

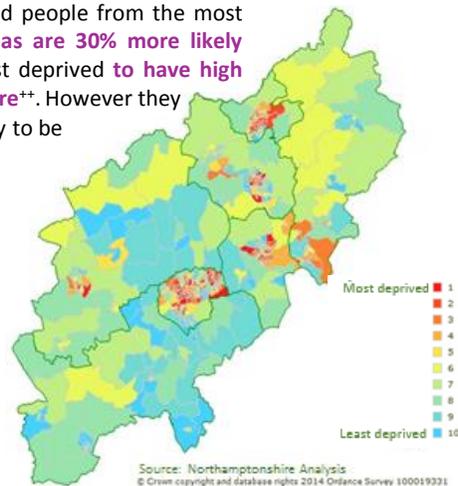
# The Public Health Call to Action for High Cholesterol and High Blood Pressure Prevention - Northamptonshire

## Prevalence



**106,762 (14.1%\*\*)** patients were recorded with hypertension in Northamptonshire in 2016/17, significantly above the England average.

It is estimated people from the most **deprived areas are 30% more likely** than the least deprived **to have high blood pressure\*\***. However they are least likely to be diagnosed.



It is estimated **6 out of 10** people have higher than recommended cholesterol levels.

**1 in 250** of the UK population are thought to have **familial hypercholesterolemia (FH)**, an inherited condition that raises blood cholesterol levels and dramatically **increases the risk of cardiovascular disease**.

## Diagnosis and Treatment Gap

An estimated **59%** of expected prevalence cases are diagnosed for hypertension\*\*.

An estimated **37,220** additional people with **undiagnosed hypertension** need to be diagnosed to meet the PHE+ ambition (80% diagnosed).

Nationally, an estimated **85%** of people with familial hypercholesterolemia (FH) are undiagnosed.

**28,910** additional people living with hypertension need to reach improved blood pressure levels (150/90) in Northamptonshire (to reach PHE ambition of 80% treated).



**80.8%** of patients with hypertension where last blood pressure measure (last 12 months) was  $\leq 150/90$  mmHg, 2016/17.



**91.3%** of patients aged 45 or over who had a record of a blood pressure reading in the preceding 5 years, 2016/17.



**68.8%\*\*** of patients with diabetes whose last measured total cholesterol (measured within the previous 12 months) was 5mmol/l or less, 2016/17.

## Health Burden



**TOP 10**



High blood pressure and high cholesterol are identified in the top ten **risk factors** locally for **premature death and disability** by the global burden of disease study.

High cholesterol and high blood pressure are **main risk factors for heart disease**. They are worsened by poor lifestyle behaviours:



eating a lot of saturated fat



not being active



smoking



having too much body fat, especially around the middle

**669.7**  
Coronary heart disease admissions, per 100,000 population, 2016/17

**89.1%**  
of patients with CHD in whom the last blood pressure reading in last 12 months is  $\leq 150/90$ ; 2016/17.

**48.8**  
deaths from cardiovascular disease considered preventable per 100,000 population (aged <75 years), 2014 – 2016.

## Prevention

If people diagnosed with high blood pressure **reduced it by 10mmHg** across Northamptonshire\*\* each year we **could prevent:**



**28%** heart failure



**27%** strokes



**17%** coronary heart disease



**13%** all-cause mortality



NHS Health Checks can spot early signs and help prevent conditions like high blood pressure, heart disease or type 2 diabetes.

In 2017/18, **15,866** people received **health checks** in Northamptonshire:

**98.3%**  
had their blood pressure (BP) recorded

**23.6%**  
of these had raised blood pressure

**94.2%**  
had a cholesterol test

**Less than half (47.6%)** re-measured blood pressure after health checks.

It is estimated that up to **80%** of premature deaths from cardiovascular disease, can be prevented through better public health, particularly addressing behaviour change in modifiable risk factors.

Compared to England Better Similar Worse Lower Similar Higher

Data Source: Fingertips; PHE; TCR, British Heart Foundation. Icons by Freepik, curso creative from www.flaticon.com and by Ricardo Moreira, itim2101 from thenounproject.com  
\* based on England estimates; \*\*Estimated for Northamptonshire STP combining Corby CCG and Nene CCG figures; ^BHF, 2012; + Public Health England; ++ Health Matters, PHE 2017.

## Vision:

Achieve personal ownership of blood pressure results, increase reliable detection, diagnosis and treatment rates to lead to a reduction of blood pressure in adults aged 40 years and over. Detect and diagnose an additional 50,000 cases of blood pressure in Nene and Corby CCGs.

Continue the downward trend in stroke and cardiovascular rates to reduce by 10% in 10 years. Reduced alcohol related cardiovascular disease and admissions.

## Our Priorities/Objectives

### Whole system approach

Partnership working with NHS, social impact bond and First for Wellbeing teams to provide joined up prevention pathways and strategic outcomes. Partnerships with regulatory services and planning and transport services to increase opportunities for healthy living.

#### Achieved through:

- Joint commissioning, pathway definition.
- Social prescribing
- Lifestyle changes (alcohol reduction, exercise increase, obesity reduction, smoking reduction, etc.)

### Commissioning

Strategic, public health and joint commissioning to meet county health opportunity for blood pressure reduction.

#### Achieved through:

- NHS health checks – new model of delivery for improved uptake, signposting to support and quality
- Support for partner organisations on opportunistic checks and pathways to treatment
- Workplace wellbeing blood pressure checks, signposting and advice

### Behavioural approaches

Amplify national campaigns with partners, for example 'Know Your Numbers'. behavioural approaches to reduction of lifestyle risks for high blood pressure and high cholesterol: diet, exercises, smoking, alcohol intake, etc.

#### Achieved through:

- Campaigns, communication with frontline health and other staff
- Work with partners to embed, especially in deprived areas

### Evidence based approach

Use of evidence and evaluation to advise and inform partners and to design and tailor strategic outcomes.

#### Achieved through:

- Joint Strategic Needs Assessment (JSNA)
- Return On Investment (ROI)
- Evaluation
- Evidence reviews, case study comparison, learning and continuous quality improvement

## Our Commitment / Enablers

Reducing inequalities – services which mitigate inequalities and work to overcome variation - by location, approach and policy.

System partnerships - engage and co-produce with partners / stakeholders e.g. NHS, schools, prisons, workplaces and local government.

Supporting investment and commissioning of effective services across the county, accessible to all.

Engagement and co-production of research to align with best evidence and implementation locally.

Embed Health in all Policies - a common way of influencing the wider determinants of health: creating places that promote good health; governance/policies based on collaboration.

## Measures of Success

- 80% detection /diagnosis rate
- PHOF outcomes related to blood pressure and cholesterol e.g. activity, obesity, alcohol and smoking
- Reduction in stroke incidence
- Improved levels of understanding in the general population
- Appropriate prescription rates in primary care
- Qof\* and similar registers e.g. registration increase to improve outcomes