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Health Needs Assessment of the Black and Minority Ethnic population within Derbyshire

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Contents

1 Introduction

There is a general consensus that inequalities exist in the health and healthcare experiences of Black and Minority Ethnic (BME) groups in England. Reasons for these variations may reflect genetic or biological differences, differences in reporting, differences in factors that lead to ill health or differences in access to and experience of healthcare services.[i]

During the consultation process for Derbyshire's Health and Wellbeing Strategy, members of the Derbyshire BME Forum raised concerns that the needs of the BME population had not been sufficiently considered within the development of the Strategy. It was therefore agreed that Public Health at Derbyshire County Council would undertake a health needs assessment to gain better awareness of the needs of the BME population in Derbyshire and use this intelligence to inform future strategy development and commissioning decisions.

1.1 Scope of Health Needs Assessment

The aim of a Health Needs Assessment is to systematically assess the needs of a population, and to assess whether local services are meeting these needs.[ii] This report, the first stage of the HNA, will be scoping in nature and will identify areas where further work may be required. The report will describe the BME population within Derbyshire, and will identify the health needs of BME groups within England. It will also summarise the findings of a Stakeholder Health Needs Analysis undertaken in 2012 with community groups represented on the Derbyshire BME Forum. Finally, it makes recommendations to improve the health of the BME population in Derbyshire.

The objectives for this report are to:

- describe the BME population within Derbyshire, with respect to geographic distribution and age
- describe the health needs of BME groups within the UK

1.2 Definition

In this HNA, BME is defined as all population groups who identify themselves with an ethnicity other than White British. This therefore includes White Irish and White Other ethnic groups (for example Eastern European communities) within the definition.

BME groups are not homogenous, and differ in respect to[iii]:

- history, culture and religion
- health and disease patterns
- exposure to risk factors relating to health
- perception of health and illness
- expectation of health and social services

These differences should therefore be considered when planning and commissioning health services.

2 Derbyshire Health and Wellbeing Strategy

The Health and Wellbeing Strategy for Derbyshire identifies five priorities to improve the health of the people of Derbyshire:[iv]

- improve health and wellbeing in early years, with a focus on early intervention and identification of vulnerable children and families
- promote healthy lifestyles, with a focus on preventing and reducing alcohol misuse, obesity and physical inactivity
- improve emotional and mental health, with a focus on improving access to evidence-based primary care psychological therapies and other local services that support recovery from mental health problems
- promote independence of people living with long term conditions and their carers, with a focus on community-based support, self-care and care close to home, including increased use of evidence-based teleheath and telecare
- improve the health and wellbeing of older people, with a focus on strengthening integrated working between health and social care providers and housing-related support services

Any actions identified to improve the health of the BME population should therefore be considered within the scope of these key priorities.

3 Demographic information

This section provides an overview of the key population features of BME groups within Derbyshire. Two routine data sources have been used: the 2011 national census and the Derbyshire School census, Spring 2013. Limitations of these data sources are discussed in section 3.4.

3.1 National census 2011

According to the 2011 census, there were 32,652 individuals from BME groups living within Derbyshire, comprising 4.2% of the population. This is significantly lower than the England and Wales proportion, where BME groups comprise 19.5% of the population.

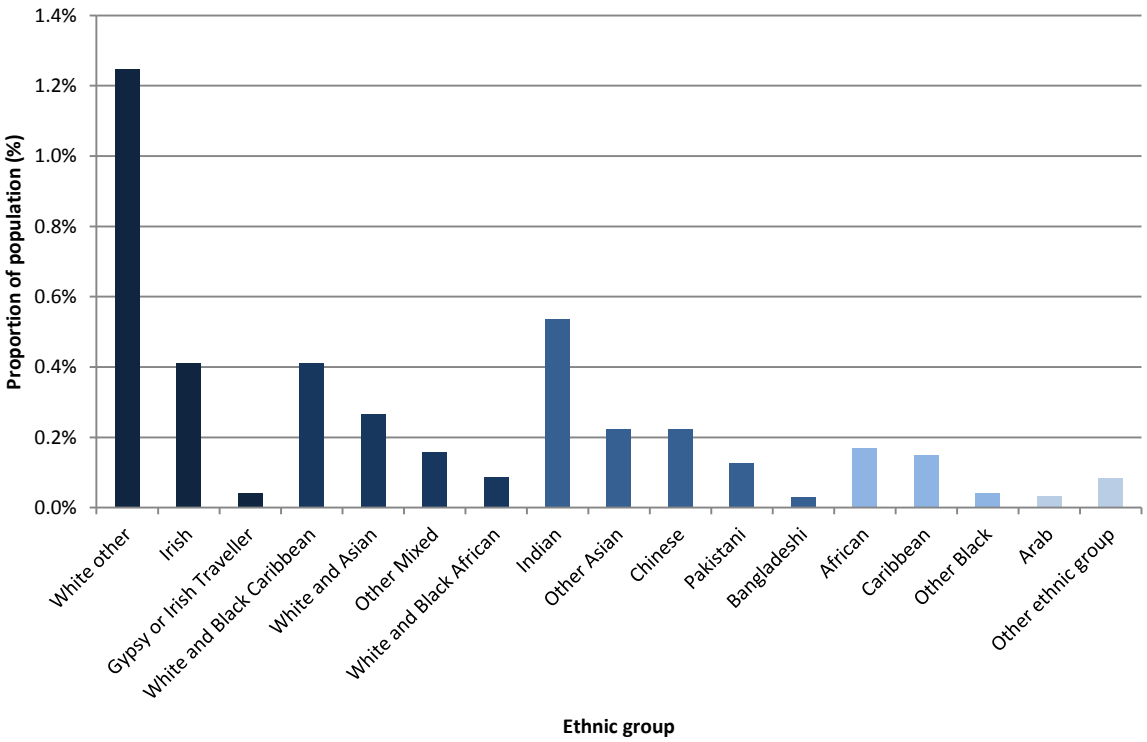
The largest BME groups within Derbyshire are White Other, Indian, White and Black Caribbean and White Irish (figure 1). For all BME groups, the proportion of the population is lower in Derbyshire than for England and Wales.

The highest rates of BME groups are located in Chesterfield, Long Eaton and the communities adjacent to Derby City. However, as figure 2 illustrates, within all urban areas, there are areas with higher rates of BME population. Stenson ward has the highest proportion of its population from BME groups, comprising 37% of the population. There are no other wards where the BME population exceeds 10% of the population. There are fourteen lower super output areas[1] where BME groups collectively comprise more than 10% of the population (table 1). These are located in South Derbyshire, Long Eaton, Chesterfield and Buxton, and are indicated with a yellow boundary on figure 2. The LSOA with the highest proportion of BME groups is South Derbyshire 003C (in Stenson

[1] Lower Super Output Areas are geographic areas that are smaller than wards and typically have a population of 1,500.

Fields), where BME groups comprise 49.9% of the population. The LSOA with the lowest proportion of BME groups is North East Derbyshire 011A (in North Wingfield), where BME groups comprise less than 1% of the population.

Figure 1: Proportion of BME groups within Derbyshire, 2011



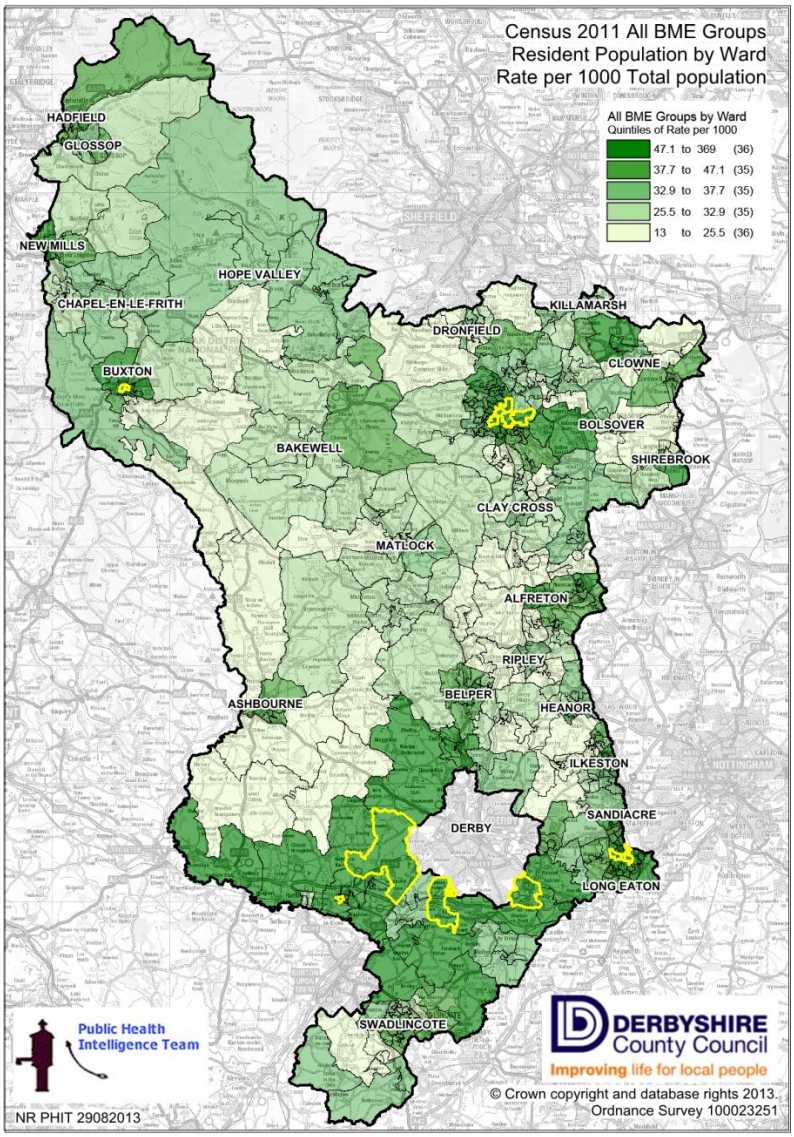
Source: 2011 census

Table 1: Lower Super Output Areas where the BME population comprise more than 10% of the population, 2011

Lower Super Output Area	Proportion of population from BME groups (%)	Lower Super Output Area	Proportion of population from BME groups (%)
South Derbyshire 003C	49.86%	Chesterfield 010C	11.20%
South Derbyshire 003B	31.68%	Erewash 011C	11.11%
South Derbyshire 003A	29.23%	South Derbyshire 002H	10.72%
Chesterfield 010F	14.01%	South Derbyshire 001A	10.56%
Chesterfield 010A	13.68%	Erewash 012A	10.53%
South Derbyshire 004D	13.51%	Chesterfield 012G	10.19%
Chesterfield 010D	12.34%	High Peak 010C	10.04%

Source: National Census, 2011

Figure 2: Distribution of all BME groups within Derbyshire, 2011

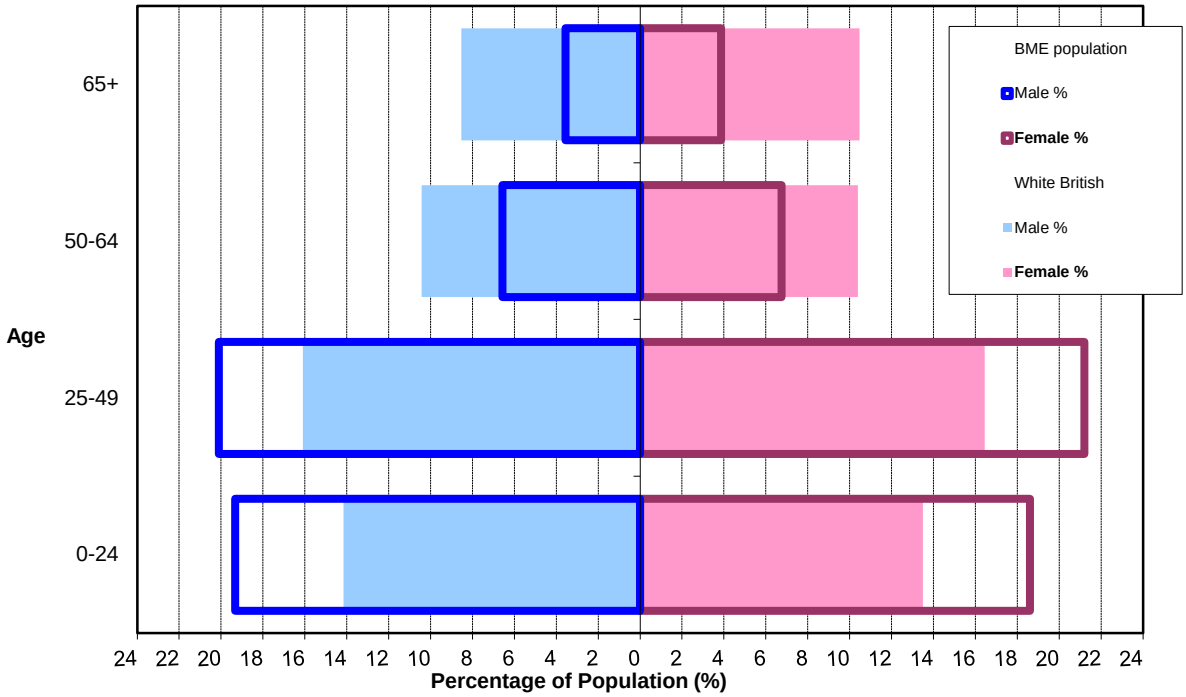


Source: National Census 2011

3.1.1 Age and gender breakdown

Limited data has been released from the 2011 National Census that allows a comparison of the age and gender breakdown of the BME population, compared to the White British population. As with the White British population, there are equal proportions of male and females within the BME population. The main contrast between the BME and White British populations is the difference in the age profile (figure 3). Compared to the White British population, there are higher proportions of 0-49 year olds in the BME population, and lower proportions of 50 years upwards. Individuals aged 0-49 comprise 79.2% of the BME population in Derbyshire, compared to 60.2% of the White British population. Individuals aged 50 years and above comprise 20.8% of the BME population, compared to 39.8% of the White British population.

Figure 3: Age and sex structure of BME population compared to White British population in Derbyshire, 2011



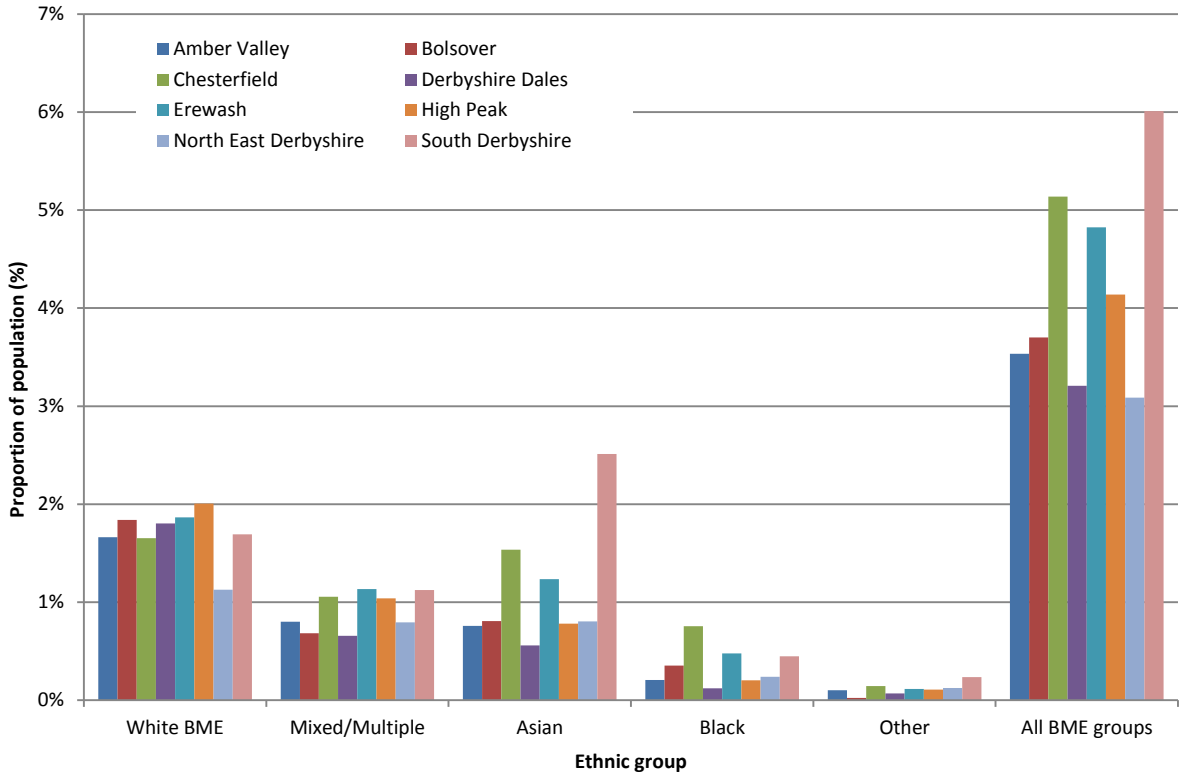
Source: 2011 National census

3.1.2 Breakdown by district

South Derbyshire has the highest proportion of individuals from a BME group (comprising 6.0% of its population), with North East Derbyshire having the lowest (3.1% of its population) (figure 4). For all districts, with the exception of South Derbyshire, White BME groups comprise the highest proportion of the BME population. In South Derbyshire, Asian groups comprise the highest proportion of the BME population.

High Peak has the highest proportion of its population from White BME groups (comprising 2.0% of its population), with North East Derbyshire having the lowest proportion (comprising 1.1% of its population). There are similar proportions of individuals from Mixed/Multiple BME groups in Chesterfield, Erewash, High Peak and South Derbyshire (comprising 1.1% of their population), with Bolsover and Derbyshire Dales having the lowest proportion (comprising 0.7% of their population). South Derbyshire has the highest proportion from Asian BME groups (comprising 2.5% of its population), with Derbyshire Dales having the lowest proportion (comprising 0.6% of its population). Chesterfield has the highest proportion from Black BME groups (comprising 0.8% of its population), with Derbyshire Dales having the lowest proportion (comprising 0.1% of its population).

Figure 4: Composition of the BME population by district, 2011



Source: 2011 National census

3.1.3 Change since 2001 census

In 2001, the BME population comprised 2.8% of the population of Derbyshire (table 2). Between the 2001 and 2011 census the BME population increased by approximately 12,000 individuals. Over the same time period the population of Derbyshire increased by 4.4%. The largest proportional increase has been amongst Black ethnic groups, with the largest increase in population size amongst Asian groups.

Table 2: Change in size of BME population between 2001 and 2011 within Derbyshire, by ethnic group

Ethnic group	2001		2011		Increase in size of population	Proportional increase (%)
	Number	Proportion of population (%)	Number	Proportion of population (%)		
White BME	9,775	1.33	13,060	1.70	3,285	27.8
Mixed/multiple	3,796	0.52	7,119	0.93	3,323	78.9
Asian	4,970	0.68	8,795	1.15	3,825	69.1
Black	1,462	0.20	2,770	0.36	1,308	80.0
Other	585	0.08	908	0.12	323	50.0
Total BME	**20,588**	**2.81**	**32,652**	**4.26**	**12,064**	**51.6**

Source: National Census, 2001 and 2011

Bolsover had the largest proportional increase in the size of the BME population, due to a doubling of size of the White BME, Mixed/Multiple, Asian and Black ethnic groups. Southern Derbyshire had the largest increase in the size of the BME population (table 3).

Table 3: Change in size of BME population between 2001 and 2011 within Derbyshire, by district

District	2001		2011		Increase in size of BME population	Proportional increase (%)
	Number within BME groups	Proportion of population (%)	Number within BME groups	Proportion of population (%)		
Amber Valley	2,485	2.13	4,321	3.53	1,836	65.7
Bolsover	1,252	1.74	2,808	3.70	1,556	112.6
Chesterfield	3,267	3.31	5,332	5.14	2,065	55.3
Derbyshire Dales	1,647	2.37	2,281	3.33	634	40.5
Erewash	3,793	3.45	5,408	4.83	1,615	40.0
High Peak	2,792	3.12	3,761	4.14	969	32.7
North East Derbyshire	1,985	2.05	3,055	3.09	1,070	50.7
South Derbyshire	3,367	4.13	5,686	6.01	2,319	45.5
Derbyshire	**20,588**	**2.81**	**32,652**	**4.26**	**12,064**	**51.6**

Source: National Census, 2001 and 2011

3.1.4 Geographical location of specific BME groups

3.1.4.1 Irish, Gypsy or Irish Traveller and Other White

The Irish, Gypsy or Irish Traveller and Other White BME groups comprise 1.7% of the population. There are no wards or LSOA where the Irish, Gypsy or Irish Traveller and Other White BME groups comprise more than 10% of the population.

Approximately three-quarters of individuals from the Other White group are from Europe, with higher numbers from Eastern Europe than Western Europe (table 4). Individuals from Poland comprise the largest proportion of individuals from Eastern Europe.

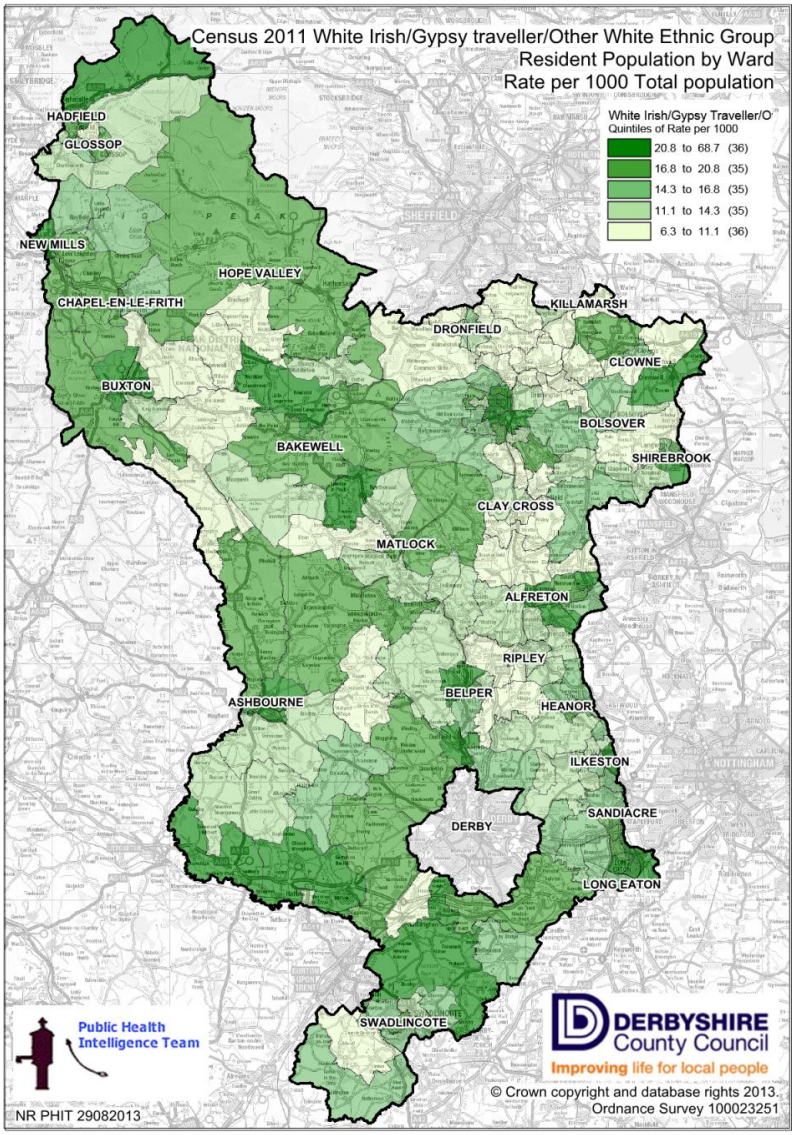
Table 4: Numbers of individuals from Europe residing in Derbyshire, 2011

	Numbers in Derbyshire
Eastern European	***3,669***
Poland	2,562
Russia/Baltic States	505
Former Yugoslavia	25
Albania	18
Other	559

	Numbers in Derbyshire
Western Europe	***2,419***
Italy	533
Greek/Cyprus	173
Turkey	102
Other	1,611
Mixed European	***1,139***

Source: National Census, 2011

Figure 5: Distribution of White Irish, Gypsy or Irish Traveller and Other White groups within Derbyshire, 2011



Source: National Census 2011

There were 3,154 individuals from White Irish communities living within Derbyshire in 2011, comprising 0.4% of the population. There are no wards or LSOAs where the White Irish population exceeds 10% of the population. The areas with the highest numbers of individuals with a White Irish ethnicity are Matlock, Glossop, New Mills and communities to the south of Derby City.

There were 311 individuals from Gypsy or Irish Traveller communities living within Derbyshire in 2011, comprising 0.04% of the population. There are no wards or LSOAs where the Gypsy or Irish Traveller population exceeds 10% of the population. The areas with the highest numbers of Gypsy or Irish Travellers are Chesterfield, Pinxton and Aston-on-Trent.

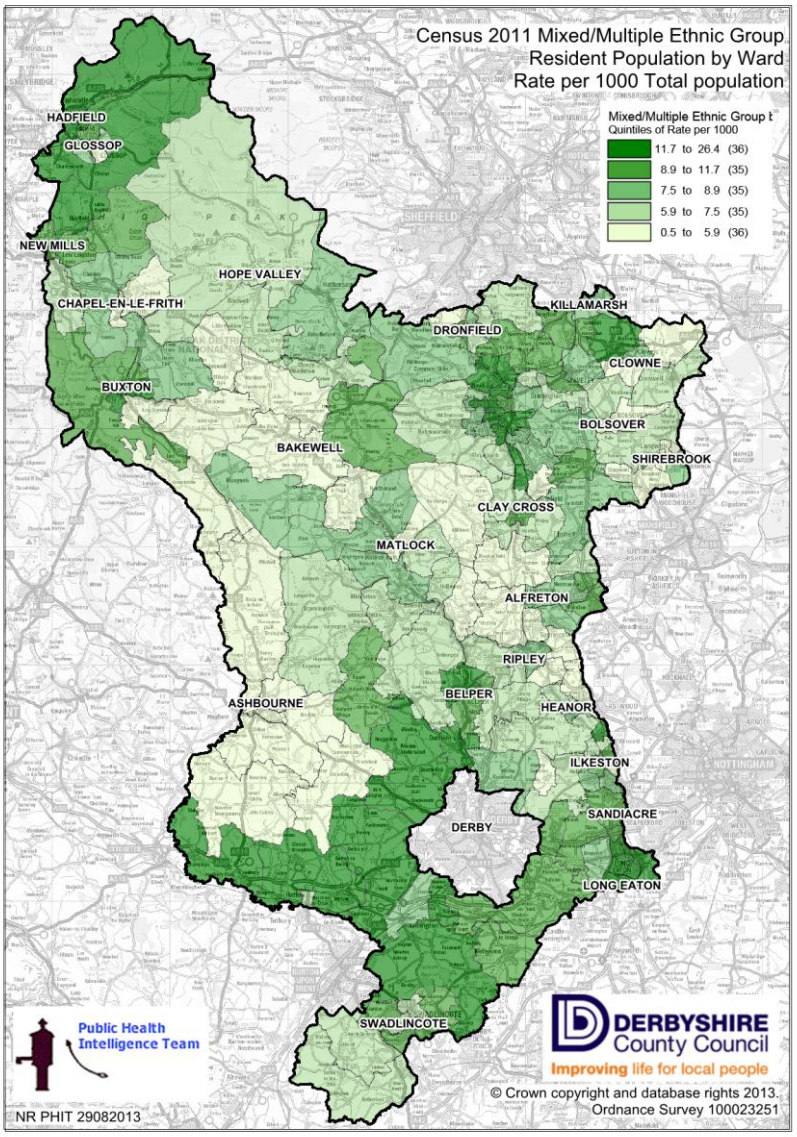
There were 3,669 individuals from Eastern European communities living within Derbyshire in 2011, comprising 0.5% of the population. There are no wards or LSOAs where the Eastern European

population exceeds 10% of the population. The areas with the highest number of individuals from Eastern European countries are in the Shirebrook/Cresswell/Langwith area, Alfreton, Long Eaton and Ashbourne.

3.1.4.2 Mixed and Multiple ethnic groups

The Mixed and Multiple BME groups comprise 0.92% of the population. Approximately half of individuals within this category are from Mixed White and Black Caribbean and one quarter from Mixed White and Asian BME groups. There are no wards or LSOAs where the Mixed and multiple ethnic group population exceeds 10%.

Figure 6: Distribution of Mixed and Multiple BME groups within Derbyshire, 2011



Source: National Census 2011

There were 3,173 individuals from Mixed White and Black Caribbean communities living within Derbyshire in 2011, comprising 0.4% of the population. There are no wards or LSOAs where the Mixed White and Black Caribbean population exceeds 10% of the population. The areas with the

highest numbers of Mixed White and Black Caribbean are in Long Eaton and communities to the south of Derby City.

There were 678 individuals from Mixed White and Black African communities living within Derbyshire in 2011, comprising 0.1% of the population. There are no wards or LSOAs where the Mixed White and Black African population exceeds 10% of the population, and the population is dispersed across the county.

There were 2,053 individuals from Mixed White and Asian communities living within Derbyshire in 2011, comprising 0.3% of the population. There are no wards or LSOAs where the Mixed White and Asian population exceeds 10% of the population. The areas with the highest numbers of Mixed White and Asian are in the communities adjacent to the southern boundary of Derby City and Duffield.

There were 1,215 individuals from Other Mixed communities living within Derbyshire in 2011, comprising 0.2% of the population. There are no wards or LSOAs where the Other Mixed population exceeds 10% of the population, and the population is dispersed across the county.

3.1.4.3 Asian and Asian British ethnic groups

The Asian and Asian British BME groups comprise 1.14% of the population. Approximately half of individuals within this category are from India, with one fifth from Chinese and one fifth from Other Asian and Asian British groups. Due to its high proportion of population from Indian ethnic groups, Stenson is the only ward where Asian and Asian British ethnic groups exceed 10% of the population. Asian and Asian British ethnic groups also exceed 10% of the population in three LSOAs in Stenson ward (South Derbyshire 003A, South Derbyshire 003B and South Derbyshire 003C).

There were 4,132 individuals from Indian communities living within Derbyshire in 2011, comprising 0.5% of the population. Stenson is the only ward where the Indian population exceeds 10% of the population. Three LSOA in Stenson ward (South Derbyshire 003A, South Derbyshire 003B and South Derbyshire 003C) are the only LSOA where the Indian population exceeds 10% of the population. The areas with the highest numbers of Indian population are in the communities bordering the southern edge of Derby City and Long Eaton.

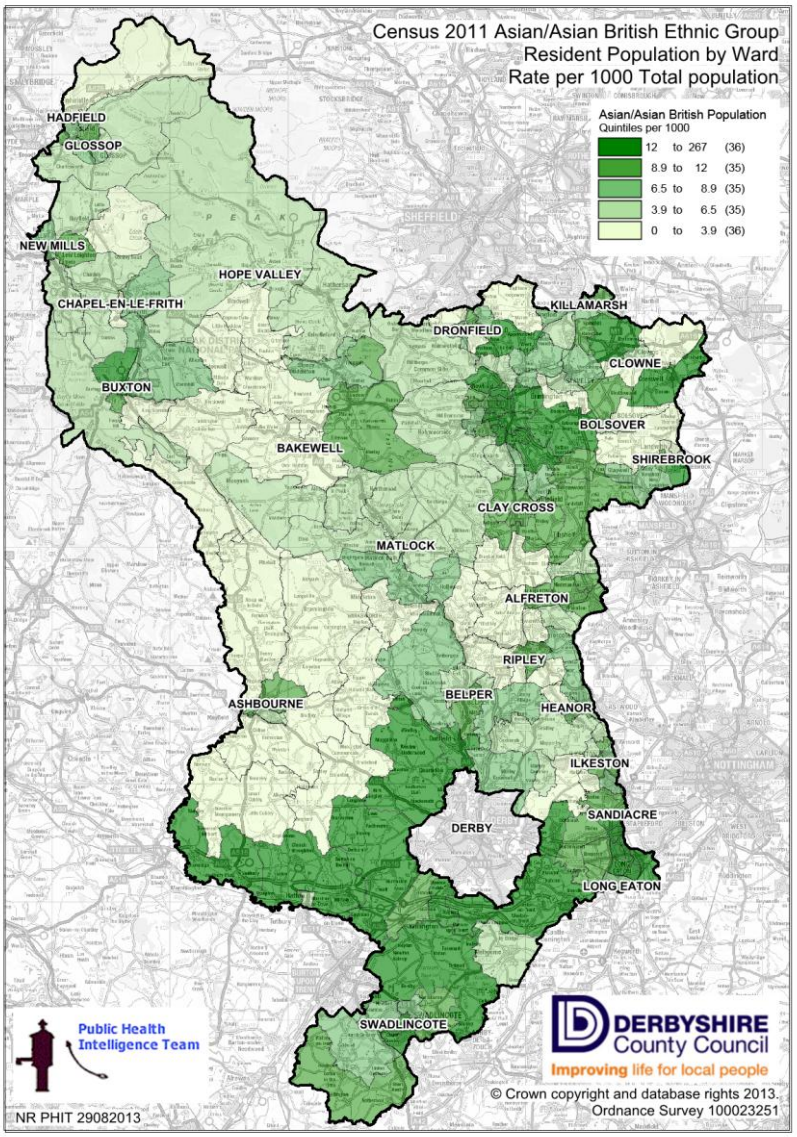
There were 979 individuals from Pakistani communities living within Derbyshire in 2011, comprising 0.1% of the population. There are no wards or LSOAs where the Pakistani population exceeds 10% of the population. The areas with the highest numbers of Pakistani population are in the communities bordering the southern edge of Derby City and Chesterfield.

There were 229 individuals from Bangladeshi communities living within Derbyshire in 2011, comprising less than 0.1% of the population. There are no wards or LSOAs where the Bangladeshi population exceeds 10% of the population. The area with the highest numbers of Bangladeshi population is Chesterfield.

There were 1,727 individuals from Chinese communities living within Derbyshire in 2011, comprising 0.2% of the population. There are no wards or LSOAs where the Chinese population exceeds 10% of the population. The Chinese communities are dispersed across Derbyshire, and the areas with the

highest numbers of Chinese population are Ockbrook, Barlborough, Buxton, Repton, Hadfield and Chesterfield.

Figure 7: Distribution of Asian and Asian British BME groups within Derbyshire, 2011



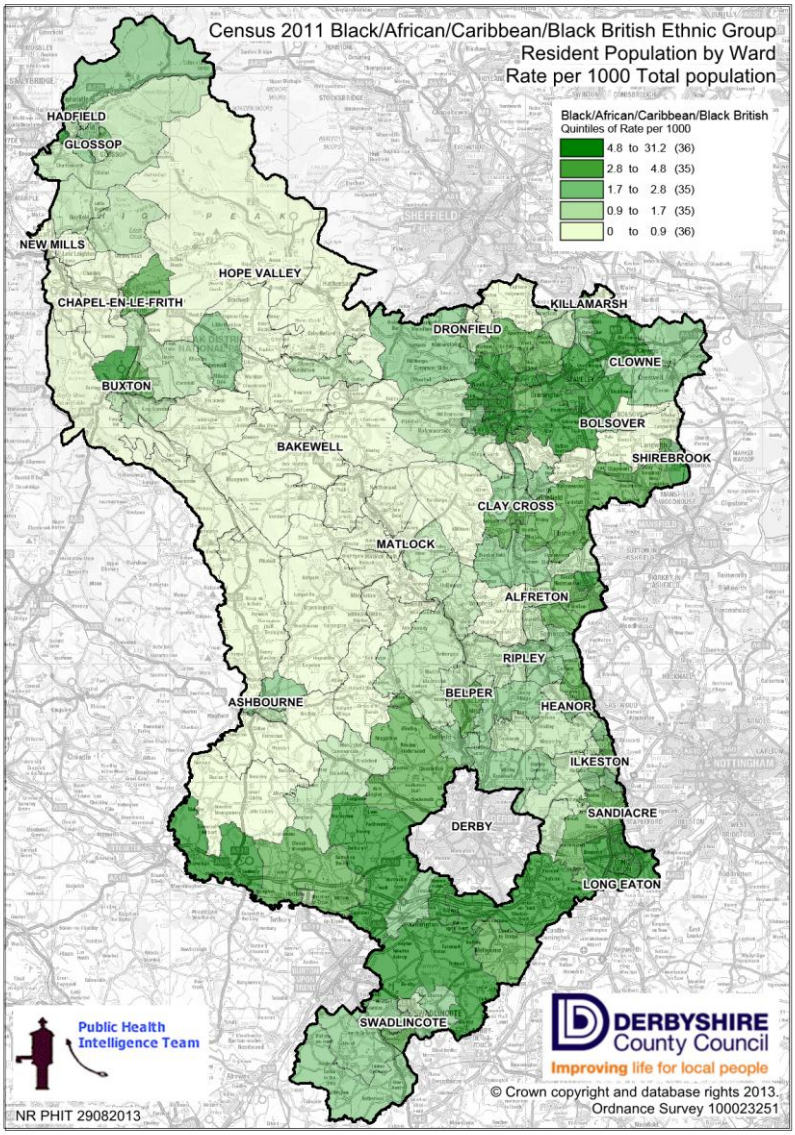
Source: National Census 2011

There were 1,728 individuals from Other Asian communities living within Derbyshire in 2011, comprising 0.2% of the population. There are no wards or LSOAs where the Other Asian population exceeds 10% of the population. The areas with the highest numbers of Other Asian population are the communities bordering the southern edge of Derby City.

3.1.4.4 Black, African, Caribbean and Black British ethnic groups

The Black, African, Caribbean and Black British BME groups comprise 0.36% of the population. Approximately half of individuals within this category are from Black African and approximately half are from Black Caribbean BME groups. No wards or LSOAs in Derbyshire have greater than10% of the population from Black, African, Caribbean and Black British BME groups.

Figure 8: Distribution of Black, African, Caribbean and Black British BME groups within Derbyshire, 2011



Source: National Census 2011

There were 1,303 individuals from Black African communities living within Derbyshire in 2011, comprising 0.2% of the population. There are no wards or LSOAs where the Black African population exceeds 10% of the population. The areas with the highest numbers of Black African population are Chesterfield, Pinxton and the communities bordering the southern edge of Derby City.

There were 1,153 individuals from Black Caribbean communities living within Derbyshire in 2011, comprising 0.2% of the population. There are no wards or LSOAs where the Black Caribbean population exceeds 10% of the population. The areas with the highest numbers of Black Caribbean population are Long Eaton and the communities bordering the southern edge of Derby City.

There were 314 individuals from Other Black communities living within Derbyshire in 2011, comprising less than 0.1% of the population. There are no wards or LSOAs where the Other Black

population exceeds 10% of the population. The areas with the highest numbers of Other Black population are Long Eaton and Chesterfield.

3.1.4.5 Other ethnic groups

The Other ethnic groups comprise 0.12% of the population. Approximately one quarter of this category are from Arab communities and the remainder comprise individuals from other ethnic groups. No wards or LSOAs in Derbyshire have greater than10% of the population from Other ethnic groups.

There were 251 individuals from Arab communities living within Derbyshire in 2011, comprising less than 0.1% of the population. There are no wards or LSOAs where the Arab population exceeds 10% of the population, and the population is dispersed across the county.

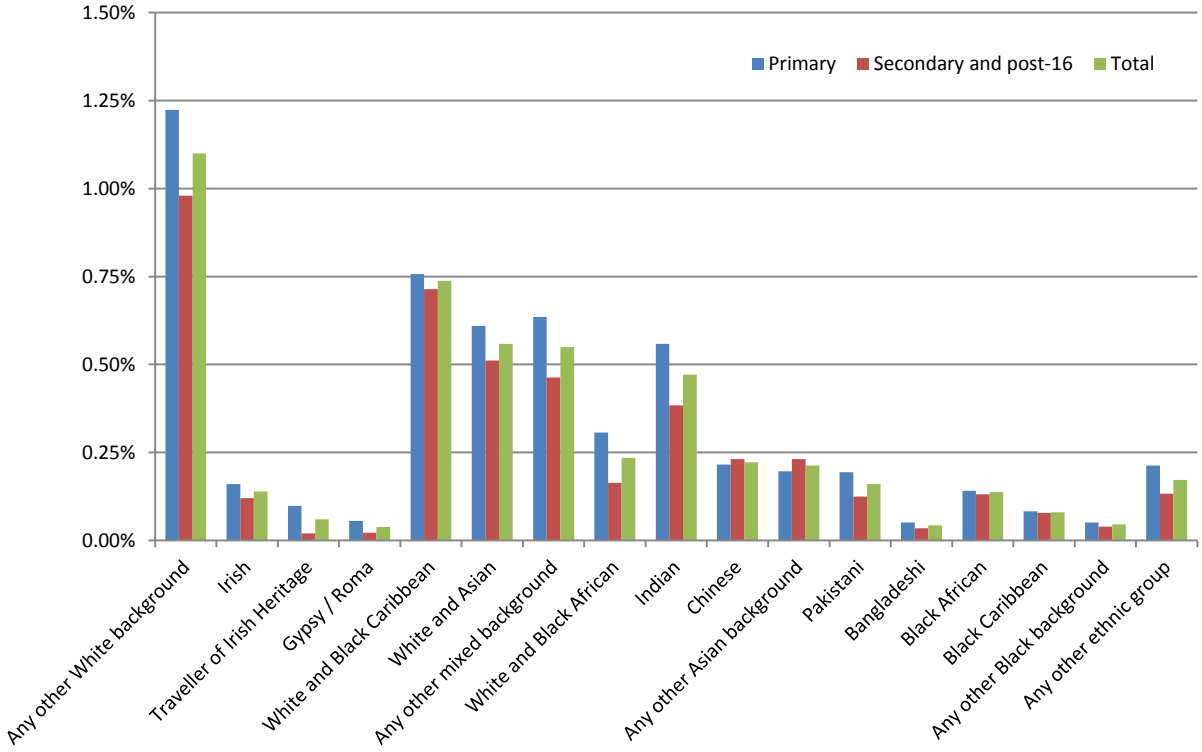
3.2 Derbyshire Schools Census

According to the Derbyshire Schools Census undertaken in January 2013 there were 4,644 young people in schools in Derbyshire from a BME group, comprising 5.0% of the school population. There were no differences in the proportion of boy and girls from each ethnic group, and therefore both sexes have been combined. The three largest BME groups within Derbyshire schools are Any other white background, White and Black Caribbean and White and Asian (figure 9). There are slight differences between the ethnicity categories used in the schools census compared to the national census, however, the makeup of the Derbyshire schools population in general mirrors that of the population as described by the 2011 census. The major difference is the higher proportion of school-aged children from Mixed and Multiple ethnic groups, compared to the 2011 census profile. Mixed and Multiple ethnic groups are the fastest growing ethnic group within England, and the schools census data suggests that the proportion of interracial relationships may be increasing within Derbyshire.

There was a higher proportion of primary school students from a BME group (5.5%) compared to the secondary school and post-16 students (4.4%). With the exception of Chinese and Any other Asian background, all the BME groups comprised a greater proportion of the primary school population than the secondary school and post-16 population.

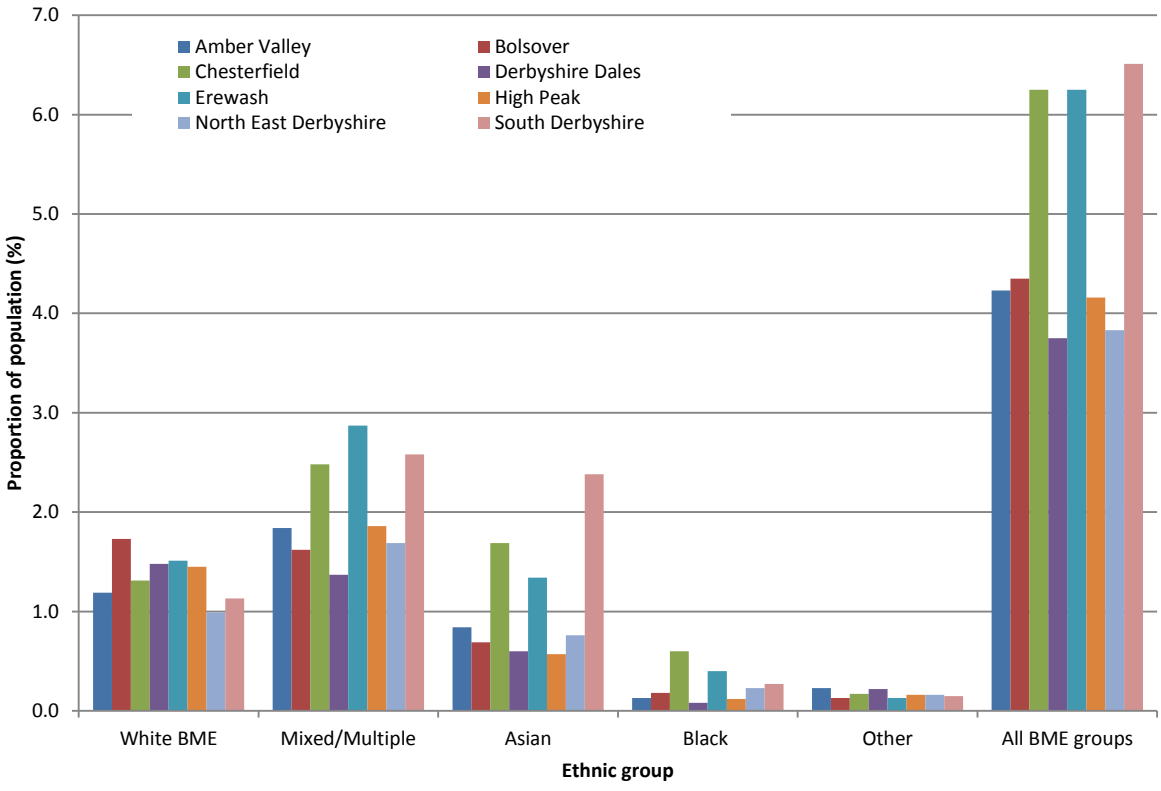
Chesterfield, Erewash and South Derbyshire have the highest proportion of students from BME groups (figure 10). For all districts with the exception of Bolsover and Derbyshire Dales, the highest proportion of students were from Mixed/multiple ethnic groups. Within Bolsover and Derbyshire Dales, the highest proportion of students were from White BME groups.

Figure 9: Proportion of BME groups within Derbyshire schools, 2013



Source: Derbyshire Schools Census, January 2013

Figure 10: Proportion of BME groups within Derbyshire schools by district, 2013



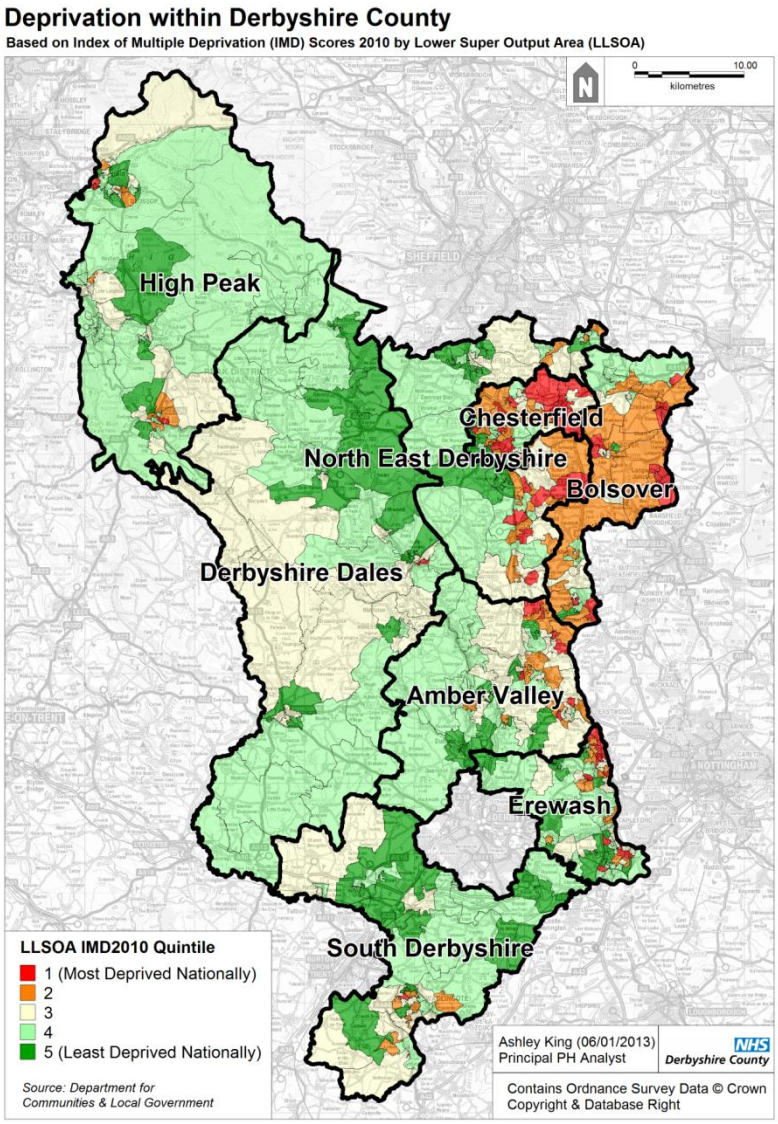
Source: Derbyshire Schools Census, January 2013

3.3 Deprivation within Derbyshire

Figure 11 illustrates the relative levels of deprivation within Derbyshire. The BME communities located on the eastern side of Derbyshire appear to reside in areas of higher deprivation, as do the smaller pockets of BME population in the towns in north west Derbyshire. However, the BME population located around the boundary of Derby City appears to reside in communities with relatively low levels of deprivation.

The reasons for this difference may be several, but suggest differences in the socio-economic status of the BME groups within Derbyshire. Individuals from areas with higher levels of deprivation experience worse health outcomes, and this information suggests within the Derbyshire BME population there may be differences in health outcomes due to differences in socio-economic position.

Figure 11: Deprivation within Derbyshire



3.4 Strengths and weaknesses of data sources used

The national census provides the most comprehensive data on the ethnic composition of the population and ethnicity data is made available by the Office for National Statistics at a local level. In addition, it allows individuals to select their ethnicity from a large number of categories. However, as the national census is only undertaken every 10 years then the data becomes out of date relatively quickly. In addition, the census will under-estimate the population size within certain population groups, and this may include temporary or illegal migrants and people who are nomadic in lifestyle.

The Derbyshire schools census is undertaken more regularly and therefore provides a more up-to-date estimation of the make-up of the school population. However, the schools census does not include the adult population, and results are based on a more limited selection of ethnic categories than used in the national census.

4 Health needs of BME groups

There has been much research published at a national level in the UK reviewing the health needs of BME groups. In the absence of local research, a narrative approach summarising the key findings from this national research has been adopted for the purposes of this HNA, with the assumption that findings from national studies will be generalisable to the Derbyshire BME population. This section therefore describes the health needs of BME groups, based on a number of key national reports, identifying where the health needs of BME groups may be expected to be greater than the general population.

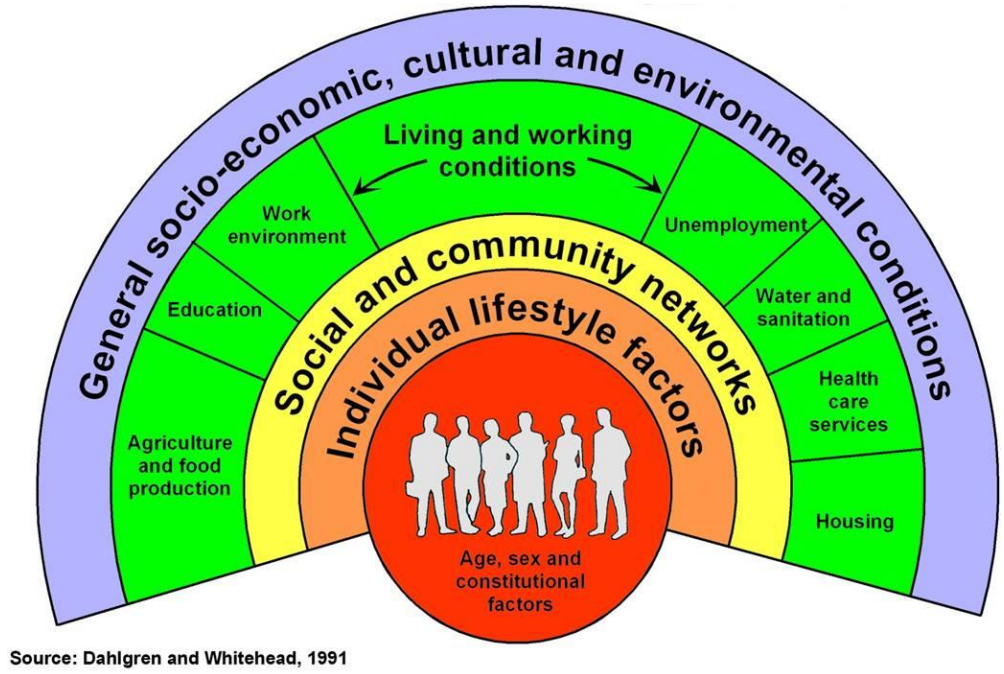
It should be noted that different research studies have grouped ethnicity categories together using different methodologies and therefore it may not be possible to directly compare different studies.

4.1 Factors impacting on health

There are a number of factors that can impact on an individual's health as demonstrated by figure 12. Certain population groups will experience worse health outcomes as a result of the effect of these factors. Determinants such as genetic differences, population structures, culture, socio-economic factors such as employment and housing quality will vary between different ethnic groups. However, differences in health outcomes are also present within ethnic groups, suggesting that more complex factors are at work than simple genetic or cultural explanations.[v] Even factoring in the effects of socio-economic disadvantage does not fully explain differences in health outcomes seen in BME groups and therefore other factors such as racial discrimination or cultural insensitivity in the provision of healthcare services may also be having an impact.[vi]

The remainder of this section highlights the health needs of BME groups, and highlights where these differ from the general population. However, it should be noted that many of the major health conditions that contribute most to mortality and morbidity in BME communities, such as cardiovascular disease, cancer and poor mental health are consistent across all ethnic groups.[vii]

Figure 12: The determinants of health



4.2 Health needs in early years

Ensuring a healthy start in life can benefit individuals for the rest of their lives. There are a number of areas where children from BME groups appear to experience different health needs and outcomes:

Self-reported health: for most BME groups, self-reported health amongst children is comparable or better to the general population. However, a smaller proportion of Bangladeshi boys and Black Caribbean girls report their health as good or very good compared to children in the general population.[vii]

Maternal and infant mortality: maternal mortality is significantly higher for Black African, Black Caribbean and Middle Eastern women compared to white women. Infant mortality rates are highest among babies born to Pakistani, Caribbean, African, Bangladeshi and Indian mothers, although it is not known whether the difference were significantly higher compared to babies born to White British mothers.[viii] [ix]

Smoking in pregnancy: there are similar smoking in pregnancy rates amongst White women and Black Caribbean women, with significantly lower rates amongst mothers from other ethnic groups.[x]

Vaccination: lower levels of childhood vaccination have been reported amongst certain population groups, including those from non-English speaking families and vulnerable children, such as those whose families are travellers, asylum seekers or are homeless.[xi] [xii]

Breastfeeding: in general, initiation and duration of breastfeeding are higher amongst mothers from BME groups compared to White British mothers. However, Asian and Black women have lower rates of exclusive breastfeeding.[xiii] [xiv]

Poverty: eligibility for free school meals is frequently used as a proxy measure of poverty, disadvantage and social exclusion. The BME groups with the highest proportions eligible for free school meals are children from the Irish Traveller, Gypsy/Roma, Black African and Bangladeshi communities. The groups with the lowest proportion eligible are children from the Chinese, Indian and White British communities.[xv]

Education: educational achievement (as measured by the % of young people achieving 5 A*-C GCSE grades) is a determinant of an individual's employment status later in life, which also affects other determinants of health such as income and housing. Educational attainment is lower amongst those eligible for free school meals. Amongst those not eligible for free school means, the lowest levels of attainment are found in the Black Caribbean and Black other BME groups. Among those eligible for free school meals, the White British group has the lowest level of attainment.[xv]

Smoking: Black Caribbean and Irish boys and girls, and Black African and Bangladeshi boys had similar levels of smoking prevalence as children in the general population, with children from other BME groups less likely to smoke.[vii]

Alcohol use: a similar proportion of Black Caribbean boys and girls and Irish boys reported ever having drunk alcohol compared to children in the general population, with children from other BME groups less likely to have tried alcohol.[vii] Young people from mixed ethnic groups report comparatively high rates of frequent use. [vii]

*Obesity: t*he prevalence of obesity among all BME groups was similar to that observed amongst children in the general population. Children from all BME groups except Pakistani boys and Irish boys and girls were less likely to exercise at recommended levels compared to children in the general population. Other research has highlighted that Indian and Bangladeshi ethnic groups are less active than children from other ethnic groups. In general, fruit and vegetable consumption is the same as or higher to consumption by children in the general population.[xvi] [vii]

Mental health: studies suggest that in general the emotional health of children from BME groups is similar or better to the general population. However, children from Black ethnic minority groups may have a higher prevalence of psychotic-like experiences and South Asian girls may be at higher risk of eating disorders. There may also be unmet need for mental health services among Pakistani and Bangladeshi children.[xvii]

Sexual health: teenagers from Black Caribbean groups are at higher risk of gonorrhoea and chlamydia than the white population and other ethnic groups. Rates of genital warts are less common amongst all BME groups compared to white teenagers. Although numbers are small, Black African young people are disproportionately more likely to be in receipt of care for HIV infection. Caribbean, Pakistani and Bangladeshi women have higher rates of teenage births than white women.[xviii]

Female Genital Mutilation (FGM): the health risks of FGM can be immediate (such as haemorrhage, wound infection, infection due to re-use of inadequately sterilised equipment), intermediate (such as delayed healing, abscesses, pelvic infections and urinary tract infection) and long-term (such as post-traumatic stress disorder, infertility, childbirth complications and trauma, and permanent pain due to cut nerve endings). FGM is illegal in the UK, but is a deeply rooted practice in some cultures. FGM is practised in approximately 28 counties 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. 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. 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.[xl]

4.3 Healthy lifestyles

Maintaining a healthy lifestyle is a key factor in determining health. Alcohol consumption, smoking, obesity and physical inactivity are risk factors for a number of long term conditions, such as diabetes, cardiovascular disease, cancer, and dementia. There are a number of lifestyles areas where the behaviour of some BME groups appears worse than the general population:

Tobacco use: compared to the general population, Bangladeshi (40%) and Irish (30%) men were significantly more likely to report cigarette smoking. Smoking rates were also higher (though not significantly) amongst Pakistani (29%) and Black Caribbean (25%) men. Irish (26%) and Black Caribbean (24%) women had higher smoking rates compared to the general population, although these were not significantly higher. Use of chewing tobacco was more prevalent amongst Bangladeshi men and women. Data suggests that actual prevalence of tobacco use is higher than self-reported estimates.[vii] Whilst smoking rates have decreased amongst the general population over the last few years, this pattern does not seem to be reflected amongst BME groups.[xix]

Alcohol use: with the exception of the Irish, individuals from BME groups were more likely than the general population to be non-drinkers, and also to drink alcohol less often. Drinking habits among Irish men and women were similar to the general population, although the number of days per week when alcohol was consumed and binge drinking (drinking twice the recommended daily limit) was higher for both Irish men and women.[vii] Evidence suggests that consumption of alcohol rose significantly amongst Chinese men and Indian women between 1999 and 2004, although there is no evidence to suggest similar rises amongst other BME groups.

Drug use: highest rates of illicit drug use are reported amongst Black men (21.8% compared to 12.4% of White men), with the lowest levels in Asian men. Amongst women, similar rates of use were reported amongst White and Black groups, with the lowest rates amongst women from Asian ethnic groups.[xx]

Obesity: obesity levels are highest amongst Black Caribbean and Irish men, although these are not significantly higher than the general population. Amongst women, Black Caribbean,

Black African and Pakistani women are significantly more likely to be obese than the general population.[vii]

Physical activity: Indian, Pakistani, Bangladeshi, Black Caribbean and Black African men and women were significantly less likely to have participated in any physical activity of at least moderate activity compared to the general population.[vii]

Eating habits: in general, a higher proportion of men and women from all BME groups[2] reported eating five portions of fruit and vegetables a day compared to the general population, and also had lower fat intake compared to the general population. However, Indian, Pakistani, Bangladeshi, Black Caribbean, Black African and Chinese groups reported higher rates of salt use in cooking.[vii]

Cancer screening: uptake rates for the national breast, cervical and colorectal cancer screening programmes are generally lower amongst BME groups than in the general population. Surveys have demonstrated lower awareness of cancer amongst BME groups compared to White men and women. [xxi]

Infectious diseases: rates of TB were highest among Indian ethnic groups (eleven times higher than the rate in the general population. Rates were nine times higher amongst Pakistani ethnic groups and seven times higher amongst Black ethnic groups, compared to the general population.[xxii] Due to differences in worldwide prevalence, migrants may be at higher risk of being infected with blood borne viruses (such as HIV and hepatitis B and C).[xxiii]

HIV infection rates amongst Black Africans in the UK are approximately 30 times higher than the general population. Factors such as acquiring the infection abroad, HIV-related stigma and discrimination contribute towards the higher rate. Approximately two-thirds of Black Africans diagnosed with HIV in the UK in 2011 were female, compared to only one-third of all cases.[xxiv]

4.4 Emotional and mental health

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

Serious mental illness include conditions such as schizophrenia, bipolar disorder and personality disorders. Common mental health problems include conditions such as anxiety, depression and phobias.

Serious mental illness: there are differences in the rates of admission, detention under the Mental Health Act and seclusion between ethnic groups. Admission rates to mental health inpatient units are significantly higher amongst Black Caribbean, Black African, Other Black, White/Black Caribbean Mixed and White/Black African Mixed groups compared to average

[2] Indian, Pakistani, Bangladeshi, Black Caribbean, Black African, Chinese and Irish

rates. In contrast, admissions rates were significantly lower amongst Indian and Chinese groups. Detention rates are significantly higher than average among Black Caribbean, Black African, Other Black and White/Black Caribbean Mixed groups, White Irish, Other White and Other Mixed groups. Seclusion rates have fluctuated over time, but have been higher than average for Black, White/Black Mixed and Other White groups in at least three of the six censuses. Length of stay was longest for patients from the Black Caribbean and White/ Black Caribbean Mixed groups and shortest for patients from the Chinese and Bangladeshi groups[xxv].

Rates of psychosis are significantly higher among Black men (3.0%) compared to white men (0.2%). There were no reported differences in rates between women from ethnic groups. [xx]

Higher rates of serious mental illness have been reported amongst the Irish population including Irish people are twice as likely to be hospitalised for mental health problems than native-born people in England and Wales, rates of schizophrenia amongst Irish people are second only to African-Caribbean people and higher rates of suicide amongst Irish people than any other minority ethnic group.[xxiv]

Common mental health problems: there is little variation in the rates of having any common mental disorders between White (12.0%), Black (12.9%) and South Asian (10.3%) men, but are highest amongst Mixed ethnic/Chinese ethnic groups (20.2%). Amongst women, rates of common mental disorders are significantly higher amongst South Asian women (34.3%) than amongst other groups (White 19.3%, Black 21.0% and Mixed ethnic/Chinese 20.6%). There are also gender differences reported, with rates of any common mental disorders higher among women than men across all ethnic groups, with rates three times higher amongst South Asian women compared to South Asian men.[xx]

Post-traumatic stress disorder: Rates of post-traumatic stress disorder are three times as high amongst black men (7.4%) compared to White men (2.5%), with no significant difference reported by ethnic groups amongst women. [xx]

4.5 Long term conditions

A long term condition is one which cannot be cured, but good management of that condition can reduce its impact on the individual. Management could be by medication, or adopting a healthier lifestyle.

Self-reported health: rates of bad or very bad health are significantly higher amongst Bangladeshi and Pakistani men and Black Caribbean women than the general population. Rates of self-reported longstanding illness are significantly higher amongst Bangladeshi men and Pakistani women. Rates of acute sickness within previous fourteen days are significantly higher amongst Pakistani men and women. [xxvi]

Cirrhosis: South Asian men, particularly from Sikh population are over-represented for alcohol-related liver cirrhosis.[xxvii] In addition, men born in Ireland, Scotland and India and women born in Ireland and Scotland have higher than average alcohol-related mortality than the general population[xxviii]

Haemoglobinopathies: sickle cell disease is more common in ethnic groups of African origin and thalassemia is more common in individuals from the Mediterranean region.[xxix]

Coronary heart disease: mortality rates from coronary heart disease by ethnicity are not available within the UK, however mortality from CHD accounts for a quarter of all deaths amongst individuals born in South Asia but dying in England and Wales compared to 15% of all deaths in the UK-born population. Rates of coronary heart disease are highest amongst the South Asian population.[xxx]

Stroke: mortality rates from stroke by ethnicity are not available within the UK, however mortality rates amongst under 70's for stoke are higher among men born in Bangladesh and West Africa and men and women born in Jamaica compared to those born in England and Wales. The mortality rate from stroke is falling in all ethnic groups, however, rates among individuals born outside the UK are falling at a slower rate than those born within the UK.[xxxi] The prevalence of stroke is highest among Black Caribbean and Irish ethnic groups.[xxx, vii]

Diabetes: Rates of diabetes are highest among South Asian and African Caribbean ethnic groups.[xxx] Type 2 diabetes is up to six times more common in people of South Asian descent, and up to three times more common among people of African and African-Caribbean origin.[xxxii] Diabetes is almost four times more prevalent in Bangladeshi men, and almost three times as prevalent in Pakistani and Indian men compared to men in the general population. Among women, diabetes is more than five times more likely among Pakistani women, at least three times as likely in Bangladeshi and Black Caribbean women, and two and a half times as likely in Indian women compared to women in the general population.[vii] Highest rates of diabetes amongst 16-34 year olds are found amongst Indian men, Black African men and Irish women.[vii]

Cancer: there are variations in cancer incidence between ethnic groups, due primarily to environmental and lifestyle factors, and less so to differences in genetic risks for particular cancers. For many cancers, incidence rates are lower amongst BME groups compared to White ethnic groups. However individuals from Black ethnic group have significantly higher rates of multiple myeloma and stomach cancer, and Black men have higher rates of prostate cancer. In addition, Asian woman have higher rates of mouth cancer, particularly among those aged 65 and over.[xxi]

National studies on cancer mortality by ethnic group is not available in the UK, however studies have reported higher mortality from most cancers amongst Irish community living in Britain.[xxi, xxiv]

Analysis of cancer survival indicates that differences between ethnic groups may exist however there is currently a high level of uncertainty in these results. Indian, Pakistani, Black Caribbean and Black African women are more likely to present with advanced breast cancer than White women, and this may be responsible for apparent poorer survival rates observed amongst Black and Asian women. There is also evidence of inequalities at each stage of the patient pathway, including information provision and palliative care.[xxi]

Learning disabilities: prevalence rates for severe learning disabilities are higher in South Asian groups in the UK, with rates approximately 3 times higher among 5-34 year olds compared to non-Asian communities.[xxxiii] Further information on ethnicity and learning Disabilities in Derbyshire can be found in the recently completed Derby and Derbyshire Learning Disability Needs Assessment, available at: http://observatory.derbyshire.gov.uk/IAS/Custom/resources/HealthandWellbeing/Health_Needs_Assessments/Derbyshire_LD_needs_assessment_final1.pdf#view=Fit

Renal failure: Incidence of end-stage renal failure in South Asian and African-Caribbean groups are three times higher than the White population in the UK.[i]

4.6 Older people

People are now living longer than ever, with populations projections suggesting that numbers of older people will increase at a faster rate than other age groups. As people get older, their health needs become more complex with an increasing reliance on health and social care support.

Dementia: it is estimated that the proportion of BME people affected by dementia is similar to that found amongst white people. However, there have been no large-scale prevalence studies within the UK involving sufficient numbers of BME participants to compare prevalence across different ethnic groups.[xxiv] However, it is expected that the numbers of individuals with dementia from BME groups will increase more sharply than the overall numbers over the few years due to an increase in the numbers of individuals from BME groups in their seventies and eighties.[xxxiv]

Early onset dementia (affecting people aged under 65 years) is more frequent amongst BME groups, with 6% of individuals from BME groups with dementia having the early onset form compared to 2% of individuals with dementia in the UK overall.[xxxiv] In addition, the prevalence of vascular dementia is thought to be higher amongst Asian and Black Caribbean groups due to individuals being more prone to important risk factors for vascular dementia such as cardiovascular disease, hypertension and diabetes.[xxxiv]

There is evidence that people from BME groups present later to dementia services, resulting in individuals only seeking help from specialist services when symptoms are already very severe. This may be due to BME groups viewing the symptoms of dementia as “normal ageing”. Research also suggests that there may be high levels of stigma in relation to dementia among certain BME groups, leading to reluctance to access support and treatment.[xxxiv]

4.7 Use and experiences of health services

Research suggests that differences in health status between minority ethnic groups and the general population are most likely due to a range of complex factors, including genetic differences, cultural differences in the presentation of ill health, differences in socio-economic status, racial discrimination and cultural insensitivity in the provision of healthcare.[vi]

4.7.1 Use of services

The Department of Health highlighted within its Race Equality Scheme concerns that some ethnic minority groups experience poorer health than others, and also poorer access to services and quality of services received.[xxxv] Assessing inequities in access and outcomes of health service provision has been hampered for many years by the lack of routine recording of ethnicity information by primary and secondary care health services.[vi] In addition, very few studies have attempted to adjust health utilisation rates for differences in socio-economic status and underlying rates of diseases.[xxxvi] However, there is evidence that South Asians and African-Caribbean ethnic groups are more likely than the white group to consult their GP, with Chinese less likely to access a GP. There is also evidence that the Chinese may also under-utilise hospital services, with lower inpatient, outpatients and A&E attendance rates compared to the general population. Pakistani respondents were less likely to access out-patient services than the general population, but more likely to be admitted as an in-patient. Bangladeshi BME groups were also less likely to access out-patient services, with Caribbean groups more likely. Individuals from BME groups are also significantly less likely to visit the dentist than the general population, with particular low rates for Bangladeshi adults and children and Pakistani children. In addition, in all BME groups, the reason for the last visit to a dentist was more likely to be due to problems with their teeth rather than for a routine check-up than in the general population.[liii] [xxxvii]

4.7.2 Satisfaction with services

The first national GP patient survey undertaken in 2007 highlighted that BME patients were less satisfied with GP services than the general population. A follow up report, commissioned by the Department of Health, identified that healthcare needs of individuals from BME communities that are not fully matched by existing services. The report highlighted four main reasons for dissatisfaction:[xxxviii]

- communication problems between the patients and practices, caused by language and cultural barriers
- a greater disease burden in BME patients due to their poorer health status
- the quality of GP services is too variable
- the expectations of BME patients are different

The report recommended that there is not a need for separate services for BME groups, but rather models of flexible, personalised care that is part of mainstream healthcare and accessible to everyone.

Analysis of a number of patient satisfaction questionnaires highlighted differences in the self-reported experience of patients from different ethnic groups. Views of patients who had accessed adult inpatient, emergency departments, primary care services and community mental health services were collated, with the main findings being:[xxxix]

- responses from White Irish groups were generally either similar to or significantly more likely to be positive than those from White British groups
- Asian/Asian British and Chinese/Other groups were less likely to give positive responses compared to the White British groups

- Respondents from White Other, Mixed and Black/Black British were also less likely to give positive responses than the White British group, however to a lesser degree than the Asian/Asian British and Black/Black British groups

5 Stakeholder needs analysis

In April 2011, the Chesterfield and North East Derbyshire Council for Voluntary Service and Action was commissioned by NHS Derbyshire County to carry out a needs analysis of BME groups across Derbyshire. A two stage process was used, with initial consultation undertaken by representatives of BME community organisations on the views of their respective communities, followed by completion of a structured questionnaire by the BME community organisation representatives on Derbyshire BME Forum. BME community organisations that participated were those that were members of the Derbyshire BME forum, and included organisations that represented the Indian, African Caribbean, Filipino, Chinese, Muslim, Gypsy and Eastern European (including Polish, Bosnia-Herzegovina and Ukrainian) communities within Derbyshire.

Participants were asked to identify the main health issues concerning members of their communities (table 5). A number of common issues were identified by different community groups, and many of these are also issues that affect the general population. As well as the health conditions identified in table 5, many of the BME communities also highlighted language barriers as a problem in accessing health care services.

Table 5: Health issues identified by BME groups represented on Derbyshire BME Forum

Groups representing	Health issues identified by community
Indian community	Diabetes, stroke, heart disease, arthritis, hypertension, high cholesterol, alcohol, stress
African Caribbean community	Diabetes, stroke, heart disease, arthritis, hypertension, obesity, sickle cell
Filipino community	Diabetes, stroke, heart disease, arthritis, strains and back pain, hypertension
Chinese community	Diabetes, stroke, heart disease, arthritis, hypertension, rheumatism, kidney disease
Muslim community	Diabetes, stroke, heart disease, arthritis, hypertension and obesity
Gypsy and Traveller community	Diabetes, strains and back pain, hypertension
Eastern European communities	Diabetes, stroke, heart disease, hypertension, alcohol use, smoking, arthritis and rheumatism

A number of recommendations were made following the Stakeholder Needs Analysis. The implementation of the Health and Social Care Act 2012 resulted in significant changes in the structure of the NHS in England, and therefore it is not known to which organisation or organisations the recommendations were taken, nor whether any organisation or committee was identified as being responsible for implementing them. The recommendations made were:

- NHS Derbyshire county to fund a pilot BME community mental health and wellbeing information, support and signposting service based at local BME community organisations

- Commissioning organisations take into account the health issues highlighted by BME communities and feed into health strategies
- Develop a better communication channel to ensure the new arrangements for GP-led commissioning improve access to healthcare for the BME population, including
    - BME groups being involved in the planning and development of the primary healthcare agenda
    - Commissioners should commission BME community groups to perform project activities that complement and connect the BME population to mainstream primary care funded services
    - Primary care providers should be more responsive to the needs of the BME population
    - Primary care providers should ensure the availability of interpreting services, and ensure staff are trained on working with interpreting issues
    - Encouraging BME patients to report dissatisfaction with services provided

6 Limitations of the Health Needs Assessment

It is hoped that this HNA report will provide valuable information on the distribution, profile and health needs of the BME communities within Derbyshire. However, there are three limitations which should be considered:

- health needs vary considerably by age, and in order to better understand the potential health needs of different BME communities, a more detailed age profile for different BME groups is needed. However, at the time of writing, no census data had been published that allowed for the breakdown of individual ethnic groups by age.
- the census data is the most comprehensive data source available that can provide information by ethnicity. However, census data can quickly become out of date, and it should be recognised that the BME population in Derbyshire will have changed in the two years between the census being undertaken in 2011 and the publication of this report
- the scope of this HNA was to provide a summary of the profile of the BME population in Derbyshire, and their likely health needs. The report has therefore not attempted to answer the question as to whether the health outcomes of the BME population in Derbyshire are being disadvantaged by current provision of health services

7 Summary and recommendations

Individuals from BME groups comprise 4.2% of the population of Derbyshire, and if current trends continue, this proportion will continue to increase over the coming years. There are a wide range of ethnic groups present within the BME population of Derbyshire. The BME population is dispersed across most of Derbyshire, however, there are a number of areas, particularly urban locations, where BME groups comprise a higher proportion of the population. Currently, the BME population have a younger age profile than the general population, however this will change over the coming decades as the population ages. The BME communities living in the east of Derbyshire, Buxton and Glossop appear to reside in areas of higher socio-economic deprivation, however the BME

population living in the communities surrounding Derby City appear to experience relatively low levels of deprivation.

As highlighted in the literature review, there are a number of conditions where the health needs of BME groups differ from the general population. However, it should be emphasised that many of the major health problems are experienced by all ethnic groups, such as coronary heart disease, stroke, cancer and poor mental health. In addition, some of the conditions where some BME communities are at increased risk may affect only a small number of individuals, for example maternal and infant mortality, sickle cell disease and HIV. BME groups are also not homogenous in their health needs, with different BME groups experiencing different outcomes. Whereas the major health concerns may be similar between all ethnic groups, what may differ between ethnic groups are belief systems, attitudes to health and life, lifestyle behaviours, access to and experience of health services.

In order to achieve the greatest impact at a population level, actions should be considered that will improve the health of the greatest proportion of BME groups. In addition, any identified actions should be proportionate in scale, that is acknowledge that across Derbyshire, the BME population comprises a relatively small proportion of the population, but that there are some localities where there are significant numbers of individuals from BME groups within the population.

Recommendations to progress this work are grouped into three categories:

1. to increase awareness of the profile and health needs of the BME population within Derbyshire
2. to determine if the health outcomes of BME groups are disadvantaged by current public health service provision in Derbyshire
3. that the BME Forum and Public Health at Derbyshire County Council work together to identify opportunities to improve the health of BME population in Derbyshire, based on the major health needs identified in the HNA

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