Agenda Item no. 10(b)

HWB Strategy 2023-2028 - Highlight Reports – Goal Achievements

Purpose

Bi-annual "Highlight Reports" will provide an overview of activity and progress of local shared projects supporting the delivery of the three goals of the Health and Wellbeing Strategy. These reports will describe what has been achieved against the outcomes, how collaborative working has aided this progress and identify new data and insights that have been released in the previous 6 months.

Highlight Reports will be used to increase awareness through organisations of delivery of the strategy and are intended for wider use with partners and the public, and to support a wider understanding of the priorities within the Health and Wellbeing Strategy.

Highlight Reports will provide an overview of each goal, describe what has been achieved in the previous reporting period and how collaborative working has aided this progress. Detailed implementation plans will continue to sit behind the Highlight Reports with risks escalated to the HWB Board as necessary.

Highlight Report

Goal 2. Fewer people die from circulatory disease

Goal 2 - Fewer people die from circulatory disease		
Reporting timeframe - 1st October 2023 – 31st March 2024		
RAG Rating – please complete status for goal achievement (tick relevant box)		
Red – no progress	Amber – Moderate progress	Green - Significant progress

Overall goal achievement/progress against outcome		Overall goal achievement against reducing health inequalities	
Red		Red	
Amber	AMBER	Amber	AMBER
Green		Green	

Outcomes by 2028

- Reduce circulatory disease deaths in Dudley so that the rate is similar or lower than the national average.
- The gap in circulatory disease deaths between the most deprived and least deprived areas of Dudley in people aged under 75 years will have narrowed

Who is leading this?	Goal sponsors: Dr. Duncan Jenkins (NHS prevention) Dr. David Pitches (DMBC prevention)
Goal 2 is focused on: • Reducing mortality, especially premature mortality, and morbidity (burden of illness) from diseases of the circulatory system • Reducing inequalities in cardiovascular disease • Identifying opportunities for collaborative and systemwide working • Providing assurance to the Director of Public Health to meet their statutory responsibility to facilitate improvement of the health of the local population	
What has been achieved for this reporting period under Goal 2: (please include specific achievements with respect to health inequalities)	Over the past six months work has progressed across the system, led by DMBC (for upstream interventions and wider determinants) and NHS primary and secondary care partners (downstream and secondary prevention). Key achievements include: **Communications** A continuous program of supportive communications has been underway, with particular emphasis on increasing physical activity, healthy eating and awareness of circulatory disease. A more detailed account of specific campaigns and messaging that complements and reinforces NHS and national awareness raising initiatives can be found in Appendix 1. Further work is planned during 2024 to promote awareness of risk factors and prompt recognition of strokes and to promote measures that can reduce the risk of occurrence. **Integrated health improvement** Our new service began in November 2023 and supports people and their families to adopt healthier lifestyles. As part of the mobilisation of the new service we have been working with the provider to increase capacity, maximise coverage and ensure community venues offer the best coverage for services. We are supporting ABL to improve pathways that will enable smokers to access smoking cessation services after being discharged from hospital. We are monitoring the delivery and impact of this program to ensure that interventions are accessible to those who have the greatest need and potential to benefit. **Placemaking approaches to maximise health potential of planning, housing, transport and regeneration** Audits of the health-promoting potential in the retail offer of high streets in four of the borough's town centres have been undertaken using a methodology developed by the Royal Society of Public Health. This has shown variation between the four centres, with lower scores (signifying for example more gambling and fast food establishments) in areas of existing deprivation This will help to inform future planning and

	regeneration priority areas that could empower residents to make healthier choices. It also complements earlier insight work undertaken during 2023 following Beat the Streets that communities have highlighted as opportunities and barriers to using physically active and more sustainable forms of transport. An empty retail unit in the Churchill shopping centre saw the trial of a “Health on the Shelf” healthy hearts hub event in November 2023: https://blackcountry.icb.nhs.uk/news-and-events/events/event-details?occurrenceID=1105 The Commonwealth Active Communities (CAC) programme supports physical activity in areas of higher circulatory disease mortality. Priority areas for this West Midlands Combined Authority funding included central Dudley, Brierley Hill and the Brockmoor and Pensnett areas. **NHS Health Checks** During 2023-4 we have continued to advocate for NHS Health Checks to be prioritised amongst people with known elevated pre-existing risk factors for circulatory disease (e.g. overweight, smoker, previous QRISK score greater than 5%) and/or people who have never previously attended an NHS Health Check. Existing local data showed an inequality of access to NHS Health Checks in areas of greater deprivation, meaning that people in more disadvantaged areas were both at greater risk of dying from circulatory disease and less likely to take up an NHS Health Check that might detect and offer interventions for cardiovascular risk factors. This could potentially widen the inequalities gap as it facilitated people at existing lower risk to reduce their personal risk further. Incentivising primary care providers through an enhanced payment for each person invited who lives in the lowest quintile of deprivation has led to a levelling off of the inequality gradient in the first full year of adopting this approach, and we have achieved the second highest number of completed NHS Health Checks in the past decade (14,797, or almost 90% of the eligible total for the year). This led to 2,987 patients being identified as having high blood pressure, 707 had high cholesterol diagnosed and 350 were identified as having a greater than 20% risk of having a stroke or myocardial infarction (heart attack) in the next decade without medical or lifestyle changes. **Healthy heart hubs** This initiative is led by health and wellbeing coaches with support from pharmacists, healthcare assistants and the GP clinical lead for health inequalities. Over a dozen events have

	been held in the past 12 months which have engaged over 500 individuals. The hub has a good geographical spread but with a focus on Dudley and Netherton Primary Care Network (PCN) and Sedgley Coseley and Gornal PCN. The healthy heart hub has attended workplaces, schools, further educational establishments, community groups, shopping centres and the African Caribbean centre. The project was due to finish March 2024 however the budget has been used widely and funds should allow the initiative to continue for at least a further 6-12 months with a view to appraise and apply for further funding. **Improving diagnosis and treatment of high blood pressure, high cholesterol and high blood glucose** Community pharmacies are now measuring blood pressure in people aged over 40 and can undertake ambulatory 24-hour blood pressure monitoring for more accurate diagnosis. This is being monitored to ensure any gaps in provision in more deprived areas are addressed. This boosts the detection capacity provided by the Healthy Hearts Hub work as well as a 'making every contact count' approach alongside the ICB mobile vaccination service. The detected prevalence of hypertension in over 18s has increased from 22.0% to 22.3% between Q1 and Q4 of the 2023-2024 financial year. The range across the PCNs at Q4 is 18.9% to 24.8%. With respect to blood pressure treatment to age-specific targets, there has been an increase from 71.5% to 78.6% across Dudley practices, against an aspiration of 80%. The range across PCNs is 75.1% to 78.2%. The percentage of patients with circulatory disease receiving lipid lowering medicines has increased from 69.8% to 84.9% between quarters 1 and 4 against a target of 90%. The range across the six PCNs in quarter 4 is 82.0% to 86.7%. With respect to the percentage of patients with circulatory disease receiving lipid lowering medicines treated to cholesterol threshold, all six PCNs have exceeded the original target (35%) with an overall achievement of 44.2% (range across PCNs, 41.0 to 46.9%). This objective is being reconsidered with a view to extending the ambition or focussing on other priorities. Overall "triple control" in people with diabetes (blood pressure, cholesterol and blood glucose) has improved from 33.9% in quarter 1 of 2023/4 to 41.9% in quarter 4 against a target of 44%. In conclusion, steady progress has been made blood pressure management, treatment of people with circulatory disease with lipid lowering medicines and triple control in people with

	diabetes. The objective relating to managing cholesterol to target in patients with circulatory disease has been achieved. Further focus on detection of hypertension is required.
Latest Data and insights	Local extraction of data showing primary care attainment is available on a quarterly basis, though mortality data is updated annually (Appendix 2). Steady progress is being made towards targets in secondary prevention of circulatory disease in people at high risk in primary care. All six PCNs have exceeded the original target for patients with circulatory disease receiving lipid lowering medicines treated to cholesterol threshold. Primary care data is also available at practice level and helps to identify the range of activity and focus on particular inequalities. However, attention should be given to age adjustment, as practices in more socio-economically disadvantaged areas tend to have younger populations. If not taken account of this can appear to suggest inequalities that are less relevant once age is accounted for. Note that the timeliness of data presented varies with the source and in some cases dates back to 2016 (e.g. for ward level mortality, which has to be counted over a period of several years due to low numbers at local level). Primary care data extracted from GP information systems can be much more recent but includes a different range of indicators.
Opportunities	The Healthy hearts hub has partnered with ABL health to deliver health checks in the community and Dudley workplaces. We look to continue this collaboration to support the wider endeavours in Dudley relating to CVD. Black Country ICB is engaging in a national campaign called May Measure Month. This actually runs from May to July and will promote the importance of detecting and managing high blood pressure. Community pharmacies are being encouraged to participate and there will be local media releases and targeted social media activity. The ICB is launching a blood pressure task force to address detection and management of hypertension as well as a continued focus on prevention in patients with kidney, circulatory disease and diabetes. Primary care pharmacy teams are being upskilled to better manage hypertension, through a targeted approach. A multi-disciplinary group has been formed which will offer targeted support to practices in disadvantaged areas with high mortality rates where blood pressure and cholesterol management could be improved. Four practices have been identified as initial focus.

	We are looking to include a smoking cessation aspect to the HHH also given the key importance of reducing smoking rates in Dudley. This is in addition to supporting referrals from secondary care to community pharmacies. We are actively looking for and applying for bids for research opportunities and pilot studies where funding is being offered.
Challenges	Whilst the HHH has many successes there have been difficulties recruiting peers. A plan to promote and develop this further is in place and there has been some tentative interest here. Progress towards addressing inequalities in cardiovascular disease prevention in primary care has been made through additional funding, so a caveat is the importance of safeguarding funding to more disadvantaged areas at a time of heightened financial pressures.
Milestones or expected achievements for the next six months	The relationship between transport and health will be supported through the local planning processes. A separate transport and health strategy had been considered but there is now expected to be a health chapter within the wider Dudley Transport Strategy. Timescales for production of this are at present unclear however, as West Midlands then Black Country strategies need to be completed before the Dudley strategy. Development of a financial wellbeing strategy – reduced stress and more affordable food and sustainable active transport will impact upon circulatory disease risk factors. Development and implementation of programme to accelerate hypertension detection through Healthy Hearts Hub, Community Pharmacy Blood Pressure Service and other community outreach opportunities. Review cholesterol-related objectives and assess other primary care-based initiatives which could contribute to a reduction in circulatory disease. For example, atrial fibrillation detection and secondary prevention in patients with coronary heart disease.

Appendix 1 Summary of public communications supported by DMBC between April 2023 and April 2024

(a) Promotion of physical activity

Family Healthy Lifestyle Service – ongoing.

Saltwells Mindful Walks – helped establish a brand, voice, communications channels and promotion.

Let's Get Moving - ongoing campaign aimed at encouraging people who don't move much, particularly those aged 50-plus to become more active and build up daily activity, strength and balance, to reduce the risk of falls.

This campaign was launched following concerns that adults were becoming more at risk of falls following the COVID-19 pandemic, where people may have stayed at home, reduced physical activity and movement and were lonely and isolated.

Eight challenges have been created and promoted so far. Since 2023 two challenges have been created and widely promoted each year.

- The May 2023 challenge tied in with National Walking Month and was called Spring In Your Step. It urged everyone to walk, either on the spot, or outside, for at least five minutes a day, and add in at least five heel raises and walk upstairs a few times daily. These exercises were designed to build up fitness and balance. An animation was produced to illustrate the challenge. Local regular walks were also highlighted.

- The January 2024 challenge was named 31 days to strong and steady. This encouraged residents to conduct five simple strength and balance exercises, listed in a calendar format, every day in January. Throughout the month the intensity and repetition of the exercises increased.

Healthier Futures stakeholder magazine – provided wording and images for a double page spread on outdoor exercise opportunities in the borough.

Swim United pop-up swimming pools at two schools – supported communications.

Wellbeing Walks – gained national endorsement for the video produced on Dudley's Rambler Wellbeing Walks from The Ramblers' national e-bulletin.

National Walking Month – promoted along with local opportunities and created and distributed a communications pack for onward sharing

Phases free gym sessions for young people – produced marketing materials and promotion

Park Active – successful communications campaign to call for more volunteers, promotion of three volunteers who had clocked up more than 100 hours of volunteering and presentation of certificates, communications campaign to promote five years of Park Active.

Ageing Well Festival – created marketing collateral and promoted the autumn 2023 festival, which included many local exercise opportunities

Exercise opportunities for children – promoted in Your Borough Your Home residents' magazine

Healthy Steps – promoted national campaign for children to exercise

Healthy Ageing Champions – created marketing collateral to encourage people to become champions, which will involve promoting moving more

Dance To Health – various promotions of taster sessions, session and digital resources for older people to dance to improve fitness, balance, strength and tackle isolation

Sustrans Moving Challenge – promoted the national campaign

New year exercise opportunities – promoted opportunities during 2024 to exercise outside for free

Junior Parkrun – promoted

UK Prosperity Fund for outdoor gyms – promoted

NHS Group Charity fun run and family day – promoted

Park Yoga – promoted new free yoga sessions in Brierley Hill and the Black Country

(b) Promotion of healthy eating

2023 Spring – introducing solid foods campaign

March – Nutrition and Hydration Week (resources were sent to care homes)

Ongoing – promoting Healthy Lifestyle service (promotes eating well for families as well as moving more)

May – promoted Healthier Futures women's health and wellbeing event

June & August – promoted national Healthy Steps (children's healthy eating and exercising campaign)

Summer – annual summer wellbeing campaign – incudes sections on staying hydrated and food safety

Autumn – Ageing Well festival promotion (this covered everything people can do to age well, including food and nutrition)

Autumn onwards – produced and promoted Healthy Lunchbox booklet and microsite (healthy and tooth friendly lunchbox ideas for parents)

Winter wellbeing campaign (particularly aimed at older residents) – includes nutrition and vitamin D advice

2024 Jan – March and ongoing – produced, printed, created and promoted a digital recipe book for young people who are newly independent, by young people.

Spring and ongoing – promoted Healthy Start vitamins

March – promoted FSA campaign on vegan foods and allergens

Currently being developed – infant feeding campaign, advocating breastmilk

(c) Communicating about circulatory disease

2023 April – diabetes type 2 awareness week promotion, including a full page article in the residents' Your Borough Your Home magazine that is sent to all households

May - stroke awareness month communications

May – stroke awareness day communications

May – type 2 diabetes prevention week communications

August – amplified national messaging on preventing heart attacks

September and October – promoted knowing your numbers

November and December – promoted abdominal aortic aneurysm

November – diabetes day communications

2024 February – circulatory disease article in the residents' Your Borough Your Home magazine

February and March – get your blood pressure checked at community pharmacies communications

April – article on hypertension in the residents' ebulletin

May – social media promoting the National Diabetes Survey

May – shared ICB Facebook message calling on people to have their blood pressure tested at community pharmacies

Currently being developed – Stroke Awareness Month**,** Type 2 Diabetes Prevention Week**,** World Hypertension Day

Appendix 2 Latest CVD outcomes – Dudley and PCN level summary

Dudley Health & Wellbeing Board

Joint Health & Wellbeing Strategy 2023-2028 Outcomes: Circulatory Disease Overview

Outcome	Period	Dudley Value	Dudley Count	WM Value	England Value	England time period if different from Dudley
Overarching						
Deaths from circulatory disease, all ages, standardised mortality ratio	2016 - 20	108.7	4,156		100.0	
Deaths from circulatory disease, under 75 years, standardised mortality ratio	2016 - 20	107.2	1,115		100.0	
Premature mortality due to cardiovascular diseases in adults with severe mental illness (rate per 100,000)	2018 - 20	14.4	100		18.9	
Wider determinants of health						
Adults cycling for travel at least three days per week (%)	2019/20	0.8			2.3	
Adults walking for travel at least three days per week (%)	2019/20	11.3			15.1	
Air pollution: fine particulate matter (µg/m3)	2021	7.7			7.4	
Utilisation of outdoor space for exercise/health reasons (%)	Mar 2015 - Feb 2016	20.5			17.9	
Behavioural and clinical risk factors						
Depression: QOF prevalence (18+ yrs) (%)	2022/23	15.9	42,135		13.2	
Obesity: QOF prevalence (18+ yrs) (%)	2022/23	17.2	45,550		11.4	
Obesity: Reception - Overweight (including obesity), 3-years data combined (%)	2020/21 - 22/23	24.6	2,265		22.1	
Obesity: Year 6 - Overweight (including obesity), 3-years data combined (%)	2020/21 - 22/23	41.7	4,525		36.6	
Physically active adults (%)	2022/23	60.7			67.1	
Smoking prevalence in adults with a long term mental health condition (18+) (%)	2022/23	26.9			25.1	
Smoking: QOF prevalence (15+ yrs) (%)	2022/23	15.9	44,179		14.7	
Primary prevention						
Eligible people offered a weight management referral in the last 3 years (%)	2022/23	90.5	45,255			
eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check (%)	2018/19 - 22/23	35.1	29,292		42.3	
Patients (aged 45+ yrs), who have a record of blood pressure in the last 5 yrs (%)	2022/23	86.9	134,121		86.0	
Patients with learning disabilities who had a health check in the last 12 months (%)	2022/23	76.3	151		79.9	
Patients with severe mental illness receiving all 6 elements of the physical health check (%)	2022/23	68.1	1,579		58.5	
Smokers successfully quit at 4 weeks (rate per 100,000)	2022/23	1669.5	540		1620.1	
Prevalence of GP recorded hypertension in patients aged 18 and over	2023/24 Q4	22.3	60,129		14.0	2022/23
Secondary prevention						
For patients with CHD, a record that aspirin, APT or ACT is taken exists (%)	2022/23	87.6	11,675		90.5	
For patients with stroke a record exists that an anti-platelet agent or an anti-coagulant is taken (%)	2022/23	87.5	4,429		90.4	
Last BP reading of patients (<80 yrs, with a history of stroke or TIA) in the last 12 months is <= 140/90 mmHg (%)	2022/23	72.6	3,047		71.4	
Last BP reading of patients (<80 yrs, with CHD) in the last 12 months is <= 140/90 mmHg (%)	2022/23	75.5	7,246		75.9	
Patients with CHD, PAD, or on Stroke/TIA Register, who have cholesterol controlled to acceptable levels	2023/24 Q4	44.2	8,511			
Patients with circulatory disease currently prescribed a statin, or another lipid-lowering therapy (%)	2023/24 Q4	84.9	17,869			
Patients with Diabetes meeting all 3 NICE treatment targets (%)	2023/24 Q4	41.9	8,146			
Hypertension: treatment to recommended age specific thresholds (all ages) (%)	2023/24 Q4	78.6	43,933		75.7	2022/23

Key

Better than England	no England data available
Similar to England	Higher than England
Worse than England	Lower than England

Dudley Health & Wellbeing Board

Joint Health & Wellbeing Strategy 2023-2028 Outcomes: Circulatory Disease

Key

- Better than Dudley
- Higher than Dudley
- Lower than Dudley
- Similar to Dudley
- Worse than Dudley

Outcome	most deprived → Community Forum Area → least deprived					
	Dudley Central	Dudley North	Brierley Hill	Halesowen	Stourbridge	Dudley Value
Overarching						
Deaths from circulatory disease, all ages, standardised mortality ratio	131.5	108.2	117.3	97.4	97.9	108.7
Deaths from circulatory disease, under 75 years, standardised mortality ratio	141.9	119.1	112.4	92.8	80.2	107.2
Behavioural and clinical risk factors						
Obesity: Reception - Overweight (including obesity), 3-years data combined (%)	26.4	28.2	24.2	21.4	22.6	24.6
Obesity: Year 6 - Overweight (including obesity), 3-years data combined (%)	46.1	44.1	40.7	39.2	36.9	41.7

Outcome	most deprived → Primary Care Network → least deprived						
	Dudley & Netherton	Brierley Hill	Sedgley, Coseley & Gornal	Stourbridge, Wollescote & Lye	Halesowen	Kingswinford & Wordsley	Dudley Value
Behavioural and clinical risk factors							
Depression: QOF prevalence (18+ yrs) (%)	15.6	17.3	16.7	14.6	15.0	16.2	15.9
Obesity: QOF prevalence (18+ yrs) (%)	18.0	18.6	17.5	15.7	16.1	17.1	17.2
Smoking: QOF prevalence (15+ yrs) (%)	20.4	18.5	15.6	15.6	13.0	11.8	15.9
Primary prevention							
Eligible people offered a weight management referral in the last 3 years (%)	86.6	97.4	88.3	91.9	85.5	93.5	90.5
Patients (aged 45+ yrs), who have a record of blood pressure in the last 5 yrs (%)	87.5	87.1	86.5	84.9	88.5	87.6	86.9
Patients with learning disabilities who had a health check in the last 12 months (%)	76.9	62.5	79.3	84.2	75.9	77.4	76.3
Patients with severe mental illness receiving all 6 elements of the physical health check (%)	63.4	69.9	62.8	67.2	65.9	83.3	68.1
Prevalence of GP recorded hypertension in patients aged 18 and over	18.9	21.2	22.4	23.9	23.0	24.8	22.3
Secondary prevention							
For patients with CHD, a record that aspirin, APT or ACT is taken exists (%)	86.8	86.7	89.6	86.8	89.5	86.7	87.6
For patients with stroke a record exists that an anti-platelet agent or an anti-coagulant is taken (...	85.5	88.1	89.1	86.5	88.1	88.1	87.5
Hypertension: treatment to recommended age specific thresholds (all ages) (%)	75.1	79.6	78.2	81.1	78.6	78.2	78.6
Last BP reading of patients (<80 yrs, with a history of stroke or TIA) in the last 12 months is <= 1...	68.4	71.7	71.3	76.7	73.7	72.8	72.6
Last BP reading of patients (<80 yrs, with CHD) in the last 12 months is <= 140/90 mmHg (%)	71.2	77.3	74.7	79.0	75.0	75.4	75.5
Patients with CHD, PAD, or on Stroke/TIA Register, who have cholesterol controlled to acceptabl...	45.8	43.3	45.0	41.0	46.9	44.7	44.2
Patients with circulatory disease currently prescribed a statin, or another lipid-lowering therapy ...	82.0	86.6	83.5	86.7	85.5	84.7	84.9
Patients with Diabetes meeting all 3 NICE treatment targets (%)	39.0	42.4	39.9	40.5	43.2	47.8	41.9

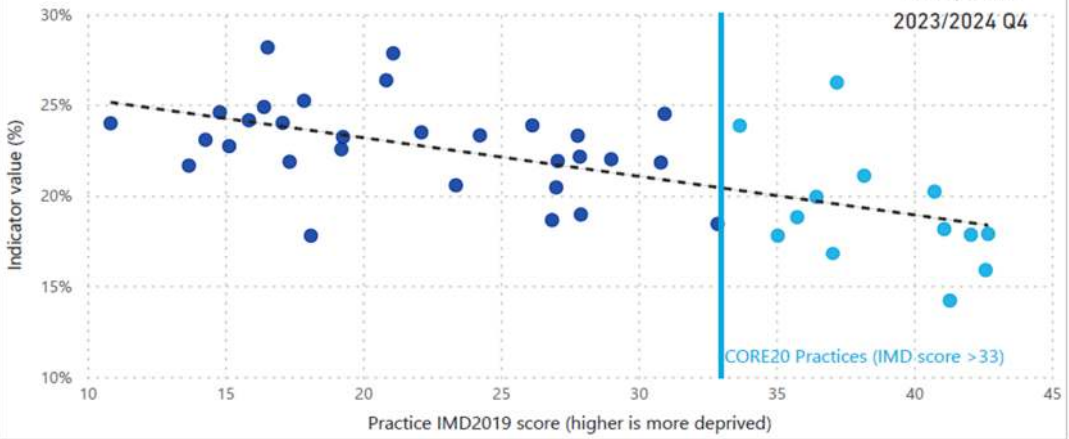
Appendix 3 Latest CVD outcomes – practice level outcomes

Prevalence of GP recorded hypertension in patients aged 18 and over — Source: EMIS web

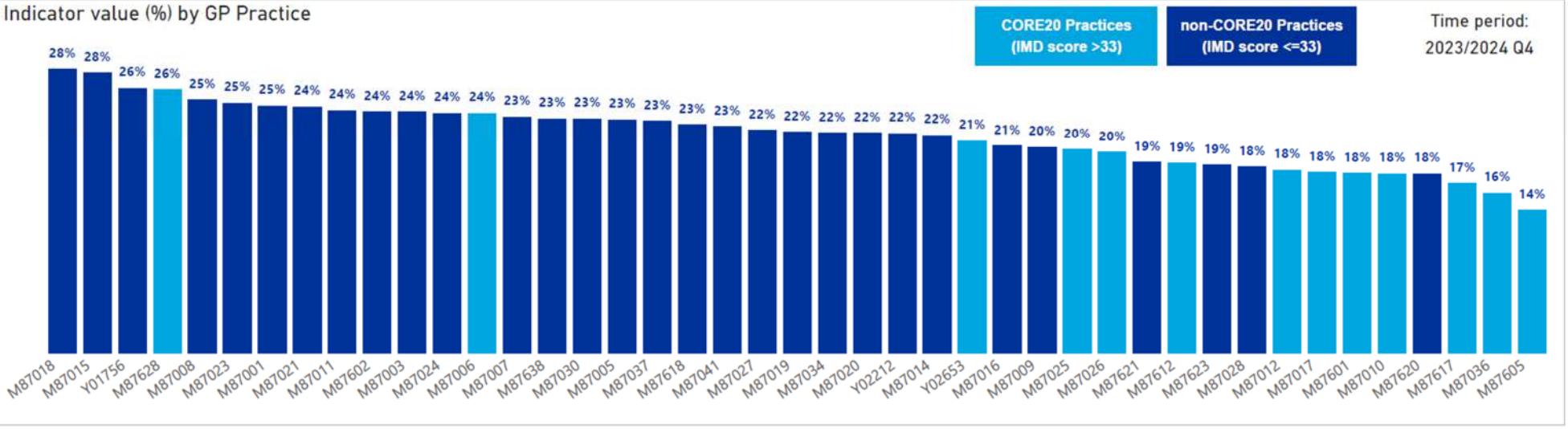
Indicator value (%) by PCN

Primary Care Network	2023/2024 Q1	2023/2024 Q2	2023/2024 Q3	2023/2024 Q4
Brierley Hill PCN	21.0%	21.0%	21.0%	21.2%
Dudley And Netherton PCN	18.8%	18.8%	18.8%	18.9%
Halesowen PCN	22.5%	22.6%	22.7%	23.0%
Kingswinford & Wordsley PCN	24.5%	24.6%	24.7%	24.8%
Sedgley, Coseley & Gornal PCN	22.2%	22.3%	22.3%	22.4%
Stourbridge, Wollescote & Lye PCN	23.3%	23.4%	23.5%	23.9%
Dudley GPs	**22.0%**	**22.1%**	**22.1%**	**22.3%**

Indicator value (%) vs Practice IMD2019 score



Indicator value (%) by GP Practice



Prevalence of GP recorded hypertension in patients aged 18 and over: Age standardised

Source: EMIS web, time period 2023-24 (annual)

Dudley GPs

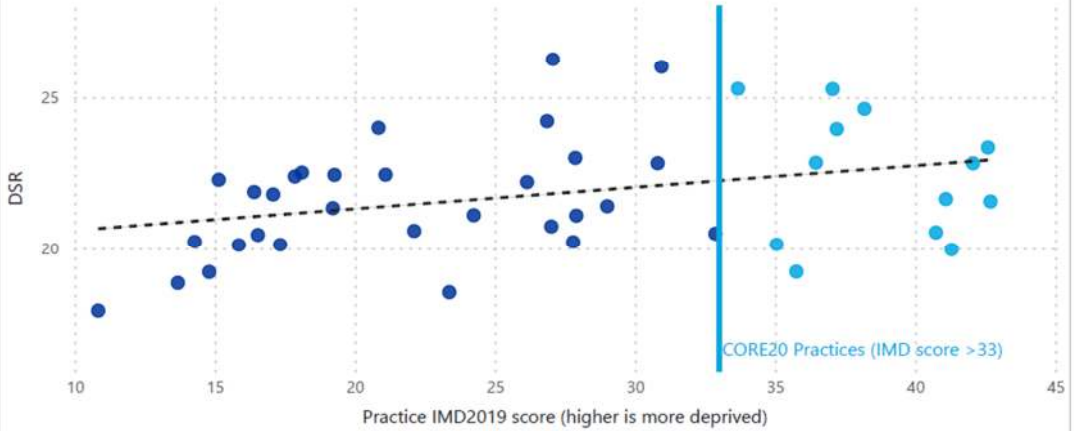
21.3

Age standardised prevalence (%)

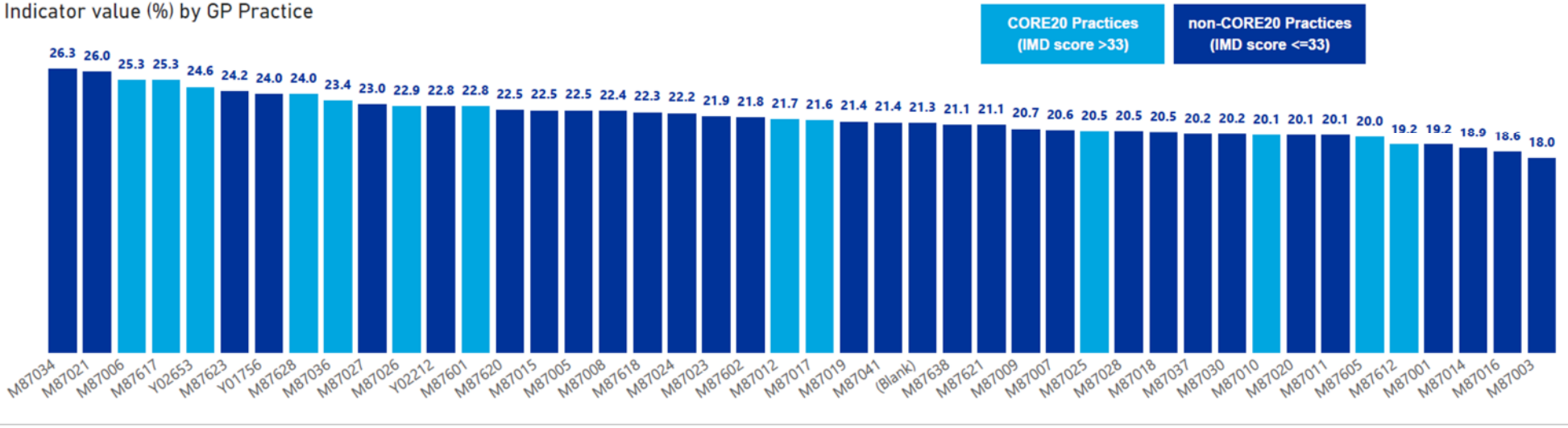
Indicator value (%) by PCN

Primary Care Network	DSR
Brierley Hill PCN	21.6
Dudley And Netherton PCN	22.4
Halesowen PCN	21.4
Kingswinford & Wordsley PCN	20.1
Sedgley, Coseley & Gornal PCN	21.5
Stourbridge, Wollescote & Lye PCN	21.1

Indicator value (%) vs Practice IMD2019 score



Indicator value (%) by GP Practice



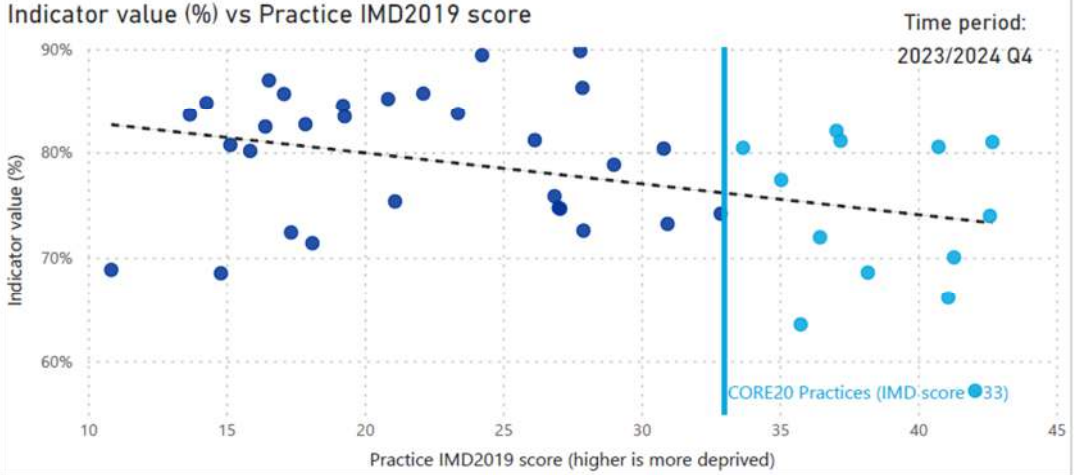
Hypertension: treatment to recommended age specific thresholds (all ages) (%)

Source: EMIS web

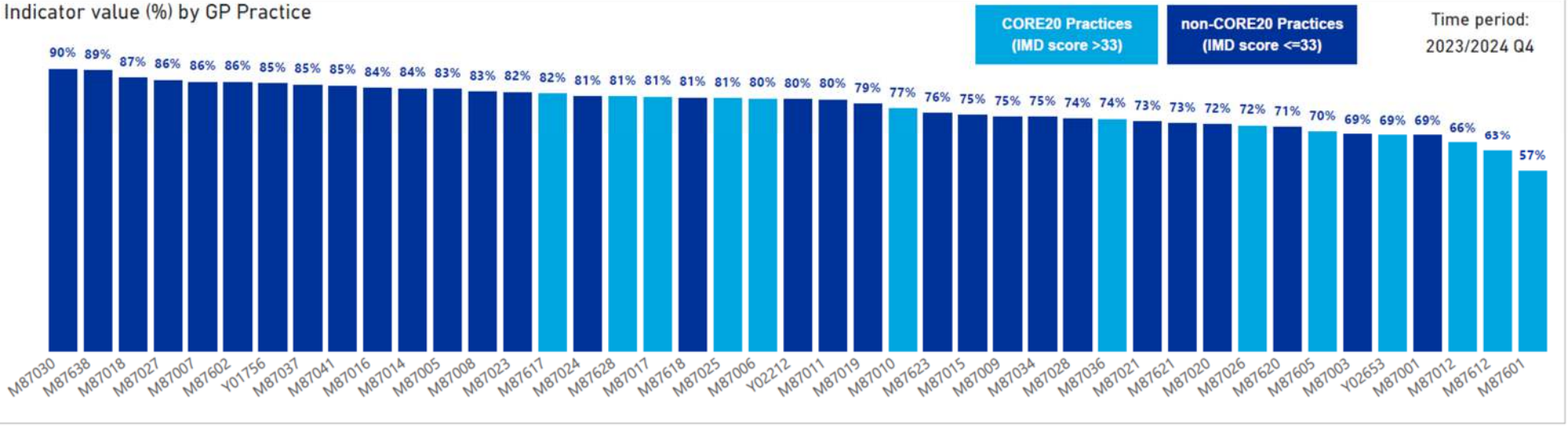
Indicator value (%) by PCN

Primary Care Network	2023/2024 Q1	2023/2024 Q2	2023/2024 Q3	2023/2024 Q4
Brierley Hill PCN	72.1%	72.7%	74.5%	79.6%
Dudley And Netherton PCN	66.1%	68.2%	70.0%	75.1%
Halesowen PCN	72.4%	71.8%	73.5%	78.6%
Kingswinford & Wordsley PCN	70.4%	70.9%	73.0%	78.2%
Sedgley, Coseley & Gornal PCN	72.0%	72.1%	74.0%	78.2%
Stourbridge, Wollescote & Lye PCN	75.0%	74.9%	74.8%	81.1%
Dudley GPs	**71.5%**	**71.9%**	**73.4%**	**78.6%**

Indicator value (%) vs Practice IMD2019 score



Indicator value (%) by GP Practice



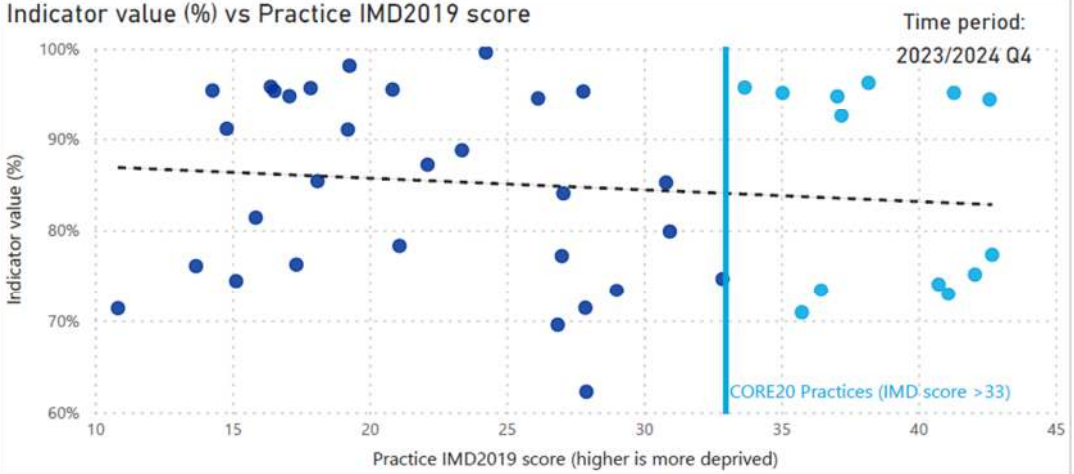
Patients with circulatory disease currently prescribed a statin, or another lipid-lowering therapy (%)

Source: EMIS web

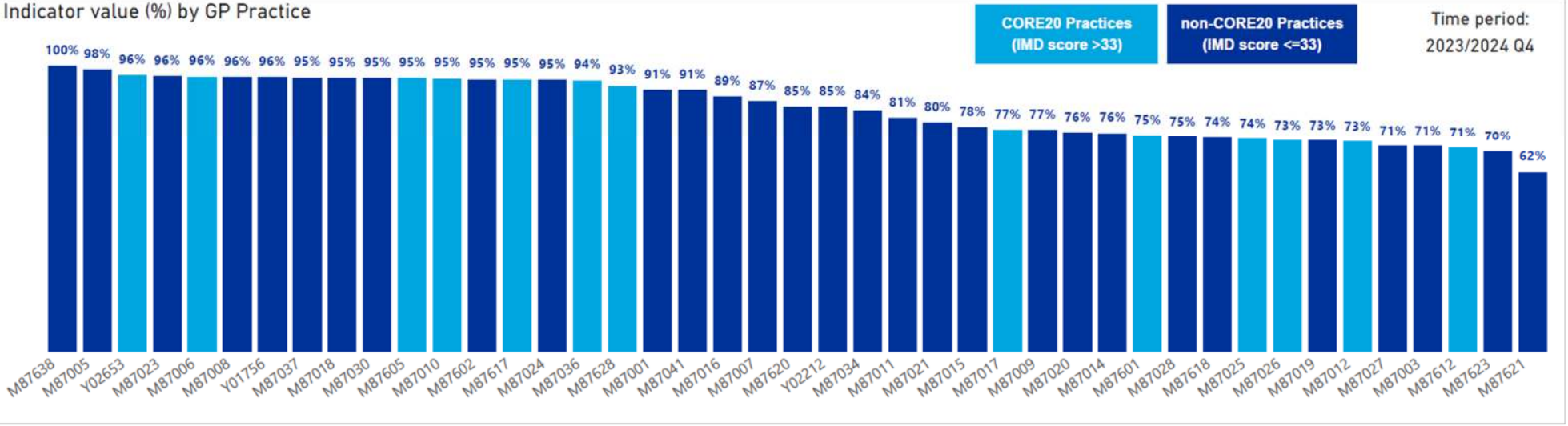
Indicator value (%) by PCN

Primary Care Network	2023/2024 Q1	2023/2024 Q2	2023/2024 Q3	2023/2024 Q4
Brierley Hill PCN	72.3%	73.0%	72.5%	86.6%
Dudley And Netherton PCN	71.3%	71.2%	71.3%	82.0%
Halesowen PCN	68.4%	68.4%	69.3%	85.5%
Kingswinford & Wordsley PCN	69.7%	70.0%	70.3%	84.7%
Sedgley, Coseley & Gornal PCN	68.8%	68.9%	68.7%	83.5%
Stourbridge, Wollescote & Lye PCN	68.8%	68.7%	66.6%	86.7%
Dudley GPs	**69.8%**	**69.9%**	**69.6%**	**84.9%**

Indicator value (%) vs Practice IMD2019 score



Indicator value (%) by GP Practice



Patients with CHD, PAD, or on Stroke/TIA Register, who have cholesterol controlled to acceptable levels (%)

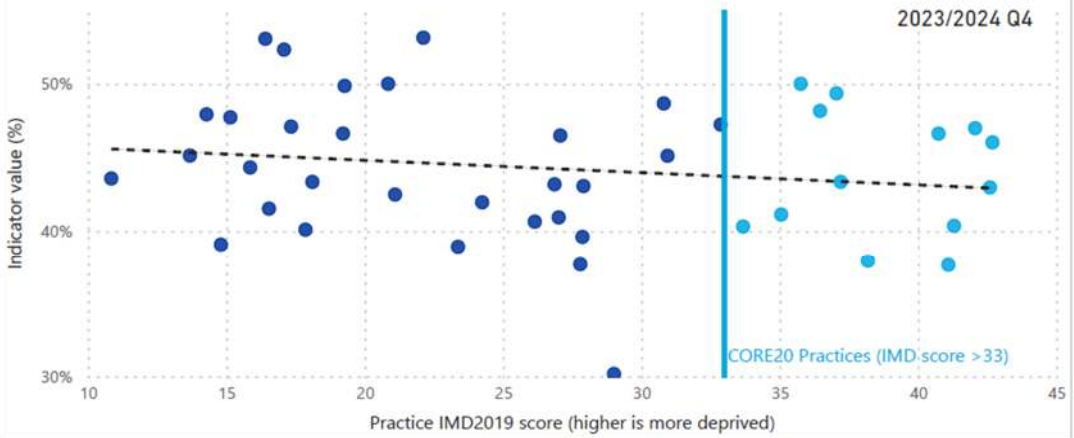
Source: EMIS web

Indicator value (%) by PCN

Primary Care Network	2023/2024 Q1	2023/2024 Q2	2023/2024 Q3	2023/2024 Q4
Brierley Hill PCN	33.0%	36.0%	40.8%	43.3%
Dudley And Netherton PCN	33.4%	35.9%	40.1%	45.8%
Halesowen PCN	31.7%	34.3%	42.2%	46.9%
Kingswinford & Wordsley PCN	33.6%	37.7%	41.6%	44.7%
Sedgley, Coseley & Gornal PCN	34.7%	38.5%	43.1%	45.0%
Stourbridge, Wollescote & Lye PCN	30.6%	33.1%	38.9%	41.0%
Dudley GPs	**32.8%**	**35.8%**	**41.0%**	**44.2%**

Indicator value (%) vs Practice IMD2019 score

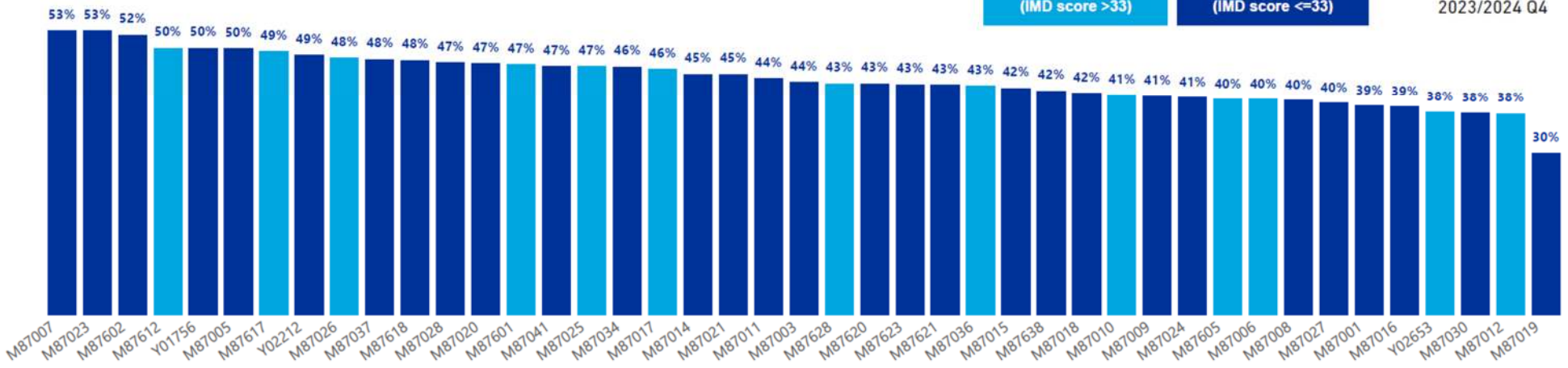
Time period: 2023/2024 Q4



Indicator value (%) by GP Practice

CORE20 Practices (IMD score >33) | non-CORE20 Practices (IMD score <=33)

Time period: 2023/2024 Q4



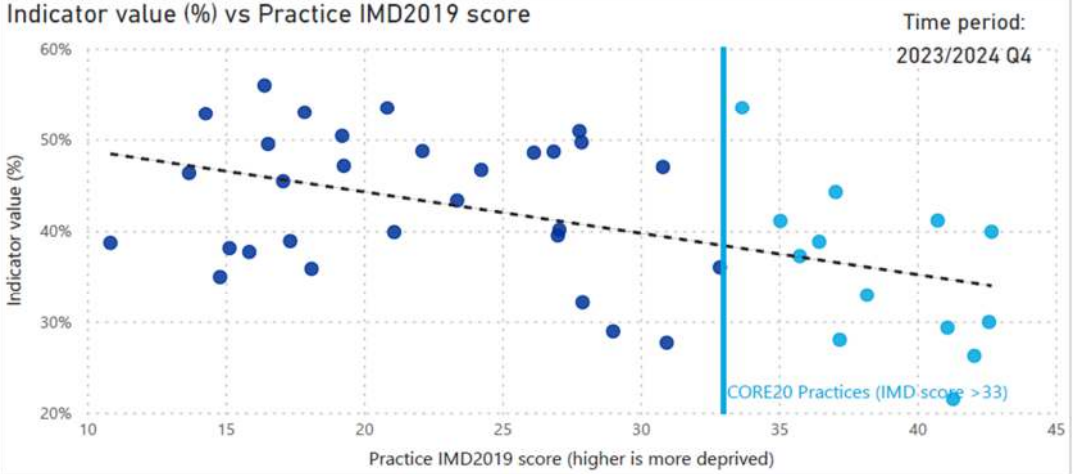
Patients with Diabetes meeting all 3 NICE treatment targets (%)

Source: EMIS web

Indicator value (%) by PCN

Primary Care Network	2023/2024 Q1	2023/2024 Q2	2023/2024 Q3	2023/2024 Q4
Brierley Hill PCN	42.6%	41.8%	42.2%	42.4%
Dudley And Netherton PCN	37.0%	38.4%	38.7%	39.0%
Halesowen PCN	36.8%	39.5%	41.8%	43.2%
Kingswinford & Wordsley PCN	38.9%	43.5%	45.7%	47.8%
Sedgley, Coseley & Gornal PCN	37.8%	39.5%	39.4%	39.9%
Stourbridge, Wollescote & Lye PCN	34.8%	34.0%	34.7%	40.5%
Dudley GPs	**37.9%**	**39.3%**	**40.2%**	**41.9%**

Indicator value (%) vs Practice IMD2019 score



Indicator value (%) by GP Practice