**Minutes**

Inequalities

Wednesday, 13th July 2022

Room W1, Westminster Hall

11:15-12:15

**In attendance:**

* Derek Thomas MP

**Apologies:**

* George Howarth MP
* Fabian Hamilton MP
* Virendra Sharma MP

**Agenda**

**Item No 1**: Derek Thomas MP, Chair - open meeting and welcomes

## Item no 2: Professor Wasim Hanif

## Topic: Disparities in care experienced by people with diabetes from ethnic minorities

Inequalities in health has been going on for a long time. Covid 19 highlighted this.

Previously, if you had type 2 diabetes at 60 years old, you’d lose about 6 years of life.

It is now possible within 5 years of developing type 2 diabetes; it is possible to reverse it.

NHS diabetes remission programmes has completely changed the lives with people with diabetes.

What is the challenge? There is inequitable health outcome in all communities.

1/3 of people with diabetes are from ethnic minorities. Almost ½ from economical deprived communities.

Publications of research regarding diabetes is mostly in Northern America, Europe and the UK, however the majority of people with diabetes are in Asia. Compared to the global population of people living with diabetes, South Asians are underrepresented in research.

From a legal aspect, the NHS follows the Equalities Act 2010 however deprivation is not a protected group.

Direct study shows that type 2 diabetes can be reversed within 5 years. However, 99% of those included in the trial. There was a 10% uptake in the community which was mostly white women from higher economic backgrounds.

Ethnic coding should also not be combined but divided into individual groups – this is the only to see extent of discrimination and inequality

Coding is needed for deprivation which is non-existent and is currently based on postcodes

Recommendations:

* Ethnic Coding
* Legal frame work for representative population in clinical trial and MHRA/NICE approvals
* Impact assessment of research on the “whole” population a mandatory requisite for funding
* Cultural competent language training for researchers
* NHS funding, QOF and other incentive schemes to be based on equitable outcomes in all population

## Item no 3: Dr Joan St John

## Topic: Health inequalities impact on Black African and Black Caribbean people

## African and African-Caribbean people 2-4 times more likely to develop Type 2 diabetes than people of white ethnicity also likely to develop diabetes 12 years before people from white backgrounds. They are also more likely to experience more diabetes-related complications and have undiagnosed Type 2 diabetes than people form white British backgrounds. Some evidence to show that they are less likely to be on the new medicines and treatments.

Core 20 plus 5: Maternity Care it is important that women living with type 1 or type 2 diabetes are prepared well for pregnancy.

This means:

* They are as healthy as possible
* HbA1c level below 48mmol/mol
* They are prescribed 5mg folic acid
* All medication that will harm them or the developing foetus is stopped

Across the board women are not being well prepared for pregnancy but women from black ethnic backgrounds are the least likely to be well prepared by health services.

The folic acid needs to be prescribed and the medications need to be stopped by a healthcare professional.

National Paediatric Diabetes Audit shows that black children and young people are least likely to be using CGM or insulin pumps and these technologies can help Children and Young people to achieve optimal HbA1c levels.

How do Black African, Black African-Caribbean people experience health inequalities?

Their lived experiences are not just their health care, for example: The Windrush scandal informed people’s perception of authority and this was seen in the covid-19 pandemic as people from these backgrounds were not as likely to take the vaccine as other communities. This was due to a certain level of mistrust and a certain level of skepticism with health services informed by examples in their lives eg Windrush Scandal.

Issues facing people with diabetes in these communities in their lives and having an impact on Diabetes and healthcare and how they could be addressed/resolved:

|  |  |
| --- | --- |
| Windrush | Representation and Trust |
| COVID-19 vaccination programme | Communication and cultural competence |
| National Diabetes Audit(s) | Data |
| Wearable technologies children and young people | Funding and resources |
| National Diabetes Audit (s) | Quality of outcomes and care |

Recommendations in ‘Activating Change in Diabetes’ Document co-produced by Committee of: Charities, Experts by experience, Researchers & Clinicians:

* Communication & Cultural Competency

E.g. Co-production to produce training for HCPs and those studying for healthcare qualifications on improving cultural competency.

* Representation & Trust

E.g. NHS England should set targets for increasing recruitment of people from Black African, Black Caribbean and South Asian groups into decision-making roles

* Data

E.g NHS organisations should standardise the way minority ethnic populations are captured in datasets, and review outcomes to ensure service improvements can be designed accordingly

* Quality of Outcomes and Care
* Funding and Resources

The Ask

**What are we asking of ourselves (the Committee):**

* Communication & Cultural Competency
  + Contact and discussion with stakeholders
* Representation & Trust
* Data
  + Contact and discussion with stakeholders
* Quality of Outcomes and Care
  + Contact and discussion with stakeholders
* Funding and Resources

**What are we asking of APPG:**

* To table a written question on recommendations raised in the Charter
* Sharing the ‘Activating Change in Diabetes’ document
* Asking for an update on what the Government is doing to improve diabetes care for minority ethnic groups
* Raise issues and recommendations covered by the Charter during any relevant parliamentary debates on health / inequalities
* Charter for Change Quality and Outcomes of Care Recommendation
  + NHSE to work with ICS& PWD enhance funding and care for people from minority ethnic groups living with Diabetes

Conclusions

* Health inequality daily reality for Black African, Black African-Caribbean people living with Diabetes (Type 1 & Type 2)
* Health inequality costs the individual, their family, community and wider society and needs action
* ‘Activating Change in Diabetes’ provides Roadmap of possible solutions, resources and best practice examples that could be taken forwards

## Item no 4: Response to asks

Derek Thomas MP: No problem in tabling a question around the Charter for Change recommendations asking around legal framework for proper representative population.

Meeting with Maria Caulfield was scheduled for this week but has been postponed. Met with Jo Churchill and NHSE a few times over the pandemic and NHSE did recognise the problem.

## Item no 5: Helen Kirrane

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## Topic: Diabetes & Inequality – the role of poverty

Complication rates are higher in more deprived areas with steep gradients, and they are

less likely to achieve all three treatment targets. People in the most deprived groups showed poorer, and people of Black ethnicity had worse HbA1c than those of White ethnicity. People in the poorest households are more likely to have type 2 diabetes. The rates of gestational diabetes in deprived communities are twice as high. Obesity rates are highest in the most deprived areas.

Pre-pandemic, people with diabetes living in more deprived areas were less likely to receive all their care processes. People living in the most deprived postcodes were nearly twice as likely to have had no contact with their diabetes healthcare team.

GP shortages, significantly worse in more deprived areas, must be addressed.

There is a move towards digital healthcare however people in poverty are at risk of digital exclusion. It is vital that people have a choice in how they access their health care.

The conditions in which we are born, grow, live, work and age are the strongest influences on our health. People in more deprived areas have less access to healthy food, are more likely to live in inadequate accommodation without the means or resource to prepare and cook healthy food, be more vulnerable to the impact of high energy costs, be targeted by a greater number of unhealthy food advertisements, and have less access to green outdoor space.

What we are calling for​

* The NHS must deliver on its renewed commitments to address health inequalities, and be supported by resources from Government to be able to do this. ​
* New Integrated Care Systems and Integrated Care Board must urgently draw up plans to catch up on the diabetes backlog, ensuring equitable recovery. ICSs should also prioritise tackling the inequalities in diabetes outcomes experienced by those from deprived communities and those from ethnic minority groups​
* We want to see bold new commitments from Governments forthcoming Health Disparities White Paper which they follow up with swift action and resources which acknowledge and address the conditions in which we live, grow and work.​
* The Government must urgently produce a cross-government strategy that addresses these underlying causes of ill health and will help create a healthier society. This is essential if we are to turn the tide of rising numbers of people living with type 2 diabetes.​
* It is also vital the Government recommits and goes further than it has before to bold population measures to address obesity.​

What we are doing at Diabetes UK

* Working with others to influence Government and champion the need for bold action address health inequalities and address the underlying causes of poor health and create a more healthy society.​
* Build trusted relationships at a local level with community organisations to develop collaborative partnerships to address inequalities experienced by those with and at risk of diabetes​
* Bringing more people, including those from local communities and health professionals, to create a diverse community of people tackling inequality in diabetes through our Tackling Inequalities Lab - providing skills and support to Lab members to prototype innovative solutions for tackling inequalities in their own services and areas. ​
* Develop an action plan to improve research design & resources to address inequalities in diabetes care.​
* Work more closely with experts, including people with lived experience, to identify recommendations for targeted action to address inequalities. ​

## Item no 5: Q&A and discussions

Research with Health Innovation Manchester found that within the South Asian community, it was felt that the health care providers were not meeting all their needs. Especially within the younger population living with type 2 diabetes, they referred to those underlying cultural and social issues such as they feel time poor so find it difficult to eat healthily and feel judged for that then disengage with services and support as they feel it is not quite right for them. It is important that people from different communities are involved in the redesign of care.

Stigma surrounding diabetes

We need to address the stigma around diabetes and ensure people with diabetes are given information to help remove the feeling of guilt. Policy makers and the wider population need to be provided with information and an understanding of all the factors that contribute to our health and we need to move away from individual responsibility.

What could we be doing to influence ICSs as they are being formed?

## The same people moving from the one to the other and they are not representative of the local population. We need to be asking boards, whether they are representative of their local area?

Providing people around the country with the information and tools to write to their ICSs to influence them.

ICSs need to be given data of local data – Diabetes UK wrote to the new ICSs with localised data and got in touch with ICSs to share some asks.

## NHSE is focused on supporting local system to have access to data.

## More funding is needed for the ICSs to enact any of these changes.