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Healthier Communities Select Committee Agenda

Wednesday, 7 September 2022
7.00 pm,
Civic Suite
Lewisham Town Hall
London SE6 4RU

For more information contact: Katie Wood (02083149446)

This meeting is an open meeting and all items on the agenda may be audio recorded and/or filmed.

Part 1

Healthier Communities Select Committee Members

Members of the committee, listed below, are summoned to attend the meeting to be held on Wednesday, 7 September 2022.

Kim Wright, Chief Executive
Tuesday 30 August 2022

Members Councillor Chris Best (Chair) Councillor Aliya Sheikh (Vice-Chair) Councillor Peter Bernards Councillor John Muldoon Councillor Laura Cunningham Councillor Stephen Hayes Councillor Jacq Paschoud Councillor Mark Ingleby (ex-Officio) Councillor Ese Erheriene (ex-Officio)	

MINUTES OF THE HEALTHIER COMMUNITIES SELECT COMMITTEE

Tuesday, 21 June 2022 at 7.00 pm

IN ATTENDANCE: Councillors Chris Best (Chair), John Muldoon, Laura Cunningham and Jacq Paschoud.

ALSO JOINING THE MEETING VIRTUALLY: Councillors Aliya Sheikh (Vice-Chair) and Peter Bernards

APOLOGIES: Councillor Stephen Hayes

ALSO PRESENT: Councillor Paul Bell (Cabinet Member for Health and Adult Social Care)

ALSO PRESENT VIRTUALLY: Nigel Bowness (Healthwatch Lewisham), Tom Brown (Executive Director for Community Services), Kenneth Gregory (Director of Adult Integrated Commissioning), Salena Mulhere (Assistant Chief Executive), Vanessa Smith (Chief Nurse, South London and Maudsley NHS Foundation Trust) and Martin Wilkinson (Director of Integrated Care and Commissioning).

NB: Those Councillors listed as joining virtually were not in attendance for the purposes of the meeting being quorate, any decisions taken or to satisfy the requirements of s85 Local Government Act 1972

1. Election Of Chair & Vice-Chair

RESOLVED: that Cllr Chris Best and Cllr Aliya Sheikh be elected as the Chair and Vice-Chair of the committee.

2. Minutes of the meeting held on 1 March 2022

RESOLVED: that the minutes of the last meeting be agreed as a true record.

3. Declarations of interest

The following non-pecuniary interest was declared:
Councillor Jacq Paschoud has a close family member in receipt of a package of adult social care from Lewisham social services.

4. Responses from Mayor and Cabinet

There were none.

5. South East London Integrated Care System

Tom Brown (Executive Director for Community Service) introduced the report, noting that the architecture of the NHS is due to change on 1st July 2022, with

many of the Lansley reforms being undone and a move towards a more co-productive structure with health and social care working together to address health and care challenges.

5.1 As part of the new architecture, local government will be represented at the South East London Integrated Care System (ICS) level on both the Integrated Care Partnership and the Integrated Care Board. There will also be a local care partnership focused on the community in Lewisham.

5.2 Martin Wilkinson (Director of Integrated Care and Commissioning) noted that the local care partnership for Lewisham will feed into and report to the Health and Wellbeing Board and that the Health and Wellbeing Strategy will be worked through the local care partnership. There will also be a broad range of clinical and care professionals working within the structure and lots of continuity with existing staff and plans.

5.3 The ICS will decide on what happens with a large amount of NHS spending and this will allow there to be joint conversations about where the pressures are and where the money should go. It was noted that money has already be directed towards social care so that it can support elective recovery and prevent hospitals getting clogged up.

5.4 The committee stressed the importance in any new structure of a continuing focus on children, families and early intervention.

5.5 In response to questions from the committee about the priority of the replacement of the Ladywell Unit, it was noted that the focus is currently on remedial and immediate safety work but work is progressing on planning for a new unit as a high priority.

5.6 In response to questions from the committee about the scrutiny of the ICS, it was noted that scrutiny will continue to be key and that scrutiny colleagues have begun conversations with the ICS about future arrangements for the previous *Our Healthier South East London* Joint Health Overview and Scrutiny Committee. It was also suggested that it might be helpful to refresh the local health and social care scrutiny protocol.

RESOLVED: that the report be noted; that Martin Wilkinson be thanked for his service to Lewisham over the last 14.5 years; and that the committee works with partners to refresh the Lewisham Health and Social Care Scrutiny Protocol.

6. Mapping the Health care and wellbeing Charter

Martin Wilkinson (Director of Integrated Care and Commissioning) introduced the item noting that the Health and Wellbeing Board has been requested to develop a health care and wellbeing charter and that the next step is to get initial comments on how this might be co-designed and co-produced.

6.1 It was noted that it would be helpful set out the responsibilities that health and care would have in offering reasonable access to appointments in GPs and hospitals, but to also cover the various responsibilities around the system in relation to this.

6.2 It was also noted that issues of inequality of access had been identified through the Birmingham and Lewisham African and Caribbean Health Inequalities Review (BLACHIR) and that the charter will develop over time.

6.3 Nigel Bowness (Healthwatch Lewisham) noted that Healthwatch already provides a wealth of information on residents' views on access to health and care services and are happy to support the process of developing the charter going forward. It was noted that the Lewisham Disabled People's Commission will be reporting in October, which may offer further insights into inequality of access, and that insight could also be gathered from regulator and ombudsman reports. Healthwatch also suggested aligning any resident engagement activity with that already happening at ICS and local level to avoid duplication.

6.4 The committee noted that it would be good to engage with stakeholders to get their views and to work in partnership with the Health and Wellbeing Board. It was also noted that a dashboard of key data, such a missed appointments, for example, could be helpful. The committee suggested setting up an informal session to meet some stakeholders, such as patient panels, to talk about what's important to them.

6.5 The committee also stressed the importance of the charter striking the right balance between acute and early intervention and remembering with stakeholder engagement that not everybody is IT literate and has the tech to find information online.

RESOLVED: that the report be noted and that the committee explore opportunities for public engagement on the proposed Health Care and Wellbeing Charter, working in partnership with Healthwatch Lewisham.

7. Empowering Lewisham Update

Tom Brown (Executive Director for Community Service) introduced the report, providing an update on the Empowering Lewisham programme and its various work-streams. A discussion followed and a number of key points were noted:

7.1 There have been regular staff surveys throughout the programme and it is felt that staff recognise that this programme is an opportunity to really make a difference to people's lives at the same time as getting more value for the public pound.

7.2 The programme in on track to deliver the cashable efficiencies planned, although there has been some slippage in the timeline.

7.3 The consultants who are supporting the programme are contractually obliged to continue working with the council until a minimum of £8.6 cashable savings are delivered, or to reduce their fee.

7.4 The finances are being closely monitored and the council is confident that the savings will be achieved within the estimated 4-year period.

7.5 The Cabinet Member also stressed that the consultants will be asked to demonstrate very clearly where those cashable savings have been achieved.

7.6 The committee stressed the importance of service user input into the process and closely tracking any barriers to progress throughout the programme. The committee asked about the kind of outreach that the council is doing and the number of service use engagement workshops it has carried out. Officers agreed to provide further information.

7.7 The committee also expressed concern about the mental health issues that may arise if additional pressure is put on families who would also consequently be in less contact with care professionals.

7.8 In response, it was noted that the intention of the programme is not to shift the burden to family carers but to help people to be able to better direct what they do with their lives and to make a local offer that allows people to stay connected to their communities and families.

7.9 The number of young people receiving children's services coming into adulthood is presenting particularly significant pressures this year. It is estimated that this will create an additional cost of £1-2m over the coming year.

7.10 The council is also currently working to understand the increasing cost of living pressures on care homes and care workers, with the significant increasing costs of heat and fuel.

RESOLVED: that the report be noted; that the committee receives further information on the number of workshops for staff carried out; and that the committee continues to receive regular updates on the Empowering Lewisham programme.

8. Select Committee work programme

John Bardens (Scrutiny Manager) introduced the report and the following work programme suggestions were noted:

8.1 That the committee schedules an update on the health and wellbeing strategy and invites the chair of the health and wellbeing board.

8.2 That the committee schedules an item on adult safeguarding and invites the chair of the Lewisham Safeguarding Adults Board.

8.3 That the committee continues to receive regular updates on the Empowering Lewisham programme.

8.4 That the committee continues throughout the year to support the work to develop the proposed Health care and wellbeing charter.

8.5 That the committee explores the possibility of considering transitions from children's to adults' mental health services alongside the item at its next meeting on social care transitions.

8.6 That the committee incorporates the consultation on the replacement for the Bridge leisure centre in its leisure update in January.

8.7 That the committee explores the possibility of a site visit to the Ladywell unit in advance of it considering an update in February.

8.8 That the committee explores the possibility of providing committee members with a dashboard of key health and care data.

RESOLVED: that the committee agrees its work programme for the year ahead, notes the suggestions made by the committee and agrees to programme these in at an appropriate time.

The meeting ended at 9.50 pm

Chair:

Date:

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Healthier Communities Select Committee

Declarations of Interest

Key decision: No

Class: Part 1

Ward(s) affected: All

Contributors: Director of Law, Governance and Elections

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. Jeremy Chambers, Director of Law, Governance and Elections, 0208 31 47648

Healthier Communities Select Committee

Report title: Primary Care Update

Date: 7 September 2022

Key decision: No.

Class: Part 1

Ward(s) affected: All

Contributors: Assistant Chief Executive (Scrutiny Manager)

Outline and recommendations

The purpose of this paper is to provide the Healthier Communities Select Committee with an update on primary care developments:

- Members of the Healthier Communities Select Committee are recommended to note the contents of the attached presentation

1. Summary

1.1. The purpose of this paper is to provide the Healthier Communities Select Committee with an update on on primary care developments including the general practice landscape and the patient experience.

1.2. More details on each element are set out in the attached presentation.

2. Recommendations

2.1. Members of the Healthier Communities Select Committee are recommended to note the contents of the attached presentation.

3. Policy Context

3.1. The Council's *Corporate Strategy 2018-2022* outlines the Council's vision to deliver for residents over the next four years and includes the following priority relevant to this item:

1. ***Delivering and defending: health, social care and support*** - Ensuring everyone receives the health, mental health, social care and support services they need.

4. Financial implications

4.1. There are no direct financial implications arising from the implementation of the recommendations in this report.

5. Legal implications

5.1. There are no direct legal implications arising from the implementation of the recommendations in this report.

6. Equalities implications

6.1. Equality Act 2010 brought together all previous equality legislation in England, Scotland and Wales. The Act included a new public sector equality duty, replacing the separate duties relating to race, disability and gender equality. The duty came into force on 6 April 2011. It covers the following nine protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

6.2. 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. Climate change and environmental implications

7.1. There are no direct climate change or environmental implications arising from the implementation of the recommendations in this report.

8. Crime and disorder implications

8.1. There are no direct crime and disorder implications arising from the implementation of the recommendations in this report.

9. Health and wellbeing implications

9.1. There are no direct health and wellbeing implications arising from the implementation of the recommendations in this report.

10. Report contact

10.1. *Chima Olugh, Primary Care Commissioning Manager, NHS South East London CCG (Lewisham), Chima.olugh@selondonics.nhs.uk*

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South East London Integrated Care System

Healthier Communities Select Committee

Primary Care Update Report

7 September 2022

Chima Olugh, Primary Care Commissioning Manager

- **The purpose of this report is to provide the Healthier Communities Select Committee with an update on Primary Care developments in Lewisham.**

- **Members of the Healthier Communities Select Committee are recommended to note the report.**

General Practice landscape

There are currently 27 GP practices in Lewisham which provide primary care services from 36 different sites.

Lewisham has two ‘super practices’ with merged contracts that are also PCNs.

Care Quality Commission Ratings:

- 26 GP practices have a CQC rating of Good overall.
- 1 GP practice has a CQC rating of Requires Improvement overall.
- In 2021/22 two GP practices had a rating of Requires Improvement and one was rated inadequate.

Over the last three years there have been several practice mergers which were all formally considered and approved by the then SEL CCG Primary Care Commissioning Committee (PCCC).

General Practice Workforce summary

Current GP and Nurse headcount

- Total number of GPs – 248 (153 female and 95 male).
- GP Full Time Equivalent – 178.98
- In 2021/22 there were 245 GPs

- Total Nurse headcount – 77
- In 2021/22 there were 82 Nurses.

Patient Experience – GP Patient Survey

- The GP Patient Survey is an England-wide survey, providing practice-level data about patients' experiences of their GP practices.

- *The limitations of the survey should be noted (sample sizes at practice level are relatively small and no qualitative data is included). The survey data is usually triangulated with other sources of feedback, such as Patient Participation Groups (PPG), CQC information and the Friends and Family Test to develop a fuller picture of patients' experience enabling the identification of best practice and areas for potential improvement.*

- Overall, there was a reduction in satisfaction rates across most questions for 2022 results compared to 2021.

Key Headlines from the 2022 GPPS

GP Patient Survey Areas	Lewisham Av 2022	Lewisham Av 2021	ICS Av
Find it easy to get through to someone on the phone	47.9%	61.5%	51%
Find the receptionists at this GP practice helpful	80.3%	87%	80%
Are satisfied with the general practice appointment times available	53.5%	64.3%	53%
Describe their experience of making an appointment as good	49.9%	66.8%	53%
Felt the healthcare professional recognised or understood any mental health needs during their last general practice appointment	79.2%	82.4%	78%
Were involved as much as they wanted to be in decisions about their care and treatment during their last general practice appointment	89.2%	91.2%	89%
Had confidence and trust in the healthcare professional they saw or spoke to during their last general practice appointment	92.1%	95.3%	92%
Describe their overall experience of this GP practice as good	68.9%	80.4%	69%

Top 10 performing practices

1. Lee Road Surgery
2. Oakview Family Practice
3. Nightingale Surgery
4. Woolstone Medical Centre
5. Groove Medical Centre
6. The Vale Medical Centre
7. ICO Health
8. Modality Lewisham
9. Deptford Medical Centre
10. Clifton Rise Family Practice

Officers will contact these practices to understand what systems and processes they have in place and how best practice can be shared.

Primary Care Networks (1)

- The NHS Long Term Plan and GP Contract reform published in January 2019 set the direction of travel for primary care over the next five years.
- A key element of this was the establishment of Primary Care Networks (PCNs) which have general practice at their core.
- PCNs have to be small enough to maintain the traditional strength of general practice, but large enough to provide resilience and support the development of integrated teams.
- Each PCN typically serves communities of between 30,000 and 50,000 and needs to be geographically coherent.
- PCNs consists of groups of GP practices working together with a range of local providers, including across primary care, social care and the voluntary sector, to offer more personalised, coordinated health and social care to a local population.
- There is also an expectation that they PCNs will work with their member practices to reduce variation in quality and outcomes.

Primary Care Networks (2)

- To support the establishment of PCNs, a national PCN contract was introduced as a Directed Enhanced Service (DES). It ensures general practice plays a leading role in every PCN and means closer working between networks and their Integrated Care System.
- Lewisham has 6 PCNs across the borough.
- All Lewisham practices belong to a PCN which covers 100% of the registered population.
- Each PCN has a named accountable Clinical Director and a Network Agreement setting out the collaboration arrangement between its members.
- PCNs were key to the successful delivery of the Covid-19 vaccination programme during the pandemic.

Additional Roles Reimbursement Scheme

- The Additional Roles Reimbursement Scheme (ARRS) is a key part of the government's commitment to improve access to general practice.

- The aim of the scheme is to support the recruitment of 26,000 additional staff into general practice to help alleviate current the workforce issues.

- As part of the PCN additional roles scheme Lewisham has plans to have about 90 additional roles by the end of 2021/22 to provide support within primary care.

PCN Additional Roles

As part of the ARRS PCNs are entitled to funding to support the recruitment of new additional staff to deliver health services. The current funding supports recruitment across 15 roles as below:

Clinical Pharmacists	Pharmacy Technicians	Social Prescribing Link Workers	Health and Wellbeing Coaches	Care Coordinators
Physician Associates	First Contact Physiotherapists	Dietitians	Podiatrists	Occupational Therapists
Nursing Associates	Trainee Nursing Associates	Paramedics	Mental Health Practitioners	Advanced Practitioner

South East London Integrated Care System

Map of Lewisham PCNs

NHS South East London

Primary Care Networks in Lewisham September 2021

NHS Lewisham Clinical Commissioning Group

GP Practices

North Lewisham PCN (80k)
Clinical Director: Dr Forgan
1 Mornington Surgery (closed) - Merged with Kingfisher MC
2 Queens Road Partnership
3 Kingfisher Medical Centre
4 Clifton Rise Family Practice
5 New Cross Health Centre
6 Grove Medical Centre
7 Vesta Road Surgery
8 Amersham Vale Training Practice
9 Deptford Surgery
11 Deptford Medical Centre

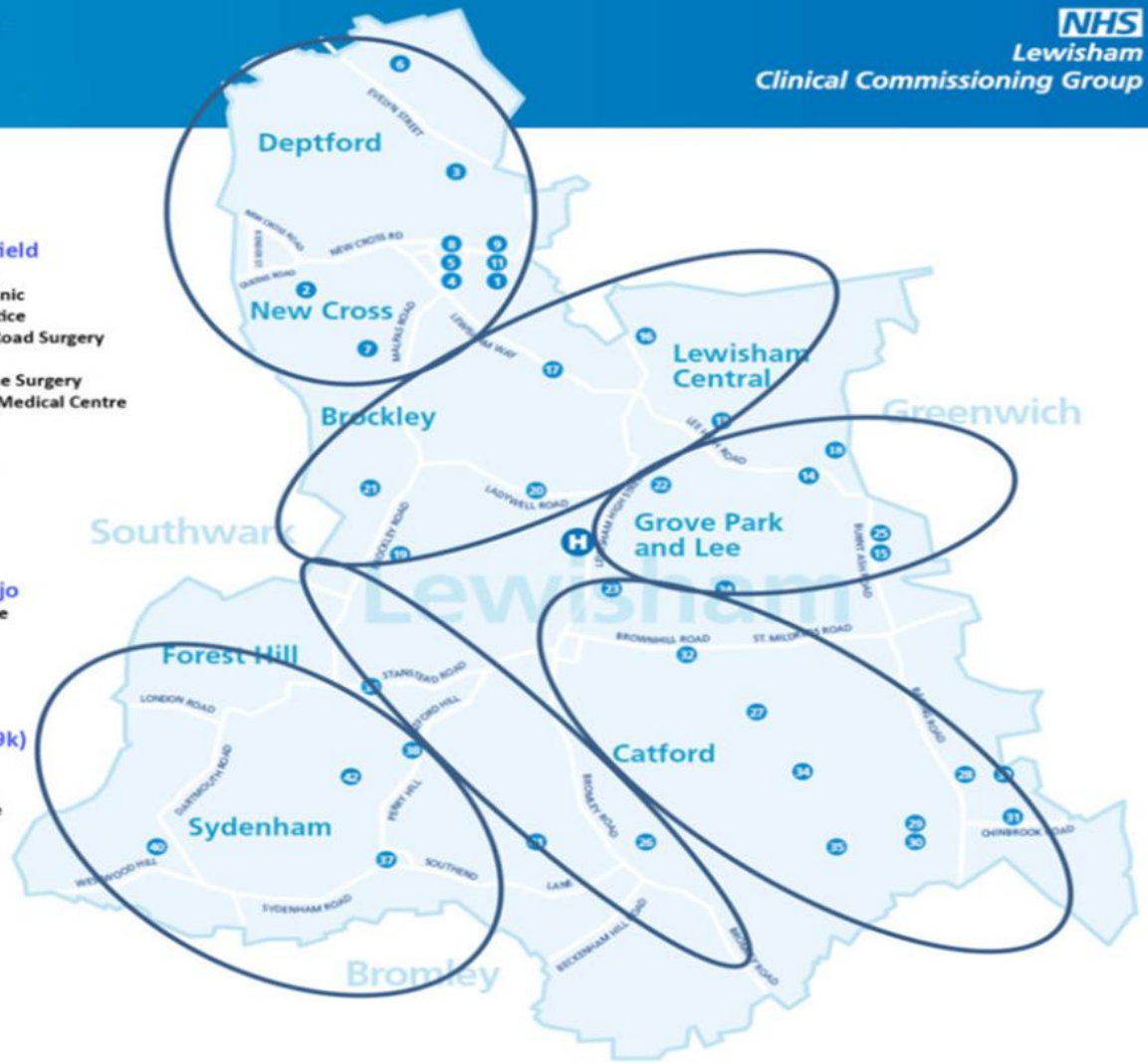
Lewisham Alliance PCN (53k)
Clinical Director: Dr Adams/Raheem
14 Lewisham Medical Centre
15 Burnt Ash Surgery
18 Lee Road Surgery
22 Triangle Group Practice
24 Woodlands Health Centre
25 Nightingale Surgery

Lewisham Care Partnership (58k)
Super-partnership
Clinical Director: Dr Ferdinand
13 Belmont Hill Surgery
16 Morden Hill Surgery
17 St Johns Medical Centre
20 Hilly Fields Medical Centre
21 Honor Oak Group Practice

Sevenfields PCN (62k)
Clinical Director: Dr Tattersfield
27 Torridon Road Medical Practice
29 ICO Health Group - Moorside Clinic
30 Downham Family Medical Practice
31 ICO Health Group - Chinbrook Road Surgery
32 Park View Surgery
33 ICO Health Group - Marvels Lane Surgery
34 ICO Health Group - Boundfield Medical Centre
35 Oakview Family Practice
Novum Health Partnership
23 Rushey Green Group Practice
28 Baring Road Medical Centre

Aplos Health PCN (50k)
Clinical Director: Dr Senbanjo
37 Sydenham Green Group Practice
38 Woolstone Medical Centre
40 Wells Park Practice
42 The Vale Medical Centre

Modality Lewisham PCN (39k)
Super-partnership
Clinical Director: Dr Knight
26 South Lewisham Group Practice
36 The Jenner Practice
41 Bellingham Green Surgery



Better health, best care for Lewisham people

GP Federation

- A GP Federation is a collective group of practices that come together with a common desire to work together at scale to deliver services.
- They share responsibility for delivering high quality, patient-focussed services for the local community.
- Federations work collaboratively with GP practices and PCNs

Lewisham GP Federation

South East London Integrated Care System

- One Health Lewisham (OHL) is the borough wide GP Federation.
- It is member led with all Lewisham GP practices being members.
- OHL works to develop pan Lewisham ways of working.
- The ICB commissions OHL to deliver a variety of services. It also delivers a range of its own specifically developed services which shows its level of maturity.
- It provides a range of primary care and community services to local residents, ‘at scale services’ for practices as well as professional staff training with an aim to reduce variation, improve quality, share good practice and support GP practices.
- OHL uses its local knowledge and expertise, to tailor services to reflect the needs of the communities.
- Services provided include, but are not limited to
  - Home Visiting service
  - Respiratory
  - Care Homes

PCN Enhanced Access DES (1)

- From 1 October 2022, PCNs will be required to offer patients a new 'enhanced access' model of care, which will see GP practices providing additional services to their population.
- PCNs need to ensure their Enhanced Access is provided between 6:30 pm and 8:00 pm Mondays to Fridays and between 9:00 am and 5:00 pm on Saturdays. This is referred to in the DES as the Network Standard Hours.
- As part of the Enhanced Access service, PCNs must provide bookable clinical appointments during the Network Standard Hours that satisfy all of the requirements set out in the DES.
- In preparation for the implementation of Enhanced Access PCNs have worked collaboratively with the Local Care Partnership (LCP) primary care team and developed Enhanced Access Plans.

PCN Enhanced Access (2)

- The plans must set out how PCNs plan to deliver the Enhanced Access DES.
- All 6 PCNs have submitted their first draft plans for review and comment.
- Responsibility for considering, reviewing and approving plans sits with the Local Care Partnership.
- A final iteration of the plans will be agreed on or before 31 August 2022 in preparation for the go-live date, 1 October 2022.
- All PCNs carried out patient surveys as part of preparing the EA DES plans to inform how the service will be delivered – time of day etc.
- The new PCN EA DES provides pre-bookable appointments for services that can include for example, long term condition care and screening.
- The new PCN EA DES does not provide the same level of coverage as the existing GP Federation service. This affects Saturday evenings, Sundays and Bank Holidays capacity.
- The LCP is actively exploring approaches to mitigate any potential negative impacts from this change. This will be linked to work on the Fuller Review requirement for an integrated, same day care offer. (See following slide).

Summary of the Fuller report - how the model of primary care needs to change to improve our population's health and wellbeing

The publication of **'next steps for integrating primary care: Fuller Stocktake report'** creates a new vision and case for change for integrating primary care. The report recommends Integrated Care System (ICS) leadership at every level to support and enable local care partnerships (LCPs) to deliver three key changes to the way in which primary and community care services are delivered at neighbourhood / Primary Care Network (PCN) levels of the system.

At the heart of the report is a new vision for integrating primary care and improving access, experience and outcomes for our communities, which centres around three essential offers:

1. **streamlining access to care and advice** for people who get ill but only use health services infrequently: providing them with much more choice about how they access care and ensuring care is always available in their community when they need it;
2. **providing more proactive, personalised care with support from a multidisciplinary team of professionals** to people with more complex needs, including, but not limited to, those with multiple long-term conditions;
3. **helping people to stay well for longer** as part of a more ambitious and joined-up approach to prevention.

To further support the implementation of these ambitions, the report **makes recommendations on the tasks and activities that are best delivered at different levels of scale** across each ICS.

There are **eight themes for ICS/local action** within the Framework, many of which the Lewisham system are already progressing across the primary care portfolio and wider work programme.

Eight actions for the ICS

- 1. Develop a single system-wide approach to managing integrated urgent care to guarantee same-day care for patients and a more sustainable model for practices
- 3. Enable all PCNs to evolve into integrated neighbourhood teams
- 4. Co-design and put in place the appropriate infrastructure and support for all neighbourhood teams
- 5. Develop a primary care forum or network at system level
- 6. Embed primary care workforce as an integral part of system thinking, planning and delivery
- 10. Develop a system-wide estates plan to support fit-for-purpose buildings for neighbourhood and place teams delivering integrated primary care
- 12. Create a clear development plan to support the sustainability of primary care and translate the framework provided by Next steps for integrated primary care into reality, across all neighbourhoods
- 13. Work alongside local people and communities

* Numbering of the actions reflect the recommendation numbering in the Fuller Review

Implementation of the Fuller Review

- Many of the recommendations reflect work already underway.
- Whilst the bulk of this work will be focused in Place, some elements will require support from SEL ICS functions i.e. Digital.
- Where appropriate, LCPs may choose to work together on certain areas.
- A local co-ordination group, that reports into the Place Executive Group will be established during September to ensure timely implementation of the recommendations.

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Healthier Communities Select Committee

Report title: Birmingham and Lewisham African and Caribbean Health Inequalities Review (BLACHIR) - Update

Date: 7th September 2022

Key decision: No

Class: Part 1

Ward(s) affected: All

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Outline and recommendations

This report provides an update to the Healthier Communities Select Committee on the innovative collaboration between Lewisham and Birmingham City Councils to tackle health inequalities for Black African and Black Caribbean residents following the launch of the Birmingham and Lewisham African and Caribbean Health Inequalities Review (BLACHIR) report in June 2022.

Members of the Healthier Communities Select Committee are recommended to:

- Note the Birmingham and Lewisham African and Caribbean Health Inequalities Report (BLACHIR) and note the contents of the BLACHIR engagement report.
- Note the approach for a refreshed Lewisham Health Inequalities and Health Equity Plan for 2022-24.

Timeline of engagement and decision-making

2 November 2021 – Update report to the Healthier Communities Select Committee.

9 March 2022 – Final report and opportunities for action presented to the Lewisham Health and Wellbeing Board

7 June 2022 – Lewisham launch of the BLACHIR report

27 July 2022 – Discussion of BLACHIR opportunities for action and their implementation by Lewisham Health and Social Care Leaders

July – October 2022 – Presentations of the BLACHIR report and opportunities for action to Lewisham stakeholder groups

1. Background

1.1. The purpose of this report is to provide the Healthier Communities Select Committee with an update on the Birmingham and Lewisham African and Caribbean Health Inequalities Review (BLACHIR).

1.2. Lewisham Council and Birmingham City Council launched BLACHIR in May 2020 as a ground-breaking approach to addressing the deficit in historic approaches to addressing health inequalities specifically for Black African and Black Caribbean communities.

1.3. 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. The partnership between Councils shares knowledge and resources through a collaborative review process following on from the work of our respective Councils as national Childhood Obesity Trailblazers.

1.4. BLACHIR undertook a 'deep dive' into available data, academic evidence and the lived of Black African and Black Caribbean residents in Lewisham and Birmingham with respect to health inequalities for Black African and Black Caribbean communities. The review has proposed 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.

1.5. 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 impact of COVID-19, which reflect many of the pre-existing health inequalities for those of Black and Asian ethnicity.

2. Recommendations

2.1. Members of the Healthier Communities Select Committee are recommended to:

- Note the Birmingham and Lewisham African and Caribbean Health Inequalities Report (BLACHIR) and note the contents of the BLACHIR engagement report.

- Note the approach for a refreshed Lewisham Health Inequalities and Health Equity Plan for 2022-24.

3. Policy Context

3.1. The NHS Race and Health Observatory was established in 2020 by the NHS to examine the health inequalities experienced by Black and minority ethnic communities in England. The Observatory is supported by NHS England, hosted by the NHS Confederation, and aims to 'close the gap on ethnic health inequalities through research, innovation, and evidence-based recommendations for practice'. The NHS Race and Health Observatory is overseen by a Board of members, chaired by Marie Gabriel CBE[1].

3.2. The Lewisham Council Corporate Strategy 2018-22 had seven main priorities with Priority 5 being 'Delivering and defending: health, social care and support'. This priority aimed to ensure that everyone receives the health, mental health, social care and support services they need. Within this priority is the commitment for the Council to 'work with our health and wellbeing partners and our communities to ensure that Black, Asian and minority ethnic groups gain appropriate access to mental health services'. This commitment continues to be overseen by the work of the Lewisham Health and Wellbeing Board on health inequalities.

4. Health Inequalities work in Lewisham

4.1. In July 2018 the Lewisham Health and Wellbeing Board 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. 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 health inequalities for Black, Asian and Minority Ethnic residents. The areas identified were: mental health; obesity; and cancer. At the November 2018 meeting of the Board it was agreed to frame the ongoing discussion concerning health inequalities around these three themes and to actively engage the Lewisham BME Network in this process.

4.2. 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. At the November 2019 Health and Wellbeing Board meeting, Board members agreed to further refine the draft action plan with the BME Network taking a co-production approach.

4.3. A Black, Asian and Minority Ethnic health inequalities working group (a subgroup of the Health and Wellbeing Board) has met since the March 2020 Health and Wellbeing Board meeting to oversee implementation of the action plan. The working group had intended to meet on a monthly basis but in light of the COVID-19 pandemic and disproportionate impact of COVID-19 on Black, Asian and Minority Ethnic (BAME) communities, the group started to meet on a fortnightly basis from April 2020.

4.4. 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.

4.5. 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)

[1] https://www.nhsrho.org/about-us/

4.6. 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:

- Organisations develop their own (and collaborative) action plans for addressing health inequalities and health equity in Lewisham.
- Develop a community event to present and discuss plans.

4.7. 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.

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

4.9. 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.

4.10. 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.

4.11. 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 7 of this report and included in the appended slide pack.

5. Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR) – key findings and report launch

5.1. 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.

5.2. 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

5.3. Overseeing this work were:

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

5.4. 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.

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

5.6. 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.

5.7. Community engagement activities were also 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.

5.8. On Tuesday 7th June 2022, the BLACHIR final report was launched in Lewisham at the Moonshot Community Centre. The launch event was hosted by Cllr Juliet Campbell, the Cabinet member for Communities, Refugees and Wellbeing with an opening address from Lewisham Mayor Damien Egan. Approximately 40 community and statutory stakeholders were in attendance to receive a copy of the final report and discuss the report's findings. A copy of the final report can be accessed online here and is appended to this report.

6. Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR) – next steps

6.1. To support local implementation of the BLACHIR report recommendations across the Lewisham system, a schedule of stakeholder group presentations and discussions has been developed.

6.2. The following stakeholder group presentations/discussions have already taken place:

- Lewisham Adult Integrated Commissioning team
- Lewisham Working Together Forum for Main Grants and Neighbourhood Community Infrastructure Levy (NCIL) funded community groups
- Lewisham Health and Social Care Leaders Forum

6.3. The following stakeholder group presentations/discussions are in development:

- Lewisham Faith Leaders (via the Lewisham Interfaith Forum)
- Lewisham Primary Care BME Network

6.4. Following the stakeholder discussions, the opportunities for action being implemented in Lewisham and the relevant stakeholder leads will be overseen and incorporated into the wider Lewisham Health Inequalities and Health Equity Plan for 2022-24.

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

7.1. A refreshed plan of action to tackle health inequalities in and work towards achieving health equity in Lewisham was approved by the Lewisham Health and Wellbeing Board on 9th March 2022. 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.

7.2. An outline of the 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

7.3. 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[2]. Building trust and collaboration with communities will be a key part of this work.

7.4. There will also be a continued focus on tackling ethnic health inequalities particularly for Black and other racially minoritised communities[3] 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 (as mentioned in section 6 of this report).

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

8. Financial implications

8.1. There are no significant financial implications of this report.

8.2. 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.

9. Legal implications

9.1. The substance of the work covered by this report directly feeds into the Council's statutory obligations within 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.

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

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

[3] 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

- 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.

9.3. 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 9.2 above.

9.4. 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.

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

10. Equalities implications

10.1. In accordance with the legal obligations referred to within paragraph 9 of this report, this report specifically outlines work that aims to tackle health inequalities in Black African and Black Caribbean communities in Birmingham and Lewisham.

11. Climate change and environmental implications

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

12. Crime and disorder implications

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

13. Health and wellbeing implications

13.1. This reports specifically relates to improving the health and wellbeing of Black African and Black Caribbean residents.

14. Report author and contact

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Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR)

Publication date: March 2022

Lewisham

Birmingham City Council

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Foreword

Birmingham and Lewisham are global communities that thrive from the many cultures and communities within them, 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 COVID-19 pandemic, both directly through infections and deaths, and indirectly economically and socially. This review has opened difficult conversations, analysed the published research alongside lived experience, and talked head on about the practical steps needed to make lasting change.

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 to be taken forward in our local communities and systems; as well as further afield in other local, regional, national and international settings.

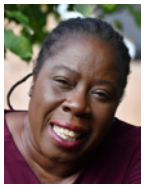
The review is the first step in a longer journey of transformation and resolution. It shines a light on the unfairness our Black African and Black Caribbean citizens live with every day which damages their health and wellbeing. This is the reality for too many citizens who live within our communities. They experience racism and discrimination, ignorance and invisibility existing within structural and institutional processes that underpin and perpetuate these inequalities.

This is a reality that 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.

We are already implementing some of these opportunities for action locally in our areas, through programmes such as Community Champions and pilots of culturally competent health and wellbeing programmes, and we have begun to engage national partners in responding to these opportunities nationally.

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
Cabinet Member for Health and Adult Social Care

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 Black African or Black Caribbean (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 to 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 we 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 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 action from the BLACHIR Academic and Advisory Boards which were 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.

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

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.

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

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, Black African or Black Caribbean people 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 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 lived 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 2 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, as outlined in the previous section.

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 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 Healthy 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.

Who	Opportunities for action
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 Boards and Integrated Care Systems	13. Address low pay and associated poverty for frontline workers who are of Black African and Black Caribbean ethnicity.
Local Directors 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.
Integrated Care Systems and Health and Wellbeing Boards	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 for 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.
Integrated Care Systems	**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 Integrated Care Systems	**20.** Support initiatives to improve uptake of vaccinations in older Black African and Black Caribbean people, focusing on areas of higher deprivation.
Local Health and Wellbeing Boards and Integrated Care Systems 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 for 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 Integrated Care System Partnerships	**25.** Promote cultural competency training within healthcare services, the criminal justice system, and the police force.
Local Health and Wellbeing Boards and 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 Integrated Care Systems	29. Provide long-term investment for trusted Black African and Black Caribbean grass roots organisations 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 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 for 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, Integrated Care Systems and 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 Black African and Black 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.

Who	Opportunities for action
Local Health and Wellbeing Boards and ICS Partnerships	**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 grassroots 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 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 Integrated Care Partnership Boards	**39.** Take action to address employment inequalities and issues around racism and discrimination 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.

Migration Museum, Lewisham

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.

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

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 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.

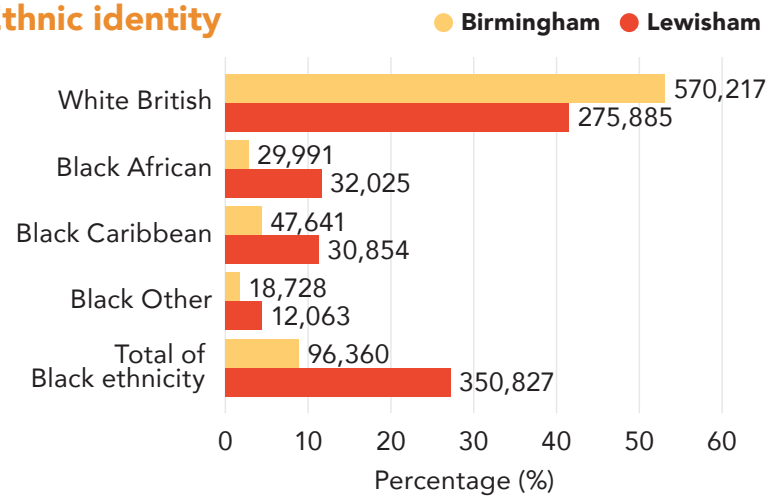
Black African and Black Caribbean groups share common ethnicities and cultures (African-Caribbean), and also identify with oppression, discrimination, marginalisation, inequalities and migration. However, there are also differences and we should not make assumptions when people from these groups access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

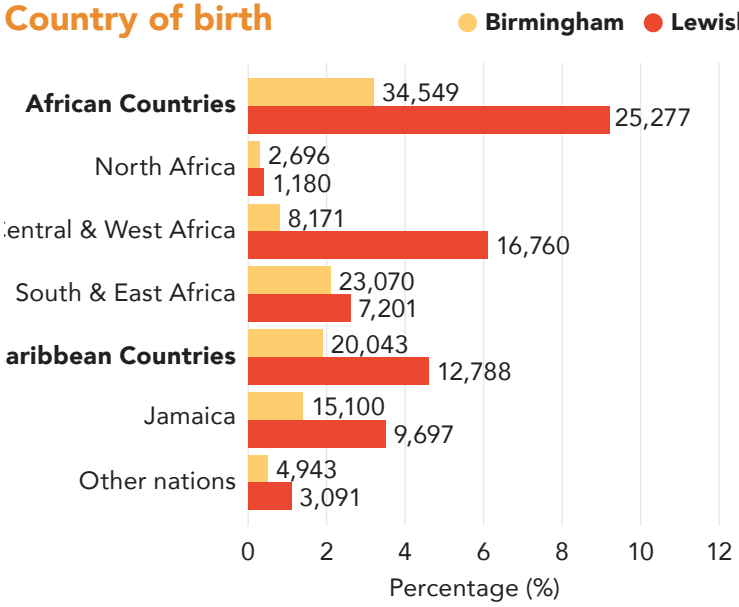
There are some differences: a larger proportion of Birmingham's Black African and Black Caribbean citizens were born overseas (48% compared to 46% in Lewisham). Lewisham's Black African and Black Caribbean population is younger than the general population and although this is similar in Birmingham, it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

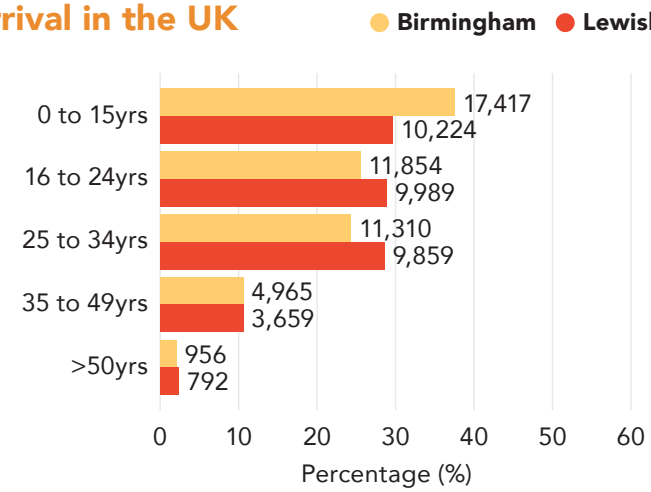
Ethnic identity



Country of birth



Age of Black African / Black Caribbean people on arrival in the UK



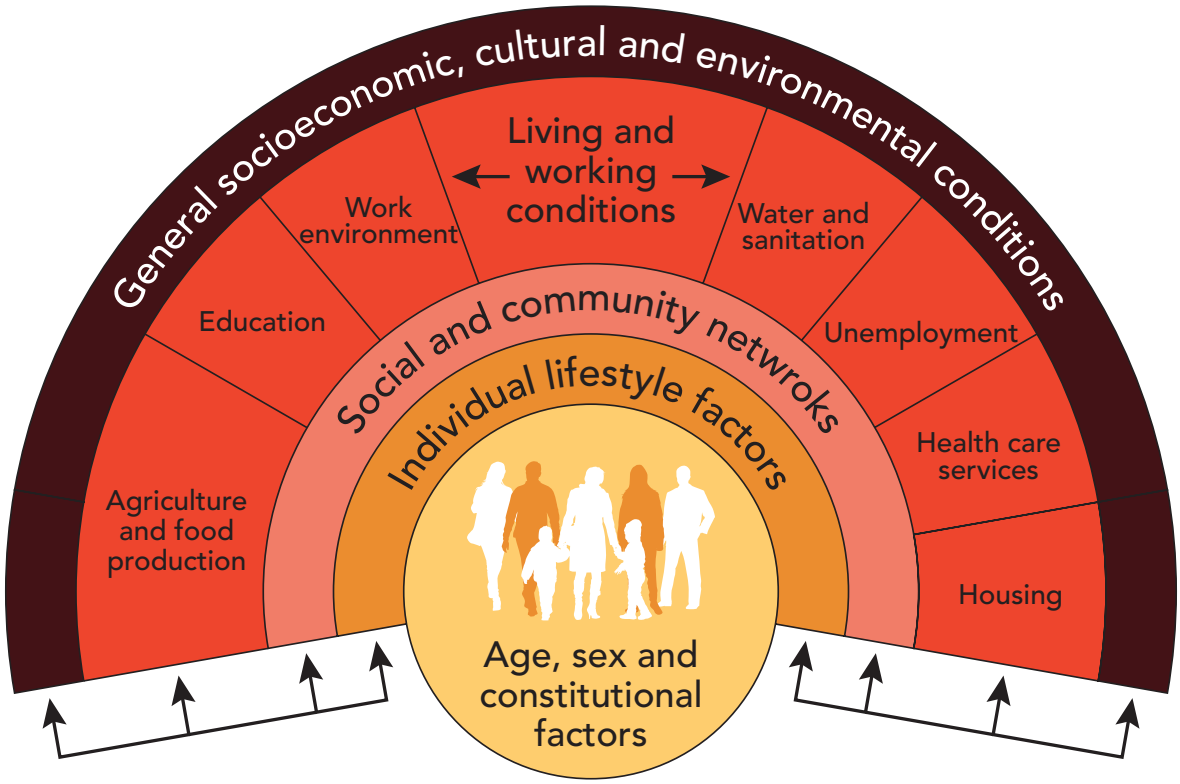
Methodology

The Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR) took eighteen months to complete 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[5]



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.

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.

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 grassroots organisations were involved in carrying out local engagement activities led by a local Black third sector organisation. Across Lewisham, a total of 88 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

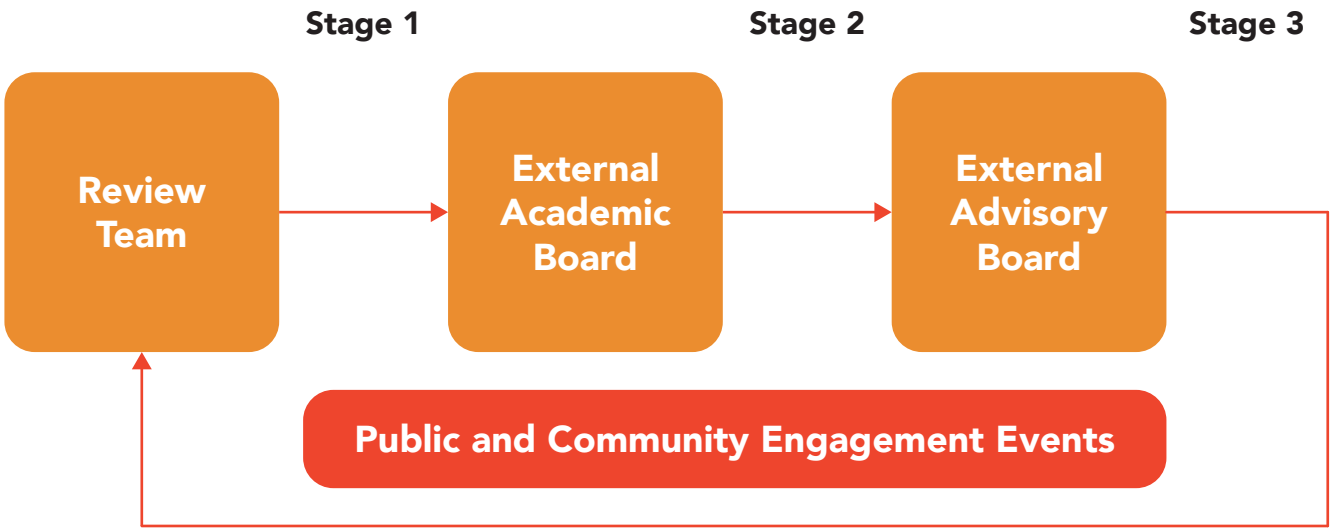
External Academic Board

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	55
% of Black ethnicity	50%		100%	
% male	33%		16%	
% female	67%		78%	
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 the Black, Asian and Minority Ethnic grouping, breadth of board membership, reach of community engagement, etc. The review 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) or Black and Minority Ethnic (BME). Where data is only available for these groupings, this terminology and data has been used in the report. 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 Lesbian, Gay, Bisexual and Trans (LGBT) people of Black ethnicity 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 ethnicity 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-2017-053

1 Racism and discrimination

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 European populations at the top and Black African and Black Caribbean populations 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 populations, 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.

Legacy Centre of Excellence, Birmingham

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.

11 Macpherson, W. (1999) The Stephen Lawrence inquiry

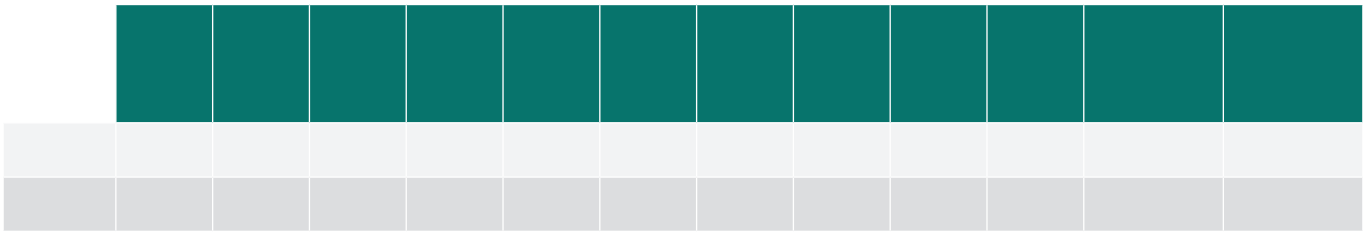
12 The Association of Directors of Public Health London (2021) Policy position: Supporting Black, Asian and minority ethnic communities during and beyond the COVID-19 pandemic.

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 those 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].

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

England & Wales, year ending 31 March



Racially motivated hate crime in England spiked following the EU referendum, 2017 terrorist attacks and the Covid-19 lockdown[11].

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[11].

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

England & Wales

Ethnic group	2007/08 & 2008/09	2009/10 to 2011/12	2012/13 to 2014/15	2015/16 to 2017/18	2017/18 to 2019/20
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

13 Allen, G. and Zayed, Y. (2021) Hate crime statistics. House of Commons Library.

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 and minority ethnic 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.[2] Prejudice exists within the NHS staff towards Black and minority ethnic staff and more bullying and harassment has been reported by Black and minority ethnic staff compared to White British staff[15].

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

x1.16

Black and minority ethnic staff were 1.16 times more likely to enter the formal disciplinary process compared to White staff. This is an improvement on 2019 (1.22) and a significant improvement from 2017 when it was 1.37.

30.3%

30.3% of Black and minority ethnic staff, and 27.9% of White staff, reported experiencing harassment, bullying or abuse from patients, relatives or the public. This is an increase for both groups. In 2016 it was 28.4% for Black and minority ethnic staff and 27.5% for White staff.

40.7%

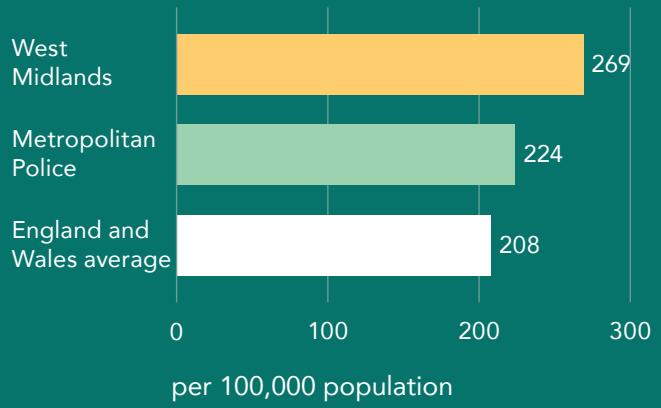
Just 40.7% of Black and minority ethnic staff believe that their organisation provides equal opportunities for career progression or promotion compared to 88.3% for White staff.

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

Key findings

West Midlands has the second highest rate for racially motivated crimes across all Police Force Areas in England and Wales



Most hate crimes in England were racially motivated

2020/21

74% of hate crimes

Proportion of British adult (16+ years) victims of racially motivated hate crime

Black **0.9%**

White **0.1%**

Risk of disciplinary action against NHS staff

Black and minority ethnic staff

1.16x higher risk

What did we find from the community and Board engagement?

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.

"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

Asquith Gibbes Memorial Plaque, Lewisham

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.

2

Maternity, parenthood and early years

Handsworth, Birmingham

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 is 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.

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.

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 are 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.

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.

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.

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

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].

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

Key findings

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

Caribbean

9.0 deaths per **1000** live births

Central Africa

8.3 deaths per **1000** live births

Risk of still birth in the UK

Black/Black British babies

2x greater risk of still birth compared to White babies

Risk of maternal mortality

Black mothers

5x more likely compared to White mothers

Good level of development of children in Reception in England

White children

72% (A B C)

Black children

68% (A B C)

What did we find from the community and board engagement?

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 was collected by services and 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 communities highlighted the need for this to be much more granular and not lump all communities together.

"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

"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 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 Healthy 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.

3

Children and young people

Theme: Children and young people

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.

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

"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

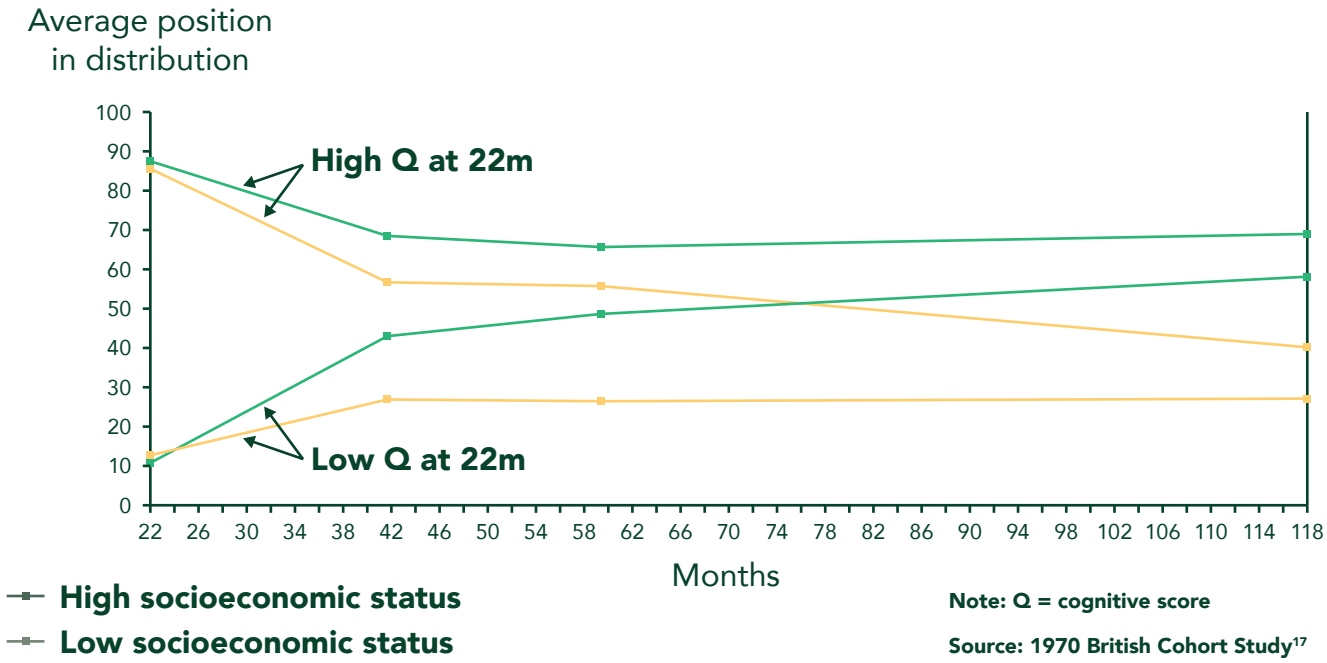
"Food poverty is caused by the social exclusion and spiralling associated costs for many living in these communities."

BLACHIR engagement participant

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

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. 8.

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[16]



Note: Q = cognitive score

Source: 1970 British Cohort Study[17]

Across both Councils there are clear commitments to reducing the social gradient (being less advantaged) in skills and qualifications, ensuring schools, 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. 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 Experiences 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 experiences (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 for 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.

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

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:

- 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.

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

We are all in it together?

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

BLACHIR engagement participant

Oaklands Youth Centre, Birmingham

As we have discussed in the introduction and will continue to reference in this review, people from 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 Institute of Fiscal Studies 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
- 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.

The following findings were identified in our review of published research.

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 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. 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.

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

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

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 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.

Oaklands Youth Centre, Birmingham

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

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)

The proportion of Black child poverty in the UK

42% (2010-11) ↑ 53% (2019-20)

Child poverty in the UK

Black children

2x more likely **grow up poor** compared to white children

Permanent exclusion of children and young people in the UK

Black Caribbean children

2.5x more likely **permanently excluded** compared to white children

What did we find from the community and 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 Boards and Integrated Care Systems	**4.** Address low pay and associated poverty for frontline workers who are of Black African and Black Caribbean heritage.
Local Directors 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.
Integrated Care Systems and Health and Wellbeing Boards	**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).

4

Ageing well

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 an 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.

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

Oaklands Youth Centre, Birmingham

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.

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.

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

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 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]

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

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]

Cardiovascular

The risk factors are higher in Black Caribbean populations compared to the White population.

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.

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

Key findings

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

Life satisfaction

7.9 Black | 7.7 White

Happiness

8.0 Black | 7.7 White

Wellbeing

7.9 Black | 7.9 White

Anxiety

3.2 Black | 2.7 White

Dementia prevalence by ethnicity

Black 9.6% | White 6.9%

Risk of developing cardiovascular dementia

Black African and Black Caribbean

10 years earlier than other ethnic groups

Proportion of deaths at home by ethnicity

Black African and Caribbean 68% | White 52%

Black African and Black Caribbean people, of all ages, are reported to underutilise services due to some of the following barriers:

- Social stigma
- Language barriers
- Poor mental health literacy
- Reluctance to discuss psychological stress

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

Who	Opportunities for action
Regional NHS England teams and Local Public Health teams	**1.** Provide targeted and culturally appropriate screening services for 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.
Integrated Care Systems	**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 Integrated Care Systems	**4.** Support initiatives to improve uptake of vaccinations in older Black African and Black Caribbean people, focusing on areas of higher deprivation.
Local Health and Wellbeing Boards and 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.

5

Mental health and wellbeing

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 Black 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.

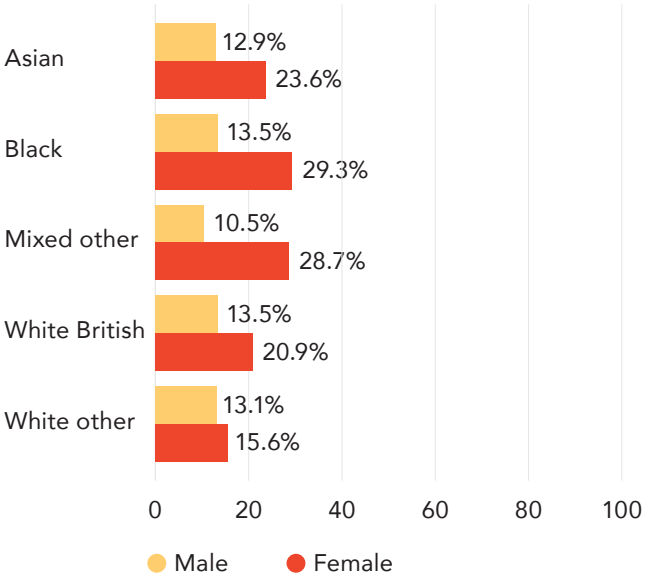
We identified evidence of inequalities in mental health experiences and results for African and Caribbean communities. The findings were reinforced by qualitative evidence from their lived experiences shared by representatives of the communities through local engagement and observations from members 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 Black African and Black 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[51] (Figure 9).

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.[52] Psychosis was consistently higher in Black populations, in particular males; findings were less conclusive regarding depression and anxiety.[56]

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.[53]

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%).[54]

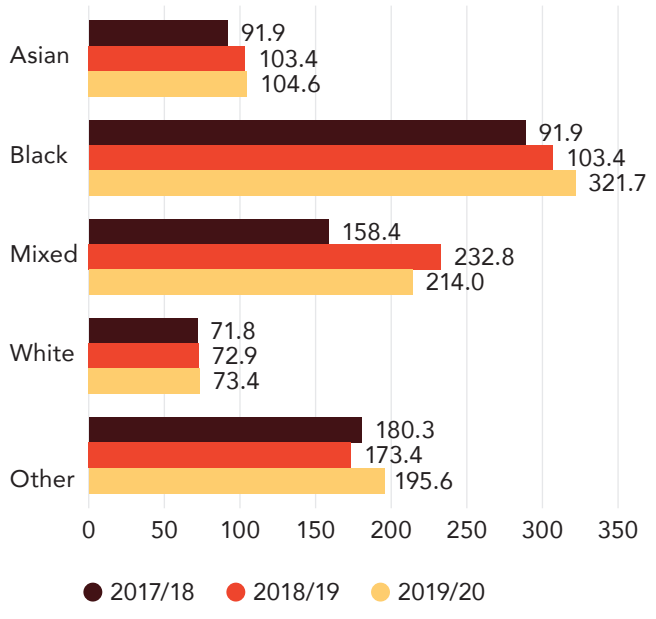
Looking specifically at talking therapy treatment, in the NHS Improving Access to Psychological Therapies (IAPT) there is a lower rate of Black African and Black Caribbean people being offered IAPT services, and where services are offered individual drop out is more likely.[55]

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.[56] Seeking help elsewhere, i.e. not from clinical settings, 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.[56]

51 NHS Digital (2014) Mental health and wellbeing in England Adult Psychiatric Morbidity Survey 2014
52 Lankelly Chase Foundation, Mind, The Afiya Trust and Centre for Mental Health. (2014) Ethnic inequalities in mental health: Promoting lasting positive change
53 NHS Digital (2014) Mental health and wellbeing in England Adult Psychiatric Morbidity Survey 2014
54 NHS Digital (2014) Mental health and wellbeing in England Adult Psychiatric Morbidity Survey 2014
55 Public Health England (2022) Fingertips: Public Health Profiles
56 The role of faith leaders in influencing health behaviour: a qualitative exploration on the views of Black African Christians in Leeds, United Kingdom 2018

Hospital admissions for Black Caribbean and Black African patients were more frequent, longer, and often involved the police, when compared to White patients.[56] 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 10).

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 The role of faith leaders in influencing health behaviour: a qualitative exploration on the views of Black African Christians in Leeds, United Kingdom
58 NHS Digital (2021). Detentions under the mental health act
59 Sport England (2022) Active Lives survey data

Key findings

Mental health in the UK

Black Women

29%
experienced a common **mental disorder** in the past week

Detentions under the Mental Health Act (UK)

Black people

4x
more likely to be detained than **White people**

Compared to White men, Black Caribbean young men are 3x more likely to have contacted mental health services in the year before suicide

Black Caribbean

3x

more likely to contact **mental health services in the year before suicide**

Emotional and mental health treatment rates in the UK

6.5%
Black

14.5%
White

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

"Too quick to label black children as mentally disturbed" with "many ending up with the wrong diagnosis and put in inappropriate places"

Lewisham 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.

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.

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

Who	Opportunities for action
Local Public Health and Community Mental Health Trusts	**1.** Coproduce awareness campaigns for 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 Integrated Care System Partnerships	**4.** Promote cultural competency training within healthcare services, the criminal justice system, and the police force.
Local Health and Wellbeing Boards and 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'.

6 Healthier behaviours

Theme: Healthier behaviours

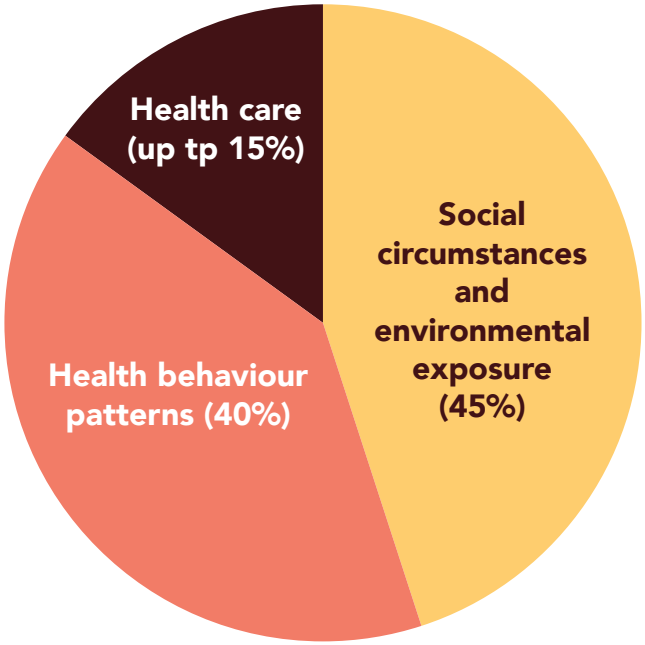
"Stop opening up fast food chains in areas of deprivation where you can get chicken and chips for £1.99 or feed a family for £9.99. Why would you sit and cook a meal for a family of five when this is on offer across the road?"

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 (Figure 11).

Figure 11: Broader determinants of health on population health McGiniss et al (2002) [59]



High Street, Lewisham

Indoor Market, Birmingham

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

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

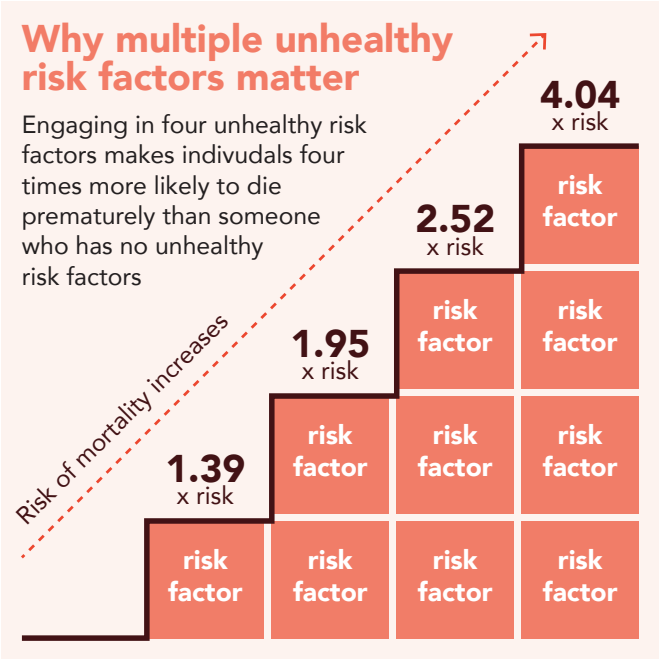
Other behaviours such as social connection are increasingly being understood as risk factors as well through the evidence of the negative impacts of loneliness on mortality risk.

Research shows that clustering and compounding unhealthy behaviors contribute to inequalities. The number of unhealthy behaviours a person has creates a multiplier effect. 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.[60]

59 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.

60 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

Figure 12: The risk of mortality from engaging in unhealthy risk factors[61]



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.[62]

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.[63]

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

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.[64]

The UK's most deprived areas have almost 10 times more the number of betting shops than the most affluent parts of the country.[65]

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 (see figure 20).

61 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
62 Blotomfield, K. (2020) Understanding the alcohol-harm paradox: what next? - The Lancet Public Health
63 Public Health England (2021) Gambling-Related Harms: Evidence Review
64 Public Health England (2018) Fast Food Outlets: Density by Local Authority in England
65 Russon, M-A. (2021) Gambling: Poorer UK towns found to have the most betting shops, study shows BBC News. BBC News

What can be done to enable behaviour change?

Figure 13: Behaviour change is a complex landscape: COM-B model of change[66]

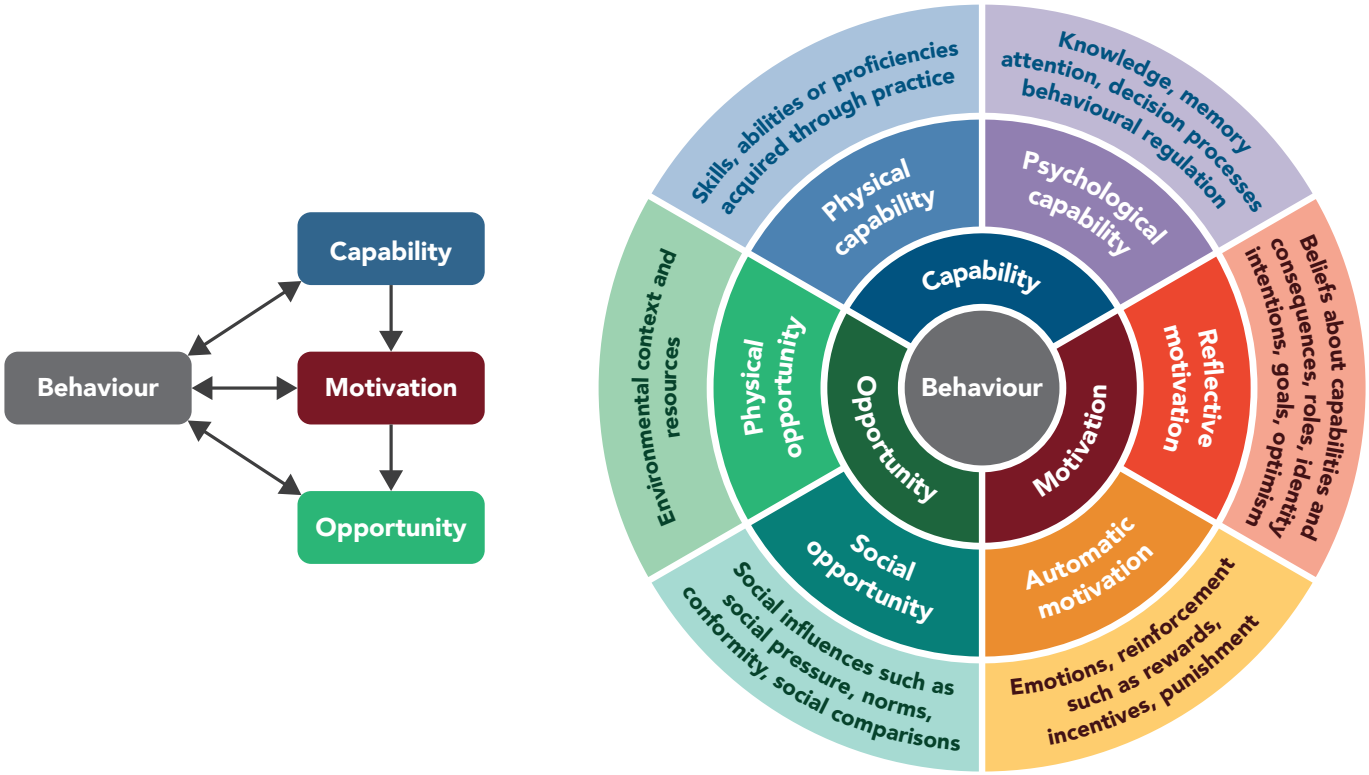
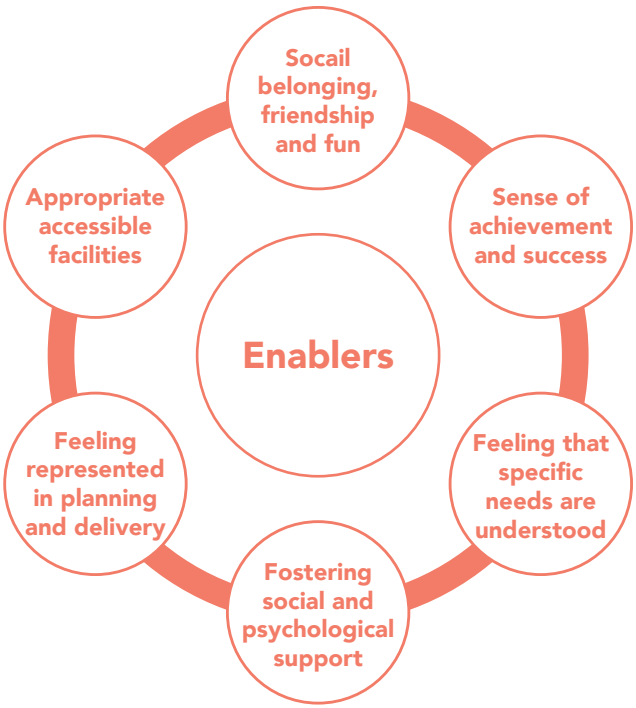


Figure 14: PHE enablers of behaviour change



66 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

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 analyse 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[67] 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 %[68] 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%.[69]
- 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.[70] The sample of the survey is too small to provide data at a local area by ethnicity.
- 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.[71]
- 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]

67 Sport England (2021) Active Lives Adult Survey November 2019/20 report
68 Sport England (2022) Active Lives Survey Data
69 Department for Digital, Culture, Media and Sport (2022) Ethnicity facts and figures - physical activity
70 Public Health England (2022) Fingertips: Physical activity
71 Department for Digital, Culture, Media and Sport (2020) Ethnicity Facts and Figures – Physical Activity

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:[72]

- 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).[73]

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%).[74]

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.[75]

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.[76]

Adult obesity

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 of excess weight in Black communities has decreased from 73.6% in 2018/19.[77]

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

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 linked to sociocultural factors was around creating barriers to healthcare services. Sociocultural factors are wider forces in cultures that affect thoughts, feelings and behaviours. 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 culturally inappropriate or prohibited and result in a barrier to seeking care because of feeling embarrassed.

Moonshot Community Centre, Lewisham

Key findings

Percentage of physically active adults by ethnicity

White British 63.1%

Black 53.3%

Percentage of adults achieving '5-a-day' in their diet by ethnicity

Black **55.9%**

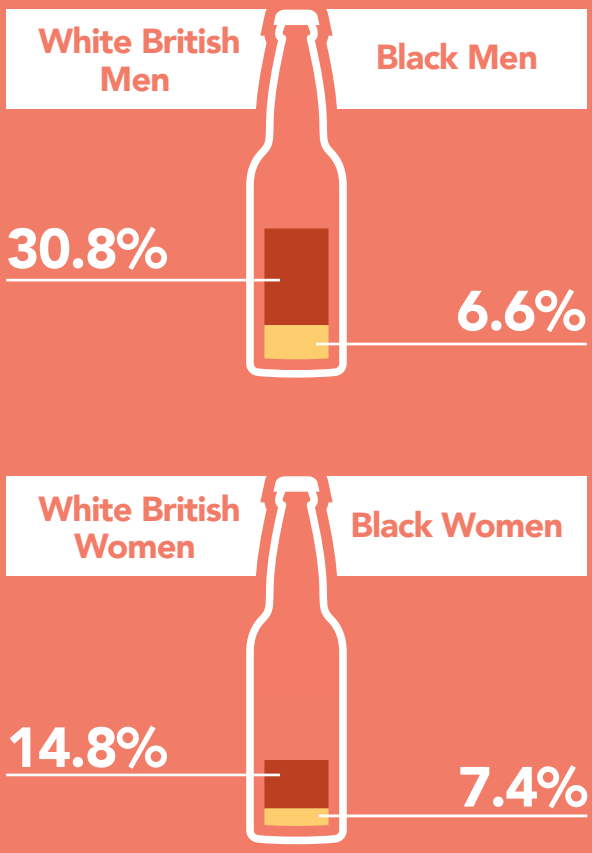
White **44.2%**

Percentage of adult smokers by ethnicity

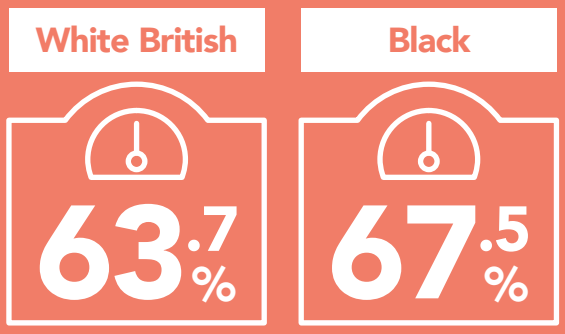
9.7% Black

14.4% White British

Harmful or dependent alcohol consumption by ethnicity and gender



Obesity in adults by ethnicity



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

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 Integrated Care Systems	3. Provide long-term investment for trusted Black African and Black Caribbean grass roots organisations 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 for 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.

7

Emergency care, preventable mortality and long-term physical he conditions

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.

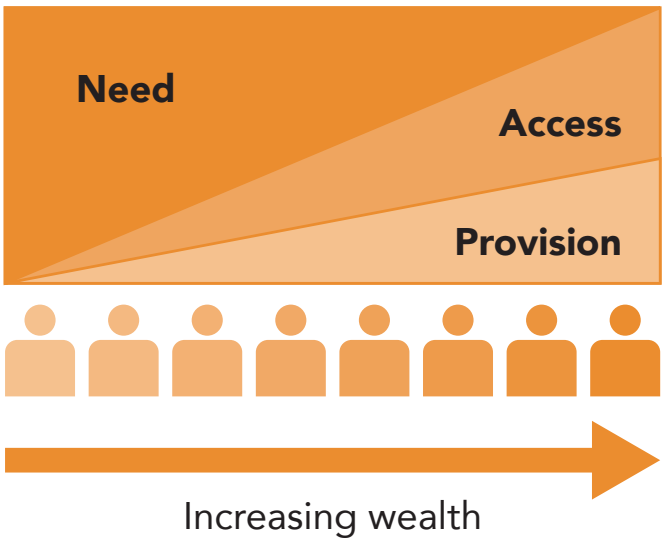
Higher rates of acute disease and emergency care were experienced by Black African and Black Caribbean communities compared to their White equals. For example, there are higher numbers of bad outcomes and preventable deaths across these groups relating to COVID-19, maternity and stroke.

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.[78]

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.

Figure 15: Summarising the Inverse Care Law



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

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 16). 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

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 menatl 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 to 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.[79]
- Diabetes and poor glycaemic control lead to emergency care admissions and has higher rates in this population.[80]
- Dominant endocrine disorders for these groups are sickle-cell disorders and these frequently require urgent care for acute events.[81]
- There are higher rates of asthma in UK born Black and minority ethnic groups.[82]
- There are higher rates of strokes in Black African and Black Caribbean populations due to hypertension, although other risk factors (smoking, coronary heart disease) are less common.[83]

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.[84]
- 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.[85]

79 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
80 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
81 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
82 Asthma UK (2018) On the Edge: How Inequality Affects People with Asthma
83 British Heart Foundation (2022) How African Caribbean Background Can Affect Your Heart Health
84 Stott C, et al. (2021) Understanding ethnic disparities in involvement in crime – a limited scope rapid evidence review, by Professor Clifford Stott et al.
85 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

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.[86]
- 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.[87]
- There is a significant difference among Black and other minority ethnic communities and the White population regarding deaths from Covid-19.[88]

Disparities in healthcare services

- Where Black and minority ethnic groups live in our cities' links to poorer quality primary care.[89]
- 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.[90]
- 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?

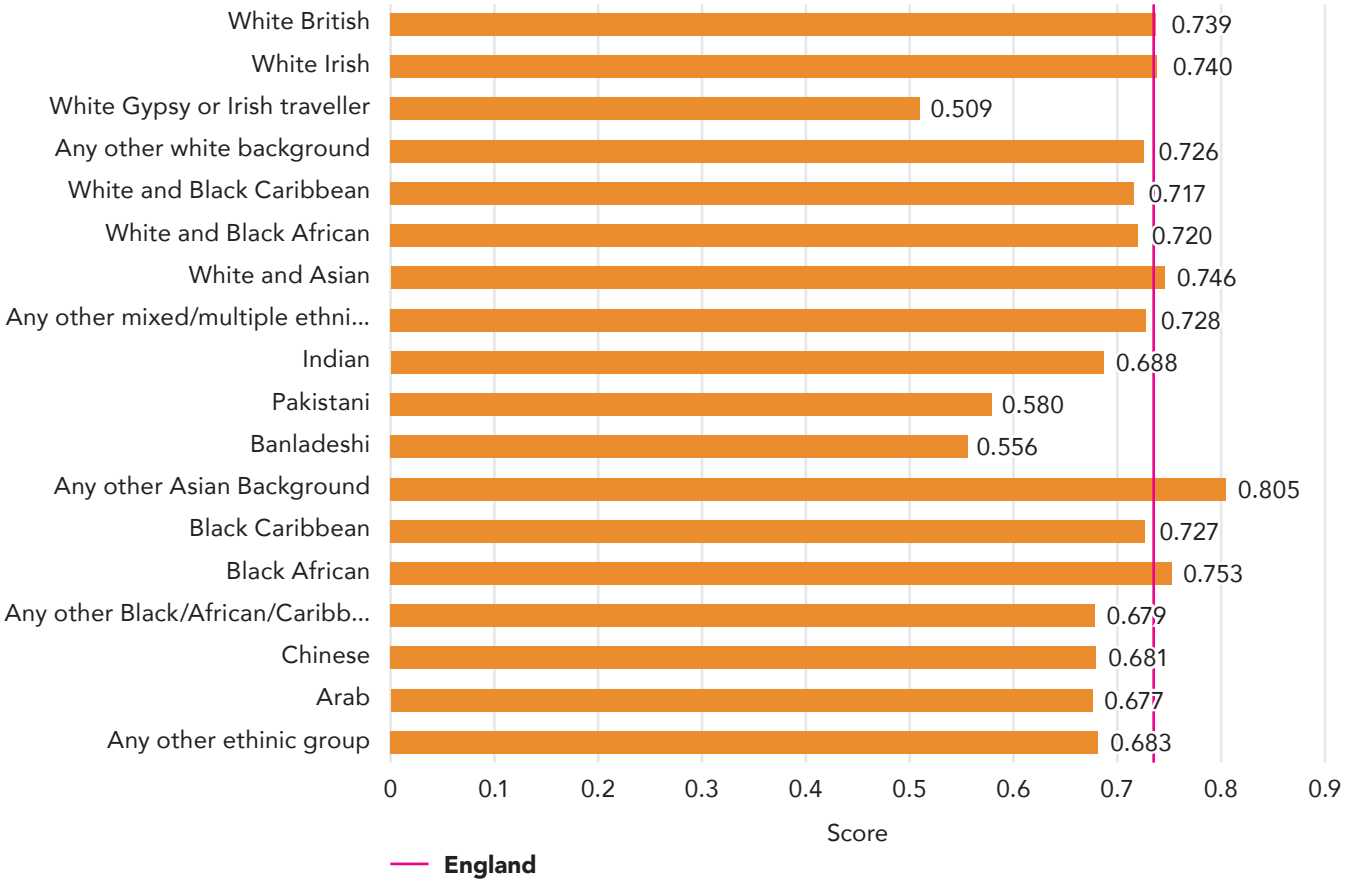
Preventable mortality can be defined as the mortality rates for causes of death which are considered preventable. These are causes where all or most deaths could potentially be prevented by public health interventions in the broadest sense (subject to age limits if appropriate).

The trends observed across the populations are described below based on the data from the Public Health Outcomes Framework, Office for Health Improvement.[91]

- 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 [92](Figure 17).

86 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
87 MBRRACE-UK (2021) UK Perinatal Deaths for Births from January to December 2019
88 Public Health England (2020) Beyond the data: Understanding the impact of COVID-19 on BAME groups
89 Raleigh, V. and Holmes, J. (2021) The Health of People from Ethnic Minority Groups in England. The King's Fund.
90 Gov.UK (2021) Independent Report: Health. Commission on Race and Ethnic Disparities
91 Public Health England (2022) Fingertips: Mortality Profile
92 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.[93]

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.[94]
- Earlier onset of cardiovascular and chronic kidney diseases
- Higher risk and earlier onset of some cancers.[2] 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[95]
- Lower rates of COPD[96] and Multiple Sclerosis[97]
- 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[98]
- Increased referral delays and longer period of sickness absence
- Poor patient satisfaction[99]
- 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.

93 Raleigh, V. and Holmes, J. (2021) The Health of People from Ethnic Minority Groups in England. The King's Fund.
94 Public Health England (2016) Diabetes Prevalence Model
95 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
96 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
97 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
98 Alzheimer's Society (2018) Research suggests fewer Black men receiving dementia diagnosis
99 NHS Digital (2021) Ethnicity facts and figures – patient satisfaction with hospital care

Key findings

Black African and Black Caribbean

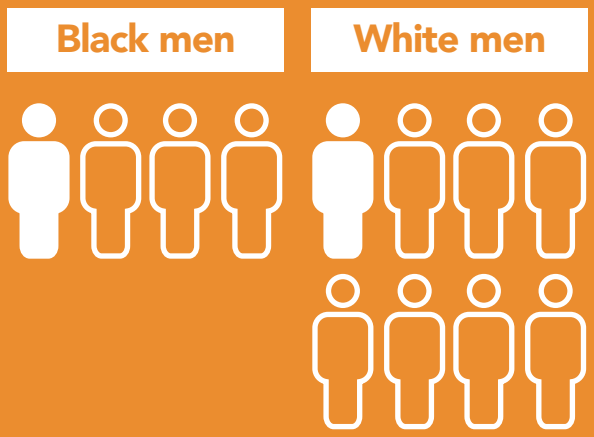
More likely to seek **emergency care**

There are higher rates of:

Asthma
in UK born Black and minority ethnic groups

Strokes
in Black African and Black Caribbean populations

The risk of being diagnosed with prostate cancer is higher for Black men compared to White men



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 are aimed directly at this ethnic group."

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

"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."

"Gateway receptionists need to more responsive and respectful"

"Undocumented slipping through the system", with "many die for fear of being reported"

"Social media becoming a 'source' for information and not necessarily good information 'misinformation'. Lack in confidence to 'challenge' GP's and healthcare professionals where they feel that they are not given sufficient information"

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, Integrated Care Systems and 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 Black African and Black 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 Boards and ICS Partnerships	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.

Who	Opportunities for action
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 grassroots organisations to provide social prescribing support (e.g. befriending, talking therapy, group therapy, forums and general health support).

8 Wider determinants of health

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 Whitehead5 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. There is a need for more investment for communities that experience more inequality, 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%).[100]

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.[101] [102]

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%).[103]

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%).[104]

Income

Nationally, Black households were most likely, out of all ethnic groups, to have a weekly income under £600.[102]

Stop and search

Within England and Wales, Black people are over three times as likely to be arrested as White people.[105] In 2020, there were 54 stop and searches for every 1000 Black people, compared to six for every 1000 White people. [106]

100 Ministry of Housing, Communities and Local Government (2020) Ethnicity Facts and Figures – Overcrowded Houses
101 Department for Education (2021) Ethnicity Facts and Figures – Temporary exclusions
102 Department for Education (2021) Ethnicity Facts and Figures – Permanent exclusions
103 Department for Education (2021) Ethnicity Facts and Figures – A level grades
104 Department for Work and Pensions (2021) Ethnicity Facts and Figures – Household Income
105 Home Office (2020) Ethnicity Facts and Figures – Arrest Data
106 Home Office (2021) Ethnicity Facts and Figures – Stop and Search Data

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.[107] 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.[108]

Deprivation

Nationally there are higher levels of deprivation among the Black African and Black Caribbean groups compared to White groups.[109]

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.[110]

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.[111]

Homelessness and fuel poverty

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.[112]

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)[113]	4.8%	9.1%	12.4%
Fuel Poverty (2018)[114] [115]	10.3%	14.2%	12.1%

The Parish Church of St Peter and St Paul, Birmingham

107 Ministry of Justice (2020) Ethnicity Facts and Figures – Young People in Custody
108 Ministry of Justice and Youth Justice Board for England and Wales (2020) Ethnicity Facts and Figures - Youth Justice Statistics: 2018 to 2019
109 Ministry of Housing, Communities and Local Government (2020) Ethnicity Facts and Figures - People Living in Deprived Neighbourhoods
110 Department for Work and Pensions (2021) Ethnicity Facts and Figures – State support
111 The Voice (2021) UK's Black Majority Churches Want Their Congregations to Consider Taking the Covid-19 Vaccine
112 Ministry of Housing, Communities and Local Government (2020) Ethnicity Facts and Figures – Statutory Homelessness
113 Ministry of Housing, Communities and Local Government (2020) Ethnicity Facts and Figures - Overcrowded households
114 LG Inform (2021) Fuel poverty in Lewisham - LG Inform
115 Department for Business, Energy & Industrial Strategy (2020) Ethnicity Facts and Figures – Fuel Poverty

Key findings

Unemployment in the UK

Black people

2x

more likely to be **unemployed** than White people

Black people

3x

more likely to be **arrested** than White people

Black people are more likely to:

- live in **low-income** and live in **deprivation**
- experience **overcrowding**
- experience **homelessness**
- experience **fuel poverty**

Black people

9x

more likely to be **stopped & searched** than White people

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

Nubia way, Lewisham

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.

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.

Legacy Centre of Excellence, Birmingham

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, who do not use the terms, 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).[116] 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 Black African communities from Spring 2022.

116 https://www.ethnicity-facts-figures.service.gov.uk/style-guide/writing-about-ethnicity

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 noicse pollution."

"Poor housing and traffic congestion adding to people's anxiety and stress levels"

Opportunities for action

Theme 8: Wider determinants

Who	Opportunities for action
Local Health and Wellbeing Boards and Integrated Care Partnership Boards	**1.** 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	**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 Integrated Care Partnership Boards	**4.** Take action to address employment inequalities and issues around racism and discrimination 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.

Acknowledgements and Credits

We would like to express our sincere gratitude to the community representatives who were involved in this review and remained committed to its creation despite the pressures of the pandemic response.

We are grateful to the Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR) Advisory Board members and wider contributors involved in the community engagement, without whom this work would not have been possible.

We also thank the members of the BLACHIR Academic Board and other partners who supported the delivery of the review and were instrumental in validating the research.

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 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 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 Healthy 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's and Integrated Care Systems	13. Address low pay and associated poverty for frontline workers who are of Black African and Black Caribbean ethnicity.
Local Council Director's 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.

Who	Opportunities for action
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.
Integrated Care Systems and Health and Wellbeing Board's	**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 for 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.
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 Integrated Care System Boards	**20.** Support initiatives to improve uptake of vaccinations in older Black African and Black Caribbean people, focusing on areas of higher deprivation.
Local Health and Wellbeing Boards and 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 for 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 Integrated Care System Partnerships	**25.** Promote cultural competency training within healthcare services, the criminal justice system, and the police force.
Local Health and Wellbeing Boards and 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 Integrated Care Systems	**29.** Provide long-term investment for trusted Black African and Black Caribbean grass roots organisations 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 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 for 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, Integrated Care Systems and 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 Black African and Black 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 Boards and ICS Partnerships	**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.

Who	Opportunities for action
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 grassroots 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 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 Integrated Care Partnership Boards	**39.** Take action to address employment inequalities and issues around racism and discrimination 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)

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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:

"*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*"[3].

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:

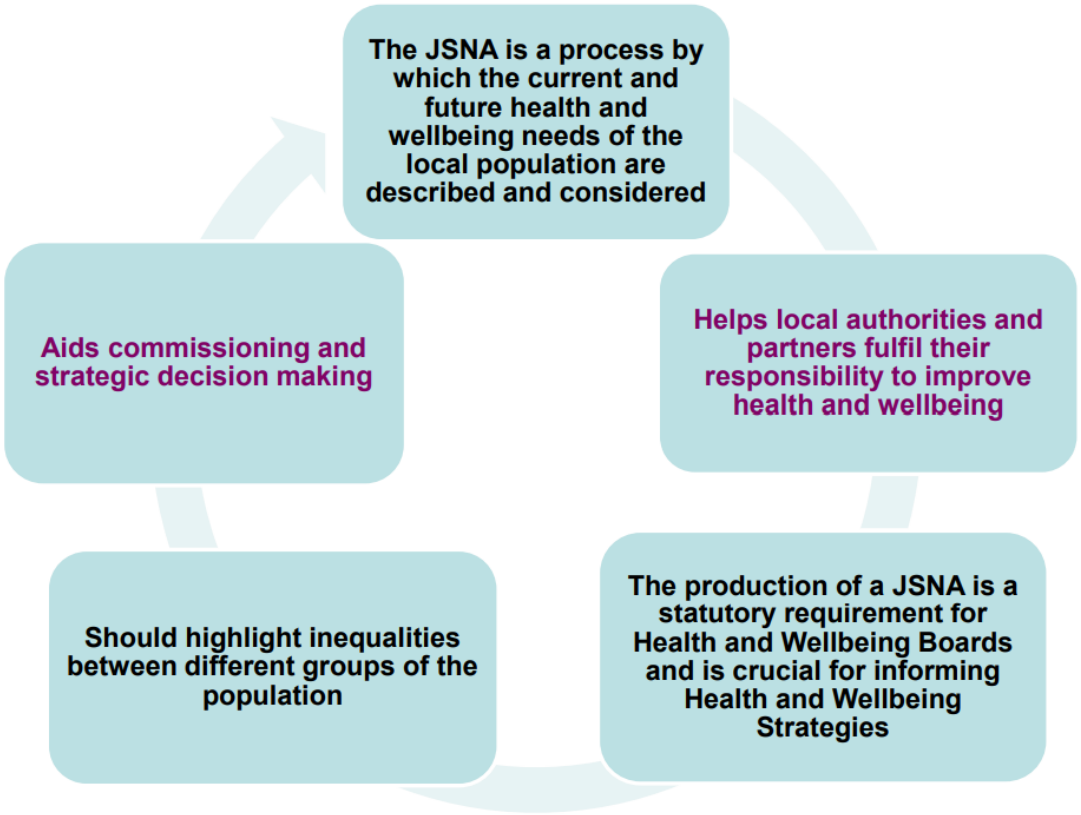
- 23% are aged 0 -17yrs

[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.

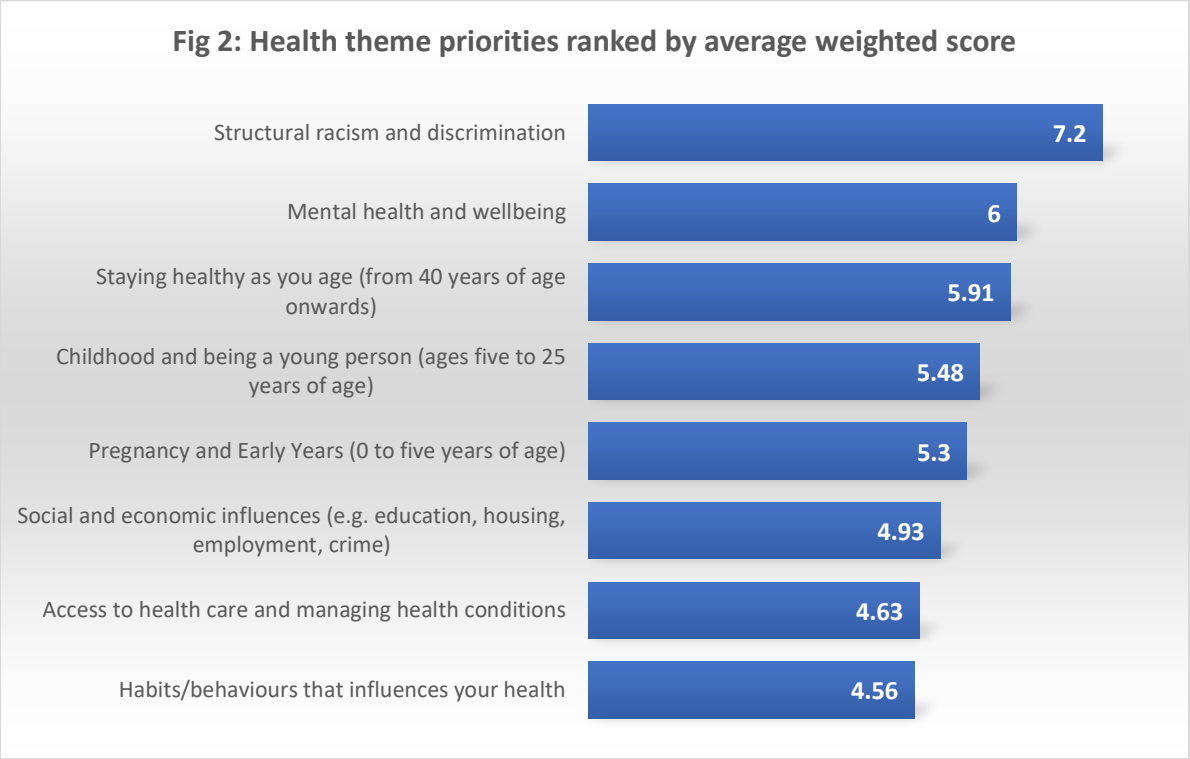
Based on feedback from the open ended questions, the focus group and 1-2-1 interviews, it is clear that African and Caribbean people living in Lewisham are concerned about the level of racism and discrimination that they perceive. Examples of comments from respondents revealed:

"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.

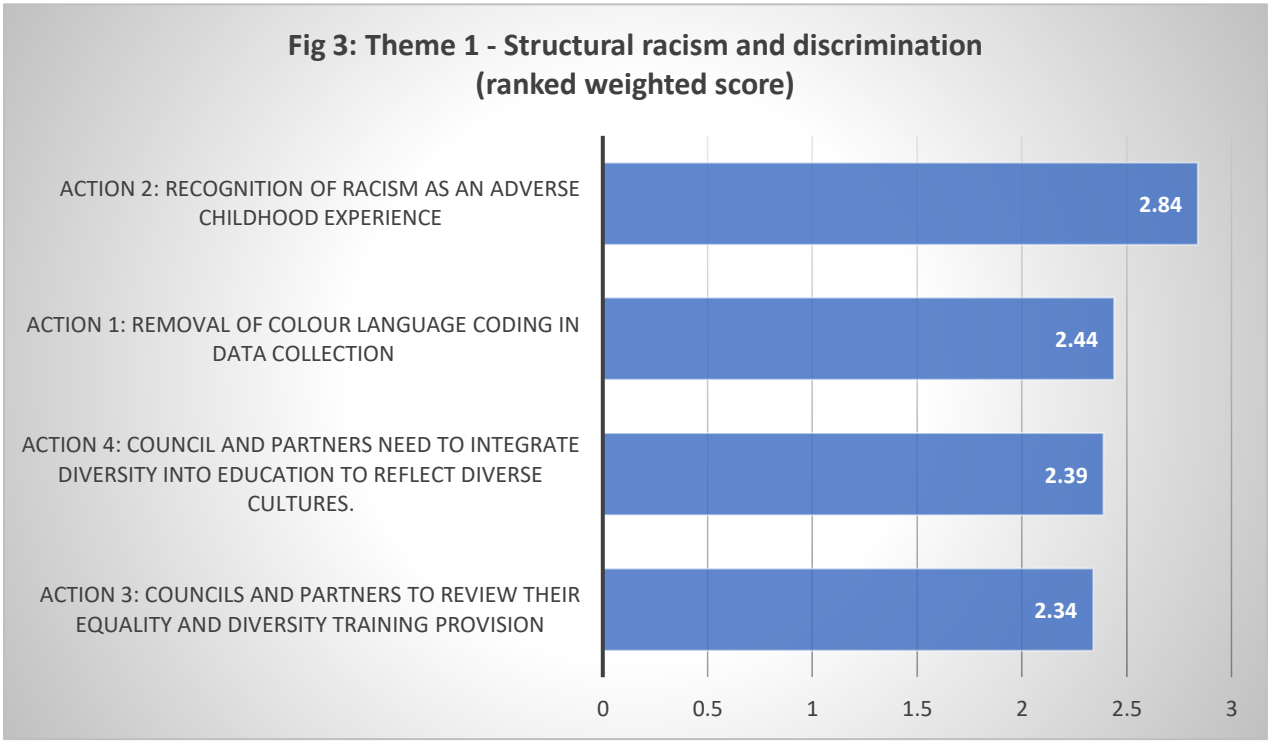
This observation was borne out through comments as:

"*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).

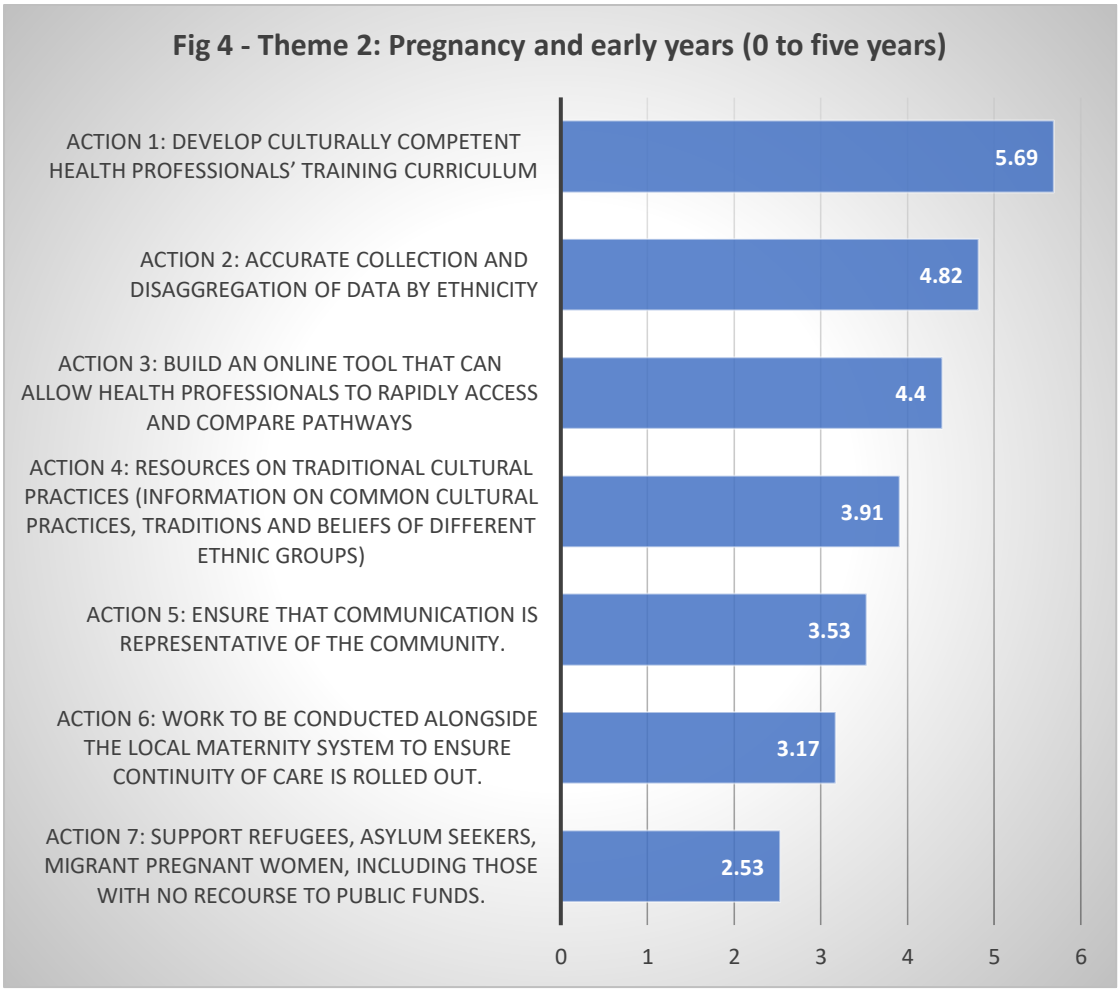
Theme 2 contained seven 'Action' imperatives that were explored with respondents, from which the top three 'Actions' identified followed the order as outlined in the Opportunities for Action plan (Fig 4):

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.

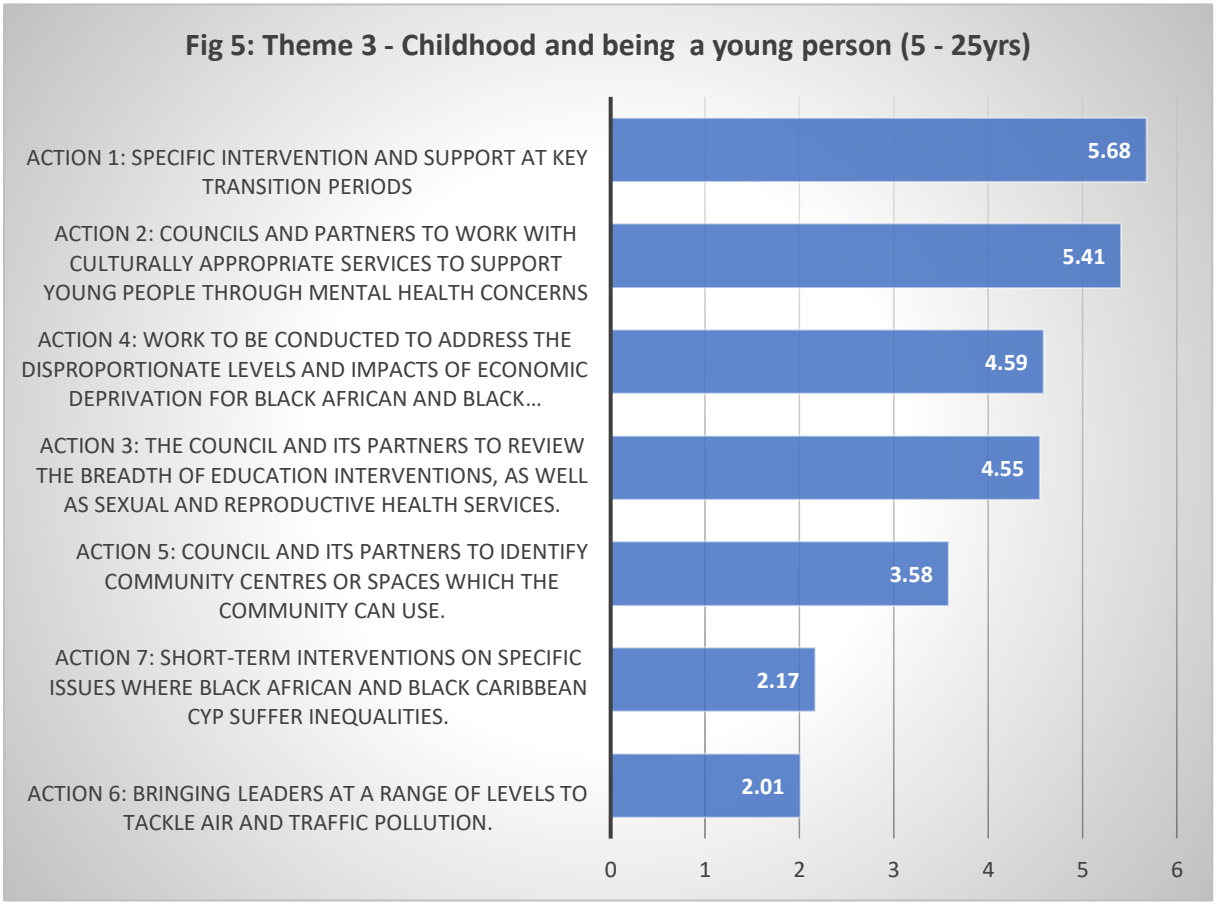
in Black African and Black Caribbean populations, including immunisation, CAMHS, and being registered with a dentist.

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]

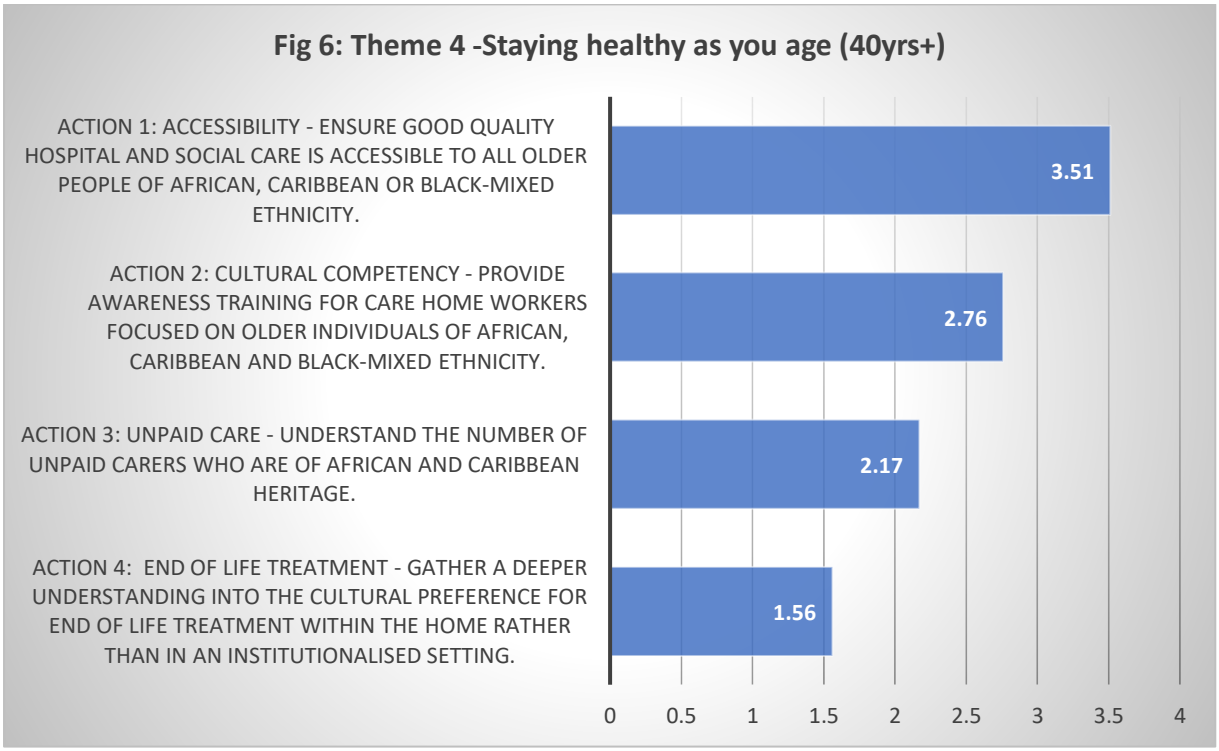
Theme 4: Staying healthy as you age (from 40 years of age and onwards)

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.



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:

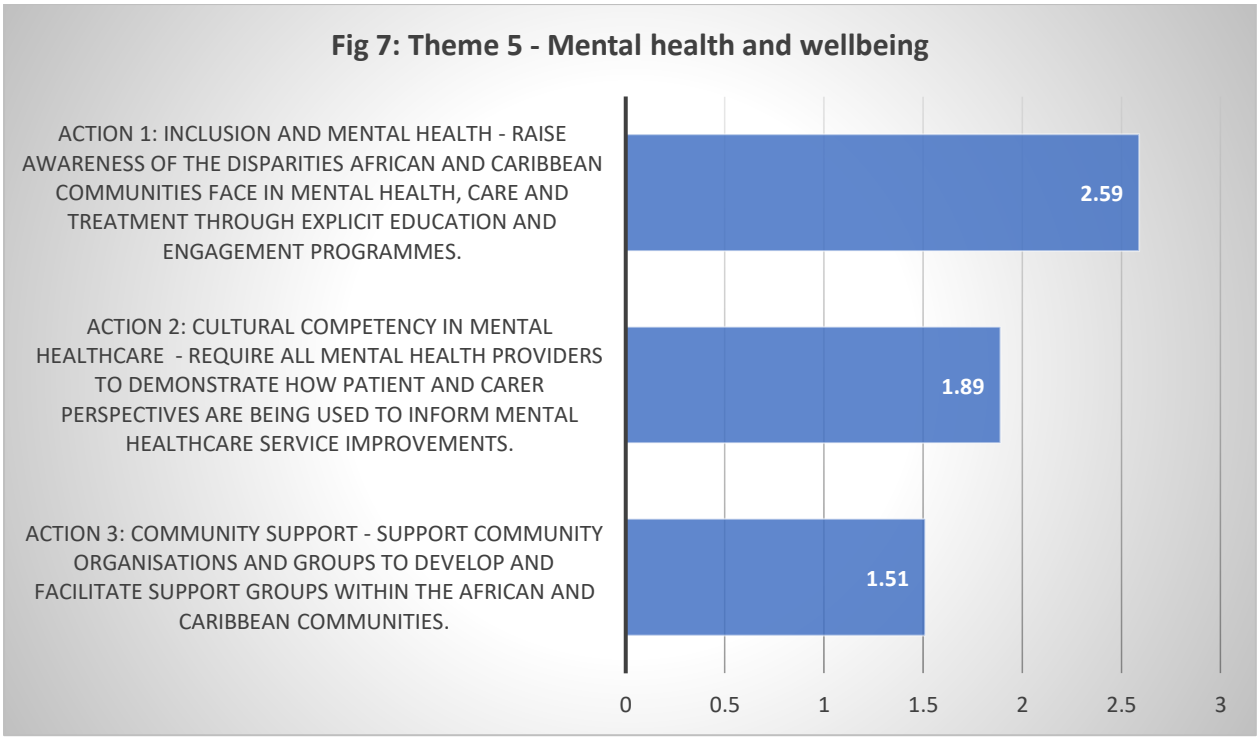
"All professionals undergo racism training and service users involved in ensuring policy and practice is adhered to." [Online respondent]

"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]

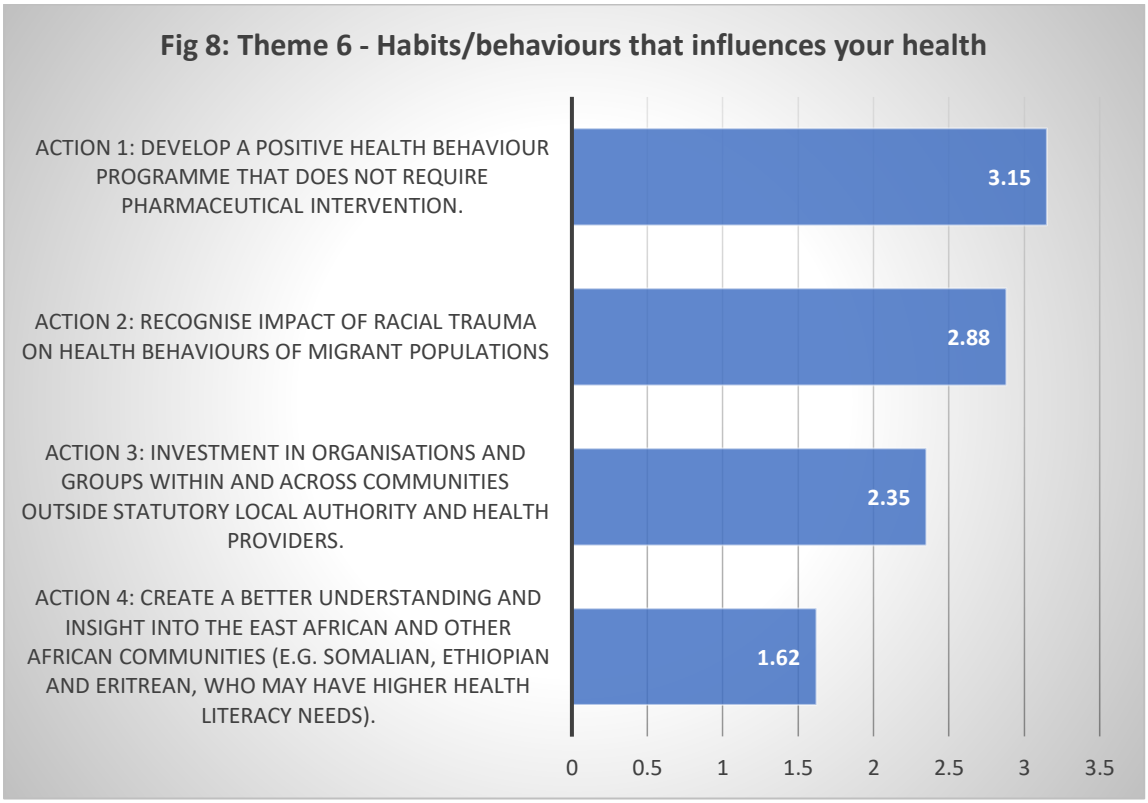
Healthcare professionals, they don't understand the black African culture backgrounds including personal life, taboos especially when it comes to mental health.



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]

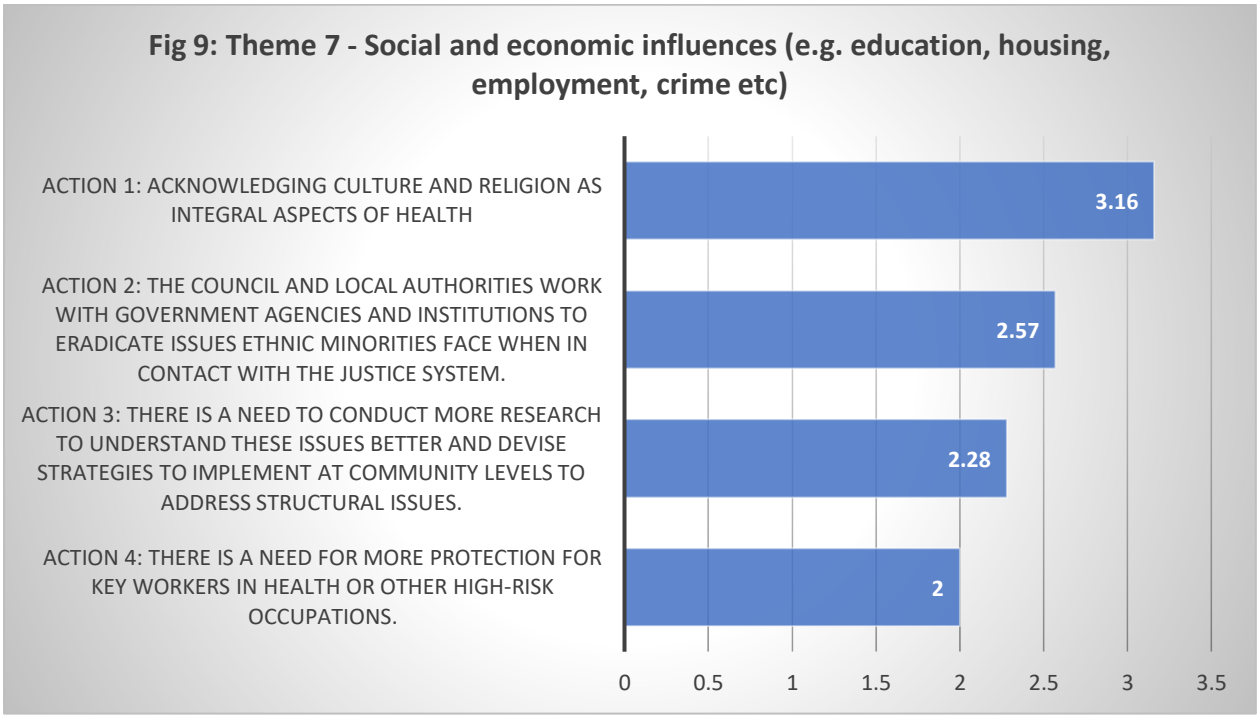
Theme 7: Social and economic influences (e.g. education, housing, employment, crime)

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.



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]

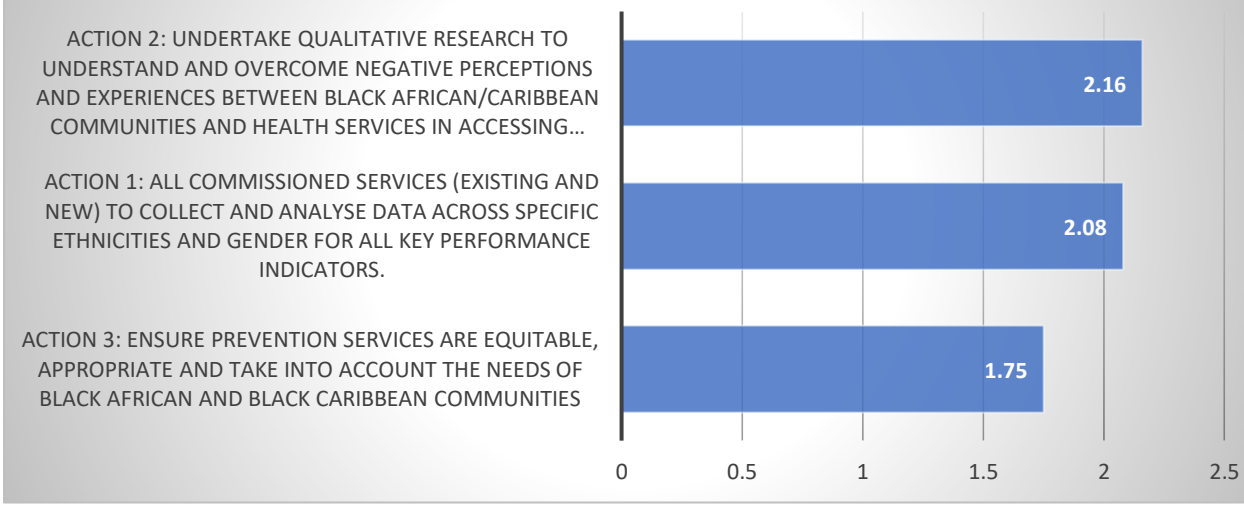
"*Ongoing leaks, can't get through to the repairs line; I am getting no response to online reporting - weeks later still nothing. I live in a high rise flat with people always sitting in the stairwell on the ground floor. It's not a good condition."* [Focus group respondent]

"… 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."

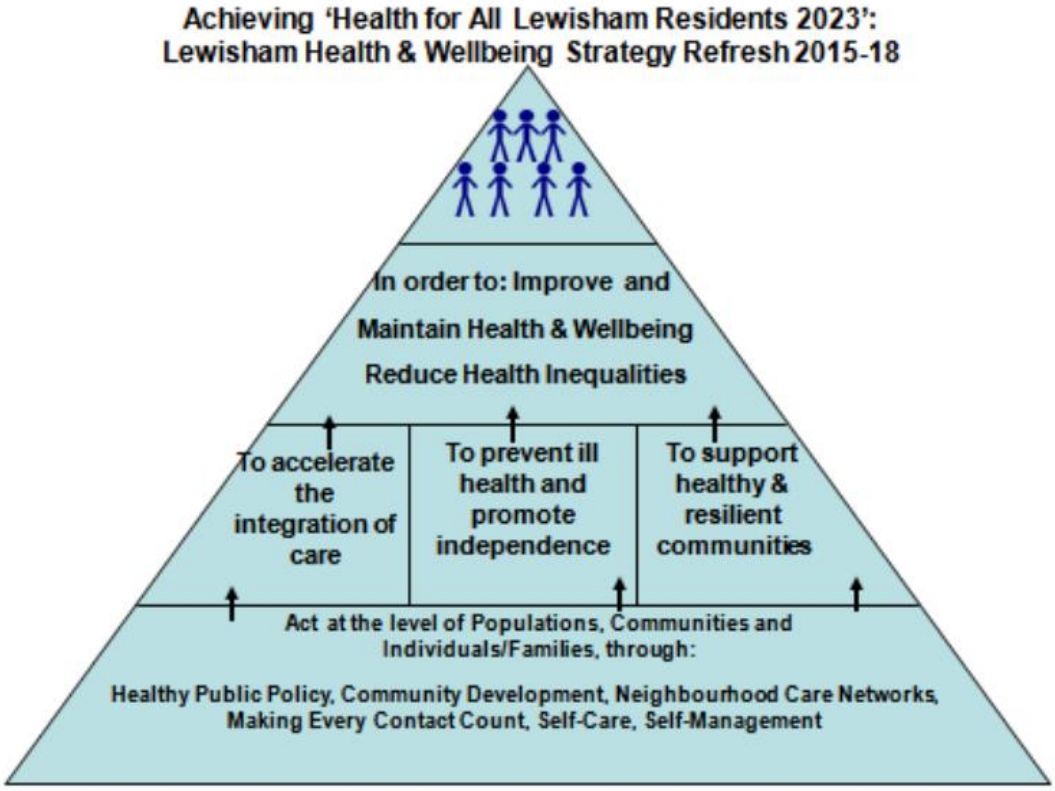
The general view was that it is not safe in the borough with people feeling scared and unsafe, even though from their own admission, *"it's not worse but bad enough.*" Stabbing and violence definitely make the area unsafe, and this is affecting some young people from going out and leaving their home. 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.

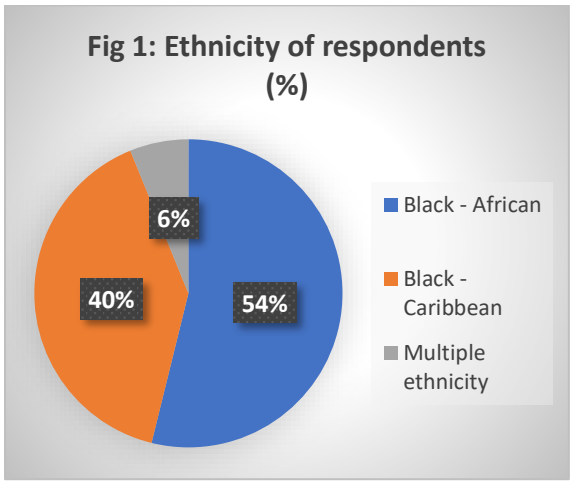
The final word of one of the participants perhaps places the challenge in the clearest perspective:

"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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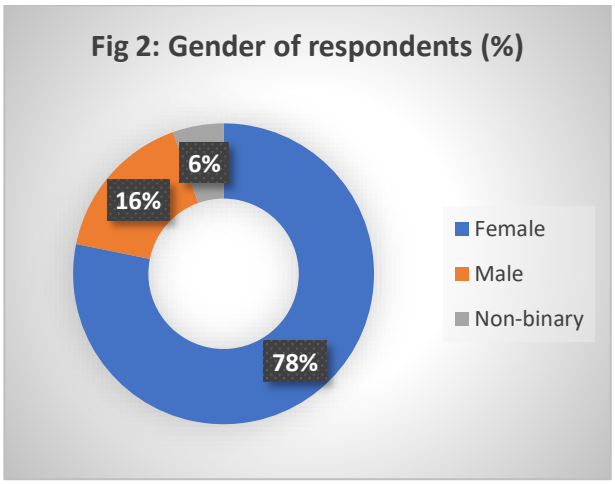

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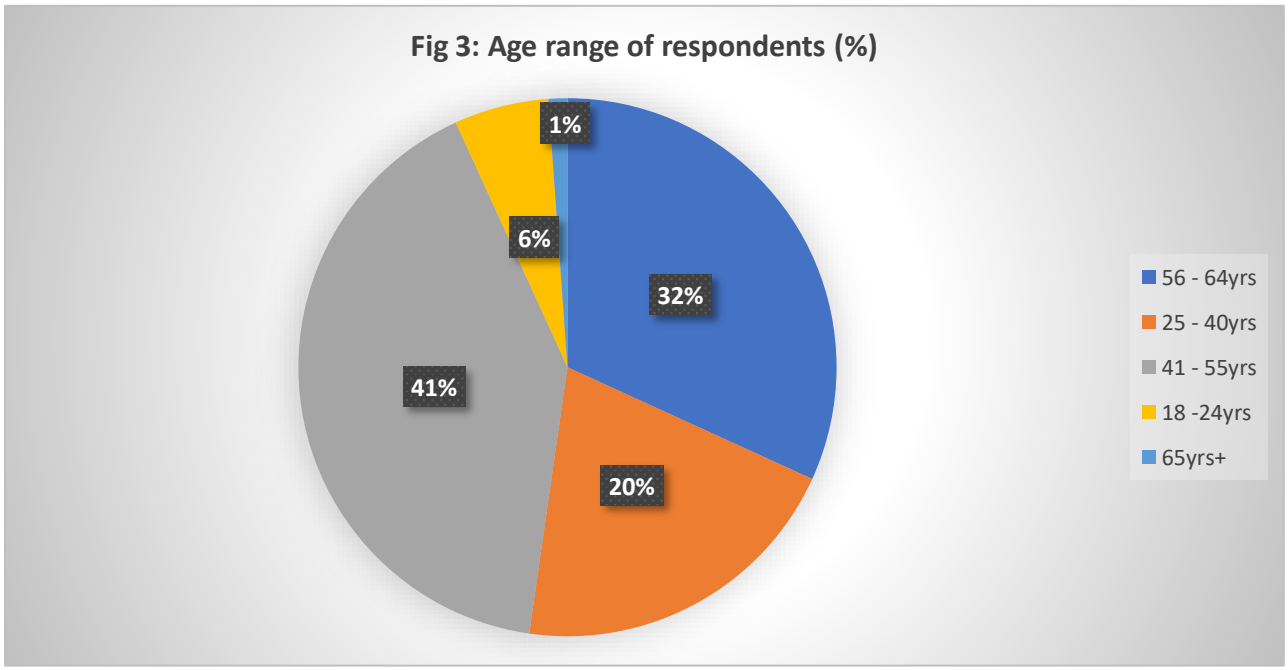

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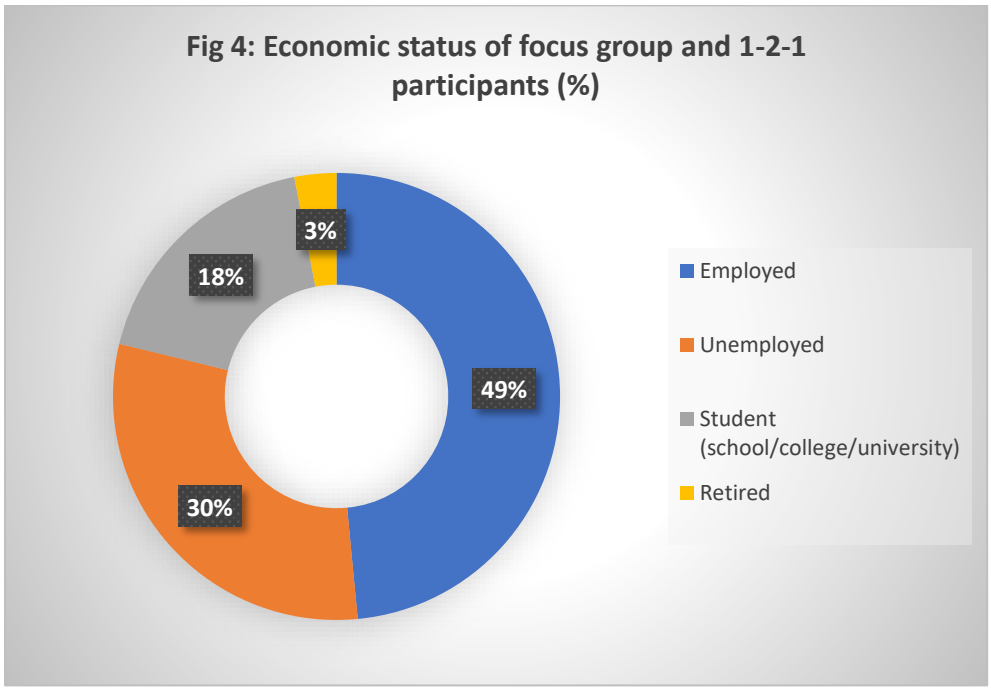

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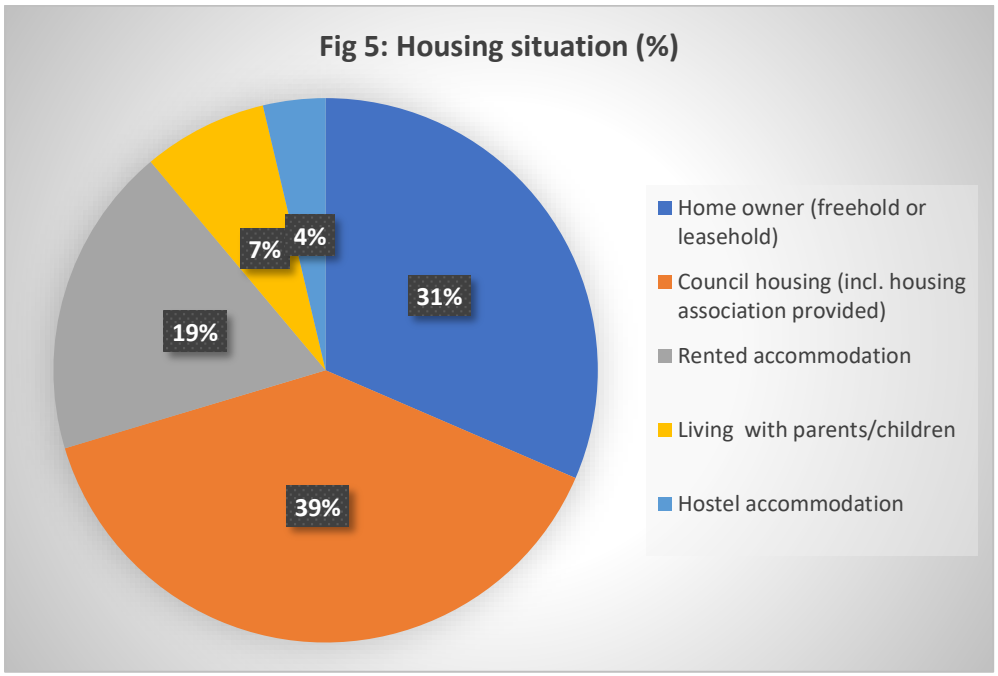

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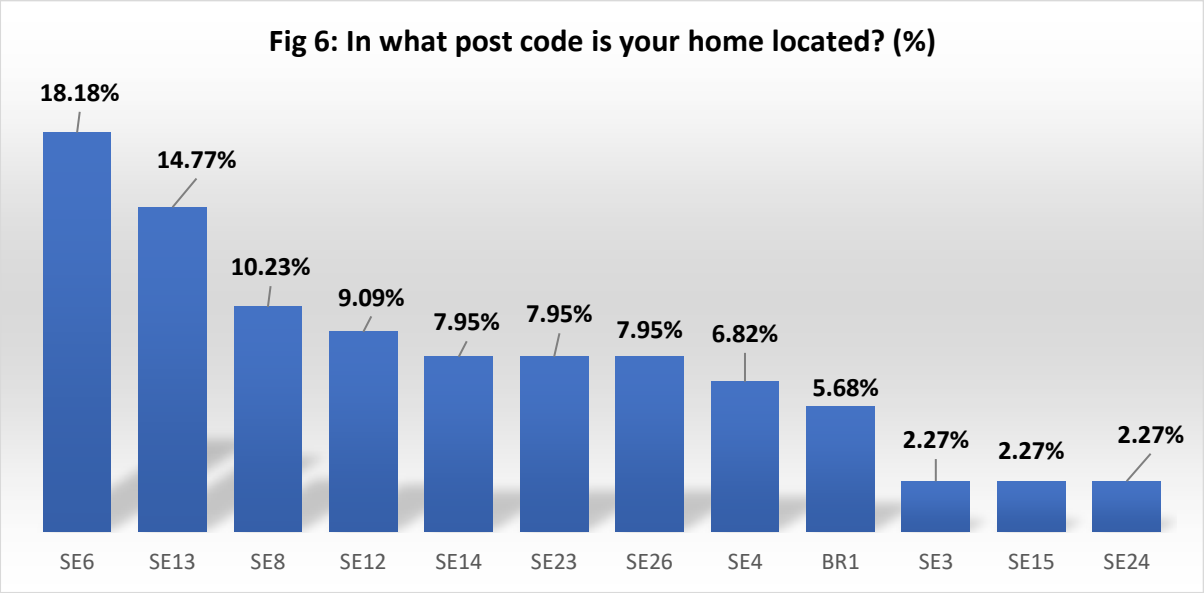

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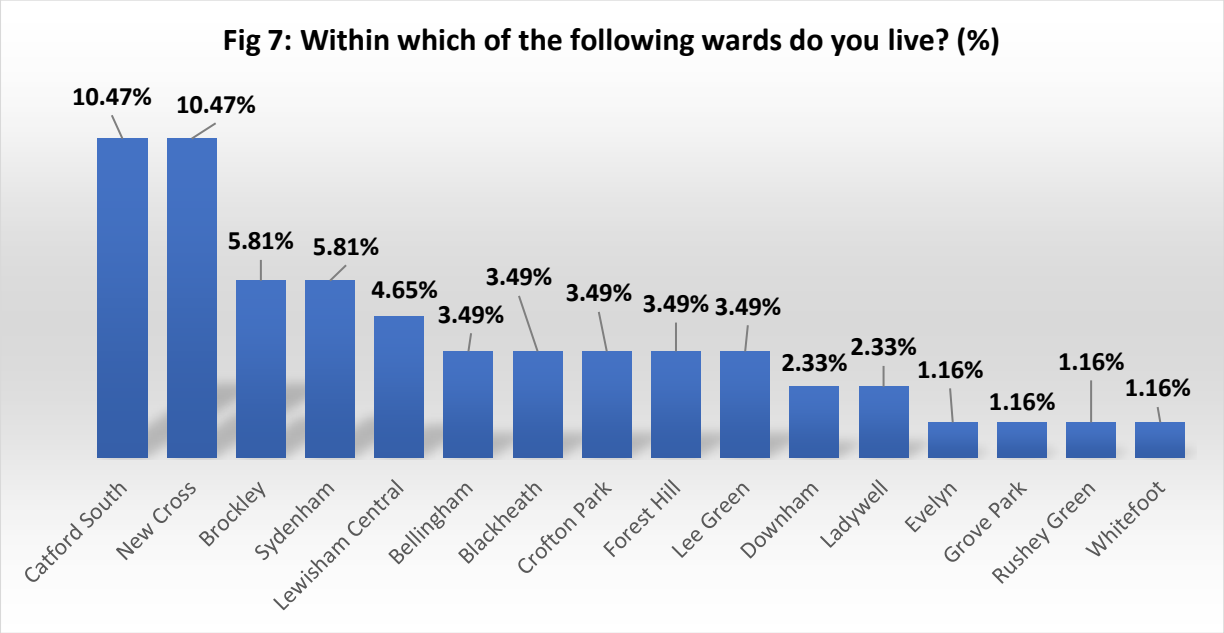

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Appendix 2: Overview of the organisations involved on the project

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)

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Lewisham Health Inequalities and Health Equity Programme 2022-24

Dr Catherine Mbema
Director of Public Health, Lewisham Council

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:

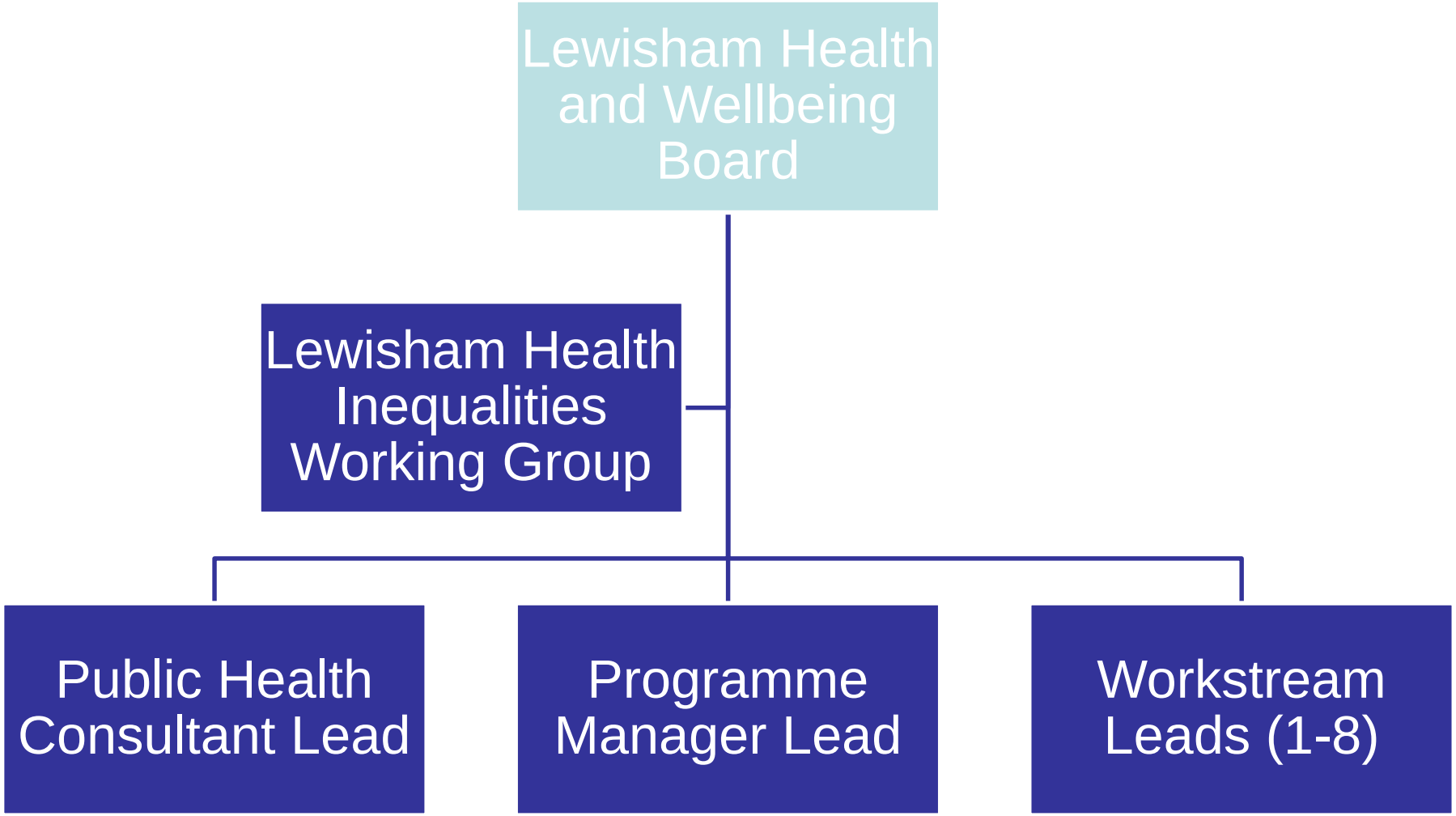
Timescale:

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

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

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Healthier Communities Select Committee

Transitions from Children's to Adult Social Care Services.

Date: 07/09/2022

Key decision: No.

Class: Part 1

Ward(s) affected: All

Contributors: Director of Education Services / Operations Director for Adult Social Care

Outline and recommendations

Member are asked to note the contents of the report.

This report provides Members of the Healthier Communities Select Committee with an update on supporting young people with special educational needs and/or disabilities (SEND) aged between 14 and 25 years to prepare for adulthood, since the previous report to the Committee in December 2017.

It recommends continuation of the implementation of the work proposed under the Learning Disabilities (LD) Preparing for Adulthood Transitions Strategy and a recommendation to expand the LD Transitions Strategy to other key cohorts within Children's Services, notably Children Leaving Care, Young People transitioning from Children's to Adults with Mental Health (AMH) Service involvement and Young People transitioning from youth offending services.

Timeline of engagement and decision-making

6th December 2017 – Report to HCSC: Transition from Children's to Adult Services

March 2017 – Report to HCSC: Transition from Children's to Adult Services.

1. Summary

1.1. This report provides Members of the Healthier Communities Select Committee with an update on supporting young people with SEND aged between 14 and 25 years to prepare for adulthood, since the previous report to the Committee in December 2017.

1.2. It also summaries transitions work across other cohort notably care leavers and young people with mental health issues.

1.3. It recommends continuation of the implementation of the work proposed under the LD Preparing for Adulthood Transitions Strategy and a recommendation to expand the LD Transitions Strategy to other key cohorts within Children's Services, notably Children Leaving Care, Young People transitioning from Children's to AMH Service involvement and Young People transitioning from youth offending services.

2. Recommendations

2.1. Members of the Healthier Communities Select Committee are asked to note the contents of the report.

2.2. It recommends continuation of the implementation of the work proposed under the LD Preparing for Adulthood Transitions Strategy and a recommendation to expand the LD Transitions Strategy to other key cohorts within Children's Services, notably Children Leaving Care, Young People transitioning from Children's to AMH Services and Young People transitioning to from youth offending services.

3. Policy Context

3.1. Transition to Adulthood for young people with a Learning Disability is covered by legislation under the Care Act 2014 and Children & Families Act 2014 and is supported by NICE Guidelines (NG43) 2016, in terms of how to fulfil those duties.

3.2. **Part 1** of the **Care Act**, prioritises individual wellbeing for adults with care and support needs over the age of 18, with a particular focus on person centred practice and outcomes, putting people in control of their care and support. Preparation for Adulthood (PfA) is a key element of the reforms and focuses on:

- Education and employment
- Good Health
- Independent living
- Friends, relationships and community

3.3. **Part 3** of the **Children and Families Act** transformed the system for disabled children and young people and those with SEND, so that services consistently support the best outcomes for them. The reforms created a system from birth to 25 through the development of a coordinated assessment and a single Education, Health And Care (EHC) Plan; improving cooperation between all services responsible for providing education, health or social care; and giving parents and young people greater choice and control over their support.

3.4. The SEND reforms focused on the following themes:

- Working towards clearly defined outcomes
- Engagement and participation of parents and young people
- Joint Commissioning and developing a Local Offer of support
- Coordinated assessments and EHC Plans
- Personalisation and personal budgets

3.5. The Local area SEND inspection framework was published in Spring 2016. Ofsted and the Care Quality Commission (CQC) jointly inspect local areas to see how well they fulfil their responsibilities for children and young people with SEND. The local

area inspection judges the effectiveness of Lewisham in implementing disability and special educational reforms, including duties to prepare young people with SEND for adulthood.

3.6. On 29 March 2022 the Government published the SEND Review: Right support, right place, right time, a consultation on the SEND and alternative provision system in England. Since 2014 demand for SEND support has increased year-on-year and there are now over 430,000 children and young people with an EHC Plan in England, an increase of 10 per cent or 40,000 in the last year alone.

3.7. The increased scope of council responsibilities post-16 was the most cited factor contributing to rising demand and costs for councils. Local Government Association (LGA) commissioned research shows that the post-16 cohort now accounts for 23 percent of EHC Plans and around 17 percent of spending.

3.8. The consultation proposed a number of improvements relating to transition:

- Invest £18 million, over the next 3 years to build capacity in the supported internships programme
- Improve transition at further education by introducing common transfer files alongside piloting the roll out of adjustment passports to ensure young people with SEND are prepared for employment and higher education.
- Introduce a new inclusion dashboard for 0 to 25 provision giving a timely, transparent picture of how the system is performing at a local and national level across education, health and care.

3.9. The **Children and Social Work Act 2017**, for a child or young person that comes into the care of the local authority, or is under 25 and was looked-after by the authority for at least 13 weeks after their 14th birthday, states that the authority becomes their corporate parent. Included within this legislation are the requirements to:

- Make sure children and young people are safe, with stable home lives, relationships and education or work
- Promote high aspirations and try to secure the best outcomes for them
- Prepare them for adulthood and independent living.

4. Background

Young people with learning disabilities

4.1. In 2019, LBL appointed a Programme Manager to develop and define a cross agency Preparing for Adulthood Transition strategy for young people with more complex needs underpinned by the principles of:

- Reducing inequality - narrowing the gap in outcomes for young people with complex needs
- Improving the quality of services - Young people should get the best possible start in their adult life by ensuring that they are adequately prepared, supported and informed.
- Delivering together efficiently and effectively – Costs are minimised by working together to avoid more costly placements and crisis entry to the adult care system in future and value for money is enhanced by ensuring that working practices are efficient and duplication and gaps are avoided.
- Complying with Legislation and following best practice – Transition to Adulthood is covered by legislation under the Care Act 2014 and Children & Families Act 2014 and is supported by NICE Guidelines (NG43) 2016, in terms of how to fulfil those duties.

This strategy outlined a vision, the intended outcomes, key priorities and indicators to provide a framework for all services in Lewisham working with children, young people and their families with SEND, who are Preparing for Adulthood and applied to the transition from childhood to adulthood, usually commencing at the age of 14 or in school year 9, specifically for those young people who are currently supported within the Children with Complex Needs (CWCN) Team:

- Having an EHC Plan
- Requiring SEN support via the SEND Code of Practice (CoP).

We took an iterative service design approach to developing this strategy ensuring that it was user centric, co-created and holistic. We benchmarked best practice preparing for adulthood approaches with sector specific organisations e.g. National Development Team for Inclusion (NDTI) PFA and other Local Councils, audited Transition Support plans and EHC Plans, conducted 1:1 interviews and focus groups with young people, parents and carers including an on-line People's Parliament in partnership with Lewisham Speaking Up (LSU) and Lewisham College and held a number of multi-agency co-production events for professionals and those with lived experience across Lewisham Council, NHS, Private and third sector organisations and parent/carer representatives.

4.3. Following this engagement, we agreed that 'We will work in partnership to create opportunities and deliver pathways to adulthood that enable and support young people to lead fulfilling, unique, inclusive and empowered lives within their communities'. These pathways include:

- Independent living, where young people have choice, control and freedom over their lives and the support they receive, including their accommodation and living arrangements
- Sustainable and meaningful employment, including pathways through higher or further education.
- Community Inclusion, including having friends and supportive relationships, and participating and contributing to the local community.
- Health & Wellbeing, being as mentally and physically healthy as possible in adult life.

Young people leaving care

4.4. Lewisham is a signatory member of the Care Leaver Covenant and has high aspirations for our care experienced young people. The dedicated Care Leaver and UASC Service, created in spring 2019 has been continuing to establish itself and this has enabled us to deliver improvements in all aspects of key performance for our service. We ensure that Care Leavers:

- Are better prepared and supported to live independently.
- Have improved access to education, employment and training.
- Experience stability in their lives and feel safe and secure.
- Have improved access to health and emotional support.
- Achieve financial stability.

5. Preparing for LD Adulthood/Transitions Update

To support the delivery of this strategy, a cross Council Steering Group has been monitoring progress and a number of workstreams have been established:

5.1. Developing Employment Pathways

We want every young person to feel inspired and prepared for the world of work. For children and young people with complex needs finding a job can pose unique demands and challenges. Research shows that the majority of young people with SEND are capable of getting paid employment, with the right preparation and support However, the unemployment rate for people with disabilities (43%) is nearly three times more than for those without (15%). To support young people to be prepared for employment and to increase employment opportunities in the borough we have:

- Launched a new Supported internship within Lewisham Council, in partnership with Lewisham College to go live in Sept 2022.
- Produced a new Careers Advice for Young People with SEND Best Practice Guidance document for education providers.
- Recruited an Employment Development Apprentice within Adult Learning Lewisham (ALL) to develop employment partnerships and create better links between the college and local employers
- Set up an external provider group to deliver a proposal to bid for UCIL funds to pilot supported internship in the Ladywell Canteen. Initial meetings held with LSU, Ignition Brewery, Mencap and The Three Cs to discuss partnership options. Given the limited funds available we conclude that it was not appropriate to bid, but that network of interested providers remains in place.
- Worked in partnership with Ignition Brewery to launch an ice cream business, Ignition Ice (Ice Cream), run by people with LD to prove the concept. Working out of Ladywell Centre, Ignition Brewery have purchased our equipment and have been working with young people who have LD on product design. They are currently employing two people part time (sales and production) on the London Living Wage as part of the summer placement programme.
- ALL are delivering a supported employment pilot.
- Lewisham Works are now reviewing and supporting LD employment.
- Worked with the Employment Hub to bid for further funds in partnership with Lambeth. The application was unsuccessful, however, there are ongoing opportunities for partnership work around supported employment.
- Ignition Brewery have been in touch with local employers – including breweries – to assess the key skills gaps and requirements.
- Ignition Brewery have created a partnership with Watergate and Brent Knoll Schools to create a Christmas enterprise with students aged 16-18 years.
- Ignition Brewery have offered a paid work-experience placement to work at the brewery.

5.2. Progression and Demand Management

We need to ensure that we have the right services available to support the needs of young people. To do this we have engaged with a range of young people, parent(s)/carer(s), provider and staff to understand what the range of needs are and to quantify the levels of demand for services in the future. This has included:

- Working across multiple IT systems to create a single view of potential demand.
- Modelling and forecasting different housing and accommodation requirements in the future and establishing where the timeline pinch points will be.
- Working with Adult Social Care (ASC) providers to create a progression planning approach to independence.
- Exploring opportunities to secure resource for specialist LD Occupational Therapist (OT) support to maximise impendence and progression opportunities.

5.3. Digital Inclusion

Digital Inclusion is critical if young people with LD are to have equal access to services and opportunities and to feel part of the community. To understand the issues and look at how to address a multi provider/agency Digital Inclusion Working Group was set up which over the course of a number of workshops agreed what the key issues were and proposed a number of actions and worked together to trial a digital inclusion tool for people with a LD. This was superseded by a Scrutiny committee being set up to review digital inclusion with a report published in June 2022 and actions agreed in February 2022.

5.4. Development of Youth Services

We have developed a number of youth specific services including:

- Reviewing the specification for Youth First services.
- Exploring the expansion of Rockbourne to support 18 to 25 year olds.
- Lewisham Mencap and Ignition Brewery have created a Wednesday Social Club which, first, identifies young people with learning disabilities and second, has begun to focus on employment.
- The Council has been developing a service consisting of 6 self-contained flats service for young people who are returning to the borough with significant levels of challenging behaviour.
- The Council is in the process of reshaping two other services in borough that will offer shared care and support: the first for four young people with a mild or borderline learning disability who need a longer period of time to learn more socially acceptable behaviour alongside new skills of daily living and who will them move onto other settings as part of the progression agenda; and the second to offer a shared living opportunity for four people with more severe learning disability and challenging behaviour who will need ongoing higher levels of support, but who may over time also move onto lower supported settings.
- LBL is embarking on plans to establish Family Hubs in the borough, which will improve access to services and deliver the fundamental support to families in Lewisham. The vision for Family Hubs is to create a system-wide model of integrated, high-quality, whole-family support services. Family Hubs will be open, accessible, physical and virtual single points of contact, that are welcoming to families, children and young people from pregnancy up to the age of 25. Family Hubs will host multi-agency support services that have been co-operatively designed and developed, and that operate across a shared culture and common language. LBL has also been selected to receive new investment from central Government, known as the ‘Start for Life Programme’, which will support LB Lewisham to transform local services into a Family Hub model by 2025, and increase provision of essential services in the crucial period from conception to age two.

5.5. New PFA Transitions Pathway Guide

Engagement with young people, parent(s)/carer(s) and professionals highlighted that the transition pathway was complex, confusing and not well documented. We worked across multiple departments including ASC, Occupational Therapy, Education, children and adolescent mental health services (CAMHS) etc. to create a new pathway document which was then tested with young people to ensure that it was written in a user friendly format. This document will be published and available on the web site imminently.

5.6. PFA Goal Setting and Planning Training

An audit of EHC Plans in 2019 demonstrated that the majority of EHC Plans did not have clear goals and outcomes around the four PFA pathways. We have benchmarked best practice planning tools and co-created a new planning document and training programme for schools. The training has been piloted and reviewed ready for roll out in September 2022, following delays due to COVID. We will re-audit EHC Plans following the full roll out and allowing for the new ways of working to be embedded.

5.7. Transitions Team Development

It was our intention to create a new Transitions Team within ASC supporting young people from 14 to 25 yeaa. Budgets were pooled between ASC and CWCN and new job descriptions written, graded and approved. However, multiple recruitment attempts did not allow us to completely resource the team. To reflect the resourcing difficulties, we are now trailing an 'in-reach' approach, initially working with 5 cases with ASC workers working closely with the CWCN social workers to transition them effectively. Current not all young people transitioning into ASC go into the transition team, some transition through AMH and ASC Neighbourhoods Teams, We will be reviewing learning s before recommending next steps, including whether to include those on the Dynamic Support Registers (DSR) client list. For the remainder we hold regular Multi-Disciplinary Teams (MDTs) and are now looking to include CAMHS/AMH and DSR cases within those MDTs.

5.8. Day Centre Strategy and New Pathway Delivery

Following extensive engagement, a new Day Centre Strategy was proposed and agreed which focused on developing wellbeing and independence pathways, alongside employment pathways. To support the development of these new pathways we developed a new curriculum/course with ALL, developed for those with LD attending day centres starting September 2021. Despite marketing and a taster day, there was no take-up, highlighting the importance of building strength-based relationships with clients and carers to enable effective progression. We have now set up a dedicated progression team within ASC and will use the learnings from that team to expand to transitions clients.

6. Corporate Parenting Care Leavers Update

6.1. We published our Corporate Strategy in 2021 and have been delivering improvements for care levers to improve transitions to adulthood, including:

- Creation of a dedicated Care Leavers Service, expanded with more Personal Advisors. Pathway Plans re-designed with young people in our CICC, so they had more meaning for the young person.
- Engagement in the I-Aspire programme which 3 neighbouring boroughs.
- Housing Protocol, to improve supported housing pathways and access to suitable accommodation.
- Lewisham has a new Specialist Nurse for Leaving Care, as part of a one-year initiative funded by SLaM and LB Lewisham. The Specialist Nurse will work with young adults Leaving Care to undertake a holistic assessment of health and wellbeing needs, help them navigate the services to meet these needs, and enable them to self-manage their health care.
- Development of a Transitions Service, for those with complex needs.
- Financial Entitlement Policy introduced to provide clarity on available financial support and equity.

- Lewisham works closely with Depaul, 145 of our care leavers are enrolled on the I-Aspire programme. Despite the challenges of COVID there have been some good outcomes achieved: 55 young people entered employment and/or training, 27 completed qualifications and/or entered higher education. 57% of our Care Leavers are in EET an improvement on previous years, and comparable with other LA's but still below our aspirational target of >80%.
- There remains a recognised gap in dedicated health and wellbeing support for YP leaving care. Online counselling services were extended up to 25 years olds in 2021, but where the care of specialist services ends at age 18, there are insufficient transitional arrangements into adult services. The connectivity between children and adult services is a key priority.92% of our care leavers are living in suitable accommodation, an increase of 21% since 2018 and a project this year has been successfully expanding the continuum of housing options for our care leavers, including staying put and supported lodgings options. We want to further improve our pathway planning and better tailor support for young to be confidently and successfully independent.

7. Other Young People Developments

7.1. LDA Programme and Transition

- The Learning Disability and Autism (LDA) Programme, is how we now refer to the Transforming Care agenda that grew out of the Concordat that followed the Winterbourne View scandal. Alongside other best practice guidance for the development of services for people with a learning disability (e.g. the Mansell reports (1993, 2007)) the programme seeks to improve health and care services better so that more people with a learning disability, autism or both can live in the community, with the right support, and close to home.
- In order to achieve this it is important that each local area understands the needs of people with a learning disability, autism or both who are likely to need additional support. A key part of the programme is the avoidance of inappropriate admissions to mental health hospitals.
- There is a requirement for each Local Authority to develop and maintain DSR, to identify children and adults with a learning disability, autism or both who engage in behaviours that are so challenging or risky, or who have acute mental health presentations, that they are at high risk of hospital admission.
- Where a person is so assessed they will be offered a Care, (Education) and Treatment Review (CETR), to ensure they are safe, receiving the treatment and care they need in the right place, and to consider what plans need to be put in place to support them in the future. By understanding people's needs and recognising early signs that might lead to a crisis, it means that extra support can be put in place quickly.
- Within Lewisham, we operate two separate DSR registers - one for children up to their eighteenth birthday and one for adults aged 18 and above. The children's DSR is monitored on a monthly basis by a panel of professionals from education, health and social care, as well as representatives from Positive Behaviour Service Consultancy and 'Select' - a South East London ICS initiative, who provide support to children and their families to help avoid hospital admission. Together they review cases to assess risk and actions to be taken to avoid admission to hospital.
- The adult DSR is monitored very two months by LD and AMH commissioners, relevant case managers, Social Work leads and CETR Chairs who work together to resolve any problems or issues that are inhibiting people's treatment as an inpatient and/or to coordinate multidisciplinary approaches to care to avoid admission. The Adult DSR meeting also reviews those young people on the Children's DSR from their seventeenth birthday onwards who are likely to transition

to the adults register. A CYP commissioner attends that part of the Adult DSR meeting to support transition planning and ensure continuity of service provision and/ or identification of the appropriate clinical team(s) in adult services.

7.2. There are two new roles in AMH and CAMHS to support young people from the age of 17 years and 9 months. A Psychosis transition role for EIS and >3year psychosis intervention and a Child and Adolescent to Adult Mental Health Transitions Practitioner.

7.3. The Positive Behaviour Service (PBS) services is currently being re-commissioned and will go live on 1st November 2022. The service is being extended to provide support for those with a learning disability, autism and a mental health concern up to the age of 25, in order to prevent admission to hospital or assist in enabling discharge from hospital. The service aims to support children, young people and young adults with challenging behaviour, so they can continue to live in the community.

7.4. There is commitment from across the system leaders for exploring the development of a system-wide approach to the development of a Single Point of Access. This will seek to bring services together through the use of the Thrive needs-based Framework so that the service offer is easier to navigate for children, their families and professionals, helping to ensure that people can access the right support at the right time to promote early intervention and prevention.

7.5. There is ongoing work to develop the transitions and PFA area of the Local Offer.

8. Financial implications

8.1. Supporting young people to maximise their independence will reduce the need for high cost and long term packages of care. ASC does not have a budgeted expenditure for Adults with Learning Disabilities (AWLD) Transitions so minimising costs, reduces the potential cost exposure to the ASC budget. The total exposure in 2021/22 is an estimated at around £2m.

8.2. The investment into Children and Young People Mental Health (across all areas) increased to £8,002m in 21/22. This has further increased this financial year (2022/23) due to investment from South London and Maudsley NHS Foundation Trust (SLaM) into the GP Youth Led Pilot and the Care Leavers Nurse (both supporting young people up to 25 years); NHSE investment into the further expansion of MHSTs and the ICB investment into supporting school based provision. In 2021/22, SEL ICB allocation in the borough for adult mental health is £64,982,000. London Borough of Lewisham contributes an additional 11%. NHSE has also allocated for 2021/22 £1,300,000 in Service Development funding for Lewisham, to be spent on adult community and crisis mental health services, suicide prevention and staff hubs. NHSE has also allocated a total of £1,403,000 of Spending Review Funding to Lewisham to bring forward the Long Term Plan deliverables in the borough.

9. Legal implications

9.1. The Care Act 2014 created a new structure for the assessment and provision of care services, encompassing a new approach (also provided for in the Children and Families Act 2014) for child carers and providing for more continuity through the transition, if eligible, of a young person from children's to adult services. There are also new general duties to promote the wellbeing of the individual in the community, and to prevent the need for escalating care and support, by the provision of signposting to relevant services, information and, when considering the delivery of many universal services

across the Borough, whether as part of our duties as the Local Authority or in conjunction with Health and other services.

9.2. The particular paragraphs relevant to the transition from children's to adult services are found at paragraphs 58-66. The Local Authority must undertake a Child in Need assessment following a request from a parent / carer of a child. Having completed an assessment, where it appears that the young person is likely to have the same needs at 18 the authority may assess:

- What the young person's needs for care and support are, and
- What they are likely to be when they become 18.

9.3. S17 Children Act 1989 is amended by s66 Care Act and there is a requirement to continue s17 services past 18 until a Care Act assessment is completed. There is a similar provision for CSDPA1970 s2 services.

9.4. There are wider duties imposed by the Care Act towards young people with whom the Local Authority are not necessarily directly engaged, for example, young people receiving CAMHS support, involved with Youth Justice, or those with Autism hitherto within the education service only. If there is a significant benefit of such a young person receiving a transition plan then there is a duty to prepare one. It is therefore important to identify such young people and to determine whether a plan would be in their interests.

10. Equalities implications

10.1. The actions and proposals in this report would not unlawfully discrimination against any protected characteristics but would positively promote equality of opportunity for children and young people with special educational needs and disabilities.

11. Climate change and environmental implications

11.1. There are no specific environmental implications arising from this report.

12. Crime and disorder implications

12.1. There are no specific crime and disorder implications arising from this report.

13. Health and wellbeing implications

13.1. The actions and proposals would positively promote health and wellbeing through promoting independence and improving opportunities for children and young people with special educational needs and disabilities.

14. Social Value implications [to be completed only when awarding a contract]

14.1. N/A.

15. Background papers

15.1. LD Transitions Strategy Proposal Document.

15.2. Day Centre Strategy.

15.3. Digital Inclusion Paper and response.

15.4. Lewisham Children & Young People's Corporate Parenting Strategy 2021–24.

15.5. CYP and adults Mental Health Transition Roles Document.

15.6. Specialist Nurse for young adults Leaving Care aged 18+ Information Guide.

16. Report author and contact

16.1. Angela Scattergood, Director for Education; angela.scattergood@lewishm.gov.uk

16.2. Joan Hutton, Director of Operations Adult Social Care; joan.hutton@lewisham.gov.uk

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Healthier Communities Select Committee

Report title: Select Committee Work Programme Report

Date: 7 September 2022

Key decision: No.

Class: Part 1

Ward(s) affected: Not applicable

Contributors: Katie Wood, Scrutiny Manager

Outline and recommendations

This report gives committee members an opportunity to review the committee's work programme and make any modifications required.

The Committee is asked to:

- To review the work programme attached at Appendix B.
- To consider the items for the next meeting and specify the information required.
- To review the forward plan of key decisions at Appendix E to consider whether there are any items for further scrutiny.
- To review the attached examples of health and care data already regularly collected by officers (see appendices) and consider what data the committee might find useful to consider itself on a regular basis as part of a potential HCSC data dashboard.

Timeline of decision-making

Healthier Communities Work Programme 2022/23 – draft agreed on 21.06.22

Healthier Communities Work Programme 2022/23 – agreed by Business Panel on 19.07.22

1. Summary

1.1. The committee proposed a draft work programme at the beginning of the municipal year. This was considered alongside the draft work programmes of the other select committees and agreed by Business Panel on 19 July 2022.

1.2. The work programme should be reviewed at each meeting to take account of changing priorities.

2. Recommendations

2.1. The Committee is asked to:

- To review the work programme attached at Appendix B.
- Consider the items for the next meeting and specify what evidence is required, including being clear about the information the committee wishes to be included in officer reports.
- To review the forward plan of key decisions at Appendix E to consider whether there are any items for further scrutiny.
- To review the attached examples of health and care data already regularly collected by officers (see appendix and to be tabled at the meeting) and consider what data the committee might find useful to consider itself on a regular basis as part of a potential HCSC data dashboard.

3. Work Programming

3.1. When reviewing the work programme the Committee should consider the following:

3.2. The Committee's terms of reference (Appendix A). The Committee's areas of responsibility, include, but are not limited to:

- Adult social care
- Primary and secondary care
- Mental health
- Adult learning
- Leisure centres

The Committee has a key role in scrutinising the performance and supporting the development of the council's health and care-related strategies and policies. It also has a role in engaging and reflecting the views of residents in relation to health and care-related matters.

3.3. Whether any urgent issues have arisen that require scrutiny. If so, consider to the prioritisation process (Appendix C) and the Effective Scrutiny Guidelines (Appendix D)

3.4. Whether a committee meeting is the most effective forum for scrutinising the issue. For example, would a briefing be more appropriate?

3.5. Whether there is capacity to consider the item - could any work programme items be removed or rescheduled?

3.6. Whether the item links to the priorites set out in the Corporate Strategy for 2018-2022:

- *Open Lewisham* - Lewisham is a welcoming place of safety for all, where we celebrate the diversity that strengthens us.
- *Tackling the housing crisis* - Everyone has a decent home that is secure and affordable.

- *Giving children and young people the best start in life* - Every child has access to an outstanding and inspiring education, and is given the support they need to keep them safe, well and able to achieve their full potential.
- *Building an inclusive local economy* - Everyone can access high-quality job opportunities, with decent pay and security in our thriving and inclusive local economy.
- *Delivering and defending: health, social care and support* - Ensuring everyone receives the health, mental health, social care and support services they need.
- *Making Lewisham greener* - Everyone enjoys our green spaces, and benefits from a healthy environment as we work to protect and improve our local environment.
- *Building safer communities* - Every resident feels safe and secure living here as we work together towards a borough free from the fear of crime.

3.7 A new Corporate Strategy is currently in development, which will include a refreshed set of priorities and describe how the Council will address the social, economic and environmental challenges facing the borough up to 2026. Once this is in place, the Committee may wish to review its work programme in light of the new strategy.

3.8 The committee should also note and take into account the four strategic themes of the borough's Covid-19 recovery plan, Future Lewisham, which support what we want for every single resident and that we know are what we need to focus on locally: *An economically sound future; A healthy and well future; A greener future; and a future we all have a part in*.

4. Healthier Communities Select Committee dashboard – direction of travel

3.9 Committee members have previously expressed an interest in developing a dashboard of key data for the committee to monitor on a meeting-by-meeting basis, with the intention of keeping the committee informed of developing trends in key areas and to assist the committee's work in supporting the council's development of a Healthcare and Wellbeing Charter.

3.10 As part of scoping a potential dashboard for the committee, last month the Chair engaged with officers from adult social care, public health, secondary care and Lewisham Health and Care Partners in order to discuss what data is already regularly collated by officers in other areas (such as care at home and mental health), what other dashboards are already in development and what additional data the committee might need.

3.11 At this meeting it was suggested that the next steps would be for the committee to consider some examples of the data already collated in other areas (see Appendix and further examples to be tabled at the meeting) in order to have an informed discussion about the areas it would like to focus on to support its work.

4 The next meeting

4.1. The following items are scheduled for the next meeting. For each item, the Committee should clearly define the information and analysis it wishes to see in officer reports. If the Committee has designated one of its members as a climate change champion, that member should work with the Chair to ensure that officers are given appropriate steers in relation to the reports, to ensure they include relevant climate change considerations.

4.2. The Committee should also consider whether to invite any expert witnesses to provide evidence, and whether site visits or enagement would assist the the effective scrutiny of the item.

Agenda Item	Information and analysis required	Review type	Corporate Priority
Budget cuts proposals		Standard item	CP5
Proud to Care update		Standard item	CP5

5. Scrutiny between meetings

5.1. Below is a tracker of scrutiny activity, including briefings, visits and engagement, that has taken place outside of the committee meetings.

Agenda Item	Date due	Outcome	Corporate Priority
Improving Downham Health through Sport, leisure and nature	29th June 2022	Engagement with local PCN and other stakeholders on potential public health initiatives in the area.	CP5
South East London ICS launch event for JHOSC members	5th July 2022	Engagement with key contacts in SEL ICS on the role of scrutiny in the new health structure.	CP5
Key data for HCSC	15th August 2022	Engagement with key officers in health and care about data already being monitored.	CP5

6. Referrals

6.1. Below is a tracker of the referrals the committee has made in this municipal year.

Referral title	Date of referral	Date considered by Mayor & Cabinet	Response due at Mayor & Cabinet	Response due at committee

7. Financial implications

7.1. There are no direct financial implications arising from the implementation of the recommendations in this report. Items on the Committee's work programme will have financial implications and these will need to be considered as part of the reports on those items.

8. Legal implications

8.1. In accordance with the Council's Constitution, all scrutiny select committees must devise and submit a work programme to the Business Panel at the start of each municipal year.

9. Equalities implications

9.1. Equality Act 2010 brought together all previous equality legislation in England, Scotland and Wales. The Act included a new public sector equality duty, replacing the separate duties relating to race, disability and gender equality. The duty came into force on 6 April 2011. It covers the following nine protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

9.2. 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.

9.3. There may be equalities implications arising from items on the work programme and all activities undertaken by the Select Committee will need to give due consideration to this.

10. Climate change and environmental implications

10.1. There are no direct climate change or environmental implications arising from the implementation of the recommendations in this report. However, in February 2019 Lewisham Council declared a Climate Emergency and proposed a target to make the

borough carbon neutral by 2030. An action plan to achieve this target was subsequently agreed by Mayor and Cabinet (following pre-decision scrtuiny by the Sustainable Development Select Committee)[1]. The plan incorporates all areas of the Council's work. Items on the work programme may well have climate change and environmental implications and reports considered by the Committee should acknowledge this.

11. Crime and disorder implications

11.1. There are no direct crime and disorder implications arising from the implementation of the recommendations in this report. Items on the Committee's work programme may have crime and disorder implications and these will need to be considered as part of the reports on those items.

12. Health and wellbeing implications

12.1. There are no direct health and wellbeing implications arising from the implementation of the recommendations in this report. Items on the Committee's work programme may have health and wellbeing implications and these will need to be considered as part of the reports on those items.

13. Report author and contact

If you have any questions about this report please contact: Katie Wood, 020 8314 9446 Katie.Wood@lewisham.gov.uk

[1] See https://lewisham.gov.uk/TacklingTheClimateEmergency for a summary of the Council's work in this area.

Appendix A – Healthier Communities Select Committee Terms of Reference

The following roles are common to all select committees:

(a) General functions

- To review and scrutinise decisions made and actions taken in relation to executive and non-executive functions
- To make reports and recommendations to the Council or the executive, arising out of such review and scrutiny in relation to any executive or non-executive function
- To make reports or recommendations to the Council and/or Executive in relation to matters affecting the area or its residents
- The right to require the attendance of members and officers to answer questions includes a right to require a member to attend to answer questions on up and coming decisions

(b) Policy development

- To assist the executive in matters of policy development by in depth analysis of strategic policy issues facing the Council for report and/or recommendation to the Executive or Council or committee as appropriate
- To conduct research, community and/or other consultation in the analysis of policy options available to the Council
- To liaise with other public organisations operating in the borough – both national, regional and local, to ensure that the interests of local people are enhanced by collaborative working in policy development wherever possible

(c) Scrutiny

- To scrutinise the decisions made by and the performance of the Executive and other committees and Council officers both in relation to individual decisions made and over time
- To scrutinise previous performance of the Council in relation to its policy objectives/performance targets and/or particular service areas
- To question members of the Executive or appropriate committees and executive directors personally about decisions
- To question members of the Executive or appropriate committees and executive directors in relation to previous performance whether generally in comparison with service plans and targets over time or in relation to particular initiatives which have been implemented
- To scrutinise the performance of other public bodies in the borough and to invite them to make reports to and/or address the select committee/Business Panel and local people about their activities and performance
- To question and gather evidence from any person outside the Council (with their consent)
- To make recommendations to the Executive or appropriate committee and/or Council arising from the outcome of the scrutiny process

(d) Community representation

- To promote and put into effect closer links between overview and scrutiny members and the local community
- To encourage and stimulate an enhanced community representative role for overview and scrutiny members including enhanced methods of consultation with local people
- To liaise with the Council's ward assemblies so that the local community might participate in the democratic process and where it considers it appropriate to seek the views of the ward assemblies on matters that affect or are likely to affect the local areas, including accepting items for the agenda of the appropriate select committee from ward assemblies.
- To keep the Council's local ward assemblies under review and to make recommendations

to the Executive and/or Council as to how participation in the democratic process by local people can be enhanced

- To receive petitions, deputations and representations from local people and other stakeholders about areas of concern within their overview and scrutiny remit, to refer them to the Executive, appropriate committee or officer for action, with a recommendation or report if the committee considers that necessary
- To consider any referral within their remit referred to it by a member under the Councillor Call for Action, and if they consider it appropriate to scrutinise decisions and/or actions taken in relation to that matter, and/or make recommendations/report to the Executive (for executive matters) or the Council (non-executive matters).

(e) Finance

- To exercise overall responsibility for finances made available to it for use in the performance of its overview and scrutiny function.

(f) Work programme

- As far as possible to draw up a draft annual work programme in each municipal year for consideration by the overview and scrutiny Business Panel. Once approved by the Business Panel, the relevant select committee will implement the programme during that municipal year. Nothing in this arrangement inhibits the right of every member of a select committee (or the Business Panel) to place an item on the agenda of that select committee (or Business Panel respectively) for discussion.
- The Council and the Executive will also be able to request that the overview and scrutiny select committee research and/or report on matters of concern and the select committee will consider whether the work can be carried out as requested. If it can be accommodated, the select committee will perform it. If the committee has reservations about performing the requested work, it will refer the matter to the Business Panel for decision.

Healthier Communities has specific responsibilities for the following:

a) To fulfill all of the Overview and Scrutiny functions in relation to the provision of service by and performance of health bodies providing services for local people. These functions shall include all powers in relation to health matters given to the Council's Overview and Scrutiny Committee by any legislation but in particular the NHS Act 2006 as amended, the Health and Social Care Act 2012, the Care Act 2014 and regulations made under that legislation, and any other legislation in force from time to time. For the avoidance of doubt, however, decisions to refer matters to the Secretary of State in circumstances where a health body proposes significant development or significant variation of service may only be made by full Council.

b) To review and scrutinise the decisions and actions of the Health and Wellbeing Board and to make reports and recommendations to the Council and/or Mayor and Cabinet.

c) To review and scrutinise in accordance with regulations made under Section 244 NHS Act 2006 matters relating to the health service in the area and to make reports and recommendations on such matters in accordance with those regulations

d) Require the attendance of representatives of relevant health bodies at meetings of the select committee to address it, answer questions and listen to the comments of local people on matters of local concern.

e) With the exception of matters pertaining to the Council's duty in relation to special educational needs, to fulfill all of the Council's Overview and Scrutiny functions in relation to social services provided for those 19 years old or older including but not limited to services provided under the Local Authority Social Services Act 1970, Children Act 2004, National Assistance Act 1948, Mental Health Act 1983, NHS and Community Care Act 1990, NHS Act 2006, Health and Social Care Act 2012 and any other relevant legislation in place from time to time.

f) To fulfill all of the Council's Overview and Scrutiny functions in relation to the lifelong learning of those 19 years or over (excluding schools and school related services).

g) To receive referrals from the Healthwatch and consider whether to make any report/recommendation in relation to such referral (unless the referral relates solely to health services for those aged under 19 years of age, in which case the referral from the Healthwatch should be referred to the Children and Young People Select Committee .

h) To review and scrutinise the Council's public health functions.

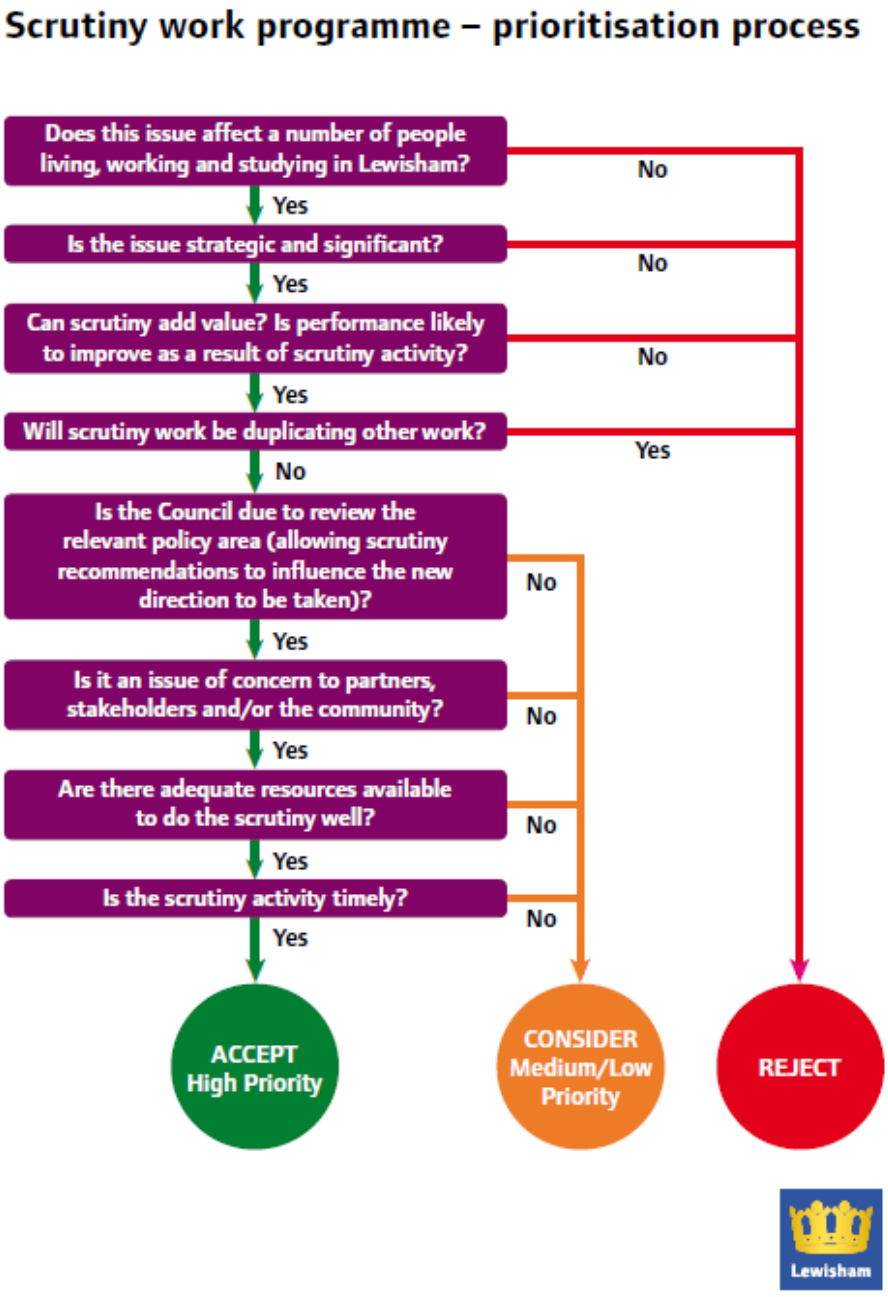
i) Without limiting the remit of this Select Committee, its terms of reference shall include Overview and Scrutiny functions in relation to: people with learning difficulties; people with physical disabilities; mental health services; the provision of health services by those other than the Council; provision for elderly people; the use of Section 75 NHS Act 2006 flexibilities to provide services in partnership with health organisations; lifelong learning of those aged 19 years or more (excluding schools and school related services); Community Education Lewisham; other matters relating to Health and Adult Care and Lifelong Learning for those aged 19 years or over.

j) Without limiting the remit of the Select Committee, to hold the Executive to account for its performance in relation to the delivery of Council objectives in the provision of adult services and health and lifelong learning.

NB In the event of there being overlap between the terms of reference of this select committee and those of the Children and Young People Select Committee, the Business Panel shall determine the Select Committee which shall deal with the matter in question.

Appendix C

The flowchart below is designed to help Members decide which items should be added to the work programme. It is important to focus on areas where the Committee will influence decision-making.



Appendix D

Effective Scrutiny Guidelines

At Lewisham we:

1. Prioritise

It is more effective to look at a small number of key issues in an in-depth way, than skim the surface of everything falling within scrutiny's remit. We try to focus on issues of concern to the community and/or matters that are linked to our corporate priorities. We only add items to the work programme if we are certain our consideration of the matter will make a real and tangible difference.

2. Are independent

Scrutiny is led by Scrutiny Members. Scrutiny Members are in charge of the work programme and, for every item, we specify what evidence we require and what information we would like to see in any officer reports that are prepared. We are not whipped by our political party or unduly influenced by the Cabinet or senior officers.

3. Work collectively

If we collectively agree in advance what we want to achieve in relation to each item under consideration, including what the key lines of enquiry should be, we can work as a team to question witnesses and ensure that all the required evidence is gathered. Scrutiny is impartial and the scrutiny process should be free from political point scoring and not used to further party political objectives.

4. Engage

Involving residents helps scrutiny access a wider range of ideas and knowledge, listen to a broader range of voices and better understand the opinions of residents and service users. Engagement helps ensure that recommendations result in residents' wants and needs being more effectively met.

5. Make SMART evidence-based recommendations

We make recommendations that are based on solid, triangulated evidence – where a variety of sources of evidence point to a change in practice that will positively alter outcomes. We recognise that recommendations are more powerful if they are:

- Specific (simple, sensible, significant).
- Measurable (meaningful, motivating).
- Achievable (agreed, attainable).
- Relevant (reasonable, realistic and resourced, results-based).
- Time bound (time-based, time limited, time/cost limited, timely, time-sensitive).

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Healthier Communities Select Committee work programme 2022/23 (draft)

Item	Type	Priority	Delivery	21-Jun	07-Sep	01-Nov	05-Jan	28-Feb
Election of Chair and Vice Chair	Constitutional req	CP5	June					
Work programme 2022-23	Constitutional req	CP5	June					
South East London Integrated Care System	Standard item	CP5	June					
Healthcare and Wellbeing Charter	Standard item	CP5	June					
Empowering Lewisham	Standard item	CP5	June					
Primary Care Update	Standard item	CP5	Sept					
The Birmingham and Lewisham African & Caribbean Health Inequalities Review (BLACHIR)	Standard item	CP5	Sept					
Transitions from children's to adults' social care	Standard item	CP5	Sept					
Autism strategy	Standard item	CP5	Sept					
Budget cuts proposals	Standard item	CP5	Nov					
Proud to Care update	Standard item	CP5	Nov					
Leisure centres update	Standard item	CP5	Jan					
Adult safeguarding update	Standard item	CP5	Jan					
One Public Estate: Ladywell Unit proposals	Standard item	CP5	Feb					
Extreme weather, advice and support	Standard item	CP5	Feb					
Health and Wellbeing Board update	Standard item	CP5	Feb					

Information reports, briefings and visits	Type	Priority	Delivery					
Lewisham Adult Safeguarding Board (LASB) annual report	Performance monitoring	CP5	tbc					
Lewisham and Greenwich NHS Trust (LGT) quality account	Performance monitoring	CP5	tbc					
South London and Maudsley NHS Trust (SLaM) quality account	Performance monitoring	CP5	tbc					
Adult Learning Lewisham (ALL) annual report	Performance monitoring	CP5	tbc					
Health & Social Care Scrutiny Protocol	Engagement	CP5	tbc					
Improving Downham Health event	Engagement	CP5	June					
Health Care & Wellbeing Charter engagement	Engagement	CP5	tbc					
Calabash update	Information item	CP5	Sept					
Empowering lewisham updates	Performance monitoring	CP5	tbc			`		

	Item completed
	Item on-going
	Proposed timeframe

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FORWARD PLAN OF KEY DECISIONS

Forward Plan September 2022 - December 2022

This Forward Plan sets out the key decisions the Council expects to take during the next four months.

Anyone wishing to make representations on a decision should submit them in writing as soon as possible to the relevant contact officer (shown as number (7) in the key overleaf). Any representations made less than 3 days before the meeting should be sent toEmma Aye-Kumi, the Local Democracy Officer, at the Council Offices or emma.aye-kumi@lewisham.gov.uk. However the deadline will be 4pm on the working day prior to the meeting.

A "key decision"* means an executive decision which is likely to:

(a) result in the Council incurring expenditure which is, or the making of savings which are, significant having regard to the Council's budget for the service or function to which the decision relates;

(b) be significant in terms of its effects on communities living or working in an area comprising two or more wards.

November 2021	**Award of Corporate Estate Maintenance Programme Phases 1 & 2 works contract**	28/06/22 Executive Director for Housing, Regeneration & Environment	Akweley Badger, Project Support Officer and Councillor Amanda De Ryk, Cabinet Member for Finance and Strategy		
May 2022	**Catford Library Winslade Way works - Contract Award**	28/06/22 Executive Director for Corporate Services	Kplom Lotsu, SGM Capital Programmes and Councillor Andre Bourne, Cabinet Member for Culture and Leisure (job		

FORWARD PLAN – KEY DECISIONS					
Date included in forward plan	**Description of matter under consideration**	**Date of Decision Decision maker**	**Responsible Officers / Portfolios**	**Consultation Details**	**Background papers / materials**
			share)		
January 2022	**Contract for Statutory Funeral Provision**	28/06/22 Executive Director for Community Services	Corinne Moocarme, Joint Commissioning Lead, Community Support and Care, Community Services, LBL and Councillor Paul Bell, Cabinet Member for Health and Adult Social Care		
June 2022	**Digital Infrastructure Fibre Wayleave**	28/06/22 Executive Director for Corporate Services	and Councillor Amanda De Ryk, Cabinet Member for Finance and Strategy		
May 2022	**Expert Assessors services for Concessionary Award Schemes**	28/06/22 Executive Director for Corporate Services	and Councillor Chris Barnham, Cabinet Member for Children's Services and School Performance		
June 2022	**Expert Assessors Services for Concessionary Award Services**	28/06/22 Executive Director for Corporate Services	and Councillor Paul Bell, Cabinet Member for Health and Adult Social Care		
May 2022	**Procurement of a replacement Housing Management System and implementation of a Customer Relationship Management System.**	28/06/22 Executive Director for Corporate Services	and Councillor Amanda De Ryk, Cabinet Member for Finance and Strategy		
May 2022	**Procurement of Learning and Development Services Provider**	28/06/22 Executive Director	and Councillor Amanda De Ryk, Cabinet Member		

FORWARD PLAN – KEY DECISIONS					
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		for Corporate Services	for Finance and Strategy		
June 2022	**Procurement of Replacement Housing Management System and implementation of Customer Relationship Management System**	28/06/22 Executive Director for Corporate Services	and Councillor Amanda De Ryk, Cabinet Member for Finance and Strategy		
June 2022	**Authority to procure ASD Post Diagnosis Parent Support**	19/07/22 Executive Director for Children and Young People	and Councillor Chris Barnham, Cabinet Member for Children's Services and School Performance		
June 2022	**Authority to Procure Mediation and Disagreement Resolution Service**	19/07/22 Executive Director for Children and Young People	and Councillor Chris Barnham, Cabinet Member for Children's Services and School Performance		
June 2022	**Authority to procure SEN and Disabilities Advice and Support Services**	19/07/22 Executive Director for Children and Young People	and Councillor Chris Barnham, Cabinet Member for Children's Services and School Performance		
June 2022	**Authority to Procure SEN Transport - Dynamic Purchasing System Licence**	19/07/22 Executive Director for Children and Young People	and Councillor Chris Barnham, Cabinet Member for Children's Services and School Performance		
June 2022	**Authority to procure Specialist Short Breaks - Mentoring Programme**	19/07/22 Executive Director for Children and	and Councillor Chris Barnham, Cabinet Member for Children's		

FORWARD PLAN – KEY DECISIONS					
Date included in forward plan	**Description of matter under consideration**	**Date of Decision Decision maker**	**Responsible Officers / Portfolios**	**Consultation Details**	**Background papers / materials**
		Young People	Services and School Performance		
May 2022	**Meliot Centre Relocation Contract Award**	19/07/22 Executive Director for Housing, Regeneration & Environment	and Councillor Paul Bell, Cabinet Member for Health and Adult Social Care		
June 2022	**Approval for Contract Award - Works contract for the former Catford Constitutional Club Pt1 & P2**	14/09/22 Mayor and Cabinet	Iqbal Iffat, Project Manager Capital Programme Delivery and Councillor Brenda Dacres, Deputy Mayor and Cabinet Member for Housing Development and Planning		
May 2022	**Approval for s106 monies to go to Deptford Challenge Trust**	14/09/22 Mayor and Cabinet	and Councillor Kim Powell, Cabinet Member for Businesses, Jobs and Skills		
May 2022	**Approval for the Local Development Scheme (LDS)**	14/09/22 Mayor and Cabinet	David Syme, Head of Strategic Planning and Councillor Brenda Dacres, Deputy Mayor and Cabinet Member for Housing Development and Planning		
May 2022	**Approval of the Lewisham Local Plan - Regulation 19 Proposed Submission document for public consultation**	14/09/22 Mayor and Cabinet	David Syme, Head of Strategic Planning and Councillor Brenda Dacres, Deputy Mayor and Cabinet Member for		

FORWARD PLAN – KEY DECISIONS					
Date included in forward plan	**Description of matter under consideration**	**Date of Decision Decision maker**	**Responsible Officers / Portfolios**	**Consultation Details**	**Background papers / materials**
			Housing Development and Planning		
August 2022	**Authority to Procure NHS health checks provision**	14/09/22 Mayor and Cabinet	Jason Browne, Public Health Commissioning Manager and Councillor Kim Powell, Cabinet Member for Businesses, Jobs and Skills		
February 2022	**BfL Programme - Approval to enter into contract**	14/09/22 Mayor and Cabinet	James Ringwood, Housing Delivery Manager and Councillor Paul Bell, Cabinet Member for Health and Adult Social Care		
June 2022	**Carer Information Advice and Support Services - permission to procure**	14/09/22 Mayor and Cabinet	Joanne Lee, Contracts Monitoring Officer and Councillor Paul Bell, Cabinet Member for Health and Adult Social Care		
June 2022	**Catford Regeneration Partnership Ltd Update**	14/09/22 Mayor and Cabinet	Kplom Lotsu, SGM Capital Programmes and Councillor Kim Powell, Cabinet Member for Businesses, Jobs and Skills		
June 2022	**Lewisham and Lee Green LTN Monitoring Update**	14/09/22 Mayor and Cabinet	Zahur Khan, Director of Public Realm and Councillor Louise Krupski, Cabinet Member for Environment and		

FORWARD PLAN – KEY DECISIONS					
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			Climate		
January 2022	**Lewisham Autism Strategy**	14/09/22 Mayor and Cabinet	Polly Pascoe, Integrated Commissioning Manager and Councillor Chris Best		
August 2022	**Lewisham Homes Business Plan**	14/09/22 Mayor and Cabinet	Fenella Beckman, Director of Housing and Councillor Sophie Davis, Cabinet Member for Housing Management and Homelessness		
June 2022	**Maximising Wellbeing of Carers**	14/09/22 Mayor and Cabinet	Tristan Brice, Associate Director, Community Support and Care and Councillor Paul Bell, Cabinet Member for Health and Adult Social Care		
June 2022	**Permission to Procure for refurbishment works and registered provider for Supported Accommodation for Young People for Site 1 and Site 2**	14/09/22 Mayor and Cabinet	Kevin Chadd, Senior Planning Lawyer and Councillor Chris Barnham, Cabinet Member for Children's Services and School Performance		
June 2022	**Permission to procure for the provision of Temporary Agency Staff/Managed Service Provider**	14/09/22 Mayor and Cabinet	Karin Courtman, Service Manager, Family Support and Intervention and Councillor Amanda De Ryk, Cabinet Member for Finance and Strategy		

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May 2022	**Permission to Procure new registered provider for supported accommodation and building management (Northover and Amersham).**	14/09/22 Mayor and Cabinet	and Councillor Chris Barnham, Cabinet Member for Children's Services and School Performance		
June 2022	**Reduction and Recycling Plan 2023-2025**	14/09/22 Mayor and Cabinet	Wendy Nicholas, Strategic Waste and Environment Manager and Councillor Louise Krupski, Cabinet Member for Environment and Climate		
August 2022	**Request to extend three Children and Family Centre contracts and client record system for 12 months from 1 April '23 - 31 March '24**	14/09/22 Mayor and Cabinet	Caroline Hirst, Joint Commissioner, Children and Young People's Services and Councillor Chris Barnham, Cabinet Member for Children's Services and School Performance		
June 2022	**To approve the procurement strategy for a Lewisham based Healthwatch service**	14/09/22 Mayor and Cabinet	Tristan Brice, Associate Director, Community Support and Care and Councillor Paul Bell, Cabinet Member for Health and Adult Social Care		
May 2022	**Watergate Special School Expansion budget approval and approval to procure**	14/09/22 Mayor and Cabinet	Iqbal Iffat, Project Manager Capital Programme Delivery and Councillor Chris Barnham, Cabinet Member for Children's		

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			Services and School Performance		
June 2022	**Young Mayor's Budget 2021-22**	14/09/22 Mayor and Cabinet	Katherine Kazantzis, Principal Lawyer and Councillor Chris Barnham, Cabinet Member for Children's Services and School Performance		
	Award of Corporate Estate Maintenance Programme Contract 2, Phase 1	27/09/22 Executive Director for Housing, Regeneration & Environment	Akweley Badger, Project Support Officer and Councillor Amanda De Ryk, Cabinet Member for Finance and Strategy		
	Award of Corporate Estate Maintenance Programme Contract 3, Phase 1	27/09/22 Executive Director for Housing, Regeneration & Environment	Akweley Badger, Project Support Officer and Councillor Amanda De Ryk, Cabinet Member for Finance and Strategy		
June 2022	**Approval of the Lewisham Local Plan (Regulation 19 'Proposed Submission' document for public consultation**	28/09/22 Council	David Syme, Head of Strategic Planning and		
June 2022	**Catford Regeneration Partnership Limited (CRPL) - Update**	28/09/22 Council	Kplom Lotsu, SGM Capital Programmes and		
June 2022	**Catford Regeneration Partnership Ltd Update**	28/09/22 Council	Kplom Lotsu, SGM Capital Programmes and Councillor Kim Powell,		

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			Cabinet Member for Businesses, Jobs and Skills		
June 2022	**Approval to procure - Beckeham Place Park Eastern side works**	05/10/22 Mayor and Cabinet	Adam Platts, Project Manager and Councillor Andre Bourne, Cabinet Member for Culture and Leisure (job share)		
	Authority to Procure Adult Weight Management Services: Universal offer; Targeted offer	05/10/22 Mayor and Cabinet	Iain McDiarmid and Councillor Paul Bell, Cabinet Member for Health and Adult Social Care		
June 2022	**BfL Appropriation for Planning purposes**	05/10/22 Mayor and Cabinet	James Ringwood, Housing Delivery Manager and Councillor Sophie Davis, Cabinet Member for Housing Management and Homelessness		
June 2022	**BfL Programme - Approval to enter into contract**	05/10/22 Mayor and Cabinet	James Ringwood, Housing Delivery Manager and Councillor Sophie Davis, Cabinet Member for Housing Management and Homelessness		
	Brownfield Land Release Fund (BLRF)	05/10/22 Mayor and Cabinet	Monique Wallace, Planning Manager, Strategic Housing and Councillor Brenda		

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			Dacres, Deputy Mayor and Cabinet Member for Housing Development and Planning		
June 2022	**Church Grove - Lease of Affordable Housing Units**	05/10/22 Mayor and Cabinet	Angela Bryan, Strategic Development Officer and Councillor Sophie Davis, Cabinet Member for Housing Management and Homelessness		
June 2022	**Consultation on a borough-wide Public Space Protection Order**	05/10/22 Mayor and Cabinet	and Councillor Andre Bourne, Cabinet Member for Culture and Leisure (job share)		
	Contract for Microsoft Licences - EMT approval to use framework. Mayor and Cabinet to note procurement and delegate authority for award to ED of Corporate Resources.	05/10/22 Mayor and Cabinet	Philippa Brewin and Councillor Amanda De Ryk, Cabinet Member for Finance and Strategy		
June 2022	**Highways Planned and Unplanned Maintenance Contract**	05/10/22 Mayor and Cabinet	Zahur Khan, Director of Public Realm and Councillor Louise Krupski, Cabinet Member for Environment and Climate		
June 2022	**Lewisham Education Strategy**	05/10/22 Mayor and Cabinet	Angela Scattergood, Director of Education Services, Education Standards and Inclusion and Councillor Chris		

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			Barnham, Cabinet Member for Children's Services and School Performance		
May 2022	**Lewisham Play Strategy 2022 - 2027**	05/10/22 Mayor and Cabinet	Sara Rahman and Councillor Chris Barnham, Cabinet Member for Children's Services and School Performance		
	Microsoft Office 365 E5 licencing (part 2 report)	05/10/22 Mayor and Cabinet	Wendy Carr and Councillor Amanda De Ryk, Cabinet Member for Finance and Strategy		
May 2022	**On Street Advertising Contract Variation and Extension**	Not before 05/10/22 Mayor and Cabinet	and Councillor Amanda De Ryk, Cabinet Member for Finance and Strategy		
June 2022	**Part 1 - Recommendation for the delivery of Extra Care Services at Hazlehurst Court, Catford**	05/10/22 Mayor and Cabinet	Heather Hughes, Joint Commissioner, Learning Disabilities and Councillor Juliet Campbell, Cabinet Member for Communities, Refugees and Wellbeing		
June 2022	**Public Realm Call Off Framework**	Not before 05/10/22 Mayor and Cabinet	Louise McBride, Head of Highways & Transport and Councillor Brenda Dacres, Deputy Mayor and Cabinet Member for Housing Development and Planning		

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June 2022	**Public Realm Framework contract award**	05/10/22 Mayor and Cabinet	Zahur Khan, Director of Public Realm and Councillor Louise Krupski, Cabinet Member for Environment and Climate		
June 2022	**Service Charge Policy**	05/10/22 Mayor and Cabinet	Fenella Beckman, Director of Housing and Councillor Sophie Davis, Cabinet Member for Housing Management and Homelessness		
June 2022	**Treasury Management Strategy Mid-Year Review**	05/10/22 Mayor and Cabinet	David Austin, Director of Corporate Services and Councillor Amanda De Ryk, Cabinet Member for Finance and Strategy		
	Walsham - Budget Requirement	05/10/22 Mayor and Cabinet	James Ringwood, Housing Delivery Manager and Councillor Brenda Dacres, Deputy Mayor and Cabinet Member for Housing Development and Planning		
	Award of a Contract for Microsoft Licences.	Not before 11/10/22 Executive Director for Corporate Services	Philippa Brewin and Councillor Amanda De Ryk, Cabinet Member for Finance and Strategy		
June 2022	**Accommodation Procurement**	02/11/22	Fenella Beckman,		

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	Strategy	Mayor and Cabinet	Director of Housing and Councillor Brenda Dacres, Deputy Mayor and Cabinet Member for Housing Development and Planning		
June 2022	**Award of Contract (Stop Smoking Service)**	02/11/22 Mayor and Cabinet	Councillor Brenda Dacres, Deputy Mayor and Cabinet Member for Housing Development and Planning and Councillor Juliet Campbell, Cabinet Member for Communities, Refugees and Wellbeing		
June 2022	**Highways and Traffic Works Partnering Contract**	02/11/22 Mayor and Cabinet	Zahur Khan, Director of Public Realm and Councillor Louise Krupski, Cabinet Member for Environment and Climate		
August 2022	**Management of Parks and Open Spaces**	02/11/22 Mayor and Cabinet	James Lee, Director of Communities, Partnerships and Leisure and		
	Oak Hill Nursery expansion of Commercial Lease into Designated Children Centre	02/11/22 Mayor and Cabinet	Michael Grant, Early Intervention Business Manager and Councillor Chris Barnham, Cabinet Member for Children's Services and School Performance		

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Date included in forward plan	**Description of matter under consideration**	**Date of Decision Decision maker**	**Responsible Officers / Portfolios**	**Consultation Details**	**Background papers / materials**
June 2022	**Part 1 - Notification of the transfer of Conrad Court Extra Care Housing**	02/11/22 Mayor and Cabinet	Beate Hellawell, Scrutiny Manager and Councillor Juliet Campbell, Cabinet Member for Communities, Refugees and Wellbeing		
June 2022	**Permission to Tender Lawrence House Ground Floor Refurbishment Works**	02/11/22 Executive Director for Housing, Regeneration & Environment	Gavin Plaskitt, Programme Manager and Councillor Amanda De Ryk, Cabinet Member for Finance and Strategy		
June 2022	**Right to Buyback 2**	02/11/22 Mayor and Cabinet	Kathy Freeman, Executive Director for Corporate Resources and Councillor Brenda Dacres, Deputy Mayor and Cabinet Member for Housing Development and Planning		
	Award of Corporate Estate Maintenance Contract Phase 2	15/11/22 Executive Director for Housing, Regeneration & Environment	Akweley Badger, Project Support Officer and Councillor Amanda De Ryk, Cabinet Member for Finance and Strategy		
June 2022	**Approval to appoint operator for concessions contract at Beckenham Place Park Lake**	Not before 01/12/22 Mayor and Cabinet	Vince Buchanan, Green Spaces Contracts Manager and Councillor Andre Bourne, Cabinet Member for Culture and Leisure (job share)		

FORWARD PLAN – KEY DECISIONS					
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June 2022	**Parts 1 & 2 - Recommendation regarding the delivery of Extra Care Services by Housing 21 at Cinnamon Court Deptford**	07/12/22 Mayor and Cabinet	Beate Hellawell, Scrutiny Manager and Councillor Juliet Campbell, Cabinet Member for Communities, Refugees and Wellbeing		
June 2022	**Building for Lewisham Budget requirements Pt1 & Pt2**	11/01/23 Mayor and Cabinet	James Ringwood, Housing Delivery Manager and Councillor Brenda Dacres, Deputy Mayor and Cabinet Member for Housing Development and Planning		
June 2022	**Council Tax Base Report 2023/24**	11/01/23 Mayor and Cabinet	Katharine Nidd, Strategic Procurement and Commercial Services Manager and Councillor Amanda De Ryk, Cabinet Member for Finance and Strategy		
August 2022	**Financial Monitoring Period 8**	11/01/23 Mayor and Cabinet	Nick Penny, Head of Service Finance and Councillor Amanda De Ryk, Cabinet Member for Finance and Strategy		

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Appendix A - Health and Wellbeing Board Performance Metrics - January 2019

	Updated indicators are in bold	Frequency	Latest Period of Availability	Previous Available Period (Lewisham)	Latest Available Period (Lewisham)	London	England	England Benchmark	Direction from Previous Period	Data Source
Overarching Indicators										
1a	**Life Expectancy at Birth (Male)(yrs)**	**Annual**	**2015-2017**	**79.1**	**79**	**80.5**	**79.6**	**similar**	↓	ONS
1b	**Life Expectancy at Birth (Female)(yrs)**	**Annual**	**2015-2017**	**83.3**	**83.7**	**84.3**	**83.1**	**similar**	↑	ONS
2	**Under 75 mortality rate from CVD (DSR)**	**Annual**	**2015-2017**	**82.2**	**80.7**	**73.2**	**72.5**	**similar**	↓	PHOF 4.04i
3	**Low Birth Weight of all babies (%)**	**Annual**	**2016**	**7.1**	**7.3**	**7.6**	**7.3**	**similar**	↑	P00455/CHIMAT Profile 2015
4	**Number of practitioners trained in Making Every Contact Count (behaviour change training)**	**Quarterly**	**Q1 2018/19**	**90**	**27**	**-**	**-**	-	-	Lewisham Public Health
Priority Objective 1: Achieving a Healthy Weight										
5	**Excess weight in Adults (%)**	**Annual**	**2016/17**	**57.9**	**57.8**	**55.2**	**61.3**	**similar**	↓	PHOF 2.12
6a	**Excess weight in Children - Reception Year (%)**	**Annual**	**2017/18**	**22.2**	**17.6**	**21.8**	**22.4**	**sig lower**	↓	PHOF 2.06i
6b	**Excess Weight in Children - Year 6 (%)**	**Annual**	**2017/18**	**39.0**	**37.9**	**37.7**	**34.3**	**sig high**	↓	PHOF 2.06ii
7	**Maternal Excess Weight at <13 weeks gestation(%)**	**Quarterly**	**Q2 2018/19**	**50.7**	**45.7**	-	-	-	↓	Lewisham & Greenwich Trust Data
8	**Breastfeeding Prevalence 6-8 weeks (%)**	**Quarterly**	**Q2 2018/19**	**79.4**	**79.3**	-	**46.4**	**sig higher**	↓	NHS ENGLAND
Priority Objective 2: Increasing the number of people who survive colorectal, breast and lung cancer for 1 and 5 years										
9a	**Cancer screening coverage - breast cancer (%)**	**Annual**	**2018**	**67.8**	**69.3**	**69.3**	**74.9**	**sig lower**	↑	PHOF 2.20i
9b	**Cancer screening coverage - cervical cancer(%)**	**Annual**	**2018**	**69.1**	**68.4**	**64.7**	**71.4**	**sig lower**	↓	PHOF 2.20ii
9c	**Cancer screening coverage - bowel cancer (%)**	**Annual**	**2018**	**46.7**	**47.0**	**50.2**	**59**	**sig lower**	↑	PHOF 2.20iii
10	Early diagnosis of cancer (%)	Annual	2016	50.2	52.4	51.9	52.6	similar	↑	PHOF 2.19 – experimental statistics
11	Conversion of Two Week Wait Referrals to Cancer Diagnosis (%)	Annual	2016/17	4.2	4.3*	5.3*	7.6*	sig lower	↑	PHE Fingertips Cancer Services Portal
12	**Under 75 mortality from all cancers (DSR)**	**Annual**	**2015-2017**	**149.4**	**146.7**	**123.6**	**134.6**	**sig high**	↓	NHSIC - P00381/ PHOF 4.05i
Priority Objective 3: Improving Immunisation Uptake										
13	**Uptake of the second dose of Measles Mumps and Rubella Vaccine (MMR2) at five years of age (%)**	**Quarterly**	**Q2 2018/19**	**83.5**	**85.3**	**74.8**	**86.4**	**similar**	↑	COVER Programme
14	**HPV Vaccine Update (All Doses) %**	**Annual**	**2017/18**	**75.5**	**79.5**	**81.0**	**83.1**	**sig lower**	↑	Public Health England - via www.gov.uk
15	**Uptake of Influenza vaccine in persons 65+ years of age %**	**Annual**	**2017/18**	**67.5**	**67.4**	**66.9**	**72.6**	**sig lower**	↓	PHOF 3.03xiv
Priority Objective 4: Reducing Alcohol Harm										
16	**Alcohol related admissions (ASR per 100,000 pop)**	**Annual**	**2017/18**	**526**	**537**	**533**	**632**	**sig lower**	↑	PHOF 2.18
Priority Objective 5 : Preventing the uptake of smoking among children and young people and reducing the numbers of people smoking										
17	**Smoking Prevalence in adults (18+) - current smokers (APS)(%)**	**Annual**	**2017**	**21.2**	**15.5**	**14.6**	**14.9**	**similar**	↓	PHOF 2.14
18	**4 week smoking quitters (crude rate per 100,000)**	**Annual**	**2017/18**	**2,203**	**2,329**	**2075**	**2,070**	**similar**	↑	Smoking Quitters
19	**Smoking status at time of delivery (%)**	**Annual**	**2017/18**	**4.8**	**5.4**	**5.0**	**10.8**	**sig lower**	↑	PHE Tobacco Profiles
Priority Objective 6: Improving Mental Health and Wellbeing										
20	**Prevalence of Serious Mental Illness (%)**	**Annual**	**2017/18**	**1.31**	**1.33**	**1.11**	**0.94**	**sig high**	→	Quality Outcomes Framework
21	**Prevalence of Depression 18+ (%)**	**Annual**	**2017/18**	**7.0**	**8.2**	**7.1**	**9.9**	**sig lower**	↑	Quality Outcomes Framework
22	**Improving Access to Physiological Therapies (IAPT) referrals entering treatment (%)**	**Annual**	**To Nov 2018**	**15.3**	**20.0**	**-**	**-**	**-**	↑	SLaM
23	**Proportion of those accessing IAPT who moved to recovery (%)**	**Annual**	**To Nov 2018**	**48.0**	**49.0**	**-**	**-**	**-**	↑	SLaM
Priority Objective 7: Improving Sexual Health										
24	**Rate of chlamydia diagnoses per 100,000 young people aged 15 to 24 (crude rate)**	**Annual**	**2017**	**4,735**	**2,573**	**2,199**	**1882**	**sig higher**	↓	PHOF 3.02i/3.02ii (NCSP & CTAD)
25	**People presenting with HIV at a late stage of infection (%)**	**Annual**	**2015-2017**	**37.3**	**39.6**	**35.2**	**41.1**	**similar**	↑	PHOF 3.04
26	**Legal Abortion rate for all ages (crude rate per 1000 women aged 15-44 yrs)**	**Annual**	**2017**	**23.1**	**23.1**	**19.8**	**16.5**	**sig high**	→	ONS Abortion Stats
27	**Teenage conceptions (Rate per 1,000 15-17 Yr olds)**	**Annual**	**2016**	**23.4**	**22.1**	**17.1**	**18.8**	**similar**	↓	PHOF 2.04
Better Care Fund Metrics										
28	**The proportion of those aged 65+ who received reablement services after hospital discharge**	**Annual**	**2017/18**	**2.3**	**4.0**	**3.8**	**2.9**	-	↑	Better Care Fund, NHS England
29	**Residential Admissions Rate (per 100,000 65+ population)**	**Annual**	**2017/18**	**687.4**	**541.2**	**406.2**	**585.6**	-	↓	Better Care Fund, NHS England
30	**Average daily rate of delayed transfers of care (per 100,000 population aged 18+)**	**Annual**	**2017/18**	**7.3**	**5.7**	**-**	**12.4**	-	↓	Better Care Fund, NHS England
31	**Non-Elective Admissions (per 100,000 population)**	**Annual**	**2017/18**	**-**	**-**	**-**	-	-	-	Better Care Fund, NHS England

Key

sig high -signficantly higher than England; sig low - significantly lower than England
similar - statistically similar to England
DSR - Directly Standardised Rates
ASR - Age Standardised Rates
ISR - Indirectly standardised Rates
PHOF - Public Health Outcome Framework

Links to Source with their abbreviations
http://www.phoutcomes.info/
http://www.phoutcomes.info/profile/sexualhealth
https://www.indicators.ic.nhs.uk/webview/
http://www.hscic.gov.uk/qof
http://ascof.hscic.gov.uk/
http://www.productivity.nhs.uk/
https://www.nhscomparators.nhs.uk/NHSComparators/HomePage.aspx

* Data Quality Issue has been reported with this indicator, interpret with caution

Latest period highlighted
Statistically Better than England
Statistically Similar to England
Statistically Worse than England
Blank where no statistical comparison could be made

Arrows Indicate up or down performance of current year /qtr from previous yr/qtr

Public Health Outcomes Framework (PHOF)
Public Health England Sexual Health Profiles
NHS Indicator Portal (NHSIC) by Health and Social Care Information Centre (HSCIC)
Quality and Outcomes Framework (QOF) by HSCIC
Adult and Social Care Outcomes Framework (ASCOF)
NHS Better Care Better Value Indicators
NHS Comparators by HSCIC

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