



JSNA Data Refresh 2013/14 Cardiovascular Disease Barnet

Cardiovascular diseases (CVD) are the main cause of death in the UK causing around 147,300 deaths in England in 2010 (around a third of all deaths). Around 45% of all deaths from CVD are from coronary heart disease (CHD) and more than a quarter from stroke (27%). CHD is the most common cause of death in England and Wales (15% of all deaths in 2010)

Key messages

Population

Cardiovascular disease increases significantly after the age of 40 years. The percentage of the population aged 40 or over in Barnet is expected to increase slightly over the next ten years.

Mortality

Cardiovascular disease (heart disease and stroke) is the largest cause of death in Barnet and the second largest cause of death after cancer in people aged under 75 years. The early death rate from cardiovascular disease are significantly lower than the national rate, and have

decreased by 63.1% since 1995. However, coronary heart disease still causes more than 1 in 8 of all deaths in both age categories.

Risk Factors

Rates of smoking, high risk drinking and obesity are lower than the London and national averages. These are the key to reducing incidence and mortality from CVD..

Treatment

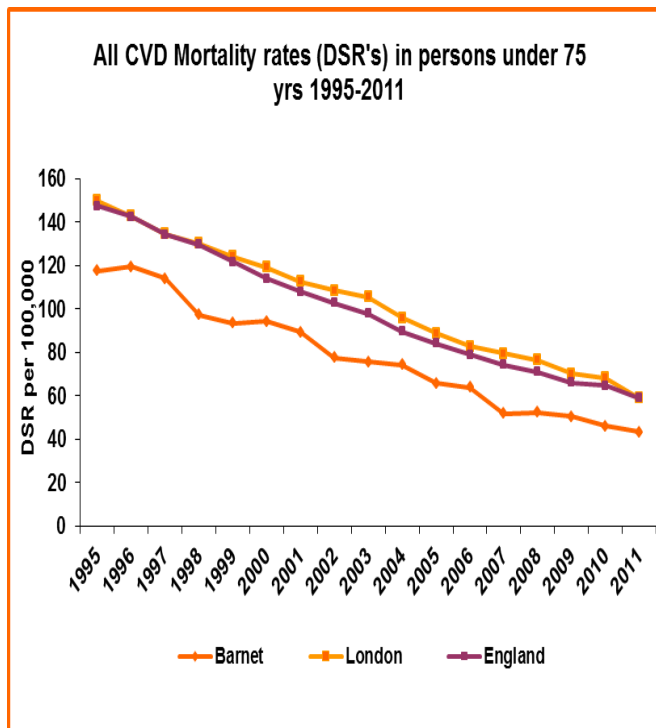
Treatment for both heart attack and stroke (especially for heart attack) is more effective than it was 10 years ago. Revascularisation rates

are similar to those of England as a whole. Emergency admission rates for CHD are significantly lower than the national rates, but for stroke the Barnet rate is significantly higher than national rate. Evidence shows that specialist units have better outcomes.

Discharge home

Stroke patients under 75 years are less likely to be discharged back to their usual place of residence compared to the national picture.

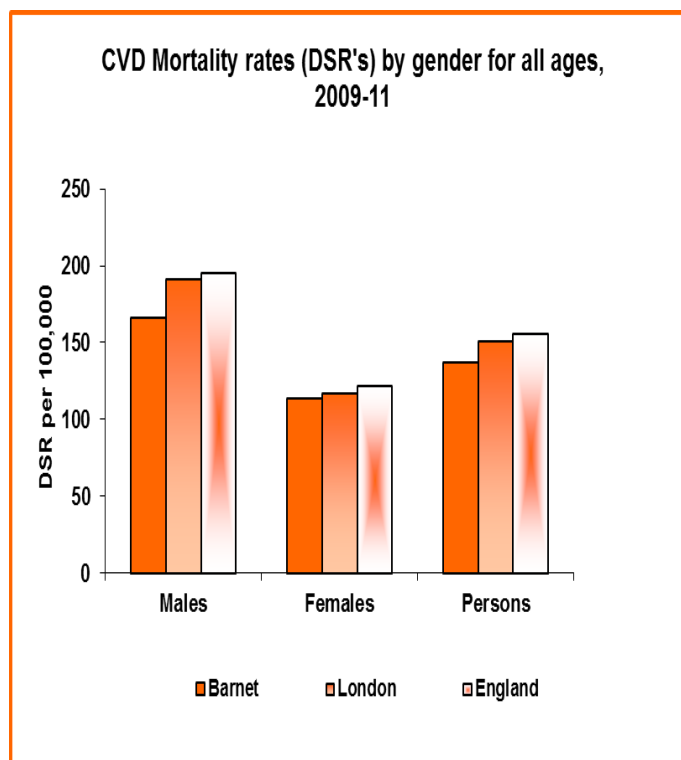
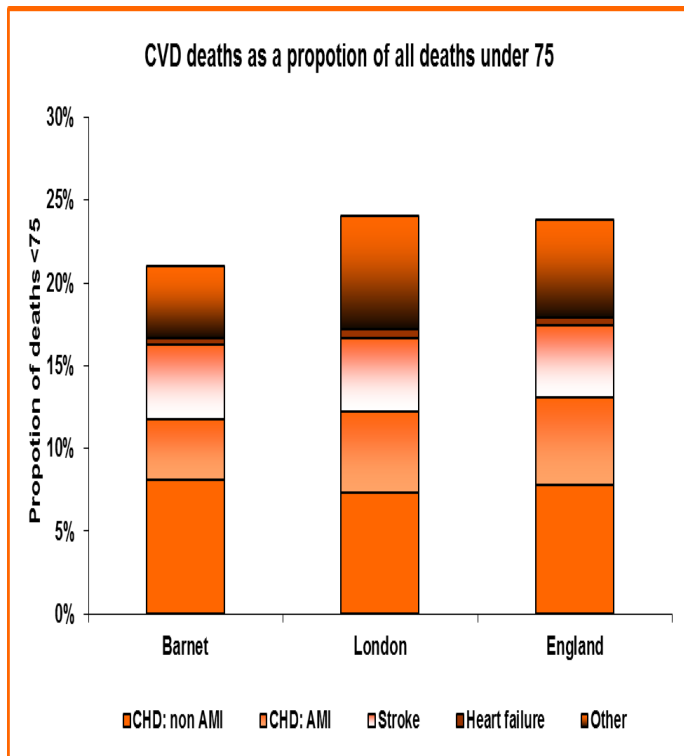
Local Data



Mortality

The Public Health Outcomes Framework has an objective of reducing the numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities. One of the key indicators for this objective is early mortality from CVD.

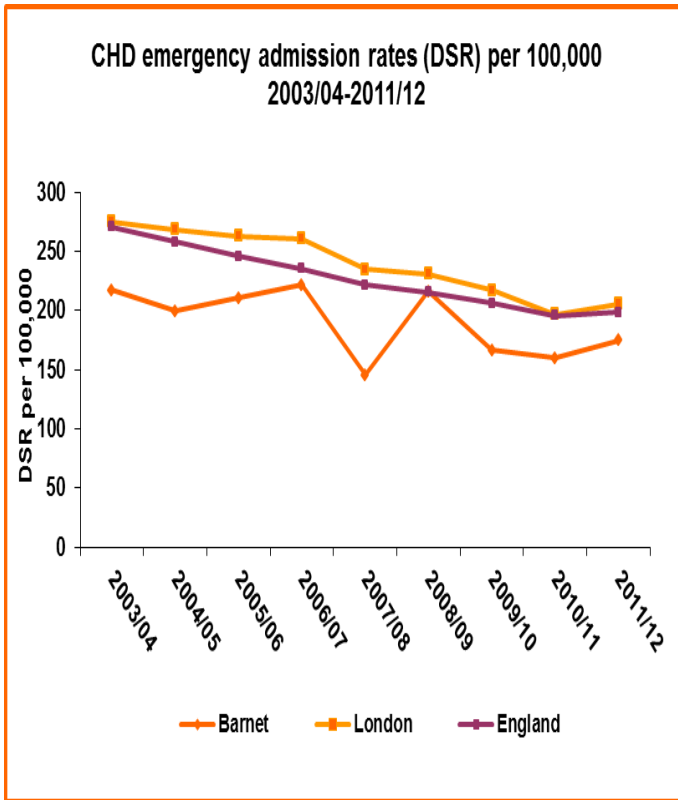
In 2014 the early CVD mortality rate in Barnet for persons under 75 years is predicted to be reduced by half compared to 10 years ago. The percentage of CVD deaths as a proportion of all deaths was 21% for people aged under 75 years and 38.1% for people aged 75 and above.



CHD makes up the biggest proportion of total deaths (within CVD) for both males and females. In 2014, the mortality rate for CHD in Barnet is predicted to be reduced by half for males and females compared to 10- years ago.

CVD mortality rate in Barnet for all persons was significantly lower than London and England.

For all ages the male CVD mortality rates in

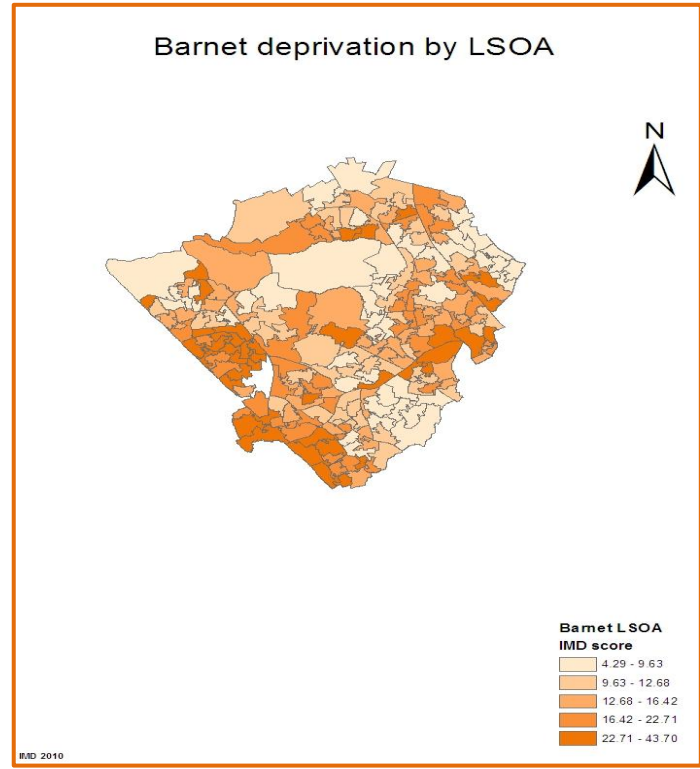
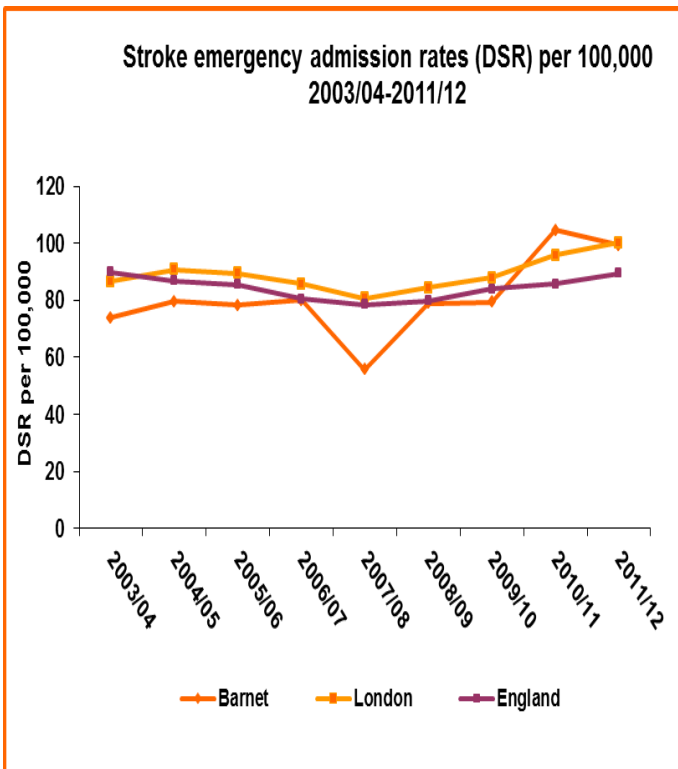


Emergency Hospital admissions

Emergency admissions for CHD in Barnet are significantly lower than those of London and England. They are higher in men than in women. Over the past eight years, rates have decreased by 12.3% whereas in London and England rates have reduced by a quarter.

Emergency admissions for stroke in Barnet are higher than England and lower than London, also Barnet has the lower emergency readmissions within 30 days compared to national average.

Emergency admissions for heart failure are higher than England but significantly lower than London. Over the past eight years, rates have decreased by 2%. Approximately half of deaths from heart failure occurred in the usual place of residence in Barnet.



5.7% of the Barnet population live in the most deprived national quintile and 11.9% of the population in the least deprived national quintile.

Procedures

Angiography procedures in Barnet are significantly lower than London and lower than England. Male angiography rates are 2.1 times greater than female. Over the past eight years, rates have increased by 18.1% where as England and London they have increased by 8.4% and decreased by 0.7% respectively.

The angioplasty procedures in Barnet are significantly lower than London and England. Male angioplasty procedures are 4.1 times greater than female.

Non-elective angioplasty in Barnet has increased by 20.8% compared to 2004/05 and the Elective procedures have decreased by 6%.

Valve procedure rates in Barnet are higher than the network average and higher than England.

Lifestyle behaviours

Smoking: Using data from the Integrated Household Survey it is estimated that 17.5% of the population in Barnet smoke. This is lower than the estimated proportion in London and England.

Increasing and high risk drinking (combined): It is estimated that 20% of the population in Barnet have increasing or high risk drinking behaviour. This is slightly lower than London and lower than England.

Adult obesity: Using modelled estimates from the Health Survey for England, it is estimated that 17.9% of the adult population in Barnet are classified as obese. This is lower than London and England.

Quality and Outcomes Framework

GPs record information on whether their patients have CHD or have a stroke. The prevalence for CHD in Barnet is higher when compared with London and England

The observed prevalence for stroke in Barnet is higher than London but lower than England.

The prevalence for hypertension in Barnet is in line with London but lower than England. The gap between recognised and treated hypertension and actual hypertension levels in the community have been long recognised.

Understanding the Spine Chart

The Spine chart

The spine chart is a way of demonstrating a lot of information on a single diagram.

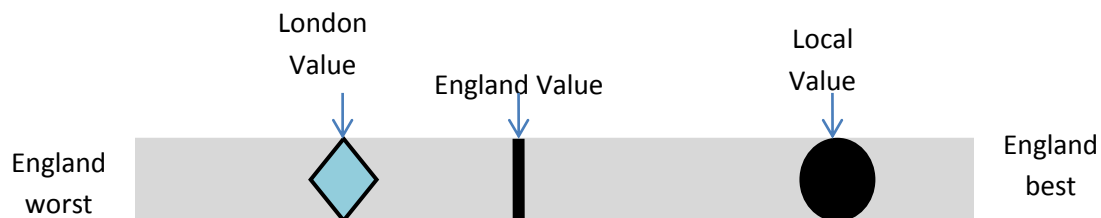
The indicators in the spine chart are generally one of three sorts:

- an indicator of higher or lower need
- an indicator of better or worse performance
- an indicator of better or worse outcomes

The “spine” is the line running down the centre. This is the England average for each indicator. The grey bar shows the range of values in local authorities across England.

Values to the **right** of the England average are better performance or outcomes or of lower need.

Values to the **left** of the England average are worse performance or outcomes or of more need.



Direction of travel indicator

- ↑ Indicator has improved since last year i.e. Improvement in performance or decrease in need
- ↓ Indicator has worsened since last i.e. decrease in performance or increase in need
- ↔ No change since previous year

Green indicates that, according to the latest data, the area is either performing better or has lower need than England average

Red indicates that, according to the latest data, the area is performing at least 2% worse or has at least 2% greater need than the England average.

Amber indicates that, according to the latest data, the area is performing worse or has greater

Spine Chart



Indicator	Direction of travel	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
1 Early cardiovascular mortality (<75 yrs)	↑	43.4	58.8	107.0		34.3
2 Stroke mortality	↓	29.3	34.5	50.8		23.0
3 Estimated % smokers (16+)	↓	18.7	20.7	31.0		14.0
4 Estimated % obese (16+)	↑	17.9	24.2	30.7		13.9
5 % of long term conditions who smoke	↓	13.1	17.4	27.2		10.0
6 Obs/Exp CHD prevalence	↔	0.6	0.6	0.8		0.3
7 Obs/Exp Hypertension prevalence	↔	0.4	0.5	0.5		0.3
8 CHD emergency admissions	↓	174.9	198.3	366.4		124.4
9 Stroke emergency admissions	↑	99.5	89.5	160.2		48.7
10 30 day mortality in STEMI	↓	11.0	8.7	20.6		0.0
11 % stroke discharged to usual residence	↓	53.9	77.9	56.7		97.5
12 % HF who die at usual place residence	NA	53.2	58.5	99.0		19.2
13 Angiography rates	↑	266.3	278.2	676.0		122.3
14 Revascularisation rates	↑	128.7	140.5	249.3		87.1

Spine chart data sources

	Data description	Other sources of information or data
1	Directly standardised rate per 100,000, 2011 under 75	Health and Social Care Information Centre, PHO annual deaths extract, ONS
2	Directly standardised rate per 100,000, 2011	Health and Social Care Information Centre, PHO annual deaths extract, ONS
3	Percentage estimate of smokers , 16+, 2006-08	Integrated Household Survey
4	Percentage estimate of obese adults, 16+, 2006-08	Health Survey for England
5	Percentage of those registered with long-term conditions who smoke, 2010/11	Quality and Outcomes Framework 2011/12
6	Ratio of 2011/12 CHD QOF disease registers to estimated prevalence in 2011	Quality and Outcomes Framework 2011/12
7	Ratio of 2011/12 hypertension QOF disease registers to estimated prevalence in 2011	Quality and Outcomes Framework 2011/12
8	Directly standardised rate per 100,000, 2011/12	HES, Health and Social Care Information Centre
9	Directly standardised rate per 100,000, 2011/12	HES, Health and Social Care Information Centre
10	Percentage, 2011	MINAP
11	% of all patients diagnosed with stroke under 75, 2011/12	HES, Health and Social Care Information Centre
12	Percentage of deaths due to heart failure at their usual place of residence 2007-2011	PHO annual deaths extract, ONS
13	Directly standardised rate per 100,000, 2011/12	HES, Health and Social Care Information Centre
14	Directly standardised rate per 100,000, 2011/12	HES, Health and Social Care Information Centre

Stakeholder views

On Services

There were general concerns about the accessibility of some services for stroke patients with particular reference to rehabilitation and therapy services..

Early supported discharge was favoured but it was stressed that

“early supported discharge needs to mean just that – discharge backed up by the support services – otherwise people will suffer.”

“Regular review is important – so something can be done if the person starts to deteriorate”

On prevention

Prevention was a strong theme in the discussion.

“We need to acknowledge that the root causes of CVD are : smoking, diet and exercise – and it needs to start in childhood, with families and in maternity services.”

“There should be a greater focus on dietary advice and its importance in preventing people getting heart disease and stroke.”

“Smoking is the biggest cause and too many young people start – if we can stop that we stand a better chance of reducing the death rates in future.”