Scrutiny Action Log

Name of Committee: Children and Education Scrutiny Sub-Committee
Municipal Year: 2022-23

Reference	Action	Assigned to	Scrutiny Lead	Due Date	Response
Insert date	Insert agenda item title and the action requested by the committee	Insert name of director	Insert scrutiny lead	Insert Date	Response provided by the service/ witness
14.07.22					
13.10.22	**1. Youth Justice: The Youth Justice Service Performance with a specific focus on drugs, grooming of young people and county lines** The committee requested a response about the new responsibilities around education and attendance.	James Thomas Corporate Director for Children & Culture	Cllr Bodrul Choudhury CESSC Chair	20.10.22	Response provided on 19.10.22. See Appendix 1 for response.
	2. Youth Justice: To understand the findings from the inspection report and review the plan for improvement The committee raised concerns about the rising number of children from Tower Hamlets entering the criminal justice system and wanted to know why.	James Thomas Corporate Director for Children & Culture	Cllr Bodrul Choudhury	20.10.22	Response provided on 19.10.22. See Appendix 2 for response.
21.11.2022	Challenge Session: Increasing women and girls access to sports provision	James Thomas Corporate Director for Children & Culture	Cllr Bodrul Choudhury	20.12.22	See Appendix 3 response received on 12th January 2023

	The committee requested data/breakdown of female participation in sports in Tower Hamlets, with a specific focus on ethnicity. The committee requested a response on whether the 'first come' policy has been reviewed. The committee requested a response on any actions or plans being taken to redesign existing sporting facilities in Tower Hamlets to make them more accommodating to women and girls.				
08.12.22					
09.02.23	5.2 Safe East School Health Service The committee requested further data on the uptake of Safe East Outreach Sessions.		Cllr Bodrul Choudhury	10.03.23	Not yet provided, will be included as Appendix 4 once received.
	5.2 Safe East School Health Service The committee requested detailed information on Tower Hamlets Together including the workplan.		Cllr Bodrul Choudhury	10.03.23	Response provided 09.03.23. See Appendix 5 for response.
	5.1 Youth Provision To provide a written response on how ethnicity data is being collected for youth service participation with specific reference to Black		Cllr Bodrul Choudhury	10.03.23	Response provided 21.03.23. See Appendix 6 for response.

	African or Caribbean young people and provide clarity on whether there is any overlap between categories e.g., Somali and Black / African.				
04.05.23					

Insert attachments as appendices where applicable

Appendix 1:

The new responsibilities and attendance

The role of the Virtual School supporting the YJS and the *educational engagement of children on orders.**

*Please note that educational engagement is the term used by the Department of Justice that means attendance but also has a wider meaning re: enabling attendance for children with no ETE offer. i.e. Taking a child presenting as NEET to ETE.

The Virtual School for Children in Our Care (CIOC) works alongside the YJS to support all children who are on an order, to improve or create engagement with education. Put simply, this is attendance with or sourcing of an educational offer.

There is an element of cross over with the most difficult to reach cases in care also coming under the YJS so the Virtual School jointly funded an education officer with the service.

The Education Officer is a qualified teacher (QTS) who works between the Virtual School and YJS.

The Virtual School also works across Education and the Social Care provision of the authority to get the best outcomes for children in its remit. This is a very powerful synergy, providing comprehensive insight and support for professionals and the children. At inspection this was seen as strength.

The Education Officer is part of a team of education professionals in the Virtual School, receiving constant educational continuous professional development (CPD) essential due to the fast-paced movement of curriculum change in KS4, KS5 and vocational education that our children access. The post holder provides strategic support to all YJS staff across the entire cohort whether in care or not. This support includes navigating school and college offers to make sure all children have an ETE offer. For example at the start of the academic year advocating for young people, often in place of their parents, to make informed decisions about education offers. This advocacy is essential due to the challenging nature of the cohort, which has high levels of SEND, EAL and histories of underachievement, exclusion and disruption to learning.

The Education Officer and Headteacher of the Virtual School are the visible face of the service for our schools and other establishments, reassuring, supporting and challenging teachers and leaders to promote the educational engagement of our children. It is essential that our children and their needs are visible. This representation extends to the Tower Hamlets Safeguarding Service (THESS) which is also under the remit of the Virtual School Headteacher. This linkage provides regular insight

into the Designated Safeguarding Lead network (DSLs) of all our schools. This allows the service to clearly communicate policy and expectations for education in the YJS across the LA.

Education placement and via this attendance, is further supported by the Education Officer being a sitting member of the Fair Access Panel (FAP) which makes sure that school age children with issues arising are placed in the most suitable provision. This linkage means that 100% of our school age children have a school to attend.

It is essential that the needs of our learners are advocated for with internal and external agencies who can offer support to improve engagement. When needs are met, attendance improves.

The education officer links with the wide variety of education, vocational and careers areas that the LA offers. For example, the SEND department has a Youth Justice Champion who assists advocating for needs assessments and health requirements to be reflected into comprehensive Educational Health Care Plans (EHCPs) sometimes created from scratch because the need has previously been missed.

The THESS also has oversight of Children Missing in Education and any child Electively Home Educated (EHE). In other authorities' children known to the YJS can fall into these categories in particularly EHE. Our joined-up services mean we are alerted to any child in these categories instantly. We do not have any electively educated child out of school on an order nor would it be allowed.

Attendance work in place - A key responsibility of the Education Officer is to promote engagement with education. This means good and regular attendance to set ETE hours and for statistical purposes, this is measured as "on the last week of the order." This is that we aim to improve attendance, or in many cases, gain education offers for children so their engagement is better by the time their order is complete, than when they joined the service.

School age - In the Virtual School, we monitor attendance in real time for all children in care. To do this for the YJS, we work with the Behaviour Attendance Support Service – BASS – to monitor attendance daily with our schools. This monitoring has 100% coverage for children of school age and has proved very effective in spotting attendance tailing off or difficulties at school. Schooling provides many the supervision hours required by an order. Our work with the BASS means that 100% of our school age children have an educational offer and 70% of those children improved or maintained their attendance while on an order last year. 30% of those children had very good attendance at 85%+. This confirms that being on an order has a positive impact on a child's engagement with education. This makes sure a child is safe and gaining the skills and support to we hope not to reoffend.

Post-16 - Monitoring attendance for young people Post-16 is more problematic. This is due to the wide range of institutions involved, varying attendance requirements for College Courses and the co-operation of FE colleges in data collection. To counter these issues, the Virtual School pays for an Attendance and Welfare Officer from the BASS to phone institutions and develop relationships. The officer has now been in place for the last year, progressing attendance monitoring from just at New City College and LEAP in the LA to a wider range of both in and out of borough institutions. Coverage is not 100% and there are children in this cohort NEET. However, 54% of children in a provision monitored had improved or maintained their attendance while on an order last year.

The challenge at Post-16 remains the number of children NEET. Many come to notice out of the academic cycle, making it very difficult to gain a place on a course. Work and apprenticeship options are limited because the majority do not have L2 English and Maths – a requirement for these options.

We have put in place three solutions to this issue

- Halilbury Youth Centre offers access to Street League, which provides sports leadership qualifications and L2 Functional Skills English and Maths. This is often 1:1 support for the most challenging young people.
- Prevista at KitKat Terrace also offer Functional Skills L2 English and Maths. This is in a group setting and can be joined on a rolling basis as children come to notice. This also supports over 18's who need to gain L2 English and Maths.
- Finally, in the past two years, LEAP – our alternative provider – has extended its offer to children Post-16. At present, this is for children already studying at LEAP graduating from KS4. This is a sizable number of our cohort. This is a fantastic support for our children as it provides a continuous education offer with professionals they know and trust. Courses include Functional Skills in English and Maths as well as pathways into work via the West Ham Foundation and NHS. The offer at LEAP has been further improved for children known to YJS by winning funding for a Task Force from the Department of Justice to support children who could be drawn into crime.

New responsibilities for the Virtual School and how these will support the YJS - The Education Officer was put in place to give expert support to our children but also because horizon scanning by the Headteacher indicated a direction of travel from the DfE and central government re: Virtual Schools being asked to support a wider remit of children vulnerable.

You will notice the Virtual School Headteacher has the additional title: Executive Headteacher of the Corporate School for Children Vulnerable. The latest of these additional responsibilities is now formally in place: Children With A Social Worker (CSW) – See attachment. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1086931/Promoting_the_education_of_children_with_a_social_worker_-_virtual_school_head_role_extension_2022.pdf This new responsibility is strategic. It requires the Virtual School to move to monitor and give support to schools and agencies working with CWS, making the needs of these children visible. Underachievement of this group is higher for all metrics than Children in Care. Care in almost all cases sees a rise in attendance, outcomes and progress for

CIOC. Our first step on meeting this challenge has been to appoint an Assistant Headteacher to be the visible advocate for CSW and champion initiatives to support key groups in the cohort. The YJS cohort is one of these groups – we will be researching what works and what are the common challenges for CSW on cohorts. This work will be supported by a DfE research partner, and we have further reached out to the National College of Education for academic support.

The new responsibility is formative, and the post holder must contribute to research re: what works for Children in Need (CIN), requiring Child protection (CP) or close to care. Every authority will be sharing their findings to agree national policy going forward.

Appendix 2:

More children are in our criminal justice system.

We are not able to compare the total number of children that we are working with in total to that of our neighbours. However, we can compare performance against Key Performance Indicators (KPIs) that all Youth Justice services are marked against.

First Time Entrants:

Our First Time Entrants are higher than Waltham Forest and Hackney. However, we have been able to reduce our numbers year on year by a similar extent to our neighbouring boroughs.

The HMIP report highlighted that we were not using our diversionary offer as well as we could have done. We have had a renewed focus on this and we have already been able to see this in our data of the last 6 months.

	Tower Hamlets and City of London	**Waltham Forest**	**Newham**	**Hackney**
First Time Entrants				
Apr 21 - Mar 22				
First Time Entrants	72	55	93	49

Rate per 100,000	**236**	**214**	**278**	**192**
Apr 20 - Mar 21				
First Time Entrants	96	72	116	82
Rate per 100,000	**313**	**279**	**345**	**321**
% difference	**-25%**	**-23%**	**-19%**	**-40%**

Use of Custody

In relation to the custody KPI of the number of children that we have in custody, we have the lowest rates of children in custody and are doing significantly better than our neighbours for the last 2 years.

	Tower Hamlets and City of London	**Waltham Forest**	**Newham**	**Hackney**
Use of Custody				
Jul 21 - Jun 22				
Custodial disposals	2	4	8	11
Rate per 1,000	**0.07**	**0.16**	**0.24**	**0.44**
Jul 20 - Jun 21				

Custodial disposals	4	4	7	8
Rate per 1,000	**0.13**	**0.15**	**0.21**	**0.31**
% difference	**-6%**	**0%**	**3%**	**12%**

Appendix 3

1. Data/breakdown of female sports participation in Tower Hamlets, with a specific focus on ethnicity.

Leisure Centre Female Participation Breakdown can be viewed in the table below and illustrates the current percentage of BAME female users across the borough. Usage figures were configured from Dec 22 Usage.

	Pre-Paid Members		Usage	
Centre	**BAME %**	**Non-BAME %**	**BAME %**	**Non-BAME %**
John Orwell Sports Centre	25.23	74.77	60.55	39.45
Mile End Park Leisure Centre	55.49	44.51	64.36	35.64
Poplar Baths Leisure Centre	60.78	39.22	60.91	39.09
Tiller Leisure Centre	51.36	48.64	51.73	48.27
Whitechapel Sports Centre	79.23	20.77	74.27	25.73
York Hall Leisure Centre	28.26	71.74	26.42	73.58
Total	**51.96**	**48.04**	**58.51**	**41.49**

Current BAME female participation has risen in Q3 but with a slight decrease in pre-paid members across the borough. It should be noted that GLL has declared that the statistics are representative of those who have listed their gender as female and does not incorporate data from pre-paid members that did not disclose their gender or “preferred not to say”. For context it is a national trend that membership and participation reduce as the nights get longer, weather changes and we build to the end of the year.

The recognised way that sports participation, including that for women, is recorded is the Sport England Active Lives Survey. The Council is currently working with Sport England and London Sport to obtain the female participation data for Tower Hamlets, which will be used to set the baseline for our Women & Girls Sport Action Plan

2. A written response on the 'first come' policy (first refusal for bookings) being a barrier to women and girl's sporting provisions in Tower Hamlets and how the council plan to address this.

The first come first served priority booking system is an industry standard employed across the country, whereby an existing booker of a sports facility get priority booking in the next period if an application is submitted within the given time period. This provides continuity for the booker and its participants and consequently the ability to maintain participation. There have been no complaints regarding limited or less access for female sport and there is no indication that this policy has adversely impacted female sports participation in any way. Examples of where female participation is well represented (in female football, hockey and rugby) can be evidenced at both John Orwell and Mile End between 18.00 – 22.00.

3. A written response on any prospective plans for the commissioning/redesigning of existing sporting and leisure spaces to ensure the safety of women and girls, once sports and leisure services move in-house. Also, a written response on working on co-production with women and girls to bring sports into the community.

All sports facilities are and will be designed in accordance with Sport England Technical guidance, which outlines best practice. Safety is a key consideration within the design guidance and the technical design guidance can be viewed on Sport England's website here.

A Women's & Girl's Sport Action group has been established initially with representation from various Council Departments with the intention to increase membership to include:

- Community / sport representatives and

- Regional and national organisations such as the Muslim Women's Sport Foundation, The Youth Sport Trust, London Sport etc

The Group is currently planning a programme of female sport starting with the tasks informed by the calls to action from the Overview and Scrutiny and the promotion of International Women's Day with a week of activity co-produced with the local community designed by women for women.

In preparation for the service coming in-house, the Council will undertake consultation and co-production with partners, users, staff and the community to inform and potential future investment and programming. It is proposed that the first workshop is held in first quarter 2023 to look at options for the future programming of the estate.

As set out above, the Council will seek to engage in April 2023 on how the Leisure Service will operate from May 2024. This consultation is being developed currently, and is expected to include the following themes, if not exclusively:

- Identify what actively deters women and girls from using leisure centres now, whether this is driven by the way facilities are designed, their condition, the cost of the service, the level of staff training, etc.
- Discover what activities women and girls would most want our leisure centres to offer, when, and in what format (e.g. mother & child swimming sessions on a Saturday morning, women only swimming for an hour every day, etc.)
- Find out what improvements would encourage more use of our leisure centres by women and girls, prioritised by the scale of impact, to identify any 'quick wins'
- Seek advice on what other, non-leisure, facilities and/or activities would encourage women and girls to enter our leisure centres, e.g. places to meet, family friendly spaces, refreshments, etc.
- How women and girls want to be engaged and find out about activity and opportunities.
- Opportunities to gain qualifications, volunteer or enter employment

Appendix 5 –Tackling Race Inequalities work (BAME commission) health workstream

BAME Commission Public Health Projects

Project Sponsor:
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Introduction

The lived experiences, opportunities and outcomes for Tower Hamlets' Black, Asian and Minority Ethnic communities (BAME) differ detrimentally from those of their White peers. Structural and institutional racism remains a debilitating issue and many residents have neither had equal access to services or employment nor fair treatment and opportunities.

These were emphasised by the London borough of Tower Hamlets BAME Commission which also highlighted the poorer health outcomes associated with ethnicity, linkages to structural racism and the impact of COVID-19 in bringing these inequalities into focus.

This paper outlines indicative projects and interventions commissioned by Tower Hamlets Department of Public Health in response to the recommendations of the BAME commission. These projects include:

- Embedding Learning from Covid-19 Health Communication in the London Borough of Tower Hamlets
- Culturally Appropriate Health Communication and Engagement
- Barriers and Enablers of Trust in Health Services
- Ethnic Health Inequalities in Tower Hamlets: key stakeholder interviews
- Quantitative data on ethnic health inequalities: June 2022

- Vaccine Hesitancy and Lack of Trust

Embedding Learning from Covid-19 Health Communication in the London Borough of Tower Hamlets

Background

This 'lessons learned' project was aimed at evidencing health communication practices with BAME communities during the Covid-19 pandemic towards replicating initiatives that worked well in the Covid-19 response on other health issues. The project adopted a three phased approach to data collection which entailed a qualitative survey completed by professionals who provided health communication and/or engagement activities in response to Covid-19 to Tower Hamlets residents (Phase 1), semi-structured interviews with residents of Tower Hamlets (Phase 2), and semi structured interviews with professionals who provided health communication and/or engagement activities in response to Covid-19 to Tower Hamlets residents (Phase 3).

Recommendations

Towards embedding learning, a model of health communication and engagement is set out for use in addressing health issues across the London Borough of Tower Hamlets. This model advocates for ensuring health messages are co-produced, use trusted settings and people to communicate health information, and adopts the use of visual representations and multiple languages in conveying health messages.

1. *Ensuring health messages are co-produced*

Co-production is necessary for creating and delivering health messages which recognise and reflect the reality of residents. However, in co-producing, it is important that the contributions of members of the community are acknowledged and incentivised.

2. *Use of trusted settings and people*

Using trusted settings and community leaders in promoting health messages is essential and underpins the need to convey health messages in settings regularly visited by members of the community for needs not aligned to health.

3. *Conveying health information using visual representation*

Conveying health information through direct and symbolic reflection highlights the broader need for the adoption of different communication format for different groups. Therefore, it is important that health messages are conveyed using direct or symbolic reflections which may be photos, images or memes towards ensuring messages have a wider reach and are understood by a large subset of the population. This also speaks to the need for ensuring messages are accessible to residents living with a disability.

4. *Conveying health information in multiple languages*

Recognising the multicultural nature of Tower Hamlets, the use of translations which reflect the ethnic makeup of the borough is essential in ensuring health messages do not unwittingly exclude sections of the community based on languages written and/or spoken.

Culturally Appropriate Health Communication and Engagement

Background

This project aimed at developing and implement guidance for culturally appropriate communications and engagement was intended to in the first instance develop a resource for culturally appropriate health communication and engagement, and thereafter, embed this resource into the working practice of all council departments. Importantly, this is aligned with all five ambitions in the Tower Hamlets Health and Wellbeing Strategy 2021-2025 as embedding

culturally appropriate health communication and engagement ensures our approach to partnership working is evidence based and informed by the lived reality of Tower Hamlets residents.

Finding

To implant the approach of culturally appropriate health communication and engagement, a checklist was generated to be used as a tool to embed this ethos across the London borough of Tower Hamlets:

	Key issue to be addressed	**Yes**	**No**	**NA**	**Comments**
1	Has the message been co-designed with the community?				
2	Has technical language been avoided?				
3	Has language of requirement and mandate been avoided?				
4	Does the message induce fear and/or stigma?				
5	Will compliance with the health message disadvantage target community?				
6	Are multiple trusted credible sources utilised to disseminate the information?				
7	Are we disseminating in multiple languages?				
8	Are we disseminating using multiple media?				
9	Have we explored the use of a culturally trusted setting?				
10	Have we made provision for questions and clarifications following message delivery?				
11	Is the message accessible to people with disabilities?				

Recommendations

- Recognising the limitations in health literacy and agency to advocate on own behalf congruent with the health reality of individuals from BAME backgrounds, ***opportunity for questions and clarifications must be provided*** following the delivery of health messages and engagement activities.
- Consideration should be given to creating a ***web version of the checklist*** to enable ease of completion.
- The importance of accountability when using the checklist was raised and underpins the need for ***sign off by divisional leads of health messages*** only following completion of the checklist.
- A mechanism to ***monitor and collate the use of the checklist*** across the council public health team should be implemented. This could be via the use of an online portal with a dedicated staff responsible for monitoring and training staff on use where appropriate.

- It is important that the checklist is ***shared across the region*** as an exemplar of good practice and to importantly ensure that the ethos of culturally appropriate health communication is embedded as a norm not only in the London borough of Tower Hamlets, but across regional health systems.

Barriers and enablers of trust in health services: health inequalities in BAME communities in Tower Hamlets

Background

Delivered by the Young Foundation and underpinned by co-creating insights with BAME communities on what will facilitate trusting relationships between Tower Hamlets residents and service providers, this was an action-focused piece of research which was resident led and involved semi-structured interviews and round table discussions with 51 Tower Hamlets residents from BAME backgrounds. Through semi-structured interviews and a final round-table discussion, data was also collected from eleven professionals representing local health, council and voluntary sector organisations.

Recommendations

- Developing an understanding of cultural competence: Training of all professionals within the health system: this should cover principles of working with ethnically diverse communities rather than attempt to curate knowledge about all cultures.
- Person-centred approach to commissioning of services: Commissioners could consider adopting a more participatory approach to commissioning. Such approaches allow residents to have greater influence over service provision, build understanding of the trade-offs required in commissioning, and help to build trust.
- Improve digital access: Ways to access care online are not straightforward. An equality impact assessment of this digital turn in health services will highlight the ways in which digital services pose a barrier to access.
- Improved in-person access: It is paramount for ethnically diverse communities that in-person access to health services is increased. Residents with specialised needs feel cut off from health services due to the shift online and reported being made to leave if they attempted to visit the GP in person. Better communication of capacity issues and proposed strategies to deal with such issues could also help to manage expectations of residents.
- Accountability and quality checking: Residents suggested using mystery shoppers at the GP or CCTV on wards during the night shift. While these suggestions may not be feasible, they show a desire to know that health services are being quality assured and that there is a route to complaint and redress. This could be achieved through working with commissioners to raise awareness of compliments and complaints processes, and to promote the activities of organisations like Healthwatch. There is a need to understand if and how such existing mechanisms can be strengthened within ethnically diverse communities or if completely new mechanisms are required. Commissioners could also work with ethnically diverse communities to create KPIs around cultural competencies that health services could be benchmarked against.
- Building advocacy capacity: There is a need for ethnically diverse communities to advocate for health service provision which meets their needs, and to have support to navigate the complaints process when inadequate care is received. Long-term funding to enable community organisations to provide this advocacy service could build trust.

Ethnic Health Inequalities in Tower Hamlets: key stakeholder interviews

Background

Twelve semi-structured interviews were carried out with key stakeholders and community leads. Participants were from a variety of fields including general practice, voluntary and community organisations, faith leaders, community participation leads, and NHS organisations. Topics covered in the interviews included:

- Experience of the pandemic and issues exacerbated by the pandemic.
- Impact of grief on communities and how this has affected their perception of health services.
- Level of trust between residents and statutory services.
- Whether residents feel that their ethnicity impacts on the services they receive.
- How services can begin to restore trust with various diverse communities.

Recommendations

<u>Access to culturally appropriate health services:</u>

- Improve health literacy so that diverse communities are better equipped to negotiate the health and care system; this should include information on migrants' rights and information on the purpose of primary care.
- Fund interpretation qualifications for people who are embedded in ethnically diverse and underserved communities; this should include specific training on how to have sensitive conversations around health.
- Continue to run/fund awareness-raising sessions for diverse communities on stigmatised issues.
- Train healthcare staff on ethnically informed care; this should include not perpetuating unhelpful racial stereotypes and recognising symptoms in all ethnicities.
- Embed options for care in community settings e.g. pop-ups, co-location.
- As far as possible, ensure ethnically diverse communities can access a range of services in one location.
- Have single-points-of-contact for each ethnically marginalised group, so that there is always a phone number people can call if they are unable to access needed services.

<u>System barriers</u>

- Use the voluntary and community sector to alleviate burden from statutory health services i.e. make the voluntary sector part of the official care pathway. This could be facilitated by shared line management.
- Funding barriers: consider the realistic length and amount of funding needed to a) meet the administrative and running needs of organisations and b) to realistically achieve the set goals.
- Representation where decisions are made: this should also include putting aside time to integrate new members from ethnically diverse communities into these spaces e.g. buddying.
- Actively work to find and support advocates from 'hidden communities' whose views are rarely represented.
- Recruitment of ethnically diverse professionals into primary care should be prioritized.
- Put in place straightforward complaint procedures, which don't rely on residents needing to 'persist'.

Data

- Come to an agreement across Tower Hamlets/North East London around how all services should be recording ethnicity data locally.
- Educate communities around why it is important that they accurately fill in their ethnicity data.
- Train frontline staff who collect ethnicity data on how to have these conversations.
- Enumerate the communities where we do not have accurate data.

Cultural competence

- When undertaking service design, be more creative about the 'cultural translation of services': this means merging biomedical models with other approaches and using a strengths-based approach for some issues.
- Reassess the use of BAME as a blanket term for ethnically diverse communities.
- Integrate family approaches in models of care.
- In terms of improving the cultural competence of workforces, it is important to a) know how to meet the basic common needs which are prevalent to your service area e.g. being able to maintain religious observance properly when in hospital and b) ensure that all staff are trained in emotionally astute approaches, where they do not necessarily need to know everything about every culture, but they need to able to show respect, to listen, and to be flexible to needs which may be culturally specific.

Trust

- Change the emphasis of KPI requirements for community and voluntary sector organisations who are working with ethnically diverse groups
- Include 'building trust' as a key objective in contracts with CVS organisations.
- Cultivate trust with ethnically diverse youth in Tower Hamlets from a young age: this can be done through mentoring, career days, and sessions in schools and youth hubs.
- Maintain feedback loops. When you haven't been able to do something, also go back and relay this.
- Services should apologise for some of the experiences people had during the pandemic.
- When services are building relationships with community partners, show that you are willing to sit and have uncomfortable and transparent conversations.
- Stop carrying out further research until recommendations from previous pieces have been acted on.
- Retain the partnership and cross-boundary working from the pandemic.

Quantitative data on ethnic health inequalities: June 2022

Background

Data held by Tower Hamlets Council and regional health data were collated towards quantitatively conveying the health profile of Tower Hamlets. It is important to highlight that accessible data was not always disaggregated by ethnicity.

Top prevalent health conditions: all TH GP-registered residents

Condition	Patients with condition	% compared to list size
Depression	36,560	9.70%
Hypertension	25,951	6.89%
Diabetes mellitus	19,820	5.26%
Asthma	15,135	4.02%
Chronic kidney disease	7,115	1.89%
Chronic heart disease	5,064	1.34%
Mental health	4,623	1.23%
Cancer	4,622	1.23%
Chronic obstructive pulmonary disease	3,535	0.94%
Stroke and transient ischaemic attack	2,519	0.67%
Atrial fibrillation	1,917	0.51%
Learning disability	1,493	0.40%
Heart failure	1,468	0.39%
Rheumatoid arthritis	1,280	0.34%
Epilepsy	1,244	0.33%
Peripheral arterial disease	866	0.23%
Dementia	779	0.21%
Palliative care	450	0.12%
Total	83,635	22.19%

Top prevalent health conditions: BAME residents*

Condition	Patients with condition	% compared to list size
Depression	18,921	9.93%
Hypertension	16,591	8.70%
Diabetes mellitus	16,222	8.51%
Asthma	9,274	4.86%
Chronic kidney disease	4,016	2.11%
Chronic heart disease	3,107	1.63%
Mental health	2,995	1.57%
Cancer	1,875	0.98%
Stroke and transient ischaemic attack	1,361	0.71%
Learning disability	1,020	0.54%
Chronic obstructive pulmonary disease	991	0.52%
Rheumatoid arthritis	792	0.42%
Heart failure	744	0.39%
Epilepsy	577	0.30%
Atrial fibrillation	572	0.30%
Dementia	443	0.23%
Peripheral arterial disease	323	0.17%
Palliative care	209	0.11%
Total	49,515	25.97%

*North East London CCG could only disaggregate the data by excluding White and Unknown ethnicities from the data in order to generate the most prevalent conditions for BAME residents

key findings

General: Analysis by ethnicity in Tower Hamlets shows that for many chronic diseases, particularly smoking associated diseases, prevalence is highest in the White population, with **diabetes more prevalent in the Asian population**, and **hypertension, obesity and serious mental illness more prevalent in the Black population**

Hypertension, CVD, and COPD: Black patients (72%) were less likely to be on optimal anti-hypertensive treatment compared to patients of White (76%) or South Asian (77%) ethnicities. COPD prevalence is markedly higher in the White population of Tower Hamlets than all other ethnic groups. Nationally, uptake of cardiac rehabilitation has been found to be lower among BAME groups.

Cancer and Smoking: There are minimal differences in the proportion of cancer diagnoses made at each stage between ethnic groups. Overall cancer incidence was lower than, or similar to, the White population in Asian, Chinese, Mixed men and women, and Black women across all London STPs, but significantly higher in Black men. High overall cancer incidence in Black men was driven by prostate cancer incidence (2.6 times higher than White men). Smoking prevalence and the prevalence of cancer and COPD, which are closely associated with smoking, is higher in the White population in Tower Hamlets

Diabetes and NHS Health Checks: South Asian adults make up 34.1% of the GP registered population, but account for 63.3% of the patients with diabetes. Diabetes prevalence is 3.2% in the White population and 7.6% in the Black population. 87% of South Asians met their target cholesterol level compared to Black patients (77%). Reduction in NHS Health Checks will have had an impact on identifying those at risk of diabetes. Clinicians have raised concerns that this has disproportionately impacted on BAME communities. South Asians and Black residents are over-represented at NHS Health Checks.

Mental Health: White residents have significantly higher rates of bipolar, depression, anxiety and postnatal depression but are significantly less likely to be diagnosed with schizophrenia and SMI. Black residents are more likely to be diagnosed with bipolar and more than twice as likely to be diagnosed with schizophrenia and SMI. Asian residents are less likely to be diagnosed with most conditions but are significantly more likely to be diagnosed with schizophrenia and SMI. Whilst there is a large population of Black residents with CMIs, fewer residents of Black ethnicity are accessing IAPT. Black adults represent 1 in 6 people in East London, but make up 1 in 3 people detained under the Mental Health Act at the point of admission.

Maternity: Tower Hamlets has the highest overall stillbirth rate in NEL at 6.2 in 1000 and this is mainly due to stillbirths to White women and those with Unknown ethnicity. Unknown ethnicity have a very high stillbirth rate at 12 per 1000 births. Babies born to Black (12%) and Asian (11%) women are twice as likely to have a low birth weight than those born to White women (5%). Tower Hamlets has one of the largest differences in rates between Black (42%) and Mixed (40%) women attending A&E during pregnancy compared with White (26%) women. On average 8% of Black women that gave birth in 2021 have hypertension compared with 5% among White women.

Children: There are higher rates of asthma incidence amongst children in South Asian and Black groups. In London, after adjusting for deprivation and health area, compared with White-British children, Somali and Bangladeshi children were less likely to have received three doses of DTaP/IPV/Hib by six months of age (−11% and −5% respectively). 2019/20 NCMP data: Children from Black and Asian ethnic groups are more likely to be overweight and obese.

Miscellaneous: Data from Tower Hamlets indicated that within the high-level ethnic groupings, all non-White groups have a higher rate of Covid-19 cases than the White population. Black, Mixed and Other ethnicities experienced the highest rates of hospitalisations and deaths. At Barts Health Trust, outpatient Did Not Attend (DNA) rates are highest in the Black ethnic group (13.56%), closely followed by the Mixed ethnic group (13.37%). Rates are lowest in the White

ethnic group (9.77%). Unplanned hospital admissions are higher for BAME patients compared to White patients, with the highest unplanned admission rates seen in the Bangladeshi population. Data from 2020 shows that there is a significantly greater proportion of White representation (88%) on the Barts Health NHS Trust Board, as compared to BAME representation (13%)

Poor quality of ethnicity data

- **Accessing high quality data** which was disaggregated by ethnicity was **extremely challenging.** Some of the data presented is taken from out-of-date datasets where more up-to-date figures could not be accessed.
- Even when consistent data on ethnicity was provided, the categories were often too broad.
- Groups other than those enumerated in the national statutory data collection systems may be important to consider because of their large numbers and/or particular health needs (e.g. Turkish, Somali).
- Qualitative information collected suggested that some people don't like to declare their ethnicity on demographic forms and may tick 'Other' or 'Prefer not to answer'. The data collected reveals this tendency, with 'Other' often being over-represented.
- Without knowing what the population number of different ethnic groups are, and without accurate recording of ethnicity, it is impossible to know if some groups are being underserved for particular health conditions.

Obvious data gaps that emerged from this piece of work

- At what ages are different ethnicities affected by their first, second, third long-term condition?
- What is the ethnic breakdown of the most common causes of premature mortality (and at what age do these deaths on average happen by different ethnic groups)?
- Collating ethnicity data of people who attend the referrals after their NHS Health Check.
- Childhood immunisation uptake by ethnicity
- Cancer screening uptake by ethnicity: **screening services do not extract this.**

Vaccine hesitancy and lack of trust

Background

Through a series of community conversations led by University of East London (UEL), issues around Covid-19 vaccines were used to explore distrust of institutions, power dynamics, historical and structural racism and neglect towards identifying ways trust can be generated and relationships built between communities and services in Tower Hamlets. The target groups for this piece of work were Somali, Black African, and Black Caribbean communities.

Update

The majority of this piece of work has been completed, with seven workshops carried out with the different target groups. The workshops were well received, and participants gave very positive feedback on how these were facilitated by UEL. The data from these workshops is currently being analysed and written up, and a final report is expected by December.

Appendix 6 – Ethnicity Reporting for Tower Hamlets Youth Services

Response:

Reporting from April 2023 will collect data on 19 ethnicity categories as listed below which includes Black Caribbean, Black African and Black Somali:

WBRI	White - British
WOTH	Any other white background
WROM	Gypsy/Roma
MWBC	White and Black Caribbean
MWBA	White and Black African
MWAS	White and Asian
MOTH	Any other mixed background
AIND	Indian
APKN	Pakistani
ABAN	Bangladeshi
AOTH	Any other Asian background
BCRB	Black Caribbean
BAFR	Black - African
BSOM	Black - Somali
BOTH	Any other black background
CHNE	Chinese
OOTH	Any other ethnic group
REFU	Refused
NOBT	Information not yet obtained

The data that has been shared was only indicative and does include some overlap due to the limited categories previously. However, going forward from April 23 as part of the new financial year the service is planning to have all data analysed including demographic analysis that will include the 19 categories listed above.