

Black, Asian and Minority Ethnic (BAME) Health Inequalities in Lewisham

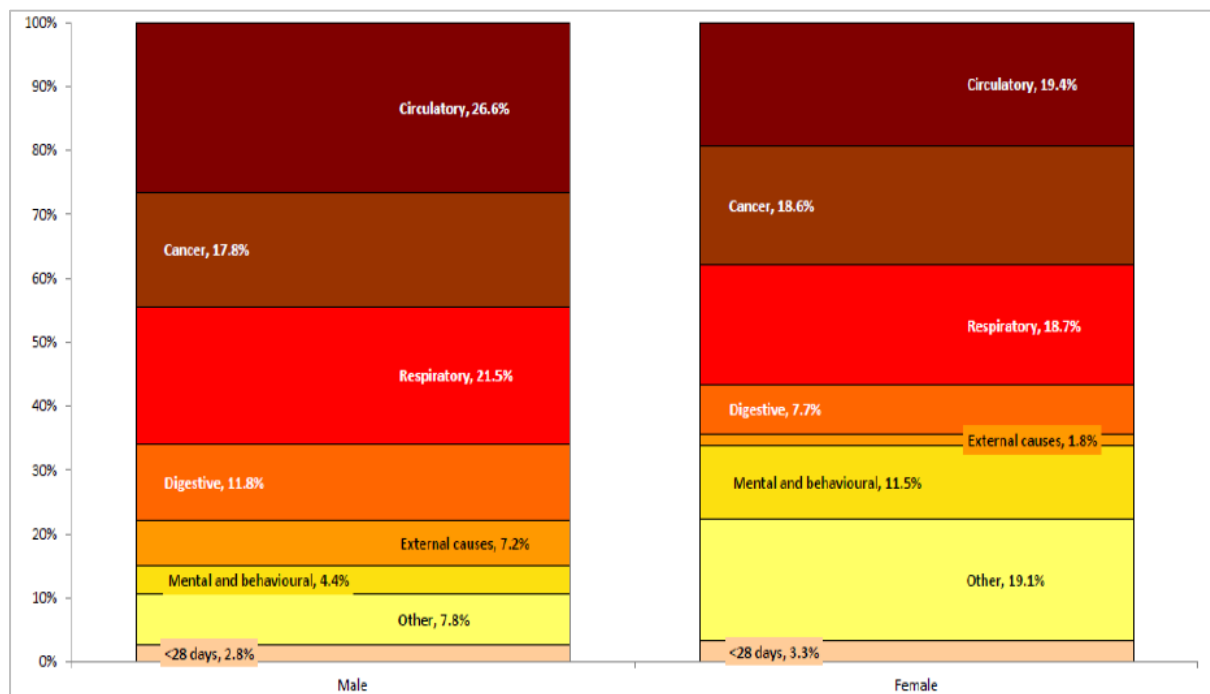
Health and Wellbeing Board Discussion Paper

Wednesday 4th July 2018

1. Health Inequalities in Lewisham

Lewisham Public Health has recently developed the 'Picture of Lewisham' slideset, which provides an annual overview of population health in Lewisham. This overview outlines some of the disease categories that contribute the most to health inequalities in Lewisham in terms of premature mortality i.e. a measure of unfulfilled life expectancy (see Figure 1).

Figure 1: Breakdown of the life expectancy gap between Lewisham's most deprived quintile and Lewisham's least deprived quintile by broad cause of death, 2012-2014



Source: Public Health England

The disease categories highlighted here may present a useful place to start in an attempt to identify the most significant health inequalities in BAME groups in Lewisham. Analysis of primary care, secondary care and mental health data to identify local differences in prevalence of the following disease categories will provide a high-level needs assessment of BAME health locally for the most important contributors to health inequalities in the borough:

- Prevalence of cardiovascular disease by ethnic group (likely most accurate from primary care EMIS data)
- Prevalence of respiratory disease by ethnic group (likely most accurate from primary care EMIS data)

- Prevalence of common and serious mental ill health by ethnic group (a preliminary analysis for serious mental illness has previously been performed in addition to prevalence work around mental health – see Appendices 1 and 2 – N.B. Appendix 2 is a separate document)
- Prevalence of most common types of cancer by ethnic group (The recent cancer JSNA for Lewisham will guide this analysis and is available at: <http://www.lewishamsna.org.uk/sites/default/files/Cancer%20JSNA%20-%20final.pdf>)

Nationally available literature and data on BAME inequalities may also help to guide analysis of the data to specific disease subgroups within which BAME health inequalities are likely to occur. National work addressing the drivers of these inequalities i.e. the wider or social determinants of health will also provide a useful basis when planning and/or reviewing work to address inequalities that are identified.

2. Best practice for BAME health

An alternative approach to assessing how well Lewisham is performing in terms of BAME health would be to measure our performance in line with nationally recognised best practice. In May 2018, the National Institute for Health and Clinical Excellence (NICE) released a quality standard entitled, ‘Promoting health and preventing premature mortality in black, Asian and other minority ethnic groups’ (NICE, QS167, 2017). The quality standard highlights some of the specific areas of inequality for people from black, Asian and other minority ethnic groups, such as increased health risks, poor access to and experience of services, and worse health outcomes. The guidance aims to support public authorities in considering their equality duty when designing, planning and delivering services, and will be a useful framework for any action that the Health and Wellbeing Board chooses to support to improve BAME health locally. The quality statements included in the guidance can be seen in Box 1 below.

Box 1: Six quality statements

Statement 1: People from black, Asian and other minority ethnic groups have their views represented in setting priorities and designing local health and wellbeing programmes.

Statement 2: People from black, Asian and other minority ethnic groups are represented in peer and lay roles within local health and wellbeing programmes.

Statement 3: People from black, Asian and other minority ethnic groups at high risk of type 2 diabetes are referred to an intensive lifestyle change programme.

Statement 4: People from black, Asian and other minority ethnic groups referred to a cardiac rehabilitation programme are given a choice of times and settings for the sessions and are followed up if they do not attend.

Statement 5: People from black, Asian and other minority ethnic groups can access mental health services in a variety of community-based settings.

Statement 6: People from black, Asian and other minority ethnic groups with a serious mental illness have a physical health assessment at least annually.

The quality standard is expected to **contribute** to improvements in the following outcomes among black, Asian and other minority groups:

- prevalence of excess weight and obesity
- physical activity levels
- tobacco use
- inequality in hospital admissions and detentions under the Mental Health Act compared with the general population using mental health services (BAME inequality demonstrated in Lewisham data).

Many of the existing health inequalities in Lewisham will be driven by the distribution of social determinants such as housing and education in the borough. Changes to services to improve experience, access and quality of services for BAME groups in line with the NICE quality standard will therefore only play a part in addressing the inequalities.

3. Where Lewisham is now in relation to best practice for BAME health

Existing data from the Public Health performance dashboards, Mental Health joint commissioning team reports, and publicly available LGT and SLAM data could be used to assess where Lewisham in relation to best practice for promoting health and preventing premature mortality in BAME groups as per the NICE guidance outlined above where data is available.

For the purposes of this report, the outcome measures for the first NICE quality statement have been used to demonstrate how this assessment could be performed. The structure, process and output measures could also be examined in more detail when the inequalities in the main outcome measures have been explored. Where data is not available to make the assessment for outcomes, the most likely data sources have been outlined.

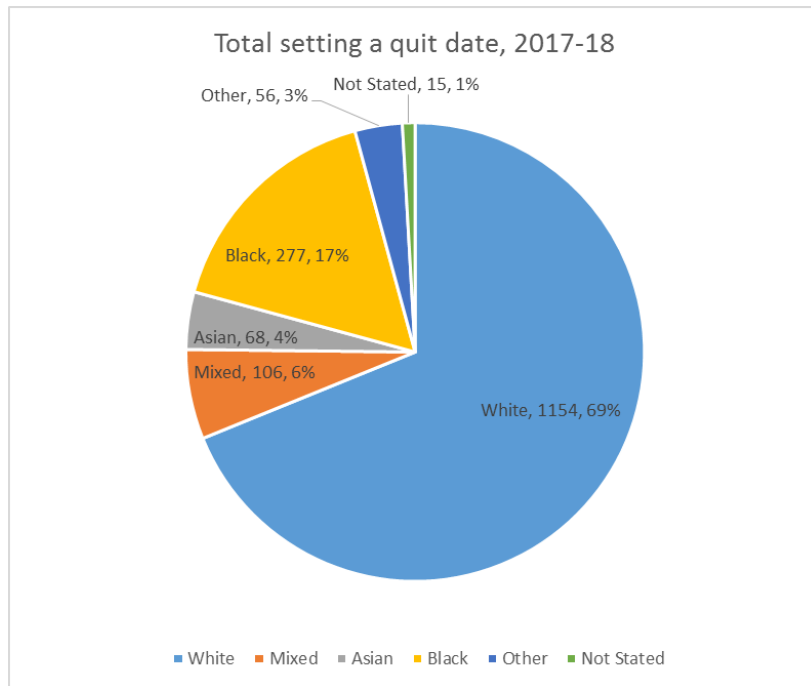
a) Designing health and wellbeing programmes

- i) Uptake of local health and wellbeing services among people from black, Asian and other minority ethnic groups.

Lewisham Stop Smoking Service (SSS)

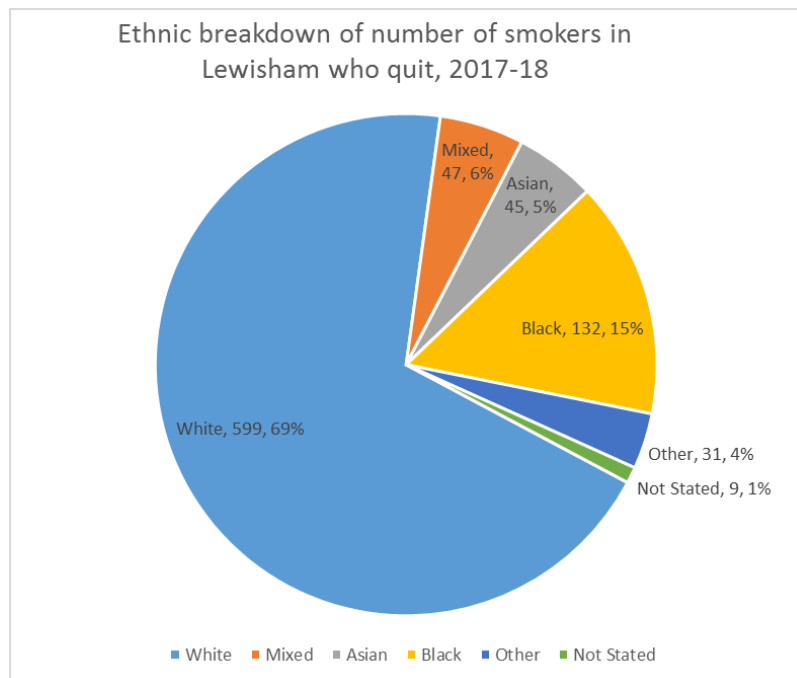
Of those engaging with the Lewisham stop smoking service, the proportion of people setting a 4 week quit date by ethnic group can be seen in chart xx below. The proportion of people then going on to successfully quit smoking at 4 weeks after setting a quit date by ethnic group can be seen in chart xxx below. It is difficult to ascertain whether those from BAME groups are underrepresented in the service (for both quit date and quit rate) as we have not analysed smoking prevalence by BAME group locally. Since smoking is a key risk factor for several long-term conditions and overall premature mortality it will be an important next step to ascertain this from data collected in both primary and secondary care services in Lewisham.

Chart 1: Total number and percentage of Lewisham SSS users setting a quit date by ethnic group in 2017-18 financial year



Data Source: Lewisham Stop Smoking Service

Chart 2: Total number and percentage of Lewisham SSS users who quit smoking by ethnic group in 2017-18 financial year



Data Source: Lewisham Stop Smoking Service

NHS Health Checks

The delivery of NHS health checks in Lewisham to those aged between 40-74 years is almost representative of the proportion of BAME groups in Lewisham (see Charts 3 and 4 below).

Chart 3: Percentage of NHS health checks delivered by ethnic group in 2017-18 financial year

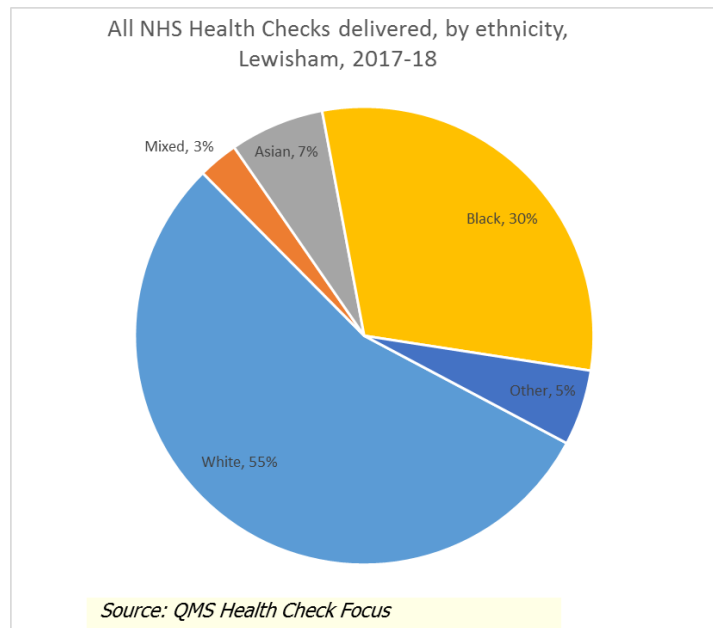
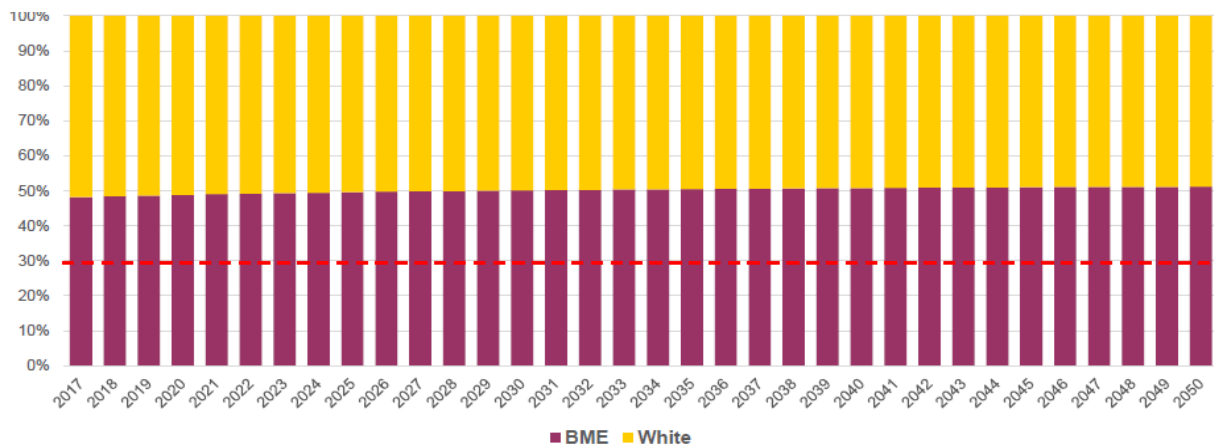


Chart 4: Proportion of BAME population in Lewisham 2018-2050



Source: 2015 Round Ethnic Group Population Projections, GLA

Data required

Data required	Likely Data Source
Proportion of people from black, Asian and other minority ethnic groups referred to local health and wellbeing services who feel that the services meet their needs.	Service questionnaires
Prevalence of obesity among local people from black, Asian and other minority ethnic groups	Primary Care (EMIS)/National Child Measurement Programme
Physical activity levels among local people from black, Asian and other minority ethnic groups	Modelling using national survey data
Prevalence of tobacco use among local people from black, Asian and other minority ethnic groups	Modelling using national survey data/Primary Care (EMIS)
Mental wellbeing among local people from black, Asian and other minority ethnic groups	Primary Care (EMIS)/SLAM

4. Key Discussion Points

- Which of the approaches outlined above would be most appropriate to use to explore BAME health and health inequalities in Lewisham (premature mortality, NICE quality standard assessment, additional areas of known inequality e.g. sexual health)?
- What resources are available to undertake further data analysis and assessment (e.g. JSNA process, analytical capacity across the partnership)?
- What else is missing from considerations concerning BAME health and health inequalities (e.g. wider determinants of health, overlap with other areas of disproportionality i.e. criminal justice, qualitative information)?

Appendix One

Severe Mental Illness Health Inequality Analysis

Introduction and Background

Severe mental illness (SMI) is a group of mental health conditions characterised by psychosis. They tend to have poorer prognosis, are more likely to require hospitalisation, and are often comorbid with other health problems. They can cause large reduction in life expectancy, in the range of 10-20 years. Given the severity of the problem and the issues of inequality we know can exist in diagnosis and accessing mental health services, analysis of local level data should be regularly undertaken to ensure any inequalities gaps are found and remedied. This analysis focuses on the diagnosis and prevalence of severe mental illness, and examines if there are any readily apparent inequalities that may require further investigation.

Key messages are:

- Lewisham has a higher prevalence of severe mental illness across the entire population, when compared to London and England.
- When this is broken down by demographic and compared to the Annual Psychiatric Morbidity Survey, Lewisham has a lower prevalence in younger people, and in particular young women, possibly reflecting underdiagnoses of this population with SMI.
- There is also a higher prevalence of SMI diagnosed in white ethnic groups. Due to the Lewisham data being taken from the GP register, this might reflect an inequality by ethnic group in terms of being registered at GPs
- There are several important limitations with these data – the most apparent is that this looks primarily at prevalence rather than outcomes, such as mortality, morbidity or access to treatment.
- A more detailed investigation should be conducted into health inequalities in severe mental illness and should investigate alternative data sources that may give outcome or service access data

Data Sources

Some routinely collected data that provides a high level overview of SMI prevalence is available on Public Health England Fingertips but this does not include data broken down by age, gender or ethnicity.¹

Local level data for the borough of Lewisham was extracted from EMIS Web, the GP IT system. Patient data with the read codes associated with severe mental illness, including schizophrenia, bipolar affective disorder and other causes of psychosis (see appendix 1 for full details) was extracted and aggregated, so no patient identifiable information was available. By using the GP data we get important demographic information including age, gender and ethnicity. The main weakness of this data is that we will be missing any of the population with SMI that are not registered with a GP, or whose GP have not been informed about an SMI diagnosis.

¹ <https://fingertips.phe.org.uk/profile-group/mental-health/profile/severe-mental-illness>

Finding comparison data was more difficult, as prevalence estimates of severe mental illness are not routinely collected by age, gender or ethnicity. The Annual Psychiatric Morbidity Survey (APMS) ² has been used instead to give an idea of the prevalence of SMI in England. The survey is commissioned and analysed by NHS Digital. It uses a multi-level stratification process to ensure that the sample (total sample size of 14,000) is representative of the England population. The weaknesses of using this data for comparison is that this is a survey of households rather than of GP lists, so the populations are not exactly the same, and the survey is not conducted by a mental health professional. However the survey itself has been well validated ³ and should still provide useful information for comparison.

Additional information is provided by South London and Maudsley Foundation Trust (SLAM). They have a clustering report that can give an idea of how many SMI patients end up making use of their services. The clusters aren't exactly a match for SMI, but by combing the clusters that include psychotic conditions, most SMI patients should be included.

Analysis

Overview

Table 1. Estimated prevalence of SMI in ages 16+

Lewisham	0.72%
London	0.51%
England	0.40%

Table 2. Prevalence of SMI in GP registered residents

Lewisham	1.31%
London	0.90%
England	1.09%

Source: PHE Fingertips

Lewisham has a significantly higher prevalence of severe mental illness, both using the estimate from the total population and the more precise numbers of only those registered at GP surgeries than both London and England. This could be due to a number of reasons. Lewisham's demographics may make SMI a more common condition – the most common age for diagnosis is 20-40, and Lewisham has a younger population than the average England population. Also it is possible that the higher prevalence reflects a greater diagnosis rate in Lewisham. The ratio between the estimated prevalence in the general population and those that are registered with GPs is similar between London and Lewisham, indicating that the proportion of SMI patients that are registered with GPs in Lewisham is similar to that of London.

Local Level data

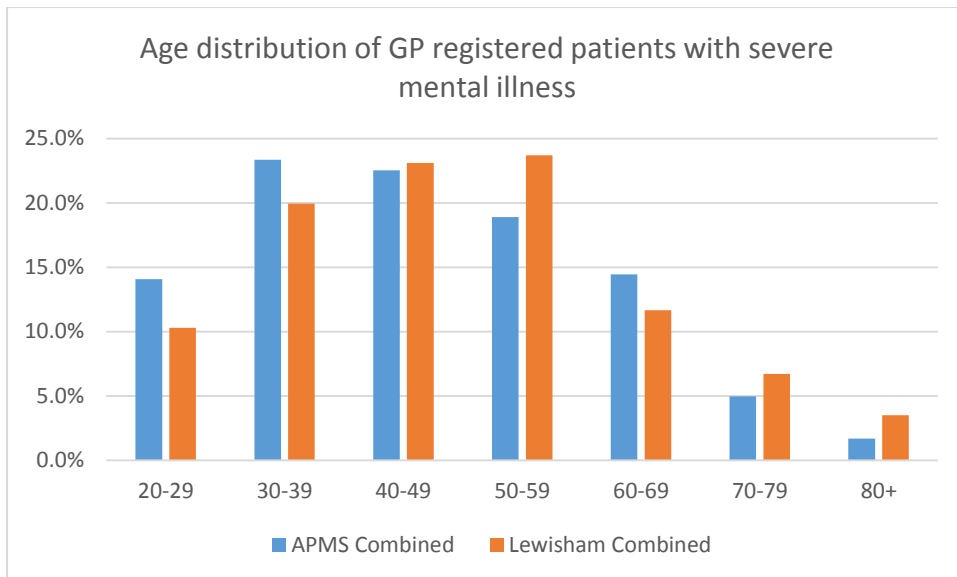
Age

Table 3. Prevalence of SMI by age, comparing Lewisham with the Annual Psychiatric Morbidity Survey – under 20s excluded (APMS)

	20-29	30-39	40-49	50-59	60-69	70-79	80+
Lewisham	10.3%	19.9%	23.1%	23.7%	11.7%	6.7%	3.5%
APMS	14.1%	23.3%	22.5%	18.9%	14.5%	5.0%	1.7%

² Annual Psychiatric Mortality Survey 2014, NHS Digital - <http://content.digital.nhs.uk/catalogue/PUB21748>

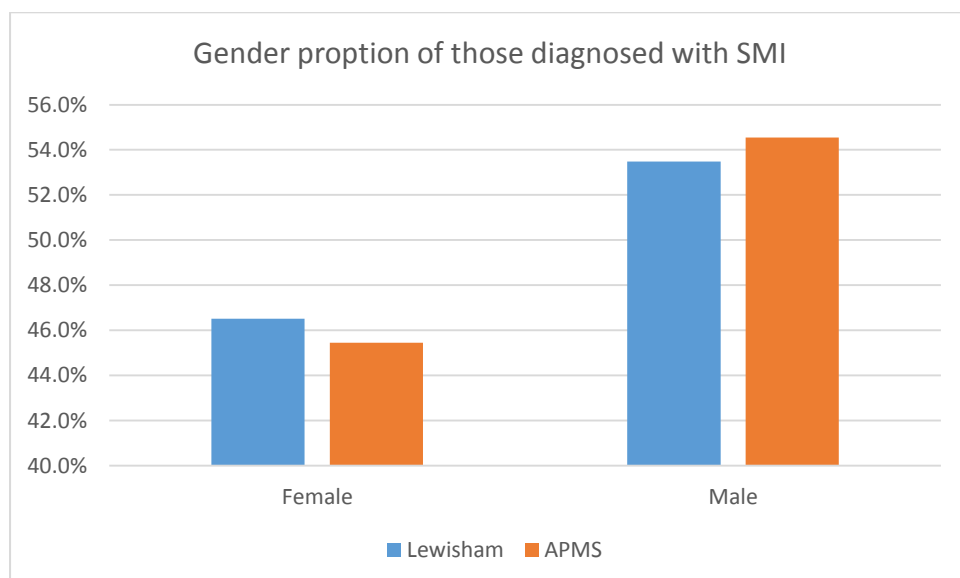
³ Bebbington, Paul, and Tony Nayani. "The psychosis screening questionnaire." *Int J Methods Psychiatr Res* 5.1 (1995): 11-19.



When compared to the Annual Psychiatric Morbidity survey data, broken down by age group. Lewisham has a broadly similar distribution of prevalence of severe mental illness to that of the APMS. There may be a slight increase in prevalence in the 50-59 group. Given that Lewisham has a relatively young population compared to the general population of England, we might actually expect the younger age groups to have a higher prevalence, so these results may actually reflect that there is under diagnosis of severe mental illness in our younger populations.

Gender

	Lewisham	APMS
Female	46.5%	45.5%
Male	53.5%	54.5%



There is a similar distribution of severe mental illness between the genders, with males more likely to be diagnosed with severe mental illness. An important note, is that neither the CCG data, nor the APMS, makes allowances for transgender individuals. While it is unlikely the absolute numbers would be large, it is a potential inequality that should be considered.

Age and Gender

Table 3. Age distribution of males with SMI

	20-29	30-39	40-49	50-59	60-69	70-79	80+
APMS Males	9.1%	23.5%	27.8%	22.3%	14.9%	2.3%	0.0%
Lewisham Males	11.6%	21.6%	23.9%	23.5%	10.6%	5.8%	2.0%

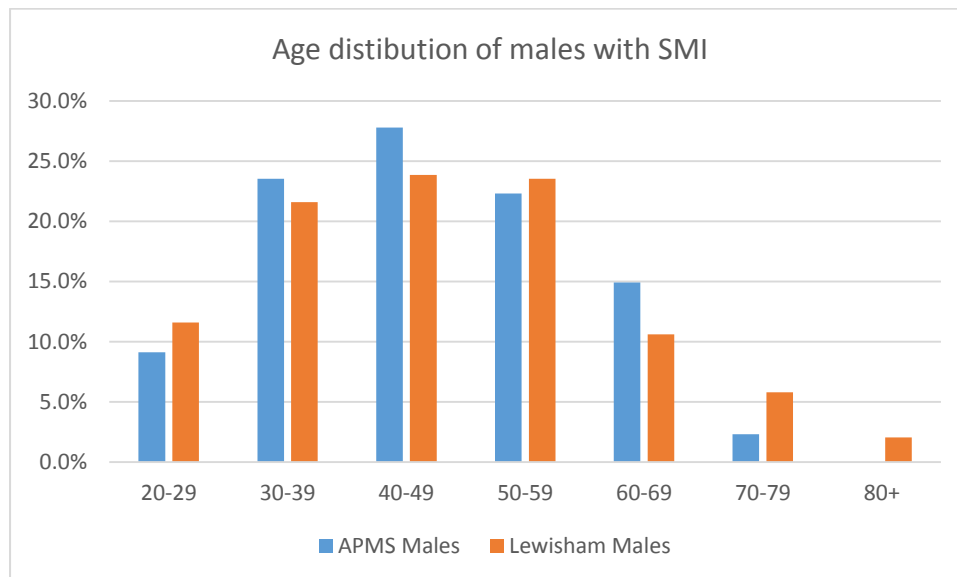
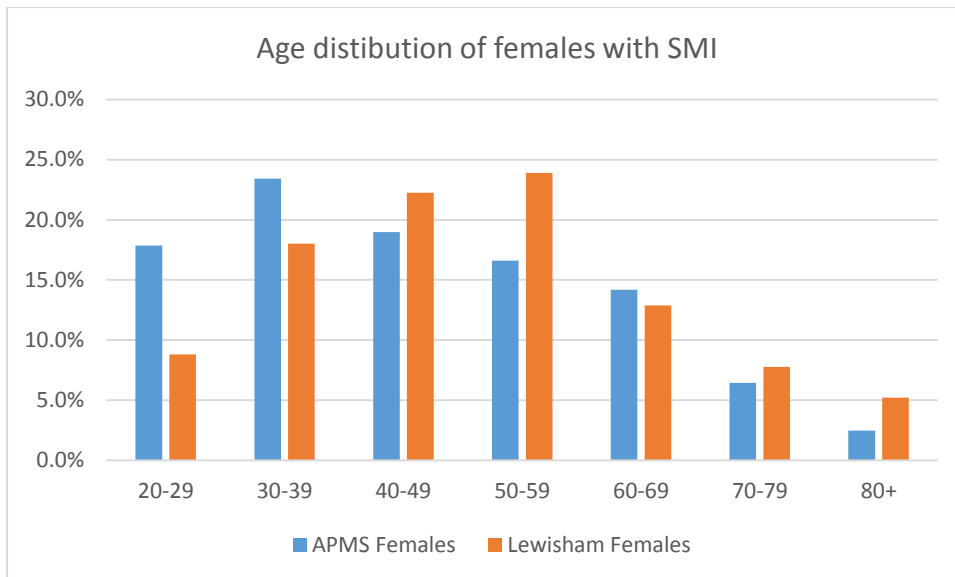


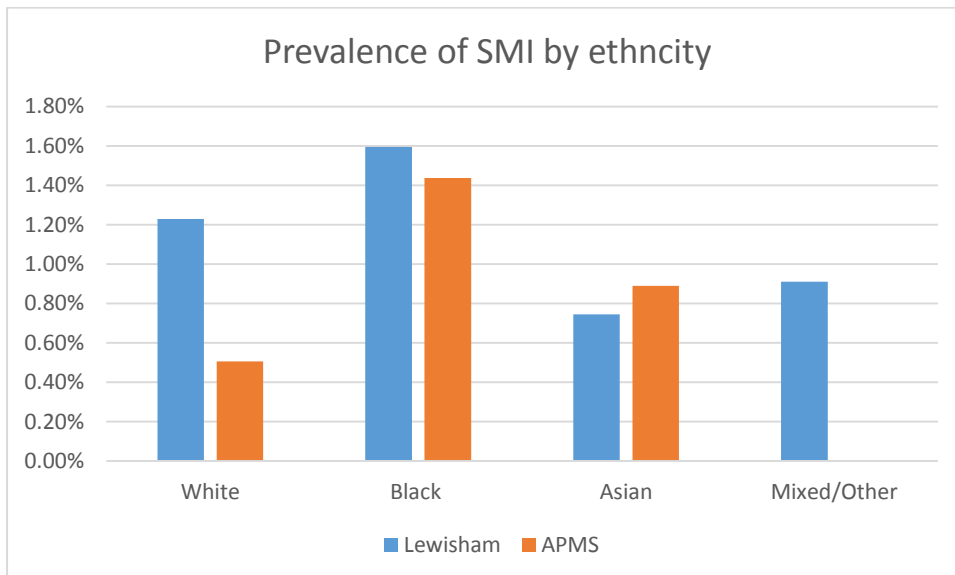
Table 4. Age distribution of males with SMI

	20-29	30-39	40-49	50-59	60-69	70-79	80+
APMS Females	17.9%	23.4%	19.0%	16.6%	14.2%	6.4%	2.5%
Lewisham Females	8.8%	18.0%	22.2%	23.9%	12.9%	7.8%	5.2%



When age and gender are further stratified, it appears that males follow a very similar trend to the APMS, while for females there appears to be a significant difference, with lower prevalence in the younger age groups and a higher age groups. This again might reflect an underdiagnoses of Lewisham residents with SMI, particularly in young women.

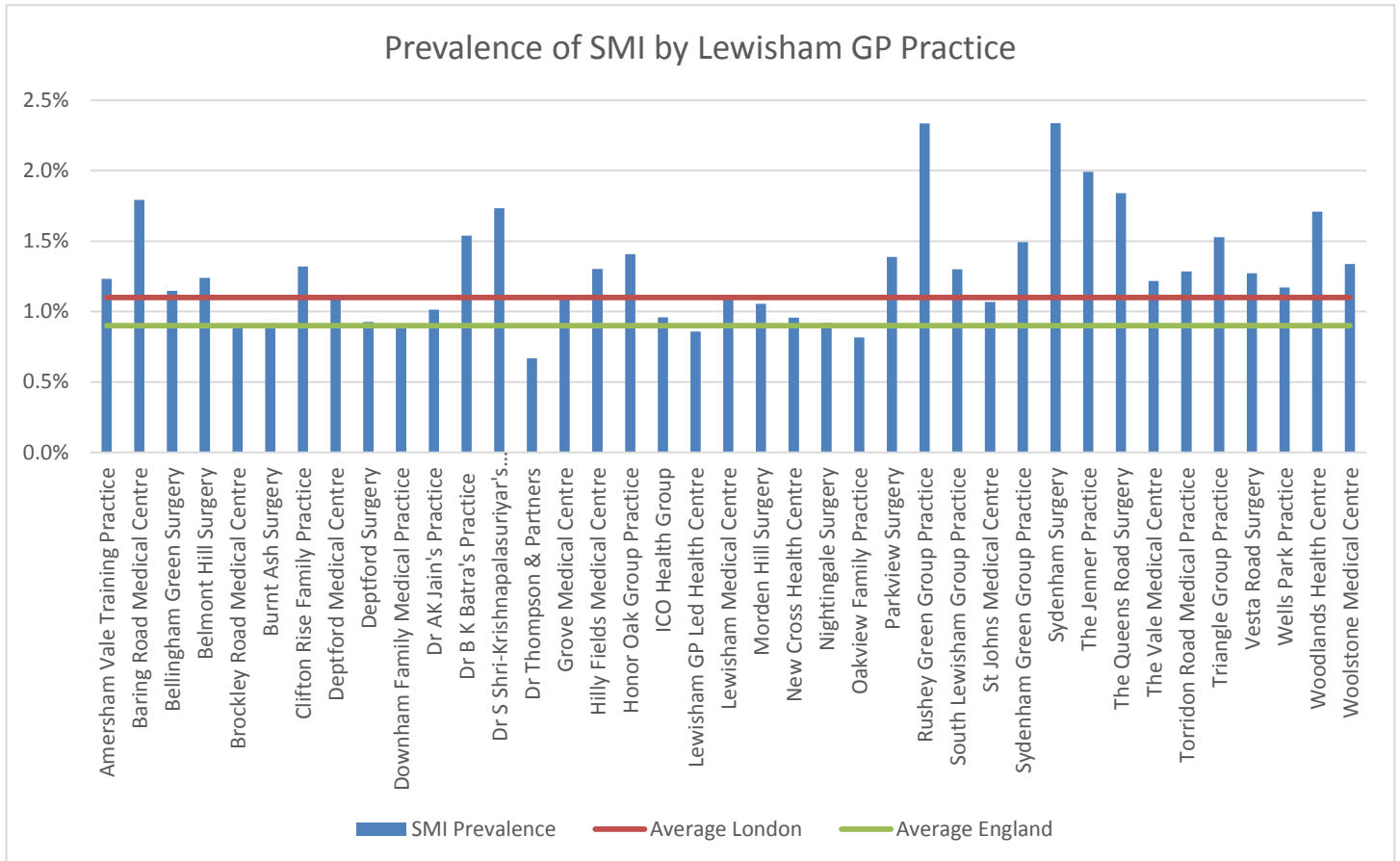
Ethnicity



Compared with the APMS, Lewisham follow the trend of those of black ethnicity having a significantly higher prevalence than those of white ethnicity. However Lewisham has a significantly higher prevalence of SMI in the white population. This could be due to the Lewisham data being from GP registers and the possibility that the white population are more likely to be registered at a GP, while the APMS is form household surveys, and therefore would not make this distinction. The APMS survey

also did not pick up any of mixed/other residents with SMI, although this might represent the small sample size in the survey, while it makes up approximately 30% of the Lewisham population.

By Practice



There is significant variation in the prevalence of SMI patients registered by GP practices in Lewisham, ranging from 0.7% to 2.3%. This could reflect the significant differences in the population these practices serve, both in terms of demographics and socioeconomic status. It could also be due to practices having different rates of registering patients on the SMI register. With a 3-fold difference between the practices with the highest and lowest prevalence, it would be worth investigating the factors that have influenced these results to ensure that all practices are providing equally effective care and reviews of these patients.

By location/deprivation

- Information on service use

Psychosis Community service access	Number of patients in service	Estimated population of neighbourhood	Percent of neighbourhood
Neighbourhood 1	151	71000	0.21%
Neighbourhood 2	221	66000	0.33%
Neighbourhood 3	79	77600	0.10%
Neighbourhood 4	159	78300	0.20%

	BME population %	Age 25-64 %	Age 65+ %	Average IMD score (Higher is more deprived)
Neighbourhood 1	53.3	60.2	6.3	32.0
Neighbourhood 2	40.2	61.7	9.9	23.3
Neighbourhood 3	49.0	55.0	10.5	31.3
Neighbourhood 4	27.0	42.7	59.1	27.0

Source: <http://www.localhealth.org.uk>

Looking at the SLAM data for community service access, there is some variation across the neighbourhoods of Lewisham (groupings of 4-5 wards), even when accounting for the difference in size of total population. This year, Neighbourhood 2 (the north east of the borough) has over 3 times the number of residents using the psychosis community service compared to Neighbourhood 3 (south east of the borough). This could be due to differences in the Neighbourhood populations (i.e. SMI prevalence etc.), although it would seem such a large difference in access could not be explained by this alone. Breaking down each Neighbourhood to look at some basic demographics shows that Neighbourhood 3 has a higher BME population and is more deprived than Neighbourhood 2, both of which could lead to a decreased rate of access to community services. However, Neighbourhood 1 has a higher deprivation and BME population than Neighbourhood 3, yet has twice as many people accessing the community service, so other factors must be at play.

Another reason for the disparity could also be due to differences in capacity of each service - if this is the case it is important to know whether there are residents of Neighbourhood 3 not able to access the community services e.g. because their nearest available service is in a different neighbourhood, and too far away.

Conclusions

Lewisham has a higher prevalence of severe mental illness across the entire population, when compared to London and England. When this is broken down by demographic and compared to the APMS, Lewisham has a lower prevalence in younger people, and in particular young women, possibly reflecting underdiagnoses of this population with SMI. There is also a higher prevalence of SMI diagnosed in white ethnic groups. Due to the Lewisham data being taken from the GP register, this might reflect an inequality by ethnic group in terms of being registered at GPs (and therefore reduce the likelihood of regular reviews for these patients).

There are several important limitations with these data – the most apparent is that this looks primarily at prevalence rather than outcomes, such as mortality, morbidity or access to treatment. While a low prevalence could indicate that these populations are not being diagnosed, not registered with GPs, or not being picked up on the SMI register (and therefore less likely to have their care reviewed) we cannot use prevalence alone to work out if any or all of these factors are playing a role, and what are the root causes that mean these populations are not being diagnosed.

There are also some notable gaps in the data; key factors that may increase risk of mental illness and could be sources of inequality, such as sexual orientation or transgender status. Socio-economic status could also be explored in greater depth. While deprivation as a whole has been analysed, more detailed factors could also be investigated to ensure equality in for example, the unemployed or those who have been in contact with the criminal justice system.

A more detailed investigation into health inequalities in severe mental illness should investigate alternative data sources that may give outcome or service access data, which would provide a more in-depth view of where the inequalities lie, and would provide more actionable intelligence.

Appendix 1- Read codes included in EMIS data extract

