CHOLESTEROL

A FORGOTTEN PUBLIC HEALTH ISSUE?

HEART UK'S ASSESSMENT OF HEALTH & WELLBEING STRATEGIES IN LONDON

HEART UK
THE CHOLESTEROL CHARITY

Acknowledgements

HEART UK wishes to thank the following organisations for their contributions to this report:

MSD has contributed to the funding of the report and provided input into it as a member of the HEART UK Campaigning Committee. MSD has reviewed the content for compliance purposes only. Data verification and final editorial control lies with HEART UK.

Unilever UK & Ireland has contributed towards the funding and production of this report and reviewed the content for compliance purposes only. Data verification and final editorial control lies with HEART UK.

Alere Ltd has contributed to the funding of the report and provided input into it as a member of the HEART UK Campaigning Committee. Alere Ltd has reviewed the content for compliance purposes only. Data verification and final editorial control lies with HEART UK.

The development of this report has been supported by a grant from Sanofi. Sanofi has not had editorial input or control over the contents of this report.

Contact

HEART UK
7 North Road
Maidenhead
Berkshire
SL6 1PE

Helpline
0845 450 5988

Business
01628 777 046

Email
ask@heartuk.org.uk

Web
heartuk.org.uk

CONTENTS

FOREWORD

The creation of Health and Wellbeing Boards in 2012 was an exciting development, designed to drive better integration of local services. By building partnerships across local government, public health and the third sector, these bodies have an important role to play in tackling the leading threats to local health and wellbeing – of which cardiovascular diseases (CVD) is high on the list. As the number one killer in the capital, I believe that these changes have the potential to help improve the heart health of local populations through the effective prioritisation of CVD.

As such, I am delighted to present this report from HEART UK, assessing the different local plans and strategies for health priorities and investigating how well these new bodies are prioritising CVD prevention in their area. Our research has uncovered interesting results, showing inconsistencies in the way CVD prevention is prioritised in local public health strategies.

The report also demonstrates that cholesterol is so often forgotten as a risk factor for CVD. Usually asymptomatic, high cholesterol is a hidden problem that needs greater attention in public health strategies.

This report is an important call to action for local public health teams to increase their focus on this pervasive issue. I want to encourage Health and Wellbeing Boards to ensure that CVD is given the focus it deserves.

Londoners have an opportunity to drive changes at the heart of this issue and I urge all who read this report to embrace its recommendations whilst also learning from the excellent case studies highlighted where prevention strategies are working well to deliver improvements in the health of local communities.

Changes in public health don't happen overnight, and progress will only be made through continued, dedicated focus. I hope that together we will be able to drive the improvements necessary to deliver better CVD management and prevention, to help engender better health for our capital.

Jules Payne
Chief Executive
HEART UK
The Cholesterol Charity

EXECUTIVE SUMMARY

Cardiovascular disease, cholesterol and public health

Cardiovascular disease (CVD) is the UK's number one killer.[1] As well as the devastating impact CVD has on patients and their families, it also places significant pressure on our health service and wider economy.

Raised cholesterol is one of the most significant risk factors for CVD. Evidence shows that as many as six out of ten adults in England have higher than recommended cholesterol levels.[2] Given that elevated cholesterol is usually asymptomatic, its management is often overlooked as a preventative measure for CVD.

HEART UK audit

At the end of 2013, HEART UK conducted an audit to see whether prevention of CVD, the leading cause of death and morbidity across all London boroughs, was being sufficiently prioritised by the local Health and Wellbeing Boards (HWBs).

HWBs were set up in 2012 to drive cooperation between local authorities and Clinical Commissioning Groups (CCGs), and they have taken on responsibility for setting out the public health needs of their local populations through Joint Strategic Needs Assessments (JSNAs). From these, they also go on to produce Joint Health and Wellbeing Strategies (JHWSs) to inform commissioning priorities.

HEART UK's findings suggest that there was wide variation across the capital in how CVD was represented within JSNAs and JHWSs. Whilst some local authorities provided an extremely thorough and detailed analysis of the CVD landscape within their community, others did not.

HEART UK invites HWBs, healthcare professionals and third sector organisations across England to consider these findings in the context of their local JSNAs and JHWSs. Given its importance to the burden of disease and health inequalities, CVD and its prevention must be given prominence. Furthermore, cholesterol should not be overlooked as a risk factor for CVD, as it can have far-reaching consequences for population health.

Key findings of this report

CVD representation within JSNAs across London is patchy and not based on prevalence.

Cholesterol is under-represented within JSNAs, with limited focus on specific reduction measures.

There is not always a clear link between CVD assessments in a borough's JSNA and prevention strategies in their JHWS.

NHS Health Checks are not universally acknowledged in JSNAs, despite being a mandated service. They are not always seen as a strategic tool to help combat CVD.

Cholesterol is being overlooked in strategies as a risk factor for CVD, with obesity and smoking instead receiving greater focus.

JHWSs are not holding policy makers to account and are failing to set out clear measures of success and establish who is responsible for CVD health within their area.

There is a lack of strategic direction around CVD inequalities in JHWSs.

RECOMMENDATIONS

Recommendations of this report

Considering that CVD is one of the biggest causes of death, disease and disability across the capital, HEART UK suggests that:

1

JSNAs should include an assessment of local CVD burden that provides details on prevalence, incidence and rate of change from the previous assessment.

2

Data on predicted future trends in CVD within the borough should be reflected in JSNAs.

3

JSNAs should include specific data on cholesterol rates and measures to reduce cholesterol within their population, particularly in light of the recent retirement of several QOF indicators related to the measurement of cholesterol.

4

JSNAs should incorporate an analysis of CVD health inequalities, looking specifically at outcomes, risk factors and access to relevant services around CVD.

5

There should be clearer links between JHWS and JSNA. At present the Assessment and Strategy are not embedded together in a clear logic of 'problem' and 'solution'.

6

The importance of raised cholesterol needs recognising within JHWSs.

7

NHS Health Checks should be highlighted as a strategic tool within JHWSs to help tackle CVD.

8

There should be a clear allocation of CVD responsibility in JHWSs.

9

JHWSs should include success measures to assess their strategy against.

10

JHWSs must include details of how local authorities plan to address inequalities in CVD as well as discuss the various dimensions of inequality, eg. gender, race, educational and socio-economic background.

11

Public Health England should provide advice and guidance to Health and Wellbeing Boards on key priority areas which should be covered in the JSNA and JHWS, including CVD burden and risk factors, such as cholesterol.

1 CVD AND THE NEW NHS

The Burden of CVD

Despite real progress in the management and treatment of cardiovascular disease (CVD) over the past decade, it remains the UK's number one killer.[3] In 2010, 180,000 people died from cardiovascular diseases, and there are roughly 2.6m men and women with coronary heart disease (CHD) in the UK.[4]

As well as the terrible toll it has on patients and their families, heart disease places significant pressure on our health service and wider economy. The cost of CVD to the UK economy is estimated to stand at around £19 billion a year.[5]

Although it has wide-ranging effects throughout the population, the burden of CVD mortality and morbidity is disproportionately shouldered by groups with the lowest socio-economic status. Professor Sir Michael Marmot's 2008 report on health inequalities found that mortality from CVD was 50% higher in the most deprived fifth of the population compared with the least deprived.[6]

These differences or inequalities in cardiovascular health also persist between different geographic areas. Recent data have shown a clear north-south divide in CHD mortality with the South West, South Central, East of England, London and South East Coastal regions all having lower than average mortality from CHD per 100,000 people.[7] Conversely, the West Midlands, East Midlands, North West, Yorkshire and the Humber, and North East all have higher than average mortality from CHD.[8]

Ethnicity has also been revealed to be a factor that contributes towards health inequalities. This is of particular relevance in London where 40.2% of its population is made up of people from Black and Minority Ethnic (BME) groups, and that percentage is expected to increase further in coming years.[9] With over 16,000 deaths from CVD every year in the capital[10], there are stark differences in CVD rates between more affluent and more deprived boroughs. For example, the residents in the borough of Newham are almost 2.5 times as likely as residents in Kensington and Chelsea to die from CVD before the age of 75 years.[11]

The Risk Factors for Heart Disease

Raised cholesterol is one of the most significant risk factors for CVD. While NICE guidance recommends that healthy adults should aim for a total cholesterol of 5mmol/L or less[12], evidence shows that as many as six out of ten adults in England have cholesterol levels at or above this level.[13]

For a proportion of the population, approximately one in 500 people, high cholesterol can be as a result of the inherited condition Familial Hypercholesterolemia (FH).[14] In these cases, it is important that patients are diagnosed with the condition as early as possible and that family members are also tested, so that patients can receive much needed cholesterol lowering treatments.

As well as raised cholesterol levels, there are a range of other clinical risk factors for heart disease including diabetes, high blood pressure, inflammatory conditions and a previous history of heart attack or stroke.

Ethnic origin also plays a role in determining risk. People from South Asian or of African-Caribbean descent have been found to be at higher risk than the rest of the population.

In addition, there are a series of lifestyle factors that can impact on cholesterol levels and the wider risk of developing heart disease, including:

- Smoking
- Being overweight
- Poor physical fitness and being generally inactive
- A poor and unbalanced diet
- Increased levels of personal stress

There are approximately 10 million adult smokers in England, equating to 22% of men and 19% of women.[15] Meanwhile, across Britain two-thirds of adults do not consume the recommended five portions of fruit and vegetables a day. Amongst younger people aged five to 15, this figure increases to about four out of five.[16] More than a third of men and over a quarter of women exceed the government recommended level of alcohol intake on a regular basis.[17]

180,000
people die from CVD every year.

2.6m
men and women with coronary heart disease (CHD) in the UK.

£19bn
The cost of CVD to the UK economy is estimated to stand at around £19 billion a year.

CVD Prevention

Prevention should be at the heart of any strategy to tackle CVD in the UK. For most people who are identified as being at an increased risk of heart disease, there are a number of lifestyle changes which can significantly lower that risk.

Once diagnosed, raised cholesterol is relatively easy to manage in the majority of cases. Some may require medicines, but for others, adopting a healthier lifestyle, increasing their exercise and improving their diet can naturally reduce their cholesterol levels.

There have been a range of initiatives over the past decade aimed at raising awareness of the dangers of poor lifestyle choices and the measures that can be taken to address these. Of these, HEART UK considers the NHS Health Check Programme, first introduced in 2009, to be one of the most exciting and important developments, representing a major step forward in adopting a preventative approach to CVD.

NHS Health Checks, offered to men and women aged 40-74 on a five yearly basis, have the potential to positively impact on long term health, preventing heart disease, stroke, diabetes, kidney disease and certain types of dementia. HEART UK firmly believes that, if fully implemented throughout England, the Health Checks can engage the public in health prevention by identifying potential risk factors for CVD and providing individuals with information to reduce their risk of CVD through behavioural changes and/or medical treatment where necessary.

As HEART UK's 2011 report, *Cholesterol and a Healthier Nation: shared responsibility for better public health* showed, the early implementation of the Health Checks Programme was patchy and inconsistent.[18] Whilst some regions had been proactive and innovative in their approach, others were yet to start delivering Health Checks, blaming lack of funding and waning support from GPs.

Critics of the Programme have claimed that it will only reach the so-called "worried well".[19] However, as highlighted in our *Cholesterol and a Healthier Nation* report, some regions have developed innovative schemes to engage with hard-to-reach groups and the individuals who would most benefit from this important, free service.[20] By offering Health Checks in places such as parks, sporting grounds, supermarkets, job centres, mosques and even fishing ports, as well as the more traditional GP practices and pharmacies, there is more scope to extend the benefits of the Programme beyond the "worried well".

At a national level, the Health Checks Programme has had good cross-party political support and take up of the Programme is one of the indicators in the Public Health Outcomes Framework, against which Public Health England (PHE) will be held to account.[21] At a local level, public health responsibilities now lie within local authorities, and HEART UK urges them to prioritise the NHS Health Checks Programme as an important driver of their prevention agendas.

Setting public health priorities at a local level

The Health and Social Care Act, passed in March 2012, significantly changed the structure of the NHS and the way services were commissioned. Directors of Public Health moved from the since abolished Primary Care Trusts (PCTs) to new posts within local authorities, although these are encouraged to work closely with GPs and other healthcare commissioners in the local Clinical Commissioning Groups (CCG).

Health and Wellbeing Boards (HWBs) were set up to improve cooperation between local authorities and CCGs, and these are the organisations which formulate local plans for health priorities in the form of Joint Strategic Needs Assessments (JSNAs). Producing an annual JSNA has been a statutory requirement for the NHS and local authorities since 2007. HEART UK welcomed the creation of HWBs as a way of driving better integration of local services, building partnerships across local government, public health, and the third sector, and working together to develop accurate JSNAs.

The primary objective of JSNAs is to accurately assess the health needs of a local population in order to guide commissioning in a way that will improve the physical and mental health and wellbeing of individuals and communities. Following on from this process, each HWB then produces a Joint Health and Wellbeing Strategy (JHWS), set according to JSNA findings. These strategies, which help determine actions and local commissioning priorities, are designed to be key strategic vehicles to address local needs and inequalities.

A good quality JSNA should highlight key health inequalities, such as CVD mortality, and provide a blueprint to inform commissioning on local health priorities. Other documents and action plans then flow from the JSNA and JHWS to deliver on these priorities. Therefore, it is crucial that the JSNA should paint a clear and comprehensive picture of local needs.

As this chapter has set out, there are huge inequalities in CVD prevalence and mortality across England and London.[22] All parts of the country – even those with the lowest rates of CVD – have higher rates than many other countries in Western Europe.[23] HEART UK believes it stands to reason that all local areas should therefore prioritise reducing CVD within their JSNAs and JHWSs.

2 JOINT STRATEGIC NEEDS ASSESSMENTS (JSNAs)

JSNA STATS

4/5
included a specific section or chapter on CVD (25/31).

4/5
Over 4 in 5 Assessments included data relating to changes in CVD prevalence and/or death rates (27/31).

3/5
mentioned NHS Health Checks (19/31), with the majority specifically mentioning them as a tool to support CVD prevention (17/31).

1/2
failed to make any mention of cholesterol (14/31).

4/5
made a reference to CVD inequalities (26/31).

Assessing the CVD needs of local London populations

Key findings

- CVD representation within JSNAs across London is patchy and not based on prevalence.
- Cholesterol is under represented within JSNAs, with limited focus on specific reduction measures
- NHS Health Checks are not universally acknowledged in JSNAs despite being a mandated service.

At the end of 2013, HEART UK conducted an audit of 31 London JSNAs* in order to collect information about how local authorities have assessed CVD as a health need within their populations. Given that the findings from JSNAs work to inform and guide the commissioning of local health, wellbeing and social care services, HEART UK was interested to see whether CVD, the leading cause of death and morbidity across all London boroughs[24], was being sufficiently prioritised within these assessments.

HEART UK's findings suggest that there was wide variation across the capital in how CVD was represented within JSNAs. Whilst some local authorities provided an extremely thorough and detailed analysis of the CVD landscape within their community, others did not.

Prevalence and death rates

JSNAs, as an evidence-based analysis of the health of a local population, are expected to include details of the prevalence, incidence and rate of change from the previous assessment for the biggest causes of ill health in that borough.

Whilst HEART UK was pleased to see that all assessments mentioned CVD, the detail included in these mentions varied significantly. They ranged from a passing reference of CVD prevalence, through to the devotion of an entire, comprehensive chapter about CVD, including detailed statistics on mortality, morbidity and rates of change. Notable examples that have this higher level of detail included Barnet, Brent, Bromley, Ealing, Havering, Haringey, Kingston, Sutton and Tower Hamlets. Overall, 2 in 3 assessments included a specific chapter or section dedicated towards CVD.

HEART UK was interested to note that this group included a mixture of boroughs with both CVD prevalence well above the London average (e.g. Haringey and Tower Hamlets) and well below (e.g. Barnet, Kingston).[25] This may suggest that other unknown factors or influences are involved in priority selection that may have pushed CVD out of JSNA priority in some boroughs.

In terms of CVD comparisons with previous assessments, HEART UK found that only 4 in 5 of the JSNAs provided comparison data relating to changes in CVD prevalence or death rates. One borough, which did not provide comparative data, did however predict future trends. This would be a welcome addition across all JSNAs in order to plan beyond immediate disease burden and prompt strategic action now to reduce CVD in the future.

* Hackney and City of London have a combined strategy, while a JSNA from Lewisham was unavailable at the time of research

NHS Health Checks

HEART UK believes that NHS Health Checks are a key mechanism to identify those people at risk from CVD (and other diseases) and support primary prevention and self management of risk.

As such, HEART UK was keen to examine how NHS Health Checks were being prioritised within JSNAs. Since 2012, NHS Health Checks have been a mandated service, with all local authorities expected to offer them to 20% of the targeted population (those aged 40-74) each year. Therefore, it would be reasonable to expect all JSNAs to reference this vital tool to ensure that it was used strategically and beneficially down the commissioning chain.

However, our audit found that 3 in 5 of all London boroughs mentioned NHS Health Checks, with the majority specifically mentioning NHS Health Checks as a tool to support CVD prevention.

For example, some boroughs, such as the one detailed on this page, have embraced the NHS Health Checks Programme within their JSNA, and are working to actively support GPs in identifying at-risk patients.

CASE STUDY

50%
of those offered a Health Check received one.

Ealing: Committed to CVD

The Borough of Ealing has included a comprehensive chapter specifically addressing the prevalence of CVD within their JSNA. This chapter not only outlines the disease burden and associated inequalities; it also discusses current services, gaps in services, evidence of what works to prevent the disease and a series of recommendations in order to see a decrease in CVD.

It is also interesting to note that the percentage of Health Checks offered in Ealing in 2013-14 was higher than average for London boroughs, as was the uptake rate, with over 50% of those offered a Health Check receiving one. This shows an alignment between goals and results.

Figure 1
Map of NHS Health Checks mentioned in JSNA

A JSNA from Lewisham was unavailable at the time of research

Cholesterol as a risk factor

Scientific evidence has shown that raised cholesterol is a major risk factor for CVD and as such, HEART UK expected the majority of JSNAs to include specific mentions of cholesterol management and treatment, particularly in relation to at-risk communities. Despite this, almost half of all JSNAs from the London boroughs made no mention of cholesterol at all.

Of those that did mention cholesterol, most did so in a minor way, without focussing on assessment or any other specific measures to reduce cholesterol within their local area. Some JSNAs highlighted cholesterol, but only in relation to a single at-risk population. For example, one JSNA stated that "cholesterol management should be targeted at South Asians" while another only mentioned cholesterol in regard to managing diabetes.

"One of the top priorities for secondary prevention includes optimal cholesterol control <4mmols/l or LDL <2mmols/l."

City of London & Hackney[26]

"NICE guidance PH15 identifies stopping smoking and the appropriate prescribing of statins to reduce cholesterol as being the most cost-effective interventions for making improvements in life expectancy in targeted communities."

Hammersmith & Fulham[27]

Inequalities in CVD

Inequalities in mortality and morbidity of CVD are well-documented and this was a point well reflected across JSNAs. HEART UK was pleased to see that roughly 4 out of 5 assessments made some reference to inequality in CVD outcomes.

However, these references were generally not followed up with specific points around service planning and delivery, as well as access to health services and the health outcomes of people affected by inequality.

"CVD in Ealing is a major contributor to health inequalities."

Ealing[28]

"There is an above average rate of stroke, hypertension and CHD in the black population in Hackney."

City of London and Hackney[29]

Recommendations

Considering that CVD is one of the biggest causes of death, disease and disability across the capital, HEART UK suggests that:

1. JSNAs should include an assessment of local CVD burden that provides details on prevalence, incidence and rate of change from the previous assessment.

2. Data on predicted future trends in CVD within the borough should be reflected in JSNAs.

3. JSNAs should include specific data on cholesterol rates and measures to reduce cholesterol within their population, particularly in light of the recent retirement of several QOF indicators related to the measurement of cholesterol.

4. JSNAs should incorporate an analysis of CVD health inequalities, looking specifically at outcomes, risk factors and access to relevant services around CVD.

3 JOINT HEALTH & WELLBEING STRATEGIES (JHWSs)

Developing strategies that support local authorities in addressing CVD needs

Key findings

There is not always a clear link between CVD assessments in a borough's JSNA and prevention strategies in their JHWS.

NHS Health Checks are not being universally recognised as a strategic tool to help combat CVD.

Cholesterol is being overlooked in strategies as a risk factor for CVD, with obesity and smoking instead receiving greater focus.

JHWSs are not holding policy makers to account and are failing to set out clear measures of success and establish who is responsible for CVD health within their area.

There is a lack of strategic direction around CVD inequalities in JHWSs.

As already outlined, JHWSs are designed to set the strategic priorities for meeting the high-level needs identified in JSNAs. They should translate the JSNAs into clear strategies for action, which will inform local commissioning.

However, the findings of HEART UK's audit of 32 London JHWSs* suggested that, overall, the content of JSNAs seemed to bear little relevance to the content of the JHWS. HEART UK was also surprised to find that in boroughs where there was known to be excellent CVD monitoring and prevention services, this was not necessarily documented in their assessment or strategy.

At this stage, HEART UK expected to see services and initiatives receiving more explicit mentions in the JHWSs. Instead, the audit suggested that the chain between assessment, strategy and delivery was not being connected.

CVD prioritisation

The results of the audit suggest that there isn't necessarily a direct correlation between a borough's JSNA and JHWS. Whilst some boroughs had a strong assessment that prioritised CVD, this prioritisation was not then reflected in their strategy.

These results imply that there is little link between the two documents or rationale about priorities, suggesting that the strategic process is flawed in some boroughs.

*There are 32 JSNAs as City of London & Hackney combined their assessment, but both provided separate JHWS. However there are still 32 JHWS, not 33, as Enfield has not completed one at the date of research.

JHWS STATS

1/3 Strategies did not include any mention of the NHS Health Checks Programme (11/32).

1/2 Of the strategies that did mention NHS Health Checks, over half did not include any specific priorities or actions relating to it (12/21).

1/4 Of the 19 JSNAs which mentioned NHS Health Checks Programme, 1 in 4 did not mention Health Checks again in their JHWS (5/19). Conversely, of the 12 JSNAs that did not reference NHS Health Checks, half mentioned them in their JHWS (7/12)

1/10 Fewer than 1 in 10 specifically recognised cholesterol as a risk factor for CVD (2/32).

1/6 Strategies included specific measurable outcomes of success for their stated CVD aims (4/32).

1/5 Less than 1 in 5 strategies identified an individual, team or organisation who assumed prime responsibility to coordinate or deliver CVD prevention in their area (6/32).

2/3 Failed to acknowledge CVD health inequalities in their area (21/32).

1/5 Of those that did acknowledge inequalities only 1 in 5mentioned how they plan to address these (2/11).

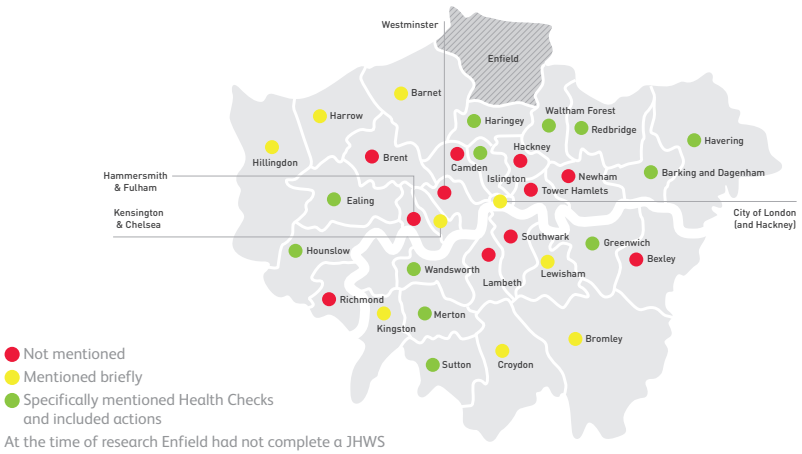
NHS Health Checks

HEART UK found that 1 in 3 strategies did not include any mention of the NHS Health Checks Programme. Of the strategies that did mention NHS Health Checks, over half did not include any specific priorities or actions relating to it.

The NHS Health Checks Programme was also an example where a delivered service was not being linked to JHWSs. As reported in the previous chapter, 19 JSNAs discussed NHS Health Checks. However, of the 19, 1 in 4 did not mention Health Checks again in their JHWS. Conversely, of the 12 boroughs that did not reference NHS Health Checks in their JSNA, half mentioned them in the JHWS.

HEART UK was surprised to see so few local authorites acknowledging the role of NHS Health Checks as a way of helping address the CVD needs of their local population. In particular, it was concerning to see some of the worst performing local authorities in terms of provision of Health Checks failing to mention these in their Strategies. For example, both Brent and Hammersmith & Fulham failed to mention Health Checks in their Strategies, despite only 2.6% of Brent's eligible population receiving a Health Check and only 2.4% in Hammersmtih & Fulham received one.[30]

Figure 2
Map of NHS Health Checks mentioned in JHWS



At the time of research Enfield had not complete a JHWS

Figure 3
Map of % NHS Health Checks offered to total eligible population

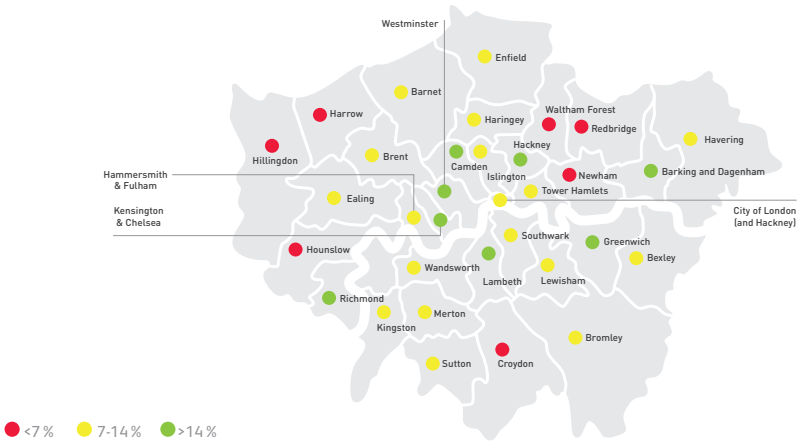
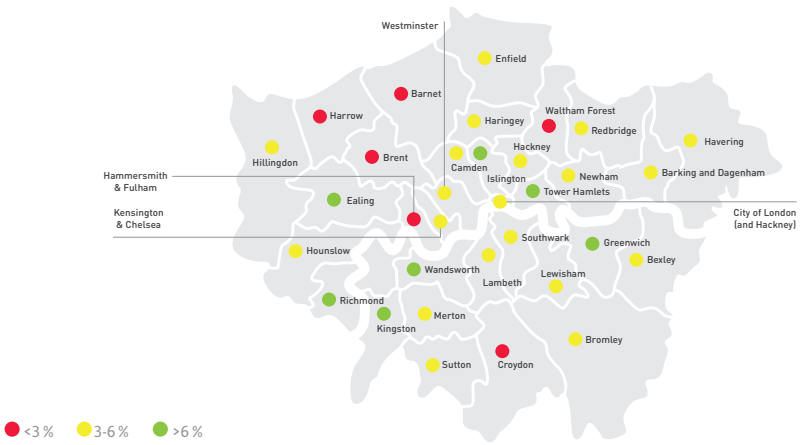


Figure 4
Map of % NHS Health Checks received by total eligible population



Meeting the targets

The NHS Health Checks Programme was designed to roll out in a five year cycle. From April 2013 local authorities have been mandated to provide the NHS Health Check Programme. Money has been allocated as part of the public health ring fence to provide NHS Health Checks for 20% of the eligible population per year aged 40-74.[31] However Figure 3, highlights that a number of local authorities will fall short of this target.

However, as we can see below, some boroughs are using the NHS Health Checks Programme innovatively:

CASE STUDY

BROMLEY HAS IDENTIFIED THAT CVD IS A LEADING CAUSE OF DEATH IN THE AREA

Bromley: Strategic ambitions

Bromley has identified CVD as a leading cause of death in the area, despite having a lower rate than the average for England. It assesses that the Health Checks Programme will be successful in identifying a high risk of CVD in the next 10 years in 8% of screened individuals. It notes that people with newly diagnosed hypertension are excluded from Health Checks and has worked to fill this gap so that, as part of the Quality & Outcomes Framework (QOF), people with newly diagnosed hypertension can have a face to face cardiovascular risk-assessment.

CASE STUDY

BARKING & DAGENHAM ACHIEVED THE SECOND HIGHEST RATE OF NHS HEALTH CHECKS IN LONDON

Barking & Dagenham: Aligning JSNA and JHWS

The national target is to offer NHS Health Checks to 20% of the target population (40-70s). Barking & Dagenham, which achieved the second highest rate of NHS Health Checks in London, recognises the value of this Programme in identifying risk and helping people to modify their own behaviour. As well as a comprehensive section within its JSNA dedicated to NHS Health Checks, the borough prioritised Health Checks in its JHWS with an aim of increasing uptake to 75%. The Strategy recognises that identification of risk is only half the issue while modifying behaviour is also a large challenge. Barking & Dagenham has therefore prioritised building intervention services tailored around their population (around weight, smoking cessation etc) to follow on from NHS Health Checks with the aim of modifying behaviour.

In 2013-14 Barking & Dagenham offered Health Checks to a greater than average number of its eligible population, compared to other boroughs, while the total number of people that actually received a Check remains less than half of those offered. It is hoped that the focus on NHS Health Checks in the JHWS will enourage efforts to boost uptake rates.

Cholesterol as a risk factor

In the JSNA audit, almost half of all assessments made no mention of cholesterol at all. HEART UK was disappointed to see even fewer acknowledgements within JHWSs of cholesterol as one of the major risk factors for CVD, with fewer than 1 in 10 strategies specifically recognising it.

However, obesity and smoking, which are also key risk factors for CVD, were mentioned by almost all JHWSs. Whilst HEART UK welcomed these mentions, as their management is vital to a CVD reduction strategy, we were concerned that cholesterol received so little priority despite posing such a significant risk factor for CVD.

Cholesterol may be considered a difficult measure to address, since it is largely asymptomatic, and is not outwardly visible compared to risk factors such as smoking. The cholesterol issue is further compounded by the continued lack of public knowledge and understanding of cholesterol.[32] However, there is a myriad of data that shows where populations have higher rates of CVD. Other data can be used to help inform levels of health literacy and understanding and where populations have greater likelihood of higher risk such as poor diet and exercise. This data can be used to consider targeting local populations at risk of higher levels of cholesterol.

Measures to address cholesterol through JHWSs might include:

- Health promotion and awareness campaigns;
- Opportunistic public testing;
- Partnership with local communities and employers;
- Advice on lifestyle measures to address cholesterol.

Holding policy makers to account

HEART UK found that only 1 in 6 strategies included specific measurable outcomes of success for their stated CVD aims and less than 1 in 5 strategies identified an individual, team or organisation who assumed prime responsibility to coordinate or deliver CVD prevention in their area.

HEART UK is concerned that a lack of specific targets and clearly identified CVD leads will make it hard for local authorities to evaluate the success of their strategies.

Inequalities in CVD

Whilst the vast majority of JHWSs included specific mentions of health inequalities, HEART UK noted that 2 in 3 failed to recognise population differences or inequalities in CVD in their area. Of those that did acknowledge inequalities only 1 in 5 mentioned how they plan to address these. Some strategies limited discussion to a single dimension of inequality. For example, a few mentioned gender inequality as the only factor, while some mentioned ethnicity without taking into account poverty, geography, age and gender.

"Ensuring that all eligible residents have a Health Check will mitigate some of the effects of health inequalities particularly those relating to socio-economic grouping, ethnicity and gender."

Redbridge[33]

Recommendations

1. There should be clearer links between JHWS and JSNA. At present the Assessment and Strategy are not embedded together in a clear logic of 'problem' and 'solution'.
2. The importance of raised cholesterol needs recognising at a strategic level within JHWSs.
3. NHS Health Checks should be highlighted as a strategic tool within JHWSs to help tackle CVD.
4. There should be a clear allocation of CVD responsibility in JHWSs.
5. JHWSs should include success measures to assess their strategy against.
6. JHWSs must include details of how local authorities plan to address inequalities in CVD as well as discuss the various dimensions of inequality, eg. Gender, race, educational and socio-economic background.
7. Public Health England should provide advice and guidance to Health and Wellbeing Boards on key priority areas which should be covered in the JSNA and JHWS, including CVD burden and risk factors, such as cholesterol.

APPENDIX I

Joint Strategic Needs Assessment (JSNAs) audit results

	Is CVD mentioned?	Does it include data relating to changes and past trends in CVD prevalence and/or death rates?	Are Health Checks mentioned?	Is there an acknowledgement of cholesterol as a risk factor for CVD?	Does it reference CVD inequalities?
Barking and Dagenham	🟢	🟢	🟢	🟢	🟢
Barnet	🟢	🟢	🔴	🟢	🟢
Bexley	🟡	🔴	🔴	🔴	🔴
Brent	🟢	🟢	🟢	🔴	🟢
Bromley	🟢	🟢	🟢	🔴	🟢
Camden	🟢	🟢	🟢	🟢	🟢
City of London (and Hackney)	🟢	🟢	🟡	🟢	🟢
Croydon	🟡	🟢	🔴	🔴	🟢
Ealing	🟢	🟢	🟢	🟢	🟢
Enfield	🟢	🟢	🟢	🟢	🟢
Greenwich	🟢	🟢	🟢	🟢	🟢
Hammersmith and Fulham	🟡	🟢	🔴	🟢	🔴
Haringey	🟢	🟢	🔴	🟢	🔴
Harrow	🟢	🟢	🟢	🟢	🟢
Havering	🟢	🟢	🟢	🟢	🟢
Hillingdon	🟢	🟢	🟢	🟢	🟢
Hounslow	🟢	🟢	🔴	🔴	🟢
Islington	🟢	🟢	🟢	🟢	🟢
Kensington and Chelsea	🟢	🟢	🔴	🔴	🟢
Kingston	🟢	🟢	🔴	🔴	🟢
Lambeth	🟡	🔴	🔴	🔴	🟢
Lewisham	JSNA unavailable at time of research				
Merton	🟢	🟢	🟡	🔴	🟢
Newham	🟢	🟢	🟢	🟢	🟢
Redbridge	🟢	🟢	🔴	🔴	🟢
Richmond	🟡	🔴	🔴	🔴	🔴
Southwark	🟢	🟢	🟢	🟢	🔴
Sutton	🟢	🟡	🟢	🟢	🟢
Tower Hamlets	🟢	🟢	🟢	🔴	🟢
Waltham Forest	🟢	🟡	🟢	🟢	🟢
Wandsworth	🟢	🟢	🟢	🔴	🟢
Westminster	🟡	🟢	🔴	🔴	🔴

🔴 Not mentioned 🟡 Mentioned briefly 🟢 Specifically mentions CVD/Health Checks/CVD inequalities

APPENDIX II

Joint Health & Wellbeing Strategies (JHWSs) audit results

	Is CVD mentioned?	Are Health Checks mentioned?	Are any measures of success included for their CVD aims?	Does it specify who should be taking responsibility for CVD?	Is there an acknowledgement of cholesterol as a risk factor for CVD?	Does it reference CVD inequalities?
Barking and Dagenham	🟢	🟢	🟢	🟢	🔴	🔴
Barnet	🟢	🟡	🔴	🔴	🔴	🔴
Bexley	🔴	🔴	🔴	🔴	🔴	🔴
Brent	🟢	🔴	🔴	🔴	🔴	🟡
Bromley	🟢	🟡	🔴	🟢	🔴	🔴
Camden	🟢	🔴	🔴	🔴	🟢	🔴
City of London	🟢	🟡	🔴	🔴	🔴	🔴
Croydon	🟢	🟡	🔴	🔴	🔴	🟡
Ealing	🟢	🟢	🔴	🔴	🔴	🔴
Enfield	JHWS unavailable at time of research					
Greenwich	🟢	🟢	🔴	🔴	🟢	🔴
Hackney	🟢	🔴	🔴	🔴	🔴	🔴
Hammersmith and Fulham	🟢	🔴	🔴	🔴	🔴	🔴
Haringey	🟢	🟢	🔴	🔴	🔴	🟡
Harrow	🟢	🟡	🔴	🔴	🔴	🟡
Havering	🟢	🟢	🔴	🟢	🔴	🔴
Hillingdon	🟢	🟡	🔴	🔴	🔴	🔴
Hounslow	🟢	🟢	🔴	🔴	🔴	🔴
Islington	🟢	🟢	🟢	🟢	🔴	🟢
Kensington and Chelsea	🟢	🟡	🔴	🔴	🔴	🟡
Kingston	🟢	🟡	🔴	🔴	🔴	🔴
Lambeth	🟢	🔴	🔴	🟢	🔴	🔴
Lewisham	🟢	🟡	🟢	🔴	🔴	🔴
Merton	🟢	🟢	🔴	🔴	🔴	🟡
Newham	🟢	🔴	🔴	🔴	🔴	🔴
Redbridge	🟢	🟢	🔴	🔴	🔴	🟢
Richmond	🟢	🔴	🔴	🔴	🔴	🟡
Southwark	🟢	🔴	🔴	🔴	🔴	🔴
Sutton	🟢	🟢	🔴	🔴	🔴	🔴
Tower Hamlets	🟢	🔴	🔴	🔴	🔴	🔴
Waltham Forest	🟢	🟡	🔴	🔴	🔴	🟡
Wandsworth	🟢	🟢	🟢	🟢	🔴	🔴
Westminster	🟢	🔴	🔴	🔴	🔴	🟡

1 Townsend et al (2012), Coronary Heart Disease Statistics 2012 edition; British Heart Foundation Health Promotion Research Group and Department of Public Health, University of Oxford

2 Townsend et al (2012), Coronary Heart Disease Statistics 2012 edition; British Heart Foundation Health Promotion Research Group and Department of Public Health, University of Oxford

3 ibid

4 ibid

5 ibid

6 Marmot M (2010), Fair society, healthy lives : the Marmot Review : strategic review of health inequalities in England post-2010

7 Public Health England (2013), National General Practice Profiles; http://fingertips.phe.org.uk/profile/general-practice/, last accessed 13 February 2014

8 ibid

9 Greater London Authority Intelligence Unit (2013), 2012 Round Interim Ethnic Group Population Projections; http://data.london.gov.uk/datastorefiles/documents/update-07-2013-R2012-interim-EGPP.pdf, last accessed 11 February 2014

10 London Health Observatory (2010), London key facts – Cardiovascular Disease (CVD); http://www.lho.org.uk/Download/Public/16573/1/Key % 20fact % 208 % 20 CVD % 20FINAL.pdf, last accessed 22 January 2014

11 ibid

12 National Institute for Health and Clinical Excellence (2010), Lipid Modification: Cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease [CG67]

13 Townsend et al (2012), Coronary Heart Disease Statistics 2012 edition; British Heart Foundation Health Promotion Research Group and Department of Public Health, University of Oxford

14 National Institute for Health and Clinical Excellence (2008), Identification and management of familial hypercholesterolaemia [CG71]

15 Action on Smoking and Health (2014), Facts at a glace: Smoking statistics; http://www.ash.org.uk/files/documents/ASH_93.pdf, last accessed 22 January 2014

16 Health and Social Care Information Centre, NHS (2012), Health Survey for England – 2011: Trend tables; http://www.hscic.gov.uk/catalogue/PUB09302 last accessed 22 January 2014

17 Townsend et al (2012), Coronary Heart Disease Statistics 2012 edition; British Heart Foundation Health Promotion Research Group and Department of Public Health, University of Oxford

18 HEART UK (2011), Cholesterol and a Healthier Nation: shared responsibility for public health; http://heartuk.org.uk/files/uploads/documents/2011_12_HeartUK_CholesterolHealthReport2011_FINAL.pdf, last accessed 22 January 2014

19 Santry C (2011), Health inequalities scheme flagging as GPs shun 'charity work', Health Service Journal; http://www.hsj.co.uk/health-inequalities-scheme-flagging-as-gps-shun-charity-work/5036300.article, last accessed 22 January 2014

20 HEART UK (2011), Cholesterol and a Healthier Nation: shared responsibility for public health; http://heartuk.org.uk/files/uploads/documents/2011_12_HeartUK_CholesterolHealthReport2011_FINAL.pdf, last accessed 22 January 2014

21 Department of Health (2012), Public Health Outcomes Framework: Healthy lives, healthy people, Improving outcomes and supporting transparency; http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_132559.pdf, last accessed 22 January 2013

22 HEART UK (2013), Bridging the Gaps: Tackling inequalities in cardiovascular disease; http://heartuk.org.uk/files/uploads/Inequalities_for_web.pdf , last accessed 22 January 2014

23 Townsend et al. European Cardiovascular Disease Statistics 2012 edition, British Heart Foundation Health Promotion Research Group and Department of Public Health, University of Oxford

24 Office for National Statistics, Ranking of top 10 death categories for each London borough, commissioned by Clean Air in London; http://cleanairinlondon.org/wp-content/uploads/CAL-267-Update-re-death-rankings-080114_Final.pdf, last accessed 17 January 2014

25 Public Health England (2013), National General Practice Profiles; http://fingertips.phe.org.uk/profile/general-practice/, last accessed 13 February 2014

26 London Borough of Hackney and the City of London Corporation (2011), The City and Hackney Health and Wellbeing Profile: our joint strategic needs assessment, 2011/12

27 London Borough of Hammersmith & Fulham (2012), Prioritising Health and Wellbeing Needs: Hammersmith and Fulham: JSNA Highlight Report 2012

28 London Borough of Ealing (2012), Ealing JSNA 2012-13: Chapter 20.1 Cardiovascular Disease

29 London Borough of Hackney and the City of London Corporation (2011), The City and Hackney Health and Wellbeing Profile: our joint strategic needs assessment, 2011/12

30 Public Health England (2013), NHS Health Check Data; http://www.healthcheck.nhs.uk/interactive_map/, last accessed 13 February 2014

31 The National Archives (2013), The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives); http://www.legislation.gov.uk/uksi/2013/351/contents/made, last accessed 18 February 2014

32 HEART UK (2012), HEART UK 'extremely concerned' by research highlighting cholesterol ignorance; http://heartuk.org.uk/latest-news/article/heart-uk-extremely-concerned-by-research-highlighting-cholesterol-ignorance#sthash.GJUx2vDI.dpuf , last accessed 30 January 2014

33 London Borough of Redbridge (2012), Redbridge Health and Wellbeing Strategy 2012-2015