

LEICESTER CITY HEALTH AND WELLBEING BOARD DATE

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| Subject: | Cardiovascular Disease Joint Strategic Needs Assessment |
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EXECUTIVE SUMMARY:

1. Introduction:

A Joint Strategic Needs Assessment (JSNA) is a statutory process by which local authorities and commissioning groups assess the current and future health, care and wellbeing needs of the local community to inform decision making.

The JSNA:

- Is concerned with wider social factors that have an impact on people's health and wellbeing such as poverty and employment.
- Looks at the health of the population with a focus on behaviours which affect health, such as smoking, diet and exercise.
- Provides a view of health and care needs in the local community
- Identifies health inequalities
- Indicates current service provision
- Identifies gaps in health and care services, documenting unmet needs

The Joint Strategic Needs Assessment of Cardiovascular Disease (CVD) provides a report of the following:

Types of cardiovascular disease including Coronary Heart Disease, Stroke, Heart Failure, Hypertension and Atrial Fibrillation

2. Risk factors associated with Cardiovascular Diseases:

This includes unmodifiable risk factors such as:

- Increasing age
- Men
- Family history of cardiovascular diseases
- Ethnic groups such as South Asian or Black
- Populations living in high socio-economic deprivation, poor housing or with low educational attainment

Modifiable risk factors such as:

- Unhealthy diet
- Physical Inactivity

- Overweight or obesity
- Smoking
- Excessive alcohol consumption

3. Impact of cardiovascular diseases on Leicester's population:

3.1 Prevalence

The prevalence of hypertension (12.2%), CHD (2.3%), stroke or TIA (1.2%), atrial fibrillation (1.1%) and heart failure (0.8%) in the Leicester City GP registered population is significantly below the prevalence in England. The prevalence of CHD in Leicester has shown a significant decreasing trend over the most recent years, whilst the prevalence of heart failure has shown a significant increasing trend.

The city's relatively young population compared to Leicestershire and Rutland likely contributes to this gap as prevalence is not age-standardised.

Crude prevalence of cardiovascular diseases in LLR ICB sub-location GP registered population, 2021/22

| Long-term condition | Leicester count | QOF prevalence by IC sub-location | | | | |
|------------------------|-----------------|---|---------------------------|------------------------------|---------|---------|
| | | Leicester (04C) | West Leicestershire (04V) | East Leics and Rutland (03W) | LLR ICB | England |
| Hypertension | 52,211 | 12.2%  | 14.9% | 16% | 14.3% | 14.0% |
| Coronary heart disease | 9,951 | 2.3%  | 2.8% | 3.2% | 2.7% | 3.0% |
| Stroke or TIA | 5,237 | 1.2%  | 1.9% | 2.0% | 1.7% | 1.8% |
| Atrial fibrillation | 4,532 | 1.1%  | 2.3% | 2.7% | 2.0% | 2.1% |
| Heart Failure | 3,567 | 0.8%  | 1.3% | 1.3% | 1.1% | 1.0% |

| |
|---|
| Statistically significantly higher than England |
| Statistically significantly below England |

| Trend, last five years | |
|---|-----------------------|
|  | Increasing |
|  | No Significant Change |
|  | Decreasing |

3.2 Hospital admissions

Between 2018/19 and 2020/21 there were over 13,000 hospital admissions due to CVD in Leicester. Of these 73% were emergency and the remainder planned admissions

Hospital admission rates are significantly higher in men (10.1 per 1,000 population) than women (8.4 per 1,000)

Rates increase with increasing age: from 2.7 per 1,000 for 25-44 year olds to 29.0 per 1,000 in 65-74 year olds and 88.1 per 1,000 in over 85s.

Hospital admission rates are significantly higher in residents from the most 20% of areas (15.1 per 1,000) compared with those from the 20% most affluent areas (10.2 per 1,000)

3.3 Mortality

In 2021 there were 663 deaths from CVD in Leicester, accounting for 22% of all deaths. Around half of all deaths from CVD are from coronary heart disease and a sixth from strokes.

Year on year, mortality rates (age-standardised) in Leicester are statistically significantly higher (289 per 100,000) than England (230 per 100,000). Mortality rates are significantly higher for both men and women in Leicester compared with England. Areas of the city which are significantly higher include New Parks, Mowmacre and Stocking Farm, St Matthews, Highfields, North Evington and Rowlatts Hill

4. Current services

There are 2 main ways of reducing the risk factors associated with CVD

- i) Better management of risk factors such as weight, diet, smoking and exercise
- ii) Identifying people at risk early

Services include:

- **Live Well:** a lifestyle hub providing a range of services intended to help individuals maintain a healthy weight, increase physical activity and reduce smoking and alcohol consumption
- **NHS Health Checks:** Screening programme for all 40-74 year olds without a current diagnosed long term condition aiming for early identification of CVD risk factors
- **Integrated CVD service:** Service commissioned by ICB for early detection, diagnosis and treatment for patients at higher risk of atrial fibrillation and heart failure
- **Defibrillators and Heartshield Project:** Provides community access to defibrillators across Leicester for use in a sudden cardiac arrest

5. Unmet needs and service gaps

- Gaps in diagnosis between estimated prevalence (based on population characteristics) and diagnosed prevalence
- Health inequalities: in health outcomes between different population groups in Leicester. People in most deprived areas of Leicester and people of Asian ethnic groups have higher hospital admission rates for Coronary Heart Disease

6. Recommendations

- Case-finding of hypertension and atrial fibrillation through PCN/primary care services

- Work towards the ambitions of Leicester's Care, Health and Wellbeing Strategy
- Support the delivery of CORE20PLUS5, focussing on homeless, severe mental illness and learning disabilities
- Develop a shared preventative strategy for all commissioners and providers of clinical care and public health interventions
- Establish a joint approach to early detection to close the 'prevalence gap' and reduce variation in ascertainment and outcome for people at high risk or with an established cardiovascular condition.
- Close the inequality gap through better understanding of need in affected populations and taking appropriate action by care commissioners and providers.
- Continue work to improve the coding of patient characteristics such as ethnicity. This will allow more in-depth analysis of health inequalities.
- Further improvements in CVD care and prevention provided in the community.
- Take the steps outlined by the National CVD Prevention Programme:
<https://www.england.nhs.uk/ourwork/clinical-policy/cvd/>

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

Note the unmet needs and service gaps and provide comment on areas identified for improvement