

Health Needs Assessment of the Black and Minority Ethnic Populations within Nottingham City

Authors

Jennifer Burton: Insight Specialist Public Health Nottingham City Council

Dima Hadid: Work Placement Student Public Health Nottingham City Council

Helene Denness: Consultant in Public Health Nottingham City Council

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Foreword

Welcome to the Nottingham City Council (NCC) and the Nottingham City Clinical Commissioning Group (CCG) Black and Minority Ethnic Health Needs Assessment (BME HNA). Ours is a young, growing, diverse city; we are committed to harnessing these strengths by tackling health inequalities and by providing services that meet the needs of all our citizens. With this in mind, this Health Needs Assessment was developed to identify the needs of Nottingham's BME populations, identify recommendations to improve health, and to inform strategy development and commissioning decisions.

Both NCC and the CCG are committed to reducing inequalities and would like to go beyond just treating disease by also preventing it. To achieve this we aim to work together to influence people's attitudes and behaviour towards health and to nurture a health and care system that fully understands the BME population and its diverse communities and cultures. Many of these communities experience health inequalities and to tackle this we need services that are truly responsive, accessible, and culturally appropriate.

To ensure the effectiveness of this HNA we extensively engaged with our BME communities, as well as with our partners working with these communities, and researched all the latest local and national evidence. This HNA identifies a range of recommendations to tackle health inequalities and to improve health outcomes for Nottingham's BME populations. These recommendations will help us and our partners meet the objectives set out in the Nottingham Health and Wellbeing Strategy 2016-2020, which aims to ensure that *'Nottingham will be a place where we all enjoy better health and wellbeing, with a focus on improving the lives of those with the poorest outcomes the most.'*

This HNA is a commissioning tool and, as such, is the starting point for an ongoing process of information gathering and analysis that will target future interventions and investments to improve the health and wellbeing of BME populations in Nottingham. Whilst it may be complex and challenging to design healthcare services in a diverse and ever-changing society, we are fully committed to achieving this by working together to implement the recommendations across the following themes:

- Access to services
- Mental health
- Data collection
- Community engagement
- Communication and resources
- Partnership working
- Discrimination
- Lifestyle risk factors

To be successful, this approach will require change and integration across the entire health and social care system and it represents an outstanding opportunity to improve the health and wellbeing of Nottingham's BME populations. As chair of the Health and Wellbeing Board and as Director of Corporate Development at Nottingham City CCG, we welcome this report and are absolutely committed to working together with citizens and stakeholders to improve the lives of Nottingham's BME communities.

Councillor Nick McDonald: Chair of the Nottingham City Council Health and Wellbeing Board

Lucy Branson: Director of Corporate Development at Nottingham City Clinical Commissioning Group

Executive summary

Nottingham City's population is increasing and projected to continue to rise. International migration and natural change and the excess of births over deaths, are the main reasons for the population growth; the number of births has risen considerably in recent years.

Nottingham has a young population: the latest mid-year population estimates (2014) suggest that 28% of the City's population are aged 18 to 29 years. This is due largely, but not entirely, to the presence of two universities. Full-time university students account for approximately 1 in 8 of the population. The percentages in other age-groups are lower than the average for England, with the proportions of those between 65 and 74 being particularly low.

The City of Nottingham is the 8th most deprived local authority area in England (Index of Multiple Deprivation, 2007). Estimates suggest that one in four children and adults in Nottingham live in relative poverty. Deprivation and poor health at every age are linked, with poorer health outcomes in areas with higher deprivation.

Health and wellbeing in Nottingham is generally below average for most indicators, reflecting the close link between poor health and deprivation but also reflecting people's own personal choices as well as the influence of services and opportunities. Health inequalities in Nottingham are stark, with life expectancy varying by up to ten years between neighbourhoods, reflecting the different life experiences of Nottingham's communities.

Nottingham City has a large Black and Minority Ethnic (BME) population which accounts for just over one third of the total population, having increased from just under a fifth in 2001. Given the changes in ethnic groups between the 2001 and 2011 census, and the younger age profile of BME groups in the City, the percentage of the population in BME groups is likely to continue to rise.

A rise in population can result in an increase in the proportion of citizens with ill-health. The contact that health services will have with BME communities is likely to increase in line with the increase in population, and this will test the ability of commissioners to deliver services that are appropriate, assessable and culturally sensitive and which meet the needs of an expanding and changing population.

National and international evidence has revealed inequalities in the health, and the healthcare experiences, of Black and Minority Ethnic groups. The diverse experiences and needs of BME

populations are often defined by other markers of identity such as age, faith, gender, sexuality, disability, marital status, education and socioeconomic status. Often these issues play a critical role in relation to how people live and interact with the processes around them (Healthcare Commission, 2006).

Poorer health outcomes for BME communities are often compounded by poor access to services for reasons including language barriers, lack of awareness or information, social isolation, lack of culturally-sensitive services and negative attitudes about communities, as well as differing expectations about how services can help them (DOH, 2014).

The particular needs of individuals from BME communities can only be addressed from within structures and systems that pay attention both to the diversity or differences between and within communities. Policy makers and practitioners must ensure the diversity of experience of BME groups are addressed and due attention given to how BME groups are engaged, in order to identify support needs, since evidence shows that people from BME groups tend to report poorer health than their white counterparts (DOH, 2014)

Health Needs Assessment Methodology

Nottingham City Council (NCC) and Nottingham Clinical Commissioning Group (CCG) requested an assessment of the health needs of Nottingham's BME communities to inform the commissioning and delivery of services. A multi-agency steering group was established to provide advice and support, including commenting on survey design and developing a robust community engagement plan.

The HNA is underpinned by a comprehensive literature review and a robust engagement plan which optimised the spread and depth of views gathered. The extensive engagement with BME communities has been a key success of this HNA and has highlighted those approaches and techniques which successfully engage local communities. The engagement has enabled understanding of how local citizens perceive health and how they experience healthcare and other services.

Data analysis was limited by gaps in the routine recording of ethnicity but nonetheless gives a useful snapshot of health service usage. Knowing the size and, at least to some extent, the overall composition of the BME populations in Nottingham is of relatively limited value without knowing how these communities are using health services and whether any are disproportionately affected by disease

and/or health conditions. The lack of ethnic monitoring data by local services is especially limiting when attempting an assessment of the differences in health outcomes at a local level for different BME populations.

In some instances, it has only been possible to relate information gained through engagement activity with wider research evidence. This presents a significant challenge when attempting to assess health at a population level and requires a shift in strategic direction to make the collection of ethnic monitoring data a compulsory requirement for all services. This will help to improve the health and wellbeing of the BME populations as, once routine ethnic monitoring data is combined with an established evidence base on the prevalence and variation in outcomes for different BME populations, informed decisions can be made about commissioning priorities and resource allocation to address the health needs of BME communities.

Key themes

The themes arising from the community engagement echo those in the published literature and locally-commissioned research. This resonance between the fieldwork and the literature validates the findings. The following themes emerged from the responses:

- Many participants felt that **mental health** problems were common in their communities with problems exacerbated by cultural bias, experience of discrimination and stigma and challenges in accessing appropriate services.
- **The importance of the built environment** was a strong theme in the survey responses and focus groups, including planning of fast food outlets, obesity, accessing open spaces, housing and homelessness, fuel poverty, sense of belonging and affordability.
- **Lifestyle risk factors** were highlighted by the majority of participants including diet, smoking, exercise and the role of personal responsibility. Interestingly, participants were divided on whether traditional or western diets were more likely to contribute to obesity and whether smoking could be seen as a 'cultural' behaviour.

- **Cultural and social norms** were hotly debated, including whether services should be tailored to meet the needs of BME communities, be BME-specific and/or whether all services should develop cultural competence. Support for communities around managing long-term conditions were discussed where it was identified that there is a lack of knowledge related to these conditions. Gender was also seen as a culturally-determined predictor of health service use.
- **Education**, in the broadest sense, was seen as important, including accessible information, health messages and health promotion tailored to BME communities. Participants suggested that social media could be used more effectively as well as schools in informing people about healthy lifestyles.
- Participants stressed the importance of **employment** for health and covered: managing stress at work; unhealthy lifestyle choices being influenced by work; low paid jobs reducing the chance of leading a healthy life; language skills restricting work opportunities and isolation for those unable to work. In addition, some participants suggested that discrimination affected their employment choices and contributed to mental health problems.
- **Access to services** including GP appointment times, long waits for services, GPs not understanding cultural needs and reception staff acting as a barrier to access were described by many participants. Some participants requested culturally-tailored services with some wanting to see a professional of the same ethnicity and others not due to fear of stigma from their own community. In addition, participants whose first language wasn't English commented on issues in accessing interpreters.
- Cultural dimensions of **health seeking behaviour**: many participants commented on how citizens from different ethnicities and cultures use health services differently. Gender was also seen as an important factor in service use, with men seen as less likely to use services proactively.

- **Stigma and/or racism and discrimination:** some participants felt that many statutory services discriminated against them including employment, mental health services, and ‘general’ health and wellbeing services.

The report has conclusively demonstrated that BME communities are not homogenous in their health needs; different BME groups experience different health outcomes. Although the major health concerns may be similar between ethnic groups, there is wide variation in belief systems, attitudes to health and life, lifestyle behaviours and access to, and experience of, health services.

A cross-sector, multidisciplinary approach is needed to improve the health of BME communities. As socioeconomic and environmental factors have considerable impact on the health and wellbeing of individuals and communities, responses should be strategic and recognise the impact of discrimination and associated exclusion as a key public health issue.

RECOMMENDATIONS

The recommendations have been identified using a synthesis of the evidence base and quantitative and qualitative methodologies and have been thematically grouped.

Access to services

- National and international evidence suggests that ethnicity should be consistently considered when developing health services, specifically, to ensure services are culturally sensitive. The citizens consulted through this HNA suggest more could be done to improve the experiences of BME populations accessing local health services. This will be best achieved through continued dialogue with patients and their families, health professionals and the community and voluntary sector.
- Commissioners should consider how they can be assured that health services are delivered in a person-centred and culturally-sensitive manner. For example, to what extent are local services aware of the diverse but specific barriers to access for people from BME communities?

- Local health service providers should consider delivering regular training for their staff on the needs of different BME communities.
- Intelligence gathered through this HNA suggests that some BME communities are not accessing health and social care services in accordance with their level of need. More work is needed to understand the mechanism underpinning this.
- Feedback from BME communities suggests that health and care needs, as can be expected, vary by age. A scoping exercise of the current provision of age-appropriate activities for elders from BME communities could inform future commissioning.
- A number of participants suggested there is not enough youth provision across Nottingham City and felt there needed to be more youth centres. A review should be undertaken to explore this further.

Mental health

- Local intelligence suggests that some BME communities find it difficult to engage with mental health services for “cultural reasons” and/or because they believe the service will not meet their needs.
- Local services could consider targeted work with BME communities to encourage access to mainstream mental health services.
- Participants suggested that greater investment is needed to increase access to responsive, culturally-appropriate mental health services in Nottingham that have the capacity and resources to prevent, as well as treat, mental health problems.

Data collection

- The lack of robust monitoring of ethnicity by local and national health services means there is a significant gap in understanding the needs of BME communities. Service providers need to work with staff to stress the importance of collecting ethnic monitoring data and put robust measures in place to support routine data collection, such as removing the “not known” category in ethnic monitoring. This will enable the appropriate planning and commissioning of services and ensure equity of access.
- The HNA did not have a specific focus on inherited blood disorders which disproportionately affect African and Caribbean communities. The Local Authority needs to consider whether a JSNA chapter on sickle cell and thalassemia is required.

Community engagement

- Citizens and stakeholders suggested that, in Nottingham, we have a tendency to keep consulting, sometimes duplicating previous consultations, without always demonstrating how we have responded to them. A city-wide consultation strategy with shared objectives and pooled resources could help reduce duplication and address the issue of limited funding for large-scale consultations.
- Participants suggested that services should improve their routine engagement with BME communities to provide more opportunities for citizens to inform the planning and commissioning of health services. This will help to ensure services are accessible and meet the needs of Nottingham’s diverse communities.
- Eastern European communities were not sufficiently represented in the engagement activity. Further work is needed to understand how best to engage with these communities.

Communication and resources

- Participants suggested that there is a lack of printed materials on health in a variety of languages in local services, such as in general practice. The availability of interpreters is also 'patchy'. A review of translation and interpreting services in Nottingham is warranted.
- Commissioners and providers should work together to ensure that health promotion materials are available in the most commonly spoken languages. In addition, services should ensure that self-help materials are available in a wide range of formats, including computerised resources, books and leaflets, audiotapes and further resources for those with literacy difficulties.
- Participants suggested that they are not always aware of the range of local services. Communication platforms, such as on-line directories, should be accessible to diverse communities so citizens are aware of local services and how to access them.

Partnership working

- Local partners and community members stressed the importance of the community and voluntary sector in influencing the health and wellbeing of BME communities in Nottingham. However, the capacity of the sector has diminished significantly. Participants suggested that further work is needed to rebuild this sector and engage with organisations, faith groups and community leaders to promote the health and well-being of Nottingham's BME communities.
- Schools were identified as a powerful communication channel for sharing health messages and influencing health behaviours. Further work is needed to explore the role of schools in delivering health and wellbeing initiatives directed at BME communities.
- Commissioners and providers of health services in Nottingham need to look outside traditional structures in order to meet the diverse needs of BME communities. Partnership working with the private sector and other public services and community groups is essential in achieving a positive impact on the mental and physical health of the whole community. For example,

participants suggested that more could be done to engage communities through churches, mosques and other places of worship.

Discrimination

- Many participants identified discrimination as a barrier to living a healthy and happy life with some stating that discrimination would be minimised if the workforce was more reflective of the BME communities in Nottingham. Measures should be put in place to ensure organisations recruit, develop and retain a workforce that reflects the city and is able to deliver high quality services that are fair, accessible, reflective and responsive to the needs of different groups and communities.

Lifestyle risk factors

- Participants identified a range of factors that reduced the opportunity for physical activity. While some of these barriers were described as cultural or religious, e.g. Muslim women only able to attend female-only sports sessions, others were related to access to facilities. Initiatives that encourage participation of BME communities should be identified.
- Education and information for BME communities regarding healthier diets and food preparation are provided through programmes such as *Cook and Eat* sessions; however, the financial support for these sessions has declined. Work should be undertaken to explore potential funding of these sessions, including through local businesses and supermarkets as part of their social responsibility commitment.
- A review of campaigns designed to address attitudes, for members of BME communities, is needed. Approaches that are more culturally aligned with the perceptions and lifestyles of BME communities may prove more successful, as might be a social marketing approach engaged around what works for these communities.
- Participants suggested that some national campaigns, such as *Change for Life*, appear targeted at white communities as they are not culturally aligned with the perceptions and lifestyles of

BME communities. Conversely, *Be Clear on Cancer* was seen to reflect the needs of BME communities. Local social marketing campaigns should be developed using similar approaches.

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1. Glossary of Terms

Analysis: Is the process of looking for patterns in information to identify cause and effect or answer specific questions.

Black and Minority Ethnic Group (BME): A self-defined ethnicity based on heritage, culture, language, physical appearance and other factors. Traditionally the term captures all people not describing themselves as White British.

Clinical Commissioning Group (CCG): CCGs are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area.

Cultural: Describes the habits, beliefs and traditions of a certain group of people.

Culturally appropriate: Describes interventions that take account of cultural or religious beliefs, language and literacy skills by developing strategies that take account of cultural or religious practices.

Community engagement: Describes the process by which community-benefit organisations and individuals build on-going, permanent relationships for the purpose of applying a collective vision for the benefit of a community.

Data: Data are the information collected through research. They can include written information, numbers, sounds and pictures.

Demography: Describes the study of a population, particularly its size, density, death rates, growth rates, personal characteristics, geographic distribution and migration.

Determinants of health: Are the range of personal, social, economic and environmental factors that determine the health of people and communities. They include behaviours that can affect health such as smoking, income, education, employment, working conditions, access to health services, housing and general living conditions.

Deprived areas: Geographic regions or areas that have significantly higher levels of unemployment and lower rates of income per head than the national average.

Discrimination: This is when a person or particular group of people are treated differently, especially in a poorer way, to other people because of factors including, skin colour, gender, sexuality, religion and their beliefs.

Engagement plan: Describes a plan of various activities to communicate and engage with a variety of stakeholders; this includes identifying the most appropriate channels and methods of communication, as well as the people that will help deliver the message.

Focus group: A small selection of people, usually between 6 – 12 in number, who are asked to give honest opinions on a subject or product. It is a good way to find out how people feel or think about an issue, or to come up with possible solutions to a problem.

Health inequalities: Health inequalities are health outcomes that have been socially or economically determined, e.g. because of age, gender, social group, ethnicity, disability, etc. They do not refer to the natural physiological differences between individuals or communities.

Health Needs Assessment (HNA): A systematic process used by NHS organisations and local authorities to assess the health problems facing a population. This includes determining whether certain groups appear more prone to illness than others and pinpointing any inequalities in terms of service provision. It results in an agreed list of priorities to improve healthcare in a particular area.

Incidence: Incidence refers to the number of individuals who develop a specific disease or experience a specific health-related event during a particular time period (such as a month or year).

Index of Multiple Deprivation (IMD): A measure of deprivation composed of six domains of deprivation: income, employment, health deprivation and disability, education skills and training, housing, and geographical access to services. This allows each area to be ranked in relation to the others, according to their level of deprivation.

Joint Strategic Needs Assessment (JSNA): Describes a process through which local authorities and various stakeholders agree a comprehensive local picture of health and wellbeing in a certain area. The JSNA identifies current and future health and wellbeing needs of a population in light of existing services and is used to help inform the commissioning of future health services.

Local Authority: Is a structure of local government.

Long-term condition: Describes an illness which lasts longer than a year and often worsens with time and causes limitations to a person's physical, mental and/or social well-being. Illnesses include cancer, cardiovascular disease and diabetes.

Methodology: Describes how research is done, including how information is collected and analysed, and why a particular method has been chosen.

Morbidity rate: The number of cases of an illness, injury or condition within a given time (usually a year). It can also refer to the percentage of people with a particular illness, injury or condition within a defined population.

Mortality rates: The proportion of a population that dies within a particular period. The rate is often given as a certain number per 1,000 people.

Population: A group of people with a common link, such as the same medical condition or living in the same area or sharing the same characteristics.

Prevalence: How common a disease or condition is within a population, either at a point in time or over a given period of time (it includes new and existing cases). It is different from incidence.

Public Health: Public health is about helping people to stay healthy and to avoid getting ill, so this includes work on a whole range of policy areas such as immunisation, nutrition, tobacco and alcohol, drugs recovery, sexual health, pregnancy and children's health.

Qualitative research: Explores people's beliefs, experiences, attitudes, behaviour and interactions. It generates non-numerical data and asks questions about how and why. For example, why people want to stop smoking, rather than asking how many people have tried to stop.

Quantitative research: Research that generates numerical data or data that can be converted into numbers. An example is the Census of England and Wales, which counts people and households. It might involve questions such as 'How many people visit their GP each year?'

Review of the literature: A summary of the evidence in a number of individual studies, with conclusions about their findings. A review may or may not be systematically researched and developed.

Risk factor: Any aspect of a person's lifestyle, environment or pre-existing health condition that may increase their risk of developing a specific disease or condition.

Socioeconomic status: Description of a person's position in society using criteria such as their occupation, income or level of education.

Social norms: These are the rules of behaviour that are considered acceptable in a group or society. Norms change according to the environment or situation and may change or be modified over time.

Stigma: This is a set of negative and often unfair beliefs that a society or group of people have about something.

Stakeholder: Describes a person such as an employee, partner, customer or citizen who is involved with an organisation or project and therefore has a responsibility towards it and an interest in its success.

Target group: is used to describe a distinct set of people that share a common set of characteristics.

Questionnaire: A study in which information is systematically collected from people, usually from a sample within a defined population.

2. Introduction

In the UK the term 'BME groups', and people of BME origin, describes people of any ethnicity other than 'White British', regardless of where they were born or their immigration status. In some studies, white minorities that are not British are also included in this definition; other studies use the term Black and Asian Minority Ethnic (BAME) groups, while others do not specify who is included in this broad definition (WHO, 2014). In this Health Needs Assessment (HNA), BME refers to non-White British people, including those born outside the UK, and focuses on the main ethnic groups living in Nottingham.

Data from the last census suggests that the White British population in England and Wales (Office of National Statistics, 2012) has declined from 91.3% in 2001 to 80.5% in 2011 (Office of National Statistics, 2012). According to the 2011 Census, 35% of the population in the Nottingham City are from BME groups, an increase of 17% from 2001.

The Equality Act (2010) states that public services are rightfully requested to certify they do not discriminate against people on the basis of religion, race or belief and are called to be responsive to the needs of specific groups such as the BME population. Public services are tasked with recording ethnicity to enable an assessment of how responsive they are to the needs of different groups. However, health outcomes for BME groups are often poorer than the general population and their White British counterparts. Several studies have addressed the differences in health outcomes and found a number of reasons for these variations including genetic or biological differences, differences in reporting, differences in health behaviours that lead to ill health and differences in access to - and experience of - health services.

This HNA aims to assess the health needs of the BME populations in Nottingham. The findings from the HNA will add to the existing body of literature by analysing qualitative and quantitative data collected from service users, service providers and those working with BME groups through qualitative methodology. Through this, the HNA provides an insight into citizens' opinions on health and wellbeing and their experiences of, and potential barriers to, accessing services in Nottingham, many of which mirror those found in previous studies conducted in the UK and internationally. Based on the findings of this study and existing literature, recommendations on how to tackle these issues are made.

3. Background

In order to have an impact on reducing inequalities in health and the prevention of disease, rather than just treating diseases as they emerge, it is necessary to influence people's attitudes and behaviours towards health. To help accomplish this, the healthcare system needs to fully understand its population and communities, which includes minority communities. Health inequalities experienced by many of these communities need to be tackled and services developed that are truly responsive, accessible and appropriate to their needs.

Nottingham City Council (NCC) and the Nottingham Clinical Commissioning Group (CCG) are jointly responsible for maintaining a Joint Strategic Needs Assessment (JSNA). The JSNA identifies where inequalities exist and describes the future health and wellbeing needs of Nottingham City's population. Local intelligence suggested there were gaps in knowledge about the health needs of Nottingham's BME communities, including a lack of robust data on population prevalence of disease, information on health and wellbeing needs and possible barriers these communities experience in accessing services.

It is essential for commissioners to fully understand the health needs of their population if they are to be successful in addressing health inequalities. This HNA was undertaken to explore the health needs of BME groups in Nottingham City. It is underpinned by a comprehensive literature review, a robust engagement process and an assessment of available data.

4. Aims of the Health Needs Assessment

This HNA was undertaken to gain greater awareness of the needs of BME populations in Nottingham in order that this intelligence could be used to inform future strategy development and commissioning decisions. To support the development of the HNA, a programme of engagement with stakeholders, partners and the public was developed to ensure the health needs identified were appropriate and reflective of the health needs of the BME community in Nottingham City.

The aim of the HNA is to systematically identify the needs of Nottingham's BME populations and to consider whether local services are meeting these needs in order to further understand the challenges citizens may face in leading a happy and healthy life. The report was scoping in nature and identifies

areas where further work may be required. Stakeholder and community engagement was undertaken using qualitative methodology, including focus groups and questionnaires.

The Health Needs Assessment objectives are to:

- Describe BME populations within Nottingham, with respect to geographic distribution and age;
- Describe the health needs of BME groups nationally and in relation to BME populations in Nottingham;
- Undertake a robust engagement and consultation process with citizens, stakeholders and local community groups in Nottingham and;
- Identify gaps and provide recommendations to inform future commissioning decisions.

5. Methodology

The importance of drawing on the knowledge, experience and assistance of key stakeholders throughout the course of the HNA was recognised. A BME HNA steering group of key stakeholders was established by NCC at the outset of the project to provide advice and support, including developing a robust community engagement plan and commenting on survey design and other methodologies. In addition, the group facilitated the HNA by identifying and supporting the engagement of other relevant stakeholders. The BME HNA Steering Group also commented on the planned literature review, identifying what they believed to be the most important health conditions affecting local BME communities including cancer, heart disease, diabetes, sexual health, mental health and lifestyle risk factors.

5.1 Literature review

A comprehensive review of relevant literature was undertaken including research journals, books, policy documents and associated materials. The literature search was compiled by the Nottingham Knowledge Resources service and included a web-based search of research relating to BME health needs alongside health inequalities and the impact of the wider determinants on BME health and wellbeing, including employment, housing, household income and education. The literature search was complemented by local research projects including, 'The barriers to the uptake of bowel cancer screening in BME communities in Nottingham' and 'Increasing the uptake of primary and community long-term conditions services in BME communities in Nottingham'.

The web-based search employed key words and phrases including 'ethnicity' and 'race' and the health themes within the HNA, for example: 'smoking and ethnicity', 'mental health and ethnicity'. The websites used included *Race for Health*, the *British Medical Journal*, the *US National Library of Medicine*, *Pub Med* and other websites linked to the area of research. As far as practicable, given the wide parameters encompassed by health and ethnicity as a research area, the web-based search was extended to include other health conditions and groups that are relevant to the HNA, e.g. cancer and ethnicity, diabetes and ethnicity and heart disease and ethnicity.

5.2 Data analysis

Datasets held by the local authority were reviewed to see if they collected ethnicity data and then checked for completeness. The following person-level (pseudonymised) datasets were included in the needs assessment as they contained ethnicity data in a format that was suitable for analysis:

- Hospital Episode Statistics (A&E and admissions to hospital)
- National Child Measurement Programme (child obesity data)
- Nottingham City Citizens Survey
- Sexual Health Commissioning dataset
- Schools Census data

Aggregated data from national surveys was also included to provide some insight where more detailed data was missing or to offer a denominator from which to calculate rates:

- The 2001 and 2011 Census
- Sport England Survey data
- Annual Population Survey data (from NOMIS)

In the majority of datasets ethnicity was coded based on the ethnic categories used in the national census. The source of the data and data quality are discussed in the main body of the text. Where possible, confidence intervals were calculated using standard statistical methods.

5.3 Engagement

An important element of the HNA was to engage with citizens, front-line workers and community groups to ensure their views were expressed throughout the HNA. The scope of the engagement was defined by the BME Steering Group where it was agreed that the engagement should be broad-reaching and use a combination of approaches including questionnaires and focus groups. The group concurred that the engagement should focus on what was important to BME citizens from a health and wellbeing perspective and should be framed by an understanding of health and wellbeing in Nottingham, drawing upon the most recent evidence and findings from the Nottingham CCG Engagement Strategy (2015-2020).

The engagement and consultation were undertaken using two methodologies: questionnaires related to health and wellbeing and focus groups with BME communities. A link to the health questionnaire and information on the focus groups were made available online. People were invited to complete the health questionnaire and also invited to book on to the focus groups taking place across the city. Information about the BME HNA was promoted via social media and on various websites, including those of Nottingham City Council, Nottingham City Clinical Commissioning Group and Nottingham Community Voluntary Service (NCVS).

Local radio was used as a platform to raise the profile of the work being undertaken. A local councillor was a guest on Radio Nottingham and members of NCC Insight Team were guests on Radio Dawn. Listeners were informed about the work being undertaken and invited to attend community events where health questionnaires were being carried out. Listeners were also invited to take part in the focus groups and asked for their support by arranging focus groups in their community.

5.3.1 Questionnaire on health and wellbeing

The questionnaire (see appendix) was developed using the Snap Survey tool, based on themes from previous local engagement activities and undertaken at targeted community events across Nottingham City. Events included the Nottingham Mela, the Sneinton Festival and the Hyson Green Cultural event, which took place during July and August 2016. These events were purposely selected as they attract citizens from BME communities (see appendix for the schedule of events). The questionnaire was divided into sections including: lifestyle, access to services, mental health and barriers to leading a healthy lifestyle. In each section there were a number of statements which respondents were asked to indicate their agreement/disagreement with using a Likert scale.

The final part of the questionnaire was demographical and sought to understand how representative of local communities the respondents were. A prize draw competition was included as an incentive for people to complete the questionnaire. Those who wished to be entered into the prize draw were asked to provide a valid email addresses or telephone number.

A weblink to the questionnaire was circulated on a variety of platforms, including NCC website, NCVS website, social media, CCG website and various partnership newsletters. The online questionnaire generated a small return for the amount of field work undertaken; however, it was deemed important that an online presence was an additional option.

5.3.2 Focus groups with BME communities

The focus group questions were developed using themes arising from the Health and Wellbeing Strategy engagement (2016) and national and international literature (see appendix for focus group questions). Council officers, NCVS and other key stakeholders helped engage potential participants and secured their informed agreement to take part in the research. Organisations across Nottingham City were asked to participate by various methods including face-to-face, email and telephone. Organisations were sent a “Partner’s Brief” asking for support with arranging a focus group with targeted groups.

Local organisations were given the option of a) being provided with a toolkit to enable them to hold their own focus group and sending the feedback to NCC for consideration; or b) of arranging a focus group where officers would attend and lead the session. The focus groups were held where it was felt participants would feel comfortable and in venues that were accessible, the majority taking place in local community venues. Evening and day time sessions were offered to make the groups more accessible to organisations and members of the community.

Organisations received a small cash sum in recognition of their time and as a contribution towards overheads. Volunteer expenses were provided to help cover the cost of travel for participants. The selection of focus groups was arrived at through consultation with the BME Steering Group and other key informants.

5.3.3 Engagement with front-line workforce

In order that the knowledge and expertise of front-line staff could be utilised, two city events were arranged where colleagues were invited to attend and participate in a focus group to offer their input and feedback. BME employees, who lived in Nottingham, were also invited to complete the questionnaires. In addition, BME workers were approached at community events and asked to complete the health questionnaire.

6 Literature Review

Ethnic identity influences the health of individuals and communities through a variety of mechanisms such as migration, direct/indirect discrimination, unmet needs, poor patient-provider communication, inappropriate diagnoses and treatment, some genetic or biological factors, differential access to health-promoting resources and cultural practices. (Nazroo, 1997; Salway and Ellison, 2010). Research has shown that BME communities experience poorer mental and physical health outcomes overall compared to the UK population (Singh et al, 2007) with asylum seekers and refugees experiencing higher rates of depression and anxiety compared to the national population (Raphaely and O'Moore, 2010). There are greater concentrations of health inequalities for members of BME groups in England, particularly in London and the Midlands with BME patients having less than optimal experiences and outcomes with psychiatric services (Runnymede Report, 2011).

Windle et al (2015) investigated barriers and facilitators in accessing pre-hospital care and the consequences of any differences in delivery for people in BME groups. They reported that barriers to accessing care were generic, given the heterogeneity of BME groups: difficulties in communication where English was the patient's second language; new migrants' lack of knowledge of the healthcare system leading to inappropriate emergency calls; clinical assumptions amongst clinical staff resulting in inappropriate diagnoses and treatment.

The main barriers of care for migrants are: language; lack of knowledge and understanding of regulations regarding entitlement; inhospitable and sometimes hostile GP surgery staff (Doctors of the World, 2010). Socioeconomic circumstances and immigration regulations negatively impact some ethnic groups' access to and use of health care (Jayaweera, 2011). Socioeconomic factors such as poor nutrition, sub-standard and overcrowded housing in areas of deprivation have been linked with the reactivation of latent tuberculosis (Abubakar et al, 2012). Poor access to welfare benefits and good quality housing also has an impact on wider determinants of health, such as a lack of transport to care facilities. Some studies postulate that an adult's socioeconomic position is shaped by their position in other structures of inequality. For example, although education is linked to higher living standards, it confers greater benefits to some ethnic groups than to others; for example, a Bangladeshi with a degree has the same risk of poverty as a white person with no qualifications (Graham, 2004).

Ethnic inequalities differ by health condition, gender, geographic area and age (ibid). Moreover, differences exist between generations, along with higher rates of ill health persistent amongst individuals native to the UK compared to first generation migrants (POSTnote, 2007). Differences amongst migrants and UK-born minority ethnic groups are poorly documented (Bradby et al., 2009). Several factors were documented to be key contributors to ethnic discrepancies in health such as socioeconomic status (Nazroo, 1997), experiences of racism (Nazroo, 2003), local area characteristics (Becares et al., 2009) and many more. Health behaviours amongst minority ethnic groups within the UK differ broadly through various cultural, religious and socioeconomic factors, in addition to geography (Gatineau et al., 2011, Siriwardena, 2004)

6.1 Local studies

(i) Increasing the uptake of Bowel Cancer Screening in BME communities in Nottingham City (2015)

The Nottingham CCG commissioned Nottingham Trent University to undertake a piece of research to investigate the barriers to bowel screening uptake in BME communities. Despite a growing and significant body of research that has enabled health academics and professionals to develop better identification of, and responses to, the incidence of bowel cancer, there remain a number of gaps. In the context of the study, Nottingham faces particular challenges in terms of higher rates of incidence (of all cancers) for men, when compared to the East Midlands. Whilst mortality rates have declined, premature mortality in Nottingham (for all cancers) is higher than the national average and higher than most comparator cities (Nottingham City Council 2010). Finally, it largely accepted that early deaths can be better prevented through behavioural change and by addressing structural, social and cultural health inequalities. In Nottingham, there is evidence of significant differential rates of health screening uptake, with the BME population less likely to engage in bowel cancer screening. The study therefore aimed to:

- Investigate the barriers to bowel cancer screening uptake amongst Nottingham's BME communities;
- Identify opportunities for increasing uptake, including drawing on good practice.

The study drew on two significant phases of work:

- A literature review, designed to capture and assess a wide range of evidence from academic work and ‘grey literature’ encompassing policy reports and good practice.
- A participatory action research project, utilising community researchers drawn from Nottingham’s BME population to undertake qualitative fieldwork with a total of 226 participants.

The research was conducted by local people who were representative of Nottingham’s diverse communities. The local researchers were employed and trained to undertake interviews and focus groups with local people. The qualitative fieldwork engaged a total of 226 participants from Nottingham’s BME population. The following key findings emerged from the research and are currently helping to inform local commissioning decisions and further involvement in community work with the aim of increasing the uptake of bowel cancer screening within the BME community in Nottingham.

Cultural differences were found to be prominent in the study, recognising that people identify themselves with a social group on cultural grounds, and that diverse racial and ethnic groups may respond differently because of their particular health beliefs and behaviours (Broch and Fraser, 2000). Cultural dimensions include religion that may affect compliance or access to services; sex, which is commonly mentioned as an obstacle to service access by women; differential presentation including “somatisation” of symptoms, which is reported to lead to misunderstandings, misdiagnosis or incorrect referrals; “fatalism” or shyness, which may also lead to a reluctance to seek help resulting in late presentation; and other cultural factors, such as family dynamics, may mean people cannot easily attend or take up services without the support of family members (Atkinson et al, 2001). It is recognised that health professionals need to take into account these types of cultural beliefs and values when communicating with patients or users.

Language and literacy were identified as key barriers for the uptake of bowel cancer screening. Poor linguistic competences were found to be an important barrier to access for many with high levels of need among older ethnic minority adults. In cases of poor linguistic competence, interpreting services are required to diagnose, consent and treat those people adequately. Differences in literacy levels may also be an issue. Although people may be able to speak English, they may not be able to read it (Johnson et al, 2000; Rudat, 1994). Additionally, despite the translation of letters and patient information sheets and leaflets, some people may not be able to read their own language (Rudat, 1994).

Newness or user ignorance. This factor is related to the migrant status of people (and taking account of older generations) in the BME population, and shows itself through unfamiliarity with the NHS and limited knowledge of available services (Lindesay et al, 1997; Iqbal, 1994; Penso and Hill, 1995; Powell, 1999).

Cultural and age factors. Crucially age and shorter acculturation were found to be the most significant in this respect. Whilst there was acknowledgement that cultural and language barriers were tackled, for example through targeted media, this was sometimes seen not to be age appropriate – e.g. the use of targeted radio stations that were not reaching the age demographic. Further findings included:

- Religion was seen to be a factor in some cases, although religious leaders who promoted positive messages were also identified in the study.
- Language barriers that persist with people who struggle with English are less likely to understand the processes involved in screening.
- Disability featured as a factor, particularly for those who had visual impairments.
- Men were reportedly less likely to engage in screening. It was noted that by the time women reach older age, they have had a 'legacy' of cancer screening interventions (cervical, breast, etc.).
- Personal pride and taboo associated with screening were persistent barriers.
- Personal experience or proximity to cancer served to either spur people on to take action or conversely to not take action. The latter was particularly evident in cases where late diagnosis or treatment had not resulted in a positive outcome for a relative or friend.
- A lack of awareness was identified in relation to the 'currency' of bowel cancer knowledge when compared to other types of cancer.
- A small number of participants believed that cancer kills, irrespective of treatment.

In summary, this study identified a number of factors associated with the uptake of bowel cancer screening by people from Nottingham's BME communities. Factors such as language skills, personal pride, taboos, cultural and social norms and fear were identified as significant factors that prevent people from participating in the bowel cancer screening programme. Evidence suggests that working closely with target BME communities to understand cultural and social norms would help to understand both barriers to and enablers of service uptake.

(ii) Increasing the uptake of primary and community long-term conditions services in BME communities in Nottingham (2016)

This study was commissioned by NHS Nottingham City CCG and undertaken by a team from two research centres at Sheffield Hallam University. The study explored the uptake of primary and community diabetes and respiratory long-term conditions services in BME communities in Nottingham City. The CCG commissioned the study to inform how they can best work in partnership with local BME communities to increase the uptake of these services in Nottingham. In particular, they wanted to better understand the barriers and enabling factors from the perspective of Black and Asian Minority Ethnic (BAME) communities in order to support the development of effective commissioning strategies that meet their needs and promote and support increased service uptake. The study was therefore framed around four research questions:

- What are the blocks and barriers to patients from BAME communities with long-term conditions in accessing and taking up existing long-term conditions services?
- How should the CCG, General Practices (GPs) and service providers engage with BME communities most effectively, including through an asset-based approach?
- What changes need to be made to the way services are delivered?
- What are the next steps for commissioners to support a sustained increase in uptake of long-term conditions services by BME communities?

The study was undertaken in two phases:

Phase 1 was an evidence review, covering UK and international literature and including published academic papers and a wider body of 'grey' material from policy and practice. Secondary data were analysed and a number of stakeholder interviews undertaken to provide contextual information and to inform subsequent phases of the study.

Phase 2 involved in-depth qualitative research to explore the local context further and to identify what the CCG, GP practices and service providers need to do differently to encourage increased uptake. 69 in-depth qualitative interviews were undertaken with BME service users from across the City of Nottingham, along with 17 stakeholders from the across the local NHS, its local statutory partners and the local voluntary and community sector.

The key findings of the study provided the CCG and its partners with a better understanding of the barriers, enabling factors and best practice associated with the delivery of long-term conditions services to people from BME communities, with a view to supporting the development of workable solutions that encourage greater uptake of these services in the future.

Findings from the literature review: The research identified findings under the following eight key themes:

Language and communication

- Poor English language skills lead to low uptake of diabetes and respiratory conditions services.
- People in contact with health professionals who spoke their first language accessed services with greater ease.
- Experiences of using NHS interpreters were positive.
- There was considerable reliance on family members to act as interpreters and translators of health information.
- All health correspondence was provided in English which meant that participants with low English literacy relied on family members to help them.

Awareness and understanding

- There was a significant knowledge gap around the symptoms and management of diabetes and asthma.
- Gaps in knowledge were explained as due to a lack of available information before and after diagnosis.
- People had more confidence in managing their condition if they had attended educational courses such as Juggle.
- Other use channels for learning about a health condition included self-research, television, community radio, and health leaflets/pamphlets.

Provision of services

- Satisfaction with the flexibility and convenience of appointment times and locations for services and educational programmes was mixed.
- Some people spoke positively about their experience of making an appointment but others encountered difficulties at their local surgeries.
- People were keen to attend educational classes but struggled to travel there if they were not within easy reach of their homes.
- Services were more readily taken up when the timings fitted with people's daily commitments.
- Continuity of staff made a difference to patient satisfaction and willingness to engage with services.
- People were positive about services if they had been attentive to specific cultural needs.

Marketing and publicity

- Translated health information on diabetes and respiratory conditions was not offered to the majority of the people in our study in their main languages.
- However, translated materials proved ineffective where patients were illiterate in their first language and health materials alone were not seen as enough to convey complex health information.
- Face-to-face contact, including the Juggle Diabetes Service, along with outreach workers, and speaking with others living with that condition, was a valued method of learning about the management of long-term conditions for many participants.

Religious and cultural barriers

- The role of religion in participants' day-to-day lives varied: from playing no role at all to a very significant one.
- Vast amounts of 'faith' and 'trust' were placed in god as providing support above and beyond assistance of any other kind.
- Some people remain poorly educated in religious principles related to their health, suggesting that community leaders could play an educative role in their communities using religion to influence change.
- There was some recognition of various cultural factors and discussion about how they influenced health.
- The cultural practice of living with extended family emerged as an interesting finding due to its implications for managing diabetes.

Sources of support

- The doctor was perceived by many people as best placed to assist them with their long-term health condition.
- The Diabetes Specialist Nurse played a significant role in the management of diabetes, giving people time and providing emotional support.
- Resources within communities, such as local community organisations, provided a valuable source of support based on cultural norms and values, familiarity, and trust.
- Family members played a significant role in providing practical help to their relatives in areas such as household chores, transport, interpretation and translation.
- There was a lack of awareness about self-help groups, with only a few participants having accessed them. However, the liked the idea of self-help and expressed interest in attending in the future.

Socio-economic status and discrimination

- Experience of discrimination was very uncommon but people's financial situations often influenced the extent to which they could maintain a healthy lifestyle.
- The cost of travel was a barrier to attending appointments, which sometimes resulted in people missing appointments altogether if they could not afford the bus or taxi fare.
- Managing diabetes by maintaining a healthy diet was sometimes difficult for people as they perceived healthier food to be more expensive.
- When people were a carer for a partner or relative, this often conflicted with the time they had available for attending health appointments, attending other services in the community, and maintaining a healthy lifestyle.

Cultural competency

- People were mainly satisfied with health professionals' understanding of language, religious and cultural needs, although some expressed concerns that there was often only basic cultural and/or religious needs.
- Some health professionals were had limited understanding of the diets of different communities when providing advice, which limited the impact of their recommendations.
- The diabetes educational programme – Juggle – was cited as an example of good practice for its cultural sensitivity in providing bilingual trainers and educational content tailored to reflect the diets of different communities.
- The diversity of BAME groups in Nottingham City, which has expanded in recent years, is not necessarily reflected in the cultural awareness training that is provided.

Findings from the qualitative research: the qualitative research identified findings under the following eight key themes:

1) Language and communication

- Poor English language skills are a significant reason for the low uptake of diabetes and respiratory conditions services by BAME people in Nottingham City.
- Participants in contact with health professionals who spoke their first language accessed services with greater ease.
- Experiences of using NHS interpreters were mainly positive and the level of service received from the interpreters was felt to be good.
- A small number of interviews highlighted a lack of consistency in the standard of service provided by interpreters. Time pressures on the interpreter to move from one appointment to the next were described as inadvertently putting pressure on a participant to rush the appointment.
- There was considerable reliance on family members to act as interpreters and translators of health information.
- All correspondence in relation to appointments, referrals and results received in English meant that a large number of participants with English literacy problems were reliant on family members to help them understand the information.

2) Awareness and understanding of long-term conditions

- There was a significant knowledge gap around the symptoms and management of both diabetes and asthma.
- Where gaps in knowledge existed, some participants explained this was due to a lack of available information, both at the point of diagnosis and subsequently.
- Participants had more confidence in managing their condition where they had attended diabetes educational courses – such as Juggle – or had engaged with a specialist diabetes nurse and/or a GP.
- Other useful channels for learning about a health condition, included self-research (via books and the internet); television; community radio; and leaflets/health pamphlets.

3) The provision of services

- Interviews revealed a mixed level of patient satisfaction with the flexibility and convenience of appointment times and locations for long-term conditions services and educational programmes. While some participants spoke positively about their experience of making an appointment, others encountered difficulties with the appointment booking systems at their local surgeries.
- Participants were keen to attend educational classes but struggled to travel there if they were not within easy reach of their homes.
- Long-term conditions services were more readily taken up when the appointment times fitted in with daily work, family, and other commitments of patients.
- Continuity of staff made a difference to patient satisfaction and willingness to engage with a long-term conditions service.

4) Marketing and publicity

- The interviews revealed that translated health information (e.g. leaflets, booklets) on diabetes and respiratory conditions was not offered to the majority of the BME research participants involved in our study in their main languages.
- Translated materials proved ineffective where patients were illiterate in their first language and health materials alone were not seen as enough to convey complex health information.
- Face-to-face contact, including the Juggle Diabetes Service, along with outreach workers, and speaking with others living with that condition, was a valued method of learning about the management of long-term conditions for many participants.

5) Religious and cultural issues

- The research found that the role of religion in participants' day-to-day lives varied; from playing no role at all to a very significant one.
- Vast amounts of 'faith' and 'trust' were placed in God as providing support above and beyond assistance of any other kind. A sense of hope ran through many accounts, which underlined that the ultimate trust lay in God.
- Members of some BME communities remain poorly educated in religious principles related to their health, suggesting that community leaders could play an educative role in their communities, using religion to influence change.

- There was some recognition of various cultural factors and discussion about how they influenced health. Members of a range of BME communities talked about their diets; the richness of food; and the cultural practice of adding oil, salt, and sugar to food.

6) Sources of support

- The doctor was perceived by a large number of participants as being best placed to provide assistance to them with regards to their long-term health condition.
- The Diabetes Specialist Nurse was recognised as playing a more significant role in the management of diabetes. Patients valued nurses giving them time and listening to them, providing emotional support in relation to their condition.
- Resources within communities, such as local community organisations, were viewed as providing a valuable source of support, particularly as the shared understanding of those accessing such places was based on similar cultural norms and values, creating familiarity and trust.
- Family members played a significant role in providing emotional and predominantly practical help to their relatives with diabetes and/or a respiratory condition – including practical help with household chores, lifts to appointments, interpretation and translation.
- There was a general lack of awareness about self-help groups, with only a few participants having accessed them. Although most participants had not attended a self-help group, when the principles were explained to them, the majority agreed with the idea and expressed interest when asked if they would attend.

7) Socioeconomic status and discrimination

- Experience of discrimination was very uncommon but participants' financial situations often influenced the extent to which they could maintain a healthy lifestyle.
- The cost of travel was a barrier to attending health appointments, which sometimes resulted in participants missing appointments altogether if they could not afford the bus or taxi fare.
- Managing their diabetes through maintaining a healthy diet was sometimes difficult for participants as they perceived healthier food to be more expensive.
- In cases where participants were the main or secondary carer for a partner or relative, this often conflicted with the time they had available for attending health appointments, for attending other services in the community and for maintaining a healthy lifestyle.

8) Cultural competency and awareness of health professional

- Participants were mainly satisfied with health professionals' level of understanding of language, religious and cultural needs, although a few participants expressed concerns that health professionals only understood basic cultural and/or religious needs.
- Some health professionals were reported as having minimal understanding of the broader diets of different communities when providing advice, therefore limiting the impact of their recommendations.
- The diabetes educational programme – Juggle – was cited as an example of good practice for its cultural sensitivity in providing bilingual trainers and educational content that was tailored to reflect the diets of the communities engaging with the programme.
- The diversity of BAME groups in Nottingham City, which has expanded in recent years, is not necessarily reflected in the cultural awareness training that is provided.

The research identified a number of factors associated with the uptake of long-term conditions services by people across Nottingham's BME communities. Key factors such as language skills, socioeconomic status and cultural competency were highlighted as significant issues that can be both barriers to and enablers of service uptake, depending on whether and how effectively they are addressed.

(iii) Hear Me Now: The uncomfortable reality of prostate cancer in Black African-Caribbean men (2013 -2015)

The report was produced by BME Cancer Communities and sets out clear recommendations on improving the outcomes of Black African-Caribbean men with prostate cancer. The report concludes that Black African-Caribbean men have an approximately 3-fold greater risk of developing prostate cancer and are more likely to present with prostate cancer at a younger age than the general population (Schlomo, et al. 2007). Evidence shows that in England, despite improvements in current ethnic data collection, there is still an incomplete picture of prostate cancer in black men due to inconsistent ethnic data collection in the NHS over many years (National Cancer Intelligence Network, 2012).

Key Findings

This section provides a summary of the key findings from the report which aims to provide a better understanding of the barriers, enabling factors, and best practice associated with preventing and detecting prostate cancer in Black African-Caribbean men with a view to supporting the development of workable solutions that encourage better awareness and detection in the future.

Data collection

- The limitations with data on ethnicity means prostate cancer may not be properly prioritised in specific cancer or general health equality initiatives, and local commissioners lack robust data that are needed to commission services to meet the needs of BME cancer populations.

Research

- In addition to a paucity of national and local data, there has been little research on prostate cancer in different ethnic groups in the UK and there is a need for further research to better understand the risk, cause, access to treatment and outcomes in this area (Hear Me Now, 2013).
- People from BME communities have consistently reported poorer experiences of NHS cancer services than their white counterparts (Department of Health. August 2012).
- Black men with prostate cancer have also described insensitive behaviour on the part of some healthcare professionals (Nanton, 2011).
- Whilst being one of the most at-risk groups, awareness remains very low amongst black men. Findings from a 2016 awareness study commissioned by Prostate Cancer UK revealed that only 14% of Black men were aware they had an increased risk of developing the disease. (Prostate Cancer UK, 2016).
- A shocking 48% of black men feel uninformed about prostate cancer; low awareness results in late presentation, which in turn leads to limited treatment options and poorer outcomes. (Prostate Cancer UK, 2016).

Black men are more than twice as likely to be refused a PSA test by their GP than men from other ethnic backgrounds (Prostate Cancer UK, 2016).

Prevention and detection

- Whilst being one of the most at-risk groups, awareness remains very low amongst black men. Findings from a DOH 2011 awareness study commissioned by Prostate Cancer UK revealed that only 14% of black men were aware they had an increased risk of developing the disease. A shocking 48% of black men felt uninformed about prostate cancer.
- Low awareness results in late presentation, which in turn leads to limited treatment options and poorer outcomes. Additionally, the study also revealed that black men were more than twice as likely to be refused a PSA test by their GP, than men from other ethnic backgrounds. (DOH, 2011)

Cancer inequalities

- A survey conducted by BME Cancer Communities in Nottingham in 2009 found that 36% of BME people in Nottingham were not sure or were unfamiliar with the signs and symptoms of cancer and 47% did not know how to reduce their cancer risk. At the same time, 55% had a family member who had experienced cancer.
- Many people from BME communities experience higher rates of poverty than white people related to income, benefits use, worklessness, lacking basic necessities and deprivation by area (National Cancer Intelligence Network. 2012).
- Socioeconomic deprivation has been linked to poorer health outcomes and cancer outcomes (King's Fund, June 2011).
- People from BME communities experience 'multiple disadvantage' as a result of being from an ethnic group and as a result of their socioeconomic status, age or another inequality factor. It is well documented that black men suffer discrimination in the workplace and as job seekers (Department of Health, 2011).
- For example, in Nottingham City the black community has the highest rate of unemployment amongst all ethnic groups; 16% black and black British people are unemployed compared to 6% of white people. The mixed ethnic group in Nottingham has 12.9% unemployment (Department of Health, 2011).
- In the current economic climate, unemployment is rising amongst young black men and this could add a further challenge in improving the cancer outcomes of black men (Woods, L.M. et al, 2006).

Accessing services

- Black men with prostate cancer have described insensitive behaviour on the part of some healthcare professionals (Nanton, 2011).
- Communications between healthcare professionals and black men, and stereotyping, have also been identified as challenges for black men with prostate cancer (Nanton, 2011).
- The report highlights some of the barriers to treatment, with first generation black men less likely to proactively ask healthcare professionals questions about their condition or treatment, with myths and misinformation in the black community also potentially inhibiting understanding of cancer (BME Cancer Voice).

Recommendations

The report sets out clear recommendations on improving the outcomes of black men with prostate cancer, some of the recommendations include:

- At a national level, there must be an increased focus on ethnicity data collection and recording, so that we can measure and understand prostate cancer inequalities.
- At a local level, local authorities in their new public health role must work with and support local community groups to promote awareness of prostate cancer in black men. On the frontline, healthcare professionals must be more aware of prostate cancer in black men, along with cultural differences and sensitivities.
- The National Institute for Health Research (NIHR), the National Cancer Research Institute (NCRI) and partner organisations to fund further research on the experience and outcomes of black men with prostate cancer in England, including a better understanding of the cultural barriers and their support needs.
- Public Health England to fund a national campaign to raise awareness of prostate cancer in high risk BME communities. The campaign should be delivered locally to reach BME communities.

Since the launch of the report, a series of roundtable meetings were held in London, Leeds, Nottingham and Birmingham as part of the *Hear Me Now* programme. The meetings aimed to address issues around

a lack of awareness and late diagnosis of prostate cancer in the male black African-Caribbean and black African populations. Building on the momentum generated by the release of a follow-up, parliamentary-backed report 'Hear Me Now: One Year On', the *Hear Me Now* campaign was developed to highlight the inequitable impact of prostate cancer on black communities. The campaign seeks to empower local communities in areas with high black populations to engage with commissioners and decision-makers to reduce the burden of prostate cancer and address health inequalities. The aim of the campaign is to work with CCGs and LA with high black populations to examine what local initiatives could be put in place to improve health outcomes in these areas. This includes considering the case for prostate cancer to be recognised in JSNAs and Joint Health and Wellbeing Strategies.

The outcome from this work has resulted in positive action for Nottingham City. In 2016, the Nottingham City CCG, in collaboration with Nottingham University Hospital and BME Cancer communities, launched a community-based prostate assessment centre in Nottingham. The clinic offers information, advice and counselling plus the option of a prostate cancer risk assessment. The *Check Things Out* social marketing campaign aims to encourage Black African and Black Caribbean men aged 45 years and over to attend the clinic; however no man with concerns around prostate cancer is turned away. A full independent evaluation of the project has been commissioned and the findings will inform future commissioning decisions. However, early results are encouraging and indicate that the uptake of the service is excellent: during the first six months of the project's launch, 100 men have undertaken a prostate cancer risk assessment where five cancers have been detected.

Summary

The report concludes that prostate cancer in black African-Caribbean men is a significant health inequality in England. Other factors such as barriers to accessing health services, cultural concerns and a lack of ethnic monitoring data present significant barriers in the prevention and detection of prostate cancer amongst black African-Caribbean men and further widen the inequality gap. It is encouraging that the report has been successful in shaping local strategies and commissioning decisions to improve outcomes and experiences of black African-Caribbean men with prostate cancer in England.

(iv) Experiences and views on seeking support during a mental health crisis engagement activity report (2016)

Healthwatch Nottinghamshire and Healthwatch Nottingham were commissioned by Nottingham City CCG on behalf of the Nottinghamshire Crisis Concordat Partnership Board to deliver engagement activity to support the development of a local action plan in response to the national Crisis Care Concordat. The engagement objective was to target five specified groups to improve understanding of the issues faced by these groups in accessing mental health crisis services. The groups were:

- BME communities, including asylum seekers and refugees
- Students
- Carers of people with a mental health illness
- Veterans/ex-military personnel
- People who are homeless or at risk of homelessness

The study aimed to gain a deeper understanding of the situations in which those from the specified groups were in and whether this influenced their experiences of seeking urgent and emergency support during a mental health crisis. The main focus of the engagement was therefore on talking face-to-face or by telephone to people from within the five groups. To identify and engage with people, the main approach was to work with community groups and organisations across Nottingham City and Nottinghamshire County. The engagement work included attending groups or services and talking to people face-to-face and providing information about the project for wider distribution. The information included a link to an online survey or hard copy surveys which invited people to take part in a more detailed conversation, at a time and date convenient to them. Through this combination of approaches the study was able to gather detailed experiences from a total of 269 people. Some of these fell into more than one of the five specified groups and were able to provide experiences from two perspectives; for example, some people from a BME background were also carers of someone with a mental health illness. The numbers engaged from each group were:

- 73 people who were from a BME community, including 10 asylum seekers and refugees
- 55 students studying at the University of Nottingham or Nottingham Trent University
- 83 carers of people with a mental health illness
- 21 veterans/ex-military personnel
- 37 people who were homeless or at risk of homelessness

Experiences were gathered through semi-structured interviews undertaken by members of the project team. The survey was circulated to contacts on the mailing lists of both Healthwatch organisations, and through other organisations and groups supporting people who might have experienced mental illness. In addition, hard copies of the survey were taken to engagement activities where members of the community were asked to either complete them at the time of contact or return in the post using freepost envelopes provided. Experiences already held on the Healthwatch database were also subject to secondary analysis. Across all of these approaches the experiences of 484 people in Nottingham City and Nottinghamshire County were included in the project.

Summary of the findings

Every group stated that they would seek urgent and emergency support from their GP during a mental health crisis episode (43%; 198 people) but a number of barriers were identified which have and could prevent this. A lack of awareness of how and where to get urgent and emergency support and the stigma associated with mental health illness were more likely to be identified as barriers in the specified groups compared to the wider population. Additional specific barriers were also key for specific groups:

- Language and cultural issues for those from a BME community;
- Alcohol and substance misuse for both veterans/ex-military personnel and people who are homeless or at risk of homelessness;
- The symptoms of the crisis episode itself were significant barriers for both veterans/ex-military personnel and homeless people.

This section details the findings from 74 experiences from the BME community including asylum seekers and refugees, 53 experiences and views collected through the quantitative survey and 21 collected through semi-structured interviews:

Accessing urgent and emergency help during a crisis

People were asked to identify where they would access urgent and emergency help if they or someone they cared for experienced a mental health crisis in the future. The top five most frequently identified sources are illustrated in figure 1, which shows that people were most likely to identify their GP as a source of urgent and emergency support. When asked why, people were most likely to state that this was because they saw their GP as the access point for other services, either through referrals or

information and signposting. The only other reason identified by multiple people was because they had no knowledge of other sources of support.

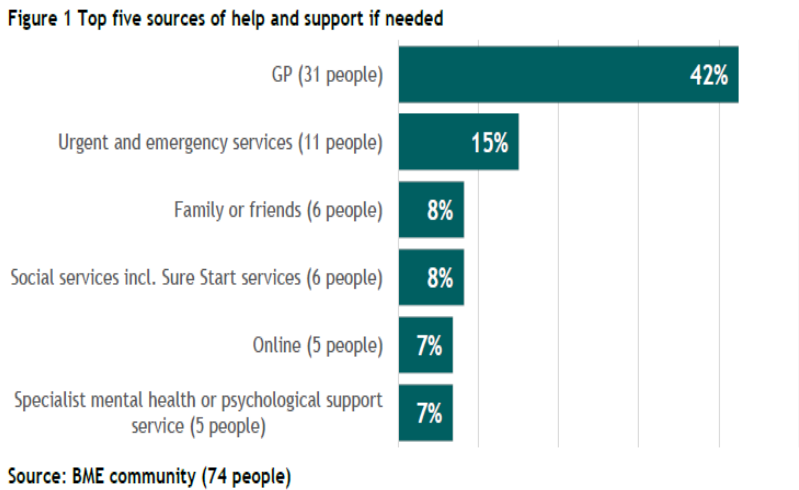


Figure 1: Top 5 sources of help and support if needed
Source: Experiences and views on seeking support during a mental health crisis engagement activity report (2016)

It is also interesting to note that four people from the BME communities identified that they did not know where they would access urgent and emergency support if needed. Five people would actively choose not to seek such support if they were to experience a mental health crisis in the future. Where people identified a reason for this, it was most likely to be due to previous negative experiences of seeking support.

Barriers to accessing support

People were also asked to identify if anything had or would stop them from seeking urgent and emergency help and support for a mental health crisis in the future. 15 people (21%) stated that nothing would stop them accessing support, but of those who did identify a barrier this was most frequently because of:

- Lack of information and awareness about services: almost a quarter (23%; 17 people) of the BME communities we spoke to made reference to this being something which would stop them accessing urgent and emergency support if needed in the future. As a result, some of these people felt that there would be no-one who could help in a crisis situation or that they had or would access support from their family and friends.

- Stigma: Over a fifth (21%; 15 people) of all the BME people we engaged made reference to the stigma associated with mental health and being embarrassed to admit they had a problem;
- Home nation cultural influence: 12 people (16%) referenced the home nation cultural influence as a potential barrier for accessing future help and support during a crisis situation. This meant people wanted to deal with their issues themselves, something which was also referenced in relation to a cultural influence amongst their community. This was often talked about alongside the stigma attached to mental health issues, identifying that this also originated from their home nation;
- Language: This barrier was identified by 12 people (16%) and was also related to the issue of confidentiality when translators, particularly family members, are required to facilitate access to services. People worried about not being able to communicate with services and convey their issues sufficiently to access the support needed;
- Previous negative experience: This barrier was discussed by 12 people (16%) and was referenced alongside comments related to accessing support from secondary mental health services and the long waiting times often involved.

Contact and involvement with services before the crisis

Where people talked about support they had received from NHS services prior to their crisis experience, they were most likely to have been in contact with a specialist mental health or psychological support service:

- The majority were involved with secondary mental health services such as psychiatrists or community psychiatric nurses.
- Others had been referred through to a shorter-term talking therapy including, for example, those provided through 'Let's Talk Well-Being' and Trent PTS.
- A smaller number of people had been in contact with their GP, referencing medications and referrals to further support.
- Where people talked about their experiences of contact with service prior to their crisis it was mostly negative. Long waiting times were the most frequently identified issue. This was a source of frustration for many with some people identifying that, as a consequence, they were not getting better and there was the potential for them to reach crisis point as a result.

Experience of accessing urgent and emergency support during a crisis

Where people from the BME community had accessed help and support during a crisis, they were most likely to have done this through accident and emergency, the NHS 111 service or a GP referral. Where details were provided of accessing support through these routes, negative comments outnumbered positive comments by around three to one. All positive experiences referenced how further support had been secured. Where negative experiences were identified the opposite was true: further support from specialist services was not offered or secured. This did not meet the patient and/or carer expectations and there were some indications that this experience was detrimental to their mental health.

Meeting the support needs of BME communities during a mental health crisis

Participants were asked to identify if they thought there was anything services could do better to ensure that people from BME communities received the care and support they needed during a mental health crisis. The following emerged as key themes as to how this group's needs could be better met:

- Greater promotion of services and sources of support. It was identified that this would be most successful if undertaken through community venues and groups where people from black and minority ethnicities already attended, particularly venues which reflected and mirrored the cultural influences of their home nation such as churches. People also suggested that this should be done alongside an education campaign to help overcome the stigma associated with mental health illness in these communities.
- Peer support could be beneficial in helping to support people to access services and provide support following discharge from crisis services. People from black and minority ethnicities and particularly refugees and asylum seekers felt that having peer support in this way would be reassuring and increase their confidence in the services and help provided.

Summary

Mental ill-health is a significant health inequality in England. Stigma associated with mental illness was more likely to be identified as a barrier in BME groups compared to the wider population. Language skill, barriers to accessing services and cultural and social norms present significant challenges for the BME community when accessing health services. The report concludes that BME communities have a

lack of awareness of how and where to get urgent and emergency support for their mental illness and that the combination of all the factors mentioned above widens the inequality gap between BME groups and the general population.

6.2. Cardiovascular disease

Cardiovascular disease (CVD) is a significant cause of deaths worldwide (Nag et al., 2013). The Global Burden of Disease (GBD) study conducted in 1990 focused on developed and developing countries and estimated the number of deaths from CVD to be 5.2 million and 9.1 million deaths respectively (Murray et al., 1997). Gubta (2005) anticipates a 75% increase in the overall CVD dominance by 2020. The evidence shows that the increase in CVD is mainly occurring in developing countries. During 2008, 13.8 million deaths from CVDs occurred. Of these, 7.3 million were as the result of coronary heart disease and 6.2 million were caused by stroke (Nag et al., 2013). Furthermore, more than 80% of CVD deaths occur in low and middle-income countries. It is predicted that by 2030, nearly 23.6 million deaths will be caused by CVDs, chiefly from stroke and heart disease (Nag et al., 2013) with four-fifths of all non-communicable disease (NCD) mortality occurring in developing countries (ASSOCHAM, 2011). NCD has been described by the World Health Organisation (WHO) as a global epidemic, which will cause approximately 76% of worldwide deaths by 2030 (WHO, 2005). This is particularly relevant to the increase in CVD at a global level since it is a key component of NCDs. Moreover, by the year 2020, 85% of the universal cardiovascular disease concern is expected to exist in developing countries, with an estimated increase in CVD-related mortality rates among both men and women (Reddy et al., 1998). Several factors, such as improved standards of medical care, advances in medical technology and firm government policies and action have led to a 50% decrease of CVD death rates in developed countries (Nag et al., 2013) yet developing countries still suffer from the constant rise of people affected from NCDs (ibid).

6.2.1 Asian communities

Nag et al (2013) conducted a systematic review on the understanding of CVDs among the Asian Indian population in rural regions (ibid). Although several surveys were carried out on CVDs no clear framework was established due to the inadequacy of data, in addition to the majority of these surveys being restricted to urban regions (Nag et al., 2013). Several factors are associated with the increasing rate of cardiovascular diseases, yet its mechanism and aetiology have not yet been recognised (Nag et

al., 2013). A survey conducted on 45 Indian rural villages showed that deaths caused by CVD constituted approximately 32% of all deaths, emphasising that further negligence of the socioeconomic framework will exacerbate the constant rise of CVD among Indians (Nag et al., 2013). Common risk factors such as smoking, hypercholesterolemia and hypertension are no greater among South Asians than among other ethnic groups; however, risk factors such as atherosclerosis and type 2 diabetes did predominate (Ghosh, 2007). The metabolic syndrome (MS), defined as the combination of several CVD risk factors, is a major emerging public health concern within the Asia-Pacific area (WHO/IASO/IOTF, 2000). According to the principal component factor analyses (PCFA), the combination of CVD risk factors is affected by various physiological mechanisms (Nag et al., 2013). In order to improve the population's health and tackle the main trigger of the hasty increase of CVD, appropriate strategies and constant effort need to be implemented (ibid).

The rising growth of CVDs in India has been observed within urban regions, yet numerous vascular deaths occurred in rural areas where the bulk of the populace resides (Nag et al., 2013). WHO (2002) predicted that by 2020 CVDs will be the major cause of deaths and disability in India. According to the Global Burden of Disease Study, India bears the utmost CVD burden (Murray et al., 1997). The INTERHEART study which compared the risk factors in men and women concluded that hypertension and diabetes were greater risk factors amongst younger female Indians than in males and that smoking was a more significant risk factor amongst men than women (Yusuf et al., 2004). Globalisation and increases in income levels have led to a nutritional shift characterised by the rise of unhealthy food consumption as well as a decrease in the consumption of vegetables and fruits (Nag et al., 2013).

Moreover, urbanisation has resulted in numerous problems such as increased exposure to pollution, shorter physical activity time, congested and unsanitary living conditions and increased stress levels, which give rise to further risk factors for heart disease such as hypertension, diabetes and atherosclerosis. It is predicted that by 2025, 70 million Indians will suffer from obesity. The Indian Lifestyle and Heart Study revealed the correlation between low and high saturated fat intake and the increasing prevalence of CVD, as well as the possible association of low saturated fat intake with lower serum cholesterol level. Furthermore, this study revealed that CVD occurs more among the higher income population leading a sedentary lifestyle, rather than the poor socioeconomic and unskilled labourers involved with physically demanding effort (Nag et al., 2013).

The poor groups tend to drink and smoke more, leading to the early occurrence of CVD (Xavier et al., 2008). These groups usually disregard treatment for the following reasons: high cost of treatment; transportation costs needed to reach the closest healthcare facility; losing wages; low awareness and poor access to healthcare facilities. Healthcare costs exacerbate the situation by driving 39 million Indians yearly into poverty (ibid). Absence of surveillance in addition to inappropriate diagnosis has been the reason behind the constant growth of CVD in India (Nag et al., 2013).

According to Gupta et al. (2010), the middle and low educational status groups are most prone to cardiovascular risks. Furthermore, differences in lifestyles could be possibly linked to the variations in prevalence of certain risk factors. For instance, risk factors such as diabetes, obesity and hypertension were more common among individuals leading sedentary lifestyles (Chadha et al., 1997). In summary, CVD is greater amongst low and middle class groups; this is primarily due to variations in lifestyle and higher levels of deprivation (Nag et al., 2013).

6.2.2 Other ethnicities

Gasevic et al. (2015) conducted a systematic review on the latest North American literature and evidence available in order to examine and understand the variable CVD risk factors among the most prevalent ethnic groups in Canada. Canada, known as “the land of immigrants” (Government of Canada, 2015) and the land of ethnic diversity is faced with the danger of cardiovascular disease with nearly 20% of deaths attributed to it (Statistics Canada, 2015). South Asian and Chinese groups remain the evident majority, along with the Arab and West Asian populations rapidly rising (Statistics Canada, 2015).

The systematic review conducted by Gasevic et al. (2015) suggested that the prevalence of several CVD risk factors differ between various ethnic groups, leading to differences in the resulting consequences. For instance, the high occurrence of diabetes, obesity and hypertension in black, in comparison with white, people could be interpreted as greater stroke (Huxley et al., 2014), cardiovascular disease (McTigue et al., 2014) and cardiovascular mortality (Meadows et al., 2011) prevalence among black individuals. Likewise, higher rates of smoking, obesity, diabetes and hypertension were seen among aboriginal compared with white individuals, hence the higher CVD rates (Gasevic et al., 2015) and

premature deaths (CDC, 2004) observed among native people. Furthermore, diabetes was more evident among Chinese compared to white individuals (Gasevic et al., 2015) thus explaining the higher prevalence of coronary heart disease among Chinese groups (Yusuf et al., 2001). Furthermore, death rates due to ischemic heart disease were higher amongst European and South Asian individuals compared with Chinese Canadians (Chiu et al., 2010).

6.2.3 Race and ethnicity

Padilla and Peters (2015) examined the impact of race and ethnicity on the prevalence of cardiovascular disease risk factors and diabetes in the USA. The constant growth of obesity rates in the USA has consequently led to the rise of diabetes among individuals (ibid). According to Chatterji et al. (2012) diabetes mellitus type 2 (DM2) increases the risk of having a cardiovascular disease incident two-fold and the mortality rate two- to four-fold. Padilla and Peters (2015) found that African Americans, non-Hispanic Blacks developed DM2 twice as often as non-Hispanic Whites; in addition they found that they had greater risks of hypertension, renal disease and retinopathy (Ferdinand et al., 2014). American Indians (AI) reported a higher rate of smoking, thus increasing their health risks, since smoking is a lifestyle risk factor and therefore related to the occurrence of obesity (Padilla et al., 2015). AI adults were three times more likely to suffer from diabetes than the overall adult US population.

In addition, higher rates of hypertension (Padilla et al., 2015), CVD (Hurtado et al., 2014) and premature death from heart disease were reported among American Indians compared to non-Hispanic Whites (O'Connel et al., 2010). Furthermore, Mexican Americans were 2.33 times more at risk of having diabetes in comparison to non-Hispanic Whites (Chatterji et al., 2016). Latinos showed higher rates of coronary heart disease, retinopathy and renal disease in addition to poor control of diabetes (ibid). Moreover, Asians were likely to either have a lower or higher rate of CVD risk than non-Hispanic Whites, contingent upon the subgroup of Asian background; nonetheless, Asians were observed to have diabetes at a lower BMI than several further ethnicities (Ferdinand et al., 2014). Therefore, it can be concluded that, in addition to having greater diabetes occurrence rates, ethnic minorities face higher morbidity rates from CVD compared to the non-Hispanic White group.

Several studies aimed to understand possible explanations for the perceived ethnic dissimilarities in CVD risk factors. Genetics was assumed to be one of these explanations, yet that assumption remained

unfounded due to the inadequate comprehension of the correlation between genetic factors and inter-ethnic dissimilarities in complex traits such as CVD risk factors (Moutain et al., 2004). Body fat distribution was another speculation, since body fat accumulation varies through ethnic groups (Lear et al., 2007).

Moreover, lower physical activity rates observed among Chinese (Sulistyoningrum et al., 2013), black (Short et al., 2013), Hispanic (McTigue et al., 2014), Filipino (Barnes et al., 2008) and aboriginal groups (Cobb et al., 2014) was considered another speculation. In addition, lower consumption of fruits and vegetables in Chinese and black people vs. white people (Chiu et al., 2010) was considered as a potential factor contributing further to variations in CVD risk factors among these ethnic groups.

Socioeconomic status of individuals and neighbourhoods has also been attributed to ethnic disparities in CVD risk factors (Gasevic et al., 2015). In other words, living in deprived neighbourhoods exposes individuals to unhealthy lifestyles (Lakshman et al., 2011) increasing their cardiovascular risk, and it was contended that ethnic differences in CVD risk are entirely reduced for individuals living in such circumstances (LaVeist et al., 2011).

Cultural beliefs and attitudes were also suggested as an explanation of the ethnic disparities in CVD factors (Short et al., 2013). For instance, an overweight woman is considered more acceptable among black compared to white groups (Gasevic et al., 2015). In addition, health insurance status, education, family history, age, race, chronic kidney disease and the length of residence in host country were factors that influenced the occurrence of CVD risk factors and diabetes (Padilla et al., 2015). Numerous additional social and environmental determinants of CVD risk among various ethnic groups have been consequently examined, emphasising the importance of implementing culturally proficient CVD prevention and management, intended to eradicate ethnic differences in CVD risk (Gasevic et al., 2015).

6.2.4 Summary

In all minority ethnic groups there was a general age-related increase in the prevalence of CVD conditions. Evidence showed that Chinese men and women had lower rates of CVD than the general population, with South Asian groups showing higher rates. The socioeconomic status of individuals and

neighbourhoods were found to be attributed to ethnic disparities in CVD risk factors. Cultural beliefs and attitudes were suggested as explanations for the ethnic disparities in CVD factors among BME groups and the general population. When all of these factors are taken into account, the differences in prevalence between BME groups and the general population are found to be statistically significant.

6.3 Stroke

Stroke is the second global leading cause of death and a main cause of disability worldwide (Tsai et al., 2013). Stroke is caused by factors including: smoking; high alcohol consumption; unhealthy lifestyle; high blood pressure; lack of physical activity; and high cholesterol (University Hospital Southampton NHS Foundation Trust, 2015). There are three types of stroke, known as ischemic stroke, intracerebral haemorrhage and subarachnoid haemorrhage (Tsai et al., 2013). Ischemic strokes constitute over 80% of the total number (WebMed, 2016).

By 2020, cerebrovascular diseases are estimated to remain the second leading cause of mortality universally (Burke et al., 2006). It is estimated that yearly, around 800,000 people in the USA have a stroke (McIntosh, 2016) and that 110,000 cases occur within the UK (NHS, 2015). In the USA, stroke is the fifth leading cause of death, with 40% of deaths occurring in males and 60% in females. According to the NHS (2015), Black Caribbeans and Asians are at a higher risk of having a stroke due to the predisposition of developing high blood pressure. The American Heart Association stated that black people in comparison with white people, have twice the risk of a first-ever stroke and a greater risk of death from stroke (McIntosh, 2016).

The impact of stroke is greater in middle-income countries. For example in China, which constitutes approximately one-fifth of the overall population worldwide, stroke is currently the foremost cause of death and adult disability (Liu et al., 2011). Tsai et al. (2013) conducted a systematic review to compare the incidence of stroke among Chinese groups vs. white groups in order to elucidate what is recognized and what remains ambiguous regarding the epidemiology of stroke occurrence among Chinese compared to white people.

Results showed that in community-based studies, the yearly age-standardized¹ first-ever stroke² is greater among Chinese compared to white people. Moreover, intracerebral haemorrhage caused a greater number of strokes in China compared to Taiwan, community-based Chinese compared to their white counterparts, and Chinese community-based vs. hospital-based studies. Several studies showed a higher proportion of lacunar (small vessel disease) ischemic stroke among Chinese than white groups but, due to the inconstant methodologies used within the studies, comparisons are prohibited and remain unreliable (Tsai et al., 2013).

Scarce research was conducted regarding stroke risk and its subtypes amongst Chinese and white individuals residing in a similar region (Feigin et al., 2006). Studies attributed variations to several reasons including: diabetes; obesity; dietary habits; genetic factors; socioeconomic status; hypertension; extreme weather and hyperlipidemia (Asch et al., 2010). These vary greatly within Chinese populations and between White and Chinese populations (Tsai et al., 2013).

Burke et al. (2006) examined the epidemiology of stroke in the East Asian region³ in order to provide an in-depth understanding of the situation, guide the development of preventive programmes and organise the allocation of healthcare resources. Results showed that stroke epidemiology is well understood in Taiwan, Japan and China, whereas scarce evidence exists for other countries. Regional differences in prevalence were seen, with the highest stroke incidence observed in rural and northern areas. In Taiwan however, after adjusting for sex and age, considerably greater stroke prevalence was observed in the eastern, least developed regions compared to the northern areas. Overall, the average stroke rate in these countries tends to be greater in comparison to the United States and Western Europe. Furthermore, haemorrhagic strokes were more frequent than ischemic strokes in the Asian countries than in the West (Burke et al., 2006).

A report by the *Health Service Journal* (2011) found the main inequality with regard to stroke and ethnicity is that BME groups are much more likely to get strokes at younger ages than their white counterparts. The findings show that, among London's Black African descent population, the incidence

¹ Age specific annual incidence

² The First-Ever Stroke was defined as a stroke occurring for the first time during a patient's lifetime

³ China, Hong Kong, Japan, Taiwan, South and North Korean and the ASEAN countries (Association of Southeast Asian Nations).

of stroke is 60% higher than that of the city's white population. Early diagnosis and treatment of hypertension and diabetes in Black African and Black Caribbean men in particular is vitally important as a preventative action for stroke. The report highlighted concerns with data collection and found the original research on incidence of stroke by ethnicity in South London, reported on in 1999, used the same stroke register from 1995 which was not updated or acknowledged in the 1999 study.

Furthermore, evidence suggests that the quality of healthcare provided after a stroke remains uneven in the UK. According to a study by Chen et al (2014) patients from more deprived areas tend to receive a poorer level of care following a stroke. The impact of socioeconomic deprivation on the care given also appears to be more pronounced in BME patients than in white patients. The study looked at the acute and long-term care provided to stroke patients. A socioeconomic deprivation (SED) score was calculated for each patient using their postcode of residence at the time of the stroke, from which a baseline SED was determined using an index derived from census data on unemployment, overcrowding, car ownership and other factors. The study also looked at ethnic differences in the impact of SED on the provision of stroke care. It found that patients from more deprived areas were a third less likely to be admitted to hospital. SED patients were also a third less likely to undergo a swallow test at hospital, which is usually deemed essential for anybody who has had a stroke and is carried out by a speech and language therapist or other healthcare professional. SED patients were half as likely to be taking drugs to lower their blood cholesterol three months after the stroke and two-thirds less likely to be taking medication to control their blood sugar levels two years on. The study also found more pronounced differences in the impact of SED on care for black patients than for white patients, suggesting that strategies to address health inequalities need to be targeted at this group.

6.3.1 Summary

The impact of stroke is greater in middle income countries with black African, black Caribbean and Asian groups being at a higher risk of having a stroke than the general population due to the predisposition of developing high blood pressure, diabetes, obesity, dietary habits, genetic factors and socioeconomic status. The evidence concludes there are pronounced differences in the impact of stroke on BME groups resulting in health inequalities between BME groups and the general population, suggesting that strategies to address health inequalities in stroke need to be targeted at the BME population.

6.4 Mental health

This section presents the incidence of mental illness in Black and Minority Ethnic communities living in the UK and aims to establish if such communities experience health inequalities specifically through differing rates of incidence and treatment of mental illness within the BME community in comparison to white groups.

The term mental health is used positively to indicate a state of psychological wellbeing (WHO, 2010). However, the use of the term 'mental health problems' describes a full range of diagnosable mental illnesses and disorders, including personality disorder (DH National Strategy 2011). Mental illness has become a major global problem: it affects 450 million people and it is widely reported that one in four people will experience mental health problems each year (McManus 2009) and up to one in two people at some point in their lives (Kessler 2007). Mental health problems are extremely common and are wide ranging in nature from common problems such as depression and anxiety, to rarer problems such as schizophrenia and other forms of psychoses.

Mental health problems can be highly disabling and affect family, working and social life. Adults with enduring mental health problems can be one of the most socially excluded groups in society, experiencing stigma and wide ranging social disadvantage as well as poor physical health outcomes, which makes it harder for those with mental health problems to live a full life.

There are many factors that influence mental health and wellbeing including personal relationships, childhood experience, employment, housing, safety, built and natural environment and experience of discrimination (WHO, 2010). There is also a growing body of evidence to show that mental health and physical health are interlinked. People with mental health problems experience higher rates of physical illness and a lower life expectancy (De Hert, 2011). People with chronic or long-term physical health problems are more likely to experience mental health problems, which are often unrecognised and untreated (Naylor 2012).

Mental health problems impact on individuals, families, communities and society as a whole, with immense social and financial costs. Estimates put the full cost of mental health problems in England at

£105.2 billion (Centre for Mental Health 2010). Mental illness accounts for about 13% of the total National Health Service (NHS) spend (Parsonage et al 2012). A further dimension of inequalities in the apparent scale of mental health problems has been attributed to ethnicity. In the United States black patients are over-represented in mental institutions; this has particularly been the case within state mental hospitals where minority groups constitute 35 % of the hospital population and are subject to higher rates of admission and readmission (Redman, 2012).

In a review of eight epidemiological studies conducted in the United States between the late 1950s and mid-1970s, Kessler and Neighbors (1986) found that among persons with low incomes, black people exhibited significantly more distress than white people. They claimed, therefore, that race is an important independent variable in determining the likelihood of an individual becoming mentally ill. However, their findings are disputed. Cockerham (1990) maintains that the majority of studies on the incidence and distribution of mental health problems suggest race alone does not appear to produce higher rates of mental disorder for particular groups. Rather, it is because more black people are in the lower social classes that they tend to demonstrate more signs of mental distress. Others, however, disagree. Halpern (1993) argues that ethnicity or experience of being in a minority group can be demonstrated to result in a tendency towards psychiatric problems.

As with gender, a number of studies have been conducted indicating that racial bias exists in the assessment, diagnosis and treatment of mental health problems. Wade (2010) found that white therapists generally rated their black clients as being more psychologically impaired than did black therapists. Patients who were uncooperative, threatening or abusive were more likely to be diagnosed as being mentally ill if they were from a BME group. In particular, it has been found that being black tends to increase the chances of a person being diagnosed as being schizophrenic (Wade, 1993, Haper, 2010, Western, 2011).

A study by The British Medical Association (BMA) Board of Science (2014) summarised the evidence of differential need and use of services by ethnicity. Differential access to, and uptake of, statutory services by some BME groups has been a particular concern given that BME individuals have a three-fold increased risk of psychosis, rising to a seven-fold increase in Black Caribbean people (Kirkbride, 2015). A report by the Disability Rights Commission (DRC) (2012) reported a thirty % increased risk of

suicide in Black Caribbean people who were registered as having a disability. The report also noted that people from BME groups were more likely than others to bypass primary care and be admitted straight to a psychiatric hospital. Based on this finding, the DRC concluded that the needs of black people with physical and mental health problems were 'likely to be under-addressed in primary care'.

A census conducted by the Care Quality Commission (CQC, 2011) found a higher-than-average rate of admissions, referrals from the criminal justice system, and detention under the Mental Health Act for Black Caribbean, Black African, and White/Black Mixed groups. Whether this was due to variations in help-seeking behaviour, cultural or language barriers, or other factors, is unclear. A contradictory situation persists whereby black groups may have higher rates of many mental illnesses, lower rates of general referral and treatment, but higher rates of compulsory treatment and forensic service contact (Thorncroft 2006). Research to identify prevalence of common mental health problems such as anxiety and depression in the community found that, after age standardisation, there was little variation between white, black and South Asian men in the rates of any common mental health problems. However, in women all common mental health problems were more prevalent in South Asian groups. (McManus 2009)

6.4.1 Treatment

Evidence suggests that people from BME backgrounds have significantly more mental health problems than the White British population; and that there are disparities between levels of care received by people from BME backgrounds in comparison to their white counterparts. This is particularly apparent in crisis and acute mental health services - a crucial part of mental healthcare.

Crisis and acute services provide support and treatment for people when they are most unwell and are comprised of Crisis Resolution and Home Treatment (CRHT) teams, inpatient wards and a variable range of community-based provision. Extensive research was undertaken between 2010 – 2013 into the state of acute and crisis care. During 2010 and 2011, a year-long independent inquiry into crisis care was conducted. The inquiry's findings were published in the 'Listening to Experience' report (2011). The inquiry found that people from some BME groups seem to be treated more neglectfully or coercively in the crisis care system than other people. It also found that there is variable access to CRHT teams, with Indian, Bangladeshi and Chinese people having consistently low referral rates. Once

assessed by a CRHT team, BME groups are generally more likely to be admitted to hospital, especially Black Caribbean people.

Census data from 2012 on the ethnicity of the population suggests that rates of access to secondary mental health services generally for BME groups are lower than previously thought. In 2012, the mental health charity, Mind, was commissioned to undertake an independent review of the crisis provision care in all mental health trusts in England to investigate issues such as staffing levels and service activity, including ethnicity data. Thirty-five trusts were approached and asked to share information about the capacity of the CRHT teams in their area. Thirty-three (33/35) responded and provided a breakdown of ethnicity for their CRHT team's activities and shared information about the crisis care provision in their locality. The findings revealed that the Indian, Bangladeshi and Chinese groups had consistently lower referral rates to crisis services compared to the White British group. The Pakistani group also had lower referrals, except in the case of Derbyshire, North East London and Oxfordshire, where referral rates were higher than for White British. Other Asian groups tended to have higher referrals but this was not consistent across. The picture was more mixed for Black Caribbean and Black African groups, which had lower referral rates in some areas and higher in others, including within two London-based trusts.

The Mind report (2013) suggests that different ethnic groups face different barriers to accessing crisis care and found stark inequalities in the way people from BME groups are treated when they are in crisis, as compared to their white counterparts. For example, the report found when comparing BME groups to white groups that there were some serious problems with the quality of life on wards and there was a lack of therapeutic interventions for inpatients. Concerns were expressed around medical dominance and the use of medication, particularly high doses of medication for some BME groups compared to their white counterparts. There was criticism that black men were disproportionately diagnosed with schizophrenia and of the high prevalence of community treatment orders (CTOs) among some BME groups. The Mind report (2013) found a lack of interpreters - e.g. interpreters being available only once a week - as well as a lack of psychological therapy in the person's first language.

A study by Harlow (2011) found there has been slow progress in changing the stark inequalities in the acute sector of mental healthcare for people from some BME groups. It highlighted that people from

BME groups continue to be over-represented in hospital and as detained patients; reported long waits, especially for talking therapies; a lack of diversity amongst staff, and cultural and religious needs not being met.

Large research studies such as Mind (2013) and McManus (2009) suggest mental health services do not have a strong strategic drive to overcome ethnic inequalities. This reflects wider concerns that race equality has fallen down the agenda in recent years (WHO, 2011). Such reports have been crucial in demonstrating the disparities between BME groups and white groups when accessing mental health crisis and acute services. When considering disparities between ethnic groups and hospital admissions, a report by the British Medical Journal (2010) found that in most areas, there was a lower proportion of white people admitted to hospital by CRHT teams and a higher proportion of other ethnic groups, particularly Black Caribbean. For example, in the South London and Maudsley Trust, the Black groups' proportion of the hospital admissions was twenty one % higher than in the local population.

In support of these findings, data from the Health and Social Care Information Centre (2013) identified that, once in contact with mental health services, rates of access to hospital services were higher for all minority groups than for the White British group. Caribbean, African and other Black groups' rates were roughly double those of the White British group after age and gender had been taken into account. The data also found that less than 40 % of White British and Irish inpatients were subject to detention under the Mental Health Act, whereas over 60 % of inpatients from the Mixed White and Black African, Black Caribbean and any other Black backgrounds were subject to compulsive admission.

Bhui et al, (2013) argue that, people from BME groups are more likely to present in crisis, with A&E being the first point of contact. South Asians of all ethnic groups are the least likely to be referred to specialist services and further studies have shown consistently higher use of inpatient services by black people and higher rates of compulsory admissions. A study by Gould (2012) of people's experiences of hospital admissions found that Black African and Black Caribbean respondents had generally poorer experiences than respondents overall. The study found that people with direct experience of services, particularly as inpatients, had reported that their biggest fear was being re- admitted to hospital and re-engaging with services as the police are more likely to be involved in admissions or readmissions.

The study participants strongly criticised what they perceived to be an unbalanced reliance on medication, with its unwanted side effects.

Conversely, evidence from the Mind report (2013) suggests that in some areas, the proportion of people referred to CRHT teams who went on to be admitted to hospital was fairly similar across ethnic groups. This suggests that people from BME groups are receiving treatment once they are seen by CRHT teams but that there may be barriers to initial access, especially for those from Indian, Pakistani and Chinese backgrounds. The higher rates of home treatment and hospital admission among BME groups suggests that those who do reach CRHT teams are more unwell than the White group overall. This is consistent with the literature which shows people from BME groups tend to come into contact with mental health services later in their period of mental illness.

The Mind report (2013) focuses on people accessing services through CRHT teams and has not included people admitted through detention under the Mental Health Act in which black groups are again overrepresented. Possible reasons for ethnicity variations in the use of services include higher levels of mental health problems among people from that ethnic group; different cultural and practical barriers to accessing care; mental health stigma in some communities or differences in how people are treated by healthcare services, including experiences of racism.

6.4.2 Summary

The evidence concludes that there are significant disparities in mental healthcare and treatment among BME groups in comparison to the general population. Eradicating the disparities in mental health treatment and outcomes for BME groups requires change in individual practices but this can only be successful if supported by changes at the organisational level. Efforts to improve mental and emotional wellbeing for BME communities should be anchored in an understanding of history, socioeconomic factors, cultural and religious norms and, most importantly, their experiences of racism and stigma.

6.5 Cancer

Cancer is a major cause of ill-health with more than 280,000 people diagnosed each year in the UK. It is also the biggest cause of death in the UK, accounting for 1 in 4, or around 125,000 individuals a year (DOH, 2011). There are significant inequalities in cancer incidence, mortality and survival. The risk of being diagnosed with certain cancers is greater among the most deprived families and communities and, for most types of cancer, survival rates for the most deprived patients are worse (Macmillan, 2014).

At an international level, although cancer survival rates increased during the 1990s, the UK failed to close the gap with the European countries with the best cancer outcomes. In response to this the NHS Cancer Plan (2000) was published and since this time mortality rates have been moving more in line with the rest of Europe and other developed countries (DOH, 2011). A recent report by Cancer Research UK (2014) undertook an analysis of cancer survival and found that:

- Cancer death rates began to fall in the late 1980s and since then they have dropped by more than 17 %.
- More people than ever before are surviving cancer. The proportion of patients surviving beyond five years has increased from only 28 % in the early 1970s to around 50 % today.
- Survival rates have improved for almost all of the 20 most commonly diagnosed cancers.

The overall picture of cancer survival is therefore positive, but at the same time there is a growing body of evidence to suggest that some disadvantaged groups do not have access to the information, resources and services required to take full advantage of these improvements in health (Macmillan 2014). A report by DOH (2000) reported that survival rates for most types of cancer have risen steadily since the 1970s. However, because rates have increased faster among more affluent groups the survival gap between the least and most deprived patients has increased and as such has had a negative impact upon people from BME communities.

There was limited evidence to demonstrate the patterns of cancer incidence, mortality and survival in BME communities. This is due to ethnicity not being systematically recorded by cancer registries.

Therefore, there is insufficient reliable data on patterns of cancer incidence, mortality and survival specific to Black and Minority Ethnic communities living in the UK (CRUK, 2014).

Cancer is a disease caused by normal cells changing so that they grow in an uncontrolled way [a detailed description of cancer can be found in the Nottingham Cancer JSNA (2015)]. There are five main sites of cancer - skin, breast, lung, large bowel (colorectal) and prostate - which account for the majority of all new cancers. The majority of skin cancers, apart from a rare type called melanoma, are easily curable and are not included in most of the statistics in this report. Breast, large bowel, lung and prostate cancers account for over half (54%) of all new cancers in the UK, excluding the non-melanoma skin cancers (CRUK, 2014). A range of harder-to-reach groups, including BME groups, have unmet needs relating to information, support and cancer services. There is evidence of inequalities at each stage of the patient pathway, from information provision through to palliative care (Cancer Research UK 2014). Evidence suggests the risk of getting cancer varies in the United Kingdom by ethnic group, see figure 2.

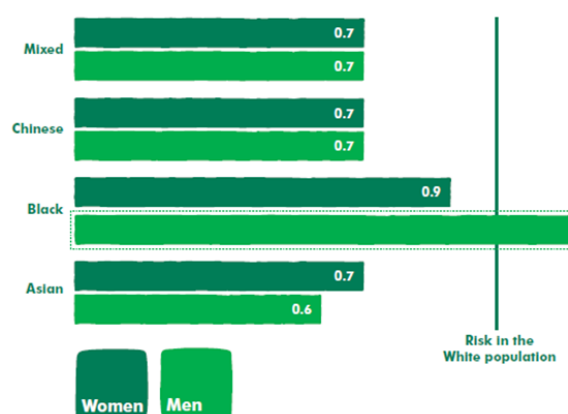


Figure 2: Cancer risk by ethnic groups in England, 2004-2006. Source: Macmillan, The Rich Picture (2014)

Figure 2 illustrates the risk of cancer in people from BME communities compared to people from the white population. The numbers in the bars show the estimated upper end of the risk range in each ethnic group compared to the white population. Black groups are at higher risk of getting cancer compared to other ethnicities with lower incidence rate, with black men being significantly higher than black women. The National Cancer Intelligence Network carried out a major study in 2009 and found black men and women have higher incidences of stomach cancer, liver cancer and myeloma, a cancer affecting bone marrow cells. There is a growing body of evidence to suggest that there are cancer

inequalities within some BME communities and harder-to-reach groups. It is therefore essential that work is undertaken to provide commissioners with the knowledge of the communities and groups who are experiencing such inequalities, including BME groups, in order to effectively commission services to meet their needs and, in so doing, improve health outcomes.

In most healthcare systems, it is acknowledged that the BME population experience poorer health and experience barriers to accessing certain healthcare services (Szczepura, 2005). A report by Macmillan Cancer (2014), 'The Rich Picture', suggests there is a range of harder-to-reach groups who are not benefiting, when compared to the general population, from improved cancer outcomes. The report recognises that people from BME communities are heavily represented within this group.

The report seeks to establish whether there is robust evidence to suggest that people from BME communities living in the UK experience poorer health outcomes attributed to cancer inequalities. Although the vast majority of the literature reviewed focused on the relationship between cancer and communities experiencing deprivation, there is evidence to suggest there is an independent relationship between cancer, ethnicity and poorer health outcomes.

There is growing evidence, often from smaller-scale studies, that BME communities may experience differing rates of some cancers. A study by Farooq (2005) found that 43 % of BME women indicated that they had never practised breast awareness, compared to 11 % of the general population. Among this group, 53 % of BME women said that they had not done so because they were unsure what to look for. The study also found a higher proportion of BME women believed that a lump was the only symptom of breast cancer - 38 % compared to 22 % of the general population.

Evidence suggests that, in general, people of BME population are twice as likely to develop prostate cancer as white males (Prostate Cancer Charter for Action, 2005). A report by Thompson (2013) highlights that people from the BME community have a greater incidence and mortality rate due to the 30% increased risk of prostate cancer in Black Caribbean men. Prostate cancer among Black Caribbean and Black African men appears to be higher than that found in the general population (Prostate Cancer Charter for Action, 2005). The incidence of prostate cancer has risen sharply in recent years, reflecting the increased awareness of this disease and detection of very early disease using the PSA (Prostate Specific Antigen) test.

Mouth cancer among South Asians appears to be higher than in the general population (Aspinall, 2004). Cancer Research UK (CRUK) delivered a targeted campaign aimed at raising the profile of mouth cancer among those groups most at risk of developing the disease. The campaign involved providing information to health professionals and the public through leaflets, posters and the CRUK website. The pilot project was based in communities with particular issues relating to mouth cancer and aimed to raise awareness amongst the Bangladeshi community through the provision of bilingual information, work with community leaders and networks and by providing mouth cancer check-up sessions. However, the effectiveness of the initiative was hindered by issues with language. This has been identified in a number of reports - such as in Parkin (2011) - as a significant barrier to accessing cancer services for many people from BME groups particularly, but not limited to, asylum seekers and refugees. This report, which focused on social inequalities, found that 41 % of people with additional language needs had no one to help with interpreting when visiting a GP or health centre, even though services should provide interpreters.

Rowen et al (2007) found that women of African and West Indian descent were being diagnosed with breast cancer on average 21 years earlier than their white counterparts. In addition, the type of cancer that was being diagnosed in this group was more likely to be an aggressive form of the disease which was unresponsive to newer drug regimens, thus resulting in poorer outcomes.

A study by Oyebanjo (2014) suggests there are ethnic disparities in skin cancer survival rates. Whilst the incidence rate of skin cancer among BME groups is significantly lower, it is often diagnosed late, resulting in higher mortality rates. This, coupled with climate change and the proportion of BME groups expected to rise in the United Kingdom from 8% in 2010 to 20% by 2051, raises public health concerns.

Social-cultural factors have also been identified as key factors that impact upon BME communities in accessing a range of health services. A study by Ehiwe (2013) examined health beliefs, knowledge and perceptions of cancer among two Black African migrant communities in Luton, specifically using participants from the Ghanaian and Nigerian communities, in addition to separate and mixed groups of different nationalities and religious backgrounds. The study suggested participants had both biomedical and faith-based understandings of cancer: seeking medical help as quickly as possible, as

well as expressing their health concerns to God in prayer. Silence, concealment and stigma were identified as barriers that prevent some individuals from accessing cancer services.

The study highlights the need to ensure professionals working with BME communities have an awareness of these perceptions in order to ensure that target populations receive culturally-sensitive care. The study also identifies the need to ensure cancer awareness campaigns are targeted and meet the needs of the community, as well as forming the basis for future research among this and other under-researched BME communities in the UK.

The National Cancer Intelligence Network (2009) studied cancer incidence and survival in ethnic groups in England (National Cancer Intelligence Network and Cancer Research UK (2009). The study found the incidence of cancer was lower in Asian, Chinese and mixed ethnic groups in both younger (under 65) and older (65 and over) people compared to the white population. In contrast, the report found that people from BME communities experienced higher incidence of cancer survival than the white population.

Black women were less likely to have cancer than white women but survival rates were lower. Incidence in black men was similar to white men; but for some specific cancer sites, such as prostate cancer, incidence was higher in BME groups. The Asian population had significantly higher rates for liver cancer, cancer of the mouth (among women over 64) and cervical cancer (among women over 64). The Asian population had lower risk of the four major cancers (breast, lung, prostate and colorectal). The black population were at lower risk of lung, breast and colorectal cancer compared with the white population; however, survival rates were lower (National Cancer Intelligence Network and Cancer Research UK (2009).

6.5.1 Summary

The evidence concludes there are inequalities in cancer outcomes between BME groups in the UK respective of the general population. There is limited data on the pattern of cancer incidence, mortality and survival in BME communities which highlights the need for further research in this area. There is a growing body of evidence which shows the relationship between ethnicity and cancer prevalence;

however, the evidence available is often from smaller-scale studies, thus demonstrating the gap in ethnicity data monitoring and collection in the UK which must be overcome.

6.6 Diabetes

Over 3.2 million people have been diagnosed with diabetes in the UK and an estimated 500,000 people are unaware they have the disease (DOH 2014). By 2020 it is expected that more than 3.8 million people will have developed diabetes in the UK, rising to more than 5 million by 2025 (DOH 2014). Current estimates suggest that type 2 diabetes costs the NHS £8.8 billion, with 80 % of this spent on treating avoidable complications such as cardiovascular disorders (PHE 2011). Nearly 250,000 people were diagnosed with diabetes in 2013 (DOH 2014).

Diabetes can cause major complications, including amputation, working-age blindness, stroke and renal failure (Diabetes UK 2013). There are an estimated 20,000 avoidable deaths due to the poor management of diabetes every year (Diabetes UK). This puts a large strain on hospitals. One in six hospital beds in England are occupied by someone with diabetes and it accounts for over 600,000 excess bed days every year (Joint British Diabetes Society 2013). It is well established that people from South Asian, Black African and Black Caribbean populations carry a considerably larger risk of developing type 2 diabetes (diabetes UK 2009).

Evidence suggests that people from a South Asian family background are six times more likely to develop diabetes than people of white European origin (diabetes UK, 2012). In Black African and Black Caribbean communities, diabetes is up to five times more prevalent than in people of white European origin. Research indicates that up to 20 % of the South Asian community and 17 % of people from black ethnic groups living in the UK have type 2 diabetes, whereas 3 % of the general population have type 2 diabetes (diabetes UK, 2007). In total, over 500,000 people from BME communities may have diabetes, including one in two people aged over 80 in BME communities, compared with only one in five people over the age of 80 in the white European population (Tillin T, Hughes AD, Godsland IF, et al, 2013).

People of African or Caribbean descent are up to five times more likely to develop type 2 diabetes compared to the general population. Figures from the 2011 census, and from the Yorkshire and Humber Public Health Observatory, suggest that over 500,000 people from BME backgrounds and communities have diabetes in England (Diabetes UK, 2006). Evidence from the National Diabetes Audit (2011) states that the diagnosed rate of type 2 diabetes in BME Communities increased by 21 % between 2009/10 and 2011/12, compared with a 14 % increase in the white population over the same period.

A study by Western et al (2010) showed that people from BME backgrounds are much more likely to face socioeconomic problems which can have an impact on health outcomes. The most deprived people in the UK are over two and half times more likely to develop diabetes than the rest of the population. Moreover, the complications of diabetes, such as heart disease, stroke and kidney failure, are three and half times higher in lower socioeconomic groups (Western et al 2010). In addition, there is a growing body of evidence to suggest that deprivation and ethnic background impact on a person's likelihood to access healthcare, with people from BME groups facing considerable barriers to accessing appropriate services and support and this is clearly having an impact on patient outcomes (DOH 2014).

In 2012 the Southall and Brent Revisited (SABRE) study concluded that almost half of all people of South Asian, Black African and Black Caribbean decent will develop diabetes by age 80. Census data indicates that there are over 5 million people in the BME population and that the UK population is still growing (Office of national Statistics 2011). This raises considerable concerns about the ability of the NHS to manage the potential implications of this diabetes 'epidemic'. Diabetes in BME communities is a significant health inequality and improving outcomes across England will depend both on increasing awareness and understanding in BME communities and on the quality of care that they receive.

A study by Insight Public Affairs (2013) was convened to discuss and critically assess the impact of diabetes in BME communities, identify the barriers to improving outcomes and share their knowledge of best practice initiatives to improve diabetes care, in order that similar initiatives could be implemented in other areas. The study highlighted issues such as: the increased prevalence of diabetes in BME communities; differences in rates of complications; how to identify and mitigate the key cultural and ethnic barriers to raising awareness of diabetes and highlighting the opportunities that the new

NHS structures present. The study was designed to provide commissioners, clinical experts, clinical commissioning groups (CCGs), GPs, specialist nurses, other health professionals, politicians and health policy makers with a clear insight and understanding of how diabetes service provision for BME communities could improve.

The study emphasised the necessity for clinicians and commissioners to appreciate the differences within and between different ethnic groups, which is essential to fully understanding the clinical consequences of a person from a BME background developing type 2 diabetes. For example, it was noted that people with diabetes from a South Asian background have a much higher chance of developing heart disease and end-stage renal failure than white European counterparts. People from Black Caribbean backgrounds who develop diabetes are more likely to develop hypertension and have harder to control blood pressure, which contributes to greater incidences of stroke.

In addition, the study indicated that people from Black Caribbean backgrounds are relatively protected from coronary heart disease compared with white Europeans, whilst people from South Asian backgrounds are at a much greater risk. Furthermore, evidence suggests that people from South Asian and Black Caribbean backgrounds have a much lower incidence of diabetic foot complications and thus a lower rate of amputations than the white European population. However, due to the greater number of people per head with diabetes, the disease burden is still greater in these ethnic groups than the white European population (Abbott C et al, 2009).

6.6.1 Summary

People from South Asian, Black African and Black Caribbean communities are significantly more likely to develop diabetes than the rest of the population. The reasons for this have been linked to deprivation and lower socioeconomic status. The evidence suggests that deprivation and ethnic background impact upon a person's likelihood to access healthcare, with people from BME groups facing considerable barriers to accessing appropriate services and support. These factors further increase health complications from diabetes such as heart disease, stroke and kidney failure, which are most prevalent in people from BME communities and which therefore has an adverse impact on health outcomes for this community.

6.7 Maternal health

The United Kingdom is one of the leading countries in maternal health development, with one of the lowest rates of maternal mortality. Nevertheless, there are still health disparities within the area of maternal ill health with a large concentration of such ill health being within BME communities. Though the United Kingdom has several distinctive features of maternity care in comparison to other developed countries, such as open access to free services, at a national level there have been reports that BME women have poorer experience of maternity services and suffer from worse maternal and infant outcomes.

The 'Towards Better Births' (2008) report produced by the Healthcare Commission stated that women of Black and Asian origin were less likely to be 'booked in' within 12 weeks of pregnancy and they reported less confidence in the staff during labour and birth (Healthcare Commission, 2008 pp. 78). Women from most minority ethnic groups were less likely than White British counterparts to have seen a health professional or had a booking appointment within 12 weeks of getting pregnant or that they had a scan at 20 weeks (Raleigh, 2010). Epidemiological research further showed that black ethnic minority women were second most likely to receive late or no antenatal care (Child Trends Data Bank, 2008) and in certain areas of the United Kingdom it was found that black residents did not use the front-line health services as much as other ethnic groups (Powell et al., 2008).

The Healthcare Commission also discovered that women from BME groups were at greater risk of poor maternal and infant outcomes (Healthcare Commission, 2008 pp. 92) with stillbirth and neonatal mortality rates higher for women of black, Asian or other ethnicities higher than for Caucasian women (Centre for Maternal and Child Enquiries, 2004, p. 6). These minority groups showed a lack of engagement and under attendance; in addition, investigations into socio-demographic predictors of antenatal and postpartum depression revealed that black ethnicity minorities have the second highest prevalence of these forms of depression (Rich-Edwards et al., 2006). On average, Black African women have a mortality rate that is seven times higher than white women and have problems with accessing maternal healthcare and are, on average, three times more likely to suffer perinatal mortality than white women (Confidential Enquiry into Maternal Deaths, 'Why Mother Die' 2002, p. 26). Knight (2009) investigated the differences in demographics and pregnancy-related risk factors between ethnic groups in the occurrence of severe maternal morbidity. They identified 686 women with severe

maternal morbidities, of whom seventy four % were white and 26 % non-white. In both Black Caribbean and Black African groups the estimated risk of severe maternal morbidity was more than double that in white women, with Pakistani women also having a significantly higher morbidity rate. The rate of severe maternal morbidities was higher in all other ethnic groups than in white women.

Though this is a national issue it sits within the context of the priority given by Nottingham City Council and Nottingham CCG to address maternal health issues in respect of BME communities in Nottingham. Anecdotal evidence indicates that BME women are less likely to join formal maternity support networks such as the National Childbirth Trust (NCT) or patient involvement mechanisms such as the Maternity Services Liaison Committees. Whilst some BME women who do not join such groups might enjoy a lot of community support from friends and family, the Health Care Commission Forum has concerns that others are less aware of these networks, and that they might feel excluded from them because of lack of funds or from a perception that such groups 'are not for them'. Furthermore, national support networks might not always cater for the needs of BME women, particularly those new to the country and who are not fluent in English, which contributes to the negative health outcomes as Lewis (2007) discovered that a lack of access to translation services was one of the factors associated with mortality.

While Knight et al. postulated that the increased risk of severe maternal morbidity among non-whites compared to whites in the UK could be related to pre-existing medical conditions and factors related to care during pregnancy and child birth, differences in health outcomes between ethnic groups should primarily be seen in respect of the inter-relationship between a numbers of different factors.

Diggle et al (2015) 'Joint Strategic Needs Assessment', highlights that recent migrants, asylum seekers and refugees who have difficulty speaking English are least likely to access maternity services. The Office for National Statistics has projected the total population of BME groups in the UK to increase from 13% in 2006 to 28% in 2031 and as high as 44% by 2056. There has also been a continuous increase in the proportion of births to women born outside the UK since 1995. In Nottingham alone, approximately one-third of births are to mothers born outside the United Kingdom, with six % of mothers having difficulty reading or speaking English. This not only places themselves at risk for poor pregnancy outcomes but also places their babies at risk.

According to the Nottingham 2011 census, the highest rate of unemployment is 13% amongst mixed ethnic groups, followed by 10.5% in Black British groups, with BME youth unemployment also being disproportionately high. Most adverse birth outcomes are strongly associated with low socioeconomic status (SES), such as lower education, lack of resources (material, social and family) and access to prenatal care (Census 2011). Preventive uptake and successful use of preventive and curative care also depend on educational level. All these pathways apply in perinatal care. For instance, the date of the first prenatal visit strongly depends on SES – that is, educational level and language competence (McIntire et al, 2008). Delayed first visit relates to increased perinatal mortality and pre-term birth. For women asylum seekers, the time period following the birth of the child may be spent in poverty and isolation and adverse social and material living conditions, increasing the likelihood of physiological and psychological stress (Moore, 2015). Not only does low income and material deprivation affect nutrition and healthcare access but SES has also been found to influence maternal age and parity.

The racial disparities in maternal morbidity are only partially understood; key biological pathways are chronic-induced and pregnancy-induced hypertension and diabetes (Tanaka, 2007). Nair and Knight (2014) investigated the factors associated with maternal morbidities in various ethnic minority groups. The research discovered that in comparison to white European women, the odds of severe maternal morbidity were eighty-three % higher among Black African women, 80 % higher among Black Caribbeans, seventy-four % higher in Bangladeshi women, fifty-six % higher in other non-whites (non-Asian) and forty-three % higher among Pakistani women. They concluded that some causes of maternal morbidities in BME communities were anaemia in current pregnancy, previous pregnancy problems, inadequate utilisation of antenatal care, pre-existing medical conditions, having more than three pregnancies, and being younger and older were independent risk factors but the odds of severe maternal morbidity did not differ by socioeconomic status, between smokers and non-smokers or by BMI. However, given that socio-cultural and socioeconomic pathways mediate ethnic maternal disparities, substandard care and health illiteracy may be involved, which coincides with underreporting of symptoms, greater need for care and poor treatment compliance (Moore, 2015).

Creating tailored education programmes for women from BME communities who show signs of low attendance may help tackle the factors which result in minimal engagement. These interventions should highlight the benefits of antenatal services and address some of the main detrimental cultural

beliefs, such as perceived low necessity of services. In addition to this, tailoring maternity services, improving access to care for women from ethnic minorities and creating outreach services in innovative local settings (such as nurseries and supermarkets) for those most at risk could help see an improvement in maternal health outcomes amongst this population demographic. Hurdle et al. (2001) justify these claims, postulating that the incorporation of tailored interventions significantly improves women's health behaviours (Noar et al., 2007).

6.7.1 Summary

This literature review serves as good preliminary research for the creation of healthcare interventions. Of foremost importance is tackling the issues surrounding maternity care engagement and access for members within this community. Given that socioeconomic factors and culturally-influenced perceptions have been seen to facilitate and underpin many of the issues surrounding BME women's engagement with maternal health facilities, addressing some of these issues may help to change these health behaviours.

6.8 Sexual health

Sexual health, as defined by the World Health Organisation (WHO), is "a state of physical, mental and social well-being in relation to sexuality" (WHO, 2013). Sexual health includes health needs related to sexual relations and enjoyment of sexual practice, safe pregnancy and childbirth, avoiding unintended pregnancy, and the absence and avoidance of sexually transmitted infections (STIs) and HIV. In order to meet these needs, services should include:

- Contraception services/ family planning
- Pregnancy and termination of pregnancy (TOP) services
- Cervical cancer services
- STI testing and treatment
- HIV testing and treatment
- Psychosexual services

Sexual health covers the provision of advice and services around contraception, relationships, sexually transmitted infections (including HIV) and abortion (Department of Health 2013a).

There is a clear relationship between sexual ill health, poverty and social exclusion: the highest burden of sexually-related ill-health is borne by groups who often experience other inequalities in health, including gay men, teenagers, young adults, black and minority ethnic groups, and more deprived communities (Department of Health, 2013a). Sexually transmitted infections, including HIV, remain one of the most important causes of illness due to infectious disease among young people (aged between 16 and 24 years old). If STIs, including HIV, are not diagnosed and treated early, there is a greater risk of onward transmission to uninfected partners and a greater risk that complications might occur. Many STIs have long-term effects on health, for example chlamydia can lead to infertility, and some infections are associated with cervical cancer (Department of Health 2013a).

In addition to this, information about sexual health and promotion of available services should also be included in sexual health services. Sexual health needs and risks vary from one person to the next and are impacted by factors such as sexual behaviour, relationship status, sexual orientation, desire for children and health-seeking behaviour. Cultural norms and expectations and religious beliefs also play a significant role. Studies (Curtis, 2005, Fenton, 2001, Fenton, 2005, Griffiths, 2008, Kapasi, 2009, Mironski, 2010, Tariq, 2007) suggest that minority populations have different and specific needs from the majority and often experience poorer sexual health.

BME populations are a hugely diverse group with a variety of needs and varying risk behaviour in terms of sexual debut, number of partners and sexual practices. It is generally established knowledge that BME groups have poorer health, including sexual health, compared to their White British counterparts (Kapasi, 2009, POST, 2007). This is often linked to lower socioeconomic status as well as additional factors, as depicted in Dahlgren and Whitehead's model on the 'Wider Determinants of Health' (see figure 3).

A review of selected literature suggests that there is a general acceptance that BME groups experience disadvantage in terms of sexual health. However, it highlights that this is not a homogenous group and a "blanket approach" may not successfully address health inequalities experienced by minority ethnic groups. Another issue identified by researchers is the lack of recording ethnicity by sexual health providers. Moreover, the current system of recording ethnicity is relatively crude and completely omits certain ethnic groups such as Koreans, Tamil and a breakdown of European groups.

BME groups are often perceived as having poor sexual health. Mironski (2010), states that, “the United Kingdom’s Black and minority ethnic populations continue to be disproportionately affected by poor sexual health”. Evidence from a 2009 report highlights that people from BME communities generally experience poorer health, that they often encounter problems accessing health services and that minority ethnic groups experience poor sexual health more often relative to their white counterpart (Kapasi, 2009). Fenton (2001) says, “Ethnic minority communities bear the brunt of poor sexual health outcomes, with high rates of HIV/AIDS, sexually transmitted infections and their sequelae”.

Curtis et al (2005) states that, as well as BME groups remaining disproportionately represented in high-risk groups for teenage conception, teenage pregnancy and sexually transmitted infection, they are also affected by poorer sexual health compared to their white counterparts. A case-control study of South Asians in London states that ethnic minorities often have higher rates of STIs and higher teenage pregnancy rates (Tariq, 2007). Another review of research on South Asian populations and sexual health in the UK, by Griffith et al (2008), also found the reproductive and sexual health of some of these groups has been identified as a particular area of concern because many are at a higher risk of teenage pregnancy and sexually transmitted infections than the general population, as well as having poor access to services.

Several studies contend that ethnicity alone does not explain variations in sexual health. Rather, risk behaviour, health-seeking behaviour, barriers to accessing services (Mironski, 2010), as well as factors such as economic disadvantage, social exclusion and racism (Fenton, 2001) impact upon an individual’s sexual health. A collaborative plan of action on the prevention of HIV among African people living in England by the National African HIV Prevention Programme (NAHIP) recognises the issue of discrimination and states that many Africans, as a “visible ethnic minority”, are affected by overt and covert racism in healthcare (as well as other social areas) (NAHIP, 2008). Tariq et al (2007) state that access to sexual health services among BME groups is often poor compared to the general population. Their case-control study also found that sexual and reproductive health, including contraception, knowledge and awareness, were poor among many South Asians. Furthermore, South Asians were more likely to have been referred to GUM clinics compared to their controls, rather than having self-referred (Tariq, 2007).

Griffiths et al (2008) also identify the relatively poor sexual health knowledge among young South Asians (2008), including STI symptoms and contraception. While ethnicity was rarely recorded in studies in the 1980s and 1990s, more recently South Asian women have shown lower uptake of contraception compared to white women. Communication issues due to language problems are also cited as one of the factors contributing to poor knowledge and uptake. Barriers to uptake of services include concerns regarding confidentiality and judgement by health professionals of the same ethnicity (Griffiths, 2008).

These findings raise questions about a number of barriers that prevent people from accessing sexual health services. The underestimation of perceived risk, lack of knowledge of sexual health issues as well as fear of discrimination and lack of confidentiality all play a role in the observed lower uptake of services. Another issue raised by the same researchers is the diversity amongst BME groups. For example, Fenton et al (2005) found that white women reported a higher prevalence of risk behaviour compared to other ethnic groups; however, these women had lower adverse sexual health outcomes than Black Caribbean and Black African women. This further highlights that, while risk behaviour is a key determinant, it is not the sole explanation for diverse risks and outcomes across ethnic groups. The authors suggest that ethnic mixing⁴ complicates generalisability of the determinants (Fenton, 2005). Griffiths et al also address the issue of heterogeneity: categorisation masks the heterogeneity of behaviours, cultures, religions, languages and beliefs that may exist between and within ethnic groups (Griffiths 2008).

BME populations are often treated as one group. It should be noted however that research suggests that, whilst sexual health needs already vary with factors such as age or sexuality, ethnicity and related factors such as culture, religion and family values also play a significant role. However, these factors are highly diverse within what is grouped together as 'BME population'. Differences in sexual risk behaviour and subsequent risk of STIs have been found in a number of studies. Fenton et al (2005) showed that individual behaviour alone does not explain variations in risk of being diagnosed with an STI. Their analysis of NATSAL (the British National Survey of Sexual Attitudes and Lifestyles) 2000 data, found Black Caribbean and Black African men to have an increased risk of reporting an STI in the

⁴ "Mixed" is an ethnicity category that has been used by the United Kingdom's Office for National Statistics since the 1991 Census. Colloquially it refers to British citizens or residents whose parents are of two or more different races or ethnic backgrounds.

previous five years compared to white men. The same was true for Black Caribbean women compared to white women. People of Asian origin were at reduced risk of STIs and also had a lower prevalence of early sexual debut (Fenton, 2005).

Another study, commissioned as part of the Teenage Pregnancy Strategy focusing on contraception use in young people in East London, found no ethnic differences in the type of contraception used. However, there were some differences in sexual behaviour by ethnic group, with fewer young people of Asian origin having had sex compared to black (both Caribbean and African) or white young people. The results did not find a clear distinction between BME groups and White British behaviour or health outcomes. Rather, it became clear that BME groups are highly heterogeneous in terms of risk behaviour, emphasising the points made about diversity above (Curtis, 2005).

A study by Roandon (2010) undertook interviews with BME organisations and reported that sexual health is often a taboo subject which is not talked about openly within some cultures. The study found this taboo can make individuals reluctant to use services. It also found that religious beliefs and cultural values play an important part in attitudes towards sexual health for many BME communities. For example, the study noted an example in respect of Asian young women and their concerns about using sexual health services before marriage.

Another finding in the case control study of London South Asians (Tariq, 2007) was the lack of recording of ethnicity in GUM clinics, which echoes the issue described by Fenton et al (2005) and Kaposi (2009) in Kingston. Fenton suggests that the approach to improving sexual health among ethnic minorities needs to include partnerships with communities and targeting high risk groups (Fenton, 2001). A similar suggestion is made by Griffiths et al (2008): “in order to inform and develop appropriate sexual health interventions and improve service access there is a need to improve our understanding of the sexual behaviours and attitudes of different minority ethnic groups and the reasons for poor health outcomes” (Griffiths, 2008).

Brook is the only young people’s charity that specialises in the promotion of sexual health and wellbeing. It stated, based on results of a youth-led participation project in London, that when

developing campaigns and sexual health services for young people, including those from BME communities, organisations should be “mindful not to contribute to stereotypes of ethnic groups” (Brook, 2009). A blanket approach to improving access to, and uptake of, sexual health services for BME groups is not viewed as ideal; rather, tailored campaigns targeted to specific groups seem to be the way forward.

These studies highlight that BME groups are at higher risk of sexual ill-health compared to their white counterparts. Furthermore, most studies focusing on BME groups concentrate on younger people. No studies were found on sexual health and behaviour of people of BME origin over the age of 45. This means a large group of sexually active people has not been researched and improving services for this group could prove difficult without detailing possible barriers to uptake of sexual health services.

There are ethnic variations in the rate of diagnosed sexually transmitted infections, with Indian and Pakistani men and women having lower rates of diagnosed STIs than other groups, Black Caribbean and Black African men having higher rates of STIs than white men and Black Caribbean women having higher STIs than white women, although the latter reported higher levels of risk behaviours than other ethnic groups. (Fenton, K. et al 2005). Individual sexual behaviour is a key determining factor in accounting for differences in the rate of STI infection between groups, although culture, age and marriage patterns and varying levels of infections within different communities are also likely to be important factors. There is a need for culturally-appropriate and targeted interventions to address these differences (Testa, A. & Coleman, L. 2006). There are lower levels of sexual health knowledge among BME students, particularly Asians, compared to White British students as well as differences in STIs and unplanned pregnancies. (Testa, A. & Coleman, L. 2006) Uptake of health and sexual advice services by young men is poor and getting young people to talk about sexual health is still a taboo in many communities (Teenage Pregnancy Unit, 2001).

BME groups as a whole experience poorer sexual health in comparison to other populations. Nonetheless, all studies highlight that this group is very diverse and subgroups have different needs in terms of improving sexual health and access to services. Many of these studies highlight the poor recording of ethnicity, which leads to gaps in defining health inequalities. With younger people, it also became apparent that sexual behaviour changes due to cultural changes and mixing of different

cultures. Finally, as with all research addressing sexual health, various forms of bias, led by social desirability or cultural norms, can influence findings.

6.8.1 HIV and AIDS

The link between social deprivation and poor sexual health is well documented, as well as the unequal distribution of sexual ill-health across the population. Evidence shows many of the deprived areas in England also have the highest HIV prevalence. It is recognised that the greatest burden is borne by women, MSM (men who have sex with men), teenagers, young adults and black and other minority groups (Miles et al 2010). HIV is an infection that disproportionately affects two key populations: Black Africans and MSMs. In 2011, HIV prevalence was approximately 30 times higher for these groups than for the general population in England. Factors such as acquiring infection abroad, HIV-related stigma and discrimination contribute to this disparity (Health Protection Agency 2012).

A report by Gerald (2012) shows that 8% of Africans living with HIV in England reside in the North West; two-thirds of people living with a diagnosed HIV infection in 2011 in the UK were male; and about two-thirds of Black Africans living with a diagnosed HIV infection were female (Gerlad 2012). HIV/AIDS is a serious concern, particularly for people from sub-Saharan Africa including Kenya, Zimbabwe, Zambia and South Africa. People from this region tend to present late with HIV, often after symptoms of AIDS have developed, making early intervention with antiviral drug treatments more difficult (British Medical Journal, April 2002).

The incidence of HIV in Black Caribbean men who have sex with men is significantly higher than for white gay men. HIV is less common in South Asian gay men than in European men (Royal College of Nursing, 2008). Cultural differences are a factor in the reluctance amongst homosexual and bisexuals from some BME communities to disclose their sexual orientation and services specifically aimed at lesbian, gay and bisexual people are used less by BME communities (Sexual Health in Practice, 2008). Sexual health issues may be encountered more frequently by refugees and asylum seekers than by the general population because of factors including: previous experience of rape and sexual torture, STIs and HIV; and unintended or unwanted pregnancies. Female genital mutilation is still practised in some African and Asian communities, though it has been illegal in the UK since 1985 (British Medical Journal, April 2002).

In 2013, the highest rates of STI diagnoses were found among persons of black ethnicity and the majority of these cases were among persons living in areas of high deprivation, especially in urban areas. This high rate of STI diagnosis among black ethnic communities is most likely the consequence of a complex interplay of cultural, economic and behavioural factors. Additionally, risk behaviours and STI epidemiology vary between Black African and Black Caribbean ethnic groups (Public Health England, 2014b).

Over the past five years, an estimated 1,000 Black African men and women acquired HIV in the UK annually. It is estimated that approximately 48% of heterosexuals born abroad acquired their infection in the UK, highlighting the need for further prevention efforts targeted towards those born in sub-Saharan countries and within Black African communities (PHE, 2013a). Late diagnosis is the most important predictor of morbidity and short-term mortality among those with HIV infection. In 2011, the proportions of HIV diagnosed late among Black African and Black Caribbean heterosexual men was 66%, compared to 47% in white heterosexual men. Among women, the proportion diagnosed late was highest among Black African (61%) and Black Caribbean (47%), compared to 44% in white women (PHE, 2013a).

6.8.2 Female Genital Mutilation (FGM)

FGM is practised in approximately 28 countries in Africa, the Middle East and South East Asia, but women and girls who have undergone FGM reside all over the world due to the increasing movement of individuals and communities between countries (WHO, 2012). Within the UK, it is estimated that 86,000 women and children have undergone FGM, with most of these being first-generation immigrants, refugees and asylum seekers, particularly from the Horn of Africa (Cambell, 2011). An additional 7,000 children and adolescents aged under 16 and living in the UK continue to be at risk each year, often being taken to their countries of origin so that FGM can be performed (WHO, 2012).

FGM is a growing public health concern: the health risk of FGM can be immediate such as haemorrhage, wound infection, infection due to re-use of inadequately sterilised equipment. There can also be intermediate health risks such as delayed healing, abscesses, pelvic infections and urinary tract infection. Long-term effects include post-traumatic stress disorder, infertility, childbirth complications

and trauma, and permanent pain due to cut nerve endings (BMJ, 2010). FGM is illegal in the UK, but is a deeply-rooted practice in some cultures (WHO, 2012).

6.8.3 Summary

The evidence concludes that people of BME communities have poorer health, including sexual health, compared to their White British counterparts. This is often linked to lower socioeconomic status as well as to additional factors including: barriers to accessing services; risk-taking behaviour; stigma and worries about privacy and confidentiality. The link between social deprivation and poor sexual health is well documented, as is as the unequal distribution of sexual ill-health across the population. Factors including ethnicity, needs, attitudes towards sexual health, religion, cultural and age should drive how services are provided and messages tailored to specific groups. In order to overcome the barriers to accessing sexual health services found in the literature, a general drive towards sexual health being more openly discussed is needed.

6.9 Lifestyles

6.9.1 Smoking

Tobacco smoking is a major cause of preventable death and ill health in the UK (Karlsen et al., 2011). Smoking rates in the population have decreased by 7% since 1998 (General Lifestyle Survey, 2008), yet there is lack of evidence showing smoking prevalence among ethnic minorities and whether rates in these communities are also decreasing (Karlsen et al., 2011). Moreover, smoking is considered the leading preventable risk factor for chronic diseases, including cancers, cardiovascular and respiratory diseases (Ford et al., 2012). Health consequences are aggravated for some ethnic groups (Centres for Disease Control, Prevention, 2009). For example, African Americans have a considerably higher smoking-attributable mortality and twice the years of possible life lost relative to White Europeans (Schorling et al., 1997). Furthermore, changing migration trends are expected to influence the smoking profile of the migrant population in the United Kingdom.

In the United Kingdom, chronic obstructive pulmonary disease (COPD) accounts for 30,000 deaths, 2% of hospital admissions, 1.4% of GP consultations, and imposes around £800 million costs on the NHS annually (Nacul et al., 2007). Tobacco smoking is the leading cause of COPD (Frew et al., 2005). COPD

management occurs mainly in primary care, with smoking cessation being considered the most efficient intervention (Martin et al., 2012).

Martin et al. (2012) showed disparities in COPD prevalence, severity and management amongst different ethnicities. In east London, COPD amongst the white community was documented in the younger groups and had a greater prevalence at all ages relative to other ethnic populations. COPD prevalence among white groups was equally recorded by gender, whereas in South Asian and black populations, COPD and smoking rates were more common among men. In those diagnosed with COPD, smoking rates were greater among the white groups relative to other populations. Black and South Asian groups described less severe symptoms compared to the white population, which could be explained by better toleration and management of symptoms or having a milder COPD. Moreover, black groups were observed to be receiving less medication than white groups. Irrespective of symptoms, South Asians were mainly on the same prescriptions as white groups. Furthermore, South Asians were more likely to have had pneumococcal and influenza vaccinations than other populations. Within the Tower Hamlets community, black patients were more likely to be admitted for COPD compared to South Asian and white patients. This could be explained by black groups having more recurrent and austere exacerbations and could be associated with the perceived lower rates of drug prescriptions (Martin et al., 2012).

The association between cigarette smoking and socioeconomic status seemed to vary, mainly amongst women and men from various South Asian communities. It was suggested that customs and values regarding smoking amongst women in certain cultural populations could be translated into a protective effect against the influence of socioeconomic deprivation on smoking behaviour. Adjusting for socioeconomic differences amongst them lowered the probabilities of recent cigarette smoking among each ethnic group, relative to White English people. Socioeconomic variations had a great impact on the disparities in smoking amongst White English, Bangladeshi, Pakistani and Black Caribbean (Karlsen et al., 2011). Moreover, this study failed to recognise ethnic and gender differences in the usage of additional tobacco products (Karlsen et al., 2011).

The effect of the 2007 ban on smoking in public places on smoking rates is not evidently recognised. Nevertheless, the gender and ethnic inconsistencies in the discrepancies of smoking rates over time

suggest that this impact has most probably been unreliable. Only 6% of the entire NHS Stop Smoking Services uptake derives from ethnic minority communities. It is crucial to create means by which to encourage the ethnic majority and minorities to engage more with these services, particularly those subsisting in poverty (Karlsen et al., 2011).

6.9.2 Smoking prevalence by ethnicity

Black Caribbean and Bangladeshi men are more likely to smoke cigarettes frequently relative to other ethnic groups (Karlsen et al., 2011). In this study, around 20-25% of white men were previous cigarettes smokers, compared to 15-20% of black and Bangladeshi men and 12% or less of Chinese, Pakistani, Black African and Indian men. Black Caribbean, Bangladeshi and white men stated never having been frequent smokers less regularly than men of other ethnic groups. Nearly all Bangladeshi, Indian and Pakistani women stated never having been regular cigarettes smokers. About a quarter of Black Caribbean and white women reported that they had been frequent cigarette smokers, whereas it was less than one in ten in Bangladeshi, Chinese, Indian, Pakistani and Black African women.

Studies show that the higher current smoking rates of Black Caribbean and Bangladeshi men relative to White English men are clarified by the discrepancies in the socioeconomic status of these communities. After adjusting for socioeconomic status, smoking rates of Black Caribbean women and Pakistani men were observed to be considerably lower compared to their white English counterparts (Karlsen et al., 2011).

The NHS National Institute of Clinical Excellence has highlighted the importance of decreasing smoking prevalence among ethnic minorities as well as deprived communities to reduce health inequalities (Aspinall et al., 2014). Small-scale studies reveal that East European migrants and communities such as Greek and Turkish record high smoking rates (Poonia, 2009). According to the General Household Survey 2001-2005, black and white African men showed the highest smoking rates followed by Bangladeshi men, whereas Asian, White Black and White Caribbean women showed highest smoking prevalence (Aspinall et al., 2014).

Aspinall et al. (2014) presented recent information on the varying risk profiles of the UK population. Results showed that smoking prevalence is significantly greater among migrants from East European

countries and from Greece and Turkey, relative to other non-UK born communities. In addition, mixed groups showed higher smoking prevalence rates. Gypsies or Irish Traveller groups recorded the highest rates: 46% and 49% for females and males correspondingly. Within ethnic groups, UK-born population showed higher smoking prevalence than non UK-born populations with the notable exception of the 'White Other' population. Chinese and White populations showed a robust socioeconomic gradient in smoking which is absent amongst South Asian populations and diminished in the black and mixed populations.

Studies have revealed that ethnic minorities retain poor awareness regarding cigarette smoking and illness and that they were less likely to mention smoking as a health threat compared with the overall UK population (Ash, 2011). 27% of Black Caribbean men cited that smoking has not affected their health, which is above the UK rate (12%), just as it was amongst Pakistani men (20%) and Bangladeshi men (22%). Moreover, it was suggested that religion could have an impact on certain ethnic minorities' attitudes towards tobacco usage. For instance, chewing tobacco is embedded in various features of South Asian culture with symbolic implications at cultural and religious rituals (Ash, 2011). Conversely, some religious leaders consider smoking and selling tobacco to be forbidden by Islam (Khayat, 2000). In addition, the level of community participation was suggested to influence tobacco use (Ash, 2011). Research showed that for both women and men of all ethnic groups, community activity is certainly correlated with a reduction in cigarette smoking rates, though this is not applicable to chewing tobacco use.

Smokeless tobacco products within the UK are mainly restricted to members of the Indian, Bangladeshi and Pakistani communities which constitute 4.5% of the overall population. These products present health consequences (SCENIHR, 2006) including:

- Oral pain (Pau et al., 2003)
- Oral cancer (Critchey and Unal, 2003)
- Loss in bone density (Quandt et al. 2005)
- Problems in pregnancy and following childbirth (including low birth weight and stillbirth)
- Late dental complications diagnosis (West et al., 2004)
- Myocardial infarction and stroke (Boffetta & Straif 2009)

Due to these health outcomes and the prevalent use of smokeless tobacco in the South Asian community, it is crucial to have strong and reliable supervision and a guarantee that the interventions implemented are the most effective ones to improve the population's health (Messina et al., 2012). Smokeless tobacco was found to be more predominant amongst the older South Asian members, whilst younger UK-born South Asians are smoking cigarettes (HAD, 2000). Croucher et al. (2002) found that older Bangladeshi women from Tower Hamlets used smokeless tobacco products more often; have been using these products for a longer period; and mentioned habit as the main reason for chewing. Among a male Bangladeshi sample within Tower Hamlets, older members were more likely to use smokeless tobacco products, have higher risks of chronic diseases, were more likely to have no proper education, cite recent oral pain, rate their health as average or poor, and have a spouse who uses smokeless tobacco products (Croucher et al., 2007). Furthermore, South Asians believe that paan relaxes, relieves stress and boredom (HAD, 2000), though traditional Hindus believe that it aids digestion, strengthens the heart and freshens the breath (Rees, 2007). 22% of a female Bangladeshi sample from Yorkshire reported that chewing paan is stimulating and enjoyable, whereas 11% assumed it helps with digestion and presents positive health benefits; 6% believed it helps relieve pain; 20% cited that it improves oral hygiene, in addition to believing that it makes the lips more appealing (Summers et al., 1994). Moreover, a Tower Hamlets sample asserted that paan was beneficial for controlling dental pain and was a refreshment and digestion aid (Pearson et al., 1999).

6.9.3 Smoking cessation by ethnicity

Despite the observed differences in smoking prevalence by BME groups in the UK, studies suggest that smoking cessation services are failing to improve the accessibility and subsequent positive outcomes of these programmes. Therefore, such services should be modified and adapted to the specific patterns of smoking behaviour and language skills within different communities (Aspinall et al., 2014).

Several studies highlight the significant health benefits as a result of smoking cessation (Bala et al., 2008) such as: 50% decrease in the prevalence of a cardiovascular incident within the first two years following smoking termination (Lightwood and Glantz, 1997) and a twofold decline in lung cancer risk (McBride et al., 2002). Considering the excessive smoking rates displayed by certain ethnic groups (Fagan et al., 2004) and consequent higher-related morbidity and mortality, there is a crucial public

health obligation to find efficient means of promoting smoking cessation among these groups (Lawrence et al., 2013).

Furthermore, studies have shown that Pakistani and Bangladeshi smokers are more likely to respond to recommendations from a GP to quit smoking. Professional helplines presenting counselling services in diverse ethnic minority languages have been shown to be efficient, such as the national charity QUIT which offers services in eight different languages. In addition, NHS Choices offers tools and resources on South Asian health concerns, such as evidence and material regarding the health threats and consequences of smokeless tobacco, as well as telephone helpline numbers in different languages to support tobacco smokers to quit (Ash, 2011).

Nierkens et al. (2013) conducted a systematic review to examine the efficacy of cultural adaptations in targeting smoking cessation, physical activity and diet among ethnic minorities. Interventions that combine an array of cultural adaptations, and those that consider family values, were observed to have a statistically substantial influence (Nierkens et al., 2013).

Evidence suggests that ethnicity is a contributing factor to smoking prevalence among BME populations and is influenced by cultural and social factors such as health behaviour and health awareness (Singer, 2012). Therefore, smoking cessation interventions in ethnic minorities should be altered to take into consideration risk patterns and defensive factors (Fiore, 2000), with an appreciation of cultural factors such as beliefs, values and practices (Liu et al., 2013).

Liu et al. (2013) proposed several approaches to adapt interventions for diverse communities such as addressing the population's cultural beliefs and using pictures depicting diverse citizens (Liu et al., 2013). Whilst it has been assumed that adopting these approaches increases the prominence of these interventions and encourages acceptability, there is no evidence of the increased effectiveness of such adapted interventions relative to non-altered cessation smoking intervention. Varying degrees of cultural identification, such as bi-culturalism among ethnic communities, has increased the adaptations' acceptability for particular individuals, but not for others. Furthermore, adapting interventions does not address the most persistent stressors influencing ethnic minority groups, including discrimination (Liu et al., 2013).

Croucher et al. (2002) concluded that 72% of Bangladeshi women found it difficult to go without tobacco, although 80% wanted to quit. 50% of Bangladeshi men wanted to quit and around 67-86% had attempted to do so. Nearly a third of people cited that it would be easy to go without tobacco (Croucher et al., 2007). Messina et al.'s (2012) systematic review on encouraging South Asians to quit using smokeless tobacco suggested that behavioural provision or counselling (both for groups and individuals) and their efficiency in reducing regular tobacco smoking among South Asians was lacking. However, an experimental study by Croucher et al. (2003) showed that within communal settings, behavioural sustenance (brief advice and encouragement) seemed successful in encouraging South Asians to quit smokeless tobacco (Croucher et al., 2003). Moreover, the use of peer leaders conveying intervention messages revealed effective uptake and implementation of these messages. Using nicotine replacement therapy (NRT) along with behavioural support was shown to increase the chances of efficaciously giving up smokeless tobacco.

Health education resources, both printed and audio-visual media, and various methods of interactive communication such as group discussions, onsite activities, lectures and one-to-one counselling were shown to be effective intervention methods (Messina et al., 2012). A comparison of pre- and post-intervention showed an increase in knowledge regarding cigarette safety, risk of heart attack, the harmful types of tobacco and the accessibility of professional cessation services (Messina et al., 2012). Yet there was inadequate evidence examining the impact of using different forms of materials on intervention results or of examining the efficacy of interventions in additional settings such as the workplace (ibid).

6.9.4 Summary

Smoking is a key driver of health inequalities and smoking rates are highest in deprived communities and amongst BME groups. Smoking prevalence rates vary by ethnic group, with Black Caribbean and Bangladeshi men and migrants from East European countries being more likely to frequently smoke cigarettes relative to other ethnic groups. Smoking is the biggest cause of preventable death and contributor to the life expectancy gap; therefore reducing the prevalence of smoking in BME groups and disadvantaged communities will help reduce health inequalities more than any other measure to improve public health. However, despite the observed differences in smoking prevalence by BME groups in the UK, studies suggest that smoking cessation services are failing to improve the accessibility

and subsequent positive outcomes from these programmes. Therefore, such services should be modified and adapted to the specific patterns of smoking behaviour, needs and language skills within different communities.

6.10 Obesity and physical activity

Obesity rates in the UK have drastically increased, with an estimated 20% of the population now considered obese, whilst the costs imposed on the UK economy are estimated to surpass 3 billion pounds per year (University of Birmingham, 2016). More than 40% of men are now considered overweight, with more than 20% within the 16-75 age range being obese. In women, the averages are lower for being overweight but higher for obesity (ibid).

Obesity is considered a risk factor for several illnesses and diseases such as hypertension, metabolic syndrome, cancer, osteoarthritis, type 2 diabetes, stroke and coronary heart disease (Swanton, 2008). Several minority ethnic groups residing in the UK are at a higher risk of stroke, type 2 diabetes and heart disease (The Nutrition society, 2012). Obesity-related illnesses have been shown to differ between ethnic groups (Gatineau et al., 2011). For example, Chinese and South Asians had higher prevalence of these conditions, more precisely hypertension and type 2 diabetes (Razak et al., 2007). According to Mindell and Zaninotto (2006), Indian, Bangladeshi and Pakistani men are four times more likely to have type 2 diabetes with Pakistani women being 6 times more likely to develop type 2 diabetes relative to the White British population. Overall, minority ethnic groups are at a higher risk of reporting ill health than the white population (Sproston et al., 2006), although a few populations, particularly Chinese, frequently report better health (Gatineau et al., 2011).

Physical inactivity is a major contributor to obesity (Butland et al., 2004). Researchers in the UK suggest that many minority ethnic groups have low levels of physical activity (Gatineau et al., 2011); South Asian groups recorded lower levels of physical activity in comparison with their white counterparts (Fischbacher et al., 2004); Bangladeshi groups showed significantly lower levels of physical activity relative to other Asian populations, whereas Indian groups recorded the highest levels, yet still remaining lower than white groups (Gatineau et al., 2011). The HSE 2004 report considered which

groups met the daily physical activity guidelines (Higgins et al., 2004). Results showed that Pakistani and Bangladeshi men were less likely to meet the guidelines than white men and South Asian and Chinese women were less likely than white women. Retired, unemployed and economically inactive men and women reported lower probability of meeting such recommendations in comparison with employed active individuals (Higgins et al., 2004).

A systematic review of the existing literature observed the participation of black and ethnic minority groups in sports and recreation and reported lower participation levels of these groups in comparison to white groups, with greater gender difference (Long et al., 2009). Bangladeshi and Pakistani communities recorded the lowest participation rates, with women of both communities reporting lower levels than white and all other ethnic communities. In contrast, mixed ethnic communities recorded greater participation rates relative to any other ethnic communities as well as to White British. Furthermore, results showed that Bangladeshi and Pakistani men engaged more in specific sports such as football and cricket. Yet, such discrepancies could be partially due to the younger age profile of minority ethnic groups (Long et al., 2009).

Koshoedo et al. (2015) conducted an ethnographic analysis in order to identify the barriers to black and minority ethnic groups participating in physical activity. Individual perception of physical activity as part of one's routine was reported variously by Asian communities as "Western" or "useless" or "inappropriate" or "harmful" (Koshoedo et al., 2015) that led to more weaknesses and diseases (Netto et al., 2007). Moreover, the Bangladeshi group perceived physical activity as pernicious that could lead to laughter and gossip amongst women (Grace et al., 2008). Physical activity was seen as a formal activity instead of a cultural one since it required distinct outfits and attendance at selected locations, such as the gym (ibid). Such perception was considered the result of a lack of physical activity exposure during childhood in home countries linked to poor promotion of healthy lifestyles, cultural restrictions and the absence of role models from BME groups (Sriskantharajah, 2007). This review suggested that South Asian communities, more precisely individuals with Islamic background, maintained resilient health beliefs and considered physical activity to have no preventative role against diseases (Netto et al., 2007). Fear of religious or racial discrimination amongst BME groups was another perceived barrier to physical activity (ibid).

Cultural and religious customs discouraged Asian groups from participating in physical activities (Ahmad, 2011) including the need to maintain Islamic dress code. Lack of culturally-sensitive indoor facilities prevented individuals from incorporating physical activity into their daily lives (Lawton et al., 2006). Some BME groups expect physical activity amenities to integrate religious and cultural beliefs such as single-sex amenities or same-sex mentors (ibid). Some South Asian groups perceive gender identity to be culturally- and family-oriented; for example, women are obliged to stay indoors, prioritise household and family responsibilities rather than their freedom (Grace et al., 2008). Although various culturally-sensitive amenities have been established, BME groups remained unaware of their existence (Koshoedo et al., 2015).

In addition, personal factors were identified as barriers to physical activity. For example, work commitments restricted the time available for certain BME groups to engage in physical activity as work was important in achieving financial stability, particularly after migration (Sriskantharajah, 2007). Individuals perceived physical symptoms, such as sweating and increased heart rate, as a sign of disease instead of a regular side-effect of a workout, creating an obstacle to participating in physical activity (Lawton et al., 2006). Another personal barrier reported was the absence of incentive and confidence amongst all BME groups (Netto et al., 2007) which was coupled with unfamiliar settings, communication barriers and the absence of social networks for implementing physical activity (Lawton et al., 2006). Lastly, external factors such as climate (Keyal, 2009), lack of information, absence of childcare amenities (Caroll et al., 2002), distance to reaching sports facilities (Sriskantharajah, 2007) and accessing alien neighbourhoods (Lawton et al., 2006) restricted the engagement of BME groups.

Scarce, thorough records on nutritional status and eating habits of minority ethnic groups have been found (Leung et al., 2011). Although the UK-wide National Diet and Nutrition Survey (NDNS) was intended to represent the population, sample sizes of BME groups were insufficient to enable further separate analysis (SACN, 2008). Several groups from minority ethnic communities were shown to have healthier eating behaviours relative to white groups (Gatineau et al., 2011). Eating habits were influenced by factors such as food beliefs, availability of food, income, dietary regulations, cultural norms and religion (ibid), in addition to occupation, age and region of origin (Gilbert et al., 2008). By using a 24-hour recall of food consumption, the Health Survey for England concluded that both BME women and men were more likely to meet the 5-a-day fruit and vegetable consumption guideline

recommended, relative to the mainstream population in 2004 (Leung et al., 2011). This study revealed the characteristics of traditional diets of these communities (Defra, 2008). Records from NHS Health Scotland (2009) reported that Chinese and Black Caribbean individuals were the most likely to achieve the 5-a-day guideline (Leung et al., 2011).

The Health Survey for England (2011) observed low fat intake in men and considerably lower intake for women from minority ethnic communities relative to the mainstream white population, with the lowest intake amongst Indians, Black African men, Chinese, Pakistani women, Bangladeshis and Black Caribbeans (Craig et al., 2006). Research on South Asians' fat consumption within the UK reported contradictory findings, although such discrepancies could be due to different methods of assessment or restrictions of the sample size (Bush et al., 1999). Inconsistencies in fat consumption amongst the same minority ethnic group were evident based on the country of origin, which impacted on income, cooking methods and social factors (Landman et al., 2001). Sodium intake was higher in minority ethnic communities than in the mainstream population (Craig et al., 2006) which could be associated with increased risk of hypertension amongst these communities (Leung et al., 2011).

Men and women from all minority ethnic groups met the Reference Nutrient Intakes; however, lower intakes of vitamin A, folate and riboflavin were reported among Asian and black women relative to white women (Nelson et al., 2007). According to The Nutrition Society (2012), various minority ethnic groups reported low iron status, with higher risk prevalence among women, which is possibly related to dietary limitations mutual to various groups. Vitamin D deficiency was reported among Black Caribbean and South Asian groups living in the UK, particularly during winter, which is related to cultural traditions regarding body covering and lack of sunlight. Vitamin D supports calcium absorption within the body, hence vitamin D deficiency leads to lack of calcium which impacts on bone health amongst minority ethnic groups (The Nutrition Society, 2012).

Migration to the United Kingdom impacts on obesity prevalence in some BME communities (Gatineau et al., 2011). For instance, obesity and overweight rates were higher among African-origin individuals residing in the UK than those residing in Jamaica and Cameroon (Jackson et al., 2007). Migrants are faced with the difficulties of maintaining their traditional eating behaviours after moving to another country since their usual foods are harder to find and substantially more expensive than western counterparts (Gatineau et al., 2011). Most migrants modify their eating patterns after moving to

another country by combining some of their traditional habits with less healthier components of the western diet. Generation and age were identified as two factors which decided the extent to which diets differed, with younger generations reporting higher consumption of processed foods relative to the older generations (Gilbert et al., 2008).

Low socioeconomic status is strongly linked with obesity (Gatineau et al., 2011). The connection between obesity prevalence and deprivation was more evident among women than men (Adult Obesity and Socioeconomic status, 2010). Clark et al. (2007) state that BME groups are at greater risk of income poverty in comparison to their white counterparts. Highest rates of poverty exist among Bangladeshi, Black African and Pakistani communities (Gatineau et al., 2011).

Additional factors such as perception of weight and body image, race-specific stigma and local area characteristics were evidently related to obesity prevalence (Gatineau et al., 2011). Weight and body image perceptions differ between families, cultures and generations. British BME groups have largely taken on the Western cultural desire for slimness, whereas non-Western communities perceive obesity as a sign of success and prosperity (ibid). For instance, despite the knowledge of young Somali women in the UK regarding a healthy and fit body, they appeared to be constrained by older Somalis' cultural attitudes preferring larger body size (Gardner et al., 2010). Likewise, Zimbabwean women revealed no concerns about being overweight in Zimbabwe; however, concerns were established once living in the UK (Lawrence et al., 2007). Moreover, Western society's preference for slimness denounces obesity and being overweight (Gatineau et al., 2011), stereotyping large body figures with greed, laziness and lack of willpower (Rees et al., 2005). Moreover, society has linked obesity with additional forms of marginalisation, such as disability, poverty and cultural and racial "layering of stigma" (Gatineau et al., 2011). The built environment, known as the "obesogenic environment", is characterised by increased availability of fast food restaurants and reduced access to green spaces, which is highly correlated with obesity (Cummins et al., 2006).

To conclude, no direct correlation exists between ethnicity and obesity (Gatineau et al., 2011). In depth research and analysis is needed in order to comprehend the array of gender and ethnic differences in the occurrence of obesity (Higgins et al., 2010), in addition to understanding the complex relationship between obesity and the factors affecting its prevalence among minority ethnic groups in the UK (Gatineau et al., 2011). Most of the studies examined were limited by small sample sizes which required

ethnic groups to be integrated in analysis to guarantee statistically significant outcomes. Although abundant research regarding the occurrence of obesity-related diseases and its risk factors for the South Asian population exists, and to a lesser degree for Black Caribbeans and Black Africans in the UK, there is scarce research relating to further minority ethnic groups (Gatineau et al., 2011). For instance, refugees, asylum seekers and migrants are not considered in many studies, bearing in mind that these communities are the most likely to suffer from poor health (Brophy et al., 2009).

Osei-Assibey et al. (2010) systematically reviewed lifestyle and dietary interventions for weight loss among BME groups. Results showed that most interventions demonstrated positive weight loss; however, substantial limitations were identified among some of these studies, such as lack of follow-up records, insignificant sample size and high acknowledgment rate. In addition, the review highlighted the lack of studies which target South Asians, who comprise 25% of the worldwide population. It therefore emphasised the need for further research to assess health beliefs and the social context within which minority ethnic groups reside and work, and to identify motivators for behavioural change and key individuals who could promote such a change (Osei-Assibey et al., 2010).

Bennet et al. (2014) conducted a systematic review on the efficiency of electronic health (eHealth) weight management interventions amongst overweight and obese minority ethnic adults. eHealth weight management programmes showed promising short-term results. However, these outcomes were drawn from a restricted evidence base. Additionally, there was no recorded evidence specifying the efficiency of mobile health approaches. Lastly, this study highlighted the need for longer-term trials in order to demonstrate the efficacy of eHealth interventions in producing clinically meaningful weight loss amongst minority ethnic groups (Bennet et al., 2014).

6.10.1 Summary

The evidence concludes that the BME community face a range of barriers when participating in physical activity which increases the risk of obesity for a variety of reasons including: language barriers; socioeconomic deprivation; lack of awareness or information; social isolation; genetic risk factors; discrimination and racism; cultural and religious influences and a lack of culturally-sensitive services. BME communities have different life experiences, values and cultures, which need to be recognised and understood to help effect change. The particular needs of individuals from BME communities can

only be addressed from within structures and systems that pay attention both to the diversity or differences between and within communities and to their shared common experiences. Policy makers need to ensure that when the diverse needs of the BME community are addressed, ethnicity is part of the solution and that attention be given to how BME communities engage with services in order to identify and support their needs.

6.11 Alcohol and substance misuse

Alcohol is a major cause of disability and death in the UK (Lavery et al., 2013). It is recognised that alcohol misuse varies amongst ethnic groups and geographically. Scarce knowledge is available regarding the distribution of alcohol-related hospital admissions amongst ethnic groups residing in diverse areas of the country. The national guidance and policy on BME populations regarding substance use, treatment and recovery, in addition to current research within this field, is scant. The 2012 Alcohol Strategy (Home Office, 2012) does not give guidance on engaging BME populations; rather, responsibility for meeting the needs of specific groups and for supplying mechanisms to confirm that the needs of all groups are met, is given to local authorities.

The National Drug Treatment Monitoring System (NDTMS) published data which indicates that White British people are over-represented in treatment in England in 2013-2014. The majority of service users were White British (83% relative to 80% of the English population), followed by Other White (4% relative to 5% of the general population). Findings showed that no other ethnic group accounted for more than 2% of the treatment population. In addition, some ethnic groups were under-represented in the treatment system relative to the general population. For example, individuals reporting their ethnicity as Pakistani, Indian or Black African made up only 1% of the treatment population, compared to 2.1%, 2.6%, and 1.8% of the English population correspondingly (Adfam, 2015). It is unclear whether this reflects less problematic drug use in these communities or issues in accessing drug services.

A thorough understanding of the fundamental factors impacting these discrepancies is crucial (Adfam, 2015). The Crime Survey for England and Wales (2011-2014) suggests that adults from mixed ethnic backgrounds were more likely to have consumed illegal drugs compared to other ethnic groups, followed by White British or Other White groups (Home Office, 2014). Adults of Asian and Asian British showed lowest amounts of illicit drug use. The Home Office (2013) suggests that age is the key driver

to the disparities among groups accessing treatment services, rather than ethnicity, alongside varying perceptions of drugs and alcohol within different BME communities. For example, Punjabi culture considers drinking among older men the norm (Galvani et al., 2013) and drug use is considered part of the traditions of some Somali and Yemeni groups (Beddoes et al., 2010).

Such perceptions may decrease engagement with treatment services (Adfam, 2015). Further challenges could include stigma and shame experienced by BME groups. For example, in some South Asian and Chinese families, high levels of stigma are directed towards families who have a drug-using member, leading to the risk of the entire family being isolated from the community (ibid). Consequently, there is an unwillingness to seek treatment or to reveal their drug/alcohol issue to family members, resulting in concealment of substance misuse (Beddoes et al., 2010). Moreover, language and cultural barriers, concerns regarding anonymity and unfamiliarity of treatment are cited as obstacles to seeking treatment. A recent survey on alcohol treatment, which included service providers, service users and commissioners, found that 43% of the respondents felt that BME individuals are underserved within the alcohol treatment system (Ward et al., 2015).

The public health and clinical features of alcohol consumption and misuse among older individuals have been highlighted over the past few years, with an acknowledgement of the rise in morbidity and mortality associated with exceeding the recommended drinking limits, alcohol-correlated deaths, alcohol-related hospital admissions and the occurrence of associated mental disorders or 'dual diagnosis' in alcohol misuse (Rao and Shanks, 2011). Some authors suggest that the current recommended limits of safe drinking are too high for older age groups (Rao et al., 2015). Within the UK, older individuals from certain black and minority ethnic groups recorded higher rates of alcohol misuse relative to the general older population, with South Asian and Irish male immigrants being most at risk (Rao, 2006).

In some areas of the UK, social marginalisation and Irish ethnicity are related with high levels of alcohol misuse when both are combined together (Rao et al., 2008). Traditional Irish drinking patterns have been linked to greater risk of unsafe drinking (McCambridge et al., 2004) which is in turn associated with negative stereotyping and low rates of primary care consultation among the Irish population

(Ramstedt et al., 2005). These factors have been assumed to impact admission to alcohol services (Rao et al., 2015).

The association between alcohol misuse and socioeconomic deprivation in older BME individuals is more difficult to describe, particularly when factors such as former profession are considered (Anderson, 2010). Higher socioeconomic status has been linked with higher drinking rates among older individuals, with income presenting a positive relationship with moderate and heavy consumption (Bonevski et al., 2014). Rao et al. (2015) studied the relationship between ethnicity, alcohol consumption, socioeconomic deprivation and health in an inner-city cohort of individuals aged 65 and over using a patient-level, primary care database from general practices within south east London. Older individuals from four different ethnic groups formed 29% of the sample. Results revealed that 21.4% of this sample exceeded the safe drinking limits. Old, unsafe drinkers were more likely to be male Irish and from white ethnic groups and less likely to be from Black Caribbean and Asian groups.

The strongest independent indicators for greater alcohol consumption in older drinkers were male gender, Irish ethnicity and younger age. Conversely, the independent predictors of low consumption rates were shown to be of Black Caribbean, Asian and Black African ethnicity. Socioeconomic deprivation and comorbidity were not substantial predictors of alcohol use in older drinkers. The strongest predictor variables for the older unsafe drinkers were shown to be Irish ethnicity and male gender; comorbidity was not a major predictor. This study did not reveal any correlation between comorbidity and physical and mental disorders. Lastly, lower socioeconomic deprivation was reported to be a substantial predictor of unsafe alcohol drinking whereas Caribbean, African and Asian ethnicity were not (Rao et al., 2015).

There is a clear link between alcohol consumption and gender, age and ethnicity amongst older drinkers, with unsafe drinking linked to gender, age and socioeconomic deprivation. It should be noted that the study population was not representative of the UK population.

Other studies emphasise the importance of recognising alcohol misuse among 'young older' men (on a spectrum of older men aged 65 and above, the younger aged group is at a higher risk of alcohol misuse), as well as the needs of individuals born outside the UK (Bhala et al., 2010) and those residing

in deprived regions. This will have implications for policy, training in detection and treatment, and commissioning amenities (Rao et al., 2015).

Laverty et al. (2013) studied the disparities in alcohol-related hospital admissions in BME groups in the UK and whether variations occurred among different geographic locations. Laverty et al noted that during 2010-2011, 264,870 cases of alcohol-related admissions occurred: 23% of these cases had an alcohol-related disorder as the primary diagnosis and 77% as a comorbidity. 69% of cases were linked with behavioural and mental health; toxic effects of alcohol accounted for 10%; and 21% were associated with alcoholic liver illness. For alcohol-related primary diagnoses, local admission proportions differed extensively for individuals of similar ethnic origin. White British had greater admission cases in the north of England relative to the south, whereas London recorded the greatest admission cases for Black Caribbean, Black African, Irish and Indian groups.

This study concluded that alcohol-related admissions varied considerably by ethnic group and geographic location. However, it had several limitations: the data did not allow for further examination of aspects such as religious association and it was also suggested that a number of patients might have had their ethnic origin inaccurately coded. Some of the dissimilarities could have been due to disparities in socioeconomic status, which was not scrutinised within the study. Interventions addressing concern of increasing alcohol misuse might need to be tailored to consider the heterogeneity of related morbidity. Lastly, population-level interventions should be evaluated for their impact on these ethnic group inequalities (Laverty et al., 2013).

Interventions for the prevention and treatment of the harms and risks associated with alcohol (O'Donnell et al., 2013) ranged from health promotion directed towards diminishing risky and detrimental drinking, to more concentrated and dedicated treatment for "ruthlessly reliant drinkers" (ibid). Primary healthcare is perceived as the best setting for the early detection and secondary prevention of alcohol-related harms, owing to its close interaction with people (Lock et al., 2009) and the frequency with which higher-risk drinkers present (Anderson, 1985). Screening and brief intervention for alcohol are a lucrative preventative approach (Hutubessy et al., 2003), which is pertinent and feasible to convey in primary healthcare (Raistrick et al., 2006), where patients tend to

display less severe circumstances and return frequently for follow-up appointments (Bernstein et al., 2009), in addition to developing lasting connections with their GP (Lock, 2004).

Research has identified the barriers facing clinicians in adopting brief alcohol interventions (Aira et al., 2003). These range from lack of training, resources and time; concern amongst practitioners about insulting patients; and the certainty that patients refuse to take advice on changing their drinking behaviours (O'Donnell et al., 2013). According to Gual et al. (2011), it is more important to encourage the acceptance and use of brief alcohol intervention in practice, rather than financing further research on its efficiency. Therefore, O'Donnell et al. (2013) looked at evaluating the scope to which the primary healthcare brief alcohol intervention base is now saturated, and whether there are any knowledge gaps necessitating further investigation.

Several reviews showed that brief alcohol interventions are efficient at decreasing risky drinking in primary healthcare (Gilinsky et al., 2011). However, some individual trials reported a null finding (O'Donnell et al., 2013). A large UK trial which was not mentioned within the reviews due to its recency, showed improvements in harmful and risky drinking among patients receiving simple feedback and a patient information leaflet, in addition to those receiving 5 minutes of structured advice, and those receiving 20 minutes of brief lifestyle counselling (Kaner et al., 2013). Screening or assessment reactivity, which is a measurement of drinking behaviour, might also elucidate these reduced drinking trends. Finally, relapse is an option in this field, since hazardous drinking can instinctively fall over time (ibid). Delivery of these interventions by an array of practitioners in primary healthcare settings has promising impacts (Huibers et al., 2003), though evidence from one review proposes more beneficial effects if conveyed by doctors (Sullivan et al., 2011). Lastly, whilst existing findings remain inadequate, evidence from a meta-analysis showed indications of the effectiveness of brief alcohol intervention on mortality outcomes, estimating a decrease in problem drinkers of about 23-36% (Cuijpers et al., 2004).

Although evidence suggests that brief alcohol intervention is similarly efficient in both women and men (Bertholet et al., 2005), most studies to date were either directed towards male drinkers or did not convey the data disaggregated by sex (Kaner et al., 2007). Specifically, there is a recognised absence of high-quality proof on its efficacy with pregnant women drinkers (Babor et al., 2013). Although Chang (2002) stated that pregnancy itself might offer a potent encouragement to reduce alcohol drinking,

Gilinsky et al. (2011) suggested that there is inadequate evidence to determine the effectiveness of brief intervention provided throughout the prenatal period, proposing that more rigorous interventions are probably vital to encourage women to reduce their alcohol consumption within the pregnancy period.

There was inadequate evidence regarding the impact of socioeconomic status on the efficacy of brief alcohol intervention in the majority of the included reviews, with an overall acknowledgment of the deficiency of evidence for underprivileged populations (Gordon et al., 2007). Furthermore, numerous reviews reported the propensity for studies either to overlook ethnic minorities (ibid) or to be poorly reported where non-white participants were involved (Jonas et al., 2012). There remain several unanswered concerns regarding the effectiveness of brief alcohol intervention in relation to different populations, settings, the optimal intervention content and the endurance of the intervention impacts. Current findings suggest that time-pressed clinicians looking for maximum effect with minimal input should address their efforts to the provision of simple, short interventions which emphasise encouraging individuals to record their alcohol consumption: these are expected to be most effective with middle-aged, male drinkers (O'Donnell et al., 2013).

In order that the BME community is able to access culturally-tailored treatment and recovery facilities, engagement of the whole system is needed (Adfam, 2015) including ensuring cultural competency runs throughout the entire commissioning system. Joint Strategic Needs Assessments (JSNAs) which examine the local population and its needs, should specifically reference BME populations and identify any emerging trend of substance use. Additionally, consultation with local community organisations and BME service users regarding their needs and experiences could greatly contribute to this procedure (Adfam, 2015).

Services should provide information around alcohol, substance misuse and drugs in a variety of languages, alongside offering information in a targeted and culturally-appropriate manner (Banton et al., 2006). Confidentiality is considered a priority as some BME families suffer from the taboo of having a drug-user family member. Adfam (2015) suggested that separately-branded literature about services should be available within places accessed by the local community, such as libraries, GP surgeries, colleges, schools and religious spaces. Drug and alcohol services should be promoted over BME-

specific TV and radio (Galvani et al., 2013). In addition, the use of social media, accessible to many people from their own home, can be important in spreading awareness of the availability of substance misuse services.

BME groups highlighted the effectiveness of telephone helplines for those with poor literacy and to maintain anonymity, in reducing the stigma and social isolation which prevents individuals seeking advice and support (Beddoes et al., 2010). Research also suggests that drug and alcohol services should 'reach out' to community organisations in order to increase awareness, ensuring that community leaders are knowledgeable about the local substance and alcohol misuse services and are able to direct those experiencing such problems (Adfam, 2015). However, it was recognised that communicating messages regarding drugs and alcohol to community and religious leaders might be challenging, although if they were successfully reached and convinced to offer advice and signposting, valuable outcomes would result (ibid).

BME migrants, who are often dealing with immigration controls, are subject to further barriers in accessing substance and treatment services due to their 'No Recourse to Public Funds' (NRPF) status. NRPF individuals are not permitted specific welfare benefits and local authority housing provision (No Recourse to Public Funds Network, 2015) thus inhibiting them from engaging with drug and alcohol treatment support services. Therefore, alcohol and drug services capable of delivering services to NRPF groups should make explicit that their services are confidential and free of charge (Adfam, 2015).

6.11.1 Summary

Alcohol and drug misuse varies amongst ethnic groups and geographically. There is a clear link between alcohol consumption and gender, age and ethnicity among older drinkers, with unsafe drinking linked to gender, age and socioeconomic deprivation. Some ethnic groups are under-represented in the treatment system. It is unclear whether this relates to less problematic drug use in these communities or to issues in accessing services; however, evidence suggests it could be linked to cultural and religious issues and fear of stigma and shame. Beyond eliminating discrimination, the evidence suggests that services should ensure they are accessible and welcoming to service users from BME

communities and are willing to challenge the additional stigma often faced. This may involve specific initiatives and promotions targeted at the BME community as well as ensuring services provided are adapted to individual needs.

6.12 Health inequalities

Health inequalities are avoidable disparities in health between groups of people within and between countries. They arise from inequalities within and between societies (WHO, 2016). The effect that social and economic conditions have on peoples' lives determines their risk of illness, in addition to the actions taken to prevent them becoming ill and their ability to treat illness when it does arise (WHO, 2016). These disparities are to be readily found where social hierarchies exist and where populations are organised according to individuals' income, education, occupation, gender and race/ethnicity.

Social determinants are responsible for significant levels of health inequities. Whilst some health inequalities are the result of natural biological differences or freedom of choice, others are beyond the control of individuals or groups and could be avoided. Examples of these determinants include: social policies, politics, economics, where people are born, grow up, work, live and learn. Individuals' social hierarchy can also affect their vulnerability to ill health and its consequences. Figure 3 was created by Dahlgren and Whitehead (1992) illustrating the causes of social economic status inequalities in health. They suggest that in order to attempt to attain social equity in health, policies and strategies should attempt to target and resolve some of these social determinants.

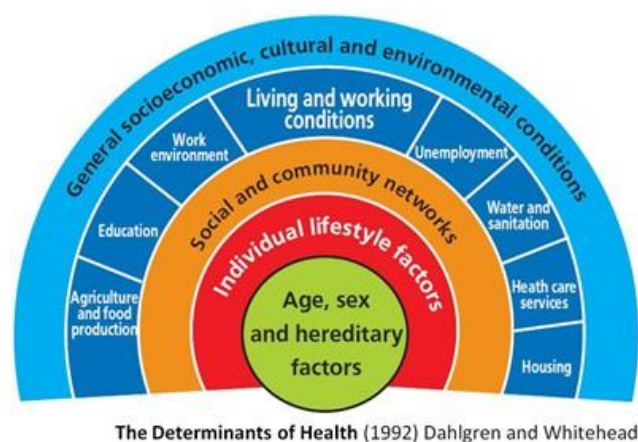


Figure 3: Representation of the wider determinants of health.
Source: World Health Organization, 1992

At an individual level, biological and behavioural factors influence health and are open to healthcare or behavioural interventions. However, social factors such as employment and education also influence health and play a role in increasing health inequalities. Recent years have seen an increasing emphasis within national and local policy to address health inequalities and ensure equal access to good quality healthcare. There has been a heightened recognition that people from the BME community face significant health inequalities and experience poorer health and life expectancy than the general population (Department of Health 2009). In addition, some BME groups have higher rates of long-term health problems and overall disability than older age groups.

Within the 16-49 age group, 12.3% of people of mixed ethnicity have some kind of long-term health problem compared to just 9.7% of the white groups. In the 50-64 age group, mixed ethnicity groups have the highest proportion of people with a long-term health problem, followed by the Asian and Asian-British ethnic groups. With respect to a range of health conditions, people from BME communities within the United Kingdom have worse outcomes than the general population, whilst experiencing more difficulty in accessing NHS services (DOH, 2014).

Following the Darzi Review (2009) every Primary Care Trust (PCT) had to prepare a Joint Strategic Needs Assessment (JSNA) and put in place strategic plans for addressing health inequalities. The NHS commitment to 'World Class Commissioning' requires CCGs to understand their local population, its demographics and health profile including health needs and any inequalities experienced by different groups. This research sits within the context of the priority given by Nottingham City Council and Nottingham CCG to addressing health inequalities with respect to BME communities in Nottingham. Whilst certain inherited conditions such as sickle cell disorders and cystic fibrosis occur more frequently in particular population groups, differences in health outcomes between ethnic groups need primarily to be seen in respect of the inter-relationship between a numbers of different factors.

Marmot's (2005) investigations into the social determinants of health inequalities revealed that socioeconomic determinants such as work and unemployment, amongst others, contributed to health inequalities in both developed and developing countries. BME communities generally experience higher levels of poverty linked to lower levels of employment, low pay and poorer conditions than the general population, which are also linked to inferior housing and physical environment (DOH, 2014).

These socioeconomic factors have a clear bearing on differences in health outcomes experienced by many BME communities. Even within a relatively deprived area, BME individuals are more likely to be further disadvantaged (Marmot, 2005). Furthermore, poverty rates are higher than average among Indian, Chinese, Caribbean and other minority ethnic communities (ibid). Migrant groups such as those born in Afghanistan, Somalia and Congo face high deprivation and are more likely to be excluded from the labour market, with high proportions of asylum seekers and refugees being part of these groups (Spence, 2005). Marginalisation and discrimination are often considered barriers to minority ethnic groups seeking to break out of poverty (Corcoran et al., 2004).

In England, members of particular black and minority ethnic groups (in particular the Pakistani, Bangladeshi and Black Caribbean groups) suffer the poorest health (Nazroo, 1997) and are also the most socioeconomically disadvantaged (Nazroo, 1998). Research in this area indicates that greater attention must be paid to non-economic forms of racial discrimination, as well as to the nature of BME individuals' participation in family and community networks which promote health and welfare (Nazroo 1998; Smaje 1996; Williams et al 1997).

6.12.1 Employment

Unemployment is associated with decreased self-esteem, increased alcohol use and elevated rates of depression, as well as with low birth weight among babies born to unemployed women (Dooley and Prause, 2004). A meta-analysis by Paul and Moser (2009) reinforces these findings as they discovered that unemployment was associated with depression, anxiety, psychosomatic symptoms, low subjective well-being and poor self-esteem.

The 2011 Census found that the unemployment rate in BME groups is almost twice that of the White British population. Disparities in employment are greatest for black ethnic groups compared with the White British majority. The 2011 Census further indicates that the unemployment rate for Black British is 10.4% compared to the white population at 6.5%. Shift work is an increasingly common form of work organisation; however, it remains more common in lower socioeconomic groups (and in some BME communities) as a result of which these groups of individuals experience more adverse consequences of shift work on health and work-life balance (Bambra et al 2008). Negative effects of shift work on health include sleep disturbances, fatigue, digestive problems, cardiovascular problems, emotional

problems and stress-related illnesses, as well as increases in general morbidity. These problems may derive from disruption to physiological, psychological and social circadian rhythms (Bambra et al 2008).

Some health inequalities are formed before or at birth. Evidence has shown that stomach cancer and stroke risks are associated more with an individual's parents' socioeconomic status than with one's own position in adult life. Low birth weights are a good marker of the environment in the womb and in turn the mother's health. Low birth weight is strongly associated with socioeconomic deprivation and low birth weight babies have continuing health and social disadvantages, not only in childhood but also in adult life. For example, low birth weight has been associated with increased risks of coronary heart disease in middle age. Some members within the BME community are biologically predisposed to suffer pregnancy complications, such as low gestational birth weight (Moser, 2008). Whilst certain inherited conditions such as sickle cell disorders and cystic fibrosis occur more frequently in particular population groups, differences in health outcomes between ethnic groups need primarily to be seen in respect of the inter-relationship between a numbers of different factors.

6.12.2 Education

Highly educated individuals have better jobs that offer safer work environments, in comparison to unskilled workers who are twice as likely to die from cancer as professionals (Cancer Research U.K). Education can provide individuals with better access to information and improved critical thinking skills. The more educated appear to be better informed, and appear to make better use of recent health-related information.

Education might be important for health, not only because of the specific knowledge that individuals gather from school and higher education but also because education improves general skills such as reading, critical thinking and decision-making abilities (Cutler, 2006). Williams et al (1998) found that patients with poor reading skills were less likely to know about and effectively manage certain chronic conditions.

6.12.3 Limiting long-term illness

Limiting long-term illnesses (LLTI) are considered to be determinants that include a range of social and environmental conditions under which people live and which highlight ethnic inequality in health and

well-being. For example, Pakistani and Black Caribbean groups show the highest rates of LLTI which, in comparison to other ethnic groups, are considerably worse than average. With regard to age, 60% of the Pakistani and Bangladeshi groups aged 50 to 64, had LLTI compared to 34% of White British people. The Indian group aged 15 to 49 years had a 44.9% LLTI rate, which is five times higher than the group average of 2.9%. The Black British group had 46.5%. LLTI data for those aged 65 in Nottingham illustrated that over 70% of Pakistani and Bangladeshi people, 58.8% in Indian groups and 62.1% in Black or Black British groups had an LLTI, compared with 55.2% of White British people (Nottingham City Joint Strategic Needs Assessment 2013, P15- 16).

6.12.4 Housing

In England, people living in the poorest areas will die an average of 7 years earlier than those living in the richest areas (Office of National Statistics (2009) life expectancy at birth). Jivraj and Khan (2013) examined the link between ethnicity and deprivation in England and showed that ethnic minority groups in England are more likely to live in deprived neighbourhoods than the White British majority, with the largest ethnic inequalities existing in the Midlands and the lowest in the south east.

The quality of housing (insulated, dry and safe from hazards), accessibility to local services and amenities (e.g. transport, work, shops) and the security of housing arrangements are all important factors for ensuring good physical and mental well-being. Poor quality housing can be the cause of numerous physical and mental health problems which can result in unnecessary hospital admissions, longer than necessary hospital stays (e.g. if homes are not fit to return to) and ultimately death. Poorer housing conditions are often in deprived areas where there are higher levels of crime and social disorder, making it a more stressful and dangerous place to live (Gibson, 2011). Access to amenities may be worse than in more affluent areas and there may be fewer jobs available. There is also evidence that housing and neighbourhood conditions can impact on factors such as an individual's well-being and quality of life (Commission on Social Determinants of Health, 2008).

6.12.5 Summary

Social determinants are responsible for significant levels of health inequalities among BME groups, whereby people from BME backgrounds experience higher levels of poverty linked to lower levels of employment, pay and conditions than the general population. Whilst some health inequalities are the result of natural biological differences or freedom of choice, others are beyond the control of individuals or group and could be avoided – for example, discrimination, poor housing, income

deprivation and unemployment. These socioeconomic factors have a clear bearing on differences in health outcomes experienced by many BME communities. The possible implications for these disparities include poorer physical and mental health outcomes, which impact on life expectancy, amongst other negative outcomes.

7. Data Analysis

7.1 General overview

The 2015 Mid-Year Estimate (MYE)⁵ gives a population of 318,901 in Nottingham City, an increase of 4,633 on the 2014 MYE and a total increase of over 15,000 since the 2011 MYE (Figure 4). This increase is higher than the average observed over the previous 10 years. Between 2014 and 2015, the City gained people due to international migration, lost people through internal migration (within the country) and gained people through natural change (the excess of births over deaths).

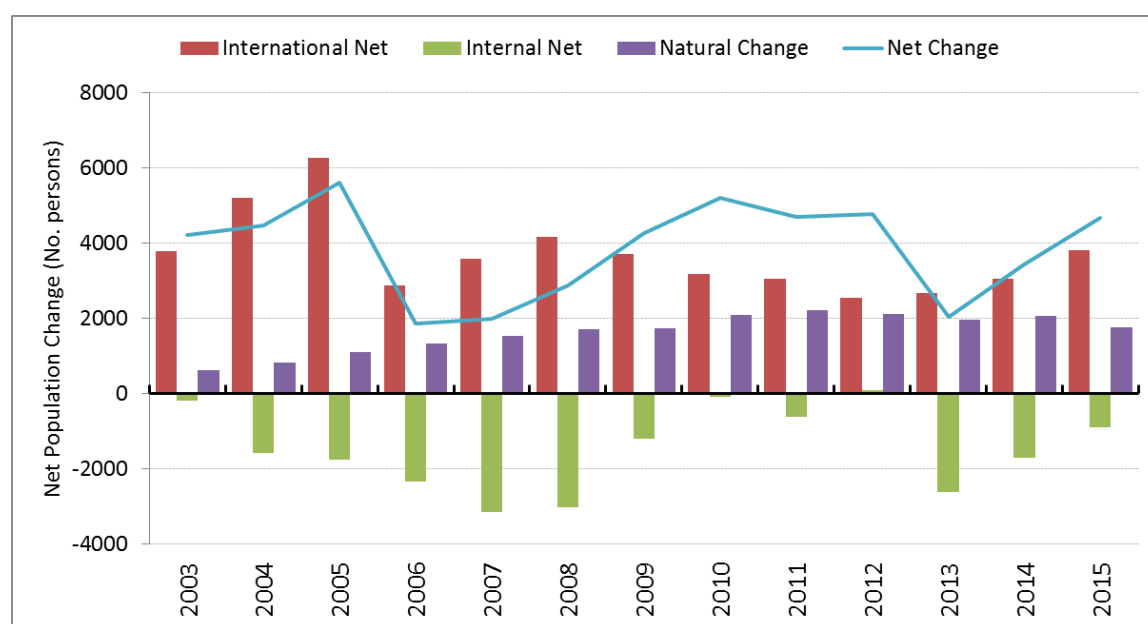


Figure 4: Components of change, 2003-2015

Source: ONS Mid-Year Estimates, detailed components of change (2015)

The ONS Mid-Year Estimates only include people staying in the country for longer than twelve months. Clearly, those staying for shorter lengths of time may also make calls upon health and other services

⁵

<https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesandnorthernireland>

and may register with a GP. The ONS publishes estimates of people staying for between three and twelve months for the purposes of employment or study, at local authority level, which give an indication of the scale of short-term migration⁶. In the year to mid-2014, there were an estimated 3,222 short-term international migrants in Nottingham, higher than 1,890 the previous year. Of these, the majority (2,540) were estimated to be students, meaning that Nottingham has one of the highest number of short-term migrant students in the country.

7.1.1 Ethnic groups

The large majority of people who live in Nottingham are White British (Figure 5). In 2011 in some of the outer estates, 80% or more of the population were White British: in Clifton South the figure was 89%.

According to the 2011 Census, 34.6% of the City's population are from Black and Minority Ethnic (BME) groups, which are defined as everyone who is not White British. This is an increase from 19.0% in 2001.

The number of people in the White British and White Irish ethnic groups fell between 2001 and 2011 with the White British group constituting 65.4% of the City's population in 2011 compared to 81.1% in 2001. The number of people in every other ethnic group increased. The largest numerical increase was of nearly 21,000 in the Asian ethnic groups and the largest percentage increase was in the number of people from mixed ethnic groups which increased by nearly 12,000 people (142.1%).

Looking in detail at the ethnic groups, those showing the biggest increases were Other White (2.5% to 5.1%), Mixed White and Black Caribbean (2% to 4%), Black African (0.5% to 3.2%), and Pakistani (3.6% to 5.5%). The largest groups other than White British are now Other White (5.1%) - which will include large numbers of people from Poland - and Pakistani (5.5%).

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<https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/internationalmigration/datasets/shorttermmigrationestimatesforenglandandwalesstim07inflowsbylocalauthoritybymainreasonformigration>

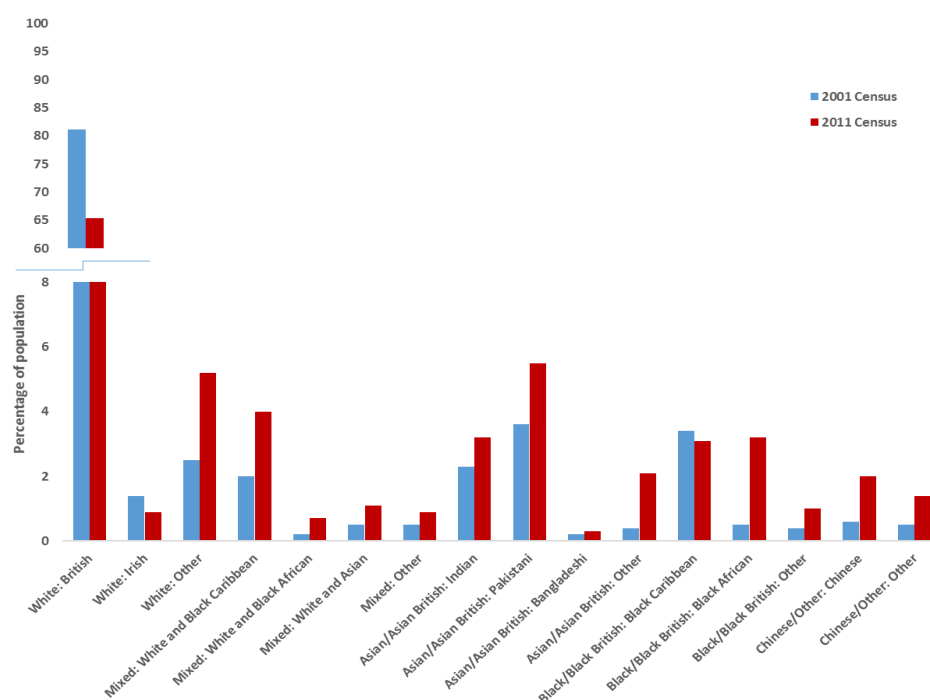


Figure 5: Change in ethnic groups between 2001 and 2011
Source: ONS Mid-Year Estimates, detailed components of change (2015)

7.1.2 School data

Data from Nottingham City's school roll also demonstrates the diversity of the city. In 2016, 50.3% of pupils were of Mixed, Asian, Black, African or Caribbean ethnicity. This is in comparison to a figure of 37% in 2008. A more detailed breakdown can be found in Table 1.

Over a quarter (29.2%) of all pupils have a first language that is not English (2016 school roll). This has risen from 18% in 2008.

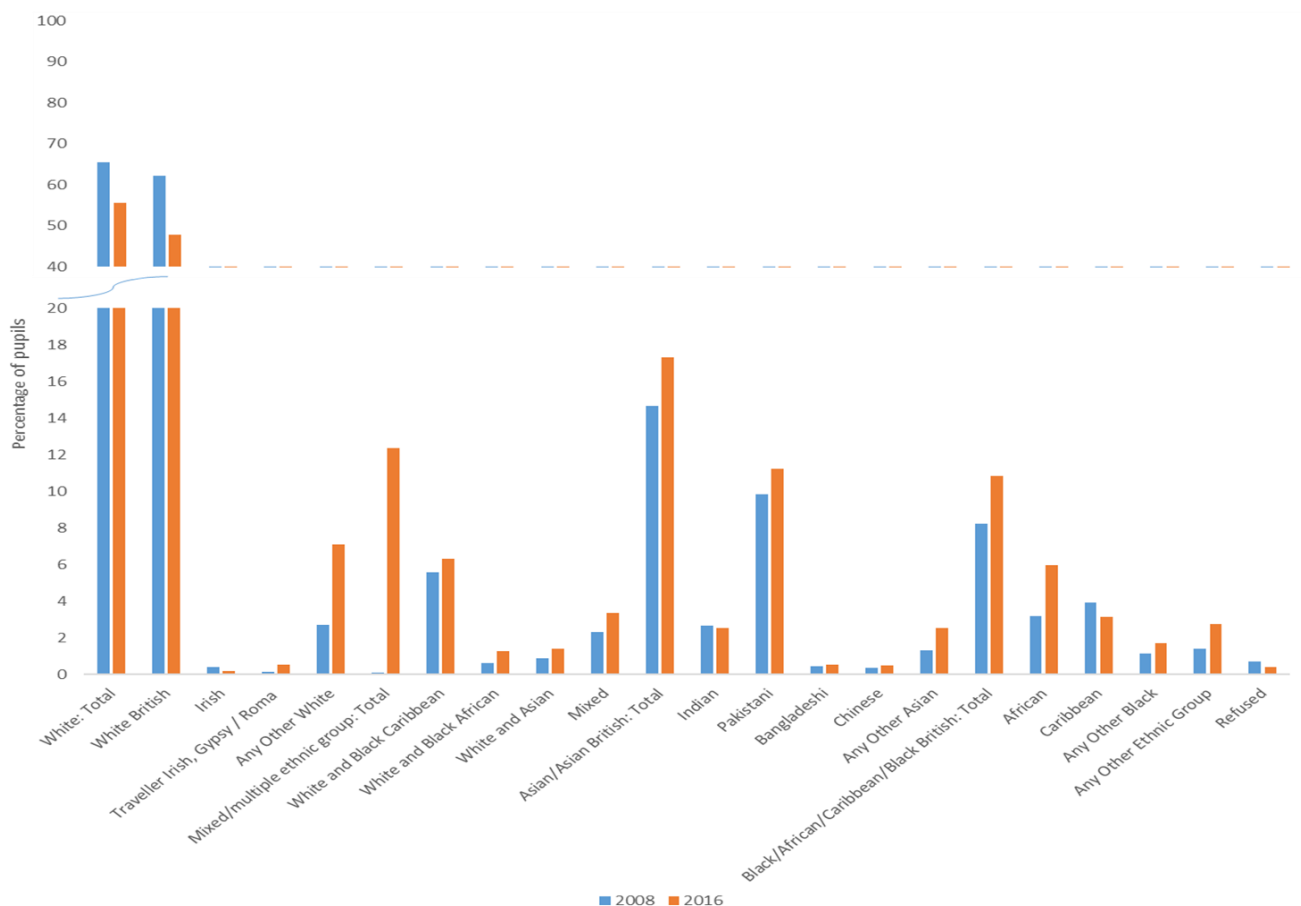


Table 1: Breakdown of Nottingham City School Roll 2008/16 by ethnicity

Source: Nottingham School Survey Data (2008/16)

7.1.3 Age and ethnicity

The City's age structure is generally influenced by the White British group, with most other ethnic groups having a younger age profile than the City average (Figure 6). The two exceptions to this are the White Irish and Black Caribbean groups which have much higher proportions of older people. The youngest age profiles are amongst the Mixed ethnic groups where 15-20% of people are aged under 5.

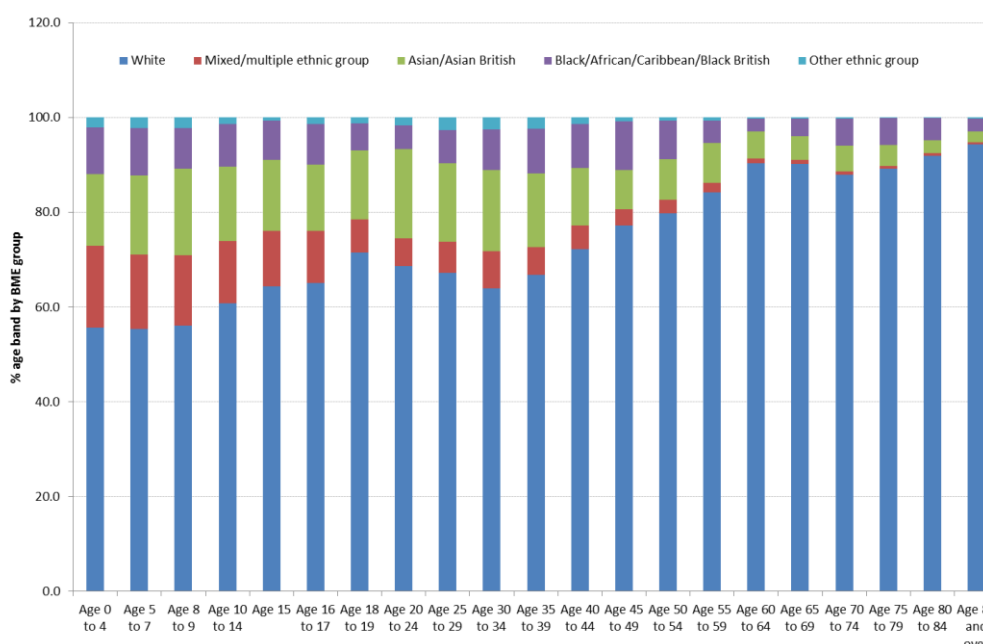


Figure 6: Ethnic breakdown of age-groups
Source: ONS Census (2011)

7.1.4 Geographical distribution of BME communities in Nottingham

Analysis of the 2011 Census shows that the main BME groups have quite different geographical distributions and in three Nottingham wards – Berridge, Leen Valley and St Ann’s – the proportion of the population who are from Black and Minority Ethnic (BME) groups is more than 50% (Figures 7 & 8).

The Pakistani group was quite highly concentrated in Berridge, Dales and Leen Valley ward; whereas the Indian group was more widely spread, with the greatest numbers being in Radford & Park and Wollaton West. The Black and Black British group was also quite widely spread, but had concentrations in Aspley, St Ann’s and Radford & Park. The Mixed group, taken as a whole, was very widely spread around the City.

The Other White group, which includes people from the EU Accession countries, and notably Poland, was concentrated around Berridge, Radford & Park, Dales, St Ann’s and Bridge wards. Evidence from a survey of migrants from the EU Accession countries suggests that the main concentrations are in Sneinton/St Ann’s and Hyson Green/Radford.

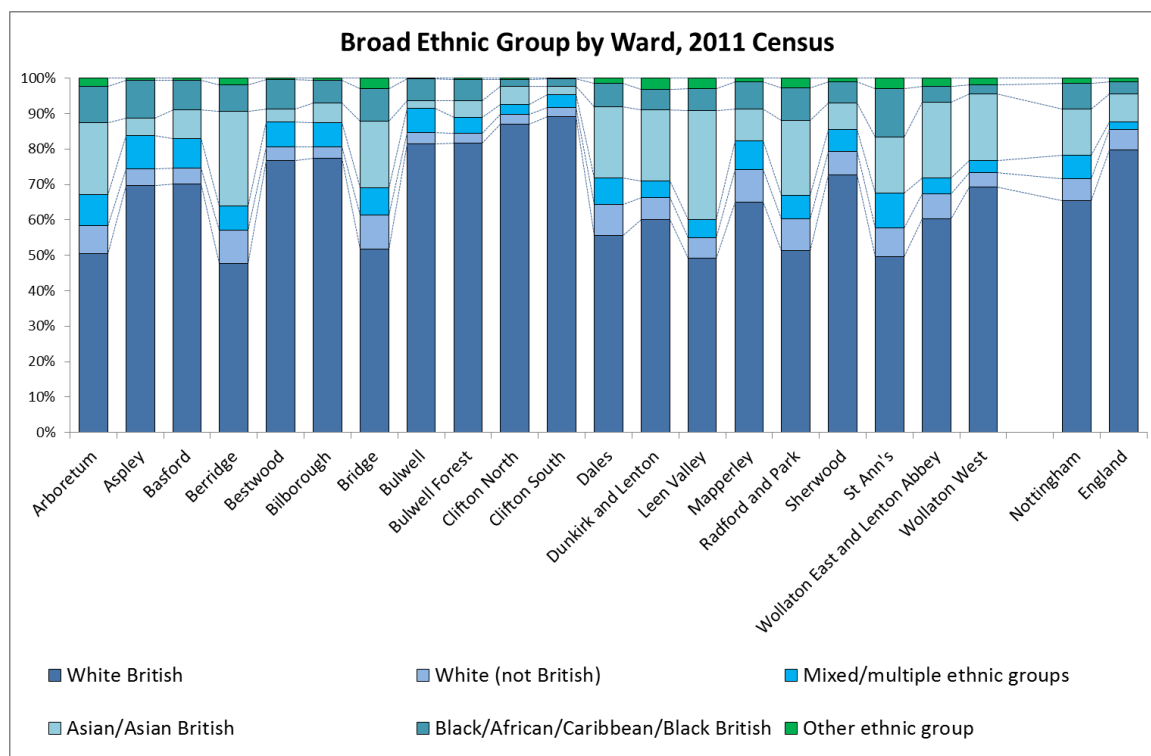
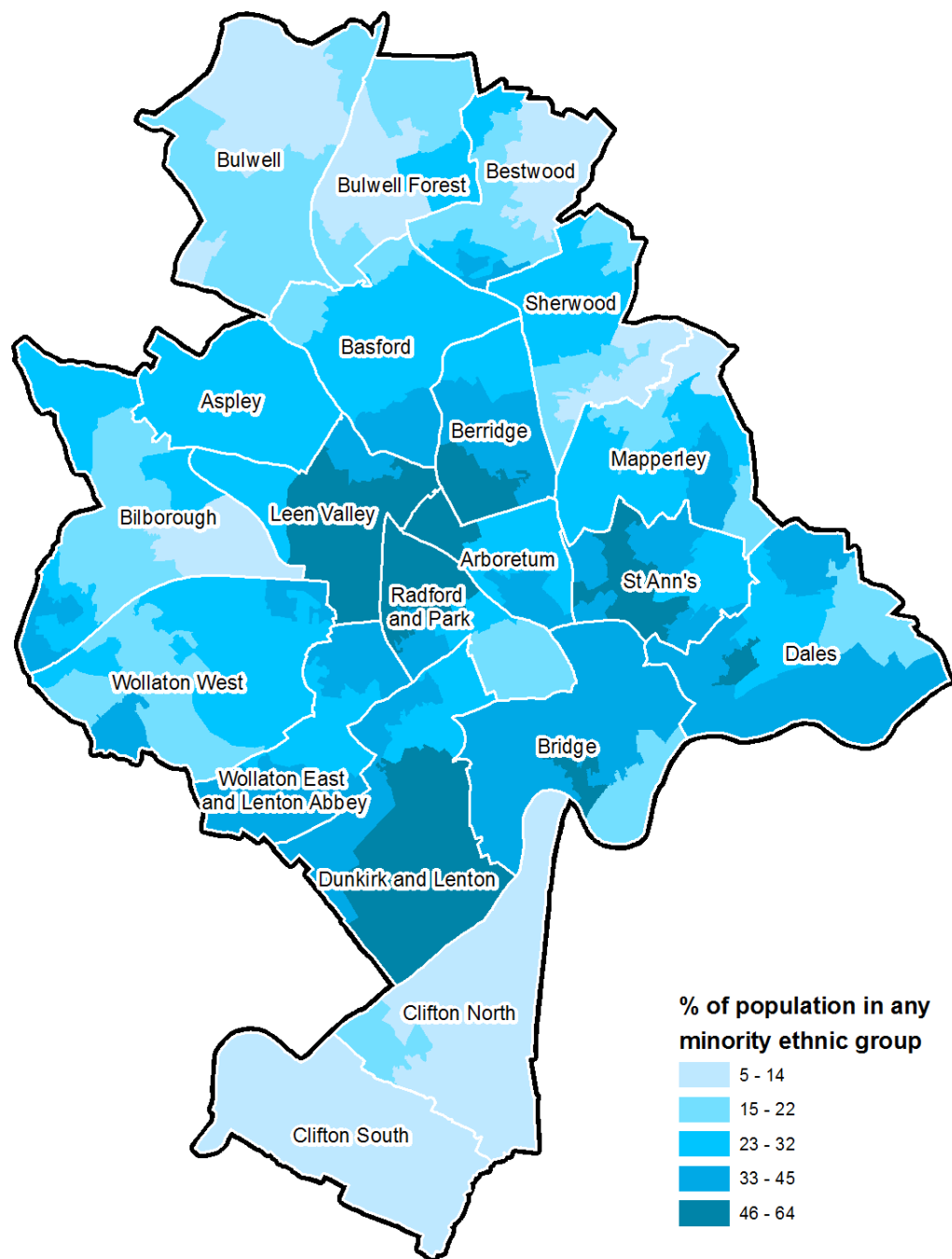


Figure 7: Ethnic populations by ward
Source: ONS Census (2011)



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 data to third parties in any form.

Figure 8: Map of BME population in Nottingham by ward

7.1.5 Migration

Based on previous Mid-Year Estimates, over the whole period since 2005, the net loss due to internal migration was -17,238, whilst the net gain due to international migration was 39,036 (including asylum seekers), equivalent to around 12% of the population.

Data from the Department of Work and Pensions indicates the number of people from outside the UK registering for a National Insurance Number (NINo). This data only includes those in work, looking for work or claiming benefits. It excludes dependants and students (unless in part-time work) and does not indicate when individuals leave the UK. Between March 2004 and March 2015, nearly 54,800 people from overseas living in the City were granted NINos, 23,600 (43%) of them from the EU Accession states. Poland was easily the largest source of these people (16,300), but the next most significant countries were the more traditional sources of India (4,210) and Pakistan (3,250).

The number arriving from the EU Accession countries in 2014/15 was 3,330, the highest annual figure, and an increase of 640 on 2013/14 (2,690). The majority of these were from Poland (1,785) but there was a notable increase in migrant workers from Romania (830) - up by more than 500 on the previous year.

The number arriving from outside of the EU Accession countries increased to 3,270 in 2014/15, from a low of 2,350 in 2012/13.

7.2 Health and wellbeing

Some differences in demographic factors result in expected inequalities in health and well-being, i.e. older people suffer more from ill-health than younger people. However, differences in health as a result of geography or ethnicity tend to be, in the main, the impact of a range of social and environmental factors which are discussed in more detail later.

7.2.1 Census data

The 2011 Census asked two questions about health, although they were phrased differently to those asked in the 2001 Census so direct comparisons cannot be made.

The proportion of people with a long-term health problem increases with age for each ethnic group, but there are large differences in the patterns for different ethnic groups (Figure 9). There is relatively little variation in the 0-15 age group. Variations start to become more pronounced in the 16-49 age group with 12.3% of people of mixed ethnicity having some kind of long-term health problem, compared to just 7% of the Asian/Asian British ethnic groups and 9.7% of the White groups. The large numbers of university students in the Asian/Asian British ethnic groups may influence these figures as students are much less likely to have a long-term health problem than the rest of the population. The largest variations are in the 50-64 age group. The Mixed ethnicity groups have the highest proportion of people with a long-term health problem, followed by the Asian/Asian British ethnic groups. The gap between the Mixed ethnicity group and the Black/Black British groups, which have the lowest proportion, is 12.7 percentage points. The differences between ethnic groups shrink again in the 65 and over age group although for the first time, the Asian/Asian British groups have the highest proportion of people with long-term health problems (68.6%) and the White groups have the lowest proportion (62.2%).

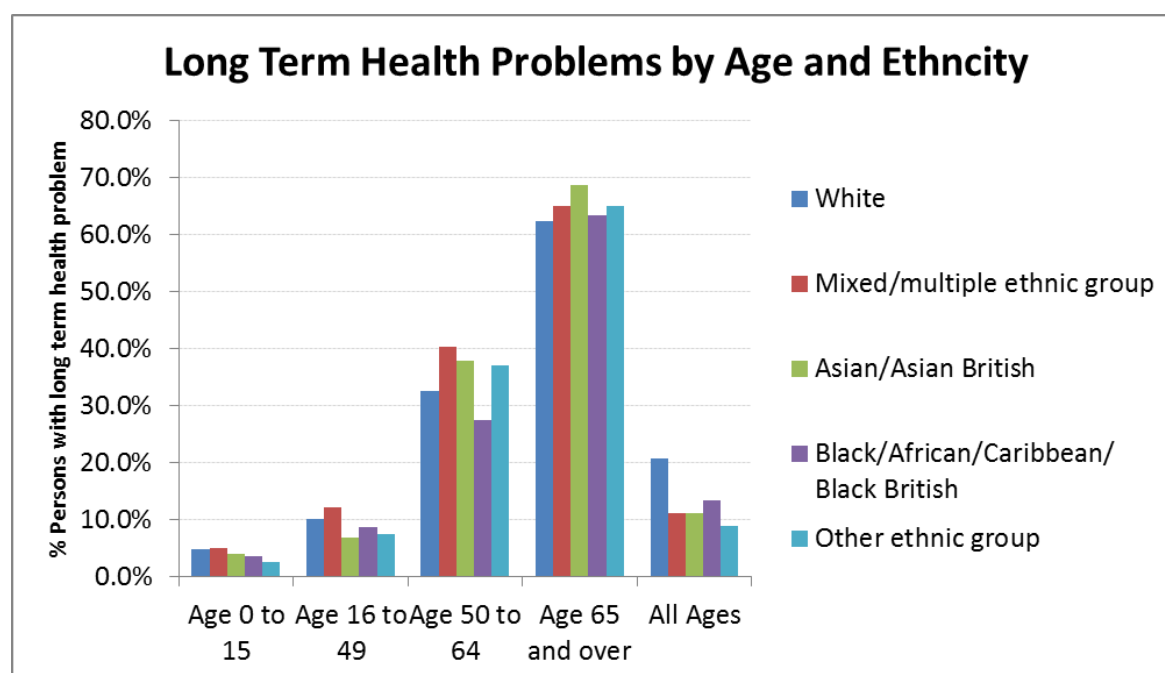


Figure 9: Long-term health problems by age and ethnicity
Source: Census data (2011)

7.2.2 Life expectancy and living with disability

Life expectancy in the UK has increased steadily to reach an all-time high of 78.85 years in men and 82.72 years in women⁷. While the upward trend is positive there remain underlying inequalities. However, the gap in life expectancy in the UK has fallen. The difference in life expectancy between the bottom 10 % of areas and the top 10 % fell from 6.9 years in 1999–2003 to 4.4 years in 2006–10⁸.

In Nottingham, life expectancy has continued to increase over the last 10 years with males living an additional 4 years and females an extra 3.1 years. Life expectancy in Nottingham City has increased at a greater rate than the UK average. However, there remains a significant difference between the life expectancy in Nottingham compared to the England average, with women living to 81.6 years, 1.6 years below the England average and men living until 77.1 years, 2.4 years below the England average (ONS, 2012 -2014). Despite a reduction in the variation of life expectancy across the city, a life expectancy gap of 7.2 years for men and 7.8 years for women still exists between the richest and poorest communities.

The data collected by the Office of National Statistics does not allow us to consider life expectancy by ethnicity; however, it is likely that variation exists. Variation in those reporting living with disability, that limits their daily activities, also showed variation by ethnic group with the highest levels of limiting disability reported in the White group (20.7%) and lowest in the Asian/Asian British and Mixed groups (11.1%).

7.2.3 Mental wellbeing

Mental wellbeing in adults is measured in Nottingham in the annual citizens' survey using the Warwick-Edinburgh Mental Well-being Scale (WEMWBS). It is not known how well it reflects the mental wellbeing of citizens who do not take part in the survey but the measure itself is a good indicator for those who do participate. There are variations at local level echoing those at national level, which would suggest inequalities in wellbeing amongst certain groups such as the unemployed, those with a

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<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/lifeexpectancies/bulletins/lifeexpectancyatbirthandage65bylocalareasintheunitedkingdom/2014-04-16/relateddata>

⁸ https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/inequalities-in-life-expectancy-kings-fund-aug15.pdf

disability or long-term condition and people living in social rented housing, who all tend to have lower mental wellbeing scores.

People who identify themselves as belonging to an ethnic minority group reported less poor mental health than those from mixed/multiple ethnic groups or white background, contradicting national ONS (2013) findings which suggested that people from black and minority ethnic backgrounds had lower levels of wellbeing than their non-BME counterparts (Table 2).

Despite the use of a validated questionnaire, this data may be influenced by cultural attitudes towards mental health. It is possible the 'hidden burden' for mental health is proportionally greater for ethnic minority groups than those who are White British.

Row Labels	Poor Mental Health (%)
White	13.9
Mixed / Multiple ethnic groups	17.4
Asian / Asian British	9.2
Black / African / Caribbean / Black British	7.8
Other ethnic group	8.5
Unknown	13.6
All	12.9

Table 2: Percentage of people with poor mental health as assessed by WEMWBS 2010

Source: Citizens' Survey by ethnicity (2011- 2015)

7.2.4 Cardiovascular disease and diabetes

Ten % of all admissions to hospital in Nottingham have a secondary code for diabetes. This ranges from 3% of Mixed BME groups to 13% of Asian groups. In 2015/16, there were 3,553 admissions with a primary diagnosis of Circulatory Disease, of which 15% were from a BME group. Overall, 23% of Circulatory Disease admissions had an additional code for diabetes. Within BME groups this ranged from 20% of Mixed BME admissions to 39% of Asian BME admissions.

7.2.5 Cancer

In Nottingham City about 1,400 people are diagnosed with cancer each year (incidence) and 685 people die from the disease (mortality). In Nottingham City half of all cancer deaths occur before the age of 75 and cancer is the cause of a third of all deaths under 75 (premature deaths) (Public Health Mortality File, 2014). Incident (new cases) and mortality rates are significantly higher in Nottingham than the average for England and the East Midlands. Data quality on BME groups is low and, as such, breakdown by ethnicity is not possible. However, variation is likely to occur in both screening and diagnosis for cancers.

7.2.6 Sexual health

In 2015, Nottingham was ranked 33 out of 326 local authorities in England (with rank number 1 having the highest rates) for cases of acute STIs. Amongst Nottingham City residents, 3,912 acute STIs were diagnosed, a rate of 1,244.8 per 100,000 residents. The majority (53%) of diagnoses were in young people aged 15-24 years. After peaking in 2013, all new STIs' (all ages) rate has been decreasing year on year and is now 15% lower than in 2013, compared to a decrease of 10% in the East Midlands and a decrease of 2% in England. Rates are still significantly higher than the East Midlands and England.

The rate of acute STIs diagnosed in GUM clinics by ethnic group is shown in Figure 10. Where recorded, 13.6% of acute STIs diagnosed in Nottingham were in people born overseas (PHE LASER Report, 2015). The number of HIV-diagnosed persons in Nottingham City has been steadily increasing since 2006. Between 2011 and 2015, there was a 16% increase in the number of HIV-diagnosed persons in Nottingham City (PHE Sexual Health Profiles). In 2015 the diagnosed HIV rate in Nottingham City was 2.9 per 1,000 aged 15-59 years, compared to an average of 2.3 per 1,000 in England. In 2015, 656 residents in Nottingham received HIV-related care. Of these, 30.6% were white, 54.5% Black African and 5.2% Black Caribbean. With regard to exposure, 24.8% probably acquired their infection through sex between men and 65.4% through sex between men and women. This compares to 563 persons in 2011 and equates roughly to a rise of 30-35 new cases diagnosed each year.

Unfortunately, due to small numbers in many local authorities, it is not possible to present a breakdown of new HIV diagnoses by route of transmission in this report. In England in 2015, 53% of new HIV diagnoses were in white and 20% in Black African populations (LASER, 2015).

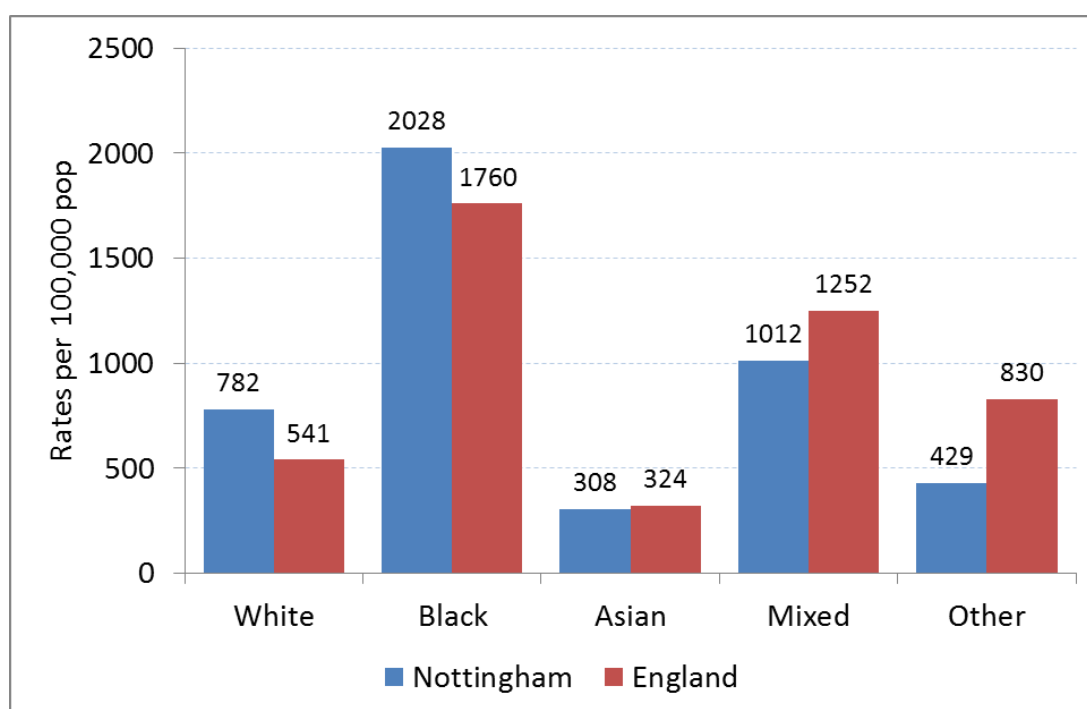


Figure 10: Rates per 100,000 population of new STIs by ethnic group in Nottingham and England
Source: Nottingham Local Authority HIV, sexual and reproductive health epidemiology report (LASER), 2015.
Data from specialist sexual health clinics, excludes chlamydia diagnoses made outside specialist clinics. Rates based on ONS population estimates, 2011

7.2.7 Other communicable diseases

Tuberculosis (TB): The number of new cases of TB in Nottingham City has been falling since 2008, though the rate is significantly higher than England (18 per 100,000 compared to 13.5 per 100,000 (TB Incidence 3 year average, 2012-2014, PHE Health Protection Profiles, fingertips tool). On average, there are 50-55 new cases per year in the City. Nearly half (47.5%) of the TB cases diagnosed in 2014 entered the UK 10 or more years previously. The most common country of birth of non-UK born TB patients in 2014 was India (43.2 %) followed by Pakistan (13.6%). NICE has developed guidance indicating that new entrants into the UK arriving from countries with a high prevalence of TB should be screened for active and latent TB and treated appropriately.⁹

7.2.8 Screening for infectious diseases

Nottingham has a large migrant (non-UK born) population with around 20% of the resident population born outside the UK. 11.5% come from Africa, the Middle East and Asia, countries with higher

⁹ NICE. Clinical diagnosis and management of tuberculosis, and measures for its prevention and control Clinical Guideline 117, 2011:1-64.

prevalence of TB and other infectious diseases (East Midlands Migrant Profile, September 2016, PHE). In 2014, there were 298 single asylum seekers and 525 asylum-seeking families in Nottingham City. A proportion of these will be from countries with high prevalence of tuberculosis, Hepatitis B and C and HIV. According to current guidance, these individuals should be offered screening for these conditions

7.3 Determinants of health

The link between individual factors and health outcomes is strongly mediated by an individual's socioeconomic environment, their lifestyle, and their access to health and social care. This range of behavioural, biological, socioeconomic and environmental factors is often described as the determinants of health (WHO 1998).

7.3.1 Socioeconomic status

Ethnicity and socioeconomic status are often reported to have close associations within the UK population. In Nottingham, 54% of the Black/Black British Group live in communities in the two lowest quintiles of deprivation compared to 33% of the Asian/Asian British population and 38% of the White British population (Table 3).

City Deprivation Quintile	White: British	White Other	Mixed	Asian	Black	Other ethnic group
Q1 - Most Deprived	19%	18%	27%	12%	30%	14%
Q2	19%	23%	25%	21%	25%	20%
Q3	20%	15%	18%	13%	18%	12%
Q4	19%	23%	17%	25%	16%	29%
Q5 - Most Affluent	23%	21%	13%	29%	12%	24%
Total Population	199990	18708	20265	40039	22185	4493

Table 3: BME Groups by Deprivation Quintile

Source: ONS Census (2011)

7.3.2 Employment

The latest employment rate for the City is 63.5%¹⁰, compared with 73.6% for England. This figure is deflated by the presence of so many university students, but even if they are excluded the rate is still low (October 2014 to September 2015 figures: 72.5% compared with 78.1% for England)¹¹. The highest unemployment rates are in Aspley (5.6%), Bulwell (5.3%), Bestwood (4.6%) and Berridge (4.6%). Unemployment decreased in all City wards during 2014, and the four wards mentioned above have seen large numerical decreases.

Employment status is broadly similar across all ethnic groups. However, the proportion of retired people is higher in the White (British) group; this may be, in part, explained by the difference in age distributions between ethnic groups as described previously.

7.3.3 Lifestyle

Diet, Nutrition and Obesity

Nottingham, like most areas, has a lack of dietary and nutritional information about its local population. It is likely that the overall dietary issues discussed below apply to Nottingham City.

Many people from minority ethnic groups have healthier eating patterns than the white population (HSCIC 2016). However there are considerable variations in dietary patterns across and within ethnic groups. These eating patterns are influenced by many factors including availability of food, level of income, health, food beliefs, dietary laws, religion, cultural patterns and customs. Additional factors include age (and, in particular, generation), region of origin and occupation (Gilbert, 2008).

Insight conducted on behalf of the Department of Health (DH) with parents from Black African, Black Caribbean, Bangladeshi, Indian and Pakistani communities looking at early feeding practices identified complementary feeding practices such as use of sweet foods, cereal-based thickeners and continuation of hand feeding, even when infants were able to feed themselves (DH 2008).

¹⁰ Proportion of people aged 16-64 who are in employment, Annual Population Survey, October 2014-September 2015, ONS.

¹¹ Unofficial figures estimated by Nottingham City Council using APS data.

Thomas. J, (2002) cites the following targets for dietary intervention in the South Asian and Black Caribbean Communities:

- South Asian Communities: Increase vitamin D, iron, folate and vitamin B12 intakes.
- Black Caribbean Communities: decrease salt and increase fruit and vegetable intakes
- Both communities: decrease total energy intake, decrease total fat, increase mono and polyunsaturated fat, increase fibre and consumption of low glycaemic index foods and reduce obesity and weight gain.

Qualitative research has identified high levels of salt use in cooking in Black Caribbean and South Asian women in the City (DH Insight, 2007); however there is no reason to assume this is higher than the general population or high income groups. Furthermore, people of Black African, Black Caribbean and South Asian family origin and those who remain covered when outside or are housebound, are at particular risk of vitamin D deficiency. Almost 75% of Asian adults may have low vitamin D status in the winter (SACN 2007). There are 1-2 cases per annum (NHS Nottingham City 2006-2008) locally of rickets due to Vitamin D deficiency.

The national variation in child obesity prevalence by ethnicity may be mirrored locally. As shown in Figure 11 (Data 2011-2014 pooled), Reception-aged children in the black and mixed ethnic groups appear to have a higher prevalence of obesity than the white ethnic group. Due to overlapping confidence intervals, it is not possible to determine whether these differences are true differences, except among the black ethnic group where obesity prevalence is significantly higher than in the white ethnic group. It appears that these ethnic differences are also apparent among Year 6 children; again, those in the black group are significantly more likely to be obese than children in the white group.

However, as described previously, there are known associations between ethnicity and area of deprivation. It is unclear if these differences in obesity levels are issues related to ethnicity or to socioeconomic status. Nevertheless, cultural issues are important for management and prevention in these areas.

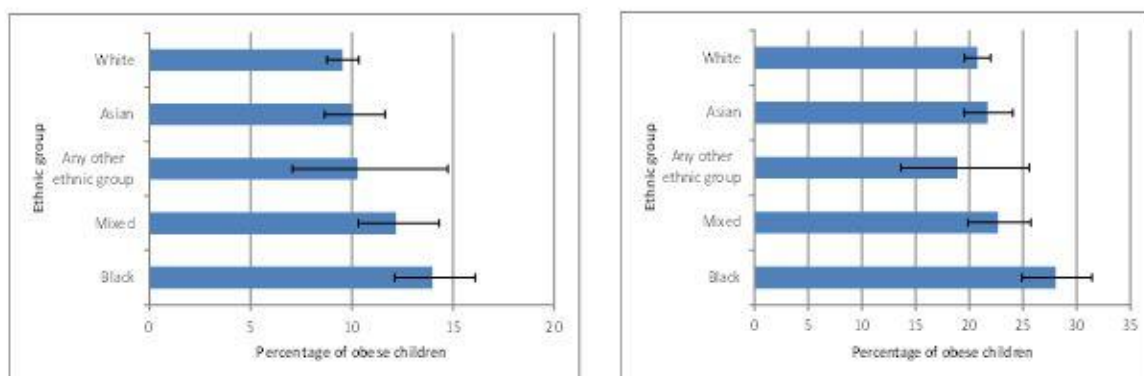


Figure 11 Prevalence of obesity among all children in Reception (left) and Year 6 (right) for Nottingham by ethnic group

Source: NCMP 11/12 to 2013/14 (pooled)

7.3.4 Physical activity

The latest data from the Sport England Active people's survey found that more people from black, Asian and ethnic minority backgrounds (2.92 million) are playing sport. This means you're more likely to be active if you're from these communities (37.5%) than if you're White British (35.9%). However, the number of individuals meeting recommended levels of physical activity varies between ethnic minorities (Table 4). No local data on physical activity participation by ethnicity is available.

	General population	Black Caribbean	Black African	Indian	Pakistani	Bangladeshi	Chinese	Irish
	%	%	%	%	%	%	%	%
Men								
Meeting recommendations	37	37	35	30	28	26	30	39
Some activity	31	29	30	26	21	23	32	28
Low activity	32	34	35	44	51	51	38	33
Base	2,873	409	386	549	429	408	348	497
Women								
Meeting recommendations	25	31	29	23	14	11	17	29
Some activity	36	30	28	32	34	21	36	38
Low activity	39	39	43	45	52	68	47	33
Base	3,818	648	467	634	508	477	375	656

Table 4: Self-reported physical activity prevalence, by sex and ethnic group in England

Source: Healthy Survey for England (2004)

7.3.5 Smoking

Prevalence of adult smoking has been measured locally through the annual Nottingham City Residents/Citizen Survey since 2006 (Nottingham City Council, 2015). The survey has shown an overall downward trend in smoking prevalence for citizens aged 18 years and over during this period to the current 2014 level, where 27.4% of survey respondents were found to smoke. Analysis of smoking by ethnicity shows that citizens of mixed heritage, White (not British) and White British have the highest smoking prevalence (Figure 12). Smoking in most ethnic groups is significantly greater in men. The proportion of women who smoke in the Asian/Asian British, Black/African/Caribbean/Black British, and other ethnicity groups is significantly lower than the city average, as is the number of Asian/Asian British men who smoke (Figure 12).

National data suggests that the higher smoking prevalence amongst the White (not British group) may in part be due to the high smoking prevalence amongst people from Eastern European countries with 39.4% of Polish and 36.1% of Romanian immigrants smoking nationally.¹²

Research conducted in 2013 in Nottingham shisha establishments, found that the majority of users smoked shisha at least once a week; 50% were unaware they were smoking shisha containing tobacco and almost half thought shisha was less harmful to health than cigarettes. Participants (n=65) recruited from the establishments were 76% British Asian with a median age of 23 years¹³. Intelligence from New Leaf indicates that users of shisha bars are predominantly young British Asian adults who frequent the establishments for socialising.

¹² 2009/10–2011/12 Integrated Household Survey (2014)

¹³ Loi 2013 (From JSNA 2015)

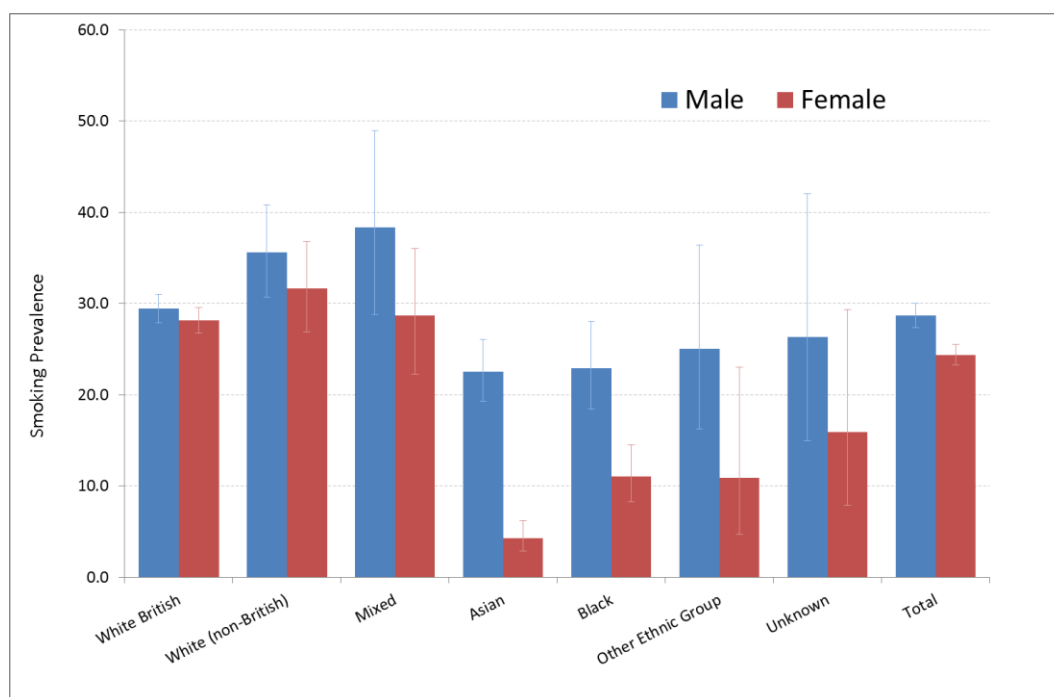


Figure 12: percentage of smokers by ethnic group

Source: Citizen Survey (2011-2015)

7.3.6 Alcohol

Local alcohol consumption data for citizens aged 16 and over is available through the Nottingham City Citizens' Survey. The survey asks participants whether they drink alcohol and, if they do, they are asked to recall what they drank during the previous 7 days.

Pooled data from the combined results of the 2012-2015 surveys indicates the proportion of the population who drink alcohol and levels of risky drinking are much lower than the national reported figures. This may in part be explained by the city's relatively higher proportion of citizens from ethnic groups who tend not to drink or who drink less alcohol than the general population. It may also indicate under-reporting of alcohol consumption in the Citizen Survey: 18% of the respondents did not answer the alcohol related questions.

Analysis of White British and other ethnic groups indicates that White British participants include a significantly higher proportion of increasing and higher-risk drinkers (Figure 13).

No ethnic group has a proportion of 'binge drinkers' significantly higher than the city average. White British and Mixed ethnic groups have the highest proportion of alcohol drinkers who binge drink (Figure

14). A significantly lower proportion of drinkers in Asian/Asian British and Black/Black British ethnic groups reported binge drinking compared to the White British group (Figure 14).

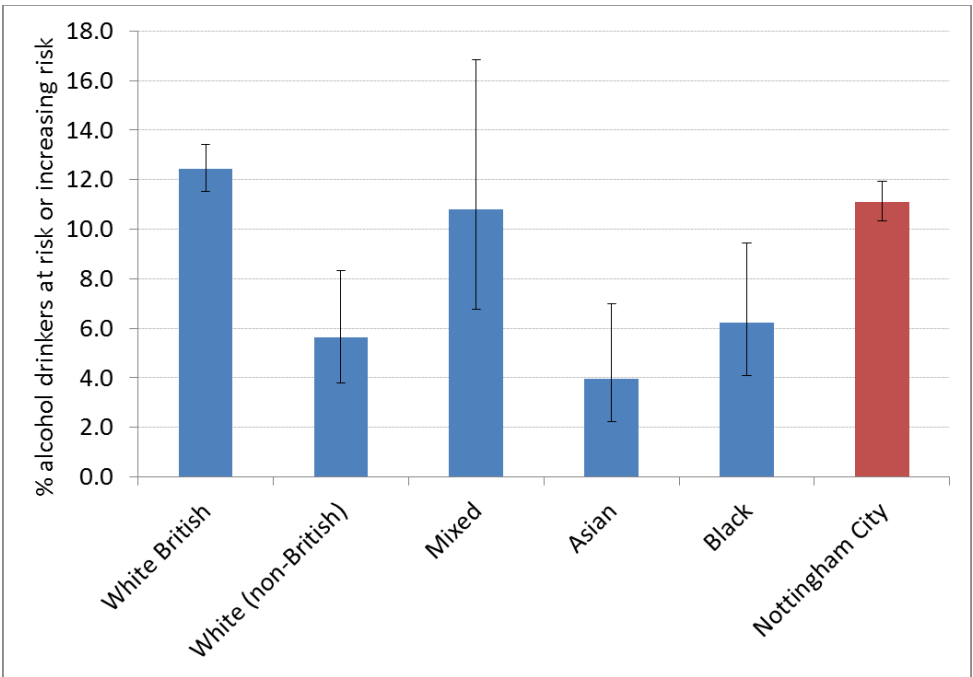


Figure 13: Percentage of alcohol drinkers at increasing risk and higher-risk within ethnic grouping

Source: Citizens’ Survey (2012-15)

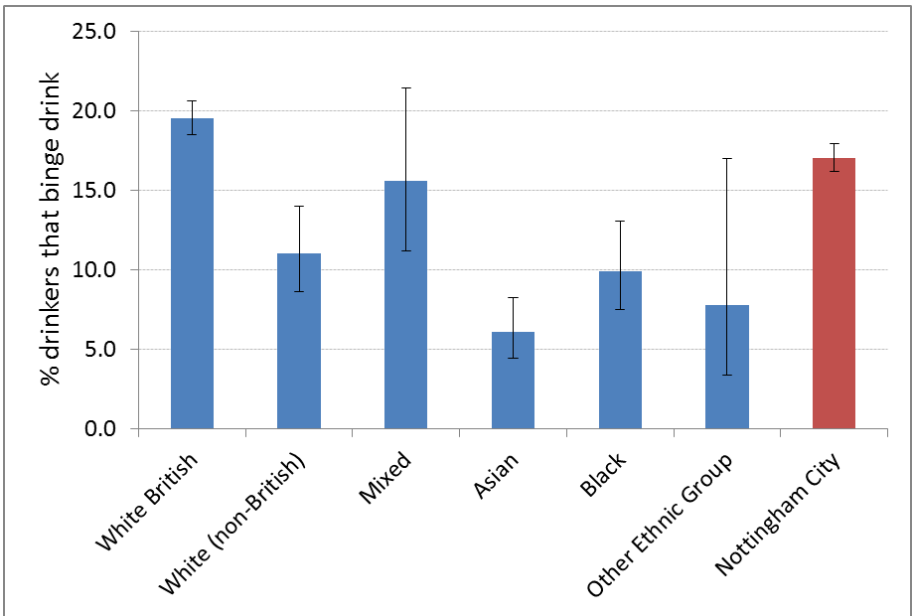


Figure 14: Percentage of alcohol drinkers who binge drink by ethnic group

Source: Citizens’ Survey (2012-15)

7.4 Health service data

Hospital admissions and A&E attendance data routinely records ethnicity but data completeness across trusts can be variable. The majority of Nottingham City residents are admitted to either Nottingham University Hospitals (NUH) – City and QMC – or to Nottingham Treatment Centre.

7.4.1 Accident and Emergency

Overall, 18% of ethnicity recording in A&E attendances, including Walk-In centres, is missing. This ranges from 40% of Walk-In centre activity (Citycare) to 10% of NUH A&E attendances. Within NUH A&E attendances, 25% of attenders are from a BME group. This varies with age: of the under 25s, 57% of attenders are white compared to 84% of those over 65 years (Source: Local Authority Public Health HES dataset; NHS Digital).

Attendance in A&E at Nottingham University Hospitals are split into three main categories; Accident/Injury, Medical, and other (not classifiable). The demographic profile of attendances across the whole of the city suggests that accidents tend to be in younger (under 25 years) and medical attendance by older (over 65 years) residents. However, there remains a sub-population of younger individuals – the under 5 year-olds – who are more likely to attend for medical reasons. Black and Asian ethnic groups are more likely to attend A&E for medical reasons than for accidents. There is little difference in the proportion of individuals attending for accident or medical reasons in the Mixed or Other ethnic groups. The proportion attending due to ‘non classifiable’ reasons is higher within BME groups.

It was observed in the data that admission or referral to clinic was twice as likely in those attending for a medical problem as opposed to accidental injury. However, within different ethnic groups variation in this relationship occurred; white ethnic groups were more likely to be admitted or referred to clinics compared to other ethnic groups both for injury and medical reasons.

7.4.2 Hospital admissions

Nottingham City residents had 83,650 admissions to Trusts across England in 2015/16. Of these, 82% were admissions to NUH, 12% to Nottingham Treatment Centre and a further 2% were to Nottinghamshire Healthcare Trust (NHCT) beds (based in QMC). Ethnicity coding at the Treatment Centre was very poor with 66% of admissions 'Not Stated'. NUH and NHCT ethnicity coding was 10% and 1% 'Not Stated' respectively.

Admissions to NUH showed a similar pattern to A&E attendances, reflecting the different age structure of the BME population. In the under 25s, a third of admissions were from BME groups compared to 9% of admissions of people aged 65 and over.

Just over one-fifth of all admissions to NUH in 2015/16 were from a BME group. Of these, the most predominant group was Asian, with 41% of BME admissions being of Asian origin. However, this varied by primary diagnosis (Table 5). Within BME groups, admissions for cancer were more likely to be black whereas admission for circulatory, respiratory or digestive complaints were more likely to be Asian.

Primary Diagnosis	All Admissions 2015/16	% BME	Within BME Group	
			% Asian	% Black
Cancer	7,624	14%	25%	40%
Circulatory Disease	3,553	15%	49%	26%
Respiratory Disease	4,898	18%	42%	23%
Digestive System Disease	5,890	15%	42%	30%
Pregnancy	9,198	31%	49%	26%
Other	37,646	21%	39%	29%
Total	68,809	21%	41%	29%

Table 5: Proportion of admissions by BME groups and primary diagnosis

Source: Local Authority Public Health HES Admissions (2016)

Admission rates of children under 14 years tended to be lower in girls than boys. Boys of Mixed ethnic groups had the lowest admission rates; admissions of white, black and Asian male children were similar to average. Admission of girls of black and mixed Ethnic groups were lower than average. Admissions of Asian and white female children were similar to average.

It had been the intention of this report to consider attendance at the Walk-in centre and the elective admissions via Circle; however, it was found that data quality was too poor (40% and 66% 'Not Stated' respectively) to conduct analysis.

8. Local Services and Assets

African Caribbean National Artistic Centre (ACNA)

The African Caribbean National Artistic Centre (ACNA) was established as a community organisation, mainly for people of Black Caribbean/West Indian descent. The centre delivers a range of services to the community including:

- Promoting awareness of cultural heritage of black people and a positive sense of identity, self-respect and respect of others;
- Playing a pivotal role between statutory and voluntary organisations for the black community through the provision of information and advice to meet the needs of the community;
- Encouraging educational achievement for members (particularly young people) of the community through emotional support and self-development;
- Promoting social welfare and community participation for the most disadvantage members of the community.

AWAAZ “voice” for all BME and New Emerging Communities

AWAAZ is a registered charity that provides support to people from BME communities who have a mental health problem both in primary and secondary care. The service’s aim is to work with mental health service users and their carers to ensure their voices are heard. AWAAZ is an established

organisation and is trusted within the South Asian communities in Nottingham and Nottinghamshire as a reliable support provider.

African Institute for Social Deprivation (AISD)

AISD is a volunteer, African-led community organisation that enables African communities to access health services, information, support, skills and opportunities. AISD works in collaboration with stakeholders across all sectors including local authorities, NHS and regional partners to inform, educate and distribute free sexual health information packs to the African community with the aim of reducing HIV and AIDS and sexual health infections.

BAC – IN – CIC Ltd

BAC-IN is a drug and alcohol recovery service targeted at the BME community. The services aim to help BME communities with recovery-focused and offender rehabilitation support. BAC-IN uses an integrated and culturally-competent approach, which offers a diverse range of services designed to maximise transformative recovery, supporting individuals to take personal responsibility so that they may achieve freedom from addiction and become productive individuals within their communities.

BME Cancer Communities

BME Cancer Communities is a social enterprise which aims to address cancer inequalities within black and minority ethnic and low income communities. One of the enterprise's most recent reports, 'Hear Me Now' (2013), highlights the greater incidence and mortality, due to the 30% increased risk of prostate cancer, in Black Caribbean men. The Network is working with the CCG and other partners to raise awareness among professionals and in the community, and to promote early identification and diagnosis of prostate cancer and provide on-going support to those affected by the disease.

Change Maker Volunteer Programme

Change Makers are local people who volunteer in their community to raise awareness of the signs and symptoms of the four most common cancers in Nottingham, lung, bowel, breast and prostate cancer. Change Makers aim to tackle health inequalities by increasing early presentation, reducing late

diagnosis, and increasing access to screening. The Change Makers utilise innovative approaches to working with communities. One of their most successful approaches is the use of drama to deliver health messages around the signs and symptoms of cancer to people from diverse cultural and religious backgrounds.

Friends and Bredrins

Friends and Bredrins is a cancer support and self-help group which is based in Nottingham, the aim of which is to help Caribbean and African men, as well as all other ethnic minorities, who have been affected by prostate cancer.

Marcus Garvey Centre

The Marcus Garvey Centre primarily caters for the needs of the older Black Caribbean community with adult care service needs including dementia and physical, sensory and mental health disabilities. All the staff at the centre are from a Black Caribbean background and are fully trained and skilled in caring for the elderly. The service aims to support people in working towards their goals and to be as independent as possible. The service works across organisations and maintains close links with carers and offers support and advice where needed. It also provides activity-based services and has a vibrant luncheon club.

Mojatu

Mojatu Foundation is a social enterprise that sources, collates, manages and distributes information through regional bi-monthly magazines and online at www.mojatu.com. The magazines are currently published in Nottingham and Berkshire with contents mainly focused on African and Caribbean communities. It also supports girls, women and young people through media training, education and health initiatives.

Muslim Community Organisation (MCO)

The Muslim Community Organisation provides a range of activities and access to services for the community. MCO takes a community development approach, empowering the community to tackle issues affecting their lives and helping individuals to improve their quality of life.

New Art Exchange (NAE)

New Art Exchange (NAE) is the largest contemporary visual arts space in the UK representing culturally diverse perspectives. Located in Nottingham's inner-city Hyson Green neighbourhood, NAE operates in the heart of a vibrant, creative community, rich in culture and heritage representative of many parts of the world. NAE has a strong mission to "stimulate new perspectives about the value of diversity in art and society". NAE has become a leading cultural player in Nottingham, profiling some of the top culturally-diverse artists in the world and supporting exceptional local talent to flourish.

Nigerian Community Group

The Nigerian Community Group caters for the general welfare and quality of life of Nigerians and Africans living in and around Nottingham. The organisation has set up a social enterprise restaurant and meeting place called 'African House' which provides a safe and welcoming environment for new arrival migrants from Africa settling in Nottingham. The organisation is set in the heart of three deprived wards: St. Ann's, Sneinton and Meadows, the neighbourhoods in which the target groups reside.

Nottingham Sports Group

The Nottingham Sports Group brings together different communities and unites them through sports, physical recreation, competitiveness and networking in an attempt to increase social cohesion. Their motto is "communities united through sports and physical recreation". The service works specifically with BME groups and aims to improve the health and wellbeing of different communities in Nottingham.

Nottingham & Nottinghamshire Refugee Forum (NNRF)

The Nottingham & Nottinghamshire Refugee Forum is an independent voluntary organisation and registered charity set up in 2000 to work with and for refugees and asylum seekers in Nottingham and Nottinghamshire, offering practical advice, information, support and friendship. The organisation is run by a volunteer Management Committee, a third of whose members are refugees and asylum seekers. NNRF aims to support asylum seekers and refugees in Nottingham & Nottinghamshire to gain fair and just outcomes, rebuild their lives and integrate into society. NNRF offers a range of services including:

- Providing a welcoming community centre;
- Offering specialised advice and support services;
- Providing programmes to develop confidence, skills and knowledge;
- Campaigning for a just and generous response to refugees and asylum seekers from government and the host community;
- Advocating on behalf of individual asylum seekers and refugees in cases of injustice and hardship.

Nottinghamshire Chinese Welfare Association

Nottinghamshire Chinese Welfare Association provides services to meet the needs of the Chinese population living in Nottingham. The service offers advice and information on housing assistance, leisure activities, home visiting and educational classes such as ESOL, Tai Chi and Chinese brush painting. The organisation aims to raise the profile of the Chinese community and promote Chinese culture.

Positive Action Training & Recruitment Agency (PATRA)

PATRA works with young people from BME backgrounds and aims to remove forms of disadvantage that prevent BME individuals from competing on an equal basis in the labour market. It also works to ensure that BME groups are properly represented in skilled and senior positions in proportion to their presence in the labour market. PATRA offers apprenticeships for young people with on-the-job training with employers, which allows trainees to study for a qualification and provides personal development, guidance and counselling.

Pakistan Centre

The Pakistan Centre provides members of the community with free information, signposting and guidance including benefits, welfare, immigration information, interpretation, translation and many other issues. The organisation helps people to complete forms and provide attestation where required. They also provide assistance to persons needing visas, Pakistan Identity cards and attestation for passport applications/documents.

Support Towards Empowering People Service (STEPS)

STEPS is a free service that offers one-to-one and group support to people with mental health needs. The service is targeted at the BME community and offers support through helping to identify an individual's needs and addressing them through personalised support plans. The programme is aimed at enabling greater independence and works closely with the community and voluntary sector and local statutory bodies.

Signpost to Polish Success

Signpost to Polish Success was established in 2005 to support new arrivals from Eastern Europe, mainly Polish migrants. The organisation aims to deliver essential services to new and emerging communities. Services include providing English language courses and offering 1-2-1 information and signposting sessions. The organisation also publishes a free monthly Polish newspaper entitled 'East Midlands po Polsku', which roughly translates as 'the East Midlands in Polish'. The newspaper contains information about local events, meetings, workshops, community events, volunteer opportunities and information on partnership work with various organisations.

Somali Unity & Cultural Centre

Somali Unity & Cultural Centre was established in 2010 to offer members of the Somali Community an opportunity to be involved in positive action and to help provide education, social, welfare and recreation activities.

Nottingham Equal

Nottingham Equal is an umbrella organisation that brings the Black and Minority Ethnic voluntary and community sectors together, to give them a voice within strategic structures, enabling them to influence policy and service delivery.

Indian Community Centre Association

The Indian Community Centre Association is a registered charity which offers a variety of services for the Indian community in Greater Nottingham, including day care, sport and activities, information and signposting, luncheon club and visa and welfare advice.

Bright Ideas Nottingham

Bright Ideas is a vibrant community-based business that works with local people to effect change and improvement in their communities. The organisation believes that the community voice should be heard and that it is the people from the community that can inspire and direct the most necessary and positive changes in the places where they live. Bright Ideas seeks to improve the quality and access to services for local people through cultural brokerage and community engagement and involvement. Some of the services they provide include:

- Research
- Training and development
- Devising campaigns and information materials
- Hosting vibrant events
- Training trainers
- Encouraging local people to be involved through volunteering

‘Hearts and Minds’ Programme run by Bright Ideas Nottingham

‘Hearts and Minds’ is a programme, initially funded by the British Heart Foundation (BHF), and developed by Bright Ideas in Nottingham. It aims to identify approaches that work in relation to

promoting heart health in Nottingham's visible and non-visible diverse black and minority ethnic communities. The programme has included an annual conference, the development of community action researchers and 'the Love Hearts', a team of volunteers that work on the project to improve the heart health of Black Caribbean communities.

Take 1 Studio

Take 1 Studios is a long-established community organisation set up as a registered charity. Take 1 Studios offers programmes and opportunities for young people including a centre for education, dance and music. It aims to work with and support young people towards building confidence and gaining qualifications that they may not have otherwise achieved.

Emmanuel House Support Centre

Emmanuel House supports homeless, vulnerable and isolated adults in and around Nottingham. It provides the basic needs for homeless and vulnerably-housed adults in Nottingham. The service employs members of staff but also has over 70 volunteers who regularly support the organisation. Emmanuel House provides additional support and services around tenancies, benefits, mental health, training and workshops, drug and alcohol support, a daily nurse and a core programme of social activities. It also has an onsite charity shop, which brings in much needed income for Emmanuel House and is a place for service users to gain first-hand work experience.

'Check Tings Out' Prostate Cancer Awareness Project run by BME Cancer Communities

'Check Tings Out' is a two-year pilot project launched in 2016 and is a BME community-led prostate cancer awareness project targeting men within Black African and Black Caribbean communities. The project has been developed in response to the 2014 follow-up 'Hear Me Now' report, which looked into the reality of prostate cancer in Black African and Black Caribbean men and revealed that Black Caribbean men in England are twice as likely to develop cancer compared to white Caucasian men and are twice as likely to die from it. 'Hear Me Now' is now a national campaign influencing positive action nationwide.

Self Help UK (SHUK)

SHUK is the national self-help group resource centre based in Nottingham that promotes, develops and supports self-help groups and their inclusion in a range of health and wellbeing priorities such as self-care and self-management of long term health conditions. One of the core aims of SHUK is to empower individuals from Black, Asian and Minority Ethnic (BAME) communities to self-manage their long term conditions and to support people to access health and wellbeing information.

SHUK has developed a range of initiatives that raise awareness of health inequalities to improve health outcomes for BAME communities, some of the services they provide include:

- Support the development of patient leaders
- Hold focus groups with BAME communities so that they have a say in shaping services.
- Plan and deliver health road shows
- Provide targeted interventions to address physical and mental health issues
- Volunteer recruitment and development of health champions
- Time to Change Hub - challenging the stigma attached to mental health

For more information visit www.selfhelp.org.uk

9. Qualitative Work: Results

In order to add a qualitative perspective to the HNA, key stakeholders and members of the BME community were canvassed for their views. The opinions and feelings of service providers and members of the community are important because it is essential that the HNA is informed by people living and working in the community in order to gain some insight into the issues and concerns that are important to those who may receive a particular service or initiative. Moreover, NICE (2016) identifies that it is good practice to support and promote sustainable community engagement by encouraging local communities to express their views and to make representations in helping shape and develop current and future services.

9.1 Health questionnaire responses

The figures in this section are, wherever possible, directly inserted from the SNAP questionnaire. Where questions required the respondent to enter “free text”¹⁴, an assimilation of responses has been included. The response percentage and number indicates which category of response in each statement had the highest ranking.

(90n) respondents completed the online version of the questionnaire, with the remainder of the questionnaires being completed at community events, focus groups and via partner organisations.

9.1.1 Demographic section

Please tick the statement which best describes you.

What gender are you?

92% of respondents answered this question.

¹⁴ Free text, in research terms, refers to replies to questions where the respondent is required to write/type information they feel important, rather than indicate their response in a pre-set category.

Ethnicity	Female	Male	Not stated	Grand Total
White	33	32	1	66
Asian	134	48	1	183
Black	158	119	1	278
Mixed	79	37	2	118
Other	12	18	0	30
Unknown	7	5	54	66
Grand Total	423 (57%)	259 (35%)	59 (8%)	741

Table 6: Number of respondents by gender and ethnicity

Table 6 shows that the majority of respondents to the questionnaire were female participants (57%), with the highest proportion of female respondents being from Black communities, followed by Asian communities. The majority of male respondents were also from Black communities followed by Asian communities.

What is your first language?

75% of respondents answered this question.

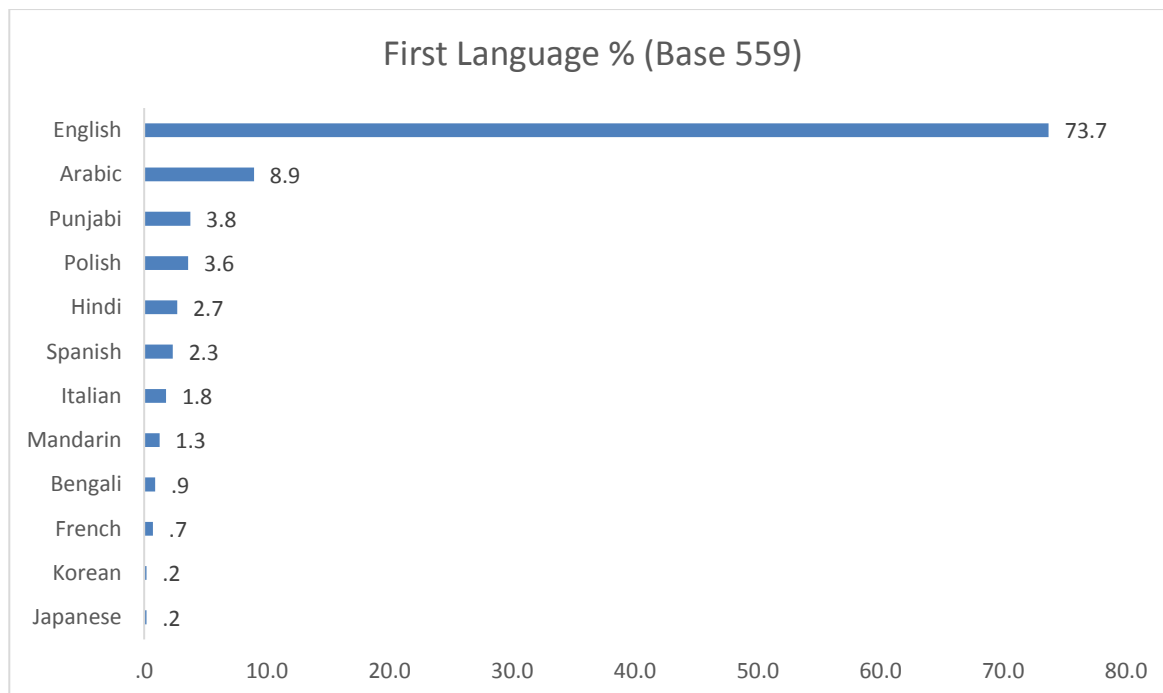


Figure 15: Survey respondents by first language

Figure 15 shows that the majority of respondents (74%) identified English as their first language, followed by Arabic (9%) and Punjabi (4%). (25%) of respondents did not state their first language.

When developing the questionnaire the 12 most common languages spoken in the UK were added as drop-down boxes. Interestingly, 124 respondents spoke languages different to the ones in those boxes, the languages included:

Afghanistan, Amharic, Aymara, Chichewa, Chinese, Greek, Gypsy, Hungarian, IGBO/Russian, Iranian, Kwale, Latvian/Russian, Malay, Mandinka, Mirpuri, Nepali, Patois, Portuguese, Romanian, Serbian, Swazi, Slovakian, Swahili, Tagalog, Telugu, Temne, Thai, Turkish, Vietnamese, Wolof, Yoron, Zaghawa. Czech, Dutch, Gujarati, Kurdish, Persian, Shona, Tamil, Tigrinya, Urdu, Yoruba

What is your country of birth?

67% of respondents answered this question.

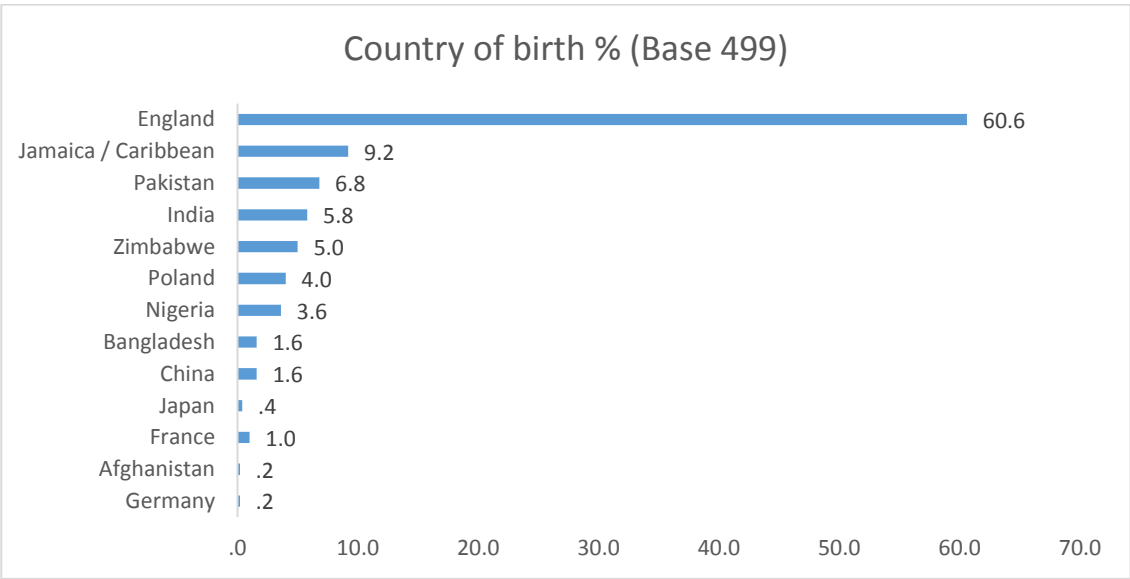


Figure 16: Respondents by country of birth

Figure 16 shows that the majority of respondents to the questionnaire were born in England (61%), followed by Jamaica (9%) and Pakistan (7%).

Ethnicity	Afghanistan	Bangladesh	China	England	France	India	Jamaica / Caribbean	Japan	Nigeria	Pakistan	Poland	Zimbabwe	Not stated
White				16	2		1	1			17		30
Asian		7	8	69		28		1		34			36
Black				119	3		38		18			24	76
Mixed				94			7				1	1	14
Other		1		3							1		25
Unknown	1			2		1					1		61
Grand Total	1	8	8	303	5	29	46	2	18	34	20	25	242

Table 7: Number of respondents by country of birth and ethnicity

Table 7 shows that the highest number of respondents who were born in England were from Black ethnic groups (119 n) followed by Mixed ethnic groups (94n) and Asian ethnic groups (69n).

When developing the questionnaire, 12 countries were added as drop-down boxes. Interestingly, 62 respondents were born in different countries (see table 8).

Countries of Birth	Number of respondents
Syria	4
Sudan	20
Spain	6
Italy	8
Iraq	11
Iran	4
Gambia	5
Africa	4

Table 8: Number of respondents born in different countries.

Furthermore, 242 respondents either did not state their country of birth or stated other countries, which included:

Algeria, Amman/Jordan, Angola, Barbados, Botswana, Belgium, Bengal, Bermuda, Brazil, Burkina Faso, Burundi, Canada, Chile, Congo, Czech Republic, Dominica, Egypt, Ecuador, Eritrea, Ethiopia, Gambia, Germany, Ghana, Greece, Guyana, Holland, Hungary, Kashmir, Kenya, Korea, Kurdistan (Iran), Kurdistan (Iraq), Latvia, Lebanon, Libya, Malawi, Malaysia, Montserrat, Morocco, Nepal, Nigeria, Northern Ireland, New Zealand, Persia, Peru, Philippines, Romania, Russia, Saudi Arabia, Sri Lanka, Sierra Leone, Slovakia, Sweden, Tanzania, Thai, Togo, Trinidad, Turkey, Venezuela, Vietnamese, Yemen, Yugoslavia.

Please tick the statement which best describes you.

What is your religion?

90% of respondents answered this question.

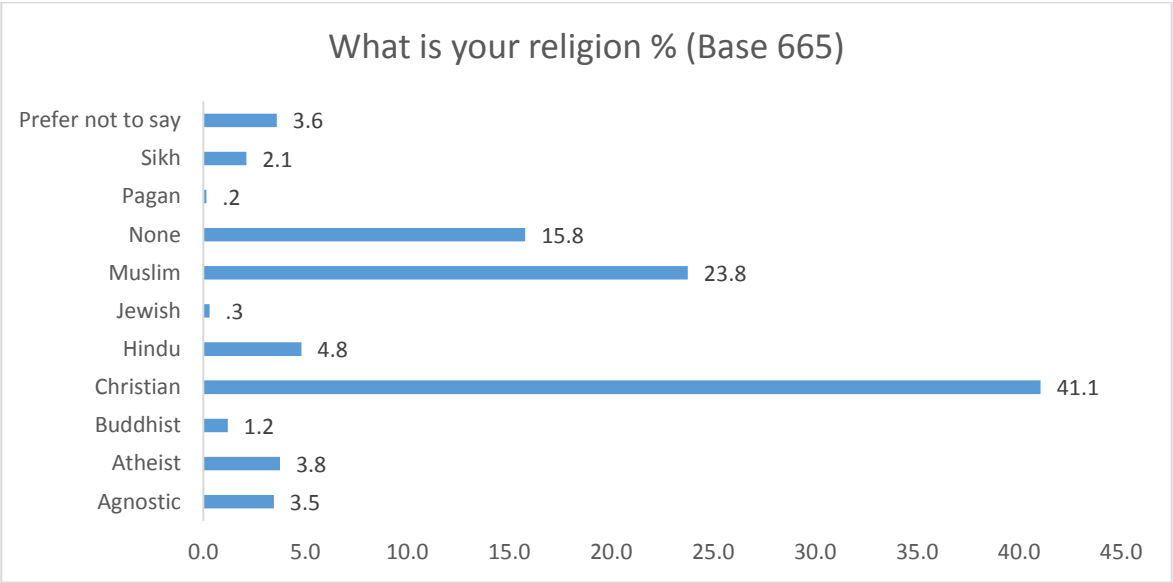


Figure 17: Number of respondents by religion.

Figure 17 shows that the highest number of respondents identified as Christian (40%) followed by the Muslim faith (24%). Interestingly, (16%) stated not having a faith while (16%) did not state their religion and (4%) preferred not to say.

Please tick the statement which best describes you

What is your ethnicity?

91% of respondents answered this question.

Ethnicity	Number of respondents
Arab	17 (2)
Asian – Bangladeshi	6 (1)
Asian – Chinese	14 (2)
Asian – Indian	53 (7)
Asian – Kashmiri	9 (1)
Asian – Other	20 (3)
Asian – Pakistani	65 (9)
Black – African	117 (16)
Black – Caribbean	141 (19)
Black – Other	14 (2)
Mixed – Other	15 (2)
Mixed - White & Asian	1 (0)
Mixed - White & Black African	14 (2)
Mixed - White & Black Caribbean	81 (11)
Other	47 (6)
Prefer not to say	3 (0)
White - English, Welsh, Scottish, Northern Irish, British	16 (2)
White - Gypsy Traveller	1 (0)
White – Irish	1 (0)
White – Other	41 (6)
Not stated	65 (9)
Grand Total	741 (100)

Table 9: Number of respondents by ethnicity

Table 9 shows that 19% of respondents described their ethnicity as Black-Caribbean, followed by Black-African (16%) and 9% of respondents did not state their ethnicity. Of the 137 respondents who identified their ethnicity as Asian-Other, Mixed-Other, White-Other, Black-Other and Other ethnicities, there were various descriptions of ethnicities, which included:

Black Caribbean, Asian-Korean, Asian-Kurdish, Black Italian, Black Pakistani, Black-Indian, Black-British, British-Asian, British-Black, Caribbean-mixed, Czech& Gypsy, English Persian, Eurasian, European, Greek, Hispanic, Hungarian, Indian, Indian-Caribbean, Italian, Jamaican Indian, Jamaican-Irish, Kurdish-Sorani, Kurdish, Latin, Mixed African-Caucasian- East Asian, Mixed Black and White British, Sea Malaysian, Serbian-British, Spanish, Turkish, Vietnamese, White Romanian, White Black Caribbean-Jewish, Polish, Czech.

Please tick the statement which best describes you

How old are you?

92% of respondents answered this question.

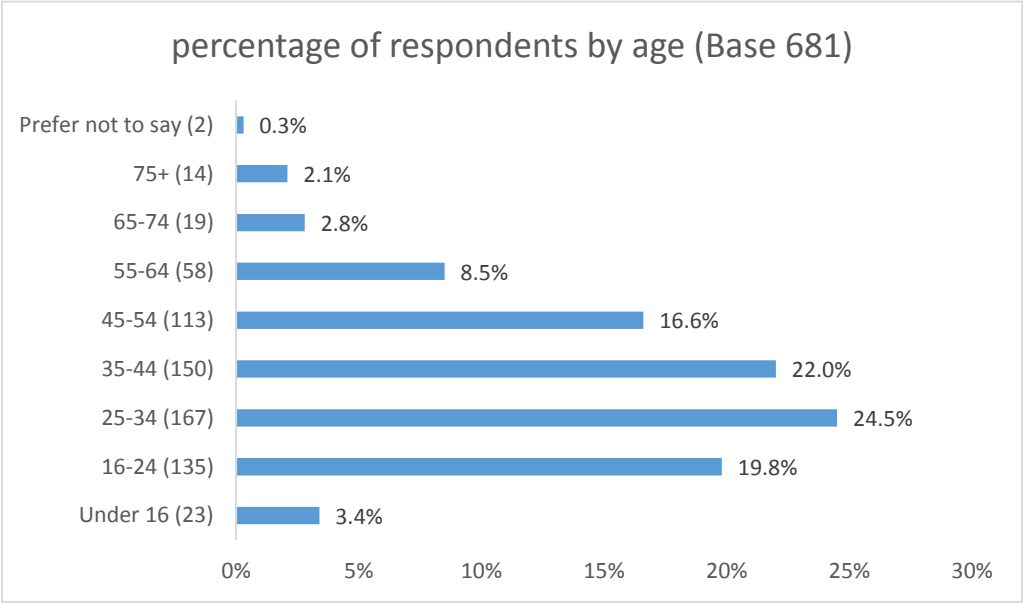


Figure 18: Number of respondents by age

Figure 18 shows that the majority of respondents (86%) were aged under 45 years, with the largest proportion (25%) of these being in the 25-34 age group, followed by the 35-44 age group (22%). The combined numbers from the 55 – 75+ age groups are (14%), this would suggest that the engagement across these age groups was limiting.

Please tick the statement which best describes you.

How do you describe yourself?

83% of respondents answered this question.

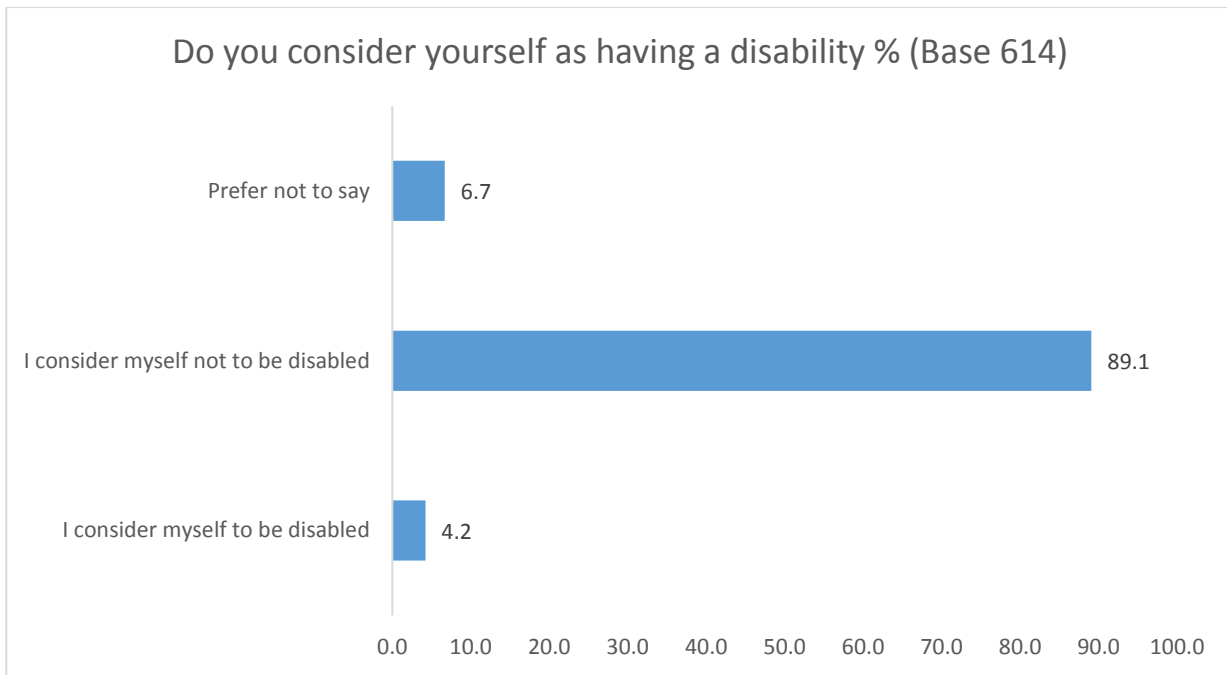


Figure 19: Number of respondents who considered themselves to be disabled or not

Figure 19 shows that the majority of respondents (89%) considered themselves not to be disabled, (7%) of respondents did not state their disability status, whilst (4%) considered themselves to be disabled.

Please tick the statement which best describes you.

What is your sexual orientation?

84% of respondents answered this question.

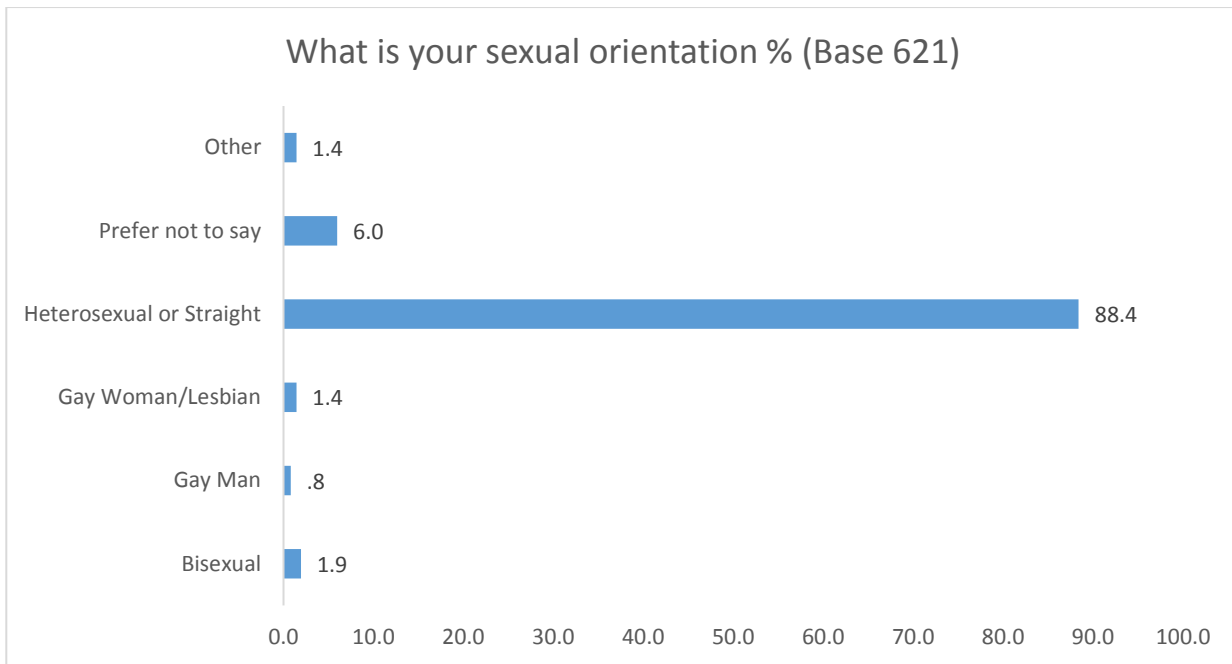


Figure 20: Respondents by sexual orientation

Figure 20 shows that the majority of respondents (88%) identified themselves as heterosexual or straight. (6%) of respondents preferred not to reveal their sexual orientation.

Some of the respondents' comments within the free text were intriguing and showed a lack of understanding of the terms used:

"Normal person", "Not into ladies", "Married", "I like females", "Not in to men"

Q1 Are you responding as a member of the a BME community or an organisation

84% of respondents answered this question.

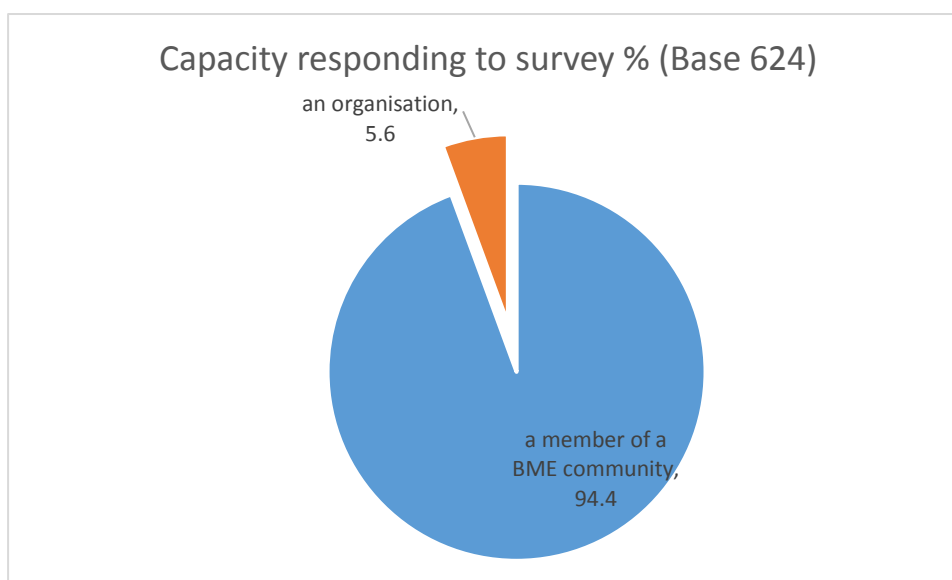


Figure 21: Number of respondents who identified themselves as a member of the BME community or as an organisation

Figure 21 shows that the majority of respondents (94%) identified themselves as a member of the BME community. This question was asked as previous consultations were criticised for engaging with BME groups and organisations rather than with members of the BME community. Thus it was reassuring to note that in this consultation the vast majority of respondents described themselves as members of the BME community.

9.1.2 Lifestyle section

In this section respondents were asked to rank statements on a Likert scale¹⁵ to indicate the extent to which they agreed or disagreed with a statement. They were asked to record responses on a continuum from 'strongly agree' to 'strongly disagree'. The statements were generated from the literature review and from a recent local consultation with the BME community commissioned by the CCG.

Q2.1 I drink alcohol more than 3-4 times per week

99% of respondents answered this question.

¹⁵ A Likert scale is a psychometric scale commonly used in questionnaires. When responding to a Likert questionnaire, respondents specify their level of agreement or disagreement on a symmetrical scale for a series of statements, thus capturing the intensity of their feelings for each statement.

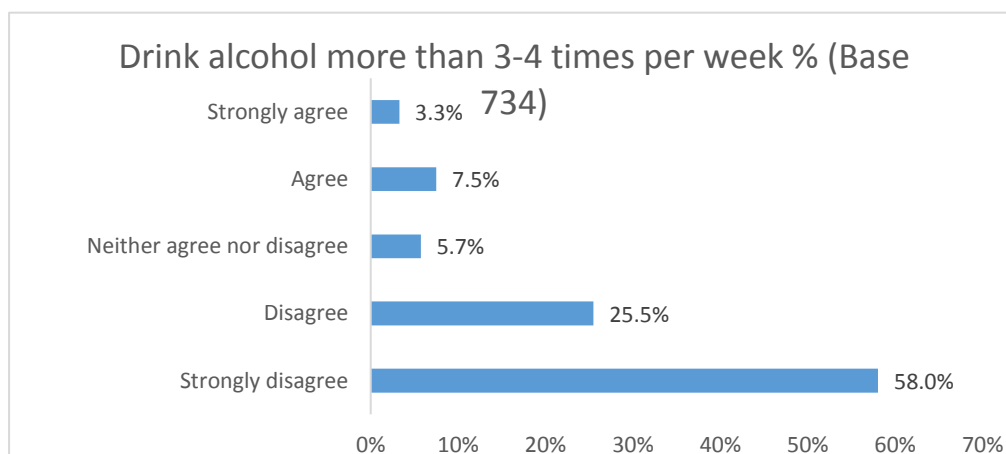


Figure 22: Number of respondents who drink alcohol more than 3-4 times per week

Figure 22 shows that the majority of respondents (84%) disagreed or strongly disagreed with the statement “I drink alcohol 3-4 times per week”.

Ethnicity	Strongly agree (n)	Agree (n)	Disagree (n)	Strongly disagree (n)	Neither agree nor disagree (n)	Not stated (n)	Grand Total (n)
White	7	20	18	28	3		76
Asian	6	8	74	156	9	1	254
Black	6	11	35	124	16	5	197
Mixed	2	8	39	59	10		118
Other		1	8	20	1		30
Unknown	3	7	13	39	3	1	66
Grand Total	24	55	187	426	42	7	741

Table 10: Number of respondents who agreed or disagreed to drinking alcohol more than 3-4 times per week by ethnicity

Table 10 shows the number of respondents who agreed or disagreed to drinking alcohol more than 3 – 4 times per week by ethnicity. Interestingly, the table shows that the highest number of those

respondents agreeing or strongly agreeing to consuming alcohol regularly are of White ethnic background (27n) followed by Black ethnic groups (17n).

The highest number of people who disagreed or strongly disagreed with the statement are from Asian ethnic groups (230n), followed by Black ethnic groups (159n). Interestingly, the highest number of people who neither agreed nor disagreed are from Black ethnic groups, followed by Mixed ethnic groups.

The free texts reflected the results, where a direct link between norms and alcohol consumption was highlighted:

“In my community we do not have many people using drugs or drinking alcohol due to religious regulations”

Q2.2 I smoke tobacco regularly

98% of respondents answered this question.

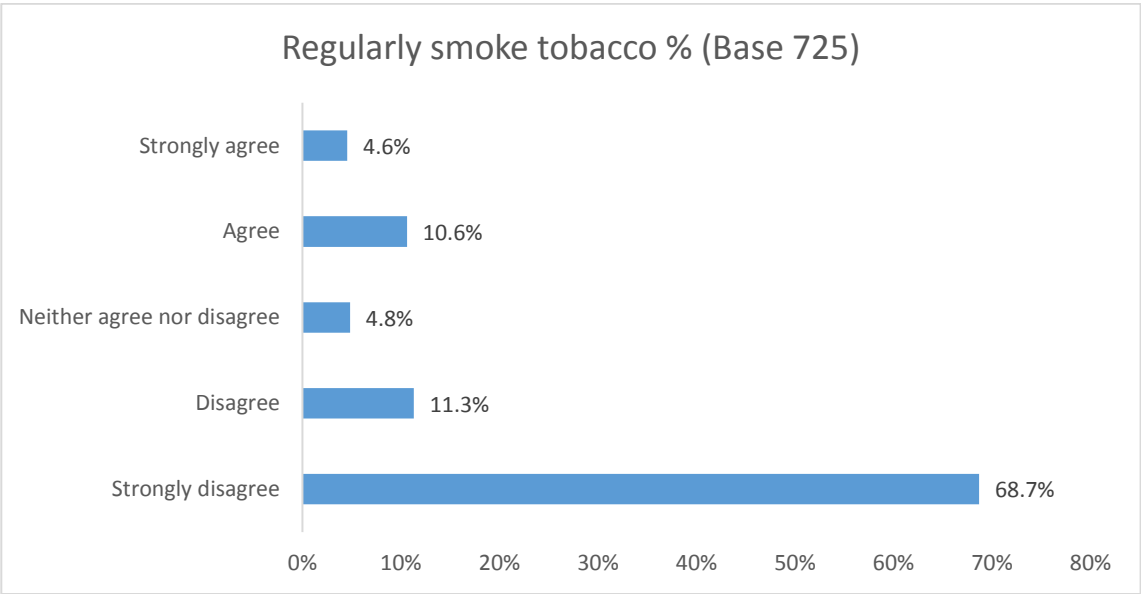


Figure 23: Number of respondents who smoke tobacco regularly

Figure 23 shows that 80% of respondents disagreed or strongly disagreed with the statement, “I smoke tobacco regularly”. This would suggest that smoking prevalence among the respondents is low.

Ethnicity	Agree (n)	Strongly agree (n)	Disagree (n)	Strongly disagree (n)	Neither agree nor disagree (n)	Not stated (n)	Grand Total (n)
White							
Female	3		4	25	1		33
Male	17	5	3	12	2		32
Not stated				1			1
Asian							
Female	1	9	13	99	7	5	134
Male	7	3	1	35	2		48
Not stated				1			1
Black							
Female	9	6	18	115	5	5	158
Male	10	1	7	85	6	3	119
Not stated	1						1
Mixed							
Female	13	7	7	50	2		79
Male	8		5	19	4	1	37
Not stated				1	1		2
Other							
Female	1			10		1	12
Male			7	9	2		18
Unknown							
Female			1	3	2	1	7
Male			1	4			5
Not stated	7	2	15	29	1		54
Grand Total	77	33	82	498	35	16	741

Table 11: Smoking prevalence by ethnicity and gender

Table 11 shows that male respondents from White, Asian, and Black ethnicities have higher smoking rates compared to their female counterparts, with the vast majority of regular male smokers being of White ethnic background (22n). The data also shows that Mixed, Black and White ethnicity women have higher smoking rates relative to Asian women.

Q2.3 The food available in the UK is not as natural and nutritious as my country of origin

96% of respondents answered this question.

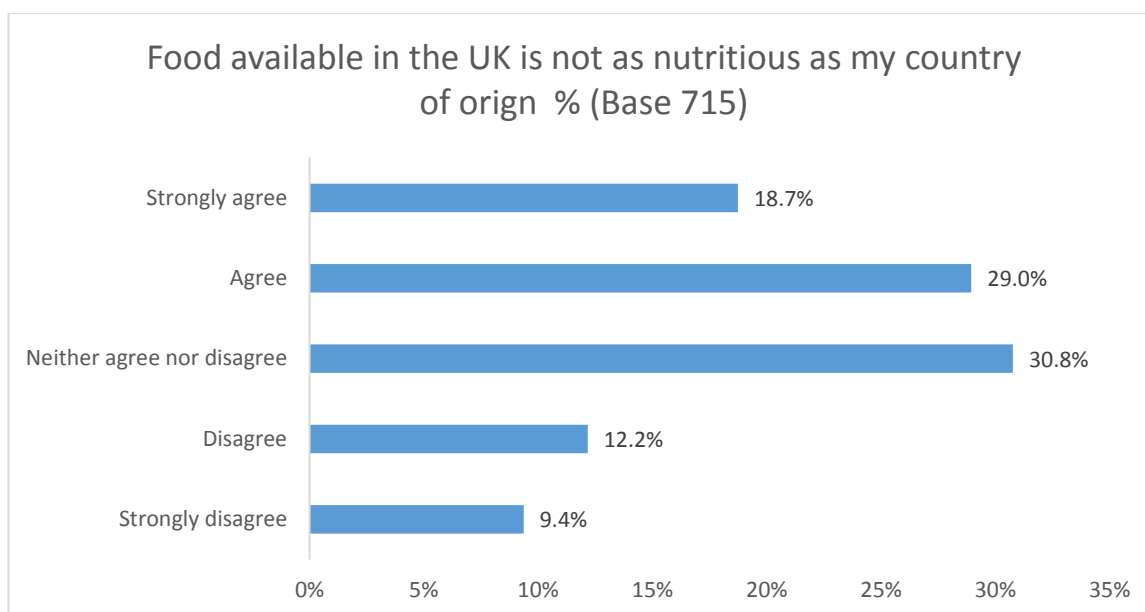


Figure 24: Food available in the UK is not as natural and nutritious as my country of origin

Figure 24 shows that 48% of respondents agreed or strongly agreed with the statement, “The food available in the UK is not as natural and nutritious as my country of origin”. However, (30%) neither agreed nor disagreed with the statement.

Ethnicity	Agree (n)	Strongly agree (n)	Disagree (n)	Strongly disagree (n)	Neither agree nor disagree (n)	Not stated (n)	Grand Total (n)
White	17	14	8	5	18	4	66
Asian	44	14	35	19	65	6	183
Black	92	71	24	26	61	4	278
Mixed	33	12	12	10	47	4	118
Other	5	10		2	12	1	30
Unknown	16	13	8	5	17	7	66
Grand Total	207	134	87	67	220	26	741

Table: The food available in the UK is not as natural and nutritious as my country of origin by ethnicity.

Table 12 shows the number of respondents by ethnicity. It demonstrates that the highest number of respondents who agreed or strongly agreed to the statement are from Black ethnic backgrounds

(163n) followed by Asian ethnicities (58n). The highest number who disagreed or strongly disagreed with the statement are from Asian ethnic backgrounds (54n) followed by Black ethnicities (50n). The majority of respondents who neither agreed nor disagreed were also from Asian ethnic backgrounds.

The question *“food available in the UK is not as natural and nutritious as my country of origin”* was based on feedback from wider local consultations. However, feedback from some respondents suggested this was an inappropriate question, particularly for respondents who identified their country of origin as Britain. One respondent stated:

“....it makes an assumption I am an immigrant...I am mixed race without similar peers.”

Whilst 341 respondents agreed or strongly agreed with the statement this was not reflected in the free text responses. Respondents were more likely to state that the UK diet was as healthy, if not healthier, than traditional diets. A respondent observed that not changing traditional diets to reflect life in the UK was the issue rather than the diet itself:

“...The traditional food of the Caribbean was slow burning and appropriate to the conditions of heat and hard work. Eating this way in the UK doesn't translate.”

Q2.4 People from my community lack the knowledge required to maintain a healthy lifestyle

97% of respondents answered this question.

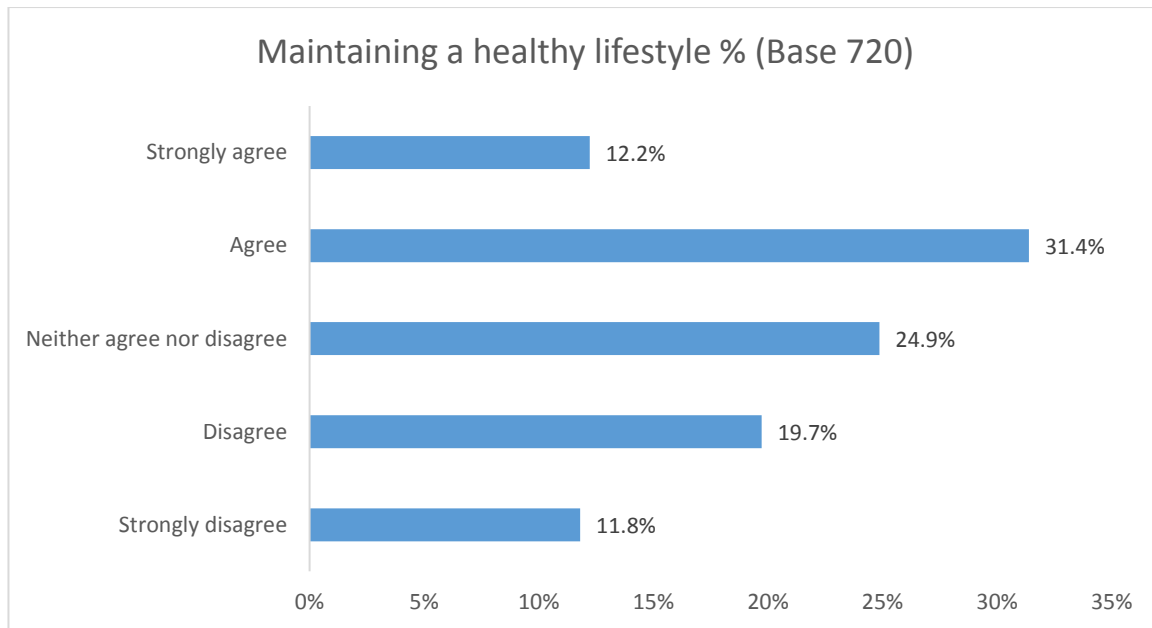


Figure 25: People from my community lack the knowledge required to maintain a healthy lifestyle

Figure 25 shows that (43%) of respondents agreed or strongly agreed with the statement “People from my community lack the knowledge required to maintain a healthy lifestyle”, whilst (25%) of respondents neither agreed nor disagreed with the statement.

Ethnicity	Agree (n)	Strongly agree (n)	Disagree (n)	Strongly disagree (n)	Neither agree nor disagree (n)	Not stated (n)	Grand Total (n)
White	22	4	11	6	22	1	66
Asian	69	21	34	20	35	4	183
Black	76	41	60	34	60	7	278
Mixed	25	12	26	12	35	8	118
Other	11	4	1	1	13		30
Unknown	23	6	10	12	14	1	66
Grand Total	226	88	142	85	179	21	741

Table 12: People from my community lack the knowledge required to maintain a healthy lifestyle, by ethnicity

Table 13 shows that the highest number of respondents agreeing or strongly agreeing with the statement are from Black ethnic backgrounds (117n), followed by Asian ethnicities (90n). The highest number disagreeing or strongly disagreeing with this statement are also from Black ethnic backgrounds (64n).

This question was based on feedback from local consultations. Feedback from some respondents suggested this was an inappropriate question and some respondents felt it could have been phrased to reflect a more positive approach. One respondent stated:

“I didn’t want to complete the rest of the questionnaire as this question is negative”.

43% of respondents agreed or strongly agreed with the statement and this was highly reflected within the free texts. There was a general consensus that BME communities need further support around knowledge and awareness regarding health and wellbeing:

“Being that we (as the BME community) are biologically different, we should have our information based on our bodies, it should be specified to us (such as how contraception affects you specifically as a black woman).”

A respondent highlighted the importance of awareness rather than the lack of knowledge:

“BME communities need more access to exercise & healthy lifestyle choices and information”

“Publicity is aimed at the white community, often in posters and leaflets”

Whilst 32% of respondents disagreed or strongly disagreed with the statement, this was not reflected within the free text; however, one respondent stated otherwise:

“General information about what is healthy and what is not is available generically from anywhere”

Q2.5 Older people living alone are at risk of isolation.

97% of respondents answered this question.

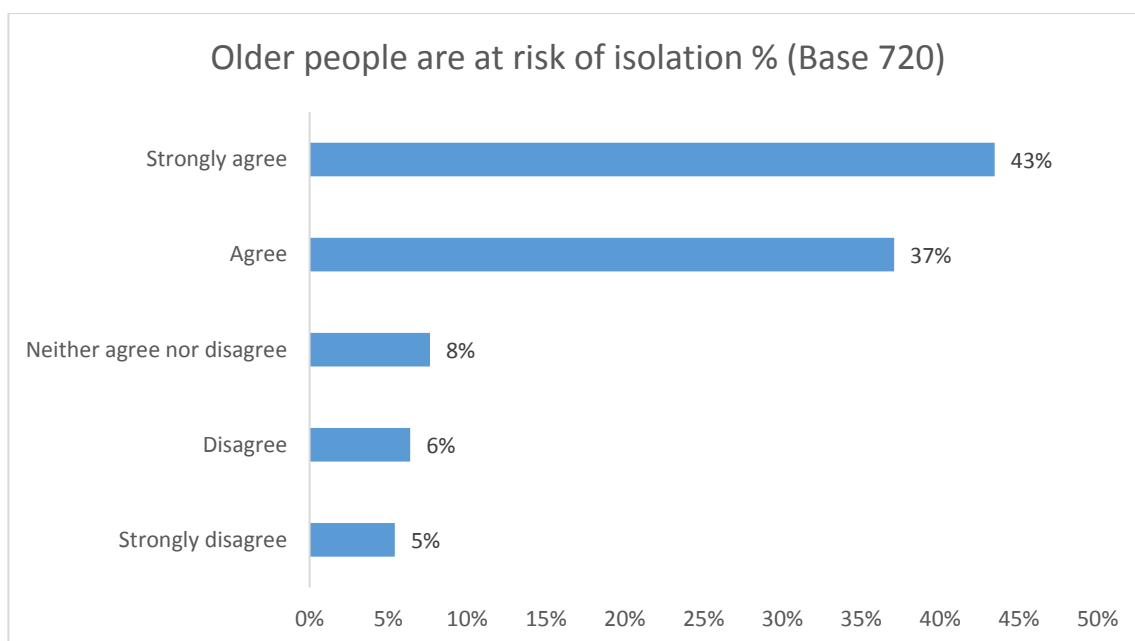


Figure 26: Older people living alone are at risk of isolation.

Figure 26 shows that there was a clear and consistent response to the statement “Older people living alone are at risk of isolation” with (80%) of respondents agreeing or strongly agreeing with the statement.

Ethnicity	Agree (n)	Strongly agree (n)	Disagree (n)	Strongly disagree (n)	Neither agree nor disagree (n)	Not stated (n)	Grand Total (n)
White	23	27	7	1	8		66
Asian	92	121	7	10	10	1	241
Black	69	86	21	16	21	7	220
Mixed	41	50	3	7	10	7	118
Other	14	9		3	2	2	30
Unknown	28	20	8	2	4	4	66
Grand Total	267	313	46	39	55	21	741

Table 13: Older people living alone are at risk of isolation by ethnicity

Table 14 shows that the highest number of respondents who agreed or strongly agreed with the statement are from Asian ethnic backgrounds (213n), followed by Black ethnicities (155n). The table also shows consistent results between respondents of Asian and Mixed ethnicities who neither agreed nor disagreed with the statement.

The free texts reflected these findings, with a direct link between mental health and isolation within the older generation being highlighted:

“Loneliness and old age have an effect on mental health”

“Loneliness is a disease in itself. If someone is unable to go out, that person will get stressed and stress is an illness.”

Several respondents highlighted the need for age-appropriate services and services that bring generations together:

“Would love schemes to get the very young to meet with the very old”

“More group activities needed for ageing people who are fit and in good health, who are not ready for the elderly clubs”

Q2.6 Women from my community can spend more time at home and do not have the opportunities to go out and socialise.

99% of respondents answered this question

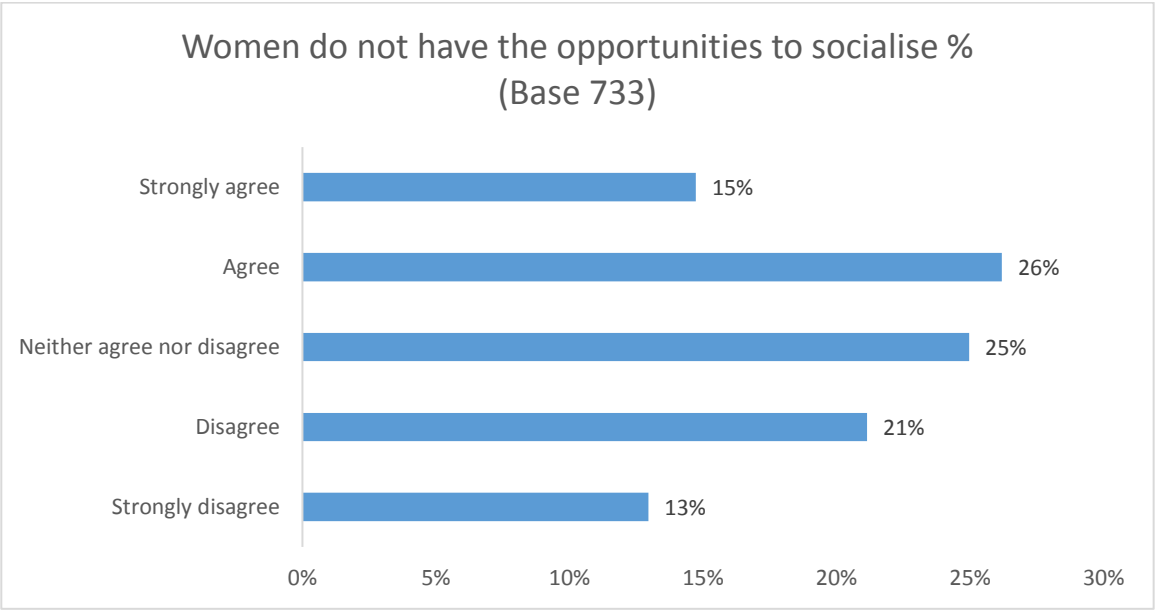


Figure 27: Women from my community can spend more time at home and do not have the opportunities to go out and socialise.

Figure 27 shows that the majority of respondents (40%) agreed or strongly agreed with the statement, “Women from my community can spend more time at home and do not have the

opportunities to go out and socialise”. However, (25%) neither agreed nor disagreed with the statement.

Ethnicity	Agree (n)	Strongly agree (n)	Disagree (n)	Strongly disagree (n)	Neither agree nor disagree (n)	Not stated (n)	Grand Total (n)
White	15	9	17	10	14	1	66
Asian	60	48	28	12	34	1	183
Black	64	38	63	38	72	3	278
Mixed	24	4	30	17	42	1	118
Other	8	3	9	5	5		30
Unknown	21	6	8	13	16	2	66
Grand Total	192	108	155	95	183	8	741

Table 14: Women from my community can spend more time at home and do not have the opportunities to go out and socialise by ethnicity

Table 15 shows that the highest number of respondents who agreed or strongly agreed with the statement were from Asian ethnic backgrounds (108n,) followed by respondents from Black ethnicities (102n). The table also shows that the highest number of respondents who disagreed or strongly disagreed with the statement are from Black ethnic backgrounds (101n). This shows a direct divide in opinions across the Black ethnic groups.

The free texts highlighted that the issue is about changing attitudes:

“It is a matter of changing men’s attitude towards women... Men need to have this spelt out for them”

Whilst 34% of respondents disagreed or strongly disagreed with this statement, this was not reflected within the free text, although one respondent stated:

“Women from every community have opportunities to go out and socialise; it is a self/family decision to choose otherwise. The city does not discriminate against women from different communities”

9.1.3 Access to services

In this section respondents were asked to indicate the extent to which they agreed or disagreed with a statement.

Q4.1 People in my community are able to recognise early signs of disease and seek appropriate help.

97% of respondents answered this question.

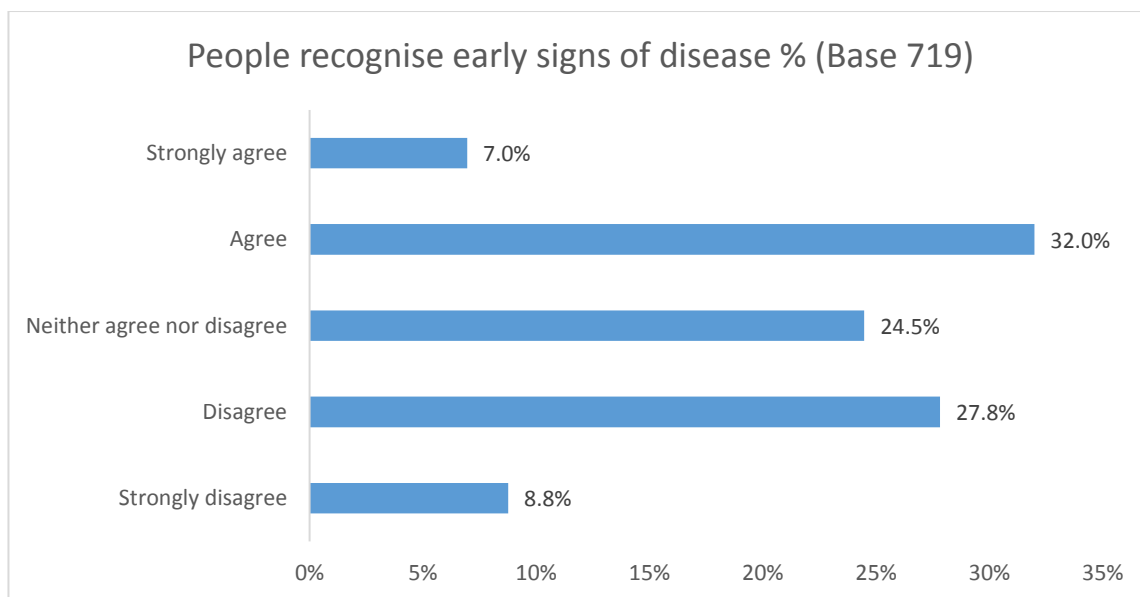


Figure 28: People in my community are able to recognise early signs of disease and seek appropriate help.

Figure 28 shows that there is no significant difference between respondents agreeing or strongly agreeing (38%) and respondents disagreeing or strongly disagreeing (35%) with the statement, "People in my community are able to recognise early signs of disease and seek appropriate help".

Ethnicity	Agree (n)	Strongly agree (n)	Disagree (n)	Strongly disagree (n)	Neither agree nor disagree (n)	Not stated (n)	Grand Total (n)
White	30	3	10	5	15	3	66
Asian	67	14	49	21	30	2	183
Black	71	21	82	29	71	4	278
Mixed	24	4	41	5	42	2	118
Other	10	4	8	1	7		30
Unknown	28	4	10	2	11	11	66
Grand Total	230	50	200	63	176	22	741

Table 15: People in my community are able to recognize early signs of disease and seek appropriate help by ethnicity

Table 16 shows that the highest number of respondents agreeing or strongly agreeing with the statement are from Black ethnic backgrounds (92n), followed by Asian ethnicities (81n), with the highest number of respondents disagreeing or strongly disagreeing also being from Black ethnic backgrounds (111n), followed by Asian ethnicities (70n). Again, this would suggest that there is a divide of opinion among Black and Asian ethnicities.

Responses to this question were not reflected within the free text; however, respondents emphasised the lack of knowledge on accessing the current available services:

“Knowledge on how to access services is lacking, there is not enough information”

One respondent highlighted a direct link between discrimination and publicity:

“Publicity is aimed at the white community, often in posters and leaflets”

Q4.2 Standard GP appointment times should be increased when an interpreter is needed.

96% of respondents answered this question.

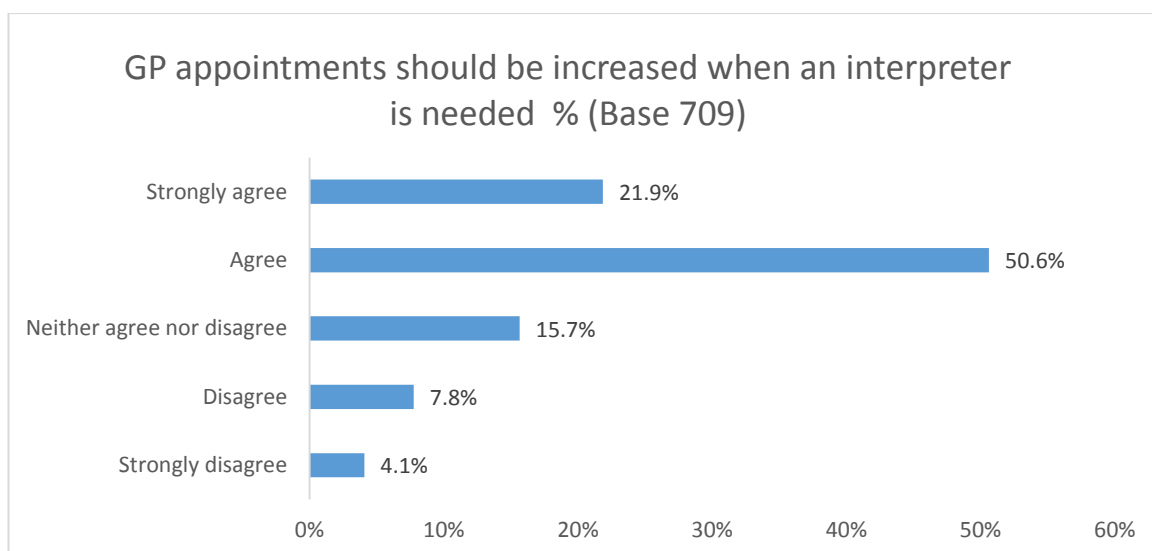


Figure 29: Standard GP appointment times should be increased when an interpreter is needed.

Figure 29 shows the majority of respondents (72%) agreed or strongly agreed with the statement, “Standard GP appointment times should be increased when an interpreter is needed”. A smaller proportion (16%) neither agreed nor disagreed with the statement.

Ethnicity	Agree (n)	Strongly agree (n)	Strongly disagree (n)	Disagree (n)	Neither agree nor disagree (n)	Not stated (n)	Grand Total (n)
White	29	18	1	5	9	4	66
Asian	95	37	6	16	24	5	183
Black	131	62	15	19	43	8	278
Mixed	53	25	3	10	25	2	118
Other	11	10		3	6		30
Unknown	40	3	4	2	4	13	66
Grand Total	359	155	29	55	111	32	741

Table 16: Standard GP appointment times should be increased when an interpreter is needed by ethnicity

Table 16 shows that the highest number of people who agreed or strongly agreed with the statement were from Black ethnic backgrounds (193n) followed by Asian ethnicities (132n).

The free texts highlight the challenges of getting GP appointments, long waiting times and the language barriers. One respondent stated:

“People recognise that there is a problem but do not seek a GP due to language barriers or no available appointments.

Sometimes the nearest available appointment is after two weeks”

Whilst (11%) of respondents disagreed or strongly disagreed with this statement, this was not reflected within the free texts, however one respondent stated:

“The GP service I use is usually good; I can mostly get an appointment on the same day”

Q4.3 I trust my GP will diagnose me correctly

96% of respondents answered this question

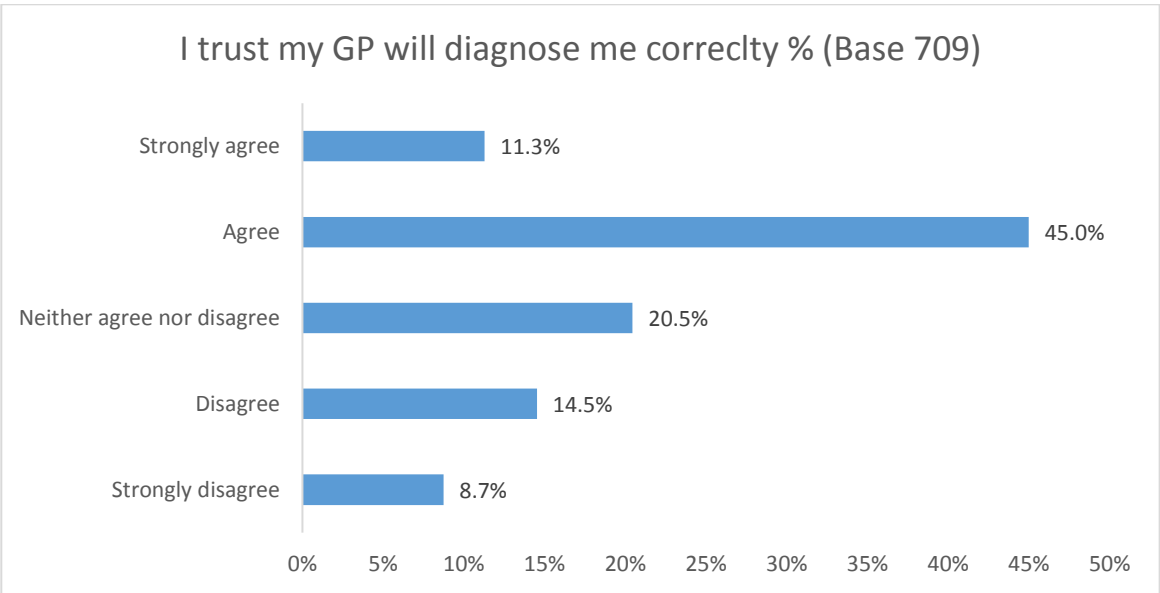


Figure 30: I trust my GP will diagnose me correctly

Figure 30 shows that the majority of respondents (56%) agreed or strongly agreed with the statement, “I trust my GP to diagnose me correctly” whilst (20%) neither agreed nor disagreed with the statement.

Ethnicity	Agree (n)	Strongly agree (n)	Disagree (n)	Strongly disagree (n)	Neither agree nor disagree (n)	Not stated (n)	Grand Total (n)
White	28	5	12	2	17	2	66
Asian	95	27	18	8	32	3	183
Black	107	25	44	28	67	7	278
Mixed	52	12	17	16	18	3	118
Other	5	6	6	5	7	1	30
Unknown	32	5	6	3	4	16	66
Grand Total	319	80	103	62	145	32	741

Table 17: I trust my GP will diagnose me correctly by ethnicity

Table 17 shows that the highest number of people agreeing or strongly agreeing with this statement were of Black ethnic backgrounds (132n) followed by Asian ethnicities (122n). The highest number of respondents that disagreed or strongly disagreed with the statement are also from Black ethnic backgrounds (72n), followed by Mixed ethnicities (33n).

Although (59%) of respondents agreed or strongly agreed with this statement, responses within the free texts reflected otherwise:

“There is a lot of ignorance about Sickle cell. As someone with Sickle cell and Diabetes, I have to do separate blood tests to monitor my diabetes. I have to keep reminding the GP. One GP was even unaware of that. I live in a white neighborhood; there might not be any other patient attending that clinic with sickle cell. That’s why I don’t believe the GPs will bother to learn more about my condition. Most of the time I do not even bother to go to the GP, I tend to buy herbal products”

Q4.4 I trust my GP will refer me to specialist services when needed.

96% of respondents answered this question.

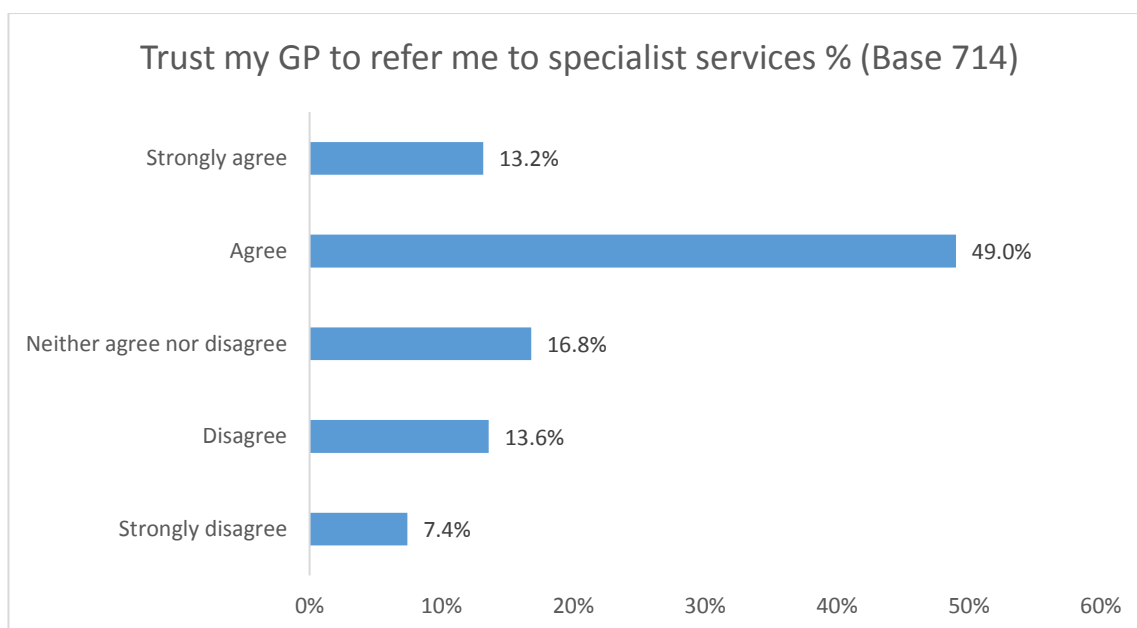


Figure 31: Respondents who trust their GP will refer them to specialist services when needed

Figure 31 shows that the majority of respondents (62%) agreed or strongly agreed with the statement, “I trust my GP will refer me to specialist services when needed”.

Ethnicity	Agree (n)	Strongly agree (n)	Disagree (n)	Strongly disagree (n)	Neither agree nor disagree (n)	Not stated (n)	Grand Total (n)
White	29	9	13	2	10	3	66
Asian	102	28	17	11	22	3	183
Black	120	37	33	19	62	7	278
Mixed	54	12	18	15	17	2	118
Other	12	3	5	4	6		30
Unknown	33	5	11	2	3	12	66
Grand Total	350	94	97	53	120	27	741

Table 18: Respondents who trust their GP will refer them to specialist services when needed by ethnicity

Table 19 shows that the highest number of people agreeing or strongly agreeing with the statement are of Black ethnic backgrounds (157n), followed by Asian ethnicities (130n).

The responses show that there was no significant difference amongst the results of all other ethnic groups. Whilst there was a clear and consistent response to this question, with (62%) of respondents agreeing or strongly agreeing, it was not reflected in the free texts:

“I went several times to a GP and they did not refer me to a specialist. I was suffering from a skin condition, and asked to be referred repeatedly”

Q4.5 It is important to have culturally-tailored services

95% of respondents answered this question.

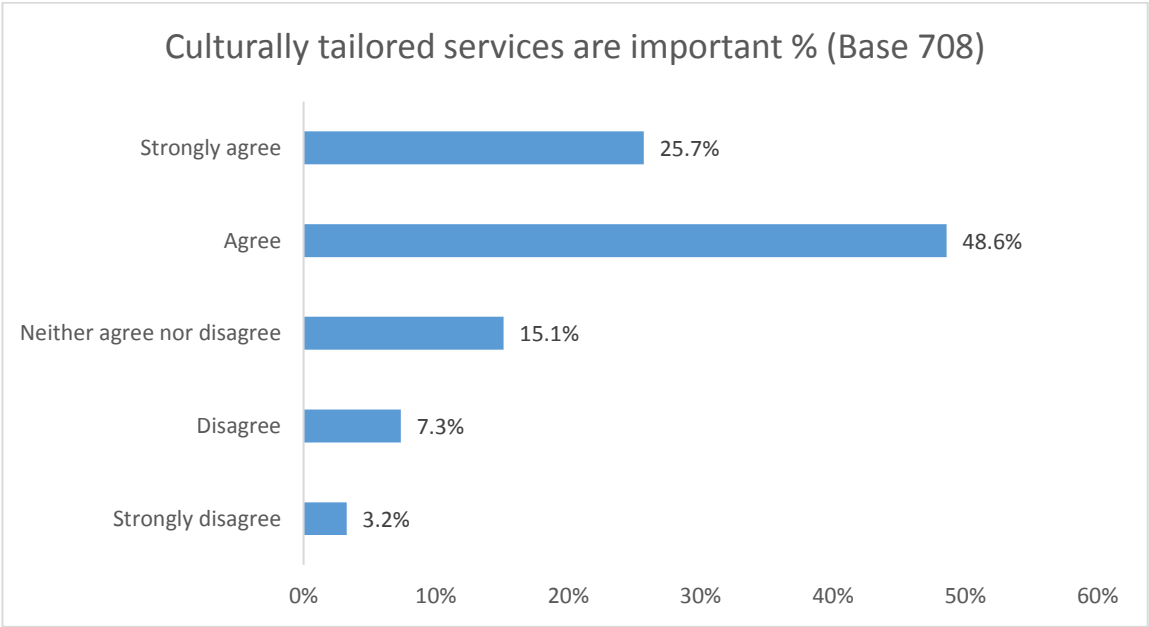


Figure 32: Respondents who feel it is important to have culturally-tailored services

Figure 32 shows that there was a clear and consistent response to this question as (76%) of respondents agreed or strongly agreed with the statement, “It is important to have culturally-tailored services”.

Ethnicity	Agree (n)	Strongly agree (n)	Disagree (n)	Strongly disagree (n)	Neither agree nor disagree (n)	Not stated (n)	Grand Total (n)
White	30	16	5		12	3	66
Asian	120	78	10	3	27	5	183
Black	90	40	21	12	38	9	278
Mixed	61	22	8	3	20	4	118
Other	9	11	5	1	4		30
Unknown	26	15	3	4	6	12	66
Grand Total	344	182	52	23	107	33	741

Table 19: Respondents who feel it is important to have culturally-tailored services by ethnicity

Table 20 shows that the highest number of people who agreed or strongly agreed with this statement are from Asian ethnic backgrounds (198n), followed by Black ethnicities (130n). The responses show that there were variable differences between the results of respondents from White and Mixed ethnicities.

The free texts reflected these results:

“We need practitioners that are culturally knowledgeable and are able to understand peoples’ individuality and the influence their cultural background plays in their lived experience”

One respondent pointed out that consultations around BME health and wellbeing have taken place in the past but that actions are yet to be taken:

“We have in the past advocated for such culturally- tailored services in Nottingham and our voice is yet to be heard”

Q4.6 It is important to have health role models from different communities who understand cultural beliefs and can give advice and support.

97% of respondents answered this question.

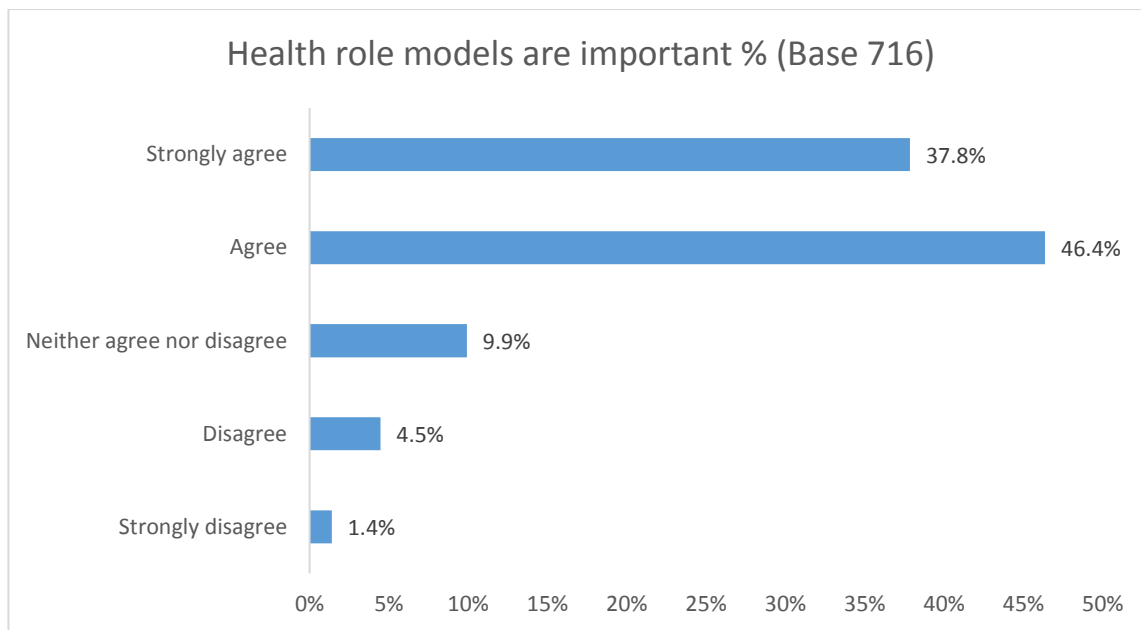


Figure 33: It is important to have health role models from different communities who understand cultural beliefs and can give advice and support.

Figure 33 shows that there was a clear and consistent response to this question with (84%) of respondents agreeing or strongly agreeing with the statement, “It is important to have health role models from different communities who understand cultural beliefs and can give advice and support”.

Ethnicity	Agree (n)	Strongly agree (n)	Disagree (n)	Strongly disagree (n)	Neither agree nor disagree (n)	Not stated (n)	Grand Total (n)
White	33	20	5		6	2	66
Asian	83	71	6	1	19	3	183
Black	119	114	9	6	26	4	278
Mixed	57	40	3	3	13	2	118
Other	9	15	4		2		30
Unknown	31	11	5		5	14	66
Grand Total	332	271	32	10	71	25	741

Table 20: It is important to have health role models from different communities who understand cultural beliefs and can give advice and support by ethnicity

Table 21 shows that the highest number of respondents who agreed or strongly agreed with the statement are of from Black ethnic backgrounds (232n), followed by Asian ethnicities (154n). There is no significant difference amongst respondents who disagreed or strongly disagreed with the statement.

The free texts however do not greatly reflect these results, although one respondent stated:

“Culturally-appropriate services are extremely important as are role models/services which are representative of the BME community”

One respondent highlighted a direct link between cultural and biological differences:

“Personally, I believe different cultural groups should be able to be informed by the GP and doctors that biologically everyone is different and not all drugs will work”

9.1.3 Mental Health

In this section respondents were asked to indicate the extent to which they agreed or disagreed with a statement.

Q6.1 There is a direct relationship between physical health and mental health

97% of respondents answered this question.

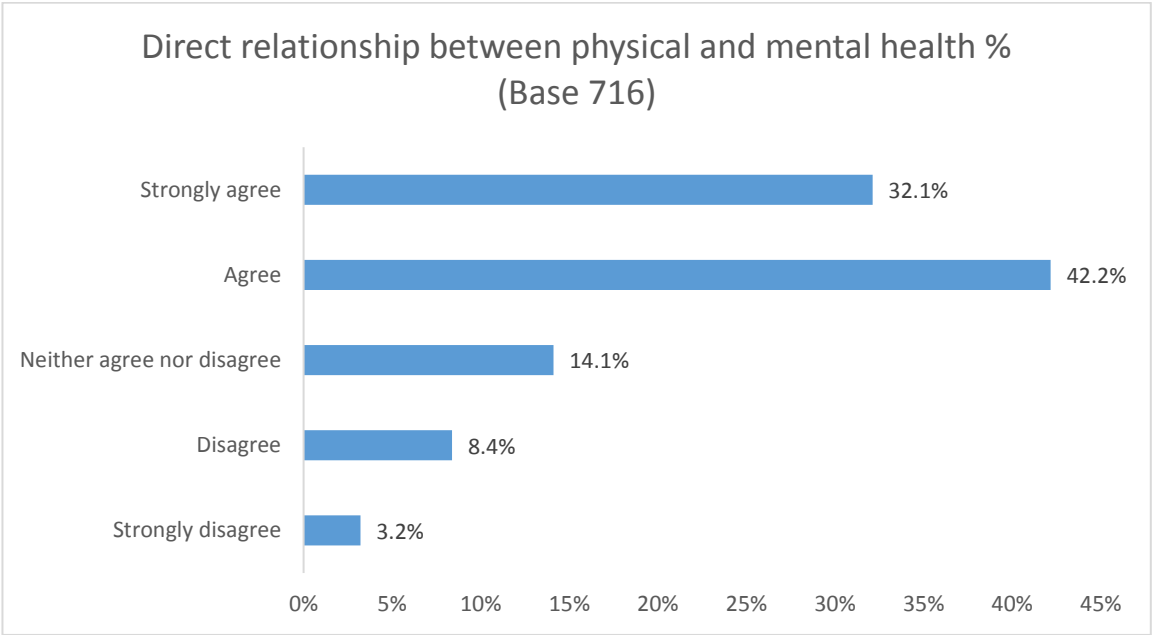


Figure 34: There is a direct relationship between physical health and mental health

Figure 34 shows that (74%) of respondents agreed or strongly agreed with the statement, “There is a direct relationship between physical health and mental health”. There was a small percentage of respondents (14%) neither agreeing nor disagreeing with the statement.

Ethnicity	Agree (n)	Strongly agree (n)	Disagree (n)	Strongly disagree (n)	Neither agree nor disagree (n)	Not stated (n)	Grand Total (n)
White	30	26	2	1	7		66
Asian	88	56	9	7	21	2	183
Black	112	84	30	7	37	8	278
Mixed	41	31	16	7	22	1	118
Other	15	9	2		3	1	30
Unknown	16	24	1	1	11	13	66
Grand Total	302	230	60	23	101	25	741

Table 21: There is a direct relationship between physical health and mental health by ethnicity

Table 22 shows that the highest number of respondents who agreed or strongly agreed with the statement were from Black ethnic backgrounds (196n), followed by Asian ethnicities (144n). Moreover, the highest number of respondents who disagreed or strongly disagreed with the statement were also from Black ethnic backgrounds (37n).

The free texts greatly reflected these results:

“Mental health is strongly correlated to physical health”

“Problems with physical health may lead to depression”

“Improved physical health can help improve mental health”

Q6.2 Prejudice and discrimination puts people from my community at greater risk of poor mental health

95% of respondents answered this question.

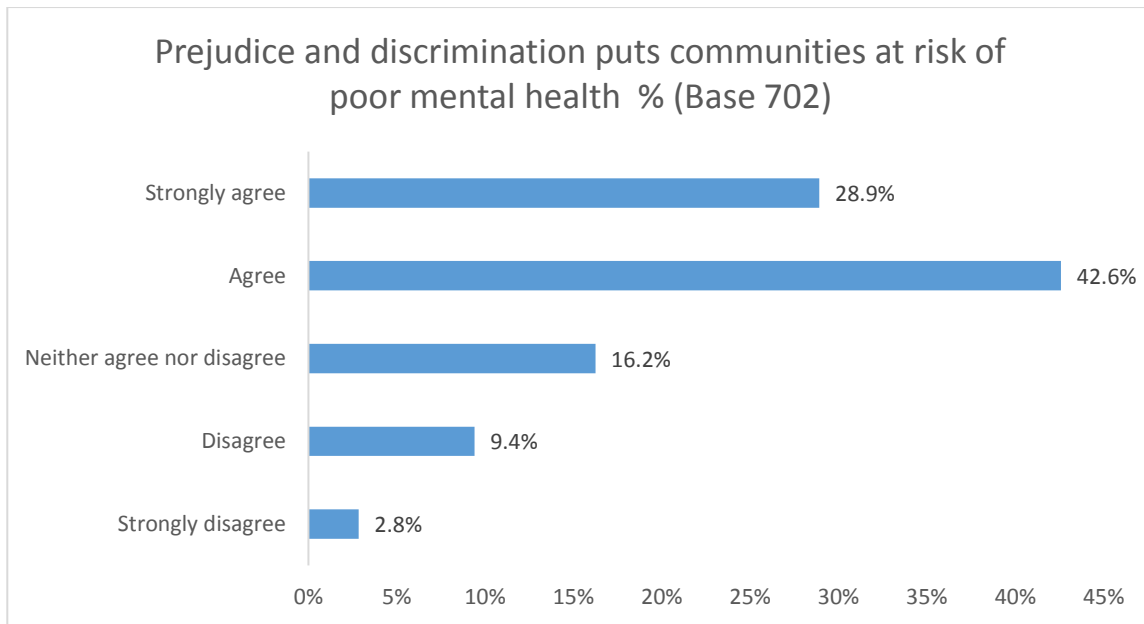


Figure 35: Prejudice and discrimination puts people from my community at greater risk of poor mental health

Figure 35 shows that there was a clear and consistent response to this question with (72%) of respondents agreeing or strongly agreeing with the statement, “Prejudice and discrimination puts people from my community at greater risk of poor mental health”.

Ethnicity	Agree (n)	Strongly agree (n)	Disagree (n)	Strongly disagree (n)	Neither agree nor disagree (n)	Not stated (n)	Grand Total (n)
White	20	23	8	1	13	1	66
Asian	90	35	19	8	26	5	183
Black	105	101	15	7	38	12	278
Mixed	54	21	13	2	25	3	118
Other	11	7	6		4	2	30
Unknown	19	16	5	2	8	16	66
Grand Total	299	203	66	20	114	39	741

Table 22: Prejudice and discrimination puts people from my community at greater risk of poor mental health by ethnicity

Table 22 shows that the highest number of respondents who agreed or strongly agreed with this statement were from Black ethnic backgrounds (206n), followed by Asian ethnicities (125n) and Mixed ethnicities (75n). There was no significant difference among respondents who disagreed or strongly disagreed with the statement.

The free texts reflected these results:

“We have identified a high level of discrimination, prejudice in our group which have led to withdrawal, loneliness and unemployment”

“Prejudice and discrimination put a person’s mental health at risk”

Respondents highlighted the need to have appropriate services in place:

“Need services that understand societies’ inherent cultural/bias/prejudices impact on peoples’ day to day experience and contribute to mental health and ill health”

“The cognitive dissonance experienced by being black in a racist society of intolerance to difference should be explored”

Q6.3 It would be useful to include mental health awareness within community group sessions.

95% of respondents answered this question.

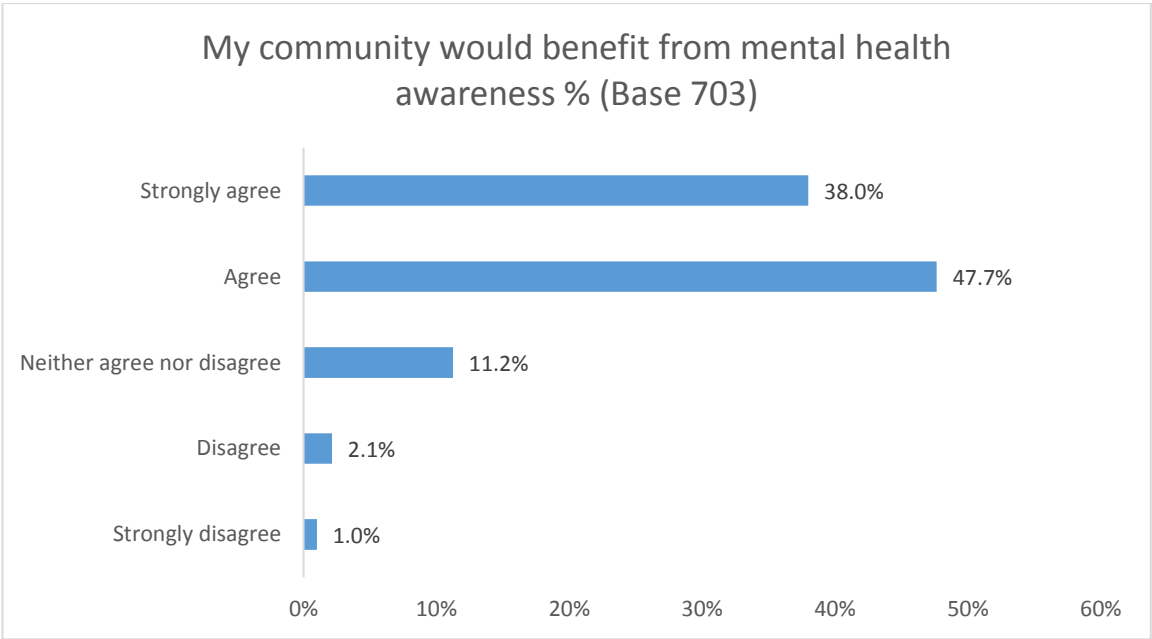


Figure 36: It would be useful to include mental health awareness within community group sessions.

Figure 36 shows that there was a clear and consistent response to this question with (86%) of respondents agreeing or strongly agreeing with the statement, “It would be useful to include mental health awareness within community group sessions”.

Ethnicity	Agree (n)	Strongly agree (n)	Disagree (n)	Strongly disagree (n)	Neither agree nor disagree (n)	Not stated (n)	Grand Total (n)
White	27	25	2		11	1	66
Asian	85	69	5	2	16	6	183
Black	124	118	4	3	18	11	278
Mixed	55	38	2	2	19	2	118
Other	13	9	1		5	2	30
Unknown	31	8	1		10	16	66
Grand Total	335	267	15	7	79	38	741

Table 23: It would be useful to include mental health awareness within community group sessions.

Table 24 shows that the highest number of respondents that agreed or strongly agreed with the statement were from Black ethnic backgrounds (242n), followed by Asian ethnicities (154n). Interestingly, there was no significant difference in respondents who disagreed or strongly disagreed with the statement.

The free texts greatly reflected these results, where a strong emphasis on the importance of awareness was highlighted:

“... We need to focus on mental health and highlight it as a key problem, as well as make people aware of the help available”

“Wider awareness is needed to remove the stigmatised view of mental health”

“Mental health seems to be a subject that is not spoken about clearly and awareness to the public seems to be lacking”

9.1.4: Barriers to leading a healthy lifestyle

Q8.1 The cost of using leisure facilities (eg: the gym, exercise classes, swimming, etc.) is a barrier to participating in physical activity.

95% of respondents answered this question.

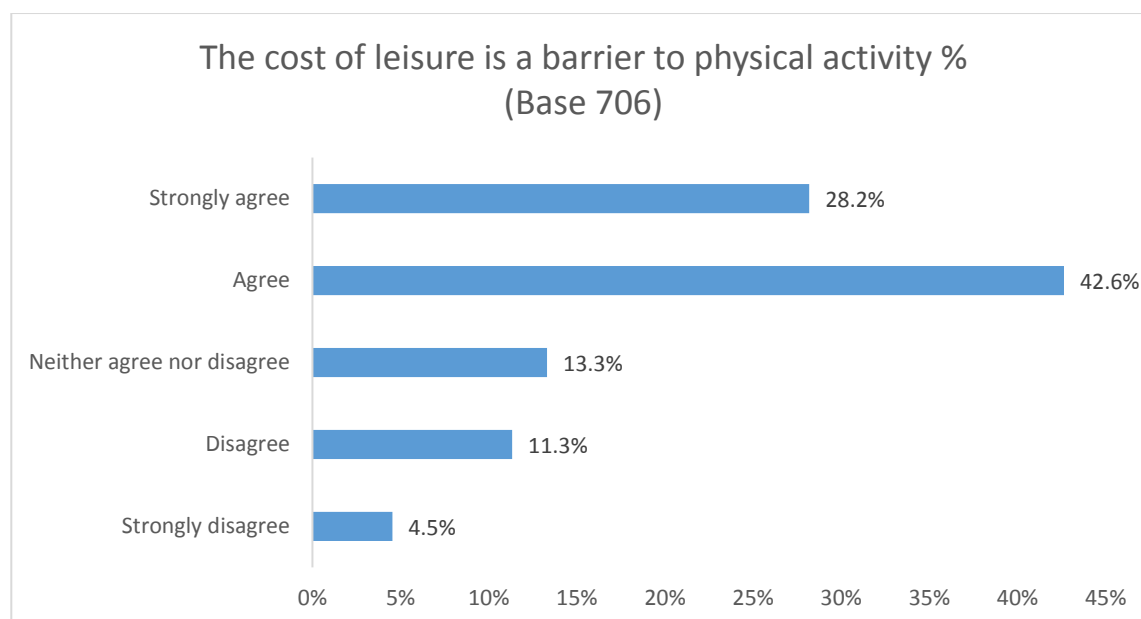


Figure 37: The cost of using leisure facilities (eg: the gym, exercise classes, swimming, etc.) is a barrier to participating in physical activity.

Figure 37 shows that the majority of respondents (70%) agreed or strongly agreed with the statement, “The cost of using leisure facilities (eg: the gym, exercise classes, swimming, etc.) is a barrier to participating in physical activity”.

Ethnicity	Agree (n)	Strongly agree (n)	Disagree (n)	Strongly disagree (n)	Neither agree nor disagree (n)	Not stated (n)	Grand Total (n)
White	27	7	15	3	12	2	66
Asian	98	93	13	10	21	2	183
Black	96	41	30	16	31	10	278
Mixed	51	27	16		21	3	118
Other	13	8	1		8		30
Unknown	16	23	5	3	1	18	66
Grand Total	301	199	80	32	94	35	741

Table 24: The cost of using leisure facilities is a barrier to participating in physical activity by ethnicity

Table 25 shows that the highest number of people agreeing or strongly agreeing to the statement are from Asian ethnic backgrounds (191n) followed by Black ethnicities (137n) and Black ethnicities

(69%). Interestingly, there was no significant difference in the ethnicity of respondents who disagreed or strongly disagreed with the statement.

The free texts reflected the results:

“Gym/fitness memberships are far too expensive”

“The cost of council leisure centres are ridiculous”

One respondent highlighted pride as a barrier to participation in physical activity rather than membership fees:

“There are a lot of cheap gyms, however black men have a traditional pride when it comes to health”

Q8.2 Traditional diets are a barrier to healthy living as they include a lot of oil, salt and sugar.

95% of respondents answered this question.

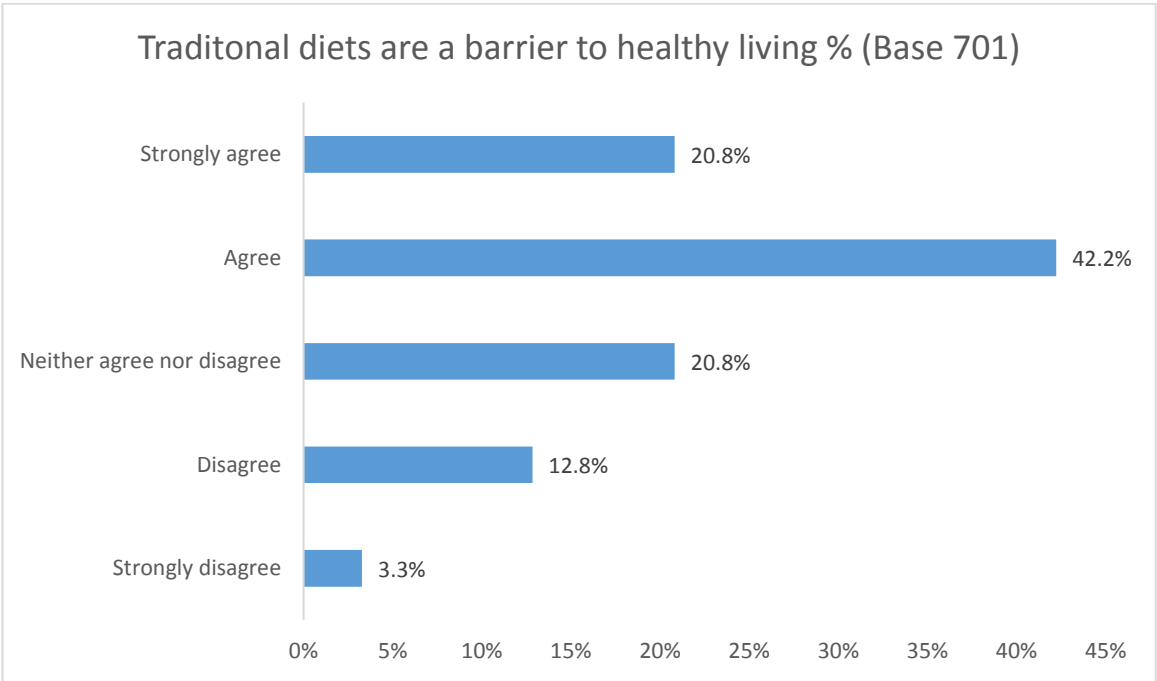


Figure 38: Traditional diets are a barrier to healthy living as they include a lot of oil, salt and sugar.

Figure 38 shows that the majority of respondents (70%) agreed or strongly agreed with the statement, “Traditional diets are a barrier to healthy living as they include a lot of oil, salt and sugar”. Interestingly, (21%) of respondents neither agreed nor disagreed with the statement.

Ethnicity	Agree (n)	Strongly agree (n)	Disagree (n)	Strongly disagree (n)	Neither agree nor disagree (n)	Not sated (n)	Grand Total (n)
White	27	10	9		17	3	66
Asian	87	39	22	6	25	4	183
Black	104	64	33	11	54	12	278
Mixed	45	16	15	2	37	3	118
Other	10	11	4		5		30
Unknown	23	6	7	4	8	18	66
Grand Total	296	146	90	23	146	40	741

Table 25: Traditional diets are a barrier to healthy living as they include a lot of oil, salt and sugar by ethnicity

Table 26 shows that the highest number of people who agreed or strongly agreed to the statement are from Black ethnic backgrounds (168n) followed by Asian (126n). The highest number of respondents who disagreed or strongly disagreed were also from Black ethnic backgrounds (65n).

The free texts did not reflect the results of this question; however, respondents greatly emphasised the direct link between lack of knowledge and leading a healthy lifestyle:

“I think there isn’t enough information about healthy lifestyle”

“Lack of knowledge showing the importance of leading healthy lifestyle”

Several respondents pointed out recommendations and suggestions they wish to see within the city:

“I think targeting mosques etc. would be a good start as well as catching parents at school to inform them about healthy lifestyles that are tailored to them, such as including what they can use instead of butter in cooking”

Q8.3 Men from my community do not get involved in community groups

92% of respondents answered this question.

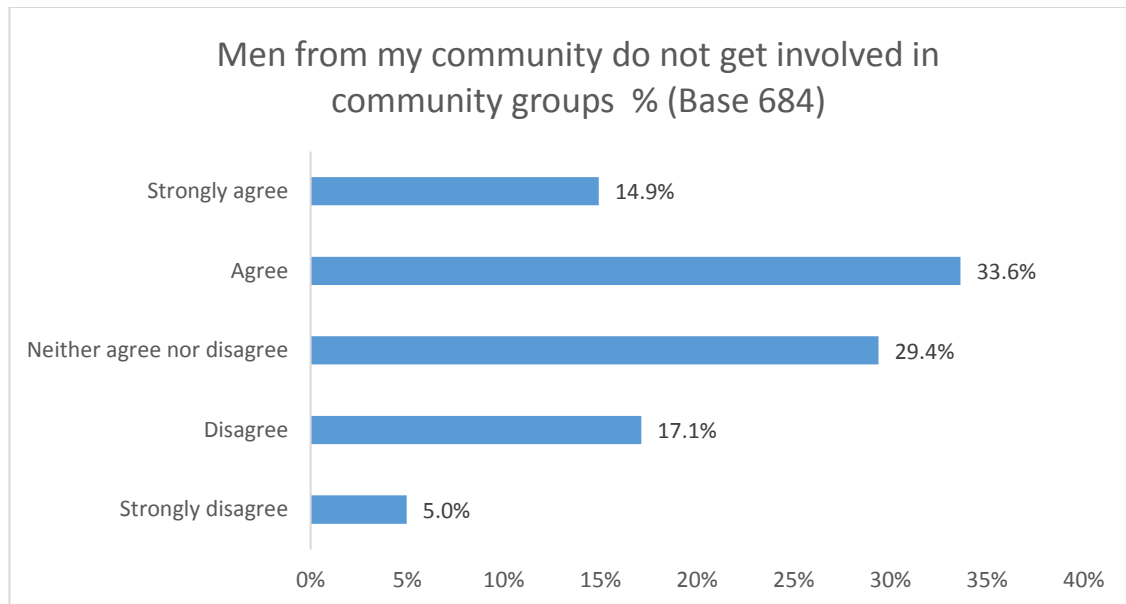


Figure 39 Men from my community do not get involved in community groups

Figure 39 shows that (49%) of respondents agreed or strongly agreed with the statement, “Men from my community do not get involved in community groups”. In contrast, (30%) of respondents neither agreed nor disagreed with the statement.

Ethnicity	Agree (n)	Strongly agree (n)	Disagree (n)	Strongly disagree (n)	Neither agree nor disagree (n)	Not stated (n)	Grand Total (n)
White	18	7	18	2	16	5	66
Asian	69	32	32	4	41	5	183
Black	96	47	35	21	62	17	278
Mixed	33	9	22	2	45	7	118
Other	8	1	8	1	10	2	30
Unknown	6	6	2	4	27	21	66
Grand Total	230	102	117	34	201	57	741

Table 26: Men from my community do not get involved in community groups by ethnicity

Table 27 shows that the highest number of people who agreed or strongly agreed with the statement are from Black ethnic backgrounds (143n), followed by Asian ethnicities (101n). Interestingly, the highest number of respondents who disagreed or strongly disagreed with the statement were also from Black ethnic backgrounds (83n).

The free texts reflected the results to this statement, where respondents pointed out inclusion as one of the barriers to leading a healthy lifestyle:

“Older generation of men from my community do not get involved in community group activities”

“Lack of inclusion is a barrier to leading a healthy lifestyle”

Q8.4 Pride, stigma and shame prevent people from my community seeking help when needed (e.g. alcoholism, depression, drugs etc.)

94% of respondents answered this question.

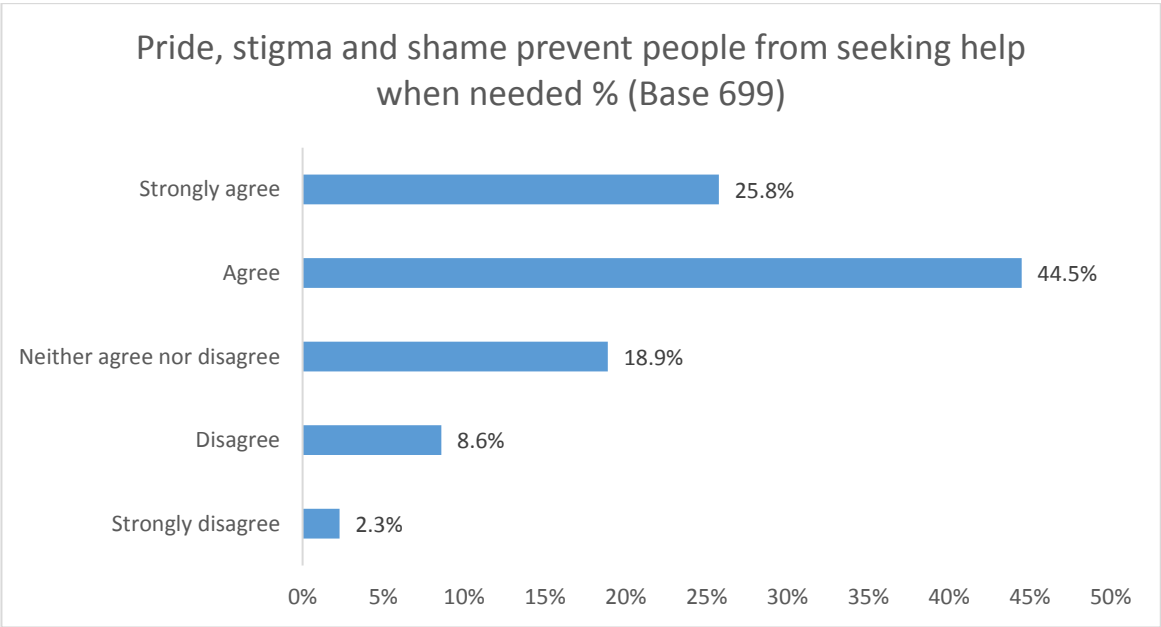


Figure 40: Pride, stigma and shame prevent people from my community seeking help when needed e.g.: alcoholism, depression, drugs etc.)

Figure 40 shows that there was a clear and consistent response to this question with (70%) of respondents agreeing or strongly agreeing with the statement “Pride, stigma and shame prevent people from my community seeking help when needed e.g.: alcoholism, depression, drugs etc.”

Ethnicity	Agree (n)	Strongly agree (n)	Disagree (n)	Strongly disagree (n)	Neither agree nor disagree (n)	Not stated (n)	Grand Total (n)
White	32	9	9		13	3	66
Asian	78	49	13	5	35	3	183
Black	115	82	19	8	43	11	278
Mixed	51	28	6	1	27	5	118
Other	10	4	7		7	2	30
Unknown	25	8	6	2	7	18	66
Grand Total	311	180	60	16	132	42	741

Table 27: Pride, stigma and shame prevent people from my community seeking help when needed (e.g. alcoholism, depression, drugs etc.) by ethnicity

Table 28 shows that the highest number of respondents who agreed or strongly agreed with the statement are from Black ethnic backgrounds (197n), followed by Asian (127n). There were no significant differences amongst the ethnicity of the respondents who disagreed or strongly disagreed with the statement.

Q8.5 Culturally-tailored information is important when helping people manage their health conditions.

94% of respondents answered the questions.

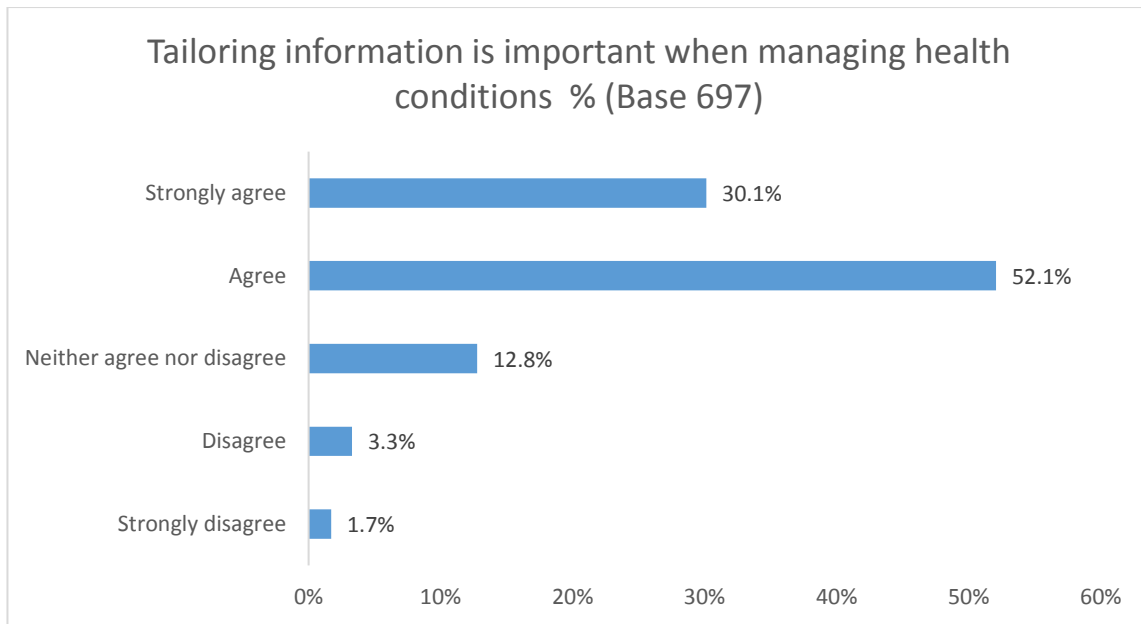


Figure 41: Culturally-tailored information is important when helping people manage their health conditions.

Figure 41 shows that there was a clear and consistent response to this question with (82%) of respondents agreeing or strongly agreeing with the statement, “Culturally-tailored information is important when helping people manage their health conditions”.

Ethnicity	Agree (n)	Strongly agree (n)	Disagree (n)	Strongly disagree (n)	Neither agree nor disagree (n)	Not stated (n)	Grand Total (n)
White	39	12	2		10	3	66
Asian	101	54	5	6	13	4	183
Black	125	94	7	3	36	13	278
Mixed	58	29	6		19	6	118
Other	12	11	2		5		30
Unknown	28	10	1	3	6	18	66
Grand Total	363	210	23	12	89	44	741

Table 28: Culturally-tailored information is important when helping people manage their health conditions, by ethnicity

Table 29 shows that the highest number of respondents who agreed or strongly agreed with the statement were from Black ethnic backgrounds (219n), followed by Asian ethnicities (155n).

9.2 Focus groups with members of the BME community

The focus groups were held across the city, the majority taking place in local community venues. Twenty focus groups were delivered where a total of 174 people attended and provided their views, see table 30.

Name of focus group	Organisation who engaged the groups	Number of participants (n)
NCC BME employee group, mixed gender, age, ethnicity.	Nottingham City Council	8
Refugee and asylum seeker groups, mixed age, ethnicity and gender group	Nottingham Renewal Trust	8
Women-only refugee and asylum seekers group, mixed age and ethnicity	Nottingham Renewal Trust	8
Multi-cultural group of young people, mixed age, ethnicity and gender	Nottingham Trent University	6
8 x groups with mixed gender, age and ethnicity including Africa, France, Spain, Iran, Pakistan, India and the Czech Republic.	Nottingham City Council Library conversation groups.	Total of 56
City Council House event, open to the community and organisations, mixed ethnicity, age and gender	Nottingham City Council	15
NCVS - mixed ethnicity, age and gender, open to the community and organisations	Nottingham Community and Voluntary service	8
Nottingham City Council citizen panel, female participants of mixed ethnicity and age	Nottingham City Council	6
Polish community, 10 males, 1 female, mixed age from 16 – 55	Emmanuel House	11
Women-only group of asylum seekers and refugees, mixed ages and ethnicities	Women's Cultural Exchange, Nottingham Refugee Forum	14
Pilgrim Church, Black Caribbean group of mixed age and gender	The Meadows Pilgrim Church	9
"Chat Bout" young people's group aged 16-23, mixed gender and ethnicity	"Chat Bout" young people's service.	8
Friends and Bredrins (FAB) prostate cancer group. Black Caribbean males, aged 40 – 75	Friends and Bredrins Prostate Cancer group	17
		total: 174

Table 29: Details of the focus groups and number of participants

The conversation groups made had a of total (56n) participants and engaged people from various ethnic backgrounds, including Poland, Africa, France, Spain, Iran, Pakistan, India and the Czech Republic. When combined, the city event at the Council House and NCVS event had a total of (23n) participants.

Table 31 shows the majority of participants (32) were from the Black Caribbean community followed by the Asian-Pakistani community (30n). The majority of participants were female (64%) with the greatest numbers being from the Black Caribbean (20n) and Asian-Pakistani communities (20n) followed by the Asian-Kashmiri community (10n). Evidence shows women are more likely to engage with health services than men and the findings shown in the table above support this theory (Kelleher, 2015).

Ethnicity	Female (n)	Male (n)	No of respondents (n)
Arab	3	2	5
Asian - Bangladeshi	2	0	2
Asian - Chinese	3	2	5
Asian - Indian	7	1	8
Asian - Kashmiri	10	0	10
Asian - Other	2	1	3
Asian - Pakistani	20	10	30
Black - African	5	8	13
Black - Caribbean	20	12	32
Black - Other	5	5	10
Mixed - Other	3	2	5
Mixed - White & Asian	0	0	0
Mixed - White & Black African	5	3	8
Mixed - White & Black Caribbean	2	3	5
Other	15	7	22
Prefer not to say	0	0	0
White - English, Welsh, Scottish, Northern Irish, British	0	0	0
White - Gypsy Traveller	0	0	0
White - Irish	0	0	0
White - Other	10	6	16
Not stated	0	0	0
Grand total	112 (64%)	62 (36%)	174

Table 30: Ethnicity and gender of focus group participants

Ethnicity	16 – 24 years (n)	25 – 34 years (n)	35 -44 years (n)	45 – 64 years (n)	65 -74 years (n)	Grand total (n)
White	0	0	0	0	0	0
Asian	10	14	12	17	7	60
Black	8	10	20	13	6	57
Mixed	2	6	3	3	2	16
Other	1	7	7	5	5	25
White other	1	5	6	4	0	16
Grand Total	22	42	48	42	20	174

Table 31: Ethnicity and age of focus group participants

Table 32 shows that the majority of participants (48n) were between the ages of 35 and 44, followed by the 25 and 34 age group (42n). The findings can be considered representative of Nottingham's BME population which makes up 35% of the total population and a growing population of young adults.

9.2.1 Infographic

The focus groups were opened with a discussion around health and wellbeing in Nottingham based on some of the key information taken from several JSNA chapters and presented in the form of an infographic, see figure 42.

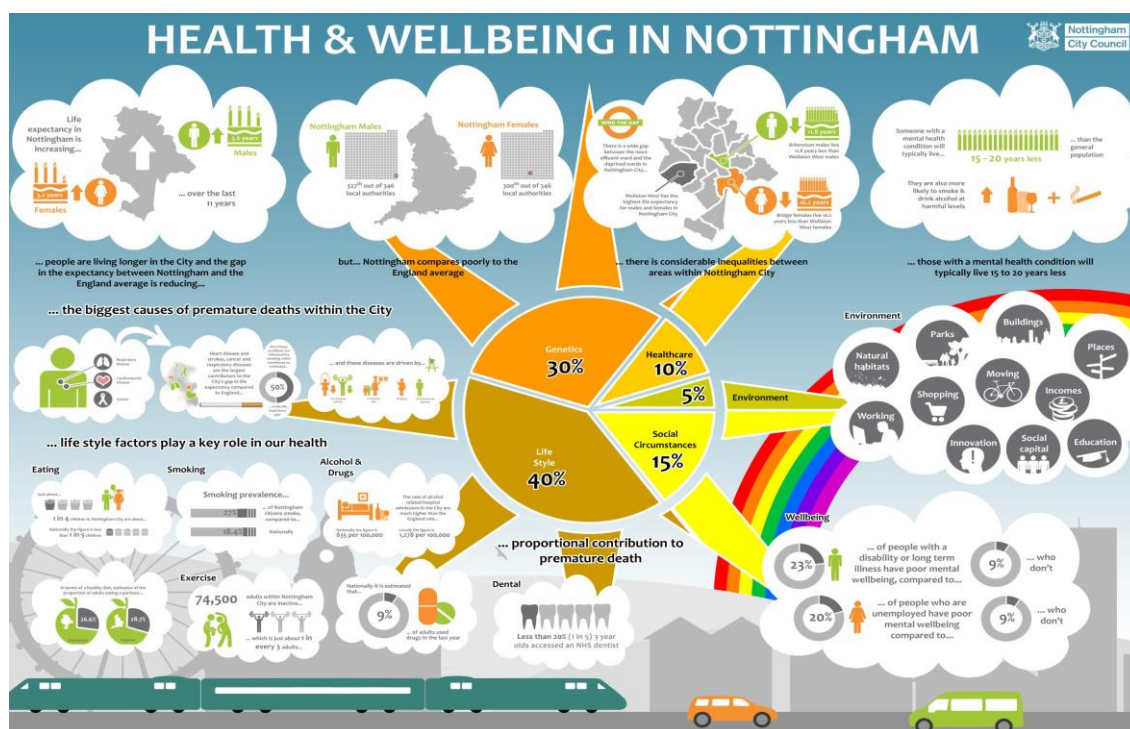


Figure 42: Infographic poster

The infographic presents a variety of information including levels of smoking, childhood obesity, mental illness and physical activity across the city and how it compares to the England average. Overall, people were genuinely interested and shocked to see that Nottingham is an outlier on most statistics when compared to the England average, especially in relation to life expectancy gap between the least and the most affluent wards. In contrast, a small number of participants were aware of the stark health inequalities in Nottingham. There was a discussion around health inequalities and how they influence the health and wellbeing of BME communities living in Nottingham. A small number of participants acknowledged there are health inequalities that need to be addressed but felt they did not adversely affect the BME community, due to Nottingham having a history of poor health outcomes which affects all citizens regardless of ethnicity.

“Nottingham’s health statistics have always been worse than other cities regardless of ethnicity or any other factors, I’m not sure of the relevance here” (Black Caribbean male)

Some people were shocked about the rates of obesity linked with ethnicity in Nottingham and felt that this may have been affected more by culture rather than their ethnicity:

“I’m not sure about this, I think ethnicity doesn’t play as much of a major role as the data suggests, I think it’s more about culture and getting people to change their ways” (Asian female)

There was a sense of surprise as to how little the data represented the impact of the environment on health and wellbeing. Participants were mostly concerned about the planning of fast food outlets, the cost of travel and making better use of open spaces. Participants questioned the validity of the mental health data and felt the statistics were not accurate, as many cases go unreported due to stigma. BME males were highlighted to be at greater risk due to racism and discrimination and many were not seeking help due to fear of stigma and shame from people within their own community.

“These stats can’t be right, mental health is a much bigger problem than the data says, I know loads of guys who have a mental health illness but they just don’t speak about it, it’s a real issue in my community” (Black Caribbean male)

9.3 Key findings

The following provides a summary of the key themes identified from the focus group sessions collected from participants’ responses to the questions in Table 33. The feedback highlighted cross-cutting themes with eight broad areas being identified: lifestyle; built environment; mental health; cultural and social norms; education; employment and access to services; health-seeking behaviour; racism and discrimination.

Focus group questions
Q.1- What do you think are the main issues affecting people's health and happiness in Nottingham and are there any issues that are specific to the BME community?
Q.2 - What is stopping you living a healthier and happier life and are there any issues that are specific to the BME community?
Q.3 -What would you like to see in your area to help make you healthier and happier and are there any issues that are specific to the BME community?
Q.4 - From your own experiences of health services in Nottingham have the health services been culturally appropriate and did they meet your needs?

Table 32: Focus group questions

9.3.1 Lifestyle risk factors

9.3.2 Healthy eating

One of the most consistently-discussed topics was lifestyle factors including physical inactivity, smoking, obesity, drugs, alcohol and poor diets. Some of the discussions around poor diet were linked to traditional foods. Participants were divided on whether traditional or western diets were more likely to contribute to obesity. Unhealthy lifestyles were discussed in the context of ethnicity and culture; there were mixed views with regards to the extent ethnicity affects a person's ability to make healthy food choices. Many participants felt culture and social norms were a bigger issue and that ethnicity did not play as much of a major role in leading a healthy lifestyle. There was a perception that leading a healthy lifestyle is more about culture and people doing things they are used to. One person reflected the views of several when stating:

"My grandma is overweight but she will not cook without using lots of salt and oil, she know the risks but it's what's she's used to and what she likes" (Black Caribbean woman)

There was a view among several participants that diet is a big issue among the BME community: participants felt that people from BME communities prefer traditional foods and cook with excessive amounts of oil and salt. This was linked to the difficulty of changing ingrained behaviour, particularly in BME elders from second and third generations.

"Traditional food is a part of our culture and it's hard to get the elders to change, they are set in their ways and will not change" (Asian male)

The groups talked at length about the importance of a healthy diet on preventing obesity. Several participants commented on whether traditional or western diets were more likely to contribute to obesity. There were very mixed views. There was an opinion that traditional diets were healthier than western diets and obesity was, in fact, driven by poor choices of the individual. The conversations relating to obesity were intertwined with the lack of physical activity and the role of the environment:

"African food is healthier than western food, we cook from fresh, not pre-packed or processed, and the food tastes good and fills you up for longer" (Black African female)

There was a view across the groups that maintaining a healthy weight is largely influenced by changes in physical activity between their home country and the UK. The example of a traditional Sudanese diet

was given: participants explained that Sudanese diets are higher in fat and sugar than British diets but people need the extra calories for energy as they do manual jobs and walk everywhere, in comparison to the UK where people have a less active lifestyle.

“Over here it is cold, people work in offices and do not do manual work to the same level as we do in Africa, plus people take public transport instead of walking, so people get fat because they eat lots of unhealthy food don’t burn off the calories” (Black African male)

Obesity linked to diet was a key point of discussion throughout the lifestyle theme, with some people highlighting individual responsibility as a key factor; one participant stated:

“The problem is personal responsibility versus people telling you what to do. People can do so much more for themselves but often people need to be told and helped, most people know what they need to do, they just need some support and encouragement” (Japanese female)

Participants discussed the importance of choice rather than knowledge and explained that people know what they need to do to be healthy. However, there were mixed views as some participants felt lifestyle choices were heavily influenced by socioeconomic and environmental factors. One participant stated:

“How can you make healthy choices when you live in an environment that fosters a culture of obesity and poor health, no money, no jobs, low aspirations, what do you expect? People are a product of their environment” (Asian male)

9.3.3 Smoking

Smoking was identified as an issue that affects health and wellbeing but, interestingly, it was not discussed at great length across the groups. The Players tobacco factory was highlighted as a key reason for Nottingham having a high smoking prevalence. There were discussions around the increasing number of young people who smoke cigarettes and cannabis; this was linked to low aspirations, peer pressure and social deprivation.

“Young people smoke because it’s seen as cool and they have nothing else to do with their lives, young people need things to do and places to go” (young Black Caribbean female)

Several participants identified smoking as a ‘cultural’ behaviour, it was suggested that smoking is more of an issue with Asian males than Asian females; one participant stated:

“I know a lot of Asian males in my family that smoke, it’s mainly the older generation, and they know it’s bad for them but they do it anyway” (Asian male)

Several participants highlighted passive smoking as an issue and made reference to smoking being an issue when using public transport, one participant stated:

“People smoke at the bus stop where my children are, this is really bad for their health and something needs to be done to stop this happening” (Polish female)

9.3.4 Physical activity

Physical activity was frequently discussed and identified as an issue that affects health and happiness, especially amongst the BME community but not exclusively. A key theme that emerged was personal responsibility with some participants describing those who do not exercise as being “lazy” and not taking responsibility for their own health. One participant stated:

“People are lazy and need to take responsibility for their own actions and health; it’s not rocket science, move more and eat less” (Black Caribbean male)

In contrast, others identified physical activity to be a socioeconomic and environmental issue. The environment was seen as a barrier to people undertaking physical activity and people feeling unsafe in their community; one participant stated:

“There are lots of parks in my area but I don’t feel safe to go out on my own, my neighbourhood isn’t safe and this prevents me from doing the things like” (Polish female)

Access to open spaces, including cycle and walking routes, were popular topics of discussion. Some participants stated they would like to see more cycle routes in the areas where they live and would welcome better access to outside gyms and parks. One participant stated:

“I like using the outside gyms but I live in Basford and have to travel to Radford. We need gyms in all parks so people can exercise for free in the fresh air” (Asian male)

Money deprivation was a common theme across all groups. Participants felt that money was a barrier to physical activity, especially for people on low incomes; one participant stated:

“My daughter wanted to go to gymnastics with her friends at our local leisure centre, the class was so expensive and I couldn’t afford it, she was really upset and felt left out, I feel really bad because some of the kids do not play with her anymore” (Black African female)

Many participants felt that gyms are too expensive for working families and looking after your health and wellbeing is last on the list when a person has so many competing priorities. One participant expressed the views of several when stating:

“When you have so many other things to pay for gym membership and looking after your health is the last on the list, all your money is spent on running your house and feeding your family” (Czech Republic male)

The appropriateness of activities was a key theme. There was an agreement across the groups that activities need to be culturally appropriate and there are not enough activities and suitable venues for people from the Black Caribbean community and Asian women. One participant stated:

“People from the Caribbean and Pakistan love to play cricket but there are no facilities to do this, it’s all about football, I know playing cricket would get my dad out the house” (Black Caribbean male)

Another participant stated:

“When you go to the gym you need to feel safe and comfortable, women only session are good but we need more of them” (Asian female)

Physical activity was identified as being important in preventing mental illness and physical health conditions such as obesity, stress, cancer, diabetes, heart disease and dementia. Participants acknowledged there are many benefits to being active and recognised that physical activity does not have to be costly. Everyday activities such as cooking and walking were identified as ways in which older generations can keep their mind and body healthy with little or no cost implications; one participant stated:

“Being active can help with your mental and physical health, gardening, dancing and walking are all good for you and keeps the body and mind young and the body feeling healthy and good” (Black Caribbean male)

Physical activity was linked to the consistency of health messages around national and local health campaigns. Some people felt that health messages would be more constructive if they focused on “fitness rather than fatness” as this may resonate more with BME communities. One participant stated:

“Health messages are confusing, the government say you need to do 30 minutes of exercise a day to prevent heart disease and diabetes, but now it’s something else and I can’t keep up” (Black African male)

There was a lengthy discussion around communication and language being a key barrier in preventing people from BME communities from participating in physical activity. Several participants, particularly from the asylum seeker and refugee groups, expressed frustration with information not being available in different languages; one participant shared the views of several when stating:

“We need information in different languages, everything is in English and this is hard for asylum seekers and refugees to understand what’s available to them” (Female asylum seeker and refugee)

9.3.5 Alcohol and drugs

Alcohol and drugs were discussed across all groups but to a lesser extent than smoking. One group of young people talked about young black males smoking cannabis and the adverse effects this has on mental health. The other groups recognised young black males as having complex needs, often facing issues such as unemployment, discrimination, gang culture, crime and low aspirations. One participant expressed the views of several when stating:

“Young black males are already at a disadvantage, low aspirations and unemployment lead to crime, you turn to drugs and alcohol to cope and to fit in with your peers, this leads to poor mental health and before you know it you’re sectioned or in jail or something” (young Black Caribbean female)

Several participants acknowledged alcohol, drugs, smoking and mental health as being interrelated; this was highlighted as a particular issue for young people and participants felt that more support and guidance is needed for this group of people. One participant stated:

“It comes back to personal choice, people can choose not to drink and take drugs, we all have choices and smoking weed isn’t cool but young people think it is” (Young Asian female)

9.4 Socioeconomic factors

Money and deprivation were discussed by many groups. Participants felt that BME communities generally experience higher levels of poverty linked to lower levels of employment and low pay and are likely to live in poorer housing conditions compared to the general population. Deprivation and attitudes towards health were thought by some to be the main driver behind people from BME communities experiencing poorer health outcomes than their white counterparts. One participant stated:

“Poverty and deprivation are the root cause to ill health, if you check it out, the majority of black people live in deprived areas and people from deprived areas have worse physical and mental health than the general population” (Young Black African male)

Affordability was mentioned by all groups and was recognised as a key barrier to leading a healthy lifestyle. The affordability of healthy food, the cost of leisure facilities and cuts to local services were described as significant barriers to people making healthy choices. One participant stated:

“Baby clubs and gyms are out of reach to most people, they are mainly for the affluent as they are far too expensive” (Young Chinese female)

There was a consensus across the groups that socioeconomic factors have a significant bearing on the differences in health outcomes experienced by BME communities. The government was seen to be responsible for BME communities having poorer health outcomes than their white counterparts. Participants acknowledged that people from BME communities live in deprived areas and are therefore more likely to experience poverty, social disadvantaged and poor health. There was an agreement across the groups that the government must do more to address this matter and create a level playing field for all ethnicities to succeed in life. One participant expressed the views of several when stating:

“The Government is responsible of poverty; they make it harder from BME people to live a good and decent life, it’s been this way since I can remember, something needs to change and it needs to happen fast (Elderly Black Caribbean male)

9.4.1 Built environment

The built environment was a vibrant topic of discussion. Participants described the environment as those places to where individuals are exposed in their everyday life and which adversely affects a person's ability to make healthy choices. Examples included the planning of fast food outlets, access to open spaces, housing and homelessness, fuel poverty and having a sense of belonging.

9.4.2 Planning

A key point of discussion was the planning of fast food outlets, with particular reference to the disproportionate numbers of fast food outlets in areas of deprivation: Sneinton, Hyson Green and Radford were given as examples. Participants felt there were too many fast food outlets selling cheap and unhealthy food, especially in areas populated by BME communities where obesity prevalence is known to be high. There was a perception that Nottingham City Council is not committed to tackling obesity: participants felt that the council should refuse planning applications for fast food takeaways in preference of more healthy food outlets.

“Why do you walk down Hyson Green and see loads of fast food takeaways, but in the nice parts of the city like Wollaton you see healthy food shops, why does where you live have to impact on you making healthy choices” (Black Caribbean female)

The role of the commercial food industry was an interesting debate. Some participants felt that eating well takes effort and is often more expensive due to food outlets over-charging for healthy food. Others felt that food outlets maximised profit by selling low quality food at cheap prices. There were very mixed views across the groups with some commenting that the food industry is not responsible for unhealthy lifestyles and personal responsibility has a bigger role to play, while others felt the food industry were to blame as they do not have any social responsibility and are driven by greed and profit. One participant stated:

“People know the benefits of eating healthy so choose fruit and veg instead of KFC and fried food” (young Asian male)

Conversely, another participant stated:

“Business is business, if there is money to be made people will sell what the people want to buy, it's all about making money, health does not come in to it (Black Caribbean male)

The affordability aspect was challenged by some groups who felt that it was more a matter of people prioritising and budgeting accordingly; one participant stated:

“You can eat well for less but people choose to spend their money on other stuff, people just need to decide what they want to spend their money on and prioritise” (Black African male)

9.4.3 Accessing open spaces

Accessing open spaces was discussed across all groups. Some participants described an open space as a park, while others described it as any place where people can socialise and exercise. The health benefits of exercising outdoors were recognised for improving physical and mental health. Participants discussed accessibility to outdoor activities. The city cycle scheme received mixed reviews: some felt it was a good service and was easy to access while others felt the service needed improvement and that access was an issue. One participant stated:

“The cycle scheme is complicated, there are no cycle routes in my area and bikes are not always available, this puts you off so you just get the bus” (Male asylum seeker and refugee)

Feeling unsafe in the community was a key concern across some groups: it was highlighted as a particular issue with the asylum seeker and refugee groups. Participants shared examples of being subjected to racial discrimination and verbal abuse while out in the community; one participant shared a personal encounter:

“I am afraid to leave the house, it’s mainly at night; there have been a few times where people have shouted racial abuse at me for wearing a hijab, I don’t feel safe in my own community” (Female asylum seeker and refugee)

Social isolation and loneliness was a common theme across the groups. Participants felt that social isolation and loneliness adversely affected health and happiness and it was identified as a particular issue amongst the BME elderly population; one participant stated:

“Where you live is important and can cause isolation especially with the elderly, my auntie used to go out for walks until the area changed, now there are lots of young people hanging out on the streets and she feels unsafe to go out on her own, now stays home most days” (Young Asian female)

9.4.4 Housing and homelessness

Housing and homelessness were discussed but not at great length. The private sector was highlighted as a particular issue and landlords were criticised for not maintaining good quality housing. There were discussions around the lack of affordable good quality housing; issues of overcrowding and damp were highlighted with many recognising these conditions as having an adverse impact on physical and mental health. On more than one occasion, participants shared experiences of having suffered respiratory conditions related to damp housing conditions; one participant stated:

“I’m paying money for living in a place that I don’t like and is damp and in bad condition, it makes me ill and causes my asthma to start up, I don’t feel well living there but on one listens to me and it makes me feel depressed” (Elderly Polish male)

People in some groups highlighted an apparent lack of “community spirit” while others talked about the area where they lived not feeling like home. This was discussed in relation to homelessness, which was often linked to social isolation and loneliness. One participant stated:

“Where I live is not a home it’s just a place, there is no community spirit and people don’t look out for each other, in Africa we live as a community not as individuals” (Young male refugee)

The reduction in tenancy sustainment, particularly for vulnerable groups, was highlighted as an issue. This was linked to the increase in homelessness and the risk of mental illness due to anxiety and stress brought on by being constantly moved around. One participant shared her experiences and stated:

“Life is a struggle for people like me who live in temporary accommodation; it’s stressful not knowing what is going to happen to you, if you’re going to be moved, where you’re going to move to, you always feel stressed and not able to settle” (Young female asylum seeker)

Language barriers were identified as a key issue when accessing housing services; this was apparent with the Polish and the asylum and refugees groups; one participant stated:

“There is no communication between me and support worker, she doesn’t understand my language or my needs and cannot help with sorting out my housing issues” (Young Polish female)

9.4.5 Fuel poverty

A number of groups highlighted fuel poverty as an issue. Participants stated that their homes are in poor condition and are costly to heat. Several participants from the Black African community had a perception that people from hot countries need warm houses to feel physically and mentally well as they are used to living in warm conditions. Several participants believed this is a reason why people from BME communities become unwell; one participant stated:

“I’m from a hot country and feel the cold more and so I need the heating on more as it is always cold in this country and the cold makes me ill, but I can’t afford to heat my home because my wages are small and I can just about live” (Black African female)

Social disadvantage and poverty were highlighted on a number of occasions and were thought to be a key cause of health inequalities; examples included unemployment and also low wages as a result of not being able to get a well-paid job due to some international qualifications not being recognised in England. One participant stated,

“I am an educated person and yet I still cannot find a job that pays me for what I am worth because my qualifications as business manager are not recognised in this county. I have to take my studies again; it’s just one barrier after the next” (Black African male)

9.5 Stigma, racism and discrimination

Stigma and discrimination were the most frequently discussed themes across all groups. The majority of participants identified stigma, racism and discrimination to be overwhelming issues. Participants agreed that stigma and discrimination can impact on every aspect of a person’s life and, as such, have a profound effect on a person’s health and wellbeing; one participant expressed the views of several when stating:

“People from BME communities have always experienced poorer physical and mental health; some of this is due to genetic differences, some due to people living in deprived communities but most is due to discrimination in all aspects of your life (Black Caribbean female)

Some participants felt that statutory services discriminated against them including employment, mental health and ‘general’ health and wellbeing services. One participant stated:

“Due to racism and discrimination people from the BME community find it harder to access services and we live in a state of anxiety, services do not understand BME people and it’s hard to get help when you need it, this messes with your head and causes you to be depressed” (young Asian male)

Interestingly, several participants stated that there have been more cases of racism and discrimination towards them and people from their community following the European Union (EU) referendum. Many believed the negative media news about immigration was to blame. There were concerns that the EU referendum will cause further inequalities and there will be more cases of hate crime, especially towards asylum seekers and refugees; one participant stated:

“Racism is worse after the UK left the European Union, no one thought it would happen and no one thought that BME people would be targeted and get picked on, this has left people in a terrible place, they are shocked and frightened” (Asian male)

9.5.1 Employment

Several groups identified that poor language skills restricted work opportunities. In addition, participants also recognised that BME communities are disproportionately under-represented in the workplace. Several participants, particularly from the Black Caribbean, Black African and Asian communities, felt the underlying reason for these disparities was due to institutionalised racism, particularly towards young black males who are at a significant disadvantage to their white counterparts when seeking employment. Participants shared their personal experiences of being discriminated against when seeking employment. Some talked about constantly applying for jobs in statutory organisations and being unsuccessful, while others talked about the lack of opportunities and aspirations among some communities which impacted upon a person’s ability to seek and maintain employment. One participant stated:

“Race plays a major role in life, whether discrimination occurs consciously or unconsciously it happens. I know that black people have to apply for a job 15 times more to be successful compared to white people, meanwhile Asian people have to apply for a job 9 times more than a white person, merely on the basis of their name” (Black Caribbean female)

Social disadvantage was discussed at length, with particular reference to how this adversely affects employment opportunities. There was a view that qualifications obtained abroad, particularly in Africa, are not recognised in the UK which therefore makes it difficult for people to succeed. One participant stated:

“I have qualifications as a nurse but they are not recognised in this country. I have to study 3 more years for the same qualification, how can this be fair?, I am an educated and skilled worker” (Black African female)

Participants also emphasised that large institutions tend not to employ people from BME backgrounds and there is a disproportionately small number of people from BME backgrounds in senior roles. Again, there was a view that this is due to institutional racism, although there was some challenge to the idea that the workplace does not demographically represent the city. Some people commented that their workplace employs a large number of people from the BME community; one participant stated:

“In my workplace there are lots of people from different BME backgrounds, personally I don’t think there is a problem” (Asian female)

Conversely, other participants stated:

“Large organisations like Nottingham City Council and the NHS do not employ people from BME backgrounds, the workforce does not represent the city population, and there are few senior black managers, why is this”? (Black African male)

Several groups highlighted Nottingham to have a disproportionately small number of BME employees working in the private sector and comparisons were made to other large cities, one participant stated:

“Nottingham needs to admit that they have a problem, when you go to Birmingham you see black men in suits and working, when you go into a retail store in Nottingham, it is unlikely you will see anyone from the BME community” (Black Caribbean female)

There was a view that Black Africans are one of the newest communities to come to the UK; however, most community resources have already been allocated which makes it increasingly difficult for Black African people to be supported into employment. Whilst it was acknowledged that there are schemes in place to support people into work, a clear area identified across the groups was a lack of strategic direction to address the issue of social disadvantage and discrimination in terms of supporting people from the BME communities with better employment opportunities.

“Government and organisations know about the problems related to the black and minority ethnic groups yet they aren’t concerned and aren’t taking any action to address any of these issues” (Black Caribbean male)

It was also acknowledged that unemployment has a significant impact on mental health and wellbeing. Many people talked about income deprivation, unemployment and the impact of benefit cuts; one participant stated:

“When you can’t find a job and have no money this has an impact on your mental health, I can’t afford to live on the benefits I get, I look for work every day but there is nothing out there, every day is a struggle and it stresses you out” (Asian female)

9.6 Mental health

Attitudes towards mental illness were seen as a barrier by many groups. A variety of issues were highlighted as contributors to poor mental health, including money-related stress, unemployment, deprivation, affordable quality housing and physical health conditions including cancer and diabetes. Participants identified problems as being exacerbated by cultural bias, with many expressing disparities between black males and white males when accessing mental health services.

“Fear of being sectioned prevents people from the BME community to seek help for any mental health issue they may have due to the fear of being sectioned and the stigma that goes with it” (Black Caribbean male)

Participants across all groups shared concerns that black males are disproportionately represented in mental health services. There was a belief that black males are sectioned unnecessarily without receiving talking therapies - again, this was thought to be related to discrimination and organisations not understanding cultural differences. Similarly, several participants felt that black males are harshly treated, over restrained and receive disproportionately higher dosages of medication than their white counterparts. One participant shared the views of several when stating:

“Members of the BME community are treated much differently in the world of health, specifically mental health, black men are sectioned before receiving preventative care for their mental health condition, and this is much higher compared to white males seeking help for their mental health status” (Black Caribbean female)

Another participant talked in detail about how discrimination and a lack of cultural awareness are key reasons why black males are harshly treated and over-represented in mental health services; he stated:

“Fear of not being able to understand a person’s culture is the main reason why our black youths have so many mental health issues, the system needs to understand different cultures and not

discriminate, things need to change and they need to change fast” (Young Black Caribbean male)

Mental health was also discussed in relation to social isolation with several groups identifying language as a key barrier to accessing services. Several participants, particularly from the asylum seeker and refugee groups, acknowledged that health information is not available in different languages. One participant stated:

“Having a mental health condition is a lonely place at the best of times, but when no one understands you it’s even worse” (Male asylum seeker and refugee)

There was a consensus across the groups that, in addition to language barriers, there is a lack of cultural awareness across mental health services; again, isolation was mentioned within the discussions with one participant stating:

“Trying to express yourself when nobody understands your needs or speaks your language is stressful and can leave you feeling lonely and isolated” (Female asylum seeker and refugee)

Provision of mental health services was frequently discussed across the groups. Some participants felt there is a lack of culturally-appropriate services due to funding cuts. Participants felt that services need to be tailored to meet the needs of individuals and communities with better provision of services in the community. One participant stated:

We need more service in the community, run by people who we can relate to, I wouldn’t feel comfortable speaking to just anyone about my mental health” (Asian male)

Awareness of counselling services was said to be poor within the BME community. Participants felt this could be due to discrimination and stigma and barriers to accessing services; one participant stated:

“There is still stigma around mental health issues and this prevents people from speaking about it so people don’t get help when they need it because they are worried about what people will think of them” (Black Caribbean male)

There was some perception that physical health and mental health are connected; however, this varied across the groups with some people identifying mental health in isolation of physical health, whilst others felt they were interrelated. This was mostly discussed in relation to cancer, diabetes, heart

disease and healthy lifestyles. Interestingly, the majority of participants from the Polish groups agreed that good physical health can improve mental health; one participant stated:

It's very important because mental health is strongly related to physical health, my dad had cancer and this affected his mental health just as much as his physical health" (Polish male)

Participants across all groups talked about mental illness and the disproportionately high levels of anxiety and depression experienced by BME communities. This was highlighted as a particular issue within the Black Caribbean and Pakistani communities and, again, was thought to be linked to racism and discrimination. One participant stated:

"Surely people know that if you face discrimination on a daily basis this is going to affect your mental health, you will have no confidence and have anxiety and feel depressed" (Pakistani female)

There was an acknowledgement across all groups that social exclusion and discrimination are risk factors for mental illness, however, the majority of participants from the Black African and Black Caribbean groups identified this as an increased risk for substance misuse. One participant stated:

"There is a lack of awareness surrounding BME issues like racism and discrimination; this can cause people to use drugs and alcohol to get away from the hard and stressful lives they lead, but this impacts on their mental health and can cause their addictions to become worse" (Young Black Caribbean male)

9.7 Social isolation and loneliness

Social isolation and loneliness were discussed across all groups, especially amongst the asylum seeker and refugee groups. Many participants talked about feeling displaced whilst others spoke of a lack of community spirit and networks. All participants felt that the elderly are at a higher risk of isolation and loneliness; one participant expressed the views of many when stating:

"Communities are not what they used to be, I don't know my neighbours and they don't know me, you can go days without speaking to anyone" (Elderly Black African female)

Participants from the asylum seeker and refugee groups expressed an overwhelming feeling of isolation and loneliness. They talked about a lack of assistance from services and organisations to support the integration of new and emerging communities; one participant stated:

“When you feel like you are different and don’t belong it’s hard not to get depressed, you need to be around your own people and people who understand you but there are no services to help with this, you feel like you’re on your own” (Young male asylum seeker and refugee)

Several groups were dissatisfied with the housing system and stated that it causes people to feel displaced and isolated. This was highlighted as a particular issue within the asylum seeker and refugee groups. Participants are unhappy with the system and feel they have no influence over where they live and are often housed in areas that are unsuitable and away from family and friends. One participant stated:

“Asylum seekers and refugees have no say in where they live, you can be moved from place to place, as soon as you make friends you get moved, we need to feel like we have a place, we need stability for our children” (Male asylum seeker and refugee)

There was a consensus across the groups that the housing system brings about isolation and loneliness, particularly for BME elders. There was a perception that BME elders are vulnerable and therefore feel most comfortable and safe around people they know and people from their own community; one participant stated:

“I just got to know my neighbours and then the family had to move, it was really upsetting for the grandma who found it really hard to settle in” (Black Caribbean female)

Interestingly, this view was not shared across all groups. Some participants felt happy with the housing system and expressed a sense of gratitude, with one stating that he and his family had been treated fairly and with dignity. Another participant stated:

“I left a world with violence and no opportunities, I feel blessed to have been given the chance of a new life for me and my family” (Male asylum seeker and refugee)

A minority of groups felt that too much emphasis is placed on the notion of community when in fact, all areas are homogeneous; this was mostly expressed among the Black Caribbean groups. One participant stated:

“All this talk about community makes no sense to me, all places are homogeneous, you have to make the effort to live with your neighbours and get along with people” (Black Caribbean female)

Conversely, some participants from the Black African and Asian groups held the view that those from BME backgrounds need to be around people they know or with whom they have particular characteristics in common. Nonetheless, all groups agreed that society is stratified between age groups and there is little integration between younger and older generations. In addition, participants felt that people do not know what services are available to them and therefore do not go out and socialise; one participant stated:

“There needs to be more social events and activities where the young and old can come together and we need to know where they are and how to access them” (Elderly Asian female)

Several groups felt that there are fewer activities for older people and this thus reduces the opportunities and motivation for people to socialise. One participant stated:

“Being of a senior age there are limitations where you can socialise. It thus leaves you in a state of seclusion and you become a social recluse and lonely. This is one of the things that are killing the BME community” (Elderly Black Caribbean male)

Interestingly, there were mixed views as to how to address this. Some felt that services and activities should be accessed in the community and targeted at the elderly, while others felt it was more important to have targeted services that visit people in their homes. One participant stated:

“Work with services and voluntary groups and set up buddy schemes to go in to people’s homes and motivate them to come out and be part of their community, people just need a gentle nudge and to know that people someone cares and there are people to help” (Elderly Black African female)

9.8 Cultural and social norms

Cultural and social norms were highlighted throughout the engagement with discussions around services not being culturally competent. The need to support communities around managing long-term conditions and a lack of knowledge relating to various health conditions was also identified. One participant stated:

“If services were tailored to meet the needs of the individual then things would be better for people from BME backgrounds, one size does not fit all” (Black Caribbean male)

Health-seeking behaviour was highlighted as a cultural issue with many participants commenting that people from different ethnicities and cultures use health services differently. Many participants felt that gender was a culturally-determined predictor of health service use; for example, some participants from the Pakistani community perceived females to be uncomfortable exercising in male environments, with one participant stating:

“I attended a ladies-only swimming session at my local gym, I was shocked to see a male lifeguard so I didn’t use the pool, and this is not what I would call a culturally-appropriate service” (Asian female)

There was an agreement among some Black African and Asian male participants that men are less likely to use health services proactively due to risk-taking behaviour aided by cultural beliefs; for example, there was a belief that if you are ill your community and family will see you as being weak and less masculine. One participant stated:

“Men are strong, they are the bread winners and have to look after the family, and this stops us from seeking help when we are ill, we don’t want to look weak to family members” (Black African male)

Interestingly, this view was not shared among female participants from these communities who stated that they support and encourage their men to seek medical advice and do not view them as less masculine for needing help. In line with these findings, some male participants from the Black Caribbean groups acknowledged that women play a key role in supporting male family members to proactively access health services. One participant shared his personal experience:

“My wife made me go to the doctors and get my prostate checked out and I was diagnosed with the early stages of prostate cancer, I still can’t believe it, if it was not for her I would have probably died, women are the key to bringing about change in the family” (Black Caribbean male)

These findings suggest that gender is a culturally-determined predictor of health and is perceived very differently from a male and female perspective.

9.8.1 Cultural barriers

Participants acknowledged that barriers to being healthy among BME communities were influenced by four main concepts: perceptions; cultural expectations; personal barriers; and factors limiting access

to services and facilities. Several participants felt that BME individuals have different understandings of health that are influenced by attitudes and patterns of behaviour, personal experiences and cultural and health beliefs. A commonly-discussed topic was predisposition; several participants recognised that people from BME backgrounds experience predisposition to illnesses associated with their ethnicity. One participant stated:

“People from my community get ill anyway, that’s what happens even if they live a healthy life so what’s the point in making healthy changes” (Elderly Asian male)

Predisposition was discussed in relation to age and ingrained behaviour. There was a perception that when you get old you develop physical health conditions such as cancer and diabetes that cannot be prevented and this was thought to be an ingrained health belief amongst second and third generations. One participant stated:

“In my community there is a belief that when you get old you will get diabetes and become unwell, I’ve tried to tell my grandparents this is not the case and that diabetes is caused by eating unhealthy food and not exercising but they will not listen, they believe illness happens when you get old and you just have to get on with it” (Asian female)

9.8.2 Cultural beliefs

In a small number of Black Caribbean participants, there was a belief that medical treatments should be tailored to the Black Caribbean community. The example of the contraceptive pill was given. There was a belief that Black Caribbean women are biologically different to their white counterparts and react differently to the contraceptive pill and therefore an alternative approach is needed. Although this was a view of a minority, it is concerning and raises questions around the understanding of how ethnicity affects medical interventions. In addition, there was a view among several participants, particularly among Black Caribbeans that healthcare professionals offer people from the BME community less information with regards to their individual health and medication; one participant stated:

“Many people, especially BME young people tend to refrain from accessing health services, as they feel they won’t be helped and are given the wrong information” (Young Black Caribbean male)

Furthermore, another Black Caribbean participant explained that members of that community are treated differently when accessing health services and are not given the correct information or

medication. Further demonstrating that there are cultural beliefs around medication and accessing health services, the participant stated:

“The medication that is given to the BME community is often not suitable to the Caribbean person. Therefore the side effect is more severe to our community and that’s why black people suffer ill health” (Elderly Black Caribbean male)

9.8.3 Culture and accessing services

There was a view among some participants that the ethnicity of health professionals can be a barrier to accessing services. Several participants said they would feel more at ease being seen by a health professional of the same ethnicity as them. Interestingly, this view was not shared across all groups; some participants felt this would be a barrier due to fear of being recognised in their community and fear of stigma; one participant stated:

“I would rather see a stranger and not someone of the same ethnicity, there are always stereotypes and you could be judged” (young Black Caribbean male)

There were discussions around the gender of health professionals, similar to the discussion around ethnicity. Some felt that seeing health professionals of the same gender was an enabler, whilst others disagreed and felt that it was a barrier. One participant stated:

“Some people don’t know you can request a female, in the Muslim culture this is important and makes women feel more comfortable” (Young Asian female)

Conversely, some participants were not concerned about the gender or culture of the health professional and focused more on their ability to meet their needs and to deliver a good service. One participant stated:

“I’m not bothered about the ethnicity or gender of my doctor, I just want them to understand my needs and give me the correct treatment” (Black Caribbean female)

9.8.4 Culture and holistic health

Holistic health was highlighted among some groups as being important. Some participants, mainly from the Asian and Black African communities, felt that greater emphasis needs to be given to holistic health rather than focusing on illness and medical interventions. Participants felt that using natural remedies

would bring about better health outcomes and that more information should be available to enable people to make informed choices about their healthcare and treatment. One participant stated:

“There needs to be more information on the benefits of holist healthcare and more information on how to access natural remedies” (Japanese female)

There was a common belief among some groups that people from BME communities have a culture and history of self-medication and have historically treated themselves with natural remedies; this view was predominantly shared by the Black African and Black Caribbean participants, with one participant stating:

“People from my community treat themselves when they are ill or they seek help from experienced family members, we have been doing it since the beginning of time and this will never change (Black African female)

Interestingly, all groups felt there should be more choice around treatment and medical interventions. Participants felt that healthcare professionals should discuss natural remedies with individuals as well as prescribing prescription drugs; one participant stated:

“Natural remedies should be discussed at GP appointments and time provided to explore the holistic approach to health; natural remedies should be discussed as opposed to just giving people prescription drugs” (Black African male)

9.9 Education

Education was discussed in the broadest sense and included discussions around accessible information, health messages tailored to BME communities, effective use of social media and technology, and the role of schools in delivering health messages. Many of the groups recognised that health information is not assessable to BME communities. Participants felt that this has an adverse impact on the health and wellbeing of certain BME communities, with one participant stating:

“People from the BME community are always at a disadvantage, health information is generalised and targeted at the white community so how are people meant to improve their health if basic information is not accessible to them” (Young Asian female)

Several participants highlighted that BME communities do not access health services due to language barriers. Furthermore, they do not engage with health promotion campaigns or respond to health messages as they are quite often not directed at certain groups and communities – this was highlighted as a particular issue for the Pakistani community and one participant expressed the views of several when stating:

“People from my community suffer ill health as they don’t always understand that health messages are directed to them, messages need to be targeted to different communities and in a way that people can relate to them and understand them, you should start by making things available in different languages” (Pakistani female)

9.9.1 Technology

A point raised on a number of occasions was the impact that technology has upon social isolation and loneliness. The discussions were both positive and negative. For example, the use of social media as a platform for networking was seen as positive when used to promote community events and services and for putting people in touch with each other and was highlighted as beneficial for people who have mobility issues. One participant stated:

“Technology is a good thing if used in the right way and not seen to be the answer to everything” (Young Polish female)

On the other hand, some participants felt that social media had a negative aspect and that technology can sometimes prevent physical and social interactions which can lead to loneliness and isolation. One participant stated:

“What’s happened to picking up the phone and talking to someone, people don’t talk anymore it’s all done over the computer, this is not good for socialising and bringing people together” (Elderly Black Caribbean male)

9.9.2 Social media

Several groups highlighted the lack of understanding of available services and questioned whether people have the skills and resources to access information. Social media was seen as a solution and many felt that information is easily accessible. This view, however, was challenged by others who highlighted that social media is not an accessible form of communication, particularly for the older generations who do not always have access to technology and may not have the necessary skills to use

social media. Furthermore, information is usually presented in English and is often not available in different languages; one participant stated:

“Social media cannot be seen as the answer to communicating to all groups of people, not everyone has a computer or smart phone, think about the elderly” (Asian male)

It was generally felt that the city did not lack services, rather the problem was people being able to access information and knowing what is available to them. One participant stated:

“There are lots of services and activities in the city, the problem is finding out where they are” (Male asylum seeker and refugee)

There was a view that children are at a greater risk of obesity due to too much time being invested in social media, technology and computer games with less time given over to socialising and being active. However, there were examples of how technology and computer games can have a positive impact on health and wellbeing. One participant stated:

“The only good thing to come out of technology is the Pokémon game where kids actually get some exercise and go out in the fresh air and look for characters” (Black Caribbean female)

9.9.3 The role of schools

The role of schools in informing students and families about healthy lifestyles was a key theme. Some groups felt there was less of a focus on health and wellbeing within schools than there should be and that more time needs to be invested in educating children on physical activity and healthy eating. Interestingly, this view was not shared across all groups and some participants felt that schools are conscious of the issues around healthy eating and healthy weight and are proactive in educating children on healthy lifestyles. One participant stated:

“My son’s school are always putting activities on after school; they are really involved with my child’s health and development” (Black African female)

Several participants felt that schools have a responsibility in educating children on skills for life and are best placed to deliver health messages and interventions. Participants felt that schools could do more to help children and young people learn how to shop, cook, budget and develop skills for independent living. There was a perception that since schools became academies, their prime concern was to make money and charge for after-school activities that were once free. Participants across all groups felt that

this approach excludes families on low incomes and further widens the inequalities gap. One participant stated:

“Schools are best placed to promote health messages to children and families but now schools are academies they are only interested in making money, they need to do more after school activities for free and stop charging for everything” (Black Caribbean male)

9.10 Access to services

Access to services, including GP appointment times, was one of the most commonly-discussed themes. Many participants highlighted long waits for services, complicated appointment systems and not enough GP appointments being available; one participant stated:

“The main problem with the NHS is the waiting times, you have to call the surgery in the morning to get an appointment but the phone is always busy and when you finally get through all the appointments are gone, it can take days before you are seen by a doctor” (French male)

GPs not understanding cultural needs and difficulties in communicating with reception staff were described by many participants. This was highlighted as a particular issue for the asylum seeker and refugee groups and was said to be a significant barrier to accessing GPs. Interestingly, this view was not shared across all groups: several participants stated they had not encountered problems in accessing their GP and the service was generally adequate and responsive to their needs. However, some groups commented that one of the biggest barriers in accessing their GP was getting past the receptionist. Reception staff were described as being “nosey” and lacking cultural awareness. Several participants suggested that staff members would benefit from equality and diversity training. One participant shared her personal experience when stating:

“I don’t like going to the doctors because I’m not taken seriously and they don’t understand my needs, plus I have to explain my health condition to the receptionist for them to decide if I’m ill enough to see the doctor” (Elderly Black Caribbean female)

9.10.1 Confidence in your GP

Many participants volunteered very positive comments about their GP and stated levels of trust and confidence, with one stating:

“I trust my GP to diagnose me correctly and have good experiences of visiting my surgery” (Black Caribbean female)

Several participants discussed their experiences of other health professionals; there was a general consensus that they treated BME groups with dignity and respect, with one participant stating:

“I find it easy to 'access services' e.g. GP, Dentist, in the help of other organisation. The NHS is very fantastic especially for asylum seeker” (Male asylum seeker and refugee)

However, this view was not shared across all groups; some participants felt that their GP did not understand them at all, or did so only partially. Some felt they were not fully treated with respect and their GP appeared not to understand increased risk factors influenced by ethnicity. One participant stated:

“There are many incidents where we go to the GP and get fobbed off because the GP does not understand the risk factors for a particular community, take Prostate Cancer for example, BME men are at higher risk but the GP does nothing about it” (Elderly Black Caribbean male)

9.10.2 Barriers to accessing services

Cultural awareness was identified by several groups as a key barrier when accessing the GP. Several participants, particularly from the Asian and Black Caribbean community, felt that their doctor did not listen carefully to them or give them enough time to discuss their health condition. Several groups also felt that people from BME backgrounds were less likely to be involved in decisions about their treatment. This was highlighted as a particular issue with the Black African community where participants compared the health system in the UK to their home country.

The UK health system was often regarded as confusing and participants reported a limited understanding of how the system works and how services can be accessed. Equally, some participants felt the health system in their home country was better than the UK, the reasons for this including having the same family doctor who knows all the family and understands their cultural needs and who takes the time to involve them in their healthcare and to explain things. One participant stated:

“In the UK the doctor's surgery is a foreign place for the BME community, your doctor is a stranger to you, the old Caribbean habits have disappeared and the new habits are hard to accept” (Elderly Black Caribbean male)

However, some participants disagreed with this statement and did not have the same expectations or necessarily want to be involved in decisions about their health and said they trusted their doctor to make decisions for them. This contrasted with some participants who felt they had been prescribed

medication and were not given the opportunity to be involved in decisions about their health. Others felt that they were not given enough information about the purpose of their treatment and medication; this was largely seen to be influenced by language barriers. One participant stated:

“My doctor does not involve me in my treatment; English is not my first language he thinks I don’t understand so he makes decisions for me” (Female asylum seeker and refugee)

9.10.3 Barriers to accessing services from a cultural perspective

There was a consensus across the groups that GPs only deal with the problem that is being presented at the time and this results in missed opportunities to discuss other important health issues; one participant stated:

“It’s a struggle to get to see a doctor and when you finally do, you get asked the same questions and can only discuss one issue at a time, it’s a waste of time” (Asian female)

Several participants thought that it would be helpful if GPs viewed health from a social perspective as they felt they were being judged and that their GPs showed little empathy or understanding of wider factors that impacted upon their health and wellbeing. This was highlighted as a particular issue for the Polish community where the example of poor housing was given. Participants felt that their GP did not understand that they felt unwell and unhappy due to their homes being cold and not being able to afford to heat them. One participant described how this has had a negative impact on his mental health and wellbeing and stated:

“I feel like my doctor does not understand me or listens to me or my problems, I feel like he judges me without understanding my struggles, that’s why I hardly go to the doctor” (Polish male)

All groups identified genetic differences as a risk factor for several diseases including high blood pressure, heart disease, sickle cell disorder, prostate cancer and diabetes. People from BME communities were recognised as being more at risk for these diseases than their white counterparts. Participants also acknowledged that BME groups have additional challenges with proactively managing their health conditions and accessing health services; one participant stated:

“GPs in Nottingham are turning BME men away from having a PSA test before they are 50. Black men are diagnosed with prostate cancer five years earlier than the white men thus making the

mortality very high. GPs need to be educated to test the BME community much earlier” (Black Caribbean male)

9.10.4 Cultural awareness as a barrier to accessing services

Cultural awareness and sensitivity were discussed in relation to accessing health services other than the GP. A number of groups stated that health professionals in hospitals lacked awareness about cultural diversity and were regarded by a number of participants as weak. A lack of awareness and cultural insensitivity were illustrated in respect of the Muslim and Black Caribbean communities. Participants felt that health services were not inclusive and culturally appropriate, examples included limited availability of Halal food and Caribbean food in hospitals, access to female practitioners, no prayer rooms in hospitals or Accident and Emergency Departments and a lack of understanding around issues of washing and cleanliness. One participant stated:

“When you’re in hospital the one thing you need the most is good food. My dad struggled to eat the food because he will only eat Asian food, this was not available to him and what they offered was very poor quality, my mum had to bring him lunch and dinner every day” (Asian male)

9.10.5 Language barriers to accessing services

Language barriers were highlighted as a main issue and a significant reason that prevent BME communities from accessing services. Many groups talked about how BME communities are less likely than the general population to feel they have sufficient time with their GP. This was due to challenges around language barriers and, as a consequence, longer appointment times are needed and appropriate translation services. Participants also highlighted issues where interpreting services are not available and family members are used. Participants felt this is problematic as relatives can pass on their own judgement as an interpretation; this was highlighted as a particular issue with the Polish community with one participant stating:

“10 minutes is not enough time for me to see my GP, people with language barriers need more time and translators need to be on hand to help but they never are so you use family members and that can cause lots of problems ” (Polish female)

In addition, participants felt that people from BME backgrounds are more likely to feel unable to complain about health services as they do not understand how local structures work and are frightened of being taken off their GP’s list; one participant stated:

“If I knew how to complain and knew it would not affect the health care me and my family get then I would definitely do it” (Male asylum seeker and refugee)

There was a consensus across the groups that communication difficulties with GPs are heightened where English is not the first language. Several participants said they have travelled outside of the area where they live to register with the same GP as a family member or friend. Participants explained that, because the GP came recommended by friends and family and spoke their language, they are willing to do this, even though this represents a considerable inconvenience:

“Variations in the quality of GP practices means people have to travel to get better care, this is a problem and affects how people from the BME communities experience and access health services” (Male asylum seeker and refugee)

Several groups expressed difficulties were intensified when there was a lack of family support and limited access to advocates and support workers. This was highlighted as a key issue for the Polish community and was said to have a negative impact on mental health and wellbeing:

“If I want to make an appointment at the GP I have to ring at 8.30 to get appointment but I have to ring a health link worker to ask her to make the appointment for me because I don’t speak the language, but she does not start work until 9.00 so it’s hard to get an appointment” (Polish male)

10. Improvements and Recommendations

This section examines the feedback from the consultations and summarises what people felt would improve the health and wellbeing of BME communities in Nottingham. The responses were a mixture of principles and approaches and particular interventions and activities. Though the replies were varied, there was an agreement on the involvement of community leaders and joined-up working between the community and voluntary sectors. It was felt this approach would allow commissioners to tailor services to targeted communities and secure acceptance of the services among BME groups. Six cross-cutting themes were identified.

10.1 Early intervention and lifestyle risk factors

Early intervention was seen as a key issue and was widely discussed in relation to children and families. Many groups expressed a desire to see more resources invested in educating children and families around healthy lifestyles. This was mostly discussed with regard to effective partnership working with community and voluntary groups, schools and faith centres. However, the principle of early intervention was not limited to children and families; it was felt to be relevant across all areas, with particular reference being paid to identifying the needs of new and emerging communities at an early stage. Some of the areas for improvement are discussed in table 34.

Issue	Summary of participants' views
Healthy eating	<ul style="list-style-type: none"> ➤ Work with schools to promote healthy lifestyle messages to children and families. ➤ Provide recipe cards to show people how to make traditional foods in a healthy and economic way. ➤ Work to address the labelling of ready-made meals. Packaging needs to clearly present the salt, fat and sugar content to help people make informed decisions.
Physical activity	<ul style="list-style-type: none"> ➤ Provide childcare facilities at health clubs and gyms, this will make access easier. ➤ Educate people on exercise for particular age groups and have age appropriate activities. ➤ Work with schools and community and voluntary organisations to provide a variety of activities and more choice. ➤ Leisure centres close on a Sunday: there needs to be more flexibility and choice. ➤ There should be more community exercise activities available at faith centres that are specifically targeted at the BME community.
New and emerging communities	<ul style="list-style-type: none"> ➤ People who are newly arrived in the UK need special attention to integrate - a specific service would be welcome.

Table 33: Summary of participants' views for early intervention and lifestyle risk factors

10.2 Working with community groups and community leaders

A key theme identified was the reduction in funding for the community and voluntary sectors. Participants acknowledged a significant reduction in community services and felt this impacted on BME health and wellbeing. Some groups commented that services are often more effective and better received by BME groups when they are delivered by community and voluntary organisations. Some participants felt that the community and voluntary sectors have a better understanding of the needs of the BME communities in which they serve. It was acknowledged, however, that there was no easy answer to the funding challenges in light of the financial climate faced by public sector organisations. The groups felt that new approaches and better partnership working would help address funding issues; some of the ideas for improvement are discussed in table 35.

Issue	Summary of participants' views
Community and voluntary sector	<ul style="list-style-type: none">➤ Support the community and voluntary sectors to apply for funding so they can deliver projects and interventions within the community.➤ Set up community projects and work with asylum seekers and refugees to use their skills to make things that can be sold to help fund the cost of living, for example, knitting, cooking and arts and crafts.➤ Work with community groups to set up projects to support Eastern European people into work.
Government bodies	<ul style="list-style-type: none">➤ Work with commissioners to jointly commission sustainable community projects and services.➤ The stress caused by the government is affecting health and happiness due to changing policies and cuts to welfare benefits; there is a need for a service to support vulnerable people and help them understand the changes and to deal with stress and pressures.

Table 34: Summary of participants' views for working with government and voluntary bodies

10.3 Focus on addressing stigma, discrimination and racism

Taking time to understand the challenges and barriers that people from BME communities endure on a daily basis was an important issue. Many groups highlighted racism and discrimination as one of the

biggest challenges. Some participants felt that statutory services discriminated against them; this was mainly discussed with regard to employment and mental health services. Some of the suggestions for improvements are discussed in table 36.

Issue	Summary of participants' views
Employment	<ul style="list-style-type: none"> ➤ There needs to be a fair and equitable process to ensure people from BME communities are not discriminated against when applying for jobs. ➤ Organisations need to demonstrate they have a representative number of BME employees in senior positions making decisions. ➤ There needs to be a system to ensure work environments, particularly large statutory organisations, are demographically representative of Nottingham's population.
Mental health services	<ul style="list-style-type: none"> ➤ There should be more BME-specific community-based organisations to respond to the increase in people seeking help and advice for their mental health condition. ➤ Talking therapies are not adequate and do not help people involved in crime and substance misuse; there needs to be culturally-appropriate services. ➤ Mental illness in Asian communities is more prevalent where families are looking after elderly relatives. It is not talked about because caring is seen as a duty. A specific support service would be welcome. ➤ There should be more informal drop-in counselling services for young people: perhaps a youth confession booth where there could be 20 minutes of anonymous conversation for young people to vent their emotions.
Racism and Discrimination	<ul style="list-style-type: none"> ➤ More councillors and people with decision-making powers need to be from the BME community to encourage positive anti-discriminatory change. ➤ There used to be a Race Equality Council but it was closed down: this needs to be reignited. ➤ There should be an umbrella organisation that protects BME groups from discrimination but, unlike past umbrella organisations, the new one must be representative of BME communities.

Table 35: Summary of participants' views for addressing stigma, discrimination and racism

10.4 Influencing decisions

Taking the time to listen to people and to seek their views was seen as very important by participants. However, there were concerns that the BME community are often consulted but that action is not taken in response to the findings. This was highlighted as a key reason why people from the BME community are reluctant to engage. BME communities would like their voice to be heard in service redesign and would like to influence commissioning decisions. Participants were also keen to see a process in place to ensure that feedback and outcomes are shared in an open and transparent way. Some of the ideas for improvements are discussed in table 37.

Issue	Summary of participants' views
Local government	<ul style="list-style-type: none">➤ Councillors should hold coffee mornings and work harder to bring communities together.➤ The council should run a 'You said, We did' policy to help people feel assured that consultations are valid and are not tokenistic.➤ Nothing happens with the feedback received from the BME community. A transparent system designed to hold officials and government bodies to account would be welcome.

Table 36: Summary of participants' views for influencing decisions

10.5 Social isolation and loneliness

Many groups recognised the negative health impact of social isolation and loneliness. This was recognised as a particular issue for the elderly and for new and emerging communities. Many groups felt one of the key ways to address this is to focus on bringing older and younger generations together and investing in voluntary programmes including buddy schemes. Some of the ideas for improvement are discussed in table 38.

Issue	Summary of participants' views
Elderly	<ul style="list-style-type: none"> ➤ Coffee mornings are easy to set up and are low cost. ➤ Invest in volunteer programmes for a buddy scheme to help older people get out of the house. ➤ Provide training to older generations on how to use social media and computers. ➤ Develop a scheme where the young meet with the old and share skills. ➤ Take services and activities to older people - not everyone is able to leave the house to socialise. ➤ Establish more group activities for ageing people who are fit and in good health and who are not ready for the elderly clubs. ➤ Provide more community centres/places in Nottingham for the 50-plus age group.
New and emerging communities	<ul style="list-style-type: none"> ➤ Establish buddying schemes so asylum seeker and refugees have friends and support systems when they arrive in Nottingham. ➤ Faith centres are good for bringing people together: utilise them more and arrange events to bring communities together. ➤ Provide sessions for women on how to network - this will help ladies to socialise and meet new people.

Table 37: Summary of participants' views for addressing isolation and loneliness

10.6 Education and awareness raising

Participants felt that health education should start from an early age and be delivered in settings that are appropriate and accessible. Several cross-cutting themes were identified including mental health, healthy lifestyles, substance misuse and holistic health. Some of the ideas for improvement are discussed in table 39.

Issue	Summary of participants' views
Mental health	<ul style="list-style-type: none"> ➤ Organisations need to educate young people about the mental health issues associated with the abuse of alcohol and drugs to give a real understanding of the long-term effects.
Healthy life styles	<ul style="list-style-type: none"> ➤ Health education should be compulsory in all schools. ➤ There is a need for positive role models in the community to promote healthy lifestyles and there needs to be a project for this.
Substance misuse	<ul style="list-style-type: none"> ➤ Education surrounding drugs need to be improved; projects such as FRANK and DARE do not educate children on what they need to know about drugs and alcohol.
Holistic health	<ul style="list-style-type: none"> ➤ There needs to be more information and education on the benefits of holistic healthcare; far too many GPs give out antibiotics when alternative medicines are available.

Table 38: Summary of participants' views for addressing education and awareness raising

10.7 Information and communication

Many of the groups felt that a key barrier for people from BME communities to leading a healthy life was the lack of accessible information and being unaware of the services available to them. In addition, the majority of participants felt that language skills presented a significant barrier to accessing services. Some of the ideas for improvements are discussed in table 40.

Issue	Summary of participants views
Health messages	<ul style="list-style-type: none">➤ Ensure written documents are accessible and easy to complete.➤ Newspapers should be more positive and have messages about good things surrounding communities, rather than focusing on negative things.➤ Health messages need to be accessible and in different languages and targeted at specific communities.➤ Publish health information in council newsletters.➤ We need an annual community event to bring all communities together; we had a great event on the Forest a few years ago with lots of health and social care services, the community needs this.
Language skills	<ul style="list-style-type: none">➤ There needs to be a volunteer scheme to help individuals learn to speak and write English and more investment in translation services when people arrive in Nottingham.

Table 39: Summary of participants' views for addressing Information and communication

10.8 The environment

Developing an environment that is safe, attractive and inclusive for all was seen as very important across all groups. Many groups highlighted the environment as being a key factor in increasing obesity. Reference was made to the planning of fast food outlets, lack of open green spaces, systems around active travel and warm, affordable housing. Some of the ideas for improvement are discussed in table 41.

Issue	Summary of participants' views
Planning	<ul style="list-style-type: none"> ➤ The city is full of fast food takeaways, why don't you plan for healthy food shops instead of fast food shops? ➤ There are not enough green spaces that are deemed safe and we need more walking routes and opportunities to cycle. ➤ Dog fouling prevents people from wanting to walk on the streets. ➤ The streets are not safe. This is a big issue and needs to be addressed. ➤ We need good quality, affordable housing that is not expensive to heat. ➤ We need communal spaces to grow fruit and vegetables.
Physical activity	<ul style="list-style-type: none"> ➤ We would like to see outdoor gyms in all parks. ➤ There should be more public facilities for different sports like tennis, table tennis and cricket. ➤ Better use should be made of public spaces that have been left derelict.

Table 40: Summary of participants' views for addressing the built environment

10.9 Accessing services

Accessing services was one of the most commonly-discussed themes. There was a general dissatisfaction across the groups, with many feeling that people from BME backgrounds experience significant challenges when accessing services. Issues highlighted included language barriers, complicated booking systems, lack of GP appointments, long waits for services and services not understanding cultural needs. Some of the ideas for improvement are discussed in table 42.

Issue	Summary of participants' views
Language barriers	<ul style="list-style-type: none"> ➤ GP appointments are not long enough and this is frustrating when you need a translator. ➤ Polish people are not offered work due to language barriers.
Cultural needs	<ul style="list-style-type: none"> ➤ Electronic registration at your GP is not culturally sensitive for people who cannot understand English - a more inclusive approach is needed. ➤ More choice is needed: some Asian women would prefer to see a female doctor. ➤ We need practitioners that are culturally literate and have an understanding of cultural needs. ➤ GP appointments are too short and need to be tailored to meet a person's needs
GP systems	<ul style="list-style-type: none"> ➤ There needs to be better referral services from GPs to secondary services like hospitals and social care. ➤ People are able to recognise early signs of disease but seeking help is difficult. Long waits, complicated phone systems and too few appointments create barriers. The whole system needs revising. ➤ GPs need to offer annual health checks to all; perhaps this could link to workplaces and work initiatives. ➤ Receptionists can act as a barrier to accessing GPs; could they be offered customer service and equality and diversity training? ➤ It would be good to have a GP in organisations like Emmanuel House once a month to prescribe medications and establish relationships.
General access to services	<ul style="list-style-type: none"> ➤ We need BME role models to normalise and encourage others to access services and self-help groups; a scheme to promote this would be welcome. ➤ Emmanuel House helps people - we need more organisations like this. ➤ In Nottingham there are no services that provide help in the late hours for the homeless and vulnerable people; this is a real gap. ➤ For Polish people there are no organisations or institutions that help with getting documents quickly. Nottingham is a big city, we need a service for this.

Table 41: Summary of participants' views to address barriers for accessing services

11. Discussion

This section of the HNA compares and contrasts the findings from the literature review and quantitative data, with the views expressed by the participants in the questionnaires and focus groups. It is structured around ten key themes that emerged from the literature and qualitative work. Where possible, and where evidence is available, each theme introduces some of the key issues to emerge

from the literature, data and qualitative findings. The report discusses what participants said about each topic and the extent to which their beliefs are confirmed or refuted by the evidence base.

11.1 Lifestyle

11.1.1 Smoking

The findings from the questionnaires showed that 78% (⁵⁸⁰/₇₄₁) of respondents disagreed or strongly disagreed with the statement, “I smoke tobacco regularly”. This is an interesting finding given the high smoking prevalence in Nottingham and suggests that people from local BME communities do not smoke tobacco on a regular basis. These findings are in line with the literature; a study by Karlsen et al (2011) showed that people from BME communities smoke less than their white counterparts.

The relationship between smoking and gender has been clearly evidenced in this HNA. Findings from the health questionnaires showed that male respondents from white ethnic, Asian, and black ethnicities have higher smoking rates than their female counterparts, with the majority of regular smokers being male and of white ethnic background. These findings correlate with data from the focus groups; several participants acknowledged smoking was more prevalent among males from older generations within their community, particularly in Pakistani and Indian communities. One participant stated:

“My granddad has smoked all of his life and his dad smoked too, this is something that happens in family and in my community” (Young Pakistani male)

Data from the Nottingham citizen survey (2011-2015) suggests that females from Asian backgrounds smoke less frequently than females from other ethnicities. Again, these findings are in line with the data from the health questionnaires which show that mixed black women and white women have higher smoking rates than Asian women. These findings are in line with data from the Nottingham Citizen survey (2015) and Karlsen et al (2011) in which Black Caribbean and white women are more likely to report frequent smoking than Asian women. There appears to be low smoking rates among Asian women, the reasons for which have been attributed to cultural behaviours and beliefs (Karlsen et al 2011).

Age can also be a predictor of smoking. The majority of respondents who participated in the questionnaire were in the 25-34 and 35-44 age groups and were less likely to report smoking regularly than those in the 55-64 age group. This is similar to findings from the Nottingham Citizen Survey which

suggests that people in the 16-24 age group from BME communities do not smoke on a regular basis (Citizen's Survey 2015). Interestingly, these findings do not correlate with the published literature: Wilcox (2014) found that smoking prevalence peaks in the 25-34 age group and decreases with age.

11.1.2 Healthy eating

Responses to the focus groups suggested that one of the main issues for people not eating a healthy diet was due to both affordability and lack of knowledge on how to prepare healthy meals; one participant stated:

"It is more expensive to buy health food, and then you have to know how to cook it"
(Black Caribbean male)

These findings correlate with the evidence from the Nottingham JSNA obesity chapter (2016) which identifies income deprivation and lack of knowledge as a barrier to maintaining a healthy diet. A NCC-commissioned local research study in 2011 identified approaches to developing healthy living interventions in people aged 40 and over who were overweight. The study showed that the participants had an understanding of the need to lose weight but possessed limited understanding of how to do this. Participants felt they had a lack of motivation and knowledge and therefore found it challenging to lose weight; they also felt that traditional dieting was not for them as it did not fit in with the 'male psyche'.

In line with these findings, HNA questionnaire responses highlighted lack of knowledge as a key barrier to maintaining a healthy lifestyle. Interestingly, the majority of respondents who felt that knowledge was a barrier to healthy eating were from 'Other' ethnicities and Asian ethnicities (49%).

These findings are in line with responses in the focus groups where several participants identified knowledge as a key barrier to both making healthy choices and accessing services. Participants agreed that culturally-tailored information should be available and accessible in different languages. In line with these findings, local research studies, such as Bowel Cancer Screening in BME Communities (2015), recognised that Nottingham's BME population requires accessible information to maintain a healthy lifestyle and to support positive behaviour change.

Furthermore, findings from the focus groups showed that some participants felt they had a lack of motivation and limited knowledge of how to maintain a healthy diet. Participants acknowledged

traditional diets could be a barrier to maintaining a healthy weight as they are high in fat and salt and this was linked to ingrained behaviours. One participant stated:

“It’s really hard to be healthy when you are used to eating traditional food, you get used to the way it tastes and it’s hard to change” (older Asian male)

Local research concurs with these findings. Nottingham CCG commissioned a study to better understand the barriers to BME groups in accessing primary and secondary long-term condition services (2015) and found that, overall, cultural factors have a considerable influence on health and diet. Interviewees talked about their diets and the richness of food and the cultural practice of adding oil and salt to food. One participant stated:

“What we eat and what you eat is a huge difference, we have oil and were cooking curries in oil and Asians add a lot of salt. I don’t but other people do” (Female Pakistani, diabetes)

Interestingly, the qualitative responses in this HNA contradict findings from the Health Survey for England (HSE) (2014) which examined the fat intake of minority ethnic communities and concluded that BME men have a lower fat intake than their white counterparts, with the least intake being among Indian and Black African men. Moreover, the HSE results showed that women recorded a considerably lower fat intake than the mainstream white population with Chinese, Pakistani, Bangladeshi and Black Caribbean women having the least intake. (Craig et al, 2006).

Responses to the HNA health questionnaires showed a polarised opinion on whether “The food available in the UK is not as natural and nutritious as my country of origin”, with many strongly agreeing and many others strongly disagreeing. Although this statement did not ask about the nutritional value of traditional foods, it does provide an understanding of people’s perceptions of traditional food in comparison to the food available in the UK.

Several participants in the focus groups stated that people from BME backgrounds prefer traditional foods and cook with high levels of fat and salt. Again, the literature contradicts these findings and suggests there is no reason to assume that salt use is higher in the BME community than the general population (DH Insight 2007). It would be prudent to consider the possible reasons for the dissension between the qualitative findings and the literature. The reason for the disparities could be due to a

lack of local and national evidence around the diet and nutrition of BME communities which would suggest there is a gap in evidence and that more research is needed in this area.

11.1.3 Physical activity

The findings from the questionnaires show that 71% of respondents agreed or strongly agreed with the statement, “The cost of leisure facilities is a barrier to participating in physical activity”. This is in line with the findings from the focus groups which showed a consistent agreement across all groups that affordability was a key barrier to physical activity. One participant stated:

*“When you have so many bills to pay, going to the gym is so expensive, so you just don’t go”
(Young Polish male)*

However, one participant stated otherwise and highlighted that there are several local activities available for a small affordable cost, which implies that people are not aware of the services available to them:

*“There are a lot of cheap gyms, people aged 13-26 can use the gym for 50p at NGY”
(Black Caribbean male)*

The perception of the expense of local leisure facilities could be due to a lack of awareness of local services; if so, this is in line with the literature which suggests that BME groups have a lack of knowledge and understanding around the existence of various facilities and services. Poor English language skills are also identified as a significant reason for not accessing local services (Koshoedo et al., 2015). Further evidence suggests additional resources need to be invested to ensure services are equitable and accessible to all groups (Mainous et al, 2006).

The literature also suggests that not all services are culturally sensitive, which can act as a barrier to some BME groups undertaking physical activity (Leung et al., 2011). This issue was highlighted in the focus groups with some participants stating that they felt services do not meet their needs and are not culturally appropriate; for example, a lack of women-only gym sessions. This was reflected in the free text of the questionnaires where several respondents highlighted the importance of culturally-appropriate services in encouraging women to take part in physical activity. One respondent stated:

“More local gym sessions for Asian women are needed to help us network in an environment free from men” (Asian female)

These findings are in line with local research studies which have recognised that culture and religion may affect compliance or access to services. Gender was commonly mentioned as an obstacle to service access by women (Increasing the uptake of primary and community long term conditions services in BME communities in Nottingham, 2016).

National evidence also supports these findings; a systematic review found that the participation of BME minority groups in sport and recreation was lower in comparison to white groups. However, the study found that Bangladeshi and Pakistani men engaged more in specific sports such as football and cricket (Koshoedo et al (2015). These findings concur with those from the HNA focus groups where Pakistani and Black Caribbean men highlighted the need for sports that are culturally appropriate and gave the example of cricket, with one participant stating:

“My dad is from the Caribbean and loves to play cricket, if we had more opportunities for him to play I know he would definitely be interested” (Pakistani male)

Unfortunately, there is no local data on physical activity participation by ethnicity as this information is not routinely collected. Without this information it is challenging to establish whether citizens from BME communities in Nottingham are more or less physically active than their White British counterparts.

There is a relationship between ethnicity and low uptake of physical activity which appears related to a lack of awareness of local services and there being few activities that are culturally appropriate and which meet the needs of the individuals and communities. The relationship between physical activity and ethnicity should be examined further at a local level, building on the Nottingham Physical Activity JSNA chapter (2016).

11.1.4 Alcohol and drugs

The responses to the questionnaire show that the majority of respondents, 83% (⁶¹³/₇₄₁) disagreed or strongly disagreed with the statement, “I drink alcohol 3-4 times per week”. This is a significant finding and would suggest that people from many of Nottingham’s BME communities do not consume alcohol on a regular basis. Conversely, respondents agreeing or strongly agreeing with the statement were more likely to be from a white ethnic background (26%).

These findings correlate with findings from the Nottingham Citizens' Survey (2015) where white ethnic respondents were identified as having an increased or higher risk of alcohol consumption (8%), followed by 6% for mixed ethnicities, 3% for Black/African/Caribbean, 2% for other ethnicities and 1% for Asian ethnicity.

The findings also reflect the national literature which suggests that people from white ethnic backgrounds have lower rates of abstinence and higher levels of drinking compared to most black and minority ethnic groups (Hurcombe, Bayley & Goodman, 2010).

Local evidence supports the findings of the consultations and literature in identifying white non-British groups as being at higher risk of alcohol consumption. Figure 43, taken from the Citizens' Survey, shows the percentages of alcohol drinkers who binge drink by ethnic groups. The evidence shows the white non-British population to have the highest percentage of binge drinkers (23.5%), followed by 23% for White British, 19% for mixed ethnicities, 14% for Black/African/Caribbean, and 12% for Asian ethnicities.

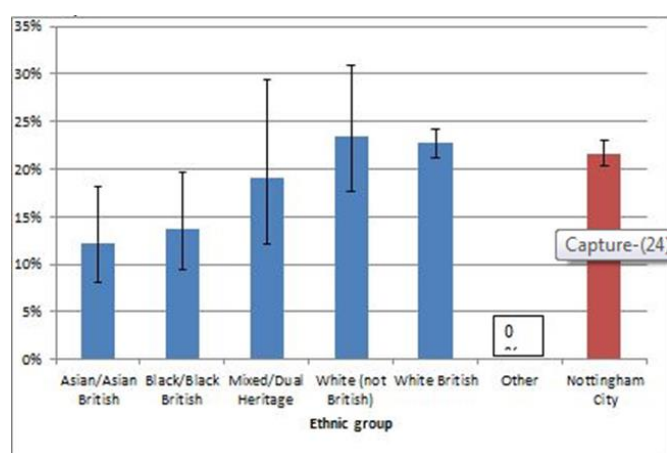


Figure 43: percentages of alcohol drinkers who binge drink by ethnic group

Source: Citizens' Survey (2012-14)

According to the literature, older males of white and Irish ethnic backgrounds have higher rates of unsafe drinking, with lower rates within Black African, Black Caribbean and Asian groups (Rao et al., 2015). These cannot be compared to the health questionnaires due to the sample size and only 13% of respondents being 60 years and above and 17% of respondents being from white ethnic backgrounds. However, feedback from the focus groups and additional local intelligence would suggest this is the case; a male respondent from the Czech Republic stated:

“Drinking alcohol is tradition in my family, my dad and my granddad are heavily drinkers, I also like to drink, and this is what we like to do especially when we are all together” (Older Czech Republic male)

Participants from the focus groups discussed alcohol consumption as a risk factor for mental illness, with particular reference to the younger population. Within the discussions, alcohol was not highlighted as a risk factor for physical health conditions; there seemed to be an understanding within the Polish community that alcohol affects your mental health but has no bearing on physical health:

“Alcohol is good and can help to relieve your stress, but this does not help your mental health” (Young Polish male)

Within the focus groups, education was highlighted as an issue where participants felt current services designed to educate people on the harmful effects of drugs and alcohol do not meet the needs of the BME community, with reasons such as poor language skills, a lack of interpreters and health messages not being accessible being identified as areas for concern. Similarly, findings from the questionnaires showed that 71% of respondents agreed or strongly agreed with the statement, “It is important to have culturally-tailored services”, with the vast majority of Asian respondents (75%) concurring, followed by Black/African/Caribbean ethnicity (71%). One participant stated:

“Projects such as FRANK and DARE do not educate BME people on what they need to know regarding drugs and alcohol, services do not speak your language and the service is targeted at white people” (Young Black African female)

These are in line with the findings of the literature. The coalition Government’s 2010 Drug Strategy (Home Office, 2010) for substance misuse identified that drug and alcohol services are not responsive to the needs of specific BME groups. In addition, the 2012 Alcohol Strategy does not discuss the importance of meeting the needs of specific groups. The findings from the consultations and literature would suggest this is an area for further consideration.

The focus groups highlighted stigma and pride as a barrier for BME groups accessing treatment for drug and alcohol misuse. This was discussed at great length with Pakistani and Indian participants:

“Alcohol and drugs are a massive issue in my community. But you can’t seek help as this will bring shame and isolation to you and your family” (young Pakistani male)

These findings reflect the literature. A study by Beddoes et al (2010) reported stigma and shame as significant reasons that prevent individuals seeking treatment or revealing their drug/alcohol issue to family members, as well as denial, under-reporting and concealment of substance misuse. The results from the questionnaire also support these findings and showed that 71% of the respondents agreed or strongly agreed to the statement, "Pride, stigma and shame prevent people from my community seeking help when needed e.g. alcoholism, depression, and drugs", with the highest concurrence coming from Black/African/Caribbean groups (71%), followed by 69% for Asian ethnicities.

Furthermore, a study by Adfam (2015) showed that minority ethnic groups accounted for no more than 2% of the drug and alcohol treatment population, in addition to some ethnic groups being under-represented in the treatment system relative to the general population; individuals reporting their ethnicity as Pakistani, Indian or Black African, for example, each made up only 1% of the treatment population (Adfam, 2015).

The evidence in this report would suggest that that BME groups are not accessing health services according to their needs. Equally, it should be highlighted that, although the findings from the questionnaires show alcohol use within the BME community is not a major issue, feedback from the focus groups and evidence from the literature would suggest the problem could be greater than expected because of cases going unreported due to fear of stigma and cultural and social norms. This is therefore an area that needs to be further explored.

11.2 Mental health

Findings from the Nottingham Mental Health and Wellbeing JSNA (2015) found that people who identify themselves as belonging to an ethnic minority group report slightly higher mental wellbeing (53.24%) than those from a white background (51.14%). This contradicts the Office Of National Statistics (ONS) (2013) findings which suggest that people from BME backgrounds have lower levels of wellbeing than their non-BME counterparts.

The qualitative findings from this study would argue that people from Nottingham's BME community experience mental health inequalities due to challenges with accessing services, discrimination, stigma and socioeconomic issues. This was clearly demonstrated in the findings from the focus groups where

several participants from the Asian, Black African and Black Caribbean ethnicities stated that they or friends or family members had experienced discrimination and stigma in relation to their mental health. Participants strongly believed that black males are over-represented in acute mental health services and are more likely to be sectioned than their white counterparts. One participant stated:

“Black men are not treated the same when it comes to their mental health, they are harshly treated and usually arrested while disregarding their mental status, due to the stereotype of black men being seen as aggressive” (Young Black male)

There is a body of evidence to support these findings. A local report commissioned by the Nottingham CCG aimed to understand the experience of BME communities in Nottingham when seeking urgent and emergency support in a mental health crisis. The study interviewed people from BME communities who had experienced a mental illness and 21% of participants stated that discrimination and stigma were major barriers to seeking help with their mental health. Participants stated that they were embarrassed to admit they had a problem due to fear of stigma and would therefore try to deal with the issue themselves (Experiences and Views on seeking Support during a Mental Health Crisis, 2016).

In line with the findings from the focus groups, the ‘Listening to Experience’ report (2011) found that BME groups are over-represented in the crisis care system. The inquiry found variations in access to Crisis Resolution and Home Treatment (CRHT) with Indian, Bangladeshi and Chinese people having consistently low referral rates. These findings demonstrate that there are disparities and inequity of care between BME groups and the general population within mental health services.

The results from the questionnaire showed that 72% of respondents agreed or strongly agreed with the statement, “There is a direct relationship between physical health and mental health”. White respondents had the highest rate of concurrence at 85%, followed by 80% for Other ethnicities, 79% for Asian ethnicity and 71% for Black/African/Caribbean ethnicities, showing a consistency across all ethnicities. The results from the focus groups support these findings: several participants acknowledged a direct link between physical health and mental health. This was largely discussed in relation to long-term conditions, such as diabetes, cancer and heart disease. One participant stated:

“Managing your diabetes daily is very stressful, you feel different than everyone else, you just don’t feel normal in social gatherings and this has an impact on your mental health and you feel isolated and depressed. (Older Asian female)

These findings are reflected in the literature. A report by WHO (2010) showed that adults with enduring mental health problems can be one of the most socially excluded groups in society, experiencing stigma and wide-ranging social disadvantage as well as poor physical health outcomes. In addition, findings from the focus groups showed a majority of participants believed poor mental health to be influenced by wider determinants. Several participants highlighted issues such as unemployment, poor housing and poverty as key factors that affect mental and physical health. One participant stated:

“When you don’t have a job for example, you feel stressed about paying the bills, which impacts your mental health. And that will ultimately affect your physical health as well” (Black Caribbean male)

The literature supports these findings and highlights wider issues that influence mental health and wellbeing, including personal relationships, childhood experience, employment, housing, safety, the built and natural environment and experience of discrimination (WHO, 2010). Feedback from the questionnaires showed that 81% of respondents agreed or strongly agreed with the statement, “It would be useful to include mental health awareness within community group sessions”. The free texts greatly reflected these findings with several comments suggesting that mental health remains a taboo subject and that opportunities to discuss the subject in different settings would be welcomed. One respondent commented:

*“Wider awareness is needed to remove the stigmatized view of mental health”
(Female asylum seeker and refugee)*

In addition, a common theme highlighted throughout the engagement was the need for culturally-tailored services. This was reflected in the questionnaire with 71% of respondents agreeing or strongly agreeing with the statement, “It is important to have culturally-tailored services”. Although this statement is not specific to mental health services, the overall findings are relevant to the mental health theme and this is supported by the literature. A report by Mind (2013) highlighted culturally-tailored mental health services as an important enabler for BME groups. The report found mental health services to be culturally inappropriate that did not meet the needs of BME groups, for reasons

such as a lack or limited availability of interpreters, as well as a dearth of psychological therapy in community languages and staff not understanding cultural needs.

The findings from the focus group are consistent with the literature. Several participants discussed their experiences of accessing health services with issues such as language barriers and services not being culturally-appropriate being main points of concern. Although the majority of discussions were in relation to health services in general, there were some specific to mental health, particularly within the Black African/Caribbean, Polish and asylum seeker and refugee groups. One participant shared his experience of accessing a mental health service and stated:

“I was referred to a service by my GP as I suffer with depression, but when I got there no one spoke my language, they could not get an interpreter and it made my anxiety even worse, I was very stressed and I didn’t go back” (Young Polish male)

Feedback from the questionnaires showed that 60% of all respondents agreed or strongly agreed with the statement, “I trust my GP will refer me to specialist services when needed”, this figure being 71% for respondents from Asian ethnicities, by 58% for white ethnicities and 56% for both Black and Mixed ethnicities. The findings from this statement show that the majority trust their GP to refer them to the appropriate services; however, the findings from the focus groups would suggest that, once referred, people experience barriers due to language skills and services not being culturally appropriate.

The literature also found that BME groups present late and are more likely to bypass primary care and be admitted straight to a psychiatric hospital, the reasons for this being attributable to stigma and cultural norms (Redman, 2012). Feedback from the focus groups supports these findings. Several participants, mainly from the Asian and Black Caribbean groups, stated that BME males were less likely to access primary care or to seek health for their mental health due to associated stigma; one participant stated:

“It is hard to admit we have a problem, when you mention the word mental health, you are automatically labelled as being ‘crazy’, so you just keep it to yourself and try to manage” (Asian male)

Interestingly, one of the focus group participants expressed a concern around seeing a healthcare professional from similar ethnicity due to fear of stigma from his own community:

“If I had mental health issues or suffering depression, I wouldn’t want to be seen by a Black doctor” (Young Black male)

The evidence in this report would argue that that BME groups are not accessing mental health services according to their needs. Equally, it should be highlighted that, despite the use of validated data collection methods, this data may be influenced by cultural attitudes towards mental health. It is possible that the “hidden burden” of mental health is proportionally greater for ethnic minority groups than for those who are White British. Therefore, the problem could be greater than expected; highlighting this is an area for further research.

11.3 Sexual health

Whilst sexual health is an important issue, it was not directly featured on the questionnaire due to length restrictions. However, it did emerge as a topic of discussion within the focus groups but not to the extent of other health concerns. The reasons for this limited amount of discussion are unclear, although it could be related to cultural and social norms – for example, participants feeling uncomfortable discussing the subject in mixed gender groups; fear of stigma; or they did not consider sexual health a priority compared to other health concerns.

In line with this hypothesis, the literature shows that sexual health is a taboo subject within the BME community and is not openly discussed in group settings due to fear of stigma and cultural bias (Holland, 2010). Further research shows that BME groups have poorer health, including sexual health, compared to the white population. Local evidence shows that BME groups in Nottingham experience poorer sexual health than their white counterparts. (Nottingham Local Authority HIV, Sexual and Reproductive Health Epidemiology Report (LASER), 2015).

Local intelligence shows that the number of HIV-diagnosed persons in Nottingham City has been steadily increasing since 2006 and between 2008 and 2012 there was a 32.2% increase (SOPHID data 2016). Data also shows that in 2013, the numbers of new HIV diagnoses were significantly higher in the Black African, Black Caribbean and Black other communities in contrast to their white counterparts. Interestingly, within these three ethnic groups, 64% of all new diagnoses were in males and 36% in females (SOPHID data 2016).

The evidence shows there are huge inequalities in HIV diagnosis among Nottingham's BME population in Nottingham. The reasons for this are unclear, however it could be related to the influx of migrants. Furthermore, evidence would also suggest that poorer sexual health outcomes amongst the BME population is often linked to lower socioeconomic status, as well as to additional factors such as poor communication due to language problems; concerns regarding confidentiality; and judgement by health professionals of the same ethnicity (Griffiths, 2008).

Interestingly, some of these findings were reflected in the focus groups: a common theme around language barriers emerged and there was a view among some participants that ethnicity of the health professional could be a barrier, although this view was not shared across all groups. While these discussions were not directly in relation to sexual health, they are relevant. One participant stated:

"I am not bothered about the ethnicity of my doctor, I just need them to understand my needs and give me the right treatment" (Young Asian female)

Furthermore, sexual health was discussed in a wider context within two groups: the mixed gender young people's group and the asylum seeker and refugee group. Both groups acknowledged sexual health as a taboo subject but were comfortable to discuss the subject. The young people's group discussed contraception. There was a view that Black Caribbean females react differently to contraceptive methods due to their biological makeup and should therefore be treated according to their needs. One participant stated:

"Being from the Black community we are genetically different. Take the contraceptive pill, it works differently on Black women" (Young Black Caribbean female).

There was no evidence to demonstrate this finding, although it was the view of a minority. It is concerning that young individuals have such a belief and raises questions around people's understanding of the relationship between ethnicity and health.

The asylum seekers and refugee group discussed cervical cancer screening and sexual health. Participants agreed that stigma prevented females from attending cervical cancer screening due to fears of the association of sexual health-related diseases. One female participant talked about fear of being screened in her home country. However, when in the UK, she was screened and educated and

came to understand that cervical screening was not related to sexual health. The participant commented:

“There is a lack of knowledge and understanding within certain communities, and as a result can act as a barrier for accessing services and seeking early interventions” (Black African female)

The findings would suggest that the underestimation of perceived risk, lack of knowledge of sexual health issues as well as fear of discrimination and lack of confidentiality all play a role in uptake of sexual health services within the BME community. Further work is needed to address this in order to improve the sexual health outcomes for BME groups in Nottingham.

11.4 Long-term conditions

11.4.1 CVD

There is a lack of local data around ethnicity and CVD therefore the discussion is based on the findings from the qualitative research and the wider literature. Whilst CVD is a very important issue it did not directly feature in the questionnaire due to the focus being on establishing an understanding of BME health needs in general. However, lifestyle risk factors, including smoking, alcohol, healthy eating and physical activity featured in the questionnaire and are relevant in preventing long-term conditions, including CVD. A summary of the findings for lifestyle risk factors are discussed in section 9.3.1 of this report.

Although CVD was not discussed in isolation, there were comments within the free text from the questionnaires which showed a general consensus among respondents that low uptake of physical activity and eating a diet high in fat and sugar increases the risk of CVD. Several respondents from Pakistani and Black Caribbean communities acknowledged that CVD is a problem within their community, particularly with first and second generations, but not exclusively. One participant stated:

“My dad suffered a heart attack, he was overweight and never exercised, it’s only when this happened that he started to lead a healthier lifestyle” (Black Caribbean male)

Respondents were aware of the risk factors associated with CVD and acknowledged the barriers preventing people from leading a healthy lifestyle. Issues such as poverty, the cost of healthy food, education and knowledge, cost of gyms, and access to services were highlighted as key issues.

Furthermore, the findings from the focus groups were in line with findings from several local research studies where it has been acknowledged that deprivation and socioeconomic issues drive ill health among BME communities in Nottingham. The 'Hear Me Now' report (2013) describes the inequalities of prostate cancer among Black Caribbean males and clearly highlights that people from BME groups experience multiple disadvantage as a result both of being from an ethnic group and because of their socioeconomic status.

In line with these findings, there was a general consensus across all focus groups that social and economic factors prevent individuals from making healthy choices which increases the risk of long-term health conditions such as CVD. One participant stated:

"There are so many things that stop you from making healthy choices, money is a big issue, not having a job and not knowing how to prepare healthy meals are just some of them"(Young Asian female)

The evidence shows that people from BME groups share similar concerns and experiences around barriers to leading and maintaining a healthy lifestyle which include education, barriers to accessing services, cost of fitness membership and the cost of healthy eating. The qualitative findings strongly suggest that affordability and social determinants are linked to poor health outcomes for BME communities and which increase the risk of long-term conditions such as CVD. The lack of local ethnic monitoring data is a limitation; commissioners need robust data to commission services that meet the needs of BME populations.

11.4.2 Cancer

Again, whilst cancer is a very important issue, it was not directly featured in the questionnaire. However there were statements on lifestyle risk factors which are relevant to the prevention of cancer. A summary of the findings for lifestyle risk factors are discussed in section 9.3.1 of this report.

The evidence shows that in England, despite improvements in current ethnic data collection, there is still an incomplete picture of cancer in BME groups due to inconsistent ethnic data collection nationally and at a local level (National Cancer Intelligence Network, 2012). The limitations with data on ethnicity mean that local commissioners lack robust data to commission cancer-specific services to meet the needs of BME populations.

Cancer was not discussed in depth within the focus groups, with the exception of one group, where the inequalities in prostate cancer among Black Caribbean males in Nottingham were discussed at length. The participants from the group were all male, with the majority being from a Black Caribbean background. They shared their personal experiences and appeared to have a good understanding of the inequalities in prostate cancer among Black Caribbean males. They discussed how black men have experienced insensitive behaviour on the part of some healthcare professionals, with one participant stating:

“When I finally got the courage to go to my GP and tell him my concerns he did not explain the process to me or even try to ease my anxiety” (Black Caribbean male)

Participants across several focus groups touched upon cancer when discussing issues around culture and predisposition. Participants acknowledged that older generations consider cancer, diabetes and heart disease as conditions that cannot be prevented and are something you acquire with age. One participant stated:

“My dad has lung cancer and he was diagnosed at 70, he believes that his diagnosis is God’s will and there is nothing he could have done to prevent it” (Asian male)

Participants from the focus groups discussed issues around socioeconomic and environmental factors, including income deprivation, poverty, poor literacy skills, education and poor lifestyle. Whilst these were not discussed within the context of cancer, evidence suggests that these factors are transferrable across all health conditions and are key issues that impact upon the health and wellbeing of BME communities and can increase the risk of physical and mental health conditions (Kelleher, 2011).

The evidence strongly suggests that there are inequalities in cancer. The lack of local ethnic monitoring data is especially limiting and presents significant barriers and challenges for commissioners when designing services to meet the needs of the BME population.

11.4.3 Diabetes

Again, whilst diabetes is a very important health condition, it was not directly featured in the questionnaire due to the focus of the questionnaire being to establish an understanding of BME health needs in general. Moreover, within the free texts of the questionnaires and the discussion in the focus groups there were very few comments relating to diabetes. The reasons for this are unclear. However,

lifestyle risk factors, including smoking, alcohol, healthy eating and physical activity featured in the questionnaire and were discussed in the focus groups. Lifestyle risk factors are important in preventing long-term conditions, including diabetes. A summary of the findings for lifestyle risk factors are discussed in section 9.3.1 of this report.

Yet again, there is a lack of local data around ethnicity and diabetes, therefore the discussion is limited to the findings of the qualitative research and the wider literature. Diabetes was not discussed in depth within the focus groups; however, as mentioned earlier, participants highlighted socioeconomic and environmental factors as key barriers. Whilst these issues were not directly discussed in relation to diabetes, they are relevant and evidenced to be cross-cutting themes that impact upon long-term conditions (WHO, 2011, Marot 2010, Kelleher 2011).

In 2015, the Nottingham CCG commissioned a local research study to explore the uptake of primary and community long-term conditions services in BME communities, with a specific focus on diabetes. Interestingly, the findings of the study showed that BME groups shared similar concerns and experiences around health and access to health services relating to: language and communication barriers; awareness and education; cultural and religious norms; the built environment; socioeconomic status; discrimination and access to health services. Further findings from the report showed a significant knowledge gap around the symptoms and management of diabetes, which concurs with the findings from the focus groups where several participants admitted to knowing nothing or very little about their own health condition. One participant stated:

“I only know what the professionals tell and I am not sure how to manage my health condition and I don’t know where to go if I need help in my community” (Pakistan female)

A survey conducted by BME Cancer Communities in Nottingham in 2009 found that 36% of BME people were not sure or were unfamiliar with the signs and symptoms of cancer and 47% did not know how to reduce their cancer risk. At the same time, 55% had a family member who had experienced cancer. These findings are in line with the findings from the focus group where several participants, particularly from the Black Caribbean and Asian communities, acknowledged that people from their community have little knowledge or understanding of health and health-related issues. Several participants highlighted that more education is needed to improve the knowledge of certain communities and there was a view among some participants that this would significantly help people

to manage their health and so help to improve the health and wellbeing of BME communities. One participant stated:

*“It’s not that we do not want to live a health life and be responsible for our own health, its more to do with knowing what you need to do and having the confidence and knowledge to do it”
(Elderly Asian female)*

Further findings from the CCG (2015) report showed participants expressed a preference for healthcare professionals who were of a similar culture, so that cultural needs around diet and food would be better understood. A British African participant with type 2 diabetes explained the importance of food, culturally, and how difficult it can be to explain diet to a healthcare professional outside of that culture. These findings are also in line with the findings from the focus groups where participants agreed that they prefer to see healthcare professionals from their own culture; however, there was disagreement when discussing issues associated with stigma such as mental health and sexual health; some participants were less likely to want to see a health professional from a similar culture due to fear of stigma from their own community.

11.5 Language and communication

Feedback from the focus groups constantly highlighted language as a principal barrier to the uptake of services by BME communities. A number of key issues related to language were revealed to include: a lack of sensitivity to language differences by healthcare professionals; challenges of using professional interpreters; challenges of using family members as interpreters; and challenges with resources not being available in different languages. One participant reflected the views of several groups when stating:

“When I go to the doctors I don’t understand what they are telling me and there are no interpreters available, I ask one of my family members to explain it to me as I do not understand English (Black African female).”

The findings from the questionnaires also highlighted communication as a principal barrier. As previously mentioned, 77% of respondents agreed or strongly agreed with the statement, “Culturally-tailored information is important when helping people to manage their health condition”. Whilst this statement is not directly referring to language as a barrier, it is significant as it clearly demonstrates

that overall, communication is a key barrier and a very important issue for the BME community. Within the free text, one participant stated:

“When you do not speak or read English, seeking medical help is very hard, I rely on family members to help me and they are not always available” (Polish female)

Evidence from local research studies also highlight language as a principal barrier to the uptake of services by BME communities (Bowel cancer screening in BME communities in Nottingham (2015). Increasing the uptake of primary and community long-term conditions services in BME communities in Nottingham (2016) ‘Hear me Now’ (2013) revealed a number of key issues related to language, including a lack of sensitivity to language differences by healthcare professionals; barriers to accessing GP appointments; poor English language skills being associated with undetected health problems; the challenge of using professional interpreters; and challenges with maintaining confidentiality and accurately expressing patient health problems and emotions to healthcare professionals.

These findings are consistent with those garnered from the focus groups and questionnaires where participants highlighted very similar challenges when trying to access health services. One participant shared her experiences of trying to access her GP and stated:

“I try to get an appointment to see my GP I am faced with so many barriers, firstly they don’t speak my language or understand me or my needs, no interpreters are there, then they ask if I am an asylum seeker, I don’t know why they need this information, but when I say yes I never get an appointment, I have to wait 2 weeks” (female asylum seeker and refugee)

Interestingly, the feedback from the focus group is very similar to the findings from a local research study commissioned by the Nottingham CCG which aimed to understand the uptake of primary and community long-term conditions services in BME communities in Nottingham. Both consultations found language and communication skills to be one of the greatest barriers for BME communities when accessing health services. One respondent from the CCG consultation shared her past experiences of seeing a doctor with whom she struggled to communicate due to language barriers. She felt that the doctor withheld information about other primary and community services that she might have been able to access for her diabetes. This participant also expressed concern about inconveniencing people when arranging interpreters to accompany her to other diabetes services; she stated:

“It’s too much trouble to others to have to arrange an interpreter to go to a group so I just won’t go” (female, 68, British Chinese, diabetes) (CCG, 2016).

In line with these findings, one participant from the focus group stated that, rather than inconveniencing her friends or family members by asking them to accompany her to a GP appointment, she would rather miss the appointment. She stated:

“Everyone is always so busy and I don’t want to burden them, I would rather miss my appointment than to inconvenience my family” (Asian female)

The findings from the research are conclusive in showing that poor language skills are a significant barrier for BME groups when accessing services. These factors affect an individual's ability to communicate with health professionals about their health needs and as a result prevent people from accessing health services and present significant challenges for people for the BME community and service providers alike.

11.6 Knowledge and education

The findings from the literature are in line with the findings from the focus groups and questionnaires and are conclusive in showing that there is a lack of information targeted at BME communities around service provision (Mainous et al., 2006, Knifton, 2012). Evidence would suggest that people from BME communities are not always aware of the services that are available to them and, most importantly, how best to access them. Feedback from the focus groups concluded this to be a significant issue; one participant stated:

“I’m sure there are lots of services for my community but the problem is knowing where they are and how to access them, more information is needed” (Asian male)

The literature found that lack of knowledge and education are principal barriers to the uptake of services by BME communities. A number of key issues were revealed, including: language skills presenting barriers to accessing services; materials not being available in different languages; and health messages being generalised and not targeted at specific communities (Mainous et al., 2006, Knifton, 2012).

In addition, findings from the questionnaires showed that 42% of respondents agreed or strongly agreed with the statement, “People from my community lack the knowledge required to maintain a healthy lifestyle”, further demonstrating that BME communities feel there is a gap in health-related knowledge and education. This was also reflected within the free text with one respondent stating:

“When you get a letter asking you to go to the doctors but you don’t understand why and if you are scared to go, you just ignore it and carry on with your life” (Polish female)

These findings conclude that knowledge and education present significant barriers for people from BME communities when leading and maintaining a healthy lifestyle and when accessing services. The evidence shows that some BME groups have a lack of baseline knowledge and awareness of health conditions which can act as a considerable deterrent to seeking medical advice and treatment in the first instance. Furthermore, a lack of adequate channels of learning and education, which are tailored to particular BME communities, means that people may fail to recognise their symptoms or connect them to a particular condition.

11.7 Access to services

Difficulties with accessing services were identified as a key barrier for BME communities. Feedback from the focus groups and questionnaires revealed that language and communication skills, awareness and education and cultural and religious norms are key challenges when accessing health services. Discussion throughout the focus groups revealed that the majority of participants were dissatisfied with the flexibility and convenience of GP appointment times and several participants felt that the appointment booking system at their local surgeries prevented them from accessing their GP.

Issues such as long waits for appointments, complicated telephone systems, a lack of interpreters and continuity of staff were identified as key challenges and created unwillingness in people in attending their GP. One participant stated:

“The GP booking system is a nightmare, it’s complicated, they don’t understand your language and you can never get an appointment, it’s so frustrating, the whole system needs to change” (Black Caribbean male)

In line with these findings, feedback from the questionnaires showed language skills are a key barrier when accessing the GP, with 73% of respondents agreeing or strongly agreeing with the statement, “Standard GP appointment times should be increased when an interpreter is needed”. One respondent commented within the free text:

“People recognise there is a problem but do not go to their GP due to language barriers and no available appointments, sometimes the nearest available appointment is 2 weeks away” (Czech Republic male)

Furthermore, feedback from the focus groups also revealed a mixed level of dissatisfaction with the flexibility and convenience of GP appointment times and the difficulties of booking an appointment. While some participants spoke positively about their experience of making an appointment, others encountered difficulties with the appointment booking systems, faced language barriers, and had issues with accessing interpreters. One participant commented:

“It’s very difficult to get an appointment, you have to call reception as soon as they open, but they are always engaged and when you finally get through all the appointments are gone and you’re told to try again tomorrow” (Elderly Asian female)

The literature supports these findings: the CCG Exploratory Research Study (2015) identified a number of barriers to the uptake of primary and community health services in relation to cultural appropriateness; for example, the location and proximity of services to the community as well as opening times were found to be key barriers, in addition to language skills and education and awareness. Interestingly, the findings of the literature correlate with the findings from the focus groups in showing that language skills and the geography of health services present significant challenges.

The evidence from the consultations and literature concluded that BME groups experience challenges around accessing health services due to a complexity of issues and challenges around services not being appropriate and attentive to specific cultural needs.

11.8 Religious and cultural barriers

The findings from the focus groups revealed that the role of religion and culture is significant in influencing a person’s health and wellbeing. Religion was acknowledged as a positive lever in influencing health behaviour. There was an agreement across the groups, particularly among the

Muslim participants but not exclusively, that community leaders play an educative role in their community using religion to influence change. One participant reflected the views of several when stating:

It's hard to get the elders to listen and change their habits. If the messages come from our community leaders they are most likely to listen as they respect them and trust what they say"
(Young Asian male)

The literature supports these findings. The CCG Exploratory Research Study (2015) undertook interviews with members of the BME community and found that religion played a key role in influencing health and behaviour. These findings correlate with the feedback from the focus groups and questionnaires; for example, 81% of respondents agreed or strongly agreed with the statement, *"It is important to have health role models from different communities who understand cultural beliefs and can give advice and support"*. This statement clearly shows that community leaders have a key role to play in influencing the health and wellbeing in their community and there would be benefit in further exploring this. The free texts reflected these findings, with several respondents stressing the importance of religion and culture in influencing health behaviour. One respondent stated:

"Personally, I think that we need to work with our community leaders and educate them in health, this way they can share their knowledge with others and help people in their community to live healthier lives"

Furthermore, the findings from the CCG study also revealed that, for many participants, religious beliefs played an influential role in their view of health with huge amounts of faith and trust being placed in God as providing support above and beyond medical interventions. One participant firmly acknowledged that if they placed all their faith and trust in God it would help to keep them healthy:

"If we have aches and pains there is a prayer we can read, if you read this prayer and you have diabetes you can get it under control, if it was about depending on just medicine you would have passed away by now" (female Pakistani lady with diabetes) (CCG 2015)

However, the CCG research showed that the role of religion varied among the participants, with some stating that religion played no role at all, in contrast to the findings from the focus groups where the vast majority of participants acknowledged religion as playing a very important role in their lives. One participant stated:

“I am a very religious person and my religion is a very important part of my life, I have had many health challenges and my religion has helped me overcome them” (Pakistani female)

Whilst there was some variation in opinion, both studies found that health conditions are influenced by religious beliefs, which can sometimes act as a barrier to individuals seeking medical treatment when they trust that their faith will help them overcome ill health. This view was predominantly found amongst the Muslim participants where several participants in the CCG study affirmed their religious beliefs played a significant role in their health and wellbeing. One stated:

*“I trust God will help me look after my health and my diabetes, I have faith in God”
(Female Pakistani, diabetes) (CCGG 2015)*

One participant from the focus groups shared very similar views and stated:

“I believe that if you are struck with illness then this is God’s will, you have to deal with the hand you are dealt and put your faith in God” (Elderly Asian male)

The qualitative findings from both studies affirm that religion is a key factor in influencing the health and wellbeing of BME communities. Furthermore, there is an extensive evidence base to underpin these findings. A review of literature found that religious explanations such as “God's will” and “fate” were mentioned by Hindu participants who looked beyond medical explanations when trying to make sense of their health conditions (Kohli and Dalal, 1998). Knifton's (2012) research with three BAME communities cited their religious beliefs as a barrier to seeking treatment for mental health because they also viewed their condition as being the will of God, and therefore medicine was not seen as offering a cure.

In addition to the discussions around religion, culture was also a key topic within the focus groups and questionnaires and was largely discussed in relation to healthy lifestyles and the importance of having culturally-tailored services. Overall, there was recognition of various cultural factors that influenced health. Feedback from the focus groups and questionnaires highlighted diet and the cultural practices of adding salt, fat and sugar to food; this has been discussed in depth in section 9.3.2 of this report.

Feedback from the questionnaires and focus groups also highlighted the importance of having culturally-appropriate services; this was largely discussed in relation to physical activity and the provision of services that are gender-specific, this is discussed in more detail in section 9.3.4 of this report. The evidence strongly suggests that religion and culture play an important role in the day-to-day lives of people from BME communities and can be both a barrier and an enabler when influencing health behaviour.

11.9 Stigma and discrimination

Experience of stigma and discrimination was a recurring theme throughout the engagement. Some participants from the focus groups felt that services discriminated against them; this was raised in relation to employment, health services and, in particular, mental health services. There was a consensus across the groups that people from BME backgrounds are disadvantaged when accessing services due to discrimination related to their ethnicity. It must be noted that several participants, particularly from the Black Caribbean, asylum seekers and refugee and Asian communities, felt that discrimination adversely affected them, and several individuals shared their personal experience. One participant shared his experiences of trying to make an appointment with his GP and stated:

"I face discrimination when I try to get an appointment with my GP about my mental health. As soon as I say I am an asylum seeker with a mental illness the conversation ends and they do not give me an appointment, it makes me feel stressed and depressed" (Male asylum seeker and refugee)

A study by the Nottingham CCG (2015) undertook interviews with members of Nottingham's BME community to explore the barriers to accessing primary and community long-term condition services. The findings of the study are interesting as they refute the findings from the focus groups. The interviewees stated that they were unanimously happy with the service they received from health professionals and most had not experienced discrimination or felt they had been treated differently based on their ethnicity. However, there was one exception, which has shaped the participant's current view of health services:

"The doctor said some time ago, "how long has it been since you came here?" Why can't you speak English?" I said, "I've just come here" (Female Pakistani, respiratory condition)

Only a minority of interviewees expressed negative experiences and attributed those to language barriers and a lack of understanding, rather than to discrimination related to ethnicity. One participant stated:

“I don't think it's about being discriminated, I think it's a lack of understanding and its cultural knowledge about somebody's culture. They do ask you a lot of questions, particularly if you're diabetic. They have to check certain things which could be quite intrusive so I find that culturally offending” (Black African male with diabetes)

This is a significant finding and the reasons for the disparities are unclear. However, it could be attributed to the fact that mental health was one of the most frequently-discussed topics across the focus groups and evidence shows that mental health is associated with stigma. In contrast, the CCG consultation had a specific focus on diabetes and respiratory conditions and, whilst these are important health issues, they are not associated with stigma in the same context as mental health. Nonetheless, there are clear disparities between the studies with some stating they had not experienced discrimination when accessing services and others stating that they had.

Some research has sought to understand patient perceptions of discrimination in healthcare. Peek et al (2011) investigated associations between self-reported healthcare discrimination in relation to diabetes outcomes. Peek found that self-reported racial discrimination in healthcare was associated with worse diabetes care and more complications. Healthcare discrimination was unrelated to self-management in practices such as self-glucose monitoring, self-foot examinations, and participation in diabetes education. The findings from the study suggest that factors beyond a patient's own behaviour may be the main source of differential healthcare outcomes.

Participants from the focus groups also recognised that discrimination was a barrier to seeking employment opportunities, particularly for BME males from Black Caribbean and Asian communities. Participants shared experiences of seeking employment and not being successful; there was a perception that this is due to institutional racism and participants felt that there are a disproportionately small number of BME people in senior roles working in large organisations. One participant stated:

“There is a clear link between discrimination and employment; people from BME communities get a rough deal, they are either unemployed or on low wages with very little prospects compared to white people” (Black African male)

These findings are in line with the literature. Marmot's (2005) investigations into the social determinants of health inequalities revealed that socioeconomic determinants, such as work and unemployment, contributed to health inequalities in both developed and developing countries. BME communities generally experienced higher levels of poverty linked to lower levels of employment, lower pay and poorer conditions than the general population, all of which are also linked to inferior housing and physical environment (DOH, 2014).

Furthermore, local research studies identified discrimination and socioeconomic status as a determinant of health for BME groups. The 'Hear Me Now' report (2013) clearly highlights that people from BME communities experience 'multiple disadvantage' as a result of being from an ethnic group, their socioeconomic status, their age or another inequality factor. The report also documented that black men suffer discrimination in the workplace and as job seekers (Department of Health, 2011). For example, in Nottingham City the black community has the highest rate of unemployment amongst all ethnic groups: 16% black and black British people are unemployed compared to 6% of white people. The mixed ethnic group in Nottingham has 12.9% unemployment (Department of Health, 2011).

The evidence clearly shows that socioeconomic factors have a bearing on differences in health outcomes experienced by many BME communities. It also demonstrates that BME individuals are more likely to be further disadvantaged by discrimination and this was reinforced in the discussion across the focus groups.

11.10 Socioeconomic and environmental factors

The focus groups and questionnaires identified that socioeconomic factors such as financial pressures, income deprivation, unemployment, poor housing, education, the cost of leisure facilities and the affordability of healthy food were significant barriers to maintaining a healthy lifestyle. Feedback from the focus groups reflected this with several participants identifying income deprivation and employment as the main factors affecting their health and wellbeing. Furthermore, there was a consensus across the groups that socioeconomic factors led to an increased risk of mental health illness. One participant stated:

“The pressure of not having a job and having no qualifications is very stressful; you can’t live a good life and provide for your family, this is depressing and really affects your mental health” (Polish male)

These findings are in line with the literature. Marmot (2005) recognised the link between poor health and socioeconomic status. Further evidence shows that people from BME communities face significant health inequalities and experience poorer health than the general population (Department of Health (2009). A research study by the Nottingham CCG (2015) interviewed members of Nottingham’s BME community to further understand the barriers to the uptake of primary and community services. It concluded that financial circumstances often influenced the extent to which people can maintain a healthy lifestyle. Managing conditions such as diabetes, through eating a healthy diet, was sometimes difficult as healthier food was perceived to be more expensive. The cost of travel was identified as a barrier to attending health appointments, with one participant stating:

“When I wanted to go to the gym, I couldn’t afford to keep going by bus, its £3 or £4 so money does play a big part” (Female 30, Pakistani, diabetes)

These findings are in line with those from the questionnaires: 81% of respondents agreed or strongly agreed with the statement, “The cost of using leisure facilities (eg: gym, exercise classes, swimming, etc) is a barrier to participating in physical activity”. This clearly shows that money is a barrier to accessing services and leading a healthy lifestyle. Feedback from the focus groups concur with these findings with the majority of participants stating that money deprivation was one of their greatest challenges: exercise classes and gym membership were viewed as luxuries and travelling to them was unaffordable. One participant stated:

“I have no money to go to the gym, I can just about afford to live and feed and clothe my family, the gym is a luxury I just cannot afford” (Polish female)

Further feedback from the focus groups showed an increasing emphasis on the impact of the built environment with several participants linking obesity and unhealthy lifestyles to where they lived. Participants highlighted the importance of the built environment and discussed issues such as the planning of fast food outlets, obesity, accessing open spaces, housing and homelessness, fuel poverty, sense of belonging and affordability. A detailed discussion on the findings can be found in sections 9.4.1 - 9.4.5 of this report.

According to the District Level Index of Multiple Deprivation results (2011) Nottingham ranks 20th most deprived out of the 326 districts in England using the Average Score measure. Furthermore, the Nottingham Demography and Social & Environmental JSNA (2015) identifies the link between health outcomes and socioeconomic and environmental factors and recognises Nottingham's elevated levels of deprivation, low educational attainment and unhealthy lifestyle to be interrelated determinants of poor health outcomes and high level of health inequalities.

Ethnicity and socioeconomic status are often reported to have close associations within the UK population. In Nottingham, 54% of the Black/Black British Group live in communities in the two lowest quintiles of deprivation in the City, compared to 33% of Asian/Asian British population and 38% of White British population. Encouragingly, there is a strategic drive to address the determinants of health in Nottingham City. Nottingham's Health and Wellbeing Strategy (2016) recognises that social and environmental factors impact upon health and wellbeing and sets out measures to create an environment in which people can live healthier lives with a greater sense of wellbeing.

12. Strengths and Limitations

12.1 Strengths and limitations of the engagement work

It is hoped that this HNA will provide valuable information on the distribution, profile and health needs of the BME communities in Nottingham. There are several strengths and limitations to be considered in relation to the engagement plan and the data collection. This section of the report will consider these limitations in light of the findings.

12.1.1 Strengths of the engagement plan

- Robust and far-reaching engagement plan supported by a multi-agency steering group.
- The engagement was community-based and citizens appreciated “not being expected to come to you”; this enabled better engagement and allowed specific communities to be targeted.
- Working with key stakeholders to make the best use of limited resources.

- Working with, and through, local communities utilising the skills of multi-lingual members of staff and volunteers.
- Robust and far-reaching engagement plan supported engagement with communities whose voices are less often heard.
- Partnership working with NCVS was useful in helping to build relationships with the community and voluntary sector and in supporting the delivery of the engagement plan.
- Support was provided by Nottingham Trent University through offering the opportunity of a student placement. This was an excellent example of partnership working and helped to further an understanding of the importance and value of supporting student placements.
- Community events provided opportunities to undertake health promotion activities and deliver health messages to a target audience.
- The engagement plan provided an evidence base for future engagement activity.
- The Positive Action Training Recruitment Agency (PATRA) trainees volunteered and supported the delivery of the engagement plan; this was a very successful partnership and was fundamental to the successful delivery of the engagement plan.

12.1.2 Limitations of the engagement plan

1. Strategy development resulted in duplication; the BME community and community groups are continuously approached for their input which brought about reluctance for people to engage and participate in the consultation.
2. Work pressures inevitably restricted the time that key stakeholders were able to give; in some cases it proved difficult for people to find time to organise focus groups and to help facilitate the gathering of information and feedback from community members.
3. Limited funding meant that community groups could not be paid to lead consultation activities and few incentives for participation were available.
4. Feedback from some BME communities suggested that consultations are repeated yet action is not taken in response to findings. This led to some communities being reluctant to engage.

5. There were difficulties in reaching and engaging with Eastern European communities when completing the questionnaires. Volunteers and staff members found it challenging to identify people who were Eastern European; this was due to the fact that they initially do not appear to have any distinct characteristics which would enable them to be immediately identifiable as such. If it was evident that a different language was being spoken they were approached.
6. Proportionately fewer respondents from Indian and Pakistani communities undertook the health questionnaire; however, there was good representation for these communities in the focus groups.
7. Proportionately fewer older people responded to the questionnaire. This appeared to be due to the community events largely attracting a younger audience. Nonetheless the age breakdown of participants reflected that of the city.
8. The scope of the engagement was extensive and as such required significant staff resource. In addition, the scope of the engagement has led to delays in completing the HNA.
9. Feedback from partners and respondents suggested that the questionnaire was too long and some people found it complicated, particularly where English was not their first language. This was highlighted more frequently among asylum seekers and refugees and within the Pakistani community.
10. Feedback from partners and community members suggested that it would have been useful to have the questionnaire available in different languages; however, due to the time frame and the cost involved this was not possible
11. The Nottingham beach event in the Market Square was not successful at engaging the BME community due to low numbers of BME people attending.
12. The engagement activity took place over the summer holidays and could have impacted on the engagement of different communities and groups for the following reasons: the availability of

staff members and partners to support the engagement; the timing of the engagement coincided with Ramadan which could have impacted on the Muslim community; the timing also coincided with university term times meaning that a large proportion of university students were away.

12.2 Limitations of the available data

1. Census data provided the most comprehensive data on the ethnicity of UK populations. However, this quickly becomes out of date and the BME populations in Nottingham have changed since the census was undertaken in 2011.
2. This HNA provides a summary of the BME populations in Nottingham and their likely health needs. Whilst the report seeks to better understand the issues and challenges around access to services, the report has not been able to establish whether the health outcomes for BME communities in Nottingham are disadvantaged by current provision or access to health services.
3. The lack of ethnic monitoring data by local services is especially limiting in attempting an assessment of differences in health outcomes at a local level between ethnic groups. In some cases, it has only been possible to relate the general observations made locally with wider research evidence.
4. The HNA does not seek to assess or evaluate the extent and effectiveness of any targeting of health services at the local BME community, beyond recording any observations made about this.

13. Conclusion

Nottingham City has a large BME population which accounts for just over one-third (35%) of the total population, having increased from just under one-fifth (19% in 2001) and is projected to continue to rise. In some respects, this increases the challenge of meeting the needs of BME communities.

An increase in population can result in an increase in the proportion of citizens with ill-health. The contact that health services will have with BME communities is likely to rise in line with the increase in population and this will test the ability of commissioners to deliver services that are appropriate, assessable and culturally sensitive and which meet the needs of an expanding and changing population.

Gaps in knowledge and data were evidenced in the report. Knowing the size and, at least to some extent, the overall composition of the BME populations in Nottingham is of relatively limited value without knowing how these communities are using health services and whether any are disproportionately affected by disease and/or health conditions. The lack of ethnic monitoring data by local services is especially limiting in attempting an assessment of the differences in health outcomes at a local level for different BME populations.

In some instances, it has only been possible to relate information gained through engagement activity with wider research evidence. This presents a significant challenge when attempting to assess health at a population level and requires a shift in strategic direction to make the collection of ethnic monitoring data a compulsory requirement for all services. This will help to improve the health and wellbeing of the BME populations as, when routine ethnic monitoring data is combined with an established evidence base on the prevalence and variation in outcomes for different BME populations, informed decisions can be made about commissioning priorities and resource allocation to address the health needs of BME communities.

The report has conclusively demonstrated that BME communities are not homogenous in their health needs; different BME groups experience different health outcomes. Whereas the major health concerns may be similar between ethnic groups, belief systems, attitudes to health and life, lifestyle behaviours, and access to, and experience of, health services vary widely. For example, some

participants suggested that increasing the representation of BME staff in the workforce would improve awareness of cultural diversity and increase cultural competence, whilst others stated they would be reluctant to see staff from their community due to fear of discrimination and stigma.

Deprivation was a recurring theme throughout the engagement with many participants highlighting money and unemployment as key contributors to deprivation. This is in line with national evidence which finds that BME communities experience higher levels of poverty, lower levels of employment, lower pay and poorer housing conditions than the general population (Marmot, 2005).

Participants highlighted the importance of the built environment as a contributor to obesity and a barrier to maintaining a healthy life. Examples include the planning of fast food outlets, accessing open spaces, homelessness and people feeling they have no sense of belonging. Reassuringly, social and environmental factors are identified as a strategic priority within Nottingham's Health and Wellbeing Strategy (2016) and a range of strategies and interventions are being developed to address these issues.

Discrimination was a common theme and was cited as a major barrier to leading a healthy lifestyle. Feedback from the qualitative research suggests that discrimination affects nearly all aspects of a person's life and can exclude individuals from succeeding in employment leading to socioeconomic disadvantage. These findings are important and should drive changes in policy and practice at a local level to address ethnic inequalities and recognise that such actions benefit not just BME communities but the health and wellbeing of society as a whole.

Ensuring equity of access to health services is the single most important factor in addressing inequalities in health outcomes between ethnic groups. This HNA suggests that, for a number of BME individuals in Nottingham, the experience of trying to access services is poor. In part, this is due to a lack of cultural awareness amongst some health professionals, which suggests additional training is required. There is cause for concern that a number of participants did not feel they were treated with respect and dignity by their GP which, again, appears to be linked to perceptions about cultural and religious sensitivity. Conversely, some participants reported very high levels of trust and confidence in their GPs.

There is a need to improve how interpreting and translation services are provided, a need to explore how the GP appointment system can be improved, and to better understand how BME communities are made aware of health services and how to access them.

The extensive engagement with BME communities has been a key success of this HNA and has highlighted those approaches and techniques which successfully engage local communities. The engagement has enabled understanding of how local citizens perceive health and experience healthcare and other services. Whilst the plan was successful at engaging almost a thousand citizens from diverse backgrounds and was successful at identifying key themes from the responses to the surveys and focus groups, some key challenges were observed which restricted the reach of the engagement and contributed to delays in completing the HNA.

Limited resources led to the engagement activity taking place over the summer which could have impacted on the engagement of different communities. For example, the availability of staff to support activities was limited. In addition, the start of the engagement coincided with Ramadan which may have impacted on the participation of the Muslim community and could explain why proportionately fewer respondents from the Pakistani community undertook the health questionnaire. The timing of the activities also coincided with university summer holidays meaning that there was little engagement with BME university students regarding their health needs.

Proportionately fewer older people responded to the questionnaire; this appeared to be due to the community events attracting a younger audience. Nonetheless, the age breakdown of participants reflected that of the city.

One of the biggest challenges was engaging with the local Eastern European communities, particularly when completing the questionnaires. Volunteers and staff found it challenging at community events to identify people who were Eastern European as, unlike other communities, visible ethnicity could not be used. Whilst two focus groups were conducted with Polish participants, Eastern European citizens were under-represented in the study; thus further work is needed to engage with these communities.

There is a need for on-going engagement and consultation with BME communities; the findings from this HNA suggest that local BME community and voluntary organisations are often best placed to facilitate engagement and most likely to reflect the concerns of particular communities.

It could be argued that in order to achieve the greatest impact, at population level, actions should be considered that improve the health of the largest BME communities in Nottingham. Conversely, new and emerging communities can have the poorest health so improving the health of these groups could result in the largest health gain. Any identified actions should be proportionate in scale and underpinned by local policies and strategies.

A cross-sector, multidisciplinary approach is needed to improve the health of BME communities. As socioeconomic and environmental factors have considerable impact on the health and wellbeing of individuals and communities, responses should be strategic and recognise the impact of discrimination and exclusion as a key public health issue.

14. Recommendations

These recommendations have been identified using a synthesis of the evidence base and quantitative and qualitative methodologies and have been thematically grouped.

14.1 Access to services

- National and international evidence suggests that ethnicity should be consistently considered when developing health services, specifically to ensure services are culturally-sensitive. The citizens consulted through this HNA suggest more could be done to improve the experiences of BME populations accessing local health services. This will be best achieved through continued dialogue with patients and their families, with health professionals and with the community and voluntary sector.
- Commissioners should consider how they can be assured that health services are delivered in a person-centred and culturally-sensitive manner. For example, to what extent are local services aware of the diverse but specific barriers to access for people from BME communities?
- Local health service providers should consider delivering regular training for their staff on the needs of different BME communities.
- Intelligence gathered through this HNA suggests that some BME communities are not accessing health and social care services in accordance with their level of need. More work is needed to understand the mechanism underpinning this.
- Feedback from BME communities suggests that health and care needs, as can be expected, vary by age. A scoping exercise of the current provision of age-appropriate activities for elders from BME communities could inform future commissioning.
- A number of participants suggested there is not enough youth provision across Nottingham City and felt there needed to be more youth centres. A review should be undertaken to explore this further.

14.2 Mental health

- Local intelligence suggests that some BME communities find it difficult to engage with mental health services for “cultural reasons” and/or because they believe the service will not meet their needs.
- Local services could consider targeted work with BME communities to encourage access to mainstream mental health services.
- Participants suggested that greater investment is needed to increase access to responsive, culturally-appropriate mental health services in Nottingham that have the capacity and resources to prevent, as well as treat, mental health problems.

14.3 Data collection

- The lack of robust monitoring of ethnicity by local and national health services means there is a significant gap in understanding the needs of BME communities. Service providers need to work with staff to stress the importance of collecting ethnic monitoring data and put robust measures in place to support routine data collection, such as removing the “not known” category in ethnic monitoring. This will enable the appropriate planning and commissioning of services and ensure equity of access.
- The HNA did not have a specific focus on inherited blood disorders which are evidenced to disproportionately affect African and Caribbean communities. The Local Authority needs to consider whether a JSNA chapter on sickle cell and thalassemia is required.

14.4 Community engagement

- Citizens and stakeholders suggested that, in Nottingham, we have a tendency to keep consulting, sometimes duplicating previous consultations, without always demonstrating how we have responded to them. A city-wide consultation strategy with shared objectives and pooled resources could help reduce duplication and address the issue of limited funding for large-scale consultations.

- Participants suggested that services should improve their routine engagement with BME communities to provide more opportunities for citizens to inform the planning and commissioning of health services. This will help to ensure services are accessible and meet the needs of Nottingham's diverse communities.
- Eastern European communities were not sufficiently represented in the engagement activity. Further work is needed to understand how best to engage with these communities.

14.5 Communication and resources

- Participants suggested that there is a lack of printed materials on health in a variety of languages in local services, such as in general practice. The availability of interpreters is also 'patchy'. A review of translation and interpreting services in Nottingham is warranted.
- Commissioners and providers should work together to ensure that health promotion materials are available in the most commonly spoken languages. In addition, services should ensure that self-help materials are available in a wide range of formats, including computerised resources, books and leaflets, audiotapes and further resources for those with literacy difficulties.
- Participants suggested that they are not always aware of the range of local services. Communication platforms, such as on-line directories, should be accessible to diverse communities so citizens are aware of local services and how to access them.

14.6 Partnership working

- Local partners and community members stressed the importance of the community and voluntary sector in influencing the health and wellbeing of BME communities in Nottingham. However, the capacity of the sector has diminished significantly. Participants suggested that further work is needed to rebuild this sector and engagement with organisations, faith groups and community leaders to promote the health and well-being of Nottingham's BME communities.

- Schools were identified as a powerful communication channel for sharing health messages and influencing health behaviours. Further work is needed to explore the role of schools in delivering health and wellbeing initiatives directed at BME communities.
- Commissioners and providers of health services in Nottingham need to look outside traditional structures in order to meet the diverse needs of BME communities. Partnership working with the private sector and other public services and community groups is essential in achieving a positive impact on the mental and physical health of the whole community. For example, participants suggested that more could be done to engage communities through churches, mosques and other places of worship.

14.7 Discrimination

- Many participants identified discrimination as a barrier to living a healthy and happy life with some stating that discrimination would be minimised if the workforce was more reflective of the BME communities in Nottingham. Measures should be put in place to ensure organisations recruit, develop and retain a workforce that reflects the city and is able to deliver high quality services that are fair, accessible, reflective and responsive to the needs of different groups and communities.

14.8 Lifestyle risk factors

- Participants identified a range of factors that reduced the opportunity for physical activity. While some of these barriers were described as cultural or religious, e.g. Muslim women only able to attend female-only sports sessions, others were related to access to facilities. Initiatives that encourage participation of BME communities should be identified.
- Education and information for BME communities regarding healthier diets and food preparation are provided through programmes such as *Cook and Eat* sessions; however the financial support for these sessions has declined. Work should be undertaken to explore potential funding of these sessions, including through local businesses and supermarkets as part of their social responsibility commitment.

- A review of campaigns designed to address attitudes of members of BME communities is needed. Approaches that are more culturally aligned with the perceptions and lifestyles of BME communities may prove more successful, as might be a social marketing approach engaged around what works for these communities.
- Participants suggested that some national campaigns, such as *Change for Life*, appear targeted at white communities as they are not culturally aligned with the perceptions and lifestyles of BME communities. Conversely, *Be Clear on Cancer* was seen to reflect the needs of BME communities. Local social marketing campaigns should be developed using similar approaches.

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Appendices

Schedule of engagement

BME HNA Community Engagement Plan: June – September 2016

Key: **GREEN:** Event is covered **RED:** Staff still needed **ORANGE:** focus group

Event details	Date	Activity	Number of staff needed	Outcomes and comments	Status
NCC BME staff focus group	Thursday 9 th June 9am – 10pm	Focus group with staff members	2 x staff members	8 people in the group 12 questionnaires completed	
Focus group Bulwell Riverside	15 th June 10 – 12pm	Focus group with the public	2 x staff	FOCUS GROUP NOT DELIVERED: Poorly attended and new sessions planned	
Focus group Mary Potters Hyson Green	20 th June 10pm -12pm	Focus group with the public	2 x staff	FOCUS GROUP NOT DELIVERED: Poorly attended and new sessions planned	
Focus Group St Anns Valley Centre	29 th June 9am – 11am	Focus group with the public	2 x staff	FOCUS GROUP NOT DELIVERED: Poorly attended and new sessions planned	
Health Fest Market Square	Friday 8 th July 2016 10am – 1pm	Completing questionnaires and promoting focus groups	4 x staff	46 questionnaires Completed	
BME Cook and eat session	Monday 11 th July 2 – 4pm St Andrews Church, Chaucer Street	Completing questionnaires and promoting focus groups	2 x staff	12 questionnaires completed	
Focus Group Renewal Trust Carlton Road	Wednesday 13 th July 10am - 12.30pm	focus group with Asylum seekers and refugees	2 x staff	8 people in attendance 5 questionnaires completed	
Celebrating women in Nottingham	Bobbersmill community centre Thursday 14 th July 9.30 – 3.00pm	.	2 x staff	29 questionnaires Completed	

Event details	Date	Activity	Number of staff needed	Outcomes and comments	Status
Focus group Loxley House	Thursday 14 th July	Focus group with NTU students	2 x staff	6 people in attendance 5 questionnaires	
Eid celebration event, Forest ground	Saturday 16 th July 12pm – 6pm	Completing questionnaires	4 x staff 3pm – 6pm	25 questionnaires completed. However, a missed opportunity to collect more as only one person volunteered on the day	
Focus Group Meadows library	Tuesday 19 th July 10.30am – 12.45pm	People from diverse communities who attend the library to learn new skills and English	2 x staff	2 x focus groups with 14 people in attendance 15 questionnaires completed Excellent event. we worked with local volunteer interpreters to deliver the focus groups	
Focus Group St Ann's Valley Centre library	Wednesday 20 th July 12.30pm – 2.45pm conversation group	People from diverse communities who attend the library to learn new skills and English	2 x staff	2 x focus groups with 15 people in total 14 questionnaires completed Excellent partnership working. we worked with local volunteers interpreters to deliver focus groups	
Focus Group Central Library	Thursday 21 st July 2m – 4.15pm conversation group	People from diverse communities who attend the library to learn new skills and English	2 x staff	2 x focus groups with 12 people in total 12 questionnaires completed Excellent partnership working, work with local people who volunteered as interpreters to deliver the focus groups	
Focus Group Hyson Green Library, Mary potter Centre	Friday 22 nd July 10m – 12pm conversation group	People from diverse communities who attend the library to learn new skills and English	2 x staff	2 x focus groups with 15 people 4 questionnaires completed Excellent partnership working, work with local people who volunteered as interpreters to deliver the focus groups	
Vernon park Funday	Friday 22 nd July 3pm – 6pm	Information stand, Completing questionnaires and promoting focus groups	3 x staff 3pm – 6pm	23 questionnaires completed	

Language Café	Saturday 23 rd July 1pm – 3pm	Completing questionnaires and promoting focus groups	3 x staff	Cancelled Not enough staff members to help	
Southglade Parklife Bestwood	Thursday 28 th July 12 – 4pm	Information stand, completing questionnaires and promoting focus groups	2 x staff members	44 questionnaires completed	
Asda Event Hyson green	Friday 29 th July 11am – 4pm	Completing questionnaires and promoting focus groups	2 x staff members	6 questionnaires Not a good venue, customers were too busy to stop and complete a questionnaire	
Focus group at the Council House	Friday 29 th July 4.30 – 6.30pm	City Focus group open to the public and targeted at the BME community	3 x staff members	15 people in attendance 9 questionnaires completed	
Sneinton Festival Greenway Park	Saturday 30 July 12pm – 4pm	Completing questionnaires and promoting focus groups	3 x staff members	76 questionnaires, this was a fantastic event, very diverse and very well attended by the public	
Focus group Refugee women's group. Renewal trust	Tuesday 2 nd August 10.30am - 12pm	Delivering a focus group	2 x staff members	8 people in attendance 3 questionnaires	
Asda Event Hyson Green	Wednesday 3 rd August 11am – 4pm	completing questionnaires and promoting focus groups	3 staff members	Cancelled Not a suitable venue	
Beach Market square	Wednesday 3 rd August 1pm – 3pm	Completing questionnaires	2 x staff members	No outcomes. Very few people from the BME community so event cut short	
Beach Market square	4 th Thursday 1pm – 3pm	Completing questionnaires	2 x staff	Cancelled Not enough staff	
Beach Market square	Friday 5 th - 1 – 3pm	Questionnaires	2 x staff members	20 questionnaires completed. This is not a good venue. low numbers of people from BME communities	
Jamaica Independence day event	Saturday 6 th August 2pm – 6pm Sycamore park St Anns	completing questionnaires and promoting focus groups	2 x staff members	Was not very busy so the team went to Nottingham Riverside, 49 questionnaires were completed, great event.	

Nottingham Riverside Victoria embankment	Sunday 7 th August = 2pm – 6pm	Work with with the Foster and Adoption team, completing questionnaires	2 x staff members	46 questionnaires completed great event and great partnership working.	
Red Cross – Refugee and asylum seekers drop in session	Tuesday 9 th August 5pm – 7pm St Andrews church	Completing questionnaires	2 x staff members	17 questionnaires completed with the support of volunteer interpreters	
Beach Market square	Wednesday 10 th August 1pm – 3pm	Completing questionnaires	3 x staff	Cancelled Past 2 attempts have not been productive.	
Asda Event Hyson Green	Friday 12 th August 11am – 4pm	completing questionnaires and promoting focus groups	2 x staff members	Cancelled Not suitable event	
Market Square Beach	Friday 12 th 1am -4pm	questionnaires	4 staff members	Cancelled Past attempts have not been productive.	
Hyson Green Cultural Event Forest ground	Saturday 13 th August 2pm – 6pm	completing questionnaires and promoting focus groups	2 x staff 2pm – 6pm	37 questionnaires completed. This was a great event lots of people from diverse communities	
Citizen Panel Loxley house LH.211	Tuesday 16 th August 12pm -1.30pm	Focus group with panel members	2 x staff members	6 people in attendance 5 questionnaires completed	
Red Cross - Refugee and asylum seeker drop in session	Tuesday 16 th August 5pm – 7pm St Andrews church	questionnaire	2 x staff members	16 questionnaires completed. with the support of volunteer interpreters	
Focus group	Emmanuel House 16 th August	Focus group with Polish community	Maria king leading this event	11 people attending 8 questionnaires completed	
citizen panel	Thursday 18 th Loxley House: room 2.32	Focus group with panel members	2 x staff members	Cancelled Low uptake	
NCVS City Focus Group:	Friday 19 th August 10am – 12pm CVS Mansfield Road	City Focus group open to the public but targeted at the BME community	2 x staff members	8 people in attendance 5 questionnaires completed	

Nottingham Carnival Victoria embankment	Saturday 20 th August 12– 4pm	Buddying up with Nottingham City Homes to complete health questionnaires:	2 x staff members 12pm – 4pm	27 questionnaires completed. Great partnership working.	
Red Cross - Refugee and asylum seeker drop in session	Tuesday 23 rd August St Andrews church Chaucer street	questionnaire completion	2 x staff members	12 questionnaires completed with the support of volunteer interpreters	
FAB prostate cancer awareness group	Monday 25 th July FAB community Group	Focus group with BME males from the FAB self-help group	FAB leading this event	14 people in attendance 5 questionnaires completed	
Women's Cultural Exchange	Friday 26 th August 12pm – 2pm Sycamore centre	focus group with the women's centre	2 x staff members	14 people in attendance 9 questionnaires completed	
Focus Group Pilgrim Church Meadows	Thursday 8 st September 7.30pm – 9.30pm	focus group with church members	2 x staff member	9 people in attendance, 9 questionnaires completed	
"Chat Bout" focus group	Thursday 8 th September 6pm – 8pm Sobar Maid Marian Way	focus group with young people	2 x staff	6 people in attendance, 6 questionnaires completed	
Nottingham Mela event	Sunday 11 th September Nottingham Castle 9.30am – 5pm	completing questionnaires	2 x staff members	8 questionnaires completed. Not a suitable event due to positioning of the stall	
Partners completing questionnaires		Partners supporting and completing questionnaires		32	
Questionnaires completed online				90	

Focus groups questions:

Q.1 -What do you think about the information provided?

Q.2 - Does any of this information surprise you?

Each group discussed the poster and notes were taken. The groups were then asked to expand on their answers by answering the following four questions:

Q.1- What do you think are the main issues affecting people's health and happiness in Nottingham and are there any issues that are specific to the BME community?

Q.2 - What is stopping you living a healthier and happier life and are there any issues that are specific to the BME community?

Q.3 -What would you like to see in your area to help make you healthier and happier and are there any issues that are specific to the BME community?

Q.4 - From your own experiences of health services in Nottingham have the health services been culturally-appropriate and did they meet your needs?

Black and Minority Ethnic Community – Health Questionnaire:

Nottingham City Council is currently undertaking an analysis on the health needs of Black and Minority Ethnic (BME) communities in Nottingham City. We would like to find out what's important to you and how we can work together to make Nottingham a happier and healthier city.

We are seeking your help and would appreciate you completing the following questionnaire. The following questions were informed by previous consultations and evidence taken from a literature review.

Below are a number of statements addressing health needs of BME groups. Please read each one and indicate to what extent you agree or disagree with each statement.

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
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Lifestyle

1. I drink alcohol more than 3-4 times per week
2. I smoke tobacco regularly
3. The food available in the UK is not as natural and nutritious as my home country
4. People from my community would benefit from additional knowledge about diet and preparing healthy meals
5. older people living alone are at risk of isolation
6. Women from my community can spend more time at home and not have the confidence or opportunities to go out and socialize

Access to services	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
7. People in my community are able to recognize early signs of disease and seek appropriate help					
8. Standard GP appointment times should be doubled when an interpreter is needed					
9. I trust my GP to diagnose me correctly, manage my condition and refer me to specialist services when needed					
10. It is important that services have a cultural understanding of different communities					
11. It is important to have health role models from different communities who understand cultural beliefs and can give advice and support					
Mental health	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
12. There is a direct relationship between physical health and mental health					
13. People from my community are at greater risk of poor mental health due to prejudice and discrimination					
14. It would be helpful if community groups and classes could be trained to					

include mental health awareness into their sessions

Barriers to leading a healthy lifestyle

Strongly disagree

Disagree

Neither agree nor disagree

Agree

Strongly Agree

- 15. The cost of using leisure facilities are a barrier to participating in physical activity
- 16. Traditional diets are a barrier to healthy living as they include a lot of oil, salt and sugar
- 17. Men from my community do not get involved in community group activities
- 18. Pride, stigma and shame are factors which prevent people from my community from seeking help when they are concerned about their health
- 19. Education that recognises cultural traditions is important when helping people to manage their health conditions

About you: We are interested in your views whatever your age or background, the next few questions are about you. This will help us to understand how representative the response we receive is of people living in Nottingham as well as the views of different groups of people. The following questions are OPTIONAL.

21- What is your postcode?

22 - Please tick the statement which best describes you:

I am an employee ☐

I am a member of the community ☐

23- What is your first language: _____

24- What is your country of birth: _____

25- Please tick the statement which best describes you:

- | | | |
|-----------------------------------|--------------------------------|--|
| <input type="checkbox"/> under 16 | <input type="checkbox"/> 35-44 | <input type="checkbox"/> 65-74 |
| <input type="checkbox"/> 16-24 | <input type="checkbox"/> 45-54 | <input type="checkbox"/> 75+ |
| <input type="checkbox"/> 25-34 | <input type="checkbox"/> 55-64 | <input type="checkbox"/> Prefer not to say |

26- Please tick the statement which best describes you:

- | | | |
|-------------------------------|---------------------------------|--|
| <input type="checkbox"/> Male | <input type="checkbox"/> Female | <input type="checkbox"/> prefer not to say |
|-------------------------------|---------------------------------|--|

27- Please tick the statement which best describes you:

- | | | |
|---|--|----------------------------------|
| <input type="checkbox"/> Heterosexual or Straight | <input type="checkbox"/> Bisexual | <input type="checkbox"/> Gay Man |
| <input type="checkbox"/> Gay Woman/Lesbian | <input type="checkbox"/> Prefer not to say | |

28- Please tick the statement which best describes you:

I consider myself to be disabled:

- | | | |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Prefer not to say |
|------------------------------|-----------------------------|--|

29- Please tick the statement which best describes you:

- | | |
|--|--|
| <input type="checkbox"/> White - English, Welsh, Scottish. | <input type="checkbox"/> Irish, British |
| <input type="checkbox"/> White- Irish | <input type="checkbox"/> White- Other |
| <input type="checkbox"/> White - Gypsy Traveller | <input type="checkbox"/> Mixed - White & Black Caribbean |

☐ Mixed - White & Asian

☐ Mixed - Other

☐ Asian - Bangladeshi

☐ Asian - Kashmiri

☐ Asian - Chinese

☐ Black - British

☐ Black - African

☐ Prefer not to say

Other - Please state below:

☐ Mixed - White & Black
African

☐ Arab

☐ Asian - Indian

☐ Asian - Pakistan

☐ Asian - Other

☐ Black - Caribbean

☐ Black - Other

To be entered into our FREE prize draw with a chance of winning Victoria Center gift vouchers to the value of £15 please provide your contact details below.

Please note this information will be kept strictly confidential, will only be used for the stated purpose and not passed onto a third party.

Name

Email

Contact number

The winners will be notified by 16th September 2016.

Thank you for taking part in the survey.

For further information on the BME health needs assessment, please contact Jennifer Burton on 0115 876 5421 or email Jennifer.burton@nottinghamcity.gov.uk