



Hertfordshire and  
West Essex Integrated  
Care System



Hertfordshire and  
West Essex  
Integrated Care Board

# Primary Care Networks Overview Pack

## HATFIELD PCN

Pack produced - January 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

Hatfield PCN population profile differs compared to England across most age categories which is lower except in the age categories 20-34 which is higher. About 45% of people live within the 5 most deprived deciles (1-5) and if you include decile 6 it is about 68%.

20.8% population have at least 1 Long Term Condition. 5.1% have more than 5 LTCs compared to 5.6% for the ICB. The population pyramid shows a similar profile to England for those living with LTCs, except the age categories 20-29 and 35-39 which is higher and lower in age categories 65-74.

Wider determinants analysis from Public Health Evidence and Intelligence shows Hatfield is one of the most deprived PCNs within the ICB across most indicators, except Employment where it is one of the least deprived.

The spread of patients for Hatfield PCN indicates 6.51% 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 must be taken into account for this population by the PCN.

Expected population growth for Welwyn Hatfield district by the Local Authority, forecasts 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 ~20k to ~23k.

When analysing the underlying Segmentation Model data the conditions with highest per 1,000 registered prevalence that are highlighted for Hatfield PCN, it is to be noted that there may be areas where data has not been collected, and areas of concern that need to be monitored going forward, such as COPD, Obesity, Diabetes, Learning Disabilities, Hypertension, Atrial Fib, Anxiety and Serious Mental Illness.

Urgent & Emergency Care in 2022/23 for Hatfield PCN A&E Attendance rates per 1,000 population, is higher than the place rate.

When comparing the Ambulatory Care Sensitive rates per 1,000 population between places, the East & North place has the lowest rate in the ICB. Within East & North place, Hatfield has the second lowest rate per 1,000 population, than the average.

When looking at the ACS conditions for Hatfield the highest volume and cost is within the Advanced Disease and Complexity segment in the over 65 age group and the next highest volume and cost is for the over 65 age group in the End of Life, Frailty and Dementia segment as well. It is to be noted that under Advanced Disease and Complexity segment, there is a notable use by the 41-64 age group for volume and cost.

Ambulatory Care Sensitive conditions of note for people aged over 65 within the Advanced Disease and Complexity, is highlighted as Heart Failure with the highest volume and cost, followed by AF and Flutter and COPD. For those people aged over 65 within the End of Life, Frailty & Dementia is highlighted as COPD with the highest volume and cost, followed by Heart Failure and AF and Flutter.

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 Hatfield 36.1% of the population in the EoL, severe frailty and severe dementia segment live within the 4 most deprived deciles.

As we would expect the average number of acute and chronic conditions is significantly higher within this segment than the general population as are all activity measures. The average number of Chronic Conditions for people within Hatfield PCN is just above the ICB, and the data shows significant higher usage of GP services.

Within this segment we can see the presence of Chronic Cardiac Disease, Chronic Respiratory Disease and Heart Disease being highlighted which chimes with the reason for admission within previous analysis for ACS conditions. It is to be noted that Hypertension is high across all deciles but is below the ICB.

For Hatfield the data shows higher Asthma, COPD and Heart Failure rates which was identified as a theme within the ACS analysis.

## 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 HATFIELD PCN

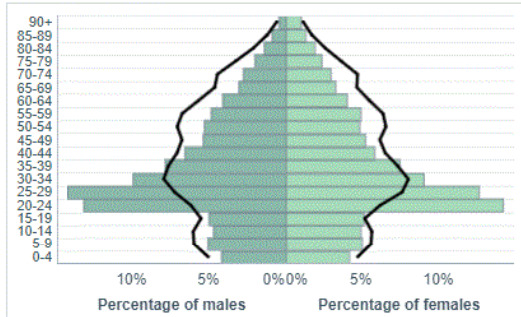
Snapshot as at: 30/06/2021

Registered population		Demographics		Prevalence		Acute utilisation		Covid	
% of total	100.0%	% White	50.1%	% with 1+ conditions	20.8%	% of annual activity (total 70,780)	100.0%	% one or more at risk conditions	12.7%
% of annual change	1.9%	% BAME	17.6%	% with 5+ conditions	2.0%	% of annual cost (total £20M)	100.0%	% two or more at risk conditions	4.6%
		% IMD top	3.3%						
		% IMD bottom	12.7%						

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

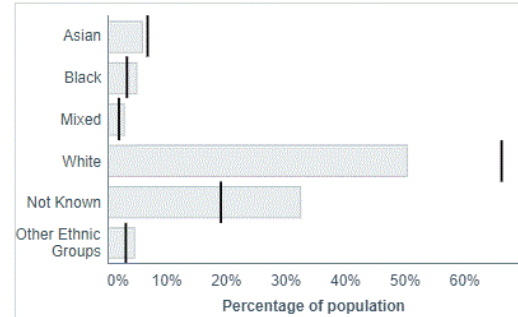
Choose benchmark:

### Population pyramid



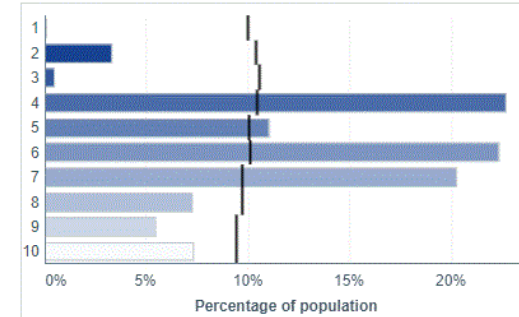
Black line represents the England average

### Population proportion by ethnic category



Black line represents the England average

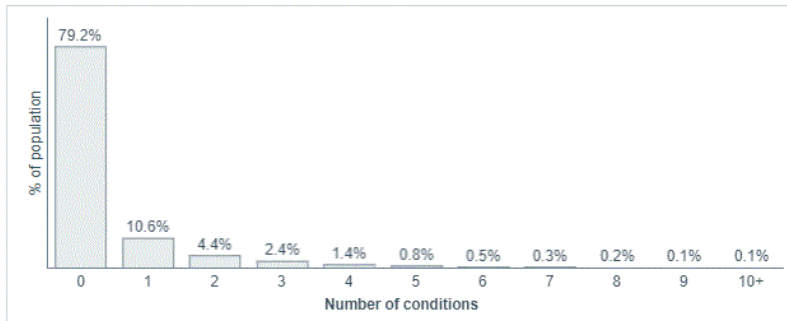
### Population proportion by IM Deprivation decile



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

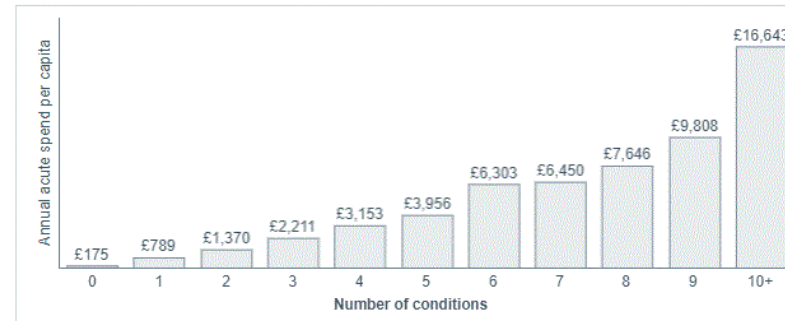
## Prevalence - Snapshot as at: 30/06/2021

### Population proportion by number of conditions



### Annual spend per capita by number of conditions

Financial Year: 2020/21



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.

Hatfield PCN population profile differs compared to England across most age categories which is lower except in the age categories 20-34 which is higher. About 45% of people live within the 5 most



# PCN Demographics - NHS England

LTC  
HATFIELD PCN

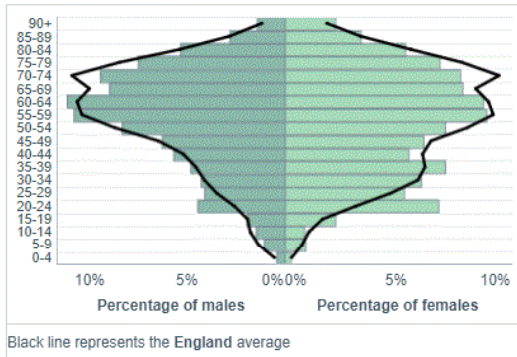
Snapshot as at: 30/06/2021

Registered population		Demographics		Prevalence		Acute utilisation		Covid	
% of total	18.1%	% White	79.1%	% with 1+ conditions	100.0%	% of annual activity (total 33,584)	47.4%	% one or more at risk conditions	54.0%
% of annual change	5.0%	% BAME	17.2%	% with 5+ conditions	5.1%	% of annual cost (total £8M)	40.9%	% two or more at risk conditions	16.2%
		% IMD top	3.9%						
		% IMD bottom	15.6%						

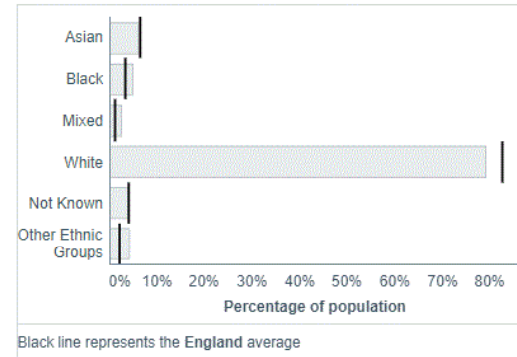
## Population demographics - Snapshot as at: 30/06/2021

Choose benchmark:

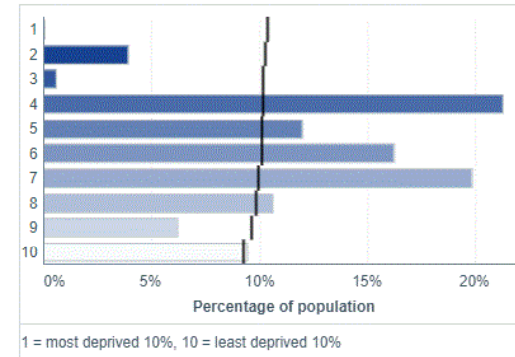
### Population pyramid



### Population proportion by ethnic category

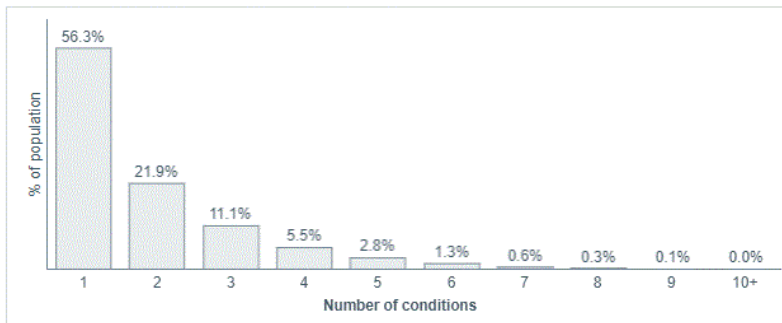


### Population proportion by IM Deprivation decile



## Prevalence - Snapshot as at: 30/06/2021

### Population proportion by number of conditions



### Annual spend per capita by number of conditions

Financial Year: 2020/21



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 20.8% population have at least 1 Long Term Condition. 5.1% have more than 5 LTCs compared to 5.6% for the ICB.

The population pyramid shows a similar profile to England for those living with LTCs, except the age categories 20-29 and 35-39 which is higher and lower in age categories 65-74.

# Practice Indicators - Triggers and Levels

Practice Indicators for		BURVILL HOUSE SURGERY			LISTER HOUSE SURGERY			POTTERELLS MEDICAL CENTRE			WRAFTON HOUSE SURGERY		
Clinical Domain	Indicator Name	Latest Score	Time Period	Trigger Level	Latest Score	Time Period	Trigger Level	Latest Score	Time Period	Trigger Level	Latest Score	Time Period	Trigger Level
HATFIELD PCN													
Clinical Domain	Indicator Name	Latest Score	Time Period	Trigger Level	Latest Score	Time Period	Trigger Level	Latest Score	Time Period	Trigger Level	Latest Score	Time Period	Trigger Level
Clinical Diagnosis	Detection rate Cancer	0.344	2020/21	Level 1	0.651	2020/21	No Trigger	0.618	2020/21	No Trigger	0.447	2020/21	No Trigger
Coronary heart disease	% AF anticoagulation therapy CHADS2-VASc score >1	84.2	2020/21	Positive	91.8	2020/21	Positive	93.2	2020/21	Positive	89.4	2020/21	Positive
	% CHD aged <=79 BP reading 140/90mmHg or less	53.5	2020/21	Level 1	42.6	2020/21	Level 1	80.1	2020/21	No Trigger	60.7	2020/21	Level 1
	% CHD cholesterol 5 mmol/l or less	59.8	2021/22	No Trigger	62.7	2021/22	No Trigger	70.9	2021/22	No Trigger	57	2021/22	No Trigger
	% hypertension aged <=79 BP reading 140/90mmHg or less	42.7	2020/21	Level 1	28.5	2020/21	Level 2	74	2020/21	Level 1	57.5	2020/21	Level 1
Diabetes	% Diabetes aged >=40 years no CVD history without moderate or severe frailty treated with statin	79.6	2020/21	Level 1	82.3	2020/21	Level 1	93.2	2020/21	No Trigger	79.6	2020/21	Level 1
	% Diabetes without moderate or severe frailty BP 140/80 mmHg or less	39.9	2020/21	Level 1	29.7	2020/21	Level 2	73.3	2020/21	Level 1	59.8	2020/21	Level 1
	% diabetes without moderate or severe frailty IFCC-HbA1c is 58 mmol/mol or less	53.5	2020/21	Level 1	53.1	2020/21	Level 1	67.9	2020/21	Level 1	49.9	2020/21	Level 2
Exception Rating	Overall Personalised Care Adjustment Rate	0.049	2020/21	No Trigger	0.059	2020/21	No Trigger	0.047	2020/21	No Trigger	0.04	2020/21	No Trigger
Medicines Management	% antibiotics Co-amoxiclav, Cephalosporins, Quinolones	6.8	2021/22 Q4	No Trigger	5.9	2021/22 Q4	Positive	9.6	2021/22 Q4	No Trigger	7	2021/22 Q4	No Trigger
	% Naproxen and Ibuprofen	79.1	2021/22 Q4	No Trigger	74.3	2021/22 Q4	No Trigger	73	2021/22 Q4	No Trigger	86.1	2021/22 Q4	No Trigger
	Antibacterial Items/Star Pu	0.626	2021/22 Q4	Positive	0.821	2021/22 Q4	Positive	0.66	2021/22 Q4	Positive	0.858	2021/22 Q4	Positive
	Hypnotics ADQ/Star Pu	0.214	2021/22 Q4	Positive	0.453	2021/22 Q4	No Trigger	0.225	2021/22 Q4	Positive	0.568	2021/22 Q4	No Trigger
	Oral NSAIDS ADQs/STAR-PU	2.646	2021/22 Q4	No Trigger	5.676	2021/22 Q4	No Trigger	2.942	2021/22 Q4	No Trigger	4.303	2021/22 Q4	No Trigger
Mental Health	% first choice generic SSRIs	68.7	2021/22 Q4	No Trigger	66.3	2021/22 Q4	No Trigger	79.8	2021/22 Q4	Positive	72.7	2021/22 Q4	No Trigger
	% MH comprehensive care plan	51.2	2020/21	Level 1	62.6	2020/21	Level 1	11.1	2020/21	Level 2	25	2020/21	Level 1
	% SMI alcohol record	64.4	2020/21	Level 1	94.9	2018/19	No Trigger	100	2018/19	Positive	46.1	2020/21	Level 1
	% SMI BP record	65.9	2020/21	Level 1	41.3	2020/21	Level 2	32.1	2020/21	Level 2	48.1	2020/21	Level 1
	Dementia Face to Face review	36.4	2020/21	Level 1	32	2020/21	Level 1	32.3	2020/21	Level 1	19	2020/21	Level 1
	Select antidepressants ADQs/STARPU	1.27	2021/22 Q4	No Trigger	1.862	2021/22 Q4	No Trigger	1.063	2021/22 Q4	No Trigger	1.728	2021/22 Q4	No Trigger
Patient Experience	Confidence and trust in healthcare professional	93.2	2020/21	No Trigger	99.1	2020/21	No Trigger	97.3	2020/21	No Trigger	96.1	2020/21	No Trigger
	Frequency seeing preferred GP	44.1	2020/21	No Trigger	38	2020/21	No Trigger	37.8	2020/21	No Trigger	25.1	2020/21	No Trigger
	Healthcare professional treating with care and concern	90.3	2020/21	No Trigger	87.8	2020/21	No Trigger	91.2	2020/21	No Trigger	88.6	2020/21	No Trigger
	Overall experience of your GP practice	83.2	2020/21	No Trigger	89.4	2020/21	No Trigger	84.9	2020/21	No Trigger	81.5	2020/21	No Trigger
	Satisfaction with appointment times	58	2020/21	No Trigger	64.6	2020/21	No Trigger	77.9	2020/21	No Trigger	56.4	2020/21	No Trigger
Public Health	% Child Imms DTaP/IPV/Hib/HepB (age 1 year)	92	2020/21	Level 1	94.9	2020/21	Level 1	92.3	2020/21	Level 1	87.7	2020/21	Level 1
	% Child Imms Hib/MenC booster	87.6	2020/21	Level 1	94.5	2020/21	Level 1	98.5	2020/21	No Trigger	93.4	2020/21	Level 1
	% Child Imms MMR (Age 2 yrs)	86.9	2020/21	Level 1	93.5	2020/21	Level 1	98.5	2020/21	No Trigger	92.6	2020/21	Level 1
	% Child Imms PCV Booster	87.6	2020/21	Level 1	95	2020/21	No Trigger	98.5	2020/21	No Trigger	91.8	2020/21	Level 1
	Cervical Screening	60.9	2021/22 Q4	Level 2	63	2021/22 Q4	Level 1	64.2	2021/22 Q4	Level 1	67.7	2021/22 Q4	Level 1
Respiratory	% Asthma review in last 6 mths	25.2	2020/21	Level 1	20.9	2020/21	Level 1	37.5	2020/21	Level 1	34.5	2020/21	Level 1
	% Asthma spirometry and one other objective test	0	2020/21	Level 2	16.7	2020/21	Level 1	20	2020/21	Level 1	0	2020/21	Level 2
	% COPD with review in last 12 mths	67.5	2020/21	Level 1	38	2020/21	Level 1	76	2020/21	Level 1	27.9	2020/21	Level 1
	% LTC patients who smoke	17.7	2020/21	No Trigger	15.8	2020/21	No Trigger	9.2	2020/21	No Trigger	16.6	2020/21	No Trigger
	% LTC Smoker offer support	63	2020/21	Level 1	81.9	2020/21	Level 1	77.9	2020/21	Level 1	76.7	2020/21	Level 1
	% Smoking patients over 15 recorded	60.4	2021/22	Level 1	70.3	2021/22	No Trigger	64.3	2021/22	No Trigger	70.7	2021/22	No Trigger
	% Smoking status recorded	88.8	2020/21	Level 1	95.8	2020/21	No Trigger	93.7	2020/21	No Trigger	93.6	2020/21	No Trigger
	% w. MRC dyspnoea score >=3 w. offer of referral to pulm. rehab. Clinic	82.8	2020/21	Level 1	100	2020/21	No Trigger	100	2020/21	No Trigger	95.9	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/>).



## Wider Determinants



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

In Hatfield PCN an estimated:

- 15.5% of children live in poverty.
- 14.1% of older people live in poverty.
- 17.1% of households live in fuel poverty.
- 13.7% of households are overcrowded.
- 33.6% of people aged 65 and over live alone.
- 2% of people cannot speak English well.
- 3.6% of working age people are claiming out of work benefits.
- 21.5% of children aged 4-5 and 34.5% of children aged 10-11 are overweight.

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Hertfordshire Public Health  
Evidence & Intelligence  
Epidemiology



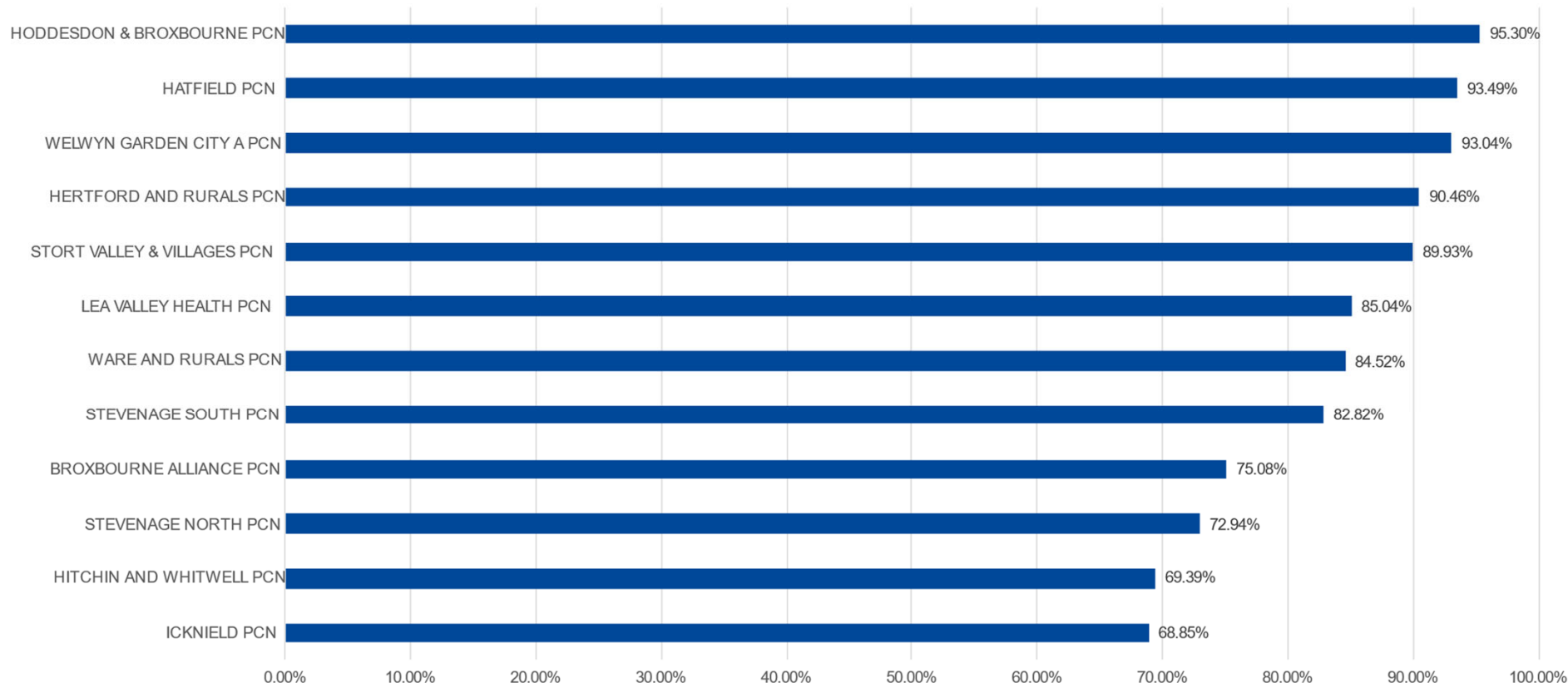
The above provides a summary of the wider determinants of health for Hatfield.

Wider determinants analysis from Public Health Evidence and Intelligence shows Hatfield is one of the most deprived PCNs within the ICB across most indicators, except Employment where it is one of the least deprived.



## SPREAD OF PATIENTS ACROSS ENGLAND CONT.

Percent of East and North Hertfordshire patients within Hertfordshire and West Essex boundary

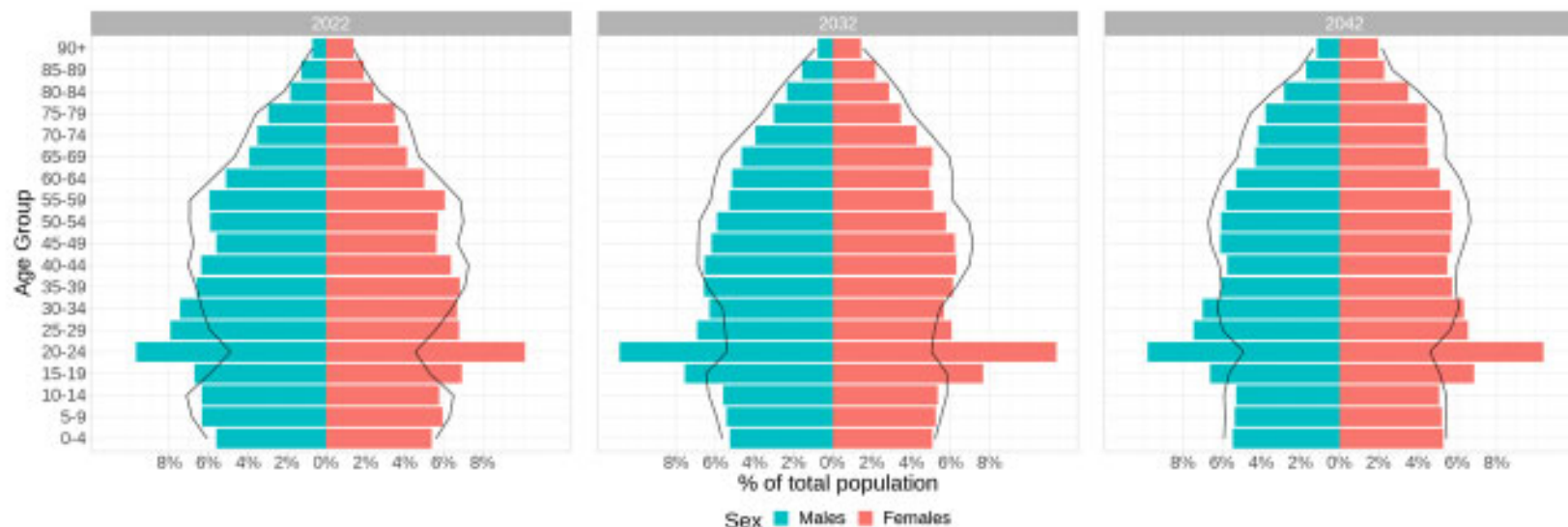


**This chart shows the proportion of the registered population living within the ICB geographical boundary.**

**The spread of patients for Hatfield PCN indicates 6.51% 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 must be taken into account for this population by the PCN.**



## Projection Pyramids



Black line indicates HWE ICS values.  
 Population pyramids and table shown for Welwyn Hatfield 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	6,916	6,767	7,208
Under 24	43,311	45,626	43,848
24-64	62,924	62,453	64,211
65+	19,648	23,456	26,229
85+	3,339	3,917	4,775

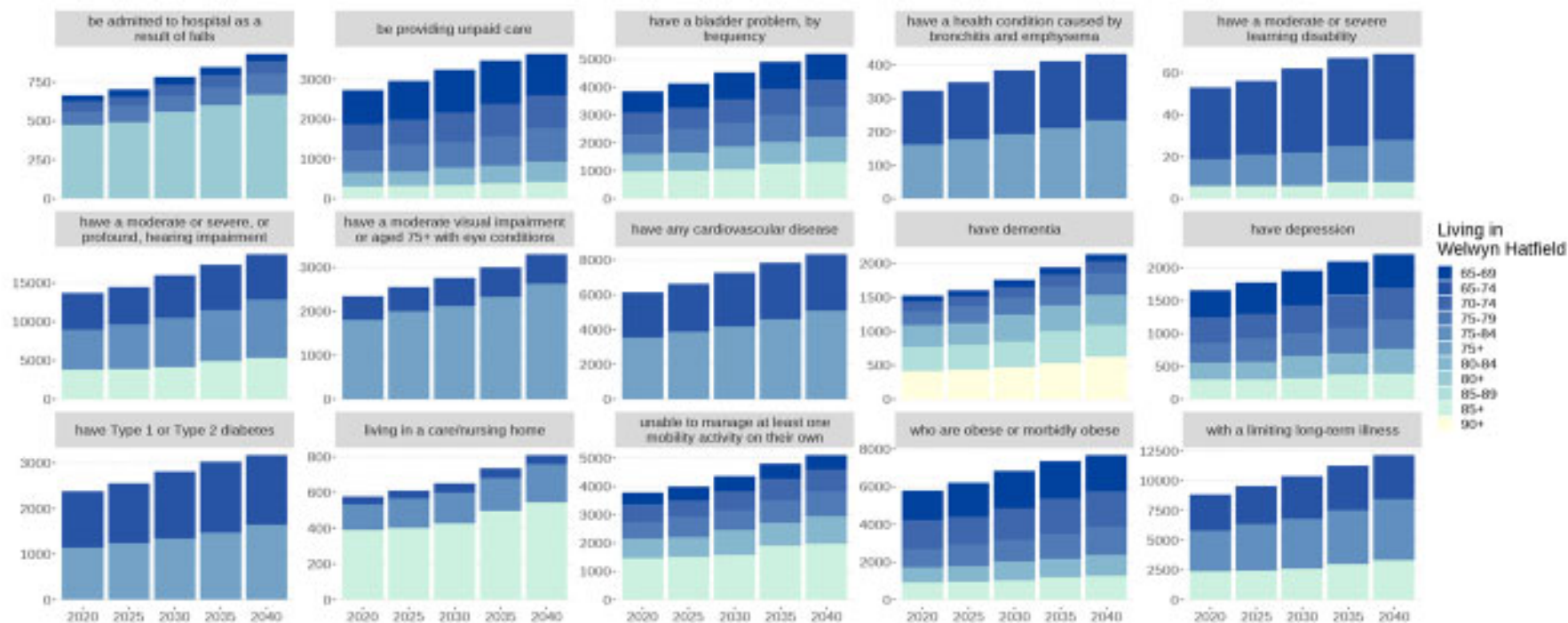
[PH.Intelligence@hertfordshire.gov.uk](mailto:PH.Intelligence@hertfordshire.gov.uk)



Expected population growth for Welwyn Hatfield district by the Local Authority, forecasts 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 ~20k to ~23k.



## People aged 65+ projected to...



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Hertfordshire Public Health  
Evidence & Intelligence  
Epidemiology



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

**Optum**

HWE

Segment & Outcomes  
Framework Documentation

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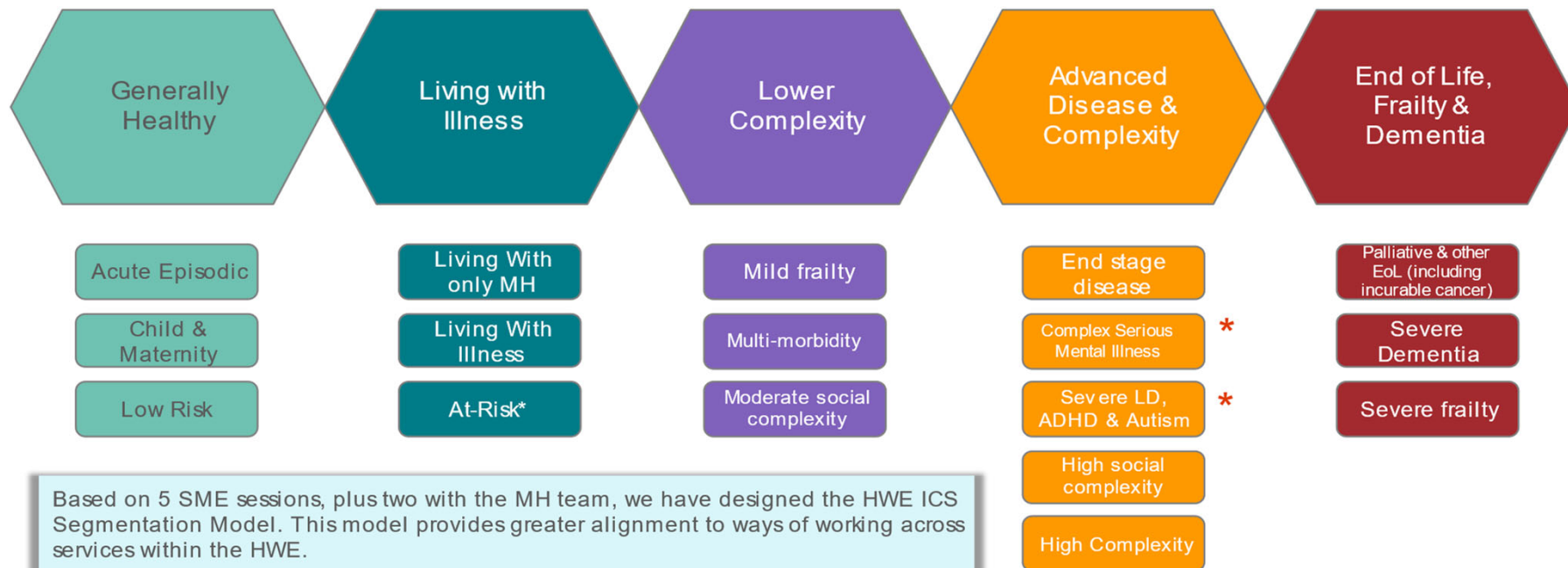
# PHM Segment Model - Overview

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



Based on 5 SME sessions, plus two with the MH team, we have designed the HWE ICS Segmentation Model. This model provides greater alignment to ways of working across services within the HWE.

It follows a MECE model, assigned in order from right to left in segment, and top to bottom in subsegment.

\* awaiting finalisation of methodology



# 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 confidence 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 day 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 to 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?

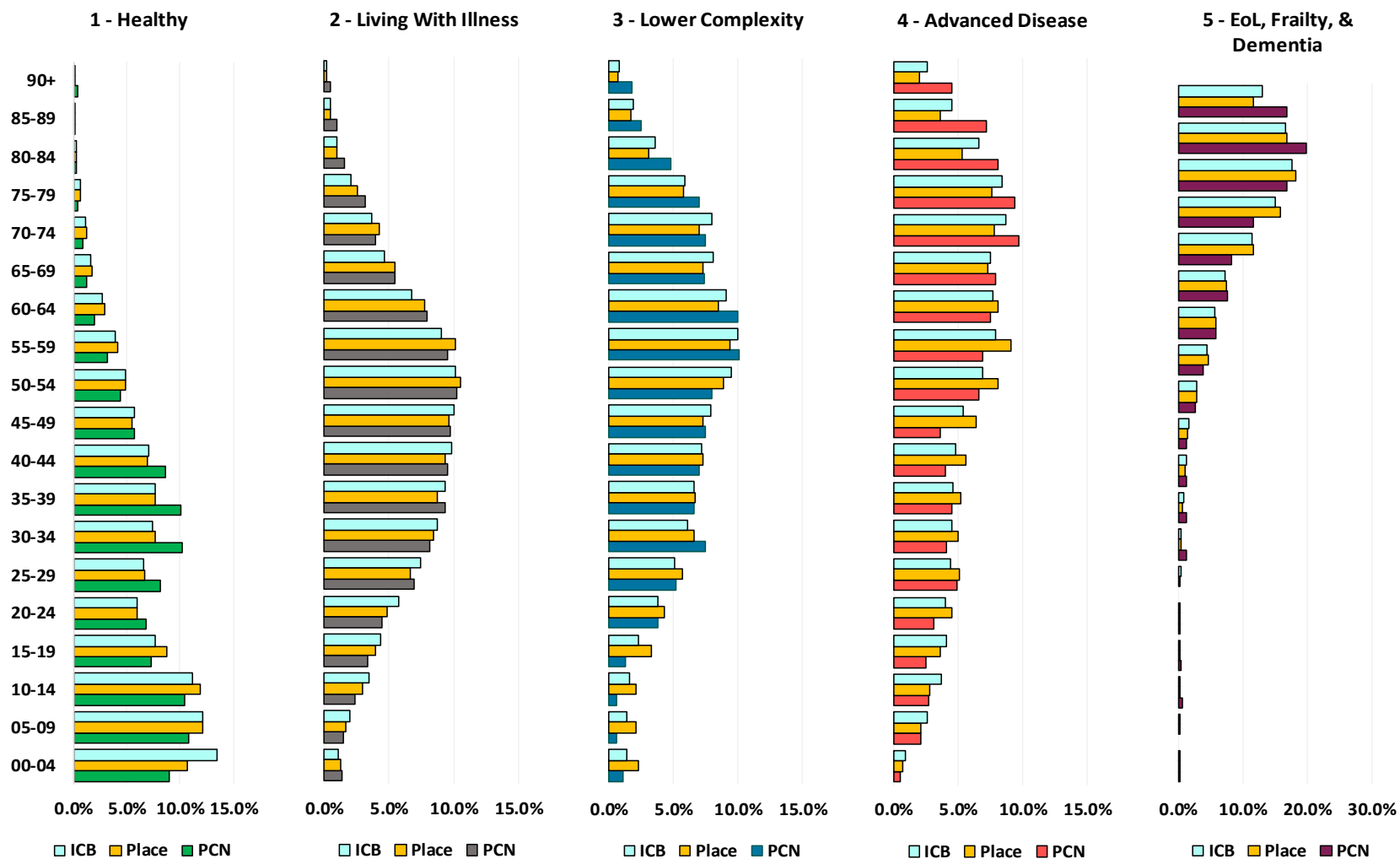
- End of Life, frailty and dementia is the first segment in the logic and is the first set of criteria on which people are assessed. The segment includes: people who are identified as being in their last year of life, or on the palliative disease register as well as people with incurable cancer. This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

# Age Profile and Health Segment

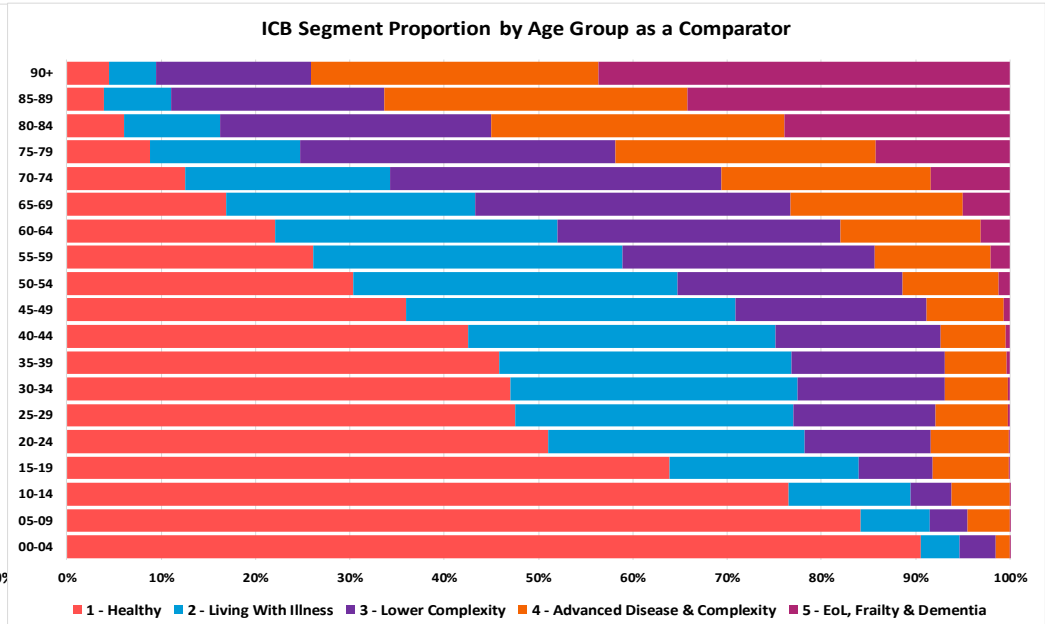
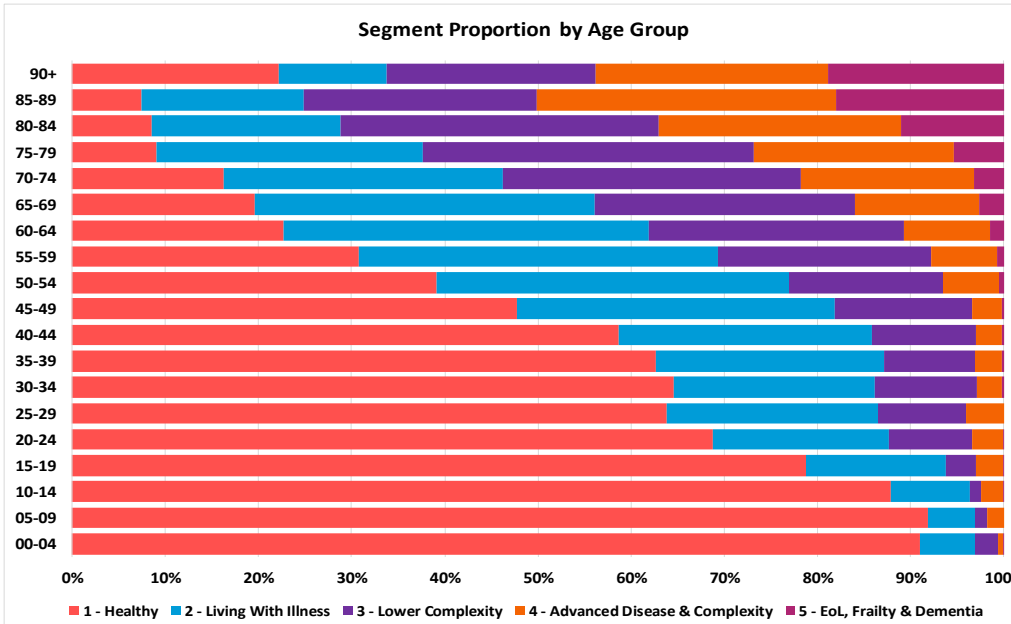
## Age Profile of PCN, Place, and ICB Segment Population Comparison



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.

# Demographic Breakdowns - Segment & Deprivation Quintiles

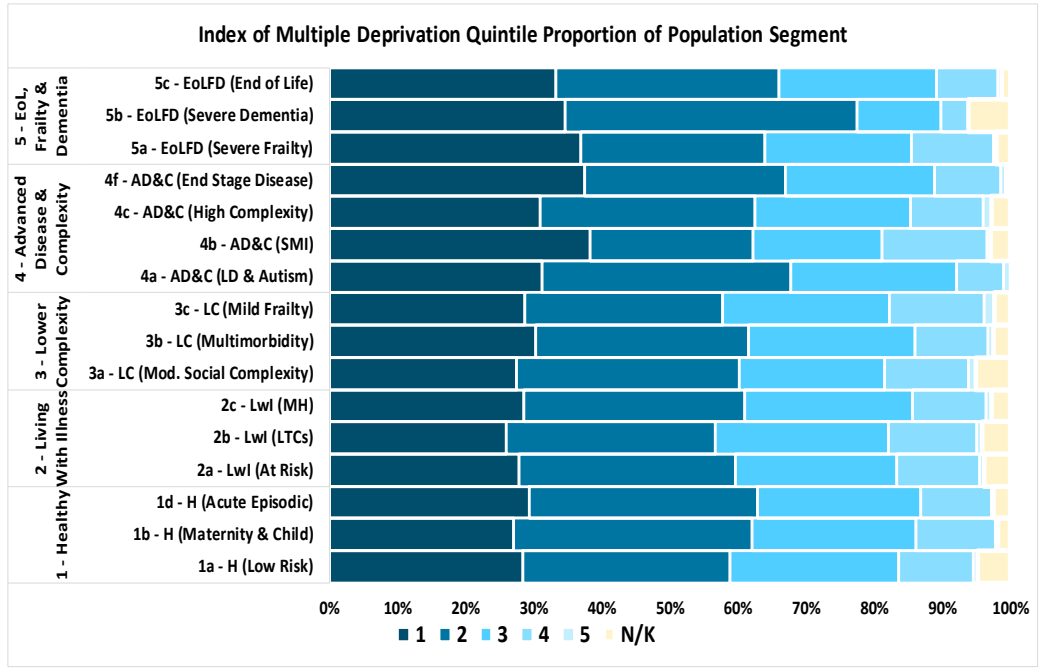


The ICB Health Segments here are broken down by total population and 5 year age groups; as expected with age the proportion of people within the healthy segment decreases.

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

Overall Hatfield has a higher profile for most age categories for segment 1 and lower for segments 2 to 5, compared to the ICB population.

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.



# Major Conditions Comparison - Per 1,000 Registered

PCN NAME	COPD	Obesity	Asthma	Diabetes	Dementia	Cancer	Learning Disabilities	Hypertension	Stroke	Chronic Kidney Disease	Heart Disease	Heart Failure	AtrialFib	Chronic Cardiac Disease	Depression	MH	Anxiety	Serious Mental Illness	Alzheimers
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
BROXBORNE 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 & BROXBORNE	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 Hatfield PCN, it is to be noted that there may be areas where data has not been collected, and areas of concern that need to be monitored going forward, such as COPD, Obesity, Diabetes, Learning Disabilities, Hypertension, Atrial Fib, Anxiety and Serious Mental Illness.



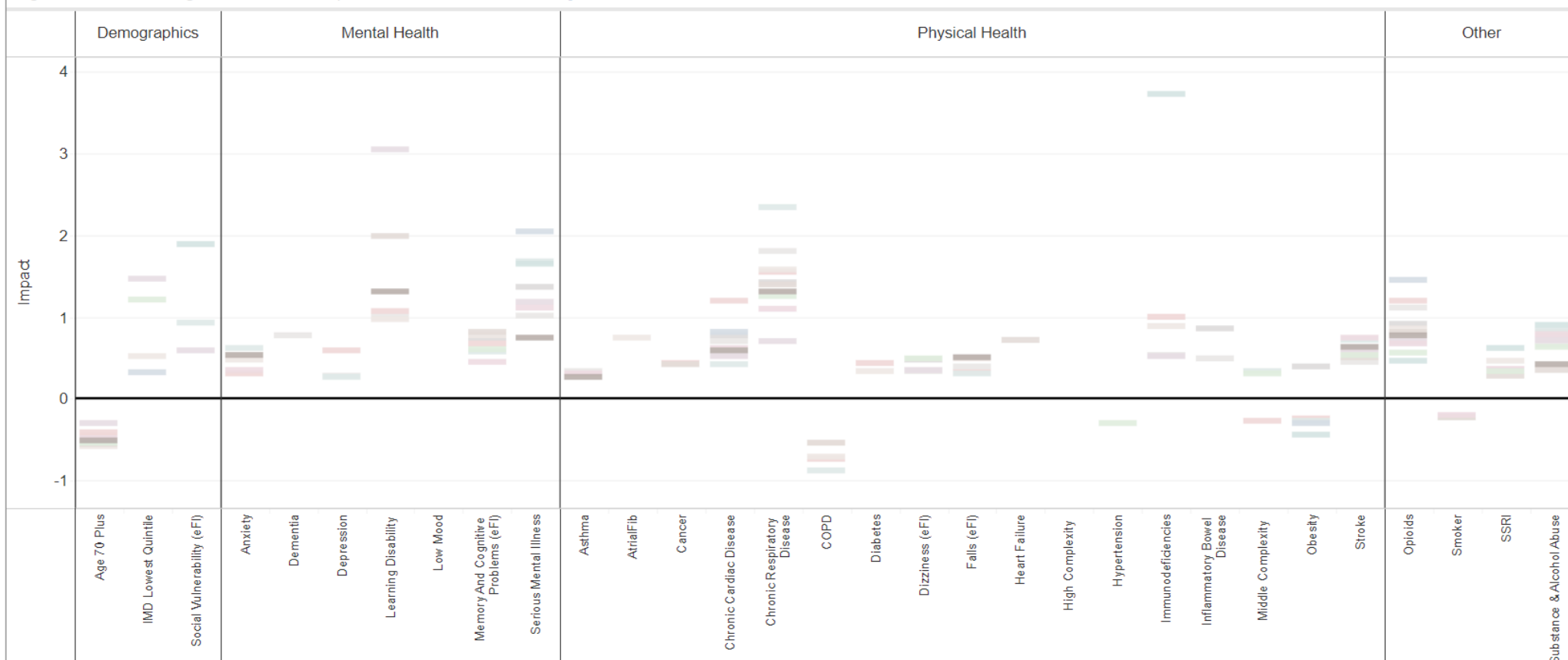
PCN NAME	ASD	Cerebral Palsy	Chronic Respiratory Disease	Cystic Fibrosis	Huntingtons Disease	Inflammatory Bowel Disease	Kidney Transplant	Metastatic Cancer	Multiple Sclerosis	Muscular Dystrophy	Myasthenia Gravis	Osteoporosis	Other Neurological Conditions	Parkinsons Disease	Rheumatoid Arthritis	Lupus (SLE)	Sickle Cell Disease	Solid Organ Transplant	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, we can see that the PCN has higher prevalence of Kidney Transplant, Osteoporosis, Other Neurological Conditions, Sickle Cell disease and High BP.



# PCN Benchmarking - A&E Activity

Higher bars indicate greater relationship with increased **AE Activity**



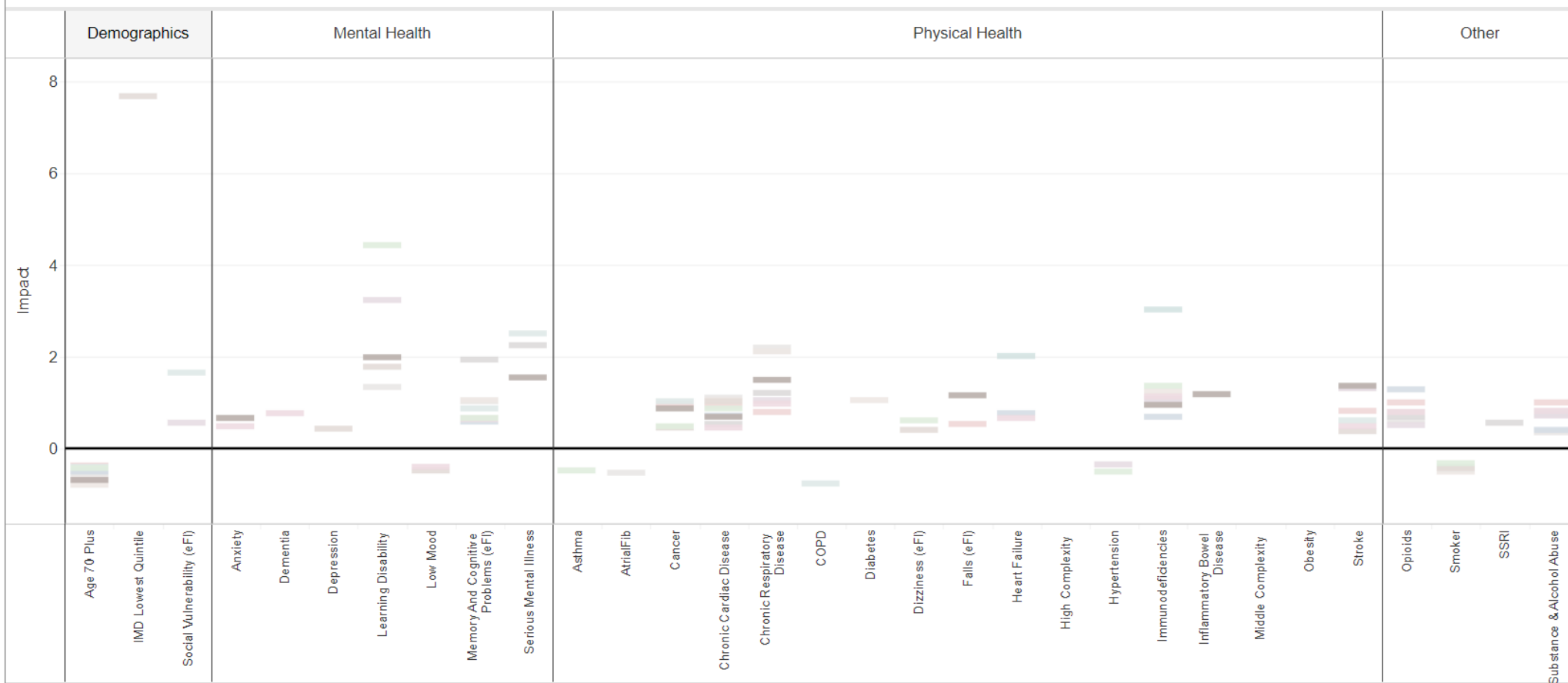
The charts in the next two pages show activity for the PCN compared against all other PCNs at the Place level.

**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

Higher bars indicate greater relationship with increased **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.

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.



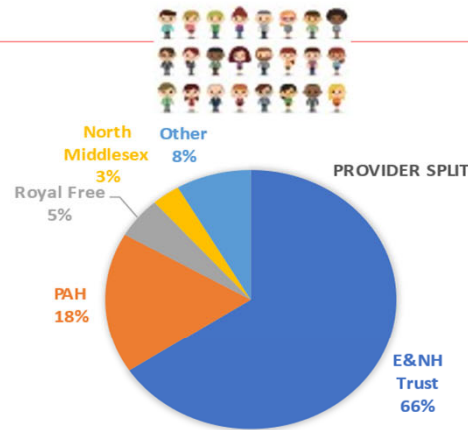
# UEC Overview

## Hertfordshire & West Essex ICB – East & North A&E Summary – Who are attending and why?

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

218,296 A&E Attendances in 2021/22  
  
Children = 56,287 (25.8%)  
Adults = 111,219 (50.9%)  
Older People = 50,790 (23.3%)

57,811 26.5% of attendances resulted in no investigation and no treatment (includes Uncoded Activity)  
  
Children = 19,082 (34%)  
Adults = 30,658 (27.6%)  
Older People = 6,944 (15.9%)

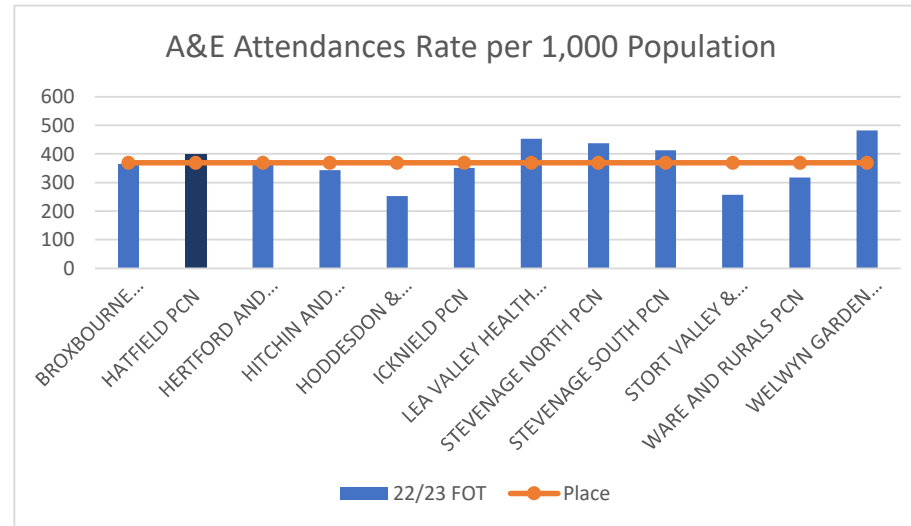
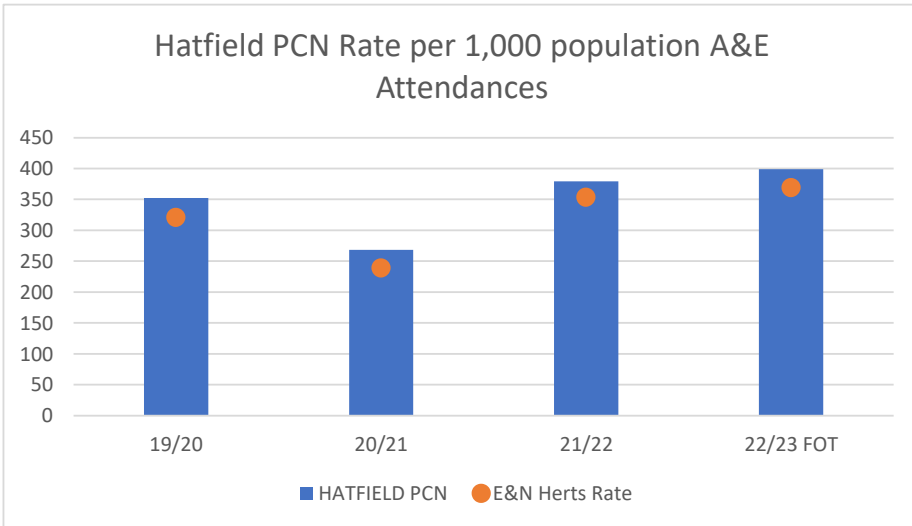
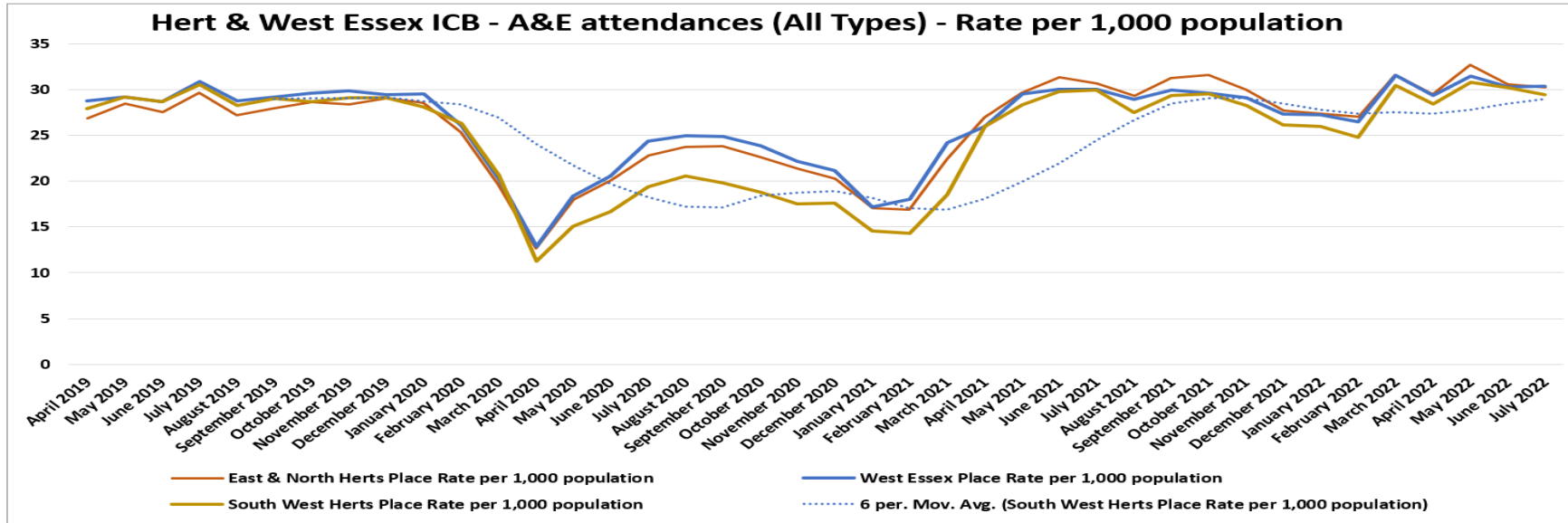


128,296 people attended A&E in 2021/22  
  
Children = 34,197 (26.5%)  
Adults = 68,101 (52.8%)  
Older People = 26,873 (20.8%)

This translates to 1 in 5 people registered with East & North attending A&E  
  
Children = 1 in 4 children  
Adults = 1 in 5 adults  
Older People = 1 in 4 older people



Source: SUS



**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 for Hatfield PCN A&E Attendance rates per 1,000 population, is higher than the place rate.**



# 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 Hatfield PCN.

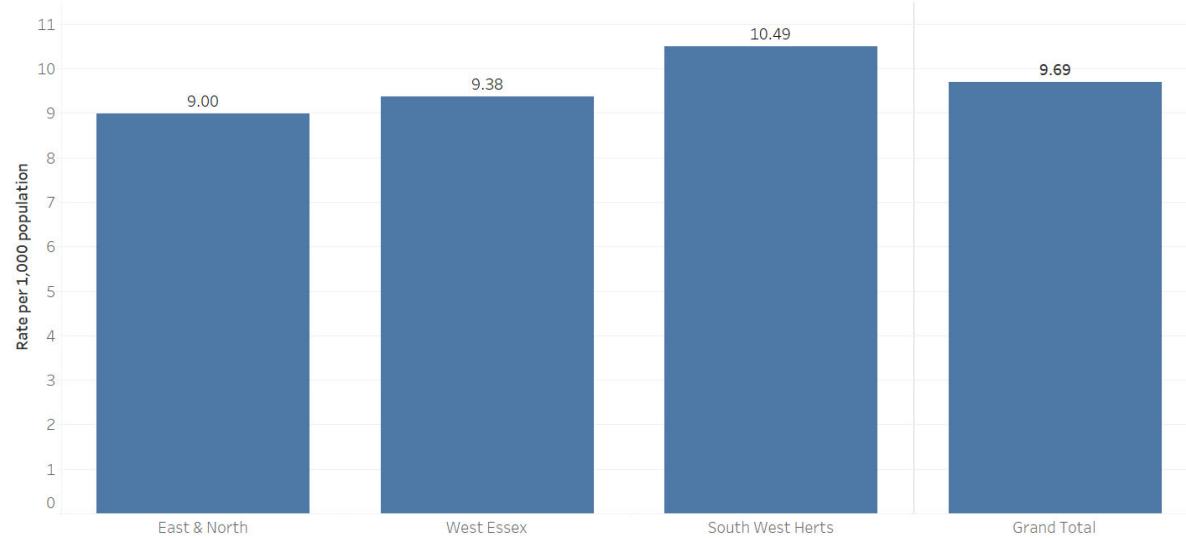
\* Average cost for Mental and Behavioural is not representative as non-PbR

## 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	41	36	£2,767	£113,457
CVD: Angina	13	12	£834	£10,841
CVD: Congestive Heart Failure	82	66	£4,667	£382,716
CVD: Hypertension	11	11	£705	£7,759
Diseases of the blood	10	10	£3,451	£34,507
Mental and Behavioural Disorders	5	4		
Neurological Disorders	29	19	£1,924	£55,796
Nutritional, endocrine and metabolic	49	38	£2,837	£139,005
Respiratory: Asthma	25	22	£1,326	£33,140
Respiratory: COPD	99	62	£2,776	£274,846
<b>Grand Total</b>	<b>364</b>	<b>274</b>	<b>£2,890</b>	<b>£1,052,067</b>

# ACS Admission Rates per 1,000 Population by Place

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

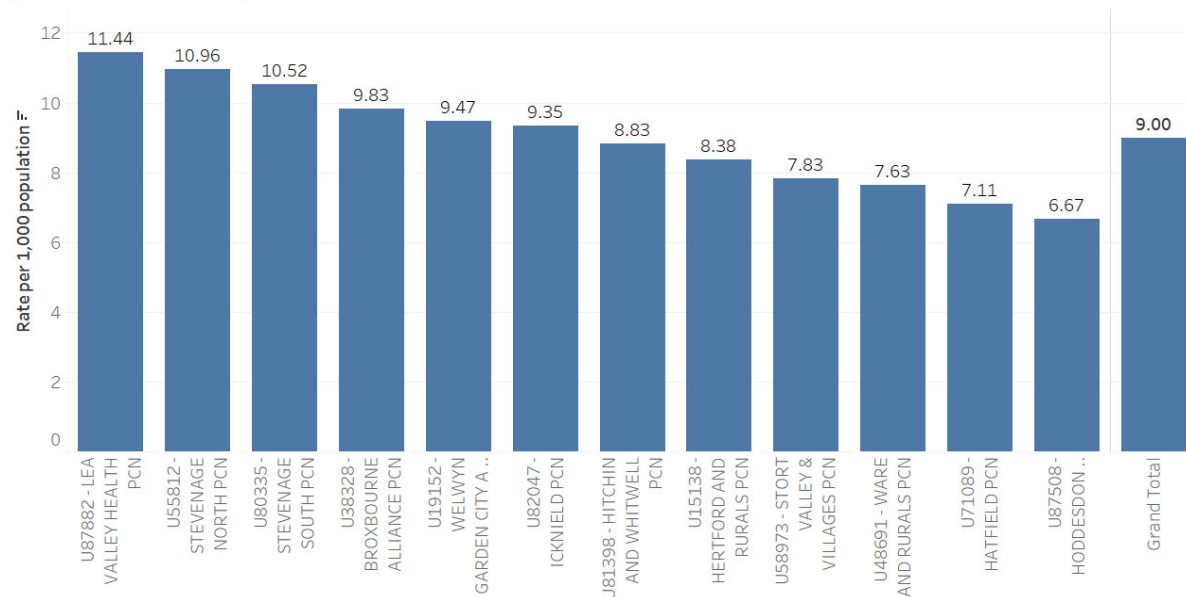


When comparing the Ambulatory Care Sensitive rates per 1,000 population between places, the East & North place has the lowest rate in the ICB.

Within East & North place, Hatfield has the second lowest rate per 1,000 population, than the average.

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

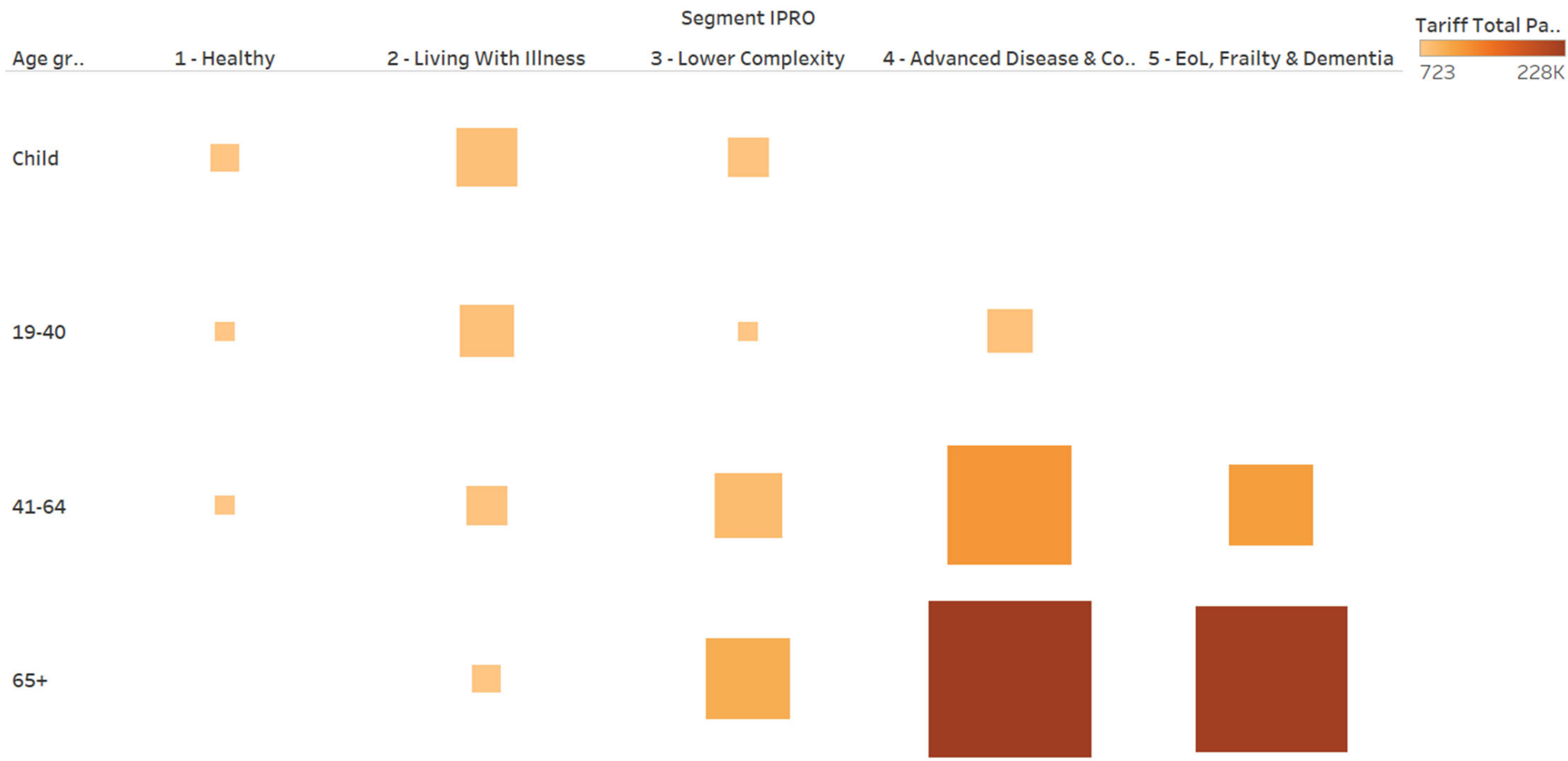
Chronic Ambulatory Care Sensitive Conditions by Place  
Rate per 1,000 Population  
(Total Population)



Source: HWE PHM Team, SUS UEC data-sets

# Chronic ACS by Segment

ACS by segment\_age



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 Hatfield the highest volume and cost is within the Advanced Disease and Complexity segment in the over 65 age group and the next highest volume and cost is for the over 65 age group in the End of Life, Frailty and Dementia segment as well. It is to be noted that under Advanced Disease and Complexity segment, there is a notable use by the 41-64 age group for volume and cost.

The following pages look at which ACSs contribute to this.

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

## Segment 4



**Ambulatory Care Sensitive conditions of note for people aged over 65 within the Advanced Disease and Complexity, is highlighted as Heart Failure with the highest volume and cost, followed by AF and Flutter and COPD.**

**For those people aged over 65 within the End of Life, Frailty & Dementia is highlighted as COPD with the highest volume and cost, followed by Heart Failure and AF and Flutter.**

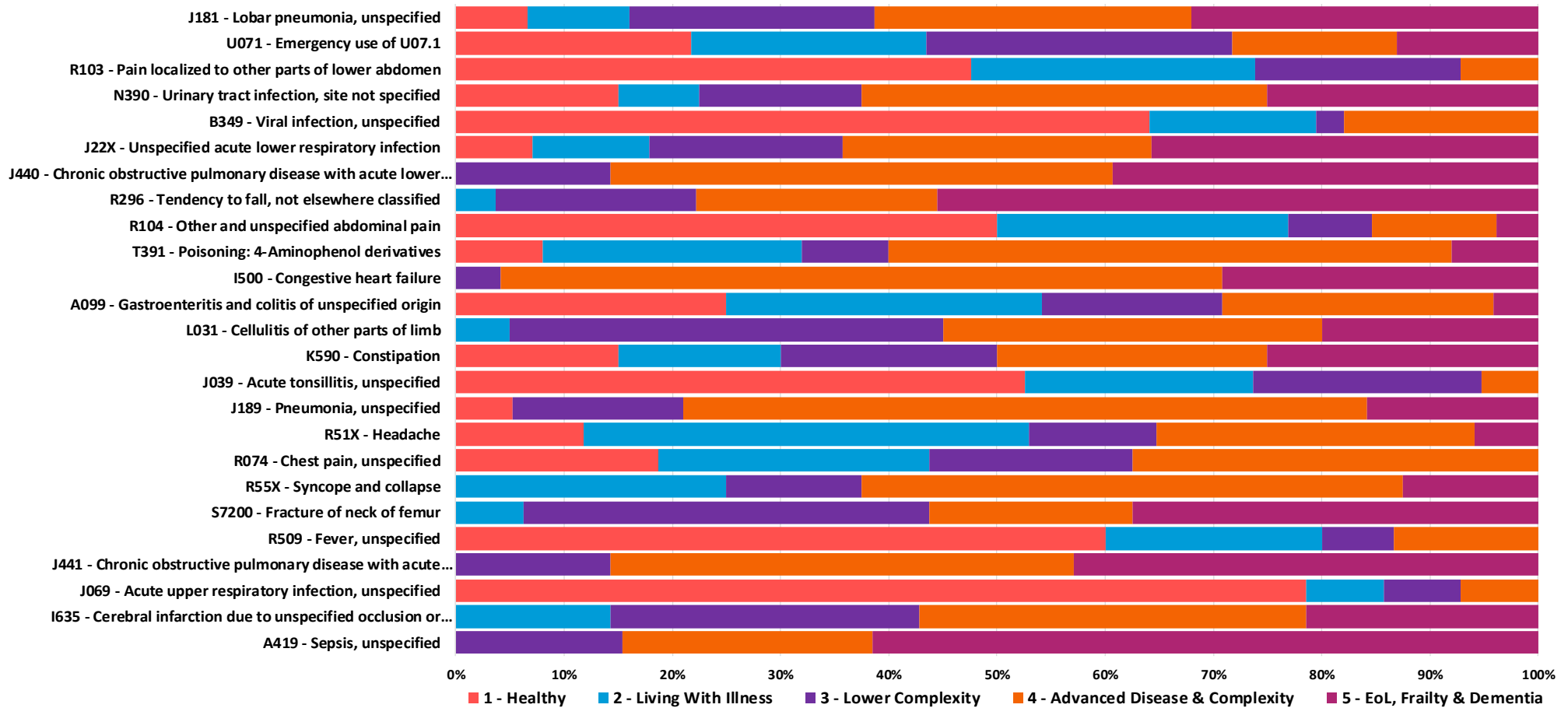
## Segment 5



# UEC Diagnoses by Segment

## PCN Population - UEC Top 25 Primary Diagnoses by Segment

Highest Emergency Admissions from Top to Bottom



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 & Ward	1 - Healthy	2 - Living With Illness	3 - Lower Complexity	4 - Advanced Disease & Complexity	5 - EoL, Frailty & Dementia	Grand Total
Ashley		1				1
Bandley Hill			1			1
Batchwood			5			5
Bishop's Stortford All Saints				3		3
Brookmans Park and Little Heath	1		2	1	2	6
Cadwell					1	1
Cheshunt South and Theobalds				1		1
Codicote			2		1	3
Colney Heath	9	10	16	15	13	63
Cunningham			1	4		5
Datchworth & Aston					1	1
Haldens	3	1	6		1	11
Handside			4	5	4	13
Hatfield Central	98	82	85	124	115	504
Hatfield East	65	60	67	77	66	335
Hatfield South	67	37	88	92	47	331
Hatfield Villages	55	52	33	49	13	202
Hatfield West	71	73	64	93	41	342
Hemel Hempstead Town			2			2
Hitchin Oughton				2		2
Hollybush	8	2	5	12	5	32
Holywell		1				1
Howlands	10		2	5	5	22
Letchworth South West	1					1
London Colney			1			1
Lower Sheering				7		7
Manor				4		4
Marshalswick North		1				1
Peartree	5	3	10	10	1	29
Potters Bar Oakmere				3		3
Rosedale and Bury Green				2		2
Sherrards	1	1		1		3
Tring West and Rural				2		2
Welham Green		3	15	17	7	42
Unknown Ward	8	10	11	5	5	39
<b>Grand Total</b>	<b>402</b>	<b>337</b>	<b>420</b>	<b>534</b>	<b>328</b>	<b>2021</b>

UEC Patients Seen by Deprivation Quintile & Ward	1	2	3	4	5	(blank)	Grand Total
1 = Most Deprived, 5 = Least Deprived							
Ashley					1		1
Bandley Hill			1				1
Batchwood			5				5
Bishop's Stortford All Saints				3			3
Brookmans Park and Little Heath			3	1	2		6
Cadwell			1				1
Cheshunt South and Theobalds	1						1
Codicote			1		2		3
Colney Heath			41	22			63
Cunningham			5				5
Datchworth & Aston				1			1
Haldens	4	6		1			11
Handside		2	6	4	1		13
Hatfield Central	348	156					504
Hatfield East	138	124		73			335
Hatfield South	131	43	157				331
Hatfield Villages		60	45	97			202
Hatfield West		188	154				342
Hemel Hempstead Town		2					2
Hitchin Oughton				2			2
Hollybush		16	16				32
Holywell		1					1
Howlands		6	11	5			22
Letchworth South West		1					1
London Colney			1				1
Lower Sheering				7			7
Manor		4					4
Marshalswick North			1				1
Peartree	29						29
Potters Bar Oakmere	3						3
Rosedale and Bury Green		2					2
Sherrards			1		2		3
Tring West and Rural				2			2
Welham Green			42				42
Unknown Ward						39	39
<b>Grand Total</b>	<b>654</b>	<b>611</b>	<b>491</b>	<b>218</b>	<b>8</b>	<b>39</b>	<b>2021</b>

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.

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 by the Government; in the graph quintile 1 is the Highest or Most deprived, and quintile 5 is the Least deprived.



## Hospital Admissions

	Period	HERTFORDSHIRE AND WEST ESSEX	HATFIELD PCN
Emergency admissions injuries due to falls in those aged 65+	2020/21	2026	2081.8
Emergency asthma, diabetes and epilepsy admissions (aged 0-18)	2020/21	130.8	
Emergency admissions for children with lower respiratory tract infections (age 0-18)	2020/21	40.5	
Emergency admissions for chronic ambulatory care sensitive conditions	2020/21	505.9	286.2
Mental health admissions (all ages)	2020/21	177.2	159.8
Emergency Cancer Admissions	2020/21	494.9	497.4
Emergency admissions for acute conditions shouldn't require admissions	2020/21	611.6	409.9

■ Similar 
 ■ Significantly Worse 
 ■ Significantly Better

[PH.Intelligence@hertfordshire.gov.uk](mailto: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.

Hatfield PCN rates vary from significantly better and similar rate of admissions to the ICB, dependent on Admission categories.

# Frailty Segment - Detailed PCN Breakdown

	← Most deprived →										← Most affluent →		
Index of Multiple Deprivation Decile	1	2	3	4	5	6	7	8	9	10	NULL	PCN	ICS
<b>Overall Population Measures</b>													
Population	1	42	5	102	55	82	52	34	18	20	3	414	37725
% of population in cohort	0.2%	10.1%	1.2%	24.6%	13.3%	19.8%	12.6%	8.2%	4.3%	4.8%	0.7%	100.0%	100.0%
Avg. Age	55.0	78.4	78.4	76.4	72.3	77.5	77.9	77.5	66.1	78.9	75.0	76.2	75.6
% BAME Where recorded		0%	0%	7%	7%	9%	4%	3%	0%	20%	33%	6%	8%
Avg. number of Acute and Chronic Condition	1.0	4.7	4.6	5.8	5.8	5.5	6.3	5.6	4.6	6.2	3.7	5.6	5.5
<b>Activity Measure</b>													
Emergency Admissions	0.0	0.6	0.0	0.9	1.0	0.6	0.7	1.0	0.5	0.9	0.3	0.8	0.6
A&E Attendances	0.0	1.0	0.4	1.6	1.4	1.1	1.3	1.4	1.0	1.3	0.3	1.3	0.9
GP Encounters	144.0	171.8	124.0	132.5	133.7	110.7	151.5	173.5	124.3	156.3	68.0	138.3	103.4
Admitted Bed Days	0.0	4.4	0.0	6.5	5.4	5.0	4.4	5.3	4.8	4.0	1.3	5.1	4.2
<b>Physical Health</b>													
Asthma	0.0%	16.7%	0.0%	23.5%	29.1%	22.0%	19.2%	14.7%	5.6%	30.0%	33.3%	21.3%	25.2%
Cancer	0.0%	23.8%	0.0%	34.3%	30.9%	20.7%	34.6%	17.6%	27.8%	20.0%	33.3%	27.3%	32.8%
Chronic Cardiac Disease	0.0%	33.3%	40.0%	48.0%	49.1%	51.2%	55.8%	55.9%	44.4%	60.0%	0.0%	48.8%	47.5%
Chronic Respiratory Disease	0.0%	23.8%	0.0%	36.3%	32.7%	22.0%	32.7%	23.5%	22.2%	35.0%	33.3%	29.0%	22.2%
CKD	0.0%	2.4%	20.0%	9.8%	9.1%	11.0%	19.2%	8.8%	5.6%	15.0%	33.3%	10.6%	20.7%
Heart Disease	0.0%	26.2%	40.0%	46.1%	38.2%	40.2%	55.8%	47.1%	38.9%	55.0%	0.0%	42.8%	39.1%
Hypertension	0.0%	57.1%	60.0%	73.5%	69.1%	68.3%	76.9%	76.5%	61.1%	75.0%	66.7%	70.0%	74.5%
Diabetes	0.0%	31.0%	40.0%	37.3%	32.7%	31.7%	40.4%	41.2%	33.3%	30.0%	0.0%	34.8%	42.8%
Obesity	0.0%	26.2%	40.0%	24.5%	16.4%	18.3%	21.2%	20.6%	27.8%	20.0%	0.0%	21.5%	32.8%
Rheumatoid Arthritis	0.0%	0.0%	0.0%	2.0%	5.5%	3.7%	3.8%	5.9%	0.0%	0.0%	0.0%	2.9%	5.3%
Stroke	0.0%	40.5%	40.0%	34.3%	38.2%	40.2%	32.7%	50.0%	38.9%	40.0%	0.0%	37.9%	34.5%
<b>Mental Health</b>													
Anxiety	0.0%	28.6%	80.0%	45.1%	50.9%	34.1%	55.8%	44.1%	27.8%	50.0%	33.3%	43.0%	29.0%
Depression	0.0%	21.4%	20.0%	26.5%	43.6%	29.3%	23.1%	8.8%	44.4%	20.0%	33.3%	27.3%	33.6%
Dementia	100.0%	50.0%	20.0%	12.7%	14.5%	45.1%	15.4%	35.3%	16.7%	20.0%	33.3%	26.3%	18.6%
Serious Mental Illness	0.0%	2.4%	0.0%	2.0%	5.5%	3.7%	3.8%	2.9%	22.2%	0.0%	0.0%	3.9%	6.5%
Low Mood	0.0%	9.5%	20.0%	13.7%	5.5%	12.2%	9.6%	20.6%	22.2%	15.0%	66.7%	12.8%	18.5%
Suicide	0.0%	2.4%	20.0%	1.0%	1.8%	3.7%	1.9%	0.0%	0.0%	0.0%	0.0%	1.9%	1.5%
Mental Health Flag	0.0%	33.3%	80.0%	55.9%	63.6%	45.1%	65.4%	52.9%	72.2%	50.0%	100.0%	54.3%	48.8%
<b>Screening and Verification Refusal</b>													
Bowel Screening Refused	0.0%	26.2%	20.0%	12.7%	14.5%	17.1%	19.2%	29.4%	16.7%	20.0%	0.0%	17.9%	25.5%
Cervical Screening Refused	0.0%	7.1%	0.0%	1.0%	3.6%	6.1%	3.8%	2.9%	11.1%	0.0%	0.0%	3.9%	3.6%
Flu Vaccine Refused	0.0%	21.4%	0.0%	22.5%	27.3%	17.1%	15.4%	14.7%	11.1%	10.0%	100.0%	19.6%	26.4%
<b>Wider Indicators</b>													
Has A Carer	0.0%	26.2%	0.0%	7.8%	5.5%	11.0%	25.0%	32.4%	5.6%	25.0%	33.3%	15.0%	19.0%
Is A Carer	0.0%	2.4%	20.0%	3.9%	3.6%	9.8%	9.6%	2.9%	5.6%	0.0%	0.0%	5.6%	11.9%
MED3 Not Fit For Work (ever)	0.0%	4.8%	20.0%	5.9%	10.9%	3.7%	3.8%	11.8%	5.6%	5.0%	33.3%	6.5%	13.4%
MED3 Not Fit For Work (in Last Year)	0.0%	2.4%	20.0%	0.0%	0.0%	0.0%	0.0%	0.0%	5.6%	0.0%	0.0%	0.7%	3.5%
MED3 Not Fit For Work (in Last Six Months)	0.0%	0.0%	20.0%	0.0%	0.0%	0.0%	0.0%	0.0%	5.6%	0.0%	0.0%	0.5%	2.8%
Avg. number of eFI Deficits	1.0	9.5	12.6	11.4	11.9	9.8	12.3	12.4	10.8	12.9	9.0	11.2	13.4
eFI_Housebound	0.0%	4.8%	0.0%	2.9%	1.8%	2.4%	7.7%	0.0%	5.6%	10.0%	0.0%	3.6%	10.9%
eFI_SocialVulnerability	0.0%	31.0%	60.0%	32.4%	34.5%	23.2%	48.1%	35.3%	27.8%	30.0%	33.3%	32.9%	27.3%
People_ChildrenInPoverty	23.6		24.4	12.8				7.6				18.5	15.5
Housing_FuelPoverty	22.0	19.0	19.2	16.6	15.7	16.6	14.7	8.1	10.0	7.0		15.0	11.1
Housing_OnePersonHousehold	37.8	47.1	35.5	34.0	25.5	28.1	25.9	22.0	23.9	26.2		30.2	28.3

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 Hatfield 36.1% of the population in the EoL, severe frailty and severe dementia segment live within the 4 most deprived deciles.

The average age of a person within the Frail and End of life segment increases with affluence, ranging from 69 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 Hatfield PCN is just above the ICB, and the data shows significant higher usage of GP services.

Within this segment we can see the presence of Chronic Cardiac Disease, Chronic Respiratory Disease, Diabetes, Stroke, and Heart Disease being highlighted which chimes with the reason for admission within previous analysis for ACS conditions. It is to be noted that Hypertension is high across all deciles but is below the ICB.

## 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<sup>5</sup> = 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
...	...

Risk Grade: High	<b>Age &lt; 3 AND Drug: Salbutamol AND eFI: Dyspnoea</b>
	<b>Med3 Not Fit For Work (last six months) AND Substance Abuse AND ONE OF:-</b> <ul style="list-style-type: none"> <li>• Drug: Pain Management AND eFI: Peptic Ulcer</li> <li>• Chronic Cardiac Disease</li> </ul>
	<b>Drug: Pain Management AND eFI: Falls AND ONE OF:-</b> <ul style="list-style-type: none"> <li>• Stroke AND eFI: Memory and Cognitive Problems</li> <li>• Stroke AND Substance Abuse</li> <li>• End Stage Disease</li> </ul>
Risk Grade: Medium	<b>Age &lt; 3 AND ONE OF:-</b> <ul style="list-style-type: none"> <li>• Drug: Salbutamol AND NO eFI: Dyspnoea</li> <li>• On any waiting list</li> </ul>
	<b>Med3 Not Fit For Work (last six months) AND Substance Abuse AND NO Chronic Cardiac Disease</b>
	<b>Age &lt; 45 AND Med3 Not Fit For Work (last six months) AND Drug: Pain Management</b>
Risk Grade: Low	<b>Drug: Pain Management AND Substance Abuse AND ONE OF:</b> <ul style="list-style-type: none"> <li>• Drug: Opioids</li> <li>• eFI: Falls AND NO Stroke AND NO End Stage Disease</li> </ul>
	All others

# Quality & Outcomes Framework

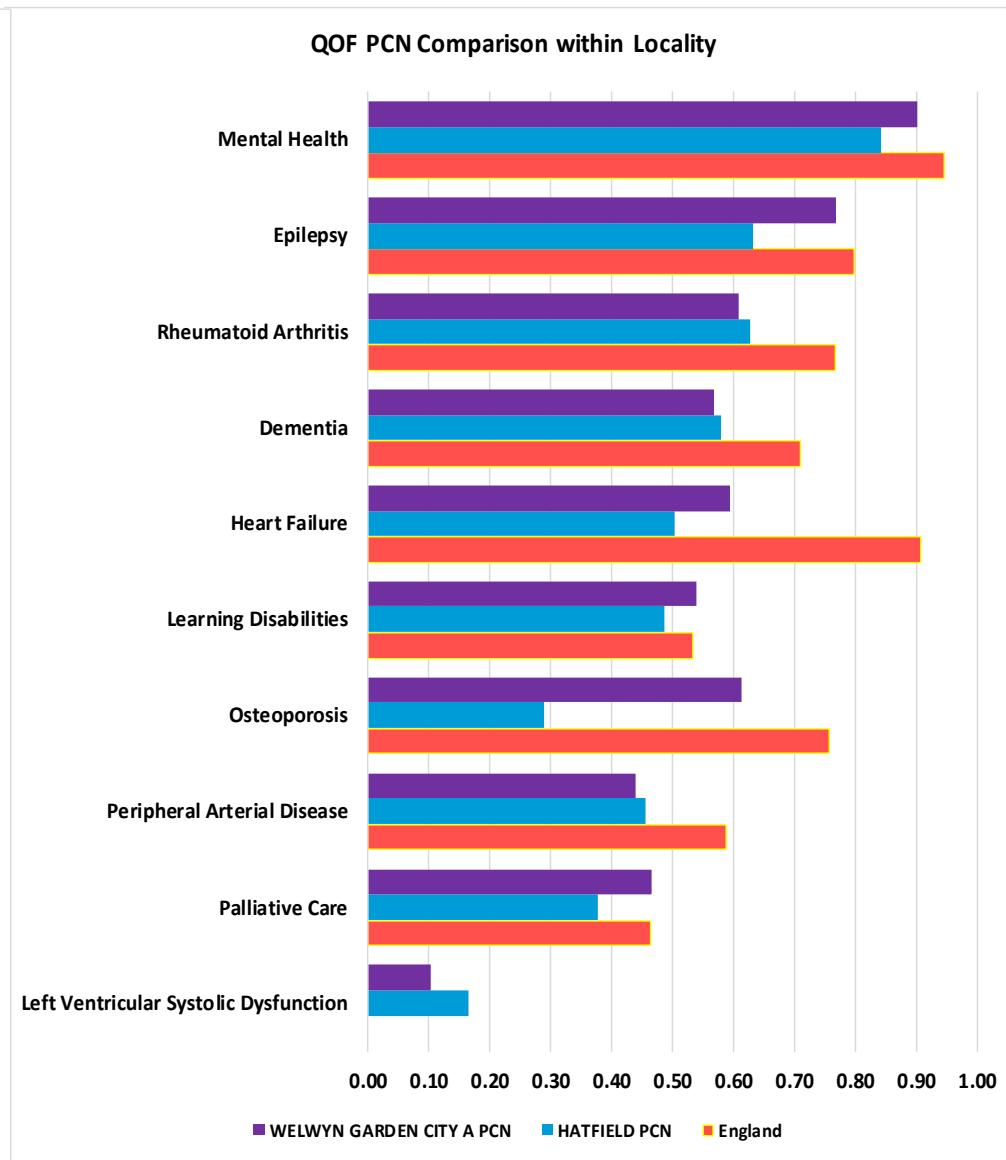
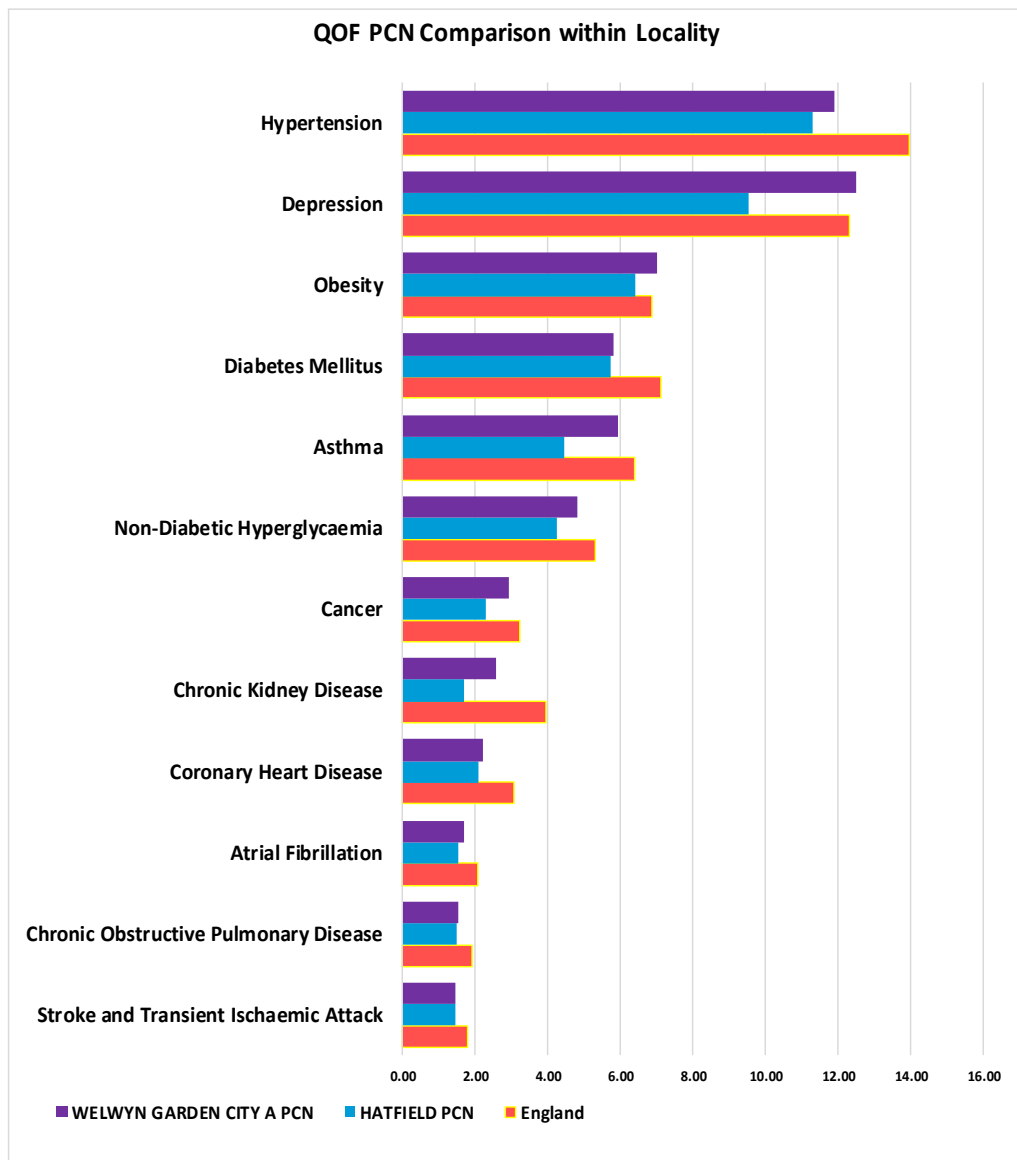
## Contents:

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





# QOF - Locality & PCN Comparison

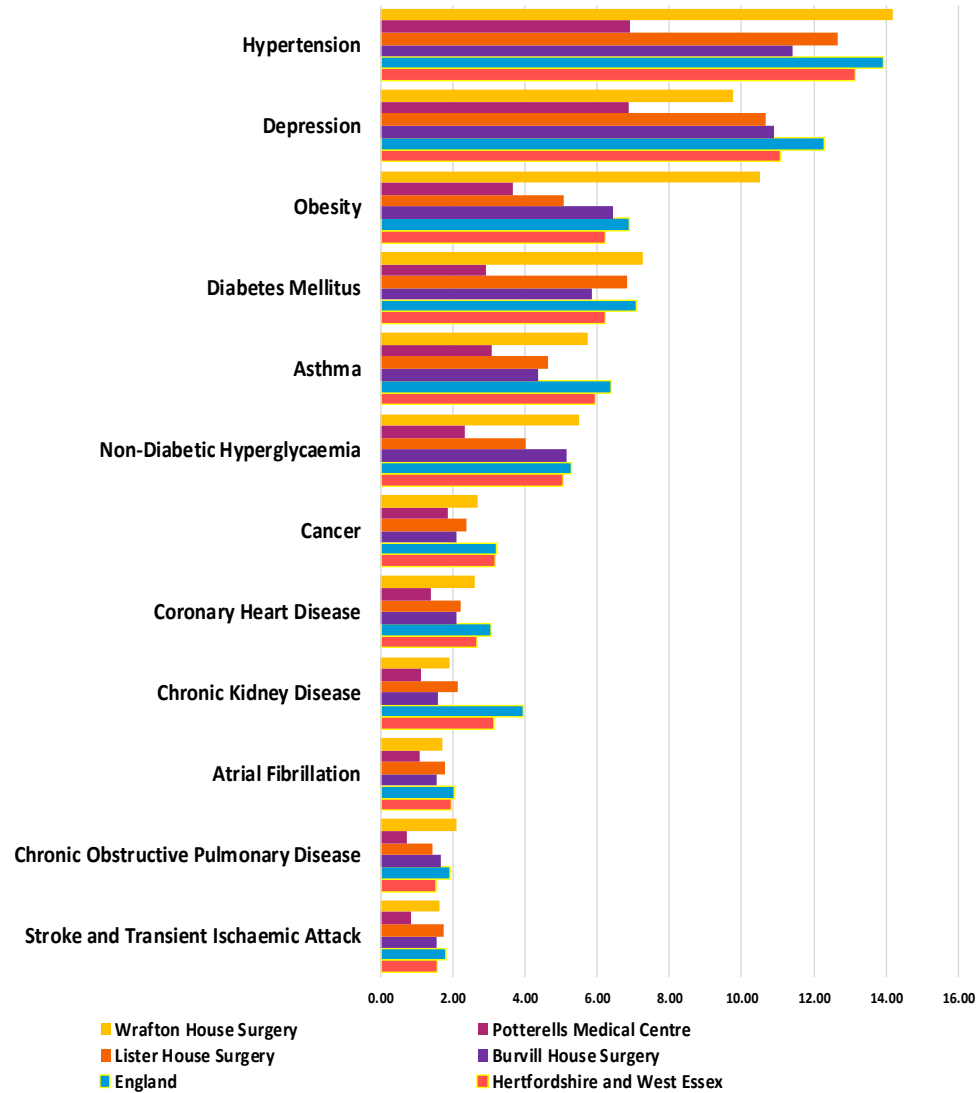


The Quality and Outcome Framework incorporates important benchmarking and scoring for all Practices across the county; we have combined a number of local, regional, and national data sets to highlight the areas that the PCN will need to consider.

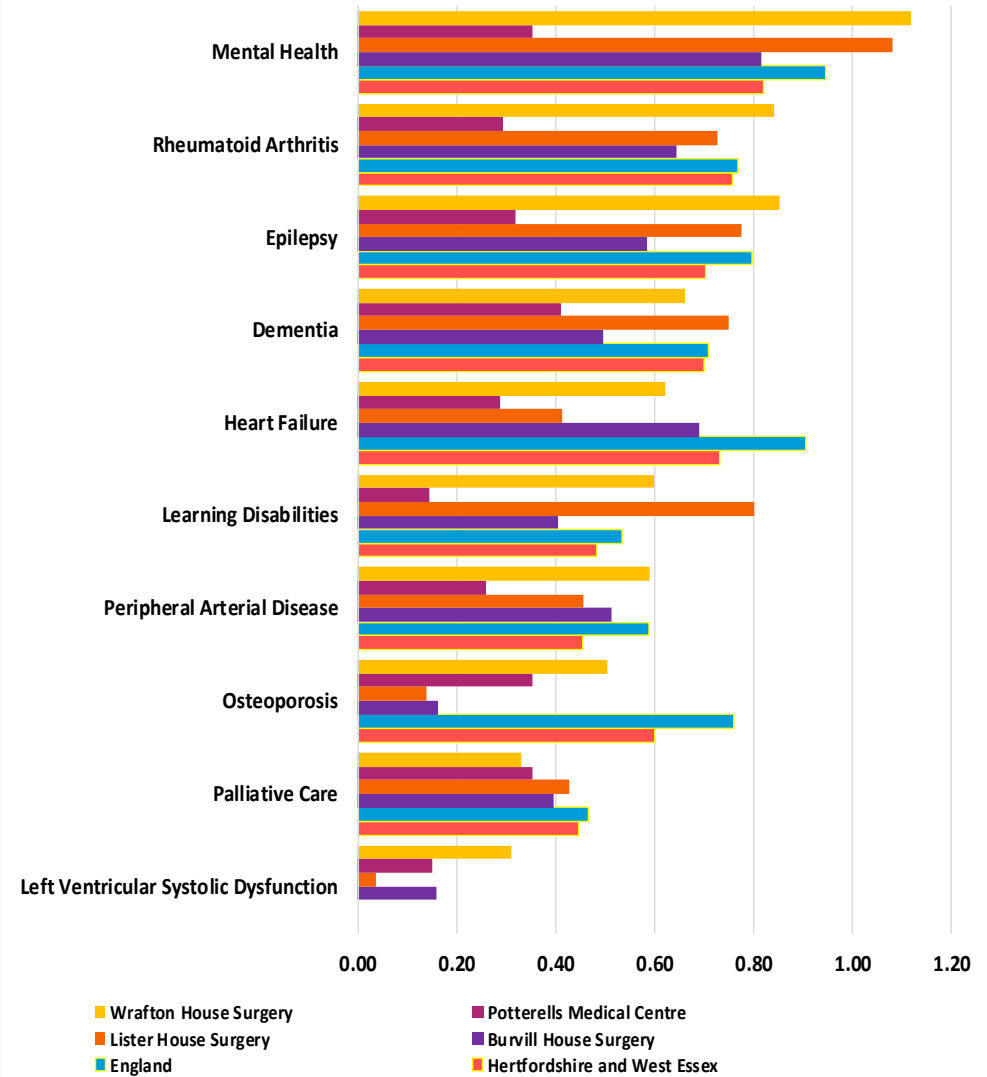
In this graph we have shown all your neighbouring PCNs within the Locality, and benchmarked against England's average.

# QOF - Local, Regional, & National Comparison

QOF - Practice Comparison with Local, Regional & National Scales



QOF - Practice Comparison with Local, Regional & National Scales



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

# QOF - Missed Diagnoses & Admission Rates

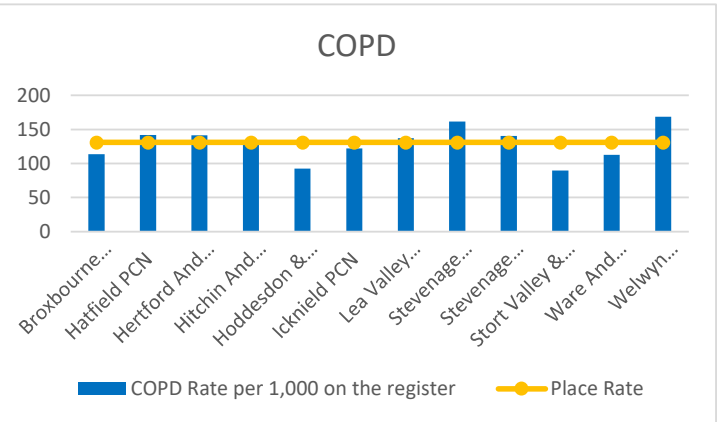
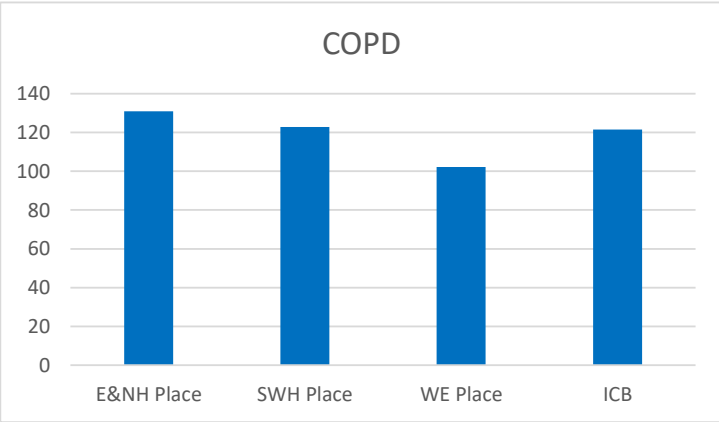
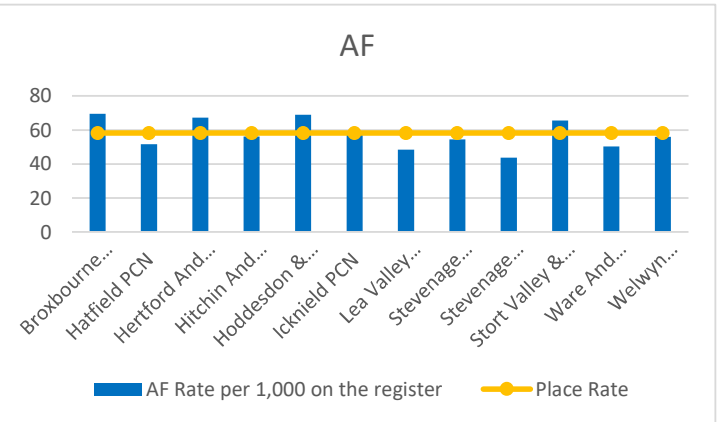
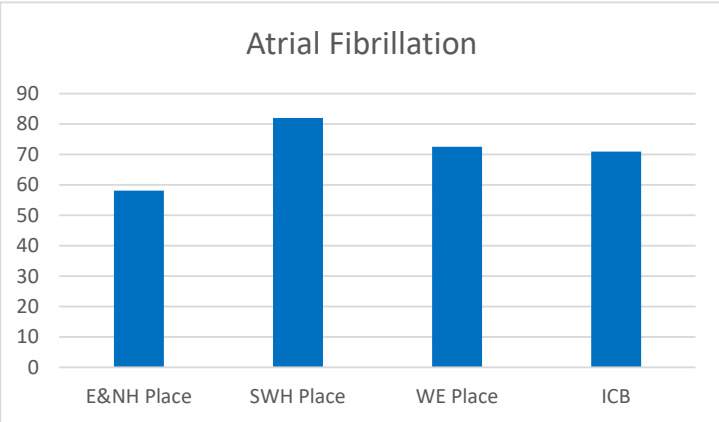
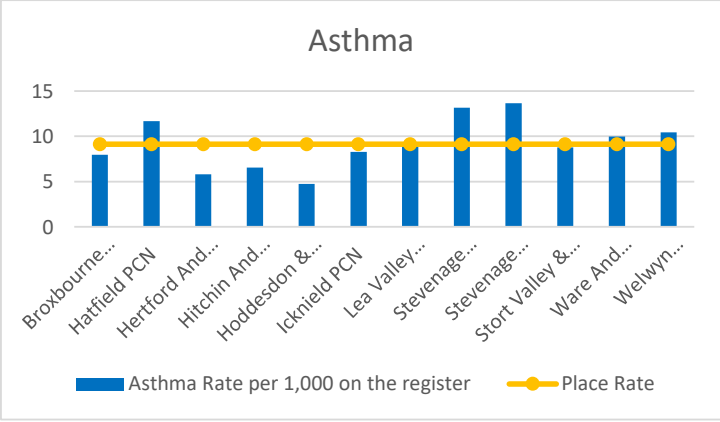
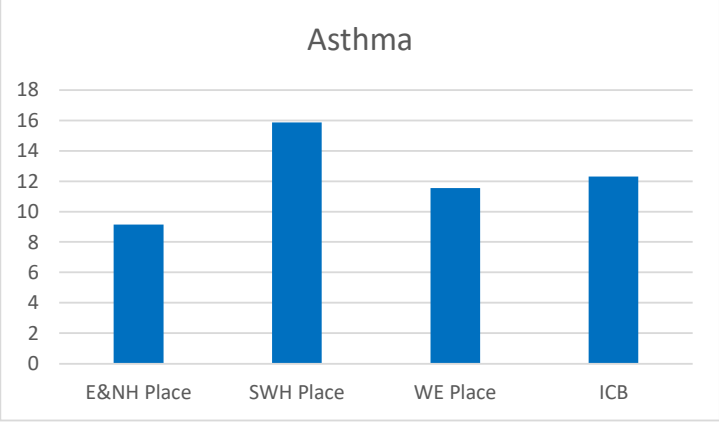
Disease	QOF List size 21-22	QOF Register 21-22	QOF Prevalence 21/22	Place prevalence	ICB prevalence	Modelled prevalence	New diagnoses to meet Place average	new diagnoses to meet ICB average	New diagnoses to meet estimated prevalence
Asthma	48902	2138	4.37%	6.39%	6.17%		986	878	
COPD	51803	697	1.35%	1.54%	1.49%	1.80%	98	73	236
Diabetes	42772	2368	5.54%	6.29%	6.39%	7.78%	322	364	958
Non-diabetic hyperglycaemia	42272	1899	4.49%	4.63%	5.87%	10.87%	59	582	2697
Hypertension	51803	5642	10.89%	13.25%	13.21%		1224	1202	
Atrial Fibrillation	51803	795	1.53%	2.01%	2.02%	2.00%	248	252	241
Stroke and TIA	51803	727	1.40%	1.70%	1.61%		153	107	
Coronary Heart Disease	51803	1038	2.00%	2.62%	2.65%		321	336	
Heart failure	51803	274	0.53%	0.71%	0.75%	1.16%	94	117	328
Left Ventricular Systolic Dysfunction	51803	94	0.18%	0.20%	0.30%		10	61	
Chronic Kidney Disease	42272	722	1.71%	2.53%	3.21%		348	634	
Peripheral Arterial Disease	51803	231	0.45%	0.46%	0.44%		6	-2	
Cancer	51803	1209	2.33%	3.33%	3.35%		516	524	
Palliative care	51803	200	0.39%	0.50%	0.43%		60	22	

The table above shows the latest prevalence (2021/22 published August 2022) 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



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.

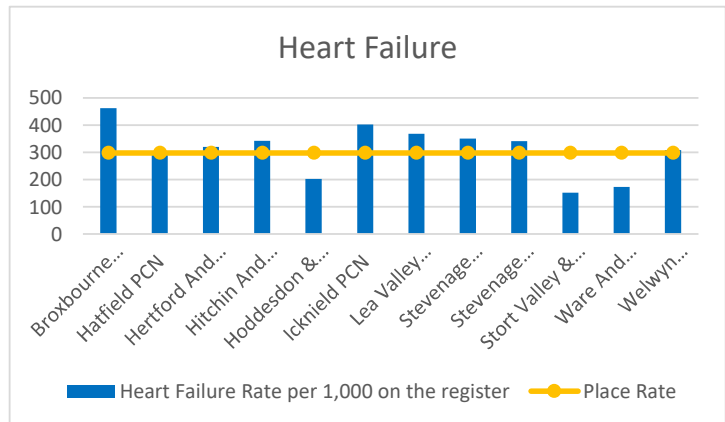
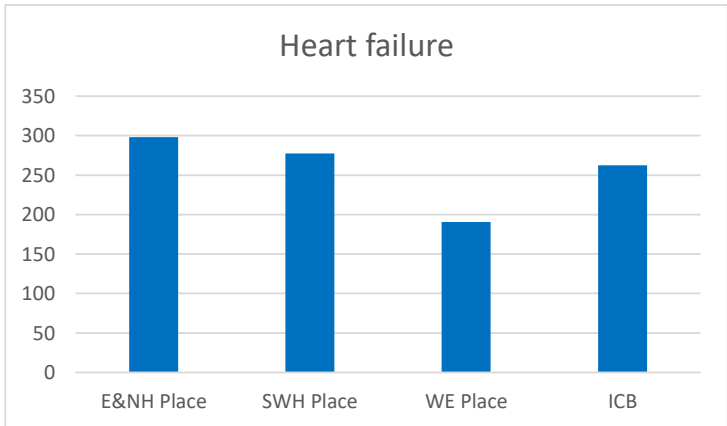
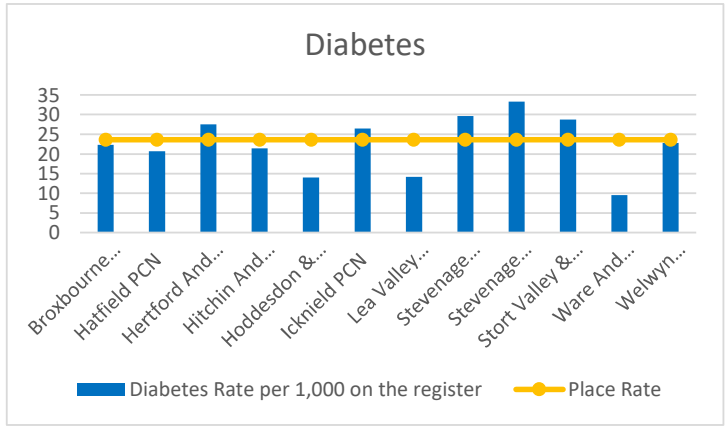
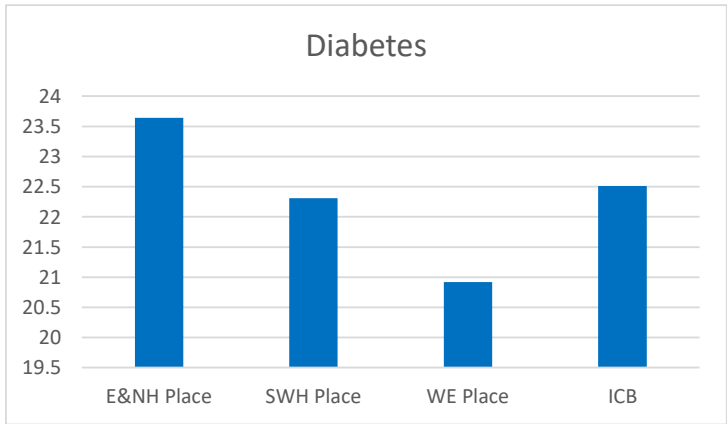
These are continued on the following place.

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

For Hatfield the data shows higher Asthma, COPD and Heart Failure rates which was identified as a theme within the ACS analysis.

Source: HWE PHM Team, SUS data

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







# Matrix Data - Ethnicity

Ethnicity Group	Other ethnic groups			Asian			Asian or Asian British		Black			Mixed			Other			White			Unknown			Grand Total	
	Low Complexity	Middle Complexity	High Complexity	Low Complexity	Middle Complexity	High Complexity	Low Complexity	Middle Complexity	Low Complexity	Middle Complexity	High Complexity	Low Complexity	Middle Complexity	High Complexity	Low Complexity	Middle Complexity	High Complexity	Low Complexity	Middle Complexity	High Complexity	Low Complexity	Middle Complexity	High Complexity		
<b>Overall Population Measures</b>																									
Population	1,044	83		2,125	657	42	63	8	1,601	434	22	328	217	8	835	330	25	12,846	7,557	1,007	4,020	602	12	34,365	
Age	33	46	83	28	45	74	27	47	27	44	60	26	38	66	28	46	69	32	52	72	33	49	82	38	
Male %	56.6%	59.0%	#####	54.5%	42.0%	47.6%	65.1%	62.5%	50.6%	46.3%	36.4%	54.7%	47.9%	46.7%	53.5%	51.5%	48.0%	52.8%	44.8%	46.9%	58.0%	60.3%	53.3%	51.5%	
IMD	5.6	5.8	4.0	5.8	6.0	6.4	5.7	5.0	5.6	5.5	5.1	5.6	5.3	5.7	5.7	5.9	5.7	5.8	5.9	5.6	5.8	5.8	5.7	5.8	
% BAME (where recorded)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	0%	0%	0%				28%	
Multimorbidity (acute & chronic)	0.0	1.4	6.0	0.0	1.5	6.2	0.0	1.8	0.0	1.5	5.8	0.0	1.5	6.0	0.0	1.8	5.3	0.0	1.8	6.4	0.0	1.4	5.4	0.7	
<b>Finance and Activity Measures</b>																									
Spend	Total	£0.1M	£0.0M	£0.0M	£0.5M	£0.6M	£0.1M	£0.0M	£0.0M	£0.4M	£0.4M	£0.1M	£0.3M	£0.2M	£0.1M	£0.3M	£0.4M	£0.1M	£3.6M	£7.4M	£4.0M	£0.2M	£0.2M	£0.0M	#####
	PPPY - Total	£73	£596	#####	£245	£981	£2,382	£105	£1,198	£266	£909	£4,240	£311	£814	£9,897	£336	£1,363	£2,053	£278	£980	£3,935	£61	£292	£1,907	£553
	Acute Elective	£11	£148	£288	£81	£468	£838	£29	£124	£89	£435	£2,062	£163	£282	£5,099	£117	£572	£717	£93	£446	£1,392	£12	£69	£274	£218
	Acute Non-Elective	£11	£305	#####	£86	£323	£1,089	£9	£837	£97	£274	£1,792	£78	£335	£4,299	£134	£598	£895	£106	£333	£2,098	£16	£118	£1,282	£217
	GP Encounters	£51	£143	£628	£78	£190	£456	£67	£237	£80	£201	£386	£70	£197	£499	£86	£193	£442	£80	£201	£445	£34	£105	£351	£118
	Community	£0	£0	£0	£0	£0	£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	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
	Social Care	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
	GP PPPY	11	29	84	14	37	68	21	13	16	41	75	13	40	147	17	41	95	16	43	101	8	26	65	25
	Beddays PPPY - Acute EM	0	0	16	0	1	2	0	1	0	1	3	0	1	27	0	1	3	0	1	4	0	0	1	1
<b>Physical Health</b>																									
Diabetes		0.0%	27.7%	0.0%	0.0%	40.6%	81.0%	0.0%	37.5%	0.0%	28.8%	59.1%	0.0%	24.0%	16.7%	0.0%	23.6%	40.0%	0.0%	15.0%	44.3%	0.0%	13.1%	33.3%	6.6%
COPD		0.0%	0.0%	100.0%	0.0%	0.2%	19.0%	0.0%	0.0%	0.0%	0.7%	9.1%	0.0%	0.0%	16.7%	0.0%	1.2%	24.0%	0.0%	2.6%	34.9%	0.0%	0.7%	25.0%	1.7%
Chronic Respiratory Di...		0.0%	0.0%	100.0%	0.0%	0.6%	21.4%	0.0%	12.5%	0.0%	1.8%	13.6%	0.0%	2.8%	16.7%	0.0%	3.3%	24.0%	0.0%	3.7%	40.6%	0.0%	1.5%	41.7%	2.2%
Hypertension		0.0%	22.9%	100.0%	0.0%	23.4%	90.5%	0.0%	37.5%	0.0%	32.3%	81.8%	0.0%	17.1%	50.0%	0.0%	24.2%	76.0%	0.0%	28.6%	77.8%	0.0%	35.9%	41.7%	10.7%
Obesity		0.8%	3.6%	100.0%	0.9%	5.2%	7.1%	0.0%	12.5%	1.9%	9.7%	22.7%	1.3%	8.8%	16.7%	1.3%	10.3%	8.0%	3.0%	13.8%	24.4%	1.1%	9.6%	8.3%	5.8%
<b>Mental Health</b>																									
Anxiety/Phobias		0.0%	20.5%	0.0%	0.0%	13.7%	28.6%	0.0%	0.0%	0.0%	14.5%	27.3%	0.0%	15.2%	0.0%	0.0%	22.1%	48.0%	0.0%	28.1%	45.3%	0.0%	18.9%	41.7%	8.8%
Depression		0.0%	19.3%	0.0%	0.0%	12.0%	19.0%	0.0%	25.0%	0.0%	17.1%	31.8%	0.0%	19.8%	50.0%	0.0%	23.9%	40.0%	0.0%	30.0%	40.1%	0.0%	23.8%	25.0%	9.1%
Learning Disability		0.0%	0.0%	0.0%	0.0%	0.8%	0.0%	0.0%	0.0%	0.0%	0.0%	9.1%	0.0%	0.0%	0.0%	0.0%	0.6%	12.0%	0.0%	1.9%	4.8%	0.0%	3.2%	0.0%	0.6%
Dementia		0.0%	1.2%	0.0%	0.0%	0.2%	9.5%	0.0%	0.0%	0.0%	0.9%	4.5%	0.0%	0.0%	0.0%	0.0%	0.6%	16.0%	0.0%	1.6%	11.4%	0.0%	1.3%	41.7%	0.8%
<b>Other Characteristics</b>																									
Housebound (eFI)		0.0%	0.0%	0.0%	0.0%	0.0%	2.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	1.6%	0.0%	0.3%	0.0%	0.1%
Social Vulnerability (eFI)		0.0%	0.0%	0.0%	0.1%	1.2%	11.9%	0.0%	0.0%	0.2%	2.1%	13.6%	0.0%	1.4%	0.0%	0.1%	1.5%	16.0%	0.2%	2.9%	19.6%	0.0%	1.3%	16.7%	1.4%
History of Smoking (T...		3.9%	2.4%	0.0%	1.1%	2.9%	0.0%	9.5%	12.5%	1.6%	4.4%	4.5%	1.3%	5.5%	33.3%	4.4%	6.1%	4.0%	4.3%	8.7%	11.0%	4.2%	12.0%	8.3%	5.2%
Not Fit for Work (In Year)		0.2%	1.2%	0.0%	0.8%	3.8%	0.0%	6.3%	37.5%	1.6%	4.6%	0.0%	0.7%	2.8%	0.0%	1.9%	6.1%	0.0%	1.4%	4.8%	1.5%	0.6%	3.0%	0.0%	2.2%
On a Waiting List		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%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

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.

# Matrix Data - Segment & Sub-Segment

Life Course Segment		1 - Healthy			2 - Living With Illness			3 - Lower Complexity			4 - Advanced Disease & Complexity			5 - EoL, Frailty & Dementia			Grand Total
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 (Multimorbidity)	3c - LC (Mild Frailty)	4a - AD&C (High Complexity)	4b - AD&C (High Social Complexity)	4e - AD&C (End Stage Disease)	5a - EoLFD (Severe Frailty)	5b - EoLFD (Severe Dementia)	5c - EoLFD (End of Life)	
<b>Overall Population Measures</b>																	
Population		18,624	468	1,258	2,613	3,541	1,061	107	3,410	1,235	1,093	162	379	200	49	165	34,365
Age		30	16	23	44	47	40	54	51	58	62	67	69	78	83	72	38
Male %		55.5%	25.6%	55.2%	52.4%	50.5%	48.7%	53.3%	44.6%	35.5%	38.2%	50.6%	48.5%	36.5%	32.7%	46.7%	51.5%
IMD		5.8	5.8	5.7	5.8	6.0	5.8	5.7	5.7	6.0	5.8	5.7	5.5	5.6	5.0	5.6	5.8
% BAME (where recorded)		36%	32%	33%	24%	27%	14%	23%	15%	15%	11%	11%	7%	6%	7%	7%	28%
Multimorbidity (acute & chronic)		0.0	0.0	0.0	0.0	1.0	1.0	0.6	2.4	2.0	4.0	3.1	5.3	6.5	4.6	4.8	0.7
<b>Finance and Activity Measures</b>																	
Spend	Total	£1.6M	£0.6M	£1.7M	£1.3M	£2.1M	£0.5M	£0.1M	£3.5M	£1.8M	£2.3M	£0.3M	£1.3M	£0.9M	£0.1M	£1.0M	£19.0M
	PPPY - Total	£85	£1,217	£1,323	£506	£601	£430	£699	£1,033	£1,442	£2,085	£1,678	£3,513	£4,735	£2,266	£5,797	£553
	Acute Elective	£22	£188	£567	£185	£291	£137	£372	£485	£668	£896	£465	£1,514	£1,084	£95	£1,544	£218
	Acute Non-Elective	£9	£886	£611	£196	£161	£156	£177	£340	£535	£878	£796	£1,625	£3,143	£1,545	£3,686	£217
	GP Encounters	£54	£143	£144	£125	£149	£137	£149	£207	£238	£310	£417	£374	£508	£626	£567	£118
	Community	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
	Mental Health	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
	Social Care	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
	GP PPPY	10	32	28	28	31	29	39	42	55	71	112	74	137	150	136	25
	Beddays PPPY - Acute EM	0	1	1	0	0	2	1	1	1	2	1	4	6	2	7	0
<b>Physical Health</b>																	
Diabetes		0.0%	0.0%	0.0%	0.0%	19.8%	0.0%	8.4%	18.5%	22.3%	30.3%	30.2%	33.2%	44.5%	26.5%	25.5%	6.6%
COPD		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.1%	1.7%	7.7%	6.2%	68.1%	30.0%	12.2%	20.6%	1.7%
Chronic Respiratory Dis...		0.0%	0.0%	0.0%	0.0%	1.6%	0.0%	0.9%	4.1%	2.7%	11.0%	7.4%	72.6%	33.5%	14.3%	27.9%	2.2%
Hypertension		0.0%	0.0%	0.0%	0.0%	26.1%	0.0%	18.7%	29.1%	43.3%	55.5%	43.8%	63.1%	85.5%	40.8%	60.0%	10.7%
Obesity		0.0%	0.0%	0.0%	17.9%	9.4%	7.3%	12.1%	12.9%	17.4%	22.4%	28.4%	19.8%	31.5%	12.2%	12.1%	5.8%
<b>Mental Health</b>																	
Anxiety/Phobias		0.0%	0.0%	0.0%	0.0%	0.0%	41.3%	7.5%	49.7%	15.5%	31.4%	36.4%	25.3%	60.0%	14.3%	30.9%	8.8%
Depression		0.0%	0.0%	0.0%	0.0%	0.0%	43.3%	6.5%	52.4%	20.6%	36.0%	16.7%	25.6%	32.5%	10.2%	26.1%	9.1%
Learning Disability		0.0%	0.0%	0.0%	0.0%	0.0%	2.7%	3.7%	2.3%	0.2%	3.3%	29.0%	2.1%	5.0%	2.0%	3.0%	0.6%
Dementia		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	11.1%	7.4%	6.1%	11.0%	100.0%	23.0%	0.8%
<b>Other Characteristics</b>																	
Housebound (eFI)		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	9.3%	0.3%	3.0%	2.0%	4.8%	0.1%
Social Vulnerability (eFI)		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	51.4%	1.4%	4.9%	8.9%	34.6%	10.8%	49.5%	8.2%	20.0%	1.4%
History of Smoking (Tw...		0.0%	0.0%	0.0%	31.1%	5.6%	11.2%	10.3%	8.3%	10.0%	12.6%	11.1%	9.5%	13.0%	8.2%	7.3%	5.2%
Not Fit for Work (In Year)		0.0%	0.0%	0.0%	9.6%	3.0%	5.1%	3.7%	4.9%	5.9%	6.8%	2.5%	1.8%	1.5%	0.0%	0.0%	2.2%
On a Waiting List		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%	0.0%	0.0%	0.0%

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			2-3			4-5		6-9			10+			Grand Total
Complexity		Low Complexity	Middle Complexity	High Complexity	Low Complexity	Middle Complexity	High Complexity	Low Complexity	Middle Complexity	High Complexity	Low Complexity	Middle Complexity	High Complexity	Low Complexity	Middle Complexity	High Complexity	Low Complexity	Middle Complexity	
<b>Overall Population Measures</b>																			
Population		2,647	155	16	1,608	83		2,426	165		2,245	229	4,410	726	7	10,026	8,530	1,090	34,365
Age		32	48	81	27	31	82	25	33	53	27	36	31	41	49	34	52	72	38
Male %		59.8%	62.6%	62.5%	63.3%	60.2%	100.0%	62.6%	66.1%	100.0%	62.0%	70.7%	58.0%	60.2%	71.4%	45.4%	43.2%	46.2%	51.5%
IMD		5.7	6.1	5.6	5.6	5.6	5.0	5.7	5.5	9.0	5.8	5.6	5.8	5.7	5.1	5.9	5.9	5.7	5.8
% BAME (where recorded)		39%	20%	13%	41%	21%	0%	34%	28%	0%	33%	31%	33%	21%	0%	32%	18%	9%	28%
Multimorbidity (acute & chronic)		0.0	1.6	5.8	0.0	1.2	5.0	0.0	1.3	7.0	0.0	1.3	0.0	1.4	5.4	0.0	1.8	6.4	0.7
<b>Finance and Activity Measures</b>																			
Spend		£0.0M	£0.1M	£0.0M	£0.1M	£0.0M	£0.0M	£0.1M	£0.0M	£0.0M	£0.2M	£0.0M	£0.5M	£0.1M	£0.0M	£4.5M	£9.1M	£4.3M	£19.0M
Total		£11	£380	£1,700	£60	£12	£565	£32	£56	£15	£69	£56	£120	£170	£73	£449	£1,067	£3,924	£553
PPPY - Total		£4	£259	£604	£49	£3	£263	£10	£12	£0	£17	£14	£33	£79	£31	£150	£477	£1,398	£218
Acute Elective		£7	£120	£1,096	£5	£3	£296	£8	£30	£0	£26	£16	£42	£44	£0	£166	£371	£2,072	£217
Acute Non-Elective		£0	£0	£0	£6	£6	£6	£15	£14	£15	£26	£26	£45	£47	£42	£133	£220	£454	£118
GP Encounters		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Community		£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	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Social Care		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
GP PPPY		0	0	0	1	1	1	2	2	2	4	5	8	8	7	28	47	103	25
Beddays PPPY - Acute EM		0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	1	4	0
<b>Physical Health</b>																			
Diabetes		0.0%	14.8%	43.8%	0.0%	1.2%	0.0%	0.0%	4.8%	100.0%	0.0%	3.9%	0.0%	6.9%	14.3%	0.0%	19.5%	45.8%	6.6%
COPD		0.0%	0.6%	18.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.2%	28.6%	0.0%	2.3%	33.7%	1.7%
Chronic Respiratory Dis...		0.0%	2.6%	18.8%	0.0%	1.2%	0.0%	0.0%	1.8%	0.0%	0.0%	0.9%	0.0%	3.4%	57.1%	0.0%	3.4%	39.2%	2.2%
Hypertension		0.0%	19.4%	81.3%	0.0%	10.8%	100.0%	0.0%	13.3%	100.0%	0.0%	11.4%	0.0%	14.7%	71.4%	0.0%	30.7%	77.7%	10.7%
Obesity		0.1%	0.6%	6.3%	0.2%	0.0%	0.0%	0.4%	4.2%	0.0%	0.6%	2.2%	0.9%	3.7%	14.3%	4.3%	14.0%	23.6%	5.8%
<b>Mental Health</b>																			
Anxiety/Phobias		0.0%	21.9%	0.0%	0.0%	24.1%	0.0%	0.0%	28.5%	0.0%	0.0%	30.1%	0.0%	29.5%	42.9%	0.0%	25.0%	44.8%	8.8%
Depression		0.0%	22.6%	12.5%	0.0%	22.9%	100.0%	0.0%	27.9%	100.0%	0.0%	23.6%	0.0%	30.0%	71.4%	0.0%	27.3%	39.1%	9.1%
Learning Disability		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.2%	0.0%	0.0%	0.0%	0.0%	0.7%	14.3%	0.0%	1.9%	4.8%	0.6%
Dementia		0.0%	3.2%	50.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	14.3%	0.0%	1.5%	11.0%	0.8%
<b>Other Characteristics</b>																			
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%	0.0%	0.0%	0.1%	1.6%	0.1%
Social Vulnerability (eFI)		0.0%	0.6%	18.8%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.4%	0.1%	0.7%	14.3%	0.3%	2.9%	19.0%	1.4%
History of Smoking (Tw...		0.2%	0.0%	0.0%	0.4%	1.2%	0.0%	0.6%	3.0%	0.0%	3.9%	8.3%	3.6%	4.8%	14.3%	5.9%	8.7%	10.6%	5.2%
Not Fit for Work (In Year)		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.2%	0.4%	0.0%	2.7%	5.3%	1.4%	2.2%
On a Waiting List		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%	0.0%	0.0%	0.0%	0.0%	0.0%

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

Life Course Segment		1 - Healthy				2 - Living With Illness				3 - Lower Complexity				4 - Advanced Disease & Complexity				5 - EoL, Frailty & Dementia				Grand Total
Deprivation		Low	Middle	High	Not known	Low	Middle	High	Not known	Low	Middle	High	Not known	Low	Middle	High	Not known	Low	Middle	High	Not known	
<b>Overall Population Measures</b>																						
Population		3,262	15,774	1,100	214	1,353	5,308	432	122	867	3,536	297	52	277	1,219	123	15	72	291	48		34,365
Age		31	29	30	38	49	44	43	50	57	52	48	53	67	64	59	57	75	76	78	75	38
Male %		52.1%	55.1%	57.2%	55.1%	51.3%	50.7%	51.6%	56.6%	44.4%	41.9%	40.7%	55.8%	40.8%	41.9%	41.5%	60.0%	52.8%	36.1%	41.7%	100.0%	51.5%
IMD		9.0	5.4	2.1		8.9	5.4	2.2		8.9	5.3	2.2		8.9	5.3	2.2		8.8	5.3	2.1		5.8
% BAME (where recorded)		28%	37%	36%	35%	20%	25%	24%	27%	15%	15%	18%	22%	11%	9%	13%	7%	7%	7%	0%	33%	28%
Multimorbidity (acute & chronic)		0.0	0.0	0.0	0.0	0.7	0.6	0.6	0.6	2.2	2.3	2.2	2.2	3.9	4.3	3.8	2.3	5.5	5.8	4.6	3.7	0.7
<b>Finance and Activity Measures</b>																						
Spend		£0.6M	£3.0M	£0.2M	£0.0M	£0.6M	£3.0M	£0.2M	£0.0M	£1.1M	£3.9M	£0.4M	£0.0M	£0.6M	£3.0M	£0.3M	£0.0M	£0.3M	£1.5M	£0.2M	£0.0M	£19.0M
PPPY - Total		£182	£191	£179	£65	£444	£571	£577	£226	£1,247	£1,099	£1,258	£678	£2,052	£2,489	£2,159	£926	£4,480	£5,234	£3,439	£1,319	£553
Acute Elective		£58	£61	£51	£24	£191	£241	£251	£118	£618	£507	£566	£419	£837	£1,080	£580	£584	£1,067	£1,300	£437	£31	£218
Acute Non-Elective		£60	£68	£66	£10	£120	£189	£188	£19	£420	£376	£476	£87	£917	£1,069	£1,195	£31	£2,855	£3,399	£2,388	£1,047	£217
GP Encounters		£64	£62	£61	£31	£133	£141	£138	£89	£208	£216	£216	£172	£298	£340	£384	£310	£559	£534	£614	£241	£118
Community		£0	£0	£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	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Social Care		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
GP PPPY		13	12	12	8	30	29	32	28	47	45	50	49	76	75	87	76	156	130	166	68	25
Beddays PPPY - Acute EM		0	0	0	0	0	1	0	0	1	1	1	0	2	3	3	0	5	6	4	1	0
<b>Physical Health</b>																						
Diabetes		0.0%	0.0%	0.0%	0.0%	6.9%	10.3%	11.8%	5.7%	19.4%	19.0%	21.2%	23.1%	28.5%	31.6%	30.1%	33.3%	36.1%	35.4%	31.3%	0.0%	6.6%
COPD		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.9%	2.7%	2.7%	1.9%	17.3%	22.5%	24.4%	0.0%	19.4%	26.1%	18.8%	33.3%	1.7%
Chronic Respiratory Dis...		0.0%	0.0%	0.0%	0.0%	0.5%	0.8%	1.4%	0.0%	3.8%	3.6%	4.0%	3.8%	20.2%	26.1%	26.8%	0.0%	26.4%	30.9%	20.8%	33.3%	2.2%
Hypertension		0.0%	0.0%	0.0%	0.0%	15.0%	12.0%	10.6%	30.3%	38.5%	31.4%	26.9%	44.2%	57.4%	56.7%	49.6%	40.0%	72.2%	71.8%	56.3%	66.7%	10.7%
Obesity		0.0%	0.0%	0.0%	0.0%	12.9%	11.9%	12.7%	12.3%	12.6%	13.9%	19.2%	21.2%	18.4%	23.8%	17.1%	26.7%	22.2%	20.6%	27.1%	0.0%	5.8%
<b>Mental Health</b>																						
Anxiety/Phobias		0.0%	0.0%	0.0%	0.0%	5.7%	6.3%	4.6%	4.9%	32.2%	41.7%	42.1%	26.9%	30.3%	31.6%	22.8%	6.7%	41.7%	45.0%	33.3%	33.3%	8.8%
Depression		0.0%	0.0%	0.0%	0.0%	5.2%	6.7%	6.0%	5.7%	34.5%	45.2%	44.4%	40.4%	23.8%	33.6%	31.7%	20.0%	20.8%	29.9%	20.8%	33.3%	9.1%
Learning Disability		0.0%	0.0%	0.0%	0.0%	0.4%	0.4%	0.2%	0.0%	0.9%	2.0%	2.4%	0.0%	2.9%	5.4%	13.0%	6.7%	2.8%	3.8%	6.3%	0.0%	0.6%
Dementia		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	12.6%	8.8%	10.6%	6.7%	26.4%	22.7%	47.9%	33.3%	0.8%
<b>Other Characteristics</b>																						
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%	0.7%	1.1%	0.8%	0.0%	4.2%	3.4%	4.2%	0.0%	0.1%
Social Vulnerability (eFI)		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.9%	3.1%	6.4%	3.8%	15.9%	11.2%	9.8%	6.7%	31.9%	33.0%	33.3%	33.3%	1.4%
History of Smoking (Tw...		0.0%	0.0%	0.0%	0.0%	10.9%	16.2%	22.0%	21.3%	7.0%	8.7%	13.5%	19.2%	6.9%	12.5%	13.8%	26.7%	12.5%	9.6%	8.3%	33.3%	5.2%
Not Fit for Work (In Year)		0.0%	0.0%	0.0%	0.0%	4.5%	5.7%	9.5%	7.4%	3.5%	5.3%	7.1%	13.5%	2.9%	5.7%	5.7%	0.0%	1.4%	0.0%	4.2%	0.0%	2.2%
On a Waiting List		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%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

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 & Deprivation

Practice		Burvill House Surgery				Lister House Surgery				Wrafton House Surgery				Grand Total
Deprivation		Low Deprivation	Middle Deprivation	High Deprivation	Not known	Low Deprivation	Middle Deprivation	High Deprivation	Not known	Low Deprivation	Middle Deprivation	High Deprivation	Not known	
<b>Overall Population Measures</b>														
Population		1,595	9,270	500	22	2,841	9,615	1,050	338	1,395	7,243	450	46	34,365
Age		39	36	34	35	43	38	39	45	42	38	44	50	38
Male %		50.2%	52.7%	51.8%	59.1%	49.7%	51.6%	50.9%	55.3%	51.4%	50.2%	55.8%	60.9%	51.5%
IMD		8.9	5.4	2.2		9.0	5.4	2.2		8.9	5.4	2.0		5.8
% BAME (where recorded)		24%	34%	34%	22%	20%	25%	27%	30%	26%	28%	21%	14%	28%
Multimorbidity (acute & chronic)		0.6	0.6	0.6	0.3	0.9	0.8	0.8	0.6	0.7	0.7	1.0	0.4	0.7
<b>Finance and Activity Measures</b>														
Spend	Total	£0.9M	£4.8M	£0.3M	£0.0M	£1.6M	£5.7M	£0.6M	£0.1M	£0.7M	£4.0M	£0.4M	£0.0M	£19.0M
	PPPY - Total	£533	£516	£601	£90	£563	£589	£559	£253	£513	£558	£807	£158	£553
	Acute Elective	£217	£200	£286	£32	£222	£240	£147	£144	£227	£216	£285	£23	£218
	Acute Non-Elective	£199	£207	£200	£0	£221	£230	£281	£31	£169	£216	£360	£44	£217
	GP Encounters	£118	£108	£114	£58	£120	£119	£132	£78	£118	£126	£162	£91	£118
	Community	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
	Mental Health	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
	Social Care	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
	GP PPPY	18	16	17	9	37	37	41	24	16	17	21	12	25
	Beddays PPPY - Acute EM	0	0	0	0	0	1	0	0	0	0	0	0	0
<b>Physical Health</b>														
Diabetes		5.8%	5.9%	4.8%	9.1%	6.5%	6.7%	9.1%	6.2%	6.3%	7.1%	10.2%	2.2%	6.6%
COPD		1.0%	1.4%	2.4%	0.0%	1.6%	1.8%	2.3%	0.6%	1.9%	2.0%	2.4%	0.0%	1.7%
Chronic Respiratory Dis...		1.8%	1.8%	3.6%	0.0%	2.0%	2.4%	2.7%	0.9%	2.2%	2.5%	3.3%	0.0%	2.2%
Hypertension		6.3%	6.6%	7.2%	4.5%	18.3%	15.0%	13.2%	19.5%	9.2%	8.2%	8.7%	2.2%	10.7%
Obesity		1.8%	2.4%	1.4%	0.0%	10.3%	11.0%	12.1%	8.3%	1.9%	2.7%	2.7%	4.3%	5.8%
<b>Mental Health</b>														
Anxiety/Phobias		6.9%	7.5%	8.6%	4.5%	8.3%	9.3%	9.6%	4.7%	9.0%	10.1%	10.0%	10.9%	8.8%
Depression		6.5%	7.6%	8.8%	4.5%	8.4%	11.3%	10.8%	8.0%	7.7%	9.1%	11.1%	8.7%	9.1%
Learning Disability		0.3%	0.4%	0.0%	0.0%	0.6%	1.0%	1.4%	0.3%	0.2%	0.5%	2.7%	0.0%	0.6%
Dementia		0.8%	0.7%	0.2%	0.0%	1.2%	0.7%	1.9%	0.6%	0.6%	0.5%	3.3%	0.0%	0.8%
<b>Other Characteristics</b>														
Housebound (eFI)		0.0%	0.0%	0.0%	0.0%	0.2%	0.2%	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
Social Vulnerability (eFI)		0.3%	0.3%	0.8%	0.0%	3.3%	2.9%	3.6%	0.9%	0.1%	0.5%	1.1%	2.2%	1.4%
History of Smoking (Tw...		0.1%	0.0%	0.0%	0.0%	8.2%	13.9%	14.8%	11.8%	0.1%	0.2%	0.2%	2.2%	5.2%
Not Fit for Work (In Year)		0.0%	0.0%	0.0%	0.0%	3.5%	5.8%	6.8%	4.4%	0.0%	0.1%	0.0%	2.2%	2.2%
On a Waiting List		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%

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.

# Bubble Matrix - Conditions

x% also have



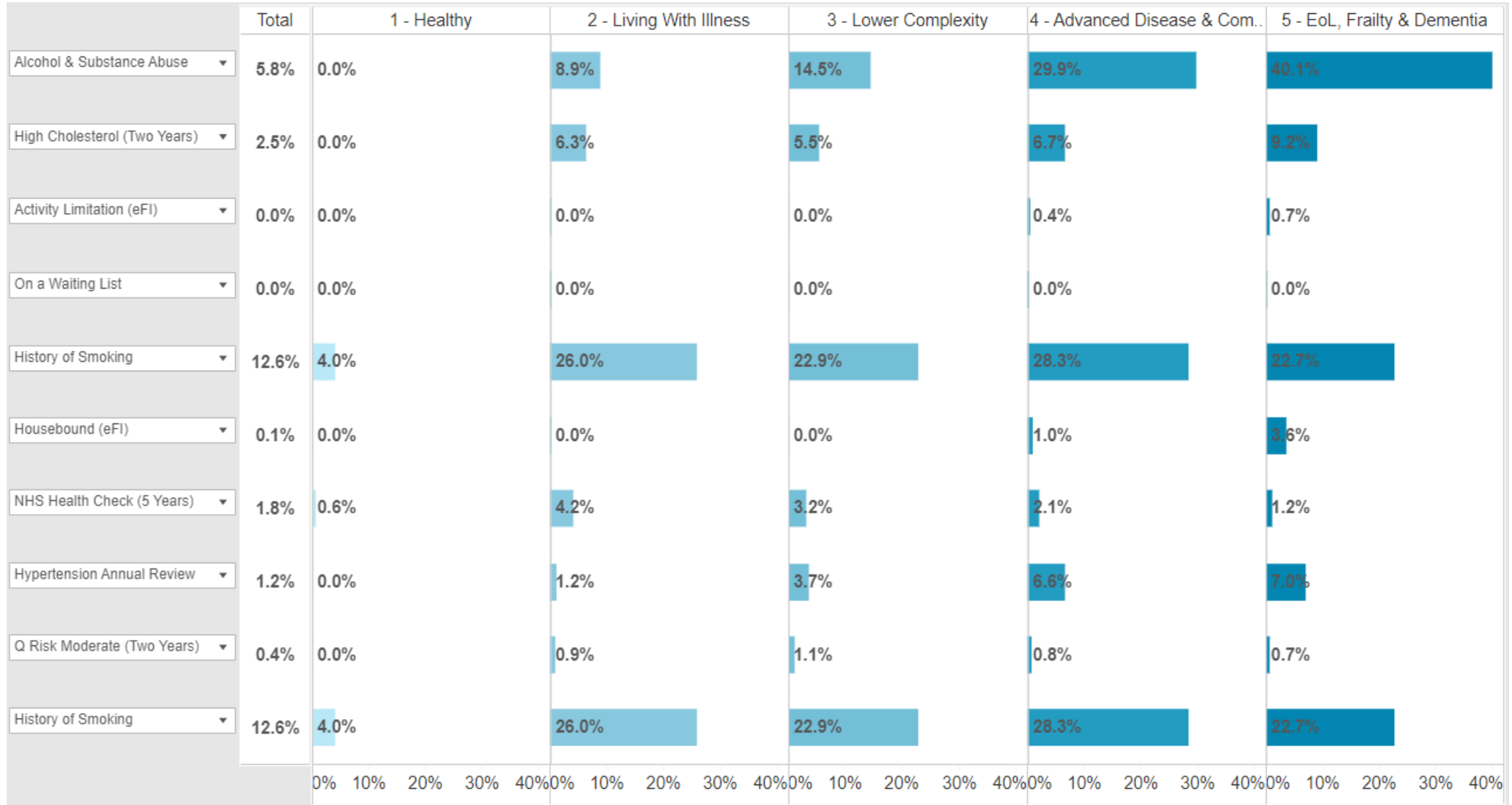
For people with this condition



Initial Condition	Other Conditions												
	Alzheimers Disease	Asthma	COPD	Heart Failure	Anxiety	Autism Spectrum Disorder	Dementia	Alcohol Abuse	ABCD Prescription	Anti-Depressive Prescription	Activity Limitation (eFI)	Housebound (eFI)	No Other Condition
Alzheimers Disease		13%	12%	8%	26%	1%	98%	5%	37%	32%	0%	4%	2%
Asthma	0%		9%	2%	21%	1%	1%	3%	16%	20%	0%	0%	47%
COPD	2%	41%		12%	32%	1%	5%	9%	39%	24%	1%	2%	0%
Heart Failure	3%	19%	24%		26%	2%	10%	7%	64%	18%	0%	2%	0%
Anxiety	1%	18%	6%	3%		1%	2%	4%	18%	42%	0%	0%	16%
Autism Spectrum Disorder	0%	12%	2%	2%	16%		2%	3%	9%	17%	0%	2%	37%
Dementia	37%	14%	12%	11%	23%	2%		6%	34%	35%	0%	3%	8%
Alcohol Abuse	1%	20%	15%	6%	34%	2%	4%		32%	36%	0%	0%	18%
ABCD Prescription	1%	15%	8%	7%	20%	1%	3%	4%		23%	0%	1%	24%
Anti-Depressive Prescription	1%	17%	5%	2%	41%	1%	3%	4%	22%		0%	0%	21%
Activity Limitation (eFI)	0%	22%	56%	11%	44%	11%	0%	0%	44%	22%		0%	0%
Housebound (eFI)	13%	13%	29%	19%	39%	13%	26%	3%	71%	48%	0%		6%

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.

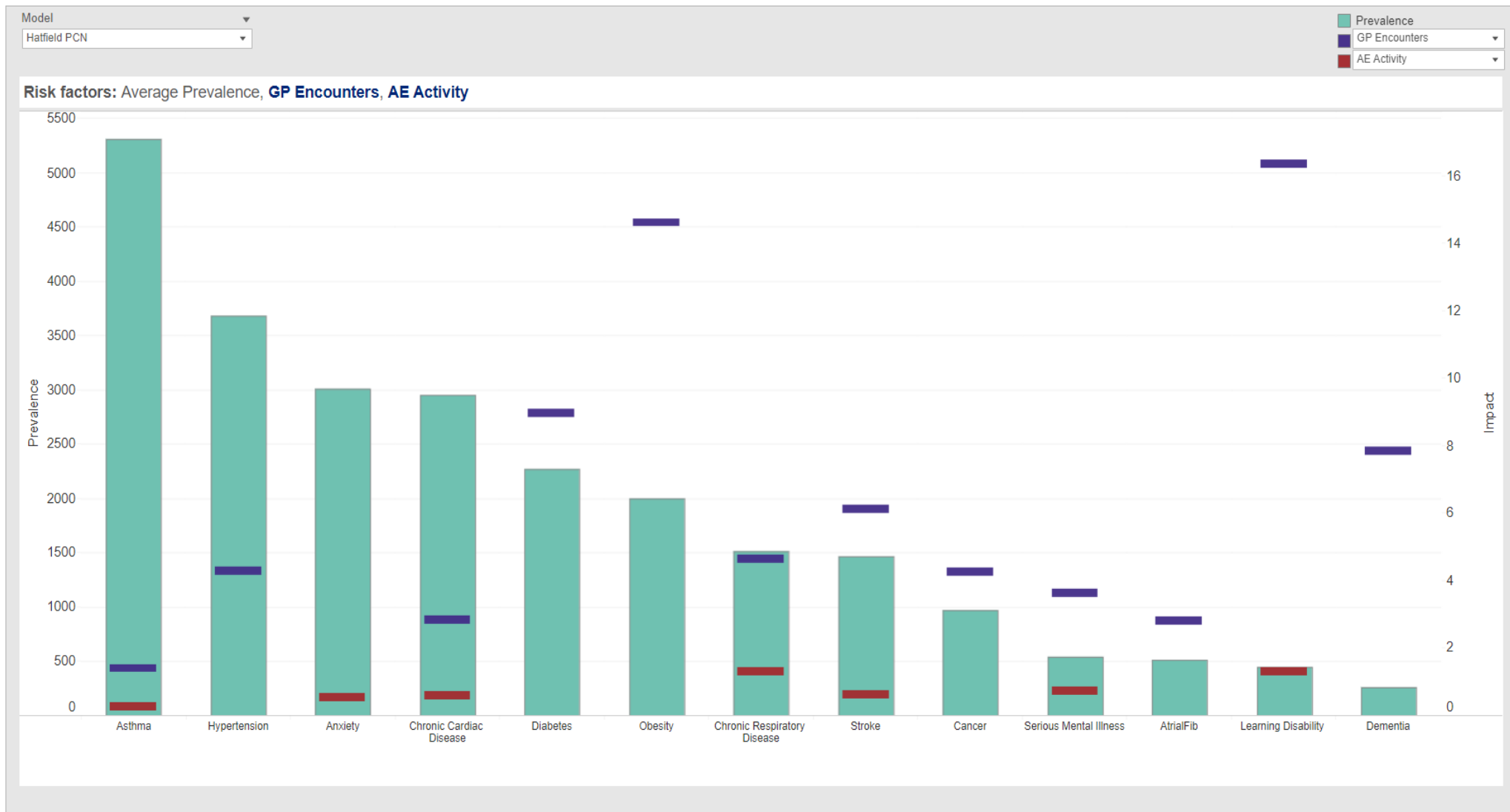
# Bio-Psycho-Social Indicators - Example



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.



## Cancer Screening

Period	HERTFORDSHIRE AND WEST ESSEX	HATFIELD PCN	WRAFTON HOUSE SURGERY	LISTER HOUSE SURGERY	BURVILL HOUSE SURGERY	POTTERELLS 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	63.1	69	64.3	55.3	66
Women, aged 50-64, with a record of cervical screening in the last 5.5 yrs (denominator includes PCAs)	2020/21 78.2	74.9	78.9	70.3	69.4	81.8
Persons, 25-49, attending cervical screening within target period (3.5 year coverage, %)	2020/21 73	62.1	67	63.7	54.8	64.4
Persons, 50-64, attending cervical screening within target period (5.5 year coverage, %)	2020/21 77	73.5	76.8	70.7	67.7	79.5
Persons, 50-70, screened for breast cancer in last 36 months (3 year coverage, %)	2020/21 63.9	43.7	49.2	47.8	56.6	22.7
Persons, 50-70, screened for breast cancer within 6 months of invitation (Uptake, %)	2020/21 61.3	57.1	59	59.9	61	43.7
Persons, 60-74, screened for bowel cancer within 6 months of invitation (Uptake, %)	2020/21 72.1	68.9	64.5	67.7	65.4	76.4
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %)	2020/21 68.8	66.2	64.4	65.1	61.5	72.2

■ Similar 
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 Hertfordshire Public Health  
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## Mortality

	Period	Hertfordshire CCGs	NHS HERTFORDSHIRE AND WEST ESSEX ICB - 06K	HATFIELD PCN
Percentage of deaths that occur at home (All age)	2021	25.3	26.8	24.6
PYLL - Neoplasms	2021	505	509.8	609.2
PYLL - Diseases of the circulatory system	2021	737.5	782.8	1004.4
PYLL - All Cause	2021	1537.7	1574	1886.6
Premature Mortality - Respiratory Disease	2021	19.2	19.5	43
Premature Mortality - Liver Disease	2021	14.6	14.6	
Premature Mortality - Cardiovascular Disease	2021	53.8	56.1	65.4
Premature Mortality - Cancer	2021	98.5	99.9	116.3
Premature Mortality - All Cause	2021	269.6	276.1	360.9

■ Similar 
 ■ Significantly Worse 
 ■ Significantly Better

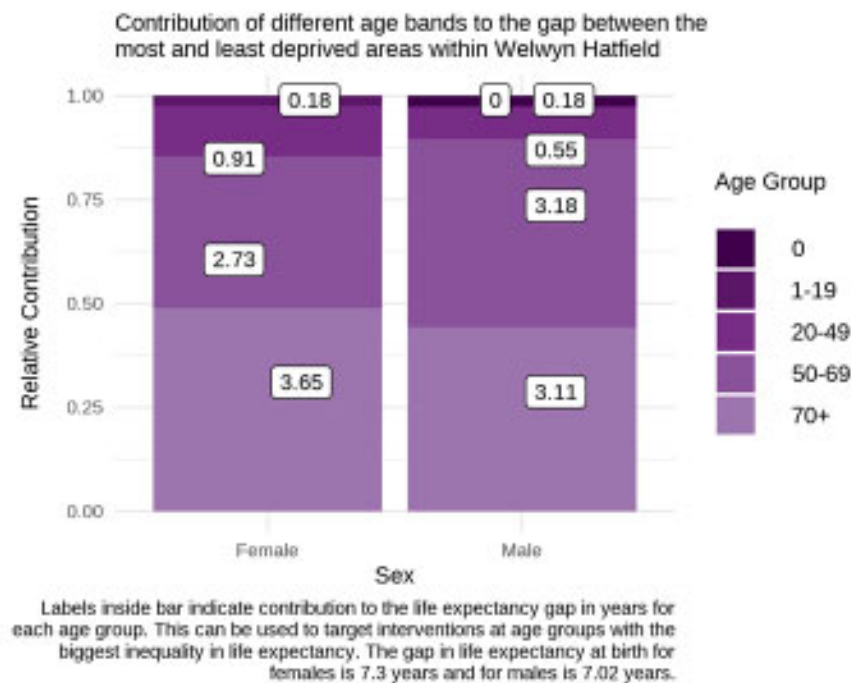
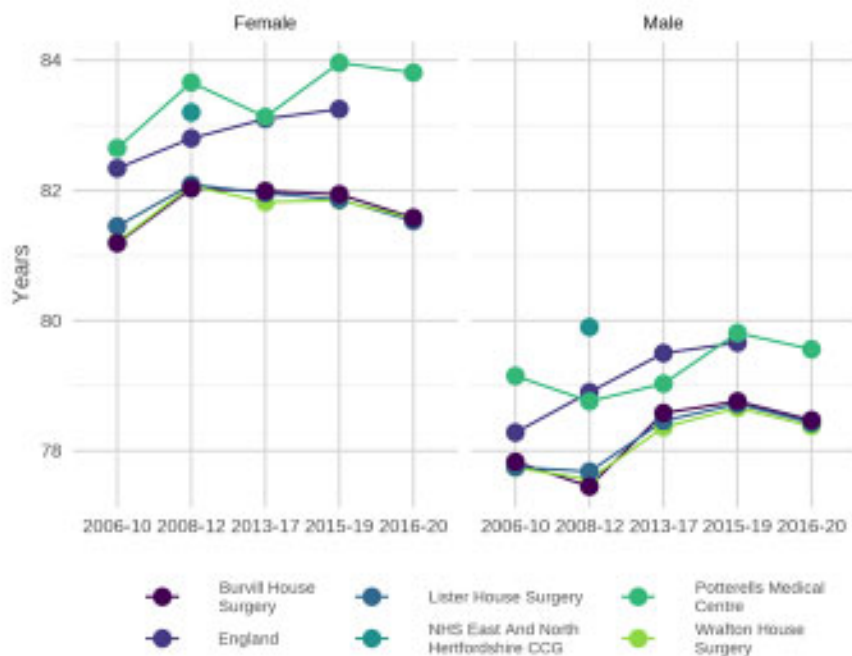
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## Life Expectancy



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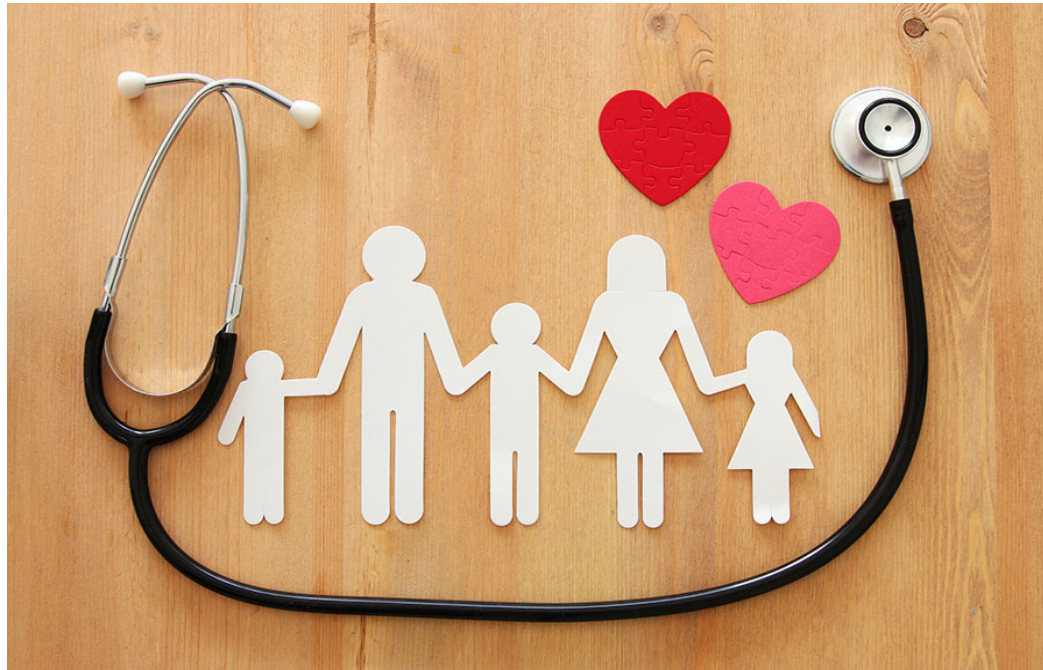




Hertfordshire and  
West Essex Integrated  
Care System



Hertfordshire and  
West Essex  
Integrated Care Board



**Working together**  
for a healthier future