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Introduction
This CVD Intelligence Pack has been compiled by the National Cardiovascular Intelligence Network in collaboration with GPs and nurses in primary care.

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From Data to Intelligence to Action
Why and How to use this CVD Intelligence Pack

Every year in England there are around 150,000 premature deaths. A quarter of premature deaths are due to cardiovascular disease. Two thirds of premature deaths could be avoided through improved prevention, earlier detection and better treatment. High quality primary care is crucial for improving outcomes in CVD because primary care is where much prevention and most diagnosis and treatment is delivered.

This cardiovascular intelligence 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 CCGs and between practices.

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

The intelligence pack has several sections – CVD prevention and hypertension, stroke and AF, diabetes, kidney and 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 comparison 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, use of audit tools to get a better understanding of the gaps in care and outcomes, agreeing local protocols and consensus approaches, assessing training and education needs, and exploring new ways of delivering care.
Data and methods

This slide pack compares the clinical commissioning group (CCG) with CCGs in its strategic clinical network (SCN) and England. Where a CCG is in more than one SCN, it has been allocated to the SCN with the greatest geographical or population coverage. The slide pack also compares the CCG to its 10 most similar CCGs in terms of demography, ethnicity and deprivation. For information on the methodology used to calculate the 10 most similar CCGs please go to: http://www.england.nhs.uk/resources/resources-for-ccgs/comm-for-value/

The 10 most similar CCGs to NHS Eastbourne, Hailsham and Seaford CCG are:
NHS Fylde & Wyre CCG
NHS Lincolnshire East CCG
NHS Isle of Wight CCG
NHS South Devon and Torbay CCG
NHS West Norfolk CCG
NHS Great Yarmouth and Waveney CCG
NHS North Norfolk CCG
NHS North Derbyshire CCG
NHS Wyre Forest CCG
NHS North Staffordshire CCG

The majority of data used in the packs are taken from the 2013/14 Quality and Outcomes Framework (QOF). Where this is not the case, this is indicated in the slide. All GP practices that were included in the 2013/14 QOF are included. Full source data are shown in the appendix.

For the majority of indicators, the additional number of people that would be treated if all practices were to achieve as well as the average of the top achieving practices is calculated. This is calculated by taking an average of the intervention rates (i.e. the denominator includes exceptions) for the best 50% of practices in the CCG and applying this rate to all practices in the CCG. Note, this number is not intended to be proof of a realisable improvement; rather it gives an indication of the magnitude of available opportunity.
Benchmarking is helpful because it highlights variation. Of course it has long been acknowledged that some variation is inevitable in the healthcare and outcomes experienced by patients.

However, 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 ie it cannot be explained on the basis of illness, medical evidence, or patient preference and is accounted for by the willingness and ability of doctors to offer treatment.

"Much variation is unwarranted – it cannot be explained on the basis of illness, medical evidence, or patient preference”

A key observation about benchmarking data is that it 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 – we will not know unless we investigate.

The strength of benchmarking 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, exception reporting 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?

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.
CVD Prevention and Hypertension
“The NHS needs a radical upgrade in prevention if it is to be sustainable”
5 year Forward View 2014

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

The WHO Global Burden of Disease Study (next slide) shows us that the leading causes of premature mortality are tobacco, raised blood pressure, obesity, physical inactivity and poor diet. The radical upgrade in prevention needs population-level approaches. But it also needs ongoing behaviour change support and medical treatment for individuals during their repeated contacts with primary care.

What questions should 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 or below average to perform as well as the best in:
   - Identifying people who are obese, inactive or smokers
   - Identifying and managing high CVD risk
   - Identifying and managing high blood pressure
   - Identifying and managing pre-diabetes
4. What is the quality of brief interventions we offer our patients?
5. How available are preventive services such as weight management and smoking cessation?

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 hypertension, CKD, diabetes and pre-diabetes. Modelling suggests that 75% uptake will lead to substantial reductions in premature mortality.

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

The size of the prevention problem
- 2/3 of people are obese or overweight
- 1/3 of people are physically inactive
- 20% of people smoke but this rises to over 50% in some communities
- 5 million people have undiagnosed and untreated hypertension
- 40% of people with diagnosed hypertension receive suboptimal treatment
- Only one in five people whose 10 year CVD risk exceeds 20% receive statins
Leading risk factors, percent of total YLLs, 2010
United Kingdom

Hypertension observed prevalence compared to expected prevalence by CCG

Comparison with CCGs in the SCN

- 0.58 ratio of observed to expected hypertension prevalence in NHS Eastbourne, Hailsham And Seaford CCG compared to 0.56 in England
- This suggests that 58% of people with hypertension have been diagnosed

Note: This slide compares the prevalence of hypertension recorded in QOF in 2013/14 to the expected prevalence of hypertension taken from the East of England Public Health Observatory modelled estimates produced in 2011. The model was developed using data from the 2003-2004 Health Surveys for England and takes into account age, sex, ethnicity, smoking status and deprivation.
Hypertension observed prevalence compared to expected prevalence by CCG

Comparison with demographically similar CCGs

NHS North Staffordshire CCG 0.61
NHS Wyre Forest CCG 0.60
NHS West Norfolk CCG 0.59
NHS Fylde & Wyre CCG 0.58
NHS North Derbyshire CCG 0.58
NHS Eastbourne, Hailsham and Seaford CCG 0.58
NHS Great Yarmouth and Waveney CCG 0.57
NHS Lincolnshire East CCG 0.57
NHS Isle of Wight CCG 0.56
NHS South Devon and Torbay CCG 0.55
NHS North Norfolk CCG 0.54
Hypertension observed prevalence compared to expected prevalence by GP practice

- It is estimated that there are 24,001 people with undiagnosed hypertension in NHS Eastbourne, Hailsham And Seaford CCG
- GP practice range of observed to expected hypertension prevalence: 0.32 to 0.72
Percentage of patients with hypertension whose last blood pressure reading (measured in the preceding 9 months) is 150/90 mmHg or less by CCG

Comparison with CCGs in the SCN

- 33,167 people with hypertension (diagnosed)* in NHS Eastbourne, Hailsham And Seaford CCG
- 26,053 (78.6%) people whose blood pressure is <= 150/90
- 2,421 (7.3%) people who are excepted from optimal control
- 4,693 (14.1%) additional people whose blood pressure is not <= 150/90

*Using QOF clinical indicator HYP002 denominator plus exceptions
Percentage of patients with hypertension whose last blood pressure reading (measured in the preceding 9 months) is 150/90 mmHg or less by CCG

Comparison with demographically similar CCGs

<table>
<thead>
<tr>
<th>CCG</th>
<th>Below 150/90</th>
<th>Not below 150/90</th>
<th>Exceptions reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Isle of Wight CCG</td>
<td>82.6%</td>
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<tr>
<td>NHS Fylde &amp; Wyre CCG</td>
<td>79.9%</td>
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<tr>
<td>NHS North Derbyshire CCG</td>
<td>79.1%</td>
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<tr>
<td>NHS North Norfolk CCG</td>
<td>78.8%</td>
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<tr>
<td>NHS Eastbourne, Hailsham and Seaford CCG</td>
<td>78.6%</td>
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<tr>
<td>NHS Wyre Forest CCG</td>
<td>78.3%</td>
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<tr>
<td>NHS West Norfolk CCG</td>
<td>78.3%</td>
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<tr>
<td>NHS Lincolnshire East CCG</td>
<td>77.7%</td>
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<tr>
<td>NHS Great Yarmouth and Waveney CCG</td>
<td>77.0%</td>
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<tr>
<td>NHS North Staffordshire CCG</td>
<td>77.0%</td>
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<tr>
<td>NHS South Devon and Torbay CCG</td>
<td>74.3%</td>
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</tbody>
</table>
Percentage of patients with hypertension whose last blood pressure reading (measured in the preceding 9 months) is not 150/90 mmHg or less by GP practice

- In total, including exceptions, there are 7,114 people whose blood pressure is not <= 150/90
- GP practice range: 13.1% to 36.7%
- If all practices were to achieve as well as the average of the best achieving practices, then an additional 1,856 people would have their hypertension controlled
New diagnosis of hypertension who have been given a CVD risk assessment whose CVD risk exceeds 20% and treated with statins by CCG

Comparison with CCGs in the SCN

<table>
<thead>
<tr>
<th>CCG</th>
<th>Treated</th>
<th>No treatment</th>
<th>Exceptions reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Swale CCG</td>
<td>72.8%</td>
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<tr>
<td>NHS Crawley CCG</td>
<td>71.0%</td>
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<tr>
<td>NHS Surrey Heath CCG</td>
<td>70.6%</td>
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<td></td>
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<tr>
<td>NHS Eastbourne, Hailsham and Seaford CCG</td>
<td>68.4%</td>
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<tr>
<td>NHS Surrey Downs CCG</td>
<td>67.3%</td>
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<tr>
<td>NHS Horsham and Mid Sussex CCG</td>
<td>65.3%</td>
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<tr>
<td>NHS Dartford, Graveshams and Swanley CCG</td>
<td>64.6%</td>
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<tr>
<td>NHS West Kent CCG</td>
<td>64.3%</td>
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<tr>
<td>NHS Medway CCG</td>
<td>62.4%</td>
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<tr>
<td>NHS Brighton and Hove CCG</td>
<td>61.9%</td>
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<td>NHS Thanet CCG</td>
<td>61.6%</td>
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<td>NHS South Kent Coast CCG</td>
<td>61.1%</td>
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<tr>
<td>NHS North West Surrey CCG</td>
<td>59.6%</td>
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<tr>
<td>NHS Coastal West Sussex CCG</td>
<td>58.2%</td>
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<td>NHS Ashford CCG</td>
<td>57.7%</td>
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<tr>
<td>NHS Guildford and Waverley CCG</td>
<td>57.6%</td>
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<tr>
<td>NHS Canterbury and Coastal CCG</td>
<td>51.4%</td>
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<tr>
<td>NHS East Surrey CCG</td>
<td>49.0%</td>
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<tr>
<td>NHS High Weald Lewes Havens CCG</td>
<td>44.6%</td>
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<tr>
<td>NHS Hastings and Rother CCG</td>
<td>43.0%</td>
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<tr>
<td>England</td>
<td>64.0%</td>
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</table>

- 152 people with a new diagnosis of hypertension with a CVD risk of 20% or higher in NHS Eastbourne, Hailsham And Seaford CCG
- 104 (68.4%) people who are currently treated with statins
- 43 (28.3%) people who are excepted from treatment with statins
- 5 (3.3%) additional people who are not currently treated with statins
New diagnosis of hypertension who have been given a CVD risk assessment whose CVD risk exceeds 20% and treated with statins by CCG

Comparison with demographically similar CCGs

- NHS Isle of Wight CCG: 68.5%
- NHS Eastbourne, Hailsham and Seaford CCG: 68.4%
- NHS Lincolnshire East CCG: 64.5%
- NHS South Devon and Torbay CCG: 64.1%
- NHS North Derbyshire CCG: 63.5%
- NHS West Norfolk CCG: 63.4%
- NHS Fylde & Wyre CCG: 60.9%
- NHS North Norfolk CCG: 58.8%
- NHS Wyre Forest CCG: 58.7%
- NHS Great Yarmouth and Waveney CCG: 54.1%
- NHS North Staffordshire CCG: 53.4%
New diagnosis of hypertension who have been given a CVD risk assessment whose CVD risk exceeds 20% and not treated with statins by GP practice

- In total, including exceptions, there are 48 people who are not currently treated with statins
- GP practice range: 0.0% to 100.0%
- If all practices were to achieve as well as the average of the best achieving practices, then an additional 30 people would be treated
Percentage of patients with a long term condition whose notes record smoking status in the preceding 12 months by CCG

Comparison with CCGs in the SCN

<table>
<thead>
<tr>
<th>CCG</th>
<th>Recorded</th>
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</thead>
<tbody>
<tr>
<td>NHS Canterbury and Coastal CCG</td>
<td>95.3%</td>
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<tr>
<td>NHS Swale CCG</td>
<td>95.2%</td>
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<tr>
<td>NHS Crawley CCG</td>
<td>95.1%</td>
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<tr>
<td>NHS Hastings and Rother CCG</td>
<td>94.9%</td>
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<tr>
<td>NHS East Surrey CCG</td>
<td>94.7%</td>
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<tr>
<td>NHS Dartford, Gravesham and Swanley CCG</td>
<td>94.4%</td>
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<tr>
<td>NHS Surrey Heath CCG</td>
<td>94.4%</td>
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<td>NHS Surrey Downs CCG</td>
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<td>NHS Horsham and Mid Sussex CCG</td>
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<td>NHS North West Surrey CCG</td>
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<td>NHS South Kent Coast CCG</td>
<td>94.0%</td>
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<td>NHS Guildford and Waverley CCG</td>
<td>93.8%</td>
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<td>NHS Thanet CCG</td>
<td>93.8%</td>
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<td>NHS Coastal West Sussex CCG</td>
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<td>NHS High Weald Lewes Havens CCG</td>
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<td>NHS West Kent CCG</td>
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<td>NHS Medway CCG</td>
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<tr>
<td>NHS Ashford CCG</td>
<td>93.3%</td>
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<tr>
<td>NHS Brighton and Hove CCG</td>
<td>93.0%</td>
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<tr>
<td>NHS Eastbourne, Hailsham and Seaford CCG</td>
<td>92.8%</td>
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<tr>
<td>England</td>
<td>94.6%</td>
</tr>
</tbody>
</table>

- 52,004 people with a long term condition in NHS Eastbourne, Hailsham And Seaford CCG
- 48,274 (92.8%) people whose notes record a smoking status
- 419 (0.8%) people who are excepted from smoking status recording
- 3,311 (6.4%) additional people whose notes do not record a smoking status
Percentage of patients with a long term condition whose notes record smoking status in the preceding 12 months by CCG

Comparison with demographically similar CCGs

<table>
<thead>
<tr>
<th>CCG</th>
<th>Recorded</th>
<th>No record</th>
<th>Exceptions reported</th>
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</thead>
<tbody>
<tr>
<td>NHS Fylde &amp; Wyre CCG</td>
<td>95.8%</td>
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<td>NHS North Derbyshire CCG</td>
<td>95.6%</td>
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<tr>
<td>NHS Isle of Wight CCG</td>
<td>95.1%</td>
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<td>NHS North Norfolk CCG</td>
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<td>NHS Wyre Forest CCG</td>
<td>94.0%</td>
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<td>NHS Great Yarmouth and Waveney CCG</td>
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<td>NHS Lincolnshire East CCG</td>
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<td>NHS Eastbourne, Hailsham and Seaford CCG</td>
<td>92.8%</td>
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<tr>
<td>NHS South Devon and Torbay CCG</td>
<td>91.8%</td>
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</table>
Percentage of patients with a long term condition whose notes do not record smoking status in the preceding 12 months by GP practice

- In total, including exceptions, there are 3,730 people whose notes do not record a smoking status
- GP practice range: 2.8% to 18.2%
- If all practices were to achieve as well as the average of the best achieving practices, then an additional 1,524 people would have their smoking status recorded
Percentage of patients with a long term condition who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 12 months by CCG

Comparison with CCGs in the SCN

- 6,869 people with a long term condition who are recorded as a smoker in NHS Eastbourne, Hailsham And Seaford CCG
- 6,519 (94.9%) people who have a record of an offer of support and treatment
- 70 (1%) people who are excepted from an offer of support and treatment
- 280 (4.1%) additional people who have no record of an offer of support and treatment
Percentage of patients with a long term condition who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 12 months by CCG

Comparison with demographically similar CCGs

<table>
<thead>
<tr>
<th>CCG</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>NHS Isle of Wight CCG</td>
<td>96.5%</td>
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<tr>
<td>NHS Wyre Forest CCG</td>
<td>95.7%</td>
</tr>
<tr>
<td>NHS Eastbourne, Hailsham and Seaford CCG</td>
<td>94.9%</td>
</tr>
<tr>
<td>NHS Fylde &amp; Wyre CCG</td>
<td>94.4%</td>
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<tr>
<td>NHS North Derbyshire CCG</td>
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<td>NHS West Norfolk CCG</td>
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<td>NHS North Norfolk CCG</td>
<td>89.8%</td>
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<td>NHS Great Yarmouth and Waveney CCG</td>
<td>88.4%</td>
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<td>NHS Lincolnshire East CCG</td>
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<td>NHS South Devon and Torbay CCG</td>
<td>86.5%</td>
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<tr>
<td>NHS North Staffordshire CCG</td>
<td>84.3%</td>
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</tbody>
</table>
Percentage of patients with a long term condition who are recorded as current smokers who do not have a record of an offer of support and treatment within the preceding 12 months by GP practice

- In total, including exceptions, there are 350 people who have no record of an offer of support and treatment
- GP practice range: 0.4% to 34.8 %
- If all practices were to achieve as well as the average of the best achieving practices, then an additional 234 people would have a record of an offer of support and treatment
Estimated smoking prevalence (QOF) by CCG

Comparison with demographically similar CCGs

- **Prevalence of 17.4% in NHS Eastbourne, Hailsham And Seaford CCG**

Note: It has been found that the proportion of patients recorded as smokers correlates well with IHS smoking prevalence and is a good estimate of the actual smoking prevalence in local areas, [http://bmjopen.bmj.com/content/4/7/e005217.abstract](http://bmjopen.bmj.com/content/4/7/e005217.abstract)

Definition: denominator of QOF clinical indicator SMOKE004 (number of patients 15+ who are recorded as current smokers) divided by QOF clinical indicator denominator of SMOK001 (estimated number of patients 15+).
Estimated smoking prevalence (QOF) by GP practice

- 27,743 people who are recorded as smokers in NHS Eastbourne, Hailsham And Seaford CCG
- GP practice range: 11.9% to 34.8%

Note: This method is thought to be a reasonably robust method in estimating smoking prevalence for the majority of GP practices. However, caution is advised for extreme estimates of smoking prevalence and those with high numbers of smoking status not recorded and exceptions.
Successful smoking quitters at 4 weeks, 2013/14

Comparison with CCGs in the SCN

- 45.2% successful smoking quitters at 4 weeks in NHS Eastbourne, Hailsham And Seaford CCG compared to 51.3% in England

Note: The local authority indicator, successful smoking quitters at 4 weeks from the Health and Social Care Information Centre, has been used as a basis for estimating CCG level smoking quitters. Where more than one local authority is contained within a CCG, the proportion of the local authority within the CCG has been allocated to the CCG and aggregated up to give CCG estimates.
Excess weight (overweight or obese) in adults, 2012

Comparison with CCGs in the SCN

- 65.0% of adults with excess weight in NHS Eastbourne, Hailsham And Seaford CCG compared to 63.8% in England

Note: Local authority prevalence estimates of excess weight from the Active People Survey, Sport England, have been used as a basis for estimating CCG level prevalence estimates of excess weight. Where more than one local authority is contained within a CCG, the proportion of the local authority within the CCG has been allocated to the CCG and aggregated up to give CCG estimates.
Percentage of inactive adults, 2013

Comparison with CCGs in the SCN

- 28.0% of adults who are inactive in NHS Eastbourne, Hailsham And Seaford CCG compared to 28.3% in England

Note: Local authority percentage estimates of inactive adults from the Active People Survey, Sport England, have been used as a basis for estimating CCG level percentage estimates of inactive adults. Where more than one local authority is contained within a CCG, the proportion of the local authority within the CCG has been allocated to the CCG and aggregated up to give CCG estimates.
**NHS Health Check offer and uptake, 2013/14**

**Comparison with CCGs in the SCN**

- **% of people offered an NHS Health check**
  - England: 18.4%
  - NHS Eastbourne, Hailsham And Seaford CCG: 17.3%
  - NHS Brighton and Hove CCG: 22.6%
  - NHS Medway CCG: 21.4%
  - NHS Asford CCG: 21.4%
  - NHS Canterbury and Coastal CCG: 21.4%
  - NHS Dartford, Gravesham and Swanley CCG: 21.4%
  - NHS South Kent Coast CCG: 21.4%
  - NHS Swale CCG: 21.4%
  - NHS Thanet CCG: 21.4%
  - NHS West Kent CCG: 21.4%

- **% of people received an NHS Health check of those offered**
  - England: 49.0%
  - NHS Eastbourne, Hailsham And Seaford CCG: 57.2%
  - NHS Brighton and Hove CCG: 60.3%
  - NHS Medway CCG: 50.3%
  - NHS Asford CCG: 44.6%
  - NHS Canterbury and Coastal CCG: 44.6%
  - NHS Dartford, Gravesham and Swanley CCG: 44.6%
  - NHS South Kent Coast CCG: 42.7%
  - NHS Swale CCG: 42.2%
  - NHS Thanet CCG: 42.2%
  - NHS West Kent CCG: 34.7%

Note: Local authority indicators NHS Health Check offer and uptake have been used as a basis for estimating CCG level NHS Health Check offer and uptake. Where more than one local authority is contained within a CCG, the proportion of the local authority within the CCG has been allocated to the CCG and aggregated up to give CCG estimates.

- 17.3% of people were offered an NHS Health Check in NHS Eastbourne, Hailsham And Seaford CCG compared to 18.4% in England
- 57.2% of people received an NHS Health Check of those offered in NHS Eastbourne, Hailsham And Seaford CCG compared to 49% in England
Stroke
It is estimated that if Atrial Fibrillation was adequately treated, around 7000 strokes would be prevented and 2100 lives saved every year.

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 about 6 fold, and strokes caused by AF are often more severe with higher mortality and greater disability. Anticoagulation substantially reduces the risk of stroke in people with AF. Despite this, AF is underdiagnosed and undertreated. Around 25-30% of people with AF are unaware they have the condition and less than a half of patients are adequately treated – many do not receive anticoagulants and of those who do, many are undertreated.

Only 30% of people with known AF admitted with stroke are on anticoagulant treatment at the time of their stroke.

What questions should 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 atrial fibrillation
   - Management of hypertension in people who have had a previous stroke or TIA
   - Anti-platelet or anti-coagulant treatment in people who have had a previous stroke or TIA

Secondary prevention of stroke
For people who have had a stroke anti-platelet treatment and good control of blood pressure are key to reducing the risk of a further stroke.

What might help
- Roll out of GRASP-AF to identify people with AF who are undertreated
- Promoting use of electronic templates with decision support tools – CHADS-VASC and HASBLED
- Roll out of Warfarin Patient Safety Audit Tool to ensure optimal time in therapeutic range for people on warfarin
- Dissemination of latest evidence on risk-benefit balance for anticoagulants including the newer treatments (NOACs)
- Ensure appropriate clinical follow up for individuals found to have an irregular pulse during the NHS Health Check
Atrial fibrillation observed prevalence compared to expected prevalence by CCG

Comparison with CCGs in the SCN

- 0.78 ratio of observed to expected atrial fibrillation prevalence in NHS Eastbourne, Hailsham And Seaford CCG compared to 0.65 in England
- This suggests that 78% of people with atrial fibrillation have been diagnosed

Note: This slide compares the prevalence of atrial fibrillation recorded in QOF in 2013/14 to the estimated prevalence of atrial fibrillation, taken from National Cardiovascular Intelligence Network estimates produced in 2015. The estimates were developed by applying age-sex specific prevalence rates as reported by Norberg et al (2013) to GP population estimates from the Health and Social Care Information Centre. Estimates reported are adjusted for age and sex of the local population.
Atrial fibrillation observed prevalence compared to expected prevalence by CCG

Comparison with demographically similar CCGs

<table>
<thead>
<tr>
<th>CCG</th>
<th>Ratio of Observed to Expected</th>
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<tbody>
<tr>
<td>NHS Eastbourne, Hailsham and Seaford CCG</td>
<td>0.78</td>
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<tr>
<td>NHS South Devon and Torbay CCG</td>
<td>0.74</td>
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<tr>
<td>NHS West Norfolk CCG</td>
<td>0.73</td>
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<tr>
<td>NHS North Derbyshire CCG</td>
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<tr>
<td>NHS North Staffordshire CCG</td>
<td>0.71</td>
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<tr>
<td>NHS North Norfolk CCG</td>
<td>0.69</td>
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<tr>
<td>NHS Lincolnshire East CCG</td>
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<td>NHS Wyre Forest CCG</td>
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<td>NHS Fylde &amp; Wyre CCG</td>
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<tr>
<td>NHS Great Yarmouth and Waveney CCG</td>
<td>0.63</td>
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<tr>
<td>NHS Isle of Wight CCG</td>
<td>0.60</td>
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</table>
It is estimated that there are 1,504 people with undiagnosed atrial fibrillation in NHS Eastbourne, Hailsham And Seaford CCG.

GP practice range of observed to expected atrial fibrillation prevalence: 0.31 to 1.07
In patients with AF with a CHADS$_2$ > 1, the percentage treated with anti-coagulation therapy by CCG

### Comparison with CCGs in the SCN

<table>
<thead>
<tr>
<th>CCG</th>
<th>Optimal management</th>
<th>No treatment</th>
<th>Exceptions reported</th>
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<tbody>
<tr>
<td>NHS Surrey Heath CCG</td>
<td>76.8%</td>
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<td>NHS Medway CCG</td>
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<td>NHS Guildford and Waverley CCG</td>
<td>74.4%</td>
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<td>NHS Surrey Downs CCG</td>
<td>73.5%</td>
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<td>NHS Dartford, Gravesham and Swanley CCG</td>
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<td>NHS Swale CCG</td>
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<td>NHS Hastings and Rother CCG</td>
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<td>NHS Eastbourne, Hailsham and Seaford CCG</td>
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<td>NHS Coastal West Sussex CCG</td>
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<td>NHS Horsham and Mid Sussex CCG</td>
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<td>NHS Brighton and Hove CCG</td>
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<tr>
<td>England</td>
<td>69.1%</td>
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</table>

- 3,154 people with atrial fibrillation with a CHADS2 score > 1 in NHS Eastbourne, Hailsham And Seaford CCG
- 2,258 (71.6%) people treated with anti-coagulation therapy
- 434 (13.8%) people who are exceptions
- 462 (14.6%) additional people with a recorded CHADS2 score > 1 who are not treated
In patients with AF with a CHADS$_2 > 1$, the percentage treated with anti-coagulation therapy by CCG

Comparison with demographically similar CCGs

<table>
<thead>
<tr>
<th>CCG</th>
<th>Optimal management</th>
<th>No treatment</th>
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<tr>
<td>NHS South Devon and Torbay CCG</td>
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<td>NHS Great Yarmouth and Waveney CCG</td>
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<tr>
<td>NHS Isle of Wight CCG</td>
<td>64.9%</td>
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In patients with AF with a CHADS$_2$ > 1, the percentage not treated with anticoagulation therapy by GP practice

- In total, including exceptions, there are 896 people with a recorded CHADS2 score > 1 who are not treated.

- GP practice range: 12.5% to 43.3%

- If all practices were to achieve as well as the average of the best achieving practices, then an additional 200 people would be treated.
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 CCG

Comparison with CCGs in the SCN

<table>
<thead>
<tr>
<th>CCG</th>
<th>Below 150/90</th>
<th>Not below 150/90</th>
<th>Exceptions reported</th>
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<tbody>
<tr>
<td>NHS Hastings and Rother CCG</td>
<td>87.9%</td>
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<tr>
<td>NHS Eastbourne, Hailsham and Seaford CCG</td>
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<tr>
<td>England</td>
<td>85.5%</td>
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- 4,841 patients with a history of stroke or TIA* in NHS Eastbourne, Hailsham And Seaford CCG
- 4,112 (84.9%) people whose blood pressure is <= 150 / 90
- 293 (6.1%) people who are exceptions
- 436 (9%) additional people whose blood pressure is not <= 150 / 90

*Using the QOF clinical indicator STIA003 denominator plus exceptions
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 CCG

Comparison with demographically similar CCGs

<table>
<thead>
<tr>
<th>CCG</th>
<th>Below 150/90</th>
<th>Not below 150/90</th>
<th>Exceptions reported</th>
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<tbody>
<tr>
<td>NHS Fylde &amp; Wyre CCG</td>
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<td>NHS West Norfolk CCG</td>
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<tr>
<td>NHS South Devon and Torbay CCG</td>
<td>81.5%</td>
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</table>
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 GP practice

- In total, including exceptions, there are 729 people whose blood pressure is not <= 150 / 90
- GP practice range: 5.7% to 29.2%
- If all practices were to achieve as well as the average of the best achieving practices, then an additional 240 people would have their blood pressure controlled
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 CCG

Comparison with CCGs in the SCN

- 3,447 people with a stroke shown to be non-haemorrhagic, in NHS Eastbourne, Hailsham And Seaford CCG
- 3,190 (92.5%) anti-platelet agent, or an anti-coagulant is being taken
- 177 (5.1%) people who are exceptions
- 80 (2.3%) additional people with no treatment
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 CCG.

Comparison with demographically similar CCGs

<table>
<thead>
<tr>
<th>CCG</th>
<th>Optimal management</th>
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<tbody>
<tr>
<td>NHS Eastbourne, Hailsham and Seaford CCG</td>
<td>92.5%</td>
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<tr>
<td>NHS North Derbyshire CCG</td>
<td>92.3%</td>
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<td>NHS North Staffordshire CCG</td>
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<td>NHS North Norfolk CCG</td>
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<td>NHS Great Yarmouth and Waveney CCG</td>
<td>89.5%</td>
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</table>
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 GP practice.

- In total, including exceptions, there are 257 people with no treatment.
- GP practice range: 0.0% to 15.0%
- If all practices were to achieve as well as the average of the best achieving practices, then an additional 135 people would be treated.
Diabetes
Diabetes Prevention and Management

Diabetes is very expensive using up 10% of the NHS budget at around £10bn per year. It is also often preventable.

Diabetes is an urgent public health issue. Since 1996 the number of people living with diabetes in England has more than doubled and has now reached 3.2 million. Of these, 500,000 remain undiagnosed.

Type 2 diabetes is often preventable
People at high risk of developing type 2 diabetes can be identified through the NHS Health Check and the disease could be prevented in 30-60% through appropriate behaviour change support.

Complications of diabetes are preventable
Diabetes is a major cause of premature death and disability and greatly increases the risk of heart disease and stroke, kidney failure, amputations and blindness. 80% 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 a third of people with diabetes do not receive all 8 care processes, and there is widespread variation between CCGs and practices in levels of achievement.

What questions should 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 diabetes
   - Delivery of the 8 care processes
   - Identification and management of ‘pre-diabetes’

What might help
- Practice level performance on delivery of the 8 care processes is measured in the National Diabetes Audit (NDA)
- Promote participation by all practices in the NDA
- Obtain and benchmark practice level data from the NDA (this important local data is currently only available on request to CCGs
- Ensure support for patient education, shared management and technology enabled support
- Promote uptake of the NHS Health Check to aid detection of diabetes and pre-diabetes
- Establish local prevention pathways for the delivery of evidence based interventions to people with ‘pre-diabetes’
Diabetes observed prevalence compared to expected prevalence by CCG

Comparison with CCGs in the SCN

- 0.75 ratio of observed to expected diabetes prevalence in NHS Eastbourne, Hailsham And Seaford CCG compared to 0.85 in England

- This suggests that 75% of people with diabetes have been diagnosed

Note: This slide compares the prevalence of Diabetes recorded in QOF in 2013/14 to the expected prevalence of Diabetes taken from the Diabetes prevalence model produced in 2012.

The expected prevalence of diabetes is based on best available data but there is an element of uncertainty around the figures especially in smaller areas. A small number of CCGs have a ratio greater than 1. It is unlikely that all people with diabetes will be diagnosed in any CCG and therefore a ratio greater than 1 suggests that the figures are underestimating the true diabetes prevalence in the area. These ratios should be taken as an indication of the comparative scale of undiagnosed diabetes rather than absolute figures.
Diabetes observed prevalence compared to expected prevalence by CCG

Comparison with demographically similar CCGs

- NHS Lincolnshire East CCG: 1.00
- NHS North Staffordshire CCG: 0.97
- NHS West Norfolk CCG: 0.97
- NHS Wyre Forest CCG: 0.94
- NHS Great Yarmouth and Waveney CCG: 0.91
- NHS North Derbyshire CCG: 0.89
- NHS Fylde & Wyre CCG: 0.85
- NHS North Norfolk CCG: 0.82
- NHS Isle of Wight CCG: 0.80
- NHS South Devon and Torbay CCG: 0.76
- NHS Eastbourne, Hailsham and Seaford CCG: 0.75
It is estimated that there are 3,185 people with undiagnosed diabetes in NHS Eastbourne, Hailsham And Seaford CCG.

GP practice range of observed diabetes: 3.0% to 7.7%
People with diabetes who had the eight recommended care processes by CCG, 2012/13

Comparison with CCGs in the SCN

- 30.4% of people with diabetes had the eight recommended care processes in NHS Eastbourne, Hailsham And Seaford CCG compared to 59.5% in England
- At least 4,143 people did not receive the 8 care processes

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

No data is available for the following CCGs: Camden, Harrogate and rural district, Mid Essex and Southampton
People with diabetes who had eight care processes by GP practice, 2012/13

No data available. Practice level data from the National Diabetes Audit can only be made available on request by CCGs.

- Practice comparison will show how much potential there is for local improvement.
- Practice level data from the National Diabetes Audit can only be made available on request by CCGs. To request the data, email diabetes@hscic.gov.uk
Kidney
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 65. In 2010 it was estimated to cost the NHS around £1.5bn. 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 identifies 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. Despite this there is often significant variation between practices in achievement and exception reporting.

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 should 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 CKD
   - More systematic delivery of evidence based care

What might help
- Promote participation by all practices in the National CKD Audit
- Obtain and benchmark practice level data from the National CKD Audit
- Promote uptake of and follow up from the NHS Health Check to aid detection and management of CKD
- Local training and education in the detection and management of CKD
Chronic kidney disease (CKD) observed prevalence (2012/13) compared to expected prevalence (2011) by CCG

Comparison with CCGs in the SCN

- 0.76 ratio of observed to expected CKD prevalence in NHS Eastbourne, Hailsham And Seaford CCG compared to 0.7 in England
- This suggests that 76% of people with chronic kidney disease have been diagnosed

Note: This slide compares the prevalence of CKD recorded in QOF in 2012/13 to the expected prevalence of CKD produced by the University of Southampton in 2011. 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.

The QOF 2013/14 data for CKD has a coding issue around episodes which has led to an underreporting of CKD. Therefore, 2012/13 QOF has been used to ensure accuracy.
Chronic kidney disease (CKD) observed prevalence (2012/13) compared to expected prevalence (2011) by CCG

Comparison with demographically similar CCGs

- NHS Fylde & Wyre CCG: 1.02
- NHS Lincolnshire East CCG: 0.95
- NHS North Derbyshire CCG: 0.89
- NHS Wyre Forest CCG: 0.86
- NHS Great Yarmouth and Waveney CCG: 0.77
- NHS Eastbourne, Hailsham and Seaford CCG: 0.76
- NHS North Norfolk CCG: 0.71
- NHS West Norfolk CCG: 0.68
- NHS South Devon and Torbay CCG: 0.66
- NHS North Staffordshire CCG: 0.65
- NHS Isle of Wight CCG: 0.55
It is estimated that there are 3,054 people with undiagnosed chronic kidney disease in NHS Eastbourne, Hailsham And Seaford CCG

GP practice range of observed CKD: 0.6% to 12.4%

Note: CCG estimates for the estimated number of people with CKD are based on applying a proportion from a resident based population estimate to a GP registered population. The characteristics of registered and resident populations may vary in some CCGs, and local interpretation is required.
Percentage of patients on the CKD register whose last blood pressure reading (measured in the preceding 12 months) is 140/85 mmHg or less by CCG, 2012/13

Comparison with CCGs in the SCN

- 9,839 people with CKD (diagnosed)* in NHS Eastbourne, Hailsham And Seaford CCG
- 6,926 (70.4%) people whose blood pressure is <= 140 / 85
- 772 (7.8%) people who are exceptions
- 2,141 (21.8%) additional people whose blood pressure is not <= 140 / 85

*Using the QOF clinical indicator CKD03 denominator plus exceptions
Percentage of patients on the CKD register whose last blood pressure reading (measured in the preceding 12 months) is 140/85 mmHg or less by CCG, 2012/13

Comparison with demographically similar CCGs

Below 140/85 | Not below 140/85 | Exceptions reported
--- | --- | ---
NHS Isle of Wight CCG | 73.0% | 
NHS Lincolnshire East CCG | 72.7% | 
NHS Great Yarmouth and Waveney CCG | 71.7% | 
NHS Fylde & Wyre CCG | 70.7% | 
NHS Eastbourne, Hailsham and Seaford CCG | 70.4% | 
NHS North Staffordshire CCG | 70.2% | 
NHS North Norfolk CCG | 69.8% | 
NHS West Norfolk CCG | 69.7% | 
NHS Wyre Forest CCG | 69.4% | 
NHS North Derbyshire CCG | 68.8% | 
NHS South Devon and Torbay CCG | 66.4% | 

Graph
Percentage of patients on the CKD register whose last blood pressure reading (measured in the preceding 12 months) is not 140/85 mmHg or less by GP practice, 2012/13

- In total, including exceptions, there are 2,913 people whose blood pressure is not <= 140 / 85
- GP practice range: 16.8% to 46.2%
- If all practices were to achieve as well as the average of the best achieving practices, then an additional 382 people would have their blood pressure controlled
Percentage of patients on the CKD register whose notes have a record of a urine albumin: creatinine ratio test in the preceding 12 months by CCG, 2012/13

Comparison with CCGs in the SCN

*Using the QOF clinical indicator CKD06 denominator plus exceptions

- 9,839 people with CKD (diagnosed)* in NHS Eastbourne, Hailsham And Seaford CCG
- 7,911 (80.4%) people who have a record of a urine albumin: creatinine ratio test
- 516 (5.2%) people who are exceptions
- 1,412 (14.4%) additional people who have no record of a urine albumin: creatinine ratio test

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Percentage of patients on the CKD register whose notes have a record of a urine albumin: creatinine ratio test in the preceding 12 months by CCG, 2012/13

Comparison with demographically similar CCGs

- NHS North Staffordshire CCG: 82.9%
- NHS Great Yarmouth and Waveney CCG: 80.5%
- NHS Eastbourne, Hailsham and Seaford CCG: 80.4%
- NHS North Derbyshire CCG: 80.1%
- NHS Isle of Wight CCG: 79.9%
- NHS Lincolnshire East CCG: 79.1%
- NHS Fylde & Wyre CCG: 78.3%
- NHS Wyre Forest CCG: 78.2%
- NHS West Norfolk CCG: 77.1%
- NHS North Norfolk CCG: 75.0%
- NHS South Devon and Torbay CCG: 71.9%
Percentage of patients on the CKD register whose notes do not have a record of a urine albumin: creatinine ratio test in the preceding 12 months by GP practice, 2012/13

- In total, including exceptions, there are 1,928 people who have no record of a urine albumin: creatinine ratio test
- GP practice range: 10.8% to 43.6%
- If all practices were to achieve as well as the average of the best achieving practices, then an additional 416 people who have a record of a urine albumin: creatinine ratio test
Heart
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 already has 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 and angiotensin converting enzyme inhibitors or angiotensin receptor blockers. There is also robust evidence to support good control of blood pressure. Each of these interventions is incentivised in QOF but variation in achievement and exception 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. Again there is good evidence that appropriate treatment including up-titration of ace inhibitors and beta blockers in heart failure due to 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. And amongst those who are diagnosed, there is significant variation in the quality of care.

What questions should 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:
   - 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. Education and training to support delivery of behaviour change interventions for CVD risk reduction in primary care
4. Ensure access to rapid access diagnostic clinics and specialist support for management of angina and heart failure
5. Ensure access to cardiac rehab for individuals with CHD and heart failure
Heart failure prevalence by CCG

Comparison with CCGs in the SCN

- Prevalence of 1.0% in NHS Eastbourne, Hailsham And Seaford CCG compared to 0.7% in England
Heart failure prevalence by CCG

Comparison with demographically similar CCGs

- NHS Fylde & Wyre CCG: 1.4
- NHS North Norfolk CCG: 1.1
- NHS Lincolnshire East CCG: 1.0
- NHS Wyre Forest CCG: 1.0
- NHS Eastbourne, Hailsham and Seaford CCG: 1.0
- NHS North Derbyshire CCG: 1.0
- NHS Great Yarmouth and Waveney CCG: 1.0
- NHS West Norfolk CCG: 0.9
- NHS Isle of Wight CCG: 0.9
- NHS South Devon and Torbay CCG: 0.7
- NHS North Staffordshire CCG: 0.7
Heart failure prevalence by GP practice

- 1,866 people with diagnosed heart failure in NHS Eastbourne, Hailsham And Seaford CCG
- GP practice range: 0.3% to 1.5%
Percentage of patients with heart failure due to left ventricular systolic dysfunction (LVSD) who are treated with ACE-I / ARB by CCG

Comparison with CCGs in the SCN

- 821 people with heart failure with LVSD in NHS Eastbourne, Hailsham And Seaford CCG
- 730 (88.9%) treated with ACE-I or ARB
- 91 (11.1%) people who are exceptions
- 0 (0%) additional people who are not treated with ACE-I or ARB
Percentage of patients with heart failure due to left ventricular systolic dysfunction (LVSD) who are treated with ACE-I/ARB by CCG

Comparison with demographically similar CCGs

- NHS Isle of Wight CCG: 90.4%
- NHS Fylde & Wyre CCG: 89.9%
- NHS Wyre Forest CCG: 89.4%
- NHS North Staffordshire CCG: 89.0%
- NHS Eastbourne, Hailsham and Seaford CCG: 88.9%
- NHS Lincolnshire East CCG: 87.0%
- NHS South Devon and Torbay CCG: 85.5%
- NHS North Derbyshire CCG: 84.9%
- NHS West Norfolk CCG: 83.7%
- NHS North Norfolk CCG: 82.4%
- NHS Great Yarmouth and Waveney CCG: 81.7%
Percentage of patients with heart failure due to left ventricular systolic dysfunction (LVSD) who are not treated with ACE-I/ARB by GP practice

- In total, including exceptions, there are 91 people who are not treated with ACE-I or ARB
- GP practice range: 0.0% to 25.0%
- If all practices were to achieve as well as the average of the best achieving practices, then an additional 62 people would be treated
Percentage of patients with heart failure due to left ventricular systolic dysfunction (LVSD) who are treated with ACE-I/ARB and BB by CCG

Comparison with CCGs in the SCN

- 728 people with heart failure with LVSD treated with ACE-I/ARB in NHS Eastbourne, Hailsham And Seaford CCG
- 502 (69%) treated with ACE-I/ARB and BB
- 180 (24.7%) people who are exceptions
- 46 (6.3%) additional people who are not treated with ACE-I/ARB and BB
Percentage of patients with heart failure due to left ventricular systolic dysfunction (LVSD) who are treated with ACE-I/ARB and BB by CCG

Comparison with demographically similar CCGs

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Percentage of patients with heart failure due to left ventricular systolic dysfunction (LVSD) who are not treated with ACE-I / ARB and BB by GP practice

- In total, including exceptions, there are 226 people who are not treated with ACE-I / ARB and BB
- GP practice range: 0.0% to 70.0 %
- If all practices were to achieve as well as the average of the best achieving practices, then an additional 82 people would be treated
Percentage of patients with CHD whose blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less by CCG

Comparison with CCGs in the SCN

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- 8,156 people with coronary heart disease* in NHS Eastbourne, Hailsham And Seaford CCG
- 7,115 (87.2%) people whose blood pressure <= 150/90
- 452 (5.5%) people who are exceptions
- 589 (7.2%) additional people whose blood pressure is not <= 150/90

*Using the QOF clinical indicator CHD002 denominator plus exceptions
Percentage of patients with CHD whose blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less by CCG

Comparison with demographically similar CCGs

- NHS Fylde & Wyre CCG: 89.4%
- NHS North Derbyshire CCG: 89.3%
- NHS Isle of Wight CCG: 88.4%
- NHS Wyre Forest CCG: 88.4%
- NHS North Norfolk CCG: 88.3%
- NHS Great Yarmouth and Waveney CCG: 87.9%
- NHS Lincolnshire East CCG: 87.6%
- NHS West Norfolk CCG: 87.5%
- NHS Eastbourne, Hailsham and Seaford CCG: 87.2%
- NHS North Staffordshire CCG: 87.0%
- NHS South Devon and Torbay CCG: 85.3%

Below 150/90 | Not below 150/90 | Exceptions reported
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NHS Fylde & Wyre CCG: 89.4% | 85.3% | 0%
NHS North Derbyshire CCG: 89.3% | 87.0% | 20%
NHS Isle of Wight CCG: 88.4% | 87.2% | 40%
NHS Wyre Forest CCG: 88.4% | 87.5% | 60%
NHS North Norfolk CCG: 88.3% | 87.6% | 80%
NHS Great Yarmouth and Waveney CCG: 87.9% | 87.7% | 100%
NHS Lincolnshire East CCG: 87.6% | 87.5% | 100%
NHS West Norfolk CCG: 87.5% | 87.4% | 100%
NHS Eastbourne, Hailsham and Seaford CCG: 87.2% | 87.1% | 100%
NHS North Staffordshire CCG: 87.0% | 86.9% | 100%
NHS South Devon and Torbay CCG: 85.3% | 85.2% | 100%
Percentage of patients with CHD whose blood pressure reading (measured in the preceding 12 months) is not 150/90 mmHg or less by GP practice

- In total, including exceptions, there are 1,041 people whose blood pressure is not <= 150/90
- GP practice range: 2.5% to 27.5%
- If all practices were to achieve as well as the average of the best achieving practices, then an additional 459 people would have their blood pressure controlled
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 CCG

Comparison with CCGs in the SCN

- 8,156 people with coronary heart disease* in NHS Eastbourne, Hailsham And Seaford CCG
- 7,508 (92.1%) people with a record that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken
- 365 (4.5%) people who are exceptions
- 283 (3.5%) additional people who are not treated

*Using the QOF clinical indicator CHD005 denominator plus exceptions
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 CCG

Comparison with demographically similar CCGs

- NHS Eastbourne, Hailsham and Seaford CCG: 92.1%
- NHS North Derbyshire CCG: 91.8%
- NHS Fylde & Wyre CCG: 91.6%
- NHS Wyre Forest CCG: 91.4%
- NHS Isle of Wight CCG: 91.4%
- NHS North Staffordshire CCG: 91.2%
- NHS North Norfolk CCG: 90.6%
- NHS Great Yarmouth and Waveney CCG: 90.3%
- NHS South Devon and Torbay CCG: 89.8%
- NHS Lincolnshire East CCG: 89.4%
- NHS West Norfolk CCG: 89.3%
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 GP practice

- In total, including exceptions, there are 648 people who are not treated
- GP practice range: 2.5% to 16.4%
- If all practices were to achieve as well as the average of the best achieving practices, then an additional 170 people would be treated
The percentage of patients with a history of MI currently treated with an ACE-I / ARB, aspirin or an alternative anti-platelet therapy, beta-blocker and statin by CCG

Comparison with CCGs in the SCN

- 604 people with a history of myocardial infarction
- 304 (50.3%) people treated with ACEi / ARB aspirin or an alternative anti-platelet therapy, beta-blocker and statin
- 295 (48.8%) people who are exceptions
- 5 (0.8%) additional people who are not on quadruple therapy
The percentage of patients with a history of MI currently treated with an ACE-I/ARB, aspirin or an alternative anti-platelet therapy, beta-blocker and statin by CCG

Comparison with demographically similar CCGs

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<tr>
<td>NHS North Derbyshire CCG</td>
<td>68.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS Isle of Wight CCG</td>
<td>66.9%</td>
<td></td>
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</tr>
<tr>
<td>NHS West Norfolk CCG</td>
<td>65.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS North Norfolk CCG</td>
<td>62.2%</td>
<td></td>
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</tr>
<tr>
<td>NHS South Devon and Torbay CCG</td>
<td>61.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS Eastbourne, Hailsham and Seaford CCG</td>
<td>50.3%</td>
<td></td>
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</tbody>
</table>
The percentage of patients with a history of MI not currently treated with an ACE-I/ARB, aspirin or an alternative anti-platelet therapy, beta-blocker and statin by GP practice.

- In total, including exceptions, there are 300 people who are not on quadruple therapy.
- GP practice range: 0.0% to 96.7%.
- If all practices were to achieve as well as the average of the best achieving practices, then an additional 168 people would be treated.
Some data on outcomes for people with cardiovascular disease
Hospital admissions for myocardial infarction for all ages 2002/03 – 2012/13

- In NHS Eastbourne, Hailsham And Seaford CCG, the hospital admission rate for myocardial infarction in 2012/13 was 561.4 (1,253 admissions) compared to 575.1 for England.

Source: Hospital Episode Statistics (HES), 2002/03 - 2012/13, Copyright © 2015, Re-used with the permission of The Health and Social Care Information Centre. All rights reserved.
Hospital admissions for stroke for all ages 2002/03 – 2012/13

- In NHS Eastbourne, Hailsham And Seaford CCG, the hospital admission rate for stroke in 2012/13 was 155.3 (386 admissions) compared to 179.1 for England.

Source: Hospital Episode Statistics (HES), 2002/03 - 2012/13, Copyright © 2015, Re-used with the permission of The Health and Social Care Information Centre. All rights reserved.
Additional risk of complications for people with diabetes, three year follow up, 2012/13

- The risk of a stroke was 48% higher and the risk of a heart attack was 56.4% higher compared to people without diabetes. The risk of a major amputation was 360.2% higher.

Note: This slide uses data from the National Diabetes Audit (NDA)
Deaths from myocardial infarction, under 75s

- In NHS Eastbourne, Hailsham And Seaford CCG, the early mortality rate for myocardial infarction in 2010-12 was 37.1 (an average of 66 deaths a year) compared to 45.1 for England.

Note: The early mortality rate for 2010-12 is an average of the early mortality rates for 2010, 2011 and 2012.

Source: Office for National Statistics (ONS) mortality data 2002 - 2012
In NHS Eastbourne, Hailsham And Seaford CCG, the early mortality rate for stroke in 2010-12 was 13.7 (an average of 23 deaths a year) compared to 14.8 for England.

Note: The early mortality rate for 2010-12 is an average of the early mortality rates for 2010, 2011 and 2012.
Data sources

- Quality and Outcomes Framework (QOF), 2012/13 and 2013/14, Copyright © 2015, re-used with the permission of the Health and Social Care Information Centre. All rights reserved

- Active people survey, Sport England, 2012 and 2013

- East of England Public Health Observatory modelled estimates 2011

- CKD Prevalence model, G. Aitken, University of Southampton

- Diabetes Prevalence model, National Cardiovascular Intelligence Network

- NHS Stop smoking services Copyright © 2014, Health and Social Care Information Centre

- NHS Health checks, 2013/14


- National Diabetes Audit, 2012/13

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- Office for National Statistics (ONS) mortality data 2002 - 2012
About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.

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