Lewisham Health Inequalities Toolkit

June 2021

What's inside?

Purpose of this toolkit

This health inequalities toolkit has been developed for Lewisham residents, community groups and all other Lewisham stakeholders with an interest in health inequalities.

The toolkit aims to give all Lewisham stakeholders:

- An introduction to health inequalities
- An overview of the health inequalities in Lewisham
- An overview of what is happening to address health inequalities in Lewisham
- Suggestions for further collaborative action to tackle health inequalities in Lewisham

This toolkit will be refreshed every other year alongside the publication of the Annual Public Health Report and Picture of Lewisham documents.

Contributors

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Introduction to Health Inequalities and Health Equity

Health inequalities are avoidable and unjustified differences in the health and wellbeing of groups and individuals, so are not inevitable or immutable.

Health equity means that everyone has a fair and just opportunity to be as healthy as possible.

In a borough guided by the principle “The welfare of the people is supreme”, we seek to address health inequalities, achieve health equity and create a just community.

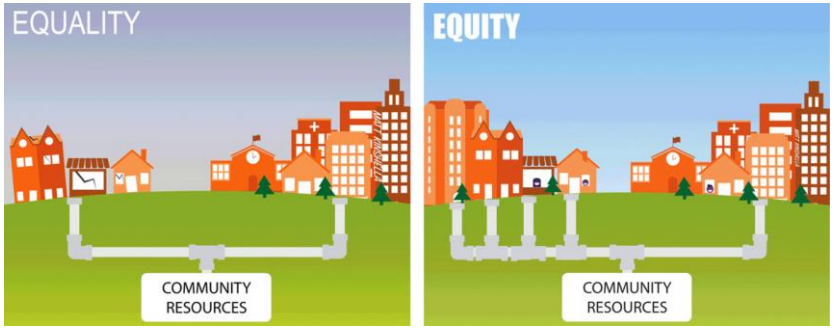
Health inequalities manifest across a number of areas and outcomes, including:

- Health status, e.g. obesity and life expectancy
- Access to care e.g. availability of NHS care
- Quality and experience of care, e.g. patient satisfaction
- Health behaviours, e.g. smoking and unhealthy diets
- Social determinants, e.g. housing and income

Despite the existence of the NHS in 1948 as a universal, free at the point of care health service, health inequalities persist and are increasing across England (e.g. a 2020 review by the Health Equity Institute and Prof Sir Michael Marmot demonstrated life expectancy has stopped increasing for the first time since 1900 and years spent in poor health is increasing, with inequalities in both increasing).

The greatest drivers of health (positive and negative) and health inequalities are not related to the health service and are driven by social and economic factors (the ‘social determinants of health’); See Figure 2 and 3.

Figure 1 Understanding equality and equity (Avarna Group, 2019, Matt Kinchella, 2016)



There are a number of aspects through which you can consider health inequalities:

- Socioeconomics and deprivation
- Geography
- Individual characteristics protected by law (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion, sex and sexual orientation)
- Socially excluded groups

Individuals and groups may span these characteristics, suffering multiple inequalities that multiply the negative impacts on health. 'Intersectionality' considers how these inequalities interact.

Figure 2 The Social determinants of health (Dahlgren and Whitehead, 1991)

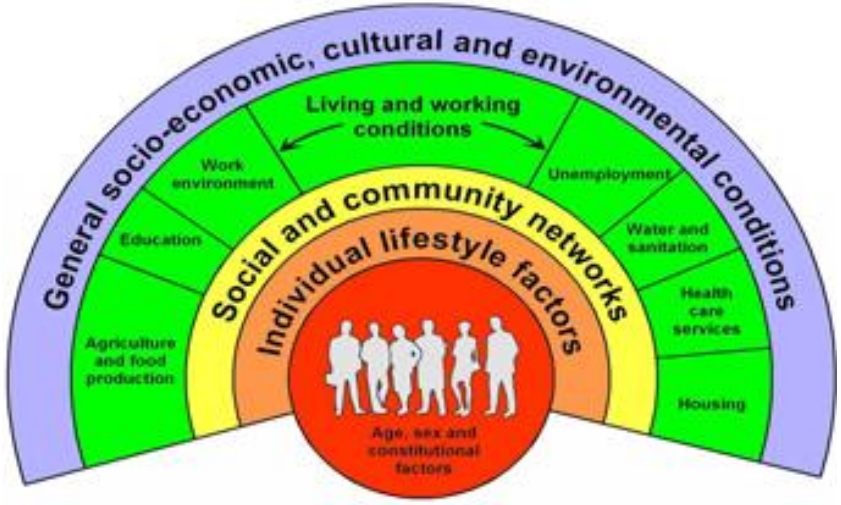
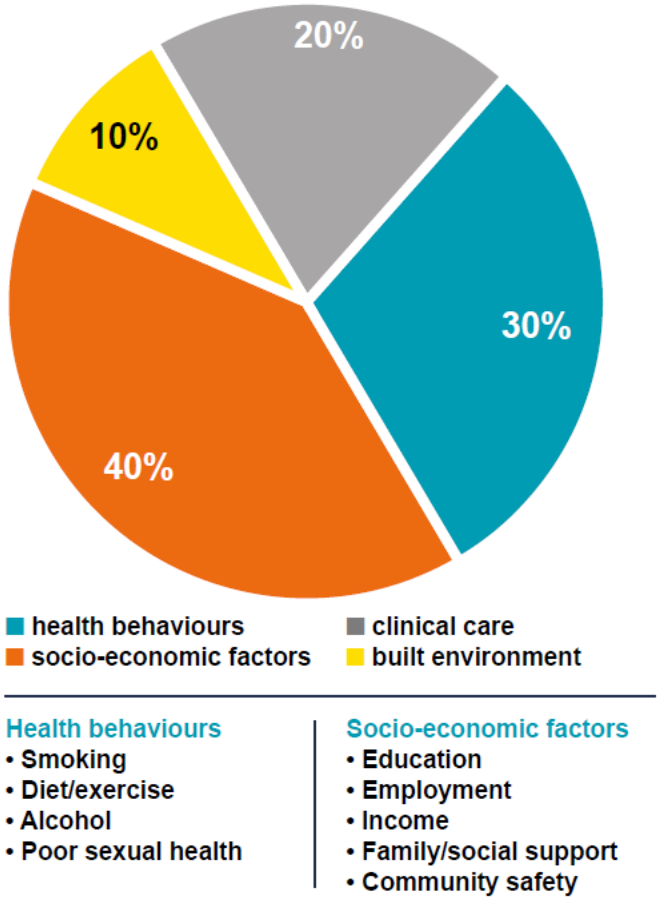


Figure 3

Figure 3: Factors that have the greatest influence on health (INSERT REF)



For most health outcomes there is a 'social gradient' of health inequalities, whereby there is an inverse relationship between your socioeconomic status and your outcome; i.e. the less income you have the worse your outcome. This is particularly stark in life expectancy and disability-free life expectancy (i.e. years of life without disability); see Figure 4.

The nature of a gradient is that everyone is on it. Unless you are at the top, you are likely to live for shorter length of time and develop a disability earlier than those at the top.

Evidence also suggests that the more unequal a society, the worse the outcome for the whole population. Comparing health and social care outcomes between countries based on income inequality suggests a direct, inverse relationship between income inequality and health and social problem; Figure 3.

Figure 4 Life expectancy (LE) & disability-free LE by income (Marmot Review 2020)

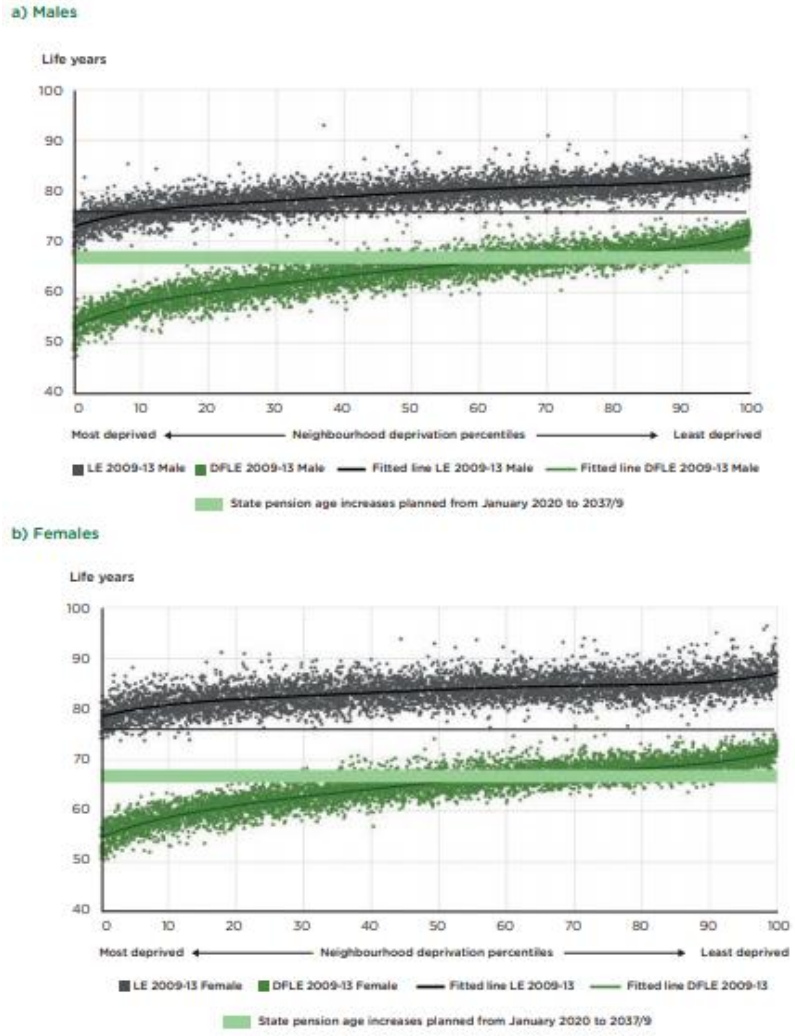
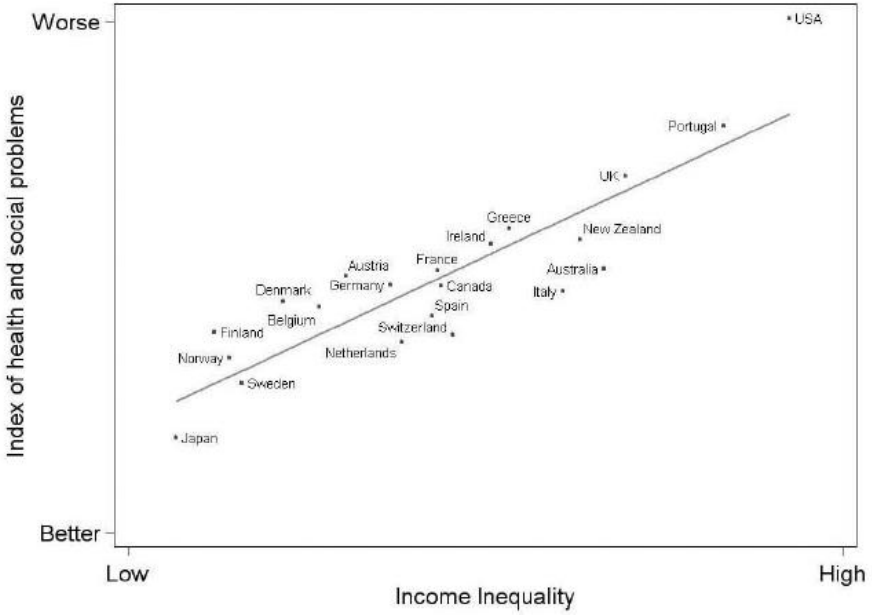


Figure 5 Association of health and social problems with income inequality



Index of health and social problems includes: life expectancy, maths and literacy, infant mortality, homicides, Imprisonment, teenage births, Trust, Obesity, social mobility, mental illness.

What works to reduce health inequalities?

The Strategic Review of Health Inequalities in England post-2010 (the Marmot Review) suggested that action to improve health and well-being for all and to reduce health inequalities should have two policy goals:

- To create an enabling society that maximises individual and community potential; and
- To ensure social justice, health and sustainability are at the heart of all policies

It demonstrated that health is accumulated through positive and negative experiences over a life-time, therefore there is a need to take a 'life course approach'. This approach focuses on six key areas:

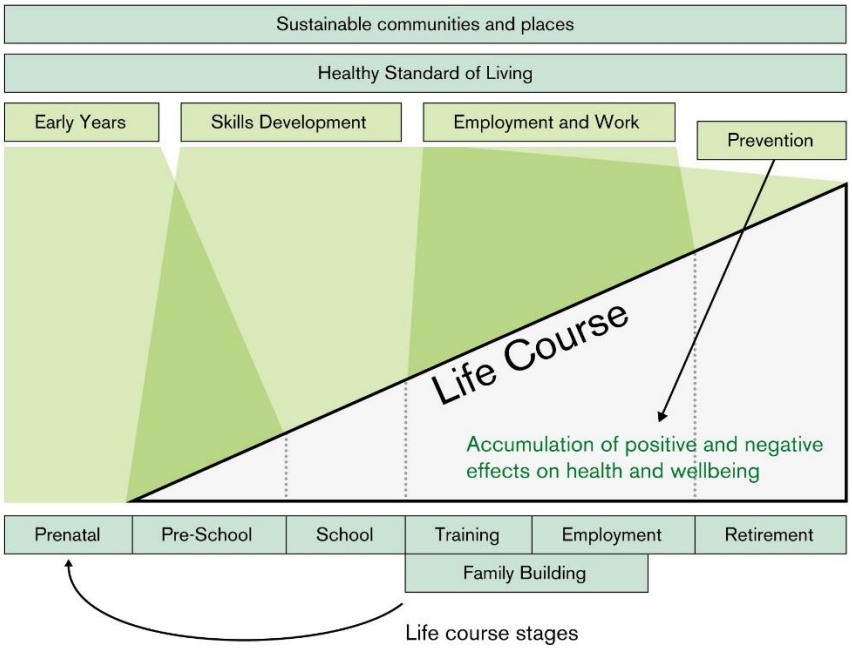
1. Give every child the best start in life.
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all.
4. Ensure healthy standard of living for all.
5. Create and develop healthy and sustainable places and communities.
6. Strengthen the role and impact of ill health prevention.

Whilst health inequalities impacts across a community, the social gradient of impacts dictates that not everyone is equally impacted. Therefore action should be based on 'proportionate universalism', with universal action delivered proportionately to need (i.e. those with the greatest need get proportionately more support.

Recognising that health inequalities are primarily driven by the physical, social and economic environment live in and that they impact communities as well as individuals, it is critical to focus on community centred approaches rather than individual behaviours. Successful action to address health inequalities must involve and actually led by communities through community-centred approach (Figure 7).

Figure 6 What works to address health inequalities? (Marmot Review, 2010)

i) Across the life course



ii) Evidence-based approaches to reduce health inequalities

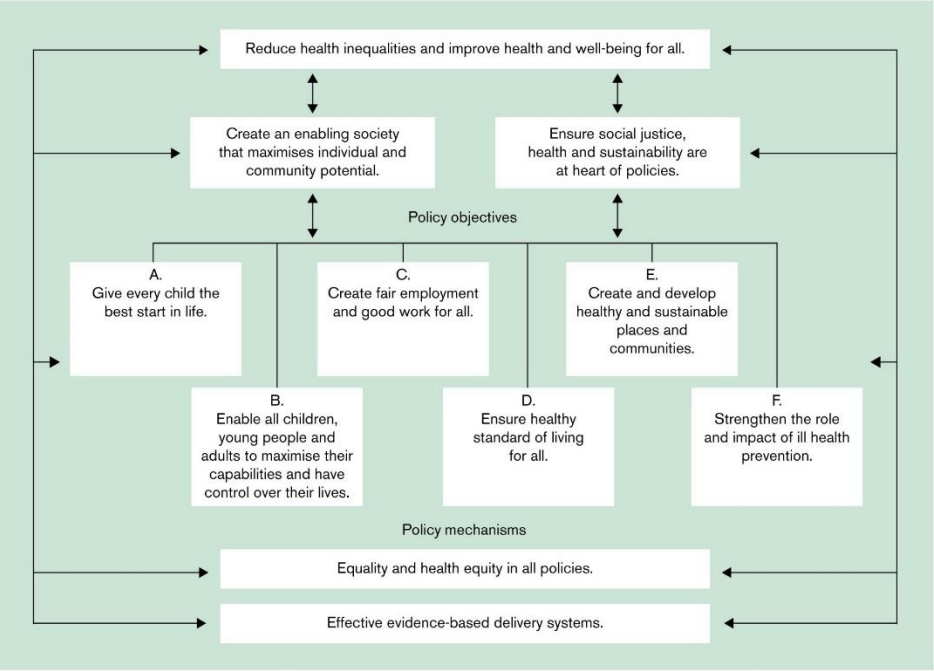
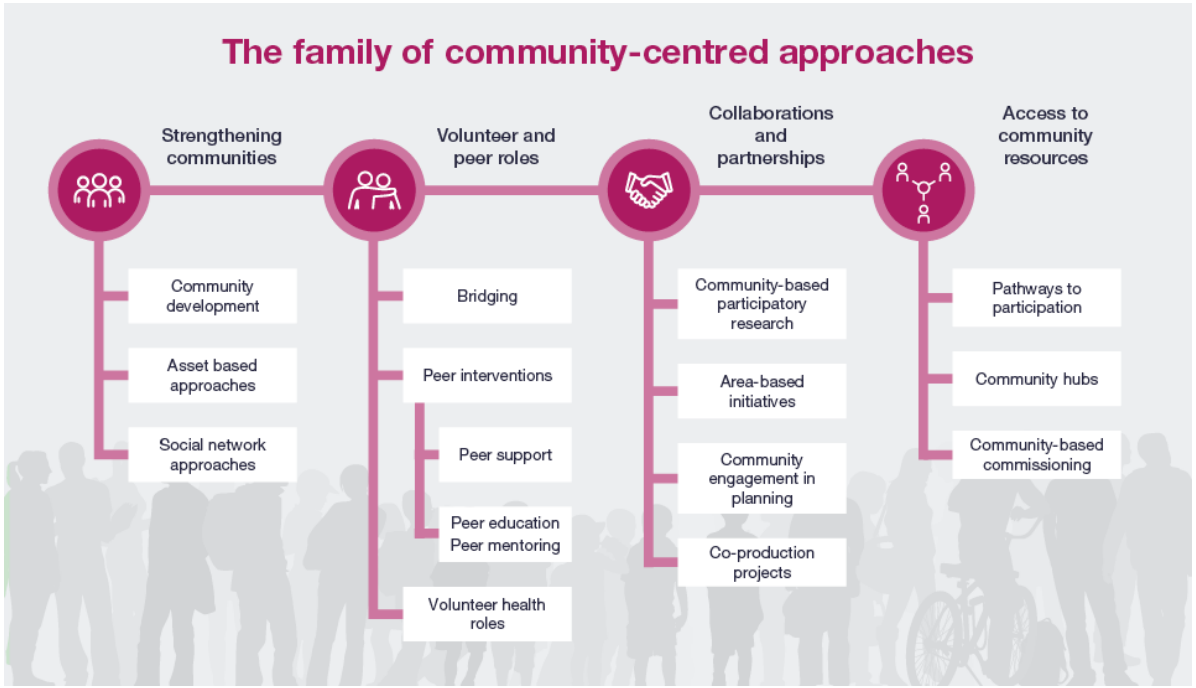


Figure 7 Community-centred approaches (PHE 2018)



Lewisham and Health Inequalities

Overview

In Lewisham, if you are a baby boy born in a household that falls within the least deprived areas within the borough you can expect to live just over 7 years longer than a fellow boy born in a household within the most deprived areas. This difference in health status (in this case life expectancy at birth) based on deprivation is a stark example of the health inequalities that are present in Lewisham.

Lewisham's greatest strength is the people who live and work here. We have a young, diverse and growing population, home to residents from more than 75 nationalities and with over 170 languages spoken.

Therefore there must be both targeted and universal action to reduce these inequalities i.e. the concept of proportionate universalism. Tackling these inequalities cannot be achieved by one organisation or group alone, it must be collaborative. In Lewisham, one of our key priorities is to reduce these health inequalities, particularly those from Black, Asian and Minority Ethnic backgrounds. We have been working with our local partners on this key priority through the local Health and Wellbeing Board (HWB) since July 2018.

Ethnic Health Inequalities

As well as focussing on socio-economic inequalities it is important to recognise health inequalities that exist between different ethnic groups. As shown later in this report, rates of disease and ill health vary widely between and within different ethnic groups. Additionally, these inequalities are not evenly spread between health conditions. Furthermore, there are often differences in health between genders, as well as between different generations of Black, Asian and Minority Ethnic groups.

The causes of these inequalities are complex. Rates of low-income households are higher in ethnic minority groups, services both health and non-health may not be culturally sensitive to users, and racial discrimination still persists. The challenges that Lewisham faces in reducing health inequalities are not unique and are seen across the country. However, data collection on these inequalities is poor. Another finding from the Marmot 10 Years On review was that there was limited data on health inequalities between ethnic groups. We echo the calls of the Marmot

Review which is for better data on ethnic health inequalities. This will help both national and local policy makers design services and policy interventions to reduce these inequalities.

Lewisham Population - Protected Characteristics and Geography

Age and Sex

Lewisham has a relatively young population with just under 25% of residents aged under 18 years.

	Male	Female	Total
0-17	35,095	33,363	68,458
18-64	102,157	104,440	206,597
65+	12,597	15,884	28,481
Total	149,849	153,687	303,536

Median age: 35.0 years

Source: ONS 2018 Mid-Year Population Estimates

Race (Ethnicity)

The latest estimated figures show that the largest ethnic group in Lewisham remains White with 51.8%, including those from White ethnic minority backgrounds, followed by Black African 11.6% and Black Caribbean backgrounds 9.8%. Black ethnic groups make up in total nearly a third of the borough's population.

The composition of the demographics for younger people is quite different to the population as a whole. While the white ethnicity group remains the single largest single group at 34%. The Black groups as a whole make up 45% of the under 18 population, with Black African and Black Caribbean population composing 24% of the population. While, Black Other population (including those of Mixed White and Black race) make up a further 21%.

Meanwhile, the over 65s population is 59% White British, with ethnic minority groups making up 30%. The Black Caribbean community is the second largest ethnic group making up 13% of the over 65 population.

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Religion or belief

	2011 Census	
	Number of residents	% of residents
All residents (as of March 2011)	275,885	100%
Christian	145,588	52.8%
Buddhist	3,664	1.3%
Hindu	6,562	2.4%
Jewish	643	0.2%
Muslim	17,759	6.4%
Sikh	531	0.2%
Other religion	1,478	0.5%
No religion	75,155	27.2%
Religion not stated	24,505	8.9%

The 2011 Census remains the most comprehensive source for data on religion/faith for residents.

Sexual orientation

Data on sexual orientation is not readily available at a local authority level. The best estimates are based upon the Office for National Statistics Annual Population Survey, which asks a question regarding sexual orientation. 2.7% of people over the age of 16 nationally identified as Lesbian, Gay or Bisexual. This rises to 6.6% of those aged 16-24% showing a changing demography that is being led by those of a younger age. 2.9% of males identified as LGB, while 2.5 of females identified as LGB. If the national figures were applied to Lewisham, this would equate to 16, 500 residents.

Source: ONS Sexual Orientation, UK: 2019.

Disability

14.5% of residents are living with a long term condition which limits their daily activities. This is slightly below the England average of 17.6%, however this is likely to be due to the younger population bias. For those of working age this reduces to 11.5%.

Pregnancy and maternity

There were 4,393 live births in Lewisham in 2019. (ONS, 2020)

Marriage and Civil Partnership

The 2011 Census asked adult residents about that marital status. Almost half of the population stated they were single.

	Single	Married	Civil Partnership	Separated	Divorced	Widowed
% Martial status	49.7	32.7	0.5	4.3	8.1	4.6

Gender reassignment

We do not have any reliable local figures regarding gender reassignment. Currently data is not readily available on gender identity. The 2021 census included a voluntary gender identity question that was asked of those 16 years and over. When released, the data on gender identity may be useful in helping to identity areas for policy development and service planning.

Overview of Lewisham Health Inequalities Indicators

The public health outcomes framework (PHOF) from Public Health England (PHE) outlines key public health indicators in five key areas:

1. **Overarching indicators**
2. **Wider determinants of health**
3. **Health Improvement**
4. **Health Protection**
5. **Healthcare and Premature Mortality**

PHE have developed a Health Inequalities Dashboard to present evidence of health inequalities in England. The dashboard provides measures of inequality for key indicators being used by PHE to monitor progress on reducing health inequalities within England.

This toolkit presents the available data for Lewisham from the PHE Dashboard across the five areas outlined. Data has been taken from the most recently updated version of the PHE Dashboard (2nd March 2021). Where there is local data available with measures of inequality in any of these five areas by geography, deprivation or protected characteristic, it will be presented.

1. Overarching indicators

Life expectancy at birth

Life expectancy at birth data is available for Lewisham by area deprivation levels. This is also available split by gender (male and female).

Life expectancy at birth has increased for men between 2001-03 (74.5 years) and 2017-19 (79.1 years), however the rate of increase has slowed in recent reporting periods. This has also increased for women between 2001-03 (79.1 years) and 2017-19 (83.8 years) with the rate of increase slowing in the last 2 reporting periods (since 2013-15).

Slope index of inequality (SII) in life expectancy based on Index of Multiple Deprivation deciles

The Slope Index of Inequality (SII) in life expectancy for men in Lewisham was 7.4 years for the 2017-19 reporting period. This indicates the variation in life expectancy across most to least deprived areas in Lewisham for men is 7.4 years. The SII in life expectancy was lower for women at 5.8 years for the 2017-19 reporting period indicating a less steep gradient of inequality in life expectancy at birth.

2. Wider determinants of health

School readiness (% children not achieving a good level of development)

Education is an important determinant of health and school readiness i.e. children defined as having reached a good level of development at the end of the Early Years Foundation Stage (EYFS) is an indicator of early childhood learning and development. In Lewisham the proportion of children not reaching a good level of development at the end of EYFS was 23.6% for the 2018/19 reporting period.

In terms of inequality, this data is available for those who receive free school meals (FSM) and those that do not, which can be used as a proxy measure for deprivation. The absolute gap in those not achieving a good level of development between those receiving FSM and those who do not was 12.1% for the 2018/19 reporting period (34% for those receiving FSM and 21.9% for those who do not), which is an increase in absolute gap since 2013-14 (9.5%). The relative gap i.e. the proportional gap between those receiving FSM and those who do not was 1.6 for the 2018/19 reporting period. This indicates that children from deprived backgrounds in Lewisham are more at risk of poorer development and the evidence shows that differences by social background emerge early in life.

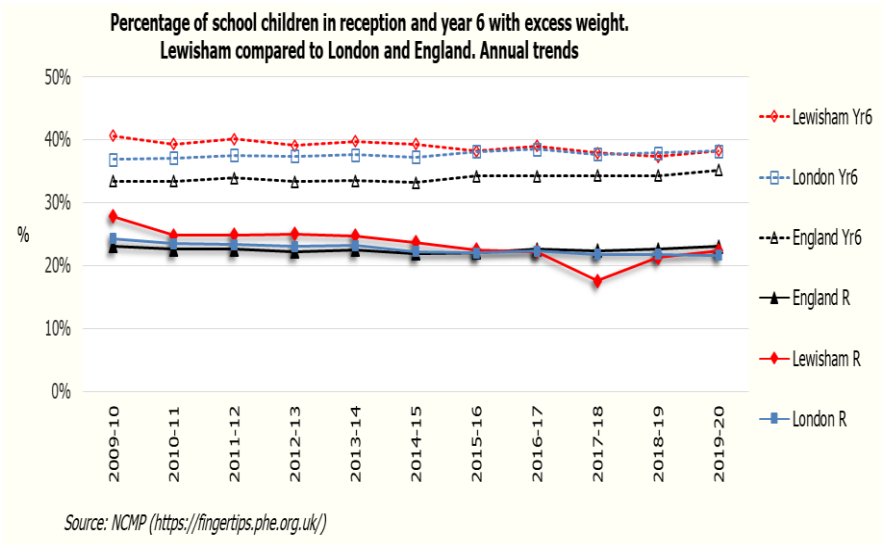
Employment rate

Employment and the availability of good work is another important determinant of physical and mental health and wellbeing. In terms of inequality the rate of employment in Lewisham is available for those that have a long-term health condition (that is expected to last for more than 1 year) and those who do not. In Lewisham the gap between employment rates in those aged 16-64 years with a long-term condition and the overall employment rate was 12.9% for the 2019-20 reporting period, with the rate being lower in those with a long-term condition. This gap has fluctuated in Lewisham since 2013 and 2020, being lowest in 2015-16 at 4.2% and highest in 2013-14 at 13.4%.

3. Health Improvement

Prevalence of overweight and obesity for reception and year 6 children (Local National Child Measurement Programme data)

Lewisham has high levels of childhood obesity with one in five children in Reception Year with excess weight (overweight or obese), similar to London and England levels. This rises to nearly two in five children in Year 6, similar to London but significantly higher than England. There has been a small reduction in prevalence but the challenges and inequalities persist. There are differences in childhood obesity levels depending on where children live in the borough with highest levels found in areas of highest deprivation, half of Year 6 children in New Cross are overweight or obese compared with just over a quarter in Crofton Park. There are differences depending on children's ethnic background too, with 43% of Lewisham's Black Year 6 children being overweight or obese compared with 26% of their White counterparts.



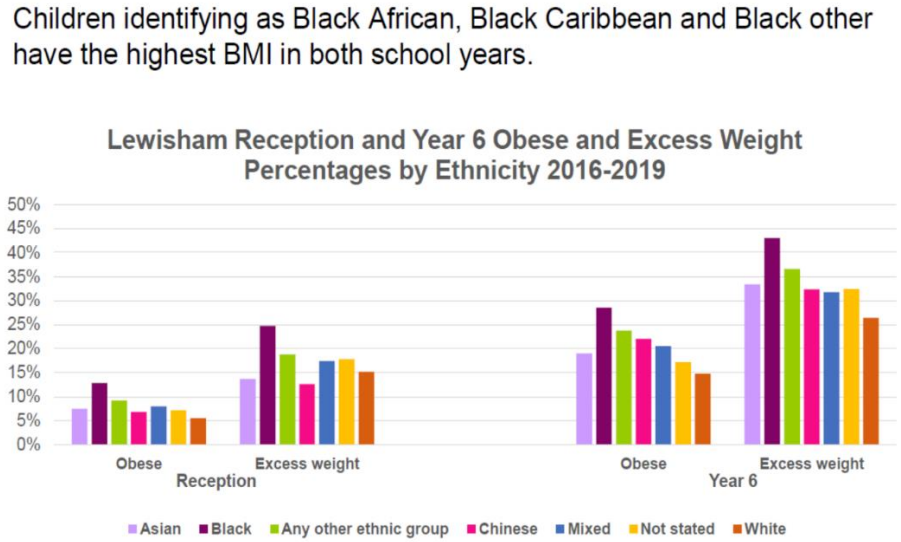


Figure 8 Excess weight in Lewisham (Annual Trends and by ethnicity)

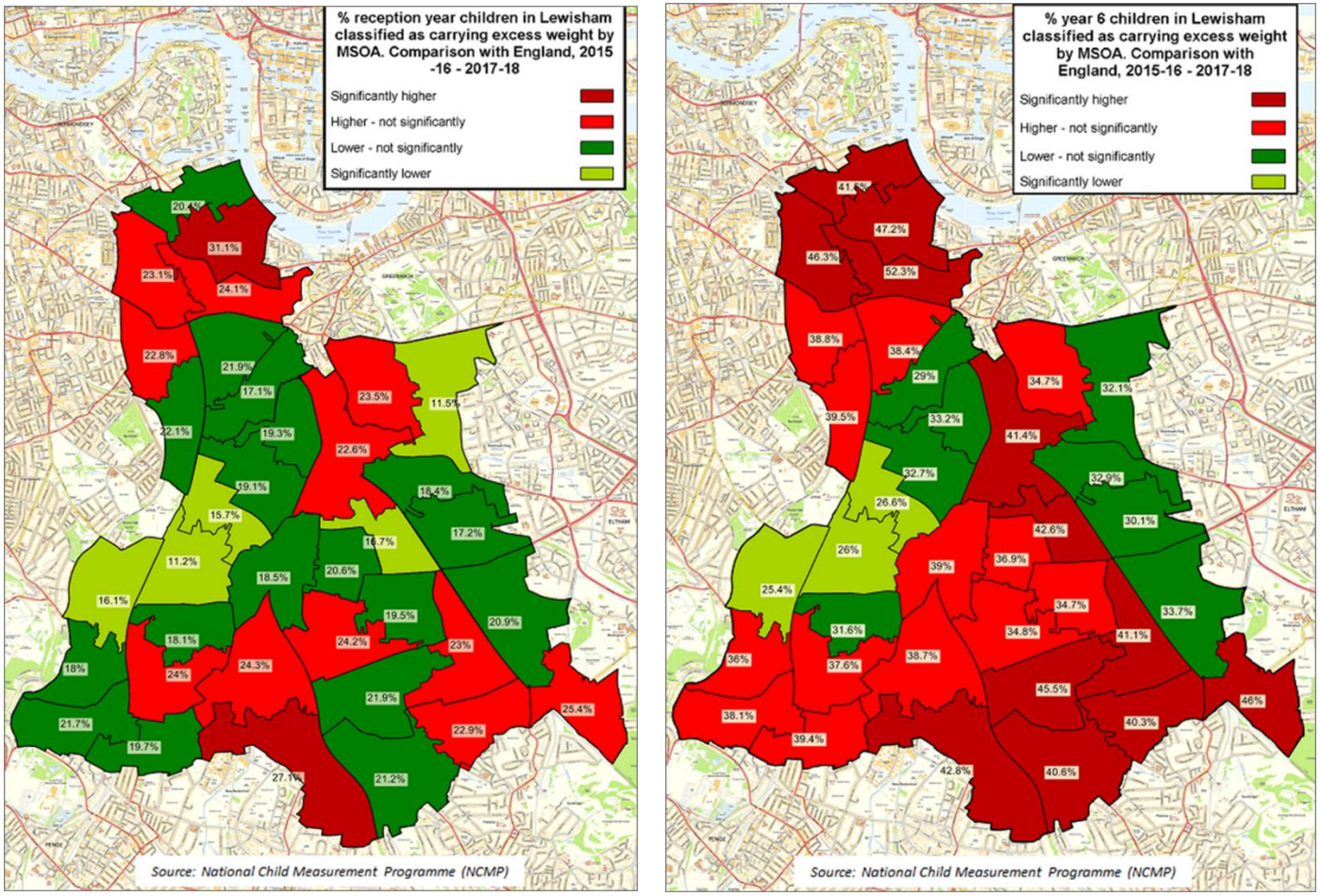


Figure 9 Excess weight in Lewisham by MSOA (reception and year 6)

Smoking Prevalence in adults (18+) - current smokers (APS)

Smoking is the one of the most important causes of preventable ill health and premature mortality in the UK. Smoking is a major risk factor for many diseases, such as lung cancer, chronic obstructive pulmonary disease (COPD) and heart disease. It is also associated with cancers in other organs, including lip, mouth, throat, bladder, kidney, stomach, liver and cervix. Smoking rates in Lewisham are above the London and England average rates.

Smoking Prevalence in adults (18+) current smokers (%) 2018	
Lewisham	16.7
London	13.9
England	14.4

In terms of inequality there is significant divergence in smoking prevalence between social classes. Those in routine and manual occupations are most likely to smoke and in Lewisham have a smoking prevalence of 25.9%, while those in managerial and professional occupations are the least likely to smoke with a prevalence of 13.8% for the 2018 reporting period.

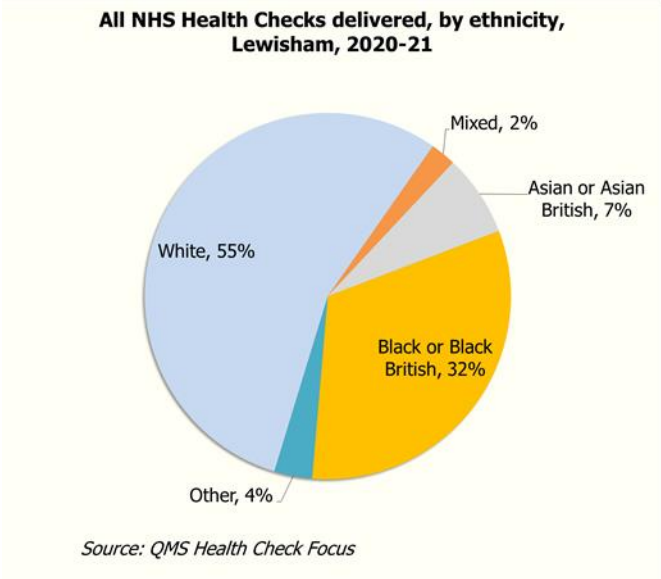
Lewisham is above the national and regional average for those who have quit smoking at 4 weeks, with 2,344 smokers quitting per 100,000 in Lewisham compared to 1960 in London and 1894 in England. This is a trend that has been in place since 2013, when Lewisham initiated and redesigned its Stop Smoking services. The target is to reduce smoking to 12%. In Lewisham we know that 30% of those who quit smoking are from minoritised groups: 8.5% black Caribbean, 5.3% black African, 1.5% other black groups, 5.2% all Asian groups, 5.4% mixed, 3.6% Chinese.

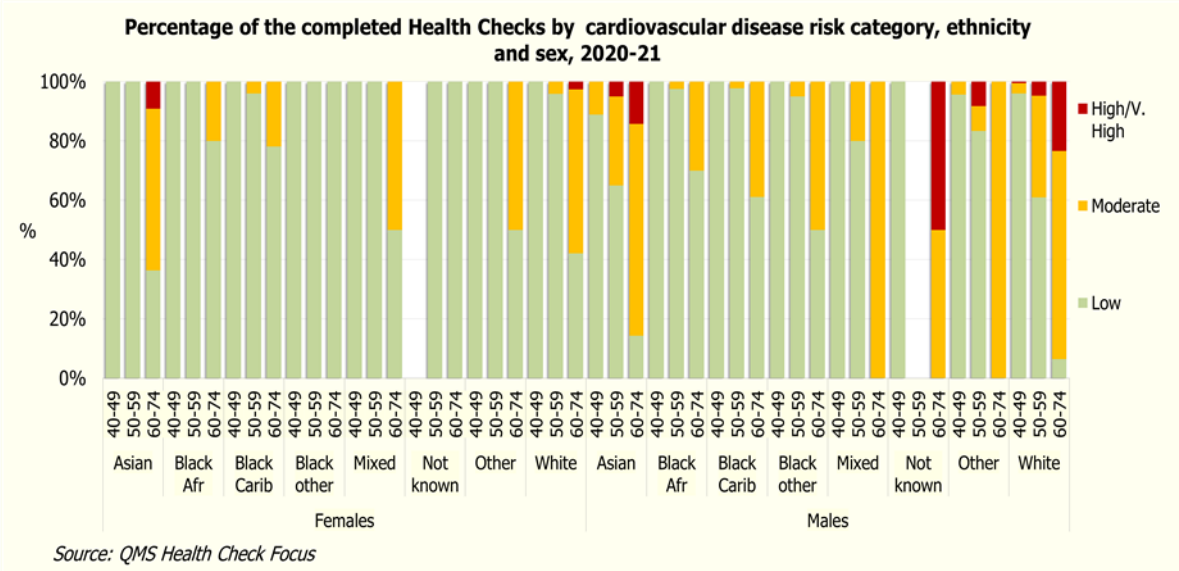
NHS Health Checks Programme

By promoting healthy ageing and tackling the top seven risk factors for early death and disability, the NHS Health Check provides a cornerstone for the prevention of cardiovascular disease, as well as kidney disease, type 2 diabetes and dementia. People are invited for a NHS health check every five years. Lewisham is now in its second five year cycle of invitations. Eligible people are defined as 40-74 year olds who are not already identified as having vascular disease or on a disease register and have not received a Health check in the past five years. Ensuring that a high percentage of the eligible population have a NHS Health Check is key to optimising the clinical and cost effectiveness of the programme.

The following key priority groups, who have an increased risk of cardiovascular disease are prioritised for invitation for a Health Check. They are: South Asians, males, people with a family history of cardiovascular disease, smokers and people residing in areas of higher deprivation by

postcode. Whilst the White population received over 50% of NHS Health Checks in Lewisham in the financial year, due to the older average age profile of this population this was representative.





4. Health Protection

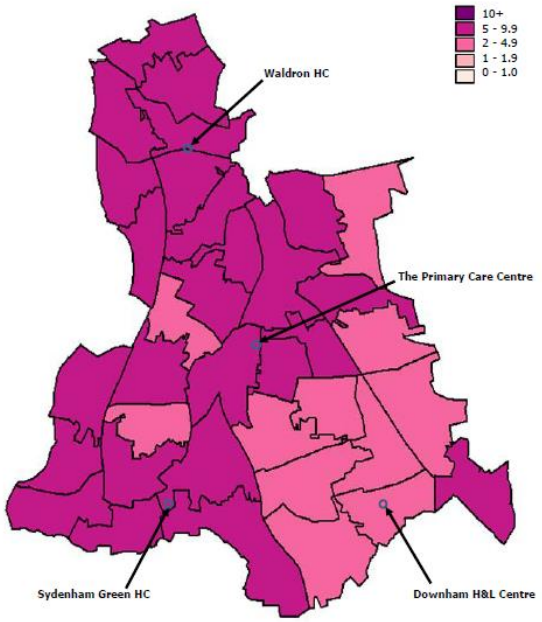
HIV Late Diagnosis

Lewisham has one of the highest rates of HIV prevalence in the country, with a new diagnosis rate at 20.1 per 100,000 aged 15+. HIV is now a treatable and liveable disease, however if diagnosed late there is a significantly higher risk of premature death. Therefore reducing the number of people who have a late diagnosis is vital. In Lewisham the late diagnosis rate from 2016-18 was 44.3%.

	Lewisham	London	England
New HIV diagnosis rate/ 100,000 aged 15+	20.1	20.9	8.8
HIV late diagnosis (%)	44.3	37.1	42.5

These figures paint a mixed picture with the new diagnosis rate lower than the London average, but the percentage of late diagnoses higher. The distribution of HIV prevalence is not even across the borough (Figure 10).

Figure 10 HIV prevalence/1000 population of all ages by Lewisham MSOA, 2017



Source: HIV and AIDS Reporting System (LASER report)

London wide the data shows that 48% of London residents diagnosed as living with HIV were White, while 31% were of Black African ethnicity. The rate of diagnosed HIV prevalence between ethnic groups varies significantly across London, from 26.0 per 1,000 residents aged 15-59 in the Black African population to 1.0 in the Indian/Pakistani/Bangladeshi population.

In Lewisham, heterosexual contact is the most common exposure type (54%) of those diagnosed with HIV. This differs from neighbouring boroughs where sex between men is the most common HIV exposure category. Late diagnosis is significantly higher in heterosexual men and women in comparison to men who have sex with men (MSM).

	HIV late diagnosis (%), Lewisham 2018
Heterosexual men	64.5
Heterosexual women	48.8
Men who have sex with men	34.8

In Lewisham free confidential home sampling kits are available for those in at risk groups, MSM, those from Black African communities, and injecting drug users.

Of those diagnosed with HIV, 99% of patients are on anti-retroviral therapy (ART). Successful ART ensures that someone who is HIV positive has an 'undetectable viral load' and are known as virally supressed, which means that the levels of HIV in someone's blood are so low they cannot be passed on to another person. Of those on ART in Lewisham, 97% are virally supressed (VS).

5. Healthcare and Premature Mortality

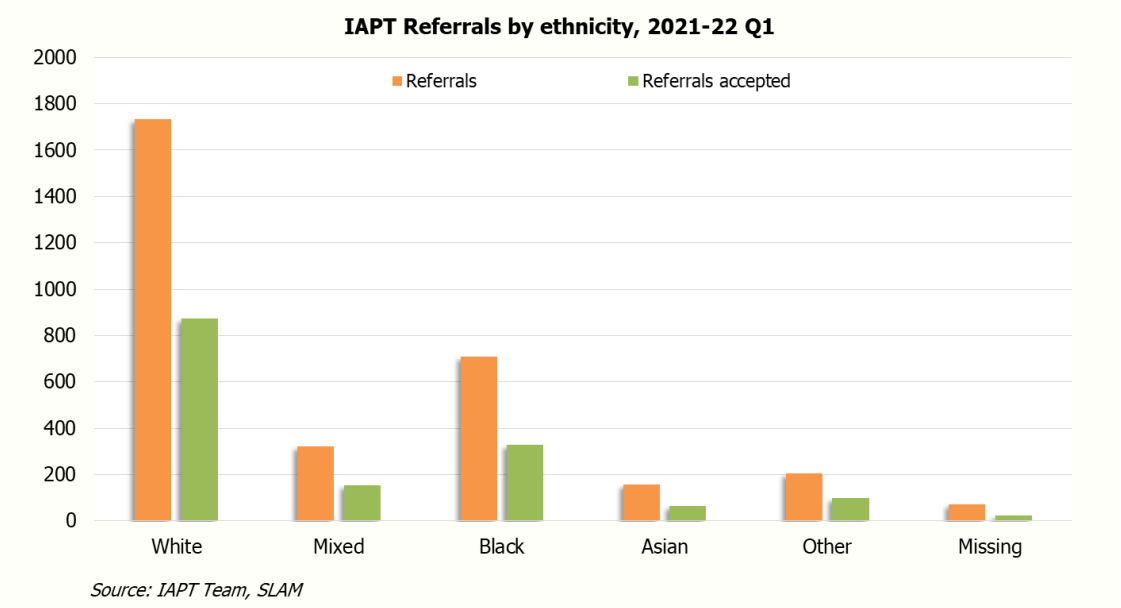
Mental Health in Lewisham

Lewisham has lower average wellbeing scores than London or England. Just over 8% of adults in Lewisham have a recorded diagnosis of depression. This is significantly higher in than in London (7.1%). This is also likely to be an underestimate of actual prevalence, as not everyone who has depression will visit their GP. Just over 1% of people in Lewisham have a recorded diagnosis of severe mental illness (SMI). This is significantly higher than in London (1.1%) and in England (0.9%).

The prevalence of mental ill health is not spread evenly across the population, and there are some population groups that have higher rates of mental ill health in Lewisham, including:

- Black, Asian and Minority Ethnic populations have higher prevalence rates of some mental health conditions, e.g. psychotic disorder, Post-Traumatic Stress Disorder (PTSD), and also experience inequalities in access to services.
- The rate of admission to hospital for mental and behavioural disorders due to alcohol is significantly higher in Lewisham than in London. Approximately a fifth of adults receiving drug misuse treatment and alcohol misuse treatment were also in contact with MH services
- The gap between the employment rate for all people and just those in contact with secondary mental health services is higher in Lewisham than in London or England, and the gap has increased steadily in the last few years
- The proportion of adults in contact with secondary mental health services and known to be living independently (with or without support) is significantly lower in Lewisham than in England and London

There is a strong link between mental health and physical health: Adults in Lewisham who are in contact with secondary mental health services are more than three times as likely to die as people of the same age in the general Lewisham population. There are many causes of this, but the higher smoking prevalence amongst people with SMI is likely to be part of the explanation.



Source: IAPT Team, SLAM

IAPT (Improving Access to Psychological Therapies) services offer talking therapies, such as cognitive behavioural therapy (CBT), counselling, other therapies, and guided self-help. They aim to provide help for common mental health problems, like anxiety and depression.

In Lewisham in Quarter 1 of 2021/21 the greatest number of referrals to the IAPT service where for patients from a White ethnic group. Referrals appear to be more likely to be accepted for White patients than from any other ethnic group.

What is happening in Lewisham to address health inequalities?

Lewisham Health and Wellbeing Board and the Birmingham Lewisham African and Caribbean Health Inequalities Review (BLACHIR)

The Lewisham Health and Wellbeing Board is continuing to prioritise tackling health inequalities in Black, Asian and Minority Ethnic residents in Lewisham, particularly in light of the disproportionate impact that COVID-19 has had on Black and Asian communities. During the pandemic the Health Inequalities working group of the Health and Wellbeing Board has developed a specific work stream around COVID-19 to drive forward action in the following areas:

- COVID-19 communications and engagement with Black, Asian and Minority Ethnic residents through the development of the Lewisham COVID-19 Community Champion programme.
- Data collection around COVID-19 deaths where we now locally collect ethnicity data the time of death registrations.
- Overseeing the collaborative work that Lewisham is undertaking with Birmingham City Council to perform an in-depth review of health inequalities in Black African and Black Caribbean residents in Birmingham and Lewisham. This review has now started and is due to complete in 2022: https://lewisham.gov.uk/myservices/socialcare/health/improving-public-health/birmingham-and-lewisham-african-and-caribbean-health-inequalities-review

Health in All Policies Annual Public Health Report

This year's Annual Public Health Report for Lewisham focuses on Health in All Policies (HiAP). HiAP describes a whole-system approach to improving health and wellbeing, reducing inequalities and delivering better outcomes for individuals and communities.
The report makes the following recommendations for implementation over the coming year:

- Harness the learning from whole system working on COVID-19 and continue to work with stakeholders across the council and wider system to increase understanding and build capacity to further implement a health in all policies approach.
- Build on existing work to formalise a health in all policies approach at all stages of service development and strategy and policy-making.
- Continue to champion the health in all policies approach at a strategic level by highlighting the links between improvements in population health and the achievement of corporate and other strategic priorities.
- Develop a framework to enable the ongoing and robust assessment of the impact of policy decisions on health and health inequalities within the Lewisham population

Glossary

Health Inequalities: the avoidable and unjustified differences in the health status of groups and individuals that are not inevitable or immutable.

Healthy life expectancy: the average number of years that an individual is expected to live in a state of self-assessed good or very good health.

Intersectionality: the idea that when it comes to thinking about how inequalities persist, categories like gender, race, and class are best understood as overlapping and mutually constitutive rather than isolated and distinct.

Life expectancy at birth: the average number of years that a newborn could expect to live.

Lower/Middle Layer Super Output Area (LSOA/MSOA): a geographic area that has a minimum population of 1,000 people.

Premature Mortality: mortality rates for deaths under age 75 for all causes combined and leading causes of death.

Proportionate universalism: is the resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need.

Protected Characteristics: Protected characteristics are specific aspects of a person's identity defined by the Equality Act 2010. The 'protection' relates to protection from discrimination. There are nine protected characteristics:

1. Age
2. Disability
3. Gender reassignment.
4. Marriage and civil partnership.
5. Pregnancy and maternity.
6. Race
7. Religion or belief.

8. Sex

9. Sexual orientation.

Slope index of inequality (SII): a measure of the social gradient in life expectancy, i.e. how much life expectancy varies with deprivation.

Social determinants of health: the broad social and economic factors that we grow up and live in that interact to influence the health of a population.

Further resources

Public Health England Health Inequalities Dashboard: https://analytics.phe.gov.uk/apps/health-inequalities-dashboard/

NICE guidance on Community engagement to reduce health inequalities: https://www.nice.org.uk/guidance/ng44

PHE guidance on local action to understand and reduce ethnic inequalities in health: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/730917/local_action_on_health_inequalities.pdf

PHE Reducing health inequalities: system, scale and sustainability: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/731682/Reducing_health_inequalities_system_scale_and_sustainability.pdf

PHE Place-based approaches for reducing health inequalities: https://www.gov.uk/government/publications/health-inequalities-place-based-approaches-to-reduce-inequalities

Marmot review Health Equity in England: the Marmot review 10 years on: https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on

Marmot Review Fair Society, Healthy Lives: https://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review

PEH Health Equity Assessment Tool: https://www.gov.uk/government/publications/health-equity-assessment-tool-heat