Background

This chapter of the cardiovascular disease profiles focuses on risk factors for cardiovascular disease and is produced by the National Cardiovascular Intelligence Network (NCVIN). The profiles are available for each clinical commissioning group (CCG) in England. Each profile is made up of five chapters which look at risk factors, coronary heart disease (CHD), diabetes, kidney disease and stroke. This profile compares the CCG with data for England, a group of similar CCGs and the Greater Manchester, Lancashire and South Cumbria strategic clinical network.

Lifestyle and behavioural risk factors (such as smoking, physical inactivity, poor diet and obesity) reflect an individual’s circumstances and choices. There are also a number of risk factors for cardiovascular disease (CVD) which are not dependant on how people behave but on biological and social aspects of their lives, such as age, sex, ethnicity and deprivation. In addition, physical risk factors (including hypertension) reflect changes to body systems that are also reversible or preventable in their early stages but may require medical treatment.

Key information

The resident population of NHS Bury CCG is 187,500 and 32,800 of these people are aged 65 and over, a lower proportion than across England as a whole.

In NHS Bury CCG, 20.3% of people live in the most deprived fifth of areas in England.

In 2015 it was estimated that 18.9% of adults in NHS Bury CCG smoked.

Between 2012 and 2014 it was estimated that 67.1% of adults in NHS Bury CCG were classified as overweight or obese.

In 2015 there were 27,000 people diagnosed with hypertension in NHS Bury CCG. This was lower than the expected number and 11.4% of adults could have hypertension that has not been diagnosed.

In 2014/15 the NHS Health Check was offered to 23.5% of the eligible population of NHS Bury CCG. 15.2% of the eligible population received a NHS Health Check.
Risk factors for cardiovascular disease

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Quantifying non-behavioural risk factors

The prevalence of CVD increases with age, which is important in the light of an ageing population. In 2013 the proportion of people aged 65 and over in NHS Bury CCG was 17.5% which is lower than across England as a whole, where 17.6% of the population were aged 65 and over.

Age profile and population projections, 2014 (per cent)  Deprivation, 2015 (per cent)

People from a more deprived background are at greater risk of CVD than the general population. In NHS Bury CCG, 20.3% of the population are in the most deprived national quintile and 18.1% of the population in the least deprived.

Minority ethnic groups, 2011 (per cent)

England has become more ethnically diverse with rising numbers of people identifying with minority ethnic groups in the 2011 Census. The relationship between ethnic group and CVD prevalence is complex. For example, the risk of stroke is higher in south Asian, African or Caribbean populations living in England. In NHS Bury CCG an estimated 10.8% of the population are from Black, Asian, mixed or other groups, compared to 14.6% across England.
Risk factors for cardiovascular disease

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Behavioural risk factors - prevalence

A number of common risk factors are recognised as increasing the likelihood of individuals developing CVD. These include smoking, obesity, physical inactivity, poor nutrition and drinking too much alcohol.

Smoking prevalence, 2014/15 (per cent)

In 2015 it was estimated that 18.9% of adults in NHS Bury CCG smoked.

Between 2012 and 2014 it was estimated that 67.1% of adults in NHS Bury CCG were classified as overweight or obese.

Physical inactivity, 2014 (per cent)

In 2014 it was estimated that 30.9% of adults in NHS Bury CCG were classified as ‘inactive’.

Healthy eating (estimated proportion of adults who consume five or more portions of fruit or veg per day), 2014 (per cent)

In 2014 it was estimated that 52.7% of adults in NHS Bury CCG ate five or more portions of fruit and vegetables a day.
In 2014 there were 1,125 episodes for alcohol-related cardiovascular disease conditions in NHS Bury CCG.

Hypertension - prevalence

Blood pressure measurements indicate the pressure which the circulating blood puts on the walls of blood vessels. Blood pressure is measured in millimetres of mercury (mmHg) and is usually written as the systolic blood pressure/diastolic blood pressure. Blood pressure measurements are on a continuous scale and therefore there is no specific point at which normotension (normal blood pressure) becomes hypertension (high blood pressure). However, a blood pressure of 140/90 mmHg or greater is usually used to indicate hypertension because persistent levels of blood pressure above this start to be associated with increased risks of cardiovascular events. For the purpose of the Quality and Outcomes Framework (QOF), hypertension is defined as a blood pressure measurement of 150/90. Hypertension is important because when uncontrolled it is a major risk factor for stroke, heart attack, heart failure, aneurysms and chronic kidney disease.

In 2015 there were 26,527 people on GP lists in NHS Bury CCG with diagnosed hypertension. This equated to 13.4% of the population registered with a GP, however, it was estimated the expected prevalence of hypertension in the CCG was 24.8%, meaning that 11.4% or 23,000 adults could have hypertension that has not been diagnosed.

Diagnosed and estimated prevalence of hypertension, 2014/15 (per cent)

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<thead>
<tr>
<th></th>
<th>Observed hypertension prevalence</th>
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<tbody>
<tr>
<td>Local</td>
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<td>Comparator CCGs</td>
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<td>England</td>
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Source: QOF, 2014/15

Variation by general practice of diagnosed hypertension prevalence, 2014/15 (per cent)

Source: QOF 2014/15 (practices censored at 30%)
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Care processes and treatment indicators

The Quality and Outcomes Framework (QOF) rewards practices for the provision of quality care and helps to standardise improvements in the delivery of clinical care. The risk of developing cardiovascular disease can be reduced in patients with hypertension by careful management of blood pressure and other cardiovascular risk factors such as physical inactivity and smoking.

The graphs below show achievement against QOF hypertension and primary prevention of cardiovascular disease clinical indicators for the CCG as a whole.

Hypertension

Patients with hypertension in whom the last blood pressure is 150/90 or less, HYP006, 2014/15 (per cent)

In those patients with a new diagnosis of hypertension aged 30 or over and who have not attained the age of 75, recorded between the preceding 1 April to 31 March (excluding those with pre-existing CHD, diabetes, stroke and/or TIA), who have a recorded CVD risk assessment score (using an assessment tool agreed with the NHS CB) of ≥20% in the preceding 12 months who are currently treated with statins, PP001, 2014/15 (per cent)

The percentage of patients aged 45 or over who have a record of blood pressure in the preceding 5 years, BP002 2014/15 (per cent)

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Smoking

QOF includes information on the percentage of patients with a smoking status recorded and whether those identified as smokers are offered support or treatment to stop smoking.

Patients with certain conditions who have their smoking status recorded CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar disorder or other psychoses, SMOK002, 2014/15 (per cent)

Patients aged 15 years and over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 24 months, SMOK004, 2014/15 (per cent)

NHS Health Check Programme

The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions, will be invited once every five years to assess their risk of developing these conditions. They are given support and advice to help them reduce or manage that risk.

In NHS Bury CCG in 2014/15 an estimated 56,000 residents were eligible to be offered a Health Check. Local authorities offer the programme to all the eligible population over a five year period. During 2014/15, 23.5% of eligible residents were offered a Health Check and 15.2% of eligible residents received a Health Check.

Proportion of eligible people who were offered and received a Health Check, 2014/15 (per cent)

Note: Local Authority data has been used to estimate CCG Health Check figures. Where more than one local authority is within the CCG, the proportion of local authority activity has been aggregated to create the CCG figures.

A list of references for each chapter is given in the indicator guide for the profiles.

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