



Hertfordshire and
West Essex Integrated
Care System



Hertfordshire and
West Essex
Integrated Care Board

Cardiovascular disease prevention

HWE data insights pack

Dr Sam Williamson, Associate Medical Director

Dr Gisèle Spencer, Clinical Fellow

Dr Jasjot Saund, Clinical Fellow

Hannah Roscoe, Specialty Registrar in Public Health

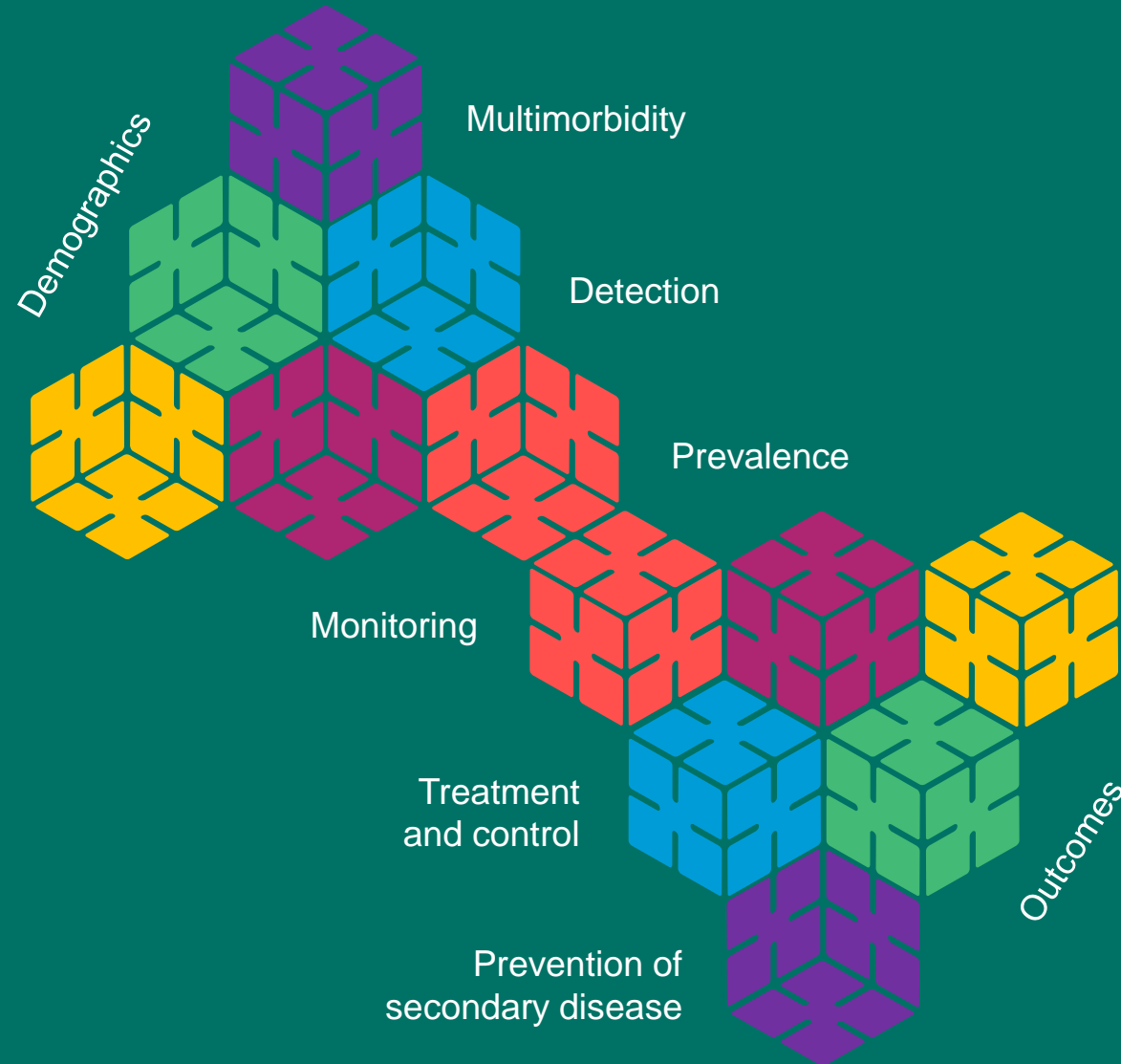
Working together
for a healthier future





Contents

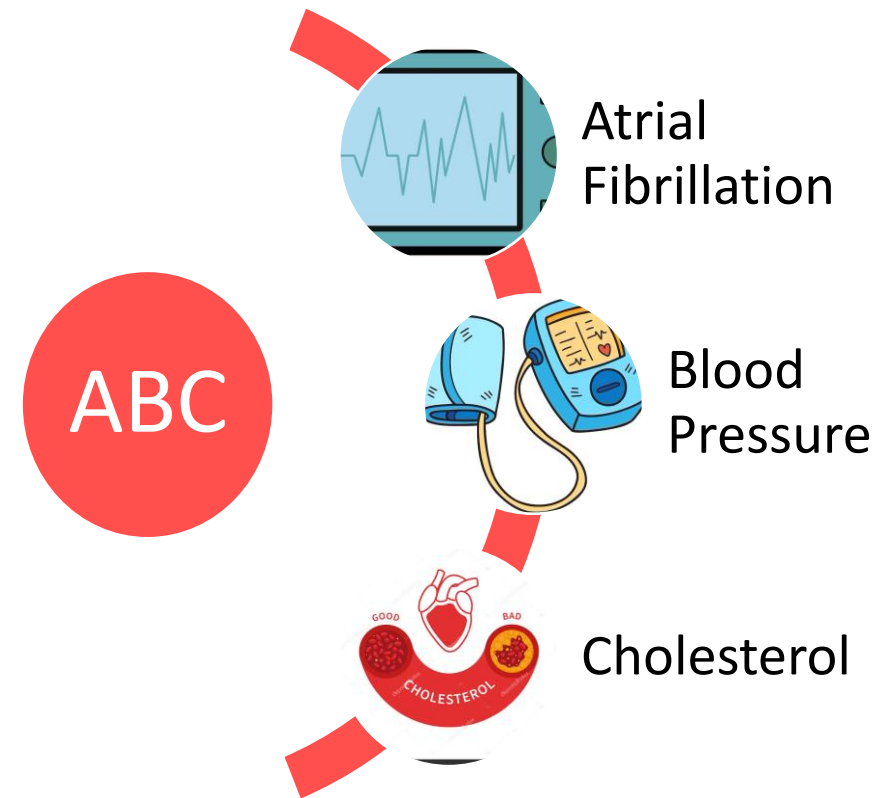
1. [Introduction](#)
2. [Atrial fibrillation](#)
3. [Hypertension](#)
4. [Cholesterol](#)
5. [Limitations](#)
6. [Additional material](#)





About this resource

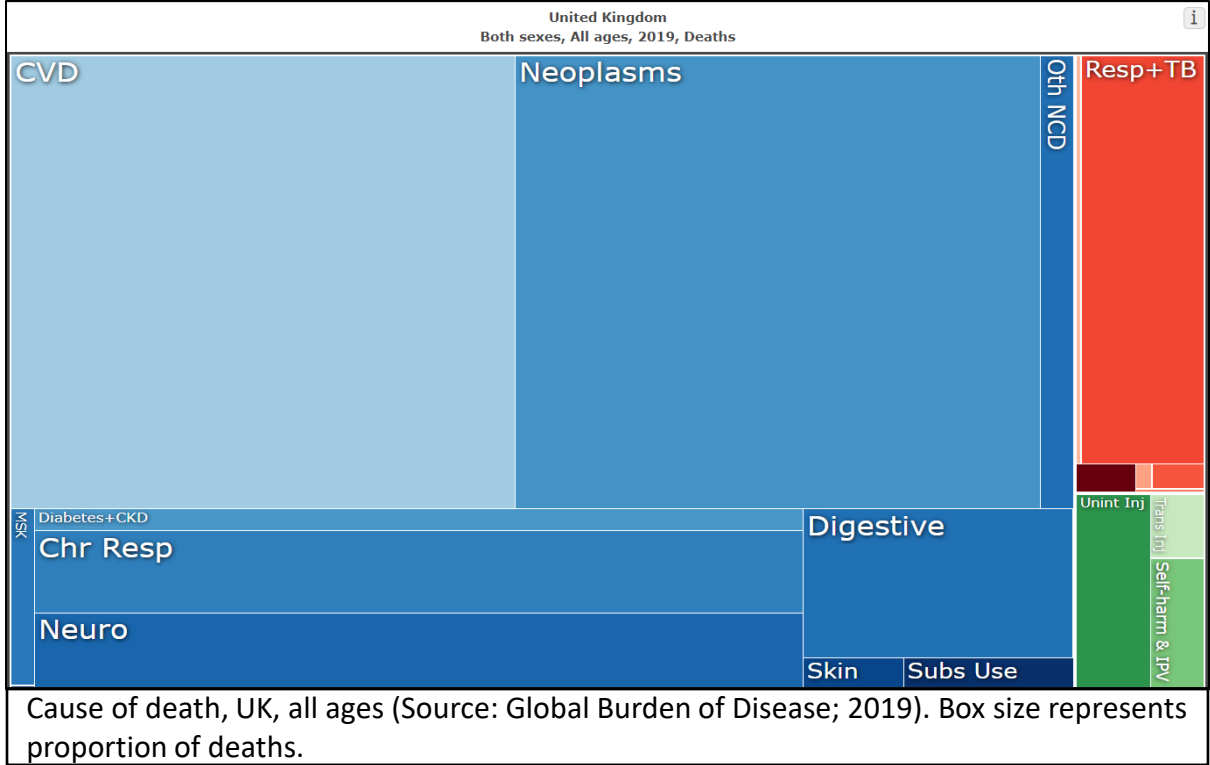
- Cardiovascular disease (CVD) is an umbrella term that encompasses diseases of the heart and circulatory system.
- This data insights pack presents data on CVD prevention, focusing on the 'ABC' conditions of:
 - Atrial fibrillation (AF)
 - Blood pressure (hypertension)
 - Cholesterol (hypercholesterolaemia).
- Detecting and managing these conditions may help to prevent more serious CVD conditions and events.
- This pack presents data across the care pathway, encompassing: detection, monitoring, routine management and management of more serious disease.
- There is a separate data insights pack on more advanced CVD conditions of:
 - Heart failure
 - Coronary heart disease (CHD)
 - Stroke.
- This pack aims to describe the health needs within the HWE population and 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.





Introduction to cardiovascular disease

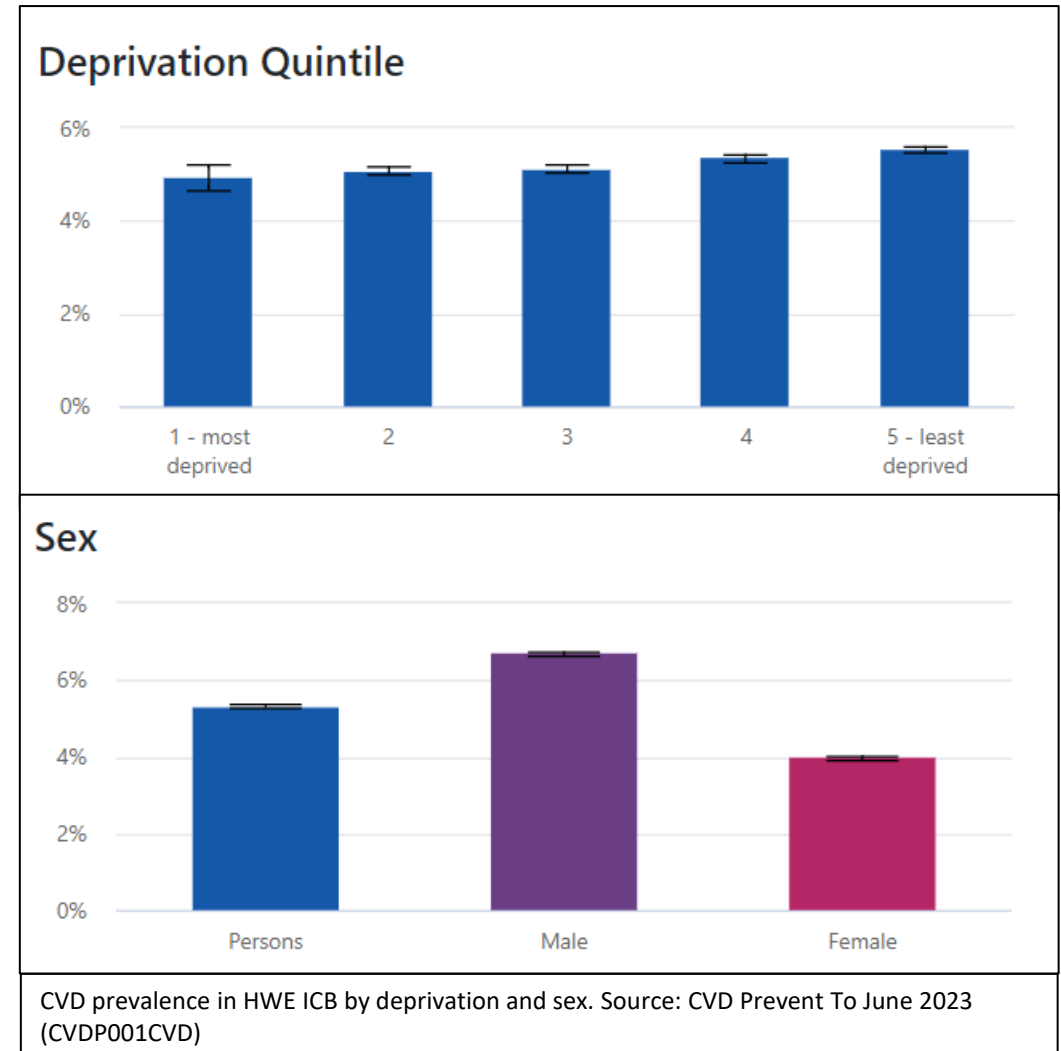
- Cardiovascular disease (CVD) is an umbrella term that encompasses diseases of the heart and circulatory system.
- CVD is the second most common cause of death and disability in the UK (Source: GBD 2019).
- CVD is largely preventable. Modifiable risk factors for cardiovascular disease include hypertension, high cholesterol, smoking, obesity, air pollution, diet, exercise, diabetes (see Diabetes pack) and kidney disease (see CKD pack). Non-modifiable risk factors include older age, gender, ethnicity and family history.
- The presence of CVDs 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.





Cardiovascular disease overview (1)

- CVD prevalence in HWE is lower than national and regional prevalence. The prevalence of GP-recorded CVD for patients 18yrs and over (Source: CVD Prevent June 2023) is:
 - HWE - 5.30%
 - East and North Hertfordshire – 5.08%
 - South West Hertfordshire – 5.34%
 - West Essex - 5.62%
 - East of England Region – 5.63%
 - England - 6.06%
- This uses the wide definition of CVD, that includes: CHD, Stroke, TIA (transient ischaemic attack), PAD (peripheral arterial disease), heart failure and AAA (abdominal aortic aneurism)
- CVD prevalence in HWE varies by deprivation. There is significantly lower prevalence in the most deprived group compared to the least deprived population in HWE. This may be due to an underdiagnosis within in the most deprived populations, or due to the HWE most deprived populations being younger (data is not age standardised) (Source CVD Prevent June 2023).
- Prevalence of CVD is higher in men than women (Source: CVD Prevent June 2023)

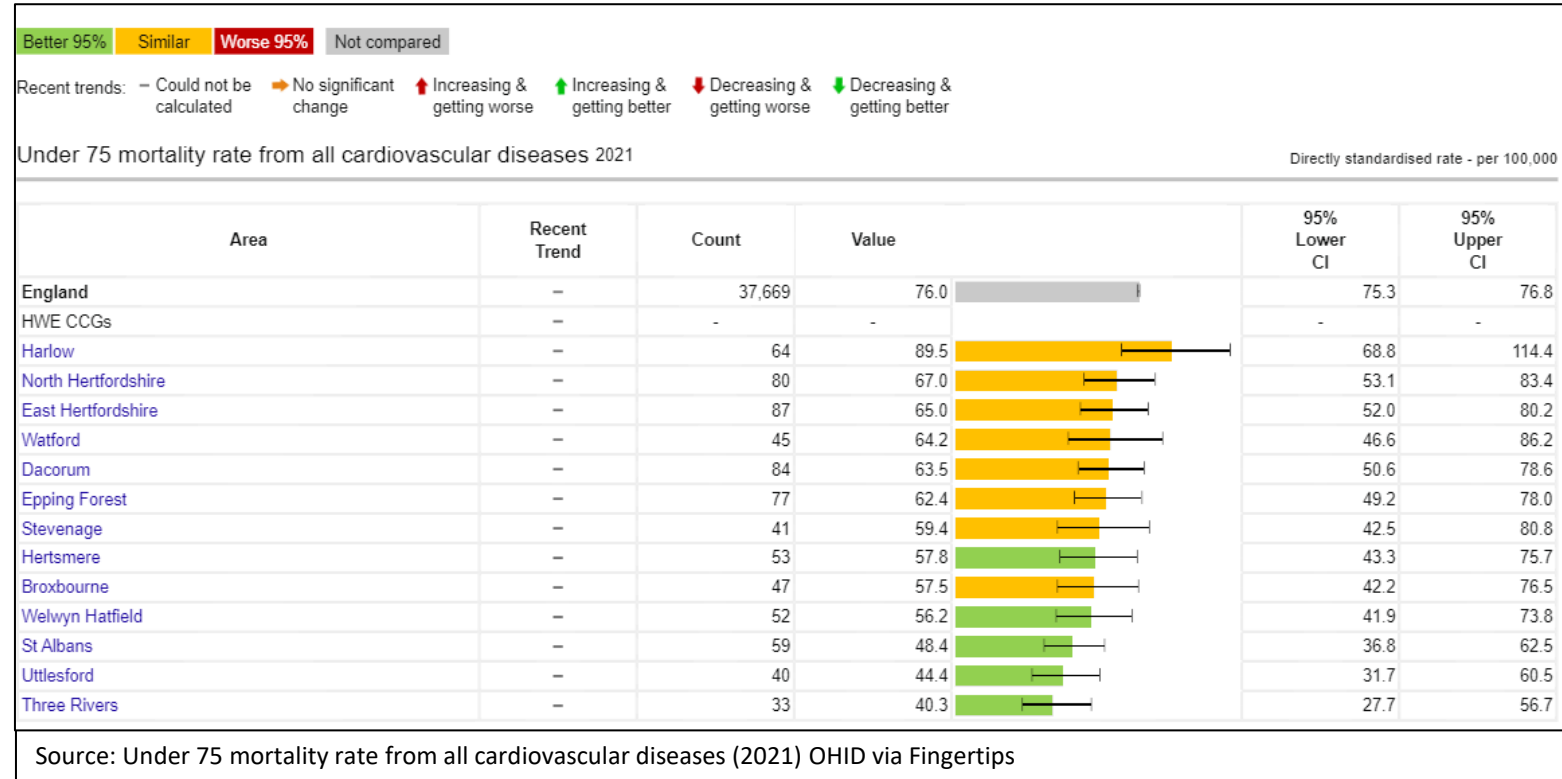




Cardiovascular disease overview (2)

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.
- 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.





Key recommendations

Based on the data in this pack, the following recommendations are made:

1. Detection and management of atrial fibrillation, hypertension and hypercholesterolaemia should remain a priority for HWE ICB as a means of preventing more serious cardiovascular diseases and events. For example, reducing systolic blood pressure by an average of 10mmHg reduces the risk of major CVD events by 20%, CHD by 17%, heart failure by 28%, stroke by 27% and all-cause mortality by 13% (Source: Ettehad et al 2016, The Lancet). Reducing LDL cholesterol by 1.0 mmol/L reduces risk of major vascular events by 22% and all-cause mortality by 10% (Source: CTT, The Lancet).
2. Detection and control of atrial fibrillation is broadly in line with national averages. However, there is an opportunity to improve rates of anticoagulant prescribing in patients who go on to experience stroke.
 - See section on [atrial fibrillation](#)
3. There is a substantial opportunity to improve detection rates for hypertension, including improving access to blood pressures checks through strategies including 'making every contact count', offering home blood pressure monitoring and targeting areas of low detection
4. Despite improvement, the proportion of those with hypertension who are treated to NICE-recommended thresholds has not reached the 2022/23 target of 77%. Efforts to improve rates of treatment to threshold should continue.
 - See section on [hypertension](#)
5. The proportion of patients with hypercholesterolaemia who are treated to threshold is below the target of 35%. Efforts to improve rates of treatment to threshold should continue.
6. There is an opportunity to reduce inappropriate use of low- and medium-intensity statins in the treatment of hypercholesterolaemia.
 - See section on [high cholesterol](#).



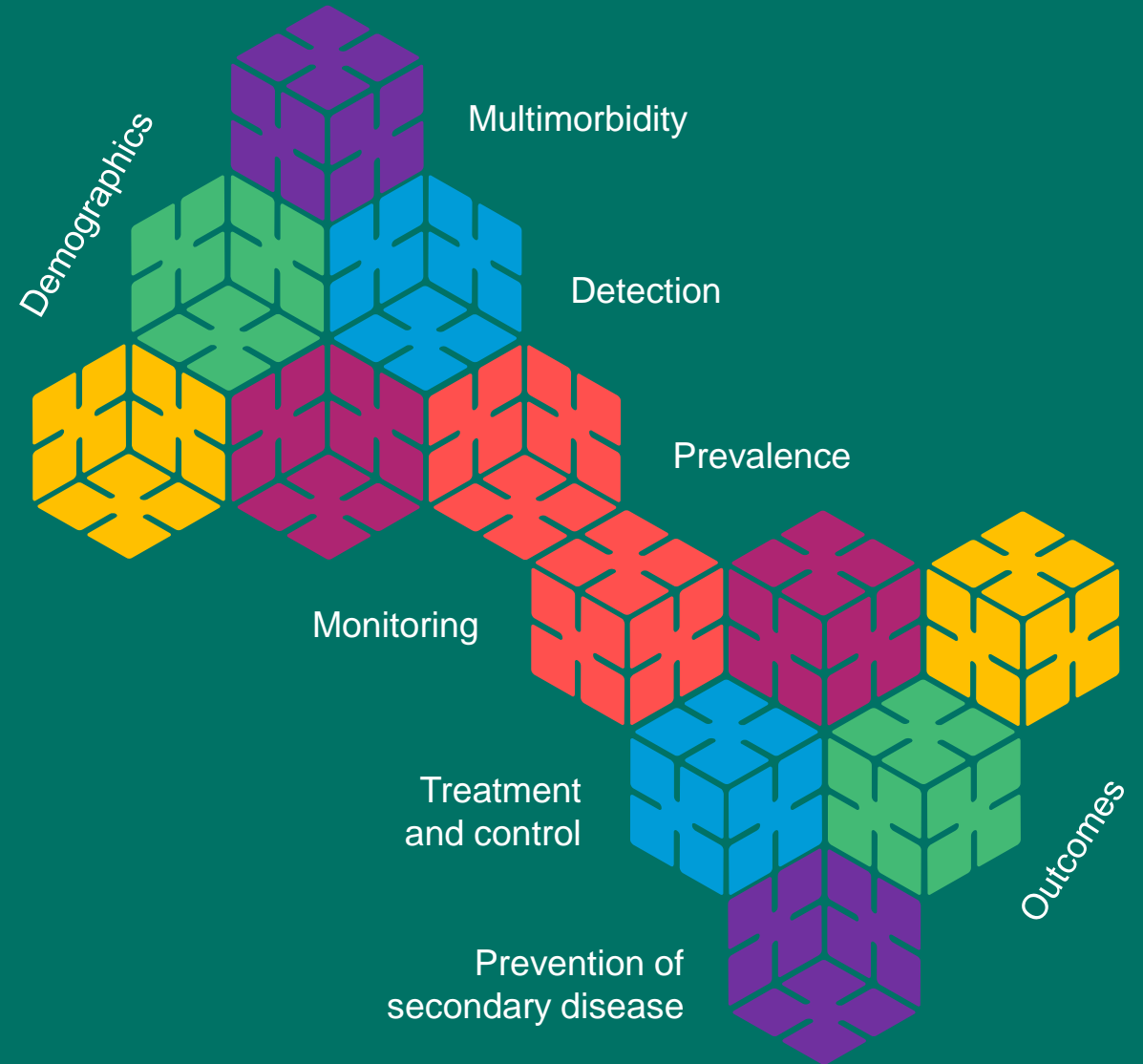
Hertfordshire and
West Essex Integrated
Care System



2. Atrial Fibrillation

- ❖ [Introduction](#)
- ❖ [Key Messages](#)
- ❖ [Prevalence and Detection](#)
- ❖ [Demographics](#)
- ❖ [Multimorbidity](#)
- ❖ [Monitoring](#)
- ❖ [Treatment](#)
- ❖ [Outcomes](#)

Working together
for a healthier future





Atrial Fibrillation Introduction

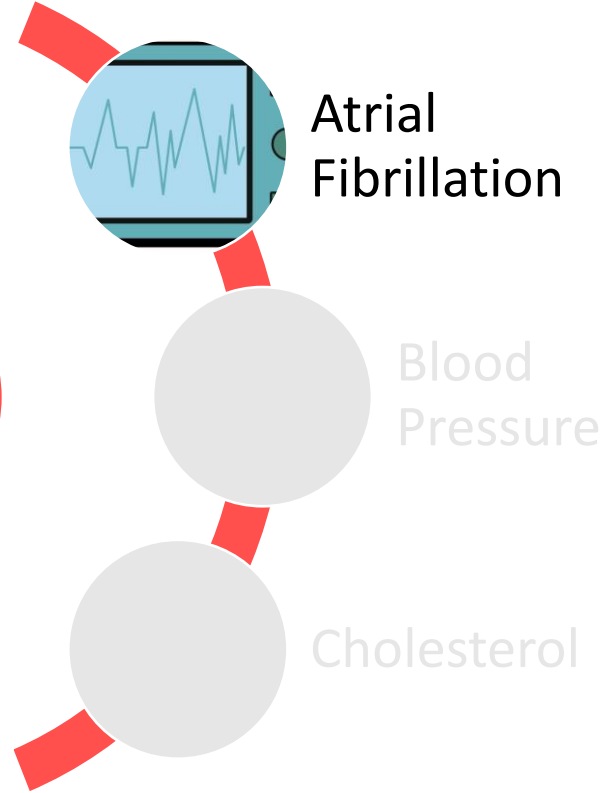
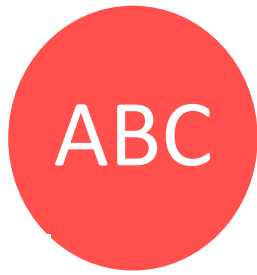
Atrial fibrillation (AF) is a common abnormal heart rhythm.

Symptoms may include palpitations, chest pain, light-headedness and shortness of breath.

If left untreated, it can increase the risk of ischaemic stroke and heart failure.

Risk factors for AF include:

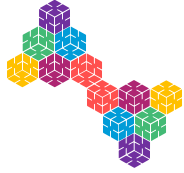
- Hypertension
- CHD
- Heart valve disease
- Congenital heart disease
- Diabetes
- Alcohol
- Obesity
- Increasing age
- Thyroid disease



Secondary prevention is required to reduce the risk of clotting. This is normally with anticoagulating medications (ACTs)

Treatment of the heart rhythm may include beta-blockers, ablation, cardioversion or implanted devices.

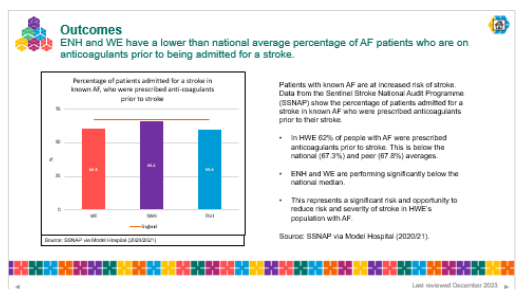
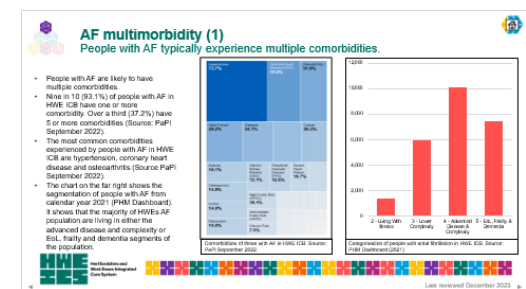
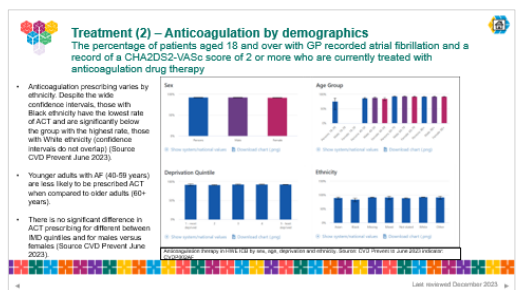
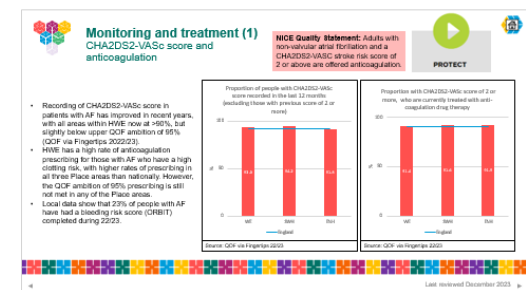
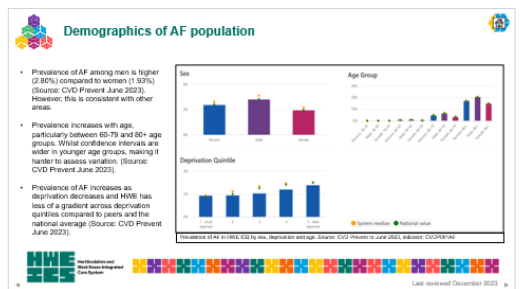
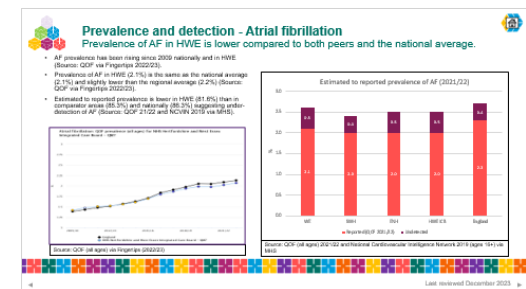




6 key messages – Atrial fibrillation

Click on each tile to explore and see more information

1. AF prevalence in HWE is the same as the national median (2.1%). It is rising yearly in line with the national trend. ENH has the largest prevalence gap and, compared to the best 5 of 10 similar peers, has the greatest opportunity to identify more patients with AF. Detection varies widely by GPs.
2. Prevalence is higher among men (2.8%) compared to women (1.9%) and increases as deprivation decreases. HWE has less of a gradient across deprivation quintiles compared to peers and the national average.
3. In 22/23, WE and SWH performed more CHA2DS2-VASc scores when compared to the national median.
4. Uptake of anticoagulation in high risk groups is lowest and below the national median for Black ethnicity and females between 40-59 years.
5. The HWE AF population is multimorbid, with the majority living in the “Advanced disease and Complexity” segment. Those living in more deprivation, or those in the Asian population, are more likely to have 5 or more co-morbidities.
6. All Place Areas are below national rates of those on anti-coagulation prior to having an AF-related stroke.

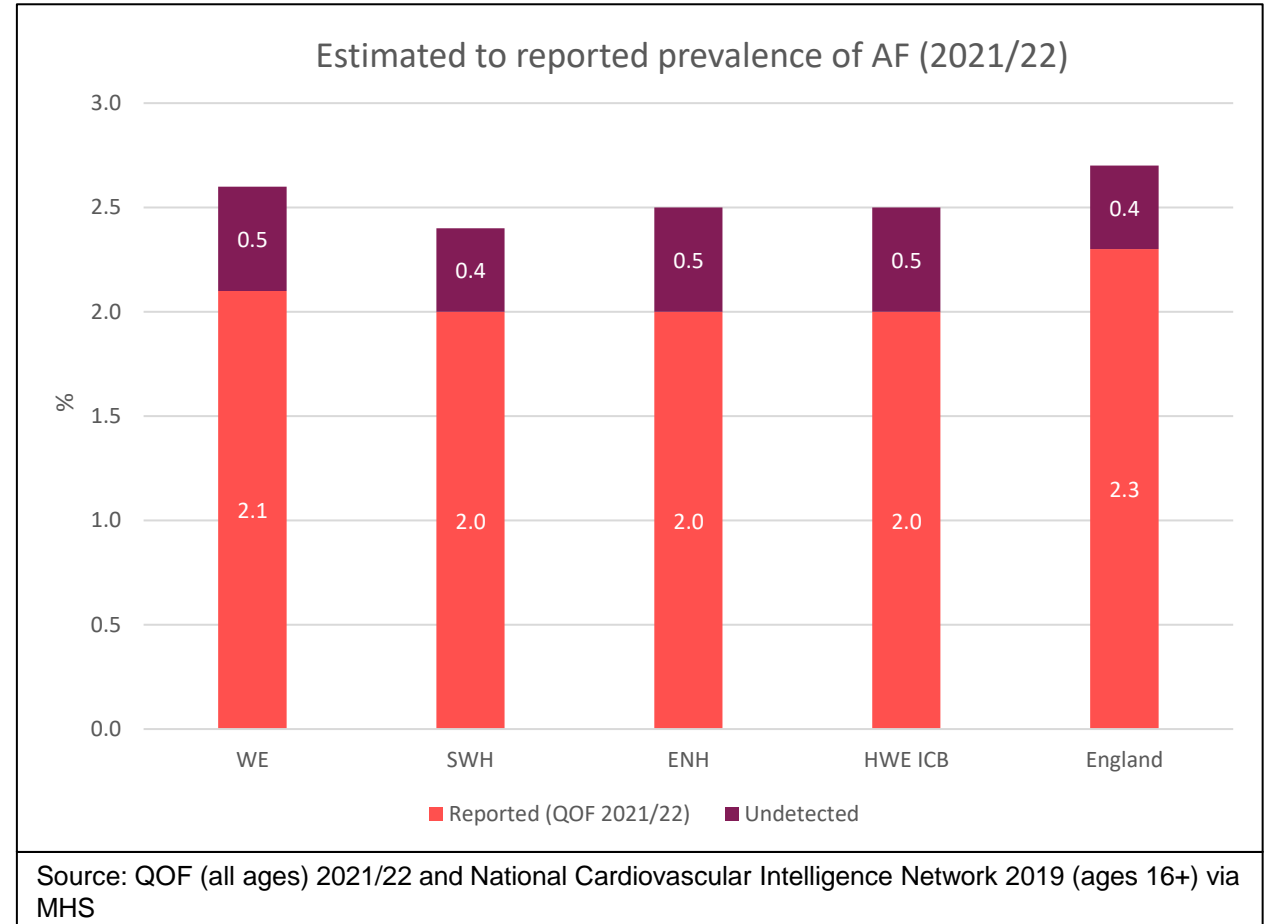
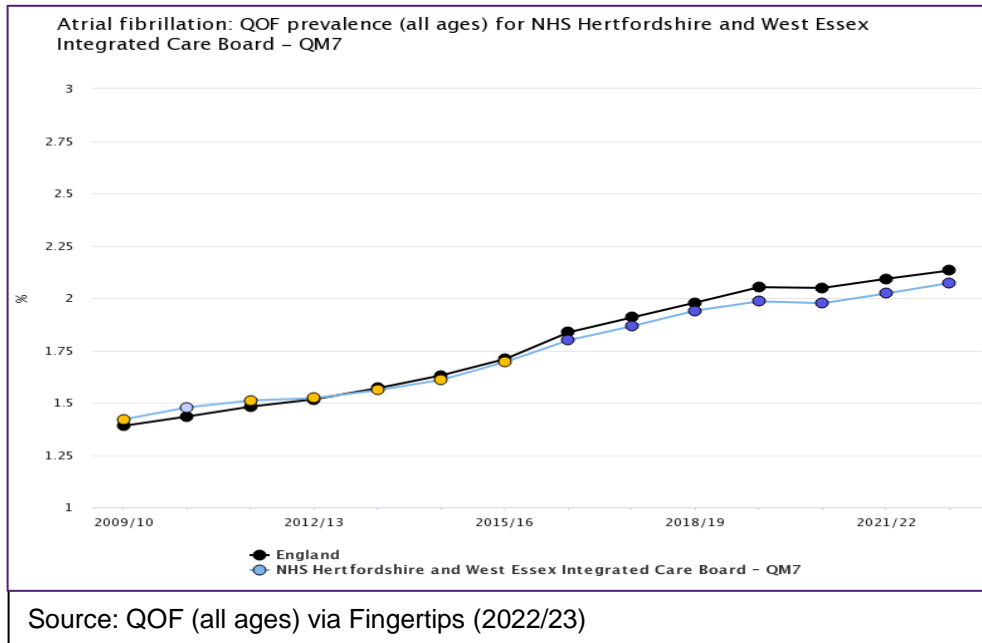




Prevalence and detection - Atrial fibrillation

Prevalence of AF in HWE is lower compared to both peers and the national average.

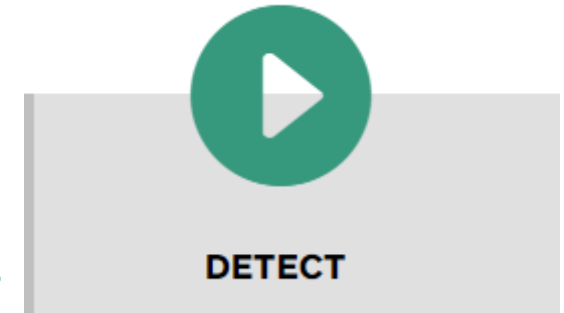
- AF prevalence has been rising since 2009 nationally and in HWE (Source: QOF via Fingertips 2022/23).
- Prevalence of AF in HWE (2.1%) is the same as the national average (2.1%) and slightly lower than the regional average (2.2%) (Source: QOF via Fingertips 2022/23).
- Estimated to reported prevalence is lower in HWE (81.6%) than in comparator areas (85.3%) and nationally (86.3%) suggesting under-detection of AF (Source: QOF 21/22 and NCVIN 2019 via MHS).








Detection – Reported to estimated prevalence for AF

Comparing HWE prevalence to the average of each place area's peer groups, there are potential opportunities to increase AF detection. The chart below shows the opportunity for each Place area by comparing the local prevalence to the average of the best 5 of the similar 10 peers for each Place area.

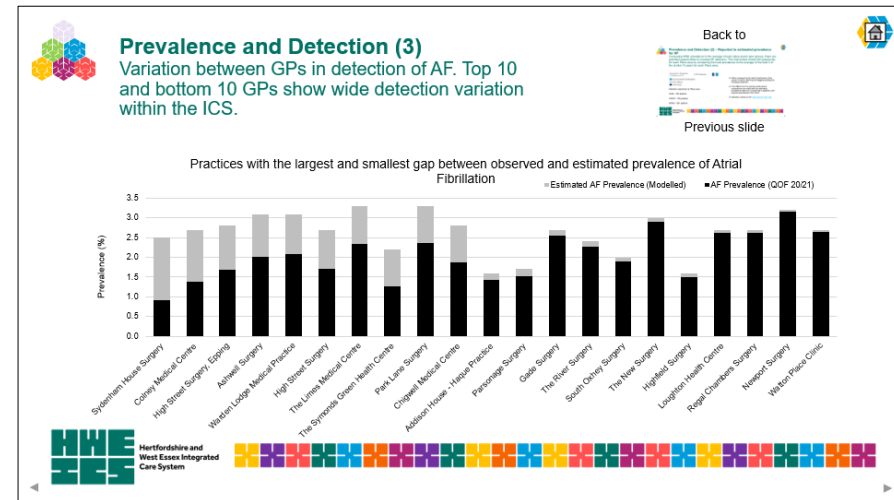


Reported to Estimated Prevalence of AF 2,152 Patients

	East and North Hertfordshire	– 851 patients
	Herts Valleys	– 766 patients
	West Essex	– 535 patients

Estimated number of patients with unidentified AF per place area. Source: NHS Right care (2019/20)

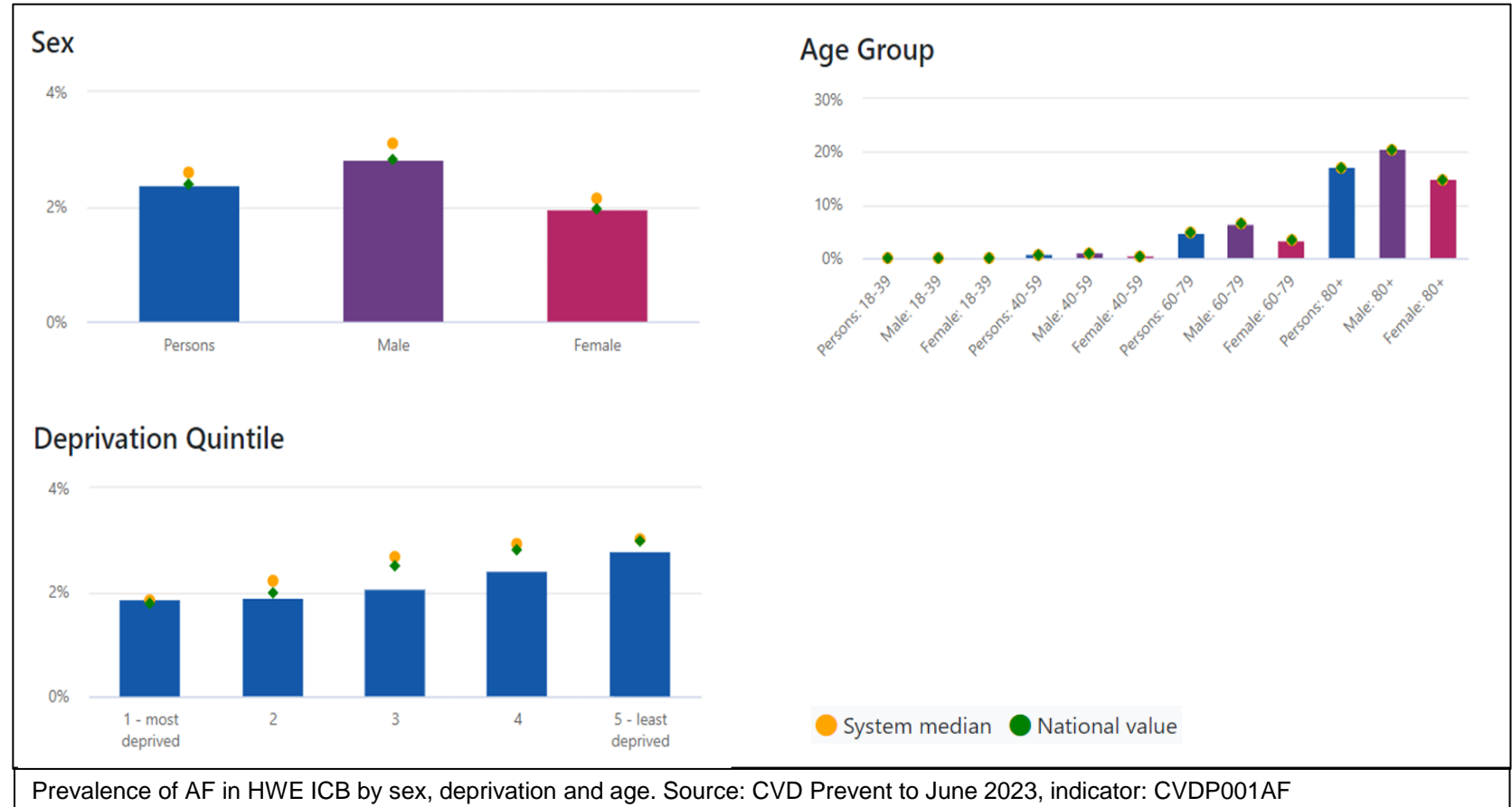
- When compared to the best 5 performers of the similar 10 peers, ENH has the biggest potential for increased detection of AF.
- Detection varies by GP, click on tile below to view detection variation by Practice.





Demographics of AF population

- Prevalence of AF among men is higher (2.80%) compared to women (1.93%) (Source: CVD Prevent June 2023). However, this is consistent with other areas.
- Prevalence increases with age, particularly between 60-79 and 80+ age groups. Whilst confidence intervals are wider in younger age groups, making it harder to assess variation. (Source: CVD Prevent June 2023).
- Prevalence of AF increases as deprivation decreases and HWE has less of a gradient across deprivation quintiles compared to peers and the national average (Source: CVD Prevent June 2023).

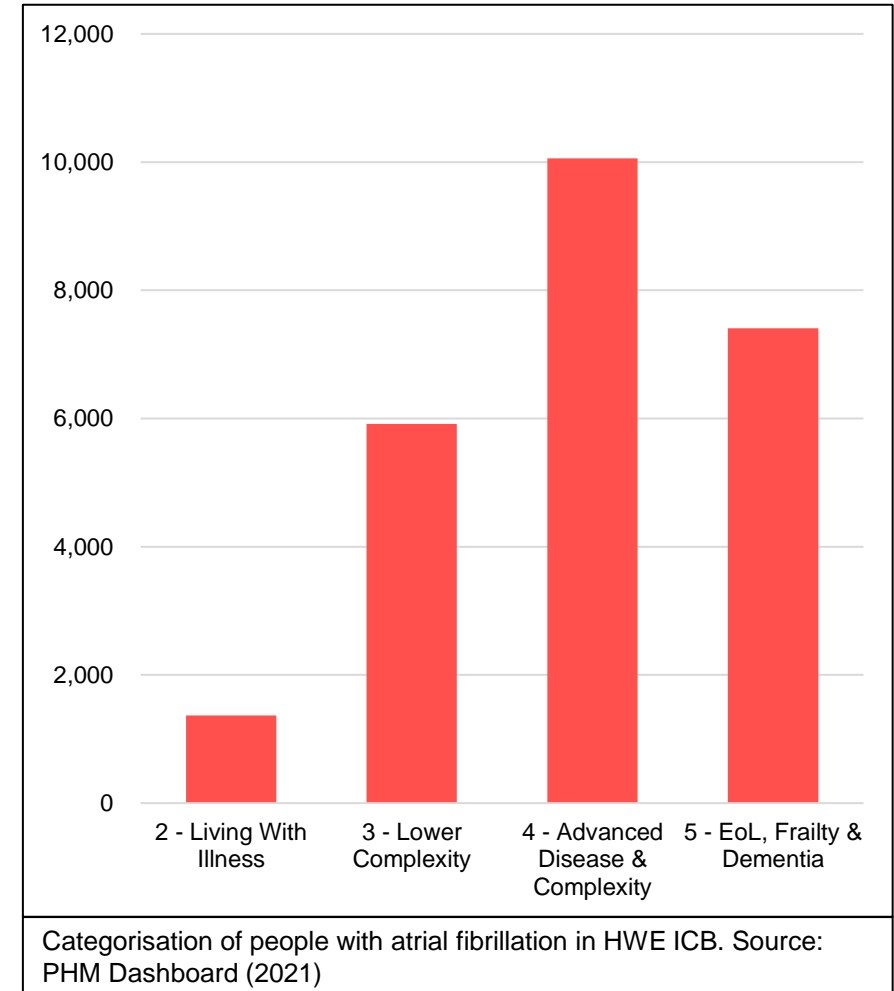
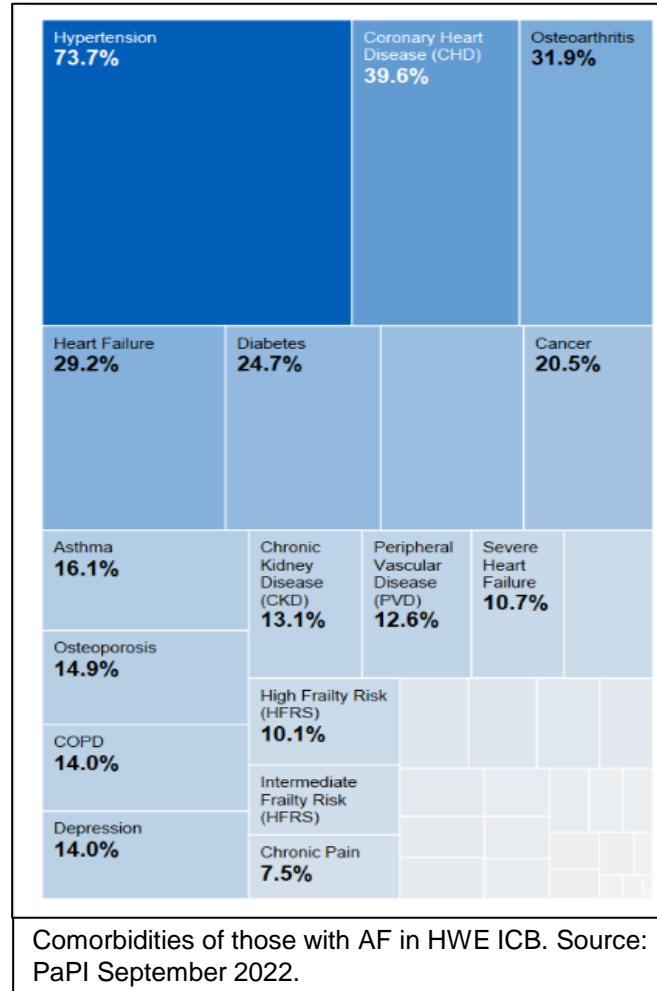




AF multimorbidity (1)

People with AF typically experience multiple comorbidities.

- People with AF are likely to have multiple comorbidities.
- Nine in 10 (93.1%) of people with AF in HWE ICB have one or more comorbidity. Over a third (37.2%) have 5 or more comorbidities (Source: PaPI September 2022).
- The most common comorbidities experienced by people with AF in HWE ICB are hypertension, coronary heart disease and osteoarthritis (Source PaPI September 2022).
- The chart on the far right shows the segmentation of people with AF from calendar year 2021 (PHM Dashboard). It shows that the majority of HWEs AF population are living in either the advanced disease and complexity or EoL, frailty and dementia segments of the population.

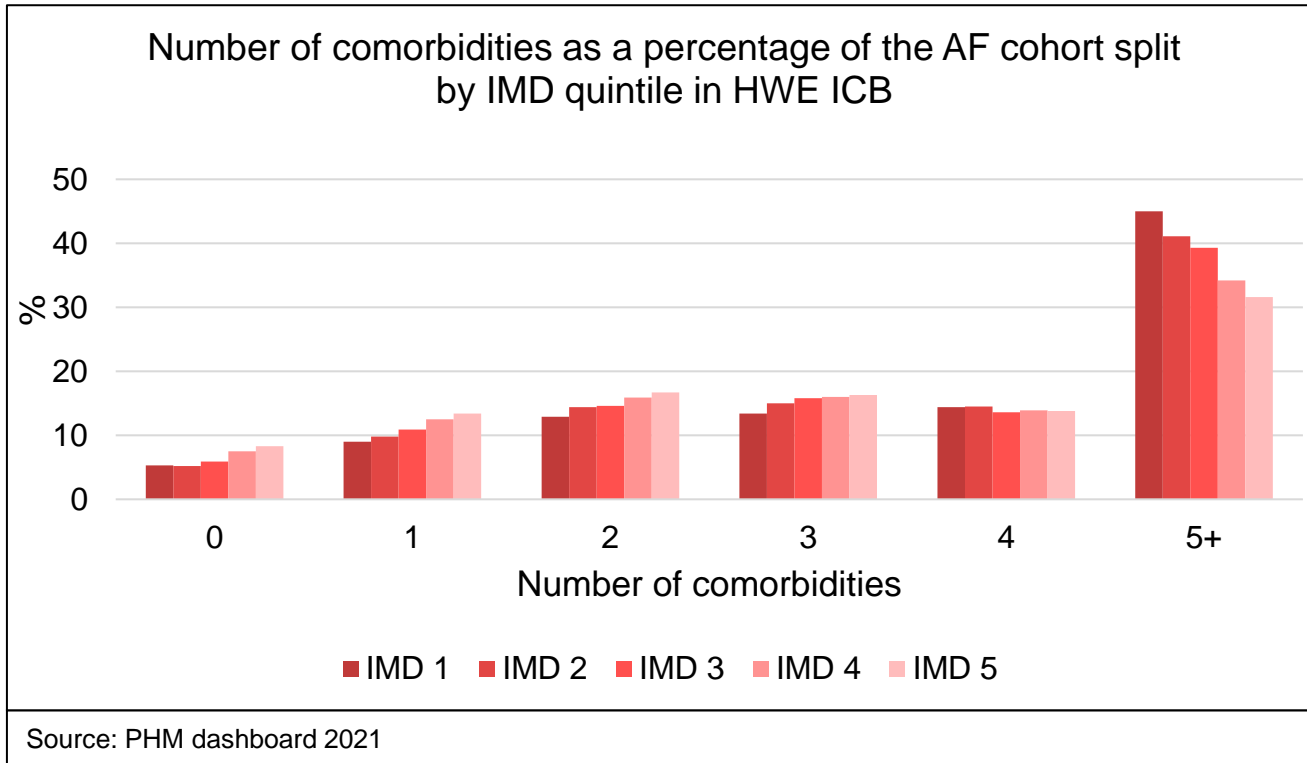




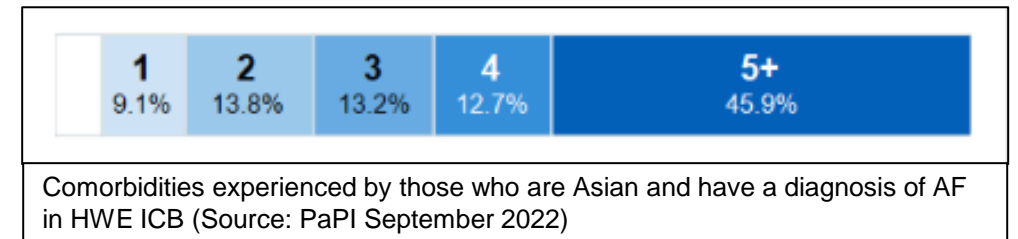
Multimorbidity (2)

Presence of 5 or more comorbidities is more prevalent with increasing deprivation

Further analysis by ethnicity show that the AF population from Asian backgrounds are more likely than the rest of the AF population to have 5+ comorbidities



- Among people with atrial fibrillation, there is a relationship between deprivation and number of comorbidities, with those in most deprived IMD quintile most likely to have 5+ comorbidities (Source: PHM dashboard 2021).
- Ethnicity is also a factor - 45.9% of those who are Asian AND have a diagnosis of AF have 5 or more comorbidities compared to 37.0% of those who are Black and 36.9% of the total AF population in HWE (Source: PaPI 2022).





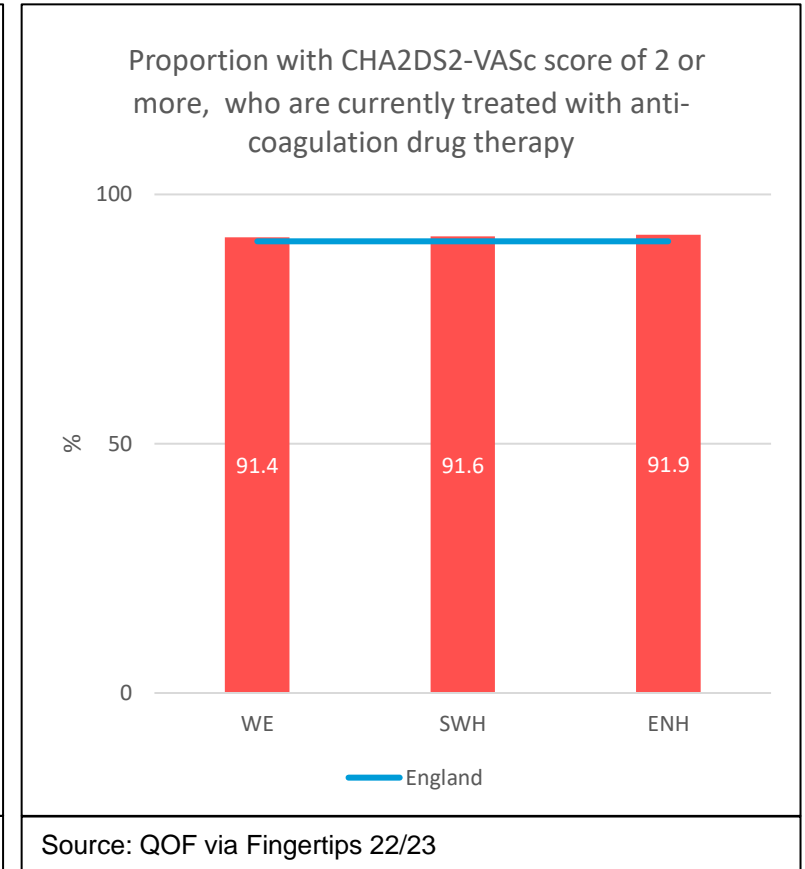
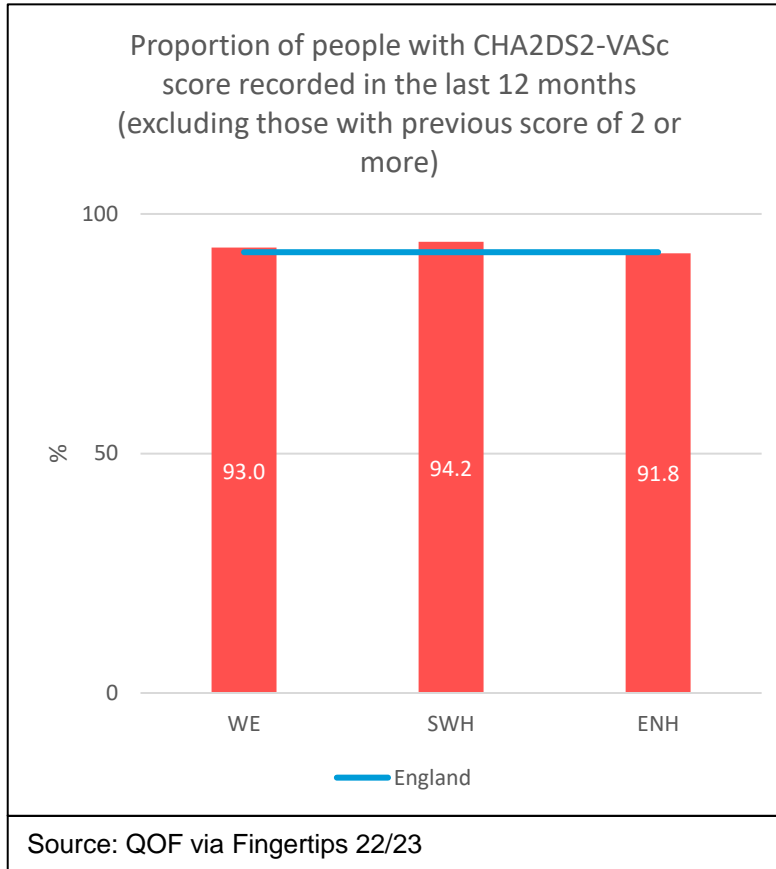
Monitoring and treatment (1)

CHA2DS2-VASc score and anticoagulation

NICE Quality Statement: Adults with non-valvular atrial fibrillation and a CHA2DS2-VASc stroke risk score of 2 or above are offered anticoagulation.



- Recording of CHA2DS2-VASc score in patients with AF has improved in recent years, with all areas within HWE now at >90%, but slightly below upper QOF ambition of 95% (QOF via Fingertips 2022/23).
- HWE has a high rate of anticoagulation prescribing for those with AF who have a high clotting risk, with higher rates of prescribing in all three Place areas than nationally. However, the QOF ambition of 95% prescribing is still not met in any of the Place areas.
- Local data show that 23% of people with AF have had a bleeding risk score (ORBIT) completed during 22/23.

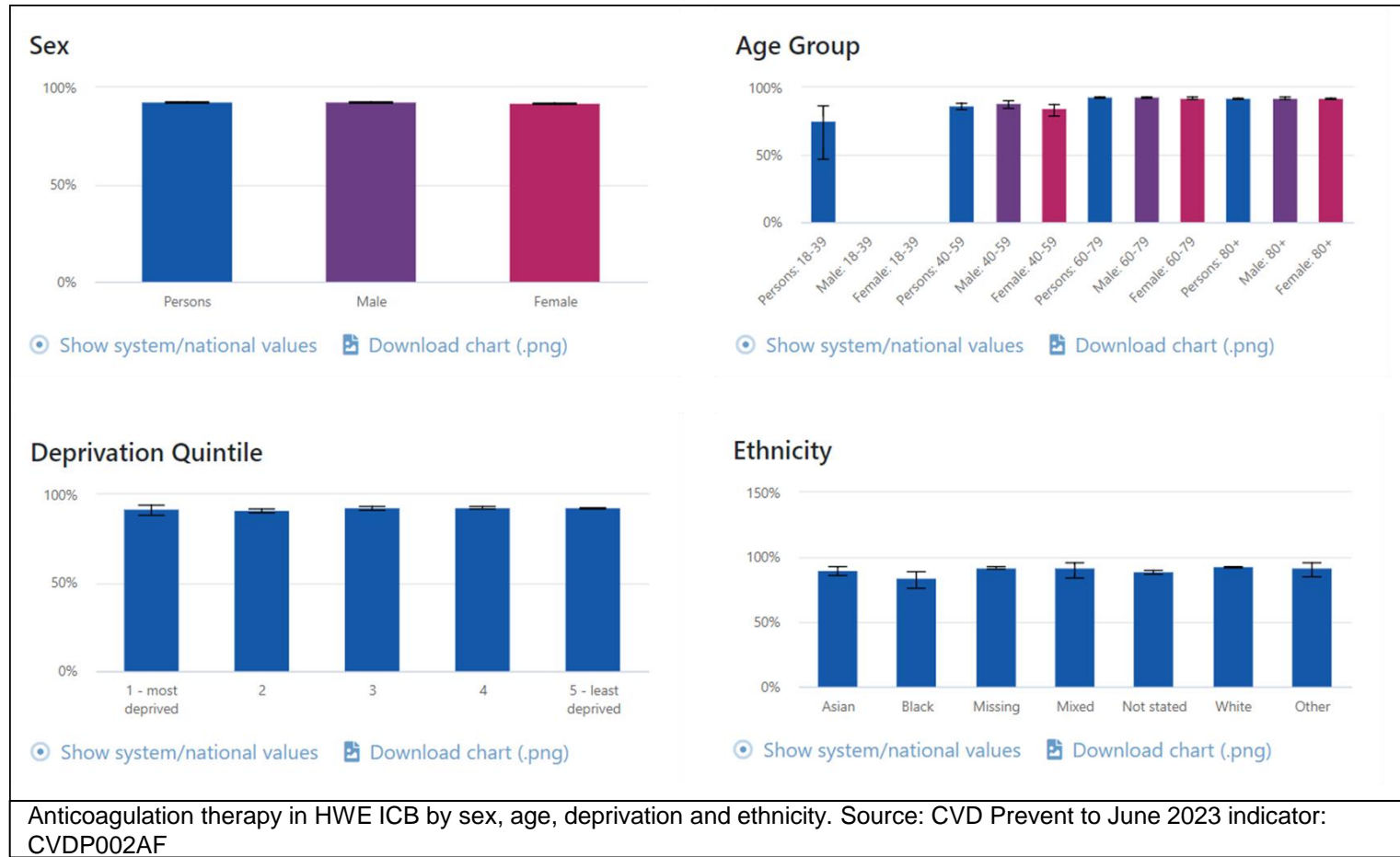




Treatment (2) – Anticoagulation by demographics

The percentage of patients aged 18 and over with GP recorded atrial fibrillation and a record of a CHA2DS2-VASc score of 2 or more who are currently treated with anticoagulation drug therapy

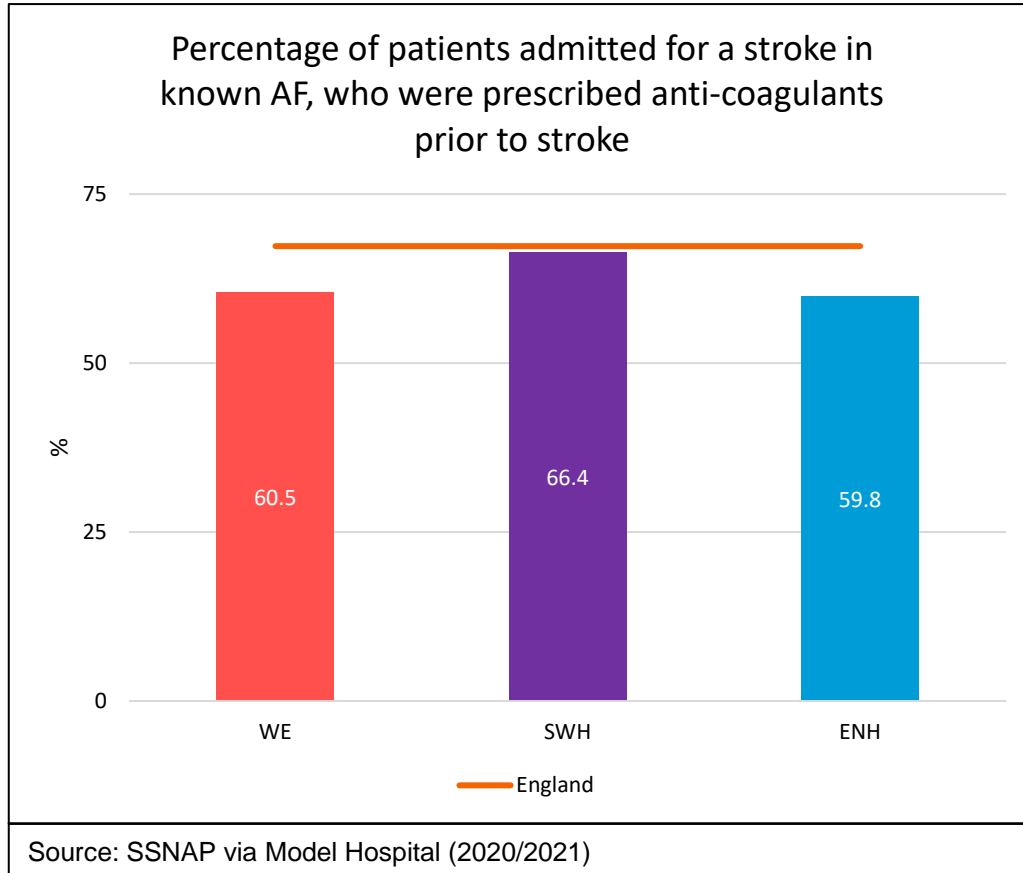
- Anticoagulation prescribing varies by ethnicity. Despite the wide confidence intervals, those with Black ethnicity have the lowest rate of ACT and are significantly below the group with the highest rate, those with White ethnicity (confidence intervals do not overlap) (Source CVD Prevent June 2023).
- Younger adults with AF (40-59 years) are less likely to be prescribed ACT when compared to older adults (60+ years).
- There is no significant difference in ACT prescribing for different between IMD quintiles and for males versus females (Source CVD Prevent June 2023).





Outcomes

ENH and WE have a lower than national average percentage of AF patients who are on anticoagulants prior to being admitted for a stroke.



Patients with known AF are at increased risk of stroke. Data from the Sentinel Stroke National Audit Programme (SSNAP) show the percentage of patients admitted for a stroke in known AF who were prescribed anticoagulants prior to their stroke.

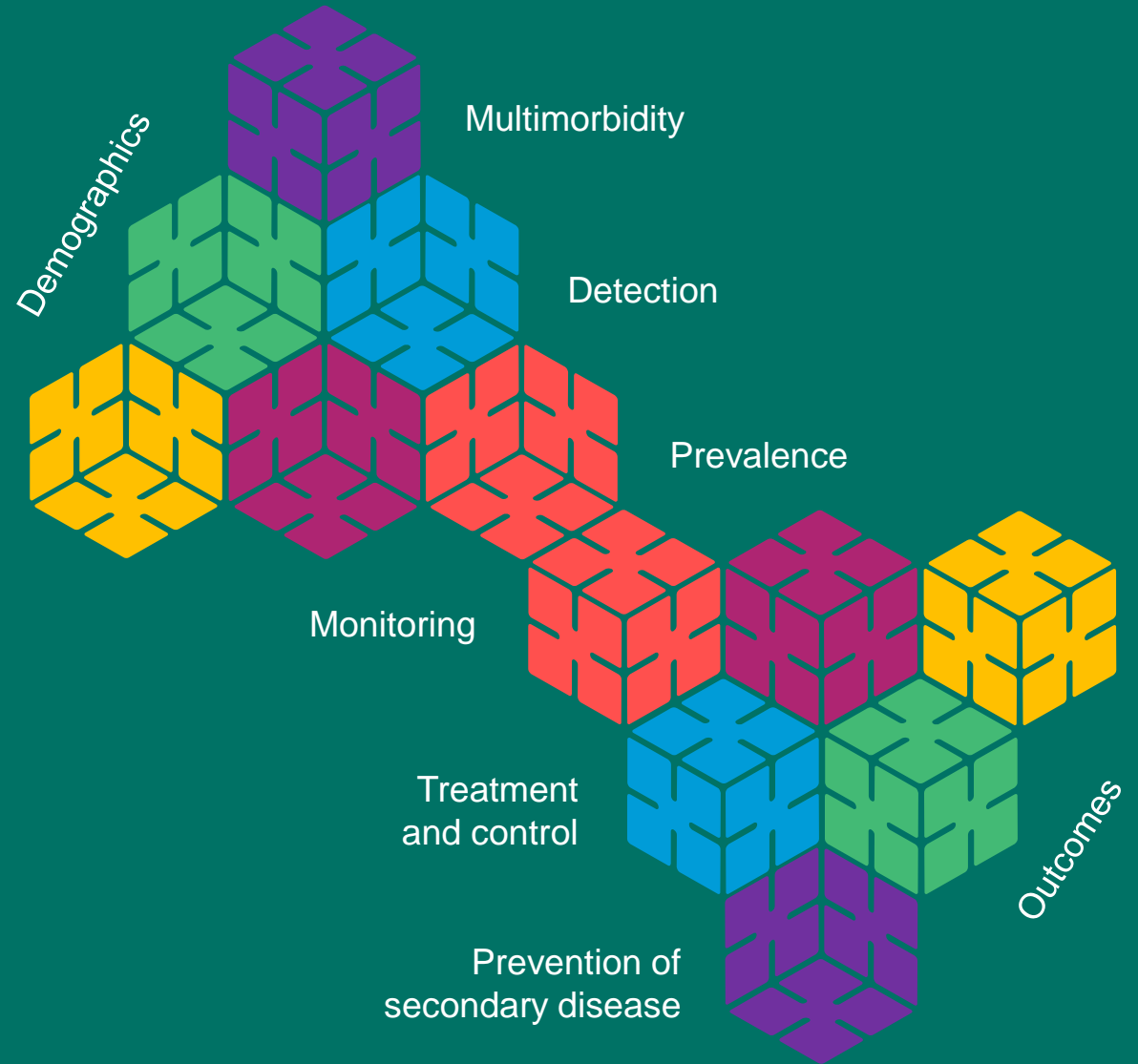
- In HWE 62% of people with AF were prescribed anticoagulants prior to stroke. This is below the national (67.3%) and peer (67.8%) averages.
- ENH and WE are performing significantly below the national median.
- This represents a significant risk and opportunity to reduce risk and severity of stroke in HWE’s population with AF.

Source: SSNAP via Model Hospital (2020/21).



3. Hypertension

- ❖ [Introduction](#)
- ❖ [Summary of Key Messages](#)
- ❖ [Prevalence and Detection](#)
- ❖ [Demographics](#)
- ❖ [Monitoring, Treatment and Control](#)
- ❖ [Multimorbidity and complexity](#)

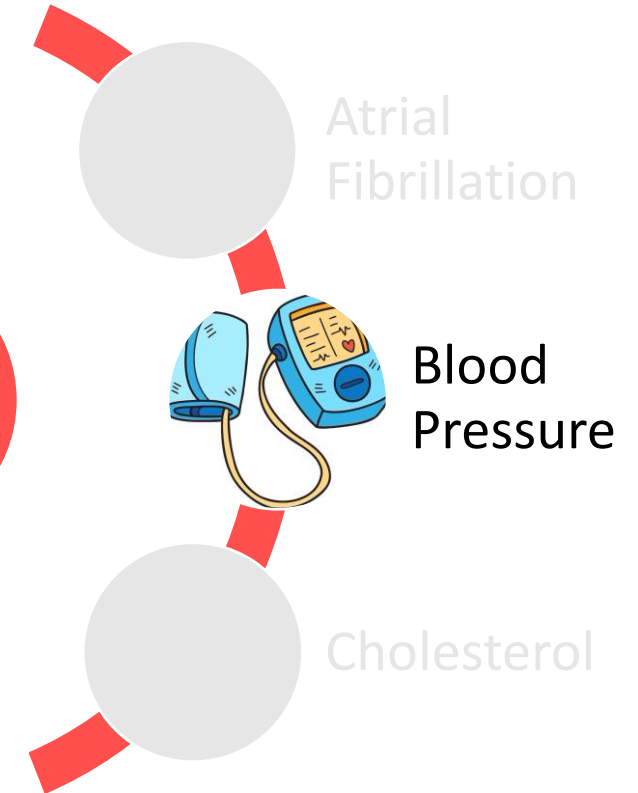
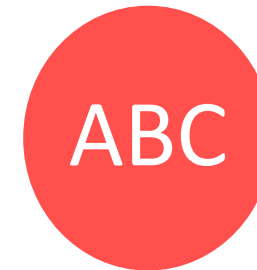


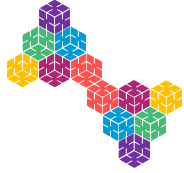
Working together
for a healthier future



Hypertension - Introduction

- Hypertension (HTN) or raised blood pressure (BP) is a condition where the pressure in your blood vessels is too high (>140/90mmHg). Things that increase the risk of developing HTN include:
 - older age
 - genetics
 - being overweight or obese
 - not being physically active
 - high-salt diet
 - drinking too much alcohol.
- Prevention is targeted at modifiable risk factors including diet, weight, exercise and alcohol.
- Most people do not have any symptoms of high BP. However it may cause headaches, blurred vision and chest pain if extremely high.
- Because HTN is predominantly asymptomatic, it can be easily missed if BP is not checked.
- Diagnosing BP is very important, as it is a significant risk factor for developing other Cardiovascular Diseases (CVDs). Evidence shows that hypertension is the leading risk factor for CVD, accounting for nearly half of disability adjusted life years (DALYs) from ischaemic heart disease (48.73%), 44.7% of DALYs from stroke and over a third of DALYs from atrial fibrillation.*





6 Key Messages - Hypertension

Click on each tile to explore and see more information

Detection (1) - Hypertension reported to estimated prevalence

HWE is in the lowest quartile of ICSs for HTN detection.

- Comparing modelled estimates of hypertension prevalence to recorded prevalence, only about half of people in HWE with hypertension have a diagnosis (53.1%. Source: QCF 2022/23 and NCVIN via MHS 2017).
- Detection rates by Place Area are as follows (Source: QCF 2022/23 and NCVIN via MHS 2017):
 - ENH - 53.1%
 - SWH - 51.0%
 - WE - 53.0%
 - England - 52.2%
- In 2021/22 all three place-based systems were in the bottom 50% nationally for hypertension detection rates. SWH is in the bottom 10 Place areas (Source: QCF and NCVIN via MHS 2021/22).

Source: QCF (all ages) 2023 and National Cardiovascular Intelligence Network 2017 (ages 16+)

Demographics of HTN population

- Analysis of sub-groups show limited evidence of variation in HTN prevalence by age, gender or deprivation. Compared to averages for each age band, gender and deprivation quartile, the ICS is consistently within the same range, below the national average (Source: CVD Prevent June 2023).
- Prevalence is more deprived communities is closer to the national average than in less deprived communities, reflecting a shallower social gradient in hypertension prevalence (Source: CVD Prevent June 2023).
- No ethnicity data available to allow for further analysis.

Source: CVD Prevent 6 June 2023 Indicator: CVDPR0107

Demographics of the hypertension population

- Local data show that prevalence increases with age.
- People living in areas of higher deprivation are more likely to have hypertension at younger ages (red line).
- Comparing people aged 50-64 years:
 - 14.5% of people in the least deprived communities have a diagnosis of hypertension
 - 32.7% of people in the most deprived communities have hypertension
- The prevalence of hypertension among 45-49 year olds in the most deprived communities in HWE is the same as the prevalence of hypertension in 60-64 year olds in the least deprived communities.
- The impact of earlier onset of hypertension is a longer time at risk of complications and consequently earlier onset of cardiovascular events and mortality.

Source: PFM Dashboard (Q2'23)

Monitoring (1) NICE Guidance recommends an annual review of BP for those with diagnosed Hypertension

- In HWE in June 2023, 84.4% of patients with HTN have a recorded BP within the previous 12 months. This is up from 80.8% in December 2022. (Source: CVD Prevent June 2023).
- This is lower than the national (85.3%) and slightly lower than the regional (84.6%) performance for this indicator (Source: CVD Prevent June 2023).
- Furthermore, the performance for this indicator in HWE varies by deprivation and ethnicity where:
 - The most deprived quintile to have 82.8% of people meeting this indicator, compared to 85.2% in the least deprived quintile.
 - Those with Black ethnicity are less likely to achieve this indicator (81.4%) when compared to all other ethnicities except for those with 'Other' ethnicity (Source: CVD Prevent June 2023).

Source: CVD Prevent 6 June 2023 Indicator: CVDPR0107

Control (1) - BP targets for those with HTN

Treating blood pressure to target is a national priority and in the NHSE operational and planning guidance, with a target of 77% of people diagnosed with hypertension that are treated to target range.

- The charts on the left show the percentage of those with HTN with BP recording in the last 12 months that is below the age specific target (<140/90mmHg for people aged <60 years and <150/90mmHg for people aged 60+). These are the recommended BP targets as per [NICE guidance](#).
- Trends over time shows a gradual improvement, up from 59.6% in June 2022 (Source: CVD Prevent June 2023).
- HWE ICS has been similar or better at meeting these BP targets when compared to the national average. We are making good progress towards meeting the national target, as shown [here](#).
- However these targets differ widely between PCNs, as shown [here](#).

Source: QCF 2020 via Kingpin

Hypertension population segmentation

- HTN is a known risk factor for many other LTCs such as coronary heart disease, stroke, chronic kidney disease and vascular dementia.
- The majority of people with HTN in HWE ICS have at least one other co-morbidity (82.8%); most commonly diabetes, osteoarthritis and coronary heart disease. (Source: PaPI September 2022).
- Local data segmentation can help understand the complexity of patients with hypertension. This shows that the majority of people with hypertension are not in the Living with Illness segment and therefore are living with another physical or mental health condition, or social complexity (Source: PFM Dashboard 2021).

Source: PFM Dashboard (2021)

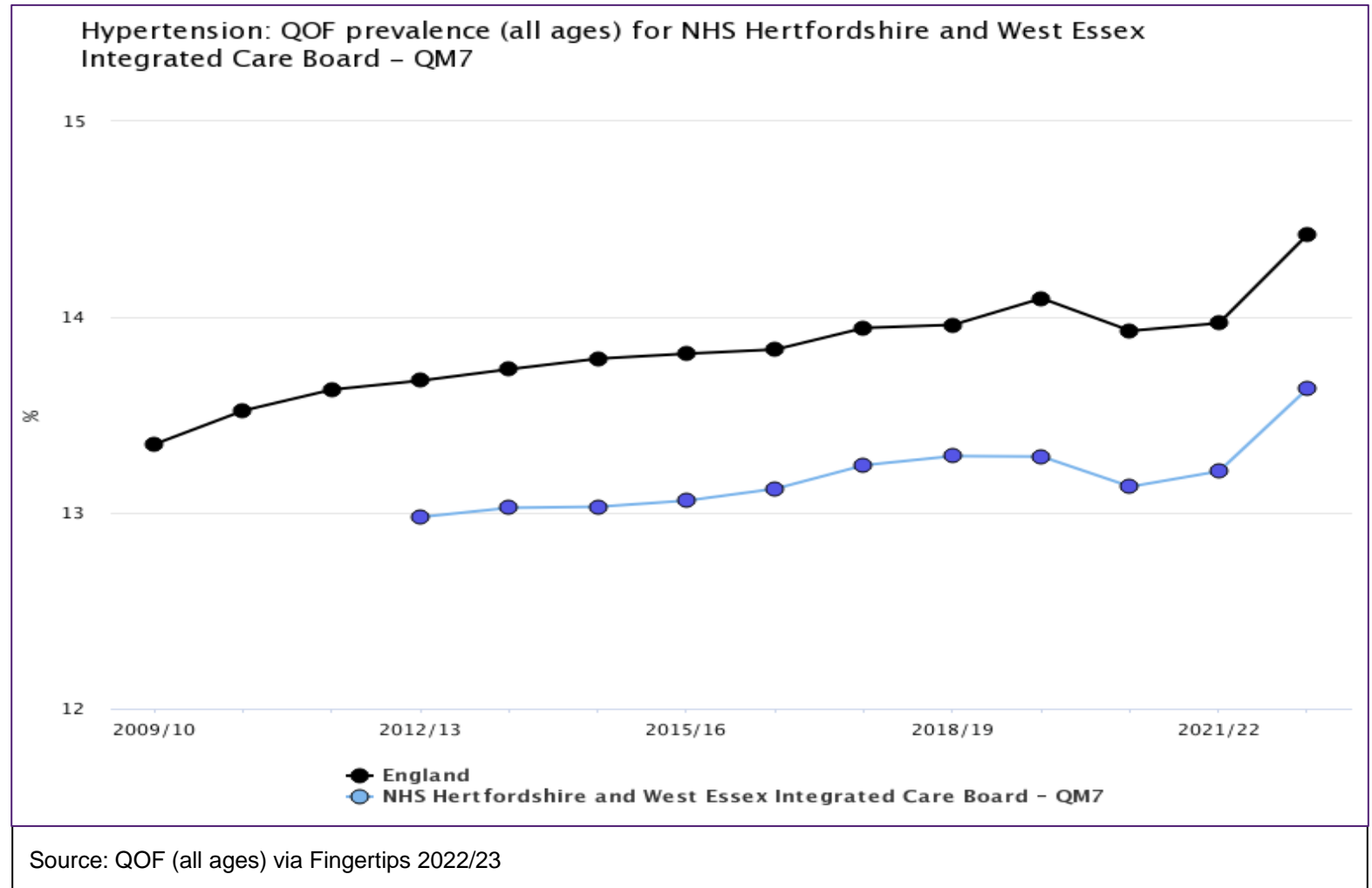
- Just over half of the estimated number of people with hypertension in HWE ICB are recorded (53.1%).
- In 2021/22 all three place-based systems were in the bottom 50% nationally for hypertension detection rates. SWH is in the bottom 10 Place Areas (CCGs).
- Rates of blood pressure checks for those over 45 are lower than nationally and have not yet recovered to pre-pandemic levels.
- There are not significant inequalities in prevalence of HTN, however:
 - Those in most deprived areas are more likely to be diagnosed with HTN at a younger age, and
 - The most deprived groups and those from Black ethnic backgrounds have lower rates of annual BP checks.
- This is reflected in the attainment of BP targets, where those with Black ethnicity or in most deprived areas are less likely to achieve their BP target.
- HWE's population with HTN typically has at least one comorbidity – this is most commonly diabetes.





Prevalence - Hypertension prevalence in HWE (all ages)

- Prevalence of hypertension in HWE has increased from 13.1% in 2020/21 to 13.6% in 2022/23, although is still below the national (14.4%) and regional (14.7%) average. (Source: QOF via Fingertips 2022/23).
- Breakdown by place is as follows:
 - East & North Herts - 13.2%
 - South West Herts - 13.6%
 - West Essex - 14.5%(Source: QOF via Fingertips 2022/23).

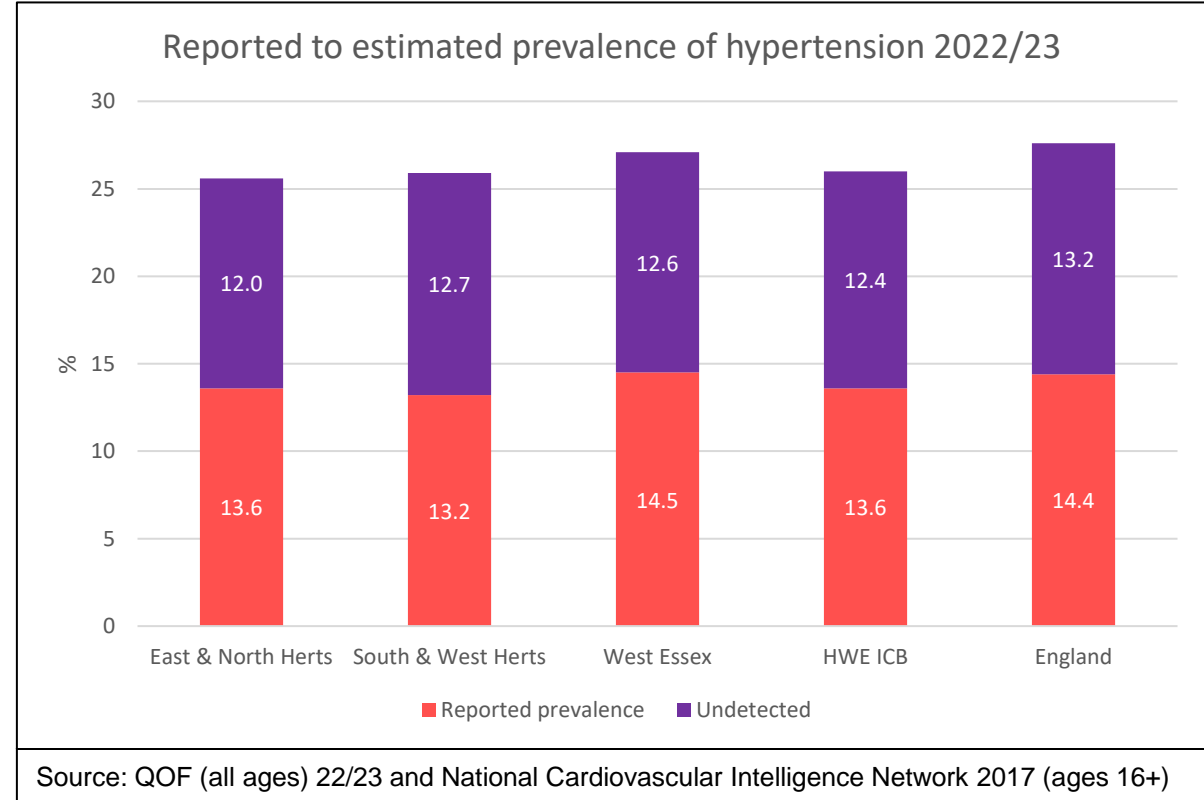




Detection (1) - Hypertension reported to estimated prevalence

HWE is in the lowest quartile of ICSs for HTN detection.

- Comparing modelled estimates of hypertension prevalence to recorded prevalence, only about half of people in HWE with hypertension have a diagnosis (53.1%, Source: QOF 2022/23 and NCVIN via MHS 2017).
- Detection rates by Place Area are as follows (Source: QOF 2022/23 and NCVIN via MHS 2017):
 - ENH – 53.1%
 - SWH – 51.0%
 - WE – 53.5%
 - England – 52.2%
- In 2021/22 all three place-based systems were in the bottom 50% nationally for hypertension detection rates. SWH is in the bottom 10 Place areas (Source: QOF and NCVIN via MHS 2021/22).

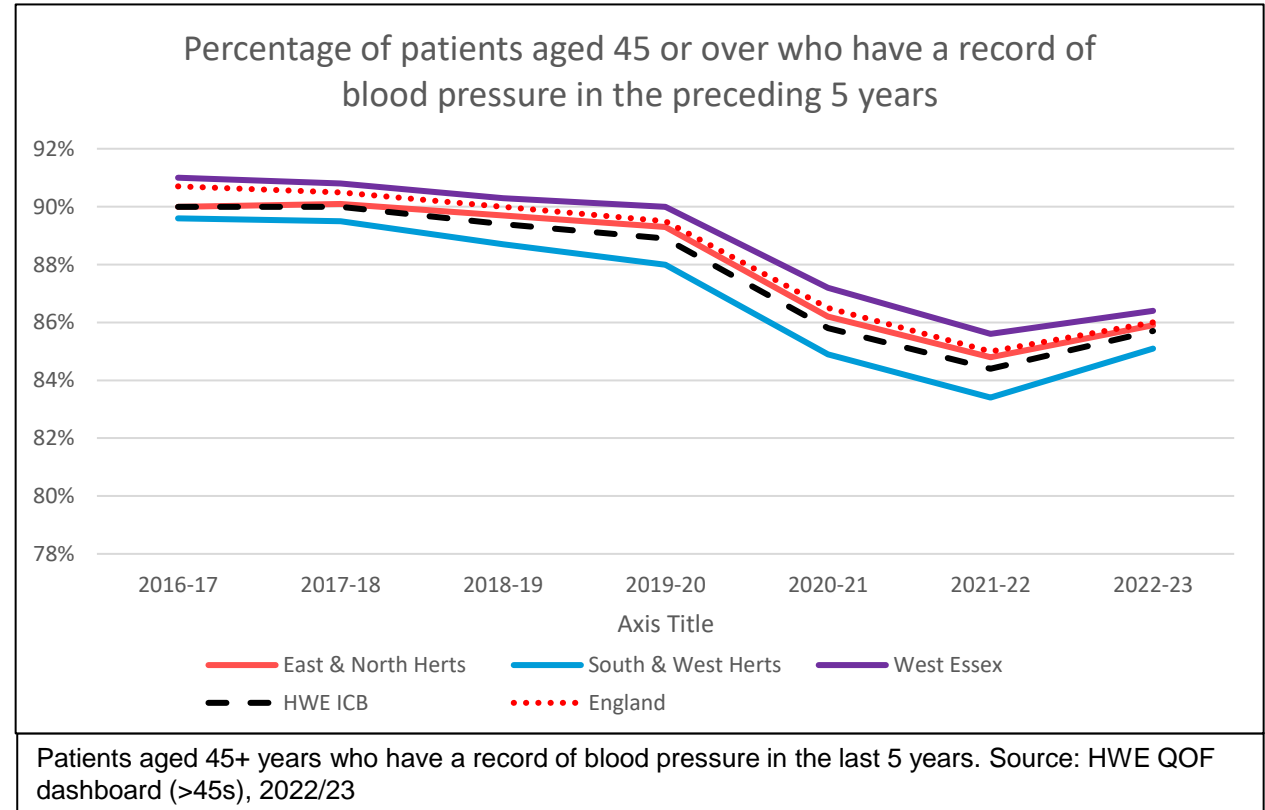




Detection (2) – Record of BP in last 5 years in >45s

[NICE guidance](#) recommends a minimum of 5 yearly BP checks in those without a diagnosis of HTN for people aged 45 years and over.

- HWE has performed consistently below the national median for 5 yearly BP checks (Source QOF via Fingertips 2022/23).
- The observed decline from 20/21 onwards is likely due to shift in priorities in primary care during the pandemic, with recovery in 22/23.
- Note also that the metric is for measurements in the past 5 years so effects of pandemic not yet fully represented here.
- In the QOF 22/23 (via Fingertips) data, we are beginning to see a recovery of levels of BP checks, although still not to pre-pandemic levels:
 - ENH – 85.9%
 - SWH – 85.1%
 - WE – 86.4%
 - HWE ICB – 85.7%



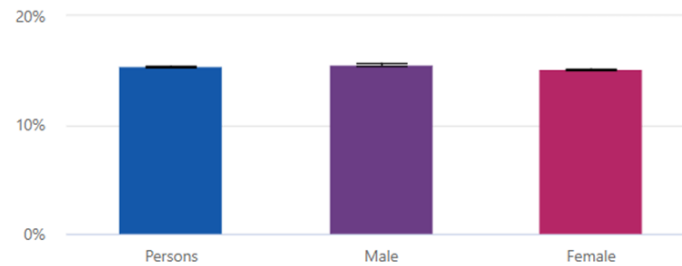


Demographics of HTN population



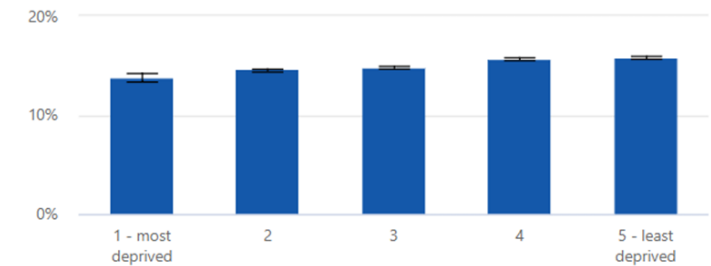
- Analysis of sub-groups show limited evidence of variation in HTN prevalence by age, gender or deprivation. Compared to averages for each age band, gender and deprivation quintile, the ICS is consistently within the same range, below the national average (Source CVD Prevent June 2023).
- Prevalence in more deprived communities is closer to the national average than in less deprived communities, reflecting a shallower social gradient in hypertension prevalence (Source CVD Prevent June 2023).
- No ethnicity data available to allow for further analysis.

Sex



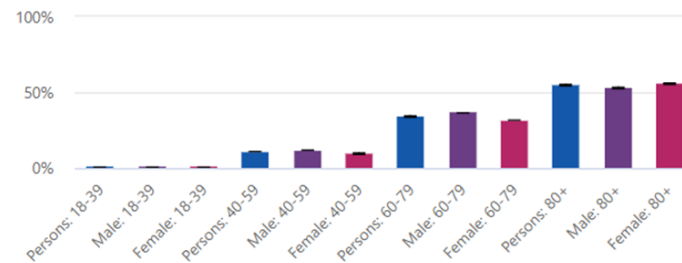
[Show system/national values](#) [Download chart \(.png\)](#)

Deprivation Quintile



[Show system/national values](#) [Download chart \(.png\)](#)

Age Group



[Show system/national values](#) [Download chart \(.png\)](#)

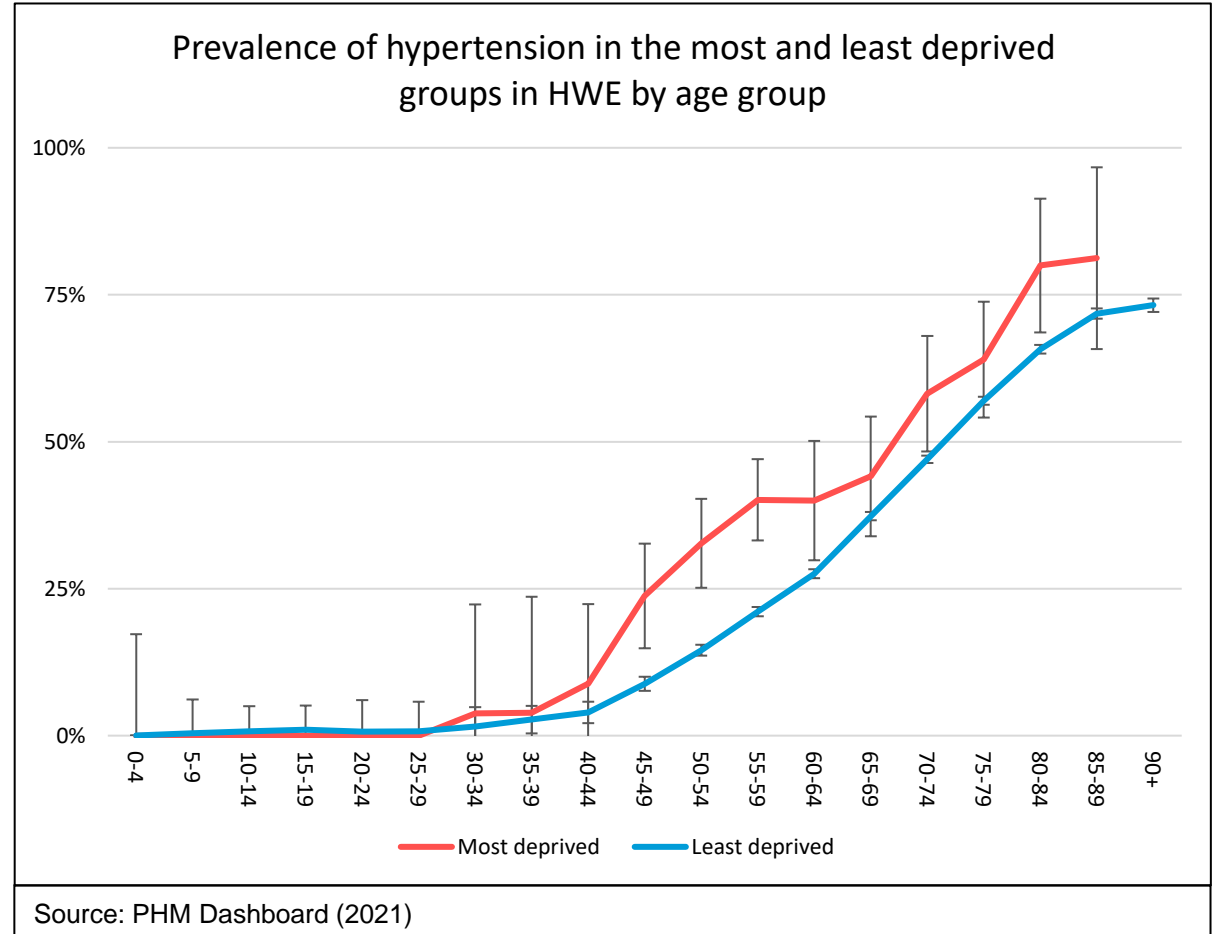
Prevalence of hypertension in HWE ICB by sex, deprivation and age. Source: CVD Prevent to June 2023 indicator: CVDP001HYP





Demographics of the hypertension population

- Local data show that prevalence increases with age
- People living in areas of higher deprivation are more likely to have hypertension at younger ages (red line).
- Comparing people aged 50-54 years:
 - 14.5% of people in the least deprived communities have a diagnosis of hypertension
 - 32.7% of people in the most deprived communities have hypertension.
- The prevalence of hypertension among 45-49 year olds in the most deprived communities in HWE is the same as the prevalence of hypertension in 60-64 year olds in the least deprived communities.
- The impact of earlier onset of hypertension is a longer time at risk of complications and consequently earlier onset of cardiovascular events and mortality.





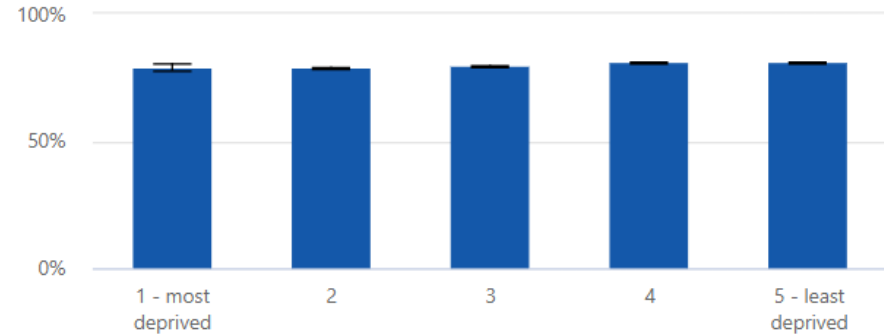
Monitoring (1)

NICE Guidance recommends an annual review of BP for those with diagnosed Hypertension



- In HWE in June 2023, 84.4% of patients with HTN have a recorded BP within the previous 12 months. This is up from 80.0% in December 2022. (Source CVD Prevent: June 2023).
- This is lower than the national (85.3%) and slightly lower than the regional (84.5%) performance for this indicator (Source CVD Prevent: June 2023).
- Furthermore, the performance for this indicator in HWE varies by deprivation and ethnicity where:
 - The most deprived quintile have 82.8% of people meeting this indicator, compared to 85.2% in the least deprived quintile.
 - Those with Black ethnicity are less likely to achieve this indicator (81.4%) when compared to all other ethnicities except for those with “Other” ethnicity (Source CVD Prevent: June 2023).

Deprivation Quintile



Ethnicity



Proportion of people with hypertension who have had their blood pressure checked in the last 12 months: CVDP004HYP. Source: CVD Prevent to June 2023, indicator: CVDP004HYP



Hertfordshire and West Essex Integrated Care System



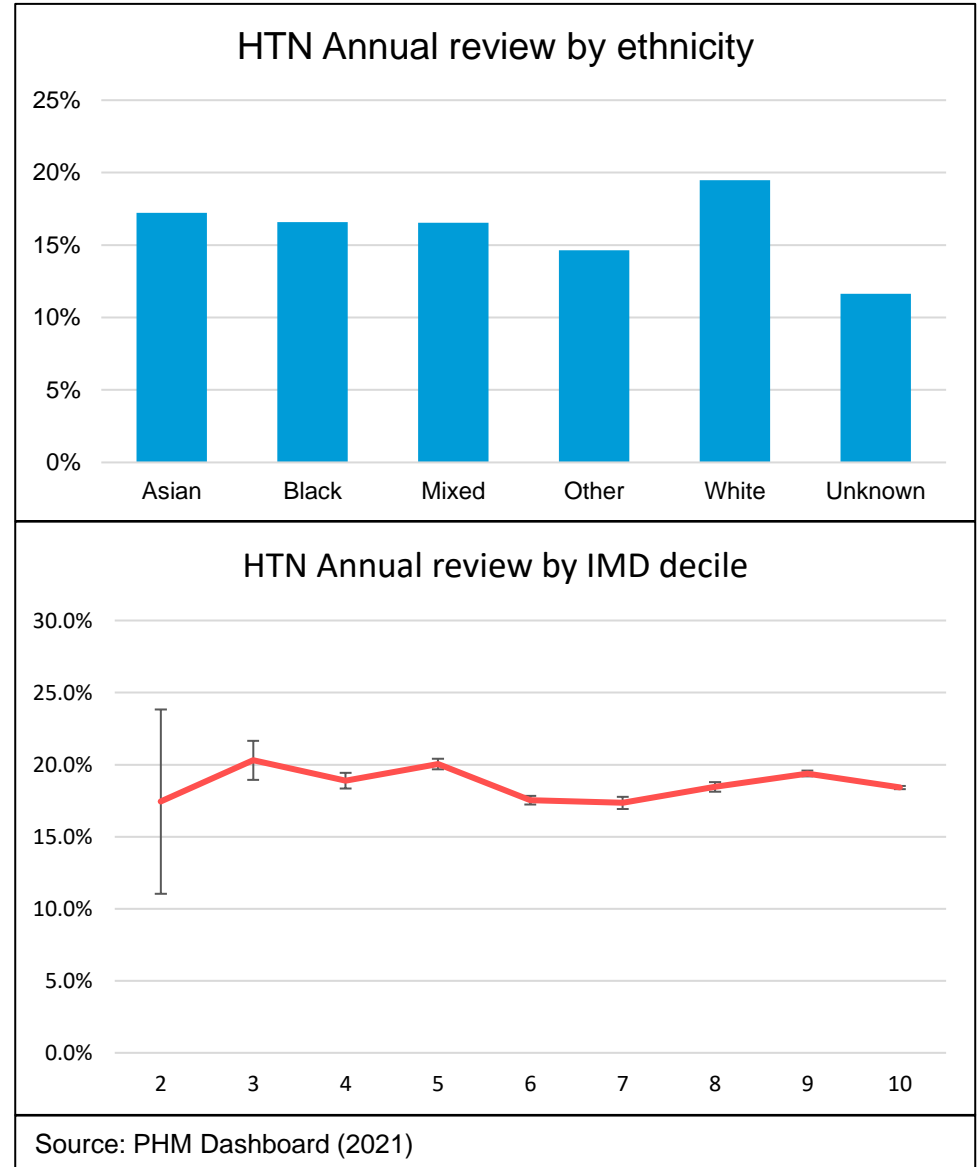


Monitoring (2) – HTN Annual Review



NICE Quality Statement: People with hypertension are offered a review of risk factors for cardiovascular disease annually.

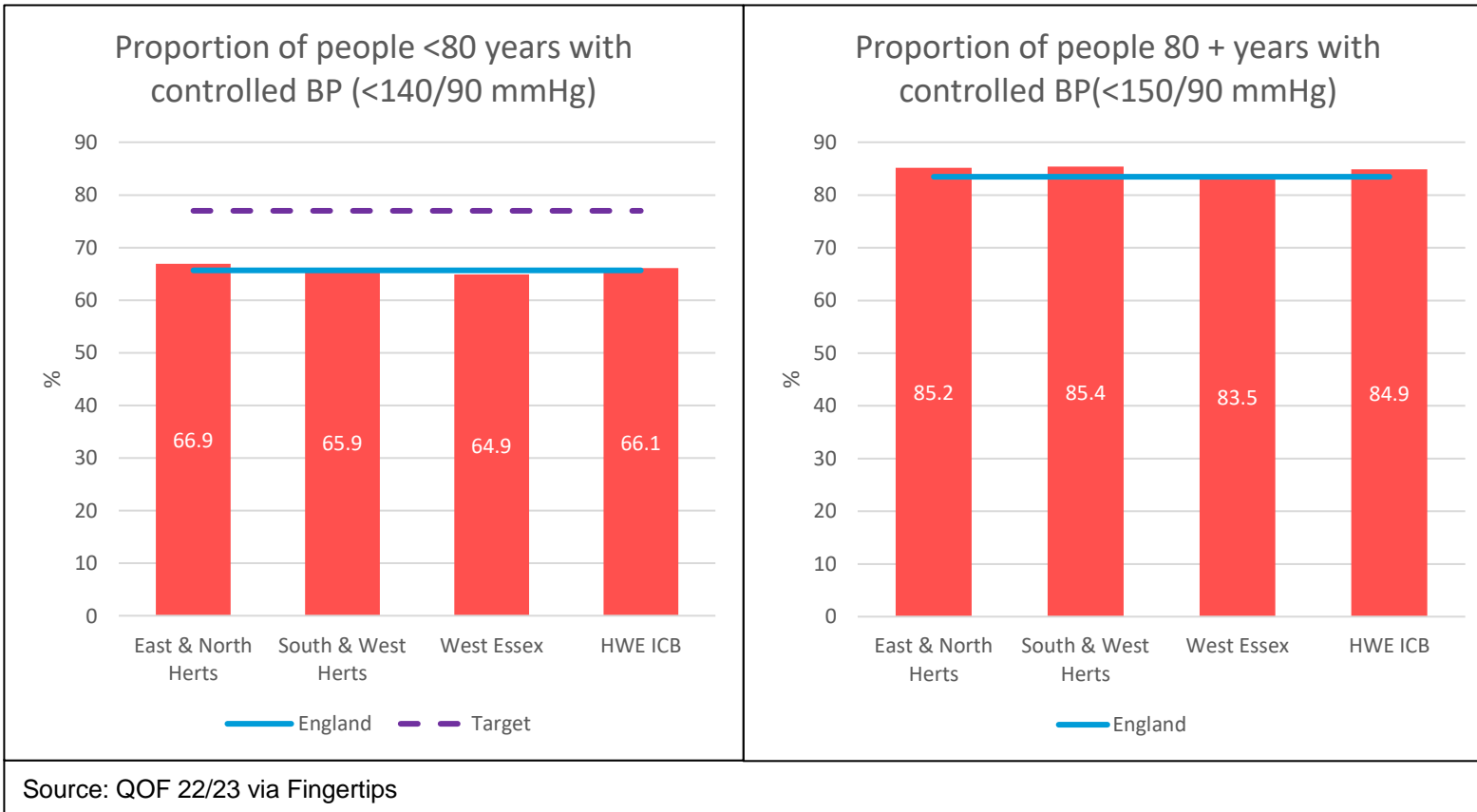
- People's blood pressure and cardiovascular disease risk will increase over time. A review of risk factors for cardiovascular disease delivered as part of an annual review of care should support identification of increased risk and provide an opportunity to address modifiable risk factors.
- Local data show that only 18.6% of people with hypertension had a review of their blood pressure in the preceding 12 months (Source PHM dashboard 2021).
 - People with complex mental health or mental illnesses are less likely to have had a review of their hypertension.
 - Recording of Hypertension annual reviews appears very low, however this may reflect coding discrepancies.





Control (1) – BP targets for those with HTN

Treating blood pressure to target is a national priority and in the NHSE operational and planning guidance, with a target of 77% of people diagnosed with hypertension that are treated to target range.



- The charts on the left show the percentage of those with HTN with BP recording in the last 12 months that is below the age specific target (<140/80mmHg for people aged <80 years and <150/90mmHg for people aged 80+). These are the recommended BP targets as per [NICE guidance](#).
- Trends over time shows a gradual improvement, up from 59.6% in June 2022 (Source CVD Prevent: June 2023).
- HWE ICS has been similar or better at meeting these BP targets when compared to the national average. We are making good progress towards meeting the national target, as shown [here](#).
- However these targets differ widely between PCNs as shown [here](#).

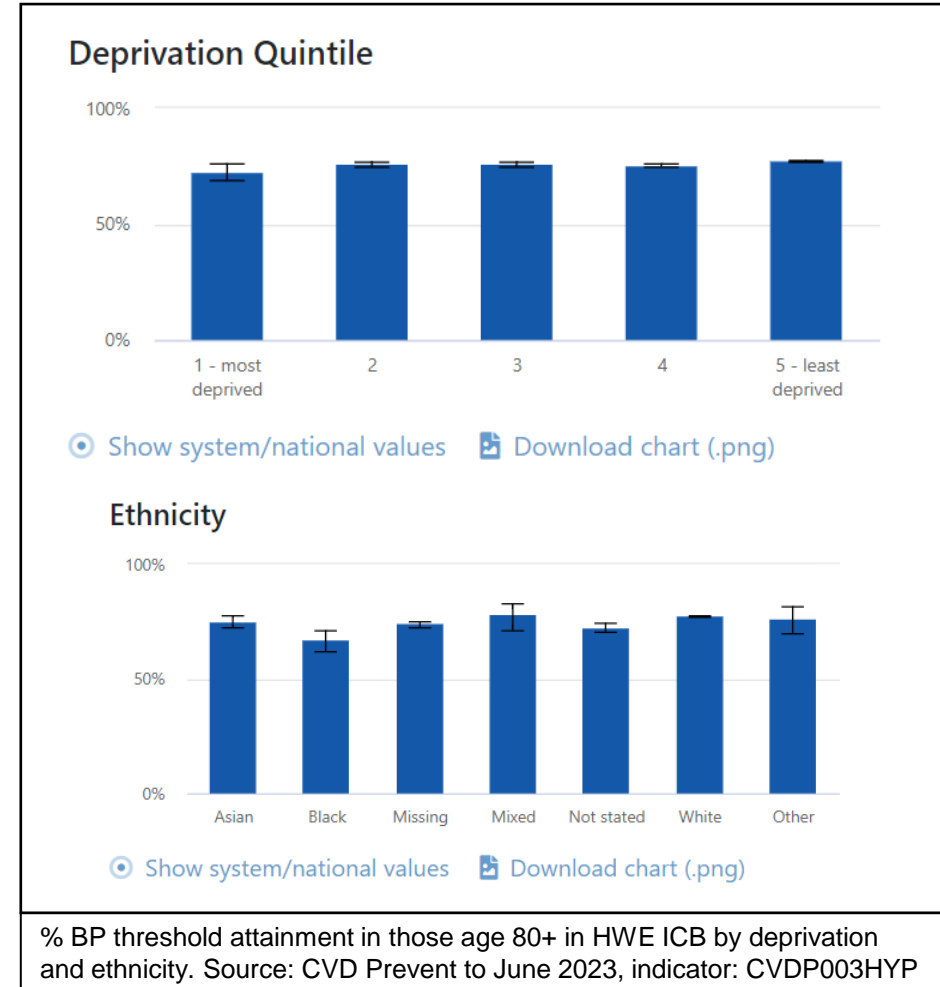




Control (2) - BP threshold attainment varies by Deprivation and ethnicity:

Proportion of people with HTN and 80 + years with controlled BP (<150/90 mmHg)

- In the population with hypertension over 80 years old, there is a difference in BP threshold attainment between most deprived and least deprived quintiles (confidence intervals do not overlap) (Source CVD Prevent June 2023).
- There is a similar picture when looking at differences between ethnicities. Where people with Black ethnicity (with HTN and over 80yrs) have a significantly lower attainment of their BP target when compared to those with Missing, Not stated and White ethnicity. (Source CVD Prevent June 2023).
- There is a similar picture for those aged under 80 years (Source CVD Prevent June 2023).



Hertfordshire and West Essex Integrated Care System



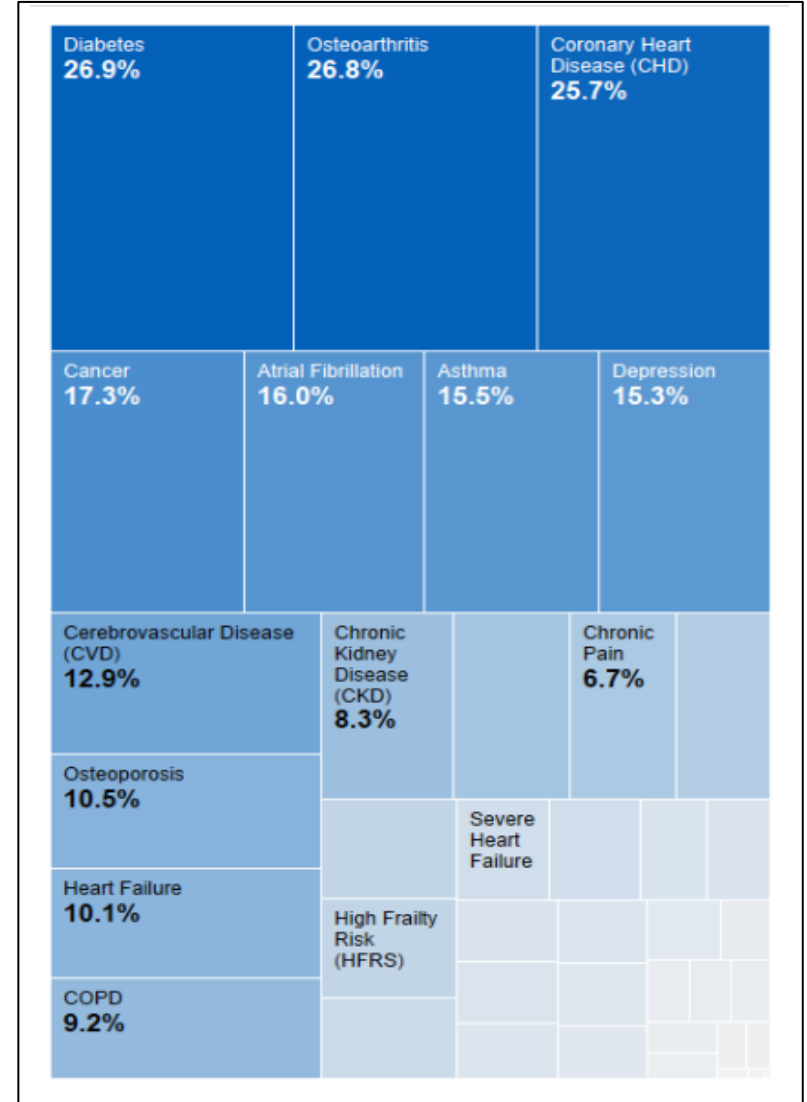
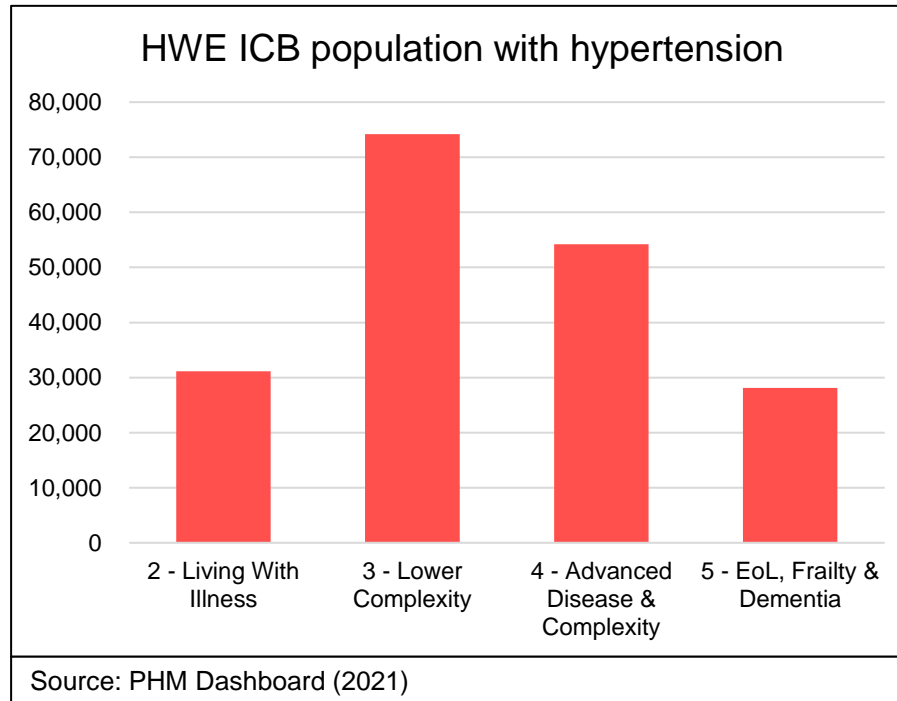


Hypertension population segmentation



- HTN is a known risk factor for many other LTCs such as coronary heart disease, stroke, chronic kidney disease and vascular dementia.
- The majority of people with HTN in HWE ICB have at least one other co-morbidity (82.6%), most commonly diabetes, osteoarthritis and coronary heart disease. (Source: PaPI September 2022).

- Local data segmentation can help understand the complexity of patients with hypertension. This shows that the majority of people with hypertension are not in the Living with Illness segment and therefore are living with another physical or mental health condition, or social complexity (Source: PHM Dashboard 2021)

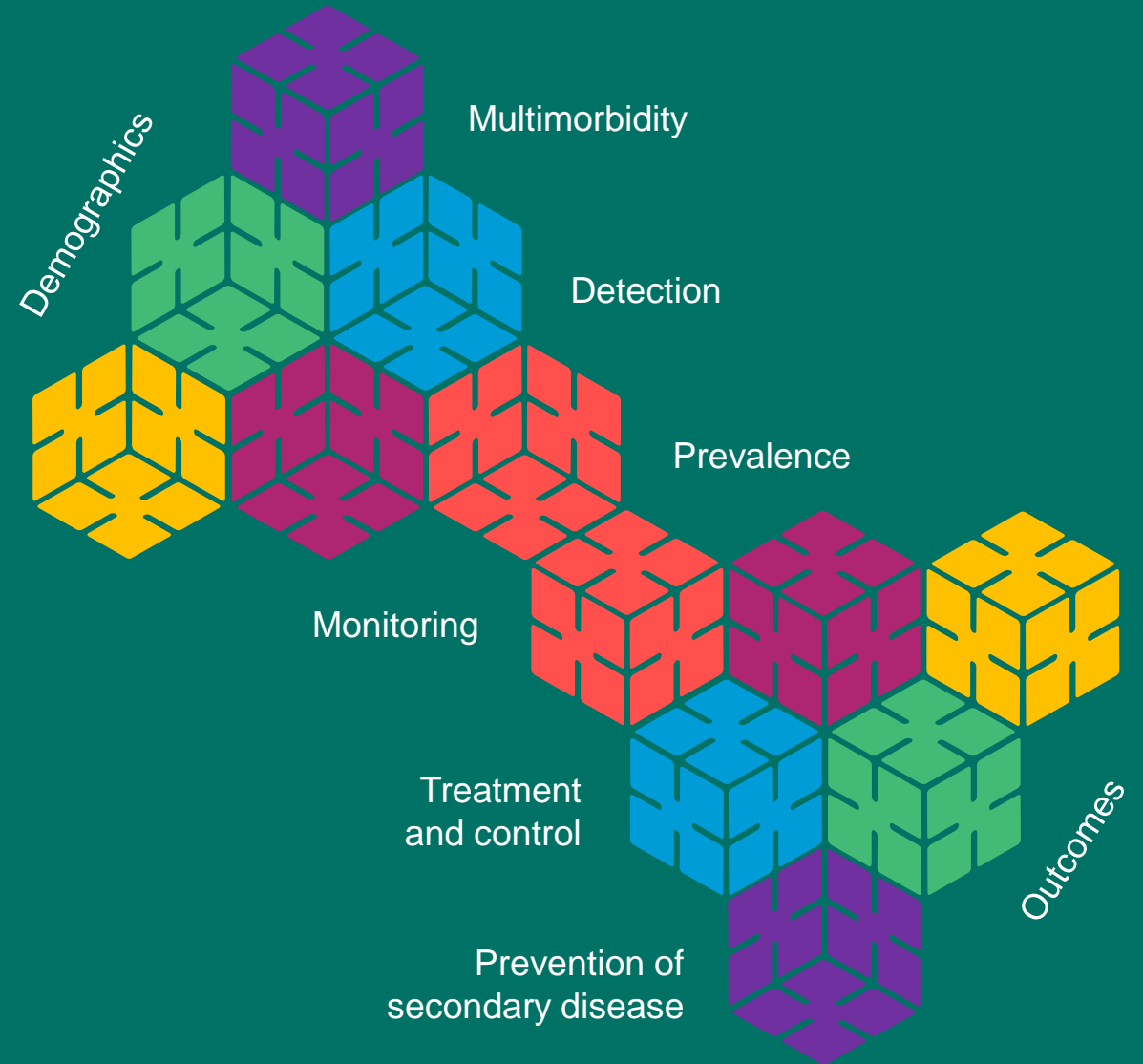


Comorbidities experienced by people in HWE ICB diagnosed with hypertension (Source: PaPI September 2022)



4. High cholesterol

- ❖ [Introduction](#)
- ❖ [Summary of Key Messages](#)
- ❖ [Primary Prevention](#)
- ❖ [Secondary Prevention](#)
- ❖ [CKD and cholesterol](#)
- ❖ [Familial Hypercholesterolaemia](#)

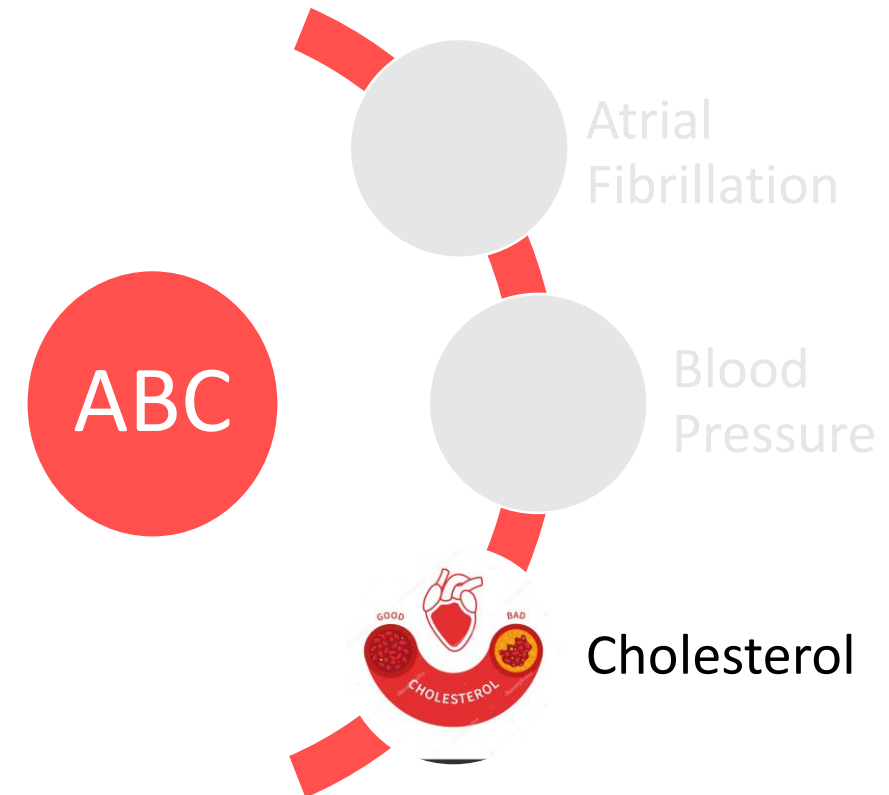


Working together
for a healthier future



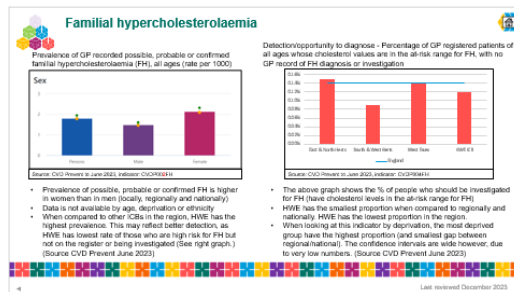
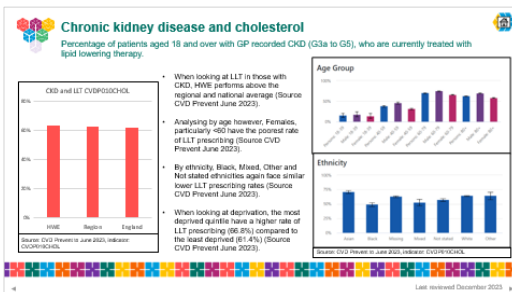
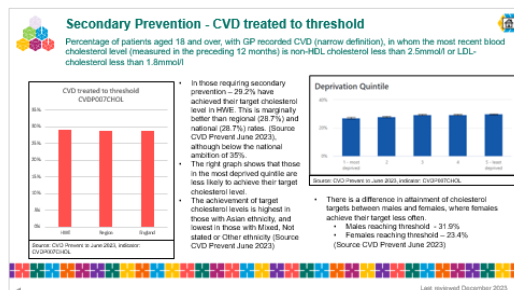
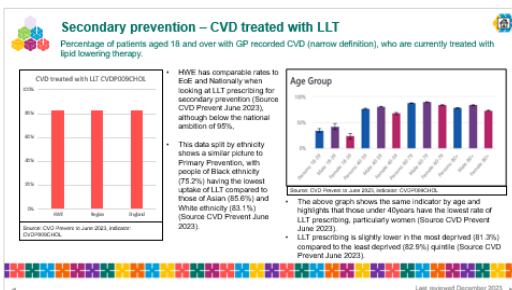
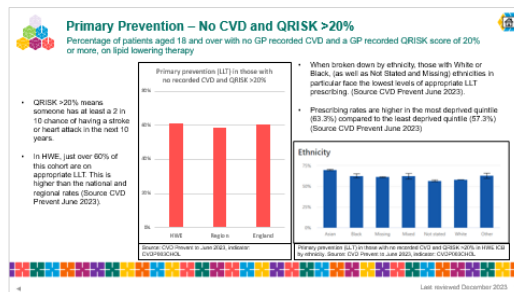
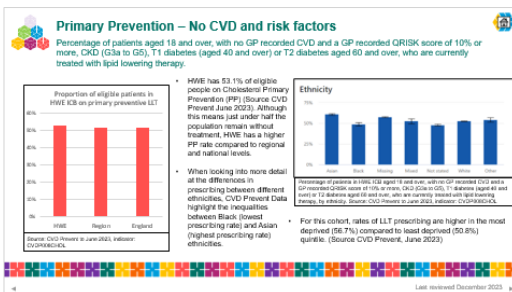
Introduction to high cholesterol

- High cholesterol (hypercholesterolaemia) is a condition characterised by abnormally high levels of cholesterol in the blood.
- Cholesterol is an essential fat-like substance that plays important roles in the production of cells and hormones. However, too much cholesterol in the blood can cause it to accumulate in arteries and lead to complications such as:
 - Coronary heart disease/coronary artery disease or ischaemic heart disease
 - Stroke
 - Peripheral arterial disease (PAD)
- High cholesterol is often associated with hypertension, obesity and Type 2 Diabetes – which together is known as metabolic syndrome; a major risk factor for cardiovascular diseases.
- High cholesterol on its own is often asymptomatic, thus making diagnosis difficult, and screening of high-risk individuals a priority.
- High cholesterol can be managed with a healthy diet, exercise, smoking cessation and lipid lowering therapies (LLT).





6 Key Messages – Hypercholesterolaemia – click on each tile



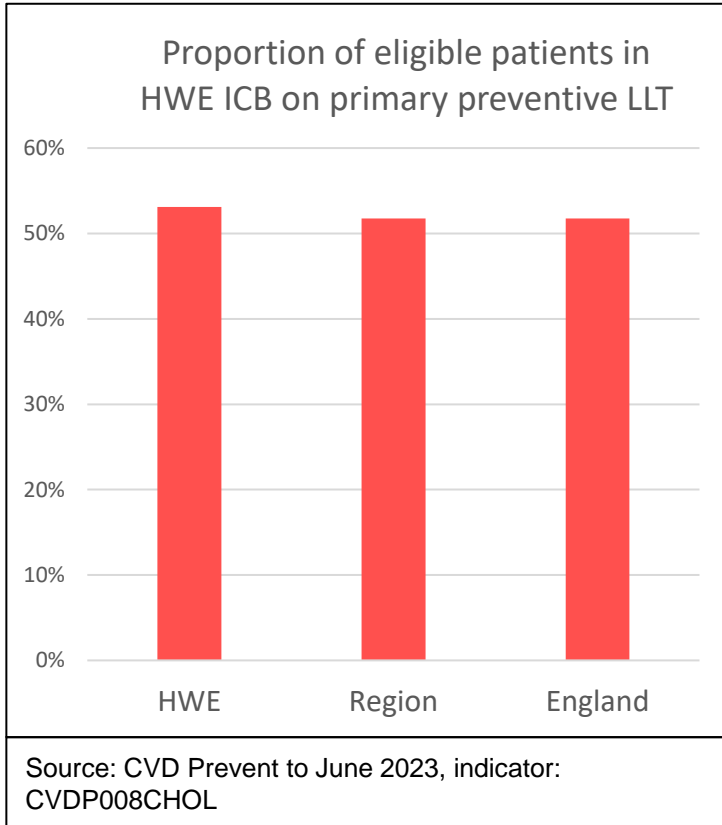
1. Rates of prescribing LLTs for patients without a diagnosis of CVD (primary prevention) are higher in HWE ICB than national and regional averages. Patients of Black ethnicity are least likely to receive LLT for primary prevention.
2. Rates of LLT for high risk patients (QRISK >20%) without a diagnosis of CVD is also higher in HWE ICB than nationally, although there are again inequalities by ethnicity.
3. Rates of LLT for patients with GP recorded CVD (secondary prevention) is in line with regional and national averages. Patients of Black ethnicity are least likely to be prescribed LLT.
4. For those requiring secondary prevention, 29.2% in HWE ICB have achieved their target cholesterol level. This is marginally better than regional (28.7%) and national (28.7%) rates although below the national ambition of 35%.
5. HWE performs above the regional and national average for LLT prescribing in CKD.
6. Compared to other ICBs in the region, HWE ICB has the highest prevalence of familial hypercholesterolaemia. This may reflect better detection, as HWE has lowest rate of those who are high risk for FH but not on the register or being investigated.



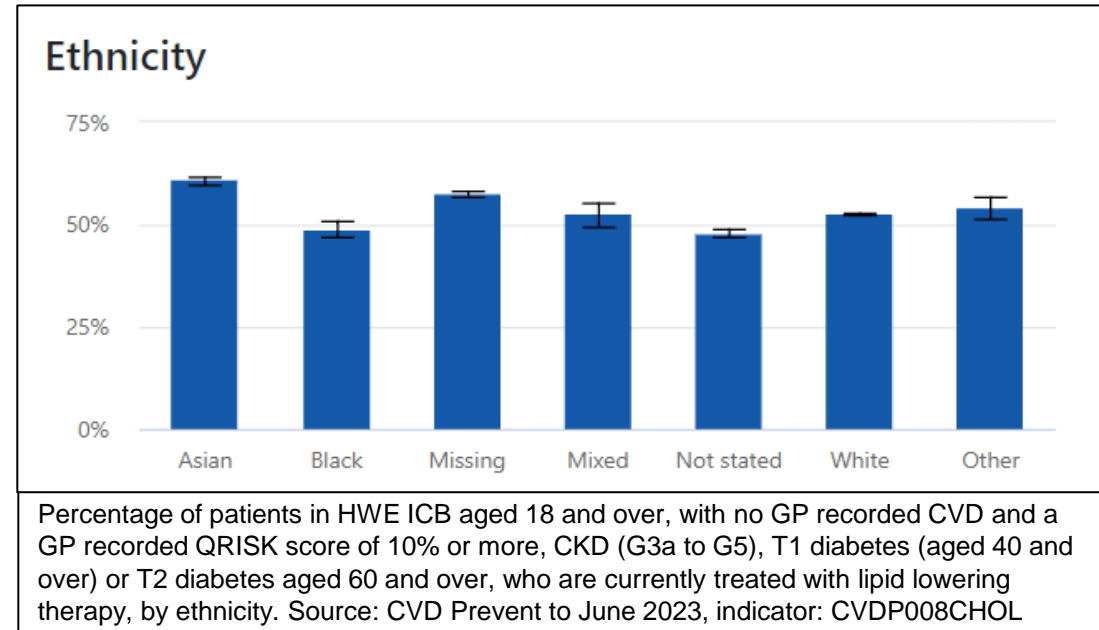


Primary Prevention – No CVD and risk factors

Percentage of patients aged 18 and over, with no GP recorded CVD and a GP recorded QRISK score of 10% or more, CKD (G3a to G5), T1 diabetes (aged 40 and over) or T2 diabetes aged 60 and over, who are currently treated with lipid lowering therapy.



- HWE has 53.1% of eligible people on Cholesterol Primary Prevention (PP) (Source CVD Prevent June 2023). Although this means just under half the population remain without treatment, HWE has a higher PP rate compared to regional and national levels.
- When looking into more detail at the differences in prescribing between different ethnicities, CVD Prevent Data highlight the inequalities between Black (lowest prescribing rate) and Asian (highest prescribing rate) ethnicities.



- For this cohort, rates of LLT prescribing are higher in the most deprived (56.7%) compared to least deprived (50.8%) quintile. (Source CVD Prevent, June 2023)

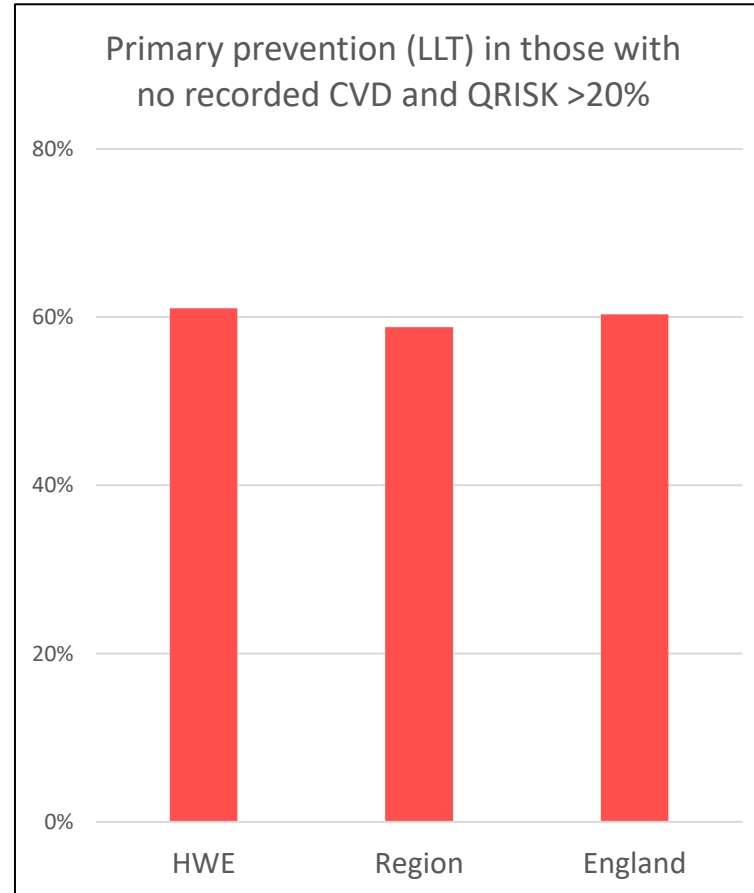




Primary Prevention – No CVD and QRISK >20%

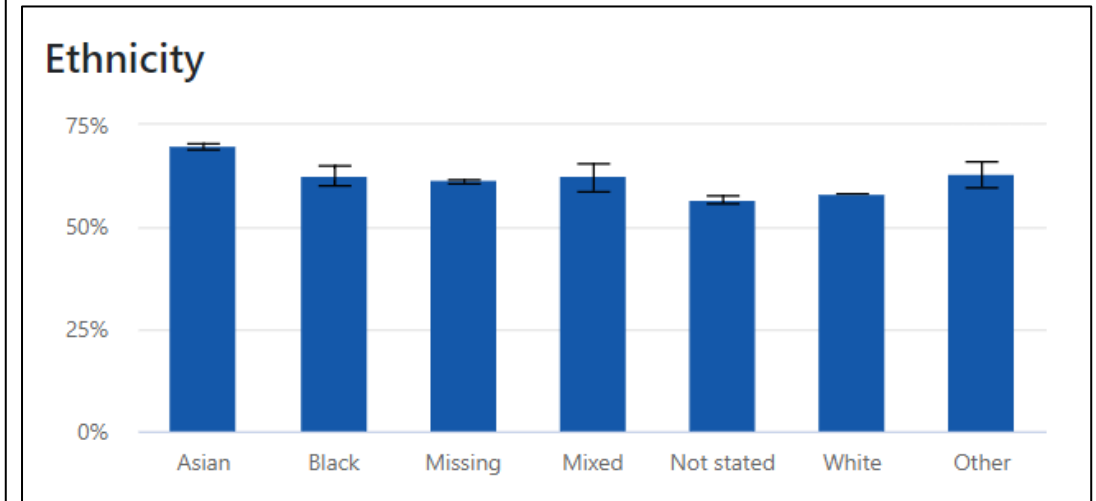
Percentage of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more, on lipid lowering therapy

- QRISK >20% means someone has at least a 2 in 10 chance of having a stroke or heart attack in the next 10 years.
- In HWE, just over 60% of this cohort are on appropriate LLT. This is higher than the national and regional rates (Source CVD Prevent June 2023).



Source: CVD Prevent to June 2023, indicator: CVDP003CHOL

- When broken down by ethnicity, those with White or Black, (as well as Not Stated and Missing) ethnicities in particular face the lowest levels of appropriate LLT prescribing. (Source CVD Prevent June 2023).
- Prescribing rates are higher in the most deprived quintile (63.3%) compared to the least deprived quintile (57.3%) (Source CVD Prevent June 2023)



Primary prevention (LLT) in those with no recorded CVD and QRISK >20% in HWE ICB by ethnicity. Source: CVD Prevent to June 2023, indicator: CVDP003CHOL

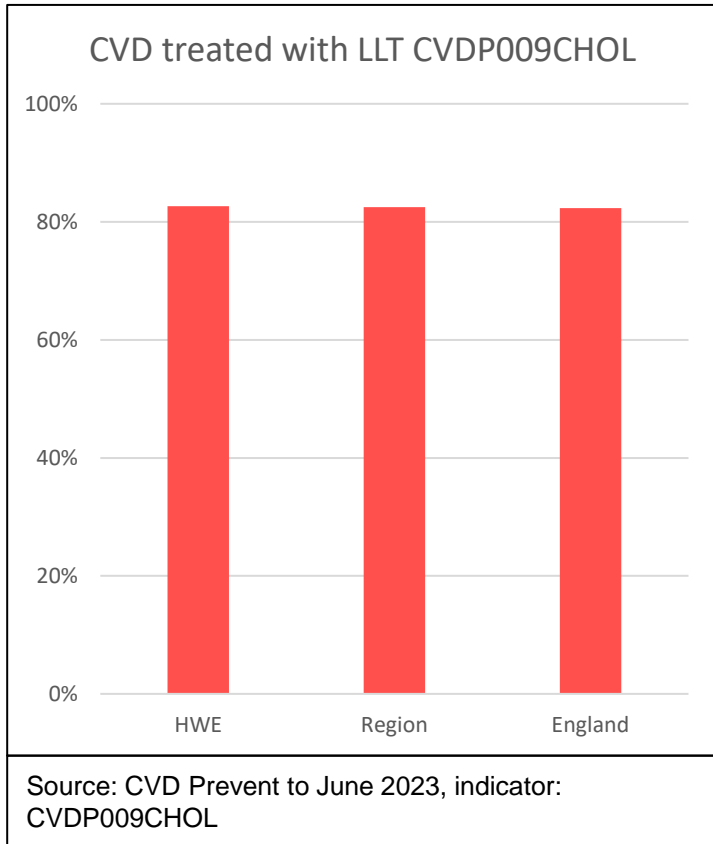




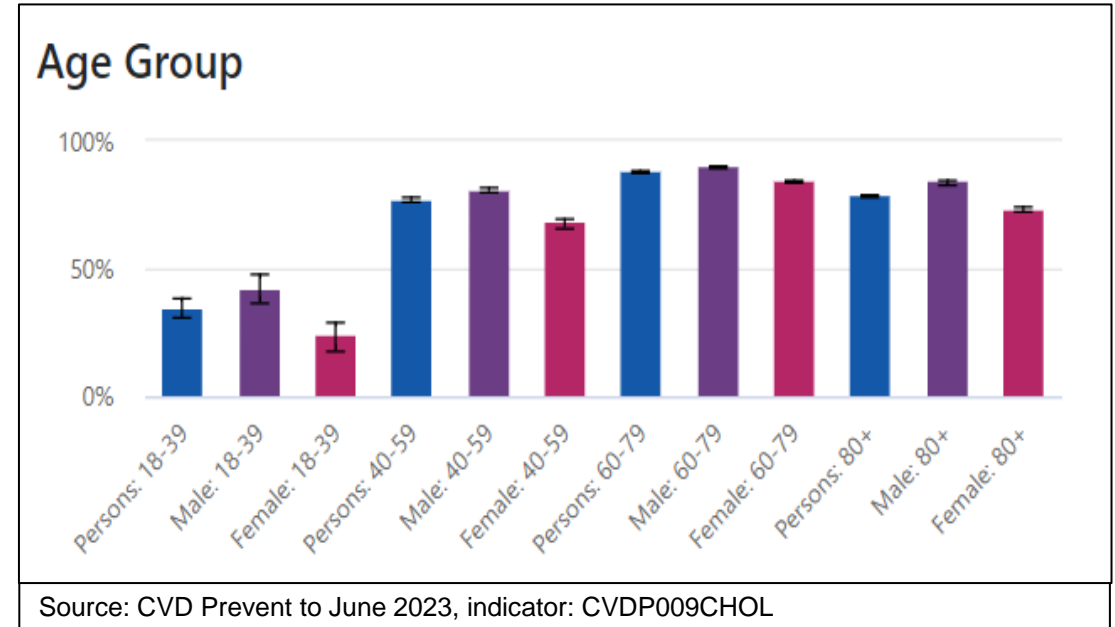
Secondary prevention – CVD treated with LLT



Percentage of patients aged 18 and over with GP recorded CVD (narrow definition), who are currently treated with lipid lowering therapy.



- HWE has comparable rates to EoE and Nationally when looking at LLT prescribing for secondary prevention (Source CVD Prevent June 2023), although below the national ambition of 95%,
- This data split by ethnicity shows a similar picture to Primary Prevention, with people of Black ethnicity (75.2%) having the lowest uptake of LLT compared to those of Asian (85.6%) and White ethnicity (83.1%) (Source CVD Prevent June 2023).



- The above graph shows the same indicator by age and highlights that those under 40 years have the lowest rate of LLT prescribing, particularly women (Source CVD Prevent June 2023).
- LLT prescribing is slightly lower in the most deprived (81.3%) compared to the least deprived (82.9%) quintile (Source CVD Prevent June 2023).

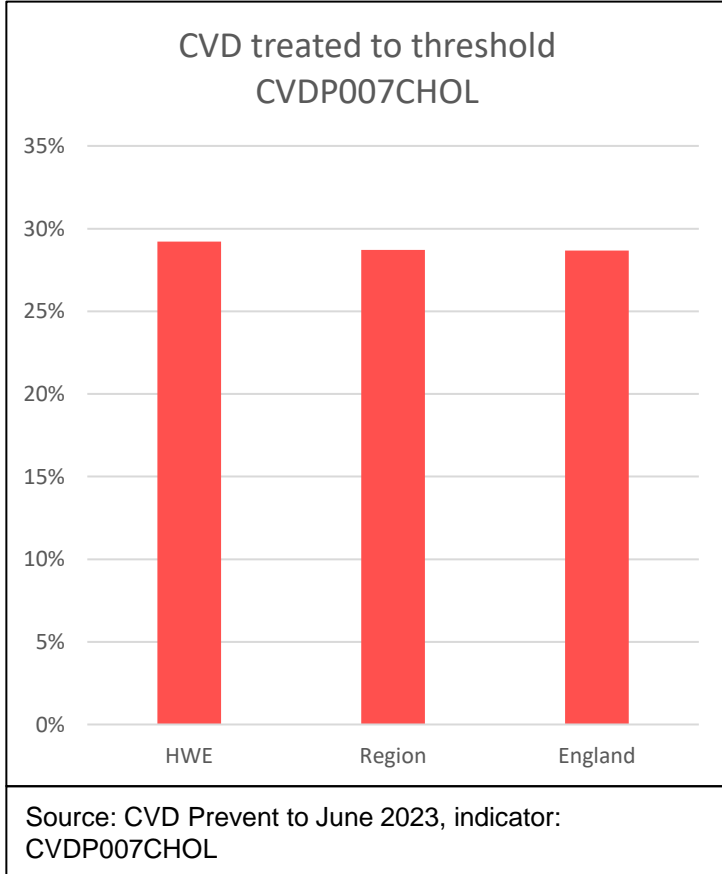




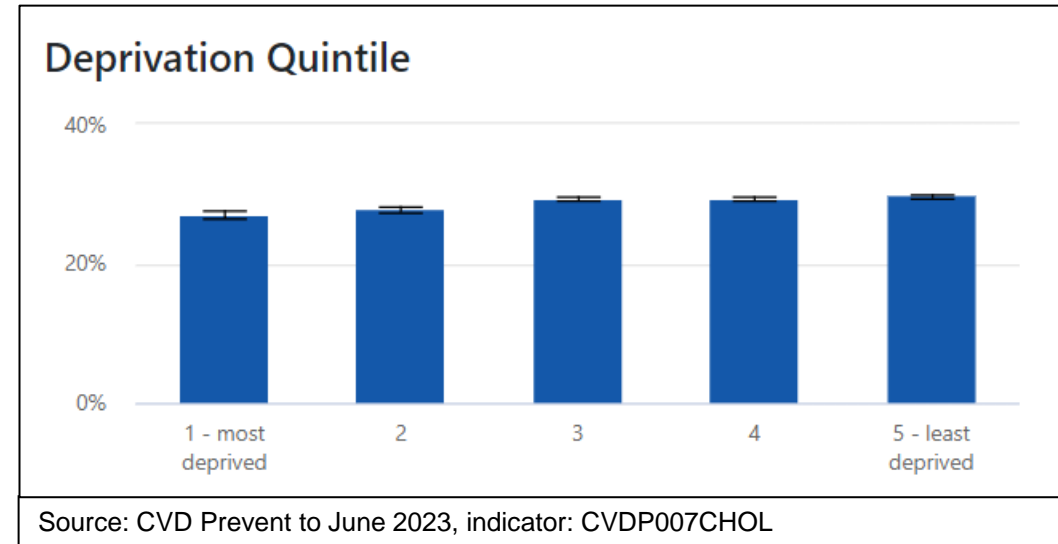
Secondary Prevention - CVD treated to threshold



Percentage of patients aged 18 and over, with GP recorded CVD (narrow definition), in whom the most recent blood cholesterol level (measured in the preceding 12 months) is non-HDL cholesterol less than 2.5mmol/l or LDL-cholesterol less than 1.8mmol/l



- In those requiring secondary prevention – 29.2% have achieved their target cholesterol level in HWE. This is marginally better than regional (28.7%) and national (28.7%) rates. (Source CVD Prevent June 2023), although below the national ambition of 35%.
- The right graph shows that those in the most deprived quintile are less likely to achieve their target cholesterol level.
- The achievement of target cholesterol levels is highest in those with Asian ethnicity, and lowest in those with Mixed, Not stated or Other ethnicity (Source CVD Prevent June 2023)



- There is a difference in attainment of cholesterol targets between males and females, where females achieve their target less often.
 - Males reaching threshold - 31.9%
 - Females reaching threshold – 23.4% (Source CVD Prevent June 2023)



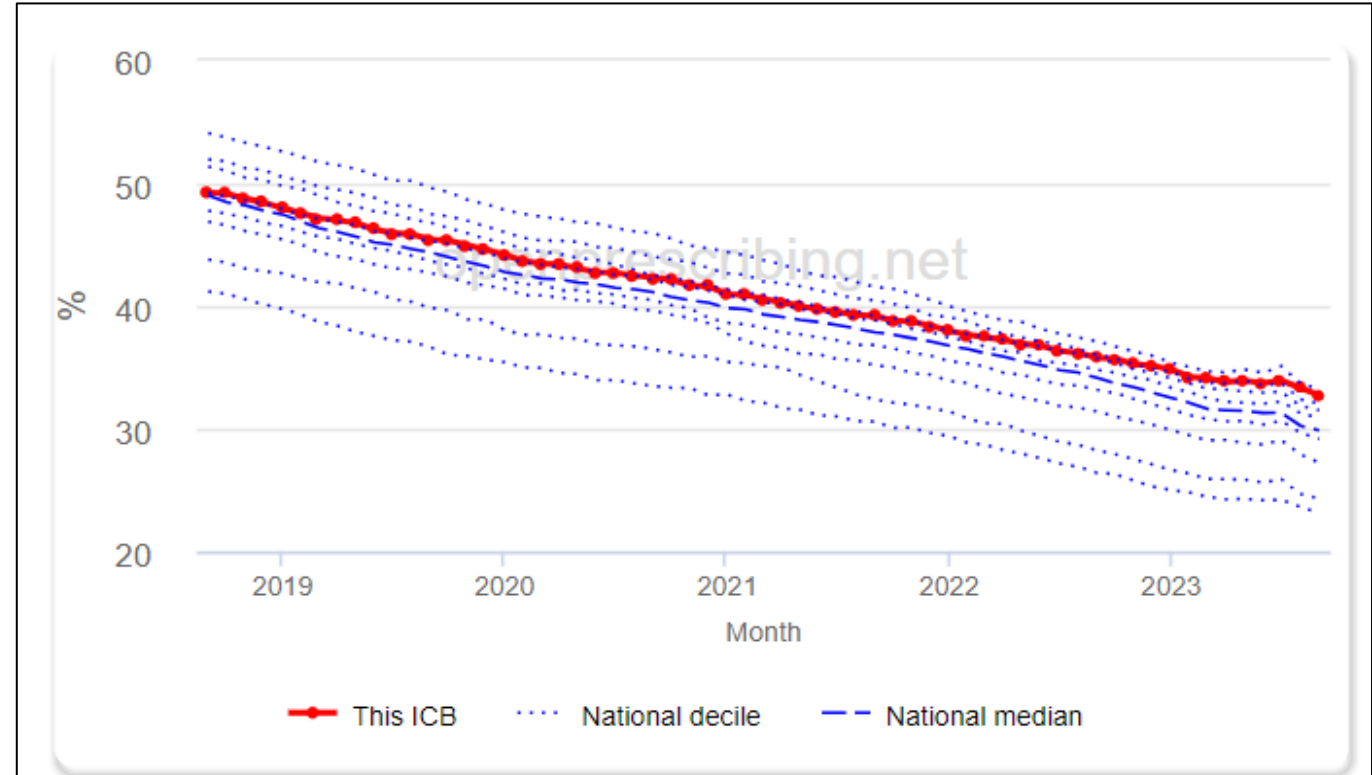


Prescribing practices

Practices in HWE ICB may be over-prescribing low- and medium-intensity statins



- HWE is on the 85th percentile nationally for prescribing low and medium intensity statins (Source: Open Prescribing September 2023).
- NICE guidance recommends the use of high-intensity statins with a low acquisition cost. Our current prescribing practices may not be as effective or cost-effective as they could be.



Items of low and medium intensity statins as a percentage of items of all statins. Source: Open Prescribing September 2023

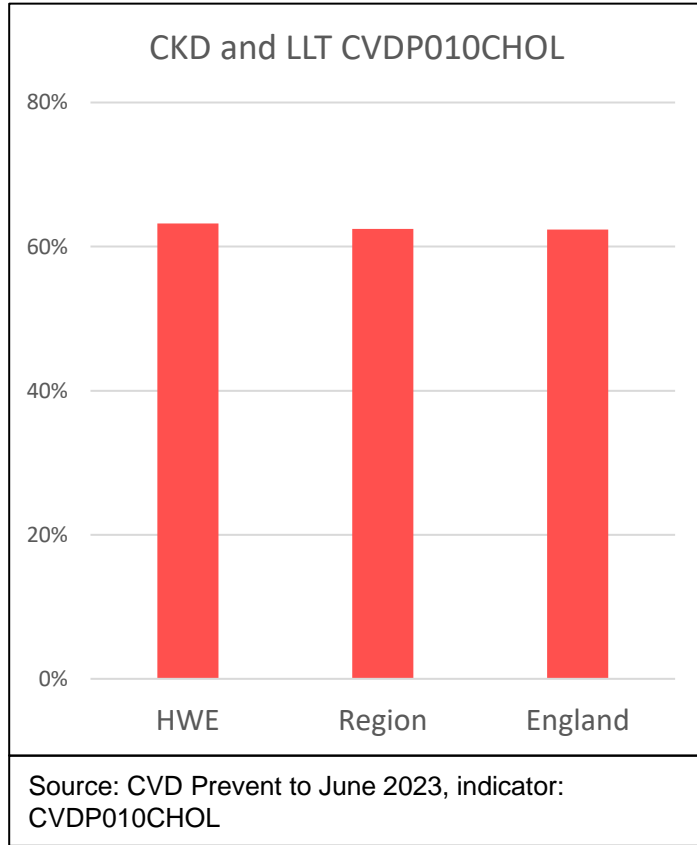




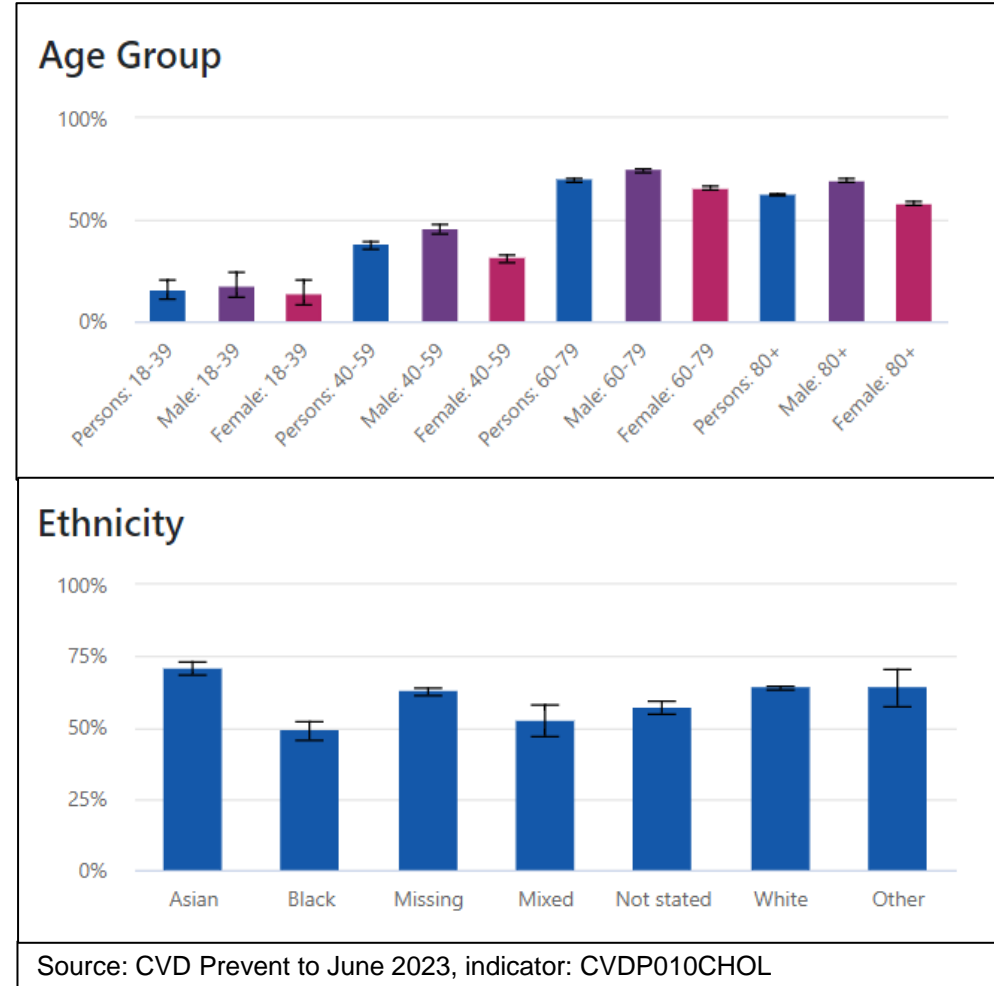
Chronic kidney disease and cholesterol



Percentage of patients aged 18 and over with GP recorded CKD (G3a to G5), who are currently treated with lipid lowering therapy.



- When looking at LLT in those with CKD, HWE performs above the regional and national average (Source CVD Prevent June 2023).
- Analysing by age however, Females, particularly <60 have the poorest rate of LLT prescribing (Source CVD Prevent June 2023).
- By ethnicity, Black, Mixed, Other and Not stated ethnicities again face similar lower LLT prescribing rates (Source CVD Prevent June 2023).
- When looking at deprivation, the most deprived quintile have a higher rate of LLT prescribing (66.8%) compared to the least deprived (61.4%) (Source CVD Prevent June 2023).

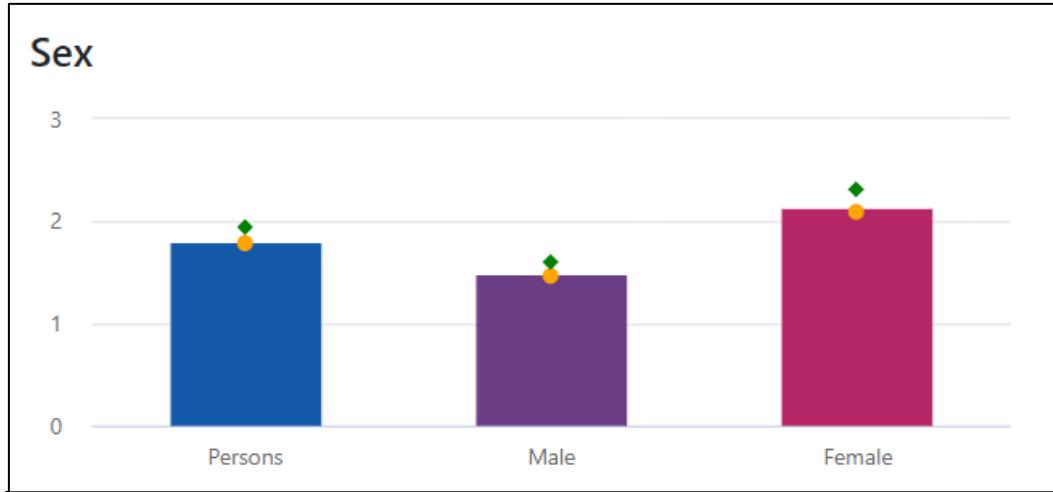




Familial hypercholesterolaemia



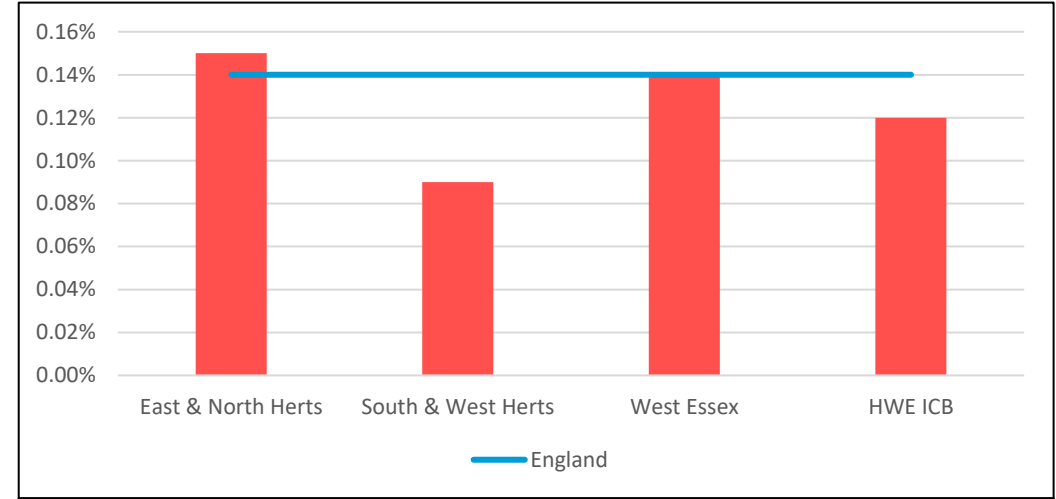
Prevalence of GP recorded possible, probable or confirmed familial hypercholesterolaemia (FH), all ages (rate per 1000)



Source: CVD Prevent to June 2023, indicator: CVDP002FH

- Prevalence of possible, probable or confirmed FH is higher in women than in men (locally, regionally and nationally)
- Data is not available by age, deprivation or ethnicity
- When compared to other ICBs in the region, HWE has the highest prevalence. This may reflect better detection, as HWE has lowest rate of those who are high risk for FH but not on the register or being investigated (See right graph.) (Source CVD Prevent June 2023)

Detection/opportunity to diagnose - Percentage of GP registered patients of all ages whose cholesterol values are in the at-risk range for FH, with no GP record of FH diagnosis or investigation

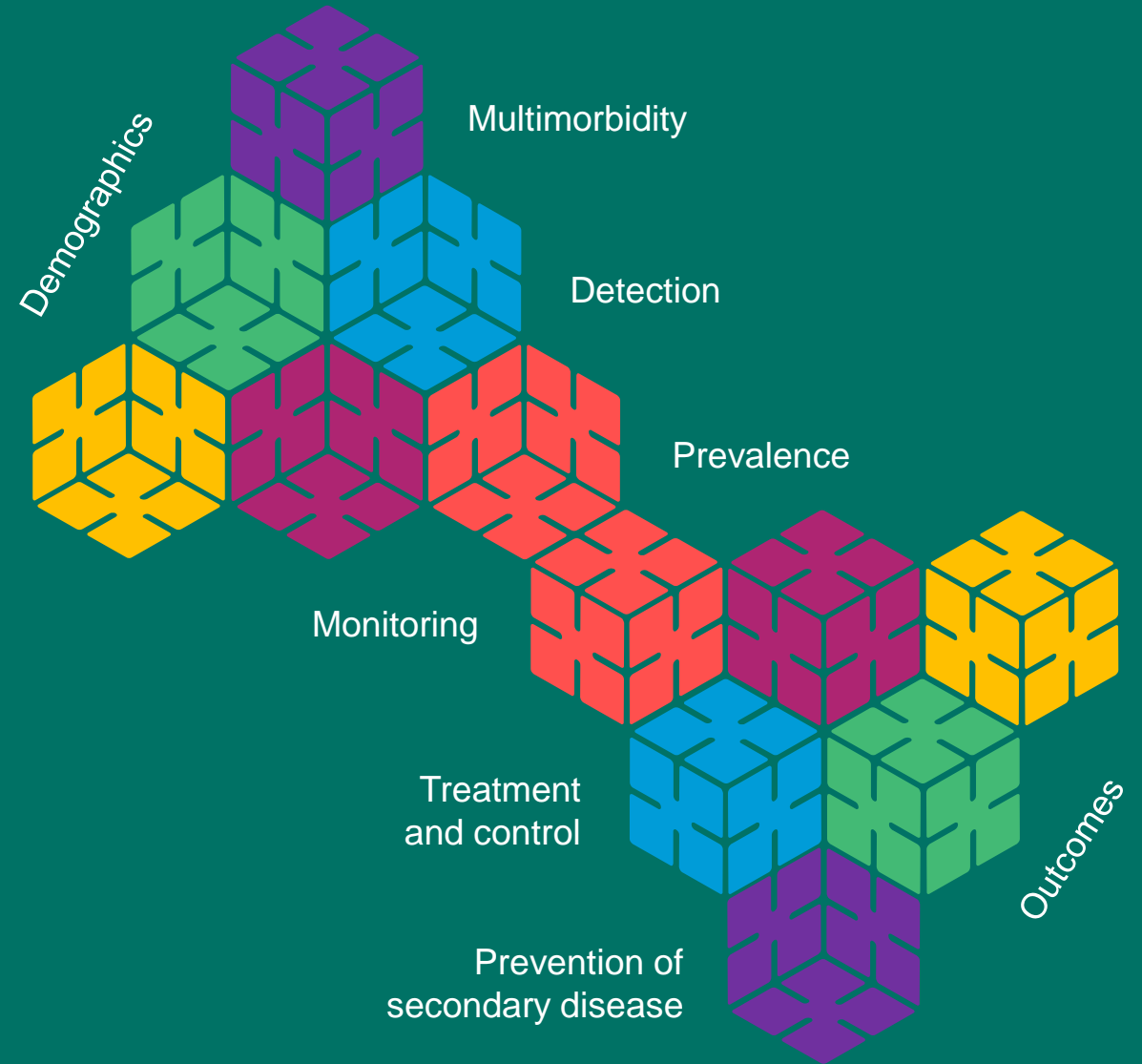


Source: CVD Prevent to June 2023, indicator: CVDP004FH

- The above graph shows the % of people who should be investigated for FH (have cholesterol levels in the at-risk range for FH)
- HWE has the smallest proportion when compared to regionally and nationally. HWE has the lowest proportion in the region.
- When looking at this indicator by deprivation, the most deprived group have the highest proportion (and smallest gap between regional/national). The confidence intervals are wide however, due to very low numbers. (Source CVD Prevent June 2023)



5. Data commentary and limitations



Working together
for a healthier future



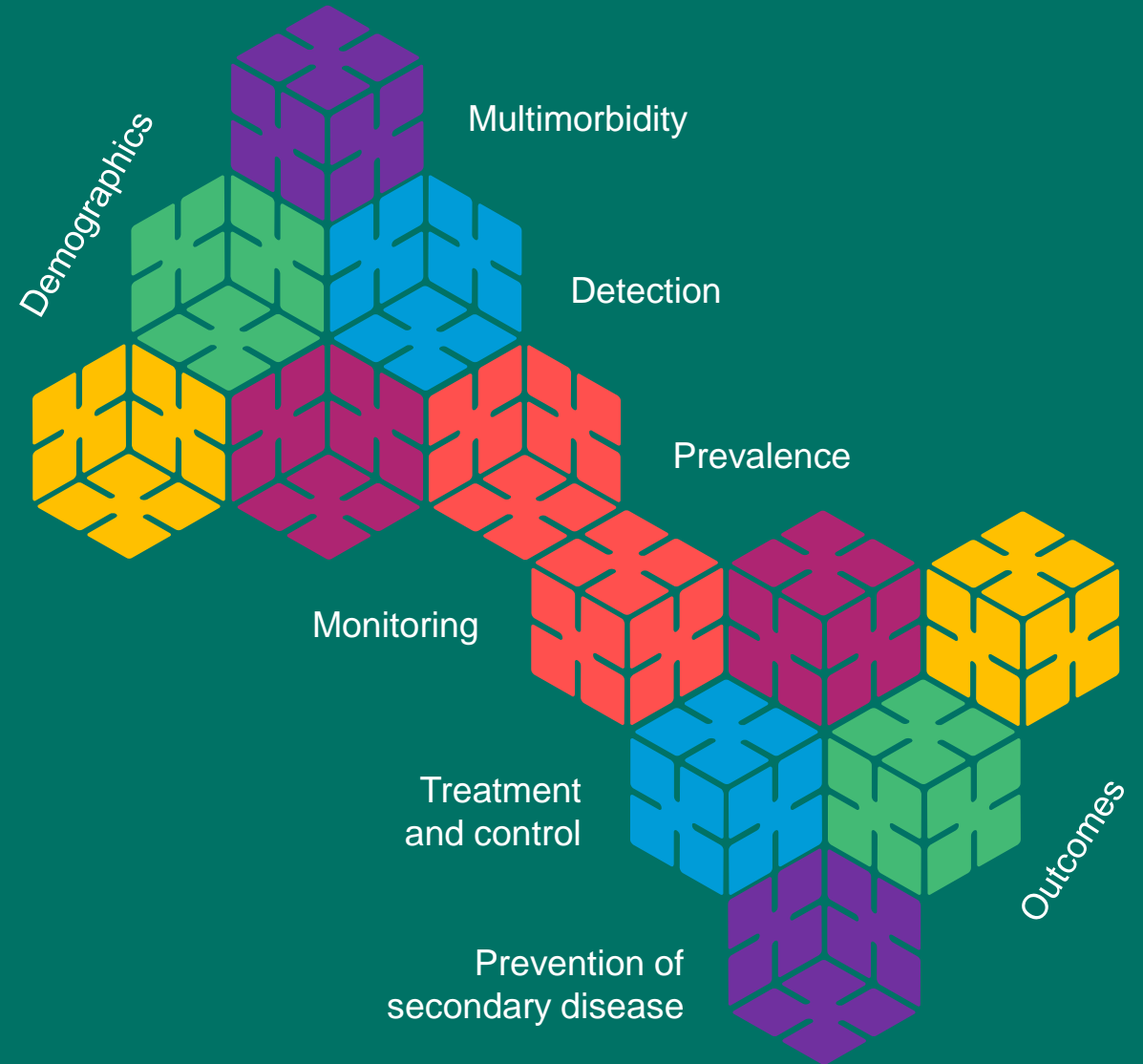
Data commentary and limitations

- 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 (3rd January 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

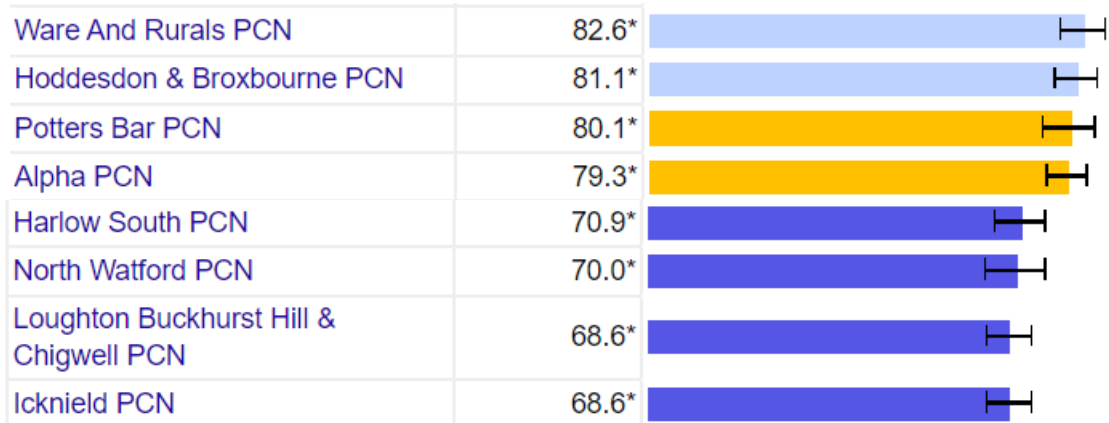
Working together
for a healthier future



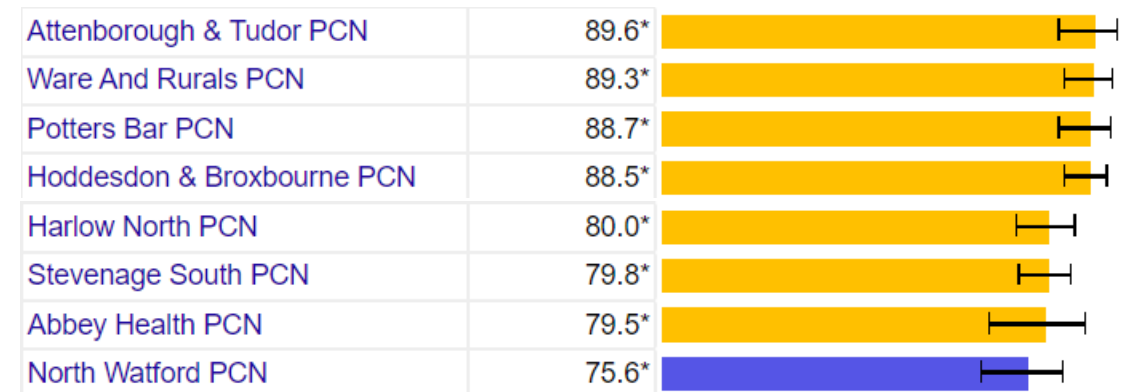
Monitoring and Control (2) - BP targets differ between PCNs

4 best performing (top) and worst performing (bottom) PCNs in the ICS for meeting BP targets in HTN patients

BP target met in <80s

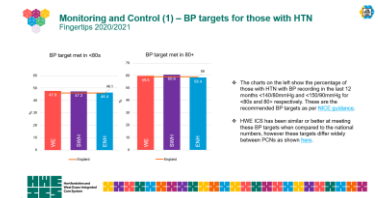


BP target met in 80+



Source: QOF via Fingertips 2022/23

Back to

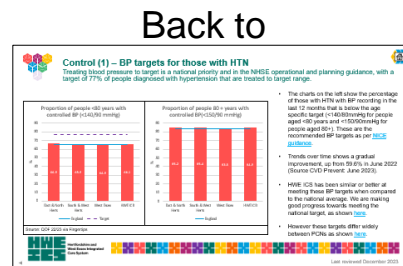
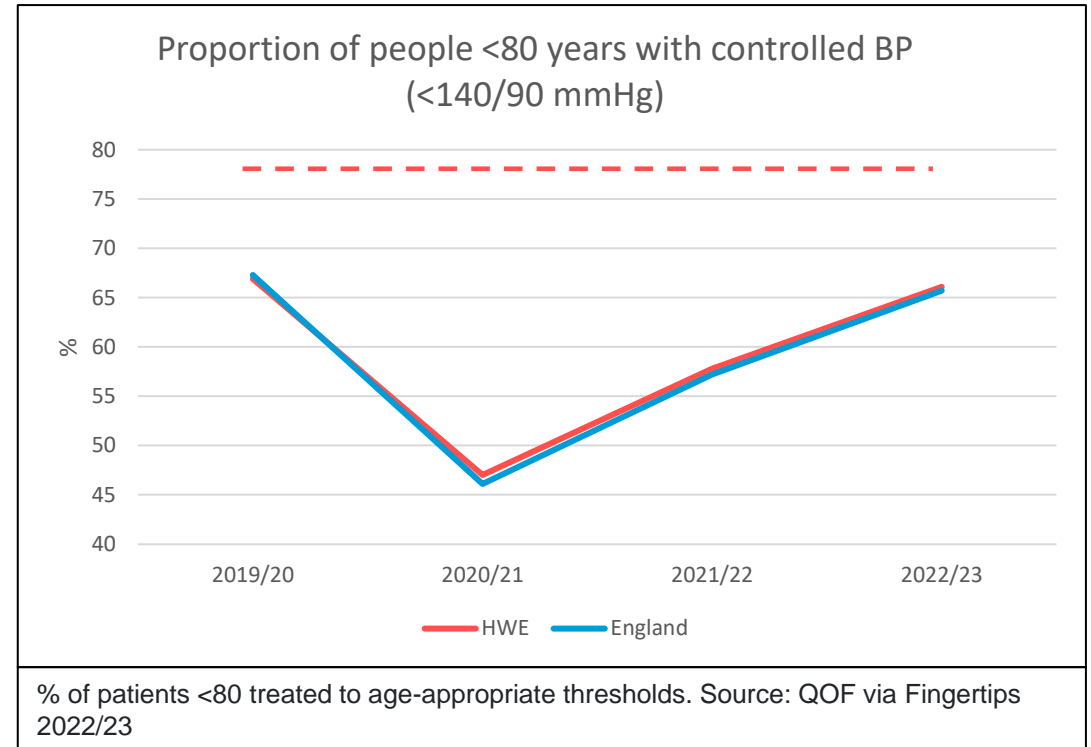


previous



Hypertension control – progress towards national target

- Control has improved. The proportion of people in HWE aged under 80 whose last BP reading was within age-appropriate thresholds rose from 57.8.1% in 2021/22 to 66.1% in 2022/23. (Source QOF via Fingertips 2022/23).
- However, we have still not met national target of 77%.**
- There is some variation between Place areas, with ENH having highest proportion (66.9%) and West Essex lowest (64.9%). (Source QOF via Fingertips 2022/23).



Previous slide

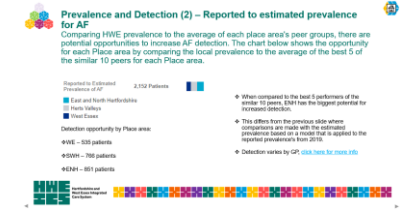




Prevalence and Detection (3)

Variation between GPs in detection of AF. Top 10 and bottom 10 GPs show wide detection variation within the ICS.

Back to



Previous slide

Practices with the largest and smallest gap between observed and estimated prevalence of Atrial Fibrillation

