Cardiovascular Disease in Royal Greenwich 2025

Public Health Intelligence Team

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Cardiovascular Disease in Royal Greenwich 2025

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CVD in Royal Greenwich: Summary and Key Findings

Summary

This JSNA examines cardiovascular disease (CVD) in Royal Greenwich – looking at the causes and impact of CVD, and how CVD is being addressed through national and local prevention and treatment strategies.

CVD is a major cause of ill-health and disability. Thousands of adults in Royal Greenwich have CVD, or a condition that could lead to a serious CVD event such as a stroke or heart attack. Rates of death due to CVD remain relatively high.

There are many opportunities to address CVD through prevention, early identification and optimal treatment - around 80% of the factors which place people at risk of developing CVD are modifiable by:

- supporting behaviour change with services such as smoking cessation
- increased early detection and improved management in primary care
- provision of primary care services such as cholesterol lowering treatments

The JSNA will also examine the impact of CVD on our different communities and where possible indicate where additional action may be needed to reduce these, working with our communities to identify solutions that work better for them.

The varying access we have to the 'building blocks of health' is fundamental to the development and experience of CVD. Many of our residents have fewer opportunities to live a healthy life. The impact of this can start in childhood or even at conception. Royal Greenwich is committed to delivering programmes and activities which reduce inequality amongst our residents, and which will help them thrive. This is set out in Our Greenwich.

There are already activities and programmes in place addressing CVD risks and providing treatment across Greenwich and South-East London. Royal Greenwich and its partners are committed to reaching more people, especially those at greater risk of developing CVD, so that they can access the support available in ways that work better for them.

This CVD JSNA chapter was developed by the Royal Greenwich CVD JSNA Steering Group and Public Health Intelligence Team, with additional information, support and feedback from the wider Public Health and Wellbeing Department and colleagues in Primary Care. Many thanks to all who contributed.

CVD in Royal Greenwich: Summary and Key Findings

*Some people will have both (and other) conditions.

CVD is a major health concern in Royal Greenwich, responsible for 24% of all deaths and 22% of premature deaths (under age 75). Rates of mortality due to CVD were amongst the highest in London in 2021-23.

CVD is also a major cause of ill-health and disability. Around 59,000 Greenwich patients have CVD or a related condition. Many more have undiagnosed illness – for example there may be 27,000 more people with undiagnosed hypertension, and 10,000 more people with undiagnosed diabetes and pre-diabetes*.

Some communities are at greater risk of developing CVD such as Black and Asian communities, people living in more deprived neighbourhoods, people with poor mental health and people with learning disabilities.

As found nationally our Black residents have a higher prevalence of diabetes, hypertension and stroke and our Asian residents a higher prevalence of diabetes and CHD. Our white residents have a higher prevalence of atrial fibrillation which is another pattern seen elsewhere.

Men have higher prevalence of CVD than women as is the case nationally. However, there are relatively high rates of admissions and deaths due to CVD amongst Greenwich women compared to their peers elsewhere in London.

There are many opportunities to address CVD through prevention, early identification and optimal treatment - around 80% of the risk factors for developing CVD are modifiable. Modifiable risk factors include (amongst others) smoking, alcohol consumption, physical activity, diabetes and high blood pressure.

Some risk factors are of increasing concern. For example, surveys indicate that fewer residents are completing the recommended amount of physical activity (only 59% of Greenwich adults did so in 2022-23). And rates of excess weight are high across all Greenwich communities and neighbourhoods (rising to an average of 57% of Greenwich adults in 2022-23).

CVD in Royal Greenwich: Summary and Key Findings

Some communities experience greater prevalence of some risk factors. For example, the percentage of residents with excess weight is higher in our deprived neighbourhoods. Black residents are also more likely to have an excess weight.

Smoking is another risk factor for CVD. While the rate of smoking has decreased substantially overall, this is not uniform. Rates are known to be higher in deprived and vulnerable groups, including people with mental health conditions and some ethnic groups. Smoking is generally higher amongst men in any social group compared to women.

Greenwich offers a wide range of programmes which address CVD and CVD risk factors such as smoking cessation, cookery clubs, exercise programmes and provision of lipid lowering therapy. Live Well Greenwich offers social prescribing to supporting behaviour change

Tools available to identify patients at risk of CVD are not reaching enough people. Uptake of NHS Health Checks is below the national target - only 21% of eligible patients received their check between 2019–2024, compared to 28% in England. The Alcohol Audit (important in addressing higher levels of alcohol consumption) appears to be underused.

Greenwich's population is growing, ageing and becoming more diverse. As a result, more people are at risk of developing CVD. Prevention and early identification will become increasingly important to ensure CVD events such as strokes and heart attacks continue to reduce in number, and do not increase at the same rate.

Effective CVD prevention requires targeted community engagement focused on reducing health inequalities. Greenwich is responding by implementing a neighbourhood-based approach to health improvement which includes for example, School based Superzones, and community-led interventions.

COVID-19 disrupted CVD prevention and care, leading to missed diagnoses and treatment opportunities. Catch up programmes were rolled out following the pandemic. Targeted outreach is also being undertaken. For example, a project reaching out to patients who have not previously taken up their health checks (at GP practices with lower take up rates).

Cardiovascular Disease in Royal Greenwich 2025 - Chapter Aims

Cardiovascular Disease in Royal Greenwich 2025: Summary and Key Findings

Introduction to Cardiovascular Disease and the risk factors, co-morbidities and wider determinants that contribute to the development of CVD

What is the Impact of Cardiovascular Disease on the Greenwich Population

Prevalence of Factors that Increase the Risk of Cardiovascular Disease in Greenwich

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Introduction to Cardiovascular Disease

The Building Blocks of Health and Health Inequalities

Health and wellbeing is a complex picture, influenced partly by personal characteristics (such as our genes) and partly by our behaviours and coping skills (e.g. whether we smoke, how active we are, what we eat, and how we deal with stress). Whilst these are important influences, the social, financial, and environmental circumstances in which we are born, live, study, work and age account for around 50% of the variation in health outcomes, These factors are known as the 'building blocks of health' (see visual, top right). They have also been described as the 'wider determinants of health'.

Many of the building blocks of health are beyond a person's control. We don't all have the same opportunities to live healthy lives. Unequal advantages and disadvantages build up over time, leading to differences in health outcomes for some people compared with others. These avoidable and systematic differences are known as health inequalities.

Other dimensions of health inequalities which contribute to our 'health status' include differences in access to care and the quality of care received. (see visual, bottom right).

Health inequalities are often measured by differences in outcomes. For example, the gap in life expectancy between the most deprived and least deprived neighbourhoods both nationally and locally. Our marginalised communities are often the most affected. An extreme example is average life expectancy amongst people who are homeless: 45 years for men and 43 years for women - almost half that found for the general population. Other health inequalities can be less obvious but still result in too many people, including people in Greenwich, living their lives in poorer health and dying earlier than they should.

Health inequalities experienced between different groups of people are often analysed across four main categories: socio-economic factors (for example, income); geography (for example, region); experience of stigma or discrimination due to specific characteristics (such as ethnicity, sex, sexual orientation or disability); and socially excluded groups (for example, people who are seeking asylum or experiencing homelessness). The effects of inequality can be compounded for groups of people who have more than one type of disadvantage (related to the concept of intersectionality).

The building blocks of health

Source: The Health Foundation/2025 RBG APHR

The different 'dimensions' of health inequalities

Source: The Kings Fund/2025 RBG APHR

The Building Blocks of Health and Health Inequalities (cont'd)

To create a fairer, healthier society and close the gaps in health, we need all the right building blocks in place, including stable jobs, fair pay, quality housing and education, access to healthy food, good transport, safe surroundings and inclusive communities.

In this JSNA we will describe the impact of CVD in Greenwich, including where possible the range of impacts across our different communities. We are limited by the information available which might not include all types of CVD, results for all communities, or any results at borough level. Hospital admissions data is not fully coded for ethnicity and mortality data does not currently include ethnicity. However, some consistent patterns have been found nationally, such as higher rates of CVD in deprived or Black and Asian communities, and some of our local findings reflect this.

Understanding the impact of CVD on our communities can support action needed to reduce health inequalities. Royal Greenwich is also committed to Neighbourhood Working – working with our communities to understand their concerns and identify solutions that work for them.

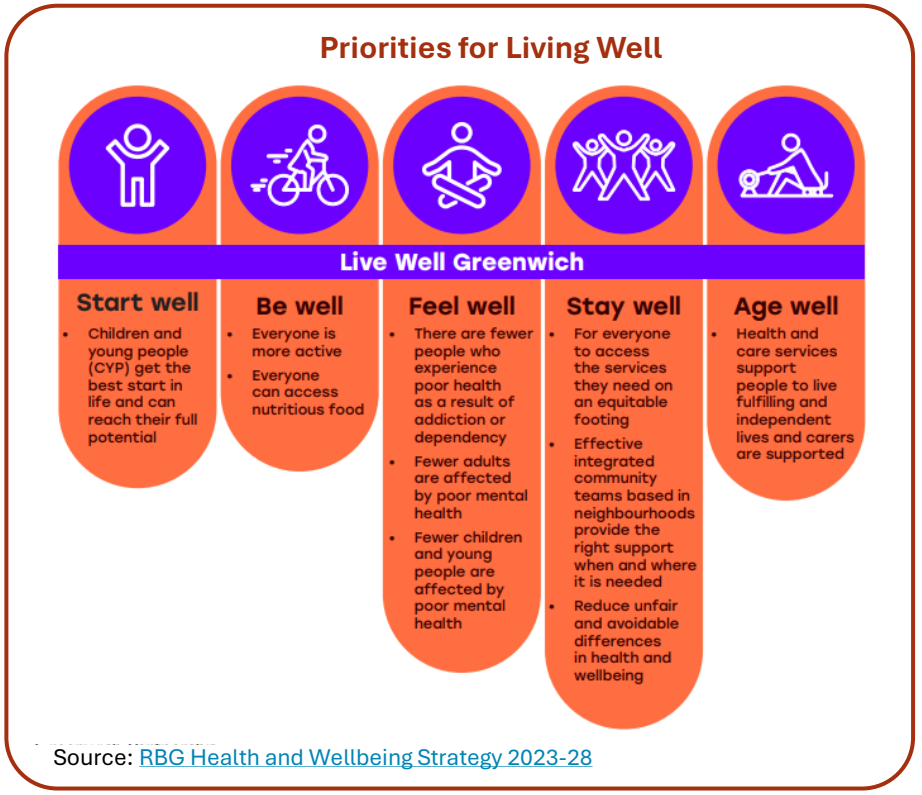
More information about health inequalities in Greenwich can be found in the 2025 Royal Greenwich Annual Public Health Report.

Supporting Everyone to Live Well

The impact of health inequalities begins before birth and continues into later life. Health inequalities prevent many children and young people from reaching their potential and can lead to greater disability and premature death in adults.

In Royal Greenwich, we want everyone to have the opportunity to "Live Well", at all the stages and transitions of their life, from "Starting Well" to "Ageing Well". Ten priority areas have been identified where actions will help residents to have better health at these life stages (right). Addressing CVD is intrinsic to this.

The Royal Greenwich Health and Wellbeing Strategy 2023-28 was developed following engagement and consultation with residents, stakeholders and staff and reflects the things they have identified as important to their lives, health and wellbeing.



Source: RBG Health and Wellbeing Strategy 2023-28

Introduction to Cardiovascular Disease

What is Cardiovascular Disease?

Cardiovascular Disease (CVD) is an umbrella term for conditions affecting the heart or blood vessels. Although some conditions are present from birth, CVD usually develops as people grow older. Many types of CVD are preventable, and more action can be taken to reduce premature deaths and disability resulting from it. Some of the main conditions are:

Coronary heart disease (CHD) – occurs when blood flow to the heart is blocked or reduced, leading to angina, heart attacks and heart failure.

Aortic disease – a group of conditions affecting the aorta, the largest blood vessel in the body, including aortic aneurysms.

Strokes and transient ischaemic attacks (TIAs) – occur when blood flow to the brain is cut off, which causes stroke or TIAs ('mini-strokes').

Other types of CVD - atrial fibrillation, chronic kidney disease, heart valve disease and vascular dementia

Peripheral arterial disease – occurs when fatty deposits in the arteries restrict blood supply to the arms or legs.

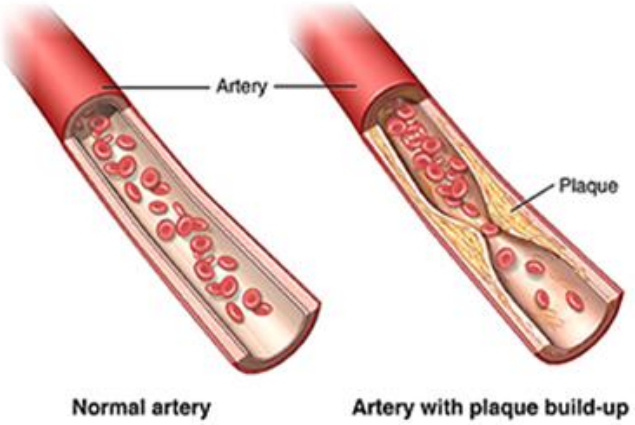
The World Health Organisation recognises CVD as the leading cause of death globally, responsible for an estimated 20 million lives per year.

Nationally, premature CVD mortality is four times higher in the most deprived communities.

CVD is the largest contributor to the gap in life expectancy Between the most and least deprived neighbourhoods in Greenwich, accounting for up to 25% of this difference.

CVD prevention and management is a national priority (as set out in strategies such as the NHS Long-Term Plan) which will also help to reduce health inequalities; a goal in Our Greenwich.

A process known as '**Atherosclerosis**' leads to many forms of preventable CVD. As cholesterol and other fats build up within the artery walls, the arteries can harden and narrow. This leads to restricted blood flow and a risk of rupture with release of blood clots from areas where fatty 'plaques' have developed.



Introduction to Cardiovascular Disease

What are the risk factors for developing CVD?

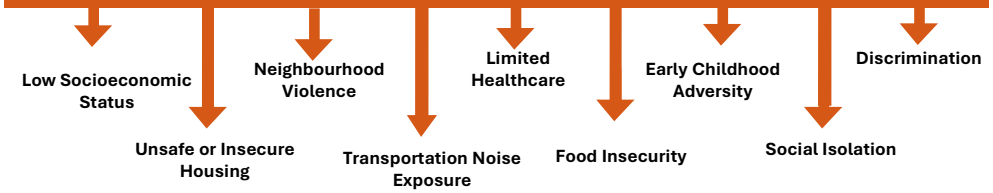
There are many factors which increase a person's risk of developing CVD. These are known as modifiable and non-modifiable risks. **Modifiable risk factors** provide opportunities to delay or prevent the onset and improve CVD outcomes. They account for nearly all (around 80%) of the risk of developing CVD across the population. **Non-modifiable risk factors** cannot be controlled – some people and communities are more at risk and might need earlier or more intensive support to help prevent CVD or control it where it has developed. This will help to avoid additional health inequalities.

Co-morbidities, risk factors and wider determinants

Co-morbidities that increase the risk of CVD	Modifiable risk factors	Non-modifiable risk factors
High blood pressure (hypertension)	Smoking	Age
High or abnormal cholesterol levels or dyslipidaemia	Physical activity	Gender – increased CVD risk in men
Irregular heartbeat (atrial fibrillation)	Diet	Ethnicity – increased CVD and diabetes risk in South Asian and Black groups
High blood glucose levels	Living with obesity	Family history of CVD
Diabetes	Alcohol consumption	
Chronic kidney disease		
All influenced by the social determinants of health		

Social Determinants of Health

Chronic Psychological and Environmental Stressors



Introduction to Cardiovascular Disease

Prevention, early identification and optimal treatment

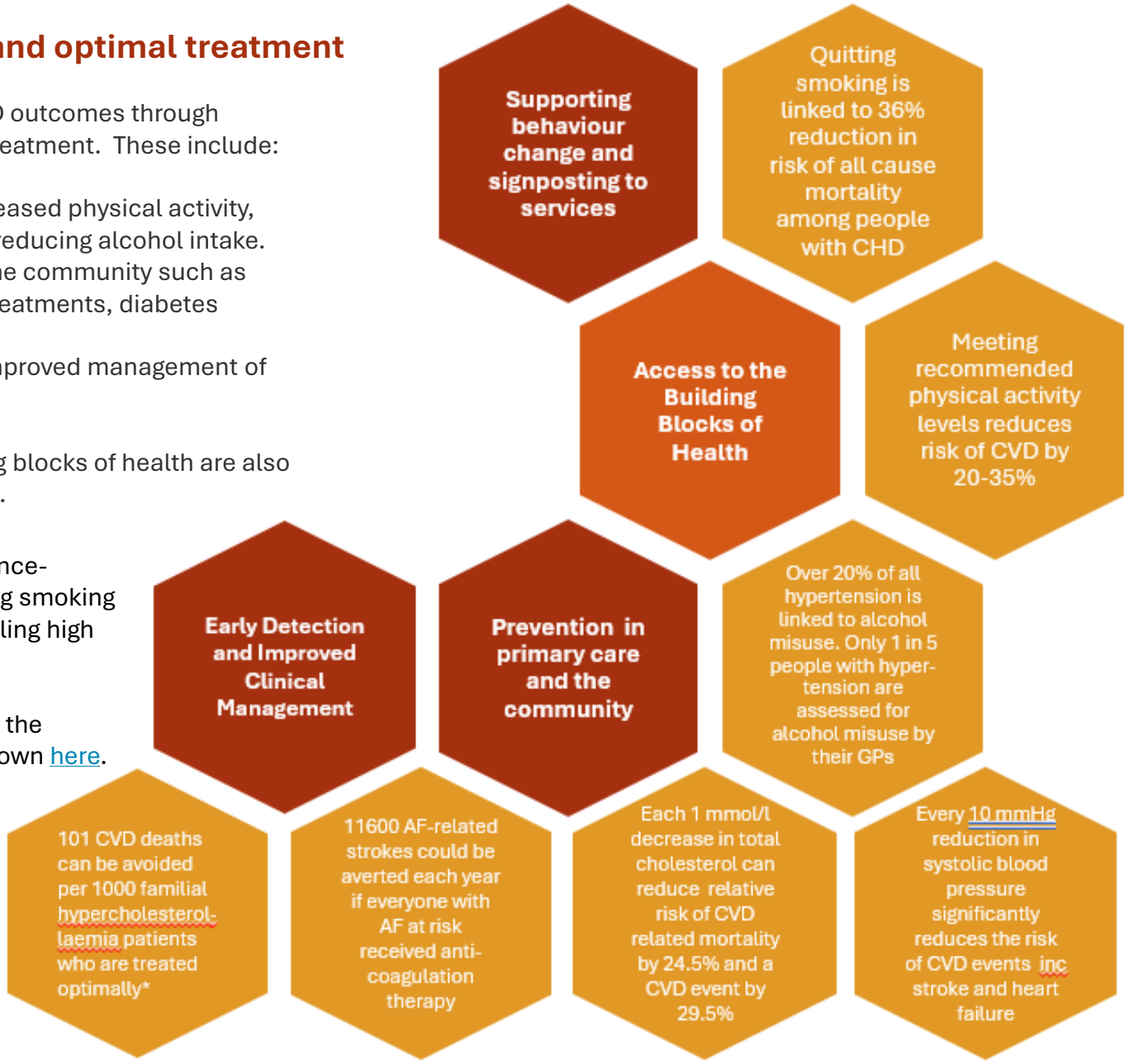
There are many opportunities to improve CVD outcomes through prevention, early identification and optimal treatment. These include:

- supporting behaviour change such as increased physical activity, eating healthier foods, stopping smoking, reducing alcohol intake.
- provision of services in primary care and the community such as cholesterol and blood pressure lowering treatments, diabetes prevention and stop-smoking services.
- increased early detection of illness and improved management of CVD risks in primary care.

Actions which increase access to the building blocks of health are also fundamental - for example poverty reduction.

PHE (2016) pointed to the wide range of evidence-based opportunities to address CVD, including smoking cessation, increased physical activity, controlling high blood pressure.

Some of their recommendations are shown in the picture, right. Other recommendations are shown here.



*compared to no treatment

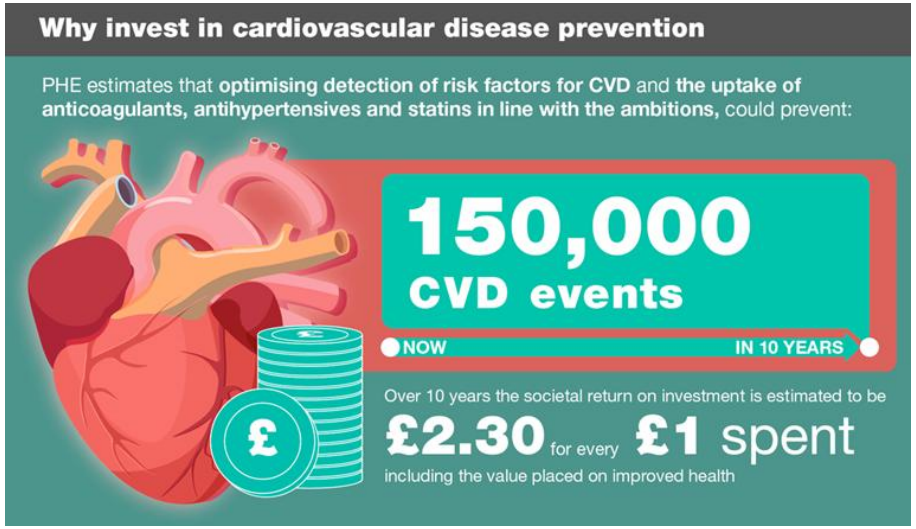
Introduction to Cardiovascular Disease

Increasing numbers of people at risk of developing CVD

Increasing access to the building blocks of health is fundamental to reducing people's risk of developing CVD and other health conditions. It is also important to identify and treat people who are at higher risk of developing CVD. This can be achieved by supporting people to reduce their risk in order to delay or prevent onset of CVD, increase diagnoses at an earlier stage and improve management of conditions which have already developed.

The NHS Long Term Plan (NHSLTP) set out the intention to prevent 150,000 cases of strokes, heart attacks and dementia by 2029 by improving the detection and treatment of atrial fibrillation (AF), hypertension (high blood pressure) and high cholesterol – the "ABC of prevention".

As the population changes, the number of people at risk of developing CVD is also likely to increase. · Prevention will be increasingly important. It has been projected that the number of people in the UK with a higher than 20% risk of developing CVD would rise from 3.5 million in 2010 to 4.2 million in 2022. (This total is likely to have increased by 2025, especially as opportunities for diagnosis and treatment were missed during the COVID-19 pandemic). Early identification and support can contribute to ensuring that CVD events such as strokes and heart attacks do not increase at the same rate. More details about the changing population in Greenwich are on the next slide.



The economic costs of CVD

In 2019, Public Health England reported that the health and social care costs relating to CVD were estimated at £7.4 billion each year, with wider costs to the UK economy (such as premature death, disability and informal costs) estimated at £15.8 billion annually. (A later report by the British Heart Foundation suggested that healthcare costs might have grown to £12 billion with the total cost to the UK economy up to £30 billion annually).

PHE estimated that if the government achieved its ambition of preventing 150,000 CVD events, it was predicted that the return on investment would be £2.30 for every £1 spent.

Introduction to Cardiovascular Disease

CVD and our changing population

Between 2011 and 2021, the Greenwich population grew from around 254,000 to 289,000 people (ONS Census). Our population is also ageing and becoming more diverse. As a result, there are a greater number of people in Greenwich who are at risk of developing CVD.

Change in ethnic populations between 2011 and 2021 census, Royal Greenwich

Ethnic Group	2011	2021	Increase from 2011 (Numbers)	Increase from 2011 (Percentage)
White	159,002	161,008	2,006	1.3
Black	48,655	60,602	11,947	24.6
Asian	29,894	38,029	8,135	27.2
Mixed/multiple	12,274	17,297	5,023	40.9
Other	4,732	12,132	7,400	156.4
Total Population	254,557	289,068	34,511	13.6

The Greater London Authority's 2022 Housing Led (Central) Projection suggests the Greenwich population will increase by a further 34,000 people by 2031. Programmes targeting CVD risk will need to keep pace to maintain and increase their impact. For example, the NHS Health Checks Programme targets people aged 40-74 – 60% of the additional 34,000 people were expected to be in this age range.

Evidence suggests some communities, including communities in Greenwich, are more at risk of developing CVD:

- it is established that people from Black and Asian communities are more at risk of developing CVD. There were 12,000 more Black residents in Greenwich in 2021 compared to 2011 (up 25%), and 8,000 more Asian residents (up 27%).
- Our White population has relatively high rates for smoking and drinking alcohol – independent risk factors for developing CVD.
- The number of people identified as 'White Other' increased by nearly 16,000 people (up 74%) between 2011 and 2021. This will include people from Eastern Europe who are understood to have higher rates of smoking (for example, the 2023 APS found that 20% of respondents born in Poland were smokers. Other health needs (and CVD risks) affecting our Eastern European communities are still to be fully identified.
- The largest percentage change between 2011 and 2021 was for people who have (an)Other ethnicity (up 156%). There are only 12,000 people in this group (up from 5,000 in 2011) but again this might represent new communities with emerging needs.
- There is currently a lower rate of (crude) CVD prevalence amongst people of Mixed ethnicity, but this seems due to a younger age-mix. Rates of CVD amongst older people with mixed ethnicity are similar to other older residents, so we can anticipate that as this community ages, the rate of CVD (all ages) will increase too.

Further information about the Greenwich population can be found in the Greenwich Data Observatory

Introduction to Cardiovascular Disease

CVD: The Policy Context

Cardiovascular disease is a global, national, and local issue and to address this, there are a number of evidence-based policies, guidelines and legislation which inform prevention, early identification and treatment of CVD.

National

The NHS Long Term Plan (NHSLTP) set out the intention to prevent 150,000 strokes, heart attacks and dementia cases by 2029 by improving the detection and treatment of atrial fibrillation (AF), hypertension (high BP) and high cholesterol.

The Government has published its 10 Year Health Plan (2025) underlined by 3 big shifts in healthcare which will all impact on treatment services for the leading causes of death such as CVD.

Lord Darzi's Independent investigation of the NHS in England (2024) concluded that care for cardiovascular conditions is going in the wrong direction.

Michael Marmot's 2024 report 'Health Inequalities, Lives Cut Short' highlights the health inequalities experienced between the least and most deprived communities. The most deprived communities experience higher death rates from CVD than the least deprived.

The Fuller Stocktake (2022) outlines a vision for integrating primary care, including helping people to stay well for longer as part of a more ambitious and joined-up approach to prevention.

The Office for Health Improvement and Disparities Outcomes Framework provides a set of outcomes by which to measure success in tackling a number of public health issues.

Global

The World Health Organisation's Global Non-Communicable Diseases action plan 2013–2020 and NCD Compact 2020-2030 recognises the primary role and responsibility of governments in responding to the challenge of NCDs and the important role of international cooperation to support national efforts.

Local

The Health and Wellbeing Strategy 2023-2028 includes practical and achievable steps to improve people's health and wellbeing including: 'Everyone is more active', and 'Everyone can access nutritious food'.

Our Greenwich seeks to tackle the root causes of ill health and prevent issues from developing in the first place; aiming to have fewer people who experience poor health as a result of addiction or dependency.

Local partners such as South-East London Integrated Care System and Greenwich Health identify the need for tackling known risk factors that drive poor health outcomes and inequalities and outline ways to tackle these known issues including the prevention and early identification of CVD in the borough.

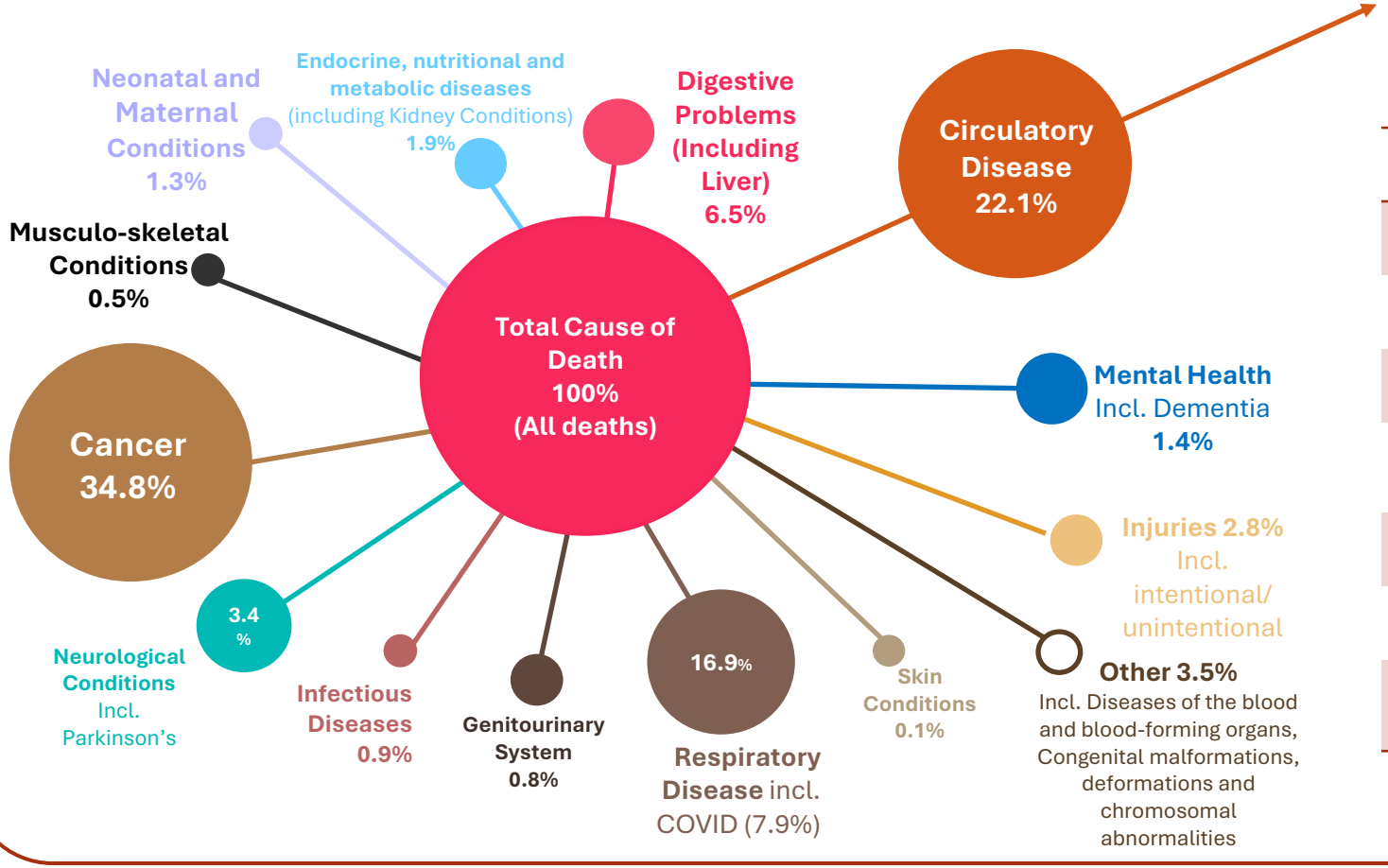
Cardiovascular Disease in Royal Greenwich 2025 - Chapter Aims

Impact of CVD in Royal Greenwich

CVD as a leading cause of disability and premature death

In the last two decades improved identification and treatment has led to fewer deaths due to CVD. In Greenwich, the rate of mortality due to CVD has also improved and moved closer to the average for London and England. However, CVD is still a major cause of disability (around 7 million people are living with CVD in England) and it causes a quarter of all deaths. In 2019-23, CVD caused 24% of deaths of Greenwich residents, and 22% of premature deaths (779 out of 3,572 deaths before the age of 75). Work still needs to be done to reduce the number of people dying younger than they should due to CVD, particularly for the communities experiencing the greatest inequalities.

Leading factors in Royal Greenwich that cause deaths for people aged <75 in Greenwich (2019-23)



Deaths for people aged <75 in Greenwich (2019-23) caused by Heart Disease (detailed cause)

Circulatory disease	100%
Heart disease	33%
Heart attack	20.8%
Stroke and TIA	12.7%
Hypertensive heart disease	3.8%
Heart failure	1.8%
Atrial fibrillation	1.2%
Other circulatory system diseases	31.5%

Source: ONS Mortality data

Impact of CVD in Royal Greenwich

CVD and life expectancy

Fewer and later deaths due to CVD have also contributed to increased life expectancy. However, CVD remains a significant factor especially when examining differences in life expectancy between different groups of people.

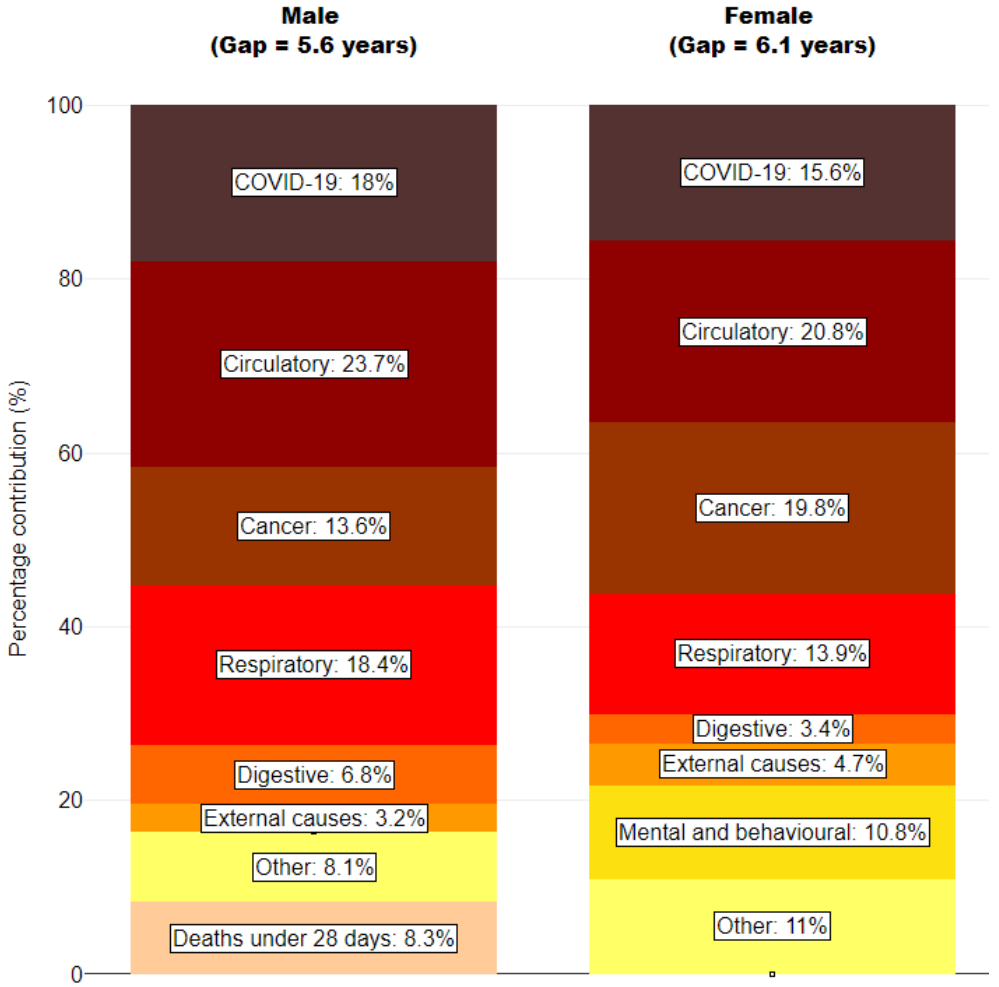
CVD is strongly associated with health inequalities. It disproportionately affects people from deprived neighbourhoods, Black and Asian communities, people with serious mental illness, and people with learning disabilities. Some people will experience more than one factor (intersectionality) and a cumulative impact (for example, a person might be Black and have a disability). Differences in access to the '[building blocks of health]' drive health inequalities, influencing the risk of developing CVD, and having access to the support needed to prevent, diagnose or treat CVD. This impact begins at conception.

The chart to the right shows that in 2020-21, there was a gap in life expectancy of 5.6 years between Greenwich men from the most deprived neighbourhoods and Greenwich men from the least deprived neighbourhoods: 23.7% of this inequality in life expectancy was caused by deaths from CVD (shown here as 'circulatory disease'). In the same year, the gap in life expectancy for Greenwich women was 6.1 years: 20.8% of this was caused by CVD.

It is understood that there are higher rates of CVD in men. However, there are continued reports that symptoms women experience can be underdiagnosed and undertreated. For example, research found that symptoms of heart attack in women can be different to those men typically experience[0]. This has meant that women can be less likely to receive appropriate interventions in the time required.

People living in deprived communities are 4 times as likely to die prematurely because of CVD compared to people in more affluent populations.

Breakdown of the life expectancy gap between the most and least deprived quintiles of Greenwich by cause of death, 2020 to 2021



Source: OHID Segment Tool

Impact of CVD in Royal Greenwich

How many people have CVD in Greenwich?

In 2025, the British Heart Foundation estimated that there were around 19,000 people living with CVD in Greenwich (around 1 in 20 residents).

In early 2025, the South-East London (SEL) Long Term Conditions Dashboard showed that nearly 59,000 patients registered with Greenwich GPs (17.8% of patients) were diagnosed with CVD or a related condition. (The *CVD Cluster includes risk factors such as obesity - the full list of conditions is shown below).

Age, Sex and CVD in Greenwich

CVD increases with age – more than 4 in 5 Greenwich patients aged 80+ had been diagnosed with a condition from the SEL CVD Cluster.

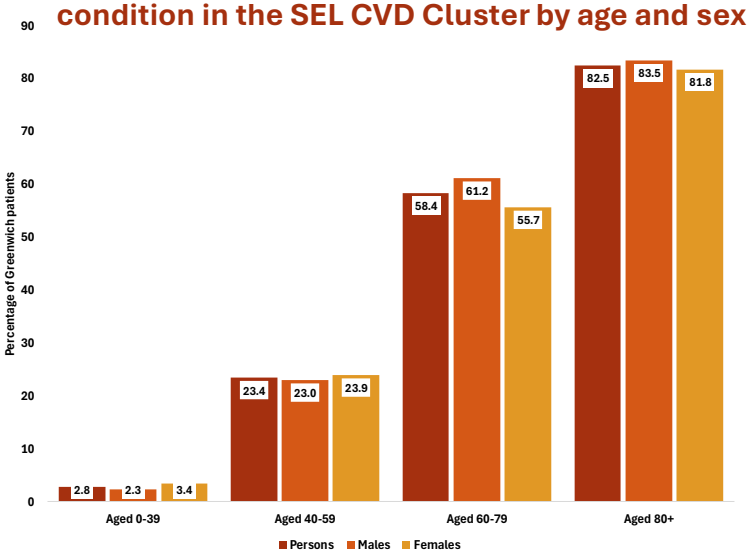
- Around 5,300 patients were aged under 40 (3% of all Greenwich patients <40)
- Around 21,500 were aged 40-59 (23% of Greenwich patients aged 40-59)
- Around 25,300 were aged 60-79 (58% of Greenwich patients aged 60-79)
- Around 6,700 were aged 80+ (83% of Greenwich patients aged 80+)
- 18.3% of all female patients (from 3.4% aged under 40 to 81.8% aged 80+
- 17.3% of all male patients (from 2.3% aged under 40 to 83.5% aged 80+)

Similar percentages of men and women had a CVD Cluster diagnosis. The largest difference was in age group 60-79 where 61.2% of male patients had a diagnosis compared to 55.7% of female patients (top, right).

Directly Standardised Rates (which take age into account) suggest male patients had slightly (but significantly) higher rates of a CVD Cluster diagnosis. For example, amongst patients aged under 75, 17,443 men per 100,000 male patients compared to 17,208 women per 100,000 women female patients (bottom, right).

*CVD conditions included in the SEL CVD Cluster were Atrial Fibrillation, CKD, CHD, Diabetes Mellitis, Heart Failure, Hypertension, Obesity, Peripheral Arterial Disease, Stroke and Transient Ischaemic Attacks

Percentage of Greenwich Patients with at least 1 condition in the SEL CVD Cluster by age and sex



Greenwich Patients with at least 1 long-term condition in the SEL CVD Cluster

	All	Female	Male
CVD Cluster	58,700	30,150	28,550
Hypertension	42,100	21,200	20,900
Diabetes	20,650	9,550	11,100
Obesity	8,250	5,800	2,450
Atrial Fibrillation	3,650	1,500	2,150
Chronic Kidney Disease (CKD)	8,050	4,400	3,650
CHD	6,100	2,150	3,950
Heart Failure	2,100	850	1,250
Peripheral Arterial Disease (PAD)	1,200	450	750
STIA	4,000	1,850	2,150
Prevalence per 100,000 patients (DSR)	24,467	24,169	24,819
Prevalence per 100,000 patients aged under 75 (DSR)	17,443	17,208	17,716

Raw numbers are rounded to nearest 100

Impact of CVD in Royal Greenwich

Prevalence of CVD in Greenwich (cont'd)

Male patients were a little more likely to have more than 1 diagnosis identified per patient: on average 1.7 compared to 1.6 per female patient. The most frequent CVD cluster diagnoses recorded were hypertension and diabetes. This was followed by obesity for women and CHD for men.

Percentage of Greenwich Patients with at least 1 condition in the SEL CVD Cluster by age and ethnicity

Age Group	White	Black	Asian	Mixed	Other	Unknown	All Patients
Aged 0-39	2.9	3.9	2.7	2.5	1.5	1.4	2.8
Aged 40-59	18.8	36.6	26.9	25.3	14.5	14.0	23.4
Aged 60-79	56.0	68.4	67.7	60.6	46.7	42.5	58.4
Aged 80+	82.0	87.2	88.4	87.9	74.9	69.6	82.5
All Ages	19.4	22.0	17.5	10.6	10.8	7.8	17.8
All Ages (Number)	30,700	14,500	7,600	1,700	2,200	2,100	58,700
Population (Number)	158,600	65,800	43,200	15,600	20,000	26,400	329,600

Numbers are rounded to nearest 100

Ethnicity and CVD in Greenwich

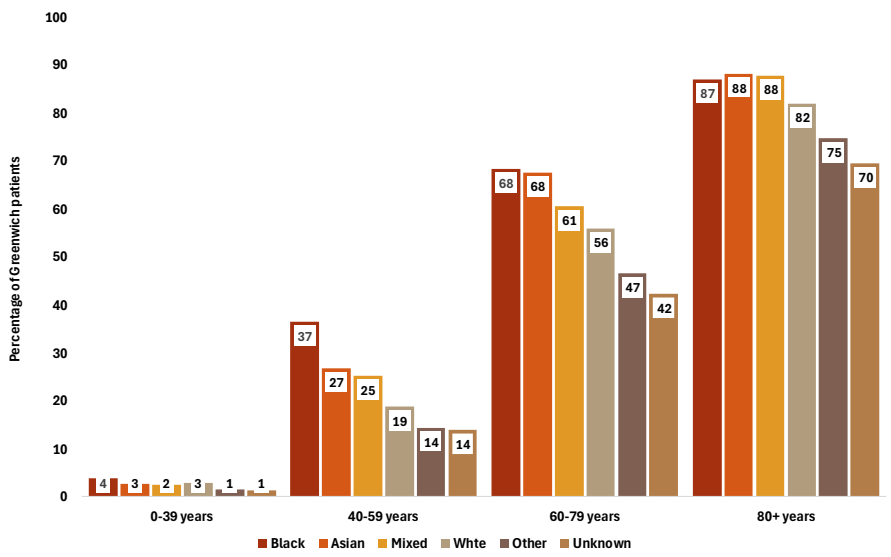
Nationally it is established that there are higher rates of CVD in Black and Asian communities as well as neighbourhoods experiencing greater deprivation. There are complex reasons for this which continue to be investigated.

Of Greenwich patients, patients with a Black ethnicity were most likely to have at least 1 CVD Cluster diagnosis (22% of around 65,800 people). There were higher percentages of Black patients in each age group until 80+. Rates for Asian patients moved closer to the rates for Black patients after the age of 60, while rates were generally lower for White And Mixed ethnicity patients until the age of 80. The low overall prevalence found for Mixed patients (10.6%) is likely to be because this is a younger community on average (table, right).

The most frequently recorded diagnoses were again hypertension and diabetes - this was the case for people in each of these ethnic groups. This was followed by diagnoses of obesity for Black and Mixed ethnicity patients, CHD for Asian patients, and CKD for White patients.

White and Asian patients were a little more likely to have more than one diagnosis identified per patient: on average 1.7 diagnoses compared to 1.5 diagnoses for Black and Mixed ethnicity patients.

Percentage of Greenwich Patients with at least 1 condition in the SEL CVD Cluster by age and ethnicity



Impact of CVD in Royal Greenwich

Prevalence of CVD in Greenwich (cont'd)

Directly standardised rates also suggested that Black patients had significantly greater prevalence of a diagnosis from the cluster of CVD conditions (see table right). For example, 24,215 patients per 100,000 Black Greenwich patients aged under 75 had at least 1 diagnosis compared to 17,442 patients per 100,000 patients on average.

The SEL Long Term Conditions Dashboard did not provide details of registered patients with CVD by deprivation.

Greenwich Patients with at least 1 long-term condition in the SEL CVD Cluster

Ethnic Group	Prevalence per 100,000 patients (DSR)	Prevalence per 100,000 patients aged under 75 (DSR)
All	24,466	17,442
Asian	27,712	20,561
Black	31,152	24,215
White	22,490	15,303
Mixed	26,629	20,109
Other	18,763	12,726
Unknown	17,738	12,314

Numbers are rounded to nearest 100

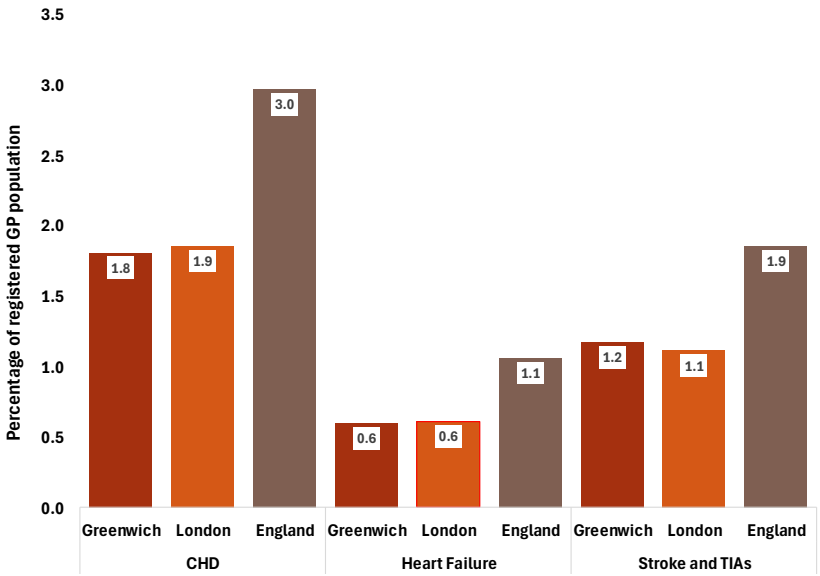
Prevalence of CVD in Greenwich (QOF)

The Quality and Outcomes Framework (QOF) provides a baseline showing how many patients registered with GPs have been diagnosed with certain types of CVD, and whether treatment milestones have been reached. *Greenwich results for 2023-24 indicated that:

- 1.8% of people had a diagnosis of CHD (just over 5,800 people)
- 1.2% had a diagnosis of stroke or TIA (nearly 3,800 people)
- 0.6% had a diagnosis of heart failure (just over 1,900 people)

The Greenwich QOF results were similar to London, and lower than the England average (see right). As Greenwich is a relatively deprived borough, it might be expected that there would be greater rates of CVD. However, the London and Greenwich populations are also younger than the England average and this might also have influenced the results (as CVD increases with age). QOF results are not age-standardised which would assist with comparison and identifying potential under-diagnosis.

Prevalence of Cardiovascular Disease (QOF 23-24)



* Some people may have been included in more than one QOF count, so the results above cannot be added together

Impact of CVD in Royal Greenwich

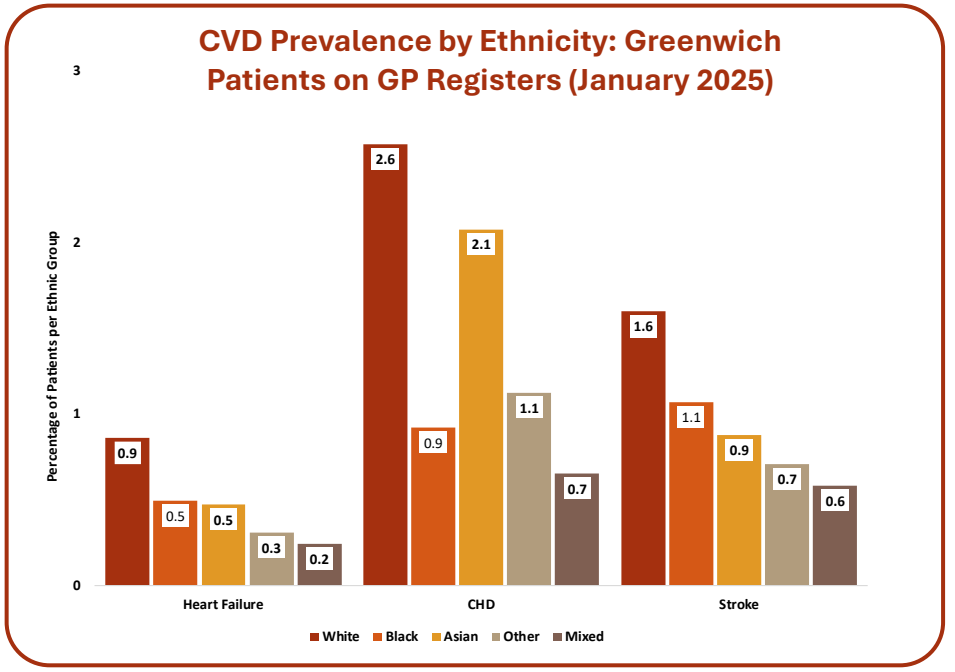
Prevalence of CVD in Greenwich (cont'd)

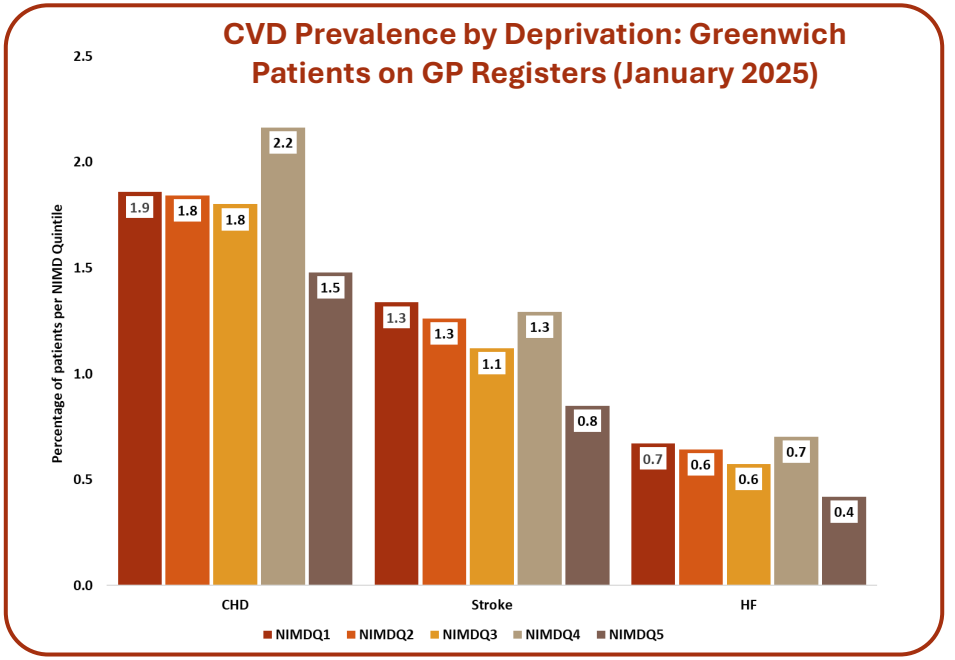
The SEL ICB Co-Morbidities Dashboard provides additional information about Greenwich patients. For example, in early 2025 it showed that:

- 1.9% of Greenwich patients were on a CHD register. This increased to 2.6% of White patients and fell to 0.9% of Black patients.
- 1.2% of Greenwich patients were on a stroke register. This increased to 1.6% of White patients and fell to 0.9% of Asian patients.
- 1.9% of patients in the most deprived neighbourhoods (NIMDQ1) were on the CHD register. This fell to 1.5% of patients in the least deprived neighbourhoods (NIMDQ5).
- CHD prevalence appeared to be highest (as it was for Stroke and Heart Failure) in Greenwich neighbourhoods that were less, but not least deprived (2.2%).
- 1.3% of female patients were on the CHD register compared to 2.4% of male patients, 0.5% were on a Heart Failure register compared to 0.8% of male patients, and 1.1% were on a Stroke register compared to 1.3% of male patients.

Not all results follow what might be expected. These results have not been standardised for age, ethnicity or sex. The White patient group might be a little older an average leading to the higher crude rates suggested for this community. The higher rates in NIMDQ4 might also be due to confounding factors such as higher numbers of older residents in less deprived areas. There might also be a level of under-diagnosis affecting some communities.

Although men are understood to have higher rates of CVD, given the known example of under-diagnosis of heart attacks in women, it is also possible there is a level of under-diagnosis affecting women.





Impact of CVD in Royal Greenwich

Hospital Admissions Due to CVD in Greenwich

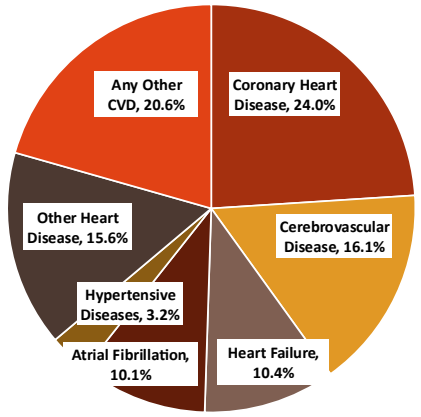
The number of admissions of Greenwich residents due to CVD fell from 3,247 in 2014-15 to 2,967 in 2023-24. (Numbers of CVD admissions also dipped during the COVID pandemic).

Between 2019 and 2024, there were 14,976 admissions of Greenwich residents due to CVD. Around 3 in 5 of these admissions were of men (58%) and 2 in 5 were of women (41%).

The most frequent diagnoses in this 5-year period included:

- CHD: 24% of CVD admissions (29% for men and 18% for women)
- Stroke: 16% (15% for men and 18% for women)
- Heart Failure: 10% (10% for men and 12% for women)
- Atrial Fibrillation 10% (10% for both men and women)

Hospital Admissions with a Primary Diagnosis of CVD in 2019-24: by Type of CVD (%)



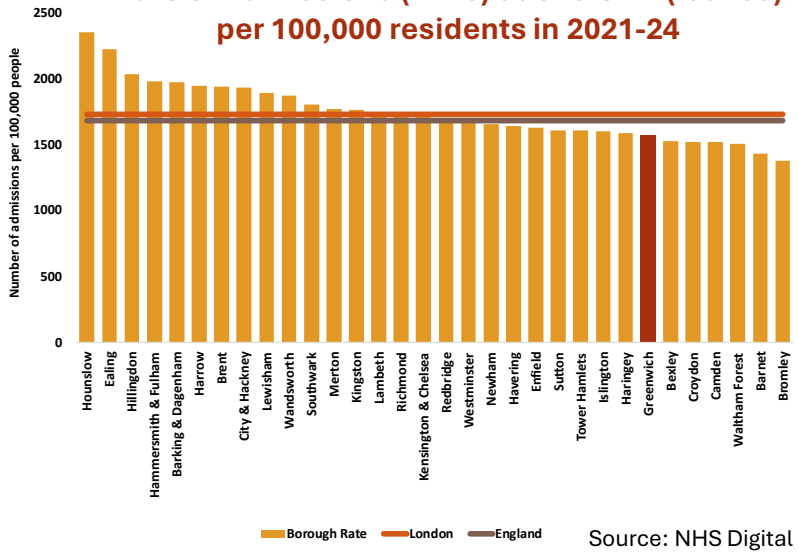
Source: NHS Digital DAE

Admissions compared to London and England

In 2021-24 Royal Greenwich had a (significantly) lower rate of CVD admissions than London and England: 1,572 CVD admissions per 100,000 people compared to 1,687 in England and 1,734 in London. Within London it is indicated that Greenwich had the 7th lowest rate of CVD admissions out of all London boroughs.

OHID Fingertips indicates that admissions due to CHD have fallen, and this may have driven the reduction in the overall CVD rate. In 2023-24 Greenwich had the 7th lowest rate of CHD admissions out of London boroughs. The rates for some other CVD conditions were higher: the rate of admissions due to Stroke remained significantly higher than the England average (with Greenwich ranked 6th highest out of London boroughs in 2023-24). The rate of admissions due to Heart Failure was also increasing, as it was elsewhere in London.

Rate of Admissions (FAEs) due to CVD (I00-I99) per 100,000 residents in 2021-24



Source: NHS Digital DAE

Impact of CVD in Royal Greenwich

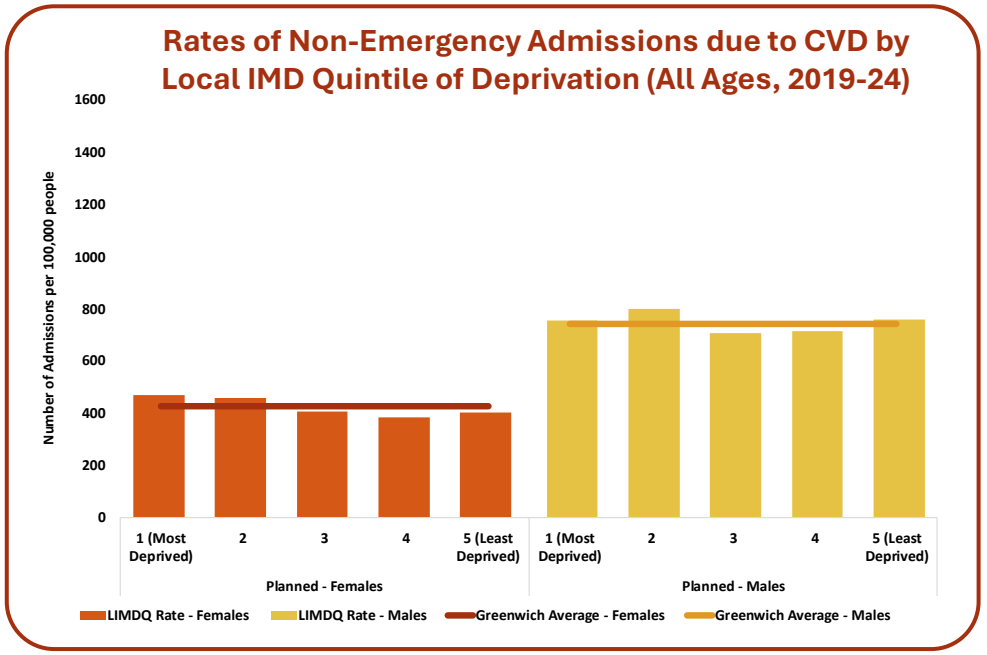
Variation in Hospital Admissions due to CVD within Greenwich: Deprivation

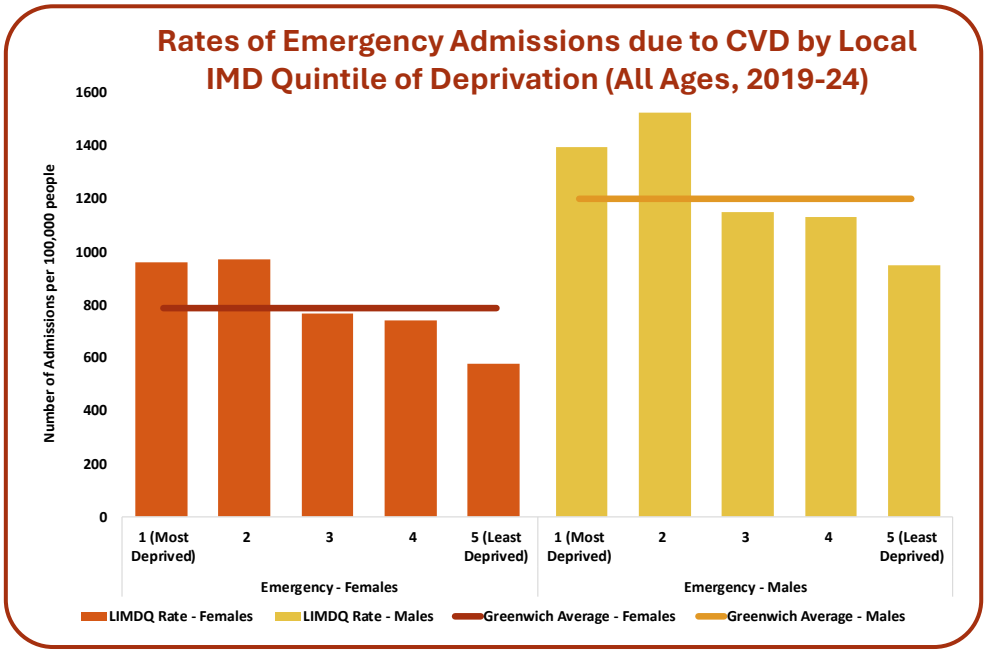
Rates of hospital admissions due to CVD were higher in more deprived Greenwich neighbourhoods and lower in less deprived neighbourhoods. (The difference between more deprived (LIMDQ1-2) and less deprived (LIMDQ3-5) neighbourhoods was statistically significant).

This pattern was also found in emergency admissions due to CVD, as well as non-emergency admissions due to CVD amongst under-75s. There was less difference found when comparing rates of non-emergency admissions due to CVD (all ages). There were 9,132 emergency CVD admissions and 5,844 non-emergency admissions.

Similar patterns were found for men and women from different deprivation quintiles, as shown in the charts below.

Research by the British Heart Foundation found that people from deprived neighbourhoods (nationally) were more likely to be admitted for emergency care and there was less variation in planned care. Health inequalities were indicated throughout the CVD pathway. This included people from deprived neighbourhoods being less likely to be referred for planned care. It was felt these inequalities contributed to exacerbation of CVD and the higher rates of emergency care. Our results might also be affected by these factors.





Source: NHS Digital DAE

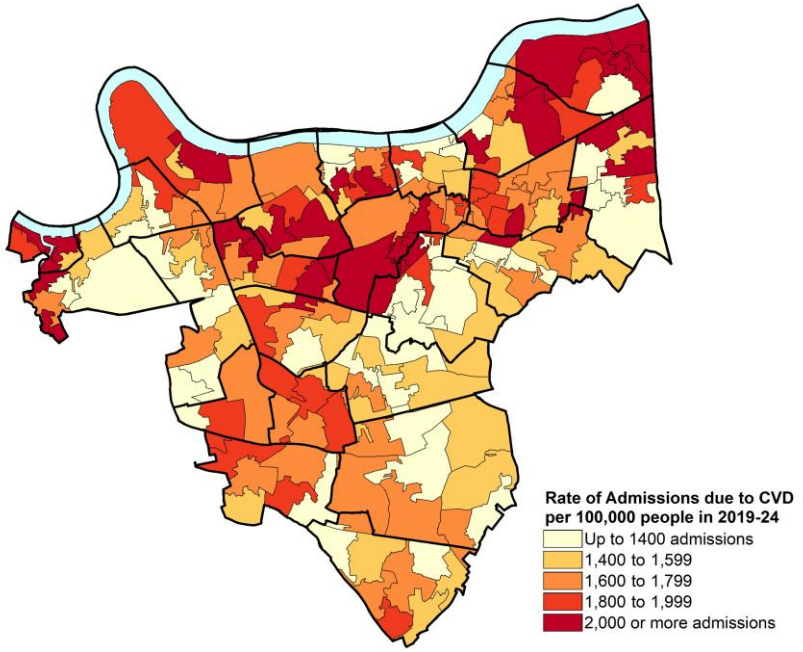
Impact of CVD in Royal Greenwich

Variation in Hospital Admissions due to CVD within Greenwich: LSOAs of Residence

The maps below indicate the range in the rate of admissions due to CVD across Greenwich for the period 2019-24. As described in the previous slide, neighbourhoods in more deprived areas of the borough often have higher rates of CVD. Neighbourhoods highlighted below include areas of Thamesmead, Woolwich, Charlton, Creekside and Horn Park. Many residents from our diverse communities – who are at greater risk of developing CVD – also live in these neighbourhoods. It is likely that these areas of the borough might benefit from targeted support.

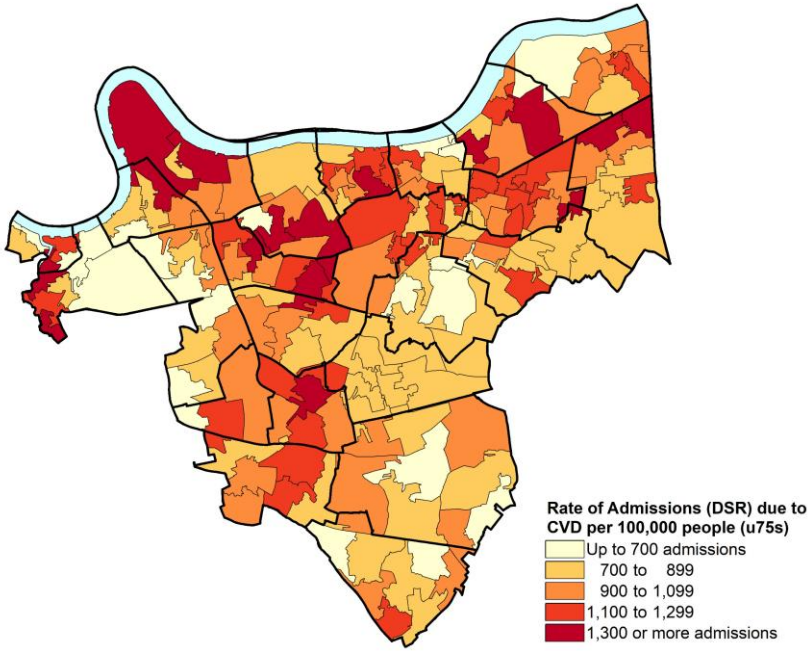
LSOAs themselves are not uniform and might contain pockets of deprivation alongside more affluent households. For example, areas of redevelopment along the riverside.

Rate of Admissions (FAEs) due to CVD in 2019-24 (All Ages)



Source: NHS Digital DAE

Rate of Admissions (FAEs) due to CVD in 2019-24 (Under 75s)



Source: NHS Digital DAE

Note: The number of admissions per LSOA can be small, with wide confidence intervals, and may be affected by random variation.

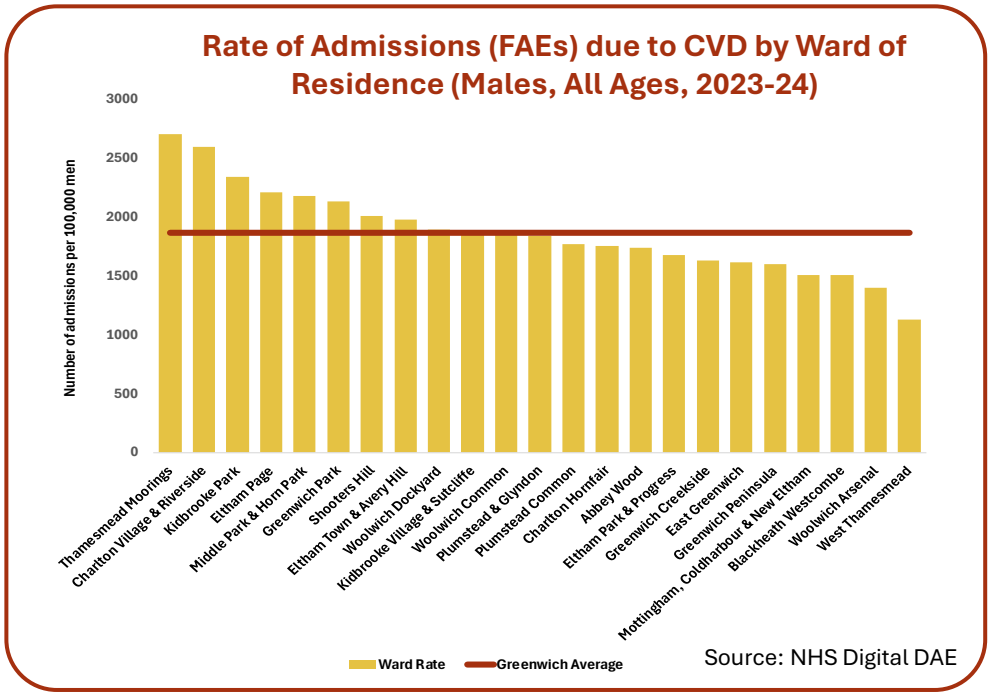
Impact of CVD in Royal Greenwich

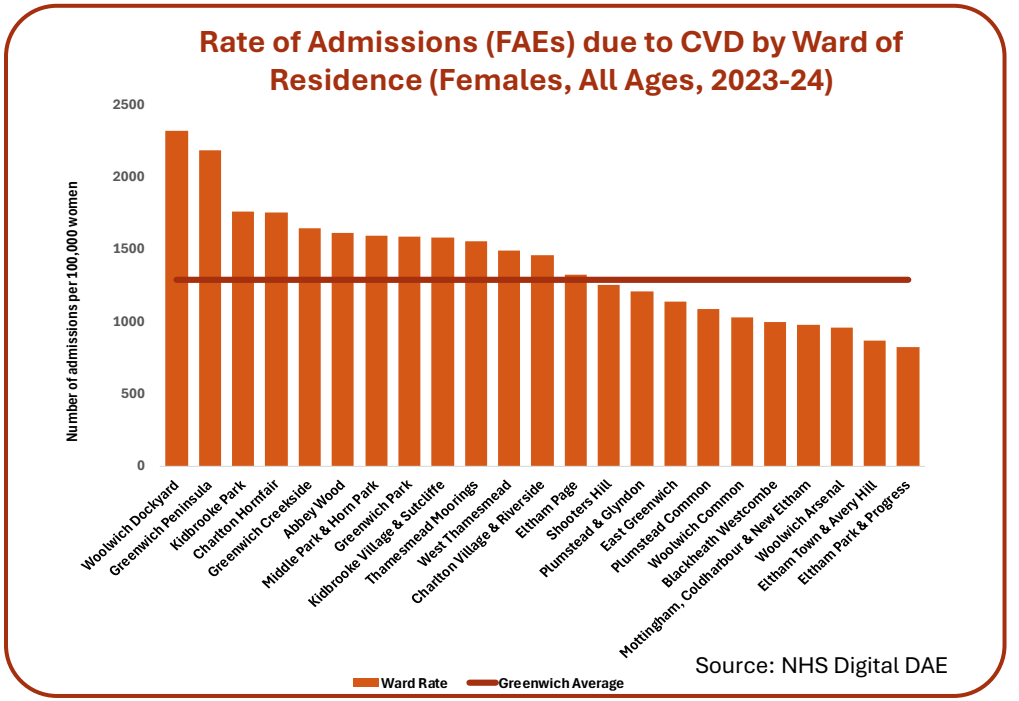
Hospital Admissions due to CVD: Ward Rates for Males and Females (2023-24)

Ward based rates of CVD admissions were only available for 2023-24 (*2022 boundaries) at the time of preparation. Despite the more limited data, the results again point to higher rates of CVD admissions in more deprived areas of Greenwich, with significantly greater rates than the Greenwich average in Woolwich Dockyard, Thamesmead Moorings, Charlton Village and Riverside and Kidbrooke Park wards. Wards with significantly lower rates were Mottingham and Coldharbour, Blackheath Westcombe and Eltham Park and Progress.

Fewer significant differences could be found when comparing admissions for men and women separately - most likely due to the smaller pool of cases. For women, the wards with the 5 highest rates (although not necessarily significantly higher than the Greenwich average) were Woolwich Dockyard, Greenwich Peninsula, Kidbrooke Park, Chalton Hornfair, and Greenwich Creekside. For men they were Thamesmead Moorings, Charlton Village & Riverside, Kidbrooke Park, Middle Park and Horn Park, and Eltham Page.

This additional information might also help to plan where future health promotion campaigns and support could be best targeted





Impact of CVD in Royal Greenwich

Hospital Admissions due to CVD and Ethnicity

In 2019-2024, ethnicity was recorded in 75% of hospital admissions which were due to CVD. The missing information makes it difficult to calculate reliable rates and compare the experience of different communities in Greenwich. Another factor increasing uncertainty is that there are far more admissions of people of 'Other' ethnicity than might be expected resulting in high rates for the 'Other' group. For example, in the table below, we can see there were 610 CVD admissions where residents identified as 'Other' ethnicity, and 600 where residents were Asian. This is despite the 2021 Census suggesting there are three times as many Asian residents in Greenwich as residents with 'Other' ethnicity. This seems unlikely.

Despite this rates of hospital admissions for Greenwich still reflect some national findings:

- Asian residents had higher rate of admissions due to CHD (all ages), significantly lower rates of admissions due to stroke (all ages and under 75s), and a lower rate of admissions due to all CVD (all ages and under 75s).
- Black residents had significantly higher rates due to stroke (all ages and under 75s) and lower rates due to CHD (all ages and under 75s).
- The results also indicate that White Greenwich residents had higher rate of admissions due to CHD and significantly higher rates due to all CVD (all ages and under 75s).

If we compare the percentage of admissions (see table on next slide), this again suggests varying impacts across our communities. A greater percentage of Black residents were admitted due to stroke and hypertension, a relatively high proportion of Asian residents due to CHD, of Other and Mixed residents due to hypertension and White residents due to atrial fibrillation.

- On average 24% of admissions were due to CHD - this increased to 36% of admissions of Asian residents.
- 27% of admissions of under 75s were due to CHD, and this increased to 40% of admissions of Asian residents.
- On average 16% of admissions were due to Stroke - this increased to 22% of admissions of Black residents.
- 15% of admissions of under 75s were due to stroke - this increased to 22% amongst Black residents.

Number and Rate (DSR) of CVD Admissions amongst u75s (by Ethnicity) in 2019-24

	Based on Annual Population	CVD		CHD		Stroke	
		Cases	DSR	Cases	DSR	Cases	DSR
Asian	36,897	600	478.6	240	201.2	80	63.1
Black	59,605	1,180	620.8	190	116.4	260	137.2
Mixed	17,181	170	635.3	30	132.5	30	100.5
Other	11,762	610	1,331.1	180	427.4	90	213.6
White	150,704	4,900	699.5	1,420	207.6	630	90.8
Unknown	Missing	2,800	Missing	690	Missing	410	Missing
Greenwich	276,149	10,258	927.5	2,754	260.2	1,492	138.7

Source: NHS Digital DAE

Impact of CVD in Royal Greenwich

Hospital Admissions due to CVD and Ethnicity (cont'd)

- On average 10% of admissions were due to Heart Failure - this increased to 14% of admissions of Black residents.
- On average 10% of admissions were due to AF - this fell to 3% of Asian residents and increased to 13% of admissions of White residents.
- 10% of admissions of under 75s were due to AF and again this increased to 13% amongst White residents.
- A smaller proportion of residents were admitted due to Pulmonary Heart Disease, but Black and Mixed ethnicity patients were more affected.
- On average 3% of admissions were due to Hypertension - this increased to 6% of admissions of Mixed residents and 9% of Black residents.
- 4% of admissions of under 75s were due to Hypertension and this increased to 11% of admissions of Black residents.
- Finally, patients with Mixed ethnicity were most likely to be admitted due to other types of CVD. For example, 32% of admissions were due to any other CVD diagnoses on average – this increased to 41% of admissions where the patient had a Mixed ethnicity.

The results for Mixed residents seem to partly follow the pattern of our Black residents but also reflect a wider range of conditions (perhaps CVD conditions more typical of a younger cohort).

Two thirds of admissions due to Atrial Fibrillation were of White residents. Ethnicity was not recorded for many of the remaining admissions.

Due to the recent push to identify and treat patients with AF in England, this could be evidence of an emerging health inequality. A recent study which found higher rates of AF in patients with white ethnicity (and considered this), found it possible that people with White European ancestry have greater risk of developing AF – possibly due to genetic inheritance.

This is an emerging area which should be kept under review.

Percentage of CVD Admissions by Ethnicity (2019-24)

All Ages	All CVD (I00-I99)	CHD (I20-I25)	Stroke (I60-I69)	Heart Failure (I50)	AF (I48)	Pulmonary Heart Disease (I26-I28)	Hypertension (I10-I15)	Other CVD
Asian	860	36%	15%	13%	3%	3%	2%	27%
Black	1,460	16%	22%	14%	4%	7%	9%	28%
Mixed	200	15%	16%	9%	7%	6%	6%	41%
Other	800	26%	16%	12%	9%	2%	5%	29%
Unknown	3,700	23%	17%	7%	9%	4%	3%	37%
White	7,950	24%	15%	11%	13%	4%	2%	31%
All	14,976	24%	16%	10%	10%	4%	3%	32%
U75s	**All CVD (I00-I99)**	**CHD (I20-I25)**	**Stroke (I60-I69)**	**Heart Failure (I50)**	**AF (I48)**	**Pulmonary Heart Disease (I26-I28)**	**Hypertension (I10-I15)**	**Other CVD**
Asian	600	40%	13%	8%	3%	4%	2%	29%
Black	1,180	16%	22%	10%	4%	8%	11%	29%
Mixed	170	15%	14%	8%	6%	7%	6%	43%
Other	610	30%	15%	6%	8%	3%	6%	32%
Unknown	2,800	25%	15%	5%	9%	5%	4%	38%
White	4,900	29%	13%	7%	13%	4%	2%	33%
Grand Total	10,258	27%	15%	7%	10%	5%	4%	34%

Source: NHS Digital DAE

Impact of CVD in Royal Greenwich

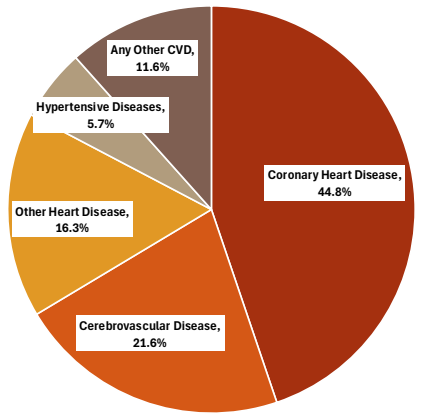
Mortality due to CVD in Greenwich

CVD is the second most frequent cause of death amongst Royal Greenwich residents, following deaths due to cancers.

The rate of mortality due to CVD fell substantially in the past two decades and the gap between Greenwich and the London and England averages had narrowed. Progress has recently slowed, however. This seems to be at least partially related to the COVID pandemic as rates of mortality increased around 2020 and have since improved a little. During COVID there were reduced opportunities for detection and support of CVD in primary care.

There were 2,018 deaths due to CVD in 2019-23 (24% of 8,488 deaths) and Coronary Heart Disease accounted for 45% of these CVD deaths.

Percentage of Deaths due to CVD in 2019-23: Type of CVD



Source: NHS Digital (Primary Care Mortality Files)

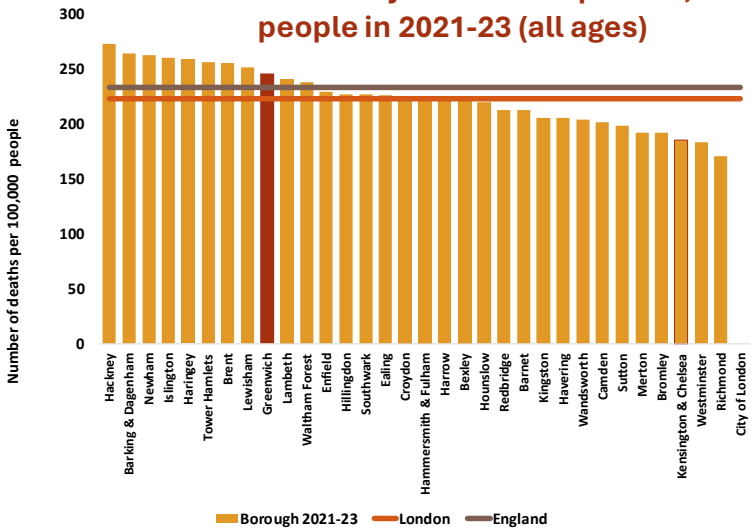
CVD Mortality compared to London and England

In 2021-23 the Greenwich rate of CVD mortality (all ages) was significantly higher than the average, at 246 deaths per 100,000 people compared to 223 in London and 233 in England. The Greenwich rate ranked 9th highest out of London boroughs.

The rate for Greenwich women was also significantly higher than London (199 deaths per 100,000 women compared to 174) and Greenwich ranked 7th highest out of London boroughs on this measure. The rate for Greenwich men was higher than the average for London (304 deaths per 100,000 men compared to 284) but was statistically similar. This rate was ranked 11th highest in London.

More information is available in OHID Fingertips: Rate of CVD Mortality - Greenwich Trend.

Rate of mortality due to CVD per 100,000 people in 2021-23 (all ages)



Source: NHS Digital (Primary Care Mortality Files)

Impact of CVD in Royal Greenwich

Premature Mortality due to CVD in Greenwich

CVD is also the second most frequent cause of premature death (a death under the age of 75) amongst Greenwich residents.

The rate of premature mortality due to CVD has also fallen substantially in the past two decades, but like all age mortality due to CVD, progress has recently slowed.

There were 775 premature deaths due to CVD in 2019-23 (22% of 3571 deaths) and CHD accounted for 54% of these CVD deaths.

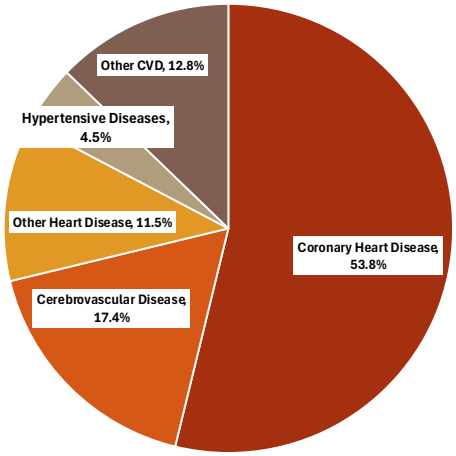
More information is available in OHID Fingertips: [Rate of Premature CVD Mortality - Greenwich Trend]

Premature CVD Mortality compared to London and England

In 2021-23 the Greenwich rate of premature mortality due to CVD was significantly higher than the average at 86 deaths per 100,000 people (aged under 75) compared to 75 in London and 79 in England. The Greenwich rate ranked 6th highest out of London boroughs.

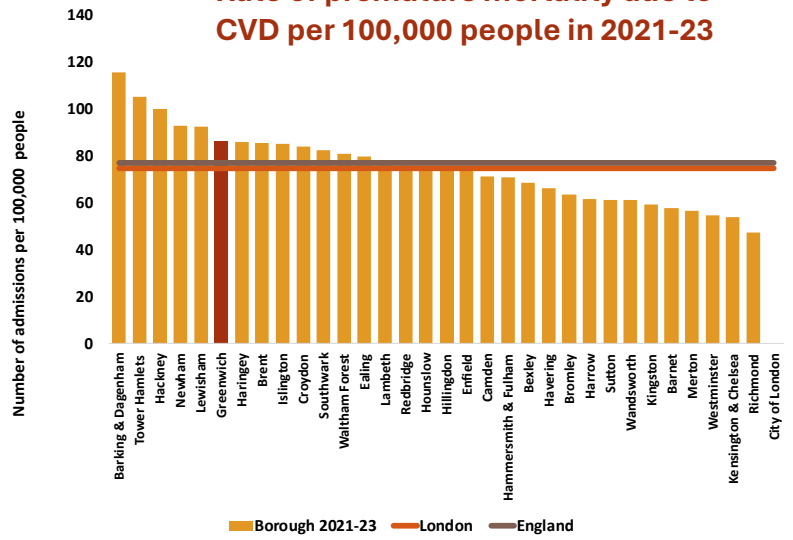
The rate for Greenwich women was also significantly higher than London (56 per 100,000 women compared to 43) and Greenwich ranked 4th highest in London on this measure. The rate for Greenwich men was higher than the London average (119 deaths per 100,000 men compared to 109) but the result was statistically similar. This rate was ranked 12th highest in London.

Percentage of premature deaths due to CVD in 2019-23: type of CVD



Source: NHS Digital (Primary Care Mortality Files)

Rate of premature mortality due to CVD per 100,000 people in 2021-23



Source: NHS Digital (Primary Care Mortality Files)

Impact of CVD in Royal Greenwich

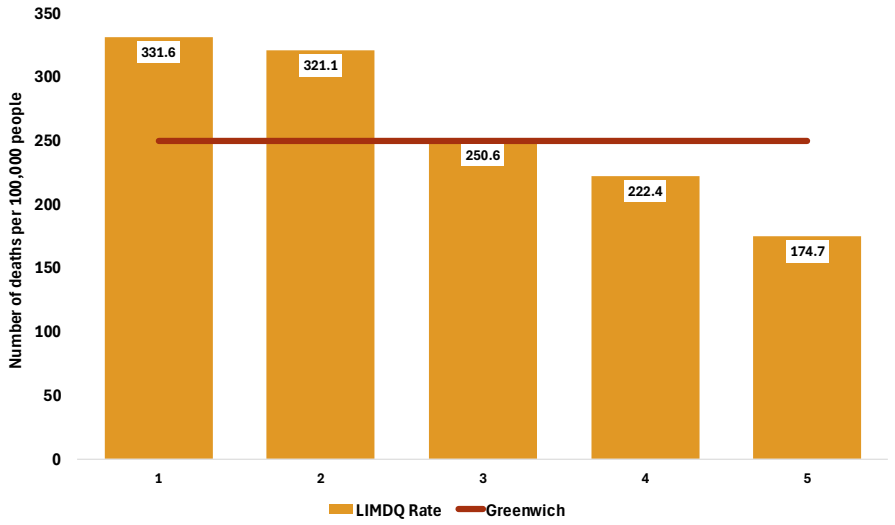
Variation in CVD Mortality within Greenwich: Deprivation

The results show that there is an association between CVD mortality and deprivation. In 2019-23 rates of mortality due to CVD were significantly higher in neighbourhoods within the two most deprived local quintiles when compared to the lesser deprived neighbourhoods. The rate of mortality due to CVD in the least deprived neighbourhoods was significantly lower than all other areas in Greenwich.

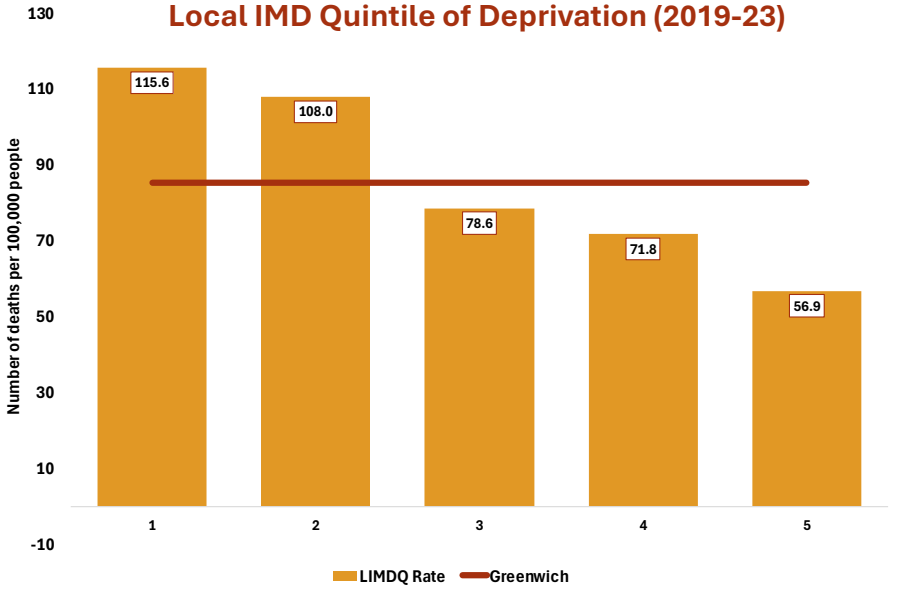
The rate of premature mortality due to CVD was also significantly higher in the two most deprived local quintiles compared to less deprived quintiles.

Overall, similar patterns were found for men and women, and for different types of CVD. There were some variations - for example, the rate of mortality due to CVD amongst men (all ages) was highest in LIMDQ2 (2nd most deprived areas in Greenwich), while the rate of premature mortality due to stroke (for all people and women) was lowest in the middle LIMDQ3.

Rate of Mortality due to CVD by Local IMD Quintile of Deprivation (2019-23)



Rate of Premature Mortality due to CVD by Local IMD Quintile of Deprivation (2019-23)



Source: NHS Digital (Primary Care Mortality Files)

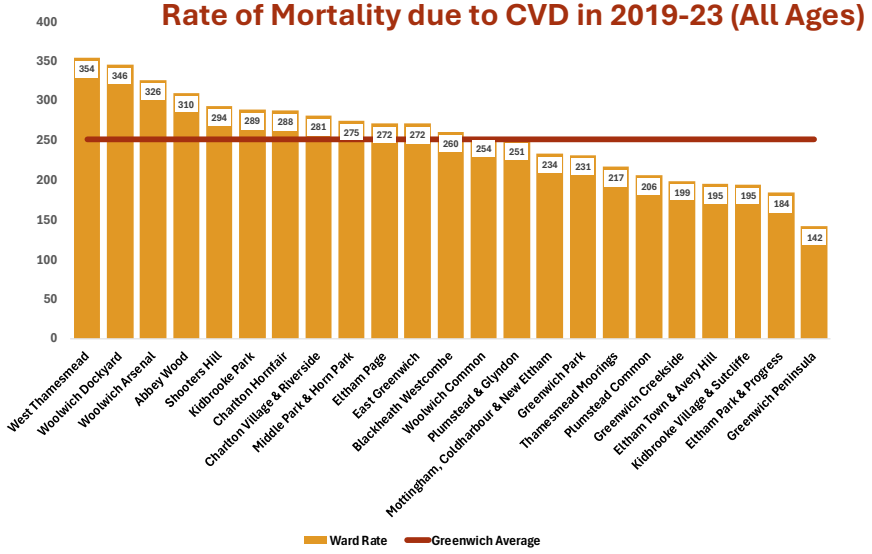
Impact of CVD in Royal Greenwich

Variation in CVD Mortality within Greenwich: Wards of Residence

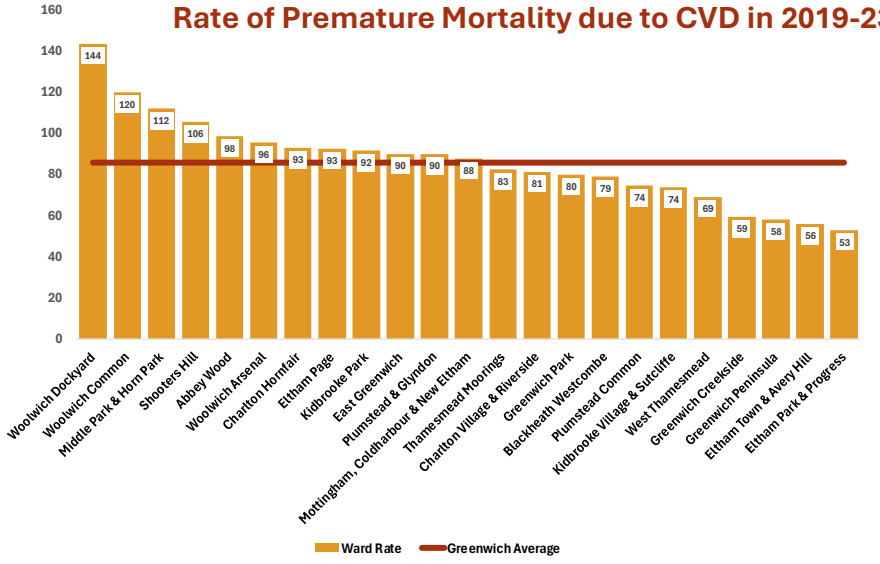
The highest rates of CVD mortality (all ages) were in West Thamesmead, Woolwich Dockyard, Woolwich Arsenal and Abbey Wood wards. The highest rates of premature mortality due to CVD were found in Woolwich Dockyard, Woolwich Common, and Middle Park and Horn Park wards. Few of the rates were significantly different from the Greenwich average. Woolwich Dockyard stood out – rates of mortality due to CVD in this ward were amongst the highest and several were significantly higher than the Greenwich average (people all ages, people under 75, and females under 75). Rates of mortality amongst women (all ages) were also significantly higher than the Greenwich average in West Thamesmead and Abbey Wood.

Some of these wards contain neighbourhoods with higher deprivation and might indicate where future health promotion campaigns could be best targeted to reach people most at risk.

There were significant differences between several wards with the greatest and lowest rates. For example, the rate of mortality (all ages) in West Thamesmead was significantly greater than Plumstead Common, Eltham Town, Eltham Park and Greenwich Peninsula. Wards with the lowest rates of mortality and premature mortality due to CVD include Greenwich Peninsula, Greenwich Creekside, Eltham Town and Eltham Park.



Source: NHS Digital (Primary Care Mortality Files)



Source: NHS Digital (Primary Care Mortality Files)

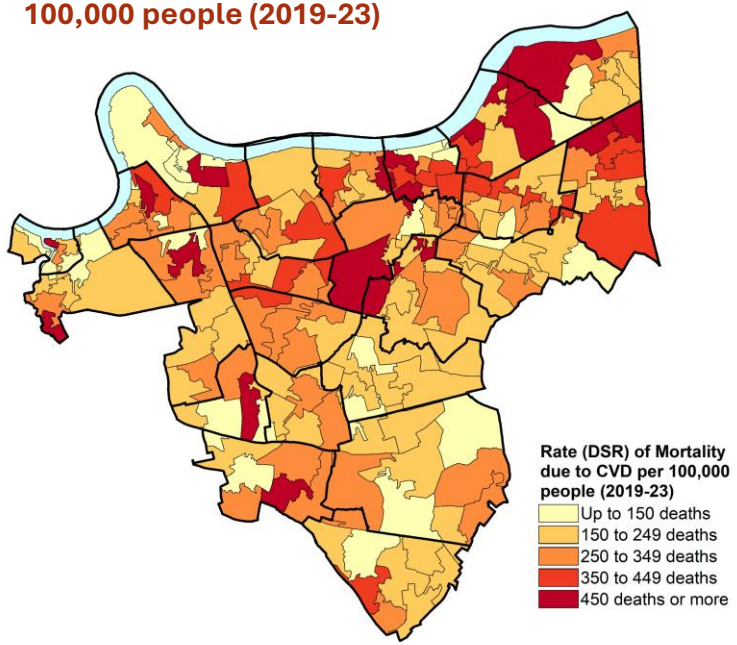
Impact of CVD in Royal Greenwich

Variation in CVD Mortality within Greenwich: LSOAs of Residence

The maps below indicate the range in the rate of mortality due to CVD at LSOA neighbourhood level for the period 2019-23. As described In previous slides, neighbourhoods in more deprived areas of the borough are often more impacted by CVD. This can be seen here with higher rates in the north and west of the borough, particularly in the Abbey Wood, Thamesmead, and Woolwich areas. Rates of premature mortality due to CVD are also higher in these areas. Many residents from our diverse communities – who are at greater risk of developing CVD – also live in these neighbourhoods. It is likely that these areas of the borough might benefit from targeted support.

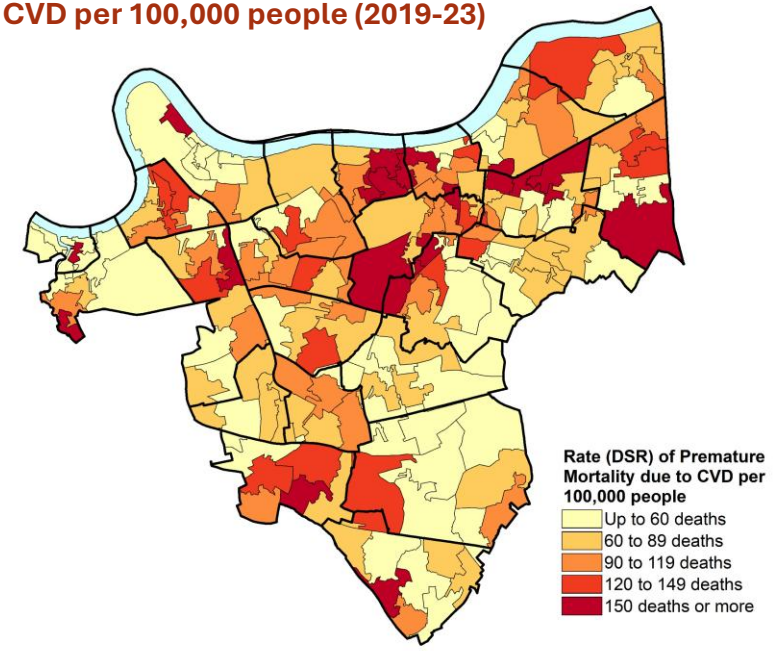
Rates of CVD mortality tend to be lower in the less deprived areas of the borough such as Eltham, although there are specific neighbourhoods with higher rates. (LSOAs themselves are not uniform and might contain pockets of deprivation alongside more affluent households. For example, areas of redevelopment along the riverside).

Rate of Mortality (DSR) due to CVD per 100,000 people (2019-23)



Source: NHS Digital (Primary Care Mortality Files)

Rate of Premature Mortality (DSR) due to CVD per 100,000 people (2019-23)



Source: NHS Digital (Primary Care Mortality Files)

Impact of CVD in Royal Greenwich

Variation in CVD Mortality within Greenwich: Region of Birth

Registrations of death do not currently provide information about ethnicity, and examining results by country of birth is not a good proxy. People born in the UK are of many ethnicities, and someone born in Africa might for example be Asian or White. However, counts of deaths registered in 2019-23 by country of birth indicated variations which might be partly linked to ethnicity (or of having a personal history of migration to the UK) and which reflect earlier results in this report:

- Deaths due to cancer were the most frequent cause of death overall, followed by CVD.
- Deaths of women born in Africa were also more likely to be due to cancer as were deaths of women born in Asia who were under 75.
- In contrast CVD was the most frequent cause of death amongst people born in Asia (all ages), of men born in Asia aged under 75 and men born in Africa (all ages and under 75s).
- Where residents died due to CVD, a greater proportion of people born in Africa died due to stroke or hypertension while a greater proportion of people born in Asia died due to CHD.

Types of CVD Mortality by Region of Birth

Where residents died due to CVD, in around 1 in 2 (45%) cases this was CHD, in 1 in 5 (22%) cases stroke, and 1 in 6 (16%) other heart disease including heart failure and atrial fibrillation. Smaller proportions were due to hypertension (6%), aortic aneurysm (5%), or deep vein thrombosis.

Where residents were born in:

- Asia, 47% of CVD deaths were due to CHD, 22% stroke, 18% other heart disease, and 8% hypertension. Few were due to aortic aneurysm or DVT.
- Africa/Caribbean: only 35% of CVD deaths were recorded as due to CHD with 28% due to stroke, 16% other heart disease, 9% hypertension and 6.4% DVT.
- UK and RoI: 46% of CVD deaths were due to CHD, 20% stroke, 16% other heart disease, 5% hypertension, 6% aortic aneurysm and 4.6% DVT.

Number of Deaths Registered by Region of Birth (2019-23)

	Total Deaths	All Cancers	All CVD	All Other Deaths	Types of CVD			
					CHD	MI	Other HD	Stroke
UK and RoI	6,425	1,673	1,486	3,266	686	233	238	299
Africa/Caribbean	841	247	220	374	77	31	36	62
Asia	461	97	126	238	59	18	23	28
Europe	342	92	80	170	34	12	13	18
Other	269	82	65	122	26	15	13	21
Unknown	150	28	41	81	22	6	6	8
All	8,488	2,219	2,018	4,251	904	315	329	436

Source: NHS Digital (Primary Care Mortality Files)

Cardiovascular Disease in Royal Greenwich 2025 - Chapter Aims

Risk Factors for CVD in Royal Greenwich

Prevalence of CVD Risk Factors

Many Greenwich residents have one (or more) factors that place them at additional risk of experiencing a serious CVD event such as a stroke or heart attack. Out of patients registered with Greenwich GPs (*QOF, 2023/24):

- Over 40,000 patients had a diagnosis of hypertension (12.5%).
- Nearly 20,000 had diabetes (7.6% of patients aged 17+).
- Over 18,000 had non-diabetic hyperglycaemia (pre-diabetes) (7.1% of patients aged 18+).
- Around 3,500 had a diagnosis of atrial fibrillation (1.1%).
- Around 35,000 were living with obesity (13.9% aged 18+).

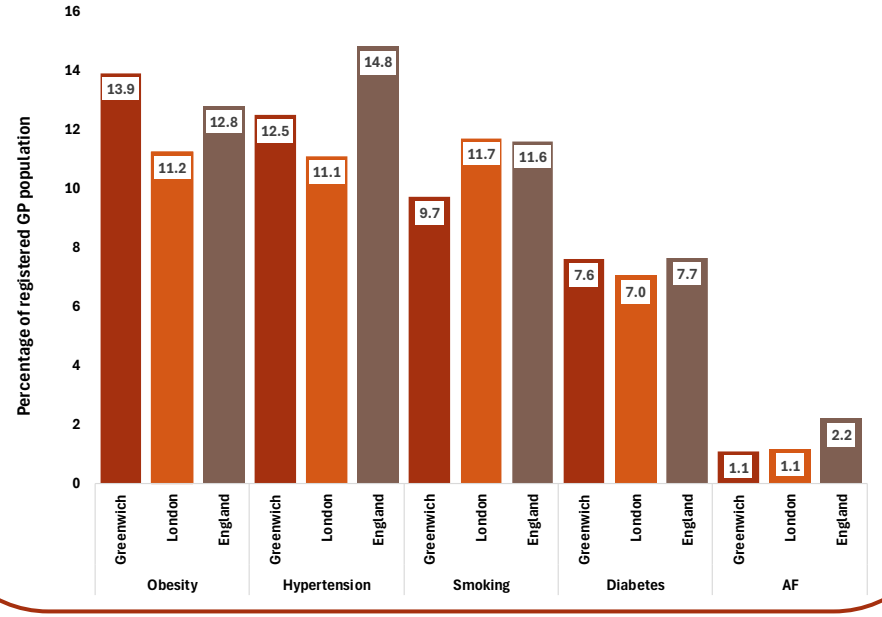
In some cases, for example obesity, results for Greenwich are higher than the average for London and England.

The ONS Annual Population Survey (APS, 2023) found 9.7% of Greenwich respondents (18+) reported they were smokers. This is another welcome decrease but is still equivalent to around 25,000 Greenwich patients aged 18+.

Prevalence of CVD Risk Factors

CVD Risk Factors	Greenwich		London	England
	Cases	%	%	%
Atrial Fibrillation (QOF 2023/24)	3,514	1.09	1.15	2.18
Hypertension (QOF 2023/24)	40,332	12.5	11.1	14.8
Diabetes (QOF 2023/24, 17+)	19,537	7.6	7.0	7.7
Non-Diabetic Hyperglycaemia (QOF 2023/24, 18+)	18,107	7.1	7.3	8.2
Obesity (QOF 2023/24, 18+)	35,250	13.9	11.2	12.8
Smoking (APS 2023, 18+)	25,200 (est)	9.7	11.7	11.6

Prevalence of CVD Risk Factors (QOF 2023-24 & APS 2023)



Underdiagnosis of CVD Risk Factors

CVD risk factors can have few or no symptoms, and as a result can be present for several years before being identified. As shown above, QOF suggests 1.1% of the Greenwich population have atrial fibrillation. However, modelled expected prevalence of atrial fibrillation for Greenwich was 1.6% (in 2019); assuming this has stayed the same, it could mean a further 1500 Greenwich patients have undiagnosed AF. Similarly, the expected prevalence of hypertension in Greenwich was 20.9%, which could mean 27,000 more patients with hypertension.

*QOF reflects only people who are registered with a GP and where a diagnosis has been made. Some facts recorded (e.g. BMI) may be out of date if a patient has not attended recently. Another drawback is that patients can register with GPs outside their area of residence. QOF reflects the experience of patients registered with Greenwich GPs and not Greenwich residents (wherever they are registered).

Risk Factors for CVD in Royal Greenwich

Diagnosed Prevalence of Atrial Fibrillation (AF)

Atrial fibrillation (AF) is a common arrhythmia resulting in the heart beating irregularly and often too fast. This can lead to heart failure or a stroke after blood clots form in the heart and travel to the brain. Many strokes are known to be caused by undiagnosed, untreated or under-treated AF.

Identifying people with AF through screening or case finding and providing appropriate treatment is vital to reduce deaths or disability. For many this will mean taking anticoagulant medications to reduce the risk of stroke.

There were around 3,500 adults on the Greenwich AF register in 2023-24 (QOF). Additional results (rounded) from the SE London ICB Co-Morbidities Dashboard indicate that in early 2025:

- 2,100 men and 1,500 women were on the Greenwich AF register (1.3% of male patients and 0.9% of female patients).
- White patients were more likely to be on an AF register – 1.8% compared to 0.4% of Black patients and 0.5% of Asian patients.
- 69% of patients diagnosed with AF who were aged under 50 were White and 84% of patients with AF who were 80+ were White.
- Patients from less deprived neighbourhoods were more likely to be on an AF register – rising from 1.0% of patients in most deprived neighbourhoods (NIMDQ1) to 1.6% in less deprived areas (NIMDQ4).

Tackling Variation in Diagnosis & Control of AF

It is estimated that a further 1,500 patients have undiagnosed AF. A 2023 review found that levels of AF diagnoses reported by some Greenwich GP practices (QOF 2021-22) were low (ranging from 0.3% of registered patients per practice up to 2%). The review also found variation in practices achieving the target set for prescribing anti-coagulation therapy to patients with AF.

Opportunities to diagnose and treat CVD had also been missed due to the COVID pandemic. The review emphasised the importance of increasing detection to previous levels and going beyond this to identify more patients with this condition and provide optimal treatment to those who had received a diagnosis.

Diagnosed Prevalence of Hypertension

Hypertension (high blood pressure) causes damage to the arteries which can lead to strokes and CHD events. High blood pressure is defined as a persistent raised blood pressure equal to or above 140/90mmHg, although the risks of developing CHD and stroke increase incrementally once blood pressure is above 115/75 mmHg.

Hypertension often has no symptoms but is more common than high cholesterol, smoking and diabetes, so is a significant risk factor.

Blood Pressure Category	Systolic mm Hg (upper number)		Diastolic mm Hg (lower
Low	up to 90	and	up to 60
Normal	90-119	and	60-79
Raised	120-139	and	80-89
High Blood Pressure (Stage 1)	140-159	and	90-99
High Blood Pressure (Stage 2)	160-179	and	100-119
High Blood Pressure /Crisis (Stage 3)	over 180	and	over 120

Source: NHS.UK/Blood Pressure UK/British Heart Foundation/American Heart Association

Risk Factors for CVD in Royal Greenwich

Diagnosed Prevalence of Hypertension (cont'd)

In 2023-24, QOF identified there were around 40,000 adults (18+) on Greenwich hypertension registers. Prevalence estimates suggest a further 27,000 Greenwich patients have undiagnosed hypertension.

The Health Survey for England (2021) found that 30% of adults (16+) had hypertension, (21% of adults in London - possibly due to a younger population). This would also suggest between 55,000 and 79,000 Greenwich patients could have hypertension.

The HSE found prevalence ranged from 4% of people aged 16-34 up to 69% of people aged 75+.

Variation in Diagnosed Prevalence of Hypertension

The HSE found that prevalence of hypertension was greatest in the most deprived neighbourhoods nationally (33%), followed by the least deprived (28%).

In Greenwich, in early 2025, the SEL ICB's Hypertension Dashboard suggested the highest rates of hypertension (age 18+) were found in our least deprived neighbourhoods, and amongst patients with Black and Asian ethnicity:

- 16.2% of men (20,900 men) were on a hypertension register as were 16.1% of women (21,100 women).
- Patients from the least deprived areas were most likely to be on a hypertension register (18.3% of patients in NIMDQ5), followed by the more deprived quintiles 1 & 2 (16.9% of patients in NIMDQ1).
- 21.7% of Black patients (10,800 people) were on a hypertension register compared to 16.8% of White patients (22,000), and 15.0% Asian patients (5,300).
- At age 70+, 73.4% of Black patients were on a hypertension register, compared to 68.6% of Asian patients and only 60.3% of White patients.

Tackling Variation in Control of Hypertension

Where hypertension is diagnosed, patients should be supported to take steps to control the condition. This might include behaviour changes such as reducing salt or alcohol intake, increasing physical activity or it might mean support to take prescribed daily medication.

Nationally, the HSE found 44% of people with hypertension were untreated, 34% were receiving treatment and controlled, and 22% were receiving treatment and their hypertension was not sufficiently controlled. (Within London, 41% were untreated, 45% were treated and controlled, and 14% were treated but not controlled).

Younger adults were more likely to have untreated hypertension, but around a third of people who were aged 65+ were also untreated.

A local review in 2023 found that hypertension was controlled within recommended limits in 61% of cases when patients were aged under 80. This increased to 77% where Greenwich patients were aged 80 or more. The review also found that hypertension was controlled in only 54% of cases involving Black patients compared to 68% of White patients.

To meet the national targets, it would be necessary to improve control of hypertension in at least 400 more patients aged 80+ and 6,000 patients aged less than 80. Some of this would be achieved by tackling unnecessary variation by GP practice. Increasing control of hypertension in communities at greater risk is also vital.

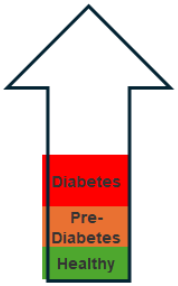
Risk Factors for CVD in Royal Greenwich

Diagnosed Prevalence of Diabetes and Non-Diabetic Hyperglycaemia (Pre-Diabetes)

Diabetes occurs where the amount of sugar in the blood is too high. It is a common disease affecting around 10% of the adult population in the UK. Diabetes can lead to a range of complications and disability, as well as reduced life expectancy.

With non-diabetic hyperglycaemia (pre-diabetes) blood sugar levels are higher than normal but not high enough to be classed as diabetes. In many cases there are no symptoms. Around 5-10% of people with pre-diabetes go on to develop diabetes each year.

People with pre-diabetes are also at greater risk of heart disease and stroke. They are more likely (but not always) to have other risk factors for CVD, such as excess weight, raised cholesterol or high blood pressure, so screening for pre-diabetes at an earlier stage, can also contribute to reducing development of CVD.



HbA1c - Average Levels of 'Glycated Haemoglobin'

	Fasting Plasma Glucose (FPG)		Oral Glucose Tolerance Test (OGTT)	
HbA1c (%)	mg/dl	mmol/l	mg/dl	mmol/l
6.5% or more	126 or more	7.0 or more	200 or more	11.1 or more
6-6.4%	100 to 125	5.5 to 6.9	140 to 199	7.8 to 11.0
Below 6.0%	Below 100	4.0 to 5.4	Below 140	Below 7.8

Source: LB Southwark/ /NICE/Diabetes.co.uk/Diabetes UK

WHO advise an HbA1c level of 6.0-6.5% indicates a high risk of diabetes. NICE guidelines advise a fasting plasma glucose result of 5.5 to 6.9 mmol/l may put someone at higher risk of developing Type 2 diabetes (especially when accompanied by other risk factors).

Results from QOF (2023-24) show that around 20,000 patients (aged 17+) were diagnosed with diabetes and around 18,000 (aged 18+) with pre-diabetes. Around 38,000 Greenwich patients in total - 14.7% of the Greenwich practice population.

Estimates from OHID suggest 18.7% of the Greenwich population have these conditions, of which 8.4% have diabetes. This would mean another 8,000 patients have pre-diabetes and 2000 diabetes but are not yet diagnosed.

Variation in Prevalence of Diabetes and Pre-Diabetes in Greenwich

Results from the SEL ICB in early 2025 indicate that around 6.8% of Greenwich patients aged 10+ have diabetes (around 20,000 patients) and around 7.9% aged 10+ have pre-diabetes (over 23,000 patients).

The results indicate there are higher rates of diabetes in males (with higher rates of pre-diabetes in females), higher rates of diabetes and pre-diabetes in Black and Asian communities, and higher rates amongst patients in our most deprived neighbourhoods. This tallies with national findings: for example, the HSE (2022) reported that 17% of adults in the most deprived areas of England had diabetes (diagnosed and undiagnosed) compared to 7% of adults in the least deprived areas.

The results from SEL for Greenwich indicate:

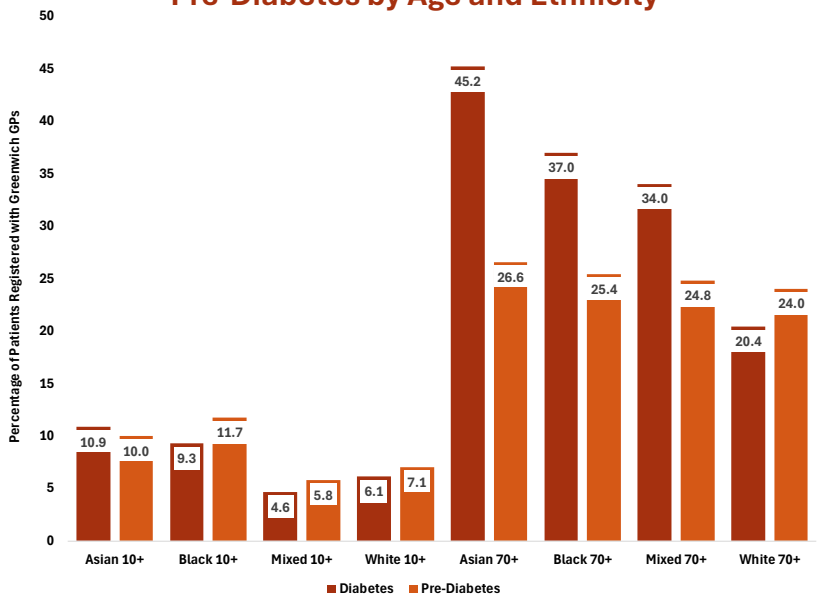
- 7.6% of males aged 10+ were on a diabetes register (11,000 males) as were 6.5% of females aged 10+ (9,500 females).
- 8.6% of females had a finding of pre-diabetes (12,500 females) as did 7.3% of males (10,600 males).

Risk Factors for CVD in Royal Greenwich

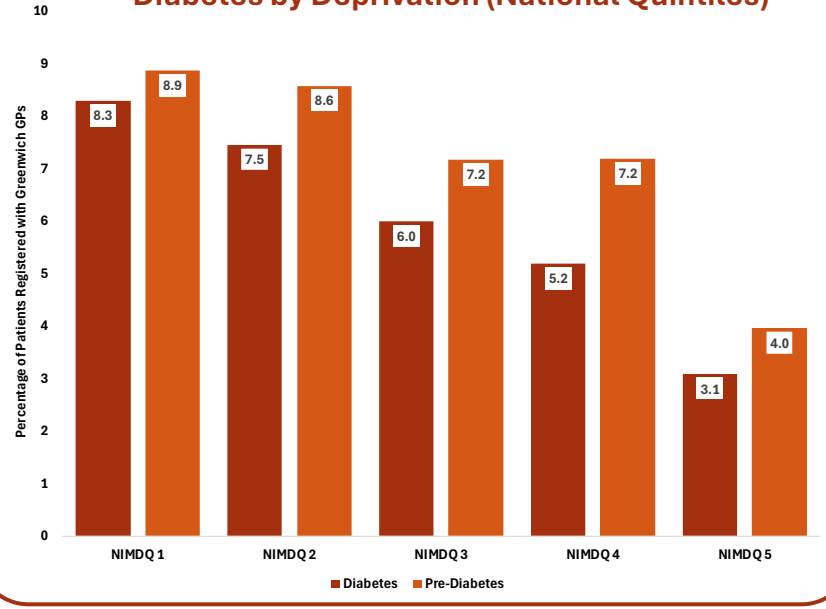
Diagnosed Prevalence of Diabetes and Pre-Diabetes

- These conditions increase with age: by 70+, 25% of patients have diabetes and 24% pre-diabetes.
- Amongst people aged 70+, 30% of men had diabetes compared to 22% of women, and 23% of men had pre-diabetes as did 25% of women.
- Prevalence of diabetes ranged from 8.3% of patients in our most deprived neighbourhoods (NIMDQ1) down to 3.1% in our least deprived neighbourhoods (NIMDQ5). Similarly, prevalence of pre-diabetes ranges from 8.9% in NIMDQ1 to 4.0% I NIMDQ5.
- 9.3% of Black patients aged 10+ (5,300) were on a diabetes register as were 10.9% (4,200) of Asian patients. This fell to 6.1% (8,800) of White patients.
- 11.7% of Black patients aged 10+ (6,700) had a diagnosis of pre-diabetes as did 10.0% of Asian patients (3,900). This fell to 7.1% of White patients (10,100).
- At age 70+, only 20% of White patients were on a diabetes register compared to 37% of Black patients and 45% of Asian patients.
- Less than 5% of Mixed ethnicity patients (age 10+) had diabetes, but this increased to 34% of patients at age 70+.
- At age 70+, 24% of White patients were diagnosed with pre-diabetes, as were 25% of Black patients and 27% of Asian patients.
- Around 6% of Mixed ethnicity patients (age 10+) had pre-diabetes, but this increased to 25% of Mixed patients aged 70+.

Prevalence of Diagnosed Diabetes or Pre-Diabetes by Age and Ethnicity



Prevalence of Diagnosed Diabetes and Pre-Diabetes by Deprivation (National Quintiles)



Risk Factors for CVD in Royal Greenwich

Physical Activity

Taking part in physical activity is important in maintaining health and reducing risk of CVD. National guidelines recommend that people aged 16+ do at least 150 minutes of moderate physical activity a week, but many people do less than this.

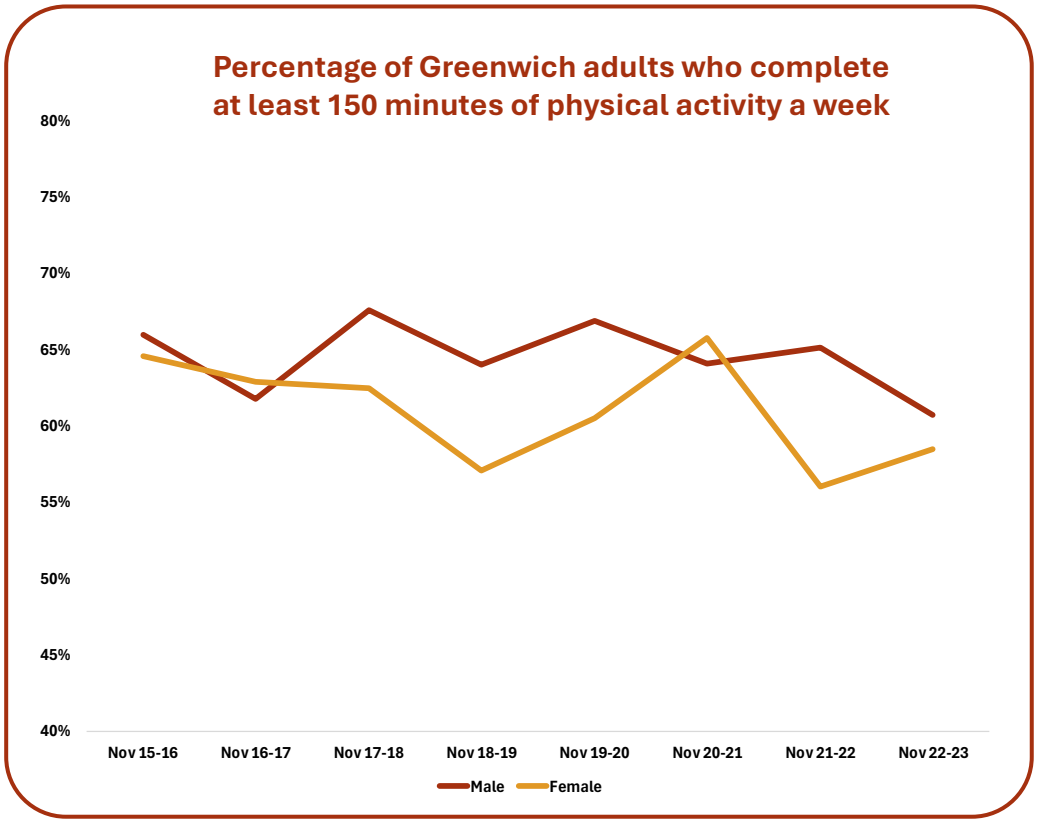
Nationally, the ALS has found that men are more likely to be physically active, and people who live in less deprived areas are also more likely to be physically active. Levels of activity also range widely by other factors such as age, ethnicity, and level of disability. For example, the ALS reported there were higher proportions of 'physically active' people who were of Mixed ethnicity or Other White ethnicity in England, while people of an Asian or Black ethnicity reported being less physically active on average.

In 2022-23. Sport England's Active Lives Survey (ALS) shows that the proportion of 'physically active' Greenwich residents fell from 64.9% in 2015-16 to 59.3% (see chart, bottom right).

Many of the remaining Greenwich residents had completed fewer than 30 minutes of moderate physical activity a week. The proportion of 'inactive' residents had increased from 24.1% in 2015-16 to 28.5% in 2022-23.

More detailed results are not always available at Greenwich level due to the small numbers of people surveyed per borough.

Where results are available, they tend to indicate that Greenwich residents are less active than the London average - e.g. 47% of Greenwich residents who were Asian were physically active compared to 57% across London (see chart on the following slide, bottom right).

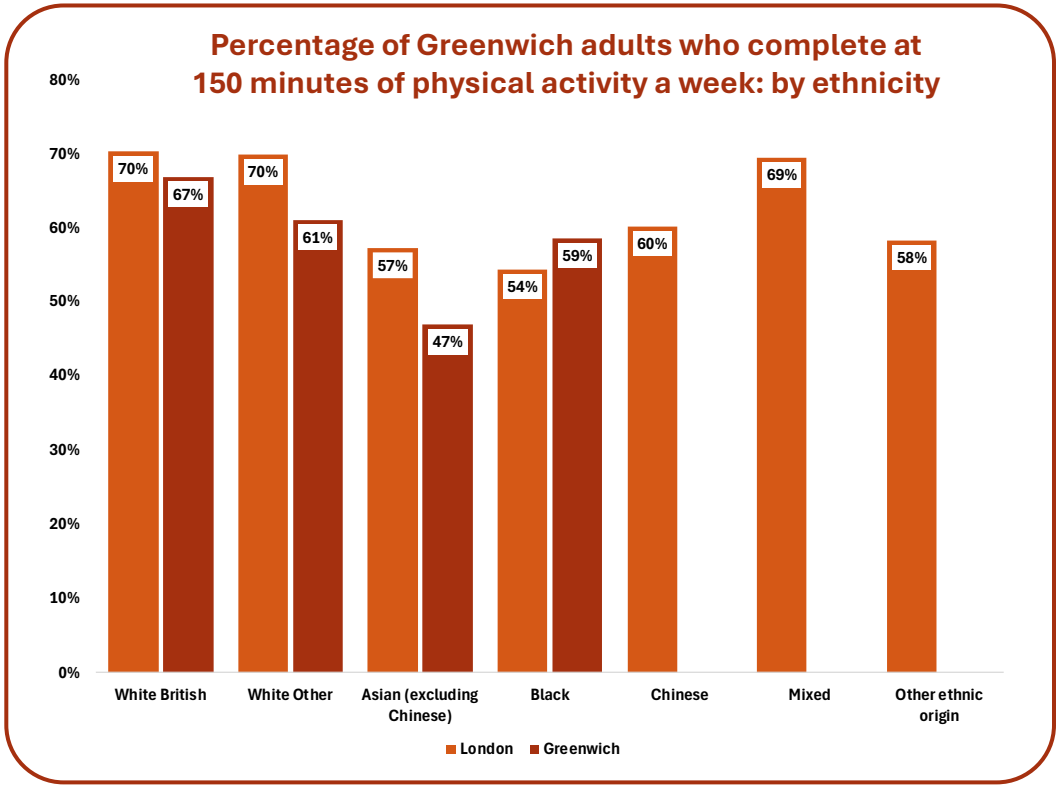


Risk Factors for CVD in Royal Greenwich

Physical Activity

Other ALS results for 2022-23 indicate that:

- A greater proportion of Greenwich men continued to report they were physically active (60.7%) compared to Greenwich women (58.5%).
- Fewer men reported they were physically inactive: 27.5% of Greenwich men compared to 29.6% of Greenwich women.
- Nevertheless the proportion of Greenwich men who reported they were physically active had fallen to the lowest level since 2015-16.
- The gap between men and women narrowed in 2020-21 during the COVID pandemic when the level of physical activity reported by women increased. This change was not sustained.
- 62% of younger people aged 16-34 in Greenwich met the target compared to 71% nationally. This was a fall on previous years when the Greenwich rate was closer to the average.
- Nationally only 43% of people aged 75+ met the target of 150 minutes of physical activity each week. This result is not available for Greenwich.
- Only 48% of people with disabilities or long-term health conditions were physically active compared to 69% of adults without these conditions. A similar difference was evident in Greenwich. In addition, levels of physical activity were a little lower than the national average for each Greenwich group.
- Sport England measures deprivation using the NS SEC categories based on people's employment. The ALS found that only 53% of adults in NS SEC 6-8 (lower socio-economic groups) were physically active compared to 62% in NS SEC 3-5 (middle) and 73% in NS SEC 1-2 (higher). Where results for Greenwich are available, they generally show a similar pattern.
- In 2022-23, a higher proportion of Greenwich residents in groups NS-SEC 6-8 reported being physically active compared to the average for these socio-economic groups on average.



Risk Factors for CVD in Royal Greenwich

Excess weight

Excess weight, especially round your waist, can lead to fatty material building up in your arteries. Atherosclerosis can lead to a heart attack, stroke or vascular dementia. Excess weight can also increase the risk high blood pressure, high cholesterol and type 2 diabetes, which in themselves are also risk factors for CVD.

Prevalence of excess weight in adults

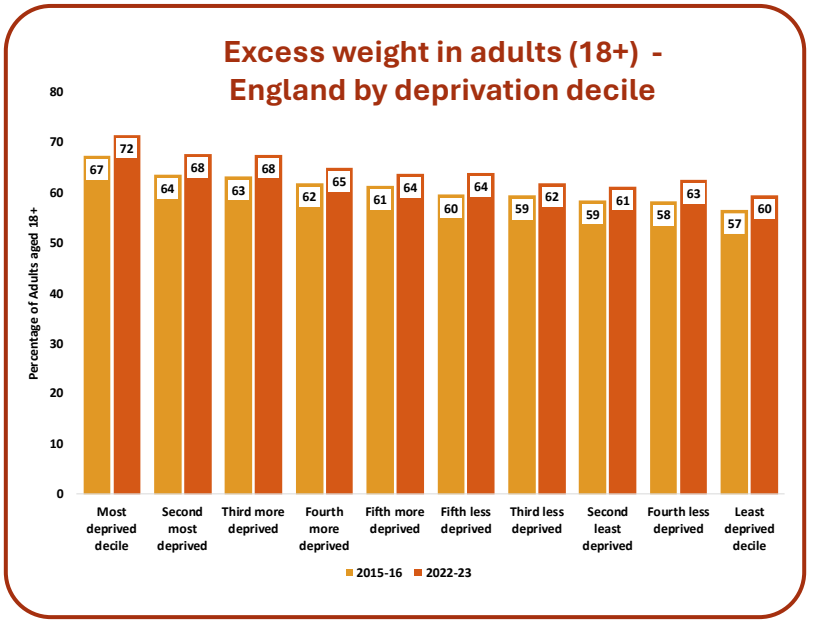
Sport England's Active Lives survey (ALS) indicates that the proportion of adults (18+) in England who have an excess weight (who are overweight or living with obesity) has increased: only around one third of adults were a healthy weight by 2022-23.

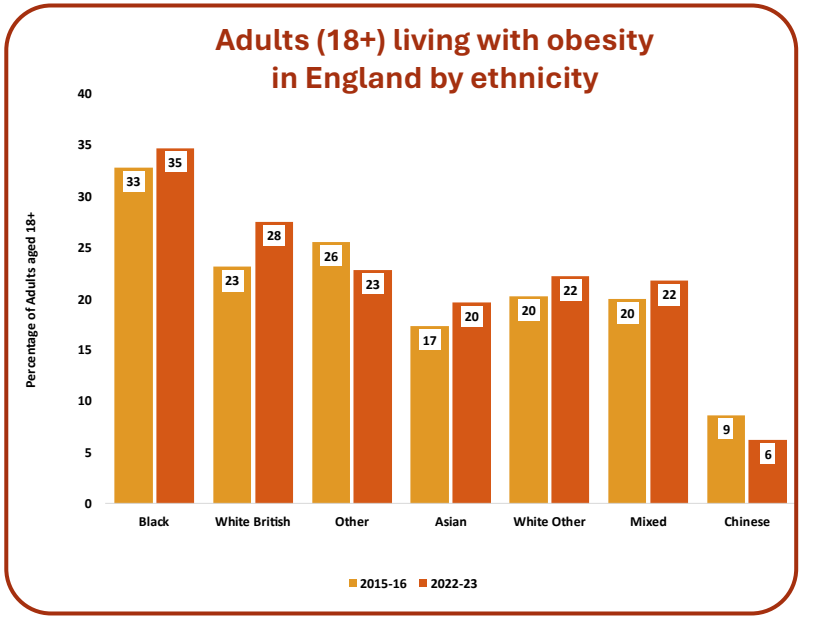
Results for Greenwich were worse than the London average (although a little better than England): 57% of Greenwich adults surveyed had excess weight and 23% were living with obesity. If these results were true of Greenwich as a whole, it could mean 150,000 adults have excess weight including 60,000 adults living with obesity.

The ALS showed that some existing inequalities had widened. For example, 57% of people in the least deprived decile (nationally) had an excess weight in 2015-16 and this increased to 60% in 2022-23. For people in the most deprived national decile the increase was from 67% to 72%. (These results are not available for Greenwich).

Nationally the rate of excess weight was highest amongst Black adults, increasing from 74% in 2015-16 to 75% in 2022-23. The rate for White British adults increased from 62% to 65%, for Other White adults from 57% to 58%, Asian adults from 58% to 59%, and Mixed ethnicity adults from 54% to 61%.

There were similar variations for obesity. In 2022-23, 21% of adults in the least deprived national decile were living with obesity but this increased to 36% of adults in the most deprived decile. In the same year, 35% of Black adults were living with obesity as were 28% of White British adults, and only 20% of Asian adults.





Risk Factors for CVD in Royal Greenwich

Prevalence of excess weight in adults

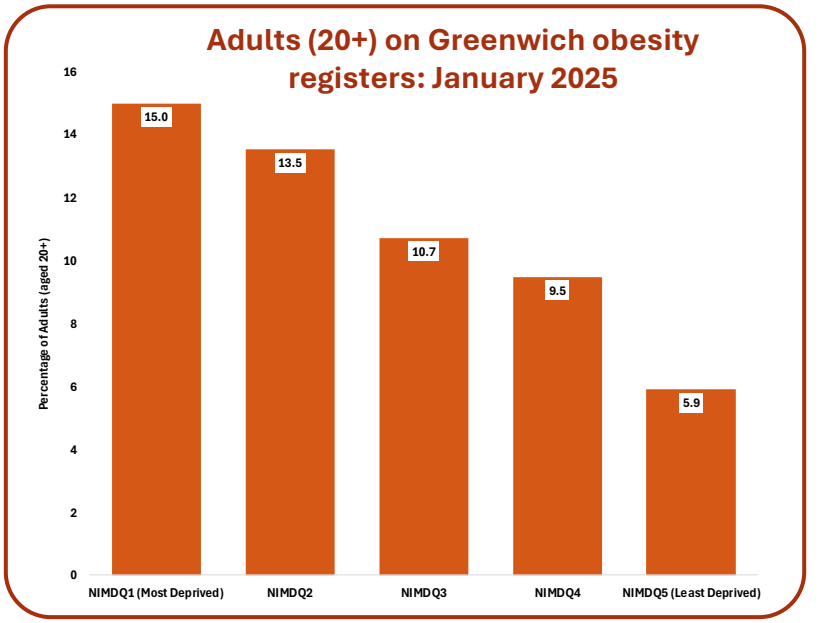
Around 35,000 adults aged 18+ were on a Greenwich GP practice obesity register in 2022-23 (14% of patients aged 18+). Although this was a little higher than both London (11%) and England (13%), the ALS results suggest there may be many more Greenwich patients living with obesity to identify and offer support to.

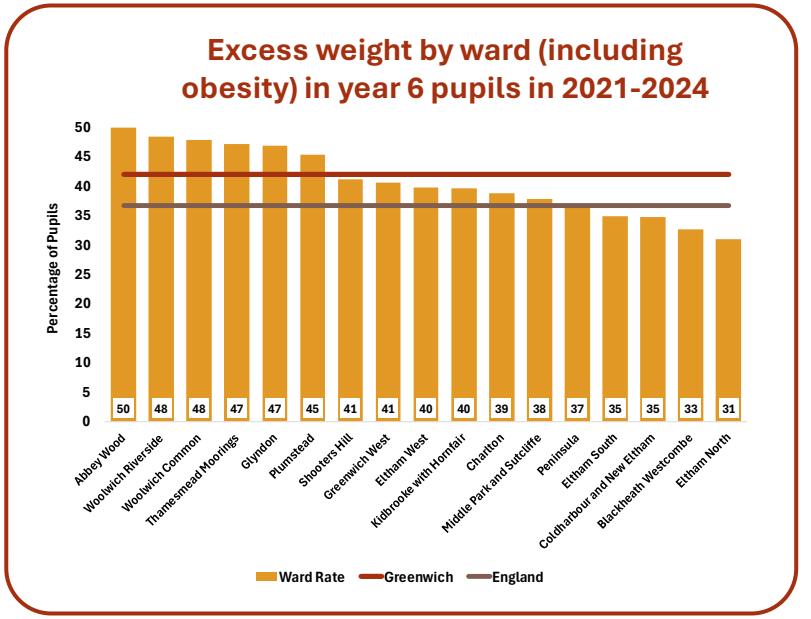
Additional results from SE London ICB show that 12.5% of Greenwich patients aged 20+ were on a GP practice obesity register (in January 2025). These results indicate higher rates of diagnosed obesity amongst women, Black residents, and residents from deprived neighbourhoods. For example:

- 12,200 men and 19,200 women (10% of men and 15% of women aged 20+).
- Diagnoses of obesity increased with age: from around 7% of adults aged 20-39 up to 22% aged 60-69 (20% of men and 24% of women aged 60-69).
- 19.0% of Black patients had a diagnosis of obesity as did 12.6% of White patients, 9.7% of Asian patients, and 11.6% of Mixed patients.
- At age 60-69, 30.7% of Black patients had a diagnosis of obesity compared to 21.9% of White patients, 17.3% of Asian patients, and 19.7% of Mixed patients.
- There was an association with deprivation: diagnoses increased from 5.9% of patients from the least deprived (NIMDQ5) Greenwich neighbourhoods up to 15.0% of patients from the most deprived (NIMDQ1) neighbourhoods.

Prevalence of excess weight in children

Excess weight can have many negative effects for a child. The health consequences can include Type 2 diabetes, hypertension, and exacerbation of conditions such as asthma. Children's mental wellbeing can be at risk due to low self-esteem, stigma and bullying. Children who are overweight or obese are more likely to have excess weight in adulthood with all the longer-term health consequences that can result from this. It is important to take steps such as increased physical activity to reduce excess weight in children and help to ensure they have the best start in life.





Risk Factors for CVD in Royal Greenwich

Prevalence of excess weight in children

The annual Child Measurement Programme (NCMP) data shows that many children in Greenwich (and nationally) have an excess weight. Results for Greenwich remain above the London and England averages and are a continuing concern.

In 2023-24, 25% of Greenwich children in reception (aged 4-5) were either overweight or living with obesity, and 41% of children in year 6 (aged 10-11) were.

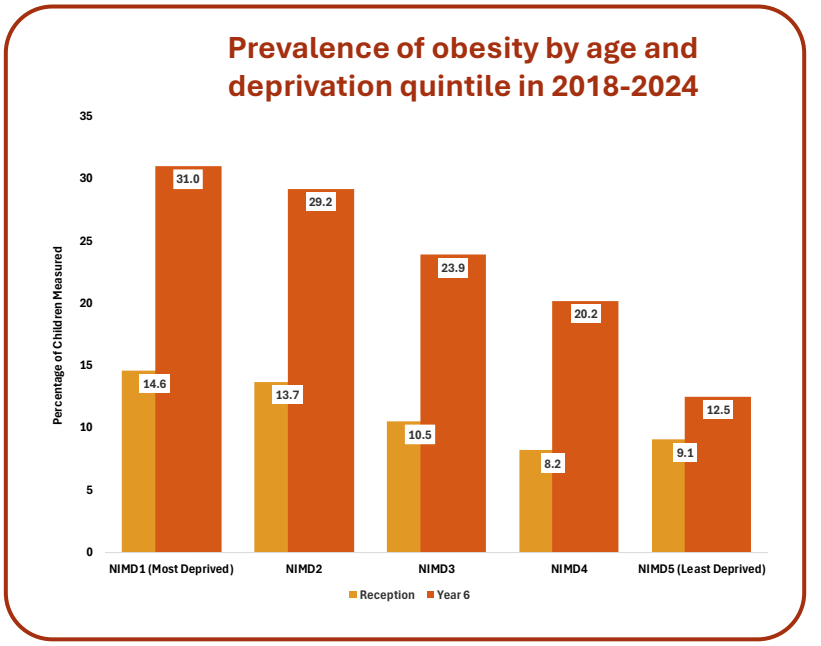
As with adults, excess weight is an issue in all Greenwich communities. In 2021-24, at least 1 in 5 reception pupils and 1 in 3 year 6 pupils in every Greenwich ward had an excess weight. And at least 1 in 5 year 6 pupils were living with obesity in every ward.

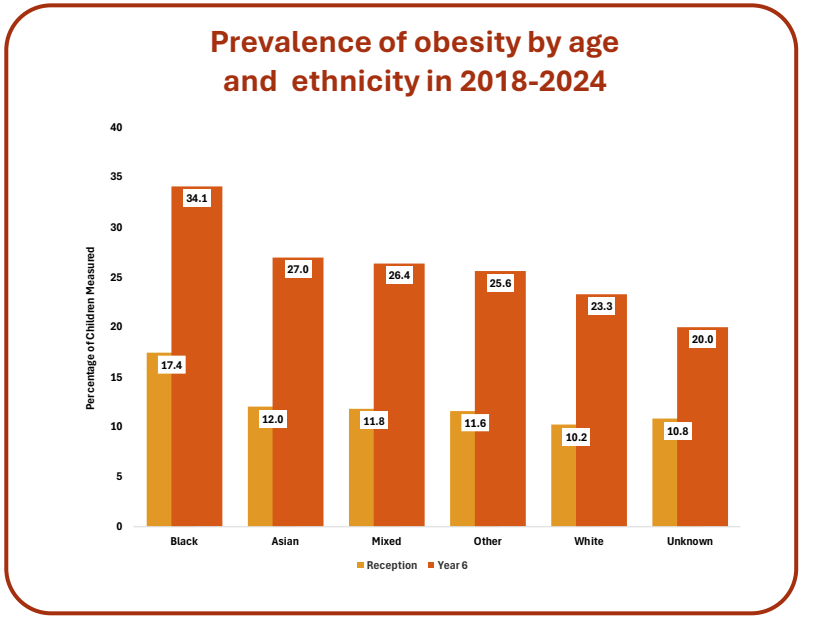
However, rates are a little higher for children from some communities. In Greenwich, in the 5-year period 2018-24 (excluding 2020-21), 17% of reception pupils with a Black ethnicity were living with obesity compared to 10-12% of pupils with other ethnicities and by year 6, 34% of Black pupils were living with obesity as were 27% of Asian pupils, 26% of Mixed pupils, and 23% of White pupils.

The most recent results also show that 15% of reception pupils and 31% of year 6 pupils resident in the most deprived Greenwich neighbourhoods (NIMDQ1) are living with obesity compared to 9% of reception pupils and 13% of year 6 pupils from the least deprived neighbourhoods (NIMDQ5).

In contrast to the NCMP results, few children and young people under the age of 20 are identified on Greenwich GP practice obesity registers.

Further information about what we are doing to ensure that children and adults can increase levels of physical activity and maintain a healthy weight can be found in the Physical Activity APHR .





Risk Factors for CVD in Royal Greenwich

Smoking Prevalence

Smoking is a major cause of ill-health, responsible for half the difference in life expectancy between the most and least affluent communities in England. The three main causes of death due to smoking are: COPD, lung cancers, and CHD.

Smoking is highly addictive, but many people can quit successfully, especially with the right support.

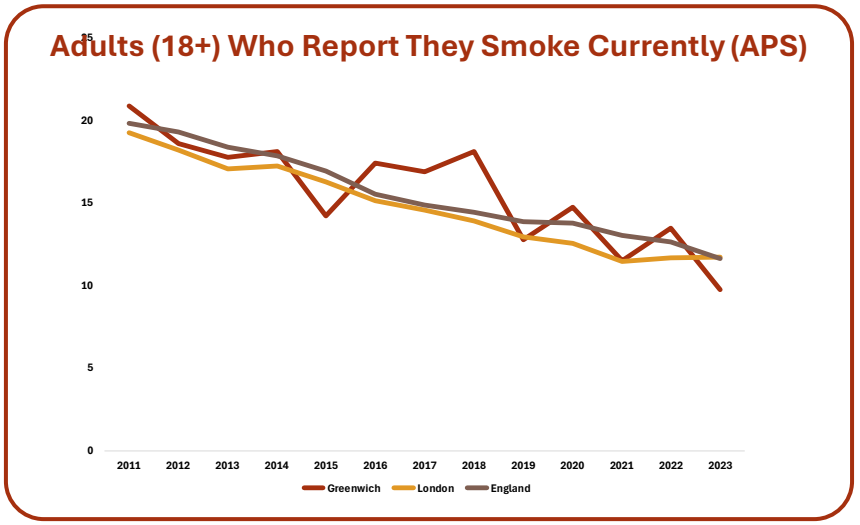
The number of people who smoke is decreasing (see right). In 2023, 9.7% of Greenwich residents aged 18+ reported they smoked (APS), around half the rate reported a decade ago. The proportion of residents who reported they had never smoked grew to 74%.

The 2023 APS also found that smoking prevalence in Greenwich had dropped below the average for London and England. This was the case for both men and women: 12.3% of Greenwich men and reported smoking compared to 13.4% men in England and 7.0% of Greenwich women reported smoking compared to 9.9% of women In England.

Smoking Prevalence – National Intelligence

There is a large amount of national intelligence demonstrating the varying impact and prevalence of smoking, including higher rates amongst men, and in many deprived and vulnerable communities. Rates of smoking may still be decreasing but at a slower rate than the average. Additional work with communities indicated may be needed:

- 22% of people in the most deprived decile nationally were smokers and only 6% in the least deprived decile (APS 2023).
- 12% of White people were smokers according to the APS (2023).



- According to the GPPS (2022-23) smoking increased to 22% of people described as 'White Other', as well as 45% of White Irish Travellers and 42% of people who are White Roma.
- The GPPS found that higher proportions of people with Mixed ethnicity were smokers including 25% of people who were Mixed White and Black Caribbean, 19% Mixed White and Black African, 18% Mixed White and Asian, and 20% Other Mixed ethnicity.
- The APS found that only 7% of Asian people and 6% of Black people were smokers. The relatively low rates were partly due to much lower rates reported by women. For example, 11% of Asian men reported they smoked compared to 2% of Asian women.
- Rates were indicated to be higher in some Asian communities: for example, GPPS found that 16% of people with Bangladeshi ethnicity and 13% with Pakistani ethnicity were smokers.
- 16% of Muslim men were smokers, as were 14% with no faith. Lower rates were reported by Sikhs (4%) and Muslim women (1%).
- The GPPS also found that 13% of people who were heterosexual smoked compared to 21% of people who were gay/lesbian and 24% of people who described themselves as bisexual.

Risk Factors for CVD in Royal Greenwich

Smoking Prevalence – Local Intelligence

Local results often reflect these national variations. In early 2025, SEL's Vital 5 Dashboard indicates that 12% of Greenwich patients (aged 19+) who had a smoking status recorded in past 5 years were smokers. Higher rates found amongst men and patients living in more deprived areas.

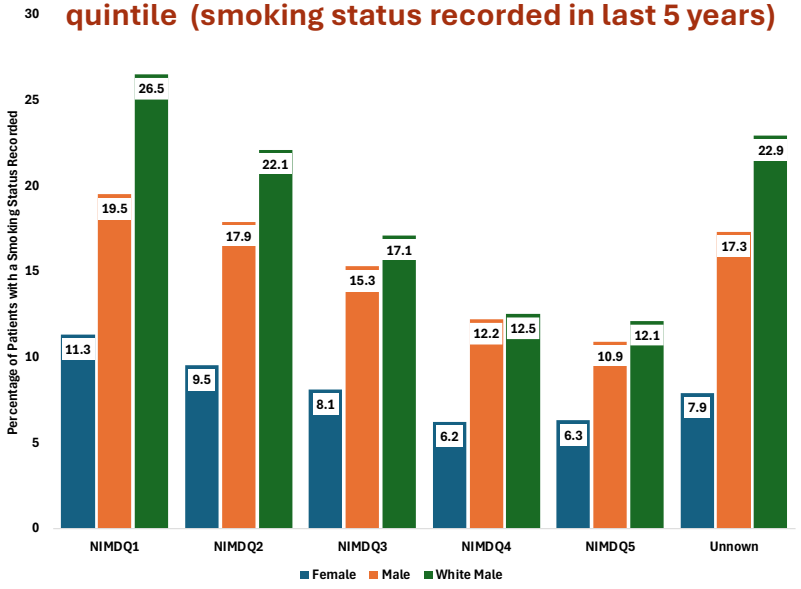
- 17% of men and 9% of women were identified as smokers.
- 15% of patients from the most deprived neighbourhoods (NIMDQ1) smoked compared to 8% from the least deprived areas (NIMDQ5).
- 20% of men and 12% of women in the most deprived areas smoked, as did 11% of men and 6% of women in the least deprived areas.
- White patients were most likely to smoke (16%) followed by Mixed patients (12%). As with national results only 8% of Asian patients and 6% of Black patients smoked. (Over 20% of White male patients living in the 2 most deprived quintiles were identified as smokers).

People with a long-term mental health condition (LTMHC)

There are higher rates of smoking amongst people with long term mental health conditions, including in communities where rates of smoking tend to be lower. National results from the GPPS (2022-23) found included:

- 29% of people in the most deprived decile and 22% in the least deprived decile
- 25% White British, 27% White Other, 33% Black African
- 39% Mixed White & Black Caribbean, 33% White & Black African, 20% Indian, 24% Bangladeshi, 19% Other Asian, 16% Chinese

Patients aged 19+ identified as smokers by deprivation quintile (smoking status recorded in last 5 years)



- 24% Muslim, 22% Christian, 19% Sikh, 15% Hindu, 27% no faith
- 24% of heterosexual people, 30% gay/ lesbian people, and 32% bisexual people

Vapes and Drug Misuse

There is a risk that access to vapes (in themselves having unestablished risks) could lead to increased addiction or uptake of cigarettes, although where properly regulated they are known to be an effective aid to quit smoking. It will be vital to control illegal devices with larger capacity (above 2ml / more than 600 puffs) and attractive packaging. Tobacco is also a component of cannabis misuse which remains widespread in the UK.

Further information about what we are doing to reduce smoking in Greenwich can be found in the Smoking JSNA.

Risk Factors for CVD in Royal Greenwich

Alcohol Misuse

Alcohol is a causal factor in more than 60 medical conditions including 7 types of cancers, cirrhosis of the liver, and high blood pressure. It carries an increased risk of Type 2 diabetes. Alcohol misuse can precipitate or exacerbate mental health and behavioural disorders. It is associated with acts of violence and may contribute to up to 35% of ambulance and Accident and Emergency costs.

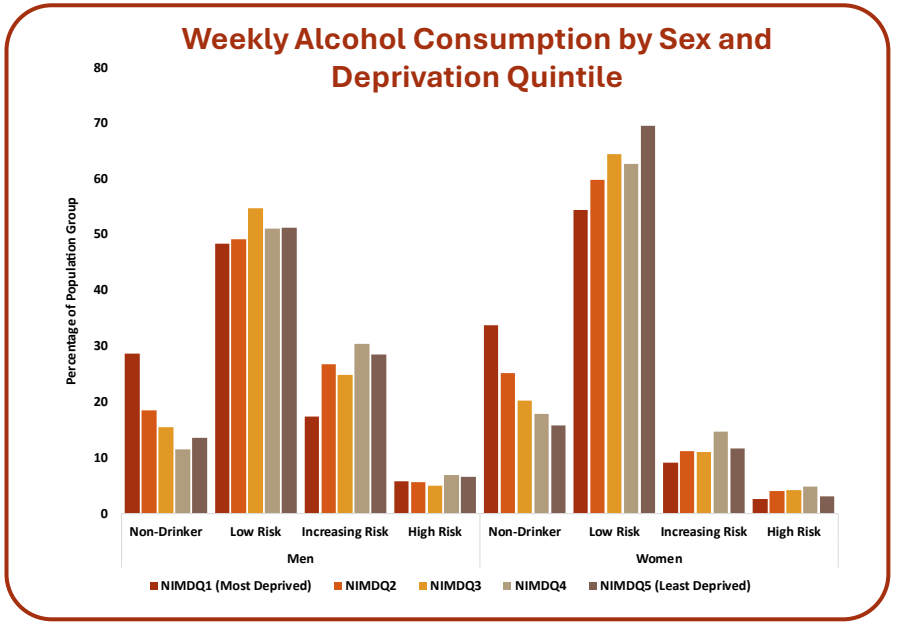
Reducing alcohol intake to sensible levels is therefore another factor in reducing both risk of developing CVD as well as a wide range of other conditions.

The rate of admissions to hospital due to alcohol related CVD has been higher than the average for England but fell to 790 per 100,000 Greenwich residents in 2023-24 compared to 837 per 100,000 in England.

Prevalence of Alcohol Misuse

There is limited information available about the prevalence of harmful drinking in Greenwich. A recent estimate for 2019-20 found that 14.5 people per 1,000 Greenwich residents were dependent on alcohol. This estimate was a little higher than found for London (13.4 per 1,000 people) and England (13.8). Of the estimated 3,178 dependent drinkers in Greenwich around 77% were expected to be men and 23% women.

Nationally the Health Survey for England (2022) found that 81% of adults drank alcohol in the previous 12 months and 7% of people drank alcohol most days. Nearly 1 in 4 of those who drank alcohol, consumed more than 14 units in the last week and were at increased health risk. And a further 1 in 20 were at high risk (drinking 35 units or more for women and 50 units or more or men).



Risk Factors for CVD in Royal Greenwich

Prevalence of Alcohol Misuse

The HSE found men were more likely to report drinking alcohol, and they also drank more on average: 17.6 units in a typical week compared to 9.0 units for women. 32% of men drank at levels that put them at increasing or higher risk of alcohol-related harm (over 14 units in the last week) compared to 15% of women.

People from less deprived neighbourhoods were a little more likely to be at increased risk of harm overall, although people from the most deprived neighbourhoods were most likely to be high risk or dependent drinkers: 2.4% of people in the most deprived quintile were dependent drinkers compared to 1.3% in the least deprived quintile.

Initial Brief Advice in Primary Care

Alcohol identification and brief advice (IBA) aims to identify and influence patients who drink more than the recommended amount (14 units weekly). Patients complete a simple audit and are provided with advice about the increased risk to their health. Research suggests IBA is effective in reducing non-dependent drinking. Where healthcare professionals identify that patients are potentially dependent drinkers, they can refer them for a specialist alcohol assessment or for further investigation of liver disease.

Results from SE London's Vital 5 Dashboard indicate that few patients have undertaken an alcohol risk assessment: in the most recent 5-year period, only 5% of Greenwich patients (adults) had taken a FAST assessment, 20% the audit-C and 33% had a drinking value recorded. Of patients who had undertaken an assessment, 19% had a positive (increased risk) FAST score, 13% a positive AUDIT-C score, and 8% were drinking more than 14 units weekly.

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36% of women had a drinking value recorded compared to 30% of men. Only 4% of women assessed were identified as drinking more than 14 units weekly compared to 12% of men who were assessed.

Of Greenwich patients who had taken a C-test, 27% of White patients had a raised alcohol risk compared to 7% of Black patients, 8% of Asian patients and 15% of Mixed patients. Of patients who had a drinking value recorded, 12% of White patients were drinking more than 14 units of alcohol each week compared to 2% of Black patients, 3% of Asian patients and 5% of Mixed patients.

As found in the HSE, residents in less deprived quintiles were a little more likely to drink alcohol and to have increased alcohol risk scores, but less likely to be dependent drinkers. For example, in mid 2025, 6.7% of patients in the most deprived quintile had a higher risk (C-Test) and this increased to 8.6% in the least deprived quintile. A very small number of patients were identified as being at risk of dependency and they were more likely to be patients from the most deprived quintile.

Early research in Greenwich indicates active follow up by a GP on an IBA score can be as low as 1% per practice. It is important to ensure that GPs are using an alcohol audit tool and are following up to ensure appropriate advice is given with signposting to support and treatment where patients are identified at higher risk.

Risk Factors for CVD in Royal Greenwich

High Cholesterol and Triglycerides

Cholesterol is a fat-like substance made in the liver which is used throughout the body and vital for many functions including digestion, and the creation of hormones. It is also found in food.

Cholesterol is transported in the blood and high levels can lead to fatty deposits building in arteries, leading to CHD and stroke. There are usually no symptoms of high cholesterol, so checks to measure levels such as those offered in the NHS Health Check are important.

For many people, high cholesterol is due to a diet high in saturated fats, and not enough unsaturated fats. Other key contributors are low intake of fruit, vegetables and other high fibre foods, being physically inactive, smoking, and drinking too much alcohol. Your age, sex, ethnicity and family history can also contribute, but most risks are 'modifiable'.

Although high-density lipoprotein (HDL) is sometimes referred to as 'good cholesterol' and low-density lipoprotein (LDL) as 'bad cholesterol', a balance of both types is required. Having over 5mmol/L of cholesterol in the blood increases the risk for CVD, whilst healthy levels of both good (HDL) and bad (LDL) cholesterol are protective.

Recent evidence places greater emphasis on the ratio of HDL to all cholesterol rather than a high level of any type of cholesterol. In the chart (right) for example, total cholesterol levels are optimal when they are less than 3.5x the level of HDL in men and less than 3.0 x the level in women.

Triglyceride (TG) is another fat that contributes to narrowing of arteries. It can build up due to excess weight, eating too many fatty and sugary foods or drinking too much alcohol.

TG is often found with low levels of HDL and this combination is linked with premature CHD. TG levels can still be high even when other cholesterol is within normal range.

		Optimal	Moderate	High
Total / HDL ratio	Men	<3.5	3.5 – 5.0	>5.0
	Women	<3.0	3.0 – 4.4	>4.4
LDL to HDL ratio		<2.5	2.5 – 3.3	>3.3
HDL to LDL ratio		>0.4	0.4 – 0.3	<0.3
TG to HDL ratio		<2.0	2.0 – 3.8	>3.8

Source: LB Southwark

Prevalence of High Cholesterol

The 2022 Health Survey for England suggested 53% of adults had raised cholesterol (56% of women and 49% of men). It also found that 5% of adults in England had a total/HDL ratio of 6 or above, indicating high risk (8% of men and 3% of women).

The 2022 HSE also found the proportion of adults with high cholesterol increased after 2019 (following a steady decline). It was felt this was influenced by reduced access to GPs during the COVID pandemic. For example, there were known to have been decreases in new prescriptions of lipid lowering drugs during this time.

There is no information available about total numbers of people with high cholesterol in Greenwich. The HSE results suggest nearly 139,000 people (aged 16+) registered with Greenwich GPs have raised cholesterol and over 14,000 are at high risk. (Over 64,000 men, with 10,000 at high risk, and nearly 74,000 women, with 4,000 at high risk).

Risk Factors for CVD in Royal Greenwich

Prevalence of High Cholesterol (cont'd)

The 2022 HSE found different patterns of raised cholesterol by age and deprivation amongst men and women in England:

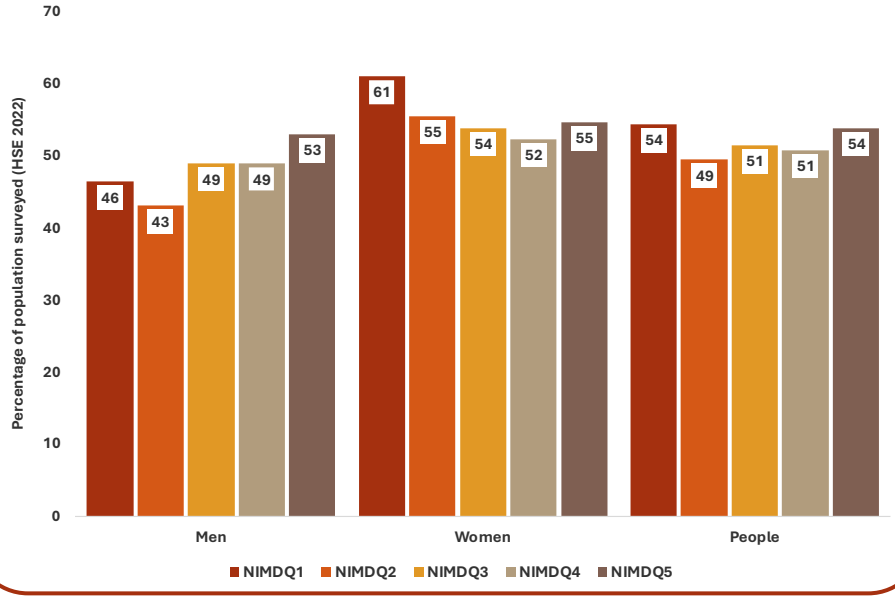
- Amongst women, the percentage with raised cholesterol peaked at age 55-64 (78.6% of women) and for men at 45-54 (65.3%).
- 15% of men aged 35 to 44 had a total/HDL ratio of 6 or above (high risk).
- Relatively few women were found to be at high risk. The highest percentage was 4% of women aged 16-34.
- Rates of raised cholesterol were slightly higher amongst people resident in both the most and least deprived neighbourhoods (as shown on the chart top right).
- Amongst women, the highest rates of raised cholesterol were in the most deprived neighbourhoods (NIMDQ1) and amongst men they were highest in the least deprived neighbourhoods (NIMDQ5).

Treatment with lipid towering therapies

QOF now measures the number of people with certain types of CVD who have been treated with lipid lowering therapies. Unfortunately, it does not yet identify the number of people with high cholesterol and who are receiving these therapies for that reason.

Results from CVDPrevent at December 2024 suggest that at least 22,000 Greenwich patients were receiving lipid lowering therapies out of nearly 35,000 patients in 2 target groups (patients with GP recorded CVD – narrow definition – and patients with no GP recorded CVD and either a Q-Risk score of 10% or a diagnosis of Diabetes and CKD). Not all these patients will have high cholesterol.

Prevalence of raised total cholesterol in England, by deprivation quintile (IMD) and sex



Familial hypercholesterolaemia (FH)

FH is an inherited condition that is caused by a genetic mutation. The liver is less able to remove excess 'bad' or LDL cholesterol, and people with FH are more at risk of heart and circulatory disease. Without treatment around 1 in 2 men with FH will experience a myocardial infarction by age 50 years and 1 in 3 women by age of 60.

FH affects 1 in every 250 people (1,200 people in Greenwich), but only 8% of people with FH are estimated to have a diagnosis. The NHS Long –Term Plan set ambitions to identify 25% of people with FH within 5 years and ensure they were offered a lipid lowering therapy.

Risk Factors for CVD in Royal Greenwich

Diet and CVD Risk

There is strong evidence of associations between several aspects of diet and increased CVD risk, including:

- low intake of fruit and vegetables
- high intake of saturated fat
- high intake of free sugars
- low intake of fibre
- high intake of salt
- low intake of oily fish

Eating Well – UK Dietary Recommendations

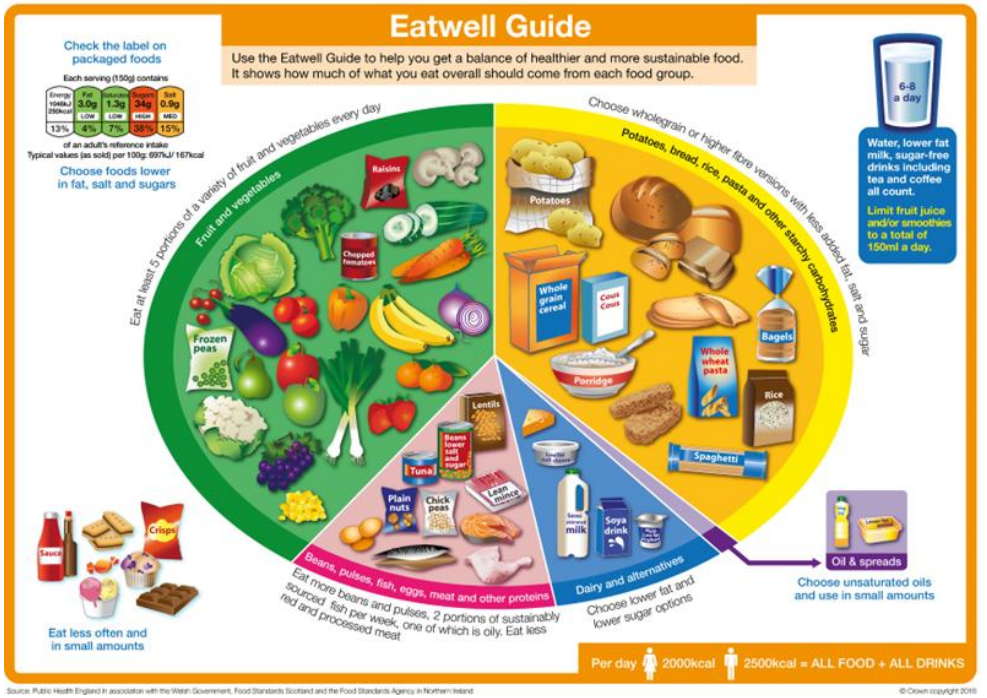
UK dietary recommendations include eating at least 5 portions of fruit and vegetables a day and reducing salt intake (adults) to less than 6g daily. The recommendations are visually represented as the Eatwell Guide, (pictured here, right).

A recent study found that following all the recommendations of the EWG could lead to a 7% reduction in mortality. Consuming the recommended intake of fruit and vegetables was found to have the strongest impact in achieving this reduction.

Only 31% of the UK population adhere to at least five of the nine recommendations in the EWG and very few people adhere to all nine.

The National Diet and Nutrition Survey (NDNS) has also shown the UK population is consistently failing to meet dietary recommendations which could reduce CVD risk. For example, in 2016-19:

- The mean (average) estimated salt intake for adults was 8.4 g/day
- On average, adults aged 19-64 consumed 4.3 portions of fruit and vegetables per day, and 11–18-year-olds only 2.9 portions per day
- Mean saturated fat intake of adults aged 19-64 was 12.3% of total energy. The recommendation is no more than 10% of total energy.



Eating Well – UK Dietary Recommendations

Diet in Greenwich

Results from the Healthy Lives Survey suggest that fruit and vegetable uptake is lower in Greenwich than elsewhere. In 2023-24 only 26.3% of Greenwich adults ate 5 portions compared to 29.7% on average in London and 31.3% in England.

Greenwich had the 9th lowest percentage out of all London boroughs.

Risk Factors for CVD in Royal Greenwich

Diet in Greenwich (cont'd)

The SHEU survey is our main source of information about children's food intake. For example, in 2023, only 25% of Greenwich primary pupils surveyed had eaten 5 portions of fruit and vegetables on the previous day and this fell to 16% of secondary pupils. Additionally, around 1 in 2 Greenwich pupils reported eating at least one type of unhealthy snack (e.g. crisps) or fast food on most days.

In 2023, over 120,000 pupils across 1315 UK schools undertook a SHEU survey, and where it was asked (questions are selected by boroughs) on average 29% of primary pupils ate 5 or more portions of fruit and vegetables the previous day, and this fell to 18% of pupils who were aged 14-15 years. These results suggest intake of fruit and vegetables amongst Greenwich children is lower than children elsewhere (in common with Greenwich adults).

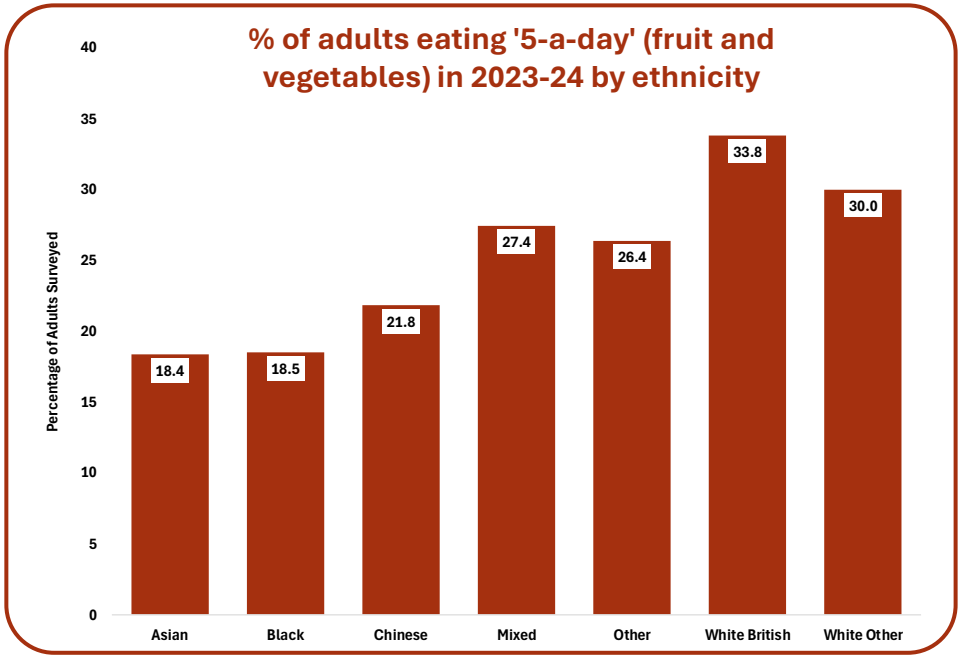
Diet and Health Inequalities

There are known to be widespread inequalities in access to food, and in the quality and cost of food that people can access.

Additional analysis of NDNS data by the Food Foundation shows significant dietary inequalities nationally, with the most deprived fifth of adults consuming 37% less fruit and vegetables on average, 54% less oily fish and 17% less dietary fibre than the least deprived fifth of adults.

Results from the Healthy Lives Survey also confirm variations in consumption of fruit and vegetables across a range of social groups. For example, in 2023-24:

- 28.9% of people with a disability reported eating 5 portions of fruit and vegetables daily compared to 32.3% of people without a disability
- 24.9% of people without any qualifications ate 5 a day compared to 36.1% of people who had qualifications at level 4 or above
- 18.4% of people who were long-term unemployed ate 5 a day compared to 34.6% of people who were in managerial, administrative and professional occupations
- 20.0% of people who lived in the most deprived IMD decile ate 5 a day compared to 38.6% of people in the least deprived decile
- 33.8% of people who were White British ate 5 a day compared to fewer than 19% of people who were Black or Asian



More information on diet and healthy eating can be found in the Royal Greenwich Food JSNA which will be published later in 2025.

Cardiovascular Disease in Royal Greenwich 2025 - Chapter Aims

How CVD is being addressed in Royal Greenwich

The importance of prevention, early identification and optimal treatment

There are many opportunities to address CVD outcomes through prevention, early identification and optimal treatment. These include:

- supporting behaviour change such as increased physical activity, eating healthier foods, stopping smoking, reducing alcohol intake.
- provision of services in primary care and the community such as cholesterol and blood pressure lowering treatments, diabetes prevention and stop-smoking services.
- increased early detection of illness and improved management of CVD risks in primary care.

Actions which increase access to the building blocks of health are also fundamental - for example poverty reduction.

Supporting behaviour change can prevent, or delay illness in individuals and reduce impact in communities that are at greater risk of developing CVD. For programmes to be most effective, it is important to understand the challenges and barriers residents can experience (particularly those experiencing greater inequalities) and include residents in the development of interventions that work better for them.

NHS England has emphasised the ABC of CVD prevention (targets within the NHS Long Term Plan and CVDPrevent programme:

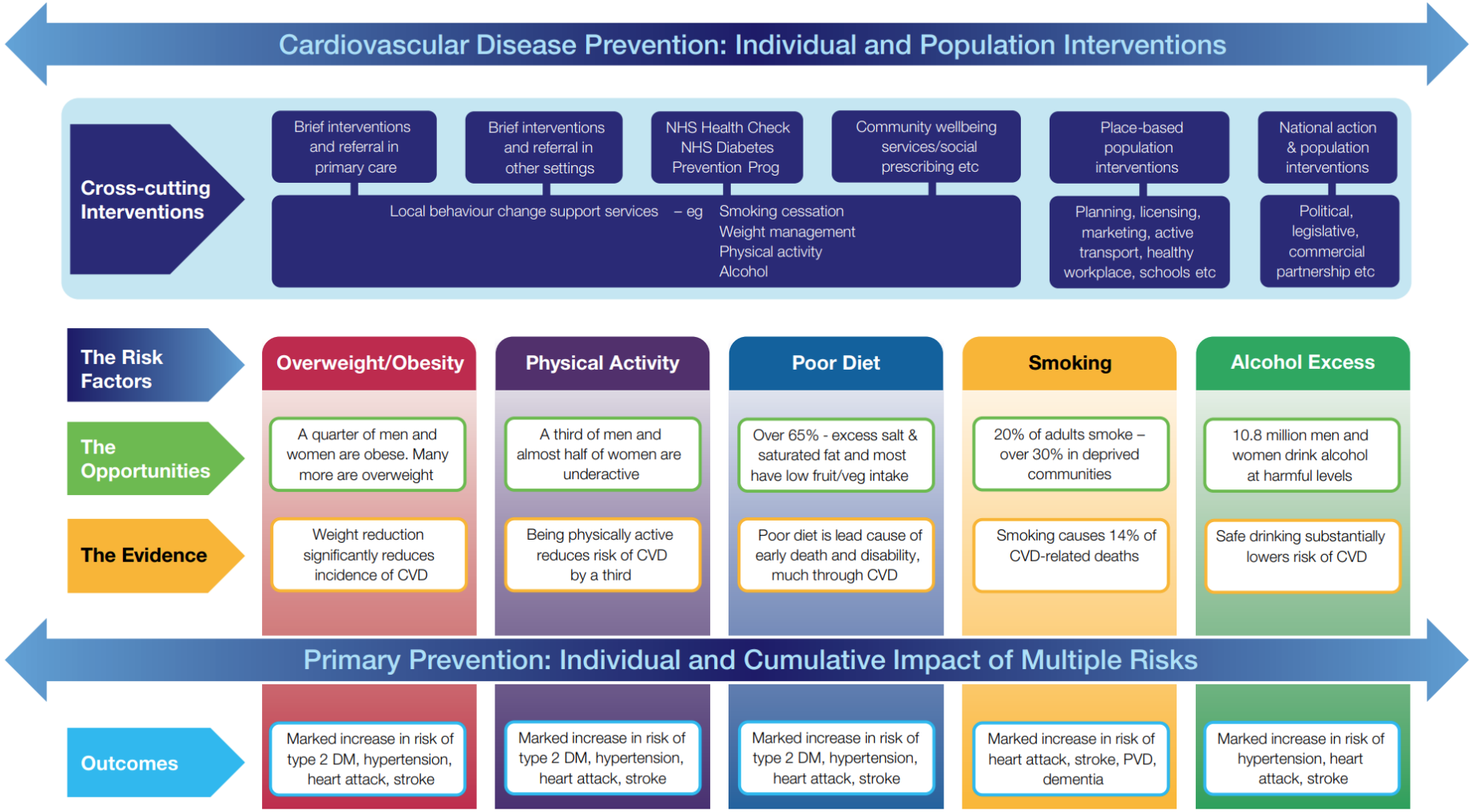
- Atrial Fibrillation: Target 85% detection and 90% anticoagulation by 2029
- Blood Pressure: Aim for 80% diagnosis and treatment to NICE guidelines
- Cholesterol: Ensure 75% of high-risk patients are prescribed statins

PHE (2016) identified a range of evidence-based opportunities to address CVD. The following two slides summarise opportunities to deliver changes through population programmes or through primary care. Other recommendations are shown here.

How CVD is being addressed in Royal Greenwich

Recommended interventions supporting behaviour change

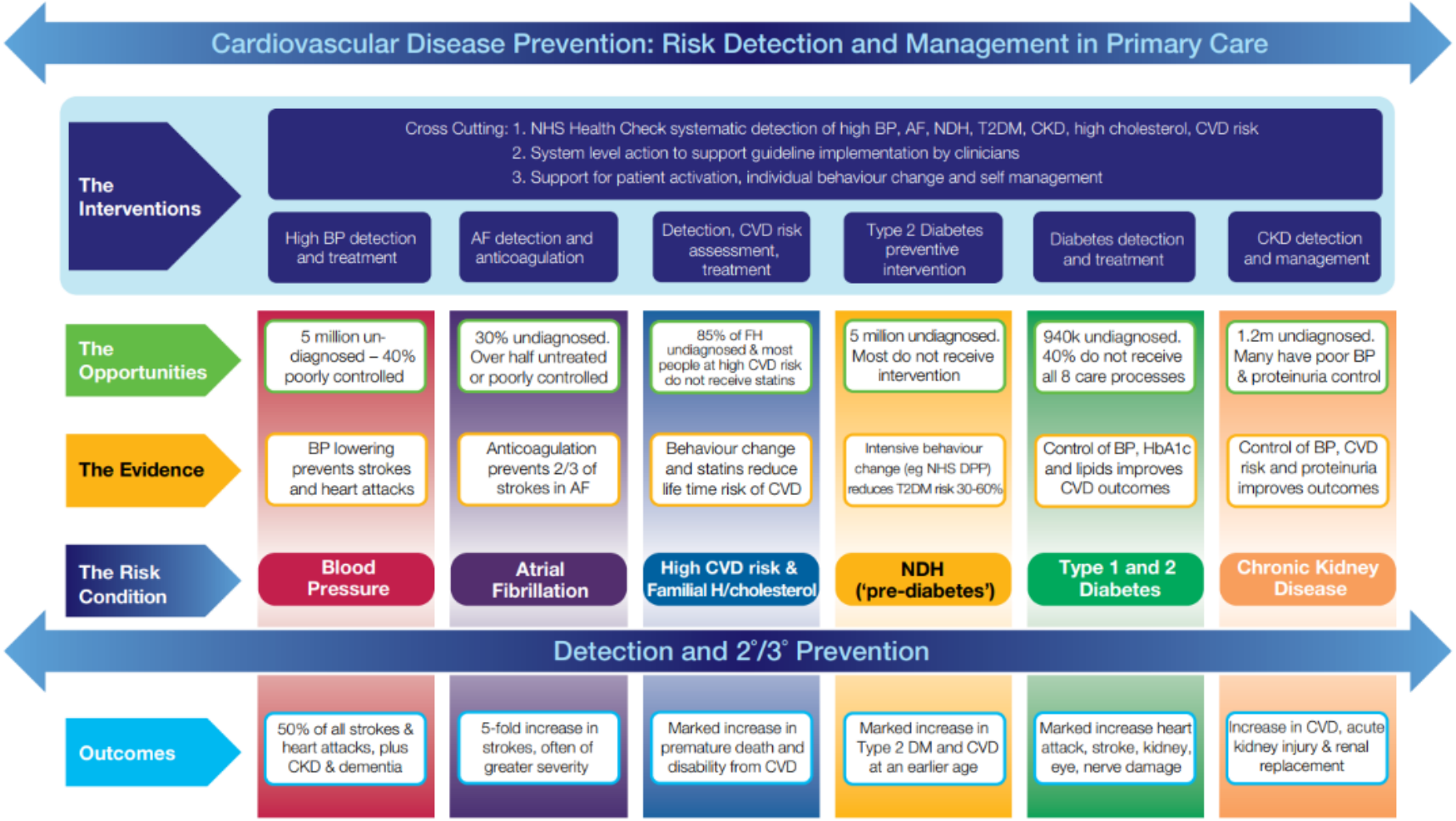
The following interventions have been recommended to improve behavioural risks such as physical inactivity and poor diet (PHE, 2016). For example, a programme of activity might combine brief interventions in primary care, with referral to local change support services such as weight management while improvements are made in the neighbourhood to make active transport an attractive option.



How CVD is being addressed in Royal Greenwich

Recommended interventions for detection and management of CVD risk in primary care

The following interventions have been recommended for detection and management of CVD risk primary care (PHE, 2016). For example, people with AF are 5 times more likely to have a stroke, but if they receive anticoagulation treatment this can prevent two thirds of these strokes. Increased action was required to identify people with AF, to ensure those who already have a diagnosis receive appropriate treatment, and to provide support where needed so that people who are prescribed treatment can maintain their treatment plan.



How CVD is being addressed in Royal Greenwich

Programmes in Royal Greenwich which support CVD prevention.

Evidence suggests preventative measures are the main opportunities to reduce CVD risk. There are several existing programmes and initiatives that provide opportunities to improve CVD outcomes, all of which can be accessed through our Live Well social prescribing model.

High quality social prescribing offer (Live Well) that signposts and refers people into services that support behaviour change in Greenwich. These help to improve physical activity, reduce smoking, increase access to health food, avoid excess alcohol intake, support social connection and better mental health.

- Promoting and utilising local physical assets effectively and Increasing access to Green Spaces
- Commissioning Better Health
- 'Greenwich Get Active'- Physical Activity and Sports Strategy, includes ways of encouraging more people to be active
- Cookery clubs, food pantries and clubs
- Non HFSS Advertising Policy, only non-HFSS products can be advertised on Council owned furniture and related social media
- Greenwich Stop Smoking Service
- Commissioning of Via (support with Alcohol and Substance Misuse)
- Community champions

Existing prevention services for clinical risk factors – identifying problems at an early stage and reducing CVD risk.

- NHS Health Check Programme: identifies and refers people, between 40-74, who have not previously been diagnosed with CVD. This group may be unaware that they are living with CVD or associated risk factors. In Royal Greenwich, the check includes collecting the following: age, gender, smoking status, family history of CHD, ethnicity, Body Mass Index, waist circumference, cholesterol, HbA1c, blood pressure and pulse check, physical activity level, alcohol use, mental health status, experience of erectile dysfunction (for men) and raising awareness of dementia (for those over 65). (Further information about NHS Health Checks can be found on slides 62-69).
- Connecting Greenwich: This is a partnership programme between Primary Care and Public Health to support practices to connect with community leaders and residents to address local health and wellbeing needs, including CVD prevention and identification activity.
- 100 Day Challenge: The 100-Day Challenge was an approach used to identify high blood pressure through the lens of community needs. Over 800 blood pressures were taken over 100 days; 10% of these were high or very high.

How CVD is being addressed in Royal Greenwich

Provision of primary care services e.g. cholesterol and blood pressure lowering treatments, diabetes prevention and management and stop smoking services

In 2019, NHS England (NHSE) set out its ambition to prevent 150,000 heart attacks, strokes and dementia cases by 2028-29. To achieve this, NHSE set the NHS five national ambitions based on detecting and treating more people with Atrial fibrillation, high Blood pressure and high Cholesterol (the "ABC" of CVD prevention). As of June 2024, the NHS was exceeding its ambitions for 2025-26 for atrial fibrillation and treating people with a greater than 20% risk of CVD with lipid-lowering therapies (for high cholesterol).

NHSE has provided guidance to all general practices on identifying and then treating people at risk of CVD, which includes providing opportunist blood pressure and cholesterol checks when patients present in surgery as well as providing guidance around how to reduce CVD risk. Added to this, the Quality and Outcomes Framework (QOF) provides the reward and incentive structure that all GPs work to. Targets are set for QOF nationally around indicators for CVD prevention and treatment. Activity levels translate into points that shape payments.

Targets are set for the detection and treatment of Atrial Fibrillation, Hypertension, Heart Failure and Diabetes plus targets for secondary prevention of these conditions.

Primary care networks across SEL have been provided with extra funding to support care for patients with diabetes. Each year a patient should achieve the following:

- HbA1c 48-64 mmol/mol;
- BP =<140/80 mm/Hg;
- Cholesterol =< 5mmol/L.

There is also an evidenced based programme of work around diabetes prevention (National Diabetes Prevention Programme). Patients who have an HbA1c between 42-47 mmol/mol are eligible to attend the programme, which consists of 18 sessions over 9 months. Classes are both face to face and digital. Greenwich clinicians refer into this service more than any other SEL Borough.

Royal Greenwich also commissions our GP Federation to provide stop smoking services in addition to our in-house Greenwich Stop Smoking Service.

Tackling wider determinants of health

- The Live Well service is a borough wide social prescribing offer, supporting residents with a wide range of health and wellbeing needs.
- 'Greenwich Supports' strategic plan to prevent and reduce poverty.
- Housing and Homelessness Strategy 2021-2026 includes a focus on delivering affordable housing for those most in need and tackling homelessness and ending rough sleeping.
- Mayor of London's Transport Strategy is implemented via the Council's Local Implementation Plan which encourages active travel.
- Greenwich Children and Young People Plan 2024-2029 supports children and young people to be healthy, understand how to help themselves and where more support is available.

How CVD is being addressed in Royal Greenwich

Programmes in Royal Greenwich which support CVD prevention.

Smoking

- Smoking cessation - RBG delivers smoking cessation through a network of advisors in GP surgeries and pharmacies. There is an active programme supporting pregnant women to stop smoking as part of their ante-natal care.
- Trading standards also undertake checks to prevent sales of cigarettes to children as well as reducing access to illicit tobacco products.

Physical Activity,

- Greenwich Get Active website helps local people find local activities such as Greenwich Get walking (24 free local walks) and Park runs.
- Physical activity on referral programme to manage and improve health conditions such as high blood pressure and circulatory disease.
- Active travel is an accessible way for many to include physical activity in their day – increase in dedicated cycle lanes and free cycle training.
- RBG improving public and recreational spaces to make these attractive and safe places to walk and play such as the new marked and measured walking and or cycling routes added to 5 local parks and outdoor gyms free to use in our parks.
- Xplore supports and their families with healthy eating workshops and physical activity sessions that are age appropriate.

Diet

- Community Meals.
- Accreditation for local food businesses who offer an increased range of healthy options.
- Cookery clubs are 5-week practical courses providing information, skills and behaviour-change support. They are delivered in community venues across the borough.
- Specialist weight management service for people with a learning disability.

Alcohol

- Initial Brief Advice - important to develop in primary care,
- RBG actively promoting tools to encourage people to consider their own risk,
- Treatment to people with higher levels of drinking through the Alcohol and Drugs Misuse Services.
- Through the licensing panel, RBG seeks to reduce the availability of alcohol in areas where there are known to be higher levels of alcohol misuse.

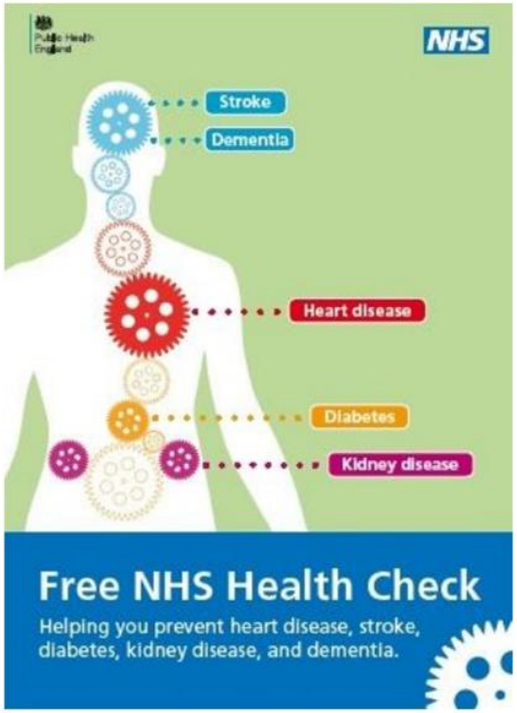
Training for Front-Line Staff

Public Health training for front-line staff and community champions supports health literacy and enables them to have conversations about health and know when to signpost to local support services above.

How CVD is being addressed in Royal Greenwich

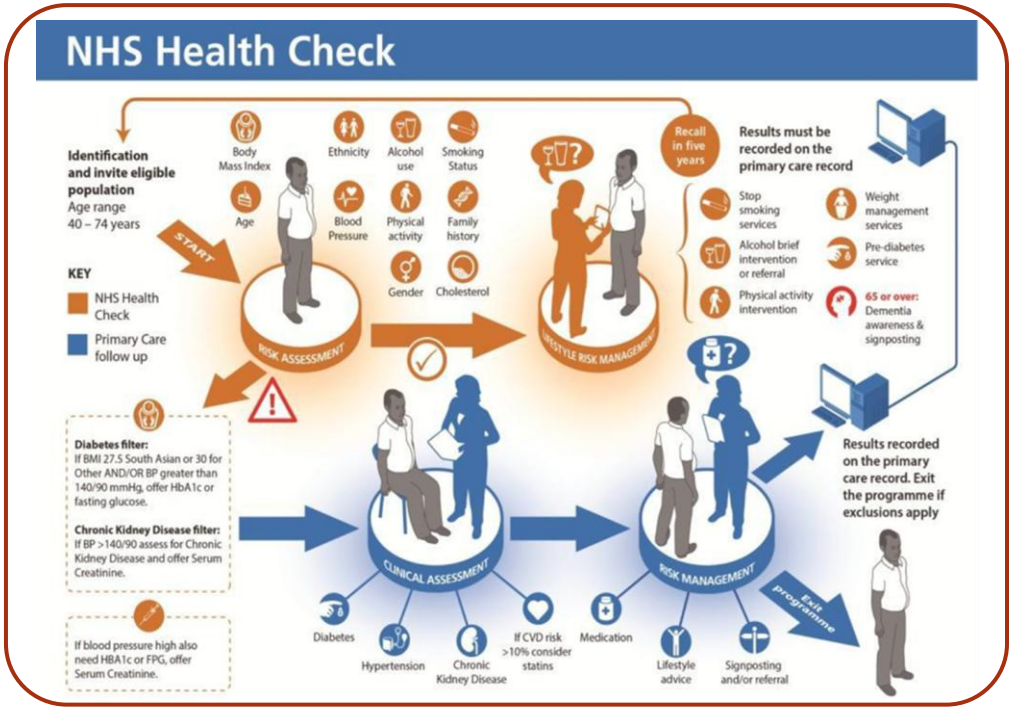
NHS Health Checks

NHS Health Checks is a key national programme which helps to identify people with undiagnosed CVD or at high risk of developing CVD. Eligible patients should be invited for a check every five years. Currently the programme targets people aged 40-74, although a national review has recommended that checks should be offered at a younger age to patients in at-risk groups.



What happens at a Health Check appointment?

Checks include factors such as family history of CHD and ethnicity, blood pressure, smoking status, Body Mass Index, waist circumference, cholesterol levels, levels of physical activity, and alcohol use. A person's 10-year CVD risk will be calculated (Q-Risk score), and information provided on how to reduce their CVD risk through behavioural changes and/or medical treatment if this is needed. (The process is outlined in the picture below).



Health Check PLUS in Royal Greenwich

As well as the standard checks for markers such as blood pressure and cholesterol levels, the following are also assessed:

- **Mental health:** question about the patient's current mental wellbeing with referral to GP/support services where indicated.
- **Cancer screening status:** reinforce the importance of cervical, bowel and breast cancer screening.
- **Erectile dysfunction (ED):** Men are asked if they have experienced ED and are referred to GP (with consent).

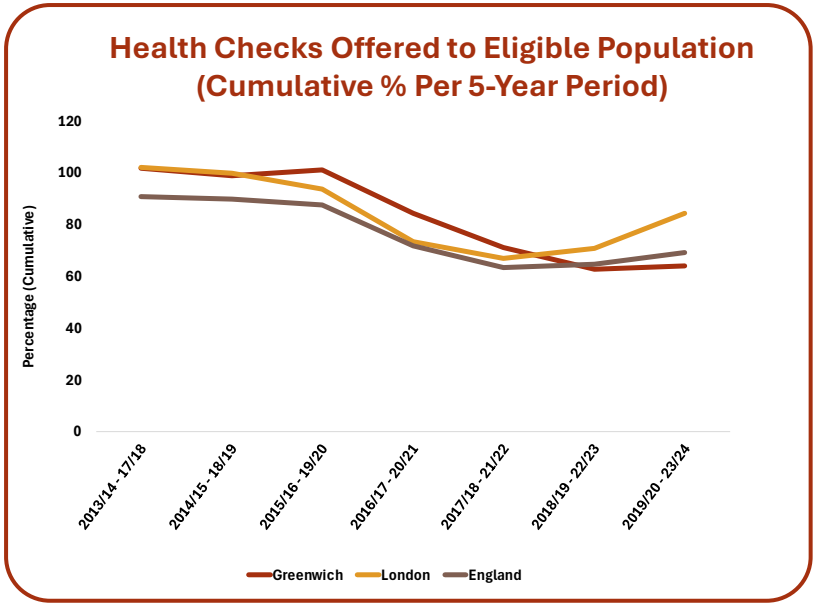
NHS Health Checks is not a diagnostic programme, but checks might lead to a referral and subsequent diagnosis.

How CVD is being addressed in Royal Greenwich

Uptake of NHS Health Checks

100% of eligible patients should be invited for an NHS Health Check over a 5-year period. Pre-COVID, NHS Greenwich was generally meeting this target. However, the programme was suspended during the pandemic and is still recovering. In the 5 years 2019/20 to 2023/24, 64% of eligible Greenwich patients were offered a Health Check compared to a London average of 84% and 69% in England (top right).

To achieve optimal clinical and cost benefits, at least 75% of eligible patients should attend their check. While this target has not yet been achieved nationally, uptake by Greenwich patients has continued to lag behind London and England. In the 5 years 2019/20 to 2023/24, only 21% of eligible patients in Greenwich had received a Health Check compared to a London average of 38% and 28% in England (bottom right).

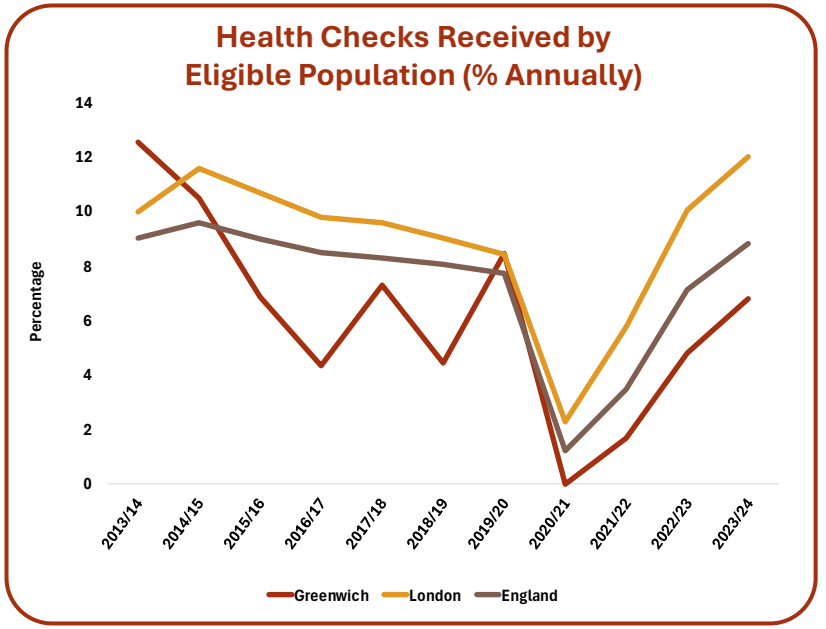


Health checks and referrals

If risks are identified during an NHS Health Check, people can be offered additional support. In 2024-25 around 1,300 referrals were made - 235 referrals were to healthy lifestyle programmes, 164 referrals to weight management programmes, and 97 to the smoking cessation service, with most other referrals for follow-up by their GP.

The most frequent reasons for a referral were a measurement of high blood pressure, a CVD Q-Risk score of 10% or more, and high glucose or high cholesterol readings. Smaller numbers of referrals were due to other risk factors such as memory problems.

A survey of Greenwich patients who attended a Health Check in early 2024, found that 88% agreed they understood their CVD risk better and 70% had made at least one lifestyle change since their check. The majority of those who had been asked to book a follow-on appointment with their GP had done so (*9.5% responded to the follow up questionnaire).



How CVD is being addressed in Royal Greenwich

Who has been reached by the Health Check program?

Understanding who receives an NHS Health Check helps us to assess if we are reaching people at a higher risk of CVD (including Black and Asian patients, and patients living in deprived areas) and to plan where extra promotion and awareness raising might be needed. Results have been published nationally for 2013-18 but there is less available since this point.

Patients Receiving a Health Check by Sex and Age Group

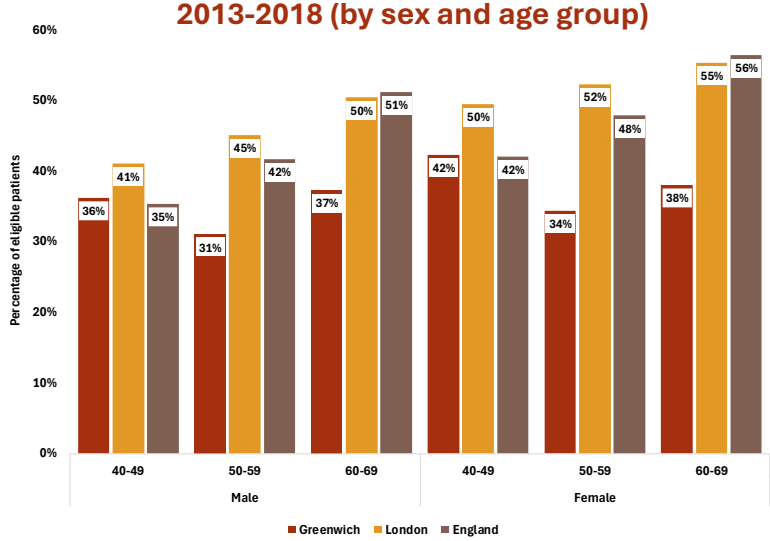
National results available for 2013-18 indicate that uptake was higher amongst women compared to men. irrespective of age group. This was also true In Greenwich. In 2013-18, 38.8% of Greenwich women attended their check compared to 34.4% of men.

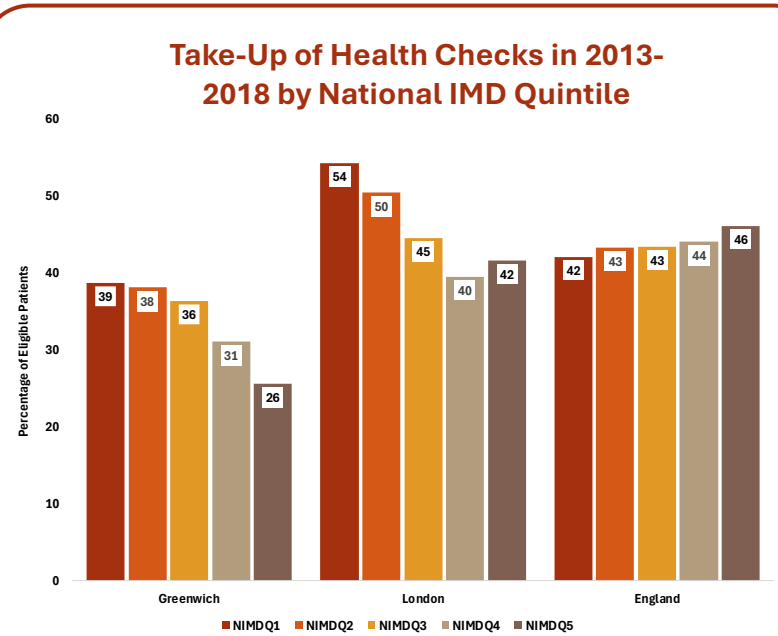
The results also show that on average take up increased with age, This was the case in London and England. In Greenwich take up was a little higher in the younger age group, especially amongst women (top right).

Results from a recent local audit (2021-23) found little difference in the proportion of Greenwich patients who attend their health check by age group. There were no results by sex of patient.

Patients Receiving a Health Check by Deprivation

In 2013-18, Greenwich patients in more deprived neighbourhoods were more likely to receive their health check: 39% of Greenwich residents in the most deprived quintile received a check compared to 26% of residents from the least deprived quintile. However, take up in all Greenwich neighbourhoods was still relatively low compared to London where at least 40% of patients had a check irrespective of neighbourhood of residence (or England where at least 42% of patients had (bottom, right).





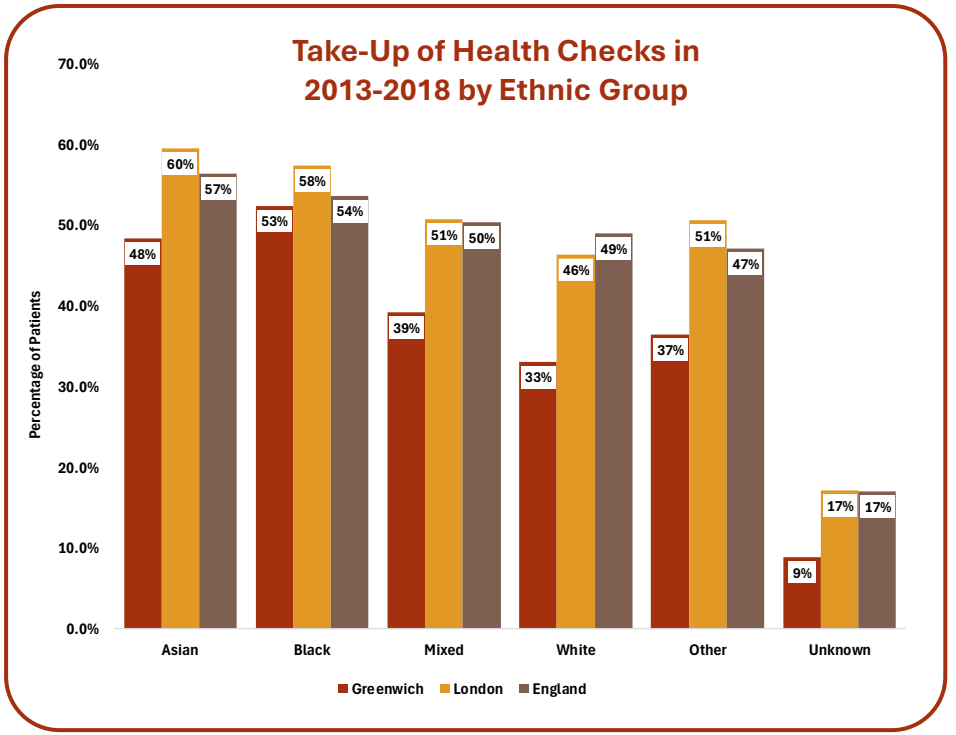
How CVD is being addressed in Royal Greenwich

The 2021-23 audit included details of who received a Health Check by deprivation quintile. The results indicate that 55% of patients who received a check lived in more deprived neighbourhoods (NIMDQ 1 & 2) and 19% lived in less deprived neighbourhoods (NIMDQ 4 & 5).

As over 50% of Greenwich patients are resident in more deprived neighbourhoods, this seems proportionate. The audit did not include details of who had been offered a health check by deprivation quintile which means we cannot compare percentage take up for each deprivation quintile.

Patients Receiving a Health Check by Ethnicity

Results from 2013-18, indicate that a higher proportion of Black and Asian patients received their health check – this was the case in Greenwich as well as in London and England. In Greenwich 53% of Black patients received a health check as did 48% of Asian patients. This fell to 39% of Mixed patients and 33% of White patients (top right).



The 2021-23 audit did not include details of who received a health check by ethnicity. There are results for patients successfully contacted, but not all patients contacted will go on to book or receive a Health Check.

How CVD is being addressed in Royal Greenwich

Health Checks: Contact with Eligible Patients

Three attempts are made to contact eligible patients to offer them a health check. The 2021-23 audit found contact was successful in 63% of cases (17,900 of around 28,500 people aged 45-74). It was possible to contact around 59% of those aged 45-49 and this increased to 69% of eligible patients aged 60-74. There were no results for patients by sex, or by deprivation level.

Health Checks Offered in 2021-23: Successful Contacts			
	Percentage	Number	Number Eligible Patients
Asian	53.3%	1,925	3,613
Asian Bangladeshi	21.0%	< 20	< 100
Asian Indian	41.0%	250	600
Asian Other	63.1%	1,250	2,000
Asian Pakistani	44.8%	50	150
Asian Unknown	0.0%	0	< 100
South East Asian	41.9%	350	800
Black	57.3%	3,191	5,571
Black African	44.8%	1,150	2,600
Black Caribbean	45.7%	200	450
Black Other	72.0%	1,850	2,550
Mixed	42.2%	247	586
Mixed Other	42.5%	100	300
Mixed White and Black African	43.3%	50	150
Mixed White and Black Caribbean	41.6%	50	100
White and Asian	37.8%	< 20	< 100
Other	50.9%	259	509
Unknown	41.3%	66	160
White	55.4%	9,462	17,067
White	73.4%	3,950	5,350
White British	50.0%	4,350	8,750
Any Other White	39.2%	1,150	3,000
Grand Total	55.1%	15,150	27,506

Contact with Eligible Patients by Ethnicity

Another extract including ethnicity was obtained. This included around records for 27,300 people. Differences in the total number of patients (compared to 28,500 above) is due to the extracts having being taken at different times from a live system.

Around 55% of the people in this cohort had been successfully contacted. This increased to 57% of Black patients and fell to 53% of Asian patients. Only 42% of eligible Mixed patients could be contacted. The 2021-23 audit also indicates some very low contact rates in specific communities, (although the lack of consistency in recording ethnicity means there is some difficulty determining this and potential overlap). For example, it was possible to contact 63% of patients grouped under 'Asian other', but contact fell to as low as 21% of Asian Bangladeshi patients.

Amongst Black patients, it was only possible to contact 45% of patients identified as 'Black African', but 72% of patients grouped here as 'Black Other'. However, 'Black Other' includes a group of patients described as Black or African or Caribbean or Black British' i.e. patients who are Black African could be found in both groups.

Amongst White patients, patients whose ethnicity was recorded only as 'White' also had a relatively high rate of take up (73%) compared to patients identified specifically as 'White British' (50.0%). Perhaps this reflects higher take up in older residents whose ethnicity was recorded when there were fewer options to choose from. Information about age is not available in the ethnicity extract.

How CVD is being addressed in Royal Greenwich

Contact with Eligible Patients by Main Language

Main language spoken was recorded in around 19,000 cases. On average 56% of patients from this subset of records could be contacted.

The largest group of patients spoke English as their main language and 58.3% of this group were contacted (top right). The next highest rate of uptake was amongst patients whose main language was Yoruba (57.8%) followed by patients whose main language was Vietnamese (55.0%).

Take up was much lower in some groups – for example only 33.7% of people whose main language was Lithuanian were successfully contacted, as were 37.8% of people whose main language was Somali.

Health Checks Offered in 2021-23: Successful Contacts				
		Percentage	Number	Number Eligible Patients
African		42.9	108	252
	Yoruba	57.6	50	100
	Somali	37.8	50	100
	Other African Language	27.0	< 20	< 100
Asian		46.3	275	594
	Nepali	51.2	100	250
	Punjabi	46.6	50	100
	Tamil	46.1	50	100
	Other Asian Language	38.8	50	150
E European		40.5	384	949
	Romanian	45.9	100	250
	Polish	43.7	50	150
	Bulgarian	34.4	50	150
	Russian	50.0	50	150
	Lithuanian	33.7	50	100
	Other E European Language	31.9	50	150
Middle Eastern		42.5	88	207
	Turkish	43.6	50	100
	Other Middle Eastern	41.2	50	100
Other		56.8	424	746
South East Asian		46.2	220	476
	Vietnamese	55.0	100	150
	Cantonese	43.7	50	100
	Mandarin	52.0	50	100
	Other South East Asian	33.0	50	100
West European		57.9	9,324	16,109
	English	58.3	8,950	15,350
	Spanish	53.0	100	250
	Portuguese	49.7	100	200
	French	46.4	50	150
	Italian	40.4	50	100
	Other W European	48.5	50	100
All		56.0	10,823	19,333

Contact with Eligible Patients by Primary Care Network

Overall, only around 6,300 patients audited received an NHS Health Check in 2021-23. There were varying levels of success in contacting patients and in take up of checks by patients by PCN (next slide, top, left).

Eltham PCN had one of the largest cohorts of eligible patients and they were able to contact 75% of this group. Even so only 17.8% of their eligible patients took up the offer of a Health Check. Fewer patients were eligible in Heritage PCN, and a smaller proportion were successfully contacted (64%). However, 34.6% of their eligible patients took up the offer of a check.

A relatively large proportion of patients registered with Heritage PCN are from our Global Majority communities including patients of Black and Asian ethnicities, and potentially they are amongst the 34.6% of Heritage patients who were successfully reached. However, the ethnicity of people attending or not attending by PCN was not provided, so that cannot be confirmed. Future audits should ensure all demographic data is extracted at the same time, for both contact and patients seen, and ideally in a format that allows for cross-referencing (knowing both age and ethnicity for example).

How CVD is being addressed in Royal Greenwich

Contact with Eligible Patients by Primary Care Network (2021-23)

PCN	Eligible Cohort	% eligible who are BAME	% Successful contact	% Uptake by PCN	% Uptake within Greenwich
Blackheath And Charlton PCN	5,738	25.9%	56.1%	24.7%	22.4%
Eltham PCN	7,118	18.2%	74.9%	17.8%	20.0%
Greenwich West PCN	3,620	36.7%	57.8%	24.6%	14.1%
Heritage PCN	2,256	51.5%	64.4%	34.6%	12.3%
Riverview Health PCN	7,706	52.4%	60.1%	16.1%	19.6%
Unity (Greenwich) PCN	2,030	56.5%	57.6%	36.0%	11.6%
Grand Total	28,468	37.6%	62.9%	22.2%	100.0%

Recommendations from the 2021-23 audit included targeting younger adults amongst the eligible cohort, targeting communities at greater risk of developing CVD and diabetes, offering NHS Health Check outside primary care settings, and exploring and responding to barriers to uptake of the NHS Health Check.

Targeting Patients who have Not Responded to Health Check Invites

A recent campaign targeted patients from 3 GP practices who had previously not responded to their invites. Appointments were made available in a wider range of community venues, posters were displayed in GP surgeries and community venues to raise awareness (top right), and invite letters had clearer NHS branding.

Out of the initial group of patients identified, some invites were found to be invalid (for example, the patient had moved). Of the remaining 669 eligible patients, 349 could still not be contacted on a further 4 occasions (using different contact methods). 320 patients were contacted successfully: of these 102 patients actively declined the offer of an NHS Health Check.

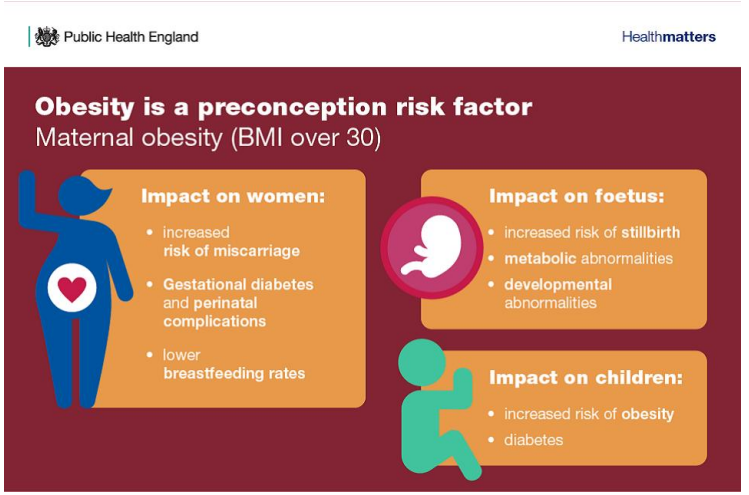
At the time of the report, 191 additional Health Checks had been completed. Ninety of the patients who received a Health Check were White (47%), 51 were Asian (27%), and 41 were Black (21%). English was the main language spoken in 128 cases (67%), Nepali in 13 cases (7%), with small numbers of people who spoke other languages as their main language. It is possible that the 349 patients who did not respond within 4 attempts are amongst our most marginalised communities, and further novel attempts may be needed to reach them.

How CVD is being addressed in Royal Greenwich

CVD and Reproductive Health

Pre-conception and maternity care provide important opportunities to identify and address health concerns, including risk factors for developing CVD. Maternity care can assist with:

- Early detection of CVD Risk
    - pregnancy can unmask underlying CVD risks such as hypertension, diabetes, and obesity. Routine maternity care allows for early identification and management of these risks which can be a cause of maternal or infant death.
    - conditions such as gestational hypertension and preeclampsia can be predictors of future CVD.
- Addressing health inequalities - comprehensive and equitable maternity care can help mitigate these disparities.
- Health education – antenatal and maternity care are opportunities to provide advice about diet, exercise, smoking cessation, and stress management, as well as signpost women (as well as partners or other people in their household) to appropriate support. For example, other family members may need support to stop smoking to reduce secondary smoke in the environment).
- Post-partum surveillance – women who have experienced complications in pregnancy are at greater risk of a future CVD event. They can be offered ongoing monitoring, and signposted to CVD prevention services.



Contraceptive and pre-conception care can also play an important role in promoting health in general. These touch points provide opportunities to discuss future plans and the importance of optimal health (for both women and men) to support conception, completion of a healthy pregnancy and maximising their and their child's future health. Pre-conception care can lead to:

- early detection and management of risk factors including obesity, diabetes and hypertension (which could lead to complications during pregnancy).
- timely interventions during pregnancy to reduce complications.
- understanding and (where possible) addressing environmental exposure.

How CVD is being addressed in Royal Greenwich

Our neighbourhood and health inclusion approach to CVD

In Greenwich, we are adopting a neighbourhood approach to help understand and be responsive to the complex social, economic, cultural, environmental and commercial drivers of health inequalities, including CVD. Neighbourhood development connects people, priorities and places to better enable community ownership and joined-up public services. Neighbourhood development involves connecting local population health, wellbeing and care needs with local decision-making and service delivery. This is supported by population health systems, community development approaches and a commitment to continuous learning.

Partners from prevention, primary care, community support, acute services, mental health, social care, care providers, VCSE (Voluntary, Community and Social Enterprise) and wider stakeholders are working together to:

- Build partnerships with local communities by improving the way the Live Well Community service, local communities and organisations work together with the NHS and the Council to improve services (including CVD-related services) closer to where people live.
- Develop community approaches that connect individuals to sources of support that address the wider determinants of health and CVD prevention opportunities.
- Build on our community development approaches and expand personalised care support including social prescribing.
- Develop the Royal Greenwich and ICB Community Champions programmes, Make Every Opportunity Count and other training offers to support this agenda including the development of the neighbourhood-based teams of volunteers and core stakeholders.
- Inform this work programme via population health and health inclusion data and insight led approaches.

Our ambition is that "everyone will be able to live a healthy, happy and independent life in a thriving community supported by joined up public services"

Developing communities of residents, patients, carers, providers and assets, with a focus on people and building connections over structure.

How CVD is being addressed in Royal Greenwich

Our neighbourhood and health inclusion approach to CVD (cont'd)

We are codesigning health and wellbeing action plans with residents in four key areas of the borough: Horn Park, Plumstead and Glyndon, Blackheath and Charlton, and Thamesmead. The plans involve the delivery of community-led interventions to improve social connection, promote good food and physical activity opportunities locally, establish better connections with healthcare services and enable earlier identification of ill health.

A range of services and interventions are available to residents and community leaders across the borough to support better heart health, including:

- Our Live Well social prescribing service and Community Directory that connects residents with our Greenwich health improvement offer. This includes interventions to support eating well, moving more and feeling well.
- Improvements to the food environment and support for residents to eat well. In Royal Greenwich, communities can access cookery clubs, community meals, food clubs, school holiday food provision and community gardening.
- Our Community Champion programme supports residents to have conversations with their friends and neighbours about health and wellbeing. Over 400 residents receive our community champion bulletin weekly, which includes key messages relating to living well alongside local service information.
- Our public health training offer supports communities to know when, where and how best to signpost to information and services that can support people to live well.
- Developing our understanding of our health inclusion communities such as people experiencing rough sleeping and sanctuary seekers, who experience the poorest health outcomes and highest level of need, through health data analysis, community insights, engagement and co-design.

How CVD is being addressed in Royal Greenwich

Spotlight on School Superzones – a place-based approach to health improvement

A School Superzone is a place-based approach to health improvement, defined as a 400m radius (approximately a 10-minute walk) around a primary or secondary school.

It is designed to protect children's health and encourage healthy behaviours through interventions across a number of the building blocks of health (as shown in the diagram on the right).

This approach is being applied in the Thamesmead area in partnership with Peabody and the London Borough of Bexley, an area with high deprivation, obesity and smoking rates and low levels of physical activity.

Insight gathered from school communities highlighted priorities for supporting healthier behaviours and spaces should include easier access to **cheaper, healthier food and drink and safer, accessible parks and outside spaces for families to be active**.

Representatives from early years, schools, youth provision, transport, environmental health, public health, economic development and local community groups have been working together to deliver specific Superzone actions including:

- Improvements to the local shops through a Good Food Retail programme.
- Alignment of community physical activity opportunities and enhanced promotion of social prescribing opportunities.
- Delivery of a Photovoice (gaining insight with photography) project.
- Delivery of cookery clubs, community meals, accredited training and training for community groups about food and nutrition and healthier events catering, holiday programmes and food club delivery.
- Road safety and traffic calming interventions to improve active travel rates.
- Specific school-based projects including playground improvements.

How CVD is being addressed in Royal Greenwich

Impact of COVID-19 pandemic on CVD prevention

The COVID-19 pandemic had a negative impact on CVD prevention and treatment. Reasons for this included:

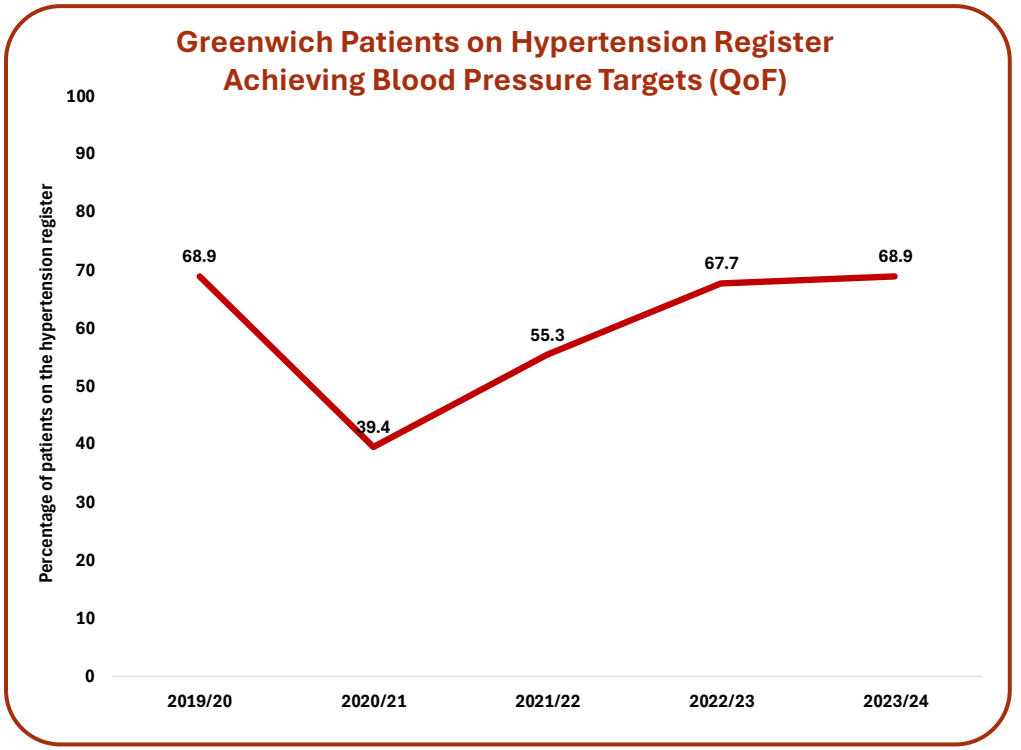
- CVD risk factors are often picked up opportunistically at GP visits – opportunities to see GPs and other primary care professionals were significantly reduced during the pandemic.
- The Greenwich NHS Health Checks programme was suspended.
- Missed clinic visits resulted in delayed acute and preventative care.
- Lockdown negatively affected healthy behaviours such as physical activity levels, diet and alcohol consumption.
- There were increased rates of social isolation, mental distress, depression, and loneliness during the pandemic – all risk factors that can increase CVD.
- Existing health inequalities were exacerbated.

In the UK, new diagnoses of CVD reduced as did new prescriptions of CVD medications. New diagnoses of atrial fibrillation reduced by nearly half the normal rate in this period.

During the peak of the pandemic, there was a 40% reduction in hospital admissions in England for acute coronary syndrome and a 20% reduction in stroke admissions.

These lost opportunities may lead to an increase in future CVD events.

An enhanced catch-up programme was undertaken by Greenwich GP practices following the pandemic. For example, the percentage of Greenwich patients with hypertension who were known to have met their BP targets dropped to 39.4% in 2019-20, but by the end of 2023-24 had returned to 68.9% (see graph, right).



Cardiovascular Disease in Royal Greenwich 2025 - Chapter Aims

CVD in Royal Greenwich: Recommendations

Taking action in these areas is recommended to address CVD in Royal Greenwich.

A - CVD and the Local Health System

1. Partners in the local and regional health system to consider patterns and trends in CVD prevention and morbidity, and co-ordinate actions to improve underdiagnosis, increase referrals to preventative services, and ensure optimal treatment is provided.
2. Planning and delivery should take into account the varying impact of different types of CVD on different segments and communities in Greenwich, and the role of the wider determinants of health.
3. Co-ordinating efforts to address inequalities in health outcomes caused by less access to the building blocks of health – such as housing, employment, and education.
4. Prevention to be embedded into system level planning and delivery.
5. It will be necessary to identify the future capacity needed in the local health system to address CVD as our population grows and changes, including maintaining and growing the NHS Health Checks programme (or other prevention programmes).

B - Improve take up of NHS Health Checks

The NHS Health Check programme is a key means to identify and address CVD risk. It is vital that the programme narrows the gap in uptake between Greenwich and the London average, as well as reaching patients most at risk.

Targeted outreach (as recommended by the 2021-23 audit) could help enhance NHS Health Check participation and effectiveness:

6. targeting younger adults amongst the eligible cohort.
7. targeting people from Black and other communities (who are at greater risk of developing CVD and diabetes).
8. targeting residents in neighbourhoods with greater deprivation (who are at greater risk of developing CVD and diabetes).
9. developing the NHS Health Check model to include provision outside the primary care setting (in areas where people live/work).
10. promoting the NHS Health Check through networks and ambassadors within communities.

Other recommendations which may increase uptake of NHS Health Checks

11. Maintaining accuracy of GP lists and reducing Health Check offers sent and chased erroneously.
12. Ongoing audit to identify which patients do not engage or accept having a check to help identify strategies to improve participation.
13. Understanding who is being referred signposting and the types of support needed, ensuring equitable access to services and treatments.
14. Digital health checks are being trialled. Explore this as a solution to increase take up in Greenwich.

CVD in Royal Greenwich: Recommendations

C - Delivering Other Opportunities for Screening and Outreach

15. Continue to develop and implement other models of targeted outreach such as the **"Vital 5" check (**BP, BMI, mental health, smoking, and alcohol status) to reach people in the community especially those who are not registered with or engaged with GPs
16. Delivering interventions like social prescribing to support healthy behaviours.
17. Promote tools such as the Heart Age Test and Better Health resources to engage residents

D- Use opportunities at other touchpoints to raise awareness, and deliver prevention activities

18. Pre-conception and maternity care can be opportunities:
    - to discuss reproductive and future health
    - for early identification of CVD risks
    - for monitoring women at greater risk of CVD related complications
    - to protect health of infants

19. Starting Well - continue working with schools (and other providers of services to children and young people) to promote physical activity and good food

E- Focus on the "ABC" of CVD Prevention

20. Primary care colleagues focusing on the ABC of CVD Prevention to drive up early identification and optimal treatment:
    - Atrial Fibrillation (AF): Aim for 85% detection and 90% anticoagulation of high-risk individuals by 2029.
    - Blood Pressure (BP): Target 80% diagnosis and 80% treatment to NICE guidelines.
    - Cholesterol: Improve identification and treatment of raised cholesterol.

21. Using case finding to ensure patients at high risk receive optimal care and offering follow up care and patient education to improve adherence to treatment plan.

CVD in Royal Greenwich: Recommendations

F - Clear referral pathways to preventative services

22. Public Health to ensure current referral pathways are up to date and made available to primary care. For example:
    - National Diabetes Prevention Programme
    - Weight management services
    - Stop smoking
23. Primary care should use tools available to identify patients at risk and refer or signpost them to additional support, such as Alcohol Audit Tools , or the GPPAQ to support to services to increase physical activity.

G- Staff Engagement and Workforce Training

24. Promoting training available to frontline staff and community champions which will enhance their ability to signpost and support people effectively e.g. MEOC.
25. Importance of developing skills and confidence of the wider workforce to spot opportunities where they can encourage clients to attend a health check or other health promotions such as having their blood pressure checked.
26. Increasing the confidence of staff who work with children and young people to discuss health care topics in a way that will reach young people, especially emerging issues such as vaping, where there is less evidence (so far) of harms.
27. Promote awareness of our approach to health inequalities amongst broader workforce when the Health Inequalities APHR is published.

H - Use of Data and Evaluation Tools

28. System partners to aim to standardise and improve data collection on ethnicity, deprivation, and risk factors, including hospital admissions data and NHS Health Checks. This will support local audit and improve planning.
29. Further development of dashboards in Greenwich and SE London, including age standardised rates, to better identify CVD prevalence and monitor trends.
30. Use national available tools to help identify whether programmes are having an impact in addressing CVD, and reaching at risk communities, including:

    - Quality and Outcomes Framework (QOF)
    - OHID Fingertips for tracking inequalities and outcomes, including the Public Health Outcomes Framework
    - NHS RightCare CVD prevention pathway.
    - CVDPrevent for benchmarking and performance monitoring.
    - CVD Return on Investment Tool to assess local impact

CVD in Royal Greenwich: Recommendations

I - Implementing Neighbourhood Working and Community Engagement

Working with and closer to our communities to develop solutions that work better for them. Recommended actions include:

31. Expand community-based prevention and neighbourhood approaches.
32. Work in ways that listen and respond to the residents' voice.
33. Better understand our diverse communities and the support they would like to reduce their CVD risks.
34. Exploring and responding to barriers to uptake interventions, including of the NHS Health Check, and co-design solutions.
35. Promoting the NHS Health Check through networks and ambassadors within communities.
36. Develop community diagnostic hubs and outreach models.
37. Consider existing examples of co-designed interventions with local communities.
38. Partner with faith leaders, community organisations, and VCSEs to deliver effective messages and solutions such as culturally relevant food guides or access to preferred physical activities.
39. Digital Health checks may be more appealing to some communities and increase access.
40. Providing health education in multiple languages helps overcome language barriers and improves understanding of CVD risks.

J - Addressing Health Inequalities

41. Target interventions to deprived areas and at-risk communities to reduce cardiovascular disease disparities.
42. Consider intersectionality to identify populations facing multiple disadvantages to provide additional tailored support.
43. Standardise and improve data collection on ethnicity, deprivation, and risk factors.
44. Providing health education in multiple languages helps overcome language barriers and improves understanding of CVD risks.
45. Addressing Healthcare Barriers - Tackling socioeconomic and cultural barriers improves healthcare access for at-risk populations.
46. Promote healthy behaviours through accessible local services and environments.
47. Monitoring and Evaluation - use data and frameworks like Marmot principles to monitor disparities in access treatment and outcomes.
48. Ensure all materials are accessible and use plain language.

CVD in Royal Greenwich: Recommendations

K - Increasing access to underserved communities

49. Understanding who might not be registered with a GP and how we can support them to access these services, including opportunities for CVD prevention. For example, rough sleepers and sanctuary seekers.
50. Understanding who might not be engaged with clinicians or where risk of developing CVD may be overlooked – for example people with serious mental illness.
51. What opportunities are there to maintain heart and circulatory health in older adults over the age of 75.

L- CVD Prevalence and People with Learning Disabilities

52. CVD accounts for a significant percentage of deaths among people with learning disabilities, yet evidence shows that many people with learning disabilities do not receive the support they need to detect and manage CVD and CVD risk.
53. Accessible health promotion materials should be available.
54. Complete annual health checks to ensure early detection and prevention of CVD.
55. Offering reasonable adjustments and professional training to improve healthcare access and management of CVD in people with learning disabilities.

M- JSNA Chapters

57. Prepare further JSNA Chapters on specific types of CVD as appropriate.
58. Update the Learning Disabilities JSNA.

Cardiovascular Disease in Royal Greenwich 2025 - Chapter Aims

CVD in Royal Greenwich: Glossary

AF	Atrial Fibrillation
ALS	Active Lives Survey
CHD	Coronary Heart Disease
CVD	Cardiovascular Disease
DAE	Data Access Environment
DSR	Directly Standardised Rate
FAE	Finished Admission Episode (Hospital Admission)
GPPAQ	General Practice Physical Activity Questionnaire
HLS	Health and Lifestyle Survey
HF	Heart Failure
HFSS	High in fat, sugar, or salt
IBA	Initial Brief Advice
ICB	Integrated Care Board
IMD	Index of Multiple Deprivation
LIMDQ/DD	Local IMD Quintile/ Decile
LSOA	Local Super Output Area (census neighbourhoods)
MI	Myocardial Infarction
NCD	Non-Communicable Diseases
NDNS	National Diet and Nutrition Survey
NIMDQ/DD	National IMD Quintile/ Decile
NHS	National Health Service
NHSLTP	National Health Service Long Term Plan
OHID	Office for Health Improvement and Disparities
PCMD	Primary Care Mortality Database
PHE	Public Health England
QOF	Quality Outcomes Framework
SEL	South East London
SHEU	School Health Education Unit (Exeter University)
STIA	Stroke or Transient Ischaemic Attack
WHO	World Health Organisation

CVD in Royal Greenwich: Definitions

Finished Admission Episodes (FAEs): a measure used to count hospital admissions. A subset of FAEs is Emergency FAEs. Emergency FAEs are defined as any FAE where the code for the 'admission method' begins with '2' (e.g. via an A&E department). All other FAEs including planned care, normal deliveries, normal births, and transfers from elsewhere (unless in an emergency) are classed as non-emergencies under this measure.

Rates: A commonly used rate to compare groups and events is the percentage (per 100 people or events). For example, 50% of group A have a fried breakfast every day and only 20% of group B do.

Rates are also often expressed as per 1000, 10,000 or per 100,000 people or events.

Rates can be based on small numbers, so knowing the denominator is helpful when interpreting rates.

Significant Difference: A statistically significant difference is more likely to be a genuine difference. Other differences are less certain and might be due to chance. A statistically significant difference is not necessarily a large difference.

Confidence Intervals: Confidence intervals indicate the likely range of results from higher to lower.

Directly Standardised Rate (DSR): a rate showing the number of cases in a population if that population had the same age (and sometimes sex) mix as a given 'standard' population. This allows the number of events in different populations (e.g. younger populations and older populations) to be more directly compared.

IMD (Index of Multiple Deprivation) Deciles and Quintiles: In the IMD, LSOA neighbourhoods are given a score based on deprivation. The LSOAs are then ranked. The most deprived LSOA in England is ranked 1. The LSOAs can then be divided into groups and compared to each other. For example, LSOAs can be divided into 10 'deciles', where each decile contains 10% of the LSOAs: from the 10% most deprived LSOAs to the 10% least deprived LSOAs. Quintiles split the LSOAs into 5 even groups.

The 151 LSOAs within Greenwich can also be divided into deciles and quintiles based on their rank. Where available, these local measures allow us to better compare the range of deprivation within a single borough. (To compare Greenwich to other boroughs or regions we must use the national deciles and quintiles).

Greenwich patients or Greenwich residents: This report will refer to both 'Greenwich patients' and to 'Greenwich residents'. This depends on the source used. Greenwich patients are people registered with a Greenwich GP. Greenwich residents live in Greenwich. Although there is cross-over between the two groups, they are not always the same.

Some people registered with Greenwich GPs live in neighbouring boroughs. Similarly, some Greenwich residents will have a GP in a neighbouring borough (or they might not be registered with a GP at all).

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