

# Black and Minority Ethnic (BME) Groups

## Health Needs Assessment



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# 1. Executive Summary and Recommendations

## Demographics

Gateshead has a comparatively small BME and White Other population compared with many areas of the country, although this is gradually increasing in size. It has risen from 1.6% (2001 census) to 3.7% (2011 census), compared with the England average of 14.6%, and schools data suggests this rise is continuing.

The ethnic minority population is on average younger than the White British population, and has a much lower proportion of older people.

The largest concentration of the BME and 'White Other' groups locally is within Gateshead town centre and surrounding areas such as Teams, Bensham and Saltwell. These areas are more deprived than the Gateshead average. Local data from the CAB suggests that for clients from BME communities, the most used advice categories are debt, benefits and tax credits.

Recording of ethnicity in primary care is low, with only 54% of patients having had their ethnicity recorded (at practice level this ranges from 11% to 87%); by comparison in secondary care recording is high (typically around the high 80% to mid-90% mark, depending on the admission type): this HNA is therefore limited in its value by the quality of the data on which it is based, particularly with regard to primary care.

### Recommendation

The CCG should ensure practices record the ethnicity of all registered patients, in line with the Equality Act (2010)

## Lifestyle factors and Long Term Conditions

Nationally, the prevalence of long term conditions such as type 2 diabetes, coronary heart disease and stroke is up to 6 times higher (and they occur from a younger age) among black, Asian and other minority ethnic groups. The evidence confirms that Asian, black African and African-Caribbean and other minority ethnic groups are at an equivalent risk of diabetes, other health conditions or mortality at a lower BMI measurement than the white European population. NICE and other sources highlight the importance of awareness raising for BMI measurement thresholds that can be used for recognising risk and as a trigger for intervention. In addition, these groups progress from being at-risk to being diagnosed with these conditions at twice the rate of white populations. So tackling this issue will help tackle health inequalities and satisfy public sector obligations under the Equality Act 2010.

However, the local data do not reflect this expected prevalence: practice disease registers (see Appendix 3) show a prevalence of every reported condition that is at least 3 times higher in the White British population than amongst BME communities. Furthermore, the practice level data on risk factors such as smoking and BMI show lower levels of prevalence amongst BME groups than in the White British population locally. All this may reflect the relatively young age of the local BME population, but there may be other reasons: limited recording of ethnicity by many practices, lack of recognition by professionals of increased risk amongst BME communities, or possibly limited knowledge of or engagement with services or poor health literacy amongst those communities (as shown by the low uptake of health checks and smoking cessation services). The focus group participants had mixed knowledge of diabetes, health checks and e.g. high cholesterol. Some knew what diabetes was as it was common in their country of origin, others did not understand the condition.

The relatively low reported level of uptake of cancer screening amongst local BME communities should be highlighted: cancer is emerging as an important issue nationally for South Asians, so it is important that they have access to information about cancer, including methods of prevention through lifestyle, diet and how to spot symptoms early.

## Recommendations

The CCG should:

- Ensure practitioners are aware that members of black, Asian and other minority ethnic groups are at an increased risk of chronic health conditions compared to the white population;
- Ensure members of black, Asian and other minority ethnic groups are aware that they face an increased risk of chronic health conditions;
- Recognise the long-term strategic implications for prevention, early detection and treatment long term conditions for the BME group, as the local population will age and grow;
- Take steps to encourage practices to record BMI and smoking status of all patients along with their ethnicity;
- Assess whether local health services are making reasonable adjustments to ensure services are accessible and appropriate for local BME communities. This includes working directly with those communities, as well as the provision of education and support for self-management;
- The CCG should work with the NHS England and PHE Screening and Immunisations team to better understand the uptake of breast and cervical cancer screening amongst women from BME (including White Other) communities, and to identify how rates might be increased;
- Review its Management of IGR Guidelines to ensure they fully reflect NICE guidance PH46 in respect of BMI in black, Asian and other minority ethnic groups;
- Use existing local black and other minority ethnic information networks to disseminate information on the increased risks these groups face at a lower BMI;
- Seek to develop trust and relationships between organisations, communities and people.

The Director of Public Health should consider whether there are particular steps that could be taken to encourage use of smoking cessation services by local BME and White Other communities.

## Mental health

Good mental health and wellbeing is fundamental to ensuring that individuals can lead fulfilling lives, contribute to society and achieve their potential. Good mental health is also interlinked with good physical health, with individuals with poor mental health reporting higher rates of long-term physical health problems.

Higher rates of some serious mental illness such as schizophrenia have been consistently reported for some black groups, and there is a higher rate of detention under the Mental Health Act for people from BME groups. Some BME communities may be less able to identify poor mental health, which, along with cultural pressures, can contribute to a lack of access to healthcare. There may also be negative perceptions of mental health services and doubts about the cultural competency of services. All of these factors can result in a delay in seeking help with the consequence that some BME communities only access services at crisis point.

Data from the CCG notes that in Gateshead recorded all-age prevalence for serious mental illness of 0.6% amongst BME communities and 1.1% amongst the White British population in Gateshead; for depression prevalence is 10.1% amongst BME (including White Other) communities and 18.9% amongst the White British population; and all-age prevalence of anxiety disorder is 8.7% amongst BME (including White Other) communities and 14.3% amongst the White British population.

Data from the Improving Access to Psychological Therapies (IAPT) service shows that recovery rates for the BME population (41.3%) are lower in NewcastleGateshead CCG area than for the White British population (48.6%).

## Recommendation

- The Mental Health Partnership Board should review whether the mental health needs of people from BME communities are being identified and recorded in General Practice, and whether services are responding effectively to the needs of local BME communities

## Experience of Services

Nationally people from Pakistani, Bangladeshi, Chinese and White non-UK ethnic backgrounds are less likely to say that doctors and nurses treated them with care and concern and were less likely to have confidence and trust in nurses. People from all these groups were significantly less likely to report a good overall experience of using a GP surgery compared with White British people

The focus groups suggested low levels of knowledge of services other than their GP and hospitals/A&E amongst BME communities – for example GP out of hours, walk-in centres, health checks, mental health services. There were concerns about language and interpreting: although people can speak English they may not be able to read it. This factor shows itself through unfamiliarity and limited knowledge of health and social services.

Locally, the overall standardised rates of use of hospital services – first outpatient attendances, elective in-patient admissions, non-elective in-patient admissions, and accident & emergency attendances – by BME (including White Other) communities across all ages are lower than for the White British population. However, there are some significant variations.

Only small numbers of social care clients are from BME communities, but this appears to be in line with their overall numbers in the population by age.

## Recommendations

Partners in the Health and Wellbeing Board should:

- Ensure that their respective organisations and organisations who they commission with are actively aware of their requirement to collect and analyse data across workforce and delivery areas in their performance measurements and monitoring;
- Make use of equality impact assessments to understand the implications of service and policy developments for local BME communities;
- Ensure that services that they commission or provide include a focus on people from minority ethnicities, and particularly within the 25-39 age groups. Outreach services are important to encourage engagement with local services and provide information;
- Assess whether local health services are making reasonable adjustments to ensure services are accessible and appropriate for local BME communities. This includes working directly with those communities, as well as the provision of education and support for self-management;
- Consider how to raise awareness of local services for individuals within BME communities by better publicising what support is already available and how to best access it. Research recommends family based educational interventions as a means of building on existing beliefs, attitudes and behaviours, with a community-based, word-of-mouth approach;
- Consult families from BME communities about their specific needs when commissioning services;
- Consult families from BME communities about information in appropriate languages and ways of promoting to BME communities;
- Consider how best to work with local BME communities and community organisations to address health lifestyle issues;
- Review whether NCMP data and QOF data in General Practice is consistently recorded and whether services are taking account of this.
- Ensure providers' information on services is readily available in appropriate languages and is promoted to BME communities;
- Commission services that are accessible for local BME communities, including in appropriate locations and at appropriate times;
- Commission peer support forums for parents and carers from local BME communities and, where appropriate, tailored support services;
- Provide advocacy, translation and interpretation services for families from BME communities who require support during health and social care pathways;
- Ensure that the BME communities chapter of the Health and Wellbeing Board's Joint Strategic Needs Assessment is 'linked to all other chapters';
- Promote accessible services to teach English as second language.

## 2. Purpose of Health Needs Assessment

'A community of interest is a group of people who may come from any gender, background or geographical area who have something in common. Their link can be an interest or a health issue and they may share some of the same concerns' (Gateshead, 2016). People from BME groups have been identified as a community of interest in Gateshead's Joint Strategic Needs Assessment. This document provides an overview of BME communities in Gateshead. This health needs assessment BME aims to provide quality evidence to inform Gateshead's Health and Wellbeing Board of the needs of this population group.

Health needs assessment (HNA) is a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities.

### Why undertake HNA?

- HNA is a recommended public health tool to provide evidence about a population on which to plan services and address health inequalities
- HNA provides an opportunity to engage with specific populations and enable them to contribute to targeted service planning and resource allocation
- HNA provides an opportunity for cross-sectoral partnership working and developing creative and effective interventions

### Benefits:

- Strengthened community involvement in decision making
- Improved team and partnership working
- Professional development of skills and experience
- Improved communication with other agencies and the public
- Better use of resources

### Challenges:

- Working across professional boundaries that prevent power-or information-sharing
- Developing a shared language between sectors
- Obtaining commitment from 'the top'
- Accessing relevant data
- Accessing the target population
- Maintaining team impetus and commitment
- Translating findings into effective action

### Health needs can be:

- Perceptions and expectations of the relevant population (felt and expressed needs)
- Perception of professionals providing services
- Perceptions of managers of commissioner/provider organisations, based on available data about the size and severity of health issues for a population, and inequalities compared with other populations (normative needs)
- Priorities of the organisations commissioning and managing services for the profiled population, linked to national, regional or local priorities (corporate needs)
- HNA should involve balancing these differing needs and using the results to improve health and health services

HNA may also involve the assessment of health inequalities between or within a population. Health inequalities are defined as 'disparities in health between population groups that are systematically associated with socioeconomic and cultural factors', such as educational status, social class, ethnicity, place of residence, income.



## 2.1 Aims and Objectives

The aim of the health needs assessment BME is to understand the needs of BME population in Gateshead, including high-risk groups, and establish whether the content and configuration of existing services meet this demand. It aims to inform the planning and development of health and social care provision for BME population across Gateshead, by understanding the population, epidemiology, current services and future need. In addition, in understanding the needs the following questions will be answered:

- How many people in Gateshead consider themselves as BME?
- What preventative factors could reduce demand for services and reduce need for primary and secondary care interventions?
- What is the impact on physical co-morbidities for people from BME communities

### Objectives for this HNA include:

- A summary of the national and local policy and strategic background;
- An estimation of current demographics in Gateshead;
- A forecast of numbers and, future population projections for Gateshead and what this may mean in terms of the needs of local people and demand for services;
- An assessment of the impact on physical co-morbidities in BME groups ;
- A summary of evidence and guidance;
- Evidence and best practice of the current response to need in Gateshead

## 2.2 Scope of Health Needs Assessment

The Health Needs Assessment (HNA) aims to systematically assess the needs of a population, and to assess whether local services are meeting these needs. This report will be scoping in nature and will identify areas where further work may be required. It will describe the BME population within Gateshead and will identify the health needs of BME groups. It has been produced by Gateshead Council's Public Health Team using national studies and reports, local quantitative data where available, and focus groups involving members of Gateshead's BME communities. Where there is an absence of local data, the assumption that findings from national studies will be generalizable to the Gateshead BME population has been adopted for the purpose of the HNA.

## 2.3 Introduction

In order to meet the challenge of designing health and social care services, it is important for commissioners and providers of healthcare to identify gaps in information about services and shortcomings in the provision of services, and to overcome these with a robust programme of work that is closely managed at board level. It is complex and challenging to meet the competencies needed to design healthcare services and deliver against the realities of a diverse society.

This HNA will:

- Describe the BME population in Gateshead with respect to the geographic distribution, age
- Describe the health needs of BME groups within Gateshead and in the UK
- Summarise the findings of a thematic analysis of the information received via HNA stakeholder focus groups undertaken with established community groups in October and November 2016
- Make recommendations to improve the health of BME communities in Gateshead



## 2.4 Definitions

For the purposes of this report the term ethnic minority groups encompasses all groups except the White British group. Throughout this report we use the term 'BME' as an abbreviation for 'Black and minority ethnic'. 'Black' refers to those non-White groups who have traditionally been discriminated against because of their ethnicity. 'Minority ethnic' refers to other groups who have traditionally been discriminated against because of their ethnicity or who represent a minority in society (e.g. White ethnic minorities). Information on definitions and abbreviations is shown in Appendix 1.

Minority ethnic groups are most commonly classified according to the methods used by the census, which asks people to define which ethnic group they feel they belong to. In principle, an ethnic group would be defined as a community whose heritage offers important characteristics in common between its members and which makes them distinct from other communities.

Ethnicity results from many aspects of difference which are socially and politically important in the UK. These include race, skin colour, language, culture, religion and nationality, which impact on a person's identity and how they are seen by others. People identify with ethnic groups at many different levels. They may see themselves as British, Asian, Indian, Punjabi and Geordie at different times and in different circumstances. However, to allow data to be collected and analysed on a large scale, ethnicity is often treated as a fixed characteristic. BME groups are usually classified by the methods used in the UK census, which asks people to indicate to which of 16 ethnic groups they feel they belong. Census data has been used to collect quantitative data for this Health Needs Assessment.

The size of the ethnic minority populations varies substantially across regions in England, from 4 to 5% in the South West and the North East, to 40% in London. London has the largest number of people in all ethnic minority groups, except Pakistani where the largest population is in Yorkshire & the Humber and the West Midlands. These variations in the size of the population can influence the ability to analyse and interpret ethnic inequalities in health.

Within all regions in England the population of ethnic minority groups is on average younger than the White British population, although there are a couple of exceptions namely the White Irish and the White Other groups.

## 2.5 Summary of National Institute for Clinical Excellence (NICE) Guidance

Information documented from key NICE guidance is summarised below (for full detailed guidance see Appendix 2):

### **BMI: preventing ill health and premature death in black, Asian and other minority ethnic groups (PH46) July 2013**

NICE guidance aimed to determine whether lower cut-off points should be used for black, Asian and other minority ethnic groups in the UK as a trigger for lifestyle interventions to prevent conditions such as diabetes, myocardial infarction or stroke.

The evidence confirms that these groups are at an equivalent risk of diabetes, other health conditions or mortality at a lower BMI than the white European population. It also highlights recommendations from NICE and other sources in relation to awareness raising, BMI measurement and thresholds that can be used as a trigger for intervening to prevent ill health and premature death among adults from black, Asian and other minority ethnic groups in the UK.

#### **Preventing type 2 diabetes**

NICE recommendations include raising awareness of the need for lifestyle interventions at a lower BMI threshold for these groups to prevent type 2 diabetes. For example, in particular, use the public health action points advocated by the World Health Organisation (WHO) as a reminder of the threshold at which lifestyle advice is likely to be beneficial for black and Asian groups to prevent type 2 diabetes.

#### **BMI assessment, multi-component interventions and best practice standards**

NICE recommendations on BMI assessment, and how to intervene, is set out in 'Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children' (NICE clinical guideline 43). Specifically, weight management programmes should include behaviour-change strategies to increase people's physical activity levels or decrease inactivity, improve eating behaviour and the quality of the person's diet and reduce energy intake

#### **General awareness raising**

- Ensure practitioners are aware that members of black, Asian and other minority ethnic groups are at an increased risk of chronic health conditions at a lower BMI than the white population (below BMI 25 kg/m<sup>2</sup>).
- Ensure members of black, Asian and other minority ethnic groups are aware that they face an increased risk of chronic health conditions at a lower BMI than the white population.
- Use existing local black and other minority ethnic information networks to disseminate information on the increased risks these groups face at a lower BMI.

#### **NICE advice: Body mass index thresholds for intervening to prevent ill health among black, Asian and other minority ethnic groups (LGB13)**

The prevalence of chronic conditions such as type 2 diabetes, coronary heart disease and stroke is up to 6 times higher (and they occur from a younger age) among black, Asian and other minority ethnic groups. In addition, these groups progress from being at-risk to being diagnosed with these conditions at twice the rate of white populations. So tackling this issue will help tackle health inequalities and satisfy public sector obligations under the Equality Act 2010.

Action now will result in significant social care and health savings, by delaying and improving the management of complications associated with limiting long-term illnesses. It could result in particularly high savings for local authorities with a high proportion of black, Asian and other minority ethnic groups.

Lifestyle interventions targeting sedentary lifestyles and diet have reduced the incidence of diabetes by about 50% among high-risk individuals. This includes people from South Asian, Chinese, black African and African Caribbean descent with a BMI of 23 kg/m<sup>2</sup> or more, where interventions to identify and manage pre-diabetes have been found to be cost effective.

## **HIV testing: increasing uptake in black Africans (PH33) March 2011**

The focus of this guidance is on increasing the uptake of HIV testing to reduce undiagnosed infection and prevent transmission.

This guideline was previously called increasing the uptake of HIV testing among black Africans in England.

It is one of two pieces of NICE guidance published in March 2011 on how to increase the uptake of HIV testing. A second publication covers HIV testing among men who have sex with men.

### **Community engagement and involvement**

Directors of public health and others with a remit for HIV prevention or with responsibility for the health and wellbeing of black African communities are guided to take action to, for example:

- Plan, design and coordinate activities to promote the uptake of HIV testing among local black African communities, in line with NICE guidance on community engagement. Seek to develop trust and relationships between organisations, communities and people. Communities should be involved in all aspects of the plan, which should take account of existing and past activities to address HIV and general sexual health issues among these communities.
- Recruit, train and encourage members of local black African communities to act as champions and role models to help encourage their peers to take an HIV test. This includes helping to plan awareness-raising activities or acting as a link to specific communities that are less likely to use existing services.

### **Planning services – assessing local need**

Directors of public health, public health specialists and commissioners with a remit for sexual health and local sexual health networks should take action to:

- Assess local need.
- Developing a strategy and commission services in areas of identified need
- Ensure the strategy is planned in partnership with relevant local voluntary and community organisations and user groups, and in consultation with local black African communities .
- Ensure the strategy is regularly monitored and evaluated.
- Ensure HIV testing is available in a range of healthcare and community settings (for example, GP surgeries and community centres) based on the outcomes of a needs assessment.

## **Smokeless tobacco: South Asian communities (PH39) September 2012**

The guidance aims to help people of South Asian origin who are living in England to stop using traditional South Asian varieties of smokeless tobacco. The phrase 'of South Asian origin' refers here to people with ancestral links to Bangladesh, India, Nepal, Pakistan or Sri Lanka.

The term 'smokeless tobacco', as it is used in the guidance, refers to 3 broad types of products:

- Tobacco with or without flavourants, for example: misri India tobacco (powdered) and qimam (kiman).
- Tobacco with various alkaline modifiers, for example: khaini, naswar (niswar, nass) and gul.
- Tobacco with slaked lime as an alkaline modifier and areca nut, for example: gutkha, zarda, mawa, manipuri and betel quid (with tobacco).

Products, like 'snus' or similar oral snuff products are not included.

The guidance is for commissioners and providers of tobacco cessation services (including stop smoking services), health education and training services, health and wellbeing boards and health and social care practitioners.

It is also for all those with public health as part of their remit, in particular, the health of South Asian communities. The guidance may also be of interest to local authority elected members and members of the public.

The 6 recommendations cover:

- assessing local need
- working with local South Asian communities

- commissioning smokeless tobacco services
- providing brief advice and referral: dentists, GPs, pharmacists, and other health professionals
- specialist tobacco cessation services (including stop smoking services)
- training for practitioners.

#### **Commissioning smokeless tobacco services in areas of identified need**

Directors of public health, public health commissioners and local authority specialists responsible for local tobacco cessation services, health and wellbeing boards, clinical commissioning groups, managers of tobacco cessation services should take action:

- Provide services for South Asian users either within existing tobacco cessation services or, for example, as:
  - A stand-alone service tailored to local needs. This might cater for specific groups such as South Asian women, speakers of a specific language or people who use a certain type of smokeless tobacco product (the latter type of service could be named after the product, for example, it could be called a 'gutkha' cessation service).
  - Part of services offered within a range of healthcare and community settings (for example, GP or dental surgeries, community pharmacies and community).
- Ensure local smokeless tobacco cessation services are coordinated and integrated with other tobacco control, prevention and cessation activities, as part of a comprehensive local tobacco control strategy. The services (and activities to promote them) should also be coordinated with, or linked to, national stop smoking initiatives and other related national initiatives (for example, dental health campaigns).

#### **Providing brief advice and referral: dentists, GPs, pharmacists and other health professionals**

Primary and secondary dental care teams (for example, dentists, dental nurses and dental hygienists), primary and secondary healthcare teams (for example, GPs and nurses working in GP practices). Health professionals working in the community, including community pharmacists, midwives and health visitors should take action to:

- Ask people if they use smokeless tobacco. In addition to delivering a brief intervention, refer people who want to quit to local specialist tobacco cessation services. This includes services specifically for South Asian groups, where they are available.
- Record the response to any attempts to encourage or help them to stop using smokeless tobacco in the patient notes (as well as recording whether they smoke).

#### **Training for practitioners in areas of identified need**

Commissioners of health and dental services, commissioners of health education and training services should take action to ensure training for health, dental health and allied professionals (for example, community pharmacists).

## 2.6 Gateshead Health and Wellbeing Strategy

Our Health and Wellbeing Strategy 'Active, Healthy and Well Gateshead' sets out a route map on how Gateshead Health and Wellbeing Board can work towards the ambitious vision for health and wellbeing based on evidence of local needs and evidence of what works.

The Strategy recognises the importance of the 'wider determinants' of health, both in securing the sustained health improvement of local people and addressing health inequality gaps within and between Gateshead communities. It recognises that there is a need to look at how, in Gateshead, people can build active and healthy lifestyles into their lives, how communities can make the most of peoples skills, community assets and diversity, and how the Board can help people to improve their life chances by learning new skills and securing employment to ensure a prosperous, attractive, healthy and safe Gateshead for all to enjoy.

*"Local people will realise their full potential and enjoy the best quality of life in a healthy, equal, safe, prosperous and sustainable Gateshead."*

*Gateshead Council's Vision 2030*

One of the System improvement priorities is to strengthen engagement and build capacity within communities, especially those with the poorest health and make the most of community assets. This is a priority because Gateshead has a strong sense of community where local people have a clear sense of belonging to their neighbourhood and want to live in a community with a sense of pride. The strategy aims to develop communities to be sustainable and cohesive places where people share values and aspirations for the future and work together to achieve them, making the most of community assets.

This involves ensuring that local communities are engaged and empowered to be involved in decisions that affect their lives, where everyone feels valued and understood and share a sense of belonging.

The strategy identifies five key priority areas, each of which will shape the work with local communities in taking forward our joint health and wellbeing agenda:

- **Community engagement and participation** – promoting positive and effective relationships, identifying issues that concern our diverse communities and responding appropriately, and ensuring hard to reach and other groups are not disadvantaged.
- **Community capacity building and making the most of community assets** – supporting the development of new skills within communities and the development of new and existing voluntary and community sector groups and social enterprises to help build community assets. Also, building community resilience to withstand the current economic climate, helping communities to make the most of their assets and to harness local resources and expertise to help themselves in an emergency (in ways which complement council and emergency service responses).
- **This will also support the 'co-production' of solutions** (for example, design of services) by people who may use them alongside those who have traditionally provided or arranged them.
- **Information and communication** – ensure that local people have access to up-to-date information in suitable formats on activities, planned developments and support available within their communities.
- **Involving children, young people and schools** – encouraging the development of children's and youth forums that provide a platform for all young people in Gateshead; promoting community cohesion, equality and diversity and citizenship in schools, out of school activities, youth and sports clubs and uniformed organisations.
- **Supporting positive community relationships** – supporting people within communities to live, work and learn together and to respect the diversity of communities within Gateshead.

Gateshead Councils Vision 2030 sets out an ambitious and aspirational vision, that:

*"Local people will realise their full potential and enjoy the best quality of life in a healthy, equal, safe, prosperous and sustainable Gateshead."*

The strategy aims to improve the wellbeing and equality of opportunity for everyone in Gateshead so that all residents and businesses can fulfil their potential. It aims to champion equality of opportunity in all aspects of health and social care and, in particular, the work to promote choice and to empower local people to have more control over their care and to remain independent for as long as possible.

## 2.7 Equality Act 2010

The Equality Act 2010 requires public bodies with strategic functions, these include government departments, local authorities and NHS bodies, when making decisions such as deciding priorities and setting objectives, to consider how their decisions might help to reduce the inequalities associated with economic disadvantage. Factors such as access to health care, education, public planning and relationships all effect the health and wellbeing of an individual (Local Government Associates 2010). Altering these environmental conditions through policy, strategy and public services may increase a person's health outcomes and overall quality of life. The Equality Act 2010 requires public bodies to determine which socio-economic inequalities they are in a position to influence.

The Equality Act 2010 supersedes the Race Relations (Amendment) Act 2000 which, in the drive for race equality, gave public authorities a new statutory duty to promote race equality. The Act also places specific duties on public (including health) authorities, together with the publication of a race equality scheme. All public authorities are also bound by the employment duty to monitor by ethnic group their existing staff, applicants for jobs, promotion and training and to publish the result annually.

The NHS Chief Executive has added to the imperative to collect and analyse high quality ethnicity-coded data.

The Ten Point Race Equality Action Plan emphasises several important activities. These include:

- meeting the service needs of people from ethnic minorities,
- ensuring a greater focus on helping people with chronic diseases and
- tackling health inequalities.

It also focuses on helping areas where ethnic minority communities are disadvantaged, and targeting recruitment and development opportunities at people from different ethnic groups, whose skills are frequently underused.

To demonstrate compliance with these duties, ethnicity monitoring data needs to be collected and analysed across the workforce and service delivery areas. Yet, experience has shown that improvements in data collection have been slow and are difficult to bring about.

The Department of Health has issued a 'Practical guide to ethnic monitoring'. This guide promotes the standard collection and use of ethnic group and related data on patients, service users and staff of the NHS and social services. It shows examples of good practice throughout the NHS which help them to meet their responsibilities.

### Recommendations

It is recommended that the Health and Wellbeing Board members:

- ensure that their respective organisations and organisations who they commission with are actively aware of their requirement to collect and analyse data across workforce and delivery areas in their performance measurements and monitoring;
- make use of equality impact assessments to understand the implications of service and policy developments for local BME communities.

### 3. Demographic Information

The national Census provides the most comprehensive picture of the BME population available. The following section predominantly outlines Census data unless otherwise stated.

Throughout this assessment, we have used the term Black and Minority Ethnic (BME) group to refer to members of non-white ethnic groups. However, we will also consider those in White groups other than White British, which includes people from Eastern European countries as well as the Irish and Gypsy or Irish Travellers. Collectively, we have referred to these as the 'White Other' ethnic group in this assessment.

#### 3.1 Overall

Gateshead has a comparatively small BME and White Other population compared with many areas of the country, although this is gradually increasing in size.

In the 2011 Census, the Gateshead BME population was 3.7% (or 7,472 people) compared with the England average of 14.6%. Gateshead's BME population has risen from 1.6% in 2001 and 0.8% in 1991. In 2011, Gateshead's White Other population was 2.2% (or 4,387) compared with the England average of 5.7%. Gateshead's White Other population has risen from 1.5% in 2001. In 2011 the White Other population consisted of 3,708 from groups including Eastern European countries, with an additional 592 people of Irish ethnic origin and 87 Gypsy or Irish Travellers.

The 2011 Census recorded 3,004 people whose religion was Jewish. Whilst this non-mandatory question appears to have improved enumeration of the Jewish community since the previous Census, the Jewish community themselves estimate their population size to be around 4,500, including 1,500 students. It is likely that a number of those in the White Other population will be from Gateshead's local Jewish community, but many will be included within the White British population: the Jewish community sees itself as a religious grouping rather than an ethnic minority.

After the White Other group, the largest single minority ethnic group is Chinese with 1,054 (0.5%) people living in Gateshead. Within the south Asian group (including Indian, Pakistani, and Bangladeshi groups) there are 1,775 people (0.9%). A further 909 people (0.5%) are from other Asian groups. In total there are 3,738 people from the Asian ethnic groups.

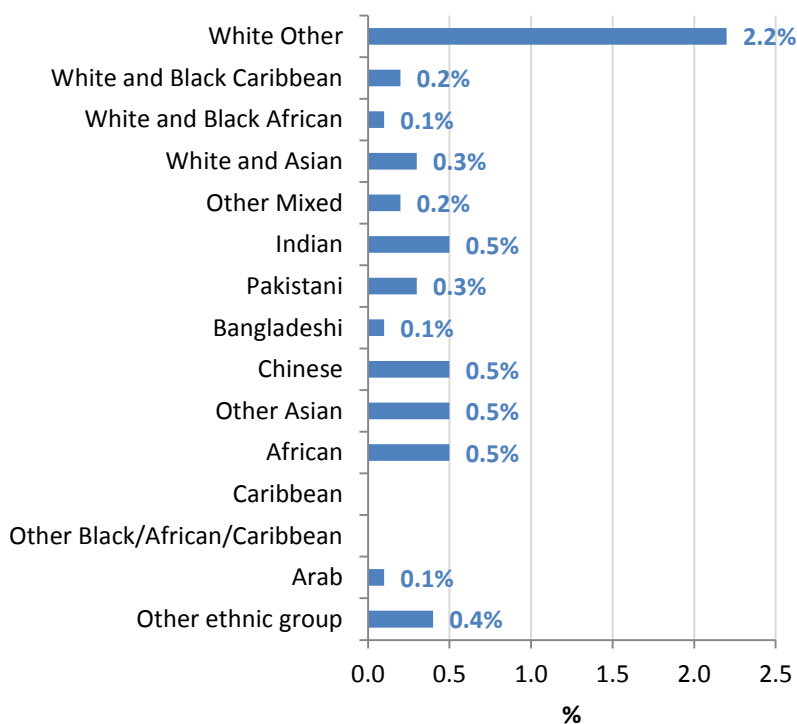
Within the Black ethnic groups there are 1,081 people. The majority come from the Black African group with 903 people.

The Mixed ethnic groups account for 1,558 Gateshead people. Most are from the White and Asian (523) or White and Black Caribbean (412) groups.

There are 1,095 people from Other ethnic groups.

2.9% of people in Gateshead do not use English as their main language.

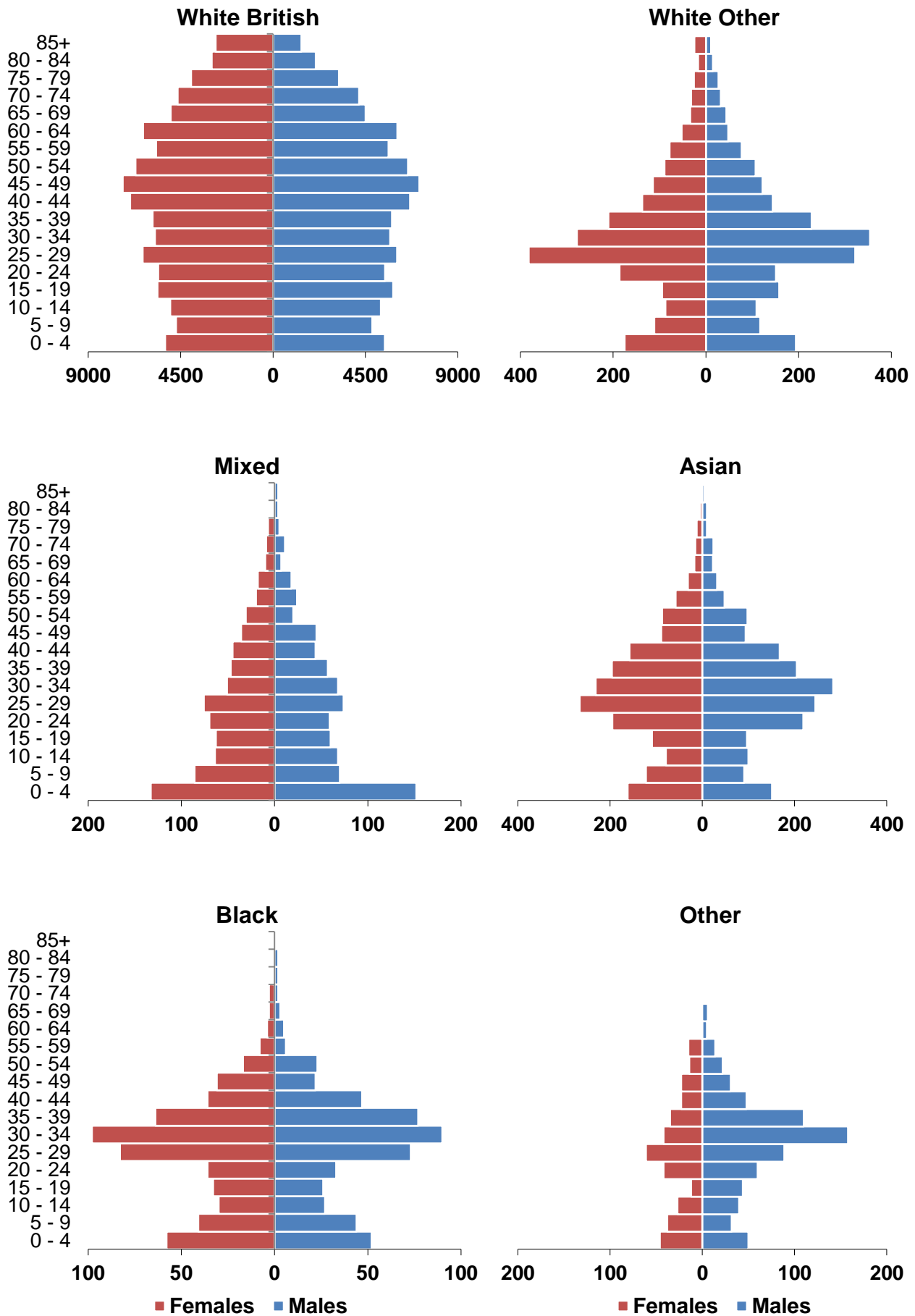
**% Non 'White British' Ethnic Groups**



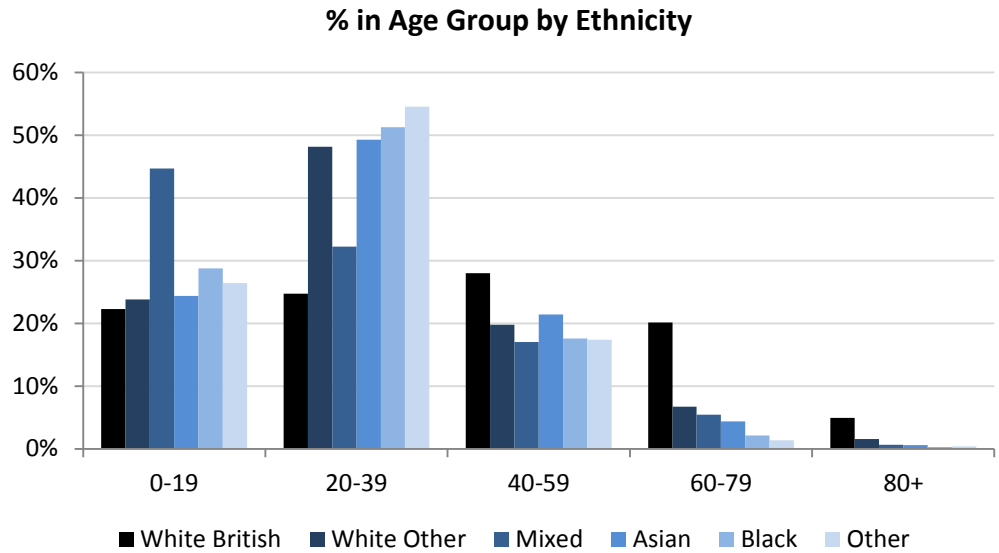


### 3.1.1 Age

As shown in the population pyramids below, the BME and White Other groups in Gateshead have a more youthful age structure than the White British group, which may lead to further natural increase in the future. This is particularly evident in those of younger working age and reflects population structures across the country.

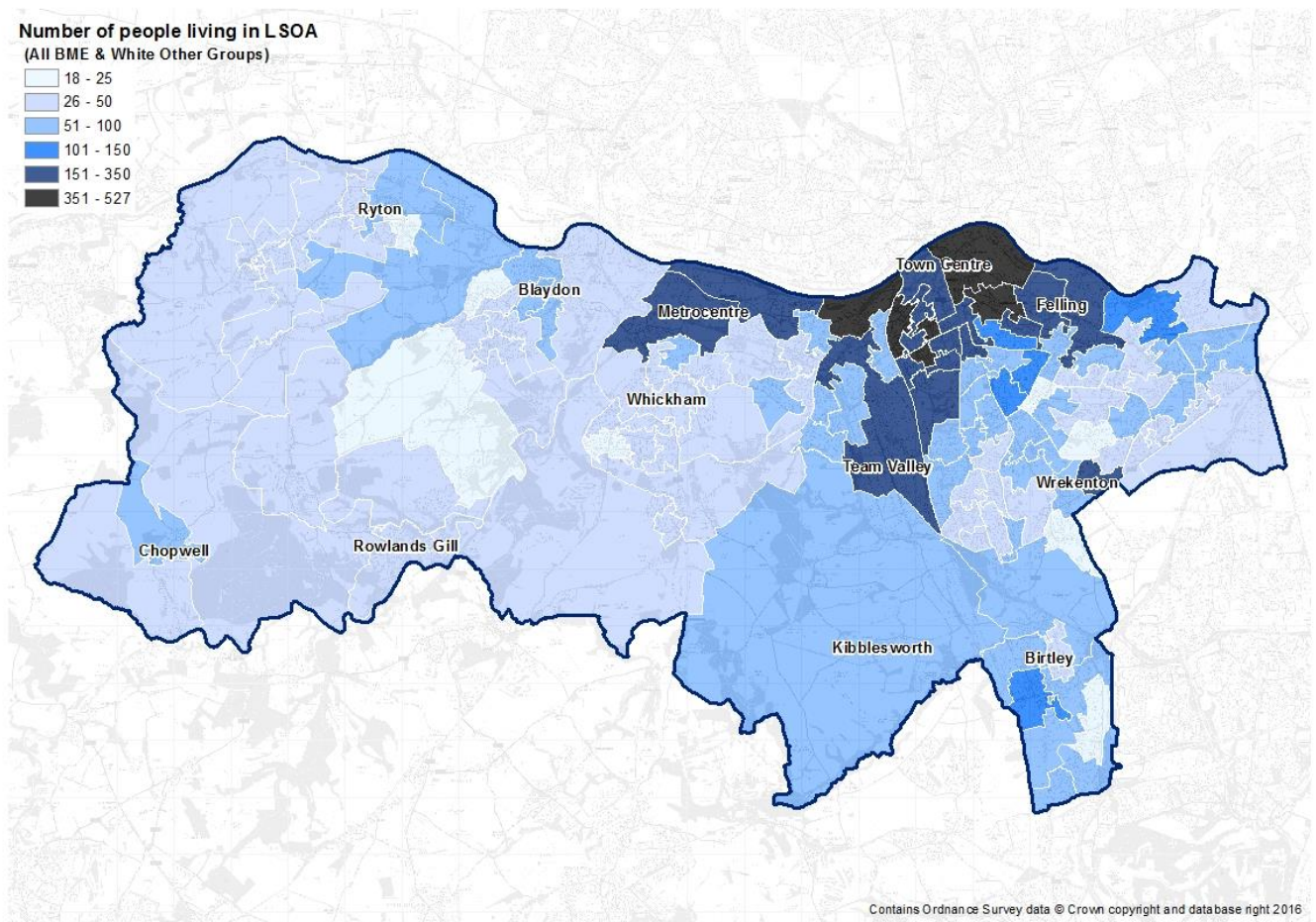


The chart on the right further demonstrates that BME and White Other groups tend to have a much lower proportion of older people when compared to the White British ethnic group. They tend to have greater proportions of young working age people. The “Mixed” ethnic group, however, has a much higher proportion of young people aged 0-19.

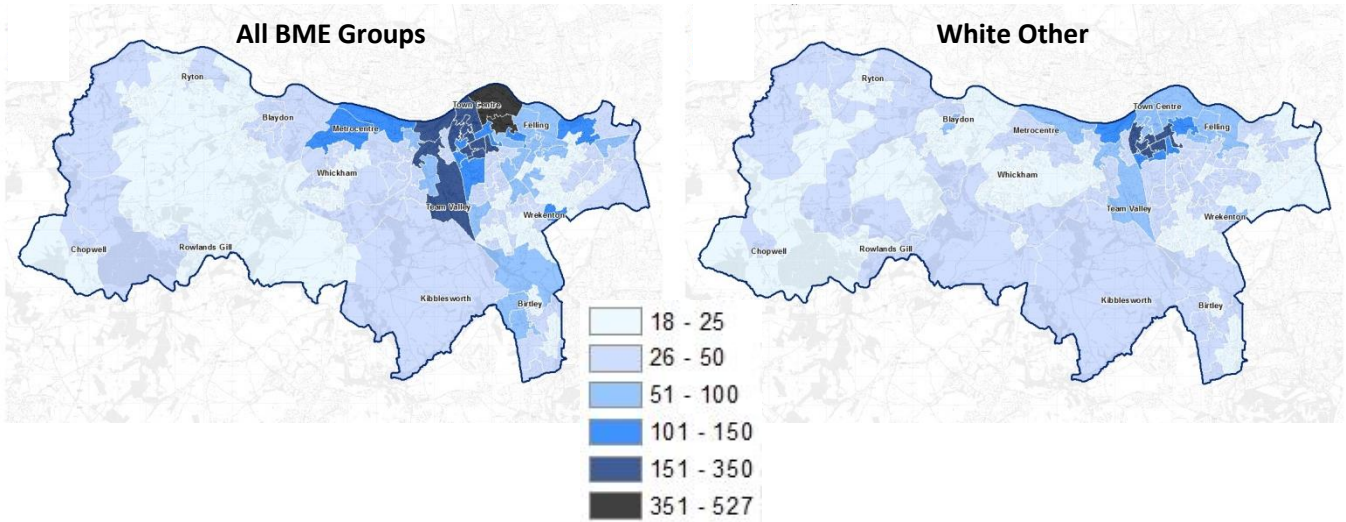


### 3.1.2 Geographical Distribution

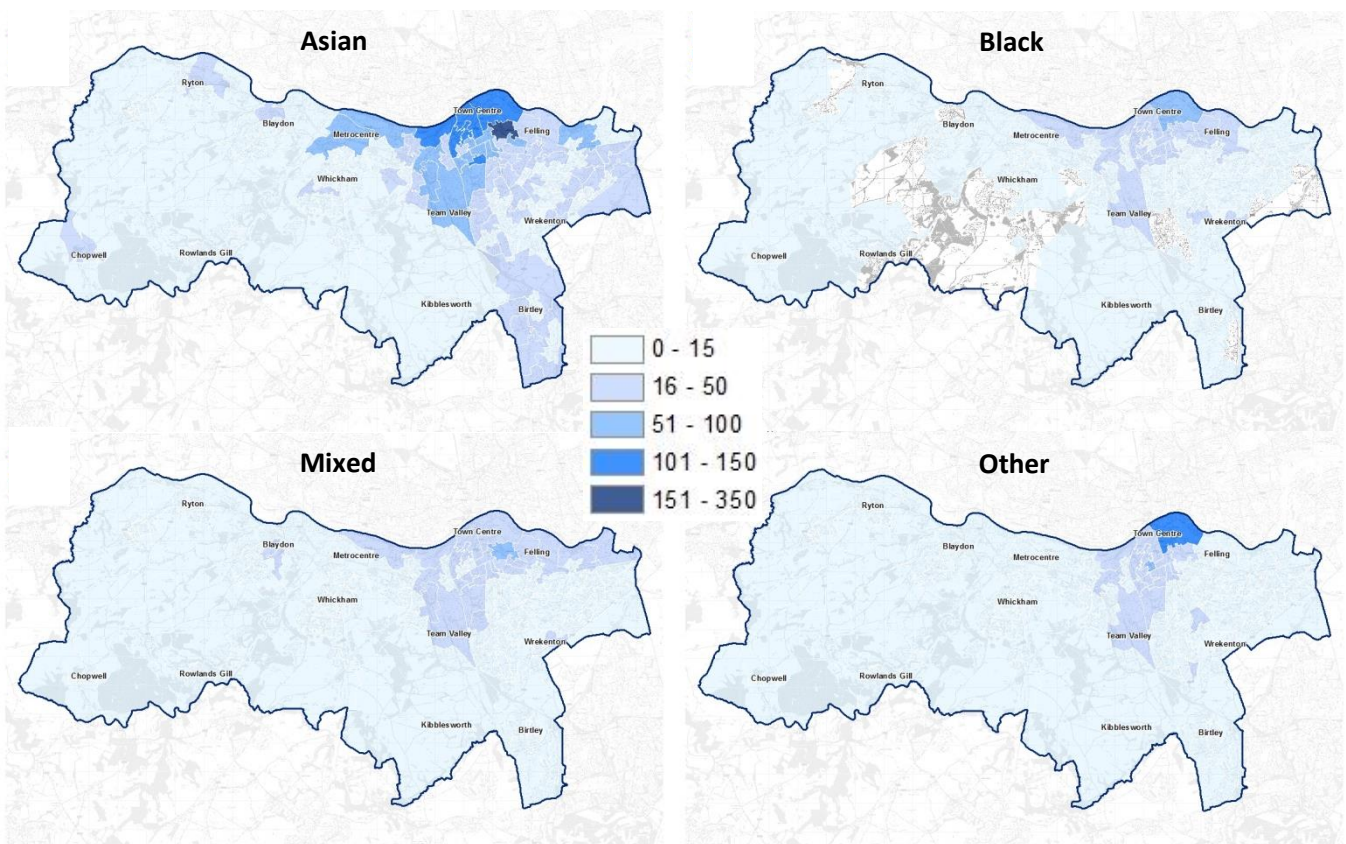
The largest concentration of the BME and White Other groups is within Gateshead Town Centre and surrounding areas such as Teams, Bensham and Saltwell.



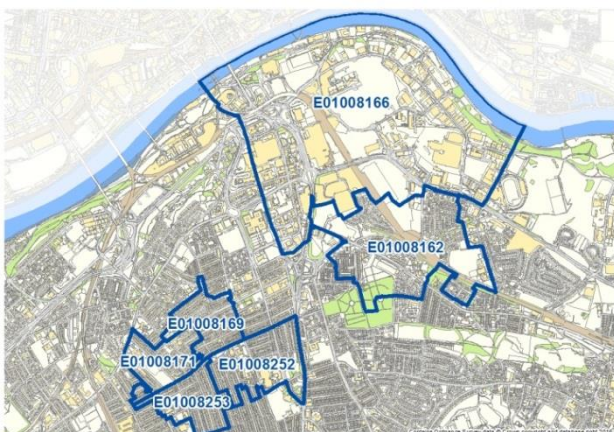




Looking at the geographical distribution for each of the broad BME groups, the pattern is similar to the 'all BME groups' map shown above, with the largest concentrations in the centre of Gateshead.



The areas with the highest concentrations of people from a BME or White Other group are shown in the map below. BME and White Other groups make up between 20% and 30% of the population in some areas as shown in the table and map below.



LSOA	Location	% BME	% White Other	% BME + White Other
E01008166	Town Centre	24	6	30
E01008169	Bensham Central	12	15	26
E01008253	Bensham South	12	11	24
E01008162	St James Village/Sunderland Road	17	5	22
E01008171	Bensham South	8	14	22
E01008252	Bensham Central	9	10	20

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### 3.1.3 Change Since 2001 Census

Between 2001 and 2011 the total population of Gateshead increased by 4.7% (9,063). Two thirds of this was due to increases in the BME and White Other ethnic groups. This is evident by the large increases over the same period in the White Other ethnic group, which increased by 55% (1,549), and the BME groups which, combined, increased by 145% (4,419).

		Total Population	White British	White Other	Mixed	Asian	Black	Other
Change 2001 to 2011	%	+4.7%	+1.7%	+55%	+95%	+126%	+274%	+250%
	No.	+9,063	+3,095	+1,549	+760	+2,085	+792	+782

The Asian ethnic group has seen the largest increase, with an additional 2,085 people since 2001. The fastest rate of increase was in the Black ethnic group, with an increase of 274%.

Change 2001 to 2011	Mixed				Asian					Black			Other	
	White and Black Caribbean	White and Black African	White and Asian	Other Mixed	Indian	Pakistani	Bangladeshi	Chinese	Other Asian	African	Caribbean	Other Black	Arab	Other ethnic group
No.	+174	+175	+239	+172	+426	+126	+122	+690	+721	+695	+40	+57	+289	+493
%	+73%	+206%	+84%	+90%	+87%	+26%	+102%	+190%	+384%	+334%	+80%	+184%	n/a	+158%

The largest increases in the Asian and Black ethnic groups were the Other Asian (+721), African (+695), and Chinese (+690). There were also notable increases in the Other ethnic group (+493) and the Indian group (+426). Some of the groups, for example the White and Black African ethnic group (+206%) and the Other Black group (+184%), have increased at a fast rate but remain relatively small in number.

### 3.1.4 School Census

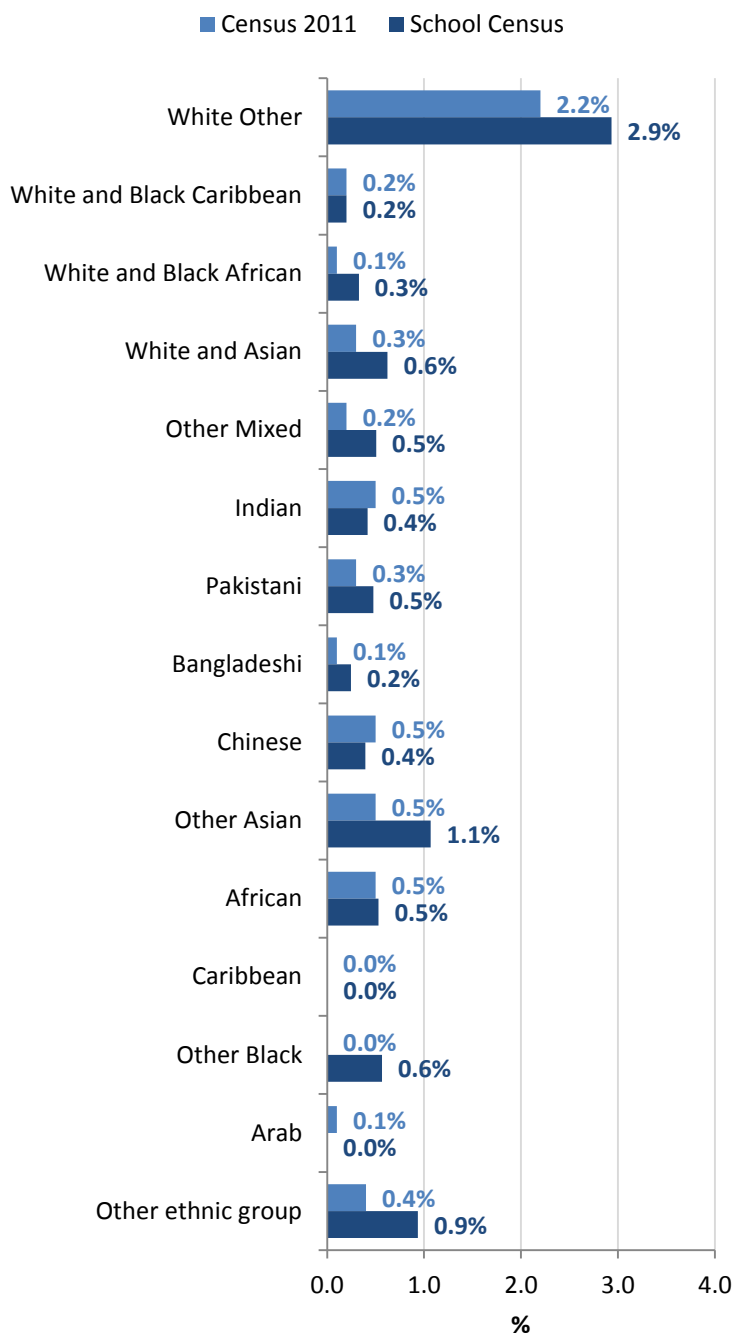
The school census is undertaken more regularly than the national Census data used throughout this report and therefore provides a more up-to-date estimation of the ethnic make-up of the school population.

9.2% of the school population are from BME and White Other groups. This compares with the total population figure of 5.9% from Census 2011. However, it should be noted that the school census only includes data from Gateshead Council maintained schools and Academies. This means that the Jewish schools, whose pupils some of whom may be of White Other ethnic origin, are not included in the figures shown.

The chart on the right shows that in almost all of the BME and White Other ethnic groups there is a larger proportion of the school age population in those ethnic groups than there was in the total population. This means that the younger generation is now more ethnically diverse than the total population was in 2011 and suggests continuing growth in the BME and White Other groups.

The largest differences between the total population and the school population are in the White Other group (+0.7 percentage points more in the school population), the Other Asian group (+0.6), and the Other Black group (+0.6). This reflects the changes outlined in the previous section on change since 2001 Census.

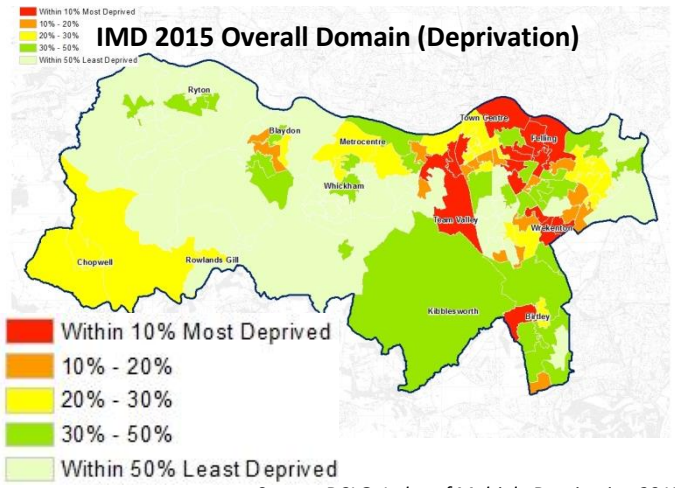
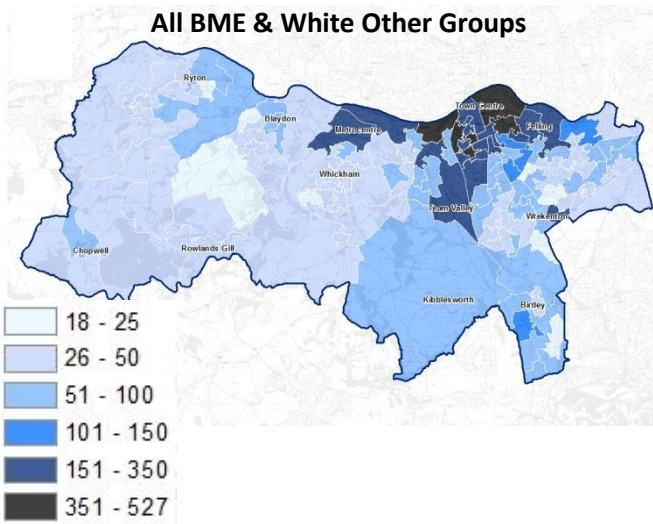
### % Non-White British Ethnic Groups



### 3.1.5 Deprivation

The maps below demonstrate that many Gateshead people from BME or White Other groups live in deprived areas. 38% of people from a BME or White Other group live in one of the 20% most deprived areas in England, compared with 24% for the White British group. Broadening the level of deprivation, 64% live in one of the 30% most deprived areas in England, compared with 43% for the White British group.

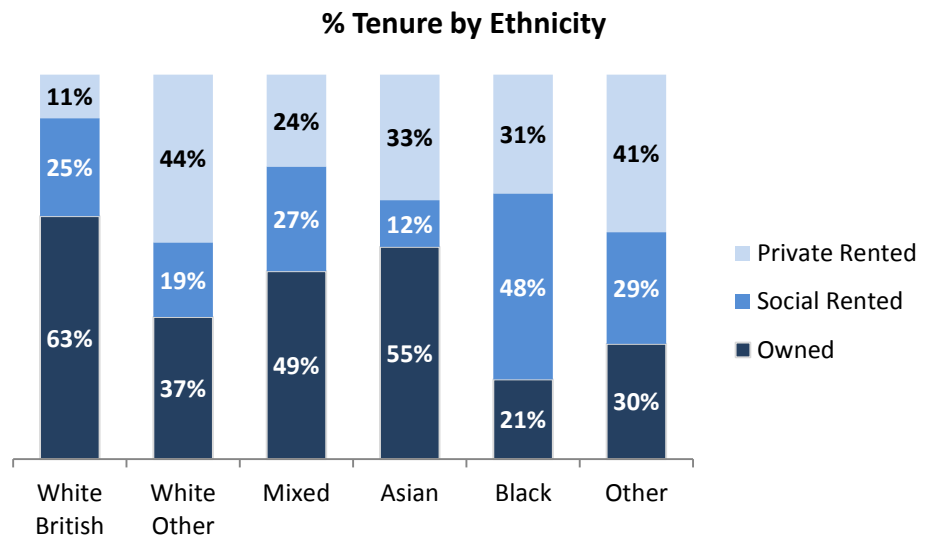




Source: DCLG, Index of Multiple Deprivation 2015  
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### 3.1.6 Tenure

People in BME and White Other ethnic groups are at least twice as likely to live in private rented accommodation than the White British population. This is shown in the chart on the right where 11% of the White British population are private renters, compared to the Mixed group at 24% and the White Other group, with the highest proportion, at 44%.



The Black group are almost twice as likely to live in social rented accommodation at 48%, than the White British population at 25%.

The White British population are most likely to own their property at 63%. The Asian group are next at 55%.

### 3.1.7 Migration

National Insurance Number Registrations provide an indication of the number of people from different ethnic backgrounds who move into the area to work. The data is limited in that it only identifies the inflow of migrants and only records the registration at the point it is made.

In Gateshead, in the year to June 2016, there were 835 registrations of migrants. The majority (544) were from within the European Union: 168 migrants were from the EU2 states (Bulgaria and Romania), 190 were from EU8 accession states (including Poland, Slovakia, and the Czech Republic) and 186 from the EU15 states.

Information on migrant workers is difficult to find. These groups are likely to be poorly recorded in sources such as the census and other national datasets.

World Region	Number of migrants
European Union EU15	186
European Union EU8	190
European Union EU2	168
European Union Other	18
Middle East and Central Asia	97
East Asia	30
South Asia	32
South East Asia	15
Sub-Saharan Africa	41
North Africa	26
North America	14
Central and South America	9
Oceania	14

Source: DWP, National Insurance Number Registration Jun 2016

## 4. Health needs of BME groups

There is a significant body of evidence that people of all ages in Black and minority ethnic communities experience health inequalities (Department of Health 2003, Equality and Human Rights Commission 2008). People working in the public sector have a responsibility to consider the needs of everyone who uses their services (Government Equalities Office 2009:30) and to engage them in discussion about developments and improvements.

In England there is a north-south divide on some health determinant indicators such as social class, with northern regions having a higher proportion in the lower social classes among most ethnic groups. The north-south pattern in educational attainment is less clear. Among health indicators, the north-south pattern in 'not good' health is very clear e.g. higher rates of 'not good' health in the northern regions among most ethnic groups

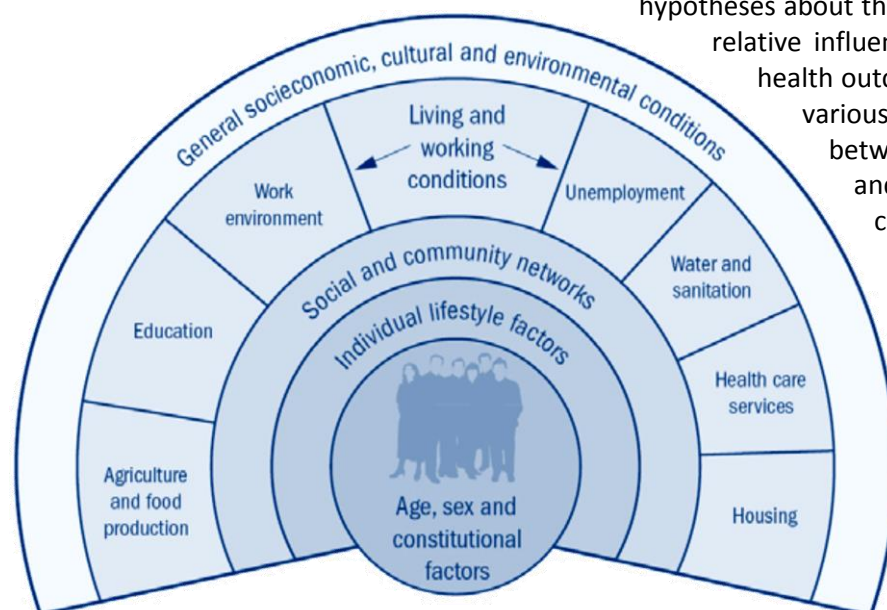
### 4.1 Factors impacting on health

There are a number of factors that can impact on an individual's health as demonstrated in the Dahlgren-Whitehead 'rainbow model' shown below. Certain population groups will experience worse health outcomes as a result of the effect of these factors. Determinants such as genetic differences, population structures, culture, socio-economic factors such as employment and housing quality will vary between different ethnic groups. However, differences in health outcomes are also present within ethnic groups, suggesting that more complex factors are at work than simple genetic or cultural explanations. Even factoring in the effects of socio-economic disadvantage does not fully explain differences in health outcomes seen in BME groups and therefore other factors such as racial discrimination or cultural insensitivity in the provision of healthcare services may also be having an impact.

Health inequalities in society – where your level of health is connected to your socioeconomic level – has led to a growing awareness that many health issues are related to social factors. The inverse equity hypothesis for health interventions ("Inverse Care law") was articulated by Tudor Hart (1971) with the concern that with health system initiatives, people from lower socio-economic groups benefit the least, as these groups are less able to take up any new health intervention (Victora et al 2000).

Under the Equality Act 2010, public bodies are required to eliminate unlawful discrimination, harassment and victimisation and promote equality of opportunity.

Economic, environmental and social inequalities can influence people's risk of getting ill, their ability to prevent sickness, or their access to effective treatments. This framework has helped researchers to construct a range of hypotheses about the determinants of health, to explore the relative influence of these determinants on different



hypotheses about the determinants of health, to explore the relative influence of these determinants on different health outcomes and the interactions between the various determinants. It maps the relationship between the individual, their environment and health. Individuals are placed at the centre, and surrounding them are the various layers of influences on health, such as individual lifestyle factors, community influences, living and working conditions, and more general social conditions.

The Dahlgren-Whitehead rainbow model remains one of the most effective illustrations of health determinants, and has had widespread impact in research on health inequality and influences.

Dahlgren-Whitehead 'rainbow model'



Source: Dahlgren and Whitehead 1991

Recommendations to reduce health inequalities frequently emphasise improvements to socio-environmental determinants of health. Proponents of 'proportionate universalism' argue that such improvements should be allocated proportionally to population need. 'Proportionate universalism' can be applied for health inequalities to be tackled across the social gradient, as well as considering the health needs of the most vulnerable. Non-health interventions can be evaluated to better understand if, and how, health inequalities can be reduced through strategies of allocating investment in social determinants of health according to need.

### **Public Health and Inequalities**

Factors such as income, housing, workplace, access to healthcare, education, public planning and relationships all affect the health and well-being of an individual (Local Government Association, 2010). Altering these environmental conditions through policy, strategy and public services may increase one's health outcomes and overall quality of life. Reducing health inequalities within the population is a statutory requirement under the Public Sector Equality Duty of the Equality Act 2010 for health and social care agencies to address inequalities (Equality and Human Rights Commission, 2010).

The role of socio-economic status and deprivation in explaining patterns of health by ethnic group and region is not entirely clear. For example the Pakistani and Bangladeshi groups have the highest proportions reporting that their health is 'not good' as well as the lowest proportions in the 'managerial and professional' occupations who are known to report higher rates of 'not good' health than other social groups. However, it is unlikely that this accounts for all of the variation or that socio-economic status correctly captures all of the forms of disadvantage that may be experienced by ethnic minority groups. Other factors are likely to be playing a part: e.g. environmental factors in influencing poor health outcomes for ethnic minority groups.

It is also being recognised that some health issues are particularly problematic for certain ethnic groups. For example, South Asians have a significantly higher risk of diabetes (Sproston, & Mindell 2006), and an increased risk of cardio-vascular disease (Wild et al 2007) while smoking is considerably more prevalent in some ethnic communities than others.

According to a report by NICE (2013), Professor Mike Kelly, Director of the Centre for Public Health at NICE said:

*"Type 2 diabetes, heart disease and stroke are potentially life-threatening conditions, which people of African, Caribbean and Asian descent and other minority ethnicities are significantly more likely to develop than the wider population. So it's vital that local authorities are supported in taking action to prevent these illnesses in people who have a high risk of developing them".*

They also suffer from these conditions at a younger age (DH 2006), up to a decade or more earlier than white Europeans:

*"Not only are people from these ethnic backgrounds up to 6 times more likely to be diagnosed with type 2 diabetes, they are 50% more likely to die from cardiovascular disease, and they also suffer from these conditions at a younger age".*

In the UK, type 2 diabetes is more prevalent among people of South Asian, Chinese, African–Caribbean and black African descent than among the white population. They tend to progress from impaired glucose tolerance to diabetes much more quickly (more than twice the rate of white populations) (Webb et al. 2011).

A substantial proportion of Asian people at high risk of type 2 diabetes have a BMI lower than the World Health Organization (WHO) recommended cut-off point for being overweight (the same or greater than 25 kg/m<sup>2</sup>). For example, South Asians tend to have a higher percentage of body fat at a given BMI than Europeans. The WHO report suggested that 23–27.4 kg/m<sup>2</sup> and 27.5–32.4 kg/m<sup>2</sup> should be used to identify people within different Asian populations who may be at risk of health conditions due to their weight (WHO 2004).

This should be used as a trigger to take action in helping people from these and other minority ethnicities to avoid ill health. This is a change from the usual threshold of 25 kg/m<sup>2</sup> signalling increased risk of chronic conditions, although 25 kg/m<sup>2</sup> is still valid for flagging risk in white European adults.

Lifestyle interventions that targets inactive lifestyles and diet can reduce the incidence of diabetes by about 50% among high-risk individuals, including people of South Asian, Chinese, African and Caribbean descent.

As well as improving the health and wellbeing of individuals, taking effective action now also reduces future demand on health and social care services by enabling people to remain as independent as possible.

Whilst some BME groups experience worse health than others, for example, surveys show that Pakistani, Bangladeshi and Black-Caribbean people report the poorest health, with Indian, East African Asian and Black African people reporting the same health as White British, and Chinese people reporting better health. However patterns of ethnic inequalities in health vary from one health condition to the next, for example, as documented, BME groups tend to have higher rates of cardio-vascular disease than White British people, but some have lower rates of many cancers.

- Ethnic differences in health also vary across age groups, and the greatest variation by ethnicity is seen among the elderly.
- Ethnic differences in health vary between men and women, as well as between geographic areas.
- Ethnic differences in health may vary between generations. For example, in some BME groups, rates of ill-health are worse among those born in the UK than in first generation migrants.

With local authorities' wider remit for public health in communities, this highlights the importance of taking steps to address diabetes, cardiovascular disease and stroke to improve the health of local people. In our diverse population, it is essential that local authorities and their partner organisations ensure that services that they commission or provide include a focus on people from minority ethnicities, and particularly within the 25-39 age groups.

### **Gypsy, Roma and Travellers**

For Gypsy, Roma and Traveller families, evidence suggest these groups often remain excluded from 'mainstream services and opportunities, particularly health and education services' (Riches, 2007). Riches (2007) argues that 'an 'open door' policy for access to services is not enough', as the individual must still know the system before accessing that system or institution.

Children of Gypsies and Travellers experience a higher burden of illness and disease, with challenges in accessing sustained healthcare, contemporary advice and information. Consequently, early identification of needs often is lacking, resulting in diagnosis and interventions not occurring until school age, which can be less effective. This can result in stress for parents trying to cope without clear support services and networks, which is why outreach services are important (Riches, 2007).

Often without a named GP, screening is extremely difficult for gypsies and travellers, with inability to access routine check-ups. Literacy difficulties are also a barrier to accessing health screening, many feeling 'ashamed to admit that they do not understand' (Bingham, 2010).

Gateshead's community engagement team works with the Gypsy Roma Travelling groups to encourage engagement with local services and provide information.

### **Recommendations**

Partners in the Health and Wellbeing Board should ensure that services that they commission or provide make reasonable adjustments to ensure they include a focus on people from minority communities, and particularly within the 25-39 age groups. Outreach services are important to encourage engagement with local services and provide information.

### 4.1.1 Public health issues faced by different communities

Having established that among some religious and ethnic groups there is a high level of attendance within a faith setting, it is pertinent to ask whether different groups have a tendency towards particular public health issues, whereby the faith setting might lend itself towards health-related interventions. The following table is not exhaustive, but summarises broadly at population level the particular health issues that different communities face.

(Source: November, L. 2014)

Public health issues summarised by ethnicity or religion	
Community	Public health issues or determinants of ill-health relevant to grouping
South Asians (predominantly Muslim, Hindu and Sikh)	<p><b>Cardiovascular disease (CVD)</b> The increased risk of CVD in the South Asian population is well recognised with various factors given as explanations for this disparity including language barriers and cultural taboos.</p> <p><b>Diabetes</b> Type 2 diabetes is up to six times more common in people of South Asian descent than in the general population. According to the Health Survey for England 2004, doctor diagnosed diabetes is almost four times as prevalent in Bangladeshi men, and almost three times as prevalent in Pakistani and Indian men, compared with men in the general population. Among women, diabetes is more than five times as likely among Pakistani women, at least three times as likely in Bangladeshi and two-and-a-half times as likely in Indian women, compared with women in the general population. During the month of Ramadan, Muslims are required to abstain from food and drink between dawn and sunset. The Koran exempts those whose health may be significantly affected, including diabetics, pregnant women and breastfeeding mothers. However in a population based study 43% of patients with type 1 diabetes and 79% of patients with type 2 diabetes report fasting in 13 Islamic countries during Ramadan. The same study showed that fasting during Ramadan significantly increased the risk of severe hypoglycaemia, with its associated health risks.</p> <p><b>Smoking</b> Smoking has a lower prevalence (20%) in Indian men compared with the general population (24%), and a much higher prevalence in Bangladeshi men (40%).</p> <p><b>Hypertension</b> The other notable difference is the prevalence of hypertension, with a significantly higher prevalence in Indian men (33%) than in other South Asians (20%) in Pakistanis and 16% in Bangladeshis), though comparable with the general population (32%) Prevalence for women in all South Asian populations is lower than the general population.</p>
Some Muslim and Jewish communities	<p><b>Consanguinity</b> Marriage to a blood relative is common in some Muslim and Jewish communities. This more than doubles the risk of recessively inherited disorders such as congenital deafness and congenital heart disease. However, social and cultural reasons, not religious belief, are behind consanguineous marriage, and public understanding of the genetic facts behind consanguineous marriage could be increased through the participation of the media, scholars, physicians, nursing staff and society leaders including religious leaders.</p>
Christians	<p>Because the Christian population is so diverse, generalisations based on ethnicity are less easily made. However, of note is that White Irish men and women, who are overwhelming Catholic, are more likely than any other ethnic group to drink in excess of government recommended guidelines (58% of men and 37% of women).</p> <p>The Determinants of Adolescent Social wellbeing and Health study shows the tendency towards obesity to be higher for Black Africans, especially in adolescent girls. A high</p>

## Public health issues summarised by ethnicity or religion

Community	Public health issues or determinants of ill-health relevant to grouping
	<p>proportion of Black Africans report as Christian.</p> <p>The majority of HIV infections in the UK is among heterosexual Black Africans, many of whom will be church (and to a lesser extent, mosque) attendees.</p> <p>Men born in the Caribbean are 50% more likely to die of stroke than the general population.</p> <p>Elevated incidence rates of schizophrenia in UK Black Caribbean's have been consistently reported.</p>

### 4.1.2 Religious constraints on prescribing medication

#### The main dietary restrictions of religions:

##### Christianity

Christians have few restrictions on their diet, and none are compulsory. The historical recommendation. Practising Roman Catholics are more likely to observe fasting on holy days and specified periods of the church year, such as Lent and Seventh-day Adventists are encouraged to eat a vegetarian diet and have prohibitions on pork, alcohol, coffee and tea.

##### Buddhism

Buddhists have no set dietary laws and there is a great diversity. Many Buddhists refrain from meat and encourage a vegetarian diet, with moderation in all foods, and some are vegan. Other Buddhists, often from China or Vietnam, will not eat 'pungent spices' eg onion, garlic or leek.

##### Islam

In Islam, under sharia law, all food and drink is permitted, ie 'halal', unless explicitly prohibited, in which case it is 'haram'. Alcohol can lead to addiction, misbehaviour and has a negative impact on health, therefore it is classed as haram and prohibited. Something considered halal can become haram in preparation, for instance by using alcohol in the process. Pork and its by-products are haram for observant Muslims but according to a letter by the WHO on the findings of Islamic legal scholars, transformation of pork products into gelatin alters them sufficiently to make it permissible for observant Muslims to receive medicines containing pork gelatin, although others do not agree.

Animals not slaughtered in a specified way or that are unhealthy, diseased or a possible cause of death are all haram. Foods containing animal fats or emulsifiers from animal derivatives, blood or its by-products are haram. The acceptance of shellfish varies by community. Muslims sometimes use the term 'mushbooh' when it is unclear whether substances are halal or haram.

Practising Muslims fast from food and drink from dawn to sunset during the month of Ramadan, the ninth month of the Islamic lunar calendar.

##### Judaism

Judaism has a complex set of dietary laws (kashrut) that determine what food and drinks are permitted. Those that can be eaten are 'kosher' and divided into three categories: meat, dairy and pareve (permitted foods that are neither meat nor dairy). Meat and dairy products must not be eaten together; pareve products can be eaten with either meat or dairy. Shellfish and pork are strictly forbidden by Jewish dietary laws. Observant Jews will only consume kosher meat, ie from ruminant animals with split hooves (eg beef, lamb, mutton and goat) or poultry (chicken, duck, turkey and goose) that has been slaughtered according to kashrut law to be passed as kosher. Foods not complying with these specifications are non-kosher.

Prescribers need to consider and alert their patients about medications that might contain wheat starch during the festival of Passover, when wheat, barley, rye, oats and spelt are not permitted.

## **Hinduism**

Many Hindus practise vegetarianism, but dietary practices vary between individuals. They do not usually eat eggs, but cakes or biscuits containing eggs are often considered acceptable. All other meat and fish is restricted or avoided. The cow is sacred, therefore beef cannot be eaten, but cows' produce is pure and desirable. There are numerous fasting days.

The use of bovine-based drugs or cartilage transplants derived from cattle, would have belief implications for Hindu patients, as well as for some vegans and vegetarians. Many Hindus will maintain a vegetarian diet during Diwali and Navratri, even though they might eat some meat at other times.

## **Sikhism**

Some Sikhs are vegetarians, and may avoid all meat, fish and eggs. Others might eat meat but not that slaughtered according to the guidelines of other religions (halal or kosher), and some do not eat beef or pork. Observant Sikhs will not consume alcohol.

Many pharmaceutical products have constituents that would have implications for Jewish, Muslim, Hindu and Sikh patients e.g. those with active ingredients directly derived from animals include: Heparin, an injectable anticoagulant, Conjugated Oestrogens, used in some HRT preparations, Insulin (bovine or porcine) extracted from the pancreas of cows or pigs. However animal insulin, although still available on prescription, has largely been replaced by human insulin or insulin analogues.

Over the counter supplements with active ingredients that could be derived from animal products include: Calcium Tablets, Glucosamine, Chondroitin, Iron supplements.

## **How prescribers can help**

Many drugs come in different forms (eg tablets or solution, as well as capsules), so a different formulation with permissible ingredients could be considered. Some manufacturers make capsule shells from a plant source, allowing Muslim and Jewish patients to consume them, as they are kosher and halal certified. There are also plant sources for stearic acid and its salts, therefore the source of magnesium stearate needs to be verified with the manufacturer before deciding on an alternative source. If the chosen treatment is not available in a different formulation, there might be a similar treatment from the same drug class that is free of nonpermitted substances. If all alternatives have been explored without success, people might wish to consult their religious leader for advice (Ogden 2016).

### **4.1.3 Language and Literacy**

Poor linguistic competence will be a major barrier to access to health and social care for some people. As such, interpreting services are required to adequately gain consent, diagnose and treat some people. This can be a complex issue due to many languages and dialects exist in the population.

Refugees are reported to develop a survival level of competence in the use of English. There is evidence that ability to speak English is lower for women than it is for men, and is poorer for those born outside of the UK, and declines with increasing age.

Also although people can speak English they may not be able to read it. This factor shows itself through unfamiliarity and limited knowledge of health and social services

## Recommendations

Gateshead Council and the Newcastle Gateshead Clinical Commissioning Group (CCG) should:

- Consult families from BME communities about their specific needs when commissioning services;
- Consult families from BME communities about information in appropriate languages and ways of promoting to BME communities;
- Ensure providers' information on services is readily available in appropriate languages and is promoted to BME communities;
- Commission services that are accessible for local BME communities, including in appropriate locations and at appropriate times e.g. highlight and promote stop smoking services to communities prior to Ramadan;
- Commission peer support forums for parents and carers from local BME communities and, where appropriate, tailored support services;
- Provide advocacy, translation and interpretation services for families from BME communities who require support during health and social care pathways;
- Ensure that the BME communities chapter of the Health and Wellbeing Board's Joint Strategic Needs Assessment is linked to all other chapters;
- Promote accessible services to teach English as second language.

### 4.1.4 Workforce equality

The link between staff equality and the quality of care is now well-established. Workforce equality in the NHS is gaining greater attention due to the NHS Workforce Race Equality Standard (WRES), (NHS England)

Nationally, staff from BME groups are still under-represented in management roles – they hold only 10% of NHS non-medical and 13% of adult social care management jobs.

Women are under-represented in health and social care management roles – men make up 19% of NHS non-medical staff, but fill 30% of management roles. The difference is not so large in adult social care – where men are 18% of the workforce and 22% of managers.

These broad categories mask some differences between grades within roles. For example, nurses from BME groups are more likely to be in the lower grade posts (for example A4C band 5, which accounts for 66% of Asian or Asian British nurses, 57% of Black or Black British nurses, and only 46% of White nurses). They are also less likely to be in the highest grade posts (bands 8 or 9 which account for 1% of Asian or Asian British nurses, 31% of Black or Black British nurses and 5% of White nurses). Female NHS managers are more likely to be in lower grade management roles than their male management colleagues (Health and Social Care Information Centre).

National evidence suggests people from minority ethnic groups are proportionately over-represented in the medical workforce when compared to the general population in all English regions. However, white staff are more likely to be employed at the Consultant grade and staff from ethnic minority groups at the lower Associate Specialist and Staff Grade levels.

We have not gathered data on local employment of staff from minority groups.

In the North East there is an under representation in the 'routine and manual' occupations for the Indian, Asian Other and Black Caribbean ethnic minority groups. The North East also has an over representation in the 'intermediate occupations' for both the Indian and Pakistani ethnic minority groups.

## Recommendations

Partners in the Health and Wellbeing Board should analyse workforce data in order to establish numbers and trends of BME workforce across health and social care.



### 4.1.5 Staff experience

From NHS England, analysis of the NHS 2015 staff survey results, it was found that staff from BME groups were more likely than staff from White ethnic groups to experience bullying and harassment from other staff across all types of trust. However, the picture was much more mixed around staff experiencing bullying and harassment from members of the public. This is similar to the analysis of the 2014 results carried out by NHS England.

The indicators with the largest difference between staff from BME groups and staff from White ethnic groups, across all types of Trust, were those relating to personal experience of discrimination, and belief that their employing Trust provided equality opportunities. This was also the case in 2015. For example, in 2015, 14% of staff from BME groups working in acute trusts said that they had experienced discrimination, compared with 6% of staff from White ethnic groups.

## 4.2 Health needs in early years (0-25 years)

### 4.2.1 Maternal and Infant Mortality

In 2016 the Equality and Human Rights Commission (EHRC) reported that some health inequalities are improving. There has been an improvement in infant mortality rates for White, Pakistani, Bangladeshi, African and African Caribbean children.

In the 2015 NHS maternity services survey, there were some differences in the support people received around childbirth. Asian, Asian British, Black, Black British and Arab people were more likely than people from White ethnic groups to report being given the information or explanations they needed during their care in hospital after birth.

### 4.2.2 Breastfeeding

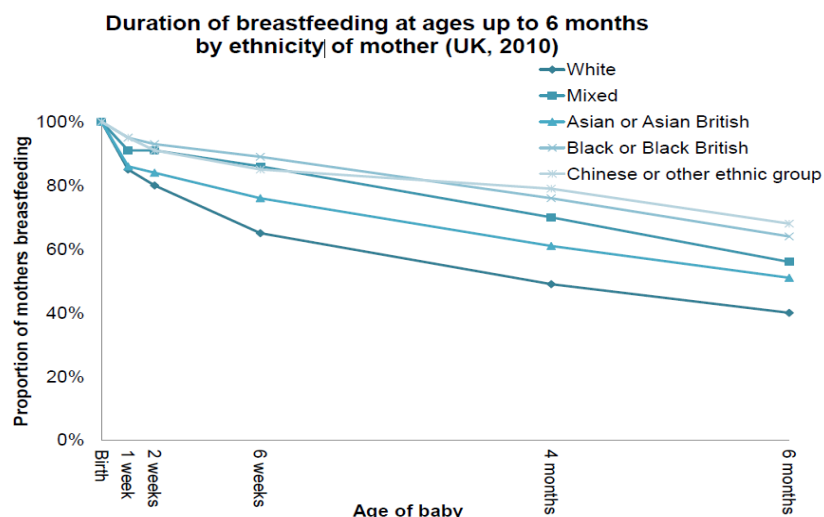
Nationally, the highest incidences of breastfeeding were found among mothers aged 30 or over (87%), those from minority ethnic groups (97% for Chinese or other ethnic group, 96% for Black and 95% for Asian ethnic group), those who left education aged over 18 (91%), those in managerial and professional occupations (90%) and those living in the least deprived areas (89%).

Prevalence of breastfeeding at all ages of baby up to nine months was highest among certain demographic groups. For example, when babies were aged six months, this was highest for mothers from managerial and professional occupations (44%), those who left education aged over 18 (46%), those aged 30 or over (45%), those living in the least deprived areas (40%) and those from minority ethnic groups (66% for Chinese or other ethnic group, 61% for Black and 49% for both Asian and Mixed ethnic groups).

#### Ethnicity of mother

We have not secured local data on breastfeeding by ethnicity.

Mothers from Asian, Black and Chinese or other ethnic groups were the most likely to breastfeed initially, while White mothers were the least likely (mothers of Mixed ethnic origin fell in between the two). This difference was maintained through until later ages, although to a lesser extent among Asian mothers: At six months, 66% of mothers of Chinese or other ethnic origin and 61% of Black mothers were still breastfeeding. Prevalence at six months among Asian mothers was the same as for mothers of Mixed ethnic origin (49%), but all



Base: All Stage 3 mothers in Great Britain who breastfed initially (7374)



these groups had higher prevalence than White mothers (32%).

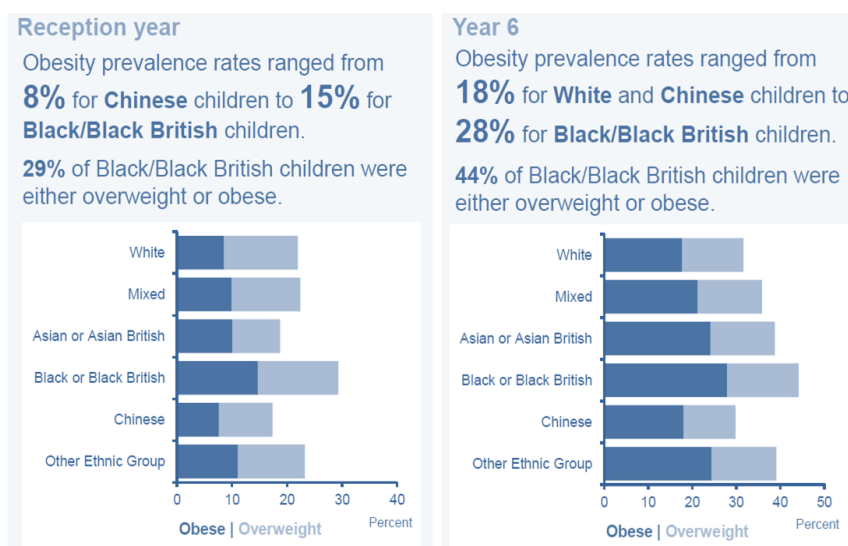
Particularly noticeable was the high level of breastfeeding among Black and Chinese or other mothers and the relatively low fall-out rate. While 95% of Black mothers breastfed initially, this had fallen to 85% at six weeks, and to 73% at four months. For mothers of Chinese or other ethnic origin, the figures were 96%, 82% and 76% respectively.

Respondents from White ethnic groups were the least likely to report being given consistent advice about feeding their baby. This is an interesting pattern, as it differed from many other health and social care surveys, which show that people in BME groups are less likely than people in White ethnic groups to say that they are given adequate information. There could be some learning from maternity services around good communication to people from a range of ethnic groups.

### 4.2.3 Childhood obesity

National data suggest the proportion of children who are overweight or obese varies by ethnicity and age, with rates being highest amongst those who were Black / Black British and lowest amongst Chinese at both ages. Rates increased from Reception to Year 6 across all ethnicities.

#### Childhood obesity by ethnicity in England



Source: National Child Measurement Programme (NCMP) 2014/15

Of the 4,344 Gateshead pupils in Reception or Year 6 who had their BMI recorded in 2015/16, 3,050 also had their ethnicity recorded (note that this data includes pupils from Jewish schools). On average 22.2% were overweight or obese at Reception and 37.5% in Year 6. However there is considerable variation across ethnic groups as follows:

Ethnicity	Reception	Year 6
	%	%
White British	23.6	37.1
White Other	25.0	49.1
Mixed	31.0	48.3
Asian	17.1	44.8
Black	37.5	37.5
Other	30.8	36.4
Ethnicity not recorded/stated	20.5	33.3
<b>Total</b>	<b>22.2</b>	<b>37.5</b>

(Caution should be exercised in interpreting these figures as confidence intervals do not show significant differences and therefore they should be treated as indicative only)

### 4.2.4 Poverty

People from most ethnic minority groups are generally more deprived in terms of socio-economic status, and poverty as indicated by eligibility for free school meals. The Pakistani and Bangladeshi groups have the lowest proportion of the population in ‘managerial and professional occupations’. The highest proportions of children eligible for free school meals are among the Travellers of Irish Heritage, Gypsy/Roma, Bangladeshi and Black African groups.

### 4.2.5 Educational Attainment

Nationally, educational attainment is highest among the Chinese group and in every ethnic group, except the Chinese, those who are eligible for free school meals have a lower educational attainment than those who are not. The difference in education attainment between those who are eligible for free school meals and those who are not is most marked amongst the White groups.

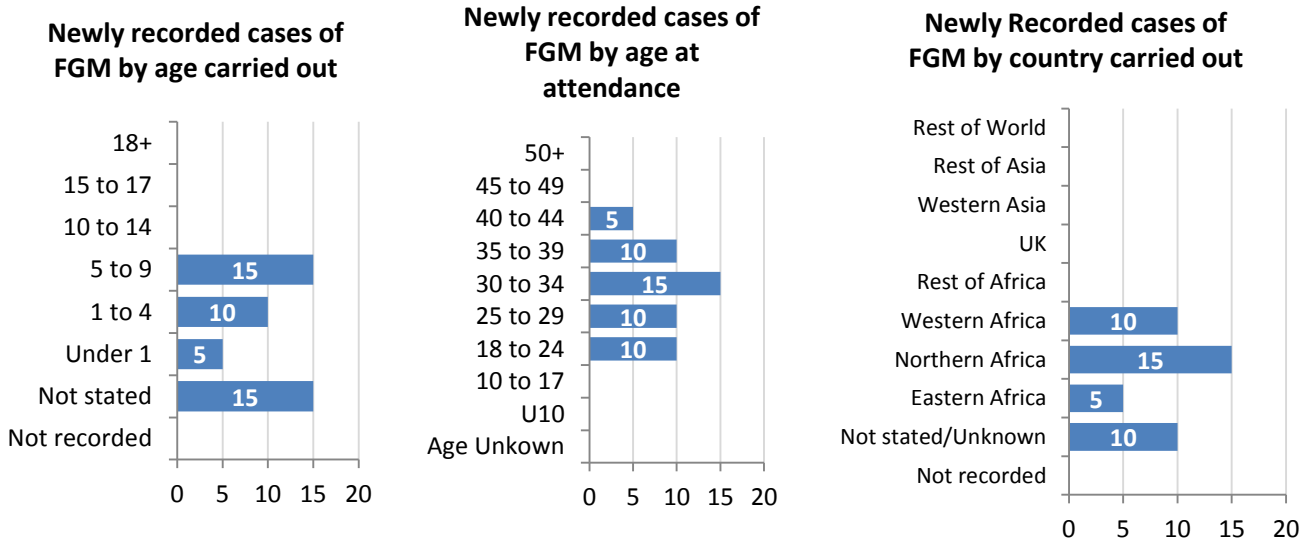
*"White families meet white professionals and seem to be on personal terms. We are made to feel like outsiders."*

'Progress 8' is an educational attainment measure that was introduced in 2016 and looks at the progress pupils have made at key stage 4. It is one of the successors to the more familiar GCSE attainment measures. With Progress 8, a score of 1.0 means pupils make on average a grade more progress than the national average; a score of -0.5 means they make on average half a grade less progress than average. In Gateshead in 2015/16, overall the Progress 8 score was -0.15. This was particularly evident for the White ethnic group with a score of -0.19. However, BME groups performed significantly better, with scores of 0.27 for Mixed, 0.85 for Asian, and 1.24 for the Black ethnic group.

### 4.2.6 Female Genital Mutilation (FGM)

Data on Female genital mutilation is not available at local authority level. The charts below show data for the combined Newcastle Gateshead CCG area. Numbers between 0 and 4 have been suppressed by the data provider (HSCIC) to avoid disclosure and figures are rounded to the nearest 5.

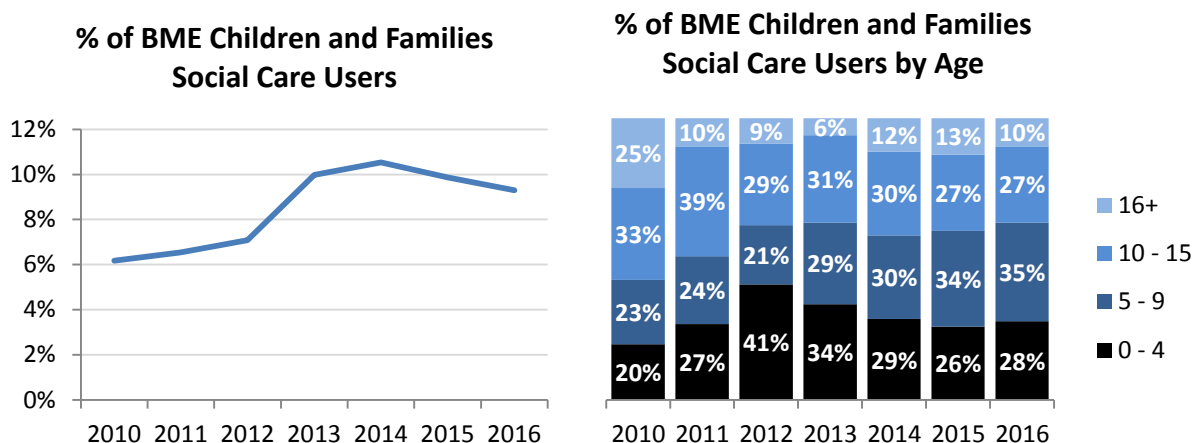
NB Where the definition ‘Newly Recorded’ is listed this stands for women and girls with FGM who have had their FGM information collected in the enhanced dataset for the first time. This will include those identified as having FGM and those having treatment for their FGM. *Please note Newly Recorded does not necessarily mean that the attendance is the woman or girl’s first attendance for FGM.*



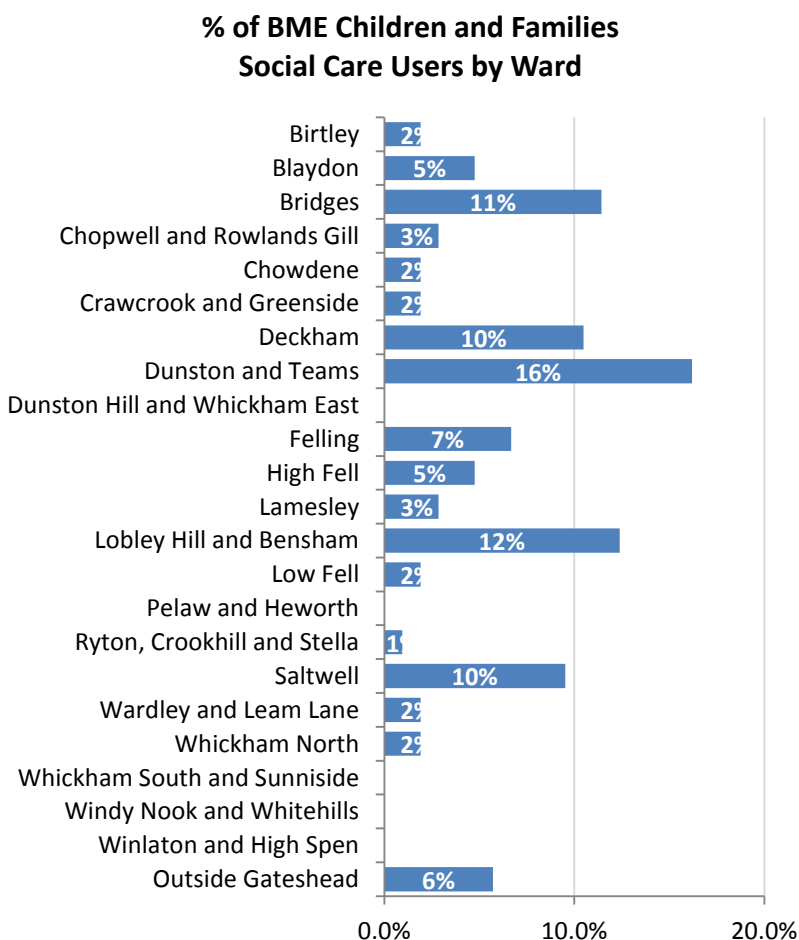
Source: HSCIC, NewcastleGateshead CCG level data rounded to nearest 5, 2015/16

### 4.2.7 Children & Families Social Care BME

This information received from Gateshead Council relates to children under 18 and excludes unborn. The data combines Children in Need (CIN), Child Protection (CP) and Looked After Children (LAC). A snap shot was taken to show data for these children as at 31st August each year back to 2010.



Note that given approximately 9% of school age children are from the BME (including White Other) population, it can be seen that children from BME backgrounds are not disproportionately represented in social care.



### 4.2.8 Vulnerable Children (LAC, CIN, CP)

In terms of the reasons that children are looked after, or are classed as ‘in need’, there is little variation between children in BME groups and those in the White British group.

#### Looked After Children

The main reason that children are classed as being in need is ‘neglect’. This was the main reason for 79% of both White British and BME children.

#### Children in Need

The main reason that children are classed as being in need is ‘neglect’. This was the main reason for 67% of White British children and 77% of those in a BME group.

The child protection register includes the additional category ‘emotional abuse’. Children on the register from BME groups are more likely to fall within this category than those from the White British group.

#### Child Protection Register

The main reasons that children are on the child protection register are ‘neglect’ and ‘emotional abuse’. ‘Neglect’ is the main reason for 62% of White British children and 49% of children in a BME group. However, ‘emotional abuse’ is the main reason for a much higher proportion of BME children at 46% compared with 28% of White British children.

## 4.2.9 Youth Offending

Information received from the Gateshead Youth Offending Team (YOT) shows that there was a decrease of 18% of the total number of Youth Justice Disposals during 2015/16 when compared to the previous year. The number of BME and White Other cases remained low.

**Ethnicity of Youth Offending Team cases 2014/15 and 2015/16**

Ethnicity	2014-15		2015-16	
	No.	%	No.	%
White - British	152	95.6	124	95.4
BME and White Other	7	4.3	6	4.7

## 4.3 Healthy lifestyles

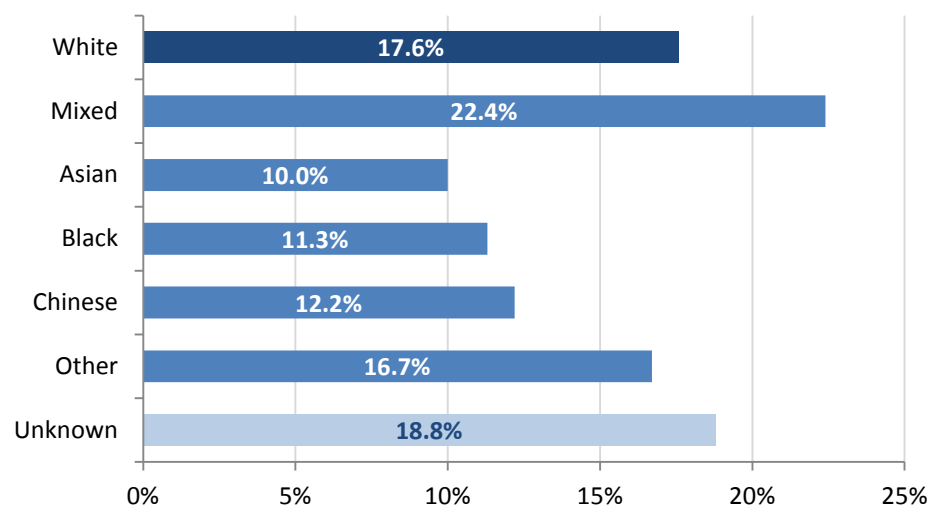
### 4.3.1 Tobacco use

All forms of tobacco use can harm health. Tobacco use amongst BME communities includes smoking of cigarettes, bidi (thin cigarettes of tobacco), or shisha (water pipe/ hookah) as well as smokeless tobacco (see guidance at Appendix 2) such as betel quid, paan or gutkha (which is a mixture of ingredients including betel nut, herbs and spices and often tobacco wrapped in betel leaf). Regarding religious themes, Bush et al (2003) found that there was some confusion about the Islamic position on smoking, with most people believing that it was mukrooh (discouraged) but not haram (forbidden), and many feeling that as long as the smoker was not addicted, smoking was acceptable.

Smoking was universally felt to be taboo for women, associated with stigma and shame, and often hidden, with associated under-reporting. Among Bangladeshi men smoking was associated with socialising, sharing, and male identity.

Smoking prevalence is substantially higher amongst lower socio-economic groups, people with a mental illness and certain ethnic groups. The chart to the right shows smoking prevalence in North East England for BME populations.

**Smoking Prevalence in the North East by Ethnic Group**



Source: Annual Population Survey 2015

Smoking is much more common among Bangladeshi men (40%) and Pakistani men than in the general population, Indian men and South Asian women (HSCIC 2013). Cancers of the trachea, lung, and bronchus are the highest cause of death from cancer in South Asian men, with smoking being the principal risk factor. Research has shown that using smokeless tobacco raises the risk of mouth cancer and oesophageal cancer.

Data from the CCG (see Appendix 3) shows that in Gateshead 8.1% of those recorded as from the BME (including White Other) population are smokers, compared to 10.9% of those recorded 'White British'. Given the prevalence of smoking locally is understood to be 17.9% there may be under-reporting in some way. We have no local data on use of smokeless tobacco.

### Smoking cessation

Monitoring of smoking cessation by ethnic group is important but hampered by a lack of reliable data on smoking prevalence. Asian, Black and Mixed minority populations have lower rates of setting a smoking quit date for both males and females. Females are more likely to set a quit date than males in every ethnic group.

The reasons for this probable under-use of stop smoking services in the main minority ethnic groupings are unknown and likely to be complex, including such barriers as the availability of materials in appropriate community languages.

**Number of people setting a quit date and successfully quitting (NHS stop smoking services 2015/16)**

	Setting a quit date			Successfully quit		
	Male	Female	Total	Male	Female	Total
White British	878	1226	2104	398	578	976
White Other	21	13	34	9	9	18
BME	23	11	34	7	6	13

Source: Gateshead Stop Smoking Services Monitoring Return 2015/16

### Recommendations

- The CCG should take steps to encourage practices to record smoking status and ethnicity of all patients
- The Director of Public Health should consider whether there are particular steps that could be taken to encourage use of smoking cessation services by local BME and White Other communities

### 4.3.2 Alcohol use

White Irish men and women are more likely than any other ethnic group to drink in excess of government recommended guidelines (58% of men and 37% of women). The highest treatment rates for drug misuse are in the Mixed group and lowest in the Asian group. Drinking prevalence for adults Health Survey for England, (2014) is shown below.



#### Drinking by ethnicity

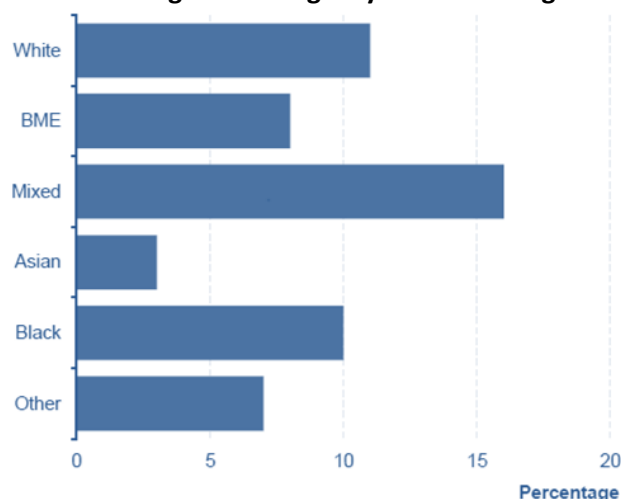
The proportion of adults who drank alcohol varied between ethnic groups. White men and women were most likely to be drinkers whilst Asian men and women were least likely to be.

### 4.3.3 Drug use

The prevalence of cannabis use among 15 year olds in England by ethnicity is shown in the chart below. It illustrates that while overall, BME prevalence is lower than that in the White ethnic group, the highest prevalence is in the Mixed ethnic group at 16%. The lowest prevalence was in the Asian ethnic group.

According to the National Drug Treatment Monitoring System's Adult Activity Report (Partnership), in 2016/17 92.9% of drug and alcohol treatment clients in Gateshead were White. 1.3% were White Other, 0.5% Mixed, 1.1% Asian, 0.4%

**Prevalence of drug use among 15 year olds in England**



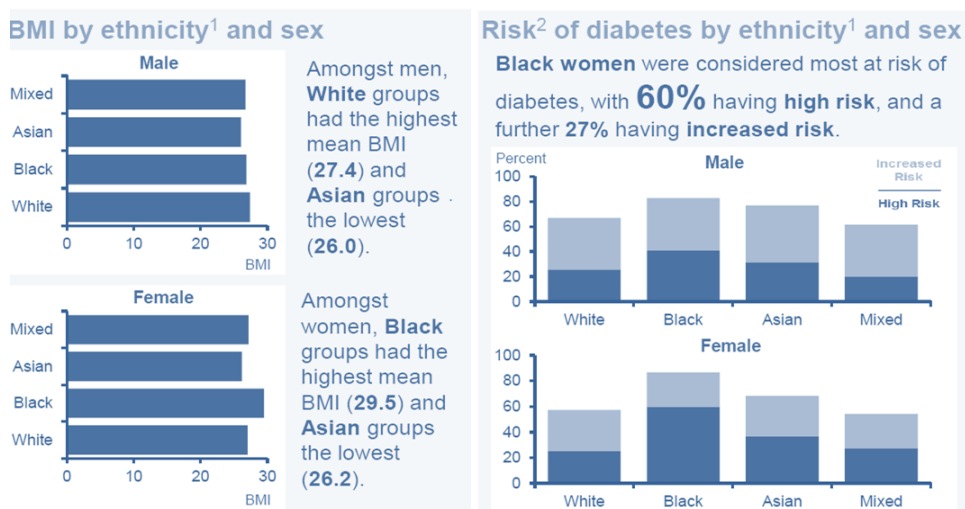
Source: What About Youth? Survey 2014

Black, 0.7% Other, and the rest had not stated their ethnicity.

### 4.3.4 Obesity

Amongst adults, national figures (HSE 2014) show the average BMI for both men and women was 27.2 kg/m<sup>2</sup>, which was in the overweight range (25 – 29.9 kg/m<sup>2</sup>).

#### Adult obesity by ethnicity in England



Figures from the CCG (appendix 2) show the recorded prevalence of obesity is 17.2% amongst the White British population but only 7.7% amongst the BME (including White Other) population. Whilst the lower levels amongst the BME population may simply reflect the younger age profile of this population (see 3.1.1 above) the overall figures suggest there may be under-recording of obesity by practices.

#### Recommendation

- The CCG should take steps to encourage practices to record BMI and ethnicity of all patients

### 4.3.5 Physical activity

Exercise and physical activity is not an issue for some cultures as people generally live active lives with active jobs. The cultural and religious issues of women and exercise have been identified by the refugee and asylum seeker community. While some men from the refugee and asylum seeker community can easily do some form of exercise through e.g. community football activities, it is harder for women from some parts of this community because of their cultural upbringing and family responsibilities.

In terms of being active, refugees and asylum seekers have said they wanted information about activities that aren't focussed on a gym, like yoga, but that these activities would need to be free. Financial allowances allocated to asylum seekers are received to purchase food only.

Regional refugee Forum NE reports that asylum policy has been cited frequently as barrier to being healthy. As people are not allowed to work while awaiting a decision on the asylum claim, they spend a lot of time indoors being inactive. Also simply walking around in some neighbourhoods is not an option because of hostile attitudes and instances of hate crime, so people stay indoors.

We have no specific local data on physical activity amongst the local BME population. National data shows that the Asian (not including Chinese) and Black ethnic groups are significantly less likely to achieve the recommended level of physical activity per week (150+ minutes) than the England average of 57.0% at 49.7% and 52.3% respectively.



### 4.3.6 Eating Habits

National data shows that the Black, Asian (not including Chinese) and Other ethnic groups are significantly less likely to consume the recommended 5+ fruit and vegetables per day than the England average of 52.3% at 36.4%, 40.0% and 46.7% respectively. We have no local data on diet.

The refugee and asylum seeker community have indicated that they would like more information about healthy food consumption as the messages weren't clear and caused confusion as they were often only relevant to common UK diets. People particularly wanted information about weight management and healthy ingredients.

Food banks are accessed by asylum seekers and access to food from this source is often greatly appreciated by the people receiving help. People accessing the food bank receive food which has been kindly donated by the public for distribution to people in who require access to food for 2-3 days. Types of food donated are non-perishable foodstuffs which are often tinned foods and dried foods. Such processed foods are often high in sugar, refined carbohydrates and low in fibre and contain artificial ingredients, for example, preservatives, artificial colours, and artificial flavours. Whilst additives are non-nutritive substances added intentionally to food, generally in small quantities to improve appearance, flavour, texture or storage properties, amounts used in food are usually regulated by law.

#### Cultural differences

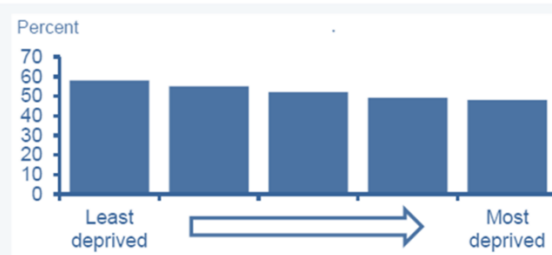
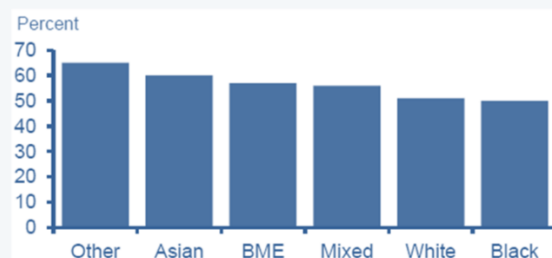
Cultural differences have been identified in local discussions as a barrier to staying healthy in the UK. Being overweight in in some cultures is seen as a positive attribute because it is a sign that people can afford to live well. Many place high value on fast food and fizzy drinks because these are marketed as desirable and denote higher social status in their home countries. In the UK they are affordable and people indulge in them without knowing the health risks. For some people this also includes alcohol, which they find more affordable here.

Many asylum seekers and refugees who come to the UK from hot climates are used to a diet high in salt, sugar and fat. In their own countries this is not an issue as people are more active, burn more calories and sweat more. However, when people come to the UK the climate is colder and they are less active. Obesity and diabetes are an increasing concern among those who have been in the UK longer. NICE Guidance on BME: preventing ill health and premature death in black, Asian and other minority groups (PH46) is summarised in Appendix 2.

### Consumption of 5+ fruit and veg per day amongst 15 year olds by ethnicity in England

#### Consumption by ethnic group

60% of Asian children reported they ate 5 or more portions a day, compared to 50% of black children.



Source: What About YOUth? Survey 2014

#### Recommendations

The Health and Wellbeing Board should:

- consider how best to work with local BME communities and community organisations to address health lifestyle issues;
- review whether NCMP data and QOF data in General Practice is consistently recorded and whether services are taking account of this.

### 4.3.7 Infectious Diseases

Tuberculosis: nationally Black Africans, along with the 'Other' ethnic group, have the highest rates of tuberculosis in the English regions. In Gateshead the incidence of tuberculosis is 6.8 per 100,000 – significantly below the



national incidence of 12 but higher than the regional level of 5.5. The total number of new cases remains small, and is not broken down by ethnicity.

HIV: the highest prevalence of HIV in the North East by ethnic group is amongst Black Africans, although the number of new infections in this group is falling. It is estimated there are less than 200 people living with HIV in Gateshead, and the number is not broken down by ethnicity. Gateshead is not considered to be an area of high HIV prevalence.

#### 4.4 Long term conditions

In England and Wales as a whole (using standardised ratios) the following groups reported lower than average 'not good' health: White British, White Other, Chinese, Black African and the Other ethnic group. All other groups have higher than average 'not good' health.

The Pakistani and Bangladeshi group reported the highest ill health in England and Wales as a whole and in every region. The Chinese have the lowest ill health in every region, significantly lower than the average for England and Wales.

The pattern by region and ethnic group is complex. Generally the northern and midlands regions and London have higher ill health than the southern regions. However, even in the southern regions, some ethnic groups have higher ill health than the average for the total population of England and Wales: White & Black Caribbean, Pakistani, Bangladeshi, Black Caribbean and Black Other.

In the northern regions some have lower ill health than the average for the total population of England and Wales e.g. the Chinese.

Long Term Conditions (LTCs) are diseases that cannot currently be cured, but are controlled by medication and/or other treatment. They are health problems that require ongoing management over a period of years or decades and are often characterised by acute exacerbations of ill health resulting in repeated admissions to hospital.

National data shows the prevalence of long term conditions such as type 2 Diabetes, Cardiovascular Disease and Stroke is up to six times higher (and occurs at a younger age) among black, Asian and other minority groups. Multi layered determinants of Cardiovascular Disease would also indicate higher levels of Diabetes and obesity.

Nationally, the prevalence of long term conditions such as type 2 diabetes, coronary heart disease and stroke is up to 6 times higher (and they occur from a younger age) among black, Asian and other minority ethnic groups. The evidence confirms that Asian, black African and African-Caribbean and other minority ethnic groups are at an equivalent risk of diabetes, other health conditions or mortality at a lower BMI measurement than the white European population. NICE and other sources highlight the importance of awareness raising for BMI measurement thresholds that can be used for recognising risk and as a trigger for intervention. In addition, these groups progress from being at-risk to being diagnosed with these conditions at twice the rate of white populations. So tackling this issue will help tackle health inequalities and satisfy public sector obligations under the Equality Act 2010.

However, the local data do not reflect this expected prevalence: practice disease registers (see Appendix 3) show a prevalence of every reported condition (asthma, cancer, coronary heart disease, chronic obstructive pulmonary disease, diabetes, epilepsy, osteoporosis, heart failure, hypertension, stroke, transient ischaemic attack, palliative care) that is at least 3 times higher in the White British population than amongst BME communities. This may be a result of under-reporting, under-recording or be because prevalence of many long-term conditions increases with age and the BME population in Gateshead is relatively young. Note the figures at Appendix 3 include 'White Other' in the BME total, although disease patterns may vary considerably between communities.

Uptake of health checks by the BME community is low at 6.7% compared to 15.9% of the White British population (see Appendix 3).

#### 4.4.1 Haemoglobinopathies

Low levels of uptake (and apparent poor access to services) may be attributable to services for 'ethnic' diseases such as haemoglobinopathies i.e. sickle cell disease among people of West African origin and West Indian descent, and thalassaemia among people of Asian and Mediterranean origin. Access may be poor because they are not required by a majority white population. Also some diseases are rare in ethnic minority populations and therefore variation in need will affect the need for services in ethnic minority populations. Therefore, service provision should take account of the fact that diverse populations may still be at risk and also that their risk profile may change over time. This is particularly linked to conditions linked to lifestyle and environmental factors as well as genetic makeup. We have no local data on the incidence of such diseases.

#### 4.4.2 Cardiovascular Disease (CVD)

Interventions to reduce the risk of CVD are documented based on the multi-layered determinants of this disease, such as smoking, diabetes, obesity, lack of exercise, poor diet, low socio-economic status and inequalities in health care. The increased risk of CVD in the South Asian population is well recognised, with various factors given as explanations for the disparity, including language barriers and cultural taboos.

A higher than average proportion of admissions due to coronary heart disease is found in the Pakistani, Bangladeshi, Indian and Mixed White & Asian ethnic groups, reflecting the higher prevalence of CHD in these groups. However, analysis of revascularisation procedures generally shows provision in proportion to need.

A number of community-based interventions for health education specific to these communities have been developed. NHS health checks have been part of public health screening strategy since 2008 and, although there is reference to faith and voluntary sector organisations being well-placed as a platform for checks for those "not in touch with organised health care", this strategy has limited worked examples. However Rao et al. (2012) recommended that "screening UK south Asians in religious settings is a feasible approach to identify a high proportion of individuals with vascular risk factors in this community" (p.266) as a route to identify CVD risk factors in members of this population who had not presented themselves anywhere else.

Men born in the Caribbean are 50% more likely to die of stroke than the general population.

Local data from the CCG reports CHD all-age prevalence of 1.4% amongst the BME (including White Other) population in Gateshead, compared with 5.5% amongst the White British population. This appears lower than may be expected for the BME communities, but could be explained by their younger age profile and the inclusion of 'White Other'.

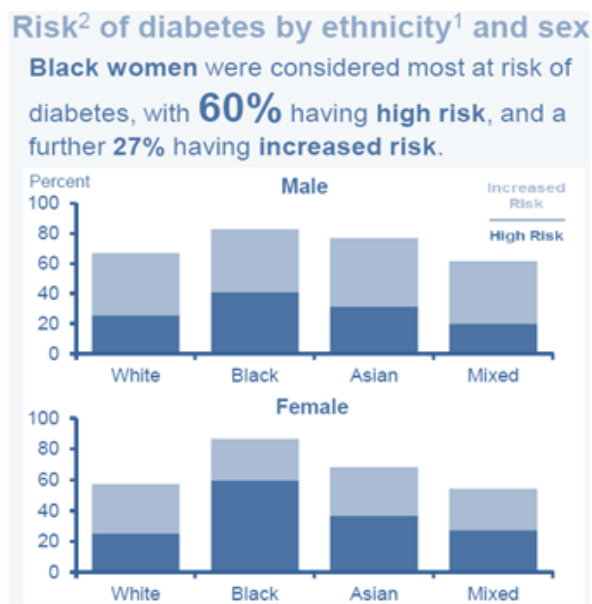
#### 4.4.3 Diabetes

NICE Guidance (see Appendix 2) emphasises that members of black, Asian and other minority ethnic groups are at an increased risk of diabetes at a lower BMI (23 kg/m<sup>2</sup> to indicate increased risk and 27.5 kg/m<sup>2</sup> to indicate high risk) than the white population (25 kg/m<sup>2</sup> is still valid for white European adults).

Nationally, there is a higher prevalence of diagnosed non-insulin dependent diabetes among Asians and a raised rate among Black Caribbean. In addition several studies report inadequate quality of health care for Asian, Black African and Black Caribbean diabetics, and poor treatment compliance, which may therefore result in a higher than average number of hospital admissions.

Indian, Pakistani, Bangladeshi, Asian Other and Black Caribbean groups have a significantly high proportion of admissions due to diabetes in all regions (except for Black Caribbean in North East), reflecting the high prevalence of diabetes among these ethnic groups. Among the Black Other group all regions have high proportions except for the North East and the South East. The Indian and Pakistani groups have a higher than average proportion of hospital episodes for cataract surgery, reflecting reports of a higher prevalence of cataracts in these groups. This is consistent with their higher prevalence of diabetes, a known risk factor for cataracts.

The risk of diabetes derived from BMI and ethnicity (HSE 2014) is shown in the chart below.



Source: Health Survey England 2014

Type 2 diabetes is up to six times more common in people of South Asian descent than in the general population. According to the Health Survey for England 2014, doctor diagnosed diabetes is almost four times as prevalent in Bangladeshi men, and almost three times as prevalent in Pakistani and Indian men, compared with men in the general population.

A recent report from the Care Quality Commission (2016) recommended that education courses are developed and evaluated so that everyone, including those from black and minority ethnic groups (and with a learning disability), can gain the knowledge and skills they need to manage their diabetes.

Local data from the CCG (see Appendix 3) reports diabetes all-age prevalence of 1.7% amongst the BME (including White Other) population in Gateshead, compared with 6.1% amongst the White British population. This appears lower than may be expected for the BME communities, but this could be explained by their younger age profile and the inclusion of 'White Other' in the BME population numbers. We can anticipate that the numbers of local people from BME backgrounds diagnosed with diabetes will increase in the next few years.

Local guidelines on the management of impaired glucose regulation state that “High risk groups include people aged >25 of South Asian, Chinese, African-Caribbean, black African and other high-risk black and minority ethnic groups”, but do not specifically advise that GPs should use the lower BMI thresholds to trigger intervention.

**Recommendation**

- The CCG should review its Management of IGR Guidelines to ensure they fully reflect NICE guidance PH46 in respect of BMI in black, Asian and other minority ethnic groups

**4.4.4 Cancer**

The British Journal of Cancer (July 2013) revealed a worrying rise in cancer rates among South Asian people in the UK. Their study showed a rise in cases of cancer in South Asians over a decade, which compares with an overall drop in the rates of non-South Asians. It is the younger generations of South Asians experiencing the most marked rise in number of cancer cases. This lifestyle change is most likely due to younger South Asians growing up and adopting western lifestyles, e.g. less fresh vegetables and more high fat processed foods. It is advised by Cancer Research UK that as cancer emerges as an important issue for South Asians it is important that they have access to information about cancer, including methods of prevention through lifestyle, diet and how to spot symptoms early.

Local data from the CCG (see Appendix 3) reports diabetes all-age cancer prevalence of 1.2% amongst the BME (including White Other) population in Gateshead, compared with 3.7% amongst the White British population. The younger age of the BME and White Other population may explain this.

### **Cancer Screening**

Initial investigation of Gateshead practice data shows that those practices where screening uptake is lower tend to be based in the more deprived areas of Gateshead. Also these practices have a higher number of non-white ethnic (all groups included) with some practices having 9% of registered patients described as non-white ethnic group.

Local data from the CCG (see Appendix 3) reports uptake of cervical cancer screening as 60.3% amongst the BME (including White Other) population in Gateshead, compared with 74.0% amongst the White British population. For breast cancer screening, local uptake is 52.3% amongst the BME (including White Other) population in Gateshead, compared with 74.0% amongst the White British population. Age is not a factor given the eligible population is age-determined.

#### **Recommendation**

The CCG should work with the NHS England and PHE Screening and Immunisations team to better understand the uptake of breast and cervical cancer screening amongst women from BME (including White Other) communities, and to identify how rates might be increased.

### **4.4.5 General**

We can expect the prevalence of long-term conditions amongst Gateshead's BME population will increase as this population continues to grow and to age. The CCG's long-term conditions strategy sets out a vision for shifting the focus towards prevention, early identification, supported self-management, pro-active management by clinical teams where required, and a positive approach to end of life care. To support implementation of the strategy amongst local BME communities, additional measures will be required.

#### **Recommendations**

The CCG should:

- Ensure practices record the ethnicity of all registered patients, in line with the Equality Act (2010)
- Ensure practitioners are aware that members of black, Asian and other minority ethnic groups are at an increased risk of chronic health conditions compared to the white population
- Ensure members of black, Asian and other minority ethnic groups are aware that they face an increased risk of chronic health conditions
- Use existing local black and other minority ethnic information networks to disseminate information on the increased risks these groups face.

## 4.5 Emotional and mental health

Good mental health and wellbeing is fundamental to ensuring that individuals can lead fulfilling lives, contribute to society and achieve their potential. Good mental health is also interlinked with good physical health, with individuals with poor mental health reporting higher rates of mental health problems, and individuals with mental health problems reporting higher rates of long-term conditions.

### 4.5.1 Serious Mental Illness

Serious mental illness includes conditions such as schizophrenia, bipolar disorder and personality disorders. Elevated incidence rates of schizophrenia in UK Black Caribbean's have been consistently reported. There is a higher rate of detention under the Mental Health Act for people from BME groups.

Some BME communities are less able to identify poor mental health or perhaps western concepts of ill health, which can contribute to a lack of awareness of sources of help (Keating, 2009). Cultural pressures and ideology can impact on some BME and religious groups' access to healthcare (Weerasinghe, 2012), for example, the imperative to 'save face' and maintain social status and moral reputation (Mereish, 2012). Fear of stigma can also be a barrier and there may be the feeling that care is a family responsibility (Cooper et al. 2012).

Negative perceptions of mental health services can stem from perceived racism, language barriers and doubts about the cultural competency of services (Cooper et al. 2012). All of these factors can result in a delay in seeking help with the consequence that some BME communities only access services at crisis point and are reluctant to engage indicates that rates of suicide and self-harm are higher than average among certain groups of Asian women and young African-Caribbean and Irish people (Keating et al. 2003).

*Two people contributing to a focus group as part of this HNA stated that they had tried to commit suicide 3 times due to them being made homeless when they arrived in the country.*

Data from the CCG notes recorded all-age prevalence for serious mental illness of 0.6% amongst BME communities and 1.1% amongst the White British population in Gateshead.

### 4.5.2 Common Mental Health Problems

Common mental health problems include conditions such as anxiety, depression and phobias. Some inequalities are not improving, including the poorer health of disabled people, higher levels of mental ill-health among people from LGB and BME groups, and lower life expectancy for people with a serious mental illness.

CQC's most recent Mental Health Act reported that the importance of providers working alongside commissioners in the local implementation of new guidelines to monitor and address long-standing inequalities in the experiences of Black and minority ethnic (BME) groups use of mental health services. Also, ensuring that care is flexible, and meets the needs of everyone including people from black and minority ethnic groups or people with a learning disability.

Locally in Gateshead, practices have recorded all-age prevalence of depression of 10.1% amongst BME (including White Other) communities and 18.9% amongst the White British population, and all-age prevalence of anxiety disorder of 8.7% amongst BME (including White Other) communities and 14.3% amongst the White British population.

Data from the Improving Access to Psychological Therapies (IAPT) service shows that recovery rates for the BME population (41.3%) are lower in NewcastleGateshead CCG area than for the White British population (48.6%). NewcastleGateshead's recovery rates are lower than the North of England averages (BME 43.9% / White British 50.2%)

## Recommendation

The Mental Health Partnership Board should review whether the mental health needs of people from BME communities are being identified and recorded in General Practice, and whether services are responding effectively to the needs of local BME communities.

### 4.5.3 Post Traumatic Stress Disorder

There are specific and unique challenges facing refugees and asylum seekers that can result in deterioration of their mental health after they arrive in the region, caused by traumas experienced before their arrival. North East Regional Refugee Forum NE has recognised that there are also challenges that ARE NOT caused by traumas experienced before their arrival in the UK but arise from the stresses of living under the Asylum system once here for example, delays in accessing health services once someone is dispersed to the region.

During consultation with focus groups in the HNA a number of groups commented that :

*“I need to repeat my story to a GP on many occasions as I cannot always see the same GP”*

This was reported as causing more distress and not helping with mental health issues. Also some participants commented that time is restricted with GPs.

### 4.5.4 Hate Crime

One focus group participant stated that she was worried about raising issues of racism in case of repercussions of their name being mentioned:

*“you wonder if you are in the right place or the wrong place”*

#### Hate Crime and Incidents

The data shown below contains data relating to any crime that has been reported to Northumbria Police since April 2014. The data relate to Gateshead only and uses crimes or incidents that are deemed to have been linked to racism, religious hate, faith hate, gender and transphobic hate. Information is taken from iBase.

#### Hate Crime

Reported levels of hate crime have increased significantly since April 2014. This is shown in the table to the right. During the 2014/15 financial year, there were 98 crimes reported that were deemed to be hate-related. This increased by 47% in 2015/16 to 144 crimes (+46 crimes). In 2016/17, 203 crimes reported to Northumbria Police were classed as hate crimes. This is an increase of 41% compared to the previous 12 months and an increase of 107% since 2014/15.

	2014/15	2015/16	2016/17
Hate-related crime	98	144	203
All crime	9,378	12,801	17,807
% of crime	1.0	1.1	1.1

The proportion of recorded crime classed as hate crime in the last three years has remained steady. However, on average, there were 17 hate crimes reported per month during 2016/17 compared to an average of eight per month in 2014/15.

There were a total of 384 hate ‘incidents’ recorded on the ARCH reporting and case management system by Northumbria Police (who record hate crimes on the system), Gateshead Council, schools and The Gateshead Housing Company. Of these, 282 (73%) were race-related.

The Office for National Statistics (ONS) has advised caution when examining crime statistics. The ONS has stated that, although figures show there is an increase in crime, there has been a renewed focus on the quality of crime recording which has led to a greater number of crimes being recorded by the police. That said, there does

continue to be a concerted effort by partner agencies in Gateshead to increase awareness of hate crime and encourage reporting.

Responsibility for tackling hate crime rests with the Community Safety Board, which has a Hate Crime Strategy and action plan in place.

## 4.6 Use and Experiences of Health and Social Services

People from different equality groups perceive their experiences of health and social care in different ways, both positively and negatively, depending on a range of factors.

### 4.6.1 Health services

#### Primary Care

Registering with a GP practice and using GP services is the cornerstone of the NHS, as it helps people access a range of other health services. Analysis of the national 2015 GP patient survey results for different equality groups and found that Gypsies and Irish Travellers, Pakistani and Bangladeshi showed that people were less likely to say that they found GP practice receptionists to be helpful compared with people from other ethnic groups. The percentage of people saying they found receptionists to be helpful rose with age group from the 18 to 24 group to the 75 to 84 group (with a slight decrease after this age for the 85 and over group).

In the GP patient survey, there were similar findings to the NHS inpatient survey around patient experience and age. Positive responses increased with age, with a slight decrease for the oldest age group for questions on confidence and trust in nurses, doctors treating the person with care and concern, and overall experience of using the GP surgery.

People from Pakistani, Bangladeshi, Chinese and White non-UK ethnic backgrounds were also less likely to say that doctors and nurses treated them with care and concern and were less likely to have confidence and trust in nurses. People from all these groups were significantly less likely to report a good overall experience of using a GP surgery compared with White British people. Muslim, Sikh and Hindu people reported a poorer overall experience of GP surgeries than Christian people.

The worst patient experience was found in the Asian group across all English regions.

GP practices in Gateshead have only recorded the ethnicity of 54% of their patients. This varies across practices, ranging from a low of 11% and a high of 87%, as shown in Appendix 3. Approximately one third of those recorded as from the BME and White Other population is in the age range 25-39, which is consistent with the Census data shown in section 3.1.1 above.

#### Recommendation

The CCG should ensure practices record the ethnicity of all registered patients, in line with the Equality Act (2010).

#### Secondary Care

The 2015 NHS inpatient survey showed that age is an important factor in how people perceive their experiences of hospital care. Sample sizes may have some influence on differences between groups, but the following points are worth considering:

The NHS North of England Commissioning Support Business Information Service supplied data for secondary care activity (**Appendix 3**). The recording of ethnicity for secondary care is relatively high across all departments.



The overall standardised rates of use of hospital services – first outpatient attendances, elective in-patient admissions, non-elective in-patient admissions, and accident & emergency attendances – by BME (including White Other) communities across all ages are lower than for the White British population. However, there are some significant variations.

The Bangladeshi community, those recorded as ‘Any other black background’ as well as ‘Any other ethnic group’ have higher rates of use of Accident and Emergency than the total population.

The Bangladeshi, Pakistani and ‘Any other ethnic’ groups have higher rates of both elective and non-elective inpatient admissions than the total population.

There are a number of BME communities that are much lower than the total population rate of attendance for first outpatients appointments and elective in-patient admissions. In particular these groups are: Any other Asian, Chinese, Irish, White and Asian, White and Black Caribbean.

#### 4.6.2 Long-term Social Care Support

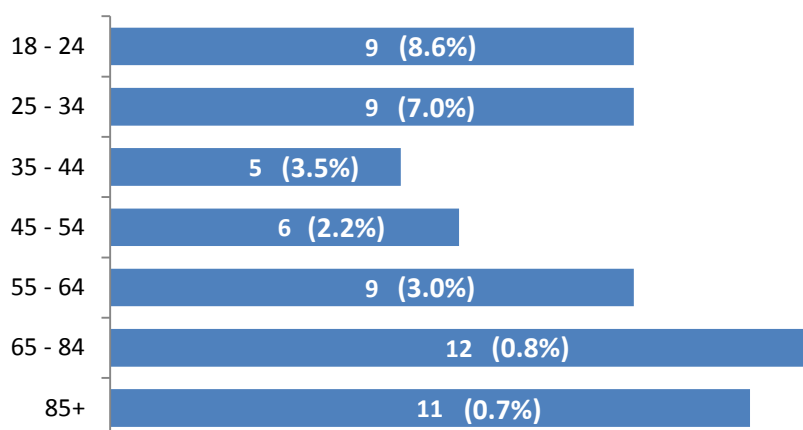
In 2014/15, only 9.6% of adults receiving from local authorities were from a BME background, which is lower than the population percentage in England (14.6%). This could be due to factors such as differences in need – while 17% of people in White ethnic groups are aged over 65, only 5% of people in BME groups are in this age range nationally. However, the prevalence of disability is higher in some BME groups, so the level of need is not easy to compare from population data alone.

Greater difficulties in accessing appropriate care due to information barriers were observed in the 2014/15 survey of people who use adult social care services. It showed that people from BME groups were more likely than people from White ethnic groups to have tried to find information, but were also more likely to say that they found it fairly or very difficult to find information or advice.

The information in the charts below relates to financial year 2015/16 and has been taken from the data set used to complete the Local Authority statutory return (the SALT return). The charts illustrate Long Term Service users in Gateshead by age group, health condition, primary support reason and location of service delivery.

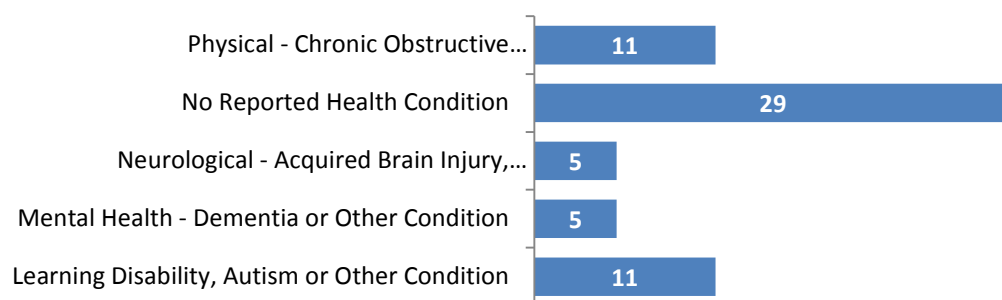
The proportion of service users who are of BME background varies by age as shown below.

**BME Adult Social Care Users by Age**  
(% of all ASC users in each age group)

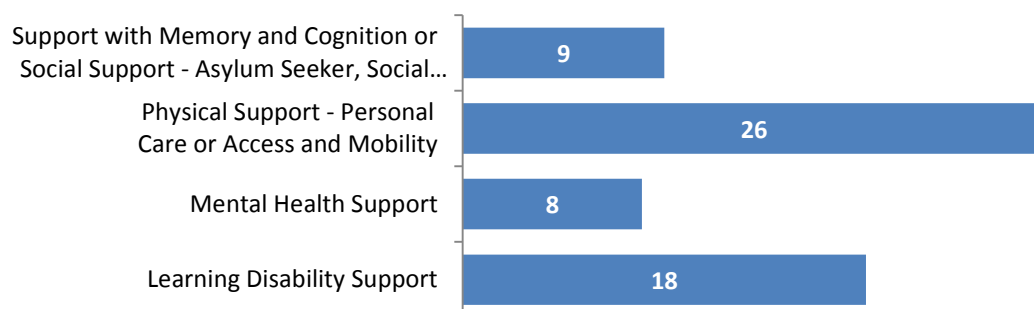


The charts below show the number of people in Gateshead who are recorded as BME who are receiving Social Care services for long term conditions and their primary support reason.

### BME Adult Social Care Users by Health Condition

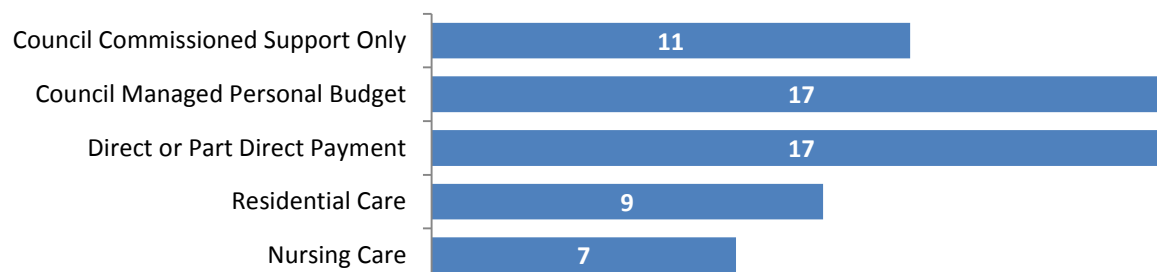


### BME Adult Social Care Users by Primary Support Reason



The support that people receive varies across care settings as illustrated in the chart below.

### BME Adult Social Care Users by Support Mechanism



#### 4.6.3 Carers

A separate health needs assessment has been undertaken in respect of carers, but its findings in respect of carers from BME communities are summarised here. The 2011 Census gathered information on the provision of unpaid care.

#### *Provision of Unpaid Care by Ethnicity*

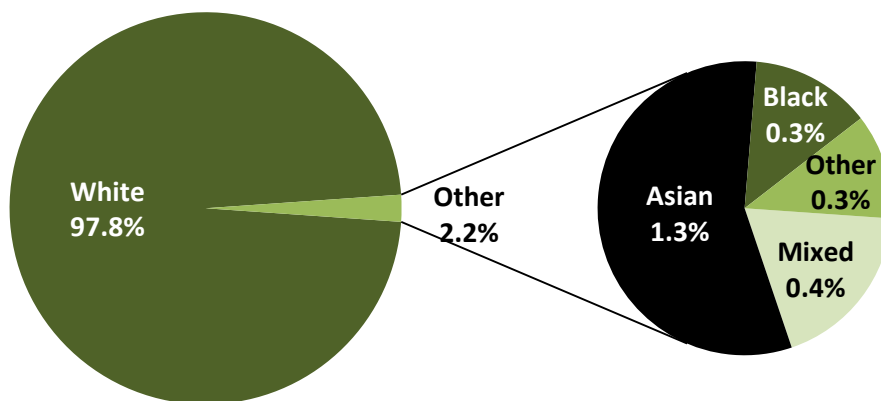
*Source: Census 2011, ONS*

Ethnic Group	Provides unpaid care: Total	Provides 1 to 19 hours unpaid care	Provides 20 to 49 hours unpaid care	Provides 50 or more hours unpaid care
White	21, 728 (97.8%)	12,318 (97.9%)	3,261 (96.5%)	6,149 (98.4%)
Mixed	92 (0.4%)	49 (0.4%)	14 (0.4%)	29 (0.5%)
Asian	278 (1.3%)	155 (1.2%)	72 (2.1%)	51 (0.8%)
Black	65 (0.3%)	35 (0.3%)	19 (0.6%)	11 (0.2%)
Other	57 (0.3%)	31 (0.2%)	15 (0.4%)	11 (0.2%)
<b>Total</b>	<b>22,220</b>	<b>12,588</b>	<b>3,381</b>	<b>6,251</b>

This showed that 2.2% of carers were from minority ethnic groups (BME communities comprise 3.7% of the total population).

Data from Gateshead’s social care services shows the ethnicity of carers who have had a joint or separate assessment or review, or were supported via a carers service during 2015/16. Only 1.1% of carers were reported as being from minority communities, around half the rate from the Census. The reasons for the lower prevalence of BME carers are not clear. This may simply be a random variation given the small numbers, it may be a result of recording (note the 317 carers where ethnicity was not obtained), it may arise from cultural factors or it may be related to lack of awareness of the support that could be available.

**Provision of Unpaid Care by minority ethnic group**



**Carers who had a joint or separate assessment or review, or were supported via a carers service during 2015/16 by ethnicity**

Carers Ethnicity	No.	%
White British	1813	84
White Other	6	0.3
Asian	15	0.6
Black, Other or Ethnicity Not Disclosed	8	0.2
Ethnicity not obtained	317	14.7
Total	2159	100

N.B. Local survey data collated by Gateshead Carers about their clients in 2014 is also available and is outlined in the 'Health Needs Assessment for Carers 2016'.

#### 4.6.4 Gateshead Advice Centre

In 2015/16 1,277 people from BME or White Other groups were supported through the Gateshead Advice Centre. This equates to 13% of the total number of clients seen throughout the year.

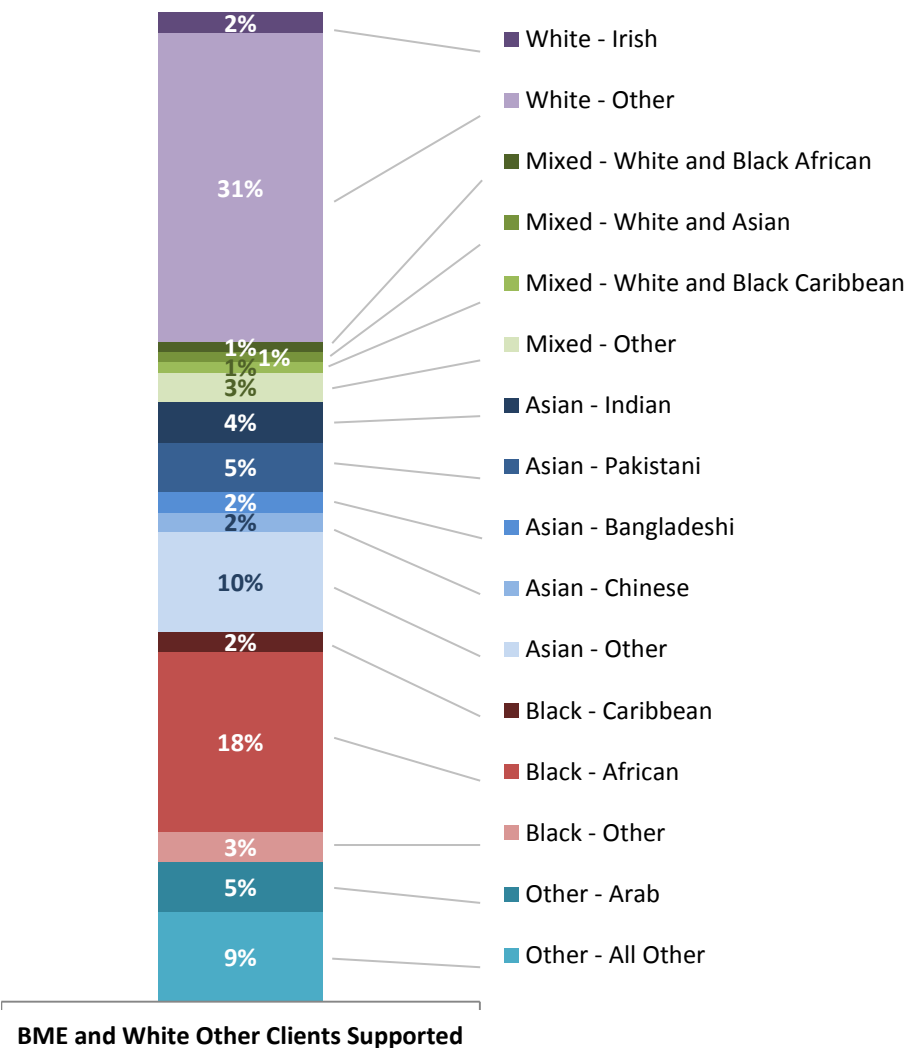
The groups that were supported the most during the year were White Other (31% of clients), Black African (18%), Other Asian (10%), and Other (9%).

Almost half of all enquiries by individuals from BME or White Other groups come from the wards of Dunston and Teams, Deckham, Bridges, and Felling. These wards are close to the centre of Gateshead and so the geographical distribution of enquiries tends to reflect the distribution of the BME and White Other groups. However, it should be noted that these wards are also close in proximity to Gateshead Advice Centre.

There are two levels of advice provided by the Centre. 'Full advice' is detailed advice and ongoing casework with appointments that may last at least an hour and many requiring several appointments. 'Gateway advice' is information, signposting and referral and is usually a short appointment of around 15-20 minutes.

The top 5 'full advice' categories for the BME and White Other groups are debt (42%), benefits and tax credits (30%), financial capability (17%), utilities and services (4%), and other (3% - including foodbank food parcels and

grants from charitable trusts). The top 5 'gateway advice' categories are benefits and tax credits (41%), immigration (10%), debt (9%), housing (9%) and employment (8%).



Lots of health information is only available in English. It is widely acknowledged in the refugee and asylum seeker community that leaflets are not the best way of finding out about information when English is not your first language. Information spreads in this community by word of mouth and peer learning.

### Recommendations

It is recommended that the Health and Wellbeing Board members:

- ensure that their respective organisations and organisations who they commission with are actively aware of their requirement to collect and analyse data across workforce and delivery areas in their performance measurements and monitoring
- make use of equality impact assessments to understand the implications of service and policy developments for local BME communities

## 4.7 Satisfaction with services

CQC (2016) reports that even within a single provider there can be large differences in the quality of care. There is also wide variation across our five key questions, with services consistently rated good or outstanding for caring across all sectors, but not necessarily for other areas of our inspections. Some groups of people say they experience lower quality care than others. For example, people with mental ill-health and younger people reported significantly poorer experiences when using NHS acute hospitals, while Black and minority ethnic groups and older people were less likely to be satisfied with adult social care services. CQC evidence continues to show that good leadership in a service can minimise the amount of variation that people experience.

The 2015 NHS inpatient survey showed that age is an important factor in how people perceive their experiences of hospital care. Sample sizes may have some influence on differences between groups, but the following points are worth considering:

Younger people (aged 16 to 35) were significantly less likely to report being treated with dignity and respect than older people (aged 66 to 80). They also reported significantly less confidence and trust in both nurses and doctors. These results show that the self-reported experience of inpatient care continues to be poorer for certain groups of people.

A number of groups were less likely to say that they received enough emotional support from hospital staff during their stay, including younger people, Muslim people, people with a mental health condition, and Asian, Asian British, and Chinese people.

We have not reviewed any local quantitative data on the satisfaction of service users from Gateshead's BME communities.

## 4.8 Focus Groups – Strengths, Weaknesses, Opportunities and Threats

The strengths, weaknesses, opportunities and threats regarding services in Gateshead are documented in the table below.

This information has been collated following a thematic analysis of information which has been documented from meetings with BME communities that have assisted with arranging focus groups attended by BME population groups (**Appendix 4**).

The thematic analysis highlighted how individuals within BME communities felt they were not aware of the range of services available to them.

## Recommendations

Partners in the Health and Wellbeing Board should:

- Consider how to raise awareness of local services for individuals within BME communities by better publicising what support is already available and how to best access it. Research recommends family based educational interventions as a means of building on existing beliefs, attitudes and behaviours, with a community-based, word of-mouth approach.
- Consult families from BME communities about their specific needs when commissioning services
- Consult families from BME communities about information in appropriate languages and ways of promoting to BME communities
- Ensure service providers' information on services is readily available in appropriate languages and is promoted to BME communities
- Commission services that are accessible for local BME communities, including in appropriate locations and at appropriate times
- Commission peer support forums for parents and carers from local BME communities and, where appropriate, tailored support services
- Provide advocacy, translation and interpretation services for families from BME communities who require support during and health and social care pathways
- Ensure that the BME communities chapter of the Health and Wellbeing Board's Joint Strategic Needs Assessment is 'linked to all other chapters.
- Promote accessible services to teach English as second language

Strengths	Weaknesses
<p>GP recognised as the first contact to access services (illness, children)</p> <p>Positive experiences received from hospital support/ cancer services</p> <p>Carer services accessed however, some cultures accept that it is a family responsibility to care for relatives and do not look for help.</p> <p>Social care/ domiciliary care, A&amp;E staff and medical staff were found to be very helpful.</p> <p>Access to dentist and opticians is positive</p> <p>People over 40yrs indicated that they would take up a health check.</p> <p>Some refugees and asylum seekers have accessed counselling services.</p> <p>The race of the GP is not an issue.</p> <p>People indicated that they will be willing to use any service to get help to meet their needs</p> <p>Having a support worker to take people to find their way is important. Support worker helps individuals and families with Bus No etc.</p> <p>Once they access the services they find it a positive experience</p> <p>Better to have an independent interpreter not a friend</p> <p>The first impression from a service can make all the difference i.e. were they welcomed?</p> <p>Customer Service should be a priority</p>	<p>Unaware of walk in centres</p> <p>Unaware of 111</p> <p>Unaware of GP out of hours service</p> <p>Most of the services users do not have a full picture of what they are entitled to in Primary and Secondary Care i.e. Core NHS services</p> <p>Tend not to use 111 due to language problems and general understanding</p> <p>Tend not to use any out of hours service</p> <p>If GP is closed people go to hospital</p> <p>Unaware of health checks for 40 -74 year old people.</p> <p>Unaware of mental health services. Signposting is generally at crisis point. Referrals generally would come from organisations like MIND</p> <p>Not aware of advice on childrens development</p> <p>Access to appointments at the GP can be an issue</p> <p>People who had accessed the walk in centre had stated that interpreter services were not available</p> <p>There are long waiting times to access an interpreter with suitable language when making an appointment at the GP.</p> <p>It is also recognised that when interpreters are present in a consultation with a GP or health care professional some people raised that there is a lack of privacy when interpreters are present.</p> <p>Doctors prescribe cheapest drugs that don't always work, and raise anxieties around health. Some communities reported returning to there home country to access appropriate health care assessment.</p> <p>Waiting times in A&amp;E is reported as a problem, particularly for children</p> <p>Some people had experienced racism and poor attitudes from ambulance service</p> <p>No Chinese centre in Gateshead. The Chinese community meets in Newcastle.</p> <p>The asylum process has a detrimental effect on children and can be a stigma. Experience of bullying at</p>



Strengths	Weaknesses
	<p>school reported. With little financial support children can feel isolated and not part of the community i.e. any new trainer's games etc.</p> <p>No general information for BME community for NHS Health Checks.</p> <p>There are many older refugees aged 55 – 60</p>

Opportunities	Threats
<p>Telephone interpreting services may be appropriate in some situations</p> <p>Support for isolated older people is becoming an issue in communities. Respect for elderly</p> <p>Surveys can be completed if delivered by an interpreter or written in appropriate language. Also translated information.</p> <p>Access to information in a range of languages</p> <p>More information on how to access health checks and child development.</p> <p>Use of football/sports clubs to promote health checks</p> <p>Giving information in different ways e.g. Living notice boards, presentations to community groups, digital stories, films &amp; DVD to deliver health messages.</p> <p>Giving information via community organisations</p> <p>Community healthy living centres can be used to get messages to communities and support wellbeing e.g. impact of religious fasting for people who have diabetes.</p> <p>Access to English classes</p> <p>Subsidies for refugees /asylum seekers</p> <p>Refugee Service would be used as good advice is always given and holds a Quality Standard</p> <p>Cultural influence and how other people tell them how the service treated them</p> <p>Informal carers are common younger people support parents etc. Neighbours can also be very helpful (a neighbour in the same predicament i.e. an Asylum seeker or refugee)</p> <p>More supportive access to service i.e. face to face</p>	<p>Cases of asylum seekers not being diagnosed: i.e. female with abnormal smears: who passes this information on to for possible action?</p> <p>Clients have a fear of speaking out due to treatment at detention centres.</p> <p>Phone lines for help can be very expensive (it cost one client £18 for one phone call from a mobile telephone)</p> <p>Information on the content of some medication is important i.e. Gelatine</p> <p>Information on the impact of fasting on Diabetes</p> <p>Fasting can lead some people to have increased paranoia.</p> <p>Accommodation can be substandard having a detrimental effect on people's health</p> <p>Leisure centres are difficult to join because of lack of finances</p> <p>Some people could have suffered from injuries and torture may not want to show these in public changing rooms</p> <p>Failed asylum seekers get a card for food, not cash Travel costs are a big issue with this group</p> <p>Food bank food is welcomed but over a long period of time it is very unhealthy i.e. processed food etc.</p> <p>Isolated older refugees without family support will impact on services eventually.</p> <p>There are worries that information regarding an individual who is using an NHS service that this information would be passed to the Home Office this can put people off accessing services.</p>

Opportunities	Threats
<p>Can the community incentive scheme be used in BME community for NHS Health Checks? This could be used as a stepping stone to other services</p> <p>Isolated people would need support and signposting. Adults with children are treated differently than single adults – equity issue?</p> <p>Training on how to recognise stress in children</p> <p>Access to ICT</p> <p>Giving information :</p> <ol style="list-style-type: none"> <li>1. Presentations/Informal</li> <li>2. Must be accurate and clear</li> <li>3. Texting would be used by the group</li> <li>4. Visual repetitive sessions are very useful</li> <li>5. Simple language i.e. bullet points</li> <li>6. Digital interviews i.e. recording or video</li> <li>7. Use of practical aids</li> <li>8. Relaxed environment always helps</li> <li>9. Surveys sent to BME communities can worry them as they think this is could be a sign of an possible underlying condition</li> </ol> <p>Key areas for information</p> <ol style="list-style-type: none"> <li>1. Support</li> <li>2. Access</li> <li>3. Knowledge</li> <li>4. Information</li> <li>5. Availability</li> <li>6. Transport i.e. high bus fares for their budget</li> </ol>	

## **5. Limitations of the Health Needs Assessment**

Most UK studies concerning health promotion interventions within minority ethnic groups focus on South Asians, possibly due to the fact that many South Asians are still first and second generation immigrants, whereas the Black American population is a long-established group in the US. The UK literature therefore deals with individual studies rather than having the benefit of reviews of many studies over time. Lessons can be learned from both of these bodies of literature, with keys to success being associated with factors such as: careful attention to partnership development and building trust.

However it is accepted that some data is not available for this population group, particularly at the local level, and data is suppressed at times due to low numbers and potential risk to anonymity. We have not been able to assess the quality of the local data that is available, but we would highlight the low level of recording of ethnicity in some practices.

Local qualitative data is rich in information; however it would have been preferable if more communities could have been consulted with.

During the duration of writing the assessment members of the working group attendance dwindled, predominantly due to other priorities within the Voluntary Sector groups. It is recognised that the Voluntary Sector groups have been hit hard by the austerity measures and suffered financial cuts, and therefore have had limited capacity to give time to working group priorities.

#### Definitions and Abbreviations

BME	Black and minority ethnic (used to refer to members of non-white communities in the UK)
BMI	The body mass index (BMI) is a measure that uses your height and weight to work out if your weight is healthy. The BMI calculation divides an adult's weight in kilograms by their height in metres squared. For example, A BMI of 25 means 25kg/m <sup>2</sup> .
FFT	Friends and Family Test. Friends and Family Test (FFT) is available in 12 languages, all in audio and video BSL. It's multi-channel, and comes with a suite of advanced real-time reporting tools
FGM	Female genital mutilation (FGM) is a procedure where the female genitals are deliberately cut, injured or changed, but where there's no medical reason for this to be done.
Health and Well-being Board	The Health and Social Care Act 2012 establishes health and wellbeing boards as a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities.
I base	A data collection system used by Gateshead Council
MIND	A charity that provides advice and support to empower anyone experiencing a mental health problem.
WHO	World Health Organisation. The WHO staff work side by side with governments and other partners to ensure the highest attainable level of health for all people. Their goal is to build a better, healthier future for people all over the world, working through offices in more than 150 countries.

## National Institute for Clinical Excellence (NICE) Guidance

Information documented from key NICE guidance is summarised below:

### BMI: preventing ill health and premature death in black, Asian and other minority ethnic groups (PH46) July 2013

NICE guidance aimed to determine whether lower cut-off points should be used for black, Asian and other minority ethnic groups in the UK as a trigger for lifestyle interventions to prevent conditions such as diabetes, myocardial infarction or stroke.

The evidence confirms that these groups are at an equivalent risk of diabetes, other health conditions or mortality at a lower BMI than the white European population, but it was not sufficient to make recommendations on the use of new BMI and waist circumference thresholds to classify whether members of these groups are overweight or obese.

As a result, this guidance supports previously published NICE recommendations on diabetes prevention and extends them to black African and African-Caribbean groups. It also highlights recommendations from NICE and other sources in relation to awareness raising, BMI measurement and thresholds that can be used as a trigger for intervening to prevent ill health and premature death among adults from black, Asian and other minority ethnic groups in the UK.

#### Preventing type 2 diabetes

NICE recommendations include:

- using lower thresholds (23 kg/m<sup>2</sup> to indicate increased risk and 27.5 kg/m<sup>2</sup> to indicate high risk) for BMI to trigger action to prevent type 2 diabetes among Asian (South Asian and Chinese) populations
- identifying people at risk of developing type 2 diabetes using a staged (or stepped) approach
- providing those at high risk with a quality-assured, evidence-based, intensive lifestyle-change programme to prevent or delay the onset of type 2 diabetes.
- Extend the use of lower BMI thresholds to trigger action to prevent type 2 diabetes among black African and African-Caribbean populations.
- Raise awareness of the need for lifestyle interventions at a lower BMI threshold for these groups to prevent type 2 diabetes. For example, in particular, use the public health action points advocated by the World Health Organisation (WHO) as a reminder of the threshold at which lifestyle advice is likely to be beneficial for black and Asian groups to prevent type 2 diabetes.

#### BMI assessment, multi-component interventions and best practice standards

NICE recommendations on BMI assessment, and how to intervene, is set out in Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children (NICE clinical guideline 43). Specifically:

- Clinicians should assess comorbidities, diet, physical activity and motivation along with referral to specialist care if required.
- Weight management programmes should include behaviour-change strategies to increase people's physical activity levels or decrease inactivity, improve eating behaviour and the quality of the person's diet and reduce energy intake
- Primary care organisations and local authorities should recommend to patients, or consider endorsing, self-help, commercial and community weight management programmes only if they follow best practice.

#### General awareness raising

- Ensure practitioners are aware that members of black, Asian and other minority ethnic groups are at an increased risk of chronic health conditions at a lower BMI than the white population (below BMI 25 kg/m<sup>2</sup>).
- Ensure members of black, Asian and other minority ethnic groups are aware that they face an increased risk of chronic health conditions at a lower BMI than the white population (below BMI 25 kg/m<sup>2</sup>).

- Use existing local black and other minority ethnic information networks to disseminate information on the increased risks these groups face at a lower BMI.

### **NICE advice Body mass index thresholds for intervening to prevent ill health among black, Asian and other minority ethnic groups (LGB13)**

The prevalence of chronic conditions such as type 2 diabetes, coronary heart disease and stroke is up to 6 times higher (and they occur from a younger age) among black, Asian and other minority ethnic groups. In addition, these groups progress from being at-risk to being diagnosed with these conditions at twice the rate of white populations. So tackling this issue will help tackle health inequalities and satisfy public sector obligations under the Equality Act 2010.

Action now will result in significant social care and health savings, by delaying and improving the management of complications associated with limiting long-term illnesses. It could result in particularly high savings for local authorities with a high proportion of black, Asian and other minority ethnic groups. (See Make significant cost savings.)

Lifestyle interventions targeting sedentary lifestyles and diet have reduced the incidence of diabetes by about 50% among high-risk individuals (Pharmacological and lifestyle interventions to prevent or delay type 2 diabetes in people with impaired glucose tolerance: systematic review and meta-analysis). This includes people from South Asian, Chinese, black African and African Caribbean descent with a BMI of 23 kg/m<sup>2</sup> or more, where interventions to identify and manage pre-diabetes have been found to be cost effective.

Diabetes is the most common cause of visual impairment and blindness among people of working age and the most common cause of kidney failure and non-traumatic lower limb amputations. See Reduce future demand on health and social care services. Interventions to prevent type 2 diabetes will also reduce the risk of other major health problems including Alzheimer's disease, coronary heart disease, hypertension and stroke.

Council scrutiny activities can add value to strategies and actions to improve the public's health. Effective scrutiny can help identify local health needs and check whether local authorities are working in partnership with other organisations to tackle the wider determinants of health. NICE guidance and briefings provide a useful starting point, by suggesting useful 'questions to ask' during the scrutiny process

### **HIV testing: increasing uptake in black Africans (PH33) March 2011**

The focus of this guidance is on increasing the uptake of HIV testing to reduce undiagnosed infection and prevent transmission.

The recommendations include advice on:

- community engagement and involvement
- planning services, including assessing local need, developing a strategy and commissioning services in areas of identified need
- promoting HIV testing and reducing barriers to testing among black African communities
- offering and recommending an HIV test
- HIV referral pathways

This guideline was previously called increasing the uptake of HIV testing among black Africans in England.

It is for NHS and other commissioners, managers and practitioners who have a direct or indirect role in, and responsibility for, increasing the uptake of HIV testing among black African communities. This includes those working in local authorities and the wider public, private, voluntary and community sectors. It will also be of interest to members of the public, in particular black Africans living in England.

It is one of two pieces of NICE guidance published in March 2011 on how to increase the uptake of HIV testing. A second publication covers HIV testing among men who have sex with men.

## **Community engagement and involvement**

- Directors of public health and others with a remit for HIV prevention or with responsibility for the health and wellbeing of black African communities should take action to:
- Plan, design and coordinate activities to promote the uptake of HIV testing among local black African communities, in line with NICE guidance on community engagement. Seek to develop trust and relationships between organisations, communities and people. Communities should be involved in all aspects of the plan, which should take account of existing and past activities to address HIV and general sexual health issues among these communities.
- Work in partnership with those running existing community activities to promote HIV testing and the benefits of early diagnosis and treatment, and to raise awareness of local services and how to access them. This includes addressing any misconceptions about HIV testing and treatment (for example, in relation to life expectancy following a positive diagnosis – or related to HIV treatment costs). It also includes reducing the stigma (real or perceived) associated with HIV testing and living with HIV, both among black Africans and health professionals.
- Recruit, train and encourage members of local black African communities to act as champions and role models to help encourage their peers to take an HIV test. This includes helping to plan awareness-raising activities or acting as a link to specific communities that are less likely to use existing services.

## **Planning services – assessing local need**

- Directors of public health, public health specialists and commissioners with a remit for sexual health and local sexual health networks should take action to:
- Collect and analyse local data to estimate the prevalence and incidence of HIV among black African communities.
- Collect information about the composition of local black African communities, including groups that are less likely to use services. Ensure there is an understanding of the particular needs of different groups.
- Gather the views and experiences of local black African communities to understand their specific concerns and needs in relation to HIV testing.
- Collect information about HIV-testing services. This includes data on where they are offered (for example, in genitourinary medicine clinics and GP surgeries), access times and general accessibility. In addition, determine the types of test offered and how frequently, the take-up rates and how quickly results are given. Note variations in factors such as waiting times and staff provision. Also gather information on service users (identified by gender, sexuality, age, ethnicity and date of last HIV test).
- Collect information about current HIV diagnoses, including the proportion of people being diagnosed late (that is, after treatment should have begun), broken down by gender, age and country of origin. Take note of the CD4 count on diagnosis, the settings where people are being diagnosed and the suspected transmission route. (This includes detail on whether or not the infection probably occurred abroad or in the UK.)
- Carry out an appraisal of local interventions that aim to increase the number of black Africans who choose to take an HIV test. Information should be gathered on where, when and how often HIV testing is promoted to these communities and by whom.

## **Planning services – developing a strategy and commissioning services in areas of identified need**

- Directors of public health, public health specialists and commissioners with a remit for sexual health and local sexual health networks should take action to:
- Ensure there is a local strategy to increase the uptake of HIV testing among local black Africans. It should encourage them to undergo HIV testing. It should also encourage professionals to offer and recommend HIV testing to them, where appropriate.
- Ensure the strategy is planned in partnership with relevant local voluntary and community organisations and user groups, and in consultation with local black African communities .
- Ensure the strategy takes into account the needs of people from different black African communities. In particular, it should pay attention to groups that are less likely to use existing services.
- Ensure the strategy is regularly monitored and evaluated.
- Ensure HIV testing is available in a range of healthcare and community settings (for example, GP surgeries and community centres) based on the outcomes of a needs assessment. These should be accessible and



acceptable to the target population, in terms of both geographical setting and service design (for example, in terms of appointment systems, opening hours and cultural sensitivity).

### **Promoting HIV testing for black African communities**

Commissioners and staff in public health, primary care (including GPs), local authorities and the voluntary sector with a remit for health promotion, education and advice for black African communities (including providers of HIV testing) should take action to ensure:

- Other local and national organisations that produce, or are responsible for providing, information about HIV, HIV testing and treatment for black Africans.
- Produce promotional material tailored to the needs of local black African communities. It should:
  - provide information about HIV infection and transmission, the benefits of HIV testing and the availability of treatment
  - emphasise that early diagnosis is a route into treatment and a way to avoid complications and serious illness in the future
  - detail how and where to access local HIV testing services, including services offering rapid testing and genitourinary medicine clinics (where people do not have to give their real name)
  - dispel myths and common misconceptions about HIV diagnosis and treatment
  - present testing as a responsible act by focusing on trigger points, such as the beginning of a new relationship or change of sexual partner, or on the benefits of knowing one's HIV status
  - address the needs of non-English-speaking black African communities, for example through translated information.
- Work with black African community organisations to promote HIV testing.
- Use venues that local black African communities frequent (for example, prayer groups or cultural events).

### **Reducing barriers to HIV testing for black African communities**

Commissioners and providers of health services should take action to:

- Ensure staff offering HIV tests emphasise that the tests are confidential. They should be able to direct those who are concerned about confidentiality to a genitourinary medicine clinic, where people do not have to give their real name.
- Ensure staff are able to recommend HIV testing and have the ability to discuss HIV symptoms and the implications of a positive or a negative test.
- Ensure staff are familiar with existing referral pathways so that people who test positive receive prompt and appropriate support.
- Ensure staff can provide appropriate information, including details of where to get free condoms or training in negotiation skills, if someone tests negative.
- Ensure primary care staff can recognise the symptoms that may signify primary HIV infection or illnesses that often co-exist with HIV. In such cases, they should be able to offer and recommend an HIV test.
- Ensure HIV testing services are staffed by people who are aware of and sensitive to, the cultural issues facing black Africans. (For example, black Africans may be less used to preventive health services and advice or may fear isolation and social exclusion should they test positive for HIV.) Staff should also be able to challenge the stigma of, and dispel any myths surrounding, HIV and HIV testing and be sensitive to the individual needs of people.
- Ensure HIV testing services can offer rapid tests to people who are reluctant to wait for results (or can refer people to a service that provides rapid tests). If people are unwilling to have a blood test, they should be offered less invasive options (such as a saliva test), or should be referred elsewhere for such a test.

### **Healthcare settings: offering and recommending an HIV test**

Commissioners and providers of healthcare in both primary and secondary care. This includes those in: accident and emergency departments, antenatal services, general practice, genitourinary medicine, outpatient departments, sexual health clinics and other healthcare settings should take action to ensure:

- In line with British HIV Association (BHIVA) guidelines all health professionals should routinely offer and recommend an HIV test to:
  - men and women known to be from a country of high HIV prevalence

- men and women who report sexual contact abroad or in the UK with someone from a country of high HIV prevalence
- patients who have symptoms that may indicate HIV or where HIV is part of the differential diagnosis (see the BHIVA guidelines for a list of indicator diseases)
- patients diagnosed with a sexually transmitted infection
- the sexual partners of men and women known to be HIV positive
- men who have disclosed that they have sexual contact with other men
- the female sexual contacts of men who have sex with men
- patients reporting a history of injecting drug use.
- In addition, health professionals should (regardless of local HIV prevalence), routinely offer and recommend an HIV test to all those who may be at risk of exposure to the virus. For example, this may be as a result of having a new sexual partner or may be because they have previously tested negative during the 'window period'.
- In line with BHIVA guidelines, all health professionals should routinely offer and recommend an HIV test to all patients attending:
  - genitourinary medicine or sexual health clinics
  - antenatal services
  - termination of pregnancy services
  - drug dependency programmes
  - tuberculosis, hepatitis B, hepatitis C and lymphoma services.
- In areas where more than 2 in 1000 population have been diagnosed with HIV:
- primary care and general medical admissions professionals should consider offering and recommending an HIV test when registering and admitting new patients (this is in line with BHIVA guidelines)[1]
- all health practitioners should offer and recommend an HIV test to anyone who has a blood test (regardless of the reason).

### **HIV referral pathways**

Commissioners and providers of HIV testing services in both the statutory and voluntary sector should take action to:

- Ensure there are clear referral pathways for people with positive and negative HIV test results.
- Ensure people who test positive are seen by an HIV specialist at the earliest opportunity, preferably within 48 hours, certainly within 2 weeks of receiving the result (in line with British HIV Association guidelines). They should also be given information about the diagnosis and about local support groups.
- For people with positive and negative HIV test results, if appropriate, offer or provide information about further behavioural or health promotion interventions available from both voluntary and statutory services (for example, advice on safer sex, training in negotiating skills and providing condoms).
- Encourage repeat testing after a negative result for those who are at risk of infection (for example, for those who have new or multiple partners).
- Ensure people who choose not to take up the immediate offer of a test know how to access testing services.

### **Smokeless tobacco: South Asian communities (PH39) September 2012**

This guidance aims to help people of South Asian origin who are living in England to stop using traditional South Asian varieties of smokeless tobacco. The phrase 'of South Asian origin' refers here to people with ancestral links to Bangladesh, India, Nepal, Pakistan or Sri Lanka.

The term 'smokeless tobacco', as it is used in this guidance, refers to 3 broad types of products:

- Tobacco with or without flavourants, for example: misri India tobacco (powdered) and qimam (kiman).
- Tobacco with various alkaline modifiers, for example: khaini, naswar (niswar, nass) and gul.
- Tobacco with slaked lime as an alkaline modifier and areca nut, for example: gutkha, zarda, mawa, manipuri and betel quid (with tobacco).

Products, like 'snus' or similar oral snuff products are not included.

The guidance is for commissioners and providers of tobacco cessation services (including stop smoking services), health education and training services, health and wellbeing boards and health and social care practitioners.

It is also for all those with public health as part of their remit, in particular, the health of South Asian communities. The guidance may also be of interest to local authority elected members and members of the public.

The 6 recommendations cover:

- assessing local need
- working with local South Asian communities
- commissioning smokeless tobacco services
- providing brief advice and referral: dentists, GPs, pharmacists, and other health professionals
- specialist tobacco cessation services (including stop smoking services)
- training for practitioners.

### **Assessing local need**

Local authority specialists and public health commissioners responsible for local tobacco cessation activities, health and wellbeing boards, clinical commissioning groups, dental public health consultants managers of tobacco cessation services should take action:

- As part of the local joint strategic needs assessment (JSNA), gather information on where, when and how often smokeless tobacco cessation services are promoted and provided to local South Asian communities – and by whom. Aim to get an overview of the services on offer.
- Consult with local voluntary and community organisations that work with, or alongside, South Asian communities to understand their specific issues and needs in relation to smokeless tobacco.
- Collect and analyse data about the use of smokeless tobacco among local South Asian communities. For example, collect data from local South Asian voluntary and community organisations, dental health professionals and primary and secondary care services. These data should provide information on:
  - prevalence and incidence of smokeless tobacco use and detail on the people who use it (for example, their age, ethnicity, gender, language, religion, disability status and socioeconomic status)
  - people who use smokeless tobacco and do not use cessation services
  - types of smokeless tobacco used
  - perceived level of health risk associated with these products
  - circumstances in which these products are used locally
  - proportion and demographics of people who both smoke and use smokeless tobacco products.
- Consider working with neighbouring local authorities to analyse routinely collected data from a wider geographical area on the health problems associated with smokeless tobacco among local South Asian communities. In particular, collect and analyse data on the rate of oropharyngeal cancers. Note any demographic patterns. Data could be gathered from local cancer registers, Hospital Episode Statistics, public health observatories and local cancer networks.
- Collect any available information from tobacco cessation services on the number of South Asian people who have recently sought help to give up smoking or smokeless tobacco. Depending on the level of detail available, data should be broken down demographically (for example, by age, ethnic suborigin, gender, religion and socioeconomic status).
- Use consistent terminology to describe the products, as specified in the Local Government Association's Niche tobacco products directory website. Note any local variation in the terminology used by retailers and consumers.

### **Working with local South Asian communities in areas of identified need**

Directors of public health, local voluntary and community organisations with a responsibility for tobacco cessation or that work with South Asian communities. Managers of tobacco cessation services, people who work with children and young people, faith leaders and others involved in faith centres and health and social care practitioners, for example, midwives, health visitors and youth workers. Health and wellbeing boards, clinical commissioning groups, dental health professionals including dentists, dental hygienists and dental nurses and others with a remit for managing tobacco cessation services or with responsibility for the health and wellbeing of South Asian communities should take action to:

- Work with local South Asian communities to plan, design, coordinate, implement and publicise activities to help them stop using smokeless tobacco. Develop relationships and build trust between relevant organisations, communities and people by involving them in all aspects of planning. Take account of existing and past activities to address smokeless tobacco use and other health issues among these communities.
- Work with local South Asian communities to understand how to make services more accessible. For example, if smokeless tobacco cessation services are provided within existing mainstream tobacco cessation services, find out what would make it easier for South Asian people to use the service.
- Work in partnership with existing community initiatives to raise awareness of local smokeless tobacco cessation services and how to access them. Ensure any material used to raise awareness of the services:
  - uses the names that the smokeless tobacco products are known by locally, as well as the term 'smokeless tobacco'
  - provides information about the health risks associated with smokeless tobacco and the availability of services to help people quit
  - challenges the perceived benefits – and the relative priority that users may place on these benefits (compared with the health risks). For example, some people think smokeless tobacco is an appropriate way to ease indigestion or relieve dental pain, or helps freshen the breath
  - addresses the needs of people whose first language is not English (by providing translations)
  - addresses the needs of people who cannot read in any language (by providing material in a non-written form, for example, in pictorial, audio or video format)
  - includes information for specific South Asian subgroups (for example, older Bangladeshi women) where rates of smokeless tobacco use are known to be high
  - discusses the concept of addiction in a way that is sensitive to culture and religion (for example, it may be better to refer to users as having developed a 'habit', rather than being 'addicted')
  - does not stigmatise users of smokeless tobacco products within their own community, or in the eyes of the general community.
- Use existing local South Asian information networks (including culturally specific TV and radio channels), and traditional sources of health advice within South Asian communities to disseminate information on smokeless tobacco.
- Use venues and events that members of local South Asian communities frequent to publicise, provide or consult on cessation services with them. (Examples include educational establishments and premises where prayer groups or cultural events are held.)
- Raise awareness among those who work with children and young people about smokeless tobacco use. This includes:
  - providing teachers with information on the harm that smokeless tobacco causes and which also challenges the perceived benefits – and the priority that users may place on these perceived benefits
  - encouraging teachers to discuss with their students the reasons why people use smokeless tobacco. This could take place as part of drug education, within personal, social, health and economic (PSHE) education, or within any other relevant part of the curriculum.

### **Commissioning smokeless tobacco services in areas of identified need**

Directors of public health, public health commissioners and local authority specialists responsible for local tobacco cessation services, health and wellbeing boards, clinical commissioning groups, managers of tobacco cessation services should take action:

- If local needs assessment shows that it is necessary commission a range of services to help South Asian people stop using smokeless tobacco. Services should be in line with any existing local agreements or local enhanced service arrangements.
- Provide services for South Asian users either within existing tobacco cessation services or, for example, as:
  - A stand-alone service tailored to local needs (see recommendation 5). This might cater for specific groups such as South Asian women, speakers of a specific language or people who use a certain type of smokeless tobacco product (the latter type of service could be named after the product, for example, it could be called a 'gutkha' cessation service).
  - Part of services offered within a range of healthcare and community settings (for example, GP or dental surgeries, community pharmacies and community).

- Ensure local smokeless tobacco cessation services are coordinated and integrated with other tobacco control, prevention and cessation activities, as part of a comprehensive local tobacco control strategy. The services (and activities to promote them) should also be coordinated with, or linked to, national stop smoking initiatives and other related national initiatives (for example, dental health campaigns).
- Ensure services are part of a wider approach to addressing the health needs facing South Asian communities. They should be planned in partnership with relevant local voluntary and community organisations and user groups, and in consultation with local South Asian communities.
- Ensure services take into account the fact that some people who use smokeless tobacco products also smoke tobacco.
- Ensure services take into account the needs of people:
  - from different local South Asian communities (for example, by using staff with appropriate language skills or translators, or by providing translated materials or resources in a non-written format)
  - who may be particularly concerned about confidentiality
  - who may not realise smokeless tobacco is harmful
  - who may not know help is available
  - who may find it difficult to use existing local services because of their social circumstances, gender, language, culture or lifestyle
- Regularly monitor and evaluate all local smokeless tobacco cessation services (and activities to promote them). Ensure they are effective and acceptable to service users. Where necessary, adjust services to meet local need more effectively. The following outcomes should be reported:
  - number of quit attempts
  - percentage of successful quit attempts at 4 weeks
  - percentage of quit attempts leading to an adverse or unintended consequence (such as someone switching to, or increasing, their use of smoked tobacco or areca nut-only products).

#### **Providing brief advice and referral: dentists, GPs, pharmacists and other health professionals**

Primary and secondary dental care teams (for example, dentists, dental nurses and dental hygienists), primary and secondary healthcare teams (for example, GPs and nurses working in GP practices). Health professionals working in the community, including community pharmacists, midwives and health visitors should take action to:

- Ask people if they use smokeless tobacco, using the names that the various products are known by locally. If necessary, show them a picture of what the products look like, using visual aids. (This may be necessary if the person does not speak English well or does not understand the terms being used.) Record the outcome in the patient notes.
- If someone uses smokeless tobacco, ensure they are aware of the health risks (for example, the risk of cardiovascular disease, oropharyngeal cancers and periodontal disease). Use a brief intervention to advise them to stop.
- In addition to delivering a brief intervention, refer people who want to quit to local specialist tobacco cessation services. This includes services specifically for South Asian groups, where they are available.
- Record the response to any attempts to encourage or help them to stop using smokeless tobacco in the patient notes (as well as recording whether they smoke).

See also NICE guidance on brief interventions and referral for smoking cessation and smoking cessation services for more information.

#### **Specialist tobacco cessation services in areas of identified need**

Providers of tobacco cessation services. This may include those working in general practice, dental practices and pharmacies should take action as part of a comprehensive specialist tobacco cessation service to ensure:

- Staff provide advice to people who use smokeless tobacco (or recommend that they get advice to help them quit).
- Staff know the local names to use when referring to smokeless tobacco products.
- Staff can advise people on how to cope with the potential adverse effects of quitting smokeless tobacco. This includes, for example, knowing how to refer people for help to cope with oral pain, as well as general support to cope with withdrawal symptoms.

- Staff offer people who use smokeless tobacco help to prevent a relapse following a quit attempt. If possible, they should also validate the quit attempt by using a cotinine test (saliva examination) and monitor for any possible increase in tobacco smoking or use of areca nut.
- Services reach people who may not realise smokeless tobacco is harmful, or who may not know that help is available should they need it.
- Services reach people who may find it difficult to use existing local services because of their social circumstances, gender, language, culture or lifestyle. For example, a home outreach service might be considered for older people or women from South Asian groups.
- Staff check whether smokeless tobacco users also smoke tobacco and, if that is the case, provide help to quit them both.

### **Training for practitioners in areas of identified need**

Commissioners of health and dental services, commissioners of health education and training services should take action to:

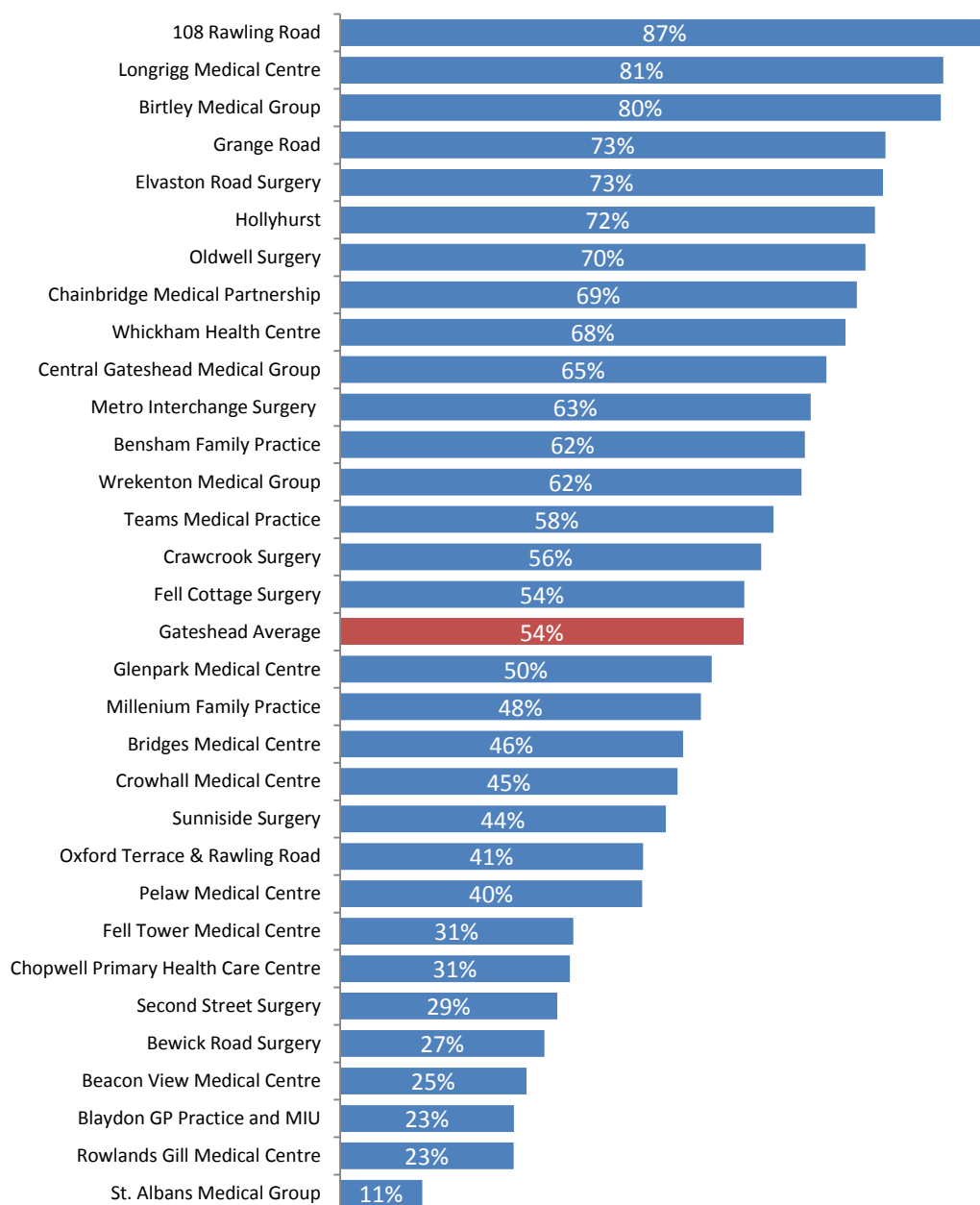
- Ensure training for health, dental health and allied professionals (for example, community pharmacists) covers:
  - the fact that smokeless tobacco may be used locally – and the need to keep abreast of statistics on local prevalence
  - the reasons why, and how, members of the South Asian community use smokeless tobacco (including the cultural context for its use)
  - the health risks associated with smokeless tobacco
  - the fact that some people of South Asian origin may be less used to a 'preventive' approach to health than the general population
  - the local names used for smokeless tobacco products, while emphasising the need to use the term 'smokeless tobacco' as well when talking to users about them.
- Training should also ensure practitioners:
  - can recognise the signs of smokeless tobacco use
  - know how to ask someone, in a sensitive and culturally aware manner, if they use smokeless tobacco
  - can provide information in a culturally sensitive way on the harm smokeless tobacco causes. (This includes being able to challenge any perceived benefits – and the relative priority that users may place on these benefits)
  - can deliver a brief intervention and refer people to tobacco cessation services if they want to quit



## Primary Care Data (supplied by NHS North of England Commissioning Support Business Information Services [NECS])

The following data supplied by NECS is a snapshot taken in March 2017:

### Recording of Ethnicity in Primary Care - March 2017



**Ethnic Group (People with a recorded ethnicity in primary care - March 2017)**

Ethnicity	0 to 4	5 to 9	10 to 14	15 to 19	20 to 24	25 to 29	30 to 34	35 to 39	40 to 44	45 to 49	50 to 54	55 to 59	60 to 64	65 to 69	70 to 74	75 to 79	80 to 84	85+
BME Total	785	2,071	1,698	1,828	2,290	2,884	3,181	2,840	2,178	1,820	1,463	1,161	830	606	405	348	301	226
White British	2,290	3,691	3,253	3,440	4,537	5,333	5,240	5,031	5,086	6,492	7,190	6,742	6,093	6,418	5,318	4,341	3,137	2,655

**Disease Prevalence (People with a recorded ethnicity in primary care - March 2017)**

Population Group	Asthma		Cancer		CHD		COPD		Diabetes		Epilepsy	
	Number on Register	All Age Prevalence	Number on Register	All Age Prevalence	Number on Register	All Age Prevalence	Number on Register	All Age Prevalence	Number on Register	All Age Prevalence	Number on Register	All Age Prevalence
White British	2,294	2.7%	3181	3.7%	4735	5.5%	3419	4.0%	5298	6.1%	737	0.9%
BME Population	168	0.6%	328	1.2%	378	1.4%	209	0.8%	448	1.7%	86	0.3%
Total	2,462	2.2%	3509	3.1%	5113	4.5%	3628	3.2%	5746	5.1%	823	0.7%

Population Group	Osteoporosis		Heart Failure		Hypertension		Stroke		TIA		Palliative Care	
	Number on Register	All Age Prevalence	Number on Register	All Age Prevalence	Number on Register	All Age Prevalence	Number on Register	All Age Prevalence	Number on Register	All Age Prevalence	Number on Register	All Age Prevalence
White British	2,790	3.2%	1123	1.3%	18912	21.9%	1647	1.9%	1010	1.2%	246	0.3%
BME Population	276	1.0%	105	0.4%	1644	6.1%	133	0.5%	67	0.2%	29	0.1%
Total	3,066	2.7%	1228	1.1%	20556	18.2%	1780	1.6%	1077	1.0%	275	0.2%

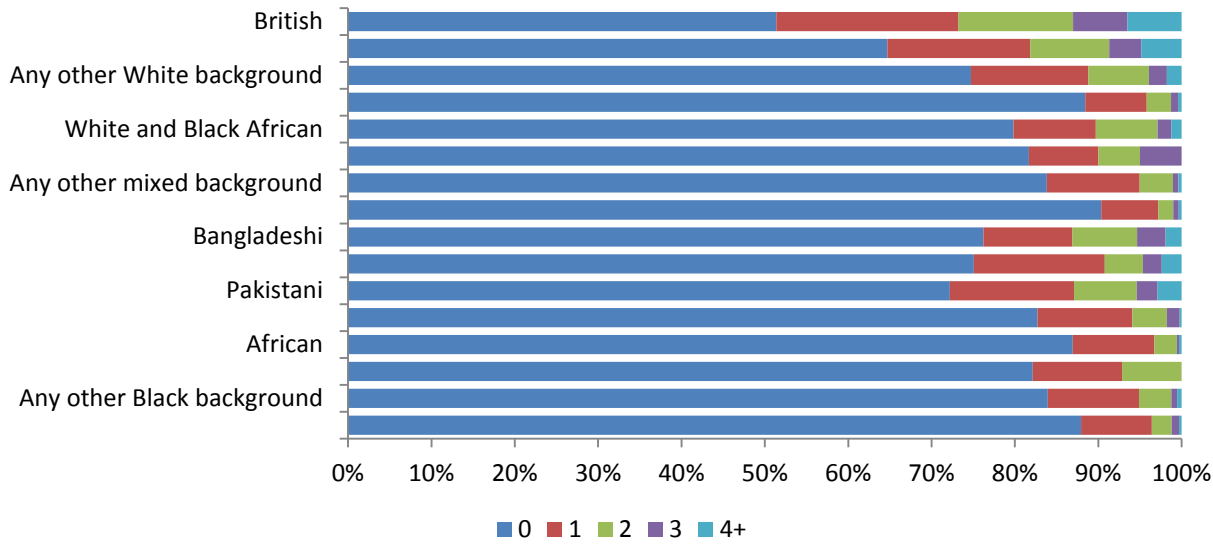
Mental Health Register Prevalence (People with a recorded ethnicity in primary care - March 2017)

Population Group	Dementia		Depression		Learning Disability		Serious Mental Illness		Anxiety Disorder	
	Number on Register	All Age Prevalence	Number on Register	All Age Prevalence	Number on Register	All Age Prevalence	Number on Register	All Age Prevalence	Number on Register	All Age Prevalence
White British	912	1.1%	16,267	18.9%	522	0.6%	921	1.1%	12,346	14.3%
BME Population	69	0.3%	2,722	10.1%	69	0.3%	166	0.6%	2,348	8.7%
Total	981	0.9%	18,989	16.8%	591	0.5%	1,087	1.0%	14,694	13.0%

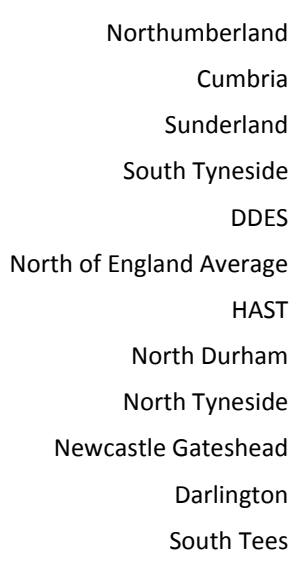
Lifestyle Indicators (People with a recorded ethnicity in primary care - March 2017)

Population Group	Obese Adults		Smokers (Adult)		Uptake of Cervical Screening		Uptake of Breast Screening		Housebound		Health Checks	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
White British	12,896	17.2%	8,191	10.9%	10,306	74.0%	8,515	61.8%	1,390	1.6%	2,549	15.9%
BME Population	1,640	7.7%	1,734	8.1%	3,732	60.3%	1,129	52.3%	109	0.4%	362	6.7%
Total	14,536	15.1%	9,925	10.3%	14,038	69.8%	9,644	60.5%	1,499	1.3%	2,911	13.6%

### Disease prevalence by number of co-morbidities



### IAPT Recovery Rates for the BME Community - 2015/16



**Secondary Care Activity 2015/16**

<b>Practice Name</b>	<b>First Outpatient Attendances</b>		<b>Elective Inpatients (incl Day Case)</b>		<b>Non-Elective Inpatients</b>		<b>Accident and Emergency</b>	
	<b>Attendances</b>	<b>Directly Standardised Rate per 100,000</b>	<b>Admissions</b>	<b>Directly Standardised Rate per 100,000</b>	<b>Admissions</b>	<b>Directly Standardised Rate per 100,000</b>	<b>Attendances</b>	<b>Directly Standardised Rate per 100,000</b>
African	573	188,238	53	14,906	118	15,399	362	46,281
Any other Asian background	175	18,918	32	8,142	73	6,823	253	26,924
Any other Black background	43	47,561	14	18,042	18	16,150	81	90,667
Any other ethnic group	524	84,302	141	34,272	250	36,885	874	118,332
Any other mixed background	113	32,765	35	10,574	72	11,042	274	56,587
Any other White background	944	25,647	201	7,375	492	12,271	1,693	45,738
Bangladeshi	120	60,010	44	27,181	52	24,687	162	76,166
Caribbean	22	31,813	5	14,956	5	6,631	27	39,000
Chinese	150	15,051	65	8,868	59	7,677	215	28,559
Indian	256	35,711	77	13,712	82	9,213	247	28,829
Irish	121	27,146	55	9,937	41	13,336	180	50,686
Pakistani	200	45,236	68	19,430	88	19,820	230	41,847
White and Asian	74	18,662	*	1,474	36	3,455	147	24,997
White and Black African	64	32,360	15	5,936	59	17,212	125	46,874
White and Black Caribbean	18	5,225	6	1,615	18	4,636	39	9,610
White British	73,268	33,870	31,840	13,845	28,018	13,199	93,448	50,445
Total Gateshead	76,665	33,721	*	13,661	29,481	13,197	98,357	49,709
<b>BME Aggregate</b>	<b>3,397</b>	<b>33,287</b>	<b>*</b>	<b>9,911</b>	<b>1,463</b>	<b>11,858</b>	<b>4,909</b>	<b>41,187</b>

Significantly Lower than the Gateshead Aggregate

Significantly Higher than the Gateshead Aggregate

\*Numbers less than 5 have been suppressed

## Comments from Asylum Seekers

- Everyone confirmed that they are registered with a GP
- Some have used a walk in centre in the past, however feel that the waiting time is too long so they go to the one in Newcastle (Westgate Road) which is quicker.
- Come into country three months ago – had to wait three months to get my father seen who has a heart problem.
- Hand injured – took a long time to get appointment at Freeman hospital – hand got better before appointment came in the post.
- When you wait at the QE for 4 hours there is no interpreter – you don't get an update. Had to wait for husband coming from work to interpret problem which caused a delay in being seen.
- Interpreter must have knowledge about human body (especially for women)
- Language barriers – paper and face to face. Letters can be complicated, too many words to read – need to be shorter and clearer.
- Need to be taught key words for health issues e.g. headache so we can communicate this.
- Nobody was aware of the NHS 111 number – PM explained that this is for non-emergencies but that they would still need to ring 999 for an emergency. Issues were raised about not being able to understand the person on the telephone (the asylum seeker not being able to understand the worker). Clear, simple words needs to be used and the pace needs to slow down.
- One participant mentioned that her father had heart problems. They had been in the country for 3 months but her father had not been seen for this yet. However she confirmed that she had an imminent appointment at the hospital for her father.
- Project worker commented that there is a delay in people getting diagnosed with serious illnesses or conditions e.g. type 2 diabetes, however once Asylum Seekers receive 'Leave to Remain' they then get their health issues looked at and people get diagnosis.
- Participants felt that they have to wait too long for appointments with their GP.
- Some participants confirmed that they had been given a health check and that improvements to their health had been made.
- There were some concerns that GPs weren't doing regular health checks.
- Mental health issues – concerns were raised by project worker and participants that GPs were prescribing medication only and not referring people for counselling. They felt that it was difficult to get one to one therapy.
- Only one person in the group had heard of talking therapies. However, she was told that her issues were not for this service. Talking therapies could present problems as initial consultations with talking therapies can be over the telephone (comment made by PM – facilitator). Participants were not aware that they can self-refer to talking therapies.
- Asylum seekers need a support worker – someone they can trust and give information to (project worker highlighted the need for this).
- Is there an anonymous reporting line for mental health issues?
- It was raise by project worker and participants that you have to keep repeating the same traumatic story to GPs as they cannot always see the same one. This was highlighted as causing more distress to asylum seekers and not helping mental health issues.
- One participant stated that she was worried about raising issues of racism in case of repercussions or her name being mentioned. "You wonder, are you in the right place or the wrong place".
- Two participants mentioned that they had tried to commit suicide 3 times. The project worker mentioned that this can be due to them constantly being made homeless when they arrive in the country, having an effect on mental health.
- One participant mentioned that she attends Prince Consort Road Medical Centre and that they meet her needs as an Asylum Seeker and a patient – a nice place to go and feel comfortable going.
- Two participants mentioned a positive experience at the Q. E. Hospital. They both had needed emergency services for themselves or a relative and had both had a positive experience.
- Most in the group confirmed that they would be happy to complete a survey if they were given one (they would help each other).
- It came across that some participants weren't clear who to contact in an emergency.



- Some commented that time is restricted with GPs. Others mentioned that they should book a double appointment.
- Some participants had been given a health check by their GP and conditions such as high cholesterol had been improved, however others didn't know what this was.
- Some knew what diabetes was as it was common in their country, others did not understand this condition.
- Project worker felt that things happen to this group of people/barriers are there in accessing services which aren't there for others.
- None of the participants had access to a computer and some didn't even have a TV (depending on where they were living)
- Asylum seekers may be sharing rooms with others who have nightmares which affects their mental health, rooms may also be damp and they can also have fleas.
- Comments from project worker – Asylum Seekers need support workers to help with other issues including health. Someone they trust and have confidence in talking to. This person also needs to be someone who knows systems and aware of guidelines/procedures for asylum seekers.

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