The percentage with a positive experience in NHS North Kirklees is 69.6%.
- The Cleckheaton Group Practice has the lowest level response with only 65.6% describing their experience as Very good" or "Fairly good".
- Link to Supporting Data

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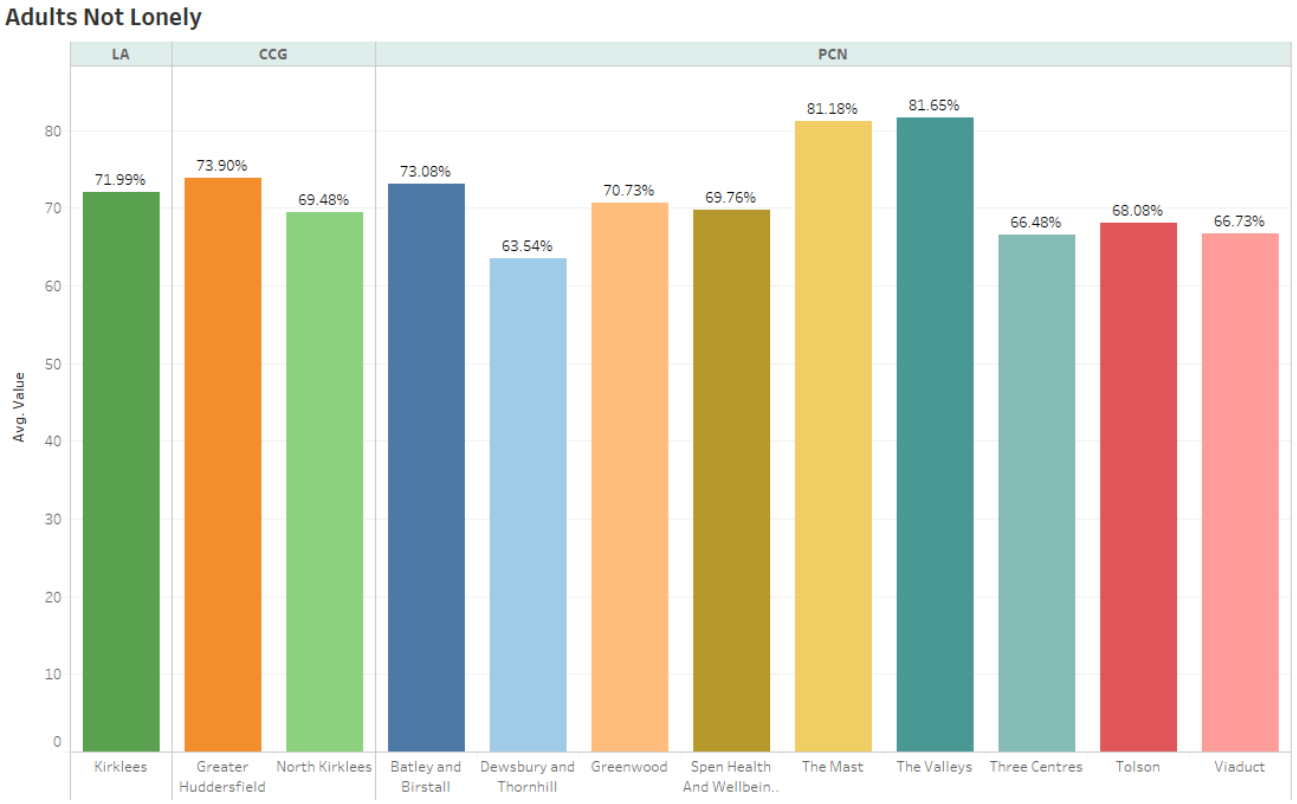
Adults Not Lonely

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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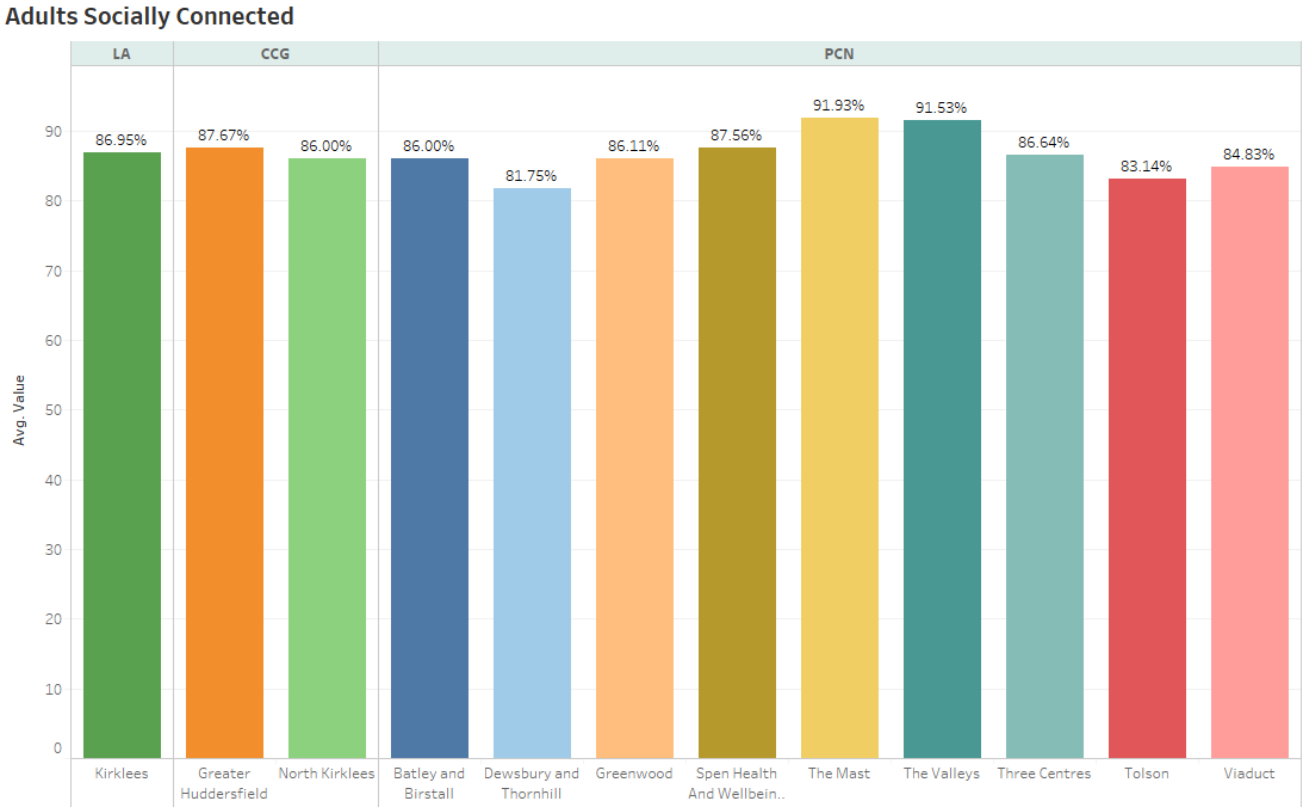
Adults Socially Connected

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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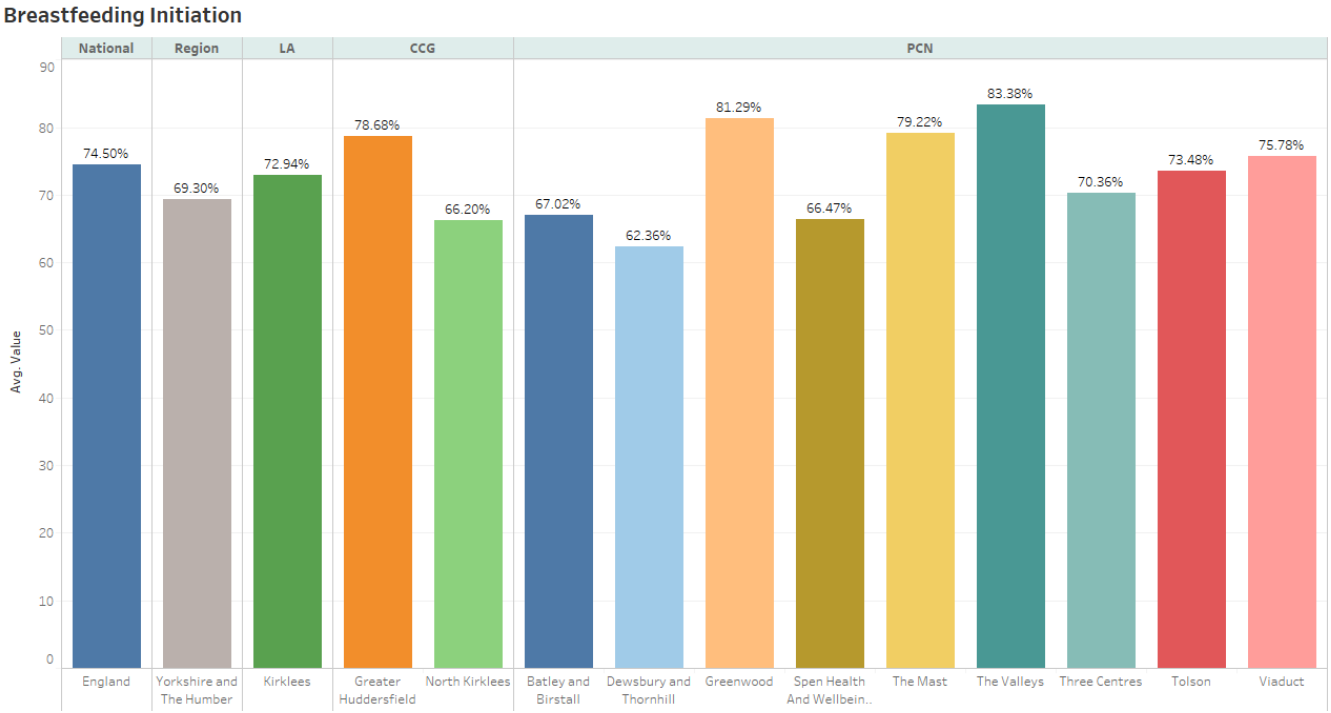
Breastfeeding Initiation

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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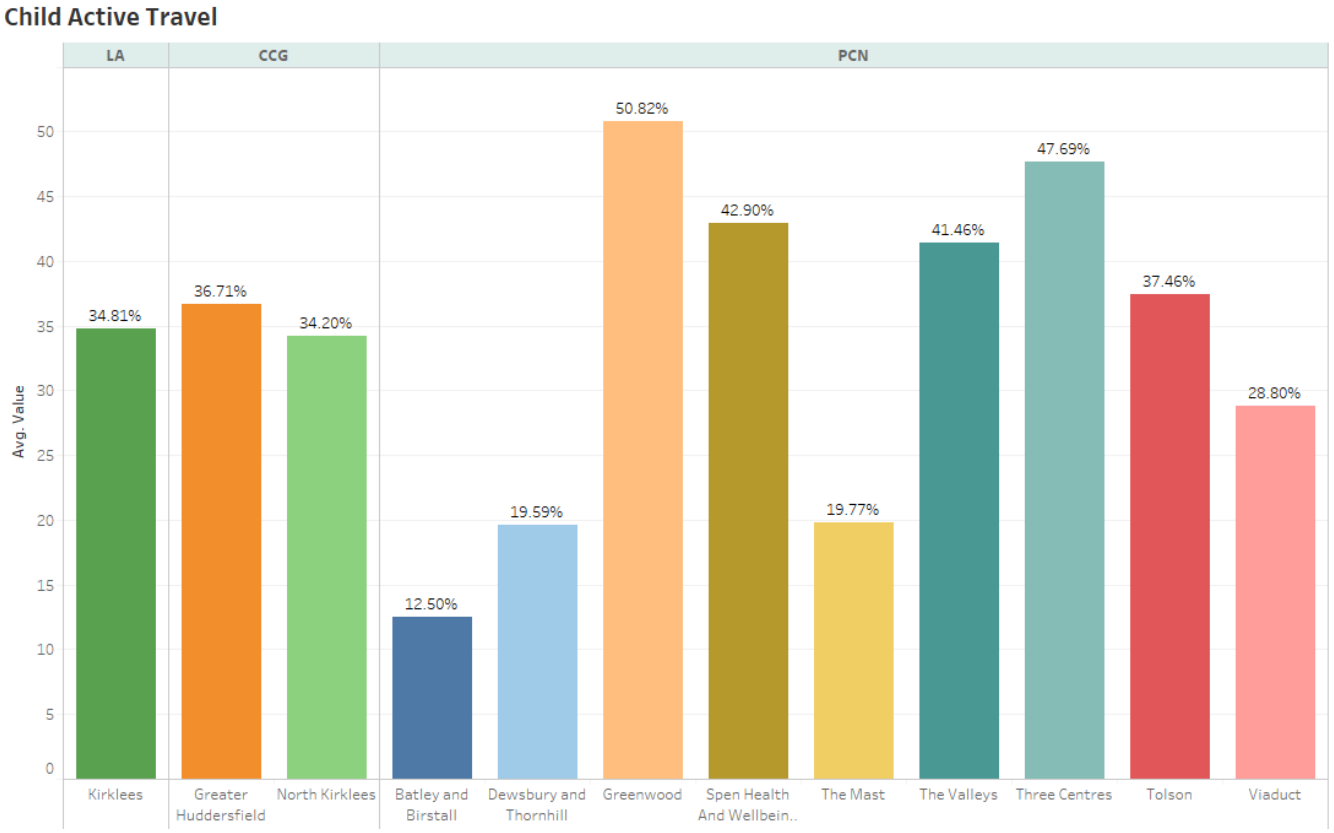
Child Active Travel

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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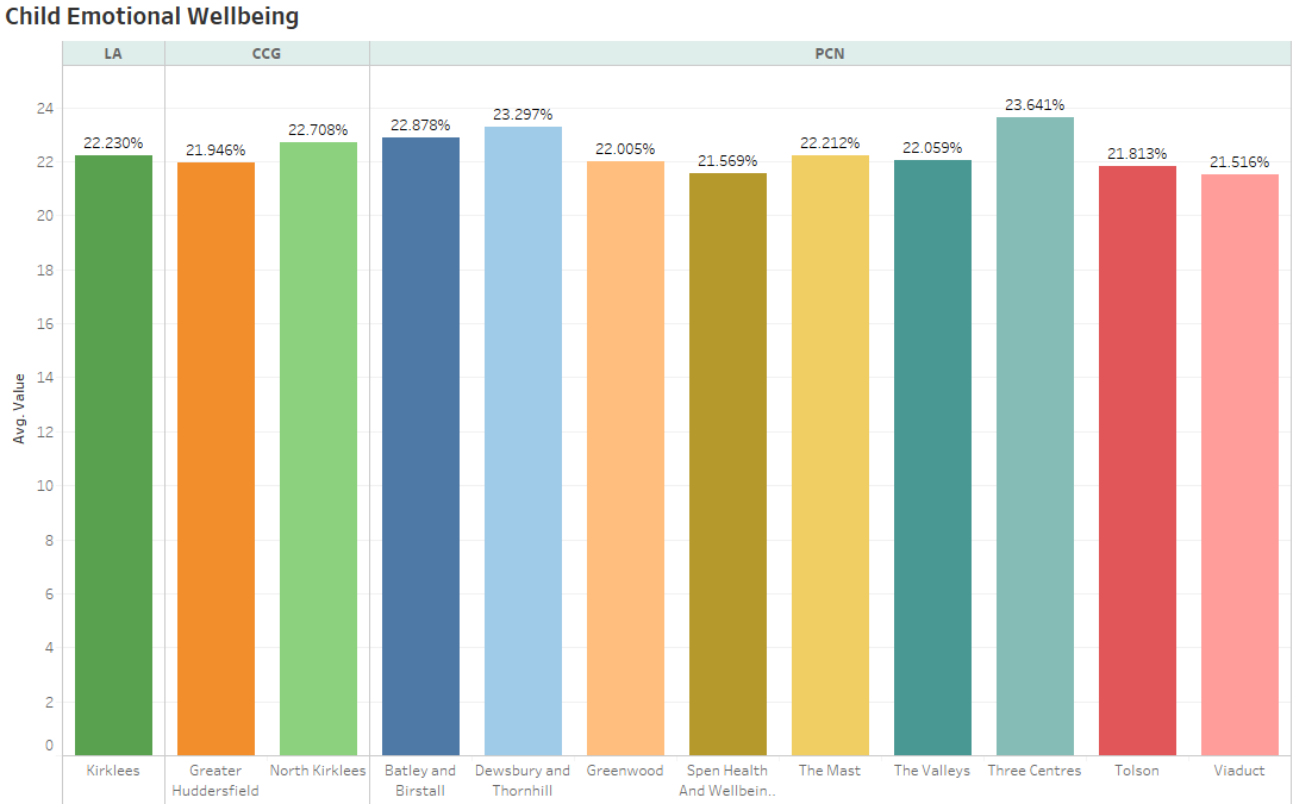
Child Emotional Wellbeing

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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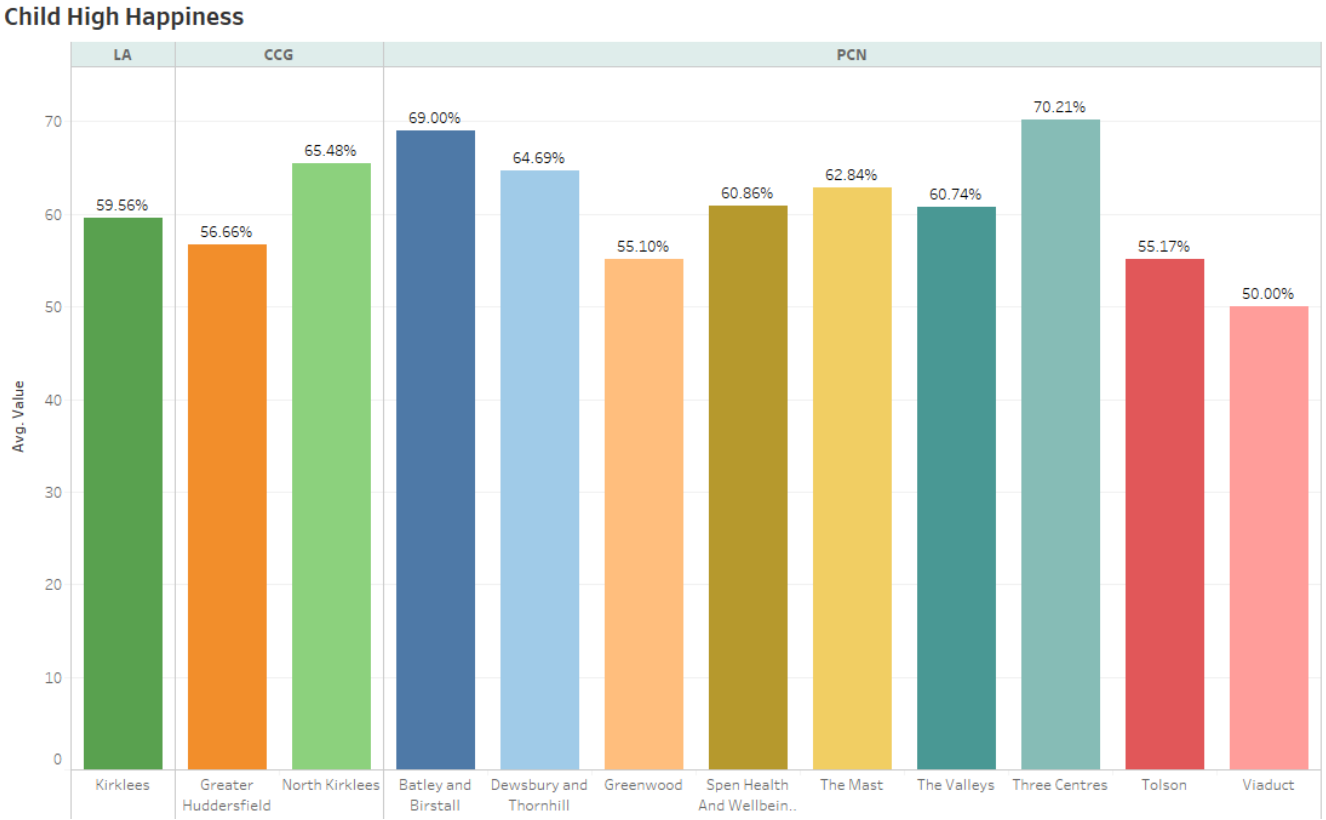
Child High Happiness

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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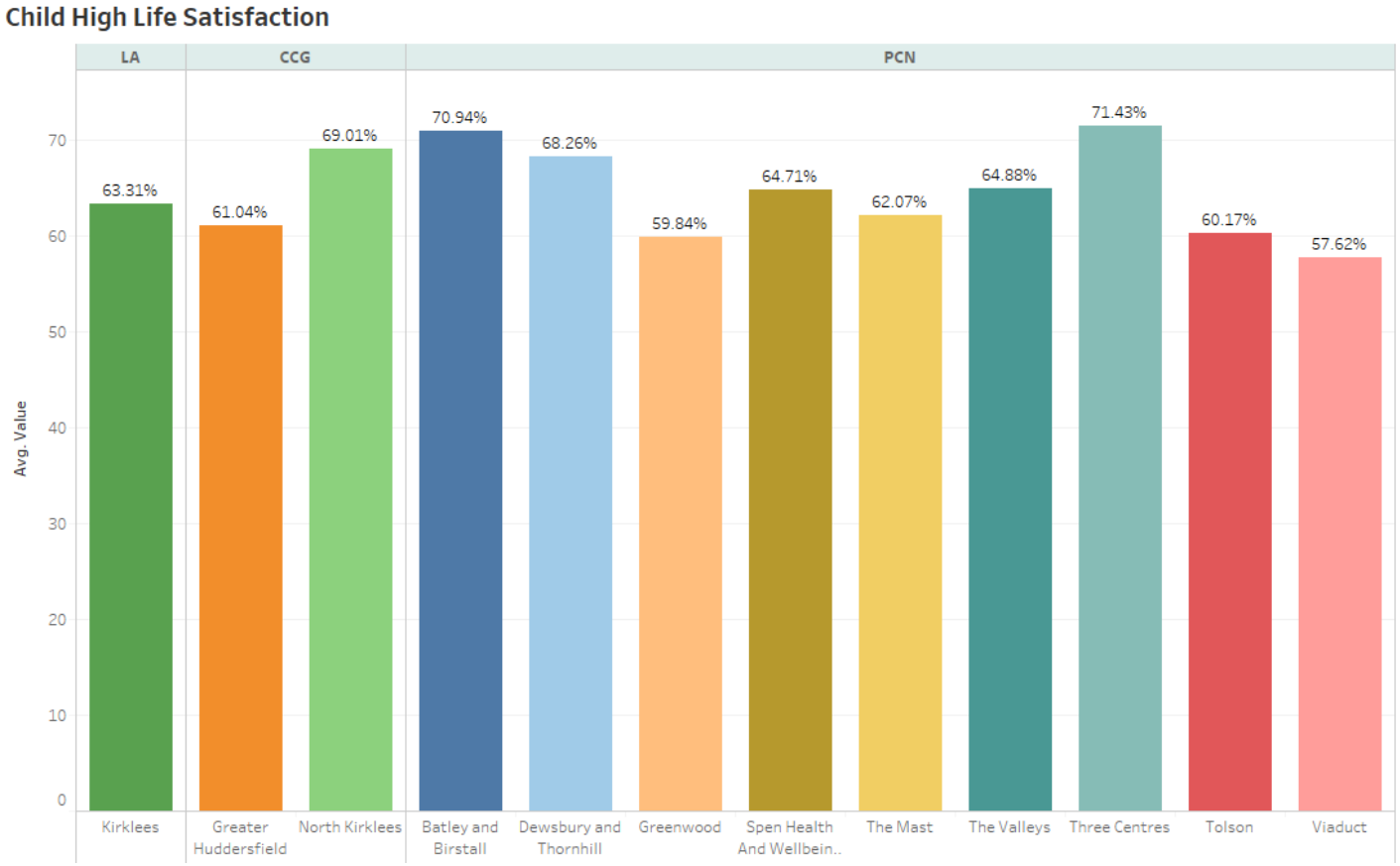
Child High Life Satisfaction

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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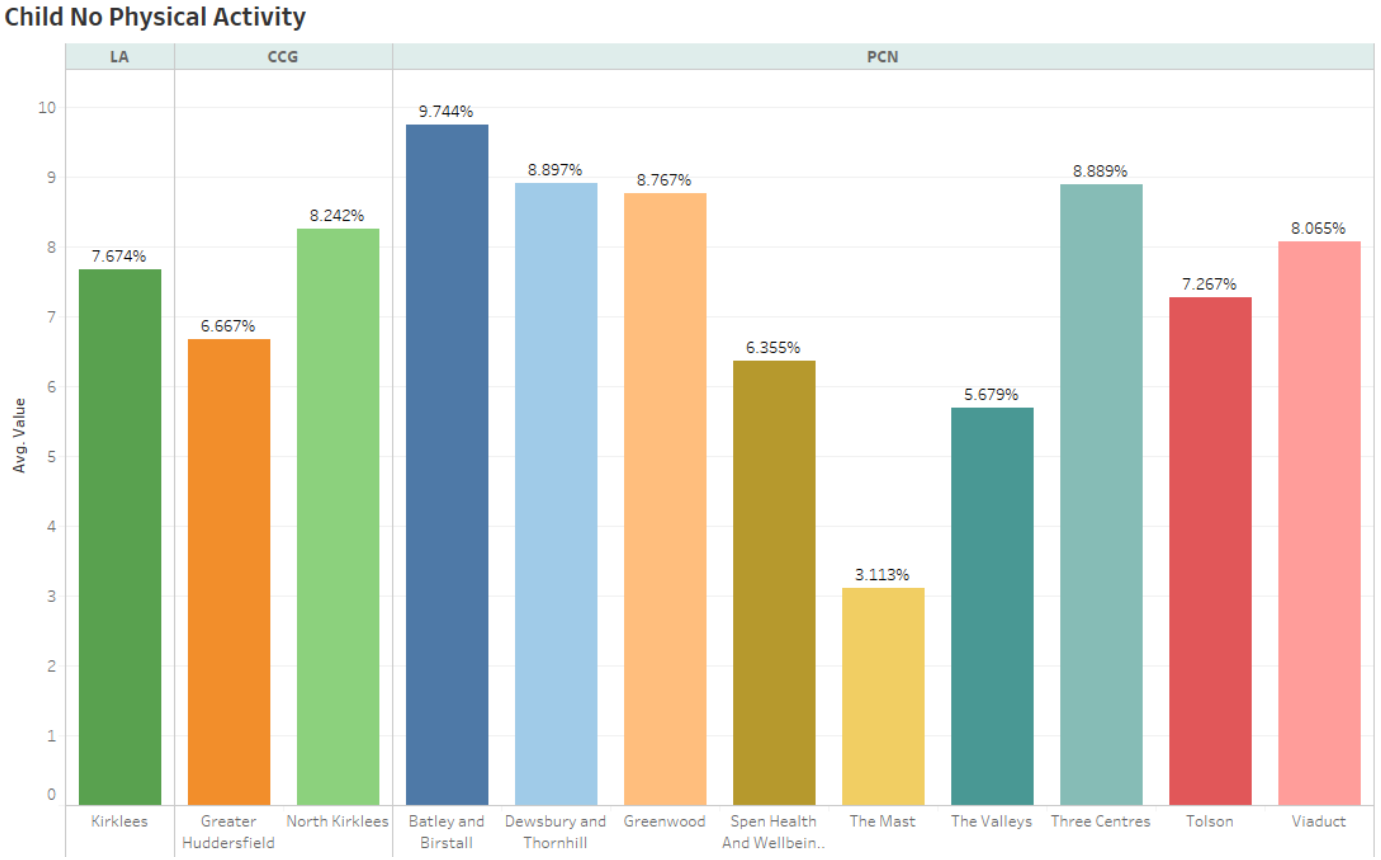
Child No Physical Activity

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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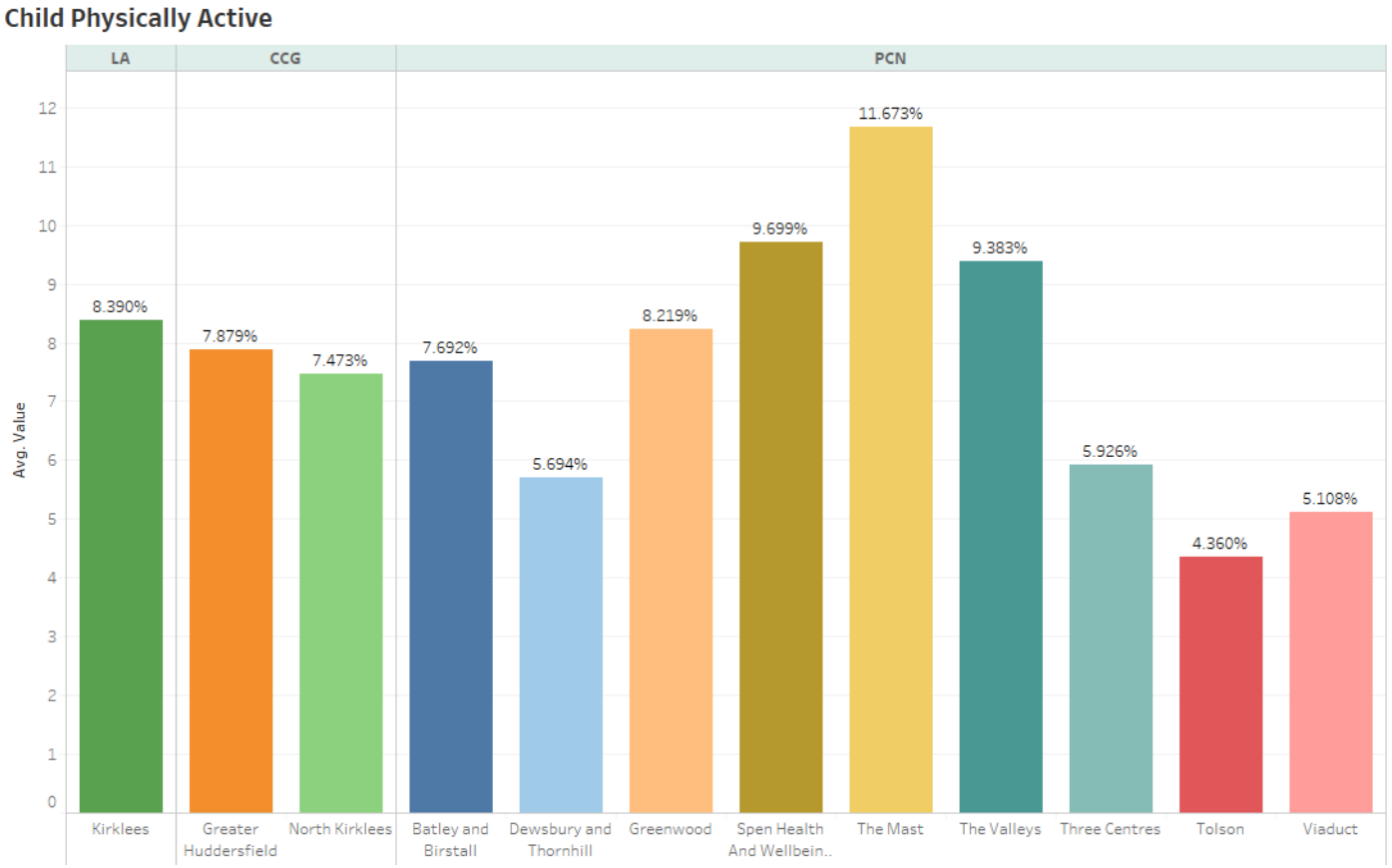
Child Physically Active

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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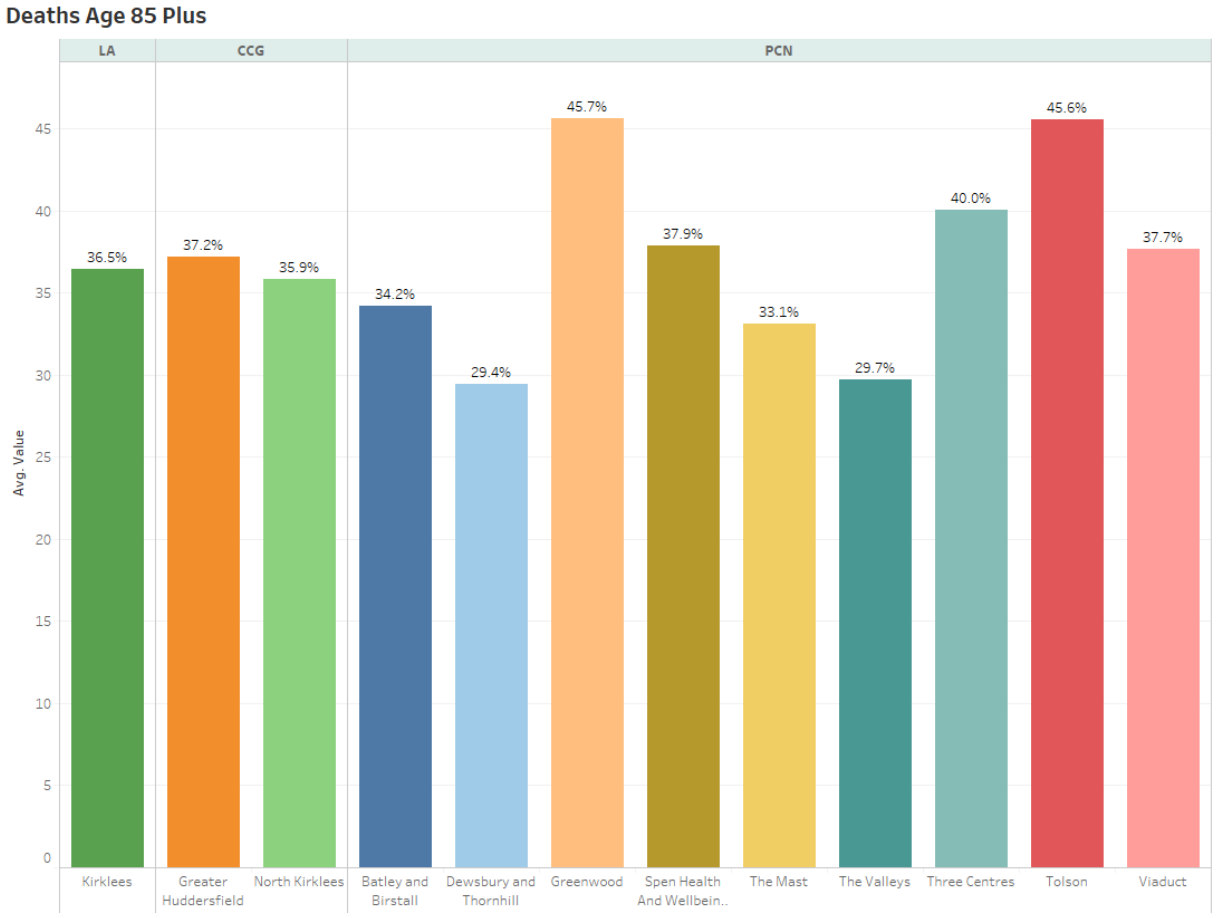
Deaths Age 85 Plus

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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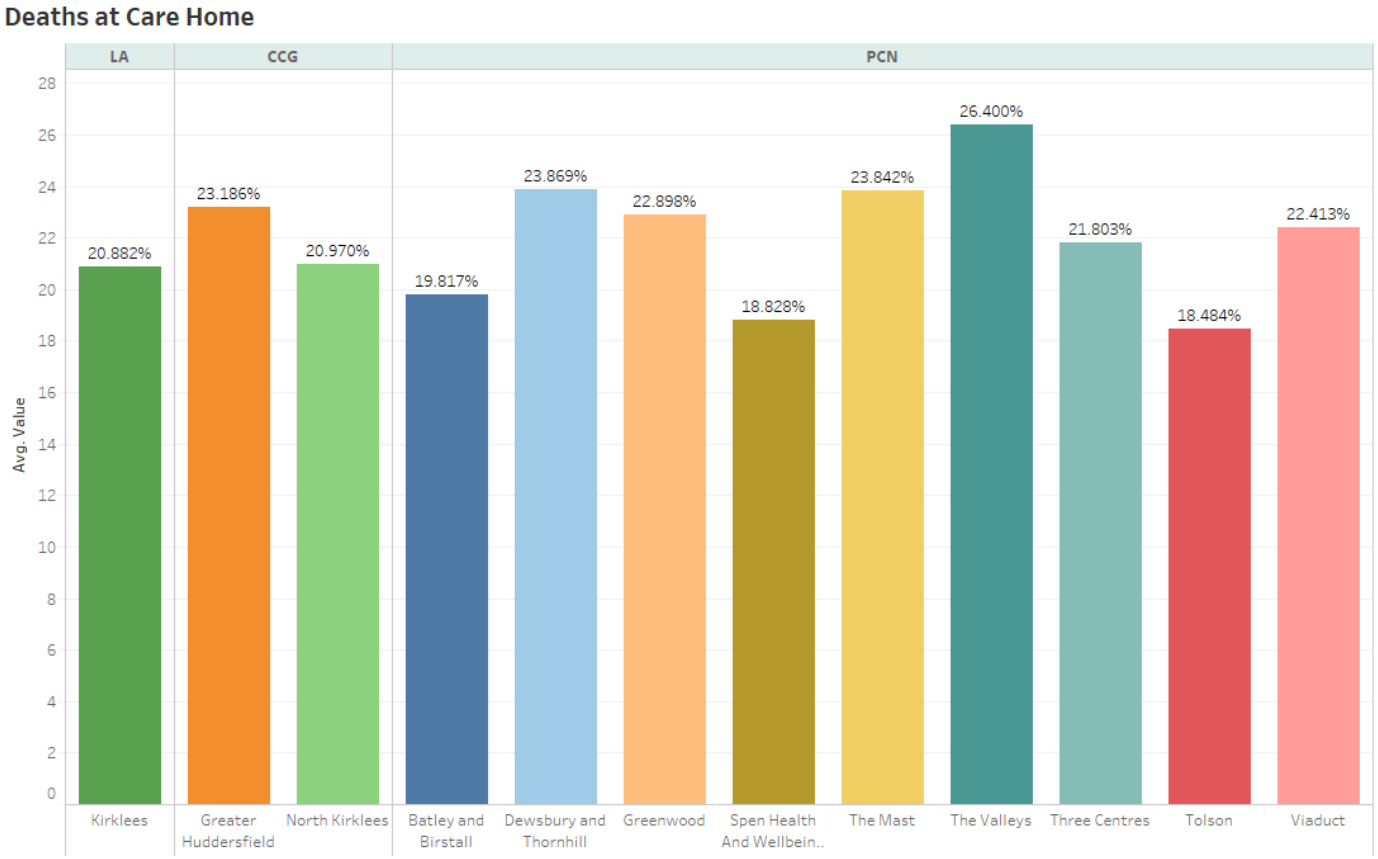
Deaths at Care Home

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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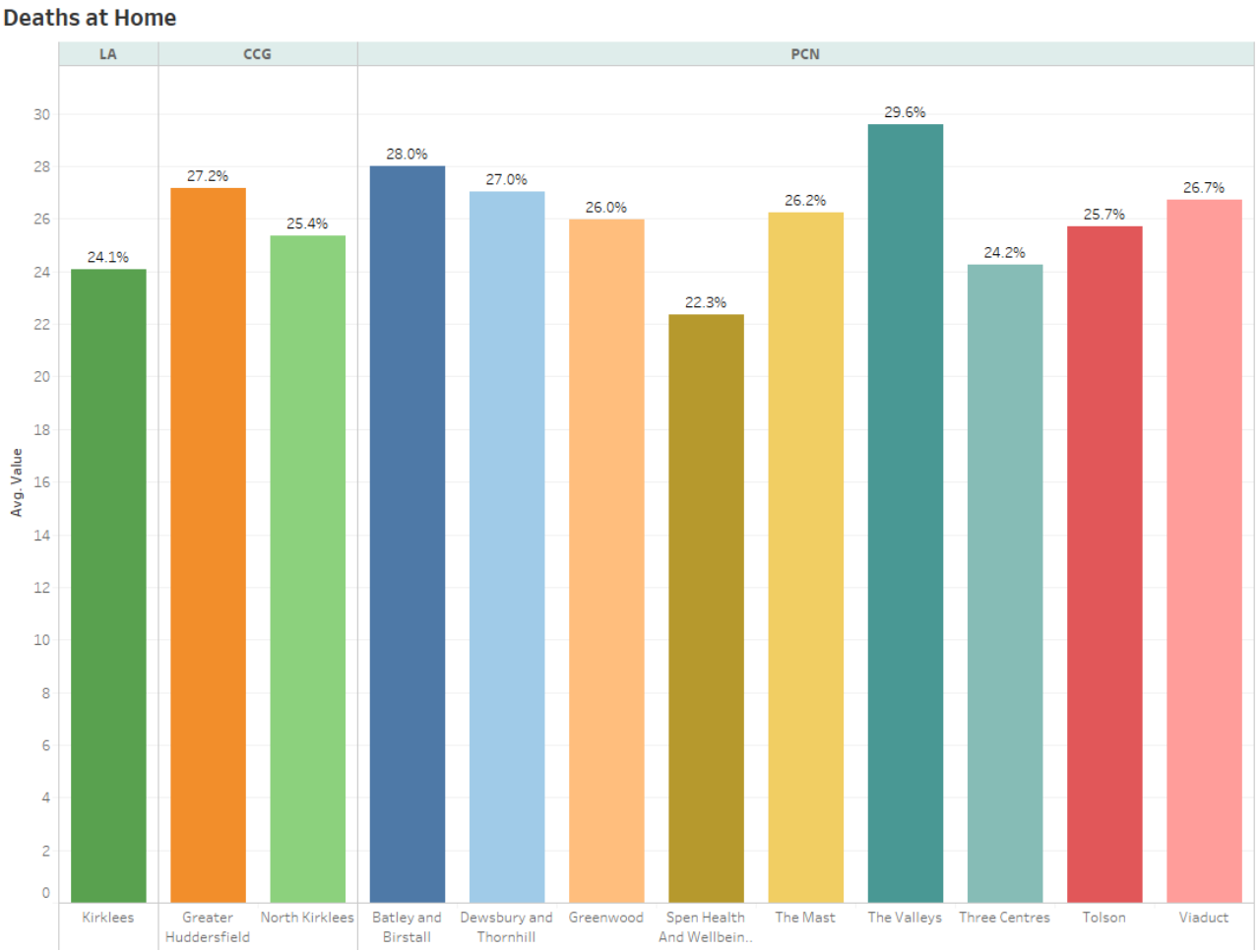
Deaths at Home

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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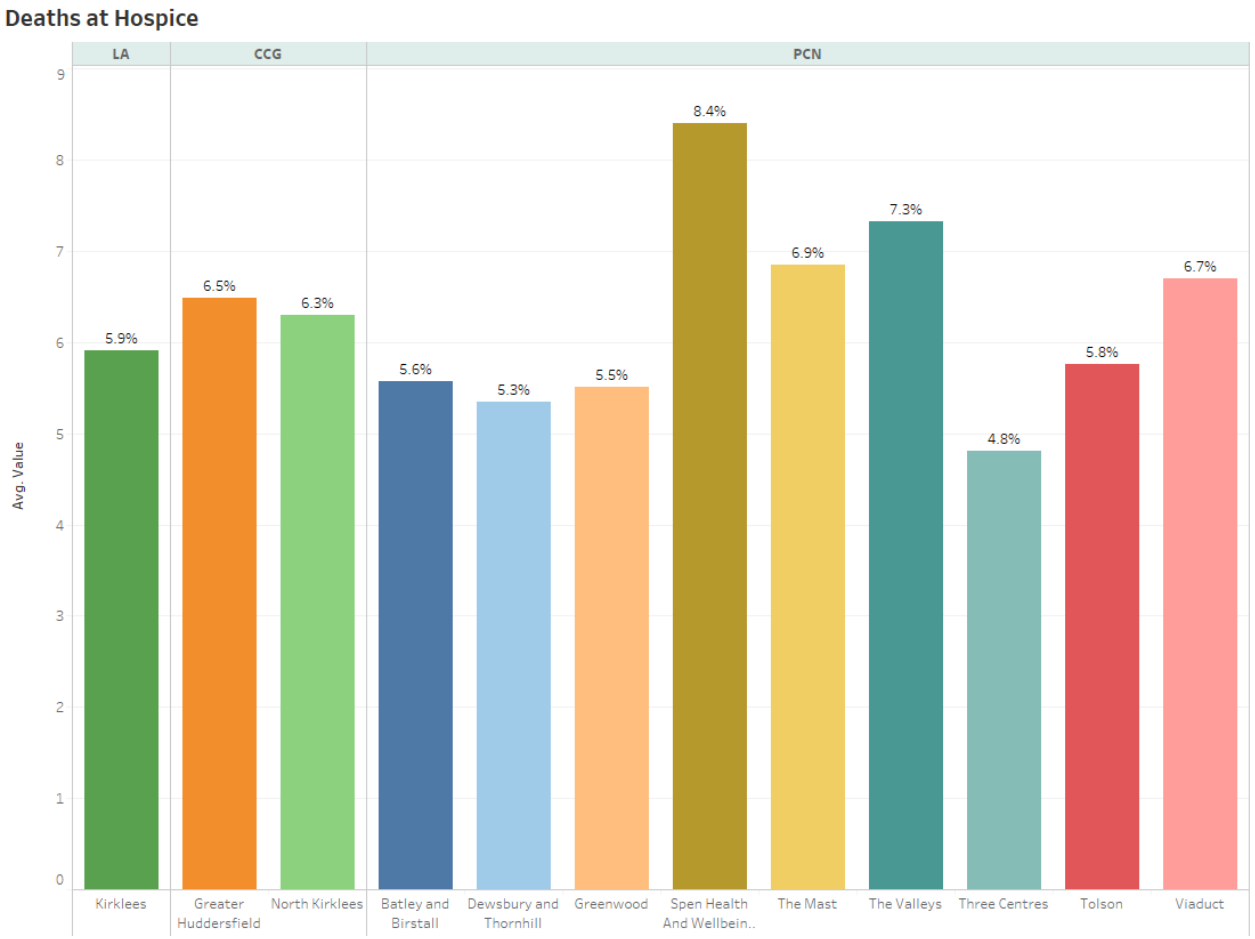
Deaths at Hospice

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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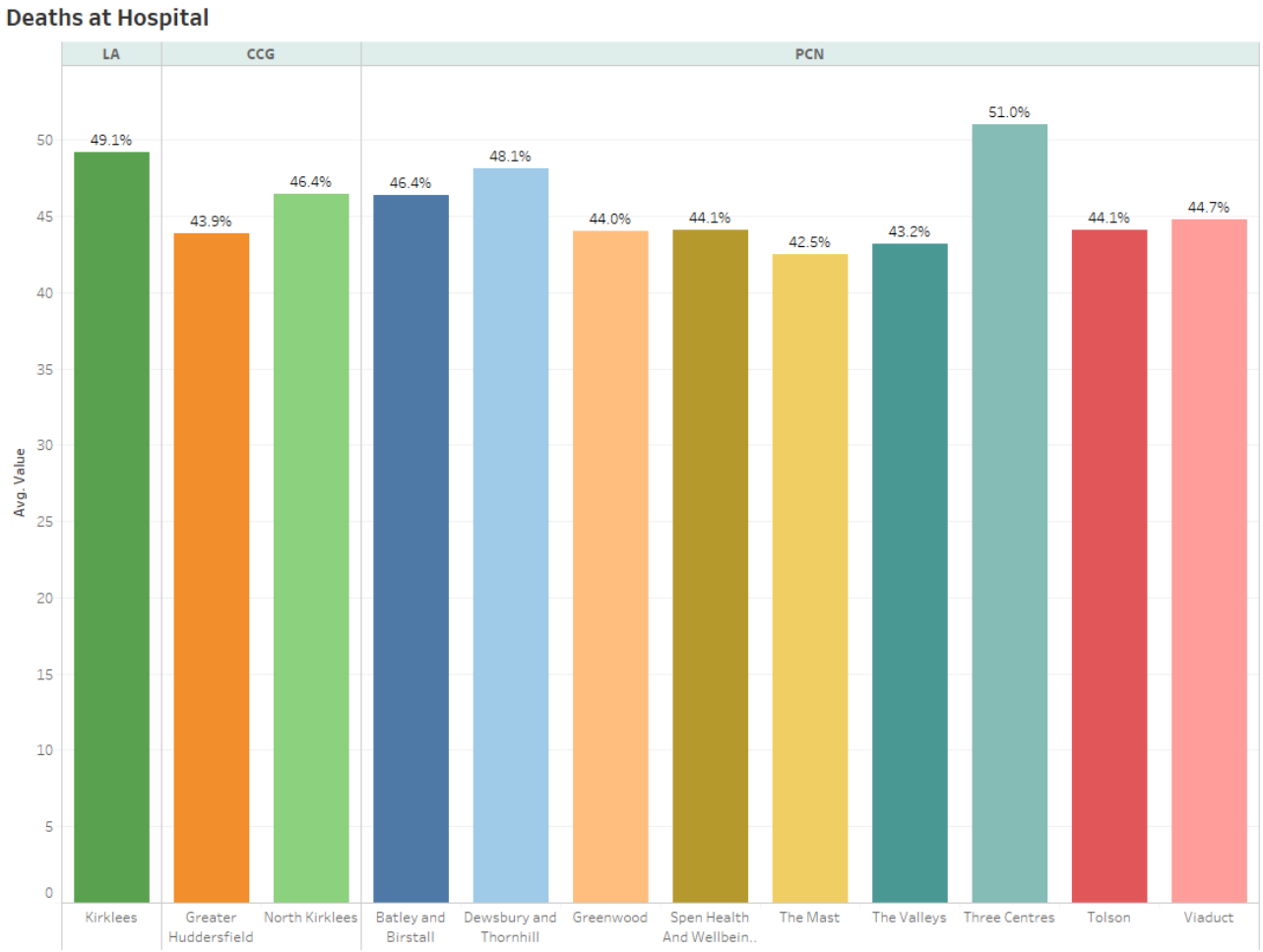
Deaths at Hospital

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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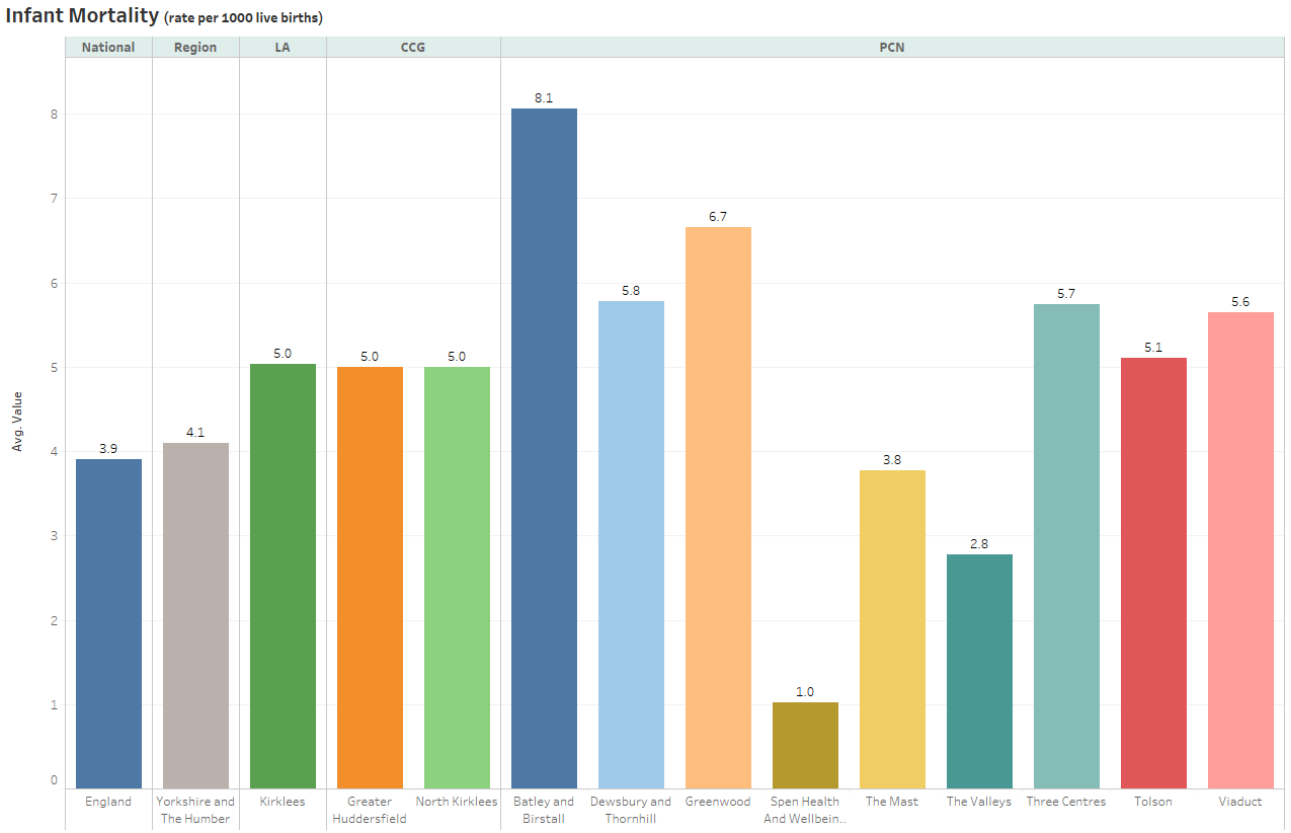
Infant Mortality

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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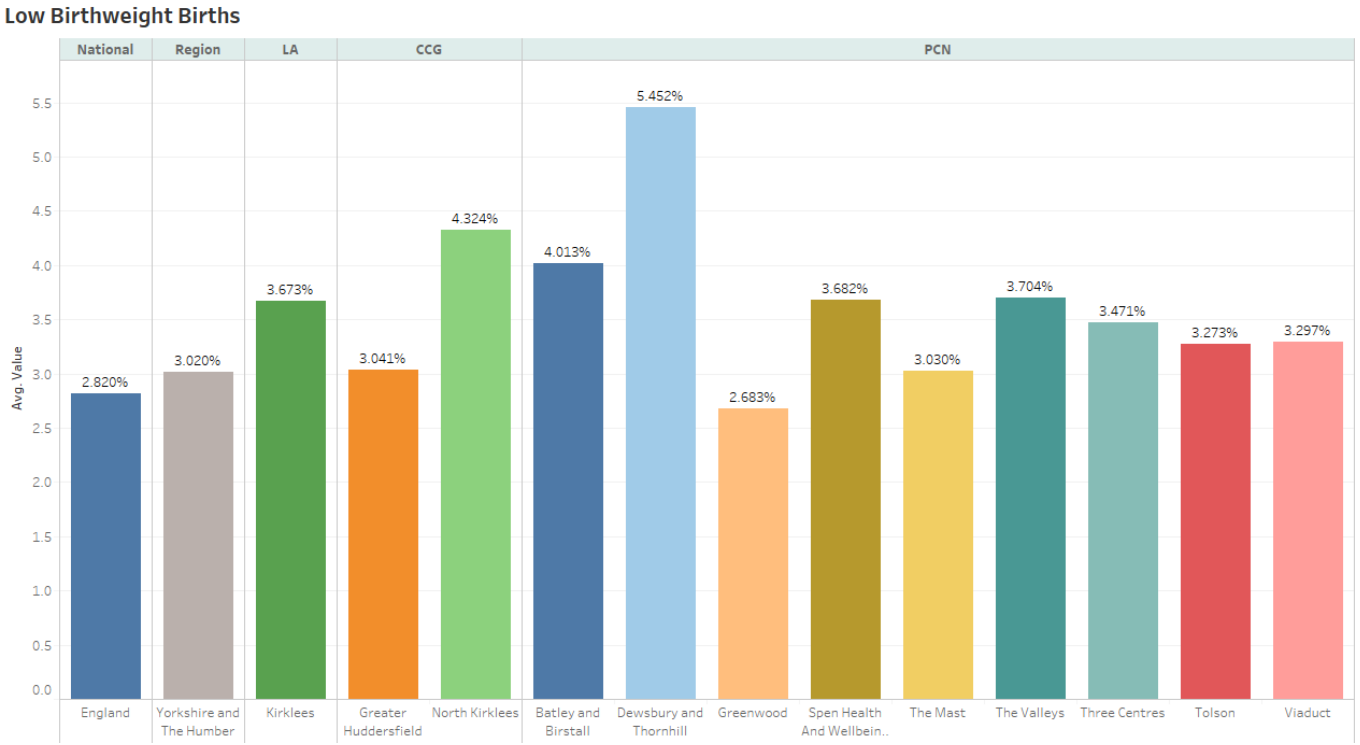
Low Birthweight Births

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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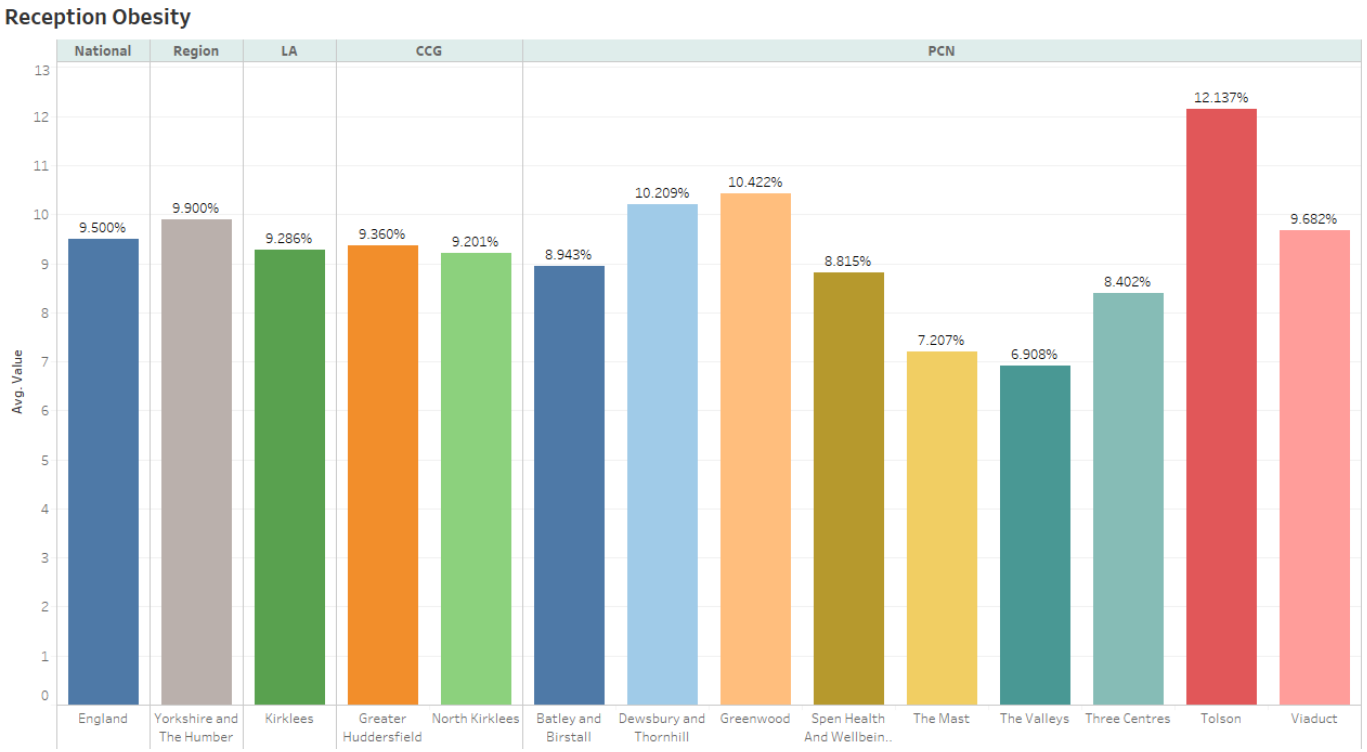
Reception Obesity

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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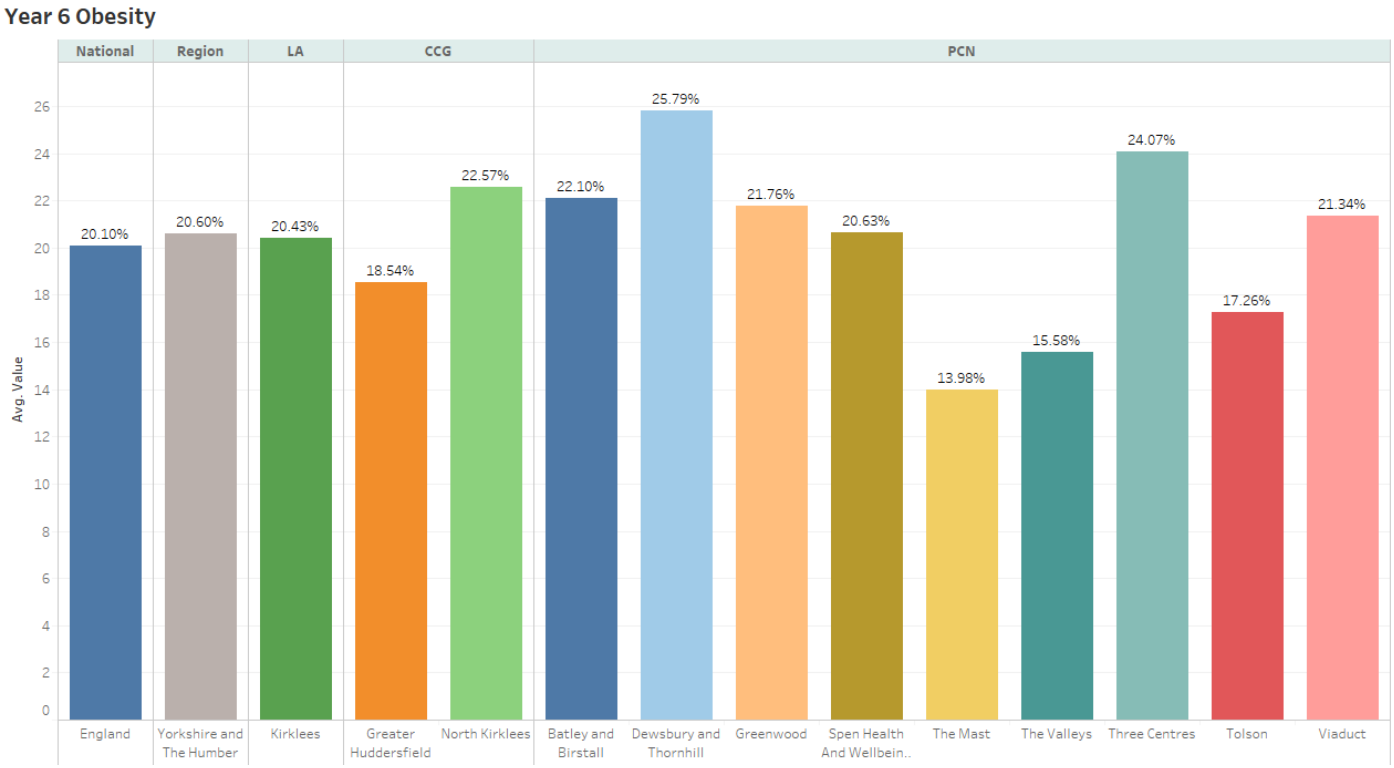
Year 6 Obesity

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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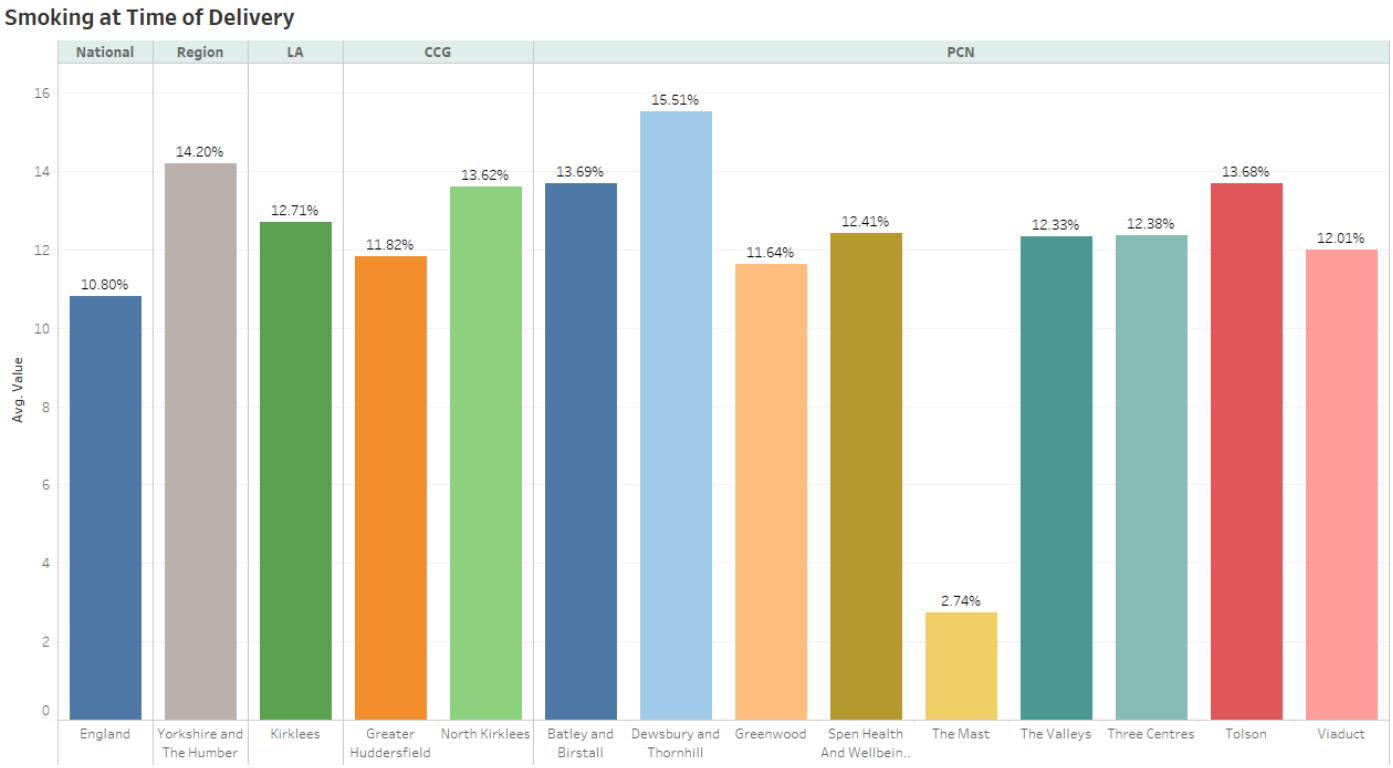
Smoking at Time of Delivery

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