



Hertfordshire and
West Essex Integrated
Care System

Locality Insights Pack 2024

Welwyn & Hatfield

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Working together
for a healthier future

Introduction

This Locality pack has been developed around the ICB Clinical Priorities signed off by the ICB Board in March 23 and how they align to the population outcomes we are aiming to achieve. (See tables on the right hand side.)

The data contained within this pack compares the Locality data against place and ICB. An overview table of all the data is available on the following page with areas of opportunity highlighted.

Where opportunities link with areas within the ECF or QOF a selection of related indicators have been shared alongside a link to Ardens Manager.

The data within this pack are shown at Locality and PCN level and are health focused. However to improve outcomes for our population, input from many partners is required. This pack can facilitate discussion within your Integrated Neighbourhood Teams as described within the Primary Care Strategy and also the wider HCP transformation spaces supported by your Primary Care Transformation leads.

Packs for the individual PCNs, other Localities and Place can be found:

[Population health management – Hertfordshire and West Essex Integrated Care System \(hertsandwestessexics.org.uk\)](https://hertsandwestessexics.org.uk)

Here you can also find previous PCN packs outlining the descriptive demographics for the PCNs.

Area	Clinical Priority
CYP	<ul style="list-style-type: none"> Improved Readiness for school in children eligible for FSM Reduce rates of Childhood obesity Reduced unnecessary A&E attendances and admissions
Prevention and Health Inequalities	<ul style="list-style-type: none"> Reduced premature mortality rate for CVD
LTC & Frailty	<ul style="list-style-type: none"> Reduce attendance and admissions for falls, people with frailty and people in last year of life Development of more proactive, preventative care models for management of LTC and Frailty
Mental Health	<ul style="list-style-type: none"> Reducing suicide rates and attendances/ admission rates for self-harm Reducing rates of A&E attendances involving substance misuse and violence

Outcome	Definition
Improve life expectancy	Average age at death for people who have died in the last 12 months
Improve healthy life expectancy	Average age of people who have left the 'healthy' segment in the last 12 months
Reduce the proportion of people living with advanced disease and complexity	Proportion of the registered population who are in the advanced disease and complexity segment (segment)
Reduce the rate of ambulatory care sensitive emergency hospital admissions	Rate of ambulatory care sensitive emergency admissions in the last 12 months
Reduce the overall spend on emergency hospital admissions	Spend on Emergency hospital admissions within a financial year



Welwyn & Hatfield at a Glance

The table on the right provides a summary of the data contained within this pack. It highlights how the Locality data compares with Place and the ICB.

For Welwyn & Hatfield areas of opportunity highlighted are :

- ***Childhood Obesity at Year 6***
- ***Admissions for diabetes in children***
- ***Lifestyle risk factors: smoking support offered***
- ***Observed versus expected prevalence of LTC including hypertension***
- ***Annual Reviews completed for LTCs***
- ***% of people living with diabetes with all 8 care processes completed***
- ***Identification of Dementia***

The following link takes you to Ardens Manager where there are reports. Here you will find the latest information on identification of LTCs and details of case finding Ardens searches available within EMIS and Systemone.

<https://app.ardensmanager.com/login>

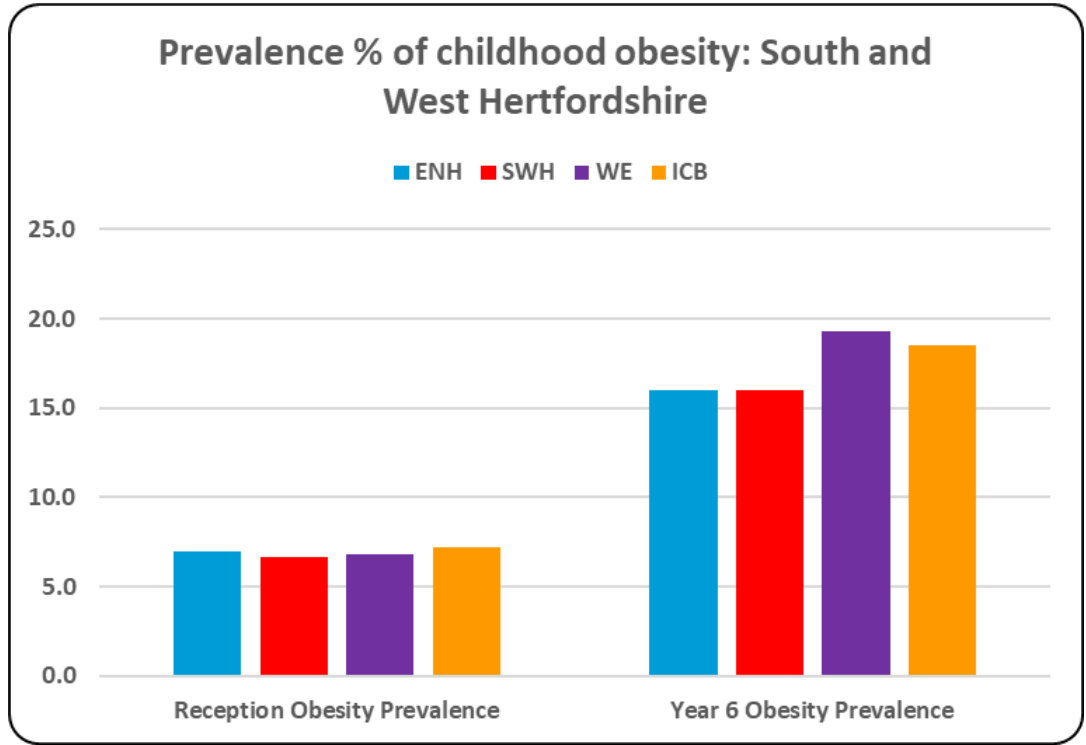
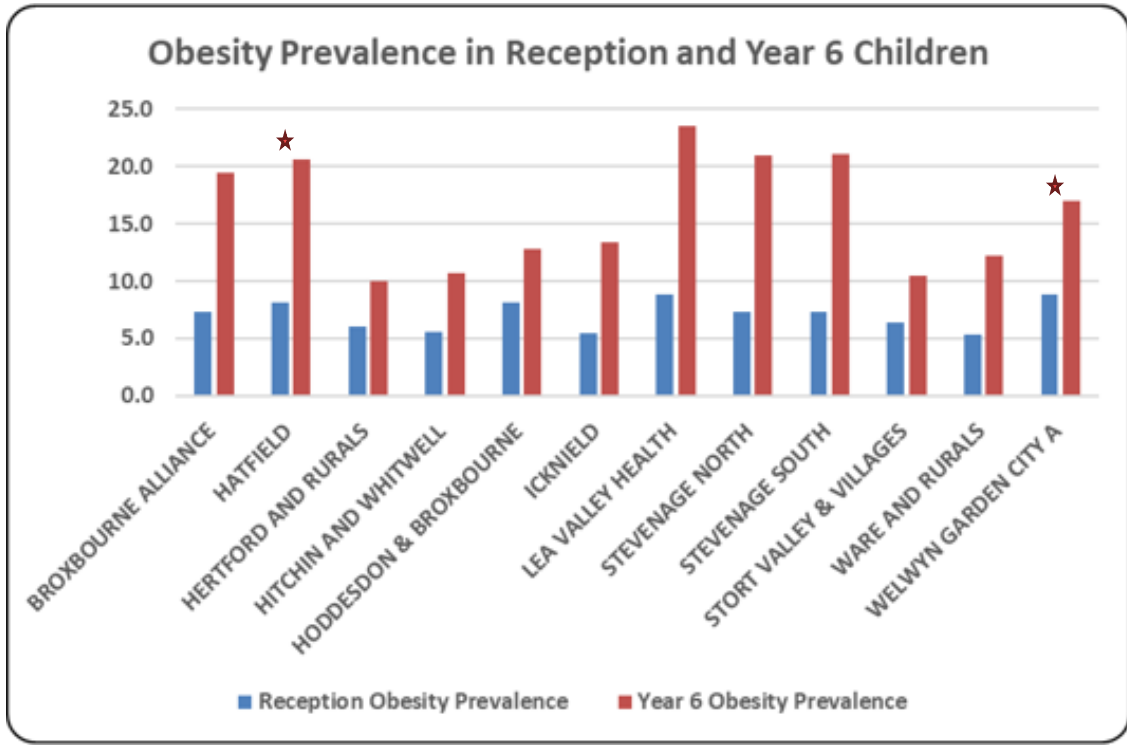
Clinical Priority	Metric	Locality compared to Place average	Locality compared to ICB average
Childhood obesity	% of children in Reception who are overweight	↔	↔
	% of children in Year 6 who are overweight	↑	↑
Reduce rates of emergency care for children and young people	A&E Attendances for Asthma (Children)	↓	↓
	Admissions for Asthma (Children)	↓	↓
	Admissions for Wheeze (Children)	↓	↓
	Admissions for Diabetes (Children)	↑	↑
Prevention and health inequalities (Premature mortality for CVD)	Lifestyle risk factors: Smoking	↓	↓
	Observed versus expected prevalence	↓	↓
	Annual Reviews completed for LTCs	↓	↓
	% of people with AF treated with Anti Coagulant	↔	↔
	Control of hypertension	↔	↔
Preventative, Proactive care models for LTC	Identification of hypertension	↓	↓
	% of people for secondary prevention CVD who are on high intensity statins	↔	↔
	% of people living with diabetes with all 8 care processes completed	↓	↓
	Reduction in emergency admissions of ACS conditions	↑	↓
Preventative, Proactive care models for frailty and EOL	Admissions for falls (75+)	↑	↓
	Admissions for Hip Fractures (75+)	↓	↓
Mental Health	Prevalence of Mental Health Conditions including LD	↓ Dem	↓ Dem
	Admissions for Self-Harm	↓	↓

Rates of Childhood Obesity

CYP outcome – Every child will have the best start and live a healthy life

ICB overarching outcome of Improving Healthy life expectancy

- Rates of childhood obesity in East and North Herts Place follows the pattern of national data with a higher percentage of children recorded as obese in year 6 compared with reception.
- Welwyn and Hatfield PCNs are highlighted by a star in the chart below. The data shows that Hatfield PCN is amongst those with the highest rates of childhood obesity.

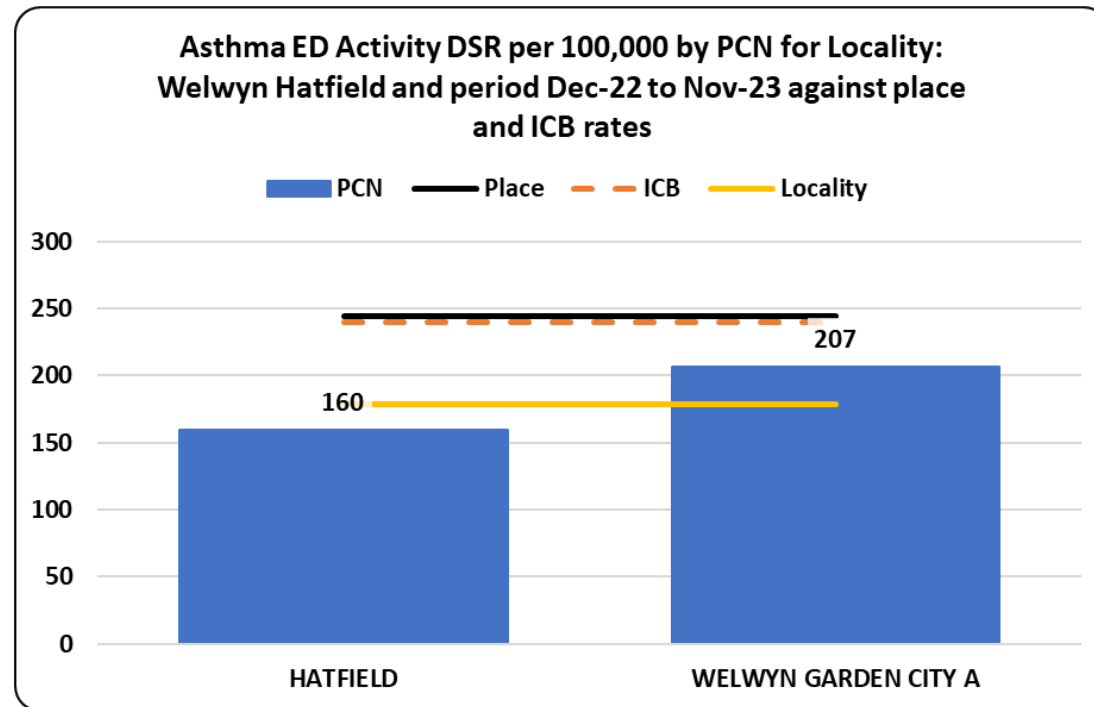
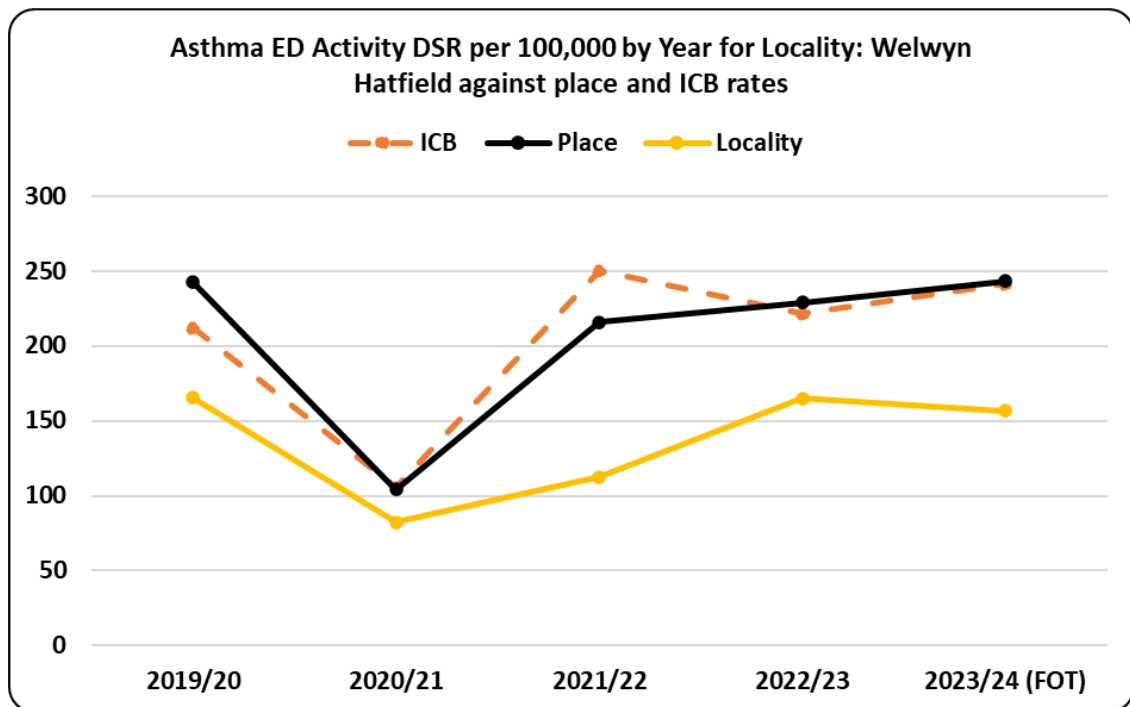


A&E attendances for Asthma (CYP)

CYP outcome – Reduce the number of unplanned admissions for long term conditions

ICB overarching outcome of reduce the proportion of people living with advanced disease and complexity

- Data for the 12 months up to November 2023 shows Welwyn & Hatfield has a considerably lower rate of A&E attendances for Children and Young People for Asthma (data on the right-hand side) compared with ICB and Place.
- Rates of Children and Young People attending A&E for Asthma have increased since 2020/21 post covid within Welwyn and Hatfield similar to ICB and place trends.
- There is variation between the PCNs with Welwyn garden City with higher rates.

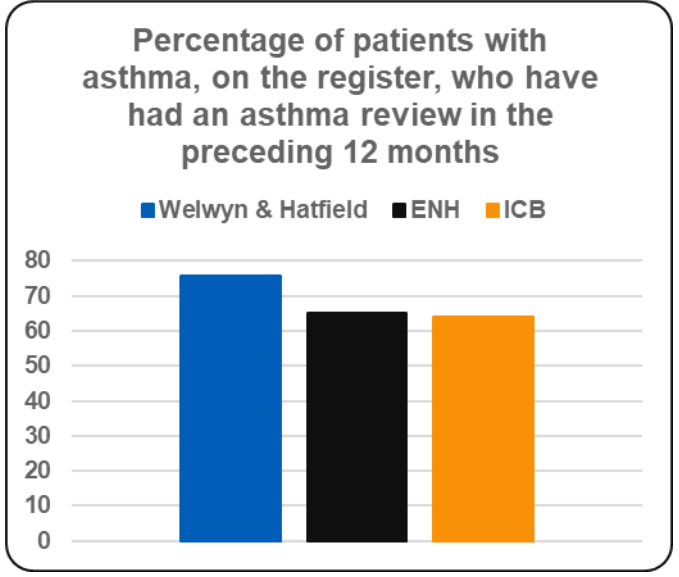
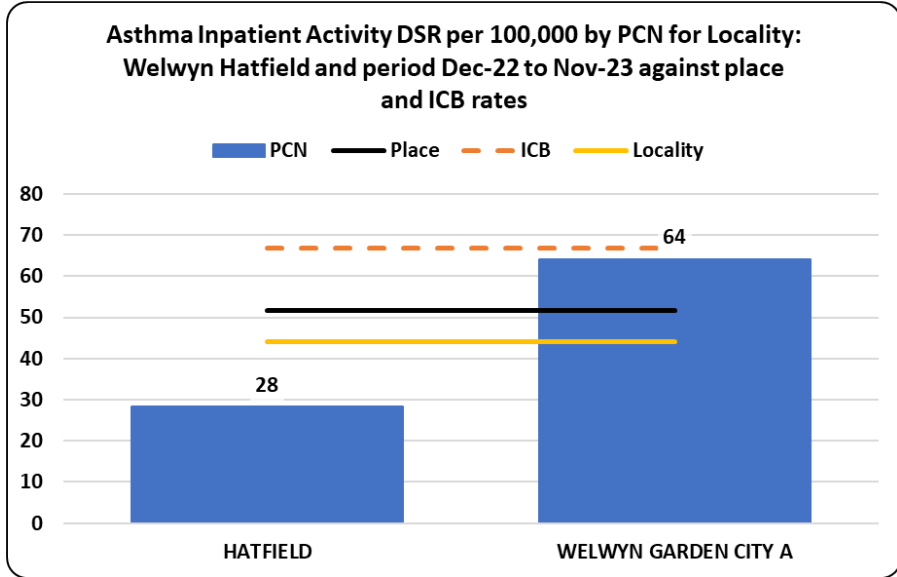
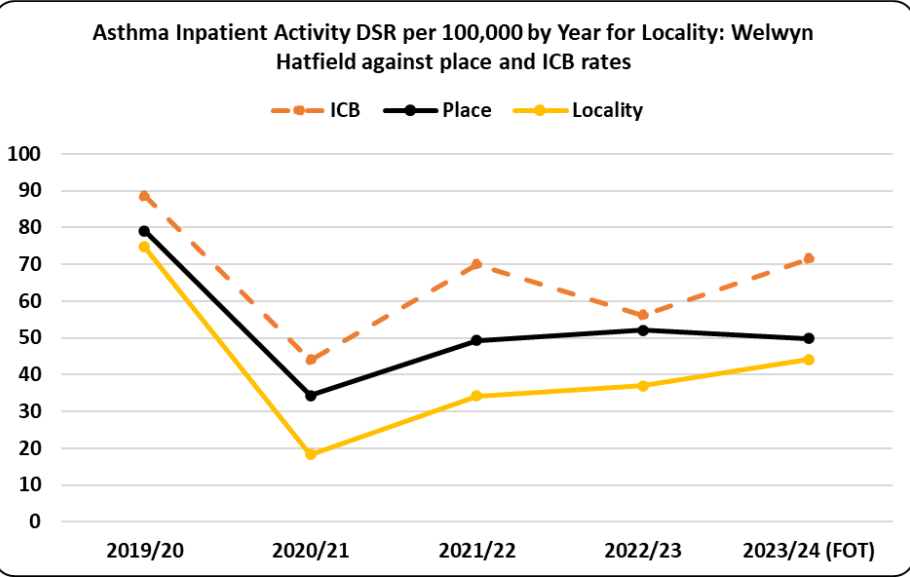


Admissions for Asthma (CYP)

CYP outcome – Reduce the number of unplanned admissions for long term conditions

ICB overarching outcome of reduce the proportion of people living with advanced disease and complexity

- Welwyn and Hatfield admission rates for asthma for Children is lower compared to the ICB and place (rolling years data middle chart).
- The trend data shows admissions consistently lower than the ICB rate.
- Higher proportion of Asthma Reviews are carried out within Welwyn and Hatfield in comparison to ENH and the ICB. However, the QOF is for all ages and children specific reviews cannot be identified within the data.

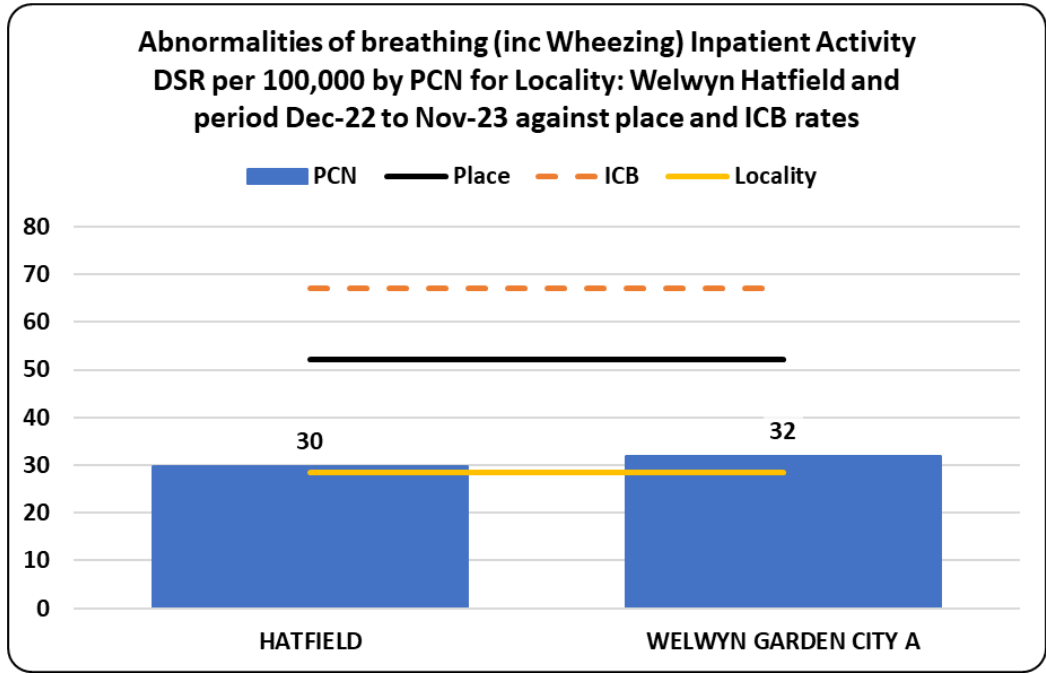
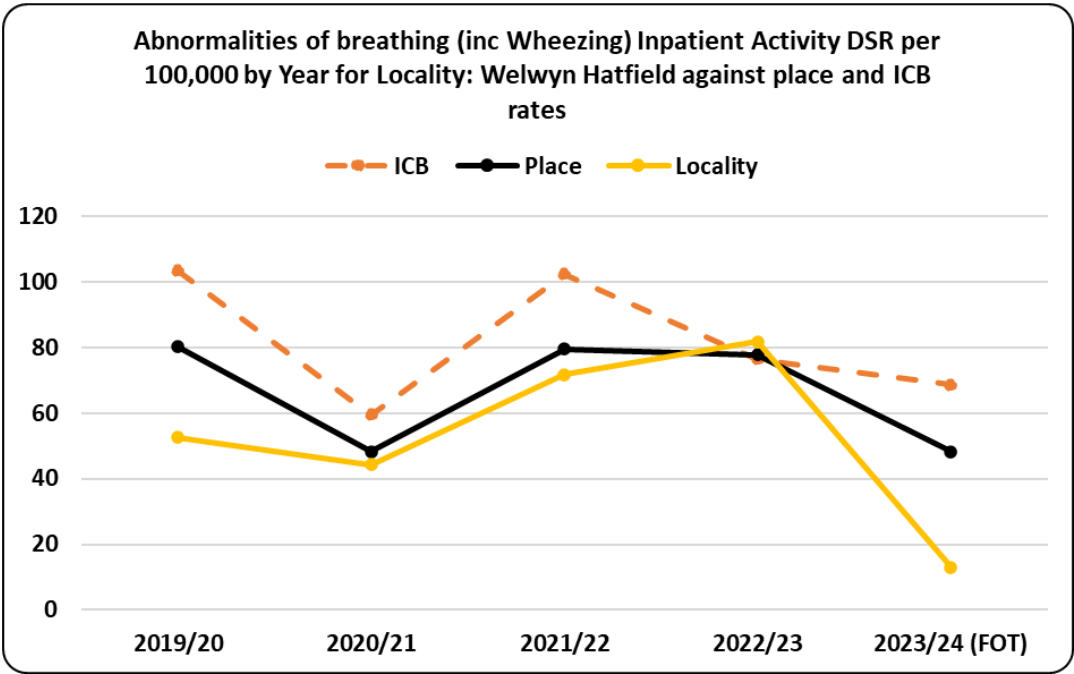


Admissions for Wheeze (CYP)

CYP outcome – Reduce the number of unplanned admissions for long term conditions

ICB overarching outcome of reduce the proportion of people living with advanced disease and complexity

- Welwyn and Hatfield has a lower rates of Children and Young People admitted to hospital for abnormalities of breathing including wheeze compared to the overall ICB. Recent analysis of UEC data showed Wheeze as a significant reason for admission within young children across HWE.
- Detail by practice can be found within the PCN packs.

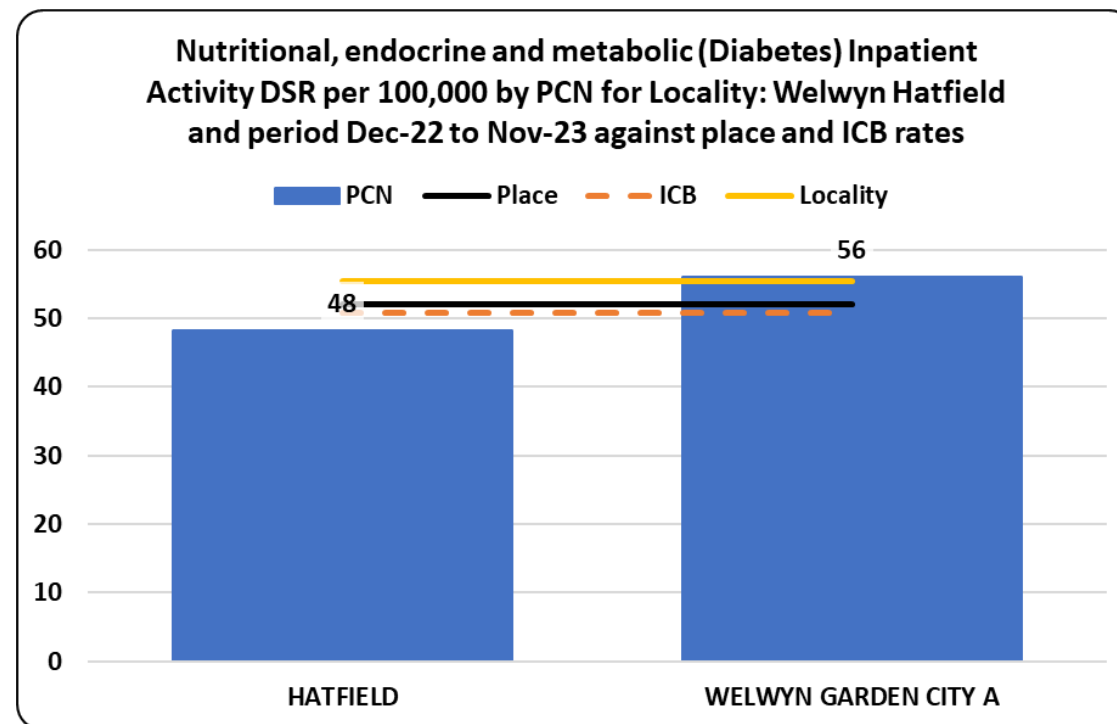
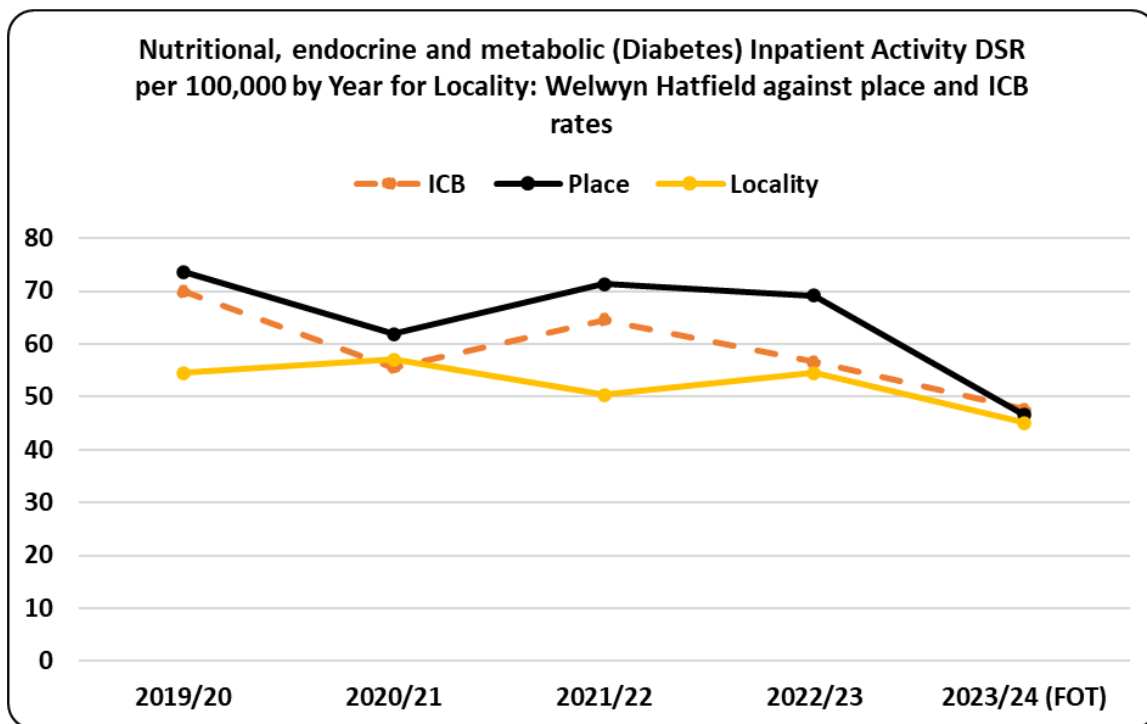


Admissions for Diabetes (CYP)

CYP outcome – Reduce the number of unplanned admissions for long term conditions

ICB overarching outcome of reduce the proportion of people living with advanced disease and complexity

- Diabetes is identified as an area of focus within the Core 20 plus 5 for children. The latest data shows that Welwyn and Hatfield Locality rate of admission is higher compared to the ICB and place.
- The numbers of children admitted for diabetes are small and this should be considered when looking at the data.
- The data for diabetes will continue to be monitored at HCP and ICB footprints. The Children and Young Peoples programme can be contacted via hweicbenh.cypteam@nhs.net for details of projects underway.

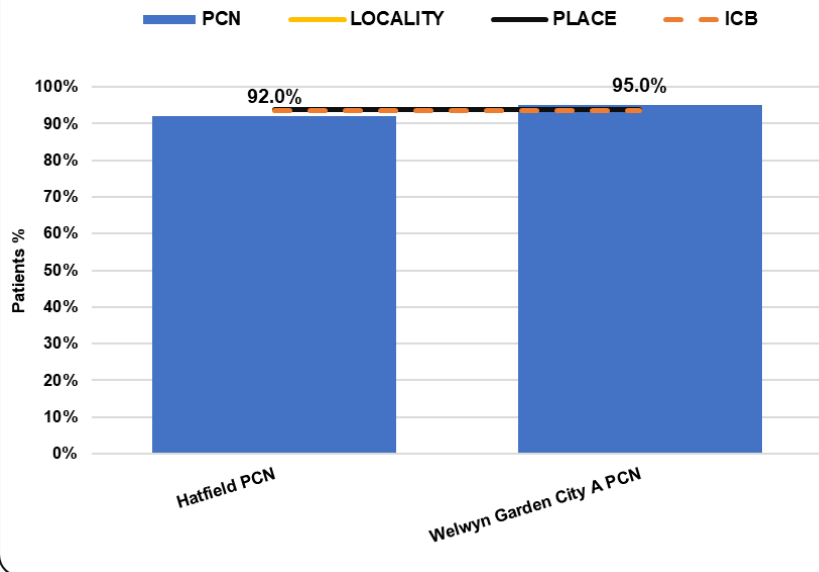


Prevention and health inequalities – Lifestyle factors - Smoking

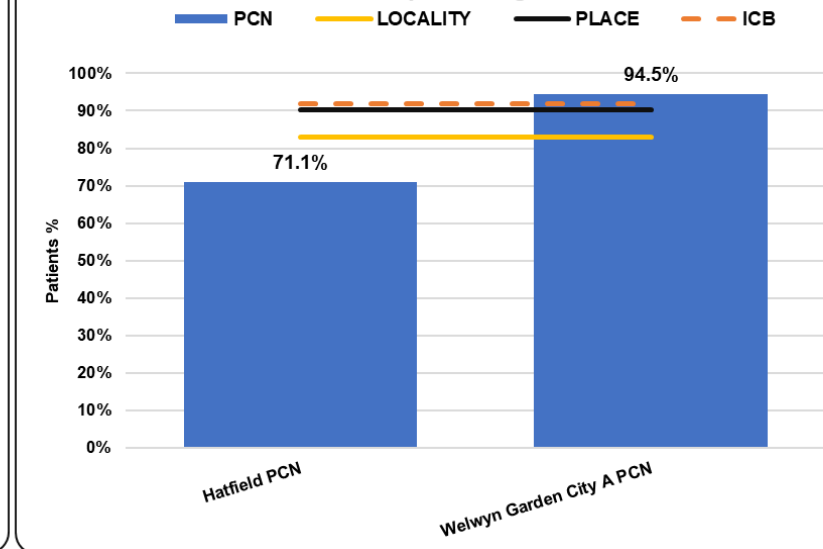
- Welwyn & Hatfield shows a similar percentage of smoking status recorded compared to Place and ICB.
- A lower proportion of patients have been offered treatment for smoking compared with place and ICB.
- The table to the right gives detail by condition of the opportunity for further recording of smoking status. This shows the position in January. The latest position can be found on <https://app.ardensmanager.com/login>

ECF 2023-24 - Condition Section Under Smoker, Smoking Status, and Smoking Status Recorded - as of Jan. 2024						
Locality's PCNs	Pre-Diabetes		Diabetes		Atrial Fibrillation	
	Remaining % of Population with a Smoking status	Smoking Available Patients - Total Number	Remaining % of Population with a Smoking status	Smoking Available Patients - Total Number	Remaining % of Population with a Smoking status	Smoking Available Patients - Total Number
Hatfield PCN	1.47%	2394	0.61%	2946	0%	63
Welwyn Garden City P	1.63%	3431	0.57%	3546	0%	78

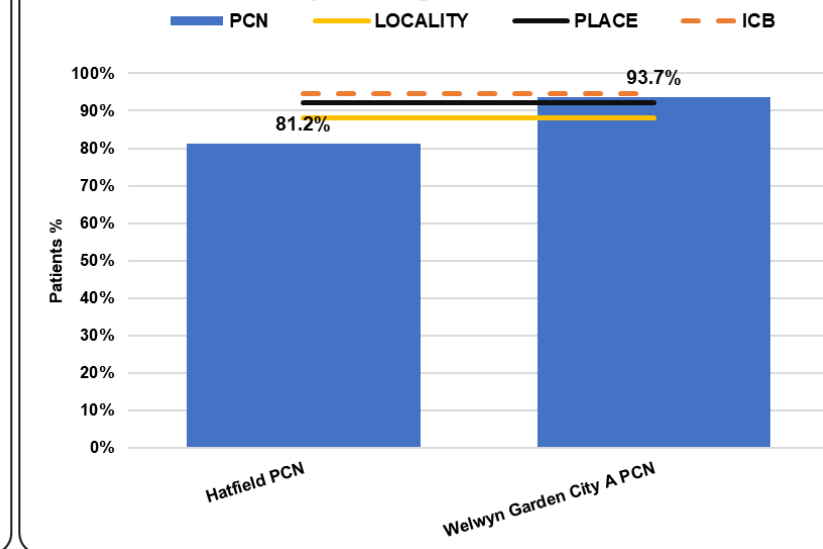
Percentage of patients* whose notes record smoking status in the preceding 12 months



Percentage of patients aged 15+ who are current smokers with a record of an offer of support & treatment within preceding 24 months



Percentage of patients* who are current smokers with a record of an offer of support & treatment within the preceding 12 months



* with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses

Prevention and health inequalities

Early Identification: Expected vs observed prevalence

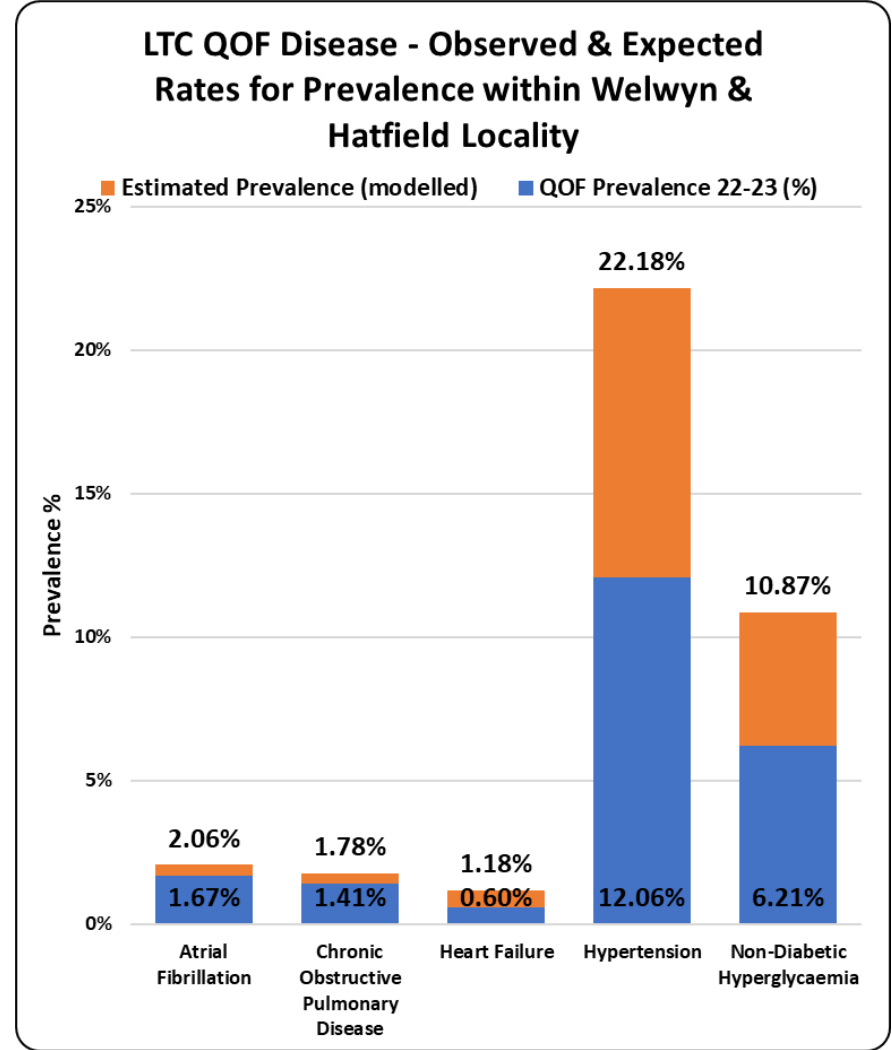
LTC Outcome – Proportion of people with a long-term condition who feel able to manage their condition

ICB overarching outcome of reduce the proportion of people living with advanced disease and complexity

The data on here shows the national modelled estimated prevalence for the Locality compared with the latest published QOF prevalence for the Place.

- Welwyn & Hatfield recorded prevalence compared with the modelled estimated prevalence for the Place is lower across all conditions.
- The data shows an opportunity for further identification for these conditions. Case finding searches can be found within the Ardens Suite of searches: <https://app.ardensmanager.com/login>
- The individual PCN details can be found here: <https://hertsandwestessexics.org.uk/pcn-packs>

Disease/ Condition	Disease Detection Modelling for Welwyn & Hatfield Locality - Total No. of New Diagnoses to Meet Locality & PLACE Rates - 2023/24	
	Total number to meet Locality rate	Total number to meet PLACE rate
Asthma	1134	1968
Atrial Fibrillation	468	1319
Chronic Kidney Disease	437	1958
Chronic Obstructive Pulmonary Disease	268	903
Coronary Heart Disease	589	1219
Diabetes Mellitus	601	2075
Epilepsy	94	296
Heart Failure	201	492
Hypertension	1979	4473
Non-Diabetic Hyperglycaemia	198	3918
Peripheral Arterial Disease	66	216
Stroke and Transient Ischaemic Attack	329	739



Development of more proactive, preventative care models for LTC - Prevalence

LTC Outcome – Reduce the proportion of people with a long-term condition who are in the advanced disease & complexity or frailty & end of life segments

ICB overarching outcome of reduce the proportion of people living with advanced disease and complexity

- Following the expected and observed prevalence modelling in the previous slide, where there are opportunities for further identification, this slide looks at the recorded prevalence by practice for the Place compared with the ICB.
- The development of an ICB Data Platform will create a longitudinal record for our patients which will allow the data to be viewed by different characteristics such as deprivation, ethnicity, co-morbidities.
- For LTCs, QOF and ECF data can help us understand areas of opportunity for improving outcomes for our population living with LTCs.

QOF Disease/ Condition	Welwyn & Hatfield Locality - Long-Term Conditions 2022-23 QOF Prevalence, with 3 Year Trend.						
	QOF 22-23 - ICB %	QOF 22-23 - PLACE %	QOF 22-23 - LOCALITY %	HATFIELD		WELWYN GARDEN CITY A	
				QOF 2022-23	3 Year Trend	QOF 2022-23	3 Year Trend
Asthma	6.16%	6.40%	5.34%	4.47%	↗	6.22%	↗
Atrial fibrillation	2.09%	2.12%	1.67%	1.53%	↘	1.81%	↗
Chronic kidney disease	3.46%	2.94%	2.58%	2.25%	↘	2.91%	↘
Chronic obstructive pulmonary disease (COPD)	1.49%	1.55%	1.41%	1.36%	↘	1.46%	↘
Diabetes mellitus	6.63%	6.54%	6.13%	6.02%	↗	6.23%	↗
Epilepsy	0.70%	0.73%	0.69%	0.61%	↘	0.77%	↘
Heart Failure	0.80%	0.74%	0.60%	0.55%	↗	0.64%	↗
Hypertension	13.84%	13.83%	12.06%	11.44%	↘	12.69%	↗
Non-diabetic hyperglycaemia	6.42%	5.29%	6.21%	5.30%	↗	7.13%	↗
Peripheral arterial disease	0.44%	0.45%	0.41%	0.43%	↘	0.39%	↘
Secondary prevention of coronary heart disease	2.67%	2.63%	2.10%	2.02%	↘	2.18%	↘
Stroke and transient ischaemic attack	1.63%	1.71%	1.48%	1.44%	↘	1.52%	↗



Hertfordshire and West Essex Integrated Care System



Development of more proactive, preventative care models for LTC : Annual Reviews (QOF 22/23)

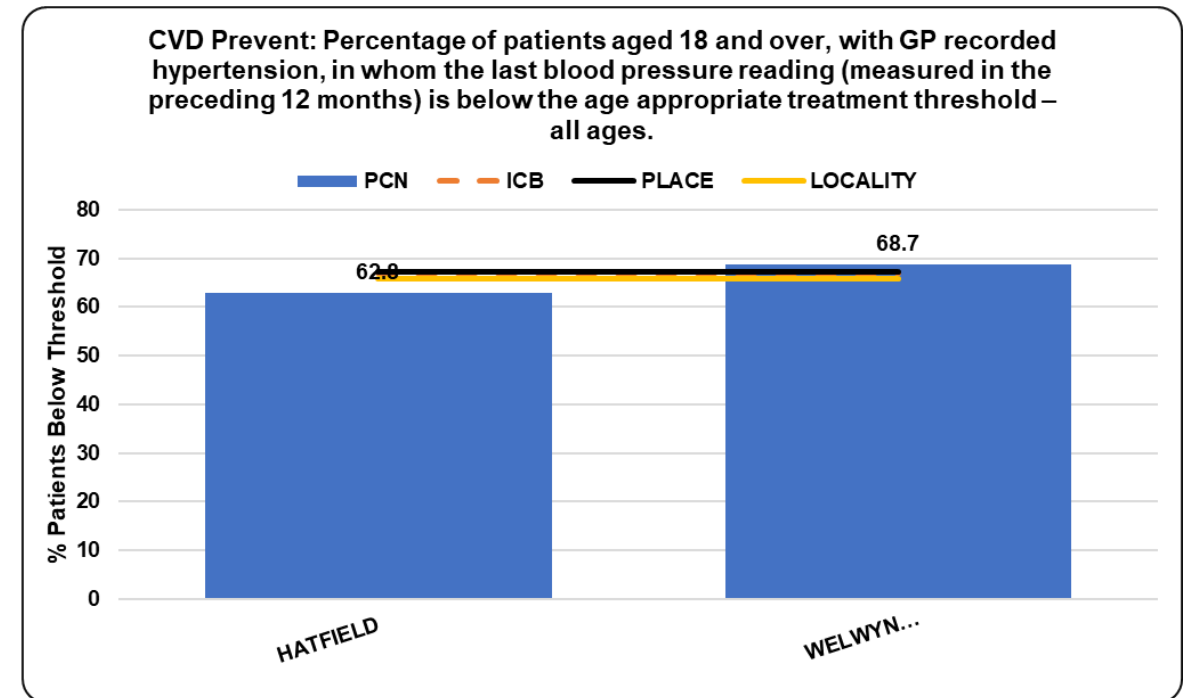
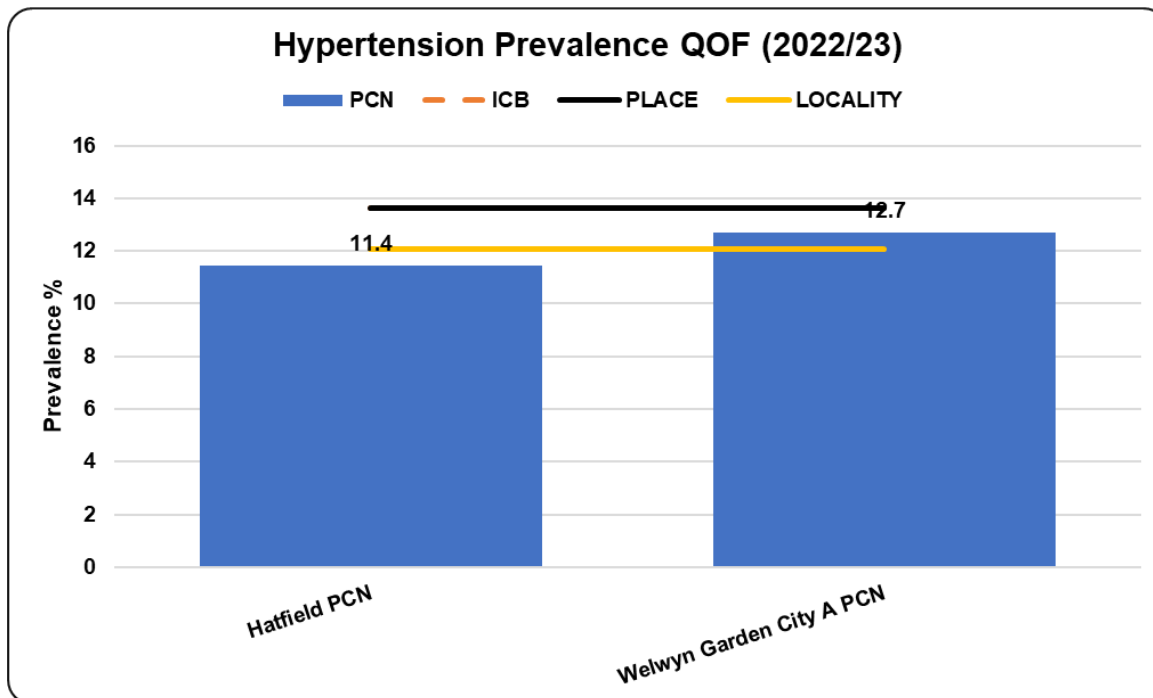
- The table on the right shows a summary of the percentage of patients receiving an annual review or risk assessment by condition.
- Where the cell is highlighted the percentage is lower than the Place value.
- The data here is shown without exceptions removed in order to be able to view the percentage of people not receiving reviews.
- The data shows that the Locality has lower percentage of reviews than place and ICB for all areas apart from AF and Heart Failure.
- The source of data in this table is QOF national reporting. More detailed information with the latest position is available to practices via <https://app.ardensmanager.com/login>

	ICB	E&N	Welwyn & Hatfield	Hatfield PCN	Welwyn Garden City A PCN
% of AF Patients with Stroke Risk Assessed in the last 12 months	92.9	91.8	94.4	94.7	94.2
The % of patients aged 45 or over who have a record of blood pressure in the preceding 5 years	85.7	85.9	83.4	81.8	84.6
The % of patients with a diagnosis of heart failure on the register, who have had a review in the preceding 12 months	72.7	67.0	76.7	64.4	85.1
The % of patients with asthma, on the register, who have had an asthma review in the preceding 12 months	64.0	65.3	62.7	52.9	68.8
The % of patients with COPD, on the register, who have had a review in the preceding 12 months	75.7	77.1	70.7	69.2	71.8
The % of patients with diabetes, on the register, with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 12 months	75.5	76.4	73.8	71.3	75.9
The % of patients with non-diabetic hyperglycaemia who have had an HbA1c or fasting blood glucose performed in the preceding 12 months.	82.9	82.9	82.1	77.7	85.0



Prevention and health inequalities – Hypertension

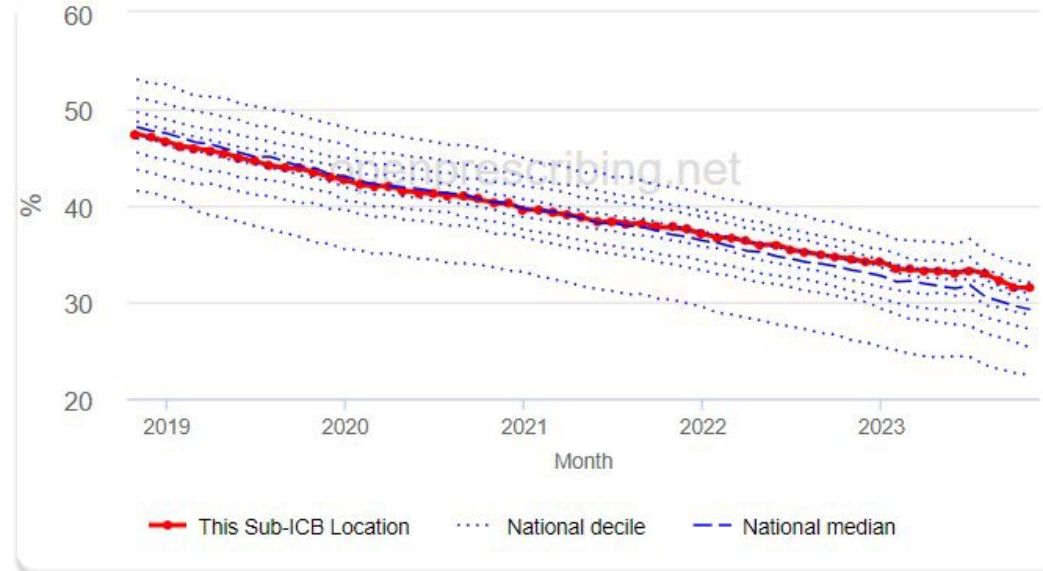
- Welwyn & Hatfield recorded prevalence for hypertension is lower than the Place prevalence.
- Once identified the data shows the percentage of patients in whom the latest BP reading is below the age-appropriate treatment threshold is similar to the ICB and Place.
- The data suggests there is further opportunity for identification of people with hypertension. Case finding Ardens searches are detailed within <https://app.ardensmanager.com/login>



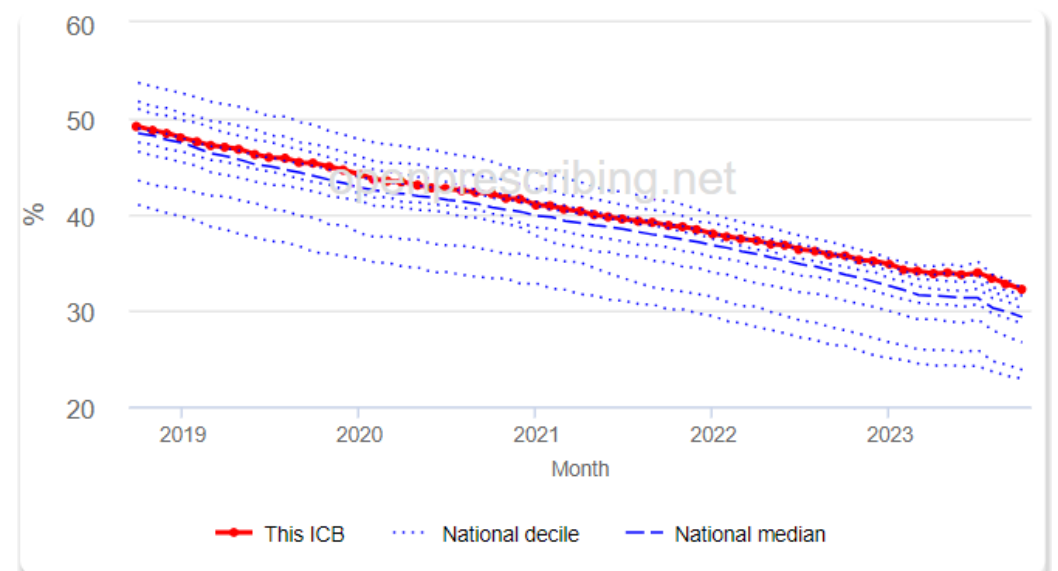
Lipid management : Percentage of people on lipid lowering therapy for secondary prevention who are on low and medium intensity statins

- National lipid management pathways (Link to guidance) recommend the use of high intensity statins for all people with a history of Cardiovascular disease as well as where high dose statins are needed to control cholesterol. People on high intensity statins will see a greater reduction in c-LDL levels and reduce the risk of cardiovascular events.
- Data from OpenPrescribing provides information on the proportion of people who are on statins that are currently prescribed low or medium intensity doses. The ICS is a negative outlier in this area, with a high proportion of people not on a high intensity statin.
- The data for ENH Place shows that there is an opportunity to improve statin treatment, prescribing a higher proportion of people onto high intensity statins. The Place is in the 74th percentile with 31.5% of people not on high intensity statins. This compares to 28.3% nationally. Welwyn and Hatfield PCN data shows a lower proportion compared to place.

ENH Place – Items of Low and Medium Intensity Statins as a Percentage of Items of All Statins by Year

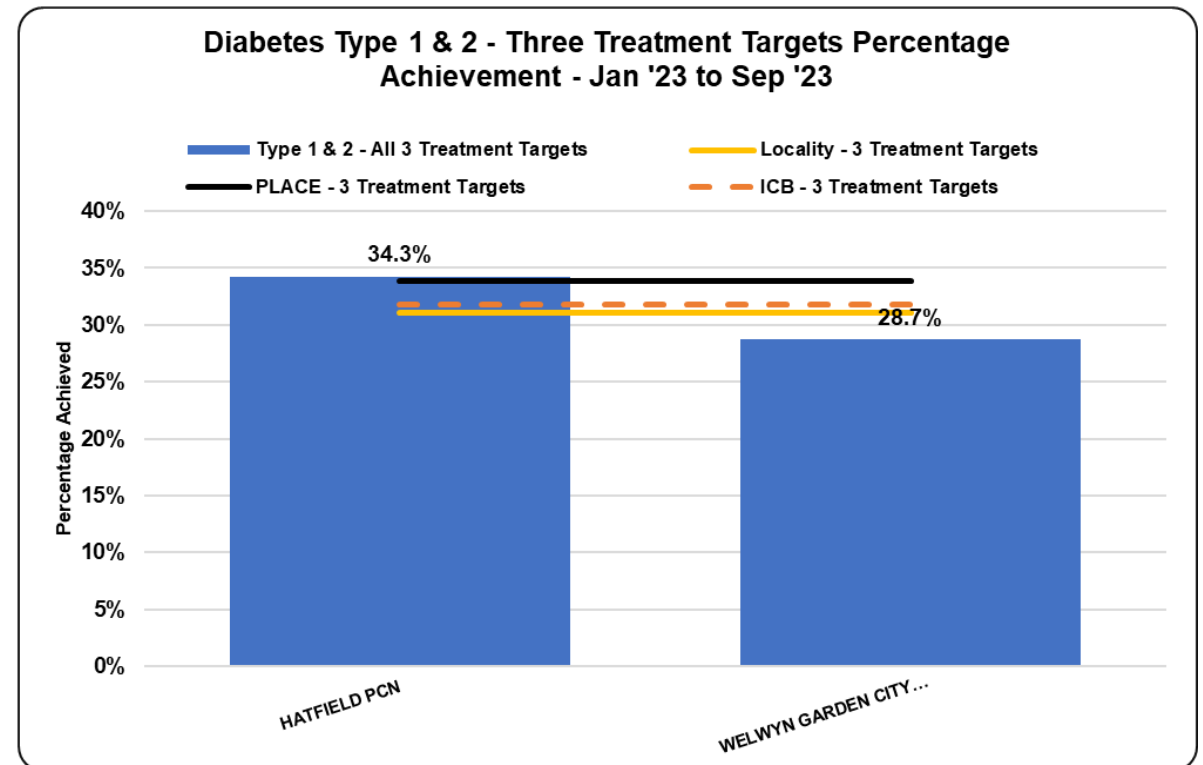
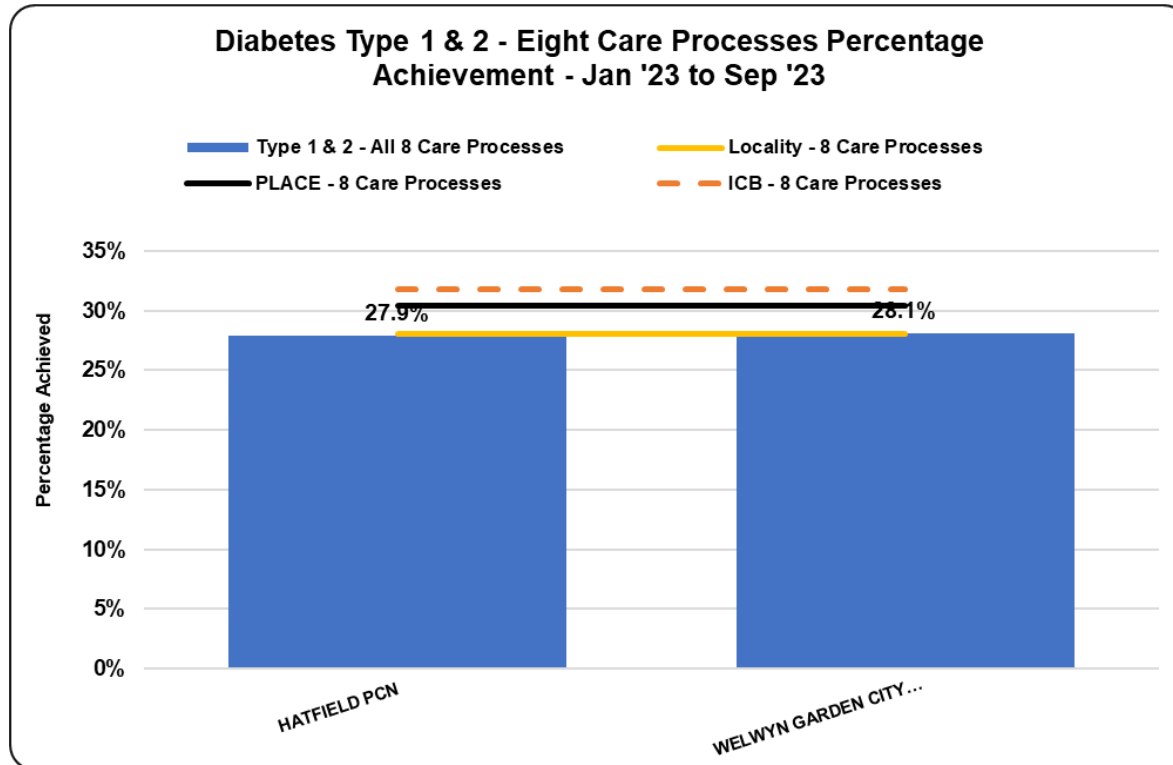


ICB – Items of Low and Medium Intensity Statins as a Percentage of Items of All Statins by Year



Development of more proactive, preventative care models for LTC : 8 Care Processes & 3 treatment targets (all diabetes type 1 & 2)

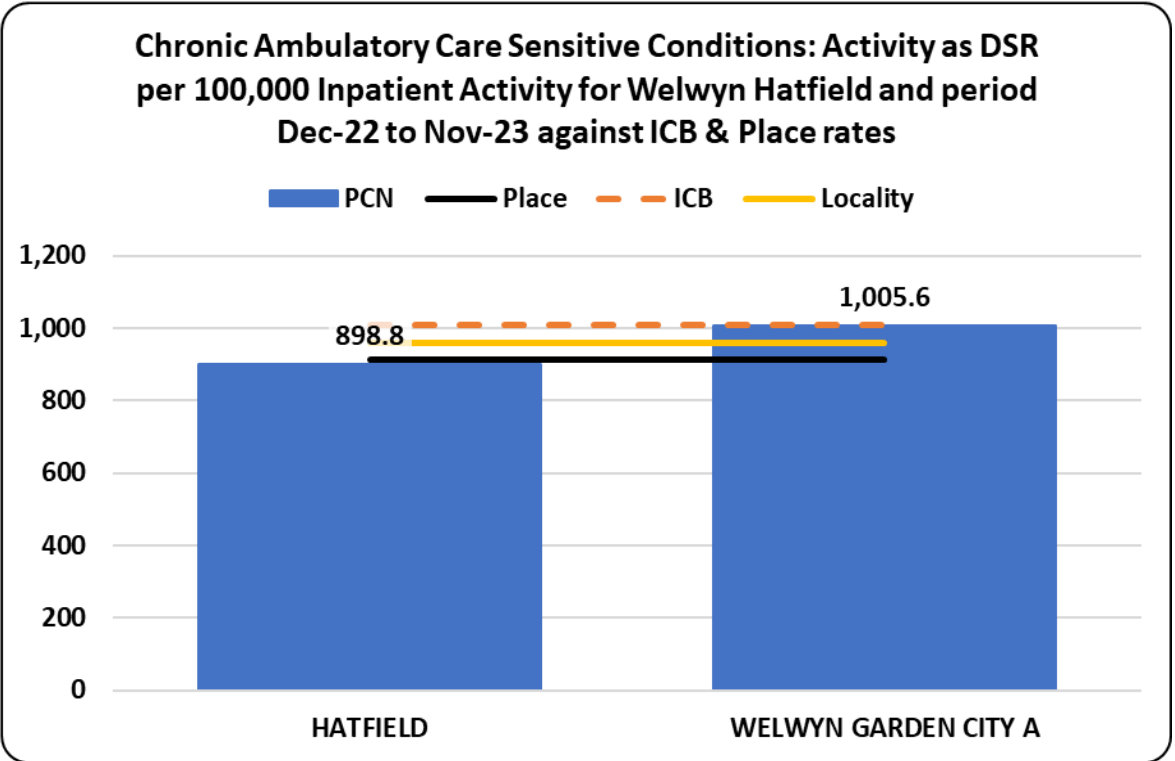
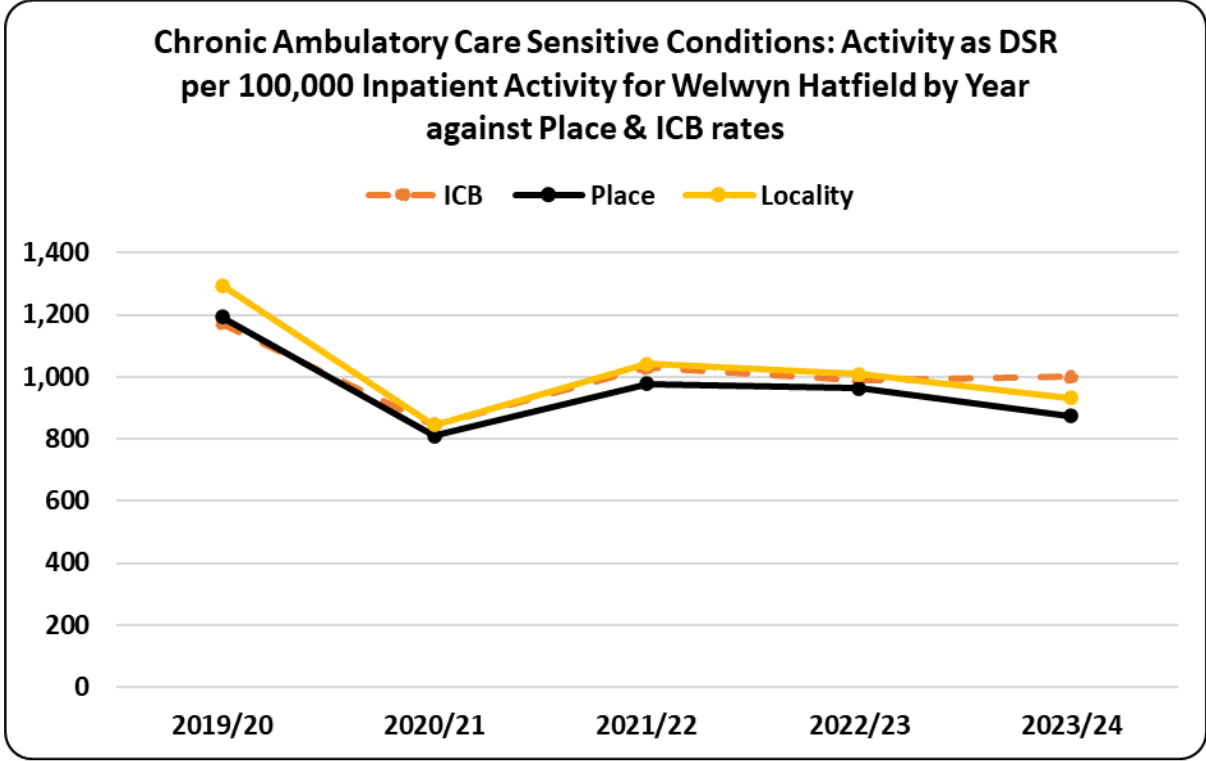
- The percentage of people living with diabetes who have received the 8 care processes in Welwyn & Hatfield is lower than the ICB and Place.
- For the three treatment targets Welwyn & Hatfield data also shows a lower percentage than the ICB and Place.
- The latest information can be found within [Ardens Manager](#).



Reduction in admissions rates of Chronic Ambulatory Care Sensitive (ACS) conditions

LTC Outcome – Reduce the rate of ambulatory care sensitive emergency hospital admissions

ICB overarching outcome of Reduce the rate of emergency admission for chronic ambulatory care sensitive conditions associated with LTCs



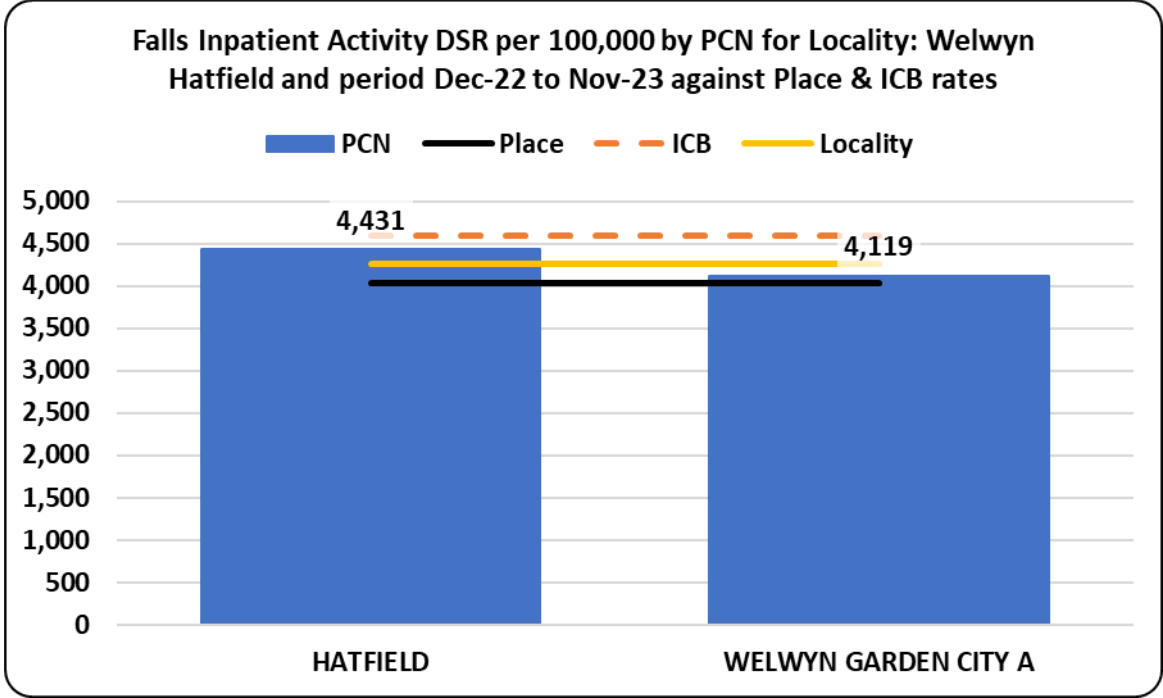
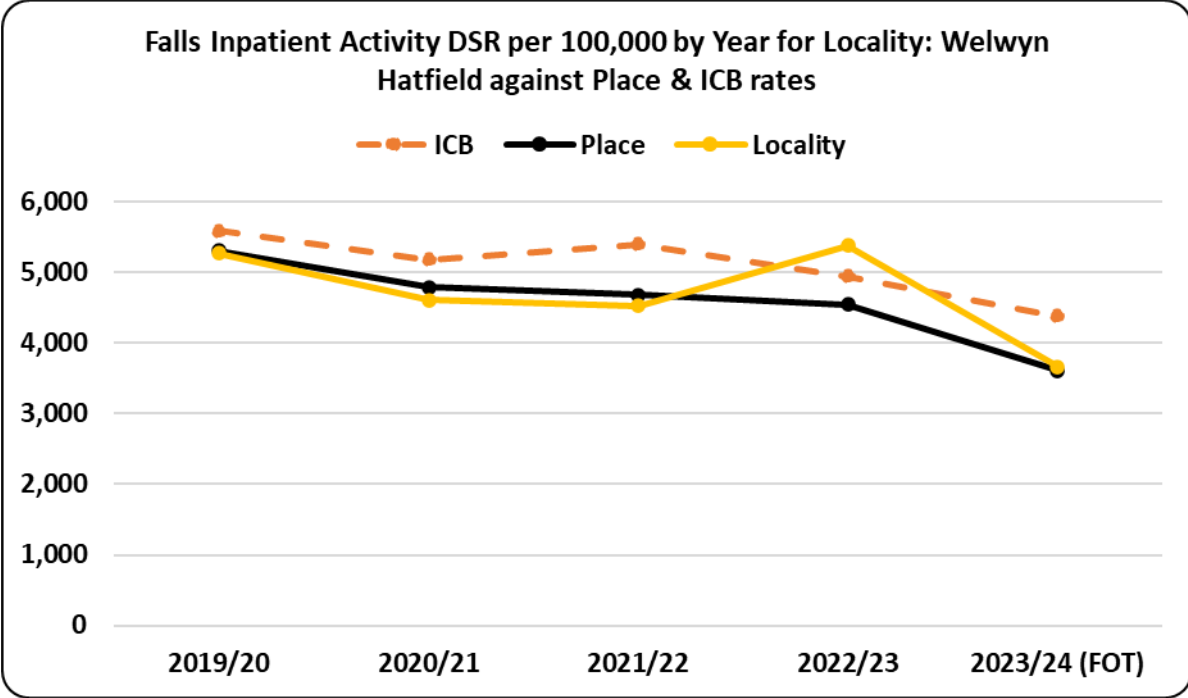
- Ambulatory care sensitive (ACS) conditions are conditions where effective community care and person-centred care can help prevent the need for hospital admission. (Nuffield Trust)
- Welwyn & Hatfield’s admission rate for Chronic ACS conditions is higher than Place but lower than the ICB rate when looking at the 12 months data up to November 2023.
- Welwyn & Hatfield data shows a similar trend to place.

Emergency Admission rates for Falls in persons aged +75

Frailty and EoL Outcome – Decrease rates of +75s emergency admissions for falls within the community

ICB overarching outcome of Reduce the overall spend on emergency hospital admissions

- When looking at the rolling 12 months up to November 2023 the data shows that Welwyn & Hatfield has a higher rate of admissions for falls than Place and lower than the ICB.
- There is variation in the data for the PCNs within the Locality.
- Data in the following pages shows the data for the PCNs compared with Locality, Place and the ICB for areas within the ECF that aim to support reducing falls. Frailty Clinical Leads will be able to advise on current programmes of work within your area aimed at reducing falls.

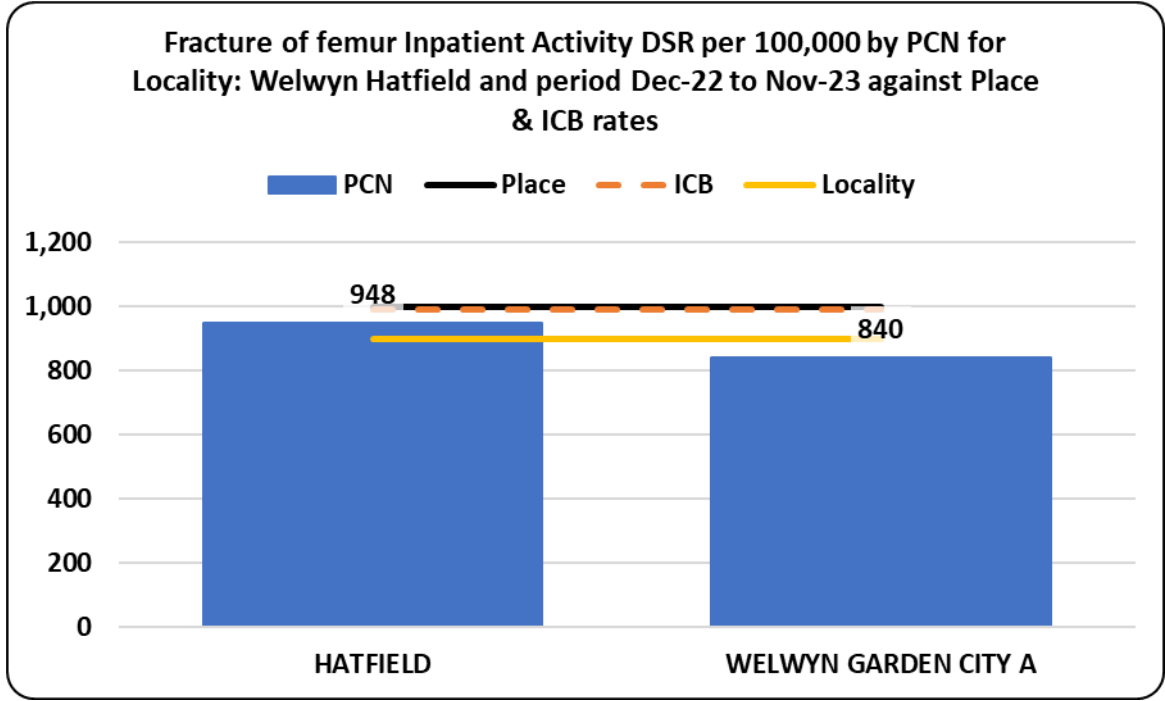
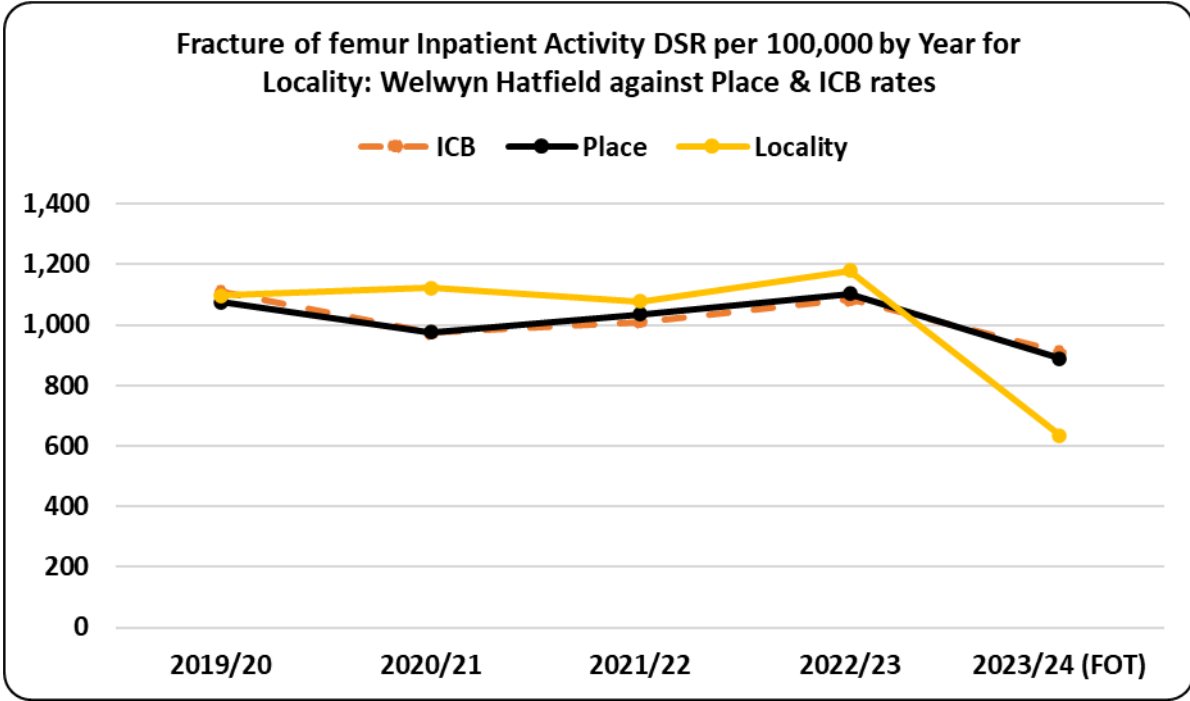


Emergency admission rates for Hip fractures in all over 75's

Frailty and EoL Outcome –
Decrease rates of +75s
emergency admissions for falls
within the community

ICB overarching outcome of
Reduce the overall spend on
emergency hospital admissions

- The 12 months data up to November 2023 the data shows that Welwyn & Hatfield has a lower rate of admissions for hip fractures than Place and the ICB.
- The latest trend data shows a fall for the latest year against last year.
- The ECF indicators on the next page shows potential areas of opportunity through benchmarking the PCNs against Locality, Place and ICB.



ECF indicators for frailty and EOL

- The data shows that Welwyn & Hatfield has a lower percentage of falls frat scores completed, when compared to the Place but higher than the ICB as at end Dec 23.
- The Locality percentage of the population recorded as moderately or severely frail is lower than Place and the ICB, which may indicate further opportunity for identification.
- The data contained within the table below is up to the end of December, the latest position can be found at [Ardens Manager](#).

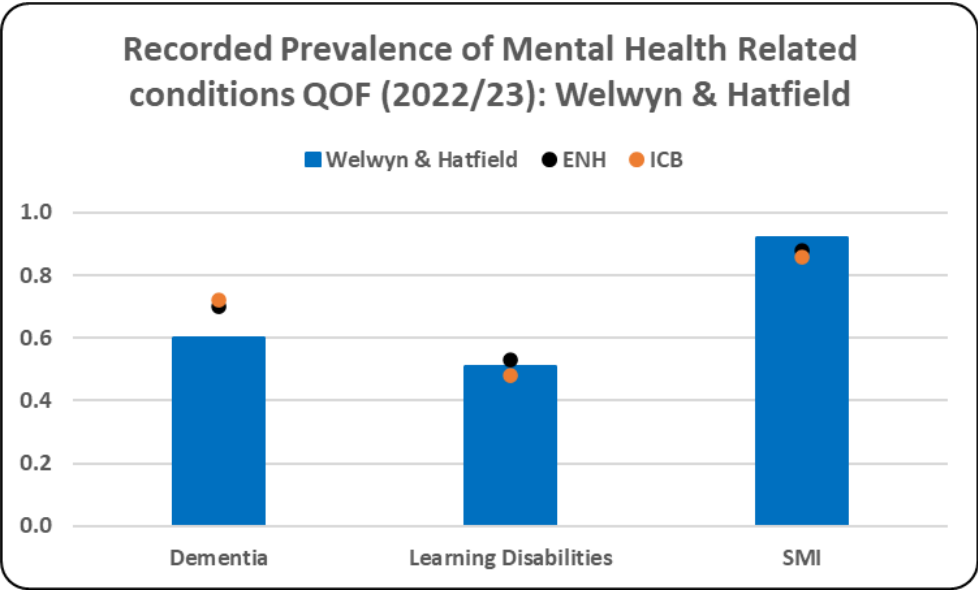
ENH Locality, PCNs & ICB Enhanced Commissioning Framework (ECF) 2023-24 for the period 1 April 23 to 31 Dec 23

	Frailty			EOL						
	Mod/Sev + falls Frat score done %	Mod frailty + SMR or polypharmacy medication review %	% Mod/Sev frailty of population	% population on EOL register	GSF %	DNACPR %	ACP %	PPD %	PPC %	SCR Consent %
ICB	16.0%	19.5%	1.9%	0.7%	64.9%	53.3%	11.3%	37.3%	39.8%	34.8%
ENH	20.0%	11.7%	1.7%	0.8%	77.5%	48.6%	9.3%	35.1%	37.1%	48.0%
Welwyn & Hatfield	18.9%	7.6%	1.3%	0.6%	66.4%	48.2%	6.8%	28.4%	33.3%	53.4%
Hatfield PCN	16.3%	16.0%	1.7%	0.5%	61.0%	56.1%	9.1%	41.7%	37.1%	48.7%
Welwyn Garden City A PCN	23.6%	0.0%	0.9%	0.7%	69.7%	43.4%	5.4%	20.3%	31.0%	55.5%

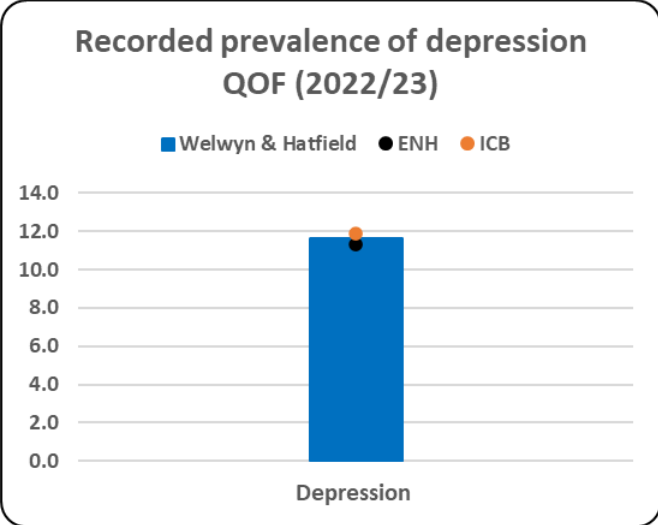


Prevalence of mental health conditions (QOF)

- The data on this page looks at the recorded prevalence of conditions within the Mental Health section of QOF. It shows the Welwyn & Hatfield prevalence compared with East and North Herts and the ICB. Future iterations will include comparisons against modelled expected prevalence.
- The data shows that Welwyn & Hatfield has a lower recorded prevalence for Dementia compared with place and ICB which may indicate an opportunity for further identification. Details for individual PCNs can be found within their packs.
- The table below shows the prevalence trend over the last three years for each of the recorded QOF mental health conditions.
- The following page looks at some of the wider QOF indicators for Mental Health.



	Welwyn & Hatfield Mental Health Conditions 2022-2023 QOF prevalence, with 3 year trend							
	Dementia		Depression		Learning Disabilities		SMI	
	QOF Prevalence 22-23	3 year Trend	QOF Prevalence 22-23	3 year Trend	QOF Prevalence 22-23	3 year Trend	QOF Prevalence 22-23	3 year Trend
ICB	0.9%	↗	11.9%	↗	0.5%	↗	0.9%	↗
ENH	0.7%	↗	11.4%	↗	0.5%	↗	0.9%	↗
Welwyn & Hatfield	0.6%	↗	11.6%	↗	0.5%	↗	0.9%	↗
Hatfield PCN	2.4%	↗	40.0%	↗	1.9%	↗	3.4%	↗
Welwyn Garden City A PCN	2.4%	↗	53.1%	↗	2.3%	↗	4.0%	↗



Mental Health QOF Indicators 22-23

- Mental Health QOF metrics for 2022-23 show that Welwyn & Hatfield has a lower achievement for all metrics for SMI and Depression when compared with ICB and place.
- Within this there is variation between the PCNs. The individual practices can be viewed within the PCN packs.
- Ardens searches are available to practices to identify those people with SMI without a care plan or recording of monitoring.

	SMI					Depression
	% of patients with SMI who have a care plan	% of patients with SMI who have a record of BMI in the preceding 12 months	% of patients with SMI who have a record of alcohol consumption in preceding 12 months	% of patients with SMI who have a record of a lipid profile in the preceding 12 months	% of patients with SMI who have a record of blood glucose of HbA1C in preceding 12 months	% of patients with a diagnosis of depression who have been reviewed within 10-56 days
ICB	82.6	88.7	89.3	83.1	83.0	83.0
E&N	79.8	88.3	89.0	81.5	81.5	82.0
Welwyn & Hatfield	78.5	84.1	83.3	76.7	75.7	78.9
Hatfield PCN	64.3	80.0	79.4	69.6	69.7	74.0
Welwyn Garden City A PCN	89.7	87.3	86.6	80.3	79.3	82.0



Emergency Admissions Rates for Self – Harm

ICB overarching outcome of Improving Healthy life expectancy

- Welwyn & Hatfield has a lower rate of admissions for self-harm compared with the ICB.
- The trend data shows a decreasing trend for Welwyn & Hatfield .
- The data will continue to be monitored at wider HCP and ICB footprints.

