Hertfordshire and West Essex Integrated Care System

NHS
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Cardiovascular Disease: Heart Failure

HWE PHM insights pack

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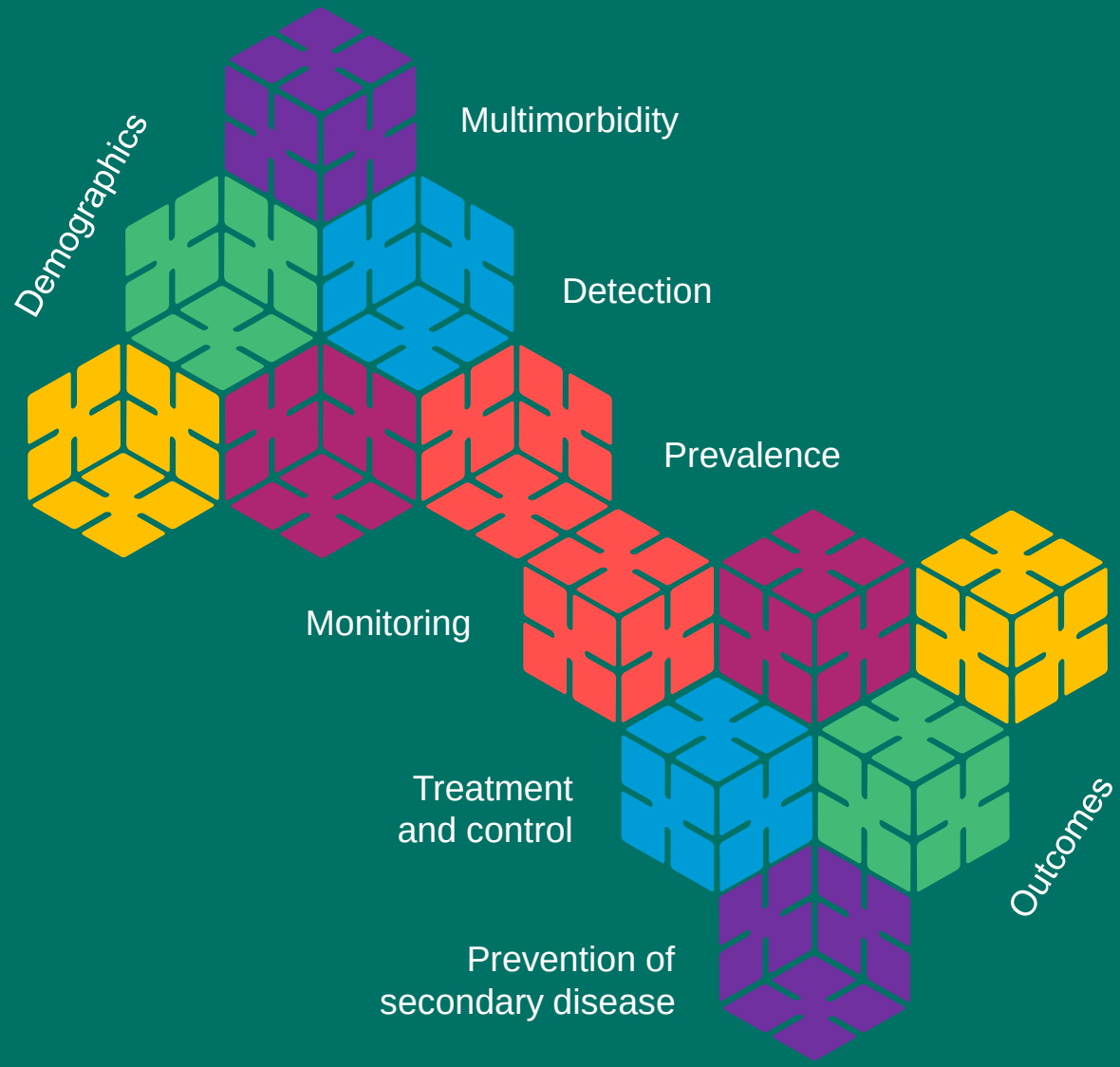
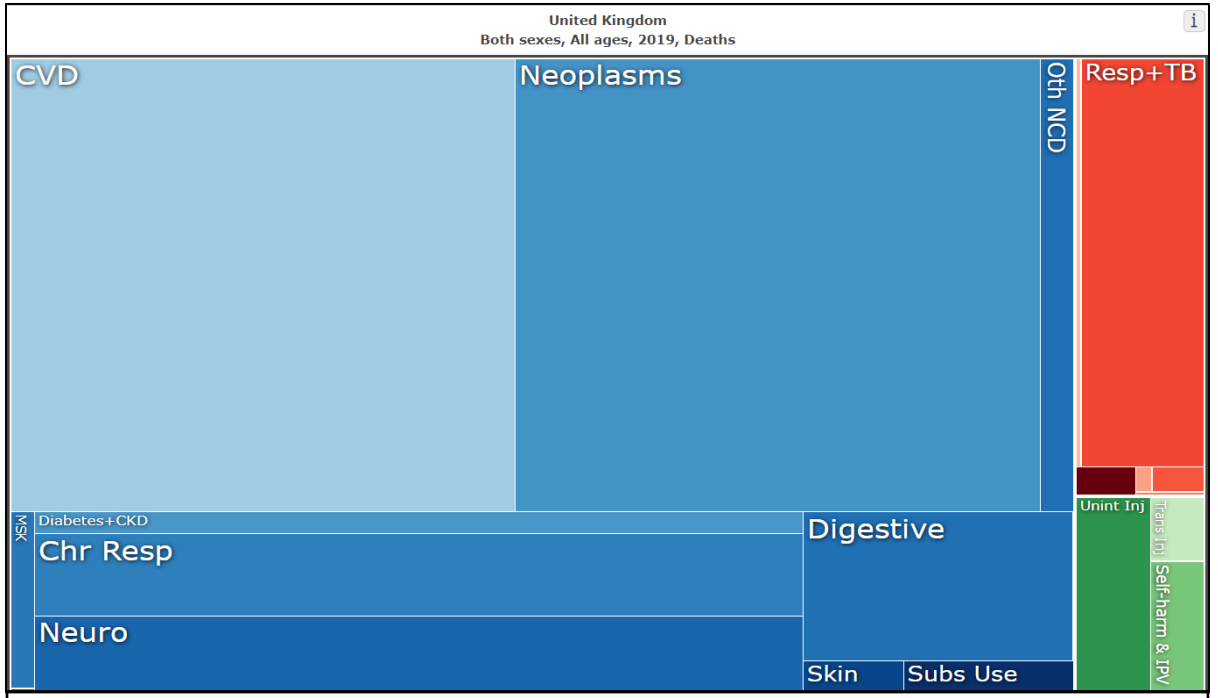
Contents



Introduction to cardiovascular disease

- CVD is the second most common cause of death and disability in the UK (Source: GBD 2019). Locally, the mortality rate from CVD is second only to cancer, with a similar picture for premature mortality (mortality <75 years of age).
- CVD is largely preventable. Modifiable risk factors for cardiovascular disease include hypertension, high cholesterol, smoking, obesity, air pollution, diet, exercise, diabetes (see Diabetes pack) and kidney disease. Non-modifiable risk factors include older age, gender, ethnicity and family history.
- The presence of CVD often increase the risk of other CVDs. For example, AF and CHD are linked to increase risk of stroke. Hypertension is linked with increased risk of all CVDs.
- 80% of people with CVD have at least one other health problem.



Cause of death, UK, all ages (Source: Global Burden of Disease; 2019). Box size represents proportion of deaths.

- This pack describes the health needs across the care pathway, encompassing: disease detection, monitoring, routine management and management of more serious disease as well as adverse outcomes. It supports evidence-based planning and decision-making.
- The pack uses data from a range of national and local sources. Please see the section on data sources and limitations for more information.
- There are separate insights pack on CVD prevention and Coronary Heart Disease published on the Population Health Management site.

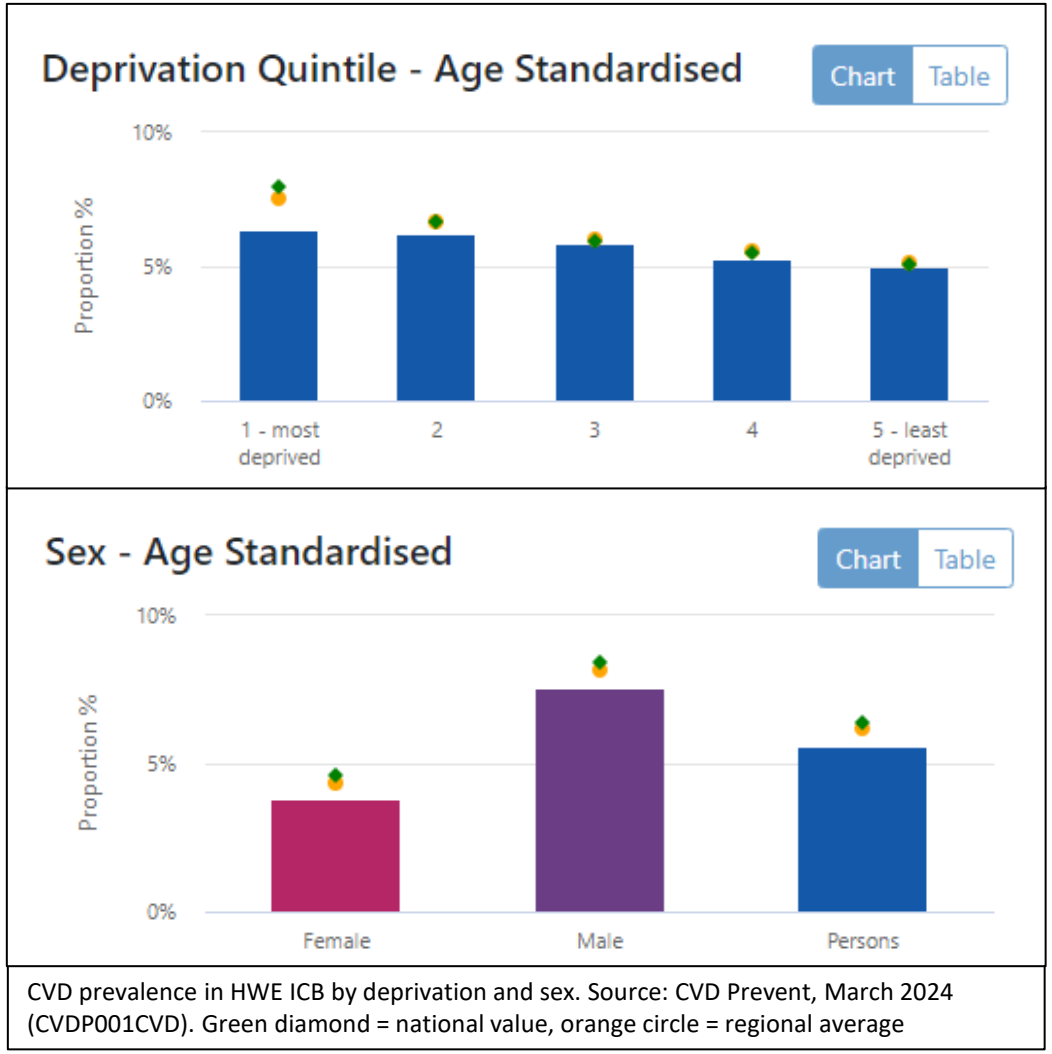
Cardiovascular disease overview (1)

- CVD prevalence in HWE is lower than national and regional prevalence. The prevalence of GP-recorded CVD for patients 18 years and over (Source: CVD Prevent March 2024) is:
  - HWE - 5.27%
  - East and North Hertfordshire – 5.03%
  - South West Hertfordshire – 5.37%
  - West Essex - 5.51%
  - East of England Region – 6.25%
  - England - 6.02%

- This uses the wide definition of CVD, that includes: CHD (coronary heart disease), Stroke, TIA (transient ischaemic attack), PAD (peripheral arterial disease), heart failure and AAA (abdominal aortic aneurism)

- CVD prevalence in HWE varies by deprivation. After adjusting for differences in age, there is significantly higher prevalence in the most deprived group compared to the least deprived population in HWE. (Source CVD Prevent March 2024).

- Prevalence of CVD is higher in men than women (Source: CVD Prevent March 2024)



CVD prevalence in HWE ICB by deprivation and sex. Source: CVD Prevent, March 2024 (CVDP001CVD). Green diamond = national value, orange circle = regional average

Cardiovascular disease overview (2)

Mortality rates in under 75s can be used as a measure of premature mortality.

- Cardiovascular mortality rates highlight that HWE overall have a lower than national under 75 mortality rate from cardiovascular disease.
- When compared to our similar peers however, HWE has a higher under 75 mortality rate.
- The snapshot from Fingertips highlights how mortality differs by district within HWE, with a more than 2-fold difference in premature mortality between the districts with the highest (Harlow) and lowest mortality (Three Rivers).
- The variation between districts in HWE is a mixed picture. Most deprived areas experience the highest rates of under 75 mortality (Harlow, Watford, Dacorum, Stevenage, Broxbourne). However some of the lesser deprived areas are also experiencing higher under 75 mortality rates (Epping Forest and East Hertfordshire).
- This data is a directly standardised rate per 100,000 – meaning this data accounts for the fact that the age distribution in each district may differ.

Better 95% | Similar | Worse 95% | Not compared

Recent trends: – Could not be calculated | → No significant change | ↑ Increasing & getting worse | ↑ Increasing & getting better | ↓ Decreasing & getting worse | ↓ Decreasing & getting better

Under 75 mortality rate from all cardiovascular diseases 2021

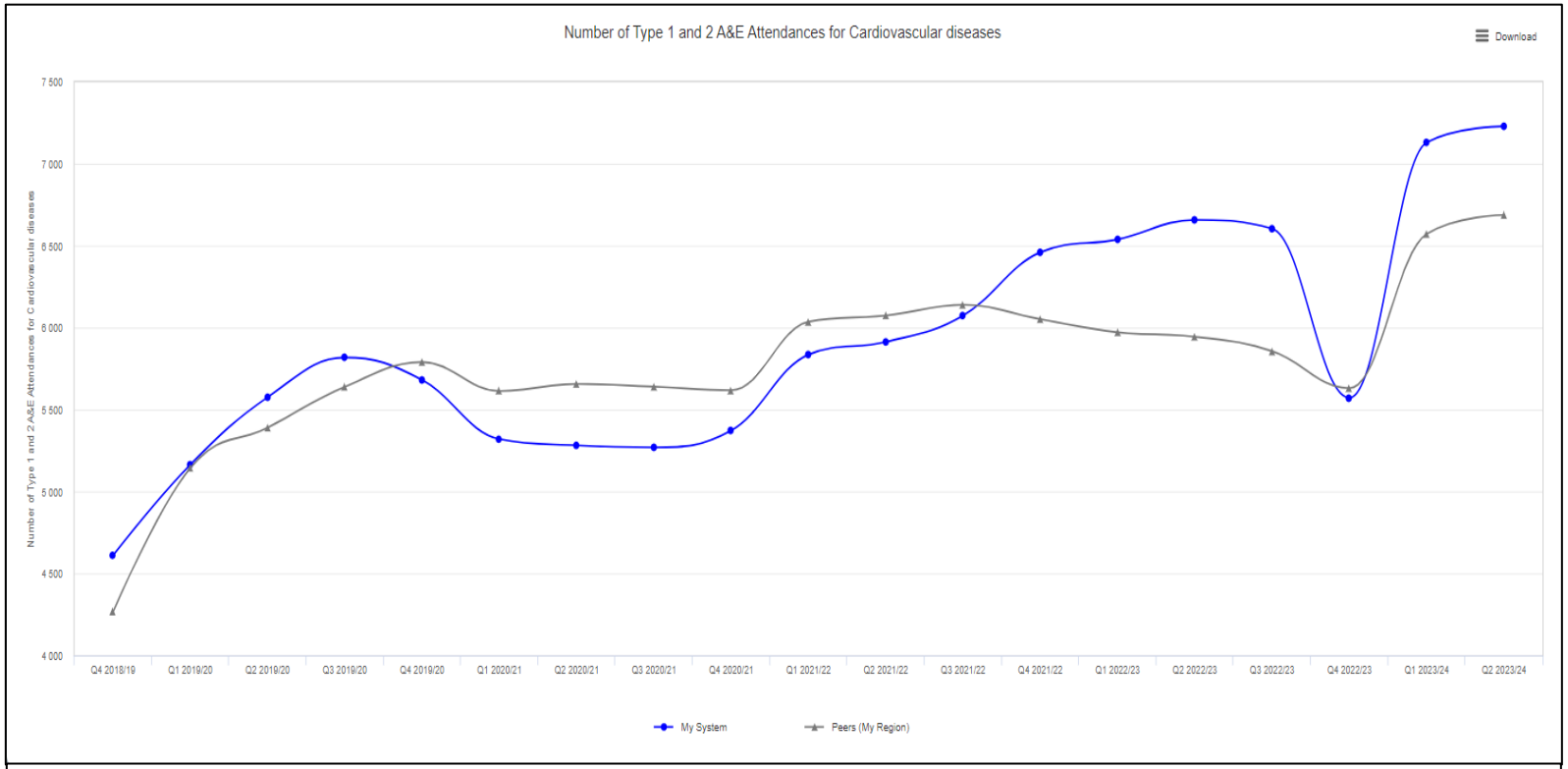
Directly standardised rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	37,669	76.0	75.3	76.8
HWE CCGs	–	-	-	-	-
Harlow	–	64	89.5	68.8	114.4
North Hertfordshire	–	80	67.0	53.1	83.4
East Hertfordshire	–	87	65.0	52.0	80.2
Watford	–	45	64.2	46.6	86.2
Dacorum	–	84	63.5	50.6	78.6
Epping Forest	–	77	62.4	49.2	78.0
Stevenage	–	41	59.4	42.5	80.8
Hertsmere	–	53	57.8	43.3	75.7
Broxbourne	–	47	57.5	42.2	76.5
Welwyn Hatfield	–	52	56.2	41.9	73.8
St Albans	–	59	48.4	36.8	62.5
Uttlesford	–	40	44.4	31.7	60.5
Three Rivers	–	33	40.3	27.7	56.7

Source: Under 75 mortality rate from all cardiovascular diseases (2021) OHID via Fingertips

Cardiovascular disease acute care utilisation

- There is evidence that service utilisation due to cardiovascular disease in HWE ICB is rising. Type 1-4 A&E attendances for CVD in HWE ICB have risen from 4611 in Q4 2018/19 to 7229 in Q2 2023/24
- Reducing A&E attendances to the rate of our demographic peers in the most recent quarter for which data are available would have saved 606 attendances (Source: MHS Q2 2023/24)
- Reducing non-elective bed days for cardiovascular disease to the rate of our best-performing demographic peer would result in a saving of 16,743 bed days (Source: MHS)



Number of Type 1 and 2 A&E attendances for cardiovascular diseases HWE ICB (Source MHS to Q2 2023/24)

Key recommendations

Based on the insights in this pack, it is recommended that:

1. Prevention and management of cardiovascular disease should remain a key priority for Hertfordshire and West Essex. Whilst CVD prevalence and CVD-related mortality and service utilisation are better than national average, HWE ICB is below demographically similar peers on these metrics. There are also significant opportunities to reduce CVD-related A&E attendance, ambulatory-care sensitive admissions and non-elective bed days and make associated cost savings.

2. The ECF continues to fund enhanced reviews for people with heart failure with a focus on optimising care and managing appropriate patients in MDT settings.

3. There is substantial opportunity to improve detection of heart failure, particularly in ENH and SWH where detection rates are currently 56.5% and 54.8% respectively.

4. There is also opportunity to improve management of heart failure in primary care, with ambulatory care sensitive admissions for congestive costing HWE ICB over £15 million between April 2021 and September 2022.

5. More work is required to understand practice in HWE ICB in relation to cardiac rehabilitation.

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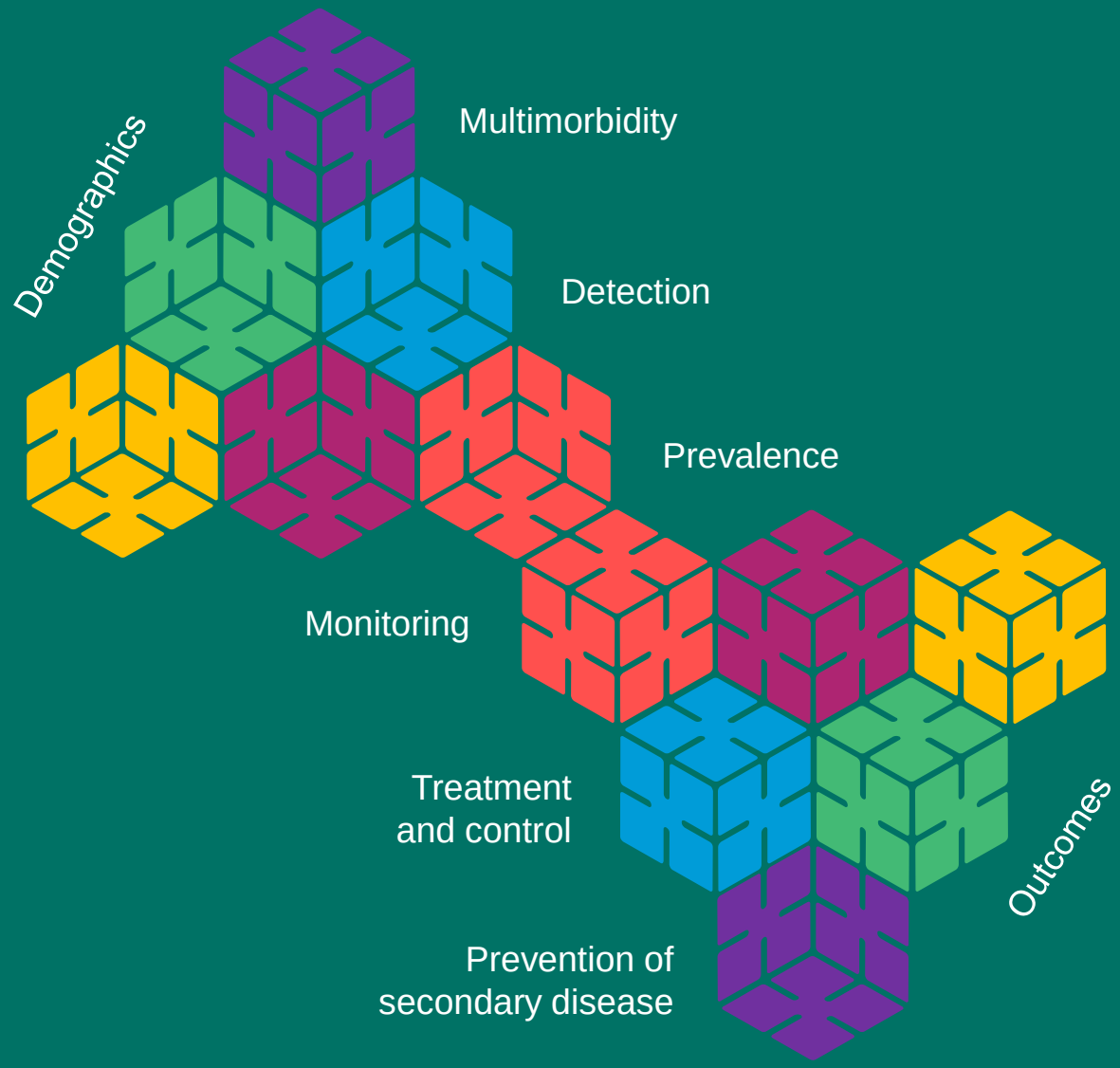
2. Heart Failure

- Introduction
- Prevalence, detection & diagnosis
- Demographic profile & multimorbidity
- Monitoring & control
- Specialist care
- Outcomes
- Data commentary
- Supplementary slides



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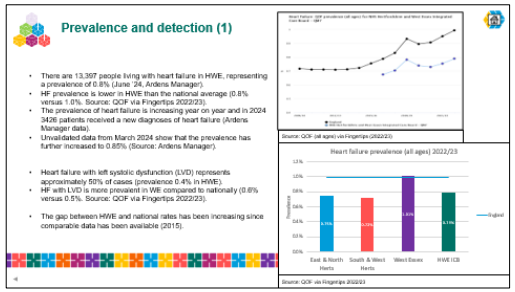
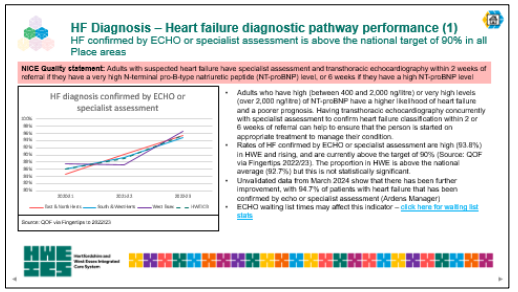
Heart Failure Introduction

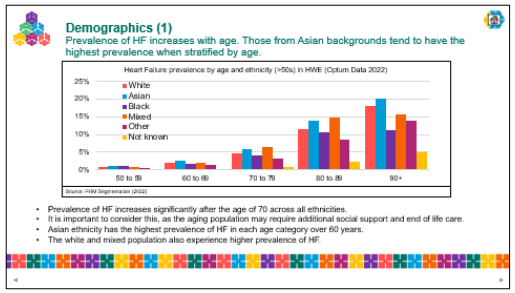
- Heart Failure (HF) is a Long-Term Condition where the heart is unable to pump blood around the body as effectively as it should.
- This condition tends to get worse over time and can cause breathlessness, light-headedness and swelling of the ankles and legs.
- There are two types of heart failure – reduced Ejection Fraction (HFrEF), also known as Left Ventricular Systolic Dysfunction (LVSD), and preserved Ejection Fraction (HFpEF).
- There are many conditions that cause, or increase the risk of, HF:
    - coronary heart disease
    - high blood pressure
    - conditions affecting the heart muscle (cardiomyopathy)
    - heart rhythm problems (arrhythmias), such as atrial fibrillation
    - damage or other problems with the heart valves
    - congenital heart disease – birth defects that affect the normal workings of the heart
- In addition to this, obesity, alcohol, hypertension and pulmonary hypertension may increase the risk of HF.
- Prevention targets the modifiable risk factors such as diet, exercise and hypertension. Management may involve medicines, implanted devices, surgery and education.

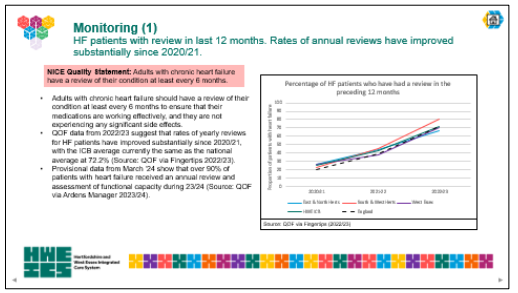
8 Key Messages – Heart Failure – Click on each tile

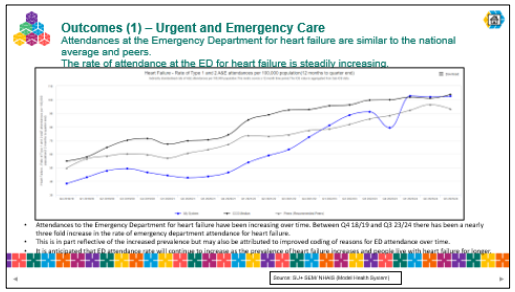
- HF and LVSD prevalence is lower than the national median in all Place areas except WE (Source: QOF via Fingertips 2022/23)
- Detection, when compared to the average of 10 similar peers, can be most improved in ENH (Source: NHS RightCare 2019)
- Echocardiography waiting lists are above the national average, with West Essex in the highest quartile nationally (Source: Diagnostic waiting times and activity via MHS November 2023). However, waiting list numbers have been decreasing rapidly since July 2023 (Source: Diagnostic waiting times and activity via MHS November 2023).
- HF patients are a very multimorbid cohort, particularly females, ethnic minorities and those with severe HF. (Source: PaPI 2021)
- HWE is in line with the national median for HF reviews (Source: QOF via Fingertips 20222/23)
- HWE is in line with average for treatment measures (Source: QOF via Fingertips 20222/23)
- HWE ICB has rates of admission and readmission for heart failure that are lower than the national average (HES/OHID 2021/22 via Fingertips)
- Congestive heart failure is associated with the highest spend on ambulatory care sensitive admissions.











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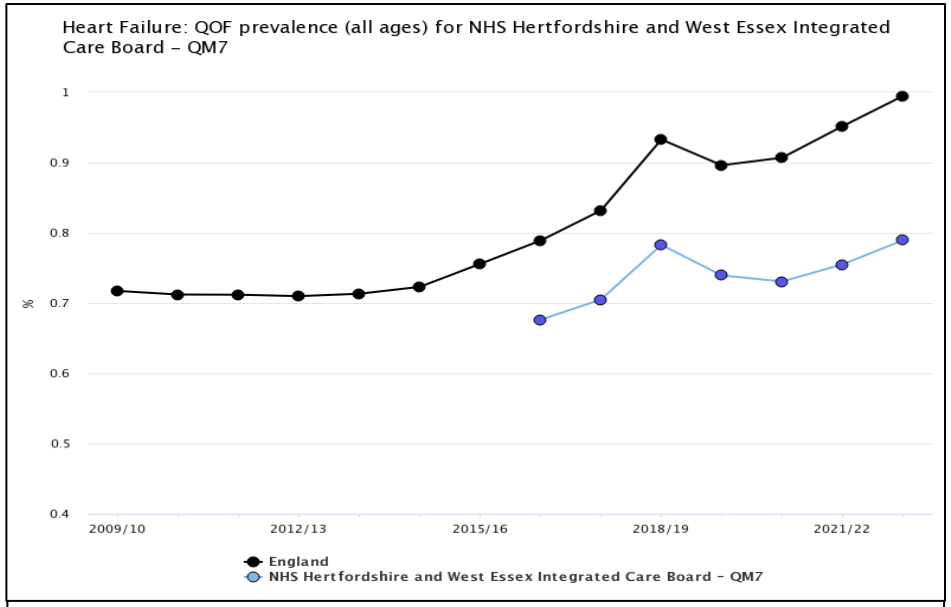
Prevalence and detection (1)

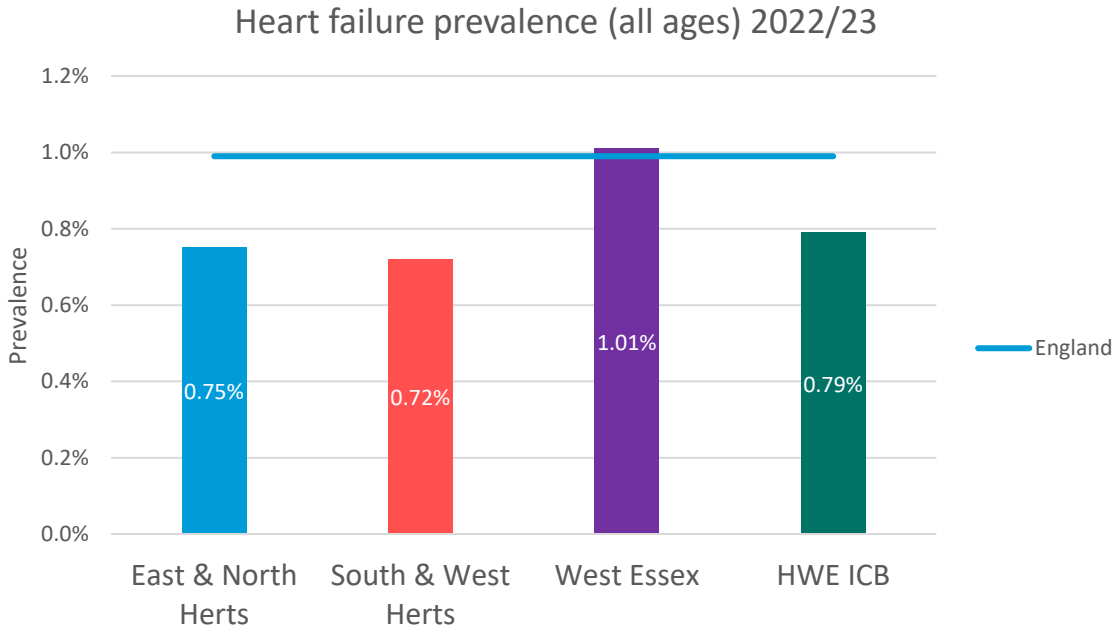
- There are 13,397 people living with heart failure in HWE, representing a prevalence of 0.8% (June ’24, Ardens Manager).
- HF prevalence is lower in HWE than the national average (0.8% versus 1.0%. Source: QOF via Fingertips 2022/23).
- The prevalence of heart failure is increasing year on year and in 2024 3426 patients received a new diagnoses of heart failure (Ardens Manager data).
- Unvalidated data from March 2024 show that the prevalence has further increased to 0.85% (Source: Ardens Manager).

- Heart failure with left systolic dysfunction (LVD) represents approximately 50% of cases (prevalence 0.4% in HWE).
- HF with LVD is more prevalent in WE compared to nationally (0.6% versus 0.5%. Source: QOF via Fingertips 2022/23).

- The gap between HWE and national rates has been increasing since comparable data has been available (2015).



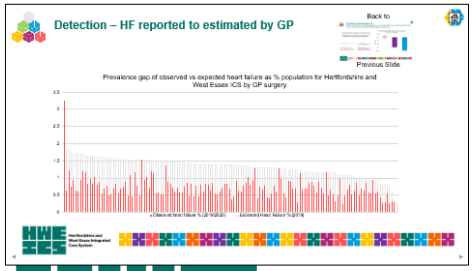
Source: QOF (all ages) via Fingertips (2022/23)

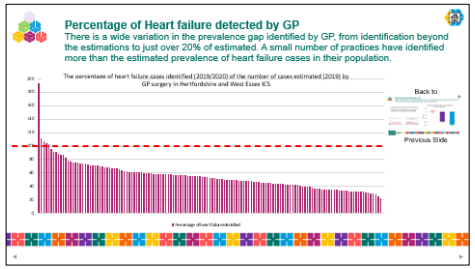


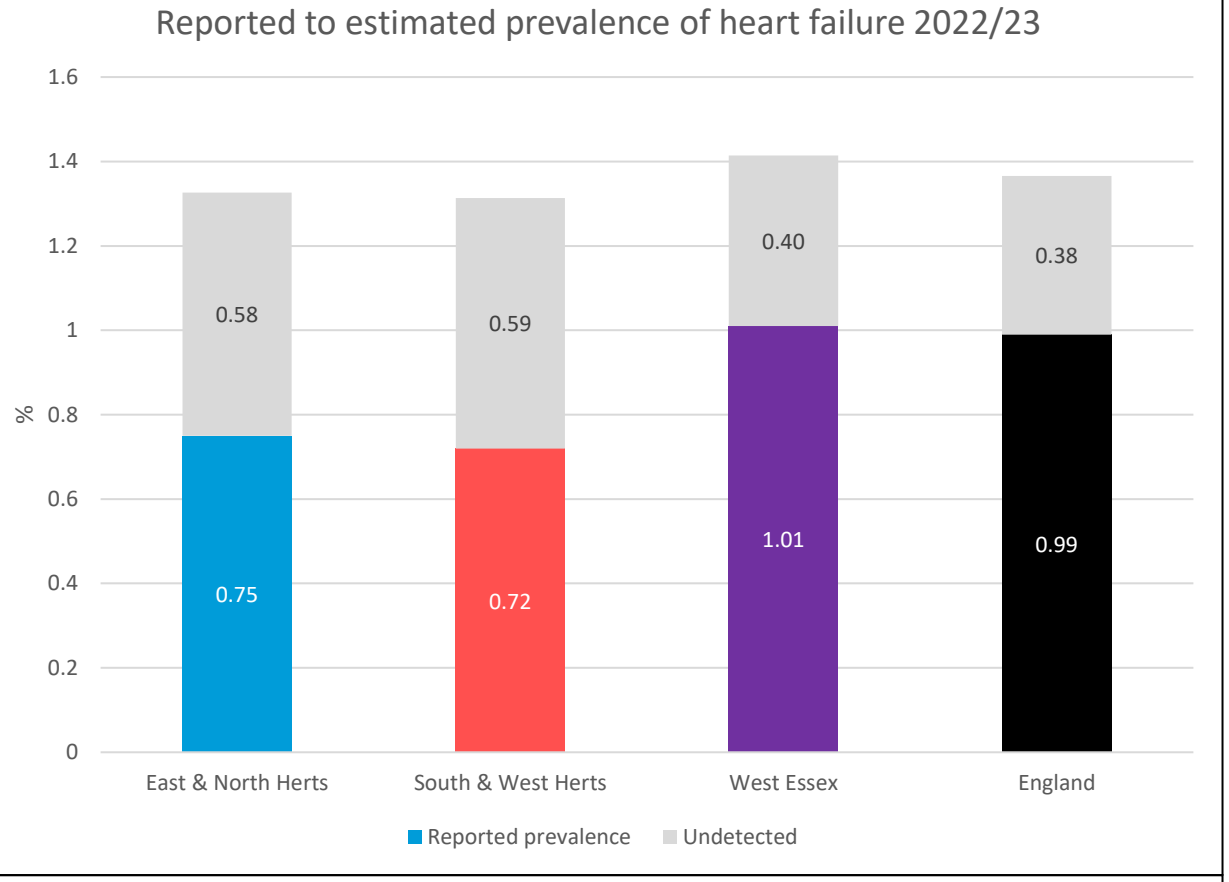
Source: QOF via Fingertips 2022/23

Prevalence and detection (2)

- Modelling, based on risk factors and demographic characteristics estimates the number of people who are potentially living with heart failure. As the modelling was completed in 2025, the estimated prevalence is likely to have increased further as the population ages.
- Comparing estimated prevalence to observed (QOF) prevalence shows that there are likely to be a significant number of people living with undiagnosed disease.
- Detection rates for heart failure vary substantially by Place area when compared to estimated prevalence based on modelling. ENH and SWH have the lowest rates of detection at 56.5% and 54.8% of cases respectively. (Source QOF 2022/23 via Fingertips and 2015 modelling data).
- Break down by GPs in HWE show a large variation in detection rates – see by clicking on the tiles below.







Source: QOF via Fingertips (2022/23) and 2015 modelling data (Fingertips)

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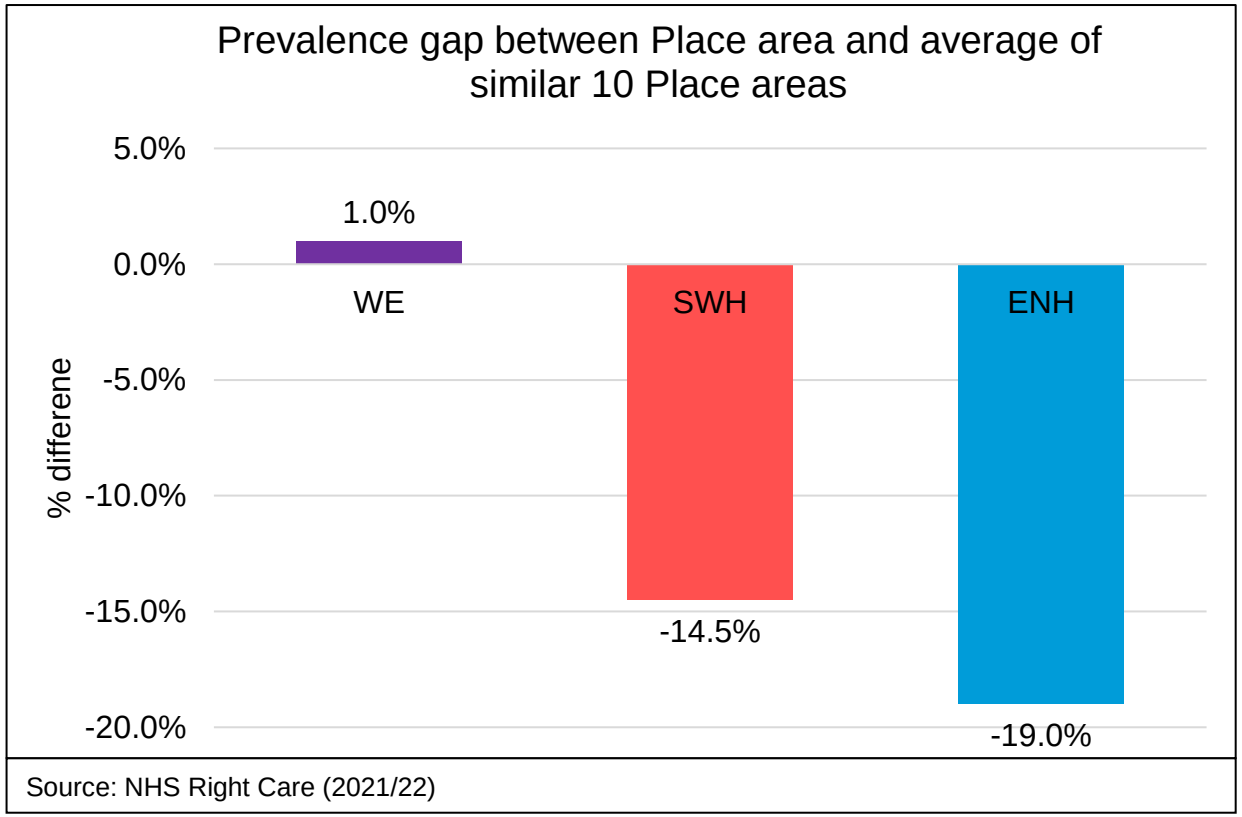
Prevalence and detection (3)

When compared to the average prevalence of 10 similar Place areas, SWH and ENH have a prevalence gap of 14.5% and 19% respectively.

- The British Heart Foundation suggests that nationally, 80% of heart failure is diagnosed in hospital, however 40% of people had symptoms that should have triggered an earlier assessment in primary care. This suggests that there may be many people living with undiagnosed Heart Failure (Source: BHF UK CVD Factsheet)

- The prevalence gap when compared to 10 similar peers in ENH and SWH highlight that there is big potential to detect undiagnosed HF in these areas. This is reflected in the Reported to Estimated rates shown on the previous slide.



Source: NHS Right Care (2021/22)

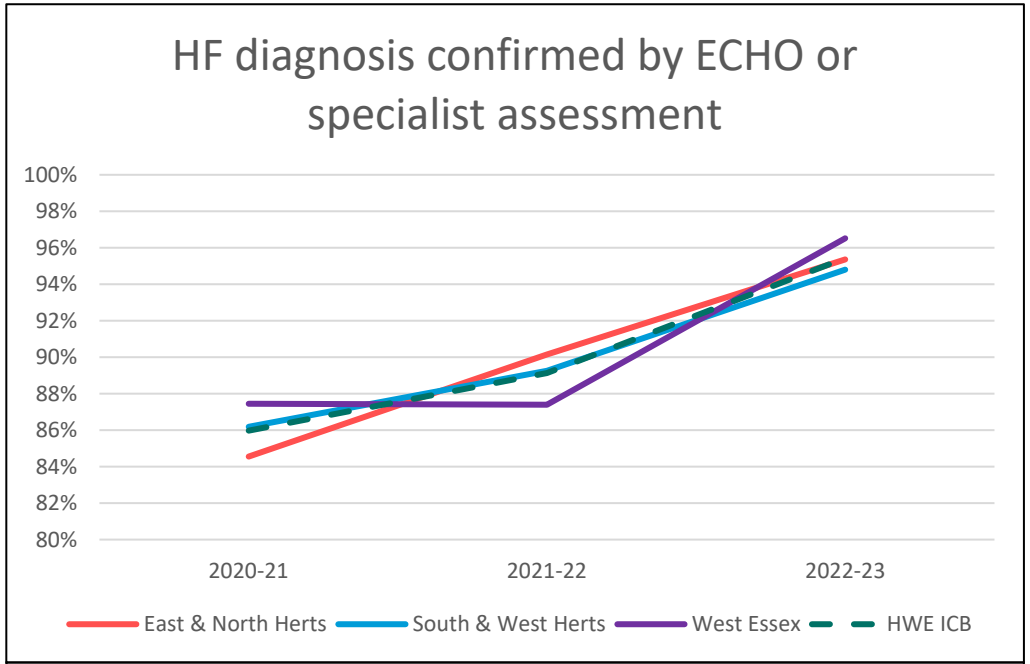
Subtypes of heart failure

- There are two types of heart failure – reduced Ejection Fraction (HFrEF), also known as Left Ventricular Systolic Dysfunction (LVSD), and preserved Ejection Fraction (HFpEF).
- Depending on subtype, the management of heart failure varies. Therefore, capturing this is important to understand the number of individuals within each subgroup to estimate prescribing costs and potential impact on heart failure services.
- At the time of publication, accurate estimates of the number of individuals within the two subgroups is being worked through and will be added to this Insights Pack when it is next updated.

HF Diagnosis – Heart failure diagnostic pathway performance (1)

HF confirmed by ECHO or specialist assessment is above the national target of 90% in all Place areas

NICE Quality statement: Adults with suspected heart failure have specialist assessment and transthoracic echocardiography within 2 weeks of referral if they have a very high N-terminal pro-B-type natriuretic peptide (NT-proBNP) level, or 6 weeks if they have a high NT-proBNP level



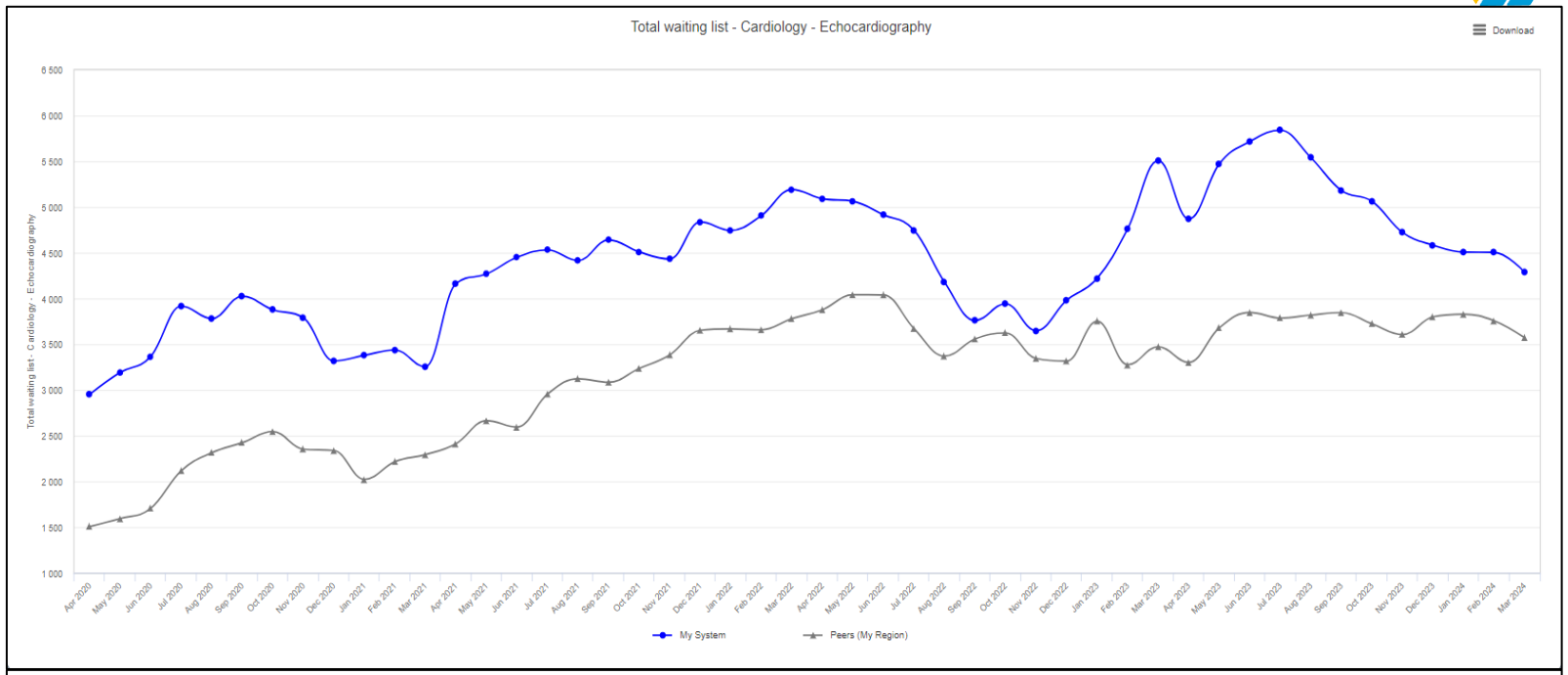
Source: QOF via Fingertips to 2022/23

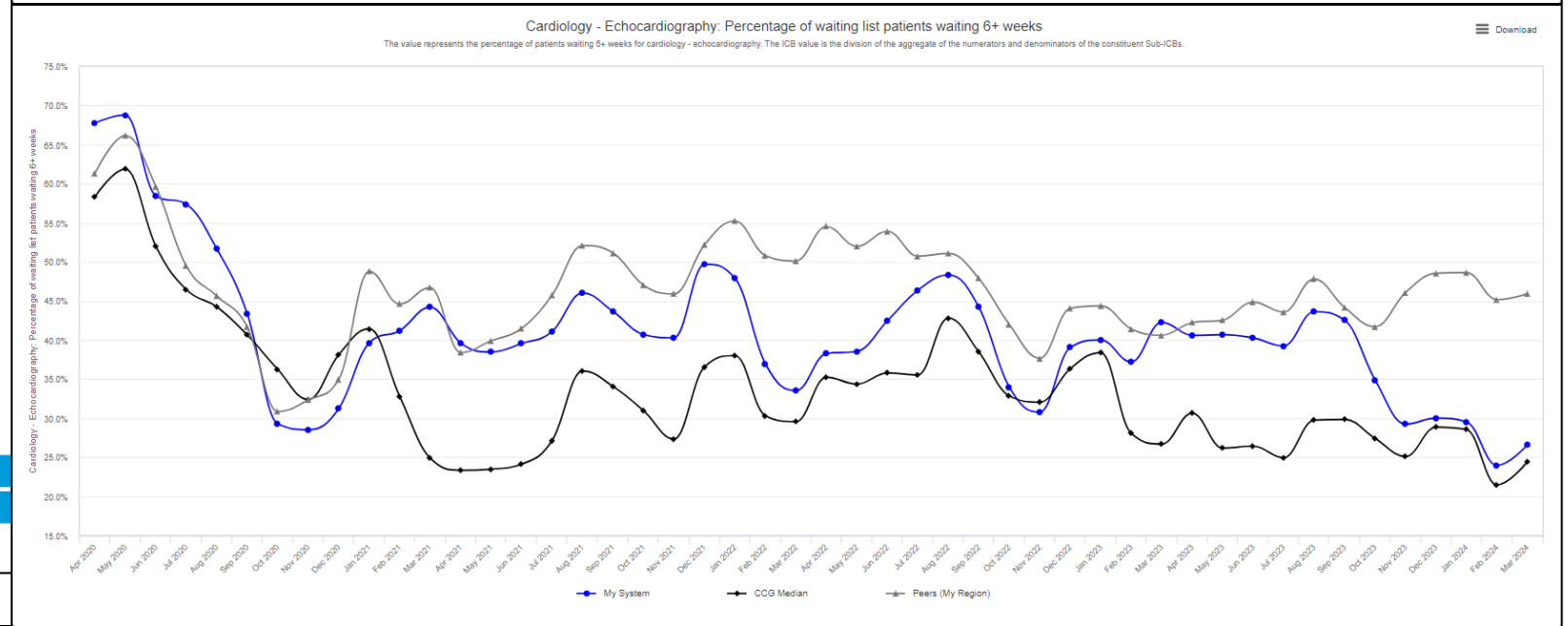
- Adults who have high (between 400 and 2,000 ng/litre) or very high levels (over 2,000 ng/litre) of NT-proBNP have a higher likelihood of heart failure and a poorer prognosis. Having transthoracic echocardiography concurrently with specialist assessment to confirm heart failure classification within 2 or 6 weeks of referral can help to ensure that the person is started on appropriate treatment to manage their condition.
- Rates of HF confirmed by ECHO or specialist assessment are high (93.8%) in HWE and rising, and are currently above the target of 90% (Source: QOF via Fingertips 2022/23). The proportion in HWE is above the national average (92.7%) but this is not statistically significant.
- Unvalidated data from March 2024 show that there has been further improvement, with 94.7% of patients with heart failure that has been confirmed by echo or specialist assessment (Ardens Manager)
- ECHO waiting list times may affect this indicator – click here for waiting list stats

Heart failure diagnosis – Diagnostic pathway performance (2)

Echo waiting list size

- The waiting list for ECHO increased through the Covid-19 pandemic and peaked in July ’23 (5841). Since then the number of people waiting for an ECHO has decreased by 27% and was 4289 in March ’24.
- The proportion of the population waiting for ECHO is higher than the national average and the average for peers (see next slide).
- There is variation at Place level, with the number of people waiting for ECHO per 100,000 highest in WE (409) and lowest in SWH (185). ENH has 263 per 100,000 people waiting for an ECHO.
- The proportion of people waiting more than 6 weeks for an ECHO has decreased from post-pandemic peak but remains above the target of 5%.





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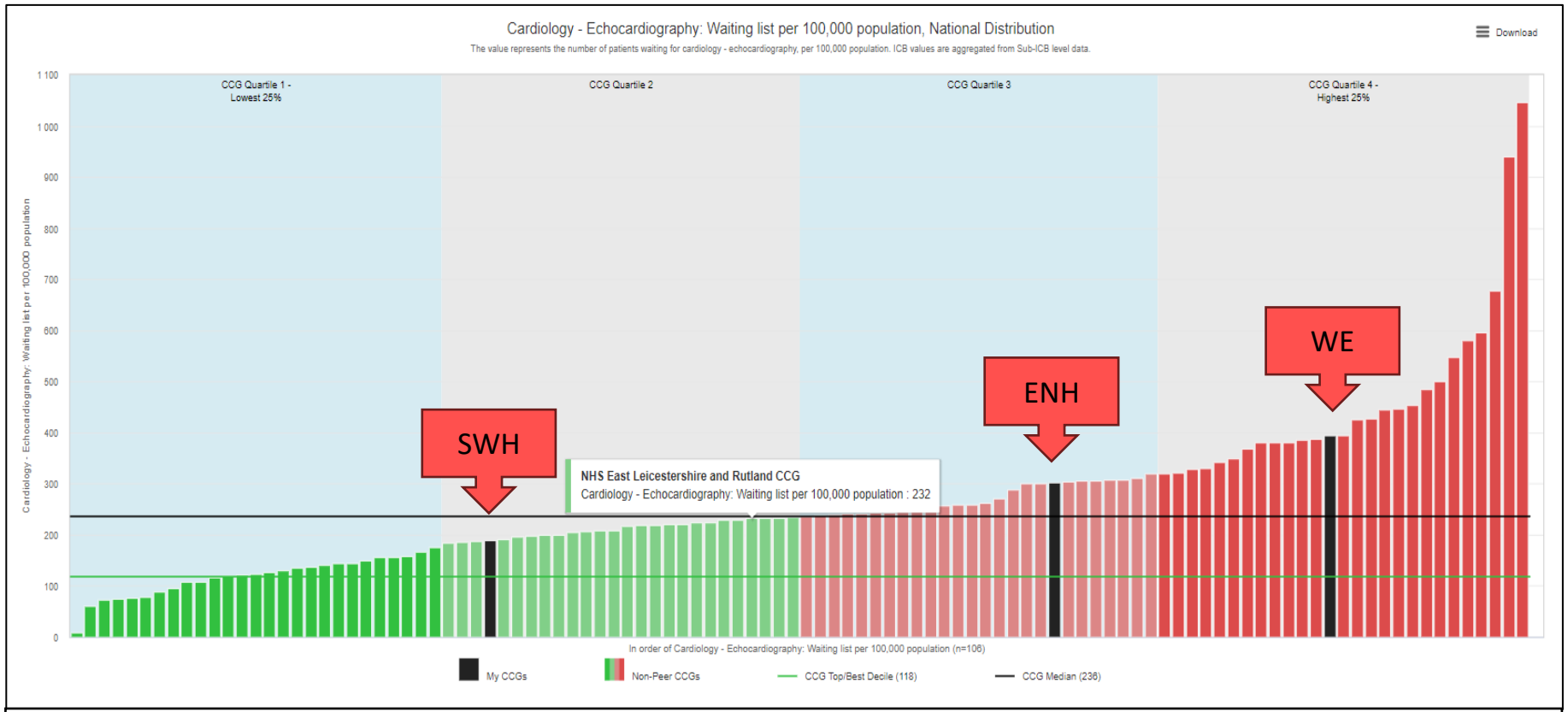
Source: Diagnostic waiting times and activity via MHS March 2024

Heart failure diagnosis – Diagnostic pathway performance (3)

ECHO waiting list per 100,000. HWE ICB has a longer waiting list than both national and peer medians. WE is in highest quartile nationally.

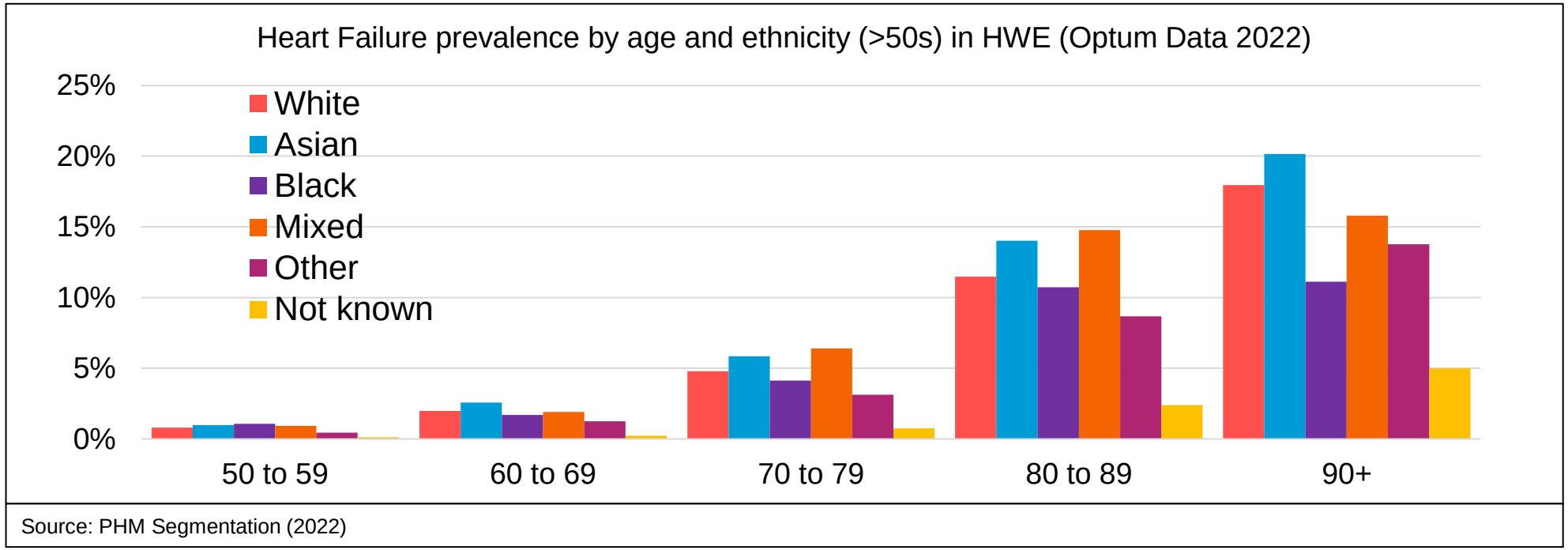


System value	CCG Quartile 3
	274
Peer median	CCG Quartile 3
	281
CCG median	
	236

Echocardiography waiting list per 100,000 population. Source: Diagnostic waiting times and activity via MHS January 2024

Demographics (1)

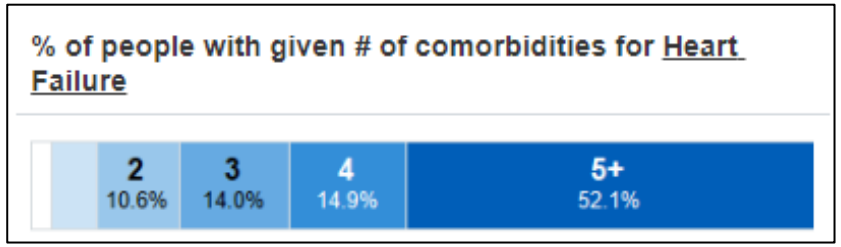
Prevalence of HF increases with age. Those from Asian backgrounds tend to have the highest prevalence when stratified by age.



Source: PHM Segmentation (2022)

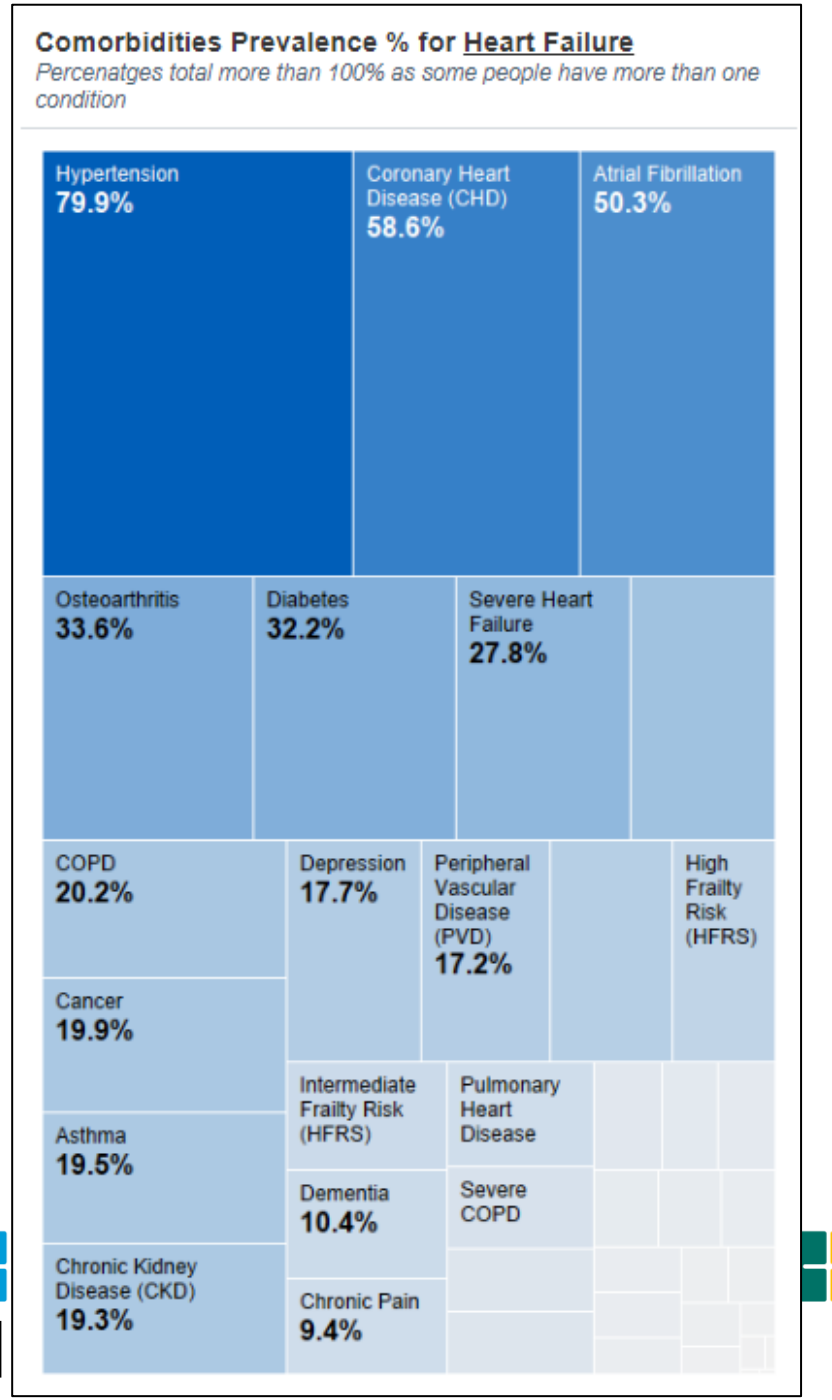
- Prevalence of HF increases significantly after the age of 70 across all ethnicities.
- It is important to consider this, as the aging population may require additional social support and end of life care.
- Asian ethnicity has the highest prevalence of HF in each age category over 60 years.
- The white and mixed population also experience higher prevalence of HF.

Multimorbidity (1)



- Very few (2.6%) of people with heart failure live with no other long term conditions and the majority (52.1%) have five or more other long term conditions.
- Unsurprisingly, risk factors for heart failure are the common comorbidities (hypertension, atrial fibrillation and coronary heart disease and diabetes). In addition, as heart failure prevalence increases with age, the prevalence of other age-related conditions is also common (frailty, cancer and dementia).

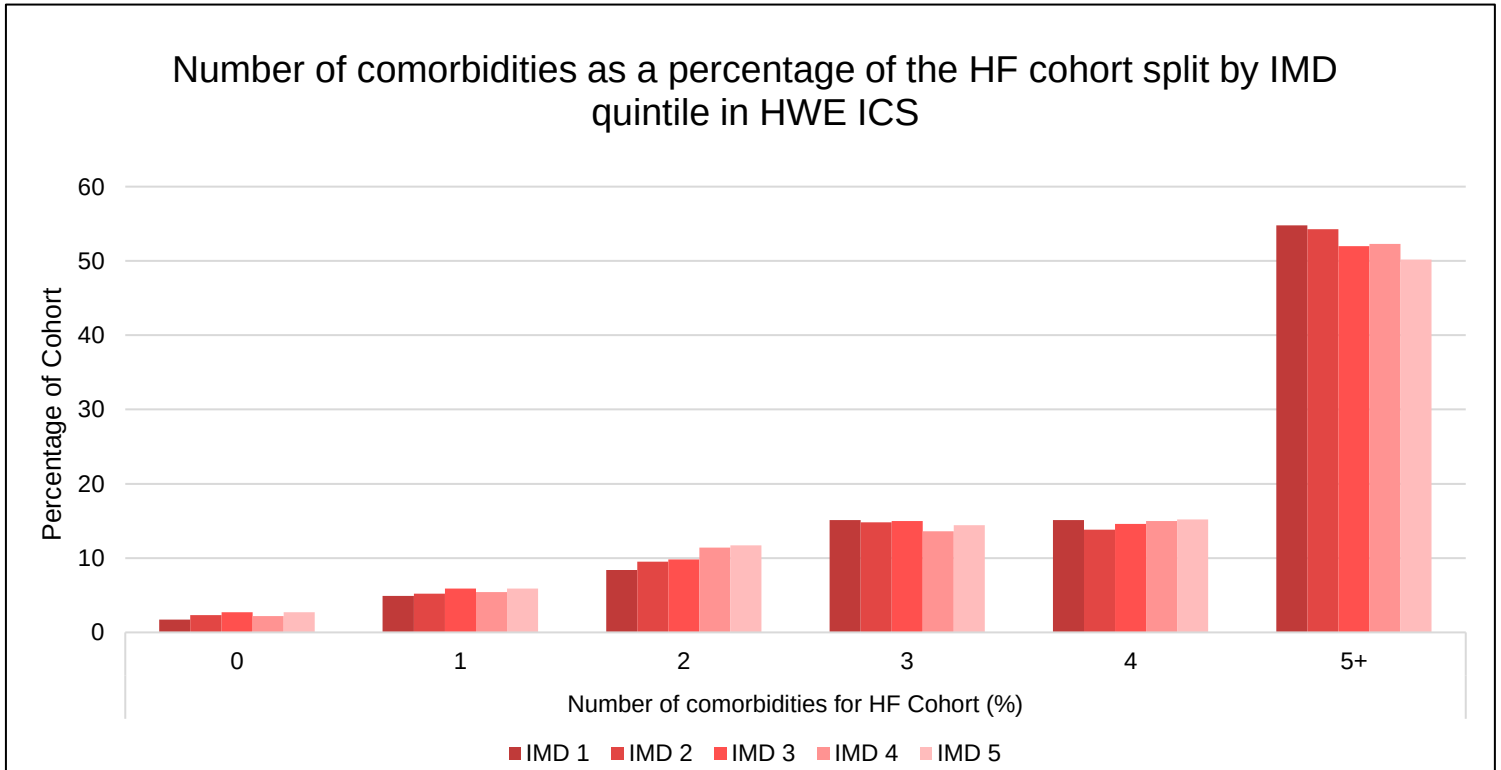
- Management of people with heart failure is therefore complex and requires considering the patient's holistic needs.



Source: Population & Person Insights (August 2023 data)

Multimorbidity (2)

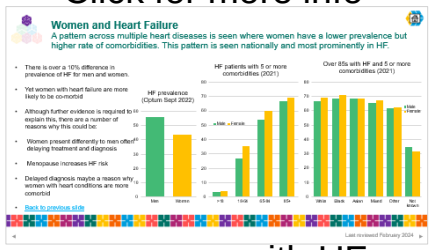
Comorbidities are highly prevalent in patient with HF, particularly severe heart failure. Those with HF from more deprived quintiles are more likely to have multiple comorbidities than more affluent groups.



Source: People and Person Insights (PaPi) 2021

- The majority of those with HF in HWE have 5 or more comorbidities.
- The graph to the left shows how increasing comorbidities are more likely in the more deprived populations.
- Those with severe HF have significantly more comorbidities (>70% with 5+ comorbidities).
- The most common comorbidities are Hypertension, Coronary Heart Disease, and Atrial fibrillation.

Click for more info

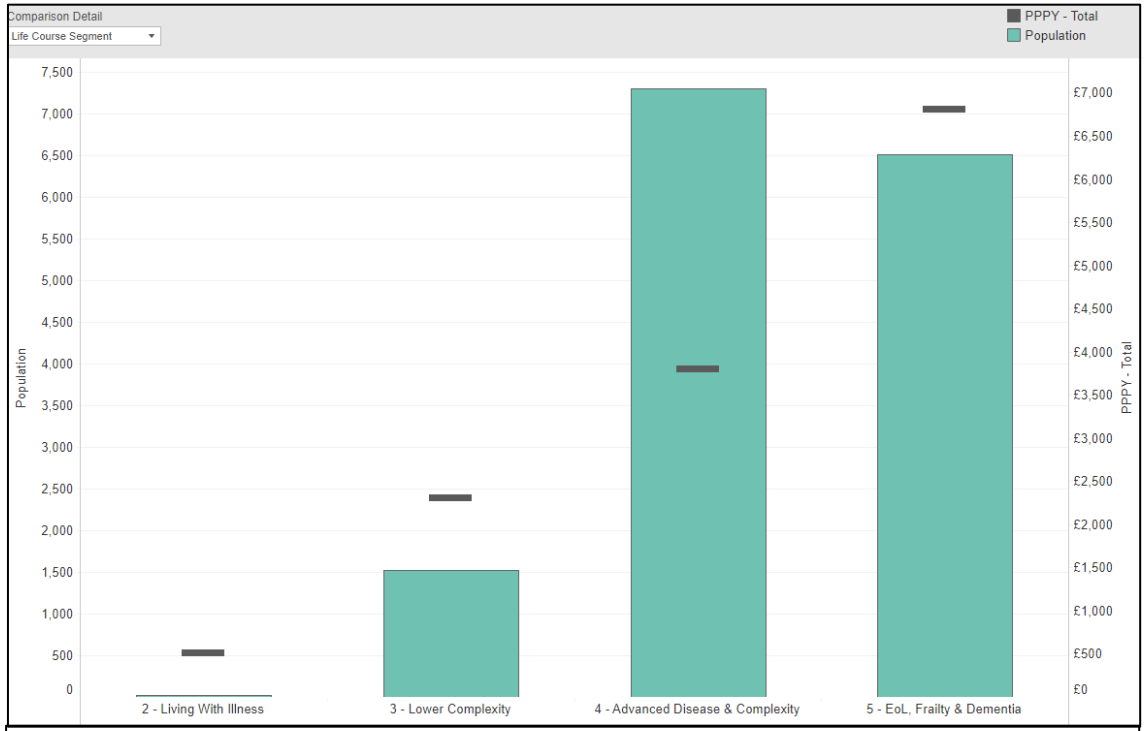


on women with HF

Multimorbidity (3)

- The majority of people with heart failure are in either the ‘Advanced disease or complexity’ or ‘Severe frailty and End of Life’ segments.
- This reflects the fact that people with heart failure tend to be living with multiple other long term conditions, be of an older age and the fact that heart failure impacts on physical and mental health as well as functional ability.

- People with heart failure experience higher costs across each of the segments, compared to people in the same segment without heart failure. For example, the average spend per patient in segment 5 is ~£4500 per patient per year, but for people with heart failure in segment 5 the average cost is nearly £7000 per person per year.



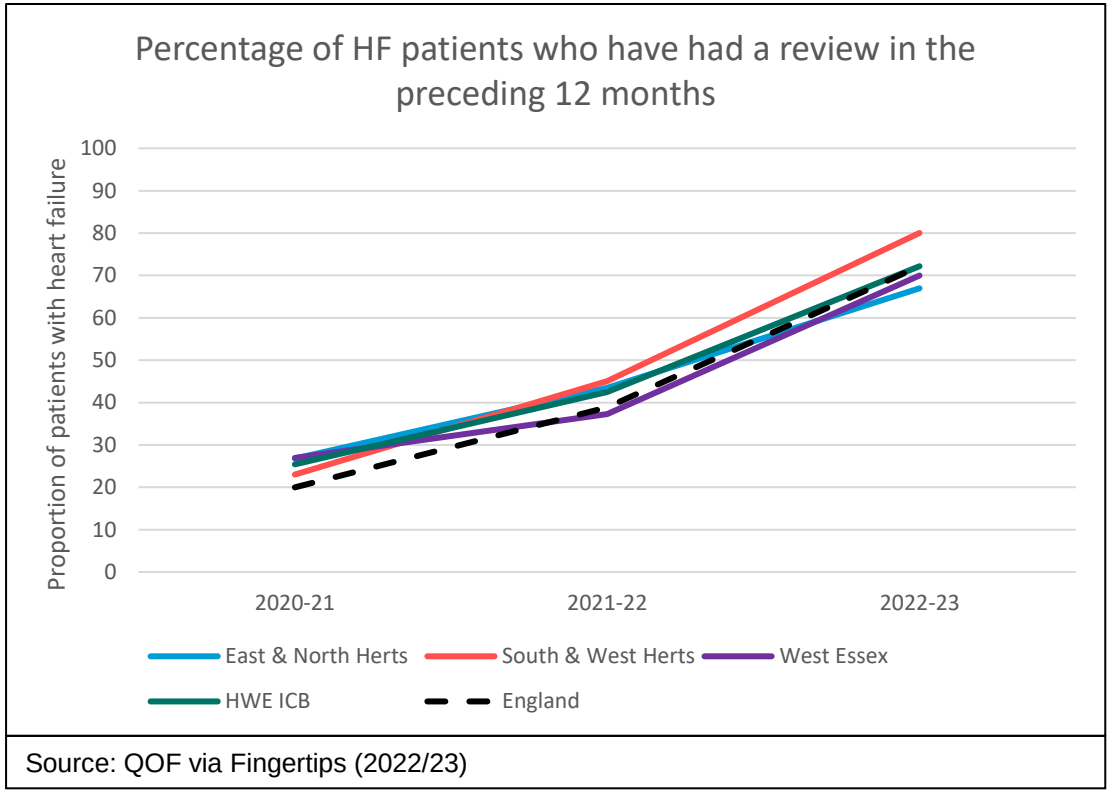
Source: PHM Dashboard (Jan 2022)

Monitoring (1)

HF patients with review in last 12 months. Rates of annual reviews have improved substantially since 2020/21.

NICE Quality Statement: Adults with chronic heart failure have a review of their condition at least every 6 months.

- Adults with chronic heart failure should have a review of their condition at least every 6 months to ensure that their medications are working effectively, and they are not experiencing any significant side effects.
- QOF data from 2022/23 suggest that rates of yearly reviews for HF patients have improved substantially since 2020/21, with the ICB average currently the same as the national average at 72.2% (Source: QOF via Fingertips 2022/23).
- Provisional data from March '24 show that over 90% of patients with heart failure received an annual review and assessment of functional capacity during 23/24 (Source: QOF via Ardens Manager 2023/24).



Source: QOF via Fingertips (2022/23)

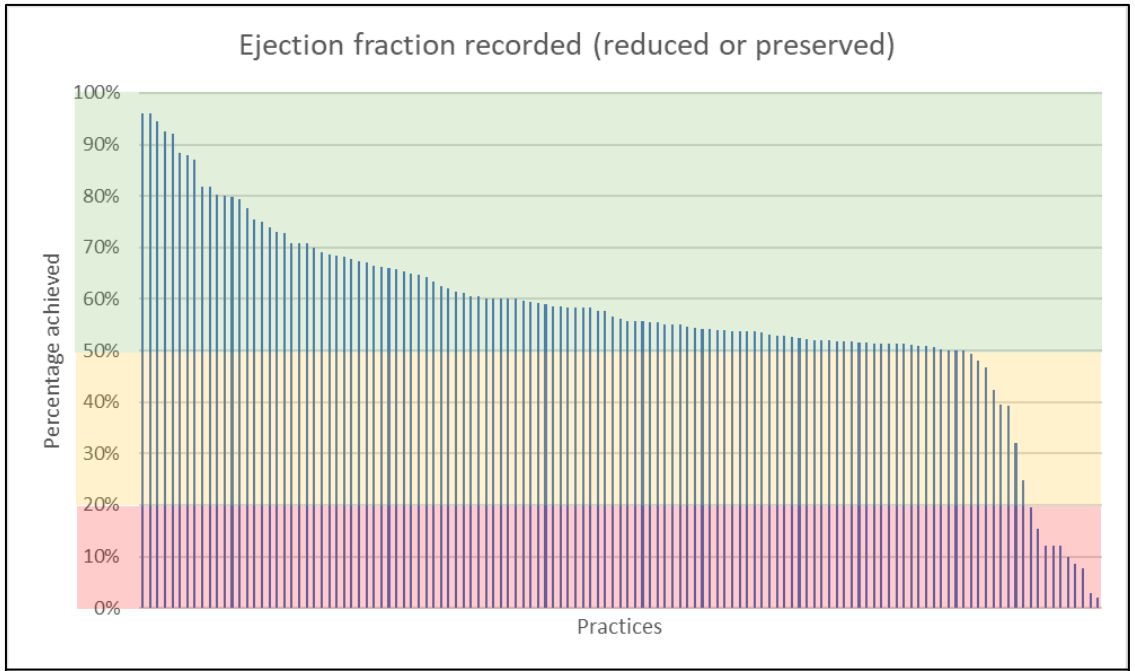
Monitoring (2)

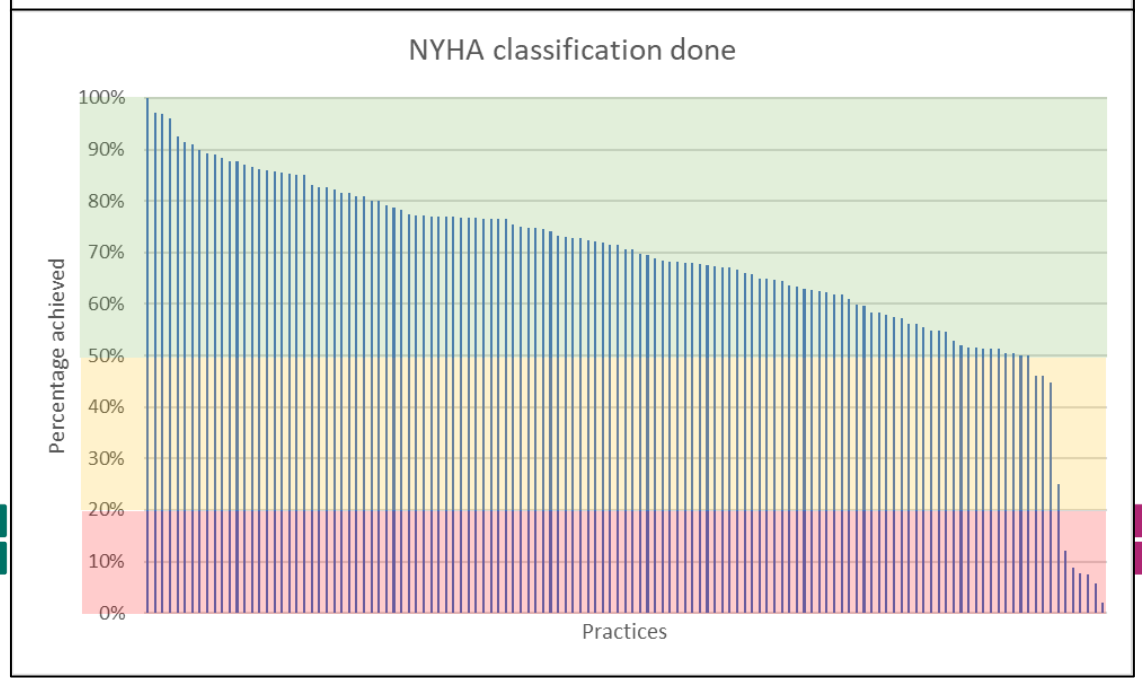
HF patients with review in last 12 months. Rates of annual reviews have improved substantially since 2020/21.

NICE Quality Statement: Adults with chronic heart failure have a review of their condition at least every 6 months.

- Practices in HWE are funded through national contracts (QOF) and the Enhanced Commissioning Framework (ECF) to deliver annual reviews in line with NICE guidance.
- In 2023/24, an NYHA status was recorded for 69% of patients with heart failure, an increase from 45% in the preceding year.
- There has also been an increase in the proportion of patients who have an ejection fraction recorded. 65% of patients with heart failure have a record of ejection fraction.
- The charts to the right show the variation across practices with the ECF thresholds (20% and 50%) for payment highlighted.

- The ECF funds practices to identify services that patients would benefit from and 23.8% of patients with heart failure were referred or signposted to social prescribing or IAPT services.





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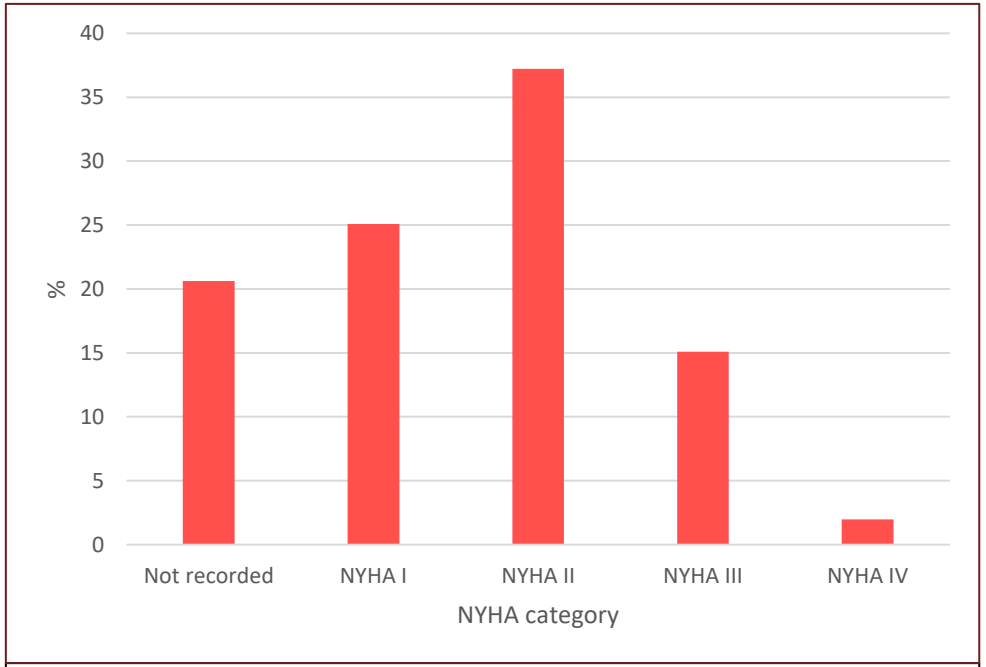
Monitoring (3)
NYHA Classification

- One quarter of patients are in NYHA I and over a third (37%) are in NYHA II. One in five patients does not have a record of NYHA status, however this has improved significantly since the introduction of this to the ECF in HWE. Previously approximately 60% of patients with heart failure had no record of NYHA status.
- The segmentation model from Local HWE data shows that most patients with HF are in either the Advanced Disease & Complexity or Severe Frailty & end of life segments. This highlights the increased need for this population as shown in the per person per year spend for each segment.

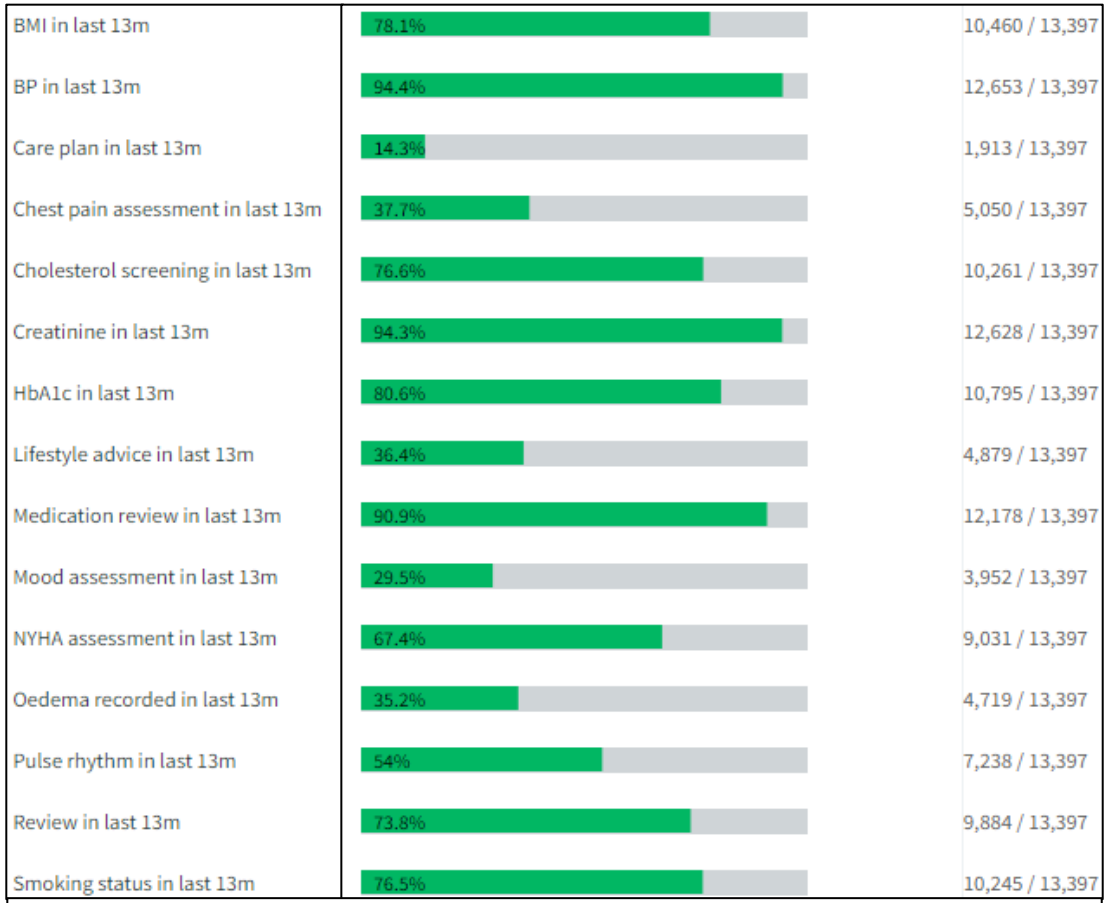


Source: Ardens Manager June 2024

Monitoring (4)

NICE Recommendation: patients with heart failure should be managed as part of an MDT and each patient should have a care plan that summarises the medical and social care needs as well as a management plan.

- Local data (Ardens Manager, June ’24) show that a high proportion of people with heart failure are having blood pressure, renal function, cholesterol, HbA1c and smoking status checks as well as medication reviews. (All care processes >70%)
- However, there are opportunities to improve annual reviews, ensuring that a holistic assessment is completed, including an assessment of mood and completing a care plan. Currently, only one in seven patients has a care plan completed (14.3%).



Source: Ardens Manager (June 2024)

Treatment (1)

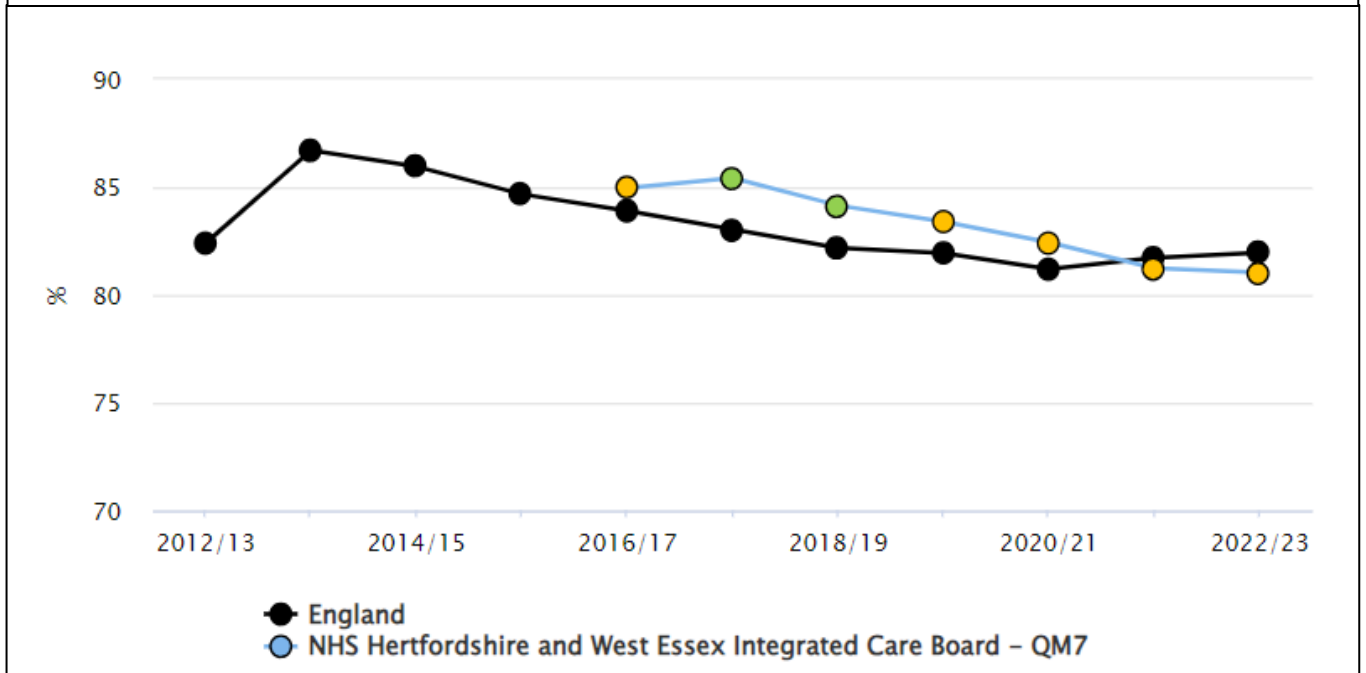
Secondary prevention - LVSD treated with ACEi/ARB and beta blocker is similar to national rates of treatment.

NICE Quality Statement: Adults with chronic heart failure who have reduced ejection fraction receive all appropriate medication at target or optimal tolerated doses

- ACEi/ARB prescribing for LVSD has been dropping both locally and nationally. The level has dropped in HWE from around 85% to just over 81% in 2022/23 (Source QOF via Fingertips 2022/23). HWE is currently below national prescribing levels of 82%.
- Provisional data from March ’24 show that there has been improvement, with 94.7% of patients with LVD currently treated with an ACE inhibitor or ARB

- Rates of beta blocker prescribing in HWE have increased from 79.7% in 2020/21 to 82.% in 2022/23 and are slightly above the national average (Source QOF via Fingertips 2022/23)
- Unvalidated local data show that there has been similar improvement in the proportion of people with LVD who are on a beta-blocker, with 96.3% in March ’24 (Ardens Manager)

Heart failure with LVD on an ACE inhibitor or ARB



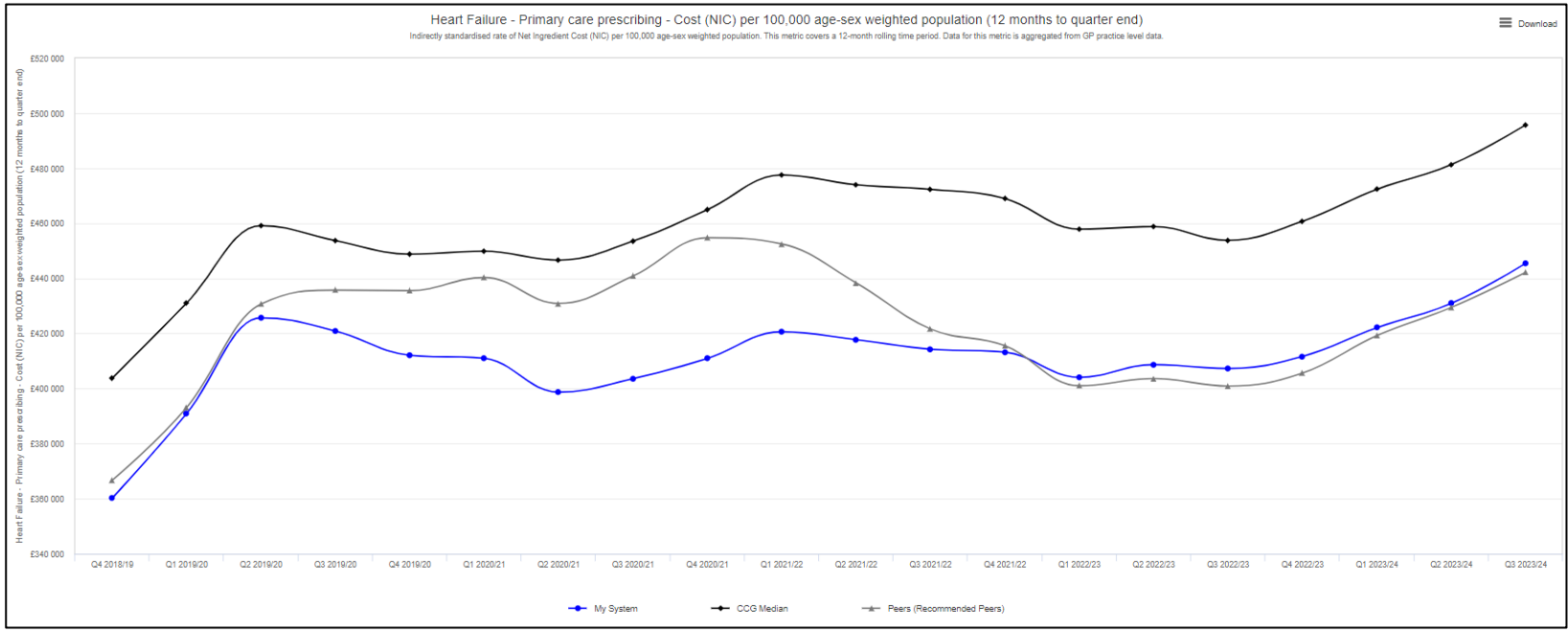
Source: QOF (2022/23) via Fingertips

Treatment (2)

Prescribing spend is increasing in line with trends nationally and among peers

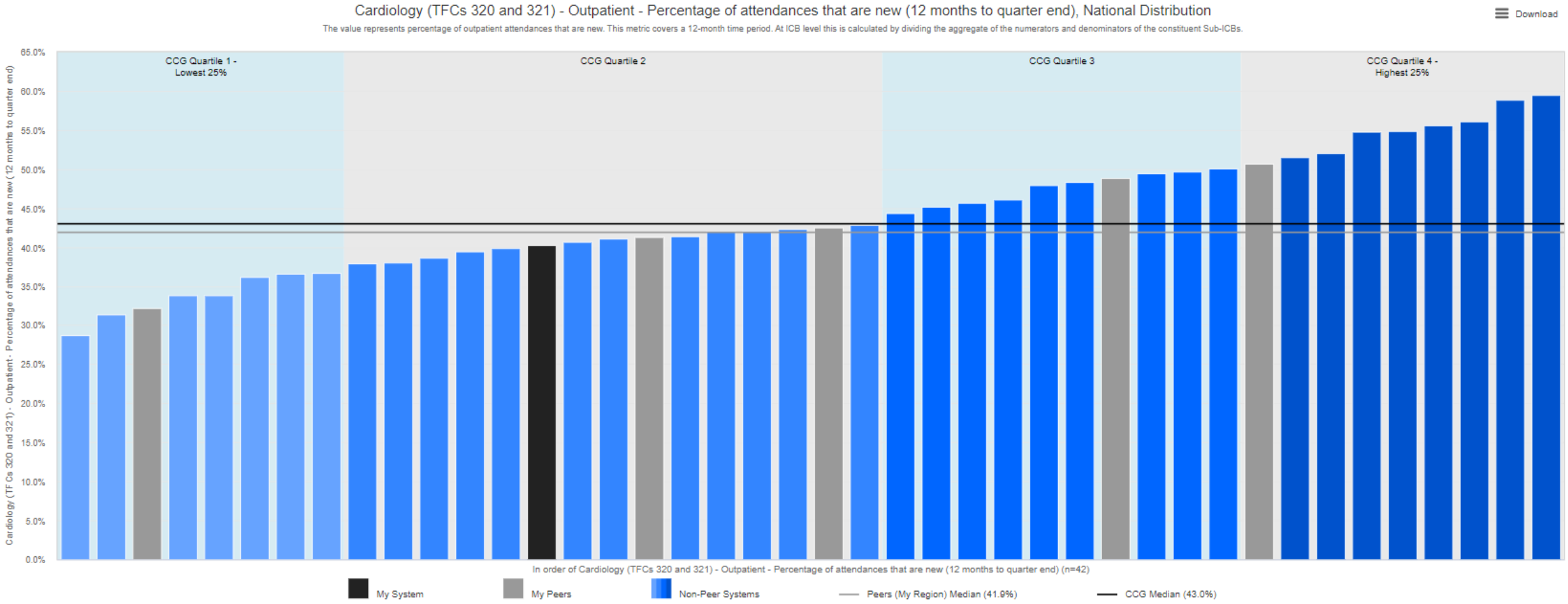
- Across HWE £445,500 is spent per 100,000 population (adjusted for age and sex), which is in the second lowest quartile nationally.
- As the prevalence of heart failure increases there is a concurrent increase in the primary care prescribing spend for heart failure.
- WE Place has the highest primary care prescribing spend, linked to the higher prevalence of heart failure.

- There are opportunities to improve prescribing through accurate diagnosis (e.g. HFpEF vs. HFrEF) and optimising care in line with guidance.



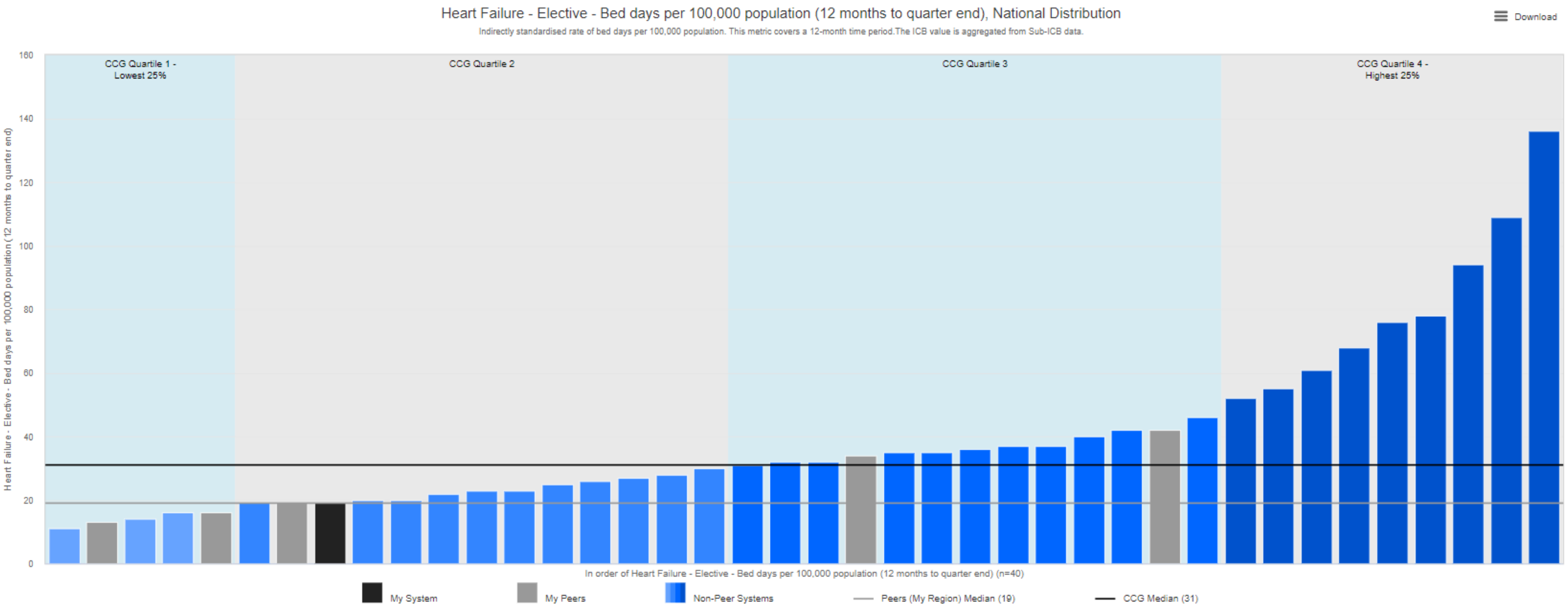
Outpatient care

HWE ICB is below the national median for the proportion of outpatient attendances that are new



Elective Care (1) – Elective inpatient bed days

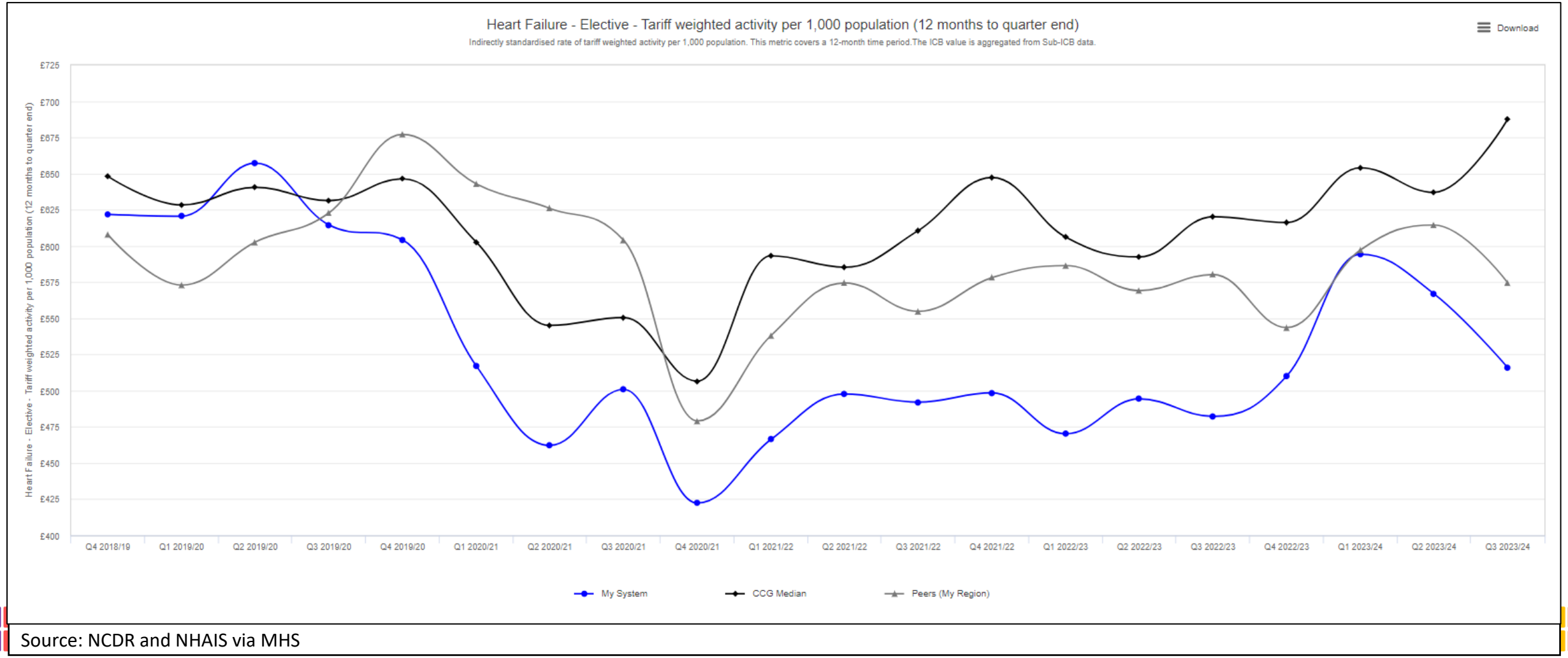
HWE has lower than national average elective inpatient bed days for heart failure



Source: NCDR and NHAIS via MHS

Elective Care (2) – Elective inpatient spend

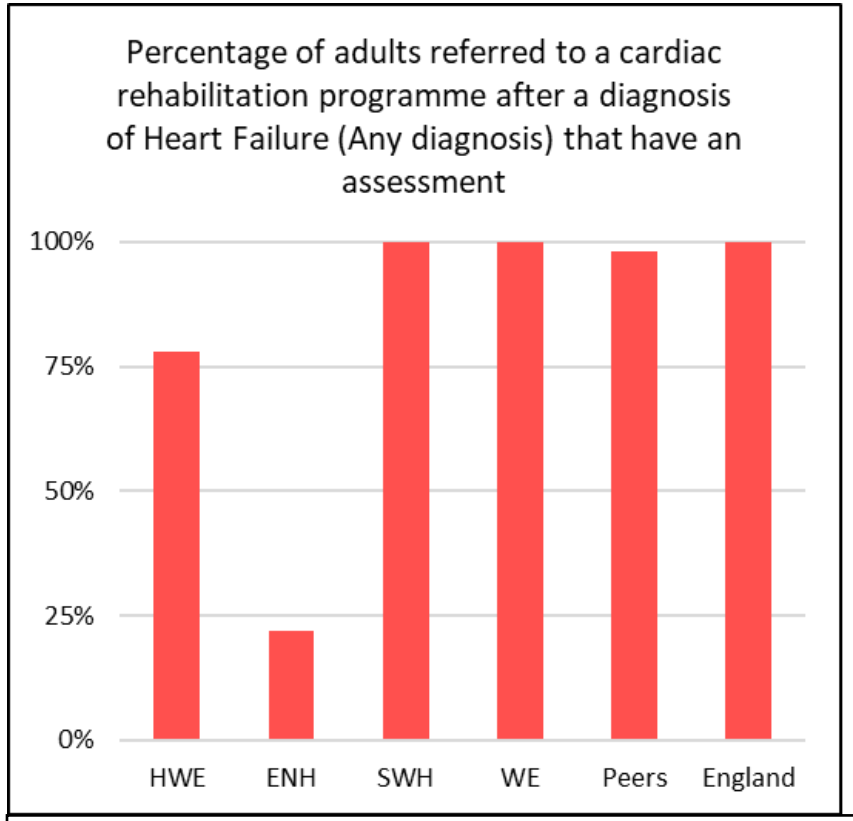
HWE has lower tariff-weighted activity per 1,000 than peer and national averages. Tariff-weighted activity has also decreased in the last two quarters

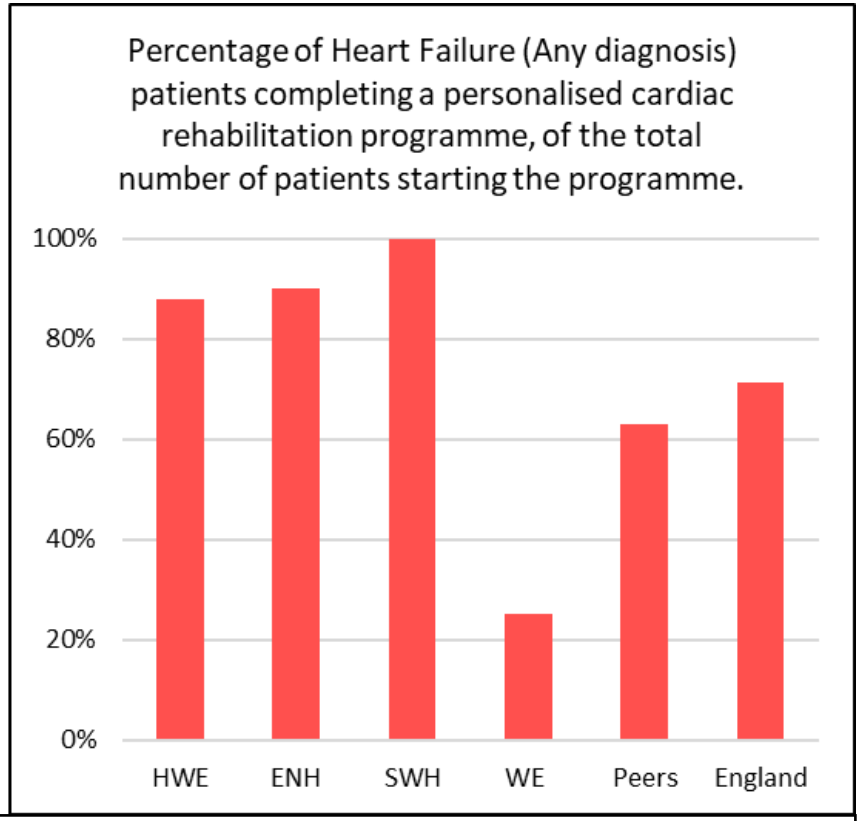


Source: NCDR and NHAIS via MHS

Cardiac rehabilitation after diagnosis of heart failure

- No data are available on referral rates to cardiac rehab after diagnosis of heart failure
- East and North Hertfordshire (ENH) has the lowest assessment rate following referral.
- Completion rates are lowest in West Essex (WE).



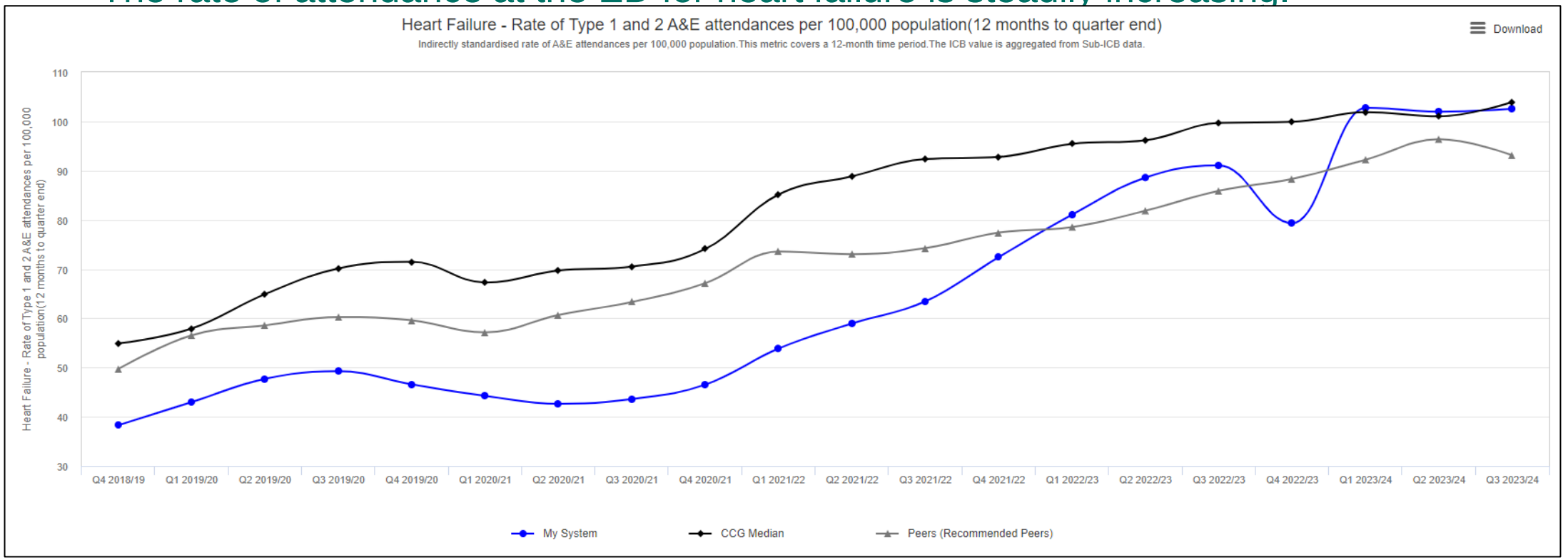


Source: National Audit of Cardiac Rehabilitation, 2022 via MHS

Outcomes (1) – Urgent and Emergency Care

Attendances at the Emergency Department for heart failure are similar to the national average and peers.

The rate of attendance at the ED for heart failure is steadily increasing.



- Attendances to the Emergency Department for heart failure have been increasing over time. Between Q4 18/19 and Q3 23/24 there has been a nearly three fold increase in the rate of emergency department attendance for heart failure.
- This is in part reflective of the increased prevalence but may also be attributed to improved coding of reasons for ED attendance over time.
- It is anticipated that ED attendance rate will continue to increase as the prevalence of heart failure increases and people live with heart failure for longer.

Source: SU+ SEM/ NHAIS (Model Health System)

Outcomes (2) – Urgent and Emergency Care

Congestive heart failure is associated with the highest spend on ambulatory care sensitive admissions

- Ambulatory care sensitive (ACS) conditions refer to acute presentations that could be resolved in ambulatory care settings (i.e. not requiring an admission).
- Congestive heart failure is associated with the highest number and spend on ACS admissions, with 3236 admissions costing over £15 million.

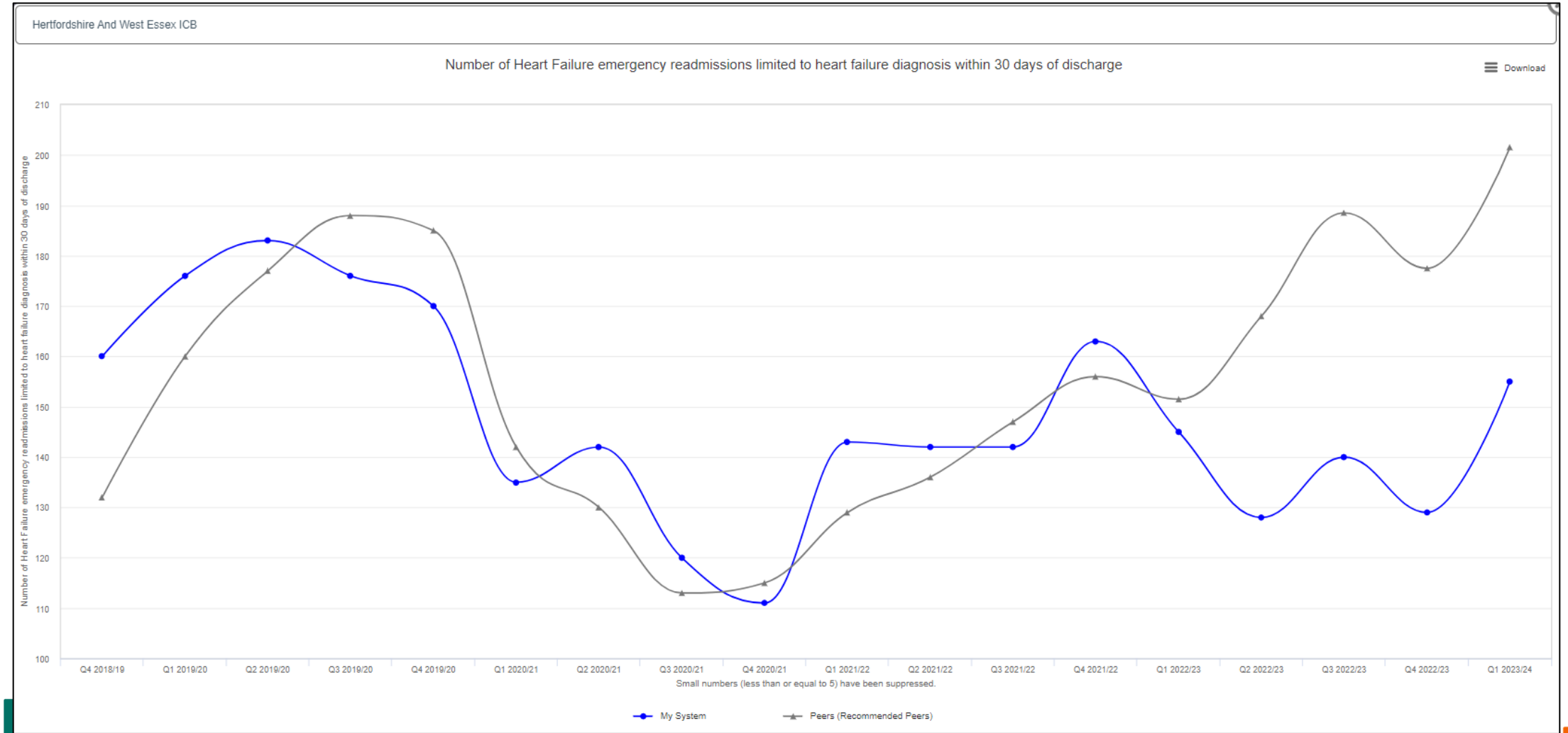
Chronic ACS admissions
April 2021 - September 2022
Herts & West Essex ICB

Chronic ACS	Admissions	People	Average cost of admission	Tariff Total Payment National
CVD: AF and Flutter	2,354	2,038	£2,308	£5,433,696
CVD: Angina	595	552	£1,377	£819,299
CVD: Congestive Heart Failure	3,236	2,669	£4,711	£15,246,404
CVD: Hypertension	957	898	£794	£759,866
Diseases of the blood	1,016	889	£2,250	£2,285,535
Mental and Behavioural Disorders	210	198	£4	£907
Neurological Disorders	1,177	776	£2,274	£2,676,404
Nutritional, endocrine and metabolic	1,895	1,470	£2,851	£5,402,644
Respiratory: Asthma	1,172	970	£1,479	£1,733,276
Respiratory: COPD	2,951	2,060	£2,862	£8,447,185
Grand Total	**15,563**	**11,953**	**£2,750**	**£42,805,216**

Source: SUS inpatient UEC data April 2021 to September 2022

Outcomes (3) – Urgent and Emergency Care

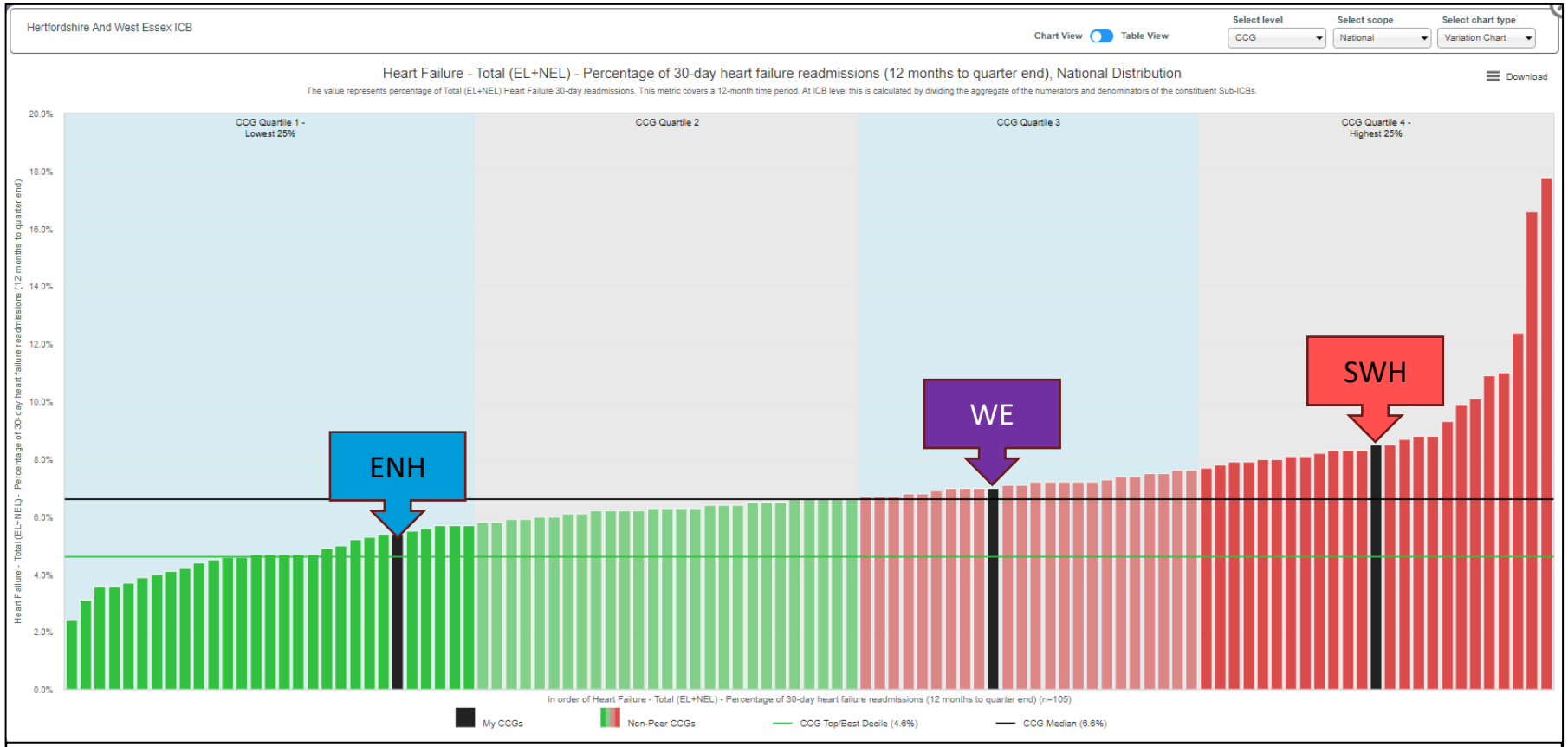
HWE ICB is below national average in number of emergency readmissions for heart failure



Source: National Commissioning Data Repository via MHS, to Q1 23/24

Outcomes (4) – Urgent and Emergency Care

Proportion of readmissions for heart failure within 30 days vary significantly between Place areas, with SWH in the highest quartile nationally, and ENH in the lowest

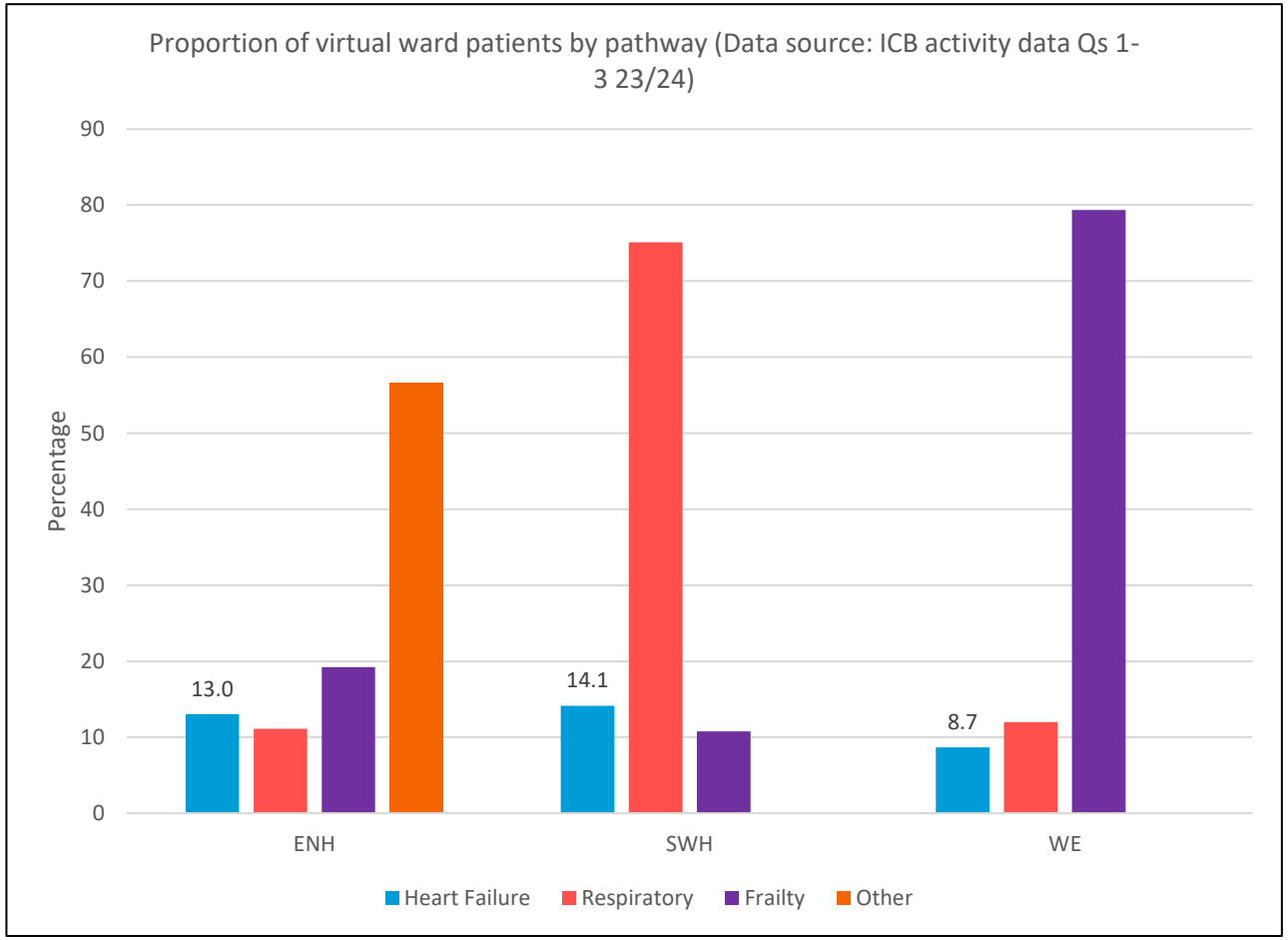


Source: National Commissioning Data Repository via MHS, Q1 23/24

Outcomes (5) – Urgent and Emergency Care

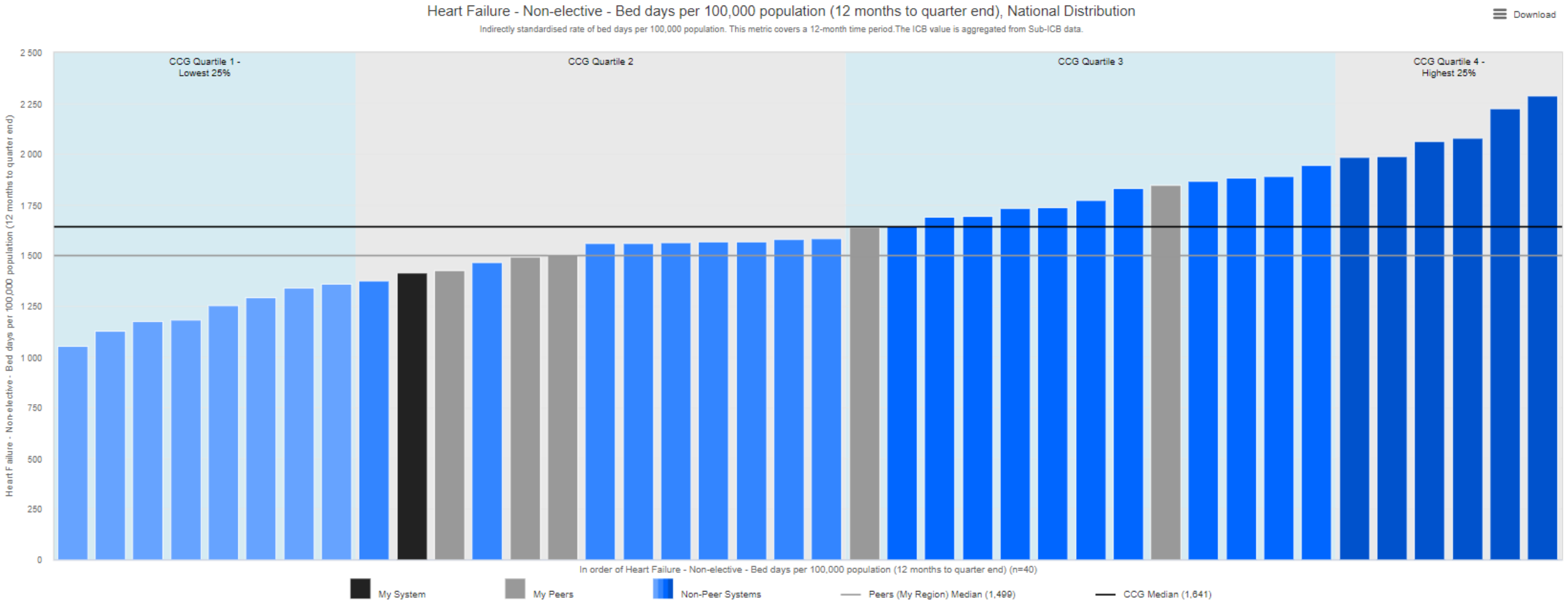
All three Place areas have established virtual hospital services for people with heart failure

- Heart failure patients make up between 8.7% and 14.1% of virtual ward patients, depending on Place area.



Outcomes (6) – Non-elective inpatient bed days

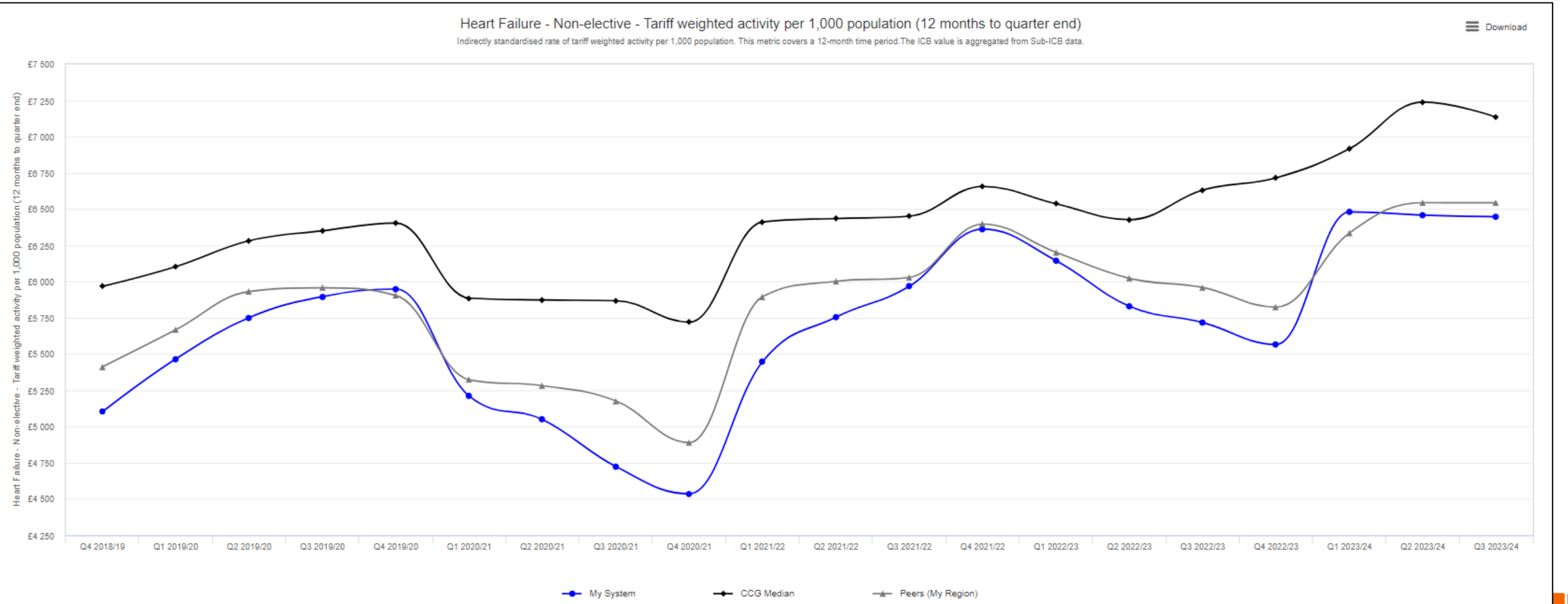
HWE has fewer non-elective inpatient bed days per 100,000 population for heart failure than our peer areas



Source: NCDR and NHAIS via MHS

Outcomes (7) – Non-elective inpatient spend

HWE has lower tariff-weighted activity per 1,000 than peer and national averages. However tariff-weighted activity has increased since Q4 22/23



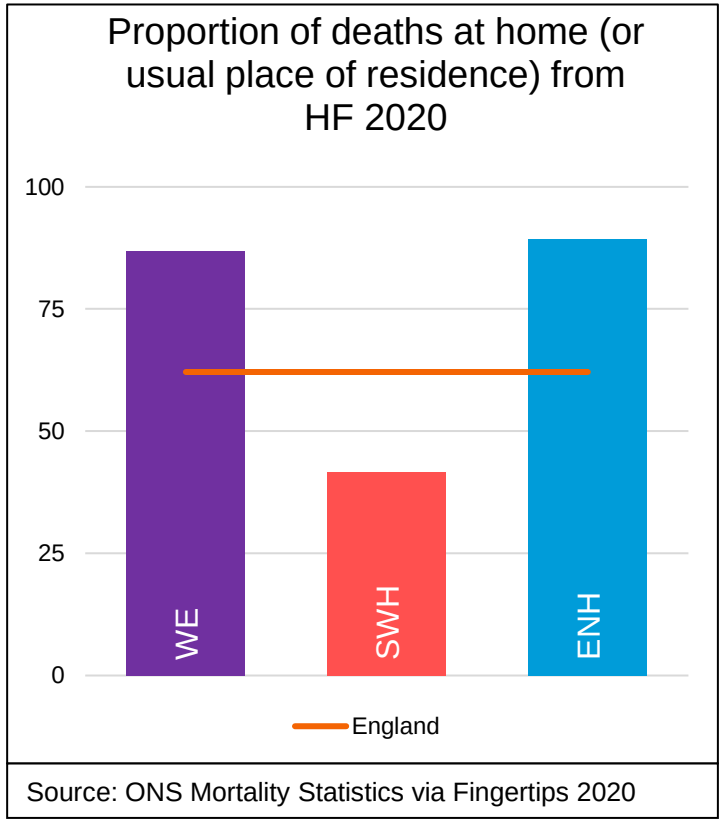
Source: NCDR and NHAIS via MHS

Outcomes (8) - Deaths

National Audit Office data indicate that between 50-74% of people would prefer to die at home

Enabling people to die at their preferred place requires good co-ordination between services, communication and resources (time for difficult conversations and facilities).

- SWH has been consistently below the national average for this metric.
- Further information on preferred place of death would be helpful to understand why this may be the case in SWH



Source: ONS Mortality Statistics via Fingertips 2020

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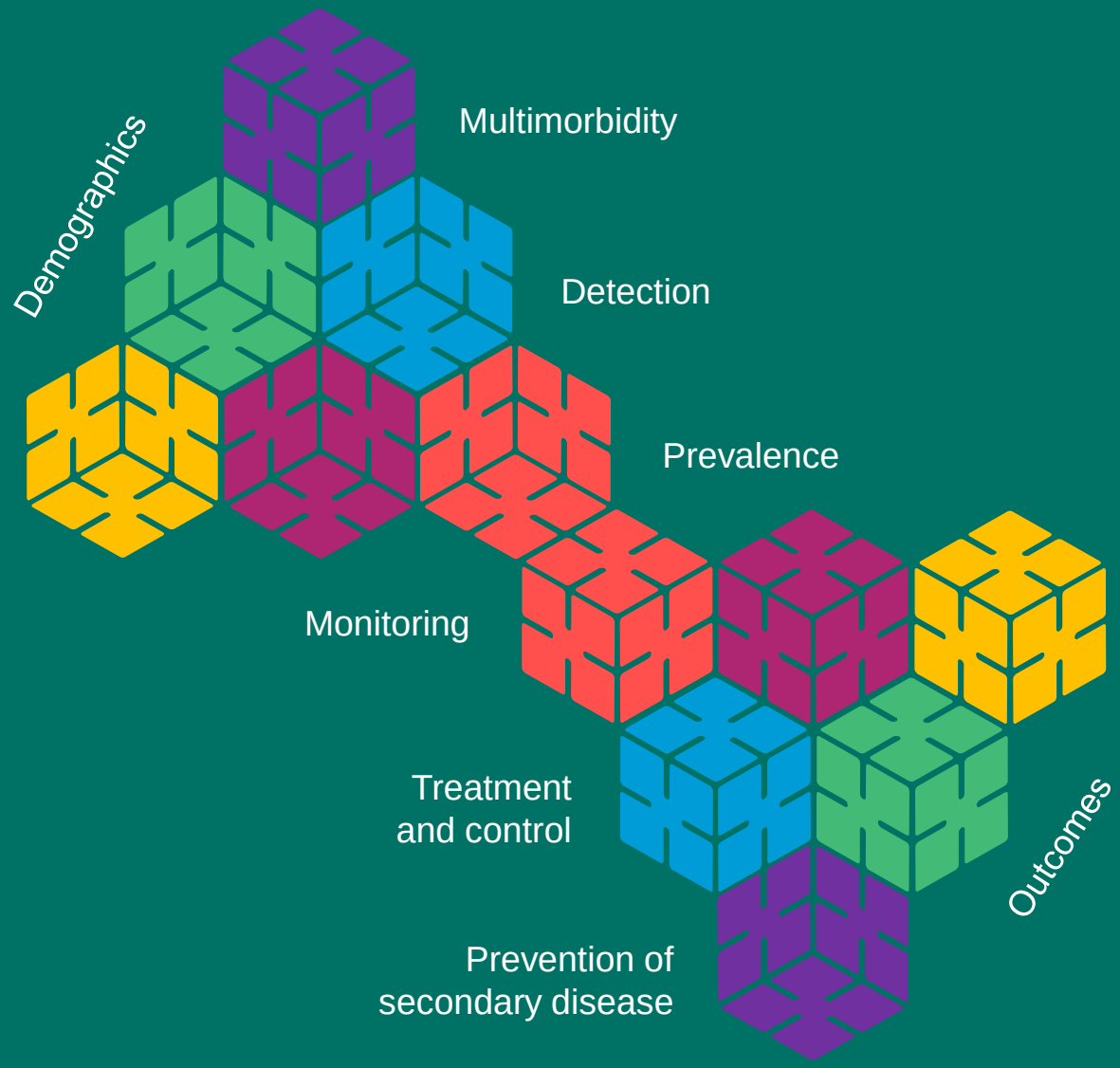
5. Data commentary and limitations



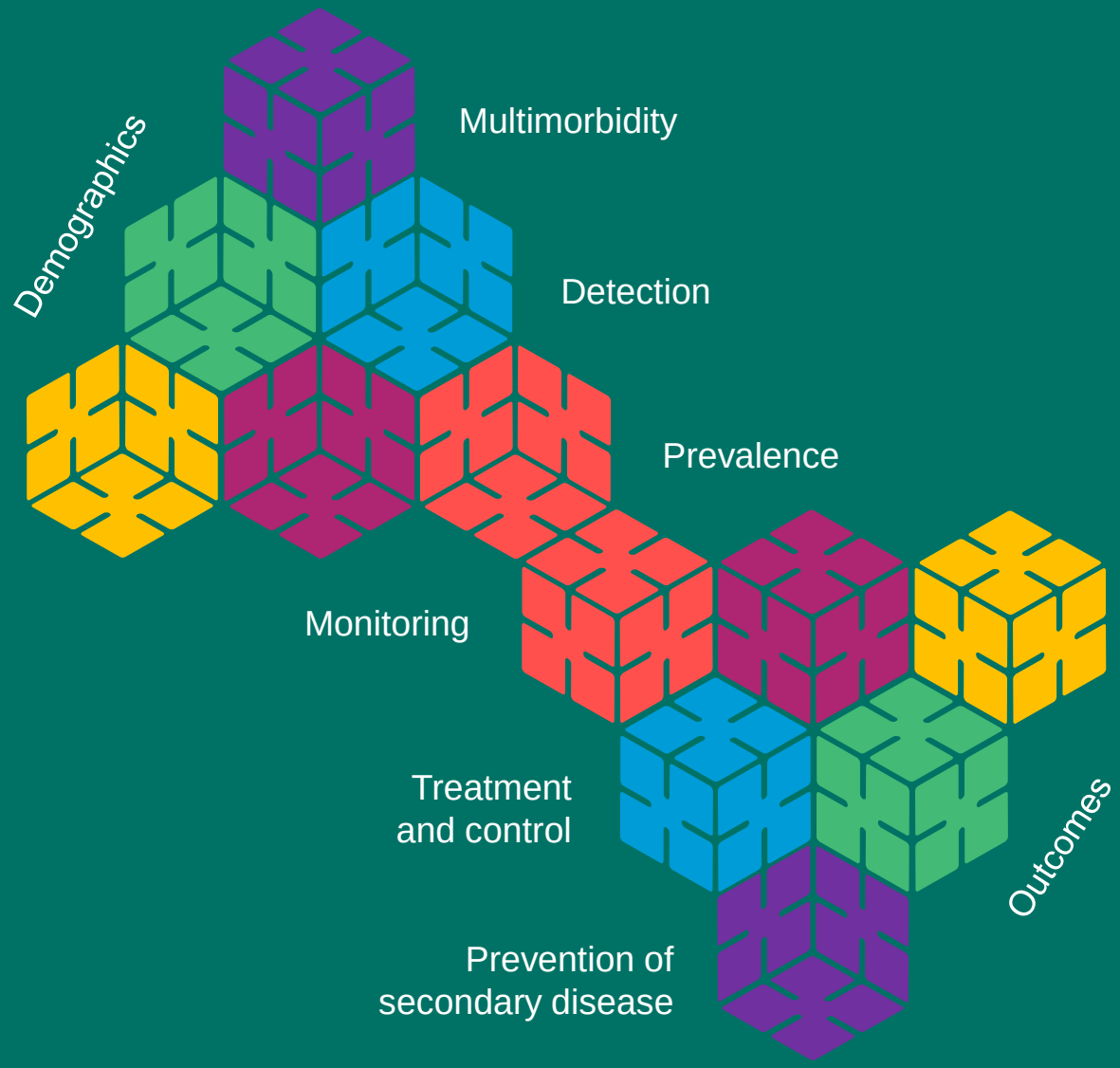
Working together
for a healthier future

Data commentary and limitations

- This data insights pack has utilised data from a range of sources and platforms, most of which are publicly available. These are referenced throughout to enable users to access the original data if they wish and accessed via the links below:
    - Fingertips
    - CVD Prevent
    - Population & Person Insights (PaPI)
    - Model Health System
    - Quality Outcomes Framework
- Slight discrepancies may occur between platforms due to how data are collected and calculated (for example, hypertension prevalence appears to be lower in QOF data than in CVD Prevent Audit). Where this is the case, the more conservative data source has been used.
- The data in this pack are the most up to date available at the time of review (9 April 2024).
- For all data sources used there is a lag between collection and publication (typically 6-12 months). It may therefore take some time for improvement activities to be reflected in the data.
- This data insights pack will be updated periodically as new datasets are released.

Hertfordshire and West Essex Integrated Care System

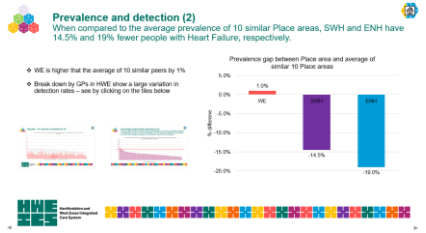
6. Additional Material



Working together
for a healthier future

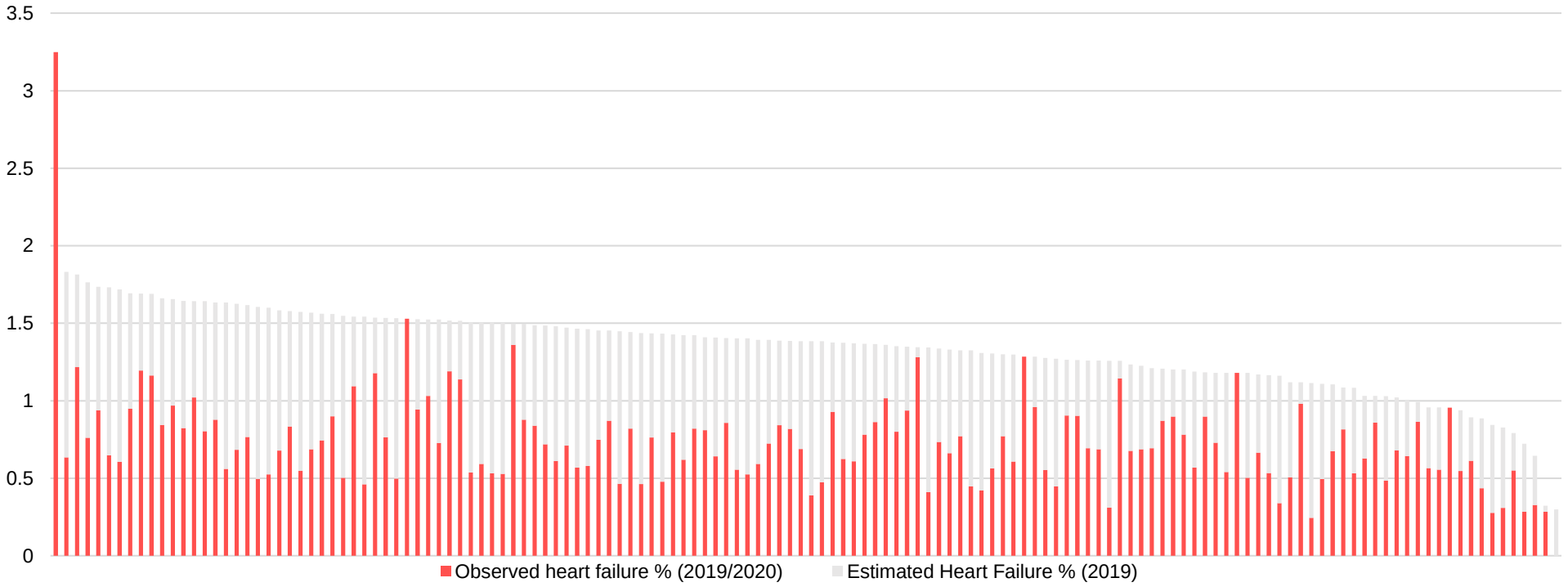
Detection – HF reported to estimated by GP

Back to



Previous Slide

Prevalence gap of observed vs expected heart failure as % population for Hertfordshire and West Essex ICS by GP surgery

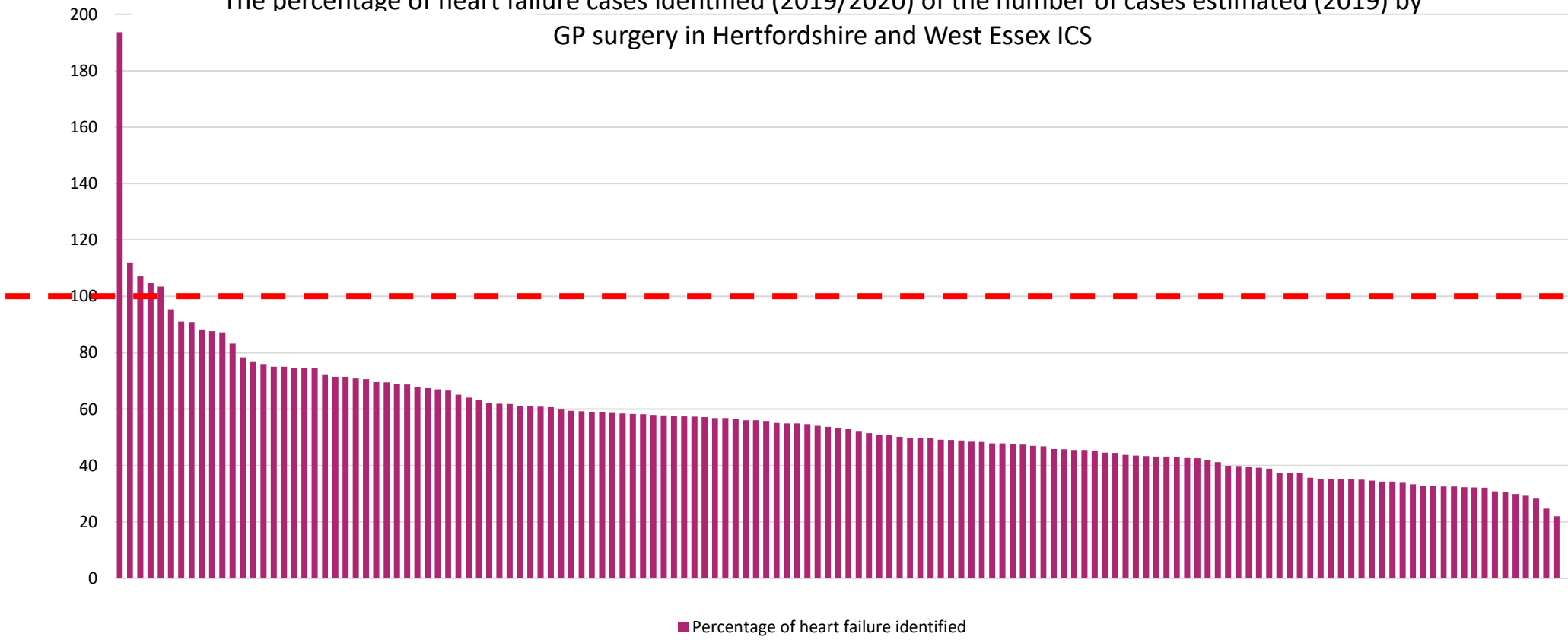


Hertfordshire and West Essex Integrated Care System

Percentage of Heart failure detected by GP

There is a wide variation in the prevalence gap identified by GP, from identification beyond the estimations to just over 20% of estimated. A small number of practices have identified more than the estimated prevalence of heart failure cases in their population.

The percentage of heart failure cases identified (2019/2020) of the number of cases estimated (2019) by GP surgery in Hertfordshire and West Essex ICS



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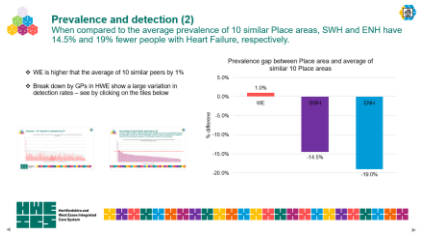


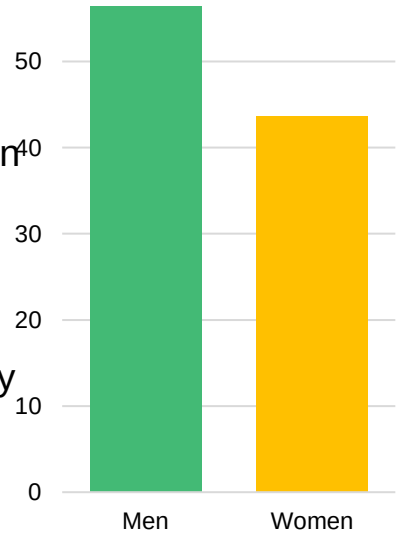
Previous Slide

Women and Heart Failure

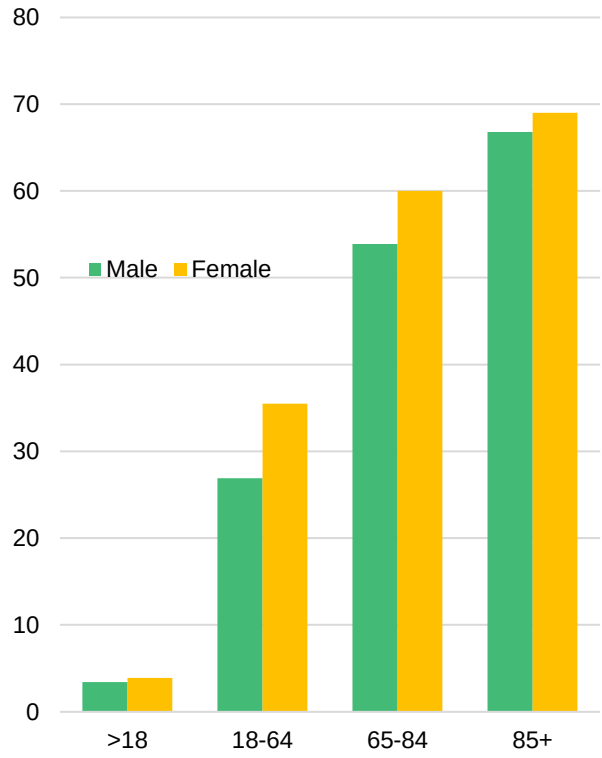
A pattern across multiple heart diseases is seen where women have a lower prevalence but higher rate of comorbidities. This pattern is seen nationally and most prominently in HF.

- There is over a 10% difference in prevalence of HF for men and women.
- Yet women with heart failure are more likely to be co-morbid
- Although further evidence is required to explain this, there are a number of reasons why this could be:
- Women present differently to men often delaying treatment and diagnosis
- Menopause increases HF risk
- Delayed diagnosis maybe a reason why women with heart conditions are more comorbid
- Back to previous slide

HF prevalence (Optum Sept 2022)



HF patients with 5 or more comorbidities (2021)



Over 85s with HF and 5 or more comorbidities (2021)