HEALTH AND WELLBEING BOARD			
Report Title	BAME Health Inequalities – Future Areas of Focus		
Contributors		**Item No.**	5
Class	Part 1	**Date:**	1 November 2018

1. Purpose

1.1 To feedback to the Board on work carried out since the last meeting to identify areas of focus (in addition to mental health) for the Board in relation to Black, Asian and Minority Ethnic (BAME) health inequalities.

2. Recommendations

2.1 Members of the Health and Wellbeing Board are invited to:

- Note the work carried out by the working group
- Agree future areas of focus relating to BAME health inequalities
- Agree actions to investigate identified areas of focus

3. Strategic Context

3.1 The Health and Social Care Act 2012 required the creation of statutory Health and Wellbeing Boards in every upper tier local authority. By assembling key leaders from the local health and care system, the principle purpose of the Health and Wellbeing Boards is to improve health and wellbeing and reduce health inequalities for local residents.

3.2 The activity of the Health and Wellbeing Board (HWB) is focussed on delivering the strategic vision for Lewisham as established in *Shaping our Future* – Lewisham's Sustainable Community Strategy and in Lewisham's Health and Wellbeing Strategy.

3.3 The work of the Board directly contributes to *Shaping our Future's* priority outcome that communities in Lewisham should be Healthy, active and enjoyable - where people can actively participate in maintaining and improving their health and wellbeing.

4. Background

4.1 In July 2018 the HWB agreed that the main areas of focus for the Board should be tackling Health Inequalities, and as an initial priority Black, Asian and Minority Ethnic (BAME) communities Health Inequalities.

4.2 It was agreed that mental health would be the first area of focus, and that future areas of focus would be identified by a working group.

5. BAME Health Inequalities – Future Areas of Focus

5.1 Following the July HWB meeting a “BAME Health Inequalities working group” was set up with representatives from the various organisations represented on the Board. The group was tasked with further reviewing available data to identify which other areas of BAME health inequalities in Lewisham would potentially benefit from an increased focus by the HWB in its role of ensuring a joint up approach to tackling Health Inequalities across the system in Lewisham.

5.2 In August 2018 Public Health England published a resource that aimed to support local authorities, and other public bodies in their approach to tackling health inequalities by ethnicity, titled *Local action on health inequalities: Understanding and reducing ethnic inequalities in health.* The resource suggested looking at the existing data around BAME health inequalities through four prisms:

- Key indicators of health status
- Social determinants of health
- Health related practices
- Access to services and interventions

5.3 The working group looked at the existing data around BAME health inequalities through the first two of the four prisms initially, with the expectation that the practice and service interventions data could then be reviewed by providers in the context of what was known about the key indicators and social determinants in a more focused way given the vast array of data the trusts advised they hold.

6. Key indicators of health status

6.1 The working group analysed the following key indicators of health status:

- Self-reported health
- Wellbeing
- Cancer incidence and stage at diagnosis
- Overweight and Obesity
- Disability free-expectancy
- Tuberculosis
- Infant and Child Health Indicators

6.2 By analysing local (where available) and national data, it was concluded that cancer and obesity had the strongest cases for future areas of focus for the Board. It is clear that both cancer and obesity affect disproportionally affect Lewisham’s BAME residents. The data that was used to form this conclusion is summarised throughout the rest of this section of the report.

6.3 Self-reported Health – Local Data

The 2011 Census asked a question on self-reported health. In Lewisham, responses of being 'Very good or good' varied by ethnic group from 89.4% for mixed ethnic groups, down to 80.4% of White residents.

6.4 Wellbeing

The Office for National statistics conducts an Annual Population Survey, which asks questions about personal wellbeing. Due to the small sample size locally, national data is presented here. Combined data for the period 2012 – 2016 shows that:

- Black population score lower for life satisfaction
- Bangladeshi and Black score lowest for feel their life is worthwhile
- Black scored lowest for happiness
- Less variation, harder to state due to larger confidence intervals for high levels of anxiety

6.5 Cancer - National and Local Data

The National Cancer Patient Experience Survey breaks down responses by ethnicity. On a national level, black ethnicities, on average, rated their overall care as significantly lower than white ethnicities, with an average score of 8.29 vs 8.73. While black ethnicities scored slightly lower across many of the sections of the survey, the most stark differences were firstly having diagnosis and treatment options explained in a manner that could be understood, with over a 10% difference between black and white scores, and secondly social support during and after treatment, with around a 15% difference between black and white scores on this questions.

6.6 There is evidence that black women are less likely to attend screenings[1] (18 and less likely to be diagnosed via the screening route[2], and therefore are more likely to be diagnosed with higher stage cancers, with the expected poorer outcomes in terms of mortality and survival rates.

6.7 Data recording residents who had received an urgent Two Week Wait in Lewisham showed that white British residents make up a higher proportion of 2 week referrals compared to their expected population (50.2% vs 41.5%). In particular Black Africans are underrepresented compared with their census data (5.3% vs 11.6%).

6.8 Data on bowel and cervical cancer screening uptake is available from Lewisham CCG by ethnic groups. The majority of BME sub groups are

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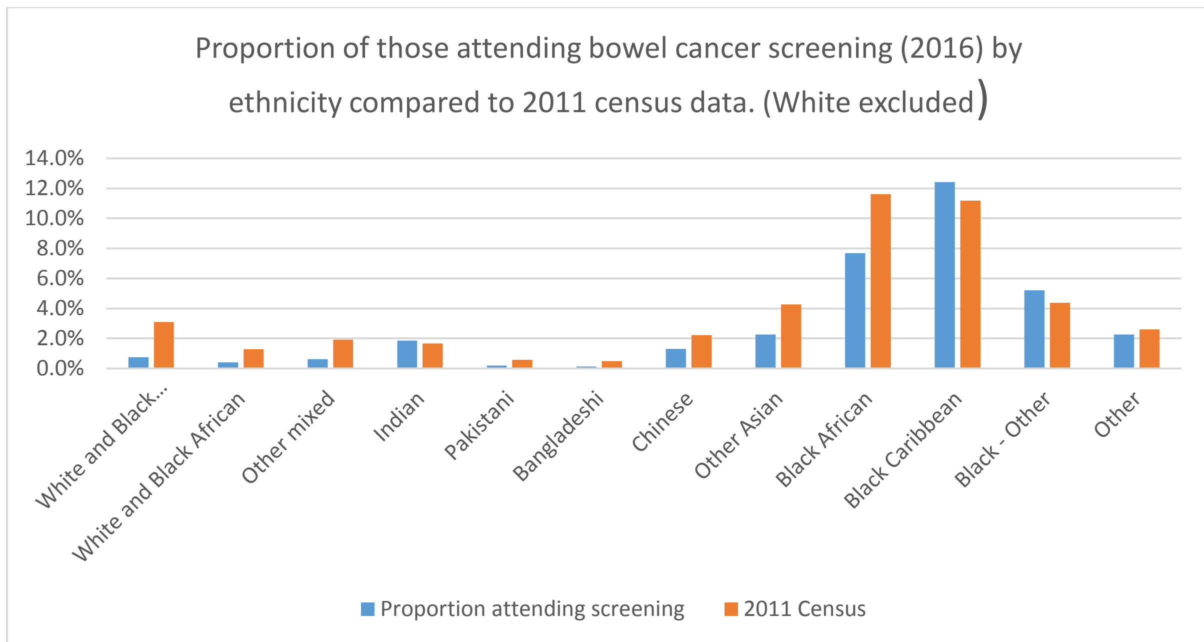
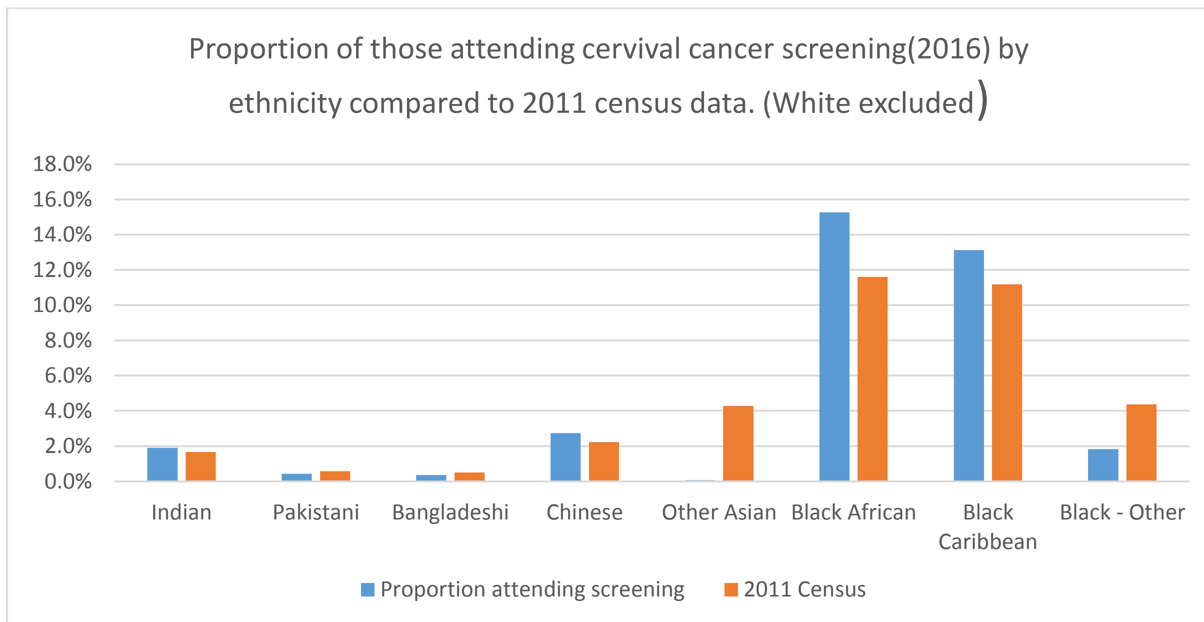
[1] Jack RH, Møller H, Robson T, et al. Breast cancer screening uptake among women from different ethnic groups in London: a population-based cohort study. BMJ Open

[2] http://www.ncin.org.uk/publications/data_briefings/breast_cancer_ethnicity

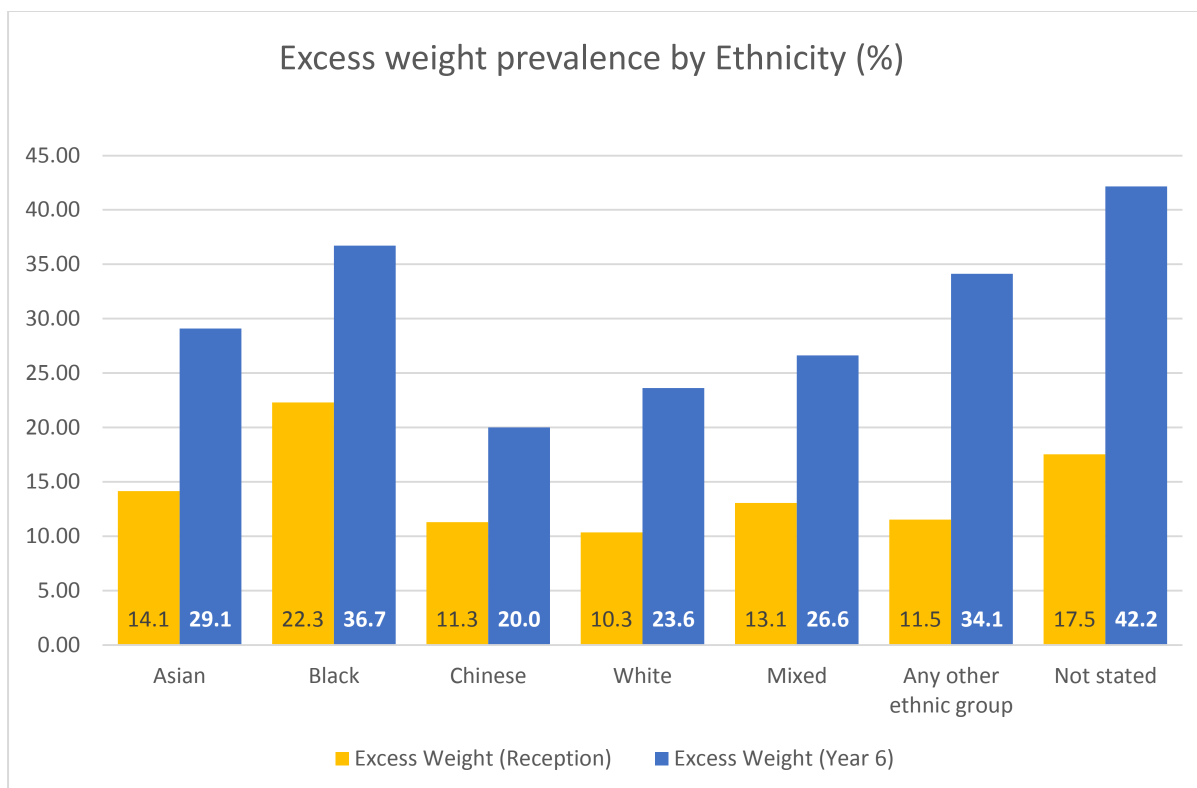
under-represented in uptake of bowel cancer screening, particularly Black African. However no BME group was under-represented in breast cancer screening.





6.9 Excess Weight

The latest published data from the National Child Measurement Programme is for 2016/17. This programme weighs and measures children in Reception and Year 6 to calculate their BMI. Looking at all excess weight (overweight and obesity) BME children in both reception and Year 6 are more likely to carry excess weight.



6.10 Disability-free life expectancy

Proxy information taken from 2011 Census on Limiting Long Term Conditions. Overall White Residents are more likely to state their day to day activities are limited to some extent. However this is likely to be due to the older population bias of this group. When looking at residents aged 65+ the proportions are very similar across ethnic groups:

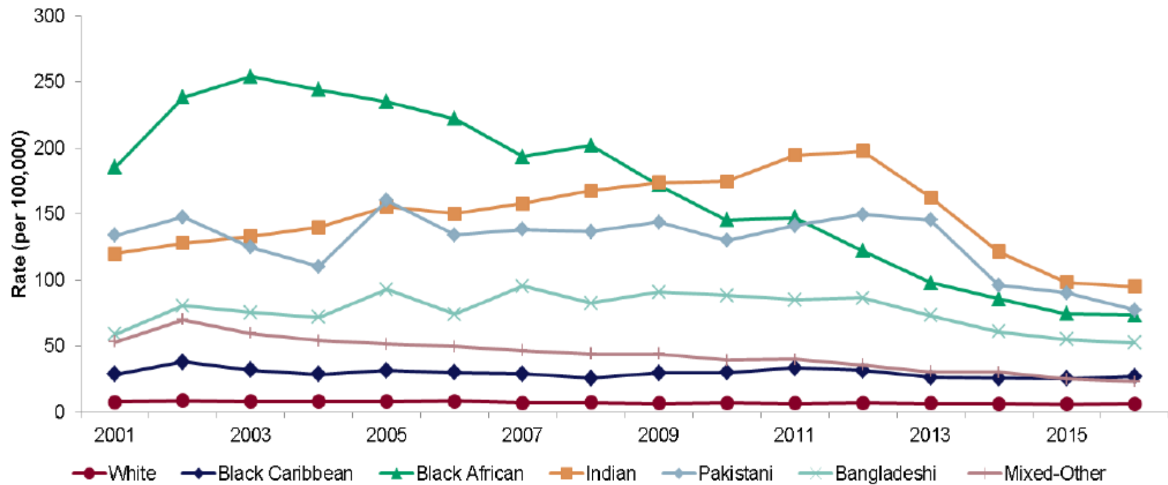
Ethnic Group (65+)	Limited to Some Extent	Not Limited
All Ethnic groups	56.3	43.7
White	56.7	43.3
Mixed/multiple ethnic group	56.4	43.6
Asian	54.6	45.4
Black	54.8	45.2
Other ethnic group	63.8	36.2

6.11 Tuberculous (taken from PHE Report on TB in London)

In 2016, those of Indian ethnicity had the highest rate of TB in London (95 notifications per 100,000 population), and accounted for the largest proportion of TB cases overall (26%, 543/2,107). Pakistani ethnicity had the second highest rate, followed by Black African. Most cases occur in people born outside the UK. Most common country of birth was India, Pakistan, Somalia, Bangladesh and Romania. Patients from Romania were more likely to be

recent entrants, with 39% diagnosed within 2 years of entering the UK. Social risk factors were seen to be high in TB patients, however this was more a feature of UK born patients. Patients with these risk factors were more likely to be infectious, be a hospital inpatient and were less likely to complete treatment.

Figure 9: TB case rates by ethnic group*, London, 2001 – 2016



* "Mixed/other" includes those of black-other ethnicity and Chinese due to small numbers.

6.12 Pre-term births and infant mortality

At the national level the percentage of women who had a pre-term birth is included in the table below. Black Caribbean women were slightly more likely to have a pre-term birth than other ethnicities.

Pre-Term Births (2013)

%	Pre-Term	Term	Post Term
Bangladeshi	8	91	2
Indian	7	90	2
Pakistani	7	90	2
Black African	8	88	4
Black Caribbean	10	87	2
White British	7	89	4
White Other	6	90	3
All Other	7	90	3
Not Stated	8	88	4

6.13 The rate of infant mortality nationally is recorded in the table below. Babies born to Pakistani women has the highest infant death rate, followed by Black African.

Infant Mortality (2015)

Ethnic Group	Infant Death (Rate per 1000 births)
All	3.2
Bangladeshi	4.3

Indian	3.1
Pakistani	5.9
Black African	5.3
Black Caribbean	4.5
White British	3.0
White Other	2.2
All others	3.6
Not stated	4.4

7. Social Determinants of Health

7.1 The working group also analysed the following social determinants of health:

- Education
- Employment
- Income
- Housing

7.2 Education

Data from the 2011 Census indicates that a greater percentage of Lewisham's BAME residents achieve a Level 4 or higher qualification than compared to the percentage at national level for all ethnic groups except the 'Other ethnic group' category. The percentage of Lewisham residents who have no qualifications is lower than the percentage for both national and inner London residents for 'white – Irish', 'other white', 'mixed', 'Asian, Asian British', Black/African/Caribbean/Black British' and 'Other Ethnic Group' categories.

7.3 Employment

The Office for National Statistics Annual Population Survey indicates that whilst a higher percentage of Lewisham BAME community is unemployed, employment rates for BAME residents are lower than both national and inner London.

7.4 Income

According to data from London's Poverty Profile 2017 only 19% of the 'White British' population in London is paid below the London Living Wage. A higher percentage of all other ethnic groups are paid below the London Living Wage with the 'Pakistani or Bangladeshi' group the highest at 46%.

7.5 Housing

Data from the 2011 Census indicates that a greater percentage of Lewisham's BAME residents are likely to be in a household which has an Occupancy Rating of -1 (indicating that there is 1 less room than is required for the number of people living).

8. Next Steps

8.1 Given what the data review to date shows, it is suggested that Obesity and Cancer are the other two BAME health inequalities areas that the HWB focus on next.

8.2 It is suggested that the Public Health, Primary Care, the CCG and provider trusts review what data they have in relation to cancer and obesity services and outcomes (including prevention and early intervention), focusing on how BAME residents experiences differ to the non-BAME population. By looking in more detail at local, service specific data, it is suggested that member organisations identify the factors contributing to inequalities within cancer and obesity. It is suggested that the findings from this data analysis, can from suggested actions for the HWB to take forward. It is suggested that the findings and subsequent actions are reported to the Board in March 2019.

8.3 It is also suggested that the corporate policy team to identify what work is already being done by the council regarding the social determinants of health (in particular poor quality housing and in-work poverty), and to determine whether there is scope for the HWB to have an impact in this area. This should also be reported back to the Board in March 2019.

9 Financial implications

9.1 There are no specific financial implications arising from this report or its recommendations.

10. Legal implications

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

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

10.2 The Equality Act 2010 (the Act) introduced a new public sector equality duty (the equality duty or the duty). 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.

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

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

10.4 The duty continues to be a "have regard duty", and the weight to be attached to it is a matter for the Mayor, bearing in mind the issues of relevance and proportionality. It is not an absolute requirement to eliminate unlawful discrimination, advance equality of opportunity or foster good relations.

10.5 The Equality and Human Rights Commission has recently issued Technical Guidance on the Public Sector Equality Duty and statutory guidance entitled "Equality Act 2010 Services, Public Functions & Associations Statutory Code of Practice". The Council must have regard to the statutory code in so far as it relates to the duty and attention is drawn to Chapter 11 which deals particularly with the equality duty. The Technical Guidance also covers what public authorities should do to meet the duty. This includes steps that are legally required, as well as recommended actions. The guidance does not have statutory force but nonetheless regard should be had to it, as failure to do so without compelling reason would be of evidential value. The statutory code and the technical guidance can be found at: http://www.equalityhumanrights.com/legal-and-policy/equalityact/equality-act-codes-of-practice-and-technical-guidance/

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

1. The essential guide to the public sector equality duty
2. Meeting the equality duty in policy and decision-making
3. Engagement and the equality duty
4. Equality objectives and the equality duty
5. Equality information and the equality duty

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

http://www.equalityhumanrights.com/advice-and-guidance/publicsector-equality-duty/guidance-on-the-equality-duty/

11. Crime and disorder implications

11.1 There are no specific crime and disorder implications arising from this report or its recommendations.

12. Environmental implications

12.1 There are no specific environmental implications arising from this report or its recommendations.

If there are any queries on this report please contact James Bravin, Principal Officer, Policy, Service Design and Analysis, London Borough of Lewisham on: 020 8314 9308 or by e-mail at james.bravin@lewisham.gov.uk