# OVERVIEW AND SCRUTINY COMMITTEE 24 MARCH 2022

**Report title:** Understanding and Addressing Health Inequalities in Lambeth

**Wards:** All

**Portfolio:** Cabinet Member for Health and Social Care: Councillors Jim Dickson and Lucy Caldicott (Job Share)

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## REPORT SUMMARY

This report outlines the approach to measuring and tackling health inequalities in Lambeth. Reducing inequality is central to the Borough Plan 2019-2021 and the Health and Wellbeing Strategy. This report is not a comprehensive overview of all the breadth of the issue and response, but rather illustrative of some of the work currently being developed to address our refreshed Health and Wellbeing Strategy including learning lessons from the pandemic and addressing its impact. The new Health and Wellbeing Strategy (2023) will aim to set out the level of ambition to reduce health inequalities in the borough The appendices include more detailed analysis and information for reference. Appendix 1 highlights some of data we have regarding both the experience of Covid but wider health inequalities in Lambeth and Appendix 2 sets out further data concerning health inequalities for long term conditions.

## FINANCE SUMMARY

None arising from this report.

## RECOMMENDATIONS

1. To note the current understanding and the work underway to address health inequalities in Lambeth to be developed through the refreshed Lambeth Joint Strategic Needs Assessment and new Lambeth Health and Wellbeing Strategy (2023).

## 1. CONTEXT

1.1 This report outlines the approach to measuring and tackling health inequalities in Lambeth. Reducing inequality is central to the Borough Plan 2019-2021 and the Health and Wellbeing Strategy. The impact of poor health and disease does not fall equally across the population and those from the most socio-economic disadvantaged communities experience the poorest health outcomes. This has also been true of the experience of Covid-19.

1.2 Lambeth Together is the strategic local partnership for health and care. Addressing health inequalities is central to its mission of improving health and care for all Lambeth people. A Lambeth Together Equalities Diversity and Inclusion (EDI) group has been established during 2021 to help drive the embedding of good practice on equality issues across the local health and care system. The EDI Group which has representation from partners across Lambeth Together was set up to

a. Hold a (constructive) mirror to the 'system' in Lambeth.
b. Develop and adopt a shared measurement approach/system
c. Create a 'social movement' that puts health and equity at the heart of delivering and service design.
d. Act as the Place level Equalities Group, engaging with other boroughs, SEL Integrated Care System, London and national.
e. Consider how to align our outcomes to the recently published NHS 5 focused clinical areas,

Appendix 3 provides an update with proposals of next steps for the Lambeth Together EDI group.

1.3 The health inequalities that were exacerbated by the pandemic brought a sense of urgency for the NHS at a national level to take more concerted efforts. “Core20PLUS5” is an NHS England and Improvement approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort – the ‘Core20PLUS’ and identifies 5 focused clinical areas requiring accelerated improvement. Core20 focuses on the 20% most deprived of the national population; PLUS - Integrated Care System (ICS) determined population groups experiencing poorer than average health access, experience and/or outcomes, but not captured in the ‘Core20’ alone e.g., ethnic groups: “5”- sets out five clinical areas of focus to achieve national aims.

1. Maternity: ensuring continuity of care for 75% of women from Black, Asian and Minority Ethnic communities and from the most deprived groups.
2. Severe mental illness (SMI): ensuring annual health checks for 60% of those living with SMI (bringing SMI in line with the success seen in learning disabilities).
3. Chronic respiratory disease: a clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving up uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations.
4. Early cancer diagnosis: 75% of cases diagnosed at stage 1 or 2 by 2028.
5. Hypertension case-finding: to allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke.

1.4 Health inequalities have continued to be evident in Lambeth. Local research has also established that the burden of disease is worse for some ethnic groups, specifically Black African and Caribbean people, those from Asian backgrounds, and those from “other” backgrounds which in Lambeth is likely to include our significant Spanish and Portuguese speaking communities. The Annual Public Health Report published in 2019 was focused on Health Inequalities.

1.5 Recent data from the Office for National Statistics (ONS) has shown that life expectancy fell in 2020 across the country, and that the inequality in life expectancy increased. In Lambeth, male life expectancy fell from 79.5 to 78.6 years and for women from 84.2 to 83.9 years. For women this drop mirrors that seen across the country, but for men it is twice as much.

1.6 The experience of Covid-19 has shown that there are differences by ethnic group, age, sex and socio-economic status on testing, access and ability to implement protective behaviours (such as self-isolation and access to PPE), vaccination status and the associated outcomes of severe disease and risk of dying. In Lambeth, throughout the pandemic we have tried to mitigate some of these impacts by working closely with communities who are at higher risk, may have barriers to accessing support or care and for whom the standard approach does not work. This report sets out some of evidence from London and Lambeth on what has been learnt over the last two years and builds on a previous report to Overview and Scrutiny Committee in October 2020.

1.7 Whilst Covid-19 has had an impact on the health outcomes for Lambeth residents, we also know that some of the risk factors for conditions like poor mental health, cardiovascular disease and some cancers will have also increased due to a reduction in prevention activities and impact of some of the restrictions which were put in place to prevent the spread of Covid-19. It is particularly important that we recover some of the screening and prevention programmes rapidly and through a lens of health equity building on what we have learnt from working with our communities through the pandemic.

1.8 As part of the Lambeth Joint Strategic Needs Assessment (JSNA) we are refreshing the health profile for Lambeth as well as the process for prioritising areas of work for the JSNA. The JSNA is a statutory requirement which assesses the current and future health and wellbeing, health and social care needs of local population. There is a requirement that the JSNA sets the local strategic direction of service delivery to meet the identified needs and informs different local policies and strategies. This will include informing the new 2023 Lambeth Health and Wellbeing Strategy and reducing health inequalities will be central to the ambition and outcomes of the Strategy. Health inequality considerations will be considered in the co-production of the Strategy and how local priorities are agreed.

1.9 In particular, the Health and Wellbeing Strategy will seek to reflect recommendations from Public Health England - now the Office for Health Improvement and Office for Health Improvement and Disparities (OHID) - on how to better focus on ethnicity within taking action on health inequalities. These include:

a. **Mainstreaming ethnicity**: Explicit consideration of ethnicity within health inequalities work.
b. **Influencing decision-makers and role of senior leadership**: The Lambeth Together Equalities, Diversity and Inclusion Group will seek to influence senior leadership across the health and care system to take into account ethnic differences in decision-making processes.
c. **Data collection, analysis and reporting**: Better quality data collection, more consistent analysis and reporting of data on ethnicity, health and healthcare so that there is adequate understanding of local needs and the extent to which they are being met by policies and services.
d. **Action on the wider social and economic determinants of health**: A Health in All Policies approach will provide a mechanism to consider health impacts of the wider determinants of health taking into account the different ethnic patterns.
e. **Tackling racism and ethnic discrimination**: Acknowledging, understanding and addressing the central role of racism must and building the evidence base around effective action.
f. **Commissioning of culturally sensitive health promotion interventions**: Interventions need to work with cultural and religious understandings and values while recognising intra-group diversity and avoiding stereotyping.
g. **Improving access, experiences and outcomes of health services**: Actions at organisational level include: regular equity audits; use of Health Impact Assessments; integration of equality into quality systems; good representation of black and minority ethnic

communities among staff; sustained workforce development and employment practices; and trust-building dialogue with service users

h. **Engagement with minority ethnic groups**: Having meaningful engagement and involvement of minority ethnic communities, across all areas of activity. This will include the JSNA and Health and Wellbeing Strategy development to help better understand needs and assets. Also, a concerted effort will be required by public and private sector employers and service providers; using the work with our anchor institutions to support this.

i. **Making use of evidence**: The evidence base to inform policy and practice remains limited, but more can be done to mobilise the available evidence and to document and evaluate promising and innovative local practice.

1.10 This report describes some of the information we have locally on health inequalities, highlighting where available, any ethnic disparities and outlining work underway to address these. It is not a comprehensive overview of all the breadth of the issue and response, but rather illustrative of some of the work to recover the impacts of the pandemic and learn the lessons for the future, for which the new Health and Wellbeing Strategy will offer strategic direction for the borough. The appendices include more detailed analysis for reference. Appendix 1 highlights some of data we have regarding both the experience of Covid but also other health inequalities in Lambeth.

## 2. PROPOSAL AND REASONS

**Pre Covid-19**

2.1 The impact of health inequalities in Lambeth has been recognised for a long time, and much of the work of the Council and NHS has centred on reducing inequalities by making a significant difference to those with the worst outcomes. Inequalities existed both between Lambeth and the rest of England and within Lambeth itself.

2.2 A critical indicator of health inequality is life expectancy (LE); a measure that offers a stark picture of unfair and avoidable health inequalities. Prior to the pandemic, the gap in life expectancy between the most and least deprived areas in England was 9.3 years for males and 7.3 years for females. Life expectancy in Lambeth was broadly in line with the average for England as a whole: for men it was one year lower than in England as a whole, for women it was the same. The gap between Lambeth and England life expectancy had closed over the last 2 decades.

2.3 Healthy life expectancy (HLE) is the number of years we live in good health. Women in Lambeth had a healthy life expectancy of 63.4 years. This had not changed in the past decade. For men there had been a 6.8 year decline in healthy life expectancy since 2011-13, and was 58.4 years . An average Lambeth resident will spend around 20 years in poor health. A man living in the most deprived ward of Lambeth could expect to be in good health for 7 years less than one living in the least deprived wards in Lambeth. A man in Lambeth could on average expect to live 3 years less in good health than a woman.

2.4 Lambeth is an ethnically diverse population and the Black, Asian and Multi Ethnic (BAME) community accounts for around 42% (60% including white other) of the total population. There is a relationship between ethnicity and ill health, with BAME groups being more likely to report ill-health. Ill-health among the Black population also starts at a younger age than in the White British population. A Black Caribbean man living in Lambeth is likely to experience his first long term condition 10 years earlier than his White British counterpart. Evidence suggests the top most influential key determinants to health inequalities Black Asian and Multi Ethnic communities are:

a. Socio-economic deprivation – access to health promoting resources;

b. Racism and discrimination;

c. Residential location – access to resources, exposure to risks; and,

d. Access to preventative and treatment health services.

2.5 The full extent of the impact of Covid-19 on health inequalities in Lambeth is yet to be fully realised. Some of the direct impacts of the pandemic were observed in relation to inequalities in virus exposure, severity and mortality and these are included in this report. Indirect impacts resulting from measures to limit transmission of coronavirus which tend to be socio-economic factors such as loss of income, furlough, unemployment, lack of digital access and isolation will be revealed over the short and long-term translating to inequalities in morbidity and mortality across certain population groups.

**Covid-19**

2.6 Since the beginning of the pandemic, Public Health England and latterly the UK Health Security Agency have provided data on Covid-19 cases and testing across the country. The quality of the data has improved overtime and we are able to analyse our local information to get an understanding of local case rates and who is testing for Covid-19. It is more difficult to access local data at a granular level on hospitalisation and mortality.

2.7 The first case of Covid-19 was reported to Lambeth's Director of Public Health on 28 February 2020. By the end of February 2022 there were 32,000 cases recorded in Lambeth residents and over 3 million tests registered to Lambeth residents. There were 644 Lambeth residents with Covid recorded as a cause of death recorded between January 2020 - December 2021. In 2021 Lambeth recorded 135 more deaths than would be expected based on the 5-year average, with these excess deaths so far totalling 409 over the course of the pandemic. Whilst some of these were certainly due to Covid-19, others may reflect impacts of lock downs and challenges of delivering preventative and routine care during a pandemic.

2.8 Case rates have fluctuated over the four distinct "waves" of Covid-19, reflective of the different tools and infrastructure available for testing. In the most recent Delta and Omicron waves, case rates tended to be highest in young adults and secondary school age children and, combined with vaccination in older and more vulnerable groups, this meant the impact on the health system was felt less acutely than in waves one (Wuhan original variant) and two (Alpha).

2.9 London level analysis clearly shows a socio-economic gradient associated with hospital admission, with highest rates in the areas with higher deprivation (see Appendix 1). Men were more likely to be admitted than women, and age was the biggest risk factor for admission. However, those with Black African, Black Caribbean, Asian or other ethnicity had the highest admission rates compared to the white ethnic groups in both wave 1 and 2 (prior to vaccination roll out). Critical care admissions follow a similar pattern. The risk of dying following hospital admission was around twice that in white ethnic group for Black Caribbean, Asian and Other ethnic groups but increased in all ethnic groups with age. Data is not yet available for the most recent Omicron wave, and although the overall numbers are likely to be lower in the most recent wave the patterns are likely to be similar. The difference in the Omicron wave is that people who were not vaccinated or boosted made up a very high proportion of admissions to hospital and in particular critical care.

2.10 As the Covid-19 vaccine has been rolled out to all age groups now except under 12s, the differences in uptake are very clear. Younger people, those from more deprived areas and those from Black and some Asian ethnic groups are less likely to be vaccinated. The Lambeth approach to the vaccination programme has been to address these issues from the beginning and work with communities to engage in conversations about vaccination to remove barriers and encourage better uptake. This work continues and whilst rates of vaccination are still significantly lower for some of our communities, every day we have people attending for first doses at our numerous community sites. Appendix 1 outlines some of the approaches we are using in Lambeth.

2.11 Work with the Black community to increase Covid-19 vaccine uptake in the Black community, highlighted some entrenched factors that have contributed to low uptake of the Covid-19 vaccine in certain communities. As a response Lambeth worked with the Office for Health Improvement and Disparities (OHID), formerly Public Health England, to take a more holistic approach to support Black residents with their general health and wellbeing while helping communities to make the vaccine decision that is right for them alongside their general health and wellbeing. A Health and Wellbeing Day for the Black community was held which was well attended and received positive feedback. Learning from the event is being taken forward in the running of regular neighbourhood informal health and wellbeing sessions and borough wide events.

**Wider Health Inequalities**

2.12 Other areas of health outcomes have been subject to increased scrutiny as the magnitude of the differences between ethnic groups has become evident. The Black Thrive partnership, including the Council and NHS, has been working for over five years to tackle racism, discrimination and poor mental health outcomes for Black people in Lambeth; local research has shown that those from certain ethnic groups experience their first long term condition up to 10 years younger than the white population impacting on their ability to remain economically active and enjoying additional years of good health.

2.13 The intersectionality between poverty, race, age, sexuality and gender can also play a significant role in health outcomes. Recent local analysis indicates that women from Black backgrounds appear to have a range of poorer health outcomes compared to both Black men and White women. Appendix 2 provides detailed breakdown on health inequalities for certain medical conditions in Lambeth related to ethnicity, social deprivation and gender. Lambeth has a significant programme of work tackling some of the underlying causes of the poor health outcomes experienced by our communities but much of the proactive and preventative care in place has also been adversely affected by the pandemic and the ability to access healthcare. For example, the interruption of programmes to support the management of hypertension (high blood pressure) have been estimated to contribute to an additional 12,000 strokes and deaths nationally over the next three years.

**Hypertension (see Appendix 3)**

2.14 Around 8% of residents registered with Lambeth GPs have hypertension (high blood pressure). Through the pandemic, the proportion of GP registered patients under 80 years who have good control of their blood pressure reduced from 72% to 41%. As hypertension is more common in Black and Asian ethnic groups, those with obesity and from lower socio-economic neighbourhoods, the impact and sequelae of poor control falls disproportionally on these groups. The data in Appendix 2 shows that after chronic pain, hypertension is the second most prevalent long-term condition affecting the Black communities in Lambeth, and the third most prevalent affecting Asian communities. The existing data may not have fully captured the scale of the problem, however the national CORE20PLUS5 programme will provide us with the opportunity to identify and diagnose more people with high blood pressure.

2.15 Local community-based approaches have been developed in Lambeth working with GPs, using community pharmacists and working with other voluntary and community sector (VCS) organisations to engage with the communities at highest risk and enable them to get support to manage their blood pressure. As we come out of the pandemic we are looking to learn from the approaches to vaccination, to build trust in the community and adapt to a more outreach model to identify and treat those with high blood pressure. Six out of our nine Primary Care Networks (PCN) have chosen high blood pressure as an area that needs extra focus due to the marked inequalities

regarding outcomes and have set out plans to address the inequalities in their PCN Neighbourhood plans.

**Diabetes (see Appendix 4)**

2.16 Diabetes is one of the most common long-term conditions in Lambeth affecting around 5% of the population, which is approximately 20,000 people. Good management of diabetes can prevent risk of further complications, and primary prevention of diabetes can also be achieved by reducing obesity. The data shown in Appendix shows that Black ethnic women have more than double the rates in the general adult population (12.3% vs 5.6%); similar to the high rate in Black ethnic male population (11.5%); and more than four times the rate in White ethnic female population (3.0%)

2.17 There has been a drop in the number of people living with diabetes who have received optimised care through the pandemic. As diabetes disproportionally affects particular ethnic groups and communities, patient management support programmes have been developed specifically for these communities.

2.18 The Lambeth Together Long-Term Conditions Diabetes Inequalities Project is working on how to better address and manage barriers to health through identifying at risk patients to provide targeted supported self-management focusing on patients with protected characteristics. Using a health coach, the project aims to explore what support is needed to enable socially appropriate self-management, and links to community groups for a focussed group of diabetic patients with low income.

**Mental Health Promotion and Wellbeing (Appendices 5 & 6)**

2.19 The pandemic has increased many of the risk factors for mental ill health in Lambeth. The number of out of work benefits claimants, for example, rose from 8,890 in February 2020 to 22,510 in March 2021. It has been declining since to reach 14,740 in January 2022. Many communities have been affected by bereavement. Many people, particularly the elderly and children and young people, have seen their social networks being disrupted by the lockdown, thus intensifying social isolation.

2.20 In January the Health and Wellbeing Board had a Mental Health themed meeting, where some of the inequalities in mental health and the local action on these were discussed. The Lambeth Suicide prevention strategy was also published. The slides from this Board are in Appendix 5.

**Maternal Health**

2.21 Health inequalities are also seen in different maternal health risk factors and outcomes. The general fertility rate in Lambeth[1] is 44.3 per 1000. 39.1% of deliveries in Lambeth are to Black and Multi ethnic mothers. Younger and older women, those of Black, Asian and Mixed ethnicity and those living in more deprived areas are less likely to book (have their first midwife appointment) within 10 weeks. In Lambeth 48% of pregnant women access maternity care early compared to the national average of 57.8%.

2.22 Folic acid is important for the development of a healthy foetus. Folic acid is less likely to be taken in preparation for pregnancy by women who are younger, Black, Asian or Mixed ethnicity and living in more deprived areas. In Lambeth only 17.5% of women took folic acid supplements prior to pregnancy, compared to 28.5% across London. Women in their 20s and 40s, those of Black or White ethnicity and those living in more deprived areas are also more likely to be recorded as obese at the time of booking.

[1] Number of live births per 1,000 women of child bearing age

2.23 Women of Black, Asian and Mixed ethnicity and those living in more deprived areas also have poorer birth outcomes, In Lambeth 3.6% of babies have low birthweight at term, higher than the London and national average. Premature birth is more likely in women of Black ethnicity, women living in more deprived areas and mothers over 35. Babies who were of Black Caribbean ethnicity were 1.7 times as likely to be born prematurely than babies who were of White Other ethnicity. Stillbirths are more likely in those of Black and Asian ethnicity, those living in more deprived areas and mothers over 35. Babies who were of Black Caribbean ethnicity were 1.7 times as likely to be born prematurely than babies who were of White Other ethnicity.

2.24 Nationally, data gaps have been identified in relation to health inequalities variation; a full complement of variation, trends and inequalities is not available for each maternal indicator. The extent to which ethnicity is recorded is improving but there is still missing data including 'Not known' and 'Not stated'.

2.25 The evidence that maternal and perinatal mortality rates are significantly higher for Black, Asian, and ethnic minority women and birthing people was heightened during the Covid 19 pandemic. As a response the maternity services across South East London ensured that women and birthing people from Black, Asian, and ethnic minorities were provided with information around COVID-19, their increased risk of being hospitalised with COVID-19, Vitamin D supplementation and also data collection.

2.26 The government announced in February 2022, a new taskforce to examine maternity care for those in the most deprived areas and from ethnic minority groups in light of the worse outcomes experienced by both mothers and babies. The taskforce seeks to increase understanding of the drivers behind the disparities, examine the social factors linked to poorer health outcomes and tackle these issues to improve the health and wellbeing of women and their babies. It will seek to do so by looking to consider and support evidence-based interventions for the following areas:

a. improving personalised care and support plans for mothers;
b. addressing how wider societal issues impact maternal health, working with experts in other government departments;
c. improving education and awareness of pre-conception health when trying to conceive, such as taking supplements before pregnancy and maintaining a healthy weight;
d. increasing access to maternity care for all women and developing targeted support for women from the most vulnerable groups; and,
e. empowering women to make evidence-based decisions about their care during pregnancy such as the development of a new digital framework, which provides women with support to make informed decisions during labour.

Caseload midwifery was tested as part of Lambeth Early Action Partnership (LEAP). Caseload midwifery describes continuity of midwifery care from booking to the postnatal period, with longer and more frequent antenatal appointments including in the home setting. Continuity of midwifery care has been shown to reduce preterm birth, but it was unclear how effective it would be for those from deprived and ethnic backgrounds. Implementing caseload midwifery in the LEAP areas resulted in a significant reduction in preterm birth rate in women allocated to caseload midwifery, when compared with those who received traditional midwifery care. Caesarean section births were also significantly reduced in women, including emergency caesarean deliveries without increase in neonatal unit admission or stillbirth compared to traditional midwifery care. The findings suggest that when applied to targeted groups (women in higher IMD quintile and women of diverse ethnicity) that the impact of the caseload intervention is greater. Caseload midwifery continues to be delivered as part of the LEAP programme.

2.27 Locally, plans for improvement are being taken forward through the Local Maternity and Neonatal System (LMNS) as part of the NHS Maternity Transformation Programme to meet the national clinical ambition for continuing maternity care for Black, Asian and Multi ethnic women. The learning from Lambeth Early Action Partnership (LEAP) will also help inform these improvement plans.

2.28 The South East London (SEL) Local Maternity and Neonatal System has set out the following actions which contribute to tackling health inequalities. These are:

a. Over the next few months, the SEL Local Maternity and Neonatal System will be carrying out an equity analysis and creating a maternity system wide equity action plan that will focus on improving maternity care and services, for women and birthing people from ethnic minorities and those living in the most deprived communities. This will be a large piece of work that will involve women and birthing people and all maternity stakeholders.
b. Continuing with plans to increase continuity of carer for women and birthing people from Black, Asian, and ethnic minorities and those living in deprivation, and ensuring that all women and birthing people receive personalised care throughout pregnancy, labour, birth and during the postnatal period. Continuity of carer has been shown to significantly reduce poorer outcomes and we are working on this becoming the default model of care for all women and birthing people.
c. Building the Maternal Medicine Network service over the next 3 to 6 months to ensure women and birthing people with medical complexities receive the right care, by the right people in the right place with a focus on reducing inequalities faced by those most vulnerable, redressing the disproportionate poorer outcomes that some women and birthing people face.
d. Continue to improve maternity services data via the maternity services data set (MSDS) highlighting where efforts and improvements need to be focused for those most vulnerable.
e. Working with perinatal mental health services to address the gap in mental health services for women and birthing people that experience fear, trauma, or loss in the context of their maternity journey.
f. Working with CCG colleagues to introduce the smoking cessation maternity pathway. Smoking is the biggest modifiable risk factor in pregnancy and contributes to many stillbirths, neonatal deaths and maternal morbidity and mortality.
g. Collaborating with SEL Maternity Voice representatives to ensure that the user voice is part of any service formation or transformation.
h. The provision over the next 5 months of culturally sensitive training for maternity staff delivered by the charity FiveXMore.
i. Working with pan London colleagues to improve translation services within maternity care so that women and birthing people are aware of their options and care pathways at all stages.
j. Funding for the provision of empowering information wallets for Black, Asian, and ethnic minority women and birthing people.
k. Roll out across SEL of informative posters that will be displayed in healthcare facilities across SEL providing information for Black, Asian, and ethnic minority women and birthing people around maternity choice and created by Lewisham maternity voices.
l. Roll out of a culturally sensitive recipe book, for women and birthing people with gestational diabetes.
m. Ensuring engagement and sign up to national and regional programmes of work such as the Capital Midwife Anti-Racist Framework and support the whole maternity workforce to thrive.

**Sickle Cell Anaemia**

2.29 In November 2021 the All-Party Parliamentary group on Sickle Cell Anaemia and Thalassemia published its report: "*No One's Listening"* with a series of recommendations to improve the care of people living with sickle cell anaemia, a disease which predominately affects Black people. The

report was triggered by the coroner's report into the early and avoidable death of a sickle patient in a North London Hospital. Sickle cell disease predominately affects Black people although there is also small population of affected people from the Middle East, India and the Mediterranean region. The report found a pattern of stigmatisation, under-funding, sub-standard care and a lack of prioritisation. The Report's recommendations to improve care extend from the Department of Health and Social care, NHSE, NICE through to individual Trusts. Guy's and St Thomas's NHS Foundation Trusts (GSTT) has the largest population of patients with Sickle cell adult patients (currently 870 on the local database) and is working at individual service, directorate and Trust level to ensure the recommendations are applied to improve care received by local patients.

2.30 Sickle cell is characterised by frequent episodes of severe pain which may need hospital admission. It is also associated with multi-organ acute and chronic complications including stroke, pulmonary hypertension, leg ulcers and renal failure, and requires life-long follow up and comprehensive long term condition management. There is a particular emphasis on shifting care from unplanned e.g. emergency admissions and crises to good planned care, including strong condition management, promoting personalised care (across professional boundaries, tailored to an individual) and promote self-care, where appropriate.

2.31 The overall prevalence of Sickle Cell Disease in Lambeth is estimated as 0.1% and 0.6% in the Lambeth Black population. Locally, many crises are managed out of hospital through the support of the South East London Sickle Cell/Thalassaemia Centre. The Centre provides services for adults, young people and children with sickle cell disease and thalassaemia and their families. It provides a specialist nursing service to the residents of Lambeth, Southwark and Lewisham, who are at risk of having, or already have an unusual haemoglobin type. It also provides the same service to families and carers who are affected by sickle cell disease and thalassaemia.

2.32 The team at the Centre consists of specialist nurses working across Lambeth, Southwark and Lewisham, delivering education, support and crisis intervention where necessary for all patients with sickle cell disease. The team provides a comprehensive service from neonatal screening to end of life care and accepts self-referrals, primary and secondary referrals. The intensive patient focused support available to both patients and families enables disease management and providing support and education to help patients cope in crisis. Care is delivered through individual care packages agreed with users, hospital consultants and the specialist nurse case managers. Agreed care packages reflect a shared care approach underpinned by protocols and guidelines.

2.33 There are times when the most appropriate place for a person in crisis is the hospital. This can facilitate fast, effective pain relief/management, fluid management and monitoring of vital signs. The GSTT Sickle cell and red cell disorders service has close links with community services and have specialist diagnostic laboratory services for red cell disorders. The haematology day unit offers a red cell apheresis service for patients with long-term chronic complications of sickle cell disease, for example stroke. Following a hospital attendance/stay, discharge information is provided to the community team who will then monitor the patient and reviewed through multi-disciplinary team meetings. A patient support group is run weekly; the support group is for patients with sickle cell disorders who are seen at GSTT, and their family members and/or carers.

2.34 Local Sickle cell services are one of the most expert in the country, Guy's and St Thomas's NHS Foundation Trust, Evelina Children's Hospital and King's College Hospital have led the South Thames Sickle Cell and Thalassemia Network (STSTN). STSTN is a haemoglobinopathy collaboration led by healthcare professionals, including consultants, nurses, psychologists and others, that work closely with other hospitals in London and South East England. The STSTN collaborates across service, teaching and research to improve the patient experience by offering better treatment outcomes for people with sickle cell disease and thalassaemia.

2.35 All Lambeth pregnant women are offered screening by a blood test for sickle cell and other haemoglobin variants. Antenatal screening identifies parents to be who have the trait (also known as a carrier). If the mother is identified with the trait, the baby's father is offered a screening test. Also, all newborn babies at five days old are screened as part of the newborn bloodspot (heel prick test). The key reason for offering newborn screening for sickle cell disease is because babies with sickle cell disease are vulnerable to serious infections. Newborn screening detects babies who may have sickle cell disease or have the trait (also known as a carrier) for sickle cell disease.

**Overarching approaches to working with communities**

2.36 In Lambeth, just as in the rest of the country, the levels of emotional wellbeing decreased, and the levels of anxiety increased during the pandemic. However, this trend seems to have reversed in the last year. A recent Lambeth Resident Survey also shows that the levels of anxiety in the borough have decreased.

2.37 The Lambeth Together approach to tackling inequalities works at different levels. There is a strategic programme looking at Equalities, Diversity and Inclusion which works with the Lambeth Together Delivery Alliances as well as the SE London Integrated Care Partnership to challenge and develop a programme of work to improve outcomes for residents and staff in the local health and care systems. The Lambeth Together Neighbourhood and Wellbeing Delivery Alliance is developing approaches working with "thriving communities" to enable bottom up, community development type approaches to addressing the issues impacting on health and wellbeing. The food hubs which were established as part of the pandemic response are morphing into health and wellbeing hubs which can support a wider network of advice and support, including benefits and debt advice as well as health improvement activities such as stop smoking support, health checks and weight management.

2.38 The learning from Covid-19 on the roll out of the vaccination programme has led to new approaches and working in partnership with Public Health England and the Beacon Project, a Black communities wellbeing event run in October helped demonstrate how to bring together trusted health professionals with communities where there is a high level of need. We continue working with the Beacon Project in running health and wellbeing sessions across the borough to particularly engage with our Black community around their broader health and wellbeing. We are also working with community groups and faith groups to encourage the development of culturally competent health improvement programmes as well as health services which tackle some of discrimination experienced by people in the health and care system.

## 3. FINANCE

3.1 There are no finance implications at this stage.

## 4. LEGAL AND DEMOCRACY

4.1 There were no legal comments.

4.2 There were no further comments from Democratic Services.

## 5. CONSULTATION AND CO-PRODUCTION

5.1 NHS and Public Health officers have contributed to this report. The programmes of work have been co-produced with residents and patients.

## 6. RISK MANAGEMENT

6.1 Not applicable.

## 7. EQUALITIES IMPACT ASSESSMENT

7.1 An Equalities Impact Assessment has not been completed as the report is for information. All Lambeth Public Health activities have an impact on equalities – where possible these seek to narrow the gap in the experience of health outcomes, and we strive to measure this in all our work programmes. Through Covid-19 we have tried as far as possible to report data on ethnicity routinely as part of our assessment of the pandemic and its impact on our residents. Whilst some of this information is not able to be shared publicly due to the context of disclosure we do use it to inform how we deliver our work programme.

## 8. COMMUNITY SAFETY

8.1 Not applicable.

## 9. ORGANISATIONAL IMPLICATIONS

**Environmental**

9.1 Not applicable.

**Health**

9.2 Covered in the body of the report.

**Corporate Parenting**

9.3 Not applicable.

**Staffing and accommodation**

9.4 Not applicable.

**Responsible Procurement**

9.5 Not applicable.

## 10. TIMETABLE FOR IMPLEMENTATION

10.1 Not applicable.

## AUDIT TRAIL

| Name and Position/Title | Lambeth Directorate | Date Sent | Date Received | Comments in paragraph: |
|---|---|---|---|---|
| Councillors Jim Dickson and Lucy Caldicott | Cabinet Member for Health and Social Care (Job Share) | 04.03.22 | 15.03.22 | |
| Andrew Eyres, Strategic Director | Adults and Health | 03.03.22 | 14.03.22 | Throughout |
| Peter Hesketh, Assistant Director of Finance | Finance and Investment | 04.03.22 | 04.03.22 | 3 |
| Andrew Pavlou, Legal Services | Legal and Governance | 04.03.22 | 09.03.22 | 4 |
| David Rose, Democratic Services | Legal and Governance | 04.03.22 | 05.03.22 | |

## REPORT HISTORY

| | |
|---|---|
| **Original discussion with Cabinet Member** | 11.03.22 |
| **Report deadline** | 14.03.22 |
| **Date final report sent** | 16.03.22 |
| **Part II Exempt from Disclosure/confidential accompanying report?** | No |
| **Key decision report** | No |
| **Date first appeared on forward plan** | Not applicable |
| **Key decision reasons** | Not applicable. |
| **Background information** | Borough Plan 2019-2021 Borough Plan<br>Health and Wellbeing Strategy Health and Wellbeing Strategy<br>Annual Public Health Report 2018 Annual Public Health Report<br>Covid 19 in Lambeth Health and Wellbeing Board report Covid 19 report<br>All-Party Parliamentary group on Sickle Cell Anaemia and Thalassemia<br>No One's Listening |
| **Appendices** | Appendix 1 - Covid-19 & Inequalities<br>Appendix 2 SEL CCG Health Inequalities report<br>Appendix 3 Lambeth Together report<br>Appendix 4 - Blood pressure and diabetes in Lambeth<br>Appendix 5 - Mental health and wellbeing update<br>Appendix 6 - HWBB Mental health inequalities |