NHS RACE & HEALTH OBSERVATORY

Intent Health

Review of NHS health communications with (and for) the Jewish community

December 2024

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ACKNOWLEDGEMENTS

First and foremost, we would like to thank the many members of the Jewish community who have shared insights and experiences, both personal and professional, and whose contributions form the core of this report.

We also thank the many Jewish support services we spoke to who shared their stories of co-creation and co-delivery within healthcare settings.

A further thank you to:

- The Intent Health advisory council
- The NHS RHO team and steering committee
- The NHS Jewish Staff Network
- All the focus group attendees and community conversation members

About Intent Health

Intent Health is the only consultancy with a unique business model designed to address health inequities through strategic communications and collaboration with expert partnership. We were founded on the premise that representation in healthcare communications matters if we are going to drive behaviour and policy change in a multi-cultural and multi-dimensional society. Our team are working towards a future where access to healthcare is more equitable and inclusive for all regardless of their background.

We believe in the power of representative communication to address health inequalities, challenge misinformation, and improve outcomes and access to health and social care.

Co-creation is at the heart of our work, and we have extensive experience working with communities across the world. We are experienced in recognising barriers, navigating mistrust and facilitating effective relationships between our clients and their stakeholders.

The Intent Health team builds itself differently, we are majority-owned by women with visible and invisible disabilities and its leadership team has always had representation from other minoritised groups (e.g., people of colour and LGBTQ+ people). We achieve the listening outcomes we do, because we can recognise the value of lived experience and know how to turn this into meaningful insights, tangible community led recommendations and impactful campaigns.

This report was authored by Jeffrey Ingold, Serena Rianjongdee and Jenny Carrington-Elson from Intent Health.

LANGUAGE AND TERMINOLOGY

The NHS Race and Health Observatory (NHS RHO) has developed a set of five principles to talk about racial and ethnic communities who experience health inequalities (NHS Race and Health Observatory, 2023). These principles are:

- Be specific where possible about the ethnic groups to which we are referring.
- Avoid use of acronyms like BME or BAME.
- Context should be the primary guide when deciding whether collective terminology is needed.
- Be transparent about the approach to language.
- Be adaptable and open to change as terminology and language evolves over time and by context.

Undertaking this piece of work has meant being both aware of and applying these principles where relevant. Most importantly, the research team has taken the time to listen to and learn from the communities we work with, and for, to be aware of the most appropriate and inclusive language at all times.

We have also put together a short list of relevant terms and definitions that will appear throughout the report. This is for the benefit of the reader, and recognises the community uses interchangeable words when referring to different activities, celebrations or groups within the community.

Antisemitism: Prejudice, hatred and discrimination against Jewish people.

The International Holocaust Remembrance Alliance definition of antisemitism is a certain perception of Jews, which may be expressed as hatred toward Jews. Rhetorical and physical manifestations of antisemitism are directed toward Jewish or non-Jewish individuals and/or their property, toward Jewish community institutions and religious facilities

Ashkenazi: One of the two major ancestral groups of Jewish people who have origins in France, Central and Eastern Europe.

Bath din/Beth din: Jewish court composed of three rabbinic judges termed a "Dayan" hear and make judgements in accordance with Jewish law (known as "halacha" or "halachic") principles.

Frum: Yiddish adjective to describe religious Jews.

Charedi/Haredi: Sometimes referred to as strictly Orthodox, the Charedi community follow a strict interpretation of Jewish law and tend to minimise their interaction with secular society and education.

Please note that throughout the report, Charedi and strictly Orthodox are used interchangeably. This is to reflect the different language used by various individuals, organisations and publications interviewed and/or cited in this report.

Hasidism/Hasid/Hasidic: A stream within strictly Orthodox Judaism that developed in the 18th century. There are several different Hasidic groups, each of which is based upon the teaching of a particular Rabbi (known as "Rebbe").

Hebrew: Semitic language of the Hebrews in either biblical or modern form. Hebrew is the main language of prayer and other religious texts.

High holidays/high holy days: The Jewish New Year (Rosh Hashanah) and the eight days which follow on from it are collectively know as the 10 Days of Penitence. The last of these days is the Day of Atonement (Yom Kippur) and is a 25 hour fast. This period is referred as the "High Holidays" and the days are regarded as the most sacred days of the year.

Jewish communities: We use this term throughout this report to encompass the variety of people within the Jewish community, whether they identify through ethnicity, religion etc.

Kosher / Kashrut: There is a system of Jewish laws which determines what food can be eaten by Jews, and which regulates how it should be prepared. The system is known as "Kashrut" and the food that is chosen and prepared according to these rules is known as "kosher" food.

Kippah/yarmulke/kuppel: Brimless skullcap that Jewish men wear.

Liberal Judaism: Denomination of Judaism which is separate from, but closely related to, the Reform Judaism denomination.

Lubavitch / Chabad: A Charedi sect that conducts outreach to non-Orthodox Jews.

Masorti Judaism: A denomination that believes in traditional Judaism for modern Jewish communities.

Mizrachi: Jewish people who come from Middle Eastern backgrounds, including Iraq, Syria and Egypt.

Orthodox/Orthodoxy: Term for people who hold to the traditional conception of Jewish law. Among Orthodox communities there is a spectrum of observance, including differences in the degree of interaction and accommodation that takes place with the secular world.

Pesach / Passover: Spring festival that commemorates the Israelites' departure from ancient Egypt. This is the most widely observed Jewish religious ceremony.

Rabbi: A Jewish religious leader.

Reform Judaism: Denomination that seeks to adapt Judaism to contemporary circumstances often emphasising ethics and spirituality over ritual and observance. In the UK, there are two movements that derive from this tradition: Reform Judaism and Liberal Judaism.

Sephardi: Jewish diaspora associated with the Iberian Peninsula. Their traditions are also used by Mizrachi Jewish communities.

Shabbat: The Jewish Sabbath observed from sundown on Friday night to Saturday night. Traditionally, Jewish people are bound by multiple restrictions about working on Shabbat, including not using electricity (eg turning lights and ovens on and off) or using transport.

Yiddish: "A language derived from German and other European languages often written in Hebrew characters and is spoken by Jewish people of central and eastern Europe and their descendants.

LANGUAGE AND TERMINOLOGY

Background context

It is important to acknowledge that this work, on identifying solutions to improve access to healthcare for Jewish communities in England, was commissioned in 2022. Since then, we have seen an escalation in hostilities and conflict between Israel and Palestine.

Following these events, and extensive media coverage, there has been a demonstrable rise in hate crime in the UK for many communities, including antisemitism for Jewish communities. As a result, some of the interviews and engagement carried out for this work refer to the impact of ongoing hostilities on access to healthcare.

The purpose of this work is to focus on improving access to healthcare for Jewish communities in England.

FOREWORD

Professor Habib Naqvi is Chief Executive of the NHS Race and Health Observatory, which leads work nationally on identifying and tackling ethnic inequalities in health and healthcare. Habib has a background in public health, health psychology, and health care policy and strategy development.

When the NHS Race and Health Observatory was established, we made a commitment to promote health equity for all ethnic and racial minorities in England. This meant looking at the mountain of evidence before us and deciding where best to intervene in order to make a genuine and tangible difference for minoritised communities.

Among the many priorities we adopted, it soon became clear that Jewish communities in England have often been neglected and overlooked in conversations about health inequality. In particular, key stakeholders raised the issue of communication and engagement as a major barrier to accessing healthcare for Jewish people.

As the Observatory has found across its portfolio of work, minority groups are too often lazily categorised as homogenous and are too often the subject of 'one-size-fits-all' policymaking. As this report demonstrates, Jewish communities in this country are diverse and heterogenous. This has meant that people are often poorly engaged in the design and development of public services and underserved by vital institutions, such as the NHS.

For these reasons, this project was aimed specifically at those points of contact with the NHS. This report highlights where opportunities for better communication with Jewish communities have been missed and offers practical resources that can be picked up by healthcare providers and immediately put into practice.

Furthermore, while these resources are reflective of the complexities and nuances of Jewish health and healthcare, the process of co-production that sits behind them provides a blueprint for the NHS, and other public service providers, to better work with the range of diverse communities on overcoming barriers to engagement, co-production and access to healthcare.

As the Observatory moves towards an even greater focus on outlining and providing practical solutions to tackling inequalities in health and healthcare, my hope is that, through this work, healthcare services can begin to meaningfully tackle the barriers that prevent people from diverse communities in this country from getting the high-quality care that they need.

Professor Habib Naqvi MBE FFPH
Chief Executive
NHS Race and Health Observatory

"This report highlights where opportunities for better communication with Jewish communities have been missed and offers practical resources that can be picked up by healthcare providers and immediately put into practice."

1.0 EXECUTIVE SUMMARY

1.1 INTRODUCTION

This report is an evidence-led review of best practice and effective NHS communications with the Jewish community concluding in recommendations for communications, initiatives and change across all parts of the healthcare system and patient engagement.

Unlike previous pieces of research and reports that were either localised or focused on one specific section of the Jewish community, this report presents findings and recommendations that are national in scope and bring together the diverse experiences of NHS care and communications for Jewish communities across England. The findings and recommendations have been derived from a variety of research approaches to gather insights, feedback and experiences from Jewish people and healthcare professionals.

The research team are part of Intent Health, a consultancy working with industry, health systems, NGOs and research organisations on complex issues affecting communities across the health landscape. Intent Health were selected by NHS Race and Health Observatory following a transparent and competitive bidding process.

1.2 RESEARCH APPROACH

The research employed a mixed-methods approach, including a rapid evidence review into current communication between healthcare providers and the Jewish community, extensive community engagement in the form of semi-structured individual interviews, and six focus groups with different community groups, healthcare professionals from a Jewish background, and clinicians who are not Jewish.

The broad remit and subsequent impact of this research project was made possible through a bespoke model of co-production and delivery with the community. Bringing in the voices of minoritised communities from the beginning of a project ensures co-creation is at the heart of decision-making, engagement and outputs, all leading to more impactful recommendations for both healthcare providers and communities themselves. The Intent Health research team brought together a diverse group of five advisors from the Jewish community, who were further complemented by a steering committee set up by the NHS RHO during the tender process.

1.0 EXECUTIVE SUMMARY

The project and its findings were informed, shaped and produced directly by the insights, feedback and recommendations gathered from these stakeholders and the wider community.

Participating in research for any minoritised community, including Jewish people, can be a complicated process due to experiences of historical and ongoing racism or discrimination leading to mistrust and apprehension. Minoritised communities often experience unfair treatment in healthcare systems, leading to unequal access and quality of care. Prejudices, cultural differences, language barriers and discrimination can exacerbate these issues and make it difficult for Jewish communities to feel confident and comfortable accessing healthcare services and trusting healthcare messaging. In order to combat these barriers, this research project built on and applied key inclusive approaches to community outreach in health research (Jameson et al., 2023).

Building trust with Jewish communities as a research team requires an open and honest dialogue to foster reciprocal and sustainable relationships which yield real insights, and in particular those that might only be previously talked about 'behind closed doors'. Integral to achieving this success was working directly with community and religious leaders to help understand the needs and interests of the communities and groups they represent. The research team and their advisors worked closely to tap into individual networks, community champions, organisational structures and formal networks to make introductions and connections with relevant participants across all workstreams.

Over the course of the project, the research team encountered a great deal of interest and goodwill from the community to actively support the project and share knowledge and contacts, as well as contributing directly with personal and professional experiences, and recommending approaches the NHS can take to better engage and communicate with Jewish communities.

It is important to note that there are numerous recognised and systemic challenges affecting the NHS at the time of writing. This was recognised by both the research team, research participants and community advisors. It is relevant to note these as they pertain to the delivery of good care and include resources and staff capacity.

1.3 FINDINGS

The findings pull together insights from our detailed and extensive range of community engagement into an analysed and thematic consolidation. These were built throughout the project, and validated continuously throughout continued community engagement, as well as by our advisory council and steering committee.

They draw together experiences, both positive and negative, barriers and enablers, examples of good practice and community-led health communications and initiatives, and align where narratives and perceptions provide meaningful and tangible findings representative of community views.

The recognition and understanding of Jewish identity

A poor understanding of Jewish identity and Judaism directly affects uptake

There is a systemic lack of knowledge (and sometimes conflation) about what it means to be Jewish and Judaism, and how this impacts communication and care across the NHS network. Miscommunications and stereotypes stemming from this lack of understanding can lead to disengagement, and a greater reliance from the community on community-led support services.

Poor and inconsistent data capture within NHS systems

The inconsistency in the ability to identify oneself as ethnically Jewish, or one's religion as Judaism, leads to feelings of otherness and lack of prioritisation as a minoritised group.

Assumptions about homogeneity create barriers in identifying appropriate access to services

The inability to identify, appropriately support and measure outcomes for the Jewish community can lead NHS systems to ineffectively allocate resources appropriately to address inequities for their patients, and lead to staff not being able to provide personalised care.

Mistrust and feeling unsafe are key barriers to improving self-identification practices

In periods of heightened antisemitism, and for older generations who may have experienced past trauma, there is a hesitancy to self-report as Jewish, as a religion or ethnicity.

Pervasive stereotypes exist and are amplified by medical education and the media

Low levels of religious and cultural literacy amongst NHS staff, which can be perpetuated by the media and inadequate education, leads to pervasive stereotypes and assumptions about the Jewish community.

Engagement between communities and services

A vast network of successful community support exists to manage gaps in national services

The vast range of embedded, trusted and successful Jewish community-led support services engender great trust and engagement from the Jewish community when it comes to healthcare messages and initiatives.

Successful initiatives always employed a co-production and delivery approach; without this, positive impact and reach is low

There is great and underutilised value in co-production, delivery and sponsorship in NHS healthcare communications from the Jewish community which leads to increased engagement and outcomes.

Role of rabbinic and community leaders

The sponsorship of communications and initiatives by the right community members, whether that is rabbinic, community organisation, community leader, or doctor, can overcome certain barriers of mistrust and allay fears with healthcare messages to improve engagement.

Combining different methods and communication channels will help reach the diversity of the Jewish community

Different members of the Jewish community seek and trust healthcare information from different outlets and in different forms, and can miss information if inaccessible behind digital or language barriers.

The Charedi communities have limited access to NHS-led medical information

Current NHS communication practices do not align with the cultural and religious lifestyle of the strictly Orthodox community, with many members feeling they will not experience as much understanding, acceptance and accommodations for their needs from the NHS than from their own services.

'Helicopter' approaches to partnerships and projects had limited success

A lack of continuous and long-term engagement and communications between healthcare bodies and marginalised communities leads to continued feeling of distrust. Learnings and best practice is not always consistently applied to new projects (in addition to funding), limiting the long-term success of projects.

Clinical tools and approaches

NHS workforce knowledge is low; training can reinforce negative stereotypes

The upskilling of NHS staff with cultural and religious competency is needed to build better relationships, improve one-to-one conversations and communications, as well as improving outcomes for Jewish patients.

Recognition of trauma can rebuild trust and improve engagement

Experiences of trauma, whether personal through discrimination and antisemitism or intergenerationally impact engagement and trust with services.

Chaperones or navigators break down trust issues and improve engagement

These can help allay the fears and hesitation in attending healthcare appointments, easing language or cultural barriers between provider and patients and fears of the unknown felt by those engaging with medical teams outside of their community.

Service design that is supportive of cultural and religious practice improves engagement

There are many barriers for the Jewish community in the practicalities of attending appointments such as working around religious observances and Jewish festivals, preference for healthcare professionals of the same sex and end-of-life practices.

1.4 RECOMMENDATIONS

For the Jewish community it is systemic change, as well as the tailoring of communications and engagement, that will provide a necessary framework to reduce the health inequalities experienced by those in England.

The recommendations in this report aim to deliver changes to the way the Jewish community is engaged; or to deliver systemic changes in the NHS to ensure Jewish patients are recognised, understood, and better engaged with NHS services.

In the full report, there is further detail on who is responsible for implementing these recommendations, and guidance on outputs created as part of the research which may help.

Who is responsible

Department of Health and Social Care

In the setting of priorities, ringfencing funding for NHS bodies and setting frameworks for action.

NHS England

In the standards, frameworks and oversight given to NHS providers to maintain and improve standards of care for all service users.

Bodies and organisations with influence

For example, the Care Quality Commission, Medical Schools Council, Professional regulators, and others.

ICBs and Service Providers

In the proactive uptake of recommendations, training and best practice to directly improve localised user experience across the community.

Independent Review Panels

In assessing the success of existing initiatives and providing clarity on the direction of inconsistent NHS policies.

NHS Communications, Marketing and Stakeholder Engagement Teams

In the dissemination and delivery of content for NHS staff, teams and patient communities.

1.0 EXECUTIVE SUMMARY

To combat harmful stereotypes and build trust between community and health service:

01 Services should **educate their workforce** about local Jewish communities to remove barriers, combat prejudice, improve understanding of how **cultural nuances affect health engagement**, and to enable the appropriate adaption of services and outreach.

02 Improve the consistent use of the principles of **trauma-informed care** when engaging marginalised communities, to directly address the barriers in accessing care

03 Review and remove assessment questions that actively reinforce **negative stereotype**s about marginalised communities, specifically including Judaism and the Jewish community, within Medical School student examinations.

To improve engagement with services and improve outcomes:

04 Improving Jewish engagement with services requires a thoughtful **adaptation of communication**s and outreach which respects cultural norms and is cognisant of the reasons for historical mistrust.

05 Supporting **community-led initiatives** can dramatically reduce health inequalities by removing barriers to access, and so this approach needs embedding quickly across all services responsible for engaging marginalised communities, ensuring the Jewish community is r**ecognised and included**.

To improve the evaluation of health outcomes among the Jewish community, including the allocation of resources:

06 Mandate the inclusion of 'Jewish' as an option for **ethnicity** and 'Judaism' as an option for **religion** in all NHS patient data records to empower patients, give NHS systems a better understanding of the community they are serving and therefore shape services, and enable personalised care.

To improve the experience of Jewish NHS staff members:

07 'Jewish' and 'Judaism' must be included across all NHS internal and external **initiatives designed to recognise and support marginalised communities.**

08 Combat antisemitism experienced by Jewish staff members by implementing clear frameworks, guidance and action plans.

1.5 CONCLUSION

The findings of this report represent the feelings and experience of Jewish communities when it comes to their interactions with the NHS. Each Jewish person's relationship to their ethnic and religious identity is unique, and this manifests in a lack of understanding across NHS staff about distinct healthcare needs and accommodations. This means there is a distinct need for urgent reform and resources to improve the way Jewish communities are communicated with and cared for by our healthcare systems.

Importantly, this report also highlights the plethora of successful community-led charity groups and support services. Some may tailor their service towards particular denominations or groups, while others operate locally, or nationally and for the wide-ranging community. These services play a vital role in supporting the community, particularly given the systemic challenges and lack of resources facing the NHS. There is a clear opportunity now for the NHS to prioritise co-production and delivery with grassroot groups to more effectively deliver care and treatment through collaboration.

The recommendations focus on improving communications at a systemic NHS level with the Jewish community, as well direct communications between healthcare professionals with Jewish patients. For the Jewish community, essential changes of NHS national and regional policies to mandate the inclusion of Judaism for religion and Jewish for ethnicity in data sets and across initiatives, alongside provisions for training to improve staff awareness and cultural competency, are critical to support better care and communications.

Beyond the scope of our engagement recommendations, we also suggest multiple strands of related, further research to develop tangible action plans for areas in which the community highlighted a need for change or review of NHS practices in order to improve relationships and experiences for the Jewish community.

2.1 JEWISH IDENTITY

The 2021 Census found that 287,360 people living in England and Wales self-identified as Jewish, which accounts for 0.5% of the overall population. Notably, the ONS states they "found little evidence to support the need for a separate Jewish ethnic group tick-box, in addition to the existing Jewish religion tick-box" therefore all ethnicity data is from Jewish people self-identifying through the 'Other' tick-box.

Whilst Jewish people are present in almost every local authority, communities tend to be concentrated in a few areas of the country with corresponding Integrated Care Boards (ICBs): North London and surrounding counties (Northwest/Central/East London, Hertfordshire and West Essex, Mid and South Essex), Greater Manchester (Greater Manchester), Leeds (West Yorkshire) and Gateshead (North East and North Cumbria). Over half of the Jewish population (56.3%) is based in London. (See Figures 1-3)

Figure 1
Population density map showing Jewish population in Local Authority Districts in England and Wales (ONS, 2021)

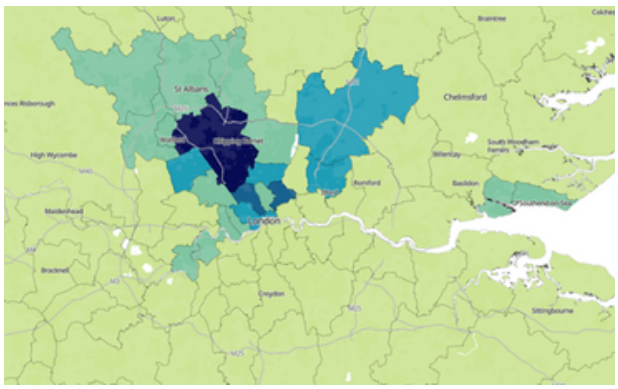

Figure 2
Population density map showing Jewish population in Local Authority Districts in London and surrounding areas (ONS, 2021)

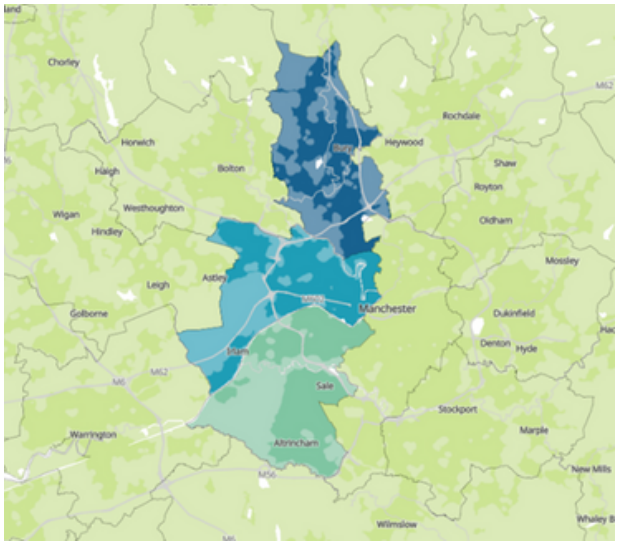

Figure 3
Population density map showing Jewish population in Local Authority Districts in Greater Manchester and surrounding areas (ONS, 2021)

2.0 INTRODUCTION

The majority of respondents identified as Jewish through religion only (219,160; 76.3%), while 16,030 (5.6%) people did so through ethnic group only, and 52,165 (18.1%) people identified themselves through both religion and ethnic group (see Figure 4).

Even though the Census data provides us with the most robust demographic picture of the Jewish population in England and Wales, it is still likely to contain some gaps.

Not only was the religion question voluntary, but the Institute for Jewish Policy Research's (JPR) own review of the data suggests that Charedi children were undercounted by as much as 35%.

The JPR also estimate the total number of Jewish people in the UK, including those with one Jewish parent, is 330,000, and this number grows to around 410,000 if one includes the 'Law of Return' which is the right to claim Israeli citizenship applies to anybody who descends from at least one Jewish grandparent (JPR, 2023).

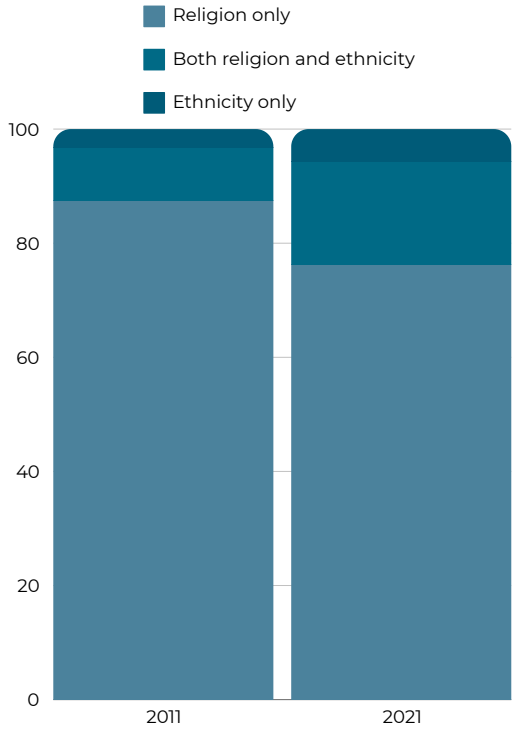

Figure 4
Ethnicity and religion: how the Jewish community identified as part of the 2011 and 2021 UK Census (ONS, 2021)

The question of what it means to be Jewish is significant because it disrupts the notion of a monolithic or homogenous 'Jewish community' in England (and beyond). While Judaism is a religion, many who identify as Jewish are not religious. Jewish identity has been defined, understood and debated at various times as an ethnicity, a nation, a culture and a race.

This diversity leads into many nuances and varying accommodations needed to provide the best care and more effective communications for the Jewish community.

> *"The challenge is all about where to draw the boundary between who is and is not Jewish. Jews themselves differ on inclusion and exclusion criteria, and depending on the reason behind the enquiry, there may be a compelling case for choosing one definition over another".*
>
> Jewish Policy Research

Accessibility and access to healthcare communications is vital to ensure equity across communities in the understanding of health, management and disease prevention, as well as an awareness of risk and interventions offered by NHS services. There are health inequities faced across the Jewish community which are coupled with both barriers to engagement with NHS services, and reduced effectiveness of healthcare communications to the Jewish community, which widen this health equalities gap.

For the purposes of this research, understanding the nuances of cultural or lifestyle differences within ethnic and religious Jewish communities is critical, both to determining intersectional needs and concerns, and to delivering culturally sensitive healthcare communications which best reaches all sections of the community.

Community-centred public health messages are most effective when there is a clear recognition of the intra-community differences and the right language, imagery, content and mediums to reach the right groups.

2.2 JUDAISM AND HEALTH

Judaism is a monotheistic religion with the belief that everything in universe is under the direct control of the one God. All aspects of Judaism have their basis in the Torah (the first five books of the Bible) as interpreted by Rabbis who provide spiritual guidance and input on decision-making. Adherence to Jewish law and the interpretation of the Torah among the various Judaism denominations can have a significant impact on Jewish people's interactions with healthcare services.

There are five main denominations of Judaism in the UK:

- Central / Mainstream Orthodox
- Reform
- Strictly Orthodox (including Charedi)
- Liberal
- Masorti

See Figure 5 for further information on the proportions of each denomination.

These denominations differ in their interpretations of Judaism, with the strictly Orthodox groups adhering to strict interpretations of Jewish Law and Halacha, through to Masorti (Conservative) to Liberal and Reform being the most progressive or relaxed in adherence to Jewish law.

Jewish communities can also differ depending on where they originated:

- Sephardis are a group descended from Spain and Portugal
- Mizrachi from the Middle East
- Ashkenazi from Eastern and Central Europe

The majority of the UK Jewish population is of Askhenazi origin, mainly coming to England from the late 1800s to the Second World War, although for many in the UK ethnic heritage may be mixed and some people may be unaware of their exact ethnic heritage. Furthermore, these often do not translate into customs as Mizrachi communities are also Sephardi in terms of their cultural and religious customs.

Strictly Orthodox, or Charedi, communities are largely clustered in Stamford Hill, Golders Green, Gateshead, Broughton Park and Canvey Island, and have grown from 30,000 in 2001 (11% of the total) to 53,000 in 2021 (20% of the total); although it is thought these populations could be even larger due to undercounting and the isolated nature of these communities (Sapiro, 2023).

This community is characterised by a younger age profile, early marriage, and an average birth rate of seven children per woman (the national average is 1.93). Conversely, the rest of the Jewish population is declining, and thus the growth in the community nationally is largely due to the strictly Orthodox population – it will become more important over time for the NHS to understand needs specific of this community as it grows.

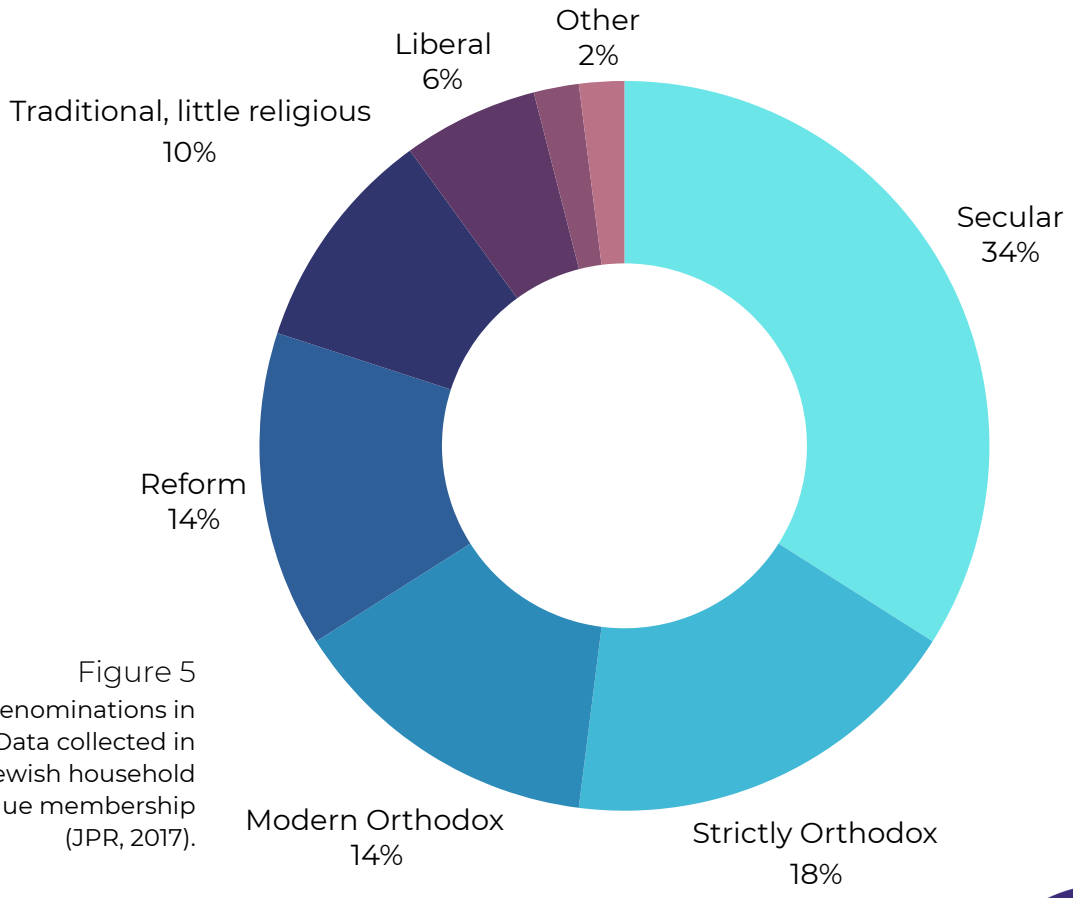

Figure 5
Jewish Denominations in the UK. Data collected in 2016 of Jewish household synagogue membership (JPR, 2017).

2.0 INTRODUCTION

A core tenet in Judaism is to maintain one's health, which is viewed as God's property, in which one should try to continue living a holy life. Preservation of life supercedes all other commandments from God, therefore most Jewish people have a positive attitude towards healthcare and are willing to seek medical help or advice when sick.

However, there are still a number of Jewish principles that may influence a Jewish person's attitudes towards certain treatments and procedures. For example the mother's health and wellbeing are important issues in the discussion of abortion; and whether or not Jews recognise brain stem death is an important question for organ donation. The more observant the individual, the more they might feel unsure about these questions. In some cases, a Jewish person may wish to seek advice from their Rabbi and family before they consider certain treatments.

There are numerous aspects of being Jewish which can be relevant for healthcare practitioners to ensure adequate levels of personalised care. Jewish teachings are a large part of some people's day-to-day lives, with customs for example on kinds of foods which one can eat (Kashrut, Kosher), cleanliness, prayer and when one should rest (Shabbat).

Different Jewish individuals and communties will follow these customs to varying levels depending on many factors including family traditions or their level of observance. Medical settings can be distressing for any patient, therefore creating an environment which accommodates to each patient's way of life can go a long way towards building trust in the NHS, and alleviating a patient's anxiety.

For example, two relevant aspects of Jewish culture in medical setting are Kashrut and Shabbat.

- Kashrut are the rules around foods that are permissible, which are deemed "Kosher"; briefly this means that Jewish people can only consume certain mammals, fish and birds, and which have been prepared a certain way. It is essential to not assume that Halal and Kosher are the same.
- Many Jewish people may follow the customs of Shabbat, where anything considered work (unless for the purpose of saving lives) such as labour, operating technology, using transport – is not permitted between sunset on Friday to after dark on Saturday. Even if an individual does not abide by these rules, Shabbat is often reserved for quality family time. Unless strictly necessary, it should be avoided when booking appointments, discharging or keeping Jewish patients in hospital. The same principle applies for Jewish Festivals.

2.3 HEALTH INEQUALITIES AND THE ROLE OF COMMUNICATIONS

People from minority ethnic groups in the UK experience inequalities across healthcare access, experience and outcomes (Race and Health Observatory, 2021). This has been attributed to factors such as racism, discrimination, barriers to accessing healthcare and incomplete ethnicity data. While being Jewish is a legally protected ethnic minority status under the Race Relations Act, like with many ethnic groups across the UK, this has failed to translate into the necessary accommodations and interventions in health and social care infrastructure and policy to see marked improvements.

Health inequalities and inequities affecting Jewish communities are increasingly being recognised across the country as this research and report is undertaken. A ground-breaking 2015 research report commissioned by NHS Salford Clinical Commissioning Group gave insights into the numerous health disparities Jewish communities experience. Some of these are inherent, which include genetic predispositions to certain cancers; rare inherited disorders such as Tay-Sachs Disorder; predisposition to Crohn's, Ulcerative Colitis.

Other limiting factors included practical and financial challenges for Jewish mothers. For example, attending clinics by public transport with several small children, or with many needing collecting from school, which can lead to lower immunisation rates and subsequent higher rates of infectious diseases like measles, mumps, and polio. These inequities may be compounded by factors such as poor communication and engagement from the NHS and healthcare staff, leading to worse long-term outcomes. For the stictly Orthodox Jewish communities in the Salford area, there were serious concerns about immunisation take-up, healthy eating, exercise, and mental health (Wineberg and Mann, 2016). (See the Co-delivery of COVID-19 immunisation programmes case study on page 60 for more information)

There has also been comprehensive research into major diseases disproportionately affecting people of Ashkenazi descent (e.g Gross et al, 2008). For example, one in 40 Ashkenazi Jewish people have the BRCA gene mutation which puts them at higher risk of certain cancers. For example, in women this means a risk of breast cancer at a younger age, along with ovarian and other cancers (CDC, 2023). (See the NHS Jewish BRCA Testing Programme case study on page 54 for more information).

More recently, the COVID-19 pandemic brought into sharp focus the ways in which certain parts of the Jewish community in England were disproportionately exposed to the negative impacts of the virus on our lives, and that public health messaging was not adequately reaching or engaging these communities.

2.0 INTRODUCTION

During 2021 a study by the London School of Hygiene & Tropical Medicine found that the UK's strictly Orthodox Jewish community experienced a seroprevalence rate of SARS-CoV-2 more than five times the estimated seroprevalence rate nationally (Gaskell et al., 2021).

Despite the widespread understanding of the health inequalities that exist, and the evidence presented by the NHS and the community nearly a decade ago; limited and inconsistent action has been taken to adopt solutions to improve communications, engagement, and care for Jewish patients, and to subsequently track progress against benchmarks on a national level. This includes adjustments and accommodations in clinical care settings including availability of kosher hospital food, difficulties with booking appointments over Shabbat and Jewish holidays, facilitating large families to attend appointments and hospital settings, end of life care, maternal health, childbirth and prayer (among others).

Accessibility of healthcare communications is vital to ensure equity across communities in each individuals understanding of health, health risks and management and disease prevention, as well as an awareness of services and interventions offered by the NHS. The health inequities faced across the Jewish community can be further exacerbated by barriers to engagement with NHS services, and lessened effectiveness of healthcare communications.

This report centres on the role of healthcare communications in engaging the Jewish community, ranging from system wide communications, to one-to-one patient–to-healthcare practitioner conversations. We explore current experiences, where improvements can be made, and how the NHS may use communications to address the health inequities seen by the community.

Healthcare communications has implications on improving healthcare uptake, perceptions, and outcomes, and varies depending on, and within, each community. In the US, a large-scale cancer study found that consumption of health media can be dependent on ethnicity, and improving access and quality according to culture may reduce disparities (Viswanath et al., 2011). According to 2021 study in public health messaging, key recommendations for effectiveness include co-production with communities, transparency, cohesive and unified messages, and framing to increase understanding, social responsibility and personal control (Ghio et al., 2022).

The WHO recommends that health communications factor in culture in order to develop the most effective messages using language, sources and content appropriate to ethnic minority and diverse populations (WHO 2017).

Furthermore, when these key cultural competency considerations such as religious observances, language preferences or gender roles are not considered, it can result in communications which are inaccessible to minoritised communities and negatively impact health equality (SPI-B, 2020).

This report adds further evidence to the notion that culturally competent and inclusive communications is an instrumental part of addressing the health inequalities and inequities faced by minoritised communities, which in this case, is the Jewish community.

2.4 CURRENT POLITICAL CONTEXT

It's important to acknowledge that at the time of writing, the ongoing conflict in Isreal and Palestine has led to Jewish people in Britain experiencing a wave of hate incidents.

- The Community Security Trust (CST), which monitors anti-Jewish abuse and attacks, and provides security for the Jewish community, found a 589% rise in incidents in 2023 compared to the same period in 2022 (CST, 2024).
- Meanwhile, seven in ten (70%) Jewish healthcare professionals have reported an increase in late 2023 (Henry C et al., 2023).

70% of Jewish healthcare professionals have reported an increase in antisemitism from colleagues

The impact of antisemitism and discrimination on Jewish people's wellbeing (both physical and mental) cannot be understated. These factors must also be understood as crucial and fluid in shaping the community's confidence and trust in accessing healthcare services at any given time. Context is important, and health outcomes in the UK for Jewish people are likely to be affected by geopolitical events happening around the world now and in the future.

Over the course of our research and community engagement we heard from numerous individuals and organisations who felt less safe accessing healthcare services over the course of the research period. Fears of antisemitism, discrimination and/or being treated differently by staff now exist where they had not previously for many Jewish people.

Our report reflects this change in experience and behaviour among Jewish communities, while at the same time, ensures recommendations are relevant to community and healthcare providers going forward.

3.0 PROJECT DESIGN

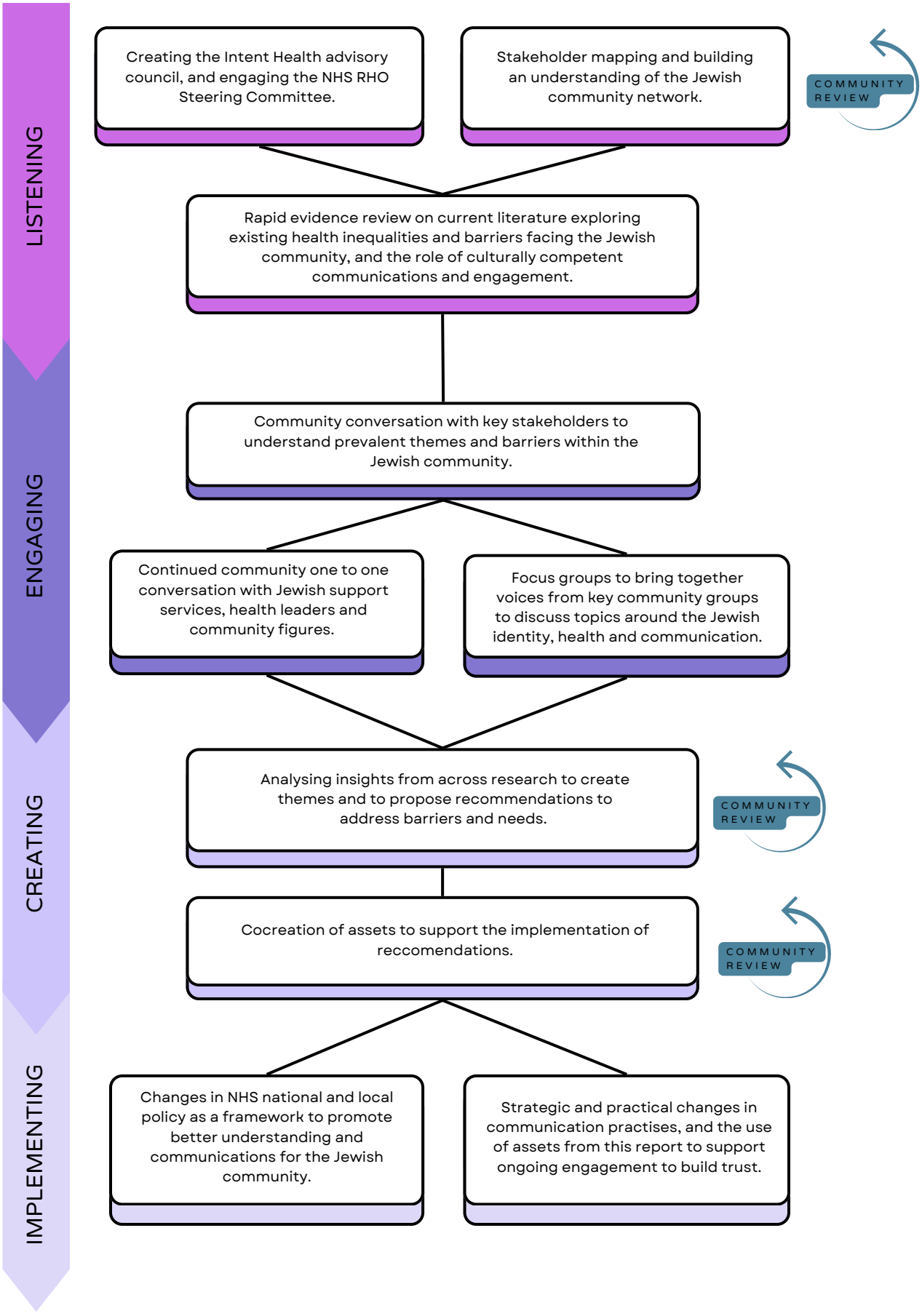

Figure 6
Flow Chart summarising the different stages the team went through to develop this report and associated recommendations and materials: Listening, Engaging, Creating, Implementing

3.0 PROJECT DESIGN

3.1 COMMISSIONING

This research project was commissioned by the NHS Race and Health Observatory in collaboration with the NHS Jewish Staff Network. The purpose of the project is to examine how the NHS communicates and engages with the Jewish community, the methods used to deliver key public health messages, and potential barriers in distributing health messages around areas including vaccinations, healthy eating, wellbeing and exercise.

The research team are part of Intent Health, a consultancy working with industry, health systems, NGOs and research organisations on complex issues affecting communities across the health landscape. Intent Health has been awarded a research commission following an Invitation to Tender published in 2023 by the independent health body.

3.2 COMMUNITY ADVISORS

From the inception of the project, Intent Health worked to build an effective advisory council of five stakeholders representing a cross-section of the Jewish community to discuss, challenge, feedback and validate every piece of activity and workstream. This council consisted of:

- Alexander Richardson
- Hila Skye
- Mark Bamberger
- Noa Weinberg
- Sarah Weiss

The NHS RHO also enlisted the help of its own steering committee comprised of:

- Dr. Martin Ware (co-chair of the NHS Jewish Staff Network)
- Dr. Fiona Sim (a public health consultant representing the Jewish Medical Association)
- Professor David Katz (Emeritus Professor of Immunopathology and chair of the Jewish Medical Association)

The NHS RHO steering committee were regularly updated and engaged throughout the project's duration. The research team met every two weeks with a representative of the NHS RHO for a progress report. Supplementary meetings were also held with Intent Health's advisory council and the NHS RHO's steering committee.

Draft reports were shared with Intent Health's advisory council and the NHS RHO steering committee, along with relevant stakeholders to validate and model the research team's co-productive approach.

3.4 EVIDENCE REVIEW AND COMMUNITY ENGAGEMENT

Unlike previous pieces of research and reports that were either localised or focused on one specific section of the Jewish community, this report presents findings and recommendations that are national in scope and bring together the diverse experiences of NHS care and communications for Jewish communities across England.

The rapid evidence review gave the research team an overview of the breadth and depth of existing evidence on health inequities in the Jewish community, and the impact of community targeted communications. The themes and findings from this piece of work were instructive and informed our approaches for conversations with community members.

It was also important for the research team to go beyond academia and speak to as many members of the Jewish community as possible. This meant reaching out to all kinds of organisations, community groups and networks (formal and informal) to gather as much insight and hear the broadest spectrum of opinion on the changes that need to take place.

People were invited to express their views through one-to-one conversations or as part of more structured focus groups. In many ways, our community engagement was an iterative process and lasted for the whole duration of the project. These open and frank discussions mean the findings, recommendations and outputs come directly from the voices of those with lived experience.

3.5 ANALYSIS OF ALL FINDINGS

The findings from the rapid evidence review, focus groups, community conversations and healthcare communications materials were analysed through a variety of qualitative methods. Thematic analysis and narrative analysis were employed when looking at the data from our focus groups and community conversations. Meanwhile, content analysis was utilised to identify and evaluate patterns in words, phrases and imagery in the communication materials aimed at engaging the Jewish community.

The team then proceeded to methodologically review the analysis to group the findings by theme. The findings were then presented back to a series of stakeholders, including Intent Health's advisory council and the NHS RHO's steering committee, for feedback and validation.

3.6 RECOMMENDATIONS AND ACTIONS

The recommendations and actions were determined, defined and designed by the Intent Health research team in collaboration with the NHS RHO and Intent Health's own stakeholders after collating the findings.

In particular, the research team followed the NHS RHO's implementation toolkit to develop actionable "recommendations, and to identify the most effective activities for implementation, together with tracking of the progress of recommendations, and evaluating the success and impact of implementation."

It was crucial for everyone involved in the project that the recommendations would not just live as words on the pages of the report. The intention is that each recommendation is achievable and accounted for by respective responsible bodies and organisations to help make healthcare anti-racist and anti-discriminatory.

3.7 OUTPUTS: COMMUNICATIONS BEST PRACTICE

The insights, recommendations and actions of this research report ladder up into the creation of new and innovative communications guidance and resources for healthcare services and providers to enable more effective engagement and communication with Jewish communities.

All of the best practice materials and resources have been co-created with the community. These materials are targeted at individuals, providers and commissioners to help make health services more culturally competent and break down barriers between the NHS and the Jewish community.

3.8 RECOMMENDATIONS FOR FUTURE RESEARCH

The scale of this research project was always ambitious for a one-year period. Not to mention that best practice when it comes to community targeted communications is constantly evolving. These issues, and the communities they impact, are not static. As such, the team have noted which areas, topics and issues came up throughout the project that could not be properly examined and instead could be put forward for future research.

4.0 RAPID EVIDENCE REVIEW

This evidence review aims to map existing literature against the project's priority areas:

- Understanding the existing health inequalities and barriers facing the Jewish community in England
- Understanding the role of culturally competent communications and engagement in improving health outcomes

Within this overall scope, the review also highlighted the various ways in which 'the Jewish community' as a term has been used, understood and operationalised by researchers, and the need for healthcare services to be specific and intentional about what parts of the community they are speaking to or trying to reach.

The findings and insights from the rapid evidence review were used primarily as a benchmark – to both ensure this research moved the discussion forward rather than covering known ground; and to support the research design for the second two phases of the project, the community conversations and focus groups.

4.1 APPROACH

In sourcing the studies, the development of selection criteria was informed by three important pieces of research:

- Review of NHS health communications with (and for) the Jewish Community (2022)
- Birmingham City Council - Jewish Faith Settings Toolkit (2022)
- Salford Jewish Community Report (2015)

The Salford Jewish Community Health Research Report found concerns about immunisation take-up, healthy eating, exercise, and attitudes towards mental health within the predominately Orthodox communities. Further academic studies also highlighted health inequalities and key health issues faced by the Jewish community.

Based on this, studies selected for analysis are specific to inequalities, culturally competent language, and barriers to appropriate communication and engagement.

The review of studies involved the screening of abstracts and summaries (reviewed by two team members) before reviewing the full study (if applicable). If selected, data was collected from the research and coded to extract the right information. Data was stored in a spreadsheet to allow for manipulation and analysis, with data from 45 relevant studies/sources included (see Figure 7).

4.2 SELECTION AND QUALITY

When selecting studies for use in this review, our criteria for inclusion was as follows

- Investigated the Jewish community
- Studies from England only
- Investigated the role, use and importance of communications in improving health engagement and outcomes in relation to NHS health communications for the Jewish community
- Used a suitably rigorous method
- Measured the impact on health outcomes.

Studies were included if data and evidence was collected from 2000 onwards and in English language only (however, a rapid sweep of grey literature in additional languages was conducted to review content for certain communities, e.g., Hebrew).

Our criteria for exclusion* removed studies if it:

- Did not nvestigate the Jewish community or was not specific to the Jewish community
- Was not from England
- Did not investigate the role, use and importance of communications in improving health engagement and outcomes in relation to health communications for the Jewish community
- Did not use a suitably rigorous method
- Did not measure the impact on health outcomes
- Could not be freely and openly accessed.

Resources included PubMed, NHS websites, NHS RHO steering group, Jewish organisation websites, international government/health websites, grey literature (toolkits, reports, initiatives), and relevant news/press articles.

Initial selection found 59 sources in total, of which 14 were deemed irrelevant after in-depth analysis, providing a final total of 45 relevant sources. See Figure 7 for a full breakdown of the sources identified and selected.

In addition, quality was assessed according to the methodological quality of the study being considered (using the Maryland scale); the relevance of that research design for answering the question; and the relevance of the study focus for answering the question.

4.3 DATA EXTRACTION

The following data was recorded and collected:

- Date published
- Title
- Author
- Journal / Publishing body
- Organisations affiliated, involved, or sponsoring the research
- Population in focus
- UK or ex-UK
- Geographic location
- What communications/engagement methods were deployed?
- What health inequalities are considered or focused on?
- What cultural adjustments were made which contributed to positive outcomes?
- What aspects of the experience of accessing health services contributed to a negative experience?
- What recommendations were made?
- What outcomes were achieved?

After reviewing and analysing sources, key thematic issues and considerations were synthesised. Ongoing stakeholder engagement, material co-creation and further recommendations or insights were summarised (see summary section).

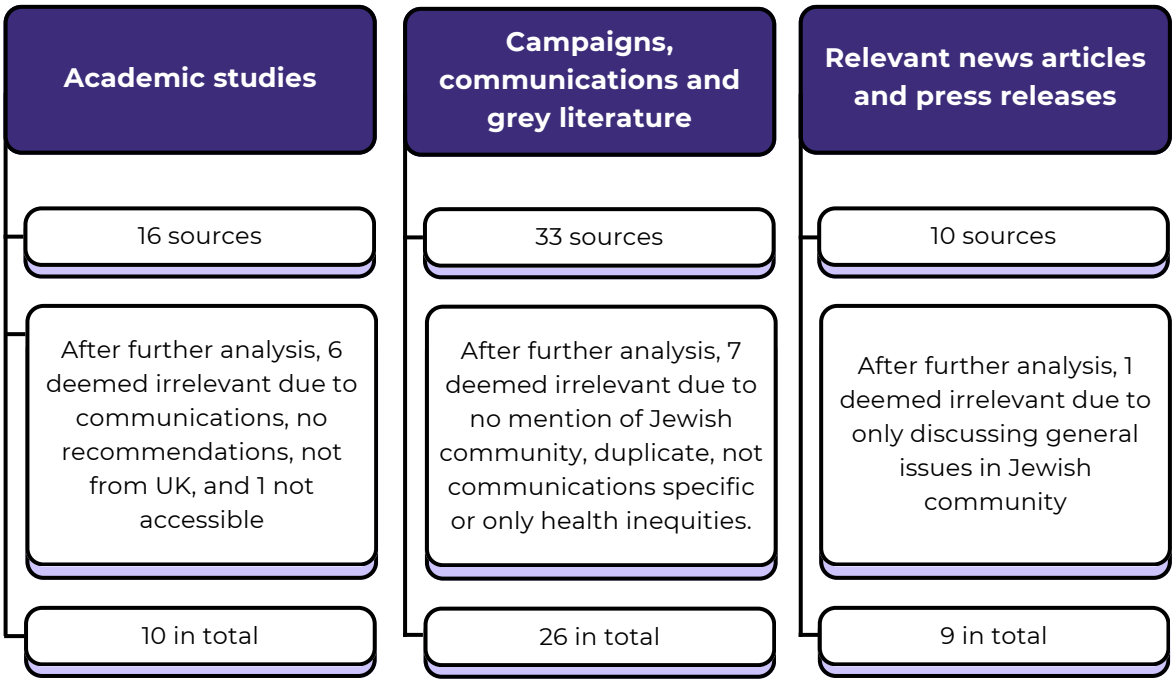

Figure 7
Total number of references analysed in rapid evidence review

4.4 RESULTS

The analysis we present provides an insight into some of the fundamental topics, thematic issues, evidence gaps, and barriers to improving healthcare communications with and for the Jewish community.

The impact of engaging community leaders and grassroots organisations	Culturally competent communications and language	The influence of family and religion on healthcare
Engaging the community utilising a multi-modal approach (digital and non-digital)	Poor evaluation and long-term follow-up to review impact	Existing NHS Toolkits and resources
Gender roles	Literature focused on strictly Orthodox/Charedi community	Engaging secular or less observant Jewish people

Findings from rapid evidence review

The impact of engaging community leaders and grassroots organisations

Numerous pieces of research highlighted the importance of bringing Jewish community leaders onboard to help co-create and launch healthcare awareness campaigns and initiatives.

Examples include videos with community leaders about:

- Mental health (Good Thinking's 'Five ways to wellbeing and Judaism')
- Vaccine uptake (Salford Primary Care's video with Rabbi Daniel Walker)
- COVID-19 (Jewish Community Council of Gatehead's video with Jonathan Klajn).

Working closely to develop and disseminate communications with these individuals helped messages reach and inspire action with segments of the Jewish community who aren't using (or don't have regular access to) existing NHS and healthcare communication channels. Our research also suggests that communication through – or initiatives that have the backing of – community leaders improve levels of trust and reduce stigma and negative perceptions of certain health issues.

Results of rapid evidence review

Culturally competent communications & language

Cultural and religious considerations such as denomination and observance are paramount to communicating with Jewish communities in a way that is effective and meaningful. A crucial component of this is language and having access to translations to make communication assets accessible across all parts of the community.

For example, in one study authors translated COVID-19 information into Yiddish for the Charedi community in London in the local Stamford Hill magazine. In Manchester, the same researchers engaged with Metropolitan police and healthcare professionals located in the Charedi Jewish community up North. As a result, they were able to successfully reach 5,000 Charedi people with vital COVID-19 information (Belk et al., 2022). The study emphasised the importance of 'linguistic sensitivities' of the community, using colloquial Yiddish and included multiple options for translation of medical terminology used in English and Yiddish. They also provided the Germanic-origin Yiddish term and Hebrew-origin synonyms. The 2019 New York State Health Department health information on measles did not involve Yiddish speakers, and this was described by a Yiddish scholar as 'barely comprehensible, almost offensive'.

The UK Government's National Resilience Hub captures key evidence about how their initiatives benefitted strictly Orthodox Jewish communities during the COVID-19 pandemic (Wheeler 2021). As part of this stream of work, the hub translated materials into Yiddish, and engaged trusted community voices who are part of strictly Orthodox Jewish communities across England (Hackney, Barnet, Manchester, Canvey Island, and Gateshead). This led to a positive response and directly lowered COVID-19 infection rates and increased vaccine uptake amongst the community. The appropriate translation was also mentioned as a recommendation from the Salford Community Health Research Report (Wineberg and Mann, 2016).

What this evidence shows us is that understanding the cultural, religious and linguistic nuances and experiences of the Jewish community across the NHS is a vital tool in tackling mistrust. What was also evident is the importance of disseminating materials through gatekeepers and community hubs/spaces, including rabbis, synagogues, community centres.

The influence of family and religion on healthcare

A number of studies and authors noted that a key consideration in engaging with the Jewish community is a strong understanding of the role family and religion can play in information sharing and decision-making about healthcare pathways. This is particularly relevant when thinking about the Charedi community, with findings suggesting they adopt a 'communities trust communities' approach.

For example, Charedi communities tend to have larger than average family sizes, and possible additional caring responsibilities for elders, so may need to contact their GP on a more regular basis, making simple appointments for the family a large and complex task.

Results of rapid evidence review

This was exemplified in a COVID-19 project aimed at the Charedi Jewish community in the London Borough of Hackney where one of the recommendations highlighted the use of key social influencers in the community including faith leaders and family members (Local Government Association, 2020).

The fluidity of people's experiences of being Jewish was noted perhaps most strongly around end-of-life care. In some cases, non-observant Jewish people reaching the end of their lives may decide they want to follow Jewish funeral traditions. This can pose challenges for both the individual and healthcare professionals if the person (or the hospice/hospital) is not connected to their faith and faith community.

Engaging the community utilising a multi-modal approach (digital and non-digital)

The approach deployed across the most successful of the studies and work was that of a multi-modal approach to communications: using digital and non-digital materials aligned, targeted and mapped to specific cross-sections of the community. Digital methods include bespoke websites, video content (by community leaders), and non-digital assets include brochures, magazines and even gamification (for younger community members). Moreover, there were several studies which highlighted the efficacy of in-person events and activities in community spaces such as synagogues and community centres.

One study tailored lifestyle interventions to low socio-economic populations and found that events/groups should be culturally tailored to diverse communities. One example given was a Jewish women-only weight loss and exercise group (Coupe et al., 2018).

Another study looked at a partnership approach to supporting the health and wellbeing of the Charedi community in North London by organising an event attended by more than 100 women in Stamford Hill (Zuriaga et al., 2022). Feedback from attendees suggested there should be a greater number of community-targeted events, such as health issues for Jewish women over 40. Informal feedback further highlighted that the event was useful and acted as a springboard for further engagement and collaboration. Examples of community spaces that could be used in this work include the Labruit Healthy Living Centre and Wellbeing project as part of the Jewish Community Council of Gateshead.

It was also recognised that disseminating information via Jewish-specific media, such as The Jewish Chronicle, whether through news stories, media partnerships or advertising, remains an important option for healthcare campaigns.

Results of rapid evidence review

Poor evaluation and long-term follow-up to review impact

Across all the research and evidence reviewed, there was extremely limited follow-up and/or comparative cohort studies to ascertain the long-term impact of any initiatives, outreach programmes or communication materials. It's worth noting that funding issues mean many pilots are restricted to be singular interventions, or are not able to robustly follow-up on research that has been previously completed.

However, the lack of long-term follow-up can have a damaging impact on trust within the community and generate a perception that the issues facing the community are not taken seriously. For example, in this research project, there could be an opportunity to bring examples of previous initiatives and communication materials to see how they resonate with new audiences now and how they could evolve to fit contemporary needs.

NHS toolkits and materials exist

There are a number of existing toolkits which have been developed by the NHS and various Trusts relating to training and cultural competency for Jewish patients. However, to better support NHS staff across the board, more needs to be done in this area aside from typical 'do's' and don'ts' sheets. There is scope for a wider, more comprehensive toolkit to be rolled out across teams.

An important facet of this activity is being aware that there is more to be done within the NHS to widen the participation and diversity of the workforce in order to effectively deliver support to the Jewish community (Health Education England, 2019; Dr. Héliot, 2022). A more representative NHS workforce is crucial to better serve the community, personalise outreach and hopefully, deliver an improved overall patient experience.

Gender roles

What becomes clear through this review is the role that women in Orthodox communities play in taking responsibility for their family's health, although not exclusively. As keepers of the household, several studies, including Scrambler et al. (2010), interviewed women and mothers in the community to better understand how they make decisions about healthcare for their family and how important it was to have communications targeted at this demographic.

Moving forward it will be important for us to explore if this is true across the whole community of Jewish women. This also doesn't mean men in Orthodox communities are not engaging with healthcare services and communication, but the focus of most research so far has been on women in the Orthodox community. Thisopened up the possibility of hosting a focus group specifically for Jewish women of all walks of life and denomination to dig into both gender roles and women's health issues.

Results of rapid evidence review

Literature focused on strictly Orthodox/Charedi community

Across much of the available, published research, there is an enormous focus on understanding and reaching the Charedi community. This isolated community leads a highly observant, communal religious life with little to no access to TV, radio, mainstream media and the digital world. They are often classified as a 'hard-to-reach' minority community both generally and within Jewish populations (Kada, 2019).

Therefore, there has been a considerable amount of academic and community-led work to consider how to get public health messages to the Charedi community. Recent estimates from the JPR say that about one quarter (25 per cent) of the UK's Jewish population is Charedi and will grow to 40% by the end of the next decade (JPR 2022). That still leaves a significant portion of the country's Jewish population who may not be getting the attention they need from the NHS or healthcare practitioners.

Engaging secular or less observant Jewish people

As noted above, much of the available research looks at behaviour and needs of the Charedi community. This means there is little discussion about engaging less observant or secular Jewish people in England – many of whom are assimilated into every day British life and are not necessarily connected to Judaism. On the one hand, these findings may or may not apply to this particular group.

While on the other, we know there are health issues that affect the whole Jewish population, regardless of observance, such as increased risks of certain cancers and genetic testing for conditions (Bressler et al., 2017; Burnell et al., 2022; Manchanda et al., 2020). We also know it's important for less observant Jewish people to be able to talk confidently about their ethnicity with their GPs, but also to believe their practitioner knows what to ask about their ethnicity.

4.4 INFORMING THE NEXT PHASE OF RESEARCH

As part of our commitment to representing the voice of the community, the research team aims to conduct an extensive, thorough and iterative period of community engagement for duration of the project.

This period of community engagement forms the cornerstone of our report, recommendations and outputs. This process provided an approach of constant validation and suggestions for next steps, an inside-out approach to building our report, and co-production and delivery from day one.

5.0 COMMUNITY ENGAGEMENT

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Approach

Our community engagement approach is founded on key principles of good practice for minority communities to ensure longevity, mutual respect, and trust between parties. Our framework is detailed below:

Area	Why is this important?
Preparation and Cultural Awareness	Recognition of the challenges communities are facing right now; Active cultural competency demonstrates understanding, levels the field and builds trust; Being clear on the benefit for family, friends and wider community can encourage engagement.
Talking about Health	People perceive and talk about health differently; A need to understand and remove any existing lens on issues of health – adapting language.
How to Listen	Communities are your peers - treating them as such is important; They're the experts; Groundwork helps make sure relationships are built on respect.
Acknowledge Experience and Expertise	Sharing stories may be also sharing trauma; an acknowledgement of this and confirmation on the importance helps. Recognise valuable work is already being done by the community, and give this both time and importance.
Managing Challenges	To manage historical relationships and fatigue with these programmes (i.e. ignored calls for funding); To manage different opinions in the room.
Reputation and Transparency	A clear commitment to information sharing and transparent communication; You cannot build trust without honesty; Acknowledge wide scope and timelines for change for the project, and consider perceptions.

5.0 COMMUNITY ENGAGEMENT

5.1 APPROACH

All engagement work begins with a period of investment. We employed and built relationships with our advisory council as our initial listening phase building our social understanding and cultural competency of the Jewish community. Moving forward, each relationship begins with research from the team to understand the organisation, initiative or motivations behind the community member we engage.

As part of each conversation, we primarily talk about shared goals, values and approaches. We seek to understand challenges (i.e., remits of support services or NHS services), barriers (i.e., experiences of past helicopter research projects, trusting an outside organisation seeking personal insights) and cultural nuances (i.e., asking questions about ill health, and how religion or culture of the Jewish community may intersect with this).

Two types of community engagement are utilised during this phase:

01

1-2-1 Community Conversations

Unstructured interviews to understand individual and organisational experiences in supporting the Jewish community within healthcare

02

Focus Groups of 6-8 people

Facilitated discussions to review insights and ideas, digging further into issues like mistrust.

5.2 STAKEHOLDER AND COMMUNITY MAPPING

The Jewish community is diverse and formalised into a number of support organisations who cater to the community's needs in the UK. An initial stakeholder mapping exercise revealed a number of prominent national and local Jewish support organisations.

Stakeholder mapping identified people whose views should be included in this research. We used social listening to find key voices in the space, and sought out individuals spearheading grassroots and community initiatives at local levels. Participating individuals were engaged through individual networks, referrals and recommendations and organised networks. To ensure a wide variety of experiences and insights, we adopted an open, non-exclusionary approach to community conversations.

5.0 COMMUNITY ENGAGEMENT

Interviews were conducted with the majority of leading Jewish support services. At key points throughout the community engagement phase, stakeholders have been re-engaged to validate prevailing insights and to help shape initial recommendations and ideas for communications outputs.

Individuals representing over 40 Jewish affiliated organisations have been engaged for this project, providing us with personal views as well as professional or organisational experience, these include:

Birmingham Jewish Community Care	Bournemouth Jewish Support Services	Camp Simcha	Chai Cancer Care
Chana Charity	Ezra Umarpeh	Hatzola	Interlink
Jewish Action for Mental Health	Jewish Association for Mental Illness	JEWEL	Jewish Blind & Disabled
Jewish Community Council of Gateshead	Jewish Leadership Council	Jewish Medical Association	Jewish Representative Council of Manchester
Jewish Visiting	Jewish Women's Aid	Jnetics	JuMP: Jewish Maternity Programme
Keshet UK	Kisharon Langdon	Leeds Jewish Representative Council	Leeds Jewish Welfare Board
Lev Chaim Cancer Support	London Jewish Health Partnership	Neshomo	NHS Jewish Staff Network
Pinter Trust	Reform Judaism	Stamford Hill Group Practice	The Fed

While our engagement covered a significant range of Jewish led community services, a few organisations declined to be involved, did not respond to invitations to participate, or became unresponsive despite numerous attempts through various channels and individuals.

5.3 FOCUS GROUP CONVERSATIONS

The focus group design encouraged rich and meaningful insights in an open and intimate environment, allowing for both convergent and contradictory points of view as well as in-depth experiences. Each participant had the opportunity to share their view, and one-to-one follow up contact allowed the expression of further perspectives outside of the room.

In accordance with the central principles of co-production of the project, the focus group design included facilitation by someone with lived experience, an Intent Health advisor, communications professional, and member of the Reform Jewish Community and Trustee at Edgware & Hendon Reform Synagogue.

The structured focus groups brought together 4-6 attendees in a 90–120-minute online Zoom session. The focus groups were audio recorded and transcribed. Groups always included a diverse demographic in terms of age and location, and where groups were not formed around religious identity or gender also ranged in observance and gender.

The structure for the sessions was as below:

- Facilitator introduction (5 mins)
- Project introduction (5 mins)
- Introductions (10 mins)
- Topic 1 (20 - 30 mins)
- Break (5 mins)
- Topic 2 (20 - 30 mins)
- Topic 3 (20 - 30 mins)
- Closing (5 mins)

Discussions have been arranged into six focus groups to as best as possible represent the diverse composition of the Jewish community and the topics of interest.
There are inherent limitations in grouping together individual within such a diverse and nuanced community in the creation of boundaries between groups which, in reality, are far more fluid.

Furthermore, by keeping focus groups to a recommended size of between 4 to 6 attendees, there are limitations on how representative these are for the wider community. However these groups were also further supplemented by a wide range of community conversation and further engagement routes to ensure diverse views and encompassing representation,

Our specific rationale and inclusion criteria are listed in the table on the next page.

5.0 COMMUNITY ENGAGEMENT

Focus Group	Rationale for inclusion	Overview of topics discussed
Health Leaders	Inclusion of both personal and professional insights from Jewish community-led health groups and academia. This discussion aims to gather wide-ranging insights from leaders with access to large, diverse communities, and therefore determine themes and focuses for future, specialised focus groups.	**Community**: How healthcare services can better understand the diversity of the Jewish community. **Trust**: Challenges in accessing healthcare services and trusted health messages. **Communication**: Differences in NHS vs Jewish community created healthcare messages.
Orthodox Community	The Orthodox community is the largest within the Jewish community. This group aims to seek insights about the nuances within the diverse Orthodox community, what can encourage greater trust and engagement from the community, as well as where the community see communication either succeeding or failing.	**Health**: What does living a healthy life mean, and health issues affecting Orthodox Jewish communities needing attention. **Trust**: Experiences in accessing healthcare services and needs/sensitivities for healthcare providers. **Communication**: Sources of information about health issues, and values to trust these.
Secular, Reform and Liberal Community	This group aims to ensure those who identify as liberal Jews have their accommodations and experiences addressed to improve outcomes.	**Identity**: The meaning and importance of health and the Jewish identity. **Accessing healthcare services**: Experiences in accessing healthcare services and needs/sensitivities for healthcare providers. **Communication**: Experiences of communications for the Jewish community, and how this could be increased or improved.
Women	Through existing research, women have been identified as holding an important role in Jewish communities, facing personal health crises such as BRCA1, also often bearing the majority of the childcaring responsibility, food/dietary habits and hygiene habits of the family and often the related family health decisions.	**Trust**: Experiences and trust with the healthcare services. **Women's health issues**: Key issues for women's health, improving NHS services in these areas and beyond. **Communication**: Sources of trusted health information and where there could be change.
Jewish Healthcare Practitioners	Gathering dual insights from professional and personal experiences of Jewish healthcare practitioners, including where they sought to support colleagues in understand the community, to also their experiences being Jewish in the current healthcare landscape.	**Serving Jewish patients**: Experiences as a Jewish HCP, and insights into how fellow HCPs could better serve the community. **Working in healthcare services**: Experience as a HCP, support from NHS organisations and colleagues around identity, and navigating the healthcare landscape as a Jewish person. **Communication**: How NHS employees cater for Jewish communities and routes of improvement.
Non - Jewish Healthcare Practitioners	A control group to ensure insights are gathered from healthcare professional experiences and understand where existing learning and barriers might exist.	**General knowledge**: Experiences of working with, and understanding of the Jewish community. **Working in the healthcare service**: Experiences in accommodating for Jewish patients, including training and guidance. **Communication**: Insights on experiences engaging and communicating with the Jewish community, and room for improvement.

5.4 FINDINGS

The findings from the rapid evidence review, focus groups, community conversations and healthcare communications materials were analysed through qualitative methods into a thematic consolidation. Meanwhile, content analysis was utilised to identify and evaluate patterns in words, phrases and imagery in the healthcare communication materials aimed at and from the Jewish community.

We draw together experiences, both positive and negative, barriers and enablers, examples of good practice and community led health communications, and align where narratives and perceptions provide meaningful and tangible findings representative of community views.

The recognition and understanding of Jewish identity

A poor understanding of Jewish identity and Judaism directly affects uptake

Poor and inconsistent data capture within NHS systems

Assumptions about homogeneity create barriers in identifying appropriate access to services

Mistrust and feeling unsafe are key barriers to improving self-identification practices

Pervasive stereotypes exist and are amplified by medical education and the media

Engagement between communities and services

A vast network of successful community support exists to manage gaps in national/systemic services.

Successful initiatives always employed a co-production approach; without this, positive impact and reach is low

Role of rabbinic and community leaders

A variety of successful communication channels could be employed to reach the Jewish community

The Charedi communities have limited access to NHS-led medical information

'Helicopter' approaches to partnerships and projects had limited success

Clinical tools and approaches

NHS workforce knowledge is low; and training can reinforce negative stereotypes

Recognition of trauma can rebuild trust and improve engagement

Chaperones or navigators break down trust issues and improve engagement

Service design that is supportive of cultural and religious practice improves engagement

The recognition and understanding of Jewish identity

A poor understanding of Jewish Identity and Judaism directly affects uptake.

Despite the almost 300,000 Jewish people in the UK, there is a systemic lack of understanding, recognition, and therefore consistent accommodations for the Jewish community with the NHS.

For those across England, being Jewish is wide-ranging and hugely diverse label, and can refer to both Judaism as a religion, and identifying as Jewish as your ethnicity. Different members of the community relate to their Jewish identity in different ways, and see the link between being Jewish, their health and healthcare needs also in different ways.

Related to this, there is a prevalent misunderstanding among people who are not Jewish as to what it means to be Orthodox. The assumption is that any Orthodox person's religiosity and subsequent healthcare needs are more closely aligned with those who are strictly Orthodox. These assumptions lead to negative perceptions from the community about a healthcare provider's knowledge, cultural and religious sensitivity as it can impose stereotypes and build barriers. This can also negatively impact healthcare communications, for example we heard of healthcare professionals pre-emptively discussing kosher vaccines with Jewish patients, or the use of stereotypical images of strictly Orthodox families being inaccessible to both strictly Orthodox and wider Jewish communities.

We heard particularly from many individuals, and in particular from the secular community, that those who identify as Jewish through their ethnicity as opposed to their religion feel this can be misunderstood or not recognised by their peers in society, or as part of NHS healthcare.

We heard this as being increasingly common, particularly among younger community members. The most recent 2021 UK Census revealed that there was a fall in the number of people who identified as Jewish through the religion question (ONS, 2021), and JPR found that only 57% of British Jewish adults they surveyed belonged to a synagogue (JPR, 2024).

4/10

43% of British Jewish adults do not belong to a synagogue

Our community insights found that many in the Jewish community are aware of how their ethnicity can impact their health, and of the various conditions prevalent in the community. However, this is usually information obtained through families or community networks, rather than discussions with healthcare professionals or from NHS health messaging.

In one-to-one communication experiences with the NHS, we heard a diversity in experiences ranging from those who felt their ethnicity or faith had little impact, to those who were nervous that there would be lack of understanding of needs such as kosher diets, modesty expectations for either gender, or barriers facing larger families.

The recognition and understanding of Jewish identity

Poor and inconsistent data capture within NHS systems.

A lack of consistent, useful data capture on the community through database systems means the NHS is limited in being able to identify, appropriately support and measure outcomes for communities themselves.

We found significant inconsistency in availability for the Jewish community to identify as Jewish across NHS services, both as an ethnicity and religion. We heard from the Jewish community that this inconsistency in the ability to identify one's religion as 'Judaism', or ethnicity as 'Jewish', can negatively impact perceptions of the NHS, as well as cause feelings of otherness. This leaves many from the community feeling ignored as an identity, or not important as an ethnic minority group at national and local levels.

> *"About a year ago, I tried to access mental health services and was on the phone signing up... she asked me, 'what's your ethnicity? Can I assume that you're British – White?' And I said technically I'm Mixed – Other... they don't have Jewish, they don't have Mizrahi, they don't have anything like that on the drop down lists. It doesn't really make you feel very nice or included when they don't even have your religion or ethnicity on the books"*
>
> Focus group attendee

Assumptions about homogeneity creates barriers in identifying appropriate access to services.

We heard insights from NHS healthcare practitioners that due to lack of knowledge and a desire to avoid stereotyping, they find it hard to identify a Jewish patient, and worry that they cannot provide the necessary accommodations in care and communication to best serve their Jewish patients.

The multifaceted definition of being Jewish creates significant complexity in deciding which individuals require which healthcare services, particularly when demographic data is not collected consistently within primary care. An individual could need one, or both, or none of the additional support which the above factors would demand.

We simultaneously found a knowledge gap across healthcare professionals, and a lack of understanding of the diversity within the Jewish community and denominations, as well as the adjustments and prevalent health conditions.

The recognition and understanding of Jewish identity

> *"All of my knowledge about our [Jewish] predispositions and genetics and things that could be an issue linked to our ethnicity of Judaism has all been through personal knowledge and going out and finding that information myself, or from Jewish charities like Jnetics. I've never learned any of this from the NHS."*

Focus group attendee

Mistrust and feeling unsafe are key barriers to improving self-identification practices.

Importantly, certain hesitations to identify as Jewish, particularly in periods of heightening antisemitism or from older generations with past trauma were reported throughout the research, so it is important to continue to allow people an option to not identify their religion and/or ethnicity.

Pervasive stereotypes exist and are amplified by medical education and the media.

There are low levels of religious and cultural literacy among NHS staff about needs of Jewish communities, reported by NHS staff themselves.

Staff reported that stereotypes about Jewish people in terms of what they may look like and conditions they may have are reinforced during training, in particular for Single Best Answers/MCQs, and for some constituted as the only medical training about the Jewish community they had received.

Furthermore, Charedi communities are often stereotyped as anti-vaccine both within the media and among some healthcare professionals. There can be an assumption that people from certain demographics are 'non-compliant' with public health measures, or 'hard to reach' with engagement. Our research found time and again that this wasn't the case, that simply not enough effort was being taken to tailor messages and understand concerns.

Engagement between communities and services

A vast network of successful community support exists to manage gaps in national/systemic services.

A vast network of Jewish health and social care support services exist, serving Jewish communities regionally and at a national level. These services range from those at a grassroots level serving even the smallest pockets of the community in need; to larger registered charities already working in tandem with NHS services.

Importantly, these services and charities engender greater trust from across the community for delivering healthcare messages and services. Events are well-attended, messages trusted and initiatives make an impact against their goals. Furthermore, the awareness, popularity and consistent use across the community of current Jewish support services has an unmeasured, but perhaps larger than appreciated impact on the number of Jewish community members accessing their equivalent NHS services. We heard almost universal reports from these services of their service user numbers increasing year on year, often coupled with patients reporting longer waiting lists or cancelled NHS equivalent services.

There is a need for a deeper understanding of the role Jewish support services play within the community for healthcare communications, and how to align with existing relationships and communication routes in order to engender confidence in healthcare journey touchpoints.

Successful initiatives always employed a co-production approach; without this, positive impact and reach is low.

The best route to build trust with the community is with the community themselves. The value of co-production and sponsorship in NHS healthcare communications is vital.

We found positive examples of the NHS collaborating with these services to great success. For example, working with community pharmacies to hand out health messaging or deliver vaccines; or providing trained NHS representatives to community health events to share information and build trust; or providing dedicated and embedded NHS staff to community health organisations to bridge communications and align services.

NHS staff members across existing and emerging NHS services wanted a greater understanding and access to the remits and service user demographics of local and regional Jewish support services and community healthcare hubs. It was noted that co-creation, delivery and overall collaboration led to better outcomes, prevented duplication of provision, improved signposting, and streamlined the patient experience.

We also explored awareness and perceptions of NHS campaigns or healthcare messages for the Jewish community. We found on an individual level, the vast majority had little to no awareness of targeted healthcare communications, and also held neither good nor bad perceptions of NHS communications for the community.

Engagement between communities and services

> *"The Orthodox Jewish community will trust people from within the community. The best way to get information out is bringing speakers in and making events within the community with speakers on breast cancer, cervical health, children safeguarding, and health professionals brought in from outside the community. When it comes from within the community, people have the trust, they'll use community organisations to help refer them out and maybe to go with them, advocate for them and signpost them to it."*
>
> Focus group attendee

The role of rabbinic and community leaders.

As with many minority communities in England, we found distrust between Jewish people and healthcare services and initiatives from outside the community, further impacting disengagement and the success of outreach programmes. In certain communities such as the strictly Orthodox, many members also seek confirmation that certain healthcare interventions follow religious and cultural norms.

Participants in our research noted that sponsorship of communications and materials by the right community members, whether that is rabbinic authorisation, community organisation, Jewish leaders, or doctors, can allay fears and improve engagement.

Religious authorities, such as rabbis, are often seen as key stakeholders and influencer in public health policy and delivery. Rabbis (and by extension synagogues) are regularly used to deliver health messages and raise awareness of public health campaigns. However, existing studies have noted that parents who do (or do not) accept vaccination "did not typically view male rabbinic authority or consultation as relevant to their decision-making." Instead, "refusal of vaccines was rooted in a tendency to over-determine and universalize safety concerns, and these concerns became legitimized by drawing on Jewish laws and teachings about risk and danger." (Kasstan, 2021).

> *"We can't underestimate the power of rabbinic authorisation. I think that's really important, particularly when we're talking about things like health, and when you're looking for trustworthy sources, a lot of communities will go to rabbis and ask their support."*
>
> Focus group attendee

Engagement between communities and services

Not so 'hard to reach': A variety of successful communication channels could be employed to reach the Jewish community.

Many different Jewish communities have a unique blend of channels and types of communications which they trust most to receive healthcare messages.

This can be misunderstood by healthcare services, for example only posting information about certain healthcare services or initiatives on websites or social media, or only in English, can lead to strictly Orthodox communities not gaining access. Similarly, many community members reported using trusted spaces and hubs such as Kosher shops, or local pharmacies, and picking up leaflets or reading information in existing Jewish newspapers to access healthcare information, which can be overlooked by NHS engagement campaigns.

> *"In this space there's two different things, there's the design of the communications and there's the delivery of the communications. Often those are together and sometimes they're not. During the campaign in London, I was involved in designing some kind of communication for the community that unfortunately didn't get delivered anywhere. And to this day, I'm still quite not sure what happened in the beast that is the NHS and how they didn't flow downwards."*
>
> Focus group attendee

The Charedi communities have limited access to NHS-led medical information.

Aligned with the existing literature, our engagement and research found that the Charedi and strictly Orthodox populations are at sharpest edge of many of the health inequities facing Jewish people.

The lifestyle of this demographic mean they have limited access to NHS-led medical information, for example many individuals in this community don't use or have access to the internet, social media, and/or smartphones.

We found that members of the strictly Orthodox community are more likely to use Orthodox community services (versus less-observant parts of the community) due to an acknowledgement that there will be more understanding, acceptance and accommodations for their cultural and / or religious needs.

Many Orthodox support services report disengagement from 'standard' NHS services. When combined with the knowledge that this is the fastest growing part of the Jewish community, all participants recognised an urgent need to address challenges and build bridges to improve engagement.

Engagement between communities and services

'Helicopter' approaches to partnerships and projects had limited success.

Learnings and best practice are not always consistently applied to new projects (in addition to funding), limiting the long-term success of projects.

Some community members commented that various statutory or other bodies had approached them to publish research about health inequities and a better understanding of the Jewish community, in particular the strictly Orthodox communities in London. However, negative perception prevailed about follow up in terms of communications and importantly practical improvements for the Jewish community.

> *"I have always had a very strong connection between my health and my Judaism, because I have family histories of diseases that are present in Jews. And I know that when the time comes for thinking about children, I will need to get screened myself for Tay Sachs... because my father is a carrier, which means there's a 50% chance that I'm a carrier. The thing that is frustrating for me is that I only know of these things because of my family and because of looking up things myself. I don't think I've ever been asked about my Judaism at the GP. And so no one's ever asked 'do you have a family history of these things specifically related to pregnancy? And therefore, you might want to think about getting genetic testing'."*

Focus group attendee

Clinical tools and approaches

NHS workforce knowledge is low; and training can reinforce negative stereotypes.

It was unanimous throughout literature and community engagement that the upskilling of NHS staff to provide the best care possible is key to building better relationships, improving one-to-one conversations and communications, as well as improving outcomes for Jewish patients.

Studies have found that cultural competence in healthcare providers leads service users to report better satisfaction with care, perception of quality healthcare, adherence to treatments, and importantly effective interaction and improved health outcomes (Henderson et al., 2018). Importantly, culturally competent healthcare systems have the potential to address ethnic health inequities (Anderson et al., 2003). Access to cultural competence training also improves the knowledge, attitudes and skills of health professionals (Beach et al, 2005).

Within the NHS, there are high levels of religious discrimination and a lack of faith competency among employees (Héliot, 2020). We heard this echoed in the insights from our non-Jewish healthcare practitioners, who raised worries about being able to accommodate any Jewish patients they serve due to a lack of understanding of religious or cultural needs, for example end-of-life care. Many Jewish support services have in the past provided cultural competency training to various statutory bodies, however many report these to be less common due to financial pressures or turn-overs in staff.

> *"99.9% of the people that I know, all the eLearning stuff that you have to do, they haven't done more than 70% of it, more than 50% probably. And most people just click through it. They don't actually read it. And when I joined this trust [in demographically Jewish area], I wasn't given any paid time to do it. I was expected to do it on my own time."*
>
> Focus group attendee

For many in the Jewish community, we heard perceptions that NHS providers are more likely to be naïve towards, or misunderstand the Jewish community, which can lead to fears that certain cultural or religious practices may be overlooked, and appropriate screening or advice for health conditions within the community may not be discussed. We heard commonly of a misunderstanding of the Jewish cultural calendar, for example appointments being booked on Friday afternoons or over Yom Kippur, and fears to reschedule these in an already busy system.

Exacerbating the issue, currently healthcare practitioners cannot currently identify if a patient is Jewish and therefore would not be able to offer them personalised care unless the patient offers this information proactively.

Clinical tools and approaches

"I don't expect any NHS service to be fully aware of my needs. I expect them to be able to ask and inquire and explore what my needs are as a patient coming into the NHS. Equally, I can say, as a member of staff, I will absolutely not be aware of all the cultural needs and different backgrounds of people accessing our service.

But I think the expectation that I have of myself and of my team is that those are questions are asked and are explored and we try and learn and understand where a person or family might be coming from and what their specific needs are."

Focus group attendee

Recognition of trauma can rebuild trust and improve engagement.

Many Jewish people have experiences of trauma. These experiences may be personal – through discrimination and antisemitism – but also intergenerationally. This community experience impacts engagement and trust with services, which can be further reinforced by a lack of understanding of antisemitism in the NHS workforce.

The ongoing conflict in Israel and Palestine, and concurrent rise in antisemitism, has had huge impact on the wellbeing of Jewish communities, including many NHS staff and patients who feel uncomfortable in clinical settings. Participants were able to document a difference in their experience, and an ongoing sense of threat and psychological impact, which underscores how vital trauma-informed care is today and in future.

Moving towards a model where healthcare professionals understand how structural oppression and inequality impact on people's responsiveness to service is an important part of building trust with minority communities.

"The health service is the one who should recognise [cultural sensitivity training] is not just for the Jewish community, it's for all those communities that you serve. Our community is slightly more complicated than others, but even so, diversity training isn't just a nice little ticker add on, it's actually content, and it can make a real difference to people making them comfortable, helping them to engage properly, and actually addressing issues."

Focus group attendee

Clinical tools and approaches

Chaperones or navigators break down trust issues and improve engagement

We heard from a range of Orthodox support services and members of the Orthodox Jewish community, that there can be greater fears and hesitation in attending healthcare appointments alone. This can be due to language or cultural barriers between provider and patients, as well as certain strictly Orthodox communities being less assimilated into everyday society and therefore having a certain fear of the unknown.

Some Jewish support services are already seeing the success of providing suitably trained 'healthcare advocates', also known as community liaison or engagement workers, who attend appointments to support with elements such as translation, confidence and attendance levels. Furthermore, this work has also been seen successfully in other minoritised communities, for example, in Australia with Aboriginal healthcare liaison officers.

'Social prescribing link workers' are already an existing role within NHS England, with their role designated to 'connect people to community-based support, including activities and services that meet practical, social, and emotional needs that affect their health and wellbeing', this report has not reviewed their success and their contact with the Jewish community.

> *"A lot of the families have a language barrier, so they could sit in a consultation with a top oncologist, and he'll be saying one thing and they will come out of that meeting having heard another.*
>
> *By giving the family support [in the form of a community advocate], and somebody going with them and listening to what is being said, then not only translating, because actually a lot of them do speak English, but it's not their mother tongue and they are hearing different things that's being said."*

Focus group attendee

Service design that is supportive of cultural and religious practice improves engagement

Many participants described a variety of challenges in the practicalities of healthcare engagement, such as attending appointments with larger families, working around religious observance, needing to see same sex healthcare professionals, and sensitivities in language and tone for conversations around maternal health.

Jewish cultural and religious practices also intertwined with healthcare services during end-of-life care. We found many from the Jewish community anticipate a lack of understanding from healthcare services which fuels a fear of certain rituals not being followed.

Non-Jewish healthcare professionals also raised concerns about a lack of understanding of these rituals, and lack of understanding or confidence that existing NHS chaplaincy services would be able to fully accommodate Jewish patients.

From the community, we heard from many Jewish support services and health leaders about the role of synagogues in supporting their communities (and non-religious community members) towards end of life.

Clinical tools and approaches

The Jewish community also observe a variety of festivals, or Yamim Tovim, and holy days which can prevent people attending events or appointments. The Hebrew calendar is a lunar calendar with changing dates year on year. However, these can be also weekly, for example Sabbath, or Shabbat, is a weekly day of holiness and rest observed from sunset on Friday to sunset on Saturday.

Many Jewish individuals and families spend the latter half of Friday preparing for Sabbath with family and friends, as well as following observance by abstaining from work, electricity and attending services. Furthermore, in certain departments, such as paediatrics, families may be unable to accompany their children on Shabbat.

> *"I recently went to visit an elderly woman in a care home during Hanukkah and the whole place was decorated for Christmas, which is absolutely fine, but her room was decorated for Christmas. And I mentioned to the staff that maybe that was a bit culturally insensitive, and it was almost like the first time anybody had ever thought about it."*
>
> Focus group attendee

6.0 LEARNING FROM REPLICABLE BEST PRACTICES

We collated these best practice case studies throughout our listening phase, exploring insights on effective and well received health campaigns as part of our community conversations. Case studies range across a spectrum of Jewish support services, and how various NHS bodies can effectively co-produce and deliver for better community engagement.

Each case study provides background information on how and why the initiative was created, the key learnings for each party, and replicable good practice.

The NHS Jewish BRCA Testing Programme

Organisations involved	NHS England, Jnetics, Chai Cancer Care, and the Genetic Cancer Prediction through Population Screening Study.
Aim of programme	Deliver a population wide screening programme for BRCA1 and BRCA2 to identify people at risk therefore improving early diagnosis of cancer in Jewish populations, as well as support with family planning for those carrying faulty genes.
Communications and engagement activity	Extended periods of community engagement from academia, Jewish support services employed through tender to deliver community engagement.
Who can replicate	NHS bodies looking to engage Jewish communities with new health initiatives, and raise community wide acceptance and engagement with a health campaign.

Background

BRCA1 and BRCA2 are two genes which repair DNA damage and normally help to protect against cancer. People of Jewish ancestry are disproportionately impacted with faults to these genes, one in 40 Ashkenazi and one in 140 Sephardi Jewish people carry faulty BRCA genes compared to one in 250 of the general population (CDC 2023). These mutations can put individuals at greater risk of developing cancers including ovarian, breast and prostate cancer.

The programme itself is an output of the Genetic Cancer Prediction through Population Screening Study (GCaPPS) which began in 2008 to evaluate the need for population-based screening for genetic testing.

The GCaPPS trial began with a year-long, extensive community engagement period encompassing all denominations in the Jewish community, a broad range of stakeholders including religious leaders, Rabbis, Boards of Deputies, Jewish charities, Jewish Medical Association, cancer charities and patient support groups (Burnell et al., 2022). This period helped shape the team's understanding of community perception of BRCA, co-produce study development, materials and delivery as well build trust, support and awareness.

In February 2024, NHS England launched their national BRCA gene testing programme with aims to identify those at risk of several cancers. This new form of population-based screening is offered free and at home, accessible by anyone with a Jewish grandparent.

Jewish support services Jnetics and Chai Cancer Care led the community engagement, working collaboratively to produce a cohesive campaign reaching as many individuals across the spectrum of the Jewish community, from people who don't know they have a Jewish grandparent to strictly Orthodox communities.

Bringing together this expertise and networks allowed the NHS campaign to reach many within the community. Chai Cancer Care began with a 'soft launch' of the campaign through their newsletter, assessing the feasibility of community engagement and to gather any feedback on existing messaging and asks.

After finding great success, the campaign continued with Jnetics using engagement methods such as a microsite, social media campaigns, online influencers, as well as mainstream print media and radio.

Outcomes

The NHS service received 15,000 signups and expressions of interest from launch alone. Coverage was seen across national and local media leading to increased awareness of BRCA not only within the Jewish community itself, but also in healthcare professionals who going forward may be able to more confidently advise their Jewish patients.

"This is a huge opportunity to gain the knowledge that will help mitigate against the impact of hereditary cancer, and ultimately save lives within the Jewish community." Jnetics.

"We are delighted to be involved in this landmark moment for the NHS and the Jewish community, we want to ensure that this programme reaches as many people as possible. We can now harness developments in genetic screening to increase the chances of preventing the onset of cancer and we hope to see the goal of 30,000 people will be tested over the next 18 months reached." Chai Cancer Care.

Professor Ranjit Manchanda of the Wolfson Institute of Population Health at QMUL and St Bart's, who led the GCaPPS, said "Offering BRCA genetic testing across the entire Jewish population, beyond traditional family-history based approach can double the BRCA carriers identified, preventing many more breast and ovarian cancers than the earlier clinical strategy, saving many more lives. It offers a new paradigm for delivering cancer genetic testing in healthcare and is an exciting step forward in cancer prevention and early detection."

Takeaways and learnings

Long-term partnerships; Longevity of engagement

The NHS Jewish BRCA Testing Programme was a culmination of many years of engagement from healthcare and academia with the Jewish community. The GCaPPS study directly engaged over 1,000 Jewish people, and indirectly thousands more through their network of Jewish charities, organisations and stakeholders.

There is benefit in having multiple, positive points of contact over a sustained period between healthcare bodies and community members to build trust and increase outcomes of initiatives upon launch.

The right charities for the right audience

As the screening programme was planned as a national rollout, it was beneficial for the NHS to partner with more than one embedded Jewish support service in order to expand their reach, and ensure the community had multiple touchpoints to receive support and further information.

The BRCA mutation is not only a genetic concern for marriage prospects or family planning in many communities, but presents an increased cancer risk which can create any health anxieties. Working together with two charities with reputations in each health area gave the campaign greater credibility and ensured the community received effective support via the campaign.

Furthermore, there is great diversity within the Jewish community in cultural and religious norms. Diversifying communication and engagement routes led to a diversified pool of participants and community engaged.

Holistic and tailored support offering

Jnetics and Chai Cancer Care were not only involved in increasing recruitment and awareness within the Jewish community, as part of their offering each charity committed to supporting informed choices, whether personal or for wider family, and to delivered expert support and care at every stage. For example, genetic counselling was made available for those taking the test.

Replicable good practice

01 Ensuring an appropriate timeline for community engagement to allow for the building of trust between NHS and the community.

02 Considering multiple Jewish support services as communications and engagement partners to maximise audiences and ensure the optimal support is there for initiatives.

03 Employment of Jewish services organically via tender to enable greater resourced outreach from within the community.

Preventative care campaign

Organisations involved	Springfield Park Primary Care Network and local Charedi organisations including Interlink, Spring Hill Practice, Stamford Hill Group Practice and Cranwich Road Surgery
Aim of programme	Increase engagement, trust and uptake among local Charedi population of healthcare services Improve preventative care for the Charedi community in North Hackney
Communications and engagement activity	Engagement lead employed by network, healthcare messages distributed through Jewish press, and holistic educational events.
Who can replicate	Integrated Care Systems, Integrated Care Boards, and NHS trusts

Background

Springfield Park Primary Care Network (PCN) is comprised of three GP practices: Spring Hill Practice, Stamford Hill Group Practice and Cranwich Road Surgery. Located in North Hackney, the PCN covers an estimated population of 38,000 people where nearly 40% of residents are part of the Charedi Orthodox community (Khan, 2023).

The Stamford Hill area has the largest population of Charedi individuals in Europe. The Charedi community is also growing by about 3.5-4% annually (Staetsky, 2022). This means that approximately 40% of the PCN's population is under the age of 18 (compared with the UK average of 20%) and 12% of the PCN patients are pregnant at any given time, putting increased pressure on GP services (Khan, 2023).

One of the primary issues raised by the health professionals working in the PCN are barriers to delivering preventative care. Low childhood immunisation rates and cancer screening uptake continue to be a big problem, alongside cardiovascular diseases. Due to low vaccination uptake, outbreaks of vaccine preventable diseases such as pertussis, mumps and measles occur frequently.

Approach and outcomes

The PCN fulfilled their enhanced access contract on Sundays rather than Saturdays as mandated by the national PCN contract. This means that routine immunisation clinics are held on Sundays as the majority of patients observe Sabbath on Saturdays. Walk-ins are also offered as part of these immunisation clinics, which has helped to improve accessibility and uptake overall.

In January 2024, the PCN also introduced home visits for vaccinations during the winter season to increase accessibility. This was in response to families citing barriers such as difficulty getting into clinics due to caregiving responsibilities and working around school timings.

The PCN employs an Engagement Lead to build trust with the Charedi community and its voluntary organisations such as Young and Inspire and Interlink who help facilitate the dissemination of healthcare messages whilst feeding back community insights. As digital messaging has little to no reach with Charedi communities, the PCN's Engagement Lead uses many other channels (Charedi print media, magazines, synagogue communication channels, and word of mouth) to reach community members.

Since the easing of pandemic restrictions, the PCN has also found great success with holistic educational health events where families are encouraged to attend for immunisations with the addition of fun family-based activities, such as bouncy castles, 'Dr bike' mechanic checks, whilst learning about health issues and prevention.

A Springfield Park community health and wellbeing day in February 2023 was attended by over 200 people and offered health checks to over-40s, COVID-19, flu and childhood immunisation clinics, Kosher nutrition advice, and an interactive dental health stall with free Kosher toothbrush and toothpaste packs.

"One of the most successful examples of the PCN working with the community using a co-production approach was our focused two-week MMR campaign in September 2023.Samina asked members of the Charedi community about what would motivate them to get their children immunised before the start of the Jewish holidays.

A discussion with a mother and grandmother led to a headline that appealed across generations: 'Get ahead of the Yomim Tovim – Keep families safe whether travelling or staying local!'. This demonstrates what real engagement with communities and tailored communications can successfully achieve, with an outcome of 200 children being vaccinated, of which 73 children were immunised for MMR over two weekends."

Samina Tarafder, Senior Public Health Practitioner, Hackney Council

Takeaways and learnings

Make local services convenient and accessible – and be sure the community are aware of accommodations

A crucial part of the PCN's success is the way in which it has adapted its service delivery to make it as convenient as possible for the Charedi community. This is evidenced in the way the clinic holds health events in Jewish community centres and its Sunday opening hours. It's also worth bearing in mind the way in which the communications from the clinic about healthcare services mention these accommodations to further emphasise to the community how easy it can be for them.

Co-production

The PCN works closely with Charedi community organisations in the production and delivery of healthcare communication assets (flyers, leaflets, etc). This is vital because the Charedi community organisations are able to ensure the messages are sensitive to the community's cultural and linguistic needs. Members of the Charedi community organisations spoke with us about how other groups and individuals have tried to produce materials to reach the local community without their input and have failed because the language, imagery and medium were not right.

Word of mouth

While the PCN makes the most of the plethora of communication channels available to reach the local Charedi population (newspapers, leaflets, radio, etc), one of the most trusted sources of information for Charedi people remains word of mouth. Information, knowledge and beliefs in this insular community partly circulate by word of mouth between families.

Long-term partnerships; Longevity of engagement

The relationship between the PCN and its Charedi patient population is built on sustained, long-term engagement. Contrary to one-off research projects, the PCN and in particular, its Engagement Lead, have worked hard to develop close ties with community leaders and stakeholders by being transparent and sharing information that provides clear benefits to the patient population. None of this would be possible without the trust which has been built through communication strategies that understand the communities' historic mistrust, and adapts to their needs, rather than treating them as problems.

Replicable good practice

01 Co-design of healthcare communications material with Charedi voluntary organisations such as Interlink, and rabbis.

02 PCN Enhanced Access provision on Sundays.

03 Holistic educational events hosted in collaboration with public health bodies and Charedi voluntary organisations.

04 NHS funded Engagement Lead post.

Co-delivery of COVID-19 immunisation programmes

Organisations involved	Hatzola, local health services and UKHSA
Aim of programme	Increase uptake of COVID-19 vaccine among Jewish communities, particularly those who are strictly Orthodox
Communications and engagement activity	Free helpline, public health adverts in local media, community liaison representatives
Who can replicate	UKHSA, local councils, Integrated Care Systems, and Integrated Care Boards

Background

The strictly Orthodox Jewish community was hit hard by the COVID-19 pandemic. A study by the London School of Hygiene & Tropical Medicine found that 64% of this demographic had been infected by COVID-19 in 2020 – an infection rate that was nine times higher than the UK average of 7% (Gaskell et al., 2021).

The disproportionate prevalence and impact of COVID-19 on the strictly Orthodox community (along with other ethnic and religious minorities) was further compounded by the fact that this group was less likely to accept vaccination. The insular and isolated lifestyle of this demographic of the Jewish community meant they had limited access to credible medical information. Not to mention that many individuals in this community don't use or have access to the internet, social media, and/or smartphones.

The urgent question facing public health authorities was how to deliver COVID-19 vaccines to the Charedi population around the country.

Approach and outcomes

The answer came in the form of localised vaccination services built in partnership with Jewish charities (Kasstan et al., 2022). The NHS, local government and the Jewish voluntary sector joined together using pre-existing relationships to support the vaccine roll-out.

In particular, Hatzola, a volunteer emergency medical service by and for Charedi neighbourhoods, played a vital role in this activity. Hatzola stepped up to provide relevant, trusted information, a free helpline, public health adverts in local media and helped facilitate vaccination events in NHS facilities, alongside offering at home visits.

The Mayor of London paid a visit to one of the vaccination events and called the event a "game-changer" (Frazer, 2021). Hatzola volunteers played a crucial role not just at the vaccination sites, but also in building trust with the community to bridge the gap with public health services.

As Aron Merlin, who helped organise vaccination centres in Manchester, said: "It shows the way to get through to the community is through people like us. As soon as we were involved, people were happy to [be vaccinated]. We just speak their language" (Tinman, 2021). By July 2021, Hatzola had supported delivery of over 5,000 vaccines to the Charedi population (Hatzola, 2021).

The success of this localised, co-delivered immunisation programme aimed at the Charedi population is significant for many reasons. Primarily in preventing COVID-19 and saving lives, and the positive impact of co-produced public health messages and delivery of activity for so-called 'hard to reach' and/or 'non-compliant' minorities.

Charedi people are often stereotyped as anti-vaccine both within the media and among some healthcare professionals. Yet the reality (as shown by this successful programme of work) is much more nuanced and to make assumptions about certain minorities as 'hard-to-reach' often obscures the more complicated structural barriers to vaccination these communities experience.

> *"Covid-19 vaccine clinics were delivered in collaboration with Hatzola in London and North Manchester. Co-production can help to ensure that communications are relevant to Jewish audiences and strike an appropriate balance between sensitivity and urgency to vaccinate.*
>
> *Co-delivery can help to address issues of confidence and convenience around vaccinations, with responsibilities shared between public health and community groups. These approaches are not cost-neutral and require flexible funding and commissioning arrangements. The ability to sustain collaborations is important to continue engaging with families around vaccination."*
>
> Dr. Benjamin Kasstan-Dabush, assistant professor of Global Health & Development, London School of Hygiene & Tropical Medicine

Takeaways and learnings

Listen and engage – don't rely on stereotypes

While Charedi people are often viewed by outsiders as a monolithic group with the same attitudes and beliefs towards vaccination, the co-production and co-delivery of the coronavirus vaccination service cut through stereotypical assumptions that all Charedi people are anti-vaccine.

Instead, what became clear through evidence and research was that "decision making processes among strictly Orthodox communities are becoming more diverse, complex and individual, highlighting heterogeneity and change within the community" (Jacobson et al., 2023).

What's evident is that by prioritising community engagement undertaken by trusted community members to share health information with professionals, the vaccination drive was able to generate trust and buy-in that ultimately got people to act.

Too often medical professionals and healthcare systems can treat 'people as problems' or assume particular demographics will be 'non-compliant' with public health measures. These unhelpful labels obscure the ways in which there can be much more complex factors at play preventing groups from accessing healthcare treatments that require culturally competent, co-produced communications with members from the affected group.

Accessibility, efficiency and responsiveness of healthcare communications and services for minorities

Following on from the above, Avraham Jacobson's 2023 research identified five barriers to vaccination (some of which contribute to the community's vaccine hesitancy) for strictly Orthodox Jewish communities:

1. Access to vaccination (e.g., logistical difficulties related to large households and system-level barriers like appointment booking)
2. Acceptance of vaccination (e.g., concerns about safety and 'side effects')
3. Awareness of need for vaccination (e.g., knowledge barriers)
4. Affordability
5. Activation and nudging

The Hatzola-supported vaccination drive's success was predicated on its ability to address a number of these barriers. In particular, the vaccination drive made access to vaccines easier, provided opportunities for individuals with questions and concerns to speak with professionals and ultimately, and raised awareness of the need for the vaccine to keep families safe.

It's important to note that vaccine hesitancy is a real problem in this community, especially given they are now the subjects of targeted messages from anti-vax groups. However, this activity should be taken as evidence that with the right mix of communications, community engagement and information those attitudes can be shifted.

Finally, there are important questions to consider about sustainable funding for, and investment in, tailored interventions like these to ensure the situation doesn't revert to what it was before the pandemic.

These types of interventions cannot be seen as one-off projects, but need to be taken seriously as long-term public health campaigns addressing the needs of underserved communities. There have already been similar vaccination campaigns done by other Jewish groups, including

- The London Jewish Health Partnership's polio booster campaign in 2022
- Hatzola's 2023 measle vaccination drive (Kasstan et al., 2023; Klawansky, 2023).

Influence of rabbinic authority

Religious authorities, such as rabbis, are often seen as a key stakeholder and influencer in public health policy and delivery. Rabbis (and by extension synagogues) are regularly used to deliver health messages and raise awareness of public health campaigns. Endorsement from rabbis featured across much of the public health messaging and media stories around the Hatzola vaccination centres (See appendix).

This was seen as particularly relevant and necessary as one of the reasons often attributed to lower levels of uptake among strictly Orthodox Jewish communities are 'cultural' and 'religious' anti-vaccine ideas (Henderson et al., 2008).

However, in-depth research from Dr. Kasstan (2021) revealed that parents who do not accept vaccination "did not typically view male rabbinic authority or consultation as relevant to their decision-making." Instead, "refusal of vaccines was rooted in a tendency to over-determine and universalize safety concerns, and these concerns became legitimized by drawing on Jewish laws and teachings about risk and danger."

Replicable good practice

01 Use of Jewish voluntary services and Jewish media publications.

02 Vaccine advocacy, outreach and co-delivery by trusted community members and organisations.

03 Co-production of communication materials with Jewish community members and organisations.

04 Running vaccination centres in Jewish community hubs (e.g. synagogues).

7.0 RECOMMENDATIONS AND ACTIONS

For the Jewish community it is systemic change, as well as the tailoring of communications and engagement, that will provide a necessary framework to reduce the health inequalities experienced by those in England.

The recommendations in this report aim to deliver changes to the way the Jewish community is engaged; or to deliver systemic changes in the NHS to ensure Jewish patients are recognised, understood, and more engaged with NHS services.

In the next section, there is further detail on who is responsible for implementing these recommendations, and guidance on outputs created as part of the research which may help.

Communications backed by systemic and policy changes

Throughout our community engagement and understanding of the steps needed to break down barriers to engagement with the NHS, we have identified vital structural, leadership-led changes which can systemically support better communications and improve experiences for the Jewish community.

The national and regional policy recommendations as part of this report provide a top-down framework to support the recognition, understanding and overall accommodations for Jewish patients, leading to more effective communications from system to community, down to doctor to patient.

Our recommendations have been thoroughly reviewed and edited according to feedback from our Jewish advisors, Jewish support services and the NHS RHO to ensure these are representative of community insights, achievable and best placed to improve the NHS' relationship with the Jewish community.

Dr. Fiona Sim OBE is a public health consultant and former NHS GP. She has a visiting chair at the University of Bedfordshire. She was a member, representing the Jewish Medical Association, of the NHS RHO's Project Steering Group

She tells us:

"The report explains some of the poorly met health and healthcare needs within the Jewish community as well as the needs of those working in health and social care for heightened cultural awareness and understanding.

That Jews value health very highly is incontrovertible and the central importance of existing services within the Jewish community and voluntary sector in provision of much-needed services is acknowledged, as is the necessity for statutory services to work collaboratively with these vital community assets for the benefit of the whole population. The examples of good practice described in the report exemplify this essence of partnership working and mutual respect between NHS organisations, Jewish service providers, and their users. There is surely scope for much more of this type of collaboration and co-creation with all minoritised groups.

Full implementation of the report's recommendations would help to transform the experience of Jewish patients, including improving outcomes of care where access and engagement have been historically less than optimal. Raising cultural awareness and stopping the use of negative stereotypes throughout healthcare are perhaps obvious goals and apply to many groups in society besides Jews: there is an urgent imperative to achieve these goals for the benefit of all who use and deliver health services."

Who are these recommendations for?

Department of Health and Social Care
In the setting of priorities, ringfencing funding for NHS bodies and setting frameworks for action.

NHS England
In the standards, frameworks and oversight given to NHS providers to maintain and improve standards of care for all service users.

Bodies and organisations with influence
For example, the Care Quality Commission, Medical Schools Council, Health professional regulators such as the General Medical Council, and others.

ICS/ICBs and Service Providers
In the proactive uptake of recommendations, training and best practice to directly improve localised user experience across the community.

Independent Review Panels
In assessing the success of existing initiatives and providing clarity on the direction of inconsistent NHS policies.

NHS Communications, Marketing and Stakeholder Engagement Teams
In the dissemination and delivery of content for NHS staff, teams and patient communities.

The NHS Jewish Staff Network

The NHS Jewish Staff network is a great resource for support and knowledge, we encourage all members to actively share resources and encourage peers to seek out appropriate training.

7.1 TO COMBAT HARMFUL STEREOTYPES AND BUILD TRUST BETWEEN COMMUNITY AND HEALTH SERVICE

01 Services should educate their workforce about local Jewish communities to remove barriers, combat prejudice, improve understanding of how cultural nuances affect health engagement, and to enable the appropriate adaption of services and outreach.

The knowledge and awareness of who Jewish people are, how this identity interacts with behaviour around health, and how to best engage with the Jewish community is severely lacking across services interacting with the community, even in local areas of high demand.

There are many nuances within the Jewish community, all of which can impact necessary accommodations for healthcare professionals and systems alike. This in turn has significant implications for the way in which any healthcare communications need to be aligned to both the section of the community being targeted and the health issue at hand.

Implementation

- In its annual allocation of budget and consideration of funding towards public health & vaccinations, the Department of Health and Social Care (DHSC) should implement a framework to build marginalised community insight into public health initiatives and include the Jewish community in this.
- The development and rollout of an NHS workforce campaign to educate staff about Jewish identity, dispel harmful stereotypes and to educate about service design, should be delivered by NHS Communications teams across Trusts, with funding from ICBs and NHS England. It is recommended that this campaign includes regular opportunities to measure success against clear objectives to evaluate success. Any campaign should always be cocreated with the Jewish community before rollout.
    - Campaign content should be integrated into induction training for new staff members, and as part of revalidation processes.
    - This should begin in NHS Trusts and services serving Jewish communities in the ICBs of (North London and surrounding counties (North West/Central/East London, Hertfordshire and West Essex, Mid and South Essex), Greater Manchester (Greater Manchester), Leeds (West Yorkshire) and Gateshead (North East and North Cumbria). This should include information about barriers to attending a variety to NHS appointments and services, end of life care needs and religious and cultural practices that impact behaviours during healthcare appointments.

Implementation cont.

- An evaluation of cultural competence training and internal campaigns at regular intervals by ICBs to ensure effectiveness against misinformation, ignorance and prejudice which can lead to disengagement, further compounding health inequalities. (See also Recommendation 6.)
- An online resource or hub should be made available to all staff members so that easily accessible materials and resources are in place. These should be accessible during the delivery of care, for example, following a patient being triaged into specialist care.

Initial resources created to support:

- *Jewish Identity, Culture and Care* – An at-a-glance guide, co-developed with the community, to support services to understand some of the nuances of the community which might affect engagement with care.
- *How to Create Health Communications for the Jewish Community Toolkit* – A material to support NHS Communications teams to develop resources, campaigns and materials that build trust and break down barriers.

02

Improve the consistent use of the principles of trauma-informed care when engaging marginalised communities, to directly address the barriers in accessing care.

Trauma-informed approaches have become increasingly cited in policy and adopted in practice as a means for reducing the negative impact of trauma experiences and supporting mental and physical health outcomes. They build on evidence developed over several decades. Government guidance released in 2022 sought to provide clarity on delivering trauma-informed care in practice.

The purpose of trauma-informed practice is not to treat trauma-related difficulties, which is the role of trauma-specialist services and practitioners. Instead, it seeks to address the barriers that people affected by trauma can experience when accessing health and care services.

There are 6 principles of trauma-informed practice: safety, trust, choice, collaboration, empowerment and cultural consideration.

Implementation

- Following the launch of various frameworks across government and NHS bodies, the Department of Health and Social Care should assess the impact of all NHS England guidance on trauma-informed care and its use with marginalised communities across England, including listening to the experiences of staff members as well as those communities. To embed this practice, clear recommendations should be further provided by NHS England which clarifies how to hold various stakeholders within the health system responsible for deploying trauma-informed care.

- ICBs should consider the funding and resources set aside for services to embed this model into everyday practice and care, given that NHS workforce are time-poor. It might be helpful to consider all the training that is designed to support care for marginalised communities and streamline this offer for staff members.

- Senior Leadership within Trusts and across NHS services should ensure that staff have adequate paid time and opportunity to undertake proposed and effective training which is essential to removing barriers to access for marginalised groups.

03

Review and remove assessment questions that actively reinforce negative stereotypes about marginalised communities, specifically including Judaism and the Jewish community, within Medical School student examinations.

Referenced repeatedly by Jewish NHS workforce during the research, the use of questions about Jewish people (and perhaps other marginalised communities) may need reviewing to ensure these do not play into harmful stereotypes which may affect the care delivered by the clinician once in practice.

Implementation

- The Medical Schools Council should review examinations and assessments used across Universities, Medical Schools and throughout British healthcare professional education. A review of the use of Single Best Answers/Multiple Choice Questions as part of all education and training using demographics or ethnicities as leading questions, should be undertaken.
    - Questions should be re-written to ensure they are culturally competent and do not reinforce negative stereotypes. This should be approached in tandem with a diverse representation of the Jewish community and rolled out on a national level.

- The Medical Schools Council should then provide guidance about cultural competency in examinations and assessments and the General Medical Council should ensure that all assessments meet their standards for cultural and religious competency.

7.2 TO IMPROVE ENGAGEMENT WITH SERVICES AND IMPROVE OUTCOMES

04

Improving Jewish engagement with services requires a thoughtful adaptation of communications and outreach which respects cultural norms and is cognisant of the reasons for historical mistrust.

For many services looking to engage, it can be tempting to talk about some parts of the Jewish community as being 'hard to reach'. This rudimental assessment ignores the barriers and challenges that are a byproduct of the service or engagement design, and the assumptions about how a community engages and behaves.

Tailoring communications is critical to improve engagement, and thereby reduce health disparities. For example, for observant and strictly Orthodox communities, imagery and visuals should respect the practices and views of the community. Generally, strictly Orthodox communities do not want to see themselves reflected in any communications that can be seen or picked up by wider society.

In more religiously conservative Jewish community, images should be modest and not feature open wounds, or images one may consider too graphic, for example by using non-anatomical imagery (on external materials). This guidance and more forms part of the toolkit, referenced below.

Implementation

- NHS Communications, Marketing and Stakeholder Engagement teams should ensure they are knowledgeable and confident about how to positively engage the Jewish community. This includes tailoring language, tone, imagery, authorship from Jewish healthcare professionals or organisations.
- Different channels for engagement must be considered. It is not enough, for example, to translate an SMS text from a GP surgery into Yiddish. Particularly for the Charedi and strictly Orthodox communities, engagement outside of digital channels, through word-of-mouth and localised campaigns is necessary and should be seen as a critical channel for success.

Initial resources created to support:

- *How to Create Health Communications for the Jewish Community Toolkit* – A material to support NHS Communications teams to develop resources, campaigns and materials that build trust and break down barriers.
- *Co-production Guide - Principles and Guidance for working with the Jewish Community* – A short guide combining best practice learnings and insights to be used by all NHS Communications or Stakeholder Engagement teams when designing service delivery, outreach campaigns or public health messaging. This also includes a framework for tiered engagement depending on the service and issue addressed.

05

Supporting community-led initiatives can dramatically reduce health inequalities by removing barriers to access, and so this approach needs embedding quickly across all services responsible for engaging marginalised communities, ensuring the Jewish community is recognised and included.

Designing community-led initiatives goes further than listening to insights – it is fundamentally about believing that communities hold the power to change their outcomes and futures if given the opportunity, resources and expertise.

The positive value of co-production has been long established in healthcare (Batalden et al., 2016). The 2019 NHS Long Term Plan put the action-driven reduction of health inequality at the centre of NHS work, further sponsored by the 2021/22 Health and Care Bill promoting integration and partnerships to improve care and tackle these inequalities.

The direction of travel is positive. In 2022, working in partnership with people and communities became part of new statutory guidance across care and policy for NHS England (NHS England, 2022) with aims to support healthcare bodies to build collaborative partnerships within the community.

But Jewish communities are not being engaged positively and consistently across England, and the idea of cocreation is still not embedded when considering public health initiatives or designing communications to reach marginalised communities.

This is despite Jewish community-led support services themselves actively delivering an excellent quality of care, and being deeply embedded, well-respected and a popular source of healthcare messages and services for the community.

Implementation

- The Care Quality Commission (CQC) should ensure that current protocols and frameworks are effective in capturing the quality of engagement and outreach between service providers and marginalised communities – specifically including the Jewish community – across public health and screening programmes.
    - In addition, the CQC should consider whether it is effective in holding these service providers to account on these measures, as recommended in the 2023 Hewitt Review of ICSs (an independent review).

Implementation cont.

- NHS Stakeholder Engagement teams (at NHS England, ICB and service level) should ensure that they are fully and completely aware of Jewish-led health support services operating in their area.
    - This should begin in NHS Trusts and services serving Jewish communities in the ICBs of (North London and surrounding counties (North West/Central/East London, Hertfordshire and West Essex, Mid and South Essex), Greater Manchester (Greater Manchester), Leeds (West Yorkshire) and Gateshead (North East and North Cumbria).
    - This should include an understanding of the crucial role community-led support services play in delivering healthcare across their community. NHS Stakeholder engagement teams should proactively build trust with these organisations to best consider how existing health inequalities can be addressed through grassroots community-led initiatives, i.e. BRCA screening.
- ICBs must ensure that the relevant guidance is embedded in everyday care and practice, with learnings and best practice from areas of positive community partnerships disseminated including from projects with different marginalised communities where learnings can be appropriately applied.
    - For example, this might include the setting up of a working group, including NHS services and communities, to understand how best to serve local areas.

Initial resources created to support:

- *Co-production Guide - Principles and Guidance for working with the Jewish Community – A short guide combining best practice learnings and insights from this research to be used by all NHS Communications or Stakeholder Engagement teams when designing service delivery, outreach campaigns or public health messaging. This resource also includes a framework for tiered engagement depending on the service and issue being addressed.*

06

Mandate the inclusion of 'Jewish' as an option for ethnicity and 'Judaism' as an option for religion in all NHS patient data records to empower patients, give NHS systems a better understanding of the community they are serving and collect essential data for tracking health outcomes.

A recurrent theme and discussion across this research, it is critical that the community is able to self-identify as part of their healthcare engagement with services. A group of people who often feel under-recognised, this change will empower those communities.

Previous examples of good practice have highlighted that self-reporting is the most effective way of asking about an individual's ethnic identity, particularly due to potential issues of stereotyping if determining ethnicity by observation. This guidance is already given across NHS England.

Offering the option to self-identify also provides opportunity for ICBs and Providers to better understand the make-up of the community they serve, and know how best to invest, divert or create resources to reduce the impact of health inequalities.

Currently, NHS England collects ethnic category using the values set by the Office for National Statistics as per the 2001 census. The values are documented in the NHS Data Model and Dictionary.

Implementation

- The ethnic category values should be updated to include 'Jewish' within the NHS Data Model and Dictionary. This should be part of a wider update by the Office for National Statistics to the data they use, reflecting the large use of the 'Other' free-text box results from the 2011 and 2021 survey, particularly by the Jewish community.
- To avoid delays while the central NHS Data Model and Dictionary is updated, it is recommended that NHS Trusts and service providers serving regions with a sizeable Jewish population adapt and immediately update their ethnicity and religious self-identifying data capture systems. This has already been implemented in some Trusts, but not consistently.
    - This should begin in NHS Trusts and services serving Jewish communities in the ICBs of (North London and surrounding counties (North West/Central/East London, Hertfordshire and West Essex, Mid and South Essex), Greater Manchester (Greater Manchester), Leeds (West Yorkshire) and Gateshead (North East and North Cumbria).
    - This should include information about barriers to attending a variety to NHS appointments and services, end of life care needs and religious and cultural practices that impact behaviours during healthcare appointments.

7.3 TO IMPROVE THE EXPERIENCE OF JEWISH NHS STAFF MEMBERS

07

'Jewish' and 'Judaism' must be included across all NHS internal and external initiatives designed to recognise and support marginalised communities.

Implementation

- NHS England should ensure that the Jewish community is recognised as a marginalised community and therefore any ongoing cultural competence training and campaigns rolled out to appropriate staff members are cognisant of the Jewish community as one of those groups.
- Each ICB should oversee the implementation of these changes. For example, updates to local and internal policies, to any new training materials being commissioned or outsourced, to any changes to external materials regarding anti-racism and EDI, for example.

08

Combat antisemitism experienced by Jewish staff members by implementing clear frameworks, guidance and action plans.

This research and engagement with NHS Jewish staff members demonstrated that they don't feel recognised as an ethnic minority, or a marginalised community, and therefore are excluded from current EDI narratives. There was also a sense that leadership could be doing more to tackle cases of antisemitism internally within the NHS.

In the aftermath of the escalation in hostilities and conflict between Israel and Palestine, there was an increase in antisemitism as reported by NHS participants engaged in this research. It is felt there is a lack of transparent policies for supporting staff and patients, and this has resulted in a changed experience for Jewish patients over a time of heightened tension. This is coupled with a lack of consistency or evolution of NHS provision to support the Jewish population during this period.

Implementation

- NHS England should deliver an evaluation of existing policies (which are inconsistently developed, applied, and policed) to measure the potential benefit of more rigorous and transparent complaint systems for antisemitism in the workplace, as well as recognising and accommodating the celebration of Jewish high holy days.

- To build on the recommendations delivered in the independent review of ICSs by Rt Hon Patricia Hewitt (Hewitt Review, 2023), a focused independent review of the impact and delivery of policies guiding the wearing of political symbols at work should be immediately conducted. This should also evaluate current internal communications and staff support practices in response to global and local political or social events, ensuring that frameworks and action plans are clear and designed to protect all staff while at work.

7.4 FOR FUTURE RESEARCH

Our research uncovered a wealth of opportunity to improve communications and care for the Jewish community. For several reasons, we could not provide a detailed set of recommendations against individual disparities (i.e. cancer survival rates) or inequalities (i.e. increased risk of certain genetic diseases.

The best practice and recommendations in this report provide rich detail on how to design and engage on initiatives which might directly tackle these issues.

But given the lack of understanding within the healthcare landscape of the Jewish identity and what this means for behaviour and engagement, targeted research would be required into the relationship between this and health outcome in question.

Implementation

- We would recommend that NHS England implements an evaluation and measurement framework to track progress against the reduction of health inequalities in this community, with data drawn from implementing 'Jewish' and 'Judaism' as self-identifying options for patients.
    - Data can be used to track health outcomes against the determined inequalities from the Salford report, which provided clarity on the key areas where inequalities or disparities are experienced.

8.0 WHAT'S NEXT

8.0 WHAT'S NEXT

An urgent need for action, not words

There has never been more interest or attention given to the way in which the health outcomes of ethnic minorities are shaped by structural, institutional, and interpersonal racism, prejudice and discrimination. An important dimension of this necessary conversation is to ensure the health inequities experienced by Jewish people are not overlooked and to highlight the role culturally competent, community-targeted healthcare communications can play in improving health outcomes.

The findings of this report echo what many in the community already know. Antisemitism is a real, present and growing problem in society. There is a multifaceted nature of Jewish identities and a growing movement calling for standardised recognition of Jewish people as an ethnic minority both in the workplace and as patients.

Knowledge among healthcare professionals who don't work in densely populated Jewish areas is still low, and stereotypes learnt in medical school continue to pervade into clinical settings. Social groups within the Jewish community each have distinct healthcare needs that require a robust understanding and recognition in the way they are communicated with.

Community-led charities and support services continue to play a vital role in supporting Jewish people. The current realities of the NHS places greater pressure on these services to plug gaps, but also opens the door for innovative opportunities for co-creation, co-delivery and collaboration.

Collaboration and coproduction are critical

This report draws attention to the multiple and intersecting ways in which there are opportunities for healthcare services and providers to better understand, engage and reach Jewish communities. The evidence in this report shows that real progress is possible - and already happening – when healthcare services work in harmony with Jewish communities. Change is possible and there are already so many models of good practice and community-led campaigns that are leading the way.

To improve perceptions from the community, the NHS needs to ensure their workforce is equipped with an understanding of the Jewish community and the accommodations such as diet, modestly and cultural calendars, as well as how best to communicate on a one-to-one level.

8.0 WHAT'S NEXT

There also needs to be a greater push for community targeted campaigns, ideally through co-production and delivery with existing support services, to share important health messaging and impact health inequities.

We recommend the NHS continues to strengthen its partnerships with Jewish support services, implementing co-production and delivery where possible to maximise trust and the audience of any health communications or initiatives, as well ensure cultural competency through community voices.

Inclusion and representation remain a barrier

Lack of religious and ethnic inclusion for the Jewish community is seen across other national and statutory bodies. For example, the UK Census, a survey which provides Jewish as an option for religion but not ethnicity, rather ethnicity data is collected only by those ticking 'Other' and adding Jewish.

Much like the lack of options seen in some NHS patient records, this similarly had a negative perception within the Jewish community, with the Board of Deputies of British Jews calling for a change stating: "We are concerned that until this situation is rectified, many Jewish citizens will not feel fully counted."

We recommend policy changes to ensure NHS patients who identify their ethnicity as Jewish, and / or their religion as Judaism, have the option to answer as such without using an 'Other' box.

Furthermore, information about the Jewish identity should be accessible to all NHS staff. This will allow those who seek resources to improve their knowledge to be able to understand how best to communicate with, and accommodate for, their patients.

Great communication is important – more needs to be done to address systemic barriers

Our recommendations centre around improving communications at an NHS system to Jewish community level; as well from healthcare professional to Jewish patient level. In order to promote this, the NHS system and its staff need a greater recognition and understanding of Jewish identity and culture, and the intersections of these with healthcare and communications for community members, as well as a focus on employing the trust and audience of existing Jewish support services.

8.0 WHAT'S NEXT

Our educational assets provide communications best practice to aid in the upskilling of NHS staff, and will support as commissioners within the NHS decide how and to which level they can ensure co-production and delivery of healthcare initiatives and campaigns for best engagement.

Our hope is that this research builds on an existing wealth of evidence to support the NHS to better understand an underserved community and the reasons for health inequities. And as a result, produce more effective, community-tailored communications which positively engage Jewish communities, and lead to better outcomes in healthcare.

However, it is important to the research team, the Intent Health team and advisors, and the NHS RHO and Steering Committee, to strongly acknowledge that the limited scope of this research does not exist in a vacuum.

For the Jewish community, systemic changes in NHS national and regional policies, alongside provision for training to improve staff awareness and cultural competency, are critical to support better care and communications. The success of this collaborative research project will only be realised with wider policy and system changes.

This is your call to action. Everyone's actions matter and small changes have a big impact.

9.0 REFERENCES

9.0 REFERENCES

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This report seeks to build an evidence-led review of best practice and community-led action driving effective NHS communications with the Jewish community which will fuel recommendations, initiatives and change across all parts of the healthcare system and patient engagement.

We present findings and recommendations that are national in scope and bring together the diverse experiences of NHS care and communications for Jewish communities across England. These have been derived from a variety of research approaches, including systematic reviews, content analysis, semi-structured interviews and focus groups, to gather insights, feedback and experiences from Jewish people and healthcare professionals.

This is your call to action. Everyone's actions matter and small changes have a big impact.

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