

Cardiovascular disease health profiles: Frequently Asked Questions

What are the cardiovascular disease profiles?

The profiles are a set of indicators relating to cardiovascular disease that are available for every PCT in England. Summary profiles have also been produced for the heart and stroke networks, collating data both at a population level across the network, and also providing comparisons between the relatively small numbers of PCTs that make up each network.

Who produces the Profiles?

The Profiles were produced by the South East Public Health Observatory, on behalf of the National Heart Team, who commissioned and funded the work. They are based on work done previously by Yorkshire and Humber Public Health Observatory.

What do the Profiles include?

The Profiles include a wide range of information: they present data on

- the local population, including measures of deprivation and the local ethnic mix,
- levels of smoking, drinking, obesity and unhealthy eating,
- levels of disease and of patients with risk factors presenting to primary care,
- details of hospital admissions for a range of cardiovascular disease related causes, measures which reflect the quality of care for heart disease and stroke patients,
- death rates, and how they have changed over time,
- variations between areas of affluence and deprivation,
- expenditure on local services.

Where possible, they provide comparisons with other PCTs in the same Strategic Health Authority area, as well as with the country as whole. The Network profiles allow direct comparisons for some of the indicators between all PCTs within a Network.

The Profile data is also available as an interactive Atlas which allows more direct comparison between different areas.

How can I access the Profiles?

The Profiles can be accessed on the SEPHO website:

<http://www.sepho.org.uk/CVDprofiles.aspx>

Where do the data come from?

The data are drawn from a number of sources, using the latest available at December 2010. They are all referenced in the Profiles themselves, but include

- ONS:
- Quality and Outcomes Framework 2009/10
- Smoking cessation data 2009/10
- Hospital Episode Statistics 2009/10
- National Audit of cardiac rehabilitation 2010
- Myocardial Infarction National Audit Programme: 2007-2009
- DoH Programme Budgeting benchmarking Tool: 2008/9

How should we be using the cardiovascular disease profiles?

The Profiles are intended to provide information to healthcare professionals, commissioners and other stakeholders about cardiovascular disease in their areas. Their strength is that they cover the full range of the care pathway, from the wider determinants of health, through lifestyle issues, preventive interventions, the acute illness and longer term outcomes.

An important part of understanding the profiles is to understand the context. Some of this is only available within local areas- for example- progress with implementing changes in care pathways which will impact on the indicators. However, the Profiles do include comparisons' with other areas, and the national comparators to help inform local judgements.

Although we have used the most up to date data available, there may well have been local changes since the data was last collated, and this will require a degree of local knowledge to fully understand whether the data presented still reflects the local situation.

Local interpretation is also important with some of the measures which can be affected by specific local issues. For example, some of the measures will be affected by the accuracy and depth of coding of hospital records.

So, whilst the Profiles may identify areas that could usefully be explored at a local level, they do present indicators- and the indications should lead to further more in depth local review prior to drawing any definitive conclusions about the quality or outcomes of local services.

How can I find out more about the how the indicators were designed?

There is a technical document which describes each indicator in detail- [here](#)

Many of the indicators use the DSR- what is this?

The DSR stands for directly standardised rate. Direct standardisation is a technique used to compensate for the impact of the age of the population on rates. For example, we know that cardiovascular disease is common in older populations. So, if an area has relatively few older people, it will have a relatively low death rate from CVD, even if people living there are just as likely to die from the disease as people of their age living elsewhere. Direct standardisation compensates for these effects, and allows for a fair comparison between two areas, regardless of the differences in their population structure.

What if the indicator is not standardised?

This applies to a number of indicators- particularly those relating to GPs and the Quality and Outcomes framework. Whilst direct comparisons can offer useful insights, caution must be taken. An area which has a relatively young population will have fewer people suffering from heart disease and stroke than an area which has a larger proportion of older people. This may be reflected in the non-standardised measures, and these should therefore be interpreted with local insight.

Queries about specific indicators

Where do the geodemographic indicators come from?

A number of methods of geodemographic segmentation are used by PCTs across the country- for example, many PCTs have purchased a system called MOSAIC. We have used a system developed by ONS, which is widely and freely available. It gives another view on the differences between the local population and the national picture, as well as showing any differences in death rates from CVD between groups.

Why is the stop smoking indicator different from that shown in the Tobacco Control profiles?

This is because the two Profiles use different measures. The Tobacco Control profiles show the numbers of people who quit smoking as a proportion of the total adult population in an area. We have used the same measure of people who quit smoking, but shown this as a proportion of the estimate of the number of smokers in the population. This was because some of our contacts felt that the local number of smokers had a significant impact on the numbers who go through Stop Smoking Services. Note that some local stop smoking services will have clients who are not resident within the local PCT, so the number of quitters may not always be taken from exactly the same population group where the estimate of smokers is taken from. The measure we have used is also dependent on the accuracy of the estimates of the local smoking population. People can also refer to the Tobacco Control profiles if they prefer the indicator used there-

http://www.lho.org.uk/LHO_Topics/Analytic_Tools/Tobaccocontrolprofiles

The indicators on myocardial infarction management are not as up to date as some of the other indicators?

These indicators are drawn from a national audit of all; cases who present to hospital with a heart attack (myocardial infarction). The audit is managed by the National Institute for Clinical Outcomes Research at University College London in conjunction with the British Cardiac Society. Data is managed by CCAD, which is part of the Health and Social Care Information Centre. The Public report is published annually and we have used the latest available.

Early review of the data currently being submitted by the team managing the audit suggests that times to access angioplasty will have reduced further when the 2008-2010 report is published.

Why are the cardiac rehabilitation uptake indicators not available at PCT level?

The National Audit of Cardiac Rehabilitation is dependent on local services providing data to them for analysis. Unfortunately the methods for estimating uptake of cardiac rehabilitation for those who have had an MI is estimated from different sources with the underlying populations prone to mismatch. For this reason it is difficult for the audit to make estimates of uptake of cardiac rehabilitation at levels lower than SHA with any degree of accuracy.

Some of the indicators refer to absolute and relative inequality gaps. What do these terms mean?

One of the major causes of health inequalities is the higher death rates from cardiovascular disease in more deprived areas. It has been a national policy to reduce this mortality gap between the poorest areas and the rest of the country. At PCT level, many PCTs also have set themselves goals of reducing the gap in mortality between the poorest and most affluent areas within their boundaries.

The absolute gap describes the gap in terms of the difference in values of the DSR. For example, if the poorer population has a DSR of 100, and the most affluent has a DSR of 50, the absolute gap is 50. However, in this case the relative gap between the two populations is 2 - that is the poorer area has a DSR twice that of the most affluent.

This is important in looking at trends over time. If we take the area described above we may see that, ten years ago, the poorer population has a DSR of 200, and the most affluent a DSR of 120. The absolute gap was 80, and the relative gap was 1.67. Over the ten years, the absolute gap has reduced, from 80 to 50, but the relative gap has increased from 1.6 to 2.

When considering health inequalities, it is important to look at both indicators.

A specific issue when looking at relative gaps is to note that the size of the gap within a PCT may be related to the range of deprivation in the area. A PCT with a fairly homogenous population, in which everyone suffers from a high degree of deprivation, will show a small difference between the most and least deprived quintiles internally - as the degree of variation in deprivation will be small. However, a PCT with a greater mix of poor and affluent areas will show a much greater degree of variation, even if the deprived population

living there actually fares better than the deprived population living in the more homogenous PCT.

Will the Profiles be updated?

Unfortunately, we cannot answer this question. The changes in the NHS currently taking place means that there is some uncertainty about the future, and we would like to know how helpful people found the Profiles. A feedback questionnaire is available, and we would value any comments - <https://www.surveymonkey.com/s/8J2YSHB>