



Heart Disease and South Asians

Delivering the National Service Framework for Coronary Heart Disease



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Document Purpose Best Practice Guidance

ROCR Ref: **Gateway Ref:** 3788

Title Heart Disease and South Asians

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Publication Date 10 Dec 2004

Target Audience Any health care professionals/partners working to deliver services to South Asian communities

Circulation List Available on request from Prolog.

Description This best practice guide aims to support service providers including SHAs, PCTs, hospitals and other organisations working with South Asian communities to deliver heart disease service. It contains background information on heart disease and South Asians, a selection of best practice case studies and details of other useful resources.

Cross Ref National Service Framework for Coronary Heart Disease, Winning the War on Heart Disease Progress Report 2004

Superseded Docs N/A

Action Required N/A

Timing N/A

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For Recipient's Use

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Foreword by the Director of Equality and Human Rights for the NHS



We live in an increasingly diverse society and public services must ensure they are responsive to, and representative of all sections of the community.

The National Health Service was founded on the principle of equal access for all and should be at the forefront of meeting this challenge. However, despite the hard work and commitment of many staff, we know that this is not yet the case.

One of the biggest challenges facing us is to reduce the obvious health inequalities that exist for some minority ethnic groups. Reducing death rates from coronary heart disease among first generation South Asians is high on our list of priorities.

Another key challenge is to improve access to health services so that the NHS is open and accessible for everyone regardless of their background. To achieve this, we must work to understand the health needs of all communities and groups and embed this practically into mainstream health care delivery. Good communication with local communities and service users is essential to ensure we offer the services that people actually want. We must also share learning – which is where initiatives like this best practice guide come in.

One of my major tasks is to champion Sir Nigel Crisp's Leadership and Race Equality Action Plan, launched in February 2004. This ten-point plan sets the strategic direction for improving race equality in the NHS. The NHS is the largest single employer of black and minority ethnic staff in England and relies on the contribution they make everyday. Every NHS organisation must play their part to ensure that the local workforce better reflects the local community they serve, and we should all encourage fresh approaches to engage local people more effectively in improving health outcomes.

The founding principles of the NHS – equal access for all and a commitment to improving the health of the whole nation – remain fundamental to the health service today. The challenge we now face is how to translate these principles into practices that can effectively deliver them to all sections of our diverse communities. We can only achieve this if we build an explicit commitment to equality, diversity and respect into everything we do. We must match that commitment by determined and practical action in all parts of the NHS. Our success in this will be measured not by what we say, but in what we do.

There is some great work already being done, but my ambition is to make the NHS – and the Department of Health – the best at tackling the equality and human rights agenda.

A handwritten signature in black ink, appearing to read 'Surinder Sharma'.

Surinder Sharma,
Director of Equality and Human Rights

MAP OF CASE STUDIES

Improving access

- ▲ South Asian Living with Heart Disease project
- ▲ Using ethnic profiling to improve services for BME communities with CHD

General prevention

- N 3 QUIT: Taking the healthy lifestyle message out to the community
- 4 Project Dil: Peer Education Programme
- 5 Rochdale Healthy Living Centre
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- 7 Bengali Bridge Project

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- 30 Manchester Heart Centre Cardiac Liaison Team
- 31 Improving care for South Asian cardiac patients in Bradford

Rehabilitation

- 32 Fair and equal access to cardiac rehabilitation in Leicester
- 33 Planning and delivering an equitable cardiac rehabilitation service in Newham
- 34 Action CHD – Dil Ke Baat
- 35 The CADISAP study (Coronary Artery Disease in South Asian Prever



KEY

- ▲ Improving access
- Prevention (smoking, diet and nutrition, physical activity and diabetes)
- Treatment
- ◆ Rehabilitation

N ● National

Introduction by the National Director of Heart Disease



Four years have passed since the National Service Framework for Coronary Heart Disease was published, but tackling heart disease remains a top priority for the government.

Hard work from the NHS has led to marked improvements across the country in the prevention and treatment of heart disease and cardiac rehabilitation services, and we are well on the way to achieving our goal of reducing the death rate from heart disease by 40% by 2010.

Nationally much work is going on to reduce heart disease in the population and to address the underlying causes of health inequalities.

Disease registers are being updated to make sure that people who have or who are at high risk of developing heart disease receive appropriate lifestyle advice and treatment. More than 1.8 million people are now receiving cholesterol-lowering statins, and that number is rising. This is saving several thousand lives a year as well as reducing the number and severity of heart attacks.

Targets have been set to reduce smoking in adults and the NHS has already made excellent progress in helping smokers quit. Between April 2003 and March 2004, NHS Stop Smoking Services helped over 200,000 people to successfully stop smoking at the 4 week follow-up, an increase of 65% on the previous year. The work of the NHS is supported by a comprehensive tobacco control strategy including national media campaigns, legislation to ban tobacco advertising, promotion and sponsorship, bigger and more direct warnings on cigarette packets and the removal of misleading terms such as "light" and "low tar".

A number of initiatives are also underway to help people improve their diet and increase their levels of physical activity. The 5 A DAY programme is helping people make healthier choices by increasing awareness and access to fruit and vegetables locally. Initiatives including the national School Fruit and Vegetable Scheme (SFVS) and the Food in Schools (FiS) programme are promoting healthy eating among children to help prevent against diseases like cancer and heart disease in the future.

There are now over 700 GP exercise referral schemes prescribing physical activity to improve health and well-being. And pilot projects such as Local Exercise Action Pilots (LEAP) and the Walking the Way to Health initiative are testing out different approaches for increasing access to and levels of physical activity.

Many of these initiatives are working specifically to reduce health inequalities and have a particular focus on minority ethnic groups and people living in areas of high deprivation. However, there is more work to be done to ensure equal access to treatment and services and make services responsive to all users.

This best practice guide focuses particularly on work which aims to improve services for South Asian people, who are 50% more likely to die prematurely from heart disease than the general population.

We hope that you will find it useful to read about the projects described in this guide.

There will doubtless be many other excellent examples where organisations are working to improve heart disease services for South Asians. If you are working in this field and would like to share your experiences with other service providers, we would invite you to get in contact with the Heart team – contact details are at the back of this guide.

Dr Roger Boyle,
National Clinical Director for Heart Disease

Coronary heart disease and South Asians

Coronary heart disease (CHD) is the UK's single biggest killer. More than 1.4 million people suffer from angina, 300,000 have heart attacks every year and more than 110,000 people die of heart problems each year. Around 41,000 of these deaths are premature, occurring in people aged under 75. CHD is responsible for approximately one in five of all deaths in men, and one in six in women.

Coronary heart disease can affect anyone, but it affects people in certain groups more than others. Rates of CHD are higher among manual workers than non-manual workers, for example, and in certain geographic areas. CHD is also more prevalent in certain ethnic minorities, particularly South Asians – a term which defines many ethnic groups, with distinctive regions of origin, languages, religions and customs.

South Asian people born in India, Bangladesh, Pakistan or Sri Lanka are approximately 50 per cent more likely to die prematurely from coronary heart disease than the general population. The death rate is 46% higher for men and 51% higher for women. In addition, the difference in the death rates between South Asians and the rest of the population is increasing. This is because the death rate from CHD is not falling as fast in South Asians as it is in the rest of the population.

It is not completely understood why South Asians suffer more from heart disease than other groups. Several explanations have been suggested, for example that South Asians may be genetically more susceptible to developing CHD, or that there may be as yet unproven risk factors, including metabolic disorders associated with insulin resistance and central obesity. The relatively disadvantaged socio-economic position of

the South Asian population has also been suggested as an explanatory factor.

It is generally agreed, however, that certain risk factors are more common among South Asians. These vary between communities, but include high levels of smoking, particularly among Bangladeshi men, low rates of exercise across all South Asian communities and a diet high in fat and low in fruit and vegetables in certain groups. Other key risk factors requiring control are diabetes, which is up to six times more common in South Asians than in the general population, high blood pressure and high cholesterol.

As well as suffering from higher rates of heart disease, there is evidence to suggest that Asian communities tend to be diagnosed at a more advanced stage of disease and have poorer survival rates.

Although we cannot fully explain why there is increased incidence of CHD in South Asian communities, it is clear that action can be taken to address the established risk factors and to address inequalities in access to and provision of services.

This best practice guide aims to support service providers, including strategic health authorities (SHAs), primary care trusts (PCTs), hospitals and other organisations working with South Asian communities to deliver heart disease services to South Asian people.

The guide contains background information on heart disease and South Asians, a selection of best practice case studies illustrating where service providers are working together to improve services and details of other resources available, including further reading, weblinks and useful organisations.

Resources

Further reading

British Heart Foundation Factfile 04/2000: South Asians and heart disease

Available on the British Heart Foundation website:

www.bhf.org.uk/professionals/uploaded/apr00.pdf

Coronary heart disease statistics.

Petersen S, Peto V and Rayner M (2004)

BHF: London – available from

www.heartstats.org/publications

The Epidemic of Coronary Heart Disease in South Asian populations: Causes and Consequences. Edited by Kiran C R Patel and Raj Bhopal CBE. South Asian Health Foundation, 2003.

Research papers

What is the risk of coronary heart disease in South Asians? A review of UK research. Raj Bhopal. Journal of Public Health Medicine Vol 22, No 3, pp375-385.

Cross sectional analysis of mortality by country of birth in England and Wales, 1970-92. Sarah Wild and Paul Mckeigue. BMJ, Mae 1997; 314:705.

Heterogeneity of coronary heart disease risk factors in Indian, Pakistani, Bangladeshi and European origin populations:cross-sectional study.

Bhopal R, Unwin N, White M. et al. BMJ 1999; 319:215-20.

Relation of central obesity and insulin resistance with high diabetes prevalence and cardiovascular risk in South Asians.

McKeigue P M, Shah B, Marmot M G. Lancet 1991;337:382-86.

Coronary Heart Disease in UK Indian Asians: the potential for reducing mortality.

Kooner J S.

Heart 1997;78:530-532.

Lay diagnosis and health-care-seeking behaviour for chest pain in south Asians and Europeans.

Chaturvedi N, Rai H, Ben-Shlomo Y (1997). Lancet. 1997 Nov 29;350(9091):1578-83.

Useful websites

British Heart Foundation website

www.bhf.org.uk

The British Heart Foundation website has a useful Health Professionals section including a number of Factfiles giving clear, concise and up to date information on heart health issues.

British Heart Foundation Statistics Website
www.heartstats.org

A comprehensive and up to date source of statistics on the incidence, prevention, treatment and causes of heart disease in the UK, including information on minority ethnic groups.

Addressing health inequalities – the national context

The government is committed to transforming the health and social care system so that it produces faster, fairer services that deliver better health and social care and tackle inequalities.

Achieving sustainable improvements in health and services for black and minority ethnic people is an integral and vital aspect of this programme of investment and reform.

The NHS Plan

The NHS Plan, published in July 2000, set out ambitious goals to transform the quality of services, tackle health inequalities and deliver patient centred services that are responsive and accessible to all parts of the community. In ensuring fair and equitable access of services to all, services must take account of personal needs such as religious, cultural and dietary needs.

For more information see www.dh.gov.uk.

Race Relations (Amendment) Act 2000

In addition, all NHS organisations are required to comply with the provisions of the Race Relations (Amendment) Act 2000. The Act places a statutory duty on listed public bodies, including the Department of Health, strategic health authorities, NHS trusts, primary care trusts and special health authorities to actively promote race equality including within service delivery.

For more information see www.dh.gov.uk.

Race for Health programme

The Department of Health is also facilitating the Race for Health programme. This is a PCT led transformational change programme to implement models of excellence and partnership, working with black and minority

ethnic communities in implementing the Race Relations (Amendment) Act and delivering improved services, employment opportunities and health outcomes for black and minority ethnic communities.

For more information see www.raceforhealth.org, which also includes case studies of work undertaken at a local level within the NHS.

Leadership and race equality action plan

In February 2004, Sir Nigel Crisp, Chief Executive of the NHS launched a ten-point action plan to improve race equality in the NHS in order to give even greater prominence to this issue as part of our drive to improve health.

For more information on the Department of Health's Race Equality Scheme and Sir Nigel Crisp's Leadership and Race Equality Action Plan please see www.dh.gov.uk/PolicyAndGuidance/EqualityAndHumanRights.

National targets for reducing CHD and tackling health inequalities

National Standards, Local Action – Health and Social Care Standards and Planning Framework 2005/06–2007/08 set out 20 key national targets for the NHS, including targets for reducing coronary heart disease and tackling health inequalities. PCTS will develop local targets and plans to meet the national targets in response to local needs and priorities, according to principles set out in *National Standards, Local Action*.

For more information see Appendix 1 of this document and *National Standards, Local Action – Health and Social Care Standards and Planning Framework 2005/06–2007/08: Annex B* – available at www.dh.gov.uk/publications.

Standards for Better Health

Standards for Better Health, a new framework of Health Care Standards, was published as an annex to *National Standards, Local Action*. It describes the standards that health care organisations, including NHS Foundation Trusts, and private and voluntary providers of NHS care, will be expected to meet in terms of safety, clinical and cost effectiveness, governance, patient focus, accessible and responsive care, care environment and amenities and public health, with core and development standards for each domain. *Standards for Better Health* will form a key part of the performance assessment by the Healthcare Commission of all health care organisations.

The standards based approach means that organizations need to take account of the quality and safety of all their services, not just where there is a national target for improvement. They also need to make sure they are reaching all parts of their population and working to reduce inequalities in health and access to all services, paying particular attention paid to black and minority ethnic communities where they are disadvantaged.

For more information see *National Standards, Local Action – Health and Social Care Standards and Planning Framework 2005/06–2007/08: Annex A – Standards for Better Health* available at www.dh.gov.uk/publications.

NHS Improvement Plan

The new standards reflect the direction set by the *NHS Improvement Plan*, including a new focus on public health, reducing inequalities and organisations working together to provide a whole systems approach to care, tailor made for the individual patient. Raising standards in this way will deliver more personalised care and ensure that all patients, including those from disadvantaged groups, are able to benefit.

For more information see *The NHS Improvement Plan – Putting people at the Heart of Public Services* available at www.dh.gov.uk/publications.

The National Service Framework for Coronary Heart Disease

The National Service Framework for Coronary Heart Disease, published in March 2000, set out a strategy to modernise CHD services over ten years. The National Service Framework (NSF) details 12 standards for improved prevention, diagnosis, treatment and rehabilitation and goals to secure fair access to high quality services.

NSFs are integral to a standards-based system and have a key role in supporting local improvements in service quality. Organisations' performance will be assessed not just against national targets but increasingly on whether they are delivering high quality standards across a range of areas, including those set out in NSFs.

For more information on the National Service Framework for Coronary Heart Disease see www.dh.gov.uk/publications.

Choosing Health – Public Health White Paper

Choosing Health is the Government's White Paper on improving public health in England. The White Paper aims to ensure that people have the information, opportunities and practical support to make it easier for them to eat more healthily, exercise more and smoke less. The White Paper sets out a strategy for action based on the principles of informed choice, personalised services and collaboration between Government, the NHS, industry and wider society.

New measures in the White Paper include action to increase the number of smoke-free workplaces; curbs on the promotion of unhealthy foods to children; clear, unambiguous labelling of the nutritional content of food; NHS Health Trainers to provide advice to individuals on how to improve their lifestyle, and a wide range of measures to tackle social and geographical inequalities in health.

For more information see www.dh.gov.uk.

Improving access to treatment and services for South Asians

The National Service Framework for Coronary Heart Disease aimed to secure fair access to high quality services for all. As the NSF is implemented, facilities and services are being deliberately targeted at the areas which need them most to reduce inequalities in access to treatment and services.

This will directly benefit black and minority ethnic groups, including South Asians, who are more likely to live in the poorest 20 per cent of local authority areas, where services have tended to be of poorer quality.¹

In addition, the NSF requires all NHS organisations to ensure that the services they provide are accessible and acceptable to the people they serve, regardless of their ethnicity. This includes assessing and meeting people's needs in ways that are culturally, religiously and linguistically appropriate. It also states that staff will need to have or acquire the relevant skills, knowledge and experience to enable them to be sensitive to the cultural and religious needs of the individuals and communities that they serve.²

It is essential to ensure that services are provided according to need and that the people these services are aimed at are actually accessing them. Where this is not the case, the barriers to access need to be identified and tackled so that local needs are met.

Potential barriers to access

Some barriers are common to all communities: poor health, lack of time and absence of support may all influence people's ability and motivation to access services and lead a healthy lifestyle. Or practical problems, for example transport issues, may make it difficult for people to get to hospital. However, South Asian communities potentially face a number of additional barriers that service providers need to be aware of and address.

There may be inadequate provision of interpreting services, leading to communication difficulties, especially for the older generation, particularly women, some of whom may not be confident in speaking and understanding English. Another common problem is a lack of culturally appropriate facilities and resources, for example single-sex exercise provision or suitable health promotion materials.

Other system limitations may include time constraints on the length of consultations, particularly when there are communication difficulties or when interpreters are being used, and a lack of medical history from the patient's country of origin for people born outside the UK.

Cultural stereotyping may also create barriers. For example low levels of reported smoking among South Asian women can lead to an assumption that South Asian women do not smoke, meaning that they are not always asked about their smoking status and those that do smoke are not offered appropriate help.

Patients' own levels of health literacy and health beliefs may also play a role in their take up of treatment and services.

Tools for planning and delivering services

Health Equity Audits

National Standards Local Action stated that primary care trusts (PCTs) and their partner organisations should demonstrate that they have taken account of different needs and inequalities within the local population in their planning, including race inequalities.

Health Equity Audit is a tool for comparing local services with need, which can be used to inform decisions about service planning, commissioning and delivery. PCTs are expected to use Health Equity Audit in the forthcoming planning round to help them achieve this.

Further information on Health Equity Audit is available on the health inequalities website: www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/HealthInequalities/BestPractice

Healthcare Needs Assessment

Everyone involved in the commissioning, planning and prioritisation of health care requires accurate and comprehensive information to answer a number of crucial questions on each major disease or health service specialty. These questions, for an average health authority or primary care group area, are:

- With what population or patients (how many and how severely ill) are we concerned?
- What services on average are currently provided?
- What is the evidence of the effectiveness and cost-effectiveness of these services?
- What is the optimum configuration of services?

In other words: What is the need and how can it be best met?

The questions are answered in part by epidemiological literature and in part by the products of the evidence-based health care movement. The Health Care Needs Assessment series combines these and offers a perspective across an entire disease, service area or specialty.

The Health Care Needs Assessment series is funded by the Department of Health and the National Institute of Clinical Excellence and is compiled and managed in the Department of Public Health and Epidemiology at the University of Birmingham.

For more information on Health Care Needs Assessment see <http://hcna.radcliffe-oxford.com>. For an overview of needs assessment for Black and Minority Ethnic Groups see <http://hcna.radcliffeoxford.com/bemgframe.htm>.

Best practice checklist for planning services for Black and Minority Ethnic Groups (BMEGs)

- a. Services for BMEGs should be part of 'mainstream' health care provision.
- b. The amended Race Relations Act should be considered in all policies.
- c. Facilitating access to appropriate services by:
 - promoting access – this will entail reviewing barriers to care and provision of appropriate information on services available
 - providing appropriate bilingual services for effective communication
 - education and training for health professionals and other staff
 - appropriate and acceptable service provision
 - provision of religious and dietary choice within

meals offered in hospitals.

- ethnic workforce issues, including addressing racial discrimination and harassment within the workplace, and promoting race equality and valuing diversity in the workforce.
 - community engagement and participation.
- d. Systematising structures and processes for capture and use of appropriate data.

For more information see: <http://hcna.radcliffe-oxford.com/bemgframe.htm>

With thanks to Dr PS Gill and Dr J Kai, Department of Primary Care and General Practice, University of Birmingham; Professor RS Bhopal Bruce and John Usher Professor of Public Health, Public Health Sciences, University of Edinburgh Medical School and Dr Sarah Wild, Lecturer in Public Health Medicine, Health Care Research Unit, University of Southampton.

<p>CASE STUDY</p> <h1 style="margin: 0;">South Asian Living with Heart Disease project</h1>		1
<p>The South Asian Living with Heart Disease project was set up to examine and improve the equity of access to primary care services between South Asian and non-South Asian patients with cardiovascular disease, with the aim of reducing the higher rate of premature mortality from CHD in South Asians.</p> <p>The project's research methods included the following:</p> <p>A semi-structured questionnaire, translated into five South Asian languages, was sent to 146 South Asian and 512 non-South Asian patients listed on cardiovascular disease registers of 16 volunteering practices in Bristol. The questionnaire was designed to:</p> <ul style="list-style-type: none"> ■ Capture perceptions of health care needs ■ Collect experiences of primary care for cardiovascular disease ■ Gain knowledge and understanding of risk factors associated with cardiovascular conditions. <p>One hundred and eighteen questionnaires were returned from South Asian respondents (81% response rate) and 408 from non-South Asian respondents (80% response rate).</p> <p>Focus groups were conducted with primary health care teams of participating practices to uncover key issues regarding the health care needs of South Asian and non-South Asian cardiovascular disease patients, from the viewpoint of health professionals.</p> <p>A baseline and repeat audit of coronary heart disease secondary prevention and lifestyle data recorded in patient clinical notes was conducted and analysed.</p>	<p>Community and primary care based interventions</p> <p>In addition, a number of community and primary care based interventions have been conducted or are underway to improve access to services for South Asians. These include:</p> <p>South Asian CVD Awareness Days</p> <p>Organised in conjunction with local South Asian Community Groups, these information days have provided an opportunity for the South Asian community to have blood pressure and blood sugar checks, find out how to reduce the risks of heart disease and stroke and learn basic life support techniques.</p> <p>A Peer Education Scheme for Tobacco Cessation</p> <p>The Peer Education Scheme is designed to equip members of the South Asian community with tobacco cessation skills to support others to quit smoking. Levels of smoking amongst men in some South Asian communities are well above average, with language and culture being the major barriers in Asians accessing important health information. The adviser scheme is an important educational tool and a boost to ethnic language health resources in Bristol. This scheme has acquired a good reputation amongst local smoking cessation specialists and the results are proving very effective.</p> <p>The focus group report <i>Access to primary health care services for South Asians cardiovascular disease patients – Healthcare professional perspective and the audit reports Ischaemic heart disease audit of primary care patients (2001-2002) and (2002-2003)</i> are available to read on the coronary heart disease section of the Department of Health website.</p>	<p>Natalie Field Assistant Director of Public Health Avon HImP Performance Scheme, 0117 900 2445 natalie.field@bristolswpct.nhs.uk</p> <p>Habib Naqvi Research Associate Avon HImP Performance Scheme, Tel: 0117 9002653 Habib.Naqvi@bristolswpct.nhs.uk</p>

CASE STUDY

2

Using ethnic profiling to improve services for BME communities with CHD

In 2002 the Secondary Prevention Project Manager for the CHD Collaborative (North Trent) and the Specialist Nurse CIRC (City Wide Initiative for Reducing Heart Disease) Project in north Sheffield worked in partnership to provide additional support to a practice with a high and diverse black and ethnic minority population.

As a result of the ethnic profiling the practice was able to effectively identify its interpreter and translation needs – resulting in the employment of two bilingual receptionists (Urdu/Punjabi and Somali) and additional support provided by two link workers (Urdu/Punjabi and Arabic). Also the use of the local interpreter service was increased dramatically to provide language support to the practice. This has reduced the numbers of DNAs and allowed the practice to adapt their systems for call and recall to improve access for patients.

The practice was experiencing a number of difficulties providing care for patients with CHD and other services including a large percentage of 'DNAs' (Did Not Attend) and a poor provision of interpreter and translation support. It was felt that the translation/interpreting needs of the population needed to be better recorded and that this might improve uptake of services and improve general communication with the practice team.

The post has since become part of mainstream funding within the PCT. The role has developed and expanded to include support for health promotion with BEM communities, in particular smoking cessation support; support for other practices with ethnicity profiling and providing a vital link for the PCT with other initiatives in BEM community areas, for example New Deal for Communities. It is also hoped that development of other services can be supported through this work – for example cardiac rehabilitation for BEM communities.

A black and ethnic minority support worker was employed by the PCT using start-up funding from the CHD Collaborative (North Trent) for an initial period of six months to support the practice (and others in north Sheffield with high BEM populations). The purpose of this post was to provide an accurate and effective record of the ethnic profile of the population and to provide cultural insight into the uptake of services. A clinical system template and data collection tool was developed with the support of the local PRIMIS (Primary Care Information Services) worker. Links were also made with national groups with an interest in ethnic profiling. A report was produced at the end of the six month period detailing the benefits and difficulties that had arisen during the project and with further recommendations on how to take this work forward.

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Prevention

The development of coronary heart disease is influenced by a number of risk factors, many of which can be influenced.

Key risk factors include smoking, physically inactive lifestyles, poor diet, excess salt, obesity, excess alcohol, high blood pressure, stress and diabetes. When several risk factors exist together, the risk of CHD is greatly increased.

A number of other risk factors cannot be influenced. For example CHD is more likely with increasing age, in men rather than women (before the menopause) and if close relatives have suffered from heart disease early in life.

There is evidence to suggest that modifiable lifestyle factors such as smoking, lack of physical activity and poor diet all contribute to the increased risk of CHD in South Asian groups. South Asians are also more likely than the general population to suffer from diabetes, another key risk factor.

These risk factors are considered in more detail later on in this chapter.

For strategies focusing on these risk factors to be effective, there are two key elements. Firstly, information needs to reach the right people and secondly, these people need to commit to behavioural changes.

Strategies need to take account of language and cultural barriers and be targeted appropriately, and communities involved in their development.

People also need to have the opportunity to make healthier choices. Some communities do not have ready access to affordable healthy foods, safe, pleasant open spaces, footpaths and cycleways, or affordable facilities for physical activity. Many non-smokers are exposed involuntarily to other people's tobacco smoke at work, in pubs, restaurants and other public spaces.

Choosing Health, the government's White Paper on improving public health in England aims to ensure that people have the information, opportunities and practical support to make it easier for them to eat more healthily, exercise more and smoke less. New measures in the White Paper include action to increase the number of smoke-free workplaces, curbs on the promotion of unhealthy foods to children, clear, unambiguous labelling of the nutritional content of food and a wide range of measures to tackle social and geographical inequalities in health. For more information see www.dh.gov.uk.

The following case studies are examples of health promotion initiatives that are working to raise awareness in communities about the increased risk of heart disease for South Asians and to help people take preventative action.

CASE STUDY

QUIT: Taking the healthy lifestyle message out to the community

3



QUIT, the British Heart Foundation (BHF), and Diabetes UK have teamed up to offer Health 'MOTs' at summer melas (community fairs), attended by large numbers of Asian families across the country.

Services on offer include a carbon monoxide check, as well as blood pressure, cholesterol and diabetes tests. Visitors accessing the service are given appropriate lifestyle advice and may be referred on to their GP.

Melas provide an opportunity to reach a large number of people in a short period of time – some melas are attended by up to 80,000 people – including many people who would not normally access services. Those at high risk of developing heart disease and other illnesses may be identified sooner than they might otherwise have been and can be referred on to their GP. Providing services in a more relaxed environment also means that people feel able to discuss issues more openly. Health professionals working at melas have commented that the level of trust is greater in the less formal environment, allowing for a more honest assessment of people's needs.

Providing an integrated health check is beneficial as it addresses many potential health concerns at the same time. This can help reinforce the need for lifestyle changes to people at high risk of developing heart disease and other illnesses and prompt a commitment to behavioural change.

QUIT also runs a programme in conjunction with the BHF to provide imams and other religious leaders with training in basic prevention of heart disease and diabetes, equipping them with the knowledge to raise awareness of issues within the communities they serve, for example in sermons at Friday prayers.

Religious leaders have access to a greater number of people than health promoters – for example around 5,000 people attend Friday prayers at the Regent's Park Mosque – meaning that health messages reach as wide an audience as possible. Imams and other religious leaders are also able to deliver health messages in a culturally appropriate way and have great influence in the community, meaning that people are more likely to act on the message.

Other activities in places of worship have been used to reinforce the health messages delivered in sermons. For example, at one mosque a focus on the need to cut down on saturated fat was followed by a demonstration on which oils contain saturated fat, and how to cut down on fat by choosing lean cuts of meat and removing the skin. Work has also taken place with food providers at places of worship to reduce the amount of fat used in cooking, and provide healthier choices, for example fruit for dessert.

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CASE STUDY

Project Dil: Peer Education Programme

4



Introduction of an accredited Peer Education Heart Health Programme in Leicester

Project Dil is a Leicester-wide primary care and health promotion programme, which aims to increase understanding of CHD and improve primary and secondary prevention of CHD in the South Asian community via interventions at general practices and in the target population.

Health promotion has a key role in changing behaviour of individuals and populations. This is particularly relevant for CHD, a condition heavily influenced by lifestyle factors. However, for health promotion to be successful it must be sensitive, accessible and relevant for the target population. Project Dil has used several strategies to raise community awareness of CHD, one of which is the Peer Education Heart Health Programme.

Peer educators are active members of their communities and have an understanding of community perspectives which health care professionals may not. This is particularly relevant for South Asians who may not share racial background, religion, culture and social background with their primary care team. Peer education however needs to be robust in terms of selection, training and support of educators.

Project Dil invited key leads of community organisations (religious, social and voluntary) to an evening workshop to explain the project and identify potential volunteers. A training programme for peer education was developed and accredited through the Open College Network. Tutors were drawn from a range of specialist areas and invited to teach modules based on their skills, knowledge and ability. Forty- five peer educators were recruited across the South Asian community, aged thirteen to seventy, male and female. On completing their initial training, they were asked as part of their induction to deliver forty-five hours of peer education over a period of eight months, while continuing to receive ongoing support and further education from their tutors. After this initial period they continue to work within the community with the support of the project and partner agencies and appropriate payment.

Project Dil has also successfully worked in partnership with secondary care to train and develop peer educators in helping to deliver cardiac rehabilitation to the South Asian community. Three educators are now employed on site in three hospitals. Further training is planned to enable the educators to support diabetes, heart failure, renal, chronic eye disease management and chronic obstructive pulmonary disease work, some of which will be across the city. The peer educators will shortly be taken on as employees of the primary care trust.

Project Dil has continued to go from strength to strength and has successfully been mainstreamed into Eastern Leicester PCT programme. It has continued to receive local, regional and national recognition and is looking to become a mainstream NHS programme.

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CASE STUDY

Rochdale Healthy Living Centre

5



Rochdale Healthy Living Centre runs a variety of initiatives to break down barriers to health information and services in the local South Asian community.

The Roots project is a group for men aged 40 and over. The group takes part in seminars run by doctors where they discuss diabetes and cardiovascular problems, as well as broader health issues. There is also a ladies 40 plus heart disease and diabetes group who meet every two weeks and are visited by doctors who give talks on health, diet and exercise. Both groups have explored health issues through art, for example producing banners showing what is healthy and what is not.

The centre is in the process of setting up a walking scheme for older people in conjunction with the PCT. Also on offer is an armchair exercise class for older people and a Passport to Leisure scheme giving concessionary fees for local leisure facilities. Staff from the Healthy Living Centre accompany members of community groups to local facilities on their first visit to help build their confidence and make them feel comfortable.

Another initiative is a new gym, funded in partnership with Revitalising Inner Rochdale, which has recently been opened in an area where previously there were limited facilities. 95% of the attendees are Asian and many of them had never previously done any exercise. The gym offers single sex classes and new attendees are offered an introduction to get them used to the facilities. Some members of the community are now training to be gym instructors. The gym also has a hall which has been used to hold relaxation days.

Rochdale Healthy Living Centre also runs healthy eating sessions, covering topics like diet and reducing fat in cooking. The sessions are run by people who are known and respected in the local community, including dietitians, nutritionists and chefs and consequently attendance is high.

Activities for young people include walks, gym sessions and workshops on diet and exercise. Young people are given the opportunity to train as Junior or Community Sports Leaders, a nationally recognised award offered by the British Sports Trust. The training is advertised in community and youth centres and the scheme has proved extremely popular. Many young people who participate go on to take part in the Duke of Edinburgh awards scheme, where they have the chance to train as walk leaders and take part in expeditions.

The centre attributes its success to a “start small” approach, which allows people to build up their confidence and make further lifestyle changes as their confidence and abilities develop.

For more information on Healthy Living Centres visit:
www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/HealthyLiving

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CASE STUDY

Khush Dil “Happy Heart” Project



Preventing coronary heart disease (CHD) in South Asians

Khush Dil is a primary care led, NHS Lothian funded, community health project with a remit to address health inequalities in CHD prevention in South Asians. Working in partnership with a wide range of individuals and organisations the project offers a culturally sensitive framework for the identification and management of CHD risk factors within the primary care setting.

Core project staff include a health visitor, dietician, two South Asian community health workers and an administration worker. The project receives professional guidance and support via Professor Raj Bhopal, Director, Department of Public Health Sciences and Epidemiology, University of Edinburgh.

The team offers the following services:

Healthy Heart and Nutrition/Dietetic Clinics

Nurse/health visitor screening clinics provide one to one cardiac health assessment using health questionnaires designed for the Asian patient and a CHD software package to record and interpret data. The latter provides the patient with a visual picture of their individual heart health profile, identifying any risk factors. A pictograph is then used to facilitate goal setting and behaviour change using motivational interviewing techniques and referral on into project activities. GPs are provided with copies of blood tests and a faxed brief on interventions. Direct contact is made if required, for example, when a new diagnosis of diabetes is made via the screening process. Minor medical queries are directed to a local GP who offers project support on a consultation basis if needed.

Dietetic clinics also provide one to one support to promote healthy eating with a specialist focus on the South Asian diet. Interpretation and translation is supplied via the local council service or via South Asian Health Workers.

Clinics are run from the project base but also operate at various community venues on request – this has worked particularly well and joint working with the voluntary sector has been a key factor. Current work has included visiting restaurants in Edinburgh to screen Asian men.

Above: Khush Dil Community Health Worker serving fruit smoothies at the Edinburgh Mela 2004

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Community Lifestyle Activities

A core programme of activities is on offer for South Asians and clinic attendees are channelled into these following clinic or dietetic assessment. Alternatively an individual can opt or be referred into an activity at any point during the project. Khush Dil also runs group programmes offering a series of taster sessions – these have worked particularly well with established groups, e.g. local women’s Pakistani society, or with groups/individuals that regularly attend a voluntary organisation. The Community Workers are trained to lead and support these activities.

Programme activities currently on offer include an introduction to cardiac risk factors and emergency life support session, nutrition and food workshops, aerobic exercise for women, circuit training for men, walking and jogging groups, stress management and smoking cessation.

Monitoring and Evaluation

Khush Dil activity has been independently monitored by an Action Research project funded by the British Heart Foundation and also operates an in-house evaluation programme gathering both quantitative and qualitative data.

Partnership working

Many partnerships have been made with South Asian community leaders, voluntary organisation workers and key individuals. With their co-operation and support the project has been able to access many local South Asian people that would otherwise have been difficult to reach. Asian workers are key to the success of the initiative – their understanding of cultural sensitivities, language and communication norms provide an essential underpinning to the project’s work.

Over the past two years Khush Dil has been successfully established as a community public health provision. Key achievements have included raising awareness about CHD risk factors in South Asian communities; provision of new, culturally sensitive, flexible and accessible services; training and employment for South Asian community workers; providing a community forum for discussion about heart health via seminars and workshops and partnership working with voluntary, public and national bodies.

In December 02 Khush Dil received a national award of excellence in CHD with Diabetes and in June 03 the project gained further recognition via the Scottish Executive when it came runner-up in the Allied Health Professions Award for innovation.

Mainstreaming the service

Khush Dil’s initial plan was to provide an intermediary service, providing a platform for the development of a culturally sensitive care paradigm to identify, screen and manage CHD risk factors in South Asians. Findings show that this model of working is successful in realising positive health outcomes. A natural progression now is to incorporate this framework within primary care mainstream services, possibly by systematising the screening process via medical practice lists. The project would also aim to maintain a parallel community outreach approach and sustain the community-based activity programme to support lifestyle change. Current work is focused around the practical aspects of mainstreaming and how to transfer key learning into wider provision.

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<p>CASE STUDY</p> <h1>Bengali Bridge Project</h1>	<h1>7</h1>
<p>Addressing chronic health conditions in the Bengali population in Euston</p> <p>Two years ago, a London pharmacist became concerned that the Bengali population in the area was not accessing mainstream health services. In general, this community did not speak English and healthcare professionals did not understand their needs and belief models.</p> <p>To address this, the pharmacist, along with a representative from Camden and Islington Health Authority and a consultant in public health medicine, developed a proposal to provide classroom-style education sessions focusing on chronic health conditions. Before the project started, translators were employed and links made with other agencies, including diabetes nurses from the local hospital and smoking cessation workers. These links were key to the success of the project.</p> <p>The two-hour evening sessions take place in the pharmacy and are open to all. Topics have included coronary heart disease, diabetes and a healthy eating session with the team from the West Euston Healthy Living Centre, as well as other topics relevant to the local community, for example travel health. Although interest had been expressed, the first sessions were poorly attended because they were mixed. Once this cultural sensitivity had been addressed, the bi-monthly sessions were packed. Similar sessions at the local hospital were also poorly attended, whereas the pharmacy is more accessible and close to the local mosque, where the sessions were promoted.</p> <p>The pharmacy is also a Local Pharmaceutical Services (LPS) pilot site and offers pharmaceutical care monitoring as part of its contract. Pharmacists identify patients suffering from coronary heart disease and diabetes and offer services such as checking blood pressure, weight monitoring and advice on diet and medicines. All the Bengali staff in the pharmacy are also trained as level two smoking cessation advisers, to help address high levels of smoking, particularly among Bangladeshi men.</p> <p><i>“Before the project started, translators were employed and links made with other agencies, including diabetes nurses from the local hospital and smoking cessation workers. These links were key to the success of the project.”</i></p> <p>The organisers are currently looking at how best to evaluate the sessions and how they have influenced health outcomes in the community. One challenge is that patients in the pharmacy have shown reluctance to fill out questionnaires with their own opinions, perhaps out of fear that any constructive criticism might give offence or jeopardize the sessions. However, informal feedback and good attendance have demonstrated that the community values the sessions and that patients understand more about diseases and are better able to manage their conditions. GPs have also remarked that many of their patients have given up smoking.</p>	<p style="text-align: right;"> Suhas Khanderia Pharmaceutical Adviser, Islington Primary Care Trust (PCT) 020 7853 5558 suhas.khanderia@nhs.net </p>

Resources

British Heart Foundation health promotion materials

The British Heart Foundation provides a range of information in South Asian languages to raise awareness of heart disease and prevention. A number of booklets are available in Urdu, Hindi, Bengali, Gujarati, Punjabi and English, covering issues such as a lifestyle, medication and diabetes and the heart. Videos in South Asian languages include Living to Prevent Heart Disease and Get Fit, Keep Fit – Prevent Heart Disease. For more information and to order materials visit www.bhf.org.uk/publications

Further information and reading

Understanding of heart disease and diabetes in a South Asian community: cross-sectional study testing the 'snowball' sample method.

J Rankin and R Bhopal. Public Health 2001; 115:253-260

Attitudes to lifestyle risk factors for coronary heart disease amongst South Asians in Leicester: a focus group study.

Farooqi A, Nagra D, Edgar T, Khunti K. Family Practice 2000;17 (4):293-297

Qualitative focus group analysis was conducted to identify key issues relating to knowledge of and attitudes to lifestyle risk factors for CHD amongst South Asians aged over 40 years in Leicester. Participants expressed a range of attitudes to and different levels of knowledge of lifestyle risk factors for CHD. Barriers to improving lifestyle with respect to diet and exercise were identified; these included lack of information (e.g. how to cook traditional Indian food more healthily) and cultural barriers, such as lack of women-only exercise facilities. Participants perceived stress as an important cause of CHD, and stress directly related to ethnic minority status was described frequently. Language was identified as a key barrier to accessing health services. The study concluded that

South Asians still face problems accessing health and leisure services due to language and cultural issues and that health professionals need to provide individually tailored health promotion for South Asians which avoids stereotyping, but recognises potential cultural obstacles to change.

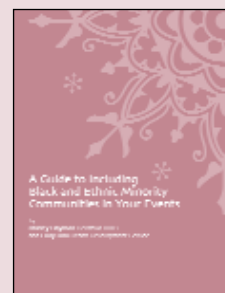
A guide to including Black and Minority Communities in Your Events: Newcastle HealthWORKS and Health Development Service

A guide aimed at organisations (both voluntary and statutory) who want to develop events for or including people from black and minority ethnic communities. The guide is written by projects in Newcastle with a number of years' experience in running successful health, information, community and consultation events, with guidelines covering all aspects of event planning and delivery, including access issues, tackling discrimination and publicity.

The guide can be read on the Department of Health website or ordered at £5.00 per copy from HealthWORKS West, C/o West End Resource Centre, Adelaide Terrace, Newcastle upon Tyne, NE4 8BE.

Management of patients with Coronary Heart Disease attending a secondary prevention clinic in primary care: Eastern Leicester Primary Care Trust

A video showing peer educators involved in role play training to help practice nurses run a good CHD clinic. The video is available nationally and can be ordered from Eastern Leicester Primary Care Trust on Tel. 0116 2954120/2954121 Fax. 0116 2954128 or by e-mailing Nayna.Unadkat@elpct.nhs.uk



Smoking

Smoking is a major risk factor in cardiovascular and coronary heart disease.

About ten million people in England smoke – over one in four people. Overall, approximately 20% of CHD related deaths in men and 17% of CHD cases in women are attributable to smoking.

Smoking just three to six cigarettes each day doubles the chances of having a heart attack. Smokers are also more than twice as likely to have a fatal heart attack than non-smokers.

Stopping smoking is the single most important thing a smoker can do to avoid a heart attack. Some studies have shown that, within five years of giving up, the risk is reduced almost to that of a non-smoker.

“42% of Bangladeshi men are smokers compared with 27% of men in the general population.”

Overall, South Asian men continue to smoke more than the general population, although smoking levels vary widely between and within ethnic groups.

Smoking levels are particularly high in the Bangladeshi community, especially among older men: 42% of Bangladeshi men are smokers, compared with 27% of men in the general population. Among older Bangladeshi men, 70% aged 50-74 smoke, as do 54% of those aged 30-49.

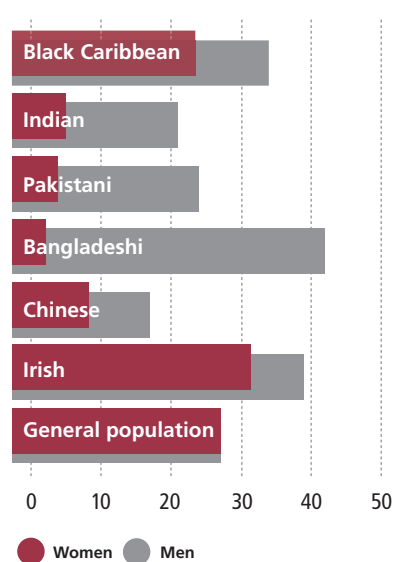


Above: Jak Patel, an ex-smoker with coronary heart disease, featured in a TV advert as part of the Department of Health's 'Don't Give Up Giving Up' campaign. The advert aimed to help raise awareness, particularly among the Asian community, that as well as causing lung cancer and stroke, smoking is also a major contributory factor to heart disease.

Smoking levels in South Asian women are much lower than in Asian men, and than in women in the overall population. However, a significant number (14%) of older Bangladeshi women reportedly smoke cigarettes. Tobacco chewing is also widespread in the Bangladeshi community, for both men and women.

These statistics highlight the need for culturally sensitive smoking cessation initiatives to be appropriately targeted, particularly at Bangladeshi men, users of chewing tobacco and also at Asian teenagers, as anecdotal evidence suggests that smoking rates among young Asians may be rising.

Fig 1: Cigarette smoking by sex and ethnic group 1999 England



Source: British Heart Foundation Statistics Website – Joint Health Surveys Unit (2001) Health Survey for England. The Health of Minority Ethnic Groups 1999. The Stationery Office: London.

Notes: Adults aged 16 and over. Age-standardised percentages (standardised risk ratios x percentage in general population); see source for method of age-standardisation.

CASE STUDY

Manchester Smoking Cessation Service

8



Working with religious and community organisations – Smoking Cessation in Manchester

Manchester Smoking Cessation Service has worked together with Salford and Trafford Smoking Cessation Service and partners, including the Muslim Council of Britain and the Islamic Society of Britain, to run an initiative centred on Ramadan, Tobacco and Health.

The initiative aimed to raise awareness in the Muslim community about the health benefits of quitting smoking and to provide accessible, appropriate services to support people wanting to make a quit attempt.

Observant Muslims do not eat, drink or smoke during daylight hours in the month of Ramadan. Ramadan is therefore a useful focus for publicity about smoking cessation services and targeted initiatives aimed at Muslim communities.

A linkworker was employed to liaise with religious and community organisations and a pamphlet 'Tobacco and Health: An Islamic Perspective' was produced in collaboration with religious leaders. Seminars were held with presentations in English, Urdu and Bangla on the impact of tobacco on the health of British Muslims and services for cessation. Participants were asked to consider their views on the role for community and religious organisations in smoking cessation and all delegates signed a declaration with the following statement:

"We the undersigned agree that tobacco use is not in accordance with the tenets of Islam. We pledge our allegiance to working with our communities to reduce tobacco use, thereby improving the health of the Muslim community in the North West."

Ramadan prayer time calendars personalised to each mosque were also produced and distributed via mosques and community centres. In addition, a number of religious and community leaders were offered training to run awareness-raising talks on tobacco cessation and signpost people into services. One-to-one appointments for those wanting help with tobacco cessation were offered at mosques and community centres before and during Ramadan.

Relationships with mosques and religious organisations are developing well. Referrals are now received directly from imams. Twenty of 26 Manchester mosques have been involved so far and an on-going weekly clinic has been set up at health centre in close proximity to six mosques and three large community centres.

Above: Community and religious leaders consider how they can support their communities to quit tobacco

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CASE STUDY

QUIT Ramadan Campaign

9

Every year QUIT runs a National Smoke Free Ramadan Campaign with partners like the British Heart Foundation, Smoke-Free London, The Muslim Health Network and the Imams of some 60 large mosques. The campaign reaches some 1.6 million Muslims in the UK.

Last year's campaign was targeted at smokers and non-smokers alike during the Muslim holy month of fasting starting 27 October 2003, to bring home the dangers of second hand smoke to the family. Smokers were urged to stop smoking as they are twice at risk from developing heart diseases. Their family and colleagues were urged to support the smokers in their quit attempt as they too risk developing the same diseases as the smokers through second hand smoke – often called passive smoking.

The campaign communicated three key messages:

“Do not kill (or destroy) yourselves for verily Allah (swt) has been most merciful to you” (4:29) – 120,000 people die from smoking related diseases in the UK each year.

“And do not make your hands contribute to your destruction” (2:195) Smoking causes fatal diseases. Some ethnic groups are twice as likely to die from heart disease and face severe complication in diabetes as the general population. 50% of the smokers will die prematurely. 1 in 2 of those who die, die before they reach middle age.

“Do not waste (resources) extravagantly.” (17:26) A smoker smoking 20 a day will spend up to £1500 per year.

The campaign was launched by Lord Ahmed in the House of Lords and used local and national ethnic media to promote awareness of smoking and its effects on the health of the Muslim communities. Calendars with prayer times were made available which also included health messages and the Asian Quitline phone number. The campaign was promoted on local Radio Ramadan stations across the country, and on the London station Sunrise radio during the daily countdown to breaking the fast, a sociable time when families are likely to be gathered together. Key Islamic organisations were contacted to form a national health network to push the message through to community leaders and workers. Mosques and their clerical community were also targeted for training in primary health issues.

QUIT also runs campaigns around Hindu and Sikh religious festivals by coming up with an appropriate theme or ‘PR hook’. Two recent examples are ‘Safety over Diwali – Cigarettes Cause Fires’ and ‘New Year Resolution for Hindu New Year’. The campaigns are backed by intensive media, PR, Poster, talks, exhibitions and outreach work by counsellors.



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CASE STUDY

New Leaf

10

Developing smoking cessation and heart disease services for hard to reach groups

New Leaf is a comprehensive and inclusive service providing one to one clinics and group sessions in a number of health and community locations across Greater Nottingham, for each of the four Nottingham PCTs.

New Leaf is committed to providing an equitable service that is both appropriate and sensitive to all its potential service users. However the service recognises that certain minority ethnic groups may find the mainstream provision inaccessible and inappropriate. Therefore a specialist advisor has dedicated time set aside to develop the service to improve access for minority ethnic groups. The role of the specialist advisor is to identify needs which are then incorporated into all New Leaf's service development and delivery. This ensures an equitable service whereby clients have a choice in where they see a New Leaf advisor and who they see, rather than waiting for the 'specialist' worker.

“Therefore a specialist advisor has dedicated time set aside to develop the service to improve access for minority ethnic groups.”

Training is provided on cultural and religious sensitivities to support advisors in working with clients from different ethnic backgrounds, including the different methods of tobacco use in various communities. It also covers attitudes around smoking which may impact on the uptake of

the service. For example, it is seen as a taboo for South Asian women to smoke and is religiously unacceptable practice for Sikhs and Muslims. Advisors are also trained in working with interpreters.

To ensure services were developed around the needs of the community, New Leaf first held a consultation with community leaders and members. Priorities identified were translating literature into various languages and promoting services through appropriate channels, for example community radio. New Leaf also tries to respond to differing needs within the various groups it serves. For example in some communities there are low levels of literacy even in the home language, so New Leaf is developing audio cassettes to make sure the no-smoking message gets through. One challenge facing the service is that because of the inclusive nature of its work, there can be additional pressure in meeting targets. For example, a consultation with an interpreter can take twice as long as a standard consultation, meaning that only half as many people can be seen.

New Leaf has developed good partnerships with local community organisations and leaders. One recent initiative has been to organise a Multi Agency Conference for Young Asian Women tackling tobacco and drugs issues. Evidence suggests that the Asian Community is not immune to the growing problem of smoking and drug use, but for cultural reasons this is not acknowledged by communities, so the conference will provide a first step in developing better understanding of the needs of young Asian women.



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CASE STUDY

Smoke Free Northants**The Northampton Stop Smoking Service has been working with the Northampton Bangladeshi Association to develop services tailored to the needs of the local Bangladeshi community.**

The service recognised that its support was not being used by the sizeable Bangladeshi community and decided to take action to investigate why this was and what was needed to make it more suitable to their specific needs.

As well as the usual health problems of smoking tobacco, this community also has a tradition of chewing tobacco, or paan, which leads to oral cancers. Chewing of paan is a part of the culture, particularly for the women, who offer paan to visitors to their homes as part of a friendly welcome. Paan has a very localised effect and can be used to dull pain in the mouth, so it can end up being chewed in order to dull pain which it has helped cause – a vicious circle!

For the past year the smoking services have been working with the Bangladeshi Community Centre, a group of 4,000 local people, to develop a new service. A new health worker has been recruited who is also a member of the Bangladeshi community. Shanaz is working with the local community to tailor a service to their needs and cultural requirements. She has also visited other similar projects to learn from their experience.

Shanaz is working with the women as a catalyst for change within the home, and has established gender based groups. Nicotine Replacement Treatment (NRT) chewing gum is proving to be a useful tool to help people stop chewing paan.

A part of the Smoke Free Northants service is delivered by a bank of associate advisors, who are drawn from nursing, health advisors and drug action workers. These advisors are trained to lead stop smoking sessions for the service. New Bangladeshi advisors are being recruited to work within their community.

“...advisors are trained to lead stop smoking sessions for the service. New Bangladeshi advisors are being recruited to work within their community.”

A key part of the development of the service is to listen to feedback and adapt the service to better meet people's needs. For example, feedback has indicated that an excess of brochures and leaflets is not the best way to get a message across, so instead a video is being used which is proving much more successful.

The service is providing a wider health message to build on the stop smoking help and is promoting exercise and diet to benefit the heart as well.

Smoke Free Northants is working with local GPs practices, community pharmacists and panel/user groups to raise awareness of the service.

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CASE STUDY

Tower Hamlets Bangladeshi Stop Tobacco Project

12



The Tower Hamlets Bangladeshi Stop Tobacco Project works with both men and women, providing an outreach service to raise awareness, recruit and support people through a tobacco cessation programme.

The project is funded by Tower Hamlets Primary Care Trust with a 'Service Level Agreement' with Queen Mary's School of Medicine and Dentistry. The project evolved from innovative research into the use of tobacco in paan chewing by women in Tower Hamlets into a recognised cessation programme for Tower Hamlets' Bangladeshi community.

Through a community-orientated approach, the project addresses the needs of the Bangladeshi community, tackling barriers to accessing tobacco cessation by overcoming language and cultural sensitivities. Motivated male clients are invited to regular drop in sessions, while home visits are offered to female clients and the elderly. The service offers support and understanding and provides Nicotine Replacement Therapy (patches, gums and inhalators).

The project is widely known within the community, participating in many events. An estimated 8000 contacts have been made with people in the local Bangladeshi

Above: Dipul Ghosh, Project Worker with the Bangladeshi Stop Tobacco Project who works specifically with Bangladeshi men, advising a male patient at a Sure Start event.

community. On a day-to-day basis the project accepts referrals from practice nurses, GPs and health professionals. A 24 hour recruitment line is advertised through the project's leaflets.

From April 2003 to March 2004, the project has actively supported 310 people: 126 women and 184 men. Sixty-two per cent of these people had given up using tobacco over four weeks, which comfortably exceeds the national short-term cessation rate.

Action research projects undertaken by the project include the 'Bag Campaign', which involved trained outreach workers visiting tobacco and paan retailers to raise awareness about the health and safety issues around tobacco handling, and reminding them of their legal responsibilities. Information about the project, a code of practice and free carrier bags advertising the help line number were distributed to 60 retailers. The outcome of the campaign was very positive – some retailers wanted their shop names on the bags in future campaigns. Other action research projects include the long term follow up of the 'quit' status of past study participants and an investigation of the oral pain reported by the female tobacco chewers when giving up tobacco.

The service model developed by the project has been enriched through a process of actively seeking feedback from the community. For example, this has enabled national institutions like 'No Smoking Day' to become 'No Tobacco Day' for Tower Hamlets residents, with a careful selection of culturally appropriate printed materials translated into simple Bengali.

The Tower Hamlets Bangladeshi Stop Tobacco Project were the winners of the 2004 'Quit' Awards.

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Resources

National helplines

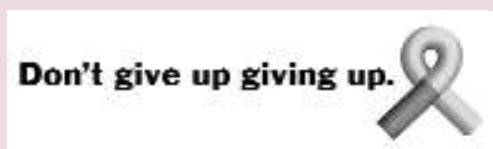
The NHS Smoking Helpline

(0800 169 0 169) provides expert, free, and friendly advice to smokers and their families. The helpline is open between 7am and 11pm every day for information requests and referrals, with unlimited access to trained advisors giving one-to-one advice and support.

The NHS Asian Tobacco Helpline (open Tuesdays 1-9pm with messages taken at other times) provides a dedicated, confidential and free advice service on how to give up smoking cigarettes, 'bidi' or the hookah as well as chewing tobacco and tobacco in paan. The phone numbers are:

0800 169 0 881 **Urdu**
 0800 169 0 882 **Punjabi**
 0800 169 0 883 **Hindi**
 0800 169 0 884 **Gujarati**
 0800 169 0 885 **Bengali**

Self-help leaflets in each language are also available.



NHS Smoking Helpline advisors can refer callers to a local NHS Stop Smoking service, offering ongoing free face-to-face support and advice near their own home. These are available across the country, offering a range of services including one-to-one meetings and group discussions with trained stop smoking advisors.

For more information see www.givingupsmoking.co.uk

Asian Quitline is a specialist service set up to meet the needs of South Asian smokers and tobacco chewers who want to quit. The service was launched by the not-for-profit organisation QUIT in September 1997 with support from the British Heart Foundation.

Asian Quitline offers a free and confidential telephone counselling service in five different Asian languages – Bengali/Sylheti, Gujarati, Hindi, Punjabi and Urdu. All the professionally trained male and female counsellors are fluent in one of these languages and English.

Counsellors offer advice and support on smoking cessation, diet and exercise in a way that is relevant to the caller's beliefs, attitudes and culture. Free information sheets and leaflets in all five Asian languages are also available and are sent to all callers who would like additional information. Callers are free to ring the service as many times as they need to for ongoing support.

A 24 hour a day messaging service is also available, which gives callers information and motivational messages. There is also an option for the callers to be called back or receive written information by post.

Asian Quitline also provides a resource centre for individuals and health professionals who want literature, advice and support on their local smoking cessation projects.

The telephone numbers for Asian Quitline are as follows:

0800 00 22 44 **Bengali**
 0800 00 22 55 **Gujarati**
 0800 00 22 66 **Hindi**
 0800 00 22 77 **Punjabi**
 0800 00 22 88 **Urdu**

For more information visit www.asianquitline.org



Resources

Further information and reading

For more information on government policy and initiatives on tobacco please see the Department of Health website

www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/Tobacco

The NHS Cancer Plan (September 2000)

The NHS Cancer Plan – Three year progress report: Maintaining the momentum (Oct 2003) – both available at www.dh.gov/publications

Understanding influences on smoking in Bangladeshi and Pakistani adults: community based, qualitative study.

Judith Bush, Martin White, Joe Kai, Judith Rankin and Raj Bhopal. *BMJ*, May 2003; 326:962.

Tobacco and England's Ethnic Minorities

HDA (2000), London

Available at www.hda-online.org.uk/documents/tobac_ethnmins.pdf

Black and minority ethnic groups in England: the second health and lifestyles survey. Executive summary.

HEA (2000), London – available at www.hda-online.org.uk/documents/black_minorities_survey.pdf

Black and minority ethnic groups in England: the second health and lifestyles survey. London: HEA (1999) –

available at www.hda-online.org.uk/downloads/pdfs/healifes_black.pdf

Black and Minority Ethnic Groups and Tobacco Use in England: A Practical Resource for Health Professionals.

HEA (1999), London – available at www.hda-online.org.uk/documents/blackminority_tobacco_use.pdf

ASH Factsheet no.6. Smoking the heart and circulation – available at www.ash.org.uk/html/factsheets/html/fact06.html

Giving up for life.

NHS information booklet on giving up smoking – available to order at: www.givingupsmoking.co.uk.

Useful websites

NHS givingupsmoking website
www.givingupsmoking.co.uk

British Heart Foundation
Statistics Website
www.heartstats.org

Asian Quitline
www.asianquitline.org

Quit
www.quit.org.uk

ASH
www.ash.org.uk

Cancer Research UK
www.cancerresearchuk.org

No Smoking Day
www.nosmokingday.org.uk

Muslim Health Network
www.muslimhealthnetwork.org.uk

Health Development Agency
www.hda-online.org.uk

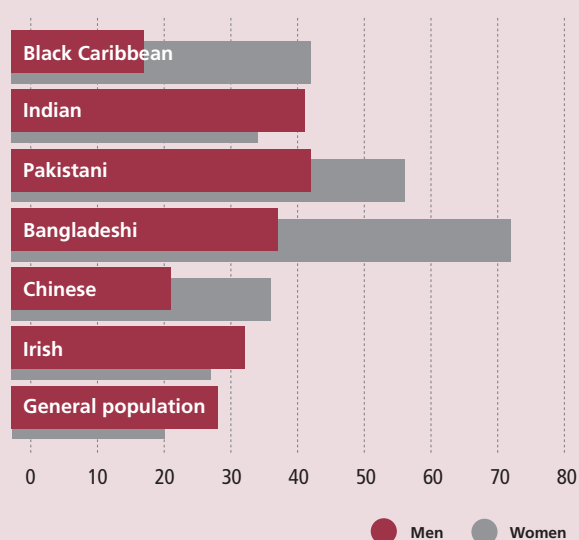
Obesity, diet and exercise

The incidence of coronary heart disease is highest among people who are obese. Overall, 22% of men and 23% of women in England are now obese.

There is a clear link between a healthy diet and increasing levels of activity in helping people maintain a healthy weight.

The adverse effect of excess weight is more pronounced when the fat is concentrated mainly in the abdomen. This is known as central obesity and can be identified by a high waist to hip ratio.

Fig 2: Prevalence of a raised waist-hip ratio by sex and ethnic group, 1999, England



Source: British Heart Foundation Statistics Website – Joint Health Surveys Unit (2001) Health Survey for England. The Health of Minority Ethnic Groups 1999. The Stationery Office: London.

Notes: Adults aged 16 and over. A raised waist-hip ratio for men is 0.95 and over and for women is 0.85 and over; age-standardised percentages; see source for method of age-standardisation.

Levels of general and central obesity vary with ethnicity in both men and women in England.

Compared with the overall population, levels of obesity are much lower in Pakistani, Indian and, most markedly, Bangladeshi men, who are three times less likely to be obese than the general population. Despite low levels of general obesity, however, Pakistani, Indian and Bangladeshi men have relatively high levels of raised waist to hip ratio, with 37% of Bangladeshi men, 41% of Indian men and 42% of Pakistani men classed as centrally obese compared to 28% of men in the general population.

Among women, obesity levels are particularly high for Bangladeshi and Pakistani women. However, women across all South Asian ethnic groups have levels of central obesity well above that of the general population, with Pakistani women twice as likely and Bangladeshi women over three times as likely to have a raised waist to hip ratio than women in general.

The prevention and management of obesity are at the heart of many of the government's health priority areas, including coronary heart disease and cancer.

The best long-term approach is prevention. In order to have the greatest impact action must start in childhood. Critical to this is improving diet – reducing intakes of fat and added sugars – and increasing activity levels.

Diet and nutrition

Poor diet plays a fundamental role in the development of coronary heart disease, and is one of the key modifiable risk factors in its prevention.

Eating at least five portions of a variety of fruit and vegetables a day could lead to an estimated reduction of up to 20 per cent in overall deaths from chronic diseases, such as heart disease stroke and cancer.

However, the *National Diet and Nutrition Survey* (published in 2002) found that only 13% of men and 15% of women consumed five or more portions a day. The average consumption of fruit and vegetables among adults in England is less than three portions a day. There are wide differences in consumption between social classes, with those in lower social class groups consuming about 50% less than those in professional groups. Children's consumption of fruit and vegetables is particularly low. In a typical week one in five children aged four to 18 years eat no fruit at all.

A recent survey found that each increase of one portion of fruit and vegetables a day lowered the risk of CHD by 4% and the risk of stroke by 6%.

Other dietary changes which would help to reduce rates of CHD in the UK population include a reduction in fat, particularly saturated

“An increase of one portion of fruit and vegetables a day lowered the risk of CHD by 4% and the risk of stroke by 6%.”

fat intake, a reduction in salt intake and an increase in carbohydrate intake.

The *Health Survey for England 1999*, which focused on the health of minority ethnic groups, asked questions about the frequency of consumption of a range of foods, including fruit and vegetables and a number of high fat and high sugar foodstuffs. Results show considerable variation in eating habits by ethnic group.

For example, Bangladeshi men and women were more likely to frequently consume both red meat and fried foods than adults from other ethnic minority groups. In contrast, Indian men and women were the least likely to frequently eat red meat and Indian men were the least likely to frequently eat fried foods.

These differences were reflected in an overall fat score (calculated from the food-frequency questionnaire). Among men, a high fat score was most common in Bangladeshi men (22%) and lowest in Indian (11%) men. In women, 27% of Bangladeshi women had a high fat score compared with 8% of Indian women.

Bangladeshi adults also have the lowest levels of fruit consumption, with only 15% of men and 16% of women consuming fruit six or more times **a week** – as opposed

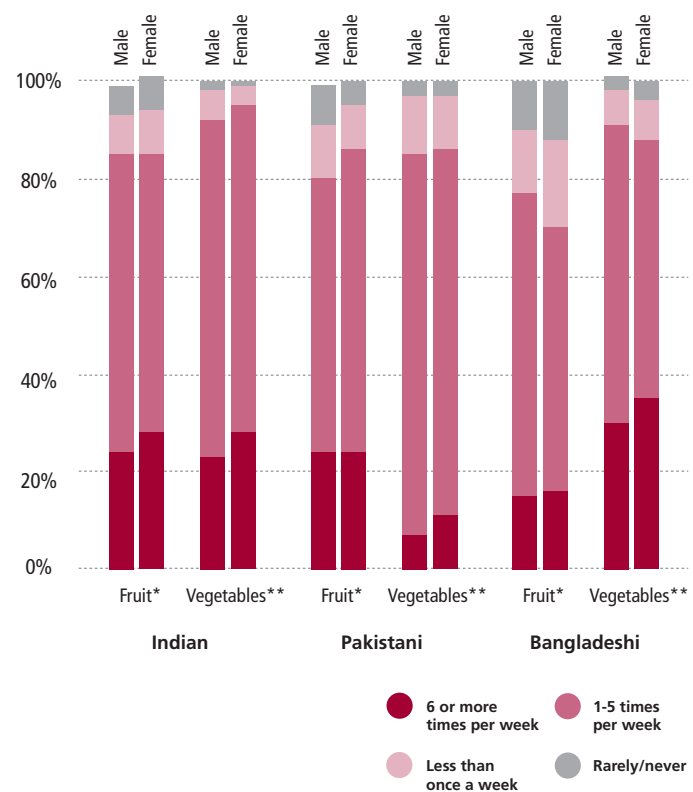


to the recommended five portions of fruit or vegetables **a day**. The lowest levels of vegetable consumption are in the Pakistani community, with just 7% of men and 11% of women eating vegetables on six or more days a week.

An HEA report, *Black and minority ethnic groups in England: the second health and lifestyles survey* showed that understanding of key terms used in healthy eating messages varied widely across groups, with Indian, Pakistani and Bangladeshi people reporting lower levels of familiarity with terms like “starchy foods”, “dietary fibre” and “fat”. The term saturated fat was particularly poorly understood. Among those who said they understood the terms, knowledge of foods high in starch, dietary fibre, fat and saturated fat was patchy and often poor. Awareness of the links between diet and cardiovascular and other diseases was low in general, particularly among Bangladeshi people.

These findings suggest that there is a great opportunity to reduce heart disease through providing information on healthier eating and improving access to fruit and vegetables, particularly in deprived areas.

Fig 3: Consumption of fruit and vegetables



Source: British Heart Foundation Statistics Website – Joint Health Surveys Unit (2001) Health Survey for England: The Health of Minority Ethnic Groups 1999. The Stationery Office: London.

Notes: Males/Females aged 16 and over. Bases (unweighted) vary: those shown are for the fried food sample. *Fresh, frozen and tinned fruit. **Fresh, frozen and tinned vegetables excluding chips.

Left: Asian children enjoying bananas from the School Fruit and Vegetable Scheme

A number of government initiatives aim to help ensure that people have information and access to healthy food wherever they live.

These include the **5 A DAY programme**, which encompasses:

- **5 A DAY local initiatives**, funded by the Big Lottery Fund, ranging from cookery classes in community centres and mobile delivery service to grow-your-own fruit and vegetable schemes and the development of farmers markets and food co-operatives
- **5 A DAY logo**, launched in March 2003 with the aim of providing clear and consistent messages to encourage people to eat more fruit and vegetables and make it easier for people to make healthy choices
- **School Fruit and Vegetable Scheme (SFVS)**, which by the end of 2004, will entitle every child aged four to six in Local Education Authority infant, primary and special schools in England to a free piece of fruit or vegetable each school day.

For more information on the 5 A DAY programme please see www.5ADAY.nhs.uk



Above: Primary School children making sandwiches for their healthier lunchboxes

In addition, the **Food in Schools (FiS) Programme** is a joint venture between the Department of Health and the Department for Education and Skills. Approximately 300 primary and secondary schools across England are involved in eight pilot projects – healthier breakfast clubs, tuck shops, vending machines, lunch boxes, cookery clubs, growing clubs, as well as work on improving water provision and the dining room environment. The results will be brought together in a “whole school approach” to assist schools across England to develop sustainable programmes to promote healthy eating among children, available early in 2005.

For more information on the Foods in Schools programme please see the Department of Health website:
www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/FoodInSchools



CASE STUDY

Coventry 5 A DAY Scheme

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The Coventry 5 A DAY scheme provides people with money-off vouchers to spend on fruit and vegetables.

Each voucher is worth £2, and people receive one voucher a week for four weeks. The recipients are required to spend £4 of their own money on fruit and vegetables at the same time. The vouchers can be used for fresh, frozen, dried or tinned produce or fruit juice, but they must be pure, with no added sugar.

The vouchers are valid in two stores in each area and in the city centre and the central market where there is a large group of fruit and vegetables stalls. The Co-op stores and a local foodstore chain are both supporting the scheme.

There is a local delivery scheme which charges 50p to deliver fruit and vegetables, so the scheme has linked in with this, and for people in areas with restricted shopping, or for people with disabilities, the 50p can come out of the voucher.

Free recipe cards provided at the retail outlets support the voucher scheme, and there is also a 'How to Get Started' leaflet which explains how to wash, prepare, chop and cook different vegetables and fruit, and how to incorporate them into meals. The healthy eating messages have also been promoted around the city on billboards and bus-shelters.

A key area for the scheme is around the Foleshill Road, where there is a large Asian community. The project is targeting families with children under five to try to introduce variety in diet and increase consumption of fruit and vegetables for the whole family. Traditionally the Asian diet uses a wide variety of vegetables in cooking so the increased consumption of fruit is being encouraged as snack foods and as part of daily meals.

Asian cooking traditions are usually passed down within the family, but sometimes the younger generation struggle when they leave home. A questionnaire is given out with the vouchers asking if people want free advice, and if they ask for it the Community Nutrition Team go into people's homes and give one-to-one help on preparing and cooking food.

When the scheme started there were concerns that the requirement to spend £6 at one time, which effectively requires the user to do a weekly shop, would not suit people who often buy a little each day. The aim was to encourage people to plan ahead and achieve economies by buying in larger quantities and more fresh produce. In fact this has not proved to be a problem, and there is also evidence of groups of people shopping together.

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CASE STUDY

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The Coriander Club, Spitalfields City Farm



Spitalfields City Farm is a community farm which has been running for 25 years on reclaimed land.

The farm is a resource open to the community for education and leisure pursuits. It also provides free training in numeracy, literacy, English language and practical skills in horticulture, and has a Sylheti speaking support worker.

The Coriander Club is a group of Bangladeshi women who get together to grow vegetables, including traditional Bangladeshi vegetables like chillies, moulis, aubergines and snakeroot. The group has two weekly gardening days and a weekly healthy cookery class. The women take some of the vegetables they grow home in return for their labour on the farm. Growing vegetables is a culturally acceptable hobby for the women, and also gives them an opportunity to be physically active.

The cookery class was started to give the women something other than gardening activities to do in winter. The class is used as an adult education opportunity, for example to give health information, as many of the

women attending have diabetes and high blood pressure. The class looks at ways of cooking more healthily, for example ideas on how to limit fat and salt, and ways to eat five portions of fruit and vegetables a day. The women cook traditional Bangladeshi dishes and have also tried dishes from other cuisines, for example Mediterranean dishes, as well as dishes to appeal to children and grandchildren. The class is also used to help the women improve their English, for example through using food vocabulary, and build their confidence.

The Coriander Club is a member of the Taste of a Better Future network, a national network of ethnic minority women's food growing groups. The Taste of a Better Future project was set up in 1999 by the Women's Environmental Network (WEN). The main aim of the project was to help ethnic minority women's groups and other community groups develop organic food growing skills. It recognises that such groups have little access to affordable organic food, particularly traditional fruit and vegetable varieties, or to gardens of their own. Many women from ethnic minority communities have food growing skills that they are not using, many more want to learn about food growing. Over the last few years the 40 plus groups in the growing network have brought new life to some of the most unlikely spaces on housing estates and disused inner city plots. As well as nutritious food, they have enjoyed making friends, sharing skills and bolstering their communities. For more information about WEN and the *Taste of a Better Future* network see: www.wen.org.uk/local_food

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CASE STUDY

Birmingham Food Net

15

The Food Net began in August 2000, funded by Health Improvement monies to promote a cardio-protective diet in a specified area of Birmingham, including some areas with a high South Asian population.

Since April 2003 the Food Net has been funded by a combination of Lottery money (5 A DAY) and local Neighbourhood Renewal funding.

The chief activity, in response to an initial needs assessment, is cook and taste sessions. These are run by Community Food Workers, recruited from the local population and trained and supported by dietitians and nutritionists. One worker is of Bangladeshi origin and speaks fluent Urdu as well as Bengali. She works in the areas with the largest Asian population where common health problems include obesity, diabetes and cardiovascular disease. Cooking sessions focus on promoting consumption of oily fish, fruit and vegetables, and reducing the amount of fat used in cooking, as well as changing to unsaturated fats.

Groups are accessed by contacting local community, voluntary and statutory organisations. A five session course is offered which starts by teaching healthy eating using the Balance of Good Health model. All sessions are as interactive, visual and as practical as possible. Participants agree what to cook, do the cooking, taste and comment on food and take home the recipe.

At the final session participants are invited to comment on what they have changed as a result of the sessions in their cooking, shopping and eating habits, as well as any other lifestyle changes. Results of this evaluation show that participants include more fruit, vegetables, fish, cereals and starchy foods in their diet, use less oil and change to unsaturated fats. Some also report being more physically active and many say how much they have learnt about healthy eating.

Some of these groups, particularly the non-English speaking ones, have had little exposure to education sessions and then it may be necessary to negotiate ground rules. Also, South Asian participants are often experienced cooks who spend lengthy periods cooking for large numbers, so may need some convincing that they have more to learn. Some of the non-English speaking groups had a low level of knowledge about healthy eating messages promoted in the UK, although virtually all participants link diet with health.

“Cooking sessions focus on promoting consumption of oily fish, fruit and vegetables, and reducing the amount of fat used in cooking, as well as changing to unsaturated fats.”

Food Net has also begun to work with local retailers. This has included training pharmacists to give out the 5 A DAY message, and supplying a range of recipes for customers to pick up at the till in shops stocking fruit and vegetables. Retailers are often broadly supportive of Food Net aims, recognising the diet related disease burden in their community and their own families.

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CASE STUDY

Bradford Trident Healthy living project weight management programme

16



Bradford Trident Healthy living project's weight management programme is targeted at communities within the New Deal for Communities (NDC) area of Bradford, which is made up of the Marshfields, West Bowling and Little Horton areas.

Health inequalities are significantly higher in the area as are rates of coronary heart disease, and type II Diabetes.

The group meets on a weekly basis for a 12 week programme, which records and monitors weight, blood pressure and body mass index.*

The Healthy living project works closely with other Trident projects particularly those in the Health and Social Care programme, such as the Dance for Life project, which is regularly involved in offering appropriate levels of dance, exercise and movement.

There is a great emphasis on food and diet, with close co-operation with the West Bowling food co-op, where fresh seasonal and affordable produce is available.

Recipes, cooking methods and the meaning of food labels are extensively discussed and members of the groups are encouraged to keep food diaries to understand and monitor their own eating habits. Many of the participants have lost weight as a result.

The diversity of the group, which includes Afro-Caribbean, South Asian and white people, ensures lots of top tips, and recipes from other parts of the world. Cook and share sessions, soon to be introduced, will include healthy, low budget and easy recipes which can be enjoyed by families.

An essential principle of the work that underpins the healthy living project is the desire to enable and empower local communities to implement change for themselves. For this their active participation and ownership of local initiatives is vital.

At the end of the programme a subsidized health and fitness club membership is given to participants as an incentive to continue adopting a healthy lifestyle.

Above: Children learn how to make healthy choices for their packed lunches during a community fun day held at the local school

* The body mass index (BMI) is measure of body fat based on height and weight

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CASE STUDY

Dietary intervention in high risk families with CHD in Ealing

17



Sustaining patient motivation for long-term adherence to dietary changes and weight control remains a substantial problem for physicians, dieticians, patients themselves and their families.

Conventional dietary interventions have limited success, reducing cholesterol by around 5% and weight by around 1kg over one year. Novel methods of reducing, and sustaining, energy intake from fat, need to be applied if major risk factors including weight and cholesterol are to be reduced more effectively in high risk populations such as Indian Asians.

The Department of Cardiology at Ealing Hospital has developed a unique 'family based' programme, where the cardioprotective diet is emphasized using the low glycaemic index approach. The shopper and cook of extended families are invited to these group sessions, rather than the patient alone. The team have altered their usual work patterns to hold joint classes for families in the evenings to ensure high attendance rates.

Above: Cardiac Dietician Baldeesh Rai running an evening session for patients and family members to discuss healthier eating.

"The Department of Cardiology at Ealing Hospital has developed a unique 'family based' programme, where the cardioprotective diet is emphasized using the low glycaemic index approach. The shopper and cook of extended families are invited to these group sessions, rather than the patient alone."

Based on a recent analysis, this 'family based' approach lowers cholesterol by 18%, systolic blood pressure by 3mmHg, and body weight by 3.7 Kg, compared to a 'conventional care' group. Furthermore, there is evidence that the behavioural changes have persisted one year beyond the completion of the intervention programme and also have an impact on the children. This approach provides a tool for dietary intervention that is low intensity, and easy to put into practice in primary care, with modest extra resources. It also validates a dietary intervention approach that can be used as a 'blueprint' for Indian Asians who live as large extended family units around the country.

The Glycaemic Index (GI) is a ranking of carbohydrate foods based on the rate at which they raise blood glucose levels. Each food is given a number or value: Foods that break down quickly will raise blood glucose quickly, and are given high GI values. Foods that break down slowly will raise blood glucose slowly, and are given low GI values. There is good scientific evidence that GI influences blood glucose levels. Slow, steady rises and falls in glucose may in addition help you feel full for longer. GI can play a role in weight management as part of a calorie-controlled diet by helping to control appetite and insulin levels. (Source: adapted from British Dietetic Association factsheet: April 2004 GI Diet)

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Resources

Further information and reading

National Diet and Nutrition Survey – adults aged 19 to 64 years. Volume 1: Types and quantities of foods consumed. Office for National Statistics (2002). The Stationery Office: London. – available at www.statistics.gov.uk/ssd/surveys/national_diet_nutrition_survey_adults.asp

Health Survey for England: The Health of Minority Ethnic Groups 1999. Joint Health Surveys Unit (2001). The Stationery Office: London – available at www.archive.official-documents.co.uk/document/doh/survey99/hse99.htm

Black and minority ethnic groups in England: the second health and lifestyles survey. Executive summary. Health Education Authority (2000), HEA, London – available at www.hda-online.org.uk/documents/black_minorities_survey.pdf

Black and minority ethnic groups in England: the second health and lifestyles survey. Health Education Authority (1999a). London: HEA – available at www.hda-online.org.uk/downloads/pdfs/healifes_black.pdf

Useful websites

British Heart Foundation Statistics Website
www.heartstats.org

British Nutrition Foundation
www.nutrition.org.uk

Food Standards Agency
www.food.gov.uk

Muslim Health Network
www.muslimhealthnetwork.org.uk

Physical activity

Physical activity is a major independent protective factor against coronary heart disease in men and women.

Inactive and unfit people have almost double the risk of dying from coronary heart disease compared with more active and fit people. People at high risk of coronary heart disease may benefit even more from physical activity compared with people at lower risk.

Thirty minutes or more of at least moderate intensity physical activity a day on at least 5 days a week significantly reduces the risk of cardiovascular disease and has general health benefits. The recommended levels of activity can be achieved either by doing all the daily activity in one session, or through several shorter bouts of activity of ten minutes or more. The activity can be lifestyle activity or structured exercise or sport, or a combination of these.

South Asian men and women from all ethnic groups are less likely to take part in physical activity than the general population. For example, only 18 per cent of Bangladeshi men and 7% of Bangladeshi women meet the current government recommended physical activity levels.

Black and minority ethnic groups in England: the second health and lifestyle survey showed that there was good unprompted understanding among all ethnic groups that taking exercise was one of the most important things people could do to maintain their health.

A variety of reasons were given for not participating in exercise, some of which varied between ethnic groups. For example Indian women were most likely 'not to have time' while Bangladeshi men were the least likely to say this.

Some reasons for not participating appeared to be specific to ethnic minority groups, notably modesty or avoidance of mixed sex activity and fear of going out alone. Language and culture were otherwise rarely mentioned as perceived barriers. Religion played an important role in the answers given, but modesty or avoidance of mixed-sex settings was not confined to Muslims.

Low levels of knowledge about recommended levels of physical activity were reported, which may be a barrier to participation. Wider determinants such as unemployment and patterns of employment among those in paid work also had significant impact on levels of physical activity.

Other possible explanations for lower levels of physical activity may include fear of racism, which may affect people's willingness to exercise in public places, and also socio-economic disadvantage. Lack of money or transport to attend facilities are commonly cited as barriers to participation in sport and leisure time activities.

A number of government and NHS initiatives have taken steps to address low levels of physical activity in the general population, with a particular focus on deprived areas. These include:

- **GP exercise referral schemes** prescribing physical activity to improve health and well-being.
- **Local Exercise Action Pilots (LEAP)**, launched in April 2003 and funded jointly by the Department of Health, Sport England and the Countryside Agency. These pilots are testing out different community approaches to increasing levels of, and access to, physical activity. Pilots are led by PCTs and based in neighbourhood renewal areas, both urban and rural. The target groups include pre-school children, young people, older people, black and minority ethnic groups, those at high risk of illnesses such as diabetes and heart disease and people recovering from illness. The pilots will help to establish the evidence base on what works, and support the delivery of milestones in the National Service Frameworks, the *Priorities and Planning Framework 2003-2006* and *National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/06-2007/08*.

- **Sporting Equals**, a national initiative working to promote racial equality in sport throughout England. Sporting Equals is a partnership between Sport England and the Commission for Racial Equality. It works with the governing bodies of various sports and with key national umbrella organisations to develop policies and working practices that promote racial equality in sport and to encourage more people from all ethnic backgrounds to take part in sport, and the coaching, administration and management of sports.

- **Walking the Way to Health**. The Department of Health has part-funded a pilot project with the Countryside Agency and the British Heart Foundation testing the effectiveness of pedometers on loan through general practitioners (GPs) as a motivational tool to encourage increased walking. Ten thousand pedometers have been distributed to PCTs in areas of high deprivation.

For more information on these initiatives please see the Department of Health website:

www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/HealthyLiving



CASE STUDY

Walking for Health in Wolverhampton

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Walking for Health in Wolverhampton is a local scheme that provides the people of Wolverhampton with regular free led group walks, map-packs of short local walk routes and general and health information on walking.

The scheme also provides some physical 'infrastructure' such as way-marking signs on walk routes and facilitates changes to the environment to enable participants to walk independently (e.g. informing the council when a dangerous hole on a walk route needs filling in!).

Most people hear about the walks through local advertising, word of mouth, visits to community events and referrals/ recommendations by doctors and other health professionals. A gift voucher incentive (REAL Miles) scheme is running. For each five led walks a person does, they are credited with £1. People can walk their way up to £20 worth of gift vouchers, which can be used at participating shops and leisure facilities in Wolverhampton. Over 400 people took part in a led walk last year (2003/2004). Evaluations of these walks show there have been many benefits mentally, physically and socially.

The scheme employs an Asian Community Walking Developer, Vidya Midha, in a half time post worked over flexible hours. The aim of this post is to increase the amount of walking undertaken by Asian people in Wolverhampton. Funding comes from the Walking the Way to Health Initiative.

Vidya is very enthusiastic about walking. She promotes walking and opportunities for walking to the Asian community by visiting community, religious and other groups. Vidya talks to the groups and the community leaders about walking and its benefits, and does what she can to help and encourage the people to walk more.

Since starting in July 2003, Vidya has built up five different weekly group walks that she currently leads. She is working at recruiting Asian volunteer walk leaders who can take over the led walks that she gets going, (six have so far undertaken the Countryside Agency training day). Vidya assists with the training of volunteers from the Asian community and helps give support to them once they are trained.

Vidya finds that it is very important to build trust and friendship into the meetings she has with groups and individuals. She has received many positive comments from walkers such as "I feel the walks have helped me lose weight and feel so much better in myself" and "I suffer with back pain which seems a little better since I've started walking" and "I love coming on the walks because it gets me out of the house and if I just stay at home I suffer from depression".

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CASE STUDY SITARA

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SITARA is a women only project, staffed by women for women, in Batley in West Yorkshire.

It provides a range of physical activities for health improvement. The majority of women who participate in the SITARA sessions are of South Asian origin (approximately 75%) although all women are welcome.

In 1997 the Kirklees exercise referral scheme highlighted a gap in service provision where no South Asian women were being referred through. Research, including discussions with local community groups, identified specific community needs which were not being met by the local leisure centre, in particular, facilities where women could exercise without any men present, anywhere in the building.

Staff undertook outreach work to engage with community leaders (for example at the local Mosque), to determine requirements and then generate interest from the targeted customer group.

Activities provided include exercise to music, lane swimming and swimming lessons, aquafit classes, weights room, circuits and sauna.

The project met with problems at first around cultural issues, but hard work, co-operation and commitment to meeting people's needs enabled these problems to be overcome, and trust has been built between the communities.

Sitara is very much a partnership project. It could not have succeeded to the extent that it has without the ownership and commitment from all the organisations involved: Kirklees Council, Kirklees Active Leisure, North Kirklees PCT, Batley Health Action Group and the help and support of local women!

The project has now been running for seven years and is self-financing, even though the prices charged are kept low. From a small start in 1997 the SITARA project now holds four sessions per week and attracts up to 300 visits per week.

This project is now being used as a blue print for the development of similar activities throughout Kirklees in other sports/leisure facilities and within community facilities.



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CASE STUDY

Hamara Healthy Living Centre, Leeds

20



Hamara Healthy Living Centre in Leeds promotes physical activity as a preventative measure for coronary heart disease.

Hamara means “ours” in Urdu. The centre is for the whole community, although many of the participants in activities come from the Pakistani and Bengali communities.

Activities have gradually built up over the last two years, and include a men’s walking group, father and son swimming sessions and circuit training. Participants are encouraged to train as volunteers to lead walks and become activity instructors, for example circuit trainers, who take an eight week course recognised by Leeds Council.

A sister organisation, Leeds Health Focus runs women’s aerobics classes and women only swimming sessions.

Initial hurdles, for example difficulties in finding a suitable venue and time slot for circuit training, were overcome when Hamara obtained its own building with a multi-purpose hall. The training of instructors has enabled the programme to continue and grow. For example a female aerobics instructor has trained as a lifeguard and now covers the women only swimming sessions.

Activities have been designed around the needs of participants and delivered in a way

that is sensitive to religion and culture. Trainers come from the community and are bilingual, and participants have a choice as to whether music is used.

Activity sessions are used opportunistically to provide health advice, for example on eating a healthier diet. Minibus rides to walk locations are also used as an opportunity to provide health advice, for example by playing an audio cassette borrowed from the PCT Resource Library on a health topic.

Hamara also carries out outreach work with specific groups, for example taxi drivers, encouraging them to incorporate physical activity (e.g. cleaning their taxis) into their everyday lives. A beginners’ circuit training class specifically aimed at taxi drivers will also soon be on offer.

Work has also taken place with four local primary schools involved in the Healthy Schools initiative. Hamara trainers offer after-school aerobics and circuit training as well as basketball, football and cricket. Parents are encouraged to sign consent forms to allow their children to take part in the after school activities, which have proved so popular there is now a waiting list. Hamara also worked in partnership with one school to organise a “fitathon”, offering fitness sessions for pupils throughout the day, supported by a drawing competition on health themes, including giving up smoking and eating healthily, with the twelve best entries being made into a health calendar.

Plans are underway to set up community football and cricket teams, and Hamara are working with Leeds South PCT to provide a cardiac rehabilitation programme for South Asians with CHD.

For more information on Healthy Living Centres visit: www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/HealthyLiving

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CASE STUDY

Al-Badr Health & Fitness

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Al-Badr Health & Fitness is a new fitness centre in East London, serving the entire Muslim community.

The centre aims to encourage and enable Muslim men and women of all backgrounds to participate more fully in physical fitness activities and health awareness programmes.



With over 6000sq feet filled with the latest cardio and resistance machines, an array of free weights, sauna, steam and therapy rooms and a friendly cafeteria and lounge area, Al-Badr Health & Fitness provides a comfortable and encouraging environment in which to train, socialise and keep fit. Competent instructors are on hand to guide clients through their training programmes, whatever their goals, whether general exercise, weight management or stress reduction.

Al-Badr Health & Fitness recognises that both heart disease and diabetes are much more common in South Asians living in the UK than in the general population and that the vast majority of Asians, particularly women, do not take part in enough physical activity, which could help reduce their risk of developing these conditions.

The centre acknowledges that there are perceived barriers to physical activity among the ethnic minority and Muslim community, particularly among women, which often relate to cultural and religious issues. One step taken by Al-Badr to overcome these barriers is to have separate male and female sessions, with no male staff on duty during female only sessions. This is advertised on their website to make sure that prospective clients are aware.

Following the success of the London centre, a second centre is due to open in Leeds in autumn 2004.

For more information see www.al-badr.org.

Al-Badr Health & Fitness
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Resources

Further information and reading

Black and minority ethnic groups in England: the second health and lifestyles survey. Executive summary.

Health Education Authority (2000), HEA, London – available at www.hda-online.org.uk/documents/black_minorities_survey.pdf

Black and minority ethnic groups in England: the second health and lifestyles survey.

Health Education Authority (1999a). London: HEA – available at www.hda-online.org.uk/downloads/pdfs/healifes_black.pdf

At Least five a week: Evidence on the impact of physical activity and its relationship to health. A report from the Chief Medical Officer. April 2004, available at www.dh.gov.uk/assetRoot/04/08/09/81/04080981.pdf

Patterns of physical activity and relationship with risk markers for cardiovascular disease and diabetes in Indian, Pakistani, Bangladeshi and European adults in a UK population.

Louise Hayes, Martin White, Nigel Unwin, Raj Bhopal, Colin Fischbacher, Jane Harland and K.G.M.M Alberti. *Journal of Public Health Medicine*. Vol 24, No 3, pp170-178.

Useful websites

BHF National Centre for Physical Activity and Health
www.bhfactive.org.uk

Walking the way to Health Initiative
www.whi.org.uk

Health Development Agency
www.hda-online.org.uk

Diabetes

Diabetes affects an estimated 1.4 million people in England with possibly another one million undiagnosed, and the figure is rising.

People with diabetes are around three times more likely to develop coronary heart disease than the general population. In addition, the death rate from coronary heart disease is up to five times higher for people with diabetes.

About 85% of people with diabetes in England have Type 2 diabetes, where cells are not able to produce enough insulin for the body's needs. The majority of people with Type 2 diabetes also have some degree of insulin resistance, where the cells in the body are not able to respond to the insulin that is produced.

Anyone can get diabetes, however the risk increases with age. Type 2 diabetes is most commonly diagnosed in adults over the age of 40, although increasingly it is appearing in young people and young adults. Symptoms, including tiredness, frequent urination, increased thirst, weight loss, blurred vision and frequent infections appear gradually and the diabetes may not be diagnosed for some years. People who are overweight or obese, physically inactive or have a family history of diabetes are at increased risk of developing diabetes.

People from minority ethnic groups are particularly at risk. Type 2 diabetes is up to six times more common in people of South Asian descent, compared with the white population. It is estimated that around 500,000 diabetes sufferers are from an Asian community. In addition, diabetes has a younger onset among Asians than whites, and is increasingly manifesting itself at young ages, including in children.

Diabetes is also more common in socially deprived groups. Morbidity from diabetes complications is three and a half times higher amongst the poorest people in our country than the richest.

While some risk factors for developing diabetes (such as family history, increasing age and ethnic origin) are non-modifiable, in many cases Type 2 diabetes can be prevented, or its onset delayed. There is therefore a need to raise awareness about the disease and for opportunistic screening for early diagnosis.

Many of the modifiable risk factors for diabetes are the same as for heart disease – including being overweight or obese, having excess fat around the waist (central obesity) and being physically inactive – so it can be helpful to consider these two conditions together when looking at prevention initiatives.

Effective management of diabetes, in particular tight control of blood glucose and blood pressure increases life expectancy and improves quality of life, reducing the risk of complications, for people with both Type 1 and Type 2 diabetes.

People with diabetes who develop cardiovascular disease can also benefit from secondary prevention measures including treatment with low dose aspirin, beta-blockers and lipid-lowering agents.

The National Service Framework for Diabetes, published in 2001, set out twelve standards and the key interventions necessary to raise the standard of diabetes care and tackle inequalities, including reducing diabetes in the population, identifying people at high risk of developing diabetes and supporting people with diabetes in managing their condition.

For more information on the National Service Framework for Diabetes please see the department of Health website:

www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/Diabetes

CASE STUDY

Focus on Asians with Diabetes

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Focus on Asians with Diabetes (FAD) was set up in 1996 in the West Midlands. The group consists of health care professionals who possess not only advanced diabetes knowledge, but also multi-lingual and multi-cultural skills to support people from South Asia.

All members of the group are fortunate enough to be in highly influential positions which enables them to empower other health professionals and act as advocates for patients and their families.

The aims of the group are:

- To provide an advisory and consultative role
- To improve the knowledge, understanding and management of diabetes in the Indo-Asian population
- To provide the most appropriate, effective and culturally sensitive education material to reinforce and support healthcare professionals when delivering diabetes education

FAD has previously worked with Lifescan and Diabetes UK in an advisory capacity and is currently on the Novo-Nordisk Diabetes Care Task Force. The group

has also been involved in producing educational material, including multi-lingual videos and supporting literature. Although videos and educational material have been produced in the past, the group feels



that many materials produced have had little impact on Asian people with diabetes. This may be because of lack of resources, material not being culturally sensitive, the level of language being inappropriate, not having enough materials in different languages and the needs of British Asians not being met.

Recent initiatives include a partnership with Diabetes UK and Lifescan to produce a video called Understanding and management of diabetes within the Asian community, for which FAD wrote the script and helped with editing. The video aims to reach Asian people with diabetes and their families, and also to educate health care professionals about Asian culture and how Asian people view their diabetes. The video is available in five Asian languages and English and covers various aspects of diabetes in the different Asian cultures. The video needed to be realistic and informative but also entertaining to achieve its aim of encouraging self-care and management of diabetes, so it was made in a soap style as many people in the Asian community love to watch Bollywood films. The video has been well received by patients, their carers and healthcare professionals in the West Midlands.

The biggest hurdle FAD has faced is obtaining funding. It can take up to two years to raise enough money for a big project and FAD needs to prove its credibility and worth in increasing awareness. The individuals involved in FAD have also had to be very committed as projects can take up a lot of their own time, which means juggling workload and family commitments.

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CASE STUDY

Slough PCT tackles diabetes in South Asian communities

23



Slough PCT is providing education sessions for patients newly diagnosed with Type 2 diabetes. The sessions give patients advice and information about their condition, including the need to make lifestyle changes to reduce their risk of developing heart disease.

Patients are referred by their GP and are given an information pack to take away at the end of the session. Special sessions are also run in Punjabi for South Asian patients. Slough also has a number of diabetes support groups, including a Pakistani group and a Sikh group.

Another initiative is a new system to treat more people with diabetes within a primary care setting. Patients will be treated either by their GP, or if their condition is more serious, an intermediate service will be offered by consultants in clinics within the primary care setting. The most serious cases will continue to be seen in secondary care.

This three-tier system will free up appointments in secondary care, and it is hoped, increase attendance at follow up appointments. Attendance is particularly low in South Asian groups – currently around 50% of appointments are not kept. In recent research with South Asian groups, people expressed a strong preference to being treated locally by their GP or in a clinic, rather than travelling to hospitals for treatment.

One reason for this is the difficulty in accessing hospitals in the area by public transport, with many people needing to take a combination of buses and trains to get there. Negative experiences of the hospital environment may also play a part, with some people feeling intimidated by the environment or having difficulties with language.

Slough PCT is also looking at new ways to reach South Asian groups with health messages about diabetes and heart disease. A mapping exercise is underway to understand local media consumption, consumer habits and where and how people shop to find the best ways to make sure the information gets through.

Above: Clients attending multidisciplinary diabetes education group in Punjabi

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CASE STUDY

Leicester STAR bus – screening for early diagnosis of diabetes

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In January 2002 a Diabetes Research Team within the University Hospitals of Leicester NHS Trust launched the STAR (Screening Those At Risk) study, which involves screening 10,000 people across Leicestershire who may be at risk from diabetes. So far over 3,500 people have been screened within hospital and community care settings.

To enable the team to screen more volunteers, a double decker bus was converted into a mobile screening unit. The bus, which has a waiting area downstairs and a clinic upstairs, means that the team can go out into the community and more people can be screened.

The purpose of the STAR study is to identify people with Type 2 diabetes, which can cause many problems such as heart disease, stroke, and problems with the feet, eyes and kidneys. Type 2 diabetes is increasing at a dramatic rate, and many people develop diabetes without knowing it, meaning complications can develop before it is diagnosed.

The focus of the STAR study is on early diagnosis, which means many of the complications can be prevented or delayed.

The diabetes team look for volunteers who are either overweight, smoke, have someone in their family with diabetes, had diabetes during pregnancy, have heart problems or high blood pressure, and fall into one of the following groups:

- of Asian, Black or Chinese origin and aged 25 to 75
- of White origin and aged 40 to 75

The team have also held Diabetes Awareness Roadshows around the county in the STAR study bus. At these events they measure the height, weight and blood pressure of volunteers and ask a series of questions, and can then tell people if they are at risk of diabetes.

From the results that have been analysed, the team have so far found 98 people (4%) with diabetes and 373 people (15%) with pre-diabetes, who will receive any necessary treatment and advice.

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CASE STUDY

The Health Development Service: a community approach in Newcastle

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The Health Development Service (HDS) works in partnership with local people and health, community, and local authority agencies. It addresses health needs in relation to diabetes and heart disease, to promote and deliver better services for minority ethnic people and communities. The service originally began as a pilot project and is now funded by Newcastle PCT.

The HDS works mainly in the west-end of Newcastle for the South Asian Community and city wide for the Chinese community. Working with individuals and groups from these communities to better understand their needs, the service provides support, information and advice in the client's first language, and works in a proactive way to raise awareness of health issues.

The service works in partnership with other service providers to share skills, knowledge and resources to develop and deliver services. Examples include working with GP practices to follow-up individual referrals and support practice nurses in clinics, and developing exercise sessions through partnership with local people, HealthWORKS and New Deal for Communities. The HDS also helps people connect with services, for example by referring clients to health and social agencies with interpreters present.

The HDS team consists of a Service Facilitator, Health Development Nurse and seven Bilingual Health Development Workers, with administrative support from a team secretary. People are referred to the service by GP surgeries, health professionals or self-referrals.

The work of the service contributes towards standards in the Diabetes, CHD and Cancer NSFs through raising awareness of symptoms and risk factors at groups and at events, for example at the Hindu Temple, and Sikh Gurdwara, and by working with other services, such as the Stop Smoking Services, community dieticians and leisure services.

The service has also worked with West-Gate Heart Beat, HealthWORKS and the British Heart Foundation to train Bilingual Health and Community Workers to become Emergency Life Support (including CPR) instructors. These will be the first national instructors to deliver training in the first language of minority ethnic client groups.

The HDS aims to provide opportunities for people from black and minority ethnic communities to gain employment and develop within the NHS, and has been successful in recruiting, retaining, and developing staff. The Health Development Workers have undertaken nationally accredited training on diabetes, heart disease, sexual health and community health. Three Health Development Workers have moved on to higher grades within the NHS and local authority.

In addition, the service is involved with strategic developments around the needs of BME people. Examples include working with the Health and Race Equality Forum on advocacy, access and racial equality training issues and with the PCT around the Improving Working Lives diversity agenda.

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Resources

Diabetes UK materials

Diabetes UK produces a number of free general information publications in the main five South Asian languages and Chinese, to support people in managing their diabetes and in leading fuller, healthier lives. Titles include Diabetes – Are you at risk?, Diabetes – It's bloody serious, What diabetes care to expect (on tape) and a video, Understanding and managing diabetes within the Asian Community. A number of fact sheets structured and written to be culturally sensitive and easy to read and understand have also been produced. These are available to order and can also be found on the website.

Diabetes UK Careline

Diabetes UK also provides a dedicated diabetes helpline, the Diabetes UK Careline, with trained counsellors who can talk about any aspect of diabetes. Translators are available for people who want to communicate in languages other than English and a textphone services is available for people with a hearing impairment.

For more information visit

www.diabetes.org.uk

Further information and reading

The National Service Framework for Diabetes (2001)

The National Service Framework for Diabetes: Delivery Strategy (2003) – both available at **www.dh.gov.uk/publications**

Useful websites

Diabetes UK

www.diabetes.org.uk

National Diabetes Support Team

www.cgsupport.nhs.uk/diabetes

Treatment

The National Service Framework for Coronary Heart Disease set national standards of treatment and care for preventing and treating CHD, with the aim of improving the standard of care and reducing inequalities.

Standards were set for better, faster treatment of patients who have had or are suspected to have had a heart attack, faster diagnosis of heart disease and reduced waiting times for heart surgery.

Key achievements in improving coronary heart disease treatment for all patients include:

Better, faster, treatment for people who have had a heart attack

Approximately 275,000 people in the UK suffer a heart attack each year. Prompt access to the right treatment is crucial, and can make the difference between living and dying.

Eighty-four per cent of eligible patients are now being treated with thrombolytic (clot-dissolving) drugs within thirty minutes of arriving in hospital, compared with 38% shortly after publication of the NSF in 2000. Ninety per cent of patients discharged from hospital after a heart attack received drugs such as aspirin, beta blockers or statins to help prevent another heart attack.

More than 600 defibrillators have been installed in railway stations, airports and shopping centres to improve the chance of survival for people who suffer a cardiac arrest in a public place.

Faster diagnosis of heart disease

Every acute trust in the country now has a Rapid Action Chest Pain clinic, to provide patients with the basic clinical assessment necessary to confirm or exclude heart disease. Work is underway to ensure patients are seen as soon as possible. Everyone who develops new symptoms their GP thinks might be due to angina should be assessed within two weeks of referral.

Reduced waiting times for heart surgery

There has been dramatic progress in reducing waiting times for heart surgery. In 1996, some patients in England waited over two years for heart surgery. Today, no-one waits more than six months; by March 2005, the target wait will be a maximum of three months for all patients needing heart surgery. By December 2008 the total waiting time from GP referral to treatment will be reduced to 18 weeks – including all necessary diagnostic procedures and tests, for example MRI and CT scans and procedures like coronary angiography. A number of factors are contributing to falling waiting times, including more staff, investment in new and expanded hospitals, specialist catheterisation labs, new equipment and greater efficiency. From April 2008, the patient choice initiative will further reduce waiting times by giving all patients requiring planned hospital care the right to choose where they have their treatment.

For more information on the National Service Framework for Coronary Heart Disease please see the Department of Health website: www.dh.gov.uk.

Improving access to treatment and services for South Asians

The National Service Framework specifically requires equitable provision of treatment and services across all ethnic groups. However, although as a result of the NSF services for all patients have greatly improved, there is some evidence to suggest that South Asian patients with Coronary Heart Disease are underdiagnosed and undertreated.

One study by Barakat *et al* (see Resources) has shown that South Asians experienced delays in receiving appropriate treatment once they had been admitted to hospital with chest pain. The study concluded that this may be because patients often presented with atypical symptoms, which may have led to slower triage in the casualty department and delays in essential treatment. Chapter three of the NSF makes reference to the fact that some groups are more likely to have an atypical presentation of acute myocardial infarction (heart attack) and need special consideration, including people from minority ethnic groups.

Emergency staff and other health professionals therefore need to be aware of ethnic and cultural differences that may influence presentation and behaviour. There also needs to be adequate provision of interpreters to surmount any communication difficulties, which are also a recognised factor that may act as a barrier to health care delivery.

Another study by Feder *et al* (see Resources) has shown that coronary revascularisation among comparable patients with heart disease is less likely to be carried out in South Asian patients than in white patients in the United Kingdom. The difference in the study could not be explained by physician bias. Suggested reasons for the discrepancy were that the administrative process through which revascularisation is provided involves written communication in English, long waiting lists, and repeated outpatient assessments, which may deter some patients from negotiating the system. It was also suggested that South Asian and white patients may differ in their understanding of the risks and benefits of revascularisation.

A number of projects are currently underway which aim to improve access to services for South Asians. For example in South-East London, a project is looking at the experiences of Asian coronary heart disease patients. Discovery interviews are being carried out with patients in Punjabi and Vietnamese, and patients' experiences will be used to inform improvements in care. Another project in Greenwich is exploring how a specially developed software package can be used to aid translation and help doctors explain patients' heart conditions to them.

The following projects are looking at ways to improve provision of services and treatment for South Asians across primary and secondary care.

CASE STUDY

The 3 Cities Project: multi-language health information

Multi-language health information on touch-screen computers in Sheffield, Leicester and Nottingham Health Action Zones.

Information is vital for people to make rational decisions about their health. For a sizeable proportion of people from minority groups, written, translated information has a limited use, as their language has a verbal rather than a written tradition.

The 3 Cities Project set out to see if new technology could be used to improve access to information for people from black and minority ethnic groups. Information was translated into five languages in an audio and written format and made available from touch-screen computers located in a range of venues including a temple, neighbourhood centre, library and health centre, in Sheffield, Leicester and Nottingham.

A user-friendly interface was designed for the touch-screens, allowing users to select the language of their choice and to listen to health information through a telephone handset attached to the side of the computer. The audio information was synchronised with the text, enabling users not literate in their own language to choose a subject from a simple menu and navigate through the information. Users were also able to print out translated information to take home.

Copyright permission was obtained to translate existing health information from a variety of reputable sources. This information was then translated into Urdu, Mirpuri Punjabi, Bengali, Gujarati and Chinese in everyday language by groups selected from local communities. The translations were then proof-read, and checked for accuracy by health professionals working in primary care. The five languages, and the health

topics covered, were chosen after discussions with the local communities in each city. Topics included heart disease prevention (healthy eating, exercise, high blood pressure, stress, alcohol, and smoking) and diabetes. Information was also included on local support groups.

The project was evaluated by Sheffield School of Health and Related Research at the University of Sheffield. Data was automatically collected by the computer on the number of users, their age group, gender, language and subject accessed and a questionnaire survey was carried out using bi-lingual interviewers to seek the views of users and non-users of the touch-screen. The vast majority (96%) of touch-screen users found the instructions clear and nearly all found the touch-screen easy (68%) or fairly easy (28%) to use. The five most popular topics accessed, were stress, diabetes, blood pressure, healthy eating and exercise.

The project has gone on to produce CDs of the software which can be used on any PC with a sound card. A website is also being developed which in addition will have the information translated into Arabic and Somali.

The project was funded through the Health Action Zone Innovations fund.

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CASE STUDY

Ealing Coronary Risk Prevention Programme



Around 30% of the population of Ealing is of Asian origin. Of the 22 practices in Southall (London Borough of Ealing), the majority are single handed, with an average list size of 3096 versus the national average list size of 1856 for England.

Most GPs in Southall work in professional isolation, have fewer practice nurses, poorer practice facilities (including low levels of computerisation), and serve highly deprived communities. The high list size, diverse workload, and inadequate facilities leave little time for practices to focus on preventative healthcare.

Audits of practice data in Southall have revealed that many records for CHD and high risk patients in primary care have key risk factor data missing and consequently patients do not receive standard treatments including aspirin, anti-hypertensive and cholesterol-lowering medications. Fewer than 10% of CHD patients are invited or participate actively in health improvement programmes. Under the circumstances it was evident that no one practice in the locality could achieve standards 3 or 4 of the NSF for CHD.

In 2001, Ealing Hospital set up a collaboration with 30 GPs in Southall to replicate an already successful nurse-led coronary risk prevention service in the cardiology department. The new programme was based in individual primary care practices in Southall with the aim of achieving standards 3 and 4 of the CHD NSF. Success has led to a further expansion of the programme to include another 28 GPs in the neighbouring London Borough of Hounslow.

Since 2001, the programme has established a team of 15 nurses/health care facilitators to hold dedicated coronary risk assessment clinics in the practices of each of the 58 participating GPs in West London. The programme is one third funded by GPs (approximately £2,500 per GP per year) and two thirds by the Cardiology Department (through grants from charities and pharmaceutical companies).

The programme aims to undertake systematic assessment of the CHD risk in all men and women aged 35-75 years from the participating practices.

Each GP is allocated one CHD nurse session per week. Patients are invited for an appointment on the practice headed paper offering a wide choice of dates and times, with a self addressed envelope. Each nurse systematically screens four to five patients per session (40 minute consultation). The nurse assists the patient to complete a structured questionnaire (including cardiac, medical, drug and family history, lifestyle and physical activity), measures blood pressure, height, weight, body fat, waist and hip circumferences, collects a urine sample and records an ECG (electrocardiogram). Fasting blood samples are taken for glucose, HbA1c,

Above: Health care facilitator Cynthia Stanley screening a patient from a Southall surgery.

total cholesterol, HDL cholesterol and triglycerides. The nurse is responsible for data collation, data entry into the customised database and importing biochemical data from the laboratories.

Personalised reports are prepared in lay language for the patient to keep, with an explanation of results, advice on where to seek treatment and information and contact details of community based services set up to modify diet, physical activity, cessation of cigarette smoking and for health promotion. More comprehensive reports are generated for the patient's GP and abnormal results are highlighted with general recommendations for intervention, based on NSF standards.

Results are sent within an average of seven days from the assessment. Reports and ECGs are verified and signed by the nurse and Professor JS Kooner. The data is entered into the practice computer the following week when the nurse returns to screen a further four to five patients (it is hoped this will soon be transferred electronically).

“The programme aims to undertake systematic assessment of the CHD risk in all men and women aged 35-75 years from the participating practices.”

Approximately 300 patients are being assessed each week in Primary Care. Over 16,000 patients have completed assessment to date. It is anticipated that the nurses will assess more than 40,000 patients from the participating practices over the next two years. Approximately two thirds of patients assessed require treatment/advice on risk factors.

In two years, the programme will have:

- fully characterised the coronary risk factors of all adults responding to an invitation on the lists of 58 GPs
- delivered structured intervention to achieve NSF standards in an estimated two third of all patients with CHD or risk factors
- evaluated the effectiveness of key practice models for coronary risk prevention in large numbers of patients
- improved awareness amongst patients, community organisations, and health care professionals of CHD risk factors and their prevention
- created a local network of organisations working as partners in health care to increase awareness of CHD and its prevention
- trained local nurses to a high standard in coronary risk prevention practice and
- worked to achieve a CHD prevention service that is integrated between primary and secondary care.

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<p>CASE STUDY</p> <h2>Birmingham Heartlands and Solihull NHS Trust</h2>	<h1>28</h1>
<p>With a wide ethnic mix of patients, Birmingham Heartlands and Solihull NHS Trust employs two full-time interpreters who are fluent in the main South Asian languages spoken in the area. These staff can be ‘booked’ at short notice by any department and also carry out ward rounds.</p> <p>There is a big take up of the service in coronary heart disease wards, where a high percentage of the patients are of South Asian origin. The interpreters play an essential role in ensuring that patients understand their condition and crucial medical information. The trust also employs an Equal Access Facilitator, who supports the interpreters if needed, particularly for male South Asian patients. In addition, software packages in Urdu and Bengali are available for translation purposes and the interpreters offer this service on request.</p> <p>The trust now also has a CHD Asian Link Nurse, Kam Sanghera, which has led to an increased take up of cardiac rehabilitation and compliance with the programme.</p> <p>As Kam speaks Punjabi, Hindi and Urdu, she is able to give information to patients in their preferred language and check their understanding. When patients are discharged, Kam gives them a follow up call if she thinks they need more help, for example in understanding their medication. All patients attend the same rehabilitation programme, however some of the classes are given in different languages to different groups. Group discussions are used to tackle</p> <p>some of the myths around heart disease, for example the belief held by many patients that they will never recover. Patients also attend exercise classes. The trust has looked into whether there is a need for single sex classes, but has found that attending mixed classes is not a concern for patients as they consider the classes to be part of their treatment. On completion of the programme, patients are given a certificate and information about heart support groups in their area, including a new Asian heart support group, set up by an ex-patient with support and guidance from Kam.</p> <p>“The interpreters play an essential role in ensuring that patients understand their condition and crucial medical information. The trust also employs an Equal Access Facilitator, who supports the interpreters if needed, particularly for male South Asian patients.”</p> <p>Before the trust had Kam in post, it was recognised that there was a need for information in other languages and a video, available in English and various Asian languages, was produced. The video called <i>Help yourself to a healthy heart</i> covers much of the information given in the cardiac rehabilitation programme, for example what happens when you have a heart attack, medication and advice on exercise and diet. The video is still used if Kam is not available and to give information to relatives. Patients are also able to buy copies if they would like the information available at home.</p>	<p>Kam Sanghera Asian Link Nurse 0121 424 3312 kamajit.sanghera@heartsof.wmids.nhs.uk</p> <p>Gillian Waterhouse Quality Development Manager 0121 424 2323 gillian.waterhouse@heartsof.wmids.nhs.uk</p>

CASE STUDY

New Cross Heart Disease Asian Link Nurse increases take up of services

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New Cross in Wolverhampton is one of the few hospitals in the UK to have a dedicated heart disease nurse, Nam Sahni, to work specifically with the Asian community.

Nam is part of New Cross's Division of Cardiothoracics and a member of the award-winning Heart Failure team. She assists with assessment, diagnosis and consultant appointments and also works with cardiac rehabilitation patients before discharge.

Nam's clinical training, combined with her understanding of the cultures of the communities she works with, helps her address some of the barriers that Asians face in accessing services and making lifestyle changes that can help them reduce their risk of a heart attack.

Nam speaks both Punjabi and Hindi. Before her arrival, patients not speaking English had to use translator services usually only available over the telephone or get members of their family, sometimes young children, to help them translate complex medical information. Providing information leaflets was not necessarily helpful, as patients' levels of literacy in both English and mother language are often low.

One common problem is patients failing to take medication or follow treatment and

rehabilitation programmes, because of a fatalist approach to heart disease. Nam works on a one to one basis with patients to explain exactly what the medication does and why they need to take it. She helps people to see that whatever their beliefs about why they have heart disease, by taking the right medication and making changes to their lifestyle, they can improve their quality of life.

Since Nam started her role working with cardiac patients, attendance at rehabilitation and heart failure clinics by Asian patients has greatly increased, compliance with medication is up and patients appear more satisfied with the information and education provided.

Nam also spends one day a week in the community raising awareness of heart disease and the simple steps people can take to reduce their risk. Recent successes have included an event at a local Sikh Temple where Nam and colleagues including diabetic link workers, an exercise development worker and a dietician addressed over 800 people. A good relationship has been built up with the Sikh community, who have also contributed funds towards the hospital's state-of-the-art Heart and Lung centre, which aims to reach more of the West Midlands' Asian population and help prevent growing numbers needing referral to New Cross for treatment.

Nam's future plans include running similar events in the Muslim community where she has built up links, and providing training for colleagues to raise their awareness of Asian culture, for example how to address patients, dietary requirements and religious customs such as fasting.

Pictured are back left to right : Sukhuir Kaur Dhillon – Bridge Project Diabetes Support Worker, Nam Sahni – CHD Asian Link Nurse, Balvinder Sahota – New Cross's Community Food Advisor, Sheila Gill – All Saints & Blakenhall Community Project Officer and front left to right Claire Jagers – New Cross's Nutritionist, Vidya Midha – Asian Community Walking Developer for HAZ and Suki Kumar – Wolverhampton Council's Assistant Coordinator for ethnic minority groups.

Nam Sahni
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CASE STUDY

Manchester Heart Centre Cardiac Liaison Team

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The Manchester Heart Centre serves a large geographical area, with a high proportion of Asian and ethnic minority patients, many of whom do not speak English as their first language.

The Cardiac Liaison team has contact with patients from point of listing through to follow-up support after discharge. The team uses written information to reinforce the advice provided at every stage of the patient journey. However, because of the limited English spoken and understood by some patients and families it became apparent that there was inequity in the information and support received by Asian patients.

“They were keen to have both written booklets and audio tapes, recognising that people do not always read the language that they speak.”

For example, the team are often dependent on either a link-worker or family member to translate the information given in a post-operative chat with every patient, which covers the operation, pain relief, exercise, wound care, returning to work, sexual activity, etc. This can make it difficult to determine exactly what information has been passed on, as well as raising issues of confidentiality.

The team felt that providing information in some of the most commonly spoken languages of ethnic minority patients might help to meet the information gap. They were keen to have both written booklets and audio tapes, recognising that people do not always read the language that they speak. This suggestion was discussed with patients, carers and the hospital’s link-worker department, all of whom were very supportive of the idea.

To produce the materials, the team sought advice from the Trust’s Patient Advisory Liaison Service (PALS), who assisted in obtaining quotes and agreed to pay half the costs. The Heart Centre’s Lead Nurse/Modern Matron and Directorate manager were also very supportive and agreed to pay the other half. Written booklets for patients to keep were produced in Urdu, Hindi and Punjabi and 50 audio tapes were made in each language, to be lent out as needed at listing, pre-admission clinic, on admission, or before discharge.

Reactions to the tapes from patients and families have been very positive. However, the team recognize the need for formal evaluation and are now devising a patient evaluation questionnaire, which will be translated and given out with the tapes.

One problem is that although the team keep a record of who has borrowed the tapes, as they lend the tapes out for as long as the patient/family require it is sometimes difficult to chase them up. To overcome this difficulty the team will now give out stamped addressed envelopes (a system currently used with patient information videos which is proving very successful with a nearly 100% return rate).

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CASE STUDY

Improving care for South Asian cardiac patients in Bradford

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The South Asian community in Bradford is largely of Pakistani origin. Many members of the community are originally from a rural area of Pakistan, do not have English as a first language and may have different health beliefs and expectations to other populations.

To improve the care of heart failure patients, Bradford City Teaching Primary Care Trust employs a bilingual Community Cardiac Worker as part of the CHD Team.

Mohammed Sharif, known as Sharif, provides information, education and support to heart failure and cardiac rehabilitation patients and their families. As Sharif speaks Urdu and Mirpuri Punjabi, he is able to communicate directly with the patient, rather than using family members, ensuring that the patient and carers receive the care and information they need.

Sharif visits patients at home, either with the heart failure specialist/CHD team nurses to assist and interpret, or separately. When he visits, Sharif checks the patient's knowledge and understanding of their illness and discusses risk factors with the patient, including diet and lifestyle. He is also

Above: Mohammed Sharif, Community Cardiac Worker, checking blood pressure at the Sikh Gurogobind Gurudwara in Bradford during National Blood Pressure Testing Week

trained to deliver advice on exercise, stress management and diabetes, and to check patient's blood pressure. He is qualified in phlebotomy (taking blood samples).

Sharif assists patients in understanding their medication. He explains what the various tablets are for, and writes this in Urdu on the boxes. The team also has a system for patients who are not able to read if a change in dosage is required. In this case, the heart failure nurse specialist marks the appropriate medicine so that the patient knows which one is to be changed when contacted by Sharif later by telephone.

Patients are able to ring Sharif directly if there is any change in their condition to report or if they have any questions. Before Sharif joined the team, it was not possible to offer this service, as many patients are elderly and speak little English, and the cardiac nurses were not able to communicate with them in their own language. Sharif also helps patients by referring them on to other services and agencies where necessary, for example Health Plus, a local initiative where they can access amongst other things benefits advice at their GP surgery.

Sharif is also involved with health promotion in the wider community. He runs a Walking for Health group and a Patient and Public Involvement CHD project for South Asian CHD patients called "Dahrkan", which means "beat" in Urdu. He also works with religious and other community leaders to promote health messages.

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Mohammed Sharif
Community Cardiac Worker

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Resources

Further information and reading

The National Service Framework for Coronary Heart Disease

Winning the War on Heart Disease: Progress report 2004

National Standards, Local Action – Health and Social Care Standards and Planning Framework 2005/06–2007/08.

Improvement, Expansion and Reform: The Next Three Years – The Priorities and Planning Framework 2003-2006

All available at www.dh.gov.uk/publications

Research papers

Bangladeshi patients present with non-classic features of acute myocardial infarction and are treated less aggressively in east London. Barakat K, Wells Z, Ramdhany S, *et al.* *Heart* 2003;89:276-279.

Improving the delivery of coronary care for ethnic minorities. K Khunti and N J Samani. *Heart* 2003;89:479-480.

Ethnic differences in invasive management of coronary disease: prospective cohort study of patients undergoing angiography. Gene Feder *et al.* *BMJ*, Mar 2002; 324:511-516.

Cardiac rehabilitation

Cardiac rehabilitation can improve health outcomes and quality of life in people with coronary heart disease.

Evidence suggests that when people are offered comprehensive and tailored help with lifestyle modification, involving education and psychological input as well as exercise training, cardiac rehabilitation can make a substantial difference, perhaps reducing mortality by as much as 20% to 25% over three years.¹

However, despite the potential benefits, many eligible patients do not attend rehabilitation or drop out prematurely.

Despite often having greater needs, women, older people, those from lower socioeconomic groups and minority ethnic groups are consistently under-represented among users of rehabilitation services.

A number of potential barriers to participation in cardiac rehabilitation are common to all patients, regardless of age, sex or ethnicity. These may include psychological factors such as lack of motivation, or a loss of self confidence, which can also act as a barrier to making the lifestyle changes necessary to reduce subsequent cardiac risk. For example, some people with heart disease may become afraid to take part in exercise or to participate as fully as they might in everyday activities for fear of damaging their heart.

A lack of understanding about the role and importance of cardiac rehabilitation may also affect a patient's take up of services. This may be influenced by how strongly rehabilitation is recommended to the patient by their doctor. Patients' own health

beliefs and attitudes may also play a part. For example, studies show that patients who see heart disease as a condition that can be managed may be more likely to take up cardiac rehabilitation than those who see themselves as unwell.

Practical problems may also deter people from attending rehabilitation, for example difficulties getting to rehabilitation sessions, or a lack of appropriate provision, for example for women or for minority ethnic groups.

The National Service Framework for Coronary Heart Disease set standards to improve cardiac rehabilitation. It states that cardiac rehabilitation should begin as soon as possible after someone is admitted to hospital with CHD (Phase 1), continue through the early discharge period (Phase 2) and the formal rehabilitation programme (Phase 3) and extend into the long-term maintenance of the best-possible health (Phase 4).

Prior to leaving hospital, all heart patients should be invited to participate in a multidisciplinary programme of secondary prevention and cardiac rehabilitation. Programmes should aim to reduce the risk of subsequent cardiac problems and to promote their return to a full and normal life and special consideration should be made to ensure that services address the needs of under represented groups.

A key principle underpinning the NSF is that services should be accessible and acceptable to all the people they serve regardless of their ethnicity. This includes meeting people's needs in ways that are culturally, religiously and linguistically appropriate, including the provision of culturally appropriate advice about health lifestyles.

The NSF also states that verbal and written information for patients and their families should be available in a language that they can understand and that it may be necessary to offer sessions that cater specifically for particular groups of people. For example Asian women, who may be reluctant to attend sessions attended mainly by white men.

However, the NSF acknowledges the existence of generic problems affecting the quality of cardiac rehabilitation programmes and also that specific problems impacting on heart patients from ethnic minority groups need to be addressed. These may include a lack of interpreters or a failure to provide single sex exercise classes, both of which may reduce the appeal of cardiac rehabilitation for certain patients.

There is therefore considerable scope for improving cardiac rehabilitation and secondary prevention services in England so that all patients are offered a high quality and appropriate service.

CASE STUDY

Fair and equal access to cardiac rehabilitation in Leicester

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Approximately 30% of Leicester's population is of South Asian origin and mortality from coronary heart disease in this group is high. Cardiac rehabilitation is essential in reducing the risk of CHD, helping the patient to understand their illness, its treatment and promoting their return to a full and normal life.

To meet the needs of Leicestershire's South Asian population, the University Hospitals of Leicester NHS Trust submitted a bid for funding to the British Heart Foundation to develop a unique role within the acute trust's cardiac rehabilitation team. The bid was successful and three part time Cardiac Rehabilitation Assistants (South Asian) have been employed to work with the department of cardiac rehabilitation, one at each hospital site.

The aim of the project was to offer fair and equal access to cardiac rehabilitation services for South Asian patients by recruiting a bilingual work force to develop and deliver a culturally and linguistically appropriate service. The link workers were recruited directly from the South Asian community; they speak a variety of Asian languages and are experienced in working with groups.

Above: (Left to right): Salim Ingar and Nina Patel, Cardiac Rehabilitation Assistants, with Dr Sally Singh, Consultant Clinical Scientist, Head of Cardiac and Pulmonary Rehabilitation

Prior to being employed, each cardiac rehabilitation assistant successfully completed an Open College Network accredited course in CHD, covering basic anatomy and physiology, pathophysiology, risk factors and risk factor management, as well as modules on the structure and organisation of the National Health Service. The link workers also had an opportunity to visit the acute sites to observe several interventions (e.g. cardiac catheterisation) and participate in cardiac rehabilitation.

The most obvious difficulty for the cardiac rehabilitation team was providing an effective, culturally sensitive intervention for non-English speaking patients. Anecdotally, patients would leave the hospital and for many reasons including lack of information, adopt the 'sick role'. Providing a better service for South Asian Patients at phase I was the immediate challenge for the rehabilitation assistants. Other service needs included delivery of phase II, phone calls and assistance in the phase III rehabilitation classes.

The rehabilitation assistants worked closely with senior rehabilitation nurses to become competent to deliver basic risk factor and lifestyle modification advice to the South Asian community. The rehabilitation assistants also provide advice and education to cardiac rehabilitation staff on the cultural, religious and social needs of South Asian patients, resulting in better understanding and improved quality of care. The current focus is to enhance phases I and II of rehabilitation for the South Asian community.

The project and post holders are now established within the rehabilitation team and the service they provide will now be evaluated. The project has been supported by both the British Heart Foundation and the Health Action Zone.

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CASE STUDY

Planning and delivering an equitable cardiac rehabilitation service in Newham

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Newham in East London has a culturally diverse community with people from a variety of ethnic, religious and linguistic backgrounds.

This has presented a significant challenge to planning and delivering an equitable cardiac rehabilitation service. Language especially is an enormous barrier to effective communication and service delivery.

Newham is fortunate to have an excellent Health Advocate service, which enables the team to communicate with the patient at the bedside and/or in his or her own home. Written information has also been translated into 10 Asian languages. In 2000, Newham was successful in obtaining an innovation grant from the BHF to employ a nurse (part time) to join the team to carry out a project aiming to:

- Identify the barriers experienced by the ethnic community in accessing the service, through patient involvement and consultation
- Review resources available within the cardiac rehabilitation team and produce information to improve access and service delivery (especially with the phase III cardiac rehabilitation classes)
- Increase uptake and improve access for those from minority ethnic groups

- Raise awareness within the ethnic communities to the risk factors of CHD.

Working closely with the Health Advocate service, the rehabilitation team translated and recorded to audio tape the health related talks used in the classes into languages including Bengali, Punjabi, Hindi and Tamil. As a result, patients who are not confident with English are able to stay within the group and listen to the talks via Walkman and headphones. The tapes have proved to be highly successful and patients are able to borrow copies to share information with the family. Following the same principle, the team also made a voice over for a health information video on cardiac risk factors, so that both audio and visual tapes are available for patients from the ethnic community. The local CHD Collaborative has now taken up the idea and the tapes have been produced in eight languages and are used by other rehabilitation teams within East London. Workshops were also held to bring together the Health Advocates and the rehabilitation team, resulting in the production of a resource pack, which is personalised to each patient attending the classes.

The two year project has proved successful in improving the delivery of the Cardiac Rehabilitation service to minority ethnic groups. Since January 2004 the team has been conducting an audit looking at those who attended and were not attending the phase III classes, in order to target groups who are under-using the service and design a more individualised service. Additional funding for the project has been made available through the local development plan.

Photo with kind permission from patients attending the Newham Cardiac Rehab Education programme.

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CASE STUDY

Action CHD – Dil Ke Baat

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Action CHD – Dil Ke Baat is a two-year action research project funded by the British Heart Foundation and run by Staffordshire University in partnership with Palfrey Community Association, Walsall.

The project aims to reduce deaths from coronary heart disease in South Asians, through developing an education programme for South Asians with coronary heart disease, covering secondary prevention and cardiac rehabilitation. It is based on the premise that information on heart disease and prevention, provided in a culturally acceptable and appropriate form, is essential for patients to take ownership of managing their illness. There is also a need for commitment from individuals to make lifestyle changes in order to beat the condition.

The project comprises six weekly sessions aimed at behavioural changes by both patients and their carers. The programme aims to develop 'experts' in heart disease from within the South Asian population.

The sessions address the following topics: the heart and its function, physical activity, medication, stress and its effect on the heart and two sessions on risk factors. Each session lasts approximately three hours. In order to maintain attendance levels participants are given the choice whether to combine the last two sessions on risk factors into a single day's event with information on diet, exercise and giving up smoking. Attendees can also have their blood sugar and cholesterol levels checked, find out their Body Mass Index and monitor their body fat, and the day includes a healthy lunch.

Sessions are delivered by various health care professionals, for example the session on the heart is run by a cardiac rehabilitation nurse and the session on medication by a pharmacist. Materials provided are in English, but include culturally appropriate visual aids. For example, an exercise manual includes photographs of an elderly Asian man and a woman dressed in a hijab doing the exercises, to show that they are suitable for anyone. The professionals delivering the sessions come from similar cultural background to the participants and are able to speak a variety of Asian languages.

Links were established with local voluntary, religious and community groups through face to face meetings to advertise the availability of the course. This method was found to be far more effective than writing to groups, which did not generate a response. Participants are also referred on to the course from local hospitals. Links have also been made with a local Heart Care cardiac rehabilitation programme, and the course is soon to be delivered in the Heart Care centre.

A next step for the programme is to train patients to become peer educators so that they can set up local heart groups in the community.

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CASE STUDY

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The CADISAP study (Coronary Artery Disease in South Asian Prevention)



Improving uptake and adherence to cardiac rehabilitation among South Asians through culturally specific interventions.

The CADISAP study set out to examine the impact of culturally specific interventions incorporated into a NSF model cardiac rehabilitation programme on the uptake of and adherence to cardiac rehabilitation among south Asian patients with established coronary heart disease. Interventions include employing bilingual health link workers; providing culturally relevant dietary advice; providing interpretation and translation services; involving local community organisations in the delivery of the service and providing support with transport.

The study is directly relevant to practice at Whipps Cross University Hospital, based in Waltham Forest and Redbridge borough, where South Asians account for at least 15% of the local population and more than a third of the annual admissions to our coronary care unit (CCU). CADISAP is funded by the British Heart Foundation, Department of Health and the Neighbourhood Renewal Fund.

The CADISAP programme is multidisciplinary and menu driven, comprising education, psychological support, dietary advice, supervised exercise training and support with smoking cessation, provided in four phases over a 12 week period. Prior to the

programme, patients were assessed for their cardiac risk, psychological and dietary needs and divided into high, intermediate and low risk groups with a formal exercise tolerance test. The programme was then tailored to meet their individual requirements.

Phase I rehabilitation comprising early mobilisation, reconditioning and education (with the emphasis on addressing any misconceptions) is provided in hospital immediately after a step improvement in the admitting condition. Phase II and III, involving dietary advice, support with smoking cessation, relaxation therapy and supervised exercise training, are delivered in the local south Asian voluntary organisations and the gym. Following successful phase III rehabilitation, patients are asked to continue with the physical activity by either joining the phase IV exercise programme offered by the CADISAP community arm or joining their local gym or exercising at home.

The study has convincingly demonstrated that incorporating culturally specific interventions into a standard cardiac rehabilitation programme can significantly improve uptake and adherence among south Asians. Of the one hundred patients offered, 79 consented to participate in the programme – an uptake rate of 79%, which compares favourably with the national range of 30-59% for Caucasians and even lower among ethnic minorities. More than 60% of the recruited patients completed at least 50% of the prescribed programme. The study has also generated learnings about the nature and extent of the problem of poor uptake of cardiac rehabilitation among south Asians.

Following the preliminary results of the pilot study, the team are now embarking on the first randomised control trial comparing the effect of culturally specific versus conventional cardiac rehabilitation on the quality of life of south Asian patients with CHD.

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Resources

Further information and reading

The National Service Framework for Coronary Heart Disease – Chapter Seven: Cardiac Rehabilitation.

Available at www.dh.gov.uk/publications

Coronary heart disease rehabilitation among South Asian and white patients: a comparative study of the role of families and services.

February 2003. Aliya Darr and Karl Atkin.

This study examines the experiences and understanding of cardiac rehabilitation amongst South Asian and white patients, looking at factors such as ethnicity, religion, language, gender and class to examine differences and commonalities between the various groups interviewed. The study was undertaken to facilitate the development of appropriate information and resource materials for South Asian people with heart disease and their families, and also to provide recommendations for practitioners and policy makers involved in planning and providing cardiac rehabilitation.

The experiences and health needs of Asian coronary patients and their partners. Methodological issues and preliminary findings.

Webster, R. (1997) *Nursing in critical care*, 2(5):215-223 (Coronary Care Unit, Leicester General Hospital).

This study suggests that cardiac rehabilitation services need a higher profile within the Asian community and that established approaches to data collection may need to be challenged if accurate and relevant feedback is to be achieved.

Promoting participation in cardiac rehabilitation: Patient choices and experiences.

Clark A.M., Barbour R.S, White M. and Macintyre P.D. (2004) *Journal of Advanced Nursing* 47(1), 5-14.

This study explores how a range of beliefs about the self, health professionals, heart disease, risk factors and rehabilitation were used to justify attendance at cardiac rehabilitation. The study is not focused on South Asians and the nature of these beliefs and circumstances is likely to differ in different populations, however it demonstrates the need to understand these factors and their role when designing interventions to promote usage.

Useful organisations and contacts

British Heart Foundation

14 Fitzhardinge Street
London W1H 6DH

T: 020 7935 0185

Heart Information Line 08450 70 80 70

www.bhf.org.uk

The aim of the British Heart Foundation (BHF) is to play a leading role in the fight against heart disease so that it is no longer a major cause of disability and premature death. The BHF funds research into the causes, prevention, diagnosis and treatment of heart disease; provides support and information to heart patients and their families through the British Heart Foundation nurses, rehabilitation programmes and support groups and provides information for the public and health professionals. It also promotes training in emergency life support skills for the public and health professionals and provides vital life-saving equipment to hospitals and other health providers.

Over the past few years the BHF has spent over £2 million on medical research to benefit minority ethnic groups and understand differences in heart disease risk, determining factors and distribution. The BHF also provides booklets and videos in South Asian languages to raise awareness of heart disease and prevention and CPR. To order materials visit **www.bhf.org.uk/publications**.

For more information on the BHF's ethnic strategy contact:

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Ethnic Strategy Co-ordinator
E: zaidiq@bhf.org.uk

Coronary Heart Disease Collaborative

4th Floor
St John's House
East Street
Leicester LE1 6NB

T: 0116 222 1414

F: 0116 222 5101

E: chdcinfo@npat.nhs.uk

www.modern.nhs.uk/chd

The CHD Collaborative is a Department of Health funded national programme that finds innovative ways of improving the delivery of CHD services.

Currently part of the NHS Modernisation Agency, the CHD Collaborative was set up in 2000 as a key element in the delivery of the standards set out in the Government's National Service Framework for CHD.

There are 30 programmes operating across England, working with local teams to improve the experience and outcomes for people who have or are at risk of developing heart disease. The Collaborative aims to achieve this goal by fundamentally redesigning the whole pathway of care of patients through the healthcare system.

From April 2005 these service improvement programmes will become more locally focused within cardiac clinical networks. The role of the Collaborative will be to support the delivery of the networks agenda, embedding service improvement approaches into their way of working.

For more information contact:

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National Discovery Interview Manager
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Useful organisations and contacts

Diabetes UK

Diabetes UK Central Office
10 Parkway,
London NW1 7AA

T: 020 7424 1000

F: 020 7424 1001

E: info@diabetes.org.uk

www.diabetes.org.uk

Diabetes UK is the leading charity working for people with diabetes, their carers, families and friends. The organisation raises money for research into diabetes and works with the media and government to ensure the best care and quality of life for people with diabetes. Diabetes UK is committed to equality for all in achieving its mission of 'improving the lives of people living with diabetes' and aims to involve and recognise the needs of people from Black and minority ethnic communities, working towards equity of access to good diabetes services for those groups at most risk.

Diabetes UK produces a number of free general information publications in the main five South Asian languages and Chinese, to support people in managing their diabetes and in leading fuller, healthier lives. These are available to order and can also be found on the web site. The organisation also has over 400 local support groups, some of which are aimed at specific groups of people, for example children, parents or people from South Asian backgrounds.

For more information on Diabetes UK's commitment to equality contact:

Jenne Dixit

Equality and Diversity Advisor, Diabetes UK

T: 020 7424 1110

E: jenne.dixit@diabetes.org.uk

QUIT

Ground Floor
211 Old Street
London EC1V 9NR

T: 020 7251 1551

F: 020 7251 1661

E: info@quit.org.uk

www.quit.org.uk

QUIT is an independent charity which aims to save lives by helping smokers to stop.

QUIT offers Smoking Cessation training to health professionals and undertakes a range of research activities to learn as much as possible about smoking and smokers to provide them with the most effective means of stopping.

QUIT also runs a variety of health promotion activities with partners (including the BHF and Diabetes UK) including healthchecks at melas, a health promotion training programme for religious leaders and the annual National Smoke Free Ramadan Campaigns, as well as campaigns around Hindu and Sikh religious festivals.

The charity also set up Asian Quitline, a specialist service set up to meet the needs of South Asian Smokers and tobacco chewers who want to quit, in partnership with the BHF.

For more information contact:

Kawaldip Sehmi

Director of Health Inequalities, QUIT

T: 0207 251 1551

E: k.sehmi@quit.org.uk

Useful organisations and contacts

The South Asian Health Foundation

The South Asian Health Foundation
26 Lightwoods Hill
Bearwood
West Midlands B67 5EA

T: 07802 288182

www.sahf.org.uk

The South Asian Health Foundation (SAHF) is a registered charity which aims to promote improvements in the quality of, and access to, healthcare and health promotion in South Asians, and to promote research that leads to these objectives, for example into why South Asians are more likely to suffer from common conditions such as heart disease, stroke and diabetes with the aim of avoiding thousands of deaths from these diseases.

The SAHF assists health professionals in ensuring that they deliver equitable healthcare promotion and that all communities receive the same level of input, and is developing a national infrastructure to build on the good work already going on in many areas. SAHF organises regional and national meetings to promote its objectives and also distributes updated literature on current research and developments in the field of ethnicity and CHD.

The foundation also aims to act as a pressure group to influence appropriate people and bodies and to be in a position to provide authoritative comment to influence initiatives.

For more information on the South Asian Health Foundation contact:

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The South Asian Health Foundation
T: 07802 288182
E: drkiranpatel@sahf.org.uk

Muslim Health Network

65a Grosvenor Road
London W7 1HR

T: 020 8799 4475

F: 020 8799 4465

E: info@muslimhealthnetwork.org

www.muslimhealthnetwork.org

The Muslim Health Network was established to play a principal role in promoting, preserving, and protecting health and health education amongst the Muslim Communities in the UK. The aim of the network is to improve the standard of health and well being within the community through information, support, news, advice, events and the promotion of general health issues.

The network encourages and organises co-operation between the voluntary organisations and statutory authorities engaged in health improvement and promotion activity within the community, and has launched various health campaigns in association with PCTs and other health promoters. These include Smoke Free Ramadan 2003, Healthy Heart Campaign 2004 and the first MHN Smoking Cessation Training Day, prepared for community volunteers, Imams and youth workers (see the website for more details).

For more information contact:

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Acknowledgements

The Department of Health Heart Team would like to thank everybody who contributed to this toolkit, especially representatives from the projects featured.

We would also like to give special thanks to Professor Raj Bhopal, Dr Sandy Gupta, Dr Kiran Patel, Veena Raleigh, Kawaldip Sehmi and Qaim Zaidi for their valuable input.

For space reasons we were unable to include all the projects we worked with. However, you can read about the following projects on the Department of Health website – www.dh.gov.uk.

**The Abaseen Foundation:
Nahaqi Research and Database Project**

**Bolton 5 A DAY – Increasing access to
fruit and vegetables in Bolton**

The Cardio Wellness Clinic

**Community Health Promotion in
Middlesbrough**

**Muslim Khatri Association (MKA)
Healthy Living Centre, Leicester**

**Fatima Women's Association – Walking
for Health**

Health Activists in Slough

**Sheffield CIRC (City Wide Initiative for
Reducing Heart Disease)**

If you are a service provider working with South Asian communities and you would like to tell us about your work, please contact the Heart Team (contact details at the back of this guide). Or e-mail us at southasians@dh.gsi.gov.uk.

Appendix 1:

National targets relating to coronary heart disease and reducing health inequalities

Priority 1:

Improve the health of the population.

By 2010 increase life expectancy at birth in England to 78.6 years for men and to 82.5 years for women.

■ **Substantially reduce mortality rates**

by 2010 (from the Our Healthier Nation baseline, 1995-97) from heart disease and stroke and related diseases by at least 40% in people under 75, with a 40% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole.

■ **Reduce health inequalities** by 10% by 2010 (from a 1997-99 baseline) as measured by infant mortality and life expectancy at birth.

■ **Tackle the underlying determinants of ill health and health inequalities**

– reducing adult smoking rates (from 26% in 2002) to 21% or less by 2010, with a reduction in prevalence among routine and manual groups 1 (from 31% in 2002) to 26% or less.

– halting the year-on-year rise in obesity among children under 11 by 2010 (from the 2002-04 baseline) in the context of a broader strategy to tackle obesity in the population as a whole. (Joint target with the Department for Education and Skills and the Department of Culture, Media and Sport).

The NHS interventions which will result in the largest reductions in deaths from heart disease and stroke by 2010 are management

of hypertension, high cholesterol, and diabetes in primary care, both for people with established disease and those at high risk. Positive effects will also be achieved by reductions in smoking, and in “call to needle time” for thrombolysis. The National Service Frameworks for coronary heart disease, diabetes, older people and children provide models of care to support achievement of reduced mortality.

All PCTs should work in partnership with Local Authorities, using health equity audit, to demonstrate that effective interventions are provided for all groups in the population, targeting those with highest needs. Key interventions are likely to include reducing smoking, particularly in the poorest areas and groups, and targeted action on prevention and treatment of cardiovascular disease (CVD) and cancers. There may also be local inequalities factors affecting access to primary care services which will need to be addressed, such as those experienced by minority ethnic groups. PCTs with the largest burdens of heart disease and cancer will need to set and achieve particularly stretching local targets, with a strong focus on the over 50s, especially those with established disease or high risk factors.

PCTs should plan to ensure that all care contacts across the system are used to promote advice on stopping smoking and on healthy eating and exercise. Increasing the number of long-term quitters through NHS Stop Smoking Services will be central. Reducing obesity, particularly in children under 11, requires further development of NHS services and interventions in primary care, specialist obesity services, and work with schools.

**Priority II:
Supporting People with
Long-Term Conditions**

To improve health outcomes for people with long-term conditions by offering a personalised care plan for vulnerable people most at risk; and to reduce emergency bed days by 5% by 2008 (from the expected 2003/04 baseline), through improved care in primary care and community settings for people with long-term conditions.

Priority III: Access to services

To ensure that by 2008 no-one waits more than 18 weeks from GP referral to hospital treatment, including all diagnostic procedures and tests – for example MRI and CT scans and angioplasty. This target applies to acute elective hospital care, but primary care trusts are encouraged to agree local plans to reduce waiting for other types of treatment.

Priority IV: Patient experience and choice

Secure sustained national improvements in NHS patient experience by 2008, ensuring that individuals are fully involved in decisions about their health care, including choice of provider, as measured by independently validated surveys. The experiences of black and minority ethnic groups will be specifically monitored as part of these surveys.

PCTs will be expected to work with local provider organisations to improve (a) the way people from black and minority ethnic communities are consulted about local health and health care issues and (b) the way their experience is monitored.

Patient choice will enable patients to personalise their care to best meet their preferences. To deliver the choice element of the new national target, PCTs and their partners will be expected to plan so that from April 2008, patients requiring planned hospital care will have the right to choose to have their treatment in any health care provider that meets the required standards and which can provide care within the price the NHS will pay.

PCTs should ensure that adequate patient information and support processes are set up and, particularly, to provide targeted support for hard-to-reach individuals and communities, including black and minority ethnic groups. PCTs should be considering how to increase patient choice in primary care and for patients with long-term conditions.

Existing commitments

Primary care trusts and their partner organisations are expected to deliver existing commitments from the previous 2003-2006 planning round by their target dates, and to maintain that level of performance beyond the target date.

These include:

- Ensure that by the end of 2005 every hospital appointment will be booked for the convenience of the patient, making it easier for patients and their GPs to choose the hospital and consultant that best meets their needs. By December 2005, patients will be able to choose from at least four to five different health care providers for planned hospital care, paid for by the NHS.

- 800,000 smokers from all groups successfully quitting at the 4-week stage by 2006.
- In primary care, update practice-based registers so that patients with CHD and diabetes continue to receive appropriate advice and treatment in line with NSF standards and, by March 2006, ensure practice-based registers and systematic treatment regimes, including appropriate advice on diet, physical activity and smoking, also cover the majority of patients at high risk of CHD, particularly those with hypertension, diabetes and a BMI greater than 30.
- Achieve a maximum wait of 3 months for an outpatient appointment by December 2005.
- Achieve a maximum wait of 6 months for inpatients by December 2005.
- Deliver a ten percentage point increase per year in the proportion of people suffering from a heart attack who receive thrombolysis within 60 minutes of calling for professional help.
- Delayed transfers of care to reduce to a minimal level by 2006.

For more information on these and other targets please see Appendix B of *National Standards, Local Action – Health and Social Care Standards and Planning Framework 2005/06–2007/08* available at www.dh.gov.uk/publications.

Appendix 2:

Tips on reaching your target group

The following tips have been compiled from learnings from the case studies featured in this guide.

1. Designing materials

- Make sure that you know what languages your target group speak and read. N.B. These may not be the same as some languages have a verbal rather than a written tradition.
- It may not be enough to provide translated written material – videos or audio tapes may be more appropriate in some cases, for example if your target group has low levels of literacy.
- When translating materials use everyday rather than overly formal language.
- Bear in mind that some ideas or phrases may not translate well e.g. idiomatic expressions like “butterflies in your stomach”.
- You may want to involve the community in translating the materials. Or, get translations proof read and checked by someone who speaks the language and understands the culture of your target group, ideally someone with a health promotion background.
- Make sure materials are culturally appropriate, for example if providing materials on healthy eating, make sure that these are relevant to the diet of your target community.

2. Organising events

- Involve your target audience to ensure that the event will meet their expectations and that they will enjoy it.
- Work in partnership with individuals and organisations working with your target groups e.g. community workers, health promoters, community groups.
- Choose a venue that is acceptable and accessible to your target audience. This may be a community centre, place of worship or even at work. Make sure that people can get to the venue easily.
- Choose a suitable date and time. Avoid clashing with religious festivals and make sure that you have taken into account days of worship, prayer times etc.
- Be aware of appropriate focal points for events that are relevant to your target group and consider timing your event to fit in with these e.g. giving up smoking in Ramadan.
- Find out what help and resources are available nationally e.g. through charities like Quit.
- Adapt events and materials for your target group, for example adapting the “No Smoking” message to a “No Tobacco” message for communities where tobacco chewing is prevalent.

- Give thought to how you publicise your event. You may want to get leaflets and posters printed in appropriate languages, use local radio or visit community groups to spread the news by word of mouth.
 - Ensure that there are interpreters present if necessary.
 - If food is provided, make sure that this meets the dietary needs of your target group. Can the food be used to support the theme of your event e.g. a healthy lunch?
 - Take into account any cultural sensitivities e.g. will the event be mixed, or would it be more appropriate to run separate event for men and women.
 - *See A guide to including Black and Minority Ethnic Communities in your Events* by Newcastle HealthWORKS and Health Development Service for more ideas.
- ### 3. Creating effective and accessible services
- Identify gaps in service provision and consider how your service could meet those gaps.
 - Consult and involve your target group when designing or modifying services to make sure that these services will meet their needs.
 - Understand what the barriers are for people in accessing services and try to find ways round these. Are there practical barriers e.g. transport difficulties or psychological barriers e.g. someone is worried about visiting a leisure centre for the first time?
 - Is there appropriate language support in the form of information, interpreters, link workers etc. for communities where English is not the first language?
 - Be clear on the objectives of your service and how best to achieve these. For example if you are trying to promote healthy eating, you may need to target the whole family, especially the shopper and cook, as well the individual.
 - Is there a need for services to be offered outside the traditional environment, for example in places of work, or within the community e.g. in a places of worship or community pharmacies?
 - Consider teaming up with other service providers (whether health services, voluntary or local authority groups) where appropriate. This could be to offer an integrated “one-stop” check up to address a number of related health issues at the same time, or to share or access resources for big projects.
 - Consider ways to involve the community in meeting its own health needs e.g. peer education schemes, or recruit bilingual health workers from your target group.

- Work with the community to overcome any initial hurdles and build trust.
- Consider what providing an equitable service actually means. Services for black and minority ethnic groups should be provided as part of mainstream health provision where possible. Can improvements be made to mainstream services to make them more inclusive rather than designing a specialist service?
- Find out who is influential in the community and whether you can involve them e.g. religious leaders, interesting speakers. This may differ for different sections of the community.

4. Publicising the service

- Consider how best to publicise the service. What media do your target audience read and consume? Options could be posters or leaflets in the right languages in the right places, local radio or specialist TV.
- Word of mouth can often be the best form of publicity.
- You may want to contact local community, voluntary and statutory organisations to recruit participants.
- Work with health professionals e.g. local doctors to raise awareness of your service, and to refer people through to it where appropriate.
- Consider ways to work with the wider community e.g. retailers, leisure centres and other businesses etc to get your message across.

5. Evaluation

- Evaluate your service to ensure it is effectively meeting the needs of its users and to get ideas on how to develop it further.
- Consider how best to gather feedback. If using questionnaires, will people need help filling these out? If gathering feedback face to face, will people tell you honestly what they think or are they afraid of offending you?
- When designing services consider what methods of evaluation you will use up front. What measures or indicators might be appropriate and how you will gather data to track these?

5. Sustainability and mainstreaming

- One issue many projects face is ensuring a steady stream of funding and service users can feel very let down if a project needs to close because the funds run out.
- Make sure that you are aware of all the different funding streams available and how to access these.
- Successful projects may want to look at ways of becoming part of mainstream service provision.
- Are there opportunities to offer training to interested participants so that the service can continue or expand?

6. Share learnings

- Capture any learnings from your own project, share these with the team and be open to sharing them with other service providers.
- Find out what other projects are doing. Talk to or visit them to understand how they developed their services, what worked well and what has worked less well.
- Are there any services in this guide which are similar to yours? What problems did they face and how did they overcome them? Contact details have been provided for each case study so that learnings can be shared.

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