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Cardiovascular Disease: Primary Care Intelligence Packs

NHS Harrow CCG

26 Feb 2019

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This intelligence pack has been compiled by GPs and nurses and pharmacists in the Primary Care CVD Leadership Forum in collaboration with the National Cardiovascular Intelligence Network

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Primary Care Leadership Forum CVD

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Data and methods

This slide pack compares the clinical commissioning group (CCG) NHS Harrow with CCGs in its sustainability and transformation partnership (STP) and the England average. The slide pack also compares the CCG to its 10 most similar CCGs in terms of demography, ethnicity and deprivation, and shows variation between practices within the CCG. Information on the methodology used to calculate the 10 most similar CCGs is here:

https://www.england.nhs.uk/publication/similar-10-ccg-explorer-tool

The 10 most similar CCGs to NHS Harrow CCG are:

NHS Hillingdon CCG	NHS Barnet CCG
NHS Merton CCG	NHS East Berkshire CCG
NHS Kingston CCG	NHS Bexley CCG
NHS Redbridge CCG	NHS Hounslow CCG
NHS Sutton CCG	NHS Crawley CCG

The majority of data used in the packs is taken from the 2017/18 Quality and Outcomes Framework (QOF). Where this is not the case, this is indicated in the slide. For the first time CCG level data from the indicators no longer in QOF (INLIQ) are included in this pack. These data are experimental statistics. Full source data and further details on the INLIQ are shown in the appendix.

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NHS RightCare CVD practice packs

NHS RightCare is a national NHS England supported programme committed to delivering the best care to patients, making the NHS's money go as far as possible and improving patient outcomes. The RightCare approach uses robust data and the best available clinical evidence to identify unwarranted variation across the country. It then provides practical resources and support to local health economies to help them work through how money can be spent most effectively to deliver the best care for their populations.

These CVD Intelligence packs produced by Public Health England are publicly available and highlight the levels of variation and opportunities that exist across health economies in terms of patient detection/management. Health economies with significant variation and opportunities may want to explore the NHS RightCare practice packs which look at variation and opportunities at individual general practice level across whole pathways.

The NHS RightCare CVD practice packs look at indicators from across Coronary Heart Disease, Stroke and Diabetes pathways including data on disease prevalence, detection, patient management, primary care prescribing, inpatient admissions and outcomes. Practice variation and opportunities are presented by comparing each practice to a national cluster of demographically similar practices. These packs are available for every CCG and can be obtained by contacting your local NHS RightCare Delivery Partner.

For further information on NHS RightCare practice packs please contact: rightcare@nhs.net

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Local intelligence as a tool for clinicians and commissioners to improve outcomes for our patients

Why should we use this CVD Intelligence pack?

High risk conditions for cardiovascular disease (CVD) - such as hypertension, high cholesterol, atrial fibrillation (AF), diabetes, non-diabetic hyperglycaemia and chronic kidney disease - are the easier targets for prevention in the NHS because late diagnosis, suboptimal treatment, and variation in treatment received is common.

High quality primary care is central to improving CVD outcomes as a large proportion of prevention, diagnosis and treatment is delivered in a primary care setting. This pack is a powerful resource for stimulating local conversations about quality improvement in primary care across a number of vascular conditions, looking at prevention, diagnosis, care and outcomes. The data allows comparison between clinical commissioning groups (CCGs) and between general practices.

This is not about performance management because variation can have more than one interpretation. But patients have a right to expect that challenging questions will be asked about how the best practices are achieving the best, what average or below average performers could do differently, and how they could be supported to perform as well as the best.

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Local intelligence as a tool for clinicians and commissioners to improve outcomes for our patients

How to use this CVD Intelligence pack

The intelligence pack has several sections - CVD prevention, hypertension, stroke and atrial fibrillation (AF), diabetes, kidney disease, heart disease and heart failure. Each section has one slide of narrative that makes the case and asks some questions. This is followed by data for a number of indicators, each with benchmarked comparisons between CCGs and between practices.

Use the pack to identify where there is variation that needs exploring and to start asking challenging questions about where and how quality could be improved. We suggest you then develop a local action plan for quality improvement - this might include establishing communities of practice to build clinical leadership, systematic local audit to get a better understanding of the gaps in care and outcomes, and developing new models of care that mobilise the wider primary care team to reduce burden on general practice.

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Why does variation matter?

The variation that exists between demographically similar CCGs and between practices illustrates the local potential to improve care and outcomes for our patients

Benchmarking is helpful because it highlights variation.

It has long been acknowledged that some variation is inevitable in the healthcare and outcomes experienced by patients. But John Wennberg, who has championed research into clinical variation over four decades and who founded the pioneering Dartmouth Atlas of Health Care, concluded that much variation is unwarranted - i.e. it cannot be explained on the basis of illness, medical evidence, or patient preference, but is accounted for by the willingness and ability of doctors to offer treatment.

Benchmarking does not tell us why there is variation. Some of the variation may be explained by population or case mix and some may be unwarranted. Its strength lies not in the answers it provides but in the questions it generates for CCGs and practices. For example:

1. How much variation is there in detection, management and outcomes?
2. How many people would benefit if average performers improved to the level of the best performers?
3. How many people would benefit if the lowest performers matched the achievement of the average?
4. What are better performers doing differently in the way they provide services in order to achieve better outcomes?
5. How can the CCG support low and average performers to help them match the achievement of the best?
6. How can we build clinical leadership to drive quality improvement?

There are legitimate reasons for exception reporting. But...

Excepting patients from indicators puts them at risk of not receiving optimal care and of having worse outcomes. It is also likely to increase health inequalities. The substantial variation seen in exception reporting for some indicators suggests that some practices are more effective than others at reaching their whole population. Benchmarking exception reporting allows us to identify the practices that need support to implement the strategies adopted by low excepting practices.

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CVD Prevention

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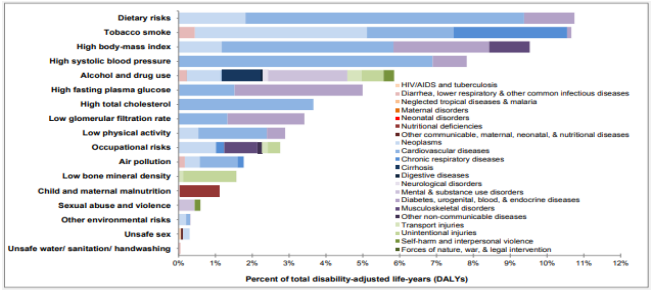
CVD Prevention

"The NHS needs a radical upgrade in prevention if it is to be sustainable"
Five Year Forward View 2014

This is because England faces an epidemic of largely preventable non-communicable diseases, such as heart disease and stroke, cancer, type 2 diabetes and liver disease.



The Global Burden of Disease Study (slide 12) shows us that the leading causes of premature mortality include diet, tobacco, obesity, raised blood pressure, physical inactivity and raised cholesterol. The radical upgrade in prevention needs population-level approaches. But it also needs interventions in primary care for individuals with behavioural and clinical risk factors.

The size of the prevention problem:
- over 60% of adults are obese or overweight
- 22% of adults are physically inactive
- average smoking prevalence is around 17% but is much higher in some communities
- in high risk conditions like atrial fibrillation, high blood pressure, diabetes and high ten year CVD risk score, up to half of all people do not receive preventive treatments that are known to be highly effective at preventing heart attacks and strokes
- around 90% of people with familial hypercholesterolaemia are undiagnosed and untreated despite their average 10 year reduction in life expectancy

What might help?
-Social prescribing and wellbeing hubs offer models for supporting behaviour change while reducing burden on general practice.
-The NHS Health Check is a systematic approach to identifying local people at high risk of CVD, offering behaviour change support and early detection of the high risk but often undiagnosed conditions such as hypertension, atrial fibrillation, chronic kidney disease (CKD), diabetes and prediabetes.

Question: What proportion of our local eligible population is receiving the NHS Health Check and how effective is the follow-up management of their clinical risk factors in primary care?

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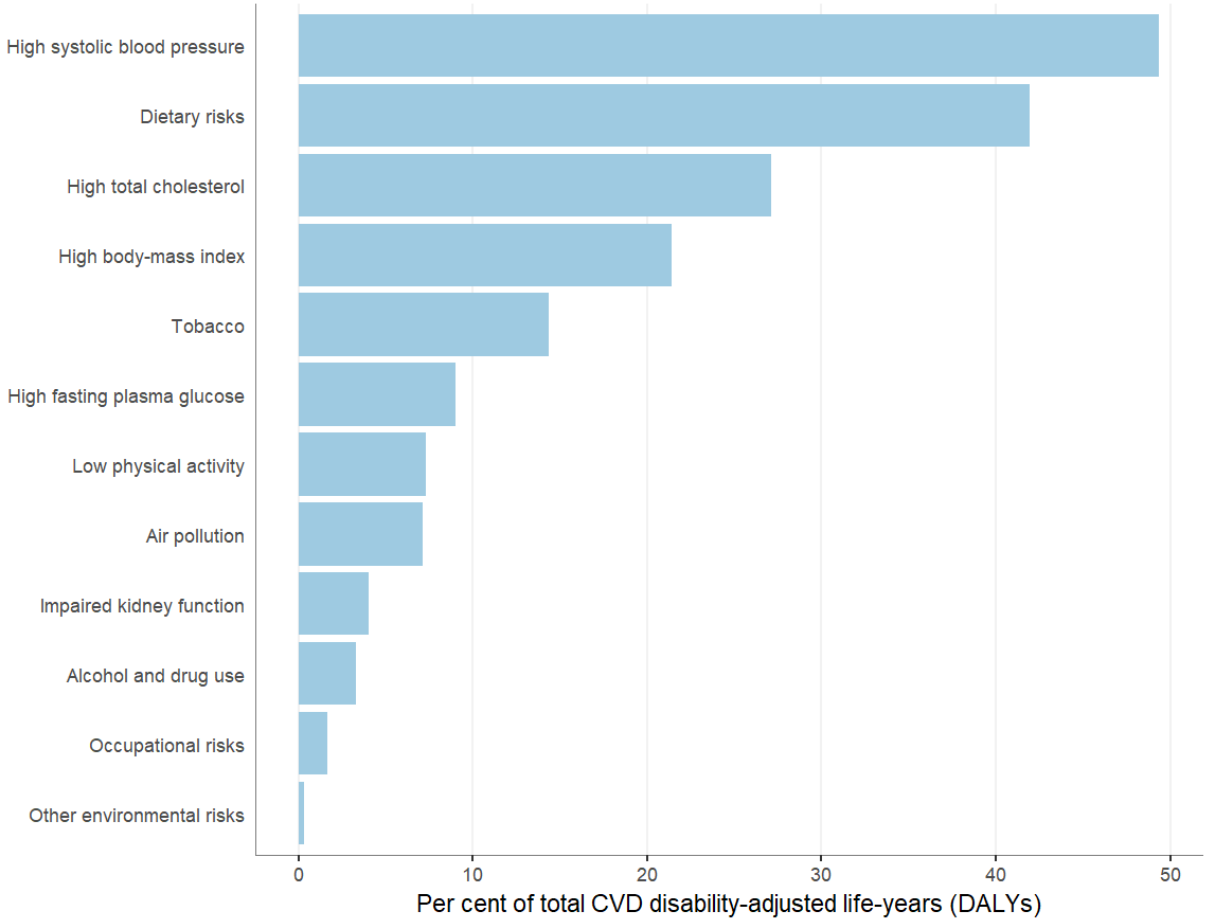
Global Burden of Disease Study 2016: Risk factors attributed to premature CVD mortality and disability in England, expressed as disability-adjusted life-years (DALYs)



Source: Global Burden of Disease Study 2016.

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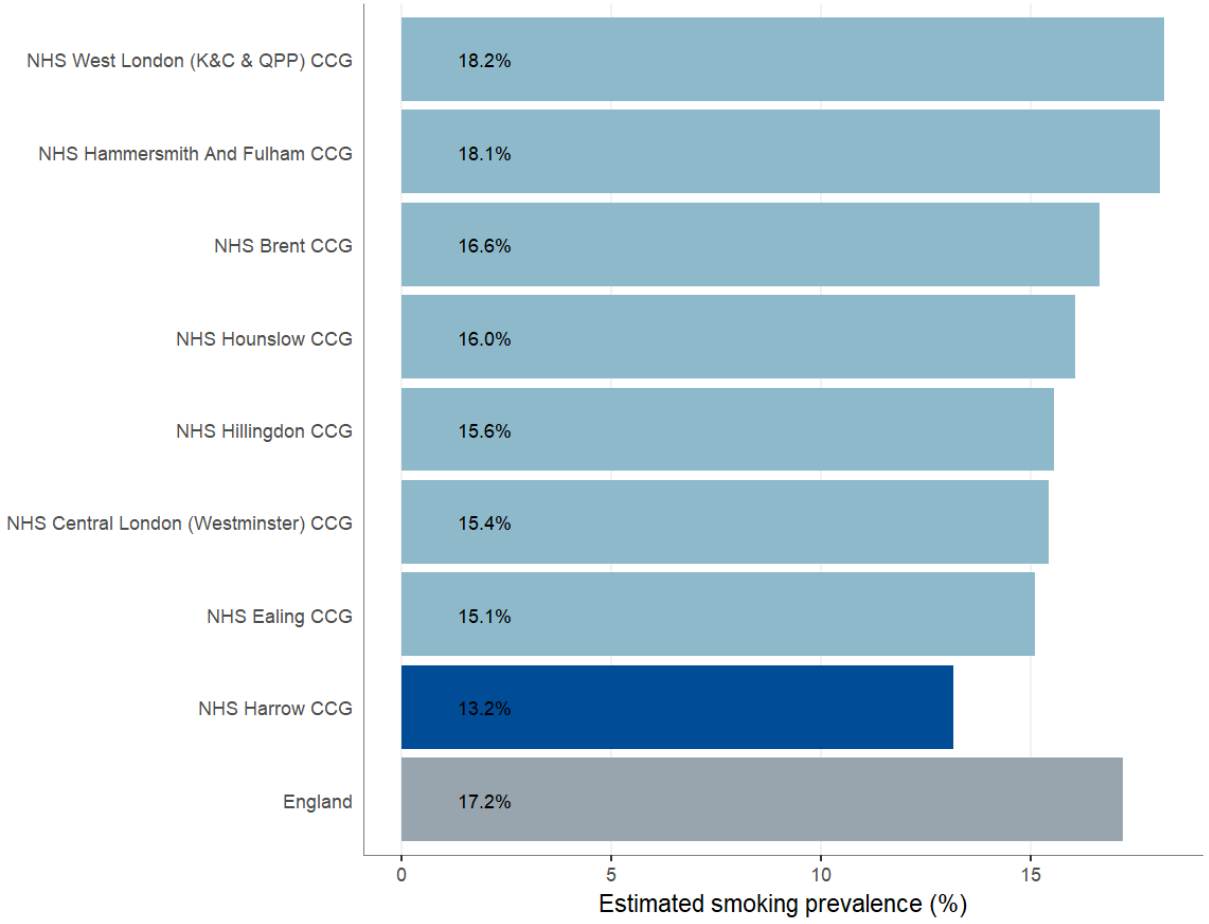
Estimated smoking prevalence, by CCGs in the STP



Smoking prevalence in NHS Harrow CCG was 13.2% in 2017/18

Note: It has been found that the proportion of patients recorded as smokers correlates well with smoking prevalence reported in the Annual Population Survey and is a good estimate of the actual smoking prevalence in local areas,

http://bmjopen.bmj.com/content/4/7/e005217

Indicator definition: denominator of QOF clinical indicator SMOK004 (number of patients 15 years and over who are recorded as current smokers) divided by general practice's estimated number of patients 15 years and over.

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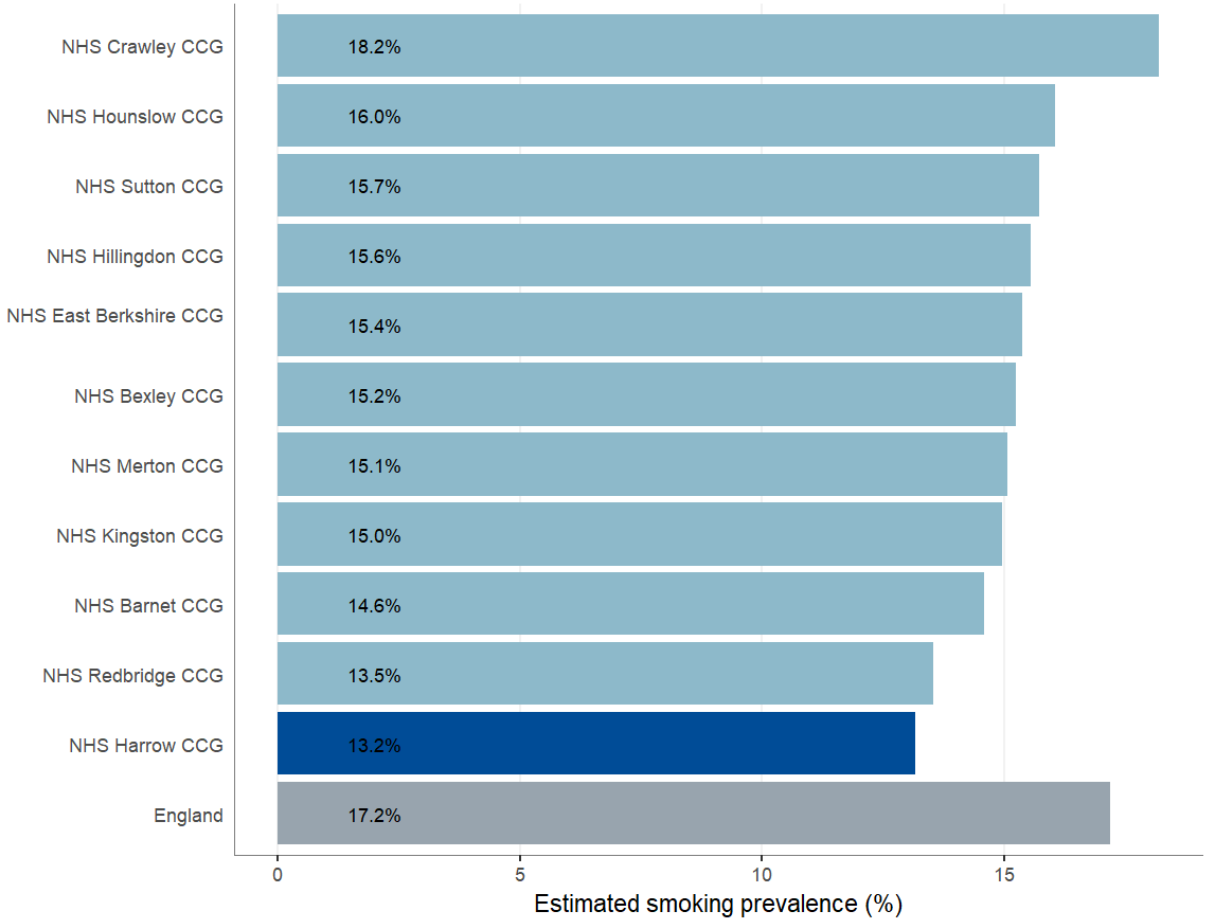
Estimated smoking prevalence, by similar CCGs



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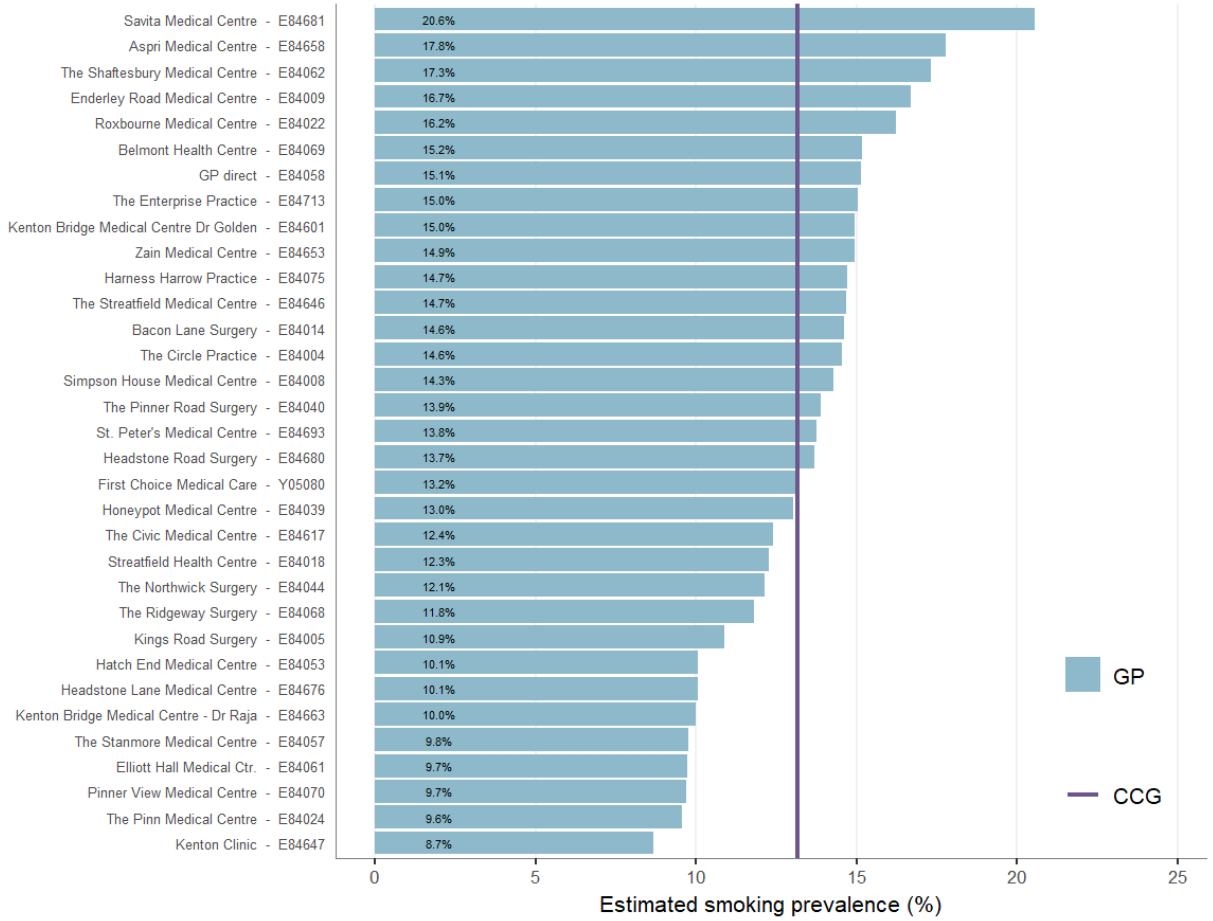
Estimated smoking prevalence, by general practice



28,631 people are recorded as smokers in NHS Harrow CCG

The range of smoking prevalence across GPs in NHS Harrow CCG is 8.7% to 20.6%

Note: For the majority of general practices the method of measuring smoking prevalence is reasonably robust. However, caution is advised for extreme estimates of smoking prevalence and those with high numbers of smoking status not recorded and exceptions.

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Hypertension

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Hypertension

The Global Burden of Disease Study confirmed high blood pressure as a leading cause of premature death and disability

High blood pressure is common and costly
- it affects around a quarter of all adults
- the NHS costs of hypertension are around GBP 2bn
- social costs are probably considerably higher

What do we know?
- at least half of all heart attacks and strokes are caused by high blood pressure and it is a major risk factor for chronic kidney disease and cognitive decline
- treatment is very effective - every 10mmHg reduction in systolic blood pressure lowers risk of heart attack and stroke by 20%
- despite this 4 out of 10 adults with hypertension, over 5 and a half million people in England, remain undiagnosed
- even when the condition is identified, treatment is often suboptimal, with blood pressure poorly controlled in about 1 out of 3 individuals

The Missing Millions
On average, each CCG in England has 26,000 residents with undiagnosed hypertension - these individuals are unaware of their increased cardiovascular risk and are untreated.

What questions can we ask in our CCG?
1. For each indicator how wide is the variation in achievement and exception reporting?
2. How many people would benefit if all practices performed as well as the best?
3. How can we support practices who are average and below average to perform as well as the best in:

   - detection of hypertension
   - management of hypertension

What might help?
1. Support practices to share audit data and systematically identify gaps and opportunities for improved detection and management of hypertension
2. Work with practices and local authorities to maximise uptake and follow up in the NHS Health Check programme
3. Support access to self-test blood pressure stations in waiting rooms and to ambulatory blood pressure monitoring
4. Commission community pharmacists to offer blood pressure measurement, diagnosis and management support, including support for adherence to medication

Public Health England

Hypertension observed prevalence compared with expected prevalence, by CCGs in the STP

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Please note: The hypertension prevalence model will be updated in 2019/20. The observed compared to expected graphs have therefore been removed from this version of the CVD Intelligence packs and will be updated as soon as the model becomes available.

For more details please contact the National Cardiovascular Intelligence Network Team NCVIN@PHE.gov.uk

Public Health England

Hypertension observed prevalence compared with expected prevalence, by similar CCGs

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Public Health England

Hypertension observed prevalence compared with expected prevalence, by general practice

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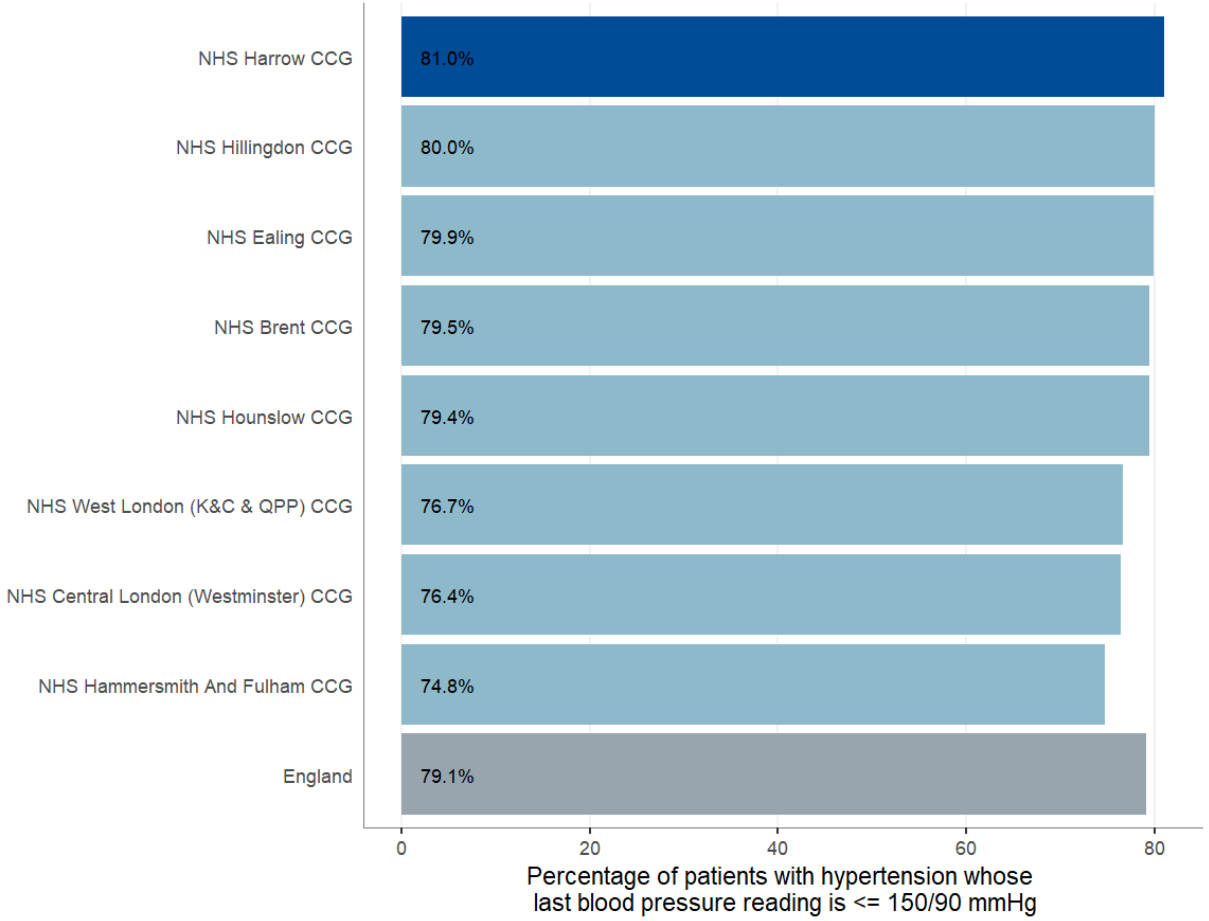
Percentage of patients with hypertension whose last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less, by CCGs in the STP



There are 35,192 people with diagnosed hypertension in NHS Harrow CCG

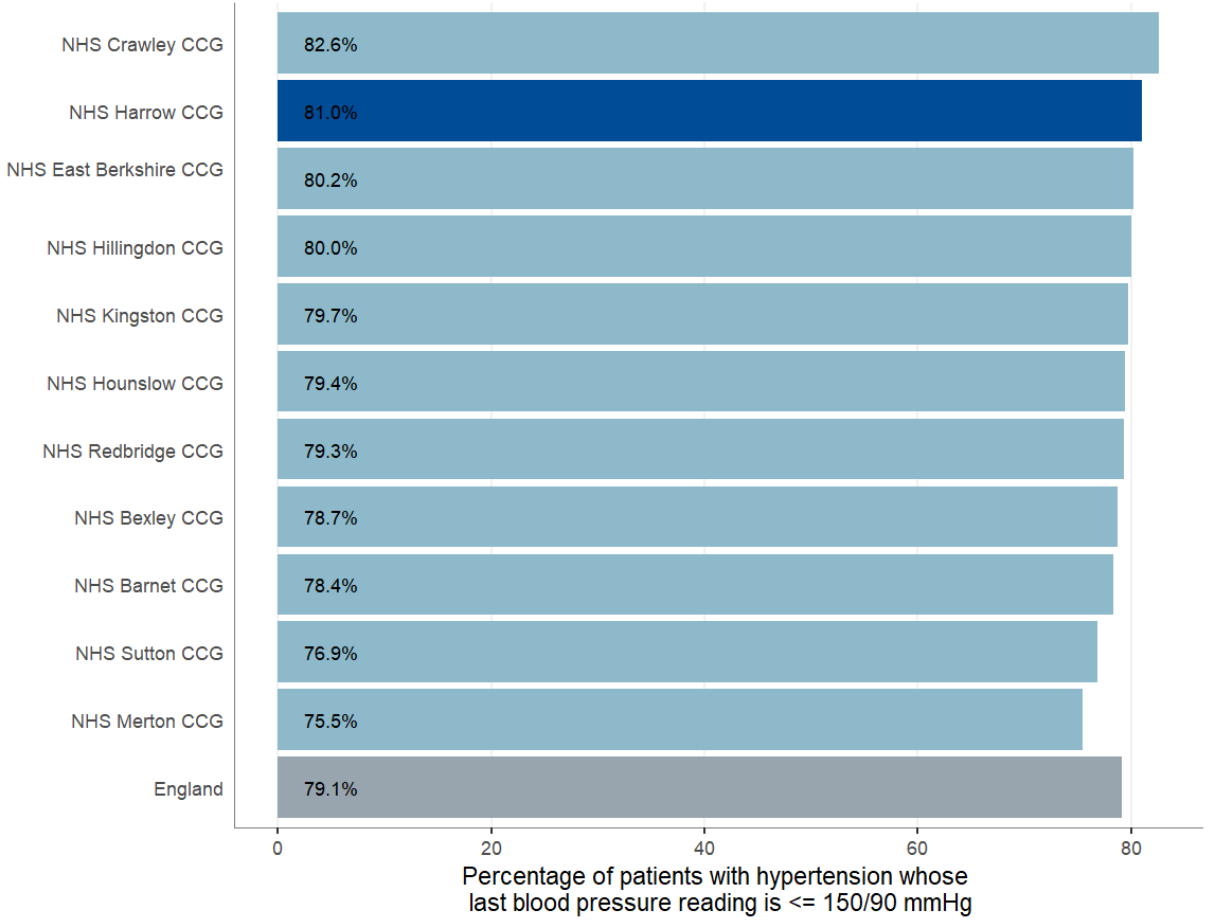
Of these, 28,523 (81.0%) people have blood pressure which is <= 150/90

6,669 (19.0%) people (including excepted cases) have blood pressure that is NOT <= 150/90

Note: Using QOF clinical indicator HYP006 denominator plus exceptions

Public Health England

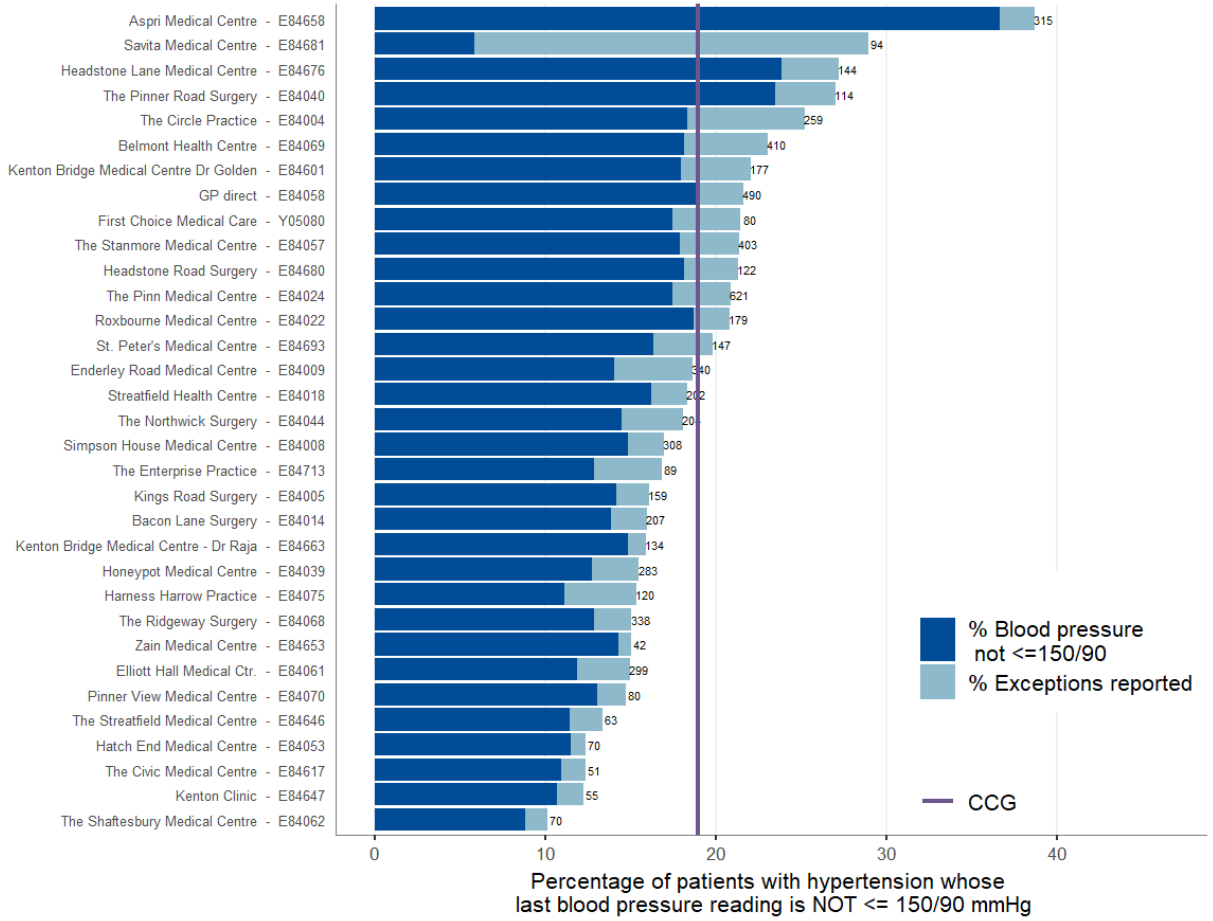
Percentage of patients with hypertension whose last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less, by similar CCGs



Note: Using QOF clinical indicator HYP006 denominator plus exceptions

Public Health England

Percentage of patients with hypertension whose last blood pressure reading (measured in the preceding 12 months) is NOT 150/90 mmHg or less, by general practice



In total, including excepted cases, there are 6,669 people whose blood pressure is NOT <= 150/90

The range of percentage of patients with hypertension whose last blood pressure reading is NOT <= 150/90 across GPs in NHS Harrow CCG is 10.1% to 38.7%

The data labels on the chart refer to the total count of people whose blood pressure is not <= 150/90, including excepted cases, by general practice

Note: Using QOF clinical indicator HYP006 denominator plus exceptions

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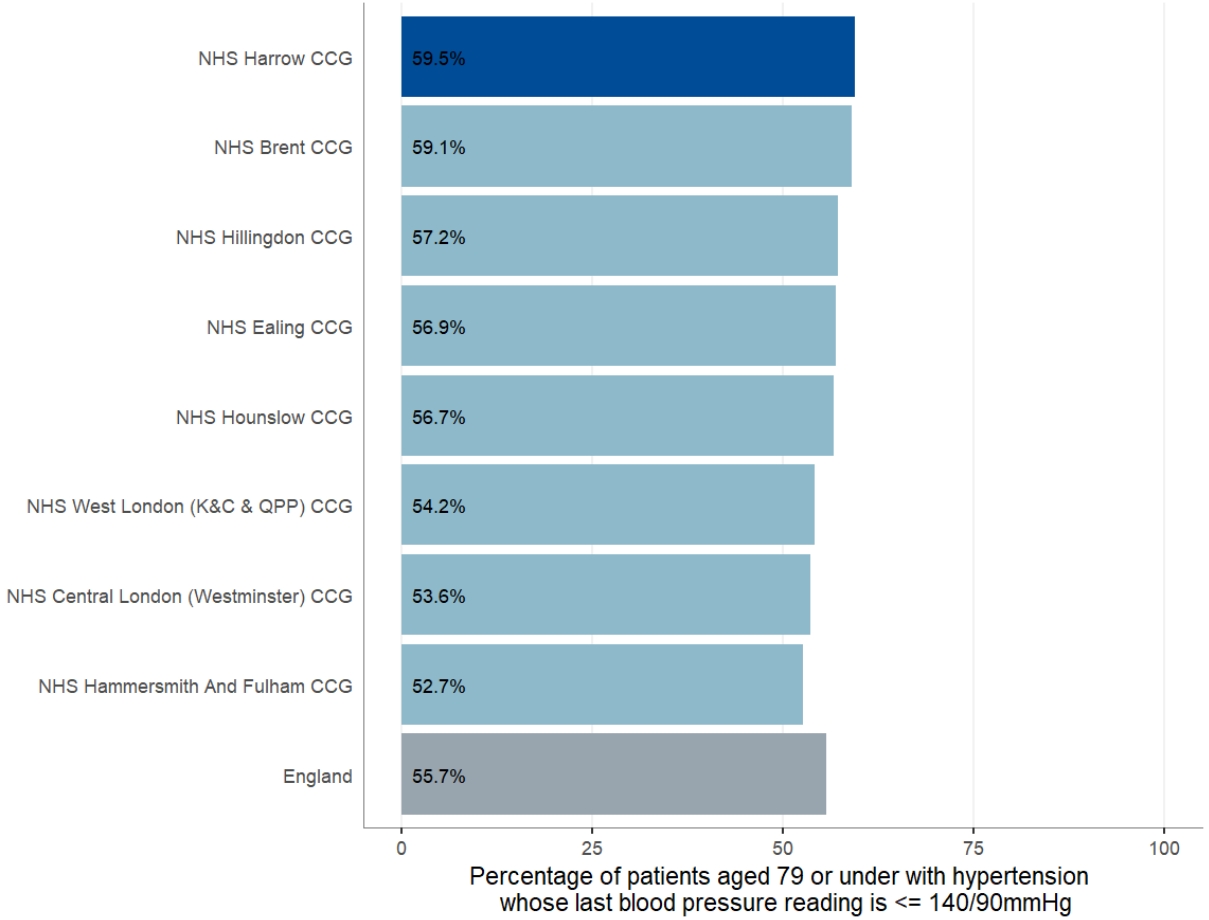
Percentage of patients aged 79 or under with hypertension in whom the last blood pressure reading (measured in the preceding 9 months) is 140/90 mmHg or less, by CCGs in the STP including only practices returning INLIQ* data



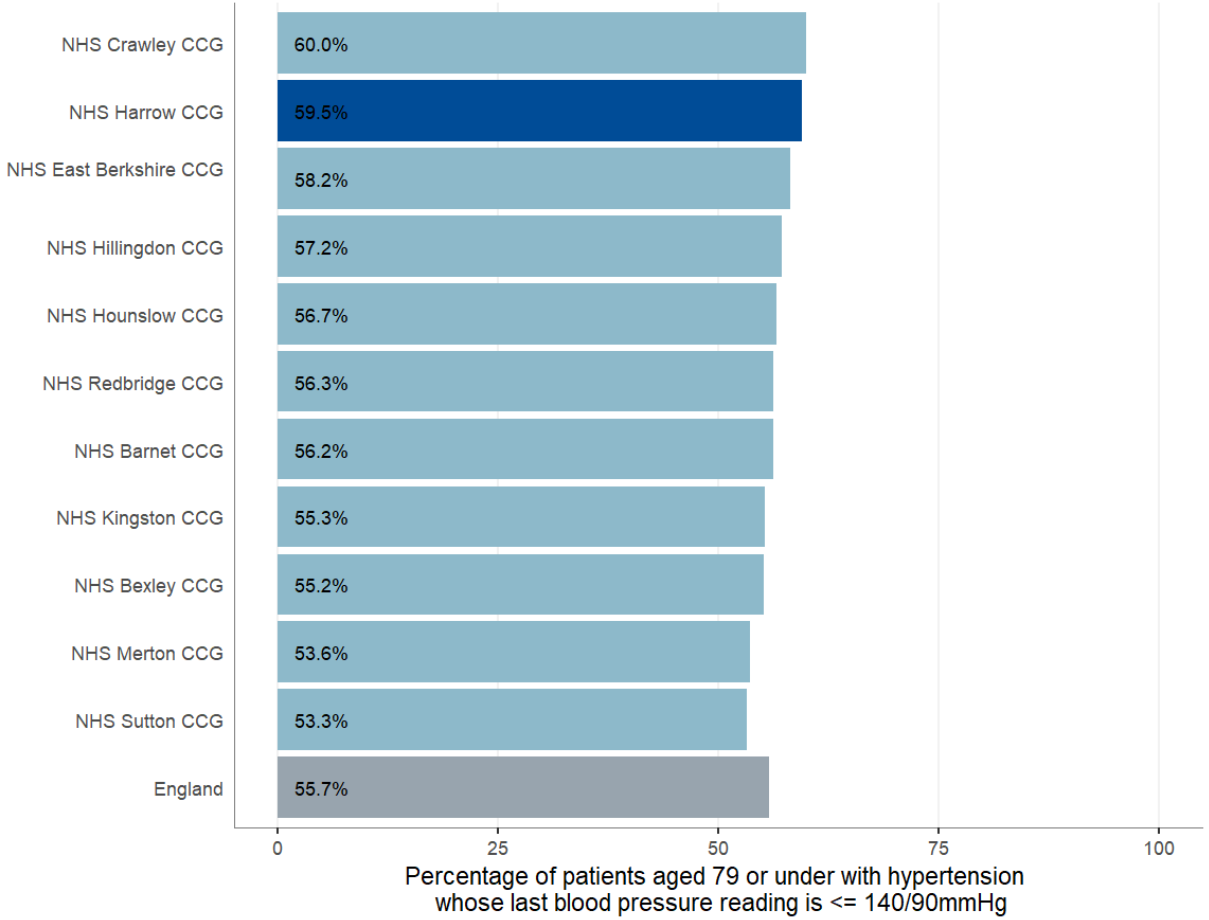
The population coverage of INLIQ in NHS Harrow CCG is 98.5%

Of those practices participating in INLIQ, the percentage of patients aged 79 or under with hypertension in whom the last blood pressure reading (measured in the preceding 9 months) is <= 140/90 mmHg is 59.5%

*Note: This information comes from the NHS Digital Indicators No Longer In QOF (INLIQ) Clinical Indicator HYP003.
Treatment data for CCGs where the population coverage is less than 60% are not displayed.
Treatment figures are calculated using the exceptions in the denominator. For more information about this data please see appendix

Public Health England

Percentage of patients aged 79 or under with hypertension in whom the last blood pressure reading (measured in the preceding 9 months) is 140/90 mmHg or less, by similar CCGs including only practices returning INLIQ* data



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Treatment data for CCGs where the population coverage is less than 60% are not displayed.
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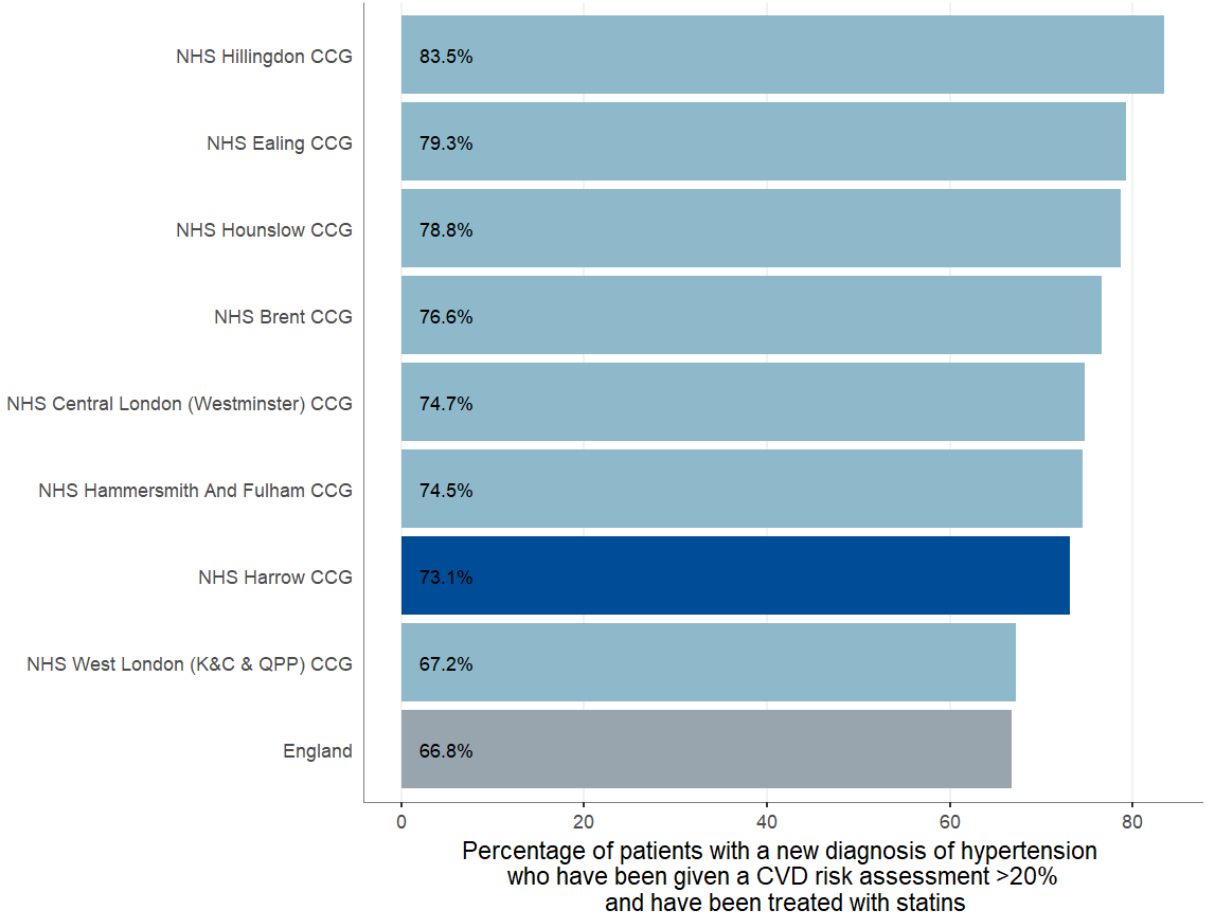
New diagnosis of hypertension who have been given a CVD risk assessment which exceeds 20% and have been treated with statins, by CCGs in the STP



There are 134 people with a new diagnosis of hypertension with a CVD risk of 20% or higher in NHS Harrow CCG

Of these, there are 98 (73.1%) people who are currently treated with statins

There are 36 (26.9%) people (including excepted cases) who are NOT currently treated with statins

Note: Using QOF clinical indicator CVD-PP001 denominator plus exceptions

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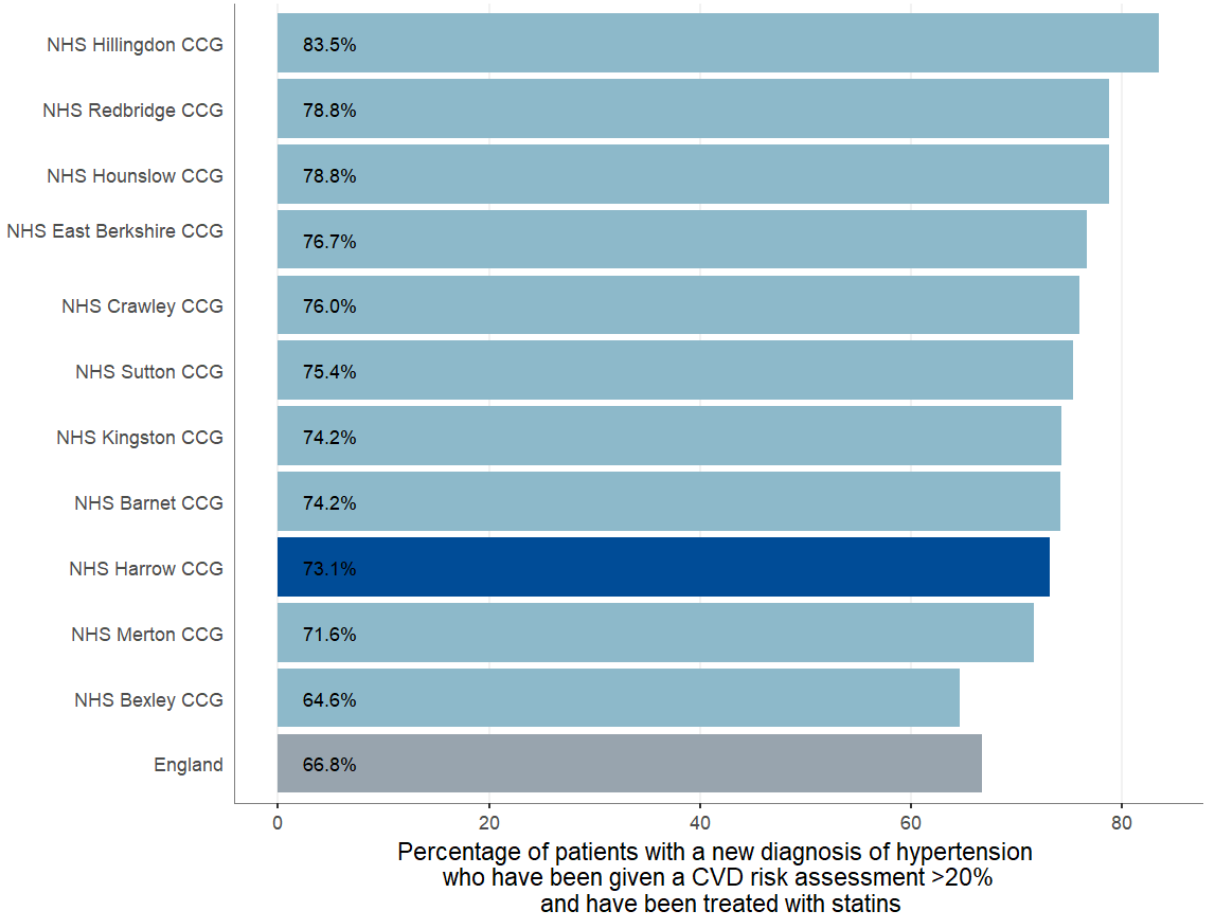
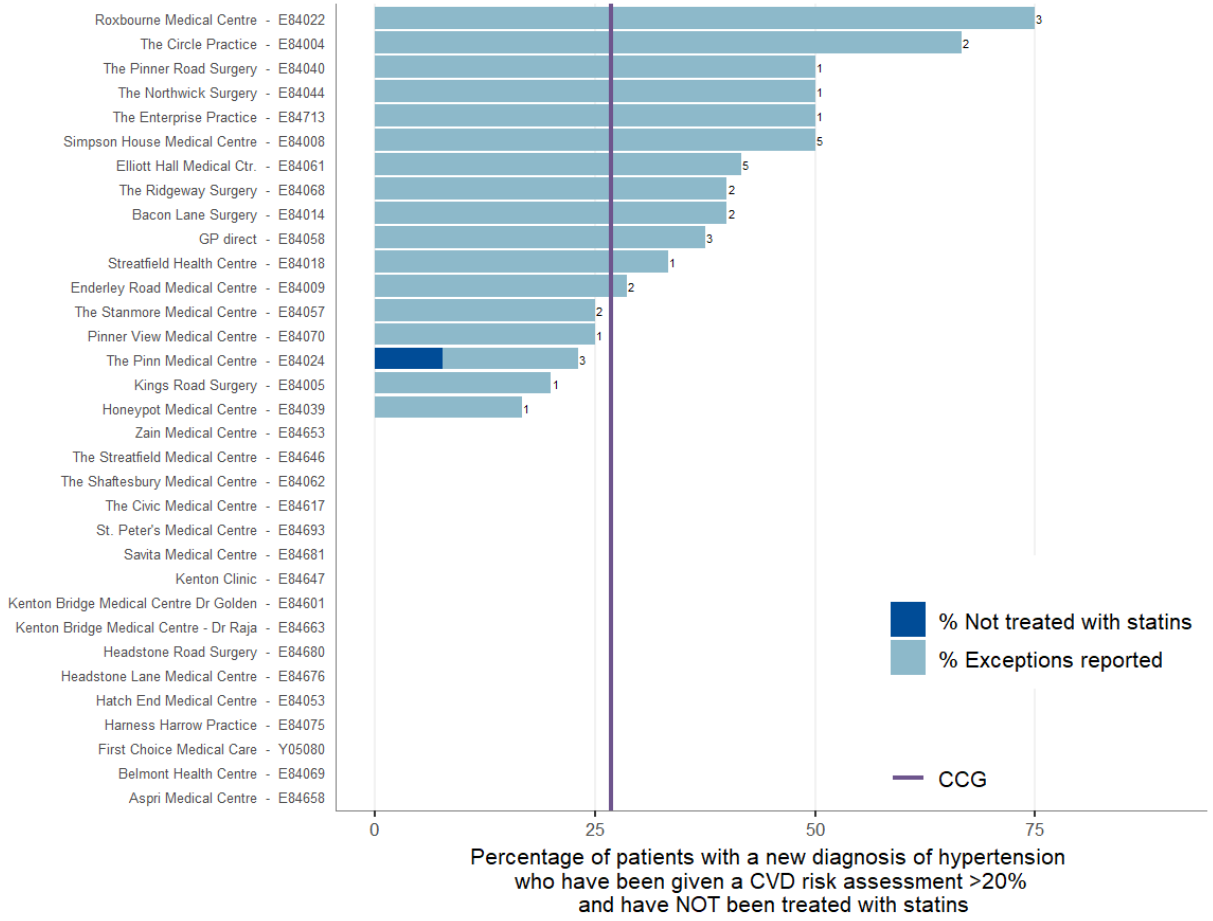
New diagnosis of hypertension who have been given a CVD risk assessment which exceeds 20% and have been treated with statins, by similar CCGs



Note: Using QOF clinical indicator CVD-PP001 denominator plus exceptions

Public Health England

New diagnosis of hypertension who have been given a CVD risk assessment which exceeds 20% and are NOT treated with statins, by general practice



In total, including excepted cases, there are 36 people who are NOT treated with statins

The range of those newly diagnosed with hypertension who have been given a CVD risk assessment that exceeds 20 per cent and are NOT treated with statins across GPs in NHS Harrow CCG is 0.0% to 75.0%

The data labels on the chart refer to the total count of people who are not treated with statins, including excepted cases, by general practice

Note: Using QOF clinical indicator CVD-PP001 denominator plus exceptions

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Stroke

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Stroke prevention

Only half of people with known atrial fibrillation (AF) who then suffer a stroke have been anticoagulated before their stroke - Source: Sentinel Stroke National Audit Programme

Stroke is one of the leading causes of premature death and disability. Stroke is devastating for individuals and families, and accounts for a substantial proportion of health and social care expenditure.

Atrial fibrillation increases the risk of stroke by a factor of 5, and strokes caused by AF are often more severe, with higher mortality and greater disability.
Anticoagulation reduces the risk of stroke in people with AF by two thirds. Despite this, AF is underdiagnosed and under-treated: around a quarter of people with AF are unaware they have the condition and even when diagnosed inadequate treatment is common - large numbers do not receive anticoagulants or have poor anticoagulant control. Indeed only half of all individuals with known AF who suffer a stroke have been anticoagulated.

What questions should we ask in our CCG?

1. For each indicator how wide is the variation in detection and treatment?
2. How many people would benefit if all practices performed as well as the best?
3. How can we support practices who are average and below average to perform as well as the best in detection of atrial fibrillation and stroke prevention with anticoagulation?

What might help?

1. Increase opportunistic pulse checking especially in over 65s
2. Support practices to share audit data and systematically identify gaps and opportunities for improved detection and management of AF - eg GRASP-AF
3. Promote systematic use of CHADS-VASC and HASBLED to ensure those at high risk are offered stroke prevention
4. Promote systematic use of Warfarin Patient Safety Audit Tool to ensure optimal time in therapeutic range for people on warfarin
5. Develop local consensus statement on risk-benefit balance for anticoagulants
6. Work with practices and local authorities to maximise uptake and clinical follow up in the NHS Health Check programme
7. Commission community pharmacists to offer pulse checks, anticoagulant monitoring, and support for adherence to medication

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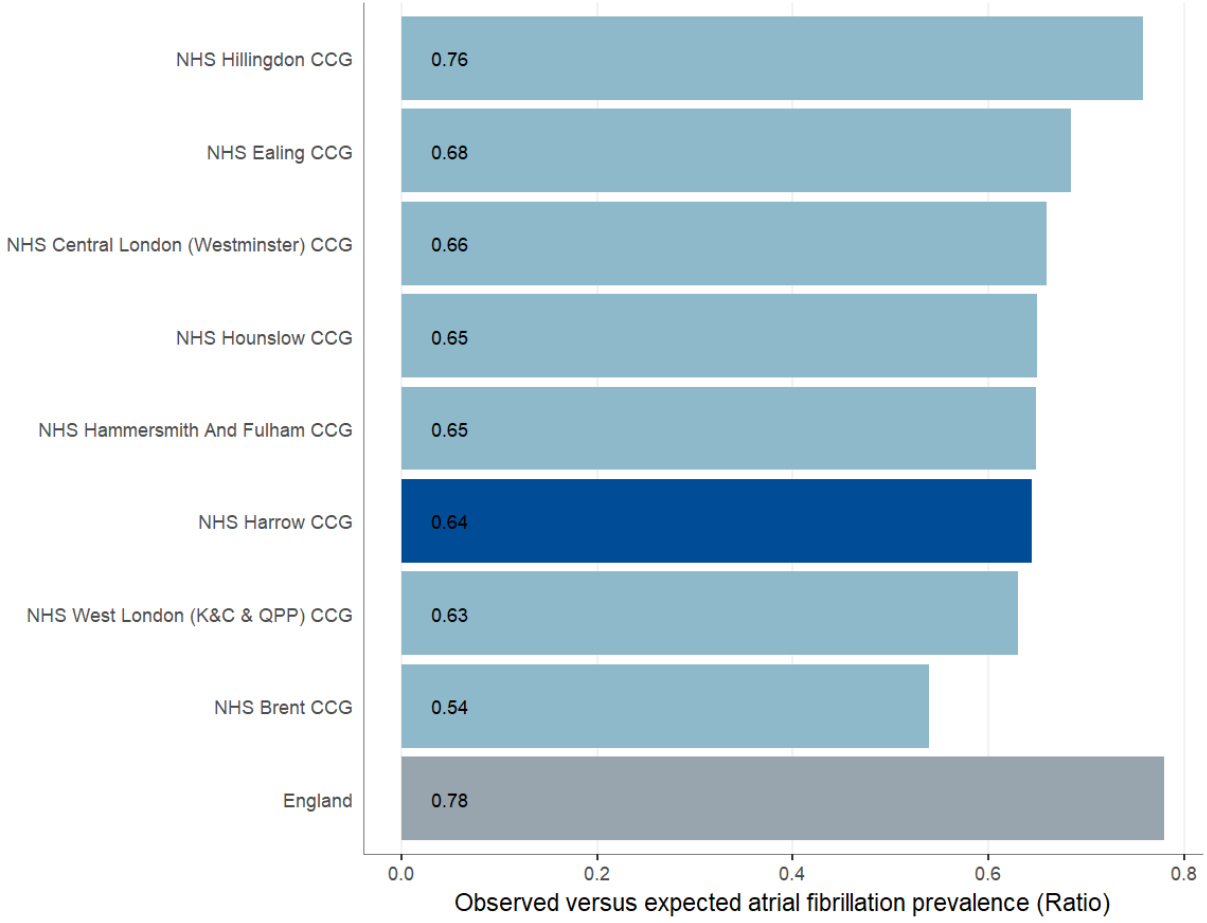
Atrial fibrillation observed prevalence compared with expected prevalence, by CCGs in the STP



The ratio of those diagnosed with atrial fibrillation versus those expected to have atrial fibrillation in NHS Harrow CCG is 0.64. This compares to 0.78 for England

This suggests that 64% of people with atrial fibrillation in NHS Harrow CCG have been diagnosed

Note: This slide compares the prevalence of atrial fibrillation recorded in QOF in 2017/18 to the estimated prevalence of atrial fibrillation, taken from National Cardiovascular Intelligence Network estimates produced in 2017. The estimates were developed by applying age-sex specific prevalence rates as reported by Norberg et al (2013) to GP population estimates from NHS Digital. Estimates reported are adjusted for age and sex of the local population.

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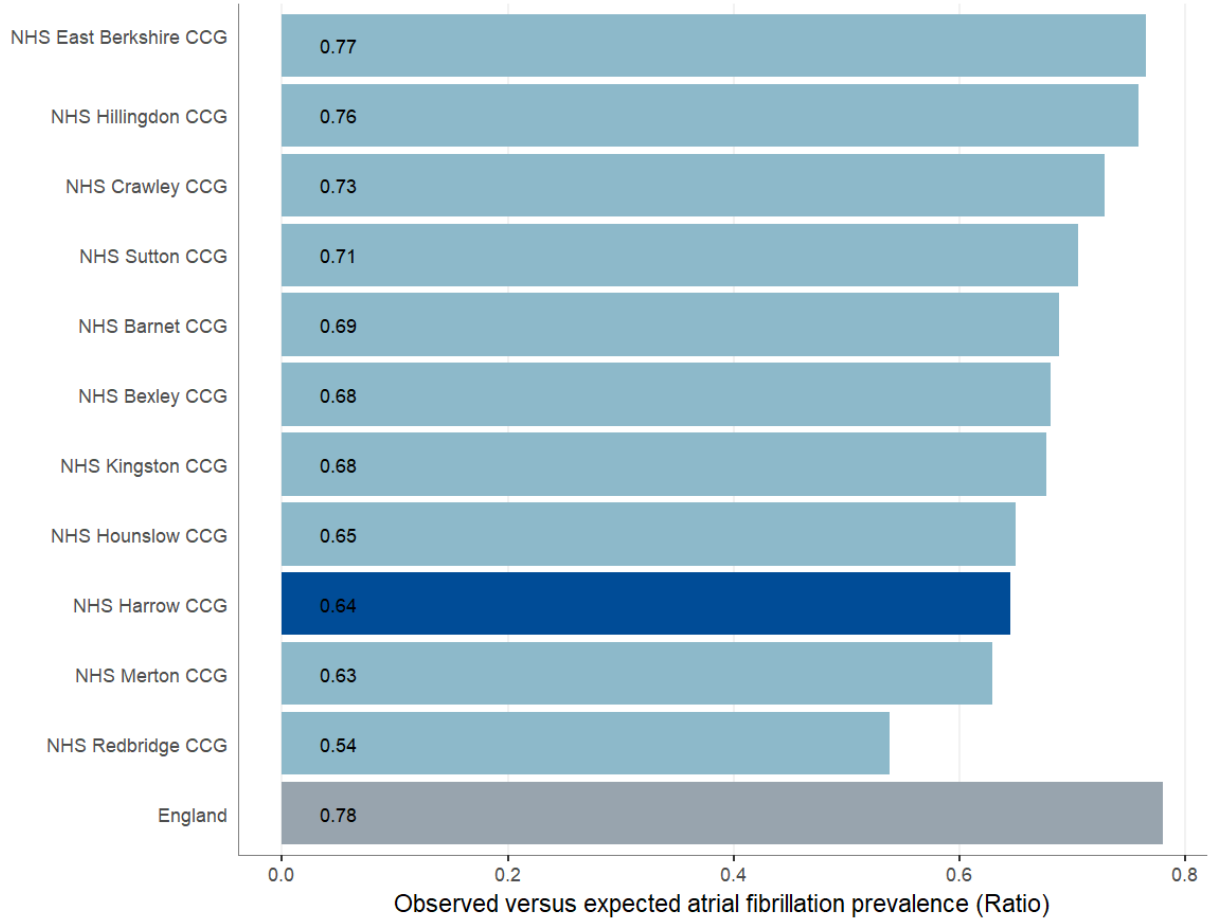
Atrial fibrillation observed prevalence compared with expected prevalence, by similar CCGs



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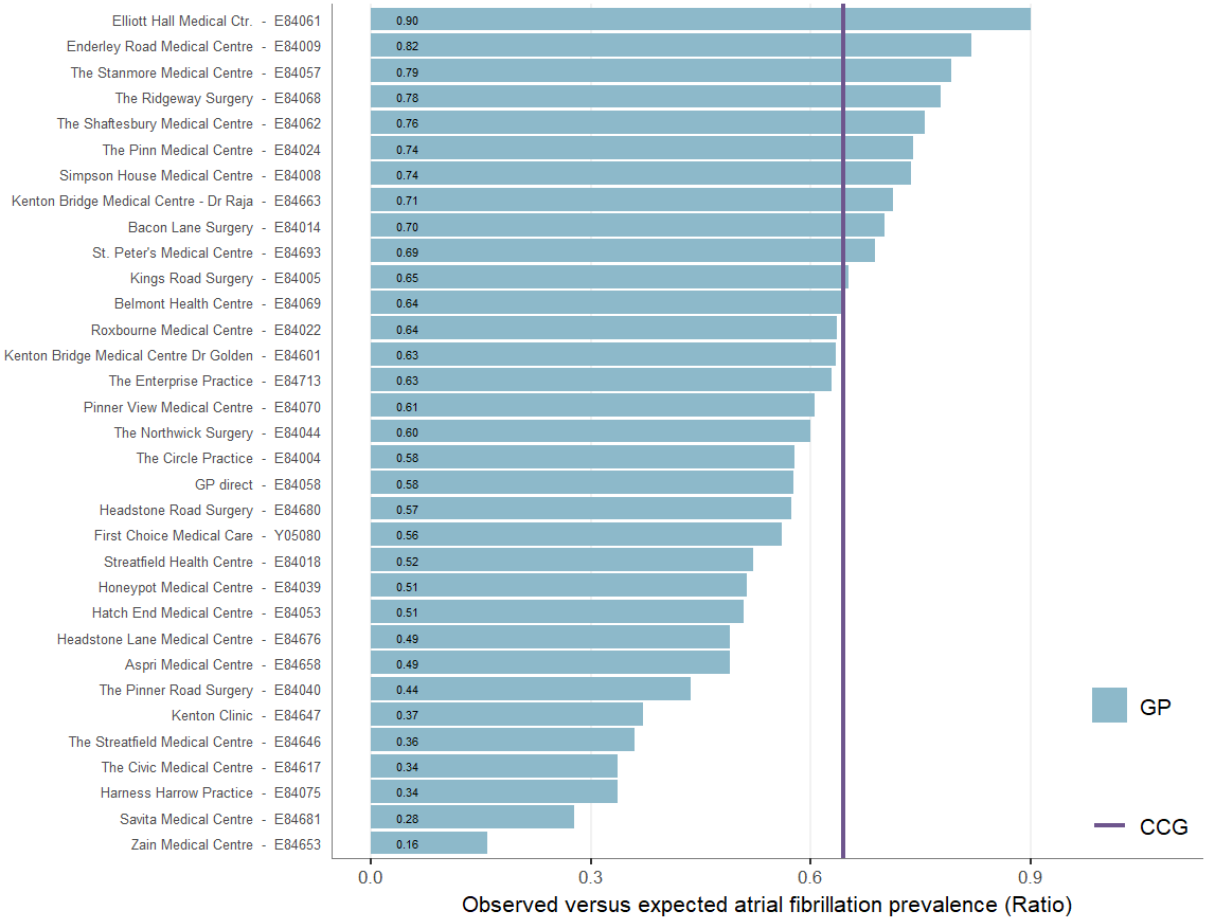
Atrial fibrillation observed prevalence compared with expected prevalence, by general practice



There are 3,613 people with diagnosed atrial fibrillation in NHS Harrow CCG

It is estimated that there are 1,993 people with undiagnosed atrial fibrillation in NHS Harrow CCG

The range of observed to expected atrial fibrillation prevalence across GPs in NHS Harrow CCG is 0.16 to 0.90

Note: This slide compares the prevalence of atrial fibrillation recorded in QOF in 2017/18 to the estimated prevalence of atrial fibrillation, taken from National Cardiovascular Intelligence Network estimates produced in 2017. The estimates were developed by applying age-sex specific prevalence rates as reported by Norberg et al (2013) to GP population estimates from NHS Digital. Estimates reported are adjusted for age and sex of the local population.

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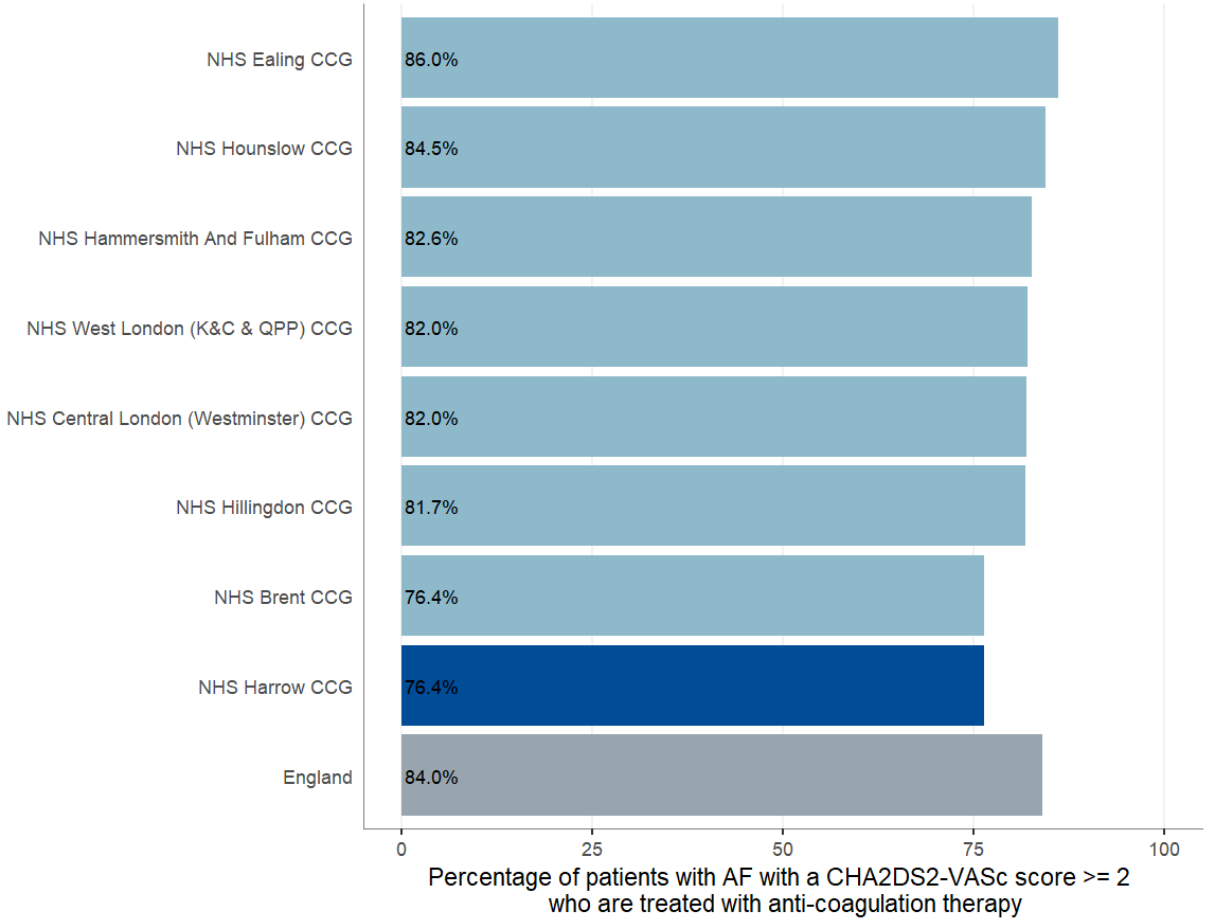
In patients with AF with a CHA2DS2-VASc score of 2 or more, the percentage treated with anti-coagulation therapy, by CCGs in the STP



There are 3,090 people with atrial fibrillation with a CHA2DS2-VASc score >= 2 in NHS Harrow CCG

There are 2,361 (76.4%) people who are currently treated with anti-coagulation therapy

There are 729 (23.6%) people (including excepted cases) with a recorded CHA2DS2-VASc score >= 2 who are NOT treated with anti-coagulation therapy

Note: Using QOF clinical indicator AF007 denominator plus exceptions

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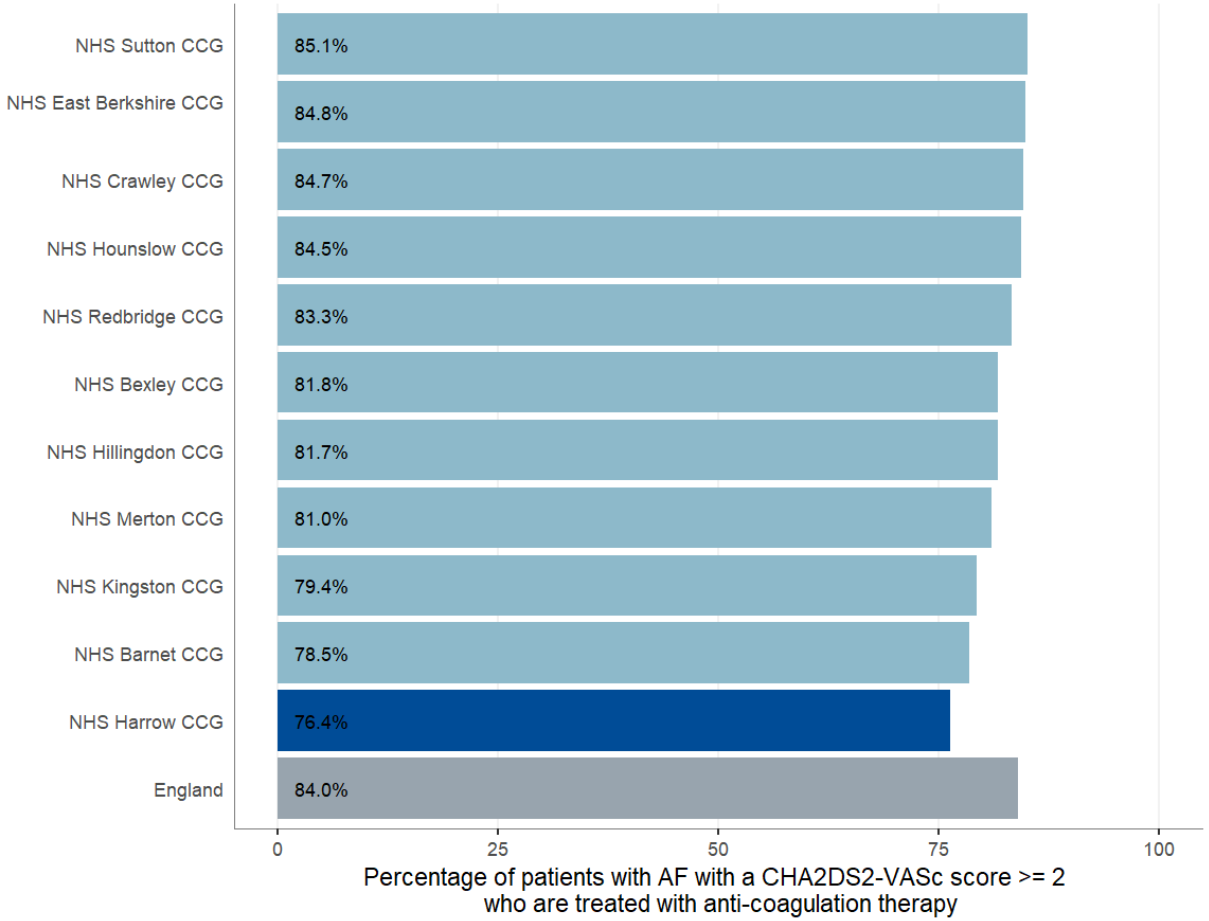
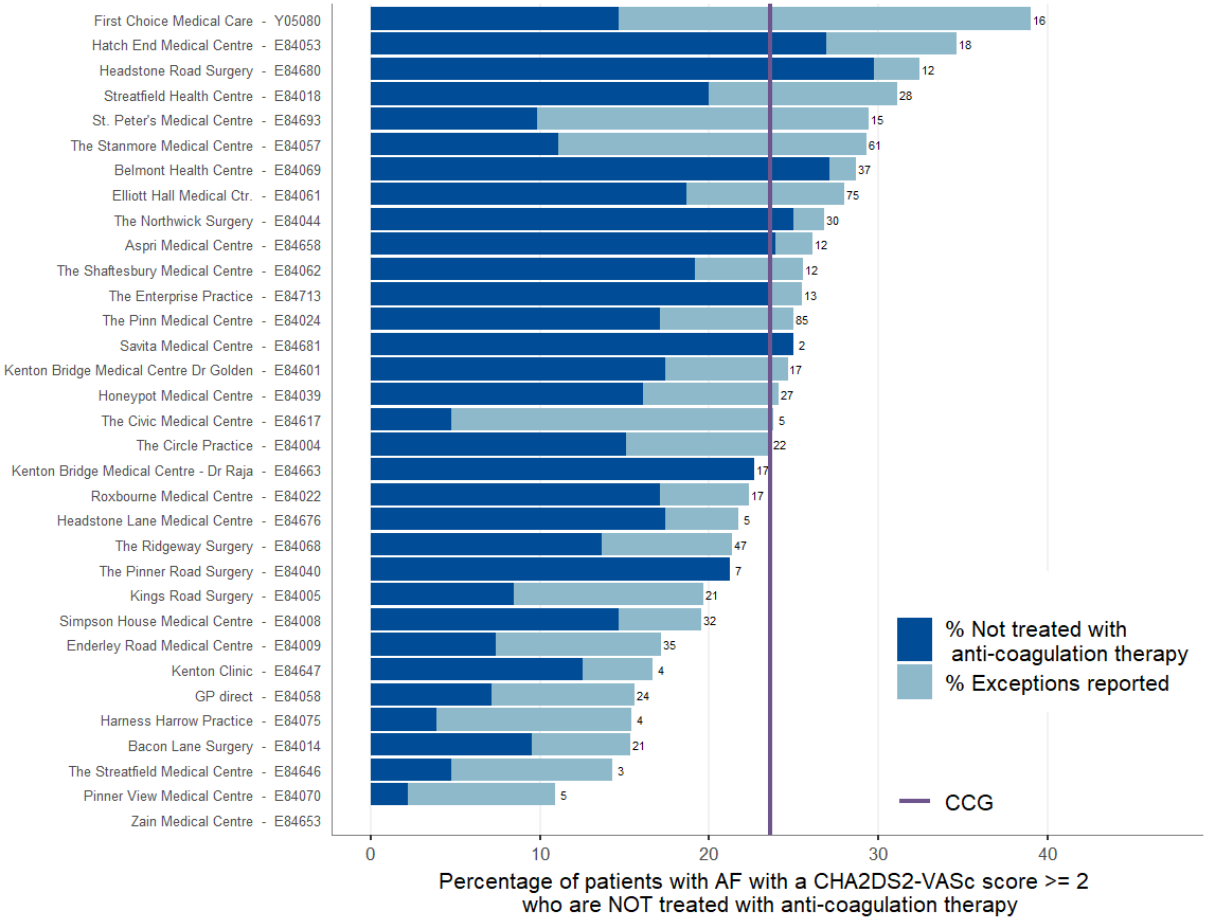
In patients with AF with a CHA2DS2-VASc score of 2 or more, the percentage treated with anti-coagulation therapy, by similar CCGs



Note: Using QOF clinical indicator AF007 denominator plus exceptions

Public Health England

In patients with AF with a CHA2DS2-VASc score of 2 or more, the percentage NOT treated with anti-coagulation therapy, by general practice



In total, including excepted cases, there are 729 people with a recorded CHA2DS2-VASc score >= 2 who are NOT treated with anti-coagulation therapy in NHS Harrow CCG

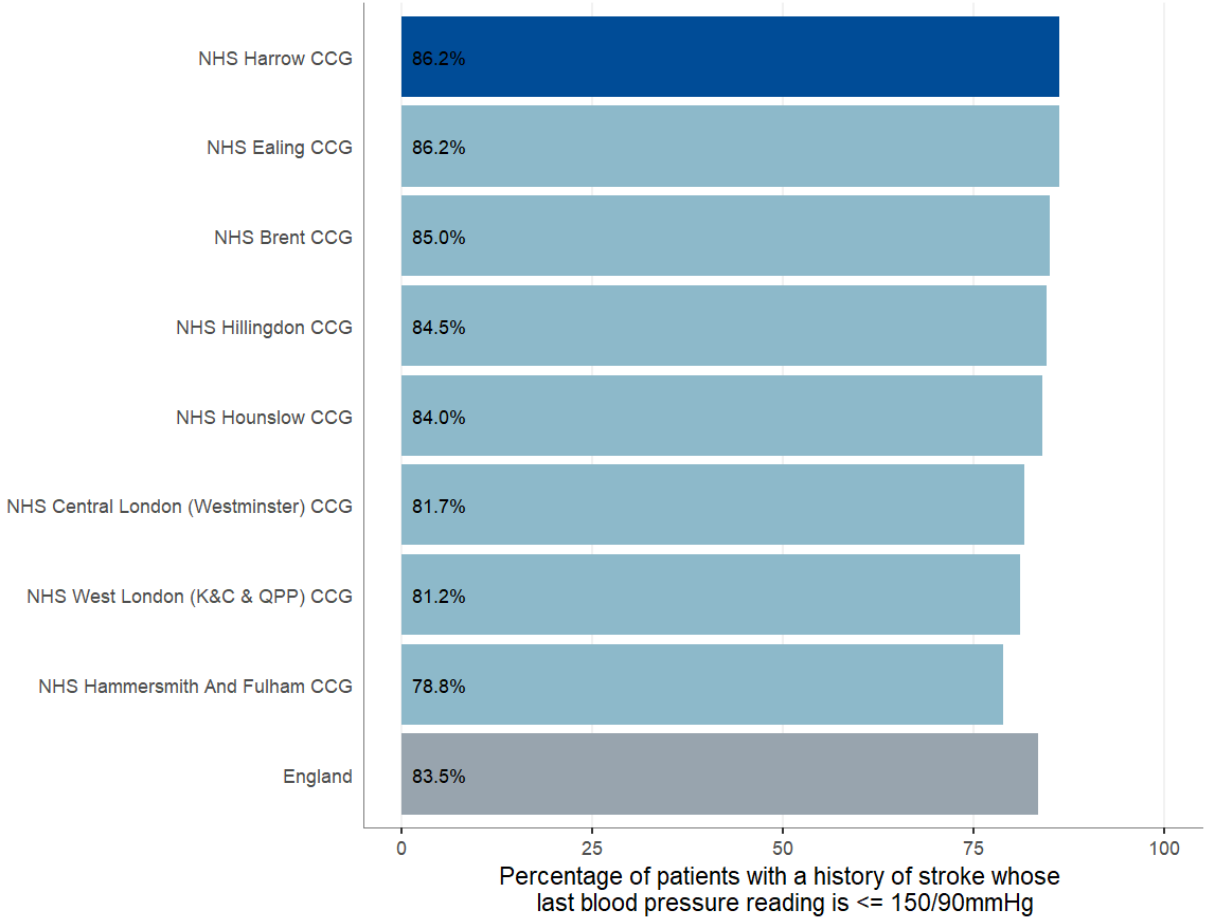
The range of the percentage of AF patients with a recorded CHA2DS2-VASc score >= 2 who are NOT treated with anti-coagulation therapy across GPs in NHS Harrow CCG is 0.0% to 39.0%

The data labels on the chart refer to the total count of people who are not treated with anti-coagulation therapy, including excepted cases, by general practice

Note: Using QOF clinical indicator AF007 denominator plus exceptions

Public Health England

Percentage of patients with a history of stroke whose last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less, by CCGs in the STP



There are 3,532 people with a history of stroke or transient ischemic attack (TIA) in NHS Harrow CCG

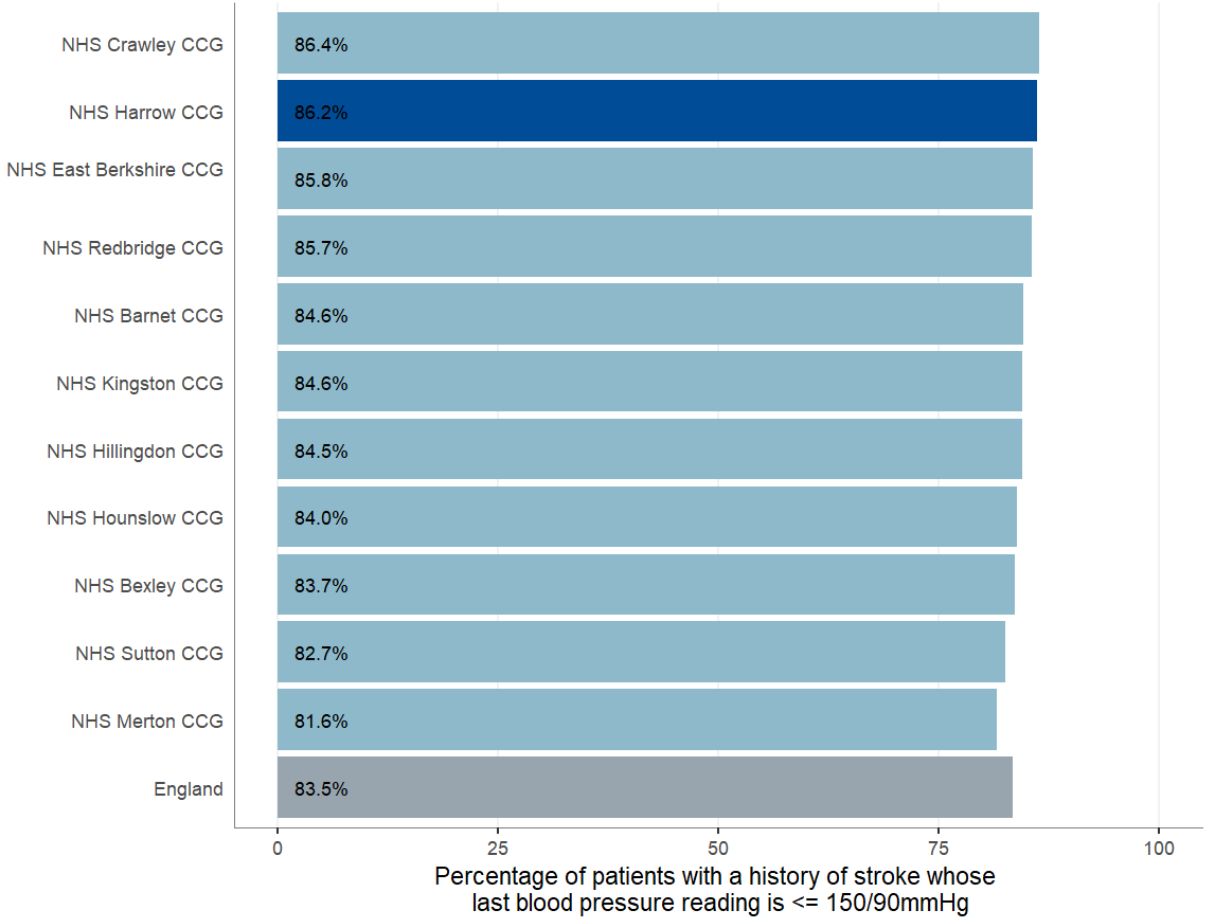
There are 3,046 (86.2%) people with a history of stroke or TIA, whose blood pressure is <=150/90

There are 486 (13.8%) people (including excepted cases) whose blood pressure is NOT <= 150/90

Note: Using QOF clinical indicator STIA003 denominator plus exceptions

Public Health England

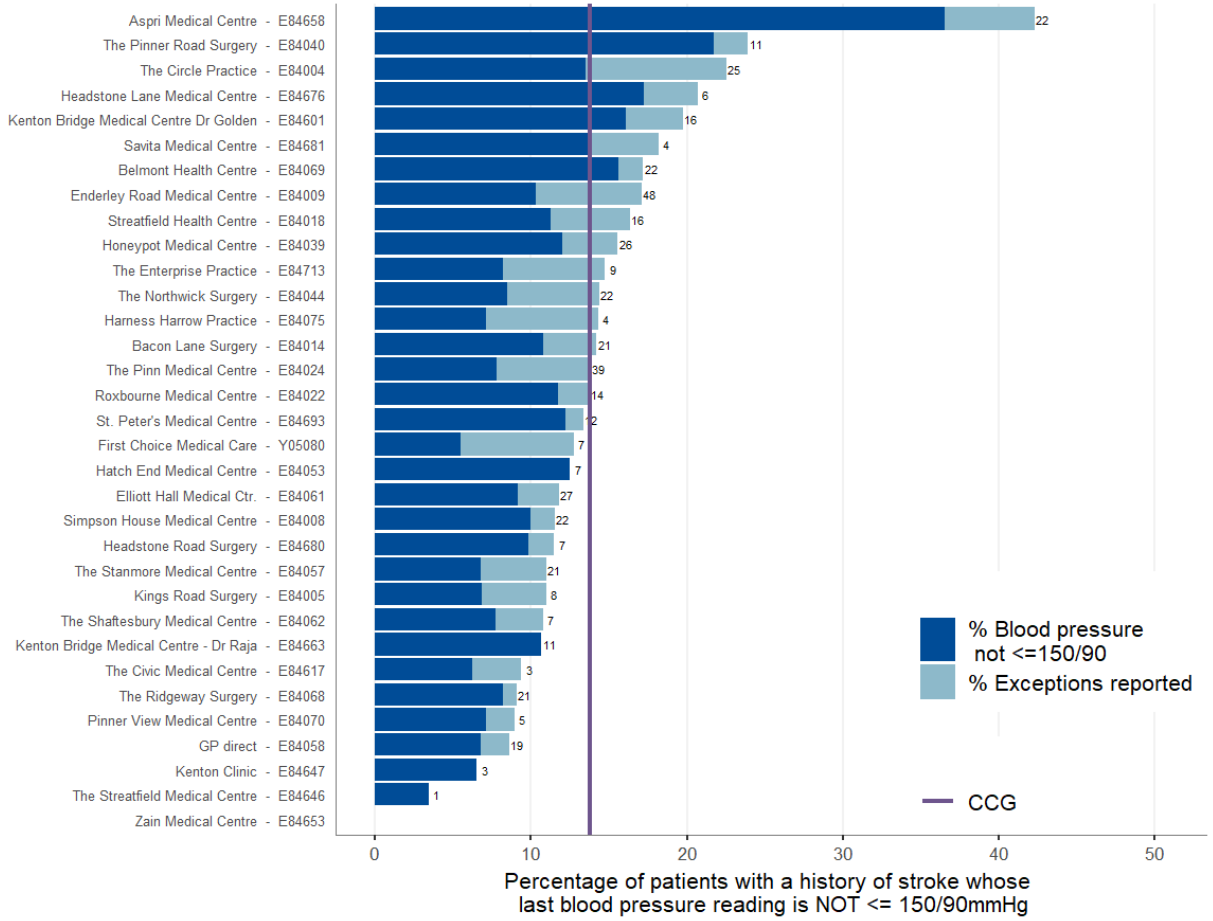
Percentage of patients with a history of stroke whose last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less, by similar CCGs



Note: Using QOF clinical indicator STIA003 denominator plus exceptions

Public Health England

Percentage of patients with a history of stroke whose last blood pressure reading (measured in the preceding 12 months) is NOT 150/90 mmHg or less, by general practice



In total, including excepted cases, there are 486 people whose blood pressure is NOT <=150/90

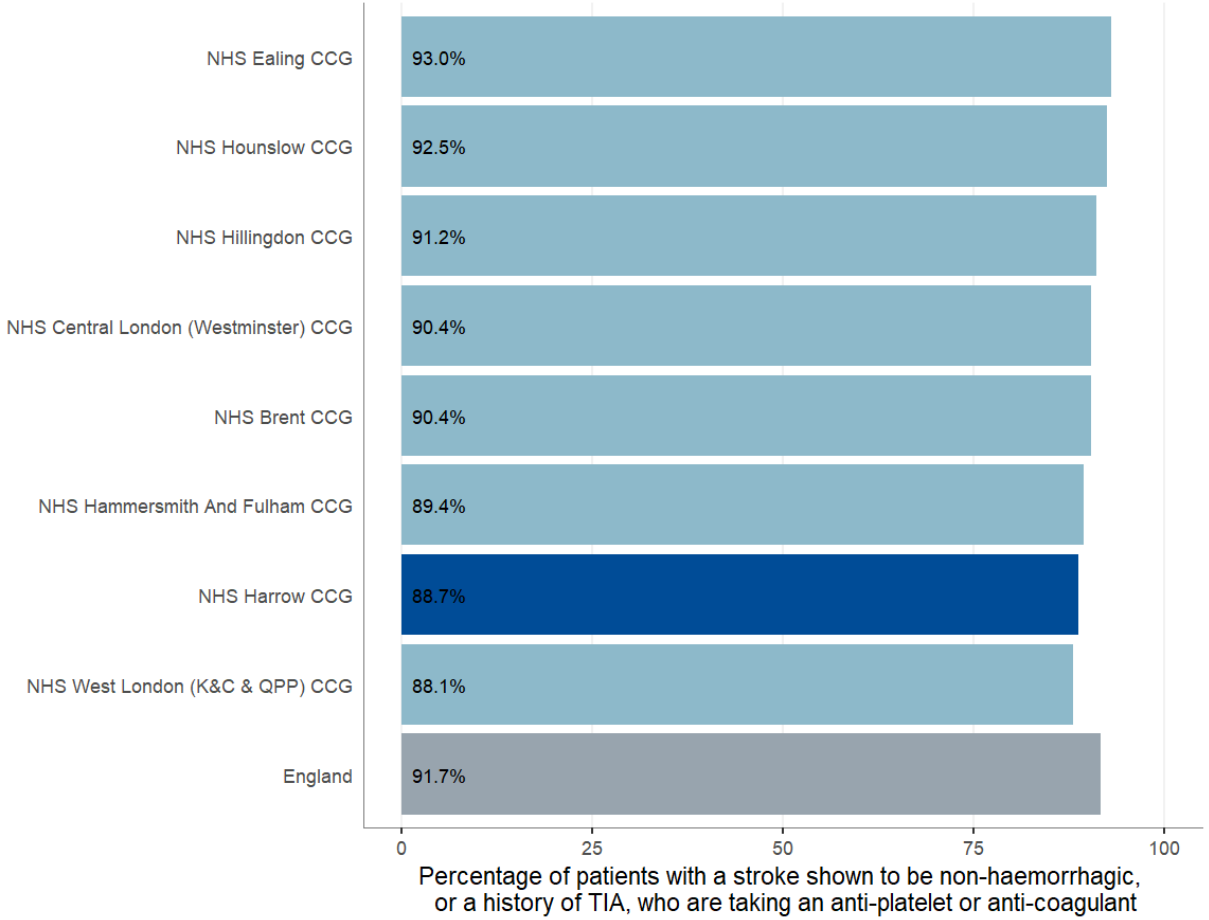
The range of the percentage of patients with a history of stroke whose blood pressure is NOT <= 150/90 across GPs in NHS Harrow CCG is 0.0% to 42.3%

The data labels on the chart refer to the total count of people whose blood pressure is not <=150/90, including excepted cases, by general practice

Note: Using QOF clinical indicator STIA003 denominator plus exceptions

Public Health England

Percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record in the preceding 12 months that an anti-platelet agent, or an anti-coagulant is being taken, by CCGs in the STP



There are 2,108 people with a stroke shown to be non-haemorrhagic or history of TIA in NHS Harrow CCG

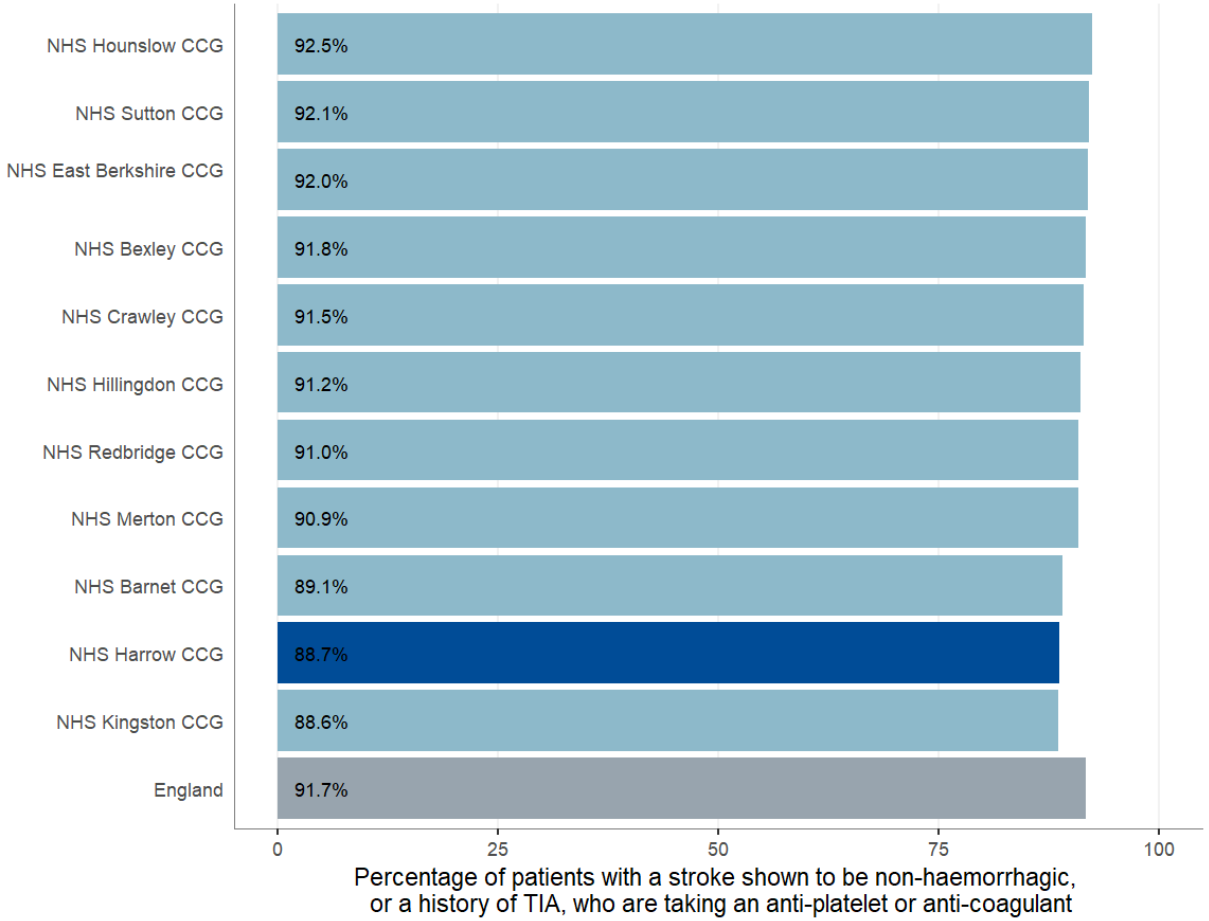
There are 1,870 (88.7%) people who are taking an anti-platelet agent or anti-coagulant medication

There are 238 (11.3%) people (including excepted cases) who have no record of receiving treatment

Note: Using QOF clinical indicator STIA007 denominator plus exceptions

Public Health England

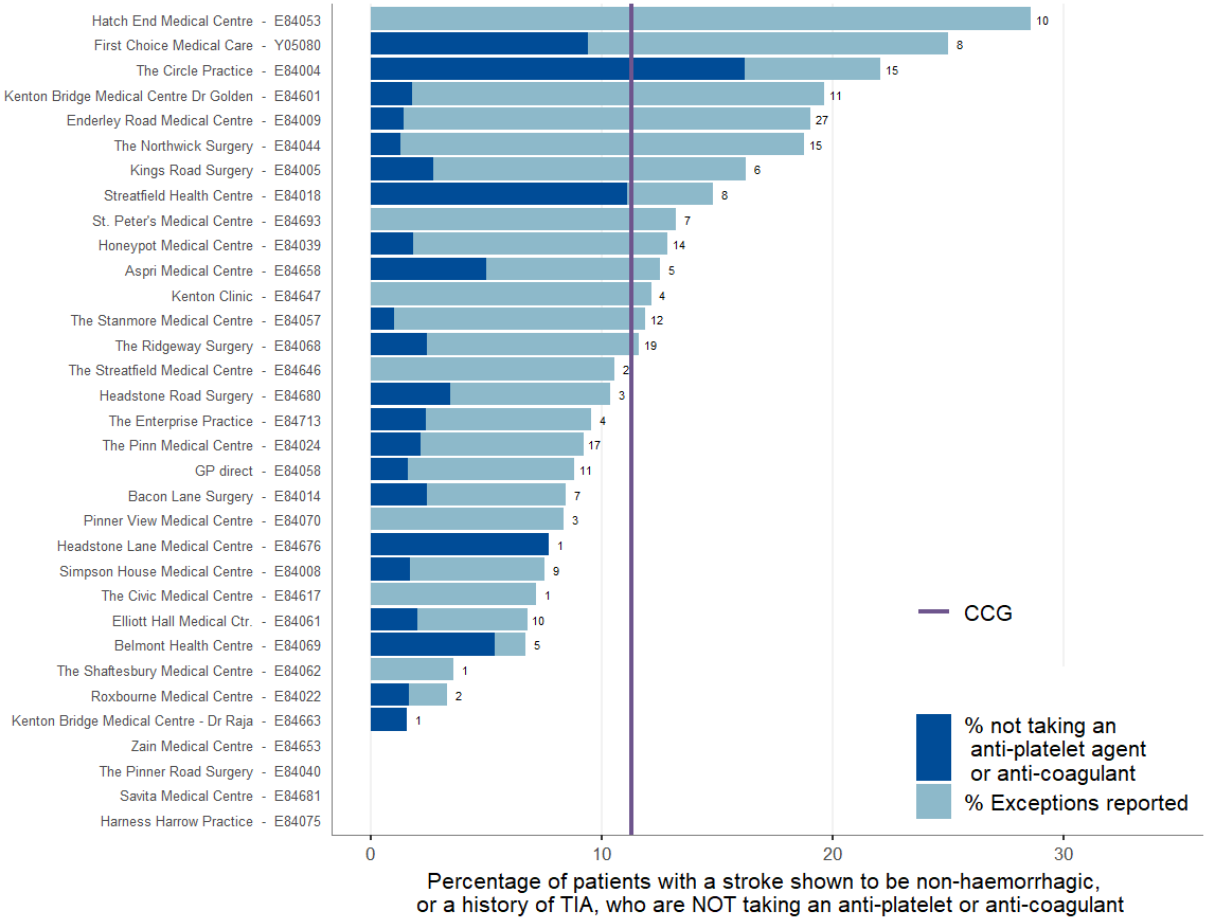
Percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record in the preceding 12 months that an anti-platelet agent, or an anti-coagulant is being taken, by similar CCGs



Note: Using QOF clinical indicator STIA007 denominator plus exceptions

Public Health England

Percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who do NOT have a record in the preceding 12 months that an anti-platelet agent, or an anti-coagulant is being taken, by general practice



In total, including excepted cases, there are 238 people who are NOT taking an anti-platelet agent or anti-coagulant in NHS Harrow CCG

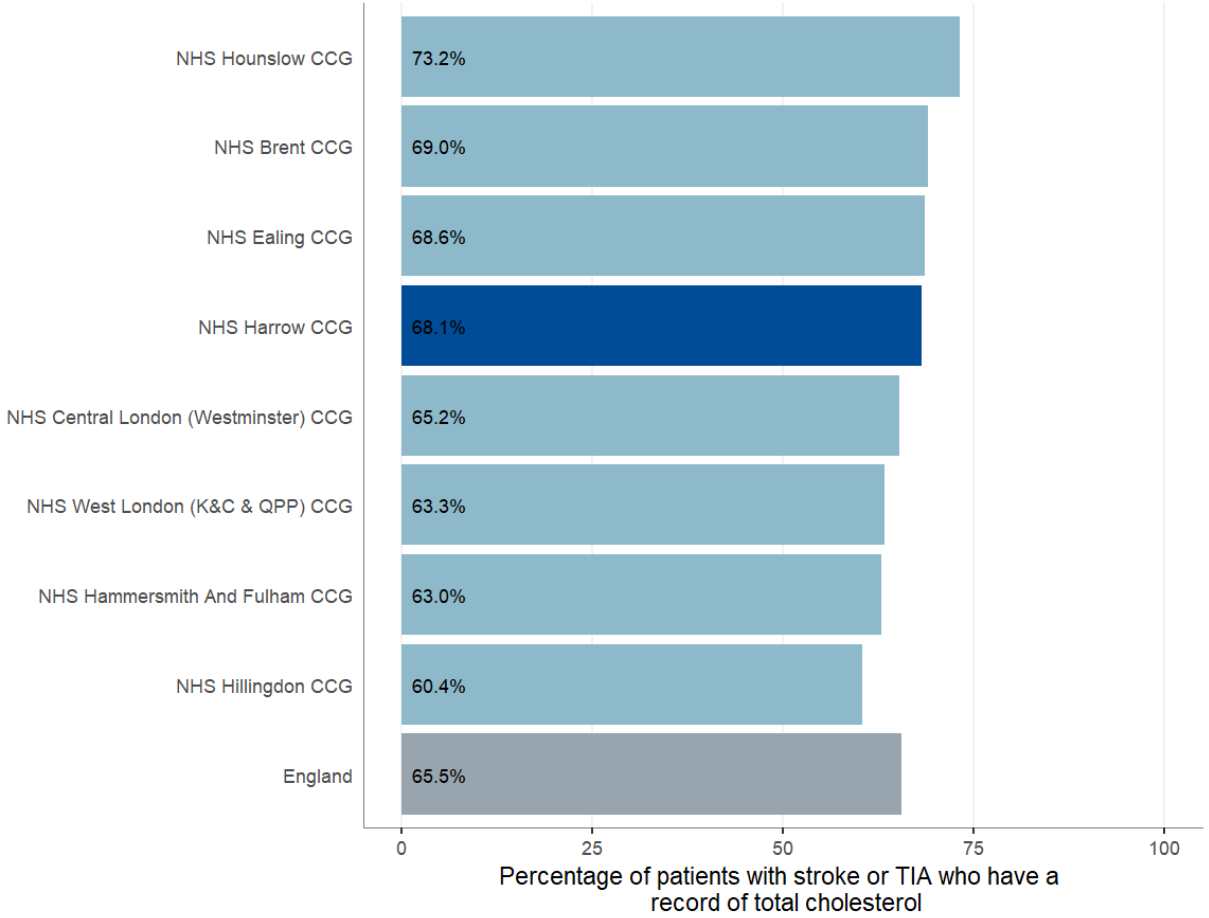
The range of the percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who are NOT taking an anti-platelet or anti-coagulant medication across GPs in NHS Harrow CCG is 0.0% to 28.6%

The data labels on the chart refer to the total count of people who are not taking an anti-platelet agent or anti-coagulant, including excepted cases, by general practice

Note: Using QOF clinical indicator STIA007 denominator plus exceptions

Public Health England

Percentage of patients with stroke or TIA who have a record of total cholesterol in the preceding 12 months, by CCGs in the STP including only practices returning INLIQ* data



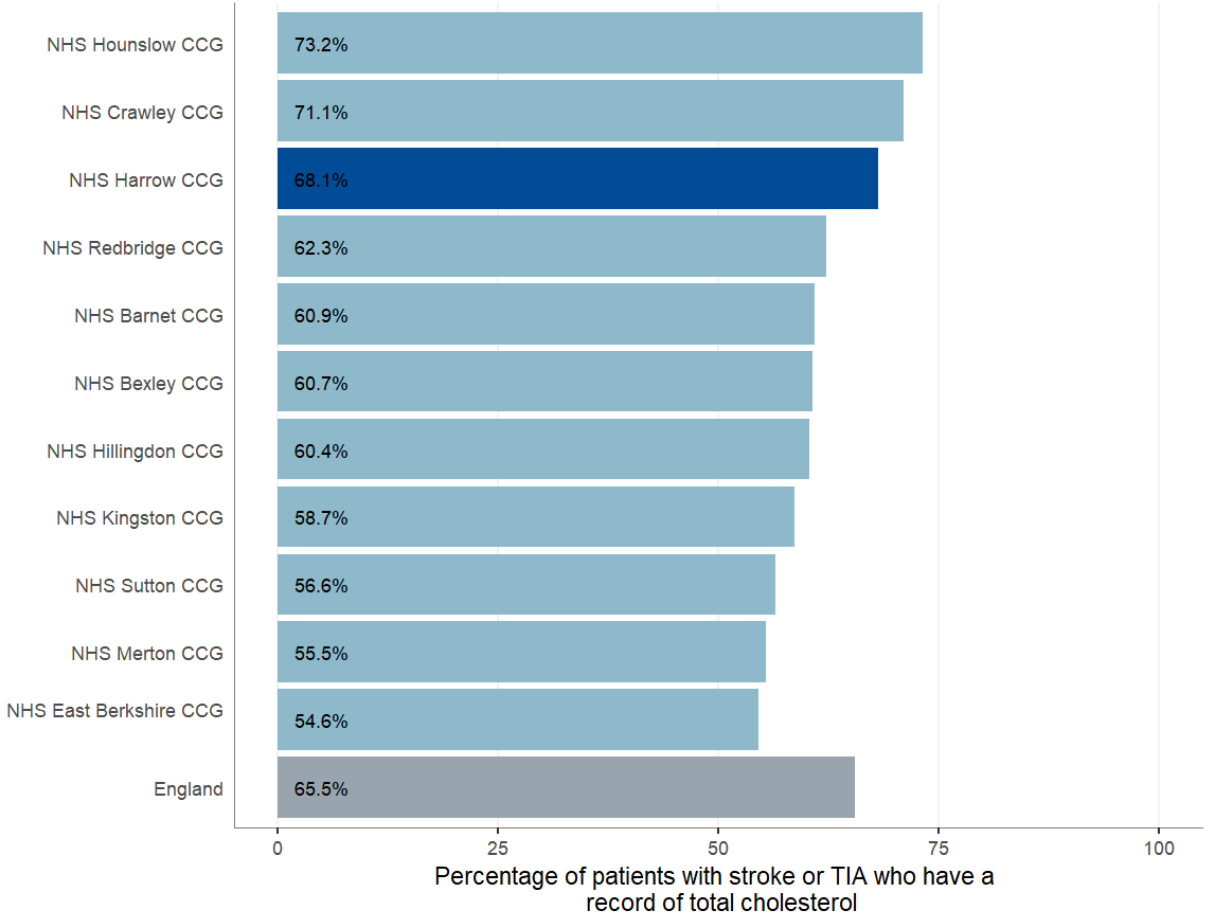
The population coverage of INLIQ in NHS Harrow CCG is 98.5%

Of those practices participating in INLIQ, the percentage of patients with stroke or TIA who have a record of total cholesterol in the preceding 12 months is 68.1%

*Note: This information comes from the NHS Digital Indicators No Longer In QOF (INLIQ) Clinical Indicator STIA004.
Treatment data for CCGs where the population coverage is less than 60% are not displayed.
Treatment figures are calculated using the exceptions in the denominator. For more information about this data please see appendix

Public Health England

Percentage of patients with stroke or TIA who have a record of total cholesterol in the preceding 12 months, by similar CCGs including only practices returning INLIQ* data



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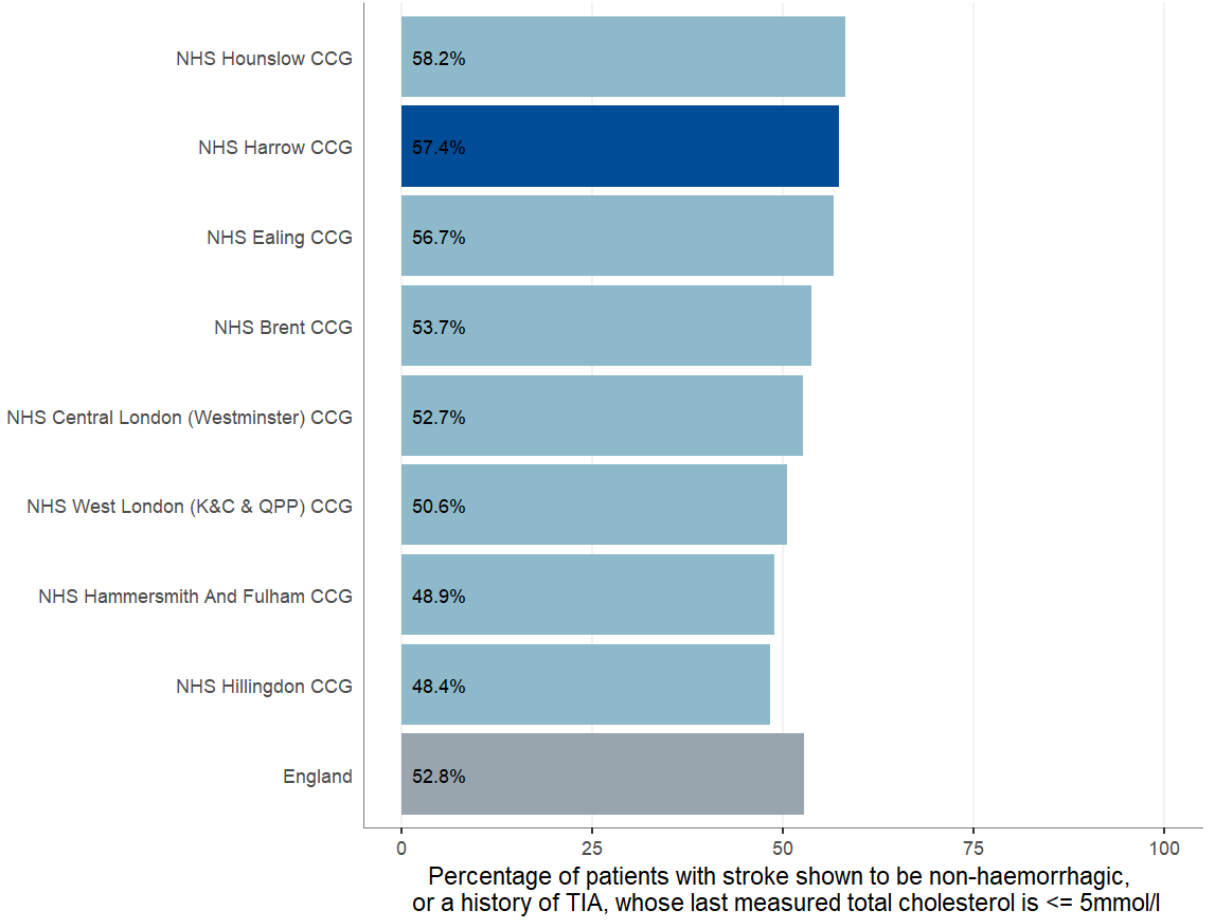
Of those practices participating in INLIQ, the percentage of patients with stroke or TIA who have a record of total cholesterol in the preceding 12 months is 68.1%

*Note: This information comes from the NHS Digital Indicators No Longer In QOF (INLIQ) Clinical Indicator STIA004.
Treatment data for CCGs where the population coverage is less than 60% are not displayed. Treatment figures are calculated using the exceptions in the denominator. For more information about this data please see appendix

Public Health England

Percentage of patients with stroke shown to be non-haemorrhagic, or a history of TIA, whose last measured total cholesterol (measured in the preceding 12 months) is 5 mmol/l or less, by CCGs in the STP including only practices returning INLIQ* data



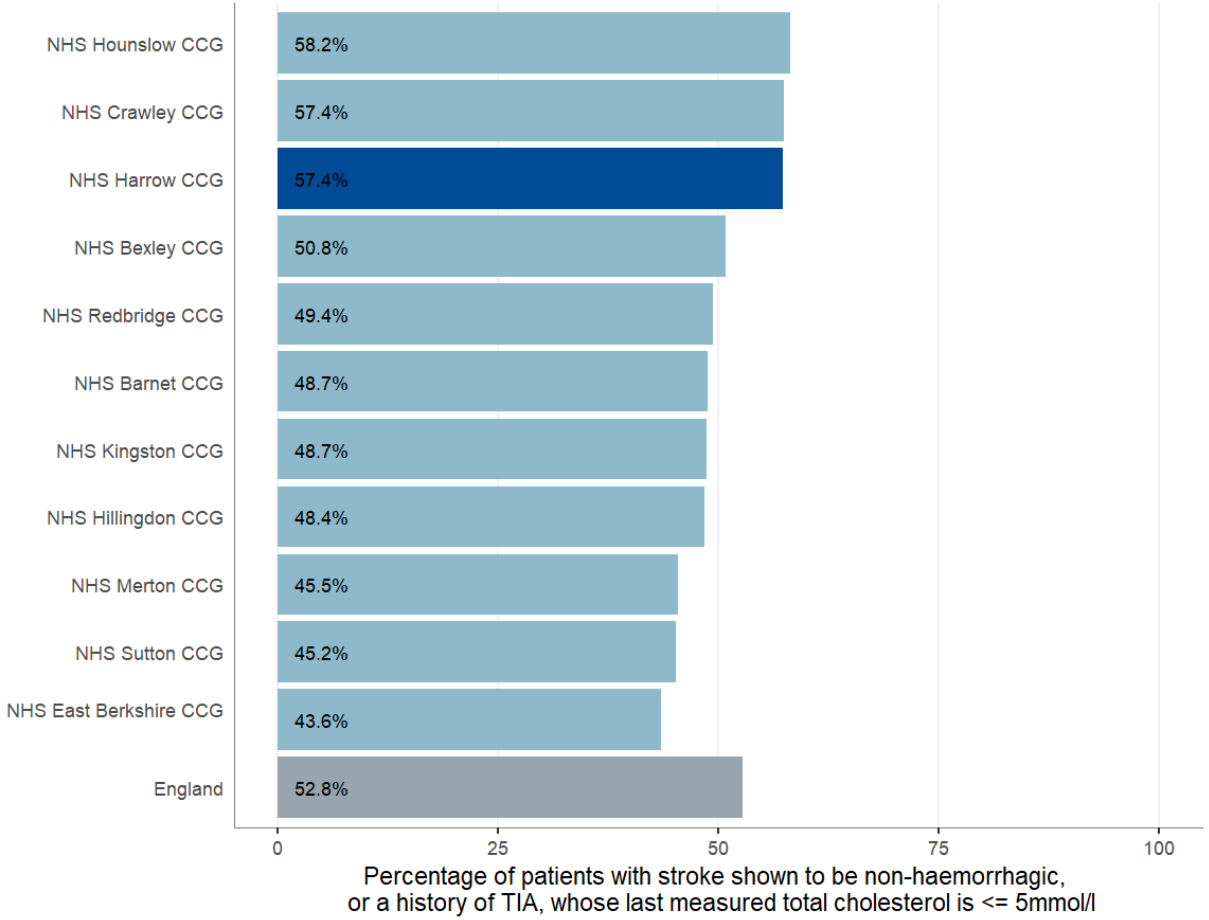
The population coverage of INLIQ in NHS Harrow CCG is 98.5%

Of those practices participating in INLIQ, the percentage of patients with stroke shown to be non-haemorrhagic, or a history of TIA, whose last measured total cholesterol (measured in the preceding 12 months) is <= 5 mmol/l is 57.4%

*Note: This information comes from the NHS Digital Indicators No Longer In QOF (INLIQ) Clinical Indicator STIA005.
Treatment data for CCGs where the population coverage is less than 60% are not displayed.
Treatment figures are calculated using the exceptions in the denominator. For more information about this data please see appendix

Public Health England

Percentage of patients with stroke shown to be non-haemorrhagic, or a history of TIA, whose last measured total cholesterol (measured in the preceding 12 months) is 5 mmol/l or less, by similar CCGs including only practices returning INLIQ* data



The population coverage of INLIQ in NHS Harrow CCG is 98.5%

Of those practices participating in INLIQ, the percentage of patients with stroke shown to be non-haemorrhagic, or a history of TIA, whose last measured total cholesterol (measured in the preceding 12 months) is <= 5 mmol/l is 57.4%

*Note: This information comes from the NHS Digital Indicators No Longer In QOF (INLIQ) Clinical Indicator STIA005.
Treatment data for CCGs where the population coverage is less than 60% are not displayed.
Treatment figures are calculated using the exceptions in the denominator. For more information about this data please see appendix

Public Health England

Diabetes

Public Health England

Diabetes prevention and management

Diabetes costs the NHS GBP 9.8 billion per year and the prevalence is rising - Source: Hex et al, 2012

Type 2 diabetes is often preventable. People at high risk of developing Type 2 diabetes can be identified through the NHS Health Check Programme and the disease can be prevented or delayed in many through intensive behaviour change support, such as that provided by the NHS Diabetes Prevention Programme.

Complications of diabetes are preventable. Diabetes is a major cause of premature death and greatly increases the risk of heart disease, stroke, kidney failure, amputations and blindness. Eighty percent of NHS spending on diabetes goes on managing these complications, most of which could be prevented. There are 8 essential care processes, in addition to retinal screening, that together substantially reduce complication rates. Despite this, around half of people with diabetes do not receive all 8 care processes, and there is widespread variation between CCGs and practices in levels of achievement.

Diabetes (type 1 and 2) in numbers:
1. Diagnosed prevalence (type 1 and 2) - 3.1 million
2. Undiagnosed type 2 diabetes - 0.9 million
3. Non-diabetic hyperglycaemia (high risk of type 2 diabetes) - 5 million

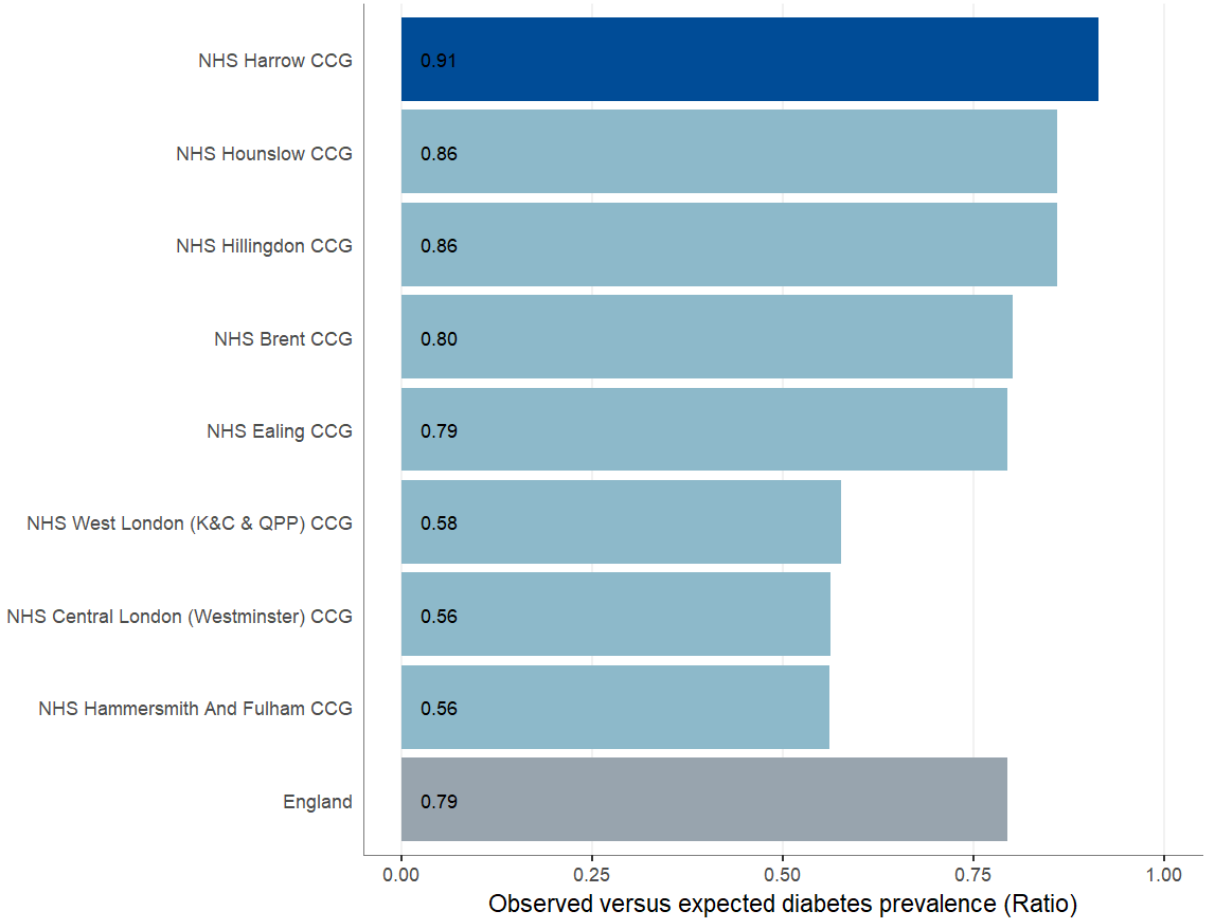
What questions can we ask in our CCG?
1. For each indicator how wide is the variation in achievement?

2. How many people would benefit if all practices performed as well as the best?
3. How can we support practices who are average and below average to perform as well as the best in:
   - detection of diabetes
   - delivery of the 8 care processes and achievement of the 3 treatment targets
   - identification and management of non-diabetic hyperglycaemia

What might help?
1. Benchmark practice level data from the National Diabetes Audit (NDA)- and support practices to explore variation
2. Increase support for patient education and shared management
3. Maximise uptake of the NHS Health Check to aid detection of diabetes and non-diabetic hyperglycaemia
4. Maximise uptake of the NHS Diabetes Prevention Programme.

Public Health England

Diabetes (type 1 and type 2) observed prevalence compared with expected prevalence, by CCGs in the STP



The ratio of those diagnosed with diabetes (type 1 and type 2) versus those expected to have diabetes (type 1 and type 2) in NHS Harrow CCG is 0.91. This compares to 0.79 for England

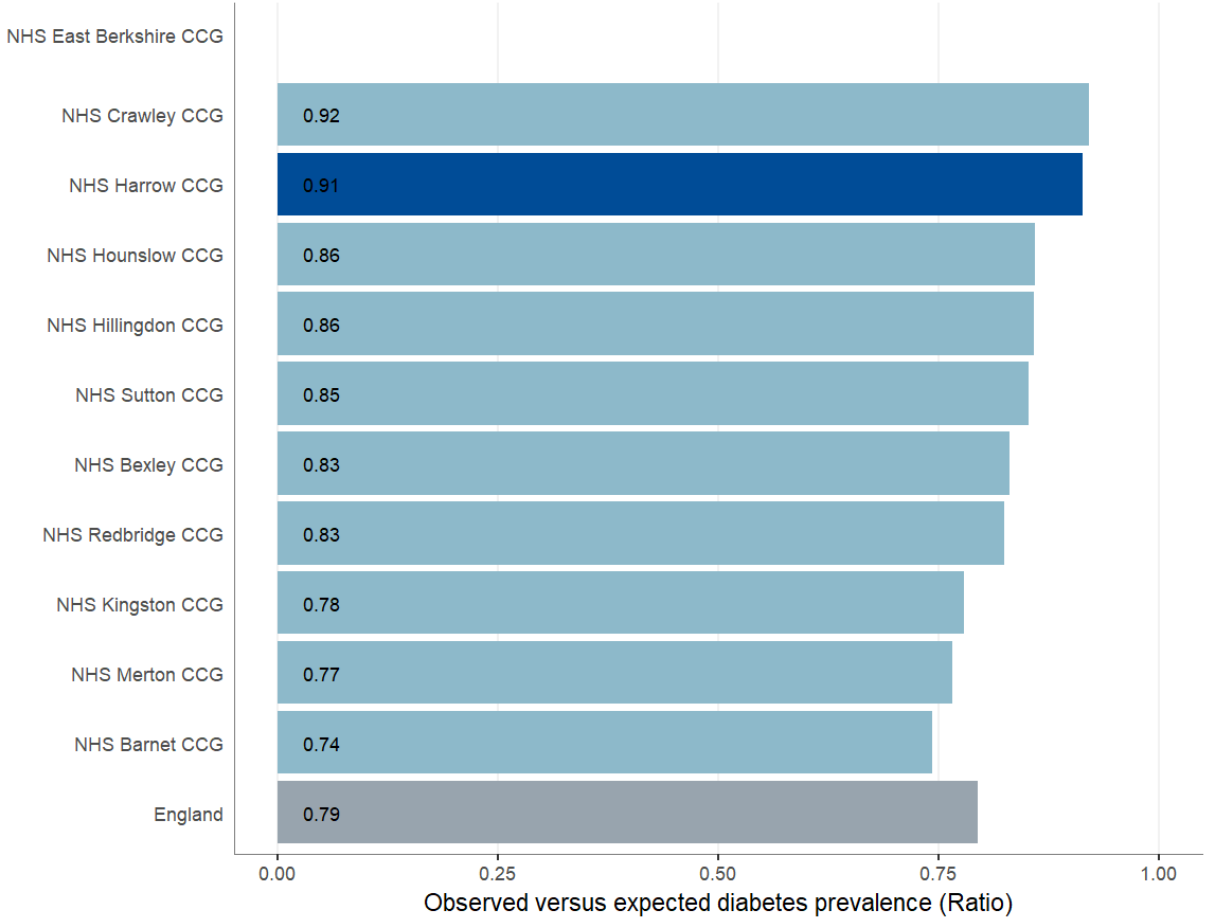
This suggests that 91% of people with diabetes (type 1 and type 2) in NHS Harrow CCG have been diagnosed

There are an estimated 1,923 people with undiagnosed diabetes (type 1 or type 2) over 16 years old in NHS Harrow CCG

Note: This slide compares the prevalence of diabetes recorded in QOF in 2017/18 to the expected prevalence of diabetes in 2017 taken from the NCVIN diabetes prevalence model produced in 2015 using the registered population. The estimated number of undiagnosed people with diabetes has been calculated by multiplying the estimated prevalence rate to the 2017/18 QOF list size and subtracting the number of people on the diabetes register.

Public Health England

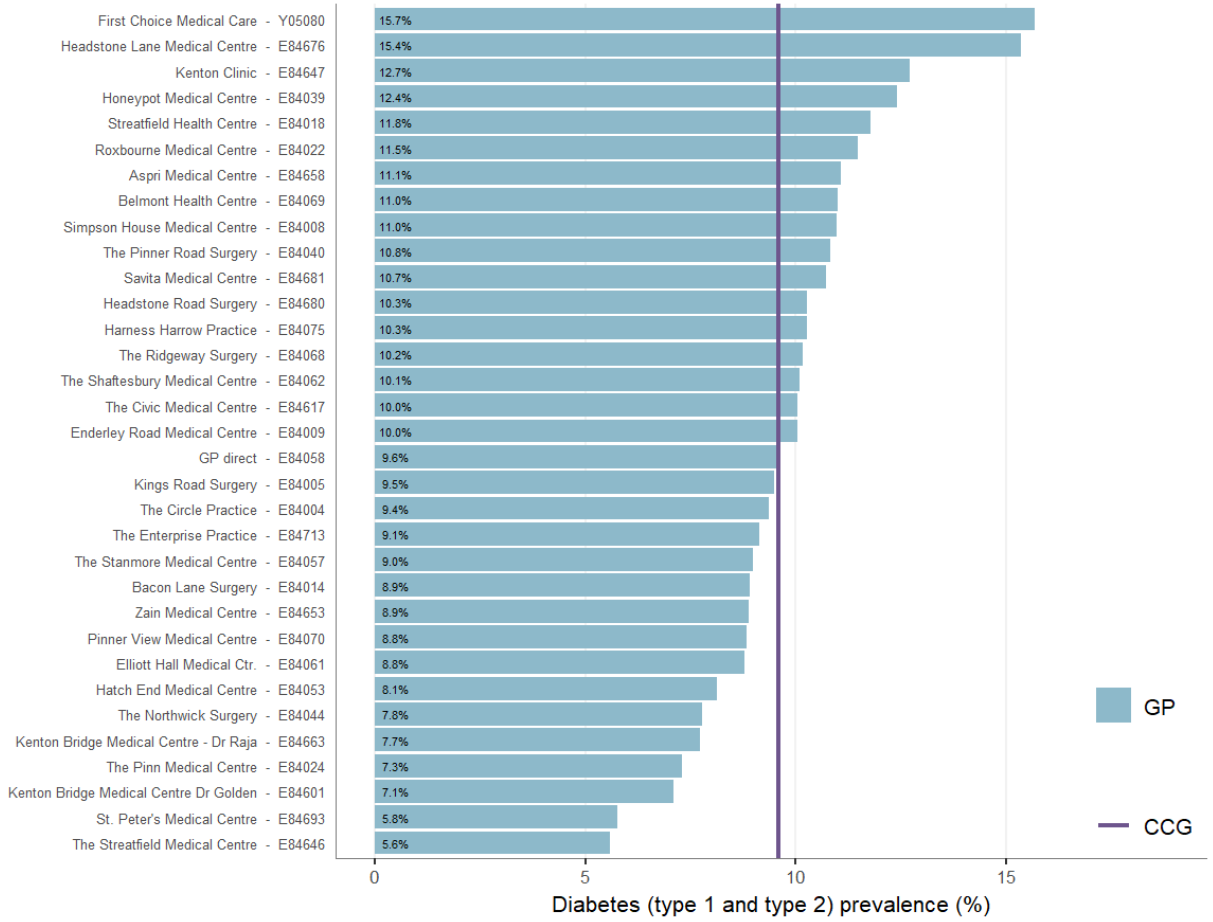
Diabetes (type 1 and type 2) observed prevalence compared with expected prevalence, by similar CCGs



Note: This slide compares the prevalence of diabetes recorded in QOF in 2017/18 to the expected prevalence of diabetes in 2017 taken from the NCVIN diabetes prevalence model produced in 2015 using the registered population. The estimated number of undiagnosed people with diabetes has been calculated by multiplying the estimated prevalence rate to the 2017/18 QOF list size and subtracting the number of people on the diabetes register.

Public Health England

Diabetes (type 1 and type 2) prevalence, by general practice



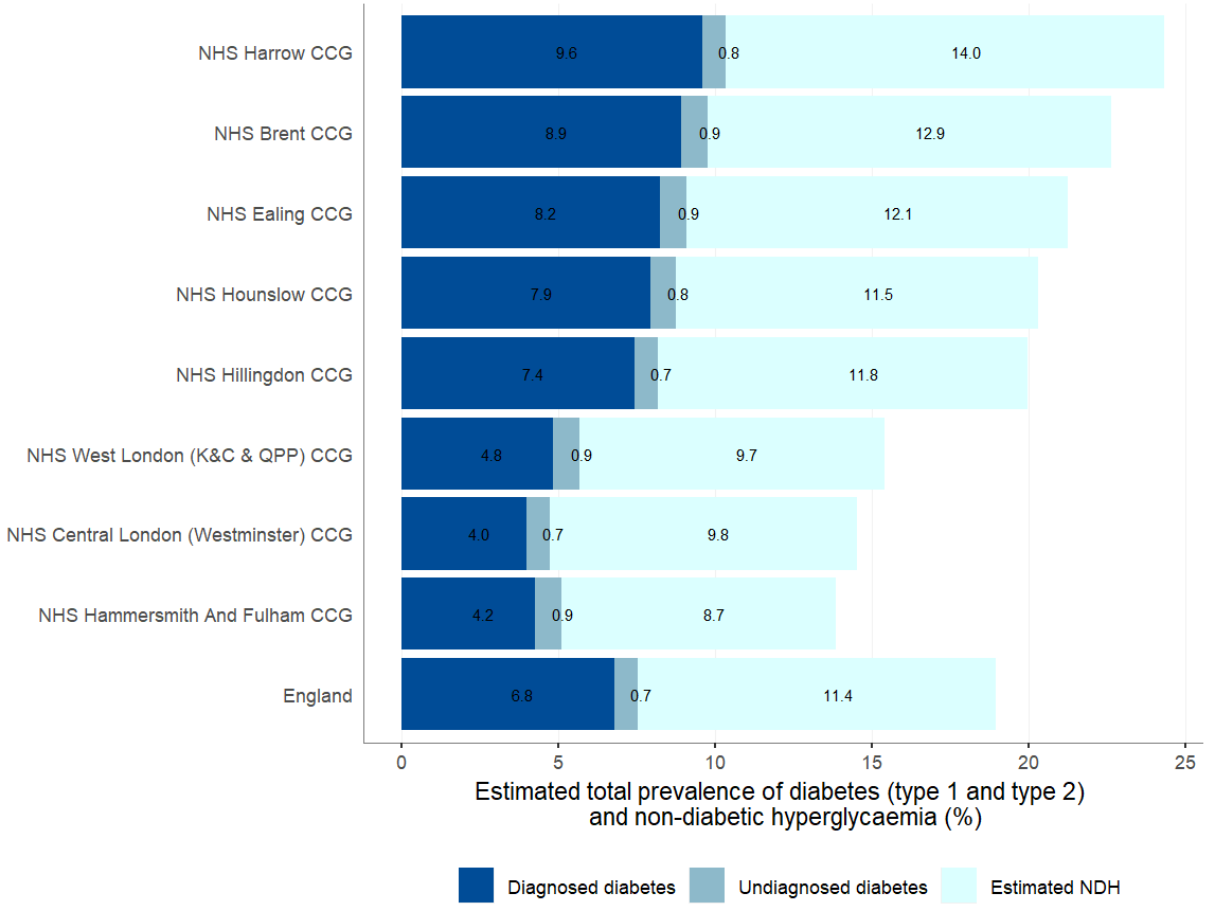
There are 20,296 people with diagnosed diabetes (type 1 or type 2) over 16 years old in NHS Harrow CCG

The range of observed diabetes (type 1 and type 2) across GPs in NHS Harrow CCG is 5.6% to 15.7%

Note: Using QOF clinical indicator DM017

Public Health England

Expected total prevalence of diabetes (type 1 and type 2) and non-diabetic hyperglycaemia, by CCGs in the STP



The estimated total prevalence of diabetes in NHS Harrow CCG is 10.3% (diagnosed and undiagnosed, combined percentage may appear different from graph due to rounding)

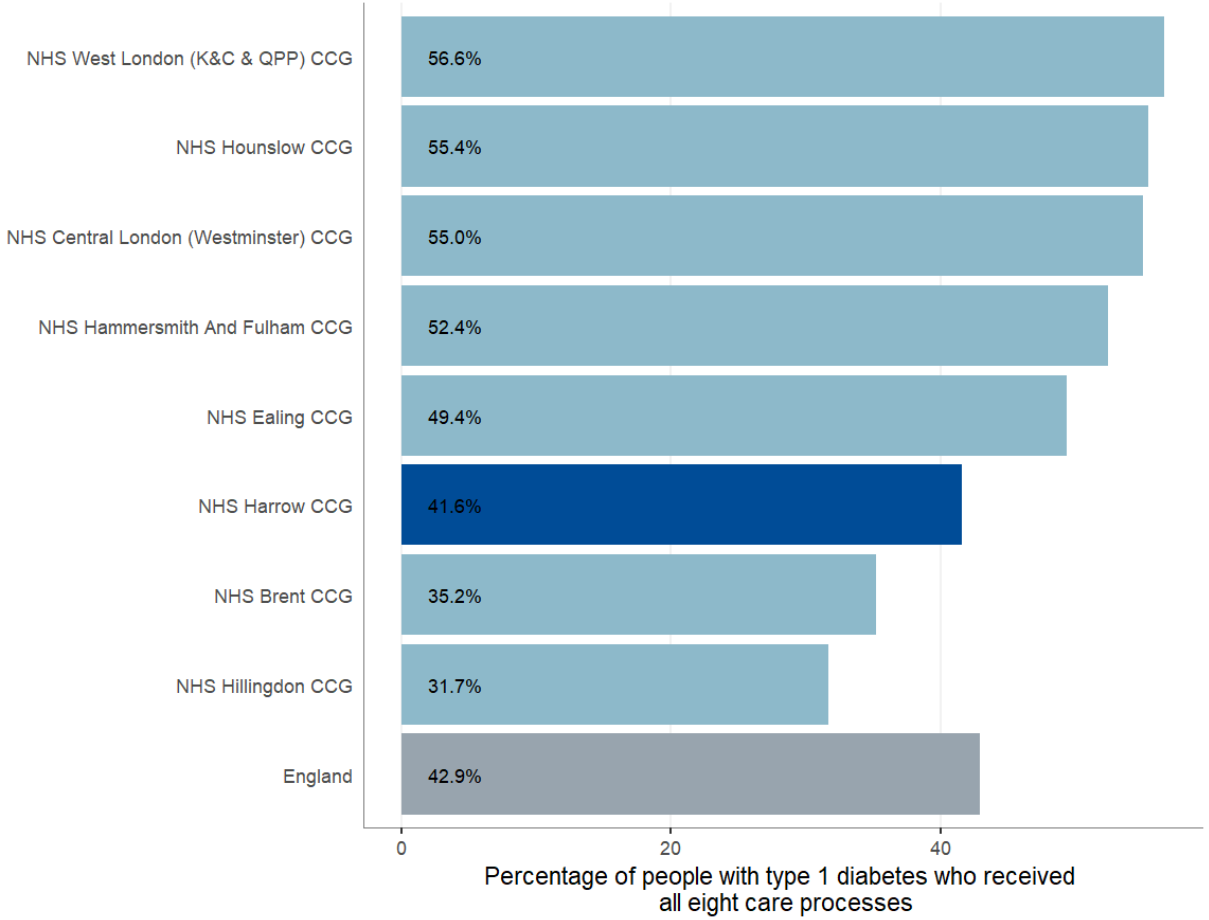
In addition, there are an estimated 14.0% of people in NHS Harrow CCG who are at increased risk of developing diabetes (i.e. non-diabetic hyperglycaemia)

This means that 24.3% of the population in NHS Harrow CCG are estimated to have diabetes, or are at high risk of developing diabetes

Note: Prevalence estimates of non-diabetic hyperglycaemia were developed using Health Survey for England (HSE) data. Five years of HSE data were combined, 2009 - 2013. The estimates take into account the age, ethnic group and estimated body mass index of the population. These estimates were produced using the GP registered population.

Public Health England

People with type 1 diabetes who received all eight care processes, by CCGs in the STP



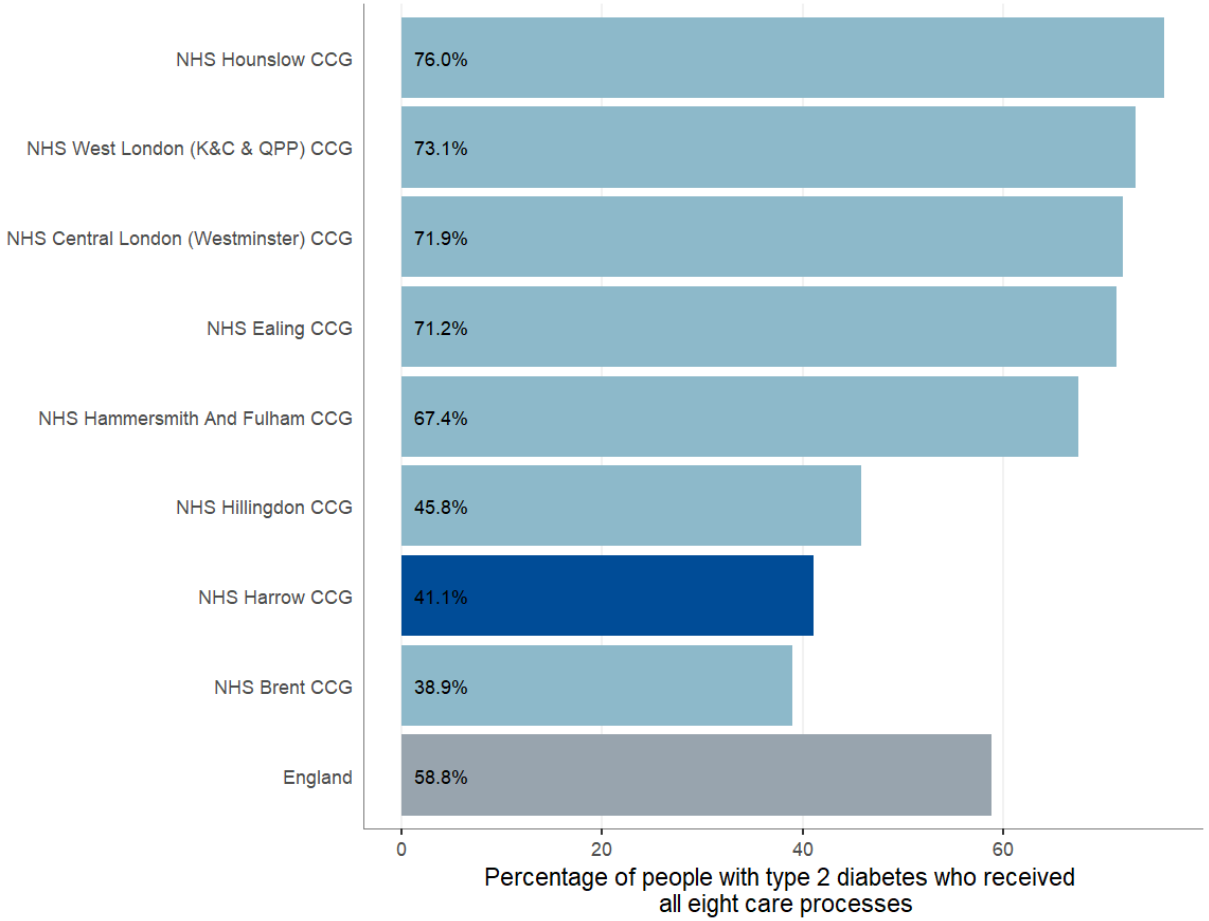
In NHS Harrow CCG, 33 out of 33 practices (100.0%) participated in the National Diabetes Audit

In the practices who participated in the audit, 41.6% of people with type 1 diabetes received the eight recommended care processes in NHS Harrow CCG, compared with 42.9% in England

Note: Data shown here are from the National Diabetes Audit (NDA)

Public Health England

People with type 2 diabetes who received all eight care processes, by CCGs in the STP



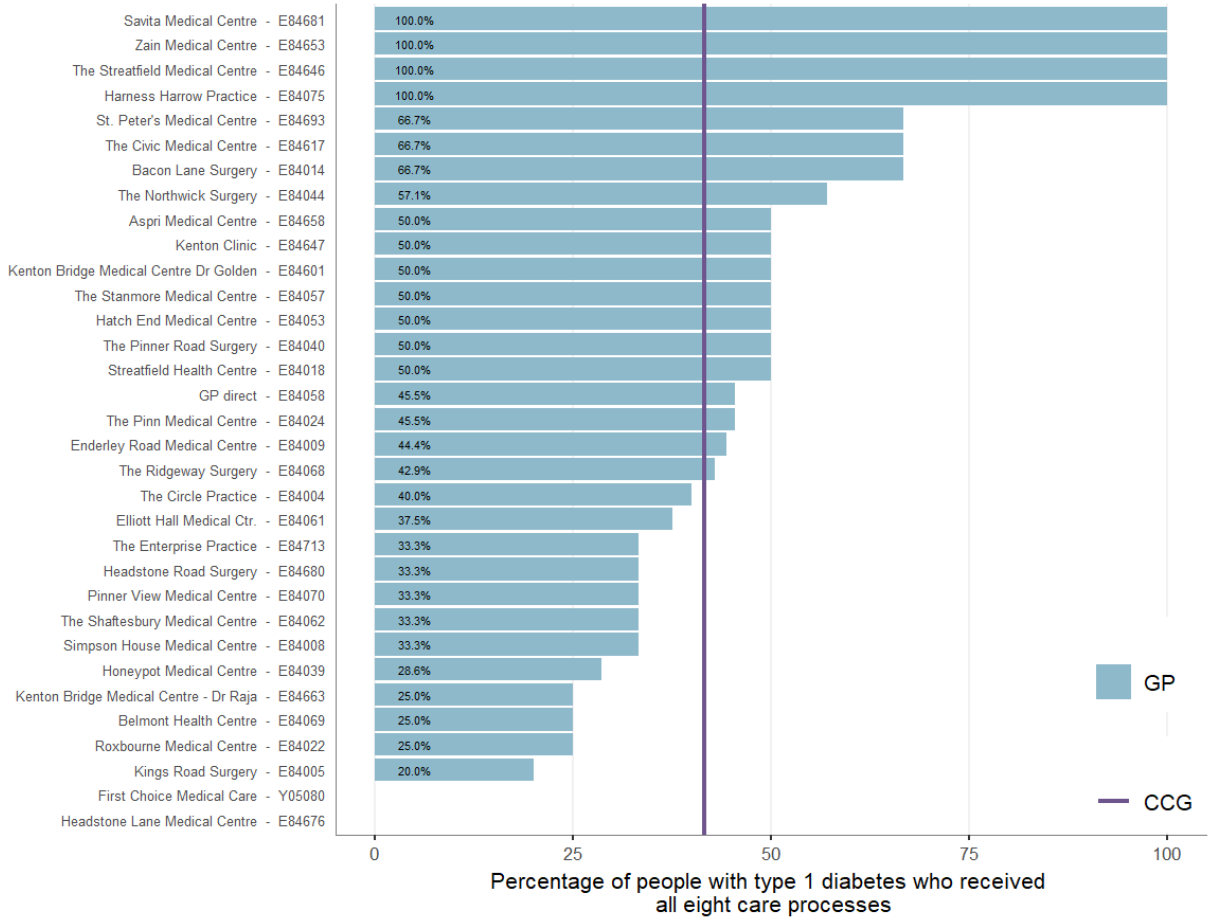
In NHS Harrow CCG, 33 out of 33 practices (100.0%) participated in the National Diabetes Audit

In the practices who participated in the audit, 41.1% of people with type 2 diabetes received the eight recommended care processes in NHS Harrow CCG, compared with 58.8% in England

Note: Data shown here are from the National Diabetes Audit (NDA)

Public Health England

People with type 1 diabetes who received all eight care processes, by general practice



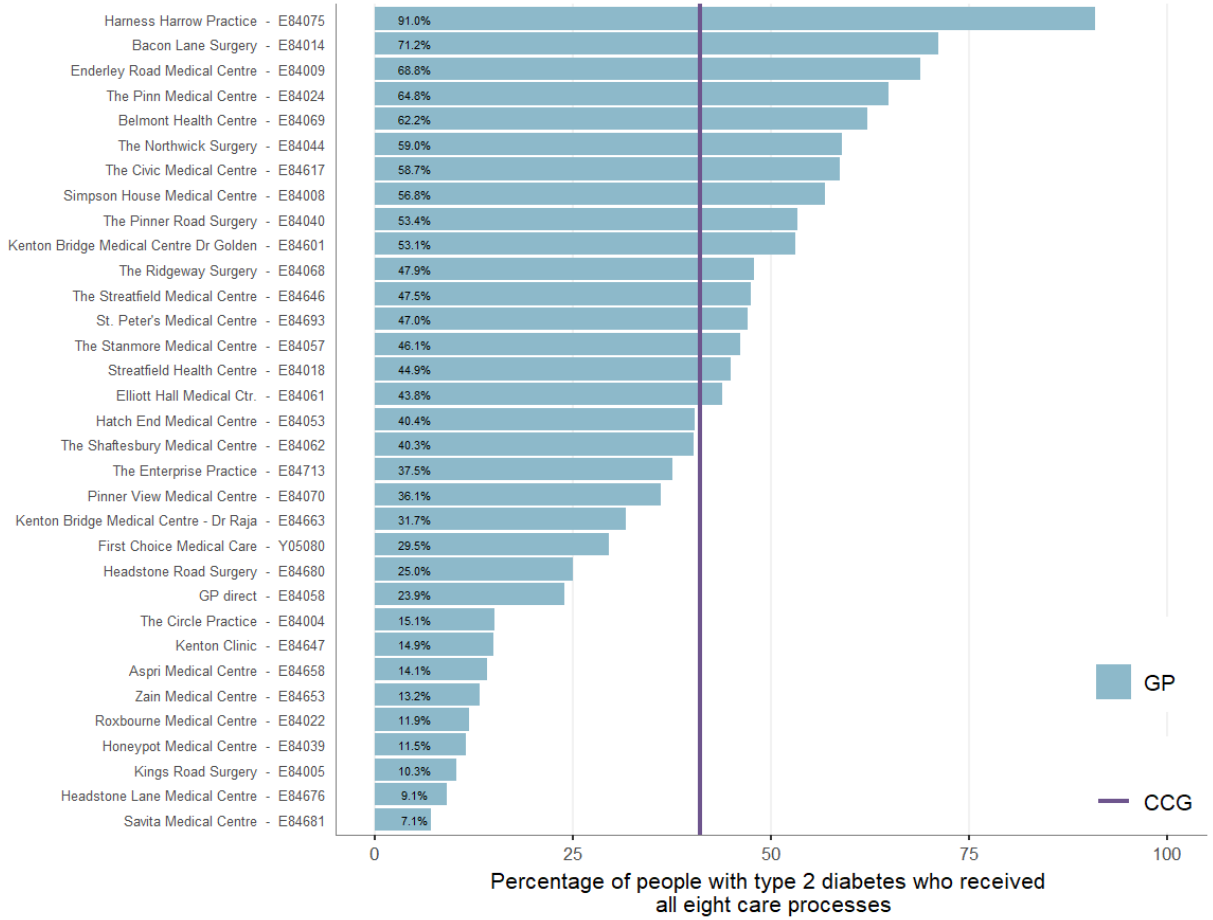
In the practices that participated in the National Diabetes Audit (NDA) in NHS Harrow CCG, 435 people with type 1 diabetes received all eight care processes

The range of the percentage of patients with type 1 diabetes who received all eight care processes in practices that provided data via the NDA in NHS Harrow CCG is 0.0% to 100.0%

Note: Data shown here are from the National Diabetes Audit (NDA)

Public Health England

People with type 2 diabetes who received all eight care processes, by general practice



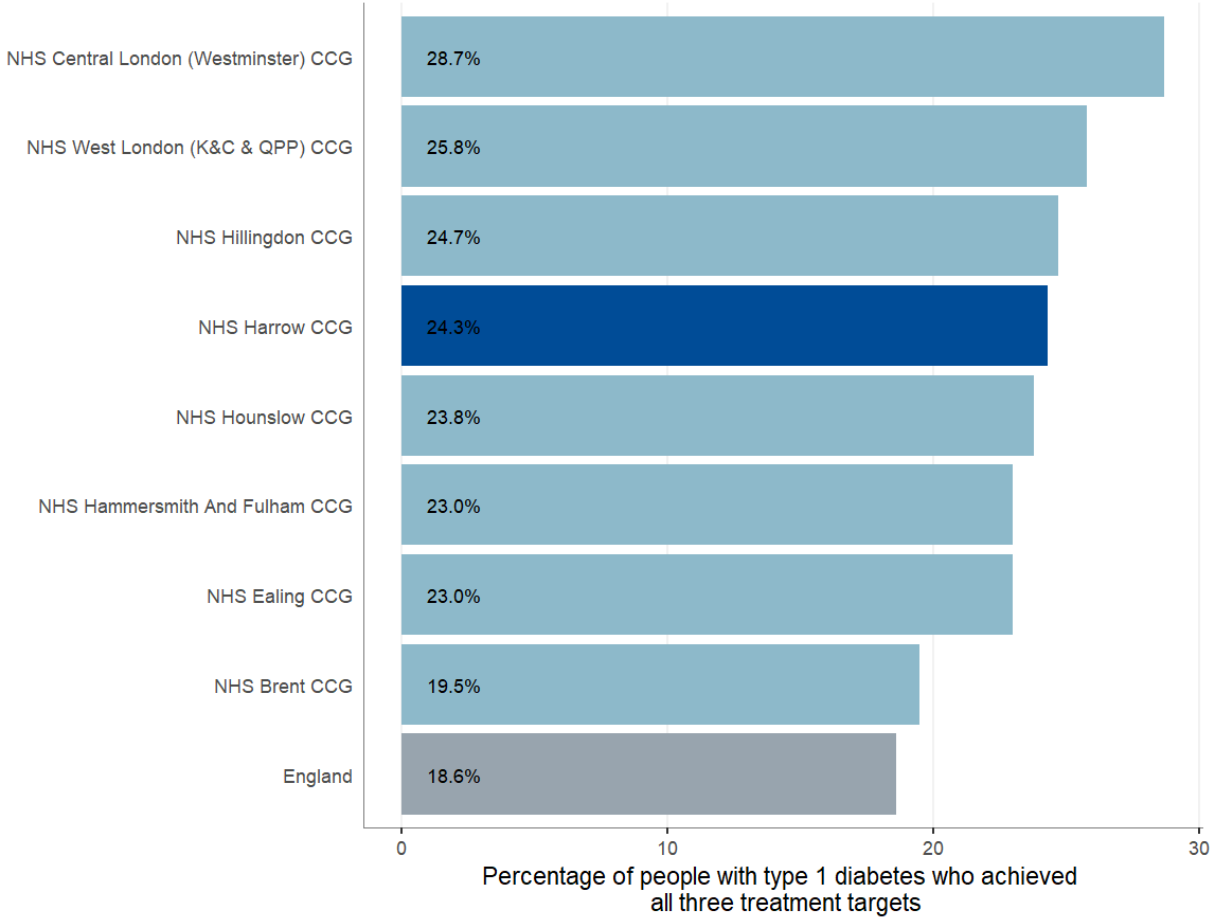
In the practices that participated in the National Diabetes Audit (NDA) in NHS Harrow CCG, 11,460 people with type 2 diabetes received all eight care processes

The range of the percentage of patients with type 2 diabetes who received all eight care processes in practices that provided data via the NDA in NHS Harrow CCG is 7.1% to 91.0%

Note: Data shown here are from the National Diabetes Audit (NDA)

Public Health England

People with type 1 diabetes who achieved all three treatment targets, by CCGs in the STP

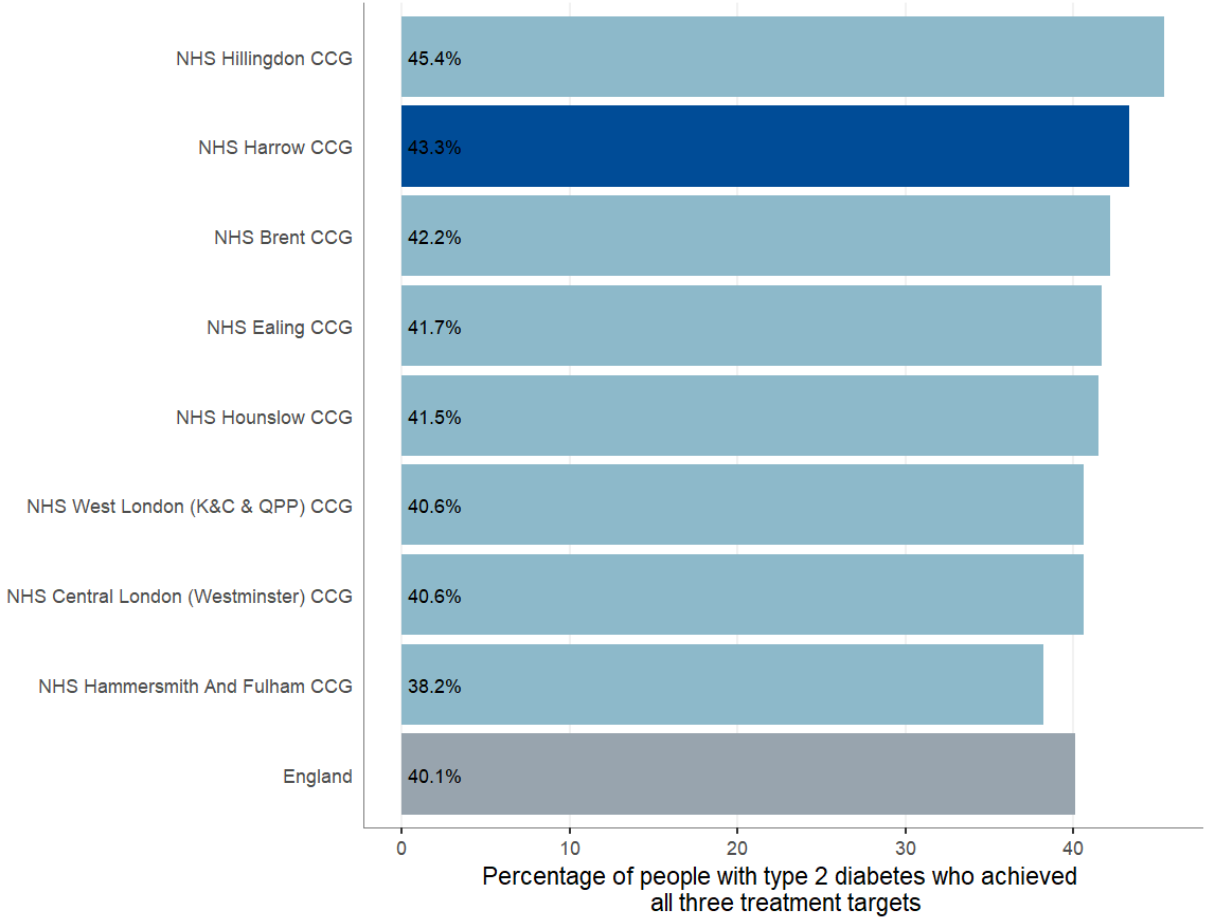


In the practices who participated in the National Diabetes Audit, 24.3% of people with type 1 diabetes achieved all three treatment targets in NHS Harrow CCG, compared with 18.6% in England

Note: Data shown here are from the National Diabetes Audit (NDA)

Public Health England

People with type 2 diabetes who achieved all three treatment targets, by CCGs in the STP

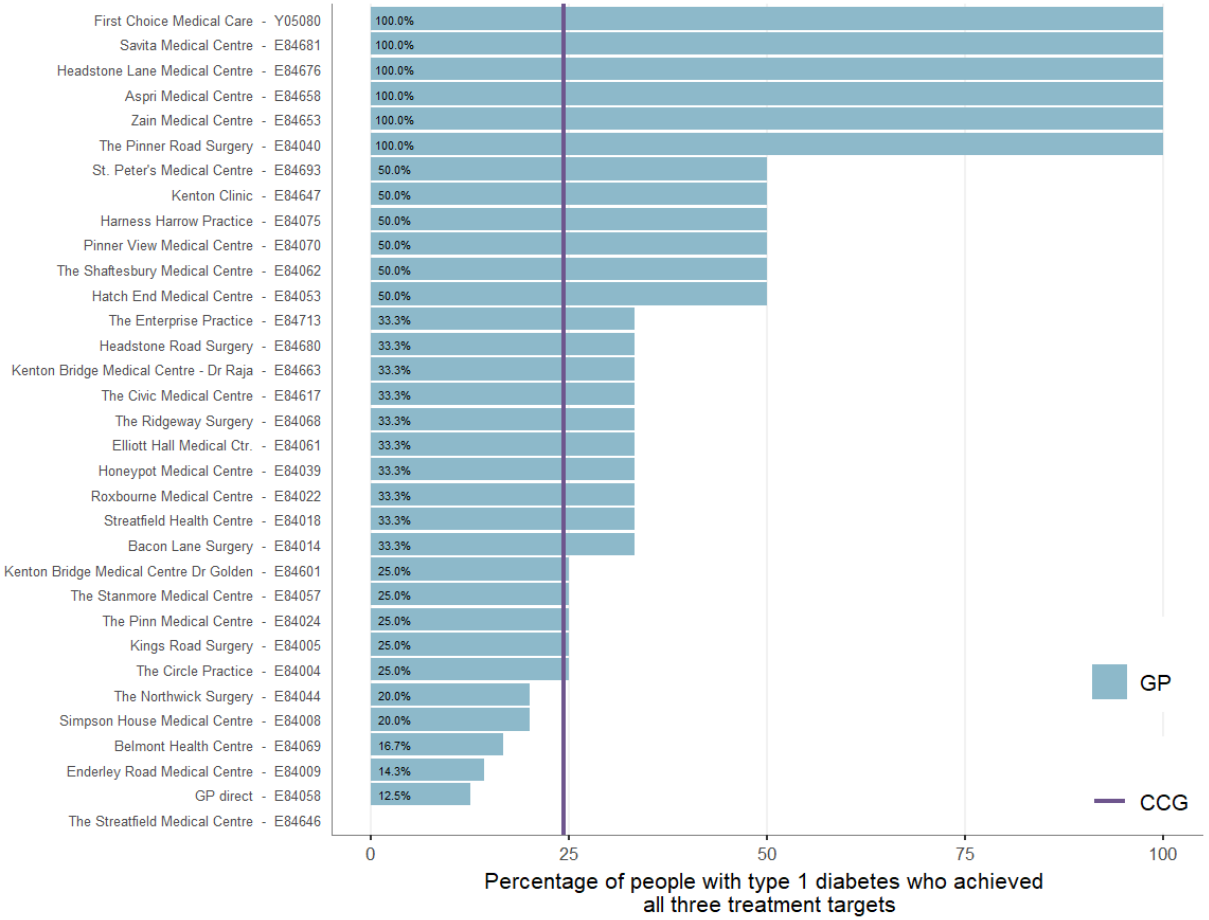


In the practices who participated in the National Diabetes Audit, 43.3% of people with type 2 diabetes achieved all three treatment targets in NHS Harrow CCG, compared with 40.1% in England

Note: Data shown here are from the National Diabetes Audit (NDA)

Public Health England

People with type 1 diabetes who achieved all three treatment targets, by general practice



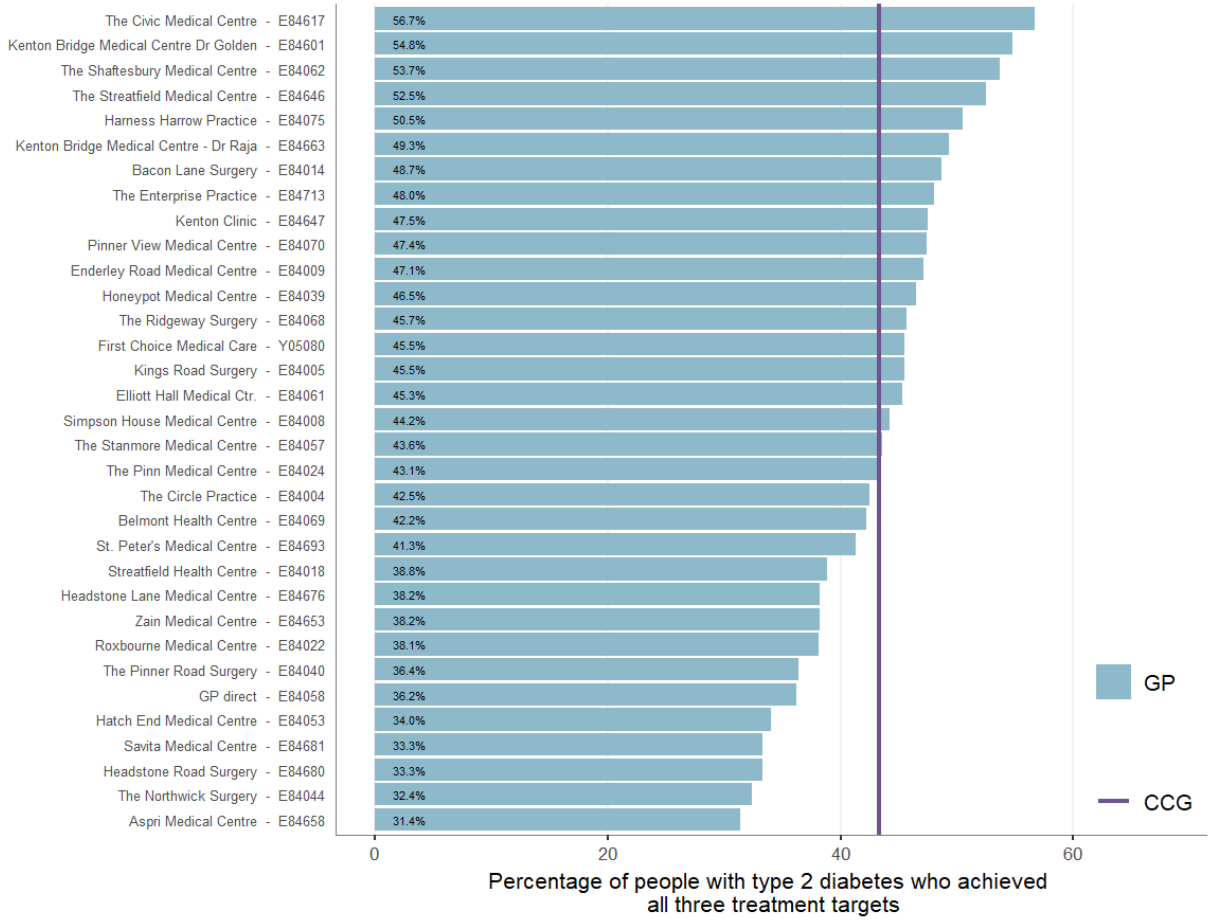
In the practices that participated in the National Diabetes Audit (NDA) in NHS Harrow CCG, 435 people with type 1 diabetes achieved all three treatment targets

The range of the percentage of patients with type 1 diabetes who achieved all three treatment targets across GPs who provided data via the NDA in NHS Harrow CCG is 0.0% to 100.0%

Note: Data shown here are from the National Diabetes Audit (NDA)

Public Health England

People with type 2 diabetes who achieved all three treatment targets, by general practice



In the practices that participated in the National Diabetes Audit (NDA) in NHS Harrow CCG, 10,035 people with type 2 diabetes achieved all three treatment targets

The range of the percentage of patients with type 2 diabetes who achieved all three treatment targets across GPs who provided data via the NDA in NHS Harrow CCG is 31.4% to 56.7%

Note: Data shown here are from the National Diabetes Audit (NDA)

Public Health England

Chronic Kidney Disease

Public Health England

Management of Chronic Kidney Disease

Chronic Kidney Disease can progress to kidney failure and it substantially increases the risk of heart attack and stroke.

Chronic Kidney Disease (CKD) is common.
It is one of the commonest co-morbidities and affects a third of people over 75. In 2010 it was estimated to cost the NHS around GBP 1.5 bn. Average length of stay in hospital tends to be longer and outcomes are considerably worse: approximately 7,000 excess strokes and 12,000 excess heart attacks occur each year in people with CKD compared to those without.

Individuals with CKD are also at much higher risk of developing acute kidney injury when they have an intercurrent illness such as pneumonia.

Evidence based guidance from NICE highlights CVD risk reduction, good blood pressure control and management of proteinuria as essential steps to reduce the risk of cardiovascular events and progression to kidney failure.

Late diagnosis of CKD is common.
Around a third of people with CKD are undiagnosed. More opportunistic testing and improved uptake of the NHS Health Check will increase detection rates.

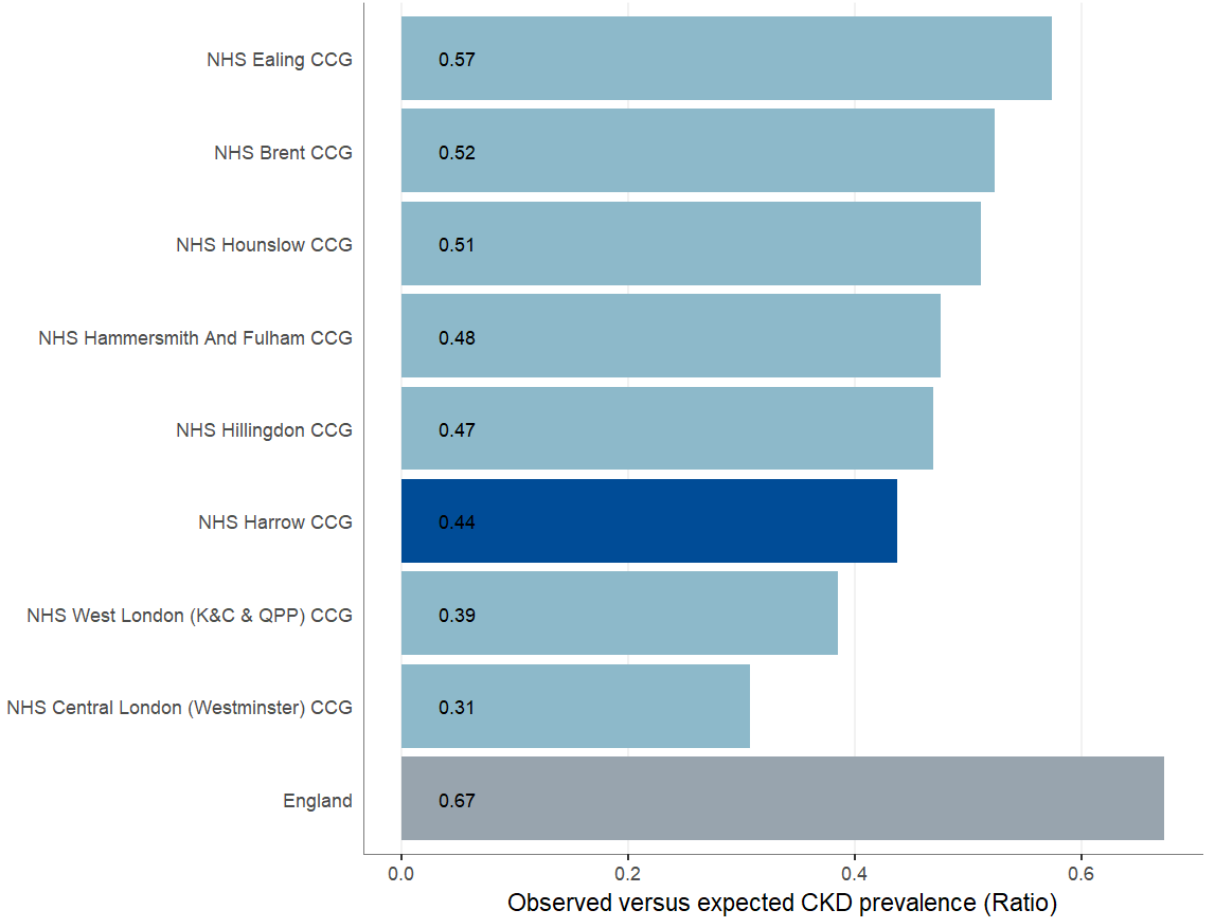
What questions can we ask in our CCG?
1. For each indicator how wide is the variation in achievement?
2. How many people would benefit if all practices performed as well as the best?
3. How can we support practices who are average and below average to perform as well as the best in:

   - detection of CKD
   - more systematic delivery of evidenced based care

What might help?
1. Support practices to share audit data and systematically identify gaps and opportunities for improved detection and management of CKD
2. Promote uptake of and follow up from the NHS Health Check to aid detection and management of CKD
3. Offer local training and education in the detection and management of CKD

Public Health England

Chronic kidney disease (CKD) observed prevalence compared with expected prevalence (2011), by CCGs in the STP



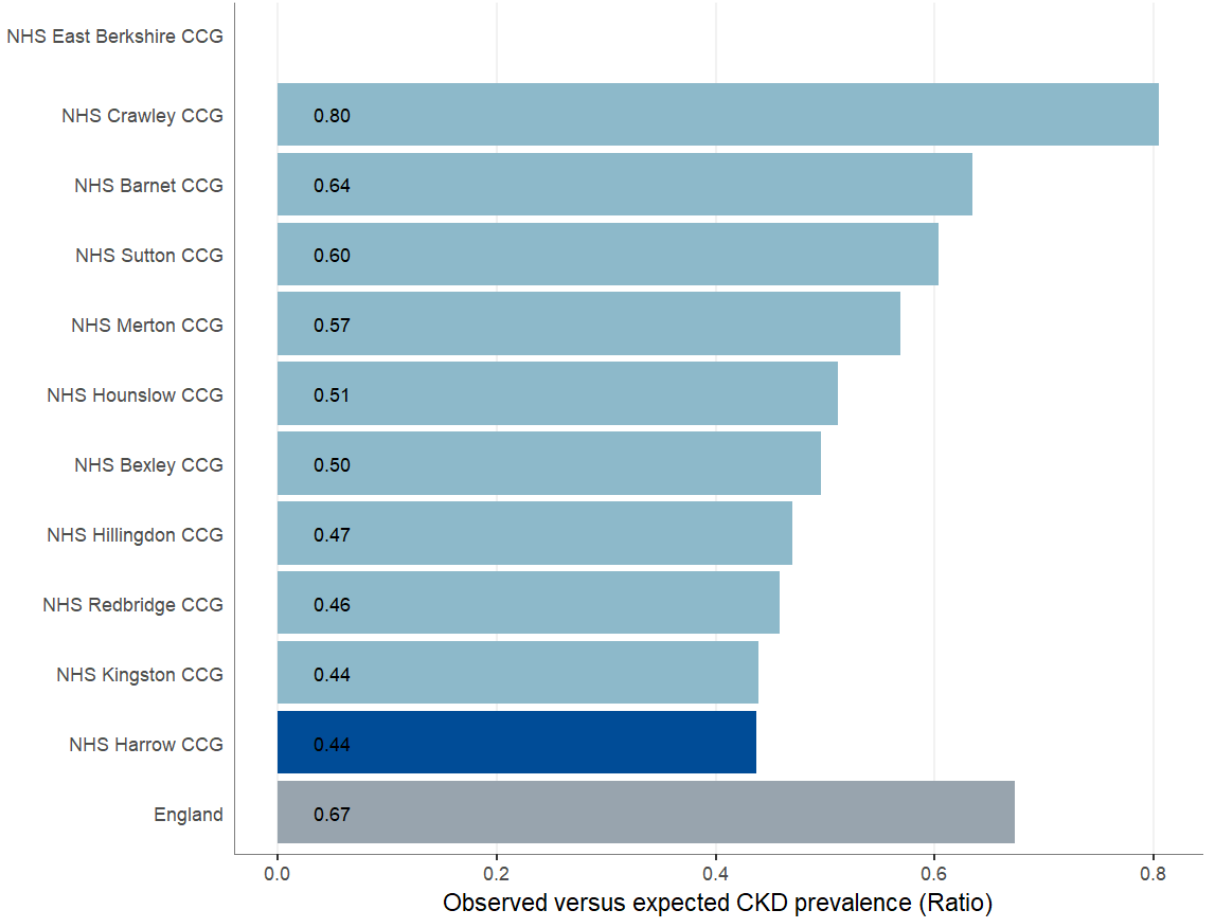
The ratio of those diagnosed with chronic kidney disease versus those expected to have chronic kidney disease in NHS Harrow CCG is 0.44. This compares to 0.67 for England

This suggests that 44% of people with chronic kidney disease in NHS Harrow CCG have been diagnosed

Note: This slide compares the prevalence of CKD recorded in QOF in 2017/18 to the expected prevalence of CKD produced by the University of Southampton in 2011. The 2011 estimates are the most recent available and are currently under review A small number of CCGs have a ratio greater than 1. It is unlikely that all people with CKD will be diagnosed in any CCG and therefore a ratio greater than 1 suggests that the figures are underestimating the true CKD prevalence in the area. These ratios should be taken as an indication of the comparative scale of undiagnosed CKD rather than absolute figures.

Public Health England

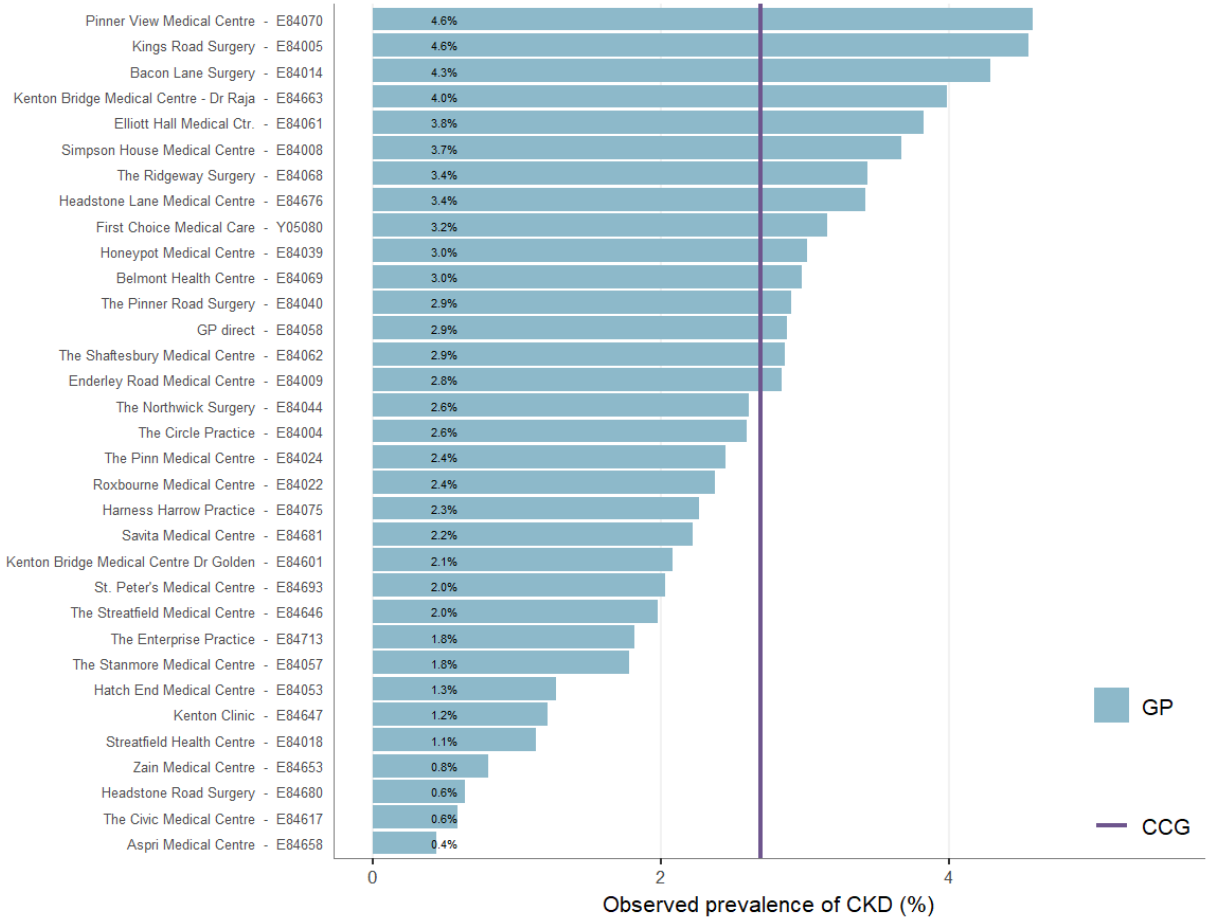
Chronic kidney disease (CKD) observed prevalence compared with expected prevalence (2011), by similar CCGs



Note: This slide compares the prevalence of CKD recorded in QOF in 2017/18 to the expected prevalence of CKD produced by the University of Southampton in 2011. The 2011 estimates are the most recent available and are currently under review A small number of CCGs have a ratio greater than 1. It is unlikely that all people with CKD will be diagnosed in any CCG and therefore a ratio greater than 1 suggests that the figures are underestimating the true CKD prevalence in the area. These ratios should be taken as an indication of the comparative scale of undiagnosed CKD rather than absolute figures.

Public Health England

Chronic kidney disease (CKD) observed prevalence, by general practice

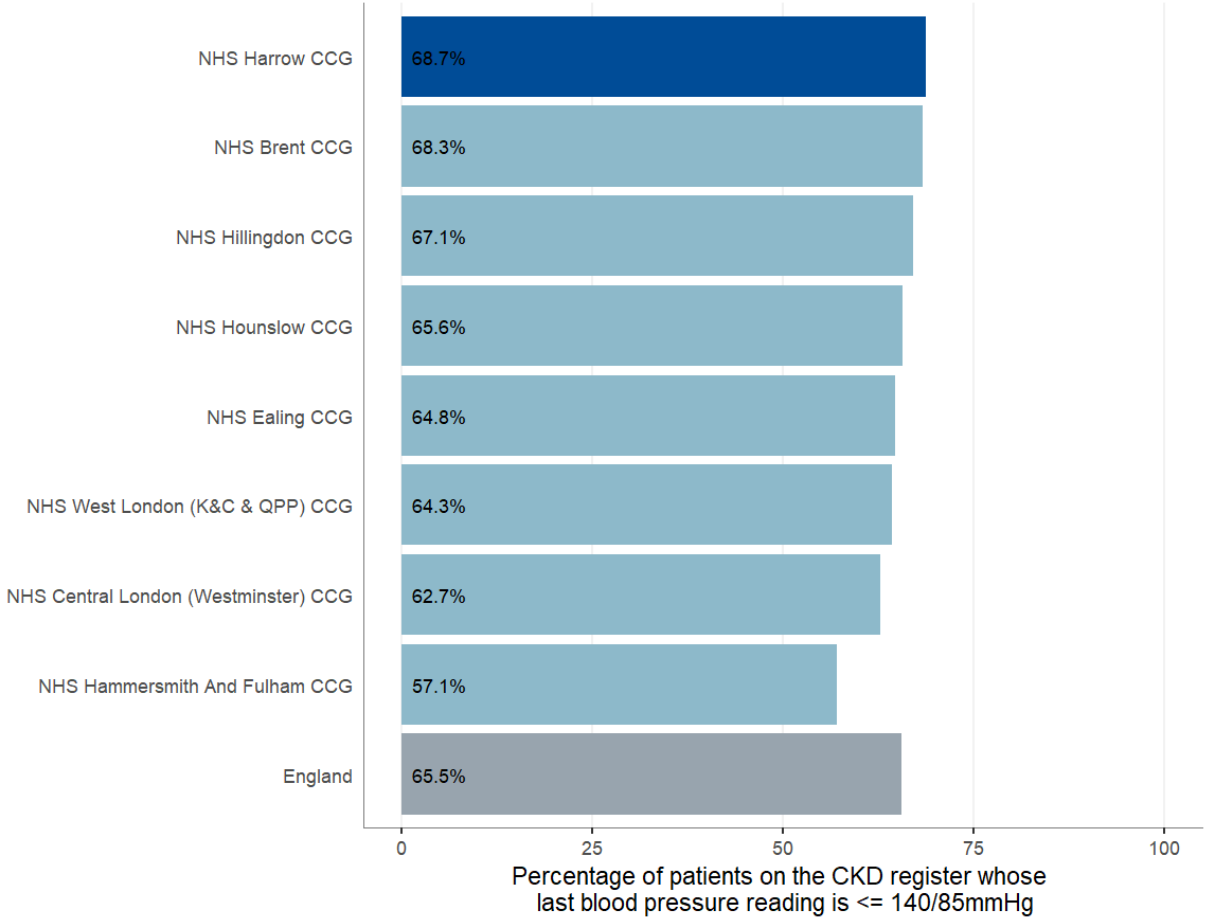


The range of observed CKD prevalence across GPs in NHS Harrow CCG is 0.4% to 4.6%

Note: The observed prevalence represents the proportion of patients aged 18 years and over, who have a diagnosis of CKD recorded on the practice CKD register.

Public Health England

Percentage of patients on the CKD register in whom the last blood pressure reading (measured in the preceding 12 months) is 140/85 mmHg or less, by CCGs in the STP including only practices returning INLIQ* data



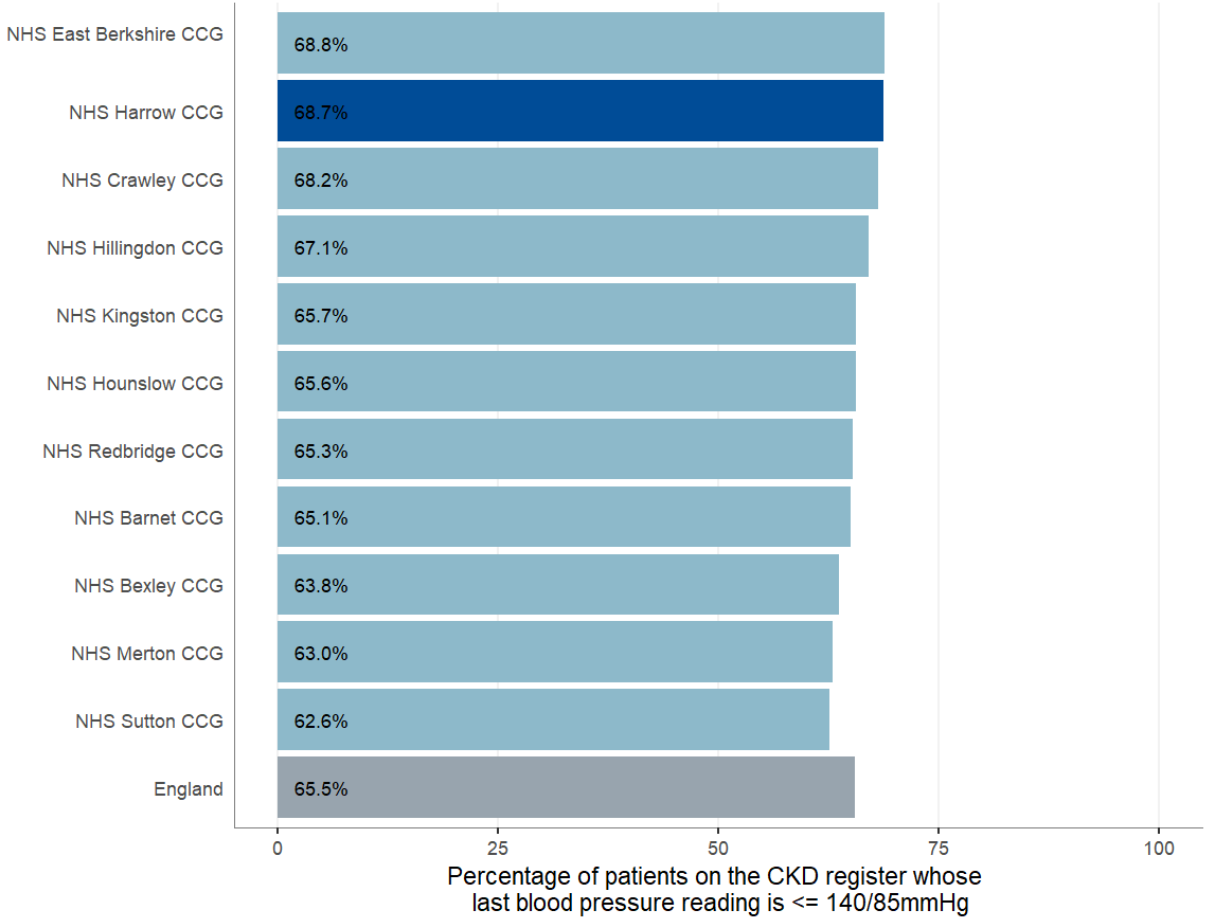
The population coverage of INLIQ in NHS Harrow CCG is 98.5%

Of those practices participating in INLIQ, the percentage of patients on the CKD register in whom the last blood pressure reading (measured in the preceding 12 months) is <= 140/85 mmHg is 68.7%

*Note: This information comes from the NHS Digital Indicators No Longer In QOF (INLIQ) Clinical Indicator CKD002.
Treatment data for CCGs where the population coverage is less than 60% are not displayed.
Treatment figures are calculated using the exceptions in the denominator. For more information about this data please see appendix

Public Health England

Percentage of patients on the CKD register in whom the last blood pressure reading (measured in the preceding 12 months) is 140/85 mmHg or less, by similar CCGs including only practices returning INLIQ* data



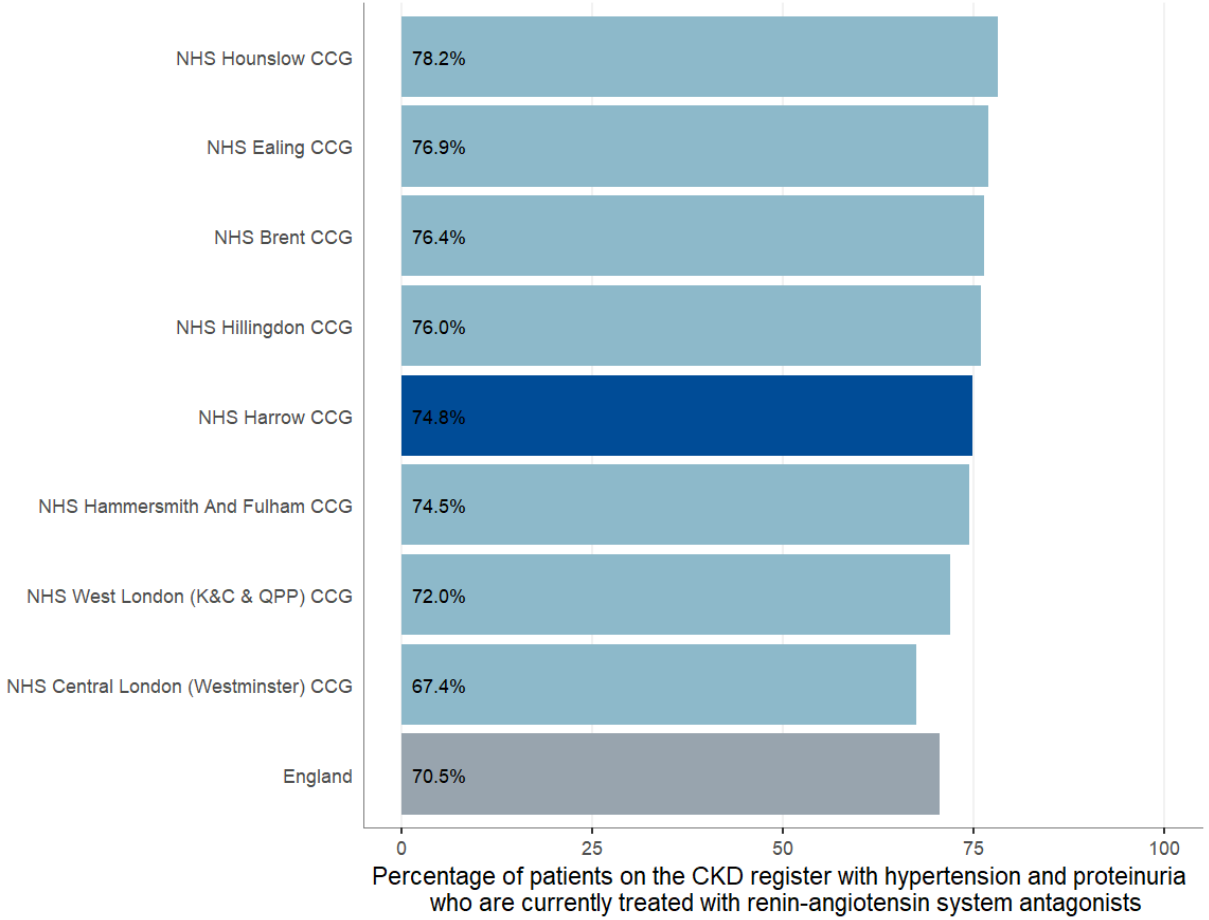
The population coverage of INLIQ in NHS Harrow CCG is 98.5%

Of those practices participating in INLIQ, the percentage of patients on the CKD register in whom the last blood pressure reading (measured in the preceding 12 months) is <= 140/85 mmHg is 68.7%

*Note: This information comes from the NHS Digital Indicators No Longer In QOF (INLIQ) Clinical Indicator CKD002.
Treatment data for CCGs where the population coverage is less than 60% are not displayed.
Treatment figures are calculated using the exceptions in the denominator. For more information about this data please see appendix

Public Health England

Percentage of patients on the CKD register with hypertension and proteinuria who are currently treated with renin-angiotensin system antagonists, by CCGs in the STP including only practices returning INLIQ* data



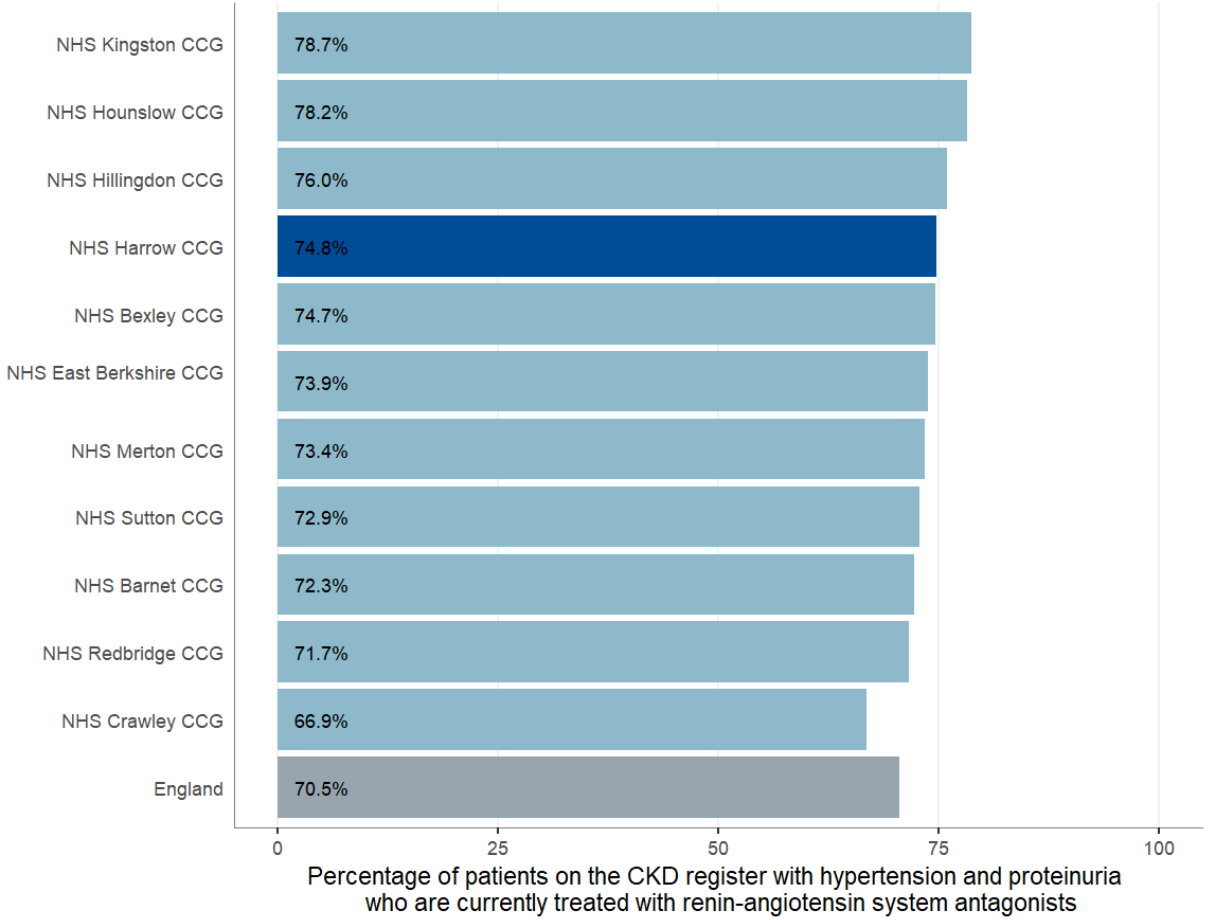
The population coverage of INLIQ in NHS Harrow CCG is 98.5%

Of those practices participating in INLIQ, the percentage of patients on the CKD register with hypertension and proteinuria who are currently treated with renin-angiotensin system antagonists is 74.8%

*Note: This information comes from the NHS Digital Indicators No Longer In QOF (INLIQ) Clinical Indicator CKD003/NM84.
Treatment data for CCGs where the population coverage is less than 60% are not displayed.
Treatment figures are calculated using the exceptions in the denominator. For more information about this data please see appendix

Public Health England

Percentage of patients on the CKD register with hypertension and proteinuria who are currently treated with renin-angiotensin system antagonists, by similar CCGs including only practices returning INLIQ* data



The population coverage of INLIQ in NHS Harrow CCG is 98.5%

Of those practices participating in INLIQ, the percentage of patients on the CKD register with hypertension and proteinuria who are currently treated with renin-angiotensin system antagonists is 74.8%

*Note: This information comes from the NHS Digital Indicators No Longer In QOF (INLIQ) Clinical Indicator CKD003/NM84.
Treatment data for CCGs where the population coverage is less than 60% are not displayed.
Treatment figures are calculated using the exceptions in the denominator. For more information about this data please see appendix

Public Health England

Heart

Public Health England

Management of Heart Disease

Premature death and disability in people with CHD can be reduced significantly by systematic evidence based management in primary care

Coronary Heart Disease is one of the principal causes of premature death and disability. The key elements of management for an individual who has already had a heart attack or angina are symptom control and secondary prevention of further cardiovascular events and premature mortality. There is robust evidence to support the use of anti-platelet treatment, statins, beta-blockers (BB) and angiotensin converting enzyme inhibitors (ACE/I) or angiotensin receptor blockers (ARBs). There is also robust evidence to support good control of blood pressure. Each of these interventions is incentivised in QOF but variation in achievement reporting at practice level shows that there is often considerable potential for improving management and outcomes.

Heart failure is a common and an important complication of coronary heart disease and other conditions. Appropriate treatment including up-titration of ace inhibitors and beta blockers in heart failure due to left ventricular systolic dysfunction (LVSD) can significantly improve symptom control and quality of life and improve outcomes for patients. Despite this, around a quarter of people with heart failure are undetected and untreated.There is significant variation in the quality of care of those who are diagnosed.

What questions should we ask in our CCG?

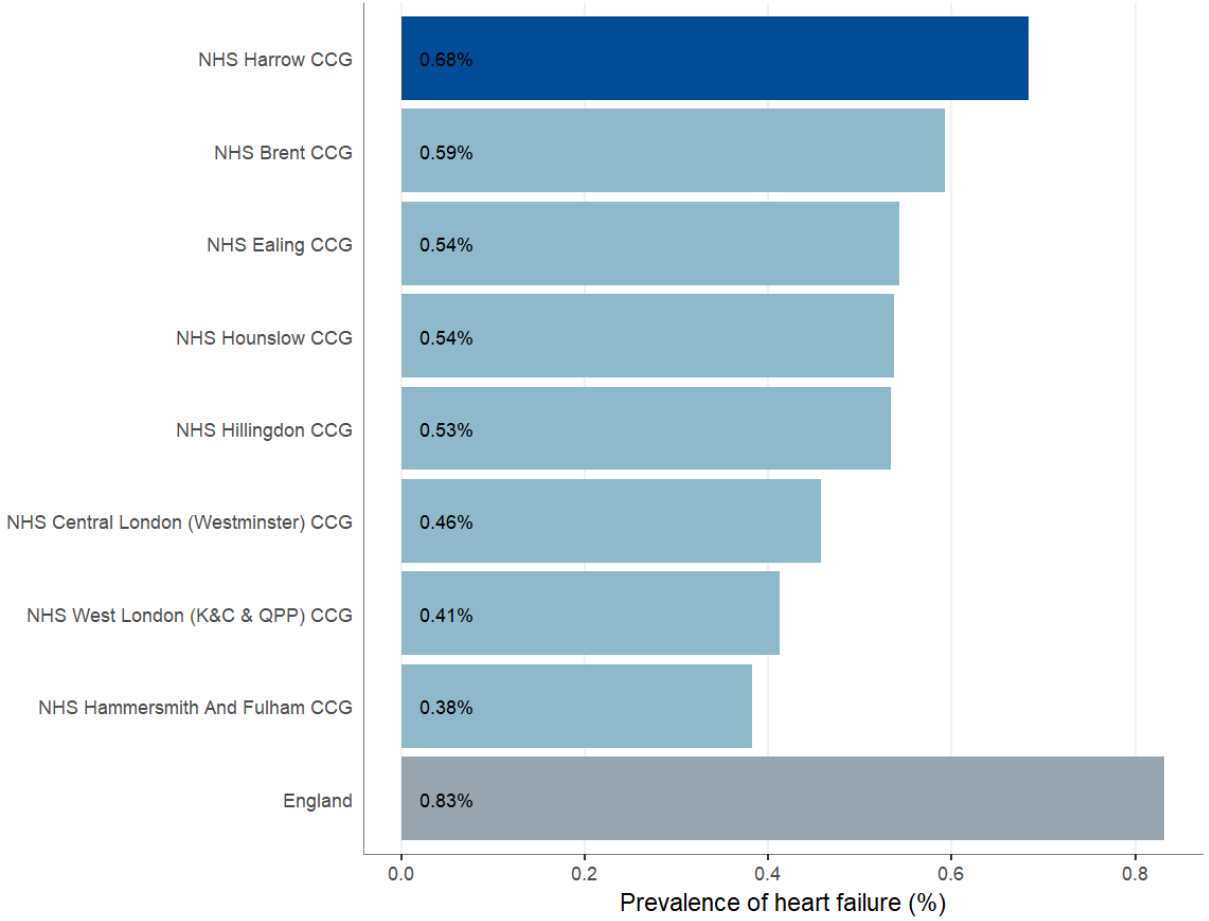
1. For each indicator how wide is the variation in detection, and treatment?
2. How many people would benefit if all practices performed as well as the best?
3. How can we support practices who are average and below average to perform as well as the best in:
   - more systematic delivery of evidence based care for people with CHD
   - improved detection and management of heart failure

What might help?

1. Roll out of GRASP-Heart Failure audit tool that identifies people with heart failure who are undiagnosed or under-treated
2. Education for health professionals to promote evidence based management of CHD and high quality measurement of blood pressure
3. Ensure access to rapid access diagnostic clinics and specialist support for management of angina and heart failure
4. Ensure access to cardiac rehabilitation for individuals with CHD and heart failure

Public Health England

Heart failure prevalence, by CCGs in the STP

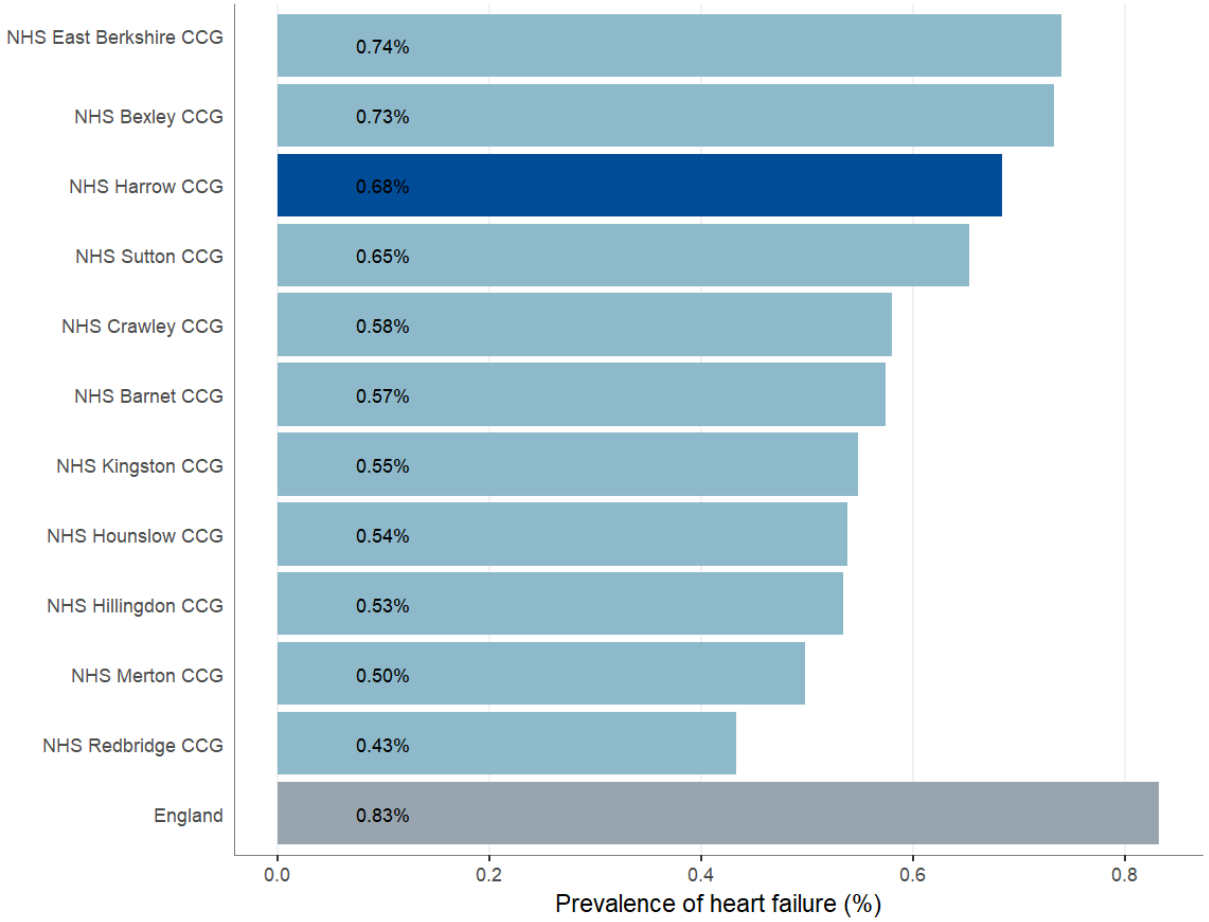


Heart failure prevalence in NHS Harrow CCG is 0.68% compared with 0.83% in England

Note: Using QOF clinical indicator HF001

Public Health England

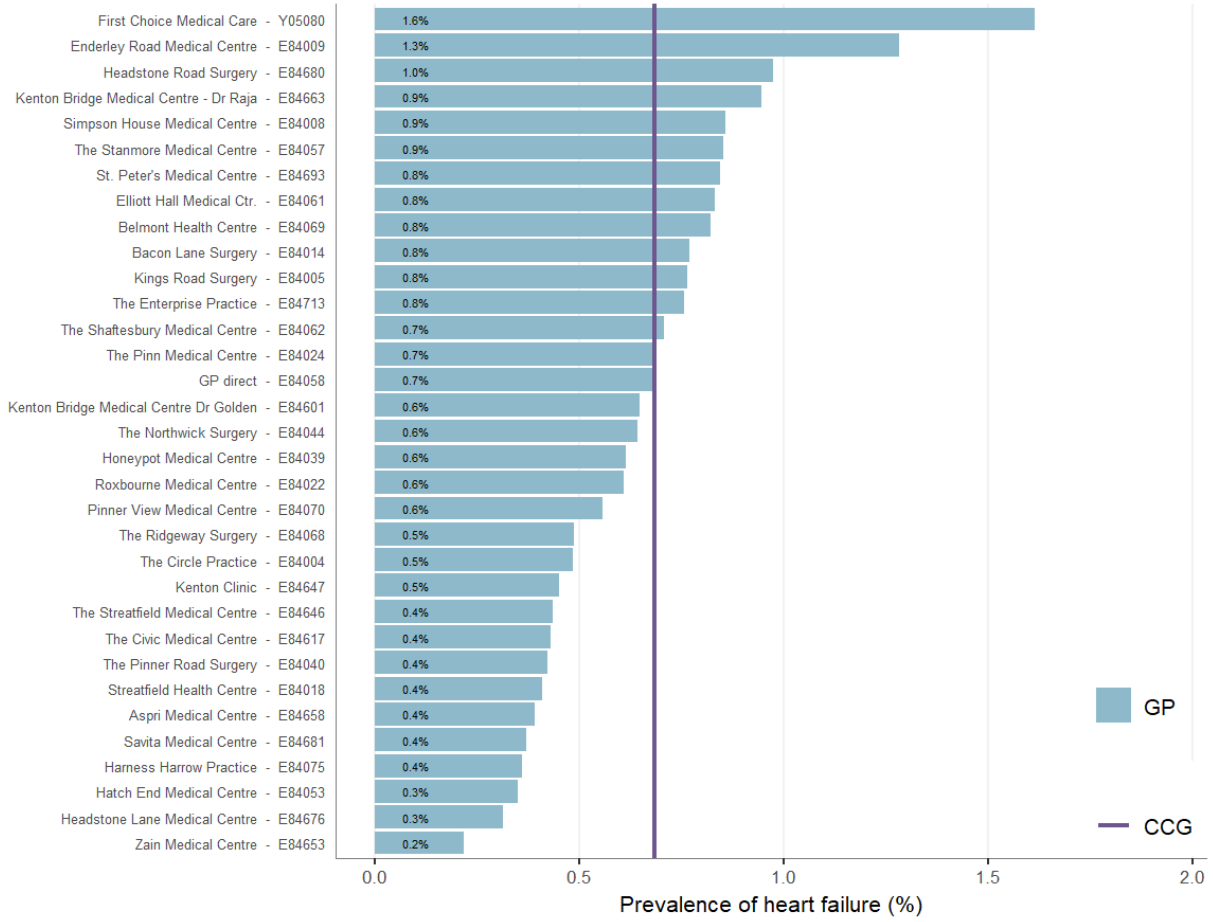
Heart failure prevalence, by similar CCGs



Note: Using QOF clinical indicator HF001

Public Health England

Heart failure prevalence, by general practice



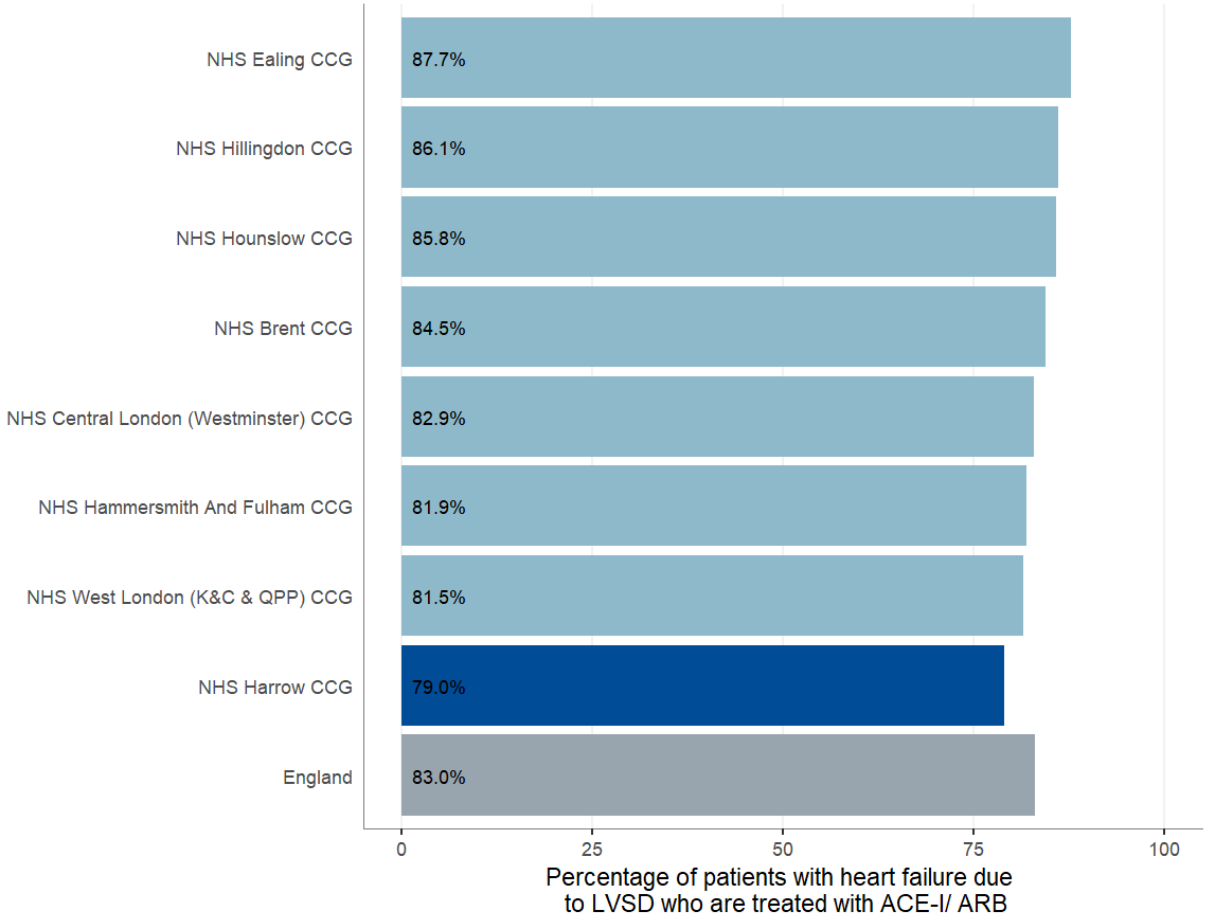
There are 1,823 people with diagnosed heart failure in NHS Harrow CCG

The range of heart failure prevalence across GPs in NHS Harrow CCG is 0.2% to 1.6%

Note: Using QOF clinical indicator HF001

Public Health England

Percentage of patients with heart failure due to left ventricular systolic dysfunction (LVSD) who are treated with ACE-I/ ARB, by CCGs in the STP



366 people have heart failure with LVSD in NHS Harrow CCG

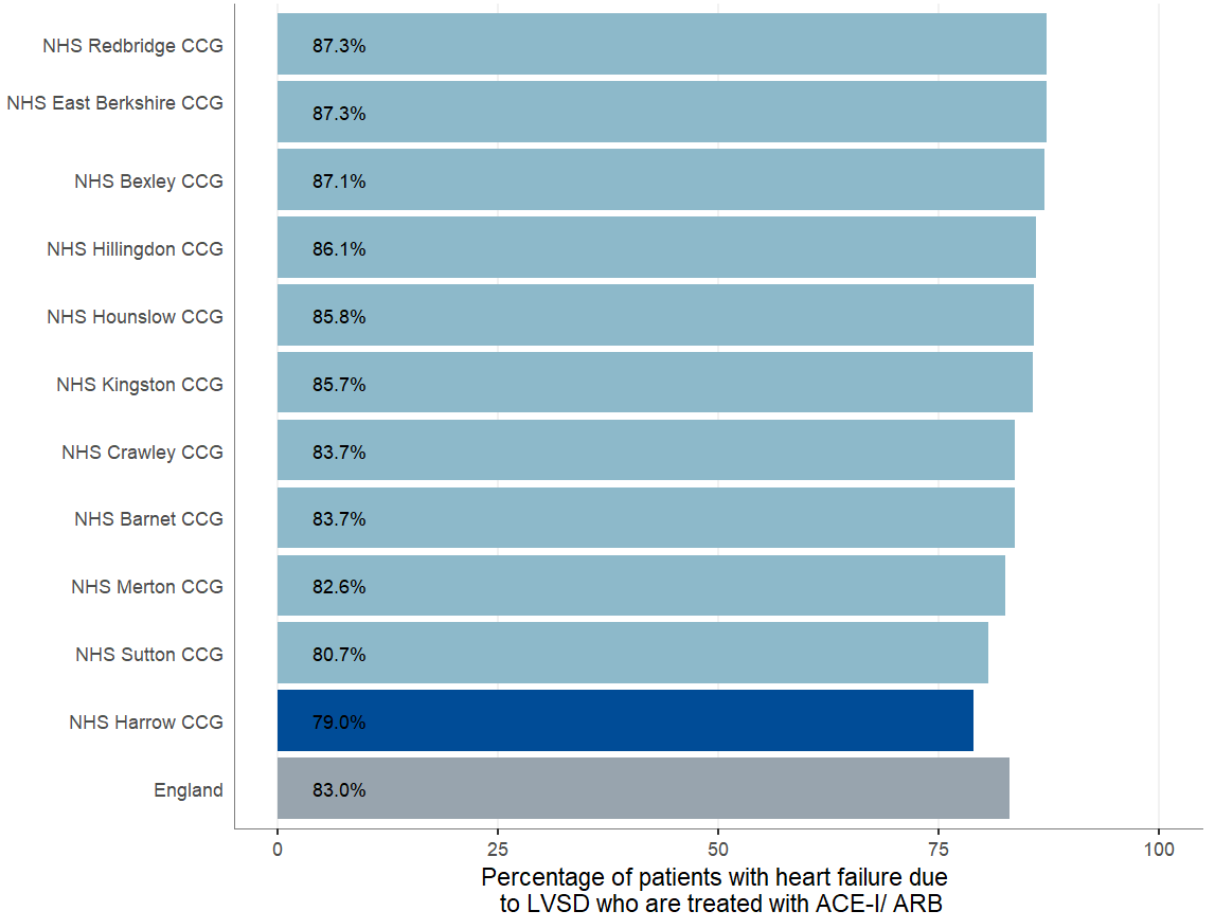
Of these, 289 (79.0%) people are treated with ACE-I or ARB

77 (21.0%) people (including excepted cases) are NOT treated with ACE-I or ARB

Note: Using QOF clinical indicator HF003 denominator plus exceptions

Public Health England

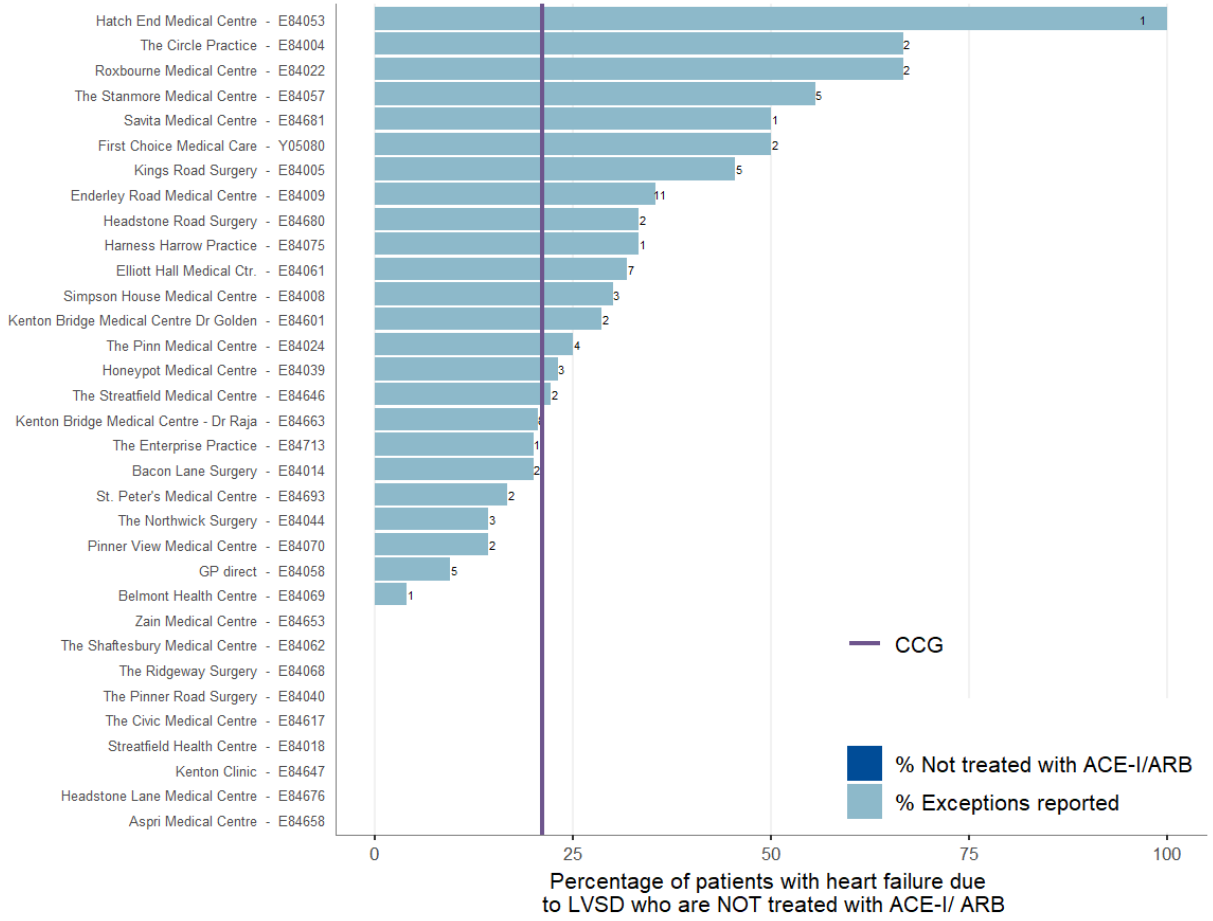
Percentage of patients with heart failure due to left ventricular systolic dysfunction (LVSD) who are treated with ACE-I/ ARB, by similar CCGs



Note: Using QOF clinical indicator HF003 denominator plus exceptions

Public Health England

Percentage of patients with heart failure due to left ventricular systolic dysfunction (LVSD) who are NOT treated with ACE-I / ARB, by general practice



In total, including excepted cases, there are 77 people who are NOT treated with ACE-I or ARB

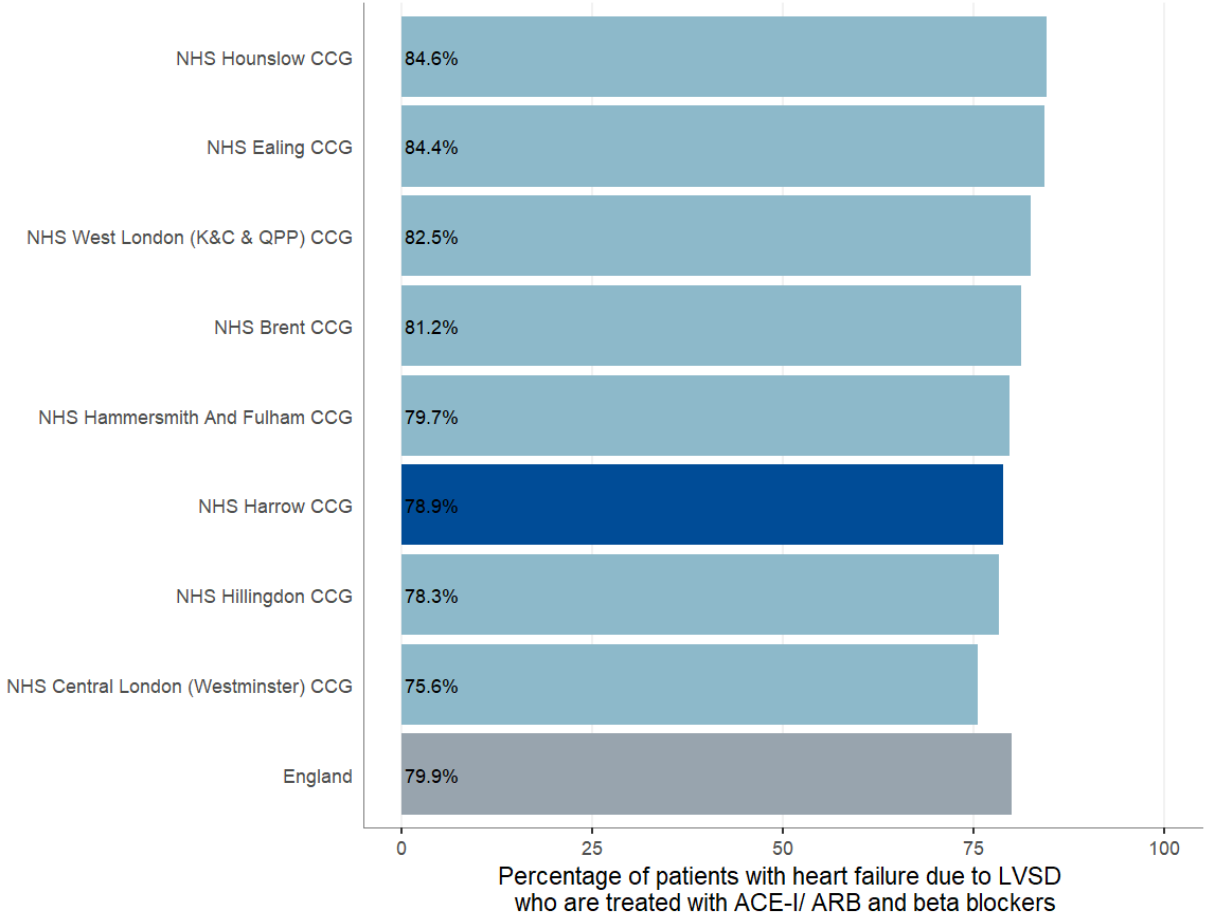
The range of the percentage of patients with heart failure due to LVSD who are NOT treated with ACE-I or ARB across GPs in NHS Harrow CCG is 0.0% to 100.0%

The data labels on the chart refer to the total count of people who are not treated with ACE-I or ARB, including excepted cases, by general practice

Note: Using QOF clinical indicator HF003 denominator plus exceptions

Public Health England

Percentage of patients with heart failure due to left ventricular systolic dysfunction (LVSD) who are treated with ACE-I/ ARB and BB, by CCGs in the STP



289 people with heart failure with LVSD are treated with ACE-I/ARB in NHS Harrow CCG

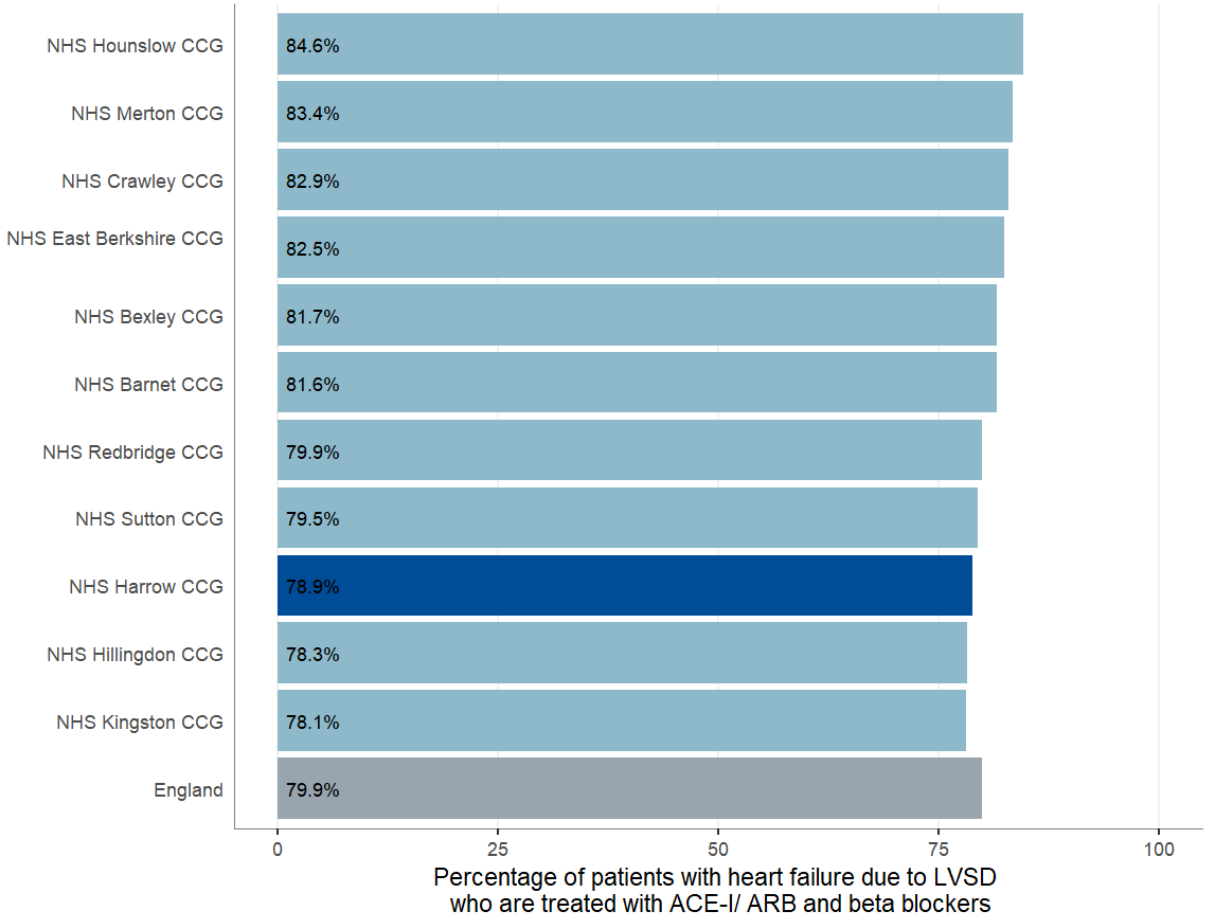
Of these, 228 (78.9%) people are additionally treated with a beta blocker (BB)

61 (21.1%) people (including excepted cases) are NOT additionally treated with BB

Note: Using QOF clinical indicator HF004 denominator plus exceptions

Public Health England

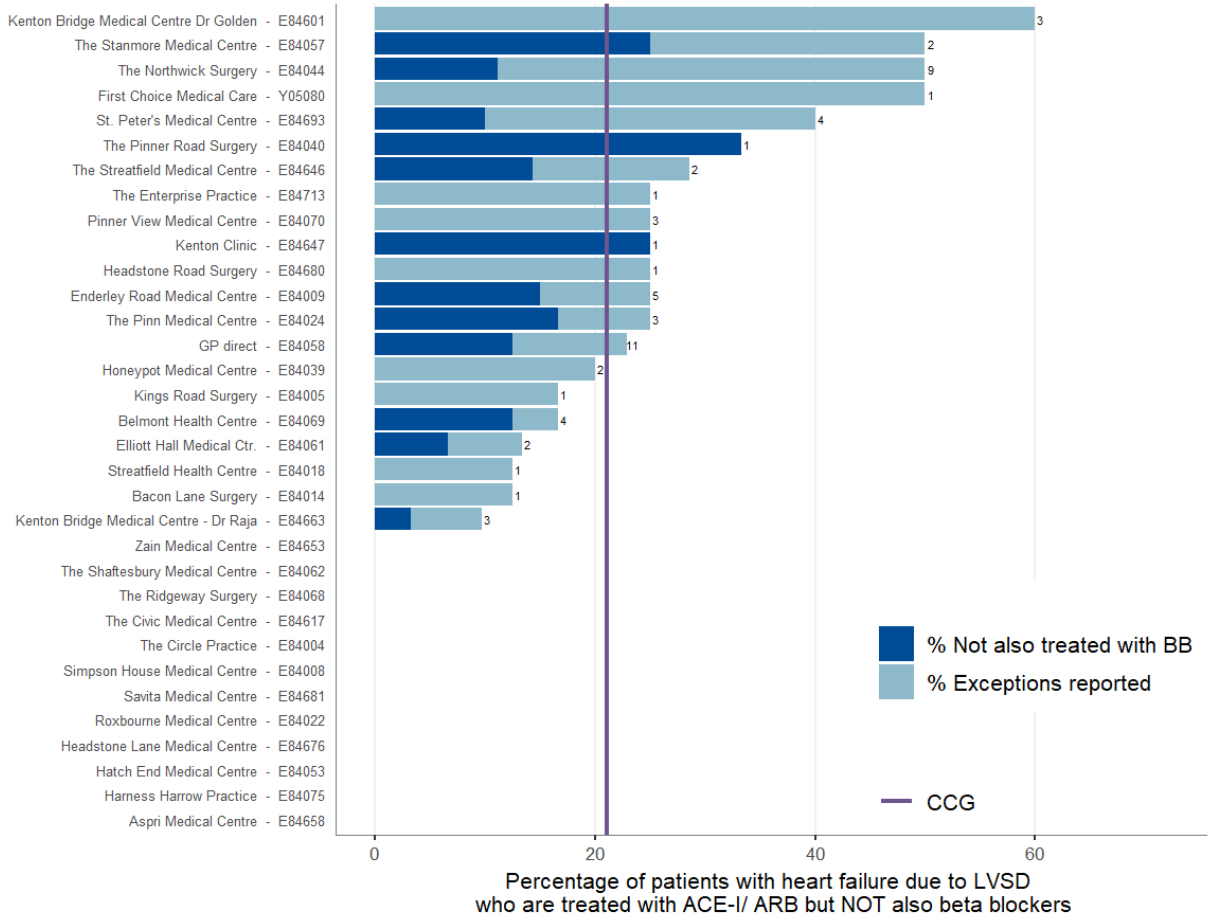
Percentage of patients with heart failure due to left ventricular systolic dysfunction (LVSD) who are treated with ACE-I/ ARB and BB, by similar CCGs



Note: Using QOF clinical indicator HF004 denominator plus exceptions

Public Health England

Percentage of patients with heart failure due to left ventricular systolic dysfunction (LVSD) who are treated with ACE-I or ARB, but NOT also with a BB, by general practice



In total, including excepted cases, there are 61 people with heart failure due to LVSD who are treated with ACE-I or ARB, but NOT additionally with a BB

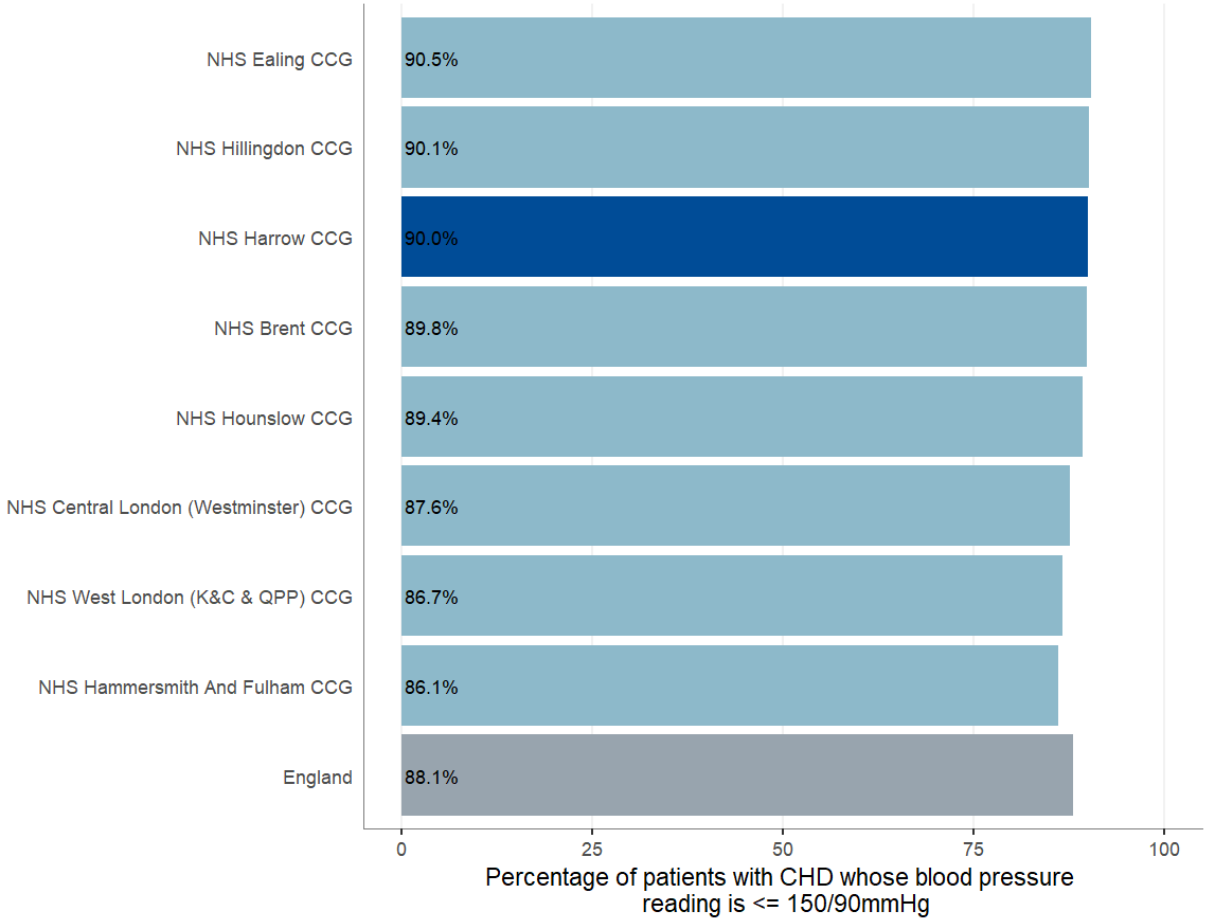
The range of the percentage of patients with heart failure due to LVSD who are treated with ACE-I/ARB but NOT also a BB across GPs in NHS Harrow CCG is 0.0% to 60.0%

The data labels on the chart refer to the total count of people with heart failure due to LVSD who are treated with ACE-I or ARB, but not also with a BB, including excepted cases, by general practice

Note: Using QOF clinical indicator HF004 denominator plus exceptions

Public Health England

Percentage of patients with CHD whose blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less, by CCGs in the STP



There are 7,302 people with coronary heart disease in NHS Harrow CCG

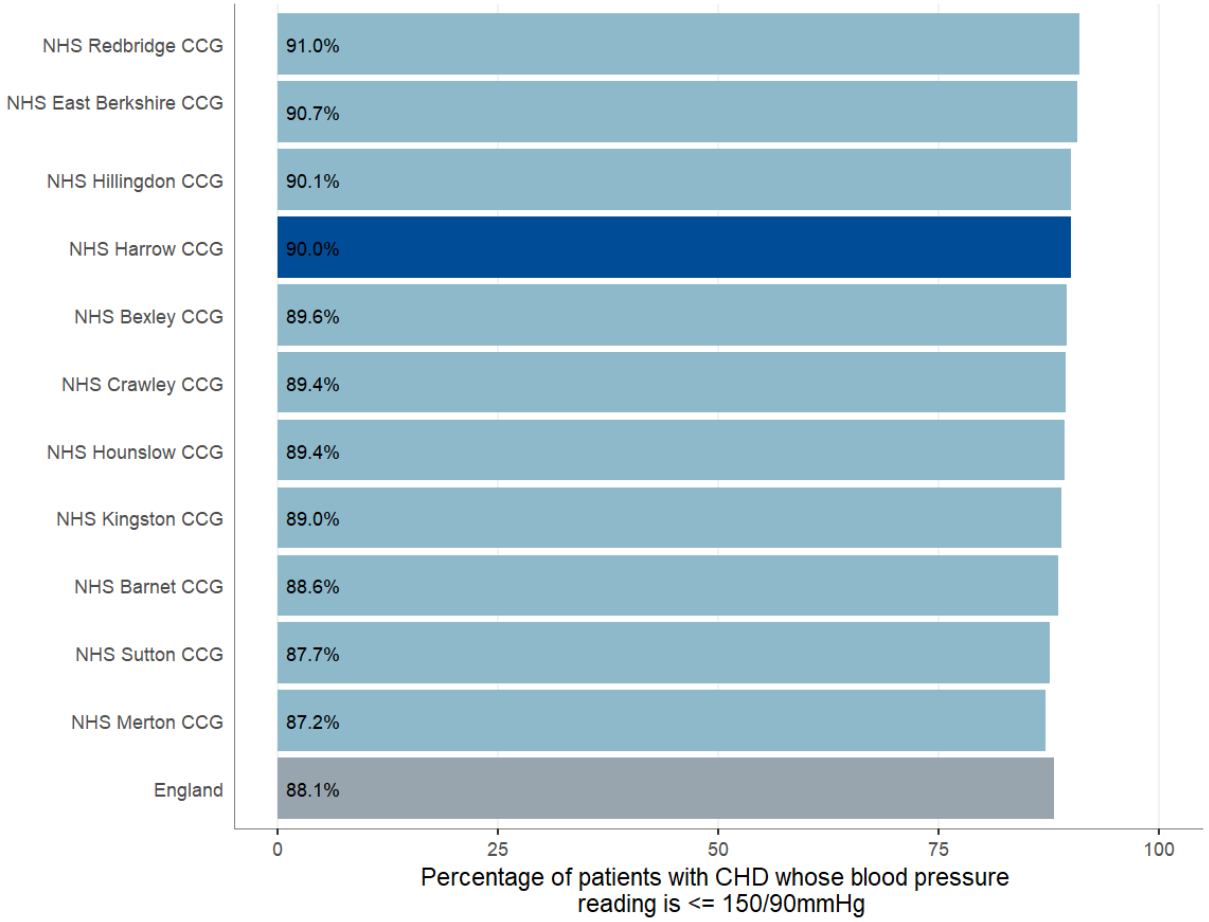
Of these, 6,573 (90.0%) people have blood pressure <= 150/90

729 (10.0%) people (including excepted cases) have blood pressure that is NOT <= 150/90

Note: Using QOF clinical indicator CHD002 denominator plus exceptions

Public Health England

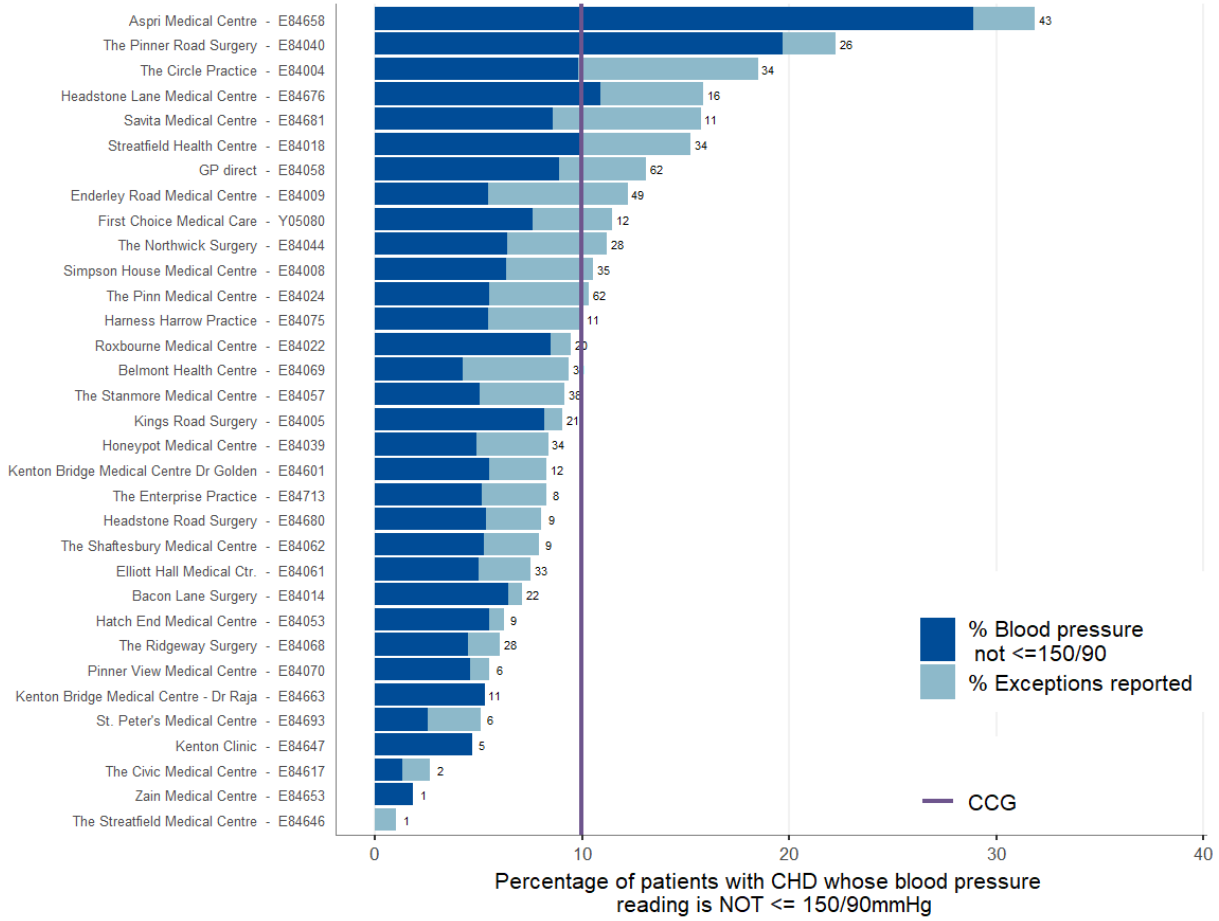
Percentage of patients with CHD whose blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less, by similar CCGs



Note: Using QOF clinical indicator CHD002 denominator plus exceptions

Public Health England

Percentage of patients with CHD whose blood pressure reading (measured in the preceding 12 months) is NOT 150/90 mmHg or less, by general practice



In total, including excepted cases, there are 729 people whose blood pressure is NOT <= 150/90

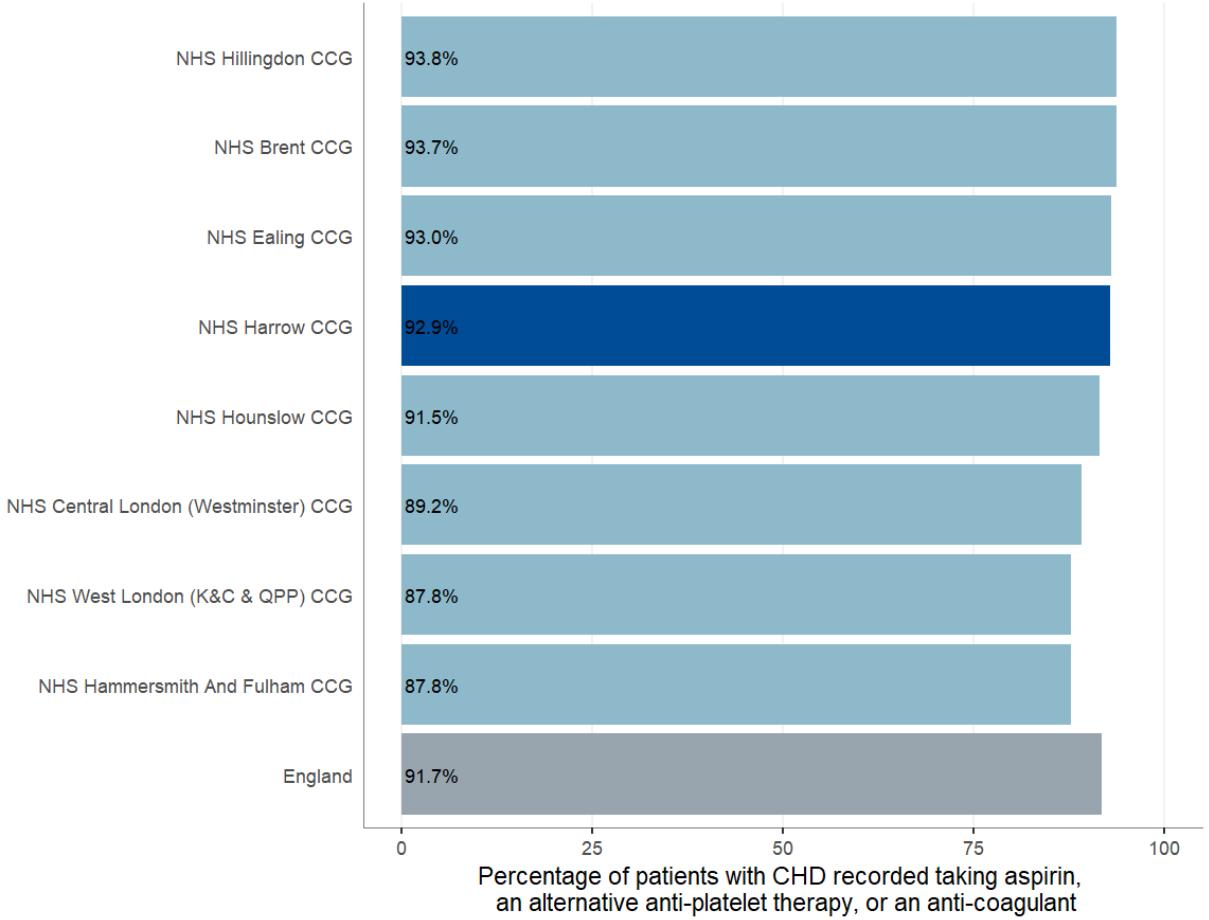
The range of the percentage of patients with CHD whose blood pressure reading is NOT <= 150/90 across GPs in NHS Harrow CCG is 1.0% to 31.9%

The data labels on the chart refer to the total count of people whose blood pressure is not <=150/90, including excepted cases, by general practice

Note: Using QOF clinical indicator CHD002 denominator plus exceptions

Public Health England

Percentage of patients with CHD with a record in the preceding 12 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken, by CCGs in the STP



There are 7,302 people with coronary heart disease in NHS Harrow CCG

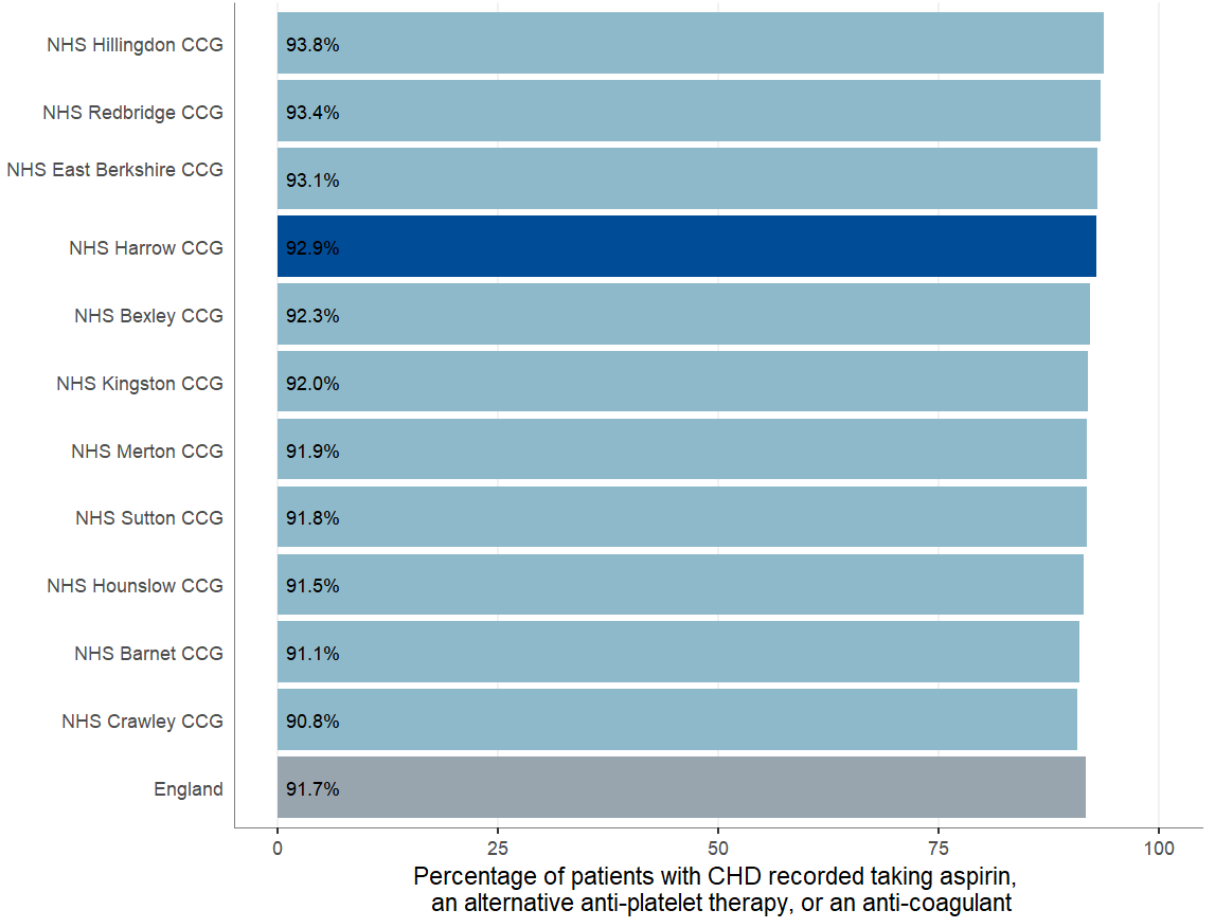
Of these, 6,787 (92.9%) people are recorded as taking aspirin, an alternative anti-platelet therapy or an anticoagulant

515 (7.1%) people (including excepted cases) are NOT recorded as taking aspirin, an alternative anti-platelet therapy, or an anti-coagulant

Note: Using QOF clinical indicator CHD005 denominator plus exceptions

Public Health England

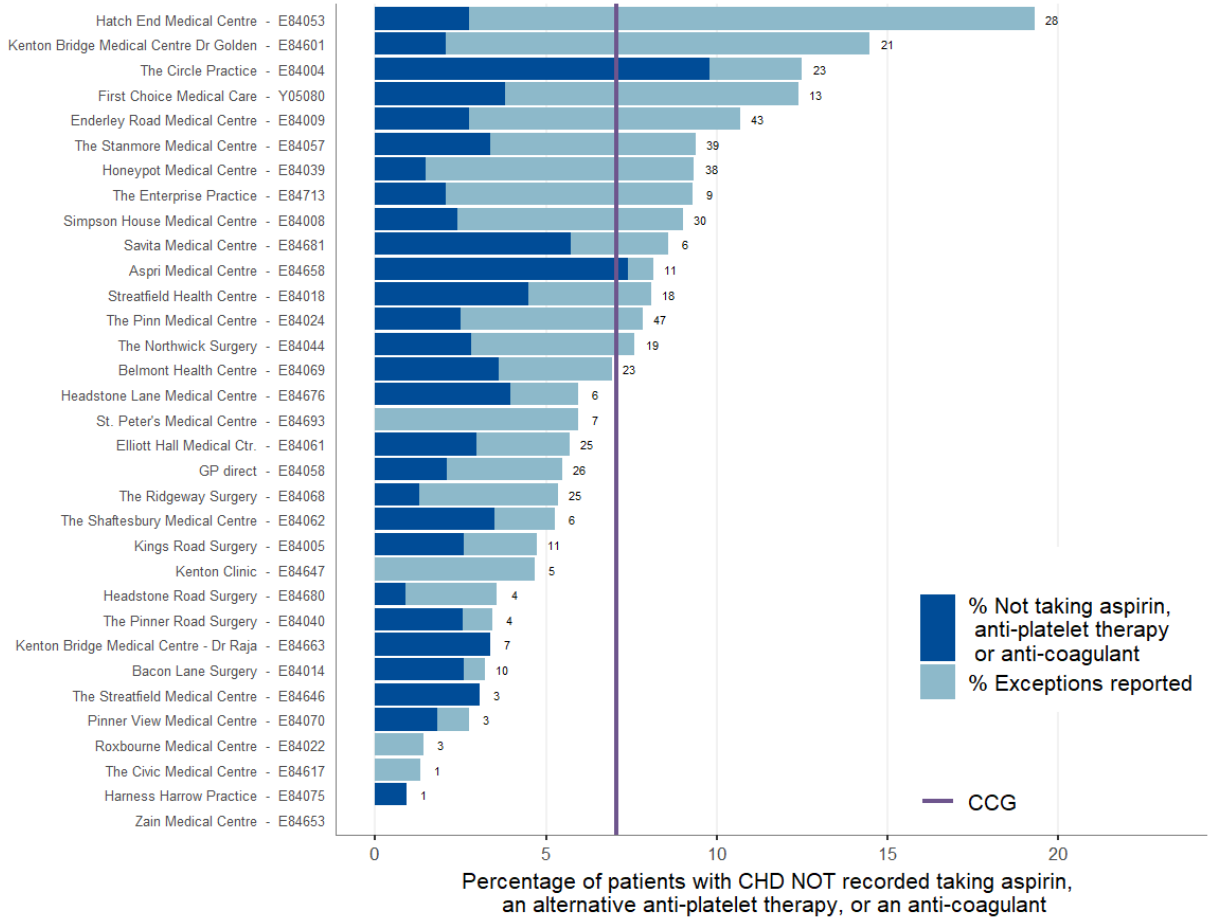
Percentage of patients with CHD with a record in the preceding 12 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken, by similar CCGs



Note: Using QOF clinical indicator CHD005 denominator plus exceptions

Public Health England

Percentage of patients with CHD without a record in the preceding 12 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken, by general practice



In total, including excepted cases, there are 515 people NOT recorded as taking aspirin, an alternative anti-platelet therapy, or an anti-coagulant

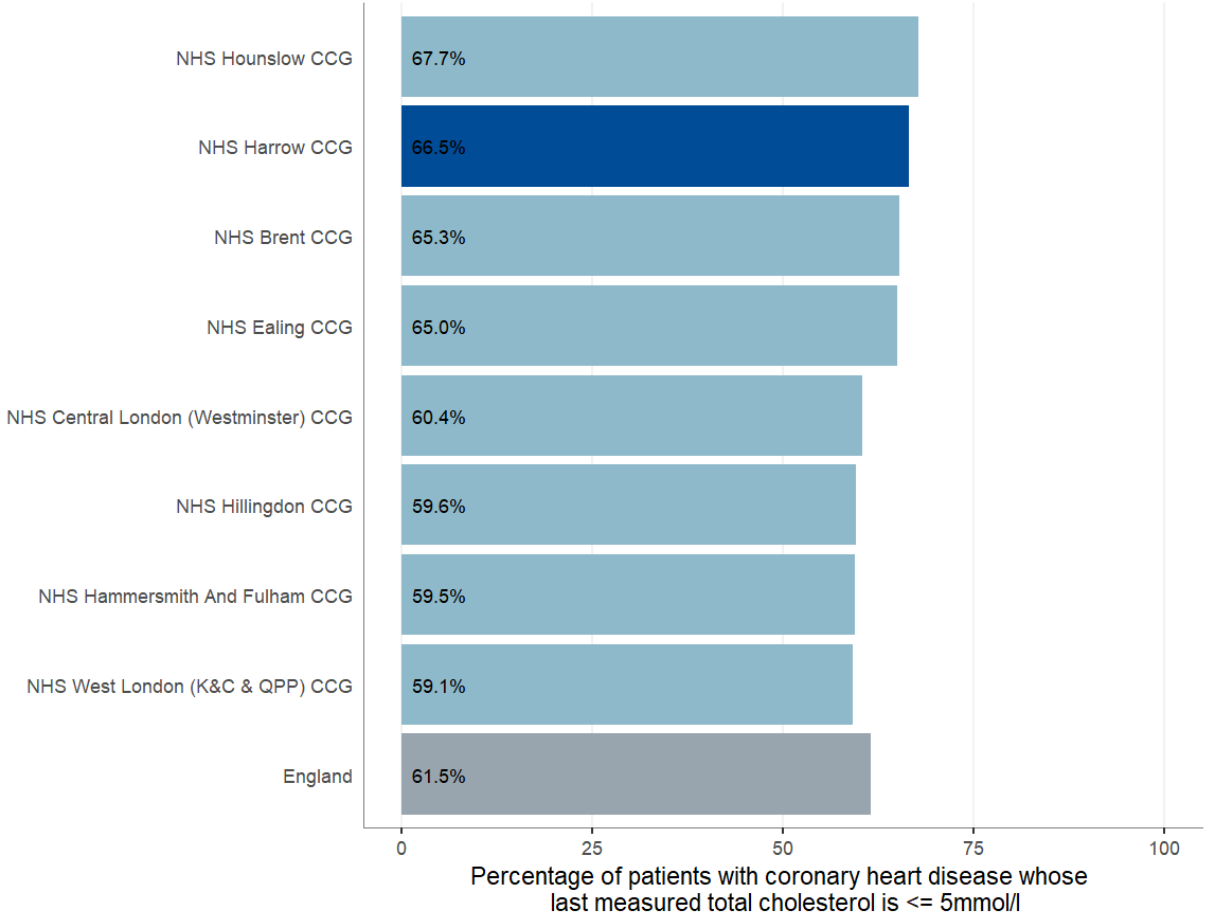
The range of the percentage of patients with CHD NOT recorded taking aspirin, an alternative anti-platelet therapy, or an anti-coagulant across GPs in NHS Harrow CCG is 0.0% to 19.3%

The data labels on the chart refer to the total count of people who are not recorded as taking aspirin, an alternative anti-platelet therapy, or an anti-coagulant, including excepted cases, by general practice

Note: Using QOF clinical indicator CHD005 denominator plus exceptions

Public Health England

Percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the preceding 12 months) is 5mmol/l or less, by CCGs in the STP including only practices returning INLIQ* data



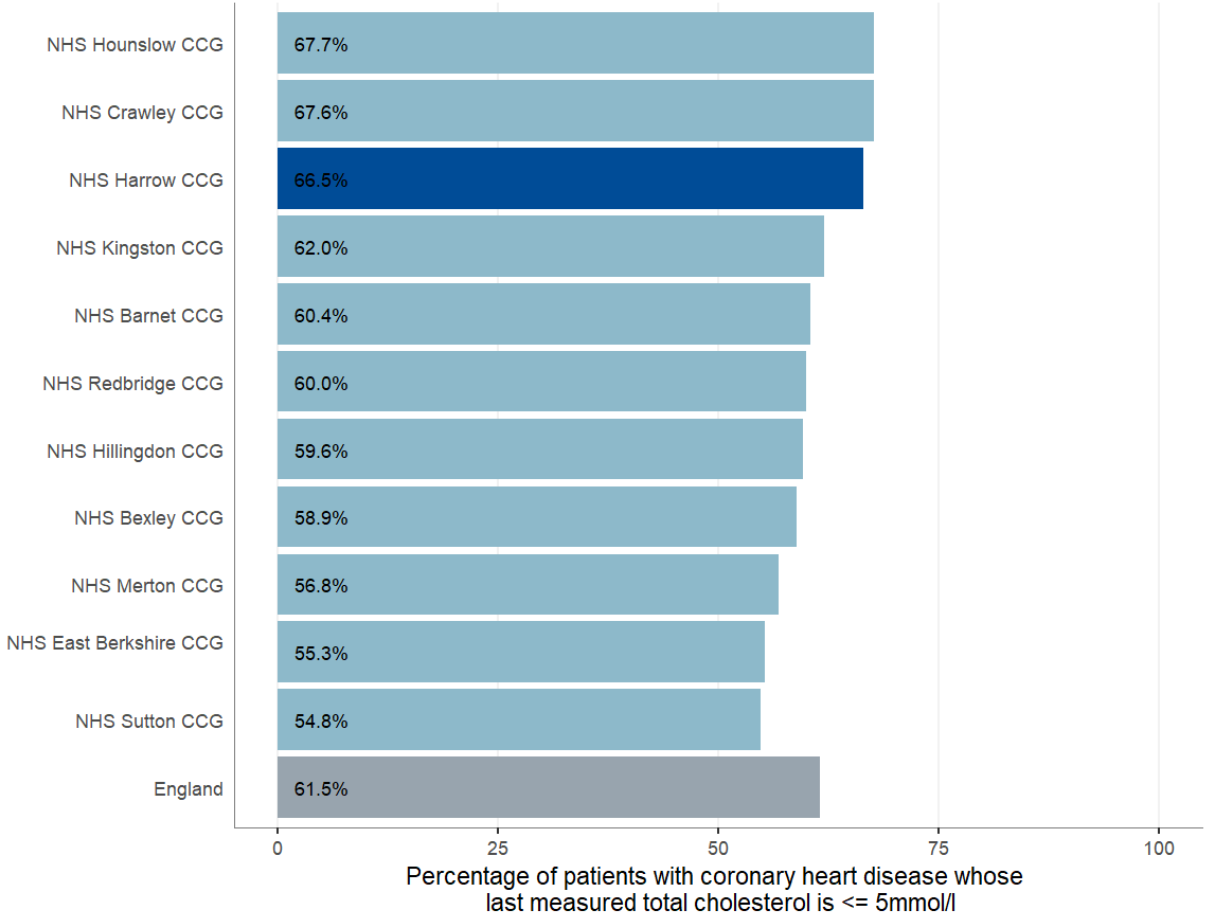
The population coverage of INLIQ in NHS Harrow CCG is 98.5%

Of those practices participating in INLIQ, the percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the preceding 12 months) is <= 5mmol/l is 66.5%

*Note: This information comes from the NHS Digital Indicators No Longer In QOF (INLIQ) Clinical Indicator CHD003.
Treatment data for CCGs where the population coverage is less than 60% are not displayed.
Treatment figures are calculated using the exceptions in the denominator. For more information about this data please see appendix

Public Health England

Percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the preceding 12 months) is 5mmol/l or less, by similar CCGs including only practices returning INLIQ* data



The population coverage of INLIQ in NHS Harrow CCG is 98.5%

Of those practices participating in INLIQ, the percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the preceding 12 months) is <= 5mmol/l is 66.5%

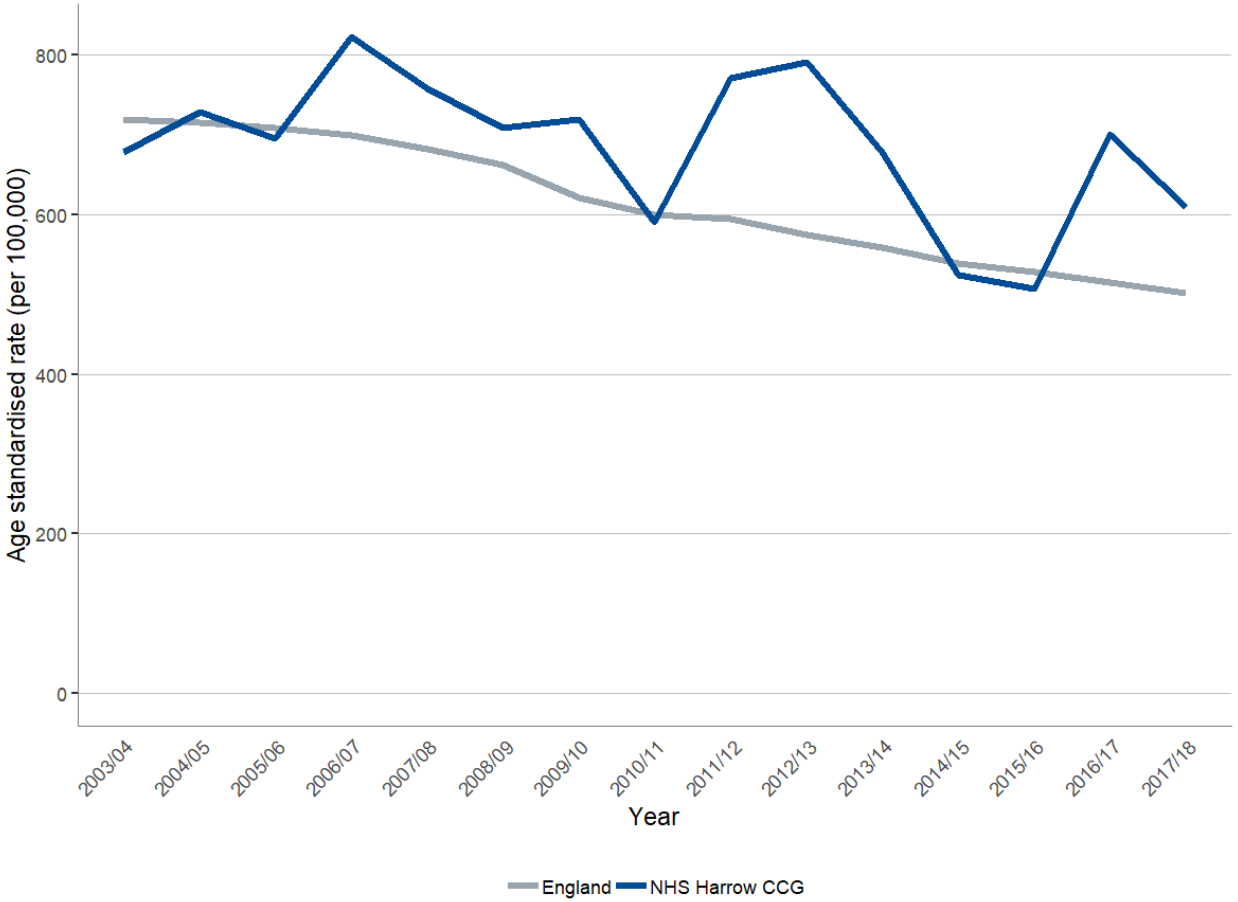
*Note: This information comes from the NHS Digital Indicators No Longer In QOF (INLIQ) Clinical Indicator CHD003.
Treatment data for CCGs where the population coverage is less than 60% are not displayed.
Treatment figures are calculated using the exceptions in the denominator. For more information about this data please see appendix

Public Health England

Cardiovascular disease outcomes

Public Health England

Hospital admissions for coronary heart disease for all ages

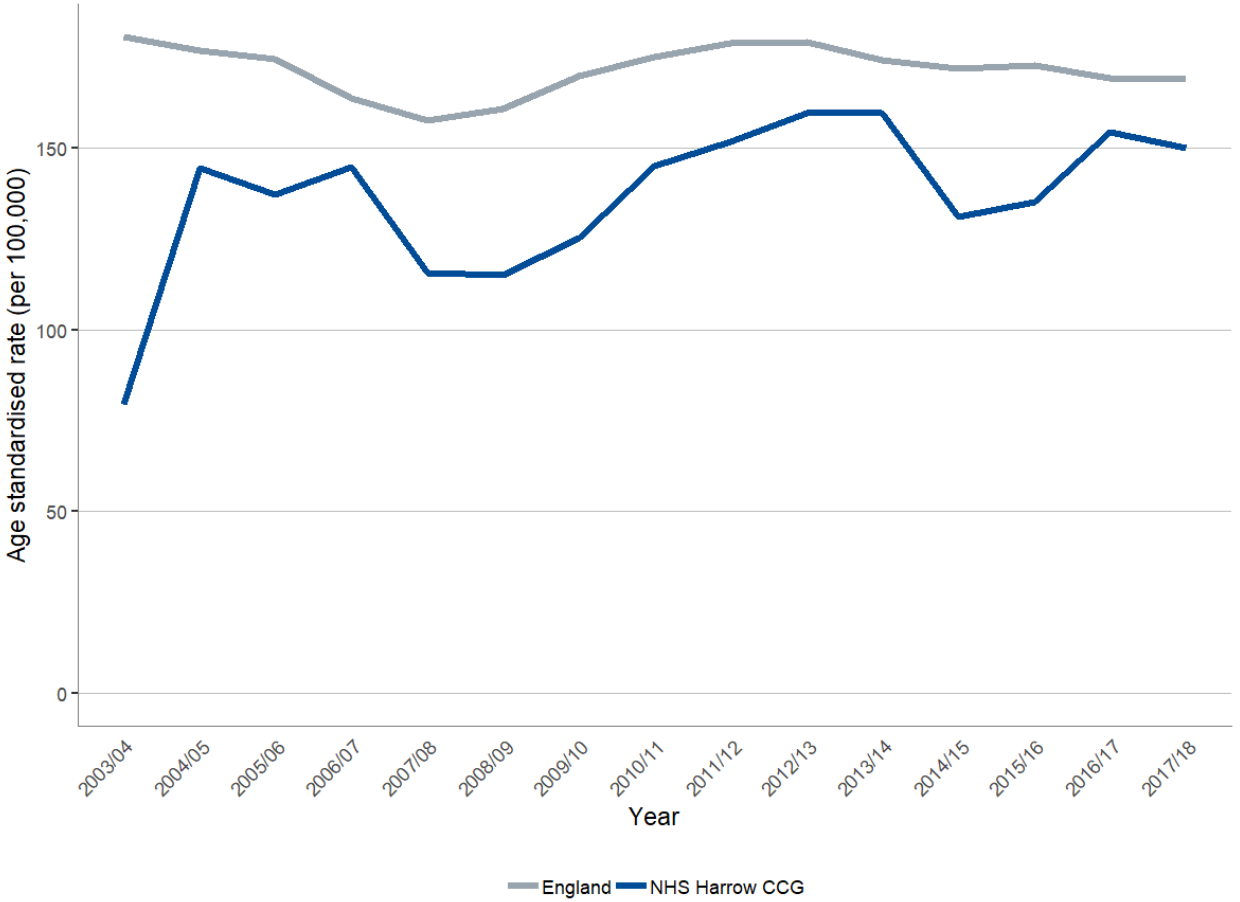


In NHS Harrow CCG, the hospital admission rate for coronary heart disease in 2017/18 was 608.8 per 100,000 population (1,270 admissions), compared with 502.3 for England

Source: Hospital Episode Statistics (HES), 2003/04 to 2017/18, Copyright ©, 2019 Re-used with the permission of NHS Digital. All rights reserved

Public Health England

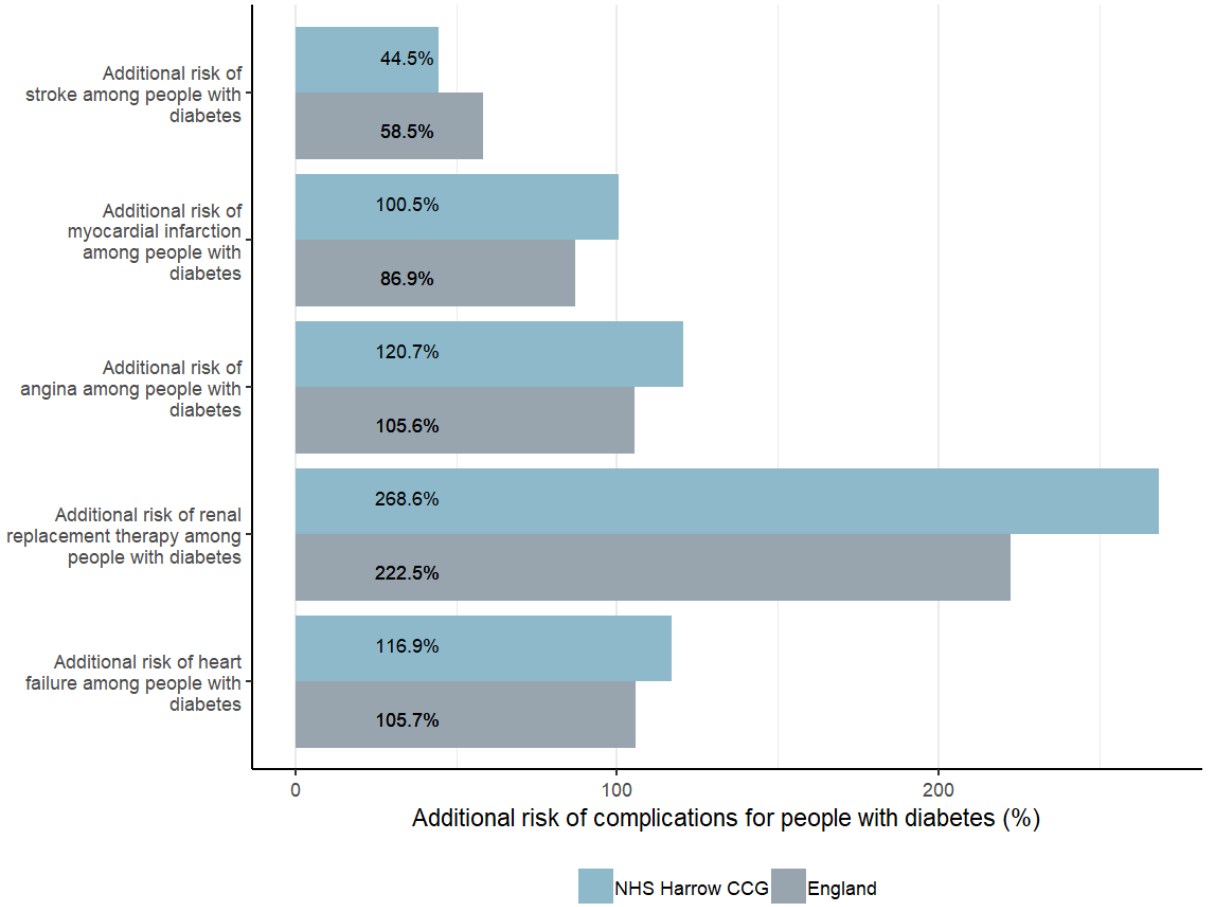
Hospital admissions for stroke for all ages



In NHS Harrow CCG, the hospital admission rate for stroke in 2017/18 was 150.0 per 100,000 population (316 admissions), compared with 169.0 for England

Public Health England

Additional risk of complications for people with diabetes, one-year follow up



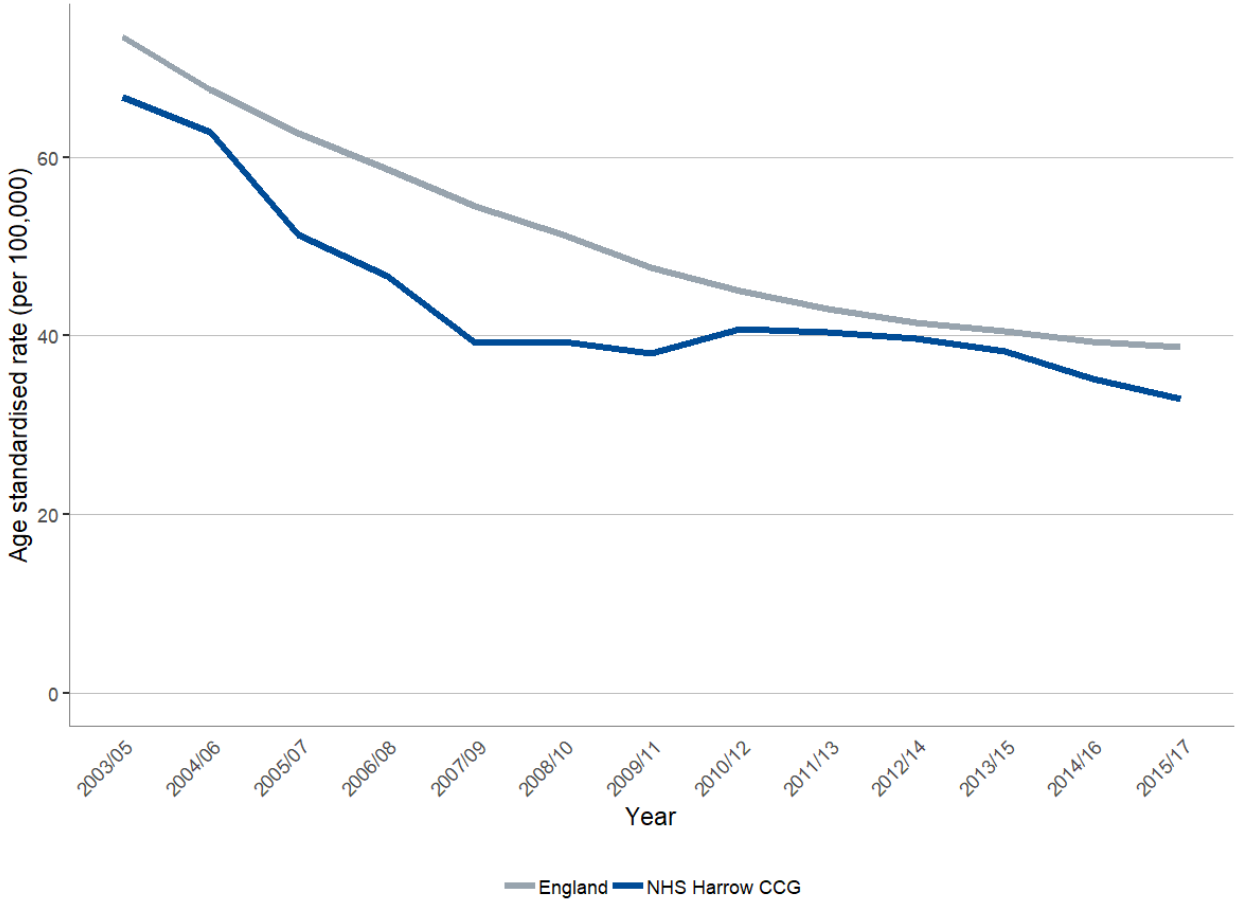
For people with diabetes in NHS Harrow CCG:

- The additional risk of a stroke was 44.5% higher
- The additional risk of a myocardial infarction was 100.5% higher
- The additional risk of angina was 120.7% higher
- The additional risk of renal replacement therapy was 268.6% higher
- The additional risk of heart failure was 116.9% higher

Note: This slide uses data from the National Diabetes Audit (NDA)

Public Health England

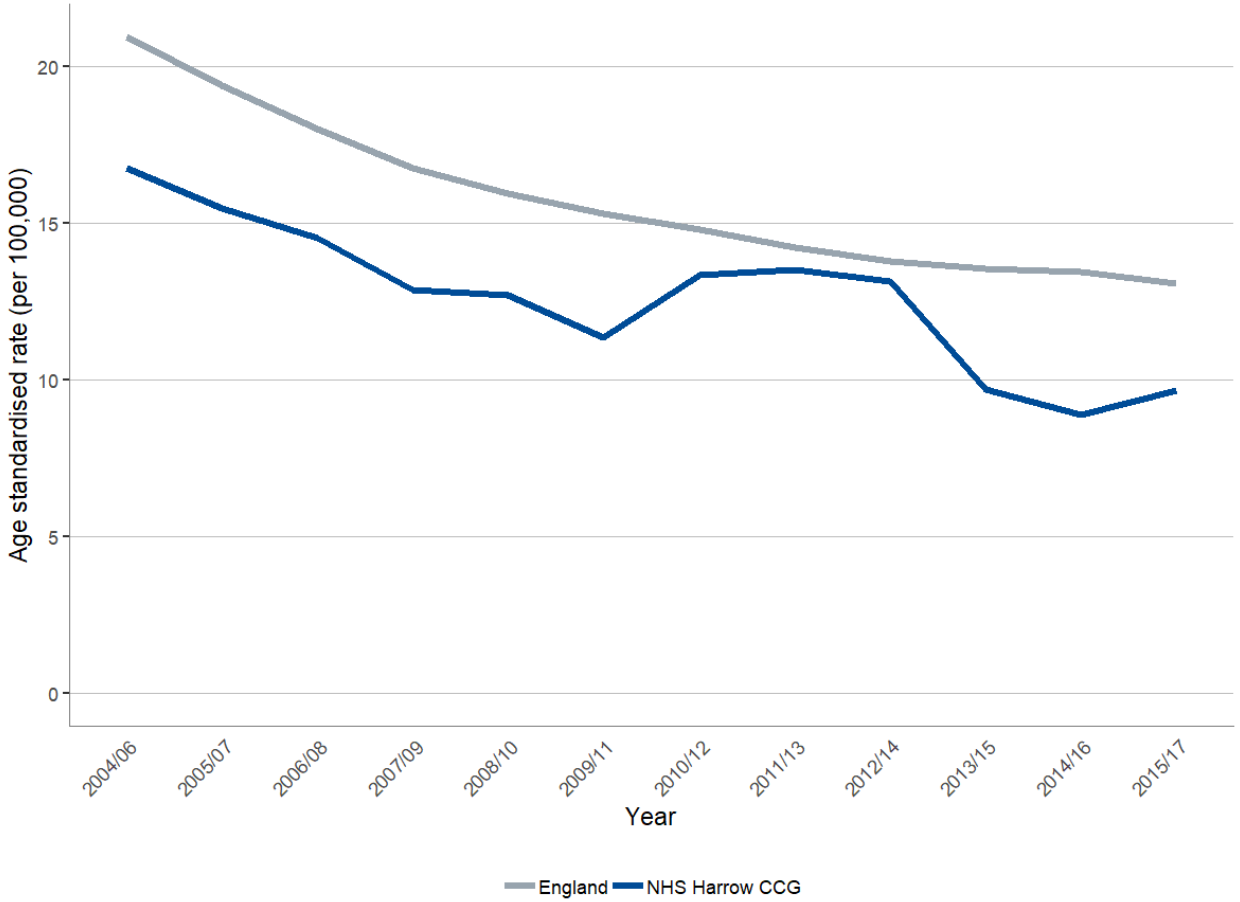
Deaths from coronary heart disease, under 75s



In NHS Harrow CCG, the early mortality rate for coronary heart disease during 2015-2017 was 32.9 per 100,000 population, compared with 38.7 for England

Public Health England

Deaths from stroke, under 75s



In NHS Harrow CCG, the early mortality rate for stroke during 2015-2017 was 9.68 per 100,000 population, compared with 13.0 for England

Source: Office for National Statistics (ONS) mortality data, 2003/05 to 2015/17, © Crown copyright, 2019 Re-used with the permission of the Office for National Statistics. All rights reserved

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Appendix - INLIQ data

Indicators no longer in QOF:

Since 2014/15 several CVD related indicators have been removed from the Quality and Outcomes Framework. The indicators are referred to as indicators no longer in QOF (INLIQ). Despite no longer being included in the QOF, NHS Digital collect and publish data on the coverage and treatment levels for these indicators. The GP contract 2017/18 has recommended the continuation of this INLIQ data collection, and practices are contractually required from 2017 to allow collection of data for a selection of activity no longer incentivised through QOF.

Despite these treatment measures no longer being incentivised in QOF, the Department of Health and Social Care, Public Health England and other healthcare groups have indicated that the information linked to these indicators is essential for their work and wider healthcare programmes. The indicators in this pack are HYP003, STIA004, STIA005, CHD003, CKD002 and CKD003/(NM84).

The INLIQ data collection is classified as an experimental statistic. This means that the data are in a testing phase and are not yet fully developed. There are differences in the data collection for the INLIQ indicators which make comparison with previous years QOF treatment outcomes data invalid. Not all practices currently submit INLIQ information; the approximate coverage (the proportion of people served by a practice that submits INLIQ information) is 81% of the population and 78.4% of practices. This population coverage varies at CCG level.

In this pack we have reported the treatment measures only in CCGs with population coverage of 60% or more and the information for the CCGs with lower coverage is not displayed. The 60% level has been selected as an arbitrary figure, as there is no precedent to show if this level is either high enough to guarantee that the INLIQ subset represent the CCG as a whole, or conversely whether coverage figures lower than 60% are sufficient to represent the CCG as a whole. Therefore to aid interpretation of the data we have presented the coverage figures for each CCG and it is important to bear this coverage figure in mind when interpreting local figures. Please contact the NCVIN for further details.

The original source for this data is NHS digital and available from:
https://digital.nhs.uk/data-and-information/publications/statistical/gp-contract-services

To be consistent with current PHE QOF reporting practice, when calculating INLIQ treatment figures, people excepted from the INLIQ indicator are included in the population denominator. In the original NHS Digital published data on the link above, for some indicators the exceptions also included those not eligible for the interventions by virtue of their age or the characteristics of the disease (exclusions). In this pack this affects indicators STIA005 and CKD003.

Public Health England

Appendix - Data sources

Figures and information throughout the intelligence pack are sourced from the following references:

- Quality and Outcomes Framework (QOF), 2017/18, © Crown copyright, 2019, Re-used with the permission of NHS Digital. All rights reserved
- Non-diabetic hyperglycaemia prevalence estimates, NCVIN, PHE:
  https://www.gov.uk/government/publications/nhs-diabetesprevention-programme-non-diabetic-hyperglycaemia
- Diabetes prevalence estimates, NCVIN, PHE:
  https://www.gov.uk/government/publications/diabetes-prevalence-estimates-forlocal-populations
- CKD Prevalence model, G.Aitken, University of Southampton , 2014:
  https://www.gov.uk/government/publications/ckdprevalence-estimates-for-local-and-regional-populations
- NHS Stop smoking services, © Crown copyright, 2019, Re-used with the permission of NHS Digital. All rights reserved
- Norberg J, Backstrom S , Jansson J-H, Johansson L. Estimating the prevalence of atrial fibrillation in a general population using validated electronic health data. Clin Epidemiol 2013 ; 5 475 - 481
- Hex N, Bartlett C, Wright D, Taylor M, Varley D. Estimating the current and future costs of type 1 and type 2 diabetes in the UK, including direct health costs and indirect societal and productivity costs. Diabet Med 2012 ; 29 855 - 862
- National Diabetes Audit, 2017/18, © Crown copyright, 2019, Re-used with the permission of NHS Digital. All rights reserved
- Hospital Episode Statistics (HES), 2003/04 to 2017/18, Copyright ©, 2019 Re-used with the permission of NHS Digital. All rights reserved
- Office for National Statistics (ONS) mortality data, 2003/05 to 2015/17, © Crown copyright, 2019 Re-used with the permission of the Office for National Statistics. All rights reserved

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