



Hertfordshire and
West Essex Integrated
Care System



Hertfordshire and
West Essex
Integrated Care Board

Primary Care Networks Overview Pack

LEA VALLEY HEALTH 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.

Lea Valley Health PCN can be seen with a slightly younger population profile compared to England. The majority of people live within the 5 most deprived deciles (1-5).

28.1% population have at least 1 Long Term Condition. 5.9% 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 long term conditions, with the exception of the age category 50-64 which is slightly higher.

Wider determinants analysis from Public Health Evidence and Intelligence shows Lea Valley is one of the most deprived PCNs within the ICB across all indicators apart from Fuel poverty.

The spread of patients for Lea Valley Health PCN indicates 14.96% 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 Lea Valley adjusted for the Local Authority forecasts shows continued increase between 2023 through to 2034 which will bring additional demands for healthcare. Projections show an expected increase in the number of people over 65 from ~18k to ~20k.

When analysing the underlying Segmentation Model data the conditions with highest per 1,000 registered prevalence that are highlighted for Lea Valley Health PCN are Depression, MH, Anxiety, COPD, Cancer, Hypertension, Obesity and Chronic Cardiac disease.

Urgent & Emergency Care in 2022/23 for Lea Valley Alliance A&E Attendance rates per 1,000 population, is the 2nd highest above 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, Lea Valley has the highest rate per 1,000 population.

When looking at the ACS conditions for Lea Valley Health PCN 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 and 41-64 age group in the Advanced Disease and Complexity segment as well.

Ambulatory Care Sensitive conditions of note for people aged over 65 within the Advanced Disease and Complexity, is highlighted as Heart Failure, COPD, AF and Flutter, with the highest volume and cost. For those aged over 65 within the End of Life, Frailty & Dementia segment, Heart Failure and COPD, 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 Lea Valley 38.5% 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 Lea Valley Health PCN is slightly lower than the ICB, and the data shows higher usage of GP services.

Within this segment we can see the presence of Chronic Cardiac Disease and Heart Disease being highlighted which chimes with the reason for admission within previous analysis for ACS conditions. There is also high Diabetes, Obesity and Mental Health Flagged patients. It is to be noted that Hypertension is high across all deciles and higher than the ICB.

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

National Tool View and Population Demographics and Projections

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

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

Public Health Wider Determinants

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



PCN Demographics - NHS England

Total Population

LEA VALLEY HEALTH PCN

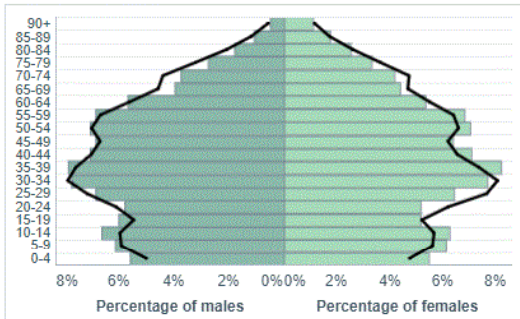
Snapshot as at: 30/06/2021

Registered population		Demographics		Prevalence		Acute utilisation		Covid	
% of total	100.0%	% White	69.2%	% with 1+ conditions	28.1%	% of annual activity (total 70,734)	100.0%	% one or more at risk conditions	17.2%
% of annual change	0.6%	% BAME	16.9%	% with 5+ conditions	3.0%	% of annual cost (total £15M)	100.0%	% two or more at risk conditions	6.4%
		% IMD top	9.0%						
		% IMD bottom	8.0%						

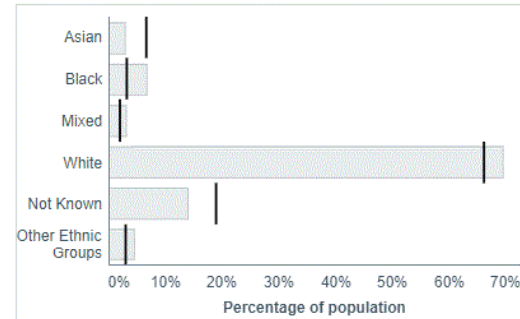
Population demographics - Snapshot as at: 30/06/2021

Choose benchmark:

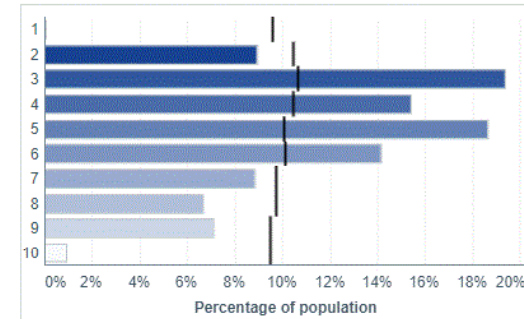
Population pyramid



Population proportion by ethnic category

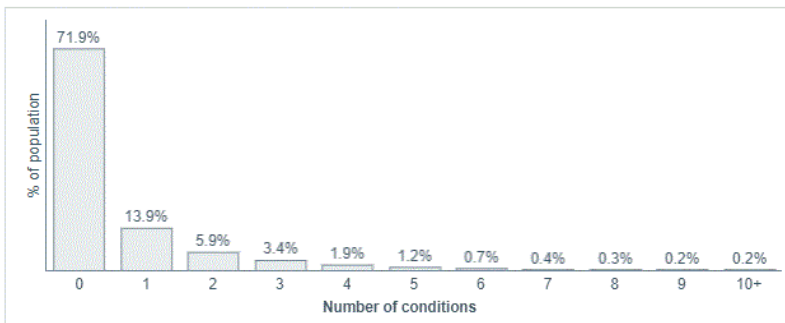


Population proportion by IM Deprivation decile



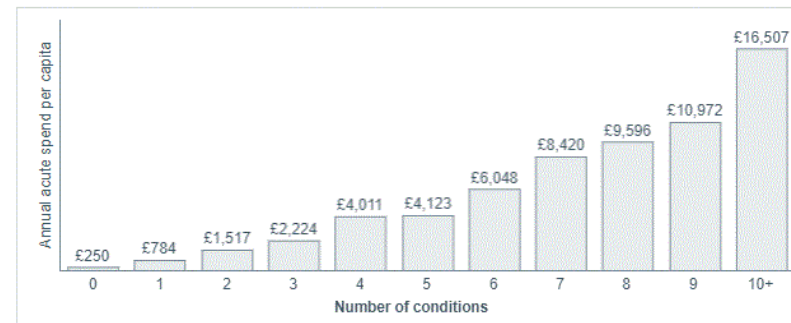
Prevalence - Snapshot as at: 30/06/2021

Population proportion by number of conditions



Annual spend per capita by number of conditions

Financial Year: 2020/21



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.

Lea Valley Health PCN can be seen with a slightly younger population profile compared to England. The majority of people live within the 5 most deprived deciles (1-5).

PCN Demographics - NHS England

LTC
LEA VALLEY HEALTH PCN

Snapshot as at: 30/06/2021

Registered population		Demographics		Prevalence		Acute utilisation		Covid	
% of total	24.8%	% White	81.8%	% with 1+ conditions	100.0%	% of annual activity (total 34,530)	48.8%	% one or more at risk conditions	53.4%
% of annual change	5.5%	% BAME	15.6%	% with 5+ conditions	5.9%	% of annual cost (total £7M)	45.3%	% two or more at risk conditions	17.0%

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

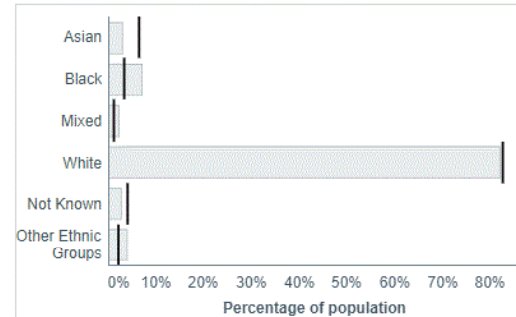
Choose benchmark:

Population pyramid



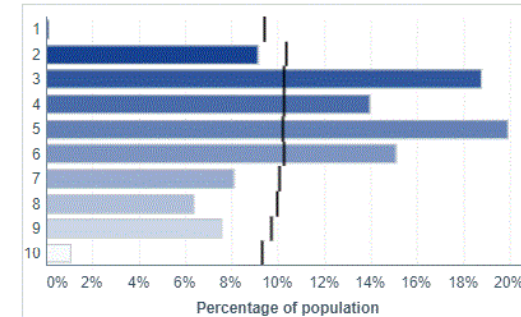
Black line represents the England average

Population proportion by ethnic category



Black line represents the England average

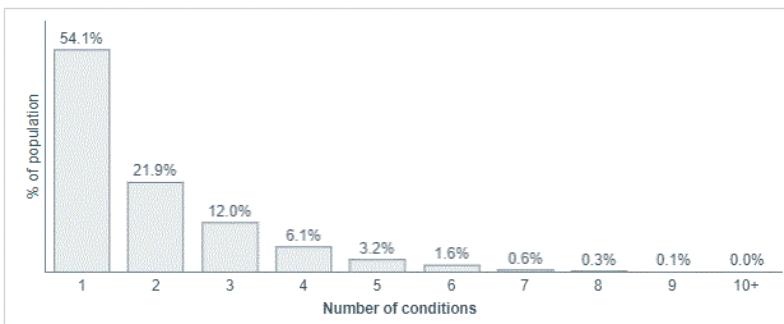
Population proportion by IM Deprivation decile



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

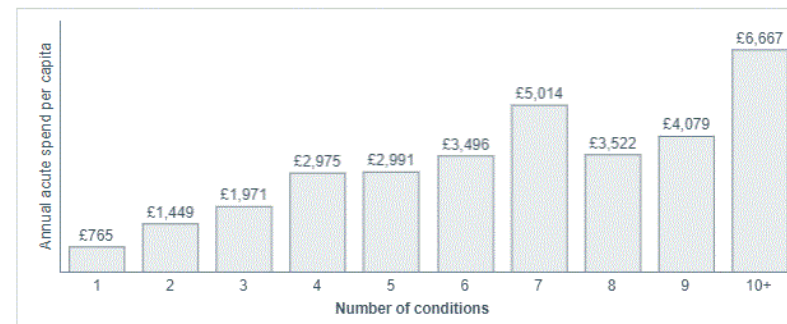
Prevalence - Snapshot as at: 30/06/2021

Population proportion by number of conditions



Annual spend per capita by number of conditions

Financial Year: 2020/21



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 28.1% population have at least 1 Long Term Condition. 5.9% 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 long term conditions, with the exception of the age category 50-64 which is slightly higher.

Practice Indicators - Triggers and Levels

Practice Indicators for		CROMWELL MEDICAL CENTRE			HIGH STREET SURGERY			STANHOPE SURGERY			STOCKWELL LODGE MED.CTR.		
Clinical Domain	Indicator Name	Latest Score	Time Period	Trigger Level	Latest Score	Time Period	Trigger Level	Latest Score	Time Period	Trigger Level	Latest Score	Time Period	Trigger Level
LEA VALLEY HEALTH PCN													
Clinical Diagnosis	Detection rate Cancer	0.343	2020/21	Level 1	0.474	2020/21	No Trigger	0.68	2020/21	No Trigger	0.603	2020/21	No Trigger
Coronary heart disease	% AF anticoagulation therapy CHADS2-VASc score >1	93.8	2020/21	Positive	94.3	2020/21	Positive	94.5	2020/21	Positive	92	2020/21	Positive
	% CHD aged <=79 BP reading 140/90mmHg or less	37.9	2020/21	Level 2	51.5	2020/21	Level 1	47.7	2020/21	Level 1	58.6	2020/21	Level 1
	% CHD cholesterol 5 mmol/l or less	52.6	2021/22	No Trigger	73.1	2021/22	No Trigger	69	2021/22	No Trigger	72.4	2021/22	No Trigger
	% hypertension aged <=79 BP reading 140/90mmHg or less	35.2	2020/21	Level 2	49.7	2020/21	Level 1	42	2020/21	Level 1	56.4	2020/21	Level 1
Diabetes	% Diabetes aged >=40 years no CVD history without moderate or severe frailty treated with statin	93.6	2020/21	No Trigger	78.6	2020/21	Level 1	81.5	2020/21	Level 1	85.1	2020/21	Level 1
	% Diabetes without moderate or severe frailty BP 140/80 mmHg or less	28.4	2020/21	Level 2	44.6	2020/21	Level 1	34.9	2020/21	Level 2	49.6	2020/21	Level 1
	% diabetes without moderate or severe frailty IFCC-HbA1c is 58 mmol/mol or less	38.7	2020/21	Level 2	57.7	2020/21	Level 1	55.5	2020/21	Level 1	54.9	2020/21	Level 1
Exception Rating	Overall Personalised Care Adjustment Rate	0.043	2020/21	No Trigger	0.054	2020/21	No Trigger	0.065	2020/21	No Trigger	0.043	2020/21	No Trigger
Medicines Management	% antibiotics Co-amoxiclav, Cephalosporins, Quinolones	8.1	2021/22 Q4	No Trigger	6.8	2021/22 Q4	No Trigger	6.1	2021/22 Q4	No Trigger	8.8	2021/22 Q4	No Trigger
	% Naproxen and Ibuprofen	82	2021/22 Q4	No Trigger	87.8	2021/22 Q4	No Trigger	91.1	2021/22 Q4	Positive	86.4	2021/22 Q4	No Trigger
	Antibacterial Items/Star Pu	0.975	2021/22 Q4	Positive	0.861	2021/22 Q4	Positive	0.731	2021/22 Q4	Positive	0.955	2021/22 Q4	Positive
	Hypnotics ADQ/Star Pu	1.497	2021/22 Q4	Level 1	0.531	2021/22 Q4	No Trigger	0.285	2021/22 Q4	No Trigger	0.869	2021/22 Q4	No Trigger
	Oral NSAIDs ADQs/STAR-PU	5.076	2021/22 Q4	No Trigger	1.992	2021/22 Q4	No Trigger	3.176	2021/22 Q4	No Trigger	4.665	2021/22 Q4	No Trigger
Mental Health	% first choice generic SSRIs	68.8	2021/22 Q4	No Trigger	69.9	2021/22 Q4	No Trigger	68.3	2021/22 Q4	No Trigger	69.1	2021/22 Q4	No Trigger
	% MH comprehensive care plan	3.3	2020/21	Level 2	75	2020/21	Level 1	95.7	2020/21	No Trigger	73.1	2020/21	Level 1
	% SMI alcohol record	25.8	2020/21	Level 2	33.3	2020/21	Level 2	15.9	2020/21	Level 2	45.7	2020/21	Level 1
	% SMI BP record	49	2020/21	Level 1	83.3	2020/21	Level 1	96.7	2020/21	No Trigger	84.2	2020/21	Level 1
	Dementia Face to Face review	2.6	2020/21	Level 1	24	2020/21	Level 1	45.7	2020/21	Level 1	37.8	2020/21	Level 1
	Select antidepressants ADQs/STARPU	1.822	2021/22 Q4	No Trigger	1.273	2021/22 Q4	No Trigger	1.371	2021/22 Q4	No Trigger	1.385	2021/22 Q4	No Trigger
Patient Experience	Confidence and trust in healthcare professional	94.4	2020/21	No Trigger	90.5	2020/21	No Trigger	96.2	2020/21	No Trigger	91.7	2020/21	No Trigger
	Frequency seeing preferred GP	49.1	2020/21	No Trigger	36.1	2020/21	No Trigger	32.7	2020/21	No Trigger	25	2020/21	No Trigger
	Healthcare professional treating with care and concern	88.4	2020/21	No Trigger	80.1	2020/21	No Trigger	88.3	2020/21	No Trigger	72.3	2020/21	Level 1
	Overall experience of your GP practice	81.7	2020/21	No Trigger	74	2020/21	No Trigger	75.1	2020/21	No Trigger	63.6	2020/21	Level 1
	Satisfaction with appointment times	65.6	2020/21	No Trigger	47.8	2020/21	No Trigger	50.2	2020/21	No Trigger	56.9	2020/21	No Trigger
Public Health	% Child Imms DTaP/IPV/Hib/HepB (age 1 year)	90.1	2020/21	Level 1	93.8	2020/21	Level 1	89.1	2020/21	Level 1	92.7	2020/21	Level 1
	% Child Imms Hib/MenC booster	97.2	2020/21	No Trigger	95.3	2020/21	No Trigger	90.6	2020/21	Level 1	84.5	2020/21	Level 1
	% Child Imms MMR (Age 2 yrs)	97.2	2020/21	No Trigger	93.4	2020/21	Level 1	91.3	2020/21	Level 1	84.5	2020/21	Level 1
	% Child Imms PCV Booster	97.2	2020/21	No Trigger	95.3	2020/21	No Trigger	89.8	2020/21	Level 1	84.5	2020/21	Level 1
	Cervical Screening	80.5	2021/22 Q4	No Trigger	76.5	2021/22 Q4	Level 1	70	2021/22 Q4	Level 1	76.6	2021/22 Q4	Level 1
Respiratory	% Asthma review in last 6 mths	18.4	2020/21	Level 1	69.4	2020/21	Level 1	79.6	2020/21	No Trigger	46.6	2020/21	Level 1
	% Asthma spirometry and one other objective test	0	2020/21	Level 2	66.7	2020/21	Level 1	0	2020/21	No Data Available	10	2020/21	Level 2
	% COPD with review in last 12 mths	14.7	2020/21	Level 2	21.2	2020/21	Level 1	35.3	2020/21	Level 1	93.6	2020/21	No Trigger
	% LTC patients who smoke	18.8	2020/21	No Trigger	15.9	2020/21	No Trigger	17.7	2020/21	No Trigger	14.3	2020/21	No Trigger
	% LTC Smoker offer support	81.4	2020/21	Level 1	92.2	2020/21	Level 1	96.9	2020/21	No Trigger	98.3	2020/21	No Trigger
	% Smoking patients over 15 recorded	71.6	2021/22	No Trigger	78.6	2021/22	No Trigger	66.6	2021/22	No Trigger	73	2021/22	No Trigger
	% Smoking status recorded	85.7	2020/21	Level 1	98.4	2020/21	Positive	90.3	2020/21	No Trigger	93.3	2020/21	No Trigger
	% w. MRC dyspnoea score >=3 w. offer of referral to pulm. rehab. Clinic	27.3	2020/21	Level 1	63.6	2020/21	Level 1	0	2020/21	Level 2	81.8	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 Lea Valley Health PCN an estimated:

- 16.8% of children live in poverty.
- 15.4% of older people live in poverty.
- 10.8% of households live in fuel poverty.
- 10.8% of households are overcrowded.
- 31.7% of people aged 65 and over live alone.
- 1.5% of people cannot speak English well.
- 5.4% of working age people are claiming out of work benefits.
- 24.4% of children aged 4-5 and 39.2% of children aged 10-11 are overweight.

PH.Intelligence@hertfordshire.gov.uk

Hertfordshire Public Health
Evidence & Intelligence
Epidemiology

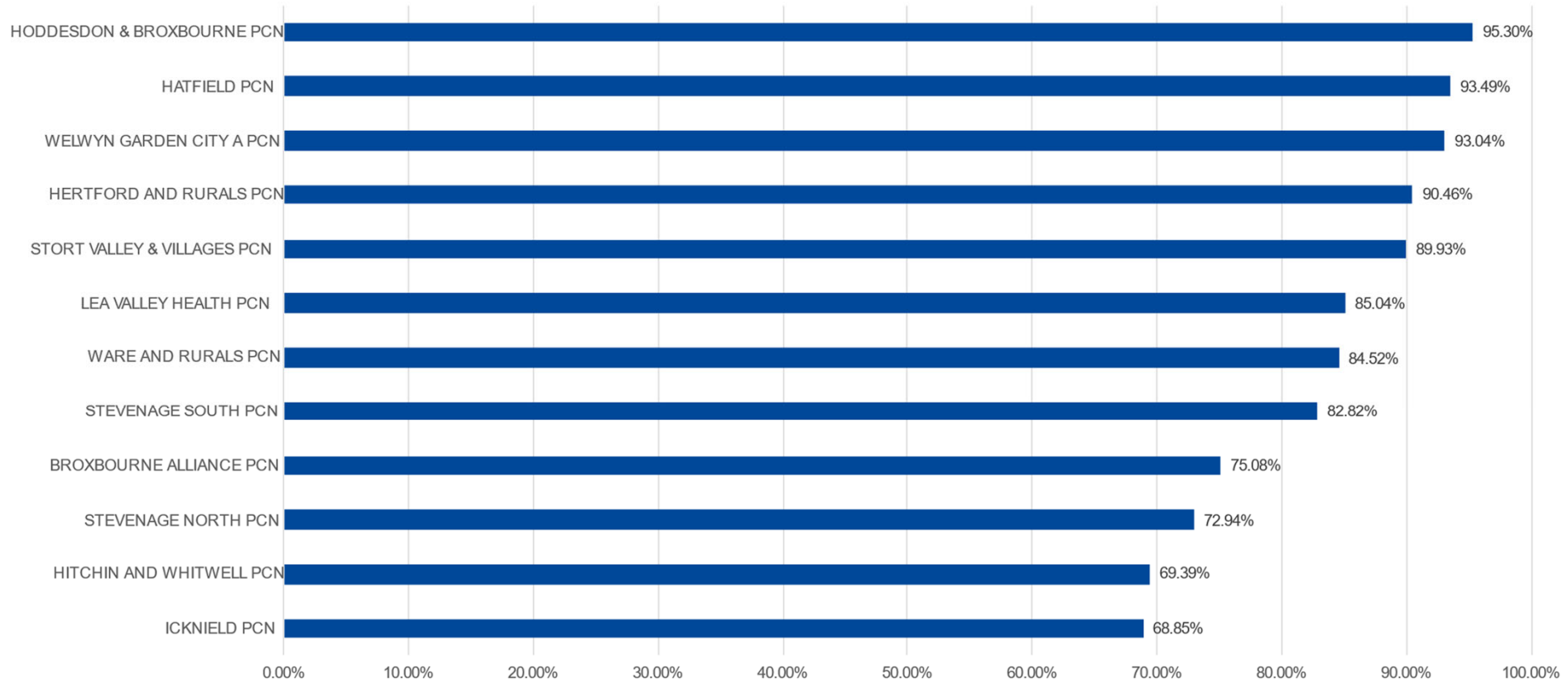


The above provides a summary of the wider determinants of health for Lea Valley.

Wider determinants analysis from Public Health Evidence and Intelligence shows Lea Valley is one of the most deprived PCNs within the ICB across all indicators apart from Fuel poverty.

SPREAD OF PATIENTS ACROSS ENGLAND CONT.

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

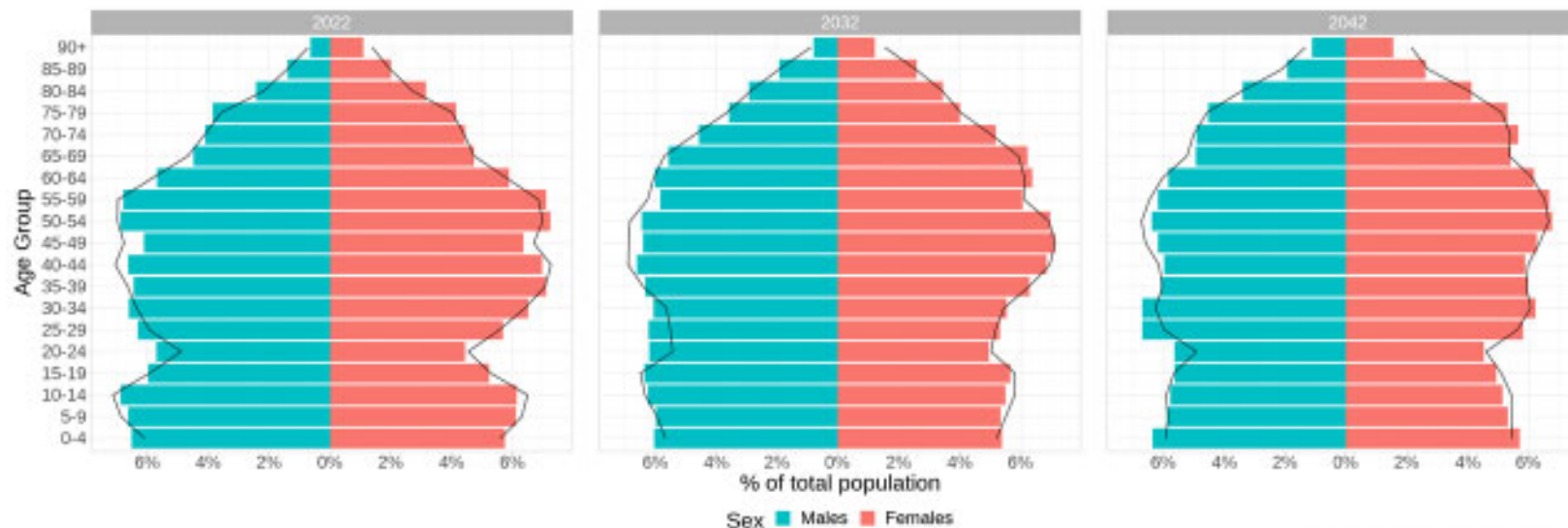


This chart shows the proportion of the registered population living within the ICB geographical boundary.

The spread of patients for Lea Valley Health PCN indicates 14.96% 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 Broxbourne 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	5,935	5,519	5,885
Under 24	28,732	27,875	26,774
24-64	50,592	48,681	48,782
65+	17,730	20,398	22,267
85+	2,511	3,175	3,534

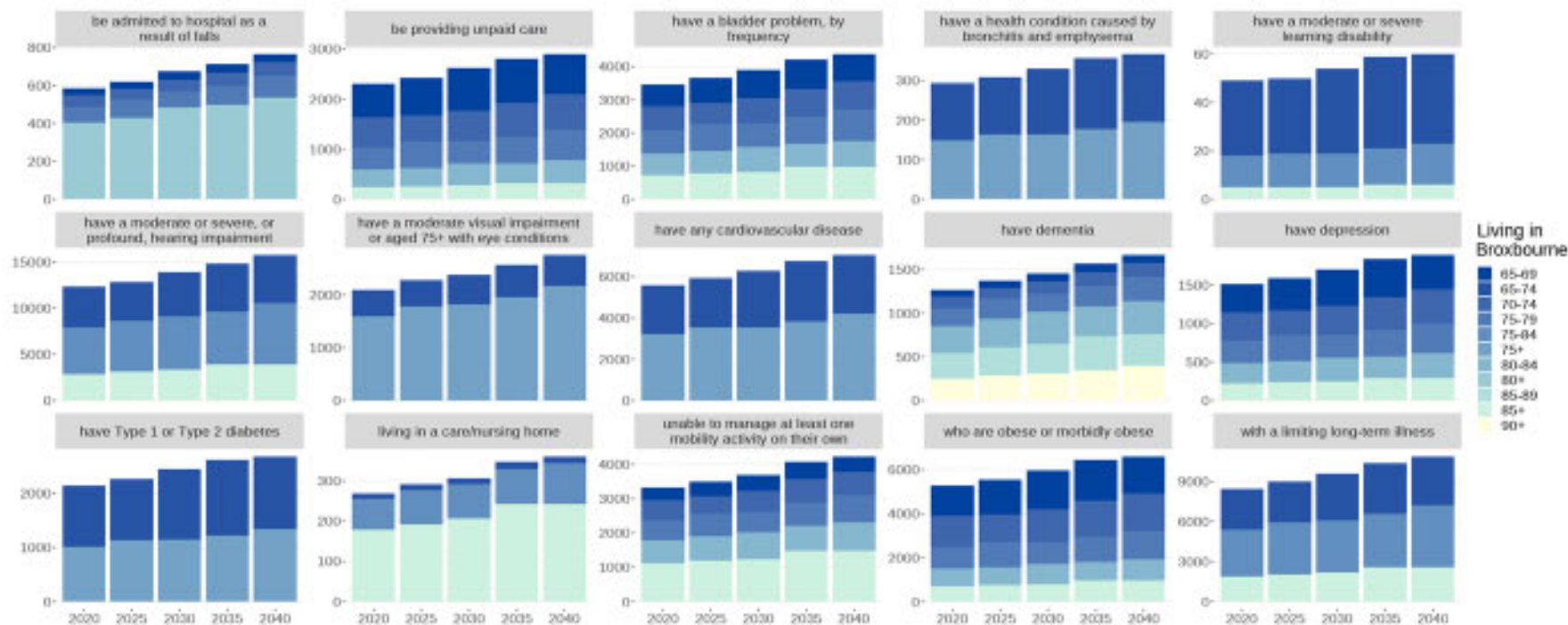
PH.Intelligence@hertfordshire.gov.uk



Expected population growth for Broxbourne 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 ~18k to ~20k.



People aged 65+ projected to...



PH.Intelligence@hertfordshire.gov.uk

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

Optum

HWE

Segment & Outcomes Framework Documentation

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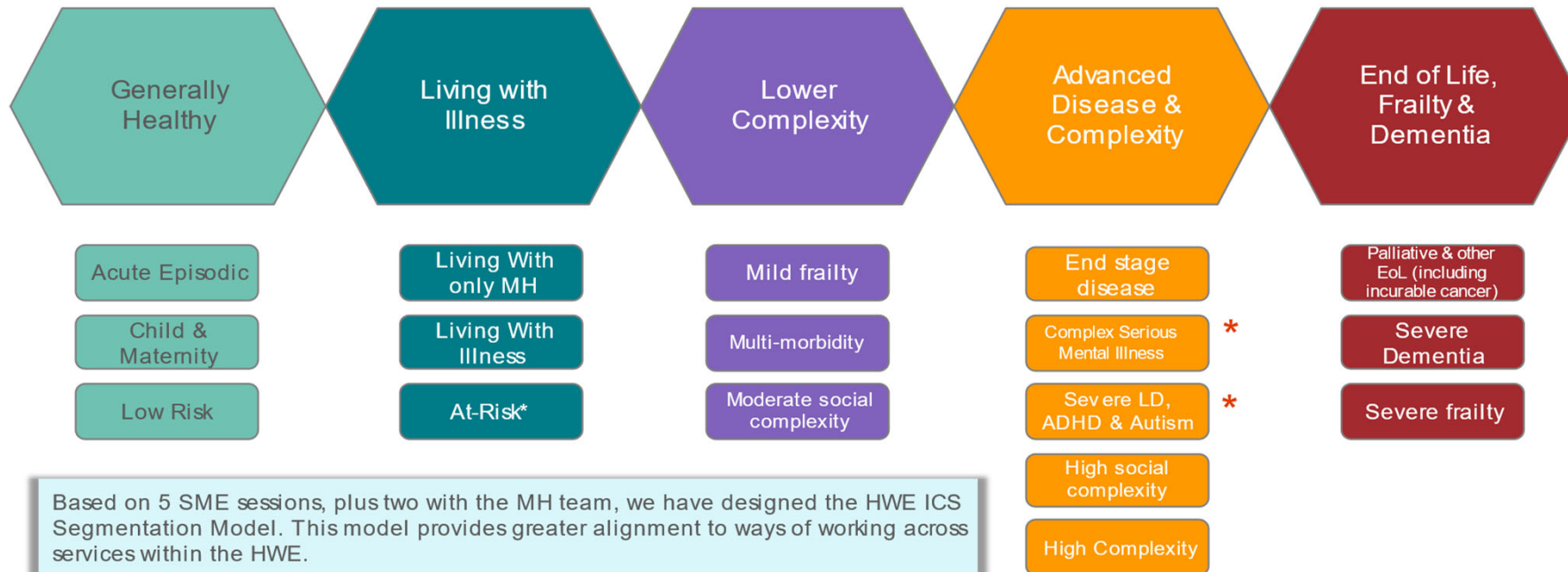
PHM Segment Model - Overview

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

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

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

Segmentation model – third iteration



Based on 5 SME sessions, plus two with the MH team, we have designed the HWE ICS Segmentation Model. This model provides greater alignment to ways of working across services within the HWE. It follows a MECE model, assigned in order from right to left in segment, and top to bottom in subsegment.

* awaiting finalisation of methodology

PHM Segment Model - Overview

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

Alongside the segmentation logic an outcomes framework was developed.

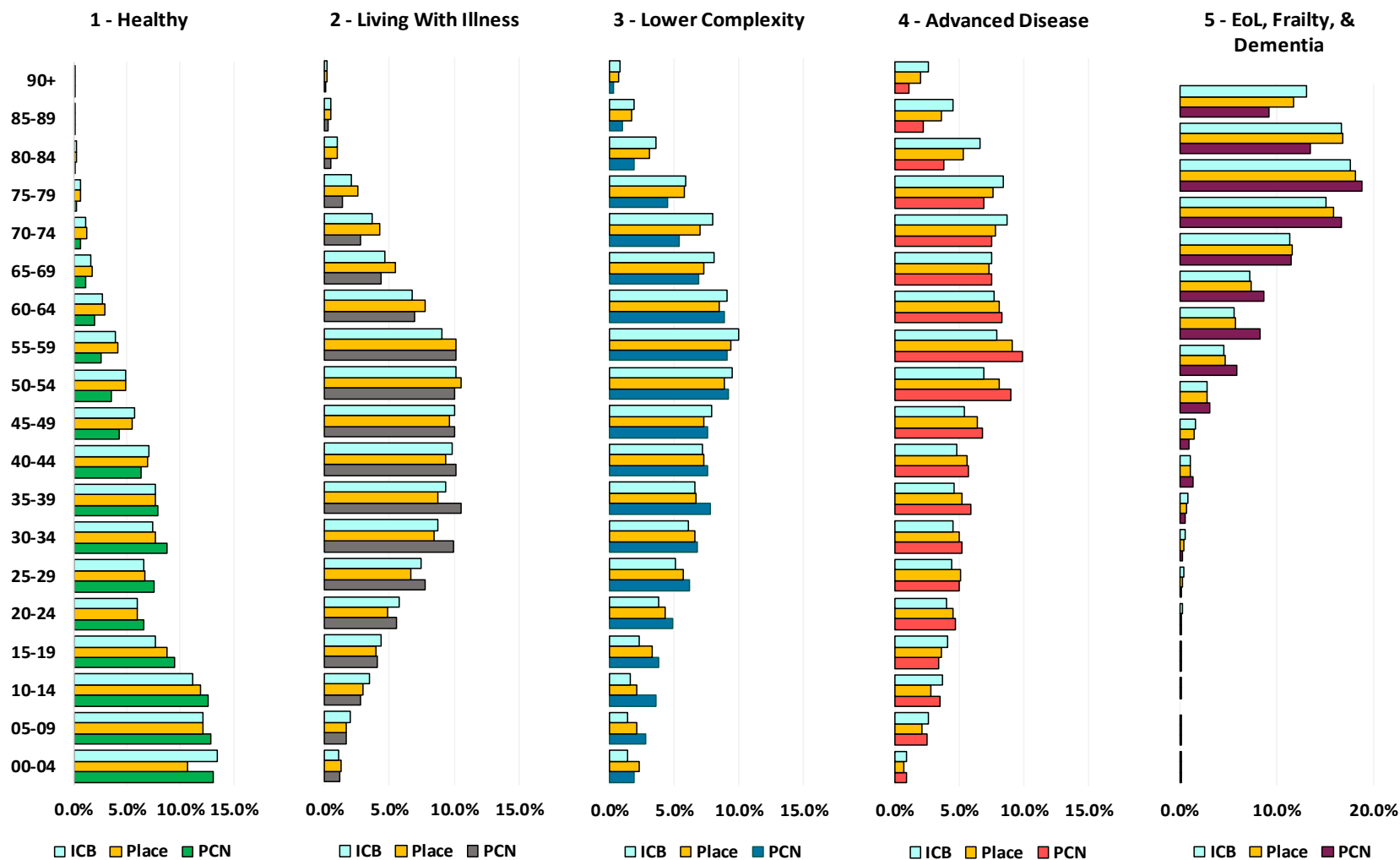
Whole Population Outcomes

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

"Generally healthy"	Living with Illness	Lower Complexity	Advanced Disease & Complexity	End of Life, Frailty & Dementia
<p>Who is in this group?</p> <ul style="list-style-type: none"> • 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. 	<p>Who is in this group?</p> <ul style="list-style-type: none"> • 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. 	<p>Who is in this group?</p> <ul style="list-style-type: none"> • 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. 	<p>Who is in this group?</p> <ul style="list-style-type: none"> • 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 	<p>Who is in this group?</p> <ul style="list-style-type: none"> • 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.
<p>Social & Clinical Outcomes</p> <ul style="list-style-type: none"> • 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. 	<p>Social & Clinical Outcomes</p> <ul style="list-style-type: none"> • 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. 	<p>Social & Clinical Outcomes</p> <ul style="list-style-type: none"> • 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. 	<p>Social & Clinical Outcomes</p> <ul style="list-style-type: none"> • 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. 	<p>Social & Clinical Outcomes</p> <ul style="list-style-type: none"> • REDUCE dependency for emergency care services e.g A&E attendances and emergency admissions. • INCREASE proportion of people who die in their preferred place of death. • INCREASE identification of frail and complex patients, including those with dementia or at end of life. • REDUCE proportion of days disrupted by emergency care in last year of life. • INCREASE number of days spent at home in last year of life. • INCREASE proportion of people supported at home instead of in residential care.

Age Profile and Health Segment

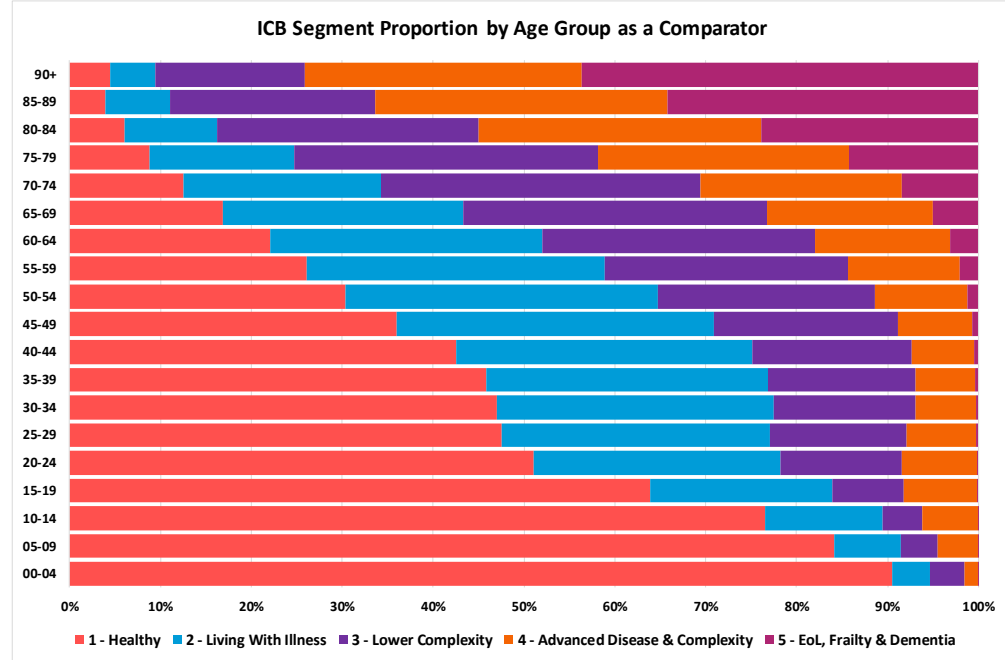
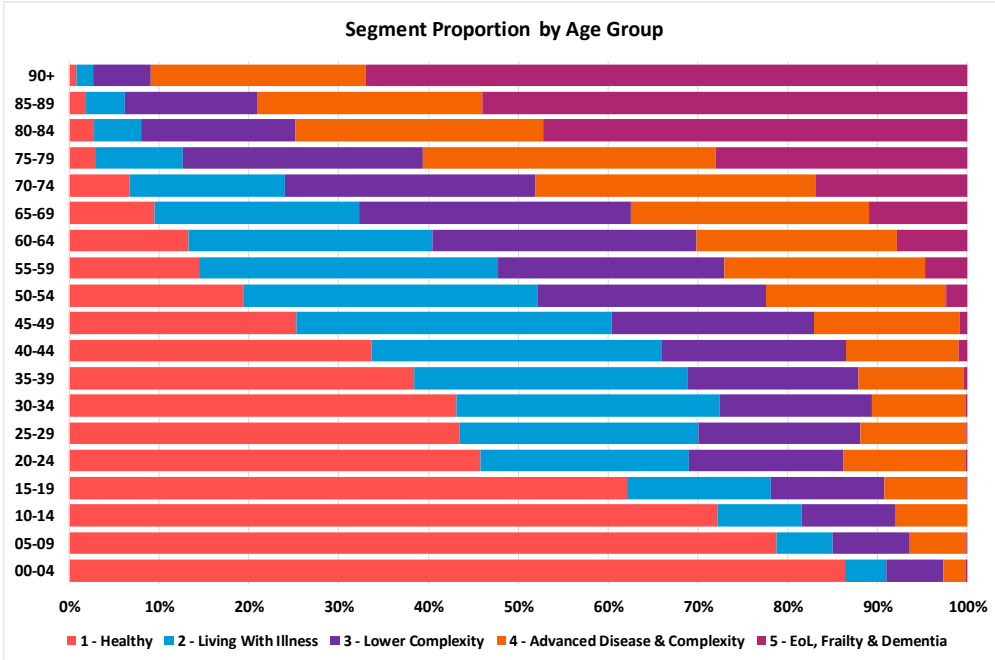
Age Profile of PCN, Place, and ICB Segment Population Comparison



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

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

Demographic Breakdowns - Segment & Deprivation Quintiles

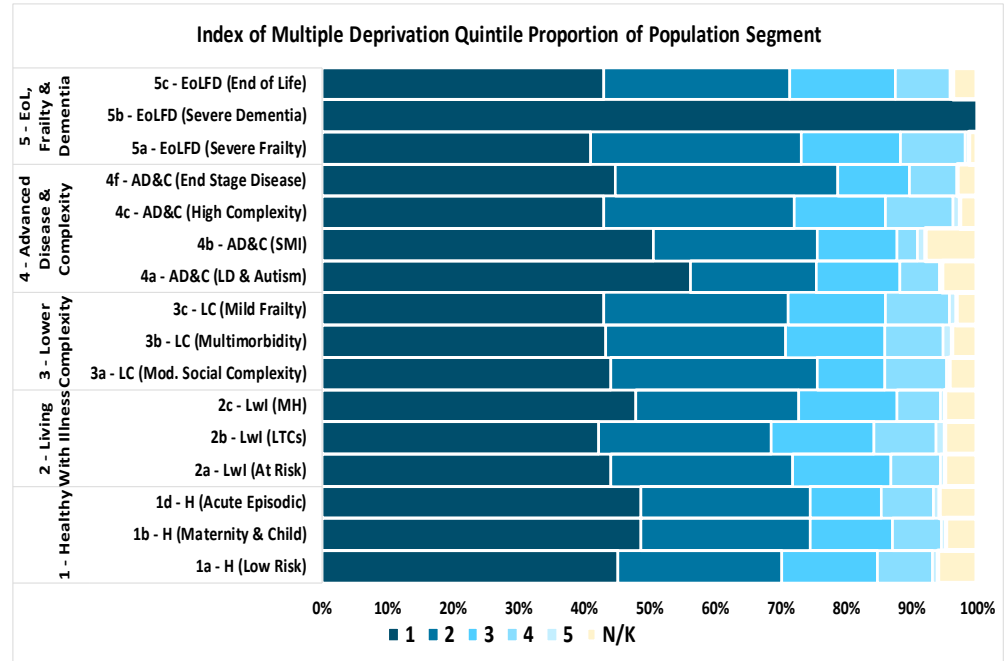


The ICB Health Segments here are broken down by total population and 5 year age groups; as expected with age the proportion of people within the healthy segment decreases.

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

Overall Lea Valley has a slightly higher profile across all age categories for segments 2 to 5, compared to the ICB population.

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



Major Conditions Comparison - Per 1,000 Registered

PCN NAME	Major Conditions Comparison - Per 1,000 Registered																			
	COPD	Obesity	Asthma	Diabetes	Dementia	Cancer	Learning Disabilities	Hypertension	Stroke	Chronic Kidney Disease	Heart Disease	Heart Failure	AtrialFib	Chronic Cardiac Disease	Depression	MH	Anxiety	Serious Mental Illness	Alzheimers	
ABBEY HEALTH	16.94	91.79	134.57	138.01	16.06	35.32	15.82	119.23	33.72	10.05	35.88	10.65	11.77	57.71	121.19	171.41	86.11	25.15	10.73	
ALBAN HEALTHCARE	16.78	79.37	154.97	90.13	16.99	53.76	14.22	149.53	34.73	24.16	39.98	10.97	17.65	50.69	127.50	205.23	111.71	23.36	13.08	
ALLIANCE	19.90	114.36	123.67	105.84	15.86	29.28	17.82	155.51	31.61	9.04	39.00	10.29	9.50	62.66	114.55	160.93	87.83	25.81	10.21	
ALPHA	16.29	121.01	139.73	97.63	14.00	55.48	10.91	161.78	34.67	18.36	42.29	11.02	21.77	53.43	153.71	233.41	120.24	17.12	9.22	
ATTENBOROUGH	18.14	113.20	126.85	105.43	15.54	36.21	11.81	130.54	33.07	15.51	42.51	11.91	11.43	50.85	118.02	176.61	95.74	19.13	8.70	
BROXBORNE ALLIANCE	20.30	160.08	122.01	81.19	7.50	61.16	6.46	171.90	29.87	23.09	49.05	11.84	19.50	68.57	135.43	191.17	116.76	7.91	4.09	
CENTRAL WATFORD	17.17	97.89	108.55	152.70	20.12	25.21	13.25	123.19	30.90	8.01	34.88	10.09	16.32	46.23	98.31	132.67	62.41	20.54	8.28	
DACORUM BETA	24.98	156.71	132.83	158.17	30.23	40.07	18.80	156.86	44.28	19.23	50.10	16.42	26.50	78.15	176.09	245.43	132.71	31.47	14.12	
DANAIS	22.41	131.50	138.52	116.70	19.56	36.00	19.66	181.38	45.29	7.84	44.34	12.86	11.35	57.63	137.60	185.74	82.50	28.26	11.88	
DELTA	16.90	150.87	135.59	125.22	17.35	45.07	13.06	152.28	34.37	21.60	42.61	10.85	19.87	55.43	142.21	222.46	128.07	22.98	10.97	
HALO	18.22	93.22	137.55	112.78	20.85	47.83	20.12	137.28	37.23	16.03	41.35	11.68	16.94	85.83	149.64	217.88	111.29	29.96	14.75	
HARLOW NORTH	32.17	113.01	160.55	104.04	9.63	65.83	5.80	185.36	41.56	27.03	59.02	17.64	18.36	73.07	152.95	249.04	129.75	8.61	4.78	
HARLOW SOUTH	30.09	197.29	169.79	120.15	9.20	57.49	8.17	162.96	38.98	37.02	62.04	19.34	19.54	83.34	174.03	246.72	118.60	11.48	4.96	
HARPENDEN HEALTH	21.78	81.60	149.03	107.08	23.86	69.52	12.79	172.72	49.21	21.85	55.34	17.04	25.35	73.71	145.13	230.18	127.83	21.83	14.49	
HATFIELD	16.88	58.23	77.11	65.91	7.71	28.28	6.46	107.06	21.36	5.41	34.69	8.47	14.84	42.95	91.34	131.15	87.53	7.83	2.94	
HERTFORD AND RURALS	16.86	116.98	126.99	67.48	7.52	54.51	5.99	147.29	25.97	13.35	42.51	10.83	20.25	52.05	138.84	203.98	117.47	7.46	3.97	
HERTS FIVE	18.05	119.79	133.62	149.84	32.47	49.57	15.73	175.39	37.47	28.64	46.04	11.72	28.70	67.86	143.18	211.93	115.95	24.53	12.18	
HITCHIN AND WHITWELL	21.11	126.63	141.53	80.38	10.25	64.91	5.36	160.97	32.99	22.56	48.88	11.81	23.23	63.10	146.25	217.69	134.47	9.83	6.42	
HODDESDEAN & BROXBORNE	22.63	163.45	129.18	88.31	9.82	69.33	6.52	182.13	32.80	23.48	54.65	14.88	26.00	65.08	128.92	211.87	124.10	7.19	5.53	
ICKNIELD	20.58	132.39	147.83	85.32	11.91	60.97	6.57	164.18	31.52	35.00	51.59	12.61	22.87	68.86	140.93	220.11	121.08	8.97	7.19	
LEA VALLEY HEALTH	23.93	166.87	126.46	86.47	6.11	51.75	9.26	172.10	28.22	18.66	48.18	13.17	18.01	57.90	154.32	231.01	165.70	10.89	5.53	
LOUGHTON BUCKHURST HILL & CHIGWELL	15.51	82.36	108.00	75.16	9.75	48.63	3.25	126.39	27.64	12.08	48.45	12.73	24.57	58.16	115.48	166.39	109.95	7.20	4.74	
MVPS	20.48	132.18	129.05	118.23	17.10	37.36	15.43	141.83	33.00	29.68	40.10	11.91	12.32	50.34	135.02	189.04	100.76	22.35	10.35	
NORTH UTTLESFORD	15.67	23.10	103.62	50.30	8.89	35.46	3.02	82.42	26.01	0.19	40.66	8.29	27.47	50.49	94.73	129.90	109.54	4.31	4.09	
NORTH WATFORD	21.96	115.98	140.15	136.45	18.26	39.04	14.64	168.63	39.54	20.47	47.73	15.48	20.13	64.24	142.44	194.02	96.65	24.51	9.80	
POTTERS BAR	22.98	140.98	142.22	136.58	24.74	53.46	12.70	148.52	37.34	84.75	44.43	12.35	20.80	65.37	132.36	187.18	88.62	20.73	11.56	
RICKMANSWORTH & CHORLEYWOOD	17.43	111.90	132.75	112.05	18.36	44.50	13.90	188.27	41.26	6.88	45.98	15.23	20.02	59.08	127.24	185.97	93.22	19.48	8.82	
SOUTH UTTLESFORD	15.28	43.19	113.74	57.46	8.33	38.05	2.34	96.24	24.00	4.96	39.00	9.02	20.59	48.74	99.33	142.19	108.67	4.65	3.60	
STEVENAGE NORTH	24.27	273.76	124.18	170.45	10.46	46.58	8.92	155.20	29.48	9.51	46.26	11.84	14.55	64.91	136.82	194.88	111.38	8.02	6.11	
STEVENAGE SOUTH	23.31	128.57	101.25	75.88	9.99	44.87	6.69	144.52	30.88	15.08	46.63	12.90	13.69	62.56	105.37	151.85	76.49	7.45	6.03	
STORT VALLEY & VILLAGES	17.85	122.87	132.49	65.60	7.18	53.86	6.92	144.16	26.39	19.45	44.05	13.41	19.82	60.97	120.51	203.15	127.69	6.34	3.43	
THE GRAND UNION	17.43	143.73	135.30	134.24	19.14	42.21	12.89	149.94	36.78	28.86	46.99	12.45	19.10	62.75	138.79	195.84	95.98	20.23	9.53	
WARE AND RURALS	18.09	163.30	165.40	77.77	7.63	58.28	5.79	154.35	27.24	22.49	47.89	12.74	20.82	60.01	132.46	198.85	108.67	6.62	4.13	
WELWYN GARDEN CITY A	19.05	104.74	104.65	68.93	6.62	41.07	6.99	132.35	23.08	10.49	38.53	10.24	17.72	48.93	117.64	178.45	109.12	7.12	3.14	

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

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

When analysing the underlying Segmentation Model data the conditions with highest per 1,000 registered prevalence that are highlighted for Lea Valley Health PCN are Depression, MH, Anxiety, COPD, Cancer, Hypertension, Obesity and Chronic Cardiac disease.

PCN NAME	Conditions																			
	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 Condi	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 Chronic Respiratory Disease, Myasthenia Gravis, Other Neurological Conditions, Sickle Cell Disease, Solid Organ Transplant and High BP.

PCN Benchmarking - A&E Activity

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



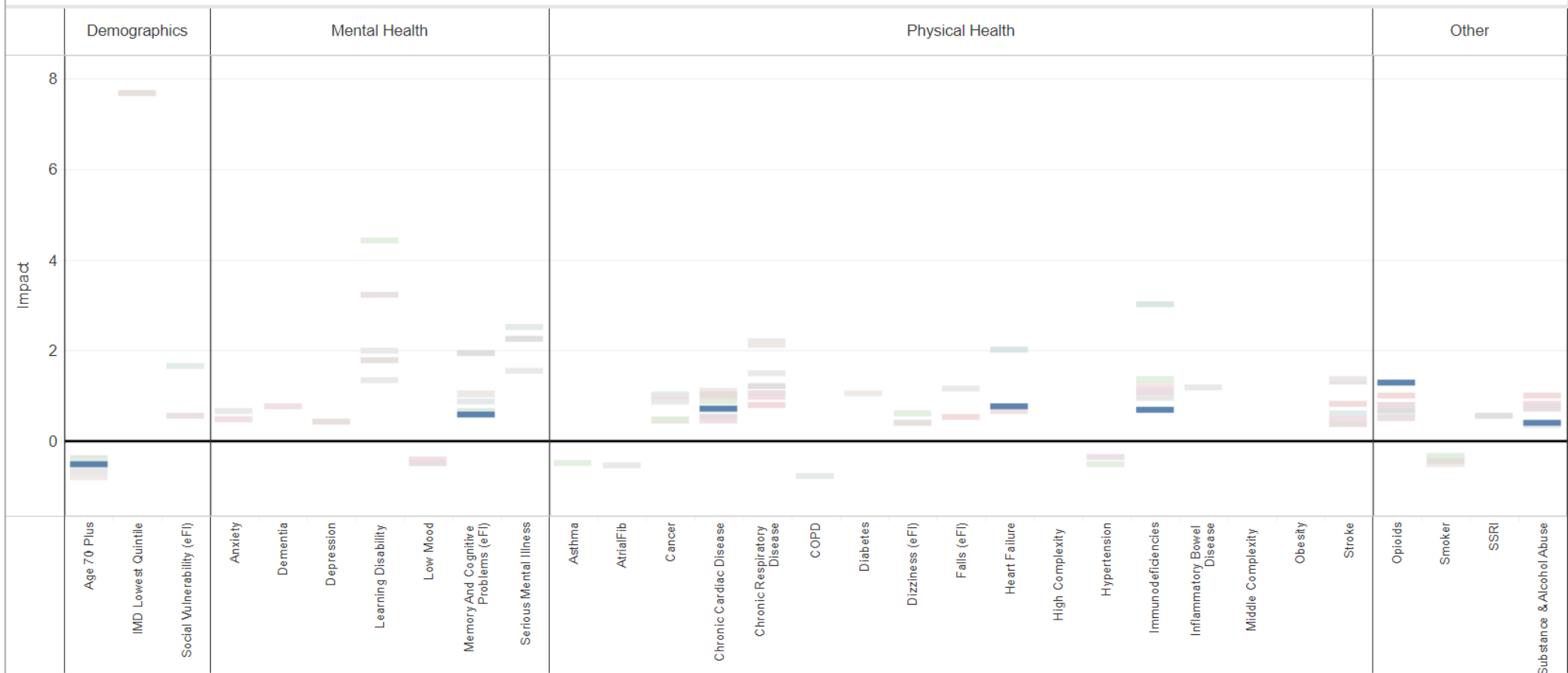
The charts in the next two pages show activity for the PCN compared against all other PCNs at the Place level.

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

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

PCN Benchmarking - Emergency Admissions

Higher bars indicate greater relationship with increased **Emergency Admissions**



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

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

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

Overall aim

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

Objectives

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

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



UEC Overview

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

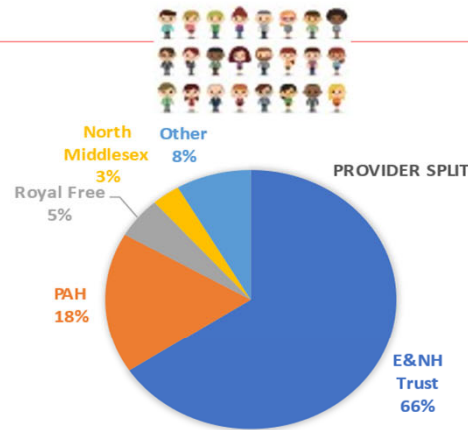
Children 0 -18
Adults 19 -64
Older People 65+

218,296 A&E Attendances in 2021/22

Children = 56,287 (25.8%)
Adults = 111,219 (50.9%)
Older People = 50,790 (23.3%)

57,811 26.5% of attendances resulted in no investigation and no treatment (includes Uncoded Activity)

Children = 19,082 (34%)
Adults = 30,658 (27.6%)
Older People = 6,944 (15.9%)



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

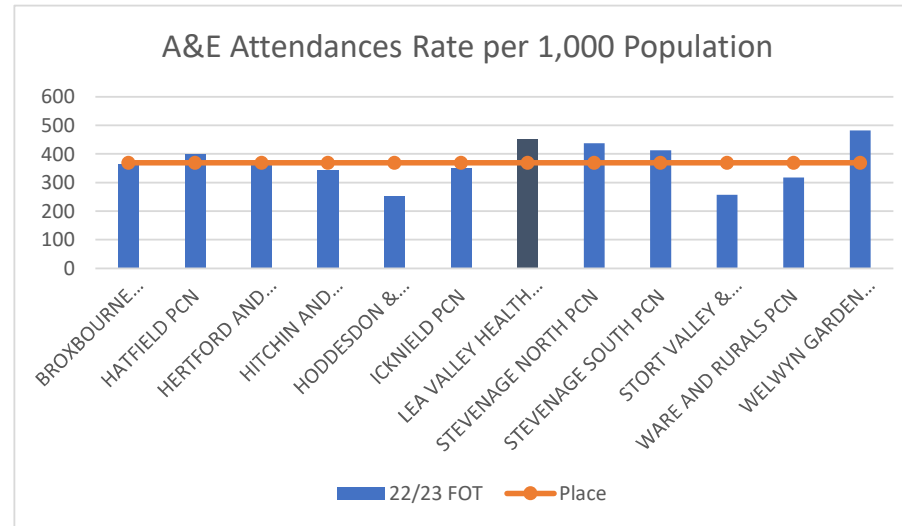
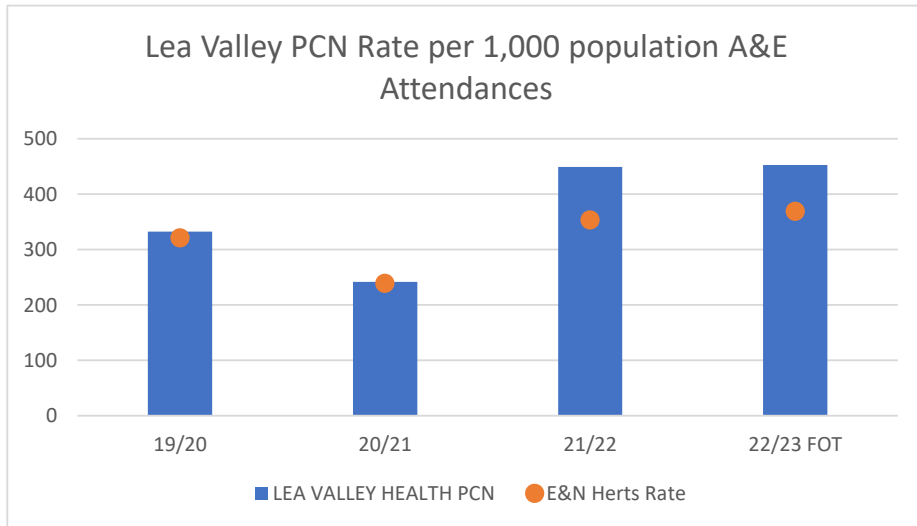
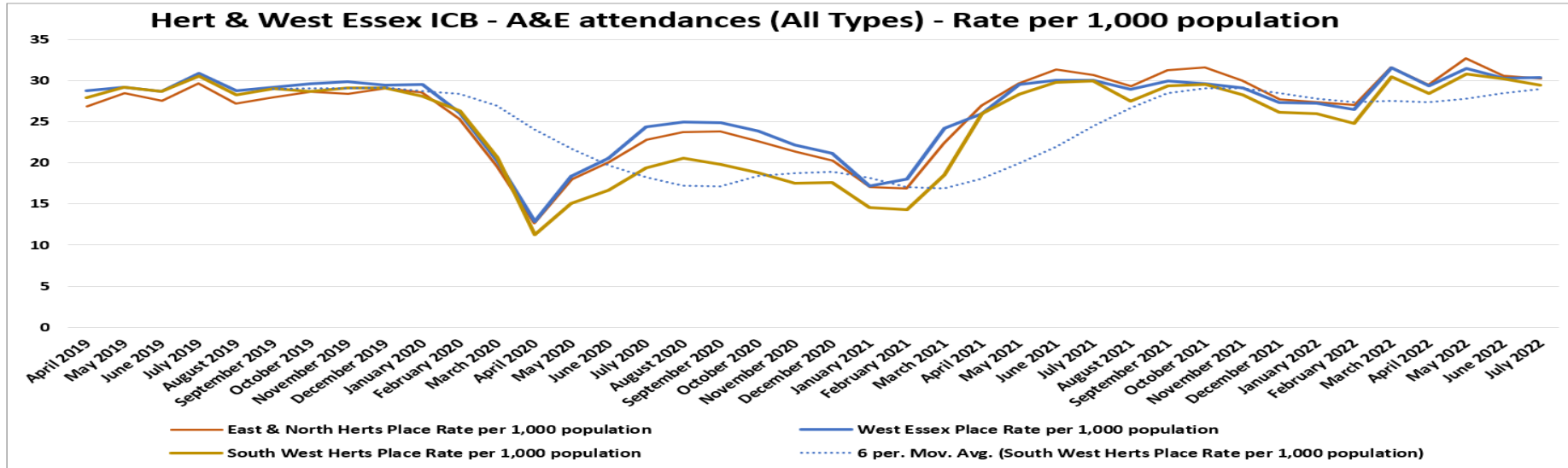
Children = 34,197 (26.5%)
Adults = 68,101 (52.8%)
Older People = 26,873 (20.8%)

This translates to 1 in 5 people registered with East & North attending A&E

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



Source: SUS



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

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

Urgent & Emergency Care in 2022/23 for Lea Valley Alliance A&E Attendance rates per 1,000 population, is the 2nd highest above 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 Lea Valley.

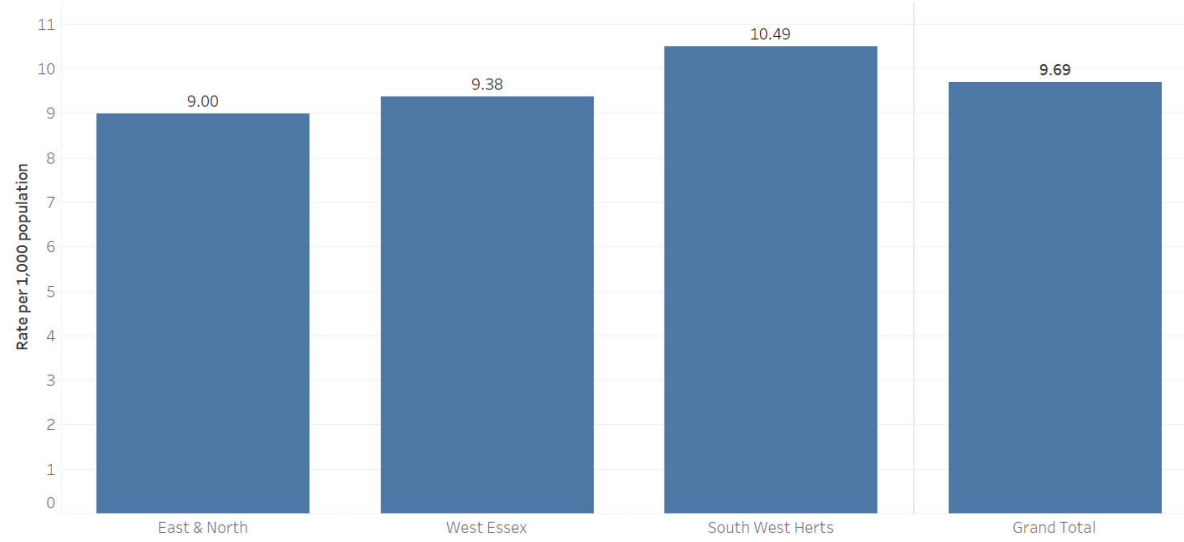
* Average cost for Mental and Behavioural is not representative as non-PbR

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	39	36	£2,537	£98,924
CVD: Angina	16	14	£2,468	£39,483
CVD: Congestive Heart Failure	104	81	£4,589	£477,219
CVD: Hypertension	16	16	£1,264	£20,217
Diseases of the blood	24	21	£2,236	£53,668
Mental and Behavioural Disorders	5	5		
Neurological Disorders	20	17	£3,085	£61,708
Nutritional, endocrine and metabolic	33	31	£2,758	£90,998
Respiratory: Asthma	19	17	£1,115	£21,178
Respiratory: COPD	94	54	£3,234	£303,999
Grand Total	370	280	£3,155	£1,167,394

ACS Admission Rates per 1,000 Population by Place

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

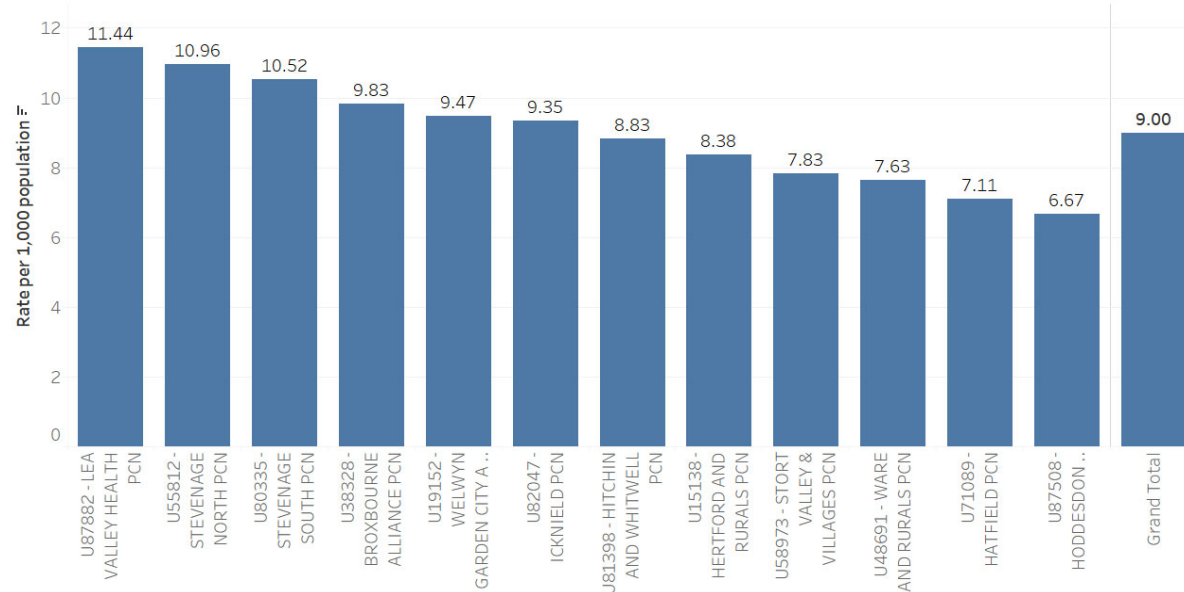


When comparing the Ambulatory Care Sensitive rates per 1,000 population between places, the East & North place has the lowest rate in the ICB.

Within East & North place, Lea Valley has the highest rate per 1,000 population.

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



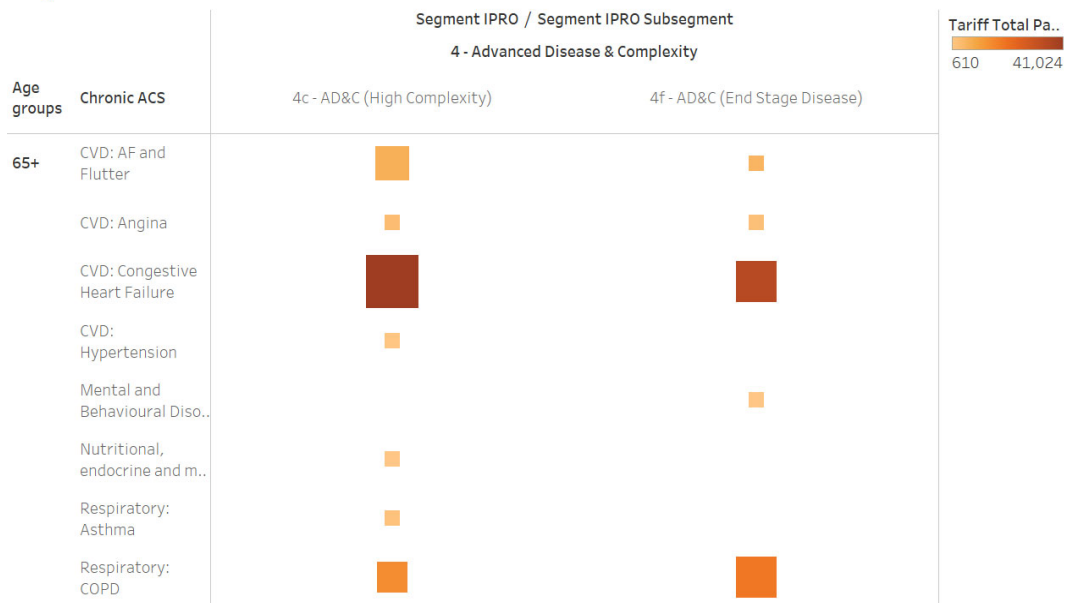
The above chart looks at the ACS admissions by age and segment. The size reflects volume and the depth of colour reflects cost.

When looking at the ACS conditions for Broxbourne 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 and 41-64 age group in the Advanced Disease and Complexity segment as well.

The following pages look at which ACSs contribute to this.

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

Segment 4



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

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

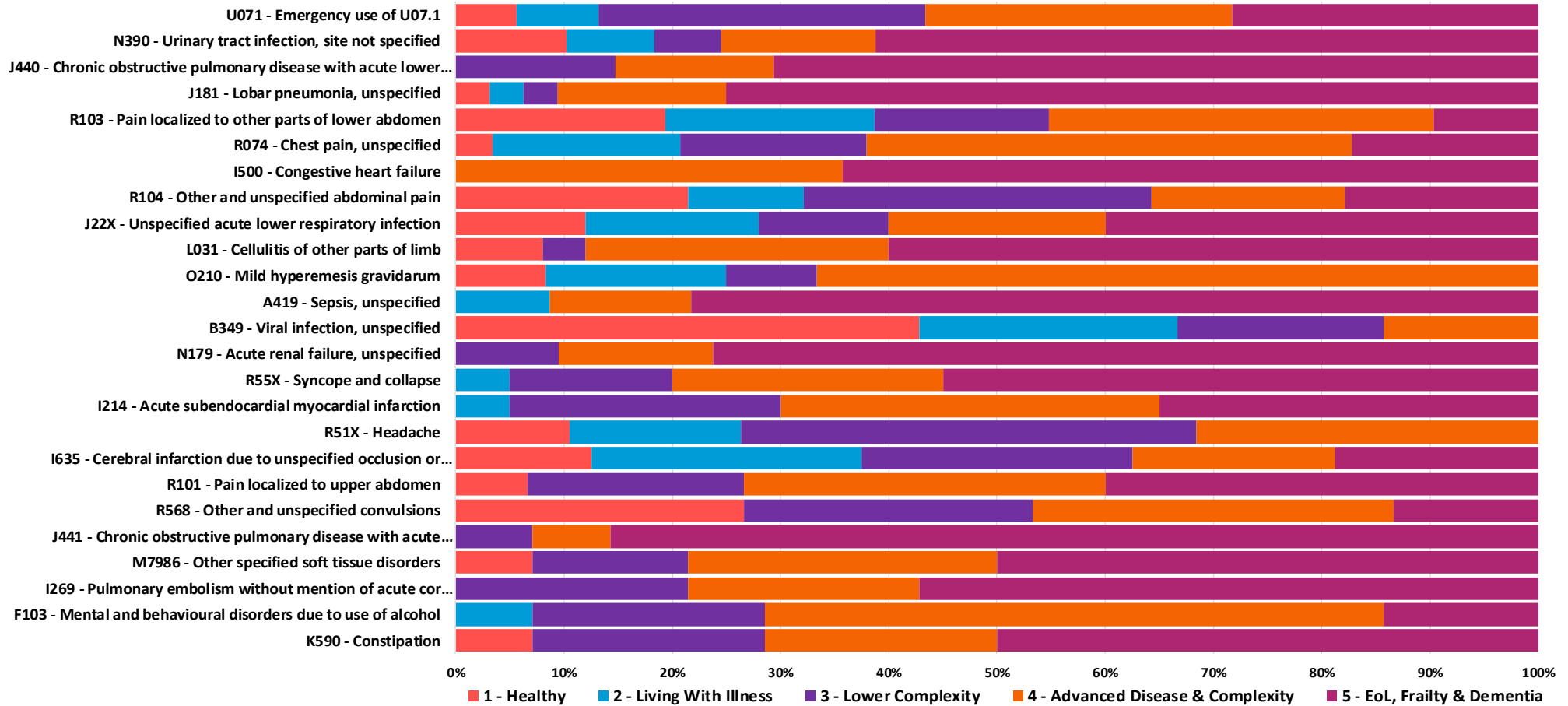
Segment 5



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
Bandley Hill	2					2
Broadley Common, Epping Upland and Nazeing				1		1
Broxbourne and Hoddesdon South	1	3	1	11	6	22
Buntingford			1			1
Cheshunt North	36	40	59	64	110	309
Cheshunt South and Theobalds	15	15	26	41	51	148
Chigwell Village			1			1
Epping Lindsey and Thornwood Common					6	6
Flamstead End	28	46	41	91	122	328
Goffs Oak	4	12	21	26	29	92
Hatfield West					1	1
Hertford Bengoe		1				1
Hertford Castle	2					2
Hertford Heath			3		1	4
Hertford Rural South	2					2
Hoddesdon North	1	3	5	1	5	15
Hoddesdon Town and Rye Park	4	1	3	1		9
Longmeadow		1				1
Lower Nazeing	1	1	6	2	3	13
Mark Hall			3			3
Much Hadham			1			1
Mundens and Cottered		1				1
Northaw and Cuffley	1	2			1	4
Park	1					1
Rosedale and Bury Green	37	57	97	125	186	502
Toddbrook			1			1
Waltham Abbey Honey Lane	1	3	4	3	8	19
Waltham Abbey North East		1	2		1	4
Waltham Abbey Paternoster			1			1
Waltham Abbey South West		1				1
Waltham Cross	48	36	64	69	83	300
Ware Christchurch				2		2
Ware Trinity				2	2	4
Welham Green			1			1
Welwyn East					3	3
Wormley and Turnford	26	34	45	66	82	253
Unknown Ward	13	13	11	23	29	89
Grand Total	223	271	396	529	729	2148

UEC Patients Seen by Deprivation Quintile & Ward 1 = Most Deprived, 5 = Least Deprived	1	2	3	4	5	(blank)	Grand Total
Bandley Hill		2					2
Broadley Common, Epping Upland and Nazeing	1						1
Broxbourne and Hoddesdon South		3		19			22
Buntingford				1			1
Cheshunt North	164	115	30				309
Cheshunt South and Theobalds	95		27	26			148
Chigwell Village			1				1
Epping Lindsey and Thornwood Common		6					6
Flamstead End	78	70	29	151			328
Goffs Oak		35	53		4		92
Hatfield West		1					1
Hertford Bengoe			1				1
Hertford Castle				2			2
Hertford Heath				4			4
Hertford Rural South			2				2
Hoddesdon North	7		5	3			15
Hoddesdon Town and Rye Park	9						9
Longmeadow	1						1
Lower Nazeing		5	7	1			13
Mark Hall	3						3
Much Hadham	1						1
Mundens and Cottered			1				1
Northaw and Cuffley			3		1		4
Park					1		1
Rosedale and Bury Green	353	149					502
Toddbrook	1						1
Waltham Abbey Honey Lane	8	5	6				19
Waltham Abbey North East			4				4
Waltham Abbey Paternoster	1						1
Waltham Abbey South West	1						1
Waltham Cross	183	67	50				300
Ware Christchurch			2				2
Ware Trinity			2		2		4
Welham Green			1				1
Welwyn East				3			3
Wormley and Turnford	77	128	48				253
Unknown Ward						89	89
Grand Total	983	586	272	210	8	89	2148

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

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

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



Hospital Admissions

	Period	HERTFORDSHIRE AND WEST ESSEX	LEA VALLEY HEALTH PCN
Emergency admissions injuries due to falls in those aged 65+	2020/21	2026	1558
Emergency asthma, diabetes and epilepsy admissions (aged 0-18)	2020/21	130.8	170.1
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	590.7
Mental health admissions (all ages)	2020/21	177.2	131.1
Emergency Cancer Admissions	2020/21	494.9	476.7
Emergency admissions for acute conditions shouldn't require admissions	2020/21	611.6	657.6

■ Similar
 ■ Significantly Worse
 ■ Significantly Better

PH.Intelligence@hertfordshire.gov.uk




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

Lea Valley Health PCN show a similar rate of admissions to the ICB.

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
Overall Population Measures													
Population	2	151	261	224	344	271	154	105	134	11	1	1658	37725
% of population in cohort	0.1%	9.1%	15.7%	13.5%	20.7%	16.3%	9.3%	6.3%	8.1%	0.7%	0.1%	100.0%	100.0%
Avg. Age	80.0	72.6	73.0	73.4	76.2	74.4	75.5	73.8	76.7	70.8	79.0	74.5	75.6
% BAME Where recorded	0%	14%	8%	11%	8%	9%	11%	13%	4%	0%	0%	9%	8%
Avg. number of Acute and Chronic Condition	3.5	5.1	5.1	5.2	5.2	5.2	5.1	4.8	5.2	4.9	2.0	5.1	5.5
Activity Measure													
Emergency Admissions	0.0	0.5	0.4	0.5	0.5	0.4	0.4	0.3	0.5	0.3	0.0	0.4	0.6
A&E Attendances	0.5	1.0	0.9	1.0	0.8	0.7	0.9	0.7	1.4	0.6	0.0	0.9	0.9
GP Encounters	44.0	133.4	122.9	137.7	127.6	107.2	116.2	120.1	104.4	100.0	47.0	121.7	103.4
Admitted Bed Days	0.0	4.0	2.9	3.7	3.6	2.0	1.9	2.4	3.1	0.0	0.0	3.0	4.2
Physical Health													
Asthma	0.0%	29.1%	24.9%	28.1%	27.9%	29.2%	26.6%	23.8%	24.6%	27.3%	0.0%	27.1%	25.2%
Cancer	0.0%	24.5%	27.6%	28.6%	30.2%	28.4%	31.8%	31.4%	35.1%	27.3%	0.0%	29.3%	32.8%
Chronic Cardiac Disease	50.0%	41.7%	41.4%	38.4%	42.2%	43.2%	38.3%	46.7%	48.5%	63.6%	0.0%	42.2%	47.5%
Chronic Respiratory Disease	50.0%	21.9%	24.1%	27.2%	24.4%	24.4%	23.4%	21.9%	22.4%	27.3%	0.0%	24.1%	22.2%
CKD	0.0%	16.6%	15.7%	20.5%	21.8%	18.8%	20.8%	14.3%	20.9%	9.1%	0.0%	18.9%	20.7%
Heart Disease	50.0%	39.7%	36.8%	32.6%	38.4%	39.1%	32.5%	37.1%	43.3%	63.6%	0.0%	37.5%	39.1%
Hypertension	100.0%	84.1%	80.5%	78.6%	82.0%	78.6%	82.5%	76.2%	82.8%	100.0%	100.0%	80.8%	74.5%
Diabetes	0.0%	43.0%	39.1%	34.8%	37.2%	45.0%	44.8%	41.9%	43.3%	36.4%	0.0%	40.4%	42.8%
Obesity	50.0%	37.1%	44.8%	36.6%	40.4%	41.3%	40.3%	34.3%	40.3%	36.4%	0.0%	40.0%	32.8%
Rheumatoid Arthritis	0.0%	5.3%	8.0%	6.3%	7.0%	5.5%	3.9%	9.5%	7.5%	9.1%	0.0%	6.6%	5.3%
Stroke	0.0%	26.5%	26.8%	23.7%	23.8%	25.5%	24.0%	21.0%	26.9%	27.3%	0.0%	24.8%	34.5%
Mental Health													
Anxiety	50.0%	45.0%	35.6%	40.6%	37.2%	36.5%	42.2%	34.3%	30.6%	9.1%	0.0%	37.6%	29.0%
Depression	0.0%	44.4%	33.3%	41.1%	31.1%	34.7%	33.8%	28.6%	26.9%	18.2%	0.0%	34.2%	33.6%
Dementia	0.0%	6.0%	8.0%	9.4%	6.4%	5.5%	7.1%	4.8%	7.5%	0.0%	0.0%	6.9%	18.6%
Serious Mental Illness	0.0%	6.6%	5.0%	2.7%	2.3%	3.0%	4.5%	1.0%	0.0%	0.0%	0.0%	3.2%	6.5%
Low Mood	0.0%	23.8%	23.0%	23.7%	23.3%	20.3%	26.6%	19.0%	16.4%	0.0%	0.0%	22.1%	18.5%
Suicide	0.0%	6.0%	3.1%	1.3%	2.3%	1.1%	1.9%	1.0%	1.5%	0.0%	0.0%	2.2%	1.5%
Mental Health Flag	50.0%	60.9%	51.7%	59.8%	52.9%	49.8%	55.8%	52.4%	41.0%	18.2%	0.0%	52.9%	48.8%
Screening and Verification Refusal													
Bowel Screening Refused	0.0%	25.8%	36.0%	33.0%	30.2%	32.1%	30.5%	32.4%	28.4%	36.4%	0.0%	31.4%	25.5%
Cervical Screening Refused	0.0%	1.3%	6.5%	6.7%	3.8%	5.5%	2.6%	7.6%	4.5%	9.1%	0.0%	4.9%	3.6%
Flu Vaccine Refused	50.0%	23.2%	19.9%	21.9%	19.5%	16.2%	15.6%	21.9%	14.9%	0.0%	0.0%	19.0%	26.4%
Wider Indicators													
Has A Carer	50.0%	25.8%	20.7%	27.2%	25.9%	20.7%	26.0%	20.0%	14.9%	9.1%	0.0%	23.0%	19.0%
Is A Carer	50.0%	19.9%	14.2%	18.3%	18.6%	16.6%	25.3%	13.3%	9.0%	27.3%	0.0%	17.2%	11.9%
MED3 Not Fit For Work (ever)	0.0%	19.9%	23.4%	17.9%	15.7%	15.9%	15.6%	17.1%	17.9%	18.2%	0.0%	17.9%	13.4%
MED3 Not Fit For Work (in Last Year)	0.0%	10.6%	6.5%	8.0%	4.4%	3.7%	3.9%	4.8%	3.7%	9.1%	0.0%	5.6%	3.5%
MED3 Not Fit For Work (in Last Six Months)	0.0%	9.3%	5.4%	4.9%	3.8%	1.8%	3.9%	5.7%	3.0%	0.0%	0.0%	4.4%	2.8%
Avg. number of eFI Deficits	10.0	15.3	15.3	15.2	15.4	15.3	15.7	14.9	15.4	15.2	13.0	15.3	13.4
eFI_Housebound	0.0%	15.9%	8.4%	14.7%	11.3%	8.1%	12.3%	5.7%	11.2%	9.1%	0.0%	10.9%	10.9%
eFI_SocialVulnerability	50.0%	36.4%	32.2%	37.5%	38.7%	33.2%	37.0%	27.6%	20.1%	18.2%	0.0%	33.9%	27.3%
People_ChildrenInPoverty	32.6	31.3	26.0	21.1	13.4	15.0	14.5			8.0		24.5	15.5
Housing_FuelPoverty	26.0	15.7	13.9	13.6	9.7	7.5	10.2	6.8	7.4	7.0		10.7	11.1
Housing_OnePersonHousehold	41.7	39.1	31.8	26.4	25.1	28.8	22.1	19.6	16.6	20.7		26.9	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 Lea Valley 38.5% 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 Lea Valley Health PCN is slightly lower than the ICB, and the data shows higher usage of GP services.

Within this segment we can see the presence of Chronic Cardiac Disease and Heart Disease being highlighted which chimes with the reason for admission within previous analysis for ACS conditions. There is also high Diabetes, Obesity and Mental Health Flagged patients. It is to be noted that Hypertension is high across all deciles and higher than the ICB.

Why Machine Learning?

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

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

Approach

- Trained several machine learning models on ~1 million linked patient records across ~200 features from the ICS segmentation dataset, for binary A&E risk prediction (will this patient use A&E within the next year?).

- Selected a final twin ensemble model with a binary classification accuracy of 81.3%.

- Extracted output probabilities for each class to estimate a risk score for each patient, and generated risk scores for all of the patients in the segmentation data. We can think of the risk score as the model's confidence in a patient requiring A&E.

- Partitioned the patient population into 3 distinct grades, Low, Medium and High risk, based on the machine learning predictions:

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

Creating search logic from significant features

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

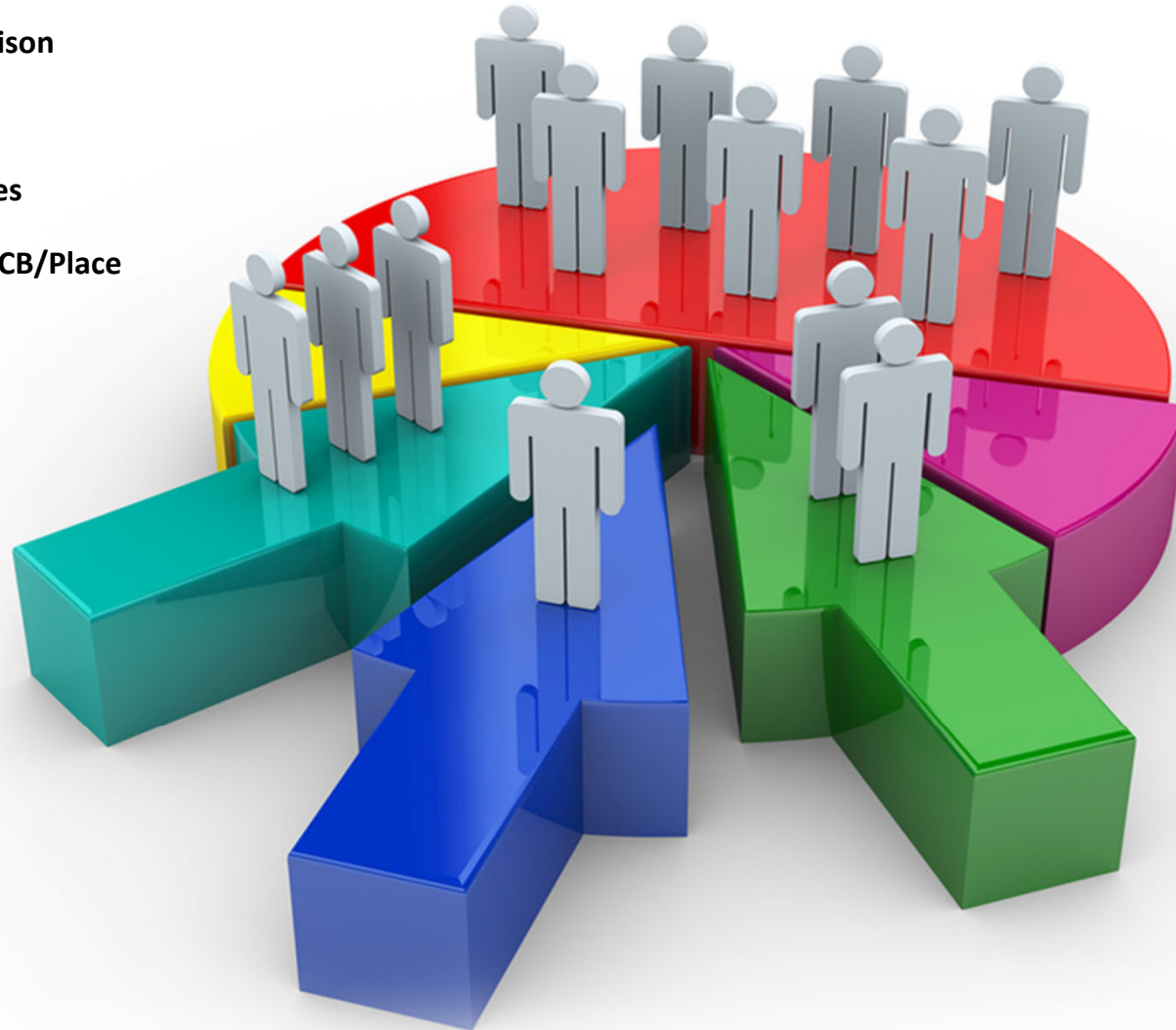
Feature	Relative significance (%)
Age	15.03
Drug: Pain Management	10.22
Substance Abuse	4.19
Med3 Not Fit For Work	3.41
Stroke	3.03
eFI: Falls	2.23
Air Rank Quality	2.01
Waiting List Count All	1.83
...	...

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

Quality & Outcomes Framework

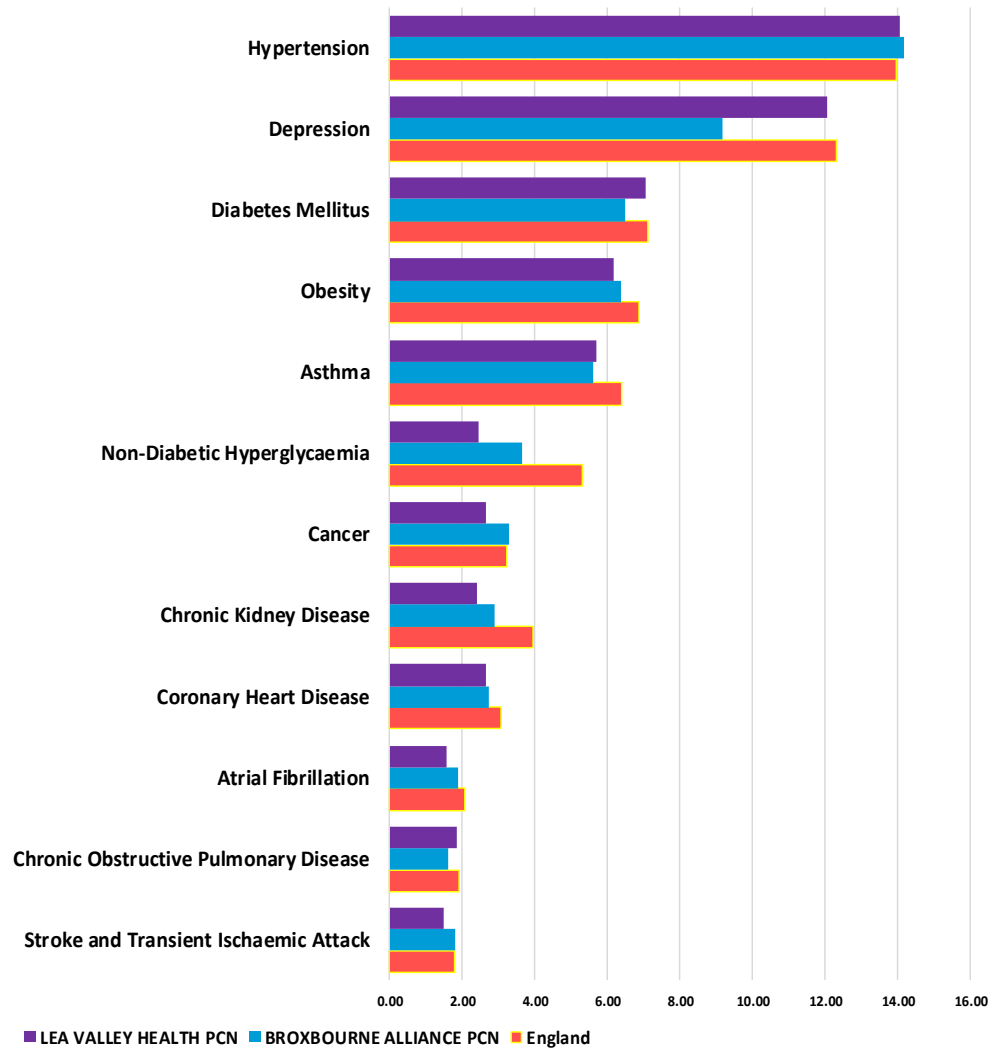
Contents:

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

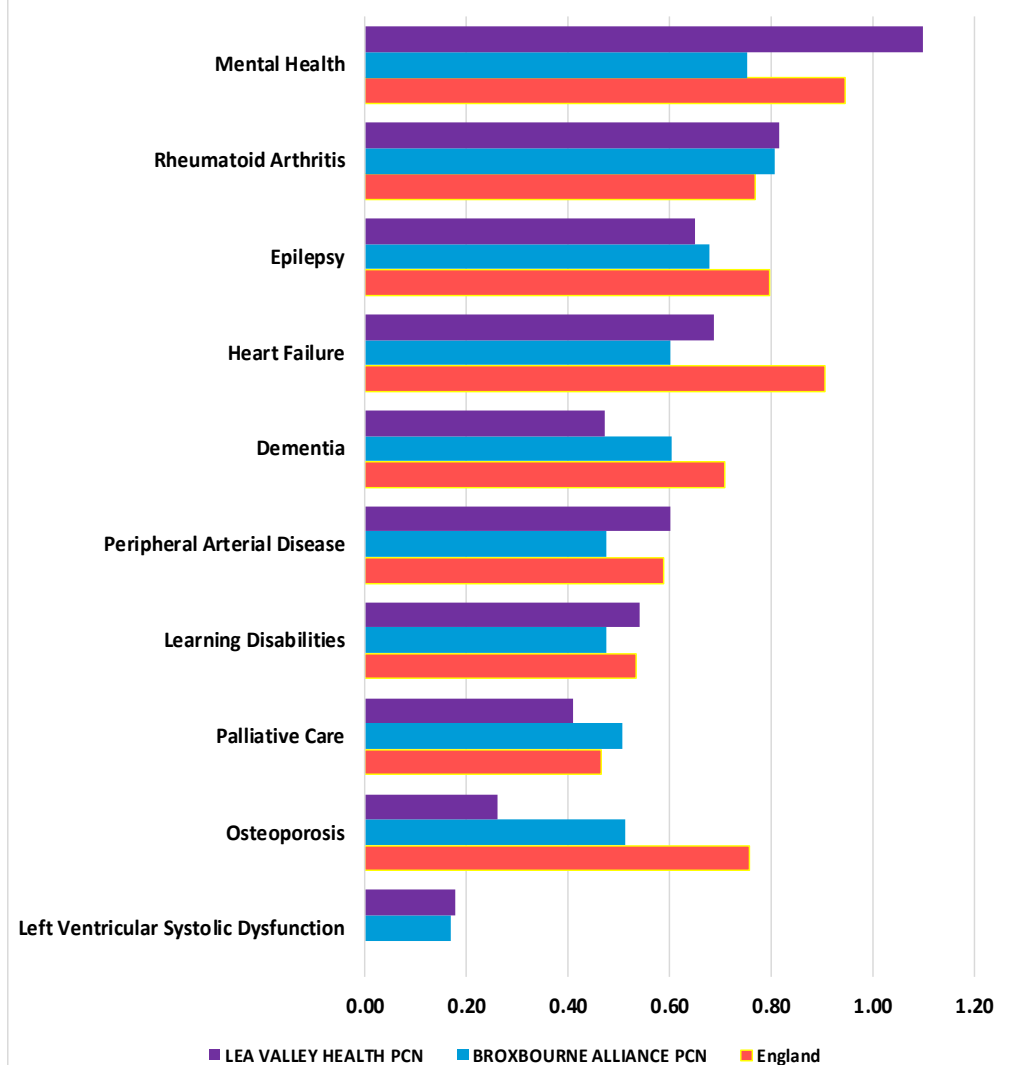


QOF - Locality & PCN Comparison

QOF PCN Comparison within Locality



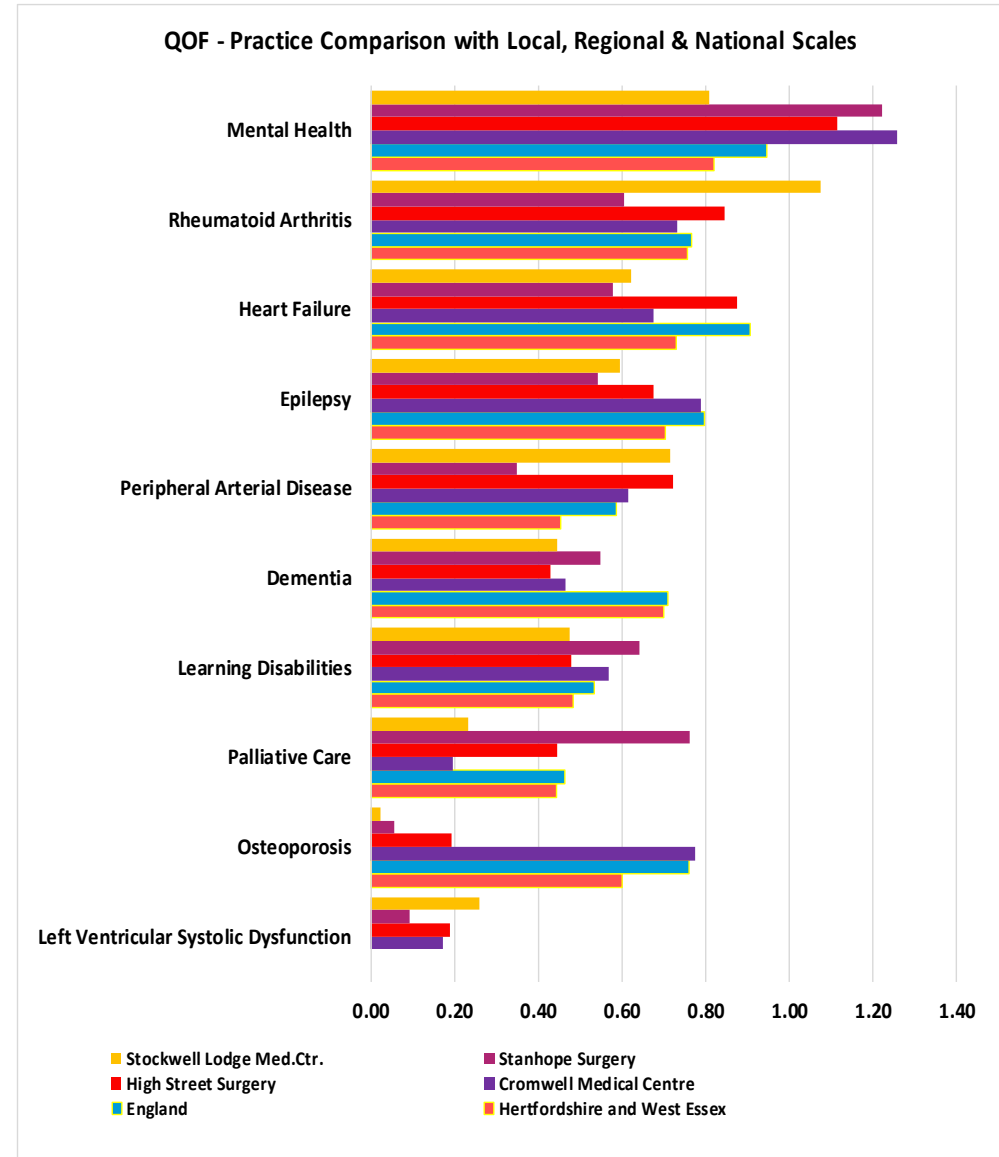
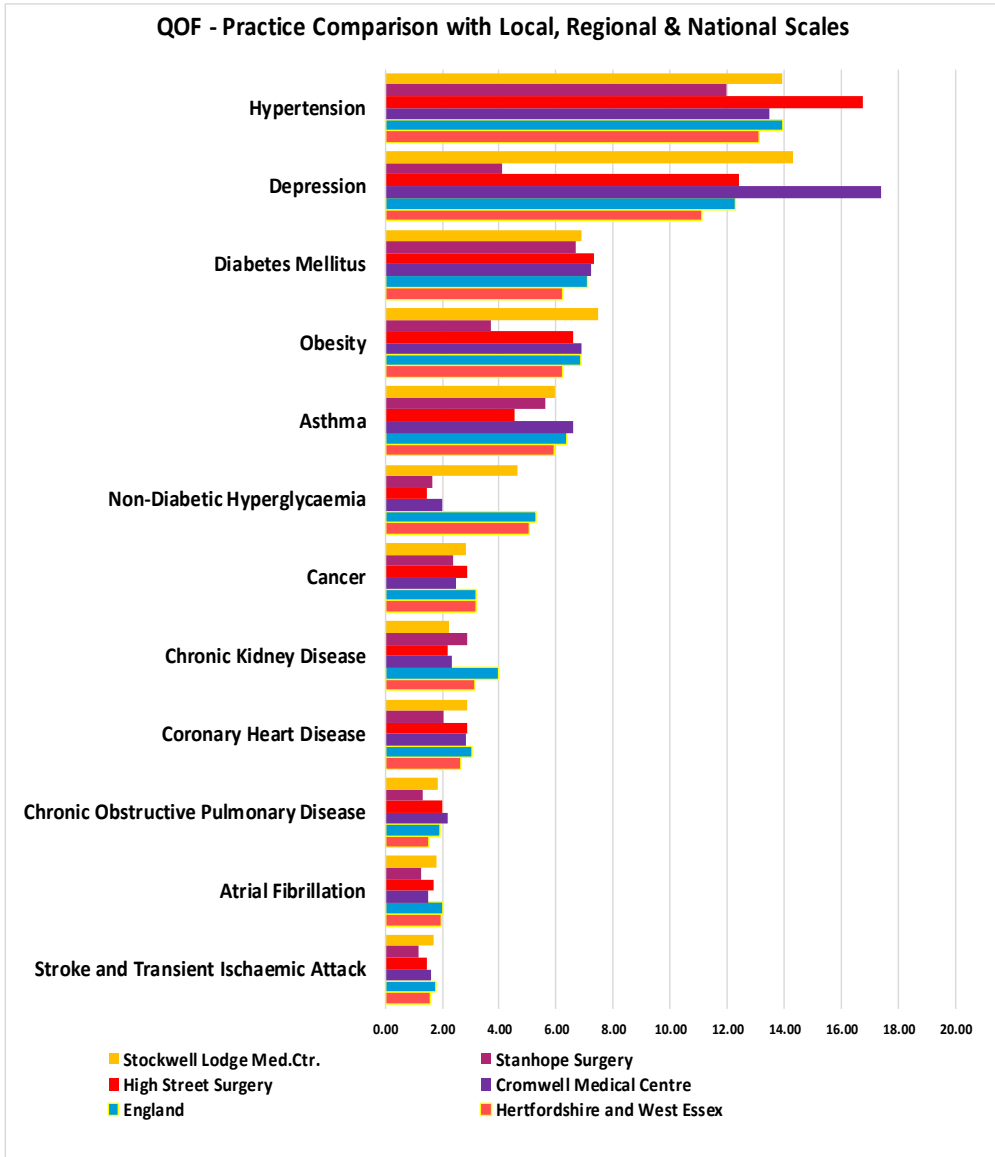
QOF PCN Comparison within Locality



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



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

QOF - Missed Diagnoses & Admission Rates

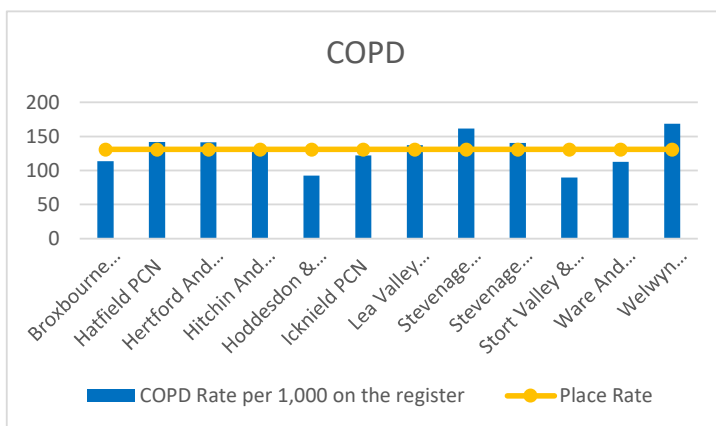
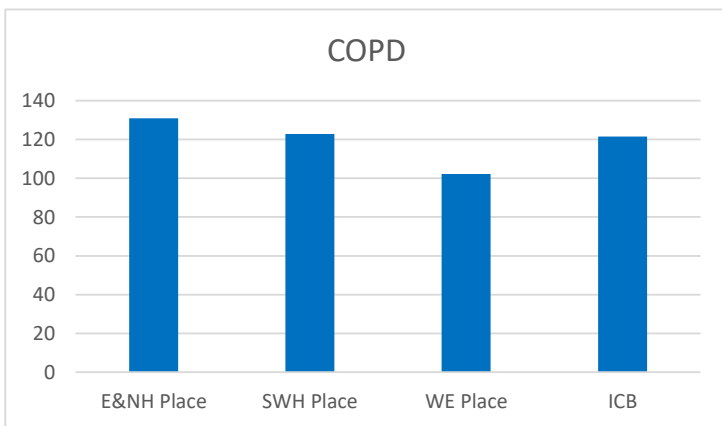
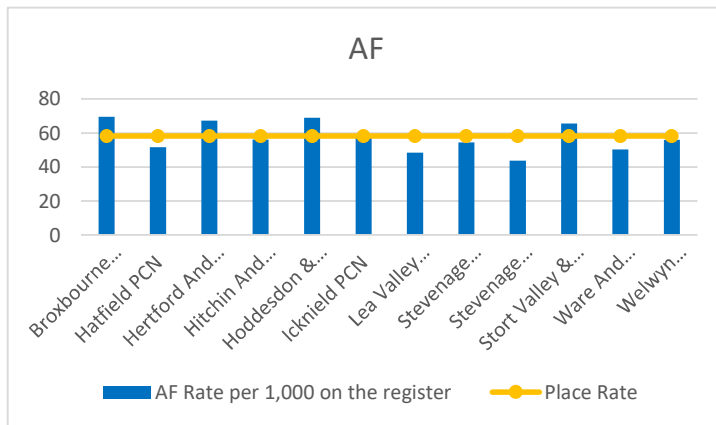
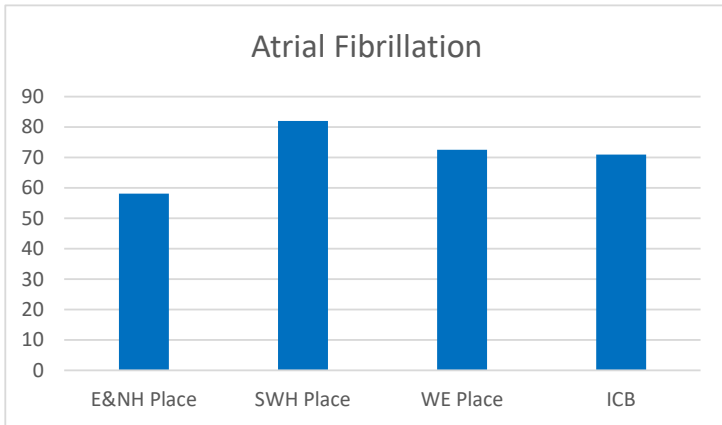
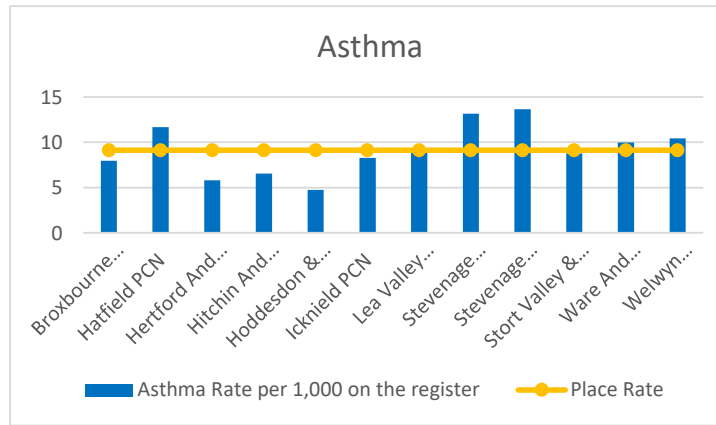
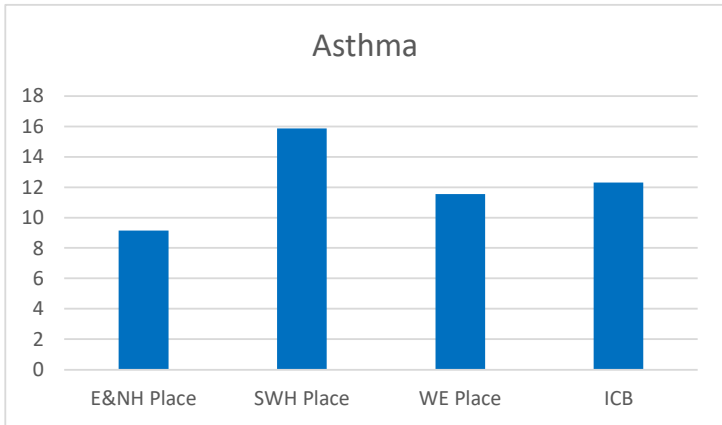
Disease	QOF List size 21-22	QOF Register 21-22	QOF Prevalence 21/22	Place prevalence	ICB prevalence	Modelled prevalence	New diagnoses to meet Place average	new diagnoses to meet ICB average	New diagnoses to meet estimated prevalence
Asthma	30008	1770	5.90%	6.39%	6.17%		147	81	
COPD	32254	598	1.85%	1.54%	1.49%	2.22%	-103	-119	119
Diabetes	25507	1830	7.17%	6.29%	6.39%	7.78%	-226	-201	153
Non-diabetic hyperglycaemia	25123	799	3.18%	4.63%	5.87%	10.87%	364	676	1933
Hypertension	32254	4402	13.65%	13.25%	13.21%		-127	-140	
Atrial Fibrillation	32254	536	1.66%	2.01%	2.02%	2.28%	113	116	198
Stroke and TIA	32254	507	1.57%	1.70%	1.61%		41	12	
Coronary Heart Disease	32254	852	2.64%	2.62%	2.65%		-6	4	
Heart failure	32254	228	0.71%	0.71%	0.75%	1.29%	1	16	189
Left Ventricular Systolic Dysfunction	32254	106	0.33%	0.20%	0.30%		-42	-9	
Chronic Kidney Disease	25123	555	2.21%	2.53%	3.21%		81	251	
Peripheral Arterial Disease	32254	183	0.57%	0.46%	0.44%		-35	-40	
Cancer	32254	908	2.82%	3.33%	3.35%		166	171	
Palliative care	32254	110	0.34%	0.50%	0.43%		52	28	

The table above shows the latest prevalence (2021/22 published August 2022) for the PCN alongside the place prevalence, ICB prevalence and the modelled prevalence for the PCN.

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

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

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



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

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

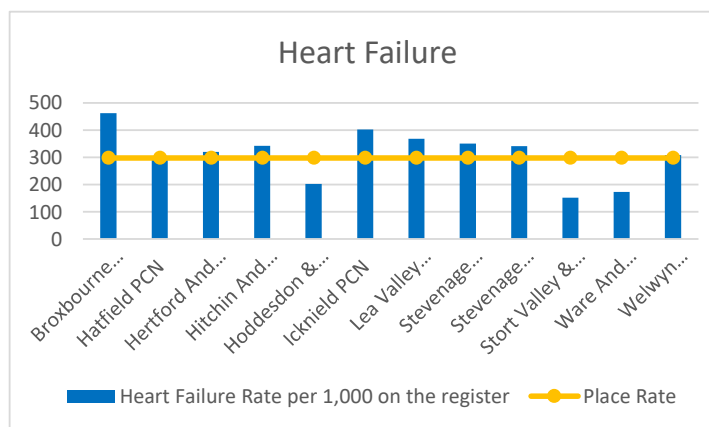
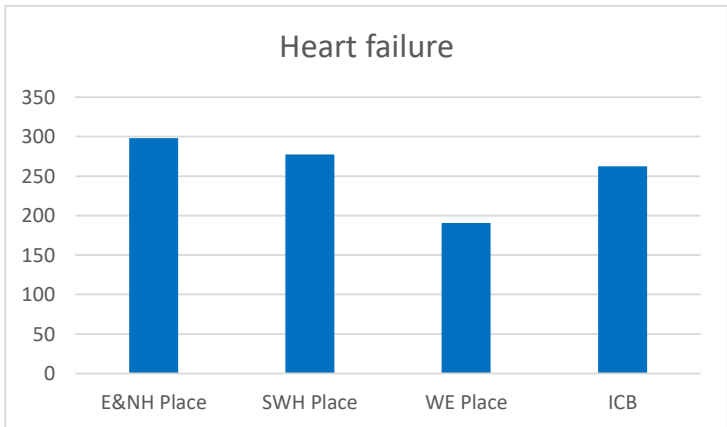
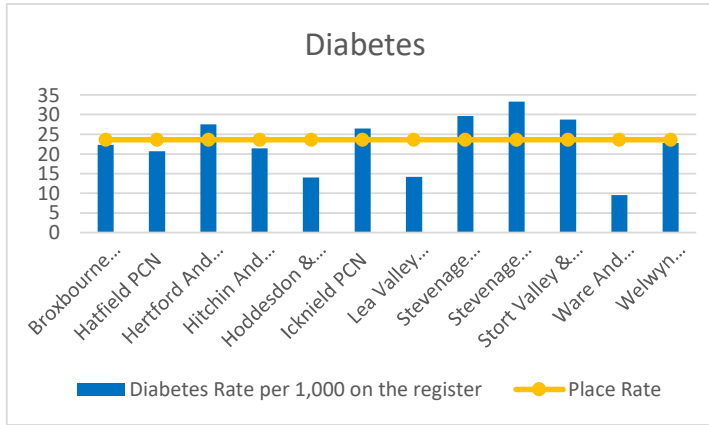
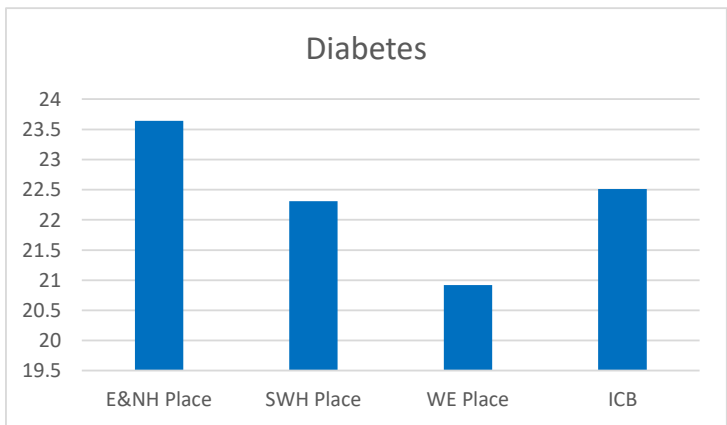
These are continued on the following place.

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

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

Source: HWE PHM Team, SUS data

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



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	
	Low Complexity	Middle Complexity	High Complexity	Low Complexity	Middle Complexity	High Complexity	Low Complexity	Middle Complexity	Low Complexity	Middle Complexity	High Complexity	Low Complexity	Middle Complexity	High Complexity	Low Complexity	Middle Complexity	High Complexity	Low Complexity	Middle Complexity	High Complexity	Low Complexity	Middle Complexity	High Complexity		
Overall Population Measures																									
Population	452	140		482	331	31	54	11	1,165	727	56	488	258	22	650	473	52	10,179	9,680	1,503	3,169	827	10	30,761	
Age	33	47	30	29	47	64	29	39	27	47	63	19	38	58	27	47	68	29	50	71	31	46	72	39	
Male %	55.8%	49.3%	#####	48.3%	45.9%	48.4%	51.9%	54.5%	49.4%	44.3%	37.5%	50.8%	49.6%	54.5%	53.7%	48.2%	50.0%	52.4%	44.9%	46.8%	60.8%	60.3%	50.0%	50.3%	
IMD	4.8	5.0	5.0	4.7	5.2	5.2	4.9	5.1	4.4	4.5	4.2	4.6	4.7	4.1	4.5	4.8	4.9	5.1	5.2	5.1	5.1	5.3	4.8	5.0	
% BAME (where recorded)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	0%	0%	0%				20%	
Multimorbidity (acute & chronic)	0.0	1.5	5.0	0.0	1.9	5.7	0.0	2.0	0.0	1.6	6.0	0.0	1.6	6.3	0.0	1.9	6.5	0.0	2.0	6.5	0.0	1.5	5.8	1.1	
Finance and Activity Measures																									
Spend	Total	£0.1M	£0.0M	£0.0M	£0.2M	£0.3M	£0.1M	£0.0M	£0.0M	£0.4M	£0.6M	£0.2M	£0.2M	£0.2M	£0.0M	£0.2M	£0.6M	£0.2M	£3.0M	£8.0M	£5.4M	£0.3M	£0.2M	£0.0M	#####
PPPY - Total		£118	£190	£49	£434	£896	£2,227	£74	£127	£315	£824	£4,421	£324	£670	£2,078	£354	£1,240	£3,414	£293	£824	£3,570	£86	£190	£738	£650
Acute Elective		£31	£69	£0	£143	£393	£1,162	£8	£26	£125	£347	£2,206	£102	£287	£664	£125	£635	£1,076	£100	£402	£1,438	£22	£81	£521	£279
Acute Non-Elective		£34	£14	£0	£200	£328	£727	£31	£0	£119	£311	£1,754	£143	£239	£1,047	£152	£425	£1,971	£121	£253	£1,749	£11	£18	£0	£248
GP Encounters		£53	£107	£49	£91	£175	£337	£35	£101	£71	£166	£461	£80	£145	£367	£78	£181	£368	£72	£169	£384	£54	£92	£216	£124
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		18	38	18	30	57	117	13	37	24	54	147	27	47	114	26	58	123	23	53	122	18	28	68	40
Beddays PPPY - Acute EM		0	0	0	0	0	1	0	0	1	0	6	0	1	2	0	1	5	0	0	4	0	0	0	0
Physical Health																									
Diabetes		0.0%	22.9%	0.0%	0.0%	32.6%	61.3%	0.0%	27.3%	0.0%	23.2%	55.4%	0.0%	19.0%	54.5%	0.0%	20.5%	51.9%	0.0%	14.1%	43.9%	0.0%	10.4%	50.0%	8.6%
COPD		0.0%	2.1%	0.0%	0.0%	0.9%	16.1%	0.0%	0.0%	0.0%	0.4%	10.7%	0.0%	1.6%	18.2%	0.0%	1.3%	19.2%	0.0%	2.1%	32.1%	0.0%	1.0%	20.0%	2.4%
Chronic Respiratory Dis...		0.0%	2.1%	0.0%	0.0%	2.7%	19.4%	0.0%	0.0%	0.0%	2.1%	19.6%	0.0%	5.0%	31.8%	0.0%	2.3%	28.8%	0.0%	3.0%	38.5%	0.0%	1.2%	20.0%	3.2%
Hypertension		0.0%	30.0%	0.0%	0.0%	29.9%	77.4%	0.0%	9.1%	0.0%	39.9%	87.5%	0.0%	22.5%	77.3%	0.0%	32.8%	78.8%	0.0%	31.9%	82.3%	0.0%	22.5%	80.0%	17.2%
Obesity		4.2%	15.7%	0.0%	5.2%	15.1%	32.3%	1.9%	0.0%	6.1%	21.5%	39.3%	4.3%	13.2%	45.5%	5.2%	18.6%	32.7%	9.7%	27.6%	43.1%	3.9%	14.0%	60.0%	16.7%
Mental Health																									
Anxiety/Phobias		0.0%	28.6%	100.0%	0.0%	23.0%	41.9%	0.0%	45.5%	0.0%	21.0%	46.4%	0.0%	22.5%	45.5%	0.0%	31.3%	59.6%	0.0%	36.4%	50.6%	0.0%	29.9%	50.0%	16.6%
Depression		0.0%	25.0%	100.0%	0.0%	21.8%	38.7%	0.0%	54.5%	0.0%	17.9%	46.4%	0.0%	23.3%	36.4%	0.0%	26.8%	55.8%	0.0%	34.1%	47.0%	0.0%	27.8%	40.0%	15.4%
Learning Disability		0.0%	1.4%	100.0%	0.0%	1.2%	3.2%	0.0%	0.0%	0.0%	0.7%	0.0%	0.0%	1.6%	9.1%	0.0%	2.1%	0.0%	0.0%	1.9%	3.7%	0.0%	1.8%	0.0%	0.9%
Dementia		0.0%	0.7%	0.0%	0.0%	1.2%	0.0%	0.0%	9.1%	0.0%	0.7%	7.1%	0.0%	0.4%	4.5%	0.0%	0.2%	7.7%	0.0%	0.5%	7.7%	0.0%	0.4%	10.0%	0.6%
Other Characteristics																									
Housebound (eFI)		0.0%	0.7%	0.0%	0.0%	0.9%	0.0%	0.0%	0.0%	0.0%	0.7%	8.9%	0.2%	2.3%	0.0%	0.2%	0.4%	7.7%	0.0%	0.9%	9.4%	0.1%	1.0%	10.0%	0.9%
Social Vulnerability (eFI)		0.4%	1.4%	0.0%	0.2%	6.3%	19.4%	0.0%	9.1%	0.9%	6.1%	28.6%	0.8%	5.8%	22.7%	0.9%	5.3%	21.2%	0.9%	6.7%	28.2%	0.6%	1.7%	20.0%	4.5%
History of Smoking (Tw...		13.3%	15.0%	0.0%	3.9%	10.0%	12.9%	7.4%	27.3%	4.3%	11.1%	10.7%	7.2%	17.8%	27.3%	8.6%	15.6%	11.5%	8.9%	19.8%	22.6%	8.6%	16.6%	20.0%	13.2%
Not Fit for Work (In Year)		2.2%	5.0%	0.0%	5.4%	10.6%	9.7%	0.0%	0.0%	4.0%	12.0%	19.6%	1.8%	10.9%	4.5%	4.6%	11.8%	13.5%	3.4%	9.7%	6.4%	1.5%	5.6%	0.0%	6.0%
On a Waiting List		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

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

Matrix Data - Segment & Sub-Segment

Life Course Segment	1 - Healthy			2 - Living With Illness			3 - Lower Complexity			4 - Advanced Disease & Complexity			5 - EoL, Frailty & Dementia			Grand Total	
	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	10,492	373	728	3,065	2,865	1,115	217	2,935	2,975	3,490	576	272	1,463		193	30,761	
Age	25	12	18	43	43	38	47	47	44	51	58	64	75	59	71	39	
Male %	57.3%	31.6%	55.5%	55.2%	57.9%	48.7%	54.8%	47.1%	40.0%	36.7%	43.2%	52.2%	40.7%	100.0%	42.5%	50.3%	
IMD	4.9	5.0	4.8	5.0	5.2	4.9	4.9	5.1	5.2	5.2	5.1	4.8	5.2	3.0	5.0	5.0	
% BAME (where recorded)	26%	29%	31%	21%	24%	16%	24%	16%	17%	14%	12%	10%	8%	0%	16%	20%	
Multimorbidity (acute & chronic)	0.0	0.0	0.0	0.0	1.0	1.0	0.5	2.4	1.4	2.2	2.7	4.6	5.1	4.0	5.3	1.1	
Finance and Activity Measures																	
Spend	Total	£0.8M	£0.4M	£1.0M	£1.2M	£1.2M	£0.4M	£0.1M	£2.0M	£2.3M	£3.5M	£0.6M	£0.7M	£4.3M	£0.0M	£1.3M	£20.0M
	PPPY - Total	£81	£1,114	£1,343	£397	£434	£386	£504	£695	£757	£1,011	£1,061	£2,562	£2,960	£3,968	£6,694	£650
	Acute Elective	£21	£218	£538	£144	£182	£135	£206	£314	£380	£478	£437	£1,201	£1,209	£625	£3,346	£279
	Acute Non-Elective	£12	£749	£670	£162	£147	£148	£190	£236	£226	£330	£385	£1,063	£1,375	£2,707	£2,900	£248
	GP Encounters	£48	£147	£136	£91	£106	£103	£109	£145	£151	£203	£240	£299	£376	£637	£449	£124
	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	16	52	45	30	34	34	37	46	48	62	76	94	119	152	145	40
	Beddays PPPY - Acute EM	0	2	1	0	0	0	0	0	0	1	1	2	3	9	8	0
Physical Health																	
Diabetes		0.0%	0.0%	0.0%	0.0%	12.6%	0.0%	8.8%	13.6%	12.9%	18.7%	19.6%	22.8%	42.3%	0.0%	26.4%	8.6%
COPD		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.4%	1.0%	3.9%	4.7%	54.0%	19.7%	0.0%	20.7%	2.4%
Chronic Respiratory Dis...		0.0%	0.0%	0.0%	0.0%	1.3%	0.0%	0.0%	3.4%	1.7%	5.4%	6.3%	59.9%	23.7%	0.0%	28.0%	3.2%
Hypertension		0.0%	0.0%	0.0%	0.0%	26.8%	0.0%	14.7%	27.9%	24.3%	34.7%	43.1%	56.3%	81.7%	0.0%	75.1%	17.2%
Obesity		0.0%	0.0%	0.0%	32.0%	18.9%	15.2%	20.7%	24.4%	23.0%	31.0%	27.3%	33.8%	41.5%	0.0%	29.0%	16.7%
Mental Health																	
Anxiety/Phobias		0.0%	0.0%	0.0%	0.0%	0.0%	48.8%	1.8%	59.8%	22.2%	35.4%	32.1%	33.8%	36.8%	0.0%	44.0%	16.6%
Depression		0.0%	0.0%	0.0%	0.0%	0.0%	39.7%	5.5%	58.7%	20.3%	33.3%	26.6%	30.9%	34.7%	0.0%	30.6%	15.4%
Learning Disability		0.0%	0.0%	0.0%	0.0%	0.0%	1.3%	0.0%	2.2%	0.3%	1.3%	19.6%	1.8%	1.9%	100.0%	1.0%	0.9%
Dementia		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.2%	5.0%	1.1%	6.6%	100.0%	8.3%	0.6%
Other Characteristics																	
Housebound (eFI)		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	15.5%	1.5%	10.0%	50.0%	17.1%	0.9%
Social Vulnerability (eFI)		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	77.9%	2.9%	5.5%	5.8%	25.0%	16.2%	34.0%	50.0%	33.2%	4.5%
History of Smoking (Tw...		0.0%	0.0%	0.0%	38.8%	13.9%	16.8%	12.0%	23.1%	16.0%	19.6%	15.8%	29.4%	16.5%	0.0%	13.0%	13.2%
Not Fit for Work (In Year)		0.0%	0.0%	0.0%	13.1%	5.7%	9.0%	5.1%	11.4%	8.3%	12.0%	6.4%	10.3%	5.3%	0.0%	7.8%	6.0%
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	
	Low Complexity	Middle Complexity	Low Complexity	Middle Complexity	Low Complexity	Middle Complexity	Low Complexity	Middle Complexity	Low Complexity	Middle Complexity	High Complexity	Low Complexity	Middle Complexity	High Complexity		
Overall Population Measures																
Population	948	148	505	89	1,074	171	1,129	241	2,762	730		10,221	11,068	1,671	30,761	
Age	23	31	27	34	21	33	24	34	29	37	64	31	51	71	39	
Male %	67.3%	81.1%	66.7%	75.3%	60.1%	74.3%	63.1%	73.0%	59.8%	67.4%	50.0%	48.5%	43.1%	46.7%	50.3%	
IMD	5.1	5.2	4.5	4.8	4.9	5.0	5.0	5.1	5.0	5.3	3.8	5.0	5.1	5.1	5.0	
% BAME (where recorded)	22%	19%	28%	24%	25%	16%	21%	19%	23%	16%	0%	25%	17%	10%	20%	
Multimorbidity (acute & chronic)	0.0	1.4	0.0	1.2	0.0	1.4	0.0	1.4	0.0	1.4	5.8	0.0	1.9	6.5	1.1	
Finance and Activity Measures																
Spend	Total	£0.0M	£0.0M	£0.0M	£0.0M	£0.0M	£0.0M	£0.0M	£0.0M	£0.2M	£0.0M	£0.0M	£4.0M	£9.7M	£5.9M	£20.0M
	PPPY - Total	£4	£186	£10	£21	£24	£13	£30	£40	£61	£67	£53	£395	£878	£3,539	£650
	Acute Elective	£1	£94	£4	£11	£7	£3	£9	£8	£17	£25	£22	£135	£424	£1,434	£279
	Acute Non-Elective	£3	£91	£4	£6	£9	£2	£7	£16	£19	£14	£0	£157	£274	£1,720	£248
	GP Encounters	£0	£0	£3	£3	£8	£8	£14	£15	£25	£28	£31	£102	£181	£384	£124
	Community	£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
	Social Care	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
	GP PPPY	0	0	1	1	2	2	4	5	8	8	8	34	57	122	40
	Beddays PPPY - Acute EM	0	0	0	0	0	0	0	0	0	0	0	0	0	4	0
Physical Health																
Diabetes		0.0%	2.0%	0.0%	2.2%	0.0%	1.2%	0.0%	0.8%	0.0%	3.0%	25.0%	0.0%	16.9%	45.1%	8.6%
COPD		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.5%	0.0%	0.0%	2.0%	30.5%	2.4%
Chronic Respiratory Dis...		0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	1.7%	0.0%	1.0%	0.0%	0.0%	3.1%	37.0%	3.2%
Hypertension		0.0%	4.7%	0.0%	2.2%	0.0%	7.0%	0.0%	7.5%	0.0%	11.4%	75.0%	0.0%	34.3%	82.2%	17.2%
Obesity		1.6%	2.0%	1.6%	3.4%	1.9%	5.8%	1.8%	7.9%	3.6%	9.6%	25.0%	11.0%	27.4%	42.6%	16.7%
Mental Health																
Anxiety/Phobias		0.0%	31.1%	0.0%	33.7%	0.0%	31.6%	0.0%	33.6%	0.0%	32.2%	75.0%	0.0%	34.4%	50.5%	16.6%
Depression		0.0%	27.7%	0.0%	29.2%	0.0%	32.7%	0.0%	29.5%	0.0%	29.2%	75.0%	0.0%	32.1%	46.9%	15.4%
Learning Disability		0.0%	2.0%	0.0%	1.1%	0.0%	1.8%	0.0%	1.7%	0.0%	1.5%	0.0%	0.0%	1.8%	3.6%	0.9%
Dementia		0.0%	0.7%	0.0%	1.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.5%	7.5%	0.6%
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%	0.1%	1.0%	9.0%	0.9%
Social Vulnerability (eFI)		0.4%	0.7%	0.8%	0.0%	0.3%	0.6%	0.3%	0.4%	0.5%	1.4%	0.0%	1.0%	6.9%	27.8%	4.5%
History of Smoking (Tw...		3.8%	12.2%	5.5%	7.9%	4.8%	11.1%	5.3%	10.0%	7.3%	13.0%	25.0%	10.0%	19.4%	21.7%	13.2%
Not Fit for Work (In Year)		0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%	0.4%	0.7%	1.5%	0.0%	4.8%	10.7%	7.1%	6.0%
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%

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	
	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	1,596	6,467	3,460	70	1,075	3,974	1,967	29	988	3,395	1,717	27	724	2,395	1,202	17	250	993	414		30,761	
Age	28	25	22	23	45	42	40	39	49	46	43	34	54	53	51	41	75	75	73	79	39	
Male %	56.4%	56.8%	55.6%	55.7%	58.9%	54.7%	54.3%	58.6%	44.8%	44.5%	42.4%	40.7%	41.3%	37.8%	38.3%	41.2%	42.8%	39.8%	42.8%	0.0%	50.3%	
IMD	8.6	5.2	2.7		8.6	5.3	2.7		8.6	5.3	2.7		8.6	5.3	2.7		8.6	5.4	2.6		5.0	
% BAME (where recorded)	18%	26%	29%	42%	15%	21%	25%	29%	13%	16%	21%	20%	9%	13%	18%	19%	8%	9%	10%	0%	20%	
Multimorbidity (acute & chronic)	0.0	0.0	0.0	0.0	0.6	0.6	0.6	0.9	1.8	1.8	1.8	1.4	2.2	2.4	2.6	2.6	5.0	5.2	5.1	2.0	1.1	
Finance and Activity Measures																						
Spend	Total	£0.3M	£1.3M	£0.7M	£0.0M	£0.4M	£1.7M	£0.8M	£0.0M	£0.6M	£2.5M	£1.3M	£0.0M	£0.8M	£2.7M	£1.3M	£0.0M	£0.9M	£3.3M	£1.4M	£0.0M	£20.0M
	PPPY - Total	£190	£196	£192	£97	£358	£417	£424	£410	£616	£728	£763	£439	£1,092	£1,145	£1,063	£1,663	£3,520	£3,332	£3,481	£577	£650
Acute Elective		£66	£60	£59	£11	£144	£157	£167	£265	£305	£345	£359	£233	£559	£524	£481	£556	£1,490	£1,475	£1,395	£391	£279
Acute Non-Elective		£69	£81	£75	£39	£123	£163	£151	£62	£169	£238	£250	£110	£324	£407	£365	£832	£1,647	£1,478	£1,684	£0	£248
GP Encounters		£55	£56	£58	£46	£91	£97	£106	£83	£142	£145	£154	£97	£208	£213	£217	£275	£383	£378	£401	£186	£124
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		17	19	19	16	27	33	34	24	41	47	49	27	58	67	68	73	111	123	126	47	40
Beddays PPPY - Acute EM		0	0	0	0	0	0	0	0	0	0	0	0	1	1	1	4	3	4	4	0	0
Physical Health																						
Diabetes		0.0%	0.0%	0.0%	0.0%	4.5%	5.6%	4.6%	6.9%	12.9%	13.4%	12.6%	7.4%	16.0%	19.4%	20.4%	11.8%	42.4%	40.0%	40.3%	0.0%	8.6%
COPD		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.5%	1.5%	1.8%	3.7%	4.4%	7.3%	8.2%	17.6%	17.6%	20.5%	19.3%	0.0%	2.4%
Chronic Respiratory Dis...		0.0%	0.0%	0.0%	0.0%	0.2%	0.4%	0.9%	0.0%	2.4%	2.2%	2.9%	3.7%	6.9%	9.0%	9.8%	23.5%	22.4%	24.9%	23.4%	0.0%	3.2%
Hypertension		0.0%	0.0%	0.0%	0.0%	12.9%	10.7%	10.0%	20.7%	29.5%	26.2%	22.7%	14.8%	38.7%	37.3%	36.1%	23.5%	80.8%	80.4%	81.9%	100.0%	17.2%
Obesity		0.0%	0.0%	0.0%	0.0%	23.2%	24.7%	23.3%	10.3%	23.6%	24.8%	21.3%	22.2%	29.0%	30.7%	31.4%	52.9%	37.6%	39.8%	42.0%	0.0%	16.7%
Mental Health																						
Anxiety/Phobias		0.0%	0.0%	0.0%	0.0%	7.0%	7.7%	8.1%	13.8%	37.3%	39.3%	41.4%	22.2%	31.9%	34.2%	37.9%	35.3%	31.2%	38.6%	39.1%	0.0%	16.6%
Depression		0.0%	0.0%	0.0%	0.0%	5.3%	6.5%	6.3%	6.9%	35.1%	37.8%	40.8%	29.6%	26.7%	32.2%	35.6%	35.3%	27.2%	34.7%	37.2%	0.0%	15.4%
Learning Disability		0.0%	0.0%	0.0%	0.0%	0.1%	0.3%	0.2%	0.0%	0.9%	1.1%	1.6%	3.7%	2.6%	3.2%	5.5%	11.8%	1.2%	1.8%	2.7%	0.0%	0.9%
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%	1.5%	1.5%	2.3%	0.0%	6.0%	6.9%	7.2%	0.0%	0.6%
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%	1.9%	2.7%	0.0%	8.8%	11.4%	11.1%	0.0%	0.9%
Social Vulnerability (eFI)		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.8%	7.2%	7.9%	3.7%	5.1%	9.5%	10.4%	0.0%	23.2%	36.7%	33.8%	0.0%	4.5%
History of Smoking (Tw...		0.0%	0.0%	0.0%	0.0%	21.6%	25.3%	27.0%	10.3%	17.0%	17.8%	23.6%	14.8%	15.1%	18.8%	24.1%	23.5%	14.4%	14.9%	20.0%	0.0%	13.2%
Not Fit for Work (In Year)		0.0%	0.0%	0.0%	0.0%	5.7%	9.6%	11.1%	10.3%	6.4%	9.8%	11.3%	3.7%	10.2%	10.3%	13.5%	5.9%	4.4%	4.9%	8.0%	0.0%	6.0%
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	Cromwell Medical Centre				High Street Surgery				Stanhope Surgery				Stockwell Lodge Med.Ctr.				Grand Total	
	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	915	5,187	2,213	44	683	3,688	1,527	23	144	3,294	2,620	21	2,891	5,055	2,400	56	30,761	
Age	40	38	36	25	39	40	37	25	39	37	35	22	45	42	39	41	39	
Male %	48.5%	49.4%	51.0%	54.5%	49.9%	51.1%	49.9%	47.8%	58.3%	49.8%	48.2%	66.7%	52.3%	50.9%	50.1%	44.6%	50.3%	
IMD	8.5	5.3	2.7		8.3	5.2	2.8		8.5	5.1	2.5		8.7	5.5	2.8		5.0	
% BAME (where recorded)	13%	18%	20%	38%	24%	22%	26%	39%	23%	33%	35%	54%	12%	11%	15%	17%	20%	
Multimorbidity (acute & chronic)	1.0	1.1	1.1	0.5	0.9	1.1	1.0	0.3	1.0	0.9	0.9	0.2	1.3	1.3	1.2	1.3	1.1	
Finance and Activity Measures																		
Spend	Total	£0.6M	£3.3M	£1.6M	£0.0M	£0.4M	£2.4M	£0.9M	£0.0M	£0.1M	£2.2M	£1.4M	£0.0M	£1.8M	£3.5M	£1.6M	£0.0M	£20.0M
	PPPY - Total	£690	£644	£726	£305	£640	£641	£599	£119	£687	£667	£552	£87	£622	£702	£650	£739	£650
	Acute Elective	£289	£264	£288	£135	£246	£274	£260	£37	£362	£282	£242	£7	£295	£315	£265	£316	£279
	Acute Non-Elective	£278	£259	£311	£101	£289	£260	£228	£34	£189	£257	£189	£21	£199	£251	£246	£286	£248
	GP Encounters	£122	£120	£127	£68	£105	£107	£110	£48	£135	£128	£121	£60	£128	£136	£138	£138	£124
	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	45	44	47	25	45	46	47	21	42	39	37	18	31	33	33	33	40
	Beddays PPPY - Acute EM	1	0	1	0	0	0	1	0	0	1	0	0	0	1	0	1	0
Physical Health																		
Diabetes		7.7%	7.8%	7.5%	0.0%	7.6%	9.9%	8.1%	4.3%	8.3%	8.1%	7.9%	0.0%	9.1%	10.0%	9.4%	8.9%	8.6%
COPD		2.3%	2.7%	3.3%	2.3%	0.9%	2.8%	2.2%	0.0%	2.8%	1.5%	1.9%	0.0%	2.1%	2.8%	2.3%	5.4%	2.4%
Chronic Respiratory Dis...		3.0%	3.3%	4.3%	2.3%	2.2%	3.6%	3.2%	0.0%	3.5%	2.4%	2.6%	0.0%	2.9%	3.4%	2.9%	7.1%	3.2%
Hypertension		17.0%	14.1%	13.5%	6.8%	15.5%	19.2%	16.4%	0.0%	16.0%	15.3%	14.0%	9.5%	21.7%	21.0%	18.5%	17.9%	17.2%
Obesity		25.5%	22.6%	21.9%	13.6%	10.8%	14.5%	13.8%	0.0%	13.9%	12.0%	11.6%	4.8%	15.9%	17.0%	15.6%	19.6%	16.7%
Mental Health																		
Anxiety/Phobias		15.4%	17.6%	18.0%	9.1%	10.0%	12.4%	14.2%	4.3%	13.2%	14.4%	15.1%	0.0%	18.2%	19.7%	19.9%	19.6%	16.6%
Depression		14.3%	16.3%	19.1%	9.1%	10.4%	13.9%	16.2%	13.0%	7.6%	10.2%	10.6%	4.8%	15.6%	19.1%	19.0%	14.3%	15.4%
Learning Disability		0.3%	0.9%	1.2%	0.0%	0.4%	0.6%	0.9%	4.3%	0.7%	0.8%	1.2%	0.0%	0.9%	1.0%	1.5%	3.6%	0.9%
Dementia		0.3%	0.6%	0.6%	0.0%	0.4%	0.4%	0.8%	0.0%	0.0%	0.7%	0.6%	0.0%	0.7%	0.8%	0.7%	0.0%	0.6%
Other Characteristics																		
Housebound (eFI)		0.7%	0.8%	1.2%	0.0%	1.3%	1.2%	1.1%	0.0%	1.4%	1.0%	0.6%	0.0%	0.7%	0.7%	0.8%	0.0%	0.9%
Social Vulnerability (eFI)		3.4%	3.8%	3.1%	0.0%	5.4%	9.5%	8.3%	0.0%	4.9%	5.2%	4.7%	4.8%	2.0%	2.3%	3.5%	0.0%	4.5%
History of Smoking (Tw...		9.0%	10.6%	13.9%	9.1%	9.1%	12.9%	15.7%	4.3%	7.6%	10.7%	11.3%	0.0%	13.5%	16.4%	19.5%	10.7%	13.2%
Not Fit for Work (In Year)		4.9%	6.6%	6.7%	2.3%	4.4%	5.5%	7.1%	0.0%	4.2%	5.3%	6.8%	0.0%	4.4%	5.8%	7.3%	7.1%	6.0%
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



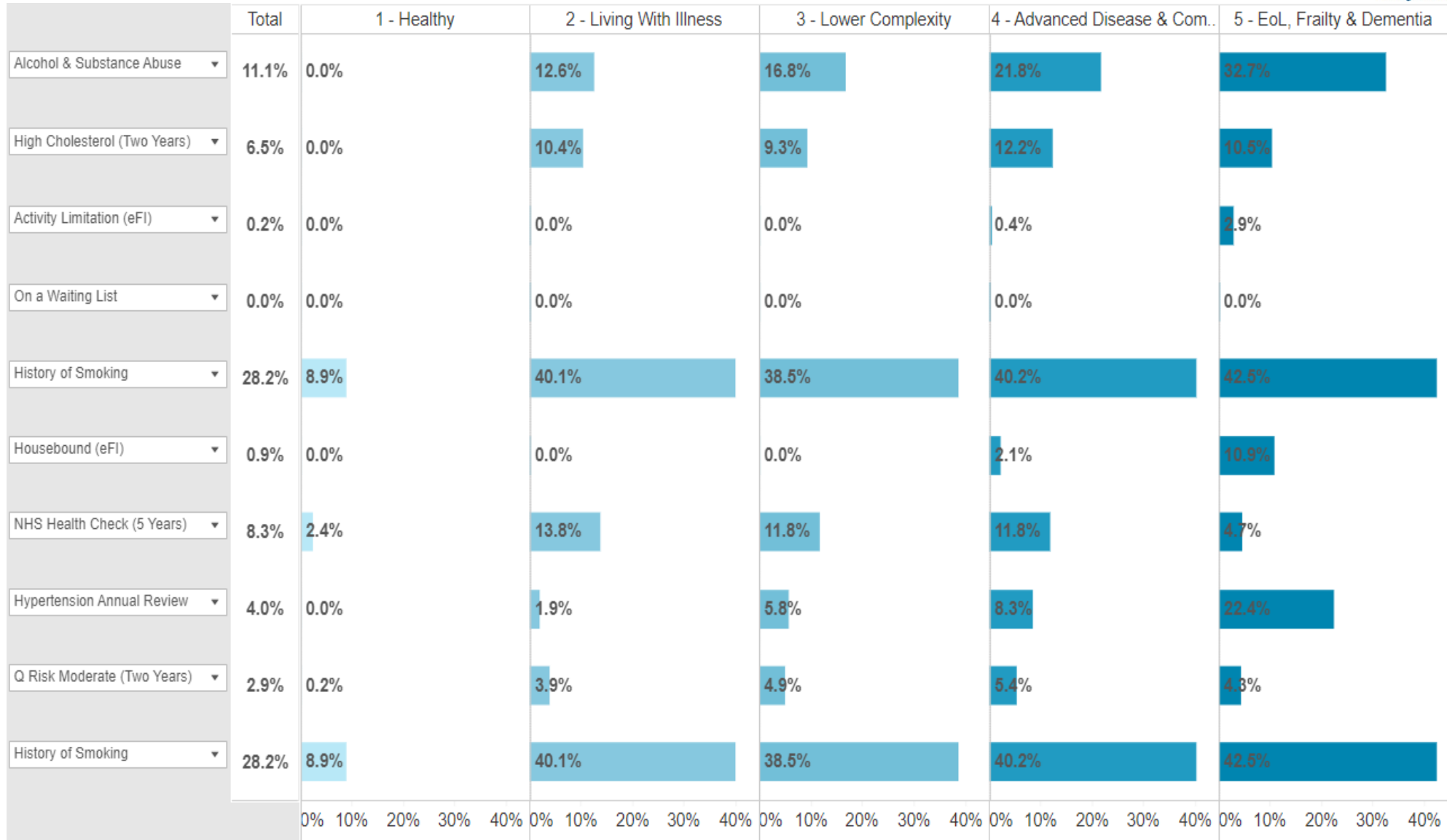
For people with this condition



Initial Condition	Other Conditions												
	Alzheimers Disease	Asthma	COPD	Heart Failure	Anxiety	Autism Spectrum Disorder	Dementia	Alcohol Abuse	ABCD Prescription	Anti-Depressive Prescription	Activity Limitation (eFI)	Housebound (eFI)	No Other Condition
Alzheimers Disease		16%	8%	6%	34%	1%	54%	6%	48%	31%	1%	9%	24%
Asthma	1%		9%	3%	28%	2%	1%	7%	23%	24%	0%	1%	42%
COPD	2%	46%		14%	36%	0%	3%	15%	62%	37%	2%	6%	0%
Heart Failure	3%	26%	26%		32%	0%	5%	10%	92%	26%	3%	12%	0%
Anxiety	1%	21%	5%	3%		2%	1%	10%	27%	48%	1%	2%	15%
Autism Spectrum Disorder	1%	20%	1%	0%	27%		1%	3%	3%	17%	0%	4%	37%
Dementia	49%	24%	10%	11%	40%	2%		11%	66%	39%	2%	23%	1%
Alcohol Abuse	1%	17%	7%	3%	33%	1%	1%		38%	26%	1%	1%	21%
ABCD Prescription	2%	17%	9%	7%	26%	0%	2%	12%		23%	1%	4%	21%
Anti-Depressive Prescription	1%	23%	7%	3%	61%	1%	2%	10%	30%		0%	2%	17%
Activity Limitation (eFI)	3%	20%	23%	17%	45%	2%	5%	14%	63%	31%		8%	9%
Housebound (eFI)	6%	20%	16%	18%	41%	4%	16%	7%	73%	34%	2%		6%

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

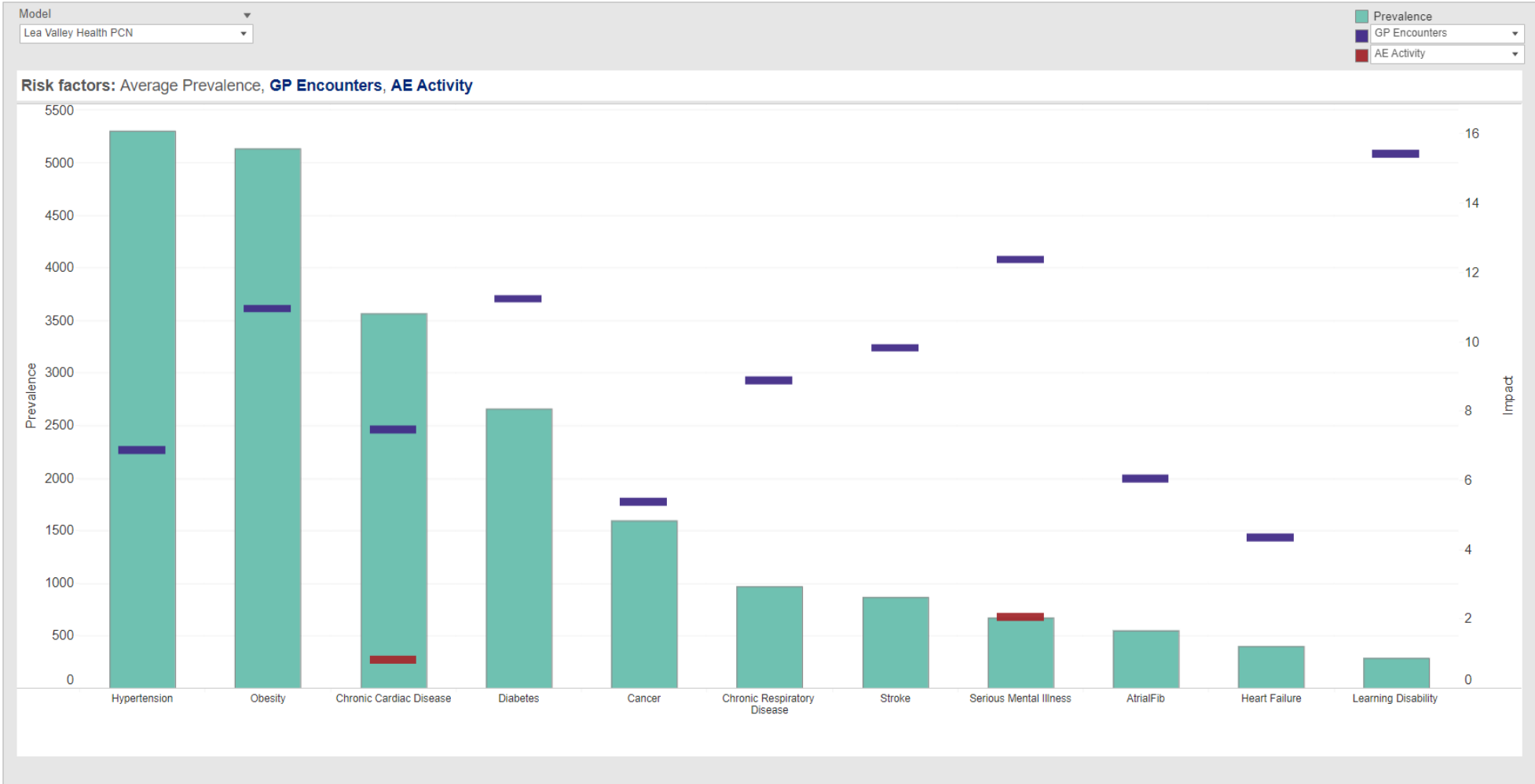
Bio-Psycho-Social Indicators - Example



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

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

Risk Modelling - Prevalence against GP Activity & A&E



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



Cancer Screening

Period	HERTFORDSHIRE AND WEST ESSEX	LEA VALLEY HEALTH PCN	CROMWELL MEDICAL CENTRE	STOCKWELL LODGE MED. CTR.	HIGH STREET SURGERY	STANHOPE SURGERY	
Women, aged 25-49, with a record of cervical screening in the last 3.5 yrs (denominator includes PCAs)	2020/21	73.3	74.7	83.7	75	76.9	62
Women, aged 50-64, with a record of cervical screening in the last 5.5 yrs (denominator includes PCAs)	2020/21	78.2	78.6	81.2	77.4	81.5	75.2
Persons, 25-49, attending cervical screening within target period (3.5 year coverage, %)	2020/21	73	74.3	83.2	74.9	76.2	61.5
Persons, 50-64, attending cervical screening within target period (5.5 year coverage, %)	2020/21	77	76.8	79	76.6	78.1	73.2
Persons, 50-70, screened for breast cancer in last 36 months (3 year coverage, %)	2020/21	63.9	51.4	20.8	67	62.9	46.5
Persons, 50-70, screened for breast cancer within 6 months of invitation (Uptake, %)	2020/21	61.3	36.4	38.1	45.5	11.8	10.3
Persons, 60-74, screened for bowel cancer within 6 months of invitation (Uptake, %)	2020/21	72.1	69.6	70	68.4	72.8	68.8
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %)	2020/21	68.8	66.1	65.1	66.2	68.5	64.5

■ Similar
 ■ Significantly Worse
 ■ Significantly Better

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Mortality

	Period	Hertfordshire CCGs	NHS HERTFORDSHIRE AND WEST ESSEX ICB - 06K	LEA VALLEY HEALTH PCN
Percentage of deaths that occur at home (All age)	2021	25.3	26.8	30.1
PYLL - Neoplasms	2021	505	509.8	377.6
PYLL - Diseases of the circulatory system	2021	737.5	782.8	708.2
PYLL - All Cause	2021	1537.7	1574	1319.4
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	45.3
Premature Mortality - Cancer	2021	98.5	99.9	106.9
Premature Mortality - All Cause	2021	269.6	276.1	256.4

■ Similar
 ■ Significantly Worse
 ■ Significantly Better

PH.Intelligence@hertfordshire.gov.uk

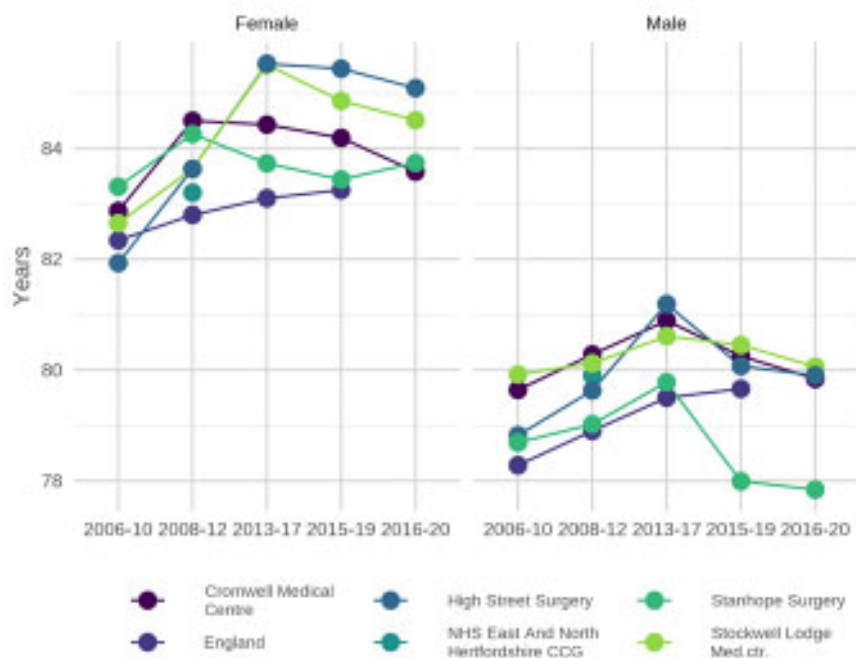


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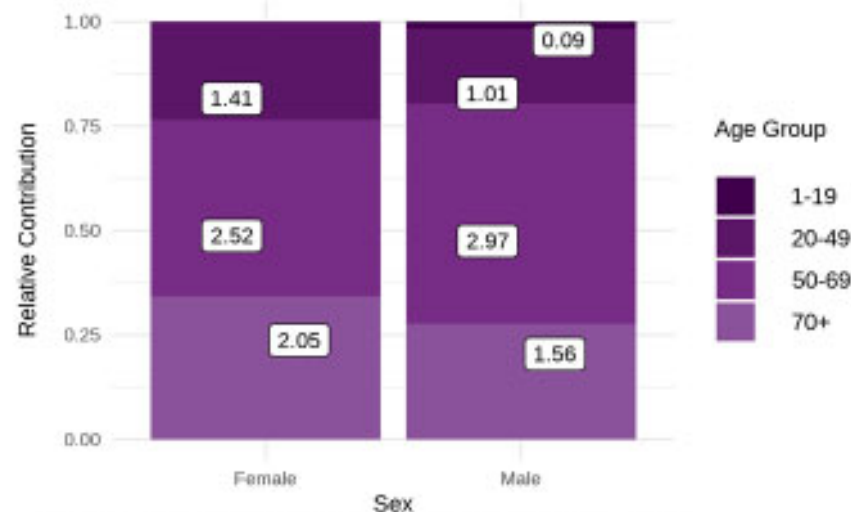




Life Expectancy



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



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 5.68 years and for males is 5.39 years.

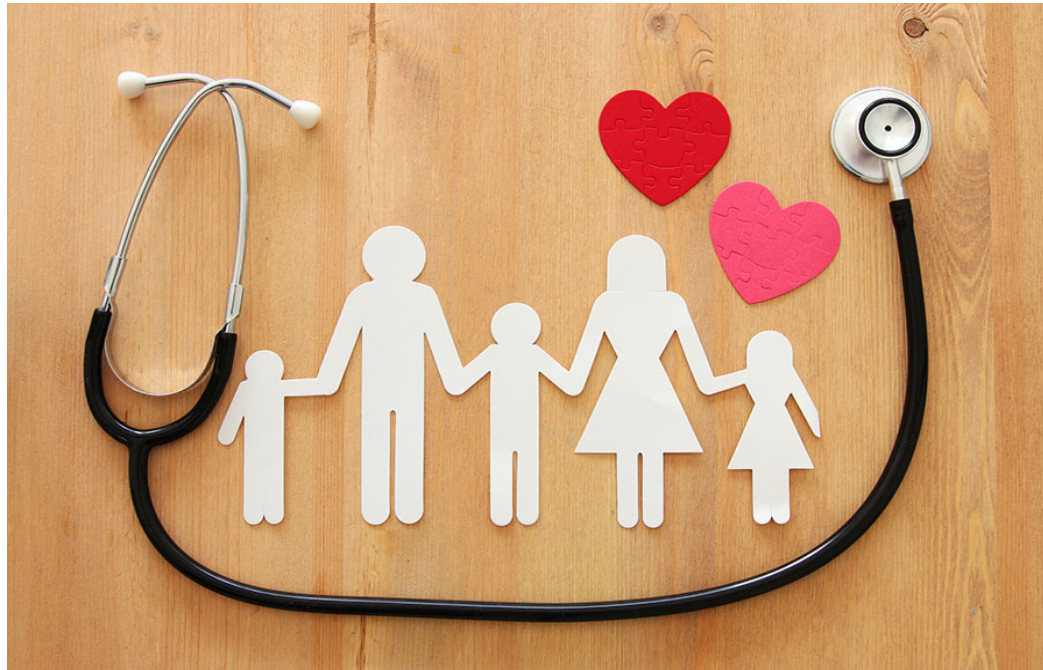
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