

Addendum

Equality and the burden of vascular disease across the Cheshire Clinical Network.



This addendum should be read in conjunction with the main report, published June 2012.

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Introduction

Following completion of a report commissioned by the Cheshire Clinical Network to inform an Equality Impact Assessment regarding the reconfiguration of vascular services across the network, the Centre for Public Health has been commissioned to provide a short addendum relating to the inclusion of data relating to Halton residents.

The Addendum provides some basic population and health information in relation to Halton to enable commissioners to scope what impact the inclusion of this new population data might have on their Equality Impact Assessment and whether this will require action, mitigation or further investigation.

Context

The Equality and the Burden of Vascular Disease report analysed data following a review of vascular services. The review recommended the establishment of two specialist centres for the provision of vascular services - one to serve a population North of the River Mersey and one to serve a population to the South. At the time it was commissioned, the report considered a variety of data in respect of the South and the three designated geographic populations: Warrington PCT, Western Cheshire PCT and Wirral PCT. Subsequent consultation has indicated that Halton and St Helens PCT, originally considered part of the North network would see service use split across the two clusters, with Halton residents primarily accessing a service South of the Mersey and St Helens residents continuing to access the services provided in the North. This addendum considers whether the inclusion of the Halton population in the overall burden of disease analysis is likely to materially affect the conclusions of the original report.

Data Considerations

Halton and St Helens PCT formed in 2006, following the merger of two separate PCTs (Halton PCT and St Helens PCT). The Halton PCT footprint no longer exists and therefore health and primary care data is not readily available at this geography. It is possible to extract hospital episode data at a lower geographic output and aggregate this up to a Halton PCT level using the historical footprint. Similarly, it is possible to identify those GP and primary care practices that operate within the former footprint. However, clearly there would need to be caution regarding the assumptions being made by introducing this virtual boundary. Similarly the data produced at this level should not be absolutely compared with the other current PCTs (Warrington, Western Cheshire and Wirral) as population and service arrangements are unlikely to be comparable.

Halton Unitary Authority (UA) data is available and some comparisons can be made with the data that is available at local authority level for Warrington UA, Cheshire West and Chester UA, and Wirral Metropolitan County District.

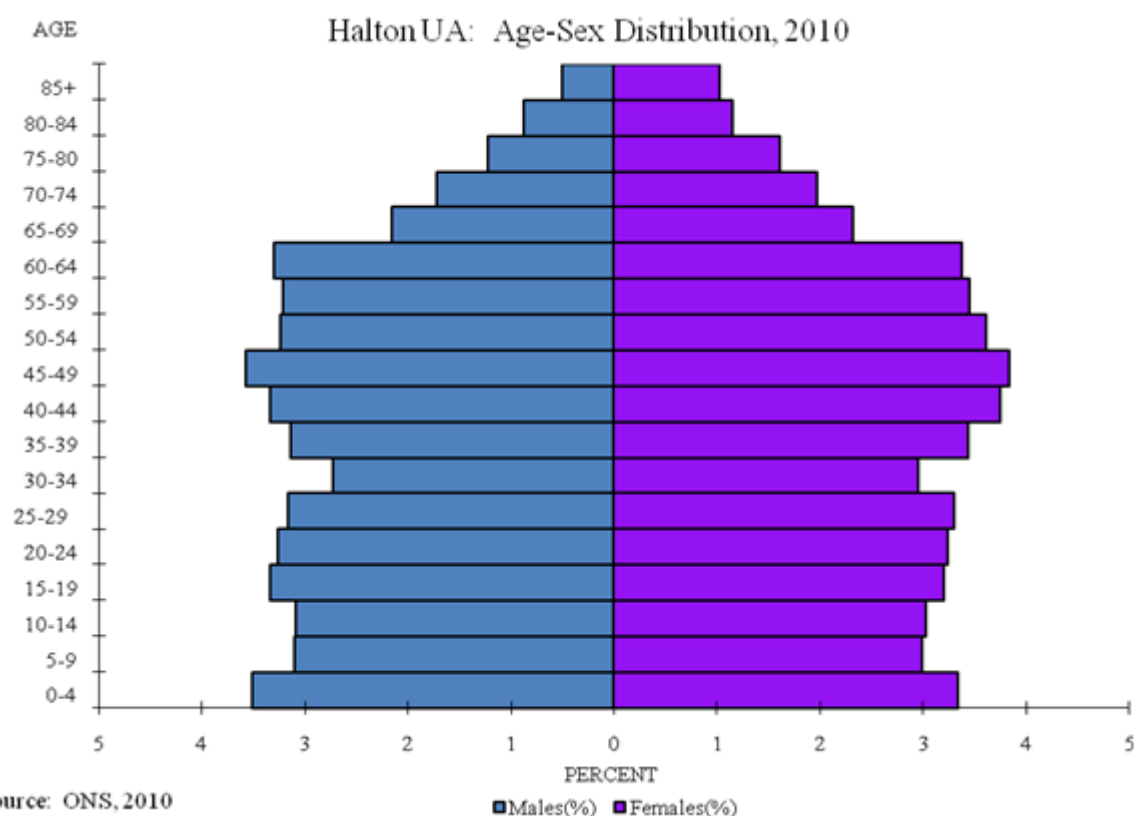
This addendum presents some of the more readily available data for consideration. Caution is advised regarding the limits of conclusions that may be drawn from presented comparisons.

Population profile

According to the Office for National Statistics (2010), Halton UA has a population of 119,263 and is one of the most deprived areas in the country. The Indices of Multiple Deprivation 2010 (IMD) identify that Halton is the 27th most deprived local authority in England.

Figure 1 shows the age-sex distribution profile for the population of Halton UA. This distribution shows that Halton has a relatively young population. Comparing this distribution with those contained within the original report it appears that this profile is considerably different from the other areas although the other area profiles are based on a PCT geography and therefore not directly comparable.

Figure 1: Age-Sex Distribution Profile for Halton UA (ONS 2010)



Deprivation

Table 1 shows that Halton is the most deprived authority in this cluster. Wirral still experiences the highest deprivation at Lower Super Output Area (LSOA) level, however, this appears to be offset at the local authority level by the number of LSOAs within the authority that have high affluence.

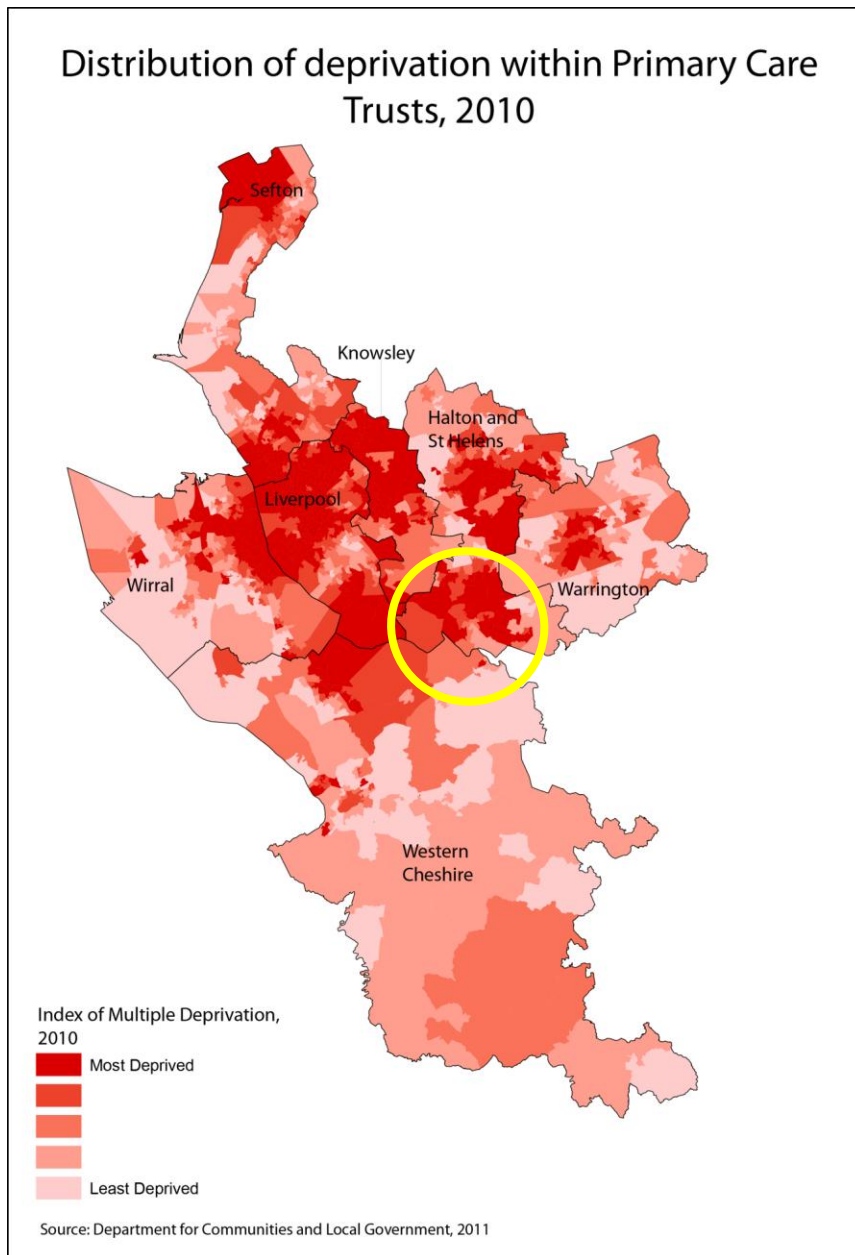
Table 1: Population and IMD scores for Local Authorities, IMD 2010

Geographic region	Population	IMD 2010 Rank of Average Score ¹
Warrington	197,763	153
Cheshire West and Chester	233,324	171
Wirral	308,495	60
Halton UA	119,263	27

Source IMD 2010

¹ IMD Score: 1 is the most deprived and 326 is the least deprived

Figure 2: Distribution of deprivation IMD 2010 highlighting Halton area



Health Profile

Table 2 shows that, consistent with its high level of deprivation, Halton UA experiences relatively poor health in comparison to the other authorities with a greater proportion of smokers; greater levels of obesity and less healthy eating.

*Table 2: Selected Health Profile Indicators (Health Profiles, 2011)**

	Adults Smoking ²	Physically Active ³	Obese ⁴	Healthy eating ⁵
Warrington	22.53	11.15	22.90	27.90
Cheshire West and Chester**	20.46	13.27	22.70	28.40
Wirral	21.55	10.21	23.10	26.70
Halton UA	26.00	12.89	25.90	22.70

*Each indicator in the 2011 profiles has a defined data period.

**The Health Profiles are produced on a Local Authority geography which it not always fully co-terminous with PCT geography

Mortality analysis

Table 3a shows the number of deaths for each area for a range of conditions. These figures are not directly comparable as the Halton figure is based on the local authority population whereas the other figures relate to PCT. Halton, with a relatively small population has much fewer deaths than the other areas.

Table 3a: Mortality – CHD, stroke, hypertension – total deaths

Geographic region	Population	All Deaths	CHD	Stroke	Hypertension	Total vascular mortality indicators
Warrington PCT	197,763	1,792	283	148	8	439
Western Cheshire PCT	233,324	2,272	306	214	30	550
Wirral PCT	308,495	3,526	506	389	17	912
Halton UA	119,263	1,106	187	81	6	274

Source: NHS IC Indicator portal 2012

² This is a measure of the percentage of adults who smoke 2009/10

³ This is the percentage of adults participating in moderate intensity sport or activities on 20 days in the last 4weeks

⁴ Modelled estimates of the percentage of adults who are obese.

⁵ Modelled estimates of the percentage of adults who eat healthily.

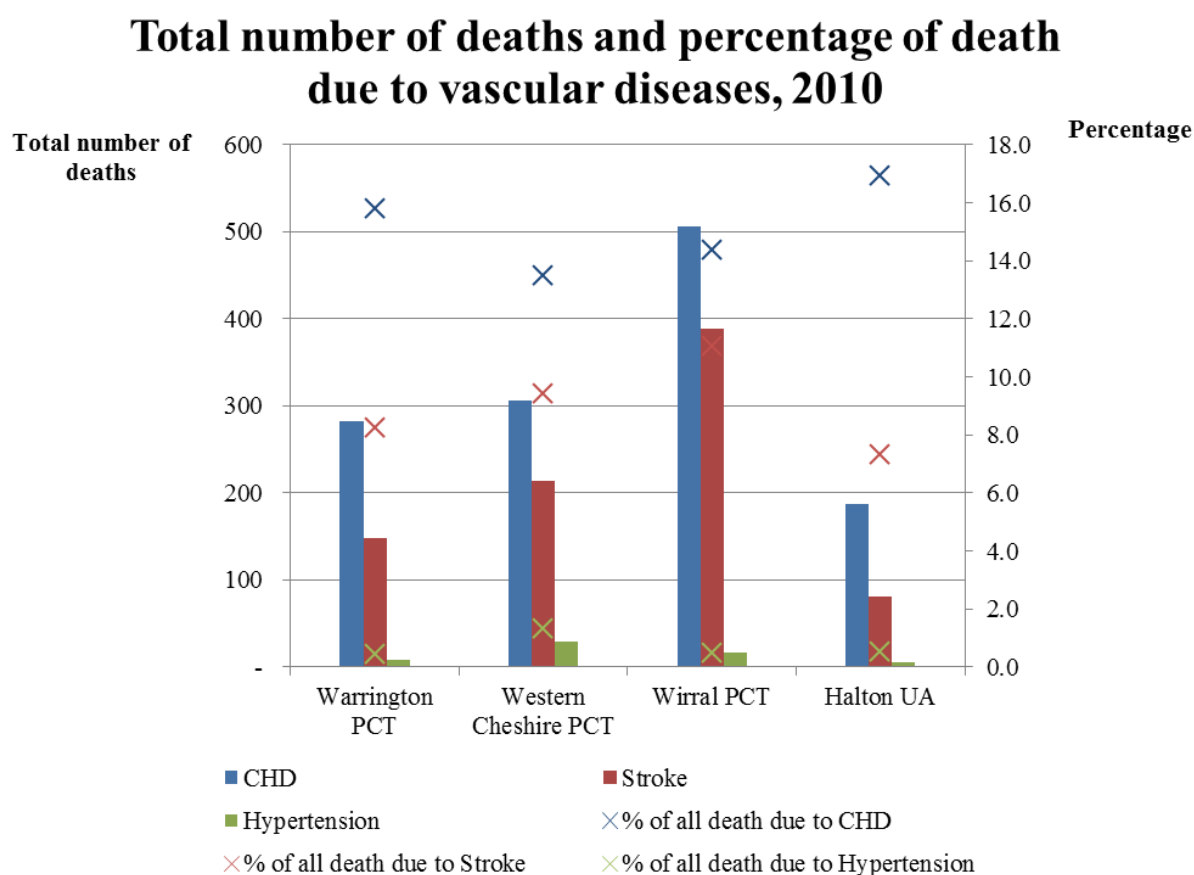
Consistent with the main report, it is important to consider not just numbers but where possible, the rates. Table 3b shows the percentage of all deaths in an area that is due to the selected conditions. While Halton has the fewer number of deaths overall, CHD is a relatively bigger problem in Halton than in any other area with 16.9% of all deaths being attributed to this disease (Figure 2).

Table 3b: Mortality – CHD, stroke, hypertension – Vascular mortality indicators as a percentage of all deaths within Geographic area

Geographic region	Population	All Deaths	Percentage of deaths due to vascular disease			
			% of all death due to CHD	% of all death due to Stroke	% of all death due to Hypertension	Total vascular mortality indicators
Warrington PCT	197,763	100	15.8	8.3	0.4	24.5
Western Cheshire PCT	233,324	100	13.5	9.4	1.3	24.2
Wirral PCT	308,495	100	14.4	11.0	0.5	25.9
Halton UA	119,263	100	16.9	7.3	0.5	24.8

Source: NHS IC Indicator portal 2012

Figure 2: Total number of deaths and percentage of deaths due to vascular diseases, 2010



Source: NHS IC Indicator portal 2012

Conclusion

This brief addendum has been compiled to scope the impact that the inclusion of Halton population data might have on the assessment of the burden of vascular disease across the southern vascular network. Although caution is urged in regards to the comparative mortality data, it is clear that Halton has fewer deaths than the other areas but CHD is a bigger cause of death in Halton than it is in the other areas.

The main report identifies that, in respect of some protected characteristics and risks associated with vascular disease, deprivation is a good proxy. Halton is the most deprived area of the four at upper tier local authority level and the general health profiles (including smoking and obesity rates) show that Halton experiences worse health overall compared to the other local authorities in the southern network. It is not within the scope of this addendum to complete a comprehensive analysis of hospital and primary care data which may describe the health inequality further.

Overall, the inclusion of Halton population data does appear to have pertinence to the general picture of disease in the network. The markedly different age profile combined with the higher deprivation and a summary comparison of mortality numbers suggests there could be considerations to be made in respect of the protected characteristics along the lines of those already made for Warrington and the protected characteristic of age. If a further geospatial analysis is conducted focussing on transport access, the relative deprivation of Halton will also play a key part. The main report concludes that in the interests of promoting equality, commissioners will need to balance the arguments of the greater number of people requiring treatment against the greatest likelihood that people will need treatment. This summary data presentation appears to suggest that the inclusion of Halton population data would make a particular contribution to the likelihood of requiring treatment dimension.



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