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Aims and objectives

The Integrated Care Partnership (ICP) is required to publish an initial draft interim strategy by the end of December 2022. For systems which already have an ICS Strategy, this will be a “refresh” of that strategy. JSNAs and Health & Wellbeing Board strategies to inform the strategy.

Through a face to face facilitated workshop with our ICP Assembly Members from across the Frimley ICS we aim to:

1. **Explain the journey so far on the development of the ICS strategy**
2. **Explore what has changed since the co-production of our strategy in 2019**
3. **Enable ICP Assembly members to co-design the key areas of focus for our ICS strategy refresh**

Following the insight generated at the ICP meeting on 22nd November, a refreshed draft strategy will be published and circulated to ICP members for review and comment prior to the draft submission on 23rd December.

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The journey so far

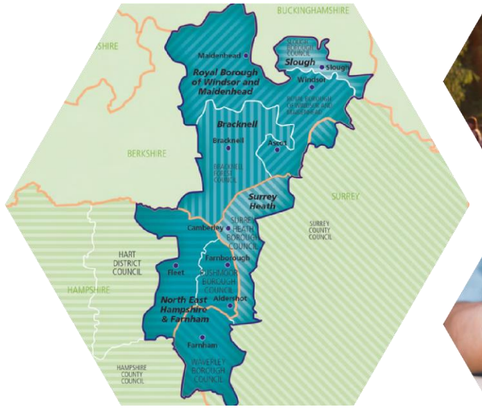
"Creating Healthier Communities" was published in 2019 as the first Frimley Health and Care ICS Strategy. The strategy was designed following significant co-production between partner organisations, the third sector, our workforce, patients and the public.

The strategy was heavily informed by the data and insight available from the Connected Care platform and led to the formation of six Strategic Ambitions which have comprised the programme architecture for strategy delivery between 2020 and 2022.

The two Objectives of the Strategy are:

- **Improving Healthy Life Expectancy**
- **Reducing Health Inequalities**

All of our strategic intent should be aligned to these objectives.



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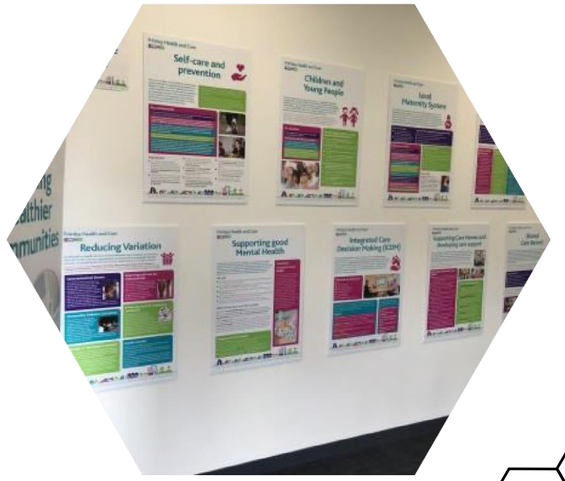
Inspiration Station 2019

Throughout July 2019 we invited over 250 people from a cross-section of our organisations to come through our ‘Inspiration Station’. This included representation from all our partner organisations, community representatives and our voluntary sector colleagues.

The aim of the sessions was to bring different expertise and experience together to collaboratively discuss what is important for our people locally. It helped us to focus on where to put our collective energy and work together to shape the ‘creating healthier communities’ plan for the next five years.



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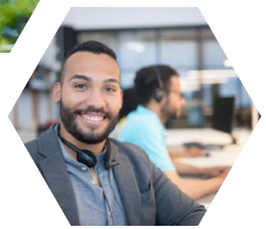
Our strategic ambitions



Starting Well
We want all children to get the best possible start in life.

Focus on Wellbeing
We want all people to have the opportunity to live healthier lives, no matter where in our system they live.

Community Deals
We will agree with our residents, families and carers how we work together to create healthier communities.

Our People
We want to be known as a great place to work, live, and to make a positive difference.

Leadership and Culture for Improvement
We will work together to build collaboration at every level across the system.

Outstanding use of resources
We will offer the best possible care and support where it is most needed, in the most affordable ways.

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November ICP

The ambition stations

By rotating thorough each of the six Ambition Stations all ICP members will have the opportunity to familiarise themselves with the ambitions.

Each station will share information relating to the ambition around the following:

- Background to the ambition
- What have been the achievements to date What next for
- the ambition?

There will be then be the opportunity to discuss the following:

- Does the ambition still reflect what we want to achieve as a system?
- What has changed for this ambition?
- What three areas of focus would you like to see reflected in the refresh?

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Output Generation	**Engagement** ICP Workshop takes place	22nd November:25Review contributions fromth November: those unable to attend ICP	
Refresh Strategy sharedth December:	By 8th December:	9Circulate for ICP reviewth December:	15Follow on amendmentsmade and
Content	Strategy refresh is drafted		
Finalise and submit	20th December:	23rd December: NHS England	**Draft Interim** Final deadline for Submit to DHSC/
Next Steps	December-March Further engagement on interim Strategy	March 2023 ICP sign off of final interim strategy	

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Timescales

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Using our insights

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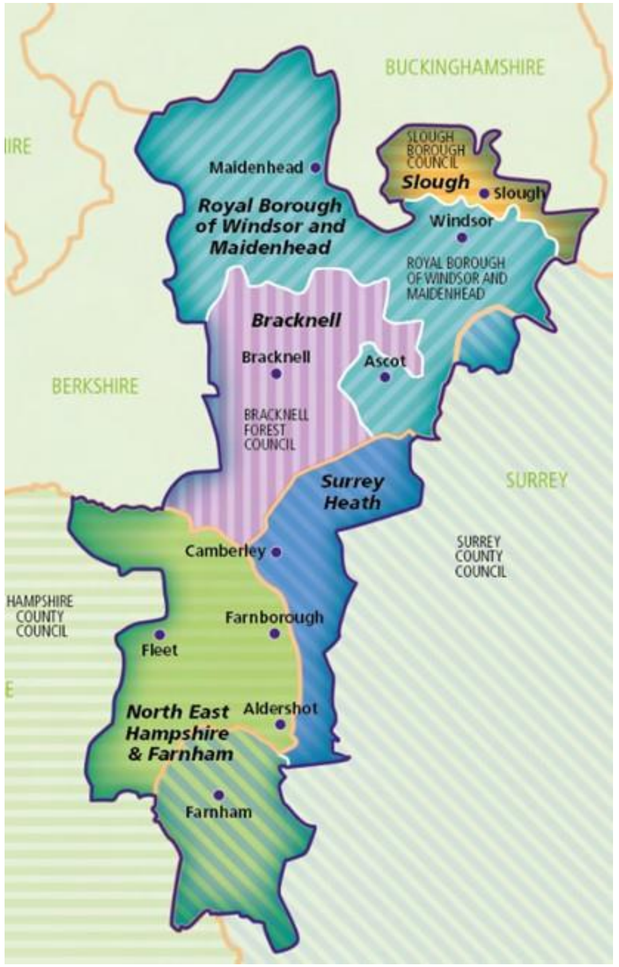
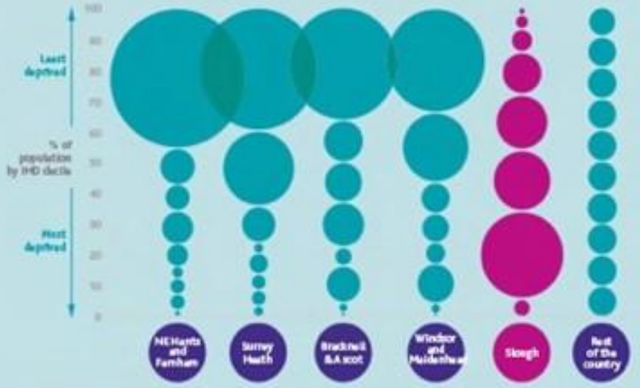


Deprivation

People that live in recognised areas of deprivation will often have poorer outcomes.

Most of our population do not live in an area of deprivation. Over 30% are in the 10% least deprived in society.

All areas contain pockets of deprivation but they can be less visible due to nearby affluence. In Slough there are more people living in deprivation.



Life expectancy

81yrs (79.5)

84yrs (83.2)

Healthy life expectancy

66.8yrs (63.3)

67.4yrs (63.9)

Demographics

Population - 800,000

x100K

3%

3% of the population live in the most deprived areas of England, while the region also includes large affluent areas.

Population increase by 2036

6.4%

(about 47,000 people with largest increases in the over 60's and 13-18 age group)

16.8%

(13.5%)

Healthy life expectancy at birth (years)

2016-2018

Female

Male

	Female	Male
Windsor and Maidenhead	70.4	70.0
Surrey	71.2	68.6
Bracknell Forest	67.7	67.9
Hampshire	67.8	66.3
England	63.9	63.4
Slough	60.0	58.7

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Creating Healthier Communities: Our Strategy

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Overall goals:

- ❑ **Living healthier for longer**
- ❑ **Reducing health inequalities**

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Our relationships are central to what we do and how we work. We will work with our communities, however large or small, to better understand, develop and build on what's already working, investing where we can make a real difference.

Delivering our strategic ambitions and overall objectives requires working at a variety of scales when planning, delivering and evaluating change.

Understanding health inequalities – Variation by Place

Key insights

Figure 1

- Slough compared to other parts of the system is ***younger***, ***higher % BAME***, ***more densely populated*** and ***multigenerational households*** and ***more deprived***

Figure 2

- Adjusting for age and sex, Slough has significantly ***higher prevalence of a wide range of conditions and risk factors***. There are strong associations between deprivation, ethnicity and prevalence of conditions such as diabetes and hypertension (see next slide)
- Increased prevalence of chronic diseases lead to ***health inequalities*** as well as disproportionate impact of Covid-19

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Demographics overview

Place name	# Population	# Average Age	% BAME Ethnic Groups	% Multigenerational households	% household >=5	Index of Multiple Deprivation (IMD)
Bracknell Forest	120,774	39.5	11.4 %	6.0 %	25.8 %	7.2
NEHF	237,110	41.0	11.2 %	7.3 %	27.4 %	7.5
RBWM	185,289	40.9	16.3 %	8.2 %	31.0 %	8.1
Slough	173,721	35.0	61.2 %	13.4 %	51.0 %	4.0
Surrey Heath	99,074	42.0	12.1 %	7.6 %	27.2 %	7.9
Total	**815,968**	**39.6**	**23.3 %**	**8.6 %**	**33.0 %**	**6.9**

Figure 2: Age-sex standardised prevalence of conditions by Place

Colour represents statistical significance: **Significantly Higher** | Similar | **Significantly Lower**

RegisterDescription	Bracknell Forest	NEHF	RBWM	Slough	Surrey Heath	**Total**
Asthma	5.67%	5.13%	4.99%	5.46%	5.10%	**5.19%**
Atrial fibrillation	2.14%	2.20%	2.34%	1.88%	2.17%	**2.18%**
BMI >= 35	6.83%	5.88%	4.43%	6.76%	5.79%	**5.79%**
Cancer	3.75%	3.71%	3.94%	2.93%	3.39%	**3.61%**
CHD	2.70%	2.60%	2.81%	4.39%	2.60%	**2.92%**
CKD	3.62%	2.73%	3.39%	4.20%	2.08%	**3.13%**
COPD	1.42%	1.46%	1.08%	1.68%	1.15%	**1.34%**
Current Smokers	11.26%	10.16%	9.63%	11.75%	9.76%	**10.42%**
Dementia	0.73%	0.81%	0.82%	0.76%	0.88%	**0.81%**
Depression	12.15%	11.35%	9.26%	8.19%	9.91%	**10.08%**
Diabetes	5.61%	5.47%	4.75%	11.18%	5.14%	**6.16%**
Epilepsy	0.61%	0.56%	0.48%	0.48%	0.54%	**0.53%**
Heart failure	0.96%	1.00%	0.95%	1.36%	0.68%	**0.98%**
Heart Failure Lvsd	0.37%	0.35%	0.36%	0.52%	0.14%	**0.35%**
Hypertension	14.66%	13.60%	13.20%	18.36%	13.20%	**14.34%**
Learning disability	0.35%	0.38%	0.30%	0.58%	0.43%	**0.41%**
Medium/High Alcohol consumption	7.37%	8.50%	9.89%	3.24%	8.72%	**7.75%**
Mental health	0.70%	0.74%	0.74%	1.18%	0.64%	**0.79%**
Mental health Lithium	0.05%	0.05%	0.06%	0.04%	0.04%	**0.05%**
Non-Diabetic Hyperglycaemia	4.37%	5.51%	3.96%	7.31%	3.61%	**5.07%**
Obesity	8.83%	7.87%	6.06%	9.28%	7.26%	**7.74%**
PAD	0.43%	0.44%	0.36%	0.64%	0.39%	**0.44%**
Palliative Care	0.44%	0.39%	0.78%	0.72%	0.32%	**0.53%**
Rheumatoid arthritis	0.59%	0.56%	0.49%	0.71%	0.59%	**0.57%**
Stroke/TIA	1.51%	1.53%	1.62%	1.86%	1.53%	**1.60%**

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Understanding health inequalities – Deprivation and Ethnicity

Join the conversation

Key insights

Figure 3

Deprivation

- Higher prevalence of smoking and obesity in deprived areas (but lower alcohol consumption)
- Strong association for diabetes, COPD, Heart failure and many other conditions
- Lower prevalence rates for Cancer which could reflect under-diagnosis

Ethnicity

- Asian / Asian British notably higher for Diabetes, Non Diabetic Hyperglycaemia and CHD
- Black / black British notably higher for Diabetes, Hypertension, CKD, Obesity
- Non-white ethnicities tend to be lower for alcohol consumption and smoking (as well as COPD)

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Figure 3: Age-sex standardised prevalence of conditions by Deprivation Quintile and Ethnicity

Colour represents statistical significance: **Significantly Higher** | Similar | **Significantly Lower**

RegisterDescription	Variation by DEPRIVATION QUINTILE (1= 20% most deprived areas)					Variation by ETHNICITY				
	1	2	3	4	5	Asian or A...	Black or B...	Mixed	Other Et...	White
Asthma	5.6%	5.5%	5.5%	5.1%	5.1%	5.4%	4.3%	5.3%	3.1%	5.7%
Atrial fibrillation	2.1%	2.0%	2.1%	2.3%	2.2%	1.2%	1.2%	1.7%	1.8%	2.4%
BMI >= 35	8.3%	7.4%	7.4%	6.3%	4.5%	4.4%	8.3%	5.6%	3.8%	6.4%
Cancer	2.9%	3.0%	3.3%	3.6%	3.9%	2.1%	3.4%	2.9%	3.2%	3.9%
CHD	4.2%	4.0%	3.4%	3.0%	2.5%	4.8%	2.4%	3.2%	2.5%	2.8%
CKD	4.7%	4.0%	3.7%	3.3%	2.7%	3.3%	5.8%	3.6%	2.1%	3.2%
COPD	2.6%	2.1%	1.9%	1.5%	0.9%	0.7%	0.5%	0.8%	0.9%	1.5%
Current Smokers	15.3%	13.9%	13.4%	10.9%	7.8%	6.1%	7.1%	9.2%	9.6%	12.0%
Dementia	0.9%	0.9%	0.8%	0.8%	0.8%	0.6%	1.1%	0.8%	0.8%	0.8%
Depression	11.1%	10.0%	11.6%	10.4%	9.6%	5.3%	6.4%	8.4%	6.1%	12.2%
Diabetes	11.8%	10.5%	7.8%	6.3%	4.4%	14.3%	11.2%	10.0%	6.1%	5.0%
Epilepsy	0.7%	0.6%	0.6%	0.6%	0.5%	0.3%	0.3%	0.4%	0.3%	0.6%
Heart failure	1.6%	1.4%	1.2%	1.0%	0.8%	1.2%	1.0%	1.0%	0.7%	1.0%
Heart Failure Lvsd	0.7%	0.5%	0.4%	0.4%	0.3%	0.3%	0.3%	0.3%	0.2%	0.4%
Hypertension	18.4%	17.7%	16.1%	14.6%	12.7%	18.8%	21.2%	17.0%	12.8%	14.0%
Learning disability	0.7%	0.6%	0.5%	0.4%	0.3%	0.4%	0.4%	0.4%	0.3%	0.4%
Medium/High Alcohol consumption	3.9%	4.1%	6.1%	7.6%	9.5%	2.1%	2.2%	3.8%	5.6%	9.3%
Mental health	1.4%	1.3%	1.0%	0.8%	0.6%	0.8%	1.5%	1.0%	0.6%	0.8%
Mental health Lithium	0.1%	0.1%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%
Non-Diabetic Hyperglycaemia	8.0%	7.1%	5.5%	5.0%	4.2%	9.0%	8.1%	6.5%	5.1%	4.3%
Obesity	11.0%	10.1%	9.4%	8.3%	6.1%	8.1%	11.2%	8.4%	5.6%	8.0%
PAD	0.7%	0.7%	0.6%	0.5%	0.3%	0.4%	0.4%	0.6%	0.4%	0.5%
Palliative Care	0.7%	0.6%	0.5%	0.5%	0.5%	0.5%	0.5%	0.4%	0.5%	0.5%
Rheumatoid arthritis	0.6%	0.7%	0.6%	0.6%	0.5%	0.8%	0.4%	0.6%	0.4%	0.6%
Stroke/TIA	2.1%	2.0%	1.8%	1.7%	1.4%	1.7%	2.2%	1.4%	1.5%	1.6%

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Core20 plus 5

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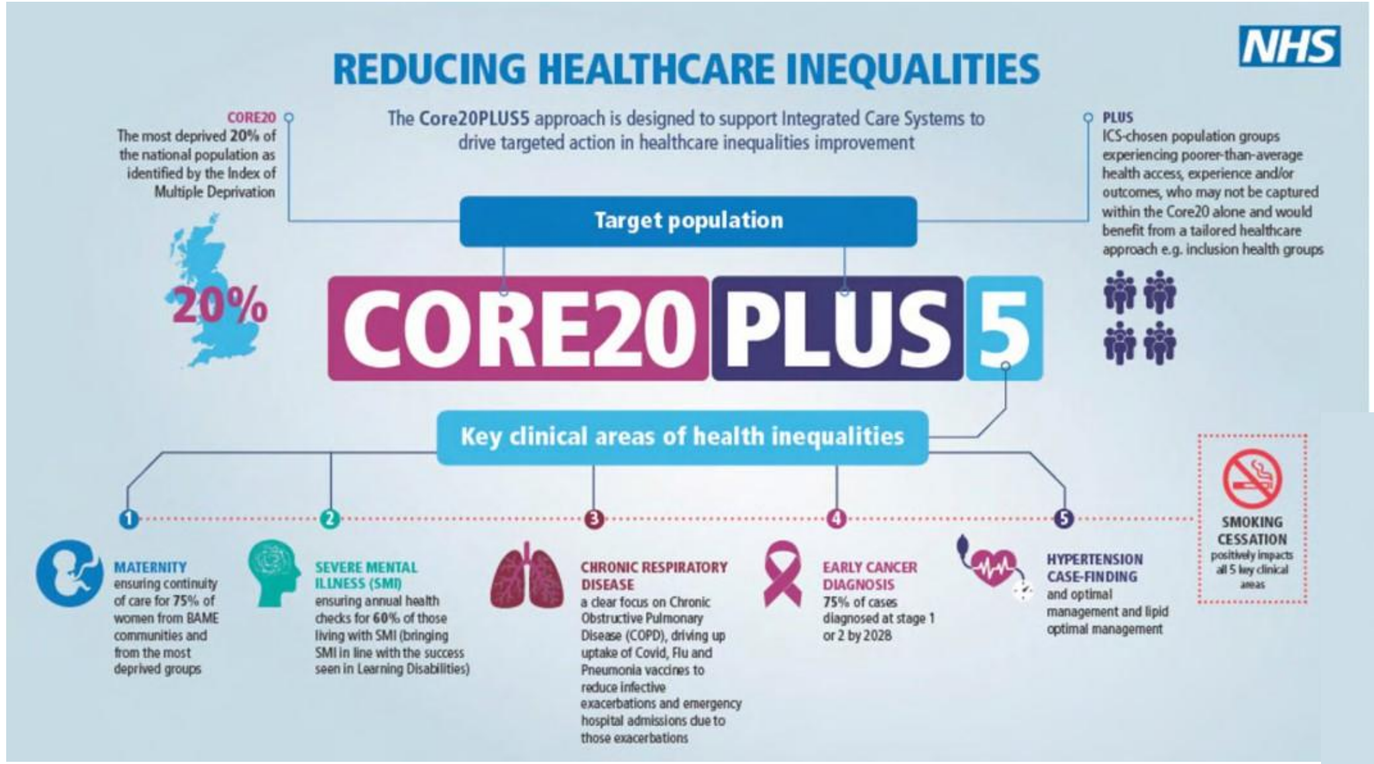

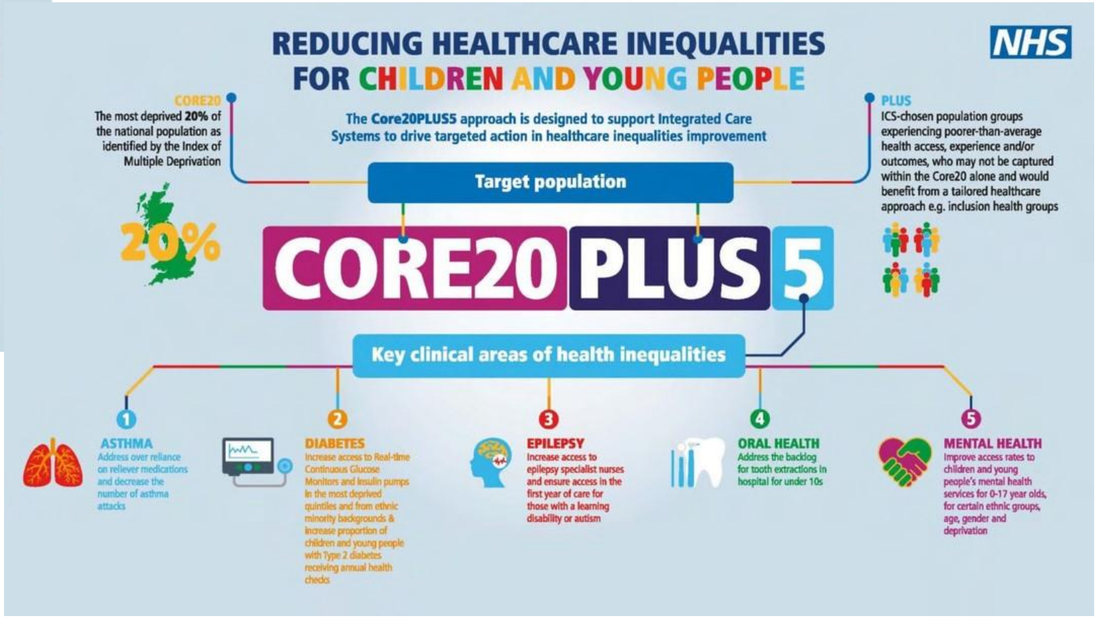

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Core 20 population breakdown across places

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Percentage population by Place by deprivation quintile

Place name	1	2	3	4	5
Bracknell Forest	0.03%	4.23%	24.95%	27.11%	43.69%
NEHF	2.87%	9.69%	12.45%	17.73%	57.27%
RBWM	0.10%	5.11%	13.77%	19.24%	61.78%
Slough	8.19%	53.04%	23.45%	14.20%	1.12%
Surrey Heath	0.05%	7.30%	13.05%	14.64%	64.97%
Total	**2.60%**	**16.73%**	**17.01%**	**18.34%**	**45.32%**

Population count by Place by Deprivation quintile

Place name	1	2	3	4	5	**Total**
Bracknell Forest	38	5,108	30,156	32,766	52,810	**120,878**
NEHF	6,785	22,922	29,466	41,958	135,530	**236,661**
RBWM	183	9,487	25,559	35,716	114,698	**185,643**
Slough	14,140	91,543	40,472	24,511	1,936	**172,602**
Surrey Heath	47	7,215	12,900	14,481	64,239	**98,882**
Total	**21,193**	**136,275**	**138,553**	**149,432**	**369,213**	**814,666**

Age standardised prevalence of selected registers for most deprived 20% of the population

Place name	Cancer	COPD	Hypertension	Mental health
Bracknell Forest	3.46%	2.05%	14.20%	0.37%
NEHF	3.11%	2.82%	16.87%	1.09%
RBWM	3.16%	2.17%	15.32%	1.52%
Slough	2.82%	1.92%	18.82%	1.37%
Surrey Heath	2.63%	2.17%	14.99%	0.69%

Total population on selected registers for most deprived 20% of the population

Place name	Cancer	COPD	Hypertension	Mental health	**Total**
Bracknell Forest	136	69	524	46	**675**
NEHF	795	722	4,352	335	**5,385**
RBWM	236	158	1,119	133	**1,436**
Slough	1,767	1,118	12,318	1,228	**14,601**
Surrey Heath	155	120	813	72	**1,021**

Key insights

- Majority of the 20% most deprived population within Frimley ICS resides in Slough and NEHF
- When looking at the age standardised prevalence of COPD, Hypertension and Mental Health within this population, it is significantly greater in prevalence compared to the connected Care baseline population. Prevalence of Cancer is significantly lower in this cohort which could be due to reduced screening.

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Core 20: Ethnicity and lifestyle factors

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Key insights

1. There is a greater over-representation of BAME ethnic groups (50.3%) within the population in deprivation quintile 1 (most deprived) in the ICS and an under-representation in the least deprived population (9.9%).
2. Some key communities with known health inequalities are much more likely to live in deprived areas. For example, Gypsy Roma Traveller community is almost 7x more likely to live in the most deprived areas than less deprived areas and for Nepalese residents it is 3x.
3. Lifestyle risk factors – obesity and smoking are more prevalent in deprived populations, however high alcohol consumption is lower.

1.

	1	2	3	4	5	Total
# Average Age	35.2	35.6	37.4	39.8	42.1	**39.6**
% BAME Ethnic Groups	50.3 %	49.6 %	29.0 %	21.6 %	9.9 %	**23.1 %**
% Multigenerational households	9.3 %	9.2 %	7.0 %	6.2 %	4.6 %	**6.2 %**
% household >=5	44.8 %	44.5 %	35.8 %	30.7 %	24.0 %	**31.2 %**

2.

Age Standardised Prevalence in 20% most deprived population (Quintile 1-2) vs rest of population

RegisterDescription	Prevalence DSR Quintile 1-2	Prevalence DSR Quintile 3-5	Prevalence DSR Quintile 1-2 vs 3-5
GRT Residents	0.4 %	0.1 %	6.65
Nepalese Residents	3.7 %	1.2 %	3.05

3.

Age Standardised Prevalence in 20% most deprived population (Quintile 1-2) vs rest of population

RegisterDescription	Prevalence DSR Quintile 1-2	Prevalence DSR Quintile 3-5	Prevalence DSR Quintile 1-2 vs 3-5
Current Smokers	14.2 %	9.7 %	1.47
BMI >= 35	7.4 %	5.4 %	1.37
Medium/High Alcohol consumption	4.3 %	8.6 %	0.50

*Prevalence DSR- Age sex standardized prevalence rates were utilized as it controls for the differences in age and sex distribution by place.

Deprivation (Core 20) and QoF conditions

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Key insights

- Prevalence of almost all QOF conditions is higher in deprived areas, including CVD risks that are a large contributor to overall health inequalities. For example, diabetes is almost 2x more prevalent than in the rest of the population.
- Lower prevalence of cancer could also indicate a need for greater screening in deprived communities.

*Prevalence DSR- Age sex standardized prevalence rates were utilized as it controls for the differences in age and sex distribution by place.

Age sex standardised Prevalence in Deprivation quintiles 1-2 vs rest of the population

RegisterDescription	Prevalence DSR Quintile 1-2	Prevalence DSR Quintile 3-5	Prevalence DSR Quintile 1-2 vs 3-5
Diabetes	10.5 %	5.3 %	1.98
Mental health	1.3 %	0.7 %	1.84
COPD	2.2 %	1.2 %	1.83
PAD	0.7 %	0.4 %	1.75
Learning disability	0.6 %	0.4 %	1.72
Heart Failure Lvsd	0.5 %	0.3 %	1.61
Non-Diabetic Hyperglycaemia	7.0 %	4.5 %	1.55
Heart failure	1.4 %	0.9 %	1.47
CHD	3.9 %	2.7 %	1.44
Obesity	10.5 %	7.6 %	1.40
CKD	3.9 %	3.0 %	1.32
Hypertension	17.7 %	13.7 %	1.29
Stroke/TIA	1.9 %	1.5 %	1.26
Palliative Care	0.6 %	0.5 %	1.21
Rheumatoid arthritis	0.7 %	0.5 %	1.21
Dementia	0.9 %	0.8 %	1.17
Mental health Lithium	0.1 %	0.0 %	1.17
Epilepsy	0.6 %	0.5 %	1.13
Asthma	5.3 %	5.1 %	1.05
Osteoporosis 75	0.3 %	0.3 %	1.01
Depression	10.0 %	10.0 %	1.00
Atrial fibrillation	2.0 %	2.2 %	0.90
Cancer	3.0 %	3.7 %	0.80

Core 20 population Cancer and Screening programs

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Percentage of diagnosed cancers by source of referral, split out by Deprivation Quintiles

Source of Referral	1	2	3	4	5
General Practitioner	53.4%	54.3%	55.2%	57.0%	59.2%
Consultant	35.0%	35.8%	33.9%	32.9%	30.4%
AE department or following AE admission	6.3%	4.8%	5.0%	3.9%	3.8%
National Screening Programme	5.3%	5.1%	5.9%	6.2%	6.6%

Key insights

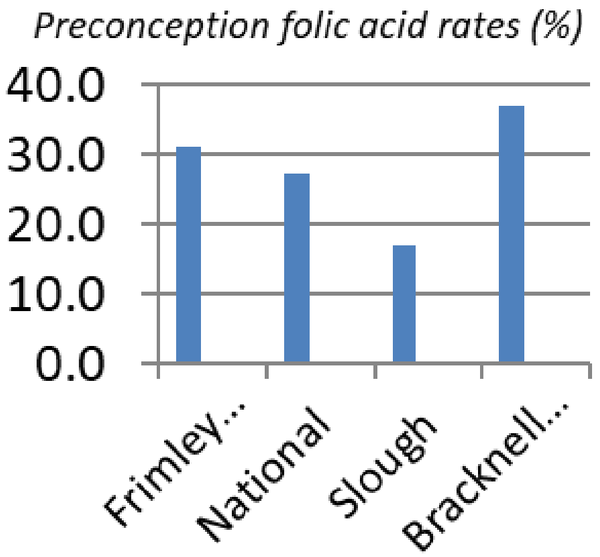
- Those in the most deprived population have a lower percentage of cancers referrals made from all sources including National Screening programs and GPs, compared to the least deprived population (quintile 5). A greater percentage of diagnosed cancers are referred from Consultants or AE departments for deprived cohorts
- For certain care processes such as Cervical Screening, achievement is lower within the 20% most deprived population, which could suggest more effort is needed to reach these communities.
- For care processes such as BMI and Blood pressure reviews, there is greater achievement in the more deprived population.

Achievement of key care processes and treatment target (20% most deprived vs rest of population)

IndicatorType	Indicator % Quintile 1-2	Indicator % Quintile 3-5	% Indicator Diff Quintile 1-2 vs Quintile 2-5
Process	**61.5 %**	**61.8 %**	**-0.3 %**
Urine ACR	33.0 %	43.5 %	-10.6 %
Retinal screening	51.1 %	59.1 %	-7.9 %
LD annual health check	59.0 %	66.8 %	-7.9 %
Cervical screening	63.7 %	70.7 %	-7.0 %
LD annual health check & action plan	55.8 %	62.3 %	-6.5 %
Rheumatoid Arthritis review	40.1 %	43.9 %	-3.8 %
Fracture risk assessment	7.1 %	8.9 %	-1.8 %
CHADVASc score	29.3 %	30.7 %	-1.4 %
Creatinine	84.5 %	84.7 %	-0.2 %
HbA1c	84.3 %	84.3 %	0.1 %
CHAD score	1.3 %	1.1 %	0.2 %
BMI	75.7 %	74.8 %	0.9 %
Blood pressure	74.1 %	73.0 %	1.1 %
Foot examination	72.8 %	71.5 %	1.3 %
Cholesterol	75.8 %	74.4 %	1.5 %
Smoking review	76.2 %	74.3 %	1.9 %

Frimley Health and Care

Understanding our population



Booking after 16 Weeks

Black/African/Caribbean or Black British:

- 18.5% (WPH) and 22.4% (FPH)

White:

- 9.8% (WPH) and 6.9% (FPH)

of FHFT's pregnant women have 1 or more long term condition
Compared
to an expected rate of 33 %

5.6% **smoking** at time of pregnancy (9.6% national average)

Data - April 2020 - April 2021

25.9% Asian/ British Asian
16.2% Black/ Black British
10.5% White
Diagnosed with **gestation diabetes**

Data - April 2020 - April 2021

Deprivation (Core 20) and HbA1c control

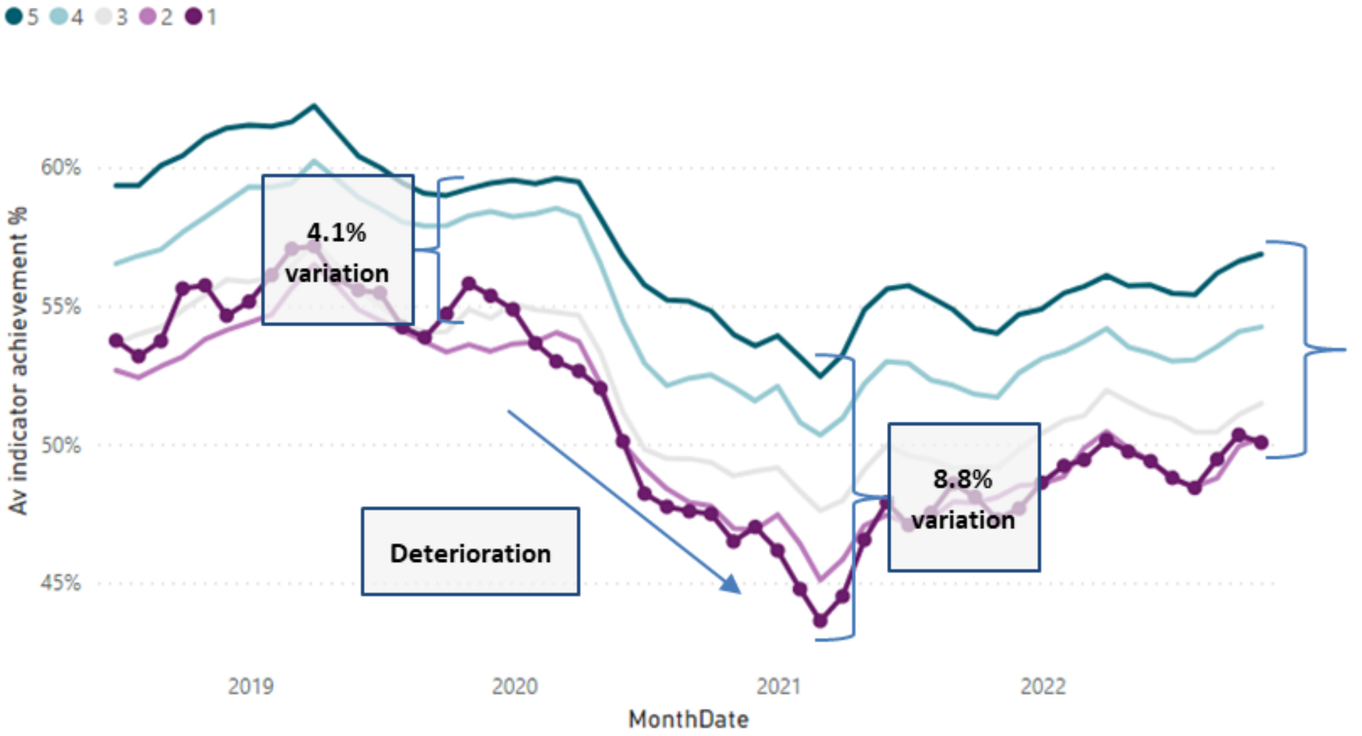
Frimley Health and Care

Join the conversation

Key insights

- Control of Diabetes in the Core 20 population deteriorated the most during the first year of the pandemic.
- The proportion of patients with HBA1C <=58 in the most deprived areas fell from 55.3% in Nov 2019 to 47.0% in Nov 2020.
- The gap between most and least deprived areas increased during first year of the pandemic increased from 4% to 9% at the height of the pandemic. It has since fell to 7%

Chart: Trend in proportion of patients with a recorded HBA1C with a value <= 58



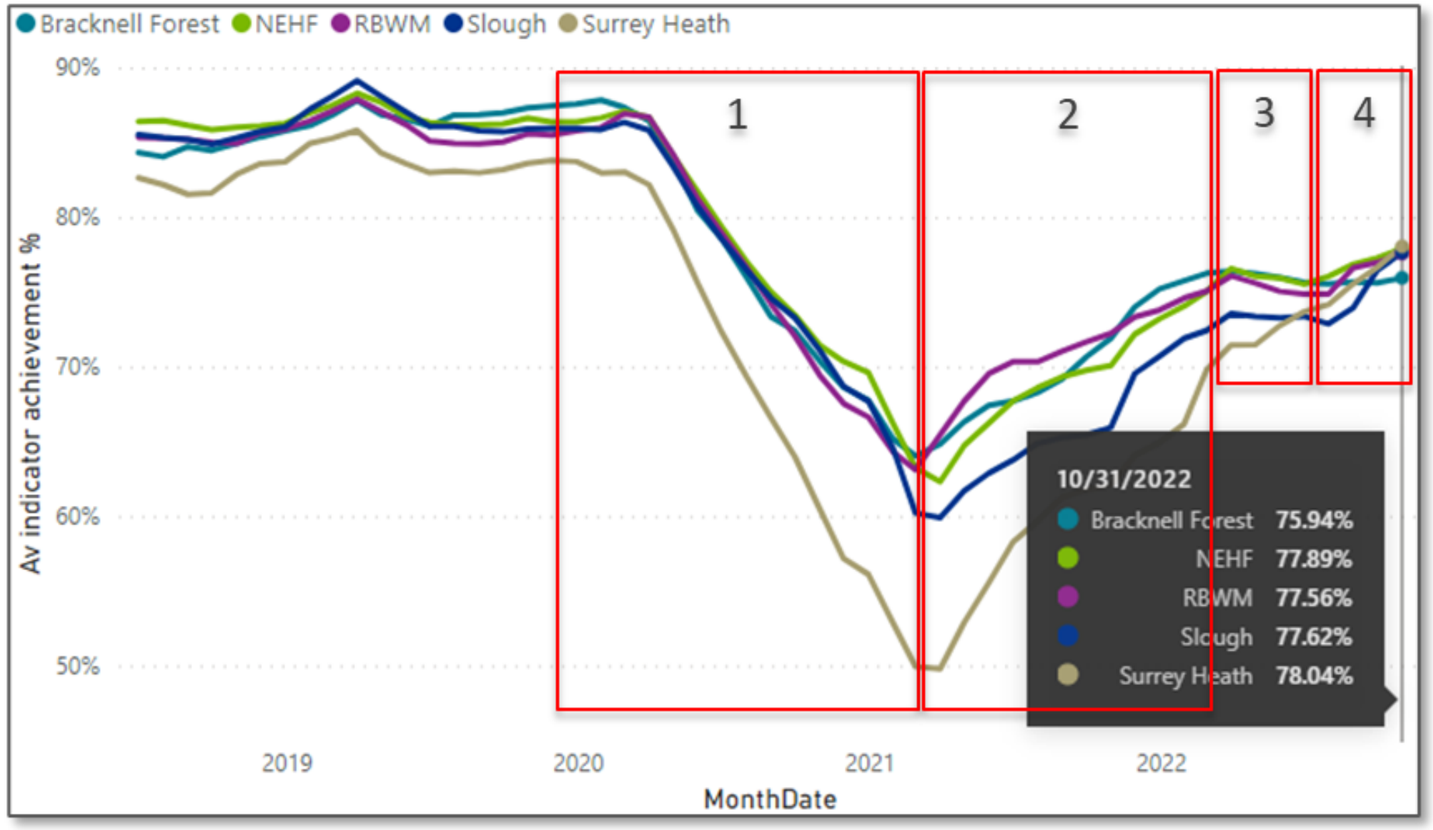
Frimley Health and Care

Recent trends – Hypertension recording

Join the conversation

% achievement of hypertension recording as of 31st October 2022

Data as of 31st Oct 2022



1. **March 2020 – March 2021:** Significant decline in hypertension monitoring due to pandemic
2. **March 2021-March 2022:** Significant recovery in hypertension monitoring but still below pre-pandemic levels
3. **April 2022-July 2022:** Observe a plateau/decline in hypertension monitoring across a number of places in the ICS and system wide initiative around hypertension and diabetes is initiated in July 2022
4. **August 2022 – October 2022:** Trends in hypertension recording improving in most areas

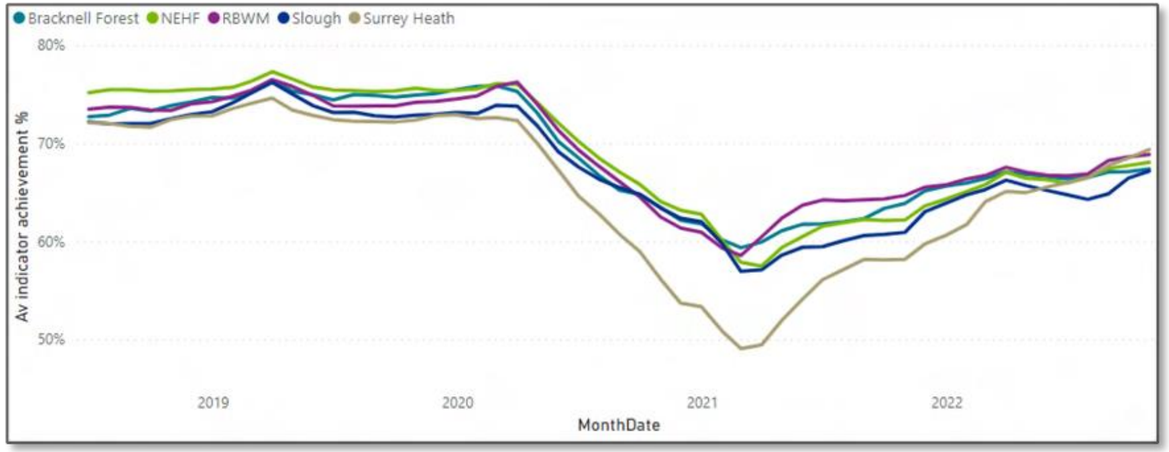
Frimley Health and Care

Recent trends – Aggregate achievement across a range of diabetes and hypertension indicators

Join the conversation

% achievement of indicators as of 31st October 2022 and change versus 30th June 2022

Data as of 31st Oct 2022



Place name		Bracknell Forest		NEHF		RBWM		Slough		Surrey Heath		**Total**	
Condition	IndicatorDescription	Current	Chge	Current	Chge	Current	Chge	Current	Chge	Current	Chge	Current	Chge
Diabetes	**Total**	**67.4%**	**1.4%**	**68.5%**	**1.4%**	**67.8%**	**1.1%**	**64.6%**	**0.9%**	**70.4%**	**1.7%**	**67.3%**	**1.2%**
	HbA1c <= 58 in last 12 months	54.3%	1.1%	55.9%	1.5%	54.1%	1.3%	49.6%	0.9%	56.9%	1.6%	**53.6%**	**1.2%**
	HbA1c <= 64 in last 12 months	63.5%	1.9%	65.3%	1.5%	64.1%	1.5%	59.4%	1.0%	67.4%	2.0%	**63.4%**	**1.5%**
	HbA1c reviewed in last 12 months	84.6%	1.2%	84.2%	1.1%	85.1%	0.6%	84.9%	0.8%	87.0%	1.5%	**85.0%**	**1.0%**
Hypertension	**Total**	**67.3%**	**0.8%**	**67.8%**	**2.6%**	**69.4%**	**2.7%**	**69.7%**	**4.0%**	**68.8%**	**4.3%**	**68.6%**	**2.8%**
	Blood pressure <= 140/90 for 0-79yo in last 12 months	56.1%	1.2%	54.4%	2.7%	57.6%	2.9%	60.0%	3.9%	56.3%	4.0%	**56.8%**	**2.9%**
	Blood pressure <= 150/90 for 80yo+ in last 12 months	70.1%	1.0%	69.1%	2.5%	72.5%	2.0%	72.6%	2.2%	69.2%	4.6%	**70.6%**	**2.4%**
	Blood pressure reviewed in last 12 months	75.9%	0.3%	77.9%	2.4%	77.6%	2.7%	77.6%	4.3%	78.0%	4.4%	**77.5%**	**2.8%**
Total		**67.4%**	**1.0%**	**68.1%**	**2.1%**	**68.9%**	**2.2%**	**67.2%**	**2.4%**	**69.4%**	**3.4%**	**68.1%**	**2.2%**

Frimley Health and Care

Recent trends – Variation by ethnicity and deprivation

Join the conversation

% achievement of indicators as of 31st October 2022 and change versus 30th June 2022

Data as of 31st Oct 2022

Ethnicity L1		Asian or Asian British		Black or Black British		Mixed		Other Ethnic Groups		White		**Total**	
Condition	IndicatorDescription	Current	Chge	Current	Chge	Current	Chge	Current	Chge	Current	Chge	Current	Chge
Diabetes	**Total**	**65.7%**	**0.7%**	**65.3%**	**1.9%**	**67.1%**	**1.1%**	**67.1%**	**1.4%**	**68.4%**	**1.4%**	**67.3%**	**1.2%**
	HbA1c <= 58 in last 12 months	51.0%	0.5%	52.0%	1.6%	53.4%	-0.8%	54.4%	1.0%	**55.1%**	**1.6%**	53.6%	1.2%
	HbA1c <= 64 in last 12 months	61.2%	0.6%	59.5%	1.8%	63.9%	1.7%	63.4%	1.4%	**64.9%**	**1.8%**	63.4%	1.5%
	HbA1c reviewed in last 12 months	85.0%	0.9%	84.4%	2.4%	84.1%	2.3%	83.5%	1.7%	**85.2%**	**0.8%**	85.0%	1.0%
Hypertension	**Total**	**69.2%**	**2.8%**	**64.9%**	**3.6%**	**65.6%**	**2.9%**	**66.7%**	**3.0%**	**68.8%**	**2.8%**	**68.6%**	**2.8%**
	Blood pressure <= 140/90 for 0-79yo in last 12 months	58.7%	2.6%	53.1%	3.7%	54.5%	3.3%	55.5%	3.4%	**56.7%**	**2.9%**	56.8%	2.9%
	Blood pressure <= 150/90 for 80yo+ in last 12 months	69.4%	1.6%	66.9%	0.4%	70.5%	4.3%	71.3%	2.4%	**70.7%**	**2.5%**	70.6%	2.4%
	Blood pressure reviewed in last 12 months	78.5%	3.1%	75.5%	3.7%	74.9%	2.2%	74.7%	2.6%	**77.6%**	**2.7%**	77.5%	2.8%
Total		**67.3%**	**1.6%**	**65.1%**	**2.9%**	**66.3%**	**2.0%**	**66.8%**	**2.3%**	**68.7%**	**2.3%**	**68.1%**	**2.2%**

Deprivation Pentile		1		2		3		4		5		**Total**	
Condition	IndicatorDescription	Current	Chge	Current	Chge	Current	Chge	Current	Chge	Current	Chge	Current	Chge
Diabetes	**Total**	**64.6%**	**0.3%**	**65.0%**	**1.6%**	**65.7%**	**0.7%**	**67.9%**	**1.3%**	**69.5%**	**1.4%**	**67.3%**	**1.2%**
	HbA1c <= 58 in last 12 months	50.1%	1.3%	50.2%	1.5%	51.5%	0.6%	54.2%	1.2%	**56.9%**	**1.4%**	53.6%	1.2%
	HbA1c <= 64 in last 12 months	59.8%	-0.4%	60.0%	2.0%	60.9%	0.5%	64.1%	1.6%	**66.7%**	**1.7%**	63.4%	1.5%
	HbA1c reviewed in last 12 months	84.0%	-0.2%	84.7%	1.2%	84.8%	0.9%	85.4%	1.1%	**85.1%**	**1.0%**	85.0%	1.0%
Hypertension	**Total**	**70.7%**	**3.6%**	**69.8%**	**3.6%**	**68.3%**	**2.7%**	**69.4%**	**3.2%**	**67.9%**	**2.4%**	**68.6%**	**2.8%**
	Blood pressure <= 140/90 for 0-79yo in last 12 months	60.0%	3.2%	58.8%	3.8%	56.4%	2.6%	57.8%	3.7%	**55.5%**	**2.4%**	56.8%	2.9%
	Blood pressure <= 150/90 for 80yo+ in last 12 months	70.8%	3.9%	71.2%	1.2%	72.0%	2.9%	70.9%	3.1%	**70.0%**	**2.3%**	70.6%	2.4%
	Blood pressure reviewed in last 12 months	80.0%	3.8%	79.0%	3.8%	77.4%	2.7%	78.1%	2.8%	**76.7%**	**2.4%**	77.5%	2.8%
Total		**67.7%**	**1.9%**	**67.5%**	**2.6%**	**67.2%**	**1.8%**	**68.8%**	**2.5%**	**68.5%**	**2.1%**	**68.1%**	**2.2%**

Frimley Health and Care

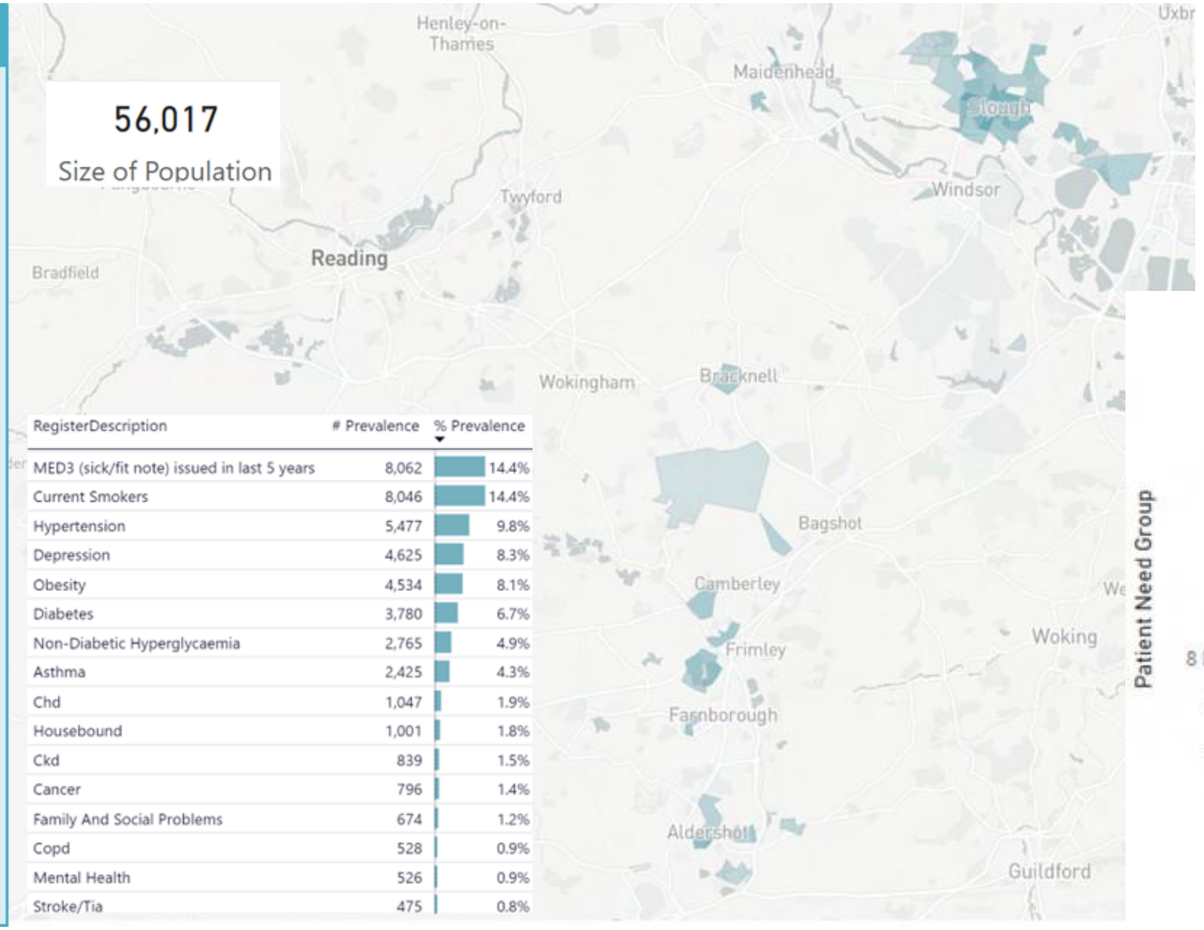
Population health insights can identify not only households at risk of fuel poverty, but also those at greater risk due to a range of health conditions

Deprivation Decile 1-4, EPC D-G [Frimley ICS and living in Frimley]

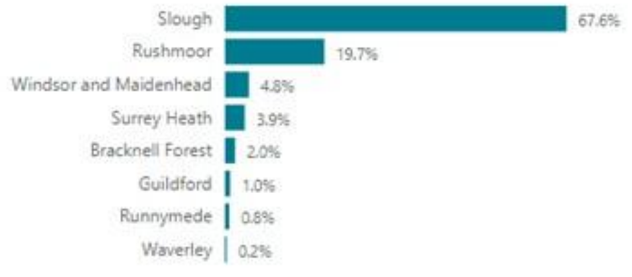
Join the conversation

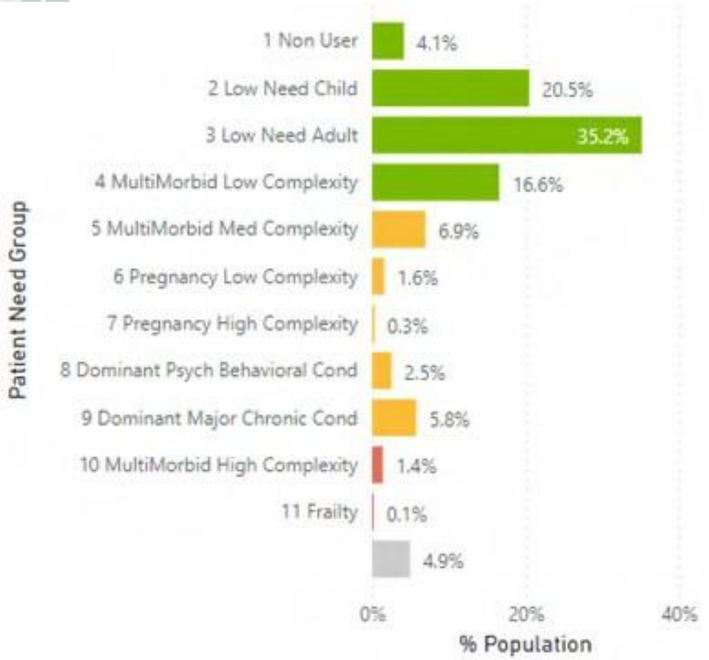
Key insights

- **56k** residents in Frimley ICS living in deprived areas (Deprivation deciles 1-4) and poorly insulated homes (Energy Performance Certificate (EPC) rating of D,E,F or G)
- **1.4%** are in the highest patient need health segments
- **17.1%** are in moderate patient need heath segments
- **76.5%** are in lower patient need health segments
- 0.9% (528) have COPD and 4.3% (2,425) have Asthma – conditions which can be exacerbated by cold homes
- 8,121 under 10's
- 4,404 patients who look like they live by themselves
- 837 with LD or SMI
- 4,625 with depression



RegisterDescription	# Prevalence	% Prevalence
MED3 (sick/fit note) issued in last 5 years	8,062	14.4%
Current Smokers	8,046	14.4%
Hypertension	5,477	9.8%
Depression	4,625	8.3%
Obesity	4,534	8.1%
Diabetes	3,780	6.7%
Non-Diabetic Hyperglycaemia	2,765	4.9%
Asthma	2,425	4.3%
Chd	1,047	1.9%
Housebound	1,001	1.8%
Ckd	839	1.5%
Cancer	796	1.4%
Family And Social Problems	674	1.2%
Copd	528	0.9%
Mental Health	526	0.9%
Stroke/Tia	475	0.8%





Frimley Health and Care

Join the conversation

Creating healthier communities with everyone