Improving Health Outcomes in Marginalised Communities 2022

Engaging with Minority Communities to Tackle the Disproportionate Impacts of Covid-19.

Presented *by*
Jenny Lanyero

In Partnership with

Wellbeing for life

‘In the aftermath of a traumatic event, successful recovery doesn’t just happen’[1]

[1]Covid-10 recovery and resilience: what can health and care learn from other disasters? King’s Fund February 2021
https://features.kingsfund.org.uk/2021/02/covid-19-recovery-resilience-health-care

Covid-19 Pandemic in Brent

- Even before the pandemic, Brent residents and communities experienced disproportionate impact of inequalities in provision and access to services.
- These included barriers to health services, employment, education and housing; leading to poor mental and physical health outcomes for people from ethnic minorities.
- There is high level of deprivation, low income, poor educational attainment, language barriers, discrimination, increase in use of substances and alcohol, high rates of crime, including violent crime.
- Limited awareness of health positive behaviours, preventative measures to reduce the prevalence of diabetes, hypertension, cardiovascular disease and cancers.
- Child health is poor in Brent, and childhood obesity is more prevalent in some wards more than others. Poor air quality and lack of green spaces all contributing to poor health outcomes.

Disparity

- During the pandemic more people in London died than across the country whereas previously more people died from health conditions in other parts of the country than in London.
- Death rates in London from COVID-19 were more than 3-times higher than in the region with the lowest rates, the South West. Overall, Brent had the highest age-standardised coronavirus death rate in England and Wales.
- Public Health England found that local authorities with the highest diagnoses and death rates are mostly urban.
- This level of inequality between regions is much greater than the inequalities in all-cause mortality rates in previous years**.**

In summary, people in deprived areas are more likely to be diagnosed and to have poor outcomes following diagnosis than those in less deprived areas. High diagnosis rates may be due to geographic proximity to infections or a high proportion of workers in occupations that are more likely to be exposed. Poor outcomes remain after adjusting for ethnicity, but the role of underlying health conditions requires further investigation.

Health Inequalities

- Health inequalities are defined as **unfair** and **avoidable** differences in health across the population, and between different groups within society.
- Health inequalities arise because of the conditions in which we are born, grow, live, work and age.
- Health inequalities can manifest in a number of ways – life expectancy, avoidable mortality, long-term health conditions, and the prevalence of mental ill-health.
- Health inequalities go against the principles of social justice because they are avoidable.
- The coronavirus pandemic has further highlighted that for some people in England there are still unfair and avoidable inequalities in their health and in their access to and experiences of NHS services.

Health Inequalities

- They are **unfair** because these health inequalities do not occur randomly or by chance, but are socially determined by circumstances largely beyond an individual's control.
- These circumstances disadvantage people and limit their chance to live a longer, healthier life.
- Health inequalities are **avoidable** because they are rooted in political and social decisions.
- There was a substantial narrowing of health inequalities in the UK and USA between the 1920s and 1970s, the period in which welfare states were constructed and income inequalities declined. However, the gaps between those with the best and worst health and wellbeing still persist, some are widening, and still too many people die prematurely.

Measuring Inequalities

- Health inequalities are described and measured by comparing the health outcomes of different groups. Health outcomes such as life expectancy, healthy life expectancy and rate of disease are compared using groupings such as:
- gender
- ethnicity
- social class
- area deprivation
- employment status
- educational attainment.

- The simplest measure of health inequalities is to compare the health of those in the lowest socio-economic group with those in the highest group. This indicates the gap in health outcomes.
- For example, men in the least deprived areas of England live nearly 20 more years in 'good health' than those in the most deprived areas.
- Individuals from different backgrounds, social groups, and countries enjoy different levels of health.

The wider environment

- The wider environment in which people live and work then shapes their individual experiences of:

- **low income**
- **poor housing**
- **discrimination**
- **access to health services.**

- This environment then shapes individual experiences across the population and leads to the inequalities in health outcomes.

Access

Access to health services refers to the availability of services that are timely, appropriate, sensitive and easy to use.

- Inequitable access can result in particular groups receiving less care relative to their needs, or more inappropriate or sub-optimal care, than others, which often leads to poorer experiences, outcomes and health status. Access to the full range of services that can have an impact on health includes access to preventive interventions and social services, as well as primary and secondary health care.
- Inequitable access might mean that a group faces particular barriers to getting the services that they need, such as real or anticipated discrimination or challenges around language. These issues are often reported for asylum seekers and refugees and Gypsy, Roma and Traveller communities. It can mean that information is not communicated in an easily understandable or culturally sensitive way.
- Those in low paid or insecure work, or with existing health conditions or who were already socially isolated, may find it increasingly difficult to afford rent, bills and food and also struggle to access the services they need. This is likely to have a significant toll on both their physical and mental health

Where we are born, grow, live, work and age

Birth / Childhood

Parental Socioeconomic Resources → Health

Adolescence / Young Adult

Educational Attainment → Health

Work / Career

Occupation & Income → Health

Elderly

Retirement Income → Health

POPULATION 328,800

23% under 18 | 11% age 65+

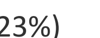
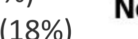
GENDER

49.7% female
50.3% male

ETHNICITY

White	33%
BAME	66% (Indian - 19%, other Asian 12%)

55% residents born outside of the UK
- Asia (23%)
- Europe (18%)
- Africa 10%)

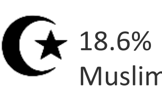
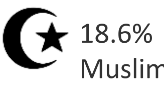



FIRST LANGUAGE

149 languages spoken
English 62.8%
Gujarati 7.9%
Polish 3.4%

RELIGION

41% Christian



18.6% Muslim

17.8% Hindu

ECONOMY/EMPLOYMENT

- **15,030** businesses based in Brent (2018) - 92% small businesses
- Economic output - **£9bn p/a (2017)**
- **72% employed** (UK 74%)
- **23% self-employed**
- 1 in 3 three residents (31%) earned less than the London Living Wage (2018)
- 17,600 residents claim out-of-work benefits – 63% disability/sickness related

Who are we?

BRENT

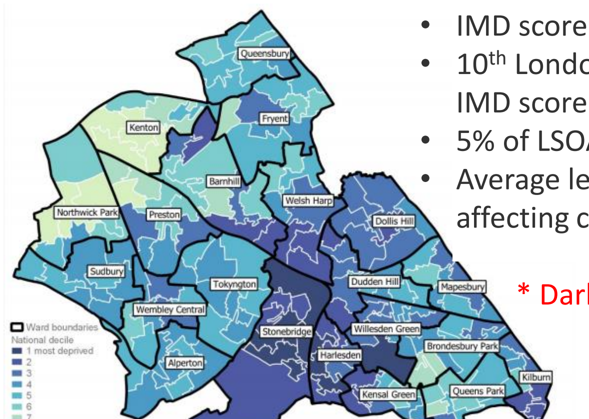
PHYSICAL HEALTH

- **Physically active adults** - 54% (London 63.6%)
- **Obesity** 55%
- **Diabetes** 9% (15% of deaths)
- **Smoking** – biggest cause of ill health and premature death (11%)

MENTAL ILLNESS PREVALENCE

- **Dementia** – 4.83%
- **Depression** – 3.4%
- **SMI** – 1.1%
- **Learning disabilities** – 0.4%
- **Substance misuse** - over 1,800 estimated opiate/crack cocaine users (2014)

DEPRIVATION



- IMD score (2015) – 26.7
- 10th London borough for average IMD score (2019)
- 5% of LSOAs in top 10% nationally
- Average level of income deprivation affecting children 18.2%

* Dark areas more deprived

CRIME

- **22** known gangs in Brent
- **3rd** highest borough in lethal gun discharge offences (rate per 100,000)
- **3,380** Domestic Abuse reports in 2018/19

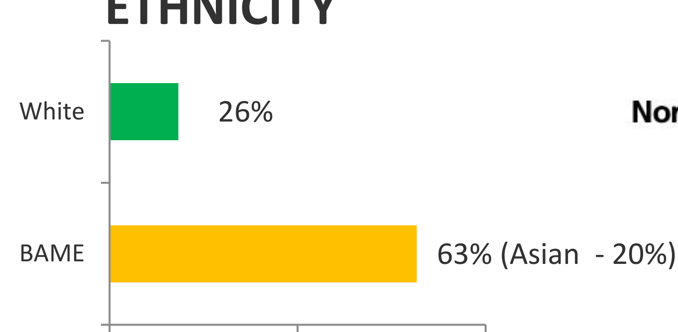
POPULATION 1,447

26% under 18 13% age 65+

GENDER

48% female
52% male

ETHNICITY



FIRST LANGUAGE

English 64.7%
Somali 7.5%
Portuguese 3.7%
Polish 3.5%

ECONOMY/EMPLOYMENT

- **48%** employed
- **10%** unemployed
- **36%** economically inactive (Student, retired)
- Median income - **£23, 700** (Brent - £34,732)
- (**Dudden Hill**) – rate of JSNA claimants (2014) **4.1**. (Brent – 3.5)

Who are we?

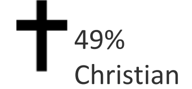
CHURCH END

PHYSICAL HEALTH

(Dudden Hill):

- **Life expectancy** – 83.9 (males) 85.5 (females)
- **Childhood obesity** 26.7%
- Rate of **alcohol-related ambulance call outs** (2014) - 0.9 (Brent – 0.7)

RELIGION

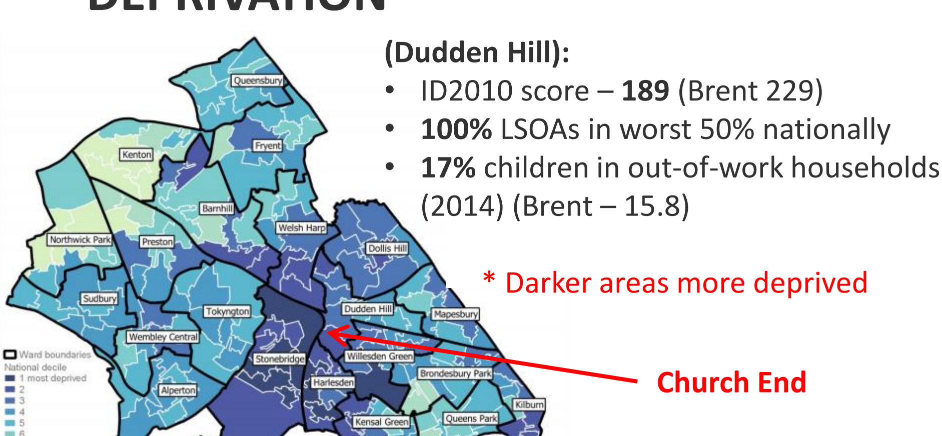


49% Christian

30% Muslim

5% Hindu

DEPRIVATION



(Dudden Hill):

- ID2010 score – **189** (Brent 229)
- **100%** LSOAs in worst 50% nationally
- **17%** children in out-of-work households (2014) (Brent – 15.8)

CRIME

- **(Dudden Hill)** crime rate (2014) – **88.2** (Brent 77.1)
- Violence against person rate – **30.2** (Brent – 25.2)

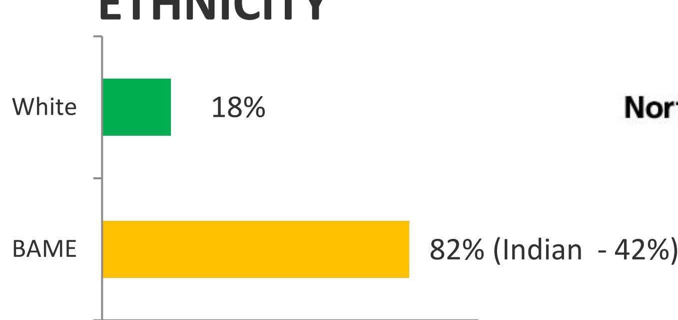
POPULATION 16,144

26% under 18 11% age 65+

GENDER

48% female
52% male

ETHNICITY



FIRST LANGUAGE

English 67.7%
Non English speaking household – 2.5%

ECONOMY/EMPLOYMENT

- Median **household income** - **£26,312** (Brent - £34,732)
- Ranked **3rd** lowest ward in Brent for household income
- **Employment rate** (2011) – **67.4** (Brent – 66.7)
- Rate of **Job Seekers Allowance** claimants (2014) – **3.3** (Brent – 4.6)
- **0.8%** claiming **disability benefits** (2011)

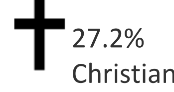
PHYSICAL HEALTH

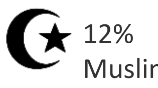
- **Life expectancy** – 80.9 years
- **Cancer** – 89.9 incidences per 100
- 12.6% report a long-term illness or disability
- **Childhood obesity** 24.1%

Who are we?

ALPERTON

RELIGION

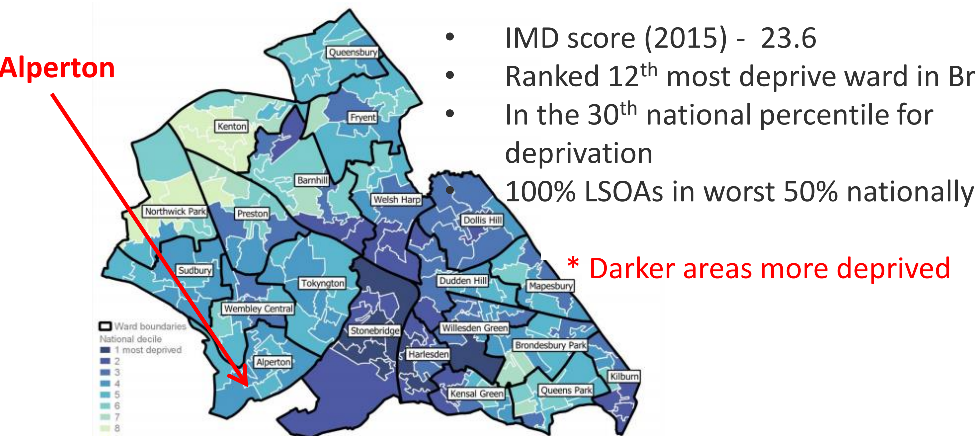

27.2% Christian


12% Muslim

47.4% Hindu

DEPRIVATION

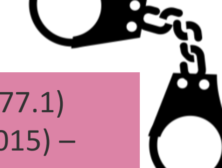
Alperton



- IMD score (2015) - 23.6
- Ranked 12th most deprive ward in Brent
- In the 30th national percentile for deprivation
- 100% LSOAs in worst 50% nationally

* Darker areas more deprived

CRIME

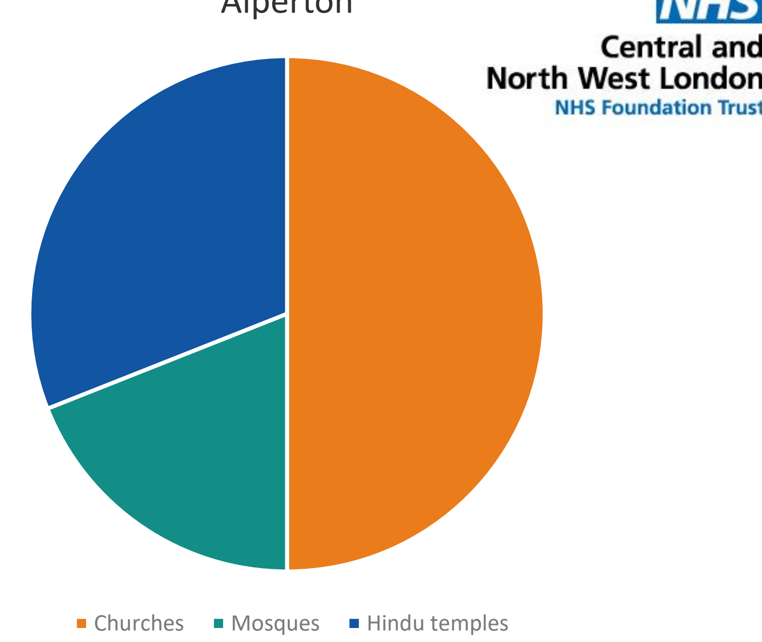


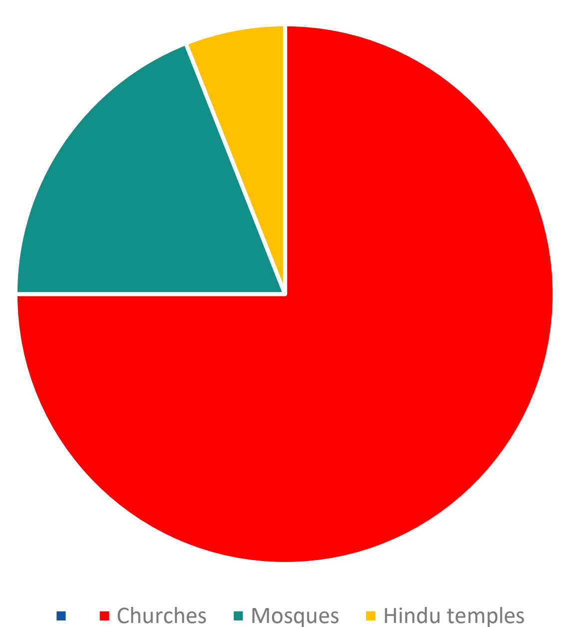
- **Crime rate** (2015) – **69.1** (Brent 77.1)
- **Violence against person** rate (2015) – **21.2** (Brent – 25.4)
- Ranked **8th** highest ward in Brent for number of **DA offences** – **167** offences in May 2018 – April 2019

Faith groups

NHS
Central and North West London
NHS Foundation Trust

Religion	Alperton	Church End
Christian	27.2%	49%
Hindu	47.4%	30%
Muslim	12%	5%
Judaism	1%	<1%
Buddhism	1%	<5%
No religion	11%	7%





Total faith groups found = **42**

- Christianity most prevalent in both (Church End 75%, Alperton 50%)
- Hinduism 2nd most prevalent in Alperton (19%)

Education

- Education is a key social determinant of health acting via multiple mechanisms. The 2011 Census revealed important ethnic inequalities in educational qualifications among adults.
- Educational attainment at GCSE and degree levels is highest for the Chinese and Indian ethnic groups. Gypsy and Irish Travellers have the lowest level of qualifications at both levels.
- The proportion of people aged 16 and over with a degree was highest among people identifying as Chinese (43%), Indian (42%) and Black African (40%).
- On average among 26 OECD countries, people with a university degree or an equivalent level of education at age 30 can expect to live more than five years longer than people with lower levels of education.
- People in the Asian and White Other groups were most likely to be educated to degree level. Those with a foreign or other qualification were most likely to be White Other. White British people were least likely to have a degree-level education and most likely to have no qualifications.

Employment

One of the important determinants of health inequalities within society is the availability and nature of employment.

Employment matters because:-

- Employment is linked to the fundamental causes of health inequality – the unequal distribution of income, wealth and power.
- Having a poor quality job, or no job, can be bad for your health; thus increasing the quality and quantity of work can help reduce health inequalities. Less likely to work from home, zero-hours contracts/cash in hand
- Frontline occupations, less likely to be managers to be able to influence working conditions
- Paid employment has the potential to protect health and contribute to reduced health inequalities. Eighty-five percent of people with a long-term mental illness are unemployed and in the UK they have the highest unemployment rate of any group of people with a disability.

Housing

- There have been increases in inequalities in employment and housing nationwide over the 2000s. Recent evidence suggests that neighbourhood poverty may indeed increase health risks; however, poor health may also systematically sort individuals into poorer neighbourhoods (meaning that if your health is consistently poor, you will not be able to work or earn enough money to live somewhere nicer).
- Poor-quality and overcrowded housing conditions are associated with increased risk of cardiovascular diseases, respiratory diseases, depression and anxiety. As external temperature falls, death rates rise much faster for those in the coldest homes. Households from minority ethnic groups are more likely than White households to live in overcrowded homes and to experience fuel poverty.
- Housing costs in the Private Rented Sector (PRS) have risen substantially faster among poorer working households compared to the average. Housing costs are 39 per cent higher for poor households than in 1996/97 in real terms, compared to a 19 per cent increase of the median for all households over the same period.
- White British people were most likely to be owner-occupiers, followed by Asian people. White Other people were most likely to be private renters compared with other groups. Black people were the least likely to be owner-occupiers and more likely to be social renters than all other groups.

Poverty

- In 2016, almost a million people (905,000 people or 2.8% of those in employment) were reported to be on a zero hours contract in the UK. In 2021 this had increased to around 996,000 and there has been a net increase of 806,000 people in the last 10 years. Over half (56%) of those are women on zero-hour contracts. The majority of people on zero-hour contracts tend to work part-time (65%) and nearly four in ten (38%) of people are aged 16 to 24. Twenty-one per cent of people on zero-hour contracts in England are based in London.
- Childcare: a lack of flexible and affordable childcare for two-working parent households on modest incomes can contribute to in-work poverty risk
- Wages failing to pay: work is failing to provide enough protection against poverty as wages have not kept pace with rising living costs. The mantra of 'work pays' is not always enough to avoid some households being pulled into poverty. Even two full-time earners at the minimum wage is not always enough to avoid poverty.
- Welfare: support for housing costs in particular is failing to keep up with the impact of increasing rents in the PRS – particularly for those households on low income. The further Local Housing Allowance is disconnected from local market rents, the more this drives homelessness.

A CNWL Way-What we did

Listen:
- Take time to sit alongside and listen
- Meet people where they are
- Go with no agenda
- Take down barriers to difficult messages

Listen

Learn

Drive Equality

Collaborate

Learn:
- Using the listening learn from that
- Understand communities needs
- Learn from their experience
- Learn from CNWL experience in different localities
- Learn from others through research and reading
- Use data e.g. JSNA, WSIC

Equality:
- Consider at each turn – is this action making any difference to people and to equality?
- Not just CNWL orbit – wider determinants, lifestyle and populations.
- So we must approach in partnership and integration

Collaborate:
- The community is the expert
- Co-production
- Work with partners at all levels
- Use changes to the NHS to improve integration

Brent Health Matters Programme

Aims

- Reduce impact of Covid on community – including vaccinations
- Reduce variation in life expectancy of long term conditions
- Increased community awareness of existing support/services
- Increased engagement with GP practices including registration

Programme

1) Reduce impacts of Covid-19 on the community

2) Increase community awareness of existing support/services and improve access to health services.

3) Increase the number of people registered with a GP

4) Reduce variation in life expectancy and long term health conditions (diabetes, hypertension, obesity, mental health and cardiovascular disease).

5) Increase uptake of vaccination and health screening

6) Work with partners to address the wider determinants of health

Prioritise disproportionately affected groups

Socio-economic/ Deprivation e.g. unemployed, low income, deprived areas

Equality and diversity e.g. age, sex, race, religion, religion, sexual orientation, disability, pregnancy and maternity

Inclusion health and Vulnerable groups e.g. homeless people; Gypsy, Roma and Travellers; Sex Workers; vulnerable migrants, people who leave prison

Geography e.g. urban, rural.

An example of how we responded to the immediate needs raised

- Delivered services in community settings that are familiar to the individuals and community groups (places of worship, community centres, libraries, sports centres)
- Delivered workshops in the languages spoken by those in the community- gurjarti
- Sourced materials and paid local tailors to make face coverings which faith leaders were then able to distribute.
- Delivered infection prevention control training to Somali leaders and Guajarati faith leaders and volunteers. Recorded a video to be shared.
- Developed simple IPC messaging developed with communities for them to share and embed learning and behaviour change.
- With faith leads and community leaders we developed health messages on the vaccine and fasting as well as how to stay safe during Diwali. Community leaders and local celebrities recorded videos on safety of the vaccine to support uptake.

Church End

Central and North West London NHS Foundation Trust

NHS nurse inspires a Somali community to produce masks

A Somali community in Stonebridge have been inspired to make their own Covid masks following help and advice from an NHS nurse.

Jenny Lanyero and colleague Judith Greening spent time with the Somali community in Church End to address any concerns they had during the continuing pandemic.

Church End had the highest recorded number of deaths during the peak in May and the Somali community were among the hardest hit.

"We reached out to the Somali community for many reasons," said Jenny, a senior nurse practitioner for Brent Primary Care Mental Health Liaison Service. "I know that they were much more severely affected by the pandemic, and dealing with it in isolation, so wanted to set up a group where we could listen to their concerns."

She got in touch with Rhoda Ibrahim, chief executive of community organisation Somali Advice and Forum of Information (SAAFI) in Willesden, who helped set up a meeting. "The group wanted to raise awareness about coronavirus, how to protect themselves and other people," said Jenny. "The training focused on hand hygiene, use of face coverings, social distancing and environmental hygiene."

A tailor in their community was found who could make batches of 100 masks, which have been distributed.

Jenny added: "We really wanted to work with the community and equip them so that when we move on they can continue to do what we brought them. It was really important that we don't go to the community to impose anything on them. We provided training which they will circulate to others. They will go into homes, cafes, places with large congregations and it will become embedded..." Ms Ibrahim said: "Most people don't speak English and rely on translations. That's where we felt something needed to be done, especially where signs are posted. Covid is not going to go away and people need to be careful. They came, so we can give the training ourselves. Some people, a lot of them, are on very low incomes. They avoided the face masks; now they are producing them."

The Somali community in Stonebridge knows how to deal with Covid risks. Picture: CNWL NHS

Alperton

Covid team take their message and training to temple ahead of festivals

NATHALIE RAFFRAY
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A Covid-busting NHS team have taken their training to a temple in Alperton.

Central North West London (CNWL) nurses Jenny Lanyero, Rash Patel and Judith Greening provided Covid-19 infection prevention training to 11 adults and a child at the Shree Sanatan Hindu Mandir in Ealing Road.

Alperton recorded the highest death rate from coronavirus in the country in the three months from March. During that time, Alperton East had the highest proportion of deaths with the virus (79 per cent), followed by Stonebridge (67pc).

Nurses Jenny and Judith kickstarted the training with the Somali community in Church End in August with a group who now make their own masks and deliver training within their community.

Rash said: "I think it worked really well. The information was simple but very important.

"Both priests mentioned some challenges with people coming into the temple.

"We spoke about our partnership with Brent Council and Brent commissioners as well as the upcoming Navratri and Diwali festivities, always stressing the importance of keeping up with infection prevention control measures."

The team also talked about being vigilant in shops.

She added: "It was evident material needs to be available in Gujarati, which we hope to make available soon.

"We will continue to keep in touch with the temple by sharing information as well as further training if required."

Jenny said: "We're just so pleased to be able to work with local communities to support them manage this extraordinary and unprecedented situation.

"The plan was to replicate the support provided to the Church End community to the Alperton community. These were the areas in Brent where people suffered extensively from the coronavirus and we wanted to engage with them and see how we can support them to be more prepared in case of a second wave.

"Before the training, we were treated to a beautiful prayer session. The building is incredibly beautiful and very peaceful, totally mesmerising; it was a lovely unexpected treat."

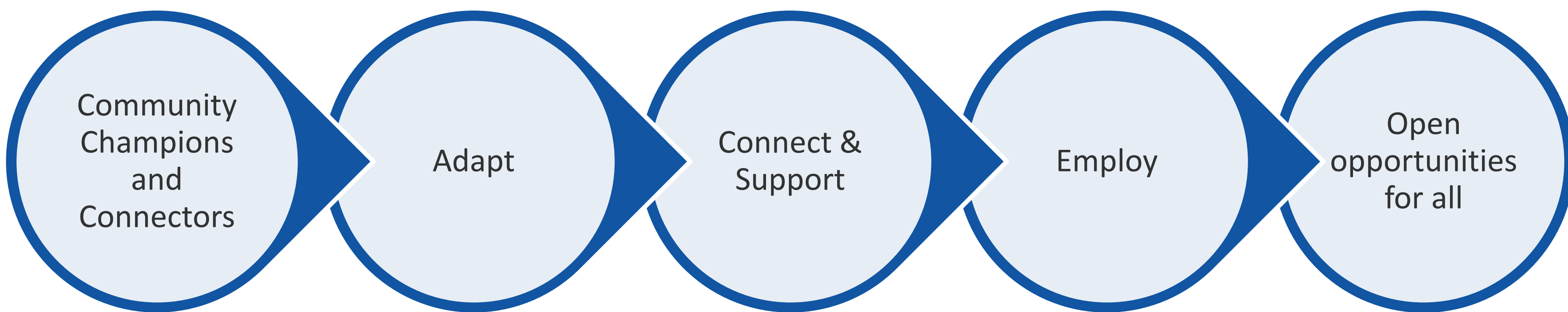
Narendra Patel, treasurer at the temple, said: "Everyone was pleased, I heard nothing negative and the volunteers and priests were pleased these staff came to them. Thank you very much."

Shree Sanatan Hindu Mandir, in Ealing Road Picture: CNWL

Community Champions

- Using the knowledge and expertise of community champions and community connectors within their local areas and communities enabled us to reach the intended audience and fostered trust leading to behavioural shift.
- The programme's use of real people from within hesitant communities to deliver the vaccine messages was important in engendering trust.
- Transport was an additional common barrier to communities receiving the vaccine, but by ensuring the vaccine was available in areas where people went to (such as the local high street, temples, churches and mosques) this made it easier to increase uptake. Rather than expecting people to attend health centres to get their vaccine, the vaccine was delivered in more accessible places, where the communities lived and worked and during evenings and at weekends. •working with local people who are deeply embedded in their community to improve outreach and engagement. Champions used their local intelligence to help us identify barriers to accessing accurate health messages and information about services. We were able to tailor support to local people based on the intelligence that champions and connectors provided. some people required practical support such as collecting prescriptions and delivering medicines and food parcels. Some required support to book online appointments, contacting housing support service or filling in applications for welfare benefits. accessing. Employing champions as community connectors, health educators, health care coordinators to work with GPs and community coordinators within the council to reduce income inequality, open routes into the NHS and council and have an ongoing talent pool.

NHS
Central and
North West London
NHS Foundation Trust


Community Champions and Connectors
Adapt
Connect & Support
Employ
Open opportunities for all

Addressing vaccine hesitancy

Mistrust

- Mistrust of health services contributed to low uptake of vaccines among ethnic minorities. An April 2021 study of 4,896 UK adults found that 15% more individuals from ethnic minority groups were concerned about the long-term side effects of COVID-19 vaccinations and 8% more were concerned about the ingredients put into the vaccine compared with White participants. There were fears that poorer communities will receive less of a choice in which vaccine they receive compared with wealthier individuals who may receive "better vaccines". Despite high profile people taking he vaccine and promoting its safety, people we spoke to did not believe they were being given the same vaccine as their more well off counterparts.

- **Inequity and Access to COVID-19 Vaccinations:** A recent study found that Ethnic minorities can also face unequal and poor access to COVID-19 vaccinations compared with the general population. For example, GP registration, waiting times, cultural and language barriers, digital exclusion and difficulty travelling to mass vaccination sites due to factors such as lack of funds, reduced access to public transport, being immunosuppressed or reduced flexibility in working hours, were identified as additional barriers for minority communities.

Addressing vaccine hesitancy

Religious belief

- In both the US and the UK ethnic minorities were more likely to be hesitant based on their religious affiliations than those of no faith background.
- ONS figures by March 2021 showed that those aged over 70 who identified as Muslims and Buddhists were the least vaccinated compared with those from other religious affiliations.
- Holding strong religious beliefs can also present specific ethical concerns regarding vaccination and can contribute to the spread of misinformation and conspiracy theories. For example, some Christian sects hold the belief that COVID-19 vaccinations are associated with the "Mark of the Beast" as seen in the Holy Bible.
- Those who anti-abortion were hesitant to have the Covid-19 vaccine as they believed it contained aborted foetal cells.
- There was a concern in Muslim communities over the halal status of vaccines, with 11% of Muslims reporting vaccine hesitancy - more so than any other religious group.

What we did

Recognised religious leaders are pivotal in relaying trusted information for vaccine acceptance, particularly within ethnic minority communities,
We worked with faith leaders and the British Council of Great Britain to develop materials around vaccinations and Ramadhan. mostly due to a trusting relationship and respect for religious authority, and this can enable informed decision-making

NHS
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North West London
NHS Foundation Trust

Get your COVID-19 vaccination here toda
Join
the millions
already
vaccinated
NHS
Brent
NHS
COVID-19
Vaccination Centre

What we are doing in Brent

- Some examples of how we are reaching those who might not access healthcare services routinely. The bus was originally used during the vaccination campaign, to bring vaccines to target areas across the borough, where vaccine uptake and engagement remained low.
- The bus launched in January, and provides resident with direct access to a multi-disciplinary, multi-agency team, including colleagues from public health and the borough's NHS providers.
- Outreach has focused on providing health and wellbeing screening checks (such as height, weight and blood pressure readings), with guidance and information for living healthily.
- The bus visited Alperton/Wembley Central, with a particular focus on support the strong South Asian community representation in the local area.
- Feedback was very positive. At several points there were long queues for accessing the bus. Additional dates have been scheduled, to provide similar support across the borough for key target areas and population groups.

NHS
Central and
North West London
NHS Foundation Trust

THANK YOU!

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