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**About ISD**

Scotland has some of the best health service data in the world combining high quality, consistency, national coverage and the ability to link data to allow patient based analysis and follow up.

Information Services Division (ISD) is a business operating unit of NHS National Services Scotland and has been in existence for over 40 years. We are an essential support service to NHSScotland and the Scottish Government and others, responsive to the needs of NHSScotland as the delivery of health and social care evolves.

**Purpose:** To deliver effective national and specialist intelligence services to improve the health and wellbeing of people in Scotland.

**Mission:** Better Information, Better Decisions, Better Health

**Vision:** To be a valued partner in improving health and wellbeing in Scotland by providing a world class intelligence service.

**Official Statistics**

Information Services Division (ISD) is the principal and authoritative source of statistics on health and care services in Scotland. ISD is designated by legislation as a producer of ‘Official Statistics’. Our official statistics publications are produced to a high professional standard and comply with the Code of Practice for Official Statistics. The Code of Practice is produced and monitored by the UK Statistics Authority which is independent of Government. Under the Code of Practice, the format, content and timing of statistics publications are the responsibility of professional staff working within ISD.

ISD’s statistical publications are currently classified as one of the following:

- National Statistics (ie assessed by the UK Statistics Authority as complying with the Code of Practice)
- National Statistics (ie legacy, still to be assessed by the UK Statistics Authority)
- Official Statistics (ie still to be assessed by the UK Statistics Authority)
- other (not Official Statistics)

Further information on ISD’s statistics, including compliance with the Code of Practice for Official Statistics, and on the UK Statistics Authority, is available on the [ISD website](http://www.isd.scot).
Introduction

The Heart Disease and Stroke Programme aims to provide a "patient-centred" data and information service to support the drive for improvements in care and services for patients with heart disease or stroke.

This publication relates to the annual update of Heart Disease (both Coronary Heart Disease (CHD) and other types of heart disease) statistics including information at NHS Board, Local Council and Community Health Partnership level. Hospital activity, operations, incidence, prevalence, survival and prescribing data to 31 March 2010 and mortality data to 31 December 2009 are included in this release.

Coronary Heart Disease, also known as Ischaemic Heart Disease, is a preventable disease which kills around 8,000 people in Scotland every year.

The disease is caused when the heart's blood vessels, the coronary arteries, become narrowed or clogged and cannot supply enough blood to the heart. This can cause a heart attack, chest pain or angina. Almost forty thousand people suffer from angina and eleven thousand people have a heart attack annually in Scotland.

CHD is a priority in Scotland where prevalence of the associated risk factors such as smoking, diet and physical inactivity is high and around 7% of men and 5% of women are living with coronary heart disease (Scottish Health Survey 2009).

The Scottish Government published their strategy document Better Heart Disease and Stroke Care Action Plan in June 2009 and this confirmed that heart disease would continue to be a national clinical priority for NHSScotland.
Key points

- The age-standardised mortality rate (for under 75s) for Coronary Heart Disease (CHD) continues to fall, from 124.6 per 100,000 population in 1995 to 50.4 per 100,000 population in 2009. The target to reduce the mortality rate by 60% between 1995 and 2010 has very nearly been achieved. The fall was 59.6%.

- 30 day survival following emergency admission for an AMI increased from 83.1% in 2000-01 to 87.8% in 2008-09 and 89.0% in 2009-10.

- Between 2008/09 and 2009/10 the incidence rate for HD (total number of people diagnosed with HD per 100,000 population, standardised by age and sex) decreased by 5.1%. (from 294.8 cases per 100,000 population for 2008/09 to 279.7 cases per 100,000 population in 2009/10.

- The number of revascularisation procedures (Coronary Artery Bypass Grafts and Coronary Angioplasties) performed by NHSScotland increased between 2008/09 and 2009/10. The standardised rate remained stable over the latest 4 to 5 years. Reductions in coronary artery bypass operations are offset by increases in the number of coronary angioplasties being performed.

- The number of prescriptions for cardiovascular disease (both coronary heart disease and cerebrovascular disease) increased by 61% in the last decade (from 15 million in 2000/01 to 25 million in 2009/10). The associated costs over the same period rose by a fifth, from £150 million to £187 million, and reached a peak of £230 million in 2004/05 before reducing to £187 million in 2009/10.
Results and Commentary

Data for year ending 31 Mar 2010 based on hospital discharges is provisional but we estimate that we have over 99% of all acute hospital discharge records.

The introduction of more sensitive tests for the diagnosis of acute coronary ischaemia - e.g. troponin - and the incorporation of troponin (and other biomarkers) levels in definitions of acute myocardial infarction (AMI), may have affected the recording of AMI over recent years. Since it is likely that cases previously undiagnosed would now be correctly determined as AMI, it may be that the size of downward trends in the incidence of AMI has been understated in the SMR01 data. Variations in the definition, recording and coding of AMI may affect inter-hospital and inter-Health Board comparisons of AMI incidence, prevalence and post-AMI survival. ISD issued coding guidance in June 2007 covering the recording of troponin levels in acute coronary syndromes- see Coding Guidelines Number 20.

Mortality

The age-standardised mortality rate (for under 75s) for Coronary Heart Disease (CHD) continues to fall, from 124.6 per 100,000 population in 1995 to 50.4 per 100,000 population in 2009. The target to reduce the mortality rate by 60% between 1995 and 2010 has almost been achieved (59.6%) (see Table MC2).

Coronary Heart Disease;
Ages Under 75;
European Age Standardised Mortality Rates per 100,000 Population

Data Source
Registrar General for Scotland - Deaths and Population

Number of deaths is based on the date of registration and main cause of death.

CHD mortality is strongly related to age. For the year ending 31st December 2009 the age-sex standardised mortality rate for 0-44 year olds was 3.7 per 100,000 population
compared to 1,354.2 per 100,000 population for people aged 75 and over (see Table MC1).

The mortality rate from acute myocardial infarction (AMI or heart attack) maintains its steady decline. For the year ended 31st December 2009 the overall AMI death rate was 58.2 per 100,000 population, a reduction of 7.9% from the previous year (see Table MC1).

**Deprivation**

In the 15% most deprived areas in Scotland, the under 75 mortality rate from CHD (standardised by age) decreased slightly from 103.5 in 2008 to 96.6 per 100,000 in 2009. This rate has shown a general decline over from the period 2000 to 2009, although there was a minor rise between 2006 and 2007 (see Table DC3 & Table DC4). Further information and data are available from the Scottish Government's web site "Scotland Performs" section.

**CHD mortality rates among under 75 year olds in the most deprived 15% areas (SIMD*);**

**European age-standardised rate per 100,000**

Data Source  
Registrar General for Scotland - Deaths between 2000 and 2009  
Number of deaths is based on the date of registration.  
Scottish Index of Multiple Deprivation. SIMD 2006 (from years 2000 to 2008) and SIMD 2009 (from year 2009 onwards) have been used at Scotland level.

There is a strong positive relationship between deprivation and CHD mortality rates. This relationship is evident for all ages but is strongest in the 0-64 age group. The 0-64 SMR is approximately 4.5 times higher in the most deprived tenth, compared to the least deprived (see Table DC1).

The relationship between operation rates and deprivation in any age/sex group does not reflect the strong relationship between CHD mortality and deprivation. Table DC2 shows
the ratio between the actual number of interventions performed and the number expected. The expected number is calculated using national procedure rates, taking into account the age and sex composition of the population, and the level of disease as measured by the relative level of CHD mortality in each deprivation decile. The figures show fewer interventions performed than expected for the more deprived areas - a finding first reported in the CHD and Stroke Task Force Report. Since there is no evidence that less deprived patients are having inappropriate interventions, the findings indicate inequity of access to, uptake of, or supply of interventions to more deprived populations (see Table DC2).

Over the decade 2000-2009 mortality rates among all deprivation quintiles reduced but the age-sex standardised rate among the most deprived category remained approximately 1.5 to 2 times that of the least deprived category in each year (see Table DC7).

Survival

30 day survival for patients admitted as emergencies with AMI has improved over the period 2000/01 - 2009/10 from 83.1% to 89.0% (see Table S1). For those aged 75 and over the figures were 68.6% in 2000/01 rising to 78.7% in 2009/10.

30 day survival for patients admitted as emergencies with heart failure has improved over the period 2000/01 - 2009/10, from 82.4% to 85.5% (see Table S3).

Incidence

Incidence (new cases) of HD has also been decreasing over the past decade, reducing by almost a fifth over the period 2000/01 to 2009/10. The number of acute myocardial infarctions (AMI or heart attacks) had decreased from 13,279 in 2000/01 to 10,419 in 2007/08 but increased to 11,337 in 2008/09 with a further slight increase to 11,449 in 2009/10. The recent increase is due to the change in the clinical definition of AMI, based on more sensitive tests - i.e. troponin (see Table IC2).

Between 2008/09 and 2009/10 the incidence rate for HD (total number of people diagnosed with HD per 100,000 population, standardised by age and sex) decreased by 5.1%. (from 294.8 cases per 100,000 population for 2008/09 to 279.7 cases per 100,000 population in 2009/10 (see Table IC1).

Incidence is related to age - the rate for under 75s in 2009/10 is 207.8 per 100,000 and for over 75s for the same period 203.2 per 100,000 (see Table IC1).

Heart disease incidence rates are consistently higher for males than females across all age groups (see Table IC1).

Prevalence

The estimated prevalence of coronary heart disease based on admission to hospital is 3.3% of the Scottish population. Prevalence is higher in males (4.2%) than in females (2.5%) and is strongly related to age (see Table PV1).

An estimated 16% of the Scottish population aged 75+ is living with coronary heart disease (CHD). In some, more deprived, community health partnerships around 25% of men aged 75+ have CHD (see Table PV1).
The highest all-ages prevalence rate is 4.6% in Inverclyde Community Health Partnership (CHP) for males and females combined. This is double the rate in West Glasgow (2.3%), the CHP with the lowest all-ages prevalence (see Table PV1).

The effect of deprivation on prevalence amongst the younger population can be seen in the 45-64 age group. The prevalence rate in males aged 45-64 in North Glasgow (8.5%) is more than double that of the rate in Shetland CHP (4.0%). For females aged 45-64 the prevalence rate in North Glasgow CHP (5.3%) is nearly five times that in Orkney CHP (1.1%) (see Table PV1).

**Operations**

The number of Coronary Artery Bypass Graft (CABG) operations decreased from 2,032 in 2008/09 to 1,919 in 2009/10. This follows a slight increase between the years 2006/07 and 2007/08. There is a general downward trend in the numbers of CABG operations reflecting the increased use of percutaneous coronary interventions (angioplasties) in the treatment of coronary artery disease (see Table OC1).

The number of coronary angioplasties increased from 6,374 in 2008/09 to 6,583 in 2009/10, continuing the upward trend of recent years which had seen a minor decrease from 2005/06 to 2006/07 (see Table OC1).

**Angioplasty; All Ages; Scotland; Age-Sex Standardised (European Standard Population) discharge rate per 100,000 population**

<table>
<thead>
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<th>Year</th>
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</tr>
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</tr>
<tr>
<td>2007</td>
<td>220</td>
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<td>330</td>
</tr>
<tr>
<td>2008</td>
<td>240</td>
<td>120</td>
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</tr>
<tr>
<td>2009</td>
<td>260</td>
<td>130</td>
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</tr>
<tr>
<td>2010p</td>
<td>280</td>
<td>140</td>
<td>420</td>
</tr>
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</table>

Data Sources
Registrar General for Scotland - Populations
ISD SMR01
P – Provisional
The number of revascularisation procedures (Coronary Artery Bypass Grafts and Coronary Angioplasties) performed by NHSScotland increased between 2008/09 and 2009/10. The standardised rate remained stable over the latest 4 to 5 years. Reductions in coronary artery bypass operations are offset by increases in the number of coronary angioplasties being performed (see Table OC1).

Coronary angiographies may be done to diagnose coronary artery disease and assist in its treatment. This year's publication splits angiographies in to these two categories. For diagnostic angiographies, with no associated angioplasty, the numbers have reduced in recent years, dropping from 13,164 in 2007/08 to 11,986 in 2008/09 and then 11,700 in 2009/10. For diagnostic angiographies, done in association with angioplasty (i.e. as part of a "follow-on procedure"), the numbers have increased annually in the last few years to their current peak, in 2009/10, of 5,119. This, again, reflects the increased use of percutaneous coronary interventions in the treatment of coronary artery disease (see Table OC1).

The number of discharges involving a valve operation increased by almost 31% between 2007/08 and 2008/09, from 853 to 1,118, but reduced slightly between 2008/09 and 2009/10 to 1,094. This figure remains higher than the average annual number of discharges involving valve surgery during the years 2000/01 to 2009/10 (see Table OC1). The rise may reflect better data capture on the SMR01 database following the establishment of the West of Scotland Heart and Lung Centre at the Golden Jubilee National Hospital. Comparison of SMR01 with the Scottish Coronary Revascularisation Register suggests this could be the case.

The mainland NHS Boards with the highest mortality adjusted operation ratios (a measure of relative level of provision) for coronary revascularisation were Forth Valley and Grampian, for men, and Lanarkshire and Lothian, for women (see Table OC2).

**Hospital Activity**

The number of acute myocardial infarction (AMI or heart attack) discharges increased by 34% from 15,585 in 2007/08 to 20,885 in 2009/10 (see Table AC1). This is probably due to recent changes in the definition of AMI, which uses more sensitive tests (i.e. troponin). The trend in mortality from AMI, and for CHD as a whole, remains downward (see Table MC1).

The number of emergency angina discharges decreased from 7,790 in 2008/09 to 6,245 in 2009/10, a fall of 20% (see Tables AC1, AC2 and AC4).

The number of angina discharges decreased in all ages and both sexes between 2008/09 and 2009/10, from 12,652 to 10,273, a fall of 18.8% (see Tables AC1, AC2 and AC4).

**GP Prescribing**

Over the decade 2000/01 - 2009/10 the numbers of prescriptions dispensed for cardiovascular related drugs continued to rise although the overall costs fell following a peak in the middle of the decade. For 2009/10 the cost of these medicines declined by a smaller proportion than in previous years, falling by under 1% from the preceding year.
compared to previous annual reductions of around 4% to 6%. Costs often reduce as medicines become available in generic form once drug patents expire (see Table G1).

The number of prescriptions for cardiovascular disease (both coronary heart disease and cerebrovascular disease) increased by 61% in the last decade (from 15 million in 2000/01 to 25 million in 2009/10). The associated costs over the same period rose by a fifth, from £150 million to £187 million, and reached a peak of £230 million in 2004/05 before reducing to £187 million in 2009/10 (see Table G1).

The full range of data tables for Heart Disease are available at the following link: File Listings – a full listing
**Glossary**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>Coronary Heart Disease. A group of conditions that includes acute myocardial infarction, angina and heart failure.</td>
</tr>
<tr>
<td>IHD</td>
<td>Ischaemic Heart Disease. Another name for coronary heart disease.</td>
</tr>
<tr>
<td>AMI</td>
<td>Acute Myocardial Infarction, commonly known as a heart attack.</td>
</tr>
<tr>
<td>CABG</td>
<td>Coronary Artery Bypass Graft. An operation in which a blood vessel from another part of the body is grafted between the aorta (the main artery leading from the heart) and the coronary artery, or arteries, to bypass blockages and restore blood flow to the heart muscle.</td>
</tr>
<tr>
<td>Heart failure</td>
<td>Failure of the heart as a pump, the commonest cause being coronary heart disease.</td>
</tr>
<tr>
<td>Angiography</td>
<td>Under the guidance of an x-ray camera, a long, thin tube is threaded into the coronary arteries via a blood vessel in the groin or arm. A dye, which can be seen on the x-ray screen, is then injected, showing the pattern of the coronary arteries, and demonstrating where the artery is narrowed.</td>
</tr>
<tr>
<td>Angioplasty</td>
<td>An operation performed to treat coronary heart disease that involves passing a thin, hollow tube up into the coronary arteries, under x-ray guidance, from an artery in the groin or arm (under local anaesthetic.) A device on the tube is then used to unblock the artery, and stretch the artery walls so that more blood and oxygen can flow to the heart muscle.</td>
</tr>
<tr>
<td>PTCA</td>
<td>Percutaneous Transluminal Coronary Angioplasty. The full name for an angioplasty.</td>
</tr>
<tr>
<td>PCI</td>
<td>Percutaneous Coronary Intervention.</td>
</tr>
<tr>
<td>Revascularisation</td>
<td>Inclusive term referring to CABG and angioplasty procedures.</td>
</tr>
<tr>
<td>Angina pectoris</td>
<td>Recurrent chest pain as a result of coronary heart disease.</td>
</tr>
<tr>
<td>ACS</td>
<td>Acute Coronary Syndrome.</td>
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# List of Tables

<table>
<thead>
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<td>Deprivation Tables</td>
<td>2000-2009</td>
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<td>GP Prescribing Tables</td>
<td>2000/01-2009/10</td>
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<td>AC1,AC2,AC4,AC5</td>
<td>Hospital Activity Tables</td>
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<td>Incidence Tables</td>
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</tr>
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<td>MC1,MC2,MC4</td>
<td>Mortality Tables</td>
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<td>OC1,OC2,OC3,OC5,OC6</td>
<td>Operations Tables</td>
<td>2000/01-2009/10</td>
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<td>PV1</td>
<td>Prevalence Tables</td>
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<td>S1,S3</td>
<td>Survival Tables</td>
<td>2000/01-2009/10</td>
<td>Excel [various]</td>
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</tbody>
</table>
**Contact**

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**Further Information**

Further information on heart disease can be found on the [Heart Disease](#) area of the ISD website.

Corresponding information on stroke and cerebrovascular disease can be found on the [Stroke](#) area of the ISD website.

Further information on other ISD publications and datasets can be found on the [ISD website](#).
Appendix

A1 – Background Information

Heart Disease & Stroke

Coronary heart disease (CHD) is a disease of the heart and coronary arteries caused by the build up of fatty materials in the blood vessels that supply the heart with oxygen. This can cause a heart attack, chest pain or angina. Cerebrovascular Disease, which includes cerebrovascular accident/stroke and transient ischaemic attack (TIA), is responsible for the deaths of more than 5,000 people in Scotland every year. A stroke or TIA happens when the blood supply to part of the brain is interrupted and the brain cells are starved of oxygen. This usually occurs because a blood vessel becomes blocked. Stroke is more common in people over the age of 65.

Risk factors associated with CHD & stroke

The main preventable risk factors for coronary heart disease and stroke are smoking, lack of exercise and a poor diet. Research also indicates a strong relationship between social deprivation and these risk factors.

Detailed information on the prevalence of these risk factors is available from the Scottish Health Survey, the latest available survey being 2008. The 2003 survey included a specific report on Cardiovascular Diseases. You may also wish to refer to previous Scottish Health Survey reports from 1995 and 1998. Currently the Scottish Health Survey is running continuously from 2008-2011.

Scottish Health Survey 2009
Scottish Health Survey 2008
Scottish Health Survey 2003
Scottish Health Survey 2003 Cardiovascular Disease Report
Scottish Health Survey 1998
Scottish Health Survey 1995

Policy Context

NHSScotland service provision for patients with coronary heart disease and stroke operates within the framework of policy devised by the Scottish Government. A chronology of policy documents that steer service provision for CHD & stroke patients is outlined below.

Coronary Heart Disease & Stroke Task Force (2001)
Coronary Heart Disease & Stroke Strategy for Scotland (2002)
Delivering for Health (2005) (Scottish Government response to the "Kerr" report "Building a health service fit for the future")
Better health, better care - action plan. (2007)
Better heart disease & stroke care action plan (2009)

The Scottish Government, in their 2009 action plan, reiterate their target of reducing premature mortality from coronary heart disease by 60% between 1995 and 2010. Our latest published information on the trend in CHD mortality among under 75s (Table MC2) indicates the mortality rate fell from 124.6 per 100,000 in 1995 to 50.4 per 100,000 in 2009, achieving a 60% reduction a year in advance of the target.

Data Quality

ISD’s Data Quality Assurance team was established in 1990. The team is experienced in clinical coding and in other aspects of medical records and information work. Its main remit is the routine assessment of the quality of data held on the national SMR database.

The most recent report "Towards Better Data from Scottish Hospitals: An Assessment of SMR01 and Associated Data 2004 - 2006" [1.77Mb] was published in September 2007 and may be viewed or downloaded.

The report contains sub-sections on specific conditions and interventions, including some related to coronary heart disease.

In hospital discharge data, clinical information for diagnoses and operations/interventions is currently recorded using, respectively, ICD10 (the International Classification of Diseases 10th Revision maintained by the World Health Organization (WHO)) and OPCS4 (the Office of Population Censuses & Surveys 4th Revision Classification of Surgical Operations and Procedures maintained by the Department of Health’s directorate NHS Connecting for Health (CfH)).

For ICD10 codes, see http://www.who.int/classifications/icd/en/ (WHO) and for OPCS4 codes see http://www.connectingforhealth.nhs.uk/systemsandservices/data/clinicalcoding/codingstandards/opcs4 (CfH). For an extract of OPCS4 codes related to the heart see the file below.

See the Extract from OPCS4 Classification of Surgical Operations and Procedures (Heart) [91kb] for details of the heart operations and procedures in its Chapter K. This document should be read in conjunction with the NHS Connecting for Health document Summary of Changes from OPCS-4.4 to OPCS-4.5 [118kb] for details of the latest updates to the coding classification.

Independent & voluntary sector

Although there are a number of independent & voluntary sector organisations involved in the provision of information and services to CHD & stroke patients, two of the main ones, with links to NHSScotland, are the British Heart Foundation (BHF) and Chest, Heart & Stroke Scotland (CHSS). Both organisations are involved in the funding of research and provide extensive information for patients and carers on their respective web sites at http://www.bhf.org.uk/ and http://www.chss.org.uk/
Further Information

Our "Links to other sources" section offers a few examples of other information sources..
## A2 – Publication Metadata (including revisions details)

<table>
<thead>
<tr>
<th>Metadata Indicator</th>
<th>Description</th>
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<tr>
<td>Publication title</td>
<td>Heart Disease Statistics</td>
</tr>
<tr>
<td>Description</td>
<td>Annual update of heart disease statistics. A full update including mortality, hospital activity and operations, incidence and prescribing.</td>
</tr>
<tr>
<td>Theme</td>
<td>Health and Social Care</td>
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<td>Date that data is acquired</td>
<td>Jan-11</td>
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<tr>
<td>Release date</td>
<td>22-Feb-2011</td>
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<tr>
<td>Frequency</td>
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<tr>
<td>Timeframe of data and timeliness</td>
<td>10 years annual data up to 31-Mar-2010.</td>
</tr>
<tr>
<td>Continuity of data</td>
<td>The introduction of more sensitive tests for the diagnosis of acute coronary ischaemia - e.g. troponin - and the incorporation of troponin (and other biomarkers) levels in definitions of acute myocardial infarction (AMI), may have affected the recording of AMI over recent years. Since it is likely that cases previously undiagnosed would now be correctly determined as AMI, it may be that the size of downward trends in the incidence of AMI has been understated in the SMR01 data. Variations in the definition, recording and coding of AMI may affect inter-hospital and inter-Health Board comparisons of AMI incidence, prevalence and post-AMI survival. ISD issued coding guidance in June 2007 covering the recording of troponin levels in acute coronary syndromes- see <a href="#">Coding Guidelines Number 20</a>.</td>
</tr>
<tr>
<td>Revisions statement</td>
<td>No revisions have occurred and there are no revisions planned.</td>
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<tr>
<td>Concepts and definitions</td>
<td>See <a href="#">Glossary</a> and <a href="#">A1</a> (Appendix 1) contained within this report.</td>
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<td>Relevance and key uses of the statistics</td>
<td>Monitoring of Scottish Government target to reduce premature mortality due to CHD between 1995 and 2010. Other uses of the data include information requests for a variety of customers, e.g. research charities; public companies; freedom of Information requests; information support to Boards;</td>
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<tr>
<td><strong>Accuracy</strong></td>
<td>SMR01 data are subjected to validation on submission. The figures are compared to previous years' figures and to expected trends. The SMR01 data are also occasionally assessed for accuracy by ISD's Data Quality Assurance – see <a href="http://www.isdscotland.scot.nhs.uk/Products-and-Services/Data-Quality/Previous-Projects/">http://www.isdscotland.scot.nhs.uk/Products-and-Services/Data-Quality/Previous-Projects/</a>.</td>
</tr>
<tr>
<td><strong>Completeness</strong></td>
<td>SMR01 data for year ending 31 Mar 2010 based on hospital discharges is provisional but we estimate that we have over 99% of all acute hospital discharge records.</td>
</tr>
<tr>
<td><strong>Comparability</strong></td>
<td>Data relating to CHD activity in English hospitals is available from <a href="http://www.hes.nhs.uk">Hospital Episode Statistics</a>. Mortality from specific causes, including heart disease, in England and Wales is available from the <a href="http://www.ons.gov.uk">Office for National Statistics</a>.</td>
</tr>
<tr>
<td><strong>Accessibility</strong></td>
<td>It is the policy of ISD Scotland to make its web sites and products accessible according to published guidelines.</td>
</tr>
<tr>
<td><strong>Coherence and clarity</strong></td>
<td>Relevant key statistics are presented on each <a href="http://www.isdscotland.scot.nhs.uk/Topics">Topic Area</a> page. Statistics are presented within Excel spreadsheets. Geographical areas and national figures are presented using drop down menus. Further features to aid clarity: 1. Tables use drop down menus to display data by Age Band, Diagnostic, Procedure and other Groupings. 2. Key data presented graphically. 3. Each Excel workbook contains a notes page.</td>
</tr>
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<td><strong>Official Statistics designation</strong></td>
<td>National Statistics</td>
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<td><strong>UK Statistics Authority Assessment</strong></td>
<td>Not yet submitted for assessment.</td>
</tr>
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<td><strong>Help email</strong></td>
<td><a href="mailto:dclark5@nhs.net">dclark5@nhs.net</a></td>
</tr>
<tr>
<td><strong>Date form completed</strong></td>
<td>16-May-2011</td>
</tr>
</tbody>
</table>
A3 – Early Access details (including Pre-Release Access)

Pre-Release Access
Under terms of the "Pre-Release Access to Official Statistics (Scotland) Order 2008", ISD are obliged to publish information on those receiving Pre-Release Access ("Pre-Release Access" refers to statistics in their final form prior to publication). The standard maximum Pre-Release Access is five working days. Shown below are details of those receiving standard Pre-Release Access and, separately, those receiving extended Pre-Release Access.

Standard Pre-Release Access:
- Scottish Government Health Department
- NHS Board Chief Executives
- NHS Board Communication leads

Extended Pre-Release Access
Extended Pre-Release Access of 8 working days is given to a small number of named individuals in the Scottish Government Health Department (Analytical Services Division). This Pre-Release Access is for the sole purpose of enabling that department to gain an understanding of the statistics prior to briefing others in Scottish Government (during the period of standard Pre-Release Access).

- Scottish Government Health Department (Analytical Services Division)

These statistics will also have been made available to those who needed access to ‘management information’, ie as part of the delivery of health and care:

These statistics will also have been made available to those who needed access to help quality assure the publication: