WIRRAL BLACK AND MINORITY ETHNIC HEALTH NEEDS ASSESSMENT REPORT – FOR CONSULTATION

February 2010

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Paul Kyprianou, Kath Hennell and Eric Gowling

Icarus, February 2010

Executive summary

- Wirral Joint Strategic Needs Assessment (JSNA) 2008/09 acknowledges a significant gap in knowledge about Wirral's Black Minority Ethnic (BME) community including the lack of robust data on population prevalence, and information on its health and well-being needs, which this research was commissioned to help address

- At the outset of this research key stakeholders expressed concern about the relevance of focusing the qualitative research on the ethnic groups specified within the commission i.e. migrant workers, Travellers and Gypsies, and refugees and asylum seekers. Following a consultation exercise the focus was changed to explore the relationship between seven of Wirral Primary Care Trust's (WPCT) health priorities and Wirral's BME communities, as well as the original objectives of considering BME experience and access to health services

- Our randomised survey of 1728 households has evidenced a relatively small numerical, though significant percentage increase in the size of the BME population in Wirral since the 2001 census which gave a figure of 3.56%, compared to a total today of 5.83% n = 18,291(adjusted figure) This survey is not able to provide a reliable account of the composition of BME population, while the Office for National Statistics (ONS) mid-year estimates based on the 2001 census are increasingly prone to error. An assessment of new National Insurance (NI) registrations tends to support anecdotal accounts of a recent decline of up to 50% in the numbers of Eastern Europeans / Poles in the Wirral

- Registration with General Practitioners (GPs) / Health Practices in Wirral at 99% is the same for all ethnic groups. Many BME interviewees volunteered very positive comments about the National Health Service (NHS), while the high levels of trust and confidence they have in their GPs (95%) is reassuring. However over a third felt their GP either did not understand them at all (4%) or did so only partially (29%) and 13% did not feel they were fully treated with respect and dignity by their GP which partly appears linked to perceptions about cultural and religious insensitivity. Other health professionals were viewed as treating BME patients with respect and dignity, with very high levels of satisfaction in how they dealt with health concerns

1.0 Introduction

This report presents the findings of an assessment of the health needs of Wirral's Black and Minority Ethnic (BME) communities, commissioned by Wirral Primary Care Trust (WPCT) and undertaken by Icarus between May and November 2009.

1.1 Background

The last decade has witnessed an increasing concern to address health inequalities within the NHS,[1] with a significant focus on the differences in health outcomes between ethnic groups.[2] In respect of a range of health conditions, people from BME communities within this country have worse outcomes than the general population, while experiencing more difficulty in accessing NHS services.[3]

Following the Darzi Review,[4] every PCT has had to prepare a Joint Strategic Needs Assessment (JSNA) and put in place strategic plans for addressing health inequalities. The NHS commitment to 'World Class Commissioning' requires PCTs to understand their local population, its demographics and health profile including health needs and any inequalities experienced by different groups.[5]

The Wirral JSNA in October 2008 acknowledged that there was a significant gap in knowledge about Wirral's BME population and limitations in the available data on ethnicity. The following key issues were identified:

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[1] Dept of Health (2004) The NHS Improvement Plan: Putting People at the Hearth of Public Services

[2] Raleigh, V.S. & Polato, G.M. (2007) Evidence of Health Inequalities, Healthcare Commission

[3] Lakhani, M. (2008) No Patient Left Behind: how can we ensure world class primary care for BME people?

[4] Darzi (2008) High Quality Care For All: NHS Next Stage Review Final Report, Dept of Health

[5] The Intelligent Board (2009) Commissioning to reduce inequalities

- There is a lack of robust data on the population prevalence of BME groups which makes assessing levels of access to services particularly difficult. The current methods, both nationally and locally of capturing data around ethnicity and migration are not fit for purpose as population change is happening faster than it has in the past.

- Services need to ensure that they are collecting monitoring data around ethnicity to enable organisations to appropriately plan services and ensure equity of access to services. It is important that service users understand the reasons why this data is being collected.

- There is a lack of local data on the health and well-being needs of the BME community; however this can in part be addressed by reviewing national data as it is unlikely to present a different picture for Wirral residents. However, there is limited evidence around the needs of the Polish and other migrant populations.

- There is some preliminary evidence to suggest that BME groups are not accessing health and social care services in accordance with their level of need; this however requires further exploration.

- Further, detailed health needs analysis should be carried out, particularly to find out the health needs of the migrant population.

1.2 Aim of the research

This research was commissioned to help address important gaps in what is known about the health needs of Wirral's BME population through achieving the following objectives:

- To provide statistically robust data on changes in the size of the BME population

- To determine how NHS Wirral services are experienced by BME communities, including their access to health provision

- To review NHS Wirral's health priorities, with a particular focus on seven of these and their relationship to the main BME communities in Wirral

- To provide a clear account of current knowledge about differences in health outcomes between ethnic groups

In the context of the key issues identified in the JSNA regarding the gaps in knowledge about Wirral's BME communities, it is relevant to note that the aim of this research was modified after the work had been commissioned. This followed a presentation of the research objectives and proposed methodology to a WPCT research and development group and subsequent discussion with the BME health needs steering group.

The outcome of the later discussion was that there was agreement that the quantitative research (household and BME community surveys) could go ahead, but a consultation exercise should be undertaken with key stakeholders in respect of the focus of the qualitative research. Icarus then undertook an e-mail survey of the key stakeholders, as well as phone interviews and meetings with a number of individuals and attended a meeting of Wirral Ethnic Health Advisory Group (WEHAG),[6] at which the research objectives and methodology were again presented and discussed.

As a result of this consultation, the next meeting of the BME health needs steering group agreed that the qualitative research should focus on the relationship between BME communities' access and experience of health services and WPCT's commissioning priorities. In particular it was decided to narrow the focus on the health priorities that mostly clearly related to individual health behaviour: alcohol use, obesity, smoking and sexual health, as well as three other priority areas, mental health, older people and children and young people.

It was also decided not to focus on the ethnic groups originally specified within the commission i.e. migrant workers, Travellers and Gypsies and refugees, and asylum seekers. Instead it was agreed to concentrate the research on the main BME communities in Wirral: Asian or Asian British (including Bangladeshi, Indian and Pakistani), Black African and Black Caribbean or Black British, Chinese, Irish, and Eastern European /Polish. The qualitative research would then principally be concerned with their experience and access to health provision, the relationship to the specified health priorities of WPCT, as well as trying to identify any additional or specific health needs in relation to these communities.

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[6] WEHAG has produced a useful 'Information and Resource File' (January 09) for use by workers in health and social organisations working with BME communities in Wirral

1.3 Methodology

Approach

The importance of drawing on the knowledge, experience and assistance of key stakeholders throughout the course of the research was recognised. A BME health needs steering group of key stakeholders was established by WPCT at the outset of the research to provide advice and support, including commenting on survey design and other methods used, as well as helping facilitate the research e.g. by identifying and helping to engage other relevant stakeholders.

It was also felt to be important to provide key stakeholders, including health and social care professionals and representatives of BME community groups and organisations, with an opportunity to comment on the main findings. This was done through a facilitated workshop towards the end of the work which also provided participants with a chance to give a further perspective on the research, to contribute additional information and to make suggestions as to actions needed to improve health outcomes for BME communities in Wirral.

Household survey

In order to establish what changes have occurred in the size of the BME population in Wirral and to gather general information about people's experience of health services, a randomised survey was undertaken involving 1728 households. Employing a survey of this size, selected through a rigorous randomised process ensures a high degree of confidence in the reliability of the findings.

The survey area (Wirral MBC) consisted of 22 electoral wards; five of these wards, namely Birkenhead, New Brighton, Liscard, Oxton and Eastham were purposefully selected to undertake a household survey to establish the ethnicity of the household. Each of these areas was divided into 16 random sampling points and the lower super output sub-areas [LSOA's] corresponding to these random sampling points were identified. In total 54 LSOA's were used across the 80 sampling points.

These sub-areas were originally selected using the "sampling with probabilities proportionate to size methodology". This provided a wide spread of areas across the five electoral wards (appendix 1, table 1 distribution of surveyed residents / table 2 summary results of ethnic distribution of households). Within each sub-area, the households to be surveyed were selected randomly from the electoral register. From each household an individual respondent was also selected randomly. Where there was more than one eligible interviewee present in the home, the interviewers were instructed to attempt to interview the person who was next to have a birthday.

The survey data was collected by face-to-face interviews that took place at the respondent's home. Where there was no respondent available following an attempt to make a face-to-face visit, a letter was left at these addresses to inform potential respondents that they would be contacted again. This enabled the face-to-face interviewers to reduce the extent of "cold-calling". Interviewers made up to four attempts to obtain a response from each household. The interviews were carried out during the day, in the early evening and at weekends. Adults aged 16 or over and resident in the Wirral MBC area were eligible to be interviewed (appendix 1, table 3 gender profile of household and BME community surveys / table 4 age profile).

A team of interviewers conducted the interviews, seven of whom were members of BME communities in Wirral, who were recruited and trained for this purpose. All the relevant community organisations working with BME communities were circulated with a printed leaflet explaining about the proposed research and inviting people to apply for a position as a community researcher. Six out of the seven local interviewers were recruited in this manner; the seventh was recruited through the first phase of the fieldwork.

Five of the seven people responding had previous experience of undertaking some form of interviewing and were familiar with the processes of sample selection, questionnaire completion and the importance of objectively recording personal comments. They were all then trained in the use of the questionnaire by a field supervisor and where possible accompanied the field supervisor on some pilot interviews. All interviewers were required to submit their first five completed questionnaires for examination and to check for inconsistencies in completion. This process established that the interviewers were competent and were also able to provide insights into local BME health issues that perhaps could not have been obtained by regular fieldwork interviewers.

Following the piloting of the survey, the fieldwork was carried out between June and August 2009; the 1728 household interviews completed represented an 83 per cent response rate after removing unusable addresses (empty properties) and replacing them with adjacent addresses. For quality control purposes 7 per cent of households were subsequently randomly selected to verify that the interviews were completed correctly.

The survey consisted of two parts: a short questionnaire (appendix 6 – Household survey) completed by all interviewees and a longer version (appendix 7 - BME community survey) completed only by those identifying themselves (in the short survey) as being from an ethnic minority community as defined by the 2001 census.

The longer survey was used to explore in greater detail BME community members experience and levels of satisfaction with NHS provision, with questions based on those used in the 2008 National Survey of Local Health Services,[7] with which the results are compared.

In total 384 BME interviewees completed the longer survey with the number participating in the household survey boosted by the purposeful selection (proportionate to relative size of Wirral BME communities) of additional BME interviewees to provide more statistical reliable data.

Desk review

This comprised of a review of relevant NHS policy and research documents, census and other demographic data and local information provided by WPCT and Wirral MBC. The scale of the task of reviewing relevant research evidence is perhaps indicated by the estimate that fifteen million medical academic articles have been published to date, with a further 5,000 added every month.[8]

A web based search of research relating BME health needs was undertaken employing key words and phrases including ethnicity and race (appendix 2 – terminology) and each of Wirral's health priorities e.g. smoking and ethnicity / race, using NHS websites including Race for Health, the British Medical Journal, the US National Library of Medicine Pub Med, Google Scholar and other websites linked to these. As far as practicable, given the wide parameters encompassed by health and ethnicity as a research area, the web based search was extended to include other health conditions and groups e.g. learning difficulties and ethnicity.

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[7] The key findings report for the 2008 National Survey of Local Health Services, Co-ordination Centre for the PCT Patient Survey Programme, Picker Institute Europe, November 2008

[8] As cited in 'Bad Science', Ben Goldacre, Forth Estate 2009

Key informants

At the outset of the research the BME health needs steering group identified who it was felt were the key informants to this needs assessment, with further names / organisations being suggested by Wirral Ethnic Health Advisory Group (WEHAG). Contact was then made with 77 representatives from statutory agencies, service providers, including 20 voluntary sector agencies (appendix 3).

The response to the initial consultation on the focus of the research, which was undertaken by e-mail, was quite poor and it was necessary to follow this up with face-to-face meetings and telephone interviews. As well as enquiring about the proposed focus of the research, people were asked to agree to be interviewed as being key informants. Where appropriate, they were also asked to help facilitate the research by helping to arrange for a group of service users/patients/clients to participate in focus groups or by asking individual service users/patients/clients whether they would be willing to be interviewed.

Interviews with key informants

A series of interviews with Wirral NHS managers and staff using a semi-structured interview schedule were undertaken (appendix 8); in a few instances managers were unable to find the time to be interviewed and responded to the questions electronically. The question areas included exploring the extent of ethnic monitoring within the service, known or perceived differences in health needs and variation in outcomes between ethnic groups, the ability to provide a culturally sensitive service, whether staff received equality and diversity training and how to overcome any barriers that BME communities faced in accessing health services.

Semi-structured interviews (appendix 9) were also undertaken with other key informants, including representatives of local BME community groups and organisations and again exploring issues to do with access to services, differences in health outcomes and the health needs of BME communities. Response to requests for involvement in the research was mixed and continuous efforts through a variety of communication methods had to be employed to engage some organisations in the research.

All the interviews were undertaken by senior members of the research team, who were all experienced interviewers. The record of each interview was shared with the interviewee to ensure its accuracy.

Focus groups

Focus groups were employed as a means of exploring in greater detail the experience and perceptions of BME community members. Local community researchers and BME community organisations and groups helped facilitate the process of engaging potential participants and gaining their informed agreement to take part in the research.

The focus groups were held where it was felt participants would feel comfortable and in venues that were accessible; the majority taking place in local community venues. Participants received either a voucher, or small cash sum in recognition of their time and as an incentive for taking part.

The selection of focus groups was arrived at through consultation with steering group and other key informants, though it was not possible to arrange some of the proposed groups. In total nine focus groups were run:

- Asian Muslim women
- Polish mixed gender group engaged through the Primary Care Advice Liaison (PCAL) BME community outreach team
- Chinese elders attending Wirral Multicultural Organisation (WMO)
- Young people of Chinese heritage from the Chinese school at WMO
- A mixed BME women's support group engaged through the mental health service at Wirral Change
- Bangladeshi young men's group
- Mixed gender Middle and East European group
- Mixed gender African group
- Young Asian women's group

In addition a group of four Irish male service users from Irish Community Care Merseyside in Wirral were separately interviewed.

The focus groups involving Asian young women and Asian young men were arranged and undertaken in collaboration with John Moores University (JMU) Centre for Public Health; researchers from the university being involved in brining these young people together as part of their own research study with the assistance of Wirral Change and Wirral Brook.

The focus group for Asian young women was conducted by a JMU researcher, while in all other cases the groups were run by senior members of the research team experienced at running focus groups. The average size of the focus groups was eight and in some instances an interpreter was involved.

The topics covered in the focus groups included exploring participants' awareness and experience of health services on the Wirral and their ideas for how these might be improved. All groups were asked their views about access to health services as well as questions that were felt particularly relevant to them e.g. young people's experience of getting advice on sexual health and older people's experience of social care support.

Stakeholder workshop

The workshop was facilitated by the researchers using two exercises designed to help participants explore BME experience and access to health services and ways in which health outcomes might be improved for BME communities in respect of the NHS Wirral's health priorities focused on in the research. Participants' observations and comments were recorded and formed part of the data analysis (appendix 4 – participants attending stakeholder workshop).

Data analysis

The qualitative data was subjected to a framework process of categorising phenomena in relation to the research aims. The data was read and commented on by at least two members of the research team, enabling an initial analysis of emerging themes and relationships, with a further and repeated refining of the data to generate new insights, interpretations, commonalities and differences.

Process

Delays in commissioning the research meant that the work did not commence until mid-May 2009. The decision to undertake a consultation exercise in respect of the focus of the qualitative research delayed the start of this area of work and meant the summer holiday period began to intervene on completing the fieldwork. This had a further knock-on effect with the intended September stakeholder workshop rescheduled to early November to give ample notice to potential participants and with the final report then timetabled for the end of December 2009.

The additional work required to undertake the consultation exercise impacted on the time available for other aspects of the research. While the steering group played an important role in re-focusing the research, it only met twice, with the second meeting poorly attended (appendix 5 – BME Health Needs steering group).

Work pressures inevitably restricted the time key stakeholders were able to give; in some cases it proved difficult for people to find time to be interviewed and in others to help facilitate access to information or other stakeholders. The latter point combined with the need to get potential participants' informed permission to be involved in the research, meant that it was not possible to conduct focus groups with some intended groups e.g. Asian elders, despite repeated efforts to arrange these.

1.4 Research limitations

This research has a number of limitations in respect of the key issues identified in the JSNA 2008/09 as previously listed. The change in the focus of the qualitative research significantly broadened its scope, inevitably impacting on the depth of enquiry; instead of a detailed health needs analysis of three groups, a more general overview of the main BME communities and WPCT health priorities resulted. To partially compensate for this, the three original groups have been included in section six, which in the main is based on a desk review of research findings, though includes some local information gathered about migrants and Travellers and gypsies.

While the household survey does provide a statistically robust estimate of the size of the Wirral BME population, it was not envisaged that it would be able to give reliable data in respect of its composition or socio-economic characteristics of different groups. The relatively low numbers of people from a BME background means that the sub-category data in respect of any single ethnic group other than White British, is very small and not statistically relevant. In practice, the resource implications of undertaking a survey large enough to compensate for this probably makes such an exercise unrealistic. Until information is available from the 2011 Census, it will be necessary to rely on other data sources, though these have their own limitations.

The findings from 2008 National Survey of Local Health Services provide an important point of comparison in reviewing the local evidence of BME access and experience of health services. In order to provide this comparison it was necessary to use the same questions as employed in the National Survey (though reduced in number), even though some of the questions it can be argued, lack precision e.g. "*Did the doctor treat you with respect and dignity*". A particular difficulty was identified during the course of the research with the question on follow-up to check progress on medication / treatment (table 14), which does not allow for the fact that some patients had regular appointments and for others there was no expectation of any follow-up e.g. for a minor health complaint.

Much of the information gathered locally rehearses what is already known about BME access and experience of health services nationally e.g. issues to do with cultural sensitivity and communication; importantly what is missing is quantifiable evidence from different service areas to provide necessary perspective. While an interviewee may have identified a particular issue in respect of BME use of a service, without reliable monitoring data, it is difficult to know what weight should be given the observation.

This is particularly problematic in that BME communities largely share the same health concerns and experiences as the population in general, so an observation that BME men are difficult to engage in health promotion activities can be seen as applying to males in general Partly the weight given to any observation is based on the competence of the informant i.e. their specialist knowledge provides them with the insight and secondly, on the extent to which it is reinforced by other informants and research findings.

The lack of ethnic monitoring data is especially limiting in attempting an assessment of differences in health outcomes at the local level between ethnic groups. It has only been possible to relate the general observations made locally with wider research evidence. This research has also not been resourced to assess or evaluate the extent and effectiveness of any targeting of health services at the local BME community, beyond recording any observations made about this.

2.0 Wirral's BME Population

2.1 Population size

Our survey of 1728 households identifies a relatively small percentage increase in the size of the BME population in Wirral since the 2001 census which gave a figure of 3.56% (n11,200) for all BME groups, compared to an adjusted figure for today of 5.83% (n18,085).

The following table shows an overall decline in the Wirral White British population from 303,800 at the 2001 Census to a figure of 292,115 in 2009 (calculated from our household survey), while in contrast the figure for all BME groups increased from 11,200 to 18,085 over the same period (table A).

	Wirral ONS 2001 Census	**Wirral 2005 ONS mid year estimate**	**Wirral 2007 ONS mid year estimate**	**Wirral 2009 household survey**
All Groups	315,000	312,300	310,200	310,200
White - British	303,800	298,300	294,600	292,115
%	96.44	95.52	94.97	94.17
All BME groups	11,200	14,000	15,600	18,085
%	3.56	4.48	5.03	5.83

Table A: Change in BME population for Wirral MBC area

This finding is in line and consistent with the ONS mid year estimates made in 2005 and 2007 that show a gradual increase in the Wirral BME population as indicated in table A above (see appendix 1, table 5 Office for National Statistics (ONS) Wirral MDC mid-year estimates by ethnic group).

Our calculation has followed the standard convention of being adjusted to take account for differences in average household size between ethnic groups (as is the case for the ONS mid year estimates). This adjustment is shown in table B below:

	%	No of Households	Average Household Size	Pop. Size	% Pop
White British	96.2	139,901	2.11 [adjusted]	295,191	94.17
All BME Groups	3.8	5,526	3.31 [adjusted]	18,291	5.83
Total	100	145,427		313,482	100

Table B: 2009 Household survey adjusted for differences in household size

2.2 Ethnic composition

It is not possible to produce a statistically reliable estimate of the ethnic composition of Wirral's population based on the number of BME individuals interviewed in the household survey. At best the assessment of this data and other information gathered during the research provides some limited indication of its composition, which can be compared with other data sources.

After White British, the largest ethnic grouping in the household survey was the combined Asian / Asian British, followed by White-other background and then White-Irish (appendix 1, table 6 - ethnicity of household survey respondents with comparison with 2004 mid-point census estimates).

In analysing the 2007 mid-year ONS estimate of Wirral's ethnicity (appendix 1, table 5) the NHS Wirral's Performance and Intelligence team[9] notes the increasing potential margin of error inherent in using the 2001 census as the basis for estimating. This estimate identifies White-other background as the largest ethnic grouping followed by the combined Asian / Asian British (in part accounted for by a 400% increase in the Asian / Asian British Pakistani numbers to 500) and then White-Irish (appendix 1, table 6).

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[9] Wirral PCT (2008, 2009) Ethnicity in Wirral: 2008 & Ethnicity in Wirral: Update for 2009

An assessment of Wirral Schools census data (January 2009)[10] tends to suggest that the estimate in respect of the growth in the Pakistani population is inaccurate with Pakistani pupils accounting for 0.19% (n91) as opposed to 0.43% (n215) for Bangladeshi pupils, though the 2007 ONS mid-year estimate gives the estimated size of both populations as the same at 500.

This is further supported by reviewing Wirral PCT GP Registers, which give the place of birth for 54% of the total registered population, as of March 2008 (though there are difficulties with this data, including using place of birth as denoting ethnicity). India (n633) is the second most commonly occurring place of birth outside of the UK after other European (n1532), followed by Germany, Poland, South Africa, Bangladesh and China, while Pakistani is the second least common (n105).[11]

Data on the issuing of new national insurance numbers (NINo) to non-UK nationals in 2006/07 shows that of the 860 new registrations over half were from Eastern Europe and in the main from Poland (390).[12] The NHS Wirral up-date on ethnicity compares the three years of national insurance data from 2006 to 2008 (appendix 1, table 7), which shows the number of new NINo falling significantly in respect of Poles in 2008 (240), though still by far the largest national group.

This pattern of Eastern European and in particular Polish migration into the Wirral is supported by the observations made by representatives of the Polish community organisation, who also thought that approximately 50% of the Poles and Eastern Europeans who had come to the area in recent years had returned home. A quarter of interviewees for the BME community survey had been resident in the Wirral for five years or less, with Poles being the largest nationality group amongst these (appendix 1, table 8).

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[10] Wirral MBC (2009) Schools Census Analysis

[11] As cited in reference 8

[12] Government Office NW (2008) Health & Migration in the NW of England : An Overview

3.0 Experience of Health Services

This assessment of BME experience and levels of satisfaction with Wirral NHS health services draws on both the household and the BME community surveys. Comparison is made with the 2008 National Survey of Local Health Services that surveyed more than 69,000 patients registered with a general practitioner (GP) nationally.[13]

3.1 National Context

Evidence from the National Patient Survey programme[14] shows that while in many areas of health provision there is no difference in the experience of BME and White British patients; where differences do exist, BME groups are more likely to report negative experiences of health services. Patients from Asian, Chinese and 'other' ethnic groups were least likely to give positive responses in respect of their experiences. Black patients had a more mixed experience and were only slightly less likely to give a positive response than White British patients, while Irish patients gave more positive responses.

Access to services, waiting times, the provision of information and being given more choice were the areas where BME groups tended to give least positive responses. The largest differences occurred in respect of Primary care and outpatients, whereas there were few differences in respect of mental health services. Bangladeshi patients were the least satisfied with access to Primary care services. Lower rates of satisfaction also tended to be associated with large GP practices in the most deprived areas, serving a significant BME population.[15]

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[13] The key findings report for the 2008 National Survey of Local Health Services, Co-ordination Centre for the PCT Patient Survey Programme, Picker Institute Europe, November 2008

[14] Dept Of Heath (2008) Report on self reported experience of patients from Black and minority ethnic groups

[15] Dept Of Heath (2007) GP Patient Survey, as cited in reference 11 above

3.2 Wirral BME patients’ experience

Household survey

This covered the following questions, asked of all respondents and compared here with the findings from the 2008 National Survey of Local Health Services:

Registration with GP

The level of registration with GPs / Health Practice is the same for all ethnic groups in Wirral at near 99% (percentages rounded to nearest whole number - appendix 1, table 9).

GP / Health Centre appointments

There was no appreciable difference in the percentage of BME patients making appointments with their GPs / Health Centre in the last 12 months, compared to patients nationally, though they were slightly more likely to do so than for White British patients in Wirral (appendix 1, table 10).

Waiting time for appointment

Fewer BME patients were seen without an appointment compared to both national patient survey findings and the experience of White patients in Wirral, or to be seen via a pre-planned appointment. BME patients were more likely to be seen on the same working day as requesting an appointment, though also more than twice as likely to say that they had to wait more than two days for an appointment than other Wirral patients (appendix 1, table 11). Given this, it is perhaps not surprising to find that BME patients were almost twice as likely to say they were put off making an appointment because the times were inconvenient, than was the case for White Wirral patients at 24% compared with 13% (appendix 1, table 12).

Trust and confidence in Doctor

All patients reported high levels of trust and confidence in their doctor (appendix 1, table 13). This finding was not affected by BME patients appearing to be less likely to have the progress of their treatment checked on than other patients (appendix 1, table 14), though this needs to be treated with a great deal of caution as some respondents did not require follow-up, and some respondents had regular appointments (these responses were not consistently recorded; none responses were recorded as ‘No’).

Wirral BME Community Respondents

The BME community survey explored in more detail the experience of Wirral BME community members, which are again compared here with the findings from the 2008 National Survey of Local Health Services.

The Courtesy of the receptionist

Wirral BME patients were less likely to rate the courtesy of reception staff as excellent (15% compared to 28.5%), though more likely to rate it very good compared to patients nationally (47% compared to 34%); there was little difference in those who rated courtesy as very poor, though BME patients were more likely to rate it as poor (appendix 1, table 15).

Listening to the patient

A third of Wirral BME patients felt their doctor did not listen carefully to them (appendix 1, table 16); this can be linked to the number of local BME patients who felt their doctor only partially understood them (27%) or did not understand them at all (8%), though this also applied to a quarter of patients nationally (appendix 1, table 17). Wirral BME patients were more likely to say that they were not given enough time to discuss their health condition than patients nationally (13% compared to 4.5% - appendix 1, table 18).

Involved in decisions

BME patients in Wirral were less likely to say that they were definitely involved in decisions about their treatment than patients nationally (appendix 1, table 19), though some respondents did not have the expectation, or necessarily want to be involved and said they trusted their doctor to make decisions for them.

Understanding

There were no BME respondents who said that they were unable to ask questions of their doctor and a large majority said they definitely understood the answers they were given, though just under 6% said they did not, as opposed to 2% of patients nationally (appendix 1, table 20). This needs to be contrasted with the differences in the percentage of BME patients who said their doctor had adequately explained their treatment with 62.5% saying their doctor had done so completely, compared with 76.5% for patients nationally (appendix 1, table 21).

Treated with respect and dignity

Wirral BME patients were less likely to say their doctor had definitely treated them with respect and dignity, with twice as many (13%) saying that their doctor had only treated them with dignity and respect to some extent, compared to the national patients survey (appendix 1, table 22). This may be linked to the next question on whether they felt they were treated appropriately in respect of their culture and religion (appendix 1, table 23) with 81% saying this was definitely the case and 19% feeling that this was only true to some extent.

Information about medicines

Two-thirds of Wirral BME patients had been prescribed new medicine in the last 12 months (appendix 1, table 24); they were less likely to say they were as involved as they wanted to be about decisions about their medicine than patients nationally (appendix 1, table 25) and also less likely to say they had been given enough information about the purpose of the medicine (appendix 1, table 26), though there was no difference in the percentage who said they were given enough information about the use of the medicine (appendix 1, table 27).

Seeing a specialist

There was no difference in the percentage of people who were referred to a specialist (appendix 1, table 28), while BME patients in Wirral were significantly more likely to have been offered a choice of hospital, 68% compared with 43% for patients nationally (appendix 1, table 29) and also to say that their specialist had all the necessary information about them (appendix 1, table 30).

Contact with other health professionals

A significant number (44%) of Wirral BME patients had seen someone other than their doctor in the last 12 months (appendix 1, table 31), with practice nurse / nurse practitioner (74%) being the most frequent health professional seen (appendix 1, table 32). Though the great majority of patients felt satisfied with how the matter was dealt with, BME patients were twice as likely (7%) to say they were not satisfied (appendix 4, table 33).

Respect and dignity – other health professionals

BME patients in Wirral overwhelmingly (98%) said that they were treated with respect and dignity by other health professionals (appendix 1, table 34), though a small number (4%) did not feel that they had been appropriately treated in respect of their culture and religion (appendix 1, table 35).

Seeking help

BME interviewees reported a number of areas in which they had sought help in the last 12 months, which is of particular relevance in respect of health promotion and preventative health measures targeted at BME communities in Wirral (appendix 1, table 36). Over 20% of BME community members did not know where to go for additional help.

4.0 Accessing health services

The evidence in respect of Wirral BME access to health services is drawn from the BME community survey and the observations of key informants. In considering access to health services and the barriers that may impede this, it is important to place this within the context of the virtual universal registration with GPs by Wirral BME community members. GPs play a pivotal role in accessing NHS services and this predictably makes them a focus for interviewees commenting on access issues. However, it is also necessary to identify other service areas where action may be required to help address any barriers experienced by BME communities.

4.1 The national context

A recent review for the Department of Health[16] suggests BME patients find it more difficult to access GP services due to four inter-related factors:

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

Language barriers have been shown to be a significant cause of communication difficulties between BME patients and GPs; BME patients are less likely than the general population to feel they have had sufficient time with their GP and as such may need longer appointment times. They are also more likely to say they feel unable to complain about Primary care services, do not understand how the local structures of the NHS work or the role of the PCT and to be frightened of being taken off their GP's list.

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[16] Lakhani, M. (2008) No Patient Left Behind: how can we ensure world class primary care for Black and minority ethnic people? Dept Of Health

The process of making appointments can be harder for BME community members, especially where there are communication problems. This can lead to conflict with receptionists, who have a key role in the respect of BME patients' relationship with GP practices. Variations in the quality of GP practices in meeting patients needs is a further factor impacting on BME patients experience and access to services.

4.2 Wirral BME access

To a large extent the picture of BME community access to health services nationally is repeated at the local level within Wirral:

Communication problems

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

In one instance it was suggested that communication difficulties between GP and patient were exasperated where neither had English as their first language. The observation was also made that people would travel outside of the Wirral to register with a dentist who spoke their own language even though this might represent a considerable inconvenience.

Not surprisingly groups newly arrived in this country and elders of some BME communities were identified as being the most likely to report language as a barrier to accessing services. Difficulties were intensified when there was a lack of family support and limited access to advocates/support workers, which could compound feelings of isolation.

The provision of effective translation and interpreting services clearly have a vital part to play in overcoming language barriers; a number of community interviewees and several key informants identified a range of issues to do with how these are provided within the Wirral:

- Language Line (the telephone interpreting service used by NHS Wirral) in some instances considered culturally inappropriate e.g. provision of a male interpreter for a female patient

- Different dialect spoken by interpreter, which for some languages can make it extremely hard for people to understand each other

- Variable quality of interpreters, who sometimes lack knowledge about medical terms

- Lack of dignity and privacy in some health service areas, for example telephones used to contact Language Line located in public access areas

- Interpreters are not always available, which can be a particular problem for voluntary organisations working with BME communities

- Translation and interpreting services can be required out of hours, but this is not always available

- Use of family members and children by some health services to translate is inappropriate

- Booking a health service appointment attended by both patient and interpreter may result in a delay in setting up appointment

- The advance access GP appointment system which enables patients to make same day appointments by phone is difficult to use by people with low or no levels of English

"If I want to make an appointment at the GPs I have to ring at 8.30 to get appointment but I have to ring health link worker to ask her to make appointment and she does not start work until 9.00"

(Chinese elder speaking through interpreter)

"Interpreting services are sometimes available but there is a lot of use by families of children for interpreting. Some staff are aware and they don't use children for interpreting. If they do, they may get answers from the relative rather than from the patient and they will pass their own judgement on as an interpretation."

(Comment by community service provider)

Additional issues were also identified around translation and health publications including:

- Letters from the GP usually sent in English with concern that some non English speakers simply dispose of these
- Incorrect translations
- There was little/no information in different languages in health care services e.g. it was reported by one interviewee that there are no leaflets in GP surgeries in Polish.

'I have a good friend who gives me lots of advice but booklets in Polish would be very good.' (Polish male aged 39)

'It would be helpful to have access to leaflets in Chinese at the local surgery.' (Chinese female aged 45)

"*Also need more information in different languages e.g. there are no leaflets in polish in GP surgeries. A Polish woman whose child had swine flu took him to hospital because she had no information about what to do in Polish*." (Comment by community organisation representative)

BME community members and representatives from BME organisations viewed the use of community interpretations as a valuable initiative in helping overcome some of the difficulties around communication. These were usually recruited from the same community as the patient and not only provided assistance with interpreting and translation but could also explain the working of the health system and give practical help such as accompanying them to medical appointments. The use of community interpreters was seen as of particular benefit to those in vulnerable groups such as the elderly, the learning disabled and newly arrived groups.

"Newcomers now are often Iraqi/Afghan asylum seekers. They tend to have a lot of problems with the language and access to interpreters is much better than translating. They feel more comfortable in using a community service and need someone there to help, someone who will take them to the hospital, optician or other health service."

Community service provider

"They do use language line but I have had a lot of negative feedback. Most patients would like to have a translator – to translate trauma you need to be very experienced and have a good understanding."

PCT Manager

Issues to do with GP practices

Given the key role GP practices play in both providing and acting as gatekeepers to other health services, it is not surprising that there were a number of additional issues identified in relation to these. However, as already noted BME patients in Wirral have the same high levels of trust and confidence in their GP as patients in general and the number expressing dissatisfaction with GP services are low. The following issues with GP services were identified:

- Some surgeries said to not always be willing to supply an interpreter
- BME patients were less likely to feel their GP listened carefully to them and more likely to say that they were not given enough time to discuss their health or medical needs
- Limited understanding of how to complain or change GP for some members of BME communities
- Inflexible consultation times
- Poor communication between GP surgery and patient
- Difficulties in relationship with receptionist including receptionist acting as gate keeper and offering incorrect advice, with lower levels of satisfaction with the courtesy of the receptionist

‘Make it easier to change your doctor.’ (Gambia male, aged 28)

‘There should be more information about how you can see a female GP or specialist – I don’t know how to find one.’
(Bangladesh female, aged 23)

‘More welcoming Receptionists/more friendly receptionists.’
(Bangladesh female, aged 56) / (Yemeni female, aged 39)

‘To spend more time with doctor.’ (Yemeni male, aged 19)

Issues relating to GP practices can impact on how BME patients access health services; members of BME communities were said by several interviewees to be more likely to present at services they feel most comfortable with rather than the most appropriate, including:

- A Polish family who were not happy with service from their GP presented at A&E although it was not an emergency
- Chinese elders with low levels of English are likely to present at A&E rather than ringing the ‘out of hours’ service
- Young people who considered the GP appointment system too complex simply presented at the Walk-in centre

‘I thought in most cases the first thing to do is phone 999 as this is the quickest way to get medical help. This will save a lot of fuss to find an interpreter’ (76 Chinese female, aged 76)

‘It’s easier to go to A & E because you have to make an appointment with GP.’ (Croatian female, aged 27)

Surgery opening times were identified as creating difficulties by a number of community interviewees and representatives of BME community organisations, in particular for people working during unsocial hours such as the catering industry.

'It's easier to go to A & E because you can't get an appointment as a shift worker.' (Ukraine female, aged 44)

'Shift working and opening hours for surgeries and pharmacies don't work together and therefore more flexible system required.' (Russian male, aged 47)

Different expectations of BME patients

Understandably many new arrivals in the Wirral find the health system very different from health services they have experienced in their home country as evidenced by the observations made by several community interviewees. The health system was often regarded as confusing and interviewees reported a limited understanding of how the system works and how services can be accessed.

'I believe more time spent explaining how the system works would be good. It's different from home – I thought I had to pay at first.' (Gambian male, aged 28)

'We need more information on how system of health works here and options for health treatments.' (Russia male, aged 47)

A number of key informants felt that BME community members were less aware of what preventative services were available and unfamiliar with them.

'He was unsure about where to get condoms. Thought the only place to obtain them was from a chemist and wasn't aware of any other contraceptive service. Found it embarrassing and suggested booklets should be made available in own language – he has looked but couldn't locate them.'

(Afghanistan male, aged 35 – talking through an interpreter)

For some BME community members the experience both in terms of waiting lists for appointments for specialists, waiting times when accessing A&E and occasionally GP surgeries was a new and unfamiliar experience. Involving an interpreter often delayed appointments still further; this was particularly relevant with ongoing routine procedures such as blood taking and monitoring of long term conditions such as diabetes.

"If you are referred on by your GP you will see somebody right away without waiting. Also can organise visit to hospital so you see everybody you need to in that one day – don't have to keep returning to see different specialists. In xx if you know what is wrong with you then you just go straight to specialist."

Eastern European interviewee

Some BME community members spoke about how they felt that their own knowledge was not valued and that their experiences were often belittled. Knowledge and experience from being a health professional aboard, or through familiarity with common illnesses in their home country was felt to be often ignored by medical practitioners in Wirral.

"I was told to go back to xx to be treated said there was no respect. I am a xxx and therefore have knowledge maybe I frightening the professionals."

Eastern European interviewee

Cultural awareness and sensitivity

Health professionals' awareness about cultural diversity was regarded by a number of key informants as weak; a link was made between this and a poor experience of services by some focus group members and several BME community representatives. A lack of awareness or cultural sensitivity was illustrated in respect of the Muslim community by the limited availability of Halaal food in hospital, access to female practitioners, no prayer room in hospital or A&E and a lack of understanding around issues of washing and cleanliness.

‘I have had to wait a year to see a female gynaecologist. I asked why it has taken so long and they said she was the only one.’

(Bangladeshi female, aged 31)

‘Female clinician always a nightmare to get and have to end up seeing a male clinician which is not sensitive to my culture or religion/alternatively have to wait a long time to see one.’

(26 Sudanese female, aged 29)

‘Doctor making comments inappropriate for Muslim female due to lack of awareness.’

(Turkish female, aged 32)

All the health service providers reported that they had access to equality and diversity training. Opinion on the adequacy of this training was mixed; where staff knowledge and experience was low the training was helpful and useful, where their knowledge and experience was high the training was generally considered too basic.

“Staff do get training however they do need more than just basic training, the training needs to be built in”

PCT Manager

Note: A recent NHS publication on communicating with diverse communities offers practical suggestions as to how health practitioners can improve communication with BME communities.[17]

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[17] NHS North West (2009) Communicating with Diverse Communities – Good Practice Toolkit (draft)

5.0 WPCT Health Priorities

This section focuses on Wirral PCT's commissioning priorities and their relationship to local BME communities; within this there is a particular focus on the following priorities:

- Mental Health
- Obesity
- Alcohol
- Sexual Health
- Smoking
- Children & Young People
- Older People

In considering these particular health priorities we have drawn on interviews with health professionals and other stakeholders as well as directly from BME community members through focus groups and interviews with community representatives. For each priority area we have identified the key informants and where appropriate given examples of relevant local initiatives.

In the main interviewees were identified by steering group members (including themselves) as being able to give an informed view on a health priority or able to represent the perspective of a particular BME community. Where statements by interviewees are potentially contentious, we have said whether this is the view of one individual or more widely held and whether there is evidence to support it. Overall interviewees spoke in general terms about the health priorities, but mostly were unable to provide specific information regarding the use of services and health outcomes relating to BME groups.

While we have been especially concerned to try to establish what is happening locally, we have also reviewed the wider research evidence in relation to each health priority and identified relevant NHS policy. The extensive scope of this task has limited the degree of detail it has been possible to provide and given that information is frequently relevant to more than one priority e.g. young people, sexual health and alcohol, we have in the main not tried to cross-reference material. It is important to acknowledge that our review of this research is from a non-medical perspective. We have tried to present this information in relatively plain language; however in many instances it is either not practical or possible to use anything other than medical terminology.

As noted Wirral's JNSA 2008/09 identified the lack of good quality monitoring data in respect of ethnicity as an important limitation in accessing the health needs of BME communities in Wirral. Whilst we understand that that ethnic monitoring data is now collected in a more robust way within the PCT, this data was not yet available to inform this research.

This section begins by first looking at Health Inequalities, which provides an important perspective in considering the other health priorities; those that are the main focus for this part of the research are next reviewed, followed by a briefer account of the remaining WPCT priorities.

5.1 Health Inequalities

Recent years have seen an increasing emphasis within NHS policy to address health inequalities and ensure equal access to good quality health care. At the same time there has been a heightened recognition that people from a BME background face significant health inequalities and experience poorer health and life expectancy than the general population.[18] This research sits within the context of the priority given by WPCT to addressing health inequalities in respect of BME communities in Wirral.

While certain inherited conditions such as sickle cell disorders and cystic fibrosis occur more frequently in particular population groups, differences in health outcomes between ethnic groups need primarily to be seen in respect of the inter-relationship between a number of different factors.

Socioeconomic

BME communities generally experience higher levels of poverty linked to lower levels of employment, low pay and poorer conditions than the general population, which are also linked to inferior housing and physical environment. These socioeconomic factors have a clear bearing on differences in health outcomes experienced by many BME communities; within a relatively deprived area BME individuals are more likely to be further disadvantaged.

Wirral is in the 20% most deprived districts nationally; ranking 60th out of 354 districts and is in a sub-region (Greater Merseyside) that is within the 20% most deprived sub-regions. Within the Wirral there are pockets of very high deprivation; on the index of multiple deprivation the average super output area (SOA) score is very high

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[18] Department Of Health (2009) Healthy Understanding: NHS Race for Health's progress report 2009

at 27.90 compared to a 21.57 for England. In respect of health Wirral is ranked in the 20% most deprived districts.[19] There is a strong association between where many BME community members live in Wirral and with the areas of higher deprivation.[20]

Migration

There is little evidence to suggest migrants in general increase the strain on Health services.[21]However, as identified in this research relatively recent arrivals will often experience difficulties in accessing health services as a result of language problems and of not understanding the system. Asylum Seekers and Refugees also frequently have particular health needs e.g. as a result of physical abuse and emotional trauma[22].

Racism

There is evidence that racism has a detrimental impact on the health of individuals, including the mental health of victims of racial harassment[23]. Institutionalised racism impacts on BME access and experience of health services and has been particularly highlighted as a cause of concern within mental health services.[24]

Culture

Different cultural practices may have a bearing on health status as for example higher levels of infant mortality linked to consanguinity, or marriage between close relatives within Pakistani communities within Britain. Religious or cultural beliefs can influence attitudes towards accessing health services, as amongst members of some communities who see mental illness as an act of God. Diet is also of potential significance e.g. in relation to coronary heart disease (CHD) and hypertension. A lack of cultural sensitivity, as noted in this research and elsewhere can have an important bearing on BME patients' experience of health provision[25].

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[19] The Local Futures Group (2009) District Profile: a deprivation profile of Wirral

[20] Wirral PCT (2008) Ethnicity in Wirral: 2008

[21] Government Office NW (2008) Health & Migration in the NW of England : An Overview

[22] Burnett, A. Peel, M. (2001) Asylum Seekers and Refugees in Britain: Health needs of Asylum Seekers and Refugees

[23] Smaje, C. (1995) Health, 'Race' and Ethnicity, making sense of the evidence

[24] Guardian (2004) NHS urged to combat institutional racism; inquiry report on the death of David Bennett / and written Ministerial Statement to the House, John Reid, DoH, 12 February 2004

[25] As cited in reference 22

5.2 Mental Health

Key local informants:

- Primary Care Advice Liaison (PCAL) Outreach Team BME
- WPCT Interim Programme Manager Mental Health
- Senior Community mental health worker
- Wirral Change Managers
- Wirral Multi-cultural Organisation (WMO) Asian Community Co-ordinator
- Irish Community Care Merseyside (ICCM) outreach worker
- Project Co-ordinator and Smoking Cessation Worker (Merseyside Polish Association Cracow)

Delayed access: A key concern to emerge from the comments of a number of interviewees was the perceived tendency for BME individuals' to be more likely to access mental health services at a late stage, often at crisis point. This increased the risk of self-harm and curtailed the range of interventions that could be employed, making it less likely that they would access talking therapies and more likely that they would be admitted to hospital. The following factors were suggested as explaining the reason for BME individuals accessing mental health services at a late stage in Wirral:

- There is reluctance by some members of BME communities to engage with early intervention services. Both mental health service providers and representatives from BME organisations observed that within some BME communities, mental illness is not seen as such and there is not an acceptance or possibly an understanding of the western psychiatric model of mental health. In other instances there was considerable stigma associated with mental illness and in either case this impacted on the willingness to engage with services

"In some groups mental health doesn't translate well. There are big cultural issues…. We need to inform people that it is usual to feel ill/depressed we need to make mental health more common."

PCT manager

- There is a lack of knowledge within BME communities about mental health provision, particularly early intervention services. Several of the focus group participants said they were unsure which service or agency was the most appropriate to contact and when they should/could do so, which resulted in people in crisis turning up at A&E.

> *"Some people from BME communities do not come in early enough, they wait until they get into crisis. Need to recognise the need for promotion around early intervention and prevention."*
>
> PCT Manager

- There was a general consensus that delays were often experienced between referral and being seen by a mental health specialist, though it was not clear whether this was thought to be more of an issue for BME individuals, or why this should be

> *"They also told me that they had sent me a letter to see a psychiatrist, but I've been waiting 5 months, and still haven't seen it."*
>
> Irish, male interviewee

Non-detection of mental illness: Another concern emerging from the comments of several interviewees and raised in the focus groups was a view that mental health needs of BME individuals were not always detected by health professionals. It was suggested that the reason for this were inaccurate assumptions and stereotyping e.g. the 'Irish drinker' as opposed the depressed and isolated individual, which could affect the treatment and support they received.

> *"There is a disproportional amount of BME in high risk categories e.g. in prison, relating to mental health issues such as being over prescribed drugs to quieten them and giving people unnecessary medication."*
>
> Service provider

Interviewees identified a range of often inter-related factors they saw impacting on the emotional and mental well-being of Wirral BME communities:

- **Social isolation** was viewed as a particular problem faced by many BME individuals who could feel ignored and sometimes not wanted. This was seen as a particular concern with regard to young Muslim men and women who were thought to be more susceptible to a sense of alienation or feelings of not belonging, possibly leading to depression and suicidal thoughts. Social isolation was also thought to be an important issue with regard to migrant workers and Irish men, who might turn to alcohol as a way of dealing with it

"Isolation is significant" Service provider

"Young Muslim men can experience depression/suicide feelings of alienation because at home they have been brought up with Muslim friends, family and interests, whilst out of home they may have white friends and interests and influences of white western culture. Can feel alienated and removed as people don't see them as them."

Service provider

- **A lack of practical support** particularly around caring responsibilities mainly in relation to older people, but also extend to other caring responsibilities including care for disabled children and adults. This was highlighted as a concern particularly with regard the Asian community

- **Poor housing**, including overcrowding, inadequate heating and poor state of repair; particularly a concern for families and people who were in poor physical health. This was also often linked to low income and financial difficulties associated with unemployment and poorly paid employment that migrant workers and other BME community members would be more likely to experience than the population in general

- **Language difficulties** in accessing services. Some interviewees suggested insensitive treatment and culturally inappropriate services were also a factor, though this was not expanded upon in specific relation to mental health provision and as with language difficulties, can be viewed as a generic comment about all services

Research review

Mental health and ethnicity has been the subject of considerable dispute, with the focus shifting from a preoccupation as to whether some ethnic groups are particularly prone to mental illness, to a concern with inequalities in service provision and differences in health outcomes. The 1999 Mental Health National Service Framework (NSF)[26] identified the lack of research in relation to mental health and ethnicity; however there is now an increasing focus on this issue, though still a lack of population-based evidence on the prevalence of psychiatric illness. In reviewing the research a somewhat confusing picture emerges.[27]

One report suggests that "*there does not appear to be a single area of mental health care in this country in which BME groups fare as well, or better than the majority population. Both in terms of service experience and the outcomes of service interventions they fare much worse*." [28] This report comments that psychiatric illness rates are generally higher in minority ethnic groups and that they have poor social networks and support, with significant differences in their experience of mental health services and in outcomes from service interventions.

A number of studies, largely based on treatment rates, report Black Caribbean people to be between three and five times more likely to suffer psychotic illness, including schizophrenia, than the population as a whole. However other research, based on psychiatric illness rates in the community, found that they did not have significantly higher rates than other groups and though the rates for psychosis were twice that of the White group, they were not statistically significant. In respect of common mental disorders (depression, anxiety, phobia, obsessive compulsive disorder and panic disorder), while rates were low for Bangladeshi women and high for Pakistani women and Irish men, there were no marked differences between ethnic groups.[29]

Overall, women have higher rates of these conditions than men from the same ethnic groups, with the exception of Bangladeshi and Irish men. Minority White and Caribbean groups had higher rates in respect of neurotic depression, suicidal thought and non-affective psychosis, Indian / African Asian and Pakistani groups'

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[26] Department of Health (1999) Mental Health National Service Framework

[27] Department of Health (2002) National Institute for Mental Health in England

[28] Sashidharan, S. P. (2003) Inside Outside – Improving Mental Health Services for BME Communities in England

[29] Aspinall, P.J. & Jacobson, B. (2004) Ethnic disparities in Health and Health Care: a focused review of the evidence and selected examples of good practice

similar or slightly higher rates than the White British group, while Bangladeshi and Chinese groups had considerably lower rates. Rates of neurotic disorders were particularly low in South Asian women, while Caribbean women had rates of psychosis twice that of White British women[30].

There are elevated rates of suicide for people born in Scotland and Ireland. Rates are low in Caribbean, East African and South Asian groups, though rates for young Asian women are twice those of young White women. Rates of self-harm and attempted suicide also reported as being much higher amongst young South Asian women[31].

Black people are often reluctant to engage with mainstream mental health services, doing so only at the point of breakdown or crisis. This makes the involvement of the police and compulsory admission under the Mental Health Act more likely and leads to disproportionately high rates of hospital admission and use of intensive care, secure services and use of seclusion and restraint. This pattern of service use is negatively experienced and is related to poor outcomes, with high rates of relapse and readmission.[32]

Service users from White Other and Black / Black British groups said they were less likely to receive talking therapies.[33] Immigration status, language difficulties, fear and cultural differences act as barriers to accessing mental health services.[34]

Local initiatives

- Initiative to increase access to psychological therapies
- Primary Care Advice Liaison (PCAL) BME Mental Health Service based at Wirral CAB
- Mental health/emotional well being women's support group at Wirral Change
- Irish Community Care Merseyside's Outreach Service

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[30] As cited in reference 24

[31] As cited in reference 24

[32] The Sainsbury Centre (2006) The cost of race inequality – policy paper 6

[33] Department of Health (2008) Report on self reported experiences of patients from BME groups

[34] CSIP (2009) Community Mental Health Research Report on Inequalities and Cultural Needs in Mental Health Service Provision for BME communities in Liverpool

- Health Link Worker Service based at Wirral Multi-cultural Organisation
- NHS Wirral has commissioned a BME service evaluation from a provider perspective to understand issues that may impact on service delivery for BME people

PCAL BME Mental Health Service

The BME Mental Health Service is part of the PCAL service for people with mild to moderate mental health problems and is based at Wirral CAB. The two Mental Health Outreach Workers provide help and support on a range of issues including employment, Welfare Benefits, Debt, Housing, Community support groups, and community care. The service is provided in GP surgeries and community venues with one outreach worker based mainly at One Stop Shops on Wirral. Clients are mostly Polish who have limited understanding of the system in the UK. The second Outreach Worker provides services primarily through local GP surgeries working with South Asian people

Key policy

1. Delivering Race Equality in Mental Health Care; DoH 2005
2. Mental Health National Service Framework, DoH 1999
3. National Institute for Mental Health in England; DoH 2002

5.3 Obesity

Key local informants:

- Wirral NHS Commissioner for sexual health and obesity
- Stop Smoking Advisor (BME)
- Asian Muslim women's group
- Mixed gender African group
- Mixed BME women's support group

A number of issues and concerns were identified by interviewees and focus group participants about the relationship between obesity and BME communities in Wirral:

- Cultural differences surround attitudes to weight desirability and body image; within some African cultures, plus size women were considered to be attractive and not thought of as unhealthy. Changes in lifestyles and activity levels in moving to Britain, while retaining dietary habits had an adverse affect on weight e.g. people coming from African countries quickly adapted to the use of cars and vehicles as the norm, whilst not changing dietary habits to compensate for lower levels of physical activity

"Here there is less activity, people are eating the same but putting on weight, nobody walks here."

African female

- Limited knowledge about food, ingredients and healthy eating was highlighted as a particular concern in respect of mothers of younger children, Muslim women and Chinese elders. Cultural and religious festivals are linked with difficulties in maintaining healthy eating and life styles e.g. during Ramadan breaking the fast by serving large platters of often fried food. There was also a concern about insufficient information being available about healthy eating and pregnancy and diabetes during Ramadan.

"Ramadan there is a lot of frying of food and people can easily put on weight as it is very rich food. Easier to put on weight here than in my home country."

Asian woman

- The Chinese elders interviewed for this study spoke about the lack of relevance of healthy eating programmes, as most programmes were not culturally specific or related to traditional Chinese foods. A healthy eating programme specific to the Chinese community had been developed and then adapted for people with diabetes, though it was said these programmes are currently not being funded.

> *"All they talk about is potatoes not rice"*
>
> Asian man talking through interpreter

- While breastfeeding rates are higher for BME mothers a concern was raised around changes in support traditionally given by other mothers and members of the extended family, particularly where families are separated through migration. It was felt that health professionals could provide more support in order to prevent a reduction in breastfeeding rates within BME communities in Wirral.
- The Asian women's group highlighted the limited availability of women only exercise facilities. Only one swimming pool on Wirral (Guinea Gap baths) is suitable for women only sessions as it does not have public viewing; women and children only sessions are run here on a monthly basis. There are women only exercise sessions at Leasowe and Birkenhead community fire station gyms.
- Commissioners involved in the study spoke about men from BME communities generally being more active than women, but being considerably more difficult to engage in activities relating to healthy eating. Men from BME communities were also considered more likely to be overweight than women within their communities.
- The School Health Support Team measures the BMI of all year 6 and reception children and modified charts are used to identify obesity in some BME groups. Discussions with the team indicate that interventions could be targeted if this data could be cross-referenced with post code data to identify any patterns or trends. The team also work with parents and children through schools on health hygiene courses and creative cookery sessions.

Research review

Obesity has become one of the major public health issues; obese people are more likely to suffer from social and psychological problems such as depression, prejudice, discrimination, stigmatization and low self-esteem. Obesity contributes to a lower life expectancy with an increase the risk of CHD, as well as being a major risk factor for high blood pressure, raised blood cholesterol, diabetes and impaired glucose tolerance.

Levels of obesity are much lower in Black African, Indian, Pakistani men and particularly amongst Bangladeshi and Chinese men, who are around four times less likely to be obese than men in the general population. However, Pakistani, Indian and Bangladeshi men, have similar levels of raised waist to hip ratio compared to the general population. The adverse effects of excess weight are more pronounced when fat is concentrated in the abdomen, known as central or abdominal obesity and is assessed using the waist to hip ratio.

Black Caribbean and Irish men have similar levels of obesity to the general population. Black Caribbean, Black African and Chinese men are less likely to have a raised waist hip ratio.

Among women, obesity rates are high for Black Caribbean, Black African and Pakistani women and low for Chinese women. Black Caribbean, Pakistani and Irish women all have levels of central obesity above that of the general female population, while Bangladeshi women are nearly twice as likely to have a raised waist to hip ratio as women in the general population[35].

It is relevant to link obesity to research findings on physical activity and diet / healthy eating within BME populations. Black Caribbean and Irish men have higher rates of physical activity, while lower rates were found among Indian, Chinese, Pakistani and Bangladeshi men; women had lower rates of physical activity than men in general with similar differences between ethnic groups as for men; which were also reflected in differences in participation in recent vigorous activity, with Bangladeshi men and women and Pakistani women being between 3 to 4 times less likely to take part in such activity. Black Caribbean men had the highest rates for recent (within last 4 weeks) vigorous activity, followed by Irish men.[36]

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[35] Department of Health (2004) England: Health Survey for England 2004

[36] Aspinall, P.J. & Jacobson, B. (2004) Ethnic disparities in Health and Health Care: a focused review of the evidence and selected examples of good practice

The consumption of fruit and vegetables is highest in the Chinese community, particularly amongst women, while Bangladeshi men and women had the lowest consumption for all groups. Bangladeshi men and women have a particularly poor diet, including consuming red meat more frequently than other groups, with Indians consuming the lowest amount. Irish and Bangladeshi men consume higher rates of fat than other groups, with Indian men amongst the lowest.

Bangladeshi women also had the highest rates for fat consumption followed by Irish women, with Indian, Chinese and Black Caribbean women having the lowest rates. Bangladeshis also have low rates of fibre consumption, followed by Indians and Irish women. Most Gujarati Hindu women and many Sikhs are lacto-vegetarians, while the majority of Pakistani women are meat eaters and there is evidence to suggest a possible relationship between the risk of breast cancer and diet amongst South Asian ethnic subgroups[37].

Local initiatives

- Some health visitors are now advising on Indian/Asian baby foods
- Female only gym sessions at Leasowe and Birkenhead Fire Stations and female and child only swim session at Guinea Gap baths
- Healthy eating courses for people with diabetes within the Chinese community have been developed
- The Healthy schools initiative has a number of programmes including culturally specific school dinners and creative cookery courses and seeking to address cultural differences in diet by working with school catering services in response to high numbers of children from BME communities attending a school, but not having school meals.

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[37] As cited in reference 31

Chinese cookery course for people with diabetes

Public Health practitioners developed a Healthy Food Cookery course for Diabetes following requests for information from people with diabetes during healthy eating/cooking programmes. The course was designed to include hints and tips that can make a real difference if followed by the person with the condition. The team then worked with the Healthlink workers based at Wirral Multi-cultural Organisation to develop a course relevant to the Chinese Community. The course was delivered in partnership with the Healthlink Worker acting as translators.

Key policy

- Be active, be healthy – a plan for getting the nation moving; DoH, 2009
- The food health action plan; DoH 2007

5.4 Alcohol

Key local informants:

- ICCM Outreach Worker
- Drugs and Alcohol Team (DAAT) Strategy Manager
- PCAL Outreach Team BME
- Project Co-ordinator and Smoking Cessation Worker (Merseyside Polish Association Cracow)

Community organisations working with BME clients from the Irish and Polish communities identified alcohol misuse as a significant issue within both communities linked to social isolation, poverty and mental health problems. There was a particular concern about alcohol abuse by older members of the Irish community who had not integrated into the wider community and as a consequence were isolated. It was also suggested that alcohol misuse was linked to drug misuse by some members of Eastern European communities, which in turn was associated with a higher incidence of Hepatitis C.

> *"Homelessness and drugs and alcohol problems are big issues for the Irish community."*
> Service provider

Alcohol misuse was not highlighted by informants from other communities as an important issue, though it should not be assumed that BME communities are unaffected by the reported national increase in alcohol misuse related health and social problems. Certainly young Asians in the focus groups recognised the issue of how alcohol affected young people's perceptions and behaviours particularly in relation to sexual health.

While alcohol misuse was seen as a significant issue for Polish and Irish communities, there was a concern that they were under-represented in both drug and alcohol treatment services in Wirral.

> *"We have little experience of dealing with BME service users on any regular basis. Services are generally not geared up to deal with particular BME issues, although we are trying to push this agenda."*
> Service Manager

A number of barriers to accessing alcohol and drug treatment services were identified by interviewees:

- Social taboos and cultural attitudes towards alcohol often resulted in people from BME communities not accessing services until they had a serious drink problem
- Irish people were said to experience difficulties in being referred to alcohol treatment services, though it was not clear why this happened, or what the evidence for this was
- GPs were often seen to be poorly informed regarding alcohol misuse and links between alcohol dependency and underlying mental health problems were not always identified by practitioners
- Alcohol treatment services were reported by some participants at the stakeholder workshop as feeling intimidating and patronising, while at the same time there was lack of choice and a lack of flexibility with regard to support packages

Research review

There are marked differences between ethnic groups in respect of alcohol consumption rates e.g. only 4% of Pakistani men reported drinking more than once a week compared to 67% of white men.

There are significant differences in alcohol related and hepatocellular cancer rates between ethnic groups, by country of birth. Mortality rates for alcohol related liver disease follow a similar pattern. Hepatocellular cancer has a high level of prevalence in people from Bangladesh, Pakistan, China and W. Africa largely because of infections such as Hepatitis B and C.

There are particularly high rates of alcohol related mortality for Irish and Scottish people and Indian men; whereas it is low for women born in other countries and men from Bangladesh, Pakistan, Middle East, China and West Africa.[38]

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[38] Bhala, N. et al. (2009), Alcohol related and hepatocellular cancer deaths by country of birth in England and Wales: analysis of mortality and census data

Local initiatives

- Central website promoting alcohol treatment pathways and services www:wirraldaat.org.uk

- Services provided by groups working with BME communities including ICCM and the PCAL BME service

- DAAT Wirral are seeking to develop a model of community champions working from within the main BME communities within Wirral

Key policy

1. Standards and Planning Framework, Dept Health 2004
2. NHS Improvement Plan: Putting people at the heart of Public Services, Dept Health 2004
3. The Alcohol Harm Reduction Strategy for England, Dept Health 2004

5.5 Older people

Key local informants:

- Asian Muslim women's group
- Chinese elders group
- Health link workers
- Irish Community Care Merseyside (ICCM) Outreach Worker
- Mixed BME women's support group
- PCAL BME outreach team
- Interim Public and Patient Involvement Manager
- Stakeholder workshop
- Wirral Multi-cultural organisation health link worker
- Head of Unplanned Care

NB. The use of the term 'elder' in this section refers to all older people, which we have taken to be those of state pension age

Access to preventative services: A concern common to all interviewees was that BME elders are less likely to access preventative services such as smoking cessation, weight management, physical activity etc and the potential implications this has in respect of their health. WPCT Health professionals commenting on this, felt there was an under-representation of BME community members receiving free health checks for the over 40's. This has further implications in that they are not then included on the 'health checks list' used to encourage access to and promote supportive and preventative services.

> *"If people don't come forward for the Health checks for 40 -70 year olds, they aren't included on the health checks list, then they won't be able to access other supportive and preventative services e.g. Smoking cessation, weight management, fitness exercise…..It is a known fact that BME groups are under-represented on this health checks list."*
>
> PCT Manager

A number of other reasons were advanced to explain why BME elders were thought less likely to use preventative services:

- A lack of awareness about what preventative services are available

- Not understanding the health system; different experiences in country of birth can create confusion, resulting in lower levels of take up of services

"Back in African countries the services are very different. Health services here are very complicated."

African female

"My mother-in-law doesn't get any information through on preventative health services."

Asian woman

- Language barriers, especially where appointments need to be made by phone
- Lack of synergy between mainstream health services and traditional cultural models of health care
- BME elders preferred to use traditional remedies e.g. Chinese elders reported being less likely to access preventative services preferring Chinese traditional medicines
- Cultural differences: The Chinese elders and Asian women's groups felt that some preventative health measures such as healthy eating initiatives were not relevant to them e.g. they did not take account of traditional foods such as rice and noodles rather than potatoes

Culturally appropriate care services: Another common and important concern that emerged from the stakeholder workshop and from interviewees from BME organisations was the lack of culturally appropriate and flexible care provision for BME elders, including dementia sufferers and the absence of practical support for BME carers. Suggestions for how to address this included the increased use of personalised care through individual budgets, the development of culturally sensitive care provision and support by third sector organisations and local BME groups.

A general need for improved cultural awareness to ensure culturally appropriate health care was also identified by several interviewees e.g. in respect of hospital meals.

"….also halaal food is not always available in the hospital." Service provider

Use of A&E and unplanned services: There was also the concern that BME elders were more likely to make use of unplanned care services and A&E**.** Observations from the Chinese elders and women's focus groups suggested a tendency for BME elders to access services they feel confident and comfortable in using, rather than the most appropriate service. An example given was the use of A&E rather than GP out of hours service as no phone call was required. There were also examples of elders not being aware of the GP out-of-hours service, or the walk-in centres and so using A&E instead.

Language difficulties: There was a general consensus that BME elders in Wirral are more likely to have lower levels of English than younger members of the community, resulting in greater difficulties in accessing services. Examples of the difficulties they encountered included using the advance access GP appointment system which enables patients to make same day appointments by phone, the need for longer appointment times which were not always available or had to be coordinated to involve an interpreter. While focus group participants said families provide a lot of support including interpreting and translating, making appointments and accompanying elders to services, those with no local family and little or no English faced particular difficulties. They relied on community services to provide support and interpreting services, for example health link workers.

Social isolation: this was viewed as potentially more of an issue for BME elders than for older people in general, particularly if they had left family to come to Britain. It was important that they had access to good social relationships and networks to support their emotional health, provide information and keep them active.

> "*Older Irish people kept themselves to themselves through the 'Troubles' and hid their Irishness, which led to greater isolation."*
>
> Service provider

Research review

There is limited research on the health and social care needs of older people from BME communities, though the perception exists that their numbers are small and that they '*look after their own*'. In practice many of the migrants coming to Britain in the 1950's and 1960's are now reaching retirement age and it is estimated that the number of BME elders will have tripled between 1991 and 2011. There is also a concern that there are some 'hidden' groups e.g. Cypriots, Irish and Eastern Europeans whose needs may not be recognised.

Black Caribbean and African male elders are much more likely to live alone than other ethnic groups and in general BME elders are over-represented in the lowest fifth of income distribution and in particular Pakistani, Bangladeshi and Black Caribbean elders. They are also more likely to live in poorer housing and in the case of South Asian elders be living in overcrowded conditions.[39]

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[39] Aspinall, P.J. & Jacobson, B. (2004) Ethnic disparities in Health and Health Care: a focused review of the evidence and selected examples of good practice

[39] PRIAE MEC (2005) BME Elders' in the UK; Health and Social Care Research Findings

There are some significant health differences between groups affecting elders; the rate of Coronary Heart Disease is high in South Asians, stroke is high for some South Asian groups and for Caribbean's, diabetes is high in Caribbean, African, Asian and Middle Eastern elders, while cancer is low in most groups with the exception of Irish elders.[40]

The main age related health conditions concerning African Caribbean, South Asian and Chinese and Vietnamese elders in the UK are to do with problems with:

- Eyesight
- High blood pressure
- Hypertension
- Dental problems
- Hearing problems
- Sleep difficulties
- Kidney / urinary tract disorders

There are also differences in hospital admission rates with Pakistani and Indian elders significantly higher than the average, while there are also marked differences in respect of specific conditions including:

- Higher rates of admission for mental illness for Black Caribbeans and Bangladeshis
- Lower rates for hip and knee replacements for several BME groups
- Higher rates for cataract replacement for all BME groups[41]

The Older Peoples Framework highlights concerns about: access to appropriate mental health services that are culturally sensitive and cultural bias in mental health assessment. Concern also that BME elders are likely to suffer discrimination in accessing services and that some BME communities as a result do not trust the agencies concerned.[42]

Key policy

The National Service Framework for Older People, DoH 2001

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[41] As cited in reference 32

[42] Department of Health (2001) The National Service Framework for Older People

Local Initiatives

- A variety of opportunities for elders including social, leisure, information, signposting at Wirral Multi-cultural Organisation
- Social opportunities for Irish elders through Irish Community Care Merseyside who facilitate an Irish Elders Group
- A community health link worker team
- Health checks are being promoted locally within BME organisations and community settings are being used for these with increasing participation rates.

Irish Elders Group
There is a thriving older persons Irish Group run by Irish Community Care, Merseyside at St. Anne’s church hall in Rock Ferry. Over one hundred people come together for socialising, dancing, lunch and activities including bingo, raffles, music and dancing. Relevant agencies such as Age Concern or The Fire Service attend the group either to raise awareness of relevant issues or simply to let the members know that they are there and how to contact them

5.6 Smoking

Key local informants:

- Wirral Multi-Cultural Organisation Centre Administrator
- Stop Smoking Advisor (BME)
- Irish service users from Irish Community Care Merseyside in Wirral
- Project Co-ordinator and Smoking Cessation Worker (Merseyside Polish Association Cracow)

A number of key informants suggested that there were particular difficulties in getting BME individuals involved in smoking cessation initiatives. Though it was not clear why this was the case, it was seen as being linked to the wider issue of engaging BME communities in health promotion and preventative measures. It was thought that smoking rates were particularly high within some BME communities in Wirral including Irish, Bangladeshis and Eastern Europeans.

> *"Coronary heart disease for Irish people is both the highest in the region and across the country. This is closely linked with alcohol and smoking."*
>
> Service provider.

The use of community champions within NHS Wirral 'Quit and Win Campaign'[43] and partnership work with local BME organisations was recognised as having been a successful approach to engagement of BME smokers.

Representatives of the BME community organisations involved in this campaign and participants at the stakeholder workshop observed that chewing tobacco was not included within Department of Health outcomes or targets for smoking cessation. This was a concern because this was a practice relatively common in some BME communities including amongst Bangladeshis, particularly women from this community, and was associated with poor oral health.

Linked to the chewing of tobacco was a concern regarding the chewing of betel nut and betel leaf within Indian and Bangladeshi communities by both men and women. It was thought that this was very addictive and resulted in high incidence of mouth ulcers and oral cancers. However, the chewing of Khat, which is used in particular by Somali's and Yemenis and acts as a stimulant, was not raised as a concern. It is perhaps relevant to note that the overuse of Khat, especially combined with alcohol is the subject of serious concern in Liverpool in respect of young Somalis.

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[43] Wirral PCT (2009) 'BME Quit and Win Campaign'; An evaluation of the impact of an incentive based smoking campaign targeted at BME communities in Wirral

"Indian/Bangladeshi men and women chewing different products such as betel nut, betel leaf and tobacco (African). Substances are very addictive and very common in these communities and can lead to mouth cancers and ulcers as well as reducing immunity. Making it difficult for some users to fight off other infections."

Service provider

Research review

There are significant differences between ethnic groups, with Bangladeshi men (44%) and Irish men (39%) being more likely to be smokers than the general population whilst Chinese men are less likely to be smokers (17%). Women from BME communities are much less likely to smoke than the general population. Tobacco chewing though is relatively common for Bangladeshi women with 26% doing so[44].

Tobacco chewing is sometimes combined with the use of the areca nut, which is often wrapped in the leaf of the betel nut palm and is commonly referred to as betel nut and used within British Asian communities. Betel nut may also be chewed by itself and there is evidence to suggest that it is an independent factor in the occurrence of oral cancer.[45] The use of betel nut substitutes gutkha and masala are also thought to be carcinogenic.[46]

Wirral BME Quit and Win Campaign

This initiative was designed to boost the number of people from BME communities stopping smoking. Prior to the programme only a small number of people from BME communities had engaged with the smoking cessation project. The campaign reached 500 BME smokers and recorded 300 'quits'. The success of the initiative was due to:

- Workers going into the communities e.g. services were provided for women in their own homes and local communities
- Developing community champions, including the community health link workers and BME organisations such as the Merseyside Polish organisation

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[44] Raleigh, V.S. & Polato, G.M. (2007) Evidence of Health Inequalities

[45] Areca nut use: an independent factor for oral cancer, Warnakulasuriya S. et al, Department of oral medicine and pathology, Dental institute, London; British Medical Journal, April 2002, p234

[46] Alert for an epidemic of oral cancer due to use of the betel quid substitutes gutkha and pan masala: a review of agents and causative mechanisms; Nair U, Bartsch H, Nair J, German Cancer Research Centre (DKFZ), Heidelberg, Germany

Key policy

1. Smoking cessation services are available through primary care services, pharmacies, local authorities and workplaces (National Institute for Clinical Excellence, February 2008)
2. Guidance on behaviour change at population, community and individual levels (National Institute for Clinical Excellence, October 2007)

5.7 Children and Young People

Key local informants:

- Asian Muslim women's group
- Bangladeshi young men's group
- Centre Administrator - Wirral Multi-Cultural Organisation (WMO)
- Clinical Nurse Manager - Genito-urinary Medicine
- Education Worker - Wirral Brook Advisory Service
- Equality & Diversity Officer - Wirral Borough Council Department of Adult Social Services
- Group of Polish service users from the PCAL BME community outreach team
- Mid and East European mixed gender group
- Mixed BME women's support group from the mental health service at Wirral Change
- Mixed gender African group
- Nurse Manager - Women's and Sexual Health Services
- Young Asian women's Group
- Young people of Chinese heritage from the Chinese school at WMO

The following themes have drawn from the focus groups, interviews with key informants and the stakeholder workshop:

Children's health services

Overall BME community members participating in the focus groups reported good experiences of children's health services in Wirral. The one exception to this was difficulties encountered by Polish parents with differences in childhood vaccinations between this country and Poland, which was a cause of some confusion and anxiety. Other BME groups reported that GPs were generally very responsive to concerns raised around children's health.

> *"We had their certificates [immunisations] but the doctor doesn't seem able to understand what they have had/haven't had."*
>
> Polish man talking through interpreter

Health awareness and education programmes

Young people from the focus groups recognised the value of health awareness and education and felt that issues should be properly explained as they needed to be well informed. Education programmes on sexual health, drug and alcohol misuse should focus on case studies of real life situations, be interesting and interactive; being able to see real life consequences was considered most likely to influence young people's behaviour.

There was general agreement that sex education at school should be more frequent and delivered by someone not only knowledgeable, but also able to provide confidential advice. The young Asian women felt that sex education was best provided by someone who was open minded and not necessarily someone from the same cultural background. However, they also regard sex education programmes as not relevant to them as they did not see themselves having sexual partners outside marriage.

> *"When the FRANK bus came we had a talk from a guy who had been a drug user and he acted like a friend and it was really informing."*
>
> Chinese male

Sexual health

Key informants involved in service provision in relation to sexual health were concerned that young BME men were unlikely to access contraception and screening services. This view was supported by the observation from the young Bangladeshi men who reported that most people they knew would have unprotected sex, with alcohol increasing the risk of this. The young Asian women were unsure whether the people they knew would be having unprotected sex.

Wirral Brook Advisory Service had noted an increase in young women from the Polish community and young Asian men accessing their services. The service reported seeing few young people from the Chinese community, while young people participating in the Chinese focus group had limited knowledge about where and how to access sexual health services.

> *"I don't think it's handy you have to go into the Brooke to get one [condom] so people see you going in"*
>
> Asian male

Young people reported difficulties around accessing sexual health services when these were situated in open, as opposed to more discrete locations e.g. not with an entrance on a busy main road. They were uncomfortable and worried about being seen, which was particularly true for young Asian women. This group also expressed a need to have female practitioners available and being able to access services during the daytime, with concerns about using sexual health services before marriage as this conflicted with religious and cultural values.

Accessing health services

In general the concerns that BME young people identified in accessing health services can be seen as those of most young people. The most important issue that concerned them was not being treated appropriately as young adults. Other issues included having negative experiences of GP receptionists, treatment not being explained to them properly or not being kept informed of its progress and the length of waiting times. For some language and cultural barriers impeded access to services.

Research review

Indian, Pakistani, and Bangladeshi children reported less acute and chronic illness, asthma, and injuries than the general population, whereas Afro-Caribbean children reported more. Indian and Pakistani children make more use of general practitioners' services, but Indian, Pakistani, Bangladeshi, and Chinese children are less likely to be referred to outpatient clinics.[47]

African-Caribbean and Pakistani girls are more likely to be obese than the general population, while Indian and Pakistani boys are more likely to be overweight. South Asian children in England do less exercise than their peers from other ethnic groups; only 54% of South East Asian met the current recommended target of spending at least 60 minutes per day in moderate levels of activity compared with 70% of White European children and 69% of Black African Caribbean children.[48]

Black children are considered to be more likely than white to have common mental disorders, with Pakistani children less likely and Bangladeshi children far less likely. A large scale survey of the prevalence of three most common mental disorders in children and adolescence (conduct disorder, hyperactivity and emotional disorders) assessed 12% of Black children as having a mental disorder, compared to 10% for White, 8% for Pakistani and Bangladeshi and 4% for Indian children. For all ethnic groups boys were more likely to be assessed as having a disorder than girls.[49]

Cancers in children are very rare; children of Asian ethnic origin in Britain have consistently been found to have a higher incidence of lymphomas, particularly in early childhood.[50]

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[47] Saxena, S. et al (2002) Socioeconomic and ethnic group differences in self reported health status and use of health services by children and young people in England: cross sectional study

[48] Owen, C. (2009) The Child Heart Health Study, reported by BBC News April 19th 2009

[49] Meltzer, H. et al (1999) The mental health of children and adolescents in Great Britain, summary report

[50] Stiller, C. et al (2004) The health of Children and Young People

Key policy

1. Healthy Lives, brighter futures. The strategy for children and young people's health. DFSF, DH. 2009.
2. The Children's Act 2004
3. Every Child Matters – Change for Children 2003

NB: The researchers were not made aware of any local initiatives targeted at BME children and young people

5.8 Sexual Health

Key local informants:

- Asian Muslim Women’s Group
- Bangladeshi young men’s Group
- Clinical Nurse Manager - Genito-urinary Medicine
- Education Worker - Wirral Brook Advisory Service
- Mid and East European mixed gender group
- Mixed BME women’s support group from the mental health service at Wirral Change
- Nurse Manager - Women’s and Sexual Health Services
- Young Asian women’s group
- Young people of Chinese heritage from the Chinese school at WMO

Several important concerns emerge in considering the local research findings in respect of sexual health:

Low take up of services

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

Improving access

Efforts are being made to make services more culturally appropriate; screening services are now offered in an increasing range of community and non-health care settings and tests can be requested in various ways; phone, text or website (though English only). In addition clients can choose how they are told the results of their screening test for example verbal or written communication and GPs do not have to be told of the result of the test.

Clinics within community centre settings were viewed as being more accessible than those at GP surgeries or health clinics. However issues with setting up sexual health clinics and promoting services in community venues have been reported, as a result of cultural conflict. The need for culturally appropriate sexual health settings was also highlighted, for example women only areas with any men accompanying family members being asked to wait in a separate area.

"Some people are loathe to go to their GP. Because the clinic at the multicultural centre makes an interpreter available, it is seen as sympathetic, and offers an opportunity to ask about health issues or to ask the clinic doctor to contact their GP if medically necessary."

Service provider

Cultural differences

Interviewees from BME organisations reported that sexual health is often a taboo subject which is not talked about openly within some cultures. This can make individuals reluctant to use services. Religious beliefs and cultural values also play an important part in attitudes towards sexual health for many BME communities as noted for example in respect of Asian young women and their concerns about using sexual health services before marriage.

"I think other girls within our community wouldn't go to Brooke and stuff if they had any problems like that because sex before marriage is a big no …. its something that you would get judged on "

Asian young woman

Language barriers

The appropriateness of a family member interpreting for another family member using sexual health services was seen as clearly problematic. Even if not interpreting, a family member accompanying an individual and being present during interpreting could be inappropriate and something that clinical staff need to question.

Knowledge and awareness

Women from BME groups involved in the research reported that they were aware of and attended family planning services. Generally they also attended for cervical smears, but were not aware of other sexual health services.

Research review

There are ethnic variations in the rate of diagnosed sexually transmitted infections (STI's); Indian and Pakistani men and women have lower rates of diagnosed STI's than other groups, while Black Caribbean and Back African men have higher rates of STI's than White men and Black Caribbean women, higher STI's than White women, though the latter reported higher levels of risk behaviours than other ethnic groups.

Individual sexual behaviour is a key determining factor in accounting for differences in the rate of STI infection between groups, but culture, age and marriage patterns and varying levels of infections within different communities are also likely to be important factors. There is a need for culturally appropriate and targeted interventions to address these differences.[51]

There are lower levels of sexual health knowledge among BME students, particularly Asians, compared to White British students and also differences in STI's and unplanned pregnancies.[52] Uptake of health and sexual advice services by young men is poor and getting young people to talk about sexual health is still a taboo in many communities.[53]

HIV/AIDS is a serious concern particularly for people from sub-Saharan Africa including Kenya, Zimbabwe, Zambia and South Africa; people from this region tend to present late with HIV, often after symptoms of AIDS have developed, making early intervention with antiviral drug treatments more difficult.

The incidence of HIV in African-Caribbean men who have sex with men is significantly higher than for White gay men, while HIV is less common in South Asian gay men than in European men. Cultural differences are a factor in the reluctance amongst homosexual and bisexuals from some BME communities to disclose their sexual orientation, while services specifically aimed at lesbian, gay and bisexual people are used less by BME communities (Sexual Health in Practice).[54]

Sexual health issues may be encountered more frequently by Refugees and Asylum Seekers than the general population including: rape and sexual torture, STI's and HIV and unintended or unwanted pregnancies.

Female genital mutilation is still practiced in some African and Asian communities, though it has been illegal in the UK since 1985.[55]

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[51] Fenton, K. et al (2005) Ethnic variations in sexual behaviour in Great Britain and risk of sexually transmitted infections

[52] Testa, A. & Coleman, L. (2006) Sexual Health Knowledge, Attitudes and Behaviours among Black and Minority Ethnic Youth in London. A summary of findings

[53] Teenage Pregnancy Unit (2001) Guidance for developing contraception and sexual health advice services to reach boys and young men

[54] Sexual Health in Practice – ethnic and cultural differences in sexual health needs; Royal College of Nursing, Healthcare A2Z, PNA, 2008

[55] As cited in reference 45

Local initiatives

- Women only clinics, with separate waiting areas for accompanying men
- Clinics in non-health care settings for example Chlamydia screening and a contraception clinic at WMO
- The Well women centre holds specific sessions for Bengali women that are culturally sensitive to their needs
- Increased provision of women practitioners, interpreting services and provision of chaperones with sexual health services

Key policy

- National Strategy for Sexual Health and HIV; DOH 2001

5.9 Cancer

There has been little ethnic monitoring of cancer rates and most evidence in respect of differences between ethnic groups comes from research studies. The risks of the main cancers is lower among West Indian and South Asian communities, but South Asians have significantly higher rates for Hodgkin's disease (in males), oral cancer and myeloid leukaemia (females) and cancer of the hypopharynx, liver and gall bladder in both sexes, while Chinese people have higher rates for nasopharyngeal cancer.[56]

Scottish and Irish migrants have raised cancer incidence rates for a number of sites and overall, the incidence of ovarian, cervical, lung and prostrate is higher in second generation Irish people living in England and Wales than for all other groups and remains high in third generation.[57]

Mortality from **lung cancer** is higher for men and women from Scotland and Ireland, but lower for people of East and West African, Caribbean, and South Asian origin. See reference above re alcohol related and hepatocellular cancer[58] and also smoking prevalence.

Mortality from **breast cancer** is also generally lower from women from migrant groups, though there is some evidence of low uptake of screening for both breast and cervical cancer amongst BME groups

There is evidence that the incidence of **prostate cancer** is significantly higher among Black men from international studies and also higher for males from the Irish Republic. There have been no comprehensive studies re equity of access, though the third national survey of patients suggests there are many areas of disadvantage for BME groups.[59]

Key policy

Cancer Reform Strategy, Dept of Health 2007

NB: Cancer was not one of the areas of focus for the research and no local information relating to BME communities was identified in relation to this area

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[56] Aspinall, P.J. & Jacobson, B. (2004) Ethnic disparities in Health and Health Care: a focused review of the evidence and selected examples of good practice

[57] Harding, S. (1998) The incidence of cancer among second generation Irish living in England and Wales
&
Hardy, S & Balarajan, R. (2000) Mortality of third generation Irish people living in England and Wales

[58] Bhala, N. et al (2009) Alcohol related and hepatocellular cancer deaths by country of birth in England and Wales: analysis of mortality and census data

[59] As cited in reference 47

5.10 Chronic Obstructive Pulmonary Disease (COPD)

A recent American study noted that although COPD is a common cause of death and disability, little is known about the effects of socioeconomic status (SES) and race-ethnicity on health outcomes.[60] This study concluded that whilst ‘race’ was associated with greater COPD severity, this was no longer apparent after controlling for socioeconomic status and other co-morbidities.

Similarly, another recent study suggests that African-Americans may be particularly susceptible to tobacco smoke and that diagnosis, treatment and natural history of the disease are affected both by race and sex, but the understanding of any differences remains limited due to low enrolment in clinical trials.[61]

An earlier American study, notes that the majority of deaths from COPD are caused by smoking and predominantly affect people aged over 55 and Whites had double the rate for Blacks, while the rates for Asians was again lower, with Hispanics having the lowest rates. White females had the highest rates of death from COPD, including for White males.[62]

Beyond these American studies, we have not been able to identify any UK research with regard COPD and ethnicity.

NB: COPD was not one of the areas of focus for the research and no local information relating to BME communities was identified in relation to this area

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[60] Eisner, M.D. (2009) *Socioeconomic status, race, and COPD health outcomes;* 2009

[61] Kirkpatrick, P. & Dransfield, M.T. (2009) Racial and sex differences in COPD susceptibility, diagnosis and treatment

[62] Chronic Obstructive Pulmonary Deaths California, 1998

5.11 Cardiovascular Disease

The prevalence of self-reported angina and heart attack is highest amongst Pakistani men and Indian men and women, while it is lowest in Black African and Chinese groups; the highest prevalence of these conditions is in those aged 55 and over. Compared with the general population BME groups report lower rates of abnormal heart murmur, abnormal heart rhythm (except Irish women) and other heart trouble (except Black Caribbean women)[63]. There is also evidence to suggest that Scottish and Irish people living in England and Wales also have higher levels of Coronary Heart Disease (CHD) than the general population.[64]

A review of research evidence suggests that overall South Asian groups have a moderately higher incidence of CHD than the general population and that the poorest groups of Pakistani and Bangladeshi origin have the highest rates. There is also some evidence to suggest that South Asians, who complain of chronic chest pains are less likely to be referred for exercise testing, wait longer and are less likely to receive invasive treatments than other groups. Key risk factors for CHD include high blood pressure, lipids, smoking, central obesity and insulin resistance, while socio-economic factors are thought to be much more significant than previously.[65]

Key policy

- The National Service Framework for Coronary Heart Disease (NSF CHD), March 2000

NB: Cardiovascular Disease was not one of the areas of focus for the research and no local information relating to BME communities was identified in relation to this area

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[63] NHS Health & Social Care Centre (2005) Health Survey for England 2004: The Health of Minority Ethnic Groups
[64] Harding S. et al (2008) Trends for CHD and stroke among migrants in England and Wales 1979 – 2003
[65] Aspinall, P.J. & Jacobson, B. (2004) Ethnic disparities in Health and Health Care: a focused review of the evidence and selected examples of good practice

5.12 Heart Failure

While heart failure is a very significant health issue, most of the research that has been undertaken on the subject has involved mainly White populations. The aetiological factors involved in its development include hypertension, diabetes, and ischemic heart disease, the incidence of which differs between patients of different ethnic groups. One study suggests heart failure is likely to account for higher mortality amongst South Asian populations[66].

A recent American study evaluating the relationship between race/ethnicity and incident congestive heart failure (CHF) found that the risk of developing CHF was higher among African Americans compared with white participants. They concluded that this was reacted to the prevalence of hypertension and diabetes mellitus and socioeconomic status.[67]

Current research is being undertaken to establish the community prevalence and severity of left ventricular systolic dysfunction (LVSD) and heart failure amongst the South Asian and Black African-Caribbean ethnic groups in the UK. Their review of available evidence has concluded that South Asians living in the UK have a 50% greater risk of dying prematurely from coronary heart disease than the general population. Premature death rates from CHD for Caribbeans and West Africans are much lower than average, around half the rate found in the general population for men and two-thirds of the rate found in women, despite the fact that hypertension is much commoner amongst these groups.

Another major risk factor for Heart Failure is diabetes mellitus, which is much more common in African-Caribbean and South Asian minority groups than in the population as a whole. Importantly, they conclude that difference in the death rates between South Asians and the rest of the population is increasing due to a slower rate of improvement in death rates from CHD compared to the rest of the population[68].

NB: Heart Disease was not one of the areas of focus for the research and no local information relating to BME communities was identified in relation to this area

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[66] Sosin, M.D. et al (2004) Heart failure – the importance of ethnicity

[67] Bahrami, H. et al (2008) Differences in the incidence of congenital heart failure by ethnicity

[68] Paramjit, S.G. et al (2009) Rationale and study design of a cross sectional study documenting the prevalence of Heart Failure amongst the minority ethnic communities in the UK: the E-ECHOES Study

6.0 Additional health areas and Ethnicity

This section of the report provides a brief review of research in respect of additional population groups and other health conditions and their relation to differences in BME health outcomes. This aims to help address the final research objective for this needs assessment of giving an account of current knowledge about differences in health outcomes between ethnic groups. While some local information is provided (particularly in relation to BME women's health), this was outside of the main focus of the research. The following topics have been reviewed:

- BME Women
- BME Men
- Travellers and gypsies
- Migrant workers
- Refugees and asylum seekers
- Cerebrovascular Disease / stroke
- Diabetes
- Inherited blood disorders
- Learning difficulties
- Neurological conditions
- Physical disabilities and sensory impairments

6.1 BME Women's health

BME Women's health has either explicitly or implicitly been an important issue for key informants and participants within the focus groups; all of WPCT's health priorities and most health conditions can be given a gender perspective. This section reviews the local findings and wider research that has specific emphasis on BME women's health that has in the main not been covered in other parts of this report, while the next section does the same in respect of BME men.

Health screening

As previously noted women involved in this research from all BME communities were generally aware of and attended for cervical screening, but there was a lack of awareness regarding other sexual health services. The later point tends to support the observation by some key informants that there is reluctance amongst BME women to access preventative services, which again may be related to factors previously commented on in relation to BME health access issues in general e.g. cultural sensitivity. However, the level of awareness and use of cervical screening would appear to run counter to this observation and also wider research findings, and should be treated with some caution. It is also relevant to record that practitioners working with Asian women in Wirral thought Asian women were less likely to present at the early stages of both breast and ovarian cancers.

Breast feeding

The commissioner for Wirral NHS weight management services referred to evidence demonstrating higher rates of breastfeeding by BME mothers. The women participating in the focus groups supported this view and perceived that they were more likely to breastfeed than White mothers. However, it was felt this could change particularly when there was separation from extended families who traditionally provide support. It was suggested that health professionals should provide more support in order to prevent a reduction in breastfeeding rates within BME communities in Wirral.

Caring responsibilities

BME community representatives spoke of a lack of support with caring responsibilities particularly for the main carers who are usually women. This was mainly in relation to caring responsibilities for older people, but also applied to other caring responsibilities including for disabled children and disabled adults. This was seen as particularly an issue in the Asian community in Wirral.

Domestic violence

Domestic violence or partner's abuse was a concern highlighted by women working within the Asian community in Wirral, especially as it was unlikely that they would seek help or support from services or from within the community. There is a cultural stigma to domestic violence that makes it a taboo subject within the community.

Research review

Much of the research relating to ethnicity and women's health is focused on maternity services; Asian women make less use of antenatal services and are more likely to book late for antenatal attendance. Women from South Asian groups are far less likely to receive prenatal testing for blood disorders and Down's syndrome[69].

Asian women had high maternal mortality rates three times higher than White women (1997-99), while the rate for Black women was somewhere between these.
Babies born of Pakistani mothers has infant mortality rate of 12.2 per 1000 births (2001), which was higher than any other groups and more than double the overall infant mortality rate; African and Caribbean groups also had elevated rates for stillbirths and perinatal deaths, while infant death rates were higher for babies born of Mediterranean and Caribbean mothers.[70] There is also an excessive prevalence of miscarriages, stillbirths and neonatal deaths for mothers from Gypsy and Traveller communities.[71]

Mothers from ethnic minority communities are more likely to breast feed (86-95%) than White mothers (67%) and they are more likely to still be breastfeeding at nine months, with Black mothers having the highest breastfeeding[72].

Nationally women from BRM communities and particularly those of Pakistani and Bangladeshi origin may have unmet family planning needs, with lower rates of use of contraception. There is a lower uptake by women from ethnic minority communities; for cervical cancer screening and breast cancer screening and in particular there is lower uptake by women from India, Pakistan and Bangladesh, although uptake by African Caribbean women is high.

The main reasons for low uptake of these two screening services include language barriers, inaccurate screening registers including poor awareness of minority ethnic naming systems and a lack of referral from health professionals. Cervical screening

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[69] Aspinall, P.J. & Jacobson, B. (2004) Ethnic disparities in Health and Health Care: a focused review of the evidence and selected examples of good practice

[70] As cited reference 62

[71] Parry, G. et al (2004) The Health Status of Gypsies and Travellers in England

[72] As cited reference 62

rates appear higher in practices with a female partner (though not for breast screening).[73]

A recent enquiry published in the report *Saving Mothers' Lives,* highlights vulnerability and deprivation as amongst the most important risk factors for maternal deaths (Lewis, 2007). For example, Black African women from relatively deprived areas of the UK are not only less likely to attend antenatal care but are up to six times more likely to die during pregnancy or shortly after birth compared to their white counterparts.[74]

The most recent CEMACH (Confidential Enquiry into Maternal and Child Health) report (2007) states that asylum seekers and refugees are up to six times more likely to die during pregnancy or childbirth compared to their white UK counterparts. While the causes of death are numerous and varied, the report highlights a poor state of health on arrival in the UK and difficulties in accessing maternity services as being contributory factors. Up to 50% of the women who died failed to access antenatal care before 22 weeks and a similar number failed to receive the WHO recommended minimum of 4 antenatal visits (CEMACH, 2007). In light of these findings there is an implicit recognition that regular and early access to antenatal care could reduce the maternal mortality rate amongst the asylum seeking population.

Research studies exploring the reasons why asylum seeking women fail to receive appropriate antenatal care are few and far between. However, several small-scale studies have identified communication problems, a lack of awareness about antenatal provision and the cultural insensitivity of health care providers as being potential stumbling blocks (McLeish, 2002; Bentham 2003; McLeish 2005). Furthermore, a recent longitudinal study of pregnant asylum seekers in Liverpool suggests that the disempowering effects of current government policies (frequent moves, limited finance, poor living conditions) may exacerbate the problem (Briscoe & Lavender, 2009).

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[73] Szczepura, A. (2005) Access to healthcare for ethnic minority populations

[74] Lewis, G. (Ed) (2007). The Confidential Enquiry into Maternal and Child Health (CEMACH). Saving Mothers' Lives: reviewing maternal deaths to make motherhood safer – 2003-2005. The Seventh Report on Confidential Enquiries into Maternal Deaths in the United Kingdom

Local initiatives

Sexual health services on Wirral have developed:

- Women only clinics, with separate waiting areas for men accompanying women
- Sexual health clinics in non-health care settings

In addition the following fitness related initiatives have been developed:

- Female only gym sessions at Leasowe and Birkenhead Fire Stations
- Monthly female and child only swim session at Guinea Gap baths

There is also a new campaign to promote breastfeeding, including a peer support group programme, which should be of relevance for BME mothers

Key policy

National Service Framework for Children, Young People and Maternity Services

6.2 BME Men's health

Engaging men

There was general consensus from informants that it was particularly difficult to engage BME men in health promotion activities, preventative services or health screening. It is not possible to say whether this is more of an issue for BME males compared to the difficulties of engaging men in general, but the health access issues previously identified would suggest that for men from some BME communities this is probably the case.

Emotional well-being

A number of key informants felt that the BME in general were at a higher level of risk of emotional difficulties and mental health problems than for the population as a whole. Several reasons were given for this belief including the observation that BME males were disproportionately affected by unemployment and financial pressures. Some groups including Irish and Polish men were likely to use alcohol as a way of coping with social isolation and resulting depression, while young Muslim males were more likely to experience feelings of alienation.

Healthy lifestyles

Wirral NHS commissioners contributing to the research suggested men from BME communities were generally being more active than women, but considerably more difficult to engage in activities relating to healthy eating. Men from BME communities were also considered more likely to be overweight than women within their communities.

Research review

Obesity: BME men are more likely than women to be overweight, and are less likely to be referred to a weight loss programme for help and support. However, if they do attend weight loss programmes, they have the same level of success as for women who attend.[75]

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[75] NHS Health & Social Care Centre (2005) Health Survey for England 2004: The Health of Minority Ethnic Groups

Cancer: Cancer kills men at about twice the rate of women. This is mainly as a result of factors such as diet, smoking and alcohol use. There is evidence that the incidence of prostate cancer is significantly higher among Black men[76]

Smoking: Irish and Bangladeshi men have the highest rates of smoking amongst all ethnic groups.[77]

Under utilisation of primary care: Statistics from the Office of National Statistics show that men under the age of 45 visit their GP less than half as often as comparable females. This decreases with age, however a marked disparity remains across all age categories, with reasons such as opening hours and bureaucracy being cited.[78]

Mental Health: The incidence of depression in men is roughly equivalent to that in women; however men are more likely to drink heavily, go missing or commit suicide in response to depression. Suicide rates for Irish men are higher than for other groups. [79]

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[76] Lees, S. & Papadopoulos, I. (2000) Cancer and men from ethnic minority groups: an exploration of the literature

[77] NHS Health & Social Care Centre, (2005) Health Survey for England 2004: The Health of Minority Ethnic Groups

[78] Stuart, O. (2008) Better Health Briefing 7: User Participation in Health Care Services

[79] Smaje, C. (1995) Health, ‘Race’ and Ethnicity; making sense of the evidence

6.3 Travellers and Gypsies

Research undertaken in the mid 1980’s evidenced the presence of Travellers and Gypsies in Wirral on a continual basis over a hundred years, stopping on unofficial sites in the absence of any permanent facility.[80] This pattern has continued, though there is now also a small settled Traveller community permanently living in housing in Wirral.

Most Gypsies and Travellers are now recognised as belonging to an ethnic group under race equality legislation, including Irish Travellers. Gypsy and Traveller men and women often experience chronic ill health, frequently suffering from more than one condition.[81]

Mental Health

Barriers to accessing health services, high levels of loss and bereavement, secrecy about depression, commonly described as “nerves”, contribute to poor mental health within the community and there are concerns about the high suicide and para suicide rates within the community.

Maternal Health and Women’s Health

Women from Gypsy and Traveller communities may not gain full access to maternity services for a range of reasons leading to a lack of continuity of care, particularly for those who are highly mobile. The communities are often seen as being resistant to services and as poor attendees,[82] which impacts on the relationships between health care staff and service users that go beyond maternity care. The Irish Traveller community has the highest rate of infant mortality and the highest maternal death rates of all groups. There is a poor uptake of preventative health care i.e. well - woman care and immunisation programmes.

Men’s Health

Men generally find it harder to access health services and it is particularly common for Traveller men to be stoical about their health. There is a tendency not to register at all with a GP practice; with health care being accessed through accident and emergency only when absolutely necessary.

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[80] Kyprianou, P. (1985) Travellers on Merseyside

[81] Parry, G. et al (2004) The Health Status of Gypsies and Travellers in England

[82] Reid, B. (2005) Networking for Traveller health

Sexual Health

Traveller families are resistant to others talking to their children about sex and contraception and there are many taboos relating to sexuality and modesty. Little is known about rates of sexually transmitted diseases in these groups, due to the cultural barriers of discussing such issues. Many women find regular contraception taking a problem again due to the cultural differences in perception of time in Gypsy and Traveller cultures. Male Midwives, GPs, and Health Visitors may have difficulty accessing many within the Gypsy and Traveller communities due to the cultural modesty rules.[83]

Substance Use

Nicotine and alcohol are very often used as a coping strategy within Gypsy and Traveller communities, both of which have wider physical and mental health implications. Drug use among Traveller young people is widely reported and feared by Traveller elders. Anecdotal evidence suggests that it is on the increase

Key policy

- The Race Relations Act amended 2000
- The Housing Act 2004

Note: Much of the information here has been provided by Irish Community Care Merseyside, which provides assistance to Travellers and Gypsies in Wirral

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[83] Van Cleemput, P. et al (2007) Health-related beliefs and experiences of Gypsies and Travellers, a qualitative study

6.4 Migrant workers

Migrant workers represent a diverse group from different ethnic backgrounds and countries of origin, with differing reasons for migration; as such they have a range of different needs and forms of support in accessing health services. As a relatively small proportion of the population in any PCT area they run the risk of becoming marginalised and the NHS needs to be able to provide a flexible response to help prevent this.

Since the 2004 expansion of the European Union, there has been a rapid and large increase in the numbers of people coming to the UK and also returning home, which makes it very difficult to get accurate numbers on those; most data systems used in the NHS do not record country of origin and ethnic monitoring is not widespread. It is estimated that 5.5% of the NW's population are foreign nationals; about 25% of these will be students, 25% people joining family or friends and the remainder migrant workers, UK nationals returning home and a small number of refugees and asylum seekers.

The majority of migrant workers are young and in employment, with just over half being male; their length of stay in this country varies as does their circumstances in respect of housing, employment situation and support networks. There is little evidence that migrants in general (including refugees and asylum seekers) present any risk to the wider population in respect of transmittal disease, though some are disproportionately affected by infectious diseases such as TB, HIV, Hepatitis B, malaria and enteric fever.

The difficulties that migrant workers face are often similar in a number of respects to those of refugees and asylum seekers and other the access issues faced by BME communities. The challenges for the NHS include:

- Developing new approaches to health promotion and service provision to address increasingly diverse health needs and cultural backgrounds
- Providing effective communication, including consultation and providing better access to translation and interpreting services
- Ensuring staff receive cultural competence training
- Having clarity about regulations governing entitlement to health care and exercising non-discriminatory practice[84]

Note: See section 2.2 for information on migrant workers in Wirral

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[84] Government Office NW (2008) Health & Migration in the NW of England : An Overview

6.5 Refugees and asylum seekers

Refugees and Asylum Seekers have specific healthcare needs, which may well be different from the general population, the most prevalent health needs are:

- Mental health needs
- Physical health problems
- Maternal and child health conditions
- Sexual health problems

Studies have shown that two-thirds of all Asylum Seekers have suffered from depression or anxiety, whilst a sixth have a life impairing physical health problem.[85] However it is important to note that these groups are not simply part of a homogenous whole, they have differing national, cultural and religious backgrounds, as well as differing experiences of health care provision.

Physical Needs

Health conditions that disproportionately affect Asylum Seekers and Refugees include Hepatitis, Meningitis, HIV/AIDS, Tuberculosis and parasitic infection. In addition to these conditions Asylum Seekers may be subject to a range of contributing factors which serve to worsen their health outcomes, such as poverty, poor diet and housing. Therefore they may well require elevated levels of support from health care providers and agencies.

Psychological Needs

It is reported that Asylum Seekers are at a higher risk of experiencing psychological distress than their host community, and they are more likely to show symptoms of conditions such as depression, anxiety, panic attacks, agoraphobia and interrupted sleep patterns. These symptoms do not necessarily lead to mental illness however, so it is important that appropriate support is given to individuals, to ensure positive outcomes.

The Refugee Council has made the following observations and recommendations in respect of the health needs of refugees and asylum Seekers: *'The basic health needs of Asylum Seekers and Refugees are broadly similar to those of the host population, although previous poor access to health care may mean that many conditions have been untreated. Symptoms of psychological distress are common but do not necessarily signify mental illness. Many Refugees experience difficulties*

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[85] Burnett, A. Peel, M. (2001) Asylum Seekers and Refugees in Britain: Health needs of Asylum Seekers and Refugees

in expressing health needs and in accessing health care. Poverty and social exclusion have a negative impact on health. Initially Refugees will need help to make contact with health and social support agencies. Professional interpreters are essential.’ [86]

Key policy

- Nationality, Immigration and Asylum Act 2001
- The National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2004

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[86] Kelly, N. & Stevenson, J. (2006) ‘First Do No Harm: denying healthcare to people whose asylum claims have failed’

6.6 Cerebrovascular Disease / stroke

The incidence of **stroke** is significantly more common in Black African and Black Caribbean populations, but also relatively high in Chinese and South Asian groups[87] and Scottish and Irish migrants;[88] hypertension (high blood pressure) is the major known risk factor.[89] Black Caribbean men have the highest self-reported incidence of stroke, while for women aged 55 and over the highest incidence was amongst Bangladeshi and Pakistani women. Diabetes and the incidence of sickle cell disease are additional factors linked to an increased risk of stroke.[90]

Key policy

The National Stroke Strategy for England, Department of Health December 2007

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[87] NHS Health & Social Care Centre (2005) Health Survey for England 2004: The Health of Minority Ethnic Groups

[88] Harding, S. et al (2008) Trends for CHD and stroke among migrants in England and Wales 1979 – 2003

[89] Aspinall, P.J. & Jacobson, B. (2004) Ethnic disparities in Health and Health Care: a focused review of the evidence and selected examples of good practice

[90] The Stroke Association (2007) Stroke in African-Caribbean people

6.7 Diabetes

There is a much higher rate of non-insulin dependant diabetes among South Asian and Caribbean populations, with mortality from diabetes related conditions 3.5 times higher among South Asian groups, with a similar rate for Caribbean men, but six times higher than the general population for Caribbean women. The age of presentation is also significantly earlier for Asian groups, placing them at greater risk of complications; amongst middle aged Asians the prevalence rate has been put at five times that of White groups. Non-insulin dependant diabetes remains undiagnosed in up to 40% of Asian Diabetics. Diabetic nephropathy and end stage renal failure are also significantly higher for South Asian diabetics[91].

Several studies report inadequate health care of Asian and African Caribbean diabetics and poor compliance amongst patients due to lack of knowledge about the disease and its management, made worse by the inappropriateness of health information.[92]

Key policy

1. The Diabetes National Service Framework (NSF) 2003
2. Making every young person with diabetes matter; DoH 2007

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[91] Aspinall, P.J. & Jacobson, B. (2004) Ethnic disparities in Health and Health Care: a focused review of the evidence and selected examples of good practice

[92] As cited in reference 78

6.8 Inherited blood disorders

Sickle cell disease and thalassaemia major are serious, inherited blood disorders that are passed on from parents to children through unusual haemoglobin genes. People only have these disorders if they inherit two genes, one from their mother and one from their father; it is strongly recommended that people who may be carriers / have the trait should be screened during pregnancy. People who inherit just one gene are known as carriers (trait). Carriers are healthy and do not have the disorder. People with sickle cell disease:

- Can have attacks of very severe pain
- Can get serious life-threatening infections
- Are usually anaemic
- Need medicines and injections when they are children and throughout their lives

People with thalassaemia major:
- Are very anaemic
- Need blood transfusions every four to six weeks.
- Need injections and medicines throughout their lives[93]

These conditions affect African, Caribbean, Middle Eastern, Asian and Mediterranean populations', carriers of both conditions are relatively common, whereas people who have a major disorder are relatively rare.[94] The sickle cell trait or thalassaemia trait is found in 1 in 10 Afro-Caribbean's, 1 in 4 West African's, 1 in 7 in Pakistanis and 1 in 7 Cypriots; about 1 baby in every 2,500 born in the UK has a sickle cell disorder.[95]

Comment

The introduction of NHS screening programme of babies at birth has resulted in more carriers of both disorders being identified. This in turn has lead to an increase in the number of referrals Wirral GPs are making to the Abercromby Centre for Inherited Blood Disorder in Liverpool (reported by the manager of the centre), though there is no formal agreement between Liverpool and Wirral PCT in respect of this arrangement.

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[93] NHS screening test for inherited blood disorders

[94] Gill, P.S. et al (2002) Clinical Reader in Primary Care Research; Ch 4, Black and Minority Ethnic Groups

[95] Centre for Inherited Blood disorders; Abercromby Health Centre

6.9 Learning difficulties

There is limited research into this area, with a focus on access issues and differences in experience of service provision. There is evidence of considerable stigma and discrimination associated with learning difficulties in people from BME communities; services may only have a ‘tokenistic’ approach to meeting socio-cultural needs, resulting in an under-usage and a lack of engagement with BME communities.

A study of people with learning difficulties from South Asian background found they made less use of available services, but had significantly lower skill levels suggesting they needed higher levels of support. Very few carers of people with learning difficulties had support from extended families or other informal support, while at the same time experiencing material disadvantage; these carers had higher levels of stress and were more likely to report depression than other groups.

There are a number of factors that seem to contribute to lower take-up of services by people with learning difficulties from BME communities including lack of appropriate information, insufficient staff with the necessary skills and services not being able to meet the religious and cultural needs of BRM service users.[96]

A report by the Valuing People support team found that under a quarter of people from BME communities were known to services and that there had been “uneven” progress in implementing the Framework for Action to ensure improvements in services for people with learning difficulties from BME communities; only 22% of learning disability partnership boards had made use of the learning disabilities development fund for initiatives relating to ‘race’ equality, despite government encouragement to do so and that services for BME communities was not a high priority. People from South Asian communities were the most under-represented in services, while White people were relatively over-represented.[97]

Key policy

1. Learning Difficulties and Ethnicity: A Framework for Action: Learning Disabilities Task Force, 2004
2. Council for Disabled Children Inclusion Policy, 2008
3. Every Disabled Child Matters 2007
4. Transition: Moving on well; DoH & Dept for Children, schools and families, 2008

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[96] Gangadharan, S.K. & Bhaumik, S. (2008) People with learning disabilities and mental health care: influence of ethnic backgrounds, reviewing research findings

[97] Valuing People Support Team / Care Services Improvement Partnership (2004) Improving services for people with learning difficulties from minority ethnic groups

6.10 Neurological conditions

There has been little research into the incidence of neurological conditions amongst BRM communities, the most important exception to this being Cerebrovascular Disease (stroke) which has a higher incidence among people from Caribbean, African and Asian populations and Scottish and Irish migrants. High blood pressure is thought to be a factor in this with one in three African-Caribbean men and two in every five African Caribbean women having high blood pressure. Increased rates of diabetes within this community, as well as the incidence of sickle cell disease, are also additional factors linked to an increased risk of stroke.[98]

There is some research that suggests a higher incidence of Alzheimer's disease amongst South Asian and African Caribbean communities linked to diabetes and increased risk factors in Northern Europeans and Africans. A higher prevalence of Cerebral Palsy has been found amongst the Asian population in Bradford; it is suggested that consanguinity is a factor in this, with a relatively high incidence of marriage between first cousins, this was also said to be a possible factor in the apparently higher rate of Myasthenia Gravis amongst some Asian groups.

Some neurological conditions appear to be less common amongst different BRM communities; motor neurone disease (MND) was found to be significantly lower in Asian groups and Huntington's disease rare in African, Asian, Chinese and Japanese people. Research has suggested a higher incidence of Parkinson's disease amongst White groups, while Spina Bifida is higher amongst Celtic groups and Sikhs.[99]

Key policy

- Long term neurological conditions: National Service Framework 2005

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[98] The Stroke Association (2007) Stroke in African-Caribbean people

[99] Icarus (2004) The use of neurological services by BME communities; Final Report

6.11 Physical disability and sensory impairment

Physical disability: Research in the 70s and early 80s suggested the prevalence of rickets and osteomalacia (which causes bone deformity) was high in South Asian populations in the UK, particularly among children and women, attributed to vitamin D deficiency; this lead to a DoH campaign targeted at these communities and today it appears less of a significant issue. However later research has suggested an increase in hip fractures among elderly South Asians, which may be exacerbated by vitamin D deficiency[100], while there is increasing concern about lower levels of Vitamin D among pregnant women from Indian Asian and Middle Eastern communities[101].

Black-Caribbean disabled people's groups were more likely to describe experiences of discrimination and prejudice and 'multiple' disadvantage, than other groups (with the exception of White lesbian and gay disabled people); the impacts of discrimination were seen as being lowered self-esteem / confidence, decreased trust, restricted opportunities to participate in key areas of life and on-going effects on physical and mental health. The effects of disability in childhood varied; South Asian disabled people were more likely to comment on the negative impact of social taboos and community responses that has an adverse affect on their early lives. People from BME communities tended to attend culturally specific disability groups and were unanimously positive about their experience of these[102].

Visual impairment: there has been little research in this area; the data that does exist suggests raised levels of Glaucoma in African-Caribbean groups and Cataract in Asian populations. Raised levels of diabetes in African-Caribbean and Asian groups have implications in terms of potential visual impairment; research is needed to investigate this and also the possible association between hypertension and glaucoma. There are low levels of registration and apparent under-utilisation of preventative and support services by BME groups and the reasons for this should be examined, while visual impairment may have a greater functional impact on BME communities[103].

Deafness: Deaf people from BME communities face many barriers to social inclusion and access to appropriate services; many experience racism from White deaf people and marginalisation within their own communities. Deaf people and their

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[100] Smaje, C. (1995) Health, 'Race' and Ethnicity, making sense of the evidence

[101] Sethi, M. et al (2008) Vitamin D status in pregnancy in four ethnic groups

[102] Molloy, D. et al (2003) Diversity in disability: exploring the interactions between disability, ethnicity, age, gender and sexuality

[103] Jones, M.R. & Scase, M.O. (2000) Ethnic Minorities and Visual Impairment; A research review

families often lack a common language in which to communicate and many BME parents were concerned that their deaf child found it difficult to learn about their ethnicity and religion. The majority of initiatives, which tend to rely on short term funding, have focused on Asian and African-Caribbean deaf people, with provision for other groups being poor and little provision made for older deaf people and for blind deaf people[104].

Key policy

1. The Disability Discrimination Act 2005
2. Disability Equality Duty 2006
3. Council for Disabled children Inclusion Policy, 2008
4. Every Disabled Child Matters 2007
5. Transition: Moving on well; DoH & Dept for Children, schools and families, 2008

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[104] Ahmad, W. et al (1998) Deaf people from minority groups: initiatives and services

7.0 Conclusion and recommendations

7.1: Conclusion

The NHS was founded on principles of universality at a time when Britain was a more homogenous society and when expectations about health service care were much more basic. The key challenge the NHS faces in the 21st century is not simply meeting raised expectations, but doing so in the context of a country that has become increasingly ethnically and culturally diverse. In the immediate future it will also have to meet these challenges within a financially constrained environment.

This research has evidenced a gradual increase in the BME population in Wirral over the last decade; however this still represents a relatively small percentage of the total population. In certain respects this increases the challenge in meeting the needs of BME communities; the contact that staff groups have with particular BME groups may be very limited and this will test their ability to deliver culturally sensitive health services. Equally, engaging and consulting meaningfully with small and spatially dispersed BME communities can present further obstacles.

Knowing the size and at least to some extent the overall composition of the BME population in Wirral is of relatively limited value without knowing how these communities are using health services and whether any are disproportionately affected by any disease or health condition.

Patient Profiling (based on primary care clinical systems) has the potential of providing up to date and important evidence and is being used effectively in Liverpool and elsewhere to monitor the prevalence of conditions such as CHD, diabetes and mental health amongst all ethnic groups. When this is combined with what is already know about the prevalence and variations in outcomes for different BME populations, informed decisions can be made about commissioning priorities and resource allocation to address the health needs of BME communities.

There is good evidence[105] to suggest that Third sector organisations can play an effective role in engaging and helping to meet health needs within BME communities. At the same time there is a need for on-going engagement and consultation with BME communities by health services; local BME community and voluntary organisations are often best placed to facilitate this and reflect the concerns of particular communities.

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[105] NHS Race for health (2005) Towards Race Equality in Health: A guide to policy and good practice for commissioning services

Ensuring equality of access to the NHS is the single most important requirement in addressing inequalities in health outcomes between ethnic groups. This research has shown that for a small number of BME individuals in Wirral the experience of trying to access services is poor, reflecting a similar picture of the experience of BME patients nationally. In part it has been suggested that this is due to a lack of cultural awareness amongst some health professionals, which suggests additional training is required in relation to this.

Increasing the representation of BME staff in the health workforce should help improve awareness of cultural diversity and has other potential benefits; the relatively low levels of employment of BME staff by health Trusts has been highlighted by the Healthcare commission.[106] It was suggested by some interviewees that the PCT could do more to promote and encourage BME employment within the NHS and there would appear to be a value in reviewing what it currently does and whether this can be enhanced.

There is cause for concern that a number of BME patients did not feel they were fully treated with respect and dignity by their GP, which at least in part appears to be linked to perceptions about cultural and religious sensitivity. However it is also the case that Wirral BME patients reported very high levels of trust and confidence in their GPs, even though some experienced difficulties in communicating with them.

The equally high levels of satisfaction that BME patients have with other health professionals and how their health concerns are dealt with is reassuring. There is though a need to improve how interpreting and translation services are provided and also of how BME communities are made aware of health services and how to access them.

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[106] Healthcare commission (2009) Tackling the Challenge – Promoting race equality in the NHS in England

7.2 Recommendations

Patient profiling / ethnic monitoring

- Develop Patient Profiling with GP practices across Wirral as recommended in the Department of Health's Practical Guide to Ethnic Monitoring in Primary Care 2005 *(section1.4 p21)*

- Ensure that ethnic monitoring data is collated and regularly assessed at strategic level to inform commissioning *(section1.4 p21)*

Improving access

- Review translation and interpreting services taking account of the findings in this research, as well as identifying any additional concerns of health professionals, including GPs, as to how these services function. Provide feedback to Language Line on the issues identified through this research and any review and ensure health professionals are familiar with how translation and interpreting services are provided in Wirral *(section 4.0 p30/33)*

- Discuss with GP practices how the advanced access appointment system can be adapted to accommodate the needs of patients with language difficulties and identify what measures might be taken to improve communication with this group of patients *(section 4 p34)*

- Reduce inappropriate attendance at Accident and Emergency (A&E) due to lack of understanding of how GP advanced appointment system works, through working with GP practices and BME community organisations *(section 4 p34)*
- Review how information is provided on 'understanding and navigating the health care system', with a particular focus on new arrivals, migrant workers and people with language difficulties *(section 4 p36/37)*

- Continue to support the provision of English for speakers of other languages (ESOL) with Wirral Metropolitan Borough Council (WMBC) and in consultation with local BME organisations *(section 4 p33)*

- Consider the development of additional community interpreting services; the Community Health-link worker initiative based at the Wirral Multicultural Centre provides a potential model of how this could be developed *(section4.0 p34)*

- Review current workforce development planning in line with 2009 Healthcare Commission report on promoting race equality within the NHS, including:
    - whether current training on diversity and equality equips staff with the necessary knowledge on cultural diversity *(section 4 p37/38)*
    - if additional measures can be taken to improve recruitment and employment of BME community members *(section 4 p37/38)*

WPCT Health Priorities

- The recommendations are to be confirmed following consultation with the reference group.

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Appendix 1: Tables

Table 1: Distribution of 2009 Household survey residents and 2004 population data

WIRRAL MD	**2004 population data**		**Survey sample**	
	Population (> 15 years)	% of total WIRRAL population	No of residents surveyed	% of residents surveyed
Birkenhead	14410	4.55%	307	17.76%
Oxton	14064	4.44%	345	19.96%
Liscard	14301	4.52%	347	20.08%
New Brighton	14450	4.56%	358	20.72%
Eastham	13637	4.31%	371	21.47%

Table 1 indicates the numbers of interviews completed within each electoral ward and compares the locational distribution of the surveyed residents with 2004 ONS mid-year population estimate (over 15 years old).

Table 2: 2009 Household Survey: Summary Results of Ethnic Distribution of Wirral Households

		WIRRAL					**Total**
Ethnicity		**Birkenhead**	**Oxton**	**New Brighton**	**Liscard**	**Eastham**	
White-British	Count	281	329	345	339	368	1662
	% within WIRRAL	91.5%	95.4%	96.4%	97.7%	99.2%	96.2%
White-Irish	Count	3	4	2	0	1	10
	% within WIRRAL	1.0%	1.2%	.6%	.0%	.3%	.6%
White-Other White Background	Count	1	3	4	3	1	12
	% within WIRRAL	.3%	.9%	1.1%	.9%	.3%	.7%
Mixed-White and Black Caribbean	Count	1	1	0	0	1	3
	% within WIRRAL	.3%	.3%	.0%	.0%	.3%	.2%
Mixed-White and Black African	Count	0	0	0	1	0	1
	% within WIRRAL	.0%	.0%	.0%	.3%	.0%	.1%
Mixed-White and Asian	Count	0	1	1	0	0	2
	% within WIRRAL	.0%	.3%	.3%	.0%	.0%	.1%
Asian/Asian British-Indian	Count	5	3	0	0	0	8
	% within WIRRAL	1.6%	.9%	.0%	.0%	.0%	.5%

Asian/Asian British-Pakistani	Count	0	0	1	0	0	1
	% within WIRRAL	.0%	.0%	.3%	.0%	.0%	.1%
Asian/Asian British-Bangladeshi	Count	8	0	1	2	0	11
	% within WIRRAL	2.6%	.0%	.3%	.6%	.0%	.6%
Asian/Asian British-Other Asian	Count	2	0	0	0	0	2
	% within WIRRAL	.7%	.0%	.0%	.0%	.0%	.1%
Black/Black British-Caribbean	Count	4	0	0	0	0	4
	% within WIRRAL	1.3%	.0%	.0%	.0%	.0%	.2%
Black/Black British-African	Count	0	1	1	1	0	3
	% within WIRRAL	.0%	.3%	.3%	.3%	.0%	.2%
Chinese or Other Ethnic Group-Chinese	Count	1	3	1	1	0	6
	% within WIRRAL	.3%	.9%	.3%	.3%	.0%	.3%
Other Group Not Stated	Count	1	0	2	0	0	3
	% within WIRRAL	.3%	.0%	.6%	.0%	.0%	.2%
	Count	307	345	358	347	371	1728
	% within WIRRAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Table 3: 2009 Household survey and BME community survey - gender of respondents

Gender of Respondent	White British Profile Household Survey (n =1662)	BME Profile [n = 384]
Male	39.2% (n=652)	44.6% (n=171)
Female	60.8% (n=1010)	55.4% (n=213)
Total	100%	100%

Table 4: Age profile of respondents Household survey and BME community survey

Age of Respondent	White British Profile – Household Survey (n = 1662)	BME Profile [n = 384]
16 – 35	20.1% (n=334)	36.4% (n=140)
36 – 50	24.1% (n=401)	40.9% (n=157)
51 – 65	29.8% (n=495)	14.4% (n=55)
66 – 80	20.0% (n=332)	7.1% (n=27)
80+	6.0% (n=100)	1.2% (n=5)
Total	100%	100%

Table 5: ONS 2005 Mid-Year Population Estimates by Ethnic Group

	Wirral (2001)	Wirral (2005)	Wirral (2007)	Net change (from 2001)	% change
All Groups	315000	312300	310200	-4800	-1.52
White: British	303800	298300	294600	-9200	-3.03
White: Irish	3100	2800	2700	-400	-12.90
White: Other White	2700	3400	3700	+1000	+37.04
Mixed: White and Black Caribbean	500	700	700	+200	+40.00
Mixed: White and Black African	300	400	500	+200	+66.67
Mixed: White and Asian	500	700	800	+300	+60.00
Mixed: Other Mixed	500	600	700	+200	+40.00
Asian or Asian British: Indian	700	1200	1500	+800	+114.29
Asian or Asian British: Pakistani	100	400	500	+400	+400.00
Asian or Asian British: Bangladeshi	400	500	500	+100	+25.00
Asian or Asian British: Other Asian	200	400	500	+300	+150.00
Black or Black British: Black Caribbean	200	300	400	+200	+100.00
Black or Black British: Black African	300	600	800	+500	+166.67
Black or Black British: Other Black	100	100	200	+100	+100.00
Chinese or Other Ethnic Group: Chinese	1300	1500	1500	+200	+15.38
Chinese or Other Ethnic Group: Other			700		

Source: NHS Wirral Performance & Intelligence Team (Public Health) - June 2009

Table 6: Ethnicity of 2009 Household survey respondents with comparison with 2004 ONS mid-point Census estimates

		2009 Survey	2004 Census
White-British	Count	1662	316,541
	% within WIRRAL	96.2%	96.49%
White-Irish	Count	10	
	% within WIRRAL	.6%	0.98%
White-Other White Background	Count	12	
	% within WIRRAL	.7%	0.84%
Mixed-White and Black Caribbean	Count	3	
	% within WIRRAL	.2%	0.16%
Mixed-White and Black African	Count	1	
	% within WIRRAL	.1%	0.10%
Mixed-White and Asian	Count	2	
	% within WIRRAL	.1%	0.16%
Asian/Asian British-Indian	Count	8	
	% within WIRRAL	.5%	0.20%
Asian/Asian British-Pakistani	Count	1	
	% within WIRRAL	.1%	0.04%
Asian/Asian British-Bangladeshi	Count	11	
	% within WIRRAL	.6%	0.12%
Asian/Asian British-Other Asian	Count	2	
	% within WIRRAL	.1%	0.07%
Black/Black British-Caribbean	Count	4	
	% within WIRRAL	.2%	0.05%
Black/Black British-African	Count	3	
	% within WIRRAL	.2%	0.08%
Chinese or Other Ethnic Group-Chinese	Count	6	
	% within WIRRAL	.3%	0.42%
Other Group Not Stated	Count	3	
	% within WIRRAL	.2%	0.11%
	Count	1728	
	% within WIRRAL	100.0%	

Table 7: National Insurance Number (NINo) registrations for non-UK nationals 2006-2008 by country of origin - Source: NHS Wirral Performance & Intelligence Team (Public Health) - June 2009

Country of origin	2006	Country of origin	2007	Country of origin	2008
Australia	20	Australia	20	Australia	20
Bangladesh	20	Bangladesh	20	Bangladesh	20
		Brazil	10		
		Bulgaria	10	Bulgaria	10
China	20	China	30	China	30
				Cyprus	10
Czech Rep	10	Czech Rep	10	Czech Rep	10
France	10	France	30	France	20
Germany	10	Germany	20	Germany	10
Greece	10	Greece	10		
Hungary	20	Hungary	20	Hungary	20
India	60	India	40	India	20
				Iran	10
Italy	10			Italy	10
		Japan	10		
				Malaysia	10
		Netherlands	10		
New Zealand	10	New Zealand	10	New Zealand	10
		Nigeria	10	Nigeria	10
Pakistan	10	Pakistan	10	Pakistan	10
Philippines	20	Philippines	20	Philippines	20
Poland	350	Poland	390	Poland	240
		Portugal	10		
Rep of Ireland	10	Rep of Ireland	10	Rep of Ireland	20
				Rep of Latvia	10
Rep of Lithuania	10	Rep of Lithuania	10		
		Romania	10	Romania	10
Slovak Rep	30	Slovak Rep	40	Slovak Rep	30
South Africa	10	South Africa	10	South Africa	20
Spain	10	Spain	20	Spain	10
Thailand	10	Thailand	10	Thailand	10
Turkey	10	Turkey	20	Turkey	10
Ukraine	10				
USA	10	USA	10	USA	10
Wirral	**770**	**Wirral**	**910**	**Wirral**	**640**

Table 8: length of residence of BME community survey interviewees

Period of residency in Wirral	% BME Respondents
1 year or less	3%
2 – 5 years	22%
6 – 10 years	21%
11 – 20 years	27%
21 – 30 years	16%
Over 30 years	11%
Total	100%

Table 9: Registration with GPs / Health Centre

Registered with Doctor	White British [n = 1662]	BME Community [n = 384]
Yes	98.9% (n=1644)	98.7% (n=379)
No	1.1% (n=18)	1.3% (n=5)
Total	100%	100%

Table 10: Made an appointment with a doctor from your GP surgery/health centre in last 12 months

Made appointment	National Patients Survey	White –British [n = 1662]	BME Community [n = 384]
Yes	85.9%	79.3% (n=1318)	84.9% (n=326)
No	14.1%	20.7% (n=344)	15.1% (n=58)
Total	100%	100%	100%

Table 11: On last visit how long waited for an appointment

Waiting Time	National Patients Survey	White – British [n = 1662]	BME Community [n = 384]
I was seen without an appointment	3.9%	6.2% (n=103)	1.4% (n=5)
I was seen on the same working day	33.8%	44.3% (n=736)	52.8% (n=203)
I waited 1 or 2 working days	26.3%	23.0% (n=382)	21.3% (n=82)
I waited more than 2 working days	20.1%	8.2% (n=136)	17.0% (n=65)
It was a pre-planned appointment	14.2%	9.9% (n=165)	2.6% (n=10)
Can’t remember	1.7%	8.4% (n=140)	4.9% (n=19)
Total	100%	100%	100%

Table 12: In last 12 months ever been put off going to GP surgery/health centre because opening times were inconvenient

Inconvenient times	National Patients Survey	White – British [n = 1662]	BME Community [n = 384]
Yes	25.1%	12.8% (n=213)	24.3% (n=93)
No	74.9%	87.2% (n=1449)	75.7% (n=291)
Total	100%	100%	100%

Table 13: Have confidence and trust in the doctor

Trust in the doctor	National Patients Survey	White – British [n = 1662]	BME Community [n = 384]
Yes	97%	94.3% (n=1567)	95.0% (n=365)
No	3%	5.7% (n=95)	5.0% (n=19)
Total	100%	100%	100%

NB: In the Key findings report for the 2008 National Survey of Local Health Services, the 'Yes' was divided into 'Yes' defiantly (76.8%) and 'Yes' to some extent' (20.2%)

Table 14: Had follow-up to check on progress with medicine/treatment

Had follow-up	National Patients Survey	White – British [n = 1662]	BME Community [n = 384]
Yes	77.7%	55% (n=914)	25.4% (n=98)
No	22.3%	45% (n=748)	74.6% (n=286)
Total	100%	100%	100%

NB: Table 14 should be treated with considerable caution; some patients had regular appointments and for others there was no expectation of any follow-up e.g. for a minor health complaint

Table 15: When you arrived, how would you rate the courtesy of the receptionist?

Performance	National Patients Survey	Wirral BME Community [n = 384]
Excellent	28.5%	14.7% (n=57)
Very good	33.9%	47.1% (n=181)
Fair	34.6%	31.3% (n=120)
Poor	2.2%	5.8% (n=22)
Very poor	0.9%	1.1% (n=4)
Total	100%	100%

Table 16: Did the doctor listen carefully to what you had to say?

Performance	National Patients Survey	Wirral BME Community [n = 384]
Yes, definitely	82.6%	69.7% (n=268)
Yes, to some extent	16.0%	28.8% (n=111)
No	1.4%	1.5% (n=5)
Total	100%	100%

Table 17: Do you think the doctor fully understood what you were saying?

Performance	National Patients Survey	Wirral BME Community [n = 384]
Yes, definitely	N/A	67.1% (n=258)
Yes, to some extent	N/A	28.6% (n=110)
No	N/A	4.3% (n=16)
Total	100%	100%

Table 18: Were you given enough time to discuss your health/medical problem?

Performance	National Patients Survey	Wirral BME Community [n = 384]
Yes, definitely	75.8%	64.7% (n=248)
Yes, to some extent	20.7%	26.9% (n=104)
No	4.5%	8.4% (n=32)
Total	100%	100%

Table 19: Were you involved as much as you wanted to be in decisions?

Performance	National Patients Survey	Wirral BME Community [n = 384]
Yes, definitely	70.1%	58.5% (n=225)
Yes, to some extent	25.4%	28.4% (n=109)
No	4.5%	13.1% (n=50)
Total	100%	100%

Table 20: Did you get answers that you could understand?

Performance	National Patients Survey	Wirral BME Community [n = 384]
Yes, definitely	74.4%	69.1% (n=265)
Yes, to some extent	22.6%	25.1% (n=96)
No	2.1%	5.8% (n=23)
No opportunity to ask questions	0.9%	0.0%
Total	100%	100%

Table 21: Did the doctor explain reasons for treatment adequately?

Performance	National Patients Survey	Wirral BME Community [n = 384]
Yes, completely	76.5%	62.5% (n=240)
Yes, to some extent	20.8%	32.4% (n=124)
No	2.6%	3.3% (n=13)
Did not need explanation	*	0.7% (n=3)
No treatment necessary	*	1.1% (n=4)
Total	100%	100%

***** This question was not asked in the National Patients Survey

Table 22: Did the doctor treat you with respect and dignity?

Performance	National Patients Survey	Wirral BME Community [n = 384]
Yes, definitely	92.7%	86.6% (n=332)
Yes, to some extent	6.2%	12.7% (n=49)
No	1.1%	0.7% (n=3)
Total	100%	100%

Table 23: Did you feel you were treated appropriate to your culture or religion?

Performance	National Patients Survey	Wirral BME Community [n = 384]
Yes, definitely	N/A	80.7% (n=310)
Yes, to some extent	N/A	19.3% (n=74)
No	N/A	0.0%
Total	100%	100%

Table 24: In last 12 months have you had any new medicine[s]?

Performance	National Patients Survey	Wirral BME Community [n = 384]
Yes	54.0%	66.8% (n=257)
No	46.0%	33.2% (n=127)
Total	100%	100%

Table 25: Were you involved as much as you wanted to be in decisions about the best medicine?

Performance	National Patients Survey	Wirral BME Community [n = 257]*
Yes, definitely	59.5%	49.6% (n=128)
Yes, to some extent	29.5%	34.8% (n=89)
No	11.0%	15.6% (n=40)
Total	100%	100%

*Number of respondents saying they had been prescribed new medicines in last 12 months (see table 24)

Table 26: Were you given enough information about the purpose of the medicine?

Performance	National Patients Survey	Wirral BME Community [n = 257]*
Yes, enough information	80.2%	67.1% (n=174)
Some – but I would have liked more	16.7%	21.9% (n=56)
I got no information but I wanted some	3.1%	3.1% (n=8)
I did not want/need information		2.6% (n=7)
Don't know/can't say		5.3% (n=12)
Total	100%	100%

* Number of respondents saying they had been prescribed new medicines in last 12 months (see table 24)

Table 27: Were you given enough information about how to use the medicine?

Performance	National Patients Survey	Wirral BME Community [n = 238]*
Yes, enough information	85.1%	81.1% (n=193)
Some – but I would have liked more	11.1%	15.0% (n=36)
I got no information but I wanted some	3.8%	2.2% (n=5)
I did not want/need information		0.4% (n=1)
Don't know/can't say		1.3% (n=3)
Total	100%	100%

*****This figure is all those who had been prescribed new medicine in the last 12 months, minus those who did not want or need information about the medicine, or answered don't know / can't say (see table 26)

Table 28: In the last 12 months have you been referred to a specialist?

Referred to a specialist	National Patients Survey	Wirral BME Community [n = 384]
Yes	35.3%	35.5% (n=136)
No	64.7%	64.5% (n=248)
Total	100%	100%

Table 29: Offered choice of hospital?

Offered choice	National Patients Survey	Wirral BME Community [n = 136]*
Yes	42.7%	67.7% (n=92)
No	57.3%	32.3% (n=44)
Total	100%	100%

* This figure is of those people who had been referred to a specialist in the last 12 months (see table 28)

Table 30: Did specialist have all necessary information about you?

Had all necessary information	National Patients Survey	Wirral BME Community [n = 136]
Yes, completely	63.5%	77.5% (n=105)
Yes, to some extent	28.3%	14.6% (n=20)
No	8.2%	7.9% (n=11)
Total	100%	100%

Table 31 Have you seen any else other than a doctor in last 12 months?

Seen anyone other than a doctor	National Patients Survey	Wirral BME Community [n = 384]
Yes	51.6%	44.3% (n=169)
No	48.4%	56.1% (n=215)
Total	100%	100%

Table 32: Who did you see?

Who did you see	National Patients Survey	Wirral BME Community [n = 170]*
Practice nurse/nurse practitioner	83.3%	73.6% (n=125)
Midwife	2.5%	6.4% (n=11)
District nurse	3.8%	2.4% (n=4)
Health visitor	1.8%	3.2% (n=5)
Someone else	7.3%	8.0% (n=14)
Not sure	1.3%	6.4% (n=11)
Total	100%	100%

* This figurer of only those people who had seen someone other than a doctor in the last 12 months (see table 31)

Table 33: Was issue dealt with to your satisfaction?

Seen anyone other than a doctor	National Patients Survey	Wirral BME Community [n = 170]
Yes	96.5%	92.9% (n=158)
No	3.5%	7.1% (n=12)
Total	100%	100%

Table 34: Did this person treat you with respect and dignity?

Treated with respect and dignity	National Patients Survey	Wirral BME Community [n = 170]
Yes	N/A	98.4% (n=167)
No	N/A	1.6% (n=3)
Total		100%

Table 35: Were you treated in a way appropriate to your culture and religion?

Treated appropriate to culture or religion	National Patients Survey	Wirral BME Community [n = 155]*
Yes	N/A	95.9% (n=149)
No	N/A	4.1% (n=6)
Total		100%

*****In responding to this question 15 of the 170 people who had seen some one other than a doctor in the last 12 months felt that it was not relevant or applicable to them, as they saw no difference in their culture / religion than that of the general population. However, it is of interest that they did not make this observation in response to whether their doctor had treated them appropriately re their culture and religion (table 23), this may possibly be explained by the repetition of this question provoking a more considered response.

Table 36: Respondents seeking help in last 12 months

Health Issue	Sought help in last 12 months % No of Respondents	Would like additional help. %No of Respondents
A weight problem	14.8%	7.9%
Giving up smoking	13.8%	6.9%
Eating a healthy diet	8.7%	7.8%
Getting enough exercise	4.9%	5.3%
Sensible alcohol intake	2.6%	0.7%

Appendix 2: Terminology

Any discussion about health and ethnicity encounters a number of conceptual issues to do with how population groups are categorised and defined, which includes consideration of the use of ethnic as a category and the validity of race as a concept. Variations in how groups are defined in terms of nationality or place of origin also create difficulties e.g. the use of South Asian and who is included within this category.

Race

The notion of 'race' as having any validity as a biological concept has for a long time been rejected in biological science, though it still has a 'commonsense' usage in defining population groups by their self-evident physical differences in relation to skin colour, facial characteristics etc. In practice differences in physical form are due to the interaction between an individual's inherited genes and their environment, while nearly all genes are common to all humans.

Of the very few genes that are not common to everyone, some are still found across all population groups e.g. the genes that determine particular blood groups. Importantly, the genetic differences within what have been previously classed as racial groups, is greater than the difference between such groups. Given this and that most genetic variation happens at the individual level, it becomes meaningless to try and characterise different population groups by differences in genetic makeup.

Ethnicity

To an extent 'ethnicity' is used as a proxy for 'race', but as a concept it has a legal definition and a sociological meaning beyond supposed genetic differences. Ethnic groups may define themselves, or be defined by others in relation to two essential criteria: a long shared history that the group is conscious of and a cultural tradition including family and social customs. In addition an ethnic group may also be defined in relation to religious observance, common geographical origin or descent from a small group of ancestors, language and literature, and by being a minority or being oppressed by a dominant group within a larger community.

Trying to identify differences in health needs on the basis of ethnicity presents a number of challenges, not least being in relation to ethnic monitoring and the criteria used to try and make objective and useful distinctions between groups. How also are differences in health status explained if they are not simply based on underlying genetic factors? However, it is very important to be able to identify differences in health outcomes between ethnic groups and while there are some problems with ethnicity data, it still has a much greater validity and usefulness than the notion of 'race'.

NB: The following definitions come from a glossary of terms relating to ethnicity and 'race' with only limited editing:[107]

Asian

Used in the United Kingdom to mean people with ancestry in the Indian subcontinent. In the United States, the term has broader meaning, but is mostly used to denote people of far Eastern origins, for example, Chinese, Japanese, and Filipinos. More specific terms should be used whenever possible. Asian Indian a term currently used synonymously with South Asian (see below), but with the important limitation that major South Asian populations such as Pakistani and Bangladeshi may not identify with it. This term is being used in North America to distinguish the population from Native Americans, previously known as American Indians.

African

A person with African ancestral origins who self identifies, or is identified, as African, but excluding those of other ancestry, for example, European and South Asian. This term is the currently preferred description for more specific categories, as in African American, for example. In practice, Northern Africans from Algeria, Morocco, and such countries are excluded from this category. (See also Black.)

Afro-Caribbean/African Caribbean

A person of African ancestral origins whose family settled in the Caribbean before emigrating and who self identifies, or is identified, as Afro-Caribbean (See also Black.)

Black

A person with African ancestral origins, who self identifies, or is identified, as Black, African or Afro-Caribbean (see, African and Afro-Caribbean). The word is capitalised to signify its specific use in this way. In some circumstances the word Black signifies all non-white minority populations, and in this use serves political purposes. While this term was widely supported in the late 20th century there are signs that such support is diminishing.

Chinese

A person with ancestral origins in China, who self identifies, or is identified, as Chinese.

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[107] Glossary of terms relating to ethnicity and race: for reflections and debate; Journal of Epideminol Health 2004, B Bhopal

European

European primarily means an inhabitant of Europe, or one with ancestral origins in Europe. Effectively this is used in epidemiology and public health as a synonym for White (see below).

Indigenous

This term is usually used to mean a person who belongs naturally to a place in the sense of long term family origins (see Native). This term is sometimes used to identify the majority population, for example, in the United Kingdom as an alternative to the word White. In some parts of the world, for example, Australia, the word indigenous is used specifically to refer to aboriginal populations (for example, Aborigene).

Native

Sometimes this word is used to refer to populations born, or with family origins, in a place (see indigenous). This was also a pejorative term meaning populations belonging to a non-European and imperfectly civilised or savage race, so writers need to take care.

South Asian

A person whose ancestry is in the countries of the Indian subcontinent, including India, Pakistan, Bangladesh, and Sri Lanka. This label is usually assigned, for individuals rarely identify with it. (See also Indian, Indian Asian, Asian, Pakistani, Bangladeshi.)

Western

A person or populations with ancestry in a region conventionally known as the west, effectively European countries, as distinguished from Eastern or Oriental populations.

White

The term usually used to describe people with European ancestral origins who identify, or are identified, as White (sometimes called European, or in terms of racial classifications, the group known as Caucasian or Caucasoid). The word is capitalised to highlight its specific use. The term has served to distinguish these groups from those groups with skin of other colours (black, yellow, etc), and hence derives from the concept of race but is used as an indicator of ethnicity. There are problems of poverty and excess disease in subgroups of the White population, which cannot be unearthed and tackled by using the label White.

Mixed and other race or ethnic group

The increasing importance of the category mixed (ethnicity or race) is self evident with the increasing acceptance of sexual unions that cross ethnic and racial boundaries. The way to categorise people born of such unions is unclear and the current approaches are inadequate, partly because the number of potential categories is huge.

NB: The following definitions are those used within WPCT commissioning document for this research, with the exception of the definition of Patient profiling:

Health Needs Assessment (HNA)

HNA is described by the National Institute for Health and Clinical Excellence (NICE) as a 'systematic method for reviewing the health and issues facing the population, leading to agreed priorities and resource allocation that will improve health inequalities.

Health Inequalities

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

Wellbeing

Wellbeing is a positive physical, social and mental state; it is not just the absence of pain, discomfort and incapacity. It requires that basic needs are met, that individuals have a sense of purpose, and that they feel able to achieve important personal goals and participate in society. It is enhanced by conditions that include supportive personal relationships, strong and inclusive communities, good health, financial and personal security, rewarding employment, and a healthy and attractive environment.

Patient profiling

Patient profiling refers to the collection of data on ethnicity, religion, diet and language, as recommended in the Department of Health's Practical Guide to Ethnic Monitoring in Primary Care (2005). It has been developed and piloted by Lambeth and Liverpool PCT. Liverpool PCT provides a tool kit containing a data collection form, a template to enter the data onto the clinical system, protocols for data entry, information around BME health, a contact sheet for local community groups and health advice leaflets in different languages. Cross-matching happens re CHD, BMI, diabetes and smoking status of patients against the new patient profiling data.

Appendix 3: Key informants

Name	Organisation	Job title
Agard, Clint	Wirral Change	Operational Manager and General Manager
Ahmed, Sabra	Wirral Change	Operational Manager and General Manager
Badwi, Abdullah	NHS Wirral Strategic Partnerships	Senior Community mental health worker
Cattell, Dean	Wirral Brook	Education Worker
Choudray, Karen	NHS Wirral Patient and Public Involvement	Interim Patient and Public Involvement Manager
Comber, Diane	Genito-urinary Medicine	Clinical Nurse Manager
Edwards, Barbara	Mental Health services	Interim Programme Manager Mental Health
Excell, Tony	Wirral Borough council Adult services	Equality and Diversity Officer
Gleave, Toni	Women's and Sexual Health Services	Nurse Manager for Wirral Sexual Health
Harrington, Sean	PCAL Outreach Service	PCAL Supervisor
Holder, Naomi	NHS Wirral Urgent Care	Acting Matron for Urgent Care
Hughes, Beverley	NHS Wirral Unplanned care	Head of unplanned care
Korzeniecki, Sylwester	PCAL Outreach Service	PCAL Outreach Advisor BME
Lamb, Nurie	Stop Smoking Service	Stop Smoking Advisor
Lodh, Raj	PCAL Outreach Service	PCAL Outreach Advisor BME
McGowan, Bob	Irish Community Care	Health Development Worker
Moula, Razza	Wirral Multi-cultural organisation (WMO)	Centre Administrator
Rahman, Mizanur	Wirral Borough council BME Support Service	BME Support Worker x 2
Rhodes, Phil	Wirral Healthy Schools	Wirral Healthy Schools Advisor
Rickwood, Gary	DAAT	Strategy Manager
Summer, Angela	Wirral Borough council BME Support Service	BME Support Worker
Syed, S	Wirral Multi-cultural organisation (WMO)	Asian Community Co-ordinator
Tattersall, Anne	NHS Wirral	Programme Manager for Sexual Health and Obesity (Public Health)
Young, Gillian	Women's and Sexual Health Services	Business Support Manager for Wirral Sexual Health
Ziolkowska, Renata	Merseyside Polish Association Cracow	Project Co-ordinator and Smoking Cessation Worker

Appendix 4: Stakeholder workshop participants

Name	Organisation
Abdullah Badwi	BRM Mental Health
Angela Carter	
Annie Jou	Wirral Multicultural Org.
Annie Tattersall	Public Health Wirral NHS
Angela Sumner	Wirral Gov.
Alex Manning	Wirral Cit. Advice Bureau
Rev Arnold Dixon	
Mrs Azmina Azad	Wirral Multicultural Org.
Bernadette King	Womens Enterprising Breakthrough
Bob Davies	
Bob McGowan	
Carol Howard	Public Health, Wirral NHS
Cathy Gill	Dept Adult Social Services
Chris Judson	
Colin Chee	Wirral Multicultural Org.
Darren Rogers	
David Bird	
David Hughes	
Deborah Fletcher	Dept Adult Social Services
Debra Smith	Reform Team Manager
Derek Ross	
Donna Divito	Wirral Alzheimers Society
Eamonn Clabby	
Emilia Korzeniecka	Wirral Change
Gareth Hill	
Helen Finney	Wirral Brook
Ian Girven	Wirral Fire Safety Manager
Ian Shaw	Commissioning Man - DAAT
Irene Marsh	Alternatives to Violence Proj
Jacqui Canning	Carers Support Coordinator
Jamie Anderson	Age Concern
Jane Collier	
Janette MacGlashen	Podiatry Team Lead - Whiston
Jenny Jones	PH Practitioner Team NHS
Jill Cox	Wirral Citizens Advice Bureau
Julie Adley-Sweeney	Membership Manager - WUTH
Julie Graham	Public Health, Wirral NHS
Mrs Kapo Ho	Wirral Multicultural Org.
Katrina Roberts	
Lesley Brogelli	TB Service Infection Prev.
Louise Hare	Drugs & Alcohol Team, NHS
Louise Ridyard	Drugs & Alcohol Team, NHS
Marilyn Maddock	H&WB Provider Services

Martin Hackett	Safeguarding Services
Michael Chantler	Diversity & Inclusivity Man.
Michelle Cox	TB Service Infection Prev.
Mike Donnelly	Stop Smoking Team - NHS
Nick Broadhead	Dept Adult Social Services
Nikki Jones	Alcohol Strategy Manager
Nusie Lamb	Stop Smoking Advisor, NHS
Patrycja Pasiok	Wirral Cit. Advice Bureau
Paul McLoughlin	Cheshire & Wirral NHS Part.
Peter Cumings	Wirral CVS
Raj Udeh	Wallasey Advice Centre
Sadra Ahmed	Wirral Change
Sarah Patterson	Acting CSM - Clatterbridge
Sean Harrington	Wirral Citizens Advice Bureau
Seham Harriz	Merseyside Probation Service
Dr Shyamal Mukherjee	Medical Director - NHS
Simon Barrigan	Comm. Engagement Officer, Merseyside Police (Deputy Chair - WEHAG)
Stacey Manion	Cultural & Equalities Dev. Man
Steve Passey	Dept. Adult Soc. Services
Mrs Sudha Pandya	Wirral Multicultural Org.
Susan Goligher	
Suzanne Hazza	Fire Service
Suzie Goligher	Coordinator BME Family Support
Sylvester Korzeniecki	Wallasey Advice Centre
Mr Syed	Wirral Multicultural Org.
Teresa Williams	Public Health, Wirral NHS
Tommy Shewhorack	Leasowe Medical Centre
Tony Excell	Equality & Diversity Officer, Adult Social Services
Tony Vaughn	Wirral Citizens Advice Bureau
Win Lawlor	Irish Community Care

NB: Names in blue - Registered but not signed in

Appendix 5: BME Health needs steering group

- Caroline Baines: Senior Health Improvement Adviser, Public Health Wirral NHS
- Anne Hayfield: interim Head of Equality and Diversity, Human Resources, Wirral NHS
- Cathy Gill: Service Manager, Health and Wellbeing, Wirral Council, Dept of Adult Social Services
- Stuart Duff: MACRA* Lead R&D Team Evaluation Support
- Karen Choudhary: Interim Patient and Public Involvement Manager, Corporate Affairs
- St Catherine's Hospital
- Tony Excel: Equality & Diversity Officer, Wirral Council, Department of Adult Social Services
- Simon Barrigan: Merseyside Police, (Deputy Chair WEHAG)
- Abdullah Badwi: BME Mental Health Coordinator, St Catherine's Hospital
- Teresa Williams: Commissioning Manager, Public Health, Wirral NHS

Appendix 6: Household survey – short questionnaire

QUESTIONNAIRE OF WIRRAL BME COMMUNITY – ACCESSING HEALTH CARE

Good morning/afternoon/evening. We are doing a survey on behalf of Wirral Primary Care Trust about the health services in Wirral. Could I start by asking you a few preliminary questions? Based on your answers we may ask you to take part in a bigger survey about accessing health needs in Wirral.

1. Are you registered with a doctor based locally in Wirral?

☐ Yes. [Go to Q2.]

☐ No. [Go to QA.]

2. Have you made an appointment with a doctor from your GP surgery/health centre in the last 12 months?

☐ Yes.

☐ No

3. The last time you saw a doctor from your GP surgery/health centre, how long did you wait for an appointment?

☐ I was seen without an appointment.

☐ I was seen on the same working day.

☐ I waited 1 or 2 working days.

☐ I waited more than 2 working days.

☐ It was a pre-planned appointment or visit.

☐ Can't remember.

4. In the last 12 months have you ever been put off going to your GP surgery/health centre because the opening times are inconvenient for you?

☐ Yes.

☐ No.

5. Did you have confidence and trust in the doctor?

☐ Yes.

☐ No.

6. *If visited GP surgery/health centre in last 12 months ask.* Have you seen anyone at your GP surgery/health centre to check how you are getting on with the medicine/treatment?

☐ **Yes.**

☐ **No.**

RESPONDENT INFORMATION

In this section of the questionnaire there are some questions about you. The reason that we ask these questions is to see if you meet the profile of people we need for the bigger survey. ALL ANSWERS WILL BE TREATED IN COMPLETE CONFIDENCE AND YOUR NAME and ADDRESS WILL NOT BE RECORDED ON THIS QUESTIONNAIRE.

A. RECORD GENDER OF RESPONDENT ☐ *Male* ☐ *Female*

B. What is your age? __________

C. Which of the following best describes yourself? ***SHOW CARD 1***

- ○ WHITE – British
- ○ WHITE – Irish
- ○ WHITE – Other White background
- ○ MIXED – White and Black Caribbean
- ○ MIXED – White and Black African
- ○ MIXED – White and Asian
- ○ MIXED – Other Mixed background
- ○ ASIAN/ASIAN BRITISH – Indian
- ○ ASIAN/ASIAN BRITISH – Pakistani
- ○ ASIAN/ASIAN BRITISH – Bangladeshi
- ○ ASIAN/ASIAN BRITISH – Other Asian
- ○ BLACK/BLACK BRITISH – Caribbean
- ○ BLACK/BLACK BRITISH – African
- ○ BLACK/BLACK BRITISH – Other Black background
- ○ CHINESE or OTHER ETHNIC GROUP – Chinese
- ○ CHINESE or OTHER ETHNIC GROUP – Other
- ○ OTHER GROUP NOT STATED ABOVE – Please specify: ____________________________

If respondent answers **White – British** thank them and say that you were looking for someone with a different profile to take part in the bigger survey. Leave them a letter explaining the background to the survey.

Appendix 7: BME community survey – long questionnaire

QUESTIONNAIRE OF WIRRAL BME COMMUNITY – ACCESSING HEALTH CARE [PART B]

Interviewer's Name ___________________________________**Date of Interview** ___________________

Area Code _________________________

1. On this card [SHOW CARD TWO] is a list of actions you could take if you felt ill or had a health concern. Based on this information what would you do if:

- You had a sprained ankle?

- You had a severe pain in your chest?

- You suffered from heavy bleeding?

- You are looking after a child who has a high temperature?

- You or someone you know has a minor head injury?

- You required contraceptive services or advice?

- You were suffering severe toothache or gum bleeding?

	A	B	C	D	E	F	G	H	I	J	K	L.
Sprained ankle												
Severe chest pain												
Heavy bleeding												
High temperature												
Minor head injury												
Contraceptive services												
Toothache/gum bleeding												

1. **I noticed that you were uncertain or didn't know what action to take on some/all of these conditions, how best do you think you could be helped to better understand the way the health service works in Wirral?**

Interviewer to encourage respondent to suggest ways that might help such as information booklets in own language, videos, detailed help maps, helpline [again in own language] etc.

3. From your own experiences of health services in Wirral have the health services been appropriate and sensitive to your cultural and religious beliefs? E.g. Access to a female clinician.

- ☐ **Yes**
- ☐ **No – 3a**

3a. Can you explain in what ways they have not been appropriate or sensitive to your cultural or religious beliefs – interviewer to establish the particular services concerned, when this occurred and what, if anything they tried to do about this and with what outcome.

4. Do you have any of the following long-standing conditions? [Tick box if answer is YES]

- ☐ **'I have a long-standing condition involving deafness or hearing impairment.'**
- ☐ **'I have a long-standing condition involving blindness or partially sighted.'**
- ☐ **'I have a long-standing condition involving a physical condition'**
- ☐ **'I have a long-standing condition involving a learning disability.'**
- ☐ **'I have a long-standing condition involving a mental health condition.'**
- ☐ **'I have a long-standing condition involving an illness such as cancer, HIV, diabetes, CHD or epilepsy.'**
- ☐ **'I do not have a long-standing condition.' [go to Q5]**

4a. Does this condition cause you difficulty with any of the following? [SHOW CARD THREE] [If more than one long-standing conditions select one only to ask this question.]

- ☐ **‘This condition causes me difficulty with everyday activities that people of my age can usually do.’**
- ☐ **‘This condition causes me difficulty at work, in education or training.’**
- ☐ **‘This condition causes me difficulty with access to buildings, streets or transport vehicles.’**
- ☐ **‘This condition causes me difficulty with reading or writing.’**
- ☐ **‘This condition causes me difficulty with peoples’ attitudes to me because of my condition.’**
- ☐ **‘This condition causes me difficulty with communicating, mixing with others, or socialising,’**
- ☐ **‘This condition causes me difficulty with other activities.’**
- ☐ **‘This condition does not cause me difficulty with any of these.’**

For each of the long-standing conditions the interviewer will explore if any of the ‘difficulties’ are made worse because of any language, cultural or religious issues that are important to the respondent or their family. Also the interviewer will seek views and suggestions about what could be done to lessen the impact of these difficulties.

For Q's 5 -14 If respondent answers in negative way interviewer to explore details and seek suggestions as to what those professionals should be doing better or differently. Record details opposite relevant question.

5. I would now like to return questions about your GP surgery/health centre - when you arrived, how would you rate the courtesy of the receptionist?

- ☐ **Excellent.**
- ☐ **Very good.**
- ☐ **Fair.**
- ☐ **Poor.**
- ☐ **Very poor.**

6. Did the doctor listen carefully to what you had to say?

- ☐ **Yes, definitely.**
- ☐ **Yes, to some extent.**
- ☐ **No.**

7. Do you think the doctor fully understood what you were trying to say?

- ☐ **Yes, definitely.**
- ☐ **Yes, to some extent.**
- ☐ **No.**

8. Were you given enough time to discuss your health or medical problem with your doctor?

- ☐ **Yes, definitely.**
- ☐ **Yes, to some extent.**
- ☐ **No.**

9. Were you involved as much as you wanted to be in decisions about your care and treatment?

- ☐ **Yes, definitely.**
- ☐ **Yes, to some extent.**
- ☐ **No.**

10. If you had questions to ask the doctor did you get answers that you could understand?

- ☐ **Yes, definitely.**
- ☐ **Yes, to some extent.**
- ☐ **No.**

11. Did the doctor explain the reasons for any treatment or action in a way that you could understand?

- ☐ **Yes, completely.**
- ☐ **Yes, to some extent.**
- ☐ **No.**
- ☐ **I did not need an explanation.**
- ☐ **No treatment or action was needed.**

12. Did the doctor treat you with respect and dignity?

- ☐ **Yes, definitely.**
- ☐ **Yes, to some extent.**
- ☐ **No.**

13a. Did you feel you were treated in a way that was appropriate to your culture or religion?

- ☐ **Yes, definitely.**
- ☐ **Yes, to some extent.**
- ☐ **No.**

14. In the last 12 months have you had any new medicine[s] [including tablets, suppositories, injections] prescribed for you by a doctor or nurse practitioner from your GP practice/health centre?

- ☐ **Yes.**

- ☐ **No.**

For Q's 15 -26 If respondent answers in negative way interviewer will explore details and seek suggestions as to what those professionals should be doing better or differently. Record details opposite relevant question.

15. Were you involved as much as you wanted to be in decisions about the best medicine for you?

- ☐ **Yes, definitely.**
- ☐ **Yes, to some extent.**
- ☐ **No.**

16. Were you given information about the purpose of the medicine?

- ☐ **Yes – enough information.**
- ☐ **Some – but I would have liked more.**
- ☐ **I got no information but I wanted some.**
- ☐ **I did not want/need information.**
- ☐ **Don't know/can't say.**

17. Were you given enough information about how you should use the medicine? [e.g. when to take it, how long you should take it for, whether it should be taken with food.]

- ☐ **Yes – enough information.**
- ☐ **Some – but I would have liked more.**
- ☐ **I got no information but I wanted some.**
- ☐ **I did not want/need information.**
- ☐ **Don't know/can't say.**

18. In the last 12 months, has anyone at your GP practice/health centre referred you to a specialist [e.g. a hospital consultant]?

- ☐ **Yes.**
- ☐ **No.**

19. When you were referred to see a specialist, were you offered a choice of hospital for your first hospital appointment?

- ☐ **Yes.**
- ☐ **No.**

20. When you first saw the person you were referred to, did he/she seem to have all the necessary information about you and your condition or treatment?

- ☐ **Yes, definitely.**
- ☐ **Yes, to some extent.**
- ☐ **No.**

21. Have you seen anyone else from a GP practice/health centre other than a doctor in the last 12 months?

- ☐ **Yes.**
- ☐ **No.**

22. The last time you saw someone other than a doctor from a GP practice/health centre, who did you see?

- ☐ **A practice nurse or nurse practitioner.**
- ☐ **A Midwife.**
- ☐ **A district nurse.**
- ☐ **A health visitor.**
- ☐ **Someone else.**
- ☐ **Not sure.**

23. Was the main reason you went to your GP practice/health centre to see this person dealt with to your satisfaction?

- ☐ **Yes.**
- ☐ **No.**

24a. Did this person treat you with respect and dignity?

- ☐ **Yes.**
- ☐ **No.**

24b. Did you feel you were treated in a way that was appropriate to your culture or religion?

- ☐ **Yes.**
- ☐ **No.**

25. In the last 12 months, have you ever been put off going to your GP practice/health centre because of difficulties in communicating with them e.g. you couldn't make yourself understood or they couldn't understand what you were trying to say? If YES can you expand?

26. In the last 12 months, have you had enough support from local services or organisations to help you manage your long-term health condition[s]? [Please think about all services and organisations, not just health services?]

- ☐ **Yes**
- ☐ **No**

For Q 26 If respondent answers in negative way interviewer will explore details and seek suggestions as to what those professionals should be doing better or differently.

For Q's 27 and 28 Interviewer will be sensitive to the cultural and religious traditions of the respondent and therefore will only focus on those issues of direct relevance and will then try to explore how current options are acceptable or otherwise. The interviewer will encourage respondent to suggest cultural or religious specific solutions to these problems.

27. In the last 12 months have you sought any help to deal with any of the following health issues? [SHOW CARD THREE.]

- ☐ **a weight problem**
- ☐ **giving up smoking**
- ☐ **eating a healthy diet**
- ☐ **getting enough exercise**
- ☐ **sensible alcohol intake.**

28. Would you like any additional help with regard to these health issues?

- ☐ **a weight problem**
- ☐ **giving up smoking**
- ☐ **eating a healthy diet**
- ☐ **getting enough exercise**
- ☐ **sensible alcohol intake.**

29. Would you know where to go to get advice or help re above?

- ☐ **Yes**
- ☐ **No**

29a Finally I would like to ask you, what would be your first three priorities to make local health services more responsive to you and your family's needs?

1 ____

2 ____

3 ____

RESPONDENT INFORMATION

In this last section of the questionnaire there are some questions about you. The reason that we ask these questions is that we want to know how different groups of people feel and think about local health services. ALL ANSWERS WILL BE TREATED IN COMPLETE CONFIDENCE. [Some of these will be repeated from the short Q but still need to be recorded]

31. RECORD GENDER OF RESPONDENT ☐ *Male* ☐ *Female*

32. What is your age? __________

33. how long have you lived in Wirral? __________

34. Which other persons, if any, live in your home? ***RECORD THE PERSONS' RELATION TO THE RESPONDENT AND THEIR AGE IN THE FOLLOWING TABLE***

Person number	**Relation to respondent**	**Age**	**Person number**	**Relation to respondent**	**Age**
1			4		
2			5		
3			6		

35. Which of the following best describes yourself? ***SHOW CARD ONE***

- o WHITE – British
- o WHITE – Irish
- o WHITE – Other White background
- o MIXED – White and Black Caribbean
- o MIXED – White and Black African
- o MIXED – White and Asian
- o MIXED – Other Mixed background
- o ASIAN/ASIAN BRITISH – Indian
- o ASIAN/ASIAN BRITISH – Pakistani
- o ASIAN/ASIAN BRITISH – Bangladeshi
- o ASIAN/ASIAN BRITISH – Other Asian
- o BLACK/BLACK BRITISH – Caribbean
- o BLACK/BLACK BRITISH – African
- o BLACK/BLACK BRITISH – Other Black background
- o CHINESE or OTHER ETHNIC GROUP – Chinese
- o CHINESE or OTHER ETHNIC GROUP – Other
- o OTHER GROUP NOT STATED ABOVE – Please specify:

  ____

ICARUS – June 2009.

Appendix 8: Interview schedule for health care providers

BME Health Needs Assessment – stakeholder survey

Interview schedule for health care providers

Introduction:

Thanks for agreeing to be interviewed, as part of the BME health needs analysis that Icarus is undertaking on behalf of WPCT; the interview should take about 15 to 20 minutes.

Confidentiality: It is not our intention to name individuals in reporting the outcomes of this research, but it will be important to relate the findings to specific areas of Health service provision; for this reason if there is anything that you do not want attributed, please let me know

---

Name: Job title:

Health service being provided:

Area covered e.g. Wirral wide:

---

1. What do you feel are the most important outcomes that this research should try to achieve

2. Does your service routinely record a patients/service user's ethnicity?
   Yes ☐ No ☐

   If yes, how can we access this information:

If no, what steps are being taken, if any, to undertake ethnic monitoring and are there any particular issues or difficulties that the service has in doing this:

3. Do you routinely record a patient's/service users first language?
   Yes ☐ No ☐

4. Does your service measure patient/service user satisfaction?
   Yes ☐ No ☐

   If yes, how can we access this information and is it disaggregate by ethnicity:

5. For your service area, are there any known differences in respect of health conditions and health outcomes between ethnic groups; if yes, can you very briefly say what they are and what, if anything, is being done to address any inequalities in health outcomes?

6. Does your Health service area provide equality and diversity training?

   Yes ☐ No ☐

   If yes, please provide brief details of the type, nature and length of the training and the number of staff trained e.g. whether it covers cultural sensitivity re service provision:

   If no, are there any plans to provide training to staff in respect of cultural sensitivity, ethnicity and racism:

   Yes ☐ No ☐

7. Do you consider that you are able to provide a culturally appropriate health care service to patients/service users from BME groups? e.g. female clinical staff
   Yes ☐ No ☐ DK☐

If yes, can you briefly illustrate how you do this:

If no, what are the barriers/issues in doing so, and how, if at all are you trying to address them?

8. Are you aware of any specific issues to do with accessing your Health service area that are experienced by BME communities e.g. language problems:

Yes ☐ No ☐ DK☐

If yes, what are they and how are these being addressed:

If no, how does your Health service area ensure BME communities have equal access to provision:

9. What support do you consider would be the most important in meeting the needs of BME patients/service users in your service?

Is there anything else you would like to add?

Appendix 9: Interview schedule for Steering group members and BME community stakeholders

BME Health Needs Assessment – stakeholder survey

Interview schedule for Steering group members and BME community stakeholders

Introduction:

Thanks for agreeing to be interviewed, as part of the BME health needs analysis that Icarus is undertaking on behalf of WPCT; the interview should take about 15 to 20 minutes.

Confidentiality: It is not our intention to name individuals in reporting the outcomes of this research, but it will be important to relate the findings to specific areas of Health service provision; for this reason if there is anything that you do not want attributed, please let me know

---

Name: Job title

Organisation e.g. vol/stat

Area e.g. Wirral wide:

Relationship to this work e.g. voluntary group representing a BME group:

---

1. What do you feel are the most important outcomes that this research should try to achieve:

2. Do you consider that culturally appropriate Health care is provided to patients/service users from BME groups in Wirral:

   Yes ☐ No ☐ DK ☐

   If yes, can you briefly illustrate why you feel this:

   If no, why not, what are the barriers/issues in this being provided:

3. Are you aware of any specific issues to do with accessing Health services in Wirral that are experienced by BME communities e.g. language problems:

   Yes ☐ No ☐ DK☐

   If yes, do you know how, if at all, these are being addressed:

   If no, how does the Health sector in Wirral ensure BME communities have equal access to provision:

4. Are you aware of any known differences in respect of health conditions and health outcomes between ethnic groups that effect BME communities in Wirral; if yes, can you very briefly say what they are and what, if anything, is being done to address any inequalities in health outcomes that you are aware of?

5. What support do you consider would be the most important in meeting the needs of BME patients/service users?

6. What specific policy initiatives are you aware of that have been developed or are in the process of being developed around BME patients/service users?

Is there anything else you would like to add?