



**WIRRAL
INTELLIGENCE
SERVICE**

Needs Assessment of Black, Asian and Minority Ethnic (BAME) Groups

**Wirral Intelligence Service and
Wirral Public Health Team**

March 2018

Needs Assessment of Black, Asian and Minority Ethnic (BAME) Groups

Author: Steven Gavin, Public Health Manager, Wirral Council Public Health Team,
Old Market House, Hamilton Street, Birkenhead, Wirral CH41 5AL
Tel: 0151 666 5185
Email: stevengavin@wirral.gov.uk

For further information please contact:

Wirral Intelligence Service Email: wirralintelligenceservice@wirral.gov.uk

JSNA Lead: John Highton, JSNA Lead, Wirral Intelligence Service

Background to JSNA – Joint Strategic Needs Assessment

What is a JSNA?

A Joint Strategic Needs Assessment, better known as a JSNA, is intended to be a systematic review of the health and wellbeing needs of the local population, informing local priorities, policies and strategies that in turn informs local commissioning priorities that will improve health and wellbeing outcomes and reduce inequalities throughout the Borough.

Who is involved?

Information from Council, NHS and other partners is collected and collated to inform the JSNA and this reflects the important role that all organisations and sectors have (statutory, voluntary, community and faith) in improving the health and wellbeing of Wirral's residents.

About this document

This JSNA section looks to contain the most relevant information on the topic and provides an overview of those related key aspects

How can you help?

If you have ideas or any suggestions about these issues or topics then please email us at wirralintelligenceservice@wirral.gov.uk or go to <https://www.wirralintelligenceservice.org/>

| Version Number | Date | Reviewer(s) | Actions |
|----------------|---------------|---|---|
| 1.0 | November 2017 | Julie Webster Nicola Jones John Highton Sarah Kinsella | Clarifications, typos, re-ordering of content, re-labelling of charts, content review and additions |
| 2.0 | December 2017 | Bev Murray Julie Webster | Content review, clarifications and additional information |

Content overview

| | |
|---------------------------------------|---|
| Abstract | <p>Summary of the health needs of Wirral's BAME population, including information in relation to:</p> <ul style="list-style-type: none"> • Demographics • The influence of wider determinants of health • How BAME health is affected • BAME stakeholder views • Local specialist service provision • Considerations for an improvement journey |
| Intended or potential audience | <p>External</p> <ul style="list-style-type: none"> • Wirral Health and Wellbeing Board • Wirral Clinical Commissioning Group • Wirral University Teaching Hospital • Statutory-commissioned services • Merseyside Police • National Probation Service • Community and Voluntary Sector Organisations <p>Internal</p> <ul style="list-style-type: none"> • Public Health Management Team • Public Health Colleagues • Adult Social Services Colleagues • Wirral Safeguarding Hub <p>Others to be determined by partners then circulated</p> |
| Links with other topic areas | <p>Access related content at Wirral Intelligence Service consider by A- Z or by Theme or by Wirral Plan for Population, Housing, Crime and Disorder, Domestic Abuse, Offenders, Cardiovascular Disease, Diabetes, Obesity, Cancer, Mental Health, Dementia, Smoking, Substance Misuse, Disability, End of Life/Palliative Care, Sexual Health, Maternal Health and Local Voice</p> |

Acknowledgements

The author would like to thank members of the advisory group, who have supported the production of this needs assessment throughout:

| | |
|-----------------|--|
| Anna Turnbull | Wirral Council |
| Bob Little | Wirral Council |
| Breege McDaid | Irish Community Care Merseyside |
| Denia Kincade | Wirral Metropolitan College |
| Ewan Roberts | Asylum Link |
| John Highton | Wirral Council |
| Kapo Ho | Wirral Multicultural Organisation |
| Malena Eriksson | Wirral Change |
| Matthew Rose | Red Cross |
| Nicola Jones | Wirral Council |
| Rachel Meadows | Alzheimer's Society |
| Raza Moula | Wirral Multicultural Organisation |
| Robert Minshall | Wirral Council |
| Robert Davies | Cheshire & Wirral Partnership NHS Foundation Trust |
| Rose Henry | Alzheimer's Society |
| Sabra Ahmed | Wirral Change |
| Sarah Kinsella | Wirral Council |
| Sheema Kalam | Wirral Council |
| Sue McCarron | Citizen's Advice Bureau |
| Winnie Lawlor | Irish Community Care Merseyside |

Contents Page

| | |
|---|-----|
| Content overview | ii |
| Acknowledgements..... | iii |
| Contents Page | iv |
| List of Figures | vi |
| List of Tables | vii |
| Executive Summary | 1 |
| Introduction | 4 |
| Limitations of the Data | 4 |
| Sociodemographics | 5 |
| Population..... | 7 |
| Ethnicity by Wirral Ward | 10 |
| Education..... | 11 |
| Population of Wirral Schools..... | 11 |
| Spoken Languages..... | 11 |
| Educational Attainment..... | 12 |
| Employment..... | 14 |
| New Applications for National Insurance Numbers (NINOs) | 15 |
| Housing..... | 16 |
| Crime | 17 |
| Domestic Abuse and Other Harmful Practices | 17 |
| Female Genital Mutilation (FGM)..... | 18 |
| Honour-based Violence (HBV) and Forced Marriage | 18 |
| Hate Crime | 19 |
| Criminal Justice | 21 |
| Prison | 23 |
| Health and Wellbeing of BAME Groups in Wirral..... | 24 |
| Cardiovascular Disease (CVD) and Coronary (or Ischaemic) Heart Disease (CHD/IHD) | 24 |
| Heart Failure..... | 27 |
| Stroke | 28 |
| Diabetes | 28 |
| Obesity | 30 |
| Cancer..... | 33 |
| Mental health..... | 34 |

| | |
|---|----|
| Dementia | 35 |
| Smoking | 36 |
| Substance Misuse | 38 |
| Disability | 40 |
| Palliative care | 40 |
| Tuberculosis (TB) | 40 |
| Maternal Health | 40 |
| Sexual Health | 41 |
| Service Data | 43 |
| Demographic Profile of Clients in Service | 44 |
| Client Outcomes | 47 |
| Equity Audit of all Public Health commissioned services | 48 |
| Local Stakeholder Views..... | 49 |
| Improving Access to Healthcare for BAME Communities | 51 |
| Improving Data Quality | 51 |
| Engaging with BAME Communities | 51 |
| Targeted vs Universal..... | 52 |
| Achieving Cultural Competence within Service Provision..... | 53 |
| Specific Action | 53 |
| Considerations | 53 |
| References | 55 |
| Contact details | 71 |

List of Figures

| | |
|---|----|
| Figure 1: Ethnic inequalities in health for men in 2011. Age-standardised ratios of Limiting Long-Term Illness for ethnic minority groups, compared to the White British group, males 2011 | 6 |
| Figure 2: Ethnic inequalities in health for women in 2011. Age-standardised ratios of Limiting Long-Term Illness for ethnic minority groups, compared to the White British group, females 2011 | 6 |
| Figure 3: Number and distribution of residents who describe themselves as being of an ethnicity other than White British in the 2011 Census, by Wirral Ward | 10 |
| Figure 4: Ethnicity of Wirral School Pupils in January 2017 | 11 |
| Figure 5: Trend in number of new National Insurance registrations to adult overseas nationals in Wirral, 2006/07 to 2015/16..... | 15 |
| Figure 6: World Area of Origin for those applying for a new National Insurance Number in 2016..... | 16 |
| Figure 7: Trend in Racially or Religiously Aggravated Crime by Month for England and Wales, 2013-16..... | 20 |
| Figure 8: Breakdown of Hate Crime by Type of Offence for England and Wales, 2015-16 | 20 |
| Figure 9: Trend in Race Hate Incidents for England and Wales, 2009-16 | 21 |
| Figure 10: Likelihood of being stopped and searched by self-defined ethnic group, compared with those from the White ethnic groups, England and Wales, year ending March 2011 compared with year ending March 2015 | 22 |
| Figure 11: Likelihood of being stopped and searched by self-defined ethnic group, compared with those from the White ethnic groups, reported by Merseyside Police, year ending March 2014 | 23 |
| Figure 12: Prison and General Population by ethnicity, England and Wales, December 2016..... | 23 |
| Figure 13: Prevalence of CVD in men by ethnicity and age..... | 26 |
| Figure 14: Prevalence of CVD in women by ethnicity and age | 27 |
| Figure 15: Proportion of Inpatients being treated for Diabetes at Wirral University Teaching Hospital by Type | 29 |
| Figure 16: Prevalence of Obesity by Ethnicity recorded within the National Child Measurement Programme in Wirral and in England and Wales, 2015-16 | 32 |
| Figure 17: Ethnicity of Wirral pupils captured within the National Child Measurement Programme in Wirral, 2015-16..... | 33 |
| Figure 18: Standardised rates of people using mental health and learning disability services and people who spent time in hospital in the year, by ethnic group, in England, 2014/15..... | 34 |
| Figure 19: Rates of detention under the Mental Health Act 1983, per 100 people who spent time in hospital due to mental ill health by ethnicity, in England, 2014/15..... | 35 |
| Figure 20: Proportion of current/former smokers and people who have never smoked in England, by ethnicity, 2014..... | 37 |
| Figure 21: Rates* per 100,000 population of new STIs by ethnic group in Wirral and England (specialist SHC diagnoses only): 2015 | 42 |

| | |
|--|----|
| Figure 22a and 22b: Trend in recording of ethnicity: Wirral and England (2010/11 – 2016/16)..... | 43 |
| Figure 23: Ethnic Profile and Proportions of the Clients Accessing the BAME Health Improvement Service in 2015-16 | 44 |
| Figure 24: Comparison of the Degree to which Each Ethnic Group is under- or over-represented on Caseload, BAME Health Improvement Service, 2015-16 | 45 |
| Figure 25: Age Profile of the Clients Accessing Wirral BAME Health Improvement Service | 46 |

List of Tables

| | |
|---|----|
| Table 1: Census 2011 Wirral Population by Ethnic Group | 8 |
| Table 2: First Languages Most Commonly Spoken by Wirral School Pupils in January 2017..... | 12 |
| Table 3: Educational Attainment of Wirral School Pupils in 2017, by Ethnicity at Key Stage 2 ¹ | 13 |
| Table 4: GCSE (or equivalent) Entry and Attainment of Wirral School Pupils in 2017, by Ethnicity at Key Stage 4 ¹ | 13 |
| Table 5: Economic Activity by Ethnicity as a Proportion of Wirral’s Population, 2011 | 14 |
| Table 6: Hate Crimes reported by the Police in England and Wales, 2011/12 to 2015/16 | 19 |
| Table 7: Prevalence of CVD and CHD by Gender and Ethnicity | 26 |
| Table 8: Prevalence of Hypertension and Diabetes among Participants with LVSD | 27 |
| Table 9: Waist-hip ratio (WHR) by ethnic group and gender for England..... | 31 |
| Table 10: Smoking Cessation–Number of Successful Quitters ¹ Ethnic Group ² , 2015-16 | 38 |
| Table 11: Numbers of Wirral People in Drug Treatment by Ethnic Group, 2005-14..... | 38 |
| Table 12: Numbers of Wirral People in Alcohol Treatment by Ethnic Group, 2009-14..... | 39 |
| Table 13: Number and proportion of new STIs by ethnic group, Wirral, 2015 | 41 |
| Table 14: Comparison of the Service Caseload Profile against Wirral’s BAME Population by Ethnic Group, 2015-16 | 45 |

Executive Summary

- Determining the profile of the local BAME population continues to be a challenge. While national mid-year population estimates are published annually, they lack any ethnicity data. Hence, 2011 Census data remains the most recent and reliable data source for this purpose.
- According to 2011 Census data, Wirral's BAME population has grown since the previous 2001 Census. In 2011, the BAME population represented 5.46% (n=16,101) of the general population compared to 3.46% (n=10,900) in 2001.
- The 2011 Census reported that more BAME individuals resided in the Birkenhead & Tranmere ward than any other, with twice the number of BAME residents than in each of next highest wards, which include Claughton, Rock Ferry and Hoylake & Meols.
- Since 2011, it is very likely that Wirral's BAME population has continued to grow, both in number and proportional representation within the general population. An indicator of this growth can be found within the annual School Census (2017) data for Wirral, where BAME pupils now make up 8.1% of the overall school population.
- Another indication of BAME population growth can be found in the analysis of pupils for whom English is a second language. The proportion of the school population with a first language other than English rose from 2.55% (n=1,150) in 2013 to 3.92% (n=1,795) in 2017.
- During the same four year period, the largest proportional increases in Wirral school pupils with a first language (other than English) could be found in Polish, Tamil (Sri Lanka) and Urdu (India/Pakistan) speakers, all of which doubled in number.
- The recording of ethnicity by Public Health commissioned services has vastly improved in recent years due to the introduction of minimum datasets. Analysis of service data from 2016/17 has indicated that whilst some BAME groups were under-represented in engagement with Public Health services (White Irish, Chinese), others showed good engagement with services (White Other – which in Wirral is primarily the Polish community).
- Recording of ethnicity information has improved in primary care in Wirral in recent years; three-quarters (74.4%) of all GP records now contain an ethnicity code (as of December 2017), compared to less than 40% of records ten years ago. This paves the way for more in-depth analysis of ethnicity and long term conditions for example.
- Secondary (hospital) care in Wirral also has seen improved levels of recording of ethnicity data, compared to previous years, with currently only 10% of records lacking ethnicity data compared to 12% in England. Meaningful analysis could now be conducted on this data to help inform local needs of the BAME community.

- A greater proportion of non-white households live in the private-rented sector in Wirral, compared to the general population, a sector that is usually associated with areas of greater deprivation.
- Educational attainment data for Wirral suggests that all ethnic groups have equitable access to a good level of education (at Key Stage 4 or GCSE, the proportion of Wirral school pupils achieving A* to C grades in English and Mathematics was greater than in the Northwest and in England and BAME groups in Wirral tended to perform better than their White counterparts).
- National police data suggests that self-reported ethnic groups are twice as likely to be stopped and searched as the white population. On Merseyside, the difference is much less pronounced at approximately 20% more likely.
- Cardiovascular and Coronary Heart Disease (CVD/CHD) risks vary considerably with ethnicity. Rates of CVD are considerably higher in Irish and Pakistani male populations, while the latter are also at greater risk of CHD. Conversely, Black African and Chinese ethnic groups are at much reduced risk of CVD/CHD. Modifiable lifestyle factors are thought to be able to reduce risks of CVD/CHD, as well as a number of other related health conditions.
- The prevalence of hypertension and stroke is significantly higher for South Asian and Black Caribbean ethnic groups. Research suggests that BAME groups are twice as likely to suffer a stroke compared to White ethnic group (British Heart Foundation, 2010).
- Some ethnic groups, such as South Asians and Black Africans, are between 2 and 4 times more likely to develop type 2 diabetes, than White ethnic groups. Diabetes is linked to a range of other health conditions such as CVD, kidney disease, blindness and amputation. Mortality rates from diabetes are between 3.5 to 6.5 times higher for South Asian and Black Caribbean groups.
- Obesity is a major risk factor for a range of other disease, such as CVD, diabetes, hypertension, osteoarthritis and cancer. Obesity disproportionately affects Black Caribbean, Pakistani and Bangladeshi women, as well as some South Asian male ethnic groups.
- The Irish population are thought to have one of the highest mortality rates for most cancers, compared to the rest of the UK. On the other hand, Asian and Chinese ethnic groups, as well as Black females, are generally less likely to get cancer than White ethnic groups.
- Some ethnic groups are prone to particular types of cancer. Asian and Black ethnic groups are twice as likely to develop liver and stomach cancer respectively, compared to the White population.

- Black males are also three times more likely to develop prostate cancer, while Black females are twice as likely to be diagnosed with late-stage breast cancer, than their White counterparts.
- Smoking continues to be particularly problematic among some BAME groups such as Bangladeshi, Pakistani and Irish males. In addition, some ethnic groups, such as Bangladeshi women, use different forms of chewing tobacco which can lead to mouth and oesophageal cancer.
- Anecdotal evidence suggests that drug and alcohol use is just as prevalent within BAME Communities as it is for the general population; yet BAME groups are largely underrepresented within local treatment services. It is thought that religious and/or cultural taboos may prevent BAME individuals from these groups from seeking support for drug and alcohol problems.
- Palliative care pathways are underused by BAME groups, for several reasons. National research indicates that some cultures prefer to take care of dying family members themselves, regarding it as their 'duty' and hospices were generally considered to be unsuitable, (Calanzani et al., 2013).
- White ethnic groups are twice as likely to have a life-limiting disability compared to Black ethnic groups, (Office of National Statistics, 2014).
- Incidence of tuberculosis is particularly low in Wirral at a rate of 2.8 cases per 100,000 compared to a national rate of 10.5 cases per 100,000 (Public Health England, 2016a).
- National infant mortality rates in 2013 were substantially higher for Pakistani, Black Caribbean and Black African groups, at 6.7, 6.6 and 6.3 deaths per 1,000 live births compared to 3.8 deaths per 1,000 live births within the general population (Office of National Statistics, 2015b).
- According to the UK Confidential Inquiry into Maternal and Child Health, maternal death rates among Black African females were found to be 5 times greater than in the White population (Knight, 2008)

Introduction

The health and wellbeing of every individual within society is determined by a complex interaction of hereditary biological traits, lifestyle choices, social networks and the socioeconomic, cultural and environmental conditions in which they live (Dahlgren and Whitehead, 1991).

It is important to understand that when determining need for a borough like Wirral, the local population is not a single homogenous group. Rather, it is a collection of groups within groups, made up of different genders, ages, ethnicities, race and cultural identities. As such, the experience of health and wellbeing will vary; this is particularly true of people from Black, Asian and Minority Ethnic (BAME) communities.

In an analysis of Annual Population Survey data, the New Economics Foundation concluded that Black, Asian and Minority Ethnic (BAME) people experience 'significantly lower' levels of wellbeing than White British people, even after controlling for other influences on health and wellbeing (NEF, 2012). There are a broad range of possible contributory factors which could offer an explanation as to why BAME Communities suffer greater health inequalities than their White British counterparts. These include such things as educational status, unemployment and "cultural bias" (Office of National Statistics, 2013). It is therefore essential that these factors are considered to better understand why BAME communities exhibit disproportionately lower levels of health and wellbeing, so that action can be taken to eliminate health inequalities which exist between different ethnic groups.

This needs assessment will consider the latest available demographic data for Wirral's BAME population. It will attempt to explore how and the extent to which Wirral's BAME Communities experience health inequalities. It will also draw upon the findings of a local research study which used an ethnographic approach to collect qualitative data from residents, service providers and local commissioners about their perceptions of the health and wellbeing of BAME Communities in Wirral. Further, it will pull this body of work together to inform a picture of local need, while mapping this to existing service provision to identify any areas where there are gaps which might need to be addressed.

Limitations of the Data

A local expert group was convened to consider the evidence and data which would eventually inform the content of this needs assessment. As part of this process, it quickly became apparent that quantity and quality of ethnicity data available to the group was poor. This is an issue which has been widely recognised (Parliamentary Office of Science and Technology, 2007; Association of Public Health Observatories, 2016). It is something that has challenged the group's efforts to produce a 'fit for purpose' needs assessment that adequately reflects the constantly changing needs of our local BAME Communities.

The Equality Act 2010 places a legal responsibility upon public bodies to monitor outcomes by ethnic group, so as to eliminate racial inequalities in any form. Under the Health and Social Care Act 2012, there is also a responsibility placed on Local Authorities and Clinical Commissioning Groups to undertake a Joint Strategic Needs Assessment (JSNA), which the Department of Health (2007) cited as a process to determine 'current and future health and wellbeing needs', as well as inequalities within a local population.

Yet in spite of this, the expert group noted that much of the literature referred back to a body of work generated from Census (2011) data, and even as far back as the Health Survey for England 2004 (Health and Social Care Information Centre, 2005). Even within statutory services, where the expert group expected some reliability, it was apparent that data quality issues existed.

For example, from 2006 onwards, the Department of Health committed to a programme of work to improve the recording of ethnicity in primary care data [Clinical Practice Datalink Research (CPDR)] and in hospital data [Hospital Episode Statistics (HES)], and figures appear to show this has been successful (see pages 46 and 47 of this report for more details). While only 78.3% of primary care data (CDPR) from patients registered after 2006 were deemed to have 'usable' ethnicity records, as of 2016/17, this figure is now 88% nationally and 90% locally. As such, although determining need across the BAME population has been problematic, it is now possible to conduct more meaningful analysis of need going forward.

As with any needs assessment, the quality and reliability of the final content will only be as good as the data which has been used to inform it. Wherever possible, this document will refer to the latest available data or evidence which can provide a picture of need among Wirral's BAME Communities. However, the reader will need to be mindful that in some instances, the most recent data sources referred to could be over a decade old.

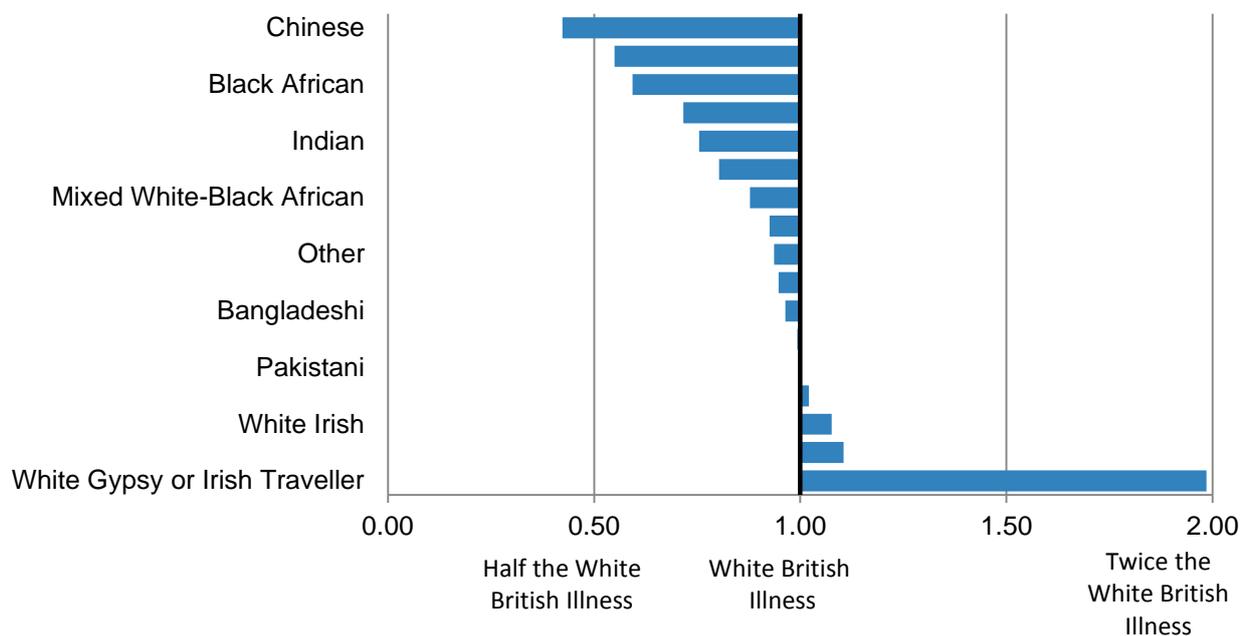
So in summary, information relating to ethnicity has some limitations and data quality could still improve further, but this problem is not unique to Wirral and there have been vast improvements in recent years. There are a number of sources that can be drawn upon which can be used to estimate the current BAME populations in Wirral but none are definitive.

Sociodemographics

Health status is shaped by many factors, such as biological determinants (age, gender, hereditary factors) and wider social determinants such as social status, education, employment and the local environment (Kings Fund, 2017). For some BAME groups, they may be biologically predisposed to developing certain medical conditions that affect their health status. Likewise, economic hardship and a lack of educational attainment are closely associated with poor health outcomes while improved housing and access to green spaces both have positive benefits on individual health.

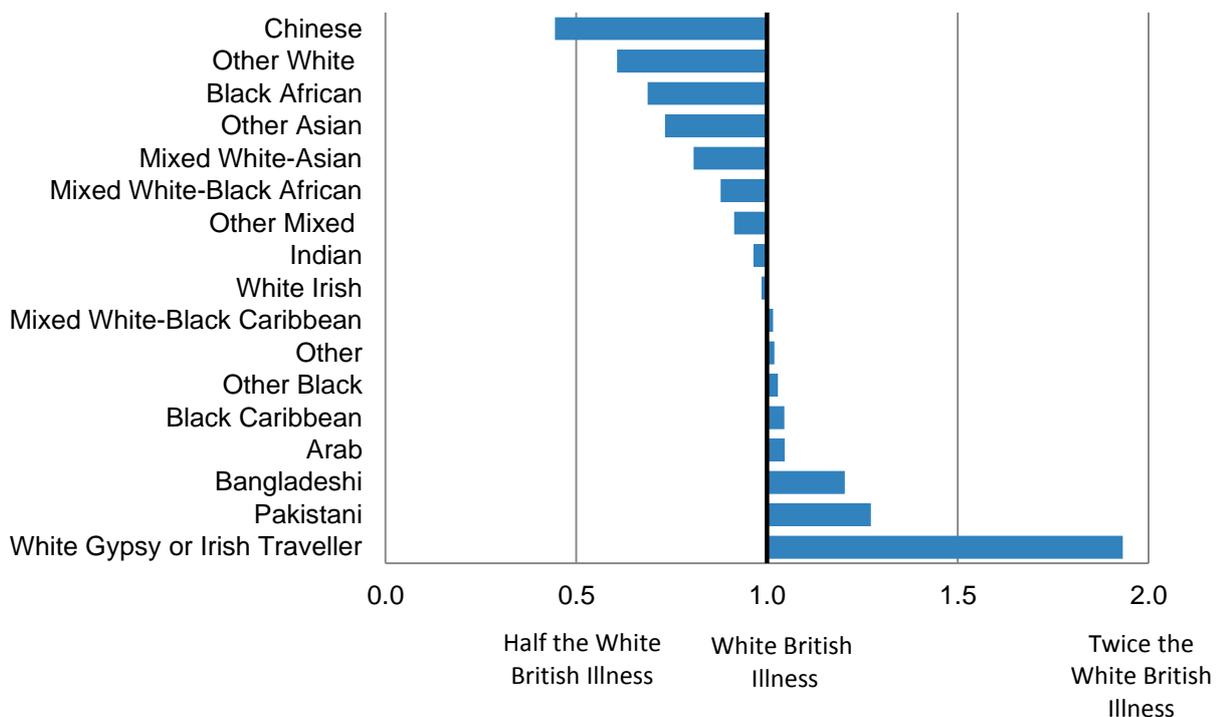
The way in which the biological and the wider social determinants can combine to produce health inequalities across different BAME groups is illustrated in the charts below (see figures 1 and 2):

Figure 1: Ethnic inequalities in health for men in 2011. Age-standardised ratios of Limiting Long-Term Illness for ethnic minority groups, compared to the White British group, males 2011



Source: [Centre on the Dynamics of Ethnicity](#) (2013)

Figure 2: Ethnic inequalities in health for women in 2011. Age-standardised ratios of Limiting Long-Term Illness for ethnic minority groups, compared to the White British group, females 2011



Source: [Centre on the Dynamics of Ethnicity](#) (2013)

The two charts are strikingly similar and suggest that some BAME groups (White Gypsy or Irish Traveller) appear to suffer significantly poorer health than the White British population, while others (Chinese and Black African) report far better health.

This argument is supported elsewhere in the literature where, for example, Ryan et al. (2014) suggest that 1 in 3 people from the Gypsy or Irish Traveller community report bad or very bad health compared to the general population.

Generally, any individuals who are living in challenging or stressful environments tend to have poorer health outcomes than the rest of the population, which gives rise to health inequalities between different groups. Leung and Stanner (2011) suggested that health inequalities among BAME groups are greater because they are more likely to face greater stresses on their health. For example, a greater proportion of BAME Communities may be more likely to underachieve at school, be unemployed and live in poorer housing. In addition, some BAME individuals may face fairly specific stresses on their health, brought about by racial inequalities, such as being excluded from access to life opportunities or being subjected violence as a consequence of racial inequality and/or racism. It is therefore worth considering how all of the broader determinants of health impact upon the health status of our local BAME Communities.

Population

According to Census data, there was a net increase in the population of Wirral between the 2001 Census (n=314,700) and the 2011 Census (n=319,783). Within the wider population, Wirral has a small but expanding ethnic minority population. Census data shows that in 2001, BAME groups accounted for 3.46% of the population, whereas this had increased to 5.03% of the population by 2011. Table 1 displays the Wirral population breakdown by ethnic group and the net change across the ten year period.

Table 1: Census 2011 Wirral Population by Ethnic Group

| Ethnicity | Census 2001 | Census 2011 | % of 2011 population | Net Change | % Change |
|---|----------------|----------------|----------------------|--------------|-------------|
| White: British | 303,800 | 303,682 | 94.7 | -118 | 0.0% |
| White: Irish | 3,100 | 2,667 | 0.9 | -433 | -14.0% |
| White: Gypsy or Irish Traveller | 0 | 77 | 0.0 | 77 | .. |
| White: Other White | 2,700 | 3,730 | 1.2 | 1,030 | 38.1% |
| Mixed: White and Black Caribbean | 500 | 964 | 0.3 | 464 | 92.8% |
| Mixed: White and Black African | 300 | 558 | 0.2 | 258 | 86.0% |
| Mixed: White and Asian | 500 | 949 | 0.3 | 449 | 89.8% |
| Mixed: Other Mixed | 500 | 815 | 0.3 | 315 | 63.0% |
| Asian or Asian British: Indian | 700 | 1,344 | 0.4 | 644 | 92.0% |
| Asian or Asian British: Pakistani | 100 | 226 | 0.1 | 126 | 126.0% |
| Asian or Asian British: Bangladeshi | 400 | 851 | 0.3 | 451 | 112.8% |
| Asian or Asian British: Chinese | 1,300 | 1,653 | 0.5 | 353 | 27.2% |
| Asian or Asian British: Other Asian | 200 | 1,042 | 0.3 | 842 | 421.0% |
| Black or Black British: African | 300 | 389 | 0.1 | 89 | 29.7% |
| Black or Black British: Black Caribbean | 200 | 189 | 0.1 | -11 | -5.5% |
| Black or Black British: Other Black | 100 | 117 | 0.0 | 17 | 17.0% |
| Other Ethnic Group | 0 | 530 | 0.2 | 530 | .. |
| All Groups | 314,700 | 319,783 | 100.0 | 5,083 | 1.6% |

Source: Office of National Statistics (2011)

For more detailed information, the 2011 Census Datasets can be accessed [here](#).

- Table 1 shows that the number of BAME residents grew from 10,900 in 2001 to 16,101 in 2011, which represents a 47.7% increase compared to the fairly static White British population. The BAME population in Wirral remains small however, at just under 5% of the population in 2011, compared to 3% in 2001
- There was an increase of 56% in the total BAME population in England & Wales between 2001 and 2001 (from 12.5% to 19.5%)
- Nationally, the White British ethnic group accounted for 80.5% of the population in 2011 (a decrease from 87.5% per cent in 2001). As the chart above shows, Wirral remains very different to the national picture, with 95% of the local population being White British
- The largest change in numbers in the Wirral BAME population has been in the White other group, which showed a 38.1% (n=1,030) increase between 2001 and 2011.
- In contrast, the White Irish group shows the largest percentage decrease (14.0%) in their number, from 3,100 in 2001 to 2,667 in 2011. Projections of the ethnic composition of the Wirral population to 2030¹ show a continued decrease in the White British population is likely, whilst all other BAME groups are likely to continue

¹ <https://www.wirralintelligenceservice.org/this-is-wirral/wirral-compendium-of-statistics/>
Wirral Intelligence Service: BAME

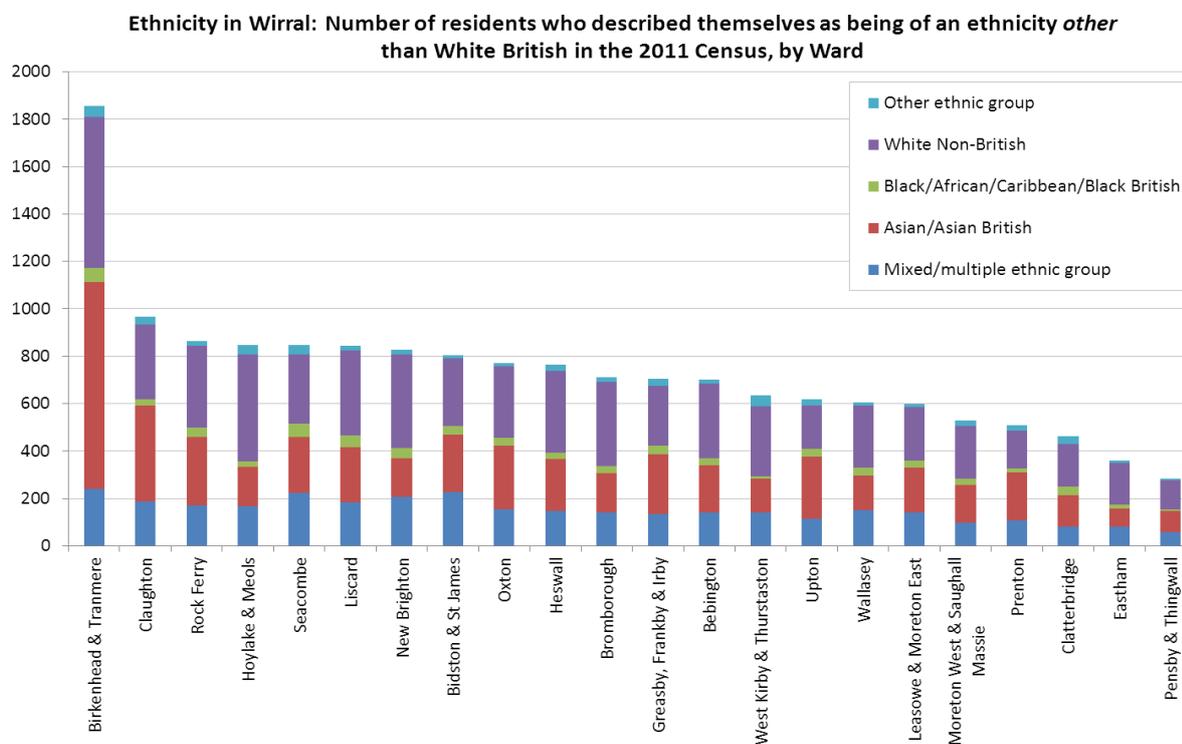
to increase slightly. The exception to this is the White Other population, which is projected to decrease. These projections were produced before the impact of Brexit was felt and recent data suggests many people who would fall into the White Other group are returning to their home countries in Europe, so the small decrease in White Other numbers may turn out to be an underestimation

- All Asian or British Asian groups showed the largest percentage increases between 2001 and 2011. The growth of Chinese population has been steady, while the Indian, Pakistani and Bangladeshi Communities have all doubled in size. The largest growth, however, can be attributed to the Other Asian group which has increased by 421%, although it should be remembered with all the BAME groups in Wirral, numbers are still small compared to England.
- In addition, although only very small numbers (n=77), the Gypsy and Irish Traveller Communities were finally recognised in the 2011 Census. Irish Traveller Movement for Britain (2013) believes that the number of Gypsy and Irish Travellers counted in the 2011 Census data are significantly underrepresented. Lack of identification as a Gypsy and Irish Traveller and a reluctance to engage with official counts were cited as the underlying reasons for this. Their estimates suggest that there were 12,782 Gypsy and Irish Travellers living in the North West, approximately three times higher than the official count of 4,147
- Each of the Mixed Race groups shows similar growth, almost doubling in number across each of the elements. This suggests greater integration and cross-cultural relationships between different ethnic groups.

Ethnicity by Wirral Ward

Analysis of the 2011 Census data in terms of ethnicity by Wirral Ward shows that local BAME groups are dispersed across all wards, however the highest numbers of self-reported ethnic groups are concentrated in the Birkenhead and Tranmere area, as illustrated in figure 3.

Figure 3: Number and distribution of residents who describe themselves as being of an ethnicity other than White British in the 2011 Census, by Wirral Ward



Source: ONS (2011) [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)

- Birkenhead and Tranmere contain more self-reported ethnic residents than anywhere else in Wirral – almost double that of any other of the wards. Of these, Asian/British Asian is the largest ethnic group, followed by White non-British.
- Elsewhere, the next largest Asian/British Asian group can be found in Cloughton and the next White non-British group is in Hoylake and Meols.
- Otherwise, the remaining ethnic groups are fairly evenly distributed and there is good representation across all Wirral wards, including Hoylake and Meols, Greasby, Frankby and Irby, as well as West Kirby and Thurstaston.

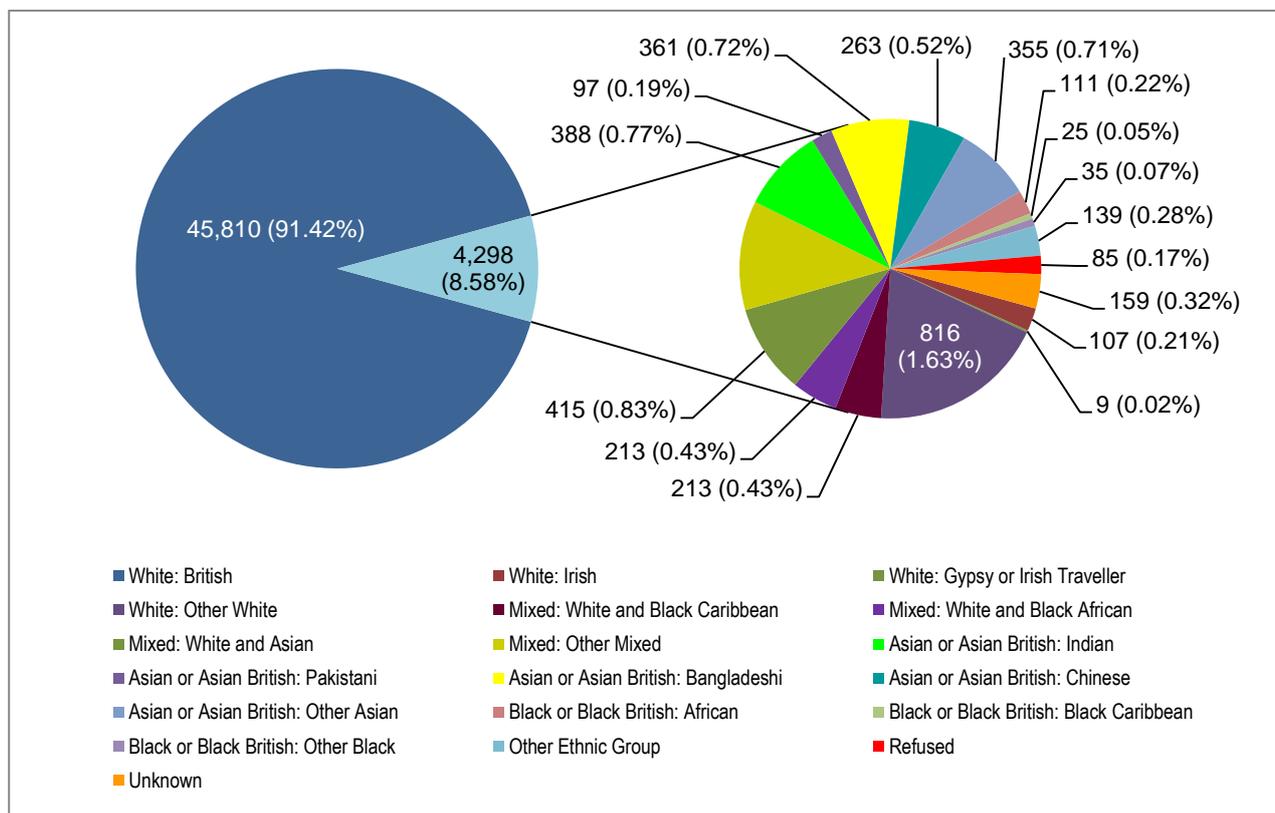
This data is of limited use however, as the demographic profile of Wirral's population has undoubtedly changed since the 2011 Census. Perhaps a better reflection of the changing ethnic profile of Wirral's population can be seen in Wirral's School Census data.

Education

Population of Wirral Schools

Every year, Wirral Council undertakes a review of pupils attending local schools, otherwise known as a Schools Census. This school level data collection process covers maintained schools and academies but does not include private schools. The available data provides a current view of the demographic profile of the pupil population.

Figure 4: Ethnicity of Wirral School Pupils in January 2017



Source: Wirral School Census (2017)

Figure 4 indicates that pupils from BAME groups now make up 8.1% of Wirral's total school population, a slight increase on the 7.7% reported in 2012. To achieve this increase it is assumed that the growth in the local BAME population must currently exceed that of the White British Group. This is consistent with the data presented in the overall population analysis (see table 1) and suggests a growing BAME population. It is therefore not unreasonable to suggest a modest increase on the 5.03% overall BAME representation suggested in the 2011 Census data is a closer reflection of the ethnic profile of the current population.

Spoken Languages

In 2017, the number of pupils with a first language other than English had risen to 1,795 (3.92% of the overall school population). This is an increase on the 1,150 (2.55% of the overall school population) reported in 2013.

This compares to a figure of 20.1% of primary school pupils and 15.7% of secondary school pupils in England, who had a first language other than English in 2016².

Additionally, there has also been an increase in the diversity of spoken languages from the 31 previously reported in 2013 to 54 in 2017. Table 2 below lists the most common languages first languages spoken by Wirral school pupils.

Table 2: First Languages Most Commonly Spoken by Wirral School Pupils in January 2017

| Language | 2013 | | 2017 | | % Change |
|--|------|--------------|------|--------------|----------|
| | Rank | No of Pupils | Rank | No of Pupils | |
| Bengali (India, Bangladesh) | 1 | 258 | 1 | 337 | 30.6 ↑ |
| Polish | 3 | 124 | 2 | 250 | 101.6 ↑ |
| Chinese (includes Mandarin, Putonghua & Cantonese) | 2 | 132 | 3 | 159 | 20.5 ↑ |
| Tamil (Sri Lanka) | 5 | 64 | 4 | 131 | 104.7 ↑ |
| Malayalam (India) | 4 | 88 | 5 | 107 | 21.6 ↑ |
| Urdu (Pakistan, India) | 7 | 32 | 6 | 67 | 109.4 ↑ |
| Romanian | - | - | 7 | 44 | - |
| Tagalog/Filipino (Philippines) | 6 | 50 | 8 | 43 | 0.14 □ |
| Spanish | - | - | 9 | 40 | - |
| Arabic (Middle East, North Africa) | 8 | 27 | 10 | 38 | 40.7 ↑ |
| Hungarian | - | - | 11 | 35 | - |
| Turkish | 9 | 24 | 12 | 33 | 37.5 ↑ |
| German | - | - | 13 | 26 | - |
| Italian | - | - | 14 | 25 | - |
| Kurdish | - | - | 15 | 24 | - |
| Hindi (India) | 10 | 22 | 16 | 21 | 4.5 □ |
| Lithuanian | - | - | 17 | 21 | - |

Source: Wirral School Census (2017)

The number of school pupils speaking Polish, Tamil and Urdu has doubled since 2013, although Bengali remains the most commonly spoken first language (other than English). New entrants to this list in 2017 are predominately European languages (6 of 7), with three of these being native to Eastern Europe.

Educational Attainment

Educational attainment is closely associated with better health outcomes and should therefore be a key consideration in efforts to reduce health inequality. The following tables provide a breakdown of educational attainment in Wirral by ethnicity at some of the more critical points in a child's education.

²https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/552342/SFR20_2016_Main_Text.pdf

Table 3: Educational Attainment of Wirral School Pupils 2017, Ethnicity at Key Stage 2 ¹

| Reading, writing and mathematics | Number of eligible pupils | | | | | | Percentage of pupils reaching the expected standard ³ | | | | | |
|-----------------------------------|---------------------------|--------|--------|--------|---------|-------------------------|--|-------|-------|-------|---------|------------|
| | White | Mixed | Asian | Black | Chinese | All pupils ² | White | Mixed | Asian | Black | Chinese | All pupils |
| Wirral | 3,366 | 85 | 90 | 14 | 18 | 3,599 | 49 | 49 | 61 | x | 61 | 49 |
| North West | 65,500 | 2,800 | 8,110 | 2,150 | 340 | 80,300 | 54 | 56 | 51 | 50 | 71 | 53 |
| England | 439,410 | 30,394 | 61,071 | 33,697 | 2,134 | 581,058 | 54 | 56 | 56 | 51 | 72 | 54 |
| Grammar, punctuation and spelling | Number of eligible pupils | | | | | | Percentage of pupils reaching the expected standard ³ | | | | | |
| | White | Mixed | Asian | Black | Chinese | All pupils ² | White | Mixed | Asian | Black | Chinese | All pupils |
| Wirral | 3,366 | 85 | 90 | 14 | 18 | 3,599 | 69 | 75 | 84 | x | x | 70 |
| North West | 65,510 | 2,800 | 8,110 | 2,150 | 340 | 80,320 | 73 | 76 | 77 | 76 | 87 | 74 |
| England | 439,482 | 30,398 | 61,075 | 33,975 | 2,134 | 581,160 | 72 | 75 | 80 | 76 | 88 | 73 |

Source: [Department for Education](#) (2016)

Note:

1. Figures for academies, free schools and CTCs are included in the individual LA figures. The figures in this table do not include pupils recently arrived from overseas.
2. Includes pupils of any other ethnic group, also those pupils for whom ethnicity was not obtained, refused or could not be determined.
3. Includes pupils who reached the expected standard, and those who reached a greater depth within the expected standard.
x = Figures suppressed to protect confidentiality.

Table 4: GCSE (or equivalent) Entry and Attainment of Wirral School Pupils in 2017, by Ethnicity at Key Stage 4 ¹

| % achieving A* to C in English and Mathematics | Number of eligible pupils ² | | | | | | Percentage of pupils achieving A* to C in English and Mathematics ³ | | | | | |
|--|--|--------|--------|--------|---------|-------------------------|--|-------|-------|-------|---------|-------------------------|
| | White | Mixed | Asian | Black | Chinese | All pupils ⁴ | White | Mixed | Asian | Black | Chinese | All pupils ⁴ |
| Wirral | 3,222 | 69 | 64 | 8 | 14 | 3,402 | 65.7 | 69.6 | 78.1 | x | 100.0 | 66.1 |
| North West | 62,415 | 2,171 | 6,339 | 1,524 | 297 | 74,057 | 61.6 | 61.1 | 64.6 | 57.3 | 83.5 | 61.7 |
| England | 421,440 | 22,753 | 50,541 | 27,589 | 1,987 | 537,808 | 63.0 | 62.9 | 68.1 | 59.8 | 84.3 | 63.3 |

Source: [Department for Education](#) (2016)

Note:

1. Includes entries and achievements by these pupils in previous academic years. State-funded schools include academies, free schools, and city technology colleges, further education colleges with provision for 14- to 16-year-olds and state-funded special schools. They exclude independent schools, independent special schools, non-maintained special schools, hospital schools and alternative provision (including pupil referral units, AP free schools and AP academies as well as state-funded AP placements in other institutions).
2. Pupils at the end of key stage 4 who are included in the measure.
3. In 2014/15 and earlier, where the English language and English literature option was chosen in English, exams in both must be taken and a C grade or above achieved in English language. In 2015/16, to meet the English requirement of the A*-C in English and maths attainment measure, a C in either English language or English literature counts and there is no requirement.
4. The figures in this table do not include pupils recently arrived from overseas.
x = Figures suppressed to protect confidentiality.

At Key Stage 2 (see table 3), the performance of Wirral school pupils is slightly behind Northwest and England averages for reading, writing and mathematics, as well as grammar, punctuation and spelling. This is true for all ethnic groups with the exception of Asian school pupils, who outperform their peers at both a regional and national level.

Yet by Key Stage 4 (see table 4), the proportion of Wirral school pupils achieving A* to C grades in English and Mathematics is greater than in the Northwest and in England. In the main, BAME groups in Wirral perform better than their White counterparts, suggesting all ethnic groups have equitable access to a good level of education.

Employment

A good level of educational attainment is linked to better employment prospects in adulthood. Together, education and employment are the critical factors in helping any individual to acquire the resources necessary to achieve and maintain good health. They help individuals to avoid poverty – a key determinant of health inequalities.

Table 5: Economic Activity by Ethnicity as a Proportion of Wirral’s Population, 2011

| | | All Ethnic Groups (n=260,498) | White: Total (n=253,970) | White British (n=248,328) | Irish (n=2,507) | Other White (n=3,135) | Mixed/ Multiple Ethnic Group (n=1,833) | Asian/Asian British (n=3,749) | Black/African/ Caribbean/ Black British (n=548) | Other Ethnic Group (n=398) |
|------------------------------|---------------------------|----------------------------------|--------------------------|---------------------------|-----------------|-----------------------|--|-------------------------------|---|----------------------------|
| | | % | | | | | | | | |
| Economically Active | FT Employment | 32.22 | 32.16 | 32.08 | 27.28 | 43.00 | 36.50 | 32.20 | 43.61 | 34.17 |
| | PT Employment | 13.37 | 13.32 | 13.35 | 11.37 | 12.47 | 12.71 | 17.36 | 10.77 | 14.32 |
| | FT Self-employment | 4.71 | 4.61 | 4.59 | 4.67 | 6.28 | 4.91 | 10.38 | 5.84 | 11.06 |
| | PT Self-employment | 2.02 | 1.99 | 1.98 | 1.91 | 3.25 | 2.40 | 3.36 | 2.01 | 3.77 |
| | FT Student | 1.69 | 1.67 | 1.67 | 1.20 | 1.82 | 4.09 | 1.55 | 2.37 | 2.76 |
| | Unemployed | 5.11 | 5.08 | 5.09 | 2.83 | 5.68 | 8.67 | 4.99 | 8.76 | 9.05 |
| Economically Inactive | Retired | 25.45 | 25.86 | 25.88 | 40.41 | 13.01 | 8.95 | 9.95 | 7.30 | 8.04 |
| | Student | 4.05 | 3.97 | 3.99 | 1.68 | 3.92 | 9.66 | 6.30 | 6.20 | 7.29 |
| | Carer | 3.51 | 3.44 | 3.43 | 1.91 | 5.26 | 3.16 | 8.01 | 5.66 | 4.27 |
| | Sick or Disabled | 5.89 | 5.95 | 5.99 | 5.23 | 2.84 | 6.22 | 2.16 | 4.74 | 1.51 |
| | Other | 1.99 | 1.95 | 1.95 | 1.52 | 2.46 | 2.73 | 3.73 | 2.74 | 3.77 |

Source: [NOMIS](#) (2011)

Table 5 illustrates the proportions of all ethnic groups who are engaged in economic activity or otherwise. A greater proportion of White European and Black ethnic groups are in full-time employment compared to the average across all ethnic groups. This is in contrast to the Irish group who trail slightly behind.

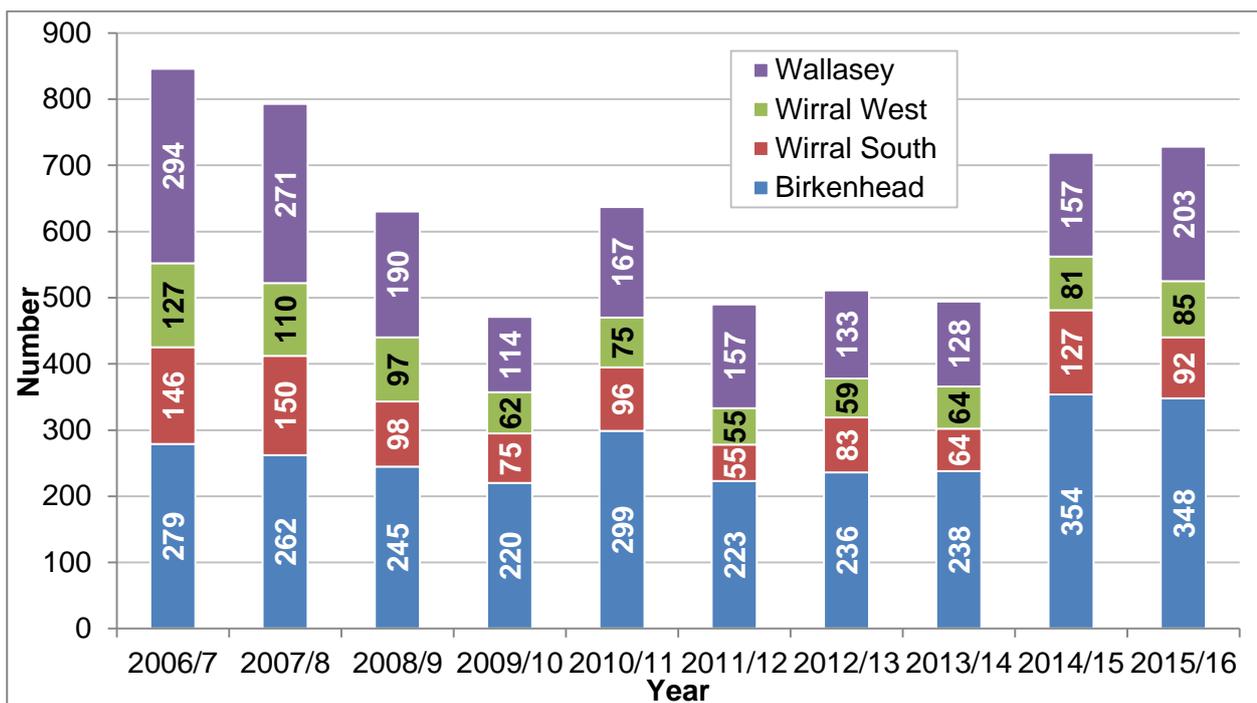
The Asian and Other Ethnic groups are almost twice as likely to be self-employed. Mixed Ethnic groups have a greater proportion of full-time students but, along with Other Ethnic groups, experience higher rates of unemployment.

The proportion of retired individuals within the Irish group is markedly higher than in any other of the groups. The proportion of carers in the Asian group is double that of the average, yet this group has lowest proportion of individuals registered as sick or disabled.

New Applications for National Insurance Numbers (NINOs)

The issuing of new national insurance numbers provides an indication of the number of migrant workers arriving in Wirral seeking employment. As the chart below illustrates (see figure 5), a total of 6,327 new NI numbers have been issued in Wirral over the past decade. In that time, the number of registrations in a given year has fluctuated quite considerably but has risen steadily in recent years. In 2015/16, there were 728 new NI registrations – a slight increase on the 719 registered in 2014/15. A significant proportion of the new registrations are resident in the Birkenhead Constituency which is consistent with the population data by ward (see figure 3, p. 8).

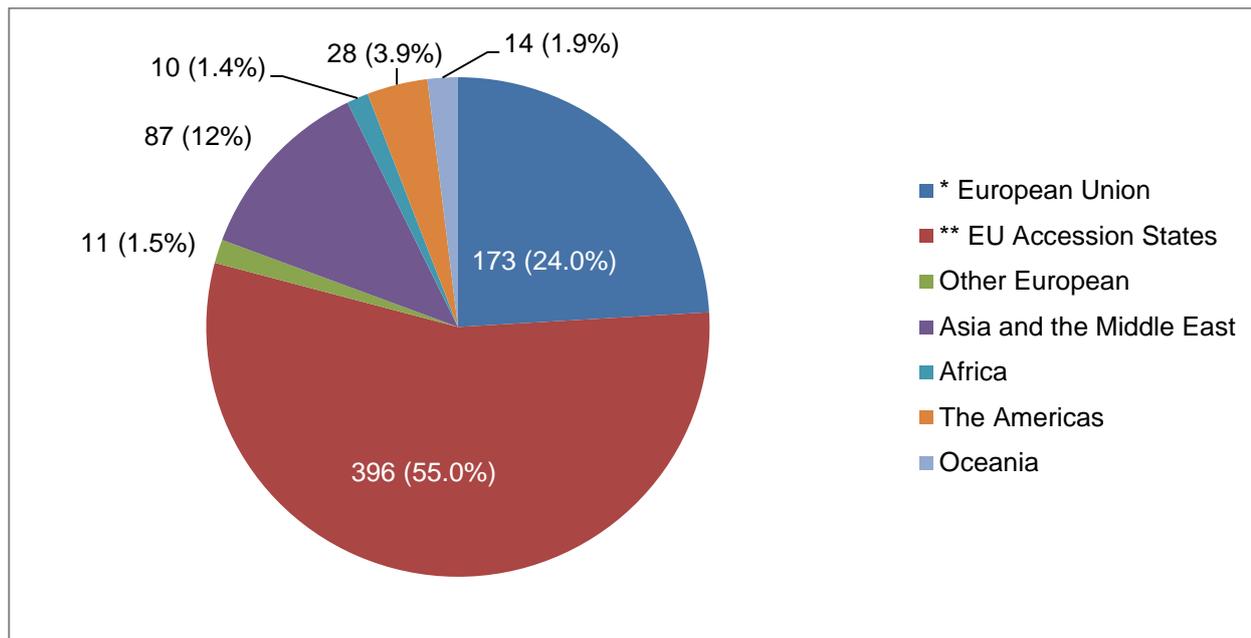
Figure 5: Trend in number of new National Insurance registrations to adult overseas nationals in Wirral, 2006/07 to 2015/16



Source: [Department for Work and Pensions](#) (2017)

In figure 6 below, new registrations for National Insurance numbers made by overseas nationals are broken down by the applicant’s world area of origin. As illustrated, the majority of registrations (4 in 5) corresponded to individuals from the European Union, particularly those from Accession States (55%). This suggests that economic migration is the greatest external influence on Wirral’s changing ethnic profile.

Figure 6: World Area of Origin for those applying for a new National Insurance Number in 2016



Source: [Department for Work and Pensions](#) (2017)

* European Union refers to those countries that were founder members - Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden and the United Kingdom.

** EU Accession States refer to countries that subsequently joined the European Union (EU) from 2004 onwards. These include Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia and Slovenia (1st May 2004), Romania and Bulgaria (1st January 2007) and Croatia (1st July 2013).

Housing

An analysis of housing data in the latest [Strategic Housing Market Assessment](#) (Wirral Council, 2016) shows that:

- 97% of Wirral’s population consider themselves as ‘white’.
- 3% of households consider themselves as non-white, one of the lowest proportions of BAME residents in the country.

The Strategic Housing Market Assessment also provides a comparison of the ethnic profile of the Housing Register against that of the wider population at a given point in time. This identified three ethnicities which appear to be significantly overrepresented on the Register:

- Other white ethnicities (e.g. European white)
- African
- Any other ethnic group (not specified)

This may provide an indication of particular affordability or housing market pressures facing these groups. In respect of White European, this could also be an indication of a significant number of migrant workers seeking employment in Wirral.

On the other hand, the number of Housing Register applicants of Asian or Asian British ethnic origin is significantly below the level that might be expected, given the size of that population group living in the area. Anecdotal reports suggest that this group has very specific housing needs which they tend to seek to meet through the private sector.

For further detailed housing data regarding BAME Communities, it is necessary to go back to the 2011 Census data (ONS, 2012). This indicates that, in general, BAME households are more likely to seek Private Rented Sector accommodation than their White counterparts:

- 16.86% of all Wirral households are located in the private-rented sector.
- Of all white households in Wirral, 16.47% live in the Private Rented Sector.
- Of all non-white households in Wirral, 25.12% live in the Private Rented Sector.
- Non-white households were generally larger, at an average of 2.54 persons compared to 2.30 persons in white households.
- Non-white households were more likely to live in overcrowded conditions than white-households, particularly Asian and Black African households.
- Only 77 people identified themselves as Gypsy or Irish Traveller, making this the smallest BAME group in Wirral at less than 1% of the local population.

Note: *Some of the findings indicated above should be viewed with caution, due in part to: (1) the small sample population size from which the findings were derived, (2) the scope of the analysis and (3) their basis being predicated on data that collected at least six years ago.*

Crime

Crime can have a major impact on the health and wellbeing, of victims of crime, their families, witnesses and the wider community (Association of Public Health Observatories, 2017).

While the link between crime and health inequalities is explored in detail in Wirral's Joint Strategic Needs Assessment (JSNA), this section will explore those aspects of crime that have the greatest influence on BAME groups.

Domestic Abuse and Other Harmful Practices

Domestic abuse is a complex social problem which is prevalent throughout many sections of our society, regardless of age, gender, ethnicity and socioeconomic status. The UK Government defines domestic abuse as:

“Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over, who are or have been intimate partners or family members, regardless of gender or sexuality” (Home Office, 2013).

The impact of domestic abuse is extensive and not only affects the health and wellbeing of the victim, it can also affect the health outcomes of children who witness it, even into adulthood [see [Wirral Domestic Abuse Needs Assessment](#) (2015)]. As a result, the cost of domestic abuse places a significant burden on the public purse.

Estimating the prevalence of any type of abuse is extremely challenging and incidences are likely to be underreported in all ethnic groups (NICE, 2014). However, this may be particularly heightened for some BAME groups for a number of reasons.

For example, Mullender et al. (2002) highlighted the complexities of domestic violence within close-knit, patriarchal communities by citing examples where some Asian women had suffered abuse by their extended family members, as well as their partners. This collusion within the Asian community served to suppress disclosure. Further pressures which might prevent BAME victims of domestic abuse from disclosing related to mistrust and cultural barriers of access to support services and a fear of ostracism or exile from their community (Gill and Banga, 2008; Wellock, 2010; Anitha, 2011).

At a local level, there were a total of 839 cases discussed at the Domestic Abuse Multi-Agency Risk Assessment Conference (MARAC) from 1st April 2015 to 31st March 2016. Only 25 of these cases were related to BAME individuals which equates to 2.98% of the total. This proportion is less than might be expected given that BAME representation in Wirral is 5.03% and could be the result of greater cultural barriers to disclosure for BAME groups, as suggested in the literature.

Female Genital Mutilation (FGM)

The revised Home Office (2013) definition of domestic abuse also encapsulates other less traditionally thought of forms of abuse, otherwise known as harmful practices, which some ethnic minority groups are vulnerable to. These include Female Genital Mutilation (FGM), Honour-based Violence (HBV) and forced marriage.

The World Health Organisation defines FGM as '*All procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons*' (WHO, 2014). The practice of FGM is associated with a number of countries in Africa, the Middle East and in Asia but as a result of migration, is increasingly being encountered in countries across North America, Europe and Australia.

According to the Foundation for Women's Health Research and Development, it is estimated that there are 137,000 females living with the consequences of FGM in the UK and a further 60,000 girls under the age of 15 are at risk of FGM (FORWARD, 2015). Locally, of the 839 cases considered at the Domestic Abuse MARAC in 2015/16, there was only 1 case relating to partnership concerns about an individual currently at risk of FGM. However, as we know from the literature, there are many historic cases of FGM which could remain undetected.

Honour-based Violence (HBV) and Forced Marriage

In addition, honour-based violence and forced marriages can also occur across a range of different faiths and cultures but are more likely in some BAME groups more than others. This is particularly true of the Pakistani, Kurdish and Gypsy and Traveller Communities where there is an oppressive patriarchal culture (Home Affairs Select Committee, 2008; Brandon and Hafez, 2008).

Dyer (2015) reported that the number of known '*honour*' killings in the UK has fluctuated over recent years (11 cases in 2010, 5 cases in 2011, 9 cases in 2013 and 4 cases in 2014). However, these data represent only those crimes which have been detected and the true extent of '*honour*' killings is likely to be significantly higher.

Likewise, the police reported a minimum number (n=2,800) cases of ‘honour’-based violence in 2010 but inconsistent data collection and recording across different constabularies is also likely to mean that such crimes are underreported (Her Majesty’s Inspectorate of Constabulary, 2015).

In 2016, the Forced Marriage Unit dealt with 1,428 possible cases of Forced Marriage, an increase of 17% on the number of cases in the previous year (Home Office, 2016). Of these cases, 80% (n=1,145) related to females and 20% (n=283) to males, while 15% (n=220) involved victims below 16 years of age. Of the 839 cases considered at Wirral’s Domestic Abuse MARAC in 2015/16, only 4 cases related to ‘honour’-based abuse, which included 1 case of forced marriage.

In the case of harmful practices, there may be an acceptance and normalisation of these practices and unwillingness on the part of BAME women to report these events in order to maintain family honour. In recognition of the challenges presented by each of these issues, the local partnership has introduced new protocols for FGM (Wirral Safeguarding Boards, 2016) and ‘honour’-based violence, including forced marriage (Merseyside Safeguarding Boards, 2014). It is intended that their introduction will lead to better identification and reporting of these crimes.

Hate Crime

In 2015/16, a total of 62,518 hate crimes were recorded by police in England and Wales, which represents a 19% increase on the previous year (Home Office, 2016). There are five different categories within the hate crime strand, depicted in the table 6 below.

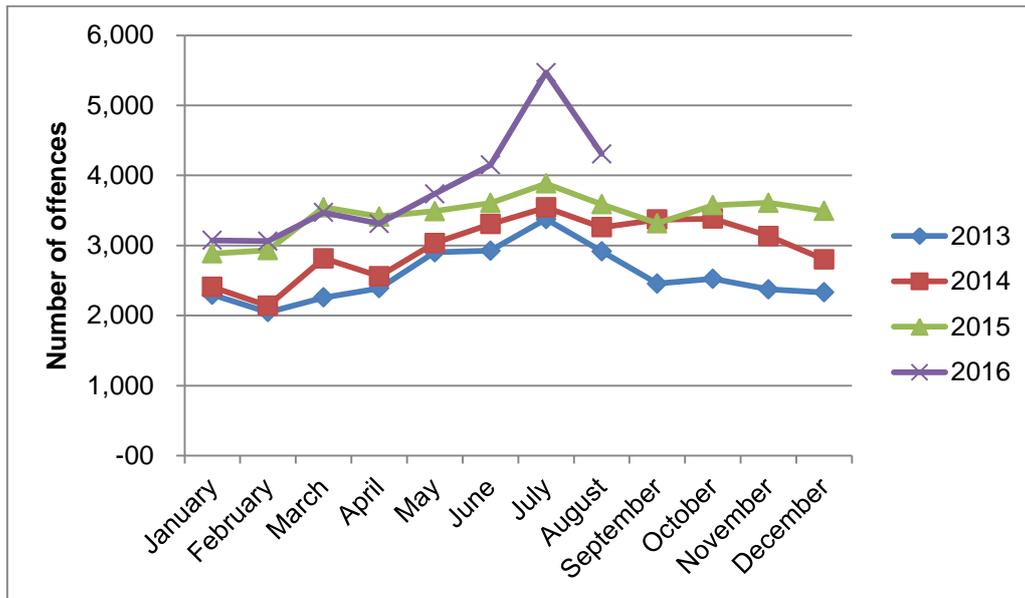
Table 6: Hate Crimes reported by the Police in England and Wales, 2011/12 to 2015/16

| Numbers and percentages | England and Wales, recorded crime | | | | | |
|--|--|----------------|----------------|----------------|----------------|------------------------------------|
| | 2011/12 | 2012/13 | 2013/14 | 2014/15 | 2015/16 | % change 2014/15 to 2015/16 |
| Hate Crime Strand | | | | | | |
| Race | 35,944 | 35,845 | 37,575 | 42,862 | 49,419 | 15 |
| Religion | 1,618 | 1,572 | 2,264 | 3,293 | 4,400 | 34 |
| Sexual Orientation | 4,345 | 4,241 | 4,588 | 5,591 | 7,194 | 29 |
| Disability | 1,748 | 1,911 | 2,020 | 2,515 | 3,629 | 44 |
| Transgender | 313 | 364 | 559 | 607 | 858 | 41 |
| Total number motivating factors | 43,968 | 43,933 | 47,006 | 54,868 | 65,500 | 19 |
| Total number of offences | N/A | 42,255 | 44,577 | 52,465 | 62,518 | 19 |

Source: [Home Office](#) (2016)

Of these, 49,419 (79%) were considered to be racially motivated and 4,400 (7%) were considered to be religiously motivated. This represents a 15% increase in race hate crime and a 34% increase in religious hate crime on the previous year

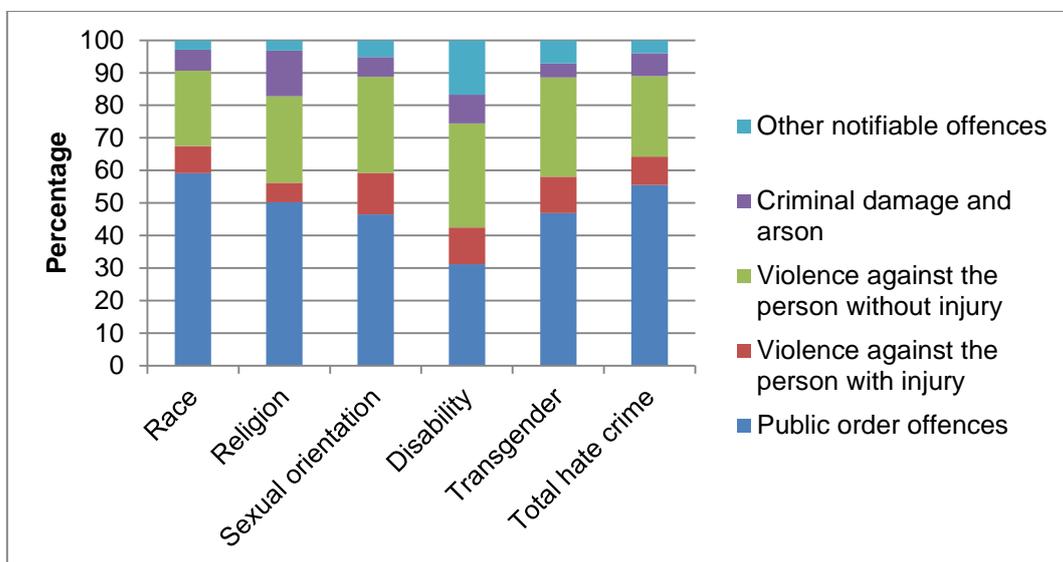
Figure 7: Trend in Racially or Religiously Aggravated Crime by Month for England and Wales, 2013-16



Source: [Home Office](#) (2016)

The evidence presented in figure 7 above illustrates a year on year increase in racially and religiously motivated hate crime. The peak in July 2016 coincided with the UK's EU Referendum which took place on 23rd June 2016.

Figure 8: Breakdown of Hate Crime by Type of Offence for England and Wales, 2015-16

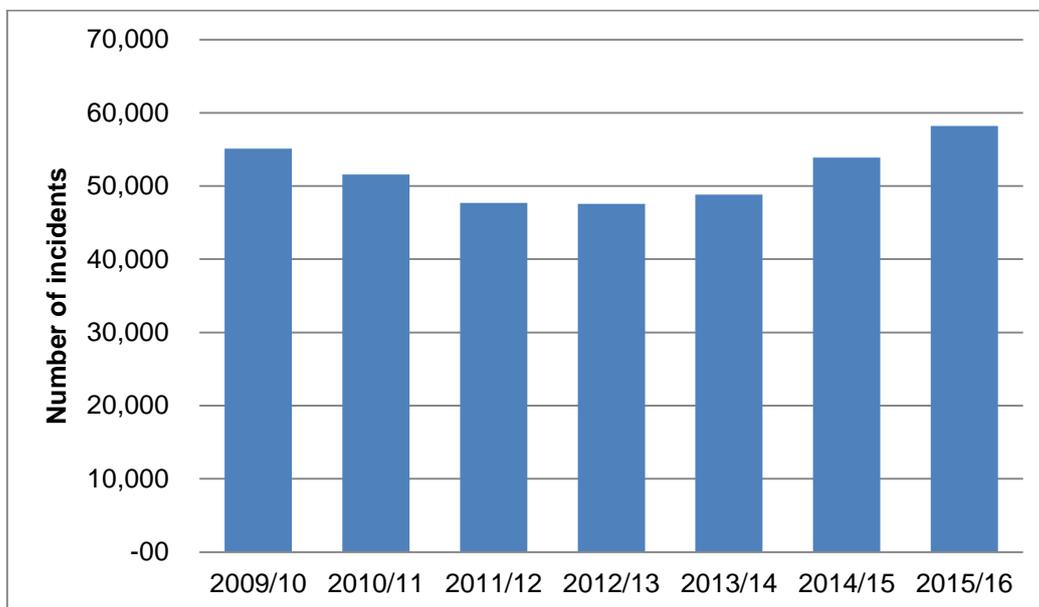


Source: [Home Office](#) (2016)

Broadly speaking, 4 out of every 5 race hate crimes are for public order offences or for violent offences against a person where the victim escaped injury. Other offences involving injury to the victim, criminal damage or arson are less frequent; although the proportion of criminal damage and arson offences for religious hate crime is double that of race hate crime.

While this data is useful, its limitation is that it only refers to cases which have resulted in a successful prosecution against the perpetrator. For this reason, some experts argue that a better measure would be the use of hate crime ‘incidents’ (Swadling et al., 2015). In addition to hate crime data, ‘incidents’ can also include reported events that do not necessarily result in a successful prosecution, including reports by third parties (see figure 9 below).

Figure 9: Trend in Race Hate Incidents for England and Wales, 2009-16



Source: [Home Office](#) (2016)

Using this measure, across in England and Wales, a total of 58,197 race hate incidents were reported to the police in 2015-16 (Home Office, 2016). This implies that at least 15% of all race hate incidents go unprosecuted.

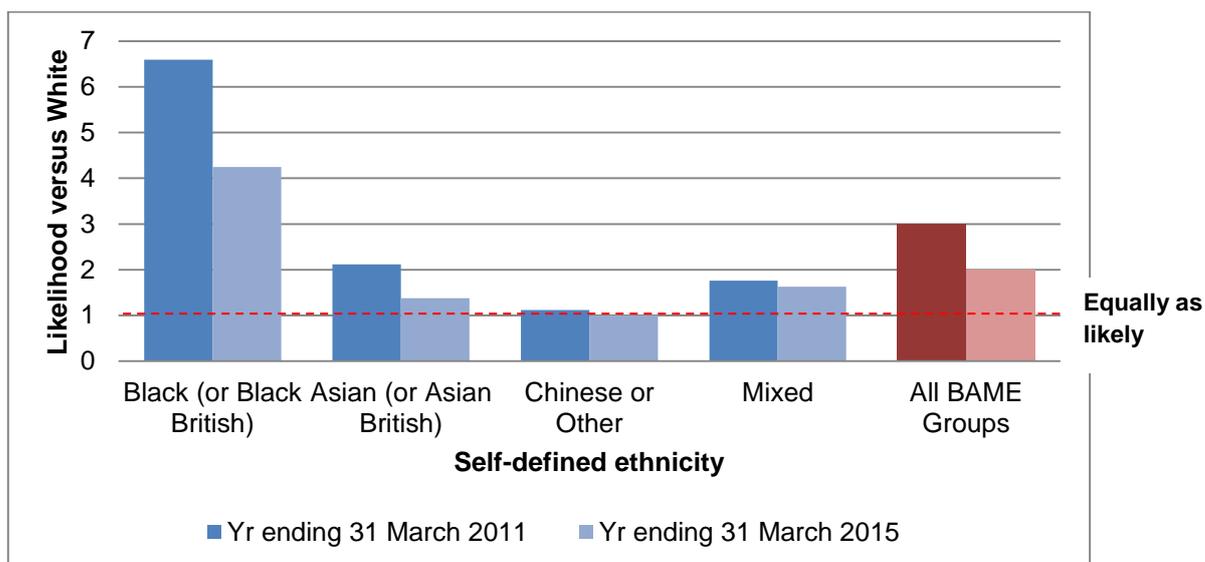
In reality, this figure is likely to be much greater, for reasons that BAME experience many barriers to reporting such crimes (Swadling et al., 2015). BAME individuals need to be able to recognise and articulate incidences when they have been a victim of racial or religious hate crime. This may be problematic for people for whom English is a second language. Additionally, BAME individuals may be reluctant to report such incidents due to a mistrust of the authorities.

While BAME groups may be at risk of becoming a victim of these crimes, alongside those that affect the general population, there is seemingly an increased risk of offending behaviour too.

Criminal Justice

There is an over representation of BAME groups throughout the criminal justice system, which the Institute of Race Relations (2017) attributes to increased likelihood of BAME groups to be stopped and searched by the police (see figure 10 below).

Figure 10: Likelihood of being stopped and searched by self-defined ethnic group, compared with those from the White ethnic groups, England and Wales, year ending March 2011 compared with year ending March 2015



Source: [Home Office](#) (2015)

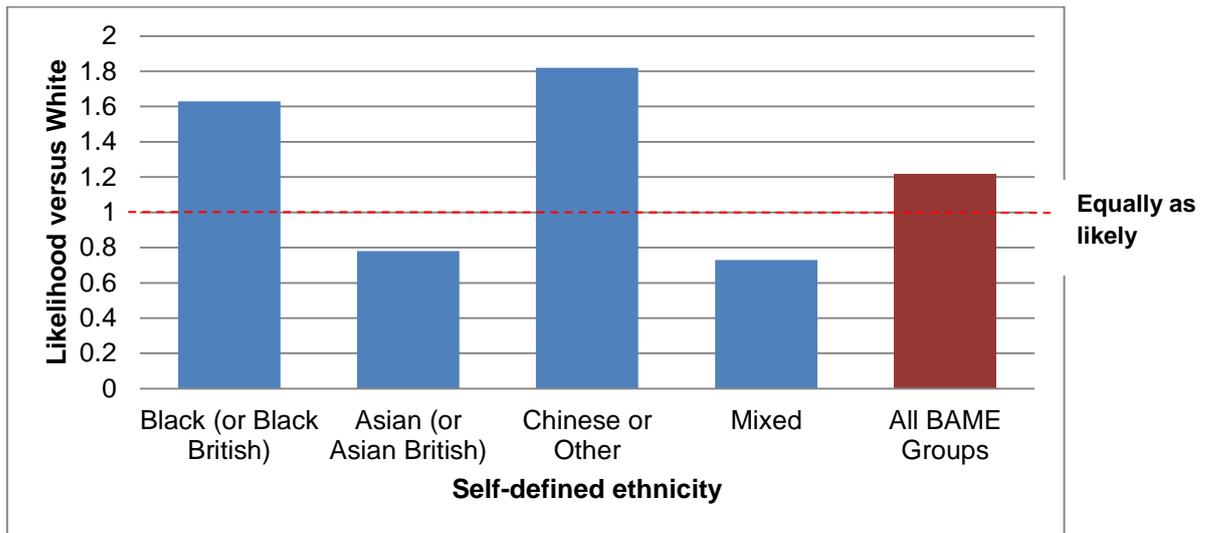
Notes:

1. Includes searches under section 1 PACE and section 60 of the Criminal Justice and Public Order Act 1994
2. Population breakdowns are based on the 2011 census. It is likely that ethnicity breakdowns have changed since 2011, so figures in this table should be considered estimates only.

National data from the Home Office (2015) suggests that BAME ethnic groups overall are twice more likely to be stopped and searched than White ethnic groups. Mixed ethnic groups are almost twice as likely to be stopped and searched, while Black ethnic groups are four times more likely.

In figure 11 below, data for stop and search reported by Merseyside police shows that the disparity between ethnic groups is far less pronounced locally. Asian and Mixed ethnic groups are less likely to be stopped and searched than White ethnic groups. Black ethnic groups are 60% more likely to be stopped by Merseyside police, rising to 80% more likely for Chinese or Other ethnic groups.

Figure 11: Likelihood of being stopped and searched by self-defined ethnic group, compared with those from the White ethnic groups, reported by Merseyside Police, year ending March 2014



Source: [StopWatch](#) (2017)

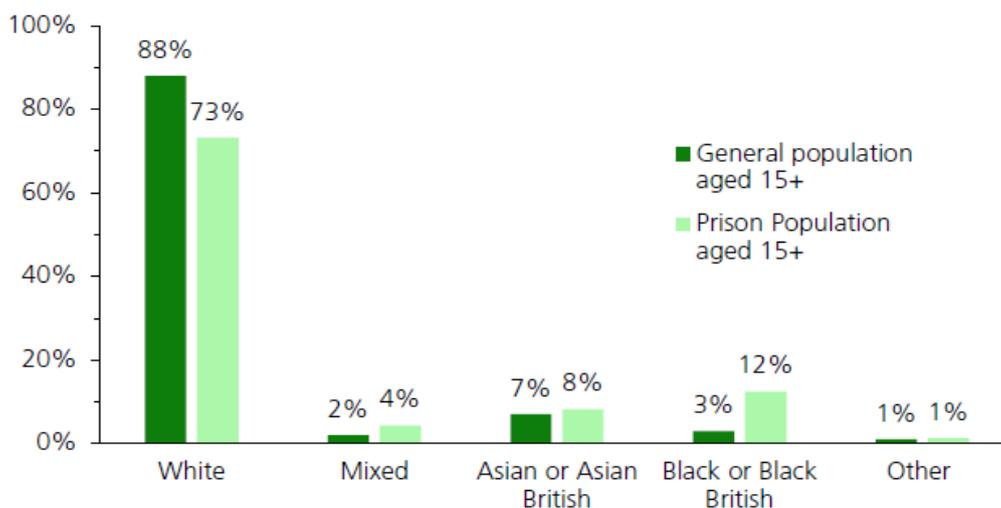
Notes:

1. Includes searches under section 1 PACE and section 60 of the Criminal Justice and Public Order Act 1994
2. Population breakdowns are based on the 2011 census. It is likely that ethnicity breakdowns have changed since 2011, so figures in this table should be considered estimates only.

Prison

The chart below details the ethnic profile within prisons in England and Wales, compared to the general population (see figure 12 below)

Figure 12: Prison and General Population by ethnicity, England and Wales, December 2016



Source: [House of Commons](#) (2017)

BAME groups are overrepresented in the national prison population. The proportional representation for Mixed Ethnic groups is twice that of the general population, while for Black Ethnic groups, it is four times greater.

In 2013, Public Health England, the Probation Chief's Association and Revolving Doors collaborated to investigate health inequalities among those in contact with the criminal justice system. Their findings included:

- 72% of male offenders and 71% of female offenders suffered from two or more mental health disorders.
- Of those that offenders that had an identified mental illness, 72% were also found to have a substance misuse problem.
- 29% of offenders reported to have suffered emotional, physical or sexual abuse as a child.
- Offenders were 4 times more likely to smoke than the general population.
- The rate of hazardous drinking among offenders was at least 50% higher than in the general population.
- The prevalence of substance misuse among offenders was around 5 times greater than in the general population.
- Rates of all-cause mortality among offenders were three times greater the general population. However, the rate of accidental deaths and suicides were 7 and 13 times higher respectively.

Health and Wellbeing of BAME Groups in Wirral

Cardiovascular Disease (CVD) and Coronary (or Ischaemic) Heart Disease (CHD/IHD)

Cardiovascular diseases are defined as 'a group of disorders of the heart and blood vessels' (World Health Organisation, 2016). This includes disorders within the blood vessels supplying the heart (Coronary Heart Disease) and the brain (Cerebrovascular Disease), as well as peripheral arterial disease in the blood vessels supplying the arms and legs. It also includes congenital heart disease (malformation of the heart at birth) and damage to the heart muscle and valves resulting from streptococcal infection (such as rheumatic fever).

Over time, blood vessels can narrow through a process called atherosclerosis (British Heart Foundation, 2016). This occurs when fatty deposits gradually build up on the inside of the blood vessels, constricting the blood flow and potentially causing a number of further problems. For example, when the blood vessels to the heart become too narrow, they become ischaemic, meaning they are less able to deliver the oxygenated blood required by the heart to function. This can result in the individual experiencing a pain or discomfort in the chest, known as angina.

Sometimes, a piece of fatty deposit can break away from the blood vessels, causing a blood clot to form, blocking vessels and major arteries and potentially starving organs of vital oxygen. When this occurs in blood vessels supplying the heart, it can cause permanent damage to the heart muscle, hence the name 'heart attack'. Alternatively, clots in blood vessels to the brain can induce a stroke or to the lungs, can cause a pulmonary embolism.

Evidence would suggest that some BAME groups are disproportionately affected by cardiovascular diseases. For example, in a recent study exploring ethnic disparities in the birth prevalence of congenital heart defects, Knowles et al. (2016) found that incidence of defects was significantly higher in Asian and Black ethnic groups compared to the White reference population.

As far as the prevalence of CVD and CHD among ethnic groups is concerned, the most recent data was published in the Health Survey for England 2004 (Health and Social Care Information Centre, 2005). As such, this data is almost 12 years out of date and its reliability is therefore questionable, however it is the best data currently available.

Within the survey, the following definitions were used in the classification of the data:

- **Cardiovascular Disease (CVD)**

Respondents to the survey were classified as having a CVD condition if they reported that a doctor had ever diagnosed them as having or had angina, a heart attack, a stroke, a heart murmur, an abnormal heart rhythm or 'any other heart trouble'.

- **Coronary Heart Disease (CHD) - Ischaemic Heart Disease (IHD)**

Respondents to the survey were classified as having a CHD/IHD if they reported suffering angina or having had a heart attack.

The findings of the survey (see table 7 below) showed that:

- A CVD diagnosis was most prevalent among Irish men (14.5%) and women in the general population (13.0%). The proportion of Black African men affected by CVD was significantly lower than any other ethnic group. Black African women, Chinese and Bangladeshi groups were also far less affected by CVD condition than the general population.
- Mortality from CHD is particularly high among Irish, Scottish and South Asian groups, particularly Pakistanis and Bangladeshis. Black Africans reported the lowest prevalence of CHD (0.7% men and 0.5% women).
- In men, the survey observed prevalence of angina and 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 7: Prevalence of CVD and CHD by Gender and Ethnicity

| Minority Ethnic Group | Any Cardiovascular Disease (CVD) | | *Coronary/Ischaemic Heart Disease (CHD/IHD) | |
|-----------------------|----------------------------------|-------|---|-------|
| | 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 |

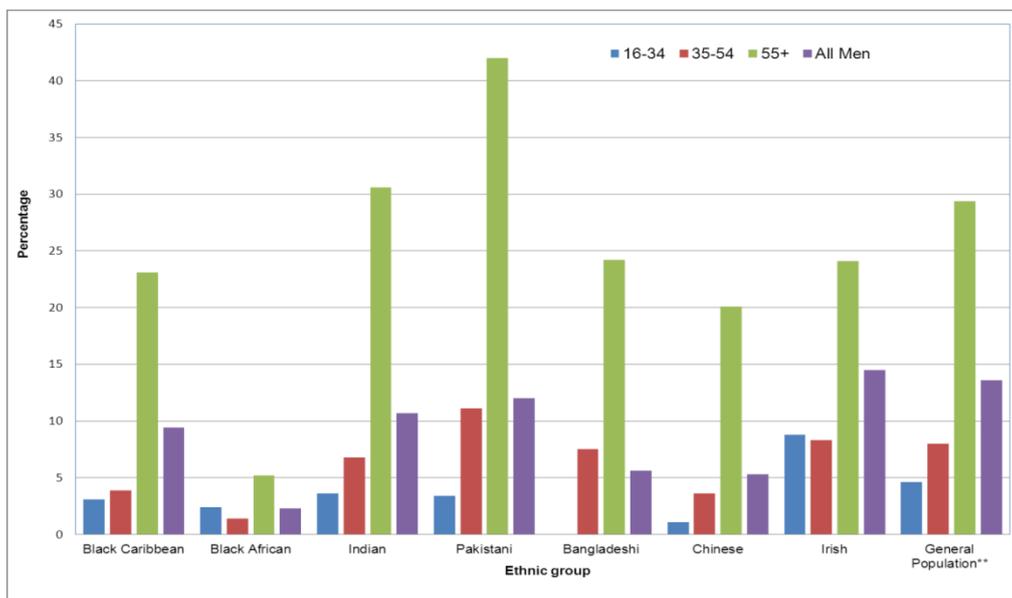
Source: [Health Survey for England 2004](#), NHS Digital (2006)

Note: * Coronary or Ischaemic Heart Disease refers to the same condition.

**General population refers to the whole population of England, regardless of minority ethnic group

Rates of CVD in the Irish ethnic group are particularly high. The charts below (see figures 13 and 14) also show that for both men and women, CVD is progressive with age, with those over 55 most affected. In this age group, Pakistani men had the highest prevalence of CVD (42%) and Black African men had the lowest (5.2%) while for women, CVD prevalence was greatest in the Indian group (23.7%) and lowest in the Chinese group (14.7%).

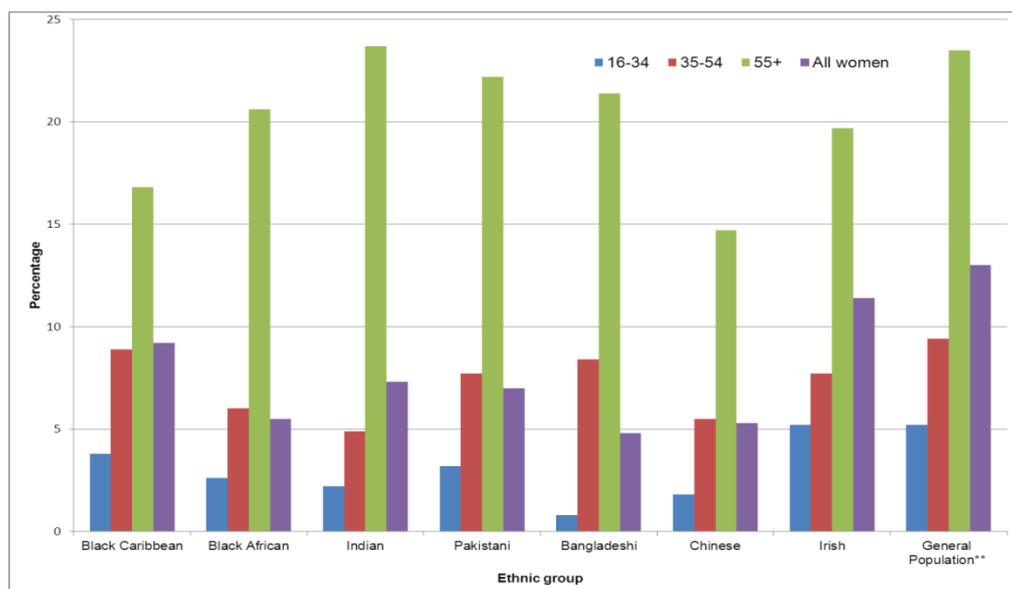
Figure 13: Prevalence of CVD in men by ethnicity and age



Source: [Health Survey for England 2004](#), NHS Digital (2006)

Note - **general population refers to the whole population of England, regardless of minority ethnic group

Figure 14: Prevalence of CVD in women by ethnicity and age



Source: [Health Survey for England 2004](#), NHS Digital (2006)

Note - **general population refers to the whole population of England, regardless of minority ethnic group

Heart Failure

UK research studies to investigate heart failure across different ethnic groups are limited; however there is a consensus among them that some ethnic variation exists (Gill et al., 2011; Bhopal et al., 2012). Despite this consensus, however, there is some variation across different studies about the extent to which each ethnic group is affected.

In a large-scale, community-based study in the UK, Gill et al. (2011) sought to determine the prevalence of left ventricular systolic dysfunction (LVSD) and heart failure amongst South Asian and Black African-Caribbean groups. Their findings indicated that the overall prevalence of heart failure across both BAME groups (0.75%) was very similar to that in the general population of England (0.7%). This was somewhat surprising, given that South Asians are at 50% greater risk of heart failure, as a result of suffering higher rates of CVD. Similarly, the mean age of heart failure among both ethnic groups was very similar to the White population.

Table 8: Prevalence of Hypertension and Diabetes among Participants with LVSD

| 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)

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 8 above.

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%).

Stroke

Research undertaken by the British Heart Foundation (2010) and the Stroke Association (2017) has highlighted some key facts in relation to stroke:

- Stroke is the fourth leading cause of death in the UK each year.
- People from Black ethnic groups twice as likely to have a stroke compared with White ethnic groups.
- Stroke is the leading cause of disability in the UK. Almost two-thirds of all stroke survivors leave hospital with a disability.
- Whilst stroke mortality rates are falling in all BAME groups, they are not falling as quickly as in the general population. This has resulted in an increased gap in stroke mortality rates between BAME groups and the general population.

Data from the Health Survey for England 2004 (Health and Social Care Information Centre, 2006) shows that for older people, aged 55 and over, self-reported incidence of stroke was greater in Black Caribbean and Pakistani men (11.5% and 9.6% respectively) and in Bangladeshi and Pakistani women (11.9% and 10.1% respectively).

Risk factors for stroke include hypertension (high blood pressure), smoking and high cholesterol. The prevalence of hypertension among Black and Chinese ethnic groups is high compared to the general population, placing them both at greater risk of ischaemic stroke and intracerebral haemorrhage. 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. However, mortality from ischaemic stroke is higher in Bangladeshi people, attributable to double the age-adjusted incidence, compared with White Europeans.

Diabetes

Diabetes is a long-term condition that describes the body's inability to regulate its own blood sugar levels effectively. This occurs when the body is depleted of insulin, the hormone used by the body to regulate blood glucose. Insulin can be depleted, either because the body's immune system attacks the cells which produce insulin (Type 1 diabetes) or because the body doesn't produce enough insulin (Type 2 diabetes).

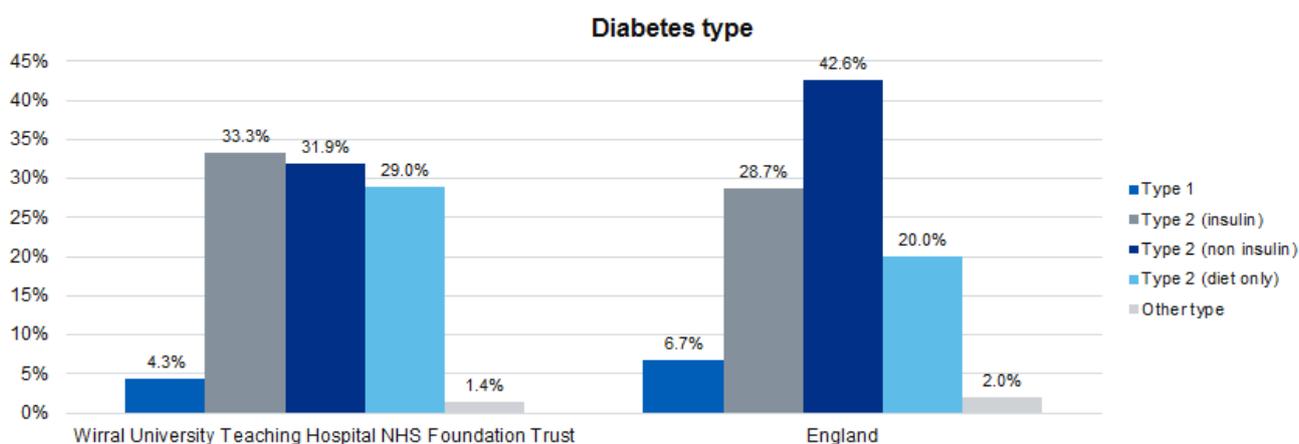
Although Type 1 diabetes can develop in any individual, the risks of an individual developing the condition are increased when a close family member has it (Diabetes UK, 2016). Type 2 diabetes is seemingly the consequence of both genetic and environmental factors. Obesity is a key risk factor for developing type-2 diabetes but there are others, usually associated with deprivation, such as physical inactivity, poor diet, smoking and alcohol use.

Diabetes can have a considerable impact on the life of the affected individual and its presence increases the risk of suffering other health conditions. These include CVD, kidney disease, eye disease, disability, amputation, neuropathy, depression, sexual

dysfunction, complications in pregnancy, increased risk of dementia, reduced life expectancy

According to Diabetes UK (2016), nearly 3.5 million people in the UK have been diagnosed as having diabetes, while an estimated 1.1 million are thought to be undiagnosed. Diabetes prevalence estimates for Wirral vary slightly. Public Health England (2017) estimate that 9.1% (n=23,867) of the adult population are affected by diabetes while NHS Digital (2017) suggest this could be slightly higher at 10.5%.

Figure 15: Proportion of Inpatients being treated for Diabetes at Wirral University Teaching Hospital by Type



Source: [National Diabetes Inpatient Audit \(NaDIA\) 2016](#), NHS Digital (2017)

Data from the National Diabetes Inpatient Audit (NaDIA) 2016 (see figure 15) also shows that only a small proportion (4.3%) of Wirral inpatients are being treated for Type 1 Diabetes, compared to 6.7% in England. This reverses for insulin-dependent Type 2 diabetes where Wirral has the greater proportion of inpatients in treatment at 33.3%, compared to 28.7% in England. Of the two, Type 2 diabetes is largely avoidable with some modification of lifestyle and behaviours.

Local data concerning diabetes prevalence in BAME groups is unavailable; however the Health Survey for England 2004 (Health & Social Care Information Centre, 2006) suggests that:

- Type 2 diabetes is known to affect BAME groups at a younger age, placing them at greater risk of complications.
- Obesity is the greatest risk factor in developing Type 2 diabetes and individuals with diabetes are twice as likely to develop CVD as non-diabetics.
- South Asian and Black ethnic groups are between 2 and 4 times more likely to develop Type 2 diabetes than White ethnic groups.
- Rates of non-insulin dependent Type 2 diabetes are significantly higher within South Asian (particularly Indian, Pakistani and Bangladeshi) and Black Caribbean ethnic groups.
- Mortality from diabetes-related conditions is 3.5 times greater among South Asian groups than in the general population, with a similar rate for Black Caribbean men. For Black Caribbean women, mortality rates are almost six times greater

- Non-insulin dependent Type 2 diabetes remains undiagnosed in up to 40% of Asian Diabetics.

Several studies also found that diabetes among BAME groups could have a more significant impact on their health, due to several reasons. These included factors such as a lack of awareness about the risk factors of diabetes, poor treatment compliance and inability to comply due to severe co-morbid mental health problems, poor access to healthcare services and inappropriate health information (Aspinall and Jacobson, 2004; Diabetes UK, 2006; Saunders, 2007).

Additionally, BAME women are at greater risk of developing gestational diabetes during pregnancy, a condition which develops when the mother is unable to produce enough insulin for both herself and her baby (Diabetes UK, 2016). Women who experience gestational diabetes during pregnancy have a much greater risk of developing Type 2 diabetes later in life, particularly if they are overweight. Likewise, the babies themselves are at much greater risk of developing Type 2 diabetes in adulthood.

For some BAME groups such as the Irish/Gypsy and Traveller community, there are other health conditions which can further complicate diabetes management. Haemochromatosis is a genetic condition which is much more prevalent among people of Irish heritage, characterised by over absorption of iron within the body. This condition can lead to the development of diabetes and organ failure in the longer-term and early treatment is vital to prevention.

Obesity

Obesity is a major risk factor for cardiovascular disease, as well as Type 2 diabetes, hypertension, metabolic syndrome, osteoarthritis and cancer. The Health Survey for England 2014 (Health and Social Care Information Centre, 2016) suggested that 65% of men and 58% of women are either overweight or obese. The UK has the highest level of obesity within Western Europe (24.9%), prompting Professor Terence Stephenson to label the UK as 'the fat man of Europe' (Academy of Medical Royal Colleges, 2013). In the government's Foresight programme, monitoring the future burden of obesity, McPherson et al. (2007) predicted that by 2050, over half of the UK adult population would be obese, at an annual cost of £50 billion by that date. While the literature includes ethnicity profiles of national obesity data, there is no reliable local data that can be drawn upon.

Gatineau and Mathrani (2013) suggested the relationship between obesity and ethnicity is complicated. Health behaviours between and within BAME groups can vary considerably, influenced by a complex interaction between cultural, lifestyle and socioeconomic factors. 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.

Evidence of the complicated relationship between obesity and ethnicity can be seen in McPherson et al.'s (2007) predictions for future obesity levels across different ethnic groups. Their model suggests that by 2050, obesity will increase (and perhaps double) for Indian men and Black African and Pakistani ethnic groups across both genders.

At the same time, the model also suggests significant reduction in obesity for Black Caribbean and Chinese ethnic groups

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 (National Institute for Health and Care Excellence, 2013).

Drawing on data from the Health Survey for England 2004 (NHS Health & Social Care Information Centre, 2006), the table below shows the proportions of each ethnic group exceeding the recommended waist-hip ratio.

Table 9: Waist-hip ratio (WHR) by ethnic group and gender for England

| | Waist Hip Ratio (WHR) | |
|----------------------------|-----------------------|----------------|
| | % Men > 0.95 | % Women > 0.85 |
| 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: [Health Survey for England 2004](#), NHS Digital (2006)

Note: *general population refers to the whole population of England, regardless of minority ethnic group

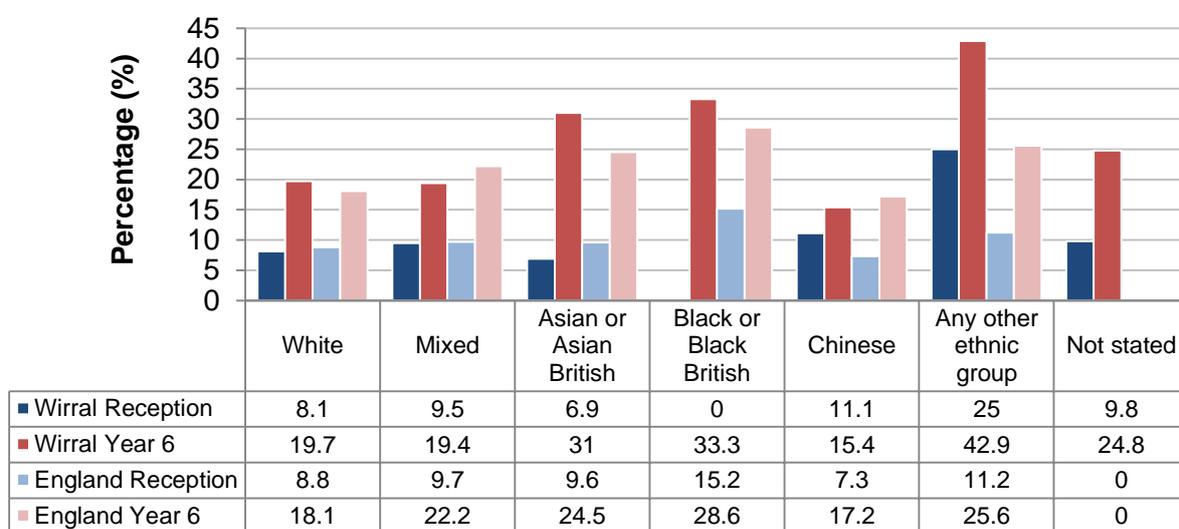
Table 9 shows that Indian (38%), Pakistani (36%) and Irish (36%) ethnic groups had a much higher proportion of males with raised waist-hip ratio compared to the general population. In contrast, Black African and Chinese males had the lowest prevalence of raised waist-hip ratio. All women, with the exception of the Chinese (22%), had a higher prevalence of raised waist-hip ratio than in the general population, with prevalence greatest in Bangladeshi women (50%).

The *Health Survey for England in 2004* further suggested 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.

There are many possible underlying reasons for ethnic variation in obesity, some of which were highlighted in the [Icarus Report](#) (2010). For some migrant groups arriving in the UK, the maintenance of eating habits associated with active lifestyles from their past, combined with the sedentary lifestyle of their new lives, carry obvious risks of obesity.

Figure 16: Prevalence of Obesity by Ethnicity recorded within the National Child Measurement Programme in Wirral and in England and Wales, 2015-16



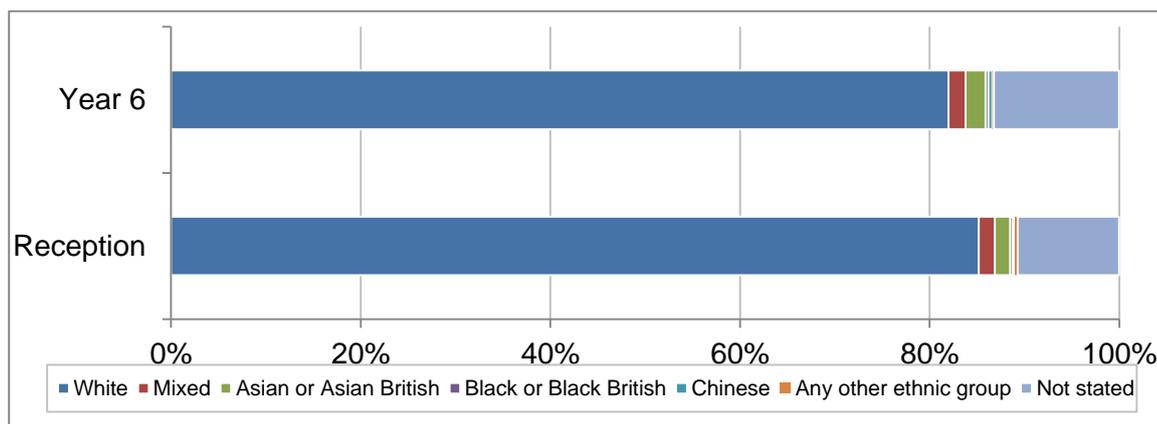
Source: [National Child Measurement Programme 2015-16](#), NHS Digital (2016)

The data presented in figure 16 above is taken from the National Child Measurement Programme (NHS Digital, 2016) and indicates the proportion of children in Reception and in Year 6 who are deemed to be obese, both nationally and in Wirral.

The national data for children in England shows a correlation with the obesity data for adults, though perhaps not as pronounced. The highest prevalence of obesity occurred in Black ethnic groups in both reception and year 6, while the lowest prevalence was in the Chinese group.

Comparing this to local data, the proportion of Wirral children considered to be obese in each ethnic group seems to follow national trends but is subject to considerable variation from the national norm in some ethnic groups. This is due to the fact that some of Wirral's ethnic groups contain much smaller numbers (see figure 17 below) and are therefore prone to greater percentage fluctuations with small changes in the overall numbers. It should also be noted that there is still a considerable number of pupils who are without a recorded ethnicity, which introduces further uncertainty.

Figure 17: Ethnicity of Wirral pupils captured within the National Child Measurement Programme in Wirral, 2015-16



Source: [National Child Measurement Programme 2015-16](#), NHS Digital (2016)

Cancer

Cancers were the leading cause of mortality in UK in 2015, accounting for 29% of all deaths registered in that year (Office of National Statistics, 2015a). The cancer incidence rate for all cancers combined in Wirral (673.0 per 100,000) is higher than the England average (614.8 per 100,000). In fact, Wirral has a higher cancer incidence rate than the England average for all the main types of cancer, with the exception of prostate cancer which is slightly lower.

Generally, cancer incidence in BAME groups is lower than in the White population, although there is some variation for different BAME groups and cancer types (National Cancer Intelligence Network, 2009). For example:

- Asian and Chinese of both genders are between 20% and 60% less likely to get cancer than the White population.
- Black females are between 10% and 40% less likely to get cancer than White females.
- Black males are three times more likely to get prostate cancer than White males, although there is no discernible difference between the two in terms of overall incidence for all cancer types.
- Black ethnic groups are nearly twice as likely to get stomach cancer as the White population.
- Asian ethnic groups are twice as likely to get liver cancer as the White population.
- Black and Asian females over the age of 65 years are at higher risk of cervical cancer compared to White females.

Cancer Research UK (2016) reported that Black African women are almost twice as likely to be diagnosed with late stage breast cancer compared to White women. Black Caribbean women followed closely behind at 1.7 times as likely compared to White women.

Harding et al. (2009) asserted that the Irish population have the highest mortality rates for most types of cancers when compared to the rest of the UK. They also suggested that while cancer mortality rates in the general population have declined, for the Irish, they

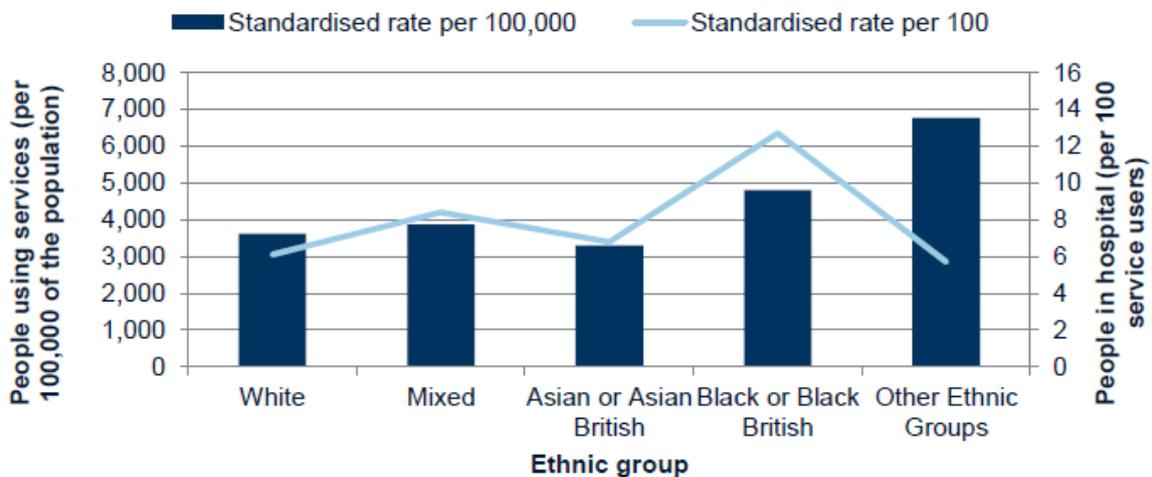
have remained pretty static. This is attributed to a lack of awareness among the Irish population concerning the risks and symptoms of cancer (Scanlon et al., 2006).

Mental health

There is a consensus within the literature that BAME groups are disproportionately affected by mental health issues. It has been noted in previous iterations of this chapter that research data into mental health and wellbeing among BAME groups is restricted to a select number of ethnic groups, namely Black African/Caribbean and the Irish (Palmer, 2012). Little is known about the mental health and wellbeing of other communities such as the Chinese, Vietnamese and recent arrivals from EU Accession countries. There are also some fundamental differences, both culturally and economically, between different ethnic groups which will give rise to different mental health needs within each group. These need to be fully understood to ensure appropriate services are commissioned for all BAME groups.

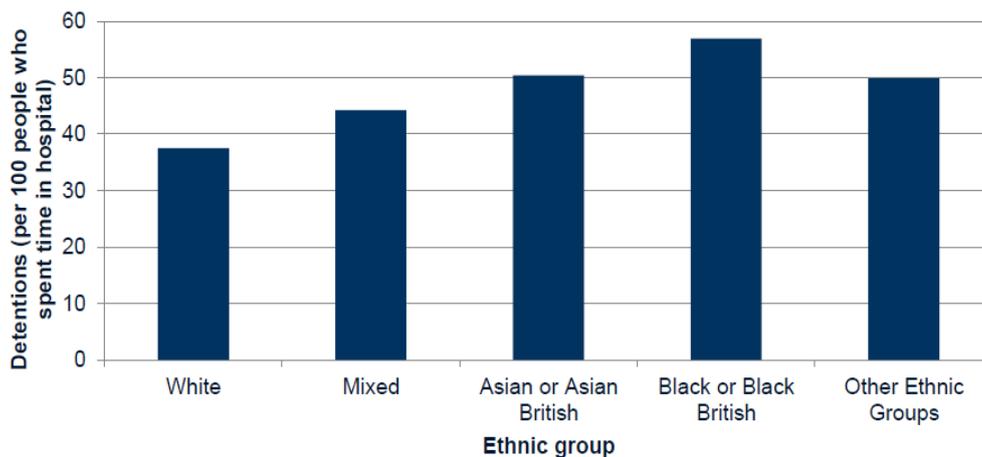
According to annual statistics published by the Health and Social Care Information Centre (2015), of the 1,834,910 individuals who were in contact with mental health and learning disability services in that year, 25.9% (n=475,242) came from BAME ethnic groups. Admission rates were much higher in Black ethnic groups and consistently lower in Chinese and Indian groups than the average (see figure 18 below).

Figure 18: Standardised rates of people using mental health and learning disability services and people who spent time in hospital in the year, by ethnic group, in England, 2014/15



Source: [Mental Health Bulletin: Annual Statistics 2014-15](#), Health and Social Care Information Centre (2015)

Figure 19: Rates of detention under the Mental Health Act 1983, per 100 people who spent time in hospital due to mental ill health by ethnicity, in England, 2014/15



Source: [Mental Health Bulletin: Annual Statistics 2014-15](#), Health and Social Care Information Centre (2015)

A similar pattern can be seen for rates of detention under the Mental Health Act (1983) across the different ethnic groups in 2014-15. Black ethnic groups were particularly affected, being more than 50% more likely to be detained than the White population (see figure 19 above). Other data suggests higher detention rates for Black African (2.2 times higher), Black Caribbean (4.2 times higher) and Black Other (6.6 times higher) groups (Care Quality Commission, 2014).

Disproportionate levels of mental ill health and suicide are features within the Irish/Gypsy and Traveller Communities too (Parry et al., 2007; Cemlyn et al, 2009). The Care Quality Commission (2010) data shows that Irish people aged 50 years and over have the highest rates of admission to mental health establishments, with a significant proportion of these also having a physical disability.

Maynard et al. (2012) asserted that suicide levels among Irish people have been consistently high for several decades and have not shown the decline seen in other populations. In addition, suicide deaths among Irish Travellers in prisons were sufficiently high in 2000 to prompt an inquiry (Commission for Racial Equality, 2003).

Dementia

Alzheimer's UK (2016) describes dementia as a set of symptoms that include memory loss and difficulties in cognition and language, which is caused when the brain is damaged by diseases such as Alzheimer's disease, a series of strokes or the narrowing of the arteries. As well as cognitive issues, a person with dementia may also experience changes to their moods or experience hallucinations. It is a progressive condition, which means the symptoms will gradually get worse. This progression will vary from person to person and each individual will experience dementia in a different way.

An All-Parliamentary Party Group (APPG) report (2013), [Dementia does not discriminate](#), estimated that in 2013, there were around 25,000 people from BME communities living with dementia in England and Wales, with projections estimating that this will rise to nearly 50,000 by 2026. More recently, the Race Equality Foundation (2016) estimated that this figure had reached 40,000.

The All-Parliamentary Party Group (2013) suggested that people from BAME communities are under-represented in dementia services and are less likely to be diagnosed or are diagnosed at a later stage.

People from BAME communities, more specifically Asian and Black Caribbean communities, are also likely to be at an increased risk of developing dementia, as the associated risk factors for dementia, (such as high blood pressure, diabetes, stroke and heart disease) are more prevalent in these groups.

As a demographically older population, there are an estimated 10,000 Irish people living with dementia in the UK (Truswell, 2013).

Smoking

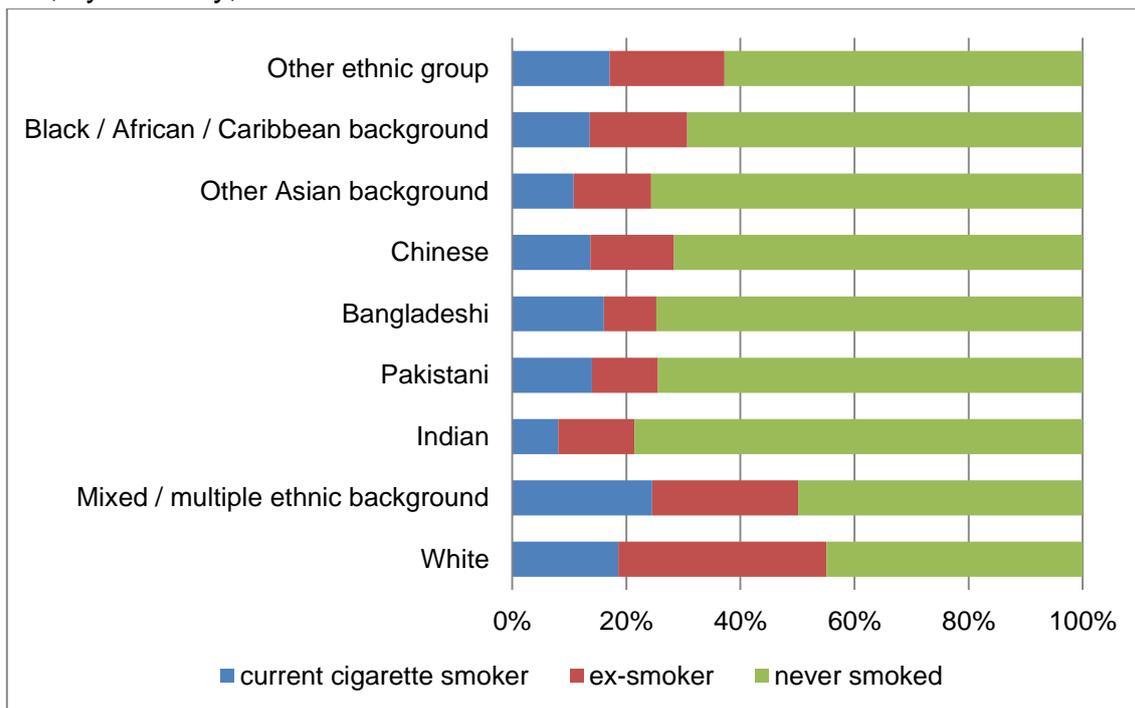
Smoking is more common among some ethnic groups than others and there are some forms of tobacco use that are only prevalent in BAME groups. In terms of smoking tobacco, the Health Survey for England 2004 (Health and Social Care Information Centre, 2006) showed that self-reported prevalence was highest in Bangladeshi men (40%), Irish men (30%) and Pakistani men (29%). Black Caribbean men (25%) were close to the national average (24%) with Black African/Chinese (21%) and Indian men (20%) least prevalent.

For women, smoking prevalence in the general population (23%) was higher than all of the other ethnic groups, with the exception of Irish (26%) and Black Caribbean (24%) women. Smoking was least prevalent among women in Black African (10%), Chinese (8%), Indian/Pakistani (5%) and Bangladeshi (2%) ethnic groups.

After adjusting the survey data for socioeconomic status, Karlsen et al. (2012) found that rates of smoking for Pakistani men and Black Caribbean women were significantly lower than those of White people. Patterns of smoking in Pakistani men, Black Caribbean and White ethnic groups appear more stable over time than those of other groups.

As with the general population, smoking prevalence in BAME groups tends to decrease with age with the highest rates in those aged 16-34. There are some exceptions though, such as Black Caribbean and South Asian men for whom prevalence is highest in those aged 35-54.

Figure 20: Proportion of current/former smokers and people who have never smoked in England, by ethnicity, 2014



Source: [Smoking prevalence by Sex and Ethnicity 2014](#), Office for National Statistics (2015)

However, it's not just smoking cigarettes that pose a health risk for BAME groups. Other methods of tobacco use, such as pipes, cigars, bidis and shishas, all carry increased risks of lung, mouth, oesophageal and stomach cancers (Aki et al., 2010; O'Connor, 2012). These methods are much more closely associated with some BAME cultures, as is the practice of chewing tobacco, which is common among Bangladeshi women

Tobacco chewing can also be combined with other substances, such as the areca nut wrapped in a betel palm leaf, sometimes flavoured with additional spices. Commonly known in various forms as betel nut or ghutka, this practice is prevalent in British Asian communities. The combination of areca nut and betel leaf acts as mild stimulant but it is carcinogenic, causing a range of health problems including mouth and oesophageal cancer (Warnakulasuriya et al., 2002). Itagi et al. (2016) also suggested a link with increased CVD risk.

Once again, data appertaining to tobacco use within local BAME communities is poor and data relating to their engagement with smoking cessation services is unreliable due to the low numbers coming through the service (see table 10 below). Of the 2,777 individuals engaged with smoking cessation services in 2015/16, only 157 came from BAME groups (Health and Social Care Information Centre, 2016b). This supports comments made in previous iterations of this chapter about the particular difficulties of engaging BME communities in health promotion and preventative measures (Icarus, 2010).

Table 10: Smoking Cessation – Number of Successful Quitters ¹ by Ethnic Group ², 2015-16

| Ethnicity ² | No setting a quit date | No of successful quitters ¹ (self-reported) | Success rate (%) |
|------------------------|------------------------|--|------------------|
| All Ethnic Groups | 2,777 | 1,382 | 34 |
| White | 2,276 | 1,198 | 35 |
| Asian or Asian British | 52 | 23 | * |
| Black or Black British | 5 | 3 | * |
| Mixed | 88 | 38 | * |
| Other Ethnic Group | 12 | 7 | * |
| Not stated | 344 | 113 | 27 |

Source: [Statistics on NHS Stop Smoking Services 2015-16](#), NHS Digital (2016b)

Notes:

1. A client is counted as having successfully quit smoking at the 4 week follow-up if he/she says they have not smoked at all since two weeks after the quit date.
 2. These categories are based on those used for the 2001 census. Further guidance on collecting ethnicity category data is available from: http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/publicationsandstatistics/publications/publication/spolicyandguidance/browsable/dh_5319155
- * suppressed where the denominator is greater than 0 and less than 20, as it is deemed the resulting percentage output is not robust enough for comparative purposes.

Substance Misuse

The National Drug Treatment Monitoring System (NDTMS) and Alcohol Treatment Monitoring System (ATMS) offer one of the more reliable data sources, given the considerable investment in these systems nationally, over many years. The data presented in tables 11 and 12 below, gives an indication of the numbers of people in drug (2005-14) and alcohol treatment (2009-14) by ethnic group over a number of years.

Table 11: Numbers of Wirral People in Drug Treatment by Ethnic Group, 2005-14

| Numbers in Drug Treatment | 2005-06 | 2006-07 | 2007-08 | 2008-09 | 2009-10 | 2010-11 | 2011-12 | 2012-13 | 2013-14 |
|---------------------------|---------|---------|---------|---------|---------|---------|---------|---------|---------|
| White | 2470 | 2640 | 2732 | 2685 | 2499 | 2424 | 2435 | 2336 | 2295 |
| Black/Black British | * | 5 | 5 | 7 | 10 | 10 | 10 | 7 | 7 |
| Asian/Asian British | 6 | 6 | * | * | * | * | * | * | * |
| Mixed | 6 | 7 | 8 | 17 | 12 | 11 | 10 | 9 | 7 |
| Other | 6 | * | * | 0 | 0 | * | * | * | * |
| Missing or Unknown | 5 | 5 | * | * | 7 | 12 | 10 | 8 | 10 |

Source: National Drug Treatment Monitoring System (2017)

Note: * indicates that these numbers have been suppressed.

Table 12: Numbers of Wirral People in Alcohol Treatment by Ethnic Group, 2009-14

| Numbers in Alcohol Treatment | 2009-10 | 2010-11 | 2011-12 | 2012-13 | 2013-14 |
|------------------------------|---------|---------|---------|---------|---------|
| White | 1353 | 1323 | 1195 | 1145 | 1342 |
| Black/Black British | * | * | * | * | * |
| Asian/Asian British | * | * | * | * | * |
| Mixed | * | 6 | * | * | * |
| Missing or Unknown | 180 | 155 | 276 | 183 | 31 |

Source: National Drug Treatment Monitoring System (2017)

Note: * indicates that numbers under 5 have been suppressed.

Although some of the data has been suppressed, it is possible to approximate that in 2013-14; at least 98.6% of people accessing drug treatment services belong to White ethnic groups. Both Black and Mixed ethnic groups made up roughly 0.3% of the people in treatment and Asian and Other Ethnic groups represented less than 0.17% of the drug treatment population. Likewise, for alcohol, each ethnic group made up no more than 0.3% of the alcohol treatment population while White ethnic groups formed the majority at a conservative estimate of 96.9% as a minimum.

Data from taken from the [Crime Survey for England Wales 2013-14](#) suggested that Mixed ethnic groups (14.3%) were more likely to have engaged in illicit drug use than any other ethnic group and Asian groups (2.5%) were least likely (Home Office, 2014). This compared to reported illicit drug use among White (8.4%), Chinese (5.4%) and Black (4.7%) ethnic groups.

Although somewhat dated, Hurcombe et al.'s (2010) review of the literature concerning alcohol and ethnicity produced some interesting results. Generally, BAME groups tend to have higher rates of abstinence and lower levels of alcohol use than White ethnic groups. Of all BAME groups, people from mixed ethnic backgrounds were less likely to abstain and more likely to drink heavily than any other.

As far as risk is concerned, individuals from Chinese, Irish and Pakistani groups tend to drink above recommended limits in higher income households. Alcohol-related deaths are higher than average within the Irish and Scottish populations and in Indian men, while Sikh men suffer higher levels of liver cirrhosis. Hurcombe et al. (2010) suggested that problematic alcohol use could well be hidden among some BAME communities and a greater understanding of cultural issues is necessary when developing mainstream and specialist alcohol services.

Locally, the situation seems very similar to the national picture. While BAME groups may be generally underrepresented in Wirral's drug and alcohol services, nevertheless there is evidence of drug and alcohol use in BAME communities. Workshops conducted by Public Health in 2013 revealed a level of hidden drug and alcohol used among BAME communities, even in those with cultural and/or religious concerning such practices.

Evidence from the workshops suggested that fear of being ostracised by their own communities could be preventing some BAME groups from revealing their drug /alcohol use by accessing treatment services.

Disability

Over 12 million, approximating to 1 in 5 people in the UK consider themselves as disabled, a figure which has remained fairly constant over time (Department of Work and Pensions, 2014). The prevalence and profile of disability varies with ethnicity, with White ethnic groups almost twice as likely to have a life-limiting disability as BAME ethnic groups (Office of National Statistics, 2014).

According to 2011 Census data, White Irish reported the biggest proportion of people with long-term health issues or disability (26%) than any other ethnic group (Papworth Trust, 2014). There is however, evidence within other studies that Indian Asian people are significantly more likely to experience higher rates of disability than White European groups (Williams et al., 2012).

Palliative care

With the number of BAME individuals over 65 years of age set to treble in the coming years, uptake of palliative care services among BAME groups is low (Calanzani et al., 2013). Lack of knowledge and information about these care pathways was cited as an underlying cause of low referrals, as was an assumption that culturally, BAME family members would not 'give up' on the dying and elect to care for their loved ones at home.

For those BAME individuals who did access to such services, a range of factors were cited as affecting outcomes relating to end of life care. Poor communication between professionals, patients and family members and a lack of cultural sensitivity were mentioned as having a detrimental effect on patient and family members' experiences of end of life care.

Tuberculosis (TB)

TB is a bacterial infection that generally attacks the lungs and can be fatal if left untreated. There has been a year-on-year decline in the number of TB cases in recent years, down to 5,758 cases reported in the UK in 2015, an incidence of 10.5 cases per 100,000 (Public Health England, 2016a). By comparison, there were only 9 recorded cases in Wirral in the same year, equating to a much lower incidence of 2.8 cases per 100,000 population.

Maternal Health

According to the Office of National Statistics (2015b), infant mortality within the general population in 2013 stood as 3.8 deaths per 1,000 live births. In comparison, Pakistani, Black Caribbean and Black African infant mortality rates were 6.7, 6.6 and 6.3 deaths per 1,000 live births respectively.

The UK Confidential Inquiry into Maternal and Child Health reported a fivefold difference between the lowest rate of maternal deaths within the White population and the highest within the Black African population (Knight, 2008). Severe maternal morbidity followed a similar pattern, with incidence much more common in Black African and Caribbean pregnancies than in the White population.

Sexual Health

Surveillance evidence shows that ethnic minority groups are disproportionately affected by sexually-transmitted infections (STIs). Rates of infection among BAME groups for gonorrhoea and chlamydia were 3 times greater than the general population and 9 times greater for trichomoniasis (Public Health England, 2016b). Many STIs have long-term effects on health, for example chlamydia can lead to infertility and some infections are associated with cervical cancer (Department of Health 2013).

Variations in rates of diagnosed STIs have been observed in numerous research studies (Fenton et al., 2005; Gerressu et al., 2012; Woestenburg et al., 2015). Fenton et al. (2005) detected lower rates of STIs among Indian/Pakistani groups and higher rates among Black African/Caribbean groups than in the general population.

Exploring the attitudes and behaviours of BAME youths towards sex, Testa and Coleman (2006) noted lower levels of sexual health knowledge among BAME groups compared to White British groups, particularly for the Asian ethnic groups.

There is local evidence of cultural differences between BAME groups where sexual health is a 'taboo' subject and not talked about openly (Icarus, 2010). This has been manifested in the low number of individuals from BAME groups who access sexual health services on Wirral. 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.

Young BAME men, from Black and Asian communities on Wirral are unlikely to access contraception and screening services. Given such variation between and within different ethnic groups in terms of their sexual health risks and needs, Fenton et al. (2005) highlighted the need for targeted and culturally appropriate services to address these differences.

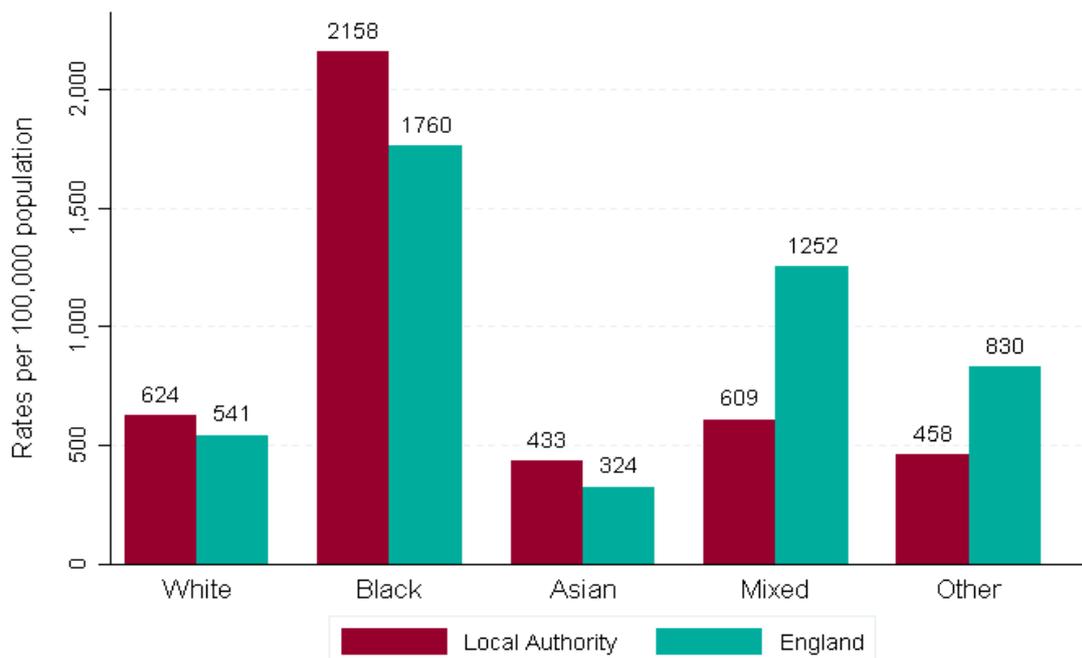
Locally, some BAME groups are proportionally overrepresented in new STI diagnoses in Wirral in 2015, compared to the rest of the UK (see table 13 and figure 21 below). However, caution should be applied when interpreting these figures, due to the small size of the overall BME population in Wirral.

Table 13: Number and proportion of new STIs by ethnic group, Wirral, 2015

| Ethnic Group | Number | % |
|------------------------|--------------|-------------|
| White | 1,935 | 96.5 |
| Black or Black British | 15 | 0.7 |
| Asian or Asian British | 15 | 0.7 |
| Mixed | 20 | 1.0 |
| Other ethnic groups | 10 | 0.5 |
| Not specified | 10 | 0.5 |
| Total | 2,005 | 100% |

Source: Wirral Local Authority HIV, sexual & reproductive health epidemiology report (LASER), PHE England (2015)

Figure 21: Rates* per 100,000 population of new STIs by ethnic group in Wirral and England (specialist SHC diagnoses only): 2015



Source: Data from specialist sexual health clinics
 Excludes chlamydia diagnoses made outside specialist SHCs
 Rates based on the 2011 ONS population estimates
 *Please note that to prevent deductive disclosure the number of STI diagnoses used to calculate the rates in this figure has been rounded up to the nearest 5

Source: Wirral Local Authority HIV, sexual and reproductive health epidemiology report (LASER), Public Health England (2015)

Notes: A small BME population in Wirral means rates can be subject to large fluctuations year on year and this should be borne in mind

- In 2015 Wirral had higher rates of new STI diagnosis in the whole population than comparator authorities
- Despite Wirral having a very small BME population, which can skew results somewhat, there was a broadly similar pattern to the overall England, e.g. highest rates in the Black/Black British population, lowest rates in the Asian/Asian British population
- The proportion of affected BAME population in Wirral who were migrant and transient is unknown
- Where recorded, 2.5% of all new STI diagnoses in Wirral in 2015 were from BAME groups (5% of the Wirral population overall were from BME groups)
- Recommendations from Public Health England and the Royal College of General Practitioners advise that all new GP registrations in all high risk populations and areas should be offered and encouraged to have a full STI test.

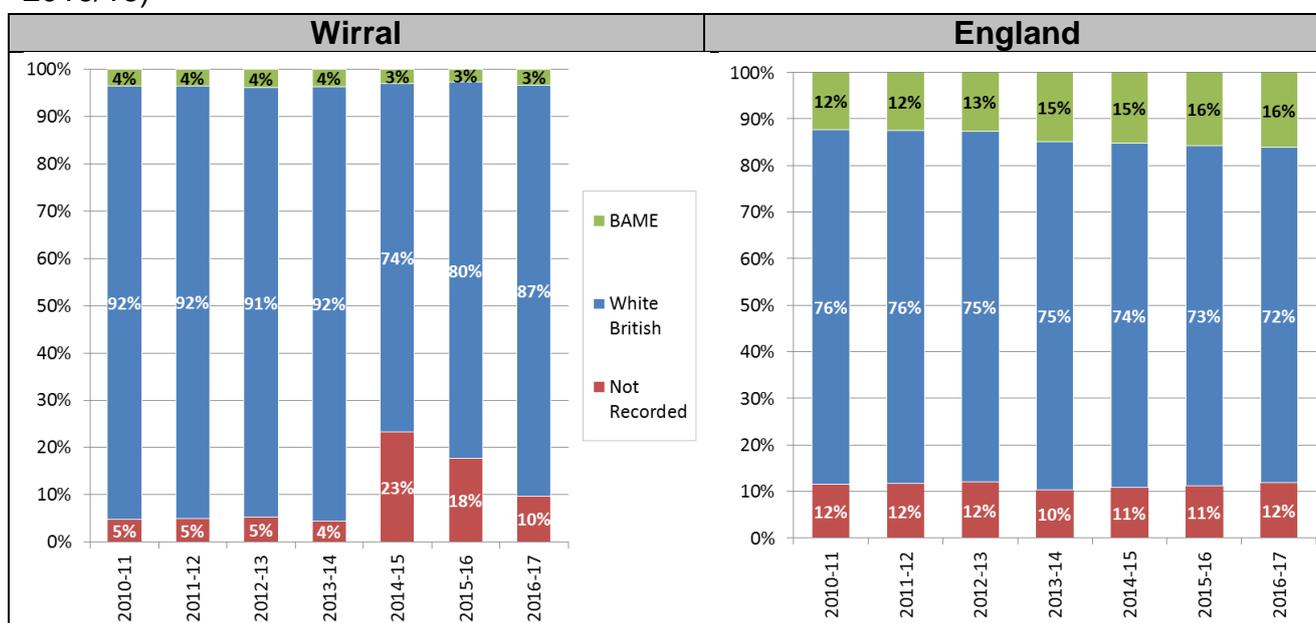
Primary care

Recording of ethnicity information has improved in primary care in Wirral in recent years; three-quarters (74.4%) of all GP records now contain an ethnicity code (as of December 2017), compared to less than 40% of records ten years ago. There is still room for improvement, for example in data quality. Next steps will be to conduct analysis looking at ethnicity and ill-health (e.g. with emphasis on those long term conditions known to be more prevalent in certain BAME groups such as diabetes in the south Asian population).

Acute (secondary) care

Recording of ethnicity on Hospital Episode Statistics (HES) data has been more variable in Wirral than is the case nationally. See Figure 22a and 22b below.

Figure 22a and 22b: Trend in recording of ethnicity: Wirral and England (2010/11 – 2016/16)



Source: HES, 2017

As the figure above shows, in 2016/17, the number of HES records with no recorded ethnicity in Wirral was 10%, slightly better than nationally (12%). HES records show data on hospital admitted patients, outpatients and A&E attendances in England and the data from HES shown above roughly correspond with Census data on ethnicity. It shows that only 3% of HES records in Wirral were in the BAME population, compared to 16% nationally. HES data does not indicate prevalence, but can be used to indicate emergency attendances for certain conditions and now that data quality has improved more in-depth analysis can be conducted on the data.

Service Data

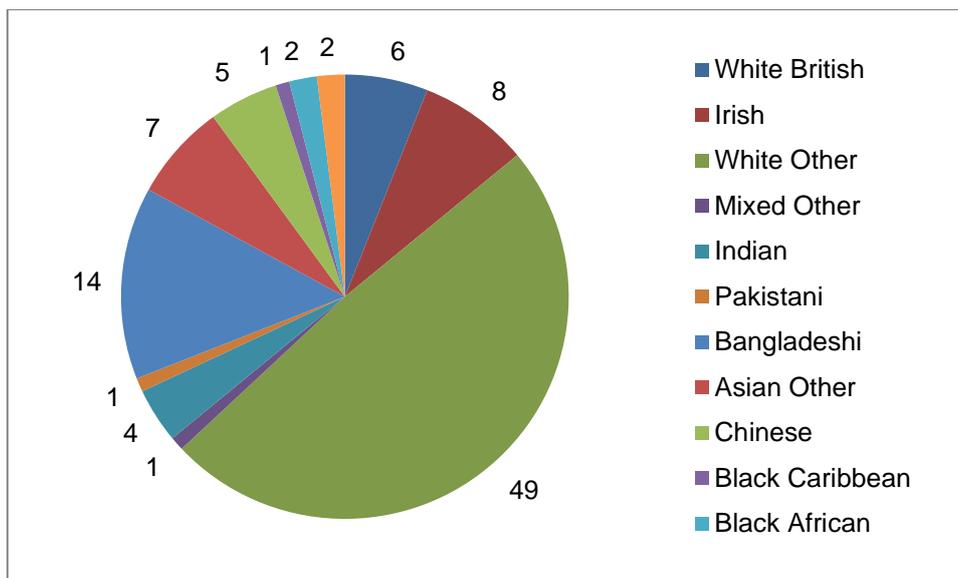
In recognition of the barriers faced by BAME communities in accessing mainstream services, Wirral Council currently commission a consortium of provider organisations to engage with local BAME Communities in order to improve access to local health services. In doing so, it is intended that this service will improve the health and wellbeing of BAME groups and reduce local health inequalities between different ethnic groups.

In addition to this provision, some of these organisations also offer a range of additional advice, information, support and advocacy services in other areas (such as housing and employment) that will undoubtedly have an impact on health and wellbeing. The following data represents a summary of all of the activities to support local BAME communities in 2015-16.

Demographic Profile of Clients in Service

The BAME Health Improvement Service engaged with 483 individuals in 2015-16, of which 51% were male and 49% were female. The ethnic profile of clients is represented in figure 18 below and over 50 nationalities were represented within their countries of origin.

Figure 233: Ethnic Profile and Proportions of the Clients Accessing the BAME Health Improvement Service in 2015-16



Source: Wirral Change (2016)

As this chart shows, the service caseload in this year is predominately made up of White other ethnic groups, which make up almost half of all clients supported. This group is likely to be predominately made up of Eastern European migrants who are looking for work. The Asian ethnic group is the next largest group, making up 27% of the caseload, comprising Bangladeshi (14%), Chinese (5%), Indian (4%) and Pakistani (1%) individuals.

Comparing the reach of this service to the proportional representation of the local BAME population of Wirral, it is evident that while caseload is fairly representative of the local BAME population, it is markedly different for some ethnic groups. Table 13 below compares the proportional representation of each ethnic group within Wirral's BAME population against that of the service caseload. Broadly speaking, the caseload should be representative of the proportional representation of each BAME group within the local population (after discounting White British on the grounds that this group is not an intended recipient of this service),

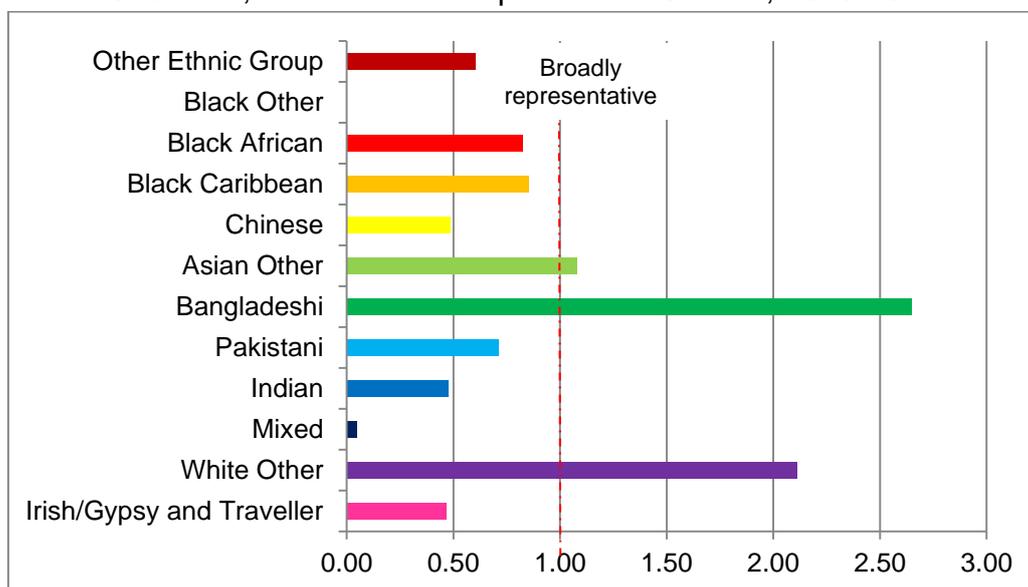
Table 14: Comparison of the Service Caseload Profile against Wirral's BAME Population by Ethnic Group, 2015-16

| Ethnic Group | 2011 Census Data (N) | % BAME Population | % 2015-16 Caseload | Difference by Factor ¹ |
|---------------------------|----------------------|-------------------|--------------------|-----------------------------------|
| Irish/Gypsy and Traveller | 2744 | 17.04 | 8 | 0.47 |
| White Other | 3730 | 23.17 | 49 | 2.12 |
| Mixed | 3286 | 20.41 | 1 | 0.05 |
| Indian | 1344 | 8.35 | 4 | 0.48 |
| Pakistani | 226 | 1.40 | 1 | 0.71 |
| Bangladeshi | 851 | 5.29 | 14 | 2.65 |
| Asian Other | 1042 | 6.47 | 7 | 1.08 |
| Chinese | 1653 | 10.27 | 5 | 0.49 |
| Black Caribbean | 189 | 1.17 | 1 | 0.85 |
| Black African | 389 | 2.42 | 2 | 0.83 |
| Black Other | 117 | 0.73 | 0 | 0.00 |
| Other Ethnic Group | 530 | 3.29 | 2 | 0.61 |
| Total | 16101 | 100.00 | - | |

Source: Wirral Change (2016)

¹n=1 where caseload is an exact match for the proportional representation for that ethnic group within the local BAME population.

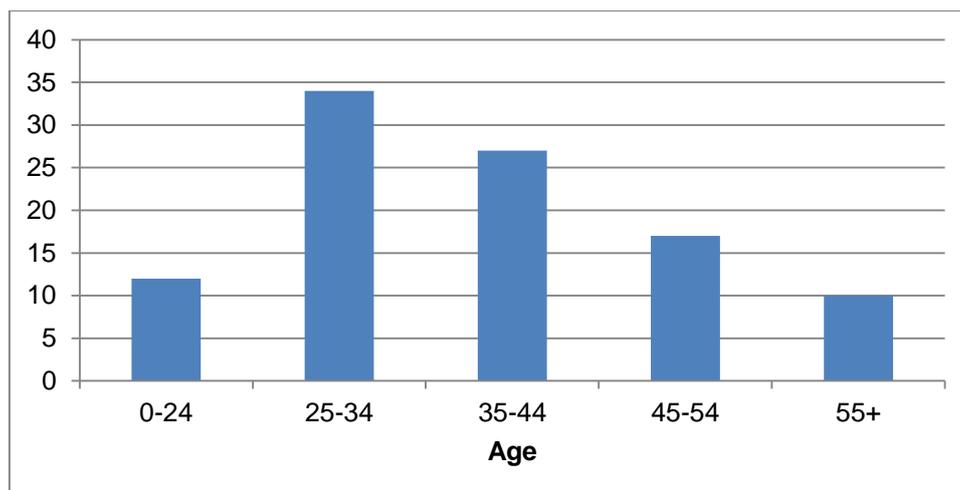
Figure 244: Comparison of the Degree to which Each Ethnic Group is under- or over-represented on Caseload, BAME Health Improvement Service, 2015-16



Source: Wirral Change (2016)

As figure 21 shows, White Other and Bangladeshi groups are overrepresented, with over twice as many of these clients engaged as might be expected. The opposite is true for Black Other, Chinese, Indian, Mixed and Irish/Gypsy and Traveller ethnic groups who are clearly underrepresented within the service. While caution should be exercised due to the potential for bias/fluctuations with such small numbers on caseload, this comparison clearly illustrates the need for some ethnic groups to be prioritised and further work to be undertaken to engage those groups.

Figure 255: Age Profile of the Clients Accessing Wirral BAME Health Improvement Service



Source: Wirral Change (2016)

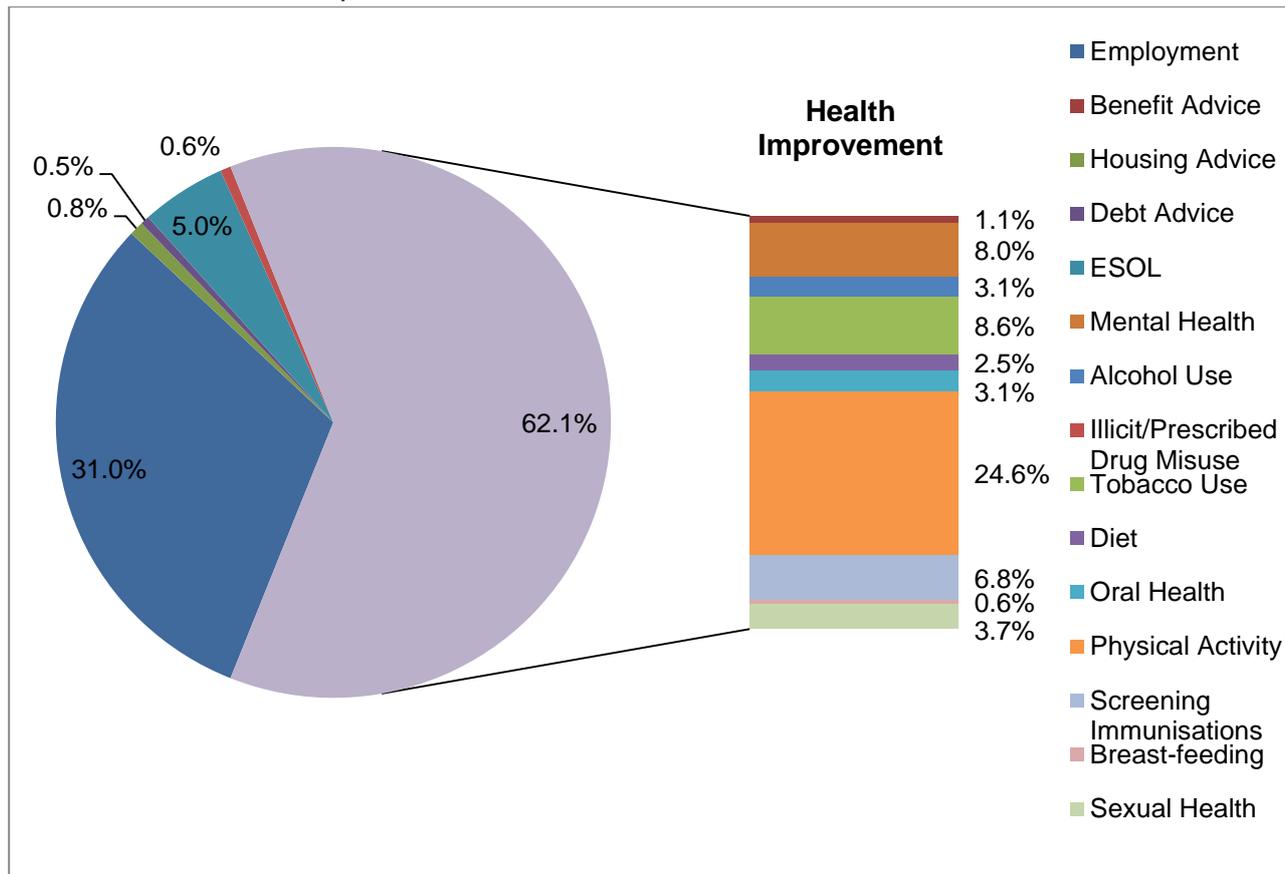
Figure 25 shows the breakdown of clients on caseload by age, with a third of these aged between 25 and 34 years of age.

The Health Improvement Service reported that of the clients engaged with the service in 2015-16, 38% classified themselves as economically inactive (e.g. students, carers, long-term sick and disabled, etc.). A further 46% of clients were employed and 15% were unemployed but fit for work. At least 1 in 5 clients were not registered with a GP on presentation to the service.

BAME individuals presenting to the Health Improvement Service cited a range of barriers which prevented them from engaging with mainstream services to have their health needs met. These included a lack of client awareness about some specific health conditions and the services available locally to treat them. Difficulties with language and communication, as well as a mistrust of mainstream services were also mentioned. Clients also suggested that cultural sensitivities around some health conditions made some clients fearful of disclosure, worried that they might be stigmatised, either by professionals within services or by their own communities.

As a result of these barriers, some BAME individuals expressed their reluctance to engage with mainstream services. This is evident within the service data, which indicates that although there were a range of presenting issues, the majority of BAME individuals were seeking support in respect of their health (see figure 23 below).

Figure 26: Profile of Presenting Needs of BAME Community, including those relating to Wirral BAME Health Improvement Service



Source: Wirral Change (2016)

Client Outcomes

The following outcomes were reported by the service in 2015-16:

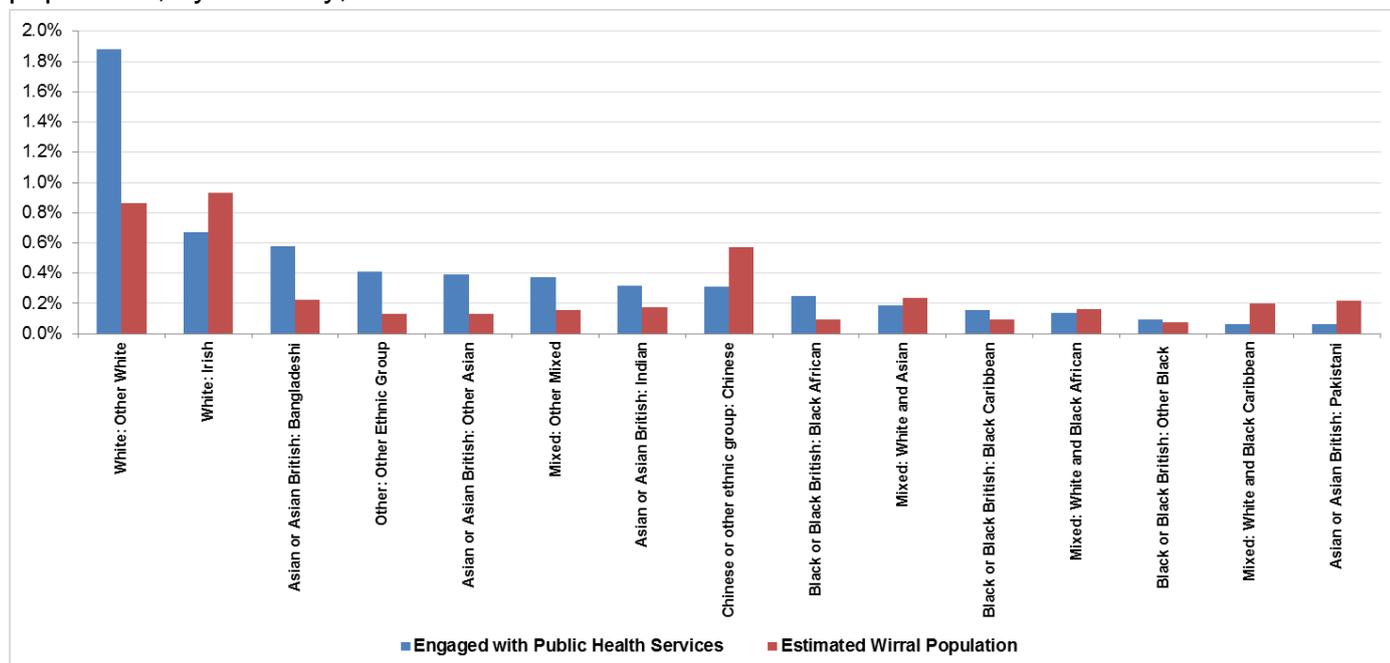
- 136 people supported employment
- 250 enrolled into Education Services Overseas Ltd (ESOL) courses to improve their language skills
- 123 gained life skills
- 693 improved their awareness of health and wellbeing through attendance at health campaigns
- 486 accessed Level 1 health intervention (advice and guidance).
- 229 accessed Level 2 health intervention (care plan and referral).
- 80% reported improvements with their health and wellbeing
- 75 supported with drug and alcohol issues and 145 families and carers offered advice
- 456 smokers supported and set a quit date; 232 self-reported 4 week quitters status and 174 sustained smoking cessation for 12 weeks
- 28 entered volunteer roles
- 37 developed skills and experience via voluntary work.

Equity Audit of all Public Health commissioned services

Equity audit aims to identify how fairly services or other resources are distributed in relation to the needs of different groups and areas and can inform the process of bringing about changes in investment and services that could reduce avoidable health inequalities, improve the determinants of good health.

The overall aim is not to distribute resources equally, but equitably, i.e. according to need. In 2017, Wirral Public Health Team carried out an equity audit of all its commissioned services, in order to check that they were targeting at risk and populations in need equitably. Ethnicity was one of the characteristics that the Equity Audit examined and analysis indicated that some groups were more likely to engage with services than their numbers in the population might have suggested (Other White), whilst others were less likely than might be expected (White Irish, Chinese).

Figure 27: Proportion of people engaged with Wirral Public Health Services and Wirral population, by Ethnicity, 2016/17



Source: Wirral BAME population projections, EthPop, 2016

The chart shows clients from the Black, Asian and Minority Ethnic (BAME) communities only, as including the 94.4% White British population engaging with PH services, compared to 5.6% from the BAME background would make the BAME groups difficult to see on the chart. Compared to the estimated Wirral BAME population of 4.6% and the 2011 census BAME population of 5.1%, data from the services indicates that this shows services are engaging with the BAME community, more than both the two estimates.

The largest BAME group engaged with Public Health services (just under 2% of the total BAME contacts) were the White: Other White group (other data indicates this group are mainly comprised of the Polish community). The White Irish and Chinese populations were amongst those ethnicities under-represented in engagement with Public Health; White Irish, 0.7% engaged with services compared to an estimated 0.9% of the Wirral population, and Chinese; 0.3% engaged with services compared to an estimated 0.6% of the Wirral population.

Local Stakeholder Views

In 2015, Wirral Council's Public Health team commissioned a programme of research to gain a better understanding of the health and wellbeing needs of the general population in Wirral. This research used an ethnographic approach to explore participants' perspectives about their health and wellbeing needs and how best they could be met.

The most recent thematic area to be explored within the research programme was the health and wellbeing of local BAME Communities. Over 80 BAME residents from different ethnic backgrounds were interviewed across all four constituency areas. Their ages ranged from 7 to 85 years of age and the time they had spent living in the UK ranged from 2 months to their entire lives. Consistent with findings from the research with the wider population, many long-term BAME residents struggled with negative feelings and pessimism about their future, particularly those who felt their options had narrowed (e.g. through employment or illness). This sometimes led to a sense of hopelessness for themselves, their families and their neighbourhood. Often, these BAME residents felt that the gap between their current circumstances and where they wanted to be was too great to overcome and as a result, they felt unable to make positive changes in their lives.

In comparison, most newcomers to the UK (e.g. new migrants) were much more optimistic, seeing the UK as a place of opportunity, prosperity and hopefulness. Many were taking proactive steps to take advantage of a fresh beginning. Yet some new migrants could not see the immediate incentive for engaging in healthy behaviours, preferring to prioritise other factors which were directly affecting their lives in the here and now.

There was also an apparent sense of fatalism among some ethnic groups, caused by the widespread prevalence of certain health conditions in those groups (e.g. diabetes in South Asian Communities). This fatalism, along with the stigma associated with some health conditions (e.g. mental health and sexual health) sometimes led to a delay in preventative actions being taken for better health.

One of the key findings of the research programme was the lack of connectivity and cohesion across different ethnic groups in Wirral. Many individuals, including more longstanding residents were comfortable when socialising as part of a specific and homogeneous ethnic network but were unwilling to explore groups further afield. As a result, BAME groups tended to have more limited social networks on which they could call upon for support. In turn, this led to a sense that some BAME groups had become overly reliant on professionals to meet their health and social needs. This was particularly apparent for BAME newcomers to the UK, where many experienced significant language barriers. Isolated by language, they often described themselves as feeling like outsiders and not integrated with the local population.

Additionally, some BAME individuals felt that local service provision could be interfering and judgemental at times. Some individuals preferred to access BAME-specific services, believing that mainstream services discriminated against them. At the same time, some mainstream service providers recognised the fact that they lacked the confidence to work with BAME groups. However other BAME individuals (particularly those who were more settled and integrated) felt that BAME specific services did not represent their own interests and instead reinforced narratives of difference and division. New arrivals to the

UK tended to rely on family and friends rather than services for support but this sometimes led to vulnerability and being victimised.

Overall, the research findings highlighted that all individuals can benefit from encouragement and reminders to improve their wellbeing but this must be appropriate to their individual circumstances. As such, the research suggested that local service provision should span three different levels of support:

- **Universal Experience:**

Everyone needs a little encouragement now and again to help with minor and/or transitory health and wellbeing challenges, controlled primarily through self-management.

- **Ongoing Challenge:**

Individuals make a concerted effort to get out of a rut and back on track. Individuals may have some ongoing health and wellbeing challenges (e.g. mental health decline or segregated individuals with limited social networks).

- **Acute Challenge:**

Support for those who are most in need and have acute health and wellbeing needs and maybe in crisis (e.g. new migrants with traumatic story, individuals at point of mental health breakdown).

The research made the following series of recommendations, to improve health and wellbeing of BAME residents:

1. Myth busting is needed around health stigmas and genetic fatalism amongst certain cultures.
2. Avoidance of labels that increase a sense of difference between cultures (BAME Vs non-BAME).
3. BAME services need to link up with mainstream groups/services better to improve links between specialist services and mainstream provision.
4. Organisation and promotion of open cultural events across the borough to encourage integration.
5. Increasing cultural understanding for front line staff, to increase their confidence to have conversations with individuals from the BAME population.
6. Monitoring and measurement of BAME data through contract management to build robust data sets to help improve local intelligence around our BAME communities.
7. Language services commissioned to enable people to make friendships as a priority and expand their social networks.
8. Intensive specialist support available especially for new asylum seekers and individuals in crisis.

A full copy of the [toolkit](#) can be found on the [Wirral Intelligence Service Website](#)

Improving Access to Healthcare for BAME Communities

There are a number of areas for action which should be prioritised in order to improve the health of BAME groups in Wirral.

Improving Data Quality

The most prominent issue that arose, both within the literature review and throughout this needs assessment process, is the insufficiency of data which can be used to inform the commissioning cycle. Several studies across different health domains were consistent in their assertion that commissioners need to '*know*' their local population by ensuring effective data collection and analysis, as a means of mobilising local evidence in relation to ethnicity and health (Bharj and Salway, 2008; Salway et al., 2013; Joint Commissioning Panel for Mental Health, 2015).

In reality, Salway et al. (2013) suggested that building the local evidence base with regard to ethnicity and health was often hampered by several factors. These included: (1) a lack of basic information about the size of local BAME populations, (2) incomplete monitoring of ethnicity data, (3) a lack of published evidence concerning the effectiveness/cost effectiveness of interventions and (4) a lack of awareness about other relevant data sources (e.g. research, reports, surveys, etc.). This meant that commissioners often opted '*...to start from scratch*' in relation to building a local evidence base.

While this picture is not exclusive to Wirral by any means, a significant improvement in data quality and completeness is vital in order to understand the full picture of BAME need in Wirral. Under Section 149 of the Equality Act (2010), commissioners have a duty to take action to monitor and reduce health inequalities between different ethnic groups. This includes having effective systems in place for data collection, as well as ensuring that BAME individuals are consulted and involved in planning services to meet their needs. In order to avoid any future repetition of starting the BAME needs assessment process '*...from scratch*', it is imperative that local commissioners take the necessary steps to review all aspects of data collection and monitoring in relation to ethnicity, including the frequency of local audit to ensure data compliance.

Engaging with BAME Communities

Some commentators have suggested that BAME individuals may be less inclined to seek treatment, as a result of feeling stigmatised (Cooper et al., 2012; Owuor and Nake, 2015). Cultural pressures and ideology can lead to feelings of shame, particularly in respect of sensitive areas, such as sexual health, mental health and drug/alcohol abuse (Weerasinghe, 2012). In turn, this can lead to a reluctance among some BAME individuals to access services, as a result of feeling pressured to '*save face*' in order to maintain their social status (Mereish, 2012).

Additionally, BAME individuals may feel stereotyped and discriminated against by service provision that lacks cultural competence and treats all minorities as a single homogenous group. Cooper et al. (2012) asserted that such treatment is unhelpful, as it breeds mistrust and can lead to a lack of engagement or late presentation to services. Poor communication can also compound the situation further, leading to a lack of understanding on the part of some BAME individuals about specific health conditions and the resources available to treat it.

There are a number of case studies, cited by The Health Foundation (2011) and The NHS Confederation (2013), in which different approaches were used to engage local BAME Communities to good effect in different health settings from across the UK. Despite differences of approach, however, there were a number of common themes to emerge.

A number of these projects focussed on developing the cultural competence of healthcare staff (see below) as part of the wider implementation of each project. In some cases, health information was made available in languages appropriate to the communities involved, either through leaflets and the use of interpreting services. In addition, one project innovatively overcame communication barriers by producing health information diagrammatically. These common themes served to encourage an open dialogue with the BAME Communities involved.

It was also evident from the case studies that healthcare services had fully involved local BAME Communities in service planning and implementation, whether this was directly or through an intermediary community organisation(s). Working closely alongside BAME Communities, healthcare services used a range of approaches, such as appreciative inquiry and co-production, to develop provision that was tailored to the specific needs of the target BAME groups involved. In each case study, healthcare services were able to achieve greater engagement with BAME groups, which inevitably led to better health outcomes. Moreover, many of these approaches used to achieve these better health outcomes were consistent with principles of best practice in community engagement, as cited by NICE (2016).

Targeted vs Universal

Within the literature, there are strong arguments supporting the provision of specialist targeted services for BAME Communities (Fenton et al., 2005; Voice4Change England, 2012; Stevenson and Rao, 2014). Voice4Change England (2012) argued that the rise of specialist BAME services only occurred as a consequence of the failure of mainstream provision to meet the needs of traditionally hard-to-reach groups. They further asserted that specialist targeted services have value in being able to reach those groups that

Voice4Change England (2012) suggested a 'false dichotomy' exists between specialist and mainstream services and a balanced provision between the two is necessary in order to meet the needs of '*disadvantaged BAME Communities*'. In addition to specialist provision, every effort should be made to embed race equality within mainstream service provision, as a means of reducing ethnic health inequalities.

This argument is seemingly supported by evidence taken from the ethnographic research approach into BAME stakeholders' perceptions of local service delivery. Opinion across the local BAME population was divided between specialist and mainstream services. Some BAME individuals felt that local mainstream services were discriminatory and they professed a desire to be supported by specialist providers who better understood their needs. Others felt that, by their very nature, specialist providers had a disabling effect which prevented them from integrating with the local population. In order to meet the needs of all BAME groups, this suggests a need for specialist services alongside mainstream provision but the latter must adapt so it can meet local service demands 'in a more equitable and efficient way (Voice4Change England, 2012).

Achieving Cultural Competence within Service Provision

In order to address ethnic health inequalities effectively, it was suggested that commissioners needed to ‘...develop their knowledge, confidence and competences’ (Joint Commissioning Panel for Mental Health, 2015). Additionally, they also needed to embed equality and diversity considerations within the commissioning cycle.

Services should be culturally competent and able to meet the diverse needs of a multi-cultural population (Joint Commissioning Panel for Mental Health, 2015). Cultural competence goes beyond an organisation’s effort to upskill staff through training alone; the quality of which Stevenson and Rao (2014) suggested is generally poor. It defines an organisation’s ability to meet the social, cultural and linguistic needs of the individuals using their service (Betancourt et al., 2002).

Specific Action

As far as improving BAME access to healthcare services is concerned, the actions previously discussed are focussed on removing systemic barriers that may prevent BAME Communities from maintaining better health. These actions are intended to lay the foundations for successful engagement by creating the right conditions for success. Yet, there is practical guidance within the literature about actions which can support better health for specific BAME groups in specific settings.

For example, the National Institute for Health and Care Excellence (2013) provided guidance relating to the prevention of diabetes among BAME groups. Recognising that some ethnic groups (South Asian, Chinese, Black African and African-Caribbean) are at greater risk of type-2 diabetes, it was suggested that interventions (such as raising diabetes awareness and lifestyle changes) should take place at a lower BMI threshold than for the general population.

Similarly, the National Institute for Health and Care Excellence (2012) has also produced guidance focussing on BAME groups who use smokeless tobacco products, such as misri, khaini, gutkha and betel quid, etc. They provided advice on the provision of specific interventions to support cessation of such use.

The literature also contains a considerable range of clinical and other guidance documents from a wide range of sources, concerning obesity, hypertension, mental health, learning disabilities, visual health, etc. Collectively, these are too numerous to list for the purposes of this needs assessment, however, it is incumbent upon every commissioner, service provider and practitioner to research and review all available evidence and best practice to promote BAME health within their particular discipline or area of work.

Considerations

In light of the evidence presented, there are clearly a number of actions that could be taken to improve the health of BAME groups in Wirral. The following points should be part of local considerations in taking a systematic approach to simultaneously improve engagement with the BAME population and reduce health inequalities:

For commissioners:

1. Local commissioners should stipulate the statutory responsibilities of health and social care providers under the Equality Act 2010 and make these explicit within every contract specification that they are responsible for.
2. A concerted effort must be taken to improve every aspect of BAME data quality, from recording to reporting. This applies to primary, secondary and tertiary health care services, as well as any other provision commissioned by statutory services in Wirral.
3. Data quality should be monitored as part of local performance management arrangements and via regular audit, with the imposition of penalties considered for non-compliance.
4. Local commissioners should continue to involve BAME Communities in the planning and design of local service provision. Where this relates to BAME-specific service provision, consideration should be given to the use of co-production approaches to ensure this provision meets local BAME need.
5. Local commissioners should seek to develop their skills, knowledge and confidence with respect to equality and diversity issues, as part of their ongoing professional development. This should be seen as a personal development plan which extends much further than mandatory training.

For service providers:

6. Mainstream service providers should consider equality and diversity issues within all structural and delivery aspects of the service, with the objective of achieving cultural competence. This should be regarded as a constant improvement journey.
7. Achieving 'cultural competence' should involve a systematic approach to embed equality and diversity considerations within organisational thinking. Actions to achieve this should include such things as recruitment and workforce diversity, staff development, BAME involvement in service planning, communication materials and translation services, facilities to monitor and provide feedback concerning patient/service user experiences, etc.
8. All providers, however large or small, should monitor the ethnicity of their patients/service users, as part of the core responsibilities of their contract. Further, that they should use this intelligence to inform decision-making about how they can improve service engagement with the local BAME population.

References

Academy of Medical Royal Colleges (2013). *Measuring Up: The Medical Profession's Prescription for the Nation's Obesity Crisis*. London: Academy of Medical Royal Colleges.

Available at: http://www.aomrc.org.uk/wp-content/uploads/2016/05/Measuring_Up_0213.pdf

[Accessed 3rd May 2017].

Aki, E. A., Gaddam, S., Gunukula, S. K., Honeine, R., Jaoude, P. A. and Irani, J. (2010). The effects of waterpipe tobacco smoking on health outcomes: a systematic review. *International Journal of Epidemiology*, Vol. 39, No. 3, pp. 834-857.

Available at: <https://www.ncbi.nlm.nih.gov/pubmed/20207606>

[Accessed 3rd May 2017].

All-Party Parliamentary Group on Dementia (2013). *Dementia does not discriminate: The experiences of black, Asian and minority ethnic communities*. London: House of Commons.

Available at: <http://www.lifestorynetwork.org.uk/wp-content/uploads/downloads/2013/07/APPG-Report-2013-Update.pdf>

[Accessed 3rd May 2017].

Alzheimers Society (2017). What is dementia? [online]

Available at: https://www.alzheimers.org.uk/info/20000/about_dementia

[Accessed 8th May 2017].

Ameh, C. A. and van den Broek, N. (2008). Clinical Governance: Increased risk of maternal death among ethnic minority women in the UK.

Anitha, S. (2011). Legislating gender inequalities: the nature and patterns of domestic violence experienced by South Asian women with insecure immigration status in the United Kingdom. *Violence Against Women*, Vol. 17, No. 10, pp. 1,260-1,285.

Available at: <https://www.ncbi.nlm.nih.gov/pubmed/22071095>

[Accessed 26th April 2017].

Aspinall, P. J. and Jacobson, B. (2004). *Ethnic disparities in Health and Healthcare: a focused review of the evidence and selected examples of good practice*. London: London Health Observatory.

Available at: <https://kar.kent.ac.uk/7769/>

[Accessed 3rd May 2017].

Association of Public Health Observatories (2016). *Ethnic Minority Health* [online]

Available at: <http://www.apho.org.uk/resource/view.aspx?RID=78571>

[Accessed 21st February 2017].

Association of Public Health Observatories (2017). *Crime and Violence* [online]

Available at: <http://www.apho.org.uk/resource/view.aspx?RID=78565>

[Accessed 26th April 2017].

Betancourt, J. R., Green, A. P., Emilio Carillo, J. and Ananeh-Firempong, O. (2003). Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and healthcare. *Public Health Reports*, Vol. 118, pp. 293-302.
Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1497553/pdf/12815076.pdf>
[Accessed 24th July 2017].

Bharj, K. K. and Salway, S. M. (2008). *Briefing Paper 11 - Addressing ethnic inequalities in maternity service experiences and outcomes: responding to women's needs and preferences*. London: Race Equality Foundation.
Available at: <http://www.better-health.org.uk/sites/default/files/briefings/downloads/health-brief11.pdf>
[Accessed 24th July 2017].

Bhopal, R. S., Bansal, N., Fischbacher, C. M., Brown, H. and Capewell, S. (2012). Ethnic variations in heart failure: Scottish Health and Ethnicity Linkage Study (SHELS). *Heart - British Medical Journal*, Vol. 98, pp. 468-473.
Available at: <http://heart.bmj.com/content/heartjnl/98/6/468.full.pdf>
[Accessed 2nd May 2017].

Blackledge, H. M., Newton J. and Squire, I. B. (2003). Prognosis for South Asian and white patients when newly admitted to hospital with heart failure in the United Kingdom: historical cohort study. *British Medical Journal*, Vol. 327, pp. 1-6.
Available at:
<http://211.103.242.133:8080/ziyuan/CDDPdf/evd/200801/British%20Medical%20Journal/%E9%98%9F%E5%88%97%E7%A0%94%E7%A9%B6/bmj200332709526.pdf>
[Accessed 2nd May 2017].

Brandon, J. and Hafez, S. (2008). *Crimes of the community – honour-based violence in the UK*. London: Centre for Social Cohesion.
Available at: <http://henryjacksonsociety.org/wp-content/uploads/2013/01/crimes-of-the-community.pdf>
[Accessed 21st February 2017].

British Heart Foundation (2010). *Ethnic Differences in Cardiovascular Disease: 2010 Edition* [online].
Available at: <https://www.bhf.org.uk/publications/statistics/ethnic-differences-in-cardiovascular-disease-2010>
[Accessed 21st February 2017].

British Heart Foundation (2016). *Atherosclerosis* [online].
Available at: <https://www.bhf.org.uk/heart-health/conditions/atherosclerosis>
[Accessed 21st February 2017].

Bullock, M. (2014). *Merseyside and West Lancashire Gypsy and Traveller Accommodation Assessment*. Cheshire: arc⁴ Ltd.

Available at:

[http://www.knowsley.gov.uk/pdf/LCR29%20Liverpool%20GTAA%20FINAL%20Report%20\(Jan%202015\).pdf](http://www.knowsley.gov.uk/pdf/LCR29%20Liverpool%20GTAA%20FINAL%20Report%20(Jan%202015).pdf)

[Accessed 21st February 2017].

Calanzani, N., Koffman, J. and Higginson, I. J. (2013). *Palliative and end of life care for Black, Asian and Minority Ethnic groups in the UK* [online]

Available at: <https://www.mariecurie.org.uk/globalassets/media/documents/policy/policy-publications/june-2013/palliative-and-end-of-life-care-for-black-asian-and-minority-ethnic-groups-in-the-uk.pdf> [Accessed 8th May 2017].

Cancer Research UK (2016). *Press Release: Black African women almost twice as likely to be diagnosed with late stage breast cancer compared to white women* [online]

Available at:

<http://www.cancerresearchuk.org/about-us/cancer-news/press-release/2016-11-16-black-african-women-almost-twice-as-likely-to-be-diagnosed-with-late-stage-breast-cancer-compared-to>

[Accessed 8th May 2017].

Care Quality Commission (2010). *Count Me In*. London: Care Quality Commission.

Available at:

<http://www.scie-socialcareonline.org.uk/count-me-in-2010-results-of-the-2010-national-census-of-inpatients-and-patients-on-supervised-community-treatment-in-mental-health-and-learning-disability-services-in-england-and-wales/r/a11G000000182rIIAA>

[Accessed 8th May 2017].

Care Quality Commission (2014). *Monitoring the Mental Health Act in 2012-13*. London: Care Quality Commission.

Available at:

<http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2014/04/CQC-Mental-Health-Annual-report-2012-13.pdf>

[Accessed 8th May 2017].

Cemlyn, S., Greenfields, M., Burnett, S., Matthews, Z. and Whitwell C. (2009).

Inequalities experienced by Gypsy and Traveller Communities: A review. London: Equality and Human Rights Commission.

Available at: <https://www.equalityhumanrights.com/en/publication-download/research-report-12-inequalities-experiences-gypsy-and-traveller-communities>

[Accessed 8th May 2017].

Centre On Dynamics of Ethnicity (2013). *Which ethnic groups have the poorest health? Ethnic health inequalities 1991 to 2011*. Manchester: The University of Manchester.

Available at: <http://www.ethnicity.ac.uk/medialibrary/briefingsupdated/which-ethnic-groups-have-the-poorest-health.pdf>

[Accessed 13th April 2017].

Commission for Racial Equality (2003). *Race Equality in Prisons: A formal investigation by the Commission for Racial Equality into HM Prison Service of England and Wales, Part Two.* London: Commission for Racial Equality.

Available at: <http://www.statewatch.org/news/2003/oct/crePrisons.pdf>

[Accessed 13th April 2017].

Cooper, C., Spiers, N., Livingston, G., Jenkins, R., Meltzer, H., Brugha, T., McManus, S., Weich, S. & Bebbington, P. (2013). Ethnic inequalities in the use of health services for common mental disorders in England. *Social Psychiatry and Psychiatric Epidemiology*, Vol 48, No. 5, pp. 685-692.

Available at: <https://www.ncbi.nlm.nih.gov/pubmed/22893107>

[Accessed 26th July 2017].

Coussens, A. K., Wilkinson, R. J., Nikolayevskyy, V., Elkington, P. T., Hanifa, Y., Islam, K., Timms, P. M., Bothamley, G. H., Claxton, A. P., Packe, G. E., Darmalingham, M., Davidson, R. N., Milburn, H. H. J. Baker, L. V., Barker, R. D., Drobniowski, F. A., Mein, C. A., Bhaw-Rosun, L., Nuamah, R. A., Griffiths, C. J. and Martineau, A. R. (2013). Ethnic Variation in Inflammatory Profile in Tuberculosis. *PLOS Pathogens* [online].

Available at:

<http://journals.plos.org/plospathogens/article?id=10.1371/journal.ppat.1003468>

[Accessed 8th May 2017].

Dahlgren, G. and Whitehead, M. (1991) *Policies and strategies to promote social equity in health.* Stockholm: Institute for Future Studies.

Department for Communities and Local Government (2015). *English indices of multiple deprivation 2015.* London: Department for Communities and Local Government.

Available at: <https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015>

[Accessed 21st February 2017].

Department of Health (2007). *Guidance on Joint Strategic Needs Assessment.* London: Department of Health. Available at:

http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/prod_consum_dh/idcplg?IdcService=GET_FILE&dID=156173&Rendition=Web

[Accessed 21st February 2017].

Department of Health (2013). *A Framework for Sexual Health Improvement in England.* London: Department of Health.

Available at: <https://www.gov.uk/government/publications/a-framework-for-sexual-health-improvement-in-england> [Accessed 8th May 2017].

Department of Work and Pensions (2014). *Family Resources Survey, United Kingdom, 2012-13.* London: Department of Work and Pensions.

Available at:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/325491/family-resources-survey-statistics-2012-2013.pdf

[Accessed 8th May 2017].

- Diabetes UK (2006).** *Diabetes and the Disadvantaged: Reducing Health Inequalities in the UK* [online]. Available at: https://www.diabetes.org.uk/Documents/Reports/Diabetes_disadvantaged_Nov2006.pdf [Accessed 3rd May 2017].
- Diabetes UK (2016).** *Facts and Stats* [online] Available at: https://www.diabetes.org.uk/Documents/Position%20statements/DiabetesUK_Facts_Stats_Oct16.pdf [Accessed 3rd May 2017].
- Dyer, E. (2015).** *'Honour' Killings in the UK*. London: The Henry Jackson Society. Available at: <http://henryjacksonsociety.org/wp-content/uploads/2015/01/Honour-Killings-in-the-UK.pdf> [Accessed 21st February 2017].
- Equality Act 2010: Chapter 15** [online]. London: HMSO. Available at: http://www.legislation.gov.uk/ukpga/2010/15/pdfs/ukpga_20100015_en.pdf [Accessed 21st February 2017].
- Fenton, K. A., Mercer, C. H., McManus, S., Erens, B., Byron, C. J., Copas, A. J. and Nanchahal, K. (2005).** Sexual behaviour in Britain: ethnic variations in high-risk behaviour and STI acquisition risk. *The Lancet*, Vol. 365, No. 9466, pp. 1,246-1,255. Available at: <http://discovery.ucl.ac.uk/1615/> [Accessed 8th May 2017].
- Foundation for Women's Health Research and Development (2015).** *FGM* [online] Available at: <http://www.forwarduk.org.uk/key-issues/fgm/> [Accessed 21st February 2017].
- Furegato, M., Chen, Y., Mohammed, H. and Mercer C. H. (2016).** Examining the role of socioeconomic deprivation in ethnic differences in sexually transmitted disease rate in England: evidence from surveillance data. *Epidemiology and Infection*, Vol. 144, No. 15, pp. 3,253-3,262. Available at: <https://www.cambridge.org/core/journals/epidemiology-and-infection/article/examining-the-role-of-socioeconomic-deprivation-in-ethnic-differences-in-sexually-transmitted-infection-diagnosis-rates-in-england-evidence-from-surveillance-data/F6FC795C89BB35761442E54C4A4B6525> [Accessed 8th May 2017].
- Gill, A. and Banga, B. (2008).** *Better Housing Briefing 9: Black, minority, ethnic and refugee women, domestic violence and access to housing*. London: Race Equality Foundation. Available at: <http://www.raceequalityfoundation.org.uk/publications/downloads/black-minority-ethnic-and-refugee-women-domestic-violence-and-access-housing> [Accessed 21st February 2017].

Gerressu, M., Mercer, C. H., Cassell, J. A., Brook, G. and Dave, S. (2012). The importance of distinguishing between black Caribbeans and Africans in understanding sexual risk can care-seeking behaviours for sexually transmitted infections: evidence from a large survey of people attending genitourinary medicine clinics in England. *Journal of Public Health*, Vol. 34, No. 3, pp. 411-420.

Available at: <https://academic.oup.com/jpubhealth/article/34/3/411/1560096/The-importance-of-distinguishing-between-black>

[Accessed 8th may2017].

Gill, P. S., Calvert, M., Davis, R., Davies, M. K., Freemantle, N. and Lip, G. Y. H. (2011). Prevalence of Heart Failure and Atrial Fibrillation in Ethnic Minority Subjects: The Ethnic-Echocardiographic Heart of England Screening Study (E-EHOES). *Public Library of Science (PLOS)*, Vol. 6, No. 11, e26710.

Available at:

<http://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0026710&type=printable> [Accessed 2nd May 2017].

Gray, R., Headley, J., Oakley, L., Kurinczuk, J., Brocklehurst, P. and Hollowell, J. (2009). Inequalities in Infant Mortality Project Briefing Paper 3 – Towards an understanding of variations in infant mortality rates between different ethnic groups in England and Wales [online].

Available at: <https://www.npeu.ox.ac.uk/downloads/files/infant-mortality/Infant-Mortality-Briefing-Paper-3.pdf>

[Accessed 12th May 2017].

Health and Social Care Act (2012): Chapter 7 [online]. London: HMSO

Available at: http://www.legislation.gov.uk/ukpga/2012/7/pdfs/ukpga_20120007_en.pdf

[Accessed 21st February 2017].

Harding, S., Rosato, M. and Teyhan, A. (2008). Trends for coronary heart disease and stroke mortality among migrants in England and Wales: Slow declines for some groups. *Heart*, Vol. 94, pp. 463-470 [online].

Available at: <https://www.ncbi.nlm.nih.gov/pubmed/17690159>

[Accessed 21st February 2017].

Harding, S., Rosato, M. and Teyhan, A. (2009). Trends in cancer mortality among migrants in England and Wales. *European Journal of Cancer*, Vol. 46, No. 12, pp. 2,168-2,179 [online].

Available at: [http://www.ejancer.com/article/S0959-8049\(09\)00123-3/fulltext](http://www.ejancer.com/article/S0959-8049(09)00123-3/fulltext)

[Accessed 8th May 2017].

Health and Social Care Information Centre (2006). *Health Survey for England 2004: The Health of Minority Ethnic Groups – headline tables* [online].

Available at: <http://content.digital.nhs.uk/catalogue/PUB01209/heal-surv-hea-eth-min-hea-tab-eng-2004-rep.pdf>

[Accessed 21st February 2017].

Health and Social Care Information Centre (2015). *Mental Health Bulletin, Annual Statistics, 2014-15* [online].

Available at: <http://content.digital.nhs.uk/catalogue/PUB18808/mhb-1415-ann-rep.pdf>
[Accessed 5th May 2017].

Health and Social Care Information Centre (2016a). *Statistics on Obesity, Physical Activity and Diet* [online].

Available at: <http://content.digital.nhs.uk/catalogue/PUB20562/obes-phys-acti-diet-eng-2016-rep.pdf>

[Accessed 5th May 2017].

Health and Social Care Information Centre (2016b). *Statistics on NHS Stop Smoking Services: England, April 2015 to March 2016* [online].

Available at: <http://content.digital.nhs.uk/article/2021/Website-Search?productid=21374&q=4+week+quitters&sort=Relevance&size=10&page=1&area=both#top>

[Accessed 5th May 2017].

Her Majesty's Inspectorate of Constabulary (2015). *The depths of dishonour: Hidden voices and shameful crimes* [online].

Available at: <https://www.justiceinspectorates.gov.uk/hmic/wp-content/uploads/the-depths-of-dishonour.pdf>

[Accessed 21st February 2017].

Home Affairs Select Committee (2008). *Domestic Violence, Forced Marriage and 'Honour'-Based Violence*. London: House of Commons.

Available at:

<http://www.publications.parliament.uk/pa/cm200708/cmselect/cmhaff/263/263i.pdf>

[Accessed 21st February 2017].

Home Office (2013). *Guidance: Domestic Abuse and Violence* [online]. Updated 8th March 2016.

Available at: <https://www.gov.uk/guidance/domestic-violence-and-abuse>

[Accessed 21st February 2017].

Home Office (2014). *Drug Misuse: Findings from the 2013-14 Crime Survey for England and Wales* [online].

Available at: <https://www.gov.uk/government/publications/drug-misuse-findings-from-the-2013-to-2014-csew/drug-misuse-findings-from-the-201314-crime-survey-for-england-and-wales#estimates-of-illicit-drug-use-by-ethnicity-and-sexual-orientation>

[Accessed 10th May 2017].

Home Office (2015). *Police powers and procedures, England and Wales, year ending 31st March 2015* [online].

Available at:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/477676/police-powers-procedures-hosb0715.pdf#page=31

[Accessed 28th April 2017].

Home Office (2016). *Hate Crimes, England and Wales, 2015/16*. London: Home Office.

Available at:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/559319/hate-crime-1516-hosb1116.pdf

[Accessed 21st February 2017].

Home Office (2017). *Forced Marriage Unit Statistics, 2016*. London: Home Office.

Available at:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/597869/Forced_Marriage_Unit_statistics-2016.pdf

[Accessed 21st February 2017].

Howlett, J. G., McKelvie, R. S., Costigan, J. et al. (2017). The 2010 Canadian Cardiovascular Society guidelines for the diagnosis and management of heart failure update: heart failure in ethnic minority populations, heart failure and pregnancy, disease management and quality improvement/assurance programs. *Canadian Journal of Cardiology*, Vol. 26, pp. 185-202.

Available at: [http://www.onlinecjc.ca/article/S0828-282X\(10\)70367-6/pdf](http://www.onlinecjc.ca/article/S0828-282X(10)70367-6/pdf)

[Accessed 21st February 2017].

Hurcombe, R., Bayley, M. and Goodman, A. (2010). *Ethnicity and Alcohol: a review of the UK literature* [online]. London: Joseph Rowntree Foundation.

Available at: <https://www.jrf.org.uk/sites/default/files/jrf/migrated/files/ethnicity-alcohol-literature-review-summary.pdf>

[Accessed 2nd May 2017].

Icarus (2010). *Wirral Black and Minority Ethnic Health Needs Assessment – For Consultation* [online]

Available at: http://info.wirral.nhs.uk/document_uploads/jsna2009-10/WPCTBMEneedsassessmentShortened.pdf

[Accessed 2nd May 2017].

Institute of Race Relations (2017). *Criminal Justice System Statistics* [online]

Available at: <http://www.irr.org.uk/research/statistics/criminal-justice/>

[Accessed 2nd May 2017].

Irish Traveller Movement for Britain (2013). *Gypsy and Traveller population in England and the 2011 Census. An Irish Traveller Movement in Britain Briefing.* August 2013.

Available at:

[http://info.wirral.nhs.uk/document_uploads/Downloads/Gypsy%20and%20Traveller%20population%20in%20England%20policy%20report%20\(2\)%20\(2\).pdf](http://info.wirral.nhs.uk/document_uploads/Downloads/Gypsy%20and%20Traveller%20population%20in%20England%20policy%20report%20(2)%20(2).pdf)

[Accessed 21st February 2017].

Itagi, A. B. H., Arora, D., Patil, N. A., Bailwad, B. A., Yunus, G. Y. and Goel, A. (2016). Short-term effects of ghutka-chewing on heart rate variability among young adults: a cross-sectional study. *International Journal of Applied and Basic Medical Research*, Vol. 6, No. 1, pp. 45-49.

Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4765274/>

[Accessed 11th May 2017].

Joint Commissioning Panel for Mental Health (2015). *Guidance for commissioners of mental health services for people from black and minority ethnic communities.*

<http://www.icpmh.info/wp-content/uploads/icpmh-bme-guide.pdf>

[Accessed 18th July 2017].

Karlsen, S., Millward, D. and Sandford, A. (2012). Investigating ethnic differences in current cigarette smoking over time using the health surveys for England. *European Journal of Public Health*, Vol. 22, No. 2, pp. 254-256.

Available at: <https://academic.oup.com/eurpub/article/22/2/254/513515/Investigating-ethnic-differences-in-current>

[Accessed 21st February 2017].

Kings Fund (2017). *Broader Determinants of Health* [online].

Available at: <https://www.kingsfund.org.uk/time-to-think-differently/trends/broader-determinants-health>

[Accessed 21st February 2017].

Knowles, R. L., Ridout, D., Crowe, S., Bull, C., Wray, J., Tregay, J., Franklin, R. C., Barron, D. J., Cunningham, D., Parslow, R. C. and Brown, K. L. (2016). Ethnic and socioeconomic variation in incidence of congenital heart defects. *Archives of Disease in Childhood* [online].

Available at: <http://adc.bmj.com/content/early/2016/12/16/archdischild-2016-311143.full>

[Accessed 21st February 2017].

Kurinczuk, J., Hollowell, J., Brocklehurst, P. and Gray, R. (2009). Inequalities in Infant Mortality Project Briefing Paper 1 – Infant Mortality: overview and context [online].

Available at: <https://www.npeu.ox.ac.uk/downloads/files/infant-mortality/Infant-Mortality-Briefing-Paper-1.pdf>

[Accessed 12th May 2017].

Leung, G. and Stanner, S. (2011). Diets of minority ethnic groups in the UK: influence on chronic disease risk and implication for prevention. *British Nutrition Foundation Nutrition Bulletin*, Vol. 36, No. 2, pp. 161-198.

Available at: <http://onlinelibrary.wiley.com/doi/10.1111/j.1467-3010.2011.01889.x/abstract> [Accessed 21st February 2017].

Mathur, R., Bhaskaran, K., Chaturvedi, N., Leon, D. A., vanStaa, T., Grundy, E. and Smeeth, L. (2014). Completeness and usability of ethnicity data in UK-based primary care and hospital databases. *Journal of Public Health*, Vol. 36, No. 4, pp. 684-692.

Available at:

<https://academic.oup.com/jpubhealth/article/36/4/684/1529704/Completeness-and-usability-of-ethnicity-data-in-UK>

[Accessed 21st February 2017].

Maynard, M. J., Rosato, M., Teyhan, A. and Harding, S. (2012). Trends in suicides among migrants in England and Wales, 1979-2003. *Ethnicity and Health*, Vol. 17, No's 1-2, pp. 135-140.

Available at: <http://eprints.gla.ac.uk/71762/1/71762.pdf>

[Accessed 9th 2017].

McPherson, K., Marsh, T. and Brown, M. (2007). *Tackling Obesities: Future Choices – Project Report: Modelling Future Trends in Obesity and Their Impact on Health*. London: Government Office for Science.

Available at: <http://veilleagri.hautetfort.com/media/02/00/2025691480.pdf>

[Accessed 21st February 2017].

Mereish, E. (2012). The intersectional invisibility of race and disability status: an exploratory study of health and discrimination facing Asian Americans with disabilities.

Ethnicity and

Inequalities in Health and Social Care, Vol. 5, No. 2, pp. 52-60. [online].

Available at: <http://www.emeraldinsight.com/doi/abs/10.1108/17570981211286796>

[Accessed 21st February 2017].

Merseyside Safeguarding Boards (2014). *Merseyside Forced Marriage and Honour Based Violence Protocol* [online].

Available at:

<http://www.wirral.gov.uk/sites/default/files/all/Health%20and%20social%20care/children/safeguarding%20children%20board/Merseyside%20%20Forced%20Marriage%20%20HBV%20protocol%20%20final%20April%202014.pdf>

[Accessed 21st February 2017].

Moe, G. W. and Tu, J (2010). Heart failure in the ethnic minorities. *Current Opinion in Cardiology*, Vol. 25, No. 2, pp. 124-130.

Available at: <https://www.ncbi.nlm.nih.gov/pubmed/20019604>

[Accessed 21st February 2017].

Mullender, A., Hague, G., Imam, U., Kelly, L. and Malos, E. (2002). *Children's Perspectives on Domestic Violence*. London: SAGE Publications.

New Economics Foundation (2012). *Wellbeing patterns uncovered: An analysis of UK data*. London: New Economics Foundation.

Available at: http://dnwssx4l7ql7s.cloudfront.net/nefoundation/default/page/-/files/Unlocking_wellbeing_webReady.pdf

[Accessed 21st February 2017].

National Cancer Intelligence Network (2009). *Cancer Incidence and Survival by Major Ethnic Group, England, 2002-2006*. London: National Cancer Intelligence Network

Available at: <http://www.ncin.org.uk/view.aspx?rid=75>

[Accessed 9th May 2017].

NHS Digital (2016). *National Child Measurement Programme 2015-16* [online].

Available at: content.digital.nhs.uk/catalogue/PUB22269/nati-chil-meas-prog-eng-2015-2016-tab.xlsx

[Accessed 9th May 2017].

National Institute for Health and Care Excellence (2008, amended 2014).

Cardiovascular Disease: identifying and supporting people most at risk of dying early (PH15) [online].

Available at: <https://www.nice.org.uk/guidance/ph15/resources/cardiovascular-disease-identifying-and-supporting-people-most-at-risk-of-dying-early-1996178220997>

[Accessed 21st February 2017].

National Institute for Health and Care Excellence (2010). *Cardiovascular Disease Prevention (PH25)* [online].

Available at: <https://www.nice.org.uk/guidance/ph25>

[Accessed 21st February 2017].

National Institute for Health and Care Excellence (2012). *Smokeless tobacco: South Asian communities (PH39)* [online].

Available at: <https://www.nice.org.uk/guidance/ph39>

[Accessed 18th July 2017].

National Institute for Health and Care Excellence (2013). *BMI: preventing ill health and premature death in black, Asian and other minority ethnic groups (PH46)* [online].

Available at: <https://www.nice.org.uk/guidance/ph46>

[Accessed 18th July 2017].

National Institute for Health and Care Excellence (2014). *Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively (PH50)* [online].

Available at: <https://www.nice.org.uk/guidance/ph50>

[Accessed 21st February 2017].

National Institute for Health and Care Excellence (2016). *Community Engagement: improving health and wellbeing and reducing health inequalities* (NG44) [online].

Available at: <https://www.nice.org.uk/guidance/NG44>

[Accessed 18th July 2017].

O'Connor, R. J. (2012). Non-cigarette tobacco products: what we have learnt and where are we headed? *Tobacco Control*, Vol. 21, No. 2, pp. 181-190.

Available at: <http://tobaccocontrol.bmj.com/content/21/2/181>

[Accessed 9th May 2017].

Office of National Statistics (2012). *2011 Census: Key Statistics for local authorities in England and Wales*. London: Office of National Statistics.

Available at:

<https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/keystatisticsandquickstatisticsforlocalauthoritiesintheunitedkingdom/2013-10-11>

[Accessed 21st February 2017].

Office of National Statistics (2013). *Differences in well-being by ethnicity*. London: Office of National Statistics.

Available at:

http://webarchive.nationalarchives.gov.uk/20160105160709/http://www.ons.gov.uk/ons/dcp171766_308226.pdf

[Accessed 21st February 2017].

Office of National Statistics (2014). *Adult Health in Great Britain*. London: Office of National Statistics.

Available at:

http://webarchive.nationalarchives.gov.uk/20160105160709/http://www.ons.gov.uk/ons/dcp171778_355938.pdf

[Accessed 15th May 2017].

Office of National Statistics (2015a). *Deaths registered in England and Wales (Series DR): 2014*. London: Office of National Statistics.

Available at:

<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsregisteredinenglandandwalesseriesdr/2015-11-09>

[Accessed 9th May 2017].

Office of National Statistics (2015b). *Pregnancy and ethnic factors influencing births and infant mortality: 2013*. London: Office of National Statistics.

<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/pregnancyandethnicfactorsinfluencingbirthsandinfantmortality/2015-10-14#main-findings>

[Accessed 9th May 2017].

Owuor, J. A. and Nake, J. N. (2015). *Briefing Paper 36 – Internalised stigma as a barrier to access to health and social care services by minority ethnic groups in the UK.* London: Race Equality Foundation.

http://www.better-health.org.uk/sites/default/files/briefings/downloads/Health%20Briefing%2036_1.pdf

[Accessed 18th July 2017].

Palmer, D. (2012). Minding Histories: Exploring early experiences of migration, settlement and wellbeing through life histories of migrants residing in the London borough of Bexley. *Family and Community History*, Vol. 15, pp. 44-60, 1st April 2012.

Available at: http://www.mindinghistories.org.uk/docs/FCH_04_David_Palmer.pdf

[Accessed 21st February 2017].

Parliamentary Office of Science and Technology (2007). *Ethnicity and Health* [online]. January 2007, No. 276.

Available at: <http://www.parliament.uk/documents/post/postpn276.pdf>

[Accessed 21st February 2017].

Papworth Trust (2014). *Disability in the United Kingdom 2014: Facts and Figures.*

Cambridge: Papworth Trust. Available at:

<http://www.papworthtrust.org.uk/sites/default/files/UK%20Disability%20facts%20and%20figures%20report%202014.pdf>

[Accessed 9th May 2017].

Parry, G., van Cleemput, P., Peters, J., Walters, S., Thomas, K. and Cooper, A. (2012). Health Status of Gypsies and Travellers in England. *Journal of Epidemiology and Community Health*, Vol. 61, pp. 198-204.

Available at: <https://www.ncbi.nlm.nih.gov/pubmed/17325395>

[Accessed 21st February 2017].

Public Health England (2016a). *Tuberculosis in England - 2016 report (presenting data to end of 2015)* [online]

Available at: <https://www.gov.uk/government/publications/tuberculosis-in-england-annual-report> [Accessed 8th May 2017].

Public Health England (2016b). *Sexually transmitted infections (STIs): annual data tables* [online]

Available at: <https://www.gov.uk/government/statistics/sexually-transmitted-infections-stis-annual-data-tables>

[Accessed 8th May 2017].

Race Equality Foundation (2016). *Dementia, Equity and Rights Report* [online]

Available at: <http://www.raceequalityfoundation.org.uk/news/dementia-equity-and-rights-report>

[Accessed 8th May 2017].

Revolving Doors (2013). *Balancing Act: Addressing health inequalities among people in contact with the criminal justice system* [online]

Available at: <http://www.revolving-doors.org.uk/file/1820/download?token=eVvaFNW3>
[Accessed 26th April 2017].

Roberts, A., Adkins, J. and Lewis (2007). *Balancing Act: Addressing health inequalities among people in contact with the criminal justice system* [online]

Available at: <http://www.revolving-doors.org.uk/file/1820/download?token=eVvaFNW3>
[Accessed 26th April 2017].

Ryan, L., D'Angelo, A., Puniskis, M. and Kaye, N. (2014). *Analysis of the 2011 Census Data: Irish Community Statistics, England and Selected Urban Areas* [online]

Available at: <http://www.irishinbritain.org/cmsfiles/Downloads/Reports/Irish-Census-Analysis-Report---England.pdf>
[Accessed 26th April 2017].

Salway, S., Turner, D., Mir, G., Carter, L., Skinner, J., Bostan, B., Gerrish, K. and Ellison, G. (2013). *Briefing Paper 28 – High Quality Healthcare Commissioning: Obstacles and opportunities for progress on race equality.* London: Race Equality Foundation.

<http://www.better-health.org.uk/sites/default/files/briefings/downloads/briefing%2028%20final.pdf> [Accessed 18th July 2017].

Saunders, R. (2007). The forgotten minority. *Diabetes Update*, Spring 2007, pp. 26-29.

Available at:
https://www.diabetes.org.uk/Documents/Reports/Diabetes_disadvantaged_Nov2006.pdf
[Accessed 3rd May 2017].

Scanlon, K., Harding, S., Hunt, K., Pettigrew, M., Rosato, M. and Williams, R. (2006).

Potential barriers to prevention of cancers and to early cancer detection among Irish people living in Britain: A qualitative study. *Ethnicity and Health*, Vol. 11, No. 3, pp. 325-341. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/16774881?dopt=Abstract>
[Accessed 3rd May 2017].

Stevenson, J. and Rao, M. (2014). *Explaining levels of wellbeing in Black and Minority Ethnic populations in England.* London: University of East London, Institute of Health and Human Development.

Available at: http://roar.uel.ac.uk/3867/7/2014_Stevenson_Rao-BME-wellbeing.pdf
[Accessed 18th July 2017].

Stroke Association (2017). *Are you at risk of stroke?* [online].

Available at: <https://www.stroke.org.uk/what-stroke/are-you-risk-stroke>
[Accessed 18th July 2017].

Swadling, A., Napoli-Rangel, S. and Khan, M. I. (2015). *Hate Crime: Barriers to Reporting and Best Practices*. York: University of York.

Available at: <http://www.yhrcn.org/wp-content/uploads/2015/10/Hate-Crime-Report-Final.pdf>

[Accessed 21st February 2017].

Sveinsson, K. P. (ed) (2012). *Criminal Justice v. Racial Justice: Minority ethnic overrepresentation in the criminal justice system*. London: The Runnymede Trust
Available at:

<https://www.runnymedetrust.org/uploads/publications/pdfs/CriminalJusticeVRacialJustice-2012.pdf>

[Accessed 2nd May 2017].

Testa, A. and Coleman, L. (2006). *Sexual Health Knowledge, Attitudes and Behaviours among Black and Minority Ethnic Youth in London: A summary of findings*. London: The Naz Project.

Available at: <https://lemosandcrane.co.uk/resources/Naz%20Project%20London%20-%20Sexual%20health%20knowledge,%20attitudes%20and%20behaviours%20among%20black%20and%20minority%20ethnic%20youth%20in%20London.pdf>

[Accessed 2nd May 2017].

The Health Foundation (2011). *Learning Report: Shared Leadership for Change – Case studies and learning a programme to improve the quality of care for people from black and minority ethnic groups*. London: The Health Foundation

Available at: <http://www.health.org.uk/sites/health/files/SharedLeadershipForChange.pdf>

[Accessed 18th July 2017].

The NHS Confederation (2013). *Engaging with BME Communities: insights for impact – Personal views from NHS Leaders*. London: The NHS Confederation

Available at:

http://www.nhsconfed.org/~/_media/Confederation/Files/Publications/Documents/Engaging-BME-communities-insights-for-impact.pdf

[Accessed 18th July 2017].

Tilki, M., Mulligan, E., Pratt, E., Halley, E. and Taylor, E. (2010). Older Irish people with dementia in England. *Advances in Mental Health*, Vol. 9, No. 3, pp. 221-232

Available at: <http://www.tandfonline.com/doi/abs/10.5172/jamh.9.3.219>

[Accessed 2nd May 2017].

Truswell, D. (2013). *Black, Asian and minority ethnic communities and dementia – where are we now? A Race Equality Foundation Briefing Paper*. London: Race Equality Foundation

Available at: <http://www.better-health.org.uk/briefings/black-and-minority-ethnic-communities-and-dementia-where-are-we-now>

[Accessed 2nd May 2017].

Voice4Change England (2014). *Specialist Services: A Guide for Commissioners.*
London: Voice4Change England
Available at: http://www.voice4change-england.co.uk/webfm_send/158
[Accessed 18th July 2017].

Warnakulasuriya, S., Trivedy, C. and Peters, T. J. (2002). Areca nut use: an independent risk factor for oral cancer – The health problem is under-recognised. *British Medical Journal*, Vol. 324, No. 7341, pp. 799-800.
Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1122751/>
[Accessed 2nd May 2017]

Wellock, V. K. (2010). Domestic Abuse: Black and minority-ethnic women's perspectives. *Midwifery*, Vol. 2, pp. 181-188.
Available at: <https://www.ncbi.nlm.nih.gov/pubmed/18606484>
[Accessed 26th April 2017].

Weerasinghe, S. (2012). Inequities in visible minority Immigrant Women's Healthcare accessibility. *Ethnicity and Inequalities in Health and Social Care*, Vol. 5, No. 1, pp. 18-28.
Available at: <http://www.emeraldinsight.com/doi/abs/10.1108/17570981211286750>
[Accessed 26th July 2017].

Williams, E. D., Tillin, T., Whincup, P., Forouhi, N. G. and Chaturvedi, N. (2012). Ethnic Differences in Disability Prevalence and Their Determinants Studied over a 20-year Period: A Cohort Study. *PLOS One* [online].
Available at: <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0045602>
[Accessed 21st February 2017].

Wirral Council (2016). *Strategic Housing Market Assessment*
Available at:
http://info.wirral.nhs.uk/document_uploads/JSNA%202017/Wirral%20SHMA%20Final%20Report%20May%202016.pdf
[Accessed 21st February 2017].

Wirral Safeguarding Boards (2016). *Female Genital Mutilation Multi-agency Protocol* [online].
Available at: http://wirrallscb.proceduresonline.com/chapters/p_fgm.html
[Accessed 21st February 2017].

Woestenburg, P. J., van Oeffelen, A. A., Stirbu-Wagner, I., van Benthem, B. H., van Bergen, J. E. and van den Broek, I. V. (2015). Comparison of STI-related consultations among ethnic groups in the Netherlands: an epidemiological study using electronic records from general practices. *BioMed Central Family Practitioner*, Vol. 16, No. 70, pp. 1-8.
Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4470336/>
[Accessed 8th May 2017].

World Health Organisation (2014). *Female genital mutilation, Fact Sheet No. 241* [online]. Updated February 2017.
Available at: <http://www.who.int/mediacentre/factsheets/fs241/en/>
[Accessed 21st February 2017].

World Health Organisation (2016). *Definition of cardiovascular diseases* [online].
Available at: <http://www.euro.who.int/en/health-topics/noncommunicable-diseases/cardiovascular-diseases/cardiovascular-diseases2/definition-of-cardiovascular-diseases>
[Accessed 21st February 2017].

Contact details

For further details please contact:

- Steven Gavin, Public Health Manager, Wirral Council stevengavin@wirral.gov.uk
- John Highton, JSNA Lead, Wirral Intelligence Service johnhighton@wirral.gov.uk

To subscribe to Wirral Intelligence Service Bulletin

- Email your contact details to wirralintelligenceservice@wirral.gov.uk

To give us feedback

- Let us know your views or if you need to find out more about a particular topic or subject then go to <https://www.wirralintelligenceservice.org/about-us/contact-us/>