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HEALTH AND WELLBEING BOARD

Date: WEDNESDAY, 9 MARCH 2022 at 3.00 pm

Council Chamber
Civic Suite
Lewisham Town Hall
London SE6 4RU

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MEMBERS

Mayor Damien Egan	London Borough of Lewisham	L
Councillor Chris Best	Community Services, London Borough of Lewisham	L
Tom Brown	London Borough of Lewisham	
Val Davison	Lewisham and Greenwich NHS Trust	
Pinaki Ghoshal	London Borough of Lewisham	
Donna Hayward-Sussex	South London and Maudsley NHS Foundation Trust	
Michael Kerin	Healthwatch Lewisham	
Dr Faruk Majid	Lewisham Clinical Commissioning Group	
Dr Catherine Mbema	Public Health, London Borough of Lewisham	
Dr Simon Parton	Lewisham Local Medical Committee	

Members are summoned to attend this meeting

Barry Quirk
Chief Executive
Lewisham Town Hall
Catford
London SE6 4RU
Date: Tuesday, 1 March 2022

ORDER OF BUSINESS – PART 1 AGENDA

MINUTES OF THE LEWISHAM HEALTH AND WELLBEING BOARD

Wednesday 15th December 2021 at 3.00pm

ATTENDANCE

PRESENT: Damien Egan (Mayor of Lewisham); Cllr Chris Best (Deputy Mayor of Lewisham and Cabinet Member for Health and Adult Social Care); Tom Brown (Executive Director for Community Services, LBL); Donna Hayward-Sussex (Service Director, South London and Maudsley NHS Foundation Trust); Michael Kerin (Healthwatch Lewisham); Dr Faruk Majid (Lewisham Member of South East London CCG); Dr Catherine Mbema (Director of Public Health, LBL); Pinaki Ghoshal (Executive Director for Children and Young People, LBL); Val Davison (Chair of the Lewisham and Greenwich NHS Trust); Martin Wilkinson (Director of Integrated Care and Commissioning, LBL/South East London Clinical Commissioning Group); Sara Rahman (Director of Families, Quality & Commissioning); Sarah Wainer (Director of Systems Transformation, Lewisham Health and Care Partners); Kerry Bourne (Programme Director, NHS Southeast London ICS); Patrick Dubeck (Director of Inclusive Regeneration); Sam Strudwick (South London & Maudsley NHS Foundation Trust); Sunil Gupta (Penrose Surgery) and Gale Burns (Deptford GP Surgery)

APOLOGIES: Sam Hawksley (Lewisham Local); Dr Simon Parton (Chair of Lewisham Local Medical Committee); and Cllr Chris Barnham (Cabinet Member for Children's Services and School Performance)

Welcome and introductions

The Acting Chair opened the meeting and invited attendees to introduce themselves.

1. Minutes of the last meeting

1.1 The minutes of the last meeting on 8th September 2021 were agreed with no matters arising.

2. Declarations of interest

2.1 There were no declarations of interest.

3. Local COVID-19 Outbreak Engagement Board

3.1 Catherine Mbema presented the latest data on COVID-19 in Lewisham. As of 6th December 2021, there have been a total of 41,460 confirmed cases of COVID-19 in Lewisham. Over the last week there has been a significant increase in confirmed cases of COVID-19 in Lewisham. The case rates for COVID-19 are currently lowest in those over the age of 60, which is reassuring given the potential vulnerability of this age cohort. As of 5th December 2021, there were 246 confirmed Omicron COVID-19 cases in the UK, 197 confirmed cases in England, 82 confirmed cases in London, with 5 in Lewisham.

3.2 As part of the local response to the new variant, efforts to maximise vaccination uptake continue in Lewisham with a marked increase in the number of booster jabs being administered over the last few weeks. The ongoing initiatives that are supporting these efforts to maximise access and confidence in the COVID-19 vaccination, include three pharmacies in the borough that are offering the vaccine on weekday evenings. Residents can walk in without an appointment to get their first, second or booster dose. A number of sites in Lewisham offer walk-in COVID-19 vaccination clinics including University Hospital Lewisham between Monday to Saturday between 9am-4pm; and the Waldron Health Centre every Saturday between 9am-1pm and 2pm-6pm. Health partners have also significantly up-scaled their offer to ethnic minority and English as a second language communities by providing outreach services, particularly in the north of the borough, to signpost clinics and the availability of the vaccination.

3.3 The COVID-19 Community Champion Programme continues to provide up to date and accurate information about COVID-19 including vaccinations to Champions recruited to share with their networks, friends and family. There are now 200 Champions in Lewisham and a Young Champions network has been launched. Members of communities have appreciated the factual and locally-informed aspects of the Champions role.

3.4 A summary of the report on the evaluation of the effectiveness of the Community Champion Programme is now available. The full evaluation report will be presented to COVID-19 Community Champions and at the Lewisham Borough Based Board, to take forward the evaluation recommendations for future planning for the programme. Given the success of the programme, it is planned to expand this approach for addressing other health related issues that are concerns within disadvantaged or marginalised communities.

3.5 In response to questions from Board members it was confirmed that there is a good general availability of Lateral Flow Tests in Lewisham and the arrangements for moving supplies from collection points to community pharmacies is working well. It was stated that active steps are being taken to encourage greater community involvement in the roll-out of the booster jabs, for example through dialogue with local inter-faith forums, coordinating efforts with Lewisham Local and ensuring the Council's website is kept up to date with the latest information.

3.6 **Action:**

The Board noted the content of the report.

4. Lewisham Health Inequalities Toolkit

4.1 Catherine Mbema introduced the report which updates the Board on the latest actions to develop a comprehensive Health Inequalities Toolkit for Lewisham. The aim of this toolkit is to present data in a user-friendly format that is available to all sections of the community in the same way, which will be refreshed every year to allow different communities and representative organisations to gauge for themselves, the progress that has been made in addressing inequality.

4.2 The main objectives of the summit and associated events will be threefold: to develop system leaders' understanding of the scale and implications of health inequalities in Lewisham and their individual and organisational role and responsibility in addressing

them; support understanding across system leaders of evidence-based actions and investment to address health and wellbeing inequalities; and identify specific, measurable actions across anchor organisations and others to address health and wellbeing inequalities.

4.3 A first summit event was held on 11th November 2021 entitled 'Beyond data towards action: Addressing health inequalities and inequity through the Lewisham health and care system'. The feedback from the event from participants was very positive:

- 100% of respondents found the event extremely / quite useful

- 100% of respondents agreed that the event increased their understanding of health inequalities and health equity in Lewisham

- 70% of respondents agreed that the event increased their knowledge of evidence-based approaches to health inequalities and health equity for planning and delivery

-90% of respondents agreed that the summit increased their motivation to incorporate health inequalities and health equity into their work

4.4 The next stage of the approach will be delivered via two summit events planned for:

- 19th January 2022 – Health inequalities action planning session for system leaders (which include building in consideration of the opportunities for action from the Birmingham and Lewisham African and Caribbean Health Inequalities Review (BLACHIR)).
- 2nd March 2022 – Health inequalities community day (where the final Lewisham Health Inequalities and Health Equity Toolkit will be launched).

Given the current rates of new cases caused by the new variant Omicron these dates are provisional at this stage, depending on case numbers closer to the time.

An update on these events will be brought to the next Health and Wellbeing Board meeting on 9th March 2022.

A full report from the Birmingham and Lewisham African and Caribbean Health Inequalities Review (BLACHIR) will also be presented to the Health and Wellbeing Board meeting in March.

4.5 Feedback from Board Members was very complementary, with the delivery of all the elements of the event working well together and forming a seamless whole. Participants felt inspired and re-energised, confident in the commitment of the partners and that there was now a clear way forward to tackle deeply rooted health access and outcomes inequality in the borough.

4.6 **Action:**

Members of the Health and Wellbeing Board agreed to note:

- the contents of this report
- the updates to the Health Inequalities Toolkit
- the updated approach to the proposed Health Inequalities Summit

Members also agreed that the organisers of the action planning session on 19th January, provide a recommendation in early January on whether the event should be postponed.

5. One Public Estate projects in Lewisham

5.1 Kerry Bourne (Southeast London ICS) gave a presentation setting out the background to One Public Estate (OPE), priorities and governance arrangements through the Lewisham Estates Steering Group (which composes of several property and non-property holding partners such as the Council, Lewisham & Greenwich NHS Trust, SLaM and the GP Federation) for taking the project forward and the key challenges faced, such as aligning timetables, identifying funding gaps and bidding for capital schemes to get the necessary financing. The OPE programme was launched in 2013 to make better use of public sector sites and free them up for more productive uses. It encourages public sector partners to work together to create local hubs where services are delivered in one place. Lewisham partners joined OPE in 2016 and has successfully secured monies in three bidding rounds and has bid for further funding in 2021.

5.2 There are several OPE supported projects in Lewisham currently in planning to improve front-line medical facilities, including the redevelopment of the Jenner and South Lewisham Health Centres and the reconfiguration and refurbishment of the Downham Health Centre. Future funding applications include OPE phase 9 with three submissions for Lewisham (Deptford Surgery, The Bridge and the SLaM estate review).

5.3 Sam Strudwick (SLaM) presented an update on the redevelopment of the new Ladywell Unit, which will be a new fit for purpose building, built to meet modern standards. The new unit will be open and spacious and provide high quality accommodation, with appropriate zoning for social activities, sleeping, therapy and staff. Progress to date includes establishing a monthly Ladywell Programme Board, appointing a programme director, planning consultant and architect and finishing a strategic outline case. An outline business case is now being developed which will look at three rebuild options before making a final decision on a preferred development proposal in early 2022. A joint planning application will be jointly submitted by SLaM and the Lewisham and Greenwich NHS Trust in 2023. An engagement plan will be developed with service users, carers, partners and the wider public to co-design the new building, so it reflects community priorities and expectations.

5.4 **Action:**

The Board noted the contents of the report, the progress being made in developing the Ladywell Unit and expressed their thanks to the presenters.

6. Latest developments on the introduction of the ICS from April 2022

6.1 Martin Wilkinson introduced the report which focused on recent Integrated Care System (ICS) developments affecting Lewisham. The Board were informed that for South East London, Richard Douglas had been appointed as the ICS Chair designate and Andrew Bland as ICS Chief Executive designate. The Integrated Care Partnership (ICP) will be a committee rather than a body and represent an equal partnership between the NHS and local authorities. The Lewisham Council representative will be the Cabinet Member for Health and Adult Social Care.

6.2 Progress is being made in setting a provider Collaborative Board and appointing its membership. The governance arrangements for the 'formal' Provider collaboratives will be based on a committee arrangement (across the partners Boards) that will allow for joint decision making in line with the mandate afforded by the ICS.

6.3 The Lewisham Health and Care Partners (LHCP) Executive Board and Lewisham Borough Based Board (BBB), will be replaced by a single committee as the Local Care Partnership Board. The LCPB will continue to report into the Health and Wellbeing Board. The LCP

Board will agree a Chair selected by the borough partnership, to be responsible for the effective running of that Board. The appointment of the chair is proposed to be from within the membership of the committee and will follow that of Place Lead, to ensure a balance of leadership from across the partnership.

6.4 Locally there is an ambition to form a joint committee from 1st April, it is expected to be a committee of the ICS NHS body with ability to transact existing Section 75s between Health and Lewisham Council including for Children and Young People, Adults and the Better Care Fund. The Executive Place lead will lead partnership working at 'Place' level; work with the Committee to receive and manage the Place delegation from the ICB and other partners and represent the partnership in the wider structures and governance of the ICS. The key areas of responsibility cover strategic leadership, building collaborative working relationships, ensuring quality improvement, managing performance, and fulfilling governance requirements. The appointment process and timetable are to be confirmed, though key elements will be partner and stakeholder involvement and for the recruitment to be concluded in time for a shadow appointment to be in place before April.

6.5 To support the Place Leader and the effective discharge of responsibilities delegated to the LCP, a multi-disciplinary leadership team will be identified in each borough to work together to secure the best outcomes for that population. In Lewisham it has been agreed that an additional lead from children and young people's services should be added to the team.

6.6 Ahead of the assumed legal establishment of the ICS NHS Body on 1 April 2022, the following key actions are still to be completed:

- Appointments of Executive Place Lead and Chair
- Confirm LCP committee status (joint committee or committee in common dependent on delegations), subject to approvals by ICB, boards of key providers, and by Mayor and Cabinet for Lewisham Council
- Confirm representatives from all partner organisations to place leadership team
- Engage with voluntary and community sector to identify a member for LCP who will provide a strategic representation and a voice for the sector
- Conclude considerations of the clinical and care professional network and community engagement within local governance

6.7 The Board expressed the view that the new ICS arrangements should use the opportunities for closer partnership collaboration and greater devolution, to tackle inequalities in health and care service access and provision. Consideration should also be given to how integrated budgets can be used creatively to achieve this.

6.8 **Action:**

The Board noted the progress being made in introducing the new ICS arrangements from 1 April 2022 and the outstanding tasks remaining.

7. Joint Strategic Needs Assessment

7.1 Catherine Mbema introduced the report and informed the Board that it is planned that the JSNA process will resume with priority given to a JSNA topic assessment examining the wider COVID-19 impacts to support recovery planning and commissioning.

7.2 The timescales for the work towards completion of the Children and Young People Self-Harm JSNA and LGBT+ JSNA should be agreed at the March 2022 meeting. A JSNA topic assessment/refresh will also be performed on the topic of Air Quality. The previously proposed JSNA topic assessment on Transition to Adulthood will be stood down. The above is pending confirmation from the JSNA Steering Group

7.3 Led by Public Health, the JSNA Steering Group will now be re-established (it has not met since early 2020) and meet in January 2022 to agree actions and confirm the completion of the suggested JSNA topic assessments. It will also be consulted on production of the COVID-19 JSNA topic assessment.

7.4 In March 2020, the Lewisham Health and Wellbeing Board agreed to the development of a new health and wellbeing strategy for 2021-26 to reflect the current health and care context and address local health and care priorities. Owing to the COVID-19 pandemic, this was postponed but will be resumed to develop a strategy for the 2022-27 five year period in line with the following next steps:

1. Data collation via the JSNA process (COVID impacts JSNA): November – March 2022
2. Develop a health and wellbeing priorities framework: March – May 2022
3. Stakeholder engagement: May – September 2022
4. Strategy final development: September – December 2022

7.5 **Action:** The Board agreed to approve:

- Resuming the JSNA process to start with a JSNA topic assessment examining the wider COVID-19 impacts to support recovery planning and commissioning.
- Additionally, the timetable for completing the Children and Young People Self-harm JSNA and the LGBT+ topic assessments will be agreed at the March 2022 Board meeting.
- An ambition to develop a new Lewisham Health & Wellbeing Strategy and Health & Wellbeing Delivery Plan by December 2022.
- In the new Strategy the Board will indicate its priorities for implementation, based on evidence of intervention effectiveness, community/stakeholder priorities and the national political context.

8. Better Care Fund Plan 2021/22

8.1 Sarah Wainer updated the meeting on the latest position regarding the development of the BCF Plan for 2021/22. The Better Care Fund Policy Framework was published on 19 August and stated that a full planning round would be undertaken in 2021/22 with areas required to formally agree BCF plans and fulfil national accountability requirements. The Plan was developed by SEL CCG (Lewisham) and the Council, covers one financial year and continues to fund activity in the following areas:

- Prevention and Early Action
- Community based care and Neighbourhood Networks
- Enhanced Care and Support
- Population Health and IT

8.2 The planning guidance for the Better Care Fund 2021/22 was published on 30 September. The Plan was submitted to NHS England by 16 November 2021 and formal approval of the Plan by the Health and Wellbeing Board is sought. This report provides members of the Board with an overview of the Better Care Fund Plan for 2021/22 (including the Improved Better Care Funding) which was submitted and recommends that the Board formally agree the Plan (Annex A in the agenda). Following its submission, the BCF plan is now subject to a national assurance process. SEL CCG (Lewisham) and the Council await to be notified of the outcome of this process.

8.3 In 2021/22 the financial contribution to the BCF from the CCG is £24,580,557. The financial contribution from the Council in 2021/22 is £773,989, in addition to the DFG contribution of £1,518,970. The IBCF grant to Lewisham Council has been pooled into the BCF and totals £14,502,373. The total BCF pooled budget for 2021/22 is £41,375,889. The BCF plan for 2021/22 reports on two new metrics:

1. Reducing length of stay in hospital, measured through the percentage of hospital inpatients who have been in hospital for longer than 14 and 21 days

2. Improving the proportion of people discharged home using data on discharge to their usual place of residence

8.4 In addition, the BCF plan reports against previous metrics for admission avoidance, residential admissions and re-enablement.

8.5 **The Board supported the recommendations made in the report:**

- Formally approve the Better Care Fund Plan 2021/22 – Annex A in the agenda.
- Delegate future approval of any BCF/IBCF quarterly returns to the S75 Agreement Management Group.
- Agree to receive the quarterly returns for information at the next Health and Wellbeing Board following submission.

9. For Information items

9.1 There were no for information items

10. Any other business

10.1 No other business was raised.

The meeting ended at 16:37 hours

Health and Wellbeing Board

Declarations of Interest

Key decision: No

Class: Part 1

Ward(s) affected: All

Contributors: Chief Executive (Director of Law)

Outline and recommendations

Members are asked to declare any personal interest they have in any item on the agenda.

1. Summary

1.1. Members must declare any personal interest they have in any item on the agenda. There are three types of personal interest referred to in the Council's Member Code of Conduct:

(1) Disclosable pecuniary interests

(2) Other registerable interests

(3) Non-registerable interests.

1.2. Further information on these is provided in the body of this report.

2. Recommendation

2.1. Members are asked to declare any personal interest they have in any item on the agenda.

3. Disclosable pecuniary interests

3.1 These are defined by regulation as:

(a) Employment, trade, profession or vocation of a relevant person* for profit or gain

(b) Sponsorship –payment or provision of any other financial benefit (other than by the Council) within the 12 months prior to giving notice for inclusion in the register in respect of expenses incurred by you in carrying out duties as a member or towards your election expenses (including payment or financial benefit from a Trade Union).

(c) Undischarged contracts between a relevant person* (or a firm in which they are a partner or a body corporate in which they are a director, or in the securities of which they have a beneficial interest) and the Council for goods, services or works.

(d) Beneficial interests in land in the borough.

(e) Licence to occupy land in the borough for one month or more.

(f) Corporate tenancies – any tenancy, where to the member's knowledge, the Council is landlord and the tenant is a firm in which the relevant person* is a partner, a body corporate in which they are a director, or in the securities of which they have a beneficial interest.

(g) Beneficial interest in securities of a body where:

(a) that body to the member's knowledge has a place of business or land in the borough; and

(b) either:

(i) the total nominal value of the securities exceeds £25,000 or 1/100 of the total issued share capital of that body; or

(ii) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which the relevant person* has a beneficial interest exceeds 1/100 of the total issued share capital of that class.

*A relevant person is the member, their spouse or civil partner, or a person with whom they live as spouse or civil partner.

4. Other registerable interests

4.1 The Lewisham Member Code of Conduct requires members also to register the following interests:

(a) Membership or position of control or management in a body to which you were appointed or nominated by the Council

(b) Any body exercising functions of a public nature or directed to charitable purposes, or whose principal purposes include the influence of public opinion or policy, including any political party

(c) Any person from whom you have received a gift or hospitality with an estimated value of at least £25.

5. Non registerable interests

5.1. Occasions may arise when a matter under consideration would or would be likely to affect the wellbeing of a member, their family, friend or close associate more than it would affect the wellbeing of those in the local area generally, but which is not required to be registered in the Register of Members' Interests (for example a matter concerning the closure of a school at which a Member's child attends).

6. Declaration and impact of interest on members' participation

6.1. Where a member has any registerable interest in a matter and they are present at a meeting at which that matter is to be discussed, they must declare the nature of the interest at the earliest opportunity and in any event before the matter is considered. The declaration will be recorded in the minutes of the meeting. If the matter is a disclosable pecuniary interest the member must take not part in consideration of the matter and withdraw from the room before it is considered. They must not seek improperly to influence the decision in any way. **Failure to declare such an interest which has not already been entered in the Register of Members' Interests, or participation where such an interest exists, is liable to prosecution and on conviction carries a fine of up to £5000**

6.2. Where a member has a registerable interest which falls short of a disclosable pecuniary interest they must still declare the nature of the interest to the meeting at the earliest opportunity and in any event before the matter is considered, but they may stay in the room, participate in consideration of the matter and vote on it unless paragraph 6.3 below applies.

6.3. Where a member has a registerable interest which falls short of a disclosable pecuniary interest, the member must consider whether a reasonable member of the public in possession of the facts would think that their interest is so significant that it would be likely to impair the member's judgement of the public interest. If so, the member must withdraw and take no part in consideration of the matter nor seek to influence the outcome improperly.

6.4. If a non-registerable interest arises which affects the wellbeing of a member, their, family, friend or close associate more than it would affect those in the local area generally, then the provisions relating to the declarations of interest and withdrawal apply as if it were a registerable interest.

6.5. Decisions relating to declarations of interests are for the member's personal judgement, though in cases of doubt they may wish to seek the advice of the Monitoring Officer.

7. Sensitive information

7.1. There are special provisions relating to sensitive interests. These are interests the disclosure of which would be likely to expose the member to risk of violence or intimidation where the Monitoring Officer has agreed that such interest need not be registered. Members with such an interest are referred to the Code and advised to seek advice from the Monitoring Officer in advance.

8. Exempt categories

8.1. There are exemptions to these provisions allowing members to participate in decisions notwithstanding interests that would otherwise prevent them doing so. These include:-

(a) Housing – holding a tenancy or lease with the Council unless the matter relates to your particular tenancy or lease; (subject to arrears exception)

(b) School meals, school transport and travelling expenses; if you are a parent or

guardian of a child in full time education, or a school governor unless the matter relates particularly to the school your child attends or of which you are a governor

(c) Statutory sick pay; if you are in receipt

(d) Allowances, payment or indemnity for members

(e) Ceremonial honours for members

(f) Setting Council Tax or precept (subject to arrears exception).

9. Report author and contact

9.1. Suki Binjal, Director of Law, Governance and HR, 0208 31 47648

Health and Wellbeing Board

Report title: Local COVID-19 Outbreak Engagement Board update

Date: 9th March 2022

Key decision: No

Class: Part 1

Ward(s) affected: All

Contributors: Dr Catherine Mbema, Director of Public Health, London Borough of Lewisham

Outline and recommendations

The purpose of this report is to provide an update to the Lewisham Health and Wellbeing Board in its role as the Local Outbreak Engagement Board.

The Health and Wellbeing Board are recommended to:

- Note the contents of the report

Timeline of engagement and decision-making

1. Recommendations

1.1. The purpose of this report is to provide an update to the Lewisham Health and Wellbeing Board in its role as the Local Outbreak Engagement Board.

1.2. The Health and Wellbeing Board are recommended to note the contents of the report.

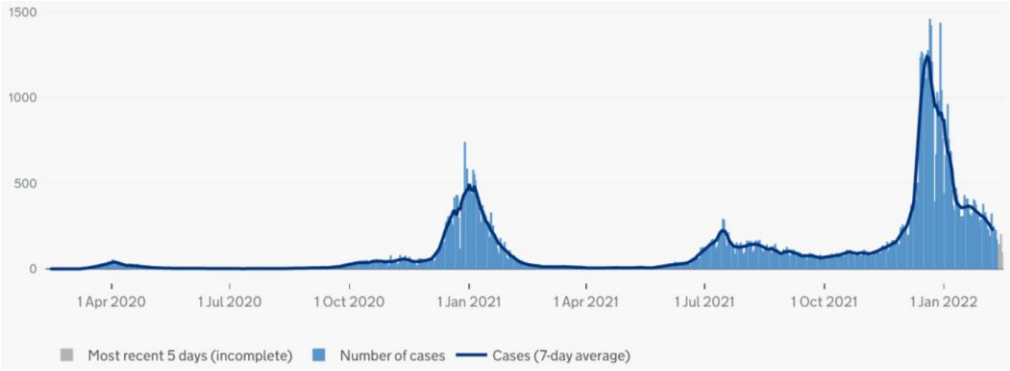
2. Background

2.1. At the September 2020 meeting of the Lewisham Health and Wellbeing Board, it was agreed that the Board will act as the Local Outbreak Engagement Board as part of the governance of the COVID-19 Local Outbreak Management Plan.

3. COVID-19 Cases in Lewisham

3.1. As of 11th February 2022 there have been a total of 82,477 confirmed cases of COVID-19 in Lewisham. Since December 2021 there was a significant increase in confirmed cases of COVID-19 in Lewisham following a national peak in cases due to the Omicron variant. This is demonstrated in Figure 1. There has since been a decline in cases nationally and locally, which alongside a number of other factors has led to a change in the national response to COVID-19 outlined in Section 4 of this report.

Figure 1. Daily number of new lab confirmed cases in Lewisham until 11th February 2022



Source: https://coronavirus.data.gov.uk/cases

4. National COVID-19 Response: Living with COVID-19

4.1. On 21st February 2022, the government announced their plan for removing the remaining legal restrictions while protecting people most vulnerable to COVID-19 and maintaining resilience. The 'Living with COVID-19' plan has outlines four main objectives:

4.2. **Living with COVID-19:** removing domestic restrictions while encouraging safer behaviours through public health advice, in common with longstanding ways of managing most other respiratory illnesses

4.3. **Protecting people most vulnerable to COVID-19**: vaccination guided by Joint Committee on Vaccination and Immunisation (JCVI) advice, and deploying targeted testing

4.4. **Maintaining resilience:** ongoing surveillance, contingency planning and the ability to reintroduce key capabilities such as mass vaccination and testing in an emergence

4.5. **Securing innovations and opportunities** from the COVID-19 response, including investment in life sciences.

4.6. The timetable for removal of national restrictions can be seen Table 1 below:

Date (comes into effect)	**Main change(s)**
21st February 2022	Staff and students in most education and childcare settings **no longer advised to undertake twice weekly asymptomatic testing**
24th February 2022	**No legal requirement to self-isolate following a positive test** (replaced by advice to stay at home for at least 5 full days and follow guidance until received 2 negative LFD tests on consecutive days) **No routine contact tracing:** • Fully vaccinated close contacts and under 18s no longer advised to test for 7 days • No legal requirement for close contacts that are not fully vaccinated to self-isolate • No self-isolation support payments • No legal requirement to tell employer when you are required to self-isolate **Health protection (Coronavirus, Restrictions) (England) (No.3) Regulations revoked**

24th March 2022	**Removal of the COVID-19 provisions** within the Statutory Sick Pay and Employment and Support Allowance regulations.
1st April 2022	**Removal of the current guidance on voluntary COVID-status certification** in domestic settings and no longer recommend that certain venues use the NHS COVID Pass. **Updated guidance setting out the ongoing steps that people with COVID-19 should take to minimise contact with other people.** This will align with the changes to testing. Universal symptomatic and asymptomatic testing for the general public in England to **no longer be free of charge**. Consolidation of guidance to the public and businesses, in line with public health advice. **Removal of the health and safety requirement** for every employer to explicitly consider COVID-19 in their risk assessments. Replace the existing set of 'Working Safely' guidance with new public health guidance.

5. Implications for the Lewisham Local Outbreak Management Plan

5.1. The Lewisham COVID-19 Health Protection Board has considered the implication of the Living with COVID-19 guidance on the Local Outbreak Management Plan (LOMP) for Lewisham. These considerations are summarised below. As further guidance is issued we will be planning to maintain a state of preparedness locally in order to respond to future variants and health protection threats.

5.2. **Prevent (Non-pharmaceutical interventions)**

The remaining non-pharmaceutical interventions (NPIs) will form the basis of local communications to residents. These include:

- Vaccination
- Staying at home if unwell
- Test if you have symptoms
- Fresh Air
- Hand washing
- Face coverings in crowded places when rates of transmission high

Tailored messaging for complex settings e.g. schools and care homes will be developed

as further government guidance is issued.

5.3. **Test**

Free symptomatic and asymptomatic COVID-19 testing is due to be stood down from 1st April. Free testing to remain in place for social care and (a small number of) at-risk groups.

5.4. Our testing leads will be making preparations to stand down testing in the borough and await clarification from government on the groups that will still receive free testing.

5.5. **Trace**

5.6. Our local contact tracing was stood down on 24th February 2022. During the course of the pandemic we had developed an effective service with a dedicated group of staff. We will be taking learning from the rapid development of the service and would like to thank the contact tracing staff for all of the support that they have provided to Lewisham residents during the pandemic.

5.7. **Contain**

Our local outbreak response support is to be refined and streamlined with prioritisation of complex settings: Care settings, supported living, schools and childcare settings. This will be supported by further guidance issued by the UK Health Security Agency (UKHSA).

5.8. **Protect (Vaccination)**

Vaccination underpins the government approach to 'Living with COVID' to protect the most vulnerable as restrictions are lifted. In Lewisham we will continue to encourage those yet to complete their course of COVID-19 vaccination to do so via a number of primary care network, hospital and pharmacy vaccination sites in the borough. Planning for ongoing engagement and vaccination provision particularly for those aged 5-11, 12-15 and over 75 (for a further booster dose) are underway via a weekly Lewisham COVID-19 vaccination group.

5.9. **Surveillance and Champion insight**

The UKHSA will continue to keep the content and frequency of COVID-19 data reporting under review. A reduction in testing will also mean that COVID-19 case rate data will need to be used differently. Locally we will be working to maintain some COVID-19 surveillance in place via the remaining national and local data sources available to us.

Our COVID-19 Community Champions are of significant value for local health promotion around a range of wider health issues. We will be planning on the future direction of the Champion programme in the coming months to build on the success of the programme to engage and communicate with Lewisham residents around health. This will be aligned with community engagement planning via the emerging South East London Integrated Care System (ICS).

6. Financial implications

6.1. Local authority COVID-19 response work has been resourced by the Contain Outbreak Management Fund (COMF) to date. Further notification is awaited as to whether further national funding will provided to local authorities to support any future local government COVID-19 response work. The grant awarding body have confirmed any unspent balances from 2021/22 can now be carried forward into the next financial year.

7. Legal implications

7.1. The legal context for managing outbreaks of communicable disease which present a

risk to the health of the public requiring urgent investigation and management sits:

- With 'Public Health England' under the Health and Social Care Act 2012,
- With Directors of Public Health under the Health and Social Care Act 2012
- With Chief Environmental Health Officers under the Public Health (Control of Disease) Act 1984
- With NHS Clinical Commissioning Groups to collaborate with Directors of Public Health and Public Health England to take local action (e.g. testing and treating) to assist the management of outbreaks under the Health and Social Care Act 2012
- With other responders' specific responsibilities to respond to major incidents as part of the Civil Contingencies Act 2004
- Specifically within the context of COVID-19 there is the Coronavirus Act 2020 which received royal assent on 25th March 2020.

7.2. The Equality Act 2010 (the Act) introduced a public sector equality duty (the equality duty or the duty). It covers the following protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

7.3. The Equality Act 2010 (the Act) introduced a public sector equality duty (the equality duty or the duty). It covers the following protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

7.4. In summary, the Council must, in the exercise of its functions, have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- advance equality of opportunity between people who share a protected characteristic and those who do not.
- foster good relations between people who share a protected characteristic and those who do not.

7.5. It is not an absolute requirement to eliminate unlawful discrimination, harassment, victimisation or other prohibited conduct, or to promote equality of opportunity or foster good relations between persons who share a protected characteristic and those who do not. It is a duty to have due regard to the need to achieve the goals listed at above.

7.6. The weight to be attached to the duty will be dependent on the nature of the decision and the circumstances in which it is made. This is a matter for the Mayor, bearing in mind the issues of relevance and proportionality. The Mayor must understand the impact or likely impact of the decision on those with protected characteristics who are potentially affected by the decision. The extent of the duty will necessarily vary from case to case and due regard is such regard as is appropriate in all the circumstances.

The Equality and Human Rights Commission has issued Technical Guidance on the Public Sector Equality Duty and statutory guidance entitled "Equality Act 2010 Services, Public Functions & Associations Statutory Code of Practice". The Council must have regard to the statutory code in so far as it relates to the duty and attention is drawn to Chapter 11 which deals particularly with the equality duty. The Technical Guidance also covers what public authorities should do to meet the duty. This includes steps that are legally required, as well as recommended actions. The guidance does

not have statutory force but nonetheless regard should be had to it, as failure to do so without compelling reason would be of evidential value. The statutory code and the technical guidance can be found at: https://www.equalityhumanrights.com/en/advice-and-guidance/equality-act-codes-practice

https://www.equalityhumanrights.com/en/advice-and-guidance/equality-act-technical-guidance

7.7. The Equality and Human Rights Commission (EHRC) has previously issued five guides for public authorities in England giving advice on the equality duty:

- The essential guide to the public sector equality duty
- Meeting the equality duty in policy and decision-making
- Engagement and the equality duty: A guide for public authorities
- Objectives and the equality duty. A guide for public authorities
- Equality Information and the Equality Duty: A Guide for Public Authorities

The essential guide provides an overview of the equality duty requirements including the general equality duty, the specific duties and who they apply to. It covers what public authorities should do to meet the duty including steps that are legally required, as well as recommended actions. The other four documents provide more detailed guidance on key areas and advice on good practice. Further information and resources are available at:

https://www.equalityhumanrights.com/en/advice-and-guidance/public-sector-equality-duty-guidance#h1

7.8. The essential guide provides an overview of the equality duty requirements including the general equality duty, the specific duties and who they apply to. It covers what public authorities should do to meet the duty including steps that are legally required, as well as recommended actions. The other four documents provide more detailed guidance on key areas and advice on good practice. Further information and resources are available at:

https://www.equalityhumanrights.com/en/advice-and-guidance/public-sector-equality-duty-guidance#h1

8. Equalities implications

8.1. COVID-19 has had a disproportionate impact on specific groups including older adults, and those from Black, Asian and Minority Ethnic groups. Health and Wellbeing Board Members' attention should be drawn to the following reports regarding these inequalities:

- Disparities in the risks and outcomes of COVID-19, PHE, 2020 (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892085/disparities_review.pdf)
- Beyond the data: understanding the impact of COVID-19 on BAME groups, PHE, 2020(https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf)

9. Climate change and environmental implications

9.1. There are no significant climate change and environmental implications of this report.

10. Crime and disorder implications

10.1. There are no significant crime and disorder implications of this report.

11. Health and wellbeing implications

11.1. The health and wellbeing implications for this report are outlined in the main body of text.

12. Report author and contact

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Health and Wellbeing Board

Report title: Lewisham Health Inequalities Update

Date: 9th March 2022

Key decision: No

Class: Part 1

Ward(s) affected: All

Contributors: Dr Catherine Mbema, Director of Public Health, London Borough of Lewisham; Livia Royle, Interim Consultant in Public Health; Lisa Fannon, Training and Development Manager.

Outline and recommendations

This report provides an update to the Board on the Lewisham Health Inequalities. The report includes updates on:

- The achievement of the existing Black, Asian and Minority Ethnic Health Inequalities work streams (mental health, obesity, cancer and COVID-19).
- Presentation of the Birmingham and Lewisham African and Caribbean Health Inequalities Report (BLACHIR) and BLACHIR engagement report.
- The proposed approach for a refreshed Lewisham Health Inequalities and Health Equity Plan for 2022-24.

Members of the Health and Wellbeing Board are recommended to:

- Note the achievements from the existing Black, Asian and Minority Ethnic Health Inequalities work streams (mental health, obesity, cancer and COVID-19).
- Approve the Birmingham and Lewisham African and Caribbean Health Inequalities Report (BLACHIR) and note the contents of the BLACHIR engagement report.
- Approve the approach for a refreshed Lewisham Health Inequalities and Health Equity Plan for 2022-24.

Timeline of engagement and decision-making

9th March – Update to the Lewisham Health and Wellbeing Board

1. Summary

2. Recommendations

2.1. Members of the Health and Wellbeing Board are recommended to:

- Note the achievements to date from the existing Black, Asian and Minority Ethnic Health Inequalities work streams (mental health, obesity, cancer and COVID-19).
- Approve the Birmingham and Lewisham African and Caribbean Health Inequalities Report (BLACHIR) and note the contents of the BLACHIR engagement report.
- Approve the approach for a refreshed Lewisham Health Inequalities and Health Equity Plan for 2022-24.

3. Background and Overview

3.1. In July 2018 the HWB agreed that the main area of focus for the Board should be tackling health inequalities, with an initial focus on health inequalities for Black, Asian and Minority Ethnic communities in Lewisham.

3.2. Following analysis undertaken by a sub group of the Board, three priority areas were identified through which the Board could play a significant role in addressing the widest gaps in ethnic health inequalities. The areas identified were: mental health; obesity; and cancer.

3.3. A draft action plan covering all three priority areas (cancer, obesity and mental health) was developed in July 2019 in response to a referral made by the Healthier Communities Select Committee.

3.4. At the November 2019 Health and Wellbeing Board meeting, Board members agreed to further refine the draft action plan with the Lewisham Black and Minority Ethnic Network taking a co-production approach.

3.5. At the March 2020 Health and Wellbeing Board meeting, a further draft of the action plan was approved by Board members with an agreement to return to the next Board meeting with monitoring metrics to capture progress and impact of completing actions within the plan.

3.6. At the September 2021 meeting of the Health and Wellbeing Board, a series of

Lewisham Health Inequalities summit events were agreed to plan the next steps for the Board's work to address health inequalities in Lewisham.

3.7. A developmental approach was agreed to support system leader and organisational change through supporting individual development (e.g. developing capability and motivation for action) and organisational development (e.g. improvement approach)

3.8. A three staged approach was proposed:

i) Developing individual and organisational understanding of health inequalities and inequities and their role and responsibility – October 2021

ii) Support collaborative evidence-based action planning and investment with a specific workshop/summit to facilitate this – November 2021

iii) Identification of actions – January-March 2021:

3.9. Organisations develop their own (and collaborative) action plans for addressing health inequalities and health equity in Lewisham.

3.10. Develop a community event to present and discuss plans.

3.11. The first two stages of the approach were delivered as part of a first summit event on 11th November 2021 entitled 'Beyond data towards action: Addressing health inequalities and inequity through the Lewisham health and care system. The event report was presented at the Health and Wellbeing Board in December 2021.

3.12. The third stage of the approach was proposed to be delivered via two further summit events, which took place on:

3.13. **26th January 2022** – Health inequalities action planning session for health and care system leaders building on the findings of the first summit event, learning from the Health and Wellbeing Board work to date and consideration of how the findings of the Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR) would be built into future action.

3.14. **2nd March 2022** – Health inequalities community planning day at the Evelyn Community Centre, where the final Lewisham Health Inequalities Toolkit was launched and the engagement findings for BLACHIR presented.

3.15. The results of these further events have led to the development of an outline approach for future work to address health inequalities and achieve health equity in Lewisham. This approach is outlined in section 6 of this report and included in the appended slide pack.

4. Addressing Black, Asian and Minority Ethnic Health Inequalities in Lewisham (2018-2021) - Achievements to date

4.1. The existing Health and Wellbeing Board work to address Black, Asian and Minority Ethnic health inequalities has been overseen by the health inequalities working group and monitored via an action plan with key impact indicators. A detailed review and update will be performed for these indicators by the working group in coming months to inform the proposed health inequalities and healthy equity plan for 2022-24 and also as part of the COVID-19 impacts JSNA topic review. Ahead of this indicator review, the key achievements of the work to date are outlined in this paper across the mental health, obesity, cancer and COVID-19 workstreams.

4.2. **Mental Health: Building a mental health inequalities approach**

4.3. Reducing inequalities within mental health services remains a priority within Lewisham and our work within the Health Inequalities Group focuses on improving access to, and suitability of, mental health services for Black African and Black Caribbean people.

4.4. In order to achieve these goals, we commissioned Mabadiliko CIC to undertake a community engagement project that would provide insight into the experience, perspectives and attitudes of our Black African and Black Caribbean residents in relation to mental health services. Over 100 Black African and Black Caribbean residents took part in the project, generating seven recommendations that focus on reducing stigma, improving cultural sensitivity, suitability of interventions and addressing structural barriers to improving equalities.

4.5. Four distinct projects were launched because of this work:

- *Mental Health Stigma Campaign* – the Public Health Team, as part of their Prevention and Promotion programme will commission a campaign that aims to reduce stigma related to mental health among the Black African and Black Caribbean community in Lewisham. The campaign will be delivered by a local grass-roots organisation and seek to promote open discussion about mental health and active involvement in services.

- *Interventions to Address Racial Trauma* – the Integrated Commissioning Team will conduct a literature review to explore the suitability of current therapeutic approaches at addressing racial trauma and the effectiveness of alternative intervention types.

- *Improving Cultural Sensitivity* – the Public Health Team as part of the proposed health inequalities and health equity programme (see Section 6 below) will commission cultural sensitivity training for staff in order to promote inclusivity and help build trust among mental health service staff and service users.

- *Reviewing Medication Approaches* – colleagues from our local Primary Care Networks will complete an audit of medical records in order to explore whether there are any discrepancies in the prescribing of medication in response to complaints of mental health issues.

- *Increasing access to Black therapists* – Lewisham Mental Health Alliance Representatives are currently working with Lambeth Mental Health Alliance Representatives to identify the most cost effective approach to providing direct access to Black therapists and counsellors.

4.6. **Mental health: Strengthening Lewisham as a borough of Sanctuary**

4.7. In 2016, Lewisham Borough Council made a commitment to becoming an open and welcoming place of sanctuary, and set a target of supporting 100 vulnerable families to resettle in Lewisham. As of April 2021, Lewisham Borough Council have resettled 107 individuals, over half of which are children and young people. It is expected a further 288 people will be resettled over the next 4 years.

4.8. In recognition of the high levels of inequality in levels of mental health needs and access to services, the Home Office has delegated funding to support refugees to become resettled not just physically, but psychologically. Members of the Integrated Commissioning Team, Refugee Resettlement Team and Public Health Team came together to develop an innovative stepped-care model that will seek to ensure individuals are supported in the short-term and mainstream services are better equipped to support them in the long-term.

4.9. **Mental Health: Supporting Black, Asian and Minority ethnic residents during COVID-19**

4.10. The arrival of COVID-19 and resulting lockdowns disproportionately impacted Black and Asian communities, embedding existing inequalities and promoting the conditions to generate new ones. In response to this, a series of emotional wellbeing workshops and resilience workshops were commissioned by the Mental Health Alliance and delivered to staff and residents in the borough to support them in coping with changes resulting from COVID-19.

4.11. Both interventions were facilitated by experienced coaches who specialise in working with

employees and employers to address racism and racial bias. Black participants in particular appreciated that the groups were formulated specifically for ethnic minority participants and felt this reduced feelings of anxiety related to discussing mental health issues and reporting experiences of racism. Both programmes were well attended, and the feedback was incredibly positive, with attendees reporting they went away with tools to help them with whatever situation they were facing.

4.12. The borough continues to offer a Vietnamese Mental Health Service, whose staff played a key role in supporting our Vietnamese community during the pandemic, particularly older community members. Work included the translation of key texts related to COVID19, the development of culturally specific newsletters to keep community members up to date on changing guidelines and practical support to elderly community members who were required to shield during lockdowns.

4.13. **Obesity: Community insights work**

4.14. In March 2020 the Council called out for expressions of interest to local VCS groups to deliver insight work with Black, Asian and Minority Ethnic communities in Lewisham into physical activity, nutrition and obesity. The aims were to understand Black, Asian and Minority Ethnic community views on what causes health inequalities around obesity; to get insight into the barriers to being physical active and eating healthily; and to identify opportunities to improve local public health initiatives and services to address health inequalities. The findings would be used to help inform the commissioning of new services to support the whole systems approach to obesity.

4.15. Two community organisations were commissioned to conduct three insight projects:

- Explore the barriers and motivations for healthy weight management in the Black African and African Caribbean community (Mabadiliko CIC)
- Obesity and physical activity levels in Black African and Black Caribbean women (Food for Purpose CIC)
- Black African – Caribbean church leaders, to understand their views on obesity and physical activity (Food for Purpose CIC)

4.16. Two of the projects were completed and the third delayed due to church leaders re-addressing priorities due to the challenges of the pandemic.

4.17. The reports were shared with the Health Inequalities working group and the Lewisham Obesity Alliance. The findings of the insight works were presented by the report authors at an open meeting of the Lewisham Obesity Alliance on re-commissioning services and at the behaviour change theme of the Birmingham and Lewisham African Caribbean Health Inequalities Review. The insight works were also shared with Public Health England through the Childhood Obesity Trailblazer programme and Lewisham was invited to share the learnings at a national event 'Interventions for specific population groups – learning and gaps' where Food for Purpose presented to a local authority audience in June 2021.

4.18. **Obesity: Co-development of a tailored weight management programme for Black-African & Black-Caribbean adults**

4.19. A recent review of the existing Tier 2 weight management services found that whilst the ethnic profile of participants was in line with the general population, there were differences in outcomes for Black African and Black Caribbean communities. Some outcomes were not as positive in comparison to other ethnic groups. Additionally, feedback from the Borough's Black African and Black Caribbean communities indicated a perception that services are not 'for them'. The community insight work identified barriers to access, programme content and delivery that could be addressed to improve outcomes and participation in programmes.

4.20. In response, Lewisham Public Health used the one-year additional Adult Weight Management Services Grant, from the Department from Health and Social Care to develop a tailored weight management programme for people of Black, African & Caribbean heritage. Working together with Black-African and Black-Caribbean communities, King's College London, Food for Purpose (FfP) and Guy's & St. Thomas' Trust (GSTT) are co-producing the new service with delivery starting March 2022.

4.21. The co-production work has engaged with a wide range of residents, community organisations and leaders such as faith leaders, service providers and healthcare professionals to seek input into the development of the programmes and gain an in-depth understanding of the needs of the Borough's Black African and Black Caribbean communities in relation to weight management services. This feedback has influenced the development of new resources, the service delivery with flexibility of attendance through a mixture of face to face an on-line access. Following the evaluation of the pilot programme (Up!Up! Living lighter the African and Caribbean way!) a training manual and on-line 'train the trainer' module will be developed so that if successful the programme can be delivered by local groups in Lewisham. This will not only facilitate growth of Up!Up! in Lewisham but also via new service providers in other areas/regions by providing a training course for new staff.

4.22. **Obesity: Co-production of health promotion posters as part of the Childhood Obesity Trailblazer Programme**

4.23. In June 2019 Lewisham Council was chosen as one of five Trailblazer Authorities to implement an innovative and ambitious pilot project to restrict of out of home (OOH) advertising for high fat, sugar or salt (HFSS) food and drink; and utilise unsold outdoor advertising space for health promoting advertisements in Lewisham. The health promoting advertisements to be co-produced by the local community.

4.24. Research demonstrates that the development of children's food preferences and behaviours are influenced by advertising and through working in this space, there is a real opportunity to positively shape behaviours and impact child obesity rates.

4.25. To date the programme has been successful in increasing restriction of advertising of HFSS through a voluntary agreement with JCDecaux; restrictions now cover 80% of the advertising estate in the borough.

4.26. Three community co-produced posters have been developed and featured on billboards across the borough. The posters have all been produced with the input of children and young people from the borough supported by community organisations with the concepts developed by the young people made into a final poster design. The intended audience has varied from influencing businesses to join Sugar Smart (poster designed by young people, facilitated by the Young Mayor's team), improving food choices (poster designed by young adults, facilitated by Rocket Nutrition) to increasing participation in the Daily Mile (poster designed by pupils, teachers and facilitated by Insipre Your Imagination). Two additional posters are in progress, again with input of children and young people and will feature in May and June.

4.27. The community designed posters featured on 56 advertising locations (including donated access to 15% of the 12 digital screens in central Lewisham), have generated an estimated 65,563,452 viewing impressions in 2021.

4.28. **Cancer: Cancer Research UK Talk Cancer Training**

4.29. A strategic priority in Lewisham has been to support in the reduction of existing health inequalities for Black, Asian and Minority Ethnic communities in Lewisham for cancer two week wait referrals and cancer screening.

4.30. To work towards achieving this, Lewisham Public Health have worked in partnership with

Cancer Research UK to offer Talk Cancer training programme to Lewisham community members. All who have attended the training have identified a special interest in raising awareness amongst local communities, by having conversations with their networks.

4.31. Sixty four Black, Asian and Minority Ethnic participants (residents/staff/wider workforce) have received the training to help raise cancer awareness and provide health promotion messaging within the Lewisham community.

4.32. The training aims to support participants to gain skills, confidence and increase awareness of the signs and symptoms of cancer, to support with early diagnosis and improve the knowledge of the main cancer screening programmes. The training also contributes towards addressing barriers and reducing the stigma around cancer within the borough.

4.33. We now want to build on this work with those who have received this training to ensure that they continue to have the confidence and capacity to support communities.

4.34. **COVID-19: Lewisham Community Champions Programme**

4.35. The Lewisham Public Health team began the Lewisham COVID-19 Community Champions project during autumn 2020 to provide clear, trustworthy information about the pandemic and related health issues to Lewisham's diverse communities.

4.36. Around 200 volunteers have been recruited via existing channels, who come from a range of backgrounds including voluntary community sector groups, Black Asian and Minority Ethnic community groups, staff groups, health providers, business owners, local councillors and faith leaders. As part of volunteering, COVID-19 Community Champions agreed to be part of a mailing list hosted by the Council.

4.37. The COVID-19 Community Champions receive the most up to date information around COVID-19, vaccination programme information, guidance and health information, via a weekly email. They are also invited to attend optional twice monthly webinars, which also provide a forum for Champions to share ideas on how they disseminate the information with community members they are in contact with and feedback to Public Health Team members on the impact of local initiatives.

4.38. Targeted promotion has been undertaken within local communities including provision of translated materials and information in printed format for those who may not be able to receive this digitally. In addition, the new Royal Society for Public Health Level 2 Award in Encouraging Vaccination Uptake has been commissioned and was delivered to Community Champions in June 2021. Champions have also received Youth Mental Health First Aid and Talk Cancer training, to support with increasing their knowledge and developing their engagement skills

4.39. A recently held Interfaith Forum webinar also provided a new opportunity to increase our Community Champion membership and work closely with faith leaders and congregations from many faiths and religion.

4.40. The Young Champions programme has been launched and is a tailored health programme for those aged 13-25. The programme allows young people to learn more about health topics they have a particular interest in and gives them the opportunity to propose new ideas.

4.41. In transition to a new stage of COVID-19 response to the pandemic the COVID-19 Community Champion evaluation (presented the December 2021 Health and Wellbeing Board) will inform the next stage of Community Champion work to include wider health and wellbeing promotion.

5. Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR)

5.1. Lewisham Council and Birmingham City Council launched BLACHIR in May 2020 as a ground-breaking approach in addressing health inequalities specifically for Black African and Black Caribbean communities.

5.2. Numerically and proportionally Lewisham and Birmingham have some of the largest populations of Black African and Black Caribbean residents in the country. The respective Councils are therefore are natural national leaders in addressing health inequalities for these communities.

5.3. BLACHIR has undertaken a 'deep dive' into available data, academic evidence, professional and lived experience of residents of Black African and Black Caribbean heritage in Lewisham and Birmingham with respect to health inequalities. The review has enabled the development of practical opportunities for action to address systemic inequalities with the ambition of breaking decades of inequality in sustainable ways that will lead to a better future for residents.

5.4. The importance of this work was highlighted at an unprecedented time following the disproportionate impact of the COVID-19 pandemic on those from Black, Asian and Minority Ethnic communities. Several national studies and reports have demonstrated this disproportionate impacts of COVID-19, which reflect many of the pre-existing health inequalities for those of Black and Asian ethnicity.

5.5. The aim of the BLACHIR partnership is to jointly undertake a series of reviews in order to explore in depth, the inequalities experienced by Black African and Black Caribbean communities and the drivers of these inequalities; and to identify opportunities for action to address the inequalities. The main objective of the review has been to produce a joint final evidence-based report that brings together the findings from the advisory boards, stakeholder events, research and data analysis conducted by the BLACHIR review team and engagement of the wider community to check and challenge findings and refine the opportunities for action.

5.6. Review themes covered by BLACHIR include:

- Racism and discrimination in health inequalities
- Maternity, parenthood and early years
- Children and young people
- Ageing well
- Mental health and wellbeing
- Health behaviours
- Emergency care and preventable mortality and long-term physical health conditions
- Wider determinants of health

5.7. Overseeing this work were:

- Nine external advisory board members and elected members across Lewisham and Birmingham who bring a range of knowledge, skills and lived experience via their community networks;
- An external academic board that consists of a network of fifteen academics.

5.8. Both the external academic and advisory boards have provided outputs on all topics following meetings of the respective boards for each review theme. These board outputs have been used to develop actionable solutions i.e. opportunities for action that have been collated to be included in the final review report, which has been appended to this

paper.

5.9. Seven key themes have been outlined for action alongside 39 opportunities for action.

5.10. The seven key themes include:

- **Fairness, inclusion and respect** with the Review calling for the Health and Wellbeing Board and NHS Integrated Care Systems to explicitly recognise structural racism and discrimination as drivers of ill health, systematically identify and address discrimination within systems and practices, and engage with Black African and Black Caribbean individuals and organisations to ensure community voice and their leadership in driving this work.
- **Trust and transparency** with the Review calling for cultural competence training of health and social care professionals led by the NHS Integrated Care Systems and the Councils.
- **Better data** with the Review calling for the Health and Wellbeing Boards to act across their partnerships to strengthen granular culturally sensitive data collection and analysis.
- **Early interventions** with the Review calling for the Health and Wellbeing Board to work with the Children's Trusts and Children's Strategic Partnerships to develop a clear action plan to provide support at critical life stages to mitigate disadvantage and address the inequalities affecting Black African and Black Caribbean children and young people.
- **Health checks and campaigns** with the Review calling for the Health and Wellbeing Board to act across their partnerships to promote health checks through public campaigns to increase the uptake of community-based health checks in easy to access locations.
- **Healthier behaviours** with the Review calling for the Public Health Teams and their partners to assess current service provision and health improvement campaigns through a cultural competency lens to improve support and access for these communities.
- **Health literacy** with the Review calling for the Health and Wellbeing Boards and NHS Integrated Care Systems to work with local community and voluntary sector partners to develop targeted programmes on health literacy for Black African and Black Caribbean communities.

5.11. Community engagement activities have also been commissioned for the wider community to check and challenge findings and refine the opportunities for action. This work has been led by KINARAA, A Black and Minority Ethnic Third Sector organisation, who have experience of engaging people from Black African and Black Caribbean communities on issues related to the determinants of health and wellbeing and health inequalities. The involvement of this organisation was pivotal in its importance in gaining local knowledge and understanding of specific communities and the Lewisham context and to ensure community voices are heard and ownership of BLACHIR was felt. The findings from this engagement have been included in the final BLACHIR report and a full engagement report appended to this paper.

6. Proposal for future work: Lewisham Health Inequalities and Health Equity Plan 2022-24

6.1. There is an intention to develop a refreshed plan of action to tackle health inequalities in and work towards achieving health equity in Lewisham. This plan will cover the next two years taking learning from the challenges identified from the existing work to in addition

to building on the achievements and opportunities to take the work forward with stakeholders.

6.2. An outline of the proposed health inequalities and health equity programme includes eight intersecting work streams being progressed over 2022/23 – 2023/24 (further detail is included in the appended slide pack):

- Equitable health services
- Health equity teams (using Primary Care Networks as the key geography around which the local work is based)
- Community development (building in Community Champion programmes)
- Community of practice
- Workforce toolbox
- Maximising data
- Evaluation
- Programme management and oversight

6.3. Funding from Health and Wellbeing Board partners has been secured to develop, co-produce and implement this plan. We will be aiming to take a community-centred approach to tackling health inequalities and achieving health equity in Lewisham, building on community-centred approaches taken to date in line with those outlined in the Public Health England (PHE) Community-centred public health: taking a whole system approach[1]. Building trust and collaboration with communities will be a key part of this work.

6.4. There will also be a continued focus on tackling ethnic health inequalities particularly for Black and other racially minoritised communities[2] in this Lewisham. This will be supported by the prioritisation and implementation of specific opportunities for action from BLACHIR report as part of the proposed programme.

6.5. The plan will be used to inform the development of a future Lewisham Health and Wellbeing Strategy.

7. Financial implications

7.1. The resourcing of the proposed health inequalities and health equity plan has been identified from contributions from Health and Wellbeing Board partners, namely South East London CCG and Lewisham Council, over a 2 year period.

8. Legal implications

8.1. Members of the Board are reminded of their responsibilities to carry out statutory functions of the Health and Wellbeing Board under the Health and Social Care Act 2012. Activities of the Board include, but may not be limited to the following:

- To encourage persons who arrange for the provision of any health or social services in the area to work in an integrated manner, for the purpose of advancing the health and wellbeing of the area.

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[1] https://www.gov.uk/government/publications/community-centred-public-health-taking-a-whole-system-approach

[2] See recommendations for use of this terminology from BMJ and Lancet - https://gh.bmj.com/content/5/12/e004508 and https://www.thelancet.com/pdfs/journals/lanpub/PIIS2468-2667(20)30162-6.pdf

- To provide such advice, assistance or other support as its thinks appropriate for the purpose of encouraging the making of arrangements under Section 75 NHS Act 2006 in connection with the provision of such services.
- To encourage persons who arrange for the provision of health related services in its area to work closely with the Health and Wellbeing Board.
- To prepare Joint Strategic Needs Assessments (as set out in Section 116 Local Government Public Involvement in Health Act 2007).
- To give opinion to the Council on whether the Council is discharging its duty to have regard to any JSNA and any joint Health and Wellbeing Strategy prepared in the exercise of its functions.
- To exercise any Council function which the Council delegates to the Health and Wellbeing Board, save that it may not exercise the Council's functions under Section 244 NHS Act 2006.

8.2 The Equality Act 2010 (the Act) introduced a public sector equality duty (the equality duty or the duty). It covers the following protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

8.3 In summary, a public body falling under the Act must, in the exercise of its functions, have due regard to the need to:

1. *eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.*
2. *advance equality of opportunity between people who share a protected characteristic and those who do not.*
3. *foster good relations between people who share a protected characteristic and those who do not.*

8.4 It is not an absolute requirement to eliminate unlawful discrimination, harassment, victimisation or other prohibited conduct, or to promote equality of opportunity or foster good relations between persons who share a protected characteristic and those who do not. It is a duty to have due regard to the need to achieve the goals listed above.

8.5 The weight to be attached to the duty will be dependent on the nature of the decision and the circumstances in which it is made. This is a matter for the decision maker, bearing in mind the issues of relevance and proportionality. The decision maker must understand the impact or likely impact of the decision on those with protected characteristics who are potentially affected by the decision. The extent of the duty will necessarily vary from case to case and due regard is such regard as is appropriate in all the circumstances.

9. Climate change and environmental implications

9.1. There are no climate change or environmental implications of this report.

10. Crime and disorder implications

10.1. There are no crime and disorder implications of this report.

11. Health and wellbeing implications

11.1. Improving health outcomes and reducing health inequalities is central to the work of the Health and Wellbeing Board. This report directly aligns with these aims by outlining the progress made with health inequalities work in Lewisham.

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Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR)

Publication date: March 2022

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Foreword

Birmingham and Lewisham are global communities, thriving through our many cultures and communities, including large, diverse and vibrant Black African and Black Caribbean populations.

For too long our Black African and Black Caribbean populations have experienced health inequalities. These have often been ignored and their voices unheard, with these inequalities often accepted as fact rather than an unacceptable wrong to be addressed.

Although it has been hard, the journey over the last eighteen months has been worth it. It has also underlined the critical need for the work as our Black African and Black Caribbean residents have been disproportionately affected by the COVID-19 pandemic, both directly through infections and deaths, and indirectly economically and socially.

Through this review, we have opened difficult conversations, reviewed the published research alongside lived experience and testimony, and talked head on about what really needs to change, and the practical steps needed to make change lasting.

We are grateful for the honesty, passion and commitment of the individuals and groups who have been part of the boards or taken part in the community sessions that have guided our work and offered challenge through every stage of this review. Their personal contributions led to the review identifying not just the challenges, but also important opportunities for action at community and systems levels. Although focused on our local communities we hope it will have resonance and benefits across the UK and further afield.

The review is the first step in a longer journey of transformation and resolution. It shines a light on the unfairness our Black African and Black Caribbean citizens live with every day which damages their health and wellbeing through racism and discrimination, ignorance and invisibility. These are often driven by structural and institutional processes that underpin and perpetuate these inequalities. This must change.

The review sets out clear opportunities for action driven by evidence and it is now for us as leaders to work together through the Health and Wellbeing Boards, new Integrated Care System Partnerships and most importantly with our communities themselves, to take them forward. As we work in each of our areas to respond to the review, we will continue to share learning and experiences to benefit our communities.

We must be committed to a better future for our citizens, and we must work together to seize every opportunity set out in this report to make our communities fairer and healthier for all.

Councillor Paulette Hamilton

Cabinet Member for Adult Social Care and Health/ Chair of the Birmingham Health and Wellbeing Board

Councillor Chris Best

Leader of the Lewisham Council/ Chair of the Lewisham Health and Wellbeing Board

Executive summary

Health inequalities are not inevitable and are unfair. Many people from different backgrounds across our society suffer health inequalities which can negatively impact the whole community, not just those directly affected. Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR) set out to urgently reveal and explore the background to health inequalities experienced by our Black African and Black Caribbean communities.

Birmingham is home to 8% of the Black African and Black Caribbean populations in England and 23% of Lewisham's population is of Black African or Black Caribbean heritage (ONS 2011). Therefore, we are uniquely placed to take on this project to improve the health and wellbeing of our populations.

We recognised the need to think and act differently, looking at not just published data and evidence but also listening professional and lived experiences to better understand health inequalities, the reasons why they exist and identify opportunities for action to address them.

The main aim of the Review is to improve the health of Black African and Black Caribbean people in our communities by listening to them, recognising their priorities, discussing, and reflecting on our findings and coproducing recommended solutions for the Health and Wellbeing Board and NHS Integrated Care Systems to consider and respond to.

Addressing the layers of disadvantage

This Review clearly demonstrates and reinforces the evidence that there are social, economic and environmental reasons that determine significant inequalities in health outcomes amongst Black African and Black Caribbean communities, both locally and nationally.

These reasons lead to growing inequalities which have continued to worsen throughout the course of the COVID-19 pandemic, with many ethnic communities, especially our Black African and Black Caribbean communities, disproportionately impacted by disease and death.

BLACHIR supports previous research into health inequalities such as the Marmot Reviews[1,2], demonstrating that widespread inequality creates barriers to healthy behaviours, as faced by Birmingham and Lewisham's Black African and Black Caribbean communities. The Review highlights that must address the root causes and not just the results of bad health by focusing on fairness, a good start in life, supporting individuals at key stages and planning interventions better in partnership with our communities. We must make sure that we offer appropriate and accessible interventions at critical times in people's lives, whilst also continuously improving the way services work with them in culturally competent ways designed with communities in collaboration.

Poor housing, lack of green spaces, pollution, unemployment, food and fuel poverty, violence and crime and inadequate education all contribute to worse health and inequalities in these must be improved alongside action in health and social care services, otherwise the gaps will persist.

Structural racism and discrimination, and associated trauma is also a negative determinant faced by our Black African and Black Caribbean communities and one that was a clear and

[1] Marmot, M., Goldblatt, P. and Allen, J. (2010) *Fair Society, Healthy Lives, Strategic Review of Health Inequalities in England post 2010.* Institute of Health Equity

[2] Marmot, M. et al (2020) *Build Back Fairer: The COVID-19 Marmot Review*. The Health Foundation

constant theme throughout the Review. This layer of disadvantage cannot be ignored and addressing it must be at the heart of the response.

This Review's purpose is to break down the layers of disadvantage by bringing them to the fore and offering opportunities for actions from the BLACHIR Academic and Advisory Boards made up of volunteer professionals and academics and volunteers from our African and Caribbean communities.

We present key findings from across eight themes and offer opportunities for action to help address them.

Our methodology

"There is an urgent need to do things differently, to build a society based on the principles of social justice" (Marmot 2020).[3]

In line with the need to think and act differently, BLACHIR took a relatively unique approach to collate and analyse data and evidence, taking a balanced approach with proper consideration for published data and evidence, expert knowledge, lived experience and community voice. This helped the review obtain both quantitative and qualitative information over the course of eighteen months.

We identified eight themes related to the health and wellbeing of our populations based on the life course and areas already highlighted in the literature. For each theme a rapid evidence review was conducted to collate the published evidence, in some cases this was done by the local public health teams, in others it was commissioned from external providers. Our board of academics discussed the results from the literature and the evidence review to identify gaps, key issues and opportunities for action. The community advisory board and public engagement events provided an 'expert by experience' perspective to further build the opportunities for action and also provide challenge to the ambition and approaches suggested.

Public engagement activities included four online surveys using the Be Heard and Survey Monkey platforms, six focus groups, five individual interviews and five online community engagement events.

Our main findings

Seven key areas that need to be addressed were identified as cutting across the eight themes explored. These are deemed as being fundamental to closing the inequality gap, providing fairer access to health and social care services, and improving health outcomes for Black African and Black Caribbean communities. The Review calls on the Health and Wellbeing Board and NHS Integrated Care System Boards to prioritise taking forward work to address the seven fundamental areas that need to change.

1. Fairness, inclusion and respect

Across settings and life stages, people of Black African and Black Caribbean heritage are exposed to structural racism and discrimination which accumulates over time leading to chronic stress and trauma. There is a need to recognise, identify, address and mitigate structural racism and discrimination as a driver of health inequalities.

The Review calls for the Health and Wellbeing Board and NHS Integrated Care Systems to explicitly recognise structural racism and discrimination as drivers of ill health, systematically identify and address discrimination within systems and practices, and engage

[3] Marmot, M. et al. (2020) *Build Back Fairer: The COVID-19 Marmot Review*. The Health Foundation

with Black African and Black Caribbean individuals and organisations to ensure community voice and their leadership in driving this work**.**

2. Trust and transparency

Trust is lacking between the Black African and Black Caribbean communities and public sector organisations, and connections with communities need to be built. A long history of discrimination, biases, poor experience and poor outcomes has destroyed trust in statutory services.

The Review calls for cultural competence training of health and social care professionals led by the NHS Integrated Care Systems and the Councils. This will require working with trusted community organisations and partners to coproduce training for professionals and volunteers that includes cultural awareness, is trauma informed and recognises the short and long-term impacts of discrimination and racism, values lived experiences and embeds and delivers inclusion in practices and policies.

3. Better data

Treating all ethnic minority or 'Black' communities as a single 'Other' group does not consider the cultural differences between Black African and Black Caribbean people. This has led to gaps in available data and limits our understanding of our communities and their needs. These communities are often grouped in research and data with other non-White British ethnic communities, denying their visibility and muting their needs to commissioners and service providers.

The Review calls for the Health and Wellbeing Boards to act across their partnerships to strengthen granular culturally sensitive data collection and analysis. Collaboration with professionals who represent these ethnic backgrounds can create a more sensitive, informed and appropriate approach to data collection and commitment that when data is collected it is used to drive better services and outcomes.

4. Early interventions

Investing early in people is essential. Too many children and young people from Black African and Black Caribbean communities are facing additional challenges that could be reduced through evidence-based interventions and this would benefit them through their whole life. Supporting children and young people's key periods of change, from birth and infancy to primary and secondary school, and then to young adulthood in culturally competent ways is essential.

The Review calls for the Health and Wellbeing Board to work with the Children's Trusts and Children's Strategic Partnerships to develop a clear action plan to provide support at critical life stages to mitigate disadvantage and address the inequalities affecting Black African and Black Caribbean children and young people. Investing early in local opportunities and partnerships is key to helping households and improving the lives of local children and young people.

5. Health checks and campaigns

Early detection and diagnosis of disease and identification of risk factors is critical for improving outcomes and empowering people to control their own health and wellbeing. Black African and Black Caribbean populations are at greatest risk of many health conditions but have lower uptake of health checks and screening services.

The Review calls for the Health and Wellbeing Board to act across their partnerships to promote health checks through public campaigns to increase the uptake of

community-based health checks in easy to access locations. This should also include specific work on mental health and wellbeing, working with community organisations and partners to increase peoples' understanding of the different types of mental illness and to encourage self-help, early intervention and self-referral to the NHS mental health services.

6. Healthier behaviours

The awareness about healthier life choices must be increased by using appropriate representation and amplified community voices to help identify and promote better health and reduce stigma. Unhealthy behaviours such as not taking enough exercise, eating an unhealthy diet and use of recreational drugs are a growing concern amongst Black African and Black Caribbean people. As with other ethnic minorities, these unhealthy behaviours can be driven by experiences of discrimination and racism. This is not helped by a lack of quality data, culturally competent resources and services to support healthier life choices.

The Review calls for the Public Health Teams and their partners to assess current service provision and health improvement campaigns through a cultural competency lens to improve support and access for these communities. This should be built on coproducing interventions with supplementary training for professionals such as health education and racial trauma awareness to help understand the psychological reasons for unhealthy behaviours and the role of lived experiences of discrimination in causing unhealthy habits.

7. Health literacy

Increasing people's skills, knowledge, understanding and confidence (health literacy) to find and use health and social care information and services to make decisions about their health is key to achieving healthier communities. Many in the Black African and Black Caribbean communities have not been supported to develop in this area in ways that work with their culture and community.

The Review calls for the Health and Wellbeing Boards and NHS Integrated Care Systems to work with local community and voluntary sector partners to develop targeted programmes on health literacy for Black African and Black Caribbean communities. Improving health literacy has been shown to have a positive impact on reducing health inequalities and helping people to manage long-term conditions effectively and to reduce the burden on health and social care services.

Opportunities for action

There are 39 opportunities for action across the eight themes explored as part of this review summarised below, they are also included in Appendix 1.

In some areas these opportunities are suggested as pilots of approaches as the evidence base and live experience supports action but there is limited evidence on effectiveness. This reflects the lack of detailed and focused research into ethnic communities' specific needs and how best to respond to them. Appendix 4 sets out the recommendations for research questions that could help close some of these gaps for the future.

These opportunities outline the potential next steps proposed to address the findings from the Review and are for the Health and Wellbeing Board and the NHS Integrated Care System Boards to consider and respond to alongside the 7 key areas for action.

Theme 1: Racism and discrimination	
Who	**Opportunities for action**
Local Councils and Health and Wellbeing Board Partners	**1.** Pilot the removal of the colour language from ethnic coding and evaluate the impact on participation and experience of data collection.
Local Councils and Children's Trusts	**2.** Pilot the integration of discrimination and racism into the approaches to adverse childhood experiences and recognise this both in the assessment of children's needs and in the design of interventions to mitigate these adverse impacts.
Local Councils and Health and Wellbeing Board Partners	**3.** Review staff equality and diversity training to ensure that this is a core part of the delivery of training, co-delivered by diverse individuals with lived experience.
Local Councils and Education Partners	**4.** Work with education partners for all ages and local communities to explore how ethnic diversity can be further integrated into education to reflect the diverse cultures and various perspectives of history and experience.

Theme 2: Maternity, parenthood and early years	
Who	**Opportunities for action**
Local Integrated Care Systems (ICS) and NHS Provider Collaboratives	**5.** Address any gaps in existing Maternity and Paediatric Health Professionals' training including topics on cultural awareness, learning from lived experience, awareness of inclusion practices and policies, and awareness of trauma caused by racism and discrimination and how to deliver sensitive care.
Local NHS Integrated Care Systems (ICS)	**6.** Co-design online tool with communities to collect information on beliefs, cultural practices and traditions from ethnic groups. This resource could then be used for training to inform practice and communication with patients and service users.
Local Maternity System Partnerships and Health Child Programme Providers	**7.** Improve data collection by specific ethnicity in maternity and early years services considering the differences in ethnic background and nationality. Work with professionals who represent the ethnic minority groups to ensure a sensitive approach when collecting data.
Local Maternity System Partnerships (LMS) working with Local Council Housing Teams	**8.** Support all women who are migrants, refugees, and asylum seekers, particularly those with no access to public funds, to access appropriate care during and post pregnancy, through appropriate support and protecting them from relocation or eviction.

Local Public Health and NHS services	**9.** Develop culturally specific and appropriate weaning support initiatives for Black African and Black Caribbean parents.

Theme 3: Children and young people	
Who	**Opportunities for action**
Education settings supported by the Regional Schools Commissioner and local Councils	**10.** Provide guidance and support for Black African and Black Caribbean parents and young people on applications and transition to secondary school and further education, including online information, support liaison officers, summer schools on core subjects and finance advice.
Local Integrated Care Systems (ICS), Mental Health Trusts & Council commissioned Healthy Child Programme Providers	**11.** Commission and develop culturally appropriate and accessible services, including schools-based support, for Black African and Black Caribbean young men and women to increase capability, capacity and trust to engage with services. This should be specifically actioned for mental health services and for sexual and reproductive health services and take into account issues around gender exploitation and gender based violence.
Education settings supported by the Regional Schools Commissioner and local Councils	**12.** Review educational approach and opportunity for targeted intervention to increase academic achievement for Black African and Black Caribbean children and young people.
Local Health and Wellbeing Board and NHS Integrated Care System	**13.** Address low pay and associated poverty for frontline workers who are disproportionately of Black African and Black Caribbean heritage.
Local Council Director of Children's Services and Strategic Children's Partnerships	**14.** Work with trusted community centres and spaces to provide violence-free, accessible and attractive youth provision for access to wider opportunities, including through existing contracts and partnerships with Black-owned businesses and leaders.
Local Councils and climate change and air quality partners	**15.** Collaborate with African and Caribbean communities and their leadership on addressing air quality issues and continue with the in-depth work already in place with explicit consideration of these communities.
NHS Integrated Care Systems and Health and Wellbeing Board	**16.** Put in place interventions for Black African and Black Caribbean children and young people that address specific inequalities (e.g. sickle cell disease services), ensuring proportionate targeting and equality assessments of whole population interventions for issues they are disproportionately impacted by (e.g. low traffic neighbourhoods and school streets).

Theme 4: Ageing well	
Who	**Opportunities for action**
Regional NHS England teams and Local Public Health teams	**17.** Provide targeted and culturally appropriate screening services Black African and Black Caribbean older adults.
Local Public Health Teams	**18.** Campaign to raise awareness and increase uptake of community-based NHS health checks in Black African and Black Caribbean older adults.

NHS Integrated Care System Boards	**19.** Assess the availability of culturally aware services for mental health and evaluate current services to determine how they meet the needs of older Black African and Black Caribbean adults.
NHS England and NHS Integrated Care System Boards	**20.** Support initiatives to improve uptake of vaccinations in older African and Caribbean people, focusing on areas of higher deprivation.
Local Health and Wellbeing Boards and NHS Integrated Care System Partnerships	**21.** Use life course approach and consider relevant findings from this Review to develop interventions that help to mitigate health inequalities experienced by Black African and Black Caribbean older people.

Theme 5: Mental health and wellbeing	
Who	**Opportunities for action**
Local Public Health and Community Mental Health Trusts	**22.** Coproduce awareness campaigns aimed at Black communities to promote a better understanding of different mental illnesses, facilitate early interventions and self-referral in collaboration with carers, families, health services, community and faith centres.
Local NHS providers and Community Mental Health Trusts	**23.** Ensure practitioners use culturally competent (cultural understanding) trauma informed patient-centred engagement styles and interventions.
NHS Mental Health Providers and Commissioners	**24.** Ensure mental health workers acknowledge service users' personal histories of racism and recognise them as trauma to enable more effective intervention.
Local Health and Wellbeing Boards and NHS Integrated Care Partnerships Boards	**25.** Promote cultural competency training within healthcare services, the criminal justice system, and the police force.
Local Health and Wellbeing Boards and NHS Integrated Care Systems	**26.** Apply the use of culturally competent language, including using language that considers stigma within communities, such as 'wellbeing' rather than 'mental health'.

Theme 6: Healthier behaviours	
Who	**Opportunities for action**
Local Directors of Public Health	**27.** Work with Black African and Black Caribbean communities and organisations to co-create and deliver culturally appropriate and accessible support on positive health behaviours, including health literacy training, social prescribing initiatives and group interventions.
Health Education England	**28.** Explicitly recognise racism and discrimination as a driver of ill health and put in place training and systems to enable trauma-informed practice and services.
Local Councils and NHS Integrated Care Systems	**29.** Provide long-term investment for trusted Black African and Black Caribbean grass roots organisation such as faith groups, schools, voluntary and community sector organisations to deliver community-led interventions.
Local Directors of Public Health	**30.** Work with faith settings to understand and utilise the positive role faith plays in healthier behaviour decision making.
Research funding bodies such as National Institute for	**31.** Address the evidence deficit in interventions for Black African and Black Caribbean communities through targeted investment in research, including capacity and skills development for

Health Research (NIHR)	community providers in 'action research' to concurrently deliver and evaluate interventions.
Local Directors of Public Health and Nationally the Office of Health Improvement and Disparities (OHID)	**32.** Undertake insight research with members of smaller Black African and Black Caribbean populations (e.g. Somali, Ethiopian and Eritrean) to understand health literacy needs.

Theme 7: Emergency care, preventable mortality and long-term physical health conditions	
Who	**Opportunities for action**
NHS England NHS Integrated Care Systems Local Councils	**33.** Ensure culturally appropriate data collection and analysis for service planning, monitoring and evaluation that distinguishes by ethnicity and gender for Black African and Black Caribbean populations. This should be supported by clear commissioning that requires data collection and analysis linked to all key relevant performance indicators. A specific example of where this can be rapidly done is through better use of the Friends and Family Test (FFT) and working with African and Caribbean communities so they engage with the tool and understand how it is used. There should also be better scrutiny and use of data from complaints and complements and this should be reviewed as part of contract monitoring and output data reported into system-leaders. This can also be strengthened through undertaking qualitative research to understand and overcome negative perceptions and experiences of health care for Black African and Black Caribbean communities to avoid delays in accessing care, including the influence of structural racism and discrimination. Through this better data and engagement, local areas should develop a more in depth understanding of the needs of communities in relation to emergency care, preventable mortality and long-term physical health conditions.
Local Health and Wellbeing Board and NHS ICS Partnership Board	**34.** Ensure that the engagement of Black African and Black Caribbean communities is meaningful and valued. This should include direct engagement and collaboration with representative organisations that is done in a way which is respectful, transparent and accessible, and considers and values participants' time and commitments. Mechanisms for doing this could include: • A team of community advocates who understand the needs and barriers for Black African and Black Caribbean communities, supporting them to 'navigate' and access support (e.g. social prescribing). • Use of faith and workplace settings to increase awareness and understanding of health issues to support informed decisions about health. • Investment in grass-roots organisations to recruit volunteers who can support Black African and Black Caribbean

	communities that may experience structural institutional racism when accessing services.
Local Directors of Public Health and NHS Prevention Leads	**35.** Ensure prevention services are fair, appropriate and consider the needs of Black African and Black Caribbean populations, and there is proactive work to address issues with health literacy. This could include: • Services considering evidence-based ethnic differences in outcome measures (e.g. BMI versus waist-to-height measures, age of heart disease issue onset for NHS Health Checks, depressive symptoms in childhood and influence on life-time physical health). • Work with communities to co-develop services that are accessible for Black African and Black Caribbean communities (e.g. opening times, location of delivery). • Work with communities to encourage and raise awareness about how to access health services, including investment and development of multi-service hubs and pop-ups based in community locations (e.g. Youth Centres, libraries, leisure centres, faith-based sites, universities, colleges, schools) • Contractual clauses that strengthen support for Black African and Black Caribbean communities when they experience racism while accessing services and offer tiered positive approaches that address reported issues. • Meaningful measurement of change and learning from communities and grass roots organisations being captured and informing service design, monitoring, improvement, and review • Whole system workforces, across all partners and professions including front-line, back-office and system leaders, to complete anti-racism training, with ongoing independent evaluation • Early help provision that supports communities when they do not meet statutory thresholds such as improved investment in grassroot organisations to provide social prescribing support (e.g. befriending, talking therapy, group therapy, forums and general health support).

Theme 8: Wider determinants	
Who	**Opportunities for action**
Local Health and Wellbeing Boards and NHS Integrated Care Partnership Boards	**36.** Consider cultural and religious influences when developing interventions to address the wider determinants of health inequalities for Black African, Black Caribbean and Black-Mixed ethnic minority groups.
Local Councils, NHS Trusts, ICS, advocates for national standards, Criminal Justice System, community organisations	**37.** Collaborate with government agencies and institutions to remove issues ethnic minorities face when in contact with the justice system and ensure these agencies work to address health inequalities.

Local Health and Wellbeing Boards	**38.** Conduct more research to understand the impacts of the food environment and food poverty on health and wellbeing of Black African and Black Caribbean communities, and devise strategies to address the structural issues at a community level.
Local Health and Wellbeing Boards and NHS Integrated Care Partnership Boards	**39.** Take action to address employment inequalities and issues around racism and discrimination affecting in the public sector. Offer more protection for key workers from Black African, Black Caribbean and Black-Mixed ethnic backgrounds in health or other high-risk occupations.

Introduction

"Of all the forms of inequality, injustice in healthcare is the most shocking and inhumane"

Dr Martin Luther King Jr

There are clear and significant differences in the health status of Ethnic communities compared with their White counterparts in many local areas across the United Kingdom[4]. These reflect inequalities in the wider determinants of health such as education and housing, in health behaviours such as diet and physical activity, across many health outcomes from birth to premature death and in unequal access to health and social care support when it is needed.

The COVID-19 pandemic revealed how the impact of poverty, ethnicity, health, work and housing led to a higher rate of deaths in Black African and Black Caribbean people.[5] This simply shone a light on inequalities that have persisted for decades. The Black Lives Matter (BLM)[6] movement was also re-energised in 2020 highlighting the longstanding racism, discrimination and inequality experienced by Black people in the UK and internationally.

Health inequalities relate to the social, economic and environmental reasons that shape people's lives and are often called the wider determinants. Recent conversations across social and mainstream media steered by these issues have shown the inadequate support and unfair access to healthcare in our Black communities. This has led us to take action through a different type of partnership.

An innovative partnership

Over 96,000 people living in Birmingham identify with the Black African, Black Caribbean and 'Black Other' ethnic identities in the 2011 Census, and in Lewisham these communities represented over a quarter of all ethnic identities in the population. These are big communities and their health inequalities are reflected in the overall picture for the populations.

The public health divisions of Birmingham City Council and the London Borough of Lewisham Council felt more serious action was needed to understand and tackle health inequalities in their communities but recognised that this needed a different partnership approach which was better done together than individually. Building from these conversations the respective Health and Wellbeing Board Chairs commissioned BLACHIR – the Birmingham and Lewisham African and Caribbean Health Inequalities Review, to be led by the respective Directors of Public Health and their teams to move forward.

Despite the challenges of the last two years of the Pandemic this work has continued to move forward which is testament to the commitment of all those involved to make this happen.

Listening to our communities

Our Councils shared the common goal of addressing health inequalities through a greater understanding and appreciation of, and engagement with, our community groups. We

[4] Raleigh, V. and Holmes, J. (2021) *The Health of People from Ethnic Minority Groups in England*. The King's Fund.
[5] Office for National Statistics (2022) *Updating ethnic contrasts in deaths involving the coronavirus (COVID-19), England: 8 December 2020 to 1 December 2021*
[6] Black Lives Matter (2022) *Home*

created an environment that enabled honest conversations throughout this review. The discussions were held with professionals and members of the public from the Academic and Advisory Boards. Fifteen academic professionals and nine Advisory Board members volunteered and attended five engagement sessions organised by each local authority's public health team. The review took place from July 2021 to January 2022 covering eight themes:

- Racism and discrimination in health inequalities
- Maternity, parenthood and early years
- Children and young people
- Ageing well
- Mental health and wellbeing
- Healthier behaviours
- Emergency care, preventable mortality and long-term physical health conditions
- Wider determinants of health

Our Black African and Black Caribbean Communities

Our Black African and Black Caribbean residents are important members of our community, many of whom were born and raised within our local areas. Irrespective of country of birth, many also have links and heritage with Africa and the Caribbean through cultural, ethnic identities and belief systems. Many Black African communities in the UK and elsewhere have roots in Sub-Saharan Africa with its rich and varied cultures, made up of mainstream and traditional belief systems. Black Caribbean communities also have distinctive cultural and ethnic identities across different Caribbean states with links to sub-Saharan Africa.

Black African and Black Caribbean groups share common ethnicities and cultures (African-Caribbean), and also identify with oppression, discrimination, marginalisation, inequalities and migration. However, there are also differences and we should not make assumptions when people from these groups access services that they all are the same.

The most recent standardised data on our communities locally comes from the 2011 Census as the 2021 Census results have not yet been released. While Birmingham has a much larger population than Lewisham, the ethnic landscape is similar with both being home to a significant proportion of Black African and Black Caribbean people.

There are some differences: a larger proportion of Birmingham's Black African and Black Caribbean citizens were born overseas (48% compared to 46% in Lewisham). The Lewisham's Black African and Black Caribbean population is younger than the general population and although this is similar in Birmingham, it is less pronounced. In general, the African populations are younger than the Caribbean populations and have much smaller proportion of very elderly citizens.

Figure 1: Local communities by ethnicity based on the 2011 Census data

[INFOGRAPHIC]

	Birmingham	Lewisham
Ethnic Identity		
White British	53.1% / 570,217	41.5% / 275,885
Black African	2.8% / 29,991	11.6% / 32,025
Black Caribbean	4.4% / 47,641	11.2% / 30,854
Black Other	1.7% / 18,728	4.4% / 12,063
Total of Black ethnicity	8.9% / 96,360	27.2% / 350,827
Country of Birth		
African Countries	3.2% / 34,549	9.2% / 25,277
• North Africa	0.3% / 2,696	0.4% / 1,180
• Central & West Africa	0.8% / 8,171	6.1% / 16,760
• South & East Africa	2.1% / 23,070	2.6% / 7,201
Caribbean Countries	1.9% / 20,043	4.6% / 12,788
• Jamaica	1.4% / 15,100	3.5% / 9,697
• Other nations	0.5% / 4,943	1.1% / 3,091
Age of arrival in the UK		
• 0 to 15yrs	37.5% / 17,417	29.6% / 10,224
• 16 to 24yrs	25.5% / 11,854	28.9% / 9,989
• 25 to 34yrs	24.3% / 11,310	28.6% / 9,859
• 35 to 49yrs	10.7% / 4,965	10.6% / 3,659
• >50yrs	2.1% / 956	2.3% / 792

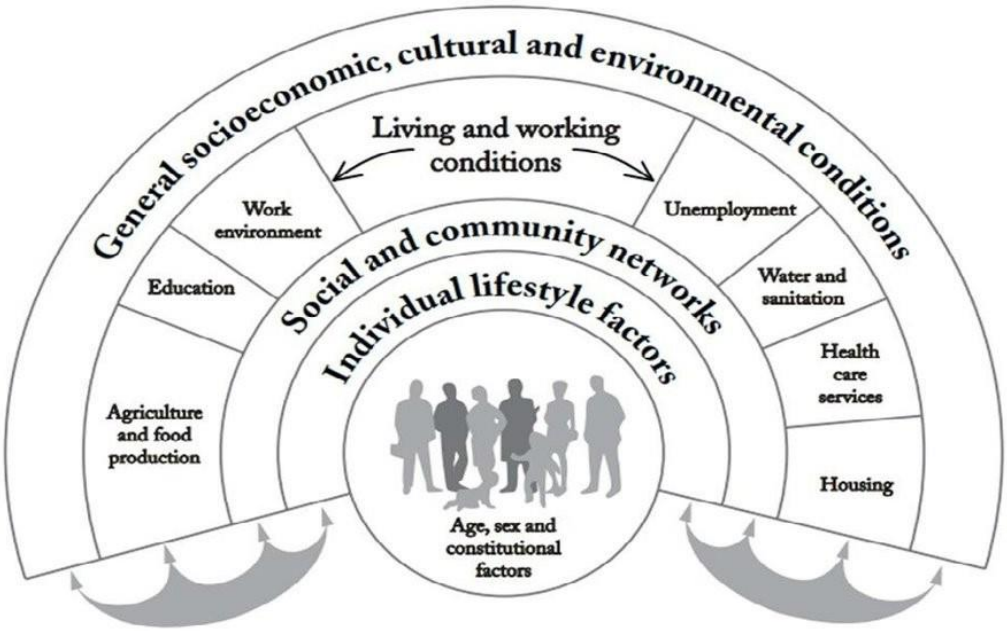
Methodology

The Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR) took eighteen months due to the impact of the COVID-19 pandemic. It involved capturing the lived experiences of Black African and Black Caribbean communities alongside exploration of the published data and evidence. The main topic themes were established based on the recognised wider determinants of health (See Figure 2) and initial scoping engagement.

In addition to disproportionate exposure to negative determinants of health, it is increasingly recognised that many ethnic minority populations also suffer from racism and discrimination as an additional determinant of health[7].

BLACHIR wanted to hear from real people and their voices informed our study, revealing what we could do to ensure better opportunities for them now and in the future.

Figure 2: Dahlgren and Whitehead model of health determinants[7]



The evidence was collected using the following methods:

- A rapid review of published research and evidence from the past ten years
- Data collation from existing data sources accessible to the Council public health teams
- An appraisal of the outcomes from the rapid review of literature and discussion on its findings by the board of academics
- A discussion on the outcomes from the evidence review and the Academic Board, and feedback from the experts by experience from the Advisory Board
- Public engagement activity including:
    - 4 online surveys
    - 5 online public events
    - 6 focus groups sessions
    - 5 one-to-one interviews.

[7] Dahlgren, G. and Whitehead, M. (2021) 'The Dahlgren-Whitehead model of health determinants: 30 years on and still chasing rainbows', *Public Health* 199, pp 20-24.

We listened and we heard

Many groups of people remain under-represented in engagement due to barriers in society. The BLACHIR was important because it heard from people with diverse lived experiences, leading to innovative ideas for better decisions and health outcomes.

We adopted a different way to engage by allowing members of the community to comment on the opportunities for action as they were developed rather than just reading them from the published review.

People from Black African and Black Caribbean communities were invited through targeted engagement to submit responses to an online survey and participate in live Mentimeter© polls at online events. Birmingham City Council opened the last local survey to the wider public on 5 January 2022 and this closed on 20 January 2022. In total, 173 Birmingham citizens participated in the engagement events. In Lewisham, three local grass roots organisations were involved in carrying out local engagement activities. Across Lewisham, a total of 71 people engaged in these activities.

There was specific promotion through targeted media and direct networking to try and engage citizens in these opportunities to comment. As we went through the process we evolved and developed the approach. For example, we captured the ethnicity of participants in digital engagement workshops as a simple step to really understand the voices in the room.

The reality of the COVID-19 pandemic prohibited face-to-face engagement and it has been recognised that this was a significant limitation for the review process.

External boards

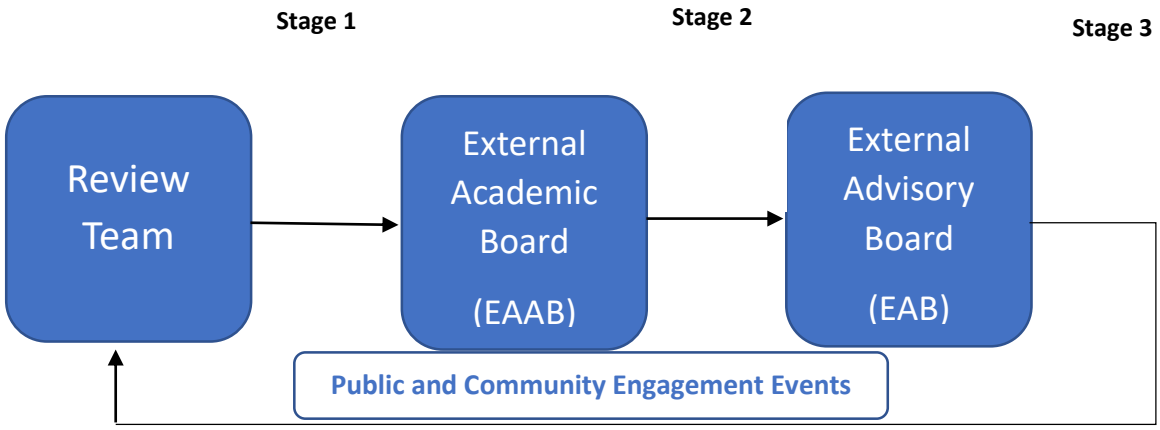
External Academic Board

Fifteen academics were appointed as volunteers to the external Academic Board. The main purpose of the external Academic Board was to provide a network of academics who have a research interest in African and Caribbean health inequalities to support and inform the Birmingham and Lewisham review. The Academic Board members represented different aspects of the Black African and Black Caribbean communities in Lewisham, Birmingham and nationwide. They conducted a two-way conversation with communities, not representing individual views and maintained wider community networks to gain and share information relevant to each theme.

External Advisory Board

The Advisory Board consists of five voluntary members from Lewisham and four voluntary members from Birmingham who are actively involved in their communities and live in the local areas. They collected and reported lived experiences from both these local authorities. The external Advisory Board's purpose was to enable regular discussions to inform the review process from a group of individuals who represented different views of Black African and Black Caribbean communities in Lewisham, Birmingham and nationwide.

Figure 3: Meeting cycle process



Recruiting participants using internal and external communications

We reached out to relevant audiences using both external and internal communications to find out directly about the issues affecting our Black African and Black Caribbean communities. Both councils' websites and other communication channels were used to provide information to all our targeted stakeholders.

The invitations were created to attract people to our engagement events and the online surveys were used to capture under-represented voices in the workplace.

The methods we applied were:

- email communications to community groups and representatives, including a list of targeted African and Caribbean organisations following a mapping exercise completed by the review team and local media outlets
- promotion of the surveys in all engagement events using slideshows and posting the link in the live MS Teams chats
- advertising using social media channels such as LinkedIn forums, Twitter, and Instagram Healthy Brum accounts.

Figure 4: Information from engagement events and surveys

	Birmingham		Lewisham	
	Engagement Events	Survey and Mentimeter© responses	Focus groups and interviews	Survey
Number of participants	129	44	33	38
% of Black ethnicity	50%		100%	
% male	33%		24%	
% female	67%		76%	
Most common age group of respondents	55-64 and 35-44 years		40-59 years	

Limitations

This review collated and analysed published evidence and available data, collected professional opinion and lived experience evidence, and utilised Academic Board, Advisory Board and community engagement processes to develop and prioritise its findings and proposed opportunities for action.

Each process had inherent limitations and potential biases, e.g. quantity and quality of published evidence and data, lack of available data collection and analyses for ethnicity beyond Black, Asian and Minority Ethnic (BAME), breadth of board membership, reach of community engagement, etc. Findings are not a comprehensive approach to addressing health inequalities for Black African and Black Caribbean communities, and other evidence-based opportunities to address health inequalities and improve health and wellbeing equity for these populations may also be beneficial.

As the Review progressed due to the pressure of the Covid response some of the evidence collation was commissioned from external providers and this led to more variability in the evidence collation.

It should also be noted that long-standing and structural drivers of health inequalities can only be addressed through long-term, progressive action. Therefore, rather than identifying a 'solution', this work represents the start of a new way to co-create action to reduce health inequalities with and by – rather than to or for - the community.

People from ethnic minorities who are not White British are often grouped together as Black, Asian and Minority Ethnic (BAME). The BAME term can mask variations between different ethnic groups and create misleading interpretations of data. The consequences of this are that we don't often get to truly understand the specific different inequalities affecting different ethnic groups or what their specific needs, or issues are.

Due to capacity and also the absence of data and evidence across the general population, this work has not looked at how minority groups within the Black African and Black Caribbean are affected by multiple inequalities ('intersectionality'). For example, evidence suggests LGBT people of Black heritage are more likely to face discrimination from other LGBT people because of their ethnicity[8], be victims of hate crime[9] and less likely to access services[10] than White LGBT people. There is a need to look at intersectionality for people of Black African and Black Caribbean heritage who have other inequality characteristics or are in inclusive health demographics.

[8] Stonewall (2018) *LGBT in Britain – Home and communities*
[9] Stonewall (2017) *LGBT in Britain - Hate crime and discrimination*
[10] Witzel, T.C., Nutland, W. and Bourne, A. (2019) 'What are the motivations and barriers to pre-exposure prophylaxis (PrEP) use among Black men who have sex with men aged 18-45 in London? Results from a qualitative study,' *Sexually Transmitted Infections* 95(4), pp 262–266. doi: 10.1136/sextrans-2018-053773

Theme: Racism and discrimination

"'Whenever we see racism, we must condemn it without reservation, without hesitation, without qualification."

Antonio Guterres, United Nations Secretary-General

The review into the drivers of health inequality being experienced by Black African and Black Caribbean communities started from a discussion on the role of racism and discrimination.

Racism is "a conduct or words, or practices which disadvantage or advantage people because of their colour, culture, or ethnic origin"[11]. It can happen at both individual and institutional levels, with a collective failure to provide an inclusive environment or detect and outlaw racism termed 'institutional racism'.

Discrimination is treating someone in a negative way because of a personal characteristic such as race, age, sex or disability.

The historical aspect of these issues cannot be ignored. Racism has its roots in colonialism and slavery. A history of hierarchical states with White Europeans at the top and Black Africans and Black Caribbean's at the bottom has resulted in racism becoming embedded into the nation's structures of power, culture, education and identity.

The disproportionate impacts of COVID-19 on people of ethnic minority heritage, especially people from Black ethnic groups, shone a light on persistent and often ignored health inequalities. Recognition is a step in the right direction, but insufficient to create change.

A recent review of the principle of the determinants of health recognised racism as a *"driving force influencing almost all determinants of health"* operating through the mechanisms of racial discrimination and stigma, institutional racism, and structural racism[5].

A position statement from the Association of Directors of Public Health declared *"Racism is a public health issue"*[12]. They set out an action plan based on: trust and cohesion; co-production with communities; improving ethnicity data collection and research; embedding public health work in social and economic policy; diversifying the workforce and encouraging systems leadership.

What did we find from the rapid review?

There has been a steady increase in hate crime, including racially aggravated incidents, over the past 10 years with the number of the crimes rising by 159% since 2012 (Figure 5). The rise can also be attributed to a better recording system and higher reporting rates, as the awareness of hate crime and how to report it increases. Nevertheless, the statistics are worrying and demonstrate deep rooted societal issues[13].

[11] Macpherson, W. (1999) *The Stephen Lawrence inquiry*
[12] The Association of Directors of Public Health London (2021) *Policy position: Supporting Black, Asian and minority ethnic communities during and beyond the COVID-19 pandemic.*
[13] Allen, G. and Zayed, Y. (2021) *Hate crime statistics*. House of Commons Library.

Figure 5: Number of recorded hate crimes based on Home Office statistics for 2021

Police recorded hate crimes by monitored strand
England & Wales, year ending 31 March

	2012	2013	2014	2015	2016	2017[c]	2018[c]	2019[d]	2020[e]	2021	% Change 2020 to 2021	% Change 2012 to 2021
Race	32,969	33,116	34,874	39,666	45,440	58,294	64,829	72,051	76,158	85,268	+12%	+159%
Religion	1,438	1,421	2,067	3,006	3,962	5,184	7,103	7,202	6,856	5,627	-18%	+291%

Racially motivated hate crime in England spiked following the EU referendum, 2017 terrorist attacks and the Covid-19 lockdown[13].

Between 2017 and 2020, 0.9% of all Black adults aged 16 and over were victims of racially motivated hate crime compared to 0.1% of White adults, 1.0% of Asian adults and 1.1% of other ethnic minority groups, with the White Other group being most affected[13] (Figure 6).

Figure 6: Percentage of adult victims of racially motivated hate crime by ethnicity based on Home Office statistics for 2021

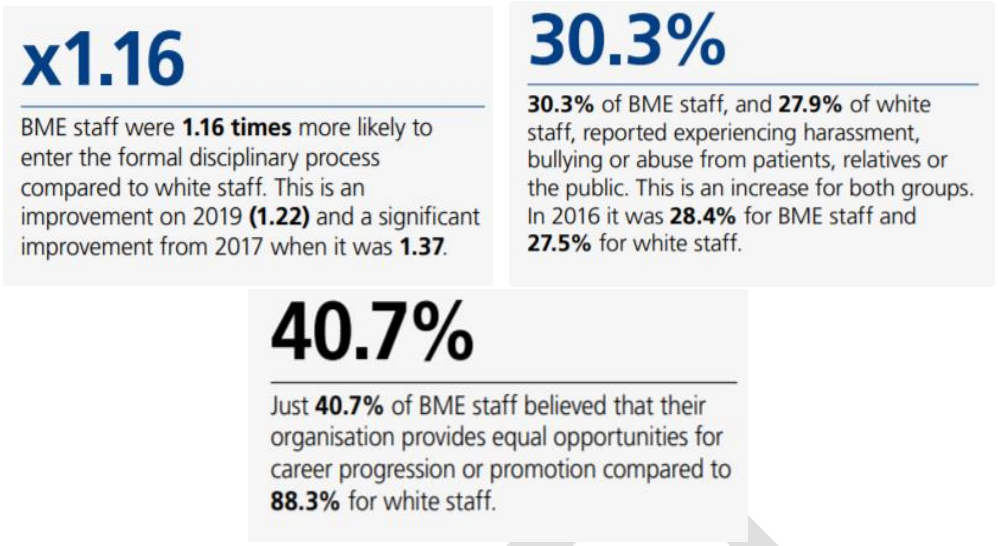
Percentage[a] of adults aged 16 and over who were victims of racially-motivated hate crime, by ethnicity and religion
England and Wales

	2007/08 & 2008/09	2009/10 to 2011/12	2012/13 to 2014/15	2015/16 to 2017/18	2017/18 to 2019/20
Ethnic group[b]					
White	0.1	0.1	0.1	0.1	0.1
Mixed/multiple ethnic groups	3.0	0.9	1.1	0.5	0.3
Asian/Asian British	2.1	1.8	1.0	1.1	1.0
Black/African/Caribbean/Black British	1.7	0.8	0.7	0.6	0.9
Other ethnic group	2.0	1.5	0.8	1.0	1.1

There is clear evidence that racism has a detrimental effect on health and those who experience it have worse outcomes across many areas of mental and physical health.[14]People from Black, Asian and Ethnic Minority (BAME) backgrounds are more likely to have a negative experience of health care, which may include insensitivity and racism, and may limit access to those vital services, e.g. racism may cause delays in treatment and mistrust in services.**Error! Bookmark not defined.** Prejudice exists within the NHS staff towards BAME staff and more bullying and harassment has been reported by BAME staff compared to White British staff[15]. (Figure 7)

[14] White, M. (2020) *What are the effects of racism on health and mental health?* Medical News Today
[15] National Health Service (2021) *Workforce Race Equality Standard. 2020 Data analysis report for NHS Trusts and Clinical Commissioning Groups*

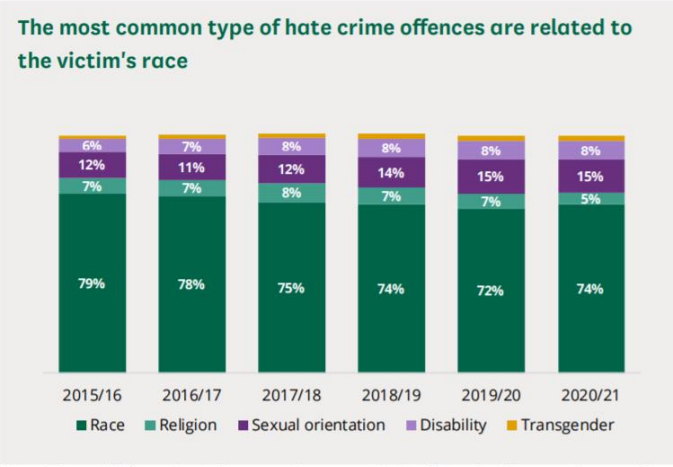
Figure 7: NHS staff statistics from NHS England 2021[15]



Key findings [INFOGRAPHICS]

Headline: **West Midlands has the second highest rate for racially motivated crimes across all Police Force Areas in England and Wales**
West Midlands – 269 per 100,000 population
Metropolitan Police – 224 per 100,000 population
England and Wales average – 208 per 100,000 population

Headline: **Proprtion of racially motivated hate crime in England in 2020-21**
74%
[refer to the stats below]



Notes: It is possible for a crime to have more than one motivating factor. For this reason the sum of the percentages of the FIVE motivating factors exceeds a 100%.

Headline: **Proportion of British adult (16+ yrs) victims of racially motivated hate crime**
Black adults – 0.9%
White adults – 0.1%

Headline: **Risk of disciplinary action against NHS staff**
BME staff have a 1.16 times higher risk than White staff

What did we find from the community & Board engagement?

"As I entered the surgery the GP said to me: *So many people from your country coming in with HIV!'"*
Lewisham community member

"The NHS staff have to be anti-racist, not just less racist."
Birmingham community member

"[Services] take all Black people to be the same."
Lewisham community member

Throughout the review, participants from across the community shared with us their own stories of lived experience of racism and discrimination. Most of these stories reflected on the structural and systemic issues of racism and discrimination present within some areas of public services, such as the NHS and the Criminal Justice System.

Stories about the experiences of racism and discrimination emerged at every discussion and engagement session during the review highlighting their deep and widespread impact on health and wellbeing, particularly on mental health and wellbeing.

The most common issues raised by the communities included:

- Racially charged/discriminatory language from healthcare professionals
- Racial abuse and attacks experienced in childhood having a traumatising effect and potentially lifelong negative impacts on self-esteem and mental wellbeing
- The use of colour language in ethnic coding having the potential to create bias and negative associations from the very first point of contact
- The importance of recognising and understanding the differences in different communities' history and experiences as even within the African and Caribbean communities there are important and significant differences between different nationalities and cultural identities.

The review welcomed the brave and difficult discussions throughout this segment of the process and highlighted the need for the public sector to invest in creating more spaces for an open and authentic exploration of racism and discrimination in ways that support individuals to be safe in their exploration and learn together from others' lived experience.

Opportunities for action

Theme 1: Racism and discrimination	
Who	**Opportunities for action**
Local Councils and Health and Wellbeing Board Partners	1. Pilot the removal of the colour language from ethnic coding and evaluate the impact on participation and experience of data collection.
Local Councils and Children's Trusts	2. Pilot the integration of discrimination and racism into the approaches to adverse childhood experiences and recognise this both in the assessment of children's needs and in the design of interventions to mitigate these adverse impacts.
Local Councils and Health and Wellbeing Board Partners	3. Review staff equality and diversity training to ensure that this is a core part of the delivery of training, co-delivered by diverse individuals with lived experience.

Local Councils and Education Partners	4. Work with education partners for all ages and local communities to explore how ethnic diversity can be further integrated into education to reflect the diverse cultures and various perspectives of history and experience.

Theme: Maternity, parenthood and early years

"It's been so bad for so many years, I don't think Black women will ever trust the NHS again."

BLACHIR engagement participant

The physical and mental health of parents are essential for the development of children with mothers playing an important role after conception and then from birth. The way in which they are supported during pregnancy can affect not only the first few years of a child's growth but also their prospects into adulthood.

In the UK, Black women are five times more likely to die in pregnancy or childbirth than White women.[16] During the Covid-19 pandemic, 55% of pregnant women admitted to hospital with coronavirus were from ethnic minority backgrounds.[17]

Prevention and early intervention are most effective when delivered in those early life stages. Prof. Sir Michael Marmot[18] who wrote the study Fair Society, Heathy Lives (The Marmot Review) notes 'giving every child the best start in life crucial to reducing health inequalities across the life course.' The *"first 1,000 days of life"* for lifetime health and wellbeing opportunities and outcomes is now recognised as critical[19].

We present the main findings from the evidence review, community engagement and stakeholder group sessions. The members of the boards suggest Opportunities for action to help improve support for African and Caribbean parents and children.

What did we find from the rapid review?

In local data, there were some interesting differences between the two areas.

Maternity

The outcomes for infant death and low birth weight in Birmingham is consistently poorer compared to England and Lewisham. In Birmingham, the highest infant mortality rates in the BLACHIR communities were found in mothers born in the Caribbean (9.0 deaths per 1000 live births) and Central Africa (8.3 deaths per 1000 live births) and this has remained so over time.[20]

Babies of Black or Black British ethnicity have greater than two times the risk of still birth than those of White British ethnicity.[21]

There are increasingly positive outcomes for continuity of care for Birmingham's Black African, Black Caribbean, and Black Mixed ethnicity mothers (Figure 8).

Pre-term birth rates are higher for Birmingham's Black Caribbean and Black Other women in 2020 compared to Black African and White British women (Figure 9).

[16] MBRRACE-UK (2021) *Mothers and Babies: Reducing risk through audits and confidential enquiries across the UK*
[17] Royal College of Obstetricians and Gynaecologists (2020) *RCOG and RCM respond to UKOSS study of more than 400 pregnant women hospitalised with coronavirus*
[18] Marmot, M. et al. (2020) *Health Equity in England: The Marmot Review 10 Years on*
[19] House of Commons Health and Social Care Committee (2019) *First 1000 days of life.*
[20] Public Health England (2016) *Infant and perinatal mortality in the West Midlands*
[21] Office for National Statistics (2021) *Births and infant mortality by ethnicity in England and Wales: 2007 to 2019*

Emergency caesarean rates, from 2019 to 2020 for Black women, show an increase across all groups with higher rates seen in Black African women. However, there is a need to compare to the service standards as this can be an indicator of high-risk pregnancy or underlying medical conditions (Figure 10).

Parenthood and early years

The evidence base around parenting and early years that is specific to Black African and Black Caribbean communities is very limited in a UK context. The academic evidence highlighted the following issues driving inequalities in early years outcomes:

- Socioeconomic factors
- Barriers to accessing prenatal, postnatal, and maternity services
- Lack of culturally competent and sensitive approaches
- Poor perinatal mental health support
- Parental feeding practices such as greater eating pressures and concerns
- Black men and young Black women facing barriers and stigmatisation
- Intergenerational care not being recognised as an obvious aspect of family care.

Fewer children are assessed as being school ready at the end of Reception in Birmingham (68%) compared to England (71.8%) and Lewisham (76.4%)[22]. In 2018-19 only 68% of all Black children achieved the expected standard of development in Reception in comparison with 72% of all White children in England[23].

Key findings [INFOGRAHPICS]

Headline: **Highest infant mortality rates in Birmingham by place of mother's birth**

Caribbean - 9 deaths per 1000 live births

Central Africa - 8.3 deaths per 1000 live births

Headline: **Risk of still birth in the UK**

Black or Black British babies more 2 X more likely than White babies

Headline: **Risk of maternal mortality**

Black mothers 5 X more likely than White mothers

Headline: **Good level of development of children in Reception in England**

All White children – 72%

All Black children – 68%

What did we find from the community & Board engagement?

[22] Public Health England (2022) *Fingertips: Public Health Profiles*
[23] Office for National Statistics (2021) *Development goals for 4 to 5 Year Olds*

"The NHS staff have to be anti-racist, not just less racist"
Birmingham community member

"More people that look like me"
Birmingham community member

"If you are not counted, you do not count"
Advisory Board member

Lack of cultural awareness

Maternity care processes (pathways) do not recognise cultural differences between Black African and Black Caribbean women which can lead to barriers and result in stigmatisation and stereotyping. There is a need to develop and apply a pregnancy needs assessment model inclusive of lived experiences and accounting for cultural traditions. Community led initiatives or models should be considered.

Conscious and Unconscious bias

Communities told us that healthcare professionals tend to have more dismissive attitudes towards ethnic minority women, preventing them from accessing services. The uniting of education, policy and practice through cultural competency (understanding) training could remove bias and stereotypical views which influence assumptions and treatment.

The bias was also visible and present in the way data on ethnicity and culture are collected by services and there seemed to be a conscious bias to not looking at when it was collected. There are significant gaps in collecting and using data about ethnicity to understand the inequalities and underpin needs assessments as well as provision of appropriate services and the discussions with community highlighted the need for this to be much more granular and not lump all communities together.

"Transparency and trust are words that have very little meaning in many deprived areas of Birmingham."
BLACHIR engagement participant

Opportunities for action

Theme 2: Maternity, parenthood and early years	
Who	**Opportunities for action**
Local Integrated Care Systems (ICS) and NHS Provider Collaboratives	1. Address any gaps in existing Maternity and Paediatric Health Professionals' training including topics on cultural awareness, learning from lived experience, awareness of inclusion practices and policies, and awareness of trauma caused by racism and discrimination and how to deliver sensitive care.
Local NHS Integrated Care Systems (ICS)	2. Co-design online tool with communities to collect information on beliefs, cultural practices and traditions from ethnic groups. This resource could then be used for training to inform practice and communication with patients and service users.

Local Maternity System Partnerships and Health Child Programme Providers	3. Improve data collection by specific ethnicity in maternity and early years services considering the differences in ethnic background and nationality. Work with professionals who represent the ethnic minority groups to ensure a sensitive approach when collecting data.
Local Maternity System Partnerships (LMS) working with Local Council Housing Teams	4. Support all women who are migrants, refugees, and asylum seekers, particularly those with no access to public funds, to access appropriate care during and post pregnancy, through appropriate support and protecting them from relocation or eviction.
Local Public Health and NHS services	5. Develop culturally specific and appropriate weaning support initiatives for Black African and Black Caribbean parents.

Theme: Children and young people

"I had Black teachers who acted as good role models."
Birmingham community member

"[I am] reluctant to go out because I don't fit."
Young Lewisham community member

*"Food poverty is caused by **the social exclusion** and spiralling associated costs for many living in these communities."*

BLACHIR engagement participant

Black children in the UK are now the second largest group living in poverty after White children. These are households defined as being below 60% of the median and it is the standard definition for poverty.[24]

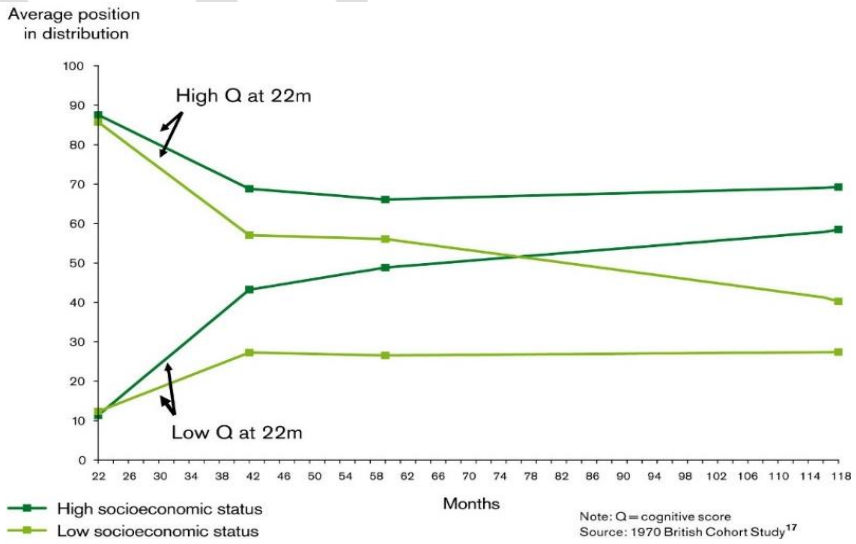
We focused in this review on the data and literature reporting the health inequalities and determinants for Black African and Black Caribbean children and young people (CYP).

So, why are children from these communities missing out on opportunities that lead to better health and life experiences?

Inequality is the main reason and can be seen in the children and young people's wider family and home environment. There is also significant evidence to suggest that these important earlier years can determine health inequalities over a lifetime.

We refer again to the seminal Marmot Review that explains where we sit in society and determines economic benefits. It presents the evidence that those with lower intellectual ability but with higher social status can overtake higher intellectual potential with lower social status in the early years by the time children are 7yrs old as demonstrated in Fig. 13.

Figure 8: The Marmot Review: Inequality in early cognitive development of children in the 1970 British Cohort Study, at ages 22 months to 10 years[18]



[24] Sparrow, A. (2022) *More than half of UK's Black children live in poverty, analysis shows*. The Guardian

Across both Councils there are clear commitments to reducing the social gradient (being less advantaged) in skills and qualifications, ensuring school, families, and communities work in partnership to reduce the gradient in health, wellbeing and resilience and improving access and use of quality lifelong learning across the social gradient.

We know that children and young people thrive in warm, stimulating, and safe homes with loving and supportive caregivers. But for Black African and Black Caribbean people inequalities often caused by structural racism can impact on being able to access parental help across health and social services when things are challenging and this in turn impacts on children.

One of the ways that we think about challenges to this positive thriving environment is through the ACE framework. The Adverse Childhood Events framework considers things that might happen to a child that have been shown to have impact on their lives in the short term and across the whole of their lifetime.

Adverse childhood events (ACE) are:

1. physical abuse
2. sexual abuse
3. psychological abuse
4. physical neglect
5. psychological neglect
6. witnessing domestic abuse
7. having a close family member who misused drugs or alcohol
8. having a close family member with mental health problems
9. having a close family member who served time in prison
10. parental separation or divorce on account of relationship breakdown.

Exposure to ACE does not automatically mean that children are 'destined' to have worse outcomes but it does highlight the potential risk, especially of negative health behaviours such as smoking, and the risks that come from having less well established personal and social connections and resilience. ACE exposure should not be used to label children but is a prism through which we can identify and consider need and step in earlier to support children and young people to achieve their potential.

There are already calls in academic papers racism to be considered *"an ACE exposure risk factor, a distinct ACE category and a determinant of post-ACE mental health outcomes among Black youth"*[25]. This reflects the sustained and long term impacts of racism on young people that can persist into adulthood and was a discussion that was reflected strongly in the Review.

What did we find from the rapid review?

We included data analysis of outcomes for children and young people locally and nationally, and a literature review of 65 sources.

Children and young people in Black ethnic groups have higher proportions of:

[25] Bernard, D. L. et al. (2021) 'Making the "C-ACE" for a culturally-informed Adverse Childhood Experiences framework to understand the pervasive mental health impact of racism on Black youth,' *Journal of Child & Adolescent Trauma* 14, pp 233-247. doi:10.1007/s40653-020-00319-9

- excess weight[26]
- living in low-income families[27]
- low birth weight[28].

Children and young people in Black Caribbean groups have significantly worse levels of:

- readiness for school[29]
- not (being) in Education, Employment or Training (NEET)[30].

The recent national YMCA research report: *Young and Black, The Young Black Experience of Institutional Racism in the UK* (October 2020)[31] emphasised four main issues:

- Racist language (school & workplaces) – 95% & 78%
- Stereotypes & pressure to conform – 70% & 50%
- Employer recruitment prejudice – 54%
- Distrust in police & NHS - 54% & 27%.

Black African and Black Caribbean children and young people often suffer the greatest inequalities resulting in Black Caribbean children and young people being 2.5 times more likely than a White British child to be permanently excluded.[32]

However, it must be noted that limited data by specific ethnicities and the lack of evidence doesn't mean inequalities are absent. We must avoid assumptions in the shared outcomes between Black Caribbean and Black African communities.

We are all in it together?

"Healthcare workers have been exposed to risk for years long before COVID."
BLACHIR engagement participant

As we have discussed in the introduction and will continue to reference in this review, Black ethnicities are more likely to be diagnosed or die from COVID-19. Statistics revealed that Black Caribbean and Black Other ethnicity categories have a 10-50% increase in deaths compared to other groups.[33]

The COVID-19 pandemic and our response to the virus had an unfair impact on minority ethnic households. People from these groups have reported greater financial impact leading to an increased use of food banks because their basic needs were not being met. For example, the IFS found that Black African and Black Caribbean men were both 50% more likely than White British men to work in shutdown sectors (areas that had been closed due to the initial lockdown).[34]

Whether the virus's impact is on an individual, or indirectly through a family member, the negative result of COVID-19 is likely to be greatest on Black children and young people given increased exposure to five risk factors:

- Negative financial impacts

[26] Office for National Statistics (2020) *Overweight children*
[27] Birmingham City Council (2022) *Supporting healthier communities*
[28] Office for National Statistics (2021) *Births and infant mortality by ethnicity in England and Wales*
[29] Office for National Statistics (2021) *Development goals for 4 to 5-year olds*
[30] Powell, A. (2021) *NEET: Young people not in education, employment or training. UK Parliament: House of Commons Library*
[31] YMCA (2020) *Young and Black. The young Black experience of institutional racism in the UK*
[32] Office for National Statistics (2021) *Statistics: Exclusions*
[33] Public Health England (2020) *Disparities in the risk and outcomes of Covid-19*
[34] House of Commons. Women and Equalities Committee (2020) *Unequal impact? Coronavirus and BAME people*

- Unemployment
- Bereavement
- Mental health issues
- Widening educational gap related to socioeconomics (status in society).

Black and minority ethnic young people have shown more increases in seeking help for mental health during the first wave of the pandemic than White young people.[35] While not identified by the literature, disproportionate COVID-19 deaths in Black and minority ethnic communities are likely to have created unequal levels of bereavement in children and young people.

Physical health
There are limited indicators for physical health in children and young people which can be reviewed in the context of ethnicity.

Black African and Black Caribbean girls have a higher body mass index (BMI) than White girls at age 11-13 (data for boys it was unclear with variation between studies). However, BMI was shown to overestimate the negative health effects of being overweight or obese in Black children because it fails to account for body composition. The body fat on average is lower in Black children and their increased height plays a part too.

The overweight and social economic status (SES) patterning varied by ethnicity with lower SES awarding higher risk of being overweight or obese for White children than Black children. However, for adolescents having overweight or obese parents could suggest they may be on the path of following suit.

Mental health and emotional wellbeing
Black African and Black Caribbean children and young people generally reported higher levels of mental wellbeing than White participants in the same studies. However, one study found that Black Caribbean children described higher levels of social difficulty at seven years old. Family activities and cultural integration (identified as ethnically diverse friendship circles) were also shown to have a protective 'bubble' effect.

Risky behaviours
White and Mixed ethnicity young people reported higher levels of substance misuse than Black young people, and Black Caribbean young people were most likely to report having unprotected sexual intercourse. Black African young people generally had fewer risky behaviours than Black Caribbean young people.

Physical activity levels were not lower in Black children, but cultural factors may affect parents' engagement with out-of-school sporting and exercise activities.

Educational attainment
Black African and Black Caribbean children on average report higher levels of aspiration than White children in areas including school. However Black Caribbean pupils on average have lower levels of academic attainment, including after adjustment for socioeconomic status (SES). The determining factors such as status in society and family achievement explain some but not all the reasons for poorer results. Black Caribbean and Black African children are less likely to be entered into higher-tier examinations by teachers compared to White children even where prior academic attainment is the same, so this is limiting their grades.

The high achievement by Black children was associated with a range of individual, family and school factors. Individual factors included good attendance at school, completing

[35] Campbell, D. (2020) *Covid-19 affects BAME youth mental health more than White peers – study*. The Guardian

homework, aspiration to attend school beyond GCSE and the development of resilience, protecting against negative school experiences. Family factors included maternal education and employment with parental involvement in education. The education factors included the recognition and celebration of cultural diversity especially the cultural identities of Black pupils in the school setting.

Social inclusion
Black young people in contact with Youth Offending Services may not have equal access to healthcare, with mental health needs less likely to be identified and supported. Young Black men's early exposure to 'adult' styles of policing may create feelings of unsafety and social exclusion.

Black children's on-average over-representation in the care system is heavily characterised by SES, locality, and type of intervention. The variation includes under-representation in more disadvantaged areas compared to White children, but over-representation in less deprived areas compared to White children.

In Black African and Black Caribbean populations engagement with a variety of health services may be lower, including immunisation, Child and Adolescent Mental Health Services (CAMHS), and being registered with a dentist. The causes of variation will be noted to sub-populations, with culture, language and prior experience of health services affecting individuals' engagement.

Key findings [INFOGRAHPICS]

Headline: **Black children and young people are more likely to:**

- be overweight
- live in low-income families
- be identified as NEET (Not in Employment, Education or Training)

Headline: **Child poverty in the UK**
Black children are now **more than twice** as likely to be growing up poor as white children

Headline: **Black child poverty in the UK**
The proportion of Black children living in poverty went up from 42% in 2010-11 to 53% in 2019-20

Headline: **Permanent exclusions in the UK**
Black Caribbean children and young people are 2.5 times more likely to be permanently excluded than White British children

What did we find from the community & Board engagement?

In Birmingham, Black young people were consulted as a group, whilst in Lewisham, we conducted one-to-one interviews. This gave us the opportunity to understand their overall experiences including those in education, physical environment, family, social environment, money, employment, and activities that influenced health.

Positive changes in health behaviour

The conversations being heard in our engagement activities with local communities were very different. We discovered that the participants all took part in physical exercise and had

access to healthy food. Young people's primary school educational experience was positive, and they had lots of support. Inevitably, as the participants became older, they encountered more social and emotional challenges in life.

What did young people say?

Physical environment and family

"Having to move from my family to foster care was very scary, not knowing where I was going at the time affected me mentally."

Food

"Chicken and chips after school, for a lot of people is a trendy thing to do and I am not sure if people generally want it."

Belonging

"Especially in university because I felt like I no longer fit into Lewisham (and with friends I had growing up) and neither did I fit in the university context."

Opportunities for action

Theme 3: Children and young people	
Who	**Opportunities for action**
Education settings supported by the Regional Schools Commissioner and local Councils	1. Provide guidance and support for Black African and Black Caribbean parents and young people on applications and transition to secondary school and further education, including online information, support liaison officers, summer schools on core subjects and finance advice.
Local Integrated Care Systems (ICS), Mental Health Trusts & Council commissioned Healthy Child Programme Providers	2. Commission and develop culturally appropriate and accessible services, including schools-based support, for Black African and Black Caribbean young men and women to increase capability, capacity and trust to engage with services. This should be specifically actioned for mental health services and for sexual and reproductive health services and take into account issues around gender exploitation and gender based violence.
Education settings supported by the Regional Schools Commissioner and local Councils	3. Review educational approach and opportunity for targeted intervention to increase academic achievement for Black African and Black Caribbean children and young people.
Local Health and Wellbeing Board and NHS Integrated Care System	4. Address low pay and associated poverty for frontline workers who are disproportionately of Black African and Black Caribbean heritage.
Local Council Director of Children's Services and Strategic Children's Partnerships	5. Work with trusted community centres and spaces to provide violence-free, accessible and attractive youth provision for access to wider opportunities, including through existing contracts and partnerships with Black-owned businesses and leaders.

Local Councils and climate change and air quality partners	6. Collaborate with African and Caribbean communities and their leadership on addressing air quality issues and continue with the in-depth work already in place with explicit consideration of these communities.
NHS Integrated Care Systems and Health and Wellbeing Board	7. Put in place interventions for Black African and Black Caribbean children and young people that address specific inequalities (e.g. sickle cell disease services), ensuring proportionate targeting and equality assessments of whole population interventions for issues they are disproportionately impacted by (e.g. low traffic neighbourhoods and school streets).

Theme: Ageing well

"Black people in their 50s and 60s have significantly lower weekly income than their White peers, are less likely to own their home outright and are more likely to live in deprived areas".

Centre for Ageing Better[36]

One of the ways of considering how well people are living in later life is to look at healthy life expectancy, this is a measure of the number of years and individual living in a particular area can expect to live without chronic disease or disability and it is calculated at birth and at 65yrs.

Within the UK, males at age 65 in the least deprived areas could expect to live 7.5 years longer in "Good" health than those in the most deprived areas. For females, the difference is 8.3 years.[37] Within Birmingham, the difference in life expectancy when comparing the most deprived and least deprived areas is 8.9 years for males and 6.6 years for females.[38] Between the most and least deprived areas in Lewisham, there is a difference in life expectancy of 7.4 years for males and 5.6 years for females.[39] People living in the most disadvantaged areas of England spend nearly a third of their lives in poor health.[40]

According to the Office for National Statistics, a disproportionate percentage of those living in the ten per cent most deprived neighbourhoods are from ethnic minorities. 15.6% of Black African people and 14.1% of Black Caribbean people live in the most 10% of deprived areas.[41] This correlation between ethnicity and place is particularly important for older adults who are less likely to move between areas in later life, this makes 'place based approaches[42]' even more important for older adults from ethnic communities.

The British Medical Journal (BMJ) discusses in an article: "older people from ethnic minorities are one of the most disadvantaged and excluded groups in society. Understanding the pathways leading to ethnic inequalities in older age requires research on these complex processes and how they link different life experiences to health and social outcomes in later life. This nuanced understanding would allow us to develop responses to these inequalities."[43]

We discussed several themes and trends relating to the health inequalities experienced by Black African and Black Caribbean older adults:

- Life expectancy
- Chronic conditions
- Suicide
- Loneliness
- Mental Health
- Frailty falls and hip fractures.

[36] Centre for Ageing Better (2020) *Ethnic inequalities among over 50s revealed in new research*
[37] Office for National Statistics (2016) *Population, People and the Community: Healthy life expectancy at birth and age 65 by upper tier local authority and area deprivation: England, 2012 to 2014.*
[38] Public Health England (2018) *Protecting and improving the nation's health*
[39] Lewisham Health Inequalities Toolkit (2021)
[40] Public Health England (2018) *Chapter 5: Inequalities in Health*
[41] Office for National Statistics (2020) *People living in deprived neighbourhoods*
[42] Public Health England (2021) *Place-based approaches for reducing health inequalities: Main report*
[43] Bécares, L., Kapadia, D. and Nazroo, J. (2020) 'Neglect of older ethnic minority people in UK research and policy', *British Medical Journal* 368, doi:10.1136/bmj.m212

Health behaviours influences include:

- Smoking
- Physical activity
- Diet
- Drugs
- Alcohol
- Vaccinations.

Wider health determinants include:

- Income and debt
- Housing
- Education and skills
- Natural and built environment
- Access to goods and services
- Racism and discrimination.

What did we find from the rapid review?

Smoking: The rates remain high for White British and Black Caribbean men. Elderly smokers are twice as likely as non-smokers to develop certain cataracts, and smoking can double the likelihood of developing advanced diabetic retinopathy.[44]

Indicators of wellbeing: In older people aged 65 to 74 it was revealed that Black people are more likely to report life satisfaction and happiness compared to White people. However, some were also likely to report anxiety compared to other groups.

Depression: There is some evidence of a higher prevalence of depressive symptoms within the Black Caribbean communities than people of White ethnicity; in addition, being aged 75 and above combined with being from an ethnic minority community is a risk factor for loneliness.[45] [46]

Dementia: Black African and Black Caribbean communities have a higher prevalence of dementia (9.6%) than in White groups (6.9%). They are also at risk of developing vascular dementia nearly eight years earlier than their White British counterparts[47].

Cancer: While the overall rate of emergency colorectal cancer surgery is reducing, elderly patients, those from a lower income background and Black African and Black Caribbean patients remain at high risk of emergency attendance.[48]

Falls: Black women are at higher risk of death after a fall compared to White women. Exploring frailty, falls, and hip fractures by gender, older black Caribbean women are more at risk of frailty than men of the same age.[49] [50]

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[44] National Health Service (2022) *Smoking and your eyes*

[45] Scharf, T. et al. (2002) *Growing older in socially deprived areas: Social exclusion in later life*. Help the Aged.

[46] Victor, C. R., Burholt, V. and Martin, W. (2012) 'Loneliness and ethnic minority elders in Great Britain: an exploratory study,' *J Cross Cult Gerontol* 27(1), pp 65-78. doi: 10.1007/s10823-012-9161-6.

[47] Adelman, S. et al. (2011) 'Prevalence of dementia in African–Caribbean compared with UK-born White older people: Two-stage cross-sectional study,' *British Journal of Psychiatry*, 199(2) pp 119-125. doi:10.1192/bjp.bp.110.086405

[48] Askari, A. et al. (2015) 'Elderly, ethnic minorities and socially deprived patients at high risk of requiring emergency surgery for colorectal cancer,' *Gut*

[49] Klop, C. et al. (2017) 'The epidemiology of mortality after fracture in England: variation by age, sex, time, geographic location, and ethnicity,' *Osteoporos Int*. 28(1), pp 161-168. doi: 10.1007/s00198-016-3787-0.

[50] Williams, E. D., Cox, A. and Cooper, R. (2020). 'Ethnic differences in functional limitations by age across the adult life course', *The Journals of Gerontology* 75(5), pp 914–921

Cardiovascular: The risk factors are higher in Black Caribbean populations compared to the White population.[51]

Death at home: This was significantly less likely in Black African and Black Caribbean individuals. Compared to the White population, Black Africans and Black Caribbean's are less likely to die at home (52% and 22%, respectively). The evidence suggests that African and Caribbean older adults make end-of-life decisions with a significant emphasis on family structure, religion and spirituality, cultural identity, migration, and communication. Other research suggests the differences become barriers when trying to access specialist care in various settings.

The main causes of inequalities in this age group are:

- poorer mental health for people of Black ethnicity
- higher deprivation levels
- barriers in accessing specialist care in different healthcare settings
- lack of culturally competent and sensitive approaches
- lack of culturally and religiously sensitive services to support with end-of-life care.

Key findings [INFOGRAHICS]

Headline: **Scores of wellbeing in older people (65-74 years) by ethnicity (out of 10)**

- Life satisfaction – Black (7.9), White (7.7)
- Happiness – Black (8.0), White (7.7)
- Worthwhileness - Black (7.9), White (7.9)
- Anxiety - Black (3.2), White (2.7)

Headline: **Dementia prevalence by ethnicity**
Black people – 9.6%
White people – 6.9%

Headline: **Risk of developing cardiovascular dementia**
Black African and Black Caribbean 10 years earlier than other ethnic groups

Headline: **Proportion of deaths at home by ethnicity**
White population – 52%
Black Africans and Black Caribbean's - 22%

[ADD IMAGE BELOW AS INFOGRAPHIC]

[51] Birmingham City Council (2021) *What is the impact of health inequalities on Black African and Black Caribbean older people in the UK?*

What did we find from the community and Board engagement?

Accessibility
We need to gather further research on the accessibility issues older Black African and Black Caribbean individuals face when accessing good quality care and health screening opportunities. We can consider topics such as othering (not fitting in with the norms of a social group) and deprivation. Surveys will help us to obtain the information about the lived experience using focus groups from this community.

Cultural expertise
Cultural expertise needs to improve through providing cultural awareness training in care homes and hospitals. The needs of older Black African and Black Caribbean individuals must be met in an institutional setting. This can be achieved by using a peer development support model.

Unpaid care
To achieve better understanding through a specialised focus group with older Black people and their unpaid carers. This will help us to understand the experience older adults face within social care services and the reasoning for opting to care at home rather than in an institutionalised setting.

End of life treatment
A personalised end of life care treatment programme needs to be put in place for older Black African and Black Caribbean people based upon better cultural understanding. This will be co-developed with the individual and their carer to appreciate family practices and the importance of culturally sensitive issues.

Training
Elderly Black African and Black Caribbean people have different cultural attitudes to care and support needs. It is important to think beyond faith settings to engage with older Black African and Black Caribbean adults appropriately. There is a need to provide training to ensure expertise in cultural awareness for health care professionals.

Community
Black African and Black Caribbean older adults frequently suffer from loneliness and isolation. However, there is a lack of evidence to suggest whether interventions offering tailored support for elderly Black African and Black Caribbean adults effectively reduce loneliness and isolation.

Opportunities for action

Theme 4: Ageing well	
Who	**Opportunities for action**
Regional NHS England teams and Local Public Health teams	1. Provide targeted and culturally appropriate screening services Black African and Black Caribbean older adults.
Local Public Health Teams	2. Campaign to raise awareness and increase uptake of community-based NHS health checks in Black African and Black Caribbean older adults.

NHS Integrated Care System Boards	3. Assess the availability of culturally aware services for mental health and evaluate current services to determine how they meet the needs of older Black African and Black Caribbean adults.
NHS England and NHS Integrated Care System Boards	4. Support initiatives to improve uptake of vaccinations in older African and Caribbean people, focusing on areas of higher deprivation.
Local Health and Wellbeing Boards and NHS Integrated Care System Partnerships	5. Use life course approach and consider relevant findings from this Review to develop interventions that help to mitigate health inequalities experienced by Black African and Black Caribbean older people.

Theme: Mental health and wellbeing

"There are still strong religious connections and thoughts about mental health and these needs changing and tackling as does the perception [of mental health] within the community and shame in the family."

Birmingham community member

"[Mental health is] not spoken about. Awareness raising is needed within the community as well as in the health care services."

Lewisham community member

Mental health and wellbeing are fundamental parts of our overall health, there is no physical health without mental health and we cannot be fully well without being in a positive state of wellbeing. While this is an incredibly important part of our overall health there is very limited data available on wellbeing or on mental health in African and Caribbean communities.

Stereotypes create a misconception of how people are and how they live in other cultures, religions, or countries causing problems such as discrimination and fuelling hate crimes. Negative and even positive stereotyping can lead to prejudging others based on interpreting one side of the story. These can damage individual and community wellbeing and also lead to mental health issues. Stigma is also a major barrier within communities to seeking help and support when mental health issues are developing and this can lead to worse outcomes for individuals and a vicious downwards spiral of isolation and marginalization.

We explored in this theme research literature reporting on mental health inequalities for men and women from Black African and Black Caribbean communities in the UK. As well as disproportionately high rates of mental health need, these groups face, in some circumstances, stigmatised views held by mental health service providers that Black people are dangerous, leading to misinterpretations of the nature and degree of their illnesses.

The evidence highlighted that Black African and Black Caribbean people have less access to effective and relevant support for their mental health. Where support is accessed, the experiences and results for Black individuals are often less effective and, in some circumstances, can cause harm. Therefore, BLACHIR considered mental health inequalities for topical research including collaborative community participation.

We identified evidence of inequalities in mental health experiences and results for African and Caribbean communities. The findings were reinforced by qualitative evidence from their lived experiences shared by representatives of the communities through local engagement and observations from members of the Advisory Board.

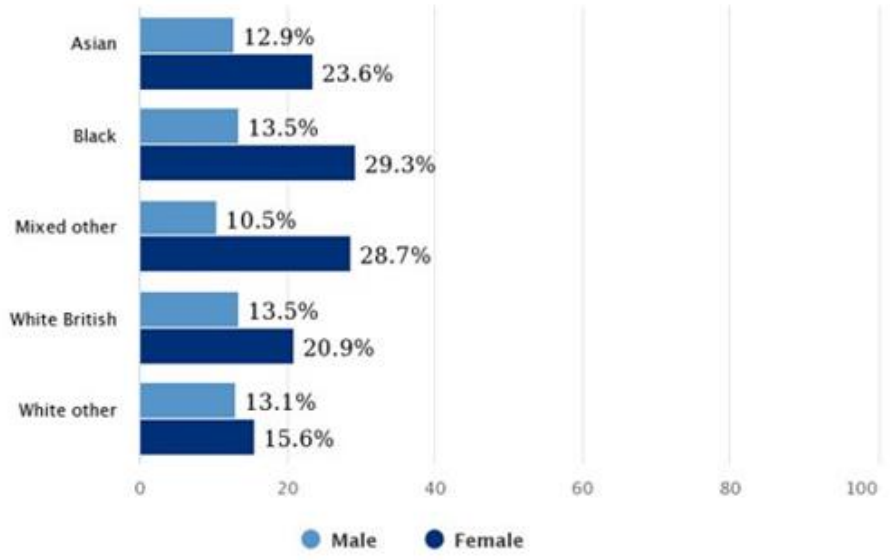
What did we find from the rapid review?

Insight was obtained from the evidence review, community engagement and stakeholder group sessions. It provides opportunities for action to improve African and Caribbean populations' access to support and services.

According to a national survey completed in 2014, 29% of Black women had experienced a common mental disorder in the past week, a higher rate than for women from all other ethnicities including Asian, White British and White other ethnic groups[52] (Figure 15).

[52] NHS Digital (2014) *Mental health and wellbeing in England Adult Psychiatric Morbidity Survey 2014*

Figure 9: The Percentage of adults who experienced a common mental disorder in the past week by sex and ethnicity



Black Caribbean young men are three times more likely to have been in contact with mental health services before committing suicide, compared to their White counterparts.[53] Psychosis was consistently higher in Black populations, in particular males; findings were less conclusive regarding depression and anxiety.**Error! Bookmark not defined.**

Despite this evidence of increased mental health need, Black African and Black Caribbean people of all ages reported to under use mental health services due to social stigma, language barriers, poor mental health literacy and reluctance to discuss psychological stress.[54]

White British people are more likely to have received treatment for emotional and mental health problems compared to all other ethnic groups (14.5%). In comparison, Black adults had the lowest treatment rate (6.5%).[55]

Looking specifically at talking therapy treatment, in the NHS Improving Access to Psychological Therapies (IAPT) there is a lower rate of Black African and Black Caribbean people being offered IAPT services, and where services are offered individual drop out is more likely.[56]

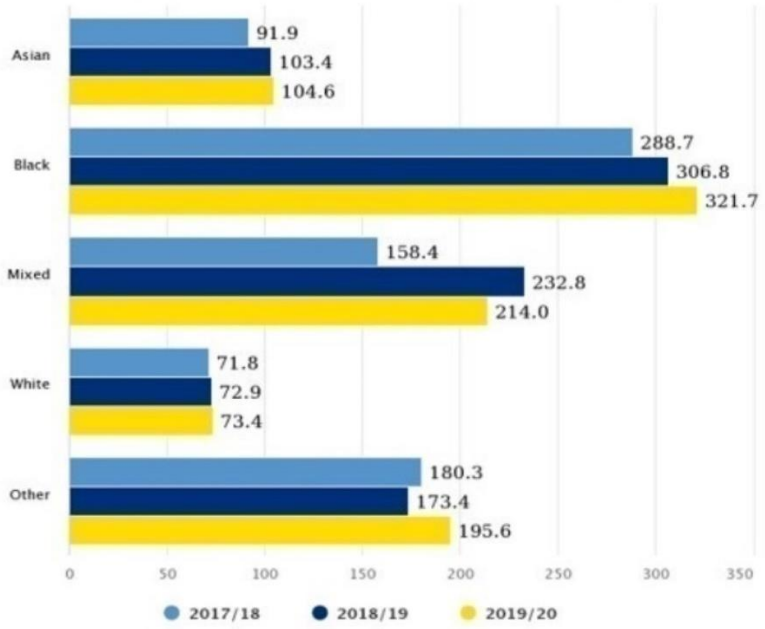
Black populations were less likely to access mental health support through traditional services. Black Africans found help from community leaders, particularly those associated with religion.**Error! Bookmark not defined.** Seeking help elsewhere, I.e. not from clinical increased the likelihood of accessing treatment at the point of crisis or breakdown. This increased risk of being detained under the mental health act and through the Criminal Justice System. Black populations were also more likely than British White populations to experience re-admission.**Error! Bookmark not defined.**

Hospital admissions for Black Caribbean and Black African patients were more frequent, longer, and often involved the police, when compared to White patients.**Error! Bookmark not defined.**

[53] Lankelly Chase Foundation, Mind, The Afiya Trust and Centre for Mental Health. (2014) *Ethnic inequalities in mental health: Promoting lasting positive change*
[54] NHS Digital (2014) *Mental health and wellbeing in England Adult Psychiatric Morbidity Survey 2014*
[55] NHS Digital (2014) *Mental health and wellbeing in England Adult Psychiatric Morbidity Survey 2014*
[56] Public Health England (2022) *Fingertips: Public Health Profiles*

One of the most serious forms of intervention for people who are mentally unwell is to detain them under the Mental Health Act. Black people are four times more likely to be detained under the Mental Health Act than White people.[57] Black Caribbean people had the highest rate of detention out of all ethnic groups (excluding groups labelled 'Other'), with 275.8 detentions per 100,000 people in the year ending March 2020. The highest rates of detention were for the Black Other, Any Other, and Mixed Other ethnic groups – but these are overestimates because 'Other' categories may have been used for people whose specific ethnicity wasn't known[58] (Figure 16).

Figure 10: The number of detentions under the mental health act, per 100,000 people, by aggregated ethnic group



There is very little data on wellbeing that can be analysed by ethnicity, the national adult population survey is not published routinely with ethnicity data. However, the Sport England Active Lives survey includes wellbeing questions for adults but the sample size means that looking at this by ethnicity in Lewisham is not possible in individual years. The most recent data from the May 2020-2021[59] survey found that:

- Nationally the average anxiety score was lower for Black participants (3.19) than for White British participants (3.51). In Birmingham the gap was even more pronounced 2.10 compared to 4.02.
- Life satisfaction scores were similar nationally between Black (6.90) and White British (6.89) participants but in Birmingham Black participants had a higher level of life satisfaction (7.74 compared to 6.51).
- The average Happiness scores were higher nationally for Black participants (7.16) than in White British (6.97) and a similar pattern was reflected in Birmingham (8.17:6.63).
- The final dimension looked at feelings of being Worthwhile. Nationally levels were similar between Black (7.28) and White British participants (7.16), but in Birmingham there were higher levels of positive responses in Black participants (8.23) than in White British(6.79).

[57] NHS Digital (2020) *Mental health act statistics, annual figures*
[58] NHS Digital (2021). *Detentions under the mental health act*
[59] Sport England (2022) *Active Lives survey data*

Key findings [INFOGRAPHICS]

Headline: **29% of Black women had experienced a common mental disorder in the past week**

Headline: **Black Caribbean young men are 3 times more likely to have been in contact with mental health services before committing suicide compared to White young men**

Headline**: Black people are 4 times more likely to be detained under the Mental Health Act than White people**

Headline: **Black adults have the lowest emotional and mental health treatment rates (6.5%) compared to White adults (14.5%)**

What did we find from the community and Board engagement?

"Racism, stigma and culture play a role in the way our communities view mental health services. Sometimes, they cause more harm than good."

Birmingham community member

"When I step out my door, I do not see the greenery I once used to see. I see a decision made by privileged White men to surround my home with large warehouses and business. Nobody thought it would affect my mental health or wellbeing, not even gave the opportunity of consultation."

Birmingham community member

Inclusion and mental health

Structural issues, such as poverty, deprivation, and racism, must be recognised as key factors contributing to African and Caribbean communities' poor mental health. Addressing this at both institutional and societal levels will create a sense of belonging in the community. The role of urban governance, including the Integrated Care System (ICS) must be explored further and strengthened. Media coverage is largely negative and stigmatising which contributes to poorer mental health outcomes.

Cultural expertise in mental healthcare

There is a lack of or limited understanding of cultural needs and backgrounds with different Black communities. Health professionals must develop better cultural understanding in mental health services when caring for Black African and Black Caribbean patients.[60]

Community support

Grassroots and faith organisations are often unfamiliar to health professionals and for that reason they are not well engaged with community assets. We must use the assets and collaborate with mental health services to provide effective support in the communities. Working with peer, personal support networks and professional networks is essential. We can skill-up more young people and community groups in mental health first aid to reduce stigma, increasing opportunities to help.

[60] Birmingham and Lewisham Black African and Black Caribbean Health Inequalities Review (BLACHIR) (2021) *Mental Health Theme: Systematic Review (sharepoint.com)*

There were concerns whether the services are appropriate and provide formal training. One individual stated that commissioned services must be “formally regulated and evaluated.”

Health literacy and early intervention were addressed as being important in mental healthcare. For that reason, mental health champions could play a vital role in community inclusion improving mental health delivery.

Opportunities for action

Theme 5: Mental health and wellbeing	
Who	**Opportunities for action**
Local Public Health and Community Mental Health Trusts	1. Coproduce awareness campaigns aimed at Black communities to promote a better understanding of different mental illnesses, facilitate early interventions and self-referral in collaboration with carers, families, health services, community and faith centres.
Local NHS providers and Community Mental Health Trusts	2. Ensure practitioners use culturally competent (cultural understanding) trauma informed patient-centred engagement styles and interventions.
NHS Mental Health Providers and Commissioners	3. Ensure mental health workers acknowledge service users’ personal histories of racism and recognise them as trauma to enable more effective intervention.
Local Health and Wellbeing Boards and NHS Integrated Care Partnerships Boards	4. Promote cultural competency training within healthcare services, the criminal justice system, and the police force.
Local Health and Wellbeing Boards and NHS Integrated Care Systems	5. Apply the use of culturally competent language, including using language that considers stigma within communities, such as ‘wellbeing’ rather than ‘mental health’.

Theme: Healthier behaviours

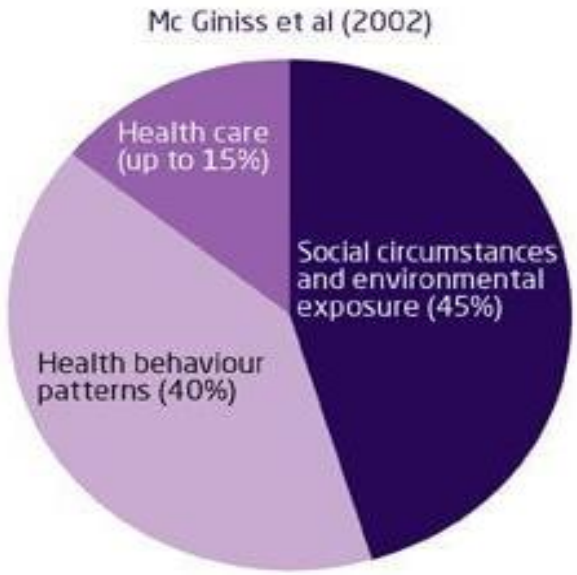
"Stop opening up fast food chains in areas of deprivation where you can get chicken and chips for £1.99 or feed a family for £9.99. Why would you sit and cook a meal for a family of five when this is on offer across the road?"

BLACHIR engagement participant

Many of the things we do each day have an impact on our health, from our diet to the amount of physical activity we take, these behaviours reduce our risk of developing conditions like diabetes and dementia and when we have illness and disease we can often improve our quality of life and reduce complications through positive health behaviours as well as clinical treatment.

Health behaviours don't happen in isolation, they are a reflection of our upbringing, our culture and heritage, our environment and social circumstances as well as our understanding of our own bodies and the health benefits of doing them. Health behaviours are a significant driver of health outcomes and the health of a population (Fig 17).

Figure 11: Broader determinants of health on population health[61]



The key behaviours that impact on the risk of death and disease are:

- Physical Activity
- Diet and nutrition
- Smoking, drugs and alcohol

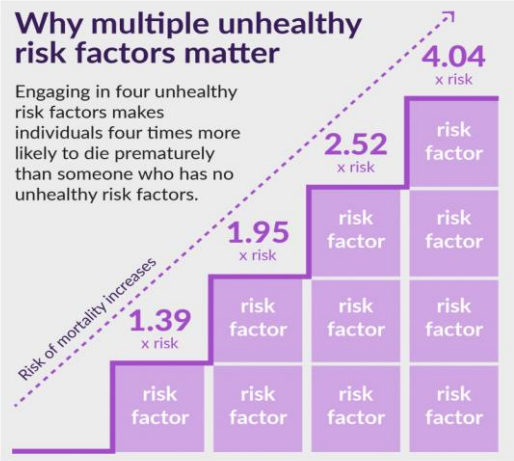
Other behaviours such as social connection are increasingly being understood as risk factors as well through the evidence of the negative impacts of loneliness on mortality risk.

Research shows that clustering and compounding unhealthy behaviors contribute to inequalities. The number of unhealthy behaviours a person has creates a multiplier effect.

[61] McGinnis, J. M., Williams-Russo, P. and Knickman, J.R. (2002) 'The case for more active policy attention to health promotion,' *Health Affairs* 21(2) pp 78-93.

After 11 years, an individual with all four risk factors had a four-fold risk of dying compared with someone who ate well, exercised and didn't smoke or drink to excess.[62]

Figure 12: The risk of mortality from engaging in unhealthy risk factors[62]



Understanding the health behaviours of Black African and Black Caribbean people in the UK, and what creates them, will help in planning effective interventions that reduce health inequalities.

Alcohol harm paradox

Disadvantaged groups can suffer greater harm with similar exposure when consuming alcohol. This has been identified as the 'Alcohol harm paradox' in a study by Alcohol research UK entitled: *Understanding the alcohol harm paradox to focus the development of intervention*.[63]

People from deprived areas who have the same or a lower level of alcohol consumption suffer greater alcohol-related harm than those from more affluent ones. Lower individual and neighbourhood socioeconomics are associated with higher rates of alcohol-related conditions and death or hospitalisation.[64]

A similar relationship can be seen in harms related to gambling where lower rates of gambling by people in poorer areas had higher rates of harm compared to people in more affluent areas.[65]

Unfair odds

"Poundland and off licences are higher in deprived areas while the healthy areas get all the fancy foods and they get the bike lanes too."
BLACHIR engagement participant

[62] Khaw, K. T. et al. (2008) 'Combined impact of health behaviours and mortality in men and women: The EPIC-Norfolk Prospective Population Study,' *PLOS Medicine*, 5(3) pp 70. doi.org/10.1371/journal.pmed.0050070
[63] Alcohol Research UK (2015) *Alcohol Research UK reports: The alcohol harm paradox, intuition school programme, social networks and alcohol identities, sight loss - Alcohol Policy UK*
[64] Bloomfield, K. (2020) *Understanding the alcohol-harm paradox: what next?* - The Lancet Public Health
[65] Public Health England (2021) *Gambling-Related Harms: Evidence Review*

The decisions we make are often influenced by our peer group, family, social status, and the wider community. A sense of belonging is important for many people and the way we behave can be shaped by the environment in which we live.

In this analysis 'fast food' refers to energy dense food that is available quickly, covering a range of outlets that include burger bars, kebab and chicken shops, chip shops, and pizza outlets. The number of fast-food outlets in local authorities across the UK ranges from 26 to 232 per 100,000 population.[66]

The UK's most deprived areas have almost 10 times more the number of betting shops than the most affluent parts of the country.[67]

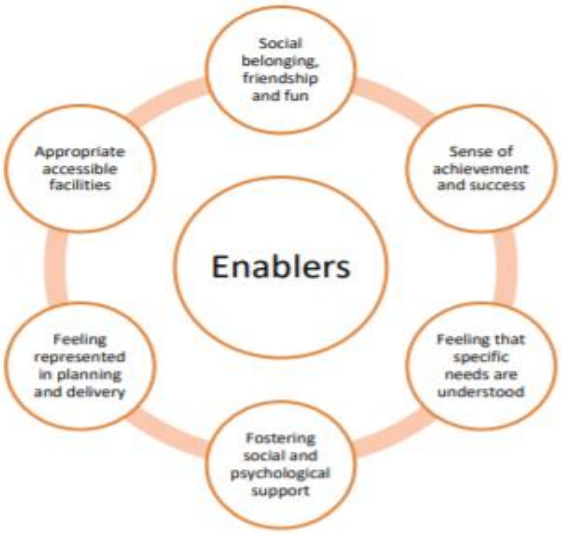
What can be done to enable behaviour change?

Figure 13: Behaviour change is a complex landscape: COM-B model of change[68]

For example, there is a call to address inequalities in the uptake of physical activity by tackling several enabling factors which contribute to behaviour change in relation to exercise.

[66] Public Health England (2018) *Fast Food Outlets: Density by Local Authority in England*
[67] Russon, M-A. (2021) *Gambling: Poorer UK towns found to have the most betting shops, study shows BBC News*. BBC News
[68] Michie, S., van Stralen, M. M. and West, R. (2011) 'The behaviour change wheel: A new method for characterising and designing behaviour change interventions,' *Implementation Sci* 6(42) doi.org/10.1186/1748-5908-6-42

Figure 14: PHE enablers of behaviour change



What did we find from the rapid review?

The rapid review looked at survey data across our populations and in the national data sets. Often national surveys do not present or analysis ethnicity at the level of local authorities for behavioural factors which limits our understanding.

The survey data highlighted the most significant inequalities are in physical activity and diet and nutrition behaviours whereas in many other areas Black populations have healthier behaviours.

Exercise

The evidence from national data analysis in the Active Lives Survey 2019/2020[69] revealed that physical activity is lower in the Black population than the White British population. This pattern was reflected in local data in the Nov 2019/20 survey %[70] for Birmingham but there were some differences for Lewisham, and overall rates of physical activity in Lewisham are higher than in Birmingham:

- Nationally the percentage of people (White British vs. Black) aged 16 years and over who were physically active between November 2019 and November 2020 were 63.1% vs. 53.3%[71].
- The percentage of Black people, aged 16yrs and over, achieving the recommended 150 minutes of physical activity every week in Birmingham was 54% compared to 53.3% nationally but in Lewisham it was much higher at 66.3%.
- The percentage of Black people achieving 30 minutes of less of physical activity, and classified as inactive, in Birmingham was 29.2% compared to 26.0% nationally but there was not a large enough sample in Lewisham to report on this.
- Nationally the percentage of physically active children and young people in Black communities (35.7%) was lower than in White British (47.7%) communities[72]. The sample of the survey is too small to provide data at a local area by ethnicity.

[69] Sport England (2021) *Active Lives Adult Survey November 2019/20 report*
[70] Sport England (2022) *Active Lives Survey Data*
[71] Department for Digital, Culture, Media and Sport (2022) *Ethnicity facts and figures - physical activity*
[72] Public Health England (2022) *Fingertips: Physical activity*

- Percentage of adults walking for travel at least three days per week (White British vs Black) – 14.7% vs 16.1% between 2019 and 2020[73].
- Percentage of adults cycling for travel at least three days per week (White British vs Black) – 2.2% vs 1.0% between 2019 and 2020[72].

Smoking

The national data for 2020 on smoking suggests that rates of current smoking are lower in Black communities than in White communities but are highest in those who identify with a Mixed ethnicity:[74]

- Mixed ethnicity – 17.1%
- White ethnicity – 12.6%
- Black ethnicity - 7.8%

Diet

We monitor dietary habits in population surveys through asking about the average daily consumption of five portions of fruit or vegetables, known as '5-a-day'. In 2017/18 nationally, the lowest percentages of those achieving '5-a-day' across ethnic groups was seen amongst Black adults (44.2% vs. 55.9% of White British adults).[75]

Alcohol

Data from 2014 showed nationally rates of those with hazardous, harmful or dependent alcohol levels was lower amongst people of Black ethnicity. 6.6% of Black men were featured in this category, compared to 30.8% of White British men. A similar pattern was observed amongst women (Black women = 7.4%; White British women = 14.8%)[76]

Sexually transmitted infections

The population rates of STI diagnoses is high among people of Black ethnicity nationally but varied amongst Black Caribbean and Black African ethnic groups. For example, in 2020, people of Black Caribbean ethnicity had the highest diagnosis rates of gonorrhoea and trichomoniasis, while people of Black African ethnicity had relatively lower rates of these STIs.[77]

There are also significant differences in HIV infection between Black African and Black Caribbean communities. In the 2020 data on people newly diagnosed with HIV and accessing HIV care in England there were 526 new cases in Black African people with almost 60% of these being in women compared to only 55 in Black Caribbean and 62 in Black Other ethnic groups. In Black African (42%) and Black Other (53%) the percentage of people diagnosed with HIV late was higher than for White British (38%) but it was similar for Black Caribbean (37%), it is important to note that this difference is consistent when looking just at HIV diagnosis in people most likely exposed in the UK, suggesting that late diagnosis in Black African and Black Other communities is not just due to migration factors.[78]

Adult obesity

[73] Department for Digital, Culture, Media and Sport (2020) *Ethnicity Facts and Figures – Physical Activity*
[74] Public Health England (2022) *Fingertips: Local tobacco control profiles*
[75] Department for Digital, Culture, Media and Sport (2020) *Ethnicity Facts and Figures - Healthy Eating Amongst Adults*
[76] NHS Digital (2018) *Ethnicity Facts and Figures – Harmful and Probable Dependent Drinking in Adults*
[77] Public Health England (2020) *Sexually transmitted infections and screening for chlamydia in England, 2020*
[78] UK Health Security Agency (2021) *Official Statistics. HIV: Annual data tables*

The percentages of adults who are overweight or obese is highest in people of Black ethnicity. In 2019/2020 the national data shows that 67.5% of Black adults were overweight/obese which is higher than White British (63.7%). The rates over excess weight in Black communities has decreased from 73.6% in 2018/19.[79]

Literature review

For this theme we were able to commission an academic provider to undertake a literature review. In the literature review, a total of 66 articles on Birmingham and 51 on London were included in research. Studies were dominated by the themes of mental health (n=77, 24.6%) and HIV/sexual health (n=53, 17%). There were 63 studies (20%) addressing the four areas of principal behavioural risk: physical activity (n=22, 7.1%), alcohol (n=17, 5.5%), smoking (n=16, 5.1%), diet/feeding practices (n=15, 4.8%).

This review has established that health behaviours result from a complex mix of individual and social factors. We often present individual behaviours in the context of the social circumstances in which they occur. Help seeking behaviour means, quite simply, admitting a need for support and relying on others for assistance. However, because of getting help from family, peers or the community this meant that health care was not being used as much.

More noticeable finding was, consistent to sociocultural factors (wider forces in cultures that affect the thoughts, feeling and behaviours), creating barriers to using health care services. These factors are obvious when looking at people being able to access mental health services. This is more heavily detailed in the mental health theme.

Cultural norms (the standards we live by) perceptions and practices among Black African and Black Caribbean people influenced behaviour risks to health. We could see this in people's choice of diet, how they fed their babies and young children, childhood weight and physical activity. Exposing parts of the body can be cultural and result in a barrier to seeking care because of feeling embarrassed.

Key findings [INFOGRAPHICS]

Headline: **Percentage of physically active adults by ethnicity**
White British – 63.1%
Black – 53.3%

Headline: **Percentage of adult smokers by ethnicity**
White British – 14.4%
Black – 9.7%

Headline: **Percentage of adults achieving '5-a-day' in their diet by ethnicity**
White British – 55.9%
Black – 44.2%

Headline: **Harmful or dependent alcohol consumption by ethnicity and gender**

Black men – 6.6%
White British men – 30.8%

Black women – 7.4%
White British women – 14.8%

Headline: **Obesity in adults by ethnicity**
White British – 63.7%

[79] Sport England (2021) *Ethnicity Facts and Figures – Overweight Adults*

Black adults – 67.5%

What did we find from the community and Board engagement?

The following quotes provide a summary of key findings from the engagement with members of the local Black African and Black Caribbean communities.

"Develop a positive health behaviours programme that does not require pharmaceutical intervention - this is fundamental".

"The 'big and Black is best' belief is very preached - trying to change the thoughts and attitudes towards being overweight and obese will require an entire cultural shift through populations - with the anti-establishment feelings/attitudes that exist I don't hold out much hope."

"Representation at the decision-making levels will not only help to create more appropriate strategies for our communities but also help to improve levels of trust in the system which is one of the fundamental issues."

The engagement highlighted the need for more culturally appropriate approaches to behaviour change in Black African and Black Caribbean communities and there were several discussions about how these need to recognise the barriers of trust and the need for recognition of culture and heritage in the approaches.

Opportunities for action

Theme 6: Healthier behaviours	
Who	**Opportunities for action**
Local Directors of Public Health	1. Work with Black African and Black Caribbean communities and organisations to co-create and deliver culturally appropriate and accessible support on positive health behaviours, including health literacy training, social prescribing initiatives and group interventions.
Health Education England	2. Explicitly recognise racism and discrimination as a driver of ill health and put in place training and systems to enable trauma-informed practice and services.
Local Councils and NHS Integrated Care Systems	3. Provide long-term investment for trusted Black African and Black Caribbean grass roots organisation such as faith groups, schools, voluntary and community sector organisations to deliver community-led interventions.
Local Directors of Public Health	4. Work with faith settings to understand and utilise the positive role faith plays in healthier behaviour decision making.
Research funding bodies such as National Institute for Health Research (NIHR)	5. Address the evidence deficit in interventions for Black African and Black Caribbean communities through targeted investment in research, including capacity and skills development for community providers in 'action research' to concurrently deliver and evaluate interventions.

Local Directors of Public Health and Nationally the Office of Health Improvement and Disparities (OHID)	6. Undertake insight research with members of smaller Black African and Black Caribbean populations (e.g. Somali, Ethiopian and Eritrean) to understand health literacy needs.

Theme: Emergency care, preventable mortality and long-term physical health conditions

"[Information]…to be in a format that is understood."
Lewisham community member

"… services just want to give out medication and I find I can't relate to the service professionals."
Birmingham community member

The important principle behind public health is the prevention of ill health through the promotion of healthy behaviours. In this review, we have established the worrying trends in health inequalities leading to lower life expectancy for some groups, especially those from Black African and Black Caribbean deprived communities. The impact of these inequalities is played out in people becoming unwell and requiring emergency care, developing long term physical health conditions and dying prematurely.

We focused on exploring research literature that reported on the inequalities in 'Emergency Care and Preventable Mortality, and Long-Term Physical Health Conditions' for men and women from these African and Caribbean communities in the UK. When considering the inequalities (access, experience and outcomes) we were focusing on evidence of differences in the results that we could measure between the community groups.

Higher rates of acute disease and emergency care were experienced by Black African and Black Caribbean communities compared to their White equals. For example, there are higher numbers of bad outcomes and preventable deaths across these groups relating to COVID-19, maternity and stroke.

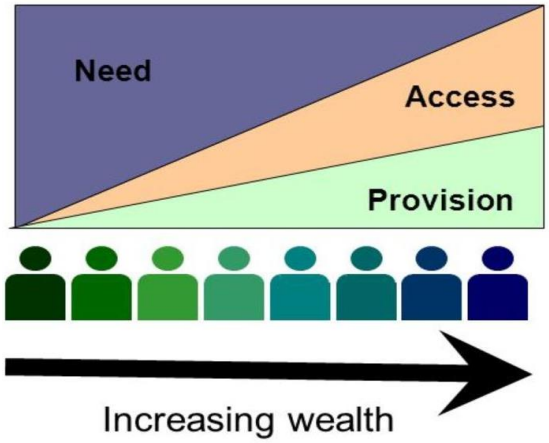
Inverse care law

The inverse care law was suggested 30 years ago by Julian Tudor Hart in a paper for *The Lancet*, to describe a relationship between the need for health care and its actual use. In other words, those who most need medical care are least likely to receive it. On the other hand, those with least need of health care tend to use health services more effectively.[80]

There is limited exploration of how this applies specifically to Black African and Black Caribbean communities but the evidence looked at by the Review strongly suggests it is applicable and needs to be addressed by services.

[80] Hart, J. T. (1971) 'The inverse care law', *The Lancet* 297(7696), pp 405-412. doi.org/10.1016/S0140-6736(71)92410-X

Figure 15: Summarising the Inverse Care Law



Reducing Premature Mortality

The pathway of someone with a disease can be complicated and there are many opportunities for intervention to reduce the risk of someone dying from the disease. Early detection is important but also improving health behaviours can make a big difference as well to premature mortality. The Vital 5 (King's Health Partners) model is used to improve the population's health and reduce health inequalities by focusing on the Vital 5 areas which can reduce premature mortality (Fig 22). In the context of this Review these Vital 5 approaches could have a major impact in reducing the inequalities in death and disease affecting Black African and Black Caribbean communities if done in culturally competent ways.

Figure 16: The Vital 5 – Addressing the Front-End of the Complete Pathway of Care

The Vital 5 – addressing the front-end of the complete pathway of care

Overall Aim: Improve the population's health and reduce health inequalities by focusing on the Vital 5 to support prevention, detection, health promotion, management and treatment wherever there is an opportunity to do so.

Vital 5	Aim	Measured through
Blood pressure	to reduce stroke and heart attack, and improve well being	BP recording
Obesity	to reduce diabetes, renal dialysis, liver transplants, amputations and other comorbidities, and improve well being	BMI from height/weight recording
Mental health score	to reduce the burden of mental illness, improve physical health, recovery and well being	GAD or PHQ-9 score
Alcohol intake	to reduce liver transplants and malignant disease, to improve well being	volume and frequency questionnaire
Smoking habits	to reduce respiratory and malignant disease, and improve well being	volume and frequency questionnaire

We set out the main findings from the evidence review, community engagement and stakeholder group sessions. The opportunities for action are given to improve Black African and Black Caribbean citizens' access to support and services.

What did we find from the rapid review?

In relation to preventable death we focused on two questions:

I. What are the health inequalities associated with emergency care and preventable mortality experienced by Black African and Black Caribbean people in Birmingham, Lewisham and the UK?

II. What evidence-based approaches are effective at preventing and addressing these health inequalities?

Acute disease and emergency care prevalence

- Males with chronic obstructive pulmonary disease (COPD) in the Black African and Black Caribbean population are more likely to seek emergency care, but less likely to be prescribed medication than similar White people.[81]
- Diabetes and poor glycaemic control lead to emergency care admissions and has higher rates in this population.[82]
- Dominant endocrine disorders for these groups are sickle-cell disorders and these frequently require urgent care for acute events.[83]
- There are higher rates of asthma in UK born Black and minority ethnic groups.[84]
- There are higher rates of strokes in Black African and Black Caribbean population due to hypertension, although other risk factors (smoking, coronary heart disease) are less common.[85]

Emergency care access

- People from an ethnic minority group (excluding non-White minorities) are 25% more likely to be a casualty than White pedestrians in trauma road accidents.
- Violent crime although has uneven reporting suggests high rates of gun and knife crime in areas of deprivation often involving young Black males.[86]
- There is an increased risk of admission observed for patients of Black or Black British ethnicity linked to poor management of chronic disease.
- General practices with higher proportions of Black or Black British patients were associated with higher rates of Accident and Emergency admissions. [87]

Preventable mortality (death)

- Poor outcomes for stroke were noted in Black African and Black Caribbean populations related to a limited awareness of symptoms and reduced health literacy, causing pre -hospital delay.
- The maternal death rate among Black women in England is growing and the gap between Black and White women in terms of their mortality rate is increasing.[88]

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[81] Gilkes, A. et al. (2016) 'Does COPD risk vary by ethnicity? A retrospective cross-sectional study,' *Int J Chron Obstruct Pulmon Dis* 11, pp 739-746. doi:10.2147/COPD.S96391

[82] Haw, J. S. et al. (2021) 'Diabetes complications in racial and ethnic minority populations in the USA,' *Curr Diab Rep* 21(1) doi:10.1007/s11892-020-01369-x

[83] Petersen, J., Kandt, J. and Longley, P.A. (2021) 'Ethnic inequalities in hospital admissions in England: an observational study,' *BMC Public Health* 21, pp 862 doi.org/10.1186/s12889-021-10923-5

[84] Asthma UK (2018) *On the Edge: How Inequality Affects People with Asthma*

[85] British Heart Foundation (2022) *How African Caribbean Background Can Affect Your Heart Health*

[86] Stott C, et al. (2021) *Understanding ethnic disparities in involvement in crime – a limited scope rapid evidence review, by Professor Clifford Stott et al.*

[87] Scantlebury, R. et al. (2015) 'Socioeconomic deprivation and accident and emergency attendances: Cross-sectional analysis of general practices in England', *British Journal of General Practice* 65, e649-e654. doi:10.3399/bjgp15X686893

[88] Government Equalities Office, Race Disparity Unit, and Badenoch, K. (2020) *Press Release: Government working with midwives, medical experts, and academics to investigate BAME maternal mortality*

- Mortality rates remain exceptionally high for babies of Black and Black British ethnicity: stillbirth rates are over twice of those for babies of White ethnicity and neonatal mortality rates are 43% higher.[89]
- There is a significant difference among Black and other minority ethnic communities and the White population regarding deaths from Covid-19.[90]

Disparities in healthcare services

- Where Black and minority ethnic groups live in our cities' links to poorer quality primary care[91].
- Patients often head directly to hospitals and accident and emergency departments, either because of difficulties in gaining access to general practice or a lack of understanding of the processes and systems.
- Delays in seeking treatment cause complications, poorer outcomes or avoidable mortality[92].
- Criticisms of elements of the healthcare workforce exist and relate to maintaining institutional racism, lacking cultural and religious understanding, or recognising diversity.

What is preventable mortality?

Preventable mortality can be defined as the mortality rates for causes of death which are considered preventable. These are causes where all or most deaths could potentially be prevented by public health interventions in the broadest sense (subject to age limits if appropriate).

The trends observed across the populations are described below based on the data from the Public Health Outcomes Framework, Office for Health Improvement.[93]

- There are higher rates of preventable mortality in under 75-year olds in both Lewisham and Birmingham than the England average.

- There are higher mortality rates from all cardiovascular disease per 100,000 in the under 75-year olds in both Lewisham and Birmingham compared to the England average.

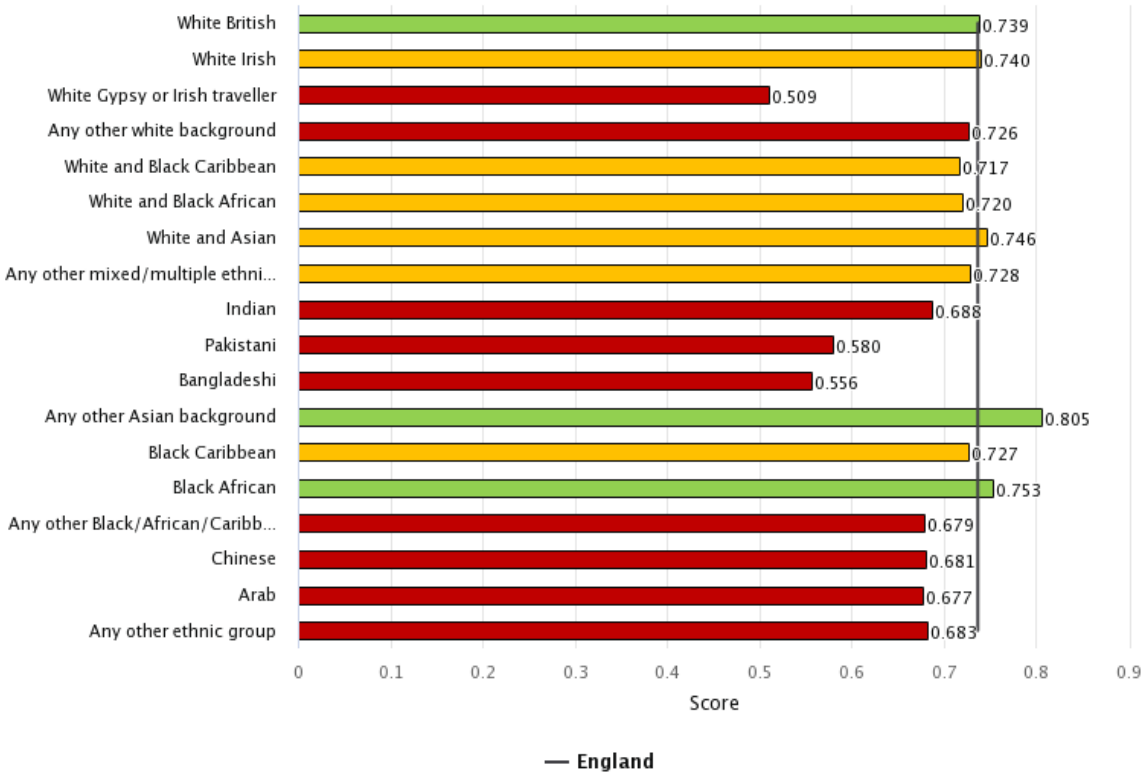
- The patterns observed in the death rates per 100,000 from ischaemic heart disease are lower in males of Black African and Black Caribbean ethnicities than White males in England and Wales.

- The patterns observed in the death rates per 100,000 from ischaemic heart disease are lower in females of Black African and Black Caribbean ethnicities than White females in England and Wales.

- The average health status score for adults aged 65 and over based on the GP Patient Survey showed similar scores reported for Black Caribbean and White older adults and better scores for Black African compared to the average score in England[94] (Figure 23).

[89] MBRRACE-UK (2021) *UK Perinatal Deaths for Births from January to December 2019*
[90] Public Health England (2020) *Beyond the data: Understanding the impact of COVID-19 on BAME groups*
[91] Raleigh, V. and Holmes, J. (2021) *The Health of People from Ethnic Minority Groups in England*. The King's Fund.
[92] Gov.UK (2021) *Independent Report: Health. Commission on Race and Ethnic Disparities*
[93] Public Health England (2022) *Fingertips: Mortality Profile*
[94] Public Health England (2022) *Fingertips: Productive Healthy Ageing Profile*

Figure 17: Health related quality of life for older people (2016/17) – England, Ethnic Groups



Long term conditions

According to the King's Fund,15 million people in England have at least one long-term condition. They affect wellbeing, social relationships and employment. Supporting people with long-term conditions uses 70% of the NHS budget and they are more common in older populations and those from disadvantaged backgrounds.[95]

In this review we considered the health inequalities associated with long-term physical health experienced by Black African and Black Caribbean people. We also wanted to know the evidence-based approaches that are effective at preventing health inequalities.

We assessed the evidence from reviewing a wide-ranging selection of published material on health conditions and multimorbidity (the presence of two or more long-term health conditions).

We found:

- Higher rates of multimorbidity, polypharmacy and earlier onset
- Increased prevalence of diabetes mellitus, poorer glucose regulation[96]
- Earlier onset of cardiovascular and chronic kidney diseases
- Higher risk and earlier onset of some cancers.**Error! Bookmark not defined.** For example, the risk of being diagnosed with prostate cancer is approximately 1 in 4 for Black men and 1 in 8 for White men, within the UK[97]

[95] Raleigh, V. and Holmes, J. (2021) *The Health of People from Ethnic Minority Groups in England*. The King's Fund.
[96] Public Health England (2016) Diabetes *Prevalence Model*
[97] Lloyd, T. et al. (2015) 'Lifetime risk of being diagnosed with, or dying from, prostate cancer by major ethnic group in England 2008–2010,' *BMC Medicine*. doi 10.1186/s12916-015-0405-5

- Lower rates of COPD[98] and Multiple Sclerosis[99]
- Inequitable change in healthcare.

Some of these inequalities have been well established for many years in research but there is very little evidence of evaluated interventions or evidence-based approaches to address these inequalities.

Healthcare:

- Increased hospital use associated with long-term conditions
- Fewer admissions with Alzheimer's disease[100]
- Increased referral delays and longer period of sickness absence
- Poor patient satisfaction[101]
- Reduced access to hospice care
- Barriers to engagement with services including communication difficulties, lack of resources, cultural and family dynamics and lack of awareness

There is some encouraging data in some areas, but inequalities remain higher with the burden of long-term health conditions for our Black communities.

Key findings [INFOGRAPHICS]

Headline: **Black African and Black Caribbean populations are more likely to seek emergency care**

Headline: **There are higher rates of asthma in UK born Black and minority ethnic groups**

Headline: **There are higher rates of strokes in Black African and Black Caribbean populations**

Headline: **The risk of being diagnosed with prostate cancer is approximately 1 in 4 for Black men and 1 in 8 for White men**

Headline: **Black communities carry a bigger burden of inequalities relating to long-term conditions**

What did we find from the community and Board engagement?

The following concerns and suggestions were shared with us by members of the local Black African and Black Caribbean communities.

"There should be more linked services within the NHS that is aimed directly at this ethnic group."

"Get a proper grasp of the barriers to accessing healthcare. Work with faith leaders to get the correct important out into the community."

[98] Gilkes, A. et al. (2016). 'Does COPD risk vary by ethnicity? A retrospective cross-sectional study', *Int J Chron Obstruct Pulmon Dis*. 11, pp 739-746. doi:10.2147/COPD.S96391
[99] Amezcua, L. and McCauley, J. L. (2020) 'Race and ethnicity on MS presentation and disease course,' *Mult Scler*. 26(5), pp 561-567. doi:10.1177/1352458519887328
[100] Alzheimer's Society (2018) *Research suggests fewer Black men receiving dementia diagnosis*
[101] NHS Digital (2021) *Ethnicity facts and figures – patient satisfaction with hospital care*

"As previously stated, the environment in relation to long term physical health and preventable mortality. But to do this it exposes institutional racism and bias within areas of Authority particularly Planning Enforcement Highways and the police."

"Equality a word used by many organisations, but actions witnessed in these communities means inequality. It's just a nice word but has no meaning for many as the actions we experience does not imply Equality in Birmingham."

"Work on the locality model to ensure fairness and use organisations rooted in communities."

Through this engagement there was significant discussion of both structural and institutional barriers as well as issues of awareness and understanding of risk and these inequalities within communities themselves. Communities shared their frustration that solutions are often focused at patching up problems rather than addressing the root causes and were keen to see a step change in the approach.

Opportunities for action

Theme 7: Emergency care, preventable mortality and long-term physical health conditions	
Who	**Opportunities for action**
NHS England NHS Integrated Care Systems Local Councils	1. Ensure culturally appropriate data collection and analysis for service planning, monitoring and evaluation that distinguishes by ethnicity and gender for Black African and Black Caribbean populations. This should be supported by clear commissioning that requires data collection and analysis linked to all key relevant performance indicators. A specific example of where this can be rapidly done is through better use of the Friends and Family Test (FFT) and working with African and Caribbean communities so they engage with the tool and understand how it is used. There should also be better scrutiny and use of data from complaints and complements and this should be reviewed as part of contract monitoring and output data reported into system-leaders. This can also be strengthened through undertaking qualitative research to understand and overcome negative perceptions and experiences of health care for Black African and Black Caribbean communities to avoid delays in accessing care, including the influence of structural racism and discrimination. Through this better data and engagement, local areas should develop a more in depth understanding of the needs of communities in relation to emergency care, preventable mortality and long-term physical health conditions.
Local Health and Wellbeing Board and NHS ICS Partnership Board	2. Ensure that the engagement of Black African and Black Caribbean communities is meaningful and valued. This should include direct engagement and collaboration with representative organisations that is done in a way which is

	respectful, transparent and accessible, and considers and values participants' time and commitments. Mechanisms for doing this could include: • A team of community advocates who understand the needs and barriers for Black African and Black Caribbean communities, supporting them to 'navigate' and access support (e.g. social prescribing). • Use of faith and workplace settings to increase awareness and understanding of health issues to support informed decisions about health. • Investment in grass-roots organisations to recruit volunteers who can support Black African and Black Caribbean communities that may experience structural institutional racism when accessing services.
Local Directors of Public Health and NHS Prevention Leads	3. Ensure prevention services are fair, appropriate and consider the needs of Black African and Black Caribbean populations, and there is proactive work to address issues with health literacy. This could include: • Services considering evidence-based ethnic differences in outcome measures (e.g. BMI versus waist-to-height measures, age of heart disease issue onset for NHS Health Checks, depressive symptoms in childhood and influence on life-time physical health). • Work with communities to co-develop services that are accessible for Black African and Black Caribbean communities (e.g. opening times, location of delivery). • Work with communities to encourage and raise awareness about how to access health services, including investment and development of multi-service hubs and pop-ups based in community locations (e.g. Youth Centres, libraries, leisure centres, faith-based sites, universities, colleges, schools) • Contractual clauses that strengthen support for Black African and Black Caribbean communities when they experience racism while accessing services and offer tiered positive approaches that address reported issues. • Meaningful measurement of change and learning from communities and grass roots organisations being captured and informing service design, monitoring, improvement, and review • Whole system workforces, across all partners and professions including front-line, back-office and system leaders, to complete anti-racism training, with ongoing independent evaluation • Early help provision that supports communities when they do not meet statutory thresholds such as improved investment in grassroot organisations to provide social prescribing support (e.g. befriending, talking therapy, group therapy, forums and general health support).

Theme: Wider determinants of health

"We can't ignore the barriers that ethnic minority communities are facing"
BLACHIR engagement participant

Where we live, how we learn, what we do and when we earn all play a part in keeping us healthy. The wider determinants term describes the factors that can influence health outcomes and include education, housing, poverty, employment and the environment in which we live. These impact on our lives both directly as we experience them but also in the longer term driving the inequalities in health outcomes we have seen throughout the Review.
This Review highlighted the evidence on inequalities caused by wider determinants of health experienced by the African and Caribbean populations. Social determinants of health are summarised in the model by Dahlgren and Whitehead[7] which is highlighted in the methodology section of this report (see Figure 2).

In 2010, The Marmot review highlighted the need to make better progress on the social determinants of health. This is because social, economic and environmental factors can impact on health, influenced by the local, national, and international distribution of power. This progress has to be invested in more for communities that experience more inequalities including the Black African and Black Caribbean communities.

What did we find from the rapid review?

We found that poverty and the wider environment has influenced Black African and Black Caribbean's health.

We identified the main causes of inequalities:

- Higher levels of deprivation, overcrowded homes, higher unemployment rates and lower education level attainment
- Racism and discrimination
- Lack of cultural expertise and sensitive methods
- Higher rates of mental health issues.

There are ten wider determinants highlighted and included as part of this review.

Housing

Within England, more Black African and Black Caribbean communities live in overcrowded homes compared to White communities (16% and 7% respectively compared with 2%).[102]

Education

National data shows that temporary exclusions across various ethnicities show differences between students: White: Gypsy/Roma (21.26%) and Irish Traveller (14.63%), Mixed White/Black Caribbean (10.69%), Black Caribbean (10.37%), Black Other (5.91%), Black African (4.13%), Mixed White/Black African (4.13%). Permanent exclusions were similar.[103] [104]

In 2019/20 the percentage of students getting 3 A Grades at A Level in England was lower amongst Black Caribbean (9.1%), Black Other (11.2%) and Black African (12.7%) students compared to White British students (20.2%).[105]

[102] Ministry of Housing, Communities and Local Government (2020) *Ethnicity Facts and Figures – Overcrowded Houses*
[103] Department for Education (2021) *Ethnicity Facts and Figures – Temporary exclusions*
[104] Department for Education (2021) Ethnicity Facts and Figures – Permanent exclusions
[105] Department for Education (2021) *Ethnicity Facts and Figures – A level grades*

Unemployment

Black people are more likely to be unemployed compared to England average in 2019, 8% of people of Black ethnicity were unemployed which is higher than rates of White British people (4%).[106]

Income

Nationally, Black households were most likely, out of all ethnic groups, to have a weekly income under £600.[106]

Stop and search

Within England and Wales, Black people are over three times as likely to be arrested as White people.[107] In 2020, there were 54 stop and searches for every 1000 Black people, compared to six for every 1000 White people.[108]

Crime

Among juveniles sentenced in 2017 within the UK, the Black ethnic group had a high percentage of offenders sent to a young offenders institution.[109] The evidence shows the disproportionate presence of Black people in the criminal justice systems is linked with racism and discrimination, worsening the negative impact on Black people's health and wellbeing, in particular their mental health.[110]

Deprivation

Nationally there are higher levels of deprivation among the Black African and Black Caribbean groups compared to White groups.[111]

Benefits and financial support

23% of people from Black ethnic groups within the UK receive income-related benefits such as help with the cost of housing. This is the second highest group after people of Bangladeshi origin.[112]

Cultural factors

Nationally, cultural factors such as family support, connectedness, sense of community, the influence of religion and ethnic density are viewed as protective factors. However, some research found these can also become barriers to accessing health and social care.

It is important not to assume and stereotype. While there have been a small number of faith leaders who have been against vaccination, many Christian denominations have no theological opposition to vaccines. Churches from different denominations have come together to help reassure Black members about the Covid-19 vaccine. [113]

Homelessness and fuel poverty

[106] Department for Work and Pensions (2021) *Ethnicity Facts and Figures – Household Income*
[107] Home Office (2020) *Ethnicity Facts and Figures – Arrest Data*
[108] Home Office (2021) *Ethnicity Facts and Figures – Stop and Search Data*
[109] Ministry of Justice (2020) *Ethnicity Facts and Figures – Young People in Custody*
[110] Ministry of Justice and Youth Justice Board for England and Wales (2020) *Ethnicity Facts and Figures - Youth Justice Statistics: 2018 to 2019*
[111] Ministry of Housing, Communities and Local Government (2020) *Ethnicity Facts and Figures - People Living in Deprived Neighbourhoods*
[112] Department for Work and Pensions (2021) *Ethnicity Facts and Figures – State support*
[113] The Voice (2021) *UK's Black Majority Churches Want Their Congregations to Consider Taking the Covid-19 Vaccine*

Lewisham has a higher percentage of homeless households from people of Black ethnicity compared to people in these groups in Birmingham and the rest of England.[114]

Figure 18: Percentage of those who live in overcrowded households and experience fuel poverty in England, Birmingham and Lewisham

	England	**Birmingham**	**Lewisham**
Overcrowded households (2011) [115]	4.8%	9.1%	12.4%
Fuel Poverty (2018) [116,117]	10.3%	14.2%	12.1%

Key findings [INFOGRAPHICS]

Headline: **Black people in England are twice as likely to be unemployed as White people**

Headline**: Black households are more likely to have low income and live in deprivation**

Headline: **Black people are over 3 times as likely to be arrested as White people and 9 times more likely to be stopped and searched**

Headline: **Overcrowding, homelessness and fuel poverty are more likely to be experienced by Black households**

What did we find from the community and Board engagement?

"All black areas even were my wider family live experience the same issues that have long term implications on long term health inequalities. It's not about more access or testing it's our environments that start many of these illnesses."

BLACHIR engagement participant

Community issues

Black African and Black Caribbean people often have strong family and community networks where they live. These are positive characteristics and can provide important individual and social connections, but they can also hinder help outside of the community bubble.

Protective factors

Cultural differences, especially those in family life, may be responsible for influencing Black African and Black Caribbean communities' health and wellbeing. Culture can also impact on how they seek health advice, achieve a healthier lifestyle and access health and social care services. It is evident from the findings that social, community and familial networks act as protective factors for Black communities. Protective factors act as a buffer for those at high risk of developing health and social problems.

[114] Ministry of Housing, Communities and Local Government (2020) *Ethnicity Facts and Figures – Statutory Homelessness*

[115] Ministry of Housing, Communities and Local Government (2020) *Ethnicity Facts and Figures - Overcrowded households*

[116] LG Inform (2021) *Fuel poverty in Lewisham - LG Inform*

[117] Department for Business, Energy & Industrial Strategy (2020) *Ethnicity Facts and Figures – Fuel Poverty*

Social, economic and environmental factors

Wider determinants of health have major influence on the wellbeing of our communities. Therefore, it is important to understand cultural identities, health beliefs and behaviour of the UK's diverse population.

Population diversity

Population diversity is complex and understanding it can be at best uneven. Health professionals can have poor cultural expertise with lack of language, underlying racism resulting in unfair treatment that can prevent access to health and social care.

.

"They have put us in a box, and I was thinking how we get out of it?"

Council elected member

The BAME and BME terms can present a standardised view of Black and ethnic communities. According to the UK government (GOV.UK) BAME (Black, Asian and Minority Ethnic) and BME (Black and Minority Ethnic) are not helpful descriptors because they emphasise certain ethnic minority groups (Asian and Black) and exclude others (Mixed, Other, and White ethnic minority groups). The terms can also mask differences between different ethnic groups and create misleading interpretation of data.

The Office for National Statistics (ONS) will have the most up to date national and local data on population diversity for the Black African communities in Spring 2022.

Our communities have said:

"*Root cause of health in many Black communities is environmental. My blood pressure is constantly high, kids have asthma, and some have neurological conditions which many have put down to accumulation of toxic fumes of industry and pollution."*

"Healthcare workers have been exposed to risk for years long before COVID. Along with many other gig economy workers who are exposed to risk daily but keeps the wheels turning. Many of the environments we live exposes us to many risks daily. Many know friends and family who have lost their positions due to vaccine mandates. Clap when it suits and dispose of when it does not."

"Food poverty is an issue that will grow in many areas, whether to eat or heat currently."

"Councils in the deprived areas of Birmingham seem to be doing the opposite if being truthful. Development plan for this area about twelve years ago spelt out the health inequalities. Twelve years later with all the data available studies and environmental laws, many residents now have chronic illnesses due to ever increasing exposure to exceeding air and noise pollution."

Opportunities for action

Theme 8: Wider determinants	
Who	**Opportunities for action**
Local Health and Wellbeing Boards and NHS Integrated	1. Consider cultural and religious influences when developing interventions to address the wider determinants of health

Care Partnership Boards	inequalities for Black African, Black Caribbean and Black-Mixed ethnic minority groups.
Local Councils, NHS Trusts, ICS, advocates for national standards, Criminal Justice System, community organisations	2. Collaborate with government agencies and institutions to remove issues ethnic minorities face when in contact with the justice system and ensure these agencies work to address health inequalities.
Local Health and Wellbeing Boards	3. Conduct more research to understand the impacts of the food environment and food poverty on health and wellbeing of Black African and Black Caribbean communities, and devise strategies to address the structural issues at a community level.
Local Health and Wellbeing Boards and NHS Integrated Care Partnership Boards	4. Take action to address employment inequalities and issues around racism and discrimination affecting in the public sector. Offer more protection for key workers from Black African, Black Caribbean and Black-Mixed ethnic backgrounds in health or other high-risk occupations.

Conclusion

Out of the huts of history's shame
I rise
Up from a past that's rooted in pain
I rise
I'm a black ocean, leaping and wide,
Welling and swelling I bear in the tide.

Leaving behind nights of terror and fear
I rise
Into a daybreak that's wondrously clear
I rise
Bringing the gifts that my ancestors gave,
I am the dream and the hope of the slave.
I rise
I rise
I rise.

An excerpt from 'I Rise' by Prof. Maya Angelou

The BLACHIR process allowed us to explore the evidence using a unique compilation of rich local data and intelligence as well as co-exploration with communities to better understand the challenges of persistent inequalities affecting Black African and Black Caribbean people in Birmingham and Lewisham.

The findings from the review clearly demonstrate that the system does not take enough notice of the needs and issues affecting Black African and Black Caribbean people as communities of identity in the UK. We are publishing alongside the Review report a more detailed data pack that we hope to evolve into a dashboard to track progress and impact following this report. We have also included in Appendix 2 recommendations for research that could help to close some of the clear evidence gaps identified through the Review.

These needs include fairness, inclusion and respect, trust and transparency, better data, early interventions, health checks and campaigns, healthier behaviours and health literacy.

This deficit is against a background of historical oppression, racism and discrimination and a clear and consistent repeating pattern of inequalities. This should not be allowed to continue.

This journey to address the needs has begun in our local areas with this review, working together to coproduce opportunities for action (see Appendix 1) for each of the eight themes explored. We commit to publish in a companion document case studies that demonstrate our work so that this can be shared and learnt from by other areas.

The review is submitting these opportunities for action to the respective local Health and Wellbeing Boards for their consideration and for the two local areas to take forward this work with their communities to build a better future and to break these cycles of inequality and disadvantage for African and Caribbean communities.

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Finally, the whole project would not have been accomplished without the dedication of the local Review Teams in Birmingham and Lewisham Councils. The teams worked diligently and tirelessly to develop and deliver this ground-breaking initiative contributing to the learning and legacy about health inequalities.

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Appendix 1: Opportunities for action

Led by research and evidence with community feedback, our review has put forward a series of detailed opportunities for action that we determined will improve the lives and experiences of Black African and Black Caribbean communities across the UK.

7 key areas that need to be addressed across the 8 themes

Fairness, Inclusion and Respect ~ Trust and Transparency ~ Better Data ~ Early Interventions ~ Health Checks and Campaigns ~ Healthier Behaviours ~ Health Literacy

Theme 1: Racism and discrimination	
Who	**Opportunities for action**
Local Councils and Health and Wellbeing Board Partners	**1.** Pilot the removal of the colour language from ethnic coding and evaluate the impact on participation and experience of data collection.
Local Councils and Children's Trusts	**2.** Pilot the integration of discrimination and racism into the approaches to adverse childhood experiences and recognise this both in the assessment of children's needs and in the design of interventions to mitigate these adverse impacts.
Local Councils and Health and Wellbeing Board Partners	**3.** Review staff equality and diversity training to ensure that this is a core part of the delivery of training, co-delivered by diverse individuals with lived experience.
Local Councils and Education Partners	**4.** Work with education partners for all ages and local communities to explore how ethnic diversity can be further integrated into education to reflect the diverse cultures and various perspectives of history and experience.

Theme 2: Maternity, parenthood and early years	
Who	**Opportunities for action**
Local Integrated Care Systems (ICS) and NHS Trusts	**5.** Address any gaps in existing Maternity and Paediatric Health Professionals' training including topics on cultural awareness, learning from lived experience, awareness of inclusion practices and policies, and awareness of trauma caused by racism and discrimination and how to deliver sensitive care.
Local Integrated Care Systems (ICS) and NHS Trusts	**6.** Co-design online tool with communities to collect information on beliefs, cultural practices and traditions from ethnic groups. This resource could then be used for training to inform practice and communication with patients and service users.
Local, regional and national government, health organisations, care providers and advocates	**7.** Improve data collection by specific ethnicity considering the differences in ethnic background and nationality. Work with professionals who represent the ethnic minority groups to ensure a sensitive approach when collecting data.
Local, regional and national government, health, housing, voluntary	**8.** Support all women who are migrants, refugees, and asylum seekers, particularly those with no access to public funds, to access appropriate care during and post pregnancy, through

organisations and advocates for national protocols	appropriate support and protecting them from relocation or eviction.
Local Public Health and NHS services	**9.** Develop culturally specific and appropriate weaning support initiatives for Black African and Black Caribbean parents.

Theme 3: Children and young people	
Who	**Opportunities for action**
Local Councils, schools, colleges, universities, community groups	**10.** Provide guidance and support for parents and young people on applications and transition to secondary school and further education, including online information, support liaison officers, summer schools on core subjects and finance advice.
Local Integrated Care Systems (ICS), NHS Trusts	**11.** Develop culturally appropriate and accessible mental health services, including schools-based support, for young men and women to increase capability, capacity and trust to engage with services.
Local Councils, schools, regional and national government, and education organisations	**12.** Review educational approach and opportunity for targeted intervention to increase academic achievement for Black African and Black Caribbean children and young people. This should include support on sexual and reproductive health services for young people, sexual exploitation, gender specific interventions and rape culture.
Local Councils, Local Integrated Care Systems (ICS), NHS Trusts, care providers, and advocates	**13.** Address low pay and associated poverty for frontline workers who are disproportionately of Black African and Black Caribbean heritage.
Local Councils, Health and Wellbeing Boards, community and voluntary sector organisations	**14.** Work with trusted community centres and spaces to provide violence-free, accessible and attractive youth provision for access to wider opportunities, including through existing contracts and partnerships with Black-owned businesses and leaders.
Local Councils and climate change and air quality partners	**15.** Collaborate with African and Caribbean communities and their leadership on addressing air quality issues and continue with the in-depth work already in place with explicit consideration of these communities.
NHS Integrated Care Systems	**16.** Put in place interventions for Black African and Black Caribbean children and young people that address specific inequalities (e.g. sickle cell disease services), ensuring proportionate targeting and equality assessments of whole population interventions for issues they are disproportionately impacted by (e.g. low traffic neighbourhoods and school streets).

Theme 4: Ageing well	
Who	**Opportunities for action**
Local Public Health	**17.** Provide targeted screening services for chronic conditions in Black African and Black Caribbean older adults.
Local and national organisations, ICS, NHS Trusts	**18.** Campaign to raise awareness and increase uptake of community-based health checks in Black African and Black Caribbean older adults.

Local and national organisations, NHS Trusts, Mental Health services, First Aid England	**19.** Assess the availability of culturally aware services for mental health and evaluate current services to determine how they meet the needs of older Black African and Black Caribbean adults.
NHS England and NHS Integrated Care System Boards	**20.** Support initiatives to improve uptake of vaccinations in older African and Caribbean people, focusing on areas of higher deprivation.
Local Councils, local, regional and national organisations and advocates	**21.** Use life course approach and consider relevant findings from this review to develop interventions that help to mitigate health inequalities experienced by Black African and Black Caribbean older people.

Theme 5: Mental health and wellbeing	
Who	**Opportunities for action**
Local Public Health and Community Mental Health Trusts	**22.** Co-produce awareness campaigns aimed at Black communities to promote a better understanding of different mental illnesses, facilitate early interventions and self-referral in collaboration with carers, families, health services, community and faith centres.
Local NHS providers and Community Mental Health Trusts	**23.** Ensure practitioners use culturally competent (cultural understanding) trauma informed patient-centred engagement styles and interventions.
NHS Mental Health Providers and Commissioners	**24.** Ensure mental health workers acknowledge service users' personal histories of racism and recognise them as trauma to enable more effective intervention.
Local Health and Wellbeing Boards and NHS Integrated Care Partnerships Boards	**25.** Promote cultural competency training within healthcare services, the criminal justice system, and the police force.
Local Health and Wellbeing Boards and NHS Integrated Care Systems	**26.** Apply the use of culturally competent language, including using language that considers stigma within communities, such as 'wellbeing' rather than 'mental health'.

Theme 6: Healthier behaviours	
Who	**Opportunities for action**
Local Directors of Public Health and Nationally the Office of Health Improvement and Disparities (OHID)	**27.** Work with Black African and Black Caribbean communities and organisations to co-create and deliver culturally appropriate and accessible support on positive health behaviours, including health literacy training, social prescribing initiatives and group interventions.
Health Education England/ NHS England	**28.** Explicitly recognise racism and discrimination as a driver of ill health and put in place training and systems to enable trauma-informed practice and services.
National Government Departments and Local Councils and NHS Integrated Care Systems	**29.** Provide long-term investment for trusted Black African and Black Caribbean grass roots organisation such as faith groups, schools, voluntary and community sector organisations to deliver community-led interventions.
Local Directors of Public Health and	**30.** Work with faith settings to understand and utilise the positive role faith plays in healthier behaviour decision making.

Nationally the Office of Health Improvement and Disparities (OHID)	
Department of Business, Innovation and Skills and research funding bodies such as National Institute for Health Research (NIHR)	**31.** Address the evidence deficit in interventions for Black African and Black Caribbean communities through targeted investment in research, including capacity and skills development for community providers in 'action research' to concurrently deliver and evaluate interventions.
Local Directors of Public Health and Nationally the Office of Health Improvement and Disparities (OHID)	**32.** Undertake insight research with members of smaller Black African and Black Caribbean populations (e.g. Somali, Ethiopian and Eritrean) to understand health literacy needs.

Theme 7: Emergency care, preventable mortality and long-term physical health conditions	
Who	**Opportunities for action**
NHS England NHS Integrated Care Systems Local Councils	**33.** Ensure culturally appropriate data collection and analysis for service planning, monitoring and evaluation that distinguishes by ethnicity and gender for Black African and Black Caribbean populations. This should be supported by clear commissioning that requires data collection and analysis linked to all key relevant performance indicators. A specific example of where this can be rapidly done is through better use of the Friends and Family Test (FFT) and working with African and Caribbean communities so they engage with the tool and understand how it is used. There should also be better scrutiny and use of data from complaints and complements and this should be reviewed as part of contract monitoring and output data reported into system-leaders. This can also be strengthened through undertaking qualitative research to understand and overcome negative perceptions and experiences of health care for Black African and Black Caribbean communities to avoid delays in accessing care, including the influence of structural racism and discrimination. Through this better data and engagement, local areas should develop a more in depth understanding of the needs of communities in relation to emergency care, preventable mortality and long-term physical health conditions.
Local Health and Wellbeing Board and NHS ICS Partnership Board	**34.** Ensure that the engagement of Black African and Black Caribbean communities is meaningful and valued. This should include direct engagement and collaboration with representative organisations that is done in a way which is respectful, transparent and accessible, and considers and values participants' time and commitments. Mechanisms for doing this could include:

	• A team of community advocates who understand the needs and barriers for Black African and Black Caribbean communities, supporting them to 'navigate' and access support (e.g. social prescribing). • Use of faith and workplace settings to increase awareness and understanding of health issues to support informed decisions about health. • Investment in grass-roots organisations to recruit volunteers who can support Black African and Black Caribbean communities that may experience structural institutional racism when accessing services.
Local Directors of Public Health and NHS Prevention Leads	**35.** Ensure prevention services are fair, appropriate and consider the needs of Black African and Black Caribbean populations, and there is proactive work to address issues with health literacy. This could include: • Services considering evidence-based ethnic differences in outcome measures (e.g. BMI versus waist-to-height measures, age of heart disease issue onset for NHS Health Checks, depressive symptoms in childhood and influence on life-time physical health). • Work with communities to co-develop services that are accessible for Black African and Black Caribbean communities (e.g. opening times, location of delivery). • Work with communities to encourage and raise awareness about how to access health services, including investment and development of multi-service hubs and pop-ups based in community locations (e.g. Youth Centres, libraries, leisure centres, faith-based sites, universities, colleges, schools) • Contractual clauses that strengthen support for Black African and Black Caribbean communities when they experience racism while accessing services and offer tiered positive approaches that address reported issues. • Meaningful measurement of change and learning from communities and grass roots organisations being captured and informing service design, monitoring, improvement, and review • Whole system workforces, across all partners and professions including front-line, back-office and system leaders, to complete anti-racism training, with ongoing independent evaluation • Early help provision that supports communities when they do not meet statutory thresholds such as improved investment in grassroot organisations to provide social prescribing support (e.g. befriending, talking therapy, group therapy, forums and general health support).

Theme 8: Wider determinants	
Who	**Opportunities for action**
Local Health and Wellbeing Boards and NHS Integrated Care Partnership Boards	**36.** Consider cultural and religious influences when developing interventions to address the wider determinants of health

	inequalities for Black African, Black Caribbean and Black-Mixed ethnic minority groups.
Local Councils, NHS Trusts, ICS, advocates for national standards, Criminal Justice System, community organisations	**37.** Collaborate with government agencies and institutions to remove issues ethnic minorities face when in contact with the justice system and ensure these agencies work to address health inequalities.
Local Health and Wellbeing Boards	**38.** Conduct more research to understand the impacts of the food environment and food poverty on health and wellbeing of Black African and Black Caribbean communities, and devise strategies to address the structural issues at a community level.
Local Health and Wellbeing Boards and NHS Integrated Care Partnership Boards	**39.** Take action to address employment inequalities and issues around racism and discrimination affecting in the public sector. Offer more protection for key workers from Black African, Black Caribbean and Black-Mixed ethnic backgrounds in health or other high-risk occupations.

Appendix 2: Research opportunities

Throughout the review there have been clear evidence gaps in the research, at times we have had to look at international evidence, which is not necessarily transferable to a UK context.

There remain significant data gaps in national collection and analysis of both NHS and Local Government data and these need to be urgently addressed in order to visualize and respond to the needs of ethnic communities. There may be a need for specific research to understand why, despite decades of policy initiatives, ethnic data collection and analysis remains so poor in the public sector.

The following are some of the research gaps that have been identified from this review's work:

- Understanding of the impact of culturally competent equality training on behaviours of professionals and on outcomes for patients/clients
- Understanding of the interventions that are most effective to improve health behaviours in different Black African and Black Caribbean communities
- Understanding of the linguistic barriers to health literacy for non-English speaking communities, especially in relation to mental health and wellbeing.

Pilots and research

Pilots and commissioned research will help to address knowledge gaps across the themes and may help identify the most effective culturally sensitive interventions to address health inequalities affecting Black African and Black Caribbean populations in Birmingham, Lewisham and the UK. In many areas the evidence is weak. Pilot schemes and small projects should guide further large-scale research and support the implementation of the opportunities of action identified as part of BLACHIR.

The Birmingham and Lewisham African and Caribbean Health Inequalities Review (BLACHIR)

Lewisham Community Consultation

Karl Murray 24 February 2022 Kinaraa CIC

Birmingham and Lewisham African and Caribbean Health Inequalities Review (BLACHIR)

Acknowledgement

We wish to gratefully acknowledge the contributions of many individuals who had various roles in the development and implementation of the research. Special thanks and appreciation are extended to the collaborative partnership organisations, who, if not for their energy and organising skills, we would never have reached the participants and undertake the level of write-up that was required. In particular, thanks and appreciation go to:

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- Leon Thompson and Francine Daley (360 Lifestyle Support Network)
- Ray Black and Joseph Oladuso (Action for Community Development)

The coordination and pulling together of the team were made easy through the work of Barbara Gray, Urban Dandelion, on behalf of Kinaraa CIC.

We wish to thank the participants who took time out in the evenings, including during childcare circumstances, to engage in dialogue with strangers. Being willing to shar your thoughts in open sessions with groups of up to eight people unknown to you cannot be easy. So, we thank them for so doing and for their honesty and willingness to share some personal experiences.

Our thanks and appreciation go to Lisa Fannon, Public Health Training and Development Manager, Communities Directorate and Dr Catherine Mbema, Director of Public Health, Public Health Community Services Directorate, Lewisham Council, for their faith and confidence in the process.

Finally, the responsibility for the sense made of the voices that helped to shape our understanding rests with me, the author, and hope I have done justice to what we have heard and not strayed too far from the shared experiences that has shaped the lives of so many residents living in Lewisham as we go forward.

KINARAA CIC

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CONTENT

Executive Summary

The Birmingham and Lewisham African and Caribbean Health Inequalities Review (BLACHIR) is a joint project between Lewisham Council and Birmingham City Council to understand and take action on long-standing health inequalities for people of Black African and Caribbean heritage. The BLACHIR External Advisory Board summarises well the context and background to the project:

"*Birmingham and Lewisham Public Health Divisions share a joint aspiration to address ethnic inequalities, through an increased understanding, appreciation, and engagement with Black, Asian, and Minority Ethnic (BAME) groups. This has resulted in a partnership between the two Public Health Divisions to share knowledge and resources through a collaborative review process to, initially, focus on the Black African and Black Caribbean communities, to enable a more detailed and culturally sensitive approach*"[1].

The overarching BLACHIR Review took a thematic approach which explored specific topics to evidence needs and to recommend actions that should drive sustainable change. The themes have been clustered around the eight areas indicated below, which informed the context for the consultation conversations:

1) Structural racism and discrimination
2) Pregnancy and early years (0 to five years of age)
3) Childhood and being a young person (ages five to 25 years of age)
4) Staying healthy as you age (from 40 years of age and onwards)
5) Mental health and wellbeing
6) Habits/behaviours that influence your health
7) Social and economic influences (e.g. education, housing, employment, crime)
8) Access to health care and managing health conditions

Within the Lewisham context, the engagement process was commissioned by Lewisham Council's Director of Public Health as part of a wider consultation process within the Black African and Caribbean communities led by a collaborative of Lewisham based Black third sector organisations, under the guidance of Kinaraa CIC. The approach was to focus on ensuring the lived experiences and voices of Lewisham's Black African and Caribbean communities was heard. Putting this into context, the Lewisham Health and Wellbeing Strategy states: "*Health inequalities are unfair and avoidable differences in health and wellbeing. Within Lewisham, and nationally, we know that people of Black African and Caribbean heritage suffer from health inequalities and this work aims to address them to make life fair."* It is against this background that this consultation report is to be read and understood.

[1] The Birmingham and Lewisham African and Caribbean Health Inequalities Review (BLACHIR): External Advisory Board, July 2020

However, it is important to get a better understanding of the Lewisham context that has prompted the need to explore health inequalities as it relates to Black African and Caribbean residents living in the borough.

The research included both qualitative and quantitative approaches, through structured 1-2-1 and focus group interviews and survey questionnaire. Some basic information was captured from each approach, which provided demographic and contextual information on the key characteristics of respondents.

Three organisations were engaged in the direct delivery of the field research (1-2-1 interviews and focus groups)[2]. Through their work and engagement, six (6) focus group sessions were conducted and five (5) 1-2-1 depth interviews completed.

As a result of the process, 33 participants engaged in the focus group sessions (28) and 1-2-1 sessions (5) while the online survey questionnaire attracted a further 55 respondents. Thus reaching 88 participants from which the report analysis is based.

Key findings

Of the eight (8) themes identified to tackle race inequalities in Birmingham and Lewisham, the top three themes identified as priorities by respondents to the online questionnaire were:

1. Structural racism and discrimination;
2. Mental health; and
3. Staying healthy as you age.

Respondents were asked to rank the key actions identified by the phase 1 academic review reports, from which the top three were identified. Under each theme, they are:

Theme 1: Structural racism and discrimination

- Action 2 – Recognition of racism as an adverse childhood experience, was the most urgent action
- Action 1 – Removal of colour language coding in data collection, was the second priority; and
- Action 4 – Council and partners need to integrate diversity into education to reflect diverse cultures - as the third priority

Theme 2: Pregnancy and early years (0 to five years of age)

- Action 1: Develop culturally competent health professionals' training curriculum
- Action 2: Accurate collection and disaggregation of data by ethnicity
- Action 3: Build an online tool that can allow health professionals to rapidly access and compare pathways.

[2] The three organisations involved were Red Ribbon Living Well, 360 SLN and Action for Community Development (AfCD). Appendix 2 provides further details on each organisation.

Theme 3: Childhood and being a young person (ages five to 25 years of age)

- Action 1: Specific intervention and support at key transition periods
- Action 2: Councils and partners to work with culturally appropriate services to support young people through mental health concerns
- Action 4: Work to be conducted to address the disproportionate levels and impacts of economic deprivation for Black African and Black Caribbean communities.

Theme 4: Staying healthy as you age (from 40 years of age and onwards)

- Action 1: Accessibility – ensure good quality hospital and social care is accessible to all older people of African and Caribbean or Black-mixed ethnicity;
- Action 2: Cultural competency – provide awareness training for care home workers focused on older individuals of African, Caribbean or Black-mixed ethnicity;
- Action 3: Unpaid care – understand the number of unpaid carers who are of African and Caribbean heritage.

Theme 5: Mental health and wellbeing

- Action 1: Inclusion and mental health - raise awareness of the disparities African and Caribbean communities face in mental health, care and treatment through explicit education and engagement programmes;
- Action 2: Cultural Competency in mental healthcare - require all mental health providers to demonstrate how patient and carer perspectives are being used to inform mental healthcare service improvements;
- Action 3: Community support - support community organisations and groups to develop and facilitate support groups within the African and Caribbean communities.

Theme 6: Habits/behaviours that influence your health

- Action 1: Develop a positive health behaviour programme that does not require pharmaceutical intervention;
- Action 2: Recognise impact of racial trauma on health behaviours of migrant populations;
- Action 3: Investment in organisations and groups within and across communities outside statutory Local Authority and health providers.

Theme 7: Social and economic influences (e.g. education, housing, employment, crime)

- Action 1: Acknowledging culture and religion as integral aspects of health;
- Action 2: The Council and local authorities work with government agencies and institutions to eradicate issues ethnic minorities face when in contact with the justice system;
- Action 3: There is a need to conduct more research to understand these issues better and devise strategies to implement at community levels to address structural issues.

Theme 8: Access to health care and managing health conditions

- Action 2 – undertake qualitative research to understand and overcome negative perceptions and experiences between Black African/Caribbean communities and health services in accessing care, including the influence of structural racism and discrimination;
- Action 1 - All commissioned services (existing and new) to collect and analyse data across specific ethnicities and gender for all Key performance indicators;
- Action 3 - Ensure prevention services are equitable, appropriate and take into account the needs of Black African and Black Caribbean communities

Using a thematic approach to clustering, six themes emerged that were consistently referenced across the sessions, which added further weight to the ranked priority Actions indicated through the prioritisation process. They were:

1. Accessibility to GPs (i.e. waiting time, booking appointments etc)
2. Trusted and accurate information (including communication and language issues)
3. Immigration status
4. Cultural expectations (i.e cultural insensitivity; taboos and stigma etc)
5. Care home v 'home care' concerns
6. Wider social and economic factors (ie. Impact of poor housing, traffic congestion and crime)

There was a strong view that the 'community bridges', seen as the roles that voluntary and community organisations could play, was critical in the roll out process, especially as they represent folks who are the recipient of services. It was noticeable that throughout the focus group conversations participants wanted services 'closer on the ground' to them; to have service practitioners able to identify culturally with their needs and to see good quality care services in place. The key here was not segregated provisions but good quality equitable services, especially services being offered to those who were elderly, those living with a disability and those living with long term diseases and condition such as HIV. All of these being concerns raised by the JSNA and included within the Health and Wellbeing Strategy. Far from being antagonistic, the reflected voices from the participation pool of close on 90 respondents, indicated very much a consistency in identifying key actions that should be prioritised.

In many ways, and perhaps not too surprising, participants on the whole indicated that any changes envisaged need to be ones that improve local resident situation and not just 'tick box' exercises and platitudes. As one person wrote in responding to the questionnaire on Theme 4: *"Action 3 - what is to be done with that understanding? If nothing then there is no outcome!!!"* The point here, is that unless something substantial and significant takes place then nothing is likely to change. Equally, participants also commented that there were many well-meaning 'Actions', and they couldn't see: *"what was going to happen as a result?"*

Participants offered suggestions which they felt could be achieved to demonstrate that their voices were being heard. In no particular order, they were:

1. Greater work with local community groups to gather information to arrive at positives changes which will educate and improve lifestyle;
2. Training and awareness raising - better customer care and culturally appropriate considerations;
3. GPs to spend more time with patients;
4. Better information and sharing outlets within the community and schools – to educate against misinformation through social media;
5. Health hubs in the community;
6. Mental health and early help support space for young people;
7. Fair and equitable treatment of black staff would improve perception.

In the final analysis, what sense is made of the voices will depend on so many other variables coalescing at the right moment to bring about the sort of changes that is needed. That is, variables that are unknown at this moment in time, but once they are aligned, it is more likely that change will happen. Until then, it is hoped that some of the thoughts emerging from the consultative process might just resonate which might make a difference.

The final word of one of the participants perhaps places the challenge in the clearest perspective:

"Allow Black African and Black Caribbean people to be part of the whole process! We have enough educated people in our community who can work and talk for us [and] relay our feelings and have a better understanding of the issues. I would like to see them!"

Birmingham and Lewisham African and Caribbean Health Inequalities Review (BLACHIR)

Introduction

The Birmingham and Lewisham African and Caribbean Health Inequalities Review (BLACHIR) is a joint project between Lewisham Council and Birmingham City Council to understand and take action on long-standing health inequalities for people of Black African and Black Caribbean heritage. The BLACHIR External Advisory Board summarises well the context and background to the project:

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A series of consultations and desk research has been undertaken to inform the *Opportunities for Action* framework (Walsall Report, 2020[4]; Children and young people's Report, 2021[5]; BLACHIR Working Group, 2020[6]). A key aspect of the overall approach has been consultation at the community level, testing out the emerging Actions as well as understanding some of the lived experiences of residents set against the emergent themes from the literature and academic conclusions.

The overarching BLACHIR Review took a thematic approach which explored specific topics to evidence needs and to recommend actions that should drive sustainable change. The themes have been clustered around eight areas as indicated below, which informed the context for the conversations so as to better understand whether those themes resonated with local people:

1) Structural racism and discrimination
2) Pregnancy and early years (0 to five years of age)
3) Childhood and being a young person (ages five to 25 years of age)

[3] The Birmingham and Lewisham African and Caribbean Health Inequalities Review (BLACHIR): External Advisory Board, July 2020
[4] Walsall Healthcare NHS Trust (2020), *'Evidence Summary Report – Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR)'*, Walsall Healthcare NHS Trust
[5] Bullock, M (2021), '*What is the impact of health inequalities on Black African and Black Caribbean children and young people in the UK? A literature review and rapid analysis*', Lewisham Council Public Health
[6] The BLACHIR Working Group (2020), *'Racism and discrimination in health inequalities: literature review'*, Report to the BLACHIR Advisory Board.

4) Staying healthy as you age (from 40 years of age and onwards)
5) Mental health and wellbeing
6) Habits/behaviours that influence your health
7) Social and economic influences (e.g. education, housing, employment, crime)
8) Access to health care and managing health conditions

Within the Lewisham context the engagement process was commissioned by Lewisham Council's Director of Public Health as part of a wider consultation process within the Black African and Caribbean communities led by a collaborative of Lewisham based Black third sector organisations, under the guidance of Kinaraa CIC. The approach was to focus on ensuring the lived experiences and voices of Lewisham's Black African and Caribbean communities was heard. Putting this into context, the Lewisham Health and Wellbeing Strategy states: *"Health inequalities are unfair and avoidable differences in health and wellbeing. Within Lewisham, and nationally, we know that people of Black African and Caribbean heritage suffer from health inequalities and this work aims to address them to make life fair."* It is against this background that this consultation report is to be read and understood.

However, it is important to get a better understanding of the Lewisham context that has prompted the need to explore health inequalities as it relates to Black African and Caribbean residents living in the borough.

The Lewisham context

The starting part in understanding the health profile of Lewisham is captured in the Joint Strategic Needs Analysis (JSNA)[7] reports (Part A and Part B), that was conducted in 2019, prior to the Covid-19 pandemic. This therefore mean that the impact of COVID-19 would not have been captured or factored into the analysis. That said, there is much within the analysis that is still very pertinent, which the pandemic has highlighted, such as the implication of obesity, respiratory conditions and diabetes, to name a few immediate concerns to emerge as strong underlining factors that could lead to serious health and/or death if the virus is contracted.

Diagrammatically, as Fig 1 shows, the purpose and definition of the JSNA is clear, pointing to a process of analysis of needs leading to the setting of priorities. The analysis is not solely dependent on academic research but also engagement at the local level with residents amongst other localised granular driven data and information from a range of sources (e.g. housing, policing, education and so on). From this approach the picture we have of Lewisham offers the following key insights pertinent to this review and consultation process:

Lewisham is a borough of 303, 500 and is the 14th largest borough in London by population size and the 6th largest in Inner London;

The population of Lewisham shows:

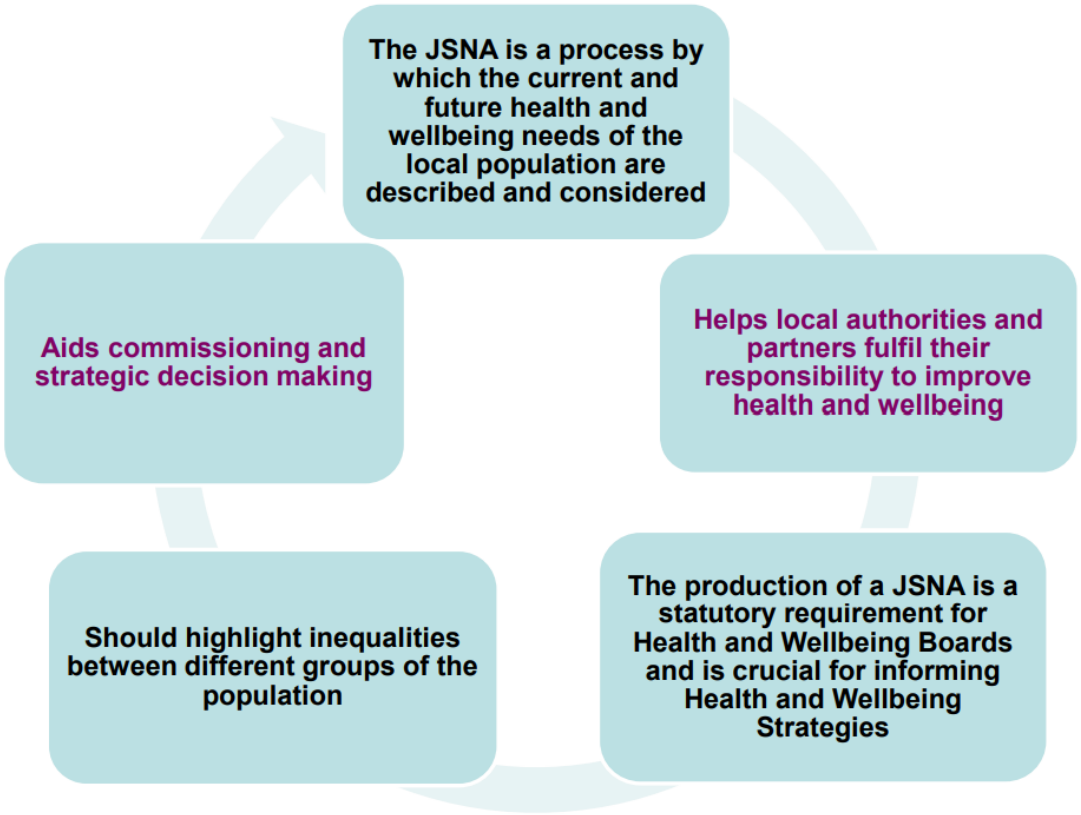
- 23% are aged 0 -17yrs

[7] Joint Strategic Needs Assessment (JSNA): Picture of Lewisham 2019 (Part A and Part B)

- 68% are aged 18 -64yrs
- 9% aged 65yrs+

The population is set to have grown following the 2021 Census to reach close to 320,000 and climbing to over 340,000 by the time of the 2031 Census. The growth will continue to follow the pattern of a younger population bias at the north of the borough (i.e. Brockley, Evelyn, New Cross and Telegraph Hill) with growth not evenly distributed across the borough. For example, Lewisham Central Ward is predicted to see notable increases due to planned developments in the area (i.e. Blackheath, Ladywell, Lee Green and Lewisham Central).

Fig 1: What is JSNA: a definitional overview



Source: Joint Strategic Needs Assessment (JSNA) Picture of Lewisham 2019 Part A

The ethnic profile of Lewisham is forecast to change by 2050:

- By 2028 it is forecast that the White and BME population will be 50/50
- Subsequently the Black and Minority Ethnic (BME) population is predicted to exceed the White population.

An understanding of the current and future ethnic composition of the borough is important as some health conditions impact disproportionately on certain ethnic groups (e.g. diabetes).

There is also disparity by ethnicity in use of and access to some services. Between 2011 and 2031 the size of the population of BME children and young people 0-19 will grow at more than three times the rate of their White counterparts while Other White residents are

growing at a faster rate than White British or White Irish (e.g. Italian, Romanian, Spanish, Irish and Portuguese being the fastest growing non-British nationalities).

The Lewisham Health and Wellbeing Board, supported by NHS Lewisham Clinical Commissioning Group (CCG) [8], has responsibility for commissioning (planning, buying and monitoring) the majority of health and care services in Lewisham. Through their work they bring together organisations across Lewisham to share expertise and local knowledge to create better health and wellbeing for Lewisham residents. The aim is to deliver joined up and co-ordinated health and social care to all residents in the borough by working together to support *'better health, better care and stronger communities'*. In 2015, they identified the following priorities:

- Prevention and early intervention
- GP practices and primary care
- Neighbourhood community care for adults
- Enhanced care and support for adults
- Children and young people's care

A fundamental plank in the strategy for delivering the priorities included *"Improving communication and engagement with the public to promote and improve the way advice, support and care is provided."* This was later refined with the production of the refreshed Lewisham Health and Wellbeing Strategy: *'Health and Wellbeing for all Lewisham residents by 2023',* which started from the premise that the:

> *"…goal of Health and Wellbeing for All by 2023 would require us to think differently about the root causes of health inequalities. We recognised that health and wellbeing is affected by social and environmental factors as well by the choices and actions taken by individuals."*[9]

The challenges that were then identified resulted in new priorities being set around three core approaches: ***populations, communities and individuals and families***[10]. A community approach – bottom up approach – was seen as critical. This was seen as a powerful way to facilitate communities' awareness of and capability to alter the factors affecting health and wellbeing delivered through community development approaches that have been pioneered in Lewisham. Pivotal within this approach was a recognition of Lewisham's voluntary, community and faith sector acting as a '*bridge'* between services and communities, and the neighbourhood care networks emerging from the integration of health and social care that is being provided. These 'bridges' can and do provide additional resources for engaging and empowering communities to improve their own health and wellbeing.[11]

It is against this backdrop that the consultation process and engagement arrangements that has enabled us to produce this report must be seen. To view it outside these parameters is

[8] *Working together for better health, better care, and stronger communities: A summary of our joint commissioning intentions for integrated care in Lewisham 2015 to 201 (January 2015)*

[9] Lewisham health and wellbeing strategy draft refresh 2015-18

[10] Lewisham health and wellbeing strategy draft refresh 2015-18

[11] Lewisham health and wellbeing strategy draft refresh 2015-18

to miss the locus of reflection and the greatest disservice to those living in the borough who are disadvantageously impacted on from the health disparity that exists.

The structure of the report moves from general descriptions to interpretative feedback and analysis arising from the exploration of the eight themes coming out of the early phases of the BLACHIR process that began in 2020 (i.e. the Birmingham study). The report is written so as to move from the general to the specific. In Section 1 we start with a focus on the methodological approach to the engagement process, which is then followed in Section 2 with our key findings arising from both the qualitative and quantitative approaches adopted. The final two sections (Sections 3 and 4) covers a discussion on the key findings with the conclusion offering some reflections on the implications for Lewisham's Health and Wellbeing Strategy.

Section 1: Engagement approach

The research included both qualitative and quantitative approaches, through structured 1-2-1 and focus group interviews and survey questionnaire. Some basic information was captured from each approach, which provided demographic and contextual information on the key characteristics of respondents.

Three organisations were engaged in the direct delivery of the field research (1-2-1 interviews and focus groups)[12]. Through their work and engagement six (6) focus group sessions were conducted and five (5) 1-2-1 depth interviews completed.

The approach adopted sought to better understand participants experience and perception with respect to:

1. Seeking support
2. Accessing healthcare services
3. Experience in using the healthcare services
4. Possible actions to overcome barriers of access and experience

As a result of the process, including the online questionnaire survey, 33 participants engaged in the focus group sessions (28) and 1-2-1 sessions (5). Through the online survey questionnaire approach, a further 55 respondents were engaged; thus reaching 88 participants from which the report analysis is based. The online survey questionnaire asked some questions that were not asked of those who participated in the 1-2-1 interviews and the focus group sessions. For example, 1-2-1 interviews and focus group sessions did not capture data on Ward categorisation, housing/accommodation status and health theme priorities, while the online questionnaire did not ask about the employment status of respondents. Where common questions were asked they have been combined to provide an overall response analysis (e.g. age range, gender, ethnicity and post code).

Quantitative analysis was made possible from information captured from the focus group sessions held, the 1-2-1 semi-structured interviews and the from the online survey questionnaire conducted. The analysis was made the more useful as the online tool used, Survey Monkey, captured and graphically represented responses as responses came in. We used a ranking approach for the eight (8) themes against which weighted average calculations were made.[13] Weighted values were applied in reverse order; that is, the respondent's most preferred choice (which they rank as #1) has the largest weight value, and their least preferred choice (which they rank in the last position) has a weight value of 1. This allowed us to evaluate the most preferred choice using the weighted score (out of the number of actions indicated across each theme, ranging from 3 to 7). We have used this

[12] The three organisations involved were Red Ribbon Living Well, 360 LSN and Action for Community Development (AfCD). Appendix 1 provides further details on each organisation.

[13] Ranking questions calculate the average ranking for each answer choice enabling the determination of answer choice being the most preferred overall. The answer choice with the largest average weighting score/percentage rate for the particular question choice is the most preferred choice (i.e. ranked position).

data to graphically represent the responses by weighted score with the highest percentage response for the chosen option shown alongside the average weighted ranked score (e.g. 2.21 etc)

Based on the three processes indicated, Appendix 2 provides graphic summaries of the characteristics of the respondents to the online questionnaire, the 1-2-1 and focus group sessions. The key features are:

- 54% were Black African and 40% Black Caribbean
- 78% were female, 16% male and 6% non-binary
- 41% were in the age range 41 - 55yrs, 32% within the broader 56 - 64yrs age and 20% within the 25 - 40yrs age band
- 49% were employed (full/part-time) while 30% were unemployed with the rest being students and retired (21%)
- 18% of respondents lived in SE6 post code, 14% in SE13 and 10% SE8, while 10% lived in Catford and New Cross wards.

Arising from the combined process, themes were extrapolated using keyword extractive approaches based on thematic analysis of qualitative responses. From this approach, further refinement was made manually to cluster the themes where they were similar and/or part of the same concerns (e.g. accessing GPs and concerns with receptionists' behaviour/disrespect, were combined under '*Accessibility to GPs'*)[14]. Where appropriate and relevant, the voices of the respondents have been incorporated to reflect the lived experiences of participants.

Thematic analysis ensured that the identified themes are relevant to the research question, and that the themes identified are applicable to the consultation process. This method was considered appropriate given the focus of the consultation and engagement process. The findings presented in this paper are organised according to the themes identified by the BLACHIR advisory team/Board.

[14] Thematic analysis is a method of 'identifying, analyzing and reporting patterns (themes) from responses and information.

Section 2: Key Findings

In their recently published report, Kapadia, Zhang et al (2022)[15], made the point that *"ethnic inequalities in access to, experiences of, and outcomes of healthcare are longstanding problems in the NHS, and are rooted in experiences of structural, institutional and interpersonal racism."* [pp.10] Their observation lay at the heart of the BLACHIR Review, and, in particular the exploration that the consultation process sought to investigate. For decades there has been widespread concerns about the health of Black and racially minoritised people in the NHS as well as the wider healthcare services. Some of the concerns alluded to in the report reflects very much the concerns we were hearing from respondents engaged in this consultation process.

Of the eight (8) themes identified to tackle race inequalities in Birmingham and Lewisham, the top three identified as priorities by respondents to the online questionnaire (based on ranking score out of 8 – Fig 2) were:

1. Structural racism and discrimination;
2. Mental health;
3. Staying healthy as you age.

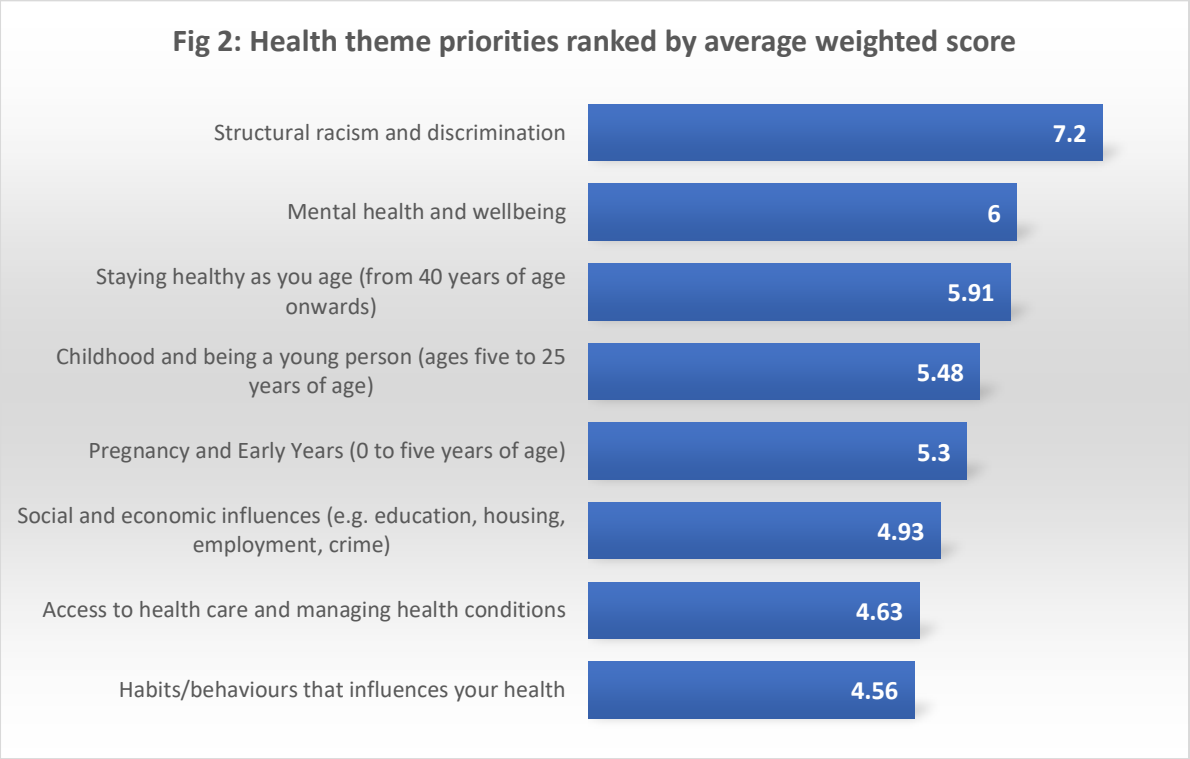
Based on feedback from the open ended questions, the focus group and 1-2-1 interviews, it is clear that African and Caribbean people living in Lewisham are concerned about the level of racism and discrimination that they perceive. Examples of comments from respondents revealed:

"As a consequence, racism has direct effects on mental, physical and social health. Effectively reducing health inequalities involves recognising and responding to the impact of racist victimisation on health: 'if we do not act to address prejudice and negative stereotyping explicitly, whatever action we take to reduce inequality…can only have partial success." [Online respondent]

"Address issues of racial profiling, stereotyping, gatekeeping, hostility and mistreatment experienced at first point of contact in GP surgeries. This negative attitude deters black people from pursuing the health care they need." [Focus group respondent]

Across each of the eight themes, respondents were asked to prioritise those key actions, drawn from the actions identified through the academic review process, that they felt would make a difference to their experience. What follows are reflections on the responses against each of the eight themes.

[15] Kapadia, D et al (2022), Ethnic Inequalities in Healthcare: A Rapid Evidence Review, Race and Health Observatory



Base n=54

Theme 1: Structural racism and discrimination

The definition commonly understood to describe 'structural racism' is that crafted by the Trade Union Congress's (TUC), which states that it is:

> *"...a collective practice that exists in workplaces and in wider society, in the form of attitudes, behaviours, actions and processes. It is the exertion of power and privilege based on race and class."*[16]

Based on this definition, respondents to the online questionnaire were offered the opportunity through the open-ended question option to provide their own feedback. From the responses, participants ranked the key actions they thought should be priorities going forward. Fig 3 shows that more people ranked *Action 2 – Recognition of racism as an adverse childhood experience*, as the most urgent action, with weighted ranking of 2.84, while Action 1 – *Removal of colour language coding in data collection,* was their second priority with weighted ranking score of 2.44.

What was most interesting was that respondents ranked Action 4 – C*ouncil and partners need to integrate diversity into education to reflect diverse cultures* - as their third most important priority with a weighted score of 2.39. What makes this interesting is the often referenced work that is taking place around equality, diversity and inclusion (EDI) within public and private sector organisations, has become prominent and pronounced since the

16 Hussain R, *Shining a spotlight on structural racism in Britain today*, March 2018 (Shining a spotlight on structural racism in Britain today | TUC)

Black Lives Matter (BLM) demonstrations in 2020[17], and yet from the feedback, it would seem that these are perhaps not actions and approaches seen as top priorities. This raises questions as to whether those affected negatively by the healthcare service actually recognise these overtures as being of any help/support to their day to day lived experiences. That is, they are not likely to change their lives significantly.

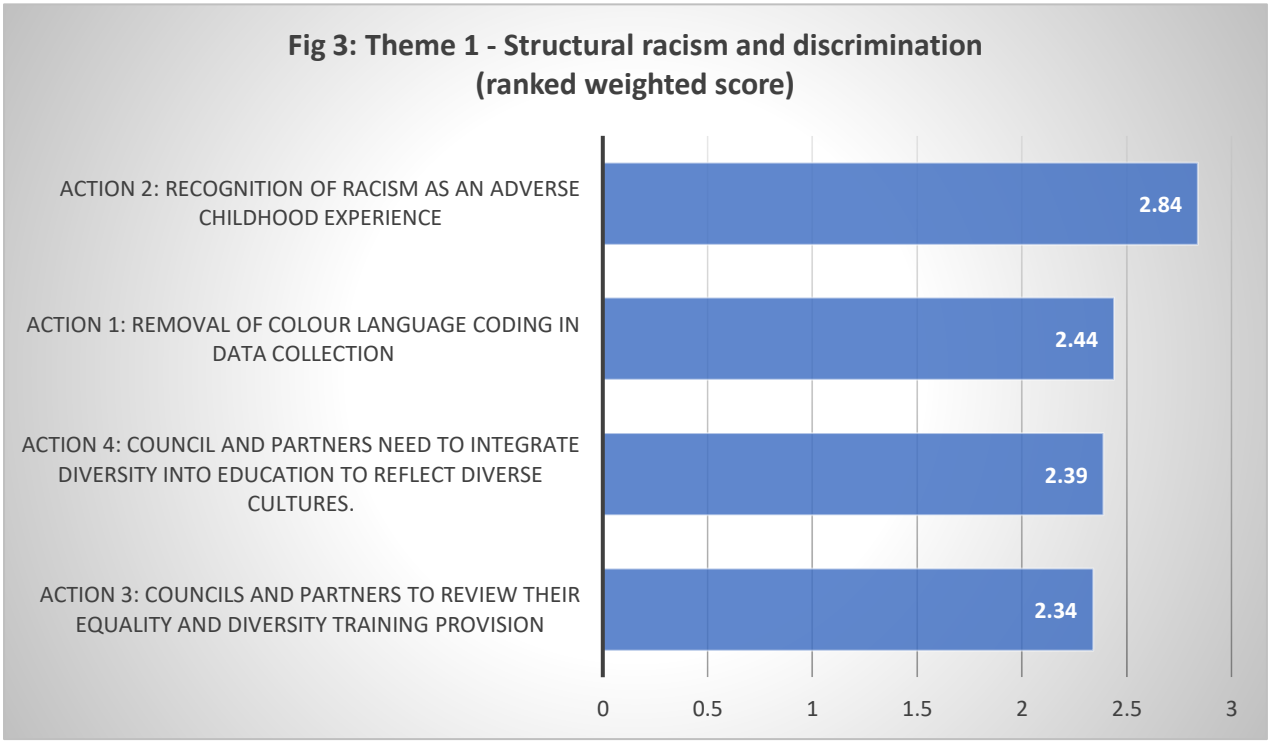
This observation was borne out through comments as:

"*Stop continually reviewing, doing more studies as the evidence and studies already exists of inequalities. Develop strategic links to actions for which all will be held accountable for implementing."* [Online respondent]

"Integrating black and other cultural histories within the British curriculum on a more permanent monthly basis rather than having things like black history month. Also, encouraging training programmes and management programmes for people of ethnic origins." [Online respondent]

"Teaching positive Black history and experiences in all schools. Teachers should all be trained on what racism is and how their behaviour impairs child development." [Online respondent]

"It is not only reviews, but actions and monitoring with clear accountability so as to be outcome driven. Not sure what outcome will be delivered with action 1. Inclusion is essential and those decision makers who orchestrate changes should be representative of those communities they serve. If the desired outcome is not achieved try again with fresh lens." [Online respondent]



Base n=80

[17] George Floyd was murdered by a police officer in May 2020, the outraged that followed, sparked a worldwide Black Lives Matter(BLM) campaign, the reverberation of which has had a major impact on issue of equality, diversity and inclusion right across all spheres of political, social and economic life.

Theme 2: Pregnancy and early years (0 to five years of age)[18]

Walsall Healthcare NHS Trust's published literature review explored various interlinked aspects of health inequalities relating to pregnancy, early years and parenthood specifically in Black African and Black Caribbean communities and comparisons to other ethnic groups. The evidence obtained highlighted health inequalities relating to pregnancy, early years and parenthood between different ethnic groups in the UK (Mindell, 2014, Phung, 2011 and Public Health England, 2017 and 2018) and disparities in UK BAME communities compared to other countries (Nazroo, 2018).

The evidence relating to pregnancy includes barriers for Black African and Black Caribbean women accessing prenatal, postnatal or maternity services (Chinouya, 2019 and Maternity Action, 2018), birth outcomes (Khalil, 2013 and Datta-Nemdharry, 2010 and 2012), diseases in pregnancy (Gopal, 2019) and deaths of mothers (Knight, 2018) compared to other ethnic groups.

The evidence relating to diet in early years highlights the variation of breastfeeding (Tariq, 2016 and Santorelli, 2013), weaning (Moore, 2014) and parental feeding practices (Gu, 2017 and Korani, 2018) between different BAME groups. The relationship between ethnicity and childhood obesity is explored (Falconer, 2014 and Whincup, 2015). Physical health in early years between BAME groups is examined in relation to exercise (Trigwell, 2015 and Love, 2019) and physique (Hancock, 2015).

The evidence relating to parenthood explored the lived experience of Black African and Black Caribbean fathers (Williams, 2013 and 2012 and Baldwin, 2019) with parenting roles of the extended family examined by some studies (Victor, 2019).

The stigma experiences by young black mothers looked after by the state is discussed (Mantovani, 2014) Initiatives supporting parenting programmes to support ethnic minorities (Scott, 2010 and Maynard, 2010) are highlighted. The evidence explores the attitudes of ethnic parents to the diet, weight management and physical activity of their children (Ochieng, 2011 and 2020 and Trigwell, 2014 and 2015) as well as beliefs about vaccination (Tomlinson, 2013). The cultural influences, lifestyle choices and attitudes relating to sexual health of Black African and Black Caribbean parents compared to other BAME groups are outlined (Gerver, 2011 and Ochieng, 2017).

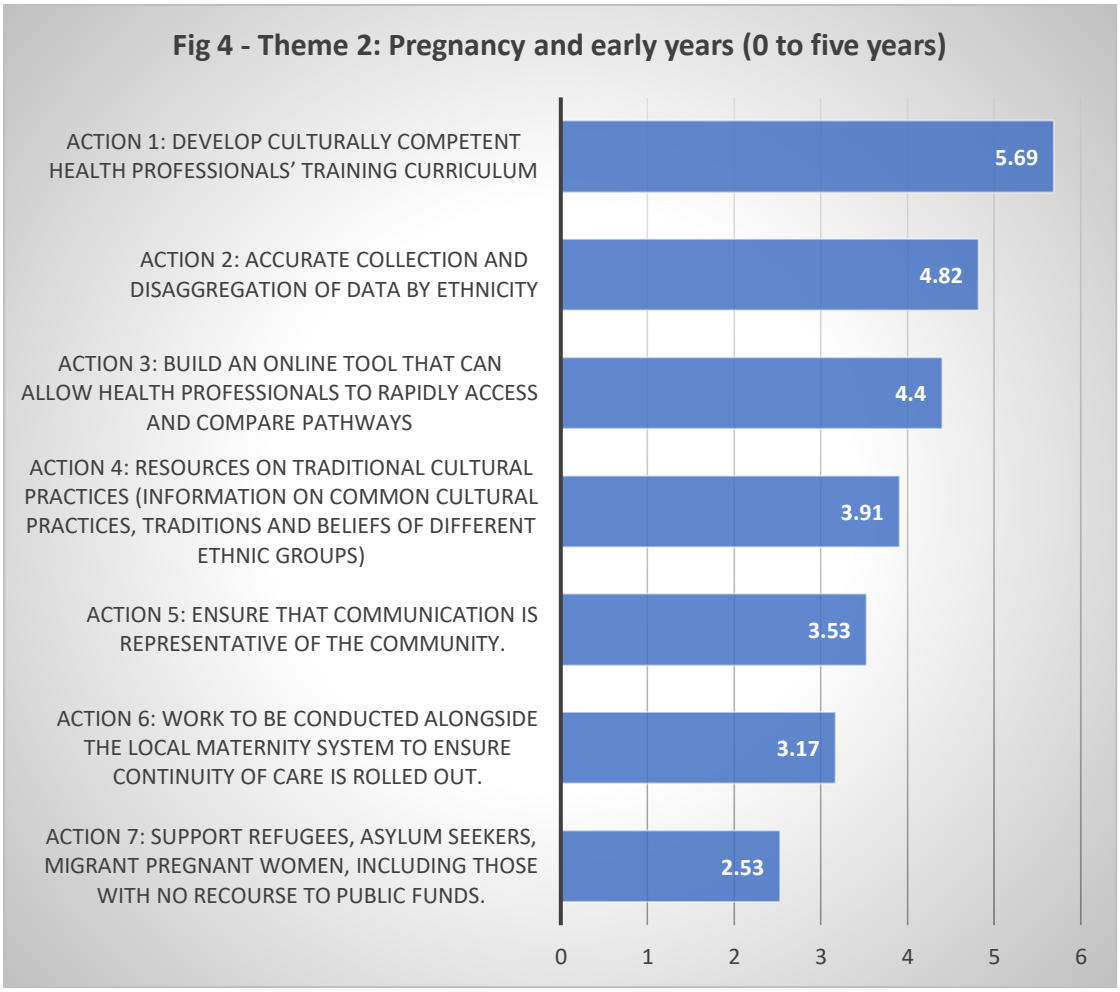
Theme 2 contained seven 'Action' imperatives that were explored with respondents, from which the top three 'Actions' identified followed the order as outlined in the Opportunities for Action plan (Fig 4):

Action 1: Develop culturally competent health professionals' training curriculum with a weighted ranking score of 5.69;

Action 2: Accurate collection and disaggregation of data by ethnicity with a weighted ranking score of 4.82;

[18] Evidence Summary Report – Birmingham Lewisham African Caribbean Health Inequalities Review (BLACHIR); November 2020 - Birmingham City Council and Lewisham Council Public Health Divisions. All references are cited in this publication.

Action 3: Build an online tool that can allow health professionals to rapidly access and compare pathways with a weighted ranking score of 4.4.



Base n=77

The observations from respondents to the focus group and 1-2-1 interviews, as well as the open-ended responses, highlighted the following comments:

"*Refreshed training for all healthcare professionals as a work-related reminder for treating people the way they would like to be treated. Reminding health care professionals to have a good customer service polite language like bankers."* [Online respondent]

"Data is essential to prioritise those most greatly disadvantaged and marginalised. In addition, the low hanging fruits should be action following by a determined plan of action for others given the limit of resources." [Online respondent]

"White counsellors seem not interested. They're going through the motion unlike black counsellors. In my experience I was able to give back some sense of empathy. There is the ability to discuss with the personal journeys and experience it with somebody from your own background while this wasn't possible with a white worker." [Focus group respondent]

Theme 3: Childhood and being a young person (ages five to 25 years of age)

From the review undertaken by Lewisham's Public Health[19] (2021) around the health and wellbeing of children and young people, a number of themes of concerns were identified, which included:

Physical health: BMI was shown to potentially overestimate the burden of overweight and obesity in Black children because it fails to account for body composition, specifically body fat, which on average is lower in Black children, who also tend to be taller; physical activity levels were not lower in Black children, but cultural factors may affect parents' engagement with out-of-school physical activity interventions; Black children generally had lower blood pressure than White children, but Black boys showed a greater increase in blood pressure from 12 to 16 years than White boys; Type 2 Diabetes risk factors in Black children were broadly comparable with those seen in White children (South Asian children were at higher risk), but Black children in higher Socio-Economic Status (SES) groups may show more risk markers than White children of the same SES.

Mental health and emotional wellbeing: Black African and Black Caribbean children and young people generally reported higher levels of mental wellbeing than White participants of the same studies, however one study found that Black Caribbean children reported higher levels of social difficulty factors at 7 years old. Family activities and cultural integration (identified as ethnically diverse friendship circles) were shown to have a protective effect.

Risky behaviours: There was evidence of ethnic diversity in risky behaviours and in risk factors for behaviours. White and mixed ethnicity young people reported higher levels of substance misuse than Black young people, and Black Caribbean young people were most likely to report having unprotected sexual intercourse; Black African young people generally had fewer risky behaviours than Black Caribbean young people; cannabis use, mental health difficulties and strong peer or neighbourhood affiliation were associated with risky behaviours; a seven year study in a London GUM clinic found that Black British and mixed ethnicity teenagers were over-represented in the cohort of teenage pregnancies, compared to the study setting's clinic population.

Educational attainment: Black African and Black Caribbean children, on average, reported higher levels of aspiration than White children in multiple domains, including school, yet Black Caribbean pupils on average have lower levels of academic attainment; school factors included the recognition and celebration of cultural diversity and of Black cultural identities within the school setting.

Social inclusion: Black young people in contact with Youth Offending Services may not have equitable access to healthcare, with mental health needs in particular less likely to be identified and supported; young Black men's early exposure to 'adult' styles of policing may create feelings of unsafety and social exclusion; Black children were, on-average over-represented, in the care system; engagement with a variety of health services may be lower

[19] Bullock, M (2021): *What is the impact of health inequalities on Black African and Black Caribbean children and young people in the UK? A literature review and rapid analysis*; London Borough of Lewisham.

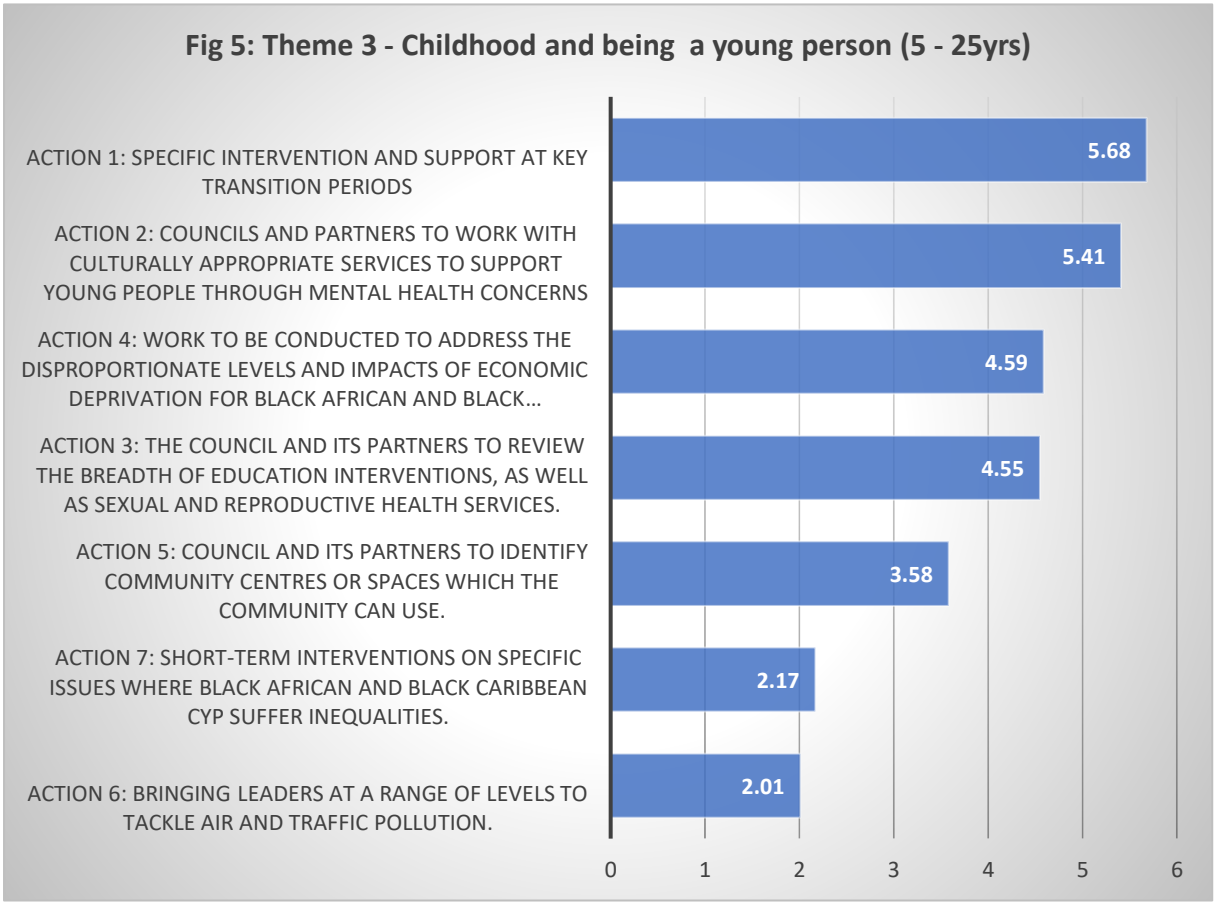
in Black African and Black Caribbean populations, including immunisation, CAMHS, and being registered with a dentist.

Theme 3 contained seven 'Action' imperatives that were explored with respondents, from which the top three 'Actions' identified were (Fig 5):

Action 1: Specific intervention and support at key transition periods with a weighted ranking score of 5.68;

Action 2: Councils and partners to work with culturally appropriate services to support young people through mental health concerns with a weighted ranking score of 5.41;

Action 4: Work to be conducted to address the disproportionate levels and impacts of economic deprivation for Black African and Black Caribbean communities with a weighted ranking score of 4.59.



Base n=76

Comments captured from respondents on their lived experiences reflected the general tenets of the findings, which reinforced the priorities identified:

"Understand the poor health experiences of black people and ensure equal access to therapies rather than being medicated." [Online respondent]

"Medium and longer term interventions to support black communities that suffer inequalities and robust sanctions when this happens to demonstrate the Council's commitment to eradicating racism and discrimination. Investment in communities developing services as they know best what they need." [Online respondent]

"Focusing on youth employment creating jobs within 16 to 25-year-olds support for mental health housing food clothing etc; fatherhood programmes when men could support each other as also support the local wider community." [Online respondent]

"Ensuring the curriculum pushed in schools isn't glorifying racist authors or texts such as Roahl Dahl, Of Mice and Men etc." [Online respondent]

"Parents to make sure that they know friend of their children and to engage young people with house activities like cleaning, cooking, washing clothes and ironing, washing up dishes, etc making sure that they are being used at home rather than depending on the outsiders like group etc. Charity begins at home. It's parent's responsibility to teach their children discipline and how to behave and respect." [Online respondent]

Theme 4: Staying healthy as you age (from 40 years of age and onwards)

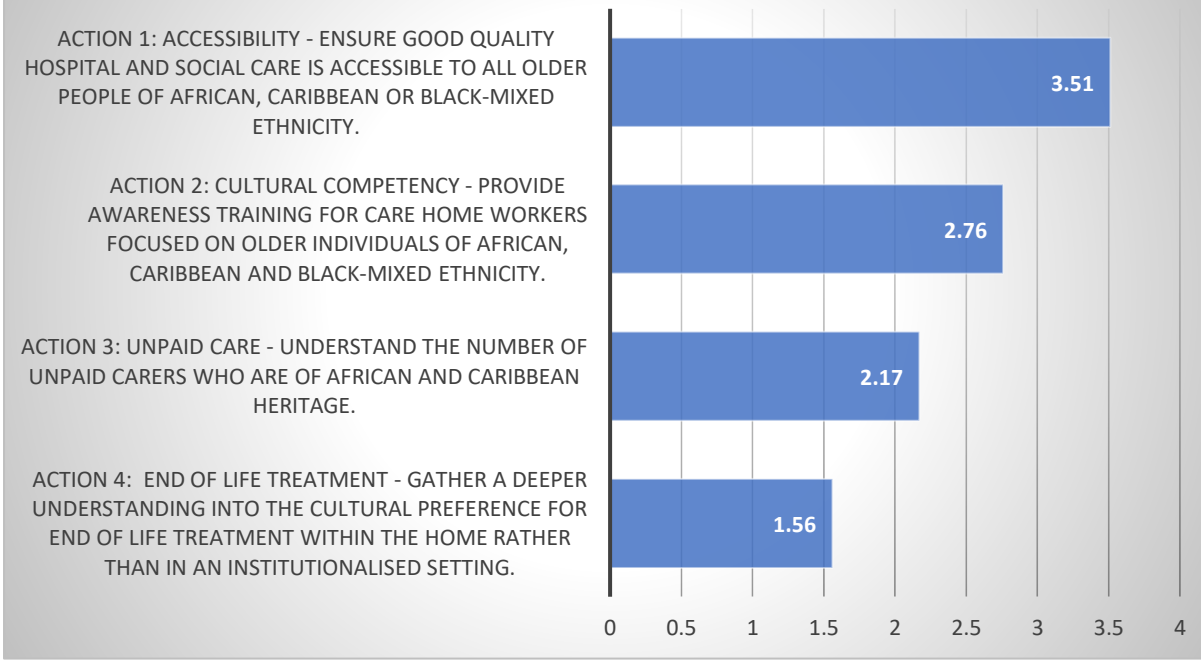
Theme 4 contained four 'Action' imperatives that were explored with respondents, from which the top three 'Actions' identified followed the order as defined in the Opportunities for Action plan (Fig 6):

Action 1: Accessibility – ensure good quality hospital and social care is accessible to all older people of African and Caribbean or Black-mixed ethnicity, with a weighted ranking score of 3.51;

Action 2: Cultural competency – provide awareness training for care home workers focused on older individuals of African, Caribbean or Black-mixed ethnicity, with a weighted ranking score of 2.76;

Action 3: Unpaid care – understand the number of unpaid carers who are of African and Caribbean heritage, with a weighted ranking score of 2.17.

Fig 6: Theme 4 -Staying healthy as you age (40yrs+)



Base n =75

From the comments and discussions that took place, it was very evident that participants were concerned about how the elderly was being treated and/or accessing the healthcare services. They included:

"Racism training compulsory for all professionals and robustly monitored with the involvement of service users." [Online respondent]

"Patient voice captured and incorporated in service improvement. Tailored relevant health information that supports good health." [Online respondent]

"Financial and respite support for carers within the community will be an advantage moving forward." [Online respondent]

"Action 3- what is to be done with that understanding? If nothing then there is no outcome!!!" [Online respondent]

"Immediate racism training to be completed by LA System Leaders." [online respondent]

"The elders have to queue up, they struggle and are not mobile savvy. It has become frustrating. The more able-bodied person can access at least three devices so they can make arrangements using mobile devices and it can take up to 45 minutes waiting to get through to somebody for an appointment. These are some of the issues that the elder generations face." [Focus group respondent]

"I needed surgery and I've been affected by mobility and having to live in pain with pain." [Focus group respondent]

"Since December 2021 I have been waiting to see a physio and I'm in pain. They tell me someone will get back to me but so far no one has. That is what we are often told." [Focus group respondent]

Accessing GP services was of particular concern and came up in all the focus groups:

"…getting to them via the online takes forever to get an appointment; almost 2 weeks. The GP services need to be more available." [Focus group respondent]

"You ring from early hours, and you still don't get an appointment. We need allocation of time." [Focus group respondent]

"We are limited to what you can discuss with the doctor in that you can only talk about three things in 10 minutes. You get cut off and then next appointment I will follow up." [Focus group respondent]

"I couldn't get any joy with my doctor in Lewisham, so I changed to one in Croydon." [Focus group respondent]

A disability participant commented: *"… I have been ringing since October 2020 and no response as yet as to an appointment. I finally got a response in May 2021 but still no one got back to me up to now [Feb 2022]."* [Focus group respondent]

Theme 5: Mental health and wellbeing

Theme 5 contained three 'Action' imperatives that were explored with respondents, from which the 'Actions' identified were in the same order as presented (see Fig 7). The responses were closely clustered, which suggests the differences between the actions were fairly small.

Comments from respondents indicate some confusion about the choices while at the same time endorsing some of the action points indicated:

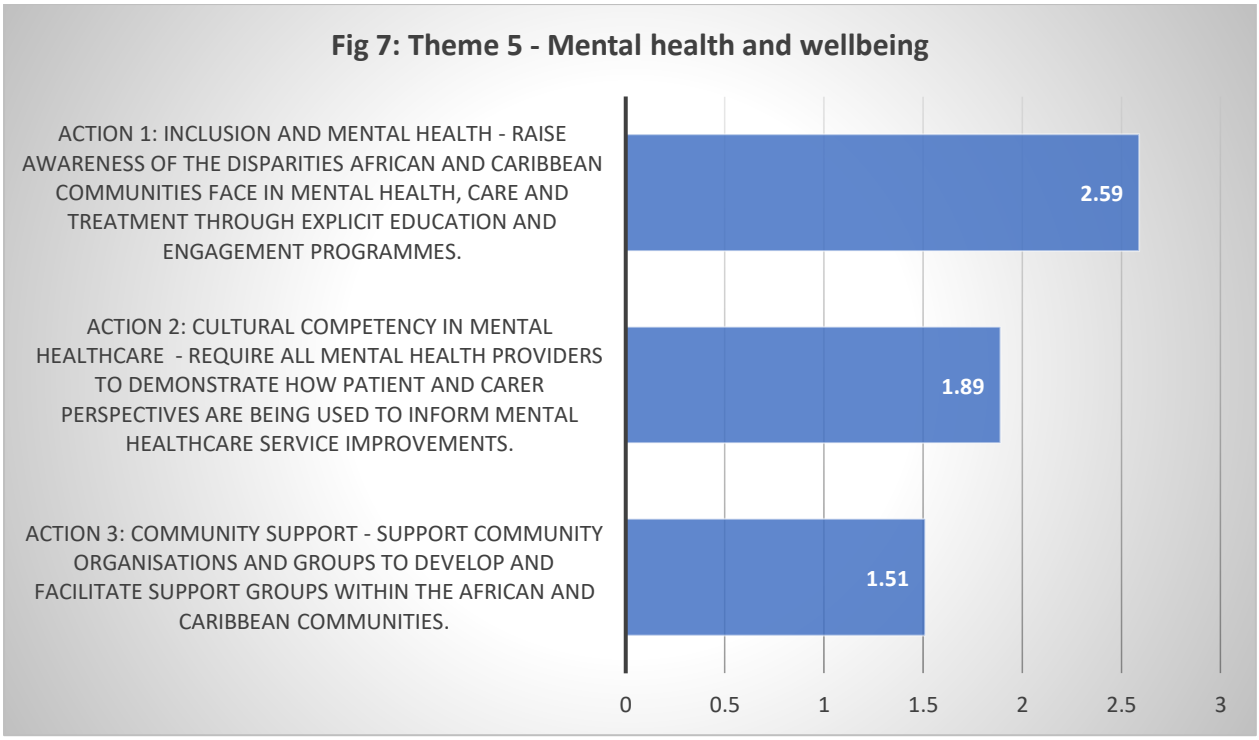
"All professionals undergo racism training and service users involved in ensuring policy and practice is adhered to." [Online respondent]

"Neuro diversity is an area that have to be explored company called neuro pool I recommend highly as they look at the abilities of neuro diverse people rather than disabilities and how to integrate them into the community as an outfit and that includes sustainable employment training and education and learning and development for further information please don't hesitate to contact me ….." [Online respondent]

"Little unclear of the outcome of action 1? Inclusion is critical but confused by narrative above. What is done once educated? Accountability is key for action 2. For action 3 clear monitoring with outcome focus is required for meaningful outcomes. To include sharing of best practice." [Online respondent]

"Creation of Community Centre healthy active group. Healthy nutritional campaign scheme and health awareness day. Healthy eating surveillance group." [Online respondent]

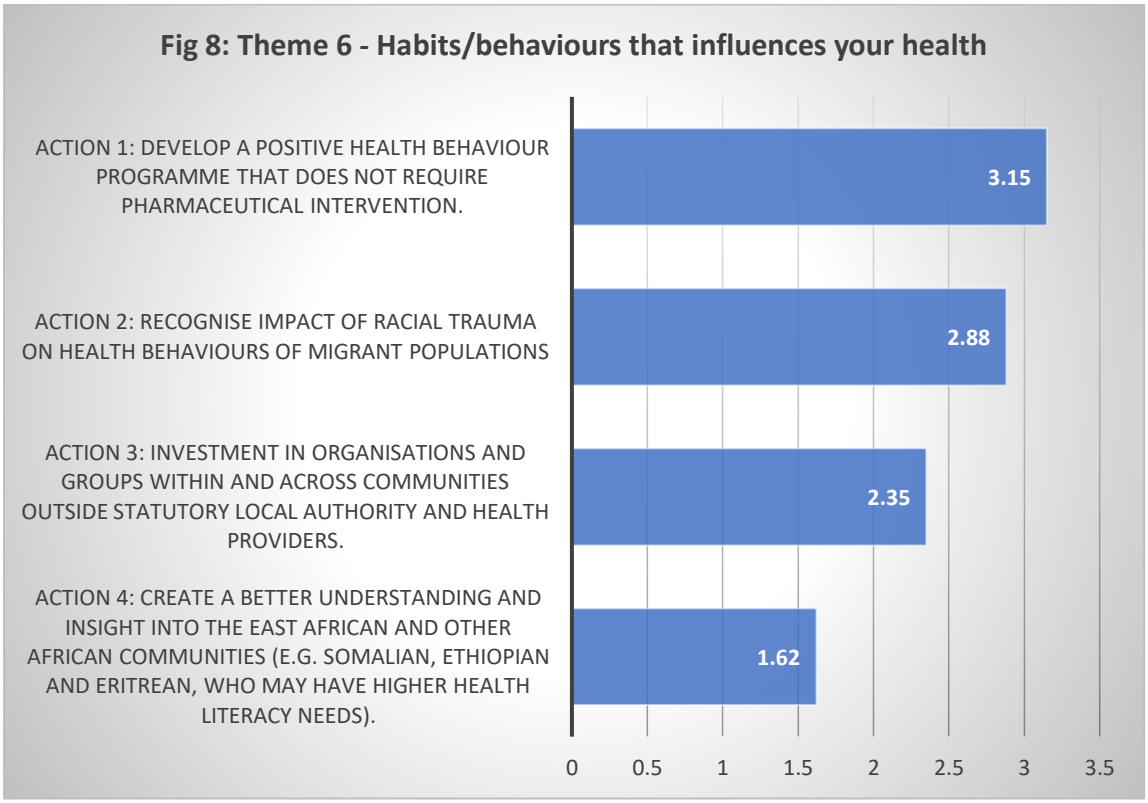
Healthcare professionals, they don't understand the black African culture backgrounds including personal life, taboos especially when it comes to mental health.



Base n =76

Theme 6: Habits/behaviours that influence your health

Theme 6 contained four 'Action' imperatives that were explored with respondents, from which the 'Actions' identified were in the same order as presented (see Fig 8). The responses to Action 1 had provoked some concerns within the focus group sessions, with participants across three of the six sessions raising this as a concern. Respondents, in the main, felt that GPs and the medical profession was too quick to 'prescribe medication' without offering them alternative options. This was especially more so from those more familiar with remedies from their country of birth: *"I would have liked to hear more about some of those remedies"* they said. [Focus group respondent]



Base n =74

Comments from respondents provided a good spread of views, especially around the question of alternative medicines. Comments included:

"Regular sessions delivered in safe spaces to communities on all health conditions."[Focus group respondent]

"Funding is a basic necessity to mobilise some of the ideas coming for the actions to be practically implemented." [Online respondent]

"For Action 3 proper support is key to success." [Online respondent]

"Recognise that the solution isn't always found in drugs. We are different in our physiology thus need to work to different tolerances. Example, black men must be tested 5 years earlier than white men for prostate cancer. Testing of black men should start at 40 years." [Focus group respondent]

"I am diagnosed with a high blood pressure, and I have tried African remedies but the support group I found to be helpful. By sharing information food nutritional approaches et

cetera and referrals through connections has been made possible." [Focus group respondent]

"I've been diagnosed with depression and thought was a family issue but found it difficult to come to terms. I didn't take tablets because people said it would put and put on weight, so I don't. Work is also impacted on having difficulty with sleeping etc." [Focus group respondent]

"Those with no recourse to public funds are affected and the ability to get medication. Support groups want passport and then the NRPF have very little support. I have a strong faith which is kept and kept me straight." [Focus group respondent]

"We're going mad if i take the medication; took it and I'm not feeling well and therefore assuming the tablet/medication worsening my condition." [Focus group respondent]

"There is also the need to raise concern options in relation to alternative medicine especially natural remedies these should be more available and should be discuss more openly." [Focus group respondent]

"*Where I have had mental health suicidal tendency there is no number I can call and not everybody can call for help. Mental health patients get little support. My religion and faith prevent me from taking my life by committing suicide*." [Focus group respondent]

"There is a need to investigate whether alternative medicines do indeed have helpful properties. Drugs are poison. Good healthcare system must be put in place." [Focus group respondent]

"Traditional remedies work, something we've been used to. Back home we are used to natural herbs from the ground and now we are faced with a system that is dependent on pharmaceutical drugs. There is therefore a clash of culture." [Focus group respondent]

Theme 7: Social and economic influences (e.g. education, housing, employment, crime)

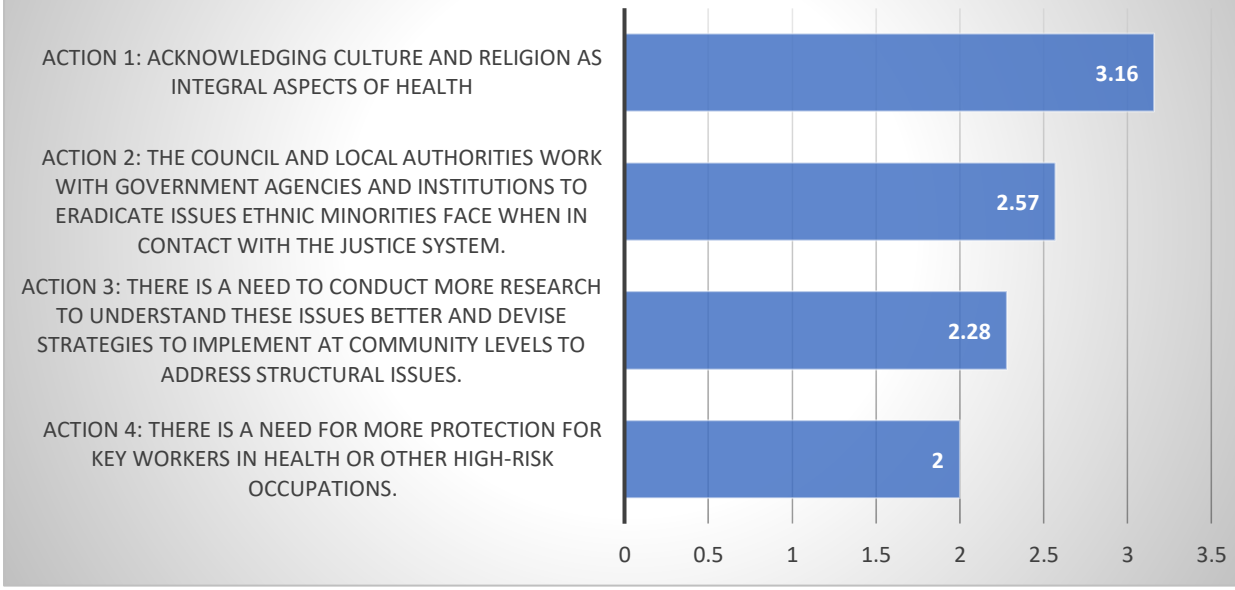
Theme 7 contained four 'Action' imperatives that were explored with respondents, from which the priority 'Actions' identified were in the same order as presented (see Fig 9). As the overall top ranking score was 3.16, suggesting that this was an overwhelming priority for those who responded to this. The inability to understand cultural background, including religion, was seen as a factor in them receiving good health care. This was a point some respondents commented on, with some participants concerned about how the actions would be realised.

The JSNA (2019) report concluded that crime has a number of impacts on health, including fear of crime and the direct impact of detrimental effect on the physical and mental health of victims. Thus:

- Lewisham has the 17th highest crime rate in London (MPS, 2017/18)
- Hospital admissions for violence are now in-line with the London and England average (HES, 2015/16-2017/18)

- 26.6% of offenders are recorded as re-offending, in-line with London and England (2014, MoJ)
- The police are involved in a number of initiatives and groups alongside the council and health partners such as the Alcohol Delivery Group.

Fig 9: Theme 7 - Social and economic influences (e.g. education, housing, employment, crime etc)



Base n= 76

Reflecting on their own experiences, respondents offered insights which shed some further light on some of the challenges in accessing good healthcare in Lewisham as well as possible shortcomings in actualising the actions. Some respondents were mindful that some of the healthcare issues related to issues such as poor housing conditions, crime and traffic and road work related congestions. They stated:

"…the wider social conditions are factors, such as housing, education criminal justice system. These are some of the challenges that also triggers mental health." [Focus group respondent]

"I live in cramped conditions and have to share rooms with different sexes. We have to remove and relocate to other accommodation, but I have to ask other councils as Lewisham doesn't have any units big enough for our needs." [Focus group respondent]

"…. without being action outcome driven, we could end up with reports and data with little difference being made. Those with decision making power should include the communities served and be held accountable on an on-going basis. We are starting from a low base and there is much to do. Allies will be important in pushing for the changes we want to see. However, those changes should be informed by our experience, and we should have representatives from our community to speak out at the decision making table." [Online respondent]

"Performance reporting should be published more readily and openly for communities to access." [Focus group respondent]

"There are other issues to contend with such as housing, financial, immigration and poverty. These compound the situation and make our health worse; this adds to our mental health." [Focus group respondents]

"We are not seeing people because there is a lack of networking due to Covid and the restrictions. This is affecting relationships. People are not eating well largely due to financial insecurity leading to unhealthy eating; we need therapeutic options, exercises and be able to see appropriate and relevant people." [Focus group respondent]

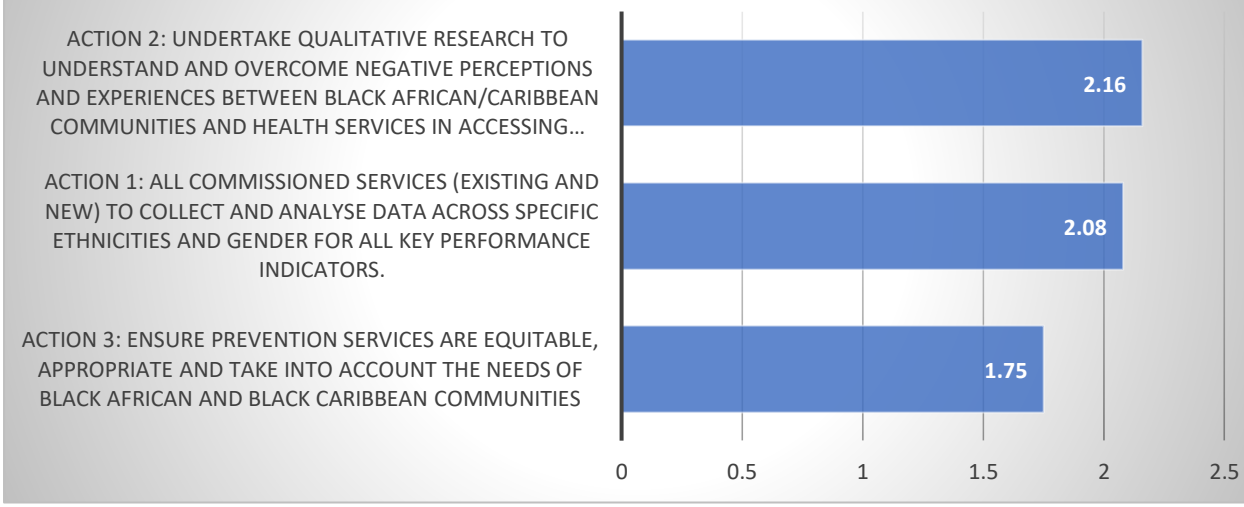
"*Ongoing leaks, can't get through to the repairs line; I am getting no response to online reporting - weeks later still nothing. I live in a high rise flat with people always sitting in the stairwell on the ground floor. It's not a good condition."* [Focus group respondent]

"… racism is an issue because of police and their reaction to black boys. Stop and search is everywhere which has led to crime." [Focus group respondents]

Theme 8: Access to health care and managing health conditions

Theme 8 (Fig 10) contained three 'Action' imperatives that were explored with respondents, from which the top priority was Action 2 – *undertake qualitative research to understand and overcome negative perceptions and experiences between Black African/Caribbean communities and health services in accessing care, including the influence of structural racism and discrimination* (weighted average ranking score of 2.16). What is of interest is that respondents felt that Action 1, which referred to the collection of data, was recorded as being of second top priority of the three Actions indicated. This, linked to Themes 1 and 2 on data capture and Themes 5, 6 and 7 to wider understanding of the impact and effect of health inequalities, suggest that Black African and Caribbean communities are not averse to engage and share their experiences. It is of interest because it is often said that Black African and Caribbean people do not want to (or indeed) engage in consultation processes. The overall responses to this process would suggest otherwise and the responses to questions of further 'qualitative' research and engagement would seem to suggest that they would.

Fig 10: Theme 8 - Access to health care managing health conditions



Base n=73

Generally, the comments from respondents reflected a sense of willingness to engage as well as indication that their voices are not being heard, especially where long term health care is concerned. Comments indicated below provide a useful summary of the tenor of the voices coming through:

"I'm a firm believer that intervention is better than cure so preventative pressures." [Focus group respondent]

"All 3 are essential. Clear accountability with action for change arising and not an exercise of data collection." [Online respondent]

"Disabled black African and Caribbean people should be provided services and support they require as they tend to be left behind." [Focus group respondent]

"Regardless of ethnicity, gender etc, as far as I'm concerned, we're all family and that we have a responsibility to put positive energy into our communities to keep this world a safer place. I aspire for utopia where we are one and support each other, where everyone has the right for warmth, food, shelter, water, education etc. I'm a romantic at heart, I will always aspire to greatness." [Focus group respondent]

"Routine collation of patient feedback should be compulsory in performance reporting." [Focus group respondent]

"Long-term care you get for the older generation is poor let alone if you have HIV?" [Focus group respondent]

"We do need a care agency that is dedicated to those living with HIV+ to be put in place; we don't see much of these around." [Focus group respondents]

"An HIV plus patient went to the hospital at 7 am in the morning until 5 pm in the evening and during this waiting time nobody came out to say sorry to him instead he was told that it was on the elderly people." [Focus group respondent]

"There are no guidelines or a proper procedure for people living with HIV, especially those housebound they have to administer their HIV medication themselves. There is no long-term physical support for people living with HIV because they are aging." [Focus group respondent]

Section 3: Discussion

One of the questions posed to participants in the focus group sessions was: *'What does it mean to live in Lewisham in terms of conditions affecting health?'* This question provoked so many reactions in terms of the impact some living condition was having on people's health and wellbeing. Not only this, but individuals were very animated in their condemnation on their attempts to secure redress, especially to concerns about getting access to GPs and other health care services. Participants offered a range of situations that they felt impacted on poor health, from housing to waiting time to get through to a GP to roadworks and congestions to crime. As the recent report by Race and Health Observatory (RHO) states: "*there is a lack of appropriate treatment for health problems by the NHS; poor quality or discriminatory treatment from healthcare staff; a lack of high quality ethnic monitoring data recorded in NHS systems; lack of appropriate interpreting services for people who do not speak English confidently and delays in, or avoidance of, seeking help for health problems due to fear of racist treatment from NHS healthcare professionals."* (Kapadia,2022)

The voices of those participants that took part in our consultation process reaffirmed many of the concerns being expressed in that report. Indeed, using a thematic approach to clustering the main concerns emerging from the conversations, we have been able to identify six themes, which seem to reflect and add further weight to the ranked Actions they were asked to prioritise. In general, we found that participants' concerns and experiences fell into the following six broad and embracing areas of concerns:

1. *Accessibility to GPs (i.e. waiting time, booking appointments etc)*
2. *Trusted and accurate information (including communication and language issues)*
3. *Immigration status*
4. *Cultural expectations (i.e cultural insensitivity; taboos and stigma etc)*
5. *Care home v 'home care' concerns*
6. *Wider social and economic factors (ie. Impact of poor housing, traffic congestion and crime)*

Accessibility to GPs (i.e. waiting time, booking appointments etc)

Participants were particularly concerned about the difficulty being faced with trying to book appointments. Those who were elderly were seen as being more vulnerable due to their inability to access and become familiar with the technology of mobile phones, laptops and other smart devices, which they now needed to be able to get in touch with their GP surgery.

Other concerns raised in respect of trying to access GPs involved what seemed to them to be a hurdle of the 'gate-keeper'. That is, the receptionists were seen as a barrier alongside the time they can spend with the doctor, when they do eventually see them. As one respondent explained:

"….the first thing you're told by your doctor is that you a medication. We need at least three visits before we get a proper diagnosis. We are almost never believed." [Focus group

respondent]. For this patient, the doctors do not wish to engage them about their illness because they 'don't have the time'.

Another respondent highlighted how long she had to take to get an appointment. Said the respondent: *" I was really ill and couldn't get access for 45 minutes waiting for someone to see me. And when I got to see my GP he said he could only talk about one issue."* Another explained that they had a respiratory problem and her doctor just *"prescribed paracetamol which turned out to be the wrong presumption and prescription as this made me worse. I was allergic and it made me worse. I had no confidence from that moment. I cannot trust them to do anything and refuse to go back to the GP."*

On the question of the gate-keeper receptionist, respondents commented that many of them are insensitive and disrespectful. One respondent offered the following:

"There is a lack of understanding with the receptionist. They are the gate-keepers into the GP and this is difficult and I end up getting depressed."

Another commented that the *"receptionist always wants to know why you want to see the doctor. This often feel intimidating." While another respond with an example exclaiming "receptionists* need to be more responsive and respectful."

And finally, this respondent's comments perhaps sum it up well when he said:

"Difficult to get appointment to see your GP due to long waiting on calls and when calls are answered, the appointment has already gone and then you are told by the receptionist to call again the next day."

Trusted and accurate information (including communication and language issues)

For many of the participants who took part in the focus group and 1-2-1 interviews a common refrain was the lack of 'proper and accurate information' coupled with difficulties around language. As one respondent explained:

"… I have been in this country for over six years, and I have still yet to fully understand how to access information. Information is fragmented with many challenges because, in Africa, we are not used to having regular check-ups. We are now finding new diseases through this process." [Focus group respondent]

More worrying is the role social media seem to be playing in both 'diagnosis' and in obtaining information as to where to go/what to do. This example from a participant was typical of the concerns being expressed: *"Social media has become the 'source' for information and not necessarily good information ('misinformation')."* For this individual – and from the response of the others in the group, it was one that was widely recognised. There seemed to be a lack in confidence to 'challenge' GPs and healthcare professionals where feel they are not being given sufficient information and so revert to online chatter and information – some of which may not be accurate.

Where English wasn't the first language some participants felt they were at a disadvantage. Some expressed concern that they weren't taken seriously, and especially 'gate-keepers', were seeming not able to 'understand them'. These two responses make the point clearly:

"…Where English is not my first language, especially as an adult, making arrangements with others is difficult. Staff on the front line are not supportive. We have to go to A&E and wait in the line and that waiting time is very high because the GP is inaccessible." [Focus group respondent]

"People are unable to express themselves therefore they are vulnerable and when you get to see the GP they suddenly come out with: "so many of your people from your country come here with HIV". [Focus group respondent]

Immigration status

It was clear that those who are still trying to resolve their immigration status have a particularly hard time. Until their status is confirmed, it they are unable to register to a GP surgery and can only access A&E, which can clog up the system with conditions/concerns that perhaps a GP could have been able to deal with. This therefore must place extra burden on the NHS more generally, as many of those caught in this limbo state, may also decide not to access even the A&E until the condition becomes unbearable. As one respondent remarked*, "prevention is better than cure."*

One respondent offered the following insight: "People who are not in the system are not able to access medical services and immigration takes long to be decided." As they see it, those who find themselves in this situation could so easily slip through the net and could, later down the road when the condition requires surgery or worse, they become additional burden on the system. As she stated: *"…undocumented people slip through the system with "many dying for fear of being reported".* And under those situations, they do not present themselves until it's too late (or not at all). If they do not have a confirmed status they are deemed to have no legal rights and *"therefore we are not registered with a GP service."*

Cultural expectations (i.e cultural insensitivity; taboos and stigma etc)

There is a need, said participants, for there to be better understanding of the cultural needs of individuals. The views that were expressed indicated that the health care service professionals "treat all black people as the same; not all Black people are the same and we are different." The concern here is that by understanding the different cultural concerns and expectations will provide for a better service to the Black communities more generally.

As one participant puts it, *"religious and cultural expectations are different around certain things, like, for instance, requests for gender specific attention/consideration: "take all black people to be the same."* Another responded by saying that health care professionals are too *"…quick to label black children as mentally disturbed*", with *"many ending up with the wrong diagnosis and put in inappropriate places."* [Focus group respondent]

This raises questions around the need for culturally specific mental health care service provision, especially as the idea of mental ill health can be seen as a taboo matter, carrying with it a stigma. It was felt that the social prescribing approach could be an area of support, especially working with and through community based organisations. In some communities,

as participants generally acknowledged, there are certain health related concerns that are not spoken about/mentioned, even with health professionals. Issues around mental health, disability and HIV were given as examples. One respondent made the following observation:

"We need awareness raising within the community as well as in the health care services generally. Stigma around HIV and issues within hospitals and amongst healthcare professionals need to be addressed. Stigma and discrimination for people living with HIV is still there. It continues to be a problem." [Focus group respondent]

And another retorted "[mental health] is taboo. We're told to shush, to hide and then to get help is even more difficult." There is a thinking that this might be spiritual which mean greater awareness is needed. Another participant felt that within the African community, more so than Caribbean communities, that there is much talk and consideration given over to spiritual considerations and therefore more needs to be done to try and redress concerns around mental health. This would seem to be a concern that is levelled at the wider health care service as well as within communities.

If people with long-term conditions are treated in this way and this is Europe with expectation that it will be much better then what hope is there? Said one responded. They didn't want to touch any anything including the bedlinen they felt the user i.e. the person with HIV positive was useless and they had to and they were wearing gloves.

Care home v 'home care concerns

Discussions around the impact and implication for the care of the elderly threw up concerns about the lack of care many believed care homes provided compared to 'home care' options. *Participants felt that some of care homes were not habitable nor conducive to the care their loved ones required. Also, it was stated that care homes are another 'taboo' subject within communities. "We need positive mindset of those who are caring in these Institutions,"* said one respondent. Overwhelmingly, the views expressed were very clear that *"care homes are uncaring and prefer end of life being at home".* Another responded saying: "*they are not getting the care they deserve. The dignity and support are not there, while there is greater accessibility and support in the home environment."* One respondent exclaimed that it is a 'common knowledge *"that once you go in you don't come out."*

At another level, we heard from participants about the impact of Covid-19 on the mental state of elderly loved ones. Concerns were expressed about the isolation many were experiencing and the absence of "social clubs as they are important in offering a space in the community for gathering." They went on to explain that many have closed down due to lack of funding and as such, what used to provide a welcoming space was no longer there: "*Programmes that enable them to get out and interact, provide some mobility and subsidised physio was no longer available."*

Wider social and economic factors (ie. Impact of poor housing, traffic congestion and crime)

Poor housing, traffic congestion and crime in the borough was seen as factors contributing to poor health and wellbeing, especially with regards to anxiety and raised stress levels.

The conditions of some homes were said to be in poor condition, especially those living in council housing, with repairs taking some time to rectify. We heard from participants living in cramped conditions and mould circumstances. For example, one participant shared that they are experiencing a situation where repairs need to be undertaken and the landlord is 'absent' and cannot be contacted has left them feeling really anxious and depressed. Another commented on their experience with their housing association not taking their 'mould' concerns seriously. As she said, *"I have to wash the walls on regular basis in order to stay healthy. The water running down the walls, but nothing has been done I have caught a cold as a result. What regulations exist to protect tenants?"*

Crime was said to be a borough-wide concern which was affecting young people's mental state and how they relate to each other. An example from a young person of a situation shared puts this concern into perspective:

"A boy was stabbed from my school and a girl got pushed into main road on to oncoming traffic. There is increased bullying and violence in schools, and I am reluctant to go out because I don't feel safe."

Another comment makes the point that in some areas, there are deep concerns:

"In Sydenham, there were stabbings, shootings and this has made me feel unsafe on the road. We used to be able to play out freely. The council need to provide something positive instead of thinking crime is the answer there is another side of life. The stabbing of a young boy by her mother is an example of how bad things have got. You can't feel safe living in Lewisham."

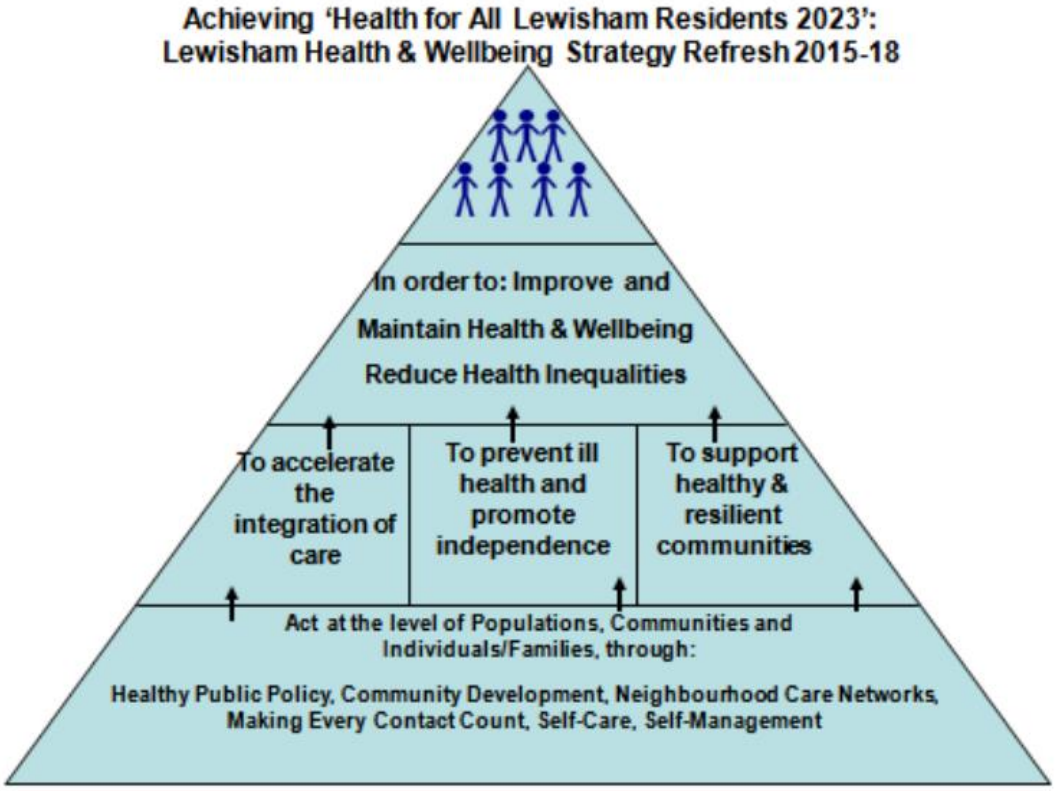
The general view was that it is not safe in the borough with people feeling scared and unsafe, even though from their own admission, *"it's not worse but bad enough.*" Stabbing and violence definitely make the area unsafe, and this is affecting some young people from going out and leaving their home. In one way, this also plays in the hand of those who perpetrate violence in that the 'streets' then becomes their playground with those not involved in that type of activities staying away.

The traffic congestion is also another factor affecting poor health. This was especially seen as a result of a new diversion traffic system that was introduced in response to the pandemic but is causing much concern. This particular system saw traffic diverted in to Catford High Road. An individual in the group expressed her concern about the level of air pollution, after spending some time in the countryside for a break. When they got back to Catford they noticed the difference in the air conditions. She said it was very noticeable.

Section 4: Conclusion

The Lewisham Health and Wellbeing Strategy, as indicated in the introduction, proposes to take action at three levels: *population, community and individual/family level.* Fig 11 below presents in a simple diagrammatic form the principles and direction of travel in meeting the objectives enshrined within the priorities.

Fig 11: Achieving 'Health for All': an overview



Source: Lewisham health and wellbeing strategy draft refresh 2015-18

The 'community development' approaches alluded to, epitomised through this consultation process, sought to better understand some of the lived experiences as well as opening up vistas as to possibilities. In using the BLACHIR framework, it is evident from the previous Section (i.e. Discussion), that participants engaged through the process were able to identify some of the key challenges for them, and which reflected some of the concerns identified in the JSNA, which provide the backdrop to the Health and Wellbeing Strategy. Many of the voices that were heard, therefore, reinforced much of what is already known and therefore points towards consistency with the strategic approach advocated. For example, to reiterate the six core challenges and considerations, in the further roll out of the strategy we were hearing voices specifically focused around the following broad areas of concerns:

1. *Accessibility to GPs (i.e. waiting time, booking appointments etc)*
2. *Trusted and accurate information (including communication and language issues)*
3. *Immigration status*
4. *Cultural expectations (i.e cultural insensitivity; taboos and stigma etc)*
5. *Care home v 'home care' concerns*

6. *Wider social and economic factors (ie. Impact of poor housing, traffic congestion and crime)*

Additionally, there was a strong view that the 'community bridges', seen as the roles that voluntary and community organisations could play, was critical in the roll out process, especially as they represent folks who are the recipient of services. It was noticeable that throughout the focus group conversations that participants wanted services 'closer on the ground' to them, to have service practitioners able to identify culturally with their needs and to see good quality care services in place. The key here was not segregated provisions but good quality equitable services, especially services being offered to those who were elderly, those living with a disability and those living with long term diseases and condition such as HIV. All of these concerns were raised by the JSNA and incorporated within the Health and Wellbeing Strategy. Far from being antagonistic, the reflected voices from the participation pool of close on 90 respondents, indicated very much a consistency in identifying key actions that should be prioritised.

What sort of changes would you like to see?

In many ways, and perhaps not too surprisingly, participants on the whole indicated that any changes envisaged need to be ones that improved local resident situation and not just 'tick box' exercises and platitudes. As one person wrote in responding to the questionnaire on Theme 4: *"Action 3 - what is to be done with that understanding? If nothing then there is no outcome!!!"* The point here is that unless something substantial and significant takes place then nothing is likely to change. Equally, participants also commented that there were many well-meaning 'Actions', and they couldn't see: *"what was going to happen as a result?"*

However, they offered some suggestions that they felt could be achieved to demonstrate that their voice was making a difference (or at least considered). In no particular order, linked to the Themes and Actions, they suggested:

1. Greater work with local community groups to gather information to arrive at positives changes which will educate and improve lifestyle (Theme 5)
2. Training and awareness raising - better customer care and culturally appropriate considerations (Theme 2)
3. GPs to spend more time with patients (Theme 8)
4. Better information and sharing outlets within the community and schools – to educate against misinformation through social media (Theme 3)
5. Health hubs in the community (Theme 3)
6. Mental health and early help support space for young people (Theme 4)
7. Fair and equitable treatment of black staff would improve perception (Theme 8)

In the final analysis, what sense is made of the voices will depend on so many other variables coalescing at the right moment to bring about the sort of changes that is needed. That is, variables that are unknown at this moment in time, but once they are aligned, it is more likely that change will happen. Until then, it is hoped that some of the thoughts emerging from the consultative process might just resonate which might make a difference.

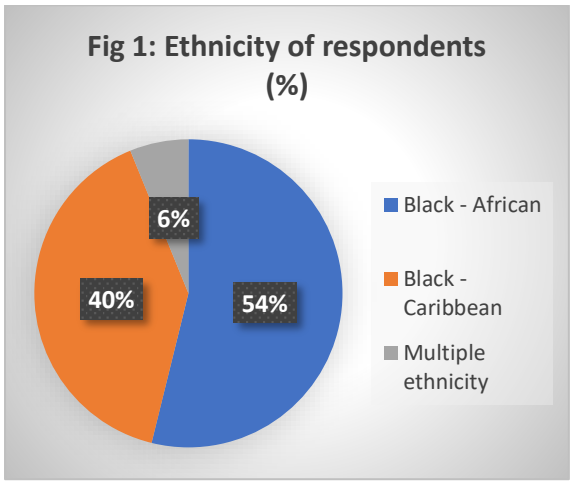
The final word of one of the participants perhaps places the challenge in the clearest perspective:

"Allow Black African and Black Caribbean people to be part of the whole process! We have enough educated people in our community who can work and talk for us [and] relay our feelings and have a better understanding of the issues. I would like to see them!"

Appendix 1: Participant characteristics

The consultation process included the capture of some key demographic information that were common across the three approaches adopted: ethnicity, gender, age, economic status, housing situation, post code and ward. Based on the responses, the following graphic summaries provide an overview of the demographic profile of the respondents.

Ethnicity



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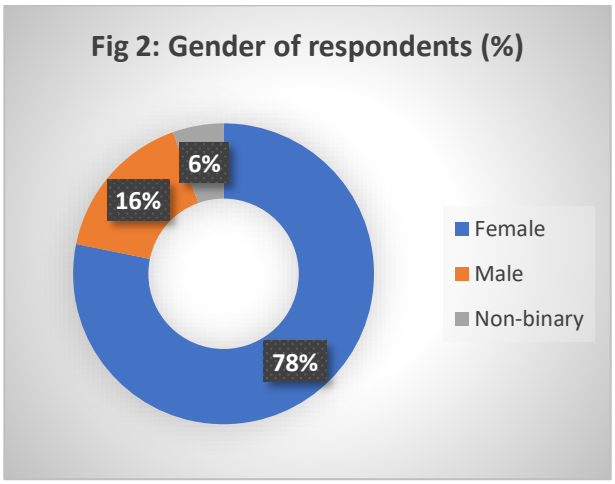

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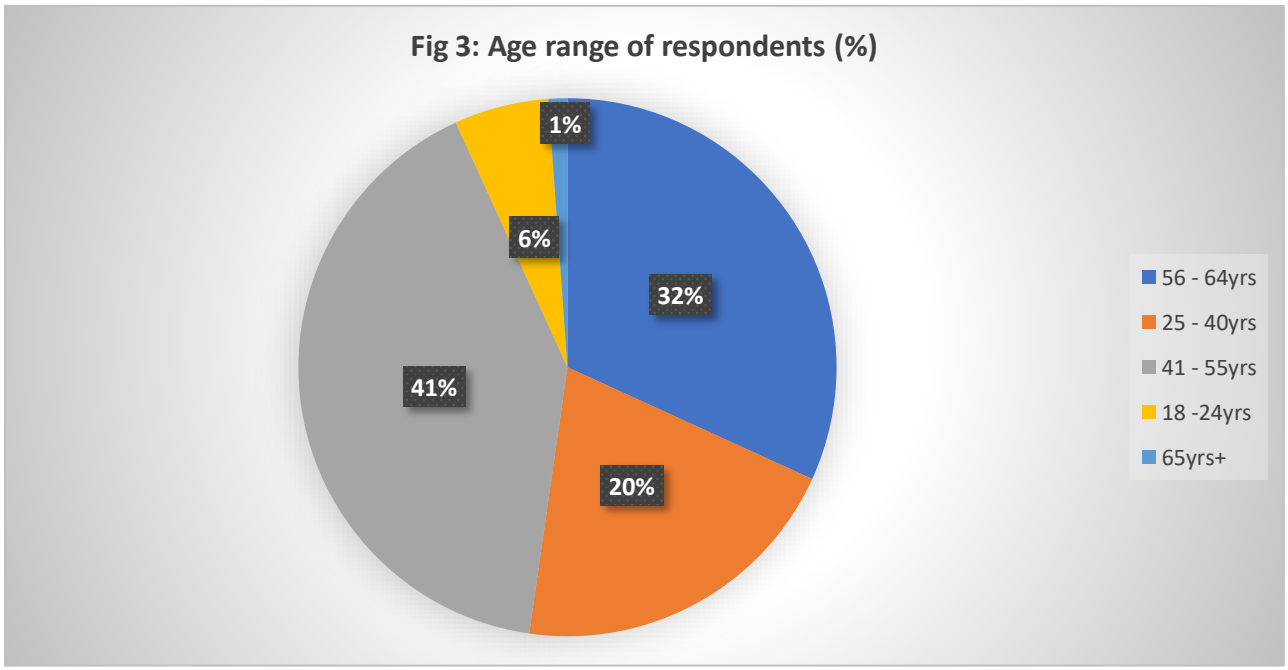

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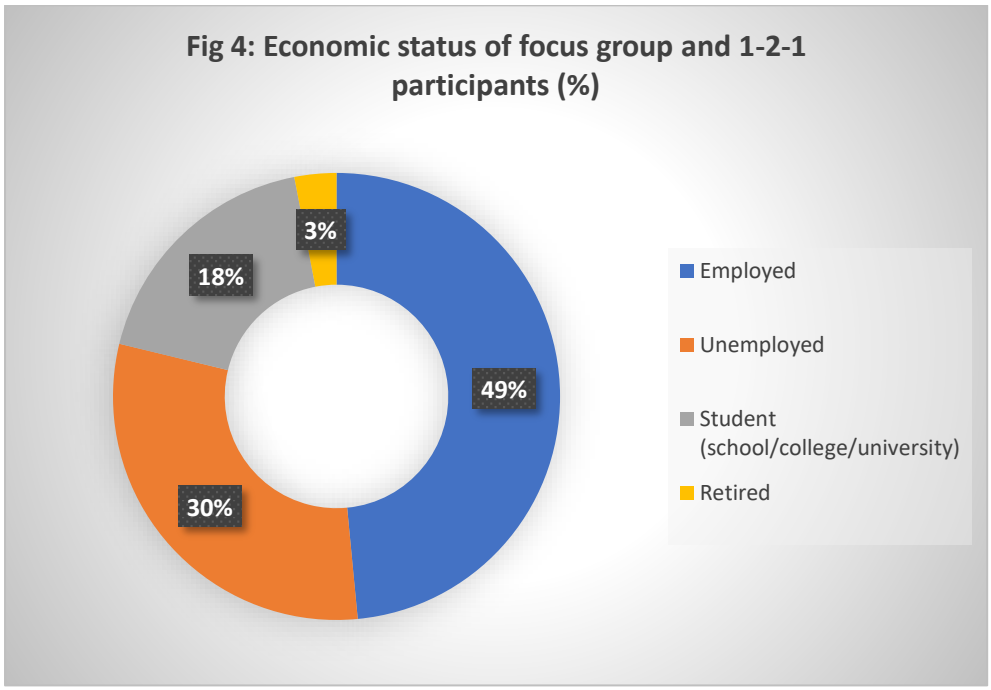

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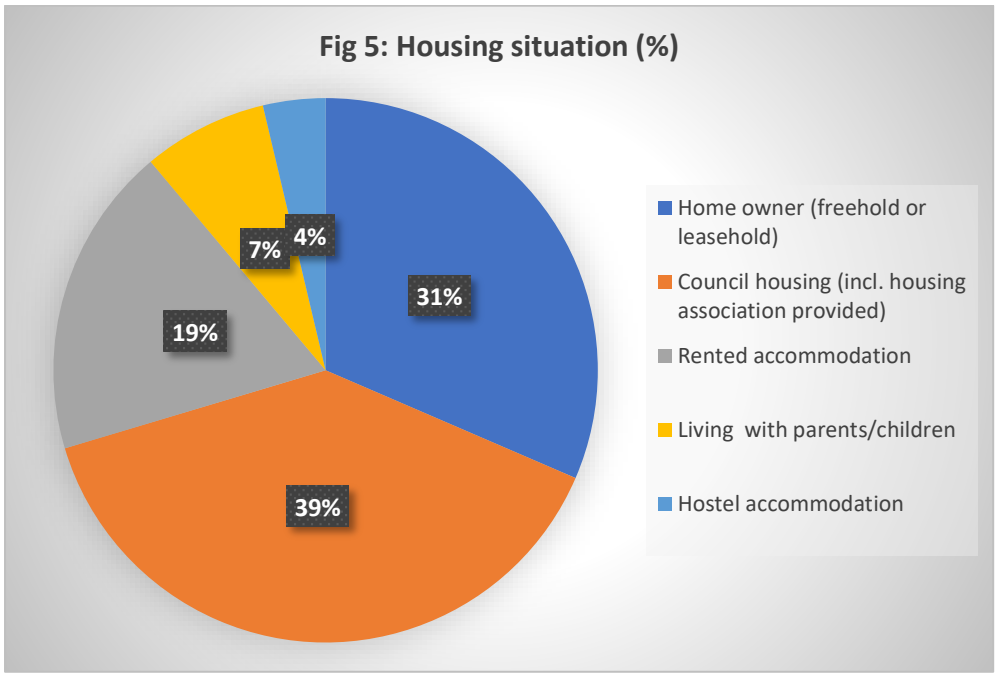

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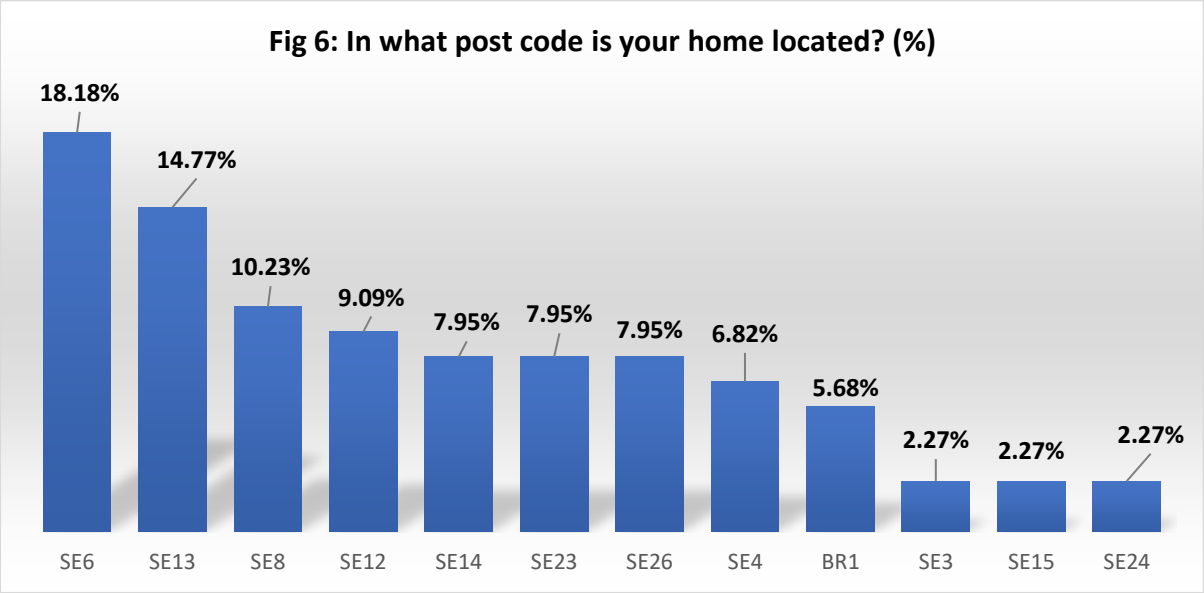

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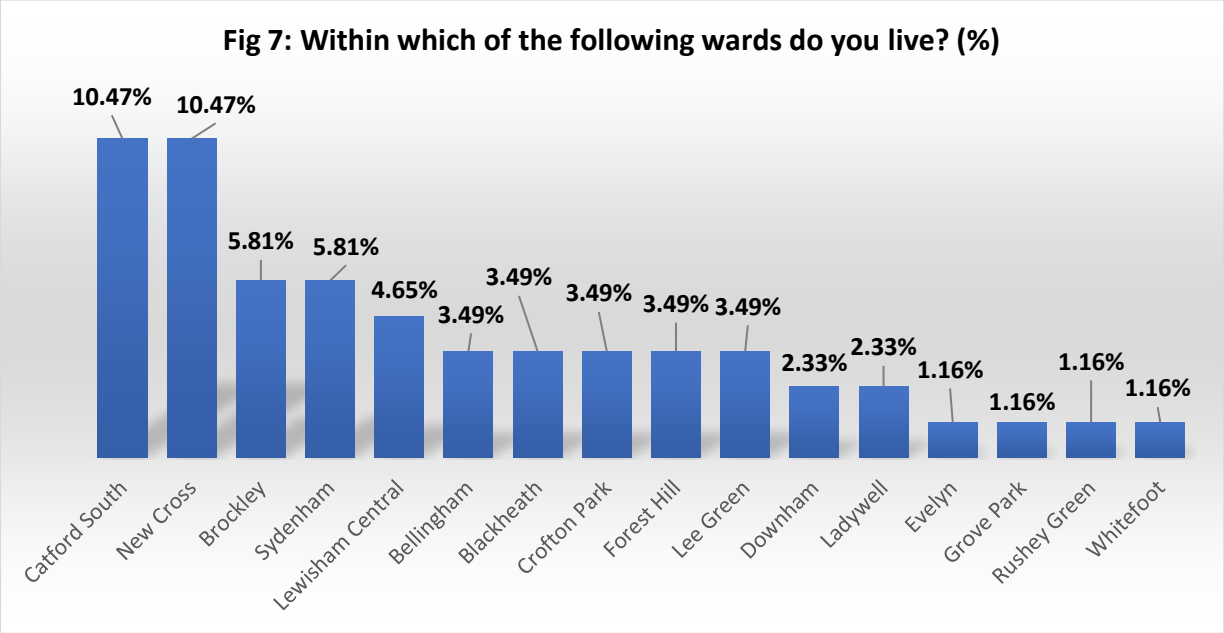

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Appendix 2: Overview of the organisations involved on the project

Action for Community Development

Action for Community Development (AfCD) is a community-based organisation assisting socially excluded members of the community such as ethnic minorities, refugees and asylum seekers and unemployed people in general. We give impartial, reliable and professional training, information, career advice and guidance.

AfCD was established to respond to reports that Refugees and people from the Black, Asian and Minority Ethnic (BAME) communities feel alienated from sources of advice, advocacy, training and statutory agencies provisions. There remain challenges to improve engagement and increased social inclusion. National statistics suggest that issues of inequality persist between different communities in British society and in many societies.

AfCD was set out to reduce these barriers, bringing about socio-economic justice and promote equal opportunities for the benefit of the wider community. We manage a resource centre in South London which offers comprehensive services to our beneficiaries. These are in the form of advice, information, casework, advocacy, counselling and training.

Our team of dedicated staff and volunteers reaches out to our beneficiaries who recently migrated to the United Kingdom and those already settled in the UK on a low income, disadvantaged or deprived. We support the transition from dependency to sustainable living. Our team consists of people with vast experience who have passion and enthusiasm for their work.

We also work with partners organisations and agencies to pool together expertise, maximise available resources to support our beneficiaries towards their goal of resettlement, skills acquisition, education and gainful employment.

Contact: ray Black and Joseph Oladuso:
Website: [Home - Action For Community Development (actionforcd.org)]

360 Lifestyle Support Network CIC

360° Lifestyle Support Network CIC was set up in 2021 by brother and sister duo Leon Thomson and Francine Daley. The 360 community aims to make healthcare more accessible for Black African / Black Caribbean individuals. We do this by sharing resources and knowledge regarding holistic health and wellness from industry professionals, to compliment advice of mainstream healthcare you may receive from your GP.

We educate and inspire people to change their lifestyle to create better versions of themselves. Although looking at all aspects of health, our niche focusses on topics such as Diabetes, Obesity, Hypertension, Stress and Mental Health as these are issues proven to affect the Black community the most.

We offer regular, weekly workshops in which you can expand your knowledge and ask your burning questions to a variety of guest speakers. The professionals we involve in our community come from backgrounds in health and fitness, holistic health, nutrition,

education, therapy, creative practice and much more! We focus on a new topic every week to keep things fresh.

Contact: Leon Thompson and Francine Daley: director@360lsn.co.uk
Website: www.360lsn.co.uk

Red Ribbon Living Well

Red Ribbon is a volunteer-led community organisation which operates in South East London. The group was founded in 2009 by members who recognised a need for peer support in the community, and it has grown from its grass-roots beginnings

Main Objectives:
Promoting HIV awareness and other related issues
Empower individuals affected and living with HIV to lead healthy lives
Educate members of the public around issues which have a direct impact on people living with HIV

Purpose of Project / Funding
Majority of our members are from the diaspora community and have been disproportionately affected by COVID. This has created anxiety, fear, trauma and isolation within the community.

Red Ribbon looked at providing culturally appropriate services and practical information that resonate with our members through virtual spaces. We aim to raise awareness about COVID, providing information in simplified language, understood by our members and sharing their experiences about the impact of COVID on their lives.

Funded Project Activities with Africa Advocacy Foundation.
Online focus group discussions which involved sharing experiences around the impact of COVID-19 (i.e. emotional lifestyle, situation, news or information, effects of lockdown etc).

The project provided a safe space, both virtually and physically, to engage, ask questions, and seek emotional and practical support by analyzing coping mechanisms for its members who suffered with mental health, isolation, loneliness, financial burdens and poverty.

The project also collaborate and work in partnership with the Phoenix Fund, Deptford People's Heritage Museum, Goldsmiths Department of Visual Cultures, Lyla's Place, Counselling with a Creative Touch, Lewisham council, Brook (Love Sex Life).

Contact: Husseina Hamza and Rose Euprase
Website: Home | Mysite (redribbonlivingwell.org)

Kinaraa CiC

KINARAA was born out of 6 Black led organisations working together during the COVID 19 lockdown spring & summer 2020 delivering a variety of culturally designed of services. That work was showcased at a national ageing summit and nominated for the Lewisham Mayor's Award 2021 for the programme and volunteering.

KINARAA CIC, an infrastructure support organisation, provides the right services for the development of a vibrant, effective, sustainable, and influential Black and Minority Ethnic led third sector and community organisations in Lewisham, and collaborates to offer services beyond its borough boundary.

This independent organisation has representation from the Lewisham BME Network, established by the Stephen Lawrence Charitable Trust, with over 50 local BAME third sector organisations and groups with expertise ranging from long established training providers, leading artists and heritage expertise, through to faith-based specialist organisations and informal social groups.

Contact: Barbara Gray

Website: Kinaraa | A Diverse Local Market of Service Providers

FW Business Ltd

We provide consultancy to concerning clients in the private, public and voluntary and community sectors. Our philosophy is based on responding to the individual needs of clients, respecting each as individual entities with their own drive and purpose. For us, *'your business is our business'* which enables us to better understand the challenges being faced and so enable us to tailor services to meet the diverse needs of clients.

Our expertise in the field of research, education, youth, community and organisation development practices enable us to offer support to practitioners and strategic managers on a range of policies, procedures and operational imperatives. We offer a service that covers a wide range of key specialist areas including:

- Policy, strategy, business planning and best practice development (incl. managing change)
- Fund raising and securing investments through commissioning and grants opportunities.
- Interim management
- Monitoring and evaluation
- Training, programme, staff development and performance management (independent investigations)
- Research and reviews

Contact: Karl Murray; **info@fwbusinessltd.com**

Website: FW Business Limited (fwbusinessltd.com)

Health Inequalities update
Lewisham Health and Wellbeing Board
9th March 2022

Dr Catherine Mbema
Director of Public Health, Lewisham Council

- Lewisham journey to date
- Achievements
- Birmingham and Lewisham African and Caribbean Health Inequalities Review (BLACHIR)
- Challenges/Areas for improvement
- Opportunities/Future priorities
- September Health and Wellbeing Board 2021
- Proposed Programme

Overview

Aim

- Focus of the Lewisham Health and Wellbeing Board to address **health inequalities for those from Black, Asian and Minority Ethnic communities** in Lewisham

Priorities

- Cancer
- Obesity
- Mental Health
- COVID-19

Actions

- 1. Black Asian and Minority Ethnic Health Inequalities Action Plan developed
- 2. Black Asian and Minority Ethnic Working Group formed
- 3. Quarterly Updates to Lewisham Health and Wellbeing Board
- 4. Outputs and impact measures developed

Lewisham Health and Wellbeing Board Journey to address heath inequalities since 2018

Lewisham

(Feedback from Lewisham Health Inequalities Working Group June 2021)

- **Mental health**
- Commissioning specific insights work for Black communities to support mental health service development via the Lewisham Mental Health Alliance
- Commissioning pilot of mental health support for Black residents and staff in Lewisham

- **Obesity**
- Commissioning specific insights work for Black communities to support commissioning of obesity services in Lewisham
- Co-development of a weight management service offer for Black residents in Lewisham
- Childhood Obesity Trailblazer co-produced health promotion out of home advertising with young residents from Black, Asian and Minority Ethnic residents

- **Cancer**
- 64 Lewisham Black, Asian and Minority Ethnic participants (residents/staff) have received Cancer Research UK ‘Talk Cancer’ training to help raise cancer and health awareness within the Lewisham community

- **COVID-19**
- Launch of Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR)

Achievements

Lewisham

The Birmingham and Lewisham African & Caribbean Health Inequalities Review (BLACHIR)

Background

Birmingham and Lewisham African and Caribbean Health Inequalities Review.

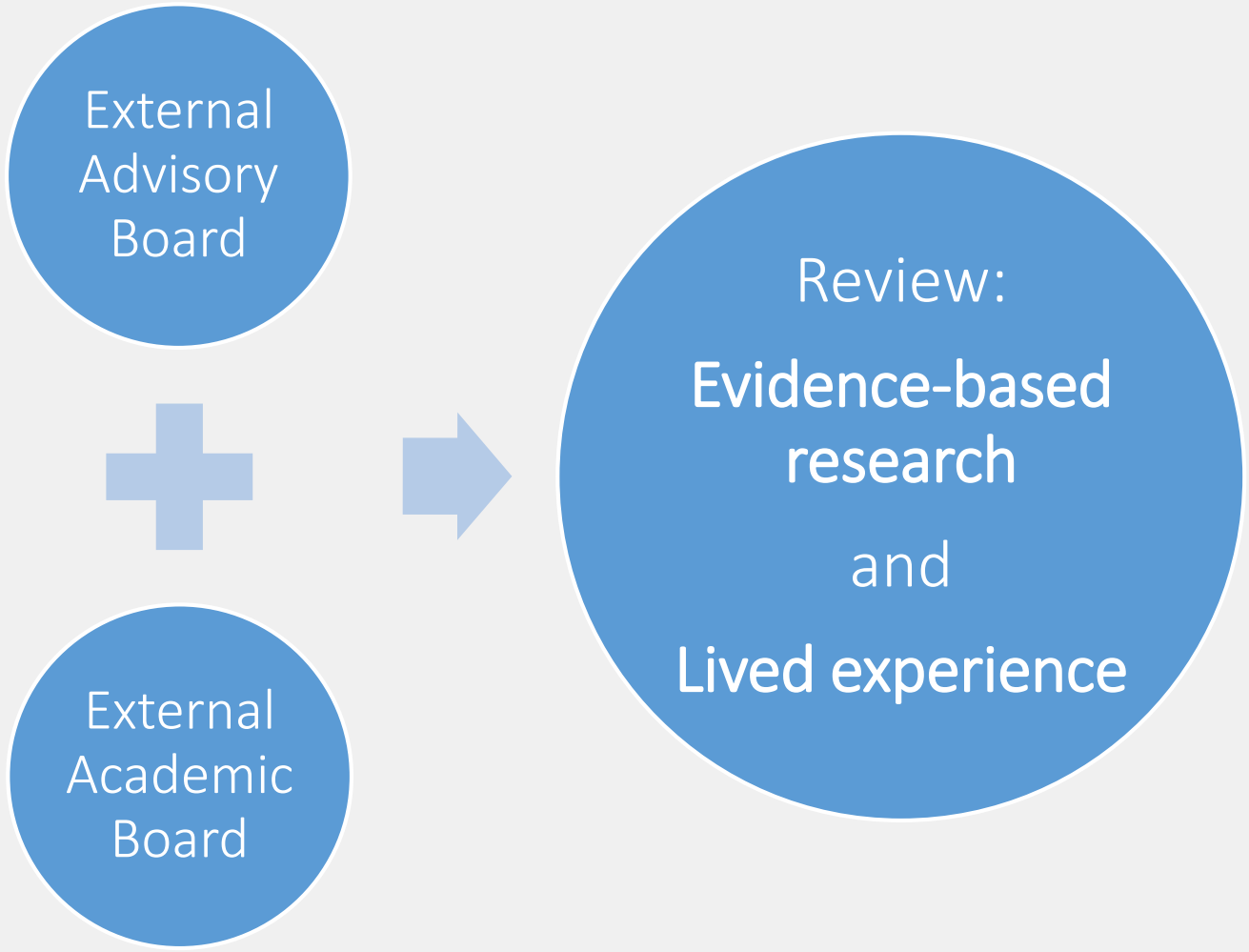
Birmingham and Lewisham Public Health Divisions share a joint aspiration to address ethnic inequalities, through an increased understanding, appreciation, and engagement with Black, Asian, and Minority Ethnic (BAME) groups. This has resulted in a partnership between the two Public Health Divisions to share knowledge and resources through a collaborative review process. The Birmingham and Lewisham African & Caribbean Health Inequalities Review (BLACHIR) will initially focus on the Black African and Black Caribbean communities, this will enable a more detailed and culturally sensitive approach.

The COVID-19 outbreak has further highlighted the impact of these inequalities in the context of infectious disease with Black African and Black Caribbean people over-represented in the deaths from COVID-19. As part of the review process, an external Academic Board will be established to help inform the work of the review team and bring together a wide and diverse range of academics with interests in this area.

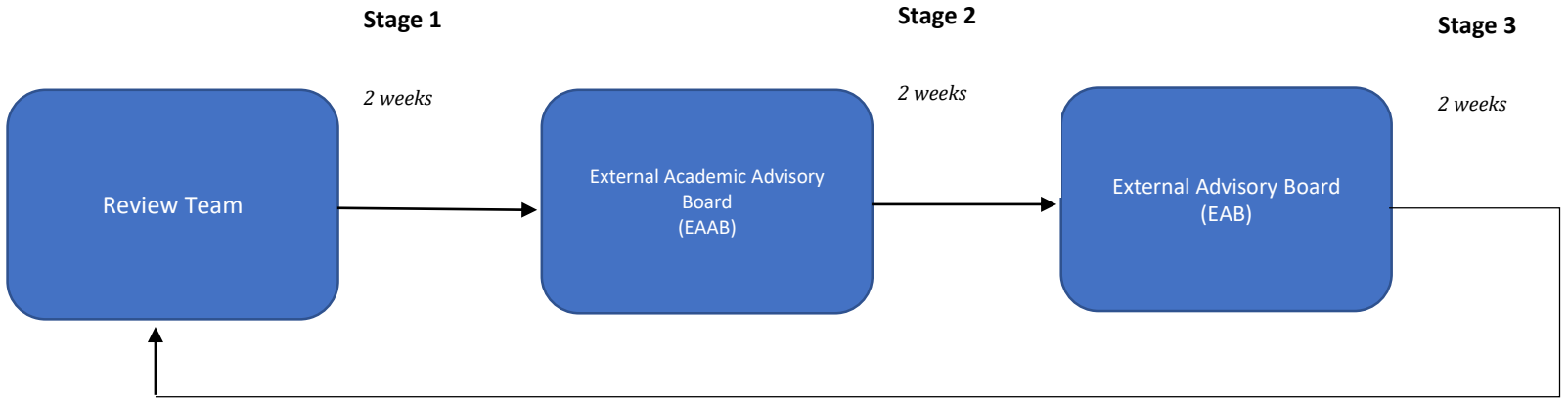
The Birmingham and Lewisham African & Caribbean Health Inequalities Review (BLACHIR)

Health Inequalities Review:

- ✓ Review Team (Birmingham and Lewisham Council members
- ✓ Academic Board
- ✓ Advisory Board



Meeting Cycle:



Themes:

- Racism & discrimination role in health inequalities
- Wider determinants of health
  (e.g. housing, employment, education, poverty)
- Early years, pregnancy and parenthood
- Children and Young People
  (e.g. youth violence, NEET, opportunities)
- Health behaviours
  (e.g. smoking, physical activity, nutrition & diet, drugs & alcohol)
- Mental health & wellbeing
- Emergency Care, preventable mortality and long-term conditions
  (e.g. hospital admissions)
- Ageing well
  e.g. Dementia & Frailty

Key Findings:

- 7 key areas identified to be addressed across the 8 themes: Fairness, inclusion and respect; Trust and transparency; Better data; Early interventions; Health checks and campaigns; Healthier behaviours; Health literacy
- 39 opportunities for action outlined in final report due to presented at Lewisham Health and Wellbeing Board 9th March

- Clearer lines of accountability
- Involving a younger voice
- Ongoing investment
- Monitoring outcomes

(Feedback from Lewisham Health Inequalities Working Group June 2021)

Challenges / Areas for improvement

- **National**
- ‘Build Back Fairer’ Marmot Report
- Integrated Care Systems
- NHS England/Improvement Health Inequalities work

- **Regional**
- London Health Inequalities Strategy
- London Association of Directors of Public Health work to address ethnic health inequalities

- **Local**
- Learning from COVID-19 work to address inequalities (North Lewisham Primary Care Network, Champions, wider community work)
- Local Care Partnership development
- South London Listens (mental health)

Opportunities and potential future priorities

Lewisham

A three staged approach was agreed to develop next stage of health inequalities work:

i) Developing individual and organisational understanding of health inequalities and inequities and their role and responsibility – October 2021

ii) Support collaborative evidence-based action planning and investment with a specific workshop/summit to facilitate this – November 2021

iii) Identification of actions – January-March 2021

- Organisations/system leaders develop action plans for addressing health inequalities in health equity.
- Develop a community event to present and discuss plans.

Aim:

Local health & wellbeing partnerships across health system and communities focussed on equitable access, experience and outcomes for Lewisham residents, particularly those from Black and other racially minoritised* communities

Objectives:

1. System leadership, understanding, action and accountability for health equity
2. Empowered communities at the heart of decision making and delivery
3. Identifying and scaling-up what works
4. Establish foundation for new Lewisham Health and Wellbeing Strategy
5. Prioritisation and implementation of specific *opportunities for action* from Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR)

Workstreams:

Eight concurrent and intersecting workstreams:

1. Equitable preventative, community and acute physical and mental health services
2. Health equity teams
3. Community development
4. Communities of practice
5. Workforce toolbox
6. Maximising data
7. Evaluation
8. Programme enablement and oversight

KHP/SEL Vital Five:

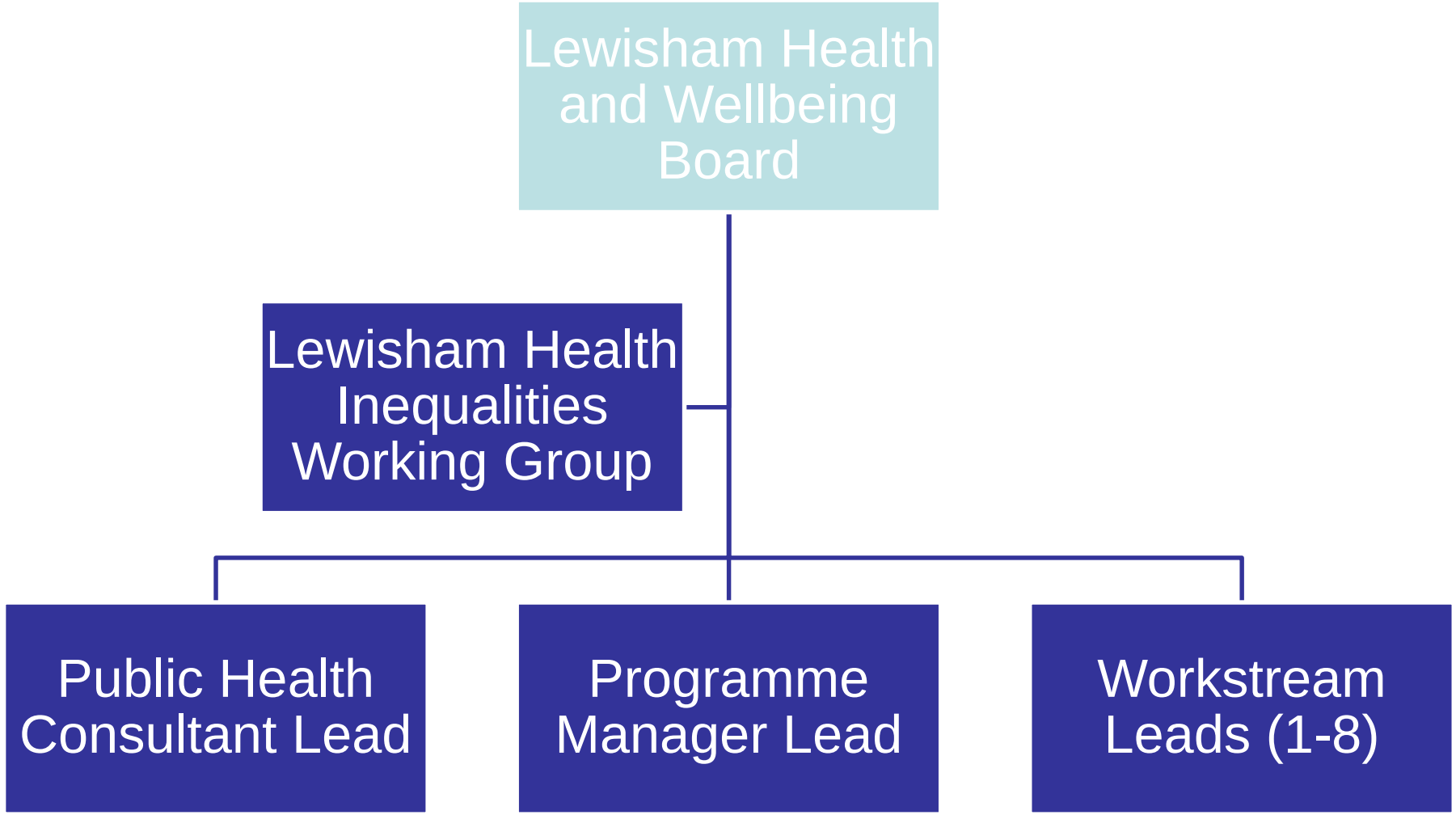
Timescale:

FY2022/23-23/24 (two years)

*See recommendations for use of this terminology from BMJ and Lancet - https://gh.bmj.com/content/5/12/e004508 and https://www.thelancet.com/pdfs/journals/lanpub/PIIS2468-2667(20)30162-6.pdf

Developing a Lewisham Health Inequalities and Health Equity programme 2022-24

Lewisham



Proposed Governance

Workstream 1: Equitable preventative, community and acute physical and mental health services

Aim

Designing, testing and scaling up new models of service provision that achieve equitable access, experience and outcomes for all

Objectives

- Equity and community voice within service review, design and development
- Identifying and scaling-up what works

Potential Activities

- Leadership & accountability across services by Health Equity Teams
- Piloting / identifying and scaling up solutions 'that work' – *e.g.:*
  - *Beacon Hubs for faith-based community outreach*
  - *Tailored weight management service for Black African and Black Caribbean residents*
  - *Targeted cardiovascular health checks*
  - *Goldsmiths mental health community service*
- *Taking up BLACHIR opportunities for action*

Potential Workstream Lead/Organisation(s): Lewisham Public Health/Lewisham Primacy Care Network (PCN) Lead(s)

Workstream 2: Health equity teams

Aim: Place-based teams to provide leadership for system change and community-led action.

Objectives:

- Primacy Care Network (PCN) leadership and accountability for health equity
- Understanding and determining neighbourhood and community needs and priorities (informed by data alongside community engagement as per BLACHIR work)
- Empowering communities to participate in service design and delivery

Potential Activities:

Scaling up North Lewisham model across 6 PCNs of:

- Health Equity Fellow (4 sessions/wk) (including MPH-level upskilling, QI project, PCN leadership role)
- SPIN (Salaried Portfolio Innovation Scheme) Fellow (4 sessions/wk) – *upon agreed from PCN and funded by HEE*
- Community Co-ordinator (1 FTE) – *upon agreement with PCN to fund from Additional Roles Reimbursement Scheme (ARRS) at SC5*
- Community seed funding
- Community outreach events (~5/year)

Potential Workstream Lead/Organisation(s): Lewisham PCN Lead(s)

Workstream 3: Community development

Aim

Infrastructure development to empower communities and deliver community-led service design and delivery

Objectives

- Sustained community voice and lived-experience input to service review and design
- Communities empowered and skilled in service design and delivery
- Building synergy between existing community development efforts across Lewisham system

Potential Activities

- Community budget to fund community-led services/initiatives
- Community empowerment programme (building on the Neighbourhood Community Development Partnerships and COVID-19 Community Champion models)

Key Synergies

- Local Care Partnership community engagement development (PPL project outputs)
- Neighbourhood Community Infrastructure Levy (NCIL) funded projects

Potential Workstream Lead/Organisation(s): Lewisham Council/Lewisham Local Care Partnership/Lewisham Healthwatch

Workstream 4: Community of practice

Aim

Sharing and synergies across PCN Health Equity teams, workforces and communities.

Objectives

- Identification and collaboration on common priorities
- Sharing promising practice and resources

Potential Activities

Specification to be developed

Potential Workstream Lead/Organisation(s): Lewisham PCN Lead(s)

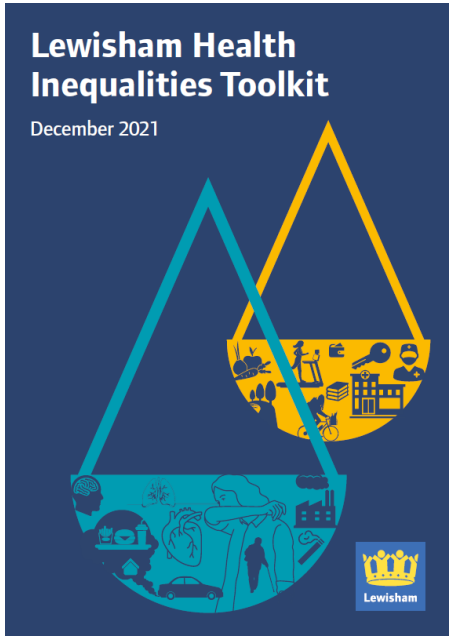
Workstream 5: Workforce toolbox

Aim

Increase awareness and capacity for health equity within practice

Objectives

- Develop resources for staff, volunteers and others to develop knowledge and skills for health equity
- Support upskilling of workforce on capability, opportunities and motivations



Potential Activities

- Racial inequalities training
- Lewisham Ethnicity Allyship Model
- Lewisham Health Inequalities Toolkit
- Trauma-informed care guidance

Potential Workstream Lead/Organisation(s): Lewisham Council

Workstream 6: Maximising data

Aim
Maximising the use of data, including Population Health platform, to understand and take action on health inequalities

Objectives:
- Ensure interventions are informed and supported by robust data interrogation
- Improve data collection in relation to all disproportionately impacted and PHE health inclusion groups
- Ensure lived experience evidence considered

Activities
- Matrix the Core20PLUS5 for Lewisham
- Identify health inequality hotspots in Lewisham
- Collating lived experience data
- Ensuring data improvement work focuses on wider health inequalities
- Interrogation throughout programme with view to bringing in further iterations

Potential Workstream Lead/Organisation(s): Lewisham Local Care Partnership/Lewisham and Greenwich Trust

Workstream 7: Evaluation

Aim

Evaluation within and across Programme to identify ‘what works / doesn’t towards achieving vision

Objectives:

- Develop an evaluation approach to understand what works / doesn’t towards achieving vision
- Ensure consideration of behaviour change in professional practice
- Ensure community voice and relevance

Potential Activities

- Develop/commission evaluation where feasible for workstreams
- Demonstrate change that community can ‘feel’.

Potential Workstream Lead/Organisation(s): Lewisham Public Health

Workstream 8: Programme enablement & oversight

Aim: Support and coordination across Lewisham PCNs

Objectives:

- Leadership & support for PCN Equity Teams
- Coordination of PCN community engagement activities
- Network governance

Potential Activities:

- Community-led governance
- Programme support (director, management)
- Communication and administration support
- Quarterly reporting (Board and public)

Potential Workstream Lead/Organisation(s): Lewisham Public Health

Regional example

ICS programme across West Yorkshire to tackle ethnic minority health inequalities following 2020 independent review

Foci: activities; system capability; system intelligence

One Year On workstreams include:

- Professional resources
- Inclusive recruitment
- Fellowship for ethnic minority staff
- Race Equality Network
- Mentoring
- Health Inequalities Academy (including communities of practice)
- Health equity fellowship
- Anti racism movement
- Allyship (IPPLAUD) model

Quarterly review reporting to Partnership Board

Development process

- Collation of learning from Lewisham Health Inequalities Summit – November 2021
- Early development with practitioners based on ‘what works’
- Discussion at Lewisham Patient Engagement Forum – January 2022
- Discussion at Lewisham Health Inequalities Working Group – 19th January 2022
- Alignment with findings of Birmingham and Lewisham African and Caribbean Health Inequalities Review (BLACHIR) – draft final report attached
- Engagement of stakeholders to secure commitment to the plan - Ongoing
- Presentation at Lewisham Health and Social Care Leaders Forum – 26th January 2022
- Presentation at Lewisham Health and Care Partners – 8th February 2022
- Presentation at Lewisham Council EMT – 16th February 2022
- Presentation at Lewisham PCN Forum – 23rd February 2022
- Community engagement at Lewisham Community Planning Day – 2nd March 2022
- Sign off of approach at Lewisham Health and Wellbeing Board – 9th March 2022

Lewisham Health Inequalities Toolkit

February 2022

Lewisham

Contents

Foreword

Lewisham's diversity is its strength – our borough is home to residents from over 75 nationalities with more than 170 languages spoken. We have a young population with 25% of residents under 18 years with the Black African and Black Caribbean making up 24% of the population. However, Lewisham is ranked the 7th most deprived borough in London. Women living in the least deprived areas of Lewisham can expect to live 5.8 years longer compared to women living in the most deprived areas of Lewisham. This statistic only increases amongst men to 7.4 years.

In July 2018, the Health and Wellbeing Board agreed its main focus would be on tackling health inequalities, with an initial focus on health inequalities for Black, Asian and Minority Ethnic communities in Lewisham. The aim of this toolkit is to provide a data overview of existing health inequalities in a user-friendly format for community members. This data has been collated via a partnership approach from Health and Wellbeing Board partner organisations.

We are driven by the policy goals as outlined in the Marmot Review: to create an enabling society that maximises individual and community potential; and to ensure social justice, health and sustainability are at the heart of all our policies. We recognise that health inequalities are primarily driven by the physical, social and economic environment we live in and that they impact on communities as well as individuals. We will focus on working with our communities in a community centred approach in taking action to improve health and wellbeing as well as reducing inequalities.

I am proud that Lewisham is leading the way on gathering better data on ethnic health inequalities to ensure we can make a difference to the quality of life for all our residents.

Cllr Chris Best
Lewisham Council Cabinet Member for Health and Adult Social Care
and Chair of Health and Wellbeing Board

Purpose of this toolkit

This health inequalities toolkit has been developed for Lewisham residents, community groups and all other Lewisham stakeholders with an interest in health inequalities.

The toolkit aims to give all Lewisham stakeholders:

- An introduction to health inequalities
- An overview of the health inequalities in Lewisham
- An overview of what is happening to address health inequalities in Lewisham
- Suggestions for further collaborative action to tackle health inequalities in Lewisham

This toolkit will be refreshed every other year alongside the publication of the Annual Public Health Report and Picture of Lewisham documents.

Contributors

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Introduction to Health Inequalities and Health Equity

Health inequalities are avoidable and unjustified differences in the health and wellbeing of groups and individuals, so are not inevitable or immutable.
Health equity means that everyone has a fair and just opportunity to be as healthy as possible.

In a borough guided by the principle "The welfare of the people is supreme", we seek to address health inequalities, achieve health equity and create a just community.

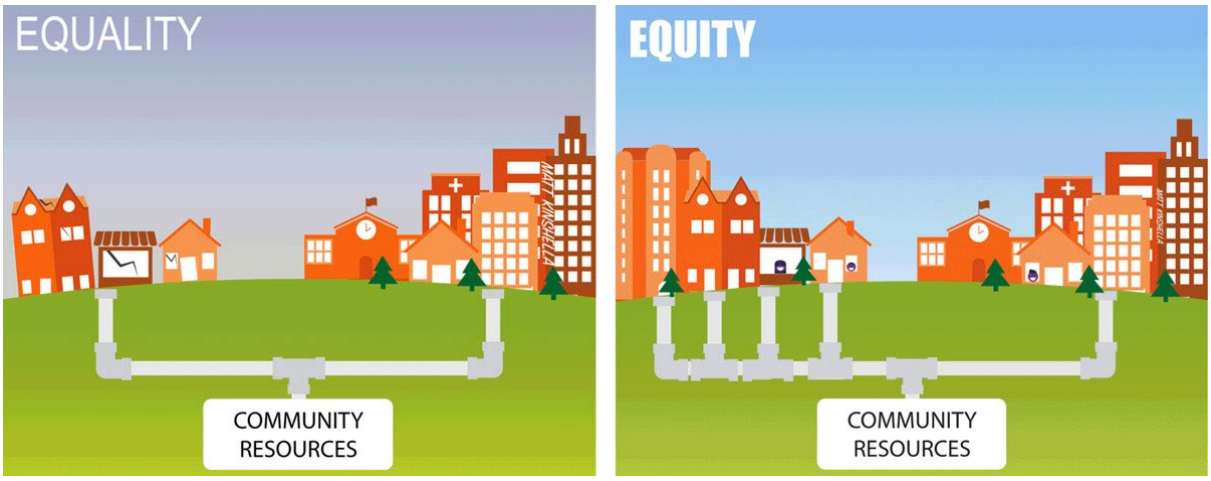
Health inequalities manifest across a number of areas and outcomes, including:

- Health status, e.g. obesity and life expectancy
- Access to care e.g. availability of NHS care
- Quality and experience of care, e.g. patient satisfaction
- Health behaviours, e.g. smoking and unhealthy diets
- Social determinants, e.g. housing and income

Despite the existence of the NHS in 1948 as a universal, free at the point of care health service, health inequalities persist and are increasing across England (e.g. a 2020 review by the Health Equity Institute and Prof Sir Michael Marmot demonstrated life expectancy has stopped increasing for the first time since 1900 and years spent in poor health is increasing, with inequalities in both increasing).

The greatest drivers of health (positive and negative) and health inequalities are not related to the health service and are driven by social and economic factors (the 'social determinants of health'); See Figure 2 and 3.

Figure 1 Understanding equality and equity (Avarna Group, 2019, Matt Kinchella, 2016)1



1 https://culturalorganizing.org/the-problem-with-that-equity-vs-equality-graphic/

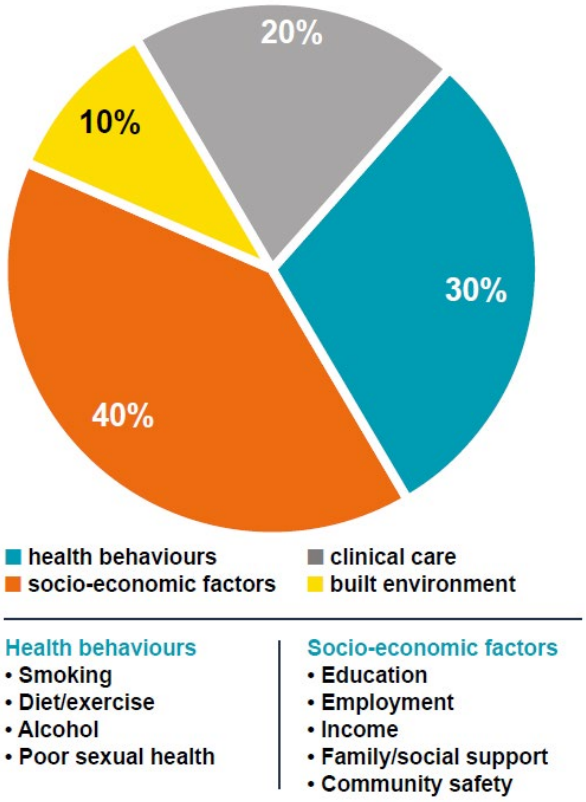
There are a number of aspects through which you can consider health inequalities:

- Socioeconomics and deprivation
- Geography
- Individual characteristics protected by law (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion, sex and sexual orientation)
- Socially excluded groups

Individuals and groups may span these characteristics, suffering multiple inequalities that multiply the negative impacts on health. 'Intersectionality' considers how these inequalities interact.

Figure 2: The Social determinants of health (Dahlgren and Whitehead, 1991)[2]

Figure 3: Factors that have the greatest influence on health[3]



For most health outcomes there is a 'social gradient' of health inequalities, whereby there is an inverse relationship between your socioeconomic status and your outcome; i.e. the less income you have the worse your outcome. This is particularly stark in life expectancy and disability-free life expectancy (i.e. years of life without disability); see Figure 4.

The nature of a gradient is that everyone is on it. Unless you are at the top, you are likely to live for shorter length of time and develop a disability earlier than those at the top.

2 Dahlgren G, Whitehead M. 1991. *Policies and Strategies to Promote Social Equity in Health. Stockholm*, Sweden: Institute for Futures Studies.

3 Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute. (2014) *County Health Rankings Model*. https://www.countyhealthrankings.org/resources/county-health-rankings-model

Evidence also suggests that the more unequal a society, the worse the outcome for the whole population. Comparing health and social care outcomes between countries based on income inequality suggests a direct, inverse relationship between income inequality and health and social problem; Figure 3.

Figure 4: Life expectancy (LE) & disability-free LE by income (Marmot Review 2020)[4]

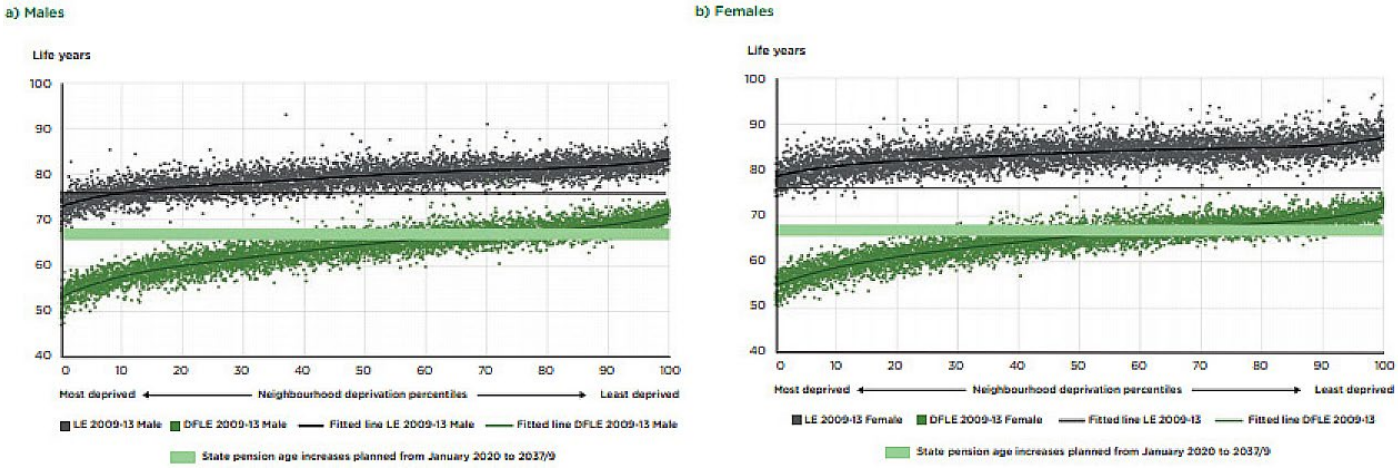
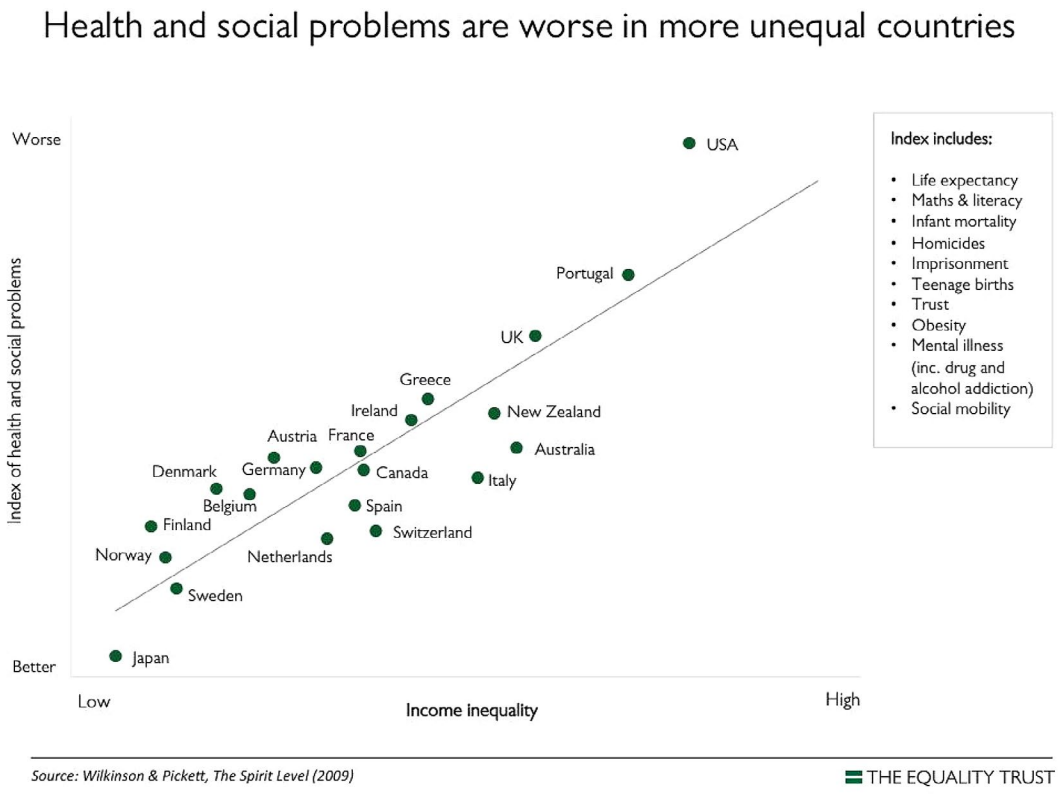


Figure 5: Association of health and social problems with income inequality (Wilkinson & Pickett, 2009)[5]



4 www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review

5 From The Spirit Level book www./equalitytrust.org.uk/sites/default/files/SpiritLevel-jpg_0.pdf

What works to reduce health inequalities?

The Strategic Review of Health Inequalities in England post-2010 (the Marmot Review) suggested that action to improve health and well-being for all and to reduce health inequalities should have two policy goals:

- To create an enabling society that maximises individual and community potential; and
- To ensure social justice, health and sustainability are at the heart of all policies

It demonstrated that health is accumulated through positive and negative experiences over a life-time, therefore there is a need to take a 'life course approach'. This approach focuses on six key areas:

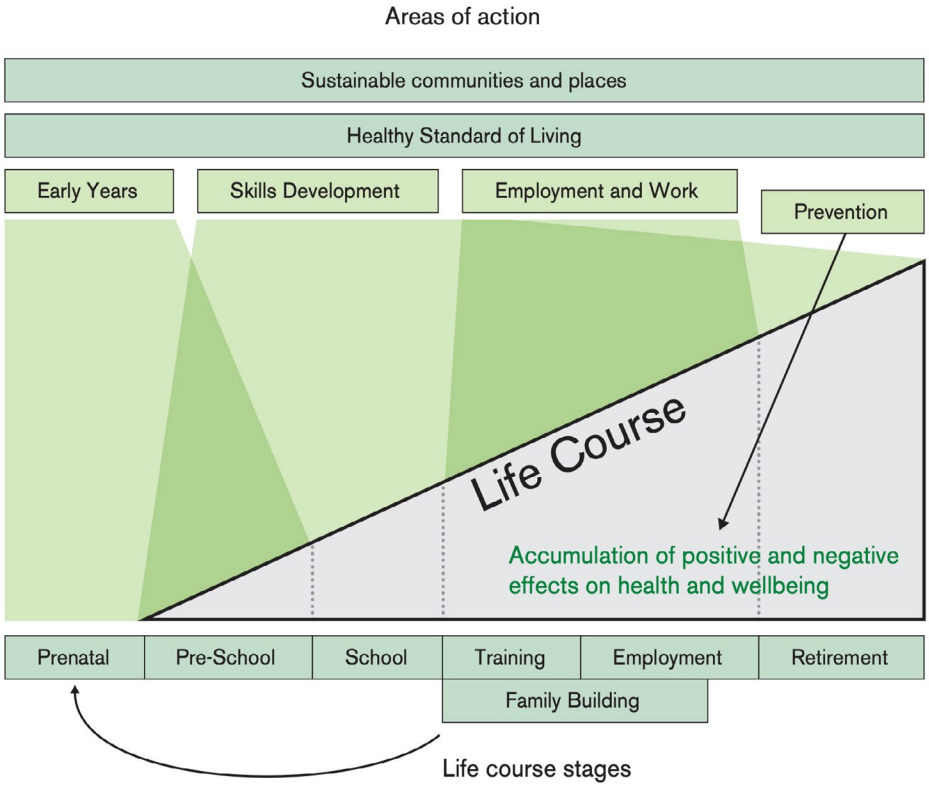
1. Give every child the best start in life.
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all.
4. Ensure healthy standard of living for all.
5. Create and develop healthy and sustainable places and communities.
6. Strengthen the role and impact of ill health prevention.

Whilst health inequalities impacts across a community, the social gradient of impacts dictates that not everyone is equally impacted. Therefore action should be based on 'proportionate universalism', with universal action delivered proportionately to need (i.e. those with the greatest need get proportionately more support.

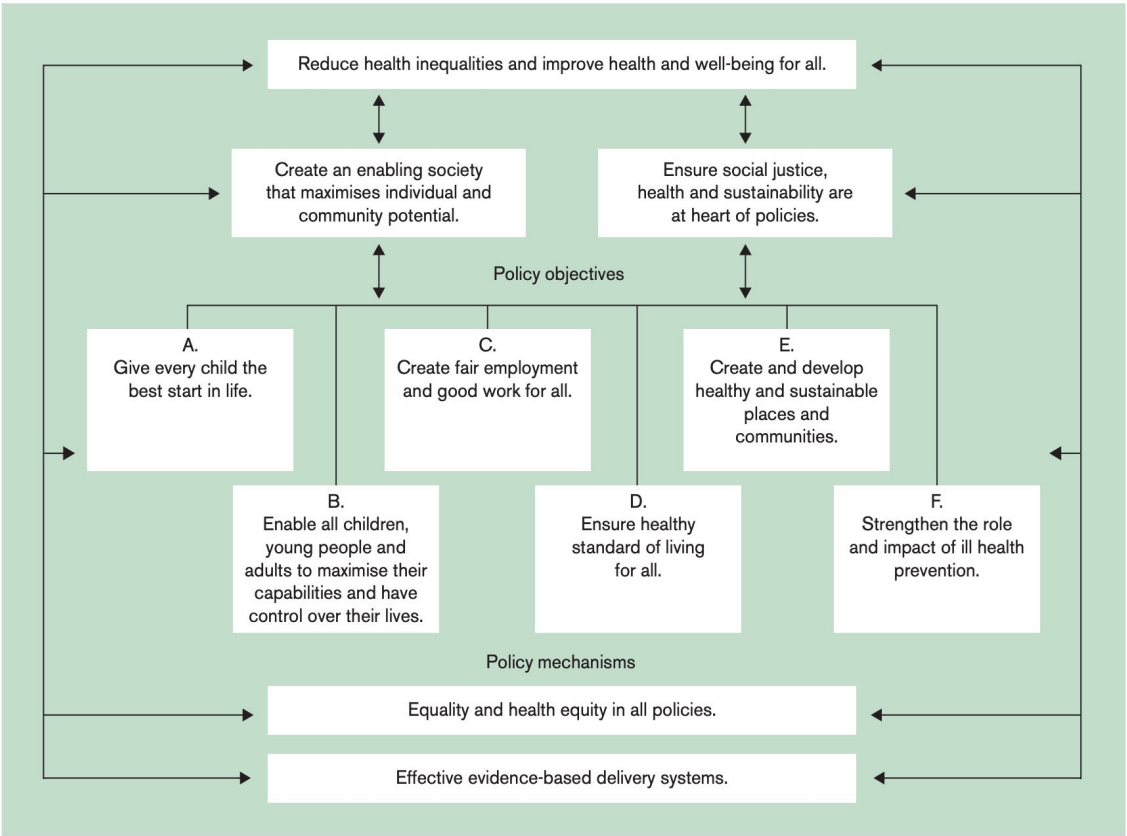
Recognising that health inequalities are primarily driven by the physical, social and economic environment live in and that they impact communities as well as individuals, it is critical to focus on community centred approaches rather than individual behaviours. Successful action to address health inequalities must involve and actually led by communities through community-centred approach (Figure 7).

Figure 6 What works to address health inequalities? (Marmot Review, 2010)[6]

i) Across the life course

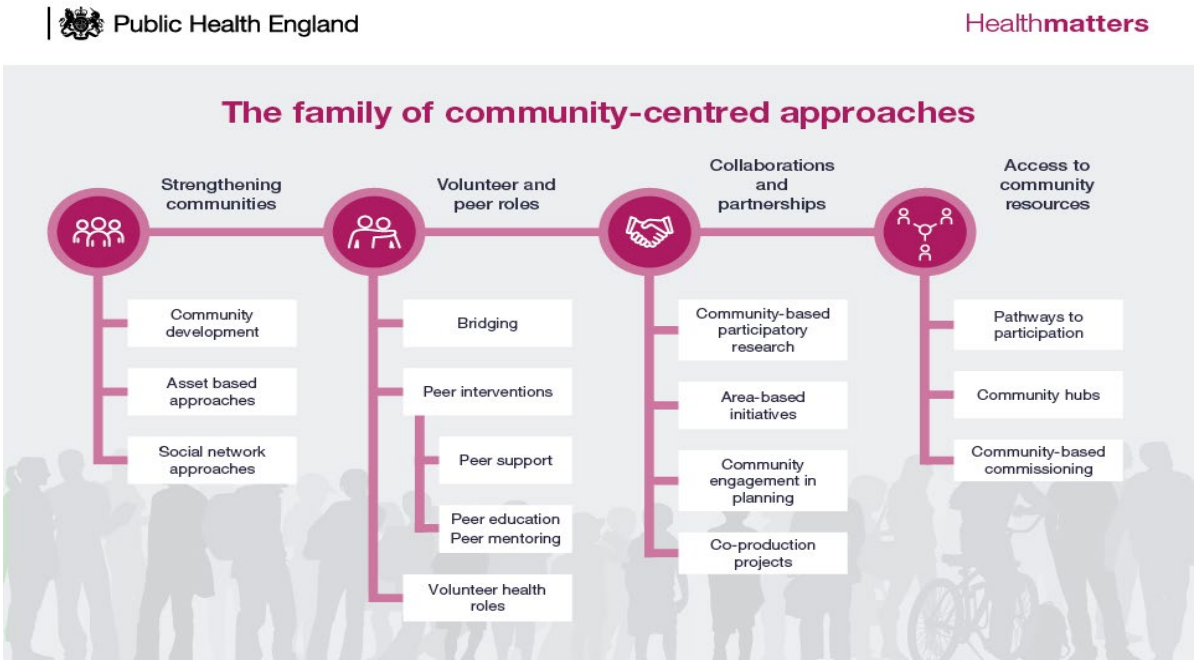


ii) Evidence-based approaches to reduce health inequalities



6 www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review

Figure 7 Community-centred approaches (PHE 2018)[7]



7 Public Health England. Health Matters: community-centred approaches for health and wellbeing. 2018 [cited 2019 30th September]; Available from: www.gov.uk/government/publications/health-matters-health-and-wellbeing-communitycentred-approaches/health-matters-community-centred-approaches-for-health-andwellbeing.

Lewisham and Health Inequalities

Overview

In Lewisham, if you are a baby boy born in a household that falls within the least deprived areas within the borough you can expect to live just over 7 years longer than a fellow boy born in a household within the most deprived areas. This difference in health status (in this case life expectancy at birth) based on deprivation is a stark example of the health inequalities that are present in Lewisham.

Lewisham's greatest strength is the people who live and work here. We have a young, diverse and growing population, home to residents from more than 75 nationalities and with over 170 languages spoken.

Therefore there must be both targeted and universal action to reduce these inequalities i.e. the concept of proportionate universalism. Tackling these inequalities cannot be achieved by one organisation or group alone, it must be collaborative. In Lewisham, one of our key priorities is to reduce these health inequalities, particularly those from Black, Asian and Minority Ethnic backgrounds. We have been working with our local partners on this key priority through the local Health and Wellbeing Board (HWB) since July 2018.

Ethnic Health Inequalities

As well as focussing on socio-economic inequalities it is important to recognise health inequalities that exist between different ethnic groups. As shown later in this report, rates of disease and ill health vary widely between and within different ethnic groups. Additionally, these inequalities are not evenly spread between health conditions. Furthermore, there are often differences in health between genders, as well as between different generations of Black, Asian and Minority Ethnic groups.

The causes of these inequalities are complex. Rates of low-income households are higher in ethnic minority groups, services both health and non-health may not be culturally sensitive to users, and racial discrimination still persists. The challenges that Lewisham faces in reducing health inequalities are not unique and are seen across the country. However, data collection on these inequalities is poor. Another finding from the Marmot 10 Years On review was that there was limited data on health inequalities between ethnic groups. We echo the calls of the Marmot Review which is for better data on ethnic health inequalities. This will help both national and local policy makers design services and policy interventions to reduce these inequalities.

Lewisham Population - Protected Characteristics and Geography[8]

Age and Sex

Lewisham has a relatively young population with just under 25% of residents aged under 18 years.

	Male	Female	Total
0-17	35,095	33,363	68,458
18-64	102,157	104,440	206,597
65+	12,597	15,884	28,481
Total	149,849	153,687	303,536

Median age: 35.0 years

Race (Ethnicity)

The latest estimated figures show that the largest ethnic group in Lewisham remains White with 51.8%, including those from White ethnic minority backgrounds, followed by Black African 11.6% and Black Caribbean backgrounds 9.8%. Black ethnic groups make up in total nearly a third of the borough's population.

The composition of the demographics for younger people is quite different to the population as a whole. While the white ethnicity group remains the single largest single group at 34%. The Black groups as a whole make up 45% of the under 18 population, with Black African and Black Caribbean population composing 24% of the population. While, Black Other population (including those of Mixed White and Black race) make up a further 21%.

Meanwhile, the over 65s population is 59% White British, with ethnic minority groups making up 30%. The Black Caribbean community is the second largest ethnic group making up 13% of the over 65 population.

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8 ONS 2018 Mid-Year Population Estimates. www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/data

Religion or belief	2011 Census	
	Number of residents	% of residents
All residents (as of March 2011)	275,885	100%
Christian	145,588	52.8%
Buddhist	3,664	1.3%
Hindu	6,562	2.4%
Jewish	643	0.2%
Muslim	17,759	6.4%
Sikh	531	0.2%
Other religion	1,478	0.5%
No religion	75,155	27.2%
Religion not stated	24,505	8.9%

The 2011 Census remains the most comprehensive source for data on religion/faith for residents.

Sexual orientation[9]

Data on sexual orientation is not readily available at a local authority level. The best estimates are based upon the Office for National Statistics Annual Population Survey, which asks a question regarding sexual orientation. 2.7% of people over the age of 16 nationally identified as Lesbian, Gay or Bisexual. This rises to 6.6% of those aged 16-24% showing a changing demography that is being led by those of a younger age. 2.9% of males identified as LGB, while 2.5 of females identified as LGB. If the national figures were applied to Lewisham, this would equate to 16, 500 residents.

Disability

14.5% of residents are living with a long term condition which limits their daily activities. This is slightly below the England average of 17.6%, however this is likely to be due to the younger population bias. For those of working age this reduces to 11.5%.

Pregnancy and maternity

There were 4,393 live births in Lewisham in 2019.[10]

Marriage and Civil Partnership

The 2011 Census asked adult residents about that marital status. Almost half of the population stated they were single.

	Single	Married	Civil Partnership	Separated	Divorced	Widowed
% Martial status	49.7	32.7	0.5	4.3	8.1	4.6

9 Source: ONS Sexual Orientation, UK: 2019

10 ONS, 2020

Gender reassignment

We do not have any reliable local figures regarding gender reassignment. Currently data is not readily available on gender identity. The 2021 census included a voluntary gender identity question that was asked of those 16 years and over. When released, the data on gender identity may be useful in helping to identity areas for policy development and service planning.

Overview of Lewisham Health Inequalities Indicators

The public health outcomes framework (PHOF) from Public Health England (PHE) outlines key public health indicators in five key areas:

1. Overarching indicators
2. Wider determinants of health
3. Health Improvement
4. Health Protection
5. Healthcare and Premature Mortality

PHE have developed a Health Inequalities Dashboard to present evidence of health inequalities in England. The dashboard provides measures of inequality for key indicators being used by PHE to monitor progress on reducing health inequalities within England.

This toolkit presents the available data for Lewisham from the PHE Dashboard across the five areas outlined. Data has been taken from the most recently updated version of the PHE Dashboard (2nd March 2021). Where there is local data available with measures of inequality in any of these five areas by geography, deprivation or protected characteristic, it will be presented.

Overarching indicators

1. Life expectancy at birth

Life expectancy at birth data is available for Lewisham by area deprivation levels. This is also available split by gender (male and female).

Life expectancy at birth has increased for men between 2001-03 (74.5 years) and 2017-19 (79.1 years), however the rate of increase has slowed in recent reporting periods. This has also increased for women between 2001-03 (79.1 years) and 2017-19 (83.8 years) with the rate of increase slowing in the last 2 reporting periods (since 2013-15).

Slope index of inequality (SII) in life expectancy based on Index of Multiple Deprivation deciles

The Slope Index of Inequality (SII) in life expectancy for men in Lewisham was 7.4 years for the 2017-19 reporting period. This indicates the variation in life expectancy across most to least deprived areas in Lewisham for men is 7.4 years. The SII in life expectancy was lower for women at 5.8 years for the 2017-19 reporting period indicating a less steep gradient of inequality in life expectancy at birth.

2. Wider determinants of health

School readiness (% children not achieving a good level of development)

Education is an important determinant of health and school readiness i.e. children defined as having reached a good level of development at the end of the Early Years Foundation Stage (EYFS) is an indicator of early childhood learning and development. In Lewisham the proportion of children not reaching a good level of development at the end of EYFS was 23.6% for the 2018/19 reporting period.

In terms of inequality, this data is available for those who receive free school meals (FSM) and those that do not, which can be used as a proxy measure for deprivation. The absolute gap in those not achieving a good level of development between those receiving FSM and those who do not was 12.1% for the 2018/19 reporting period (34% for those receiving FSM and 21.9% for those who do not), which is an increase in absolute gap since 2013-14 (9.5%). The relative gap i.e. the proportional gap between those receiving FSM and those who do not was 1.6 for the 2018/19 reporting period. This indicates that children from deprived backgrounds in Lewisham are more at risk of poorer development and the evidence shows that differences by social background emerge early in life.

Employment rate

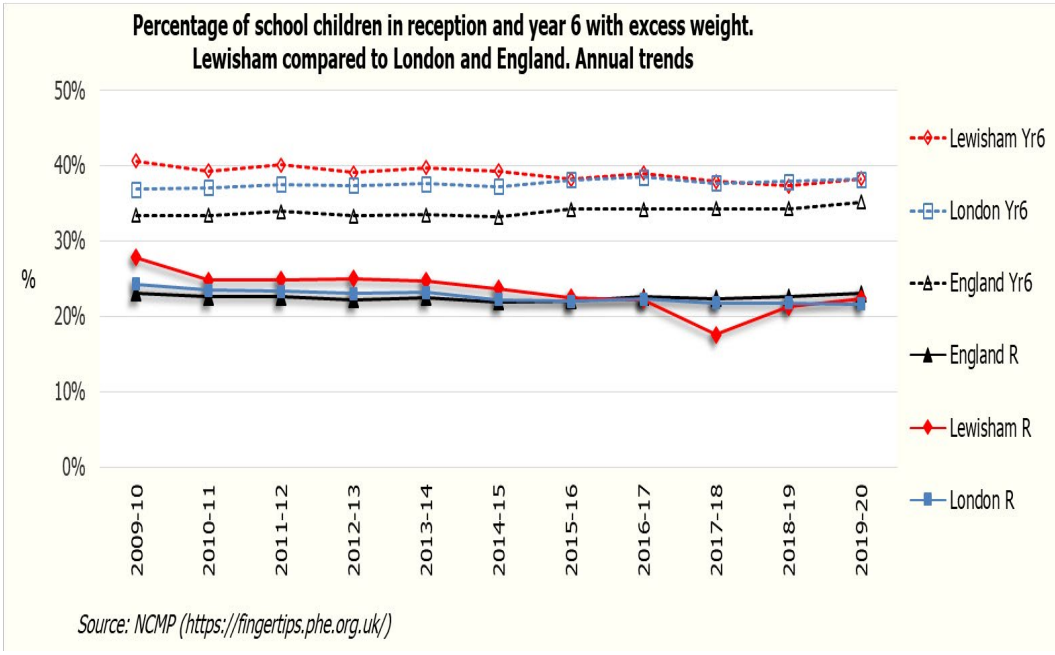
Employment and the availability of good work is another important determinant of physical and mental health and wellbeing. In terms of inequality the rate of employment in Lewisham is available for those that have a long-term health condition (that is expected to last for more than 1 year) and those who do not. In Lewisham the gap between employment rates in those aged 16-64 years with a long-term condition and the overall employment rate was 12.9% for the 2019-20 reporting period, with the rate being lower in those with a long-term condition. This gap has fluctuated in Lewisham since 2013 and 2020, being lowest in 2015-16 at 4.2% and highest in 2013-14 at 13.4%.

3. Health Improvement

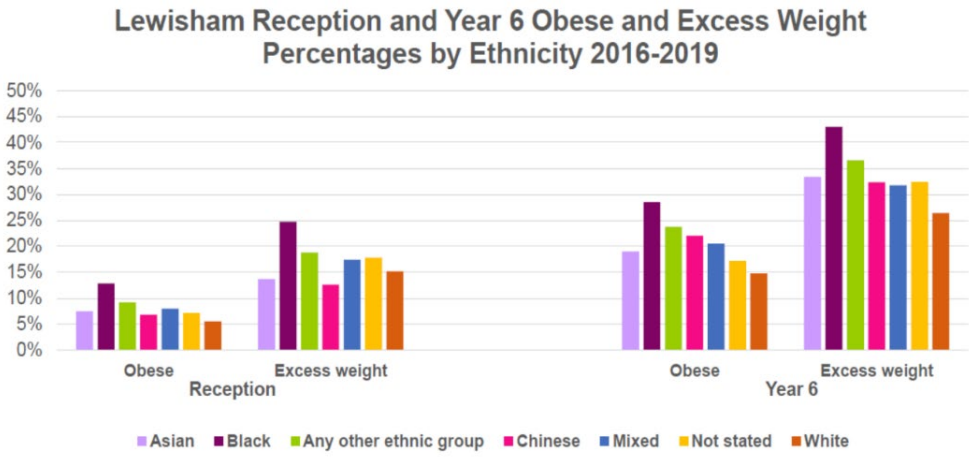
Prevalence of overweight and obesity for reception and year 6 children (Local National Child Measurement Programme data)

Lewisham has high levels of childhood obesity with one in five children in Reception Year with excess weight (overweight or obese), similar to London and England levels. This rises to nearly two in five children in Year 6, similar to London but significantly higher than England. There has been a small reduction in prevalence but the challenges and inequalities persist. There are differences in childhood obesity levels depending on where children live in the borough with highest levels found in areas of highest deprivation, half of Year 6 children in New Cross are overweight or obese compared with just over a quarter in Crofton Park. There are differences depending on children's ethnic background too, with 43% of Lewisham's Black Year 6 children being overweight or obese compared with 26% of their White counterparts.

Figure 8 Excess weight in Lewisham (Annual Trends and by ethnicity)[11]

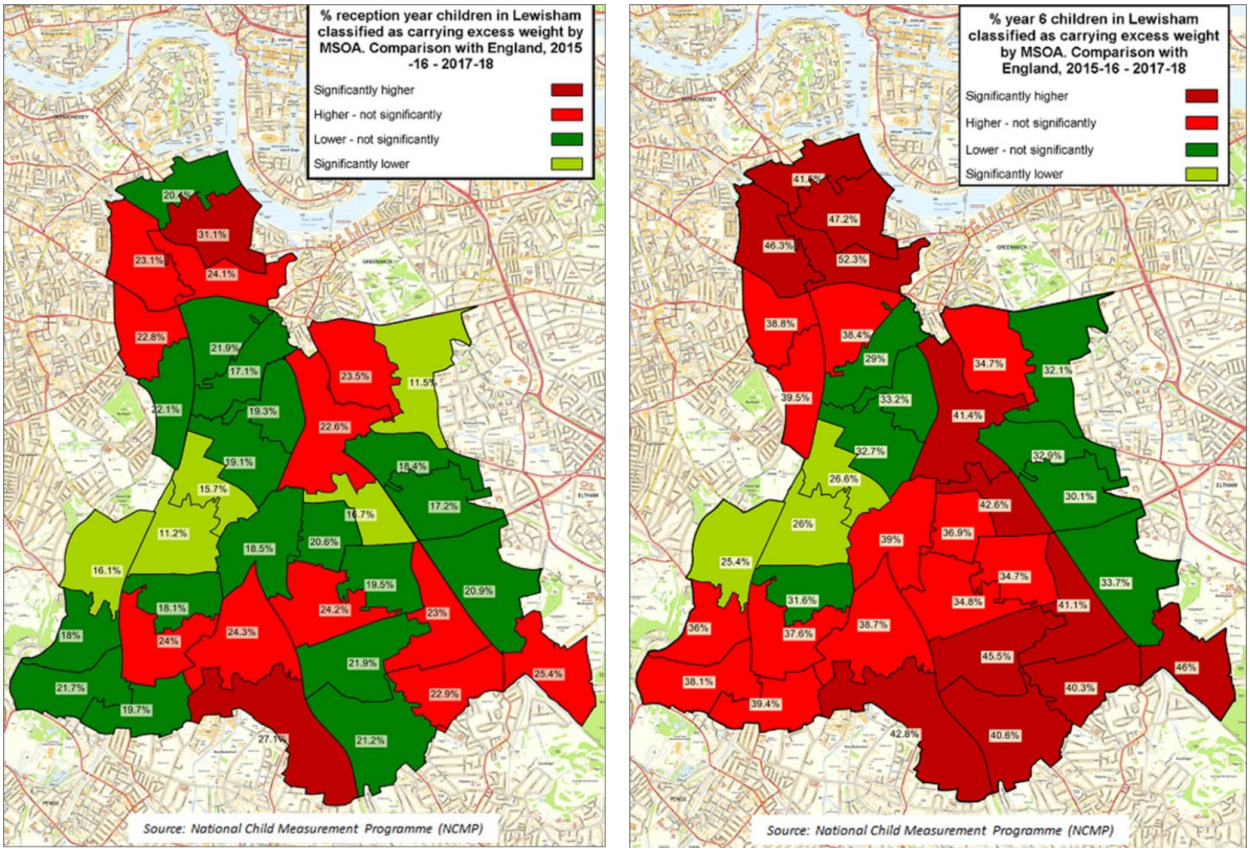


Children identifying as Black African, Black Caribbean and Black other have the highest BMI in both school years.



11 https://fingertips.phe.org.uk/

Figure 9 Excess weight in Lewisham by MSOA (reception and year 6)



Smoking Prevalence in adults (18+) - current smokers (APS)

Smoking is the one of the most important causes of preventable ill health and premature mortality in the UK. Smoking is a major risk factor for many diseases, such as lung cancer, chronic obstructive pulmonary disease (COPD) and heart disease. It is also associated with cancers in other organs, including lip, mouth, throat, bladder, kidney, stomach, liver and cervix. Smoking rates in Lewisham are above the London and England average rates.

Smoking Prevalence in adults (18+) current smokers 2018	
Lewisham	16.7%
London	13.9%
England	14.4%

In terms of inequality there is significant divergence in smoking prevalence between social classes. Those in routine and manual occupations are most likely to smoke and in Lewisham have a smoking prevalence of 25.9%, while those in managerial and professional occupations are the least likely to smoke with a prevalence of 13.8% for the 2018 reporting period.

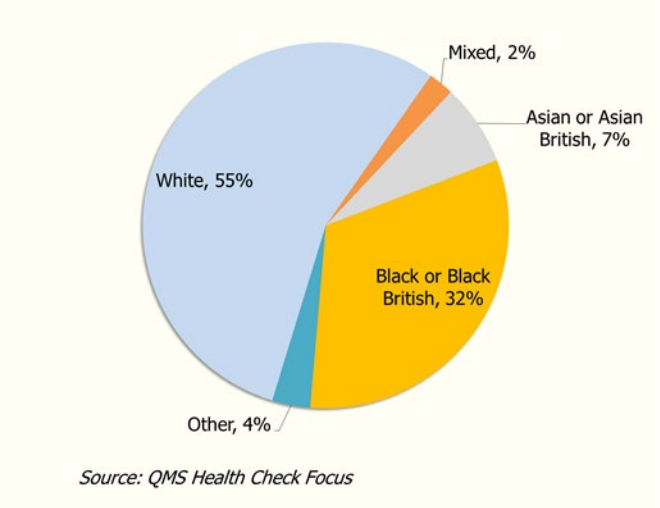
Lewisham is above the national and regional average for those who have quit smoking at 4 weeks, with 2,344 smokers quitting per 100,000 in Lewisham compared to 1960 in London and 1894 in England. This is a trend that has been in place since 2013, when Lewisham initiated and redesigned its Stop Smoking services. The target is to reduce smoking to 12%. In Lewisham we know that 30% of those who quit smoking are from minoritised groups: 8.5% black Caribbean, 5.3% black African, 1.5% other black groups, 5.2% all Asian groups, 5.4% mixed, 3.6% Chinese.

NHS Health Checks Programme

By promoting healthy ageing and tackling the top seven risk factors for early death and disability, the NHS Health Check provides a cornerstone for the prevention of cardiovascular disease, as well as kidney disease, type 2 diabetes and dementia. People are invited for a NHS health check every five years. Lewisham is now in its second five year cycle of invitations. Eligible people are defined as 40-74 year olds who are not already identified as having vascular disease or on a disease register and have not received a Health check in the past five years. Ensuring that a high percentage of the eligible population have a NHS Health Check is key to optimising the clinical and cost effectiveness of the programme.

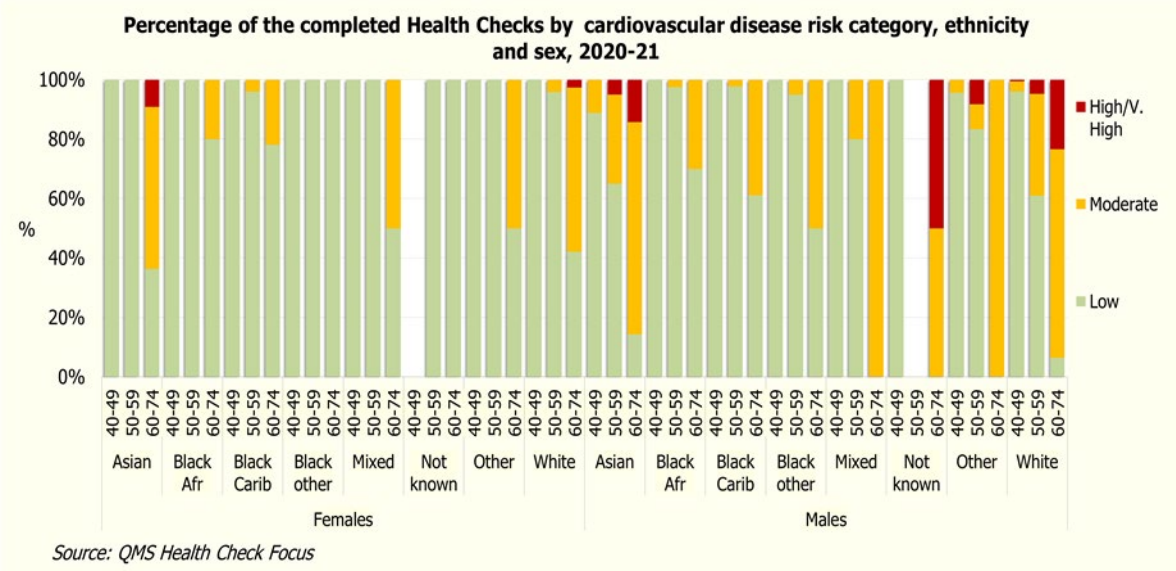
The following key priority groups, who have an increased risk of cardiovascular disease are prioritised for invitation for a Health Check. They are: South Asians, males, people with a family history of cardiovascular disease, smokers and people residing in areas of higher deprivation by postcode. Whilst the White population received over 50% of NHS Health Checks in Lewisham in the financial year, due to the older average age profile of this population this was representative.

All NHS checks delivered, by ethnicity, Lewisham 2020-21



Source: QMS Health Check Focus

Percentage of completed health checks by cardiovascular disease risk category, ethnicity and sex, 2021



Source: QMS Health Check Focus

4. Health Protection

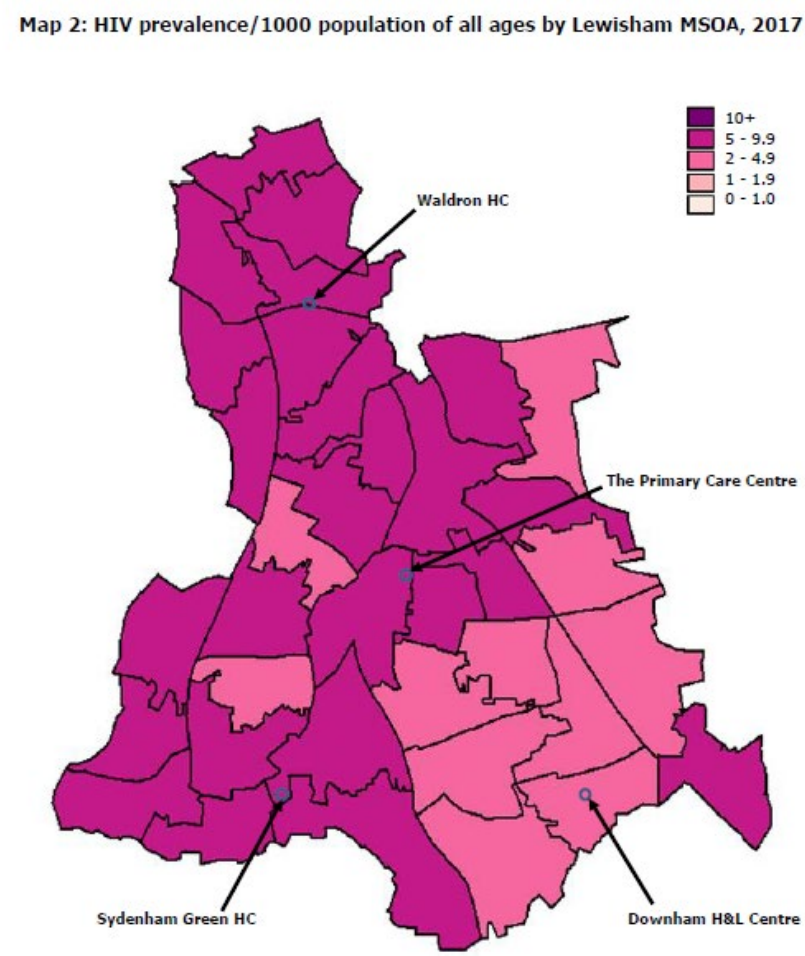
HIV Late Diagnosis

Lewisham has one of the highest rates of HIV prevalence in the country, with a new diagnosis rate at 20.1 per 100,000 aged 15+. HIV is now a treatable and liveable disease, however if diagnosed late there is a significantly higher risk of premature death. Therefore reducing the number of people who have a late diagnosis is vital. In Lewisham the late diagnosis rate from 2016-18 was 44.3%.

	Lewisham	London	England
New HIV diagnosis rate/ 100,000 aged 15+	20.1	20.9	8.8
HIV late diagnosis (%)	44.3	37.1	42.5

These figures paint a mixed picture with the new diagnosis rate lower than the London average, but the percentage of late diagnoses higher. The distribution of HIV prevalence is not even across the borough (Figure 10).

Figure 10 HIV prevalence/1000 population of all ages by Lewisham MSOA, 2017



Source: HIV and AIDS Reporting System (LASER report)

London wide the data shows that 48% of London residents diagnosed as living with HIV were White, while 31% were of Black African ethnicity. The rate of diagnosed HIV prevalence between ethnic groups varies significantly across London, from 26.0 per 1,000 residents aged 15-59 in the Black African population to 1.0 in the Indian/Pakistani/Bangladeshi population.

In Lewisham, heterosexual contact is the most common exposure type (54%) of those diagnosed with HIV. This differs from neighbouring boroughs where sex between men is the most common HIV exposure category. Late diagnosis is significantly higher in heterosexual men and women in comparison to men who have sex with men (MSM).

	HIV late diagnosis (%), Lewisham 2018
Heterosexual men	64.5
Heterosexual women	48.8
Men who have sex with men	34.8

In Lewisham free confidential home sampling kits are available for those in at risk groups, MSM, those from Black African communities, and injecting drug users.

Of those diagnosed with HIV, 99% of patients are on anti-retroviral therapy (ART). Successful ART ensures that someone who is HIV positive has an 'undetectable viral load' and are known as virally supressed, which means that the levels of HIV in someone's blood are so low they cannot be passed on to another person. Of those on ART in Lewisham, 97% are virally supressed (VS).

5. Healthcare and Premature Mortality

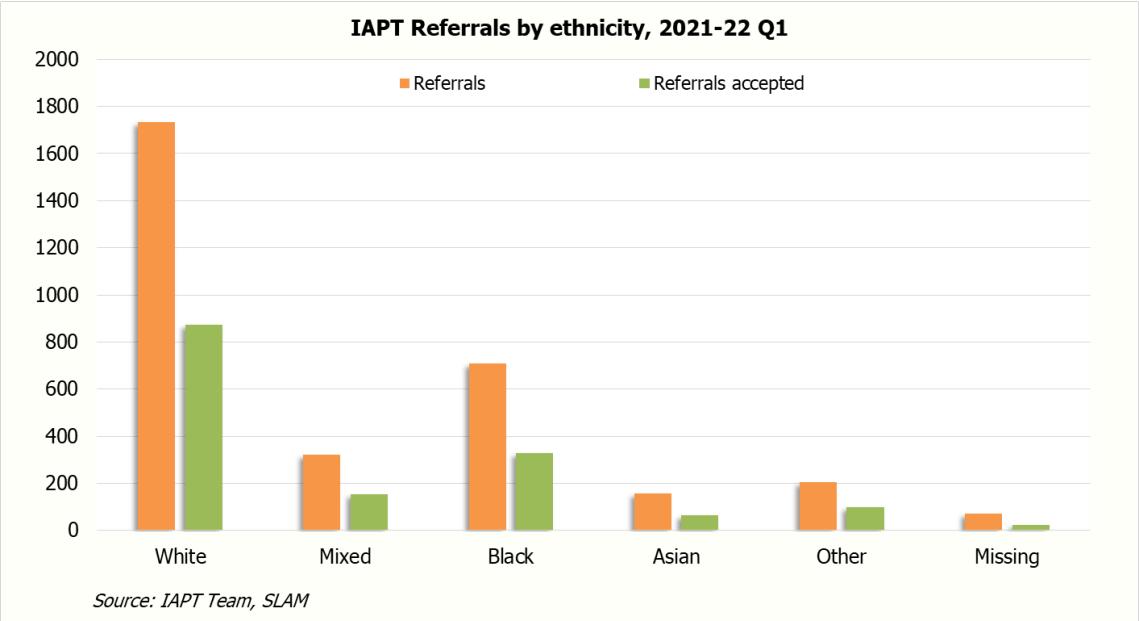
Mental Health in Lewisham

Lewisham has lower average wellbeing scores than London or England. Just over 8% of adults in Lewisham have a recorded diagnosis of depression. This is significantly higher in than in London (7.1%). This is also likely to be an underestimate of actual prevalence, as not everyone who has depression will visit their GP. Just over 1% of people in Lewisham have a recorded diagnosis of severe mental illness (SMI). This is significantly higher than in London (1.1%) and in England (0.9%).

The prevalence of mental ill health is not spread evenly across the population, and there are some population groups that have higher rates of mental ill health in Lewisham, including:

- Black, Asian and Minority Ethnic populations have higher prevalence rates of some mental health conditions, e.g. psychotic disorder, Post-Traumatic Stress Disorder (PTSD), and also experience inequalities in access to services.
- The rate of admission to hospital for mental and behavioural disorders due to alcohol is significantly higher in Lewisham than in London. Approximately a fifth of adults receiving drug misuse treatment and alcohol misuse treatment were also in contact with MH services
- The gap between the employment rate for all people and just those in contact with secondary mental health services is higher in Lewisham than in London or England, and the gap has increased steadily in the last few years
- The proportion of adults in contact with secondary mental health services and known to be living independently (with or without support) is significantly lower in Lewisham than in England and London

There is a strong link between mental health and physical health: Adults in Lewisham who are in contact with secondary mental health services are more than three times as likely to die as people of the same age in the general Lewisham population. There are many causes of this, but the higher smoking prevalence amongst people with SMI is likely to be part of the explanation.



IAPT (Improving Access to Psychological Therapies) services offer talking therapies, such as cognitive behavioural therapy (CBT), counselling, other therapies, and guided self-help. They aim to provide help for common mental health problems, like anxiety and depression. In Lewisham in Quarter 1 of 2021/21 the greatest number of referrals to the IAPT service where for patients from a White ethnic group. Referrals appear to be more likely to be accepted for White patients than from any other ethnic group.

What is happening in Lewisham to address health inequalities?

Lewisham Health and Wellbeing Board and the Birmingham Lewisham African and Caribbean Health Inequalities Review (BLACHIR)

The Lewisham Health and Wellbeing Board is continuing to prioritise tackling health inequalities in Black, Asian and Minority Ethnic residents in Lewisham, particularly in light of the disproportionate impact that COVID-19 has had on Black and Asian communities. During the pandemic the Health Inequalities working group of the Health and Wellbeing Board has developed a specific work stream around COVID-19 to drive forward action in the following areas:

- COVID-19 communications and engagement with Black, Asian and Minority Ethnic residents through the development of the Lewisham COVID-19 Community Champion programme.
- Data collection around COVID-19 deaths where we now locally collect ethnicity data the time of death registrations.
- Overseeing the collaborative work that Lewisham is undertaking with Birmingham City Council to perform an in-depth review of health inequalities in Black African and Black Caribbean residents in Birmingham and Lewisham. This review has now started and is due to complete in 2022: www.lewisham.gov.uk/myservices/socialcare/health/improving-public-health/birmingham-and-lewisham-african-and-caribbean-health-inequalities-review

Health in All Policies Annual Public Health Report

This year's Annual Public Health Report for Lewisham focuses on Health in All Policies (HiAP). HiAP describes a whole-system approach to improving health and wellbeing, reducing inequalities and delivering better outcomes for individuals and communities.

The report makes the following recommendations for implementation over the coming year:

- Harness the learning from whole system working on COVID-19 and continue to work with stakeholders across the council and wider system to increase understanding and build capacity to further implement a health in all policies approach.
- Build on existing work to formalise a health in all policies approach at all stages of service development and strategy and policy-making.
- Continue to champion the health in all policies approach at a strategic level by highlighting the links between improvements in population health and the achievement of corporate and other strategic priorities.
- Develop a framework to enable the ongoing and robust assessment of the impact of policy decisions on health and health inequalities within the Lewisham population

Glossary

Health Inequalities: the avoidable and unjustified differences in the health status of groups and individuals that are not inevitable or immutable.

Healthy life expectancy: the average number of years that an individual is expected to live in a state of self-assessed good or very good health.

Intersectionality: the idea that when it comes to thinking about how inequalities persist, categories like gender, race, and class are best understood as overlapping and mutually constitutive rather than isolated and distinct.

Life expectancy at birth: the average number of years that a newborn could expect to live.

Lower/Middle Layer Super Output Area (LSOA/MSOA): a geographic area that has a minimum population of 1,000 people.

Premature Mortality: mortality rates for deaths under age 75 for all causes combined and leading causes of death.

Proportionate universalism: is the resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need.

Protected Characteristics: Protected characteristics are specific aspects of a person's identity defined by the Equality Act 2010. The 'protection' relates to protection from discrimination. There are nine protected characteristics:

1. Age
2. Disability
3. Gender reassignment.
4. Marriage and civil partnership.
5. Pregnancy and maternity.
6. Race
7. Religion or belief
8. Sex
9. Sexual orientation.

Slope index of inequality (SII): a measure of the social gradient in life expectancy, i.e. how much life expectancy varies with deprivation.

Social determinants of health: the broad social and economic factors that we grow up and live in that interact to influence the health of a population.

Further resources

Public Health England Health Inequalities Dashboard:
www.analytics.phe.gov.uk/apps/health-inequalities-dashboard/
NICE guidance on Community engagement to reduce health inequalities:
www.nice.org.uk/guidance/ng44
PHE guidance on local action to understand and reduce ethnic inequalities in health:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/730917/local_action_on_health_inequalities.pdf
PHE Reducing health inequalities: system, scale and sustainability:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/731682/Reducing_health_inequalities_system_scale_and_sustainability.pdf
PHE Place-based approaches for reducing health inequalities:
www.gov.uk/government/publications/health-inequalities-place-based-approaches-to-reduce-inequalities
Marmot review Health Equity in England: the Marmot review 10 years on:
www.health.org.uk/publications/reports/the-marmot-review-10-years-on
Marmot Review Fair Society, Healthy Lives:
www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review
PEH Health Equity Assessment Tool:
www.gov.uk/government/publications/health-equity-assessment-tool-heat

www.lewisham.gov.uk

Health and Wellbeing Board

Report title: Lewisham Safeguarding Adults Board (LSAB) Annual Report 2020 – 2021

Date: 9 March 2022

Key decision: No

Class: Part 1

Ward(s) affected: N/A

Contributors:

- Lewisham Safeguarding Adults Board Business Unit
- London Borough of Lewisham - Adult Social Care
- South East London Clinical Commissioning Group
- Lewisham & Greenwich NHS Trust
- South London & Maudsley NHS Foundation Trust
- Metropolitan Police Service
- Lewisham Homes

Outline and recommendations

This report provides members of the Health and Wellbeing Board (HWB) with an overview of the partnership work carried out by the Lewisham Safeguarding Adults Board and its partner agencies from April 2020 – March 2021.

- The report is for the HWB member's information.
- The contents of the report are agreed.

Timeline of engagement and decision-making

N/A

1. Summary

1.1. This report contains information on the following:

1.2. Message from the Lewisham Safeguarding Adults Board Independent Chair

1.3. Key Outcomes in 2020-21

1.4. Covid – 19 Pandemic Response: Highlighting Inequalities

1.5. Case Studies

1.6. New Lewisham Adult Safeguarding Pathway

1.7. Communication and Engagement Work

1.8. Learning, Training and Development Delivery

1.9. Safeguarding Information

1.10. Safeguarding Adult Reviews

1.11. Work of the Lewisham Safeguarding Adults Board Sub-Groups

1.12. Business Plan on a page 2021-22.

2. Recommendations

2.1. The report is for the HWB member's information.

2.2. The contents of the report are agreed.

3. Policy Context

3.1. Safeguarding is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action.

3.2. Local authorities are required to: lead a multi-agency local adult safeguarding system; making or causing enquiries to be made where there is a safeguarding concern; hosting Safeguarding Adults Boards; carrying out Safeguarding Adult Reviews; and arranging for the provision of independent advocates.

3.3. The Board are committed to 'Making Safeguarding Personal' (MSP); to improve

outcomes for people at risk of harm. This is achieved, during a safeguarding enquiry, by establishing a real understanding of what people wish to achieve and the 'outcomes' they want at the beginning then checking throughout, and at the end the extent to which these outcomes were realised.

3.4. The work of the LSAB contributes to the Council's priorities as set out in the Corporate Strategy specifically:

3.5. Commitments - All health and social care services are robust, responsive and working collectively to support communities and individuals - We will continue to do our utmost to defend and deliver health and social care services that protect the most vulnerable in our borough.

3.6. Creating and Inclusive Lewisham - Continue to ensure that everyone in Lewisham has equitable access to the support and services they need.

3.7. Achieving better outcomes for people.

3.8. Comprehensive Equality Scheme, Strategic Framework.

4. Background

4.1. The LSAB brings together a wide range of agencies from across the borough to ensure that there is a joined-up approach to adult safeguarding.

5. Main body paragraphs

5.1 Message from the Lewisham Safeguarding Adults Board Independent Chair

5.2 Key Outcomes in 2020-21

5.3 Safeguarding Information

5.4 Safeguarding Adult Reviews

5.5 Work of the Lewisham Safeguarding Adults Board Sub-Groups

5.6 Business Plan on a page 2021-22.

6. Financial implications

6.1. There are no additional financial implications arising from this report.

7. Legal implications

7.1. There are no additional legal implications arising from this report.

8. Equalities implications

8.1. As highlighted in the "Safeguarding Information" section of the LSAB Annual Report (page 6) there are ongoing equalities implications to ensure that all communities across Lewisham are engaged with relevant agencies and services to help prevent adult abuse and neglect.

8.2. The further development and analysis of data by the Board's Performance, Audit and Quality Sub-Group will enable the Board to understand any potential barriers to reporting abuse, and also accessing protective and preventative services and links to the following aims in the LSAB Business Plan 2021-2022:

8.3. Prevention Aim – Objective - Focus on equality and narrowing inequality, particularly in relation to racial disparity and disproportionality.

8.4. Prevention Aim– Objective - Help to break down barriers to reporting abuse and improving access to supportive and protective services.

8.5. Prevention Aim – Objective - Listen to the voices of adults, ensuring their experiences shape how services are designed and delivered.

9. Climate change and environmental implications

9.1. There are no climate change or environmental implications arising from this report or its recommendations.

10. Crime and disorder implications

10.1. There are no specific crime and disorder implications arising from this report.

10.2. The LSAB works in close collaboration with the Safer Lewisham Partnership Board to ensure a joint approach to overlapping issues such as domestic violence, hate crime and the government's counter-terrorism strategy 'Prevent' thereby contributing to meeting the duty placed on local authorities by the Crime and Disorder Act 1998 to identify community safety implications in all our activities.

11. Health and wellbeing implications

11.1. There are no specific health and wellbeing implications arising from this report or its recommendations.

12. Background papers

12.1. N/A

13. Glossary

13.1. Please see table below for Acronyms and sector-specific language used in the annual report.

Term	Definition
LSAB	Lewisham Safeguarding Adults Board
SAB	Safeguarding Adults Board
SAR's	Safeguarding Adults Reviews (Section 44 Care Act 2014)
Safeguarding	The process of ensuring that adults at risk are not being abused, neglected or exploited, and ensuring that people who are deemed 'unsuitable' do not work with them.
Advocacy	Help to enable adults to get the care and support they need that is independent of the local council. An advocate can help adults express their needs and wishes, and weigh up and take decisions about the options available to them. They can help the adult find services, make sure correct procedures are followed and challenge decisions made by councils or other organisations. The advocate represents the interests of the adult, which they do by supporting the adult to speak, or by speaking on their behalf.
Abuse	Harm that is caused by anyone who has power over another person, which may include family members, friends, unpaid carers and health or care workers. It can take various forms, including physical harm or neglect,

Term	Definition
	and verbal, emotional or sexual abuse. Adults at risk can also be the victim of financial abuse from people they trust. Abuse may be carried out by individuals or by the organisation that employs them.
Making Safeguarding Personal (MSP)	Making Safeguarding Personal (MSP) is a sector-led initiative which aims to develop an outcomes focus to safeguarding work, and a range of responses to support people to improve or resolve their circumstances

14. Report author and contact

14.1. Martin Crow

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15. Comments for and on behalf of the Executive Director for Corporate Resources

15.1. N/A

16. Comments for and on behalf of the Director of Law, Governance and HR

16.1. N/A

Lewisham Safeguarding Adults Board

A working partnership to prevent abuse

Annual Report 2020-21

1 April 2020 to 31 March 2021

Image courtesy of
Lewisham & Greenwich NHS Trust

Message from the Independent Chair

"I want to pay tribute to all those who have contributed to safeguarding adults at risk of, or experiencing abuse and neglect. You have shown real leadership"

We have all had to adjust our lives this year due to the Covid -19 pandemic. Our patterns of daily life have been significantly disrupted; our liberties curtailed by the Coronavirus Act 2020. Throughout this period, however, the adult safeguarding duties within the Care Act 2014 have remained in place. Consequently the Lewisham Safeguarding Adults Board has continued to seek assurance that adult safeguarding has remained "everyone's business" and that statutory, voluntary and community services have worked together effectively to prevent and/or protect individuals from abuse and neglect. The Board has also continued to deliver its Business Plan and to commission and complete Safeguarding Adult Reviews, as required by the Care Act 2014. This Annual Report summarises what the Board has achieved during the year.

Throughout the pandemic the Board has sought assurance that services have worked effectively together when responding to this unprecedented situation. The response of local services has been commendable, with enhanced levels of collaboration to ensure the resilience of health and social care provision for people at risk. Going forward the Board will be concerned to ensure that this degree of cooperation and collaboration, working together, is maintained. We already have seen increased demand for care and support, and rising referrals of adult safeguarding concerns, whether occasioned by mental distress and social isolation, domestic abuse or self-neglect.

As the country emerges from lockdown, we expect to see a rising number of concerns, as families, friends and practitioners begin to meet adults who may be at risk in person again. The resilience of all our services will be needed as never before.

As the Board's Independent Chair, I am especially proud of the web pages that carry important information for practitioners and for Lewisham's residents and communities. I am especially proud of the outreach into Lewisham's local neighbourhoods, community and faith groups. The Board has made good progress with its data collection and analysis, an essential part of gaining assurance about the effectiveness of adult safeguarding provision and of setting new priorities.

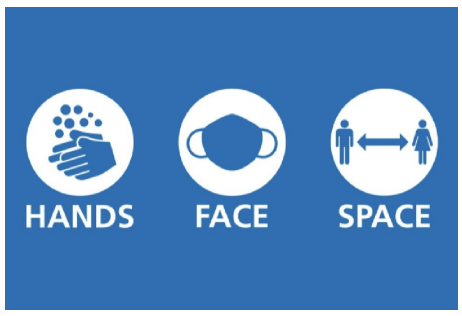
We are learning and disseminating lessons too from the Safeguarding Adult Reviews that have been completed, and from other reviews already underway, ensuring service improvement and enhancement where necessary. This report shines a light on that work.

Finally, I want to pay tribute to all those who have contributed to safeguarding adults at risk of, or experiencing abuse and neglect. You have shown real leadership.

I want to thank Martin Crow, Vicki Williams and Tiana Mathurine, the Board's business team, without whom we would not have made the progress summarised in this annual report.

Professor Michael Preston-Shoot

Key Outcomes in 2020-21



1. Covid 19 - Pandemic Response:

In addition to the Board's normal schedule of meetings partners met more regularly to discuss the response to the pandemic and local risk factors. Focus was given to:

- Domestic Abuse and the delivery of local services
- Adult mental health services
- The voice of the adult - the Board worked with and supported Lewisham Speaking Up to stay engaged with adults living with a learning disability who have been disproportionately affected by Covid-19
- Rough sleepers
- Hospital discharges
- Out of borough placements.

The Board also supported the work on the 'shielding' programme, and with the development of a national data set analysing safeguarding trends, as well as publishing monthly e-Bulletins and a dedicated webpage. See pages 3 & 4 for further information in relation to the impact of the pandemic.

2. Self-Neglect & Hoarding Multi-Agency Policy, Practice Guidance and Toolkit:

This was revised based on consultation with key practitioners and clinicians working in the borough, taking into account training that had been delivered on this subject and the feedback from delegates that had been received on the previous policy. Read the policy, guidance and toolkit HERE

3. Launch of the Lewisham Adult Safeguarding Pathway:

This included the publication of a revised Single Agency Adult Safeguarding Policy and Procedures Template, and the launch of a series of new leaflets and posters (see the back cover). Specific details are on page 5.

4. Communication and Engagement Work: See page 6 for more detail.

5. Learning, Training and Development Programme: Also page 6 for the detail.

6. Publication of three Safeguarding Adult Reviews: See pages 9 & 10.

7. Supported the launch of the Lewisham Modern Slavery and Human Trafficking Network: See page 11 for more detail.

8. Review of Statutory Advocacy Services:

This review commenced in March 2021 and will be completed in September.

From the Board's nine Strategic Objectives eight were either fully completed or are ongoing as outlined above, with the training programme and leadership project linked to adopting a 'Trauma Informed Approach' delayed due to the pandemic.

Covid - 19 Pandemic Response: Highlighting Inequalities

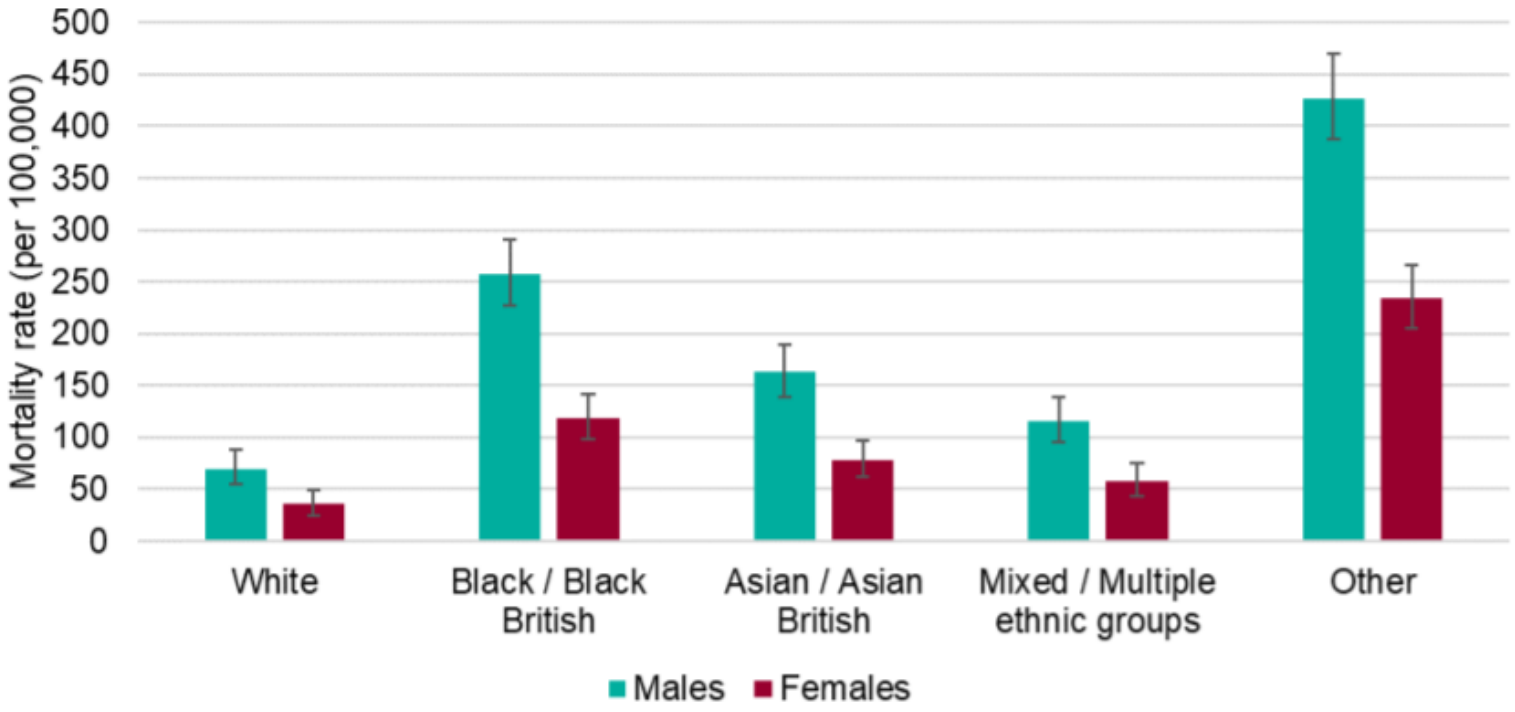
Nationally

Public Health England (PHE) described health inequalities in the following way:

"*Some groups have an increased risk of adverse outcomes from COVID-19 including some ethnic groups, males, those with certain pre-existing conditions such as obesity, those in deprived communities, older people, some occupations, people living in care homes, and other vulnerable groups.*

(PHE Beyond the Data: Understanding the Impact of COVID-19 on BAME Groups - June 2020)

- ⇒ People aged 80+ are seventy times more likely to die than those under 40
- ⇒ Mortality rates are double in the most deprived areas compared to the least
- ⇒ Rates are also Higher for Black, Asian and Minority Ethnic (BAME) groups
- ⇒ Death rates in London are 3+ times higher than in the South West (lowest area).



(PHE Disparities in the Risk and Outcomes of COVID-19 - Aug 2020)

Locally

"As well as the tragic toll of the disease, the lockdown has affected both mental health and wider determinants of health and wellbeing, including access to vital services, our local economy, and the education of our children and young people. The full extent of this impact and the inequalities that are created or exacerbated will only begin to emerge over the coming months and years".

- ⇒ Lewisham residents born in the Americas, the Caribbean, Middle East or Asia have a significantly higher death rate than people born in either the UK or Europe
- ⇒ 22% of deaths from COVID-19 were residents who normally lived in care homes
- ⇒ The analysis shows no significant difference in the rate of death between those living in the most and least deprived areas of Lewisham
- ⇒ Almost 10,000 people were shielding in Lewisham, and a wider cohort of approx. 3,000 vulnerable people (not known to services) were identified, and prioritised for a welfare call/ referral to other support if required.

Birmingham City and Lewisham Councils are launching ground-breaking work into the health inequalities of African and Caribbean communities. The aim is to find approaches to break decades of inequality that will lead to better futures for citizens.

(COVID-19: Lewisham System Recovery Plan - September 2020)

Case Studies

The following case studies provide an insight into the pressures and challenges that were faced by professionals in relation to safeguarding adults across Lewisham.

An 81year old man lived in a residential care home due to a progressive dementia diagnosis and his inability to remain safely in his own home. At this time the care home was closed to all visitors, and outside professionals where communicating virtually with the care home staff. The residents were being encouraged to remain in their own rooms to reduce the risk of transmission of infection, and staffing were also affected due to positive COVID tests, which all contributed to increasing the carers workload.

Although appropriate care was being provided, due to the pressures across the system, there was a delay in a pressure relieving mattress being provided and the man developed an unstageable pressure ulcer. The case was investigated by the Community Pressure Ulcer Panel and an action plan was jointly developed.

This was an unprecedented time for all of the services involved, but lessons were still identified and systems improved. The pressure ulcer is now completely healed and the gentleman remains happy living in the care home.

Local police worked with a man living with a learning disability who was a victim of several robberies, assaults and anti-social behaviour. He also felt intimidated going out in his local community because of these incidents, as well other problems, some of which extended from Adverse Childhood Experiences (ACE's).

His basic living conditions were very poor including mould and mildew on the walls, bare and rotting floorboards, no fridge and no lock on his front door. Police instigated a multi-agency meeting bringing together his sister, a new social worker and the relevant housing association's property manager.

Following on from this the property was cleaned, painted, repaired and updated, and carers are now giving the man appropriate support. Despite having felt let down by services previously, this man is feeling a lot more positive and now starting to interact more in his local community. (Case refers to periods in between lockdown periods).

Staff managing mental ill-health related safeguarding enquiries faced a number of challenges because of Covid-19, including an increase in the severity of symptoms being experienced in the community, and a shift to remote working, which was not always conducive to engaging the adult at risk.

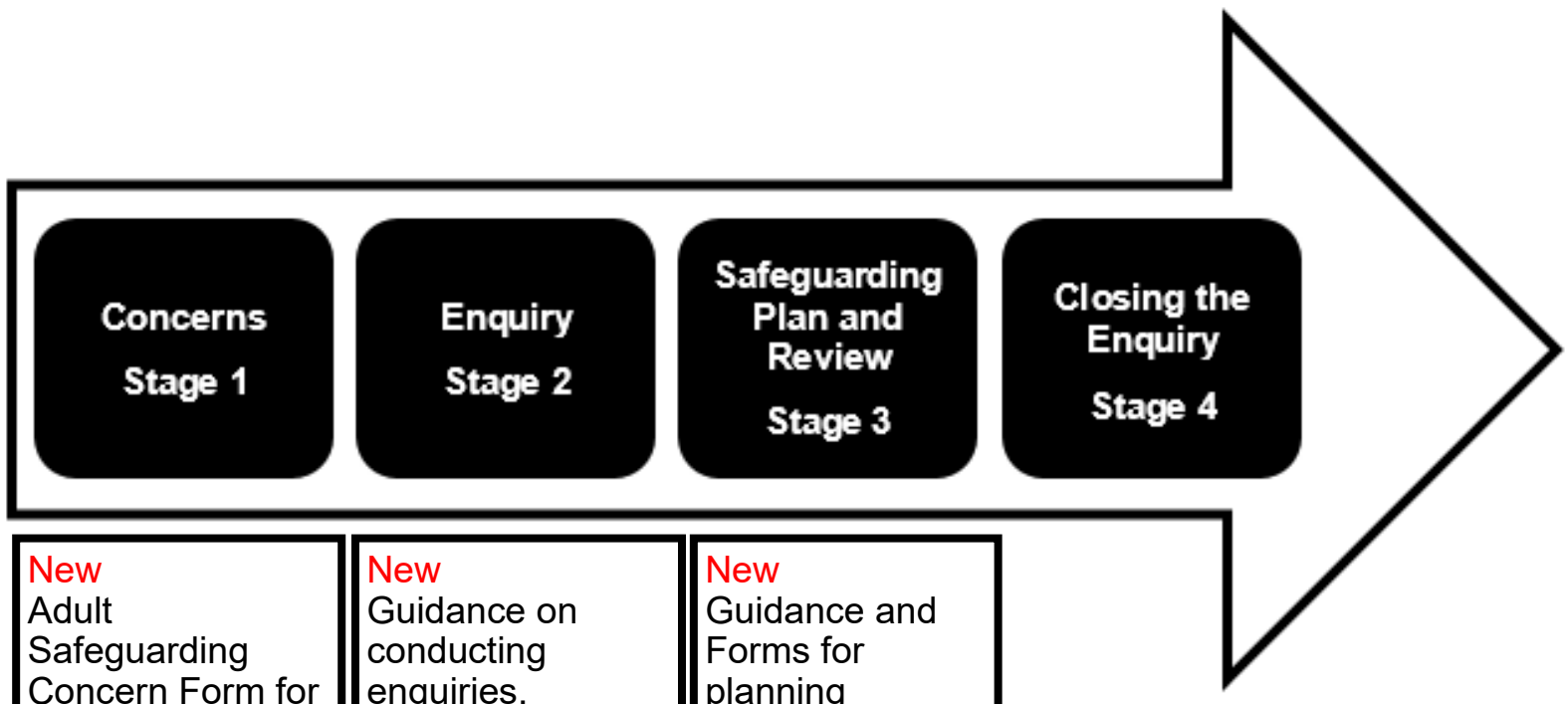
A positive example was the case of an adult who was initially identified by the London Ambulance Service as suffering from acute self-neglect, having attended their home due to the distressed state of the person. The Safeguarding Enquiry Officer worked with the Care Co-ordinator online, who then co-produced a care plan with the adult (Making Safeguarding Personal). Supportive outcomes and actions were generated in a very prompt manner as part of a wider harm minimisation plan.

What is this?
Comprehensive set of web pages providing local guidance, tools, forms and resources to support the London Multi-Agency Adult Safeguarding Policy and Procedures, as well as a platform to share good practice and build a local network of connected agencies all working to help prevent abuse and neglect.

Why do we need it?
To make it easier for professionals to understand and digest the pan London Policy and Procedures, and to create a step by step guide (Stages 1-4) which is embedded into local agencies ways of working (practice) and systems.

Who is it for?
All professionals working with adults at risk of abuse and neglect in Lewisham, as well as members of the public, including carers.

Who developed this Pathway?
A range of professionals from across partner agencies were involved in developing the work, as well as the public who helped to co-produce the leaflets and posters.



What do I need to do?

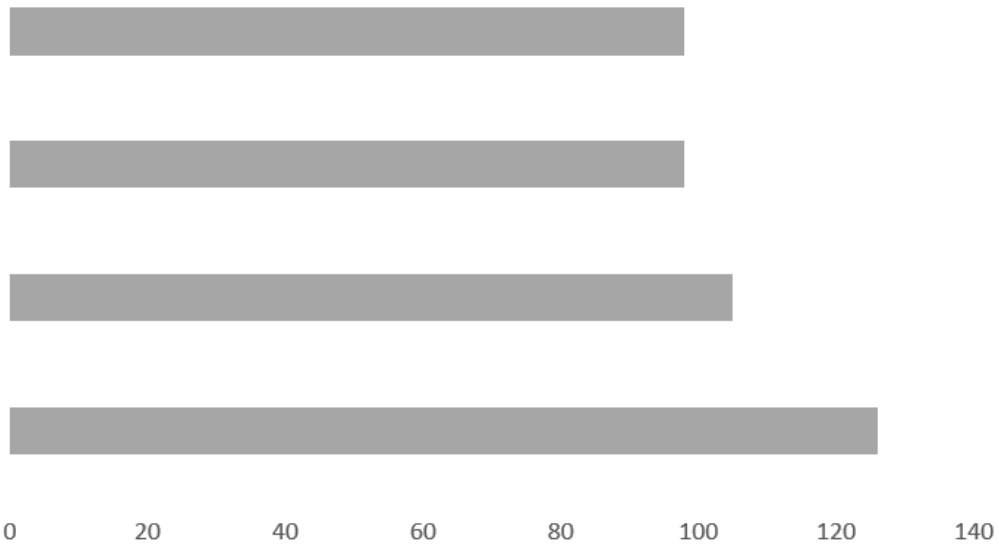
1. Use the New Adult Safeguarding Concern Form if you make a referral to the Local Authority.
2. Read and use all of the guidance throughout the four stages as outlined, and as applicable.
3. Embed this Pathway into your agency's way of working and systems if you are the lead professional responsible for safeguarding.
4. Use the template Policy and Procedures if you work in a non-statutory agency.
5. Use the leaflets and posters.

Contact: LSAB@Lewisham.gov.uk when you have completed number three above.

Communication and Engagement Work

"evidence of community awareness of adult abuse and neglect and how to respond"
(Care Act Statutory Guidance 14.157)

Fig 1:Annual Survey 2020-21: What should the Board's priorities be in 2021-22?

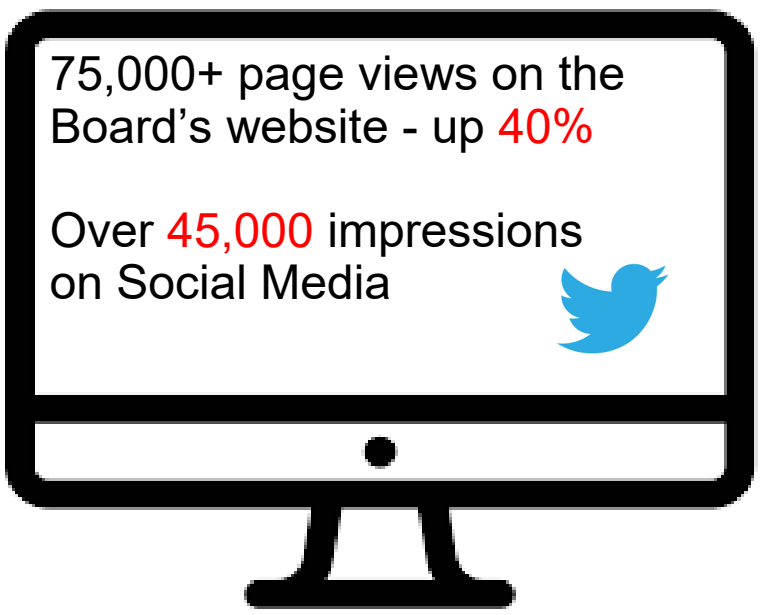


Over 200 professionals and members of the public engaged with the survey, which helped to inform the development of the Board's strategic objectives (see page 12).

Fig 2: I think LSAB is effective?

- **70% Strongly Agree/ Agree**
- **23% Couldn't answer the question/ Don't know**
- **7% Disagree**

"I feel that we are further down the road in terms of achieving this (vision) than we have ever been"



Over 6,000 reads of e-Bulletins

Learning, Training and Development Delivery

10 Learning and training events were cancelled/ postponed between March - June 2020 due to Covid -19.

A transition to entirely online delivery was then made after this which wasn't easy, although targets were still achieved within a condensed six month period. This demonstrates the positive effect that online delivery can have in increasing the numbers who can engage with learning interventions (annual average has been 320 places since 2018).

"increase the SAB's understanding of prevalence of abuse and neglect locally that builds up a picture over time"
(Care Act Statutory Guidance 14.139)

Table 1: Safeguarding Concerns and Concluded Section 42 Enquiries

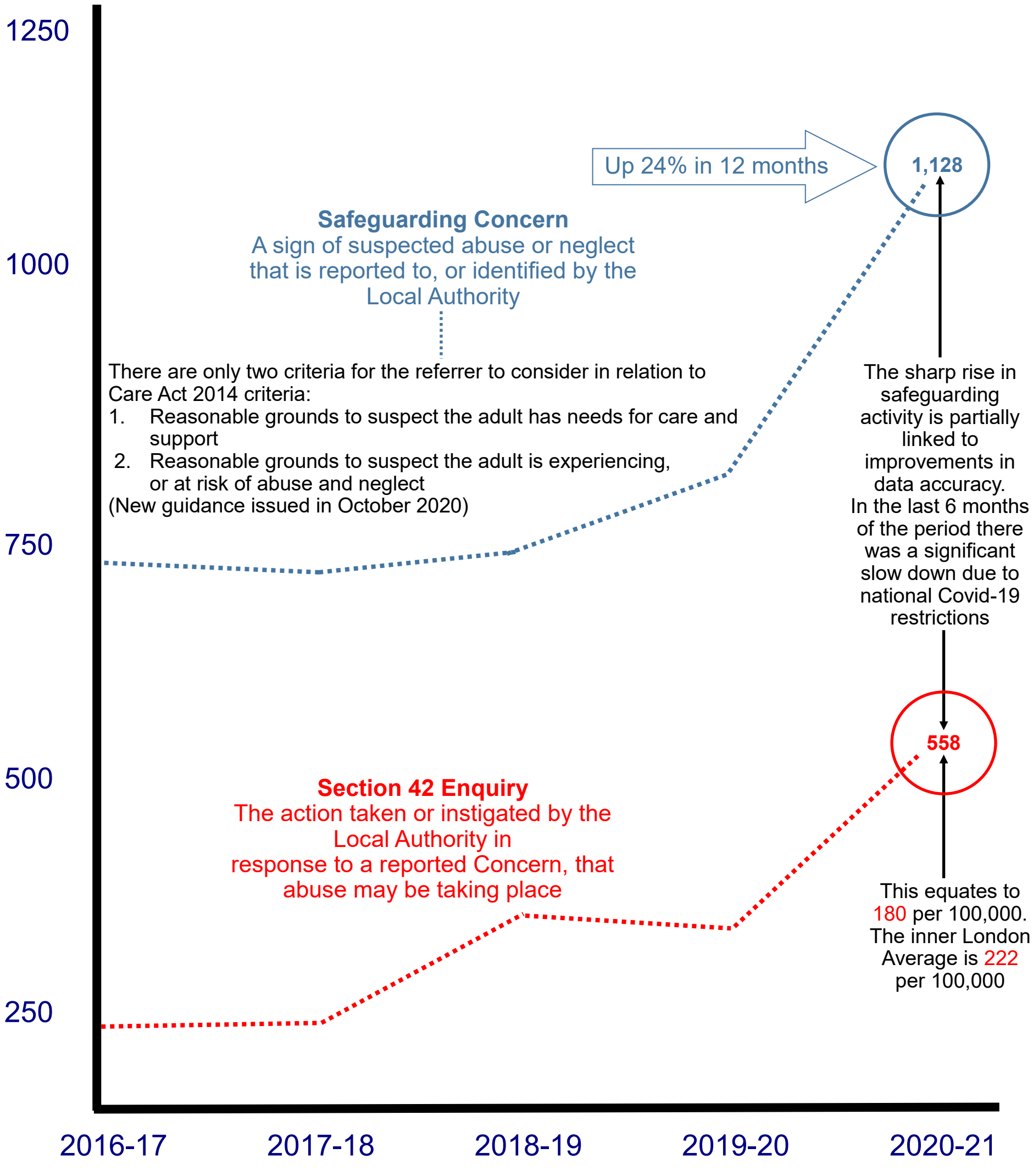


Table 2: Types of Abuse: Concluded Section 42 Enquiries

This is the 1st Section 42 Enquiry for Modern Slavery in Lewisham since the Care Act 2014 came into force

There were c6,000 domestic abuse incidents reported to Police

4% of the total

Themes:
- ⇒ Medication errors
- ⇒ Falls
- ⇒ Missed/late homecare visits
- ⇒ Pressure sores

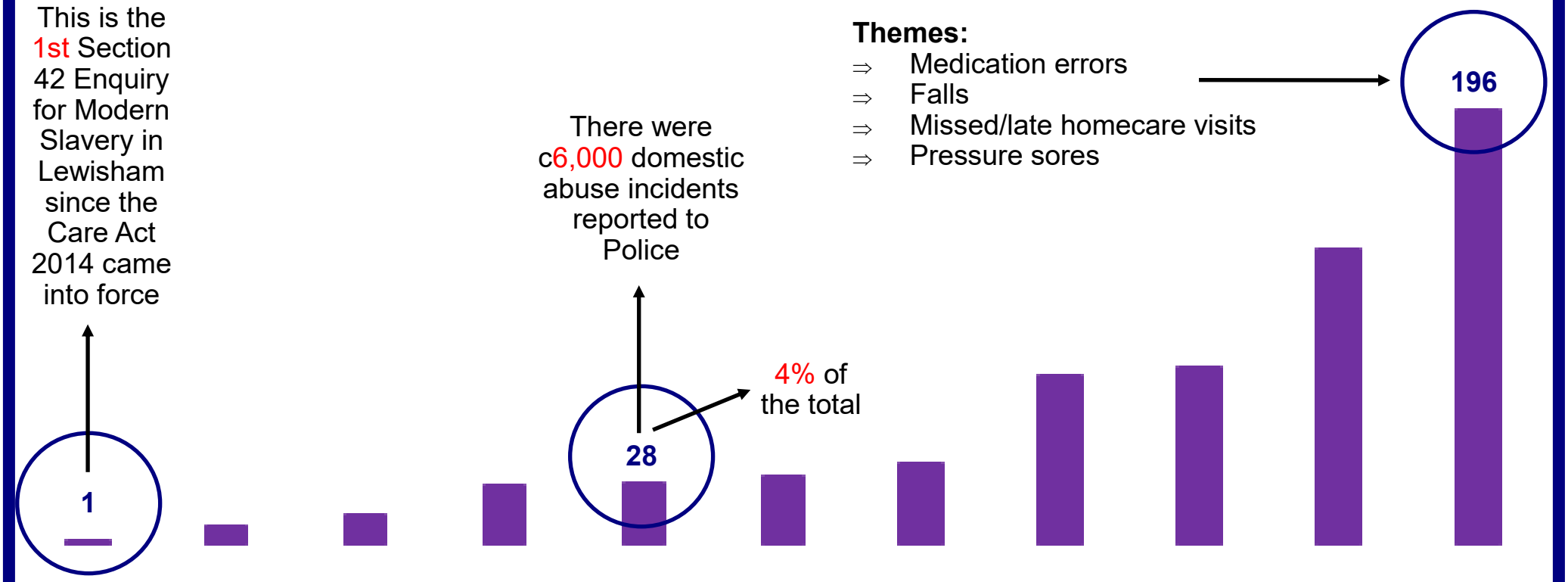
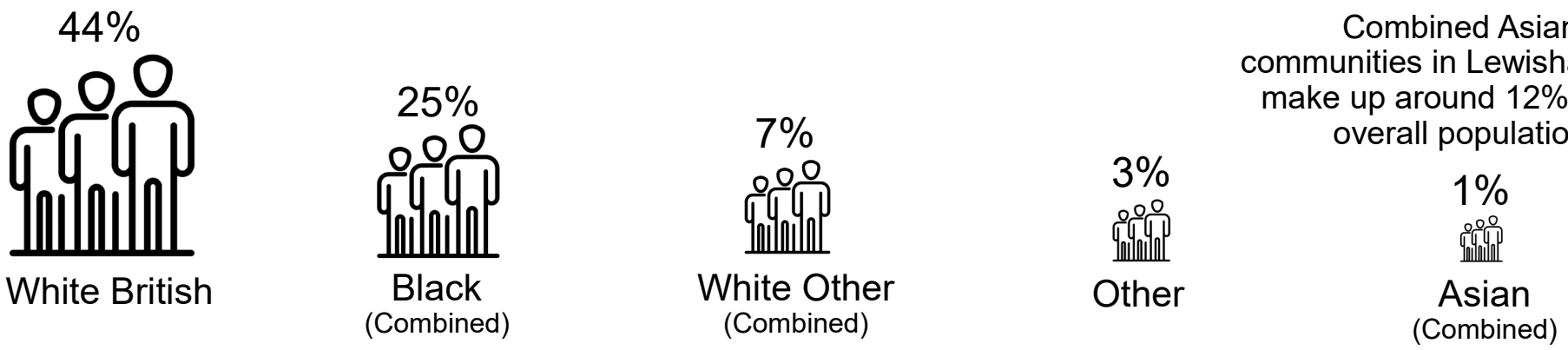


Table 3: Concluded Section 42 Enquiries By Ethnic Code Group



- ⇒ 36% of concluded s.42 Enquiries involved adults from Black, Asian and Minority Ethnic backgrounds (BAME)
- ⇒ Most up to date data projections are that the BAME population is around 48% in Lewisham (and rising)
- ⇒ This data indicates that there are still barriers to reporting abuse, which in turn suggests there is racial disparity and disproportionality in accessing protective services

Table 4: Source of Concern Leading to Section 42 Enquiry (Who reported the abuse)

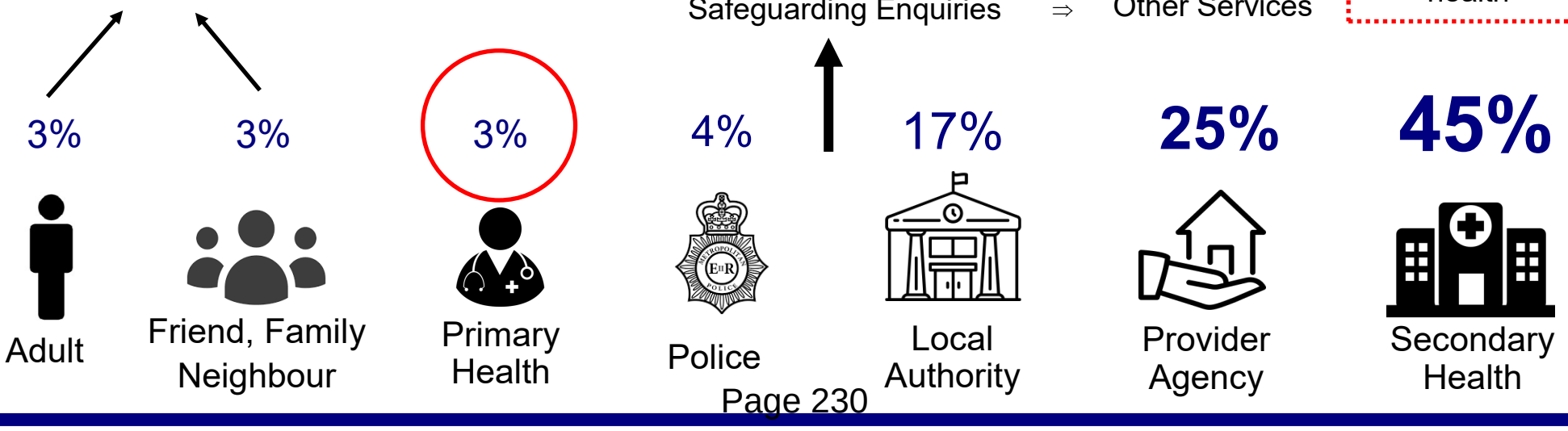
In 2019-20 the combined total across these two areas was 19%, and in real terms is a 50% reduction

Risks not being identified by GP's is a national trend, and also highlighted in more than one SAR in Lewisham

Police shared more than 3,500 'Adult Come to Notice' intelligence reports with the Local Authority, but less than 25 of these went onto become statutory Safeguarding Enquiries

- ⇒ Nursing Homes
- ⇒ Care Homes
- ⇒ Homecare
- ⇒ Housing
- ⇒ Other Services

High % linked to ill-mental health



Safeguarding Adult Reviews

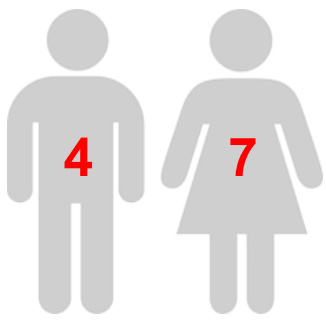
"Safeguarding Adults Boards must arrange a Safeguarding Adult Review (SAR) when an adult dies either as a result of abuse or neglect, known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult".
(Care Act Statutory Guidance 14.162)

The Case Review Sub-Group

In total 11 cases were considered and or monitored by the Sub-Group, which is made up from the Board's statutory partners, throughout the year (see page 9).

A National Analysis of SARs was also published in October 2020: Read HERE

SAR Demographics and Themes (11 cases considered)



Age

18 - 44:	3
45 - 59:	3
60 - 74:	2
75+	3

Most Common Types of Abuse
- ⇒ Organisational Abuse
- ⇒ Neglect & Acts of Omission

	Themes: All Cases
1	Lack of inter-agency working
2	Mental ill-health (including death by suicide)
3	Response to urgent care and support needs
4	Mental Capacity
5	Substance misuse
6	Self-Neglect
7	Physical assault/ Domestic Abuse

SAR Lee (5 June 2020)

Read the 7 Minute Briefing HERE

Background
On 11 January 2016 Lee walked out of a hospital where he had been an in-patient, and was found dead in the street eight miles away three days later. Lee was 46 years old and had a history of alcohol related illnesses, depression and anxiety.

Key Learning Points
1. No formal assessment of risk was completed when Lee left the hospital that drew on previous knowledge of him. It took three days before Lee was formally recorded as missing by police. NHS Procedures should have been used to conclude that Lee was high risk of going missing from hospital.
2. There was miscommunication involving the police, family and hospital with respect to whether Lee was missing, and then whether a missing person enquiry should be raised.
3. No formal Mental Capacity Act assessment was ever conducted.

SAR Tyrone Goodyear (12 June 2020) ➡ Read the 7 Minute Briefing HERE

Background

Mr Goodyear had been in irregular contact with mental health services since he was 15 years old and had been assessed to have Autism Spectrum Disorder (ASD), learning difficulties and Obsessive-Compulsive Disorder.

Tyrone lived with his mother and five of his siblings in four-bedroom temporary accommodation. This was causing friction between the family members. Tyrone left home after trying to secure alternative accommodation and his mother reported him missing. He was later found dead in a hotel room on 21 February 2019 having taken his own life via an overdose. He was 24 years old.

Key Learning Points

1. People with ASD are more likely to commit suicide than the general population, and the factors that predict this can also be different from the wider general public.
2. People with ASD may 'camouflage' their needs in order to fit in. They may not be accessing any services but this does not mean that they do not have unmet needs.
3. Services need to be made more accessible for people living with ASD.

Extract: Statement from the family of Tyrone to accompany the SAR

"We hope that the changes recommended in this report can be put into place as soon as possible, to ensure that when someone with Autism Spectrum, learning and communications difficulties, and suspected mental health issues, will be treated with the correct priority that they need and deserve".

SAR Mrs A and Miss G (26 June 2020) ➡ Read the 7 Minute Briefing HERE

Background

Mrs A (102 years old) and Miss G (73 years old) both lived on their own at home and were receiving Homecare Services linked to mobility and other health conditions. They both also had periods where they were admitted to hospital and discharged, which led to complications in relation to the care they subsequently then received.

Key Learning Points

1. Problems arose in the reassessment of needs during admission to hospital.
2. After mobility had decreased this should have informed a full reassessment.
3. Discharge from hospital resulted in the 'restart' of previous levels of care which were no longer appropriate to meet an increase in care needs.
4. Discharge planning was not undertaken in line with the good practice standards.
5. Carers continued to attempt to meet clients' needs rather than escalate either difficulties with the delivery of effective care, or the impact on the clients' health where needs were not met.
6. Community Nursing did not always respond appropriately or in a timely manner to referrals made by hospital or community services.
7. Equipment that was required at home was not ordered, delivered or set up.
8. Other delays in practical aspects of setting up changes to care caused needs to remain unmet, which led to serious health consequences for the adults.
9. Decision making was not assessed even though poor physical health can lead to a deterioration in mental capacity linked to associated risks in the community.

Work of the Sub-Groups

Case Review Sub-Group

The Sub-Group oversees Safeguarding Adult Reviews (SAR) processes locally, and is led by the Board's Independent Chair Professor Michael Preston-Shoot.

The group met 7 times and considered 3 new SAR Notifications during 2020-21. 4 SARs commenced during the year (which includes 2 that were pending from 2019-20), with a further 2 on hold due to 'parallel processes'. The SARs that were published during the year are outlined on pages 9&10.

Lewisham Modern Slavery and Human Trafficking Network

This group was newly launched and involves a range of Board partners across all age domains, but has been initially guided by the Board's business team, supported by the Human Trafficking Foundation.

The Network is developing a new local strategy and guidance for, and with practitioners, which will include a Victim Care Pathway. This subject does not have a high profile in relation to adult safeguarding locally, and is evolving all of the time with new approaches and guidance being created nationally.

Mission Statement

"We will robustly tackle all forms of modern slavery and human trafficking in Lewisham through effective and collaborative partnership working, and by identifying, protecting and supporting potential victims of modern slavery and human trafficking.
We will empower people to move on safely and successfully from exploitation, and proactively target and pursue criminals".

The Governance for the Network has not been decided yet, but this is likely to come from the Safer Lewisham Partnership Board.

Performance, Audit and Quality Sub-Group

This group continued to meet quarterly throughout the year to monitor the Performance Indicators below:

Pi	Performance Indicators (Pi)	Pi Criteria	Risk is
1	Percentage of Concerns leading to Section 42 Enquiries	> 40%	
2	Percentage of Section 42 Enquiries that involved an adult with a previous enquiry in a rolling 12 month period	< 25%	
3	Percentage of those who were asked their desired outcomes	> 75%	
4	Percentage of those who were satisfied with their outcome	> 75%	
5	Percentage of those where risk has been reduced or been removed	> 89%	

Risks have increased since the end of 2019-20 due to the pressures and challenges the Council and the NHS have faced during the last 12 months.

The group also monitors other pieces of relevant data some of which is outlined on pages 7&8. This informs the groups work programme of audits and reviews, and has played a significant part in informing the development of the Board's current strategic objectives (page 12).

SAR Mrs A and Miss G Task and Finish Group

This group was established to support and track the delivery of the Action Plan linked to this SAR. This was paused to allow Lewisham & Greenwich NHS Trust to focus on the pandemic response, but has now re-commenced.

Lewisham Safeguarding Housing Forum

The group continued to meet quarterly throughout the year, bringing a wider range of agencies and providers together. The Forum has now been stood down having achieved its stated objectives.

Business Plan 2021-22 on a Page

Lewisham Safeguarding Adults Board

A working partnership to prevent abuse

All of the elements outlined below have been developed based on feedback from members of the public and practitioners, performance and other relevant data, audits, and by Board partners providing specific input. This plan is designed to give relevant agencies and professionals a generic template to use in conjunction with the Board.

Vision

Ensure adults are safeguarded by empowering and supporting them to make informed choices and decisions (Making Safeguarding Personal)

Priority One

Prevent adult exploitation, abuse and neglect

Priority Two

Develop intelligence led, evidence based practice

Priority Three

Strengthen partnership working

Prevention Aim

Develop preventative strategies by working with those most at risk of abuse and neglect

Accountability Aim

Use monitoring information and data to help develop evidence based practice

Partnership Aim

Support 'the whole family approach' to protecting those most at risk of abuse in Lewisham

Prevention Objectives

1. Focus on equality and narrowing inequality, particularly in relation to racial disparity and disproportionality.
2. Help to break down barriers to reporting abuse and improving access to supportive and protective services.
3. Listen to the voices of adults, ensuring their experiences shape how services are designed and delivered.

Accountability Objectives

1. Support the roll out of the new Lewisham Adult Safeguarding Pathway which includes comprehensive guidance, tools, forms and resources for use across the borough.
2. Combine the findings from higher level reviews to create a joined up and more strategic approach to learning and improvement.

Partnership Objectives

1. Focus on ill-mental health support and recovery, which is one of the most significant risk factors linked to adult abuse and neglect locally.
2. Fully support the delivery of the new Domestic Abuse Strategy in Lewisham and the implementation of the Domestic Abuse Act 2021.

Lewisham Safeguarding Adults Board

A working partnership to prevent abuse

www.safeguardinglewisham.org.uk/lsab

HEALTH AND WELLBEING BOARD				
Report Title	Healthwatch Lewisham Digital Exclusion report 2021			
Contributors	Mathew Shaw, Operations Manager		Item No.	
Class		Date: 22/02/2022		

1. Purpose

1.1 This report and accompanying copy of the Healthwatch Lewisham Digital Exclusion Report 2021 outlines the experiences of residents who were more likely to be at risk of being digitally excluded and their experiences of accessing health and care services (with focus on primary care) during the COVID-19 pandemic.

2. Background

2.1. Healthwatch is a voice for children, young people and adults in health and social care living in Lewisham. Anyone, young or old can speak to us about their experiences of health or social care services and tell us what was good and what was not good. Healthwatch then ensures that service providers and commissioners hear this feedback to make changes to their services.

2.2 Local Healthwatch are intended to hold both commissioners and providers of services to account by delivering the 6 statutory functions:

- Gathering the views and understanding the experiences of patients and the public.
- Making people's views known.
- Promoting and supporting the involvement of people in the commissioning and provision of local health and social services and how they are scrutinised.
- Recommending investigation or special review of services via Healthwatch England or directly to the Care Quality Commission.
- Providing information (signposting) about access to services and support for making informed choices.
- Making the views and experiences of people known to Healthwatch England and the local Healthwatch network,and providing a steer to help it carry out its role as national champion.

2.3. Healthwatch Lewisham carried out a research project in June and July 2020 to understand the experiences of residents during the first COVID-19 lockdown (https://www.healthwatchlewisham.co.uk/wp-content/uploads/2020/10/The-Impact-of-Covid-19-on-Lewisham-Residents.pdf)

Through this work we recognised there was a gap in local knowledge around the experiences of digitally excluded residents using health and care services since the increase in remote delivery models in response to the pandemic. We developed a research project in order to have a better understanding of the impact of digital exclusion to inform the local system.

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3. Policy Context

3.1 In 2012 the Health and Social Care Act received Royal Assent. From April 2013, local authorities were required to commission a local Healthwatch organisation.

3.2.1 The Lewisham Corporate Strategy 2018 – 2022 has as one of its commitments that 'all health and social care services are robust, responsive & working collectively to support communities and individuals'. Healthwatch Lewisham supports the Council to deliver its commitment to local people.

4. Healthwatch Lewisham Digital Exclusion Report 21

4.1 For this research project, we wanted to engage with people who are more likely to be digitally excluded and gain a better understanding of how this might impact their experience with health and care services. We focused on primary care as this is the first point of contact for people accessing services. However, our findings will be relevant to all services which are using or moving towards digital delivery

4.2 Phone interviews were carried out with **45** residents either by staff, volunteers or community organisations as part of the project.

Those we spoke with included older people, people who speak English as their second language, and people with disabilities. The reason why we chose these groups is because they traditionally experienced barriers before the pandemic, and we wanted to understand whether this had exacerbated as a result of the lockdowns

4.3 **Summary of findings**

- The patient stories we heard about access were mixed. Some people found remote GP consultations to be beneficial and were understanding of the need to shift to these digital care methods whilst the pandemic spread rapidly. Others were unhappy with access barriers and the quality of care and treatment received using remote consultations and didn't feel confident with the diagnosis and/or treatment plan.
- 23% of participants valued the support they received from their health services during the COVID-19 pandemic. Their experiences incorporated themes such as good communication, convenient access arrangements and excellent service
- Some participants highlighted how they had an established relationship with services who understood their personal circumstances and communication needs. These support needs which were factored in when booking and giving appointments
- Most participants we spoke with had access to a digital device (computer or smart phone) but did not have the confidence to access health or care services. Limited digital skills made it harder for residents to access health information or know what services are available to them
- Several participants shared the stark reality that they don't have a digital device or internet connection at home and how services moving to remote appointment systems had created a significant barrier when accessing care
- 40% of participants told us that GP telephone waiting times were the biggest challenge faced when trying to book an appointment. Phone bills were increasing as result of the waiting times which was having a significant impact on those on lower incomes

- Residents that are regular visitors to their GP practice expressed their frustration in the lack of communication about how service arrangements have changed during the COVID-19 pandemic
- Some participants felt that receptionists lacked empathy when they informed them that they couldn't use online booking systems. Rather than being empowered, people were being encouraged to rely on support from family members
- People expressed their concerns around having to share personal information over the phone with a receptionist as part of the triage process. They didn't want to be discussing private health matters with anyone other than trusted health professionals
- 44% of participants felt the shift to phone, video or e-consultations had impacted their ability to access GP services in a negative way. If given a choice, most of the participants would choose face-to-face appointments

4.4. **Summary of recommendations**

- Services to clearly outline and communicate to their patients all appointment types available and how to access them. Additional efforts should be put in place to communicate with adults most at risk
- Services must look to re-establish the option of booking appointments in-person to ensure residents who cannot afford to engage with the digital systems are able to access care
- Training for front line staff on digital isolation and how to sensitively support people to access appointments
- Services to review telephone systems in place to ensure they are fit for purpose and do not disadvantage those that only have this access route as an option
- With the expansion of digital services, local systems should look at supporting residents by providing a clear and comprehensive support and digital training offer for using their service
- When services are developing new appointment models, they should always seek to capture patient feedback to help shape services that meet the needs of digitally excluded residents
- Services should look to capture information on whether a resident is digitally excluded or has a basic level of IT skills in order to better understand if they have additional communication or access needs and what support is needed

5. Financial Implications

5.1 There are no specific financial implications arising from this summary.

6. Legal Implications

6.1 There are no specific legal implications arising from this summary.

7. Crime and Disorder Implications

7.1. There are no direct crime and disorder implications from this summary

8. Equalities Implications

8.1 Through the work of Healthwatch and our targeted engagement with communities and groups that are often harder to reach or seldom heard we will support the reduction in inequalities in health and social care

9. Environmental Implications

9.1. There are no direct climate change or environmental implications from this summary.

10. Report Author and Contact

10.1. If there are any queries on this report please contact Mathew Shaw, Operations Manager, Healthwatch Lewisham on 020 3886 0196 or email mathew@healthwatchlewisham.co.uk

Digital exclusion and access to health services

2021

healthwatch Lewisham

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Your Voice in Health and Social Care is an independent organisation that gives people a voice to improve and shape services and help them get the best out of health and social care provisions. YVHSC holds the contracts for running the Healthwatch services for Healthwatch Hounslow, Healthwatch Ealing, Healthwatch Waltham Forest and Healthwatch Bromley. HW staff members and volunteers speak to local people about their experiences of health and social care services. Healthwatch is to engage and involve members of the public in the commissioning of Health and social care services. Through extensive community engagement and continuous consultation with local people, health services and the local authority.

Contents

Executive Summary

For this research project, we wanted to engage with people who are more likely to be digitally excluded and gain a better understanding of how this might impact their experience with health and care services. We focused on primary care as this is the first point of contact for people accessing services. However, our findings will be relevant to all services which are moving towards digital delivery. We partnered with North Lewisham Primary Care Network (NLPCN), who have a shared interest in using patient experience to improve the offer and health of the community they serve.

We paid particular attention to people's experience of accessing services during the COVID-19 pandemic. In total, we carried out interviews with 45 residents as part of the project. Those we spoke with included older people, people with English as their second language, and people with disabilities. The reason why we chose these groups is because they traditionally experienced barriers before the pandemic, and we wanted to understand whether this had exacerbated as a result of the lockdowns.

Digital exclusion can be the result of a variety of factors, including affordability and limited accessibility because of disabilities, lack of support and language barriers. The stories we heard about people's access to health and social care were mixed. Some people found remote GP consultations to be beneficial and were understanding of the need to shift to these digital care methods whilst the pandemic spread rapidly. Others were unhappy with the quality of care and treatment received using remote consultations and didn't feel confident with the diagnosis and/or the treatment plan. Both groups advocated for a return to face-to-face appointments.

Feedback also suggests that many participants were disappointed with the level of service received, especially when it came to administration. Numerous participants highlighted the challenges they faced when trying to get through on the telephone. Waiting times for appointments were undesirable with some people not being able to receive appointments for over two weeks, which echoes similar experiences prior to the pandemic.

Some residents experienced multiple barriers when trying to access health care support (affordability, lack of IT skills, and language barriers) which caused high levels of stress and anxiety.

Primary Care professionals we engaged with as part of this project discussed the benefits of remote care but also acknowledged that a shift to remote consultations risked excluding a significant proportion of service users from health and social care services. As the NHS supports primary care to move towards a digital first approach it is essential that the needs of digitally excluded residents are embedded within delivery plans.

There is the danger that the drive for greater digital access leaves behind those who are unable to engage with technology and therefore deepens existing health inequalities. Through our engagement, it is evident that the majority of participants would prefer face-to-face appointments as they value them more than the digital approach. Services must ensure that they deliver a hybrid approach of in-person and remote consultations which meets the needs of the local population and which takes account of their access needs.

About Healthwatch

Our organisation is an independent champion for people who use health and social care services. We exist to ensure that people are at the heart of care. We listen to what people like about services, and what could be improved, and we share their views with those with the power to make change happen. Under the General Data Protection Regulations (GDPR) and the Data Protection Act 2018, we have a lawful basis to process information that is shared with us by services and service users. Confidentiality is important to us, and we will only keep data for as long as is necessary. If you would like to know more about how we use the data we collect, our privacy statement is available on our website, www.healthwatchlewisham.co.uk

Introduction

The unprecedented COVID-19 pandemic forced services to adapt their service strategies in order to protect staff and patients as well as mitigate the risk of the virus spreading. As a result, services had to adapt quickly and introduced new models of access, which included remote access and a total triage system*.

The rapid changes meant that there was little time to research the possible impact on health outcomes, patient experience, or health-related inequalities when using digital platforms. There is a legitimate fear, that as a result, a 'one size fits all' approach may further widen local health inequalities. Twenty months on and digital exclusion remains a great concern and raises multiple challenges that need to be addressed urgently.

To help understand the impact of the changes, we carried out a research project looking to better understand the impact of a 'virtual by default' access model (with focus on primary care) implemented by health and social care services in response to the COVID-19 pandemic on a socially deprived and vulnerable population.

The aim of the research project was to deliver targeted engagement with residents who have limited access to or don't use digital technology to address the gap in local knowledge. The project aimed to understand how the change to a digital model has impacted on this cohort's experiences of accessing health and care services. Intelligence gathered has been used to help support the development of alternative methods and pathways for those who are digitally excluded to have equity of access to the care and treatment they need. The project helped us:

1. To gain an understanding of the needs and potential barriers people who do not use/or have limited access to technology when engaging with services, with a focus on GP practices.

2. To produce a series of recommendations to help address the needs of people who are digitally 'excluded' based on the feedback received.

The findings from our report will not only highlight issues residents have had with new remote models in primary care but will be applicable to all local health and care services which provide a digital offer. We want to work closely with partners to address the issue of digital exclusion and the challenges residents face.

* Total digital triage uses an online consultation system to gather information and support the triage of patient contacts, enabling care to then be provided by the right person, at the right time, using a modality that meets the patient's needs.' 15 September 2020. https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0098-total-triage-blueprint-september-2020-v3.pdf

Background

The COVID-19 pandemic forced health and care services to make changes to their models of care and how they support residents. There has been a shift towards a digital model of telephone and online appointment systems. The Covid-19: Lewisham system recovery plan shows that between March and June 2020, 85% of primary care appointments were delivered virtually. New precautionary measures were established to keep vulnerable people and staff safe during the pandemic, however these methods of delivering primary care may become the new normal.

We conducted research with over 1000 residents on their experiences of remote consultations and accessing health services as part of our 'Impact of COVID-19 on Lewisham' [1] report during the first lockdown with the aim to understand how this rapid shift was received in the borough. Many residents highlighted the benefits of the digital shift, such as greater ease in securing appointments. However, there were also concerns raised about the exclusion of residents who cannot use or afford digital technology to access primary care. It was evident that there was a gap in local information regarding the experiences of residents that are digitally excluded and a need for research to be carried out to understand the views of those that have limited or no access to digital devices.

The London Borough of Lewisham is extremely diverse with 46% of the population being from a Black, Asian and minority ethnic background and residents representing over 75 nationalities. It is the 10th most deprived borough within London and ranked in the top 20% most deprived Local Authorities in England [2]. Vulnerable people already experienced barriers to primary care pre-COVID-19, including poverty, language barriers and mistrust of the system, amongst others. Research that was conducted with GPs and support services for vulnerable patients indicates that these issues have likely worsened because of the pandemic [3]. Furthermore, new pandemic-related barriers have formed, which include issues around quality of information about changes to local service delivery, a hesitancy to share personal information via a triage system, removal of walk-in services and digital exclusion [4].

The NHS Long Term Plan outlines how the model of care found across the NHS will change over 10 years through the introduction of digital health technologies (DHTs).

Primary care services will adopt a 'digital first' system in which most patients are assessed through healthcare apps, telephone consultations, or through web-based platforms. This system would give GPs more time to have longer consultations with those in need [5]. The steady introduction of digital services enables feedback by patients and healthcare professionals to be incorporated, such that these services meet the demands of the communities that they serve.

COVID-19 resulted in the Total Triage (TT) model being implemented in a matter of days in March 2020 [6]. How each service incorporated the policy changes into their practice is still being examined, as is the impact of these changes on vulnerable groups [7&8]. The government planned for the changes enacted over the pandemic, such as TT to be embedded into services permanently [9]. However, the TT model ended in May 2021 as 'GPs were told the use of telephone and online consultations

can remain where patients benefit from them, but physical appointments must also be available' [10]. This report understands the experiences of digitally excluded residents and how they found these new systems. We have primarily focused on groups that historically have issues accessing healthcare, and those that could be at risk of digital services impeding their access.

Over the course of 2020 there has been a substantial increase in users of the NHS app [11], and the number of consultations conducted remotely in February 2021 was 40.9% [12]. Over the first lockdown positive reviews of GP consultations were reported, with people feeling that remote consultations fit more conveniently with their schedules [13]. However, reports also found that most participants highlighted a need for the availability of face-to-face appointments to support those who have issues accessing digital services.

According to the Consumer Digital Index Report, approximately 9 million people across the UK struggle to get online without assistance (16%), and 11.7 million (22%) lack the skills for everyday life. These values are compounded by factors such as age, disability, and ethnic minority, with elderly individuals, and those who are most disadvantaged, having higher levels of digital disengagement [14]. These findings draw concern as digital exclusion could worsen already existing health inequalities, and risk some people being left behind in a 'one size fits all' system.

Currently, studies have documented how those from deprived areas receive poorer access to primary care [15], and how marginalised groups, such as sex workers, homeless individuals, drug-users, and prisoners have poor health outcomes [16]. This risks the NHS mandate of everyone having equal and fair access to care not being met. While the national Healthwatch report 'GP access during COVID-19' highlights some positive experiences of service users, it found ongoing issues within health services that need to be addressed, and the need for a more detailed assessment of the aforementioned groups experience of digital healthcare at local level [17].

The Healthwatch Lewisham study and resulting report supports many of the Healthwatch England key findings and addresses areas that need to be improved when accessing health and social care services.

Methodology

Our engagement was delivered across the London Borough of Lewisham from March – July 2021. Research suggests that residents with language barriers and disabilities experience difficulties accessing services. We wanted to hear from residents that do not use or have limited access to digital devices and the internet. Our primary focus was engaging with residents who are at risk of being digitally excluded and whether the shift to remote access has exacerbated existing issues.

We focused our engagement on people who were likely to have no access or limited access to digital technology. This included:

1. Residents who do not speak English as a first language
2. Older residents
3. Residents with disabilities or sensory loss

We partnered with North Lewisham Primary Care Network (NLPCN) who share interest in reducing health inequalities exacerbated by the recent COVID-19 pandemic.

We developed accessible leaflets to promote the project and encourage participation. We worked with local organisations and food banks to help distribute the leaflets to residents from targeted groups. Examples of methods of distribution included local newsletters, community mailing lists, leaflets, and attending online engagement forums.

To engage with this cohort of people and reach residents who would not normally use digital devices, we aimed to carry out face-to-face and telephone interviews. To recruit suitable participants, and to encourage participation, we worked with community organisations, such as Lewisham Refugee and Migrant Network (LRMN), Age UK, Voluntary Services Lewisham, Lewisham Homes and Phoenix Housing. This required a lot of assistance from partners who actively recruited participants for the project and we would like to thank them all for their continuous support (Thank you, pg.31). On certain occasions, interviews and recruitment were conducted directly by partner organisations. This was the case where ethical considerations had to be considered. Some participants were reluctant to speak to external organisations. However, they felt comfortable sharing their experiences with organisations who supported them.

The Lewisham Refugee and Migrant Network (LRMN) empowers 'people and families who are destitute, homeless or have No Recourse to Public Funds (NRPF), from refugee, asylum seeker and migrant communities' [18]. Their team received consent and conducted interviews with 11 participants. We were also supported by Lewisham Council in identifying and facilitating conversations with Deaf residents.

Although our initial intention was to carry out face-to-face engagement, national lockdown measures meant that most interviews were carried out remotely to reduce the risk of spreading the virus and ensure the safety of staff, volunteers and residents. The interview questions were developed in partnership with the NLPCN using Healthwatch England's template from a similar study.

Participants were predominantly interviewed over the telephone. Zoom calls were also used in a small number of cases when requested by professionals and participants who felt it was more appropriate for residents that experience learning disabilities, language barriers and/or have long term health conditions. We also delivered several paper copies of the questionnaire to residents who preferred to fill it in by hand. This was mostly due to hearing difficulties when initially contacting them over the telephone.

The feedback collated consisted of both qualitative and quantitative data which was analysed to identify themes and trends. To mitigate bias, two members of the Healthwatch team (a Project Officer and Research Volunteer) analysed the data separately. We carried out two online engagement sessions that we promoted with the help of NLPCN to local primary care professionals. The sessions were attended by 10 participants. The aim of the first session was to better understand the impact of the new access models on patient experience from the perspective of primary care professionals, particularly hearing from GPs. A second session was set up to present the initial findings of this project and assist with co-designing the recommendations for this report.

Participant Profiles

Healthwatch Lewisham spoke to 45 residents between April – July 2021. In addition, we engaged with 10 primary care professionals to understand their perspective on this issue. These sessions took place in April and August 2021.

We gathered a substantial amount of monitoring information, and it is evident there is intersectionality. For example, several residents we engaged with would fall under the three traditionally disadvantaged groups we wanted to focus on: English as a second language, older residents, and people with disabilities.

People over the age of 55

25 people were over 55 years old (see Appendix 3). This group included:

- 65% women and 35% men
- 83% confirmed that they are 'Not in Employment/ not actively seeking work (Retired)'
- Several people had age-related conditions such as hearing or sight impairment

Disabled People

21 people identified themselves as disabled. This group included:

- 76% Women and 24% men
- People with physical disabilities, mental health issues, mobility and sensory impairment, long-term conditions, and learning disabilities
- Those that were happy to share their ethnicity identified as White British (38%), Black British (African/Caribbean) (38%), White Other (10%) and Asian British (Bangladeshi/Indian) (1%)

Primary care professionals

With the support of the North Lewisham Primary Care Network, we organised two engagement sessions open to all primary care professionals. The participants mostly consisted of GPs.

English is their second language

Of the 45 participants engaged with the research project, 16 people confirmed that English is their second language. This group included:

- People with varying levels of English proficiency. In some cases, we provided an interpreter to assist with carrying out interviews
- One Deaf person who uses Portuguese and British Sign Language (BSL). We organised an interview with the resident through Zoom with the support of a BSL interpreter.
- People who spoke Arabic, Igbo (also known as Ibo), Romanian, Maltese, Tamil, Twi (also known as Akan Kasa), and Spanish.

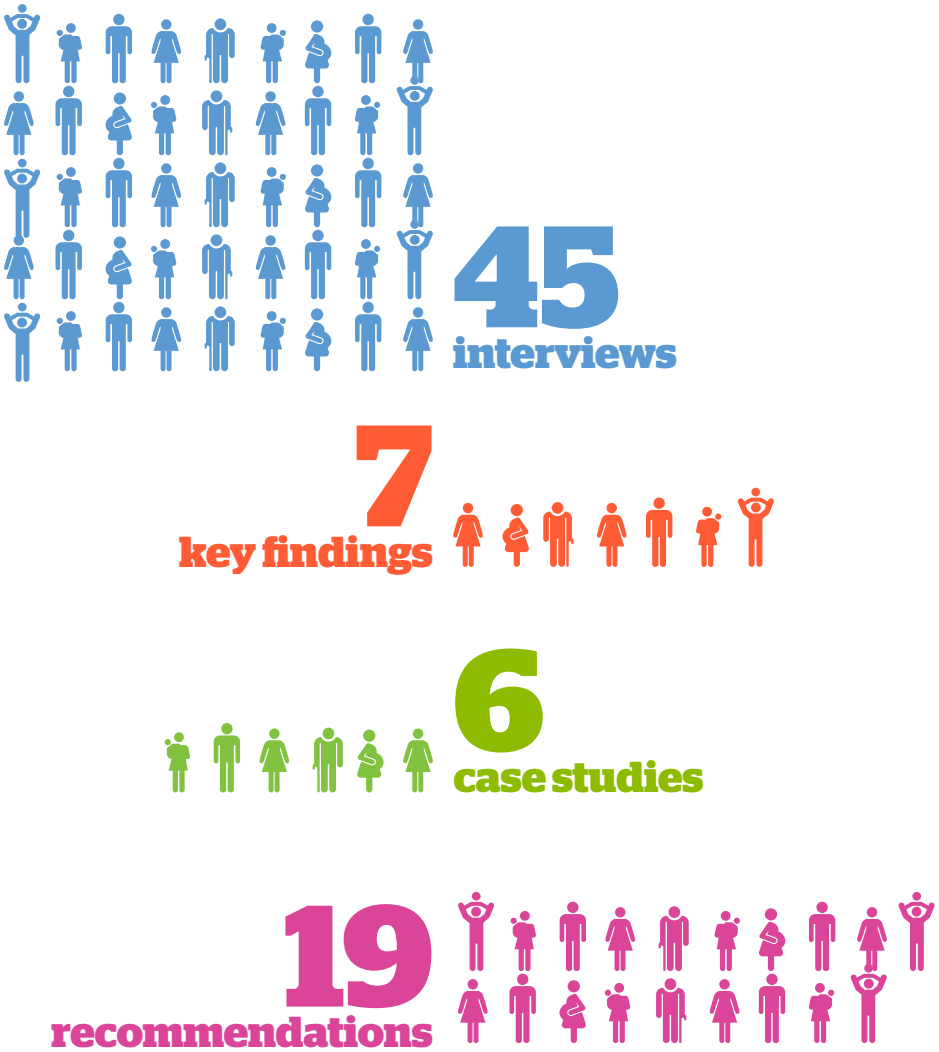
Ethnicity

Studying the monitoring information shared by most participants, we identified the following ethnic groups (see Appendix 4):

- 33% Black British (African/Black Caribbean)
- 31% White British (English/Welsh / Scottish / Northern Irish/ British)
- 9% White Other
- 5% Arab
- 2% Asian British (Bangladeshi/Indian)
- 2% Mixed Multiple (White & Asian)

Report Layout

The following chapters focus on analysis of the 45 interviews. We have highlighted the key issues which emerged through the conversations and have included several case studies which showcase the different experiences for participants when accessing services.



Key Findings: Limited or lack of Technology & IT Skills

Online appointments have created barriers for some of the residents we interviewed many of whom do not have adequate IT skills to access their GPs this way. This left them feeling unable to use the service after the introduction of new remote access methods because of the pandemic. The new model of access exacerbated by difficulties in contacting the practice via telephone, has led to some people giving up trying to seek help from their GP.

A participant explained that they can't get through when ringing their practice and due to poor health rarely feel able to attempt a call again. Another participant felt the new system was not inclusive as they were unable to access their GP because they didn't possess digital devices. When they called their practice, they were consistently advised to book appointments through the online system which they felt was discriminatory. They tried to get an appointment for months over the telephone and had no success, which caused a huge level of stress.

Feedback suggests that some respondents relied on family members to help with digital access and/or making steps to improve their IT skills by attending classes. Whilst some residents have had family members support them with digital issues, services should not rely on this support. They should take the necessary steps to empower all residents to have privacy for confidential discussions if necessary, and parity of access to their services.

The lack of digital skills has made it harder for some participants to access health information or know what services are available to them. This could be particularly challenging for those that are socially excluded for multiple reasons, such as learning difficulties or language barriers. During a NLPCN discussion, a primary care professional spoke about how "Our digital triage system has shifted the demographic of patients at the surgery. We have a university population close by so the demographic is young students. ...There is a shift away from patients who probably need services, because they can't use e-consult as well as younger professionals."

CatBytes is a non-profit organisation that support residents in developing their IT skills. We attended one of their technology workshops to get a better understanding of the work that they do and hear about their first-hand experience of working with individuals that want to develop their IT skills. Catbytes' Damian Griffiths said "I think the experience of helping people use digital devices has taught me that there are far more ways of getting things wrong than there are getting things right. They don't explain that in the instruction manuals. This is why person-to-person support will always be part of keeping people in the digital loop."

The above feedback suggests that change to new digital models may have had a negative impact on people who are used to accessing services in the traditional way. The difficulties in getting through on the telephone add further barriers for those who are unable to use digital technologies to access services.

"The advancement of technology makes you feel a bit alienated..."

".... I feel so restricted. I don't have a computer and they have an online app that is not working during the pandemic. There are no appointments available."

"I don't have access to online. There must be many in the same position as me."

Key Findings: Digital Poverty

Our aim was to engage with residents that are more likely to be digitally excluded. Whilst most participants we spoke with have access to a digital device (computer or smart phone), a few participants said that they don't have a computer or internet connection at home. 11% of participants confirmed they had used e-consult or had a video consultation with their GP practice (See Appendix 5). The findings suggest that some of the participants experienced significant barriers in accessing care remotely as a result of the lack of affordability. Some of the examples are outlined below:

- During an interview, a participant on low income asked if we could find them "a cheap computer" as they weren't sure how to locate one themselves and their financial situation has impacted access to technology.

- Several participants commented on phone bills being more expensive because of long waiting times when trying to get through to a GP practice. One participant doesn't own a landline or mobile phone. They had to use a phone box which they found exceptionally difficult as it costs more money. Although they eventually got through and had a positive experience getting a referral, they found accessing the service extremely frustrating and felt it was an overly complicated process. It took up a lot of their time, was more expensive and they would have preferred walking into their GP practice to book an appointment.

- Similarly, a participant highlighted the challenges they faced when trying to register at a GP practice. When engaging with a receptionist, they informed them that they didn't have access to a laptop and only have a telephone. The receptionist couldn't believe this and advised they go to a friend's house for digital support. The participant felt they were treated without empathy, and that their individual needs were ignored, which left them facing additional barriers registering with their GP.

Dr Al Mathers at Good Things Foundation says there has been a rise in data poverty during the COVID-19 pandemic. Approximately 10% of internet users have a smartphone to get online and 6% (down from 11% in 2020) of households were without access to internet and devices in March 2021 [19]. 55% of those that are offline earn under £20,000 [20].

"It also costs a lot.... you have to hold onto the line, and you are in a list of people. Then something goes wrong, and you go right back to the start again."

"You are made to feel like a second-class citizen if you don't use the internet."

Key Findings: Appointment availability & booking system

Prior to the pandemic, our organisation regularly found through our intelligence reports that access to GP appointments was the biggest issue for Lewisham residents in relation to health and care services. Overall, the findings from our digital exclusion project show that 90% of participants were able to access help from a primary care professional at least once during the pandemic. 59% confirmed they had managed to get a telephone consultation and 30% had received a face-to-face consultation. In most cases participants received face-to-face appointments if they were being seen by a nurse, having a blood test, or required urgent physical examination. This particular cohort of residents were grateful to receive their preferred type of appointment.

18 participants, however, highlighted that waiting times on the GP practice's telephone was the biggest barrier faced when trying to book an appointment. Other technical barriers were flagged such as people finding it difficult to use apps to book appointments, extensive phone queues and unreliable phone connections which would cause people to be cut off and must start the process again. The new remote system has not improved access to appointments for many residents. Difficulty engaging with services means that patients can choose to give up contacting the service and this could result in them interacting with services at a point of crisis.

Despite having access to a smartphone or the internet, the majority of participants rang their GP practice to get appointments. One person shared their story of being unable to get hold of their doctor and ringing NHS 111 for support. They were referred to a walk-in clinic in a neighbouring borough who managed to speak to their GP practice and arrange an appointment. It has been extremely difficult for them to get through to a person on the phone and they wished for better communication and more support.

Red Ribbon is a volunteer-led community organisation supporting people affected by HIV in the London Borough of Lewisham and surrounding areas. Most of the people they support are migrants, on low income and have no recourse to public funds. We attended a Zoom workshop with the organisation where participants shared their experience of healthcare access over the past 18 months. One of the key issues for Red Ribbon service users was the long waiting time trying to get through to a GP practice on the telephone. One participant said they tried calling and their GP practice was fully booked for the whole week. This is a concern for many Red Ribbon service users as they have a long-term health condition which can require regular medical attention but aren't always able to reach their GP when they need support.

The implementation of remote booking systems has also resulted in residents being unable to book appointments in-person within their GP practice. This provides an additional barrier for residents who either do not have access to technology or cannot afford to incur increased phone bills due to long waits on the telephone.

"They don't answer the phone and when you get through, they don't pay attention to you ..."

"You are fifteenth in line and there is so much jargon."

Key Findings: Communication

Several participants told us that a lack of communication from services during the pandemic meant they weren't aware of the access arrangements prior to engaging with the service. In some severe cases this led to hospital visits or a participant not addressing their health issues immediately causing further complications.

Internal communication between health and care services was also highlighted as an area for improvement. During an interview, a participant said that their prescriptions were delayed due to miscommunication between their GP practice and the pharmacy. This was an immediate concern as they have long term health conditions, which require regular medication. Another participant, that has Chronic Obstructive Pulmonary Disease (COPD), spoke about an issue concerning their repeat prescriptions. When they spoke to a GP at their practice, the doctor was unaware of their medical history and not a chest specialist.

The feedback we received shows that 33% of participants found out about changes to their GP's booking system when they rang the practice themselves. Whilst 20% of participants received a letter in the post and 11% received a telephone call from their practice to inform them of the changes being made. The other methods of communication, which received less than 10%, were email, leaflets, text, GP website and word of mouth (see Appendix 7).

A participant said that they have been registered for more than 8 years with their GP practice. They never received any correspondence related to changes at their surgery and only discovered the new triage system when calling the practice directly.

Another participant also was unaware of the changes accessing their GP until an LRMN advisor rang the practice on their behalf. Prior to this, the participant had made several attempts to call their GP and the line kept going to voicemail. Eventually they had to ring 111, which then led to them ringing 999 and being taken to a hospital.

Residents with sensory disabilities further highlighted challenges they faced including confidentiality, communication barriers and concerns around data protection.

A Deaf participant highlighted the barriers of accessing their GP as a result of interpreting services provided by the Council being paused. Prior to the pandemic they used the same interpreter at healthcare appointments which meant the professional was familiar with their issues and could communicate their concerns. During the pandemic, interpreter provision has been provided nationally which has prevented continuity and the resident found that some interpreters did not have the required skills to communicate their specific health issues with the doctor. Virtual appointments also meant that they couldn't meet with the interpreter beforehand to build a rapport.

Residents that access their GP practice regularly expressed their frustration in the lack of communication about changes in access during the COVID-19 pandemic. One patient, that has multiple health issues as well as being unemployed, described their current situation as "living through hell".

Key Findings: Communication (continued)

The lack of access to their GP has impacted their health and well-being because they have serious health issues that haven't been addressed. Due to not having a computer and limited technology skills, the patient has struggled to see a doctor over the past 18 months and resulted to visiting A&E when their health condition deteriorated.

During a NLPCN discussion, a primary care professional said that "Running a total triage system has given us increased capacity. But not having an open-door policy as well as poor messaging, makes some people think that our service is closed. Primary Care communication across multiple platforms is an issue." This finding was also identified in our 'Impact of COVID-19 on Lewisham Residents' report [21].

"My own GP would know me, and I have ended up in hospital when I don't need to go."

".... government needs to give more money to GPs so they can take longer to listen to people, especially now after we have the problems of Covid."

Key Findings: Face-to-face vs. remote appointments

The majority of participants said that their GP practice has been operating remotely since the start of the COVID-19 pandemic. 44% of participants felt the shift to phone, video or e-consultations had impacted their ability to access GP services in a negative way, with many expressing concerns that their health issues could not be addressed properly if they weren't physically seen by a doctor. 33% of participants expressed neutral sentiment, and felt their health needs were met, and 23% had a positive experience with remote consultations.

The majority of participants said that they weren't given a choice to choose between remote or face-to-face appointments. If given the option, most service users would choose face-to-face (See Appendix 6).

One of the reasons for preferring face-to-face appointments was the concern of being misdiagnosed, or the wrong medication being prescribed. People felt this was more likely to happen without a thorough examination in person. This indicates that the remote model reduces people's trust in the diagnosis and treatment plan.

Many participants felt that the face-to-face appointment was of better quality as it was 'easier' to communicate, especially for patients with multiple and/or complex conditions. The discussion with the primary care staff as well as feedback from participants suggests that face-to-face appointments creates a rapport between the patient and doctor and allows for more meaningful interactions.

One participant said they have multiple medical issues where it's only appropriate to talk to someone in person. They sometimes find it difficult to remember everything they wanted to say over the telephone. During a NLPCN discussion, a primary care professional spoke about the issues they had faced with remote consulting from a clinical perspective; "There are very few set things that remote consulting are good for, i.e., contraceptive pill. For the vast majority of problems, it is very difficult to do it in a satisfactory way for both a GP and a patient."

Similarly, a GP in Lewisham that attended one of our NLPCN discussion groups, told us that some asylum seekers have access to a telephone via their home office accommodation. However, language is often an issue, and they feel dissatisfied with the appointments they are receiving remotely. A telephone appointment, rather than face-to-face, is not valued and "acts as a deterrent to them booking appointments".

"You can't give a thorough examination without being in person."

"I would like to be able to have face-to-face....I can use Google translate on my phone to speak in person, I can't use this when I am on a phone."

Key Findings: Confidentiality

The issue of confidentiality was raised by several participants. People expressed their concerns around having to share personal information over the phone with a receptionist. They didn't want to be discussing private health matters with anyone other than their doctor. People also expressed concern around the use of personal data.

> **"I would prefer to have face to face ... You can sit down and tell them your griefs and it is confidential."**

One participant, who is visually impaired, spoke about the challenges they faced when accessing appointments. They don't have an internet connection at home and booking an appointment requires a support worker, which they were unable to get over the past 18 months. Therefore, accessing health services during the pandemic was exceptionally difficult for them. Out of good will, a neighbour stepped in to help read letters sent from their GP practice. However, this has resulted in them no longer having privacy or confidentiality.

Key Findings: Continuity of care

Several participants expressed their concern about how the new access models impacted on continuity of care and being able to book appointments and interact with the same health professional. A Red Ribbon service user said that sometimes they are afraid of trying to access a health care service because they can't guarantee they will see their GP. They commented that members of Black communities tend to rely on people they know and connect with and that there is a lot of action to be done to ensure continuity of care and avoid a lack of trust in health care services.

> **"If you live alone, it is hard. I have my daughter and a carer for support."**

Key Findings: Impact on mental health

Several participants said they felt incredibly anxious as a result of not being able to speak to a GP in person about their health conditions over the past 18 months. One participant commented that they found it difficult to trust what a GP said to them over the telephone and stressed how much more relaxed they would feel if they could be seen in person by a doctor.

"Last year I gave up contacting the GP for anything.... it was causing me more anxiety than usual. My advocate stepped in ..... and only then did I get an appointment."

On the other hand, another person said they felt safer speaking over the phone during the COVID – 19 pandemic. They thought it was better to only see a doctor in person if it was an emergency because they were worried about contracting the virus when visiting a practice.

"One is inclined to worry more about their ailments."

Another participant said they had a 'fear of germs' in the small waiting rooms with chairs that faced each other. They felt more wary and at risk of getting COVID-19 in their GP practice. The participant also felt there was a lack of mental health and wellbeing support for people that are digitally excluded. Whilst they had been made aware of online resources, they preferred to have in-person counselling and couldn't access this over the past 18 months.

During a NLPCN discussion, a primary care professional discussed their first-hand experience with healthcare access for refugees and asylum seekers; "I had a patient who was coming to see me, on the same day he completed an e-consult... He submitted it because he got really anxious.... it meant that someone else has got to look at that through a triage system. But he also had booked to see me face-to-face at the same time."

Positive Experiences and Good Practice

The key findings from our engagement highlighted a variety of different issues that digitally excluded residents faced when trying to access their GP practice during the pandemic. However, as previously mentioned within the report, 23% of participants commented on how much they valued the support they received from their health services during the COVID-19 pandemic. Their experiences incorporated themes such as good communication, convenient access arrangement and excellent service.

For example, a participant spoke about the positive experience they had had with their GP practice's triage system. They received a mixture of telephone and face-to-face appointments which they said were equally satisfactory. They thought the quality of care received over the telephone was good and they felt safe going into the GP practice when the surgery required an in-person examination. The participant had found access to primary care during the pandemic to be easy. However, they also said they were not attempting to get same day appointments, which meant they weren't attempting to call their GP when the service opens at 8am.

Another participant commented that their GP practice "understands my limitations and they have known me for years. They always support me, so when I call, I don't have to go online." This shows how some services understand the needs of their patients and ensure they have a good experience when accessing health services.

Finally, another participant said their practice gave them the option to choose between remote consultation or face-to-face appointments. At the height of the pandemic, their experience with a telephone consultation was comprehensive and effective, and they were happy with the quality of care they received from their GP.

A NLPCN discussion group identified that some health services have adopted strategies to better support those that are digitally excluded. These include:

- A direct phone line that is given out to vulnerable clients.
- Front of House Champions who support service users that need additional support i.e., online registration for a GP practice.

"They got in touch with me to let me know their telephone number has changed."

"The GP is round the corner from me so it was easy to commute."

"I have had both vaccines. The GP came to where I live and did them at my home. We had letters to inform us about it."

"I was quite happy speaking to the doctor over the phone."

Case Studies

For this report, we carried out extensive interviews with local residents. This enabled us to gain a greater understanding of people's experiences during the pandemic. We have collated a series of case studies, which showcase both positive and negative experiences.

Case Study: Participant A

Participant A is deaf and gave birth in late 2020. They primarily communicate in either Portuguese or British Sign language. Their experience of giving birth was complicated due to the number of people talking in the hospital and having no interpreter to translate for them. There have been multiple barriers, mainly due to poor communication, which has made accessing primary care more difficult for them over the past 18 months.

Participant A said that trying to access information remotely "has been quite upsetting at times". When they attended a remote consultation, technology wasn't always reliable; "...the picture kept freezing. They were wearing masks which made it harder to communicate. Those were the two main issues that were big for me".

They also told us that the interpreters provided by the GP practice had only basic British Sign Language (BSL) Level 1 or 2, which made it difficult to explain health issues.

Prior to the pandemic, Participant A had used an interpreting service provided by Lewisham Council to call a GP practice on their behalf and book a consultation with a BSL interpreter present. They also have experience using Sign Live, a service provider of online video interpreting services through its Video Relay Service (VRS) and Video Remote Interpreting (VRI). However, they explained that most council services supporting deaf people stopped when the COVID-19 pandemic spread rapidly. This lack of interpreting support created a substantial barrier to accessing healthcare services. Pre-COVID-19, it was easier to use GP services but since interpreting services have changed, face-to-face interpreting stopped. Participant A's GP practice made face masks mandatory which added additional stress as communication became more challenging. Participant A said that they would like face-to-face appointments to go back to how they were pre-COVID-19 as you could "meet with the interpreter beforehand and discuss my situation... and appraise them. Having an interpreter physically with you and accompanying you through the whole process is much easier."

Participant A felt that doctors had not taken responsibility and reception staff hadn't taken into consideration how to get an interpreter that's suitable for discussing primary care needs of a deaf person. Communication needs to improve dramatically so that information is passed on correctly between staff to ensure support from BSL services improve within health and social care services.

Case Study: Participant B

Participant B, a Spanish national, had only positive things to say about the treatment he has received over the past 18 months. Whilst English is not his first language, a relative was able to act as a translator and has helped arrange remote consultations as well as being seen in person for ongoing treatment. Participant B said the only issue he faced when visiting a hospital was that he had requested a Spanish speaking nurse beforehand. Unfortunately, this hadn't been organised, but staff managed to find someone to act as a translator very quickly and the participant felt well looked after.

Participant B said he was very satisfied with his GP practice; "I have been here since 2002 and had no problems at all." He received his COVID-19 vaccines in January and March 2021 and the appointments were conveniently arranged by telephone.

Case Study: Participant C

Participant C commented on the positive experience she has had with her GP practice since the start of the COVID-19 pandemic; "I would say I always thought they were pretty bad, but they were excellent over the past year from the beginning of COVID."

When asked if their practice was using a triage system, Participant C said that she was able to book an appointment over the phone and would receive a call back from a doctor the same day. Pre-COVID-19, Participant C said that sometimes she would wait on the phone up to 30 minutes to get through to someone, and that things had significantly changed over the past 18 months. Participant C did say that she was fortunate not to have to ring her GP for anything seriously wrong. It was typically smaller problems that could be dealt with over the phone. In the past, she had to visit her practice often and it was unpleasant sitting in the surgery's reception. She said that a telephone call with her GP practice was more suitable, and less time is wasted.

Case Study: Participant D

Participant D is partially sighted. They said that their GP practice has been okay' during the pandemic. They mostly spoke with their surgery over the phone but saw a doctor when it was necessary, and fortunately the practice is walking distance from their home.

Participant D said that their GP predominantly offers telephone consultations and has introduced Personal Protective Equipment (PPE) for patients visiting the practice. The practice didn't contact them directly to communicate the changes to their system. Participant D found out through exchanges with close friends.

Participant D doesn't have access to a smartphone as they are unable to use one due to their visual impairment. They have a mobile but can't see texts therefore cannot engage with health services via this method. They also don't have access to internet at home. The GP practice's reception staff have a good rapport with service users and Participant D said they had had a positive experience with telephone calls and that remote consultations had not affected the quality of care. They have also been able to walk-in and book appointments in person provided they are wearing PPE.

The patient said that if they had a health concern that was treatable using remote consultations, this wouldn't have been a problem. However, due to their health condition, it is necessary to have face-to-face consultations when the matter is serious.

Conducting an appointment over the phone would not be beneficial for them if they needed a thorough examination and their condition was causing distress.

Participant D's only negative comments referred to the hospital. Last year they had 6 appointments cancelled for tests to examine their eyes as well as waiting 3 months for an ultrasound. When their last appointment was cancelled, they received no letters or correspondence from the hospital about rescheduling a visit.

Case Study: Participant E

Participant E has diabetes, mobility, and mental health issues. Their main experience has been a lack of accessing health and social care services since the start of the pandemic. One of the main issues for them is difficulty in getting through on the telephone. The shift to remote consultations has impacted their ability to access GP services. An increase in the number of people trying to call the surgery makes it very difficult for them to speak to anyone. They said that they call their practice at 07:00, wait in a queue, and then get told by reception staff to call back another time. Due to their health issues, they don't always feel up to calling back and waiting again in another queue hoping to get through to a doctor.

Participant E said that they are unemployed and on benefits, which has impacted their access to technology and made it difficult to access a GP practice during the pandemic. They don't own a computer and struggle to use a mobile phone, which has made it more stressful trying to contact a doctor. They hate using a mobile phone because their eyesight is poor. On several occasions they have had to ring 111 to get antibiotics because it has been so challenging trying to get through to their GP and request a prescription.

Participant E received a letter inviting them to get a COVID-19 vaccine. However, they haven't been able to leave the house stating that they have been isolating "even long before the pandemic...because of family history issues". In addition to not having the vaccine, they haven't been to a diabetes eye clinic or had their flu jab.

When asked what they felt a GP could have done differently to help them access care, Participant E said that if the doctor would call and check on them, on a semi-regular basis, they would really appreciate this. Pre-COVID-19 they had monthly check-ups, but this stopped when the pandemic rapidly spread. They said more support in the form of communication from a doctor was needed to help vulnerable people access services.

Case Study: Participant F

Participant F, has chronic obstructive pulmonary disease (COPD). They said their main issue with health and social services is the negative experience they have had trying to access their GP practice; "you just get in a loop of recordings that go on and on repeating itself".

Since the start of the COVID-19 pandemic, Patient F said that their GP practice has changed their automated phone recording several times. Previously, it would inform you of your position in the queue. Currently, it lets you know your position when you first connect but then never updates your progress, which has led to them being on hold for 30 minutes not knowing where they are in the queue; "when do you give up cause you can't stand it any longer.... there are quite a few occasions where I have given up entirely."

Participant F also commented on the automated phone system continuously informing patients that online consultations are available. They found this very frustrating as they don't use a computer. When their GP text to let them know their first COVID-19 vaccination was ready to book, they were given the option to telephone or use the practice's website to arrange an appointment. With their second vaccination, the text message only gave them a website option. They had to ring the practice multiple times to try and book an appointment. After several failed attempts, they eventually spoke to a kind receptionist who managed to book their second vaccine over the telephone; "it did work beautifully after a hiccup."

When we asked Participant F what has changed in the way their GP operates since the start of COVID-19, they said "it had gone very impersonal even before the pandemic. It was difficult to get appointments anyway." Their practice had written to say that changes would be made, and leaflets were also distributed locally informing residents that they would be using an online system; "there were fewer appointments available over the phone."

Because of their health condition, Participant F said they normally would have an annual review. In 2020, their review was carried out over the telephone. However, they were not given the option to get tested. Their GP practice also doesn't appear to have a primary care professional with COPD expertise since one of their nurses retired; "I don't know if I am getting the best possible treatment." They believe their condition has deteriorated because they have been unable to do as much exercise as they normally would over the past 18 months.

Participant F said that they would not be happy if the changes to the system stayed the same after the pandemic. They would like to be treated like a "human being... we are patients and not customers. The current system turns you into a customer, like phoning an energy company."

Conclusion

Through our engagement, we found that digitally excluded participants had mixed experiences when accessing and using GP services. 27% felt that their experiences had been positive during the pandemic (Appendix 1) and were supportive of the changes brought by the total triage model. However, 47% felt that the new systems either exacerbated or created new barriers which impacted on their access to services. It is vital that local systems learn from these experiences and address the challenges highlighted by disadvantaged residents to ensure they are not excluded from accessing basic health and care services.

Services would benefit from improving communication around access arrangements with patients, especially those who are most vulnerable and do not have easy access to the internet. People should be given a choice on the type of appointment available to them which meets their accessibility needs.

Practices must take into consideration that not everyone is confident with digital technology or has access to the necessary devices. There is a need for services to identify those users who are/ are at risk of being digitally excluded to ensure that all patients can access care when they need it.

During our interviews, we spoke with several people that had sensory disabilities, including sight and hearing loss. These interviews further highlighted challenges these residents faced including confidentiality, communication barriers and concerns around data protection.

The majority of participants would prefer face-to-face appointments when accessing their GP practice. Whilst some participants valued remote consultations and, in some cases, thought it improved patient access, other participants felt that a high level of care and treatment could only be delivered in person. Participants shared their experiences of unsuccessful remote consultations leading to misdiagnosis and felt a physical examination would have been more effective. Lewisham Speaking Up, a local charity supporting people with learning disabilities outline in their 'Research on Digital Exclusion since the Covid-19 pandemic 2020' report, that "Digital technology should be available, but as one element of a range of options for people to choose from" [22] and this is similarly echoed by our findings.

Residents who had positive experiences with their GP practices during the pandemic were pleased at having a mixture of remote and in-person consultations depending on the severity of the issue. A primary care professional said they had "found a combination of different things in communication with the patient quite useful...from an IT perspective, offering different routes (languages) and a variety of access through the platform as well as different services.... allows them the choice."

Several participants highlighted the stark reality of digital poverty and the impact total triage and remote booking systems had on their access to care. Some were unable to easily engage because they couldn't afford digital technology. Others highlighted the increasing cost of phone bills due to long waits in telephone queues or faults with telephony systems which cut them off.

Conclusion (continued)

Being unable to book appointments in person meant that residents had to incur charges if they wanted to have an appointment. Services must ensure that their access models enable equity of access or otherwise they could discourage people seeking support for their health and care.

The NHS Long Term Plan outlined the intention for more appointments to be made available via digital methods and the increased delivery of remote consultations. However, the outbreak of the pandemic has seen rapid digital developments within primary care. Our digitally excluded participants felt that the changes had had a negative impact on their experience of GP services.

Feedback of service users must be taken into account as we move out of lockdown and systems are reviewed to ensure adequate service and parity of access. For the implementation to be ultimately successful, services must bring residents along with them by empowering them to use digital methods and most importantly providing alternative access options for those who cannot afford or cannot use digital solutions.

"I am really happy that I have had the opportunity to be interviewed and shared my concerns. There are people in the system who are responsible to check on the vulnerable and ensure they aren't left out."

Lewisham Resident

Recommendations

The feedback received from patients who participated in our research further endorses the idea that there is not a 'one size fits all' model for access to services. Based on our data analysis, we have made the following recommendations, with support from primary care professionals that attended our NLPCN discussion groups, on digital isolation.

Appointment availability & booking system

Finding:

Getting through on the telephone to a GP practice was the biggest barrier for digitally excluded residents when accessing services. In extreme cases, people chose to no longer access the service due to frustrations in getting through to their practice.

Recommendation:

1. Investment in improved telephone systems which are fit for purpose.

2. The adoption of telephone systems which can gather data on the number of people accessing the services would enable local services to have a greater understanding of the true demand on services and help them to monitor the issue.

3. Developing solutions to help reduce waiting times when residents are trying to access appointments through the telephone. One Lewisham practice has adopted a call back system which gives residents the opportunity to receive a call from the service rather than waiting on the telephone.

Finding:

The implementation of remote booking systems has meant that residents are unable to book appointments in-person within their GP practice. This provides an additional barrier for residents who either do not have access to technology or cannot afford to incur increased phone bills due to long waits on the telephone.

Recommendation:

1. Services must look to re-establish the option of booking appointments in-person to ensure residents who cannot afford to engage with the digital systems are able to access care.

Limited Technology & IT Skills and Digital Poverty

Finding:

For some of our participants, affordability and limited access to digital devices created significant barriers when trying to book appointments at health and social care services. Primary care professionals explained that they need to take into consideration that a certain cohort of patients may need different methods of access than others.

Recommendation:

1. Services to clearly outline and communicate to their patients all the appointment types available to them and how to access them. Additional efforts should be put in place to communicate the above with the most vulnerable patients.

2. Services to review telephone systems in place to ensure they are fit for purpose and do not disadvantage those that only have this access route as an option. For example, a Lewisham GP practice has set up a separate direct phone line that is given out to vulnerable patients. This has helped reduce the waiting times on their main service phone line and helped minimise the cost of some patient's phone bills. This model could be adopted by other services.

3. Services to ensure appointment systems allow for patient choice.

4. Healthwatch England (HWE) carried out a national research project 'Locked Out' which focused on people's experiences with remote GP appointments. Within their report they highlighted the need to further develop digital support on a national and local level to ensure everyone has access to public services. This is a key finding which was also evident from our engagement with Lewisham residents and therefore we would support the following HWE recommendations:
   I. Ensuring all GP practices are reachable by a freephone number
   II. Arrangements with telecom firms that no data charges will incur when accessing any NHS services.
   III. Including access to the internet in social prescribing schemes, funded by the NHS for those whose health may benefit from it.

Finding:

We found that the majority of residents we interviewed did have access to a digital device. However, most people used a telephone as the main method of accessing health services.

Recommendation:

1. With the expansion of digital services, local systems should look at supporting residents by providing a clear support and digital training offer for using their service.

Communication

Finding:

Several participants highlighted challenges communicating with front line staff when trying to access services. They told us that a default approach for certain services was to direct patients to book appointments through online systems such as Patient Access. On one occasion, a resident was advised to ask their family to help them book online appointments when they explained they couldn't do it themselves.

Recommendation:

1. Training for front line staff on digital isolation and how to sensitively support people to access GP appointments. This report and associated case studies could form a basis for this training.
   For example, a GP practice within North Lewisham has established Front of House Champions which support patients with registration and being able to identify people that might need further assistance when booking appointments. This is an example of good practice which could be rolled out across the borough.

2. Services should look to capture information on whether a resident is digitally excluded or has a basic level of IT skills, or their preferred appointment type, in order to better understand if they have additional communication or access needs.
   Research carried out by Healthwatch England found that patients and primary care professionals 'suggested that it would be helpful for practices to code patient records with information regarding a patient's language and communication needs or level of digital skills, so that staff can be proactive about offering people an appropriate consultation type or pre-empt requests for adjustments in future' [23].

3. Services should ensure that staff are aware and able to signpost service users to local digital support groups.

4 Many health and care organisations are increasingly using their websites and social media as their primary approach to communication with their clients or the wider public.
   We would encourage organisations to engage with people who may have difficulty accessing such digital media to identify alternative communication methods to reach people who may not have easy access to the internet.

Finding:

Participants had varying levels of awareness around current GP access arrangements. Some residents had been directly contacted by their practice (11%) whilst others had received no communication during the pandemic (Appendix 7).

Communication (continued)

Recommendation:

1. The COVID-19 pandemic has seen rapid developments with digital access. Services should actively communicate with patients, via texts, calls, or follow up letters, about changes to appointment and access systems. There should be additional focus on vulnerable groups who have barriers in engaging with online information. This will enable residents to be better informed when seeking to access treatment and care.

Finding:

A Deaf participant highlighted the barriers of accessing healthcare services as a result of interpreting services provided by the Council being paused. There were also challenges with interpreters provided not having the required skills to communicate the specific health issues or having the opportunity to discuss issues prior to the appointment.

Recommendation:

1. Services should look to reinstate interpreting services which enable deaf residents to have access to a designated interpreter. The automatic provision of face-to-face appointments for patients which need translation support would improve patient experience by reducing communication issues.

Choice

Finding:

The majority of participants explained that their GP practice has been operating remotely since the start of the COVID-19 pandemic and that they weren't given a choice between remote or face-to-face appointments. If given the option, most people would choose physical appointments. Several residents had positive experiences with accessing services as they were able to have a mixture of remote and face-to-face consultations.

Recommendation:

1. Services to offer a hybrid consultation system which embeds patient choice.

2. When services are developing new appointment models, they should always seek to capture feedback to help shape services that meet the needs of digitally excluded and vulnerable people.

Wider system recommendations

Finding:

Multiple participants told us that a lack of communication from services during the pandemic meant they weren't aware of the access arrangements prior to engaging with the service.

Recommendation

1. There is a need for a communication plan at national, regional and local levels to provide residents and professionals with clear and consistent information about changes to the health care system. Residents need to be informed about changes to access arrangements and the benefits of the different types of consultations.

Finding:

Primary care professionals informed us that there is a lack of data available indicating whether there has been increased demand on other services because of people being unable to access a GP.

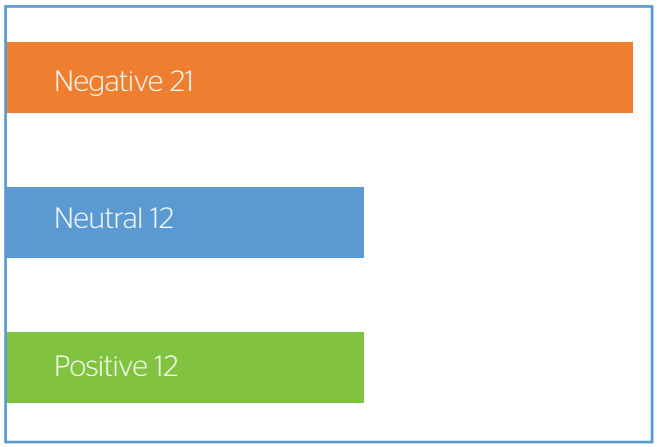
Recommendation

1. Local health and care systems should collate the different access data from GP services, GPEA, 111 and A&E departments to understand the current access demand on primary care services and impact on the rest of the system. The data can be used to identify where resources would be best used within the system to tackle the issue of demand on primary care services.

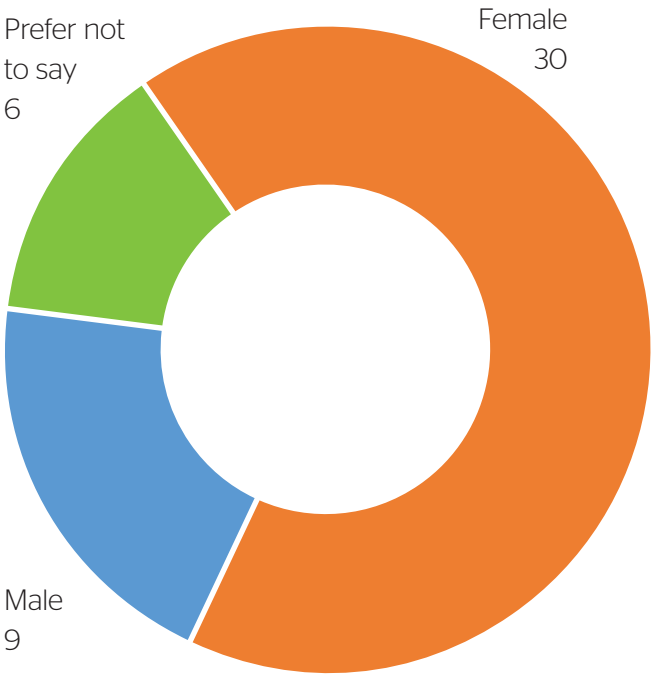
2. A&E departments should look to capture information from patients on whether issues accessing primary care services had led to them attending hospital.

Appendix

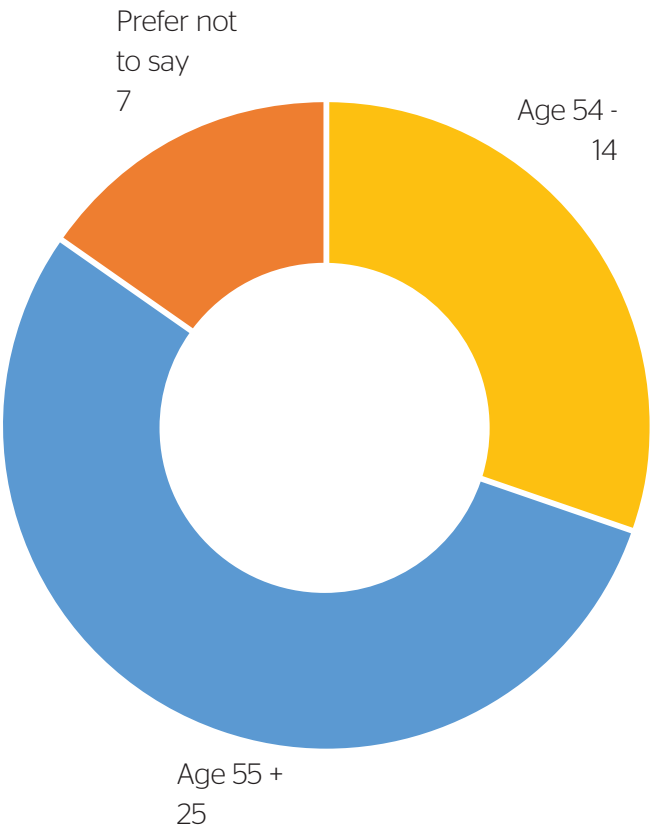
Appendix 1: What was your experience of trying to access primary care during the pandemic?



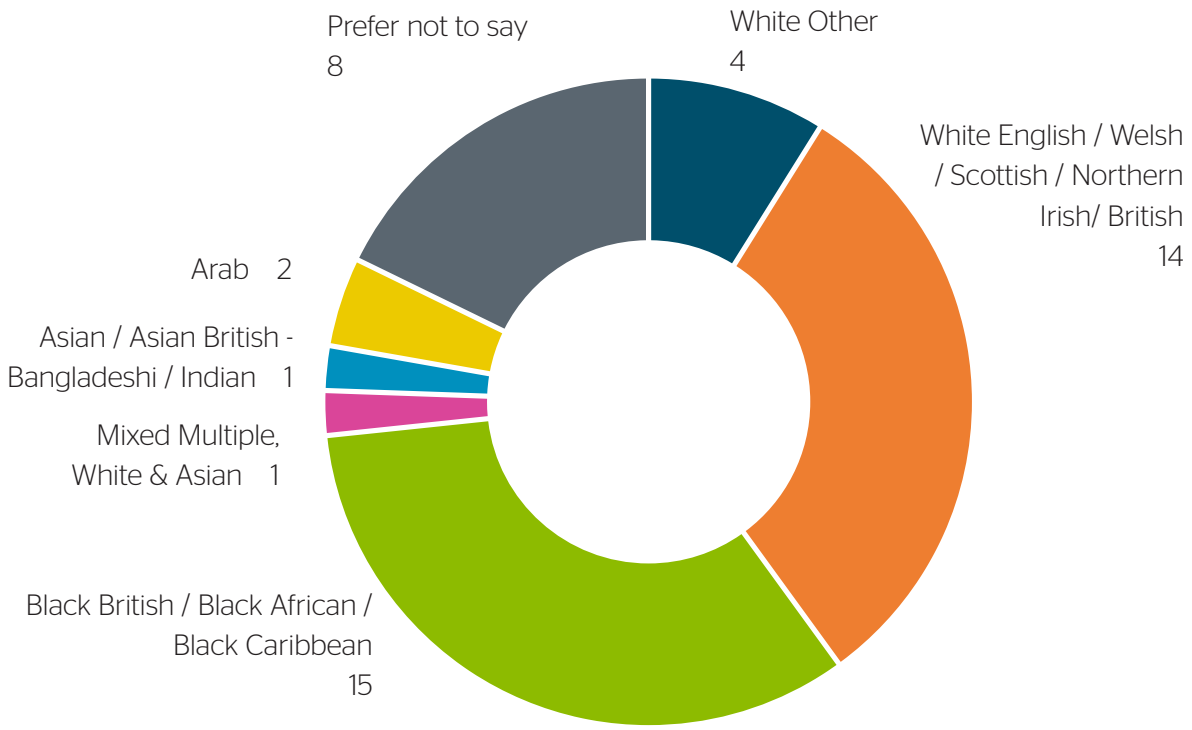
Appendix 2: Monitoring Information, Gender



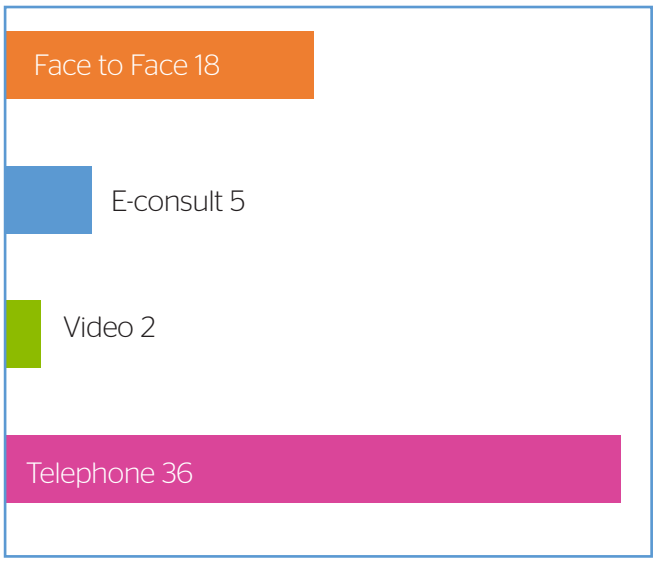
Appendix 3: Monitoring Information, Age



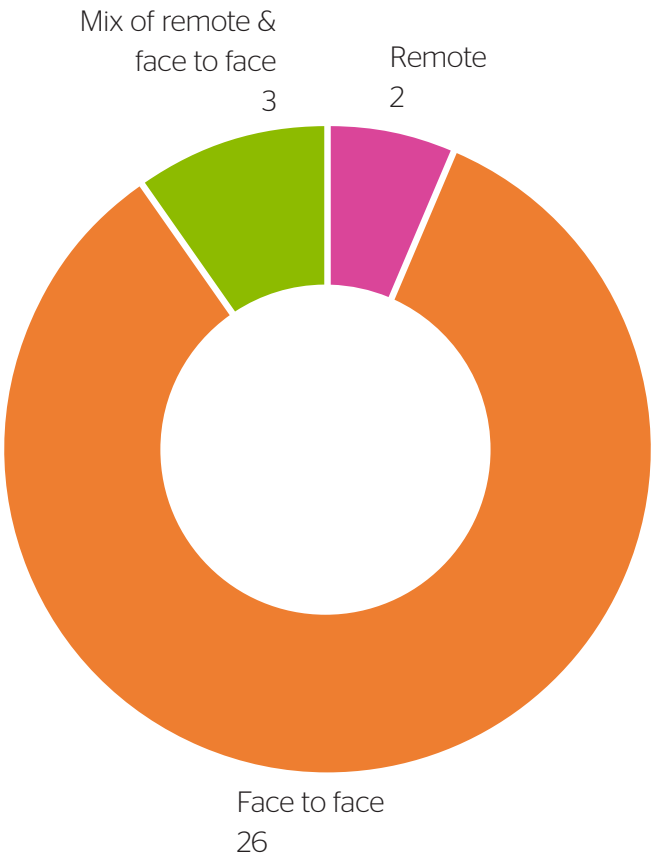
Appendix 4: Monitoring Information, Ethnicity



Appendix 5: What type of appointment did you have?



Appendix 6: If given a choice, would you have wanted a remote consultation or face-to-face appointment?



Appendix 7: How did you find out about changes to the system?

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Thank you

Healthwatch Lewisham would like to thank all those that agreed to participate and be interviewed at such a difficult time as well as North Lewisham Primary Care Network (NLPCN) for their research support and recommendations. Everyone spoke honestly about their experiences, be it personal or organisational, and of the ways they have had to tackle the past 18 months since the start of the COVID-19 pandemic.

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- Cat Bytes
- Community Connections
- Entelechy Arts, The Albany Deptford
- Good Gym
- King's Church London
- Phoenix Housing
- Lewisham Homes
- Lewisham Local
- Lewisham Refugee & Migrant Network
- Lewisham Speaking Up
- Lewisham Visual Impairment Team, London borough of Lewisham
- Metro Charity
- London Borough of Lewisham, Senior Specialist Advice & Information Officer D/deaf and Deaf/ Blind
- London Borough of Lewisham, Adult Learning Lewisham Culture, Learning and Libraries
- LGBT Forum
- North Lewisham Primary Care Network (NLPCN)
- Red Ribbon Foundation
- Sign Language Interactions
- SLAM
- St Peter's Church, Brockley
- Table Talks
- Voluntary Services Lewisham

Digital exclusion and access to health services

Summer 2021

This report is available to the public and is shared with our statutory and community partners. Accessible formats are available. If you have any comments on this report or wish to share your views and experiences, please contact us.

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Your Voice in Health and Social Care is an independent organisation that gives people a voice to improve and shape services and help them get the best out of health and social care provisions. YVHSC holds the contracts for running the Healthwatch services for Healthwatch Hounslow, Healthwatch Ealing, Healthwatch Waltham Forest and Healthwatch Bromley. HW staff members and volunteers speak to local people about their experiences of health and social care services. Healthwatch is to engage and involve members of the public in the commissioning of Health and social care services. Through extensive community engagement and continuous consultation with local people, health services and the local authority.

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Engaging communities, shaping services

healthwatch
Lewisham

Health & Wellbeing Board

Report title: Joint Strategic Needs Assessment and Pharmaceutical Needs Assessment Update

Date: 9 March 2022

Key decision: ~~Yes~~/No.

Class: Either Part 1

Ward(s) affected: ALL

Contributors: Dr Catherine Mbema, Director of Public Health, London Borough of Lewisham

Outline and recommendations

This report provides an update on the COVID-19 Impact JSNA and the Pharmaceutical Needs Assessment (PNA).

The board is recommended to:

- Note the contents of the report
- Agree delegation of the 2022 Lewisham PNA sign off to the PNA Steering Group

Timeline of engagement and decision-making

This paper is being submitted as part of the revised JSNA process originally agreed by the Health and Wellbeing Board in 2017

1. Summary

1.1. The scope of the COVID-19 Impact JSNA has now been agreed. The aim of the topic assessment is to assess the direct and indirect impacts of the COVID-19 pandemic on the health and wellbeing of the population of Lewisham and identify any inequalities within those impacts. This will help to inform the development of the new Health and Wellbeing Strategy and other local strategic plans relating to the boroughs recovery from COVID-19.

1.2. The 2022 Pharmaceutical Needs Assessment has begun, with publication due by October 2022.

2. Recommendations

2.1. The board is recommended to approve:

2.2. The request that sign off of the PNA can be deferred to the PNA Steering Group.

3. Policy Context

3.1. JSNA

3.2. The Local Government and Public Involvement in Health Act 2007 placed a statutory duty on PCTs and upper-tier local authorities to jointly deliver a JSNA from April 2008. The Health and Social Care Act 2012 placed a new statutory obligation on Clinical Commissioning Groups, the Local Authority and NHS England to jointly produce and to commission with regard to the JSNA. The Act placed an additional duty on the Local Authority and CCGs to develop a joint Health and Wellbeing Strategy for meeting the needs identified in the local JSNA.

3.3. The objective of a JSNA is to provide access to a profile of Lewisham's population, including demographic, social and environmental information. Locally this is presented via the 'Picture of Lewisham' document. The JSNA also provides access to in-depth needs assessments which address specific gaps in knowledge or identify issues associated with particular populations/services. These in-depth assessments vary in scope from a focus on a condition, geographical area, or a segment of the population, to a combination of these. The overall aim of each needs assessment is to translate robust qualitative and quantitative data analysis into key messages for commissioners,

service providers and partners.

3.4. The most recent version of the JSNA can be found here: https://www.observatory.lewisham.gov.uk/jsna/

3.5. The priorities of The Health and Wellbeing Strategy 2013-2023 were informed by the JSNA.

3.6. PNA

3.7. Every Health and Wellbeing Board (HWB) in England has a statutory responsibility to publish a statement of the needs for pharmaceutical services of the population in its area (known as the PNA) and update it at least every three years, from 2015 onwards. Previous assessments have been published in April 2015 and April 2018. The originally timeframe to republish in April 2021 was pushed back for all local authorities due to the COVID-19 pandemic, with a new date of October 2022 set instead.

4. Background

4.1. JSNA

To undertake its responsibilities the Board needs to be periodically updated on the local population and its health needs. Individual JSNA topics provide in-depth analysis and recommendations for that specific service / population group.

4.2. PNA

PNAs are used by NHS England to make decisions on which funded services need to be provided by local community pharmacies. These services are part of local health care and public health and affect NHS budgets. PNAs are also relevant when deciding if new pharmacies are needed, in response to applications by businesses, including independent owners and large pharmacy companies. If there is a notable change in the population or an area that warrants a review of pharmaceutical services then a PNA supplementary statement must be produced by the Health and Wellbeing Board.

5. COVID-19 Impact JSNA

5.1. The broad purpose of the COVID-19 Impact JSNA is to identify the effect of COVID-19 on the Lewisham population and inequalities within those populations in terms of their vulnerability to COVID-19, their experience of the disease and outcomes including; the impact of Long COVID, mortality from COVID and impacts on life expectancy. It will also look at how the response to the pandemic impacted other areas of health including; access to care / delays in diagnosis, mental health and wellbeing, pregnancy and childbirth.

5.2. Ultimately the aim of the COVID JSNA is to assess the direct and indirect impacts of the COVID-19 pandemic on the health and wellbeing of the population of Lewisham and identify any inequalities within those impacts. This will help to inform the development of the new Health and Wellbeing Strategy and other local strategic plans relating to the boroughs recovery from COVID-19.

5.3. To inform our continued approach to *Health in All Policies* there is a need to examine how the wider determinants of health impacted on vulnerability to COVID-19, as well as how COVID-19 impacted on the wider determinants of health. This should aid prioritisation within strategies and effective targeting.

5.4. Even before the COVID-19 pandemic, progress in life expectancy had stalled for some groups. Inequalities are still driving differing prevalence of heart disease, lung cancer and lower respiratory diseases. This provides a rationale for the COVID-19 Impact JSNA to also examine COVID-19 within the context of Vital 5 .The Vital 5 initiative advocates for people, communities and organisations to make improvements in/to five

factors that have a major impact on health at an individual and population level: Blood pressure, Obesity, Mental Health, Smoking status and Alcohol intake.

5.5. There is a wealth of data around COVID-19, however much of it is at national and regional level. The assessment will look to use Lewisham data wherever possible but will use regional/national information when needed, giving context as and when it is considered that the Lewisham population is likely to be similar or different to the population for which the data applies.

6. JSNA Steering Group

6.1. The JSNA Steering Group is responsible for topic prioritisation, review and approval of completed assessments to recommend to the Health and Wellbeing Board. The group was established following the agreed change in the JSNA process in mid-2017 and was meeting regularly from November 2017. Meeting were not held after the start of the COVID-19 pandemic in early 2020 but a reintroduction meeting has now been scheduled. Representatives from Public Health, Lewisham CCG, Lewisham and Greenwich Trust, South London and Maudsley Trust, Voluntary Action Lewisham, a representative of the local community organisations, Children and Young People's Commissioning, Health Watch and the Local Medical Committee are invited.

6.2. Led by Public Health, the JSNA Steering Group will agree actions and gain input on the production of the COVID-19 JSNA topic assessment.

7. PNA

7.1. The 2022 PNA has been contracted out due to continued pressures of COVID-19. The final document will provide an assessment of the need for pharmaceutical services within Lewisham; as well as outlining the current provision of such services and considering what may be required in the future.

7.2. There are over 50 pharmacies in Lewisham, providing a range of services, including three core levels of services categorised as Essential, Advanced and Enhanced. As a minimum all community pharmacies are required to provide Essential Services which include dispensing, signposting and promotion of healthy lifestyles.

7.3. The PNA is due to be published by October 2022. In many local authorities the HWBB defers the sign off of the finished assessment to the PNA Steering Group. If agreed by the Lewisham HWBB this could then be added to the PNA Steering Group's Terms of Reference, with the final assessment coming back as an information item.

8. Financial implications

8.1. There are no specific financial implications. However the financial implications of any recommendations arising from the assessments subsequently produced will be considered either during or once the assessments are completed as appropriate.

9. Legal implications

9.1. The requirement to produce a JSNA is set out in the Policy Context section.

9.2. The requirements to produce a PNA are set out above.

9.3. Members of the Board are reminded that under Section 195 Health and Social Care Act 2012, Health and Wellbeing Boards are under a duty to encourage integrated working between the persons who arrange for health and social care services in their area.

10. Equalities implications

JSNAs are a continuous process of strategic assessment and planning, with a core aim to develop local evidence based priorities for commissioning which will improve health and reduce inequalities. The services provided by community pharmacies help to address health inequalities. Equitable access is necessary to ensure the reduction of inequalities. The Equality Act 2010 (the Act) introduced a public sector equality duty (the equality duty or the duty). It covers the following protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

11. Climate change and environmental implications

11.1. There are no climate change or environmental implications from this report.

12. Crime and disorder implications

12.1. There are no crime and disorder implications from this report.

13. Health and wellbeing implications

13.1. The aim of JSNAs are to inform planning and commissioning to improve the health and wellbeing of Lewisham residents.

14. Report author and contact

14.1. Dr Catherine Mbema, Director of Public Health, catherine.mbema@lewisham.gov.uk

Health & Wellbeing Board

Report title: Annual Public Health Report 2021-22

Date: 09 March 2022

Key decision: ~~Yes~~/No.

Class: Part 1

Ward(s) affected: ALL

Contributors: Dr Catherine Mbema, Director of Public Health, London Borough of Lewisham

Outline and recommendations

This report introduces the topic for the 2021-22 Annual Public Health Report (APHR) by the Director of Public Health.

The Lewisham Public Health team are proposing to develop an APHR on the topic of 'Culture and Health', in line with Lewisham being the London Borough of Culture for 2022.

The board is asked to discuss and agree the topic for the report for 2021-22.

Timeline of engagement and decision-making

March 2022: Lewisham Health and Wellbeing Board (Report topic proposal)

December 2022: Lewisham Health and Wellbeing Board (Final report)

1. Summary

1.1. This report introduces the topic for the 2021-22 Annual Public Health Report (APHR) by the Director of Public Health.

1.2. The report outlines a proposal to develop an APHR on the topic of Culture and Health for 2021-22, in line with Lewisham being the London Borough of Culture for 2022.

2. Recommendations

2.1. The board is asked to discuss and agree the topic for the report for 2021-22.

3. Policy Context

3.1. The Health and Social Care Act 2012 stated that the production of an APHR is a statutory duty of the Director of Public Health, which the local authority is responsible for publishing.

4. Annual Public Health Report 2021-22: 'Culture and Health'

4.1. Lewisham is the Mayor's London Borough of Culture 2022 and will be home to a range of cultural activity over the year through a programme that has been created by and with the people of Lewisham. The Lewisham Public Health team would therefore like to propose the topic of 'Culture and Health' for the APHR for 2021-22.

4.2. UNSECO defines culture as: "the set of distinctive spiritual, material, intellectual and emotional features of society or a social group … [which] encompasses, in addition to art and literature, lifestyles, ways of living together, value systems, traditions and beliefs" (UNESCO, 2001)

4.3. Using this definition we can see several clear links between aspects of culture and health and wellbeing.

4.4. The proposed 2021-22 APHR on 'Culture and Health' will aim to cover:

- An overview of the role of culture on health and wellbeing.
- Best practice examples (national and international) of how cultural activities and initiatives can impact positively on health and wellbeing of Lewisham residents.
- Local examples of how cultural activities and initiatives impact positively on health and wellbeing of Lewisham residents.
- Case studies of London Borough of Culture activity and health.
- Recommendations for further local work on culture and health building on recommendations from the last APHR on 'Health in all Policies'.
- Overview of health and wellbeing indicators for Lewisham.

4.5. In line with the Borough of Culture ethos, we will aim to take a community-centred approach to develop the report.

4.6. The completed report will be presented to the Lewisham Health and Wellbeing Board in December 2022.

5. Financial implications

5.1. There are no specific financial implications arising from this report.

6. Legal implications

6.1. The requirement to produce an APHR is set out in the Policy Context section.

7. Equalities implications

7.1. This report has no specific implications for equalities.

8. Climate change and environmental implications

8.1. There are no direct climate change or environmental implications from this report.

9. Crime and disorder implications

9.1. There are no direct crime and disorder implications from this report.

10. Health and wellbeing implications

10.1. The report outlines the topic for the 2021-22 APHR to explore the role of culture in health and wellbeing, particularly for Lewisham residents.

11. Report author and contact

11.1. Dr Catherine Mbema, Director of Public Health, catherine.mbema@lewisham.gov.uk

HEALTH AND WELLBEING BOARD				
Report Title	Integrated Care System Update			
Contributors	Martin Wilkinson, Director of Integrated Care & Commissioning, Lewisham Council and NHS South East London CCG Charles Malcolm-Smith, People & provider Development Lead, Lewisham System Transformation Team, South East London CCG		Item No.	
Class	Part 1	Date:		

1. Purpose

1.1 This paper provides an update on the development of Local Care Partnership (LCPs) within Integrated Care Systems (ICSs) and the priority actions to be taken in Lewisham, subject to the completion of the legislative process for the Health & Care Bill, following the previous report to the Board.

2. Background

2.1 The Board received an update at its meeting in December 2021. The planned establishment of ICSs has been postponed from April to July 2022.

2.2 The SEL ICS is continuing to implement the national design framework in line with the revised timescales, and the four core elements: Integrated Care Partnership (ICP), Integrated Care Board (ICB), Provider Collaboratives (Acute and Mental Health), Place Based Partnerships or Local Care Partnerships (LCPs).

2.3 Also at place, or borough, level an Executive Lead position and leadership team will be established.

2.4 The Department of Health & Social Care has published a white paper 'Joining up care for people, places and populations', which sets out the government's proposals for health and care integration and is part of a wider set of mutually reinforcing reforms, including the Adult Social Care Reform white paper 'People at the Heart of Care', the Health & Care Bill and reforms to the public health system.

2.5 The white paper focuses on the following key areas:

- A more joined up approach for public health and NHSE services
- Developing a shared outcomes framework for individual and population health and wellbeing
- Support for local authorities and the NHS to go further and faster on financial alignment and pooling of budgets to underpin joined up health and care
- Supporting digital and data transformation at both ICS and place-level; including the aim to have shared care records by 2024 across health and care, accessible by service users, caregivers and care teams
- Joint health and care work-planning at ICS-level and improved training, learning and development including joint roles across health and care.

2.6 This paper also sets out expectations for the development of effective leadership for integration, which align to our existing principles for collaboration, and we will be looking to role-model in our ways of working within the Lewisham Health & Care Partnership (LHCP).

- Bringing partners together around a common agenda with decisive action in the interest of local people, even when it runs counter to organisational interests
- Being able to judge when it is right to remove or challenge organisational boundaries and when it is better to make connections between distinct organisations
- Being responsible for delivering outcomes, ensuring data is used and shared safely and effectively, to provide shared insight and a holistic understanding of the health and care needs of their local population
- Focusing decisions both on what happens at the point of care, and on what is of most benefit from a population perspective, taking a strong interest in what delivers value for money over time
- Listening to the voices of people who draw, or may need to draw, on services when designing and improving those services and in defining which outcomes matter to individuals and populations
- Supporting and enabling clinical and adult social care leadership in the development and delivery of services.

3. Progress & Next Steps

3.1 Ahead of the assumed legal establishment of the ICS NHS Body on July 2022, the following key actions will be completed:

- Appointment of Executive Place Lead – a consultation has been held with staff impacted by the establishment of these roles across south east London
- Appointment of Chair for Lewisham LCP – this will be undertaken from the membership of the LCP following appointment of the Place Lead to ensure distributed leadership amongst the partnership
- The intended LCP committee status has been agreed as committee in common, in line with SEL ICB delegation
- Representation from all partner organisations to place leadership team to be confirmed

- Primary care representation agreed as primary care networks (PCNs), LMC and GP alliance (One Health Lewisham)
- Engage with voluntary and community sector to identify members for LCP who will provide a strategic representation and a voice for the sector
- Proposals for social care provider sector LCP representation to be finalised providing opportunity for both domiciliary care and care home sectors
- Clinical and care professional leads being recruited to develop a strong multi-disciplinary leadership network within the partnership
- A task group has been established with senior leadership from the partnership to implement recommendations for improved approach and co-ordination in citizen and community engagement.

4. Financial Implications

4.1 There are no additional financial implications arising from this report.

5. Legal Implications

5.1 Members of the Board are reminded that under Section 195 Health and Social Care Act 2012, health and wellbeing boards are under a duty to encourage integrated working between the persons who arrange for health and social care services in the area.

6. Crime and Disorder Implications

6.1 There are no specific crime and disorder implications arising from this report

7. Equalities Implications

7.1 There are no specific equalities implications arising from this report.

8. Environmental Implications

8.1 There are no specific environmental implications arising from this report.

If there are any queries on this report please contact Charles Malcolm-Smith, People & provider Development Lead, Lewisham System Transformation Team, South East London CCG, charles.malcolm-smith@nhs.net .

Background documents

'Integrating care Next steps to building strong and effective integrated care systems across England' can be found here

'Integrated Care Systems: design framework' can be found here

Further NHS England guidance relating to the establishment of Integrated Care Systems can be found here

The Department of Health & Social Care white paper ‘Joining up care for people, places and populations’ can be found here