13. Black and Minority Ethnic Groups

Chapter Summary

Wirral BME population issues

- Information relating to ethnicity in Wirral is limited. Wirral is by no means unique in this respect; many other areas are faced with this issue due to the limitations and relative inconsistencies in the recording of BME population data.
- This possible lack of local data on the health and wellbeing needs of the increasing range of Wirral BME communities can in part be addressed by reviewing national data as it is likely to present a similar picture for Wirral residents.
- National and previous local evidence might suggest that BME groups may not be accessing health and social care services in accordance with their level of need or in a timely manner.
- Research suggests poorer communication, undue expectation, possible stereotyping , need for further training and cultural awareness that can combine to impact on BME residents in relation to their service provision and access
- Census 2011 shows us an increase in the BME population, from 3.46% in 2001 to 5.03% in 2011 (From 10,900 people in 2001 to 16,101 people in 2011)
- More BME residents live in Birkenhead and Tranmere ward than any other part of Wirral followed by Claughton, Rock Ferry and Hoylake & Meols.
- There is a need for more robust data on the population prevalence of Black and Minority Ethnic (BME) groups to aid assessing levels of access to services particularly. The current methods, both nationally and locally of capturing data around ethnicity and migration would not appear able to cope with population change happening faster than it has in the past.

Wider BME population issues

- Black and Minority Ethnic (BME) groups generally have worse health than the overall population, although the patterns of ethnic health inequalities are very diverse within and between different ethnic groups.
- **Cardiovascular (CVD) and Coronary Heart Disease (CHD)** affect BME and general populations differently with Irish and South Asian men at higher risk of health related problems. Some male and female populations such as Chinese and Black African have significantly lower risk to CVD and CHD, it is suggested that modifying lifestyle behaviours will reduce prevalence for CVD, CHD, stroke, hypertension and a number of related diseases.
- **Stroke and Hypertension** can show disproportionate effects on certain BME populations such as South Asians Black Africans and Black Caribbean
- **Diabetes** – South Asian, Caribbean and Gypsy Traveller populations are substantially at greater risk to the impact of diabetes. A combination of lack of self-management, health care and ineffective communication with services can combine to make worse the condition.
- **Cancer** – although there are lower rates of cancer in some male and female populations' such as West Indian, South Asian and East/West African for certain cancers there are equally a number of ethnic population groups in which there are higher rates of certain cancers.

- **Mental Health** and ethnicity suggests a focus shifting from predisposition to mental illness, to inequality in service access and provision and differences in health outcomes may be contributing underlying factors to higher population rates for a range of mental illnesses. There could also be a limited amount of data on illnesses for certain ethnic groups and some of the groups presenting later and in crisis due to perceived stigma and lack of service knowledge. It is suggested there could be higher rates of poor mental health generally, admissions, Community Treatment Orders and seclusions are evident for certain ethnic groups and for males and females by type of mental health illnesses.
- **Dementia** is not widely understood in ethnic population groups due to the limited wide-scale research. Later presentation, and so a diagnosis then access to services, occurs when the illness can be seen as natural ageing in some ethnic group families. Research into Irish Communities suggests dementia is an increasing issue for their elder population.
- **Smoking** - the numbers of people from ethnic groups smoking has disproportionate effects on men and women and within different ethnic groups. Much lower rates of Bangladeshi women smokers from national prevalence comparison and Irish women is in turn compared to highest rates in Indian, Bangladeshi and Irish men. The use of cessation services is thought to be limited as linked to reasons why ethnic groups are already not accessing existing health promotion/preventative services.
- **Obesity** would appear to have a greater impact on Black African, Bangladeshi and Pakistani women. Differences according to how ethnic population obesity comparisons are made should be borne in mind as well as cultural, religious, subsequent lifestyle changes and socio-economic variations. The subsequent negative health outcomes for obesity are similarly problematic to those for the general population
- **Obesity in Children –** with information derived from the national and local National Child Measurement Programme it suggests that being obese and/or overweight is impacting on all populations but particularly on certain BME population groups.
- **Alcohol** appears to be an issue for men from Irish, Polish and other eastern European populations in terms of frequency and amount consumed. More specific local data is limited on alcohol issues for ethnic minority populations.
- **Sexual Health** – STIs affect different ethnic groups – with some being below and others above national comparators. Due to sexual health being a subject often not discussed by the members of number ethnic groups the need for culturally appropriate and targeted service interventions is more relevant and would likely raise awareness and prevents further issues.
- **Women's Health** – access to maternal services can be lower by ethnic minority women with reasons such as late access, previous experience and uncertain awareness of important prenatal testing. On the other hand there is evidence to suggest higher levels of breastfeeding in BME communities. Earlier national research suggests maternal mortality rates being higher than the general population, a lower uptake of cancer screening services and also elevated rates for stillbirth and neonatal issues in Gypsy and Traveller communities.
- **Children & Young People** from BME communities again have a variation in health outcomes – sometimes better than the general population and at times worse.

- **Older People** numbers for both BME groups and the general population are growing. Expectations that families continue to care for their elders are being challenged and the health of all elders could be compromised. Local data is limited on this aspect.
- **Irish Travellers & Gypsies**, although local numbers are low, they could be significantly more likely to have a long-term illness, health problems or disabilities with access and use of health services being worse than the general population. Cultural pride and other barriers often prevent better access or increase late presentation and so more acute use of services.
- **Palliative Care** services for BME elders, as suggested by earlier research, are possibly not being accessed as extensively because of language difficulties and lack of provision awareness. Recent national insight suggests an increasingly important need to improve communication, training and awareness of patient and family needs in light of the ageing BME and general population.
- **Disabilities and health** of BME communities has a range of differences to general population with wider and more pronounced negative outcomes and inequalities according to recent research. For example, Learning Disability services are disproportionately accessed less by BME residents, specific affects eye and deaf BME residents with Census 2011 highlighting greater locally self-reported health problems for the Irish community
- **Local services** are accessed by a lower proportion of BME residents compared to population estimates. There is a need to develop improvements in recording BME status to improve data accuracy and subsequent analysis.

Acknowledgements
I would like to thank Breege McDaid, Clint Agard, Sabra Ahmed, Mindy Rutherford, Raza Moula, Rose Kumwenda and Win Lawlor for their continued contribution to this JSNA chapter.

Contents

This chapter focuses on the needs of Black and Minority Ethnic (BME) groups, this not only includes people who describe themselves as non- white, but also people from other key minority groups in the UK such as Irish and Eastern Europeans**.** It is however important to note that there is a lack of information on the health needs of migrant people and consequently has been identified as a key issue.

Wirral Ethnic Health Advisory Group (WEHAG) has recently developed its health and wellbeing strategy. The content in the previous BME JSNA chapter supported that approach and it is hoped this revised content will provide WEHAG with added information as they continue to monitor their strategy.

For the purposes of this chapter we will use the term BME as an overarching term to describe people of black and minority ethnic groups unless otherwise stated.

13.1 Socio demographics

In considering social demographics, it is important to understand health status and how it helps determine health inequalities between different population groups. Health status is shaped by a multitude of factors including the characteristic and behaviours of individuals and the physical, social and economic environment (Leung and Stanner, 2011). They also suggest that health inequalities can exist more among minority ethnic groups as they tend to show poorer health outcomes.

Information relating to ethnicity in Wirral is limited. Wirral is by no means unique in this respect; many other areas are faced with this issue due to the limitations and relative inconsistencies in the recording of BME population data. There are sources that can be used to estimate ethnicity in Wirral, none are complete or definitive but taken overall can be a useful illustration of ethnicity in Wirral. These are noted later in this chapter but are discussed in some more detail in the Population Chapter (see section 2.2 ethnicity).

Therefore interventions that are designed to improve the health and wellbeing of the BME community need to consider the wider determinants that impact on people's health. Addressing some of these and understanding some of the wider issues that they face or concern these groups could contribute towards an overall improvement in health.

13.1.1 Population

Wirral overall has seen an increase in population from 314,700 (2001 Census) to 319,783 (2011 Census).

This latest ONS Census data continues to highlight Wirral has a small, but increasing, ethnic minority population. Using data from the Census 2011, 96.8% of the population were classified as white (White British, White Irish or White Other).This compares to the Census 2001 figures of 98.4% locally.

In table 13.1.1a displays the Wirral population breakdown by ethnic group and the net change from 2001.

Table 13.1.1a: Census 2011 Wirral Population by Ethnic Group

Ethnicity	Census 2001	Census 2011	% of 2011 population	Net Change (from 2001)
White: British	303,800	303,682	94.70	-118
White: Irish	3,100	2,667	0.88	-433
White: Gypsy or Irish Traveller	0	77	0.03	77
White: Other White	2,700	3,730	1.23	1,030
Mixed: White and Black Caribbean	500	964	0.32	464
Mixed: White and Black African	300	558	0.18	258
Mixed: White and Asian	500	949	0.31	449
Mixed: Other Mixed	500	815	0.27	315
Asian or Asian British: Indian	700	1,344	0.44	644
Asian or Asian British: Pakistani	100	226	0.07	126
Asian or Asian British: Bangladeshi	400	851	0.28	451
Asian or Asian British: Chinese	1,300	1,653	0.54	353
Asian or Asian British: Other Asian	200	1,042	0.34	842
Black or Black British: African	300	389	0.13	89
Black or Black British: Black Caribbean	200	189	0.06	-11
Black or Black British: Other Black	100	117	0.04	17
Other Ethnic Group	0	530	0.18	530
All Groups	**314,700**	**319,783**	**100.00**	**5,083**

Source: ONS, 2011 (http://www.ons.gov.uk/ons)

Please consider accessing via this link Census 2011 Release dates for content

- Table 13.1.1a suggests that the overall population of Wirral has increased slightly, from 314,700 at the 2001 Census to 319,783 by 2011.
- It further suggests that according to the 2011 Census that 5.03% of Wirral's population is from a BME group (i.e. not white British) which compares to 3.46% in 2001 (From 10,900 people in 2001 to 16,101 people in 2011).
- While there has been a slight increase in population numbers classified as white (White British, White Irish or White Other) from 309,600 in 2001 to 310,156 in 2011, the collated other ethnic group numbers have risen from 5,100 in 2001 to 9,627 in 2011.
- If we consider white British only population there has been a slight reduction from 303,800 in 2001 to 303,682 in 2011.
- Considering all ethnic population groups in the same period, the numbers in these groups have increased from 10,900 in 2001 to 16,101 in 2011.
- The largest increase appears in the Other White population with an increase of 1,030 from 2001 to 2011 Census (From 2,700 to 3,730)
- In contrast, the, 'White: Irish' group appears to have shown the largest percentage decrease, from 3,100 in 2001, to 2,667 in 2011.

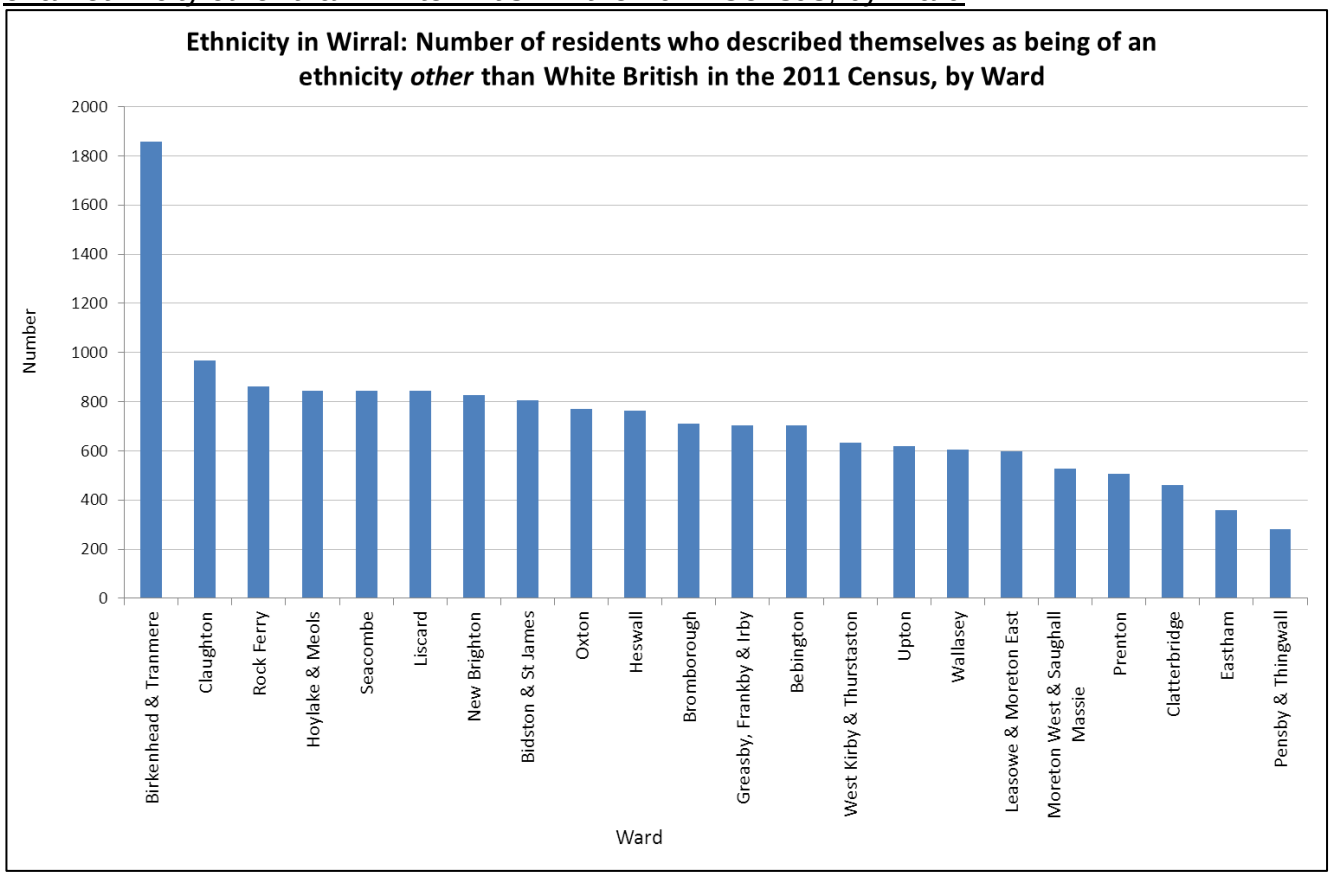
- Other ethnic group appears for the first time with 530 people registering in this category. This includes a wide range of nationalities that individually are too numerous with too few recorded numbers to list separately by ONS.
- In 2011 a Census category for Gypsy & Irish Traveller was included. Despite the potential barriers around identifying as Gypsy/Irish Traveller, 77 people in Wirral identified this ethnicity. Irish Traveller Movement for Britain (2013) report suggests this to be an underestimation with the North West alone by possibly 68% under recorded if compared to Local Authority Gypsy and Traveller Accommodation Assessments.

Further population analysis is available via Wirral JSNA Population Chapter

Ward Populations

In figure 13.1.1b Wirral's ward population is described with the numbers of residents from ethnic groups other than white British.

Figure 13.1.1b: Ethnicity in Wirral: Number of residents who described themselves as being of an ethnicity *other* than White British in the 2011 Census, by Ward

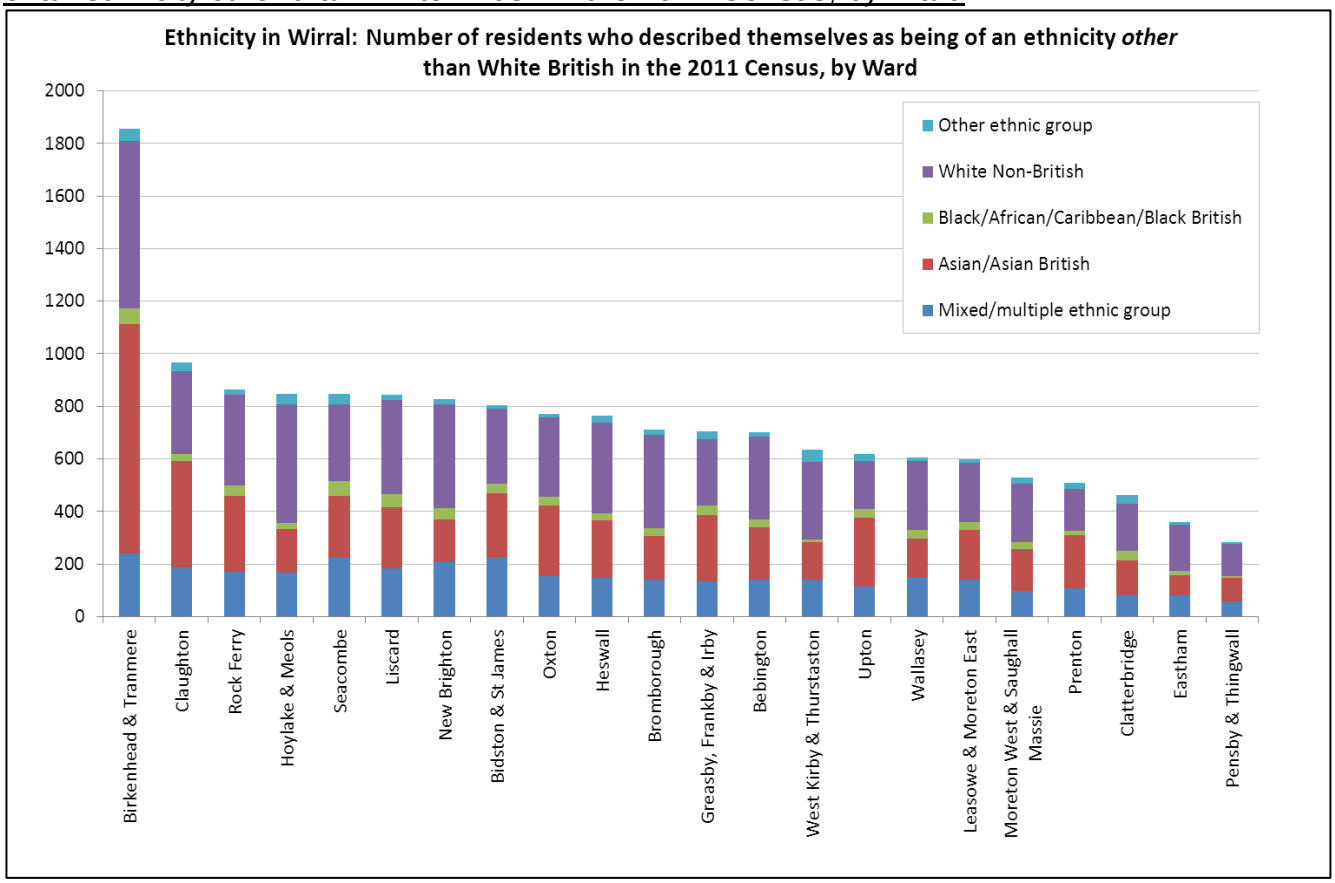


Source: ONS 2011 Census (Data release 2013)
Notes: see table 13.1.1c notes that apply

- Birkenhead & Tranmere have the highest numbers of self-reported ethnic groups being almost double that of the Claughton ward second highest ethnic population (Over 1800 in Birkenhead & Tranmere compared to just less than 1000 in Claughton). There are no reported conclusions to the population distribution though it could be related to available affordable housing, rental property and proximity to work place but further work could be undertaken to ascertain this detail.

In figure 13.1.1c the ethnic groups by ward are described.

Figure 13.1 .1c: Ethnicity in Wirral: Number of residents who described themselves as being of an ethnicity *other* than White British in the 2011 Census, by Ward



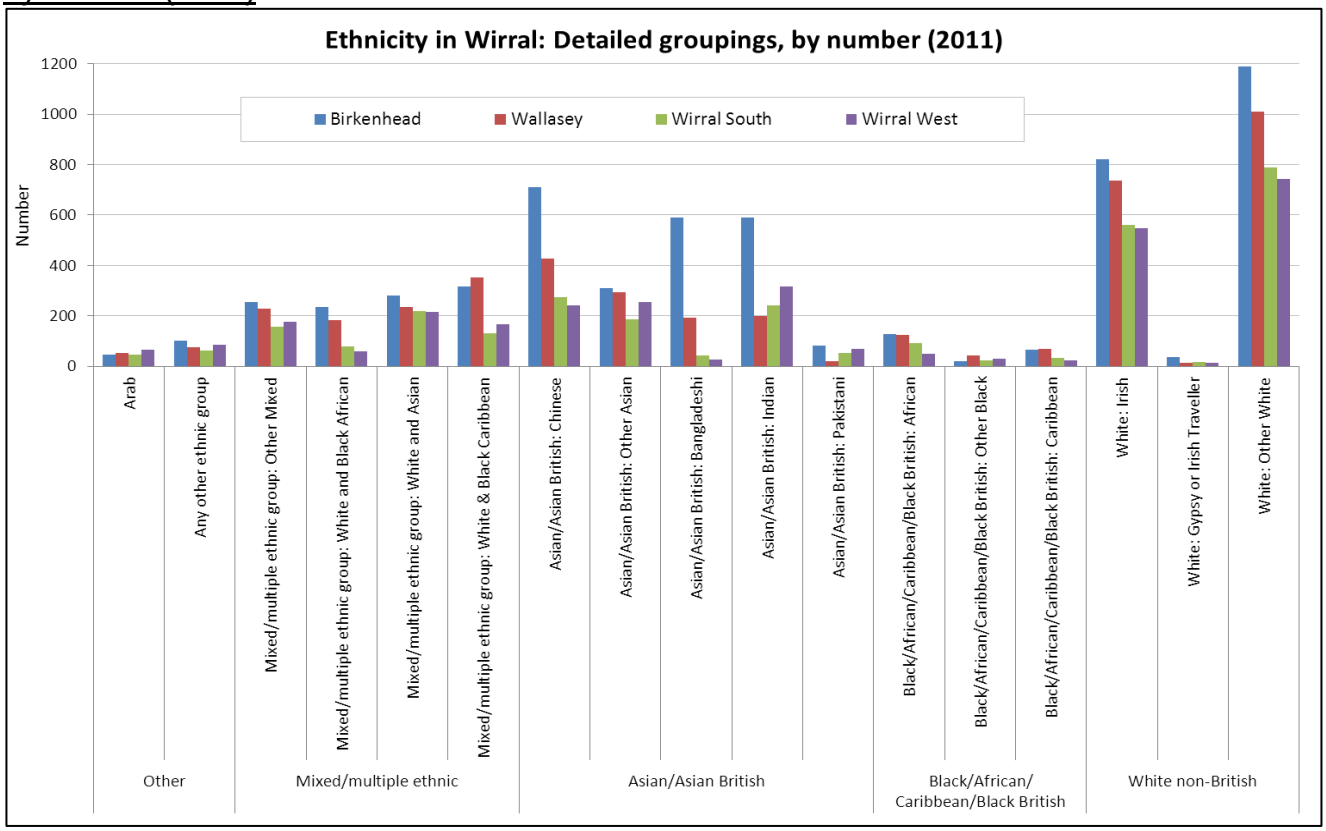
Source: ONS 2011 Census (Data release 2013)
Note: broad ethnic groupings are constituted as follows:
(Mixed – Arab and any other ethnic group) (Mixed/multiple ethnic group - Mixed/multiple ethnic group – other mixed, White and Black African, White and Asian, White and Black Caribbean) (Asian/Asian British – Chinese, Other Asian, Bangladeshi, Indian, Pakistani) (Black/African/Caribbean/Black British – African, Other Black, Caribbean) (White Non-British – Irish, Gypsy or Irish Traveller, Other White)

- Here the predominant ethic groups in the Birkenhead & Tranmere ward (ward with highest ethnic group population) are Asian/Asian British and white non-British.
- The proportion of those groups highlighted in figure 13.1.1c is generally similar across all wards with the exception of Hoylake & Meols where the proportion of white non-British is higher than other wards.

In figures 13.1.1d and 13.1.1e below the information is collated into the local parliamentary constituency which in turn equates the Wirral Public Service Board geography of four operational areas.

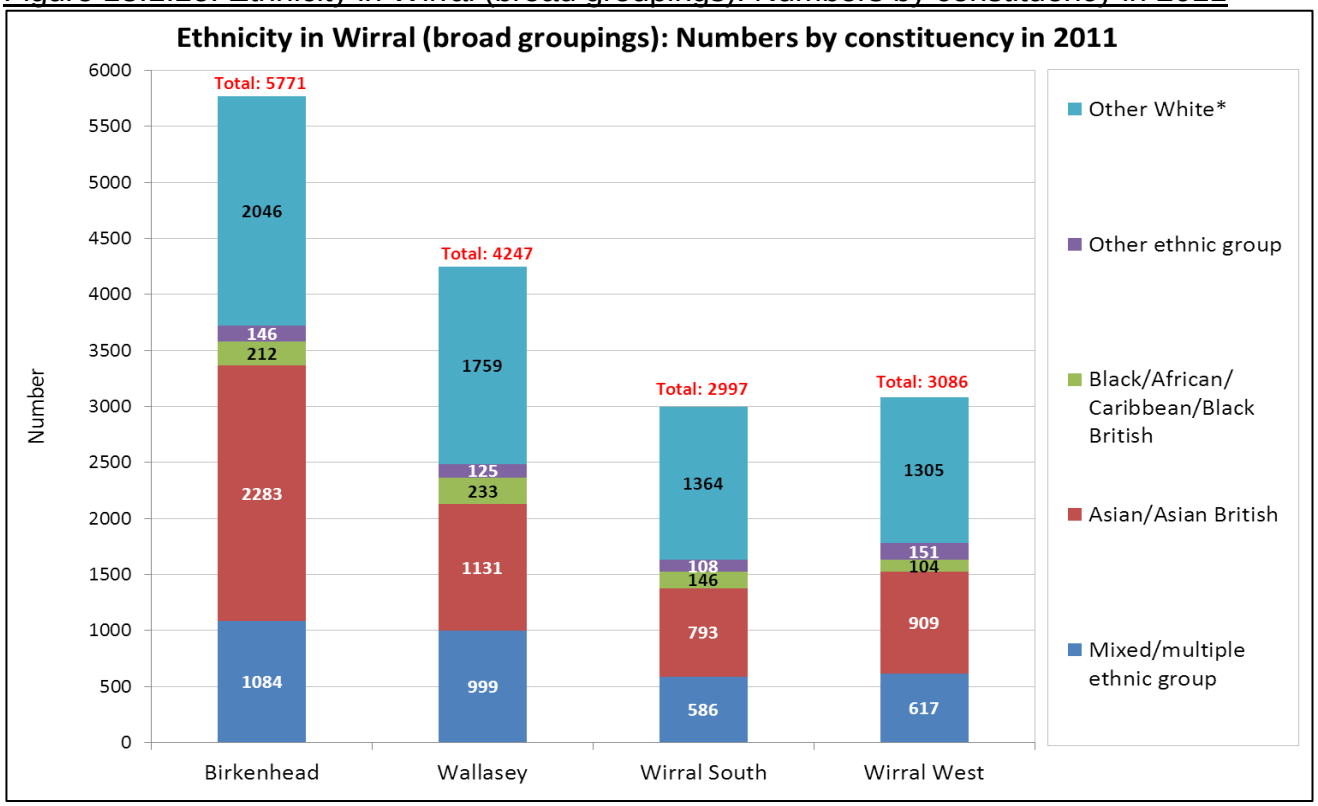
- Birkenhead local constituency area has the highest population numbers from ethnic groups
- The Irish population numbers can be seen to be spread relatively evenly across constituency areas.

Figure 13.1.1d: Ethnicity in Wirral: Detailed groupings, by local parliamentary constituency, by number (2011)



Source: ONS 2011 Census (Data release 2013)
Notes: see table 13.1.1c notes that apply

Figure 13.1.1e: Ethnicity in Wirral (broad groupings): Numbers by constituency in 2011



Source: ONS 2011 Census (Data release 2013)
Notes: see table 13.1.1c notes that apply

13.1.2 Employment

Table 13.1.2a illustrates that the highest proportion of people claiming Jobseekers Allowance (JSA) in Wirral was from the white ethnic background. Within the remaining ethnicities (but excluding those in the group who prefer not to say) in Wirral, people from the Mixed and Chinese groups also had high levels of JSA claimants.

The current (June 2013) number of young people from a BME group not in employment, education or training (NEET) for Wirral is 21 and this equates to 2.26% of the total NEET numbers for Wirral. (Wirral Council, Connexions Service, 2013)

Table 13.1.2a: The number of jobseekers allowance claimants all ages, November 2012

Ethnicity	**Numbers**		
	Wirral	North West	England
White	7,230	160,170	931,540
Mixed	60	2,810	27,170
Asian or Asian British	30	8,950	79,350
Black or Black British	30	5,510	95,490
Chinese or Other Ethnic Group	40	3,060	30,430
Prefer Not to Say	300	5,740	53,940
Unknown	50	2,150	16,610
Total	7,730	188,390	1,234,550

Source: Nomis, 2013

Tables 13.1.2b, 13.1.2c and 13.1.2d illustrate the number to people who describe themselves as being economically active broken down by their ethnic group in those are aged 16 and above.

Table 13.1.2b: The number of unemployed people by ethnicity, age 16 and over

Ethnicity	**Wirral**		**Constituencies**								**North West**		**England**	
			Birkenhead		**Wallasey**		**Wirral South**		**Wirral West**					
	Numbers	**%**	**Numbers**	**%**	**Numbers**	**%**	**Numbers**	**%**	**Numbers**	**%**	**Numbers**	**%**	**Numbers**	**%**
White: English/Welsh/Scottish/ Northern Irish/British	12,645	94.9	4,592	93.8	4,122	95.8	1,955	94.9	1,976	95.6	237,339	82.5	1,444,703	71.4
White: Irish	71	0.5	31	0.6	14	0.3	10	0.5	16	0.8	2,119	0.7	15,703	0.8
White: Other White	178	1.3	74	1.5	46	1.1	33	1.6	25	1.2	6,857	2.4	96,297	4.8
Mixed/multiple ethnic group	159	1.2	84	1.7	45	1.0	17	0.8	13	0.6	6,714	2.3	65,642	3.2
Asian/Asian British	187	1.4	87	1.8	50	1.2	24	1.2	26	1.3	21,984	7.6	208,605	10.3
Black/African/Caribbean /Black British	48	0.4	16	0.3	21	0.5	10	0.5	0	0.0	9,270	3.2	158,567	7.8
Other Ethnic Group	36	0.3	12	0.2	5	0.1	10	0.5	9	0.4	3,239	1.1	33,968	1.7
Total	**13,324**	100	4,896	100	4,303	100	2,059	100	2,066	100	**287,522**	100	**2,023,485**	100

Source: Nomis; Census 2011 economic activity

The table above (Table 13.1.2b) shows the highest proportions of unemployed people are from the Asian/Asian British ethnic group (when excluding all the White ethnicities). (Please see tables 13.1.2c & 2d for related employment data for Asian/Asian British)

Table 13.1.2c: The number of people in employment by ethnicity, age 16 and over

Ethnicity	Wirral		Constituencies								North West		England	
			Birkenhead		Wallasey		Wirral South		Wirral West					
	Numbers	%	Numbers	%	Numbers	%	Numbers	%	Numbers	%	Numbers	%	Numbers	%
White: English/Welsh/Scottish/ Northern Irish/British	112,811	95.0	29,654	93.5	32,099	95.4	26,914	95.9	24,144	95.3	2,393,606	89.4	16,661,475	81.5
White: Irish	969	0.8	258	0.8	296	0.9	203	0.7	212	0.8	23,607	0.9	206,473	1.0
White: Other White	1,739	1.5	605	1.9	477	1.4	348	1.2	309	1.2	75,719	2.8	1,173,182	5.7
Mixed/multiple ethnic group	902	0.8	293	0.9	272	0.8	165	0.6	172	0.7	27,117	1.0	294,352	1.4
Asian/Asian British	1,858	1.6	746	2.4	395	1.2	327	1.2	390	1.5	115,381	4.3	1,332,481	6.5
Black/African/Caribbean /Black British	298	0.3	92	0.3	91	0.3	72	0.3	43	0.2	30,612	1.1	615,631	3.0
Other Ethnic Group	193	0.2	54	0.2	34	0.1	42	0.1	63	0.2	10,483	0.4	158,902	0.8
Total	118,770	100	31,702	100	33,664	100	28,071	100	25,333	100	2,676,525	100	20,442,496	100

Source: Nomis; Census 2011economic activity

Table 13.1.2d: The number of self-employed people by ethnicity, age 16 and over

Ethnicity	Wirral		Constituencies								North West		England	
			Birkenhead		Wallasey		Wirral South		Wirral West					
	Numbers	%	Numbers	%	Numbers	%	Numbers	%	Numbers	%	Numbers	%	Numbers	%
White: English/Welsh/Scottish/ Northern Irish/British	16,306	93.1	3,747	90.5	4,284	92.7	3,854	94.9	4,421	94.1	372,538	86.8	3,069,547	79.8
White: Irish	165	0.9	37	0.9	39	0.8	36	0.9	53	1.1	4,138	1.0	44,727	1.2
White: Other White	299	1.7	78	1.9	96	2.1	52	1.3	73	1.6	10,297	2.4	270,303	7.0
Mixed/multiple ethnic group	134	0.8	42	1.0	36	0.8	25	0.6	31	0.7	3,823	0.9	48,829	1.3
Asian/Asian British	515	2.9	204	4.9	135	2.9	77	1.9	99	2.1	31,702	7.4	291,278	7.6
Black/African/Caribbean /Black British	43	0.2	18	0.4	11	0.2	9	0.2	5	0.1	3,773	0.9	82,770	2.2
Other Ethnic Group	59	0.3	15	0.4	19	0.4	9	0.2	16	0.3	2,943	0.7	38,835	1.0
Total	17,521	100	4,141	100	4,620	100	4,062	100	4,698	100	429,214	100	3,846,289	100

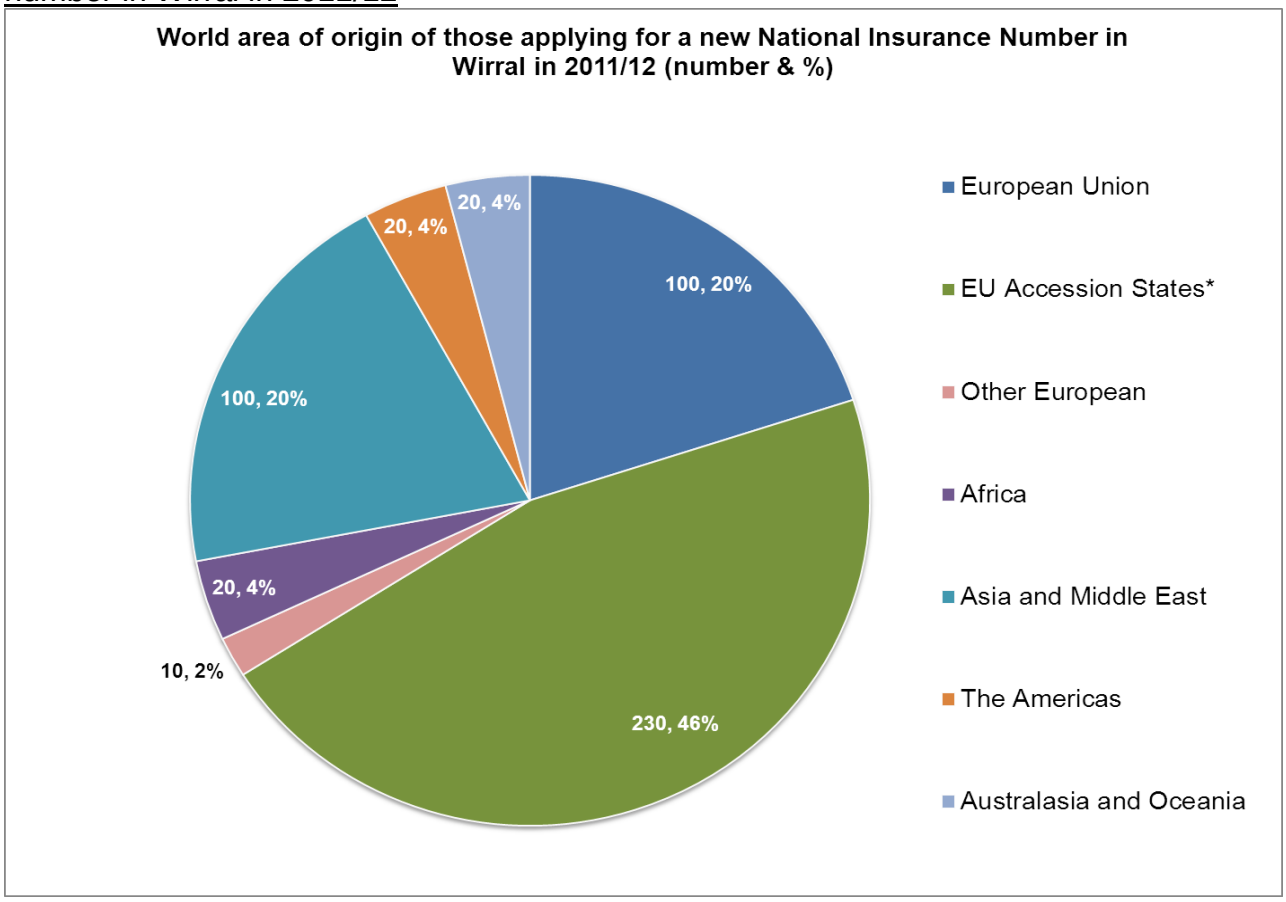
Source: Nomis; Census 2011economic activity

As illustrated in Table 13.1.2c and Table 13.1.2d the ethnic groups with the highest proportion of people in employment and those who are self-employed is the White: English/Welsh/Scottish/Northern Irish/British group, this is followed by Asian/Asian British with 1.6%.

This general pattern is also the same for the self-employed (Table 13.1.2d). With those who are self-employed the highest proportion of working residents other than the white ethnicities are Asian/Asian British.

The number of new national insurance numbers (NI) issued to migrants living in Wirral can provide an indication of the number of new adult arrivals from abroad who are seeking work as can be seen in figure 13.1.2e.

Figure 13.1.2e: World area of origin of those applying for a new National Insurance (NI) number in Wirral in 2011/12



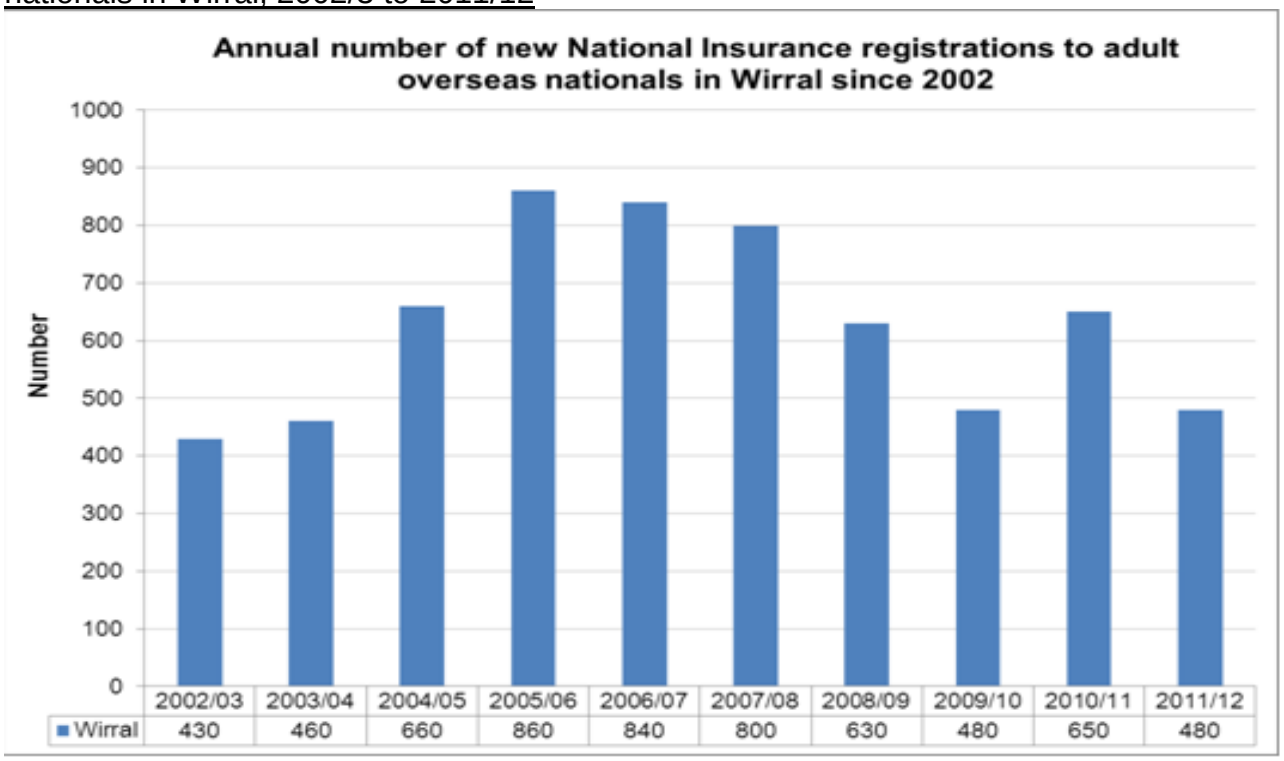
Source: Census 2011

*Accession nationals refers to overseas nationals from the 12 Accession countries. These are Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia and Slovenia, which joined on the European Union (EU) on 1st of May 2004, and Romania and Bulgaria, who have joined on 1st January 2007.

Figure 13.1.2e shows that in 2011/12, almost half (46%) of all new adult arrivals in Wirral were from the European Union (EU) Accession states. The next largest groups were from other EU countries, Asia and the Middle East. Total new NI numbers were 480 in 2011/12.

The trend in Wirral for new NI registrations from overseas nationals can be seen in figure 13.1.2f below.

Figure 13.1.2f: Trend in number of new National Insurance registrations to adult overseas nationals in Wirral, 2002/3 to 2011/12



Source ONS
Notes: For further information please refer to Wirral Migration Profile No.11 – June 2013

As Figure 13.1.2f shows, the peak in new NI applications was in 2005/06. Since then, it has fallen year on year and is now around the level seen in 2003/04. In total since 2002, around 6,000 new NI numbers have been issued in Wirral.

13.1.3 Education

The first measure of educational attainment that directly affects later employment outcomes is GCSE results, but there are substantial variations in attainment levels in different BME groups. A report by Liverpool John Moores University (2010) suggests that attainment of 5 GCSEs A*-C including English and Mathematics, the preferred government measure, is generally much higher among young people from groups where the first generation were well qualified, for example Indians (64.1%) or Chinese (69.7%). In contrast, the proportion of pupils who achieve five or more GCSEs is much lower among Black Caribbean (36.0), White and Black Caribbean (40.0), Black African/White and Black African (50.2 per cent), Pakistani (41.7) and Bangladeshi (46.1) pupils.

However, the report goes onto to describe that national evidence highlights the performance of some BME groups with lower than average GCSE results (e.g. Pakistani or Bangladeshi) actually improves when taken into account other factors such as socio-economic background and English spoken in the home. When all factors are taken into account, it is deprived i.e. eligibility of Free School Meals (FSM) is often an indicator of deprivation or low income families, White or mixed White Caribbean boys who perform worst, followed by Black Caribbean boys.

As previously discussed within Children & Young People Chapter of the JSNA, in general terms both Key Stage 2 (age 10-11 years) and Key Stage 4 (GCSE level) BME pupils in

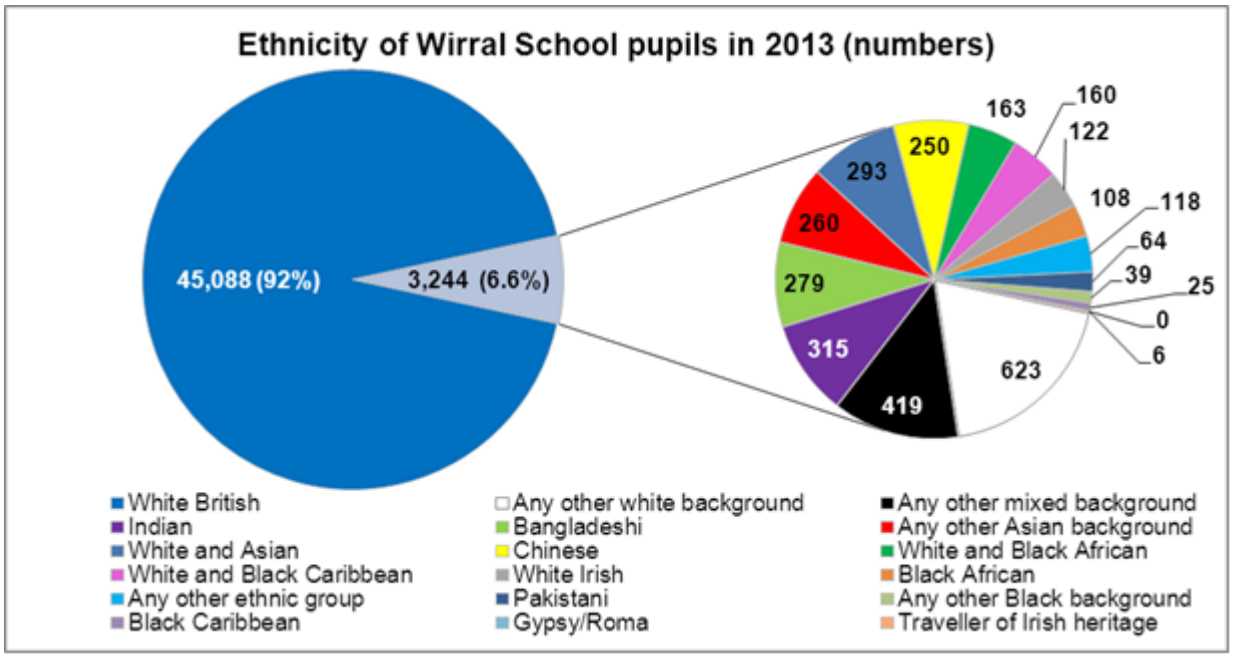
Wirral perform better than the national average, although there are some exceptions (*see Figure 4.3.2a: Key Stage Two % Level 4+ in both English and Maths 2010 on page 14 of Chapter 4*). As summarised within Chapter 4, overall in Wirral the following BME groups perform below the national average on educational attainment:

- At Key Stage 2: Chinese, Bangladeshi and Irish groups.
- At Key Stage 4: Black, Bangladeshi and Irish groups.
- *For further information see Chapter 4: Children & Young People'.* (this chapter is currently being updated)

Information on the ethnicity of school pupils in Wirral is collected by the annual School Census. In 2012, the majority (45,220 or 92.3%) of pupils in Wirral were recorded as White British. Although Irish are included within 'any other white background' there is recorded status of Traveller of Irish heritage.

Figure 13.1.3a below shows the breakdown for 2012 by ethnic group of student with 6.6 % of pupils recorded as being from other non-white British groups. The largest proportion seen from pupils classified as 'any other mixed background'.

Figure 13.1.3a: Ethnic Group of the students in Wirral schools (January 2013)



Source: Wirral School census 2013

Additionally, this survey also collects information on primary language spoken by pupils at home. The survey found 1,187 pupils were from a bi-lingual/multi-lingual household. A total of 226 pupils had no response to this question. The table below, (Table 13.1.3b) illustrates only the top ten languages which are spoken by pupils at home.

Table 13.1.3b: Top 10 most common first languages spoken at home by Wirral pupils (as at January 2013)

Language	Number of pupils (2013)	Number of pupils (2012)
Bengali (India, Bangladesh)	258	268
Chinese (includes Mandarin ,Putonghua &Cantonese)	132	140
Polish	124	148
Malayalam (India)	88	93
Tamil (Sri Lanka)	64	78
Tagalog/Filipino (Philippines)	50	52
Urdu (Pakistan, India)	32	39
Arabic (Middle East, North Africa)	27	32
Turkish	24	25
Hindi (India)	22	n/a

Source: Wirral School Census, 2013
Notes: In total the survey identified 31 different languages are spoken which total 1,170 pupils. We have highlighted the most frequently used languages which cover 821 students. Numbers would be too low to present. For further information go to (add link to where data is provided)
n/a – numbers not recorded in 2012 within top 10 most common languages

13.1.4 Housing and Accommodation

Information about BME households derived from the Strategic Housing Market Assessment (2007) has shown that in Wirral:

- 98.7% of all households in the Borough are headed by someone who describes themselves as white;
- 1.3% of households being non-white;
- non-white households were generally larger, at an average of 2.54 persons when compared to 2.30 in white households;
- a higher number of non-white households were renting in the private sector (12.9% compared to 9% of white households);
- non-white households were less likely to live in unsuitable housing than white-households;
- 28.7% of non-white households have a member with support needs, which is higher than that of non-white households. This indicates that there may be a need to provide appropriate housing or adaptations to existing homes to ensure independence and quality of life.

Note: the findings indicated above should be viewed with caution due to the small sample size which was derived from a small fraction of the population in this group, and scope of analysis.

The housing content will be updated following the publication of the new Strategic Housing Market Assessment and any other pending Housing reviews after January 2014. This should also include information related to Gypsy and Traveller accommodation.

13.1.5 Crime

Crime can impact on an individual's health and wellbeing. The most recent information, the 2010/11 British Crime Survey (BCS), showed that BME groups fear they risk being a victim of crime far more than their white counterparts.

Nationally in 2010/11, 51,187 racist incidents were recorded by the police - a decrease of almost 18% in the number of racist incidents reported across England and Wales over the five-year period (2006/07 to 2010/11).

The recent report for Merseyside Hate Crime Profile Data (December 2012) undertaken on behalf of Merseyside Criminal Justice Board (MCJB) and its Hate Crime Sub-group (HCSG) highlights a number of key aspects related to race and crime. The full report can be viewed here.

The report suggests that race is the largest motive behind hate crime that is reported (nearly eight in ten) followed by disability and homophobia in roughly equal proportions at about one in ten each. This is regardless that in straight number terms it is not necessarily the largest population by minority protected characteristic. Religion and transphobic crimes were numerically small, though no less serious for the victims. The overview of reported crimes can be seen in Figure 13.1.5a below.

Table 13.1.5a: Merseyside Hate Crime Strands (3 year figures) December 2012

Merseyside Hate Crime Strands	Rolling Years Jan-10 to Dec-10	Jan-11 to Dec-11	Jan-12 to Dec-12	(1) Proportions Current Year	(2) Change Current Year to Last	(3) Proportion Crimed of All Incidents
Recorded Crimes:						
Disability	57	120	137	9.7%	14.2%	68.5%
Racial	1135	1052	1093	77.4%	3.9%	77.8%
Religious	24	25	27	1.9%	8.0%	81.8%
Homophobic	153	137	148	10.5%	8.0%	74.7%
Transphobic	4	8	7	0.5%	-12.5%	70.0%
All Crimes	1373	1342	1412	100.0%	5.2%	76.5%
Non-crime Occurrences:						
Disability	33	91	63	14.5%	-30.8%	
Racial	264	196	311	71.8%	58.7%	
Religious	4	8	6	1.4%	-25.0%	
Homophobic	40	35	50	11.5%	42.9%	
Transphobic	2	2	3	0.7%	50.0%	
All Occurrences	343	332	433	100.0%	30.4%	

Source: Merseyside Hate Crime Profile Data (2012)
Notes: Please read full report here

Racially motivated recorded crime is most prevalent in Liverpool North, though it must be remembered that this also includes the city centre. (View full report). Over a number of years there has been a marginal decline in recorded crime, notwithstanding that the current rolling year is an increase on the previous one. Within BCUs, however, some are seeing reductions and other increases which may mean this is caused by changes in demography. Non-crime occurrences are a more volatile with a modest rise in Wirral. (View full report)

Another matter the report considers is the split of White into those who identify themselves as coming from the old countries that merged to form the UK and those from elsewhere including Gypsy and Irish Travellers. It is generally held that this 'non-UK' group is subject to discrimination in the same way as non-White populations and consequently producing information on the numbers has value. The full report can be viewed here.

13.1.6 Carers

Recent Census 2011 data provides an overview for Wirral of ethnic group by provision of unpaid care by general health as can be seen in table 13.1.6a below.

Table 13.1.6a: Ethnic group, by number and provision of unpaid care by general health based on Census 2011 for Wirral

Ethnic Group	All categories Provision of unpaid care	Provides no unpaid care	Provide unpaid care: Total	Provides 1 to 19 hours unpaid care a week	Provides 20 to 49 hours unpaid care a week	Provides 50 or more hours unpaid care a week
All categories: Ethnic group	319,783	279,443	40,340	23,879	5,768	10,693
White: Total	310,156	270,528	39,628	23,419	5,661	10,548
White: English/Welsh/ Scottish/Northern Irish/British	303,682	264,766	38,916	22,992	5,555	10,369
White: Irish	2,667	2,290	377	214	52	111
White: Other White	3,807	3,472	335	213	54	68
Mixed/multiple ethnic group	3,286	3,046	240	167	30	43
Asian/Asian British	5,116	4,737	379	240	57	82
Black/African/ Caribbean/Black British	695	641	54	28	13	13
Other ethnic group	530	491	39	25	7	7

Source: NOMIS, 2013

In general terms almost 13% of Wirral residents consider themselves as carers, or 1 in 8 people, with now over 40,000 people considering they have a carer role. This figure is slightly higher, though similar, at 14% for the White Irish population and around 12% for other ethnic groups. Please see Wirral JSNA Carers Chapter for more details on Carers.

13.2 Health, Wellbeing and Inequalities

Healthy lives, Healthy people (Department of Health, 2010) the government's strategy for public health suggest that health and wellbeing is influenced by a wide range of factors including social, cultural, economic, psychological and environmental, across our lives. These change through the key transition points in life, from infancy and childhood, through our teenage years, to adulthood, working life, retirement and the end of life. The Department of Health (2009) progress report highlights an increasing emphasis within NHS policy to address health inequalities and ensure equal access to good quality health care. At the

same time there has been a heightened recognition that individuals from BME backgrounds face significant health inequalities and experience poorer health and life expectancy than the general population. However, research by Burnett and Peel (2001) identified relatively recent arrivals will often experience difficulties in accessing health services as a result of language problems and of not understanding the system. Additionally, they also highlight that Asylum Seekers and Refugees frequently have particular health needs e.g. as a result of physical abuse and emotional trauma.

It is reasonable to expect that the access to health services for Wirral BME residents reflects similar issues and outcomes as those at a national level. It should be noted that some researchers suggest (Davey Smith et al (2000),Tilki et al (2010)) there are hidden issues for some ethnic groups primarily because population data is not consistently reviewed at all ethnic group levels. For example, white Irish population, can have disproportionate levels of dementia just on the basis of its age profile but this can be masked when looked at as all white British and not a distinct population group. Service planners and researchers should be aware of making themselves aware of as much defined population group data as possible.

It is generally accepted that inequalities exist in health and health care in relation to BME groups in the UK; the Race Relations Amendment Act (2000) explicitly states that all public bodies have a duty to reduce inequalities between ethnic groups. However it is important to note that not all inequalities have a negative impact on BME groups. For example, according to Johnson et al (2004), Chinese people in particular appear to have lower levels of disease and report less ill-health generally than the White British population.

13.3 Health related behaviour and risk factors

The last decade has witnessed an increasing concern to address health inequalities within the NHS and across public bodies, with a significant focus on the differences in health outcomes between ethnic groups. In respect of a range of health conditions, people from BME Communities within this country can have worse outcomes than the general population, while potentially experiencing more difficulty in accessing NHS services. This can be compounded by geographic disadvantage with BME populations also often living in deprived areas. (See 13.1.1b)

Wirral Primary Care Trust (WPCT) commissioned an assessment of the health needs of Wirral's Black and Minority Ethnic (BME) communities. This was undertaken by Icarus between May and November 2009. This research was commissioned to help address important gaps in what is known about the health needs of Wirral's BME population. Please use this link to access the Icarus report.

13.3.1 Cardiovascular Disease (CVD) and Coronary Heart Disease (CHD)

According to NICE (2010a) in more than 90% of heart attack cases, the risk of a first heart attack is related to potentially modifiable risk factors, including smoking, poor diet, obesity/overweight, and insufficient physical activity. Healthy Lives, Healthy People, the Public Health Strategy for England (Department of Health, 2010) suggests that it is not better treatment but prevention that includes tackling the wider social factors that influence health which in turn is likely to deliver greater overall increases in healthy life expectancy.

A survey was conducted by NHS Health & Social Care Centre (2006) which examined the health of adults from various minority ethnic groups within England. The Health Survey for England (Department of Health, 2004) defined Cardiovascular Disease (CVD) and Coronary Heart Disease (CHD) as being:

.

- Any CVD condition': Informants are classified as having any CVD condition if they reported having any of the following conditions confirmed by a doctor: angina, heart attack, stroke, heart murmur, irregular heart rhythm, 'other heart trouble'.
- 'Coronary heart disease' (CHD) (also called 'Ischaemic heart disease' (IHD)): informants are classified as having IHD if they reported having angina or a heart attack confirmed by a doctor.

The survey illustrated the following:

- Cardiovascular disorder diagnosed by a doctor was most prevalent among Irish men (14.5%) and among women in the general population (13.0%), as described in table 13.3.1a. Black African men and Chinese and Bangladeshi women were significantly less likely than the general population to have any CVD condition.
- Mortality from CHD is particularly high among Irish and Scottish people and those from South Asian groups, particularly Pakistanis and Bangladeshis. Black African informants reported the lowest prevalence of CHD (0.7% men and 0.5% women), see table 13.3.1a.
- In men, the survey observed prevalence of angina and of heart attack was lowest among Black African men (0.7% angina, none with heart attack) and highest among Pakistani men (6.9% angina, 4.1% heart attack). In women the observed prevalence of angina was lowest among Black African women (0.5%) and highest among Indian women (3.3%).
- The prevalence of heart failure in these minority communities appears comparable to that of the general population but less than anticipated given the high rates of cardiovascular disease in these groups.

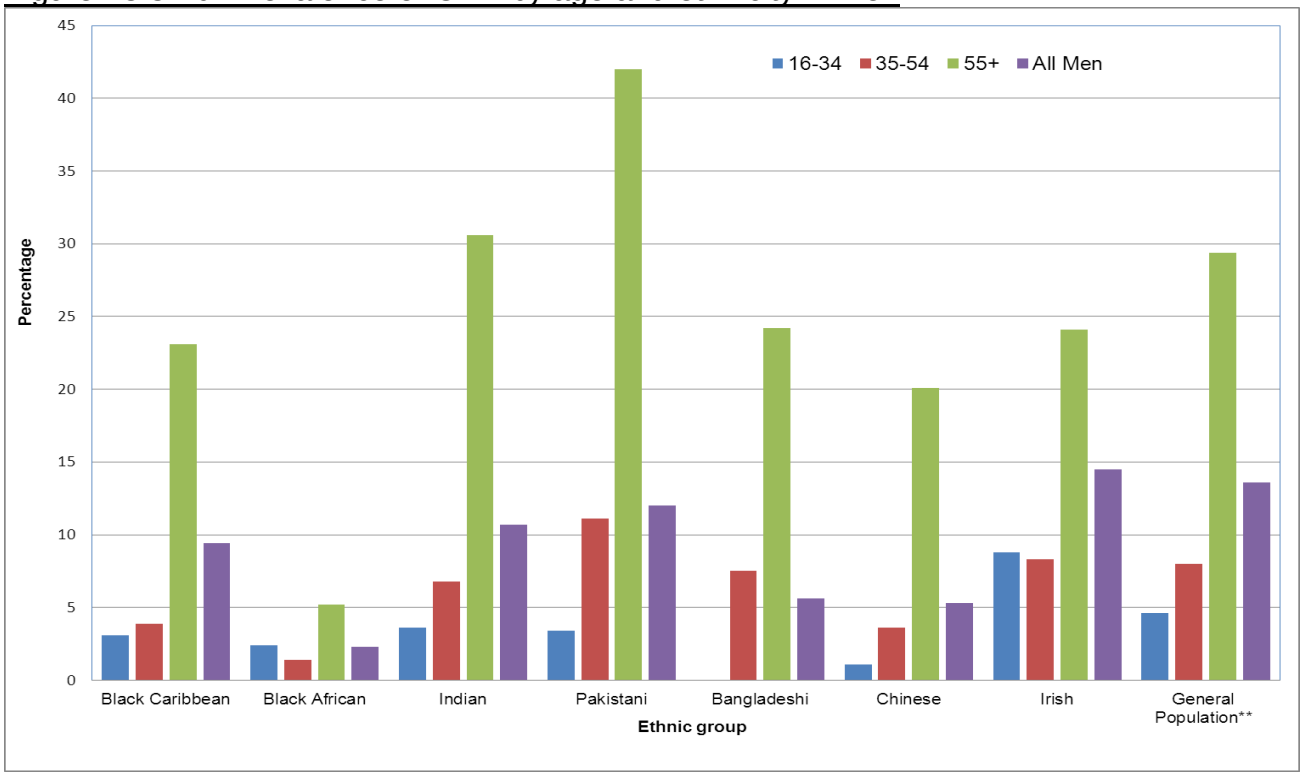
Table 13.3.1a: Prevalence of CVD and CHD by ethnicity and gender

Minority Ethnic Group	**Any Cardiovascular Disease (CVD)**		***Coronary Heart Disease (CHD)**	
	Observed %		**Observed %**	
	Men	**Women**	**Men**	**Women**
Black Caribbean	9.4	9.2	4.4	2.4
Black African	2.3	5.5	0.7	0.5
Indian	10.7	7.3	6.4	3.3
Pakistani	12.0	7.0	8.2	2.7
Bangladeshi	5.6	4.8	4.2	2.0
Chinese	5.3	5.3	1.6	1.2
Irish	14.5	11.4	5.5	2.9
General Population**	13.6	13.0	6.4	4.1

Source: NHS Health & Social Care Centre, (2006)
Note - *This condition is known by 2 different names: Coronary Heart Disease (CHD) and Ischaemic heart disease (IHD)
**general population refers to the whole population of England, regardless of minority ethnic group

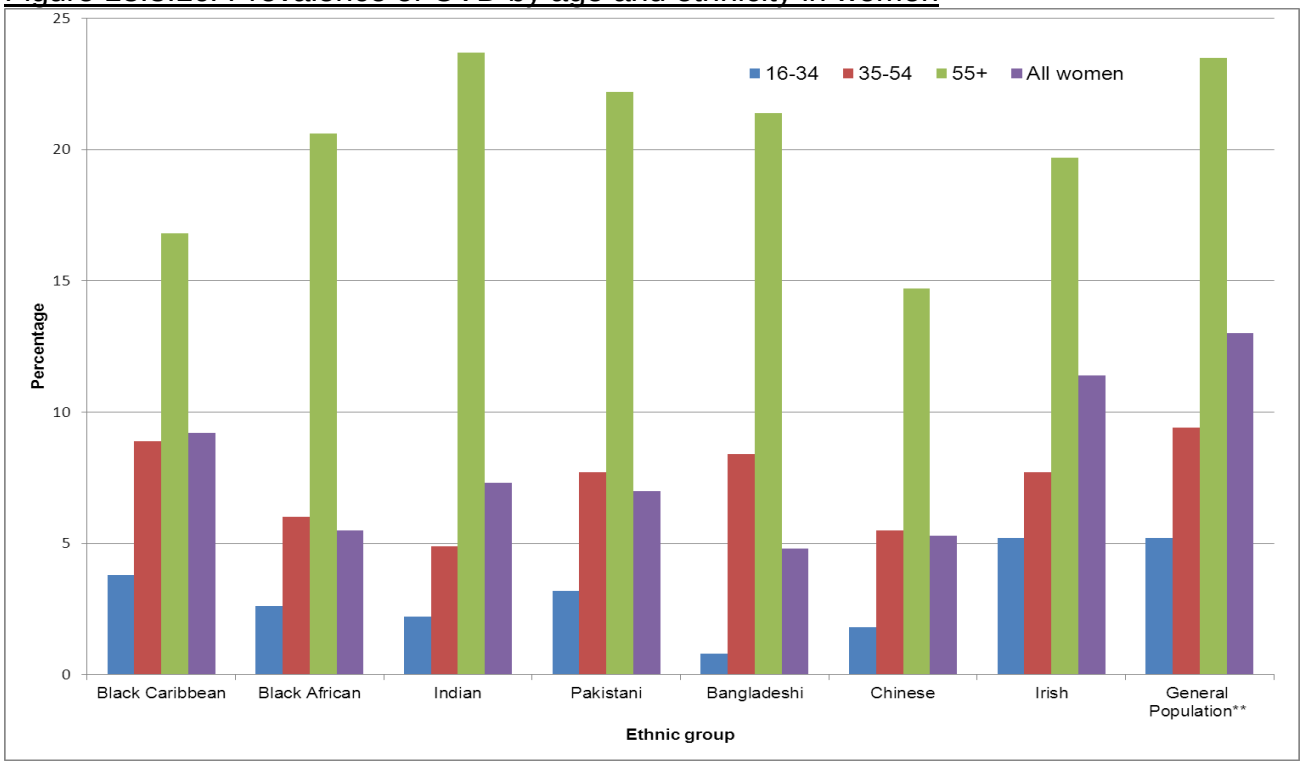
Figure 13.3.1b suggests that Pakistani men aged 55 and over had the highest prevalence of CVD (42%) and Black African men had the lowest (5.2%). For women, as seen in figure 13.3.1c, those aged 55 and over, the prevalence of CVD was highest in the Indian group (23.7%) and lowest in the Chinese group (14.7%).

Figure 13.3.1b: Prevalence of CVD by age and ethnicity in men



Source: NHS Health & Social Care Centre, (2006)
Note - **general population refers to the whole population of England, regardless of minority ethnic group

Figure 13.3.1c: Prevalence of CVD by age and ethnicity in women



Source: NHS Health & Social Care Centre (2006)
Note - **general population refers to the whole population of England, regardless of minority ethnic group

For more information – Health survey for England 2004 volume 1 - the health of minority ethnic groups

The British Heart Foundation Fact File (2007) adds further insight to corroborate the health survey findings.

- Compared with their European counterparts people of South Asian and African-Caribbean origin in the UK experience differences in risk of cardiovascular disease (CVD).
- South Asians are at increased risk of coronary heart disease (CHD) and stroke and are particularly prone to the metabolic syndrome
- African-Caribbean people have less risk of CHD but greater risk of hypertension and stroke.
- Ethnic origin should be taken into account when assessing risk and when preventing or treating CVD

13.3.2 Heart Failure

A University of Birmingham Centre for Cardiovascular Sciences conducted a large community based epidemiological study (Gill et al, 2011) which documented the prevalence of left ventricular systolic dysfunction (LVSD) and heart failure amongst UK minority ethnic groups. The evidence from this study found that overall prevalence (0.75%) of heart failure was similar to that documented in primary care for the general population in England (0.7%). This is surprising given that South Asians living in the United Kingdom have a 50% greater risk of dying prematurely from coronary heart disease than the general population.

The study also points out that the mean age of heart failure amongst South Asian and African Caribbean groups is similar to that amongst the White population. The prevalence of hypertension and diabetes in participants with LVSD appears higher in these two minority ethnic groups than in the White population, as illustrated in table 13.3.2a below. This table also shows that the Myocardial Ischaemia rate is comparable amongst the South Asians (54.8%) and White (53%) groups and much lower amongst the African Caribbean group (41.2%).

Table 13.3.2a: Prevalence of Hypertension and Diabetes

Ethnic Group	(%) Prevalence of Hypertension	(%) Prevalence of Diabetes	(%) Myocardial Ischaemia Rate
South Asian	78.6	40.5	54.8
African Caribbean	76.5	58.8	41.2
White British	39.0	15.0	53.0

Source: Gill et al (2011)

13.3.3 Stroke

British Heart Foundation and the Stroke Association (2009*) Stroke Statistics* highlighted some key facts:

- Stroke is the second most common cause of death in England after heart disease and closely followed by all cancers.
- African-Caribbean people are twice as likely to have a stroke compared with white people.

- Stroke is a leading cause of adult disability. More than half of all stroke survivors are left dependent on others for everyday activities.
- Whilst stroke mortality rates are falling in all Black and minority ethnic (BME) groups, they are not falling as quickly as in the general population. This has resulted in an increased gap in stroke mortality rates between such groups and the general population.

NHS Health & Social Care Centre (2006) *Health Survey for England 2004: The Health of Minority Ethnic Groups* suggests that the risk factors for stroke are similar to those for CHD. High blood pressure, smoking and high cholesterol, are all risk factors which are closely associated with stroke. Black Africans and Black Caribbean's have above average prevalence of hypertension and of ischaemic stroke.

The survey goes onto to say that intracerebral haemorrhage, which is less common but more frequently fatal, has different risk factors, although hypertension is again significant, individuals from Chinese and Black backgrounds are at particular risk of both types of stroke.

For men aged over 55, Black Caribbean and Pakistani men suggested in the survey that they had the highest self-reported incidence of stroke (11.5% and 9.6% respectively), while for women aged 55 and over the highest incidence was amongst Bangladeshi (11.9%) and Pakistani (10.1%) women.

Survival after a first stroke has been shown to be greater in Black patients than the general population, allowing for age, type and severity of stroke.

Mortality from ischaemic stroke is higher in Bangladeshi people, attributable to double the age-adjusted incidence, compared with White Europeans (NHS Health & Social Care Centre, 2006)

13.3.4 Diabetes

Diabetes is a long-term condition which can lead to an increased risk of cardiovascular disease, kidney problems, blindness, amputation and infections.

According to Diabetes UK (2012) more than 2 million people in the UK have diabetes and people from Black and other minority groups are up to 6 times more likely to develop diabetes than white people.

NHS Health & Social Care Centre (2006) Health Survey for England highlights these key issues:

- There is a much higher rate of non-insulin dependent (type 2) diabetes among South Asian and Caribbean populations. Amongst middle aged Asians the prevalence rate has been put at five times that of White groups. Type 2 diabetes has the highest association with obesity.
- The age of presentation is significantly earlier for Asian groups, placing them at greater risk of complications.
- Mortality from diabetes related conditions is 3.5 times higher among South Asian groups, with a similar rate for Caribbean men, but six times higher than the general population for Caribbean women.

- Non-insulin dependent (type 2) diabetes remains undiagnosed in up to 40% of Asian Diabetics.
- Among women, diabetes is more than five times as 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 with women in the general population.

Diabetes UK report (2006) *Diabetes and the Disadvantaged* highlighted a number of key concerns:

- Those communities that are least well educated are more likely to have retinopathy, heart disease and poor diabetes control.
- One in five people with a severe mental illness has diabetes.

A review of several studies by Aspinall and Jacobson (2004) highlighted that inadequate health care of Asian and African Caribbean diabetics and poor compliance amongst patients due to their lack of knowledge about the disease and its management, is made worse by the inappropriateness of health Information.

Research by Saunders (2007) reported a high prevalence of diabetes and a lack of knowledge of risk factors or of the implications of having the condition among Gypsies and Travellers. It was also found that the risk of premature death from cardiac disease was particularly high for Gypsy and Traveller men as described by Roberts et al (2007).

Certain conditions are known to be more prevalent in the Irish community generally and impact on diabetes. Irish Haemochromatosis Association suggests that this is a particular example of a genetic condition which is much more common in people of Irish heritage. It is a disorder which is characterised by iron overload and may be undiagnosed because it is less frequently seen in the general population. Early treatment is important in preventing long-term damage and complications of the condition can also include diabetes.

13.2.5 Cancer

Aspinall and Jacobson (2004) suggest that there has been limited amount evidence on cancer rates within ethnic minorities; a large proportion of evidence in respect of differences between ethnic groups is derived from research studies. The risk of main cancer is lower among West Indian and South Asian communities, however some of the rarer cancer are significantly higher in South Asians particularly for Hodgkin's disease (in males), oral cancer and myeloid leukaemia (females) and cancer of the hypopharynx, liver and gall bladder in both sexes, while Chinese people have higher rates for nasopharyngeal cancer.

Both Harding and Rosato (1999) and Harding and Balarajan (2001) point to Scottish and Irish migrants having raised cancer incidence rates for a number of sites and overall, the incidence of ovarian, cervical, lung and prostrate is higher in second generation Irish people living in England and Wales than for all other groups and remains high in third generation. Harding et al (2008) suggest that despite general declines in cancer death rates, inequalities in migrant mortality remain.

The indicative evidence from the UK and considerable evidence from other countries (Aspinall and Jacobson, 2004) suggest that rates of prostate cancer are substantially higher in the black ethnic groups (Cancer Research UK, 2013) and are evident at younger ages.

The highest incidence rates for clinically-evident prostate cancer are found amongst the black population in the USA. Prostate cancer is rare in Asia, with the lowest rates amongst Japanese men.

Cancer Research also suggest that mortality from lung cancer is higher for men and women from Scotland and Ireland, but lower for people of East and West African, Caribbean, and South Asian origin. Mortality from breast cancer is also generally lower for women from migrant groups, though there is some evidence of low uptake of screening for both breast and cervical cancer amongst BME groups with outcomes improved from breast screening regardless of ethnic group (National Cancer Intelligence Network 2009).

The mortality rate for hepatocellular carcinoma is raised in men and women born in Bangladesh, China, Hong Kong, West Africa and Pakistan. Mortality rates for men born in the West Indies and North Africa were also higher than the national average. This could be related to endemic chronic viral hepatitis in those areas. (Bhala et al 2009).

The indicative evidence from the UK and considerable evidence from other countries suggest that rates of prostate cancer are substantially higher in the black groups (CRUK 2013) and are evident at younger ages. Prostate cancer is rare in Asia, with the lowest rates amongst Japanese men (Aspinall and Jacobson, 2004).

13.3.6 Mental Health

Mental health and ethnicity has been the subject of considerable debate with the focus shifting from the position that some ethnic groups could be predisposed to mental illness, to a notion that inequalities in service provision and differences in health outcomes may also be a contributing underlying factor.

According to Palmer (2012) whilst research and information is available on mental health issues, it only relates to selected minority groups. There would appear to be very little known about the mental well-being of communities such as Chinese, Vietnamese and the recent arrivals from EU accession counties.

It is important to recognise that there are fundamental cultural and socio-economic differences between many groups, for instance between Indians, Pakistanis and Bangladeshis and between Afro-Caribbean's and even regional sub groups of these populations (Palmer, 2012).

In April 2009 the Care Quality Commission's (CQC) review of the final *Count me in Census* showed that little progress had been made in reducing the mental health admission rate for Black and other minority groups. 23% of inpatients in mental health services in 2010 belonged to these groups despite efforts over the previous 6 years to reduce admissions. The rates of admission, detention and seclusion were effectively unchanged and evidence from the Census outlined the following:

- Admission rates remain higher than average among some racial groups, especially those recorded as being Black or mixed race (White/Black) for whom rates were two or more times higher than average in 2010. In contrast, admission rates were consistently lower than average among the Indian and Chinese groups, and about average in the Pakistani and Bangladeshi groups.

- Detention rates had almost consistently been higher than average among those recorded as Black or mixed race (White/Black) as well as those classed as 'Other White'. The rates for being placed on a Community Treatment Order (CTO) were higher among the South Asian and Black groups.
- Seclusion rates were higher than average for the Black, Mixed (White/Black) groups and Other White groups, in at least three of the six censuses.

Significantly, the CQC noted that many service providers did not collect data which would have permitted it to monitor equality and anti-discriminatory compliance. This consequently limited the impact of strategies designed to reduce inequalities,

These issues were also highlighted in the CQC reports (2011) '*Monitoring the Mental Health Act in 2011/12'* which used data available quarterly from the Mental Health Minimum Data Set (MHMDS)

A 2008 study by the Independent Police Complaints Commission (IPPC, 2010) on the use of Section 136 found that the rate of detention for BME people was almost twice as high as that for white people.

Wilkins and Kemple (2010) and Newbigging et al (2007) highlight a possible negative relationship between mental health services and African and Caribbean men, who are under-represented as users of enabling services and over-represented in the population of patients who are admitted to, compulsorily detained in, and treated by mental health services. The consequences of this are poor engagement with mainstream services, restricted choices and high levels of dissatisfaction with mainstream care.

Research by Fitzpatrick (2005) and Bracken et al (1998) relating to the Irish community suggests:

- The Irish population in Britain has a history of higher rates of mental ill-health than the general population.
- Irish people are substantially over-represented as users of psychiatric services, particularly for depression and alcohol related disorders.
- They are more than twice as likely to be hospitalised for mental health problems as native-born people in England and Wales.
- Irish rates of schizophrenia are second only to those of African-Caribbean people.
- Studies have shown that Irish-born people living in the UK have a higher rate of suicide than any other minority ethnic group living in the country.
- A study carried out by University of Central Lancashire (2008) in Birmingham looked specifically at the mental health needs of Irish women. One of the themes which came through strongly was the stigma which was attached to mental ill-health, especially among older women.

Research by Maynard et al (2012) put forward that Irish people have some of the highest rates of suicide and the admission rates of Irish people in their 50s and over to mental health establishments are higher than in other groups

A key area of concern for Gypsies and Travellers within social care is mental health. The DoH Sheffield report (Parry et al, 2004) found that Gypsies and Travellers were over twice as likely to be depressed, and almost three times as likely to suffer from anxiety, as others. The Equality and Human Rights Commission (EHRC) (2009) review of inequalities experienced by Gypsies and Travellers found that 'evidence from a number of studies

(Parry et al, 2004; Goward et al, 2006) shows that Gypsies and Travellers have greatly raised rates of depression and anxiety, the two factors most highly associated with suicide, with relative risks 20 and 8.5 times higher than in the general population (Harris & Barrowclough, 1997).

A local study of inequalities and cultural needs in mental health service provision for BME communities in Liverpool (CSIP, 2009) considered experiences of Asylum Seekers and Refugees, Irish and Irish Travellers, and Chinese elders; with few exceptions the experience of mental health services of these diverse groups were very similar. The study found that

- GP's and primary care staff were not always aware of the impact of stigma and discrimination around mental health issues in BME communities
- Do not have up to date knowledge of culturally appropriate services in their area, making appropriate referrals for support and treatment problematic.
- There are delays between referral by a GP to seeing a mental health specialist
- In some instances the persistence of physical ailments was not linked to a possible mental illness.
- Few participants in the research had knowledge of mental health services or how to access them,
- Immigration status, language difficulties, fear and cultural differences acted as barriers to accessing mental health services.
- Many of the participants had existing mental health issues that were not being addressed.

Research conducted by Mind (2009) found that despite experiencing high levels of mental distress, refugees and asylum-seekers face many challenges accessing mental health services in England and Wales.

NICE (2010b) and Kings Fund (2012) highlight that long term physical conditions are associated with increased risk of mental health problems. For instance, rates of depression are doubled in diabetes, hypertension, coronary artery disease and heart failure, tripled in end-stage renal failure, chronic obstructive pulmonary disease and cerebrovascular disease and seven times more common among those with two or more chronic physical conditions compared to healthy controls. There is also a documented (RNIB, 2012) link between sight loss and reduced wellbeing. For example, over one-third of older people with sight loss are also living with depression.

There is strong evidence, provided by National Aids Trust (2010), for a higher prevalence of mental health problems among people living with HIV, compared with the general population. Kings Fund (2012) implies that people who have been diagnosed with HIV are more likely to develop a mental health problem, for example anxiety or depression.

Sashidharan (2003) suggests that there does not appear to be a single area of mental health care in England in which BME groups fare as well, or better than the majority population. Both in terms of service experience and the outcomes of service interventions they fare much worse. The report comments that psychiatric illness rates are generally higher in minority ethnic groups and that they have poor social networks and support, with significant differences in their experience of mental health services and in outcomes from service interventions.

Aspinall and Jacobson (2004) highlight the number of studies, largely based on treatment rates, that report Black Caribbean people to be between three and five times more likely to

suffer psychotic illness, including schizophrenia, than the population as a whole. However other research, based on psychiatric illness rates in the community, found that they did not have significantly higher rates than other groups and though the rates for psychosis were twice that of the White group, they were not statistically significant. In respect of common mental disorders (depression, anxiety, phobia, obsessive compulsive disorder and panic disorder), while rates were low for Bangladeshi women and high for Pakistani women and Irish men, there were no marked differences between ethnic groups.

They go on to describe that overall women have higher rates of these conditions than men from the same ethnic groups, with the exception of Bangladeshi and Irish men. Minority White and Caribbean groups had higher rates in respect of neurotic depression, suicidal thought and non-affective psychosis, Indian / African Asian and Pakistani groups' similar or slightly higher rates than the White British group, while Bangladeshi and Chinese groups had considerably lower rates. Rates of neurotic disorders were particularly low in South Asian women, while Caribbean women had rates of psychosis twice that of White British women.

Sainsbury Centre (2006) report implies that black people are often reluctant to engage with mainstream mental health services, doing so only at the point of breakdown or crisis. This makes the involvement of the police and compulsory admission under the Mental Health Act more likely and leads to disproportionately high rates of hospital admission and use of intensive care, secure services and use of seclusion and restraint. This pattern of service use is negatively experienced and is related to poor outcomes, with high rates of relapse and readmission.

Wirral's BME Needs Assessment (Icarus, 2010) provided the key points established from what people said about their personal experiences as patients or as service providers and health professionals:

- Perceived tendency for BME individuals' to be more likely to access mental health services at a late stage, often at crisis point.
- Considerable stigma associated with mental illness which impacts on the willingness to engage with services.
- Lack of knowledge within BME communities about mental health provision
- Inaccurate assumptions and stereotyping by health professionals
- Social isolation and alienation
- Language difficulties in accessing services

The Icarus Report (2010) can be accessed here.

13.3.7 Dementia

The Alzheimers Society (2013) suggest that current UK evidence base on supporting Black and other minority groups with dementia and their carers is limited with some evidence available from local surveys, with overall the proportion of BME people affected by dementia broadly the same as that found among white people although, as yet, Social Care Institute for Excellence (SCIE) (2011) suggest that there have been no large-scale UK prevalence (frequency) studies. However the Alzheimers Society (2013) estimate there are over 11,500 people with dementia from Black and other minority groups in the UK.

The Federation of Irish Societies (2010) *(now known as Irish in Britain)* carried out an exercise in mapping the services for elders within the Irish community and identified that in the apparent absence of culturally sensitive mainstream or culture specific services, the Irish third sector had developed a range of services that are popular and well utilised by the community. Despite this there was still considerable unmet need in relation to older Irish people in general and for people with dementia and their carers specifically. This could be exacerbated by the higher median age of Irish people than that of the general population and other BME groups (Census, 2011) and in turn a potential increased risk of dementia. Tilki et al (2010) suggest on the basis of this mapping work that dementia is increasingly a key issue within the Irish community, yet there is evidence to suggest that service providers may not be recognising this need and Irish people may not be accessing support from healthcare services. The mapping survey also suggests that within the Irish community there could also be disproportionately high levels of hypertension, coronary heart disease and strokes which can all contribute to the development of vascular dementia which is comparable to the African-Caribbean community.

Early onset dementia (a rare type affecting people under 65) is thought to be more frequent among Black and other minority people, according to SCIE (2011) with 6% of people having it compared to 2% of the white population. SCIE (2011) go onto suggest that Black and other minority groups and their families are more likely to see the symptoms of dementia as 'normal ageing' which leads to the assumption that nothing can be done to assist them and results in families only seeking help when the dementia become more severe. This could be further compounded by the suggestion that Black and other minority groups with dementia present later to dementia services than their White counterparts, when their dementia becomes more severe.

Research by the Royal College of Psychiatrists (2009) and Mukadam et al (2010) warns that Black and other minority groups are less likely to receive a diagnosis or receive it at a later stage thereby delaying access to memory assessment services.

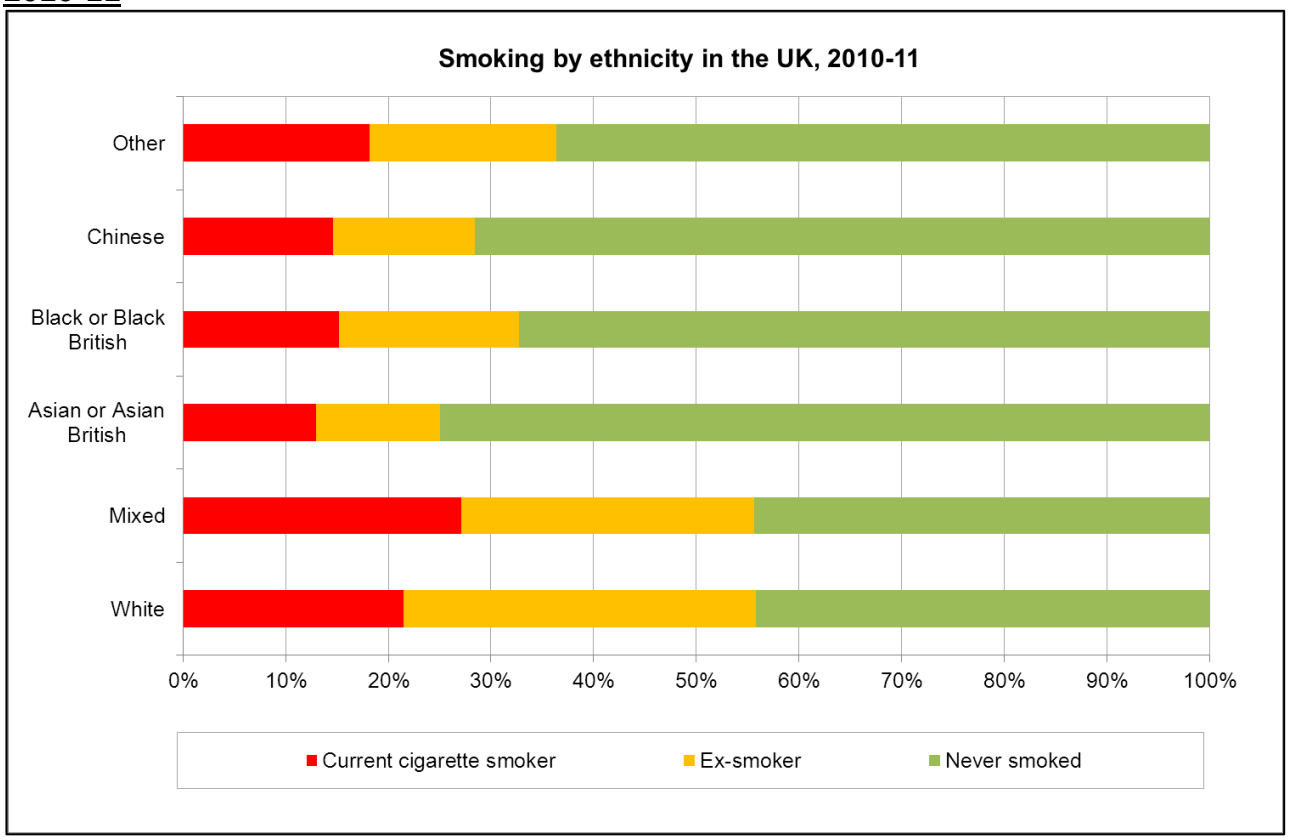
13.3.8 Smoking

Behavioural risks such as smoking and physical inactivity are more common in some racial groups. The NHS Health & Social Care Centre (2006) report on the Health Survey for England identified that 40% of Bangladeshi men and 20% of Indian men smoked compared to the national average of 24%. In women the rates ranged from 2% for Bangladeshi women to 26% for Irish women compared with the national average of 23% at that time.

As with the general population, smoking prevalence in Black and other minority groups tends to decrease with age with the highest rates in those aged 16-34. Cancer Research UK (2012) implies that the exceptions are Black Caribbean and South Asian men in whom prevalence is highest in those aged 35-54.

Based on the results found in the report by NHS Health & Social Care Centre (2006) in relation to the Health Survey for England 2004, the prevalence of self-reported cigarette smoking in England was 24% and 23% for males and females respectively. Prevalence varied between the BME groups but was consistently higher amongst males. Figure 13.3.8a describes different numbers of smokers by ethnicity.

Figure 13.3.8a: Proportion current, former and people who have never smoked, by ethnicity, 2010-11



Source: ONS, Integrated Household Survey, 2011

- People of White or Mixed ethnicity are most likely to be current and ex-smokers
- People of Asian or Asian British are less likely to smoke (although this overall figure hides considerable differences between males and females, with rates amongst men much higher than those for women)

This trend, from research by Raleigh and Polato (2007), implies this is also observed for Black or Black British people (higher rates of smoking amongst men compared to women). There are significant differences between ethnic groups, with Bangladeshi men (44%) and Irish men (39%) being more likely to be smokers than the general population whilst Chinese men are less likely to be smokers (17%). Women from BME communities are much less likely to smoke than the general population. Tobacco chewing though is relatively common for Bangladeshi women with 26% doing so.

Tobacco chewing is sometimes combined with the use of the areca nut, which is often wrapped in the leaf of the betel nut palm and is commonly referred to as betel nut and used within British Asian communities. Betel nut may also be chewed by itself and Warnakulasuriya et al (2002) point to evidence to suggest that it is an independent factor in the occurrence of oral cancer. The use of betel nut substitute's gutkha and masala are also thought to be carcinogenic (Nair et al, 2004).

Finding from the Icarus Report (2010) suggested there were particular difficulties in getting BME individuals involved in smoking cessation initiatives. Though it was not clear why this was the case, it was seen as being linked to the wider issue of engaging BME communities in health promotion and preventative measures. It was thought that smoking rates were

particularly high within some BME communities in Wirral including Irish, Bangladeshis and Eastern Europeans.

Recent study by Das-Munshi et al (2013) on smoking and alcohol in migrant populations and published in the European Journal of Public Health (2013) also suggests that there could be intergenerational 'transmission' of health disadvantage in migrant groups. This would be across generations and where possible more attention should be afforded on the public health legacy of inequalities transferring from one migrant generation to the next.

Evidence based on local data from the Wirral Smoking Cessation Service, table 13.3.8b below for 2012/13, suggests 88% (4,732) of users who were accessing Wirral's smoking cessation service were from White ethnic backgrounds. Only 2% (111) of people making use of this service were from Asian or Asian British group and less than 1% (16) of people was from the Black or Black British and Mixed communities. Thus suggesting, people of minority ethnic groups may not be accessing their local health and social care services in accordance with their needs.

Table 13.3.8b: Number of people who have accessed Wirral smoking cessation service 2012/13

Ethnicity	Number who set a quit date	Number who were Successful	Success Rate (%)
British	4,499	1,913	42.5
Irish	37	15	40.5
Any Other White background	196	75	38.3
White	**4,732**	**2,003**	**42.3**
White and Black Caribbean	1	1	100.0
White and Black African	3	3	100.0
White and Asian	6	2	33.3
Any Other Mixed Background	8	3	37.5
Mixed	**18**	**9**	**50.0**
Indian	10	6	60.0
Pakistani	1	0	0.0
Bangladeshi	49	27	55.1
Any Other Asian Background	51	26	51.0
Asian or Asian British	**111**	**59**	**53.2**
Caribbean	4	0	0.0
African	10	3	30.0
Any other Black Background	2	1	50.0
Black or Black British	**16**	**4**	**25.0**
Chinese	14	7	50.0
Any Other Ethnic Group	18	8	44.4
Other Ethnic Groups	**32**	**15**	**46.9**
Not Stated	**494**	**169**	**34.2**
Total	**5,403**	**2,259**	**41.8**

Data Source: Wirral Smoking Cessation 2012/13

13.3.9 Obesity

Obesity is a major risk factor for cardiovascular disease, as well as Type 2 diabetes, hypertension, metabolic syndrome, osteoarthritis and cancer. The Government's Foresight programme (McPherson et al, 2007) showed that over half of the UK adult population could be obese by 2050, resulting in total annual direct and indirect costs of obesity of approximately £50 billion by this date. The report goes onto suggest that obesity rates vary by BME group, particularly for women. Black African (38%), Black Caribbean (32%) and Pakistani (28%) women are more likely to be obese than women from the general population (21%).

However there is continuing debate about the validity of using current definitions of obesity for non-white ethnic groups, for both adults and children. Different ethnic groups are associated with a range of different body shapes, and different physiological responses to fat storage. Revised Body Mass Index (BMI) thresholds and waist circumference ratios have been recommended for South Asian populations who are at risk of chronic diseases and mortality at lower levels than European populations.

In terms of public health action, it is particularly important for South Asian populations in the UK to be aware of the health risks of increased BMI and waist circumference. Information provided by the National Obesity Observatory (NOO) suggests that the prevalence of obesity-related conditions such as cardiovascular disease and type 2 diabetes varies by ethnic group. A NOO report on obesity and ethnicity can be accessed here. Health behaviours also differ according to different religious, cultural and socioeconomic factors, as well as by geography. Whilst many people from minority ethnic groups have healthier eating patterns than the White population, unhealthy diets and low levels of physical activity are known to be of concern in some minority ethnic groups, in particular those of South Asian origin. Members of minority ethnic groups in the UK often have lower socioeconomic status, which is in turn associated with a greater risk of obesity in women and children. People from minority ethnic groups may experience elevated levels of obesity-related stigma.

Using the 2004 Health Survey for England (NHS Health & Social Care Centre, 2006) it found that women of Black Caribbean, Black African and Pakistani origin had a significantly higher prevalence of raised waist circumference (88cm or higher) than the general population and Chinese women had a lower prevalence of raised waist circumference than the general population. Cultural differences surround attitudes to weight desirability and body image; within some African cultures, plus size women were considered to be attractive and not thought of as unhealthy.

Changes in lifestyles and activity levels in moving to Britain, while retaining dietary habits has had an adverse effects in some groups, for example individuals relocating from some African countries have quickly adapted to the use of cars and vehicles as the norm, whilst not changing dietary habits to compensate for lower levels of physical activity (Icarus Report, 2010).

Table 13.3.9a: Waist-hip ratio (WHR) by ethnic group and sex for England using 2004 Health Survey for England

Ethnic Group	% with Waist-Hip Ratio (WHR)	
	% ratio 95+ for Men	% ratio 85+ for Women
Black Caribbean	25	37
Black African	16	32
Indian	38	30
Pakistani	36	39
Bangladeshi	31	50
Chinese	17	22
Irish	36	37
General Population*	33	30

Source: NHS Health & Social Care Centre, 2006
Note: *general population refers to the whole population of England, regardless of minority ethnic group

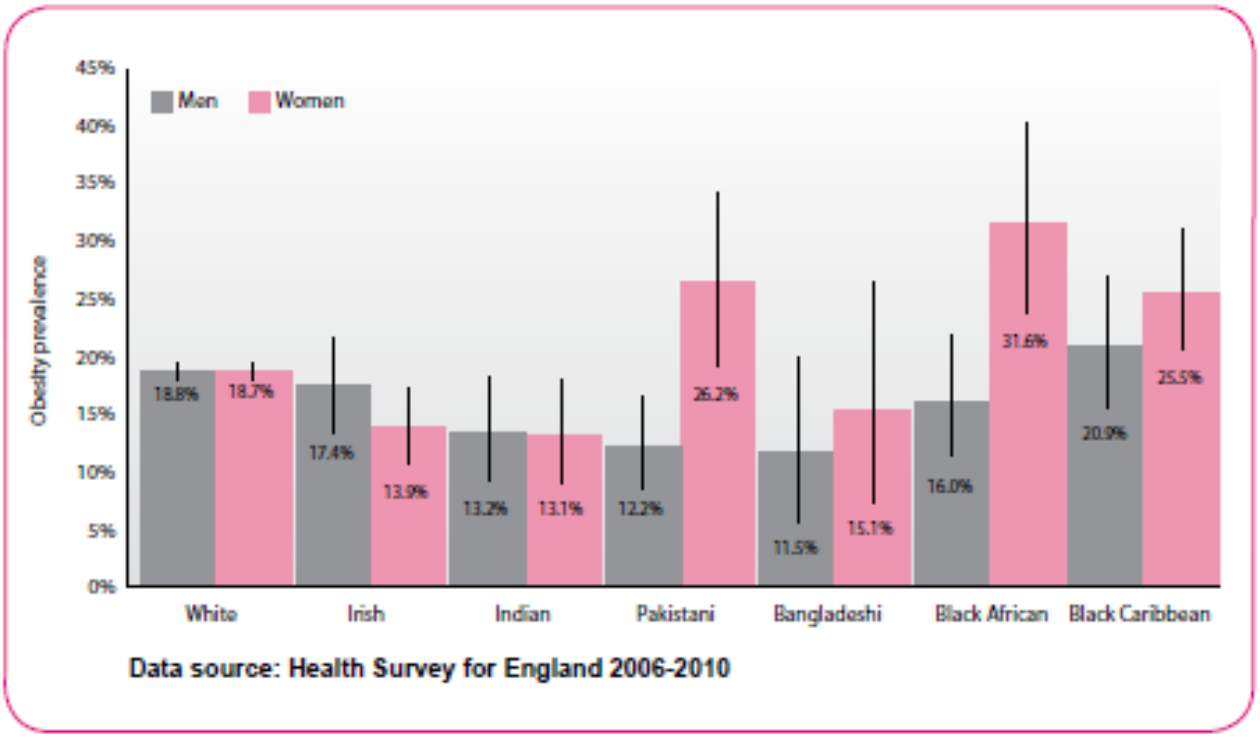
Table 13.3.9a illustrates that Indian, Pakistani and Irish and Bangladeshi men had a higher prevalence of raised waist-hip ratio (WHR) than men in the general population. The lowest rate in men was found among Black African (16%) and Chinese men (17%); the highest prevalence was among Indian men (38%). Women in all but one ethnic group had a higher prevalence of raised WHR (0.85 or more) than the general population. The lowest rates in women were found among Chinese informants (22%), and the highest (50%) among Bangladeshi women.

The NHS Health & Social Care Centre (2006) *Health Survey for England in 2004* further suggests that Chinese and Bangladeshi men were least likely to be overweight or obese (standardised risk ratios, compared with the general population, of 0.62 and 0.75). Indian and Pakistani men were also less likely to be overweight or obese (risk ratios 0.82 and 0.89 respectively). After adjusting for age, Bangladeshi men were almost five times, and Chinese men almost four times, less likely to be obese than men in the general population. The likelihood of Black African, Black Caribbean and Irish men being overweight or obese was the same as for men in the general population.

Among women, this same survey pointed to the prevalence of overweight including obesity was higher among Black Caribbean (65%), Black African (70%) and Pakistani (62%) groups than in the general population (57%). Bangladeshi (51%) women and, particularly, Chinese women (25%) had lower prevalence of overweight including obesity than the general population.

A recent Public Health England and Local Government Association publication, *Social Care and Obesity: A discussion paper* (2013) suggests that obesity prevalence varies by socioeconomic and ethnic group, as highlighted in figure13.3.9b, with rising obesity rates possibly resulting in increased ill-health among disadvantaged communities and among particular black and minority ethnic groups. This can lead to widening inequalities in health and social care. The report goes onto imply that obesity may also result in adverse social impacts such as discrimination, social exclusion and reduced earnings. Inequalities may also exist in terms of social care need. Among adults aged 65 and over, support with activities of daily living is more likely to be required by those on low incomes and those living in deprived areas.

Figure 13.3.9b: Age standardised prevalence of obesity among adults aged 16 years and over by ethnic group (with 95% confidence limits), 2006-2010, England,



Source: LGA & PHE (2013)

Obesity in Children

The National Child Measurement Programme (NCMP) is an annual programme which aims to measure the height and weight of all children in Reception and Year 6 in school. The information is used to help the NHS and local authorities plan and provide better health services for children. Below are the results for both national figures (Table 13.3.9c, 13.3.9d, Table 13.3.9e and Table 13.3.9f) and Wirral (Table 13.3.9g and Table 13.3.9h) for 2011/12.

Table 13.3.9c: Proportion of underweight, healthy weight, overweight and obese – Reception (aged 4 -5) children by ethnicity, National NCMP (2011/12) for England.

Ethnic category	Underweight	Healthy Weight	Overweight	Obese	
	Reception	Reception	Reception	Reception	Reception
	Prevalence	Prevalence	Prevalence	Prevalence	
Total	**0.9%**	**76.5%**	**13.1%**	**9.5%**	**565,662**
White	0.5%	77.0%	13.6%	8.9%	369,186
Mixed	1.0%	76.8%	12.3%	9.9%	25,087
Asian or Asian British	3.4%	77.0%	9.2%	10.4%	52,673
Black or Black British	1.0%	68.8%	14.6%	15.6%	28,454
Chinese	0.6%	82.5%	9.6%	7.3%	1,953
Any Other Ethnic Group	1.2%	73.7%	13.2%	11.9%	8,937
Unknown	0.9%	76.9%	13.0%	9.1%	79,372

Source: The Health and Social Care Information Centre, Lifestyle Statistics / Department of Health Obesity Team NCMP Dataset (2012)
Notes: see below 13.3.9c

Table 13.3.9d: Proportion of underweight, healthy weight, overweight and obese – Year 6 (aged 10 - 11) children by ethnicity, National NCMP (2011/12) for England

Ethnic category	Underweight	Healthy Weight	Overweight	Obese	
	Year 6	Year 6	Year 6	Year 6	Year 6
	Prevalence	Prevalence	Prevalence	Prevalence	
Total	**1.3%**	**64.9%**	**14.7%**	**19.2%**	**491,118**
White	1.0%	66.4%	14.5%	18.1%	318,897
Mixed	1.3%	62.7%	14.8%	21.2%	16,791
Asian or Asian British	3.6%	58.3%	14.8%	23.4%	43,665
Black or Black British	1.0%	55.4%	16.2%	27.5%	22,148
Chinese	1.8%	68.2%	13.3%	16.7%	1,501
Any Other Ethnic Group	1.6%	59.3%	14.5%	24.7%	7,724
Unknown	1.2%	65.9%	14.8%	18.1%	80,392

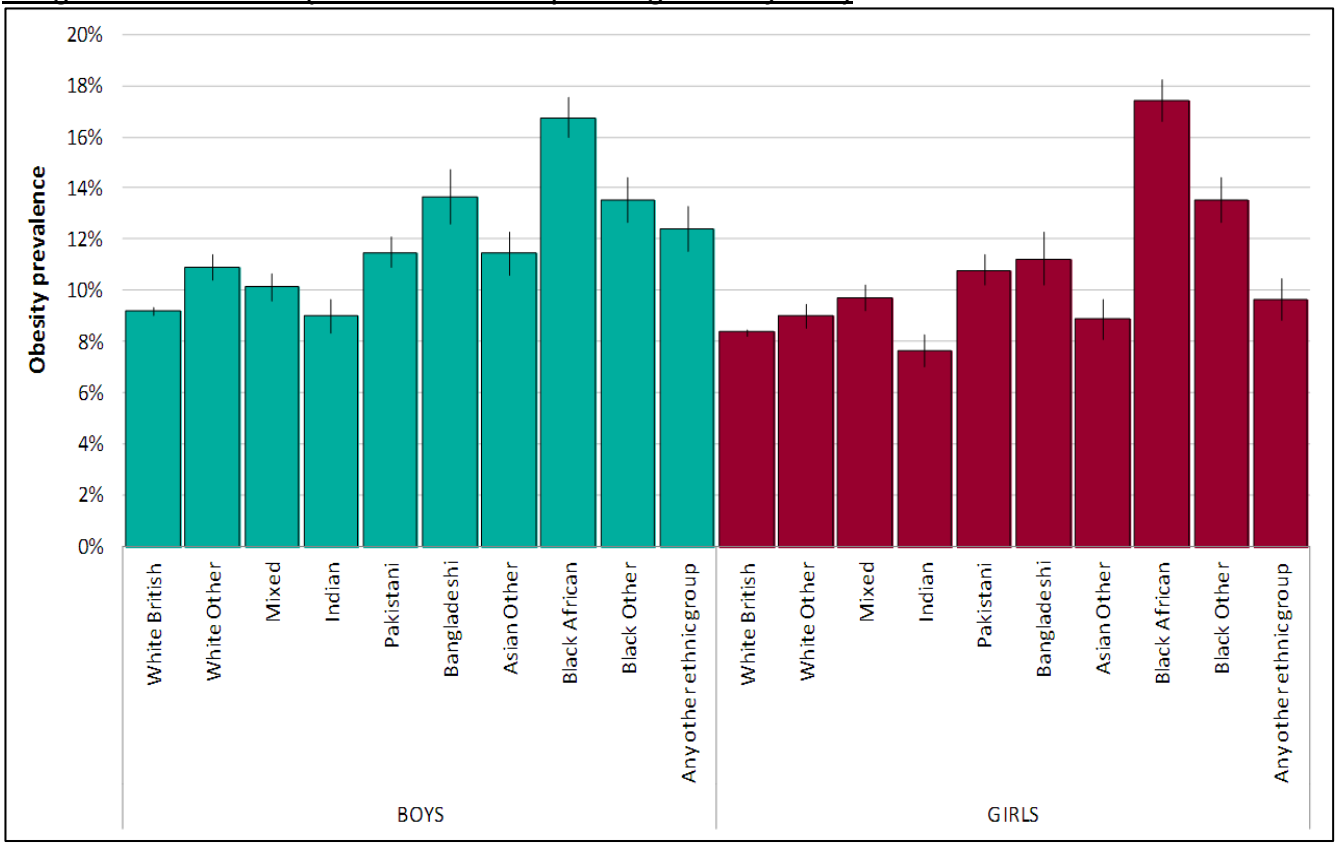
Source: The Health and Social Care Information Centre, Lifestyle Statistics / Department of Health Obesity Team NCMP Dataset (2012)

Notes: The seven ethnic categories used for analysis have been derived by combining the following NHS ethnic categories: http://www.isb.nhs.uk/documents/dscn/dscn2004/212004.pdf

- White: White British, White Irish, White Any other White background
- Mixed: Mixed White and Black Caribbean, Mixed White and Black African, Mixed White and Asian, Mixed Any other mixed background
- Asian or Asian British: Asian and Asian British Indian, Asian and Asian British Pakistani, Asian and Asian British Bangladeshi, Asian and Asian British Any other Asian background
- Black or Black British: Black or Black British Caribbean, Black or Black British African, Black or Black British Any other Black background;
- Chinese: Chinese;
- Any other ethnic group: Any other ethnic group;
- Unknown: Not Stated or data not returned by PCT

The national average percentage for all 4/5 year old children who were obese was 9.5% as we can see from Figure 13.3.9c above. In Figure 13.3.9e below, nationally a number of 4/5 year olds from ethnic minority groups have higher levels than this average, such as Bangladeshi, Black Other and Any Other Ethnicity boys and Pakistani, Bangladeshi, Black African and Black other girls.

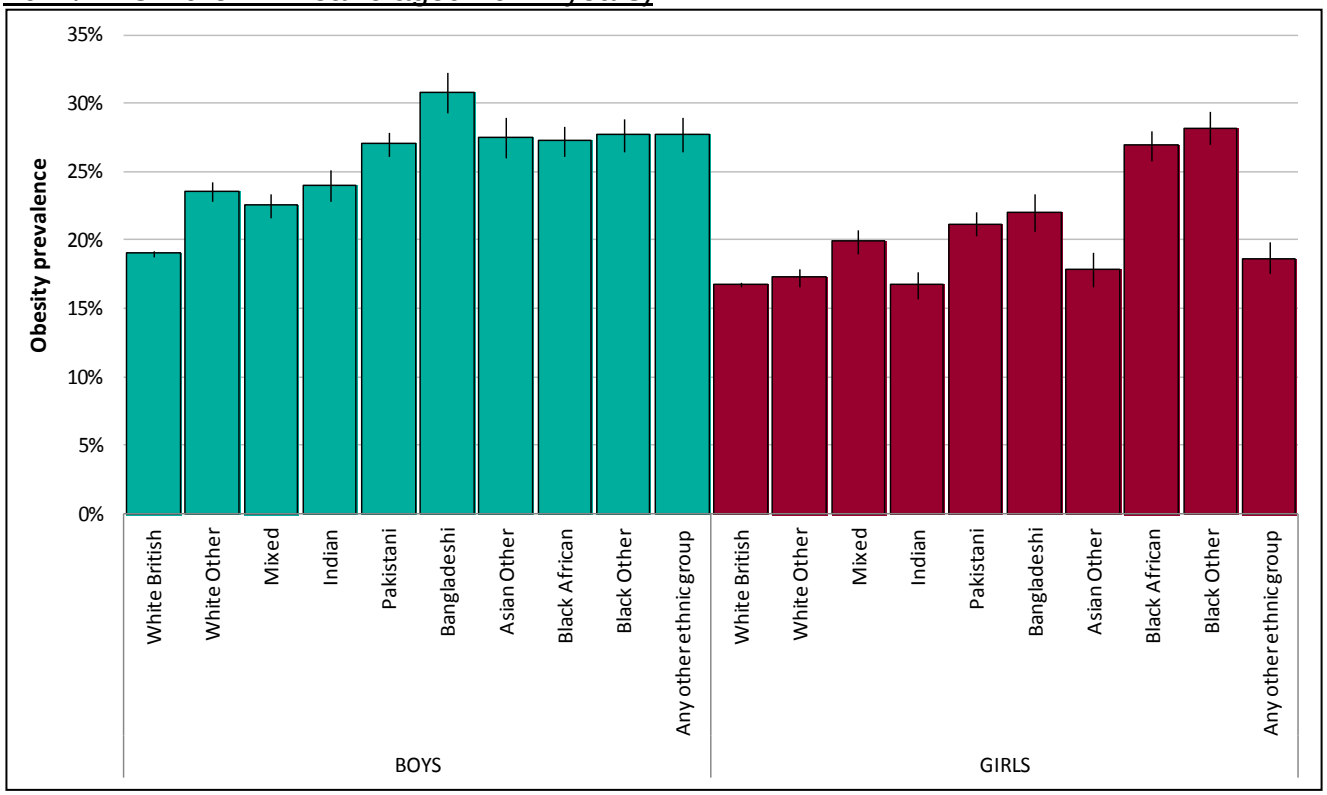
Figure 13.3.9e Obesity prevalence by ethnic group National Child Measurement Programme 2011/12 (Children in Reception aged 4-5 years)



Source: National Obesity Observatory data and information
Notes: Child obesity: BMI ≥ 95th centile of the UK90 growth reference

The national average percentage for all 10/11 year old children who were obese was 19.2% as we can see from Figure 13.3.9d above. In Figure 13.3.9f below, nationally all 10/11 year old boys from ethnic minority groups had higher levels than this average, except for White British boys, whilst Pakistani, Bangladeshi, Black African and Black other girls were again higher than the national average.

Figure 13.3.9f Obesity prevalence by ethnic group National Child Measurement Programme 2011/12 Children in Year 6 aged 10-11 years)



Source: National Obesity Observatory data and information
Notes: Child obesity: BMI ≥ 95th centile of the UK90 growth reference

For Wirral, the proportion of underweight, healthy weight, overweight and obese at reception year and year 6 can be seen in figures 13.3.9g and 13.3.9h. These provide a comparison to the national data previously considered.

Figure 13.3.9g: Proportion of underweight, healthy weight, overweight and obese at reception (aged 4 – 5) children by ethnicity, 2011/12 for Wirral

Ethnicity Group	Reception: Healthy Weight	Reception: Obese	Reception: Overweight	Reception: Underweight	Total
Total	**2705**	**347**	**543**	**13**	**3608**
White	2535	323	515	12	3385
Mixed	73	8	11	*	92
Asian or Asian British	58	10	8	*	76
Black or Black British	**	*	*	*	12
Chinese	**	*	*	*	13
Other Ethnic Groups	*	*	*	*	9
Not stated	15	*	*	*	21

Source: Source: National Child Measurement Programme 2011/12
Notes:

- *Numbers of people being 5 or less are suppressed in order not to reveal the identity of individuals
- ** Numbers of people between 6 and 10 are suppressed in order not to reveal the identity of individuals
- In total Wirral NCMP records account for 223 children at Reception Year being measured. Caution is advised when considering ethnic groups and weight categories in relation to low overall measured numbers for BME groups. Low numbers can create high percentage differences. This compares to 3,385 children who were measured from a white background
- see notes below 13.3.9c

Figure 13.3.9h: Numbers of underweight, healthy weight, overweight and obese at Year 6 (aged 10 - 11) children by ethnicity, 2011/12 for Wirral

Ethnicity Group	Year 6: Healthy Weight	Year 6: Obese	Year 6: Overweight	Year 6: Underweight	Total
Total	**2072**	**644**	**520**	**28**	**3264**
White	2005	612	498	24	3139
Mixed	29	**	14	*	51
Asian or Asian British	18	12	*	*	35
Black or Black British	7	*	*	*	13
Chinese	8	*	*	*	16
Other Ethnic Groups	*	*	*	*	6
Not stated	*	*	*	*	4

Source: Source: National Child Measurement Programme 2011/12
Notes:

- *Numbers of people being 5 or less are suppressed in order not to reveal the identity of individuals
- ** Numbers of people between 6 and 10 are suppressed in order not to reveal the identity of individuals
- In total Wirral NCMP records account for 125 children at Year 6 being measured. Caution is advised when considering ethnic groups and weight categories in relation to low overall measured numbers for BME groups. Low numbers can create high percentage differences. This compares to 3,139 children who were measured from a white background
- see notes below 13.3.9c

Also see: National Obesity Observatory data and information

The comparison of national and Wirral data, as described in figures 13.3.9g and 13.3.9h, can be difficult given the differences in numbers being considered but local data has:

- 347 reception children of 3,608 measured, or 9.6% of the 2011/12 cohort, are considered obese (Compared to 9.5% nationally see Table 13.3.9b)

- 890 reception children of 3,608 measured, or over 24% of the 2011/12 cohort, are considered overweight and obese.
- 644 Year 6 children of 3,264 measured, or over 19.7% of 2011/12 cohort, are considered obese. (Compared to 19.2% nationally see Table 13.3.9c)
- 1,164 Year 6 children of 3,264 measured, or over 36% of 2011/12 cohort, are considered overweight or obese.
- Over 93% of reception year and 95% of Year 6 children who are considered obese are from the White British ethnicity group
- Less than 6% of reception year children, either overweight or obese , are from a black or other minority ethnic group
- Almost 95% of reception year and over 95% of Year 6 children who are considered overweight are from the White British ethnicity group
- Less than 5% of Year 6 children, either overweight or obese , are from a black or other minority ethnic group

The National Obesity Observatory suggests that trends in childhood obesity would appear to be increasing nationally and this is particularly evident in some BME groups (as highlighted in supplementary document here). Locally numbers overall remain small, in line with low ethnic group population figures, however this aspect is heightened when considered with higher numbers in some local ethnic minority population groups such as Asian or Asian British and Black or Black British.

13.2.10 Alcohol

Although the evidence is dated, NHS Health & Social Care Centre (2006) suggested in the general population 8% of men and 14% of women were non-drinkers. All other minority ethnic groups were more likely than the general population to be non-drinkers, apart from the Irish who were as likely. The highest percentage of non-drinkers were found among Pakistani adults (89% of men and 95% of women), and Bangladeshi adults (97% of men and 98% of women).

In the general population, the mean number of days in the past week when alcohol was consumed was 2.7 for men and 1.8 for women. Estimates for Irish men and women were slightly higher than the general population (3.0 for men and 2.1 for women), but were much lower for the other minority ethnic groups: for example, the highest mean number of days among the other groups was 1.8 days for Black Caribbean men and 1.0 days for Black Caribbean women.

The 2010 Icarus Report on local BME health needs highlighted that local community organisations working with BME clients from the Irish and Polish communities identified alcohol misuse as a significant issue within both communities linked to social isolation, poverty and mental health problems. Research by Erens et al (2001) also tells us that information provided by the 1999 Health Survey for England, Irish men were drinking more than 21 units per week compared to the general population (34% compared to 30% of all men) and Irish women (19%) were more likely to drink more than 21 units when compared to all women (14%).

During March/April 2013, Wirral Council's Public Health team hosted a series of four specialist BME workshops which focussed on raising awareness about and improving access to drug and alcohol treatment services for local BME Communities. The

communities that took part included: Bangladeshi males; Bangladeshi females; Polish/Eastern European and Chinese/Asian Communities. Please see 13.3.17.1 below for further details.

13.3.11 Sexual Health

According to research by Fenton et al (2005) there are ethnic variations in the rate of diagnosed sexually transmitted infections (STI's) with Indian and Pakistani men and women have lower rates of diagnosed STI's than other groups, while Black Caribbean and Black African men have higher rates of STI's than White men and Black Caribbean women, higher STI's than White women, though the latter reported higher levels of risk behaviours than other ethnic groups.

Fenton et al (2005) research also suggests individual sexual behaviour is a key determining factor in accounting for differences in the rate of STI infection between groups, but 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.

Research into the attitudes and behaviours of BME Youth in London by Testa and Coleman, (2006) point to lower levels of sexual health knowledge among BME students, particularly Asians, compared to White British students and also differences in STI's and unplanned pregnancies.
Wirral's BME needs assessment (Icarus report 2010) found that sexual health is often a taboo subject which is not talked about openly within some cultures. This can make individuals reluctant to use services. Religious beliefs and cultural values also play an important part in attitudes towards sexual health for many BME communities and their concerns about using sexual health services before marriage.

Key informants working in sexual health services on Wirral reported (Icarus, 2010) low numbers of BME community members accessing services. While people from Eastern European communities have a good take up and generally appear to be confident about their contraceptive needs, members of the Bengali and Chinese communities often appear less confident and need more support to access services. As previously noted above, young BME men, from Black and Asian communities on Wirral are unlikely to access contraception and screening services.

13.3.12 BME Women's Health

Much of the research relating to ethnicity and women's health is focused on maternity services. According to review by Aspinall and Jacobson (2004) Asian women make less use of antenatal services and are more likely to book late for antenatal attendance. Women from South Asian groups are far less likely to receive prenatal testing for blood disorders and Down's syndrome.

The research by Aspinall and Jacobson (2004) has found that maternal mortality rates were three times higher in Asian women then White women (1997-99), while the rate for Black women was somewhere between these. The 2007 report by Lewis (2007) points to Black African women, including asylum seekers and newly arrived refugees, as having a maternal mortality rate which is nearly six times higher than White women. As Lewis (2007) goes

onto to suggest this may not only reflect the cultural factors implied in ethnicity but their social circumstances and the fact that some of these women may have recently migrated to the United Kingdom under less than optimal circumstances and may have had difficulties accessing health care.

Lewis (2007) study in maternal death she also concluded that:

- Across all ethnic groups, on average 20% of women who died failed to access antenatal care before 22 weeks or missed more than four antenatal visits
- Babies born to Pakistani mothers had an infant mortality rate of 12.2 per 1,000 births (2001), which was higher than any other groups and more than double the overall infant mortality rate (5.5 per 1,000 live births).
- HIV/AIDS is a serious concern particularly for people from sub-Saharan Africa including Kenya, Zimbabwe, Zambia and South Africa; people from this region often present late with HIV, often after symptoms of AIDS have developed, making early intervention with antiviral drug treatments more difficult. She also suggests that the key sexual health issues for refugees and asylum seekers include HIV/AIDS, genital mutilation, rape and sexual torture and resulting unwanted pregnancies

Aspinall and Jacobson (2004)

- African and Caribbean groups also had elevated rates for stillbirths and perinatal deaths, while infant death rates were higher for babies born of Mediterranean (9.6) and Caribbean mothers (10.4)
- Mothers from ethnic minority communities are more likely to breast feed (86-95%) than White mothers (67%) and they are more likely to still be breastfeeding at nine months, with Black mothers having the highest breastfeeding.

Parry et al, 2004

- There is also an excessive prevalence of miscarriages, stillbirths and neonatal deaths for mothers from Gypsy and Traveller communities

Other research by Szcepura (2005) shows there is a lower uptake by women from ethnic minority communities for cervical cancer screening and breast cancer screening and in particular there is lower uptake by women from India, Pakistan and Bangladesh, although uptake by African Caribbean women is high. The main reasons for low uptake of these two screening services include language barriers, inaccurate screening registers including poor awareness of minority ethnic naming systems and a lack of referral from health professionals. Cervical screening rates appear higher in practices with a female partner (though not for breast screening).

13.3.13 Children & Young People

Research by Saxena et al (2002) reported that Indian, Pakistani, and Bangladeshi children reported less acute and chronic illness, asthma, and injuries than the general population, whereas Afro-Caribbean children reported more. Indian and Pakistani children make more use of general practitioners' services, but Indian, Pakistani, Bangladeshi, and Chinese children are less likely to be referred to outpatient clinics.

South Asian children in England do less exercise than their peers from other ethnic groups, according to the CHASE study by Owen (2009), with only 54% of South East Asian

residents meeting the then current recommended target of spending at least 60 minutes per day in moderate levels of activity compared with 70% of White European children and 69% of Black African Caribbean children.

Black children are considered to be more likely than white children to have common mental disorders with Pakistani children less likely and Bangladeshi children far less likely. A large scale survey (Meltzer et al, 1999) of the prevalence of three most common mental disorders in children and adolescence (conduct disorder, hyperactivity and emotional disorders) assessed 12% of Black children as having a mental disorder, compared to 10% for White, 8% for Pakistani and Bangladeshi and 4% for Indian children. For all ethnic groups boys were more likely to be assessed as having a disorder than girls.
Cancers in children are very rare; children of Asian ethnic origin in Britain have consistently been found to have a higher incidence of lymphomas, particularly in early childhood.
The Equality and Human Rights Commission (EHRC) (2009) review *Inequalities experienced by Gypsies and Travellers* reported that low levels of immunisation for children can be a particular problem where families are highly mobile, continuity of care is lacking, and specialist health visitors for the Gypsy and Traveller community are not available and concerns over the possible ill-effects of inoculations can also be an issue.

13.3.14 Older People

Aspinall and Jacobsen (2004) suggest that there is limited amount of research on the health and social care needs of older people from BME communities, though the perception exists that their numbers are small and that they '*look after their own'*. In practice many of the migrants coming to Britain in the 1950's and 1960's are now past retirement age, and could be in poor health. There is also a concern that there are some 'hidden' groups e.g. Irish and Eastern Europeans whose needs may not be recognised. According to the report researched by the Federation of Irish Societies (2010) *(now known as Irish in Britain)* the Irish population is an ageing one, In fact, 24.9% of white Irish people are aged over 64 years in comparison with 15.9% of the population as a whole. The ageing population of the Irish is an important aspect for consideration, specifically in relation to Dementia/Alzheimer's and memory loss. Aspinall and Jacobsen (2004) research in London also suggests that Black Caribbean and African male elders are much more likely to live alone than other ethnic groups and in general BRM elders are over-represented in the lowest fifth of income distribution and in particular Pakistani, Bangladeshi and Black Caribbean elders. They are also more likely to live in poorer housing and in the case of South Asian elders be living in overcrowded conditions.

13.3.15 Irish Travellers and Gypsies

Most Gypsies and Travellers are now recognised as belonging to an ethnic group under race equality legislation, including Irish Travellers. Studies have found that the health status of Gypsies and Travellers is poor compared to the general population. According to Parry et al (2004) and Irish Traveller Movement for Britain (2012) Irish and Gypsy Travellers are significantly more likely to have a long-term illness, health problem or disability which limits their daily activities or work compared with their age-sex matched comparators.

Within this community access to health care can also be very poor. Gypsy Travellers, particularly men, were much less likely than their counterparts to be registered with a GP

and likely accessing heath care through Accident and Emergency departments, Travellers living on sites or in houses are more likely to have a doctor. (Parry et al, 2004).

The research by Parry et al (2004) implied that men take pride in being 'fit' and strong. Particularly when travelling, it is thought rarely possible to 'give in' to health problems for purely practical reasons. A fear of being perceived as weak by others, as well as not wishing to cause distress to close relatives, often results in conditions such as depression being kept secret or minimised. Cultural pride, for being resilient and self-reliant, led people to dismiss health complaints that were deemed minor.

The study also found that Gypsies and Travellers have specific healthcare needs in relation to mental health, maternal health and women's health. The issues relating to these needs are listed below: (full report can be viewed here)

Mental Health

- Gypsy Travellers were nearly three times more likely to be anxious than their counterparts, and just over twice as likely to be depressed.
- Depression was perceived to be common, but seen as shameful and something that should be kept hidden. There is a stigma about being labelled 'mentally ill'. Denial of depression resulted in delay or absence of help seeking and also resulted in increased suffering. Known suicides were referred to in this context.
- Bereavement was a very common precipitating factor in depression or other manifestation of psychological ill health. Grief or depression resulting from bereavement was profound and prolonged.

Maternal Health and Women's Health

- Gypsy and Traveller mothers had more pregnancies and deliveries. There was no significant difference between the number of Gypsy and Traveller women, and comparison women reporting a number of problems with pregnancy or childbirth, such as morning sickness, preterm birth, breech presentation or post-natal depression.
- However, more Gypsy Travellers experienced one or more miscarriages – 43 (29%) and Caesarean sections – 33 (22%) Gypsy Traveller women compared with 18 (16%), and 20 (14%) respectively of the non-Gypsy Traveller group with children.
- Conversely, hypertension was less commonly reported by the Gypsy and Traveller women — 2 (1%) compared with 11(8%) of comparators.
- Many women are multiparous because of a cultural desire for large families.
- Women often described avoiding early antenatal care and others had difficulty in accessing care.
- There was an excess prevalence of miscarriages, stillbirths, neonatal deaths and premature death of older offspring amongst Gypsy Travellers.

Parry et al (2004) study also found evidence that alcohol and drug use is an issue. The study reported depression was often associated with excessive alcohol consumption and that this often began as a coping strategy following bereavement. There was a recreational drinking culture among male Traveller youths, but it was culturally unacceptable for girls to join this social scene. Additionally, drug use among Traveller youths was widely reported and a source of great concern. Some parents would go to desperate lengths to get their affected child away from drugs, without the help of outside support. There was insufficient knowledge about drugs and resulting increase in fear of drugs.

13.3.16 Experience of Health Services

Evidence from the National GP Patient Survey programme conducted by the Department of Health (2007) shows that while in many areas of health provision there is no difference in the experience of BME and White British patients; where differences do exist; BME groups are more likely to report negative experiences of health services.

A further report by Lakhani (2008), for the Department of Health, suggested BME patients find it more difficult to access GP services due to four inter-related factors:

- Substantial communication problems caused by language and culture
- A greater disease burden experienced by BME patients, who tend to have a poorer health status
- The variable quality of GP practices
- The expectations of BME patients are different

Wirral's BME Health Needs Assessment (2010) provided by Icarus suggested that people who had low levels of English, or none at all experienced communication difficulties, which were intensified by the use of unfamiliar medical terms, idioms and jargon; for some literacy was a further issue. It has not been possible to quantify how extensive problem language difficulties are for members of BME communities in Wirral. However, some indication may be given by reference to the fact that a third of interviewees in the BME community survey either felt their GP only partially understood what they were saying (29%), or did not understand at all (4%).

Results from a BME health needs study by University of East Anglia (2010) found that a common expectation among some BME groups was broader access to specialist medical services, for example members of the East European community expect a good childcare with baby progression being monitored by a paediatrician and readily available to prescribe antibiotics and direct access to a specialist. Some BME groups are not well informed about healthcare and some did not know where to access health services, which meant some went directly to Accident and Emergency while others dialled emergency services.

For disadvantaged groups with transitory lifestyles, such as Gypsies and Irish Travellers, Attenbury (2010) and Shelter (2008) both imply that difficulty registering with a Doctor is a barrier to accessing primary care. There is also some evidence that access health care services within primary care settings may be more difficult to obtain for certain communities. This is also relevant to preventative programmes. Moving from a transitory lifestyle to housing can exacerbate mental ill-health.

The level of support delivered by BME community organisations in facilitating and supporting access to health services including GP services is an indicator that communication including language, literacy and understanding is a key issue for BME communities in Wirral.

13.3.16.1 Understanding barriers to services

Working with BME Communities to better understand barriers to services
Public Health Specialist BME Workshops – Drug & Alcohol- March & April 2013

Local needs assessment suggest that there is significant underrepresentation of BME Communities within the local alcohol and drug treatment population, although anecdotal

reports suggest that drug and/or alcohol problems could be prevalent within each community to varying degrees. Public Health team has been keen to better understand, and so address, any barriers to accessing services.

During March/April 2013, Wirral Council's Public Health team hosted a series of four specialist BME workshops which focussed on raising awareness about and improving access to drug and alcohol treatment services for local BME Communities. The communities that took part included: Bangladeshi males; Bangladeshi females; Polish/Eastern European and Chinese/Asian Communities.

The overall purpose of the workshops was to work towards determining how best services can be delivered; increasing the understanding of treatment workers about the specific barriers of access to services for each of the participating BME Communities and increasing awareness amongst BME Communities about the range of drug and alcohol treatment services available to them and how they can be accessed.

The workshops were comprised of a mix of drug/alcohol treatment workers and community members. They reviewed fictional case studies of people from BME communities in order to consider some key questions.

The suggestions made informed the recommendations, many of which are practical, affordable and can be implemented with minimal effort and can likely be applied to the provision of drug and alcohol services and wider healthcare services. These covered three core aspects:

- Getting services closer to local BME Communities
- Services closer by increasing the flexibility of service delivery and access to substance misuse treatment
- Services closer by overcoming the language barrier

The Executive Summary can be accessed here and Full Report of the BME Community engagement can be accessed here

Next Steps:
The Public Health team are undertaking the following steps in order to disseminate any learning as widely as possible:

- The final version of this report will be hosted on the Joint Strategic Needs Assessment (JSNA) website and in the BME chapter, Public Voice and other areas to increase awareness among other commissioners and service planners in general.
- It will be presented to key stakeholders involved in improving healthcare services to the local BME Community and also present at Wirral Ethnic Health Advisory Group (WEHAG).
- Actions taken in light of the recommendations outlined above will be reviewed on a regular basis.
- Updates regarding progress made with any actions will be provided to key stakeholders on a regular basis.

For further information on the evaluation please contact Steve Gavin on 0151 606 2000

13.3.17 Palliative Care

Research by Firth (2001) and Gunaratnam (2007) suggests that there are lower levels of awareness of hospice and palliative care with language differences amongst minority groups also limiting their use of services.

This research goes onto suggest that people from deprived areas are less likely to use palliative services and those who do are less likely to do so in their own home. Causes of inequality in access to palliative care include: shortages of specialist staff, increased demand for services and lack of knowledge about the needs of patients from deprived areas or BME communities. Also implying that BME groups are less likely to be referred to and use hospice cancer services.

According to research carried out by Jesper et al (2008) the needs of terminally ill Gypsies and Travellers may be overlooked by hospitals and GPs. None of the Gypsies and Travellers interviewed in the study (regardless of accommodation status) felt able to use palliative care services for their family members. The reasons included pride in caring for a person at home, clashes with medical staff over large numbers of visitors, and limited knowledge of the services available. Enforced mobility reduced access to GPs and made it difficult to organise programmes of palliative care to support Gypsies and Travellers who wished to die at home.
Bowling et al (2010) looked at fear of dying in this study and concluded that 'enabling older people to express fears about dying is likely to be important when planning supportive end-of- life care. They go onto suggest that practitioners should not assume that fears about dying are the same in different social groups, or that extensive family support is protective against such anxiety. Older people from minority groups had more anxieties about dying than others, and were more likely to express fear the more extensive their family support'. These findings could have implications for commissioners and practitioners of primary and secondary care.

Kings College London (2009) study points to the possibility that there has been little documented work to date addressing spiritual care for BME populations, despite indications that some ethnic groups have a strong reliance on spiritual belief and practice. In particular, there appears limited guidance for palliative care services on how to meet the spiritual and cultural needs of people from BME groups. Specific challenges include a lack of evidence to inform service provision (e.g. evaluated service models and spiritual care services), and barriers to BME groups accessing palliative care (e.g. mistrust of medical institutions, possible fears of racism and misperceptions of palliative care).

With Black, Asian and minority ethnic (BAME) groups aged 65 and over set to treble in the next 25 years, a Cicely Saunders Institute (2013) recently commissioned report highlights the growing need to make end of life care more accessible and appropriate.

The report, *Palliative and End of Life Care for Black, Asian and Minority Ethnic Communities in the UK,* highlights that the end of life care needs of BAME communities are varied, growing, and despite examples of good practice, overall not adequately met.

In England and Wales it is predicted that by 2026 there will be over 1.3 million people from BAME groups aged 65 and over, compared to just over half a million in 2001. By 2026 almost half a million will be aged 70 and over. With this ageing population, there is an

urgent need to address reasons for low levels of use of palliative and end of life care services by BAME communities.

A systematic review found that lack of knowledge about services, misunderstandings and mistrust (due to previous experiences of discrimination), and a lack of cultural sensitivity on the part of service providers are identified as some of the reasons for low uptake of end of life care by BAME communities. The report authors suggest these issues can in part be addressed by improving communication with the patient and their family, better training for health and social care professionals and the importance of avoiding assumptions and stereotypes and listening to patients and their families about their needs and preferences at the end of life.

13.3.18 Disability and Health

Equalities National Council/SCOPE (2012) study suggests that there are at least one million disabled people who are Black or from a minority ethnic background in the UK. There is a lower prevalence of impairments amongst BME disabled people of working age, but over the age of 40 this prevalence increases dramatically.

This Equalities National Council/SCOPE (2012) study also suggests:

- Pakistani and Bangladeshi groups have the highest rates of disability in old age of any ethnic group.
- 44% of BME disabled people live in household poverty, compared with 32% of all disabled people and 17% of the population as a whole.
- Individual incomes for BME disabled people are 30% lower than for the general population.
- Less than 4 in 10 BME disabled people of working age are in employment.
- Services are not yet fully inclusive for disabled people from ethnic minority backgrounds, and many report poor experiences of accessing statutory and voluntary services.

Tonkiss and Staite (2012) suggest that individuals from BME communities are often underrepresented in the uptake of learning disability services. In a local study conducted by INLOGOV in 2012 only 0.2% of clients were recorded as being from South Asian backgrounds, and 0.05% as Black Caribbean yet Azmi et al (1996) suggests that the prevalence of a learning disability, when compared to the rest of the population, is three times higher than average for South Asian people and significantly higher in the African Caribbean community. As Poxton et al (2012) imply BME people with learning disabilities and their families continue to experience inequalities in health and social care despite various efforts to improve engagement.

The Race Equality Foundation briefing paper (Fulton & Richardson, 2010) further highlights a possible lack of understanding and response to ‘learning disability’ and it continues to be an issue within some communities, affecting whether and how people come forward for support.

Previous research by Deaf Education Advocacy Fellowship (DEAF) to canvas the views and experiences of deaf BME individuals about mainstream services found that Sixty per cent of respondents identified problems in accessing healthcare services. Building on this research, (Silver and Patel, 2011), identified the following key issues for deaf BME people:

- A lack of exposure of deaf BME residents to other British Sign Language (BSL) users in their community as many deaf BME people have a disadvantage in their ability to use BSL functionally.
- This has an impact when accessing information via a Sign Language Interpreter, whose numbers from a BME background are considered low, as their understanding of standard BSL is often poorer than their non-BME peers.
- As a consequence many deaf people from minority backgrounds feel isolated and do not have peer networks of support available, especially in rural areas. This means that they are often isolated from access to specialist services that are available to deaf people

UK Vision Strategy (2013) suggests that people from Black and other minority communities are at greater risk of some of the leading causes of sight loss such as glaucoma with Asian people at greater risk of developing cataracts compared to the Black and white population, and Black and Asian populations at a greater risk of developing diabetic eye disease compared to the white population.

The most recent Census (2011) highlighted, in table 13.3.18a, the long-term health problems by ethnic group. Almost 12% of Wirral residents consider their long term health condition to affect their day-to-day activities a lot. With almost 23% suggesting their activities are affected a little and/or a lot. Although numbers are smaller compared to the white population the proportion of White Irish considering their day-to-day activities affected a little or a lot is over 34% or 916 of a population of 2,667 people and this compares to 23% of white population*. This in turn compares to Black/African/Caribbean/Black British of 13%, Mixed or multiple ethnicity at 12%, Asian/Asian British at 10% or Other Ethnic Group at 10%.

Table 13.3.18a: Long-term health problems by ethnic group, Census, 2011

Ethnic Group	Total of all categories: Long-term health problem or disability	Day-to-day activities limited a lot	Day-to-day activities limited a little	Day-to-day activities not limited
All categories: Ethnic group	319,783	37,898	34,306	247,579
White: Total	310,156	37,420	33,674	239,062
White*: English/Welsh/Scottish/Northern Irish/British	303,682	36,702	33,003	233,977
White: Irish	2,667	496	420	1,751
White: Other White	3,807	222	251	3,334
Mixed/multiple ethnic group	3,286	196	221	2,869
Asian/Asian British	5,116	219	325	4,572
Black/African/Caribbean/Black British	695	43	51	601
Other ethnic group	530	20	35	475

Source: NOMIS, 2013

13.3.19 Tuberculosis (TB)

Health Protection Agency Report (2013) *Tuberculosis in the UK* highlights that in the UK, a total of 8,963 cases of tuberculosis (TB) were reported in 2011 with TB notifications and rates remaining relatively stable since 2005.
The majority of non-UK born cases originated from South Asia (59%,3694) and sub-Saharan Africa (24%,1484) with the largest proportions of cases being Indian (26%, 2261), White (20%, 1762) and Black African (18%, 1557). The majority of cases were notified from urban centres, amongst young adults, those from countries with high TB burdens, and those with social risk factors for TB.

The report goes onto suggest that as in previous years, London accounted for the highest proportion of cases in the UK (39%, 3511), followed by the West Midlands region (11%, 1,011). The main burden of disease remains concentrated in large urban areas.

In the report it suggests that common perceptions among Black and other minority groups which contribute to stigma include: belief that TB infection also means co-infection with HIV; fear that one's relatives will be 'marginalised'; belief that TB reflects poor living conditions; belief that TB results from poor hygiene. As a consequence there is a strong stigma attached to TB in many minority communities. While communities may understand the risk of developing TB, a failure to undertake treatment or to complete courses of drugs can lead to further spread of the disease and the development of multi-drug resistant strains.

The subsequent report for Health Protection Agency (2012) North West region annual surveillance report for *Tuberculosis 2011 Enhanced Surveillance Data* has Wirral's three year average (2009-2011) TB incidence rate as 3.9 per 100,000 population. This compares to North West incidence rate of 11.9 per 100,000 population for 2011 (with North West figures at 11.7 per 100,000 population in 2010 and 11.6 per 100,000 population in 2009). Overcrowding and poor housing conditions are proven risk factors for TB transmission, according to the Better Housing Briefing (2013) suggests. Also that poor housing can increase the risk of getting TB, making it spread faster and making it harder for the individual and family members to recover. Overcrowding and poor ventilation make it more likely to catch TB.

A report, by Marta Schaaf for the Open Society Institute (2007), highlighted qualitative and anecdotal data showing lower treatment completion rates among Roma TB patients. Roma women (as women and as members of an excluded minority group) can face particular issues with the health system. The Roma community may lack trust in health care systems that may have sometimes excluded or mistreated them and coupled with possible low TB knowledge and health literacy may also result in failure to access TB testing or treatment. Individuals may not know that they are experiencing symptoms of a potentially fatal disease or that the disease is treatable.

13.3.20 Other conditions

Other conditions that are more common in certain BME groups include,

- Thalassemia, which is a genetic condition that impedes the body from making new blood cells, is more common in people from Southern Europe, the Middle East and South Asia.

- Sickle cell is also a genetic disease that affects red blood cells and reduces their ability to carry oxygen around the body, and is most common in African and Caribbean populations (Johnson et al, 2004).
- Coeliac disease is higher in people of Irish origin
- Haemochromatosis incidence high in Irish people (Irish Haemochromatosis Association)

13.4 Primary and Secondary Care

13.4.1 Primary and Secondary Care Activity

As previously stated, recording of ethnicity has not always been adequately completed within patient records to provide robust analysis of the use of services. Locally the situation with regard to secondary care data, whilst improving, is still incomplete with further accuracy of recording of disease codes required. Whilst work continues to try and improve the quality of coding on patient records a preliminary analysis has been undertaken to assess the proportions of inpatients admissions by ethnic category. Table 13.4.1a presents inpatient activity data by ethnic group for 2011/12.

Table 13.4.1a Inpatient Activity 2011/12

Ethnicity	Elective	Non-Elective	Other	Grand Total	Percentage (%)
Any British or Irish White Background	42,951	37,924	12,324	93,199	92.69
Any Asian background	118	116	120	354	0.35
Chinese	125	97	63	285	0.28
Indian	87	82	73	242	0.24
African	132	63	68	263	0.26
Any other mixed background	75	70	52	197	0.20
Bangladeshi	48	59	56	163	0.16
Any other ethnic group	47	55	31	133	0.13
White and Black Caribbean	31	34	40	105	0.10
Any other Black background	36	26	13	75	0.07
Pakistani	9	20	14	43	0.04
Caribbean	19	**	**	35	0.03
Not stated	3,442	1,162	183	4,787	4.76
Null	526	**	**	665	0.66
Grand Total	**47,646**	**39,852**	**13,048**	**100,546**	**100%**

Source: Wirral Inpatient Data Tables year (2011/12)
Notes:

- Comparative 2011/12 data suggests that there would be in the region of 164 non-elective cases related to Irish residents.
- ** Numbers of people are suppressed in order not to reveal the identity of individuals
- Data is reliant on input data accuracy at source

As the table above illustrates, simple analysis of the data available suggests that overall the BME groups appear to be accessing secondary care services in lower proportions than expected given the current BME population numbers. Improved data quality will enable

more comprehensive analysis to be undertaken. At present over 5.4% of the records do not state the patients' ethnic origin suggesting that just 1.8% of patients are from a BME group. Patient ethnicity is recorded for all new patient registrations as part of the Quality Outcomes Framework (QOF). This implies that over time additional information will be available from GP systems to assess levels of access to primary care amongst BME populations, in addition to enabling the comparison of actual prevalence of long-term conditions with the estimates generated by statistical models.

13.4.1b: Numbers of people accessing Wirral Adult Social Care by Client Type, 2012

Primary client type : 18+ Years							
By Ethnicity	**Physical Disability**	**Mental Health**	**Learning disability**	**Substance misuse**	**Other vulnerable people**	**Primary Client Type Not Recorded**	**Total**
White - British	7588	1998	945	25	527	77	**11160**
- Irish	35	**	*	*	*	*	**47**
- Traveller of Irish Heritage	*	*	*	*	*	*	*****
- Gypsy/Roma	*	*	*	*	*	*	*****
- Any other white background	24	10	*	*	*	*	**39**
Mixed -White and Black Caribbean	*	*	*	*	*	*	*****
- White and Black African	*	*	*	*	*	*	*****
- White and Asian	*	*	*	*	*	*	*****
- Any other mixed background	*	*	*	*	*	*	**8**
Asian or Asian British - Indian	*	*	*	*	*	*	**5**
- Pakistani	*	**	*	*	*	*	*****
- Bangladeshi	*	*	*	*	*	*	*****
- Any other Asian background	*	*	*	*	*	*	**10**
Black or Black British - Caribbean	*	*	*	*	*	*	*****
- African	*	*	*	*	*	*	*****
- Any other black background	*	**	*	*	*	*	**10**
Chinese or other ethnic group	*	*	*	*	*	*	*****
- Chinese	21	9	*	*	*	*	**35**
- Any other ethnic group	8	**	*	*	*	*	**18**
Not Stated **-** Refused	61	**	**	*	*	*	**84**
- Information not yet Obtained	41	12	*	*	*	*	**61**
No Ethnicity recorded	**	*	*	*	*	*	**9**
Total	**7806**	**2074**	**975**	**25**	**536**	**89**	**11505**

Source: Wirral Council, Adult Social Services, 2013

Notes: - Comparative 2011/12 data suggests that there would be in the region of 164 non-elective cases related to Irish residents. ** Numbers of people are suppressed in order not to reveal the identity of individuals. Numbers do not total to services likely due to multiple use of services

Table13.4.1b suggests that numbers known to and using social care services from black and ethnic minority groups are limited. Over 97% of clients are from White British group with over 1.3% of people who refused to state; detail was not obtained or did not have their ethnicity recorded. This would imply that BME groups are not accessing local social care services in the numbers that could be expected.

13.4.1c: Numbers of Wirral people accessing Wirral Adult Social Care by Service Type, 2012

Service Type: 18+					
By Ethnicity	**Community based services**	**Residential care**	**Nursing care**	**Service Type Not Recorded**	**Total of all clients**
White - British	9378	1439	809	*	**11629**
- Irish	35	**	**	*	**49**
- Traveller of Irish Heritage	*	*	*	*	*****
- Gypsy/Roma	*	*	*	*	*****
- Any other white background	31	*	*	*	**39**
Mixed -White and Black Caribbean	*	*	*	*	*****
- White and Black African	*	*	*	*	*****
- White and Asian	*	*	*	*	*****
- Any other mixed background	*	*	*	*	**8**
Asian or Asian British - Indian	*	*	*	*	*****
- Pakistani	*	*	*	*	*****
- Bangladeshi	*	*	*	*	*****
- Any other Asian background	**	*	*	*	**11**
Black or Black British - Caribbean	*	*	*	*	*****
- African	*	*	*	*	*****
- Any other black background	**	*	*	*	**10**
Chinese or other ethnic group	0		0	*	*****
- Chinese	29	*	*	*	**35**
- Any other ethnic group	14	*	*	*	**19**
Not Stated - Refused	64	**	*	*	**89**
- Information not yet Obtained	57	*	*	*	**64**
No Ethnicity recorded	**	*	*	*	**9**
Total	**9660**	**1485**	**838**	**3**	**11986**

Source: Wirral Council, Adult Social Services, 2013
Notes:

- *Numbers less than 5 have been supressed to protect the identity of individuals
- ** Numbers less 10 but more than 5 have been supressed to protect the identity of individuals
- Numbers do not total to clients likely due to multiple use of services

Table13.4.1c also suggests that numbers known to and using social care services from black and ethnic minority groups are limited. The table highlights that 1.3% of people refused to state, was not obtained or did not have their ethnicity recorded with over 97% of

clients being from the White British group. This would imply that BME groups are not accessing local social care services in the numbers that could be expected.

13.4.1d: Numbers of Wirral people accessing Cheshire & Wirral Partnership NHS Foundation Trust services by Service Type, 2012/13

Ethnicity	CAMHS	Adult	Older People	Learning Disabilities	Liaison Psychiatry	Drug and Alcohol	Total
Asian or Asian British, Bangladeshi	*	*	*	*	*	*	**6**
Asian or Asian British, Indian	*	**	*	*	*	*	**12**
Asian or Asian British, Other	*	**	*	*	*	*	**13**
Asian or Asian British, Pakistani	*	*	*	*	*	*	**4**
Black or Black British, African	*	5	*	*	*	*	**10**
Black or Black British, British Caribbean	*	**	*	*	*	*	**8**
Black or Black British, Other	*	*	*	*	*	*	**5**
Mixed, Other	*	*	*	*	*	*	**8**
Mixed, White & Asian	*	*	*	*	*	*	*****
Mixed, White & Black African	*	*	*	*	*	*	**6**
Mixed, White & Black Caribbean	*	*	*	*	*	*	**12**
Not Stated	305	177	33	*	*	346	**881**
Other Ethnic Groups, Chinese	*	**	*	*	*	*	**14**
Other Ethnic Groups, Other	*	7	*	*	*	*	**14**
White, British	1,088	2,464	1,358	406	115	1,499	**6,930**
White, Irish	*	**	28	*	*	**	**64**
White, Other	**	**	19	*	*	*	**69**
Total	**1,424**	**2,752**	**1,447**	**437**	**121**	**1,877**	**8,058**

Source: Cheshire & Wirral Partnership NHS Trust, 2013
Notes:

- *Numbers less than 5 have been supressed to protect the identity of individuals
- ** Numbers less 10 but more than 5 have been supressed to protect the identity of individuals

Table13.4.1d highlights service use by BME group for Cheshire & Wirral Partnership NHS Trust. It suggests that numbers known to and using their services from black and ethnic minority groups are limited. Again just over 97% of clients are from white British group with over 1.3% of people who refused to state; detail was not obtained or did not have their ethnicity recorded. This would imply that BME groups are not accessing local social care services in the numbers that could be expected.

Links:
Wirral Borough Council 2007 - Strategic Housing Market Survey
Home office – British Crime Survey 2007
Race Relations Act 2007
Icarus Report 2010
Wirral Economic Profile (2012)
Wirral Ethnic Health Advisory Group (WEHAG) Health and Wellbeing Strategy

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