Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Primary Care Networks
Overview Pack

ABBEY 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

NHS Hertfordshire and West Essex Integrated Care Board

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.

Source: HWE PHM Team, Cerner, England.nhs.uk

Key Messages

NHS Hertfordshire and West Essex Integrated Care Board

Abbey Health have more people between the ages of 35 to 55 than the England profile. The majority of people living within areas categorised as affluent IMDs.

23.8% of the population have at least 1 Long Term Condition. 5.1% have more than 5 LTCs compared to 5.6% for the ICB. This is a reflection of a higher proportion of working age adults and fewer older people than the England profile.

Wider determinants analysis from Public Health Evidence and Intelligence shows Abbey Health wider determinants overall are in better than the ICB average particularly for Education, Skills and Training and housing.

Population projections show an expected increase in the number of people over 65 from ~26k to ~35k from 2022 to 2042.

When analysing the underlying Segmentation Model data in general Abbey Health has slightly higher proportions within the healthy segment than the ICB population. Conditions that are highlighted for Abbey Health are Diabetes, Learning Difficulties, Serious Mental Illness, Muscular Dystrophy and and ASD.

2022/23 A&E rates for Abbey Health are similar to 19/20 rates and are lower than the place rate.

When comparing the rates per 1,000 population between places for chronic ambulatory care conditions, South West Herts has a higher rate than the ICB.
Within South West Herts Place, Abbey Health has a lower rate per 1,000 population.

For Abbey Health the highest volume and cost for ACSs is within the Advanced Disease and Complexity segment for those aged over 65 for AF, Heart Failure and COPD. For those aged over 65 within the End of Life, Frailty & Dementia segment, Heart Failure, COPD and AF, 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 Abbey Health 7.3% of the population in the EoL, severe frailty and severe dementia segment live within the 4 most deprived deciles.

Within this segment we can see the presence of Chronic Cardiac Disease, Heart Disease and Diabetes being highlighted which chimes with the reason for admission within previous analysis for ACS conditions.

For Abbey Health the data shows higher rates for AF and Diabetes which was identified as a theme within the ACS analysis.

Estimated prevalence for Heart Failure, AF and COPD is higher than that currently recorded within Abbey Health. Within Ardens Manager there are case finding searches that can support PCNs with identification.

Source: HWE PHM Team

Demographics, Conditions & Segment Overview

NHS Hertfordshire and West Essex Integrated Care Board

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

NHS Hertfordshire and West Essex Integrated Care Board

Total Population
ABBEY HEALTH PCN

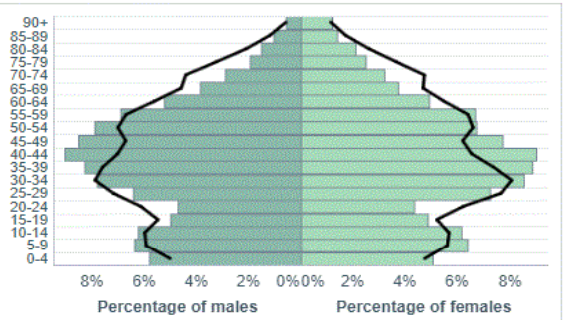
Snapshot as at: 30/06/2021

Registered population		Demographics				Prevalence		Acute utilisation		Covid	
% of total	100.0%	% White	66.7%	% IMD top	0.1%	% with 1+ conditions	23.8%	% of annual activity (total 37,572)	100.0%	% one or more at risk conditions	14.2%
% of annual change	0.3%	% BAME	15.1%	% IMD bottom	51.7%	% with 5+ conditions	2.4%	% of annual cost (total £10M)	100.0%	% two or more at risk conditions	5.4%

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

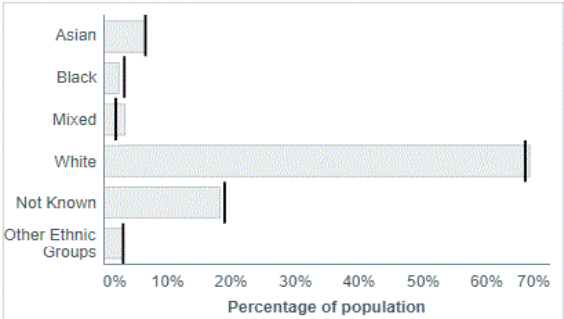
Choose benchmark: England

Population pyramid



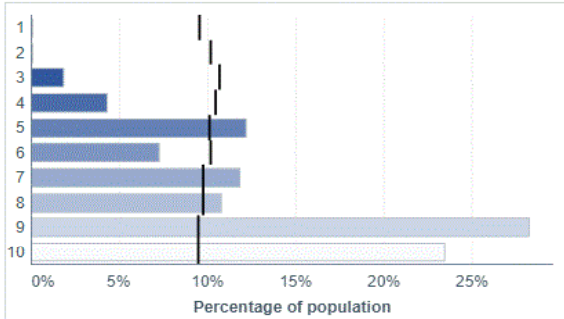
Black line represents the **England** average

Population proportion by ethnic category



Black line represents the **England** average

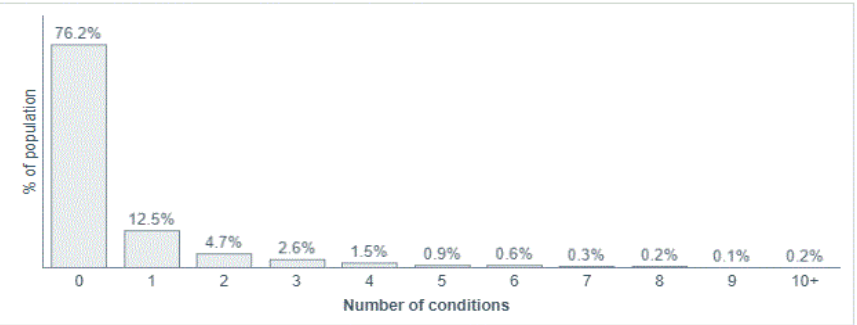
Population proportion by IM Deprivation decile



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

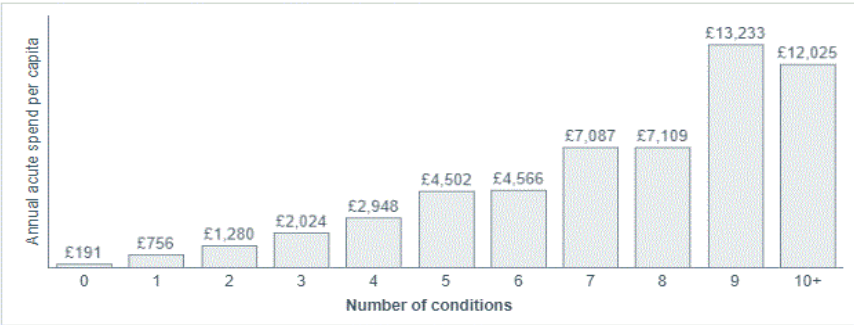
Prevalence - Snapshot as at: 30/06/2021

Population proportion by number of conditions



Annual spend per capita by number of conditions

Financial Year: 2020/21



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

Abbey Health have more people between the ages of 35 to 55 than the England profile.

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

PCN Demographics - NHS England

NHS Hertfordshire and West Essex Integrated Care Board

LTC
ABBEY HEALTH PCN

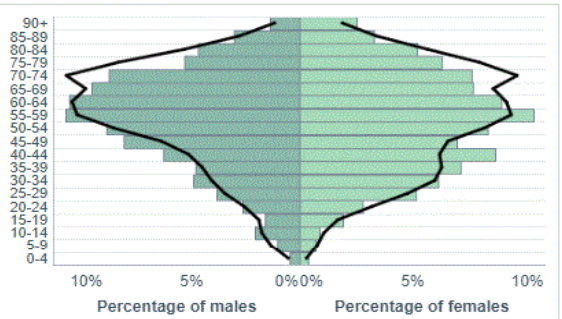
Snapshot as at: 30/06/2021

Registered population		Demographics				Prevalence		Acute utilisation		Covid	
% of total	20.6%	% White	80.2%	% IMD top	0.1%	% with 1+ conditions	100.0%	% of annual activity (total 16,321)	43.4%	% one or more at risk conditions	50.7%
% of annual change	4.5%	% BAME	17.2%	% IMD bottom	46.7%	% with 5+ conditions	5.1%	% of annual cost (total £4M)	38.8%	% two or more at risk conditions	16.2%

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

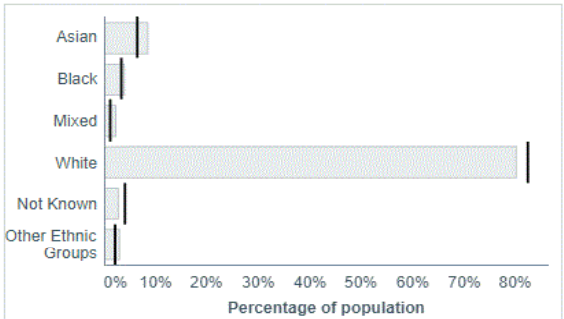
Choose benchmark: England

Population pyramid



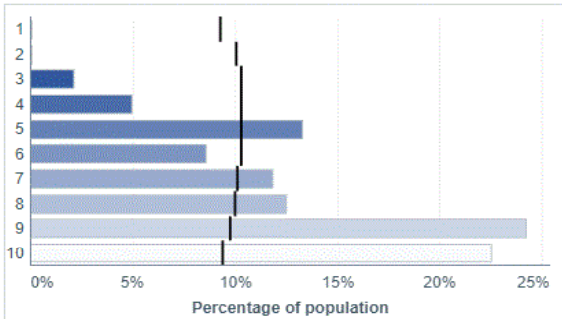
Black line represents the **England** average

Population proportion by ethnic category



Black line represents the **England** average

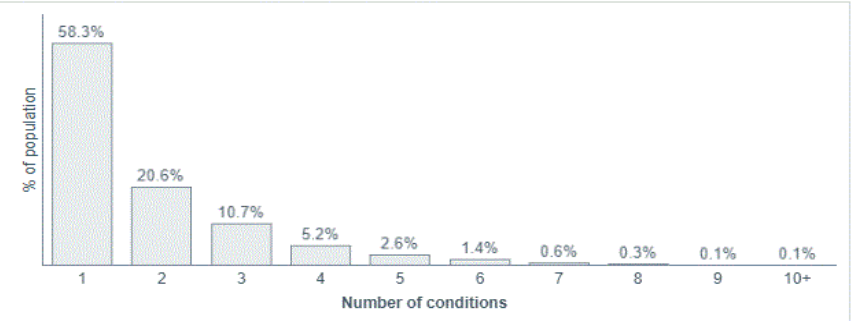
Population proportion by IM Deprivation decile



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

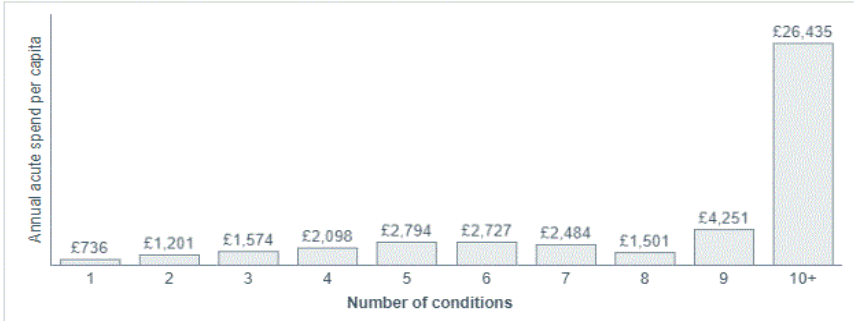
Prevalence - Snapshot as at: 30/06/2021

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 23.8% of the population have at least 1 Long Term Condition. 5.1% have more than 5 LTCs compared to 5.6% for the ICB. This is a reflection of a higher proportion of working age adults and fewer older people than the England profile.

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

Practice Indicators - Triggers and Levels

NHS Hertfordshire and West Essex Integrated Care Board

Practice Indicators for ABBEY HEALTH PCN		MALTINGS SURGERY			MALTINGS SURGERY		
Clinical Domain	Indicator Name	Latest Score	Time Period	Trigger Level	Latest Score	Time Period	Trigger Level
Clinical Diagnosis	Detection rate Cancer	0.471	2020/21	No Trigger	0.471	2020/21	No Trigger
Coronary heart disease	% AF anticoagulation therapy CHADS2-VASc score >1	90.5	2020/21	Positive	90.5	2020/21	Positive
	% CHD aged <=79 BP reading 140/90mmHg or less	44.8	2020/21	Level 1	44.8	2020/21	Level 1
	% CHD cholesterol 5 mmol/l or less	42.7	2021/22	Level 1	42.7	2021/22	Level 1
	% hypertension aged <=79 BP reading 140/90mmHg or less	44.3	2020/21	Level 1	44.3	2020/21	Level 1
Diabetes	% Diabetes aged >=40 years no CVD history without moderate or severe frailty treated with stati	79.7	2020/21	Level 1	79.7	2020/21	Level 1
	% Diabetes without moderate or severe frailty BP 140/80 mmHg or less	50.6	2020/21	Level 1	50.6	2020/21	Level 1
	% diabetes without moderate or severe frailty IFCC-HbA1c is 58 mmol/mol or less	52.7	2020/21	Level 1	52.7	2020/21	Level 1
Exception Rating	Overall Personalised Care Adjustment Rate	0.064	2020/21	No Trigger	0.064	2020/21	No Trigger
Medicines Management	% antibiotics Co-amoxiclav, Cephalosporins, Quinolones	12.2	2021/22 Q4	Level 1	12.2	2021/22 Q4	Level 1
	% Naproxen and Ibuprofen	74	2021/22 Q4	No Trigger	74	2021/22 Q4	No Trigger
	Antibacterial Items/Star Pu	0.554	2021/22 Q4	Positive	0.554	2021/22 Q4	Positive
	Hypnotics ADQ/Star Pu	0.461	2021/22 Q4	No Trigger	0.461	2021/22 Q4	No Trigger
	Oral NSAIDS ADQs/STAR-PU	2.012	2021/22 Q4	No Trigger	2.012	2021/22 Q4	No Trigger
Mental Health	% first choice generic SSRIs	70.5	2021/22 Q4	No Trigger	70.5	2021/22 Q4	No Trigger
	% MH comprehensive care plan	32.8	2020/21	Level 1	32.8	2020/21	Level 1
	% SMI alcohol record	65.5	2020/21	Level 1	65.5	2020/21	Level 1
	% SMI BP record	50.5	2020/21	Level 1	50.5	2020/21	Level 1
	Dementia Face to Face review	36	2020/21	Level 1	36	2020/21	Level 1
	Select antidepressants ADQs/STARPU	1.258	2021/22 Q4	No Trigger	1.258	2021/22 Q4	No Trigger
Patient Experience	Confidence and trust in healthcare professional	98.8	2020/21	No Trigger	98.8	2020/21	No Trigger
	Frequency seeing preferred GP	27.5	2020/21	No Trigger	27.5	2020/21	No Trigger
	Healthcare professional treating with care and concern	91.9	2020/21	No Trigger	91.9	2020/21	No Trigger
	Overall experience of your GP practice	85.7	2020/21	No Trigger	85.7	2020/21	No Trigger
	Satisfaction with appointment times	66	2020/21	No Trigger	66	2020/21	No Trigger
Public Health	% Child Imms DTaP/IPV/Hib/HepB (age 1 year)	96.7	2020/21	No Trigger	96.7	2020/21	No Trigger
	% Child Imms Hib/MenC booster	96	2020/21	No Trigger	96	2020/21	No Trigger
	% Child Imms MMR (Age 2 yrs)	96	2020/21	No Trigger	96	2020/21	No Trigger
	% Child Imms PCV Booster	95.6	2020/21	No Trigger	95.6	2020/21	No Trigger
	Cervical Screening	69.2	2021/22 Q4	Level 1	69.2	2021/22 Q4	Level 1
Respiratory	% Asthma review in last 6 mths	21.8	2020/21	Level 1	21.8	2020/21	Level 1
	% Asthma spirometry and one other objective test	33.3	2020/21	Level 1	33.3	2020/21	Level 1
	% COPD with review in last 12 mths	20.4	2020/21	Level 1	20.4	2020/21	Level 1
	% LTC patients who smoke	10.5	2020/21	No Trigger	10.5	2020/21	No Trigger
	% LTC Smoker offer support	97.3	2020/21	No Trigger	97.3	2020/21	No Trigger
	% Smoking patients over 15 recorded	68	2021/22	No Trigger	68	2021/22	No Trigger
	% Smoking status recorded	93.9	2020/21	No Trigger	93.9	2020/21	No Trigger
	% w. MRC dyspnoea score >=3 w. offer of referral to pulm. rehab. Clinic	26.3	2020/21	Level 1	26.3	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/).

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

NHS Hertfordshire and West Essex Integrated Care Board

Wider Determinants

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

In Abbey Health PCN an estimated:

- 9% of children live in poverty.
- 11.1% of older people live in poverty.
- 10.1% of households live in fuel poverty.
- 9.1% of households are overcrowded.
- 32.6% of people aged 65 and over live alone.
- 1.4% of people cannot speak English well.
- 3.4% of working age people are claiming out of work benefits.
- 19.3% of children aged 4-5 and 27% of children aged 10-11 are overweight.

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Hertfordshire Public Health Evidence & Intelligence Epidemiology

Hertfordshire

The above provides a summary of the wider determinants of health for Abbey Health. Rank of 1 indicates the most deprivation.

Abbey Health wider determinants overall are in better than the ICB average particularly for Education, Skills and Training and housing.

Source: Public Health Team

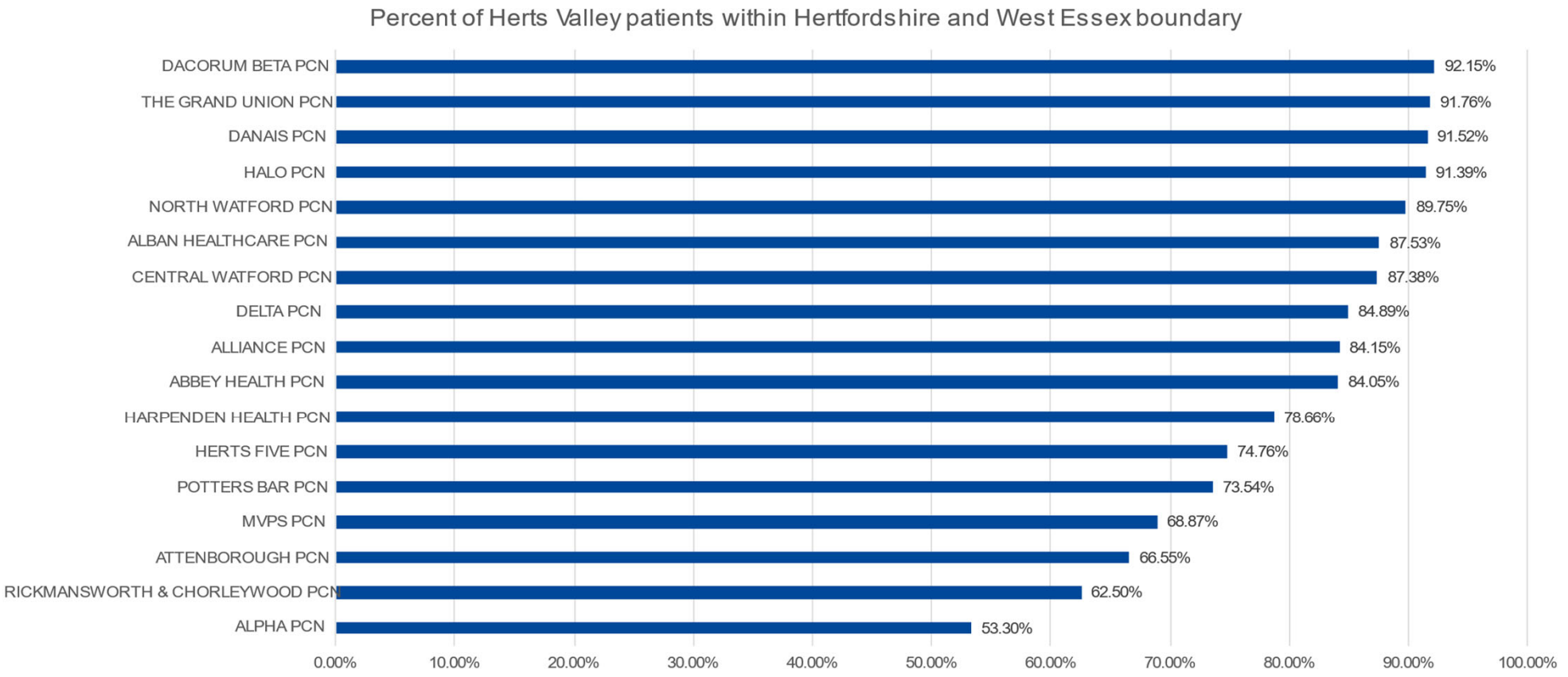
Spread of Patients

NHS Hertfordshire and West Essex Integrated Care Board

Correct as of July 2022

Source: NHS Digital (2022)

SPREAD OF PATIENTS ACROSS ENGLAND CONT.



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

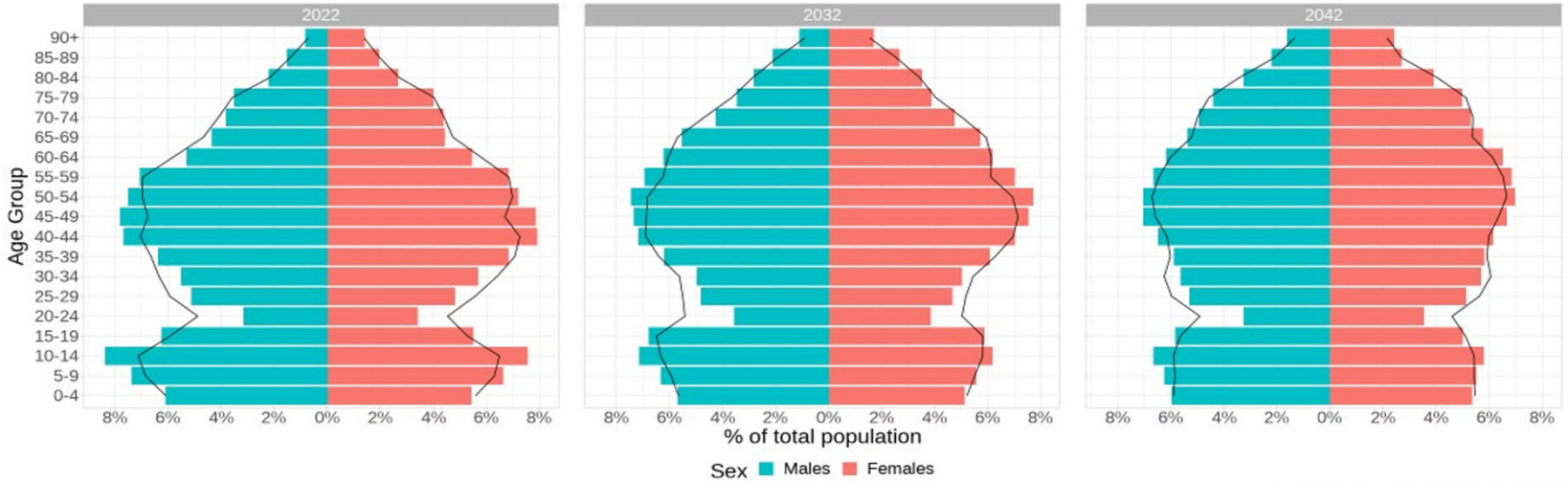
This shows Abbey Health with 84% living within the ICB geography.

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

Public Health - Population Projections

NHS Hertfordshire and West Essex Integrated Care Board

Projection Pyramids



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

Age Band	2022 Projection	2032 Projection	2042 Projection
Under 5	8,566	7,993	8,444
Under 24	44,413	41,481	39,572
24-64	77,983	75,685	74,534
65+	26,154	30,729	34,961
85+	4,278	5,620	6,676

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Hertfordshire Public Health Evidence & Intelligence Epidemiology

Hertfordshire

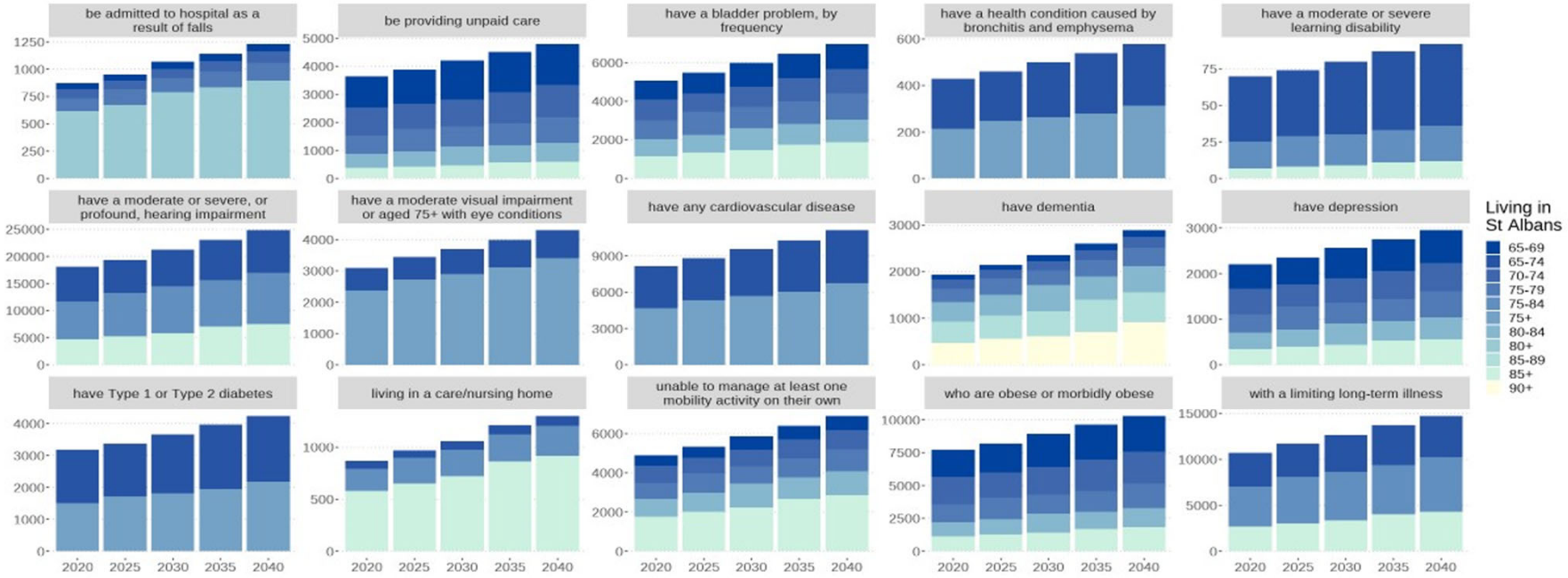
The above projection pyramids show the growth in population expected for Epping Forest District. These projections show an expected increase in the number of people over 65 from ~26k to ~35k from 2022 to 2042.

Source: Public Health Team

Public Health - Projections on Conditions

NHS Hertfordshire and West Essex Integrated Care Board

People aged 65+ projected to...



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Hertfordshire Public Health Evidence & Intelligence Epidemiology

Hertfordshire

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

Source: Public Health Team

Segmentation within the ICB

Optum

HWE

Segment & Outcomes
Framework Documentation

PHM Segment Model - Overview

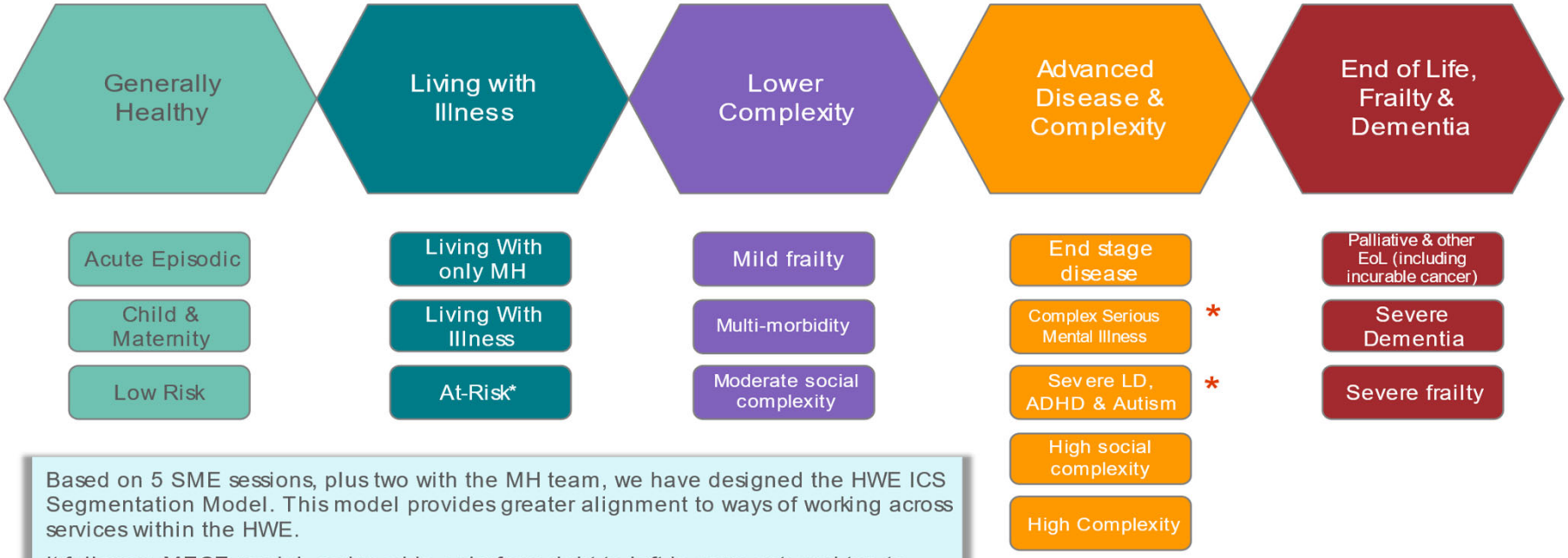
NHS Hertfordshire and West Essex Integrated Care Board

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

Optum

2

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

PHM Segment Model - Overview

NHS Hertfordshire and West Essex Integrated Care Board

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.

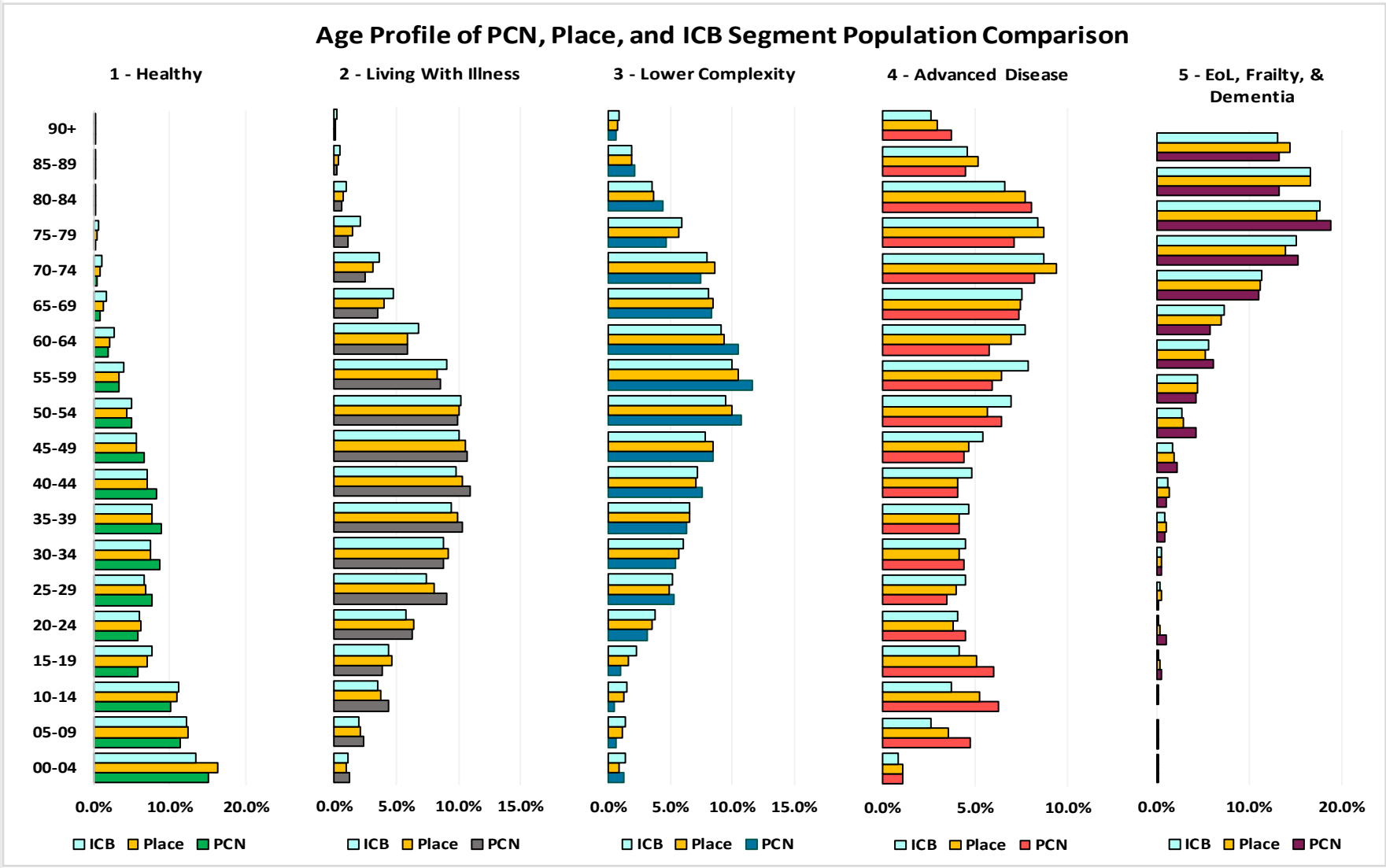
Whole Population Outcomes

- 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
Who is in this group? • Children and adults in the general population who are not otherwise captured in other segments. • Most likely receive episodic care due to accidents and injuries or linked to maternity and CYP routine services. • No diagnosed conditions.	**Who is in this group?** • Includes people with single illnesses (including MH), that are currently controlled or able to self-manage and will receive most of their care in a planned way through primary care. • Includes people with social or behavioural risk factors for more advanced disease.	**Who is in this group?** • Includes people with moderate levels of morbidity and complexity. This is either as a result of: Multi-morbidity (2-4 long term conditions), Mild frailty and/or Social complexity.	**Who is in this group?** • Advanced disease and complexity represents a cohort of people with one or more significant illnesses that impact on their day to do functioning as well as people with significant risk from social complexity	**Who is in this group?** • End of Life, frailty and dementia is the first segment in the logic and is the first set of criteria on which people are assessed. The segment includes: people who are identified as being in their last year of life, or on the palliative disease register as well as people with incurable cancer. This segment also includes those with severe frailty and/or severe dementia.
Social & Clinical Outcomes • 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.	**Social & Clinical Outcomes** • INCREASE proportion of patients who feel able to self-manage their condition. • REDUCE prevalence of behavioural risk factors for more advanced diseases, including: obesity, smoking status and drug abuse. • REDUCE episodes of ill -health requiring emergency admissions for long term condition. • INCREASE percentage of people with mental health problems in employment. • INCREASE proportion of people who are able to maintain life routines considered important to the individual, e.g work, .. • REDUCE emergency attendances due to alcohol -related harm.	**Social & Clinical Outcomes** • INCREASE proportion of patients who feel able to self-manage their condition. • REDUCE rate of emergency admissions for people with lower complexity. • INCREASE proportion of patients offered personalised care and support planning. • REDUCE prevalence of behavioural risk factors for more advanced diseases, including: obesity, smoking status and drug abuse.	**Social & Clinical Outcomes** • INCREASE five year survival from cancer. • REDUCE rate of emergency admissions in people with advanced disease or complexity. • REDUCE the difference in average age of death between people with learning disability/SMI compared to general population. • REDUCE proportion of whole population who are living with advanced disease and/or complexity.	**Social & Clinical Outcomes** • REDUCE dependency for emergency care services e.g A&E attendances and emergency admissions. • INCREASE proportion of people who die in their preferred place of death. • INCREASE identification of frail and complex patients, including those with dementia or at end of life. • REDUCE proportion of days disrupted by emergency care in last year of life. • INCREASE number of days spent at home in last year of life. • INCREASE proportion of people supported at home instead of in residential care.

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

Age Profile and Health Segment



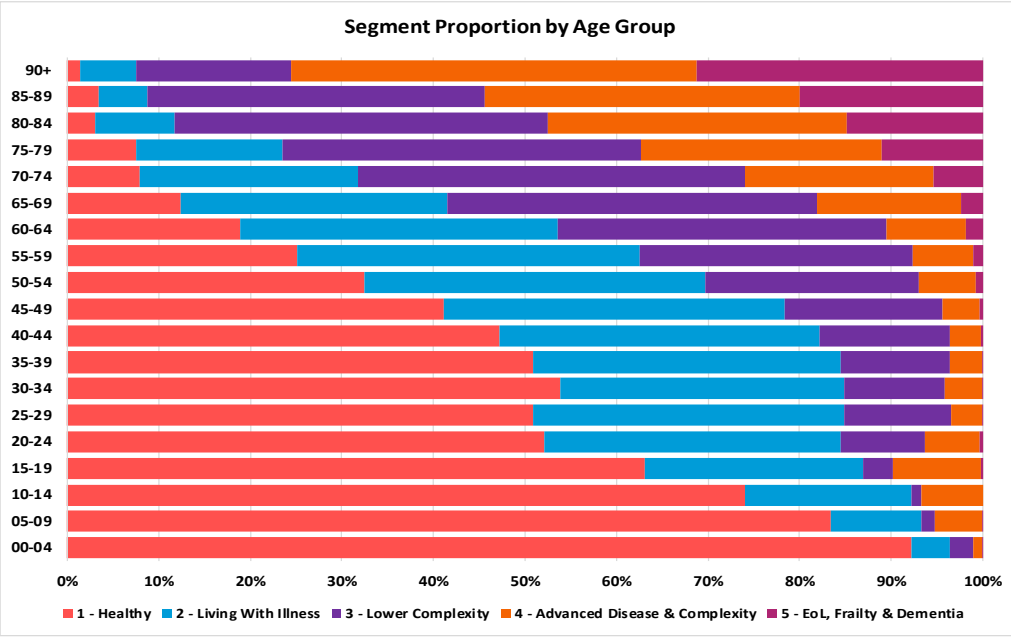
Each registered person is assigned to a segment and this can be cut by age group and also geographically by Place or PCN.

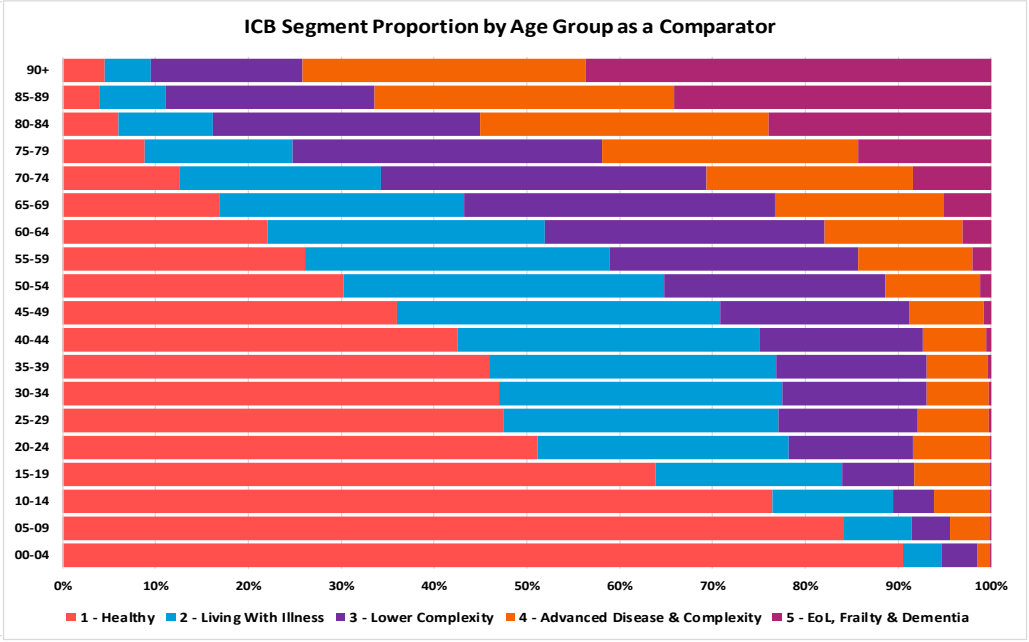
The above looks at the breakdown by age of people within each segment. It provides the PCN value against the Place and ICB value.

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

Demographic Breakdowns - Segment & Deprivation Quintiles

NHS Hertfordshire and West Essex Integrated Care Board



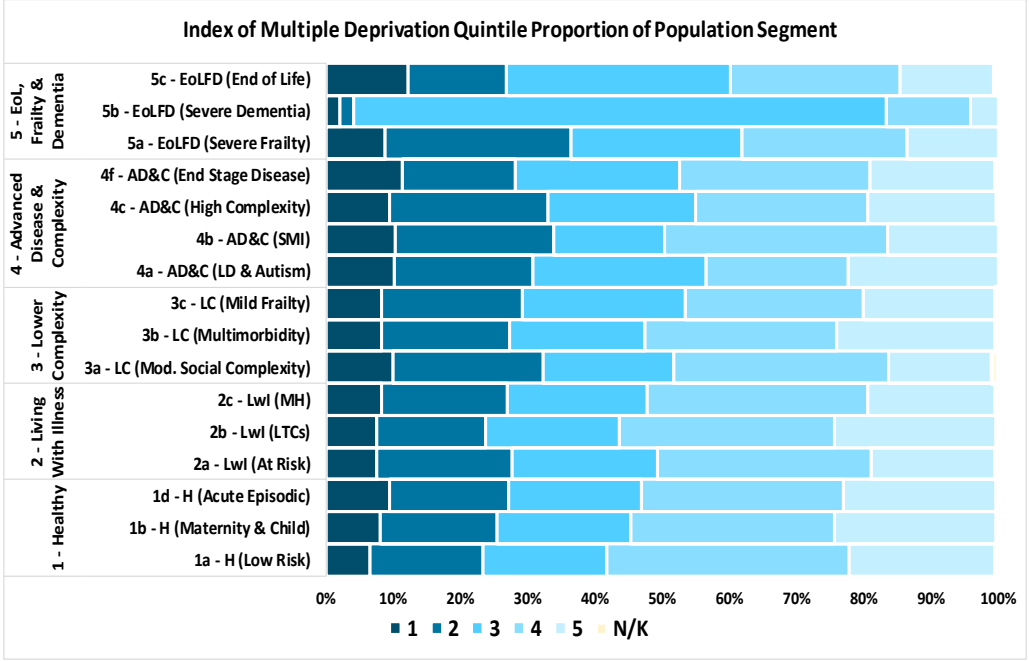


The ICB Health Segments here are broken down by total population and 5 year age groups; as expected with age the proportion of people within the healthy segment decreases.

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

In general Abbey Health slightly higher proportions within the healthy segment than 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.



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

Major Conditions Comparison - Per 1,000 Registered

NHS Hertfordshire and West Essex Integrated Care Board

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

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

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

Conditions that are highlighted for Abbey Health are Diabetes, Learning Difficulties, Serious Mental Illness.

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

Continued

NHS Hertfordshire and West Essex Integrated Care Board

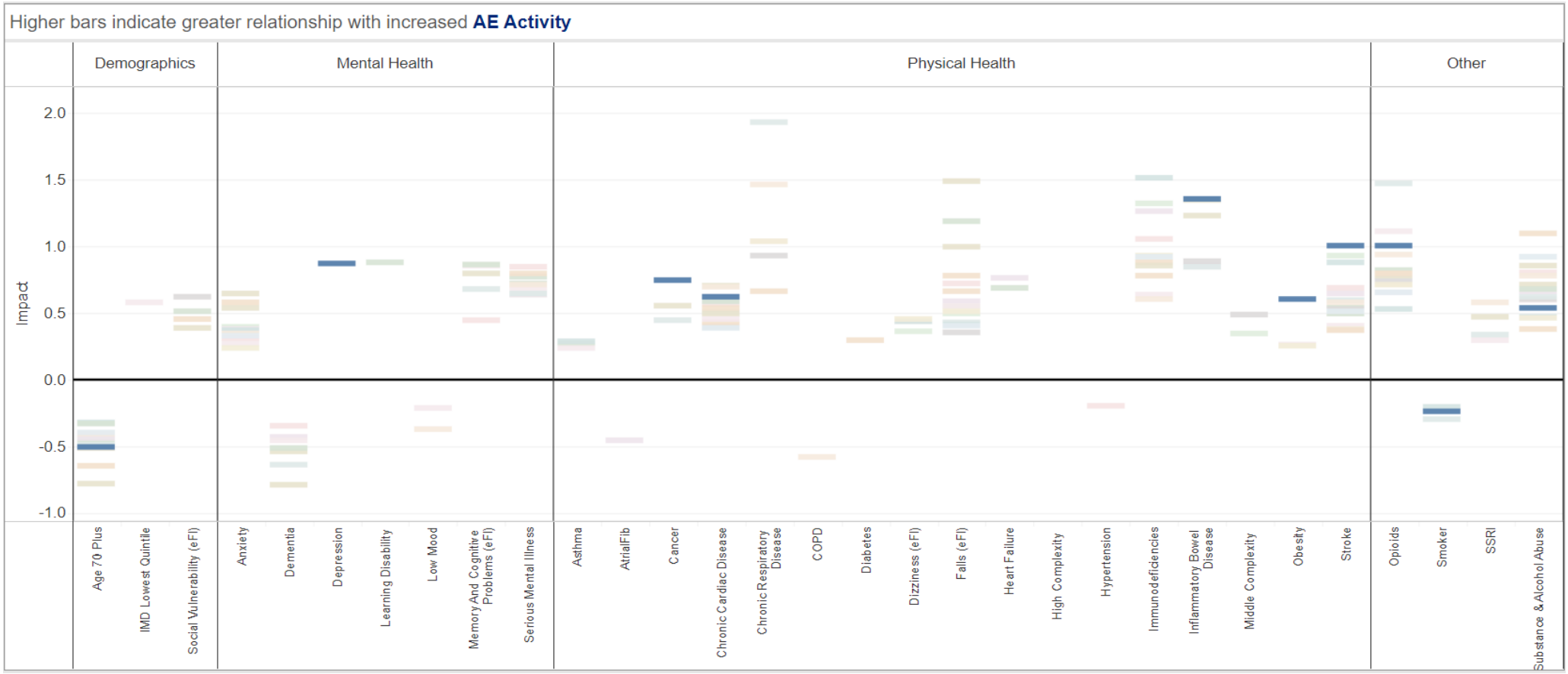
PCN NAME	ASD	Cerebral Palsy	Chronic Respiratory Disea	Cystic Fibrosis	Huntingtons Disease	Inflammatory Bowel Dise	Kidney Transplant	Metastatic Cancer	Multiple Sclerosis	Muscular Dystrophy	Myasthenia Gravis	Osteoporosis	Other Neurological Condi	Parkinsons Disease	Rheumatoid Arthritis	Lupus (SLE)	Sickle 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
BROXBOURNE ALLIANCE	8.71	1.08	27.27	0.55	0.02	13.59	2.21	3.15	2.09	0.32	0.34	24.44	1.56	1.95	9.86	1.43	0.78	1.45	87.88
CENTRAL WATFORD	10.69	1.11	20.87	0.87	0.15	7.62	2.32	2.65	1.20	0.27	0.21	11.29	1.30	2.44	7.53	1.17	0.54	1.14	29.37
DACORUM BETA	17.95	1.28	29.89	1.09	0.15	11.68	2.62	4.19	2.11	0.53	0.10	17.54	1.16	3.61	9.52	1.33	0.75	1.60	36.87
DANAIS	16.34	1.18	26.91	0.79	0.26	10.93	2.13	3.22	1.77	0.39	0.30	8.73	1.31	2.92	10.14	1.21	0.89	1.71	39.02
DELTA	13.39	1.02	21.36	0.96	0.27	11.99	2.31	3.60	2.28	0.42	0.24	18.70	0.96	2.97	8.99	1.14	0.51	1.20	37.04
HALO	20.38	1.52	23.45	0.73	0.18	11.68	2.31	3.56	1.90	0.23	0.20	20.47	1.40	3.88	8.70	1.34	0.41	0.99	31.92
HARLOW NORTH	7.53	1.38	42.10	1.26	0.06	13.93	3.47	3.41	2.51	0.30	0.36	29.48	2.45	2.39	13.51	1.49	0.60	2.21	69.06
HARLOW SOUTH	11.58	2.48	42.29	0.93	0.10	13.55	2.38	4.24	1.65	0.52	0.52	40.02	2.27	2.38	13.55	2.48	0.31	1.86	95.65
HARPENDEN HEALTH	12.54	1.06	28.25	0.66	0.12	10.84	2.47	5.89	2.22	0.39	0.48	29.04	1.89	4.68	9.54	1.18	0.39	1.41	28.50
HATFIELD	6.55	0.76	21.97	0.47	0.06	10.21	2.74	1.89	0.90	0.32	0.23	19.79	1.43	1.51	6.72	1.25	0.84	1.54	71.96
HERTFORD AND RURALS	8.19	0.81	24.68	0.69	0.12	15.00	2.38	2.24	2.26	0.44	0.30	27.37	1.37	2.38	7.72	0.89	0.10	1.53	90.91
HERTS FIVE	13.79	1.39	23.04	0.77	0.13	12.86	2.98	2.86	2.45	0.25	0.36	22.67	1.69	3.63	17.88	1.26	0.62	1.66	34.03
HITCHIN AND WHITWELL	9.93	1.49	30.11	0.50	0.00	15.61	2.87	3.41	2.41	0.32	0.32	34.83	1.42	2.52	8.34	1.63	0.14	1.60	92.26
HODDESDON & BROXBOURNE	9.14	0.96	31.53	0.58	0.27	14.77	2.84	3.29	2.38	0.43	0.23	33.55	1.73	2.33	9.37	1.35	0.22	1.73	96.87
ICKNIELD	10.67	1.08	29.47	0.62	0.08	16.17	2.69	2.91	3.58	0.43	0.32	27.18	1.29	2.67	8.51	1.27	0.05	2.02	82.47
LEA VALLEY HEALTH	10.05	1.27	31.63	0.59	0.10	12.74	2.37	2.80	1.53	0.36	0.46	22.43	1.89	1.72	10.47	1.63	1.11	1.98	97.79
LOUGHTON BUCKHURST HILL & CHIGWELL	4.13	0.84	22.95	0.79	0.14	14.26	2.42	3.62	1.77	0.46	0.33	38.42	1.90	2.04	8.87	1.53	0.19	1.35	65.68
MVPS	14.28	1.17	34.30	10.11	0.07	11.35	2.43	3.60	2.06	0.30	0.15	15.86	1.17	2.47	8.53	1.69	0.59	1.30	32.96
NORTH UTTLESFORD	2.34	0.78	21.65	0.73	0.05	11.09	1.18	2.48	1.13	0.48	0.11	23.32	1.16	1.27	10.04	1.29	0.03	1.72	26.93
NORTH WATFORD	12.70	1.07	27.72	2.17	0.11	12.20	2.44	3.36	2.40	0.42	0.31	16.47	1.53	2.63	9.42	1.45	0.34	0.92	37.13
POTTERS BAR	12.98	0.76	27.06	0.62	0.17	8.31	1.90	2.70	2.01	0.38	0.48	21.07	1.49	3.25	7.96	1.07	0.42	1.28	33.70
RICKMANSWORTH & CHORLEYWOOD	11.74	1.12	23.30	2.02	0.25	9.40	2.45	3.20	1.33	0.54	0.18	15.52	0.97	2.88	7.38	0.97	0.11	1.51	32.44
SOUTH UTTLESFORD	3.05	1.02	21.93	0.53	0.02	10.61	1.97	2.44	1.89	0.28	0.22	29.23	1.34	1.71	10.30	1.48	0.08	2.01	24.13
STEVENAGE NORTH	12.22	1.43	32.98	0.27	0.05	16.52	3.40	2.92	2.23	0.64	0.27	15.67	1.81	2.71	7.06	1.27	0.48	1.54	94.81
STEVENAGE SOUTH	10.81	1.57	31.16	0.88	0.06	13.08	2.69	4.03	2.09	0.27	0.33	14.90	1.57	2.09	5.81	1.12	0.39	1.73	75.58
STORT VALLEY & VILLAGES	10.22	1.05	25.19	0.51	0.00	12.73	1.89	3.26	1.95	0.41	0.36	41.69	1.69	2.08	9.13	1.63	0.13	1.39	76.18
THE GRAND UNION	13.30	1.32	22.90	1.36	0.18	11.75	2.22	3.19	2.19	0.25	0.25	26.69	1.27	2.29	9.07	1.53	0.53	1.68	74.02
WARE AND RURALS	7.25	1.01	25.52	0.77	0.09	14.85	2.67	2.64	1.81	0.18	0.27	26.11	1.63	2.58	7.58	1.22	0.03	1.75	86.12
WELWYN GARDEN CITY A	9.18	0.77	25.87	0.71	0.05	13.17	2.65	2.13	1.92	0.46	0.20	20.42	1.30	1.37	7.02	1.11	0.38	1.55	89.89

On this page of conditions, we can see that the PCN has higher prevalence shown for Muscular Dystrophy and and ASD.

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

PCN Benchmarking - A&E Activity

NHS Hertfordshire and West Essex Integrated Care Board



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

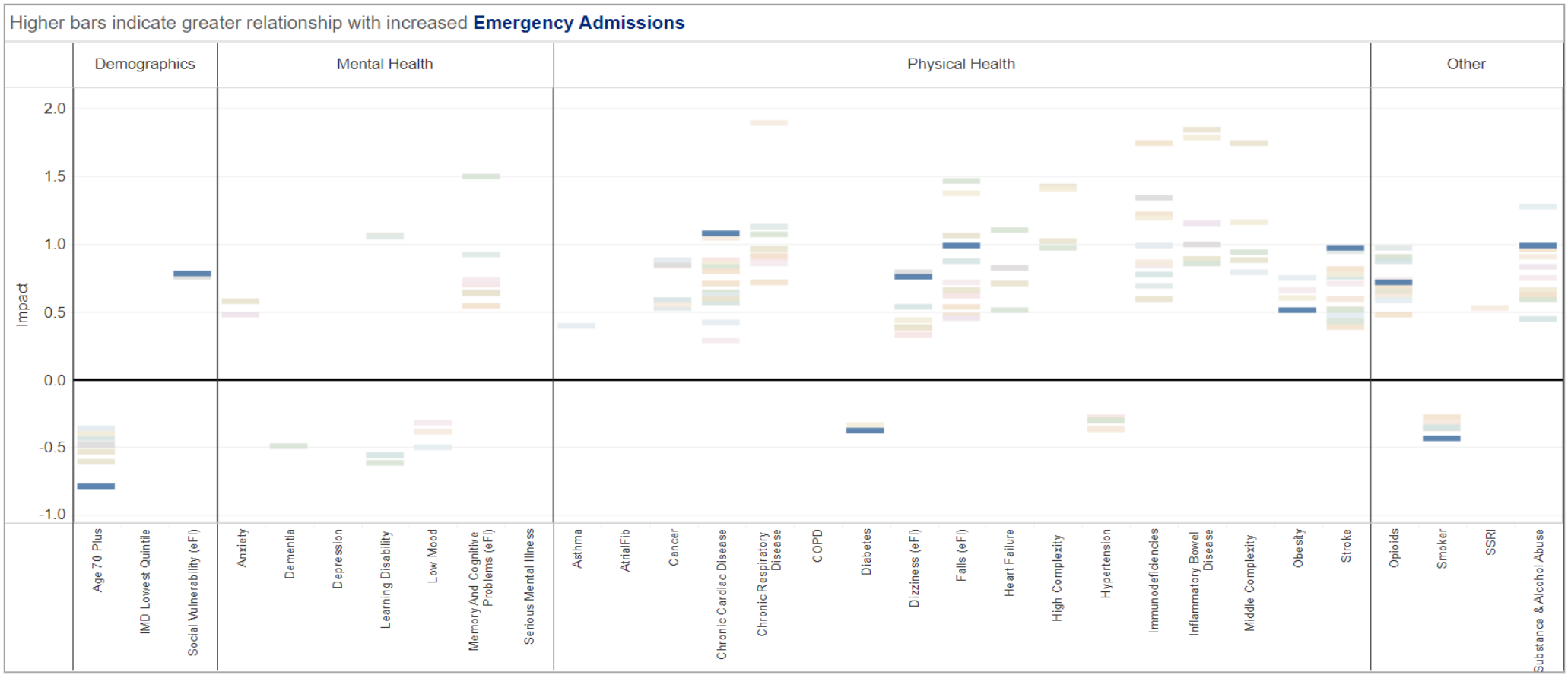
The Model - A statistical regression model is used to decide which Risk Factors correlate with a significant impact on the selected targets as presented in these charts, the height of the bar for each PCN relates to the correlation of a Risk Factor and an increase in impact on the selected target condition.

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

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

PCN Benchmarking - Emergency Admissions

NHS Hertfordshire and West Essex Integrated Care Board



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

Chronic Cardiac Disease admissions shows in the data as a characteristic that has a high impact on emergency admissions.

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

Urgent and Emergency Care

NHS Hertfordshire and West Essex Integrated Care Board

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

Overall aim

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

Objectives

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

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

UEC Overview

Hertfordshire & West Essex ICB – South & West

A&E Summary – Who are attending and why?

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

223,830 A&E Attendances in 2021/22

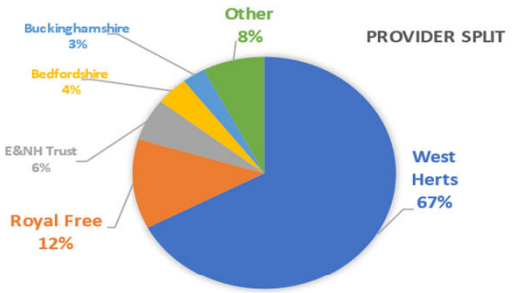
Children = 62,944 (28.1%)
Adults = 113,994 (50.9%)
Older People = 46,892 (20.9%)

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

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

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

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



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

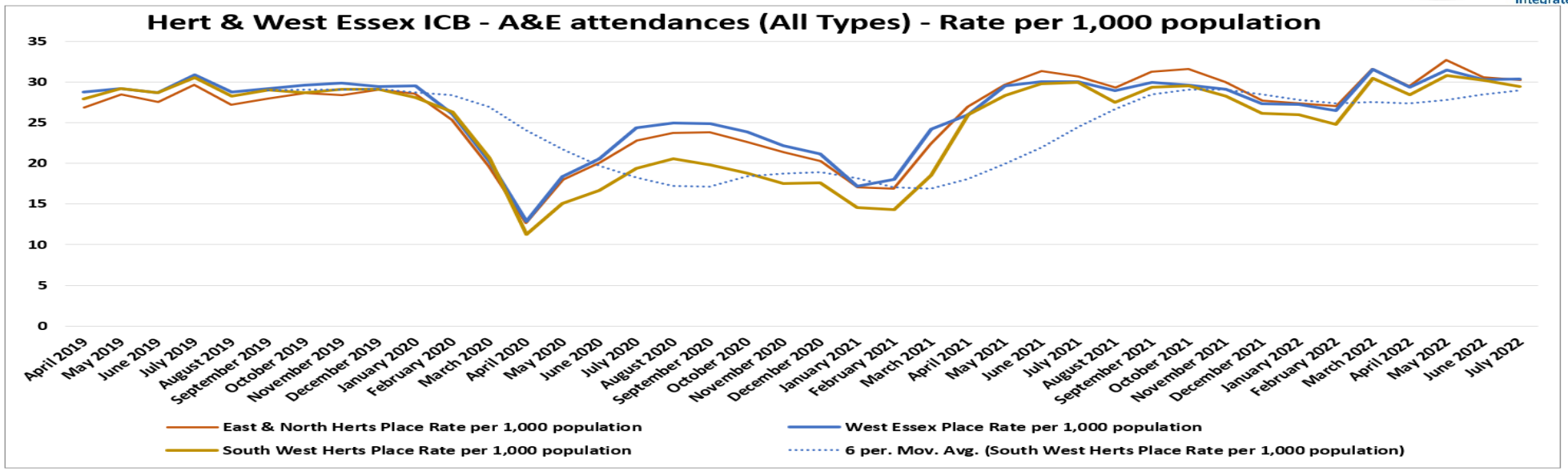
Children = 1 in 4 children
Adults = 1 in 5 adults
Older People = 1 in 4 older people

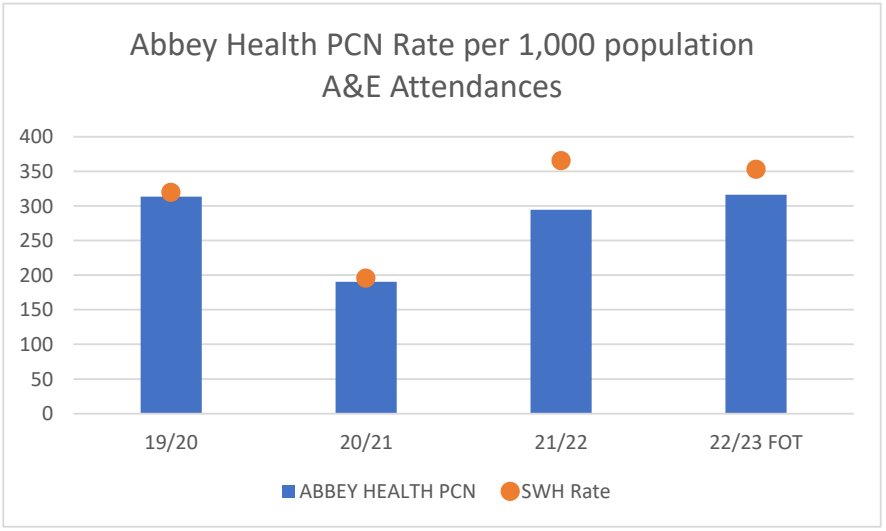
Hertfordshire and West Essex Integrated Care System

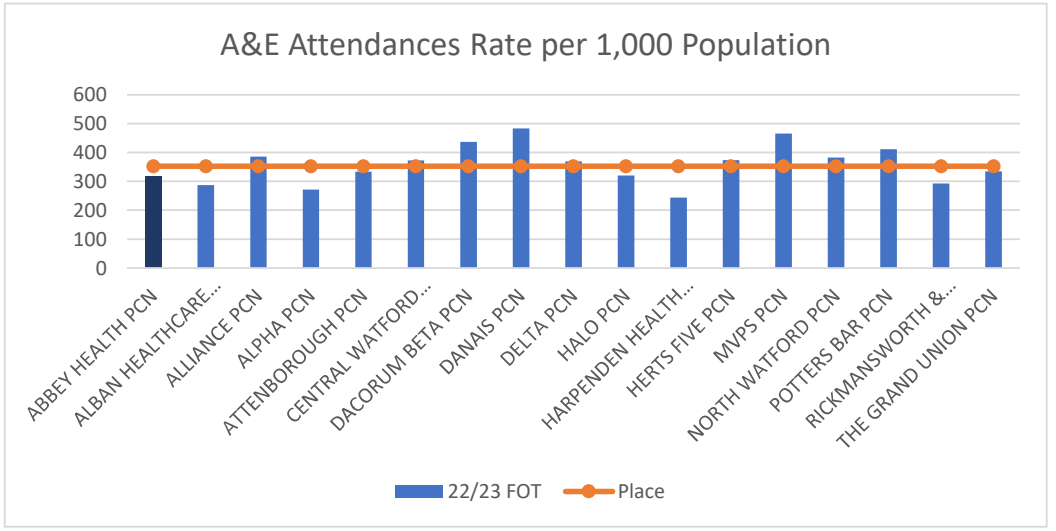
Source: SUS

Source: HWE PHm Team, SUS Data Sets

UEC







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

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

2022/23 rates for Abbey Health are similar to 19/20 rates and are lower than the place rate.

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

Unplanned Hospitalisation for Chronic Ambulatory Care Sensitive Conditions

NHS Hertfordshire and West Essex Integrated Care Board

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 Abbey Health PCN.

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

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

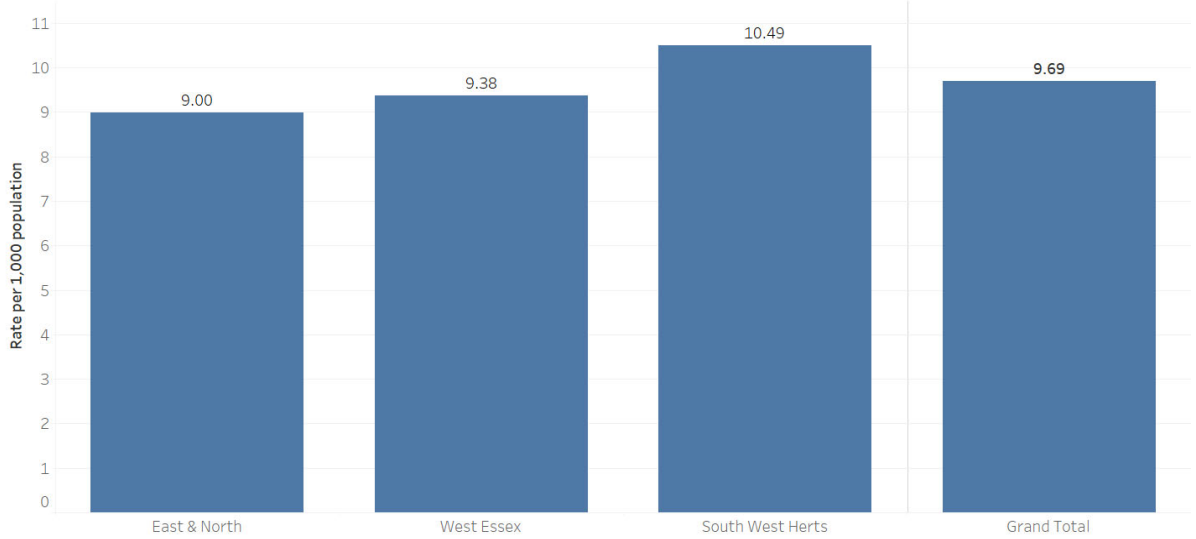
Chronic ACS	Admissions	People	Average cost of admission	Tariff Total Payment National
CVD: AF and Flutter	43	35	£2,700	£116,089
CVD: Angina	11	11	£1,254	£13,797
CVD: Congestive Heart Failure	39	34	£4,933	£192,383
CVD: Hypertension	21	19	£792	£16,631
Diseases of the blood	17	15	£1,849	£31,436
Neurological Disorders	25	18	£2,894	£72,358
Nutritional, endocrine and metabolic	29	24	£2,795	£81,051
Respiratory: Asthma	15	12	£1,361	£20,412
Respiratory: COPD	41	31	£2,447	£100,314
Grand Total	**241**	**192**	**£2,674**	**£644,471**

Source: HWE PHM Team, SUS UEC data-sets

ACS Admission Rates per 1,000 Population by Place

Hertfordshire and West Essex Integrated Care Board

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

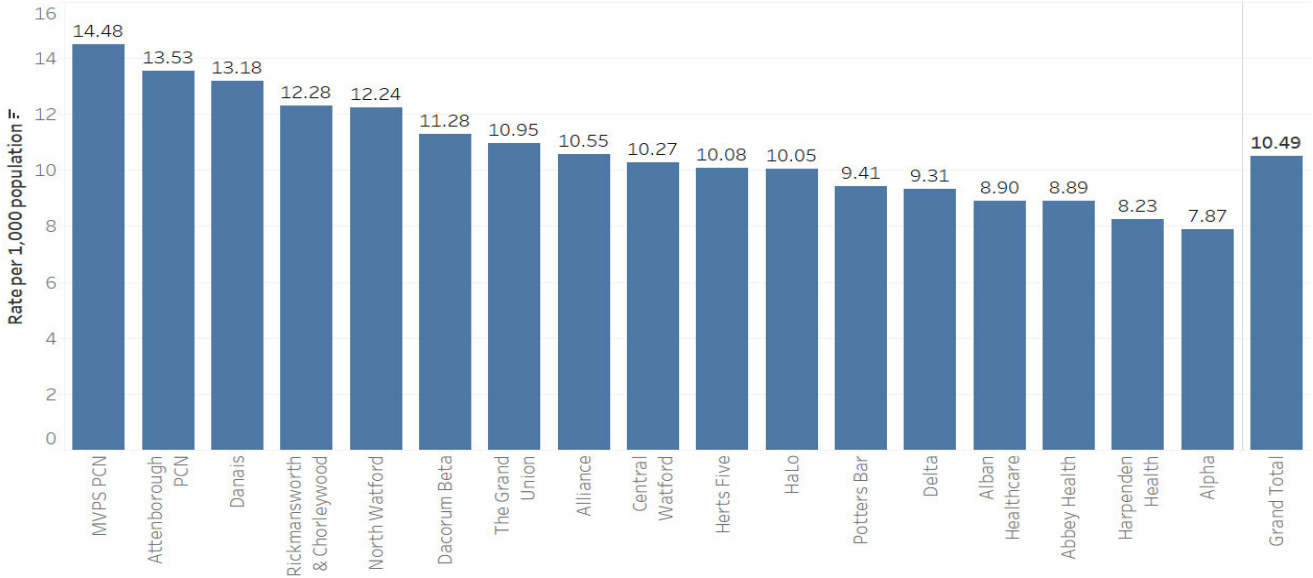


When comparing the rates per 1,000 population between places, South West Herts has a higher rate than the ICB.

Within South West Herts Place, Abbey Health has a lower 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.

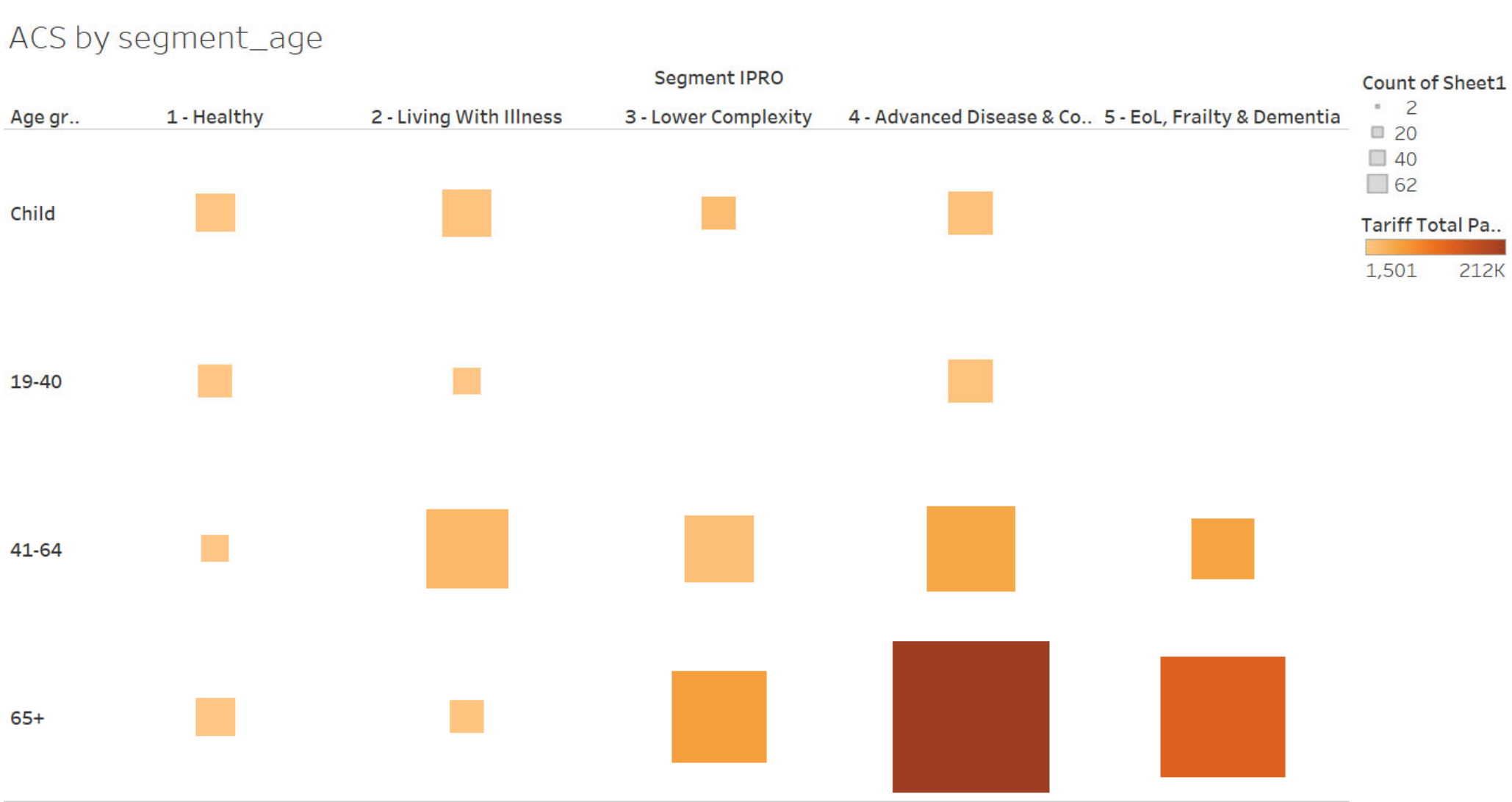
Chronic Ambulatory Care Sensitive Conditions by Place
Rate per 1,000 Population
(Total Population)



Source: HWE PHM Team, SUS UEC data-sets

Chronic ACS by Segment

NHS Hertfordshire and West Essex Integrated Care Board



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

For Abbey Health the highest volume and cost is within the Advanced Disease and Complexity segment for those aged over 65.

The following pages look at which ACSs contribute to this.

Source: HWE PHM Team, SUS UEC data-sets

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

Hertfordshire and West Essex Integrated Care Board

Segment 4

Ambulatory Care Sensitive conditions of note for people aged over 65 within the Advanced Disease and Complexity segment are AF, Heart Failure and COPD.

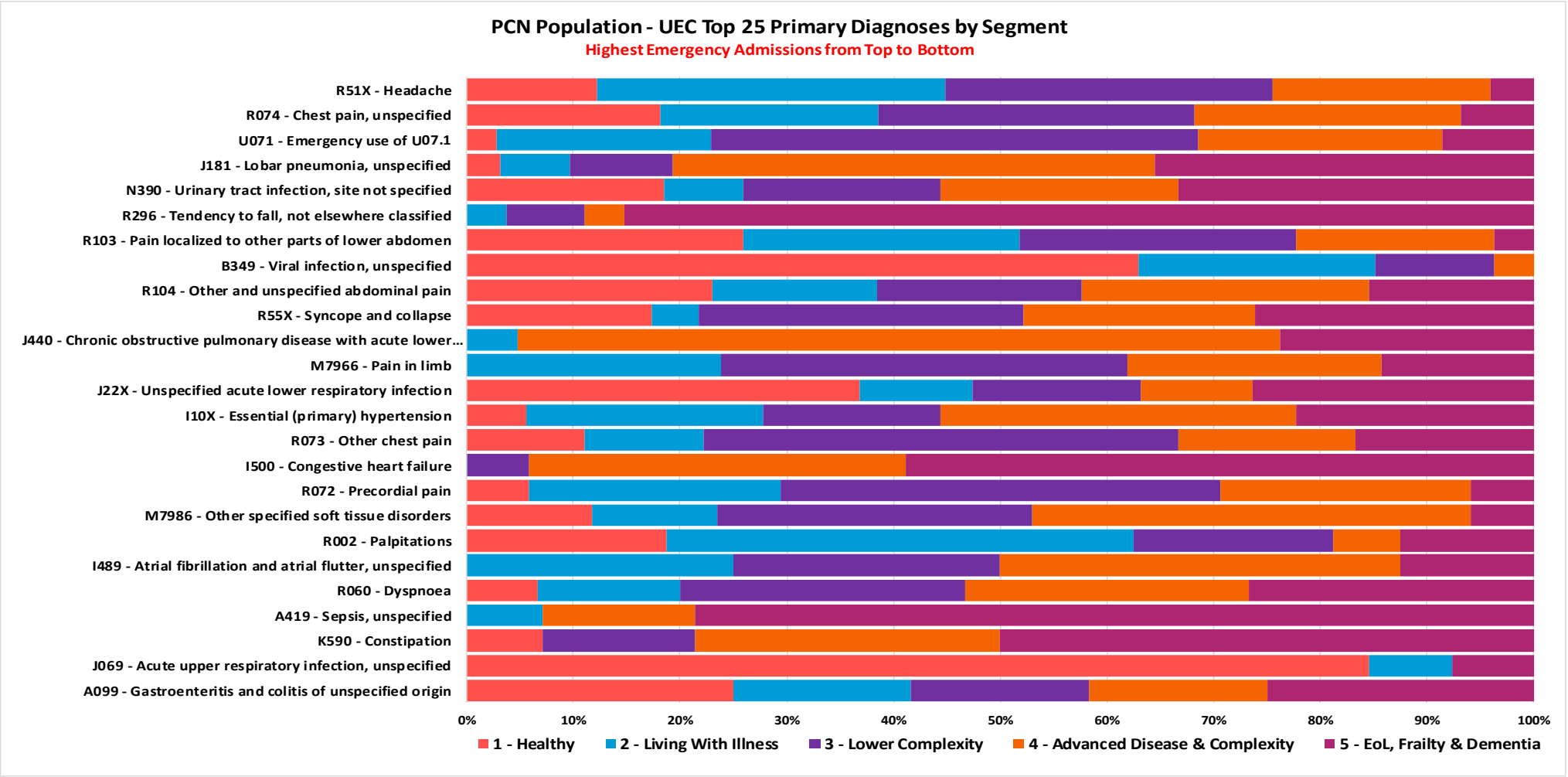
For those aged over 65 within the End of Life, Frailty & Dementia segment, Heart Failure, COPD and AF, is highlighted with the highest volume and cost.

Segment 5

Source: HWE PHM Team, SUS UEC data-sets

UEC Diagnoses by Segment

NHS Hertfordshire and West Essex Integrated Care Board



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.

Source: HWE PHM Team, SUS UEC data-sets

UEC & Segmentation + Deprivation by Ward

NHS Hertfordshire and West Essex Integrated Care Board

UEC Patients Seen by Segment & Ward	1 - Healthy	2 - Living With Illness	3 - Lower Complexity	4 - Advanced Disease & Complexity	5 - EoL, Frailty & Dementia	Grand Total
Ashley	23	36	35	56	54	204
Ashridge				1		1
Batchwood	18	21	31	34	12	116
Bennetts End	2					2
Bushey Heath					2	2
Clarence	18	22	14	7	28	89
Colney Heath	16	19	35	28	15	113
Cunningham	21	27	37	37	27	149
Hatfield East	1					1
Hatfield South			2			2
Hollybush	1	1				2
London Colney	51	65	121	109	84	430
Marshalswick North	14	10	5	18	21	68
Marshalswick South	22	15	9	23	4	73
Park Street	1	2	3	6	10	22
Redbourn	2	1	1		1	5
Sandridge	6	4	12	7	2	31
Shenley	3	1	4			8
Sopwell	30	32	44	47	103	256
St Peters	51	26	51	49	13	190
St Stephen	4	5	5	5	2	21
Verulam	14	14	14	11	9	62
Watling	1	3				4
Wheathampstead		1		1		2
Unknown Ward	2	7	1	2		12
Grand Total	301	312	424	441	387	1865

UEC Patients Seen by Deprivation Quintile & Ward 1 = Most Deprived, 5 = Least Deprived	1	2	3	4	5	(blank)	Grand Total
Ashley			87	28	89		204
Ashridge			1				1
Batchwood	42	35	22	17			116
Bennetts End	2						2
Bushey Heath			2				2
Clarence				47	42		89
Colney Heath		18	18	77			113
Cunningham	43	36	31	39			149
Hatfield East	1						1
Hatfield South	1		1				2
Hollybush		2					2
London Colney		186	148	96			430
Marshalswick North			16	20	32		68
Marshalswick South				24	49		73
Park Street		11	5	5	1		22
Redbourn		5					5
Sandridge			10		21		31
Shenley		8					8
Sopwell	115		66	43	32		256
St Peters		94		96			190
St Stephen			1	13	7		21
Verulam				1	61		62
Watling			3	1			4
Wheathampstead		1		1			2
Unknown Ward						12	12
Grand Total	204	396	411	508	334	12	1865

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

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

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

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

Public Health - Nationally Reported Admissions

NHS Hertfordshire and West Essex Integrated Care Board

Hospital Admissions

	Period	HERTFORDSHIRE AND WEST ESSEX	ABBEY HEALTH PCN
Emergency admissions injuries due to falls in those aged 65+	2020/21	2026	2675.6
Emergency asthma, diabetes and epilepsy admissions (aged 0-18)	2020/21	130.8	
Emergency admissions for children with lower respiratory tract infections (age 0-18)	2020/21	40.5	
Emergency admissions for chronic ambulatory care sensitive conditions	2020/21	505.9	621.4
Mental health admissions (all ages)	2020/21	177.2	162.1
Emergency Cancer Admissions	2020/21	494.9	590.9
Emergency admissions for acute conditions shouldn't require admissions	2020/21	611.6	559.5

Similar | Significantly Worse | Significantly Better

PH.Intelligence@hertfordshire.gov.uk

Hertfordshire Public Health Evidence & Intelligence Epidemiology

Hertfordshire

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

The data for Abbey Health PCN rates vary from Similar to Significantly Worse rate of admissions to the ICB, dependent on Admission categories.

Source: Public Health Team

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			4	21	36	33	96	39	67	48	1	345	37725
% of population in cohort			1.2%	6.1%	10.4%	9.6%	27.8%	11.3%	19.4%	13.9%	0.3%	100.0%	100.0%
Avg. Age			51.0	71.6	71.1	79.2	79.9	70.8	70.9	72.4	30.0	74.1	75.6
% BAME Where recorded			25%	19%	25%	6%	13%	21%	24%	11%	100%	17%	8%
Avg. number of Acute and Chronic Conditions			2.5	6.9	6.8	7.4	6.7	6.4	6.1	6.2	8.0	6.5	5.5
Activity Measure													
Emergency Admissions			1.0	1.5	1.2	1.2	1.0	0.6	1.1	1.3	0.0	1.1	0.6
A&E Attendances			1.8	1.7	1.4	1.5	1.2	0.7	1.2	1.6	0.0	1.3	0.9
GP Encounters			48.8	61.9	74.9	61.5	82.1	61.7	61.7	62.5	2.0	68.5	103.4
Admitted Bed Days			1.5	11.2	9.9	12.5	10.4	4.0	7.2	8.3	0.0	8.8	4.2
Physical Health													
Asthma			0.0%	19.0%	30.6%	45.5%	20.8%	41.0%	26.9%	33.3%	100.0%	29.3%	25.2%
Cancer			75.0%	47.6%	44.4%	33.3%	19.8%	33.3%	49.3%	45.8%	0.0%	36.8%	32.8%
Chronic Cardiac Disease			0.0%	71.4%	58.3%	69.7%	50.0%	56.4%	53.7%	52.1%	0.0%	55.1%	47.5%
Chronic Respiratory Disease			25.0%	38.1%	30.6%	27.3%	13.5%	38.5%	26.9%	25.0%	100.0%	25.5%	22.2%
CKD			0.0%	4.8%	16.7%	21.2%	16.7%	10.3%	17.9%	12.5%	100.0%	15.4%	20.7%
Heart Disease			0.0%	66.7%	47.2%	51.5%	41.7%	43.6%	41.8%	50.0%	0.0%	45.5%	39.1%
Hypertension			25.0%	76.2%	83.3%	75.8%	77.1%	74.4%	74.6%	66.7%	100.0%	74.8%	74.5%
Diabetes			50.0%	76.2%	75.0%	60.6%	55.2%	59.0%	55.2%	68.8%	100.0%	61.4%	42.8%
Obesity			50.0%	33.3%	41.7%	33.3%	22.9%	41.0%	38.8%	31.3%	0.0%	33.0%	32.8%
Rheumatoid Arthritis			0.0%	4.8%	8.3%	3.0%	4.2%	7.7%	1.5%	0.0%	0.0%	3.8%	5.3%
Stroke			25.0%	71.4%	44.4%	57.6%	57.3%	51.3%	47.8%	45.8%	0.0%	52.2%	34.5%
Mental Health													
Anxiety			0.0%	14.3%	25.0%	30.3%	36.5%	23.1%	22.4%	33.3%	0.0%	28.1%	29.0%
Depression			0.0%	28.6%	38.9%	42.4%	42.7%	30.8%	31.3%	39.6%	100.0%	37.1%	33.6%
Dementia			0.0%	23.8%	16.7%	33.3%	68.8%	25.6%	14.9%	16.7%	0.0%	33.6%	18.6%
Serious Mental Illness			0.0%	19.0%	13.9%	18.2%	21.9%	20.5%	16.4%	10.4%	0.0%	17.4%	6.5%
Low Mood			0.0%	9.5%	13.9%	9.1%	21.9%	10.3%	14.9%	10.4%	0.0%	14.5%	18.5%
Suicide			0.0%	4.8%	0.0%	0.0%	3.1%	2.6%	0.0%	0.0%	0.0%	1.4%	1.5%
Mental Health Flag			0.0%	38.1%	47.2%	48.5%	59.4%	43.6%	47.8%	50.0%	100.0%	49.9%	48.8%
Screening and Verification Refusal													
Bowel Screening Refused			0.0%	38.1%	36.1%	24.2%	27.1%	20.5%	37.3%	31.3%	100.0%	30.1%	25.5%
Cervical Screening Refused			25.0%	4.8%	2.8%	6.1%	4.2%	2.6%	7.5%	2.1%	0.0%	4.6%	3.6%
Flu Vaccine Refused			0.0%	47.6%	30.6%	33.3%	31.3%	41.0%	28.4%	37.5%	100.0%	33.6%	26.4%
Wider Indicators													
Has A Carer			0.0%	14.3%	25.0%	33.3%	34.4%	25.6%	20.9%	20.8%	0.0%	26.1%	19.0%
Is A Carer			0.0%	4.8%	2.8%	9.1%	3.1%	10.3%	6.0%	8.3%	0.0%	5.8%	11.9%
MED3 Not Fit For Work (ever)			25.0%	28.6%	22.2%	9.1%	5.2%	20.5%	22.4%	16.7%	100.0%	15.9%	13.4%
MED3 Not Fit For Work (in Last Year)			0.0%	9.5%	8.3%	0.0%	2.1%	7.7%	4.5%	6.3%	0.0%	4.6%	3.5%
MED3 Not Fit For Work (in Last Six Months)			0.0%	9.5%	2.8%	0.0%	1.0%	2.6%	1.5%	6.3%	0.0%	2.6%	2.8%
Avg. number of eFI Deficits			5.0	12.2	12.2	12.9	12.7	9.8	10.5	10.1	8.0	11.4	13.4
eFI_Housebound			0.0%	14.3%	16.7%	33.3%	9.4%	15.4%	13.4%	4.2%	0.0%	13.3%	10.9%
eFI_SocialVulnerability			0.0%	38.1%	50.0%	45.5%	43.8%	41.0%	28.4%	39.6%	0.0%	39.7%	27.3%
People_ChildrenInPoverty													15.5
Housing_FuelPoverty			13.0	13.9	13.9	11.0	12.9	9.9	10.3	9.0		11.5	11.1
Housing_OnePersonHousehold			27.8	32.6	35.1	31.1	33.0	21.4	29.0	22.0		29.3	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 Abbey Health 7.3% of the population in the EoL, severe frailty and severe dementia segment live within the 4 most deprived deciles.

The average age of a person within the Frail and End of life segment increases with affluence, ranging from 69 in the most deprived decile to 77 within the most affluent decile within the ICB.

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

Within this segment we can see the presence of Chronic Cardiac Disease, heart disease and diabetes being highlighted which chimes with the reason for admission within previous analysis for ACS conditions.

Source: HWE PHM Team, SUS UEC data-sets

Applying Machine Learning factors without our data platform

NHS Hertfordshire and West Essex Integrated Care Board

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

Source: HWE PHM Team

Quality & Outcomes Framework

NHS Hertfordshire and West Essex Integrated Care Board

Contents:

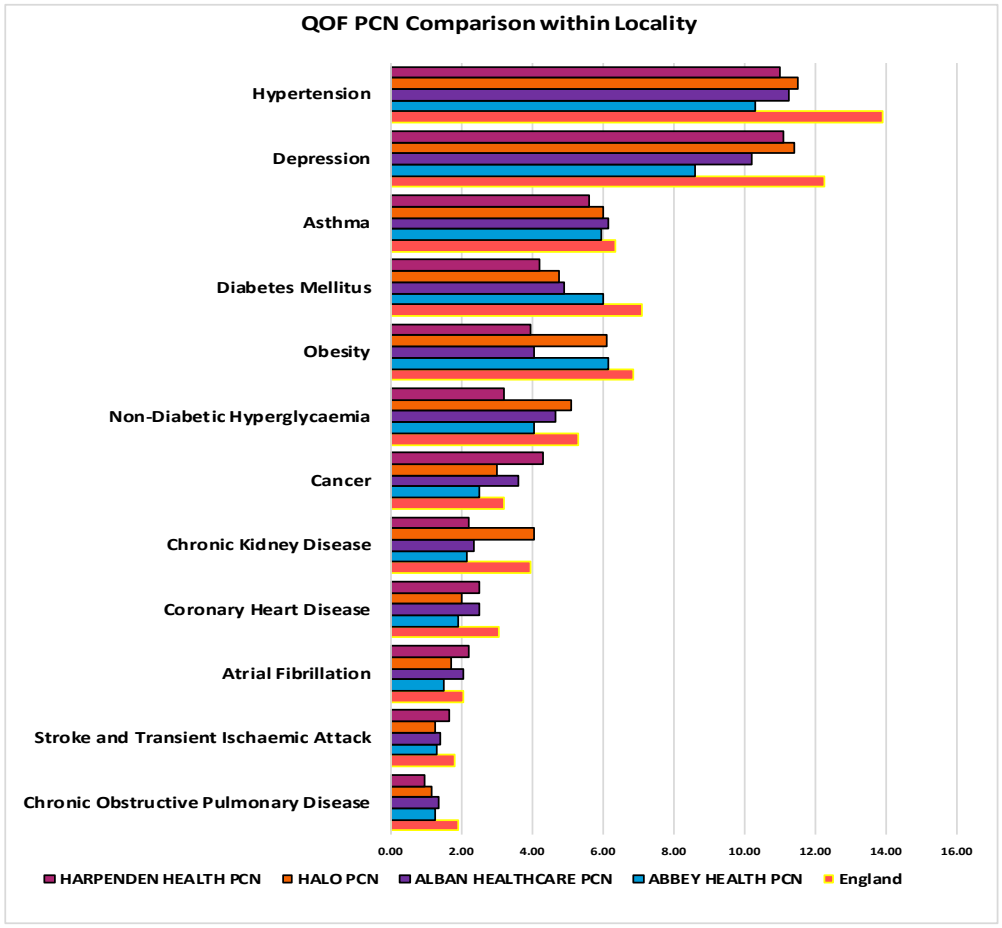
- **QOF Local, Regional, & National Comparison**

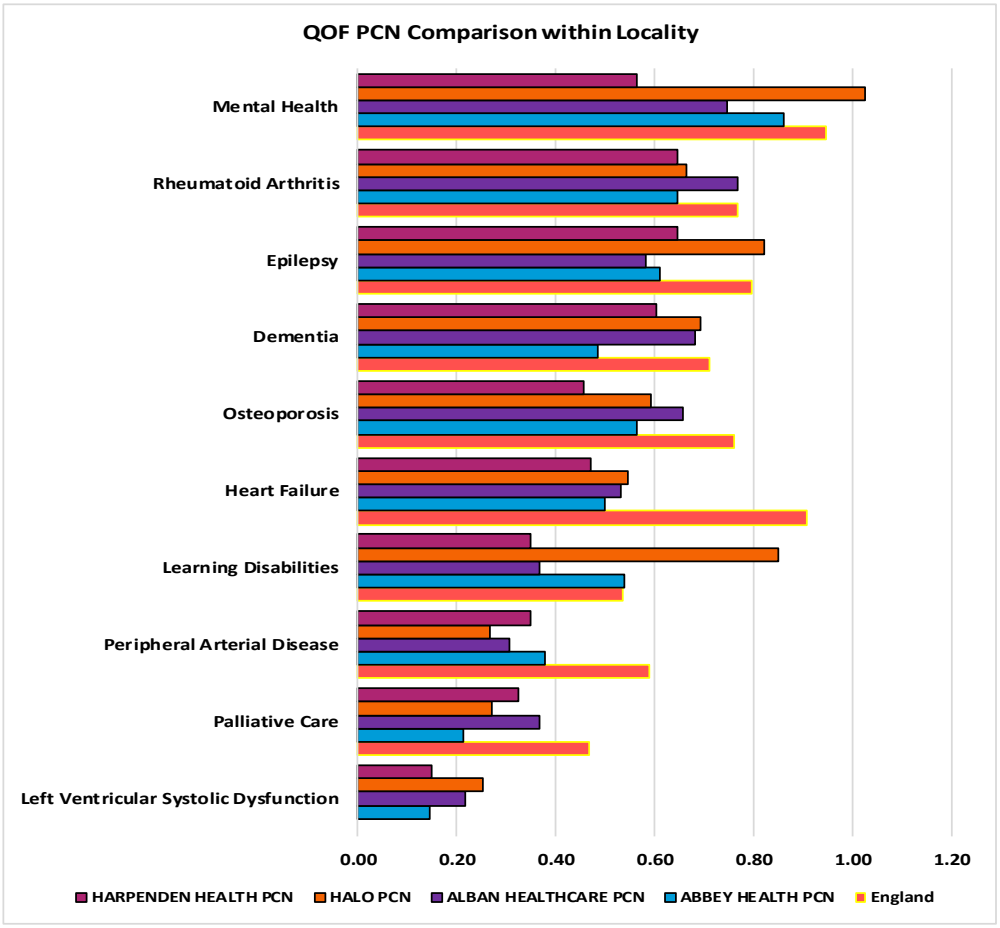
- **QOF Locality & PCN Comparison**

- **QOF Missed Diagnoses & Admission Rates**

- **Admission Rates Benchmarking against ICB/Place**

QOF - Locality & PCN Comparison



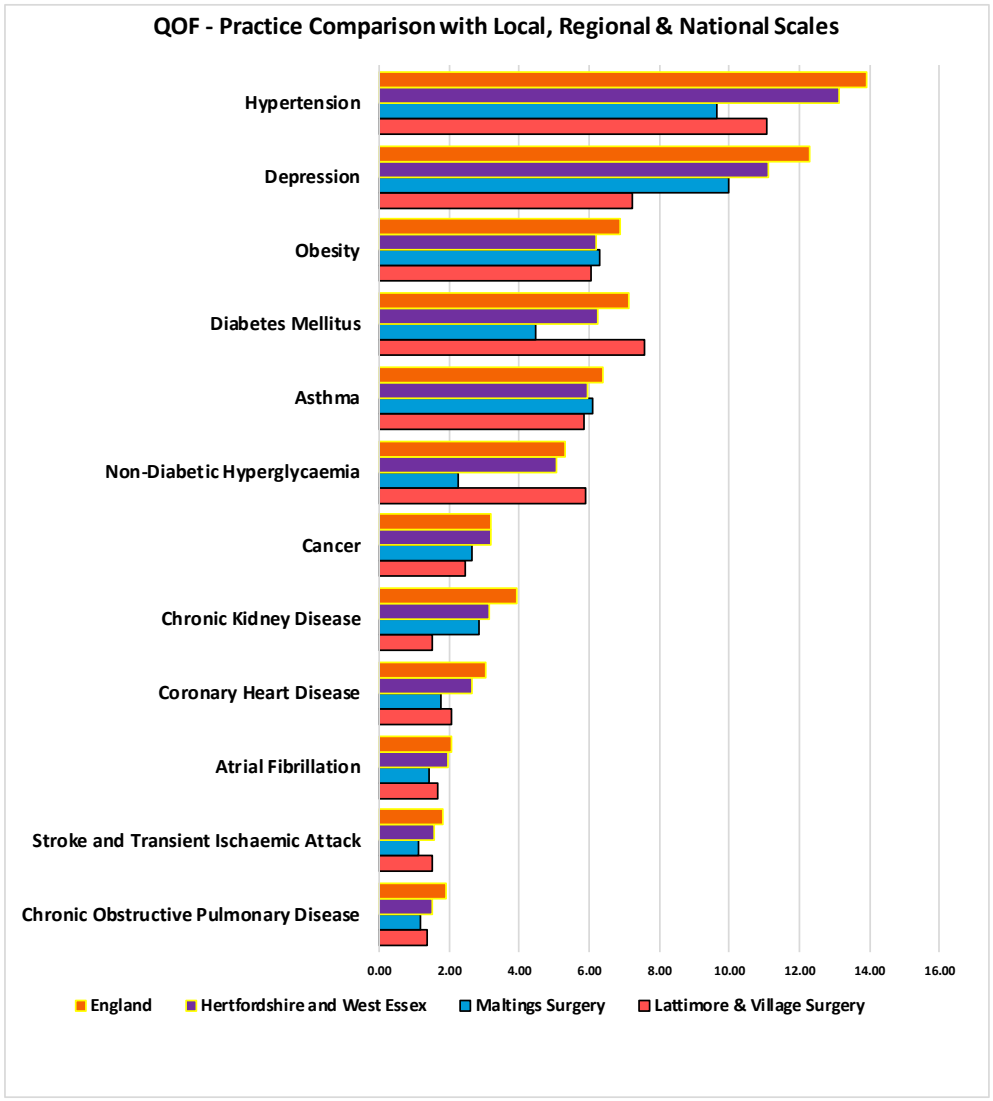


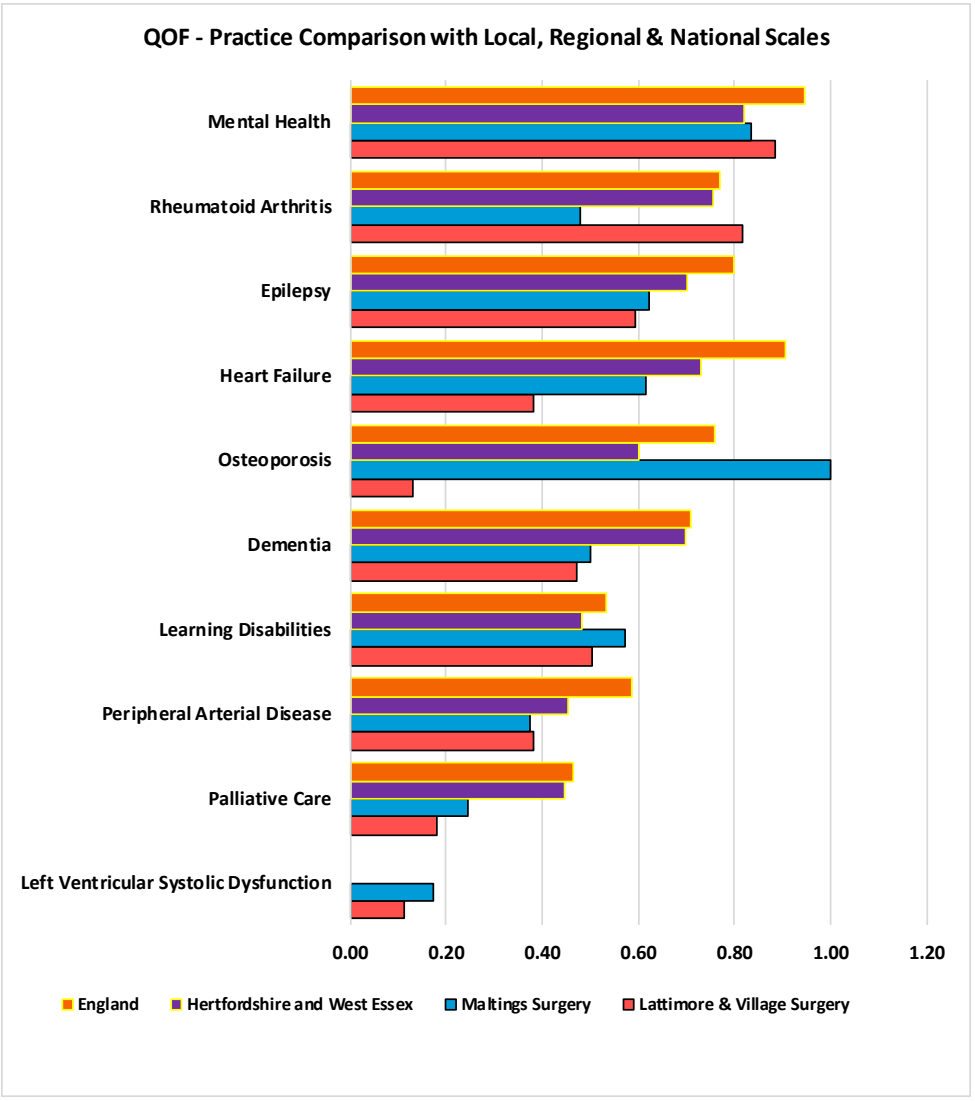
The Quality and Outcome Framework incorporates important benchmarking and scoring for all Practices across the county; we have combined a number of local, regional, and national data sets to highlight the areas that the PCN will need to consider.

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

Source: QOF National Figures, HWE PHM Team

QOF - Local, Regional, & National Comparison





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

Source: QOF National Figures, HWE PHM Team

QOF - Missed Diagnoses & Admission Rates

NHS Hertfordshire and West Essex Integrated Care Board

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	25441	1634	6.42%	5.89%	6.17%		-136	-65	
COPD	27146	349	1.29%	1.38%	1.49%	1.80%	26	54	140
Diabetes	21624	1249	5.78%	6.26%	6.39%	7.77%	104	132	432
Non-diabetic hyperglyaemia	21340	895	4.19%	6.73%	5.87%	11.28%	540	358	1513
Hypertension	27146	2801	10.32%	12.66%	13.21%		637	786	
Atrial Fibrillation	27146	420	1.55%	1.98%	2.02%	2.05%	118	129	136
Stroke and TIA	27146	354	1.30%	1.53%	1.61%		61	83	
Coronary Heart Disease	27146	540	1.99%	2.60%	2.65%		167	180	
Heart failure	27146	154	0.57%	0.69%	0.75%	1.08%	34	51	140
Left Ventricular Systolic Dysfunction	27146	44	0.16%	0.29%	0.30%		34	37	
Chronic Kidney Disease	21340	543	2.54%	3.75%	3.21%		256	141	
Peripheral Arterial Disease	27146	90	0.33%	0.42%	0.44%		23	30	
Cancer	27146	765	2.82%	3.38%	3.35%		154	143	
Palliative care	27146	65	0.24%	0.33%	0.43%		25	51	

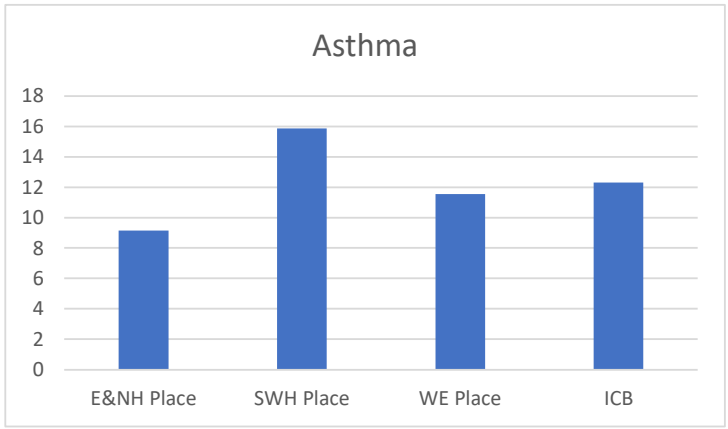
The table above shows the latest prevalence (2021/22 published August 20222) for the PCN alongside the place prevalence, ICB prevalence and the modelled prevalence for the PCN.

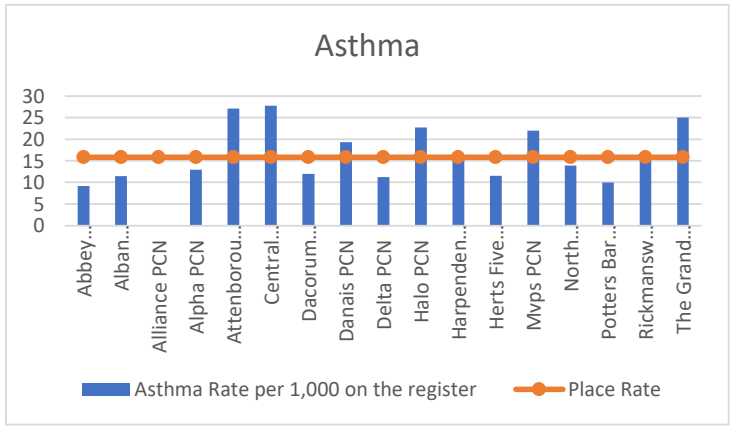
This table shows opportunities for further identification. It outlines the diagnoses to meet the place, ICB and estimated prevalence.

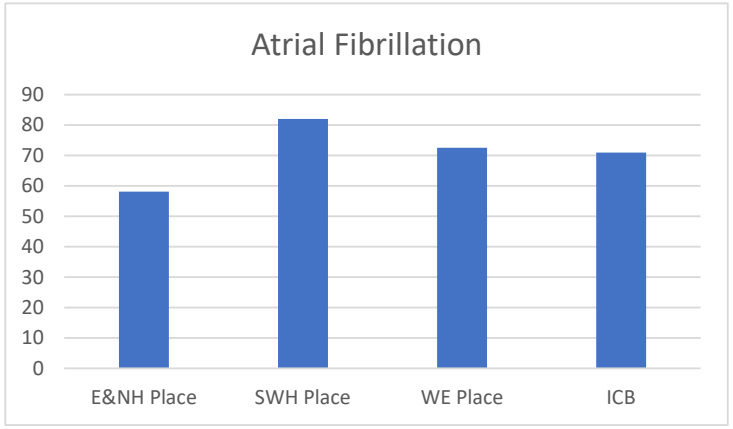
Within Ardens Manager there are case finding searches that can support PCN with identification.

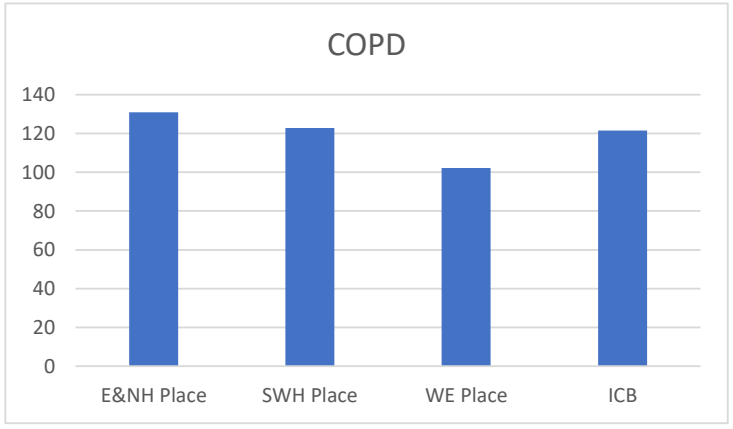
Source: QOF National Figures, HWE PHM Team

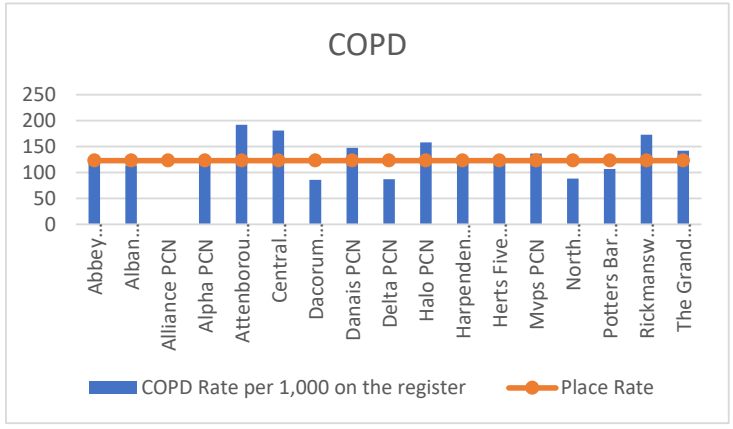
Emergency Admission Rates per 1,000 population on the Disease Register











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

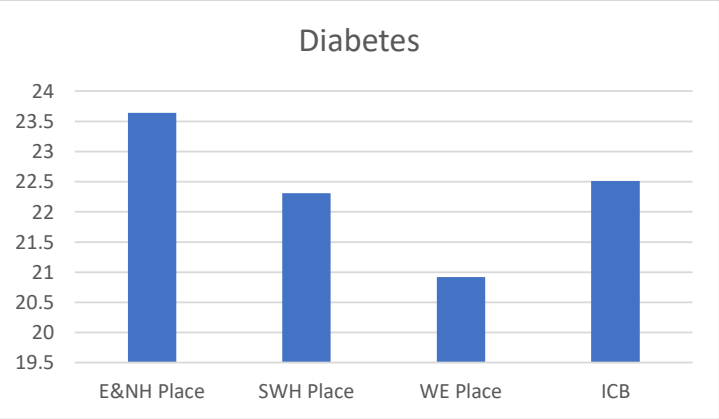
It shows the places compared with the ICB on the left and on the right it show the PCNs within a Place. These are continued on the following place.

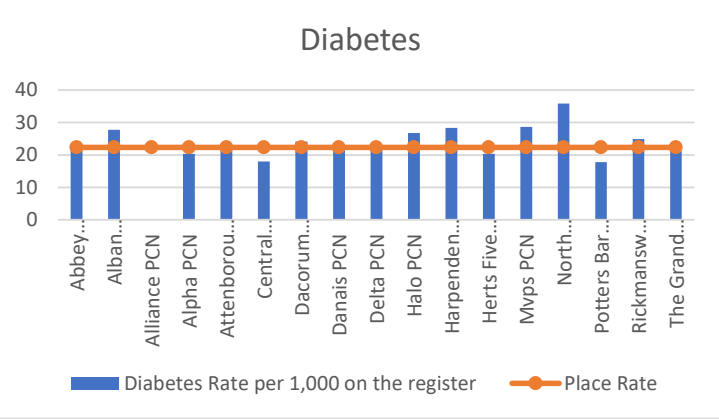
Rates may be high due to a number of factors which may include low identification.

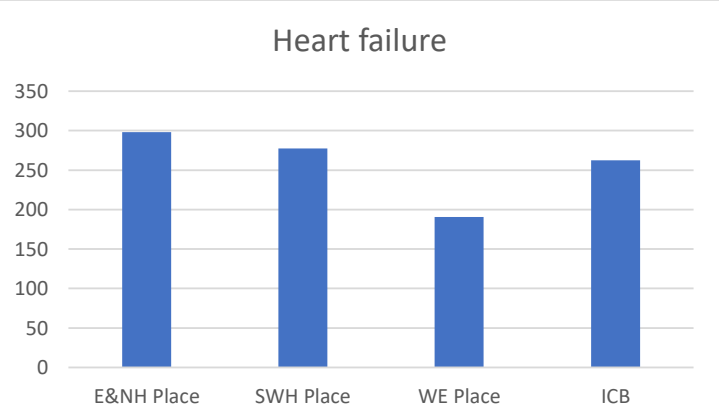
For Abbey Health the data shows higher rates for AF and Diabetes which was identified as a theme within the ACS analysis.

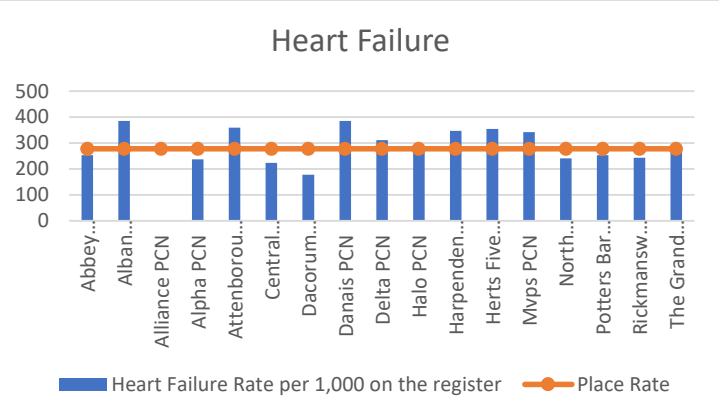
Source: HWE PHM Team, SUS data

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









Source: HWE PHM Team, SUS data

Appendices

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

Contents:

Matrix Data - Ethnicity

NHS Hertfordshire and West Essex Integrated Care Board

Ethnicity Group	Other Ethnic Groups		Asian		Black		Mixed		Other		White		Unknown		Grand Total
Practice	Maltings Surgery	Summerfield Health Centre	Maltings Surgery	Summerfield Health Centre	Maltings Surgery	Summerfield Health Centre	Maltings Surgery	Summerfield Health Centre	Maltings Surgery	Summerfield Health Centre	Maltings Surgery	Summerfield Health Centre	Maltings Surgery	Summerfield Health Centre	
Overall Population Measures															
Population	218	92	856	1,041	375	225	457	287	1,335	747	11,770	5,408	1,640	518	**24,969**
Age	35	30	33	34	41	34	22	22	30	32	38	39	35	40	**37**
Male %	46.3%	45.7%	47.9%	49.9%	53.1%	49.3%	52.5%	55.4%	53.3%	53.7%	49.2%	49.7%	62.0%	66.0%	**51.0%**
IMD	8.1	7.1	7.5	6.9	7.4	6.9	7.9	7.2	7.9	7.1	8.2	7.3	8.2	7.3	**7.8**
% BAME (where recorded)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	0%	0%	100%	100%	**25%**
Multimorbidity (acute & chronic)	0.4	0.5	0.8	1.0	1.4	1.0	0.7	0.7	0.8	1.0	1.0	1.2	0.3	0.3	**1.0**
Finance and Activity Measures															
Spend: Total	£0.0M	£0.0M	£0.5M	£0.6M	£0.3M	£0.1M	£0.2M	£0.1M	£0.6M	£0.6M	£7.6M	£4.0M	£0.1M	£0.0M	**£14.8M**
Spend: PPPY - Total	£129	£172	£530	£605	£851	£517	£359	£469	£440	£805	£644	£737	£73	£96	**£592**
Acute Elective	£45	£26	£141	£179	£242	£140	£89	£134	£143	£205	£217	£279	£6	£20	**£198**
Acute Non-Elective	£29	£27	£259	£249	£432	£227	£110	£194	£159	£445	£274	£288	£28	£32	**£248**
GP Encounters	£55	£98	£119	£129	£142	£107	£91	£84	£114	£115	£121	£129	£39	£40	**£114**
Community	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	**£0**
Mental Health	£0	£21	£11	£47	£35	£42	£69	£55	£23	£34	£31	£39	£0	£3	**£30**
Social Care	£0	£0	£0	£1	£1	£1	£0	£2	£1	£6	£1	£2	£0	£1	**£1**
GP PPPY	8	17	18	23	21	19	14	15	17	20	18	23	6	7	**18**
Beddays PPPY - Acute EM	0	0	0	1	1	0	0	0	0	1	1	1	0	0	**0**
Physical Health															
Diabetes	13.8%	10.9%	17.5%	20.7%	29.9%	12.9%	9.6%	6.3%	11.5%	10.4%	16.1%	11.9%	2.9%	2.7%	**13.8%**
COPD	1.4%	0.0%	0.6%	1.0%	1.3%	0.4%	0.9%	1.7%	0.7%	1.3%	1.9%	2.7%	0.1%	0.2%	**1.7%**
Chronic Respiratory Dis...	1.4%	0.0%	0.8%	1.4%	2.4%	1.3%	1.3%	2.1%	0.9%	1.5%	2.2%	3.4%	0.3%	0.2%	**2.1%**
Hypertension	4.6%	7.6%	9.0%	14.8%	26.7%	15.6%	5.9%	4.9%	6.7%	11.0%	12.2%	16.0%	4.1%	2.5%	**11.9%**
Obesity	0.5%	2.2%	3.6%	5.1%	12.8%	9.8%	1.5%	3.8%	3.9%	6.6%	10.0%	14.6%	2.1%	2.1%	**9.2%**
Mental Health															
Anxiety/Phobias	2.8%	5.4%	8.1%	3.7%	5.6%	7.6%	8.5%	5.6%	10.2%	7.6%	10.3%	8.5%	3.5%	2.1%	**8.6%**
Depression	3.7%	5.4%	9.1%	9.2%	12.5%	10.7%	8.1%	7.0%	13.0%	11.5%	12.8%	15.6%	4.6%	5.0%	**12.1%**
Learning Disability	0.5%	2.2%	0.7%	1.5%	2.4%	2.2%	1.8%	2.4%	1.2%	1.9%	1.7%	2.1%	0.1%	0.4%	**1.6%**
Dementia	0.5%	2.2%	0.5%	1.2%	1.6%	1.8%	2.0%	2.4%	1.6%	2.5%	1.7%	2.1%	0.1%	0.2%	**1.6%**
Other Characteristics															
Housebound (eFI)	0.0%	0.0%	0.1%	0.6%	0.3%	0.9%	0.0%	0.0%	0.0%	0.5%	0.3%	0.9%	0.1%	0.0%	**0.4%**
Social Vulnerability (eFI)	0.5%	3.3%	2.3%	4.0%	4.0%	4.9%	0.9%	3.8%	1.6%	4.4%	2.9%	3.8%	0.6%	0.4%	**2.9%**
History of Smoking (Tw...	4.1%	3.3%	5.3%	2.8%	7.2%	4.0%	5.3%	3.5%	4.1%	5.6%	5.9%	6.9%	1.6%	1.9%	**5.4%**
Not Fit for Work (In Year)	1.4%	2.2%	4.1%	6.3%	8.0%	8.4%	3.3%	3.8%	5.2%	7.1%	3.1%	6.2%	1.2%	1.9%	**4.1%**
On a Waiting List	1.8%	3.3%	7.5%	6.5%	6.7%	6.2%	5.5%	5.9%	5.3%	8.0%	6.1%	8.9%	1.5%	1.4%	**6.3%**

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

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

Matrix Data - Segment & Sub-Segment

NHS Hertfordshire and West Essex Integrated Care Board

Life Course Segment	1 - Healthy			2 - Living With Illness			3 - Lower Complexity			4 - Advanced Disease & Complexity					5 - EoL, Frailty & Dementia			Grand Total
Life Course Subsegment	1a - H (Low Risk)	1b - H (Maternity & Child)	1c - H (Acute Episodic)	2a - LwI (At Risk)	2b - LwI (LTCs)	2c - LwI (MH)	3a - LC (Mod. Social Co..	3b - LC (Multimorbidi	3c - LC (Mild Frailty)	4a - AD&C (High Complexity)	4b - AD&C - High Social Co..	4c - AD&C (Severe LD/ASD/..	4d - AD&C (Complex SMI)	4e - AD&C (End Stage Dis..	5a - EoLFD (Severe ..	5b - EoLFD (Severe ..	5c - EoLFD (End of Li..	
Overall Population Measures																		
Population	10,974	729	644	2,060	3,438	1,133	224	3,110	825	662	206	49	287	283	126	48	171	**24,969**
Age	28	8	17	39	43	38	41	50	63	64	59	28	32	64	79	75	70	**37**
Male %	55.6%	40.9%	50.5%	53.4%	52.4%	39.4%	42.4%	44.9%	41.1%	47.1%	37.4%	53.1%	49.8%	53.7%	34.1%	27.1%	40.4%	**51.0%**
IMD	7.9	7.8	7.8	7.7	7.9	7.7	7.5	7.8	7.6	7.6	7.4	7.6	7.4	7.6	7.3	7.4	7.4	**7.8**
% BAME (where recorded)	28%	27%	33%	22%	25%	22%	31%	21%	23%	19%	19%	14%	24%	14%	20%	10%	16%	**25%**
Multimorbidity (acute & chronic)	0.0	0.0	0.0	0.0	1.0	1.0	0.4	2.4	2.6	5.4	3.0	3.1	5.9	5.5	7.7	7.5	5.4	**1.0**
Finance and Activity Measures																		
Spend - Total	£0.9M	£0.5M	£1.0M	£0.9M	£1.5M	£0.4M	£0.1M	£2.2M	£1.3M	£1.5M	£0.3M	£0.1M	£0.9M	£1.0M	£0.7M	£0.2M	£1.6M	**£14.8M**
PPPY - Total	£78	£634	£1,492	£427	£422	£384	£394	£715	£1,615	£2,217	£1,357	£2,326	£2,995	£3,449	£5,214	£3,938	£9,071	**£592**
Acute Elective	£19	£119	£590	£149	£182	£126	£150	£300	£689	£857	£372	£593	£255	£1,094	£1,139	£81	£2,662	**£198**
Acute Non-Elective	£6	£390	£754	£149	£116	£127	£70	£234	£664	£1,044	£664	£242	£876	£1,923	£3,454	£2,863	£5,909	**£248**
GP Encounters	£51	£124	£147	£119	£120	£122	£139	£169	£249	£276	£237	£277	£259	£285	£441	£393	£422	**£114**
Community	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	**£0**
Mental Health	£2	£1	£1	£9	£3	£9	£33	£12	£13	£39	£4	£1,127	£1,586	£143	£162	£594	£61	**£30**
Social Care	£0	£0	£0	£0	£0	£0	£1	£0	£0	£2	£79	£88	£19	£3	£18	£7	£16	**£1**
GP PPPY	8	20	23	19	19	20	23	27	40	44	39	44	41	46	73	62	67	**18**
Beddays PPPY - Acute EM	0	0	1	0	0	0	0	0	1	2	1	0	6	4	7	10	14	**0**
Physical Health																		
Diabetes	0.0%	0.0%	0.0%	0.0%	27.0%	0.0%	6.3%	37.3%	47.0%	63.0%	42.2%	14.3%	35.2%	46.3%	79.4%	47.9%	52.0%	**13.8%**
COPD	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.5%	1.5%	13.1%	4.9%	0.0%	1.4%	56.5%	29.4%	14.6%	16.4%	**1.7%**
Chronic Respiratory Dis...	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	3.5%	2.7%	16.0%	4.9%	0.0%	1.4%	60.4%	32.5%	16.7%	22.8%	**2.1%**
Hypertension	0.0%	0.0%	0.0%	0.0%	13.9%	0.0%	5.4%	31.2%	53.6%	70.5%	48.1%	10.2%	29.6%	56.5%	90.5%	72.9%	63.7%	**11.9%**
Obesity	0.0%	0.0%	0.0%	24.7%	9.5%	9.4%	8.0%	18.9%	27.0%	29.3%	27.7%	20.4%	22.3%	29.0%	42.9%	22.9%	28.7%	**9.2%**
Mental Health																		
Anxiety/Phobias	0.0%	0.0%	0.0%	0.0%	0.0%	31.5%	2.2%	36.0%	13.1%	30.7%	13.1%	28.6%	57.8%	19.1%	32.5%	43.8%	20.5%	**8.6%**
Depression	0.0%	0.0%	0.0%	0.0%	0.0%	59.8%	10.3%	44.1%	22.5%	42.3%	23.8%	36.7%	74.9%	27.9%	41.3%	64.6%	26.3%	**12.1%**
Learning Disability	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	1.3%	1.6%	0.0%	7.6%	23.3%	75.5%	47.0%	9.2%	7.1%	35.4%	7.0%	**1.6%**
Dementia	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	16.8%	4.4%	8.2%	46.7%	9.5%	19.0%	100.0%	25.7%	**1.6%**
Other Characteristics																		
Housebound (eFI)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	18.9%	0.0%	0.7%	2.5%	22.2%	6.3%	8.8%	**0.4%**
Social Vulnerability (eFI)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	68.8%	2.9%	9.3%	10.9%	35.9%	26.5%	19.5%	14.5%	54.0%	41.7%	28.7%	**2.9%**
History of Smoking (Tw...	0.0%	0.0%	0.0%	17.8%	5.8%	6.2%	7.1%	11.0%	11.3%	15.3%	8.7%	14.3%	21.3%	14.8%	8.7%	18.8%	9.4%	**5.4%**
Not Fit for Work (In Year)	0.0%	0.0%	0.0%	14.7%	4.2%	8.6%	7.1%	8.6%	7.9%	7.7%	3.9%	8.2%	16.4%	6.0%	0.8%	4.2%	7.6%	**4.1%**
On a Waiting List	2.5%	5.9%	10.2%	6.2%	5.6%	6.6%	9.8%	8.9%	17.7%	20.5%	13.6%	16.3%	17.8%	23.0%	27.0%	6.3%	19.9%	**6.3%**

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.

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

Matrix Data - GP Activity

NHS Hertfordshire and West Essex Integrated Care Board

GP Activity	0			1			2-3			4-5			6-9			10+			Grand Total
Complexity	Low Complexity	Middle Complexity	High Complexity	Low Complexity	Middle Complexity	High Complexity	Low Complexity	Middle Complexity	High Complexity	Low Complexity	Middle Complexity	High Complexity	Low Complexity	Middle Complexity	High Complexity	Low Complexity	Middle Complexity	High Complexity	
Overall Population Measures																			
Population	1,549	193		843	116		1,768	262	13	1,872	449	8	3,354	1,319	39	5,237	6,812	1,127	24,969
Age	28	37	61	22	35	17	20	32	25	28	39	24	31	43	39	31	50	64	37
Male %	66.8%	63.7%	40.0%	56.9%	65.5%	66.7%	60.9%	66.8%	53.8%	61.2%	58.8%	75.0%	58.1%	55.7%	51.3%	42.5%	42.6%	45.1%	51.0%
IMD	7.7	7.8	6.0	7.7	7.4	6.7	7.9	7.5	6.9	8.0	7.9	8.4	8.0	7.8	7.6	7.9	7.8	7.5	7.8
% BAME (where recorded)	30%	21%	40%	32%	38%	0%	29%	31%	23%	31%	22%	38%	26%	22%	21%	25%	22%	18%	25%
Multimorbidity (acute & chronic)	0.0	1.2	6.4	0.0	1.3	5.7	0.0	1.3	7.7	0.0	1.4	7.9	0.0	1.4	7.3	0.0	1.9	6.8	1.0
Finance and Activity Measures																			
Spend: Total	£0.0M	£0.0M	£0.0M	£0.0M	£0.0M	£0.0M	£0.1M	£0.0M	£0.0M	£0.1M	£0.0M	£0.0M	£0.4M	£0.2M	£0.0M	£2.6M	£7.0M	£4.3M	£14.8M
PPPY - Total	£0	£52	£440	£12	£10	£27	£29	£30	£318	£65	£62	£293	£131	£139	£673	£503	£1,023	£3,807	£592
Acute Elective	£0	£51	£0	£4	£0	£22	£8	£4	£65	£14	£9	£107	£37	£43	£55	£161	£403	£989	£198
Acute Non-Elective	£0	£0	£0	£1	£3	£0	£5	£6	£7	£19	£15	£46	£45	£34	£324	£188	£371	£2,147	£248
GP Encounters	£0	£0	£0	£6	£6	£5	£15	£16	£15	£28	£28	£29	£48	£50	£51	£148	£200	£337	£114
Community	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Mental Health	£0	£0	£440	£0	£0	£0	£0	£5	£231	£6	£10	£113	£1	£11	£244	£6	£46	£324	£30
Social Care	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£1	£0	£0	£3	£11	£1
GP PPPY	0	0	0	1	1	1	3	3	3	4	5	5	8	8	8	24	32	54	18
Beddays PPPY - Acute EM	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	5	0
Physical Health																			
Diabetes	0.0%	10.4%	40.0%	0.0%	12.1%	33.3%	0.0%	12.2%	53.8%	0.0%	20.5%	50.0%	0.0%	23.4%	48.7%	0.0%	32.8%	63.3%	13.8%
COPD	0.0%	0.0%	20.0%	0.0%	0.9%	0.0%	0.0%	0.8%	23.1%	0.0%	0.7%	0.0%	0.0%	0.8%	5.1%	0.0%	1.7%	25.0%	1.7%
Chronic Respiratory Dis...	0.0%	0.5%	20.0%	0.0%	1.7%	0.0%	0.0%	1.9%	23.1%	0.0%	0.9%	0.0%	0.0%	1.4%	7.7%	0.0%	2.5%	28.3%	2.1%
Hypertension	0.0%	4.1%	100.0%	0.0%	15.5%	0.0%	0.0%	6.5%	38.5%	0.0%	10.2%	50.0%	0.0%	14.3%	66.7%	0.0%	27.2%	71.6%	11.9%
Obesity	0.4%	2.6%	0.0%	0.4%	5.2%	0.0%	0.9%	3.4%	15.4%	1.6%	4.5%	25.0%	4.0%	7.4%	2.6%	6.5%	18.2%	33.6%	9.2%
Mental Health																			
Anxiety/Phobias	0.0%	20.2%	40.0%	0.0%	8.6%	66.7%	0.0%	16.0%	61.5%	0.0%	17.8%	62.5%	0.0%	17.0%	48.7%	0.0%	18.8%	39.1%	8.6%
Depression	0.0%	30.6%	40.0%	0.0%	27.6%	100.0%	0.0%	25.2%	92.3%	0.0%	22.9%	87.5%	0.0%	24.2%	66.7%	0.0%	26.9%	50.0%	12.1%
Learning Disability	0.0%	0.0%	20.0%	0.0%	2.6%	33.3%	0.0%	1.9%	53.8%	0.0%	1.3%	100.0%	0.0%	1.6%	43.6%	0.0%	1.7%	18.4%	1.6%
Dementia	0.0%	0.0%	40.0%	0.0%	0.0%	66.7%	0.0%	0.8%	84.6%	0.0%	0.4%	62.5%	0.0%	0.7%	56.4%	0.0%	0.9%	25.4%	1.6%
Other Characteristics																			
Housebound (eFI)	0.0%	0.0%	20.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.7%	0.0%	0.0%	0.0%	0.0%	0.1%	2.6%	0.0%	0.5%	4.7%	0.4%
Social Vulnerability (eFI)	0.4%	1.6%	0.0%	0.7%	2.6%	33.3%	0.4%	1.5%	0.0%	0.5%	1.3%	12.5%	0.6%	2.1%	12.8%	1.2%	4.5%	21.7%	2.9%
History of Smoking (Tw...	0.1%	1.6%	0.0%	0.4%	2.6%	0.0%	1.0%	3.8%	7.7%	1.8%	2.4%	0.0%	3.1%	5.4%	5.1%	4.1%	10.3%	15.4%	5.4%
Not Fit for Work (In Year)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.1%	0.2%	0.0%	1.0%	1.8%	0.0%	5.3%	8.9%	7.9%	4.1%
On a Waiting List	0.0%	0.0%	0.0%	0.4%	0.9%	0.0%	1.1%	0.4%	0.0%	1.1%	0.2%	0.0%	1.8%	1.9%	10.3%	8.1%	11.3%	22.7%	6.3%

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.

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

Matrix Data - Health Segment & Deprivation

NHS Hertfordshire and West Essex Integrated Care Board

Life Course Segment	1 - Healthy				2 - Living With Illness				3 - Lower Complexity				4 - Advanced Disease & Complexity				5 - EoL, Frailty & Dementia				Grand Total
Deprivation	Low Deprivation	Middle Deprivation	High Deprivation	Not known	Low Deprivation	Middle Deprivation	High Deprivation	Not known	Low Deprivation	Middle Deprivation	High Deprivation	Not known	Low Deprivation	Middle Deprivation	High Deprivation	Not known	Low Deprivation	Middle Deprivation	High Deprivation	Not known	
Overall Population Measures																					
Population	7,890	4,231	215	11	4,108	2,366	152		2,487	1,590	80		820	629	37		154	186			24,969
Age	27	25	24	35	42	39	35	50	53	51	44	25	56	56	42	65	71	77	51	30	37
Male %	53.5%	56.0%	56.7%	63.6%	50.9%	49.7%	52.6%	0.0%	43.9%	44.8%	31.3%	0.0%	48.2%	46.6%	59.5%	0.0%	40.3%	33.3%	25.0%	0.0%	51.0%
IMD	9.2	5.7	2.9		9.2	5.8	3.0		9.2	5.7	3.0		9.2	5.7	3.0		9.1	6.1	3.0		7.8
% BAME (where recorded)	25%	34%	34%	33%	21%	28%	34%	0%	19%	26%	31%	0%	18%	20%	30%	100%	19%	15%	25%	100%	25%
Multimorbidity (acute & chronic)	0.0	0.0	0.0	0.0	0.7	0.7	0.8	0.6	2.4	2.3	2.4	2.5	5.1	5.0	5.7	11.0	6.2	6.9	2.5	8.0	1.0
Finance and Activity Measures																					
Spend: Total	£1.4M	£0.9M	£0.0M	£0.0M	£1.7M	£1.0M	£0.1M	£0.0M	£2.2M	£1.4M	£0.1M	£0.0M	£2.1M	£1.5M	£0.1M	£0.0M	£1.0M	£1.3M	£0.1M	£0.0M	£14.8M
PPPY - Total	£172	£205	£228	£60	£417	£411	£521	£140	£894	£850	£878	£237	£2,597	£2,316	£2,987	£20	£6,636	£6,744	£30,165	£8	£592
Acute Elective	£50	£63	£61	£13	£162	£160	£203	£0	£374	£362	£342	£0	£884	£506	£337	£0	£1,991	£1,161	£20,038	£0	£198
Acute Non-Elective	£59	£81	£105	£8	£129	£124	£189	£0	£326	£287	£323	£0	£1,057	£1,103	£2,021	£0	£4,124	£4,886	£9,814	£0	£248
GP Encounters	£61	£59	£62	£39	£121	£120	£117	£140	£180	£186	£202	£237	£267	£271	£280	£20	£387	£461	£313	£8	£114
Community	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Mental Health	£1	£4	£0	£0	£5	£7	£12	£0	£13	£15	£11	£0	£374	£410	£349	£0	£109	£229	£0	£0	£30
Social Care	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£15	£26	£1	£0	£25	£8	£0	£0	£1
GP PPPY	10	10	10	7	19	20	18	24	29	30	31	37	42	44	44	3	62	75	49	2	18
Beddays PPPY - Acute EM	0	0	0	0	0	0	0	0	0	0	0	0	2	4	2	0	8	13	19	0	0
Physical Health																					
Diabetes	0.0%	0.0%	0.0%	0.0%	15.3%	11.6%	15.8%	40.0%	38.4%	36.4%	36.3%	0.0%	49.8%	49.8%	56.8%	100.0%	60.4%	62.4%	50.0%	100.0%	13.8%
COPD	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	2.7%	2.5%	0.0%	17.3%	17.8%	16.2%	100.0%	23.4%	18.8%	0.0%	100.0%	1.7%
Chronic Respiratory Dis...	0.0%	0.0%	0.0%	0.0%	0.2%	0.1%	0.0%	0.0%	2.9%	3.5%	5.0%	0.0%	20.0%	19.1%	16.2%	100.0%	29.2%	22.0%	25.0%	100.0%	2.1%
Hypertension	0.0%	0.0%	0.0%	0.0%	7.7%	6.6%	4.6%	0.0%	34.3%	34.5%	26.3%	0.0%	56.0%	53.7%	48.6%	100.0%	72.1%	78.0%	25.0%	100.0%	11.9%
Obesity	0.0%	0.0%	0.0%	0.0%	13.7%	15.0%	15.8%	0.0%	18.2%	22.5%	21.3%	0.0%	25.9%	29.1%	29.7%	100.0%	37.0%	29.6%	50.0%	0.0%	9.2%
Mental Health																					
Anxiety/Phobias	0.0%	0.0%	0.0%	0.0%	5.8%	4.8%	3.3%	0.0%	29.4%	29.9%	27.5%	100.0%	30.4%	31.6%	43.2%	0.0%	26.0%	30.6%	0.0%	0.0%	8.6%
Depression	0.0%	0.0%	0.0%	0.0%	9.8%	10.8%	13.8%	0.0%	36.6%	40.1%	37.5%	100.0%	42.4%	43.2%	54.1%	100.0%	33.8%	40.3%	0.0%	100.0%	12.1%
Learning Disability	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.0%	0.0%	1.0%	1.6%	3.8%	0.0%	19.0%	20.3%	32.4%	0.0%	11.7%	10.8%	0.0%	0.0%	1.6%
Dementia	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	18.3%	19.7%	27.0%	100.0%	18.2%	47.3%	0.0%	0.0%	1.6%
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%	2.6%	4.1%	0.0%	100.0%	11.0%	15.6%	0.0%	0.0%	0.4%
Social Vulnerability (eFI)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.1%	8.7%	8.8%	0.0%	13.8%	21.3%	24.3%	0.0%	35.1%	44.6%	0.0%	0.0%	2.9%
History of Smoking (Tw...	0.0%	0.0%	0.0%	0.0%	8.7%	11.5%	5.3%	0.0%	9.4%	12.9%	15.0%	0.0%	14.6%	16.4%	16.2%	0.0%	9.7%	11.3%	0.0%	0.0%	5.4%
Not Fit for Work (In Year)	0.0%	0.0%	0.0%	0.0%	6.7%	10.8%	7.2%	0.0%	7.1%	10.4%	7.5%	50.0%	8.5%	8.3%	13.5%	0.0%	5.8%	3.8%	0.0%	0.0%	4.1%
On a Waiting List	3.0%	3.2%	5.6%	0.0%	5.5%	6.6%	9.9%	0.0%	10.9%	10.4%	11.3%	0.0%	19.9%	18.4%	24.3%	0.0%	19.5%	21.5%	25.0%	0.0%	6.3%

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.

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

Matrix Data - Practice & Deprivation

NHS Hertfordshire and West Essex Integrated Care Board

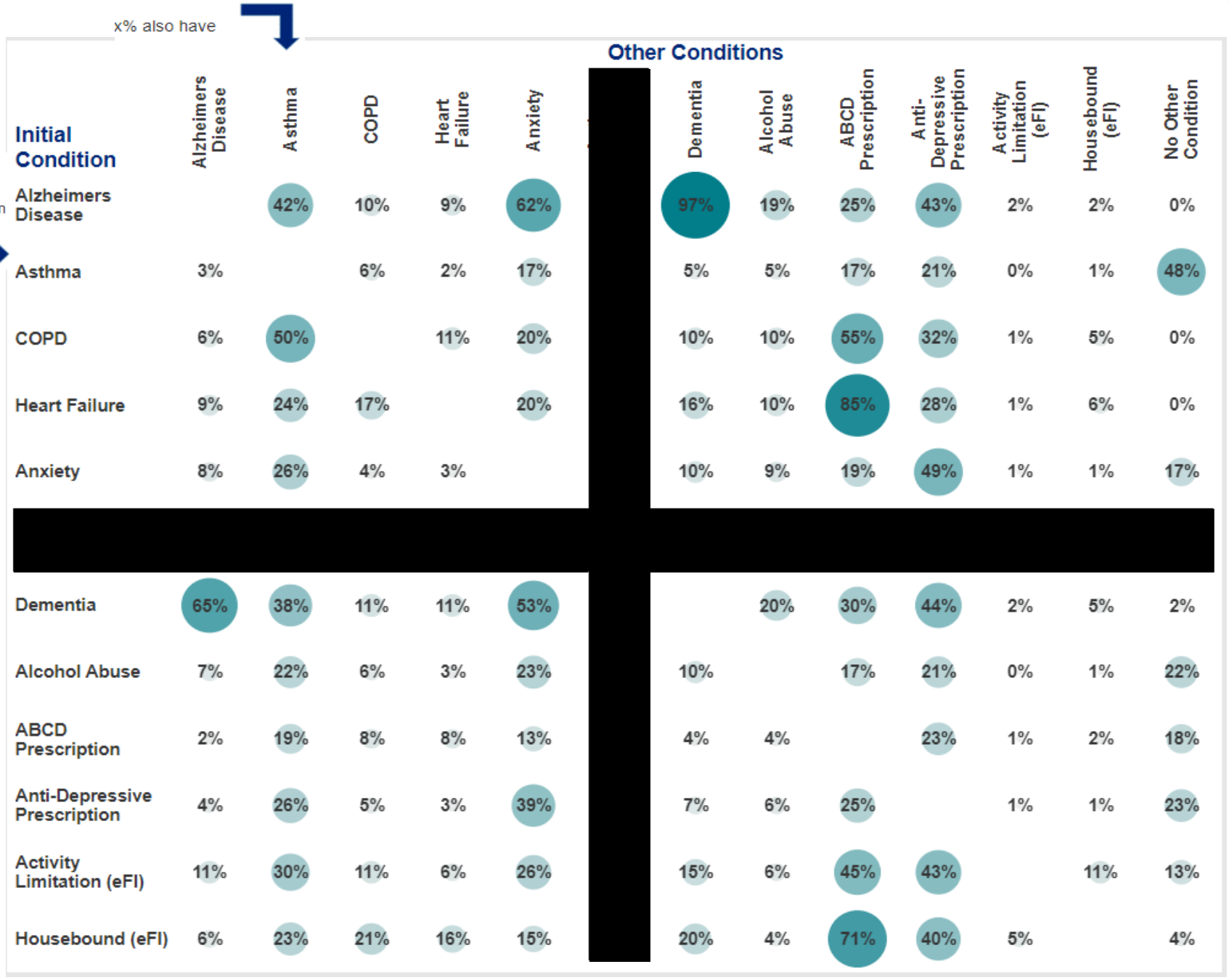
Practice	Maltings Surgery				Summerfield Health Centre				Grand Total
Deprivation	Low Deprivation	Middle Deprivation	High Deprivation	Not known	Low Deprivation	Middle Deprivation	High Deprivation	Not known	
Overall Population Measures									
Population	11,445	4,838	355	13	4,014	4,164	133	7	**24,969**
Age	37	37	34	46	38	37	28	24	**37**
Male %	50.5%	51.8%	51.0%	38.5%	51.9%	50.6%	51.9%	28.6%	**51.0%**
IMD	9.3	5.6	3.0		8.8	5.9	3.0		**7.8**
% BAME (where recorded)	20%	27%	30%	22%	29%	32%	40%	33%	**25%**
Multimorbidity (acute & chronic)	0.9	1.1	1.1	2.1	1.0	1.1	0.9	0.0	**1.0**
Finance and Activity Measures									
Spend: Total	£5.9M	£3.0M	£0.3M	£0.0M	£2.5M	£2.9M	£0.1M	£0.0M	**£14.8M**
PPPY - Total	£516	£625	£898	£82	£634	£692	£834	£114	**£592**
Acute Elective	£184	£160	£371	£0	£230	£235	£241	£21	**£198**
Acute Non-Elective	£203	£304	£369	£0	£247	£294	£453	£12	**£248**
GP Encounters	£108	£119	£128	£82	£118	£122	£101	£81	**£114**
Community	£0	£0	£0	£0	£0	£0	£0	£0	**£0**
Mental Health	£21	£41	£30	£0	£38	£38	£38	£0	**£30**
Social Care	£1	£1	£0	£0	£1	£3	£0	£0	**£1**
GP PPPY	16	18	19	14	21	21	18	14	**18**
Beddays PPPY - Acute EM	0	1	1	0	0	1	1	0	**0**
Physical Health									
Diabetes	14.2%	15.4%	17.5%	30.8%	11.4%	12.9%	10.5%	0.0%	**13.8%**
COPD	1.3%	1.8%	1.7%	15.4%	1.7%	2.4%	1.5%	0.0%	**1.7%**
Chronic Respiratory Dis...	1.7%	2.1%	2.3%	15.4%	2.5%	2.8%	2.3%	0.0%	**2.1%**
Hypertension	10.1%	12.7%	11.0%	15.4%	14.6%	13.8%	6.0%	0.0%	**11.9%**
Obesity	7.5%	9.4%	11.8%	7.7%	10.7%	12.0%	9.0%	0.0%	**9.2%**
Mental Health									
Anxiety/Phobias	8.7%	10.7%	10.4%	15.4%	6.7%	7.9%	4.5%	0.0%	**8.6%**
Depression	10.4%	13.9%	15.2%	30.8%	12.8%	13.6%	12.8%	0.0%	**12.1%**
Learning Disability	1.2%	1.9%	3.1%	0.0%	1.7%	2.1%	3.0%	0.0%	**1.6%**
Dementia	1.0%	2.6%	2.0%	7.7%	1.6%	2.1%	2.3%	0.0%	**1.6%**
Other Characteristics									
Housebound (eFI)	0.1%	0.4%	0.0%	7.7%	0.5%	0.9%	0.0%	0.0%	**0.4%**
Social Vulnerability (eFI)	1.9%	3.6%	3.7%	0.0%	3.1%	4.3%	2.3%	0.0%	**2.9%**
History of Smoking (Tw...	4.6%	6.9%	5.6%	0.0%	5.1%	6.4%	4.5%	0.0%	**5.4%**
Not Fit for Work (In Year)	2.8%	4.3%	3.1%	7.7%	5.4%	6.5%	8.3%	0.0%	**4.1%**
On a Waiting List	5.4%	5.9%	7.6%	0.0%	7.5%	7.9%	14.3%	0.0%	**6.3%**

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

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

Bubble Matrix - Conditions

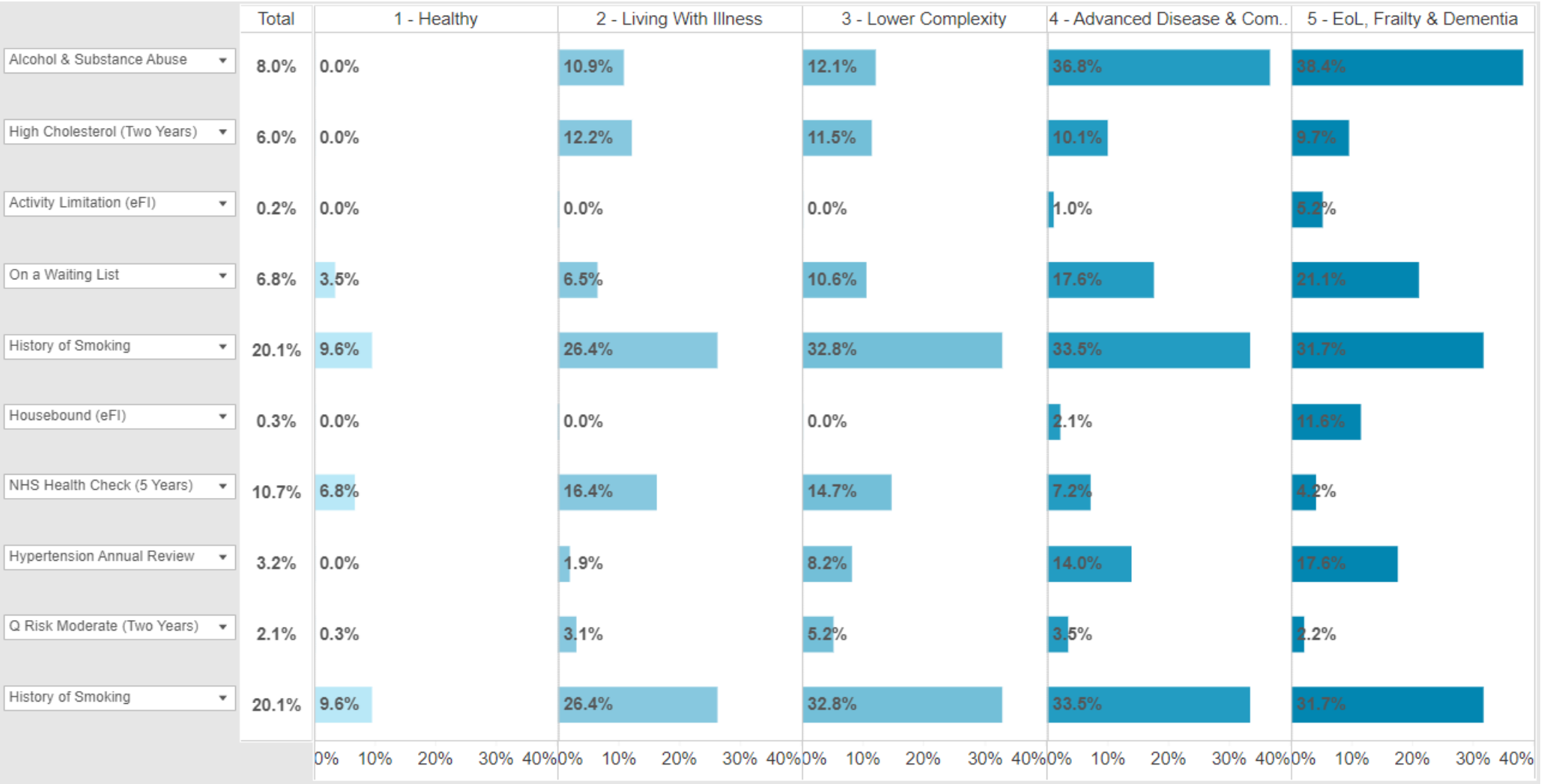
NHS Hertfordshire and West Essex Integrated Care Board



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.

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

Bio-Psycho-Social Indicators - Example



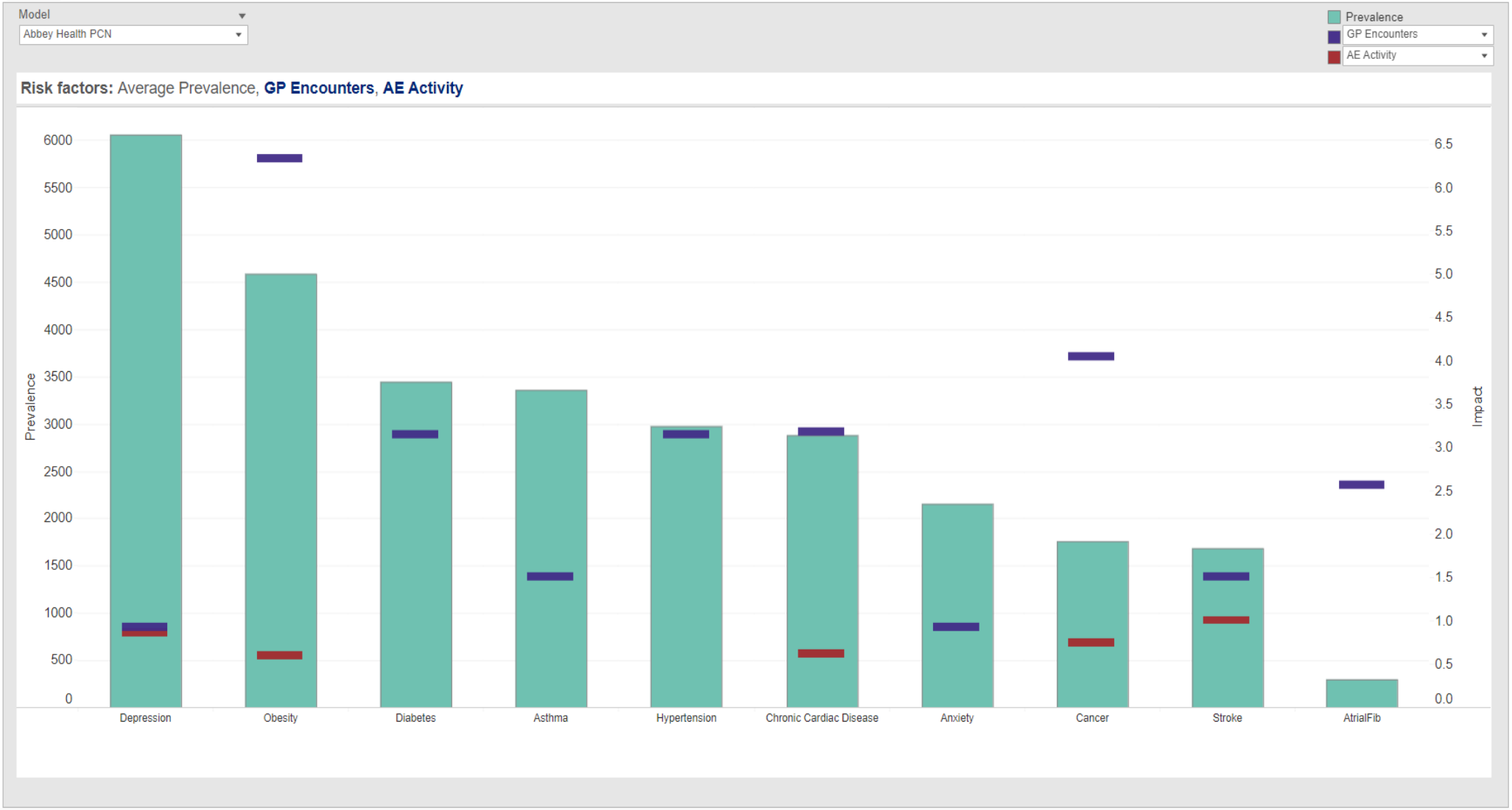
This chart gives a comparison across various selected risk conditions or characteristics, within the health segments of the PCN's population.

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.

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

Risk Modelling - Prevalence against GP Activity & A&E

NHS Hertfordshire and West Essex Integrated Care Board



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

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

NHS Hertfordshire and West Essex Integrated Care Board

Cancer Screening

	Period	HERTFORDSHIRE AND WEST ESSEX	ABBEY HEALTH PCN	MALTINGS SURGERY	SUMMERFIELD HEALTH CENTRE
Women, aged 25-49, with a record of cervical screening in the last 3.5 yrs (denominator includes PCAs)	2020/21	73.3	68	68.3	67.3
Women, aged 50-64, with a record of cervical screening in the last 5.5 yrs (denominator includes PCAs)	2020/21	78.2	74.6	74.4	75.2
Persons, 25-49, attending cervical screening within target period (3.5 year coverage, %)	2020/21	73	68.1	68.3	67.5
Persons, 50-64, attending cervical screening within target period (5.5 year coverage, %)	2020/21	77	74.1	74.7	72.8
Persons, 50-70, screened for breast cancer in last 36 months (3 year coverage, %)	2020/21	63.9	62.6	61	65.7
Persons, 50-70, screened for breast cancer within 6 months of invitation (Uptake, %)	2020/21	61.3	60.7	61	46.9
Persons, 60-74, screened for bowel cancer within 6 months of invitation (Uptake, %)	2020/21	72.1	69	71.7	64.8
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %)	2020/21	68.8	66.7	67.9	64.7

Similar | Significantly Worse | Significantly Better

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Hertfordshire Public Health Evidence & Intelligence Epidemiology

Hertfordshire

Source: Public Health Team

Hertfordshire and West Essex Integrated Care Board

Mortality

	Period	Hertfordshire CCGs	NHS HERTFORDSHIRE AND WEST ESSEX ICB - 06N	ABBEY HEALTH PCN
Percentage of deaths that occur at home (All age)	2021	25.3	23.9	28.3
PYLL - Neoplasms	2021	505	498.3	369.6
PYLL - Diseases of the circulatory system	2021	737.5	690.5	1621.8
PYLL - All Cause	2021	1537.7	1496.4	2518.8
Premature Mortality - Respiratory Disease	2021	19.2	19	
Premature Mortality - Liver Disease	2021	14.6	14.4	
Premature Mortality - Cardiovasular Disease	2021	53.8	51.4	103.3
Premature Mortality - Cancer	2021	98.5	97.1	81.6
Premature Mortality - All Cause	2021	269.6	262.3	301.1

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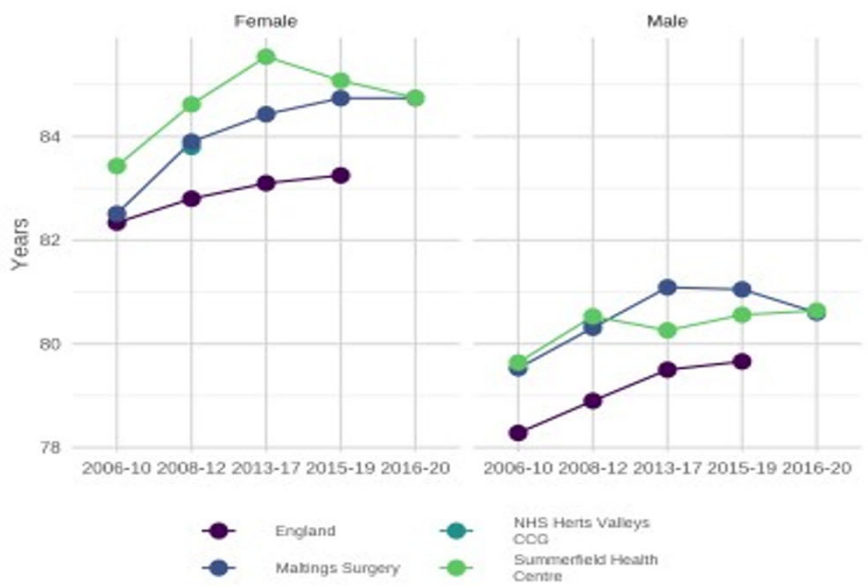
Hertfordshire Public Health Evidence & Intelligence Epidemiology

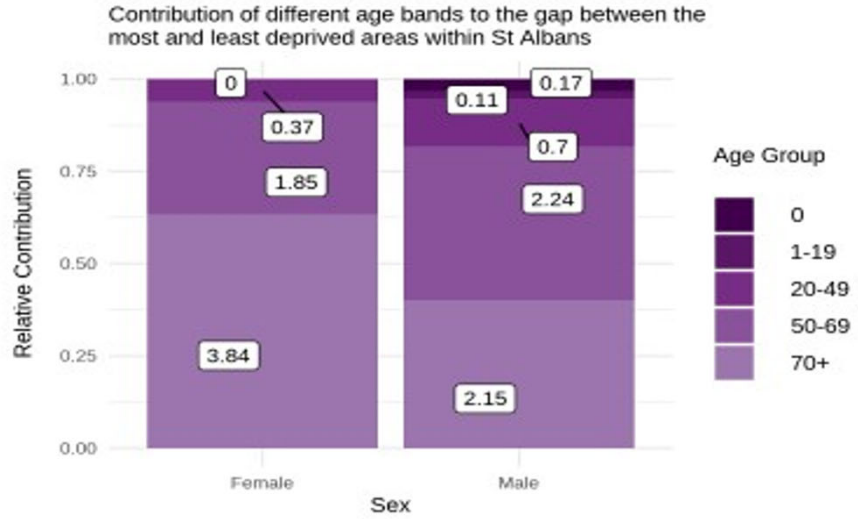
Hertfordshire

Source: Public Health Team

NHS Hertfordshire and West Essex Integrated Care Board

Life Expectancy





Labels inside bar indicate contribution to the life expectancy gap in years for each age group. This can be used to target interventions at age groups with the biggest inequality in life expectancy. The gap in life expectancy at birth for females is 5.95 years and for males is 5.37 years.

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Hertfordshire Public Health Evidence & Intelligence Epidemiology

Hertfordshire

Source: Public Health Team

Hertfordshire and
West Essex Integrated
Care System

NHS
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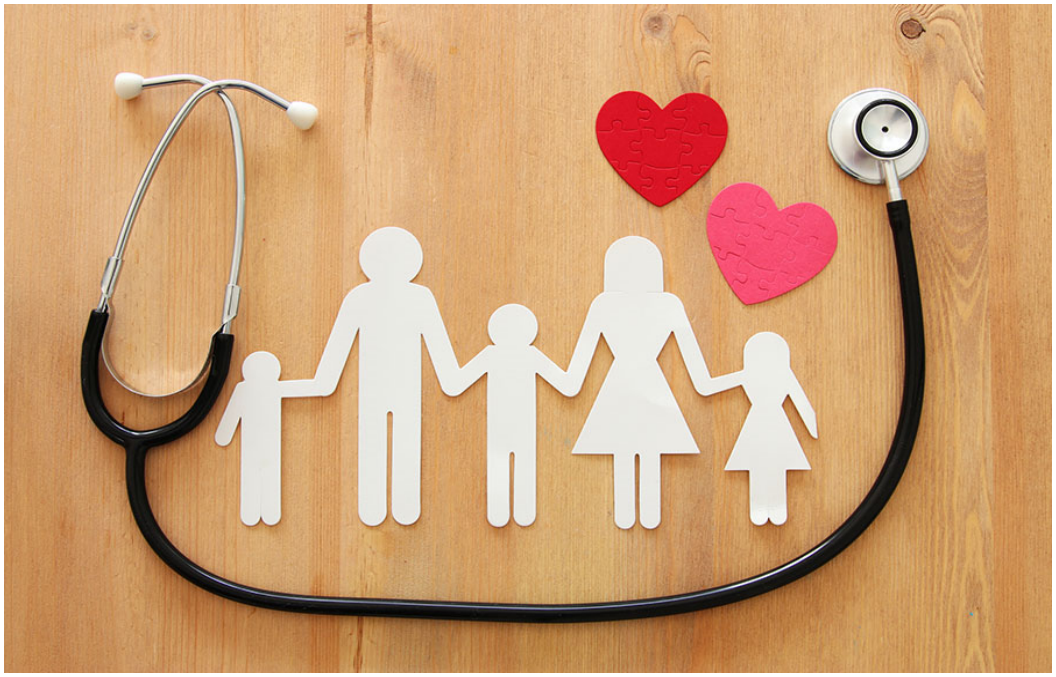
Integrated Care Board



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for a healthier future