# Chapter 7: Strengthen the Role & Impact of Ill Health Prevention

# Cardiovascular disease

*Lead author: Dr Sapna Chauhan*

## Introduction

Cardiovascular disease (CVD) is an overarching terms that describes a family of diseases including coronary heart disease, stroke, and kidney disease sharing a common set of risk factors.

- 4.9 million people aged 16 or over in England have CVD, which is 11.7% of the population.
- CVD is responsible for 200,000 deaths per year- 1 in 3 deaths in UK.
- The combined cost of cardiovascular disease to the NHS and UK economy is estimated at £30 billion.

Preventing cardiovascular disease may also reduce the burden on social care, families and carers by preventing long-term illness and disability from heart attacks, strokes and other conditions caused by cardiovascular disease.

The prevalence of CVD increases with deprivation and is more common among people from black and minority ethnic groups, including South Asian, African and African-Caribbean descent.

A number of common risk factors are recognised as increasing the likelihood of individuals developing CVD. There are three broad groups.

Fixed risk factors are by definition non-modifiable, but are taken into account in advising people about their overall risk:
- age;
- gender; and
- family history/genetic factors.

Lifestyle/behavioural risk factors reflect an individual's circumstances and choices, and can be changed for the better to reduce personal risk:

- smoking;
- physical inactivity;
- poor diet;
- obesity; and
- harmful use of alcohol.

'Bodily' risk factors reflect changes to body systems that are also reversible or preventable in their early stages, but may require medical treatment:

• hypertension/raised blood pressure;

• raised cholesterol/disordered lipids;

• Impaired glucose tolerance/diabetes; and

• chronic kidney disease (CKD).

Obesity is a major cause of cardiovascular disease. Currently 1 in 3 adults and children are overweight or obese. By 2050 these figures are projected to rise to 9 in 10 adults and 2 in 3 children, at a cost of £50 billion per year.

The complications of diabetes also share the same modifiable risk factors as CVD and having diabetes increases individuals' risk of CVD.

There are also significant issues for different equality groups in the population. For example people with mental health problems have a much higher incidence of CVD, and poorer outcomes. Depression has been associated with a four-fold increase in the risk of cardiovascular disease, even when other factors are controlled.[1]

## Level of need in Ealing

### Prevalence

It is estimated that CVD in Ealing affects 24,063 people. 9.39% of the adult (aged 16+) population is affected by CVD. This is lower than both London (9.7%) and England (11.7%) for the same year. The prevalence of CVD in Ealing is predicted to increase for males and females within the next 10 years, resulting in an additional burden on health and social care services [2].

Table 1 shows recorded and expected prevalence rates for various cardiovascular disorders in Ealing. The ratios of recorded against predicted prevalence indicate that there are about 68% of coronary heart disease, 27% of hypertension and 56% of stroke cases that remain undiagnosed in Ealing. Hypertension shows the biggest gap.  With increasing trends in obesity levels it is anticipated there will be a significant increase in the number of diabetes and pre-diabetes, which is likely to have an impact on the incidence of CVD. Case finding for CVD is therefore an important strategy in reducing the number of undiagnosed patients and hence providing appropriate care.

---

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/217118/9387-2900853-CVD-Outcomes_web1.pdf

[2] http://www.apho.org.uk/diseaseprevalencemodels

Table 1: GP Recorded and expected cardiovascular disease (CVD) prevalence in Ealing.

| CVD Conditions | GP recorded Prevalence (QOF 2012/13) | | Expected Prevalence All Ages | | Undiagnosed cases | |
| | Number | % | Number | % | number | Ratio (recorded/expected prevalence) |
|---|---|---|---|---|---|---|
| Coronary Heart Disease | 10,090 | 2.5 | 13,283 | 3.4 | 3,193 | 0.32 |
| Hypertension | 46,743 | 11.5 | 80,862 | 21 | 34,119 | 0.73 |
| Stroke | 3,872 | 0.9 | 5,565 | 1.4 | 1,693 | 0.44 |
| Atrial Fibrillation | 3,462 | 0.8 | N/A | N/A | N/A | N/A |
| Heart Failure | 1,900 | 0.5 | N/A | N/A | N/A | N/A |

*Source: NHS Indicators Portal*

The borough has a higher burden of lifestyle risk factors for circulatory disease which includes smoking, physical inactivity, higher level of alcohol intake, unhealthy eating and obesity.

## Hospital Admissions

Ealing has the highest CVD elective admission rate (7/1,000) in London which is also higher than the London (5.4/1,000) and England (4.6/1,000) averages. In 2012/13 a total of 2127 admissions were reported which were higher than expected (718 more admissions) (Figure 1)

Figure 1: CVD Elective (Inpatient and Day Case) admissions per 1,000 population London CCGs and England, 2012/13
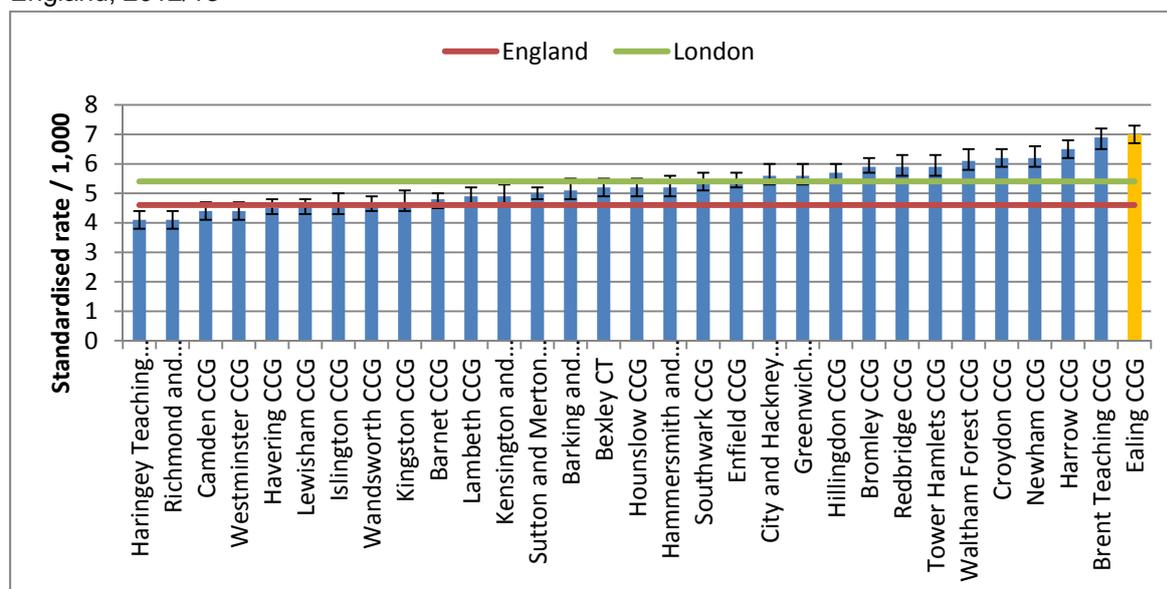


*Source NHS Comparators*

Ealing has a higher CVD Emergency admission rate (3.8/1,000) than the England average (3.3/1,000). In 2012/13 a total of 963 admissions were reported which were higher than expected (159 more admissions) (Figure 2).

Figure 2: CVD Emergency admissions per 1,000 population, London CCGs and England, 2012/13
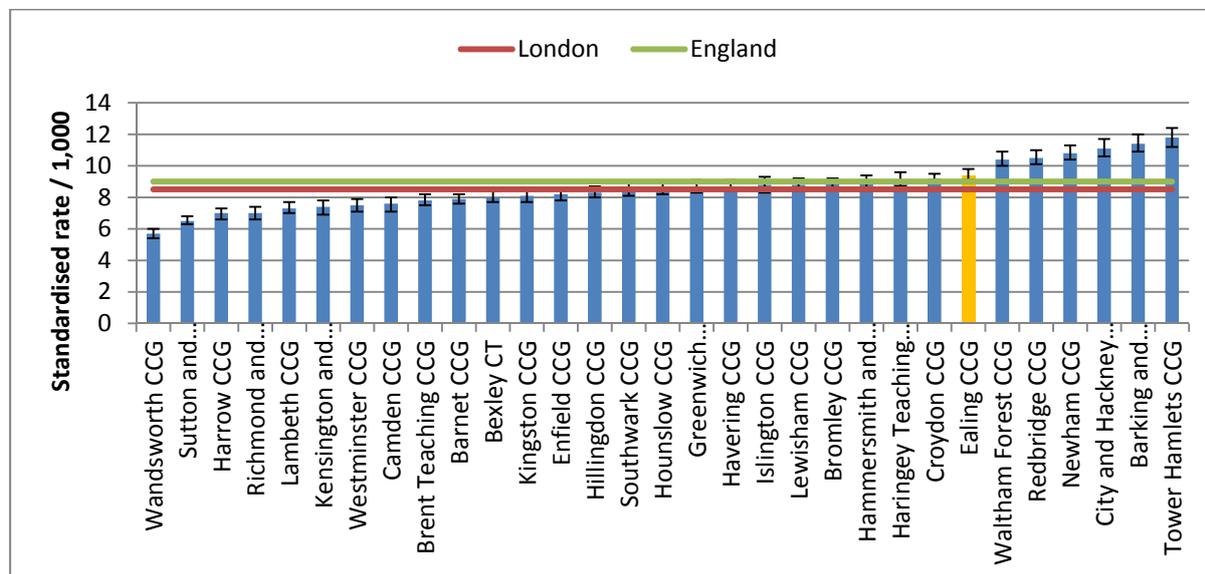


*Source NHS Comparators*

Table 2 shows CHD and Stroke standardised emergency admission ratios[3] for LB Ealing and wards. A locality with the same death rate as the standard population would have a SMR of 100. During the 2008-2013 period a total of 4,708 CHD and 1,767 Stroke admissions were reported. Ealing had significantly more admissions than expected for both CHD and stroke.

Table 2: CHD and Stroke emergency standardised admission ratios (SAR), Ealing wards, LB Ealing and England, 2008-2013

| Area Name | CHD observed admissions | SAR CHD | Stroke observed admissions | SAR Stroke |
|---|---|---|---|---|
| **Acton Central** | 196 | 142.3 | 68 | 97.5 |
| **Cleveland** | 129 | 80.3 | 84 | 104.5 |
| **Dormers Wells** | 326 | 242.1 | 78 | 119.3 |
| **Ealing Broadway** | 132 | 91.5 | 72 | 93.7 |
| **Ealing Common** | 154 | 106.3 | 70 | 95.3 |
| **East Acton** | 188 | 125.5 | 63 | 84.6 |
| **Elthorne** | 198 | 150.9 | 72 | 113.1 |
| **Greenford Broadway** | 255 | 148.3 | 115 | 128.5 |
| **Greenford Green** | 180 | 126.7 | 76 | 108.5 |
| **Hanger Hill** | 166 | 102.3 | 76 | 90.5 |

[3] The Standardised Admission Ratio (SMR) is the ratio of the number of admissions observed in a specified population to the number that would be expected if that population experienced the same admission rate, age and sex structure as a reference population (in this case England).

| Area Name | CHD observed admissions | SAR CHD | Stroke observed admissions | SAR Stroke |
|---|---|---|---|---|
| Hobbayne | 159 | 108.5 | 95 | 130.3 |
| Lady Margaret | 277 | 200.0 | 93 | 139.6 |
| North Greenford | 203 | 135.8 | 73 | 99.9 |
| Northfield | 145 | 105.6 | 68 | 98.2 |
| Northolt Mandeville | 185 | 126.6 | 78 | 106.5 |
| Northolt West End | 234 | 166.8 | 67 | 95.7 |
| Norwood Green | 319 | 241.6 | 78 | 118.0 |
| Perivale | 247 | 163.5 | 95 | 131.4 |
| South Acton | 162 | 114.8 | 63 | 88.6 |
| Southall Broadway | 334 | 267.1 | 93 | 155.1 |
| Southall Green | 294 | 249.5 | 82 | 149.1 |
| Southfield | 81 | 63.5 | 44 | 73.9 |
| Walpole | 142 | 114.2 | 65 | 104.5 |
| Ealing LB | 4,708 | 144.5 | 1,767 | 109.2 |
| England | 706,513 | 100.0 | 368,284 | 100.0 |

*Source: Public Health England*
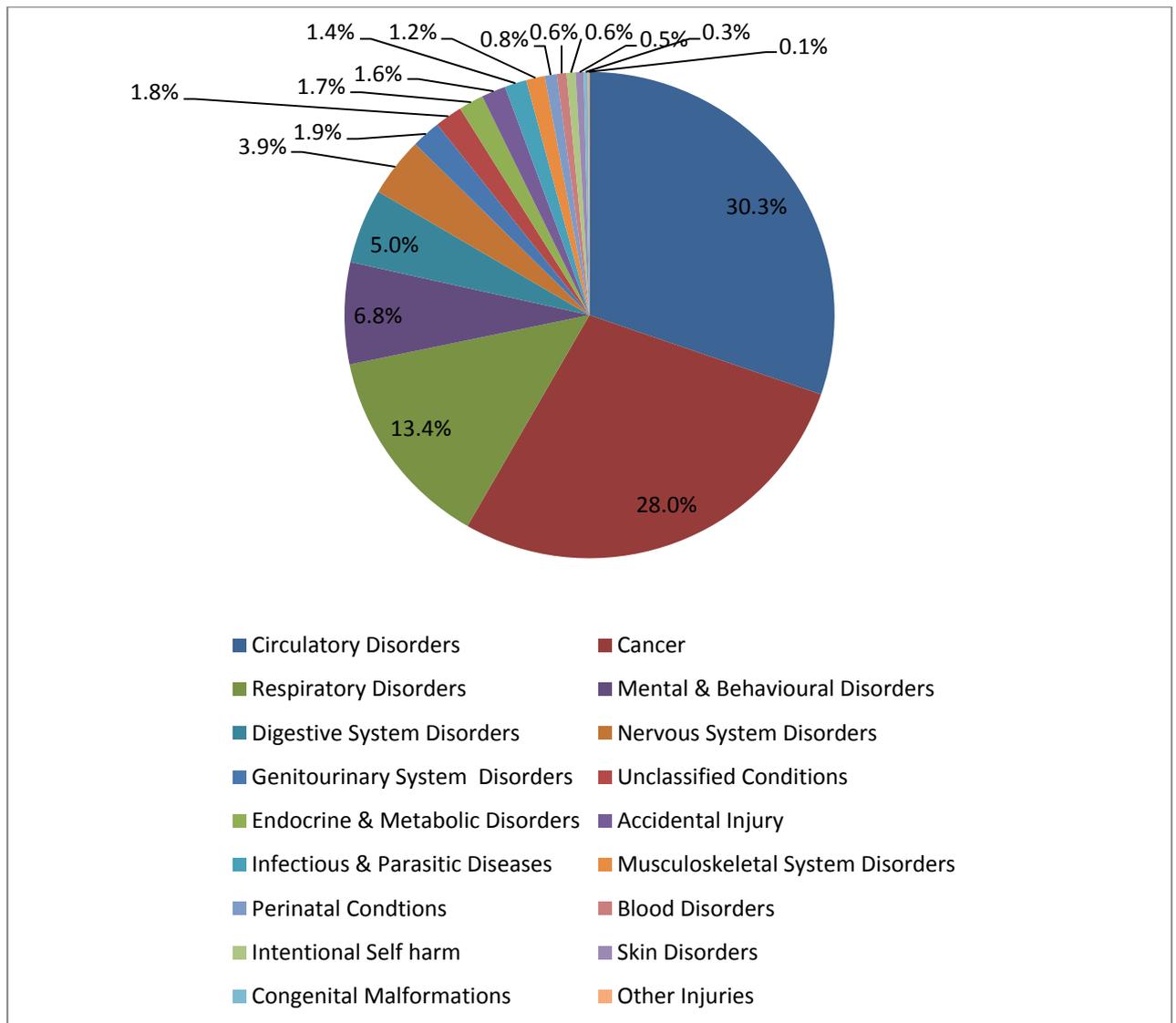
**Key**

| | |
|---|---|
| 🟩 | Statistically significantly less admissions than expected |
| 🟧 | The difference is not statistically significant |
| 🟥 | Statistically significantly more admissions than expected |

## Mortality

There were a total of 1,875 deaths reported in Ealing in 2013. Circulatory disorders accounted for nearly a third of all deaths (568 deaths, 30%) (Figure 3)

Figure 3: Causes of death in Ealing, 2013 (n=1,875)



Legend:
- Circulatory Disorders
- Cancer
- Respiratory Disorders
- Mental & Behavioural Disorders
- Digestive System Disorders
- Nervous System Disorders
- Genitourinary System Disorders
- Unclassified Conditions
- Endocrine & Metabolic Disorders
- Accidental Injury
- Infectious & Parasitic Diseases
- Musculoskeletal System Disorders
- Perinatal Condtions
- Blood Disorders
- Intentional Self harm
- Skin Disorders
- Congenital Malformations
- Other Injuries

Source: ONS Primary Care Mortality Database

Ealing's CVD mortality rates for the period 2010-2012 were not significantly different from the London and England averages (Figure 4). However the Males and Persons under 75 mortality rates were significantly higher than the London and England averages (Figure 5).

Figure 4: CVD Mortality DSR All Ages, LB Ealing, London & England, 2010-2012
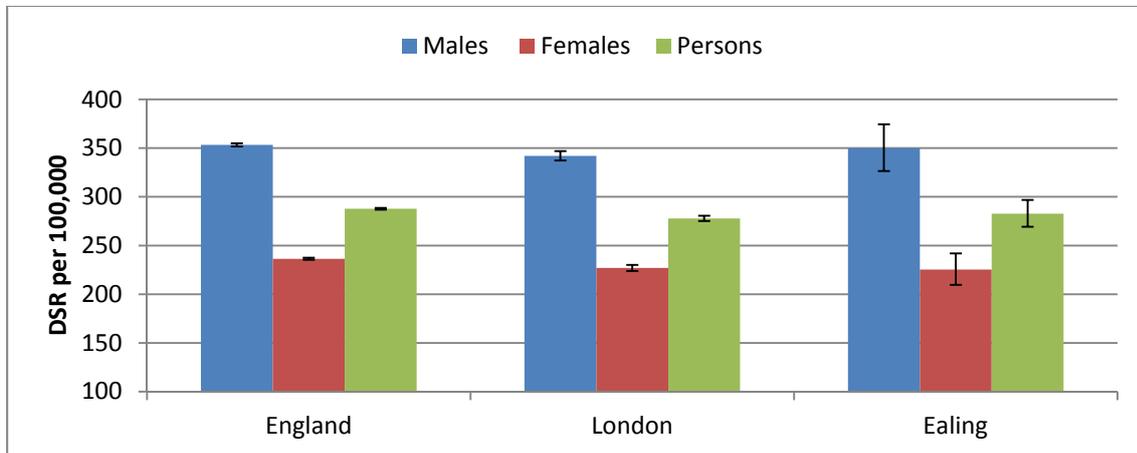


*Source: Office for National Statistics*

Figure 5: CVD Mortality DSR under 75, LB Ealing, London & England, 2010-2012
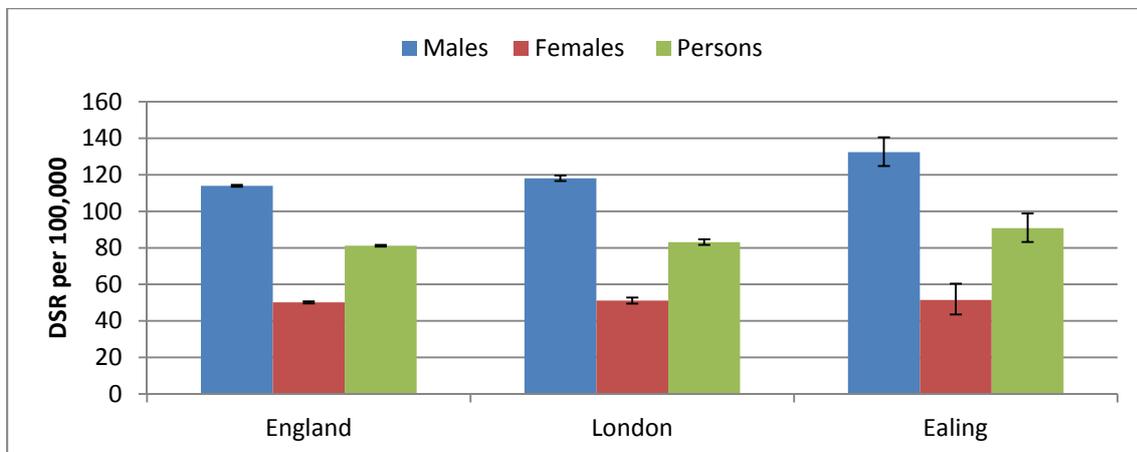


*Source: Office for National Statistics*

There were more circulatory disease related deaths than expected in Ealing during the 2008-2012 period. Among Ealing wards, Dormers Wells, Southall Broadway, Southall, Northolt West End and Norwood Green had more than expected number of deaths (Table 3).

Table 3: Circulatory diseases standardised mortality ratios, Ealing wards, LB Ealing and England, 2008-2012

| Area Name | Circulatory diseases all ages observed deaths | SMR all ages Circulatory diseases | Circulatory diseases under 75 observed deaths | SMR under 75 Circulatory diseases |
|---|---|---|---|---|
| Acton Central | 106 | 83.5 | 43 | 121.8 |
| Cleveland | 123 | 84.4 | 35 | 88.4 |
| Dormers Wells | 123 | 110.0 | 58 | 159.4 |
| Ealing Broadway | 134 | 87.3 | 29 | 83.5 |
| Ealing Common | 136 | 103.2 | 40 | 109.9 |
| East Acton | 115 | 92.2 | 41 | 108.5 |
| Elthorne | 125 | 108.4 | 43 | 126.9 |
| Greenford Broadway | 190 | 112.8 | 51 | 119.6 |
| Greenford Green | 124 | 98.1 | 40 | 101.7 |
| Hanger Hill | 132 | 80.8 | 33 | 79.1 |
| Hobbayne | 116 | 93.0 | 35 | 93.8 |
| Lady Margaret | 117 | 101.7 | 43 | 115.1 |
| North Greenford | 101 | 82.1 | 32 | 80.0 |
| Northfield | 90 | 75.5 | 26 | 74.8 |
| Northolt Mandeville | 129 | 96.6 | 50 | 133.8 |
| Northolt West End | 141 | 111.8 | 55 | 153.4 |
| Norwood Green | 132 | 103.2 | 50 | 146.4 |
| Perivale | 111 | 90.5 | 38 | 91.1 |
| South Acton | 162 | 114.3 | 35 | 96.4 |
| Southall Broadway | 140 | 148.1 | 61 | 181.6 |
| Southall Green | 104 | 126.2 | 52 | 164.8 |
| Southfield | 91 | 89.8 | 31 | 88.6 |
| Walpole | 108 | 95.2 | 39 | 116.4 |
|  |  |  |  |  |
| Ealing LB | 2,852 | 98.5 | 960 | 113.4 |
| England | 686,806 | 100.0 | 176,217 | 100.0 |

*Source: Public Health England*

**Key**

Statistically significantly less deaths than expected
The difference is not statistically significant
Statistically significantly more deaths than expected

CVD mortality rates have significantly declined in Ealing since 2000. There were 527 (135/100,000) CVD related deaths reported in 2012 as compared to 832 in 2000 (DSR 244/100,000). Ealing's mortality trend was not significantly different from the London's and England's (Figure 6).

Figure 6: CVD Mortality DSR All Ages, Persons, LB Ealing, London & England, 2000-2012
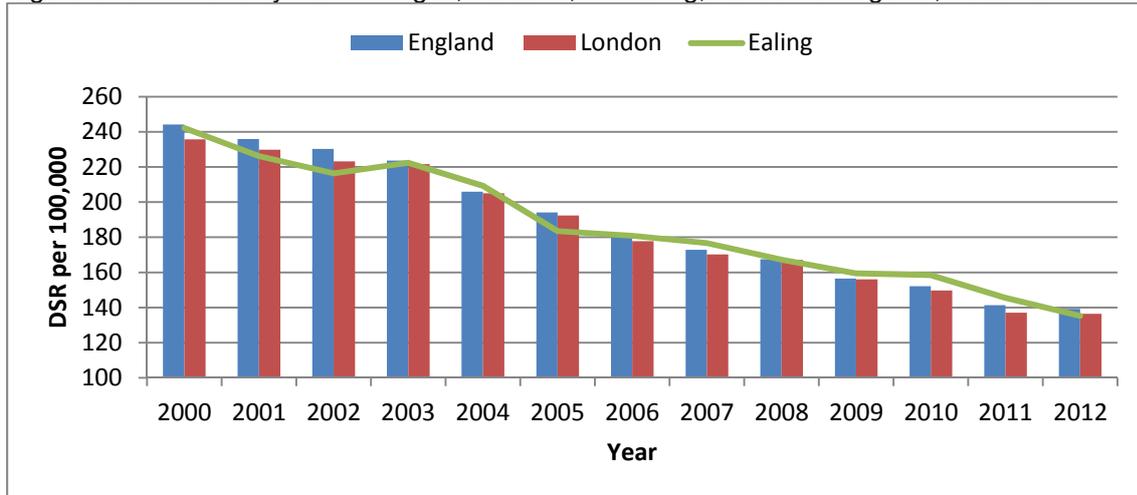


*Source: Office for National Statistics*

CVD mortality rates were higher among males as compared to females in Ealing, London and England during the 2000-2012 period. Ealing had a relatively higher mortality rate among males between 2009 and 2011 but the rate declined thereafter to similar levels as London and England (Figure 7). The females' mortality trend was not significantly different from the London's and England's.

Figure 7: CVD Mortality DSR by Gender, All Ages, Persons, LB Ealing, London & England, 2000-2012
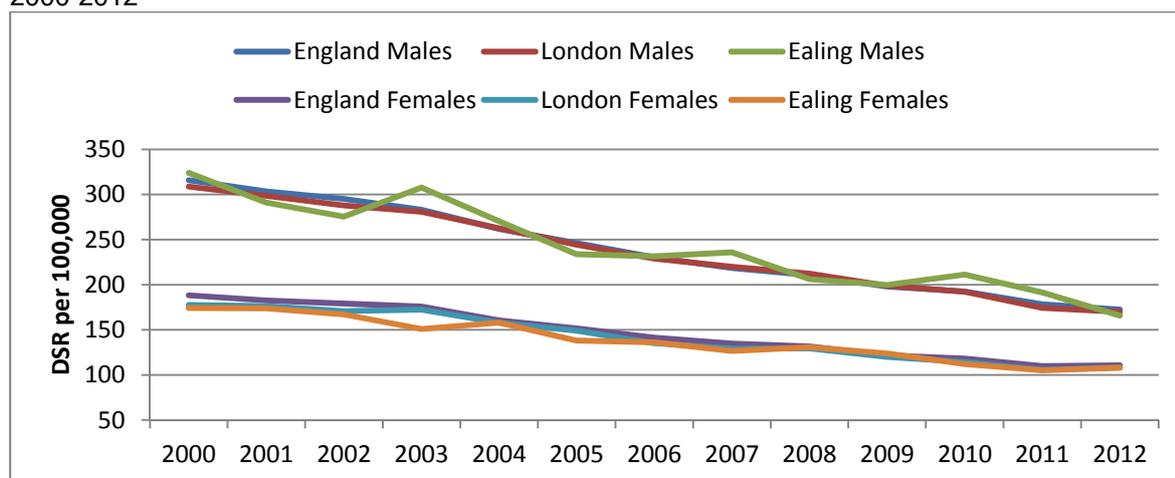


*Source: Office for National Statistics*

CVD mortality rates among persons aged under 75 also significantly declined in Ealing between 2000 and 2012. There were 165 (59/100,000) CVD related deaths reported in 2012 as compared to 295 in 2000 (119/100,000). Ealing's CVD Mortality rates among persons under 75 remained higher than the London and England averages during most of the 2000-2012 period (Figure 8).

The males and females under 75 CVD mortality rates also show a declining trend between 2000 and 2012. The Ealing males' mortality rate remained higher than the London and England averages during most of the 2000-2012 period but declined to similar levels in 2012 (Figure 9).

Figure 8: CVD Mortality DSR under 75, Persons, LB Ealing, London & England, 2000-2012
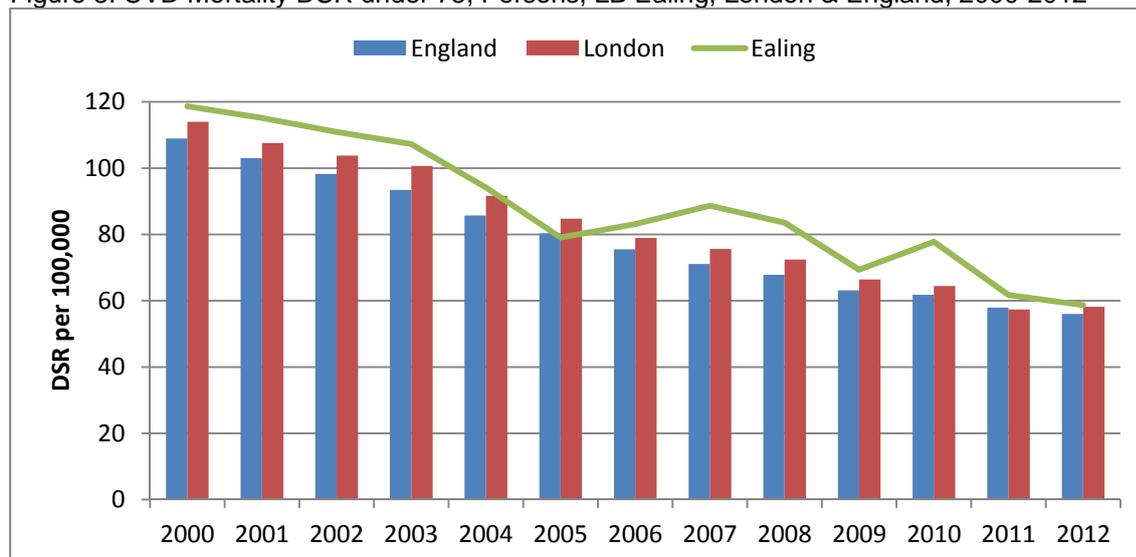


*Source: Office for National Statistics*

Figure 9: CVD Mortality DSR Under 75 by gender, LB Ealing, London & England, 2000-2012
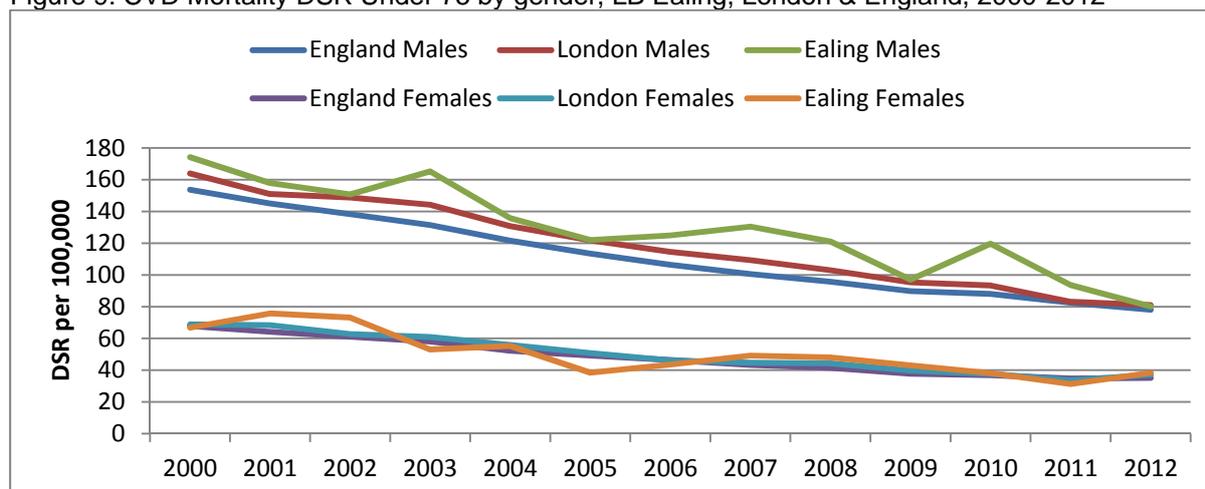


*Source: Office for National Statistics*

## QOF Performance 2012/13

Figures 10, 11 and 12 show Ealing CCG's CHD, Stroke & TIA, Heart Failure & Atrial Fibrillation QOF performance compared to the England average. QOF performance data for all practices in Ealing CCG can be accessed via this link: http://fingertips.phe.org.uk/profile/general-practice/data

## Coronary Heart Disease (CHD)

Figure 10: CHD QOF performance, Ealing CCG and England

| Indicator | Period | Practice Value | CCG Value | England Average | England Lowest | England Range | England Highest |
|---|---|---|---|---|---|---|---|
| CHD: QOF prevalence (all ages) | 2012/13 | - | 2.5% | 3.3% | 0.0% | | 9.1% |
| Estimated prevalence of CHD (all ages) | 2011 | - | 3.4% | 4.7% | 0.0% | | 12.9% |
| Ratio of recorded vs expected CHD prevalence | 2010/11 | - | - | 0.72 | 0.00 | | 2.72 |
| Heart failure w LVD: QOF prevalence | 2012/13 | - | 0.2% | 0.4% | 0.0% | | 2.5% |
| Exception rate for CHD indicators | 2012/13 | - | 9.5% | 9.5% | 0.0% | | 54.5% |
| CHD emergency admissions (per 100 patients on register) | 2010/11 | - | 8.2 | 7.1 | 0.0 | | 100.0 |
| CHD elective admissions (per 100 patients on register) | 2010/11 | - | 8.1 | 5.3 | 0.0 | | 57.1 |
| CHD 6: Last BP reading in last 15mths is <=150/90 | 2012/13 | - | 89.9% | 90.6% | 0.0% | | 100% |
| CHD 8: Last total cholesterol is <=5mmol/l | 2012/13 | - | 78.8% | 80.1% | 0.0% | | 100% |
| CHD 9: Record that aspirin, APT or ACT is taken | 2012/13 | - | 93.9% | 93.3% | 67.6% | | 100% |
| CHD 10: Currently treated with beta blocker | 2012/13 | - | 76.3% | 76.3% | 43.8% | | 100% |
| CHD 12: CHD patients given flu immunisation 1 Sep - 31 Mar | 2012/13 | - | 91.8% | 92.2% | 0.0% | | 100% |
| CHD 14: History of MI: treated with ACE-I | 2012/13 | - | 88.6% | 88.2% | 0.0% | | 100% |

*Source: National GP Profiles*

## Stroke & TIA

Figure 11: Stroke & TIA QOF performance Ealing CCG and, England

| Indicator | Period | Practice Value | CCG Value | England Average | England Lowest | England Range | England Highest |
|---|---|---|---|---|---|---|---|
| Stroke: QOF prevalence (all ages) | 2012/13 | - | 0.9% | 1.7% | 0.0% | | 6.5% |
| Estimated prevalence of stroke (all ages) | 2011 | - | 1.42% | 2.07% | 0.16% | | 5.44% |
| Ratio of recorded vs expected stroke prevalence | 2010/11 | - | - | 0.83 | 0.00 | | 2.84 |
| Exception rate for stroke indicators | 2012/13 | - | 7.9% | 7.7% | 0.0% | | 75.0% |
| Stroke 13: New patients referred for further investigation | 2012/13 | - | 91.6% | 88.7% | 0.0% | | 100% |
| Stroke 6: Last BP reading is 150/90 or less | 2012/13 | - | 89.4% | 89.3% | 40.0% | | 100% |
| PAD 3: last blood pressure reading (last 15 mnths) <=150/90 | 2012/13 | - | 93.3% | 89.6% | 0.0% | | 100% |
| Stroke 7: Total cholesterol recorded in last 15mths | 2012/13 | - | 92.3% | 91.0% | 0.0% | | 100% |
| PAD 4: last total cholesterol measurement (last 15 mnths) <= 5.0 mmol/l | 2012/13 | - | 84.9% | 79.9% | 0.0% | | 100% |
| Stroke 8: Last measured total cholesterol <=5mmol/l | 2012/13 | - | 78.8% | 77.3% | 0.0% | | 100% |
| Stroke 12: Record of aspirin, APT or ACT taken | 2012/13 | - | 95.3% | 93.8% | 0.0% | | 100% |
| PAD 2: record of aspirin being taken (last 15 mnth) | 2012/13 | - | 94.8% | 90.4% | 0.0% | | 100% |
| Stroke 10: Influenza immunisation given 1 Sep-31 Mar | 2012/13 | - | 89.0% | 89.7% | 0.0% | | 100% |

*Source: National GP Profiles*

## Heart Failure & Atrial Fibrillation

Figure 12: Heart Failure & Atrial Fibrillation QOF performance, Ealing CCG and England

| Indicator | Period | Practice Value | CCG Value | England Average | England Lowest | England Range | England Highest |
|---|---|---|---|---|---|---|---|
| Heart Failure: QOF prevalence (all ages) | 2012/13 | - | 0.5% | 0.7% | 0.0% | | 3.9% |
| Heart failure w LVD: QOF prevalence | 2012/13 | - | 0.2% | 0.4% | 0.0% | | 2.5% |
| Exception rate for heart failure indicators | 2012/13 | - | 11.8% | 12.0% | 0.0% | | 100% |
| Atrial fibrillation: QOF prevalence | 2012/13 | - | 0.8% | 1.5% | 0.0% | | 5.1% |
| Exception rate for atrial fibrillation indicators | 2012/13 | - | 9.9% | 8.2% | 0.0% | | 100% |
| HF 2: Diagnosis conf. by ECG/specialist assessm. | 2012/13 | - | 97.0% | 95.3% | 0.0% | | 100% |
| HF 3: HF w LVD: treated with ACE-I or ARB | 2012/13 | - | 91.2% | 89.7% | 0.0% | | 100% |
| HF 4: Heart failure w LVD: treatment w ACE inh. or ARB, and beta-blocker | 2012/13 | - | 90.2% | 86.7% | 0.0% | | 100% |
| AF 5: stroke risk assessed with CHADS2 (last 15 mnths) | 2012/13 | - | 97.3% | 97.2% | 0.0% | | 100% |
| AF 6: treated w anti-coag./platelet therapy (if CHADS2 =1) | 2012/13 | - | 96.1% | 95.1% | 0.0% | | 100% |
| AF 7: treated w anti-coag. therapy (CHADS2 >1) | 2012/13 | - | 80.8% | 81.3% | 0.0% | | 100% |

**Spend**

Ealing spend a total £47,581,748 on circulatory disease related health and social care during the 2012/13 financial year. Most of the expenditure was on inpatient: non elective cases (34.8%).[4] The spend and outcome matrix (Figure 13) shows Ealing in the '*high spend worse outcome quadrant.*'

Figure 13: Ealing CCG Spend and Outcome Fact Sheet 2011/12
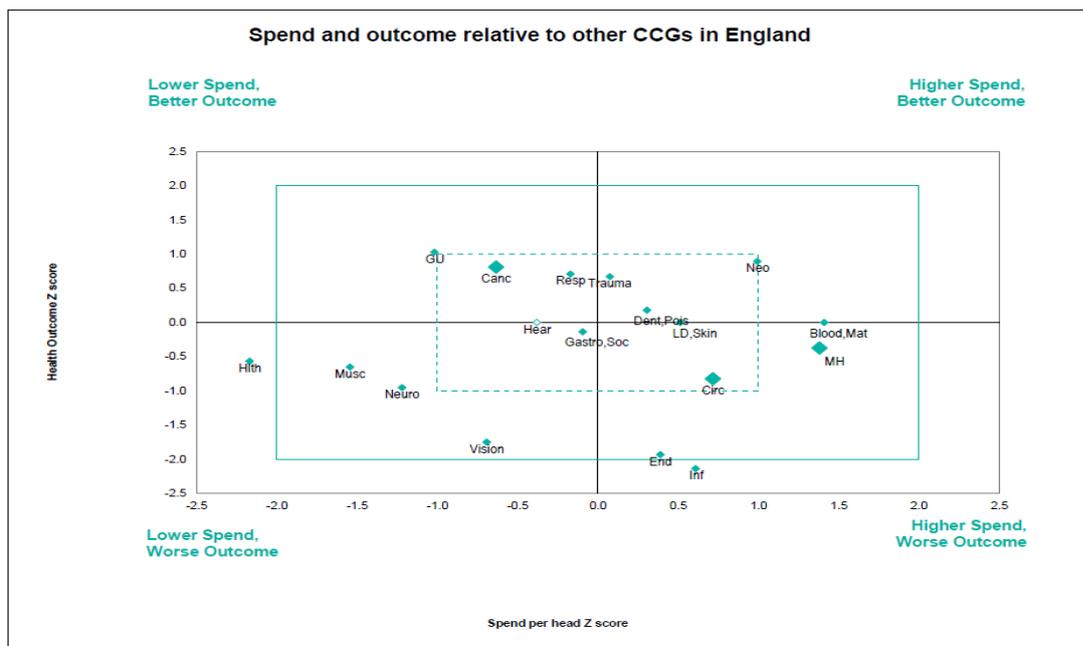


*Source: Public Health England*

# Current Interventions in Ealing

### Health Trainers

NHS Health Trainers in Ealing provide advice, motivation and practical support to adults who want to adopt healthier lifestyles. They give practical support and advice to help develop and maintain a healthy lifestyle, and act as a link between professionals and communities .Individuals can self-refer via email or phone or practices can refer.

---

[4] NHS England: Programme Budgeting Benchmarking Tool

**The Ealing Healthy Lifestyle Programme (EHLP)**

- A free comprehensive behaviour change 12-week programme for adults over 18 in relation to increasing physical activity, improving nutrition intake, maintaining a healthier weight and stopping smoking, for patients who meet the eligible criteria for the programme, identified though the NHS health check. Courses were run over 12 consecutive weeks, and each weekly session was split into 2 parts:
    - a) Lifestyle management and healthy eating talks with a dietician or outside speaker (45 min-1hour).
    - b) Exercise with a fully qualified exercise instructor (45 min-1hour).

| *EHLP performance for April 2013 – March 2014* | |
|---|---|
| | **Number** |
| *Referrals* | |
| *Total number of GP Referrals* | 389 |
| *Total number of Self Referrals* | 728 |
| *Total number of 'To Health' referrals ( community NHS health checks)* | 171 |
| *TOTAL NUMBER OF REFERRALS* | 1288 |
| *Courses* | |
| *TOTAL NUMBER OF COURSES RUN* | 30 |
| *Completers* | |
| *Total number of 3/12 completers on 12 week courses (i.e. attended 2 of first 3 core sessions and 1 of last 3 sessions)* | 444 |
| *Total number of 9/12 completers on 12 week courses (i.e. attended 9 or more sessions)* | 339 |
| *Conversion rate* *Conversion rate of referrals to completers on 12 week courses* | 34.47% |
| *Percentage of participants who attended at least 1 session who went on to become 3/12 completers* | 64.16% |

**Ealing Walks programme**

A programme of walks opens to all people across the borough. People who would like to undertake more activity can join on or more of the walks offered across Ealing on different days of the week at varying times including evenings and weekends.

**MEND (Physical Activity & Healthy Eating)**

MEND is a 10 – week family based healthy lifestyle programme for children aged 7 – 13 years, who are classified as overweight or obese through the national weighing and measuring programme in schools and their families. Sessions include physical activity, nutrition and support on motivating behaviour changes.

**NHS health checks**

The NHS health check programme for adults 40-74 years, serves a good opportunity to assess the risk of developing Type 2 diabetes and cardiovascular disease and to manage the risk factors of those identified at high risk to prevent disease progression and improve outcome. It is estimated that there are over 60,000 pre-diabetics in Ealing. The progression to Type 2 diabetes can be avoided in 60 per cent of people who are at high risk, if it is detected early and they are given lifestyle interventions.

In Ealing, NHS health programme is currently being delivered by 78 GP practices and a community outreach provider. The programme made significant progress last year, the uptake of health checks increased from 62% in 2012/13 to 75% in 2013/14. This is the second highest NHS Health Check uptake rate across London boroughs and in the top 5% of boroughs nationally. However, there are variations across practices. Many of the practices underperforming are in wards of great epidemiological need. We need to do more to increase uptake and referral to appropriate risk management services, particularly in those communities at greatest risk and make sure the programme is of consistent high quality across Ealing.

A community based NHS health check service was commissioned in January 2014 in order to provide equitable service delivery in Ealing borough, raise the public profile of NHS Health Checks in general, and target specifically those with highest CVD risk by focussing publicity on populations affected by specific determinants.

# NHS health check performance (April – March 2014)

Performance targets for the NHS Health Checks relate to the Public Health Outcomes framework indicators and are quarterly monitored at the corporate board level in Ealing Council.

In 2013/14 nearly 78,000 people were eligible for the NHS health check in Ealing. There are targets to invite 20% of eligible population and provide a NHS health check assessment for at least 75% of the 20% eligible patients invited in 2013/14.

- In 2013/14 **22.1% of the eligible Ealing population were offered** a health check compared to 21% in London.

- The targets on number of NHS health check received increased by 14% in Ealing, this represents 62% in 2012/13 to 75.6% in 2013/14.

- In 2013/14 **13,023 health checks were received** in Ealing, **11,514 by GP practices and 1,508 by To Health** at various community settings across Ealing.

**Findings from Community NHS health checks (Jan- March 2014)**
A health check was carried out on 1508 people who qualified under the eligibility criteria. The following report refers to them as the screened population. These health checks were carried out at 39 different locations in Ealing. 1508 people completed a full health check and had a risk score recorded.

**Demographics**
- Of 1508 people undergoing health checks, 899 were females (60%) and 610 males (40%).
- The most common ethnic groups were 420 Indian or British Indian (28%), 259 White British (17%) and 190 Other Asian (16%).

**Distribution by Age**



(Age: 55 - 64) - 326 - 21.60 %
(Age: 65 - 74) - 145 - 9.61 %
(Age: 45 - 54) - 638 - 42.28 %
(Age: 40 - 44) - 400 - 26.51 %
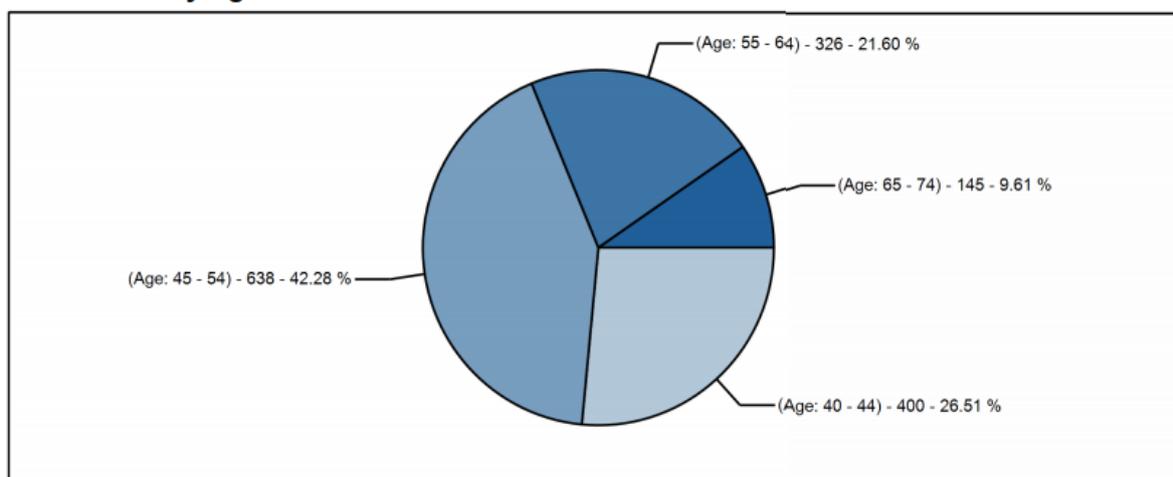
Pie-chart showing the age distribution of people.

- Out of the screened population, 1354 people (90%) were recorded as being registered to a GP Practice. **155 people (10%) indicated that they were not registered with a GP.**

## Cardiovascular Risk (QRISK2)

Of the screened population 1508 individuals had a QRISK2 risk score recorded

- **57 people were found with a risk score of 20% or greater**, 44 males and 13 females.
- **196 people were found with risk score between 10% - 20%,** 98 males and 98 females
- 1256 people had a risk score lower than 10%, 468 males and 788 females

**Cardiovascular Risk (QRISK2)**

| | Average | Std.Dev. | Min. | Max. | TOTAL |
|---|---|---|---|---|---|
| **QRISK2 <10%** | 3.90 | 2.51 | 0.40 | 9.90 | 1256 |
| **QRISK2 >=10%** | 13.45 | 2.58 | 10.00 | 19.80 | 196 |
| **QRISK2 >=20%** | 25.50 | 5.38 | 20.10 | 51.40 | 57 |
| | | | | | 1509 |

Table of QRISK2 Risk Score distribution for all 1509 people who had a risk score recorded. Individuals requiring urgent referral might not have completed the check sufficiently for a QRISK2 score to be generated.

## Blood Pressure

363 people (24%) were found to have an elevated blood pressure.
173 men (11%) and 190 women (13%) were recorded as having elevated blood pressure.

**Blood Pressure**



363 - 24.06 %
1146 - 75.94 %
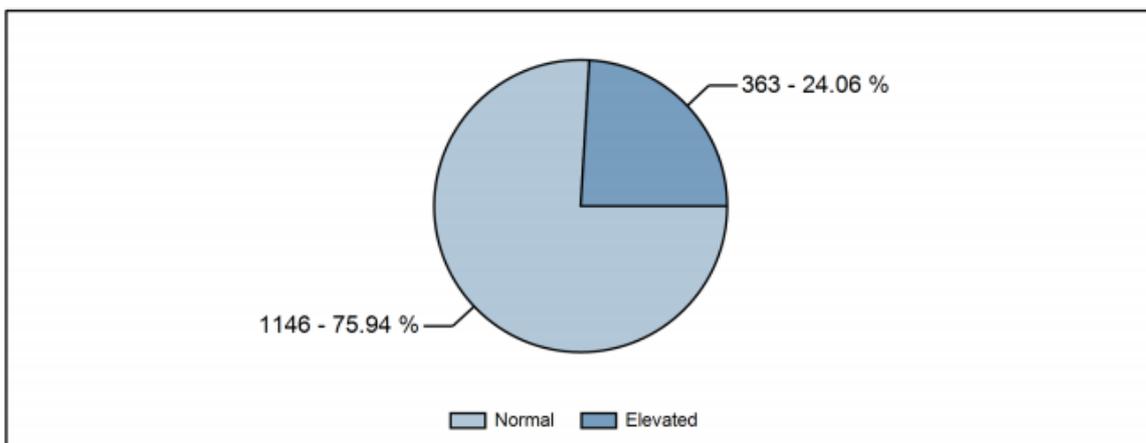
Normal    Elevated

Pie chart showing results of individuals according to their blood pressure reading. Elevated blood pressure is defined as systolic >= 140 mmHg and/or diastolic >= 90mmHg.

**Cholesterol**

Normal Total Cholesterol (TC) is defined as a TC reading < 5mmol/L.
Raised Total Cholesterol (TC) is defined as a TC reading >= 5mmol/L and < 7.5mmol/L.
 High TC is defined as a TC reading >= 7.5mmol/L.
Normal Cholesterol Ratio (TC/HDL) is defined as < 4.5.

| |
|---|
| Out of the screened population 901 people (100.0%) had a serum cholesterol reading recorded. |
| Of these 817 people (54.1%) had a serum cholesterol value within the normal range. **667 (44.2%) people presented a *raised level* Whilst 25 people (2%) were recorded as having *high serum cholesterol*.** |
| Results for the total cholesterol/HDL ratio for people who had a cholesterol reading recorded showed that 1,136 people (75%) had a ratio within the normal range |

**HbA1c**

Normal HbA1c is defined as < 42 mmol/mol.
Raised HbA1c is defined as >= 42mmol/mol and < 48 mmol/mol.
High HbA1c is defined as >= 48 mmol/mol and < 86 mmol/mol.
Very high HbA1c is defined as >= 86 mmol/mol.

| |
|---|
| Out of the screened population 786 people (52.1%) required an HbA1c test to be carried out because they had a BMI >= 30 (27.5 for South Asian) or an elevated blood pressure. |
| Of these: |
| 621 people (79.0%) had a normal HbA1c reading. |
| **119 people (15.1%) had a raised result. 45 people (5.7%) had a result that was high and 1 people (0.1%) had a reading in the very high range.** |

**BMI**

| |
|---|
| Out of the screened population, 1,509 people (100.0%) had a BMI reading recorded. |
| Of these: |
| 449 people (29.8%) had a normal BMI value. |
| 490 people (32.5%) were in the overweight category whilst 570 people (37.8%) were classified as obese |

.

**Pulse rate**

| |
|---|
| Out of the screened population, 1,509 people (100.0%) had a pulse check performed. |
| Of these: |
| There were 4 people (0.3%) who were considered to have an irregular pulse. |

**Inward and Outward Referrals**

| Service Area | Count |
|---|---|
| Physical Activity Referral Service | 193 |
| CVD Risk Referral Service | 130 |
| Stop Smoking Referral Service | 10 |
| Alcohol Referral Service | 8 |
| Weight Management Referral Service | 258 |
| Dementia Awareness Advice | 125 |

All results of every NHS Health Check to the GP Practice that has been specified by the patient at the time of the check, ensuring the patients' GP is made aware that their patient has used this service along with the results of the check. The process used to transfer data strictly follows the Information Governance guidelines and protocols

## Identified needs and intervention gaps

There is a wide programme of preventative programmes in place, covering the four major risk factors for the condition (smoking, diet, physical activity and alcohol). However, **the referrals to services are low** and there are issues around those at highest need are not necessarily taking up these interventions due to a number of perceived individual barriers.

There are gaps in current service provision in particular community based cardiac rehabilitation programmes in Ealing. Cardiac rehabilitation is fundamental to the care of CHD patients and has been shown to have a significant positive impact on patients' health. It is important that this service continues to be closely monitored and efforts made to increase uptake above the national average.

# Recommendations for Commissioners

1. Address the primary prevention of CVD through the NHS health checks programmes, address practice variation in the management of patients identified as being at high risk of CVD though the Health checks programme

2. Improve AF care pathway to promote proactive case finding, identify and appropriately manage high risk patients to improve prescribing of anticoagulants adhering to NICE guidance.

3. Continue to designate smoking as a priority in reducing prevalence to achieve NHS and Local targets whilst reducing health inequalities.

4. Maintain and develop the self-care programme to enable those with CVD to effectively manage and live with their condition.

5. Commissioners need to ensure that there is provision of support for lifestyle interventions such as physical activity, healthy eating, sensible drinking, smoking cessation and weight management; and consider the creation of integrated community lifestyle service model.

6. Commissioners across the partnership need to identify how to integrate work on the wider long term conditions agenda to streamline pathways of care, with a focus on putting prevention first, reducing unnecessary hospital admissions, and ensuring early discharge from hospitals. .

7. Active case management of patients with CVD within community should be considered to reduce the rate of emergency admissions and complications. The implementation of community based cardiology service may result in lower admission rates.

8. Commissioning cardiac rehabilitation, particularly the extension of hospital phase II rehab into phase III will improve the quality of care received by patients who may not want to go back to hospital for cardiac rehab.