BAME Commission Public Health Projects

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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 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

1. 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.

2. Culturally Appropriate Health Communication and Engagement

Background

This project aimed at developing and implementing 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 settings?				

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.

3. 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.

4. 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

Access to culturally appropriate health services:

- 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.

System barriers

- 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.

5. 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 ethnicities 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.**

6. 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

Most 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 end of January 2023.