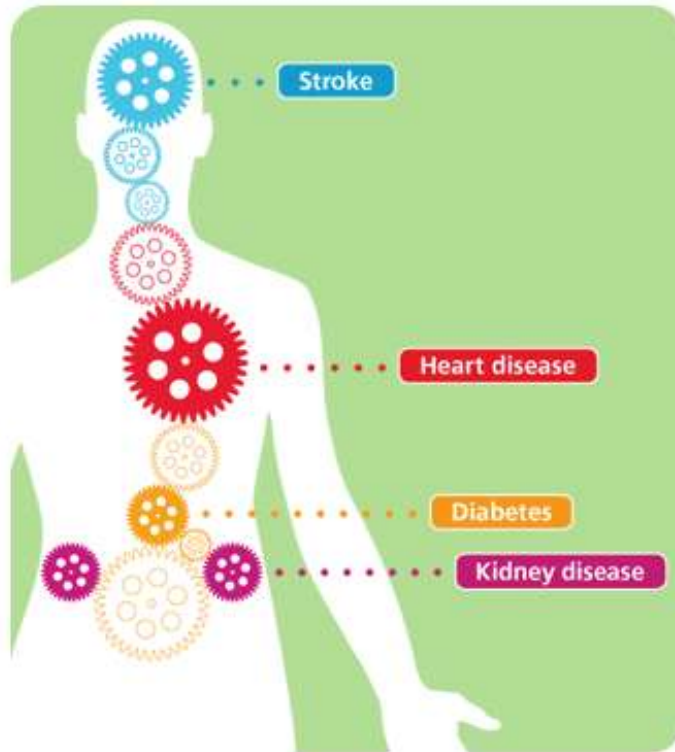


# Health Equity Audit – Lewisham NHS Health Check Programme

Lewisham Public Health Department



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2013

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I would also like to thank Dr Ratna Ganguly for her contribution to the background of this report.

## **Executive Summary**

A Health Equity Audit examines how health determinants, access to relevant health services, and related outcomes are distributed across the population, relative to need. An HEA advises decision-makers at all levels of governance to prioritize resources in the planning of policies, strategies and projects in a way that reduces inequities.

We undertook such an audit on the Lewisham Health Check Programme as this programme is large in size and as been set up with the aim of reducing the health inequalities. **(1)**

Lewisham has high cardiovascular disease premature mortality rates compared to England. Jointly with Greenwich, Lewisham has the highest premature directly standardised mortality rate for the years 2008/10 for females compared to other South East London boroughs.

We examined the usage of the health check service over a two year period (01/02/11 to 31/01/13) by extracting data from the Lewisham Health Check

Focus database. We identified uptake of the health checks service by sex, age, deprivation and ethnicity.

During the two year period, an approximate total of 37,800 people were invited for a health check and over 12,000 health checks were undertaken. GPs provided 9,108 health checks, pharmacies provided 2,602 health checks and the outreach team provided 511 health checks. The numbers provided by GPs were steady until the last six months when they declined. The numbers provided by pharmacies remained fairly steady throughout the two year period. The numbers provided by the outreach team steadily increased, from 19 in the first six months to 193 in the last six months.

GPs and pharmacies provided the most number of health checks to individuals of white ethnicity throughout the two year period; the outreach team provided the highest number of health checks to Black Caribbean and Black African in two different six month periods. The uptake of health checks by the Black community and the South Asian community remained fairly stable throughout the two year period. Health Check uptake by those of White ethnicity declined throughout the two year period, although the numbers picked up in the last six months.

There was a higher uptake of health checks from the female population. The older the patient, the less likely they were to have a health check.

It was unclear as to whether deprivation had an effect on health check uptake; more work would have to be done to become clearer on this issue.

## **1: BACKGROUND**

### **a) Health Equity**

The Health Equity Audit is a method of identifying how services and resources are distributed in relation to the healthcare needs of different groups of people

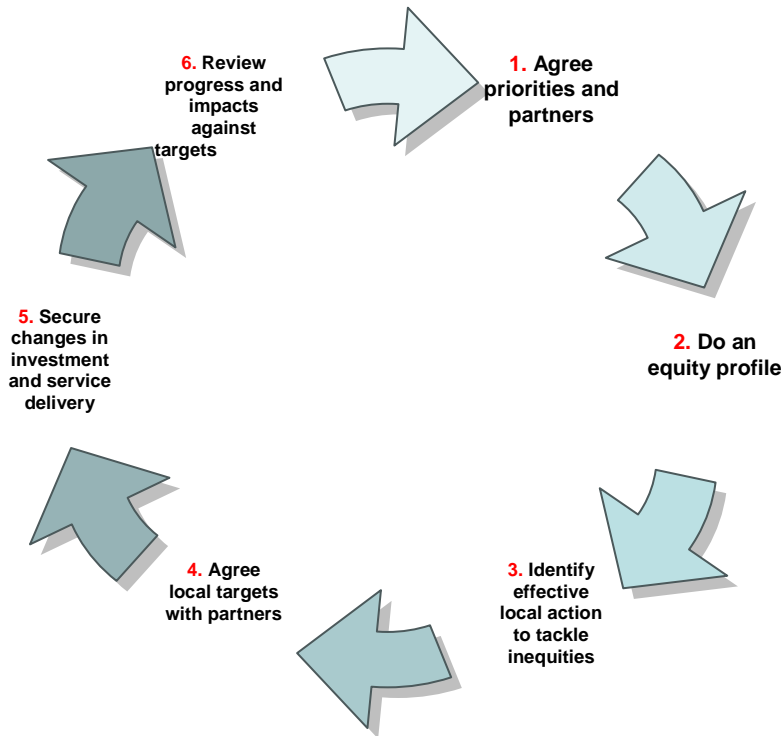
and different areas. The term equity denotes “fairness” and equitable health care provision takes into consideration the provision of services, access to services/resources, and uptake of services and the outcomes of services.

Health equity audits involve systematic reviews of the inequities which contribute to ill health.

The purpose of a health equity audit is to:

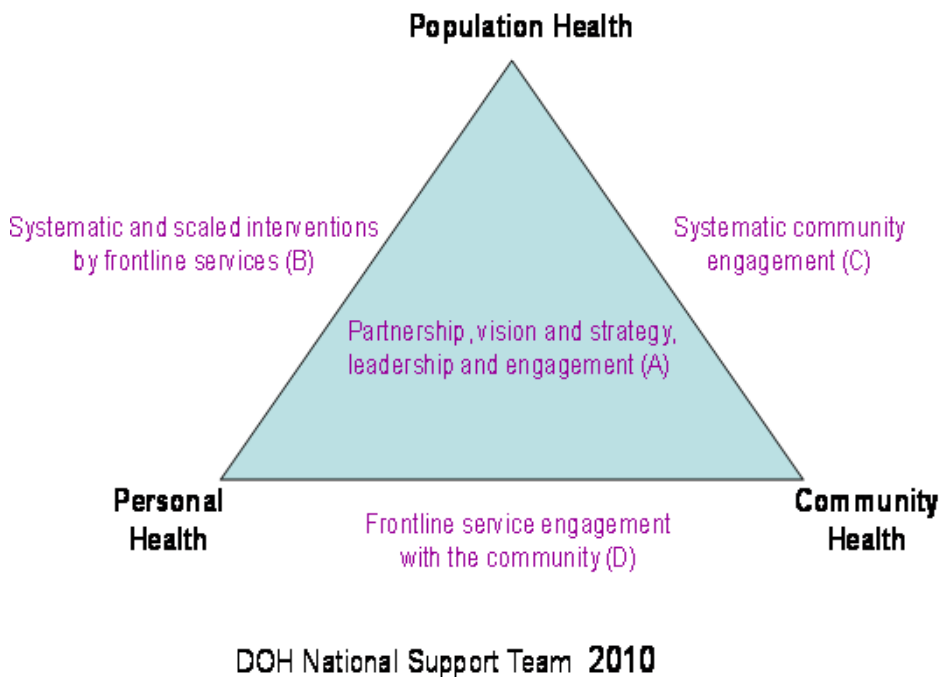
1. Provide information to commissioners about appropriate and accessible services to groups of people with poor health outcomes, who are underserved by services.
2. Produce regular, robust evidence that facilitates performance management and examines whether people’s health needs are being met. They also help to develop local health inequality targets.
3. Create a common framework that guides local strategic partnerships / health and wellbeing board, to tackle inequalities in their service and allocate resources effectively.
4. Inform the public of the inequalities and encourage the involvement of community/voluntary groups in planning.

The method of conducting a Health Equity Audit is regarded as cyclical, and is best illustrated in the following diagram. **(2)**



There are several key social domains in which inequalities and inequities exist. A HEA endeavors to examine each one and identify the presence of inequities. These domains include age, sex, ethnicity, socio-economic group, geographical residence, and vulnerable groups comprising of the homeless, asylum seekers, disabled people and those with chronic illnesses or mental health illnesses.

A model has been established by the DH Health Inequalities National Support Team to achieve change and reduce health inequalities at a population level in three main ways, at a personal health level, a community health level and a population health level.



Source: North Lewisham Evaluation Report

### **Achieving percentage change at population level**

This model includes four key components: systematic and scaled interventions by front line services; systematic community development, rather than ad hoc, targeting engagement and support to the weakest and least capable of responding; a range of processes to connect frontline services into the heart of communities, reaching out to seldom seen, seldom heard groups and individuals; and driven by committed leadership fostering engagement, effective local strategic partnership and a locally owned coherent vision and strategy<sup>1</sup>.

#### **b) Overview of Cardiovascular Disease**

Cardiovascular disease is an umbrella term encompassing conditions such as coronary heart disease, Stroke, TIA, peripheral artery disease, Type 2 Diabetes and Chronic kidney disease (CKD). There is significant overlap between the conditions in that they share common risk factors such as obesity, raised blood pressure and cholesterol levels.

<sup>1</sup> Health Inequalities National Support Team (2010), Redoubling Efforts to achieve 2010 National health inequalities Life Expectancy Target, Department of Health

In the UK, Cardiovascular diseases (CVD) are the predominant cause of death accounting for one third of all deaths in England. ONS mortality statistics for 2011 have shown that 26% of deaths in Lewisham are attributed to CVD **(3)**.

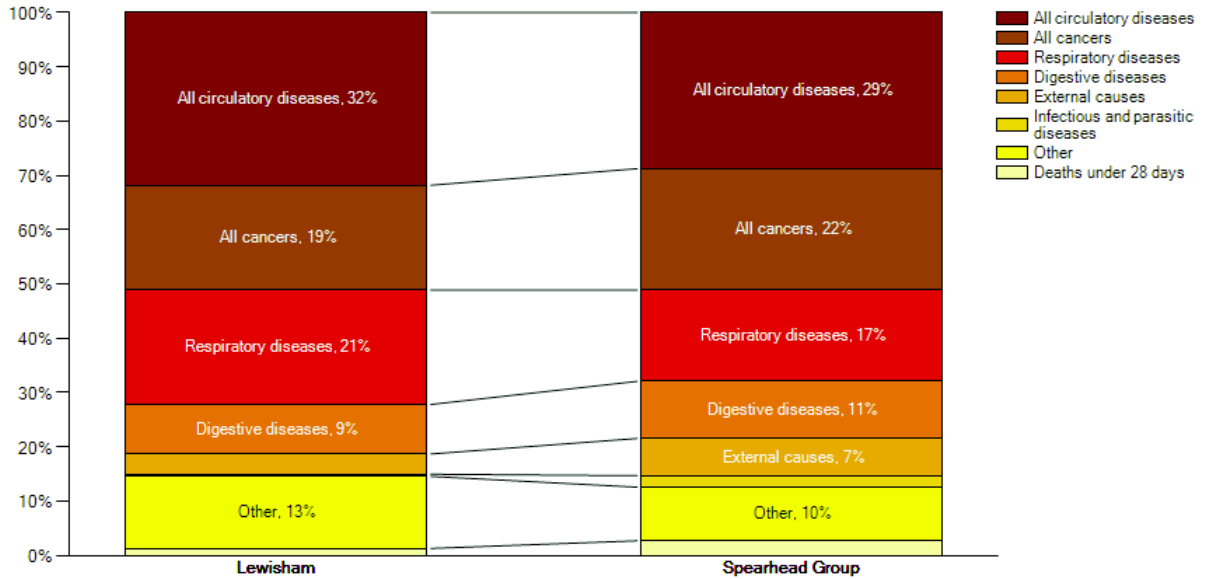
Lewisham has high cardiovascular disease premature mortality rates compared to England. **(4)** The premature directly standardised mortality rate for the years 2008/10, from all circulatory diseases for women in Lewisham was 58.18 per 100,000. This is above the rate for both London (43.1) and England (40.9). Jointly with Greenwich, Lewisham has the highest rate for females compared to other South East London boroughs.

Over the period 2003/4- 2009/10, hospital admissions for coronary heart disease (CHD) have decreased. During the same period, emergency hospital admissions for stroke and heart failure have increased substantially in Lewisham compared to a decrease in emergency admissions in London and England. **(4)**. Emergency admissions make up a greater proportion of admissions in the age group 75 and over than in younger age groups. **(4)**.

Circulatory diseases accounted for 32% of the male life expectancy gap between Lewisham and England in 2006 -2008 and 40% of the female life expectancy gap. This is a higher proportion of the gap in comparison with other Spearhead areas for males (3% higher) and significantly higher proportion of the gap for females (14% higher).



**Breakdown of the life expectancy gap between Lewisham and England, by cause, 2006-08 - Males  
(Equivalent gap between Spearhead Group and England shown for comparison)**



Lewisham identifies less people than expected on all GP cardiovascular disease registers. Additionally, Lewisham performs below the England average for all cardiovascular disease indicators in primary care. The benefits of a health check is to improve the public’s awareness, diagnosis and management of previously undiagnosed cardiovascular disease and risk.

In Lewisham, the highest CVD admissions are in the 40-74 age group. This is also the age group targeted by the NHS health checks.

**c) Overview of the Health Check Programme**

Disease control programmes have been defined by the World Health Organization (WHO) as ‘the co-ordination of disease prevention, screening and early detection, as well as disease management’ **(5)**

In 2008 the DOH proposed England's first 'vascular check' or single, universal, integrated programme aimed at preventing vascular disease and reducing health inequalities. The programme now called the NHS health check was implemented in 2009 in the publication of the NHS Health Check 'Best Practice Guidance.

The Health check programme invites all people aged 40-74 (once every five years) with no prior CVD risk factors to have a comprehensive assessment of their risk of developing a vascular disease.

The health checks are undertaken by general practitioners, 17 pharmacists and one community outreach team. Where appropriate, patients are followed up and if required, given lifestyle advice, support, referrals and therapeutic interventions to manage their risk factors.

Preliminary results from the NHS health checks revealed 10% of those checked to be at high risk of cardiovascular disease.

## **2: AIMS, OBJECTIVES & METHODS**

### **Aims**

The aim of this Health Equity Audit is to assess and describe how the resources of the Health Check Service are distributed in relation to different population groups in Lewisham.

### **Objectives**

- To establish current access to the Health Check Service
- To undertake a preliminary analysis of service use by age, gender and ethnicity of the Health Check Service from the time period 01/02/11 to 31/01/13.

- To match uptake of service to differing areas of deprivation.

## **Methods**

We used the Health Equity Audit methodology outlined on page 7 to undertake this piece of work, focusing on stages 2 & 3 of the cycle.

We also compared the approach taken by the programme as a whole to the model developed by the DH Health Inequalities National Support Team to reduce health inequalities at a population level.

The health equity audit profile used data on health checks undertaken and also drew on the findings of insight work with potential beneficiaries. Findings from research undertaken by Kings with those who have had health checks was not available in time for this report.

This insight was based on the opinions of sixty-nine people aged between 40 and 73 who took part in the research. Key contributors were from the Afro-Caribbean and White British descent population. In order to gather key information, a questionnaire and an online survey was created.

Data was extracted from an Excel spreadsheet, derived from the Lewisham Health Check Focus database about service use from the time period 01/02/11 to 31/01/13. Data was analysed by age, gender, ethnicity and deprivation. A total of over 12,000 health checks were performed during this time period.

In order to understand whether the ethnic make up, age groups, gender and deprivation of Lewisham were reflected in the uptake of the health checks, we projected estimates of each aforementioned category by applying the appropriate proportion figure from the projected GLA estimate (based on the 2011 census) for the year 2012 to the health check number. For example,

60.8% of the Lewisham population aged 40-74 in 2012 were calculated to be of white ethnicity. Hence one would estimate that out of 12,221 health checks, 7430 of the health checks would approximately be of white ethnicity. We then compared these values to how many of the health checks actually occurred, again analyzing the usage by age, gender, ethnicity and deprivation status.

We approximated the deprivation of the patients undergoing the health checks by assigning them an Index of Deprivation (IMD) index number (see appendix for more detail) according to what GP practice they belonged to.

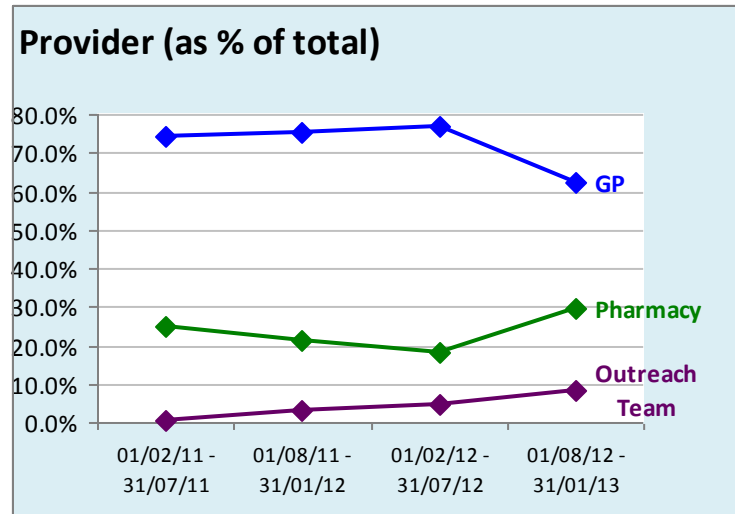
The year 2012 was chosen for the GLA estimates due to it being more recent in chronology; in actual fact there was negligible difference seen between the years of 2011 and 2012.

### **3) RESULTS**

We looked at over 12,000 health checks performed between 01/02/11 and 01/08/13. In this section, the health checks are described in the context of the providers, the proportion of uptake by gender, age, deprivation and ethnicity.

#### **Analysis of the Providers of the Health Checks**

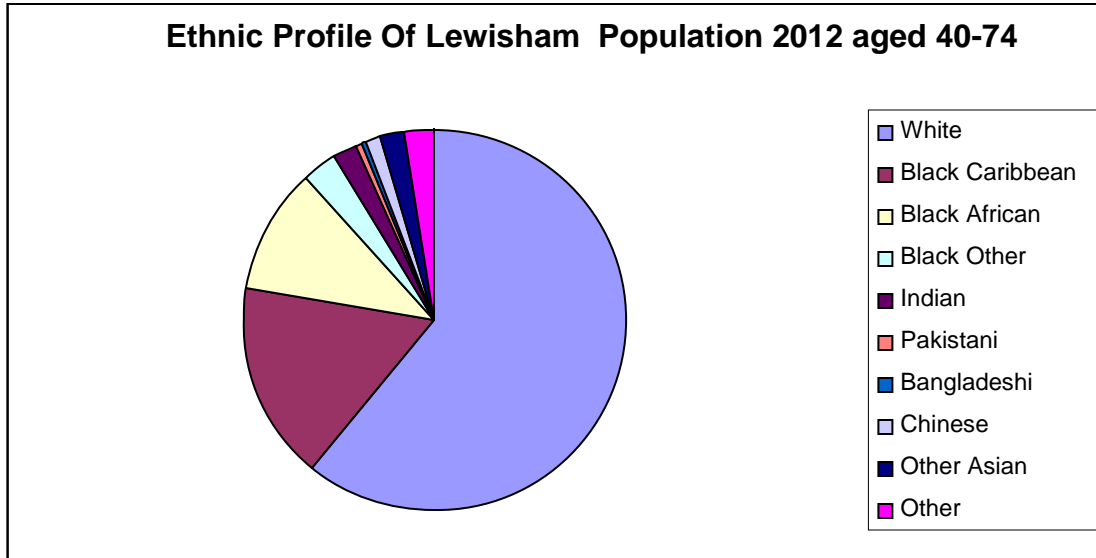
Provider	01/02/11- 31/07/11	01/08/11- 31/01/12	01/02/12- 31/07/12	01/08/12- 31/01/13
GP	2457	2644	2484	1523
Pharmacy	724	633	557	688
Outreach Team	19	147	152	193



Throughout the two year period analysed, GPs consistently provided the most health checks, although this started to decline towards in the last six months. This was in contrast to pharmacies and the outreach team, both whom simultaneously increased their number of health checks performed.

GPs provided between 62% and 77% of health checks. Pharmacy provided between 18% and 30% of health checks. The outreach team provided between 0.7% and 8.2% of health checks.

### **Ethnic Profile of Health Checks in Lewisham 2011-2013**



**Lewisham ethnicity in 40-74 population**

<b>White</b>	60.8%
<b>Black Caribbean</b>	17.0%
<b>Black African</b>	10.6%
<b>Black Other</b>	3.0%
<b>Indian</b>	2.0%
<b>Pakistani</b>	0.4%
<b>Bangladeshi</b>	0.3%
<b>Chinese</b>	1.3%
<b>Other Asian</b>	2.1%
<b>Other</b>	2.4%

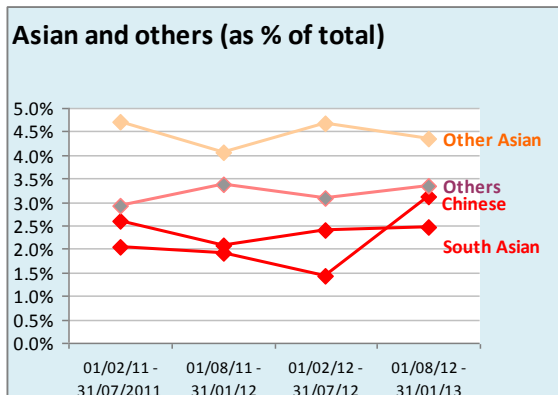
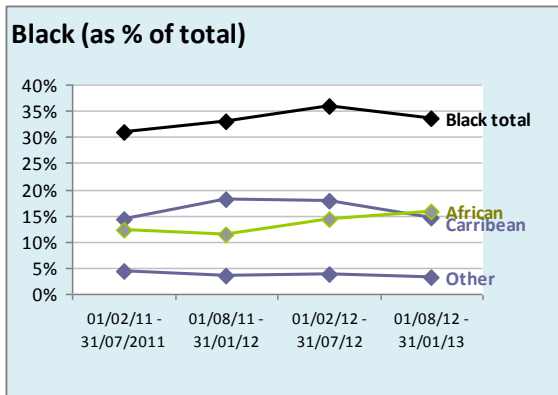
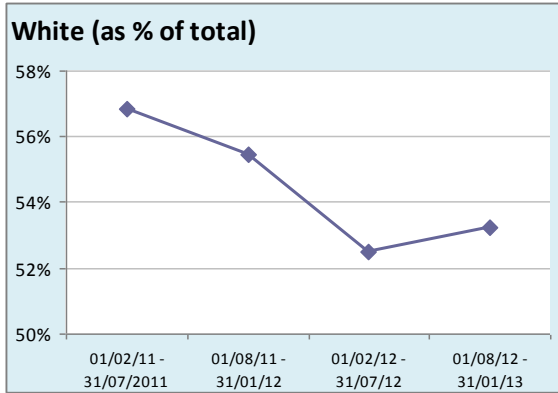
Source: GLA estimate

**Lewisham ethnicity all ages**

<b>White</b>	57.6%
<b>Black Caribbean</b>	13.8%
<b>Black African</b>	12.0%
<b>Black Other</b>	6.0%
<b>Indian</b>	2.3%
<b>Pakistani</b>	0.6%
<b>Bangladeshi</b>	0.5%
<b>Chinese</b>	1.3%
<b>Other Asian</b>	2.6%

**Other** 3.4%  
Source: GLA estimate

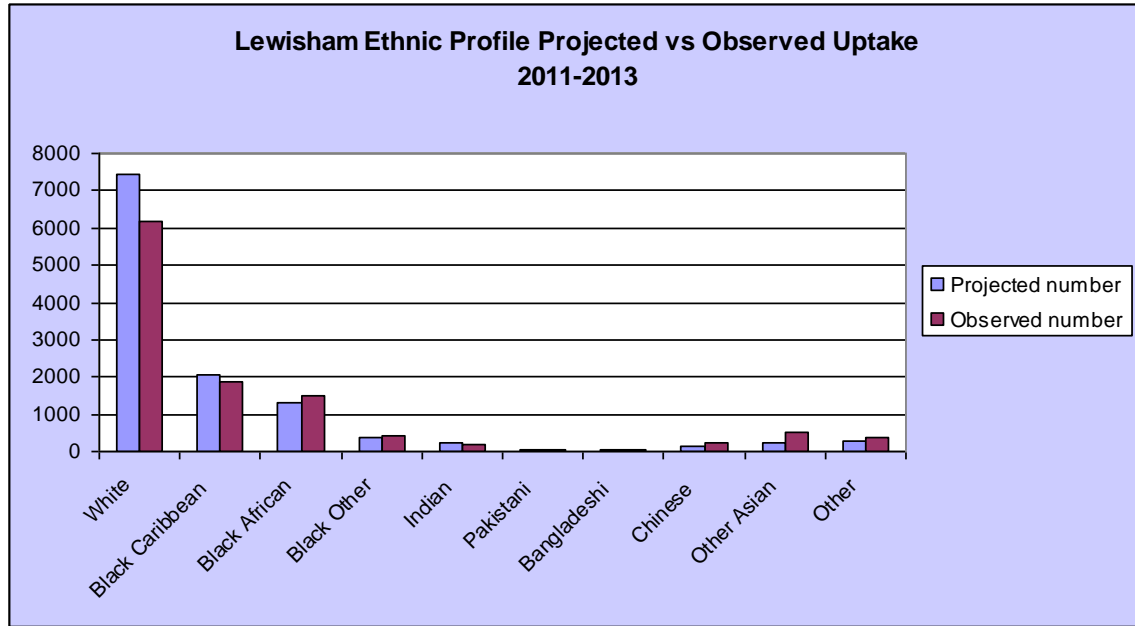
Black Caribbean individuals make up a larger proportion of the 40-74 age group (17.0%) in Lewisham than they do as a proportion of all the age groups (13.8%). There is double the proportion of Black other individuals in the Lewisham population as a whole in comparison to the 40-74 age group. The proportions of the other ethnic groups in the 40-74 age group are comparable to the Lewisham population as a whole.



The uptake of health checks by the Black community and the South Asian community remained fairly stable throughout the two year period. The Black African uptake ranged from 11% to 16%. The Black Caribbean uptake ranged from 11% to 16%. Black other uptake ranged from 3-4%.

Health Check uptake by those of white ethnicity declined throughout the two year period, from 57% to 53% (2 sf) although the numbers picked up in the last six months.



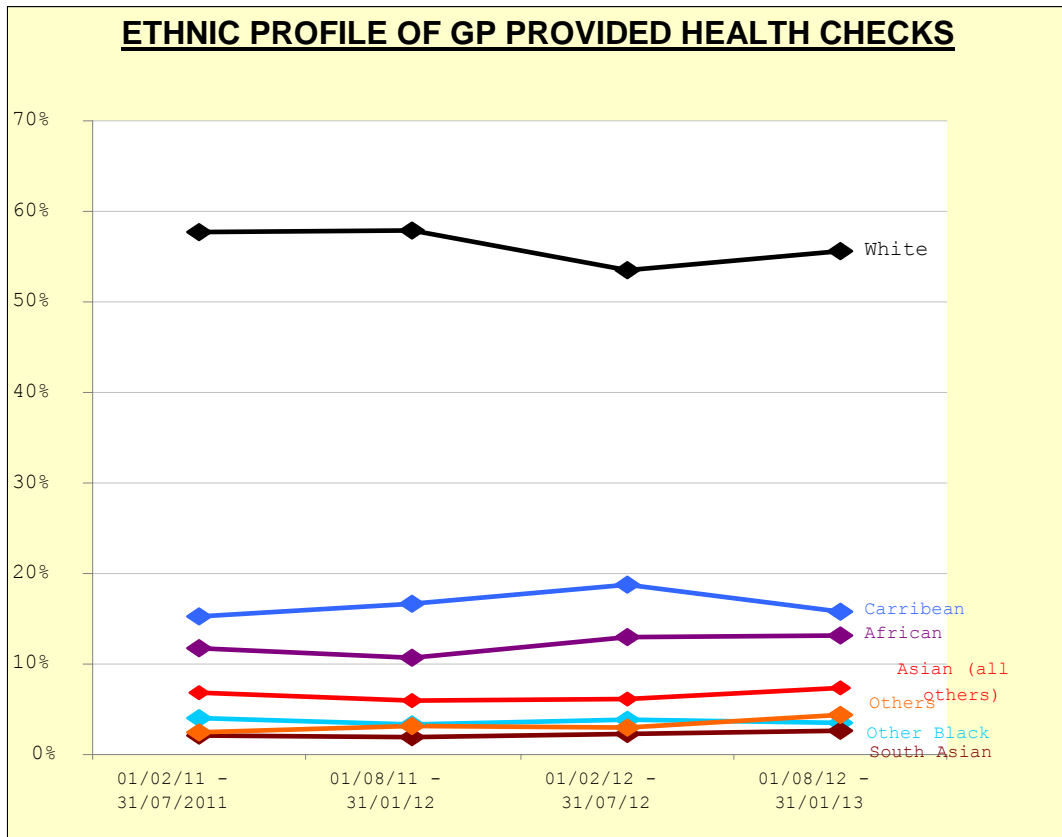


<b>Ethnicity</b>	<b>Percentage of pop (GLA estimate)</b>	<b>Projected total of Health Check usage as per proportion applied to GLA population numbers</b>	<b>Observed number of Health Checks</b>	<b>Percentage %</b>
White	60.8%	7430	6198	83%
Black Caribbean	17.0%	2078	1863	90%
Black African	10.6%	1295	1508	116%
Black Other	3.0%	367	421	115%
Indian	2.0%	244	187	77%
Pakistani	0.4%	49	49	100%
Bangladeshi	0.3%	37	35	95%
Chinese	1.3%	159	235	148%
Other Asian	2.1%	257	504	196%
Other	2.4%	293	361	123%
All Ethnicities	100.0%	12221	11331	

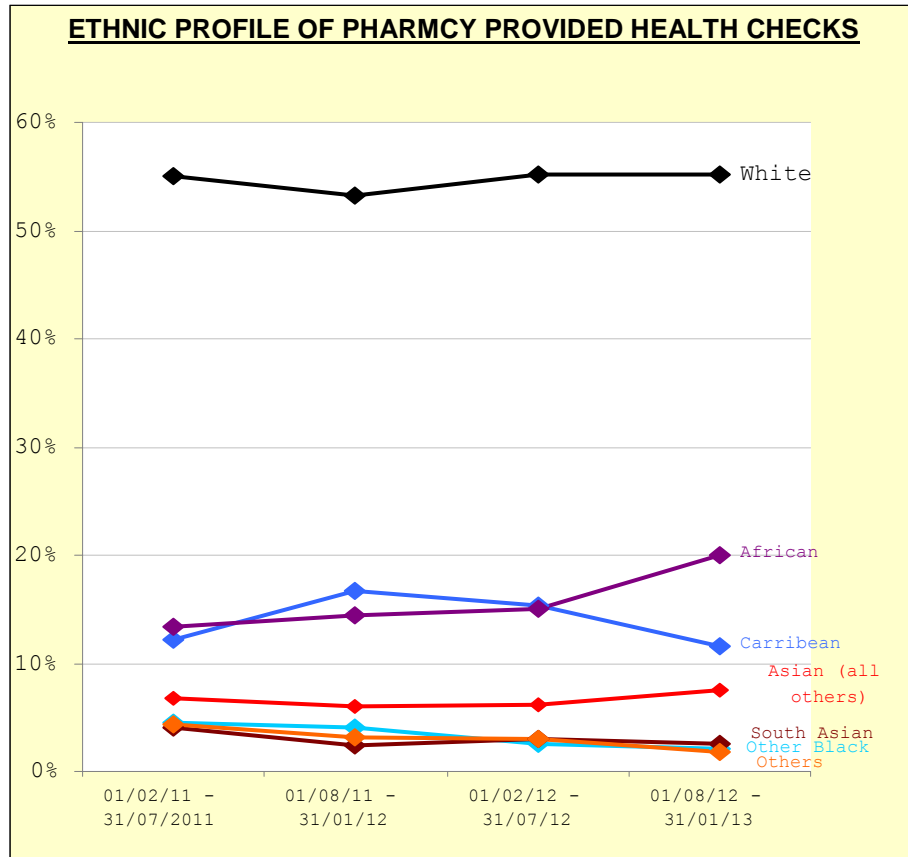
The Chinese population and the Other Asian population are overrepresented with respect to their uptake of the health checks. This must be taken into context that these ethnic groups have much lower numbers compared to the black and white community.

Black african, Black other, Chinese and 'Other' ethnic groups all used the service more than would be expected looking at the demographic make up of Lewisham.

The most under-represented ethnic groups who went for health checks were the Indian population; again this needs to be taken into context that this ethnic group has a much smaller population living in Lewisham to the Black and White community.

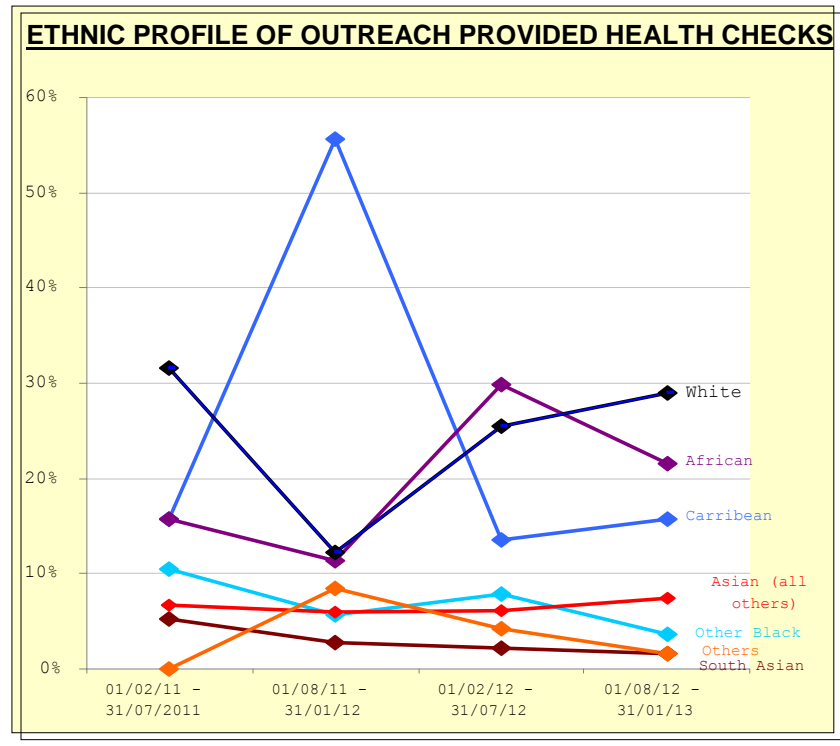


GPs provided the most health checks to the White ethnic groups, from 54% to 58%. Black Caribbean took up the second highest number of health checks, from 15% to 19%. This was followed by the Black African group, from 11% to 13%. South Asian uptake ranged from 2.0% to 2.6%. South Asian, all other Asians and other Black all had a relatively low uptake of health checks.



Again it can be seen that pharmacies provided the most health checks to those of white ethnicity, ranging from 53% to 55%. The next highest provision of health checks were to those of Black african ethnicity, ranging from 13% to 20%, followed by those of Black caribbean ethnicity, ranging from 12% to 17%. Black caribbean uptake started to decrease after the first six months, whereas Black african uptake continued to increase throughout the two year period, peaking at 20%.

South asian uptake ranged from 2.4% to 4.0%. Again South Asian, all other Asians and Other Black had similar relatively low numbers of health checks provided by pharmacies.

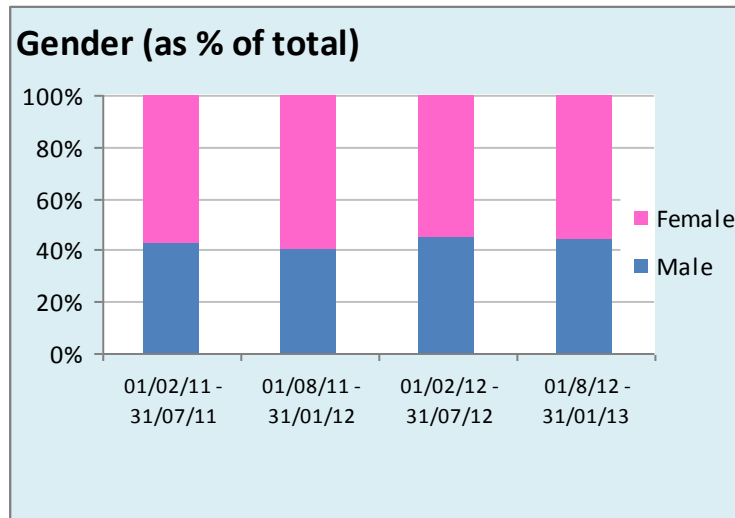


In contrast to the GPs and the pharmacies, the outreach team provided the most health checks to those of Black caribbean ethnicity during 01/08/11 to 31/01/12 and to those of Black african ethnicity from 01/02/12 to 31/07/12; the outreach team provided the most health checks to those of white ethnicity during the other two periods.

Provision of health checks to people of white ethnicity ranged from 12.3% to 31.6%. Provision of health checks to people of Black caribbean ethnicity ranged from 13% to 56%. Provision of health checks to people of Black african ethnicity ranged from 11% to 30%. Provision of health checks to people of South asian ethnicity ranged from 2.1% to 5.3%.

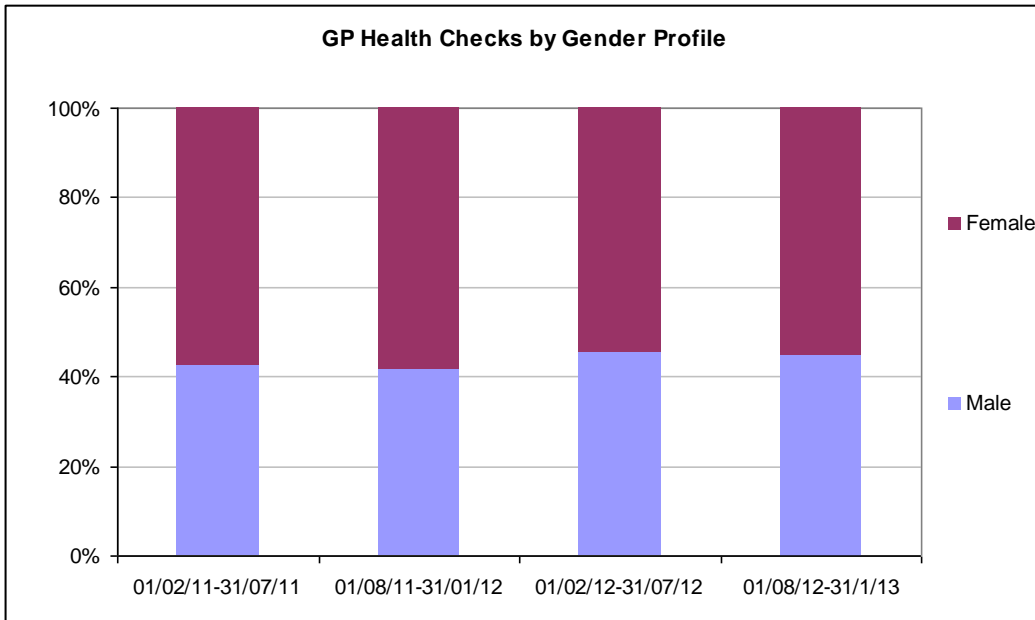
## **Gender profile of health checks in Lewisham 40-74 population 2011-2013**

<b>Gender</b>	<b>Percentage of population</b>	<b>Projected total of Health Check usage as per proportion applied to GLA population numbers</b>	<b>Observed number of health checks</b>
Male	49%	5988	5231
Female	51%	6233	6990

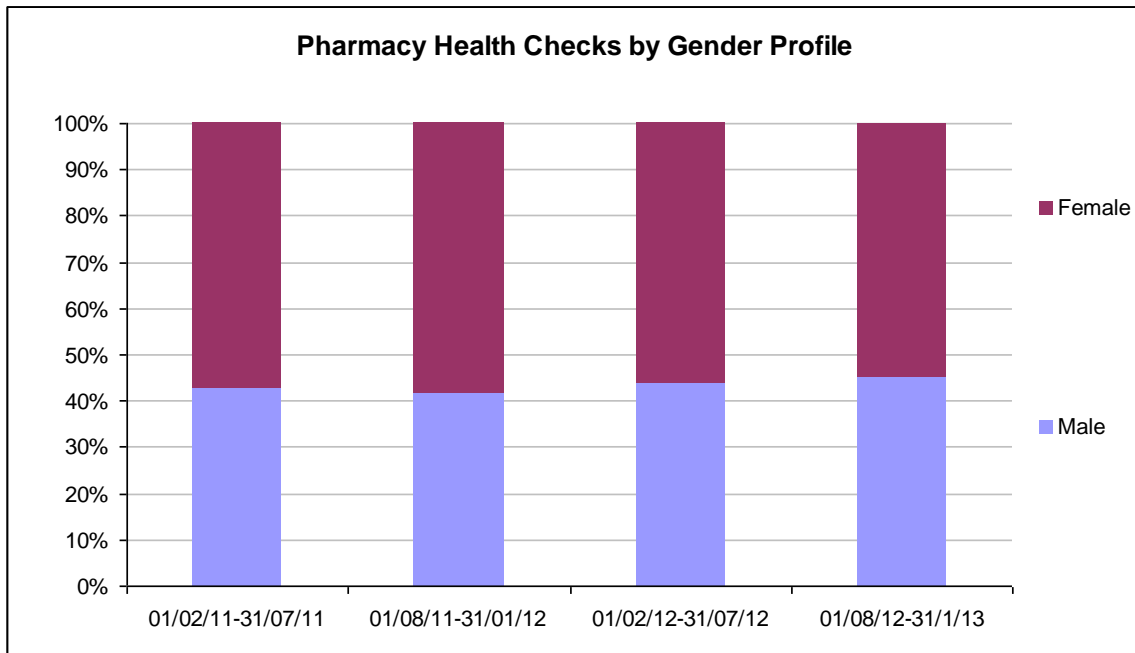


It can be seen that the eligible male population for health checks (87%) accessed the system less than would have been expected. In contrast, the eligible female population accessed the system more (112%) than would have been expected.

The above graph illustrates that although the higher proportion of patients who have undergone the health checks are female, this proportion was starting to decline as the quarters progressed. This is crucially relevant given the aforementioned concern regarding Lewisham females having the highest premature mortality rates compared to surrounding boroughs (CVD JSNA Highlights April 2013)

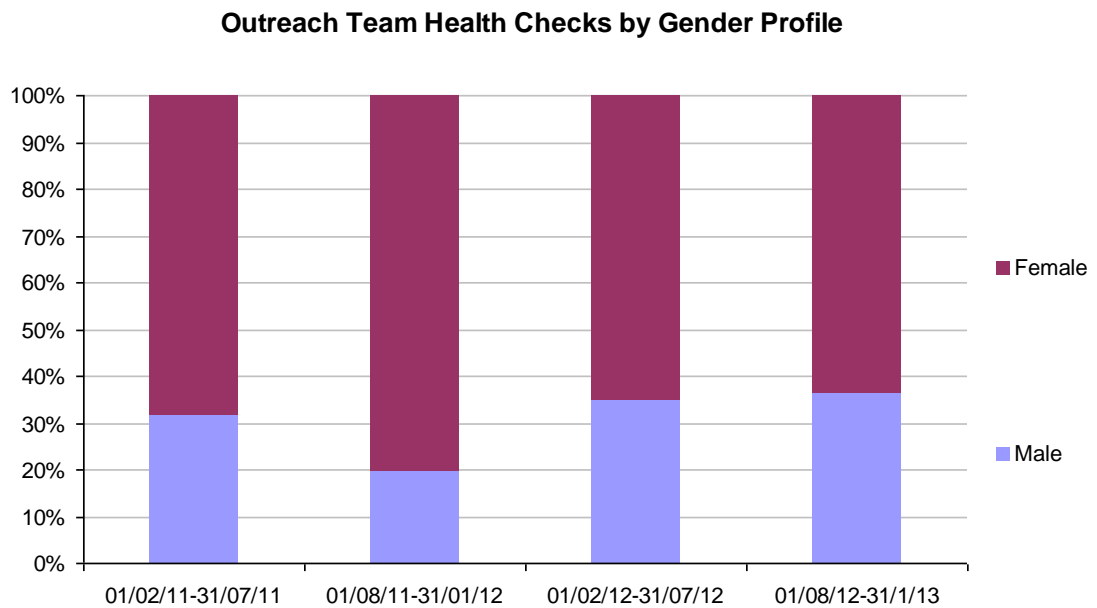


GPs consistently provided more health checks to females compared to males. This gap reduced in the last six months analysed.



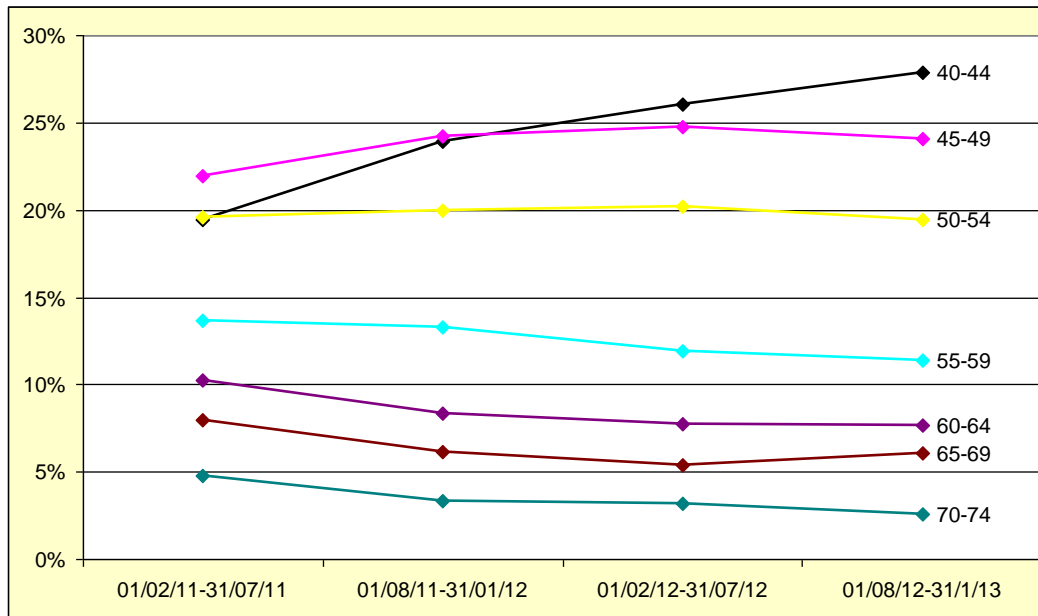
Pharmacies provided more health checks consistently to females compared to males. This trend remained relatively constant throughout the two year period.

### **Outreach team Provided Health Checks**



Compared to GPs and pharmacies, the outreach Team provided a substantially larger proportion of health checks to females in comparison to males. The highest number of females given health checks were in the period 01/08/11 to 31/01/12.

### **Age profile of health checks in Lewisham 40-74 population 2011-2013**



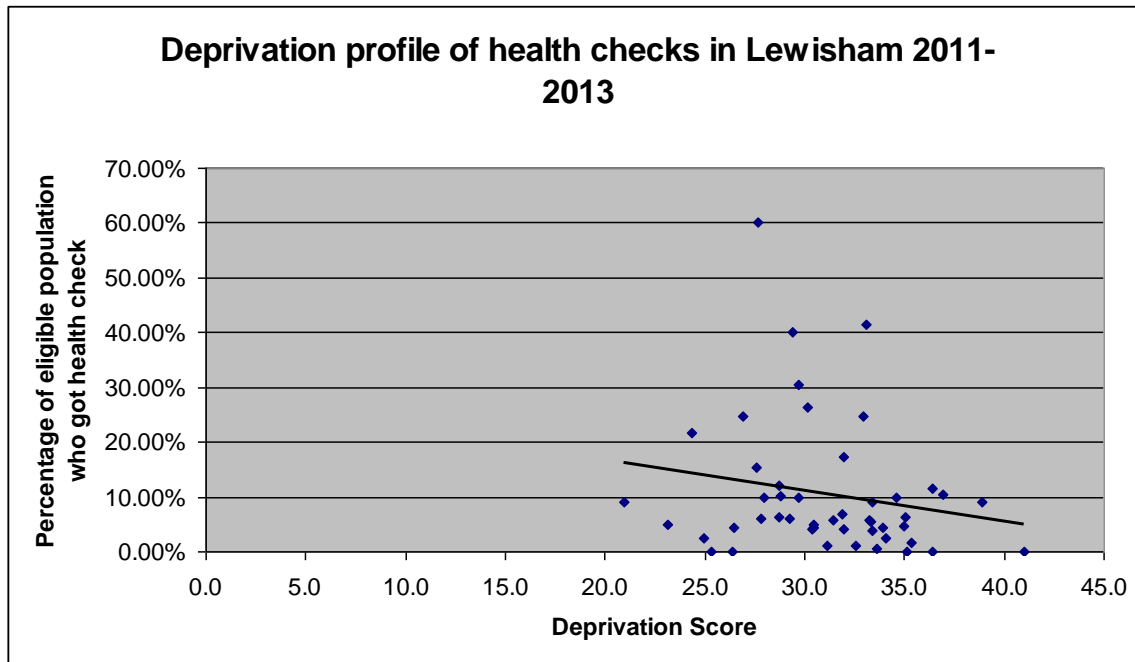
It can be seen that age groups 40-44 and 45-59 comprised the highest uptake of the health checks. The 40-44 age group ranged from 19% to 28% of the health checks. The 45-49 age group ranged from 21% to 25% of the health checks.

For the remaining age groups, the older the age groups, the less health checks were correspondingly performed. The lowest uptake was for the 70-74 age group.



## DEPRIVATION

### Effect of Deprivation on the Uptake of the Health Checks



Correlation coefficient  $r = -0.189$  (3 sf)

R squared = 0.0357 (3 sf)

The scatter graph suggests the following general trend: that the higher the deprivation score, the less health checks were performed in that area. However, the correlation coefficient suggests that there is a probably meaningless correlation between the deprivation score and the number of health checks performed. The r squared values suggests that only three per cent of the difference seen in the number of health checks conducted in certain areas could be attributed to the deprivation index score.

The programme is broadly in line with the model. It focused on:

- (B): Systematic and scaled interventions by frontline services.

Over the two years, we invited an approximate total of 37,880

people for a health check.

- (C): Systematic community engagement.

Three different providers were chosen; the outreach team in particular was chosen with the aim of trying to reach all areas of the community. Insight work has been done and is still continuing to gain insight into the public perception of the health checks (see results for more detail).

- (D): Frontline service engagement with the community

As outlined, GPs, pharmacies and the outreach team were chosen for this purpose.

- The insight into the Health Checks provided some information about health checks, even though only 16% of those interviewed had undertaken a health check. The vast majority of those who had attended a health check were motivated by a letter of invitation; second most common cause of motivation was concerns regarding health. Awareness of the NHS health check was low, despite some of the venues where the survey was being conducted being venues such as GP surgeries and walk-in clinics. The majority of the respondents had not seen the current Lewisham health check promotional materials. A key observation made was that there were no posters or leaflets in any health based venue where the research was conducted.

There was an overwhelming belief amongst those surveyed that the publicity would encourage people to attend their health checks. It was felt that approaches to the further roll-up of this programme should include partnership working in local communities with community and statutory partners to ensure it is embedded in Lewisham and increases opportunities to raise awareness.

#### **4) LIMITATIONS**

There were a number of limitations associated with this audit.

- We could not calculate the actual numbers of the population of Lewisham in 2011 and 2012, thus we had to use modeling data from the 2001 census data. It would have quite clearly been more accurate to have been able to gather the data of the Lewisham population of 2011 and 2012 and as a consequence make a more accurate estimation of the expected numbers of health checks that should have been performed as per age, gender, ethnicity and deprivation status. However, this data was simply not available, which can be attributed to limitations in time and resources in going about trying to access this data.
- Not everybody in the 40-74 age group would be called up for a health check if they were on a disease register. Information about the age of patients on disease registers is not available, thus there is likely to be an overestimation of the numbers who would fit the criteria for a health check.
- When looking at the ethnicity data, there were 890 patients (7% of the total) who did not state an ethnicity or who simply refused. This would obviously affect the accuracy of the analysis of this data.
- When looking at the deprivation data, we could not use the health checks that were obtained by the pharmacy or the outreach team on account of not having access to the IMD data for the people who attended these providers, thus the analysis of deprivation on the number of health checks performed was confined to only those who had their health checks at their GP surgery.
- We did not have each individual IMD score for each health check, thus the deprivation analysis could only be performed by looking at the IMD score assigned to the GP practice where the patient was registered. However, it is known that in certain GP practices, the make up of the patient population can be very diverse. Thus the IMD score per practice can give us some idea of the average deprivation per health check.

- The data was extracted from the Health Check Focus database in April 2013. In June, updates were made to the database which changed the numbers slightly for the data that was extracted (hence there is a slightly different total of health checks for the health checks by age data set in comparison to the other data extracted). The Health Check Focus Team have confirmed that the changes to the numbers were miniscule in size.
- The database would not allow us to correlate certain variables that we would have ideally have liked to explore for example looking at the different age groups who had a health check by their ethnic profiles.

## **5) DISCUSSION AND CONCLUSION**

GPs provided the most health checks, followed by pharmacies, with the outreach team providing the least number of health checks (the latter ranging from providing 19 in the first six months analysed to 190 health checks in the last six months analysed).

GPs and pharmacies consistently provided the most health checks to those of white ethnicity throughout the two year period. In contrast, the health checks provided by the outreach team to different ethnicities more closely reflected the different ethnic groups of the Lewisham population. In fact, the outreach team provided the most health checks to Black africans in one six month period and Black caribbeans in another six month period, with the highest number of health checks provided to those of white ethnicity in the remaining two six month periods.

Throughout the two year period, the uptake of health checks by the white community declined. However, the uptake of health checks by the black and South asian communities remained stable throughout. Black African, Black other, Chinese and 'Other' ethnic groups all used the service more than would be expected looking at the demographic make up of Lewisham, which might

be explained by the work of the outreach team. The most under-represented group were the Indian population.

There was a higher uptake of health checks from the female population compared to the male population; the outreach team particularly provided a substantial higher number of health checks to the female population (although the latter must be taken into context of the lower number of health checks provided by this provider.) It is positive to see females taking up the health checks in the context of Lewisham and Greenwich having the highest rate for premature directly standardised mortality rate for the years 2008/10 compared to other South East London boroughs. However, ideally the aim would be to achieve equal male and female uptake of the health checks.

The older the patient, the less likely they were to have had a health check. The most likely explanation is that a large proportion of the older age groups would already be on a disease register which would eliminate them from being invited for a health check.

It is uncertain currently whether deprivation has an effect on the access to the Health Check Services due to the methodology that was used – more analysis would need to be done to confirm this finding.

## **6) RECOMMENDATIONS**

- Further detailed analysis of the data sets for the Health Check Services over a longer time period for more accurate comparisons between different demographic categories between the different population groups. This could include detailed analysis year by year to identify trends.
- To incorporate the findings from the current research about patients views about the health check programme, which is due out soon into the HEA and to conduct similar research with the providers in the future.

- To include a full postcode per health check in data records in order to obtain more accurate analysis regarding the deprivation status on the health check numbers.
- To increase the number of health checks undertaken by the outreach team.
- To learn from the outreach team the methods utilized to connect with hard to reach communities.
- To improve the Health Check database or consider moving to a different database provider given the limited ability to correlate all variables desired and the constant unexplained fluctuations of the data within the database.

## **7) REFERENCES**

(1) [http://www.healthinequalities.eu/HEALTHY/EN/tools/health\\_equity\\_audit/](http://www.healthinequalities.eu/HEALTHY/EN/tools/health_equity_audit/)

(2) [http://www.sepho.org.uk/NationalCVD/docs/N23\\_CVD%20Profile.pdf](http://www.sepho.org.uk/NationalCVD/docs/N23_CVD%20Profile.pdf)

(3) ONS Public Health Mortality Files - [www.statistics.gov.uk/STATBASE/Product.asp?vlnk=1255](http://www.statistics.gov.uk/STATBASE/Product.asp?vlnk=1255)

(4) CVD JSNA Highlights April 2013

(5) The Handbook for Vascular Risk Assessment, Risk Reduction and Risk Management. University of Leicester 2012.

**8) APPENDIX****Census Ethnic Categories:**

<b>Ethnic Category</b>
White: English/Welsh/Scottish/Northern Irish/British
White: Irish
White: Gypsy or Irish Traveller
White: Other White
Mixed/multiple ethnic group: White and Black Caribbean
Mixed/multiple ethnic group: White and Black African
Mixed/multiple ethnic group: White and Asian
Mixed/multiple ethnic group: Other Mixed
Asian/Asian British: Indian
Asian/Asian British: Pakistani
Asian/Asian British: Bangladeshi
Asian/Asian British: Chinese
Asian/Asian British: Other Asian
Black/African/Caribbean/Black British: African
Black/African/Caribbean/Black British: Caribbean
Black/African/Caribbean/Black British: Other Black
Other ethnic group: Arab
Other ethnic group: Any other ethnic group

**Demography****Age Demographics in 2011 (GLA estimate)**

<b>2011</b>	
All	88,428
Males (40-74)	43,054
Females (40-74)	45,374
Aged 40-44	21,309
Aged 45-49	18,814
Aged 50-54	14,623
Aged 55-59	11,029
Aged 60-64	9,467
Aged 65-69	7,188
Aged 70-74	5,998

**Age Demographics in 2012 (GLA estimate)**

<b>2012</b>	
All	89,606
Males (40-74)	43,654 (49%)
Females (40-74)	45,952 (51%)
Aged 40-44	21,114
Aged 45-49	19,172
Aged 50-54	15,141
Aged 55-59	11,370
Aged 60-64	9,298
Aged 65-69	7,604
Aged 70-74	5,907



**Ethnic demographics in 2011 (GLA estimate)**

<b>Ethnic Group</b>	<b>Lewisham Numbers</b>	<b>Lewisham Percentage (%)</b>
<b>2011</b>	Total pop: 88,428	
White	54,370	61.4
Black Caribbean	14,894	16.8
Black African	9120	10.3
Black Other	2613	3.0
Indian	1712	1.9
Pakistani	351	0.4
Bangladeshi	254	0.3
Chinese	1175	1.3
Other Asian	1838	2.1
Other	2101	2.4

(Percentages rounded up to one decimal point).

**Ethnic demographics in 2012 (GLA estimate)**

<b>Ethnic Group</b>	<b>Lewisham Numbers</b>	<b>Lewisham Percentage (%) (rounded to 1 dp)</b>
<b>2012</b>	Total pop: 89,612	
White	54,493	60.8
Black Caribbean	15,238	17.0
Black African	9,500	10.6
Black Other	2,699	3.0
Indian	1,775	2.0
Pakistani	363	0.4
Bangladeshi	259	0.3
Chinese	1,192	1.3
Other Asian	1,902	2.1
Other	2,191	2.4

**Health Checks by Gender (obtained from health check database)**

<b>Gender</b>	<b>01/02/11-31/07/11</b>	
Male		1360
Female		1840
<b>Gender</b>	<b>01/08/11-31/01/12</b>	
Male		1386
Female		2038
<b>Gender</b>	<b>01/02/12- 31/07/12</b>	
Male		1426
Female		1767
<b>Gender</b>	<b>01/8/12-31/01/13</b>	
Male		1060
Female		1344

### **Ethnic profile of health checks in the Lewisham population 2011-2013**

**(obtained from health check database)**

**01/02/11-  
31/07/11**

GP	Pharmacy	Outreach Team	Total	
White	1228	398	6	1632
Black Caribbean	324	88	3	415
Black African	250	97	3	350
Black Other	87	33	2	122
Indian	34	18	1	53
Pakistani	6	7	0	13
Bangladeshi	5	4	0	9
Chinese	31	27	1	59
Other Asian	113	19	3	135
Other	52	32	0	84

**01/08/11-  
31/01/12**

GP	Pharmacy	Outreach Team	Total	
White	1384	356	13	1753
Black Caribbean	400	111	59	570
Black African	255	96	12	363
Black Other	81	27	6	114
Indian	38	10	2	50
Pakistani	3	3	0	6
Bangladeshi	6	3	1	10
Chinese	34	25	2	61
Other Asian	110	16	2	128
Other	77	21	9	107

**01/02/12-  
31/07/12**

GP	Pharmacy	Outreach Team	Total	
White	1244	305	36	1585
Black Caribbean	438	85	19	542
Black African	304	83	42	429
Black Other	89	14	11	114
Indian	31	14	0	45
Pakistani	14	2	3	19
Bangladeshi	8	1	0	9
Chinese	26	14	3	43
Other Asian	103	17	21	141
Other	70	17	6	93

	<b>01/08/12- 31/01/13</b>			
	GP	Pharmacy	Outreach Team	Total
White	798	375	55	1228
Black Caribbean	227	79	30	336
Black African	189	136	41	366
Black Other	50	14	7	71
Indian	27	10	2	39
Pakistani	6	4	1	11
Bangladeshi	4	3	0	7
Chinese	27	23	22	72
Other Asian	47	24	29	100
Other	62	12	3	77

**Age profile of health checks in the Lewisham population 2011-2013**  
**(obtained from health check database)**

<b>01/02/11-31/07/11</b>					
	GP	Pharmacy	Outreach Team	Total	
40-44	470	181	6	657	
45-49	601	137	5	743	
50-54	523	138	2	663	
55-59	371	91	1	463	
60-64	276	68	2	346	
65-69	212	57	1	270	
70-74	129	31	2	162	

<b>01/08/11-31/01/12</b>					
	GP	Pharmacy	Outreach Team	Total	
40-44	662	160	38	860	
45-49	688	148	32	868	
50-54	561	126	31	718	
55-59	378	79	21	478	
60-64	241	50	10	301	
65-69	173	41	6	220	
70-74	93	20	7	120	

<b>01/02/12-31/07/12</b>					
	GP	Pharmacy	Outreach Team	Total	
40-44	673	149	36	858	
45-49	644	128	43	815	
50-54	530	101	34	665	
55-59	305	70	18	393	
60-64	200	49	7	256	
65-69	140	31	6	177	
70-74	80	19	5	104	

<b>01/08/12-31/01/13</b>					
	GP	Pharmacy	Outreach Team	Total	
40-44	480	189	44	713	
45-49	399	158	59	616	
50-54	323	132	43	498	
55-59	195	74	22	291	
60-64	131	56	10	197	
65-69	96	48	12	156	
70-74	47	17	2	66	

## **Deprivation profile of Health Checks performed in Lewisham between 2011-2013**

The Indices of Deprivation (ID 2004), produced by The Office of the Deputy Prime Minister's (ODPM) Neighbourhood Renewal Unit, are the Government's official measures of deprivation.

The IMD 2004 combines indicators across seven key domains to provide a single score and rank for each area. People may be counted in one or more of these domains, depending on the type of deprivation they experience.

The 7 domain scores are:

- Income
- Employment
- Health Deprivation and Disability
- Education, Skills and Training Deprivation
- Barriers to Housing and Services
- Living Environment Deprivation (with subdomains for both Indoor and Outdoor Living Environments)
- Crime

In order to analyse whether deprivation status had an effect on the number of health checks performed, we analysed health check data per practice as each practice has an IMD assigned to them.

<b>IMD 2010</b>	<b>Population aged 40-74</b>	<b>Observed</b>	<b>% eligible population having health check</b>
27.6	2499	388	15.50%
28.7	6079	381	6.30%
33.4	5548	505	9.10%
33.6	2048	11	0.50%
33.9	4221	192	4.50%
30.4	1834	74	4.00%
28.8	1241	125	10.10%
32.0	5310	224	4.20%
32.6	1959	20	1.00%
25.3	2634	239	0.10%
24.3	4073	878	21.60%
31.9	3009	204	6.80%
28.7	2278	278	12.20%

29.2	4558	275	6.00%
35.2	912	0	0.00%
20.9	4116	371	9.00%
23.1	1655	82	5.00%
24.9	4552	108	2.40%
36.4	2072	236	11.40%
29.7	3103	308	9.90%
36.4	1703	0	0.00%
30.4	1121	51	4.50%
31.1	2184	25	1.10%
35.1	2330	150	6.40%
30.1	2940	774	26.30%
32.0	774	134	17.30%
33.1	945	391	41.40%
27.8	1535	94	6.10%
33.3	3102	169	5.40%
31.5	2889	171	5.90%
29.7	1399	425	30.40%
38.9	2456	223	9.10%
34.0	3215	76	2.40%
34.6	703	1	10.00%
30.4	3018	151	5.00%
34.9	1973	91	4.60%
28.0	873	1	10.00%
26.9	1055	262	24.80%
33.4	693	27	3.90%
41.0	801	0	0.00%
36.9	1367	141	10.30%
35.3	1707	29	1.70%
27.7	791	5	60.00%
29.4	1706	685	40.20%
26.4	1259	57	4.50%
26.4	1231	0	0.00%
33.3	815	47	5.80%
32.9	117	29	24.80%

