



Hertfordshire and  
West Essex Integrated  
Care System



Hertfordshire and  
West Essex  
Integrated Care Board

# Primary Care Networks Overview Pack

## HERTFORD AND RURALS 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

Hertford and Rurals PCN has a similar population profile compared to England except in the age categories 20-39 which is lower and the age categories 40-64 which is higher. The majority of people live within the 2 least deprived deciles (9-10). 27% population have at least 1 Long Term Condition. 4.5% 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.

Wider determinants analysis from Public Health Evidence and Intelligence shows Hertford and Rurals is one of the least deprived PCNs within the ICB across all indicators.

The spread of patients for Hertford and Rurals PCN indicates 9.54% 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 East Hertfordshire 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 ~29k to ~36k.

When analysing the underlying Segmentation Model data the conditions with highest per 1,000 registered prevalence that are highlighted for Hertford and Rurals PCN are Cancer, Atrial Fib, Depression, Anxiety, MH and Obesity.

Urgent & Emergency Care in 2022/23 for Hertford and Rurals PCN A&E Attendance rates per 1,000 population, is similar to 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, Hertford and Rurals has a lower rate per 1,000 population, than the average.

When looking at the ACS conditions for Hertford and Rurals the highest volume and cost is within the End of Life, Frailty and Dementia in the over 65 age group and the next highest volume and cost is for the over 65 age group in the Advanced Disease and Complexity segment as well. It is to be noted that under End of Life, Frailty and Dementia and Advanced Disease and Complexity segments, there is a notable spread across 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 AF and Flutter, Heart Failure and COPD, with the highest volume and cost. For those people aged over 65 within the End of Life, Frailty & Dementia segment, Heart Failure, COPD and AF and Flutter, is highlighted 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 Hertford and Rurals 8.5% 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 Hertford and Rurals PCN is lower than the ICB, and the data shows higher usage of GP services.

Within this segment we can see the presence of Obesity, Chronic Cardiac Disease, Heart Disease and Diabetes 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 and just lower than the ICB.

For Hertford and Rurals the data shows higher AF, COPD, Diabetes and HF 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

HERTFORD AND RURALS PCN

Snapshot as at: 30/06/2021

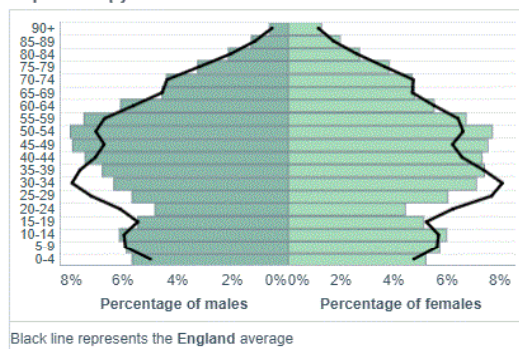
<b>Registered population</b>		<b>Demographics</b>		<b>Prevalence</b>		<b>Acute utilisation</b>		<b>Covid</b>	
% of total	100.0%	% White	78.8%	% with 1+ conditions	27.0%	% of annual activity (total 89,056)	100.0%	% one or more at risk conditions	14.9%
% of annual change	0.6%	% BAME	5.5%	% with 5+ conditions	2.5%	% of annual cost (total £23M)	100.0%	% two or more at risk conditions	5.5%
		% IMD top	0.0%						
		% IMD bottom	60.4%						

## Population demographics

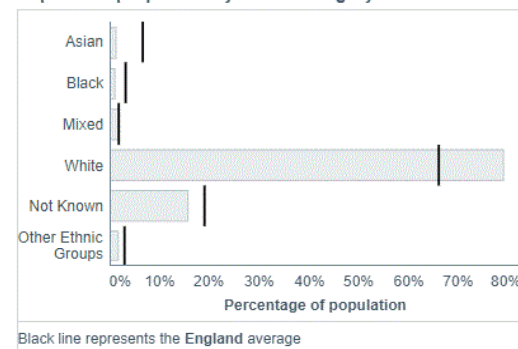
- Snapshot as at: 30/06/2021

Choose benchmark: England

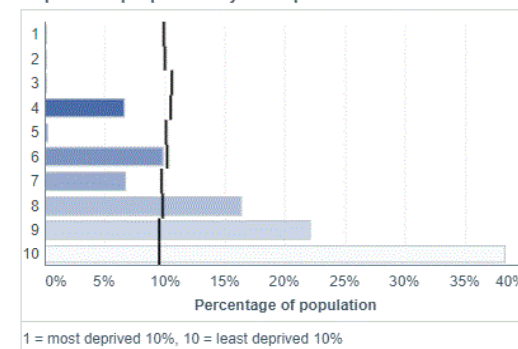
### Population pyramid



### Population proportion by ethnic category



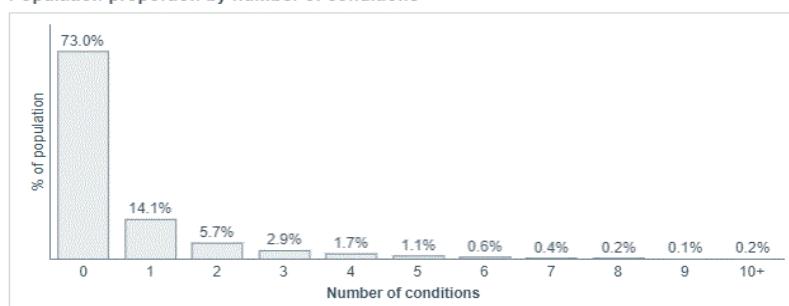
### Population proportion by IM Deprivation decile



## Prevalence

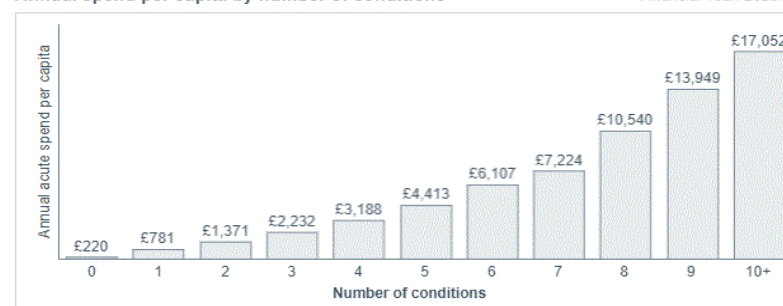
- Snapshot as at: 30/06/2021

### Population proportion by number of conditions



### Annual spend per capita by number of conditions

Financial Year: 2020/21



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.

Hertford and Rurals PCN has a similar population profile compared to England expect in the age categories 20-39 which is lower and the age categories 40-64 which is higher. The majority of people live within the 2 least deprived deciles (9-10).



# PCN Demographics - NHS England

## LTC

HERTFORD AND RURALS PCN

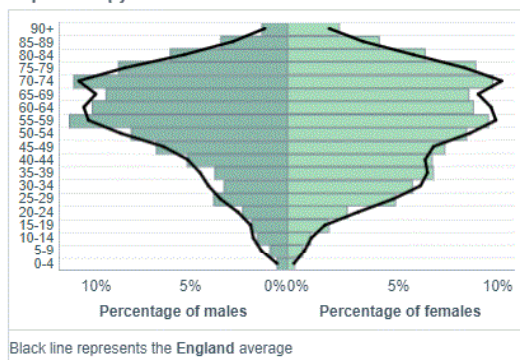
Snapshot as at: 30/06/2021

Registered population		Demographics		Prevalence		Acute utilisation		Covid	
% of total	23.9%	% White	91.8%	% with 1+ conditions	100.0%	% of annual activity (total 43,892)	49.3%	% one or more at risk conditions	47.9%
% of annual change	4.3%	% BAME	4.6%	% with 5+ conditions	4.5%	% of annual cost (total £10M)	43.0%	% two or more at risk conditions	14.6%
		% IMD top	0.0%						
		% IMD bottom	57.5%						

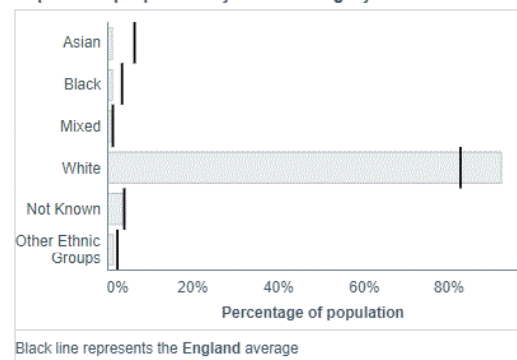
## Population demographics - Snapshot as at: 30/06/2021

Choose benchmark: England

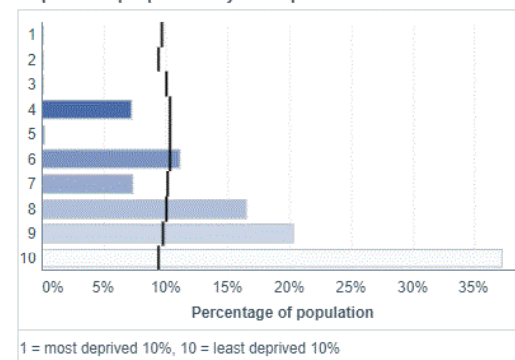
### Population pyramid



### Population proportion by ethnic category

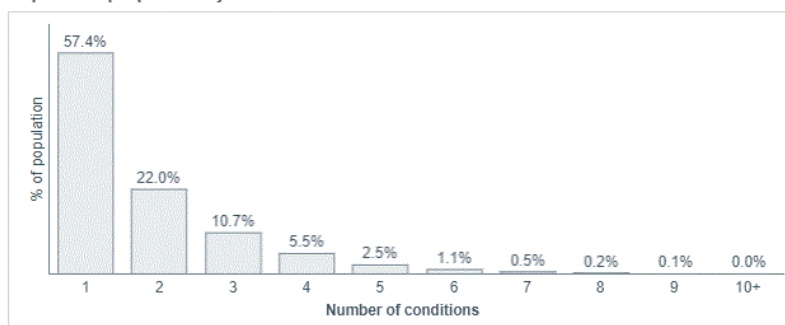


### Population proportion by IM Deprivation decile



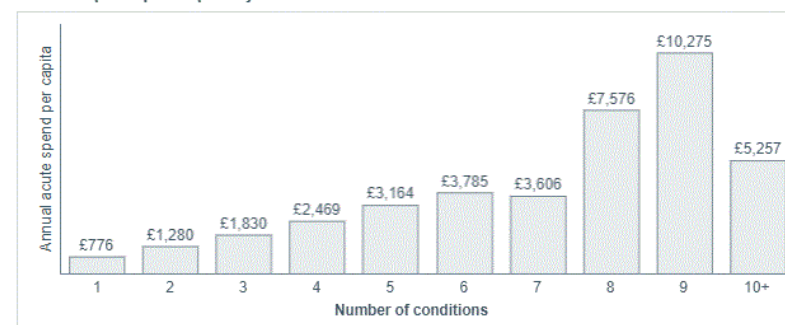
## Prevalence - Snapshot as at: 30/06/2021

### 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 27% population have at least 1 Long Term Condition. 4.5% 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 .

# Practice Indicators - Triggers and Levels

Practice Indicators for		HANSCOMBE HOUSE SURGERY			NEW RIVER HEALTH			WALLACE HOUSE			WATTON PLACE CLINIC		
HERTFORD AND RURALS PCN		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 Domain	Indicator Name												
Clinical Diagnosis	Detection rate Cancer	0.66	2020/21	No Trigger	0.573	2020/21	No Trigger	0.556	2020/21	No Trigger	0.724	2020/21	No Trigger
Coronary heart disease	% AF anticoagulation therapy CHADS2-VASc score >1	94.1	2020/21	Positive	88.7	2020/21	Positive	93.2	2020/21	Positive	91.5	2020/21	Positive
	% CHD aged <=79 BP reading 140/90mmHg or less	42.6	2020/21	Level 1	54.1	2020/21	Level 1	52.2	2020/21	Level 1	38.1	2020/21	Level 1
	% CHD cholesterol 5 mmol/l or less	55.1	2021/22	No Trigger	70.4	2021/22	No Trigger	46.6	2021/22	No Trigger	48.3	2021/22	No Trigger
	% hypertension aged <=79 BP reading 140/90mmHg or less	42.6	2020/21	Level 1	50.8	2020/21	Level 1	55.7	2020/21	Level 1	31.9	2020/21	Level 2
Diabetes	% Diabetes aged >=40 years no CVD history without moderate or severe frailty treated with statin	72.4	2020/21	Level 1	74.8	2020/21	Level 1	72.4	2020/21	Level 1	80.4	2020/21	Level 1
	% Diabetes without moderate or severe frailty BP 140/80 mmHg or less	43.8	2020/21	Level 1	56.2	2020/21	Level 1	62	2020/21	Level 1	37.3	2020/21	Level 2
	% diabetes without moderate or severe frailty IFCC-HbA1c is 58 mmol/mol or less	50.3	2020/21	Level 1	58.6	2020/21	Level 1	53.7	2020/21	Level 1	42.5	2020/21	Level 2
Exception Rating	Overall Personalised Care Adjustment Rate	0.027	2020/21	No Trigger	0.053	2020/21	No Trigger	0.03	2020/21	No Trigger	0.027	2020/21	No Trigger
Medicines Management	% antibiotics Co-amoxiclav, Cephalosporins, Quinolones	10.5	2021/22 Q4	Level 1	9.7	2021/22 Q4	No Trigger	9.2	2021/22 Q4	No Trigger	9.4	2021/22 Q4	No Trigger
	% Naproxen and Ibuprofen	75.8	2021/22 Q4	No Trigger	71.4	2021/22 Q4	No Trigger	79.9	2021/22 Q4	No Trigger	45.2	2021/22 Q4	Level 2
	Antibacterial Items/Star Pu	0.945	2021/22 Q4	Positive	0.737	2021/22 Q4	Positive	0.787	2021/22 Q4	Positive	0.715	2021/22 Q4	Positive
	Hypnotics ADQ/Star Pu	0.574	2021/22 Q4	No Trigger	0.637	2021/22 Q4	No Trigger	0.587	2021/22 Q4	No Trigger	0.246	2021/22 Q4	Positive
	Oral NSAIDs ADQs/STAR-PU	2.74	2021/22 Q4	No Trigger	3.609	2021/22 Q4	No Trigger	3.567	2021/22 Q4	No Trigger	5.8	2021/22 Q4	No Trigger
Mental Health	% first choice generic SSRIs	79.6	2021/22 Q4	Positive	75.5	2021/22 Q4	No Trigger	76.7	2021/22 Q4	Positive	71.7	2021/22 Q4	No Trigger
	% MH comprehensive care plan	45.2	2020/21	Level 1	11.1	2020/21	Level 2	17.4	2020/21	Level 1	81.3	2020/21	Level 1
	% SMI alcohol record	36.4	2020/21	Level 1	11.5	2020/21	Level 2	10.9	2020/21	Level 2	100	2018/19	No Trigger
	% SMI BP record	55.7	2020/21	Level 1	48	2020/21	Level 1	43.1	2020/21	Level 2	75	2020/21	Level 1
	Dementia Face to Face review	44.3	2020/21	Level 1	22.5	2020/21	Level 1	33	2020/21	Level 1	43.8	2020/21	Level 1
	Select antidepressants ADQs/STARPU	1.483	2021/22 Q4	No Trigger	1.647	2021/22 Q4	No Trigger	1.787	2021/22 Q4	No Trigger	1.112	2021/22 Q4	No Trigger
Patient Experience	Confidence and trust in healthcare professional	98.7	2020/21	No Trigger	95.2	2020/21	No Trigger	97.5	2020/21	No Trigger	92.7	2020/21	No Trigger
	Frequency seeing preferred GP	43.8	2020/21	No Trigger	37.6	2020/21	No Trigger	49	2020/21	No Trigger	65.9	2020/21	No Trigger
	Healthcare professional treating with care and concern	94.9	2020/21	No Trigger	85.6	2020/21	No Trigger	93.1	2020/21	No Trigger	84.7	2020/21	No Trigger
	Overall experience of your GP practice	96.5	2020/21	Positive	83.9	2020/21	No Trigger	77.2	2020/21	No Trigger	90.3	2020/21	No Trigger
	Satisfaction with appointment times	81.3	2020/21	No Trigger	72.8	2020/21	No Trigger	53.6	2020/21	No Trigger	72.4	2020/21	No Trigger
Public Health	% Child Imms DTaP/IPV/Hib/HepB (age 1 year)	97.8	2020/21	No Trigger	94	2020/21	Level 1	94.7	2020/21	Level 1	98.2	2020/21	No Trigger
	% Child Imms Hib/MenC booster	93.5	2020/21	Level 1	97.1	2020/21	No Trigger	96.5	2020/21	No Trigger	96.4	2020/21	No Trigger
	% Child Imms MMR (Age 2 yrs)	92.9	2020/21	Level 1	96.7	2020/21	No Trigger	95.3	2020/21	No Trigger	94.5	2020/21	Level 1
	% Child Imms PCV Booster	93.5	2020/21	Level 1	97.1	2020/21	No Trigger	95.9	2020/21	No Trigger	94.5	2020/21	Level 1
	Cervical Screening	78.8	2021/22 Q4	Level 1	78.5	2021/22 Q4	Level 1	79.4	2021/22 Q4	Level 1	76.6	2021/22 Q4	Level 1
Respiratory	% Asthma review in last 6 mths	44	2020/21	Level 1	72.3	2020/21	No Trigger	28.6	2020/21	Level 1	20.5	2020/21	Level 1
	% Asthma spirometry and one other objective test	0	2020/21	Level 1	50	2020/21	Level 1	0	2020/21	Level 2	0	2020/21	Level 1
	% COPD with review in last 12 mths	39.6	2020/21	Level 1	79.4	2020/21	Level 1	48.8	2020/21	Level 1	36.4	2020/21	Level 1
	% LTC patients who smoke	9.5	2020/21	No Trigger	9.7	2020/21	No Trigger	13.6	2020/21	No Trigger	10.7	2020/21	No Trigger
	% LTC Smoker offer support	54.5	2020/21	Level 1	100	2020/21	No Trigger	66	2020/21	Level 1	23.9	2020/21	Level 2
	% Smoking patients over 15 recorded	77.5	2021/22	No Trigger	75.8	2021/22	No Trigger	74.9	2021/22	No Trigger	74.4	2021/22	No Trigger
	% Smoking status recorded	92.5	2020/21	No Trigger	100	2020/21	Positive	92.2	2020/21	No Trigger	85	2020/21	Level 1
	% w. MRC dyspnoea score >=3 w. offer of referral to pulm. rehab. Clinic	100	2020/21	No Trigger	91.7	2020/21	No Trigger	80	2020/21	Level 1	0	2020/21	Level 1

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 Hertford And Rurals PCN an estimated:

- 8.4% of children live in poverty.
- 8% of older people live in poverty.
- 10% of households live in fuel poverty.
- 6.5% of households are overcrowded.
- 32.3% of people aged 65 and over live alone.
- 0.3% of people cannot speak English well.
- 3% of working age people are claiming out of work benefits.
- 18% of children aged 4-5 and 25.4% of children aged 10-11 are overweight.

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Hertfordshire Public Health  
Evidence & Intelligence  
Epidemiology



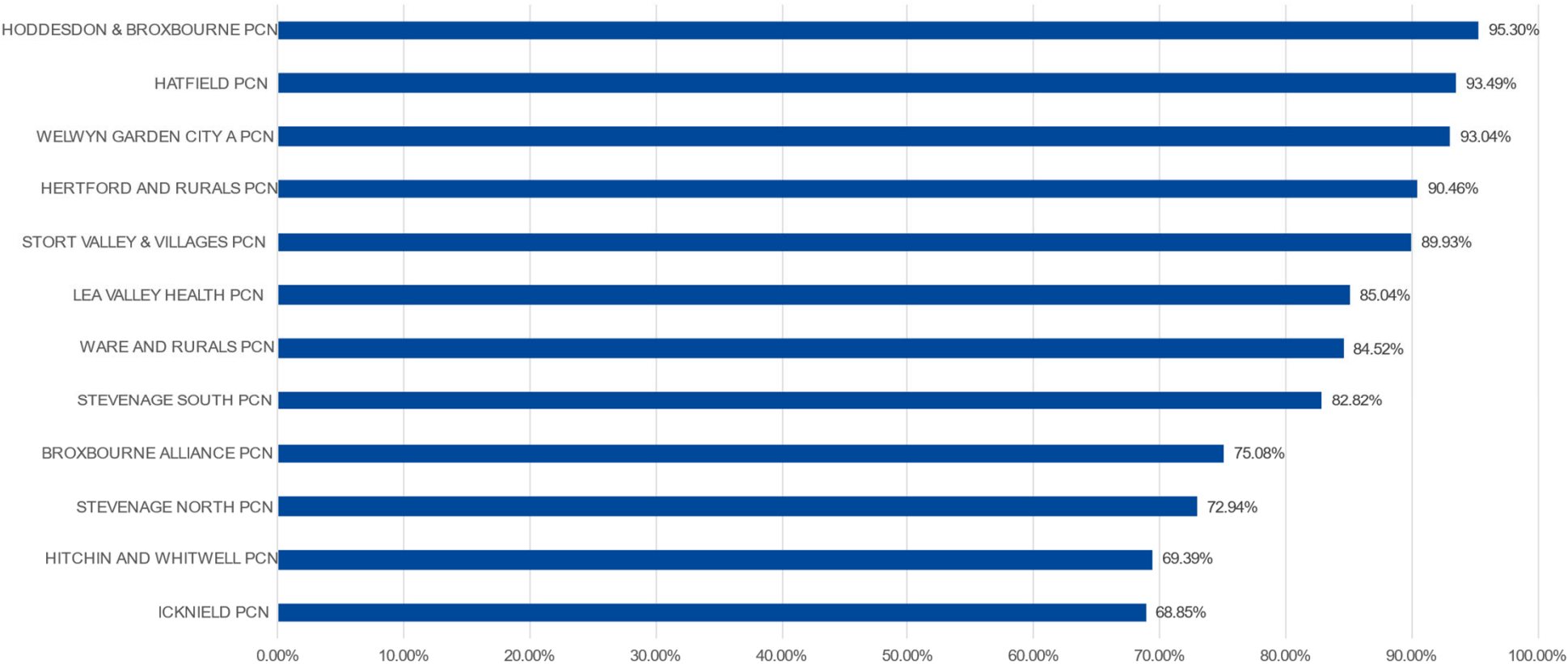
The above provides a summary of the wider determinants of health for Hertford and Rurals.

Wider determinants analysis from Public Health Evidence and Intelligence shows Hertford and Rurals is one of the least deprived PCNs within the ICB across all indicators.



## SPREAD OF PATIENTS ACROSS ENGLAND CONT.

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

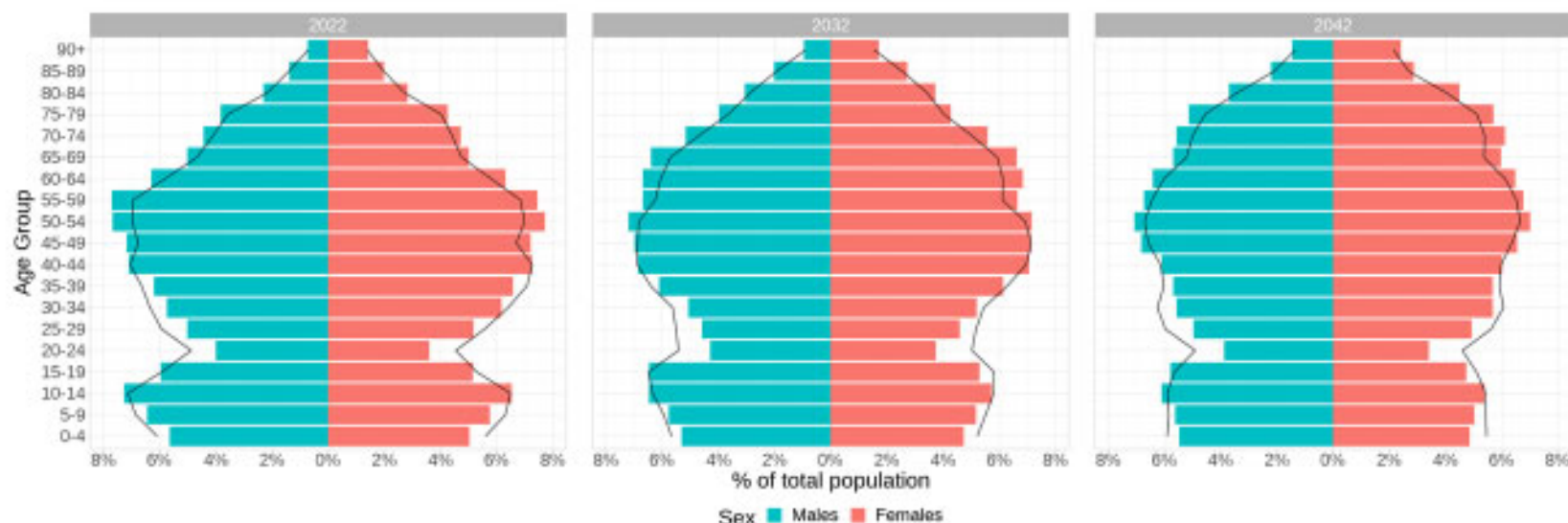


This chart shows the proportion of the registered population living within the ICB geographical boundary.

The spread of patients for Hertford and Rural PCN indicates 9.54% 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 East Hertfordshire 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	8,083	7,908	8,377
Under 24	41,946	41,640	40,726
24-64	80,932	79,458	79,926
65+	28,770	36,444	41,717
85+	4,196	5,871	7,269

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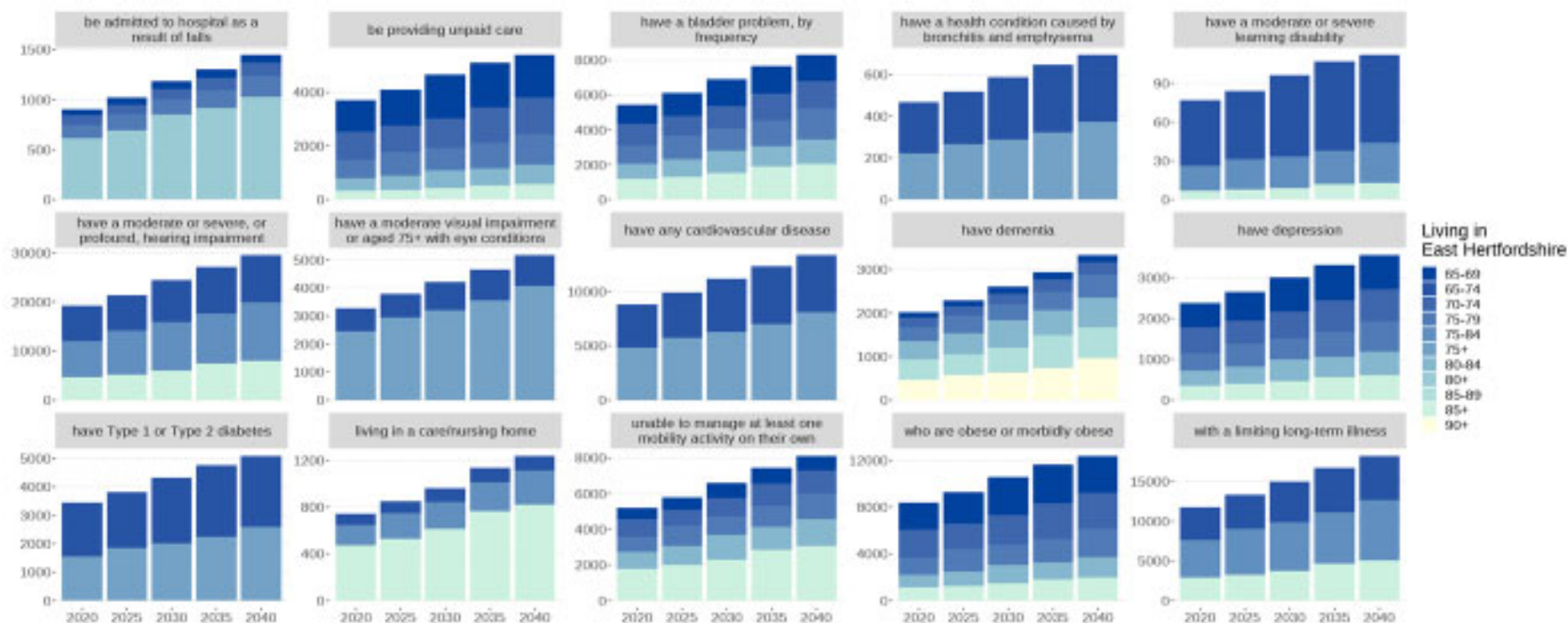
Hertfordshire Public Health  
Evidence & Intelligence  
Epidemiology



Expected population growth for East Hertfordshire 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 ~29k to ~36k.



## 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.

# Segmentation within the ICB

**Optum**

HWE

Segment & Outcomes  
Framework Documentation

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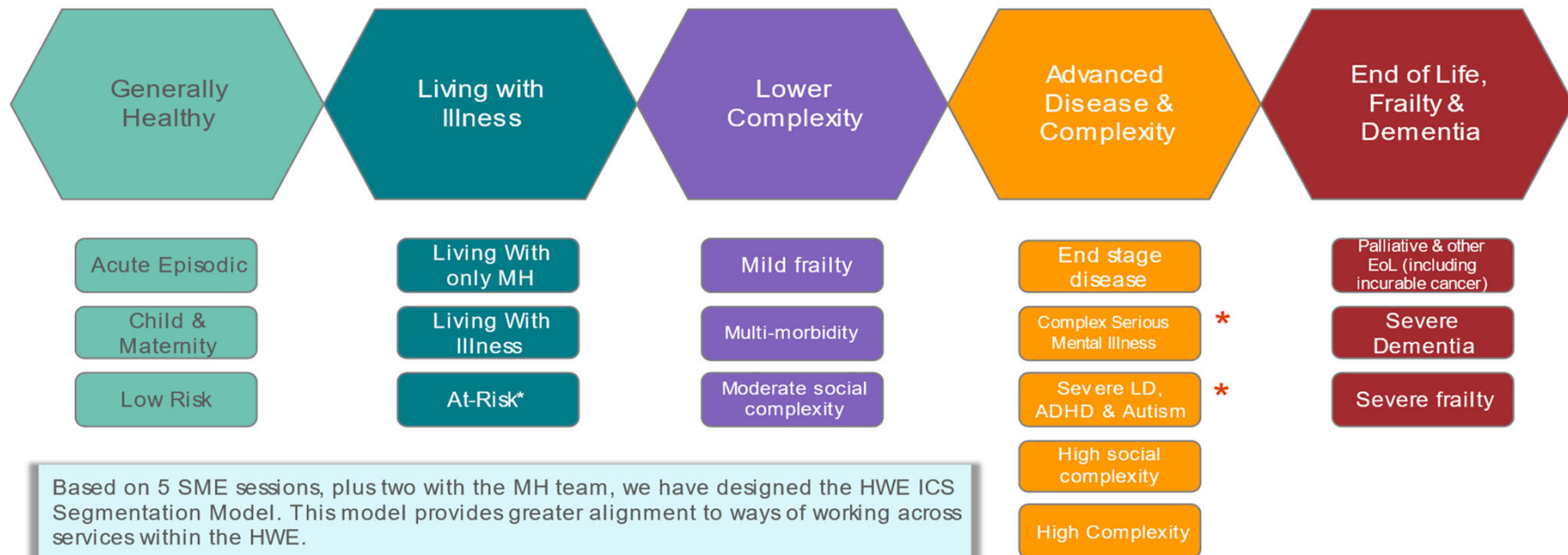
# PHM Segment Model - Overview

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



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

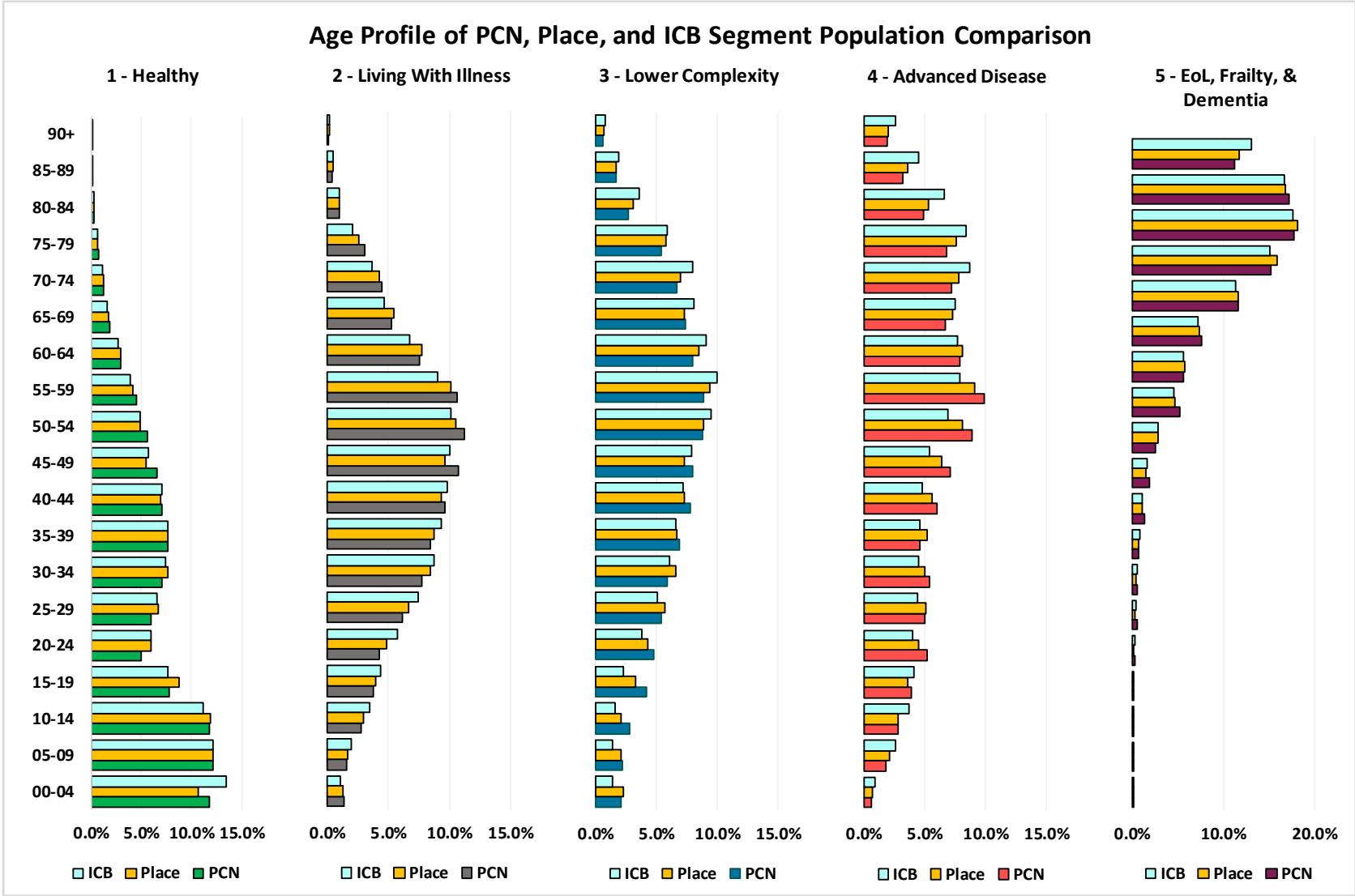
#### Who is in this group?

- 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

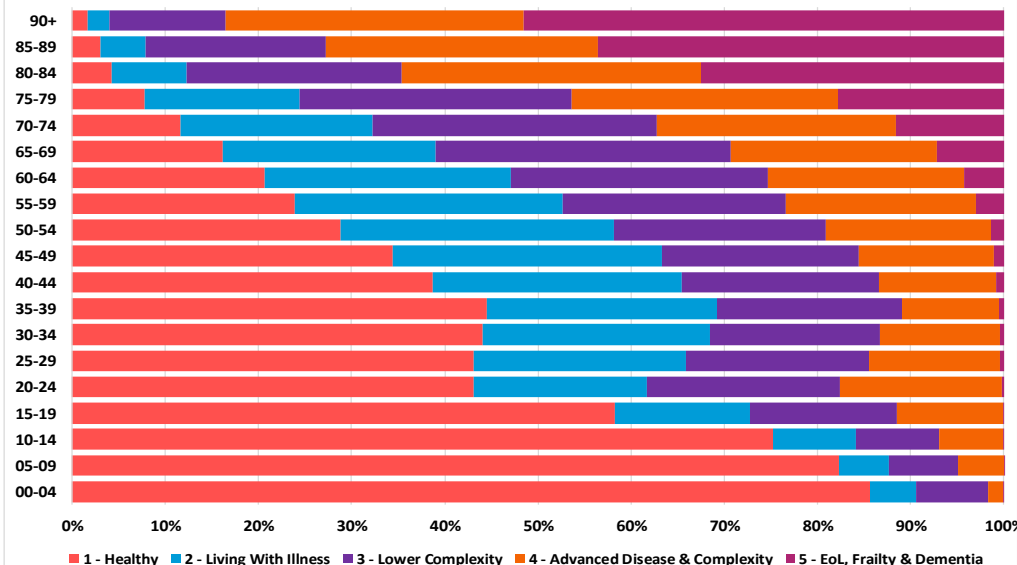


Each registered person is assigned to a segment and this can be cut by age group and also geographically by Place or PCN.

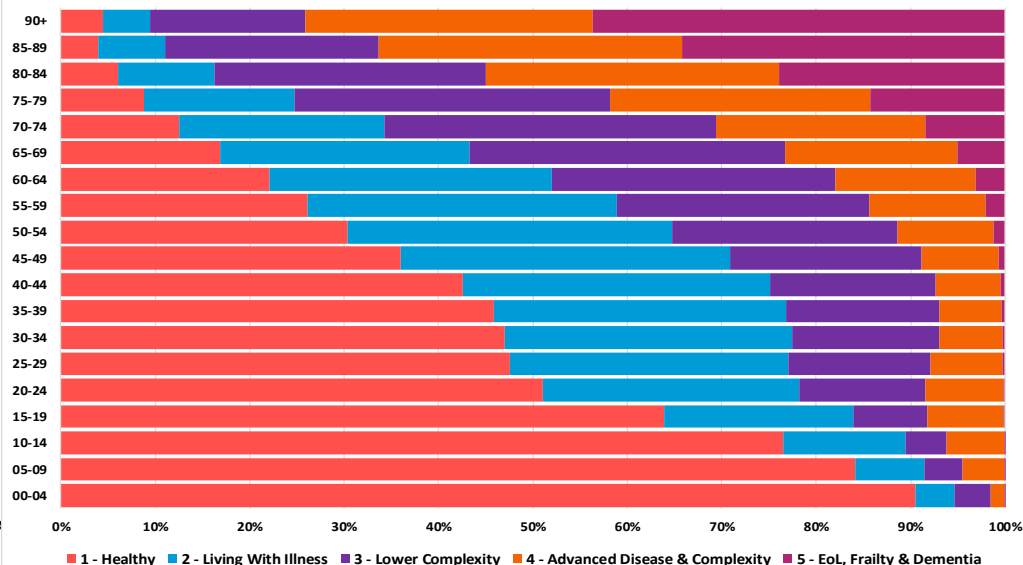
The above looks at the breakdown by age of people within each segment. It provides the PCN value against the Place and ICB value.

# Demographic Breakdowns - Segment & Deprivation Quintiles

Segment Proportion by Age Group



ICB Segment Proportion by Age Group as a Comparator



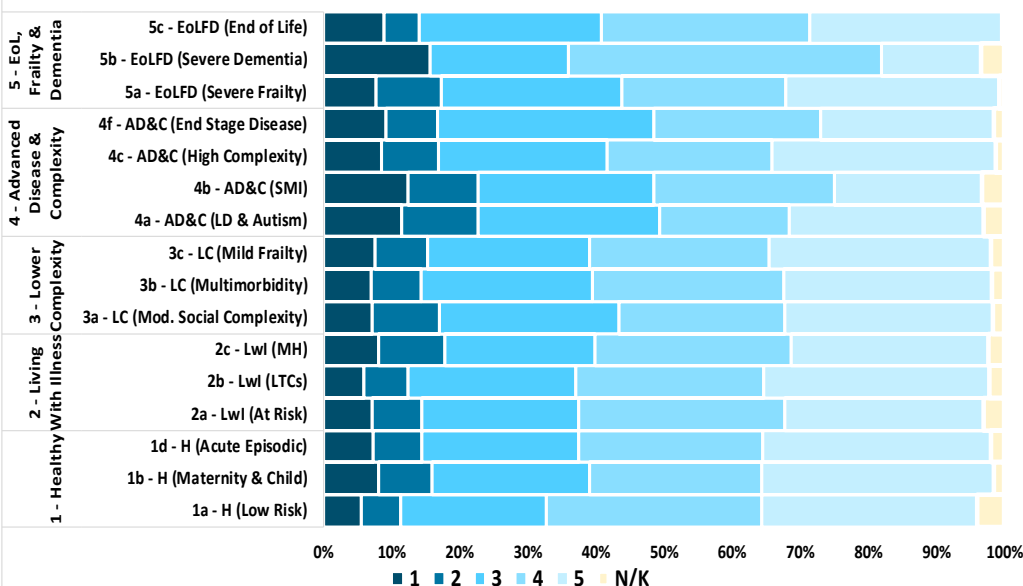
The ICB Health Segments here are broken down by total population and 5 year age groups; as expected with age the proportion of people within the healthy segment decreases.

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

Overall Hertford and Rurals has a slightly higher profile for age categories 15-90+ for segments 3 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.

Index of Multiple Deprivation Quintile Proportion of Population Segment



# 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
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 Hertford and Rurals PCN are Cancer, Atrial Fib, Depression, Anxiety, MH and Obesity.



# Continued

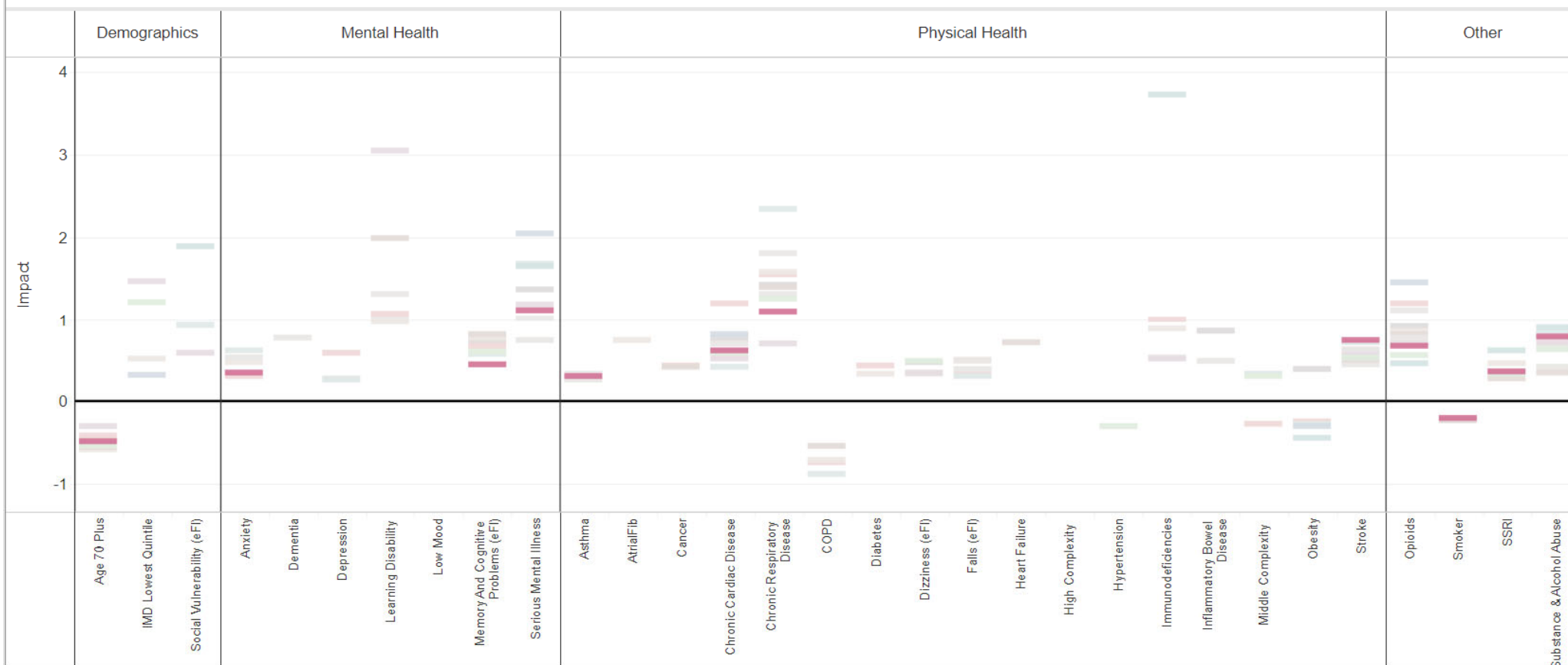
PCN NAME	ASD	Cerebral Palsy	Chronic Respiratory Disease	Cystic Fibrosis	Huntingtons Disease	Inflammatory Bowel Disease	Kidney Transplant	Metastatic Cancer	Multiple Sclerosis	Muscular Dystrophy	Myasthenia Gravis	Osteoporosis	Other Neurological Conditions	Parkinsons Disease	Rheumatoid Arthritis	Lupus (SLE)	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
BROXBORNE 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 & BROXBORNE	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 Inflammatory Bowel Disease, Osteoporosis and High BP.



# PCN Benchmarking - A&E Activity

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



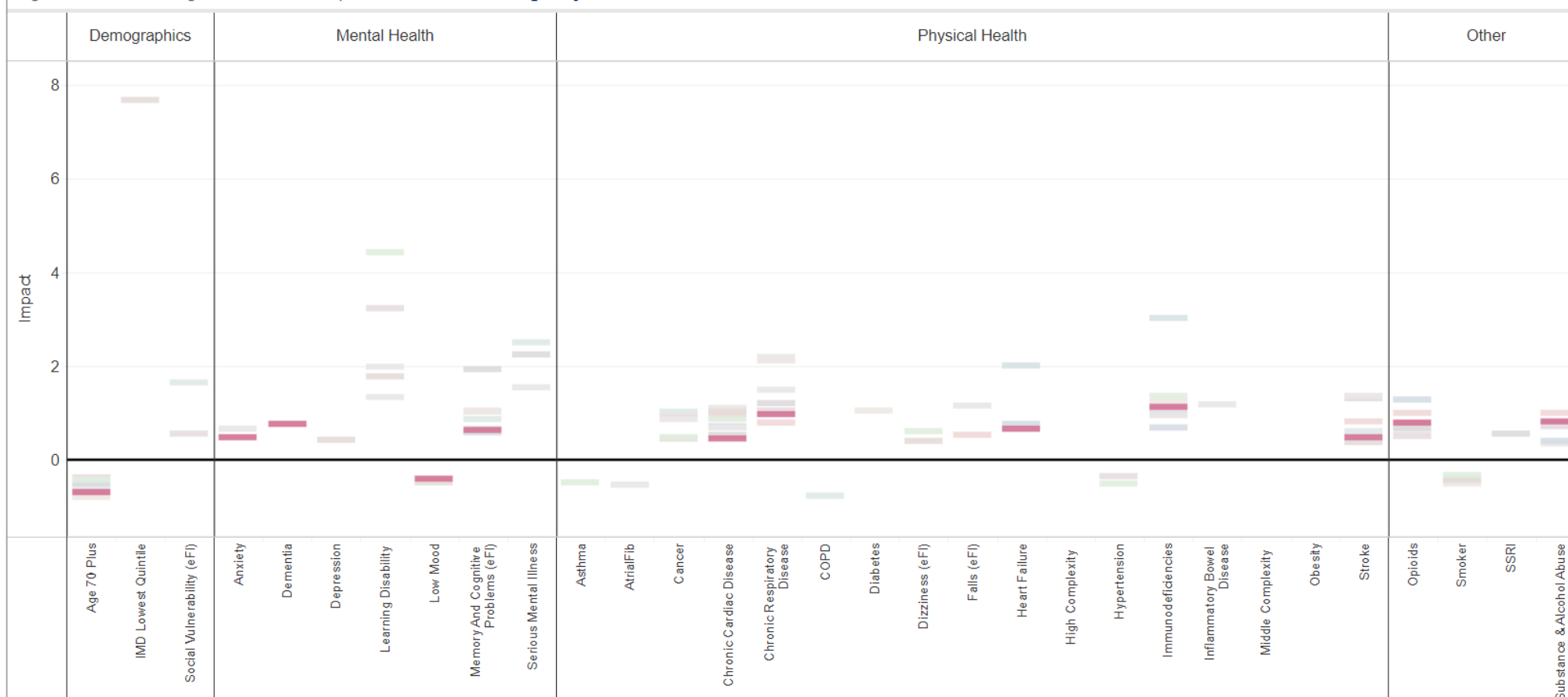
The charts in the next two pages show activity for the PCN compared against all other PCNs at the Place level.

**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.

# 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.



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

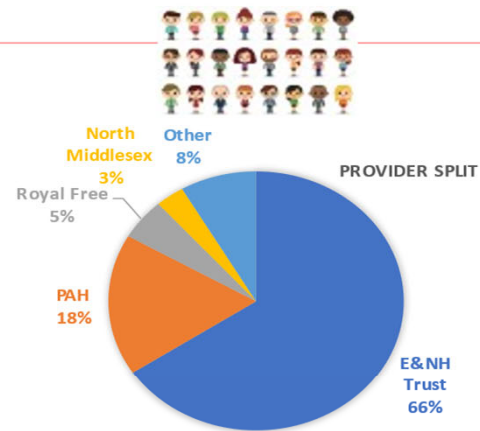
Children 0 -18  
Adults 19-64  
Older People 65+

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%)

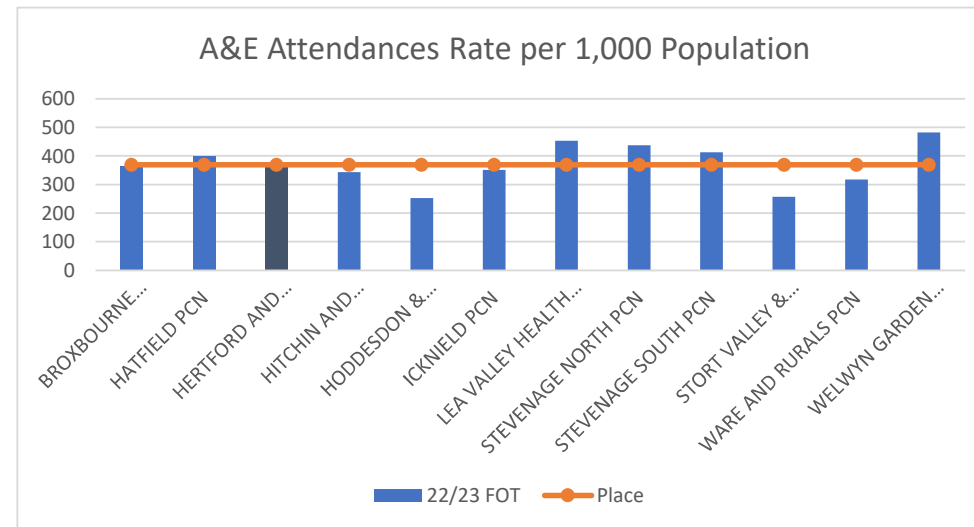
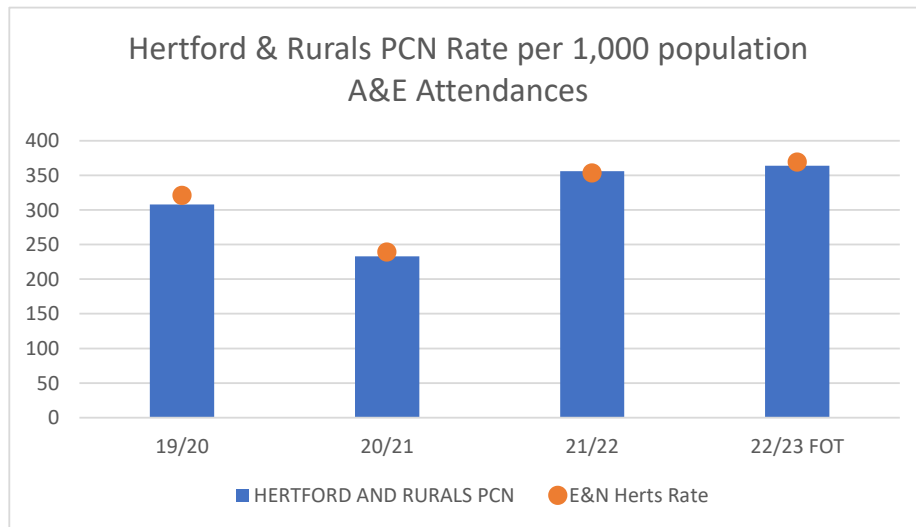
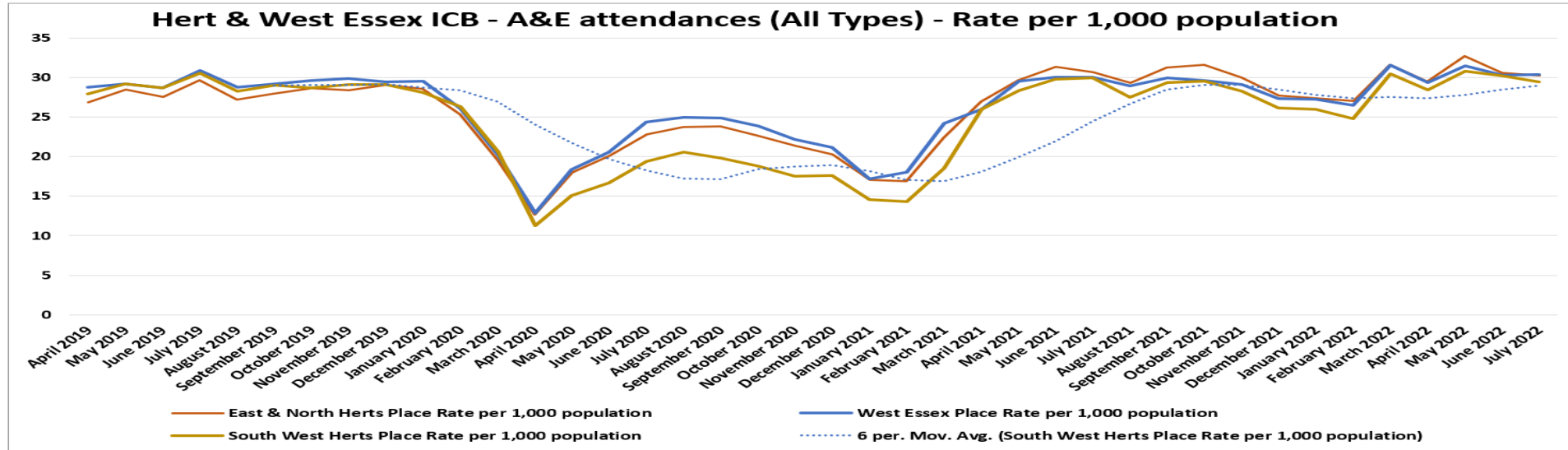


128,296 people attended A&E in 2021/22

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



**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 Hertford and Rurals PCN A&E Attendance rates per 1,000 population, is similar to 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 Hertford and Rurals PCN.

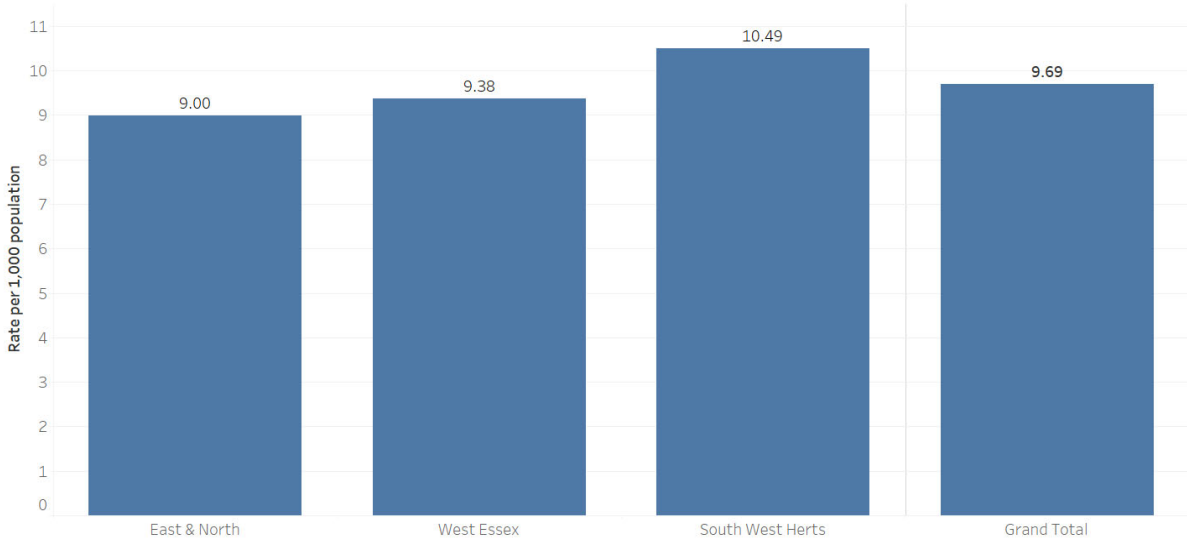
\* Average cost for Mental and Behavioural is not representative as non-PbR

## 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	75	60	£1,844	£138,314
CVD: Angina	8	8	£1,245	£9,961
CVD: Congestive Heart Failure	101	86	£4,031	£407,093
CVD: Hypertension	21	21	£764	£16,047
Diseases of the blood	25	24	£3,005	£75,120
Mental and Behavioural Disorders	13	13		
Neurological Disorders	19	16	£3,196	£60,724
Nutritional, endocrine and metabolic	63	51	£3,079	£193,952
Respiratory: Asthma	19	17	£1,287	£24,454
Respiratory: COPD	91	50	£2,993	£272,390
Grand Total	435	332	£2,754	£1,198,055

# ACS Admission Rates per 1,000 Population by Place

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

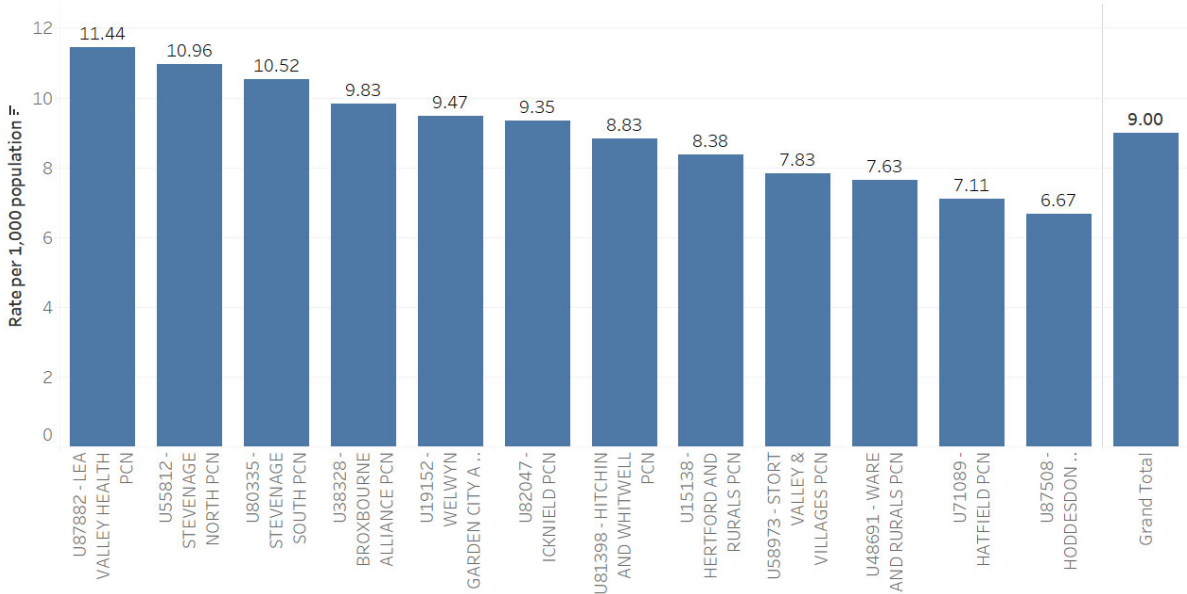


When comparing the Ambulatory Care Sensitive rates per 1,000 population between places, the East & North place has the lowest rate in the ICB.

Within East & North place, Hertford and Rurals has a lower 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 Hertford and Rurals the highest volume and cost is within the End of Life, Frailty and Dementia in the over 65 age group and the next highest volume and cost is for the over 65 age group in the Advanced Disease and Complexity segment as well. It is to be noted that under End of Life, Frailty and Dementia and Advanced Disease and Complexity segments, there is a notable spread across 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

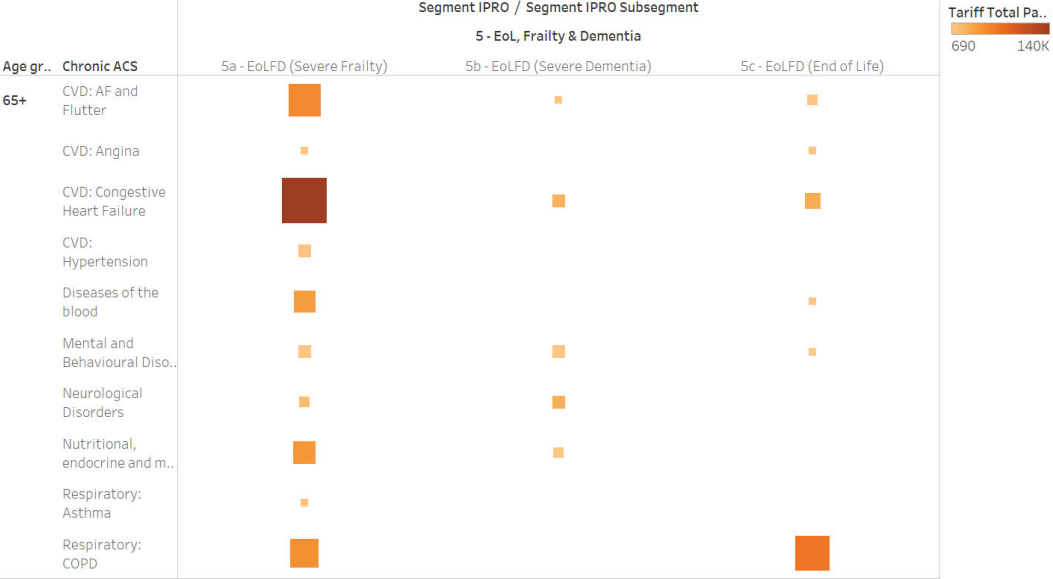
## Segment 4



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

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

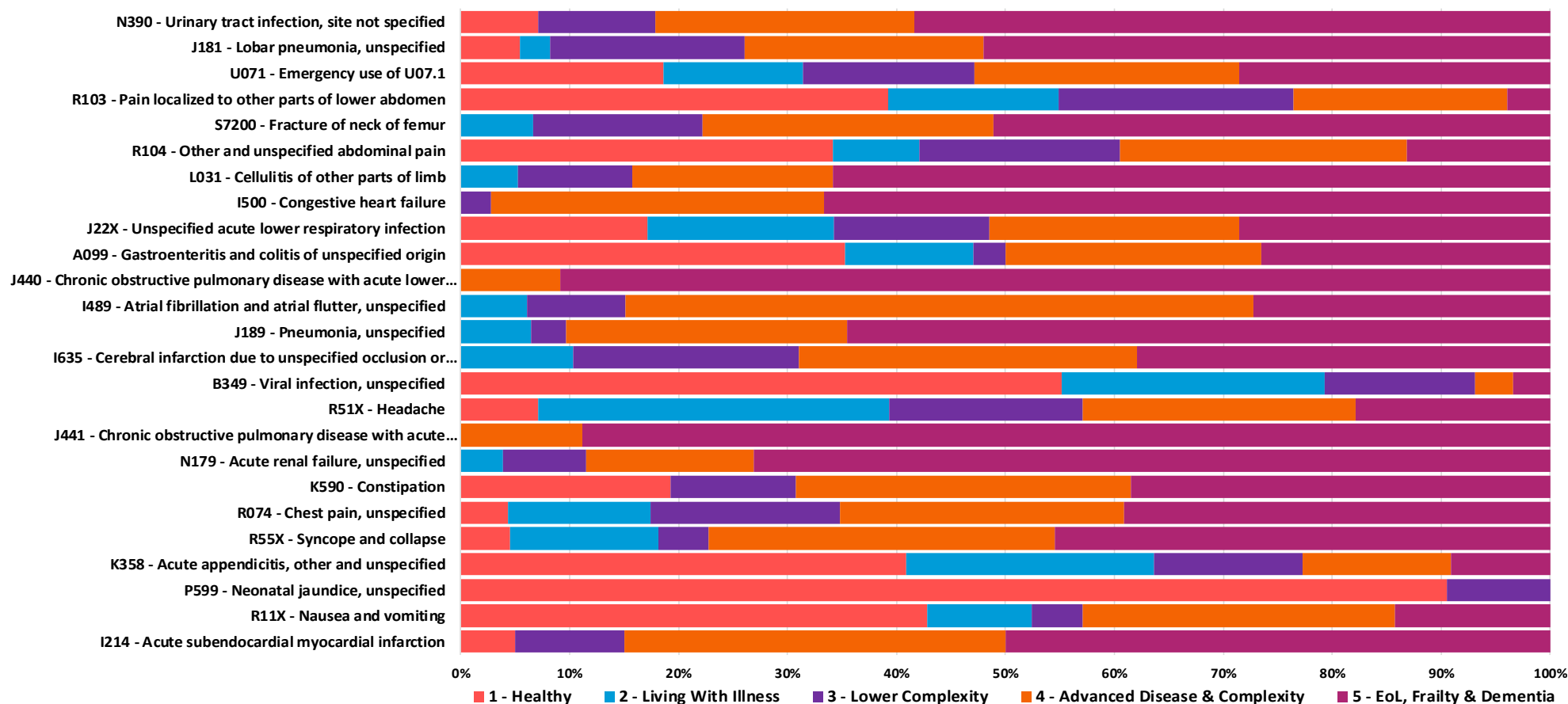
## Segment 5



# 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
Baldock Town				8		8
Bandley Hill	1					1
Batchwood		1				1
Bishop's Stortford All Saints			2			2
Bishop's Stortford Central					1	1
Bishop's Stortford Meadows					3	3
Bishop's Stortford Silverleys			1	1		2
Broadley Common, Epping Upland and Nazeing		1				1
Brookmans Park and Little Heath			1			1
Broxbourne and Hoddesdon South	3	1	2	3		15
Buntingford	1		1	3		10
Bush Fair			2			2
Chells		1	1			2
Chesfield	2					2
Cheshunt North				3	1	4
Cheshunt South and Theobalds	1	1			1	3
Codicote		1				1
Colney Heath	1					1
Datchworth & Aston	4	3	5	6		28
Felsted & Stebbing			2			2
Flamstead End		1		1		2
Great Amwell	4	10	4	20	2	40
Great Dunmow North		2				2
Great Parndon				2		2
Handside		1				1
Harpenden North			1			1
Hatfield East			2	3	1	6
Hertford Bengoe	89	52	66	102	122	431
Hertford Castle	105	69	61	132	185	552
Hertford Heath	18	9	18	25	43	113
Hertford Kingsmead	66	49	51	89	73	328
Hertford Rural North	16	5	15	20	37	93
Hertford Rural South	9	14	15	18	16	72
Hertford Sele	54	49	84	86	138	411
Hitchin Bearton			3		4	7
Hoddesdon North	1	3		3	1	8
Hoddesdon Town and Rye Park	1		1			2
Hunsdon	1	4	3	7		22
Letchworth South West	1					1
Longmeadow			1			1
Manor	1		4	1		6
Mark Hall	1					1
Martins Wood	1					1
Much Hadham					3	3
Mundens and Cottered	6	1	1	5	16	29
Netteswell				1		1
Northaw and Cuffley		1	1			2
Old Harlow			1			1
Old Town	1					1
Panshanger			1			1
Peartree		1				1
Potters Bar Furzefield				1		1
Potters Bar Oakmere	1					1
Puckeridge				4		4
Rosedale and Bury Green				4	1	5
Stanstead Abbots	4	1	3	9		26
Staple Tye				1		1
Symonds Green			1	5		6
Thundridge & Standon	3	2	12	12	15	44
Walkern	8	8	16	6	8	46
Waltham Abbey Paternoster		1				1
Waltham Cross	1					1
Ware Chadwell	8	3	7	24	30	72
Ware Christchurch	19	9	13	47	100	188
Ware St Mary's	11	18	29	38	58	154
Ware Trinity	17	14	21	38	45	135
Watton-at-Stone	20	10	20	43	39	132
Welwyn East		1	1	1		3
Wheathampstead	1					1
Wormley and Turnford				4	12	16
Unknown Ward	4	10	15	4	3	36
Grand Total	485	357	488	778	997	3105

UEC Patients Seen by Deprivation Quintile & Ward 1 = Most Deprived, 5 = Least Deprived	1	2	3	4	5 (blank)	Grand Total
Baldock Town	8					8
Bandley Hill			1			1
Batchwood	1					1
Bishop's Stortford All Saints				2		2
Bishop's Stortford Central					1	1
Bishop's Stortford Meadows					3	3
Bishop's Stortford Silverleys					2	2
Broadley Common, Epping Upland and Na	1					1
Brookmans Park and Little Heath				1		1
Broxbourne and Hoddesdon South				15		15
Buntingford				8	2	10
Bush Fair	2					2
Chells		1	1			2
Chesfield				2		2
Cheshunt North	2	1	1			4
Cheshunt South and Theobalds	1		1	1		3
Codicote					1	1
Colney Heath				1		1
Datchworth & Aston				28		28
Felsted & Stebbing			2			2
Flamstead End	1		1			2
Great Amwell		24			16	40
Great Dunmow North					2	2
Great Parndon			2			2
Handside		1				1
Harpenden North					1	1
Hatfield East	6					6
Hertford Bengoe			82	139	210	431
Hertford Castle		112		363	77	552
Hertford Heath			78	35		113
Hertford Kingsmead			148		180	328
Hertford Rural North			93			93
Hertford Rural South			72			72
Hertford Sele	259			73	79	411
Hitchin Bearton		3		4		7
Hoddesdon North			4	4		8
Hoddesdon Town and Rye Park	1		1			2
Hunsdon		20	2			22
Letchworth South West	1					1
Longmeadow			1			1
Manor		2		4		6
Mark Hall	1					1
Martins Wood	1					1
Much Hadham					3	3
Mundens and Cottered			29			29
Netteswell	1					1
Northaw and Cuffley			1		1	2
Old Harlow		1				1
Old Town			1			1
Panshanger					1	1
Peartree	1					1
Potters Bar Furzefield		1				1
Potters Bar Oakmere			1			1
Puckeridge				4		4
Rosedale and Bury Green	3	2				5
Stanstead Abbots			16		10	26
Staple Tye	1					1
Symonds Green	1	5				6
Thundridge & Standon		41		3		44
Walkern			31	15		46
Waltham Abbey Paternoster	1					1
Waltham Cross	1					1
Ware Chadwell				37	35	72
Ware Christchurch			127		61	188
Ware St Mary's			70		84	154
Ware Trinity		32	59		44	135
Watton-at-Stone				132		132
Welwyn East				1	2	3
Wheathampstead				1		1
Wormley and Turnford	8	4	4			16
Unknown Ward					36	36
Grand Total	302	250	829	873	815	3105

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

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



## Hospital Admissions

	Period	HERTFORDSHIRE AND WEST ESSEX	HERTFORD AND RURALS PCN
Emergency admissions injuries due to falls in those aged 65+	2020/21	2026	1814.4
Emergency asthma, diabetes and epilepsy admissions (aged 0-18)	2020/21	130.8	135.1
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	248.1
Mental health admissions (all ages)	2020/21	177.2	121.8
Emergency Cancer Admissions	2020/21	494.9	398.7
Emergency admissions for acute conditions shouldn't require admissions	2020/21	611.6	418.1

■ Similar 
 ■ Significantly Worse 
 ■ Significantly Better

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

Hertfordshire Public Health  
Evidence & Intelligence  
Epidemiology



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

Hertford and Rurals 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	2	3	2	176	1	266	173	338	447	738	7	2153	37725
% of population in cohort	0.1%	0.1%	0.1%	8.2%	0.0%	12.4%	8.0%	15.7%	20.8%	34.3%	0.3%	100.0%	100.0%
Avg. Age	72.0	82.3	64.0	74.8	54.0	73.2	73.2	75.6	77.5	75.5	72.3	75.4	75.6
% BAME Where recorded	0%	0%	0%	2%	0%	3%	2%	2%	2%	3%	33%	2%	8%
Avg. number of Acute and Chronic Condition	6.0	6.0	5.5	4.6	5.0	4.8	4.9	4.7	4.8	4.4	2.9	4.7	5.5
<b>Activity Measure</b>													
Emergency Admissions	0.5	1.0	4.5	0.4	0.0	0.3	0.5	0.6	0.5	0.3	0.1	0.4	0.6
A&E Attendances	1.5	1.0	5.0	0.8	0.0	0.7	1.0	1.1	0.9	0.8	0.1	0.9	0.9
GP Encounters	168.0	156.3	132.0	113.8	145.0	111.0	120.8	130.0	115.1	108.3	67.9	114.9	103.4
Admitted Bed Days	0.5	4.7	13.5	3.8	0.0	1.7	4.8	3.1	3.0	1.9	0.0	2.7	4.2
<b>Physical Health</b>													
Asthma	100.0%	33.3%	0.0%	23.9%	100.0%	28.6%	24.9%	21.6%	20.1%	22.1%	28.6%	22.9%	25.2%
Cancer	0.0%	0.0%	0.0%	25.0%	0.0%	30.8%	30.6%	26.3%	25.1%	29.5%	14.3%	27.8%	32.8%
Chronic Cardiac Disease	50.0%	66.7%	0.0%	29.5%	100.0%	37.6%	45.1%	41.4%	43.6%	36.6%	14.3%	39.0%	47.5%
Chronic Respiratory Disease	50.0%	0.0%	0.0%	21.6%	0.0%	23.3%	19.7%	19.8%	16.6%	16.4%	0.0%	18.4%	22.2%
CKD	0.0%	0.0%	0.0%	17.0%	0.0%	21.1%	17.9%	12.4%	15.2%	14.6%	14.3%	15.6%	20.7%
Heart Disease	0.0%	33.3%	0.0%	27.3%	0.0%	29.7%	39.3%	35.2%	38.5%	30.4%	0.0%	33.0%	39.1%
Hypertension	100.0%	100.0%	100.0%	69.3%	100.0%	73.3%	78.6%	74.9%	74.5%	73.2%	57.1%	73.9%	74.5%
Diabetes	50.0%	66.7%	0.0%	32.4%	0.0%	38.7%	35.3%	32.8%	33.3%	31.7%	14.3%	33.4%	42.8%
Obesity	0.0%	0.0%	50.0%	30.7%	100.0%	32.7%	33.5%	27.5%	27.1%	25.3%	42.9%	28.1%	32.8%
Rheumatoid Arthritis	0.0%	0.0%	0.0%	3.4%	0.0%	5.3%	5.2%	4.1%	5.1%	4.2%	0.0%	4.5%	5.3%
Stroke	0.0%	33.3%	50.0%	26.7%	100.0%	30.1%	22.0%	26.9%	27.7%	22.6%	14.3%	25.6%	34.5%
<b>Mental Health</b>													
Anxiety	50.0%	0.0%	50.0%	31.3%	0.0%	33.5%	27.7%	29.0%	25.1%	26.8%	28.6%	28.1%	29.0%
Depression	0.0%	33.3%	50.0%	35.2%	100.0%	39.5%	36.4%	32.8%	32.0%	32.8%	42.9%	34.0%	33.6%
Dementia	50.0%	33.3%	50.0%	14.8%	0.0%	3.8%	8.7%	13.3%	16.6%	9.5%	14.3%	11.3%	18.6%
Serious Mental Illness	0.0%	33.3%	0.0%	2.8%	0.0%	1.9%	1.7%	2.4%	3.6%	1.8%	0.0%	2.4%	6.5%
Low Mood	50.0%	0.0%	0.0%	19.9%	100.0%	25.6%	17.3%	16.9%	18.3%	15.9%	0.0%	18.2%	18.5%
Suicide	0.0%	0.0%	0.0%	1.1%	0.0%	0.8%	1.7%	0.9%	2.0%	0.8%	0.0%	1.2%	1.5%
Mental Health Flag	100.0%	33.3%	50.0%	48.3%	100.0%	53.8%	48.6%	46.4%	44.7%	44.4%	42.9%	46.7%	48.8%
<b>Screening and Verification Refusal</b>													
Bowel Screening Refused	0.0%	0.0%	50.0%	27.3%	0.0%	32.0%	30.1%	22.8%	19.0%	21.5%	28.6%	23.6%	25.5%
Cervical Screening Refused	0.0%	0.0%	0.0%	0.6%	0.0%	6.0%	8.7%	2.4%	1.8%	2.2%	14.3%	3.0%	3.6%
Flu Vaccine Refused	50.0%	33.3%	0.0%	22.7%	0.0%	18.8%	20.2%	23.7%	22.6%	18.7%	14.3%	20.8%	26.4%
<b>Wider Indicators</b>													
Has A Carer	0.0%	0.0%	0.0%	12.5%	0.0%	6.4%	5.2%	7.1%	9.4%	7.5%	0.0%	7.8%	19.0%
Is A Carer	0.0%	0.0%	0.0%	8.0%	0.0%	14.7%	11.0%	9.2%	11.0%	11.5%	0.0%	11.0%	11.9%
MED3 Not Fit For Work (ever)	0.0%	0.0%	50.0%	15.9%	100.0%	16.2%	19.7%	11.5%	11.2%	12.2%	0.0%	13.3%	13.4%
MED3 Not Fit For Work (in Last Year)	0.0%	0.0%	0.0%	4.0%	0.0%	4.5%	5.8%	3.6%	2.0%	2.6%	0.0%	3.2%	3.5%
MED3 Not Fit For Work (in Last Six Months)	0.0%	0.0%	0.0%	3.4%	0.0%	4.5%	4.0%	2.1%	2.0%	1.6%	0.0%	2.5%	2.8%
Avg. number of eFI Deficits	14.0	16.7	15.5	14.5	13.0	14.9	14.8	14.4	14.4	14.3	12.7	14.5	13.4
eFI_Housebound	0.0%	33.3%	0.0%	10.2%	0.0%	9.8%	9.8%	11.2%	11.6%	12.3%	0.0%	11.3%	10.9%
eFI_SocialVulnerability	50.0%	33.3%	0.0%	31.3%	0.0%	29.3%	36.4%	29.0%	27.1%	24.7%	14.3%	27.9%	27.3%
People_ChildrenInPoverty	32.6	30.0								8.5		23.7	15.5
Housing_FuelPoverty	17.5	14.7	15.0	14.6	8.0	14.8	12.7	11.0	10.7	8.0		10.8	11.1
Housing_OnePersonHousehold	29.2	36.9	28.2	36.7	34.2	29.3	26.3	31.3	38.2	26.3		30.8	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 Hertford and Rurals 8.5% 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 Hertford and Rurals PCN is lower than the ICB, and the data shows higher usage of GP services.

Within this segment we can see the presence of Obesity, Chronic Cardiac Disease, Heart Disease and Diabetes 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 and just lower than the ICB.

# 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  $\rightarrow 2^5 = 32$  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.

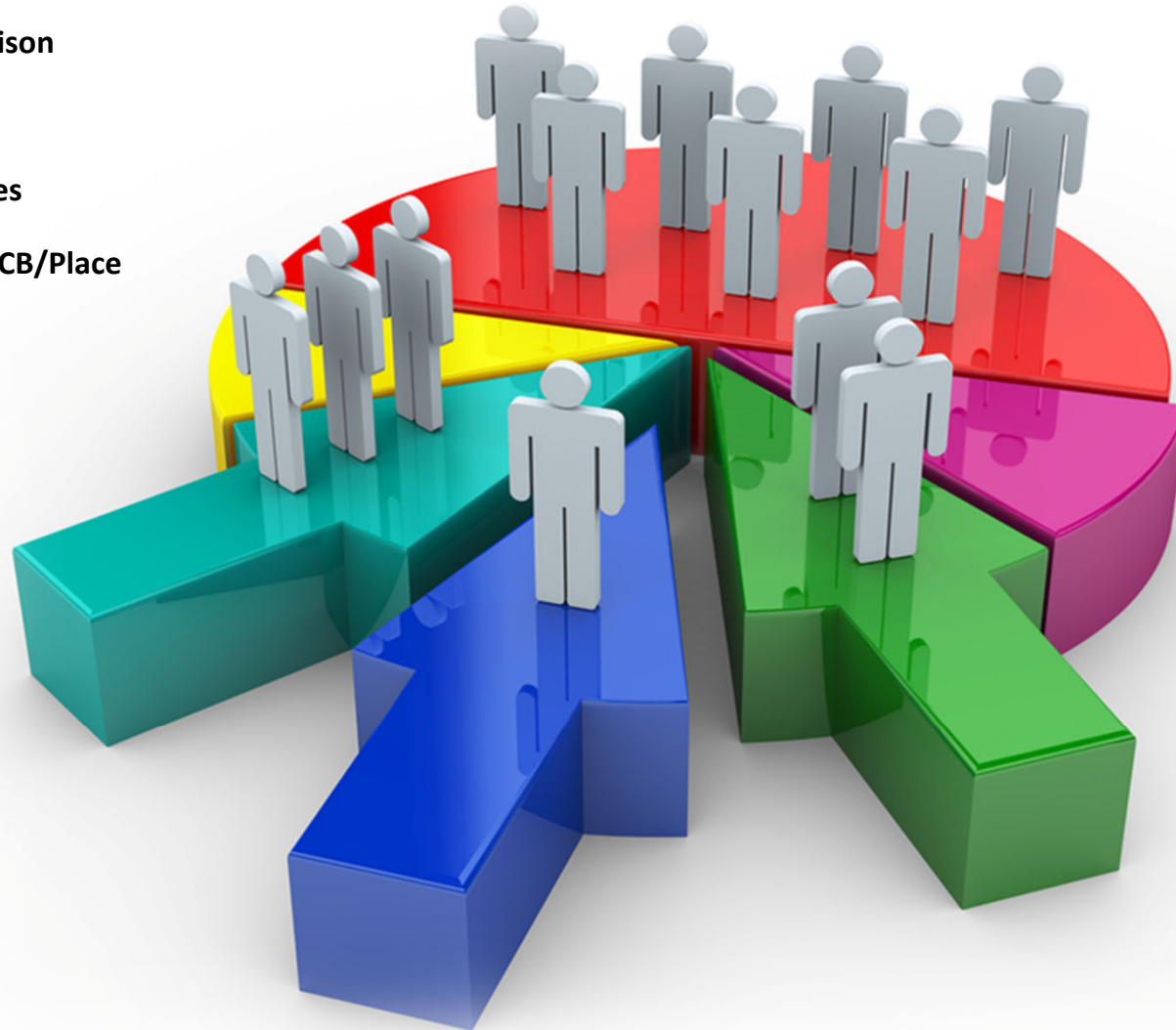
Feature	Relative significance (%)
Age	15.03
Drug: Pain Management	10.22
Substance Abuse	4.19
Med3 Not Fit For Work	3.41
Stroke	3.03
eFI: Falls	2.23
Air Rank Quality	2.01
Waiting List Count All	1.83
...	...

Risk Grade: High	Age < 3 AND Drug: Salbutamol AND eFI: Dyspnoea
	Med3 Not Fit For Work (last six months) AND Substance Abuse AND ONE OF:- <ul style="list-style-type: none"><li>• Drug: Pain Management AND eFI: Peptic Ulcer</li><li>• Chronic Cardiac Disease</li></ul>
	Drug: Pain Management AND eFI: Falls AND ONE OF:- <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	Age < 3 AND ONE OF:- <ul style="list-style-type: none"><li>• Drug: Salbutamol AND NO eFI: Dyspnoea</li><li>• On any waiting list</li></ul>
	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
Risk Grade: Low	Drug: Pain Management AND Substance Abuse AND ONE OF: <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

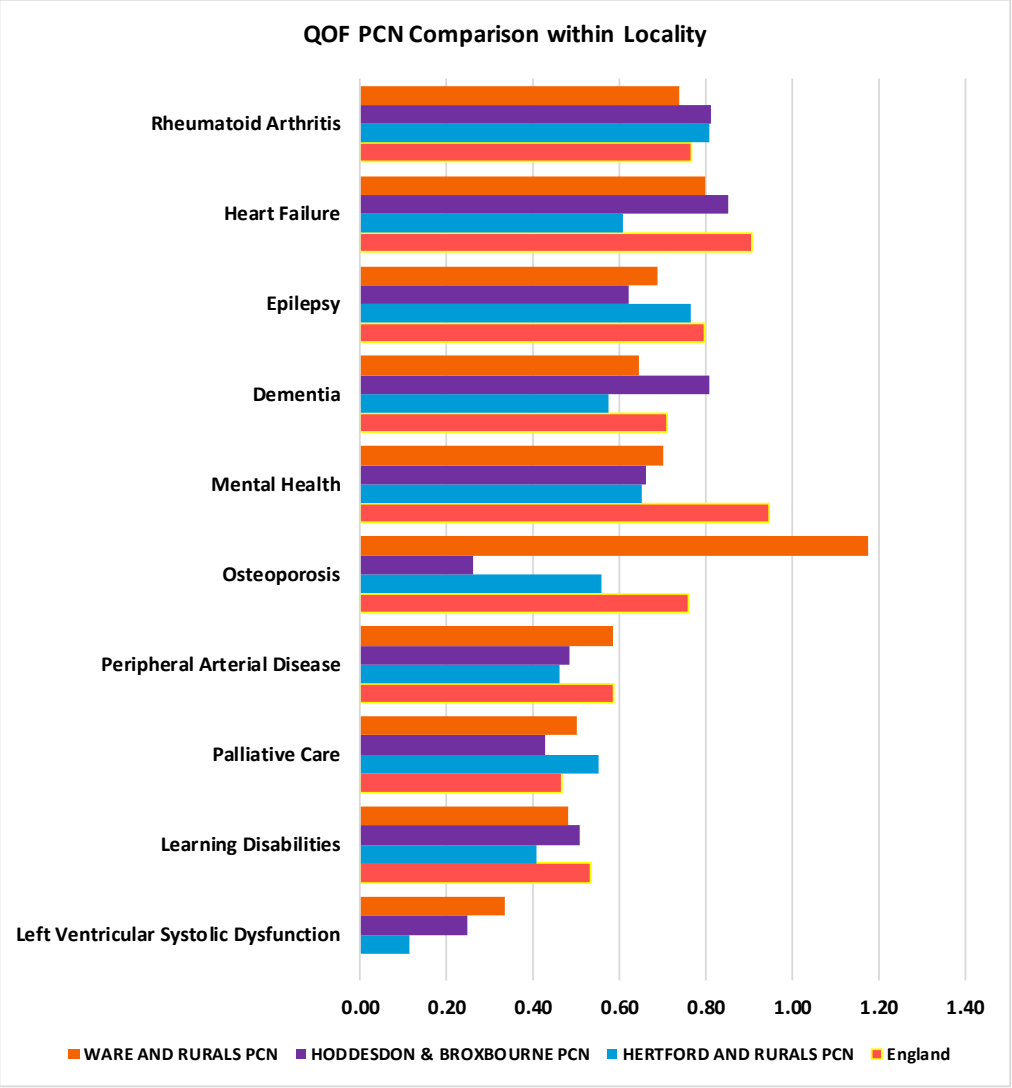
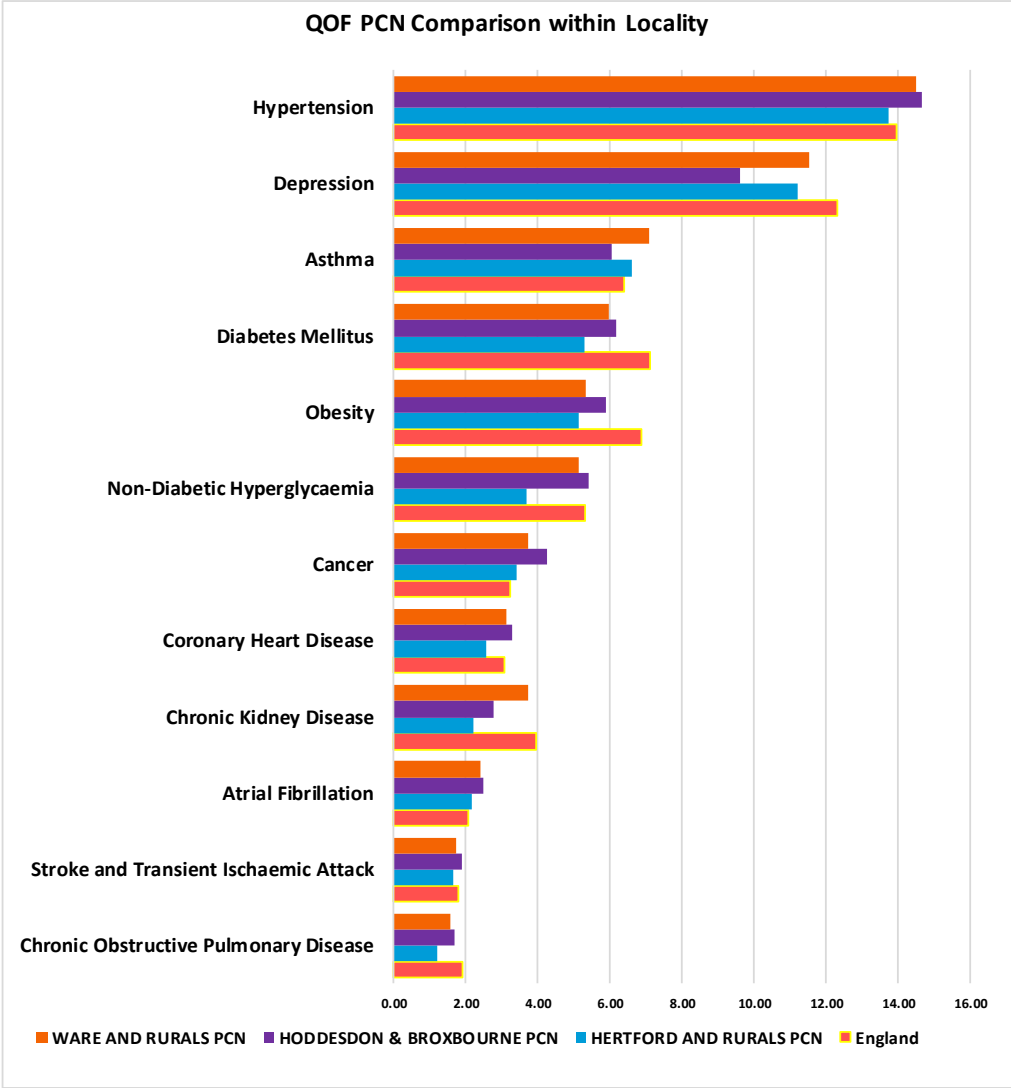
# Quality & Outcomes Framework

## 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



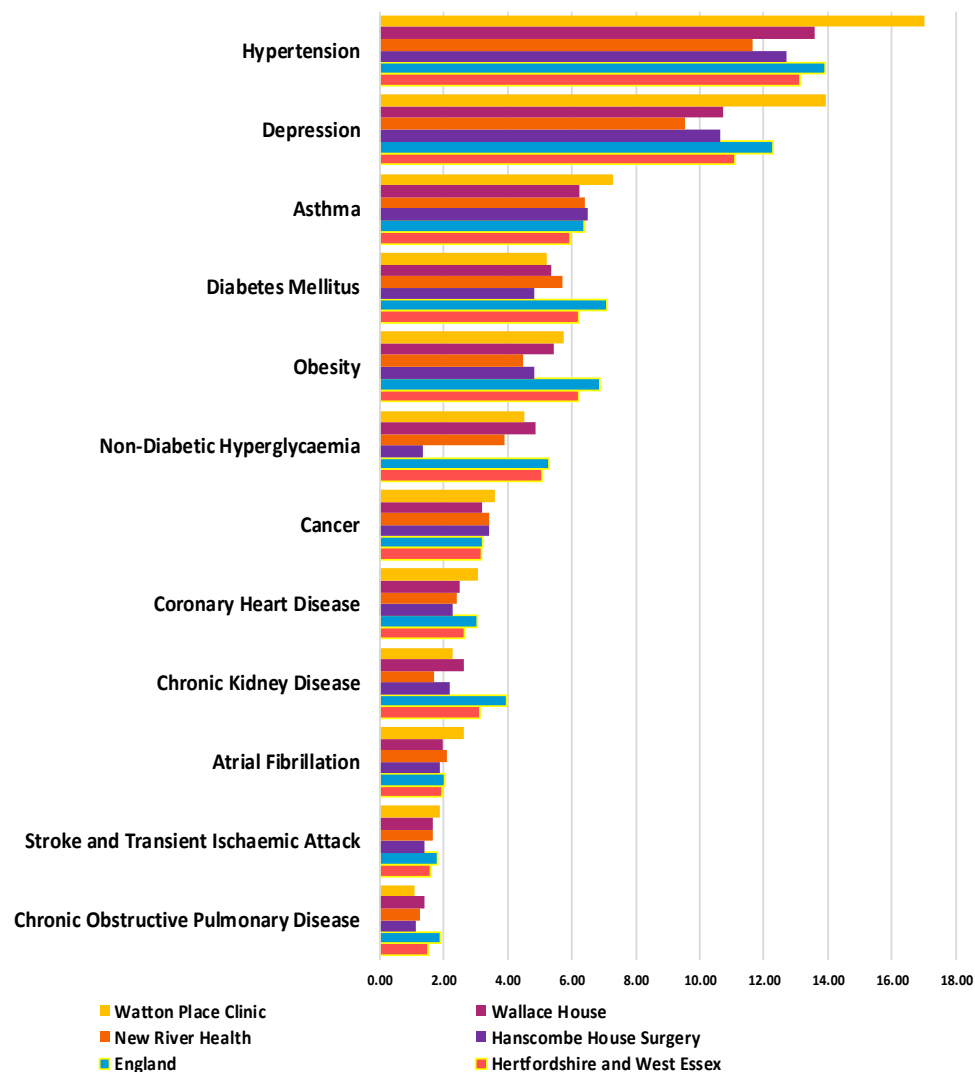
The Quality and Outcome Framework incorporates important benchmarking and scoring for all Practices across the county; we have combined a number of local, regional, and national data sets to highlight the areas that the PCN will need to consider.

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

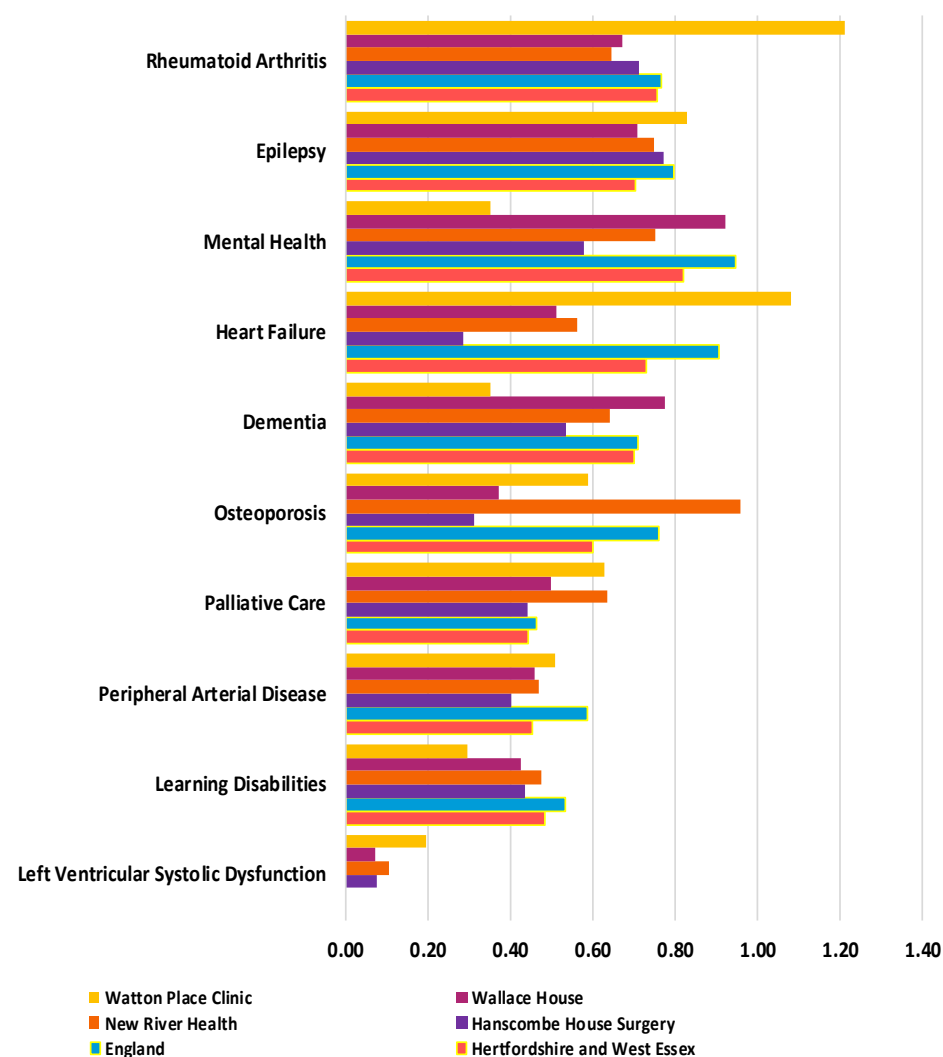


# QOF - Local, Regional, & National Comparison

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

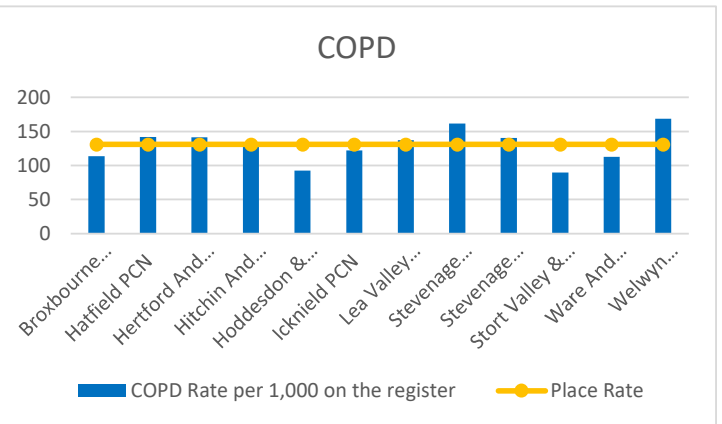
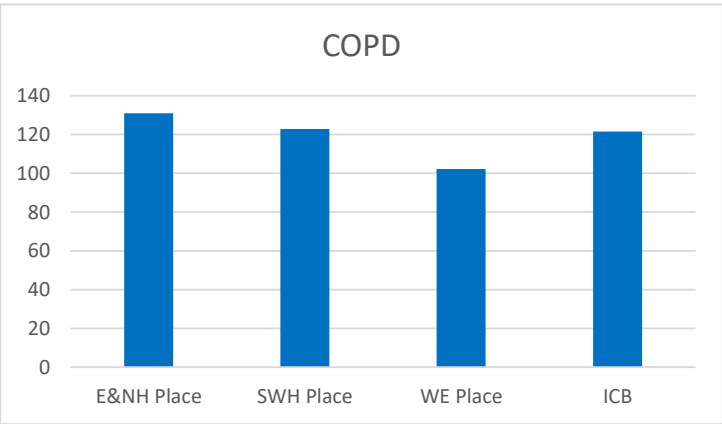
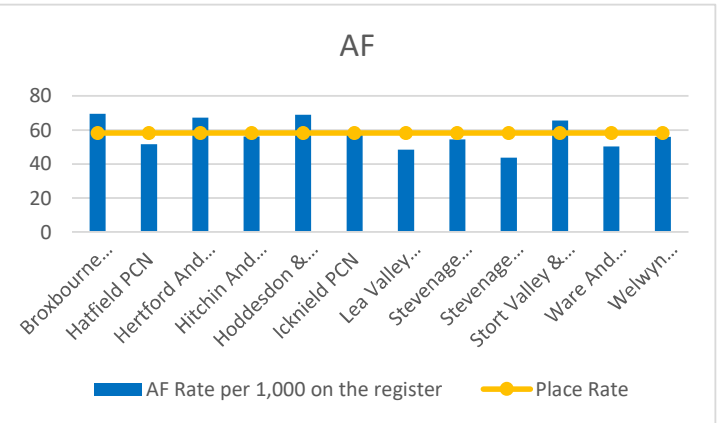
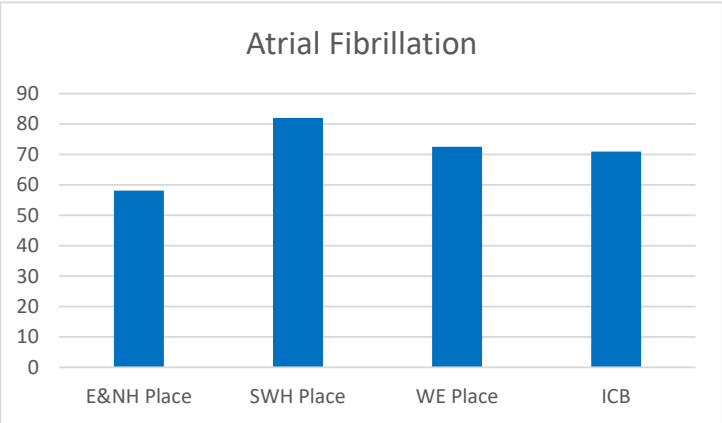
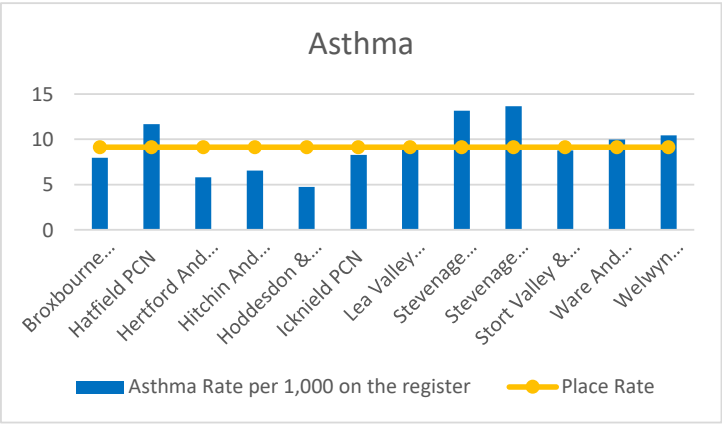
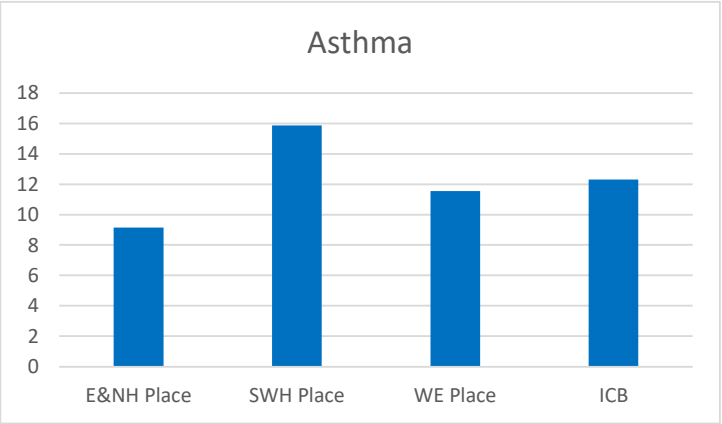
Disease	QOF List size 21-22	QOF Register 21-22	QOF Prevalence 21/22	Place prevalence	ICB prevalence	Modelled prevalence	New diagnoses to meet Place average	new diagnoses to meet ICB average	New diagnoses to meet estimated prevalence
Asthma	48304	3268	6.77%	6.39%	6.17%		-183	-289	
COPD	51733	643	1.24%	1.54%	1.49%	2.10%	151	126	443
Diabetes	41479	2288	5.52%	6.29%	6.39%	7.78%	321	361	937
Non-diabetic hyperglycaemia	40939	1646	4.02%	4.63%	5.87%	10.87%	250	757	2805
Hypertension	51733	6953	13.44%	13.25%	13.21%		-96	-118	
Atrial Fibrillation	51733	1116	2.16%	2.01%	2.02%	2.70%	-74	-70	281
Stroke and TIA	51733	883	1.71%	1.70%	1.61%		-4	-51	
Coronary Heart Disease	51733	1256	2.43%	2.62%	2.65%		101	116	
Heart failure	51733	316	0.61%	0.71%	0.75%	1.35%	52	75	381
Left Ventricular Systolic Dysfunction	51733	56	0.11%	0.20%	0.30%		47	99	
Chronic Kidney Disease	40939	869	2.12%	2.53%	3.21%		167	444	
Peripheral Arterial Disease	51733	229	0.44%	0.46%	0.44%		8	0	
Cancer	51733	1827	3.53%	3.33%	3.35%		-105	-96	
Palliative care	51733	241	0.47%	0.50%	0.43%		18	-19	

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



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

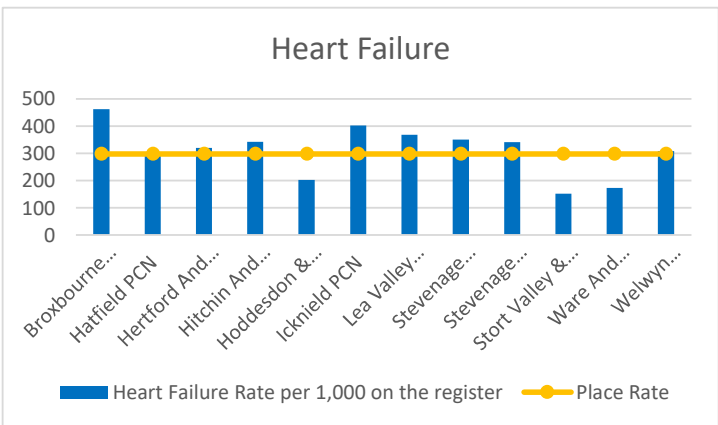
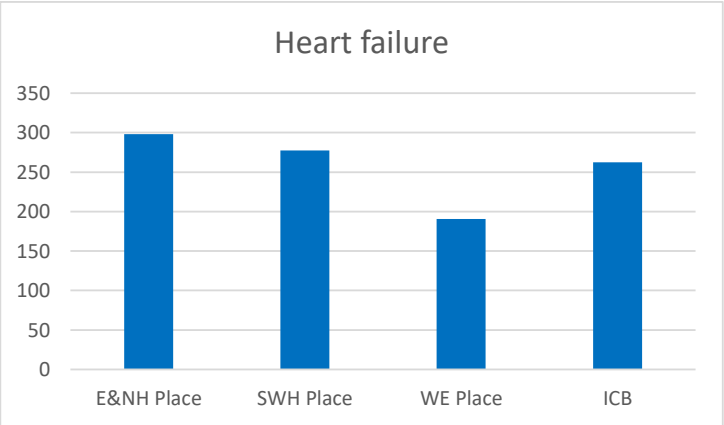
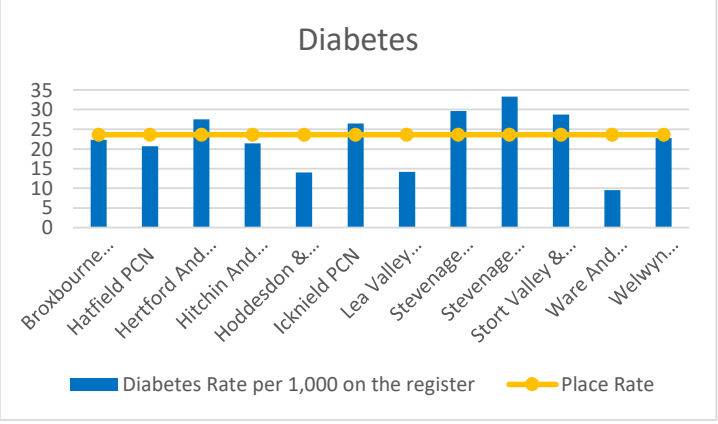
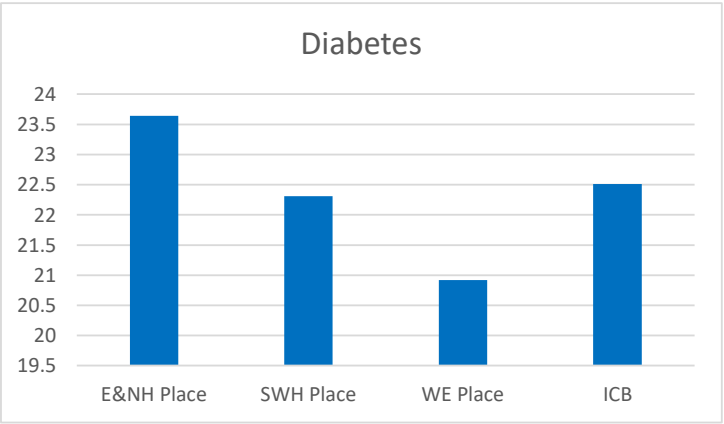
It shows the places compared with the ICB on the left and on the right it show the PCNs within a Place.

These are continued on the following place.

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

For Hertford and Rurals the data shows higher AF, COPD, Diabetes and HF rates which was identified as a theme within the ACS analysis.

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



# 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		Other Ethnic Groups		Asian			Asian or Asian British			Black			Mixed			Other			White			Unknown			Grand Total
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	Low Complexity	Middle Complexity	High Complexity	Low Complexity	Middle Complexity	High Complexity	
Overall Population Measures																									
Population		413	82	387	166	19	29	16		260	155		364	152	7	411	256	18	19,554	16,465	1,991	6,591	2,216	30	49,588
Age		36	48	30	47	67	35	54	68	30	43	73	19	37	56	30	49	73	32	52	73	33	49	76	41
Male %		52.1%	48.8%	45.2%	38.0%	31.6%	69.0%	37.5%	0.0%	49.2%	52.3%	80.0%	49.7%	36.8%	28.6%	51.8%	48.8%	50.0%	51.5%	44.7%	48.8%	56.0%	54.3%	46.7%	49.7%
IMD		8.6	8.4	8.3	8.2	8.5	8.5	8.2	10.0	7.8	7.6	8.4	8.1	8.0	9.0	8.1	8.2	7.9	8.4	8.3	8.2	8.5	8.5	8.9	8.4
% BAME (where recorded)		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	0%	0%	0%				7%
Multimorbidity (acute & chronic)		0.0	1.4	0.0	1.6	6.9	0.0	1.6	6.0	0.0	1.7	6.0	0.0	1.6	6.1	0.0	1.7	6.6	0.0	1.8	6.3	0.0	1.5	5.7	1.0
Finance and Activity Measures																									
Spend	Total	£0.0M	£0.0M	£0.1M	£0.1M	£0.1M	£0.0M	£0.0M	£0.0M	£0.1M	£0.1M	£0.0M	£0.1M	£0.1M	£0.1M	£0.2M	£0.2M	£0.1M	£6.2M	#####	£7.2M	£0.6M	£0.6M	£0.1M	#####
	PPPY - Total	£110	£180	£318	£843	£4,536	£314	£332	£172	£236	£958	£3,027	£337	£761	#####	£499	£952	£4,196	£317	£830	£3,626	£92	£256	£3,469	£603
Acute Elective		£20	£35	£87	£358	£1,604	£38	£168	£0	£105	£424	£1,338	£76	£298	£9,353	£191	£462	£841	£113	£394	£1,312	£17	£83	£936	£246
Acute Non-Elective		£28	£13	£149	£298	£2,490	£198	£23	£0	£49	£349	£1,260	£167	£295	£2,804	£202	£273	£2,957	£112	£248	£1,888	£14	£33	£2,049	£219
GP Encounters		£61	£132	£83	£187	£442	£78	£142	£172	£81	£184	£429	£94	£169	£328	£106	£217	£398	£92	£189	£426	£61	£140	£485	£138
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		20	41	24	57	137	26	47	57	25	56	136	28	49	99	29	57	132	26	52	118	16	32	93	38
Beddays PPPY - Acute EM		0	0	0	0	5	0	0	0	0	0	1	0	0	3	0	1	7	0	0	4	0	0	3	0
Physical Health																									
Diabetes		0.0%	18.3%	0.0%	25.9%	57.9%	0.0%	31.3%	100.0%	0.0%	18.1%	80.0%	0.0%	10.5%	57.1%	0.0%	14.1%	44.4%	0.0%	12.8%	43.5%	0.0%	8.6%	53.3%	6.7%
COPD		0.0%	0.0%	0.0%	0.6%	26.3%	0.0%	0.0%	0.0%	0.0%	0.0%	20.0%	0.0%	0.7%	0.0%	0.0%	1.6%	27.8%	0.0%	1.7%	26.5%	0.0%	0.6%	16.7%	1.7%
Chronic Respiratory Dis...		0.0%	0.0%	0.0%	1.8%	42.1%	0.0%	0.0%	0.0%	0.0%	1.9%	20.0%	0.0%	1.3%	14.3%	0.0%	2.3%	33.3%	0.0%	3.1%	32.7%	0.0%	1.1%	26.7%	2.5%
Hypertension		0.0%	20.7%	0.0%	29.5%	73.7%	0.0%	50.0%	100.0%	0.0%	31.0%	100.0%	0.0%	12.5%	57.1%	0.0%	23.4%	77.8%	0.0%	29.4%	80.6%	0.0%	27.2%	70.0%	14.7%
Obesity		1.0%	11.0%	2.8%	11.4%	21.1%	10.3%	0.0%	100.0%	5.4%	11.6%	20.0%	3.8%	8.6%	14.3%	5.1%	9.0%	27.8%	7.2%	19.1%	31.8%	3.2%	10.6%	26.7%	11.7%
Mental Health																									
Anxiety/Phobias		0.0%	22.0%	0.0%	14.5%	36.8%	0.0%	6.3%	100.0%	0.0%	16.8%	20.0%	0.0%	27.0%	57.1%	0.0%	24.2%	50.0%	0.0%	26.4%	37.8%	0.0%	23.4%	26.7%	11.7%
Depression		0.0%	24.4%	0.0%	16.3%	52.6%	0.0%	18.8%	100.0%	0.0%	27.1%	20.0%	0.0%	26.3%	28.6%	0.0%	30.5%	44.4%	0.0%	31.2%	45.2%	0.0%	27.7%	33.3%	13.9%
Learning Disability		0.0%	2.4%	0.0%	1.2%	5.3%	0.0%	0.0%	0.0%	0.0%	2.6%	0.0%	0.0%	2.6%	0.0%	0.0%	2.7%	0.0%	0.0%	1.2%	2.4%	0.0%	1.4%	0.0%	0.6%
Dementia		0.0%	0.0%	0.0%	1.8%	21.1%	0.0%	6.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.7%	14.3%	0.0%	0.8%	22.2%	0.0%	0.8%	10.6%	0.0%	0.8%	13.3%	0.8%
Other Characteristics																									
Housebound (eFI)		0.0%	0.0%	0.3%	0.0%	10.5%	0.0%	0.0%	0.0%	0.0%	0.0%	20.0%	0.0%	0.0%	0.0%	0.0%	0.0%	11.1%	0.0%	1.0%	9.1%	0.1%	0.6%	16.7%	0.8%
Social Vulnerability (eFI)		0.7%	2.4%	0.8%	4.2%	10.5%	3.4%	6.3%	0.0%	1.5%	5.2%	40.0%	0.0%	3.9%	0.0%	0.5%	3.1%	11.1%	0.5%	4.3%	23.8%	0.2%	2.2%	6.7%	2.8%
History of Smoking (Tw...		8.7%	11.0%	3.4%	15.1%	26.3%	3.4%	18.8%	0.0%	3.5%	18.7%	0.0%	3.0%	10.5%	0.0%	6.3%	18.8%	11.1%	5.0%	15.7%	21.7%	2.8%	8.9%	16.7%	9.3%
Not Fit for Work (In Year)		1.2%	7.3%	2.6%	6.6%	21.1%	3.4%	12.5%	0.0%	3.8%	9.7%	0.0%	1.6%	7.9%	0.0%	5.4%	10.9%	11.1%	2.2%	6.8%	4.0%	1.0%	4.8%	10.0%	3.9%
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

Integrated Care Board																	
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)	
Overall Population Measures																	
Population		18,046	605	1,214	3,601	4,720	1,865	257	4,266	5,721	6,248	513	379	1,753	89	311	49,588
Age		29	15	19	46	45	40	49	51	45	51	68	68	75	85	74	41
Male %		55.8%	26.9%	54.4%	51.9%	54.9%	46.3%	51.8%	46.9%	43.0%	40.7%	44.8%	53.3%	38.8%	22.5%	42.8%	49.7%
IMD		8.4	8.4	8.4	8.3	8.5	8.2	8.2	8.3	8.3	8.3	8.1	8.0	8.2	8.0	8.3	8.4
% BAME (where recorded)		10%	11%	9%	8%	6%	6%	8%	4%	6%	4%	3%	4%	2%	6%	3%	7%
Multimorbidity (acute & chronic)		0.0	0.0	0.0	0.0	1.0	1.0	0.4	2.4	1.1	1.9	2.4	4.5	4.6	5.2	4.7	1.0
Finance and Activity Measures																	
Spend ▼	Total	£1.7M	£0.7M	£1.7M	£1.7M	£2.3M	£0.7M	£0.1M	£3.1M	£3.5M	£5.9M	£0.6M	£1.2M	£4.6M	£0.4M	£1.7M	£29.9M
	PPPY - Total	£97	£1,160	£1,413	£465	£495	£367	£468	£727	£604	£948	£1,217	£3,063	£2,621	£3,948	£5,428	£603
Acute Elective		£23	£223	£601	£174	£231	£128	£210	£332	£278	£470	£353	£1,324	£920	£276	£2,114	£246
Acute Non-Elective		£9	£788	£662	£164	£128	£118	£133	£211	£171	£284	£563	£1,395	£1,330	£3,178	£2,766	£219
GP Encounters		£64	£149	£149	£127	£136	£122	£124	£184	£156	£194	£300	£344	£371	£494	£548	£138
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		18	44	42	35	35	33	33	48	43	56	78	94	106	158	151	38
Beddays PPPY - Acute EM		0	1	1	0	0	0	0	0	0	0	1	3	2	5	6	0
Physical Health																	
Diabetes ▼		0.0%	0.0%	0.0%	0.0%	9.3%	0.0%	1.2%	14.4%	9.1%	14.2%	17.3%	20.1%	35.4%	28.1%	23.5%	6.7%
COPD ▼		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.2%	0.6%	2.5%	3.3%	55.9%	14.5%	9.0%	19.3%	1.7%
Chronic Respiratory Dis... ▼		0.0%	0.0%	0.0%	0.0%	2.0%	0.0%	0.4%	3.4%	1.2%	4.1%	4.7%	63.6%	17.9%	11.2%	23.8%	2.5%
Hypertension ▼		0.0%	0.0%	0.0%	0.0%	24.3%	0.0%	10.1%	30.0%	18.7%	28.1%	43.1%	56.5%	77.6%	57.3%	57.6%	14.7%
Obesity ▼		0.0%	0.0%	0.0%	34.1%	12.4%	9.1%	9.7%	18.4%	15.4%	21.4%	17.5%	24.8%	31.0%	6.7%	17.7%	11.7%
Mental Health																	
Anxiety/Phobias ▼		0.0%	0.0%	0.0%	0.0%	0.0%	38.2%	4.7%	47.3%	15.1%	23.4%	14.8%	20.6%	29.5%	21.3%	21.5%	11.7%
Depression ▼		0.0%	0.0%	0.0%	0.0%	0.0%	51.7%	9.7%	51.8%	17.9%	28.0%	16.6%	24.8%	35.0%	28.1%	29.9%	13.9%
Learning Disability ▼		0.0%	0.0%	0.0%	0.0%	0.0%	1.2%	0.8%	2.0%	0.4%	0.8%	16.8%	0.5%	1.3%	3.4%	0.3%	0.6%
Dementia ▼		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.4%	5.5%	3.4%	5.8%	100.0%	17.0%	0.8%
Other Characteristics																	
Housebound (eFI) ▼		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	26.3%	1.6%	9.2%	24.7%	19.3%	0.8%
Social Vulnerability (eFI) ▼		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	55.3%	2.3%	2.4%	4.0%	22.8%	12.9%	29.7%	12.4%	22.2%	2.8%
History of Smoking (Tw... ▼		0.0%	0.0%	0.0%	27.7%	10.5%	9.4%	9.7%	14.9%	10.8%	17.1%	18.5%	23.7%	20.4%	23.6%	13.8%	9.3%
Not Fit for Work (In Year) ▼		0.0%	0.0%	0.0%	10.6%	3.2%	8.6%	2.7%	8.1%	5.2%	7.7%	2.1%	7.1%	3.1%	0.0%	4.8%	3.9%
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	Low Complexity	Middle Complexity	High Complexity	Low Complexity	Middle Complexity	High Complexity	Low Complexity	Middle Complexity	High Complexity	
Overall Population Measures																			
Population		570	48	8	481	48		1,041	101	1,455	194		4,335	800		20,127	18,317	2,059	49,588
Age		32	45	77	24	31	26	19	32	21	33	52	26	35	68	35	52	73	41
Male %		64.2%	75.0%	37.5%	62.6%	75.0%	100.0%	59.1%	72.3%	59.8%	68.0%	100.0%	60.8%	67.4%	100.0%	49.2%	44.3%	48.5%	49.7%
IMD		7.5	7.0	6.8	8.6	8.5	10.0	8.4	8.3	8.4	8.0	4.0	8.4	8.3	9.0	8.4	8.3	8.2	8.4
% BAME (where recorded)		11%	15%	0%	22%	7%	0%	10%	3%	11%	9%	0%	9%	4%	0%	8%	5%	2%	7%
Multimorbidity (acute & chronic)		0.0	1.6	5.8	0.0	1.1	9.0	0.0	1.3	0.0	1.2	7.0	0.0	1.2	5.0	0.0	1.8	6.3	1.0
Finance and Activity Measures																			
Spend	Total	£0.0M	£0.0M	£0.0M	£0.0M	£0.0M	£0.0M	£0.0M	£0.0M	£0.0M	£0.0M	£0.0M	£0.3M	£0.1M	£0.0M	£7.0M	£14.8M	£7.6M	£29.9M
	PPPY - Total	£34	£433	£1,097	£6	£4	£4	£16	£21	£32	£24	£425	£58	£70	£51	£350	£809	£3,681	£603
Acute Elective		£8	£153	£210	£1	£0	£0	£4	£9	£7	£5	£0	£13	£16	£0	£120	£379	£1,339	£246
Acute Non-Elective		£26	£279	£886	£1	£0	£0	£3	£2	£9	£1	£407	£15	£21	£0	£120	£237	£1,913	£219
GP Encounters		£0	£0	£0	£4	£4	£4	£9	£10	£16	£17	£18	£30	£33	£51	£110	£193	£429	£138
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	5	5	5	8	8	9	31	53	118	38
Beddays PPPY - Acute EM		0	0	1	0	0	0	0	0	0	0	43	0	0	0	0	0	4	0
Physical Health																			
Diabetes		0.0%	4.2%	25.0%	0.0%	0.0%	100.0%	0.0%	1.0%	0.0%	1.0%	0.0%	0.0%	1.8%	0.0%	0.0%	13.2%	44.1%	6.7%
COPD		0.0%	0.0%	50.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.3%	0.0%	0.0%	1.6%	26.2%	1.7%
Chronic Respiratory Dis...		0.0%	0.0%	50.0%	0.0%	2.1%	0.0%	0.0%	2.0%	0.0%	0.5%	100.0%	0.0%	1.4%	0.0%	0.0%	2.9%	32.5%	2.5%
Hypertension		0.0%	20.8%	87.5%	0.0%	2.1%	100.0%	0.0%	5.0%	0.0%	10.8%	100.0%	0.0%	9.3%	100.0%	0.0%	30.2%	80.2%	14.7%
Obesity		0.2%	6.3%	12.5%	0.6%	2.1%	0.0%	0.4%	3.0%	0.5%	2.1%	0.0%	2.3%	4.1%	0.0%	7.8%	18.7%	31.7%	11.7%
Mental Health																			
Anxiety/Phobias		0.0%	16.7%	25.0%	0.0%	25.0%	100.0%	0.0%	21.8%	0.0%	15.5%	100.0%	0.0%	23.5%	0.0%	0.0%	26.1%	37.8%	11.7%
Depression		0.0%	25.0%	62.5%	0.0%	18.8%	100.0%	0.0%	25.7%	0.0%	22.2%	0.0%	0.0%	26.3%	50.0%	0.0%	30.9%	44.9%	13.9%
Learning Disability		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.5%	0.0%	0.0%	1.3%	2.4%	0.6%
Dementia		0.0%	4.2%	25.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.8%	10.7%	0.8%
Other Characteristics																			
Housebound (eFI)		0.0%	2.1%	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%	1.0%	9.3%	0.8%
Social Vulnerability (eFI)		0.5%	6.3%	25.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.2%	0.5%	0.0%	0.3%	1.4%	0.0%	0.5%	4.2%	23.3%	2.8%
History of Smoking (Tw...		0.0%	2.1%	0.0%	0.0%	2.1%	0.0%	0.9%	5.0%	1.4%	1.5%	0.0%	2.1%	5.1%	0.0%	5.7%	15.6%	21.6%	9.3%
Not Fit for Work (In Year)		0.0%	2.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.4%	0.0%	2.7%	7.1%	4.3%	3.9%
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 Deprivation	Middle Deprivation	High Deprivation	Not known	Low Deprivation	Middle Deprivation	High Deprivation	Not known	Low Deprivation	Middle Deprivation	High Deprivation	Not known	Low Deprivation	Middle Deprivation	High Deprivation	Not known	Low Deprivation	Middle Deprivation	High Deprivation	Not known	
Overall Population Measures																						
Population		15,120	4,443	137	165	7,641	2,412	70	63	7,477	2,648	51	68	5,055	2,028	30	27	1,523	616	7	7	49,588
Age		29	26	32	33	46	42	36	47	48	45	38	48	54	50	54	53	76	74	74	72	41
Male %		54.5%	55.8%	55.5%	61.8%	52.7%	50.8%	42.9%	63.5%	44.8%	44.9%	47.1%	45.6%	42.6%	39.6%	40.0%	25.9%	39.4%	37.0%	28.6%	57.1%	49.7%
IMD		9.3	5.7	2.5		9.3	5.7	2.5		9.3	5.7	2.6		9.3	5.7	2.4		9.3	5.7	2.0		8.4
% BAME (where recorded)		10%	9%	22%	16%	6%	7%	14%	14%	5%	5%	10%	2%	4%	4%	3%	9%	2%	2%	0%	33%	7%
Multimorbidity (acute & chronic)		0.0	0.0	0.0	0.0	0.6	0.7	0.5	0.7	1.6	1.7	1.5	1.5	2.0	2.1	1.7	2.1	4.6	4.8	5.9	2.9	1.0
Finance and Activity Measures																						
Spend ▾	Total	£3.2M	£0.9M	£0.0M	£0.0M	£3.5M	£1.2M	£0.0M	£0.0M	£4.9M	£1.8M	£0.0M	£0.0M	£5.4M	£2.2M	£0.0M	£0.0M	£4.6M	£2.0M	£0.0M	£0.0M	£29.9M
	PPPY - Total	£213	£199	£209	£131	£457	£478	£454	£266	£651	£663	£471	£472	£1,071	£1,098	£1,374	£878	£3,044	£3,174	£5,407	£623	£603
Acute Elective		£66	£62	£54	£42	£187	£212	£147	£96	£309	£273	£176	£205	£502	£516	£764	£318	£1,030	£1,175	£93	£210	£246
Acute Non-Elective		£74	£70	£87	£30	£138	£141	£172	£58	£171	£235	£123	£132	£357	£377	£443	£421	£1,600	£1,631	£4,597	£210	£219
GP Encounters		£74	£67	£68	£58	£132	£125	£135	£112	£171	£155	£172	£135	£212	£205	£167	£138	£414	£369	£717	£203	£138
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		20	20	18	16	35	36	41	33	44	46	44	37	58	63	60	48	115	115	153	68	38
Beddays PPPY - Acute EM		0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	3	4	6	0	0
Physical Health																						
Diabetes ▾		0.0%	0.0%	0.0%	0.0%	4.3%	4.4%	0.0%	7.9%	10.8%	12.1%	11.8%	2.9%	14.2%	16.0%	20.0%	14.8%	32.4%	35.9%	42.9%	14.3%	6.7%
COPD ▾		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.2%	1.5%	0.0%	0.0%	4.7%	7.1%	16.7%	3.7%	13.6%	18.5%	14.3%	0.0%	1.7%
Chronic Respiratory Dis... ▾		0.0%	0.0%	0.0%	0.0%	0.9%	1.2%	0.0%	0.0%	2.0%	2.2%	3.9%	0.0%	6.8%	8.4%	16.7%	3.7%	17.2%	21.8%	14.3%	0.0%	2.5%
Hypertension ▾		0.0%	0.0%	0.0%	0.0%	11.8%	9.8%	4.3%	9.5%	23.6%	22.4%	13.7%	14.7%	31.5%	29.1%	16.7%	7.4%	73.9%	73.7%	100.0%	57.1%	14.7%
Obesity ▾		0.0%	0.0%	0.0%	0.0%	18.9%	21.5%	14.3%	20.6%	15.3%	20.2%	15.7%	7.4%	20.5%	23.4%	6.7%	25.9%	26.3%	32.5%	14.3%	42.9%	11.7%
Mental Health																						
Anxiety/Phobias ▾		0.0%	0.0%	0.0%	0.0%	6.7%	7.8%	11.4%	6.3%	27.5%	30.1%	35.3%	36.8%	21.8%	24.6%	16.7%	29.6%	26.8%	31.2%	28.6%	28.6%	11.7%
Depression ▾		0.0%	0.0%	0.0%	0.0%	8.9%	11.2%	8.6%	12.7%	30.1%	36.1%	35.3%	51.5%	25.0%	31.8%	16.7%	44.4%	32.6%	37.5%	28.6%	42.9%	13.9%
Learning Disability ▾		0.0%	0.0%	0.0%	0.0%	0.1%	0.5%	0.0%	0.0%	0.9%	1.7%	3.9%	1.5%	1.5%	2.8%	0.0%	3.7%	1.1%	1.6%	14.3%	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%	1.9%	1.4%	6.7%	7.4%	12.4%	8.3%	42.9%	14.3%	0.8%
Other Characteristics																						
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%	1.9%	2.3%	0.0%	0.0%	11.9%	9.9%	14.3%	0.0%	0.8%
Social Vulnerability (eFI) ▾		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.3%	4.7%	2.0%	8.8%	5.0%	7.8%	6.7%	7.4%	26.3%	31.8%	28.6%	14.3%	2.8%
History of Smoking (Tw... ▾		0.0%	0.0%	0.0%	0.0%	16.0%	17.3%	21.4%	17.5%	10.9%	16.8%	23.5%	11.8%	15.5%	22.6%	13.3%	22.2%	18.1%	23.5%	14.3%	0.0%	9.3%
Not Fit for Work (In Year) ▾		0.0%	0.0%	0.0%	0.0%	6.5%	7.7%	12.9%	7.9%	5.8%	7.6%	17.6%	8.8%	6.5%	9.0%	6.7%	7.4%	2.6%	4.7%	0.0%	0.0%	3.9%
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		Hanscombe House Surgery				New River Health				Wallace House				Watton Place Clinic				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	Low Deprivation	Middle Deprivation	High Deprivation	Not known	
Overall Population Measures																		
Population		8,901	2,326	6	25	13,403	5,133	232	237	10,422	3,995	20	29	4,090	693	37	39	49,588
Age		41	40	31	38	41	40	37	44	42	39	43	36	44	41	33	34	41
Male %		48.2%	48.1%	33.3%	52.0%	49.5%	48.7%	51.3%	57.0%	51.2%	49.0%	40.0%	37.9%	51.6%	50.1%	40.5%	64.1%	49.7%
IMD		9.3	5.5	2.8		9.3	6.1	2.5		9.3	5.2	2.5		9.2	6.3	2.6		8.4
% BAME (where recorded)		7%	6%	0%	12%	7%	6%	17%	13%	7%	8%	6%	11%	4%	5%	10%	5%	7%
Multimorbidity (acute & chronic)		0.8	1.1	0.5	0.6	0.9	1.1	0.6	0.7	1.0	1.2	1.3	0.6	1.0	0.9	0.7	0.4	1.0
Finance and Activity Measures																		
Spend	Total	£5.0M	£1.6M	£0.0M	£0.0M	£7.6M	£3.2M	£0.1M	£0.1M	£5.9M	£2.7M	£0.0M	£0.0M	£3.2M	£0.5M	£0.0M	£0.0M	£29.9M
	PPPY - Total	£560	£672	£445	£471	£567	£633	£552	£248	£565	£674	£470	£575	£775	£682	£629	£289	£603
Acute Elective		£232	£253	£31	£100	£241	£298	£182	£95	£235	£254	£218	£292	£265	£216	£90	£91	£246
Acute Non-Elective		£207	£284	£352	£251	£215	£221	£271	£76	£210	£287	£112	£193	£191	£147	£229	£14	£219
GP Encounters		£120	£135	£62	£121	£111	£114	£99	£77	£120	£133	£139	£90	£319	£319	£309	£184	£138
Community		£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
Social Care		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
GP PPPY		34	38	18	34	40	41	36	28	39	43	46	28	32	32	30	18	38
Beddays PPPY - Acute EM		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Physical Health																		
Diabetes		5.1%	7.4%	0.0%	4.0%	6.5%	7.7%	5.2%	3.8%	7.3%	9.3%	10.0%	3.4%	6.4%	4.6%	2.7%	2.6%	6.7%
COPD		1.0%	3.6%	0.0%	0.0%	1.6%	1.9%	2.2%	0.4%	1.5%	2.9%	5.0%	0.0%	1.6%	0.3%	0.0%	0.0%	1.7%
Chronic Respiratory Dis...		1.8%	4.1%	0.0%	0.0%	2.3%	2.7%	2.6%	0.4%	2.4%	3.8%	10.0%	0.0%	2.7%	0.9%	0.0%	0.0%	2.5%
Hypertension		12.9%	15.7%	0.0%	8.0%	14.5%	14.6%	7.8%	6.8%	14.7%	15.9%	15.0%	0.0%	18.5%	17.5%	2.7%	10.3%	14.7%
Obesity		9.3%	13.8%	33.3%	12.0%	8.8%	11.4%	6.0%	8.9%	15.3%	18.9%	10.0%	6.9%	10.3%	10.4%	8.1%	5.1%	11.7%
Mental Health																		
Anxiety/Phobias		10.8%	13.7%	16.7%	12.0%	11.7%	13.7%	9.5%	12.2%	10.9%	14.8%	15.0%	13.8%	10.3%	9.2%	18.9%	7.7%	11.7%
Depression		11.9%	17.2%	16.7%	8.0%	13.0%	16.9%	7.8%	21.1%	12.6%	18.8%	20.0%	13.8%	14.4%	12.4%	21.6%	5.1%	13.9%
Learning Disability		0.3%	1.2%	0.0%	0.0%	0.6%	1.1%	1.3%	0.8%	0.4%	0.9%	0.0%	0.0%	0.3%	0.6%	0.0%	0.0%	0.6%
Dementia		0.8%	0.6%	0.0%	4.0%	0.8%	0.5%	2.2%	0.8%	0.9%	0.9%	0.0%	0.0%	0.4%	0.3%	0.0%	0.0%	0.8%
Other Characteristics																		
Housebound (eFI)		0.6%	0.7%	0.0%	0.0%	0.9%	1.0%	0.0%	0.0%	0.6%	0.8%	0.0%	0.0%	0.9%	1.2%	2.7%	0.0%	0.8%
Social Vulnerability (eFI)		1.4%	2.7%	0.0%	4.0%	3.1%	4.2%	1.7%	3.4%	2.7%	4.7%	0.0%	0.0%	1.7%	2.3%	2.7%	0.0%	2.8%
History of Smoking (Tw...		4.5%	8.6%	16.7%	0.0%	7.2%	8.8%	10.8%	8.0%	14.6%	19.0%	25.0%	13.8%	5.2%	7.6%	2.7%	5.1%	9.3%
Not Fit for Work (In Year)		3.2%	4.8%	0.0%	0.0%	3.6%	5.0%	5.2%	4.2%	3.5%	5.3%	20.0%	6.9%	4.0%	3.0%	10.8%	2.6%	3.9%
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%

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.

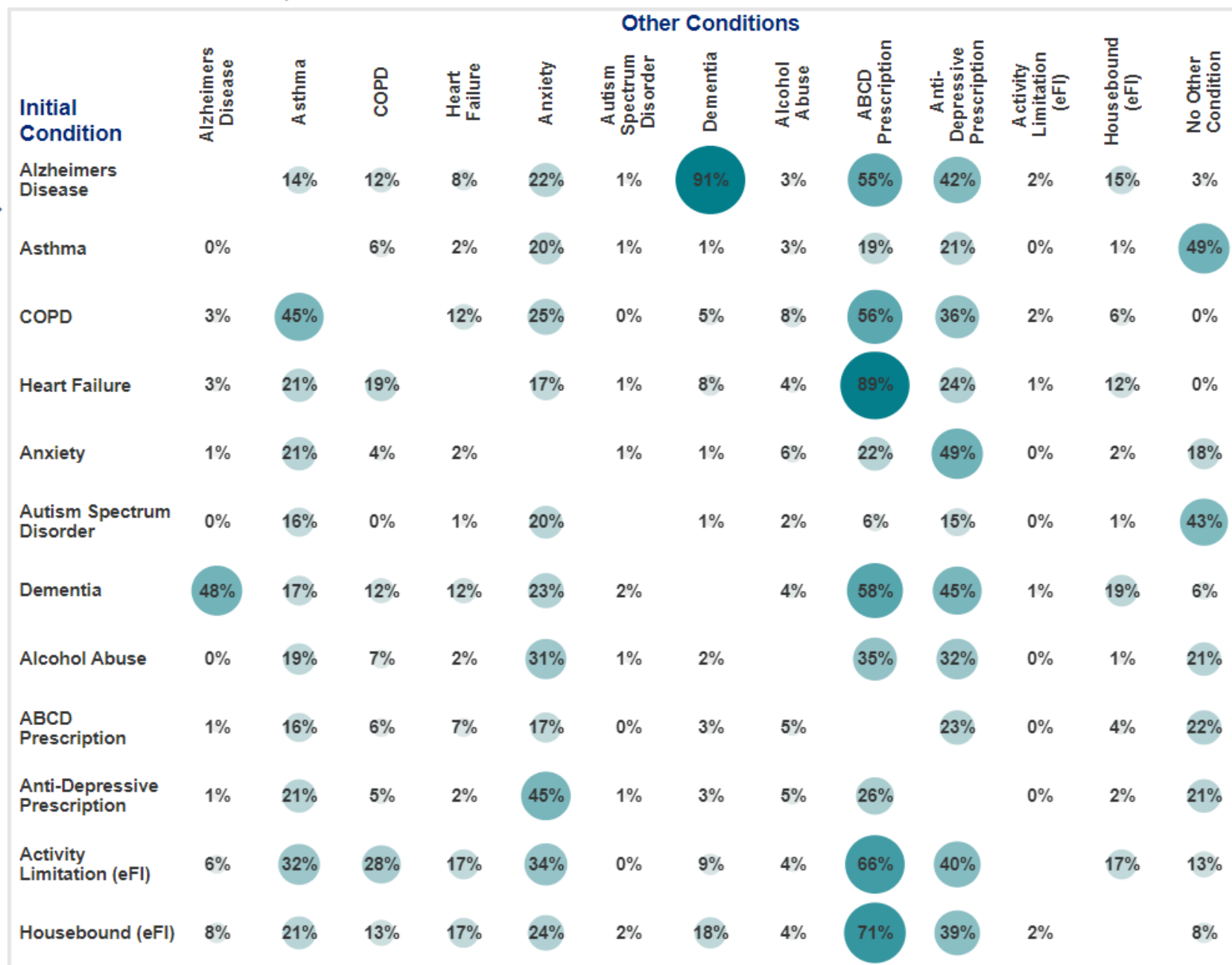


# Bubble Matrix - Conditions

x% also have

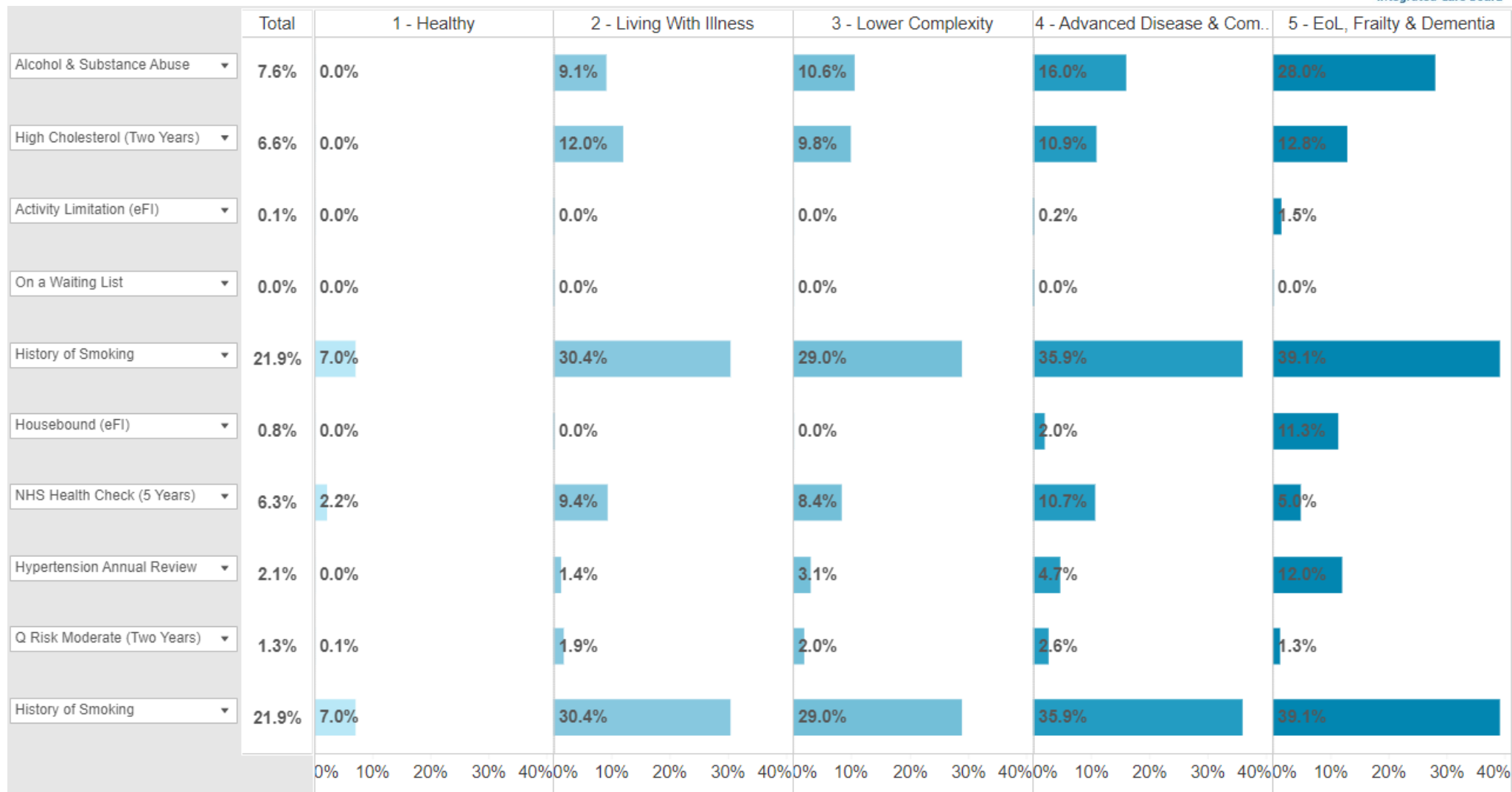


For people with this condition



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

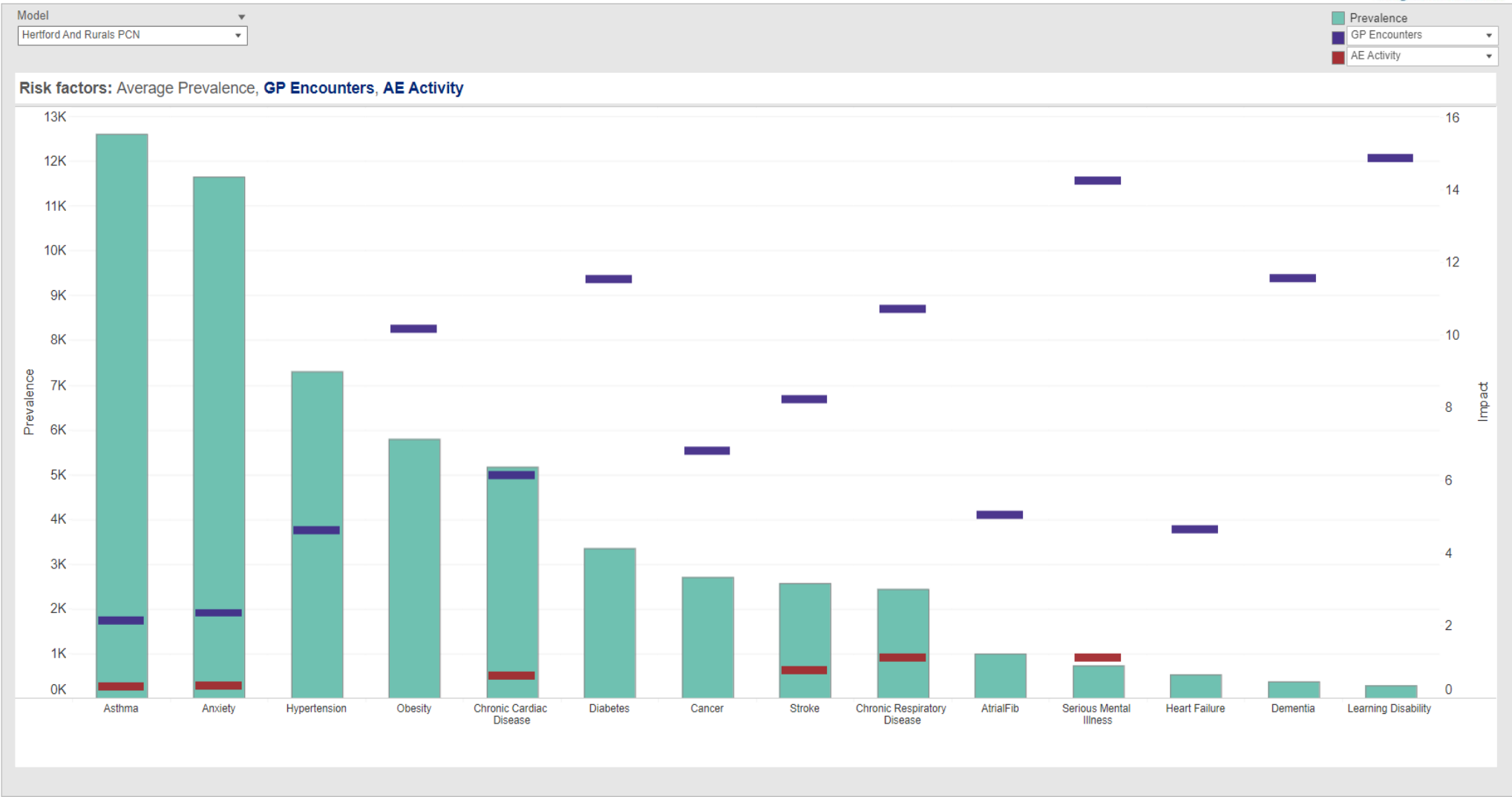


This chart gives a comparison across various selected risk conditions or characteristics, within the health segments of the PCN's population.

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	HERTFORD AND RURALS PCN	HANSCOMBE HOUSE SURGERY	WALLACE HOUSE	NEW RIVER HEALTH	WATTON PLACE CLINIC
Women, aged 25-49, with a record of cervical screening in the last 3.5 yrs (denominator includes PCAs)	2020/21	73.3	79.5	79.4	78.7	80.7	76.6
Women, aged 50-64, with a record of cervical screening in the last 5.5 yrs (denominator includes PCAs)	2020/21	78.2	80.5	78.2	82.3	80.9	79
Persons, 25-49, attending cervical screening within target period (3.5 year coverage, %)	2020/21	73	78.9	79.3	77.7	80.2	75.9
Persons, 50-64, attending cervical screening within target period (5.5 year coverage, %)	2020/21	77	79.1	77.3	80.6	79.4	77.4
Persons, 50-70, screened for breast cancer in last 36 months (3 year coverage, %)	2020/21	63.9	71.8	77.7	65.8	73.6	69
Persons, 50-70, screened for breast cancer within 6 months of invitation (Uptake, %)	2020/21	61.3	46.7	45.2	45.3	47.3	58.8
Persons, 60-74, screened for bowel cancer within 6 months of invitation (Uptake, %)	2020/21	72.1	75.6	79.8	73.7	73.9	76.6
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %)	2020/21	68.8	73.4	76.1	70.9	73.2	74.2

Similar Significantly Worse Significantly Better

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## Mortality

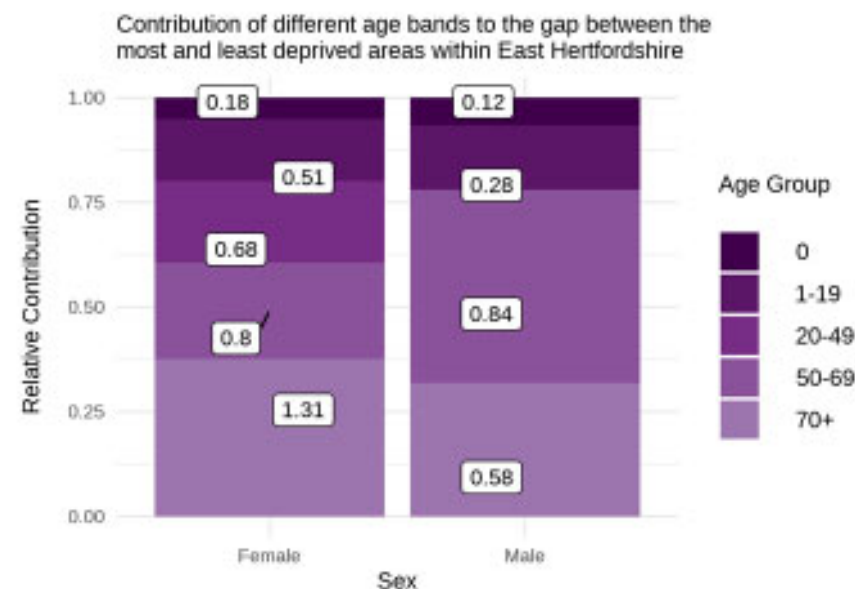
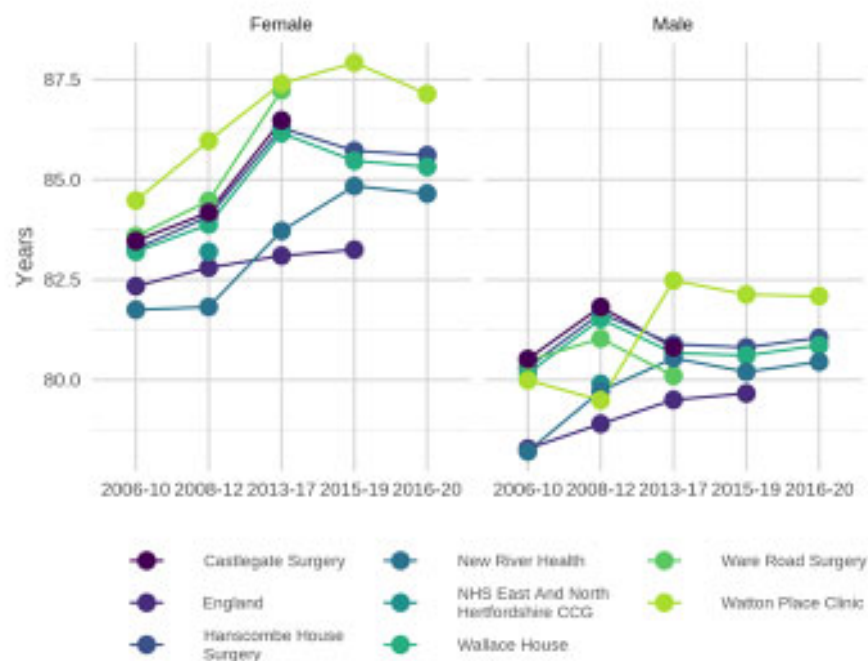
	Period	Hertfordshire CCGs	NHS HERTFORDSHIRE AND WEST ESSEX ICB - 06K	HERTFORD AND RURALS PCN
Percentage of deaths that occur at home (All age)	2021	25.3	26.8	26.8
PYLL - Neoplasms	2021	505	509.8	566.8
PYLL - Diseases of the circulatory system	2021	737.5	782.8	769.8
PYLL - All Cause	2021	1537.7	1574	1665.3
Premature Mortality - Respiratory Disease	2021	19.2	19.5	
Premature Mortality - Liver Disease	2021	14.6	14.6	
Premature Mortality - Cardiovascular Disease	2021	53.8	56.1	57.6
Premature Mortality - Cancer	2021	98.5	99.9	112
Premature Mortality - All Cause	2021	269.6	276.1	272.7

■ Similar 
 ■ Significantly Worse 
 ■ Significantly Better

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## Life Expectancy



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 3.48 years and for males is 1.43 years.

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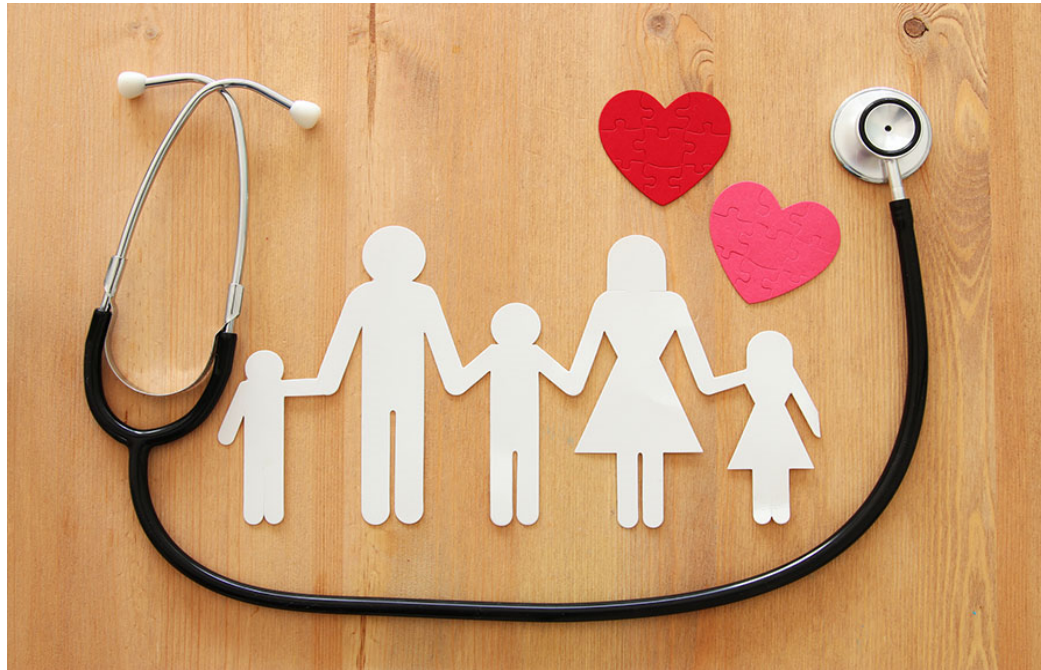




Hertfordshire and  
West Essex Integrated  
Care System



Hertfordshire and  
West Essex  
Integrated Care Board



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