Cardiovascular Disease (CVD) is the second largest cause of death in England causing around 130,190 deaths in 2011 (29% of all deaths). Around 46% of all deaths from CVD are from coronary heart disease (CHD) and almost a fifth from stroke (18%). CHD is the most common single cause of death in England (13% of all deaths in 2011).

This Cardiovascular Disease (CVD) Health Profile brings together a wide range of data on cardiovascular disease in each upper tier local authority in England and in associated Strategic Clinical Networks. Its aim is to provide information to health care professionals, commissioners and other interested parties about CVD issues in their local community, as an aid to planning and development.

Solihull lies within the boundaries of the West Midlands Strategic Clinical Network (as of 1st April 2013, pictured right).

This information is also available for each strategic clinical network, and as an interactive atlas.

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Benchmarking

The area is benchmarked against the national value and the average value of the strategic clinical network in which it is either entirely or mostly located.

Solihull is classified as a member of the West Midlands strategic clinical network.

Key messages

Early mortality (under 75 years) rates from cardiovascular disease are similar to the national rate, and have decreased by 63.6% since 1995.

Emergency admission rates for CHD are significantly lower than the national rates, but for stroke the local rate is similar to the national rate.

There were less than 5 deaths recorded within 30 days of hospital admission for STEMI patients.

For people having myocardial infarction reperfusion in 2011/12, the median time to primary angioplasty treatment from a call for help was 117 minutes in Solihull, this is higher than in West Midlands and England (113 and 111 respectively).

There is a slightly higher proportion of stroke patients under 75 years discharged back to their usual place of residence compared to the national picture.
## Summary Indicators

| Indicator                                      | Local Value | Eng Avg | Eng Low | England Range | Eng High |
|------------------------------------------------|-------------|---------|---------|               |         |
| 1 Early cardiovascular mortality (<75 yrs)    | 49.3        | 58.8    | 34.3    |                | 107.0   |
| 2 Stroke mortality                            | 31.6        | 34.5    | 23.0    |                | 50.8    |
| 3 Estimated % smokers (16+)                   | 17.5        | 20.7    | 14.0    |                | 31.0    |
| 4 Estimated % obese (16+)                     | 24.9        | 24.2    | 13.9    |                | 30.7    |
| 5 % of long term conditions who smoke         | 15.6        | 17.4    | 10.0    |                | 27.2    |
| 6 Obs/Exp CHD prevalence                      | 0.6         | 0.6     | 0.3     |                | 0.8     |
| 7 Obs/Exp Hypertension prevalence             | 0.5         | 0.5     | 0.3     |                | 0.5     |
| 8 CHD emergency admissions                    | 170.8       | 198.3   | 124.4   |                | 366.4   |
| 9 Stroke emergency admissions                 | 89.3        | 89.5    | 48.7    |                | 160.2   |
| 10 30 day mortality in STEMI                  | 8.7         | 0.0     | 0.0     |                | 20.6    |
| 11 % stroke discharged to usual residence     | 82.7        | 77.9    | 56.7    |                | 97.5    |
| 12 % HF who die at usual place residence      | 33.7        | 58.5    | 19.2    |                | 99.0    |
| 13 Angiography rates                          | 281.0       | 278.2   | 122.3   |                | 676.0   |
| 14 Revascularisation rates                    | 147.9       | 140.5   | 87.1    |                | 249.3   |

- **Significantly Higher than England average**
- **Significantly Lower than England average**
- **Not significantly different from England average**
- **No significance available**

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2. Directly standardised rate per 100,000, 2011.
3. Percentage estimate of smokers, 16+, 2006-08.
5. Percentage of those registered with long-term conditions who smoke, 2010/11.
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7. Ratio of 2011/12 hypertension QOF disease registers to estimated prevalence in 2011.
8. Directly standardised rate per 100,000, 2011/12.
9. Directly standardised rate per 100,000, 2011/12.
11. % of all patients diagnosed with stroke under 75, 2011/12.
12. Percentage of deaths due to heart failure at their usual place of residence 2007-2011.
13. Directly standardised rate per 100,000, 2011/12.
14. Directly standardised rate per 100,000, 2011/12.
The proportion of the population in Solihull which is from black and minority ethnic groups is estimated to be 10.9%. South Asian men are more likely to develop CHD at younger age, and have higher rates of myocardial infarction. Black people have the highest stroke mortality rates.

The definition of BME used here excludes ‘White Irish’, ‘White Gypsy or Irish traveller’, ‘ and ‘White other’ ethnic groups.

Demographic profile

Age profile and population projections in Solihull

The population estimate of Solihull in 2011 was 206,900 and is projected to increase to 221,200 in 2021.

Age is a key factor in cardiovascular disease. The prevalence of cardiovascular disease increases significantly after the age of 40 years.

The percentage of the population aged 40 or over in Solihull is expected to decrease from 25.5% to 25.3% for males and from 28.7% to 28.4% for females between 2011 and 2021. The population aged 40 or over in the West Midlands Network is expected to increase from 23.7% to 23.9% for males and remain unchanged at at 25.7% for females. In England it is expected to increase from 23.5% to 23.9% for males and from 25.7% to 25.8% for females.

National deprivation structure (IMD 2010)

Solihull has 16.2% of its population in the most deprived national quintile and 39.0% of the population in the least deprived quintile.

Ethnicity recorded from the 2011 census

The proportion of the population in Solihull which is from black and minority ethnic groups is estimated to be 10.9%. South Asian men are more likely to develop CHD at younger age, and have higher rates of myocardial infarction. Black people have the highest stroke mortality rates.

The definition of BME used here excludes ‘White Irish’, ‘White Gypsy or Irish traveller’, ‘ and ‘White other’ ethnic groups.
Lifestyle estimates for adults

<table>
<thead>
<tr>
<th></th>
<th>Smoking</th>
<th>Increasing and high risk drinking (combined)</th>
<th>Obesity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solihull</td>
<td>17.5%</td>
<td>22.0%</td>
<td>24.9%</td>
</tr>
<tr>
<td>West Midlands</td>
<td>20.6%</td>
<td>21.4%</td>
<td>26.4%</td>
</tr>
<tr>
<td>England</td>
<td>20.7%</td>
<td>22.3%</td>
<td>24.2%</td>
</tr>
</tbody>
</table>

Sources: Smoking: Integrated Household Survey, 2010/11
High Risk drinking: Modelled estimates from the General Lifestyles Survey, 2008-09
Obesity: Modelled Estimates from Health Survey for England, 2006-08

Smoking
- Using data from the Integrated Household Survey it is estimated that 17.5% of the population in Solihull smoke. This is lower than the estimated proportion in England (20.7%) and lower than West Midlands (20.6%).

Increasing and high risk drinking (combined)
- Using modelled estimates from the General Lifestyle Survey, it is estimated that 22.0% of the population in Solihull have increasing or high risk drinking behaviour. This is lower than England (22.3%) and higher than West Midlands (21.4%).

Adult obesity
- Using modelled estimates from the Health Survey for England, it is estimated that 24.9% of the adult population in Solihull are classified as obese. This is higher than England (24.2%) and lower than West Midlands (26.4%).

Percentage of patients registered with a GP with any combination of registered long-term conditions who smoke, QOF 2011/12

QOF data shows that the percentage of patients with long-term conditions who smoke in Solihull was 15.6% in 2011/12. This is significantly lower than the rate in England (17.4%) and significantly lower than the rate in West Midlands (17.4%).

Source: Quality and Outcomes Framework 2011/12
Effective exception rate (EER)

<table>
<thead>
<tr>
<th>Area</th>
<th>2011/12 EER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solihull</td>
<td>4.4%</td>
</tr>
<tr>
<td>West Midlands</td>
<td>5.3%</td>
</tr>
<tr>
<td>England</td>
<td>5.6%</td>
</tr>
</tbody>
</table>

GPs can exclude patients from the calculation of measures in the Quality and Outcomes Framework, to allow practices to pursue the quality improvement agenda and not be penalised, where, for example, patients do not attend for review, or where a medication cannot be prescribed due to a contraindication or side-effect. However, the number of such exceptions varies substantially between practices. In 2011/12, the exception rate in Solihull was 4.4%. Within England, the exception rate varied between 3.9% to 8.6% for individual areas.

Number and percentage of practices with high exception reporting rates

<table>
<thead>
<tr>
<th></th>
<th>Atrial fibrillation</th>
<th>Coronary heart disease</th>
<th>Heart failure</th>
<th>Hypertension</th>
<th>Stroke &amp; TIA</th>
<th>CVD Primary Prevention</th>
<th>Practices with any high exception rates</th>
<th>Total number of practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solihull %</td>
<td>3.3%</td>
<td>13.3%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>3.3%</td>
<td>0.0%</td>
<td>20.0%</td>
<td>30</td>
</tr>
<tr>
<td>West Midlands %</td>
<td>2.0%</td>
<td>6.8%</td>
<td>4.2%</td>
<td>1.5%</td>
<td>4.0%</td>
<td>1.3%</td>
<td>19.7%</td>
<td>956</td>
</tr>
<tr>
<td>England %</td>
<td>2.1%</td>
<td>7.5%</td>
<td>3.6%</td>
<td>2.0%</td>
<td>4.1%</td>
<td>2.1%</td>
<td>21.3%</td>
<td>8124</td>
</tr>
</tbody>
</table>

Quality and Outcomes Framework - prevalence

Observed (GP registered) prevalence in 2011/12 versus estimated prevalence in 2011

Coronary heart disease

GPs record information on whether their patients have CHD or have a stroke. This information is crude and does not consider population structure. The estimated prevalence is population structure adjusted, but is for the 16+ population, so does not match the all age population of GP registers.

The observed prevalence for CHD in Solihull is 59.7% of the estimated prevalence. This compares to 58.2% for England and 52.8% for West Midlands.

Stroke

The observed prevalence for stroke in Solihull is 72.0% of the estimated prevalence. This compares to 68.4% for England and 63.5% for West Midlands.

Hypertension

The observed prevalence for hypertension in Solihull is 45.5% of the estimated prevalence. This compares to 46.0% for England and 46.4% for West Midlands. The gap between recognised and treated hypertension, and actual hypertension levels in the community have been long recognised.

Sources: Quality and Outcomes Framework 2011/12 and modelled estimates of prevalence, Eastern Region Public Health Observatory, December 2011
## Cardiovascular disease health profile - Solihull
### Quality and Outcomes Framework - performance

#### 2011/12

<table>
<thead>
<tr>
<th>Coronary heart disease</th>
<th>Stroke</th>
<th>Hypertension</th>
<th>Heart failure</th>
<th>Primary prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>% newly diagnosed angina patients referred for exercise testing or assessment</strong></td>
<td>Solihull</td>
<td>West Midlands</td>
<td>England</td>
<td>Solihull</td>
</tr>
<tr>
<td>99.0</td>
<td>97.9</td>
<td>98.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>% CHD patients in whom last blood pressure reading was 150/90 or less</strong></td>
<td>88.0</td>
<td>89.7</td>
<td>90.1</td>
<td></td>
</tr>
<tr>
<td><strong>% CHD patients in whom last cholesterol measurement was 5mmol/l or less</strong></td>
<td>79.0</td>
<td>80.2</td>
<td>80.4</td>
<td></td>
</tr>
<tr>
<td><strong>% CHD patients taking aspirin, an alternative anti-platelet therapy or an anti-coagulant in last 15 months</strong></td>
<td>93.1</td>
<td>93.5</td>
<td>93.3</td>
<td></td>
</tr>
<tr>
<td><strong>% CHD patients currently treated with beta blocker</strong></td>
<td>71.2</td>
<td>73.3</td>
<td>74.2</td>
<td></td>
</tr>
<tr>
<td><strong>% patients with history of myocardial infarction currently treated with ACE inhibitor or angiotensin II antagonist</strong></td>
<td>97.8</td>
<td>91.4</td>
<td>91.1</td>
<td></td>
</tr>
<tr>
<td><strong>% CHD patients immunised against influenza in Sept-March 05</strong></td>
<td>93.7</td>
<td>92.5</td>
<td>92.5</td>
<td></td>
</tr>
<tr>
<td><strong>% atrial fibrillation patients currently treated with anti-coagulation drug therapy or an anti-platelet therapy</strong></td>
<td>94.1</td>
<td>93.6</td>
<td>93.7</td>
<td></td>
</tr>
<tr>
<td><strong>% heart failure patients diagnosed after 1st April 2006 with diagnosis confirmed by an echocardiogram or specialist assessment</strong></td>
<td>96.9</td>
<td>96.1</td>
<td>95.7</td>
<td></td>
</tr>
<tr>
<td><strong>% patients with a current diagnosis of heart failure due to LVD currently treated with an ACE inhibitor or angiotensin receptor blocker</strong></td>
<td>91.9</td>
<td>89.5</td>
<td>89.3</td>
<td></td>
</tr>
<tr>
<td><strong>% stroke patients whose blood pressure was 150/90 or less</strong></td>
<td>86.6</td>
<td>88.0</td>
<td>88.6</td>
<td></td>
</tr>
<tr>
<td><strong>% stroke patients with record of cholesterol in last 15 months</strong></td>
<td>91.4</td>
<td>91.9</td>
<td>91.4</td>
<td></td>
</tr>
<tr>
<td><strong>% stroke patients whose cholesterol was 5mmol/l or less</strong></td>
<td>76.2</td>
<td>77.4</td>
<td>77.2</td>
<td></td>
</tr>
<tr>
<td><strong>% stroke patients immunised preceding Sept-March</strong></td>
<td>91.1</td>
<td>89.9</td>
<td>90.0</td>
<td></td>
</tr>
<tr>
<td><strong>% non-haemorrhagic/with history of TIA stroke patients taking anti-platelet agent/anti-coagulant</strong></td>
<td>93.4</td>
<td>93.6</td>
<td>93.6</td>
<td></td>
</tr>
<tr>
<td><strong>% new patients with a stroke referred for further investigation</strong></td>
<td>90.3</td>
<td>89.5</td>
<td>89.6</td>
<td></td>
</tr>
<tr>
<td><strong>% hypertension patients with record of blood pressure in last 9 months</strong></td>
<td>91.4</td>
<td>91.2</td>
<td>91.0</td>
<td></td>
</tr>
<tr>
<td><strong>% hypertension patients (with record in last 9 months) in whom last blood pressure was 150/90 or less</strong></td>
<td>78.1</td>
<td>79.6</td>
<td>79.7</td>
<td></td>
</tr>
<tr>
<td><strong>% hypertension patients who are given lifestyle advice in the for physical activity, smoking cessation, alcohol consumption and diet</strong></td>
<td>86.7</td>
<td>81.4</td>
<td>81.5</td>
<td></td>
</tr>
</tbody>
</table>

Source: Quality and Outcomes Framework 2011/12
The NHS Health Check programme was formally introduced in April 2009 as a key policy to reduce health inequalities and increase life expectancy from preventable CVD conditions.

Based on PCT performance data submitted in 2011-2012, there were 62,968 local authority residents in Solihull who were eligible to be invited for an NHS Health Check. Local authorities are mandated to offer the programme to 100% of their eligible population over a five year period, from April 2013. During 2011-2012, 20.6% of eligible residents were invited to attend the programme with an uptake rate of 48.1%.

Local authorities can access a 'Ready Reckoner' that allows them to identify the potential service implications, benefits and cost savings resulting from implementing NHS Health Checks: http://www.healthcheck.nhs.uk/national_resources/ready_reckoner_tools

**Percentage people offered a health check from those eligible to be invited for a health check during 2011/12**

- Solihull: 20.6%
- West Midlands: 13.6%
- England: 13.9%

**Percentage uptake of people offered a health check (within the eligible population) during 2011/12**

- Solihull: 48.1%
- West Midlands: 55.3%
- England: 51.6%

CHD emergency admission rates (DSRs), for all ages, 2011/14

In 2011/12 the emergency admission rate for CHD, all persons, in Solihull was 170.8 per 100,000 (539 admissions). This is significantly lower than England (198.3 per 100,000) and West Midlands (195.9 per 100,000).

Male CHD emergency admission rates are significantly higher than female CHD emergency admission rates.

The emergency admission rate for CHD in 2011/12 for persons living in the most deprived areas of Solihull was 264.9. This is 2.4 times greater than emergency admission rates for persons living in the least deprived areas of Solihull (112.2).

Trend in CHD rates (DSRs), 2004/05 to 2011/12

The emergency admission rate for CHD in Solihull has decreased by 15.0% between 2004/05 and 2011/12.

In England it has decreased by 23.1% and in West Midlands it has decreased by 21.8%.
Heart failure emergency admission rates (DSRs), for all ages, 2011/12

In 2011/12 the emergency admission rate for heart failure, all persons, in Solihull was 71.6 per 100,000 (300 admissions). This is significantly higher than England (60.7 per 100,000) and higher than West Midlands (69.3 per 100,000).

The emergency admission rate for heart failure in 2011/12 for persons who live in the most deprived areas of Solihull was 69.5. This was 1.3 times greater than the emergency admission rates for persons who live in the least deprived areas of Solihull (52.3).

In England, the emergency admission rates for persons who live in the most deprived areas are 2.3 times greater respectively compared to persons who live in the least deprived areas and 2.5 times greater in West Midlands.

Heart failure emergency admission rates (DSRs) for all ages, by quintile of relative deprivation, 2011/12

Male heart failure emergency admission rates are significantly higher than female heart failure emergency admission rates.

Trend in heart failure rates (DSRs), 2004/05 to 2011/12

The emergency admission rate for heart failure in Solihull has decreased by 13.9% between 2004/05 and 2011/12.

In England it has decreased by 18% and in West Midlands it has decreased by 18.2%.

Proportion of deaths from heart failure that occur at home or usual place of residence, 2007-2011

33.7% of deaths from heart failure occurred in the usual place of residence in Solihull which is a lower proportion than West Midlands (54.7%) and England (58.5%)
Stroke emergency admission rates (DSRs) for all ages, 2011/12

In 2011/12 the emergency admission rate for stroke, all persons, in Solihull was 89.3 per 100,000 (327 admissions). This is lower than England (89.5 per 100,000) and West Midlands (90.1 per 100,000).

Male stroke emergency admission rates are higher than female stroke emergency admission rates.

Stroke emergency admission rates (DSRs), by quintile of relative deprivation, 2011/12

The emergency admission rate for stroke in 2011/12 for persons who live in the most deprived areas of Solihull was 113.2. This is 1.4 times greater than the emergency admission rates for persons who live in the least deprived areas of Solihull (79.2).

In England, the emergency admission rates for persons who live in the most deprived areas are 1.8 times greater respectively compared to persons who live in the least deprived areas and 1.6 times greater in West Midlands.

Trend in stroke rates (DSRs), 2004/05 to 2011/12

The emergency admission rate for stroke in Solihull has increased by 21.1% between 2004/05 and 2011/12. In England it has increased by 3% and in West Midlands it has increased by 2.1% .

The rate of emergency readmissions within 30 days for Solihull is 3.8%, this is higher than England and West Midlands (2.9% and 2.2% respectively).
Myocardial Infarction management

Percentage Primary Angioplasty used in reperfusion treatment for patients with STEMI* diagnosis, 2011/12

Primary Angioplasty median time to treatment from calling for help, for STEMIs, 2011/12

Non-STEMI patients can be treated less invasively, but still need specialist management. The proportion of non-STEMIs seen by a member of the cardiology team for Solihull residents is 100%, this is higher than West Midlands and England (96% and 93.7% respectively).

Source: Myocardial Ischaemia National Audit Project (MINAP)

Primary angioplasty for Solihull residents was 100% of all reperfusion for patients diagnosed as STEMI, compared to 95% in England.

The median time to primary angioplasty treatment from a call for help was 117 minutes for Solihull residents, this is higher than in West Midlands and England (113 and 111 respectively).

* STEMs are ST elevated myocardial infarctions (as seen in an ECG) and best treated by thrombolysis or primary angioplasty

Proportion of non-STEMIs seen by member of cardiology team, 2011/12

Mortality within 30 days of admission to hospital for STEMI patients, 2011/12

There were less than 5 deaths recorded within 30 days of hospital admission for STEMI patients resident in Solihull in 2011/12. The 30 day mortality rate in West Midlands and England was 7.9% and 8.7% respectively.

Source: MINAP
Angiography procedures

Angiography procedure rates (DSRs) for all ages, 2011/12

In 2011/12 the angiography procedure rate in Solihull was 281 per 100,000 (784 procedures). This is higher than England (278.2 per 100,000) and West Midlands (276.8 per 100,000).

Male angiography rates are 2 times greater than female angiography rates in Solihull.

Angiography rates in Solihull have decreased by 10.9% between 2004/05 and 2011/12. In England and West Midlands they have increased by 8.4% and 4.9% respectively.

Angiography procedure rates (DSRs) for persons who live in the most deprived areas of Solihull are 1.6 times greater than those who live in the least deprived areas. In England and West Midlands they are 1.5 and 1.8 times greater respectively.

Angiography procedures

Angiography procedure rates (DSRs) for all ages, by quintile of relative deprivation, 2011/12

Network

England

LA

Source: HES, Health and Social Care Information Centre, ONS, DCLG

Source: HES, Health and Social Care Information Centre, ONS

Cardiovascular disease health profile - Solihull
Revascularisation

Elective & non-elective angioplasty procedure rates (DSRs) for all ages, 2011/12

CABG procedure rates (DSRs), for all ages, 2011/12

In 2011/12 the all persons angioplasty procedure rate in Solihull was 109.2 per 100,000 (310 procedures), 38.2 per 100,000 elective and 71 per 100,000 non-elective. This is lower than England (111 per 100,000) and West Midlands (112.9 per 100,000).

Male angioplasty procedure rates are 3.3 times greater than female angioplasty rates in Solihull.

In 2011/12 the CABG procedure rate, all persons, in Solihull was 38.7 per 100,000 (115 procedures). This is significantly higher than England (29.5 per 100,000) and higher than West Midlands (31 per 100,000).

Trend in Angioplasty rates (DSRs), 2004/05 to 2011/12

Trend in CABG rates (DSRs), 2004/05 to 2011/12

Non-elective angioplasty rates in Solihull have decreased by 2.5% between 2004/05 and 2011/12. Elective procedure rates have increased by 7.4%. In England and West Midlands non-elective procedure rates have increased by 74.8% and 47.5% respectively. Elective procedure rates have decreased by 15.7% and 18% respectively.

CABG procedure rates in Solihull have decreased by 2.7% between 2004/05 and 2011/12. In England and West Midlands CABG procedure rates have decreased by 25.4% and 21.6% respectively.

Source: HES, Health and Social Care Information Centre, ONS

Source: Quality and Outcomes Framework, 2007/08

Source: ONS 2006 - based subnational population projections by sex and quinary
Revascularisation - deprivation

Revascularisation rates (DSRs) for all ages, by quintile of relative deprivation, 2011/12

Revascularisation rates for persons who live in the most deprived areas of Solihull are 2.5 times greater than those who live in the least deprived areas. In England and West Midlands they are 1.6 and 2 times greater respectively.

Cardiac procedures

Valve procedure rates (DSRs), 2010/11-2011/12

Valve procedure rates in Solihull were 14.7 per 100,000 in 2010/11-2011/12, higher than the network average (14) and lower than England (14.8).
Heart Transplants by SHA, 2011/12

<table>
<thead>
<tr>
<th>Strategic Health Authority</th>
<th>Rate per million population</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Midlands</td>
<td>3.8</td>
</tr>
<tr>
<td>North East</td>
<td>3.4</td>
</tr>
<tr>
<td>East Midlands</td>
<td>2.7</td>
</tr>
<tr>
<td>North West</td>
<td>2.7</td>
</tr>
<tr>
<td>East Of England</td>
<td>2.2</td>
</tr>
<tr>
<td>South West</td>
<td>1.9</td>
</tr>
<tr>
<td>South Central</td>
<td>1.7</td>
</tr>
<tr>
<td>South East Coast</td>
<td>1.6</td>
</tr>
<tr>
<td>Yorkshire and The Humber</td>
<td>1.1</td>
</tr>
<tr>
<td>London</td>
<td>1.1</td>
</tr>
</tbody>
</table>

The rate of heart transplantation varies from 1.1 per million in London to 3.8 per million in the West Midlands. This data is not available at a geography lower than strategic health authority.

Stroke management

Percentage of hospital stroke patients discharged to home or usual place of residence, 2011/12

The proportion of patients under the age of 75 discharged to home or usual place of residence in Solihull is 82.7%, which is higher than West Midlands (80.7%) and England (77.9%). 86.5% of patients aged 75 or over are discharged to home, which is significantly higher than West Midlands (71.1%) and England (70.1%).

Rate of carotid endarterectomy procedures (DSR’s), 2010/11-2011/12

The rate of carotid endarterectomies performed per 100,000 for Solihull is 8.3, which is significantly lower than West Midlands (8.7) and England (8.7). West Midlands is significantly lower than England.
Cardiovascular disease health profile - Solihull

CVD early mortality trend

All CVD mortality rates (DSRs) in persons under 75 yrs: 1995 to 2011 (predicted to 2014)

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 Solihull for persons under 75 yrs is predicted to be 43, which would be a 10 year decrease of 38.0% (from 2004). The early CVD mortality rate for England is predicted to be 50.1, a 10 year decrease of 44.2% and the West Midlands rate is predicted to be 51.1, a 10 year decrease of 46.3%.

Contribution of CVD deaths to overall mortality

CVD deaths as a proportion of all deaths under, <75 and 75+, 2009-11

In Solihull the percentage of cardiovascular deaths as a proportion of all deaths was 23.5% for people aged under 75 years and 32.3% for people aged 75 and above. This is lower than England for under 75s (23.8%) and lower than England for those aged 75 and over (34.7%).

CHD makes up the biggest proportion of total deaths (within CVD) for both males and females, 15.9% (7% AMI and 8.9% non AMI) and 9.9% (3.8% AMI and 6.1 % non AMI ) respectively in Solihull. For males, 7.5% of deaths are due to stroke and 1.7% are due to heart failure. For females, 9.8% of deaths are due to stroke and 2.1% are due to heart failure.

Source: Health and Social Care Information Centre, PHO annual deaths extract, ONS
CVD mortality rates (DSR's) by gender for all ages, 2009-11

The 2009-11 CVD mortality rate in Solihull for all persons was 128.5 per 100,000. This is significantly lower than England (155.6) and West Midlands (159.1).

Male CVD mortality rates in Solihull are significantly higher than female CVD mortality rates (167.8 and 96.4 respectively).

In England the mortality rate for persons who live in the most deprived areas was 213.1, 1.4 times greater than the overall mortality rate for England and 1.8 times greater than the mortality rate for persons who are in the least deprived areas. In West Midlands the mortality rate for persons who live in the most deprived areas was 214.2, 1.3 times greater than the overall mortality rate and 1.8 times greater than the mortality rate for persons who live in the least deprived areas.
In 2014, the mortality rate for cerebrovascular disease in Solihull is predicted to be 32.2 for males and 27.3 for females, this is a 10 year decrease of 45.3% for males and 30.0% for females. In England, the mortality rate is predicted to decrease by 44.4% to 33.1 for males over the same 10 years and by 41.7% to 31.9 for females. The rates in West Midlands are predicted to decrease by 49.9% for males to 33.3 and by 46.2% to 31.3 for females.

Note that due to mortality recording changes introduced for 2011 data, there will be some decreases in CVD numbers, particularly cerebrovascular disease between 2011 and previous years that are not accounted for in population outcomes, but coding rules.
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With special thanks to Yorkshire and Humber Public Health Observatory whose original work formed the basis for these reports.