



Primary Care Networks Overview Pack

ALLIANCE PCN

Pack produced - February 2023 - NHS Hertfordshire & West Essex ICB

Produced by Hertfordshire & West Essex ICB's - Population Health Management & Public Health Teams



Working together for a healthier future

Population Health Management





Population Health Management (PHM) is a partnership approach across the NHS and other public services including councils, the public, schools, fire service, voluntary sector, housing associations, social services and police. All have a role to play in addressing the interdependent issues that affect people's health and wellbeing.

The coronavirus (COVID-19) pandemic has further highlighted the known link between poorer health outcomes, ethnicity and deprivation. Integrated care systems, working with the local authority and the voluntary sector, have used PHM to identify people who need more support and those with the most complex needs within their localities, so that efforts can be targeted to protect certain populations through personalised care models, public health advice, testing and vaccination programmes.

For the public, it should mean that health and care services are more proactive in helping people to manage their health and wellbeing, provide more personalised care when it's needed and that local services are working together to offer a wider range of support closer to people's homes.

For doctors, nurses, social care, therapists and other frontline staff, this should mean greater support and insight from integrated care systems to enable care and support to be designed and proactively delivered to meet individual needs – it should mean less duplication and a reduction in workload pressures as it ensures the right care is given at the right time by the right person.

For local councils, health care managers and clinicians who commission services – greater understanding of the local population will ensure they can better predict what residents need. PCNs are key to this, as health and care providers work together and take collective responsibility for the care and support offered to improve outcomes, they can use their resources to keep people healthier.

Key Messages



Alliance PCN can be seen with a slightly larger middle age population profile than England. The majority of people live within the 4 middle deprived deciles (4-7), but the PCN has a significant population within the most deprived areas.

27.3% population have at least 1 Long Term Condition. 5.6% have more than 5 LTCs on a par with the 5.6% for the ICB. The population pyramid shows a similar profile to England for those living with long term.

Wider determinants analysis from Public Health Evidence and Intelligence shows Alliance is amongst the most deprived PCNs within the ICB, across Income, Employment, Older People and Child Poverty indicators.

The spread of patients for Alliance PCN indicates 15.8% of the population are not located within the Hertfordshire & West Essex boundaries; this means that this population may be accessing services outside of the ICB and the impact of coterminous alignment with neighbouring ICBs would need to be taken into account for this population by the PCN.

Expected population growth for Alliance adjusted for the Local Authority forecasts shows continued increase between 2023 through to 2034 which will bring additional demands for healthcare. Projections show an expected increase in the number of people over 65 from ~28k to ~35k.

When analysing the underlying Segmentation Model data the conditions with highest per 1,000 registered prevalence that are highlighted for Alliance are Learning Disabilities, Serious Mental Illness, and Alzheimer's; Cancer appears very low - but we should question that the data is being recorded correctly within all the Practices. Further, ASD related patients, Cerebral Palsy, and Sickle Cell Disease prevalence is also one of the highest rated in the ICB.

Urgent & Emergency Care in 2022/23 has seen one of the highest in the area for the A&E Attendance rates per 1,000 population, above the South West Herts rate.

When comparing the Ambulatory Care Sensitive rates per 1,000 population between places, the South West Herts Place has the highest rate in the ICB. Within South West Herts Place, Alliance has a rate per 1,000 population at 10.55, just above the place rate of 10.49.

When looking at the ACS conditions for Alliance, the highest volume and cost is within the End of Life, Severe Frailty and Dementia in the over 65 age group followed by the same age in the Advanced Disease and Complexity segment.

ACS conditions of note for people aged over 65 within the Advanced Disease and Complexity, is highlighted as AF and Flutter and Heart Failure, with the highest volume and cost. For those within the End of Life, Frailty & Dementia, COPD, Asthma, Heart Failure, AF and Flutter and Diseases of the Blood, are the ACS with the highest volume and cost.

14.8% of the general population in HWE ICB live within the 4 most deprived deciles, whilst 16.1% of the population in the EoL, severe frailty and severe dementia segment live within the 4 most deprived deciles. In Alliance PCN, 30.8% of the population in the EoL, severe frailty and severe dementia segment live within the 4 most deprived deciles, this is a significant indicator.

The average age of a person within the Frail and End of life segment increases with affluence, ranging from 66 in the most deprived decile to 77 within the most affluent decile within the ICB. As we would expect the average number of acute and chronic conditions is significantly higher within this segment that the general population as are all activity measures. The average number of Chronic Conditions for people within Alliance PCN is higher than the ICB. Within this segment we can see the presence of Chronic Cardiac Disease, high Hypertension rates, and Diabetes being highlighted here.

Emergency Admission Rates per 1,000 on the Disease Registers shows that Alliance PCN has higher rates for Asthma, AF, Diabetes and Heart Failure, which was identified as a theme within the ACS analysis.

Source: HWE PHM Team

Demographics, Conditions & Segment Overview



National Tool View and Population Demographics and Projections

The following slides represent screen shots from the Nationally Available Tools provided via NHSE.

The information within these tools are used by NHSE to measure and monitor progress. There is some valuable information available within these tools, however the value of these tools is realised when the information within them is triangulated with local data and intelligence.

Public Health Wider Determinants

These provide context for understanding the wider population need, so as Integrated Neighbourhood Teams develop you have a shared understanding of the health and care needs of your population to inform the development of interventions for different patient groups.



PCN Demographics - NHS England



Total Population ALLIANCE PCN

ALLIANCE PCN

Registered population
% of total 100.0%
% of annual change 0.1%

 Demographics

 % White
 62.9%
 % IMD top
 7.2%

 % BAME
 18.8%
 % IMD bottom
 11.9%

 Prevalence

 % with 1+ conditions
 27.3%

 % with 5+ conditions
 2.9%

Acute utilisation

% of annual activity (total 53,301)

% of annual cost (total £14M)

100.0%

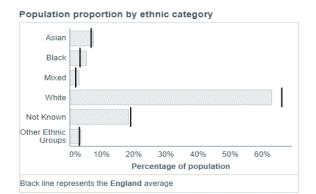
Covid
% one or more at risk conditions 17.6%
% two or more at risk conditions 6.5%

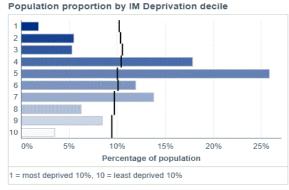
Snapshot as at: 30/06/2021

Population demographics - Snapshot as at: 30/06/2021

- Shapshot as at, 50/06/202

90+ 85-89 80-84 770-74 66-69 60-64 55-59 50-54 45-49 40-44 33-39 30-34 40-44 8% 6% 4% 2% 0%0% 2% 4% 6% 8% Percentage of males

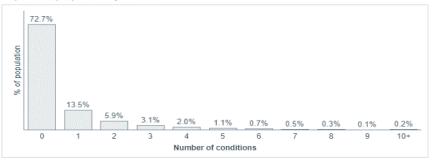


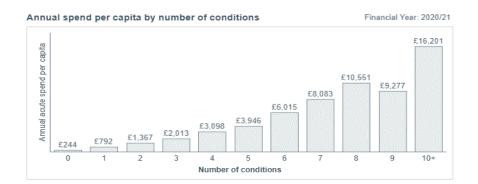


Choose benchmark:

Prevalence - Snapshot as at: 30/06/2021

Population proportion by number of conditions





The Population & Person Insights dashboard has provided good overall summary metrics on the PCN's total population, here we have benchmarked views on standardised demographics, such as deprivation deciles, and proportion of the PCN population by number of conditions.

Alliance PCN can be seen with a slightly larger middle age population profile than England. The majority of people live within the 4 middle deprived deciles (4-7), but the PCN has a significant population within the most deprived areas.

Source: NHS Digital (2022) https://apps.model.nhs.uk/report/PaPi

PCN Demographics - NHS England



LTC ALLIANCE PCN

Registered population % of total % of annual change 3.5%

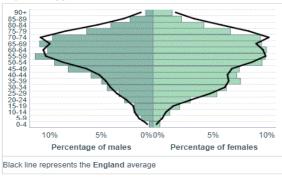
Demographics 18.4% % IMD bottom 12.3% Prevalence % with 1+ conditions % with 5+ conditions 5.6% Acute utilisation % of annual activity 46.2% (total 24,635) % of annual cost 40.4% (total £6M)

Covid 56.2% % one or more at risk conditions 17.8% % two or more at risk conditions

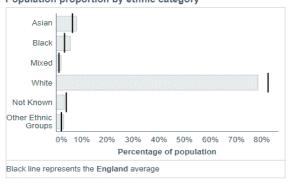
Snapshot as at: 30/06/2021

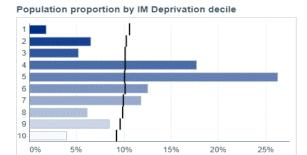
Population demographics - Snapshot as at: 30/06/2021

Population pyramid







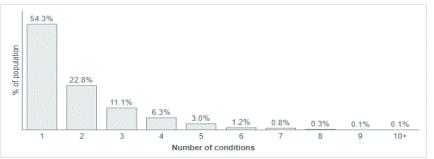


Percentage of population

Choose benchmark:

Prevalence - Snapshot as at: 30/06/2021

Population proportion by number of conditions





1 = most deprived 10%, 10 = least deprived 10%

When compared with the overall PCN demographics on the previous page, those in the PCN whom have an LTC as defined by NHS England, are benchmarked against the English averages, the view for the PCN shows us that 27.3% population have at least 1 Long Term Condition. 5.6% have more than 5 LTCs on a par with the 5.6% for the ICB.

The population pyramid shows a similar profile to England for those living with long term .

Source: NHS Digital (2022) https://apps.model.nhs.uk/report/PaPi

Practice Indicators - Triggers and Levels

Practice Indicators for		CONSULTING ROOMS		GROVE	HILL MEDICAL	CENTRE	HATE	IELD ROAD SU	RGERY	VERUL	AM MEDICAL	GROUP	VERULAM MEDICAL GROUP - COLERIDGE		OLERIDGE	Integrated Care Boa WOODHALL FARM MEDICAL CENTRE			
	ALLIANCE PCN		I = =				.		T 5. 7. 1		1.1	T 5. 4. 1						T	*********
Clinical Domain	Indicator Name	Latest Score		Trigger Level			Trigger Level		Time Period				Trigger Level		Time Period Tr		Latest Score		
Clinical Diagnosis	Detection rate Cancer	0.606	2020/21	No Trigger	0.545	2020/21	No Trigger	0.667	2020/21	No Trigger	0.294	2020/21	Level 1	0.333		o Trigger	0.375		No Trigger
Coronary heart disease	% AF anticoagulation therapy CHADS2-VASc score >1	88	2020/21	Positive	100	2020/21	Positive	90.9	2020/21	Positive	87	2020/21	Positive	81.8		o Trigger	60	2020/21	Level 1
	% CHD aged <=79 BP reading 140/90mmHg or less	30.1	2020/21	Level 2	80.6	2020/21	No Trigger	20.3	2020/21	Level 2	39.3	2020/21	Level 1	42.5	2020/21	Level 1	38.5	2020/21	Level 1
	% CHD cholesterol 5 mmol/l or less	60.4	2021/22	No Trigger	67.8	2021/22	No Trigger	53.6	2020/21	No Trigger	52.1	2021/22	No Trigger	60		o Trigger	39.7	2021/22	Level 1
	% hypertension aged <=79 BP reading 140/90mmHg or less	23.7	2020/21	Level 2	72.7	2020/21	Level 1	16.9	2020/21	Level 2	36.3	2020/21	Level 2	32.6		Level 2	29.3	2020/21	Level 2
Diabetes	% Diabetes aged >=40 years no CVD history without moderate or severe frailty treated with stati	68	2020/21	Level 1	84.9	2020/21	Level 1	71.5	2020/21	Level 1	65.1	2020/21	Level 1	67.2	2020/21	Level 1	59.3	2020/21	Level 2
	% Diabetes without moderate or severe frailty BP 140/80 mmHg or less	24.7	2020/21	Level 2	66.3	2020/21	Level 1	18.8	2020/21	Level 2	35.7	2020/21	Level 2	44.8	2020/21	Level 1	32.2	2020/21	Level 2
	% diabetes without moderate or severe frailty IFCC-HbA1c is 58 mmol/mol or less	39.9	2020/21	Level 2	55.2	2020/21	Level 1	36.4	2020/21	Level 2	42.1	2020/21	Level 2	47.4	2020/21	Level 1	40.5	2020/21	Level 2
Exception Rating	Overall Personalised Care Adjustment Rate	0.04	2020/21	No Trigger	0.062	2020/21	No Trigger	0.036	2020/21	No Trigger	0.023	2020/21	No Trigger	0.032	2020/21 N	o Trigger	0.069	2020/21	No Trigger
Medicines Managemer	nt % antibiotics Co-amoxiclav, Cephalosporins, Quinolones	6.8	2021/22 Q4	No Trigger	9.4	2021/22 Q4	No Trigger	6.4	2021/22 Q4	No Trigger	9.3	2021/22 Q4	No Trigger	9.6	2021/22 Q4 N	o Trigger	14.8	2021/22 Q4	Level 1
	% Naproxen and Ibuprofen	84.2	2021/22 Q4	No Trigger	69.4	2021/22 Q4	No Trigger	78.8	2021/22 Q4	No Trigger	85.3	2021/22 Q4	No Trigger	77.4	2021/22 Q4 N	o Trigger	66	2021/22 Q4	No Trigger
	Antibacterial Items/Star Pu	1.028	2021/22 Q4	Positive	0.839	2021/22 Q4	Positive	0.672	2021/22 Q4	Positive	0.77	2021/22 Q4	Positive	0.836	2021/22 Q4	Positive	0.763	2021/22 Q4	Positive
	Hypnotics ADQ/Star Pu	0.914	2021/22 Q4	No Trigger	0.221	2021/22 Q4	Positive	0.337	2021/22 Q4	No Trigger	0.206	2021/22 Q4	Positive	0.583	2021/22 Q4 N	o Trigger	1.06	2021/22 Q4	No Trigger
	Oral NSAIDS ADQs/STAR-PU	2.092	2021/22 Q4	No Trigger	1.738	2021/22 Q4	Positive	2.788	2021/22 Q4	No Trigger	2.388	2021/22 Q4	No Trigger	7.161	2021/22 Q4 N	o Trigger	5.492	2021/22 Q4	No Trigger
Mental Health	% first choice generic SSRIs	70.1	2021/22 Q4	No Trigger	64.8	2021/22 Q4	No Trigger	81.1	2021/22 Q4	Positive	80.7	2021/22 Q4	Positive	88.7	2021/22 Q4	Positive	65.8	2021/22 Q4	No Trigger
	% MH comprehensive care plan	86.5	2020/21	Level 1	31.7	2020/21	Level 1	38.6	2020/21	Level 1	27.3	2020/21	Level 1	14.7	2020/21	Level 1	29.6	2020/21	Level 1
	% SMI alcohol record	97.3	2018/19	No Trigger	13.3	2020/21	Level 2	6.5	2020/21	Level 2	86.4	2018/19	Level 1	66.7	2018/19	Level 1	88.5	2018/19	Level 1
	% SMI BP record	71.4	2020/21	Level 1	51.2	2020/21	Level 1	36.4	2020/21	Level 2	27.3	2020/21	Level 2	55.6	2020/21	Level 1	34.6	2020/21	Level 2
	Dementia Face to Face review	11.7	2020/21	Level 1	72.7	2020/21	No Trigger	50	2020/21	Level 1	0	2020/21	Level 2	100	2020/21 N	o Trigger	25	2020/21	Level 1
	Select antidepressants ADQs/STARPU	1.262	2021/22 Q4	No Trigger	1.197	2021/22 Q4	No Trigger	0.672	2021/22 Q4	Positive	0.793	2021/22 Q4	Positive	1.772	2021/22 Q4 N	o Trigger	1.163	2021/22 Q4	No Trigger
Patient Experience	Confidence and trust in healthcare professional	92.6	2020/21	No Trigger	91.4	2020/21	No Trigger	92.5	2020/21	No Trigger	96.3	2020/21	No Trigger	93.7		o Trigger	95.7	2020/21	No Trigger
·	Frequency seeing preferred GP	53.1	2020/21	No Trigger	54.8	2020/21	No Trigger	64.1	2020/21	No Trigger	71.2	2020/21	No Trigger	40.8	2020/21 N	o Trigger	60	2020/21	No Trigger
	Healthcare professional treating with care and concern	79.1	2020/21	No Trigger	83.4		No Trigger	83.2	2020/21	No Trigger	81.4	2020/21	No Trigger	93		o Trigger	84.5		No Trigger
	Overall experience of your GP practice	78.6	2020/21	No Trigger	84.6		No Trigger	80.7	2020/21	No Trigger	75.7	2020/21	No Trigger	85.5	-	o Trigger	77.6		No Trigger
	Satisfaction with appointment times	82.3	2020/21	No Trigger	68.3	2020/21	No Trigger	63.1	2020/21	No Trigger	64.6	2020/21	No Trigger	68.8		o Trigger	54.3		No Trigger
Public Health	% Child Imms DTaP/IPV/Hib/HepB (age 1 year)	45.3	2020/21	Level 2	81.9	2020/21	Level 1	85.9	2020/21	Level 1	73.7	2020/21	Level 1	81.7	2020/21	Level 1	85.5	2020/21	Level 1
r abiic ricarar	% Child Imms Hib/MenC booster	70.5	2020/21	Level 2	75	2020/21	Level 1	65.9	2020/21	Level 2	83	2020/21	Level 1	85.1	2020/21	Level 1	95.8		No Trigger
	% Child Imms MMR (Age 2 yrs)	69.3	2020/21	Level 2	73.6	2020/21	Level 1	65.9	2020/21	Level 2	83	2020/21	Level 1	85.1		Level 1	93.8	2020/21	Level 1
	% Child Imms PCV Booster	70.5	2020/21	Level 2	75	2020/21	Level 1	61	2020/21	Level 2	78.7	2020/21	Level 1	85.1		Level 1	95.8		No Trigger
	Cervical Screening	66.8	2021/22 Q4		68.7	2021/22 Q4	Level 1	66.5	2021/22 Q4	Level 1	68.2	2021/22 Q4	Level 1	65.7	,	Level 1	61.8	2021/22 Q4	Level 2
Respiratory	% Asthma review in last 6 mths	5.6	2020/21	Level 1	69	2020/21	Level 1	13.8	2020/21	Level 1	19.6	2020/21	Level 1	70.3		o Trigger	10.7	2020/21	Level 1
ncopii attiry	% Asthma spirometry and one other objective test	33.3	2020/21	Level 1	0	2020/21	Level 2	0	2020/21	по рата	0	2020/21	по рата	25	2020/21	Level 1	0	2020/21	Level 1
	% Astrima spirometry and one other objective test % COPD with review in last 12 mths	1.2	2020/21	Level 2	63.3	2020/21	Level 1	0	2020/21	Level 2	55.6	2020/21	Level 1	87	2020/21	Level 1	4.7	2020/21	Level 2
			· · · · · ·		17			14		No Trigger		· ·				Level 1	12.7		
	% LTC patients who smoke	18.8	2020/21	No Trigger		2020/21	No Trigger		2020/21		9.5	2020/21	No Trigger	24.3					No Trigger
	% LTC Smoker offer support	90.8	2020/21	Level 1	63.7	2020/21	Level 1	29.9	2020/21	Level 2	39.7	2020/21	Level 1	54.6		Level 1	44.1	2020/21	Level 1
	% Smoking patients over 15 recorded	71.8	2021/22	No Trigger	67.5	2021/22	No Trigger	64.2	2020/21	No Trigger	62.8	2021/22	No Trigger	70.6		o Trigger	68.5		No Trigger
	% Smoking status recorded	87.2	2020/21	Level 1	91.5		No Trigger	80.5	2020/21	Level 1	89.7	2020/21	Level 1	82	2020/21	Level 1	90.3		No Trigger
	% w. MRC dyspnoea score >=3 w. offer of referral to pulm. rehab. Clinic	0	2020/21	Level 2	10.5	2020/21	Level 1	0	2020/21	Level 1	0	2020/21	Level 2	0	2020/21	Level 2	100	2020/21	No Trigger

Primary Care clinical domain indicators as provided by NHS England as highlighted here with Trigger Levels against each, and represents a consolidation of data sets, designed to reduce the burden on GPs following these outlier identification. This indicator set is to support quality assurance and improvement of GP services; here, the higher the Level indicated, the more indicative of risk that has been found for that indicator.

The Practices have opportunities for every Level 1 indicated metric; however, any Level 2 indicator must be reviewed; guidance on this data set can be found in the below link, and for more up-to-date data, please log into your Ardens Manager (https://app.ardensmanager.com/).

Source: NHSE&I - https://www.primarycareindicators.nhs.uk/

https://www.primarycareindicators.nhs.uk/wp-content/uploads/2022/02/GPI-Tech-Guidance-v5.pdf

Public Health - PCN Wider Determinants





Wider Determinants



Where 1 is the most deprived in HWE ICB and 35 the least

In Alliance PCN an estimated:

- 15.3% of children live in poverty.
- 13.8% of older people live in poverty.
- 11.9% of households live in fuel poverty.
- 8.2% of households are overcrowded.
- 31.5% of people aged 65 and over live alone.
- 1.2% of people cannot speak English well.
- 4.6% of working age people are claiming out of work benefits.
- 22.7% of children aged 4-5 and 35.3% of children aged 10-11 are overweight.

PH.Intelligence@hertfordshire.gov.uk





The above provides a summary of the wider determinants of health for Alliance PCN.

Wider determinants analysis from Public Health Evidence and Intelligence shows Alliance is amongst the most deprived PCNs within the ICB, across Income, Employment, Older People and Child Poverty indicators.

Source: Public Health Team

Spread of Patients

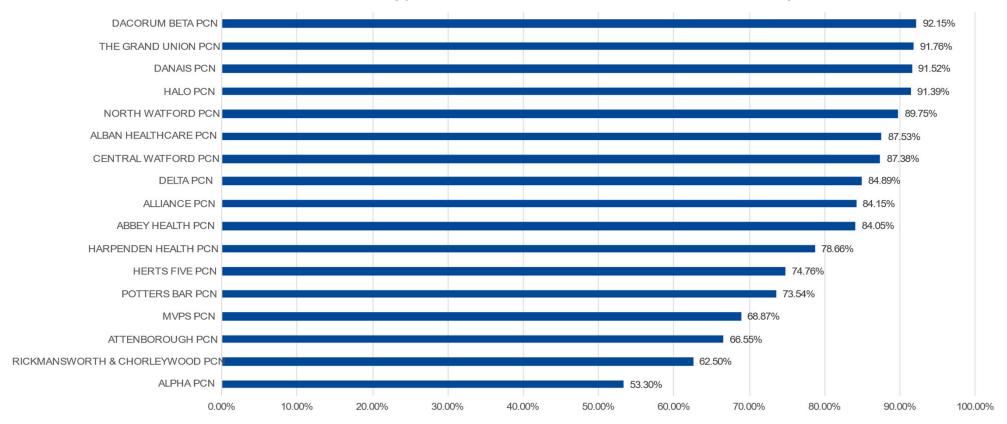


Correct as of July 2022

Source: NHS Digital (2022)

SPREAD OF PATIENTS ACROSS ENGLAND CONT.

Percent of Herts Valley patients within Hertfordshire and West Essex boundary



This chart shows the proportion of the registered population living within the ICB geographical boundary.

The spread of patients for Alliance PCN indicates 15.8% of the population are not located within the Hertfordshire & West Essex boundaries; this means that this population may be accessing services outside of the ICB and the impact of coterminous alignment with neighbouring ICBs would need to be taken into account for this population by the PCN.

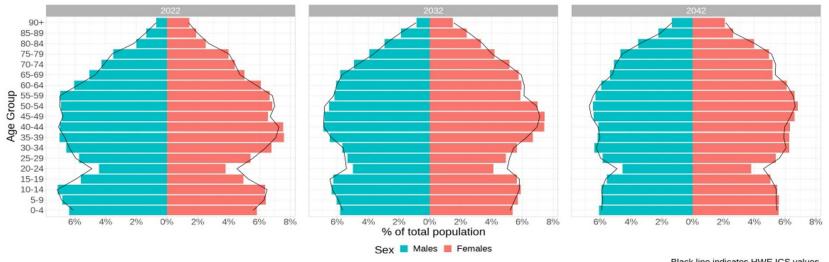
Source: Essex County Council PHM Team, NHS Digital (2022)

Public Health - Population Projections





Projection Pyramids



Black line indicates HWE ICS values.
Population pyramids and table shown for Dacorum district.
District shown is based on the largest majority of the PCN's registered population.

Age Band	2022 Projection	2032 Projection	2042 Projection
Under 5	9,581	9,050	9,626
Under 24	45,285	45,492	44,180
24-64	83,652	81,742	82,679
65+	28,434	34,526	38,238
85+	4,253	5,368	6,853

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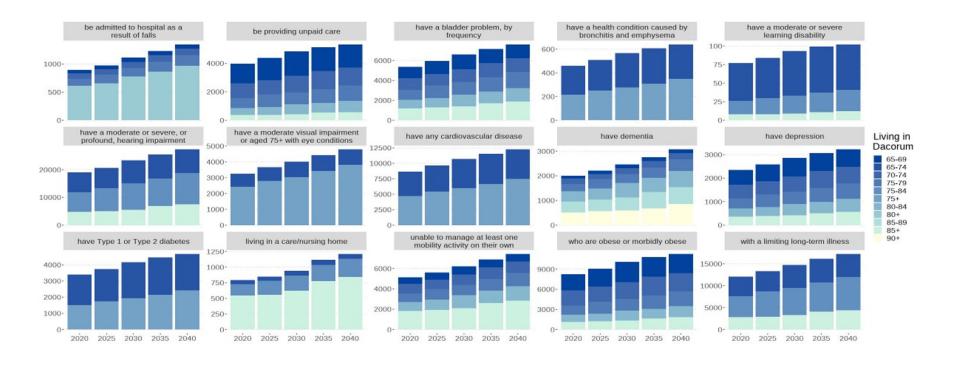
The above projection pyramids show the growth in population expected for Alliance, and adjusted for the Local Authority forecasts shows continued increase between 2023 through to 2034 which will bring additional demands for healthcare. Projections show an expected increase in the number of people over 65 from ~28k to ~35k.

Public Health - Projections on Conditions





People aged 65+ projected to...



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The above shows the impact on health due to the expected increase in the number of people over 65.

Source: Public Health Team

Segmentation within the ICB



Optum

HWE

Segment & Outcomes Framework Documentation

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PHM Segment Model - Overview

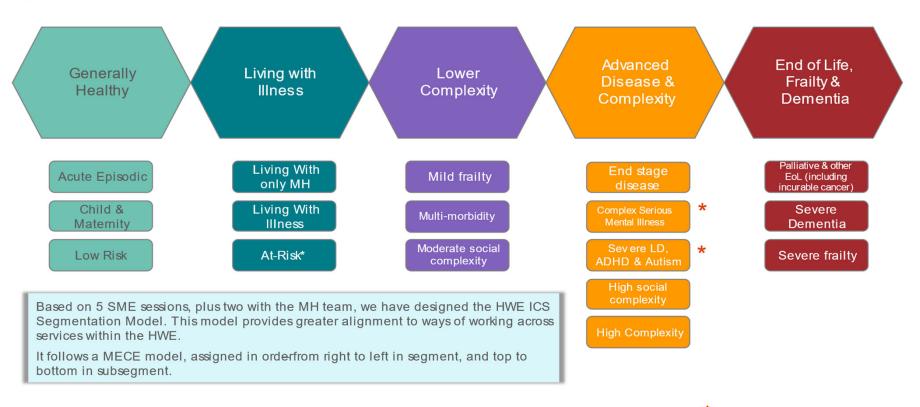


The ICB has worked in partnership with Optum to develop a Health Segmentation model using linked data covering 1.2m of our ICS population. As part of the process representation from different care settings and internal ICB teams were engaged.

Our core PHM and Population Segmentation model combines primary and acute care data with wider determinants and community, mental health and social care data where available. The model has been built with a view to include additional data sets as they become available. The segmentation model provides the foundations for advanced population health management analytics that goes beyond patient level risk stratification.

The below demonstrates the 5 high level segments and the sub segments beneath within the model.

Segmentation model – third iteration



awaiting finalisation of methodology

2

Optum

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PHM Segment Model - Overview



The logic behind the ICB Health Segmentation model has been developed to allow the ICB to consider its whole population and the different interventions required to improve the outcomes of different groups of people with similar characteristics.

Alongside the segmentation logic an outcomes framework was developed.

Whole Population Outcomes

- INCREASE life expectancy / INCREASE average age at death in adults.
- REDUCE gap in age at death between most and least deprived deciles.
- INCREASE disease-free life expectancy
- · REDUCE rates of suicide
- REDUCE proportion of population who are digitally excluded either by lack of equipment, connectivity, skills, cost, or coeffide to be able to access clinical services.

"Generally healthy"

Who is in this group?

- Children and adults in the general population who are not otherwise captured in other segments.
- Most likely receive episodic care due to accidents and injuries or linked to maternity and CYP routine services.
- No diagnosed conditions.

Social & Clinical Outcomes

- INCREASE screening.
- IMPROVE experience of Maternity services.
- REDUCE rates of childhood obesity in reception and year 6.
- REDUCE rate of infant mortality
- REDUCTION in proportion of people diagnosed with low mood and/or depression.

Living with Illness

Who is in this group?

- Includes people with single illnesses (including MH), that are currently controlled or able to self-manage and will receive most of their care in a planned way through primary care.
- Includes people with social or behavioural risk factors for more advanced disease.

Social & Clinical Outcomes

- INCREASE proportion of patients who feel able to self-manage their condition.
- REDUCE prevalence of behavioural risk factors for more advanced diseases, including: obesity, smoking status and drug abuse.
- REDUCE episodes of ill -health requiring emergency admissions for long term condition.
- INCREASE percentage of people with mental health problems in employment.
- INCREASE proportion of people who are able to maintain life routines considered important to the individual, e.g work, ..
 REDUCE emergency attendances due to alcohol -related harm.

Lower Complexity

Who is in this group?

 Includes people with moderate levels of morbidity and complexity. This is either as a result of: Multi-morbidity (24 long term conditions), Mild frailty and/or Social complexity.

Social & Clinical Outcomes

- INCREASE proportion of patients who feel able to self-manage their condition.
- REDUCE rate of emergency admissions for people with lower complexity.
- INCREASE proportion of patients offered personalised care and support planning.
- REDUCE prevalence of behavioural risk factors for more advanced diseases, including: obesity, smoking status and drug abuse.

Advanced Disease & Complexity

Who is in this group?

 Advanced disease and complexity represents a cohort of people with one or more significant illnesses that impact on their day to do functioning as well as people with significant risk from social complexity

Social & Clinical Outcomes

- INCREASE five year survival from cancer.
- REDUCE rate of emergency admissions in people with advanced disease or complexity.
- REDUCE the difference in average age of death between people with learning disability/SMI compared t general population.
- REDUCE proportion of whole population who are living with advanced disease and/or complexity.

End of Life, Frailty & Dementia

Who is in this group?

 End of Life, frailty and dementia is the first segment in the logic and is the first set of criteria on which people are assessed. The segment includes: people who are identified as being in their last year of life, or on the palliative disease register as well as people with incurable cancer. This segment also includes those with severe frailty and/or severe dementia.

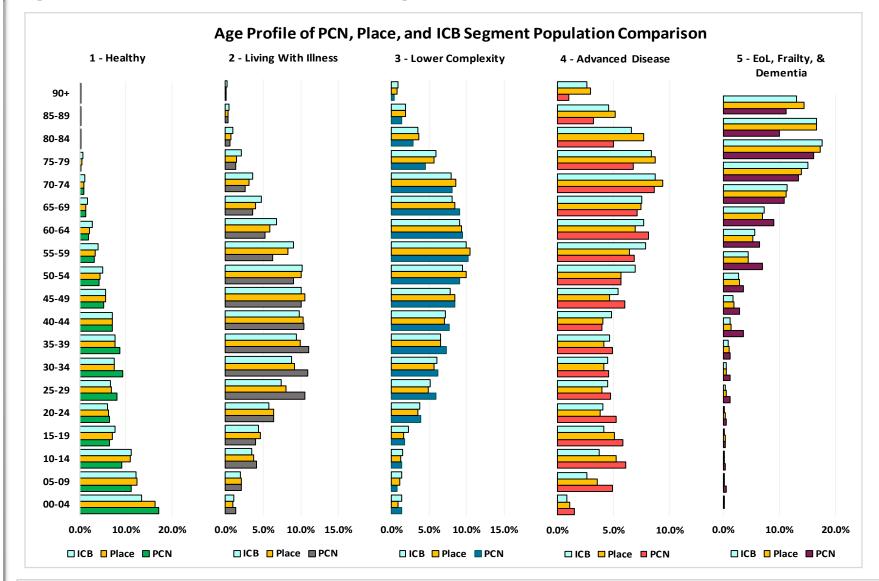
Social & Clinical Outcomes

- REDUCE dependency for emergency care services e.g A&E attendances and emergency admissions.
- INCREASE proportion of people who die in their preferred place of death.
- INCREASE identification of frail and complex patients, including those with dementia or at end of life.
- REDUCE proportion of days disrupted by emergency care in last year of life.
- INCREASE number of days spent at home in last year of life.
- INCREASE proportion of people supported at home instead of in residential care.

Source: Optum & HWE PHM Team - 14th Oct 2022

Age Profile and Health Segment





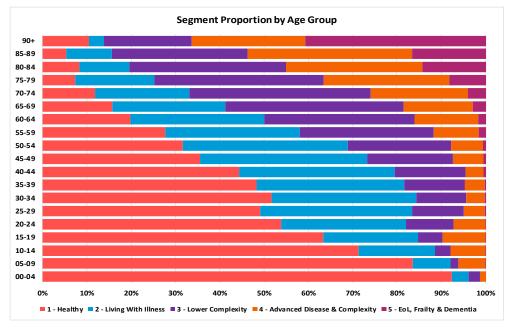
Each registered person is assigned to a segment and this can be cut by age group and also geographically by Place or PCN.

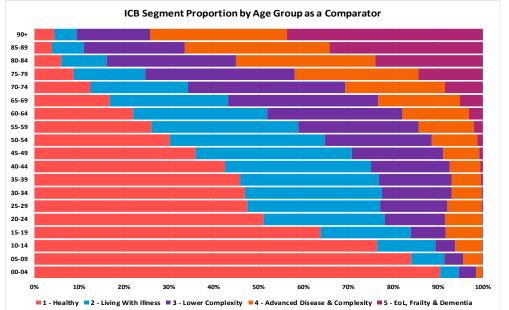
The above looks at the breakdown by age of people within each segment. It provides the PCN value against the Place and ICB value.

Source: HWE PHM Team, Combined population data re-extract via Optum

Demographic Breakdowns - Segment & Deprivation Quintiles





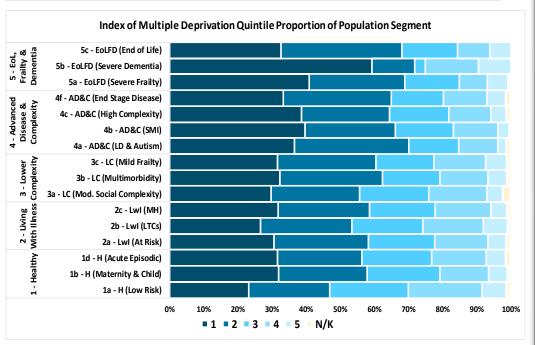


The ICB Health Segments here are broken down by total population and 5 year age groups; as expected with age the proportion of people within the healthy segment decreases.

The illustration on the left represents the PCN breakdown whilst the one on the rights shows the ICB breakdown.

In general Alliance PCN has a similar profile to the ICB population, but with larger numbers of patients Living with Illness.

The illustration bottom right shows the Sub-Segments by Deprivation Quintile, here we can see the levels of deprivation illustrated within the earlier wider determinants slide demonstrated within this breakdown.



Source: HWE PHM Team, Combined population data re-extract via Optum

Major Conditions Comparison - Per 1,000 Registered



PCN NAME		/ /		//		/	, Disbling	ju. vo	/	Chronic Kidney D.	7/5¢35p	/ / &	/	Chronic Gradia	Joseph J		//	Serious Mentalli	s _{our}
	Ø ,	This op	Asthma .	Diabetes	Dementia	Suce.	Cominge O		, o o	Gronic Kie	Heart Disease	Heart Failure	AtrialFib	Si Onic P	Depression	May .	Antien	Serious Me	Atheimers
ABBEY HEALTH	16.94	91.79	134.57	138.01	16.06	35.32	15.82	119.23	33.72	10.05	35.88	10.65	11.77	57.71	121.19	171.41	86.11	25.15	10.73
ALBAN HEALTHCARE	16.78	79.37	154.97	90.13	16.99	53.76	14.22	149.53	34.73	24.16	39.98	10.97	17.65	50.69	127.50	205.23	111.71	23.36	13.08
ALLIANCE	19.90	114.36	123.67	105.84	15.86	29.28	17.82	155.51	31.61	9.04	39.00	10.29	9.50	62.66	114.55	160.93	87.83	25.81	10.21
ALPHA	16.29	121.01	139.73	97.63	14.00	55.48	10.91	161.78	34.67	18.36	42.29	11.02	21.77	53.43	153.71	233.41	120.24	17.12	9.22
ATTENBOROUGH	18.14	113.20	126.85	105.43	15.54	36.21	11.81	130.54	33.07	15.51	42.51	11.91	11.43	50.85	118.02	176.61	95.74	19.13	8.70
BROXBOURNE ALLIANCE	20.30	160.08	122.01	81.19	7.50	61.16	6.46	171.90	29.87	23.09	49.05	11.84	19.50	68.57	135.43	191.17	116.76	7.91	4.09
CENTRAL WATFORD	17.17	97.89	108.55	152.70	20.12	25.21	13.25	123.19	30.90	8.01	34.88	10.09	16.32	46.23	98.31	132.67	62.41	20.54	8.28
DACORUM BETA	24.98	156.71	132.83	158.17	30.23	40.07	18.80	156.86	44.28	19.23	50.10	16.42	26.50	78.15	176.09	245.43	132.71	31.47	14.12
DANAIS	22.41	131.50	138.52	116.70	19.56	36.00	19.66	181.38	45.29	7.84	44.34	12.86	11.35	57.63	137.60	185.74	82.50	28.26	11.88
DELTA	16.90	150.87	135.59	125.22	17.35	45.07	13.06	152.28	34.37	21.60	42.61	10.85	19.87	55.43	142.21	222.46	128.07	22.98	10.97
HALO	18.22	93.22	137.55	112.78	20.85	47.83	20.12	137.28	37.23	16.03	41.35	11.68	16.94	85.83	149.64	217.88	111.29	29.96	14.75
HARLOW NORTH	32.17	113.01	160.55	104.04	9.63	65.83	5.80	185.36	41.56	27.03	59.02	17.64	18.36	73.07	152.95	249.04	129.75	8.61	4.78
HARLOW SOUTH	30.09	197.29	169.79	120.15	9.20	57.49	8.17	162.96	38.98	37.02	62.04	19.34	19.54	83.34	174.03	246.72	118.60	11.48	4.96
HARPENDEN HEALTH	21.78	81.60	149.03	107.08	23.86	69.52	12.79	172.72	49.21	21.85	55.34	17.04	25.35	73.71	145.13	230.18	127.83	21.83	14.49
HATFIELD	16.88	58.23	77.11	65.91	7.71	28.28	6.46	107.06	21.36	5.41	34.69	8.47	14.84	42.95	91.34	131.15	87.53	7.83	2.94
HERTFORD AND RURALS	16.86	116.98	126.99	67.48	7.52	54.51	5.99	147.29	25.97	13.35	42.51	10.83	20.25	52.05	138.84	203.98	117.47	7.46	3.97
HERTS FIVE	18.05	119.79	133.62	149.84	32.47	49.57	15.73	175.39	37.47	28.64	46.04	11.72	28.70	67.86	143.18	211.93	115.95	24.53	12.18
HITCHIN AND WHITWELL	21.11	126.63	141.53	80.38	10.25	64.91	5.36	160.97	32.99	22.56	48.88	11.81	23.23	63.10	146.25	217.69	134.47	9.83	6.42
HODDESDON & BROXBOURNE	22.63	163.45	129.18	88.31	9.82	69.33	6.52	182.13	32.80	23.48	54.65	14.88	26.00	65.08	128.92	211.87	124.10	7.19	5.53
ICKNIELD	20.58	132.39	147.83	85.32	11.91	60.97	6.57	164.18	31.52	35.00	51.59	12.61	22.87	68.86	140.93	220.11	121.08	8.97	7.19
LEA VALLEY HEALTH	23.93	166.87	126.46	86.47	6.11	51.75	9.26	172.10	28.22	18.66	48.18	13.17	18.01	57.90	154.32	231.01	165.70	10.89	5.53
LOUGHTON BUCKHURST HILL & CHIGWELL	15.51	82.36	108.00	75.16	9.75	48.63	3.25	126.39	27.64	12.08	48.45	12.73	24.57	58.16	115.48	166.39	109.95	7.20	4.74
MVPS	20.48	132.18	129.05	118.23	17.10	37.36	15.43	141.83	33.00	29.68	40.10	11.91	12.32	50.34	135.02	189.04	100.76	22.35	10.35
NORTH UTTLESFORD	15.67	23.10	103.62	50.30	8.89	35.46	3.02	82.42	26.01	0.19	40.66	8.29	27.47	50.49	94.73	129.90	109.54	4.31	4.09
NORTH WATFORD	21.96	115.98	140.15	136.45	18.26	39.04	14.64	168.63	39.54	20.47	47.73	15.48	20.13	64.24	142.44	194.02	96.65	24.51	9.80
POTTERS BAR	22.98	140.98	142.22	136.58	24.74	53.46	12.70	148.52	37.34	84.75	44.43	12.35	20.80	65.37	132.36	187.18	88.62	20.73	11.56
RICKMANSWORTH & CHORLEYWOOD	17.43	111.90	132.75	112.05	18.36	44.50	13.90	188.27	41.26	6.88	45.98	15.23	20.02	59.08	127.24	185.97	93.22	19.48	8.82
SOUTH UTTLESFORD	15.28	43.19	113.74	57.46	8.33	38.05	2.34	96.24	24.00	4.96	39.00	9.02	20.59	48.74	99.33	142.19	108.67	4.65	3.60
STEVENAGE NORTH	24.27	273.76	124.18	170.45	10.46	46.58	8.92	155.20	29.48	9.51	46.26	11.84	14.55	64.91	136.82	194.88	111.38	8.02	6.11
STEVENAGE SOUTH	23.31	128.57	101.25	75.88	9.99	44.87	6.69	144.52	30.88	15.08	46.63	12.90	13.69	62.56	105.37	151.85	76.49	7.45	6.03
STORT VALLEY & VILLAGES	17.85	122.87	132.49	65.60	7.18	53.86	6.92	144.16	26.39	19.45	44.05	13.41	19.82	60.97	120.51	203.15	127.69	6.34	3.43
THE GRAND UNION	17.43	143.73	135.30	134.24	19.14	42.21	12.89	149.94	36.78	28.86	46.99	12.45	19.10	62.75	138.79	195.84	95.98	20.23	9.53
WARE AND RURALS	18.09	163.30	165.40	77.77	7.63	58.28	5.79	154.35	27.24	22.49	47.89	12.74	20.82	60.01	132.46	198.85	108.67	6.62	4.13
WELWYN GARDEN CITY A	19.05	104.74	104.65	68.93	6.62	41.07	6.99	132.35	23.08	10.49	38.53	10.24	17.72	48.93	117.64	178.45	109.12	7.12	3.14

The data from the ICB model has been collated and the above provides a rate per 1,000 population with a recording of each condition. The darker the blue the higher the presence of the condition within the PCN's population.

Further information and tools that monitor identification and management of people with conditions are available in Ardens Manager rolled out to support the ICB's ECF. Searches available via Ardens can support with case finding and identifying people with management indicators that are due.

When analysing the underlying Segmentation Model data the conditions with highest per 1,000 registered prevalence that are highlighted for Alliance are Learning Disabilities, Serious Mental Illness, and Alzheimer's; Cancer appears very low - but we should question that the data is being recorded correctly within all the Practices.

Continued



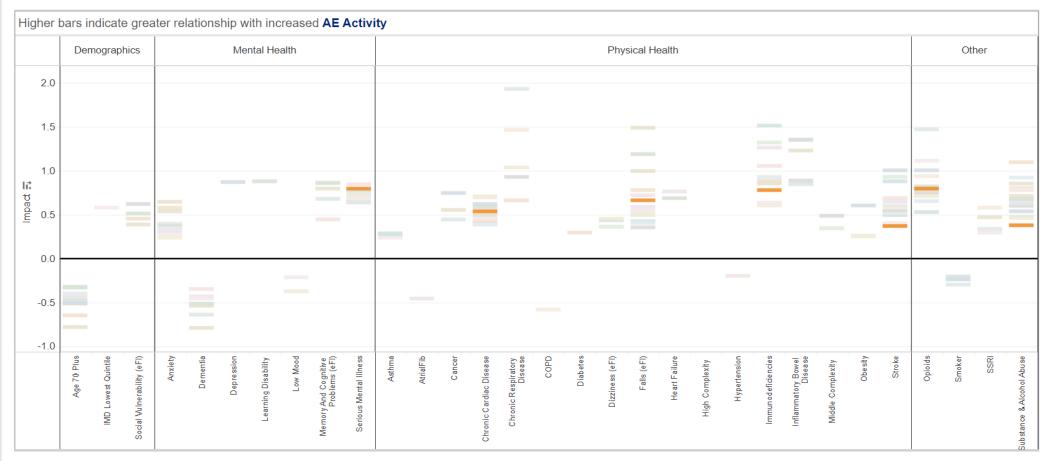
PCN NAME		/ /%	Chronic Resp.	osio Vojeces	Huntingtons Di.	oseosc. International Property of the Property	somel Dise	ii,	, is	Muscular District	May 90 me. So	* / * * / * * * * * * * * * * * * * * *	Office Neurologic	Oscal Condi	Rheumatojo Arri	sining.	/ /ss	Solid Orean Trail	
	480	Cerebral palsu	Change Change	Cystic Fibrosis	Huntingto	ieuwejjuj	Money Translation	Metassatic Can	Multiple Sciences:	Muscular,	Mashenia Gay	Osteopolosis	OHO NOW	Parkinsons Dises	Pheumoto	(3)S) Snan7	Sichle Gell Dise.	Solio	High Bp
ABBEY HEALTH	14.98	1.20	20.95	0.40	0.04	9.37	2.04	2.48	1.56	0.52	0.28	14.46	1.20	2.08	7.53	0.92	0.44	1.48	25.51
ALBAN HEALTHCARE	13.61	1.20	22.10	0.77	0.23	11.13	2.30	3.02	1.73	0.30	0.33	24.28	1.10	2.77	8.39	1.43	0.28	1.34	31.80
ALLIANCE	17.30	1.66	25.28	1.73	0.04	10.85	2.45	3.01	1.13	0.19	0.15	10.55	1.06	2.60	9.01	1.24	1.70	1.09	30.03
ALPHA	11.10	0.64	21.64	0.66	0.13	10.97	2.67	2.41	2.46	0.36	0.30	20.86	1.30	3.14	9.41	1.22	0.17	1.39	35.30
ATTENBOROUGH	11.11	0.96	22.70	1.41	0.13	10.43	2.57	2.70	1.80	0.42	0.29	17.75	1.12	1.99	7.64	1.25	0.55	1.44	42.89
BROXBOURNE ALLIANCE	8.71	1.08	27.27	0.55	0.02	13.59	2.21	3.15	2.09	0.32	0.34	24.44	1.56	1.95	9.86	1.43	0.78	1.45	87.88
CENTRAL WATFORD	10.69	1.11	20.87	0.87	0.15	7.62	2.32	2.65	1.20	0.27	0.21	11.29	1.30	2.44	7.53	1.17	0.54	1.14	29.37
DACORUM BETA	17.95	1.28	29.89	1.09	0.15	11.68	2.62	4.19	2.11	0.53	0.10	17.54	1.16	3.61	9.52	1.33	0.75	1.60	36.87
DANAIS	16.34	1.18	26.91	0.79	0.26	10.93	2.13	3.22	1.77	0.39	0.30	8.73	1.31	2.92	10.14	1.21	0.89	1.71	39.02
DELTA	13.39	1.02	21.36	0.96	0.27	11.99	2.31	3.60	2.28	0.42	0.24	18.70	0.96	2.97	8.99	1.14	0.51	1.20	37.04
HALO	20.38	1.52	23.45	0.73	0.18	11.68	2.31	3.56	1.90	0.23	0.20	20.47	1.40	3.88	8.70	1.34	0.41	0.99	31.92
HARLOW NORTH	7.53	1.38	42.10	1.26	0.06	13.93	3.47	3.41	2.51	0.30	0.36	29.48	2.45	2.39	13.51	1.49	0.60	2.21	69.06
HARLOW SOUTH	11.58	2.48	42.29	0.93	0.10	13.55	2.38	4.24	1.65	0.52	0.52	40.02	2.27	2.38	13.55	2.48	0.31	1.86	95.65
HARPENDEN HEALTH	12.54	1.06	28.25	0.66	0.12	10.84	2.47	5.89	2.22	0.39	0.48	29.04	1.89	4.68	9.54	1.18	0.39	1.41	28.50
HATFIELD	6.55	0.76	21.97	0.47	0.06	10.21	2.74	1.89	0.90	0.32	0.23	19.79	1.43	1.51	6.72	1.25	0.84	1.54	71.96
HERTFORD AND RURALS	8.19	0.81	24.68	0.69	0.12	15.00	2.38	2.24	2.26	0.44	0.30	27.37	1.37	2.38	7.72	0.89	0.10	1.53	90.91
HERTS FIVE	13.79	1.39	23.04	0.77	0.13	12.86	2.98	2.86	2.45	0.25	0.36	22.67	1.69	3.63	17.88	1.26	0.62	1.66	34.03
HITCHIN AND WHITWELL	9.93	1.49	30.11	0.50	0.00	15.61	2.87	3.41	2.41	0.32	0.32	34.83	1.42	2.52	8.34	1.63	0.14	1.60	92.26
HODDESDON & BROXBOURNE	9.14	0.96	31.53	0.58	0.27	14.77	2.84	3.29	2.38	0.43	0.23	33.55	1.73	2.33	9.37	1.35	0.22	1.73	96.87
ICKNIELD	10.67	1.08	29.47	0.62	0.08	16.17	2.69	2.91	3.58	0.43	0.32	27.18	1.29	2.67	8.51	1.27	0.05	2.02	82.47
LEA VALLEY HEALTH	10.05	1.27	31.63	0.59	0.10	12.74	2.37	2.80	1.53	0.36	0.46	22.43	1.89	1.72	10.47	1.63	1.11	1.98	97.79
LOUGHTON BUCKHURST HILL & CHIGWELL	4.13	0.84	22.95	0.79	0.14	14.26	2.42	3.62	1.77	0.46	0.33	38.42	1.90	2.04	8.87	1.53	0.19	1.35	65.68
MVPS	14.28	1.17	34.30	10.11	0.07	11.35	2.43	3.60	2.06	0.30	0.15	15.86	1.17	2.47	8.53	1.69	0.59	1.30	32.96
NORTH UTTLESFORD	2.34	0.78	21.65	0.73	0.05	11.09	1.18	2.48	1.13	0.48	0.11	23.32	1.16	1.27	10.04	1.29	0.03	1.72	26.93
NORTH WATFORD	12.70	1.07	27.72	2.17	0.11	12.20	2.44	3.36	2.40	0.42	0.31	16.47	1.53	2.63	9.42	1.45	0.34	0.92	37.13
POTTERS BAR	12.98	0.76	27.06	0.62	0.17	8.31	1.90	2.70	2.01	0.38	0.48	21.07	1.49	3.25	7.96	1.07	0.42	1.28	33.70
RICKMANSWORTH & CHORLEYWOOD	11.74	1.12	23.30	2.02	0.25	9.40	2.45	3.20	1.33	0.54	0.18	15.52	0.97	2.88	7.38	0.97	0.11	1.51	32.44
SOUTH UTTLESFORD	3.05	1.02	21.93	0.53	0.02	10.61	1.97	2.44	1.89	0.28	0.22	29.23	1.34	1.71	10.30	1.48	0.08	2.01	24.13
STEVENAGE NORTH	12.22	1.43	32.98	0.27	0.05	16.52	3.40	2.92	2.23	0.64	0.27	15.67	1.81	2.71	7.06	1.27	0.48	1.54	94.81
STEVENAGE SOUTH	10.81	1.57	31.16	0.88	0.06	13.08	2.69	4.03	2.09	0.27	0.33	14.90	1.57	2.09	5.81	1.12	0.39	1.73	75.58
STORT VALLEY & VILLAGES	10.22	1.05	25.19	0.51	0.00	12.73	1.89	3.26	1.95	0.41	0.36	41.69	1.69	2.08	9.13	1.63	0.13	1.39	76.18
THE GRAND UNION	13.30	1.32	22.90	1.36	0.18	11.75	2.22	3.19	2.19	0.25	0.25	26.69	1.27	2.29	9.07	1.53	0.53	1.68	74.02
WARE AND RURALS	7.25	1.01	25.52	0.77	0.09	14.85	2.67	2.64	1.81	0.18	0.27	26.11	1.63	2.58	7.58	1.22	0.03	1.75	86.12
WELWYN GARDEN CITY A	9.18	0.77	25.87	0.71	0.05	13.17	2.65	2.13	1.92	0.46	0.20	20.42	1.30	1.37	7.02	1.11	0.38	1.55	89.89

On this page of conditions, ASD related patients, Cerebral Palsy, and Sickle Cell Disease prevalence is also one of the highest rated in the ICB.

Source: HWE PHM Team, Combined population data re-extract via Optum

PCN Benchmarking - A&E Activity





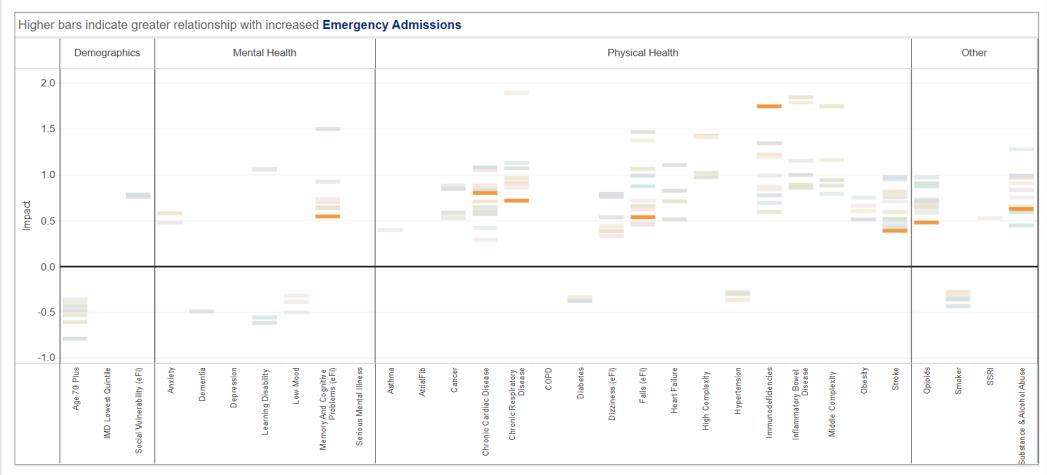
The charts in the next two pages show activity for the PCN compared against all other PCNs at the Place level.

The Model - A statistical regression model is used to decide which Risk Factors correlate with a significant impact on the selected targets as presented in these charts, the height of the bar for each PCN relates to the correlation of a Risk Factor and an increase in impact on the selected target condition.

The impact for the PCN is given and will vary for each characteristic; a wide variance may indicate differences in care or good practice which could be shared; some impacts are positive. Higher bars indicate a greater relationship with increased A&E attendances

PCN Benchmarking - Emergency Admissions





This uses the same principles as the previous slide but looks at Emergency Admission.

Learning Disability admissions shows the most variance across all PCNs, meaning that characteristic has a high impact on emergency admissions.

Urgent and Emergency Care



As part of the ICB Urgent and Emergency Care Programme a needs analysis was undertaken.

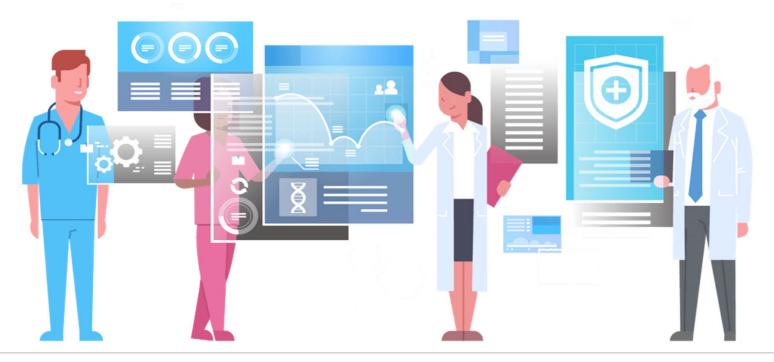
Overall aim

* To understand what and where the need is for access to urgent and emergency care in Hertfordshire and West Essex

Objectives

- * To build a comprehensive picture of who needs to access UEC in HWE and who could be better cared for in alternative settings.
- * To understand the root causes of why people are accessing UEC when there could have been more appropriate alternative pathways
- * To build consensus among stakeholders around what the key issues in UEC are
- * To draw conclusions based on public health intelligence and triangulation of data to inform a successful and achievable UEC strategy

Some of the initial outputs from this work have been included within the next few pages, providing the PCN benchmarking.



UEC Overview



Hertfordshire & West Essex ICB – South & West A&E Summary – Who are attending and why?

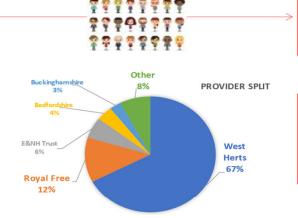
Children 0 -18 Adults 19 -64 Older People 65+

223,830 A&E Attendances in 2021/22

Children = 62,944 (28.1%) Adults = 113,994 (50.9%) Older People = 46,892 (20.9%)

84,710 (37.8%) of attendances resulted in no investigation and no treatment (includes Uncoded Activity)

> Children = 31,599 (50.2%) Adults = 42,719 (37.5%) Older People = 10,392 (22.2%)



141,377 people attended A&E in 2021/22

Children = 40,129 (28.4%) Adults = 73,984 (52.3%) Older People = 27,548 (19.5%)

This translates to 1 in 5 people registered with South & West attending A&E

Children = 1 in 4 children Adults = 1 in 5 adults Older People = 1 in 4 older people

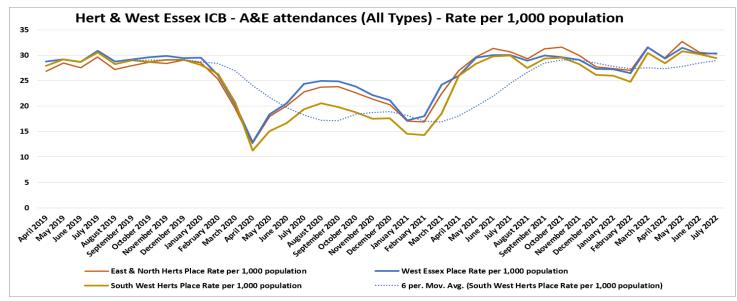


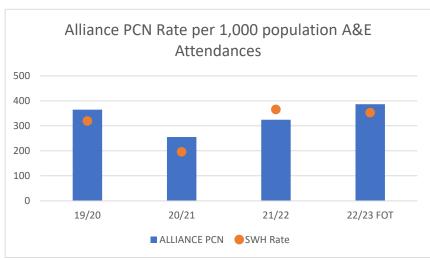


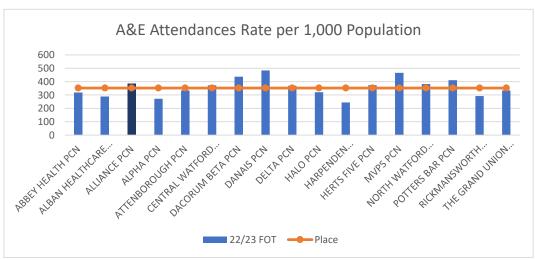
Source: SUS

UEC









Rates of A&E attendances across the ICB have returned to pre covid levels and above.

The impact of covid can clearly be seen in the top left chart.

Urgent & Emergency Care in 2022/23 has seen one of the highest in the area for the A&E Attendance rates per 1,000 population, this is above the South West Herts rate.

Source: HWE PHM Team modelled data, phm.optum.co.uk - Calendar Year 2021

Unplanned Hospitalisation for Chronic Ambulatory Care Sensitive Conditions



This analysis looks at Unplanned hospitalisation for chronic ambulatory care sensitive conditions
NHS Outcomes Framework Methodology.

Between April 2021 and September 2022 there have been 11,953 people admitted 15,563 times for chronic ambulatory care sensitive conditions across the ICB.

Costed at tariff the value was approximately £42 million.

The table here shows the breakdown for Alliance PCN.

Chronic ACS admissions April 2021 - September 2022 Herts & West Essex ICB

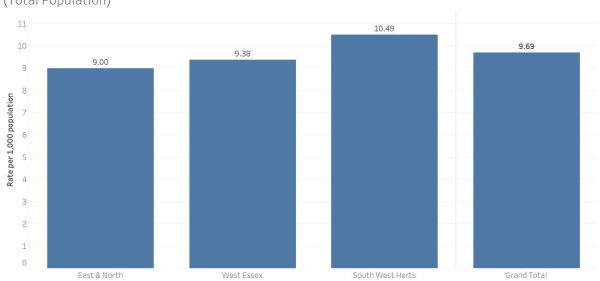
Chronic ACS	Admissions	People	Average cost of admission	Tariff Total Payment National
CVD: AF and Flutter	43	35	£2,030	£87,274
CVD: Angina	8	7	£860	£6,883
CVD: Congestive Heart Failure	46	41	£4,569	£210,186
CVD: Hypertension	17	16	£656	£11,145
Diseases of the blood	22	17	£2,297	£50,529
Mental and Behavioural Disorders	2	2	£0	£0
Neurological Disorders	25	14	£1,466	£36,652
Nutritional, endocrine and metabolic	51	34	£2,126	£108,447
Respiratory: Asthma	30	22	£1,612	£48,370
Respiratory: COPD	41	32	£2,506	£102,763
Grand Total	285	211	£2,324	£662,249

^{*} Average cost for Mental and Behavioural is not representative as non-PbR

ACS Admission Rates per 1,000 Population by Place





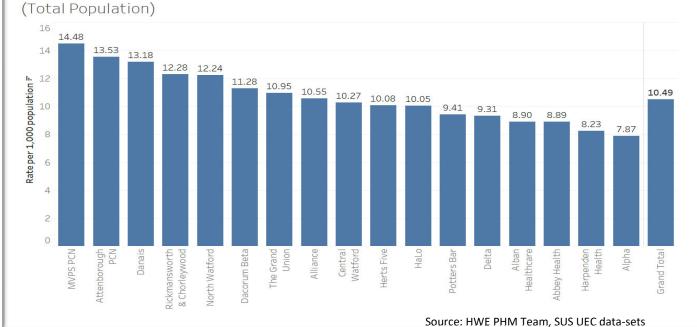


When comparing the Ambulatory Care Sensitive rates per 1,000 population between places, the South West Herts Place has the highest rate in the ICB.

Within South West Herts Place, Alliance has a rate per 1,000 population at 10.55, just above the place rate of 10.49.

The following slides look at how this is broken down by the different ACSs and how the patients fall within the different segments.

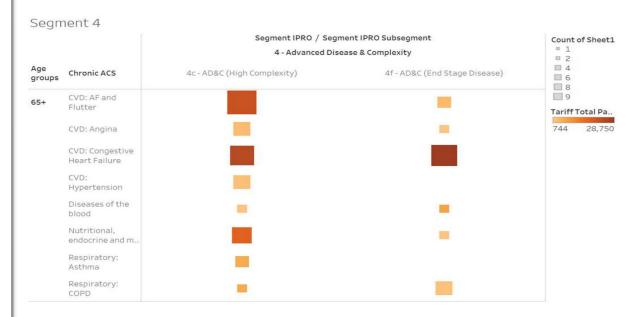
Chronic Ambulatory Care Sensitive Conditions by Place Rate per 1,000 Population



Chronic ACS by Segment Hertfordshire and **West Essex** Integrated Care Board ACS by segment_age Segment IPRO Count of Sheet1 * 1 2 - Living With Illness 3 - Lower Complexity 4 - Advanced Disease & Co.. 5 - EoL, Frailty & Dementia 1 - Healthy Age gr.. **10** □ 20 30 **40** Child 54 Tariff Total Pa... 659 203K 19-40 41-64 65+ The above chart looks at the ACS admissions by age and segment. The size reflects volume and the depth of colour reflects cost. When looking at the ACS conditions for Alliance, the highest volume and cost is within the End of Life, Severe Frailty and Dementia in the over 65 age group followed by the same age in the Advanced Disease and Complexity segment. The following pages look at which ACSs contribute to this.

UEC by Advanced Disease & Complexity, and EOL, Frailty & Dementia





ACS conditions of note for people aged over 65 within the Advanced Disease and Complexity, is highlighted as AF and Flutter and Heart Failure, with the highest volume and cost.

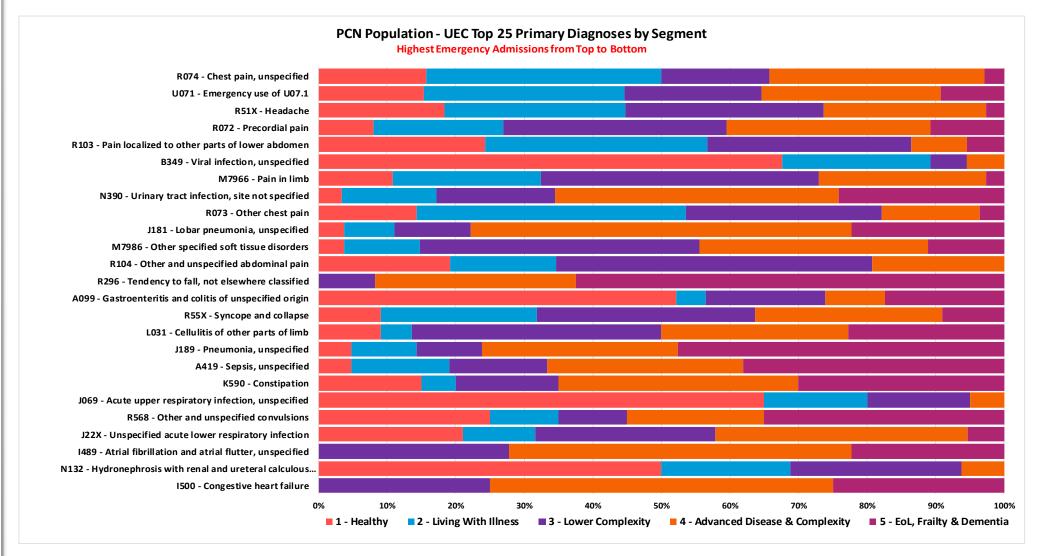
For those within the End of Life, Frailty & Dementia, COPD, Asthma, Heart Failure, AF and Flutter and Diseases of the Blood, are the ACS with the highest volume and cost.

Segment 5



UEC Diagnoses by Segment





Here we have identified the top 25 primary diagnoses for the PCN's population, for all UEC admissions - and then these diagnoses split these by the health segments that each patient falls into to see where outliers are for the PCN.

UEC & Segmentation + Deprivation by Ward



UEC Patients Seen by Segment &	1 - Healthy	With	3 - Lower Complexity		5 - EoL, Frailty &	Grand Total
Ward		Illness		Disease & Complexity	Dementia	
Adeyfield East	22	6	15	10	2	2 55
Adeyfield West	2			4		
Apsley and Corner Hall Ashley	3 15			1 11	17	
Batchwood	4			3		
Bennetts End		3				
Berkhamsted East	1					1
Borehamwood Kenilworth				1	4	5
Bovingdon, Flaunden and Chipperfield	2	. 1	1	2		6
Boxmoor				7		7
Bushey Heath				1		1
Bushey North Bushey St James	1 1			1	1	1 4
Callowland			1			1
Carpenders Park	16	14		53	19	
Central				1		1
Chaulden and Warners End	1	6		4	5	
Chorleywood South & Maple Cross			1			1
Clarence	8			10		28
Colney Heath	5 11	1 14	1 8	3 12		13 45
Cunningham Gade Valley	11	. 14	0	2		2
Gadebridge		3	4	5		
Grovehill	64		101	121		
Harpenden East	1					1
Harpenden North		1				1
Hatfield Central		1				1
Hatfield East Hatfield South			1	2		1 2
Hatfield West	1					1
Hemel Hempstead Town	5		1	10	2	
Highfield	4			16		
Holywell					9	5
Leavesden	1	1	1			3
Leverstock Green	3			3		
London Colney Marshalswick North	15 4			48 7	25	
Marshalswick South	1		1	/	2	
Moor Park & Eastbury		1				2
Nascot			1	1		2
Nash Mills				1		1
Oxhey	2	. 2	5	6	4	19
Oxhey Hall & Hayling	26			73		
Park Street	6	10	12	8		
Peartree Penn & Mill End	1			3		3
Redbourn		3		2		5
Rickmansworth Town			1	1		2
Sandridge	2	1	1	9		13
Shenley		1				1
Sopwell	6			2		15
South Oxhey	29		76	79		
St Peters St Stephen	20 29		4 25	10 32		
st stepnen Stanborough	1		25	32	10	116
Verulam	2		3	3		9
Vicarage			1			1
Watling	2			3		5
Welham Green			1			1
Welwyn East			1			1
Wheathampstead	2					2
Woodhall Farm Woodside	54	53	59	72 1		
Unknown Ward	4	. 3	5	8		2 22
	-	409				

UEC Patients Seen by Deprivation Quintile & Ward						(blank	Grand
1 = Most Deprived, 5 = Least Deprived							Total
Adeyfield East	49		6				55
Adeyfield West	16						16
Apsley and Corner Hall	3	14	4	2			23
Ashley			33	15	20		68
Batchwood	3	3	4	6			10
Bennetts End	7		1	3			1:
Berkhamsted East Borehamwood Kenilworth		5	1				9
Bovingdon, Flaunden and Chipperfield		5		6			
Boxmoor			7	U			-
Bushey Heath				1			
Bushey North				1			
Bushey St James			3	1			4
Callowland			1				:
Carpenders Park	73		33	7	23		136
Central	1						:
Chaulden and Warners End		14	1	5			20
Chorleywood South & Maple Cross	1						
Clarence				25	3		28
Colney Heath		4	4	5			13
Cunningham	7	11	21	6			45
Gade Valley		7	6	1			1
Gadebridge Grovehill	278	156	ь				13 434
Harpenden East	2/0	136					434
Harpenden North	_		1				
Hatfield Central	1	_					
Hatfield East		1					
Hatfield South	_		2				
Hatfield West		1					:
Hemel Hempstead Town	16	8					24
Highfield	37						37
Holywell		5					
Leavesden			3				
Leverstock Green	1	13	4		7		25
London Colney		40	76	27			143
Marshalswick North			7	7 2	8 5		22
Marshalswick South Moor Park & Eastbury				2	2		1
Nascot			1		1		
Nash Mills		1		_			
Oxhey	10			9			19
Oxhey Hall & Hayling	10	193		21			214
Park Street		12	1	33	1		47
Peartree	3						3
Penn & Mill End		1					:
Redbourn		5					
Rickmansworth Town					2		:
Sandridge	_		13				13
Shenley		1			_		
Sopwell	11		2	1	1		15
South Oxhey	174	148		26			322
St Peters		6		38			44
St Stephen			59 1	7	50		116
Stanborough Verulam			1	4	5		9
veruiam Vicarage		1		4	5		
Vicarage Watling		3	2				
Welham Green		3	1				
Welwyn East					1		
Wheathampstead		2					
Woodhall Farm	89		133	41			263
Woodside		1					:
						22	22

It is also important to know that a Ward may be made up of different LSOAs, and therefore have different levels of deprivation as found in the Indices of Multiple Deprivation scoring given to us be the Government; in the graph quintile 1 is the Highest or Most deprived, and quintile 5 is the Least deprived.

It is also useful to note under which Wards that the PCNs population are linked to, and specifically here, where the admissions are highest.

The indication then for these patients split by health segments also adds a layer of importance when considering how the District Councils may help you investigate your population and where the wider determinants and health inequalities may be present.

Source: HWE PHM Team, Combined population data re-extract via Optum, NHS England

Public Health - Nationally Reported Admissions





Hospital Admissions

Period	HERTFORDSHIRE AND WEST ESSEX	ALLIANCE PCN
2020/21	2026	2483.8
2020/21	130.8	
2020/21	40.5	
2020/21	505.9	1197.4
2020/21	177.2	325.9
2020/21	494.9	752.3
2020/21	611.6	1085.6
	2020/21 2020/21 2020/21 2020/21 2020/21 2020/21	2020/21 2026 2020/21 130.8 2020/21 40.5 2020/21 505.9 2020/21 177.2 2020/21 494.9

PH.Intelligence@hertfordshire.gov.uk





The above table produced by the Hertfordshire Public Health Evidence and Intelligence team shows the emergency admissions data within fingertips.

Alliance PCN show a higher rate of admissions to the ICB.

Source: Public Health Team

Frailty Segment - Detailed PCN Breakdown



	Most dep	rived					Most affluent						
Index of Multiple Deprivation Decile	1	2	3	4	5	6	7	8	9	10	NULL	PCN	ICS
Overall Population Measures													
Population	13	21	30	117	182	71	66	34	37	17	1	589	3772
% of population in cohort	2.2%	3.6%	5.1%	19.9%	30.9%	12.1%	11.2%	5.8%	6.3%	2.9%	0.2%	100.0%	100.0
Avg. Age	66.6	65.5	64.3	72.9	73.7	71.4	69.5	73.9	72.7	77.3	80.0	71.9	75.6
% BAME Where recorded	23%	10%	14%	13%	14%	20%	17%	12%	32%	31%	0%	16%	8%
Avg. number of Acute and Chronic Condition	7.2	6.0	5.0	7.1	6.4	6.4	6.0	5.3	6.3	5.4	2.0	6.3	5.5
Activity Measure													
Emergency Admissions	0.7	0.9	1.2	1.0	1.0	0.7	0.9	0.7	0.9	0.8	2.0	0.9	0.6
A&E Attendances	1.3	1.1	1.6	1.6	1.5	1.1	1.2	1.0	1.2	1.1	2.0	1.4	0.9
GP Encounters	94.2	56.4	70.4	80.2	91.7	91.3	81.1	69.0	80.6	66.7	69.0	83.1	103
Admitted Bed Days	0.4	5.8	10.1	6.0	7.1	4.1	9.9	6.0	8.6	7.6	40.0	6.9	4.
Physical Health													
Asthma	23.1%	42.9%	23.3%	30.8%	25.8%	21.1%	28.8%	23.5%	21.6%	11.8%	0.0%	26.1%	25.2
Cancer	38.5%	38.1%	30.0%	22.2%	35.2%	38.0%	34.8%	35.3%	21.6%	35.3%	0.0%	31.9%	32.8
Chronic Cardiac Disease	61.5%	52.4%	33.3%	59.0%	59.3%	47.9%	54.5%	44.1%	51.4%	64.7%	0.0%	54.5%	47.5
Chronic Respiratory Disease	38.5%	38.1%	23.3%	31.6%	32.4%	19.7%	28.8%	26.5%	29.7%	29.4%	0.0%	29.5%	22.2
CKD	61.5%	14.3%	20.0%	27.4%	35.7%	23.9%	34.8%	38.2%	29.7%	23.5%	0.0%	30.9%	20.7
Heart Disease	53.8%	33.3%	30.0%	46.2%	46.2%	39.4%	47.0%	44.1%	48.6%	52.9%	0.0%	44.5%	39.1
Hypertension	76.9%	81.0%	76.7%	74.4%	79.1%	70.4%	66.7%	76.5%	70.3%	88.2%	100.0%	75.2%	74.5
Diabetes	61.5%	66.7%	33.3%	58.1%	50.0%	47.9%	48.5%	47.1%	40.5%	23.5%	0.0%	49.6%	42.
Obesity	53.8%	47.6%	43.3%	38.5%	43.4%	42.3%	37.9%	47.1%	37.8%	23.5%	0.0%	41.3%	32.
Rheumatoid Arthritis	15.4%	19.0%	10.0%	12.0%	3.8%	7.0%	4.5%	0.0%	10.8%	5.9%	0.0%	7.3%	5.3
Stroke	30.8%	47.6%	40.0%	49.6%	35.2%	46.5%	37.9%	38.2%	43.2%	17.6%	100.0%	40.6%	34.
Mental Health	30.070	47.070	40.070	43.070	33.270	40.570	37.370	30.270	43.270	17.070	100.070	40.070	54
Anxiety	30.8%	33.3%	30.0%	38.5%	26.9%	38.0%	30.3%	14.7%	35.1%	23.5%	0.0%	31.1%	29.0
Depression	53.8%	47.6%	36.7%	43.6%	39.0%	42.3%	37.9%	23.5%	40.5%	29.4%	0.0%	39.6%	33.
Dementia	15.4%	4.8%	16.7%	29.9%	17.6%	26.8%	15.2%	11.8%	29.7%	23.5%	0.0%	20.9%	18.
Serious Mental Illness	15.4%	9.5%	6.7%	17.9%	10.4%	15.5%	9.1%	5.9%	18.9%	0.0%	0.0%	12.2%	6.5
Low Mood	23.1%	19.0%	23.3%	23.1%	14.3%	28.2%	19.7%	8.8%	18.9%	11.8%	0.0%	19.0%	18.
Suicide	0.0%	4.8%	3.3%	4.3%	1.6%	7.0%	0.0%	5.9%	2.7%	0.0%	0.0%	3.1%	1.5
Mental Health Flag	69.2%	66.7%	46.7%	59.0%	45.1%	56.3%	45.5%	35.3%	51.4%	41.2%	0.0%	50.3%	48.
Screening and Verification Refusal	03.270	00.770	40.770	33.070	45.170	30.370	43.370	33.3/0	J1.4/0	41.2/0	0.070	30.370	40.
Bowel Screening Refused	46.2%	47.6%	23.3%	35.0%	35.2%	32.4%	22.7%	17.6%	35.1%	5.9%	0.0%	31.6%	25.
Cervical Screening Refused	7.7%	14.3%	6.7%	7.7%	7.1%	9.9%	6.1%	2.9%	5.4%	0.0%	0.0%	7.1%	3.6
Flu Vaccine Refused	30.8%	61.9%	30.0%	39.3%	37.9%	47.9%	31.8%	47.1%	48.6%	52.9%	100.0%	40.7%	26.
Wider Indicators	30.070	01.570	30.070	33.370	37.370	47.570	31.0/0	47.1/0	40.070	32.370	100.070	40.770	20.
Has A Carer	7.7%	9.5%	13.3%	25.6%	13.7%	19.7%	12.1%	14.7%	16.2%	23.5%	0.0%	16.8%	19.
Is A Carer	7.7%	14.3%	0.0%	13.7%	4.9%	9.9%	6.1%	0.0%	10.2%	5.9%	0.0%	7.6%	11.9
MED3 Not Fit For Work (ever)	53.8%	23.8%	30.0%	20.5%	16.5%	23.9%	31.8%	20.6%	13.5%	0.0%	0.0%	21.2%	13.
MED3 Not Fit For Work (in Last Year)	0.0%	14.3%	10.0%	7.7%	3.8%	2.8%	10.6%	5.9%	2.7%	0.0%	0.0%	5.8%	3.5
MED3 Not Fit For Work (in Last Six Months)	7.7%	14.3%	10.0%	6.8%	3.3%	2.8%	9.1%	2.9%	2.7%	0.0%	0.0%	5.3%	2.8
Avg. number of eFI Deficits	13.7	12.0	11.8	13.4	13.3	12.7	12.7	12.8	11.9	10.4	15.0	12.9	13
eFI Housebound	0.0%	4.8%	6.7%	13.7%	8.2%	12.7%	10.6%	2.9%	10.8%	11.8%	0.0%	9.7%	10.
				ì			i						
eFI_SocialVulnerability	7.7%	33.3%	16.7%	26.5%	20.3%	16.9%	15.2% 	11.8%	24.3%	23.5%	0.0%	20.4%	27.
People_ChildrenInPoverty	17.0	17.0	24.4	145	10.2	0.0	0.1	12.0	7.0	5.8		13.2	15
Housing_FuelPoverty	17.0	17.6 33.6	13.8 36.1	14.5 33.4	13.7 28.9	8.9 28.8	9.1 29.8	12.0	7.8	7.4		12.3	11

14.8% of the general population in HWE ICB live within the 4 most deprived deciles, whilst 16.1% of the population in the EoL, severe frailty and severe dementia segment live within the 4 most deprived deciles.

In Alliance PCN, 30.8% of the population in the EoL, severe frailty and severe dementia segment live within the 4 most deprived deciles, this is a significant indicator.

The average age of a person within the Frail and End of life segment increases with affluence, ranging from 66 in the most deprived decile to 77 within the most affluent decile within the ICB.

As we would expect the average number of acute and chronic conditions is significantly higher within this segment that the general population as are all activity measures. The average number of Chronic Conditions for people within Alliance PCN is higher than the ICB.

Within this segment we can see the presence of Chronic Cardiac Disease, high Hypertension rates, and Diabetes being highlighted here.

Applying Machine Learning factors without our data platform



Why Machine Learning?

With limited capacity available across the ICB available to review lists of patients it is important that the data available is used to its maximum to refine our process and target our resources where they will have the most impact.

The aim is to build the features identified from the machine learning in to system searches for EMIS and SystmOne.

Approach

- Trained several machine learning models on ~1 million linked patient records across ~200 features from the ICS segmentation dataset, for binary A&E risk prediction (will this patient use A&E within the next year?).
- Selected a final twin ensemble model with a binary classification accuracy of 81.3%.
- Extracted output probabilities for each class to estimate a risk score for each patient, and generated risk scores for all of the patients in the segmentation data. We can think of the risk score as the model's confidence in a patient requiring A&E.
- Partitioned the patient population into 3 distinct grades, Low, Medium and High risk, based on the machine learning predictions:

Risk grade	Range of predicted risk scores	Number of patients in grade	% of population in grade
High	0.8 to 1.0	22603	1.8
Medium	0.6 to 0.8	100446	8.1
Low	0.0 to 0.6	1115544	90.1

Creating search logic from significant features

- Features input to the predictive model include demographic features, diagnosis codes, prescribed medication, waitlist information and environmental factors such as housing and proximity to healthcare.
- Used feature rankings learned by the model to reduce the set of ~200 features to the 30 most significant features that best explain the variance in the predicted class (requiring A&E or not).
- Trained secondary machine learning models, 5-split decision trees, to classify patients into each of the three risk grades based on these 30 significant features.
- Extracted decision tree logic to create search filters for patients by risk grade. 5 splits → 2^5 = 32 unique rules. These rules have been merged and prioritised (by considering individual accuracies and sample sizes) to maximise precision and recall in the final search filters.

Feature	Relative significance (%)
Age	15.03
Drug: Pain Management	10.22
Substance Abuse	4.19
Med3 Not Fit For Work	3.41
Stroke	3.03
eFI: Falls	2.23
Air Rank Quality	2.01
Waiting List Count All	1.83

	Age < 3 AND Drug: Salbutamol AND eFI: Dyspnoea
Risk Grade:	Med3 Not Fit For Work (last six months) AND Substance Abuse AND ONE OF: Drug: Pain Management AND eFI: Peptic Ulcer Chronic Cardiac Disease
High	 Drug: Pain Management AND eFI: Falls AND ONE OF:- Stroke AND eFI: Memory and Cognitive Problems Stroke AND Substance Abuse End Stage Disease
Risk Grade: Medium	Age < 3 AND ONE OF: Drug: Salbutamol AND NO eFI: Dyspnoea On any waiting list Med3 Not Fit For Work (last six months) AND Substance Abuse AND NO Chronic Cardiac Disease Age < 45 AND Med3 Not Fit For Work (last six months) AND Drug: Pain Management Drug: Pain Management AND Substance Abuse AND ONE OF: Drug: Opioids eFI: Falls AND NO Stroke AND NO End Stage Disease
Risk Grade: Low	All others

Source: HWE PHM Team

Quality & Outcomes Framework



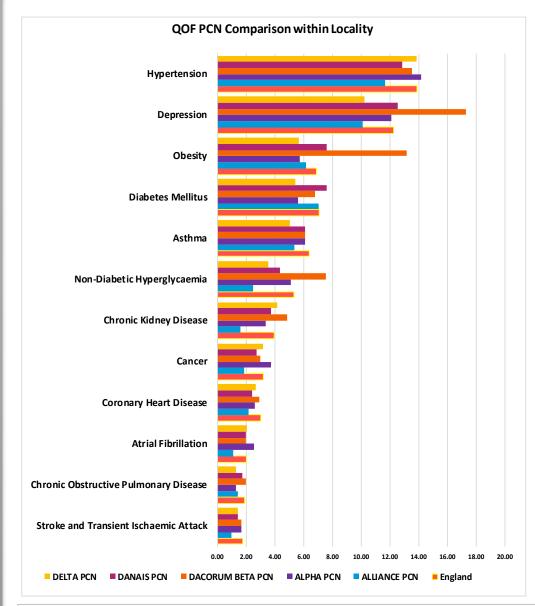
Contents:

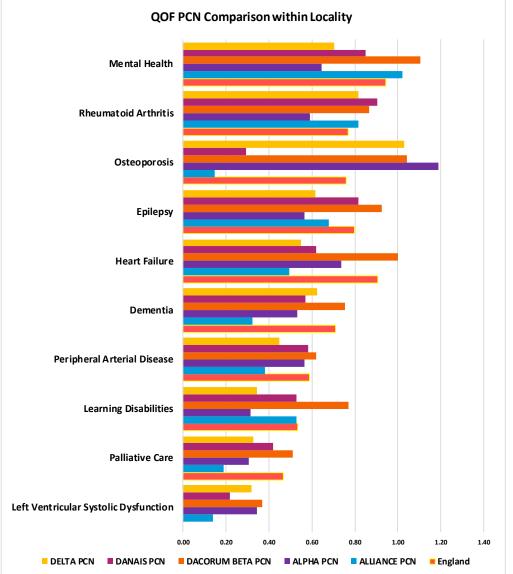
- QOF Local, Regional, & National Comparison
- QOF Locality & PCN Comparison
- QOF Missed Diagnoses & Admission Rates
- Admission Rates Benchmarking against ICB/Place



QOF - Locality & PCN Comparison







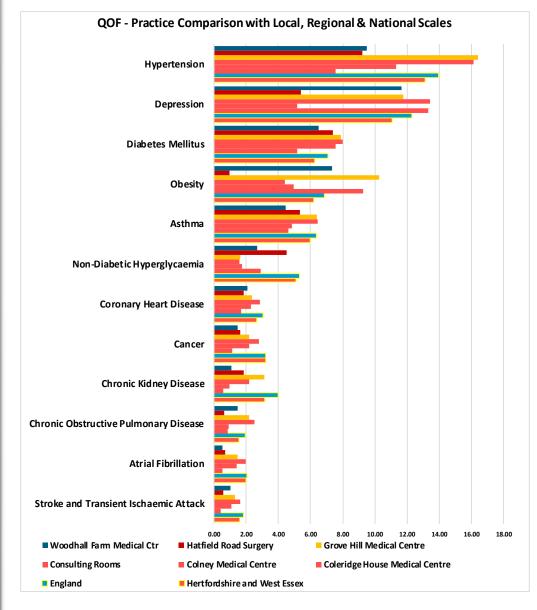
The Quality and Outcome Framework incorporates important benchmarking and scoring for all Practices across the county; we have combined a number of local, regional, and national data sets to highlight the areas that the PCN will need to consider.

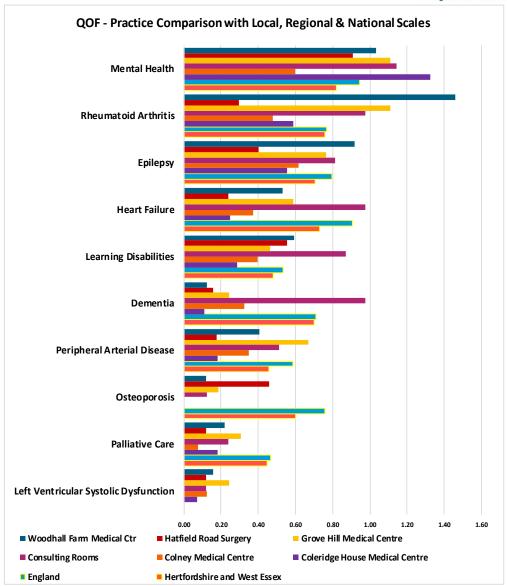
In this graph we have shown all your neighbouring PCNs within the Locality, and benchmarked against England's average.

Source: QOF National Figures, HWE PHM Team

QOF - Local, Regional, & National Comparison







The charts here are similar to the previous slide but provides the comparison between practices within the PCN.

Source: QOF National Figures, HWE PHM Team

QOF - Missed Diagnoses & Admission Rates



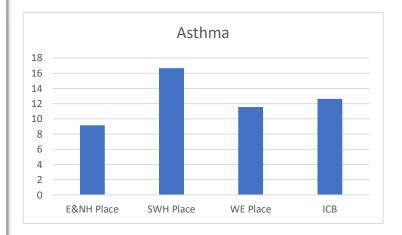
Disease	QOF List size 21-22	QOF Register 21- 22	QOF Prevalence 21/22	Place prevalence	ICB prevalence	Modelled prevalence	New diagnoses to meet Place average	new diagnoses to meet ICB average	New diagnoses to meet estimated prevalence
Asthma	25019	1292	5.16%	5.89%	6.17%		181	251	
COPD	27034	399	1.48%	1.38%	1.49%	2.02%	-26	3	146
Diabetes	21234	1541	7.26%	6.26%	6.39%	7.77%	-212	-185	110
Non-diabetic hyperglyaemia	20930	630	3.01%	6.73%	5.87%	11.28%	778	599	1732
Hypertension	27034	3255	12.04%	12.66%	13.21%		168	317	
Atrial Fibrillation	27034	323	1.19%	1.98%	2.02%	1.82%	213	223	168
Stroke and TIA	27034	292	1.08%	1.53%	1.61%		122	143	
Coronary Heart Disease	27034	595	2.20%	2.60%	2.65%		109	122	
Heart failure	27034	137	0.51%	0.69%	0.75%	1.00%	50	67	135
Left Ventricular Systolic Dysfunction	27034	32	0.12%	0.29%	0.30%		46	49	
Chronic Kidney Disease	20930	354	1.69%	3.75%	3.21%		430	317	
Peripheral Arterial Disease	27034	103	0.38%	0.42%	0.44%		10	17	
Cancer	27034	579	2.14%	3.38%	3.35%		336	326	
Palliative care	27034	44	0.16%	0.33%	0.43%		46	72	

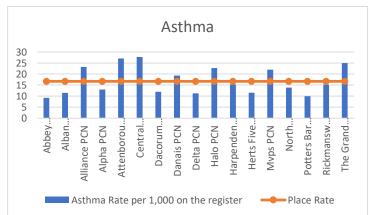
The table above shows the latest prevalence (2021/22 published August 20222) for the PCN alongside the place prevalence, ICB prevalence and the modelled prevalence for the PCN.

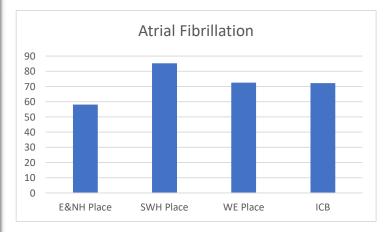
This table shows opportunities for further identification. It outlines the diagnoses to meet the place, ICB and estimated prevalence.

Within Ardens Manager there are case finding searches that can support PCN with identification.

Emergency Admission Rates per 1,000 population on the Disease Register

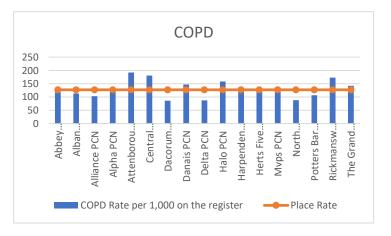












Source: HWE PHM Team, SUS data



The charts on the left shows the Emergency Admissions Rates per 1,000 population on the disease register.

It shows the places compared with the ICB on the left and on the right it show the PCNs within a Place.

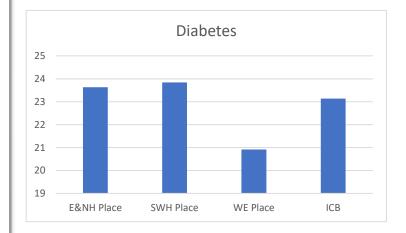
These are continued on the following place.

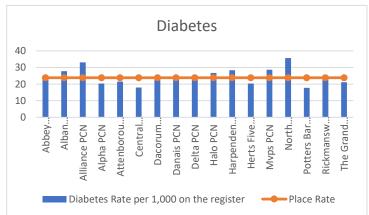
Rates may be high due to a number of factors which may include low identification.

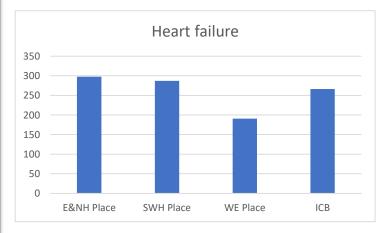
For Alliance PCN, the data shows higher rates for Asthma, AF, Diabetes and Heart Failure which was identified as a theme within the ACS analysis.

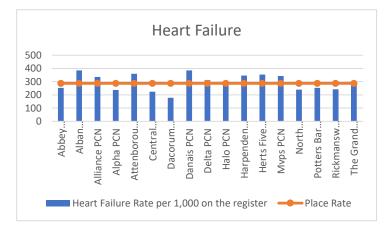
Emergency Admission Rates per 1,000 population on the Disease Register











Source: HWE PHM Team, SUS data

Appendices



The following pages provide additional information breakdowns relating to the segmentation and population data

Contents:

- Matrix by Ethnicity
- Matrix by Health Segment & Subsegment
- Matrix by GP Activity
- Matrix by Health Segment & Deprivation
- Matrix by Practice & Deprivation
- **Bubble Matrix on Conditions**
- Bio-Psycho-Social Example
- Risk Factors by Prevalence against GP Activity & A&E
- Public Health Cancer Screening
- Public Health Mortality
- Public Health Life Expectancy
- Public Health Projection on Populations



Matrix Data - Ethnicity



Ethnicity Group ▼	Othe	r Ethnic Gr	oups		Asian			Black			Mixed			Other			White			Unknown		
Complexity ▼	Low Complexity	Middle Complexity	High Complexity	Grand Total																		
Overall Population Measures	•																					
Population	336	63		2,456	1,317	147	1,034	637	54	622	247	39	2,964	1,560	161	10,007	8,033	1,534	3,575	725	8	35,521
Age	33	48	63	27	46	61	28	46	53	22	38	39	24	42	53	29	48	61	34	46	62	37
Male %	55.1%	47.6%	50.0%	52.3%	49.9%	56.5%	50.5%	46.3%	51.9%	52.3%	47.0%	56.4%	53.7%	48.9%	50.9%	52.0%	46.5%	45.0%	65.5%	60.3%	62.5%	51.8%
IMD	6.8	6.3	6.0	6.3	6.5	6.7	5.6	5.4	5.1	5.9	5.7	6.3	5.8	5.6	5.3	6.0	5.8	5.4	6.0	5.7	6.8	5.9
% BAME (where recorded)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	0%	0%	0%	100%	100%	100%	39%
Multimorbidity (acute & chronic)	0.0	1.4	7.5	0.0	1.7	6.3	0.0	1.8	6.8	0.0	1.7	7.3	0.0	1.7	6.7	0.0	1.9	6.8	0.0	1.5	5.4	1.0
Finance and Activity Measur	res																					
Spend → Total	£0.0M	£0.0M	£0.0M	£0.7M	£1.0M	£0.6M	£0.3M	£0.7M	£0.2M	£0.1M	£0.2M	£0.1M	£0.7M	£0.8M	£0.4M	£3.1M	£6.9M	£6.3M	£0.1M	£0.1M	£0.0M	£22.5M
PPPY - Total	£65	£154	######	£276	£752	£3,747	£294	£1,132	£4,336	£227	£815	£3,097	£249	£518	£2,274	£307	£862	£4,104	£37	£138	£2,100	£633
Acute Elective	£7	£48	£271	£89	£309	£1,244	£78	£522	£1,061	£68	£415	£1,166	£73	£190	£759	£97	£351	£1,275	£4	£36	£467	£223
Acute Non-Elective	£4	£1	£20,600	£116	£243	£1,988	£144	£392	£2,561	£93	£176	£1,319	£104	£149	£1,014	£134	£312	£2,168	£3	£20	£1,345	£269
GP Encounters	£54	£99	£409	£71	£158	£341	£70	£164	£284	£65	£154	£214	£71	£145	£253	£72	£159	£318	£30	£77	£276	£109
Community	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Mental Health	£1	£3	£0	£0	£42	£172	£2	£48	£413	£1	£59	£397	£1	£29	£242	£4	£39	£333	£0	£4	£13	£31
Social Care	£0	£3	£0	£0	£1	£1	£0	£7	£18	£0	£11	£0	£0	£5	£5	£0	£2	£10	£0	£1	£0	£1
GP PPPY	9	17	53	13	27	59	13	31	56	11	27	39	12	25	44	13	29	60	6	15	64	20
Beddays PPPY - Acute EM	0	0	34	0	0	4	0	1	5	0	1	5	0	0	2	0	0	4	0	0	6	0
Physical Health																						
Diabetes ▼	0.0%	27.0%	100.0%	0.0%	42.5%	72.1%	0.0%	30.8%	48.1%	0.0%	21.5%	41.0%	0.0%	20.4%	57.8%	0.0%	16.8%	50.8%	0.0%	15.0%	50.0%	10.2%
COPD ▼	0.0%	1.6%	0.0%	0.0%	0.8%	17.0%	0.0%	0.5%	9.3%	0.0%	0.4%	15.4%	0.0%	1.3%	18.6%	0.0%	2.5%	28.1%	0.0%	1.0%	12.5%	2.1%
Chronic Respiratory Dis ▼	0.0%	1.6%	50.0%	0.0%	2.0%	25.9%	0.0%	1.7%	13.0%	0.0%	2.4%	20.5%	0.0%	1.8%	23.0%	0.0%	3.3%	32.6%	0.0%	1.2%	12.5%	2.6%
Hypertension ▼	0.0%	22.2%	0.0%	0.0%	33.0%	81.6%	0.0%	45.4%	88.9%	0.0%	27.9%	56.4%	0.0%	27.3%	57.1%	0.0%	33.3%	72.4%	0.0%	27.0%	62.5%	15.5%
Obesity ▼	1.8%	9.5%	50.0%	3.5%	10.0%	23.8%	7.1%	17.6%	29.6%	3.4%	9.7%	17.9%	4.1%	13.1%	26.7%	8.3%	28.7%	42.1%	1.8%	9.4%	37.5%	13.5%
Mental Health															· · · · · ·							
Anxiety/Phobias ▼	0.0%	14.3%	100.0%	0.0%	9.2%	30.6%	0.0%	11.6%	50.0%	0.0%	15.4%	53.8%	0.0%	24.4%	49.1%	0.0%	22.8%	45.8%	0.0%	21.8%	50.0%	9.8%
Depression ▼	0.0%	23.8%	100.0%	0.0%	13.3%	38.8%	0.0%	15.2%	57.4%	0.0%	14.6%	59.0%	0.0%	28.7%	59.6%	0.0%	30.9%	57.6%	0.0%	26.1%	62.5%	12.8%
Learning Disability ▼	0.0%	6.3%	0.0%	0.0%	1.5%	8.2%	0.0%	1.6%	16.7%	0.0%	4.5%	56.4%	0.0%	2.2%	31.7%	0.0%	2.1%	17.3%	0.0%	1.7%	0.0%	1.7%
Dementia ▼	0.0%	0.0%	50.0%	0.0%	0.8%	15.0%	0.0%	0.8%	25.9%	0.0%	2.4%	48.7%	0.0%	0.4%	34.2%	0.0%	0.8%	23.7%	0.0%	1.0%	37.5%	1.6%
Other Characteristics	5.570	5.570	00.070	3.370	0.070		5.576	5.570	20.070	5.575	2	1070	5.570	5.170	5 1.270	3.576	0.070	20 70	5.570	1.070	21.070	110.10
Housebound (eFI) ▼	0.0%	0.0%	0.0%	0.0%	0.2%	1.4%	0.0%	0.2%	3.7%	0.0%	0.0%	0.0%	0.0%	0.3%	0.6%	0.0%	0.5%	3.7%	0.0%	0.3%	0.0%	0.3%
Social Vulnerability (eFI) ▼	1.5%	4.8%	100.0%	0.7%	3.1%	10.2%	1.2%	4.2%	18.5%	1.0%	4.9%	17.9%	0.8%	4.2%	16.1%	1.0%	4.4%	18.1%	0.2%	1.2%	0.0%	2.8%
History of Smoking (Tw ▼	6.3%	12.7%	50.0%	1.9%	6.8%	10.9%	1.5%	6.6%	13.0%	2.1%	9.3%	17.9%	4.0%	13.5%	26.1%	5.2%	14.8%	23.5%	1.8%	8.7%	12.5%	8.0%
Not Fit for Work (In Year) ▼	2.1%	1.6%	50.0%	2.8%	7.2%	12.9%	3.6%	11.9%	11.1%	1.8%	6.1%	12.8%	3.6%	9.7%	11.2%	2.7%	8.9%	10.1%	0.8%	4.6%	12.5%	5.1%
On a Waiting List	1.8%	4.8%	50.0%	3.9%	8.3%	23.1%	3.9%	10.2%	33.3%	5.0%	11.3%	20.5%	4.5%	7.9%	13.7%	5.1%	11.3%	23.7%	1.0%	2.1%	12.5%	7.2%
on a training cot	1.0%	4.0%	50.0%	3.5%	0.5%	23.1%	3.5%	10.2%	33.3%	5.0%	11.376	20.5%	4.5%	1.5%	13.1 %	5.1%	11.376	23.170	1.0%	2.170	12.5%	1.270

PHM is underpinned by good linked data, with an appropriate method of extracting segmented or patients under key metrics; this matrix is showing the complexity of ethnic groups is broadly categorised across the PCN.

Source: HWE PHM Team modelled data, phm.optum.co.uk - Calendar Year 2021

Matrix Data - Segment & Sub-Segment



Life Course Segment ▼		1 - Healthy		2 - L	iving With Illr	ness	3 -	Lower Comple	exity		4 - Advanc	ed Disease &	Complexity		5 - EoL	, Frailty & De	ementia	
Life Course Subsegment	1a - H (Low Risk)	1b - H (Maternity & Child)	1c - H (Acute Episodic)	2a - Lwl (At Risk)	2b - Lwl (LTCs)	2c - Lwl (MH)	3a - LC (Mod. Social Co	3b - LC (Multimorbidi	3c - LC (Mild Frailty)	4a - AD&C (High Complexity)	- High	4c - AD&C (Severe LD/ASD/	4d - AD&C (Complex SMI)	4e - AD&C (End Stage Dis	5a - EoLFD (Severe	5b - EoLFD (Severe	5c - EoLFD (End of Li	Grand Total
Overall Population Measure	s													d annistrati				
Population	12,299	734	987	2,871	3,534	1,114	274	3,657	1,604	1,477	262	97	407	395	343	34	212	30,301
Age	28	7	18	42	42	38	38	48	57	58	51	21	33	65	74	75	68	37
Male %	56.9%	38.6%	53.7%	50.3%	53.5%	46.8%	47.1%	47.2%	37.2%	40.9%	48.1%	50.5%	49.1%	49.4%	36.2%	44.1%	44.3%	51.2%
IMD	5.7	5.6	5.6	5.6	5.7	5.4	5.7	5.4	5.6	5.4	5.4	5.1	5.1	5.4	5.4	5.2	5.5	5.6
% BAME (where recorded)	45%	41%	45%	35%	37%	33%	35%	28%	29%	23%	27%	32%	25%	15%	18%	9%	14%	36%
Multimorbidity (acute & chronic)	0.0	0.0	0.0	0.0	1.0	1.0	0.4	2.4	2.1	4.2	2.7	3.1	6.0	5.5	6.6	7.6	5.7	1.1
Finance and Activity Measu	ires																	
Spend • Total	£0.8M	£0.5M	£1.3M	£1.4M	£1.7M	£0.4M	£0.1M	£2.6M	£1.8M	£3.0M	£0.3M	£0.2M	£1.1M	£1.3M	£1.8M	£0.3M	£1.6M	£20.2M
PPPY - Total	£69	£641	£1,315	£476	£474	£400	£492	£714	£1,108	£2,021	£1,136	£2,110	£2,635	£3,203	£5,253	£7,761	£7,733	£665
Acute Elective	£16	£100	£477	£168	£196	£125	£218	£311	£473	£914	£324	£546	£307	£1,194	£1,483	£254	£2,549	£236
Acute Non-Elective	£7	£449	£688	£196	£162	£159	£155	£231	£416	£841	£516	£406	£730	£1,563	£3,208	£6,365	£4,587	£283
GP Encounters	£44	£91	£134	£111	£113	£105	£109	£157	£214	£244	£211	£228	£221	£282	£425	£408	£421	£112
Community	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Mental Health	£1	£0	£15	£2	£3	£12	£9	£15	£6	£21	£34	£876	£1,356	£164	£129	£488	£172	£32
Social Care	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£52	£54	£21	£0	£8	£246	£5	£1
GP PPPY	8	16	23	20	20	19	18	29	40	47	38	41	41	51	86	83	79	21
Beddays PPPY - Acute EM	0	1	1	0	0	0	0	0	1	1	1	1	2	3	6	15	8	0
Physical Health																		
Diabetes •	0.0%	0.0%	0.0%	0.0%	15.5%	0.0%	4.0%	22.8%	29.6%	37.2%	23.7%	16.5%	37.3%	41.3%	52.2%	41.2%	46.7%	10.2%
COPD v	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.6%	2.4%	9.9%	5.0%	0.0%	2.9%	63.0%	25.4%	17.6%	20.8%	2.3%
Chronic Respiratory Dis ▼	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	3.8%	3.2%	12.4%	6.5%	2.1%	4.4%	66.8%	30.6%	23.5%	28.8%	2.8%
Hypertension ▼	0.0%	0.0%	0.0%	0.0%	26.8%	0.0%	8.4%	39.4%	47.1%	57.5%	35.5%	14.4%	31.7%	67.3%	81.3%	67.6%	66.5%	16.4%
Obesity •	0.0%	0.0%	0.0%	35.7%	17.7%	16.6%	15.7%		36.1%	37.2%	26.3%	14.4%	26.0%	40.0%	45.5%	26.5%	36.8%	15.1%
Mental Health	0.070	0.070	0.070	33.1 70	17.770	10.070	13.7 70	20.070	30.170	31.270	20.370	14.470	20.070	40.070	45.570	20.570	30.070	15.170
Anxiety/Phobias ▼	0.0%	0.0%	0.0%	0.0%	0.0%	32.9%	3.3%	40.0%	16.8%	32.1%	21.0%	30.9%	61.7%	27.3%	33.2%	47.1%	25.0%	10.6%
Depression ▼	0.0%	0.0%	0.0%	0.0%	0.0%	57.2%	6.9%	47.4%	24.9%	41.6%	25.6%	40.2%	77.9%	37.0%	42.0%	55.9%	33.0%	13.9%
Learning Disability	0.0%	0.0%	0.0%	0.0%	0.0%	0.7%	1.1%	2.3%	0.5%	5.2%	17.6%	50.5%	48.4%	5.6%	7.9%	29.4%	9.9%	1.8%
Dementia V	0.0%	0.0%	0.0%	0.0%	0.0%	0.7%	0.0%	0.0%	0.5%		4.2%	13.4%	45.7%	6.8%				
Other Characteristics	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	11.4%	4.2%	13.4%	45.7%	6.6%	15.2%	100.0%	17.5%	1.7%
Housebound (eFI)	0.00/	0.00/	0.0%	0.00/	0.00/	0.00/	0.00/	0.00/	0.00/	0.00/	40.00/	2.40/	0.20/	4.00/	0.00/	47.00/	0.40/	0.40/
` '	0.0%	0.0%		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	16.0%	3.1%	0.2%	1.0%	9.0%	17.6%	9.4%	0.4%
Social Vulnerability (eFI) Uistant of Organian (To)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	71.2%		5.4%	7.9%	26.0%	15.5%	20.1%	15.9%	22.2%	44.1%	13.7%	2.8%
History of Smoking (Tw ▼	0.0%	0.0%	0.0%	24.1%	9.8%	13.4%	10.2%	16.4%	12.3%	19.5%	11.8%	14.4%	34.4%	29.9%	13.7%	14.7%	14.6%	8.9%
Not Fit for Work (In Year) ▼	0.0%	0.0%	0.0%	13.9%	4.9%	9.0%	6.6%	11.6%	10.5%	9.9%	6.9%	9.3%	12.3%	10.6%	5.5%	2.9%	6.6%	5.2%
On a Waiting List ▼	2.8%	5.9%	11.8%	7.0%	7.4%	7.9%	7.7%	10.4%	15.0%	18.3%	13.4%	12.4%	9.8%	27.8%	35.3%	20.6%	24.1%	7.7%

This matrix is important in defining the PCN's main segment and sub-segment health classifications, giving simple volumes but also linking how many as a percentage of each subsegment, have defined and diagnosed conditions.

Matrix Data - GP Activity



GP Activity		0			1		e:	2-3			4-5			6-9			10+		
Complexity	Low Complexity	Middle Complexity	High Complexity	Grand Total															
Overall Population Measure	s	171																	
Population	2,167	226		1,444	232	8	2,923	510	20	2,416	632	20	4,468	1,669	54	7,576	9,313	1,838	35,521
Age	29	36	43	27	40	49	25	36	26	27	38	33	29	42	40	30	49	61	37
Male %	66.5%	67.3%	60.0%	61.6%	61.2%	75.0%	61.3%	62.7%	55.0%	62.1%	63.1%	55.0%	56.7%	56.8%	59.3%	43.5%	43.7%	46.2%	51.8%
IMD	5.8	5.6	6.4	5.7	5.6	6.3	6.1	5.8	5.7	6.0	5.9	5.5	6.2	5.9	5.6	6.0	5.8	5.5	5.9
% BAME (where recorded)	50%	40%	40%	44%	36%	25%	48%	40%	35%	48%	38%	25%	45%	37%	28%	42%	33%	20%	39%
Multimorbidity (acute & chronic)	0.0	1.3	7.0	0.0	1.4	7.3	0.0	1.4	6.8	0.0	1.4	7.2	0.0	1.5	7.1	0.0	1.9	6.8	1.0
Finance and Activity Meas	ıres																		
Spend - Total	£0.0M	£0.0M	£0.0M	£0.0M	£0.0M	£0.0M	£0.1M	£0.0M	£0.0M	£0.2M	£0.1M	£0.0M	£0.6M	£0.3M	£0.0M	£4.2M	£9.4M	£7.6M	£22.5M
PPPY - Total	£1	£2	£0	£13	£7	£18	£33	£31	£463	£71	£112	£270	£124	£191	£657	£560	£1,004	£4,122	£633
Acute Elective	£1	£2	£0	£4	£1	£0	£6	£7	£9	£14	£44	£47	£34	£68	£13	£177	£413	£1,288	£223
Acute Non-Elective	£0	£0	£0	£3	£0	£0	£12	£7	£264	£31	£37	£0	£45	£57	£184	£242	£348	£2,180	£269
GP Encounters	£0	£0	£0	£6	£6	£6	£14	£15	£15	£26	£27	£28	£45	£46	£51	£136	£195	£327	£109
Community	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Mental Health	£0	£0	£0	£0	£0	£13	£1	£2	£175	£0	£4	£195	£1	£19	£409	£5	£45	£317	£31
Social Care	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£3	£10	£1
GP PPPY	0	0	0			1	2	3	2	4	4	5	8	8	8	24	36	61	20
Beddays PPPY - Acute EM	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	4	0
Physical Health																			
Diabetes ▼	0.0%	4.9%	0.0%	0.0%	4.3%	50.0%	0.0%	10.6%	40.0%	0.0%	11.2%	40.0%	0.0%	13.2%	44.4%	0.0%	24.0%	53.5%	10.2%
COPD ▼	0.0%	0.9%	0.0%	0.0%	0.0%	0.0%	0.0%	1.0%	0.0%	0.0%	0.9%	15.0%	0.0%	1.3%	16.7%	0.0%	2.3%	26.4%	2.1%
Chronic Respiratory Dis ▼	0.0%	1.8%	0.0%	0.0%	0.4%	12.5%	0.0%	2.0%	0.0%	0.0%	2.1%	25.0%	0.0%	1.7%	16.7%	0.0%	3.1%	31.4%	2.6%
Hypertension ▼	0.0%	12.4%	20.0%	0.0%	19.4%	75.0%	0.0%	19.8%	55.0%	0.0%	21.0%	35.0%	0.0%	22.6%	48.1%	0.0%	36.7%	73.2%	15.5%
Obesity ▼	1.6%		0.0%	2.0%	4.7%	0.0%	1.5%	6.3%	5.0%	2.3%	8.4%	10.0%	5.1%	12.0%	13.0%	10.7%	27.3%	40.3%	13.5%
Mental Health	1.070	1.070	0.070	2.070	1.1 70	0.070	1.070	0.070	0.070	2.070	0.170	10.070	0.170	12.070	10.070	10.170	21.070	10.070	101070
Anxiety/Phobias ▼	0.0%	20.4%	100.0%	0.0%	13.8%	62.5%	0.0%	17.1%	65.0%	0.0%	15.8%	45.0%	0.0%	16.0%	64.8%	0.0%	22.3%	44.3%	9.8%
Depression ▼	0.0%	23.9%	100.0%	0.0%	28.0%	75.0%	0.0%	21.0%	80.0%	0.0%	23.9%	90.0%	0.0%	23.1%	77.8%	0.0%	28.8%	55.0%	12.8%
Learning Disability ▼	0.0%	0.9%	40.0%	0.0%	1.3%	37.5%	0.0%	2.7%	45.0%	0.0%	1.6%	35.0%	0.0%	23.1%	38.9%	0.0%	20.0%	17.3%	1.7%
Dementia ▼	0.0%		60.0%	0.0%	0.4%	50.0%	0.0%	1.4%	60.0%	0.0%	0.3%	80.0%	0.0%	0.7%	64.8%	0.0%	0.8%	22.2%	1.6%
Other Characteristics	0.076	1.370	00.076	0.0%	0.470	50.0 /6	0.0%	1.470	00.0%	0.0%	0.376	00.0%	0.0%	0.776	04.0 %	U.U 76	0.076	22.270	1.0%
Housebound (eFI) ▼	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	1.9%	0.0%	0.5%	3.3%	0.3%
Social Vulnerability (eFI)																			
	0.4%		20.0%	0.7%	1.7%	25.0%	0.5%	1.4%	10.0%	0.5%	2.8%	15.0%	0.8%	2.7%	20.4%	1.1%	4.6%	17.4%	2.8%
History of Smoking (Tw ▼	0.3%		0.0%	1.3%	2.6%	12.5%	0.9%	4.5%	5.0%	2.5%	5.4%	10.0%	3.6%	8.3%	9.3%	7.0%	15.2%	23.1%	8.0%
Not Fit for Work (In Year) ▼	0.0%		0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.4%	1.4%	0.0%	1.4%	2.9%	0.0%	6.0%	11.1%	11.2%	5.1%
On a Waiting List ▼	0.4%	0.0%	0.0%	0.6%	0.0%	0.0%	0.8%	0.6%	0.0%	1.3%	0.6%	0.0%	2.2%	2.7%	5.6%	8.9%	12.9%	24.2%	7.2%

Whilst the previous GP activity matrix was to investigate HIUs, this matrix has split out the GP activity by order of complexity; another method of looking at distinct patient volumes coming into the PCN which may be managed in a different way.

Matrix Data - Health Segment & Deprivation



Deprivation •		Lo	ow Deprivati	on			Mic	ddle Depriva	ation			Hig	gh Deprivati	on				Not known			
Life Course Segment ▼	1 - Healthy	2 - Living With Illness	3 - Lower Complexity		5 - EoL, Frailty & Dement	1 - Healthy	2 - Living With Illness	3 - Lower Complexity	4 - Advanced Disease	5 - EoL, Frailty & Dement	1 - Healthy		3 - Lower Complexity		5 - EoL, Frailty & Dement	1 - Healthy	2 - Living With Illness	3 - Lower Complexity	4 - Advanced Disease	5 - EoL, Frailty & Dement	Grand Total
Overall Population Measure	s	A CONTRACTOR		-	I marriage en conscionar	a r	I	ala.		I CONTRACTOR OF THE PARTY OF TH		Lambinatorica					II WALLES		-		
Population	4,590	2,121	1,297	536	105	10,763	5,686	4,109	1,900	444	1,757	906	741	417	64	50	16	11	7		35,521
Age	29	43	55	55	74	25	41	50	53	72	24	38	45	48	65	38	37	48	48	80	37
Male %	56.3%	51.0%	48.3%	47.9%	45.7%	56.1%	51.4%	43.9%	44.5%	39.0%	55.0%	50.0%	43.7%	45.8%	40.6%	70.0%	56.3%	36.4%	42.9%	0.0%	51.8%
IMD	9.0	9.0	9.0	8.9	8.9	5.4	5.4	5.3	5.3	5.2	2.3	2.3	2.3	2.2	2.3						5.9
% BAME (where recorded)	43%	36%	32%	35%	26%	48%	39%	32%	23%	16%	48%	41%	30%	26%	14%	62%	19%	40%	29%	0%	39%
Multimorbidity (acute & chronic)	0.0	0.7	2.3	4.4	5.8	0.0	0.6	2.2	4.5	6.5	0.0	0.6	2.3	4.7	5.8	0.0	0.6	1.9	3.3	2.0	1.0
Finance and Activity Measu	ires																				
Spend ▼ Total	£1.0M	£1.0M	£1.2M	£1.3M	£0.7M	£1.9M	£2.6M	£3.2M	£4.2M	£2.8M	£0.3M	£0.4M	£0.6M	£0.9M	£0.4M	£0.0M	£0.0M	£0.0M	£0.0M	£0.0M	£22.5M
PPPY - Total	£209	£465	£956	£2,465	£6,436	£178	£460	£768	£2,193	£6,393	£182	£437	£781	£2,165	£5,817	£28	£90	£269	£696	£14,160	£633
Acute Elective	£62	£179	£473	£936	£1,556	£46	£175	£328	£779	£1,776	£56	£167	£265	£625	£2,247	£0	£0	£88	£71	£1,215	£223
Acute Non-Elective	£86		£301	£959	£4,347	£79	£174	1000000	£870	£3,970	£74	£152	£337	£933	£3,129	£4	£25	£75	£185	£12,566	£269
GP Encounters	£58		£175	£240	£389	£51	£107	£168	£240	£440	£51	£115	£167	£245	£364	£24	£59	£107	£254	£379	£109
Community	£0			£0	£0	£0	£0		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Mental Health	£3			£319	£121	£2	£4		£291	£185	£1	£3	£12	£357	£77	£0	£6	£0	£186	£0	£31
Social Care	£0			£12	£24	£0	£0		£12	£22	£0	£0	£0	£6	£0	£0	£0	£0	£0	£0	
GP PPPY	9			40	70	9	20		46	88	9	21	31	46	71	4	11	19	51	69	
Beddays PPPY - Acute EM	0	0	0	2	9	0	0	0	2	8	0	0	0	2	7	0	0	0	0	40	0
Physical Health																					
Diabetes ▼	0.0%	9.0%	29.8%	39.0%	41.9%	0.0%	8.1%	23.7%	35.2%	51.8%	0.0%	7.9%	25.6%	41.5%	50.0%	0.0%	12.5%	9.1%	28.6%	0.0%	10.2%
COPD +	0.0%	0.0%	2.5%	13.1%	21.0%	0.0%	0.0%	2.4%	15.7%	23.9%	0.0%	0.0%	2.7%	20.1%	23.4%	0.0%	0.0%	0.0%	14.3%	0.0%	2.1%
Chronic Respiratory Dis ▼	0.0%	0.0%	3.8%	16.4%	28.6%	0.0%	0.2%	3.4%	18.1%	29.7%	0.0%	0.4%	3.4%	23.0%	31.3%	0.0%	0.0%	0.0%	14.3%	0.0%	2.6%
Hypertension ▼	0.0%	14.3%	46.4%	55.2%	76.2%	0.0%	12.3%	39.7%	50.9%	74.8%	0.0%	9.6%	32.3%	47.5%	78.1%	0.0%	6.3%	45.5%	42.9%	100.0%	15.5%
Obesity ▼	0.0%	18.0%	19.7%	29.3%	36.2%	0.0%	23.6%	29.1%	33.9%	41.0%	0.0%	24.2%	29.1%	33.8%	46.9%	0.0%	12.5%	9.1%	42.9%	0.0%	13.5%
Mental Health	,																				
Anxiety/Phobias ▼	0.0%	4.4%	24.4%	25.7%	21.0%	0.0%	5.0%	31.7%	35.5%	32.2%	0.0%	4.5%	37.9%	40.8%	31.3%	0.0%	6.3%	18.2%	42.9%	0.0%	9.8%
Depression ▼	0.0%	6.8%	28.8%	34.0%	27.6%	0.0%	8.3%	38.8%	44.9%	40.8%	0.0%	10.7%	48.2%	53.2%	43.8%	0.0%	0.0%	18.2%	42.9%	0.0%	12.8%
Learning Disability	0.0%	0.2%	1.4%	14.6%	5.7%	0.0%	0.1%	2.0%	14.9%	10.6%	0.0%	0.1%	1.6%	18.2%	10.9%	0.0%	0.0%	0.0%	0.0%	0.0%	1.7%
Dementia ▼	0.0%		0.0%	15.9%	21.9%	0.0%	0.0%	0.0%	15.6%	22.1%	0.0%	0.0%	0.0%	16.3%	12.5%	0.0%	0.0%	0.0%	14.3%	0.0%	1.6%
Other Characteristics	2.370	2.370	2.270	12.270	21.070		2.370	2.370	13.570	22.170	2.270	2.270	5.570		12.270	5.570	2.270	3.370		5.570	
Housebound (eFI) ▼	0.0%	0.0%	0.0%	0.7%	7.6%	0.0%	0.0%	0.0%	2.1%	10.8%	0.0%	0.0%	0.0%	2.2%	4.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%
Social Vulnerability (eFI) ▼	0.0%		8.2%	11.6%	18.1%	0.0%	0.0%	8.3%	13.8%	20.9%	0.0%	0.0%	7.2%	13.9%	20.3%	0.0%	0.0%	9.1%	14.3%	0.0%	2.8%
History of Smoking (Tw ▼	0.0%		9.2%	11.6%	8.6%	0.0%	15.5%	15.0%	22.3%	14.9%	0.0%	20.2%	18.6%	30.9%	21.9%	0.0%	12.5%	18.2%	57.1%	0.0%	8.0%
Not Fit for Work (In Year) ▼	0.0%		8.0%	7.5%		0.0%	9.4%	11.3%	10.6%	5.6%	0.0%	12.8%	14.6%	12.2%	9.4%	0.0%	12.5%		14.3%	0.0%	5.1%
On a Waiting List					2.9%													9.1%			
On a realing List	2.9%	6.9%	10.4%	12.7%	20.0%	3.5%	6.8%	11.1%	17.9%	31.1%	3.6%	7.9%	13.0%	20.6%	37.5%	0.0%	0.0%	0.0%	28.6%	100.0%	7.2%

Deprivation is an important marker for a variety of issues and not just in health, and this matrix has taken the PCN's population split them by health segment, and then further by high, middle, or low deprivation groupings - this may further allows the PCNs to target that selected cohort of individuals to find where the determinants may be, and where a targeted approach from local partners, could be directed.

Matrix Data - Practice & Complexity



Practice	Colerid	ge House I Centre	Vledical	Colne	y Medical (Centre	Con	sulting Ro	oms	Grove H	lill Medical	Centre	Hatfie	ld Road Su	ırgery	Theoba	ld Medical	Centre	Woodha	ll Farm Me	dical Ctr	
Complexity	LOW	Middle Complexity	High Complexit	Low Complexity	Middle Complexity	High Complexity	Low Complexity	Middle Complexity	High Complexit	Low Complexity	Middle Complexity	High Complexity	Grand Total									
Overall Population Measure	s			•																		
Population	1,887	839	101	2,528	1,235	138	3,537	2,591	477	2,585	1,905	332	3,562	1,503	155	4,994	3,400	588	1,901	1,109	154	35,521
Age	24	42	46	33	52	64	29	46	62	25	46	58	27	44	57	31	50	64	26	43	51	37
Male %	52.0%	45.4%	45.5%	54.8%	50.6%	45.7%	56.4%	47.7%	41.5%	52.1%	45.1%	51.8%	56.7%	50.7%	56.8%	53.6%	48.0%	45.2%	55.0%	48.4%	51.3%	51.8%
IMD	5.6	5.5	4.7	7.9	7.9	7.7	5.1	5.1	5.0	4.8	4.8	4.6	7.8	7.8	8.0	5.3	5.3	5.4	5.9	5.9	5.6	5.9
% BAME (where recorded)	52%	40%	27%	34%	27%	16%	33%	23%	14%	44%	34%	19%	57%	55%	56%	45%	32%	16%	53%	42%	32%	39%
Multimorbidity (acute & chronic)	0.0	1.7	6.7	0.0	1.7	6.9	0.0	1.9	6.8	0.0	1.9	6.6	0.0	1.6	6.5	0.0	1.9	6.9	0.0	1.8	6.8	1.0
Finance and Activity Measu	ires																					
Spend → Total	£0.5M	£0.7M	£0.3M	£0.6M	£1.2M	£0.8M	£0.8M	£2.0M	£1.8M	£0.6M	£1.4M	£1.0M	£0.8M	£0.9M	£0.6M	£1.3M	£2.7M	£2.6M	£0.5M	£0.9M	£0.5M	£22.5M
PPPY - Total	£245	£801	£2,669	£245	£948	£5,922	£223	£782	£3,795	£215	£709	£3,045	£222	£622	£3,815	£269	£802	£4,472	£276	£790	£3,234	£633
Acute Elective	£61	£371	£573	£80	£457	£1,421	£75	£312	£1,220	£66	£284	£1,125	£56	£277	£854	£82	£306	£1,453	£98	£275	£1,121	£223
Acute Non-Elective	£127	£244	£1,542	£88	£280	£3,789	£88	£295	£2,003	£88	£245	£1,442	£102	£178	£2,091	£117	£284	£2,344	£105	£313	£1,349	£269
GP Encounters	£56	£126	£203	£73	£173	£367	£57	£133	£276	£59	£144	£261	£61	£130	£279	£68	£179	£382	£72	£158	£311	£109
Community	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Mental Health	£2	£57	£344	£5	£31	£344	£2	£41	£272	£1	£34	£214	£2	£34	£578	£2	£31	£291	£1	£39	£451	£31
Social Care	£0		£7	£0	£7	£0	£0	£1	£25	£0	£2	£4	£0	£2	£13	£0	£1	£2	£0	£4	£3	£1
GP PPPY	10	22	36	9	21	46	11	25	51	11	26	48	11	22	46	15	40	85	9	19	37	20
Beddays PPPY - Acute EM	0	1	3	0	0	7	0	0	4	0	0	2	0	0	4	0	0	4	0	0	2	0
Physical Health																						
Diabetes ▼	0.0%	24.3%	46.5%	0.0%	21.2%	52.9%	0.0%	15.7%	48.0%	0.0%	26.0%	61.7%	0.0%	28.5%	65.8%	0.0%	15.8%	48.5%	0.0%	24.3%	55.8%	10.2%
COPD ▼	0.0%	1.4%	18.8%	0.0%	1.9%	21.7%	0.0%	2.6%	30.2%	0.0%	1.8%	27.1%	0.0%	1.3%	22.6%	0.0%	2.1%	24.7%	0.0%	1.5%	22.7%	2.1%
Chronic Respiratory Dis ▼	0.0%	2.0%	24.8%	0.0%	2.8%	27.5%	0.0%	3.7%	34.0%	0.0%	2.7%	31.6%	0.0%	2.4%	27.7%	0.0%	2.7%	30.3%	0.0%	2.1%	26.6%	2.6%
Hypertension ▼	0.0%	21.0%	49.5%	0.0%	38.5%	73.9%	0.0%	41.2%	79.9%	0.0%	37.3%	73.2%	0.0%	28.6%	69.0%	0.0%	28.2%	70.2%	0.0%	25.6%	65.6%	15.5%
Obesity ▼	5.4%	24.2%	32.7%	3.6%	18.2%	37.0%	4.9%	22.8%	43.4%	5.1%	24.7%	34.6%	1.9%	8.2%	25.8%	10.9%	29.2%	39.6%	4.9%	22.4%	46.8%	13.5%
Mental Health																						
Anxiety/Phobias ▼	0.0%	20.4%	56.4%	0.0%	12.7%	37.0%	0.0%	19.6%	45.9%	0.0%	23.0%	45.8%	0.0%	14.9%	38.1%	0.0%	26.5%	44.2%	0.0%	19.1%	53.9%	9.8%
Depression ▼	0.0%	34.2%	75.2%	0.0%	16.9%	44.9%	0.0%	25.9%	55.3%	0.0%	27.1%	59.0%	0.0%	17.8%	40.6%	0.0%	34.1%	57.8%	0.0%	29.9%	62.3%	12.8%
Learning Disability •	0.0%	1.9%	33.7%	0.0%	1.7%	13.8%	0.0%	2.9%	16.8%	0.0%	1.7%	15.7%	0.0%	2.5%	19.4%	0.0%	1.4%	17.0%	0.0%	2.7%	29.2%	1.7%
Dementia ▼	0.0%	0.4%	30.7%	0.0%	1.2%	31.2%	0.0%	0.8%	24.3%	0.0%	0.5%	21.1%	0.0%	0.8%	24.5%	0.0%	1.0%	21.3%	0.0%	0.5%	35.7%	1.6%
Other Characteristics	0.070	0.470	30.1 /0	0.070	1.2/0	31.270	0.070	0.070	24.570	0.070	0.570	21.170	0.070	0.070	24.570	0.070	1.070	21.570	0.070	0.570	55.1 70	1.070
Housebound (eFI) ▼	0.0%	0.1%	0.0%	0.0%	0.0%	5.1%	0.0%	0.5%	2.7%	0.0%	0.5%	1.8%	0.0%	0.1%	1.3%	0.0%	0.6%	4.9%	0.0%	0.4%	3.2%	0.3%
Social Vulnerability (eFI) •	0.7%	4.4%	17.8%	0.5%	2.7%	11.6%	0.8%	5.5%	26.4%	1.4%	3.1%	16.3%	1.1%	6.5%	18.7%	0.3%	2.2%	10.4%	1.2%	5.8%	22.1%	2.8%
History of Smoking (Tw ▼	3.2%	13.5%	27.7%	3.1%	8.3%	10.1%	6.3%	18.8%	30.8%	4.8%	14.9%	22.0%	1.5%	6.3%	14.8%	4.0%	13.3%	19.7%	3.1%	8.4%	21.4%	8.0%
Not Fit for Work (In Year) ▼																						
0 111 111 1111	2.6%	10.0%	13.9%	2.2%	5.6%	10.9%	2.5%	10.2%	10.5%	3.1%	9.6%	9.3%	2.9%	7.7%	14.2%	1.9%	7.9%	8.8%	3.1%	9.4%	13.6%	5.1%
On a Waiting List	4.3%	11.0%	16.8%	3.2%	9.2%	16.7%	4.6%	10.7%	24.7%	4.6%	10.2%	22.3%	2.8%	5.9%	13.5%	4.4%	11.6%	27.4%	4.4%	8.4%	22.1%	7.2%

This detailed table is offering actionable insight across the PCN's population for each Practice and where their populations are in terms of a High, Medium, or Low deprivation ranking; deprivation is levied from the IMD 2019 scoring per LSOA, and is applied for every individual registered within the PCN's borders.

Source: HWE PHM Team modelled data, phm.optum.co.uk - Calendar Year 2021

Bubble Matrix - Conditions

x% also have



For people with this condition

						Othe	r Condit	ions					
Initial Condition	Alzheimers Disease	Asthma	COPD	Heart Failure	Anxiety		Dementia	Alcohol Abuse	ABCD Prescription	Anti- Depressive Prescription	Activity Limitation (eFI)	Housebound (eFI)	No Other Condition
Alzheimers Disease		42%	9%	5%	67%		97%	23%	20%	48%	0%	3%	1%
Asthma	4%		8%	2%	22%		5%	5%	21%	23%	0%	0%	43%
COPD	4%	45%		11%	26%		7%	9%	55%	35%	1%	2%	0%
Heart Failure	5%	22%	22%		16%		8%	6%	92%	26%	1%	5%	0%
Anxiety	7%	26%	6%	2%			10%	9%	21%	54%	0%	1%	13%
Dementia	61%	38%	9%	5%	59%			19%	27%	45%	0%	5%	1%
Alcohol Abuse	7%	18%	6%	2%	28%		9%		21%	27%	0%	1%	17%
ABCD Prescription	2%	18%	9%	7%	15%		3%	5%		22%	0%	2%	20%
Anti-Depressive Prescription	5%	25%	7%	3%	49%		7%	8%	27%		0%	1%	17%
Activity Limitation (eFI)	2%	15%	17%	7%	29%		2%	7%	24%	27%		0%	20%
Housebound (eFI)	9%	14%	16%	15%	24%		26%	7%	71%	36%	0%		4%

When targeting specific conditions to look into, a simple Bubble matrix helps us understand that a single condition will rarely be occurring by itself; this chart then highlights the PCN's linked conditions and breaks down the common diseases linked together in the PCN.

Bio-Psycho-Social Indicators - Example



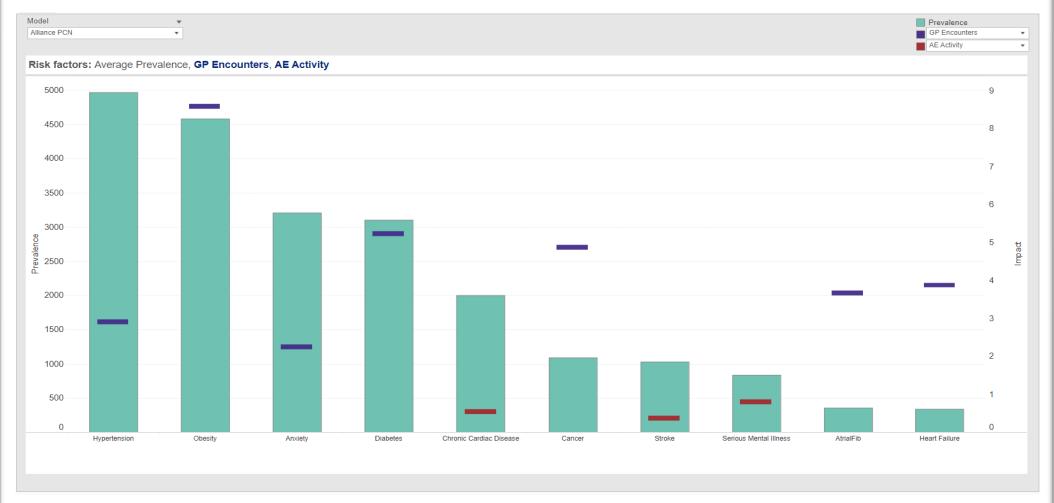
	Total	1	- Healthy	2 -	Living With III	ness	3 - L	ower Compl	exity	4 - Advar	nced Diseas	e & Com.	5 - Eo	L, Frailty & I	Dementia
Alcohol & Substance Abuse ▼	10.3%	0.0%		13.1%			16.7%			35.8%			47.5%		
High Cholesterol (Two Years) ▼	6.7%	0.0%		12.5%			12.9%			11.7%			12.7%		
Activity Limitation (eFI) ▼	0.1%	0.0%		0.0%			0.0%			0.8%			3.2%		
On a Waiting List	7.7%	3.6%		7.3%			11.6%			17.7%			30.4%		
History of Smoking ▼	29.1%	13.8%		39.3%			44.0%			47.4%			43.3%		
Housebound (eFI) ▼	0.4%	0.0%		0.0%			0.0%			1.9%			9.7%		
NHS Health Check (5 Years) ▼	6.7%	2.4%		13.2%			9.2%			7.2%			3.2%		
Hypertension Annual Review 🔻	4.3%	0.0%		3.0%			11.9%			13.3%			13.1%		
Q Risk Moderate (Two Years) ▼	1.4%	0.1%		2.2%			3.2%			2.0%			1.2%		
History of Smoking ▼	29.1%	13.8%		39.3%			44.0%			47.4%			43.3%		
		0% 2	20% 40%	0%	20%	40%	0%	20%	40%	0%	20%	40%	0%	20%	40%

This chart gives a comparison across various selected risk conditions or characteristics, within the health segments of the PCN's population.

Here we have selected a few characteristics within the PCN's data as an example, within each segment the percentage with that risk condition is highlighted proportionately by the shaded bars in the chart.

Risk Modelling - Prevalence against GP Activity & A&E





This Risk Model looks at the PCN's prevalence for major conditions, and this chart illustrates the number of people with certain risk factors, and also shows the impact on service utilisation, that these factors have. The height of each bar for each risk factor, shows the number of people who meet that criteria, as shown on the left hand axis; the horizontal lines relate to the correlation of a risk factor and an increase in impact on the selected target, shown on the right hand axis.

Source: HWE PHM Team modelled data, phm.optum.co.uk - Calendar Year 2021

Public Health - Cancer Screening





Cancer Screening

	Period	HERTFORDSHIRE AND WEST ESSEX	ALLIANCE PCN	HATFIELD ROAD SURGERY	CONSULTING	GROVE HILL MEDICAL CENTRE	WOODHALL FARM MEDICAL CTR	COLNEY,COLERIDGE HSE & BRICKET WOOD MCS	COLERIDGE HOUSE MEDICAL CENTRE
Women, aged 25-49, with a record of cervical screening in the last 3.5 yrs (denominator includes PCAs)	2020/21	73.3	63.8	64.2	64	68.1	60.8	60.7	61.8
Women, aged 50-64, with a record of cervical screening in the last 5.5 yrs (denominator includes PCAs)	2020/21	78.2	71.7	78	71.7	72.6	67.5	74.6	70.9
Persons, 25-49, attending cervical screening within target period (3.5 year coverage, %)	2020/21	73	64.7	64	66.9	68.9	62.2	62.3	62.8
Persons, 50-64, attending cervical screening within target period (5.5 year coverage, %)	2020/21	77	68.7	77	68.6	70.7	66.2	73	66.5
Persons, 50-70, screened for breast cancer in last 36 months (3 year coverage, %)	2020/21	63.9	65.4	62.1	68	67.7	59.4	68.1	64.9
Persons, 50-70, screened for breast cancer within 6 months of invitation (Uptake, %)	2020/21	61.3	45.1	27.4	33.3	38.5	33.3	46.5	20
Persons, 60-74, screened for bowel cancer within 6 months of invitation (Uptake, %)	2020/21	72.1	62.7	54.5	56.8	71.2	61.4	68.5	63.2
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %)	2020/21	68.8	58.9	55	51.7	68.2	57.7	63.2	59.6
L				Similar Si	gnificantly Worse 📕	Signflicantly Better			

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Public Health - Mortality





	Period	Hertfordshire CCGs	NHS HERTFORDSHIRE AND WEST ESSEX ICB - 06N	ALLIANCE PCN
Percentage of deaths that occur at home (All age)	2021	25.3	23.9	26.5
PYLL - Neoplasms	2021	505	498.3	551.6
PYLL - Diseases of the circulatory system	2021	737.5	690.5	721
PYLL - All Cause	2021	1537.7	1496.4	1817.5
Premature Mortality - Respiratory Disease	2021	19.2	19	
Premature Mortality - Liver Disease	2021	14.6	14.4	
Premature Mortality - Cardiovasular Disease	2021	53.8	51.4	
Premature Mortality - Cancer	2021	98.5	97.1	73.7
Premature Mortality - All Cause	2021	269.6	262.3	318

Similiar Significantly Worse Significantly Better

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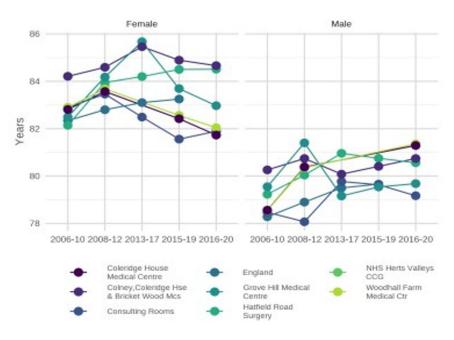


Public Health - Life Expectancy

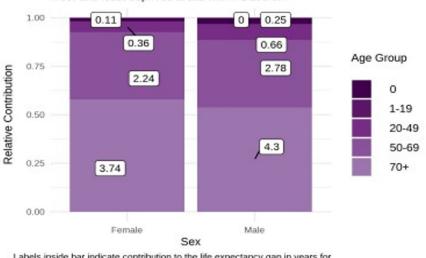




Life Expectancy



Contribution of different age bands to the gap between the most and least deprived areas within Dacorum



Labels inside bar indicate contribution to the life expectancy gap in years for each age group. This can be used to target interventions at age groups with the biggest inequality in life expectancy. The gap in life expectancy at birth for females is 6.27 years and for males is 7.99 years.

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Working together for a healthier future