

death recorded in their GP record. Where cause of death was obtained from national records (n=163), primary causes were MI (n=29, 17.8%) and pneumonia (n=23, 14%). Mean age at death was 77.7±9.3 years. Mortality was significantly higher among patients who were older at baseline. Gender, diabetes type, smoking status and clinical parameters at baseline were not significant predictors of mortality.

**Discussion** Improvements in the clinical profile of patients enrolled in the programme since its introduction suggests primary-care-led integrated diabetes management can perform favourably in the long-term. However, the high incidence of macrovascular complications, prevalence of retinopathy and mortality rate indicates the importance of effective management.

OP16

# CHALLENGES EXPERIENCED BY COMMUNITY-BASED CLINICAL NURSE SPECIALISTS IN SUPPORTING THE DELIVERY OF INTEGRATED DIABETES CARE: A QUALITATIVE STUDY

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**Background** In Ireland, more Diabetes Nurse Specialists (DNSs) have been introduced into the community as part of a national programme to standardise and improve diabetes care. DNSs support the delivery of a new model of care whereby uncomplicated type 2 diabetes (T2DM) is managed in primary care, and complicated T2DM is managed between primary and secondary care. Historically diabetes care in Ireland has often been delivered in an unstructured way, lacking integration between primary and secondary care. Given this context we wanted to understand the challenges faced by community-based DNSs in delivering a standardised service.

**Methods** We purposively sampled DNSs from community-based respondents to a national survey (n=25) according to four administrative regions of the national health service. We conducted focus groups and interviews using a semi-structured topic guide. Interviews were digitally recorded and transcribed into NVivo V.11 software for coding and analysis. Data analysis is on-going using thematic analysis.

**Results** Sixteen DNSs participated in 2 focus groups, and 8 interviews. Preliminary analysis suggested elements of the role presented a challenge. As DNSs require their Collaborative Practice Agreement to be signed off by each GP using their service, they were currently unable to prescribe in the community. Despite describing this as 'frustrating', DNSs suggested that prescribing could remove opportunities for relationship-building with GPs through discussion of medications. In the community, DNSs lacked the safety net of the hospital team to check things with, and had to work more autonomously, described as 'daunting'. Role understanding by other staff was another challenge; DNSs felt managers did not understand how the community role should work, which created difficulty when negotiating aspects of the role, including flexible working hours. The lack of a shared record between settings meant patient information from hospital appointments was not readily accessible by DNSs at GP practices and vice versa. This made patient follow-up and case discussion difficult when DNSs were off-site. The absence of administrative support in the role, considered 'crucial', was also highlighted. Further interviews with community DNSs are ongoing.

**Conclusion** Community-based DNSs faced challenges presented by aspects of their role, their relationship with other staff, their work environment, and the available organisational infrastructure and resources. Although recent policy reforms in Ireland have focused on improving the integrated management of diabetes in the community, findings from this study suggest DNSs may need to be better supported to ensure delivery of a standardised model of diabetes care.

## Ethnicity 1

OP17

# ETHNIC DIFFERENCES IN ILL HEALTH AND IN SOCIOECONOMIC INEQUALITIES IN HEALTH: POPULATION STUDY USING 2011 SCOTTISH CENSUS

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**Background** Much has been written about high rates of poor health and health inequalities in Scotland, increasingly it is shown how these outcomes vary by ethnicity. Scottish Government has made a policy commitment to understand and address inequalities in health among minority ethnic groups. This study contributes to this by comparing health outcomes and socioeconomic inequalities in health across ethnicities

**Methods** Two self-reported health measures, poor general health and limiting long-term illness (LLTI), by 5 year age groups, ethnicity and area (Datazones; population mean=815, sd=275) from the 2011 Scottish Census were examined. Ethnicity was self-reported and grouped into 9 main categories. This paper focused on the 5 largest groups: White Scottish (n=4,445,678), White British (n=417,109), White Irish (n=54,090), Other White (n=167,530) and Asian (n=140,678) and ages 0–64. Deprivation was measured using Census based indices and SIMD. Age standardised rates of ill health per 1000 people were calculated for these groups and by deprivation quintiles. Inequalities by area deprivation were measured using the slope index of inequality (SII).

**Results** For ages 0–64 the standardised rates are lowest for Other Whites and highest for White Scottish for both measures of ill health (LLTI rates respectively 89.1 and 134.9). Differences are greatest for younger adults, LLTI rate for Other Whites aged 15–29 is 32.4, but for White Scottish 71.7, for ages 30–44 these rates are 63.6 and 124.2 respectively. On average White Scottish had poorer health than White British and Irish, both of who are also least likely to live in the most deprived areas. For ages 0–64 inequalities in health were highest for White Scottish (for LLTI the SII=164.4, 95% CI=163.1–165.7), but not much lower for White British (SII=150.8, CI=146.2–155.4) and Irish (SII=145.2, CI=133.6–156.8). Inequalities were much lower among Asians (SII=74.2, CI=64.1–84.1) and among Other Whites (SII=59.3, CI=51.3–66.9). Differences in health inequalities between ethnicities were greatest for ages 30–44. Ill health and inequalities among Asians increased more rapidly for older ages and were similar to White Scottish for those 60+.

**Results** White Scottish have poorer health compared to other ethnicities, but are also more likely to live in deprived areas compared to White British and Irish. Deprivation affects the health of all ethnicities, but much less so for some groups.