Health equity in primary care:
Cardiovascular disease, diabetes and COPD in inner east London

Summary
Final Report

Funded by the Health Foundation
Based in the Clinical Effectiveness Group
Working in partnership with Social Action for Health and NHS Tower Hamlets
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Executive summary

- For the three long term conditions targeted by this project we have demonstrated inequalities in disease process and outcomes by gender, age and ethnicity.

- Inequalities of service provision are often hidden and difficult to identify. The use of health equity audits helped to demonstrate differences which could then be addressed by primary care teams.

- Analysis over 3 years showed improvement across all three local PCTs for most disease indicators. Inequalities in Tower Hamlets were not reduced in comparison to neighbouring PCTs. Health inequalities are persistent and need continuing review.

- Practices are keen to know about health inequalities in the PCT, and their performance relative to their peers and national benchmarks. Facilitated network meetings were very productive.

- The GP/Practice Nurse survey showed good support for disease specific self management programmes but less for generic ‘expert’ patient programmes.

- We developed evaluation of self-management courses with a local provider (Social Action for Health). This partnership approach was responsive to community needs and showed the value of their locally designed courses involving physical activity.

- Qualitative work highlighted the need for improved methods of referral to self-management courses, targeted, flexible and on-going courses and better planning and promotion.

- In spite of many good local schemes, self management groups often remain disconnected from practices and patients. High turnover of schemes, variable referral methods, and lack of practice feedback are problems which need addressing.

Recommendations for Tower Hamlets PCT

- Continue support for practices and networks by CEG in the form of PCT-level equity audits. Audits should be supported by face to face facilitation at practice and network level.

- Maintain the dialogue with service providers using facilitators to ensure successful engagement of stakeholders and continuity of services.

- Develop a PCT wide ‘health equity dashboard’ to monitor progress in the reduction of health inequalities by age, gender, ethnicity and in vulnerable groups in common chronic diseases.

- PCT wide focus on publicity, self referral mechanisms and a single point of entry for health professional referral to self management groups.

- Use key points from the project experience as a fact sheet on Health Inequalities. This will contribute to the Public Health Joint Strategic Needs Assessment for Tower Hamlets.
1. Project background

Tackling health inequalities is a key aim of UK Government health policy. However, in spite of a range of national and local initiatives mortality differences by social class have widened over the last 20 years. The recent Marmot review ‘Fair Society: Healthy lives’ illustrates a continuing mortality gradient of seven years between the richest and the poorest groups in society, and a gap of 17 years of disability free life expectancy when compared across neighbourhood incomes in England. With an inequality gradient as steep as this there is little benefit in just attending to those at the bottom. The effects of inequality are felt, to some degree, by everyone below those at the top of the slope. Universal action is required to reduce the slope of the gradient, to allow the effect of the intervention to be felt throughout the population.

Tower Hamlets is one of the ‘Spearhead localities’, areas with the highest levels of social deprivation and premature mortality. The national focus is to reduce the inequalities in outcomes between the Spearhead areas and the rest of the UK. This project focuses on reductions in inequality in three major chronic diseases; coronary heart disease, diabetes and COPD.

Over half of the Tower Hamlets population comes from ethnic minority groups, with the majority from Bangladesh. There is a responsibility to examine health inequalities from the perspective of ethnicity, alongside age, gender and social deprivation.

The project is located in the Clinical Effectiveness Group (CEG) based in Queen Mary University of London. For the past ten years, CEG has supported general practice development and the management of chronic disease through the provision of local guidelines, audit and practice based facilitation. For the past five years CEG has developed and supported practice level ethnicity recording in the whole population, and particularly in chronic disease registers. This information can be used in the development of local health policy, for responsive local services and to assess the equitable provision to ethnically diverse populations. High levels of ethnicity recording have been an essential prerequisite for much of the health equity work done by the project team.

Table 1.1 Progress in ethnicity recording. % recording in the last five years in east London practices.

<table>
<thead>
<tr>
<th>Year</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>East London registered population</td>
<td>757,481</td>
<td>802,689</td>
<td>817,927</td>
<td>843,910</td>
<td>843,710</td>
<td>894,579</td>
</tr>
<tr>
<td>Total</td>
<td>38%</td>
<td>48%</td>
<td>62%</td>
<td>70%</td>
<td>78%</td>
<td>80%</td>
</tr>
<tr>
<td>IHD register</td>
<td>79%</td>
<td>85%</td>
<td>91%</td>
<td>96%</td>
<td>97%</td>
<td>98%</td>
</tr>
<tr>
<td>COPD register</td>
<td>74%</td>
<td>84%</td>
<td>99%</td>
<td>96%</td>
<td>98%</td>
<td>98%</td>
</tr>
<tr>
<td>Diabetes register</td>
<td>83%</td>
<td>88%</td>
<td>94%</td>
<td>98%</td>
<td>98%</td>
<td>98%</td>
</tr>
</tbody>
</table>

To find out more about the work of the Clinical Effectiveness Group in east London visit: [http://www.ihse.qmul.ac.uk/chs/ceg/index.html](http://www.ihse.qmul.ac.uk/chs/ceg/index.html)
2. Evidence of health inequalities in east London: baseline inequalities in the three target chronic diseases for localities in inner east London (Tower Hamlets, Newham, City and Hackney)

Coronary Heart Disease

Table 2.1 illustrates that among people on the CHD registers in all the 139 practices in the three inner east London primary care trusts of City and Hackney, Newham and Tower Hamlets, those over 85 years are least likely to be on statin treatment. Those aged 65-74 are the most likely to be on a statin. Gender differences in beta blocker prescribing are observed with men being one third more likely to receive medication than women.

Table 2.1 Prescribing in the IHD register 2007

<table>
<thead>
<tr>
<th>Age group</th>
<th>Statins</th>
<th>Odds Ratio</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>45-54 (reference group)</td>
<td>1,970</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>55-64</td>
<td>3,235</td>
<td>1.2</td>
<td>(0.98, 1.46)</td>
</tr>
<tr>
<td>65-74</td>
<td>4,821</td>
<td>1.34</td>
<td>(1.07, 1.68)</td>
</tr>
<tr>
<td>75-84</td>
<td>8,695</td>
<td>0.98</td>
<td>(0.80, 1.20)</td>
</tr>
<tr>
<td>≥85</td>
<td>1,087</td>
<td>0.32</td>
<td>(0.25, 0.40)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>Beta Blockers</th>
<th>Odds Ratio</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female (reference group)</td>
<td>4,501</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>7,632</td>
<td>1.37</td>
<td>(1.27, 1.48)</td>
</tr>
</tbody>
</table>

Odds ratios are adjusted for ethnicity, age, gender and locality
Diabetes

Figure 2.2 illustrates that White people have a significantly lower mean HbA1c level than either Black African/Caribbean or south Asian people. These figures are adjusted for the different age groups within these populations and include all individuals on the diabetic disease register in the three inner east London PCTs.

**Figure 2.2** Mean HbA1C levels by ethnicity in the diabetic register 2007

![Graph showing mean HbA1C levels for different ethnicities.](image)

Diabetic register size 34,359, Mean HbA1C adjusted for age, gender, and locality.

Chronic Obstructive Pulmonary Disease (COPD)

Table 2.3 illustrates that White people are far more likely to continue smoking with a COPD diagnosis than either Black African/Caribbean or South Asian people (using multiple linear regression these significant differences persist even when adjusted for age and gender).

**Table 2.3** Proportion of people on the COPD register who are still smoking 2007 (unadjusted rates)

<table>
<thead>
<tr>
<th>COPD registered patients</th>
<th>% still smoking</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>43.3</td>
</tr>
<tr>
<td>South Asian</td>
<td>28.1</td>
</tr>
<tr>
<td>Black</td>
<td>25.3</td>
</tr>
<tr>
<td>Other</td>
<td>42.6</td>
</tr>
<tr>
<td>Not recorded</td>
<td>39.5</td>
</tr>
<tr>
<td><strong>Overall rate</strong></td>
<td><strong>40.4</strong></td>
</tr>
</tbody>
</table>

COPD register size 7,531

For full details of the tables from which these figures are drawn please see the full report and appendix.
3. Project Aims

The Health Equity project had two major workstreams. One with general practice teams in Tower Hamlets to deliver health equity audits to each practice; the other with the PCT and local providers of self management groups, to link generic and disease specific courses to the patient pathway.

**General Practice Teams**
- Health equity audits
- Practice facilitation
- Template prompts
- Case management prompts
- Pathways into self management groups

**Self Management Programs**
- Self management integrated into primary care pathway
- Provide generic (EPP) programmes
- Disease specific groups
- Exercise Maintenance

1. Developing and disseminating Health Equity Reports to each GP practice in Tower Hamlets
We aimed to develop individual GP practice health equity reports to demonstrate any inequalities in provision and utilisation and facilitate improvement where necessary.

2. Developing self-management programmes as a core component of the disease pathway for CHD, diabetes, and COPD
The project also aimed to develop the use of self management programmes by linking existing self management courses to the GP care pathways for CHD, diabetes and COPD.

Strategies to achieve this goal included:
- Computer prompts in chronic disease templates to remind staff to refer to self management courses.
- Work with course providers to facilitate GP referrals and to improve course evaluation.
- Work with the PCT to ensure that sufficient self management courses were commissioned.
- A survey of clinicians understanding and use of self management groups.
4. Practice Health Equity Reports

Developing Health Equity reports for practice teams

The Health Equity Project wanted to display information visually to actively engage practice teams in discussions about the findings for each chronic condition.

We identified key indicators for each condition and built the information into the charts below.

Figure 4.1 Building the health equity reports for practices

For further details and for an example of a practice equity audit report please see the appendix.
Report dissemination, facilitation and feedback

Year 1 (2008)

Printed and email copies of individual practice health equity reports were sent to all clinicians in the 38 general practice teams in Tower Hamlets. Facilitation was available on request, but was focused at the 10 practice teams where there was most evidence of differences between groups, and where we felt the intervention would have the greatest impact.

The format of the visit included a short presentation on the background to the project, a discussion focused on understanding the practice level report, and further discussion to identify some of the clinical areas which the team found challenging. Common areas of concern included:

- Inexperience in more intensive blood pressure and lipid treatments
- Problems with patient recall, particularly with groups spending time in Bangladesh
- Poor access to lifestyle change (self management) courses

The feedback forms from practices and facilitators can be summarized as follows:

What did the practices think?
- Reports were seen as interesting but complex. Practices valued comparisons with local peers.
- Reports were seen as using ‘old’ data, from the previous year. Real time data was wanted.

What did the facilitators think?
- The reports were a tool to get practices talking about chronic disease management.
- Clinical conversations covered prescribing and behaviour change.
- Lack of patient recall systems and local lifestyle support groups were key themes

Using the feedback from these visits we
- made the format simpler in year 2
- Reviewed the clinical support which the CVD nurses provided to practices
- Identified commissioning gaps for supporting services

Report dissemination, facilitation and feedback

Year 2 (2009)

For year 2 we undertook the practice facilitation at network level. Groups of 4 or 5 practices form networks which work together on a ‘federated practice’ basis sharing educational events. A clinical lead and CVD nurse attended learning events in 6 of the 8 Tower Hamlets networks. The meetings included a brief overview of the network report and aimed to generate discussion from clinical scenarios to encourage participants to identify solutions to common problems in CHD/Diabetes/COPD management. This was a more efficient method of practice education; the larger numbers of participants made the meetings more interactive and enabled the sharing of ideas for managing complex problems.
Mapping the self management menu
We mapped self-management courses and identified three broad categories: generic self management (expert patient programmes), disease specific self management courses and exercise programmes. We summarised the current evidence base for the different types of self management group. (see Appendix 3 Self management mapping report).

Figure 5.1 The self management menu

Generic Self-management

EPP = Expert Patient Programme.
DIANA = Daily Insulin Adjustment to Nutrition and Activities
HAMLET = Hands-on Approach to Motivation and Lifelong Empowerment Training

Linking self management programmes to the chronic disease pathway
The project worked with both NHS Tower Hamlets and practices to extend the range of generic and disease specific self management groups (SMGs), and to link them more effectively with general practice care pathways. The methods we used to do this included:

1. Including computer template prompts for course referral.
2. Work with the PCT to develop a single point of referral into these programmes and courses.
3. Installing self management referral forms on practice computers
4. Using the practice chronic disease register for invitations thus linking the providers of SMGs to practices
Assessing primary care clinicians’ understanding and use of self management groups

In January 2009 a survey of all health care professionals (GPs, nurse practitioners, practice nurses) from all GP practices in Tower Hamlets was undertaken to explore understanding of and current referral rates to generic self-management groups (SMGs), such as the expert patient programme (EPP) and disease-specific self-management courses such as HAMLET (for diabetes) and pulmonary rehabilitation (for COPD).

One hundred health care professionals (37%) responded from 31 of the 38 practices. 88% of responders had heard of the EPP and 76% were aware of the courses based within Tower Hamlets. However 52% were not aware of the referral process to self management groups. (See appendix 4 for a copy of the questionnaire). Figure 5.2 illustrates the low level of referrals to EPP courses initiated by primary care teams.

Figure 5.2 Referrals to expert patient programmes in the last year by health care professionals

Feedback and views on self management courses

In general respondents were more positive about disease specific courses, than the generic EPP.

Improved uptake of generic courses will depend on a PCT wide focus on publicity, self referral mechanisms and a single point of entry for health professional referral.

Disease specific SMGs showed better attachment to disease management pathways.
**Evaluation of the ‘Good Moves’ Self Management group**

We evaluated Good Moves courses which were developed by Social Action for Health as a hybrid self management/exercise course. They included the self efficacy elements of the EPP programme, but also additional sessions on diet, physical activity, diabetes and heart disease. Initial findings using the SF-36 showed an improvement in the mental and physical health of the participants \( n=284 \) patients attending 20 courses between January and June 2009, 166 of the patients had pre and post course SF-36 scores.

**Comparison of the generic EPP courses with the Good Moves courses**

Having established the benefit to patients of the Good Moves course we wanted to compare it with a locally run generic EPP course. Once again we used the SF-36 scores before and after course attendance as the evaluation tool.

The sample included 189 patients attending one of 17 EPP courses in Tower Hamlets run by Social Action for Health between July 2007 and April 2009. 137 \( (72\%) \) of these patients had pre and post SF-36 scores, 52 \( (28\%) \) of patients had at least one missing pre or post SF-36 score. The Good Moves course sample was made up of 284 participants and is described in the previous section.

Using multiple regression our analysis adjusted for gender, age and co-morbidities. This model used the 292 \( (62\%) \) patients who had no missing data. The average increase in physical health score of the Good Moves course is significantly \( (p=0.015) \) greater by 6.4 points in comparison to the EPP course \( (95\% \text{ CI: } 1.3, 11.5) \).

The average increase in physical health score of the Good Moves course is significantly \( (p<0.001) \) greater by 11.2 points in comparison to the EPP course \( (95\% \text{ CI: } 5.7, 16.6) \).

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**In Tower Hamlets self-management courses attendees are generally Bangladeshi, have at least one health problem, are over 36 years old and more likely to be women.**

Over 75\% of patients heard about these courses through a friend, indicating the importance of ‘word of mouth’ as a recruitment method.

Those attending Good Moves are younger, fitter and healthier than those attending the EPP courses.

Attending the Good Moves course improves a patient’s physical and mental health more than attending an EPP course.

The Good Moves course was considered more user friendly and enjoyable, and is more applicable to the Tower Hamlets population than the standard EPP programme.
Qualitative study exploring factors influencing attendance at self-management programmes in Tower Hamlets

Aims
The purpose of this nested qualitative study was to explore the views of both attendees and non-attendees of the SMGs in Tower Hamlets.

Background
In Tower Hamlets both course commissioners and course providers of self management groups find that attendance at the courses is often low, with high rates of drop out and non-attendance. The views of people who attended these courses were sought to identify what factors facilitated their attendance and the barriers to attendance.

Methods
Qualitative methodology with purposive sampling and a topic guided approach was used. The perspectives of attendees were explored through 20 face to face interviews, and 10 short telephone interviews explored perspectives of non-attendees. The data was translated and transcribed by researchers at Social Action for Health. All respondents were South Asian. The interviews were all conducted in Bengali. The face to face interviewees were aged between 26-65 years and 50% were male. The telephone interviewees were not asked their age, 70% of them were male.

Results
For attendees, encouragement by family, friends and the GP along with a friendly approach by the course provider increased their motivation to attend. For non-attendees, the major reasons why people declined to attend or dropped out, included; physical health issues, family and work commitment.

“I was interested but could not manage to get there because my daughter in law was admitted to hospital and I needed to look after the family and her children”

“I was interested in the first place…. I have a full time job and have a big responsibility to look after my family”

“I declined the invitation because I was very ill. I also have a problem with hearing. I like to go outside, but I can’t”

Courses should be more effectively marketed for the target population
Courses need to be flexible to the requirements of attendees
Courses should be run frequently, and allow people to dip in and out as their other commitments allow
6. Main Project Findings and Outputs

Figure 6.1 provides a summary of the additional outputs of the project which has:

- Supported providers to evaluate their self management groups, and hence provide better value products for commissioners
- Worked with PCT CVD specialist nurses to undertake practice facilitation and extend their educational offering
- Worked with EMIS Web and PCTs to develop a range of IT solutions to support practice audits
- Recruited partners to manage a range of additional research projects on health inequalities

**Figure 6.1 Summary of project outputs**

- Work with PCT on course delivery
- Work with Specialist nurses on practice facilitation
- Integrate EMIS web into project
- NHS health check DVD
- Engage with PCIP

<table>
<thead>
<tr>
<th>Self Management Groups</th>
<th>GP survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral forms</td>
<td>Link providers with practices</td>
</tr>
</tbody>
</table>
- Develop course evaluation
- Assess participant experience

- Health equity audits
- 2 Annual reports for Tower Hamlets practices
- Computer prompts
- Practice facilitation
- Assess practice delivery on equity

Document progress in ethnicity recording
- Explore multimorbidity by ethnicity
- Examine inequalities in BP management and CKD severity
- COPD severity – variation by ethnicity
- Diabetes management by ethnicity
- Conference dissemination
Main findings: Improvement in disease indicators across all PCTs in inner east London

Over the lifetime of the project there has been year on year improvement in the majority of chronic disease indicators across east London general practice

These changes are illustrated by table 6.1, with data taken from the CEG annual chronic disease audits. There has been improvement in the major CVD risk factors of hypertension and raised cholesterol. 90% of patients on CHD registers are now prescribed statins. There are also improvements in glycaemic control. Progress in these, physician initiated domains of care, are much greater than for smoking, where rates among those on chronic disease registers have hardly altered over the life of the project.

Table 6.1 Change in chronic disease indicators between 2007 and 2009 in east London

<table>
<thead>
<tr>
<th></th>
<th>% CHD patients with Statin prescribed</th>
<th>% diabetic patients with BP ≤ 145/85</th>
<th>% diabetic patients with HbA1C ≤ 7.4%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tower Hamlets</td>
<td>88.0</td>
<td>90.8</td>
<td>46.7</td>
</tr>
<tr>
<td>City and Hackney</td>
<td>86.3</td>
<td>89.2</td>
<td>37.9</td>
</tr>
<tr>
<td>Newham</td>
<td>88.1</td>
<td>90.5</td>
<td>41.4</td>
</tr>
<tr>
<td>All 3 PCTs</td>
<td>87.5</td>
<td>90.2</td>
<td>42.0</td>
</tr>
</tbody>
</table>

*all values taken from the CEG Report “Recognising Improvement” published Jan 2010.

Figure 6.2 Changes over time in CHD/Diabetic risk factors by ethnicity

If we break down the whole east London population by the three major ethnic groups we see that there have been year on year improvements for each ethnic group. However, for the indicators illustrated, we also see that improvements run in parallel, and there is little ‘catch up’ or convergence between the separate groups over time.
Main Findings: Reduction in the differences in disease indicators by ethnicity, age, and gender across all PCTs in inner east London

We have demonstrated improvements in key disease indicators across the 3 PCTs. Practice Health Equity Reports increased practice and PCT awareness of the problem, but we cannot directly attribute reduction in inequalities to our reports, as our project was not designed as a randomised controlled trial. We investigated differences between three PCTs: Tower Hamlets PCT (our intervention site), Newham and City and Hackney. We analysed key indicators in chronic diseases by year to determine whether differences observed between PCTs in the crude rates (by age, gender or ethnicity) were present in a fuller, adjusted, analysis to assess if differences between groups had been reduced.

Differences by ethnicity
Table 6.3 shows the odds of an increase in performance for each indicator relative to the previous year. For example in Tower Hamlets statin prescribing for each ethnic group has increased annually (but non-significantly for Black groups). When the PCTs are compared there are clear differences. For example cholesterol attainment for patients in City and Hackney and Newham is increasing at a faster rate than in Tower Hamlets. The PCT level analysis does not provide a consistent picture of improvements in Tower Hamlets compared to the other PCTs. More work would be needed to assess the impact of practice audits.

<table>
<thead>
<tr>
<th>PCT</th>
<th>Ethnic Group</th>
<th>CHD Patients % Statin Prescription</th>
<th>CHD patients % Chol Target</th>
<th>COPD patients % Current Smokers</th>
<th>COPD patients % with FEV1 &lt; 140 SBP</th>
<th>Diabetes patients % HbA1c ≤7.5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tower Hamlets</td>
<td>White</td>
<td>1.2 (1.2,1.3)</td>
<td>1.0 (0.9,1.0)</td>
<td>1.1 (1.0,1.1)</td>
<td>1.3 (1.2,1.5)</td>
<td>1.1 (1.0,1.1)</td>
</tr>
<tr>
<td></td>
<td>S Asian</td>
<td>1.3 (1.1,1.4)</td>
<td>1.1 (1.1,1.2)</td>
<td>1.0 (0.9,1.1)</td>
<td>1.3 (1.1,1.5)</td>
<td>1.1 (1.1,1.2)</td>
</tr>
<tr>
<td></td>
<td>Black</td>
<td>1.2 (1.0,1.4)</td>
<td>1.0 (0.8,1.2)</td>
<td>1.1 (0.8,1.5)</td>
<td>0.4 (0.7,2.6)</td>
<td>0.9 (0.9,1.0)</td>
</tr>
<tr>
<td>City &amp; Hackney</td>
<td>White</td>
<td>1.2 (1.1,1.2)</td>
<td>1.7 (1.6,1.8)</td>
<td>1.0 (0.9,1.0)</td>
<td>1.4 (1.3,1.5)</td>
<td>1.3 (1.2,1.3)</td>
</tr>
<tr>
<td></td>
<td>S Asian</td>
<td>1.2 (1.0,1.4)</td>
<td>2.0 (1.7,2.3)</td>
<td>1.1 (0.8,1.4)</td>
<td>1.2 (0.8,1.7)</td>
<td>1.4 (1.2, 1.5)</td>
</tr>
<tr>
<td></td>
<td>Black</td>
<td>1.1 (1.0,1.2)</td>
<td>1.7 (1.5,1.9)</td>
<td>1.0 (0.8,1.2)</td>
<td>1.5 (1.2,1.9)</td>
<td>1.1 (1.0,1.1)</td>
</tr>
<tr>
<td>Newham</td>
<td>White</td>
<td>1.1 (1.1,1.2)</td>
<td>1.6 (1.5,1.7)</td>
<td>1.0 (0.9,1.0)</td>
<td>1.2 (1.1,1.3)</td>
<td>1.0 (0.9,1.0)</td>
</tr>
<tr>
<td></td>
<td>S Asian</td>
<td>1.3 (1.2,1.4)</td>
<td>1.6 (1.5,1.7)</td>
<td>1.0 (0.9,1.1)</td>
<td>1.3 (1.1,1.5)</td>
<td>1.1 (1.0,1.1)</td>
</tr>
<tr>
<td></td>
<td>Black</td>
<td>1.1 (1.0,1.3)</td>
<td>1.5 (1.3,1.7)</td>
<td>0.9 (0.7,1.1)</td>
<td>1.5 (1.2,1.9)</td>
<td>1.0 (0.9,1.0)</td>
</tr>
</tbody>
</table>
Differences by ethnicity

Real Improvements in statin prescribing and corresponding cholesterol attainment are seen for all ethnic groups

Differences by Age Group

Improvement in diabetes management in older patients has reduced inequalities in all inner east London PCTs

We investigated differences by age groups using the same methods. We categorised the patients into two groups 44-74 and ≥75 years to investigate any inequity in provision by age. Table 6.5 indicates where significant differences were observed between age groups and PCT over time.

We find that statin prescribing between age groups has improved in all PCTs over time, with the largest improvements seen in the over 75s for all PCTs. Significant differences are seen in all PCTs by age group for HbA1c target attainment, this too is driven by higher achievement in older age groups.

(The complete results and tables supporting these statements are available in the long version of this report)

Differences by Gender

Improvements in CHD and diabetes management have reduced inequalities by gender across all three PCTs

Results by gender for heart disease patients show significant improvements in statin prescribing and cholesterol target attainment in women relative to men in City and Hackney and Newham with less improvement in Tower Hamlets.

Our analysis showed, unfortunately, an increase in smoking rates for all PCTs and both genders.

(The complete results and tables supporting these statements are available in the long version of this report).
7. Related work on health inequalities

Using the resources of the Health equity project we were able to attract a range of additional researchers to work with us on health inequalities and ethnicity.

1. **Chronic Kidney Disease (CKD)**
   Working with partners in the Barts and the London NHS Trust renal department we have examined the prevalence of CKD in patients with diabetes, and with hypertension. We found that there is a higher prevalence of more severe forms of CKD among the South Asian population in comparison to White groups, even though blood pressure is on average lower among South Asian groups. We are conducting further work in these areas.

2. **Cardiovascular Multimorbidity**
   We have examined cardiovascular multimorbidity by ethnicity (CHD, CVA and TIA, Diabetes and Hypertension). We found that the burden of multimorbidity falls on ethnic minority groups particularly South Asians; we also found that though the management of risk factors improves for patients with greater multimorbidity, important differences in the management of risk factors by ethnicity remain.

3. **Exploring COPD prevalence and management by ethnicity.**
   Working with a medical student we found differences in prevalence, severity and treatment of COPD by ethnicity. Prescribed medication differed significantly by ethnic group, and was not related to the severity of disease process.

4. **Exploring the difference in HbA1c, by ethnicity, over time.**
   Using the diabetes registers we aimed to identify differences in HbA1c levels between ethnic groups. We found the difference in HbA1c between White people and other ethnic minority groups decreased significantly between 2004 and 2009. We also explored the influence of social deprivation and treatment modality on HbA1c by ethnicity. We found that South Asian patients responded less well to all diabetes treatments in comparison to other ethnic groups. Further work to investigate which practice level factors influence HbA1c levels will report in 2011.
8. Dissemination

Health Equity conference
The Health Equity Conference was held on 15.7.2010 at Queen Mary University Innovation Centre. Over 100 people attended including community representatives, local GP practices, local authorities, Primary Care Trusts, hospital acute Trusts, the Department of Health, voluntary and other third sector organisations and university academics.

For details of the conference presentations please see http://www.ihse.qmul.ac.uk/chs/ceg/Events/index.html

Conference Summary
Health equity reports were well received by practices
Differences between ethnic groups persist after adjustment for social deprivation.
Differences in some disease indicators between ethnic groups had reduced over time.
Self management groups are more integrated into disease management pathways for major chronic diseases in Tower Hamlets.

Continuing work with Tower Hamlets PCT
Tower Hamlets PCT has been an influential stakeholder throughout the life of the project. We have worked with the PCT in a number of key areas, these include:

1. Support for the commissioning of adequate self management groups
2. Working with course providers to improve marketing to GP practices, and to develop course evaluation.
3. Working with PCT employed specialist cardiovascular nurses to develop their facilitation skills to support a wider range of work with practices and networks.

Tower Hamlets PCT has a firm commitment to identifying and reducing health inequalities for patients with common chronic disorders over the coming years. Many of the findings from the project can be used to support PCT plans. Two aspects of the project outputs will be used in shared future work with the PCT.

1. Development of a ‘health equity dashboard’. Using data drawn from EMIS Web, the PCT plans to develop indicators to monitor progress in the reduction of health inequalities over time. An example of this might be progress in managing BP to target among diabetics, displayed by ethnic group, age group and gender.
2. Contributions to the PCT joint needs assessment plan for 2011-12, including a fact sheet on health inequalities to form part of the future PCT public health report.

This project was funded by a grant from the Health Foundation as part of their programme of ‘Engaging with Quality in Primary Care’. We are grateful to our funders for providing developmental support to the team throughout the course of the project, and for opportunities to engage with other project teams and share the highs and lows of the project journey.
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For information on Self Management groups and Expert Patient Programmes in Tower Hamlets refer to the Self care manual online at http://www.thpct.nhs.uk/your-health/self-care