Project Report

Comprehensive Needs Assessment for Black and Minority Ethnic Groups (Including Gypsies and Travellers) in East Sussex

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Our thanks go to all those others who gave of their time, whether by phone, interview or in focus groups, to inform and shape this project and report.

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Executive Summary

A comprehensive health needs assessment of Black and minority ethnic groups (BME), including Gypsies and Travellers, was commissioned from PHAST by the East Sussex Downs & Weald and Hastings & Rother PCTs and East Sussex County Council, following on from the Joint Strategic Needs Assessment process and as part of the Race for Health Action Plan. It began in the late summer of 2009 and was completed by Christmas.
The principle groups on which they wished to concentrate were:

- Asylum seekers
- Migrants workers
- Rural isolates
- Gypsies and Travellers
- Older people from ethnic minority groups

The methodology used was based on the epidemiological healthcare needs assessment approach expounded by Stephens and Rafferty in www.hcna.bham.ac.uk/, and modified due to the availability of data, and the necessary time constraints.

In this report the term "Black and minority ethnic" (BME) usually includes not only those who do not consider themselves White e.g. from South Asia, China, Africa, Caribbean, but also White Others such as Irish, Italian, or Polish who do not make up the majority of the population. "All White" is the term that will be used for White British, White Irish and White Other groups added together, and in this context Black and minority ethnic will be the remainder. The term Black and minority ethnic will overlap with terms such as migrant workers, asylum seekers & refugees, and andTravellers. Black and minority ethnic communities may be first, or a later, generation.

Ethnic groups are not homogenous. They differ in respect of:

- History, culture, and religion
- Health and disease patterns
- Exposure to risk factors relating to health
- Perceptions of health and illness
- Expectations of health and social services

The most detailed data on the ethnic composition of the population is collected at the Census (last one 2001), but this becomes increasingly out of date, and each year an 'experimental' estimate of the population is provided by the Office for National Statistics. In addition the Annual Schools Census gives an insight into the ethnic composition of 5-16 year olds. Difficulties arise in estimating the numbers of temporary or illegal migrants, those who do not register for work, and people who are nomadic in lifestyle. There is a large difference in numbers of ethnic minority peoples in East Sussex depending on whether the White ethnic group is broken down into its' component parts e.g. White British, White Irish, White Other.

The major health concerns of the ethnic minority populations are the same as for the rest of the population (coronary heart disease, stroke, cancer, diabetes). What may be different are the belief systems, the attitudes to health and life, and their ability to access services (knowledge of, expectations of, experience of). The beliefs and actions, in terms of services access, are shown by research to be coherent.

As well as highlighting areas of good practice, the qualitative research provides examples of poor experience for people from ethnic minority groups both in gaining access to services, and when they have accessed them. The poor experience is not necessarily a function of ethnicity, but can reflect poor practice towards any people. However there are areas e.g. mental health and sexual health where there can be particular cultural sensitivities for some minority ethnic groups.

The findings for the 5 groups of interest are presented in the text alongside findings for all other minority ethnic groups, but are summarised together in Section 9.7. The Recommendations of the report apply equally to the 5 groups of interest and the other minority ethnic groups.

Recommendations revolve around:

- Leadership and governance
- Developing joint working and building on good practice
- Improving data recording by ethnic group
- Improving staff equality & diversity training, and ensuring that it is universal. This to include customer and cultural awareness, and how to respond sensitively to poor literacy or comprehension.
- Improving access to & use of the language & interpreting services. This will include staff being made aware of what is available for their patients/clients, and monitored for using it, as well as making ethnic minority groups aware of their rights and the services.
- Working with minority ethnic groups to increase access to health & social care services, and healthy lifestyle services & messages, in a way that respects and responds to their beliefs and attitudes.

Most of the Recommendations refer to known good practice, and can build on the existing Equality & Diversity Action Plans.

Table of Contents

1. Introduction

A comprehensive health needs assessment of Black and minority ethnic groups (BME), including Gypsies and Travellers, was commissioned from PHAST by the East Sussex Downs & Weald and Hastings & Rother PCTs and East Sussex County Council, following on from the Joint Strategic Needs Assessment process and as part of the Race for Health Action Plan.
The principle groups on which they wished to concentrate were:

- Asylum seekers
- Migrants workers
- Rural isolates
- Gypsies and Travellers
- Older people from ethnic minority groups

Health needs assessment is a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities. Need is defined as the ability to benefit, and only those needs which could reasonably be expected to be met are considered. Benefit may ensue from health promotion, prevention, primary, community, secondary, or rehabilitation/maintenance care. The objective was to obtain a comprehensive baseline profile of health needs of Black and minority ethnic people including Gypsies and Travellers in East Sussex, so that services planned for them in future are as appropriate and culturally acceptable as possible.

2. Methodology

The methodology used was the epidemiological healthcare needs assessment approach expounded by Stephens and Rafferty in www.hcna.bham.ac.uk/

It requires 7 stages, as follows:

1) An estimate of population size, composition and characteristics derived from a variety of sources and compared, to gain best estimates of numbers.
2) A quantification of expected need derived by applying research and national prevalence rates to the demographic composition of the population.
3) A quantification of met need derived from service activity data, and compared with expected need in order to identify service gaps.
4) Best practice established from the research literature and examples of best practice demonstrated locally and elsewhere.
5) Interviews and focus groups with staff and service providers to understand the quantitative and qualitative aspects of health and social services provided, and the perceived gaps/shortfalls. The user perspective gained from interviews with small groups, which enables a better understanding of

how concepts of health and related services are interpreted within different cultures, and how well services are perceived to respond, or are accessible.

6) Taking an overview of service provision, both generic and specific to Black and minority ethnic groups, ideally including the relative uptake and accessibility of services by Black and minority ethnic groups.
7) Making recommendations on how unmet health needs can be addressed to achieve cultural competency and race equality.

The degree to which these 7 stages can be completed depends on availability of data, research and access to stakeholders.

2.1 Definitions

There has been a burgeoning of literature on ethnicity and health in recent years. Most of the journals do not have a clear policy on terminology of ethnicity and health research.[1] The definition of "ethnic" is blurred especially after the first generation. Cruickshank and Beevers in "Ethnic Factors in Health and Disease" stated that the term "ethnic" presupposes cultural differences.[2] Also in research on race, ethnicity and health the term White was largely bypassed. Minority groups are usually compared with populations described as White, Caucasian, European, Indigenous, Native, Western and majority. Such populations are heterogeneous, the labels non-specific and the comparisons misleading.[3] Additionally groups are considered on the basis of religion, belief or faith, where country of birth is not the only factor that defines a person's ethnicity.

In this report the term "Black and minority ethnic" (BME) will usually include not only those who do not consider themselves White e.g. from South Asia, China, Africa, Caribbean, but also White Others such as Irish, Italian, or Polish who do not make up the majority of the population. "All White" is the term that will be used for White British, White Irish and White Other groups added together, and in this context Black and minority ethnic will be the remainder. The term Black and minority ethnic will overlap with terms such as migrant workers, asylum seekers & refugees, Gypsies and Travellers. Black and minority ethnic communities may be first, or a later, generation.

The NHS currently deals with Black and minority ethnic groups for which the Office of National Statistics (ONS) has not yet collected data at a Census (but they may do so at the next). Such groups include Gypsies and Travellers[4], although the NHS now has Medical Read Coding for them.
Throughout this report the term 'migrant' rather than 'immigrant' is used in line with United Nations (UN) definitions.

- Long-term migrant: A person who moves to a country other than that of his or her usual residence for a period of at least a year (12 months), so that the country of destination effectively becomes his or her new country of usual residence.

- Short-term migrant: A person who moves to a country other than that of his or her usual residence for a period of at least 3 months but less than a year (12 months) except in cases where the movement to that country is for purposes of recreation, holiday, visits to friends and relatives, business, medical treatment or religious pilgrimage.

These definitions are not, however, used by all organisations and, in terms of health surveillance it is often difficult to apply these definitions since limited data are collected.

Ethnic groups are not homogenous. They differ in respect of:

- History, culture, and religion
- Health and disease patterns
- Exposure to risk factors relating to health
- Perceptions of health and illness
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3. Population

This section provides an overview of key population features from routinely available data. Additional, and/or more detailed data are available in the Data Appendix.

The most comprehensive population profile that exists is the Census 2001. As each year progresses after the Census it becomes a less accurate record of population composition. The Office of National Statistics produce annual experimental data as a best estimate of the current situation, taking into account births, deaths and net migration.

The Census had a large number of ethnic categories from which people could self declare. These are aggregated into smaller groups, especially where the numbers/percentage are relatively small in the total population. One such group is White, which is made up of White British, White Irish, and White Other. The numbers/percentage of Black and minority ethnic groups in a population can differ noticeably depending on whether White Irish and White Other are included or not (see Table 1 below).

Data from other sources suggests the Black and minority ethnic population has increased year by year, particularly from the European Union Accession States[5]. The group from European Union Accession States has not been classified as a separate ethnic group but will be captured in White Other (as far as possible bearing in mind the transient nature of economic migrants).

3.1 Ethnicity

In the 2001 census, the population of East Sussex was 94.4% White British, compared with 91.2% in the South East. Table.1 gives the population estimates of Black and minority ethnic groups including and excluding White Irish & White Other. The total Black and minority ethnic population including White Irish & White Other in 2007 was estimated as 45,700, and excluding them was estimated at 26,500. The difference in estimates from the two methods of calculation is 19,200 people.

Considering the Black and minority ethnic groups as including White Irish & White Other, the ethnic minority population of East Sussex more than doubled by 2007, so that they form at least 10% of the population of Eastbourne and Hastings. Hastings has had the highest percentage rise (4%) in this period.

Table 1: Numbers and percentages of the Black and minority ethnic populations by local authority, 2001 and 2007, ONS

	2001				2007			
Ethnic groups	**BME**		**BME inc White Irish and White other**		**BME**		**BME inc White Irish and White other**	
	Number	**Percentage**	**Number**	**Percentage**	**Number**	**Percentage**	**Number**	**Percentage**
Hastings	2,500	2.9	5,100	6.0	5,200	6.0	8,600	10.0
Rother	1,600	1.9	3,900	4.6	3,500	4.0	6,400	7.3
Eastbourne	2,900	3.2	6,700	7.5	5,900	6.2	9,900	10.4
Lewes	1,900	2.1	4,400	4.8	4,600	4.9	8,100	8.6
Wealden	2,300	1.6	6,700	4.8	6,100	4.2	11,500	8.0
East Sussex	12,000	2.4	27,600	5.6	26,500	5.2	45,700	9.0
South East	400,200	5.0	707,400	8.8	661,200	8.0	1,062,300	12.8
England	4,552,800	9.2	6,523,900	13.2	6,009,100	11.8	8,355,900	16.4

Source: Office of National Statistics

Many studies on ethnicity, including the Health Survey for England (HSE 2004), use the broad ethnic group classification All White, which includes the White Irish and White Others. Table 2 adopts this approach and shows that the main ethnic group in East Sussex is Asian or Asian British (n = 8200), making up one third of the total Black and minority ethnic population (where n = 26,500).

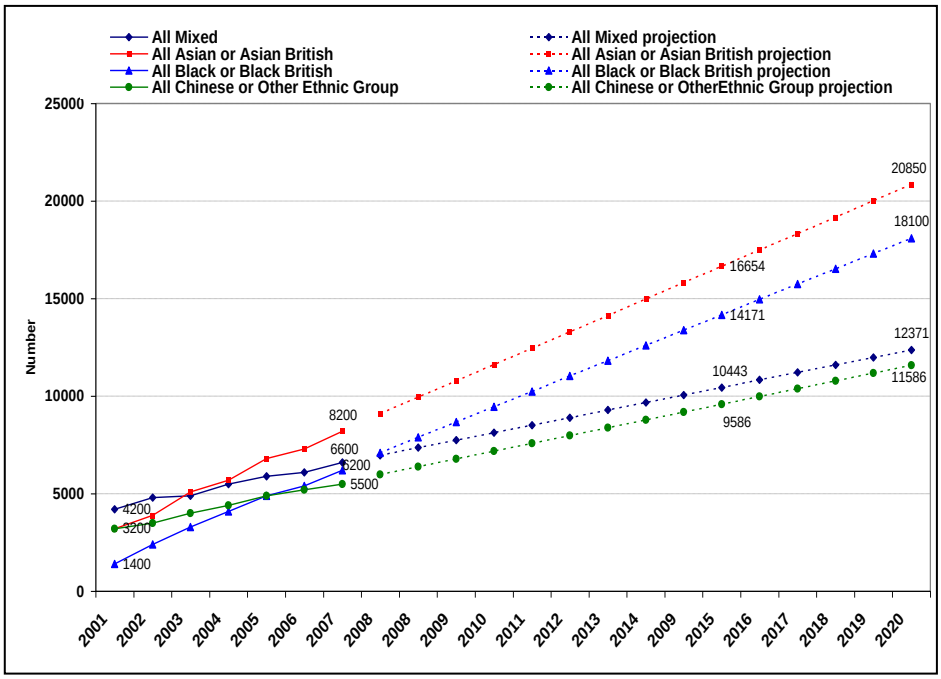
Table 2: Number and percentage of ethnic groups by local authority, 2007, ONS

	All White		**All Mixed**		**All Asian or Asian British**		**All Black or Black British**		**All Chinese or Other Ethnic Group**	
	Number	%	Number	%	Number	%	Number	%	Number	%
Hastings	80,700	93.6	1,300	1.5	1,600	1.9	1,500	1.7	800	0.9
Rother	84,300	95.6	800	0.9	1,100	1.2	1,000	1.1	600	0.7
Eastbourne	89,400	93.5	1,300	1.4	2,000	2.1	1,100	1.2	1,500	1.6
Lewes	89,800	95.0	1,100	1.2	1,500	1.6	900	1.0	1,100	1.2
Wealden	137,600	95.7	1,600	1.1	1,700	1.2	1,300	0.9	1,500	1.0
East Sussex	481,800	94.8	6,600	1.3	8,200	1.6	6,200	1.2	5,500	1.1
South East	7,647,700	92.0	126,800	1.5	288,400	3.5	130,100	1.6	115,900	1.4
England	45,082,900	88.2	870,100	1.7	2,914,800	5.7	1,447,800	2.8	776,400	1.5

Source: Office of National Statistics All Mixed = all those with mixed parentage

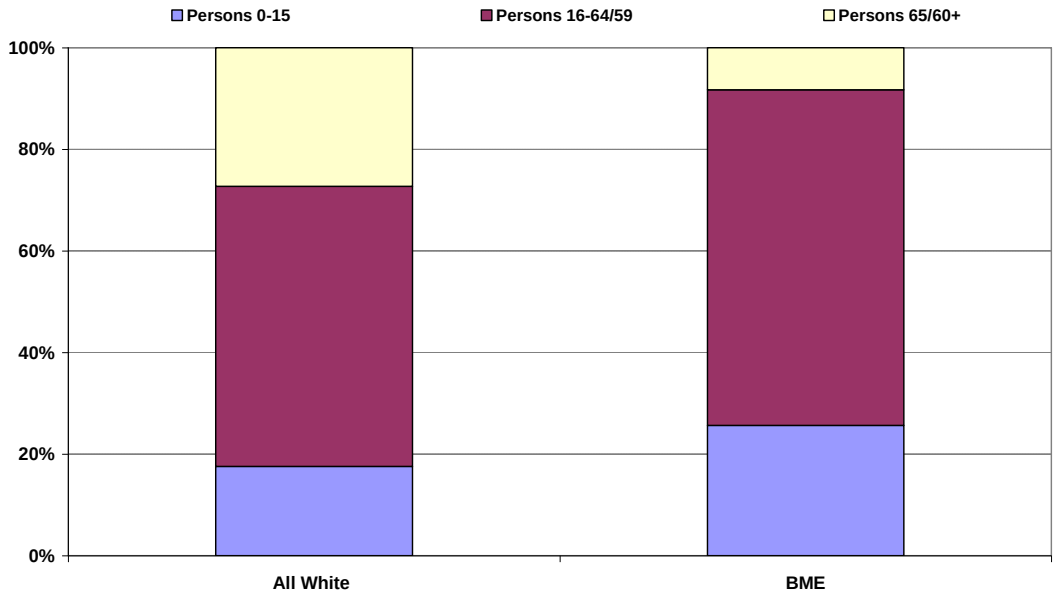
Figure 1 shows that if the number of Black and minority ethnic groups continues to increase in the same patterns as from 2001 to 2007 then it is estimated that the number of All Asian and Asian British, and Black and Black British will more than double by 2015 and 2020.

Figure 1: Projection of Black and minority ethnic groups by 2020, ONS



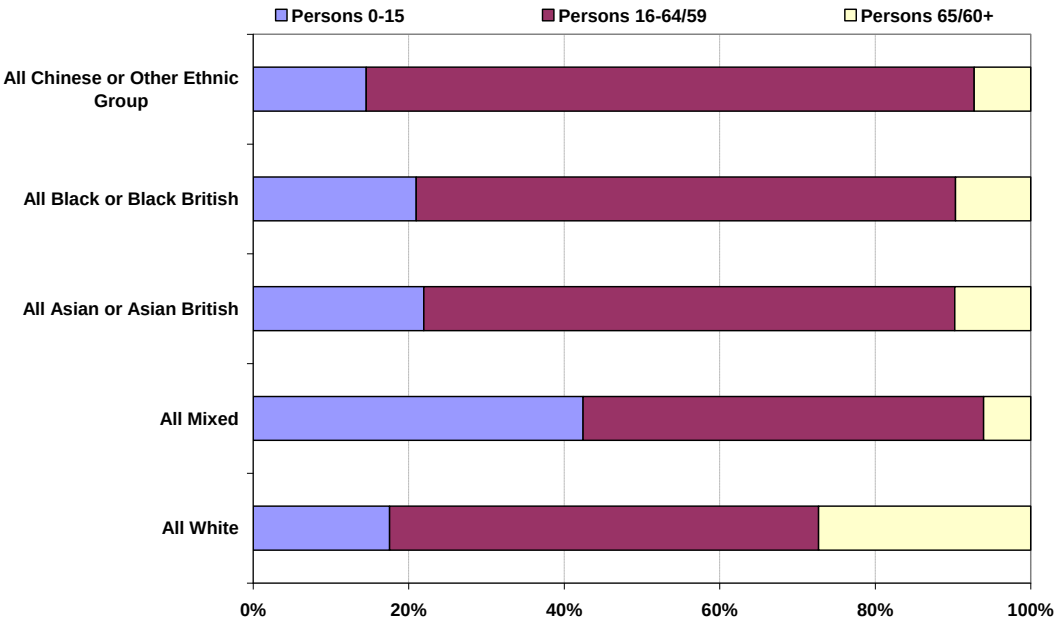
In 2007, 92% of the Black and minority ethnic population in East Sussex were under the age of 65 years compared to 73% of the White population (Figure 2), and 25.66% of the Black and minority ethnic population is aged 0-15 years compared with 17.5% of the White population.

Figure 2: Percentage of White and Black and minority ethnic groups, by age groups, 2007, ONS



The All Mixed (self allocated or mixed parentage) ethnic population has highest percentage (42%) of under 15's year olds compared to other ethnic groups (Figure 3). A young Mixed ethnic group suggests stability of the population, inter-marriage and child bearing.

Figure 3: Age structure by ethnic groups, East Sussex, 2007, ONS



In East Sussex the ratio of females to males (all ages) within the Black and minority ethnic group is 1.03, whereas the ratio is 1.0 in the South East, and 0.98 in England.

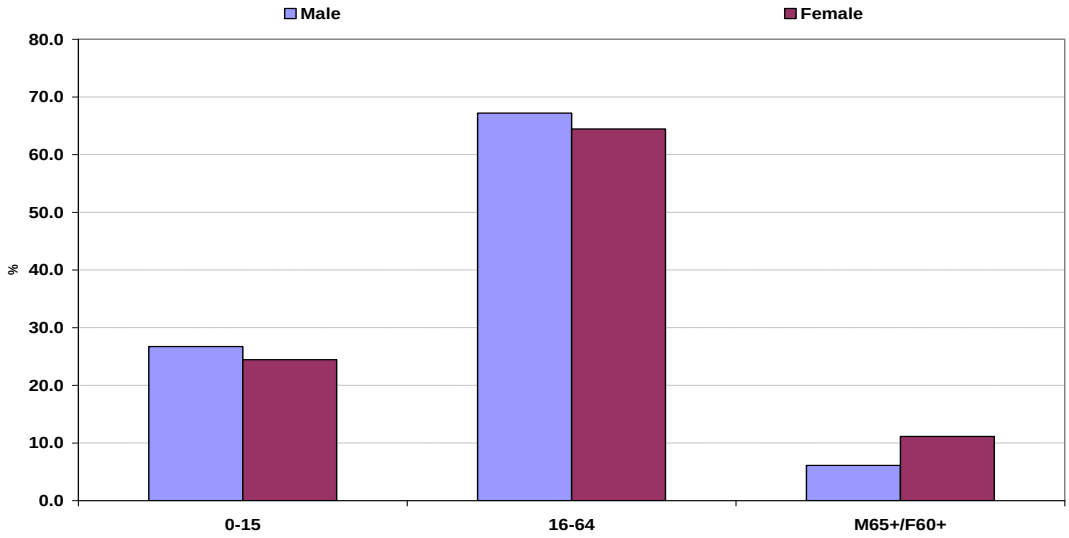
The percentage of Black and minority ethnic males aged 0-15 years and 65+, and females aged 65+ is higher than the average for the South East or England (Table 3). However, comparing the age groups 50-64 with those over 65 suggests that the proportions of older people in Black and minority ethnic groups will increase over the next 10-15 years.

Table 3: Number & percentages of Black and minority ethnic population, by age & sex, 2007, ONS

Within BME's	East Sussex		South East		England	
	Num	%	Num	%	Num	%
Male 0-15	3500	26.7	83600	25.3	777100	25.6
Male 16-64	8800	67.2	230200	69.7	2089700	69.0
Male 65+	800	6.1	16300	4.9	163000	5.4
	13100	100.0	330100	100.0	3029800	100.0
Female 0-15	3300	24.4	79900	24.1	745000	25.0
Female 16-59	8700	64.4	226200	68.4	1997600	67.1
Female 60+	1500	11.1	24800	7.5	236600	7.9
	13500	100.0	330900	100.0	2979200	100.0

Figure 4: shows that percentage of Males are slightly higher at age under 64 and that females overtake them above the age M(65+) and F (60+) years of age.

Figure 4: Percentage of Black and minority ethnic groups by age and sex, 2007



Source: Office of National Statistics

Because ethnic communities have high percentages of young people, school age populations can experience higher proportions of Black and minority ethnic than the population as a whole. The 2009 school census (Table 4) gives estimates of ethnic minority numbers in the 5 to 16 years age group. Over 10% of the school population are Black and minority ethnic which is marginally more than the 2007 population estimates in Table 1.

96.4% of White pupils in primary schools and 97% in secondary schools are White British which means 3.5% of primary and 2.9% of secondary school pupils are White Other group. This is one of the few means of collecting data on Travellers of Irish Heritage and Gypsy and Traveller and Roma people.

Table 4: School census by ethnicity, East Sussex, January 2009. DCSF

Ethnic group		Primary school		Secondary school	
		Number	%	Number	%
White	White British	26,513	89.45	24,807	89.69
	White Other	987	3.33	76,300	2.76
Traveller of Irish Heritage		9	0.03	6	0.02
Gypsy/Roma		93	0.31	72	0.26
Mixed		1,020	3.44	710	2.57
Asian		450	1.52	320	1.16
Black		170	0.57	150	0.54
Chinese		84	0.28	84	0.30
Other		123	0.41	70	0.25
Totals		29,640		27,660	

3.2 Religion

Census 2001 records religion by ethnic group and for each local authority. It demonstrates that specific ethnic group and religious groups are not equivalent (for instance there are White British Jews, and White British Buddhists). As Table 5 shows the majority of residents in East Sussex in 2001 were of Christian religion (74%).

It is not possible to update the Census 2001 estimates of religious groups by ethnicity, and the longer it is since the Census the more inaccurate the data becomes.

Table 5: Numbers and Percentage of residents by religion, Census 2001.

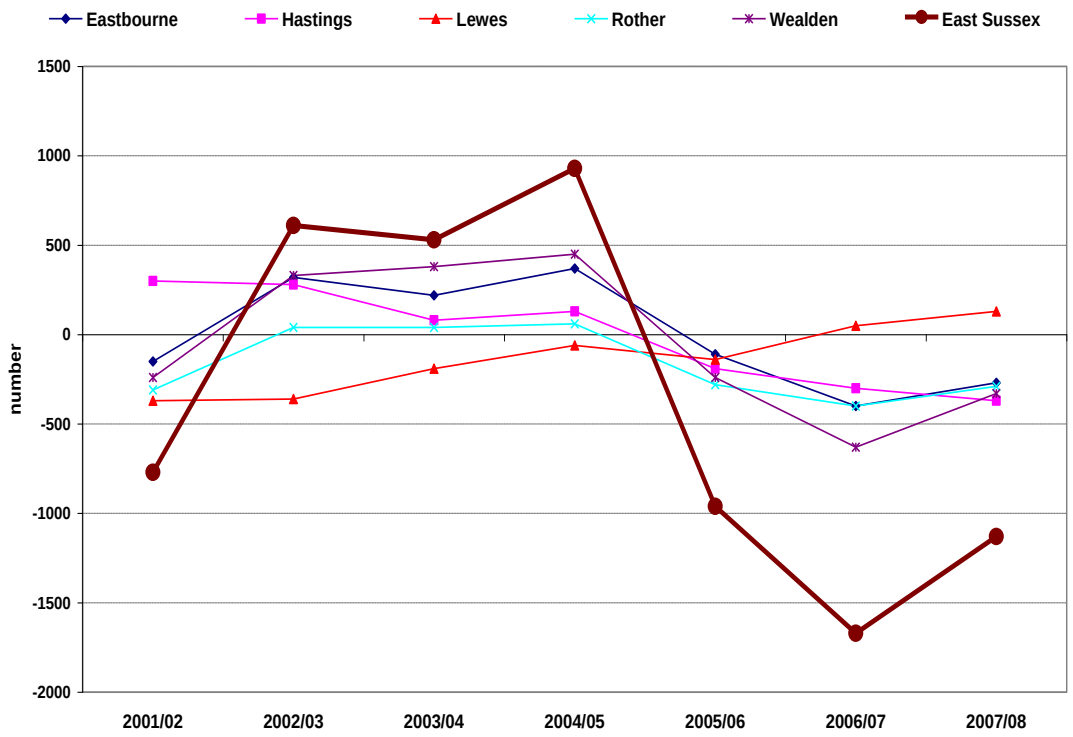
		Eastbourne	Hastings	Lewes	Rother	Wealden	East Sussex	South East	England and Wales
	number	65278	57298	66388	65354	108102	362420	5823025	37338486
Christian	%	72.8	67.4	72.0	76.5	77.2	73.6	72.8	71.7
	Number	306	274	272	157	280	1289	22005	144453
Buddhist	%	0.3	0.3	0.3	0.2	0.2	0.3	0.3	0.3
	Number	213	226	136	120	112	807	44575	552421
Hindu	%	0.2	0.3	0.1	0.1	0.1	0.2	0.6	1.1
	Number	259	112	263	126	261	1021	19037	259927
Jewish	%	0.3	0.1	0.3	0.1	0.2	0.2	0.2	0.5
	Number	880	635	401	546	522	2984	108725	1546626
Muslim	%	1.0	0.7	0.4	0.6	0.4	0.6	1.4	3.0
	Number	45	35	24	25	20	149	37735	329358
Sikh	number	0.1	0.0	0.0	0.0	0.0	0.0	0.5	0.6
	%	415	399	365	297	981	2457	28668	150720
Other religions	Number	0.5	0.5	0.4	0.3	0.7	0.5	0.4	0.3
	%	14971	18159	16759	11886	19410	81185	1319979	7709267
No religion	Number	16.7	21.4	18.2	13.9	13.9	16.5	16.5	14.8
	%	7300	7891	7569	6917	10335	40012	596896	4010658
Religion not stated	Number	8.1	9.3	8.2	8.1	7.4	8.1	7.5	7.7

3.3 Migrants

International migration to and from districts is estimated through the International Passengers Survey. All International migrants who intended to stay/leave for at least one year are included as international migrants.

In East Sussex the number of international migrants varied between 2001 and 2008. Figure 5 shows the number of international moves into and out of each district of East Sussex from 2001 onwards. A positive number is thus a net inflow to the area while negative number is a net outflow from the area. The number of internationals migrants in Lewes steadily increased between 2001 and 2008. All other districts show drops in migrant numbers from 2004-05.

Figure 5: International net- migrants to and from East Sussex, 2001-2008 by district council, ONS

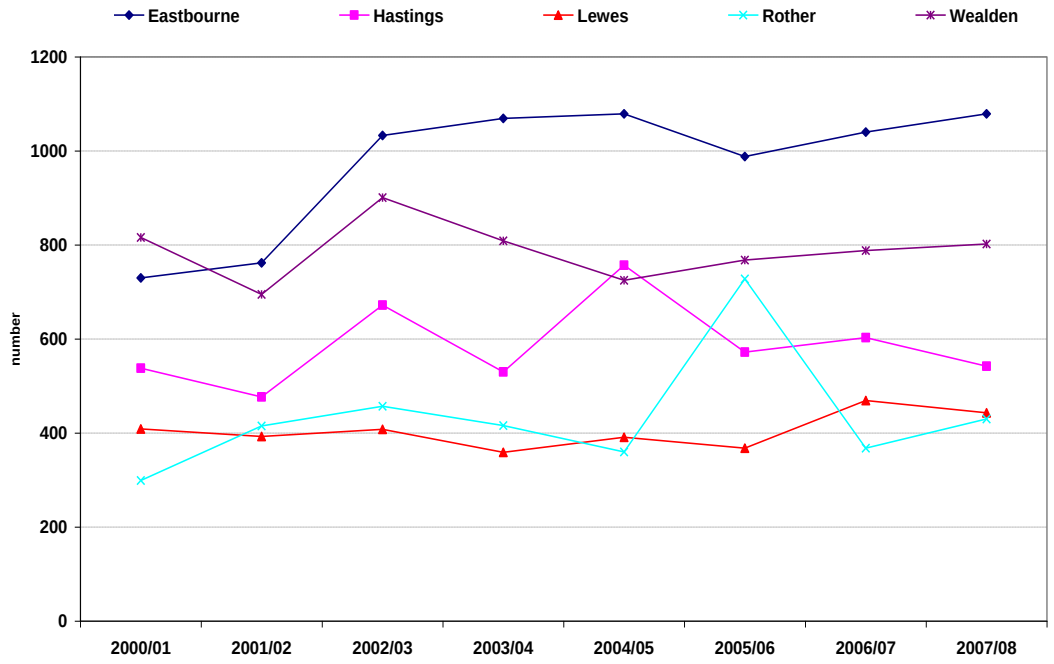


The number of international in-migrants registering with a NHS General Practitioner (GP) in East Sussex is captured through the Patient Register Data Service (PRDS).The Office of National Statistics (ONS) releases this dataset, formally named "Flag 4". A Flag 4 is generated when an individual registers with an NHS GP if:

- an individual was born outside the UK and enters the England and Wales for the first time and registers with NHS GP or
- if the previous address of an individual is reported as outside the United Kingdom, and time spent outside the UK is more than three months.

Figure 6 shows that the trend in numbers of international in–migrants registering with the GP, by district councils, was upwards with the highest number registering in Eastbourne since 2001. However despite the steady increase in number of international migrants in Lewes (Figure 5) this is not reflected in GP registrations.

Figure 6: International in-migrant GP registrations 2000-2008. by district council in East Sussex, ONS

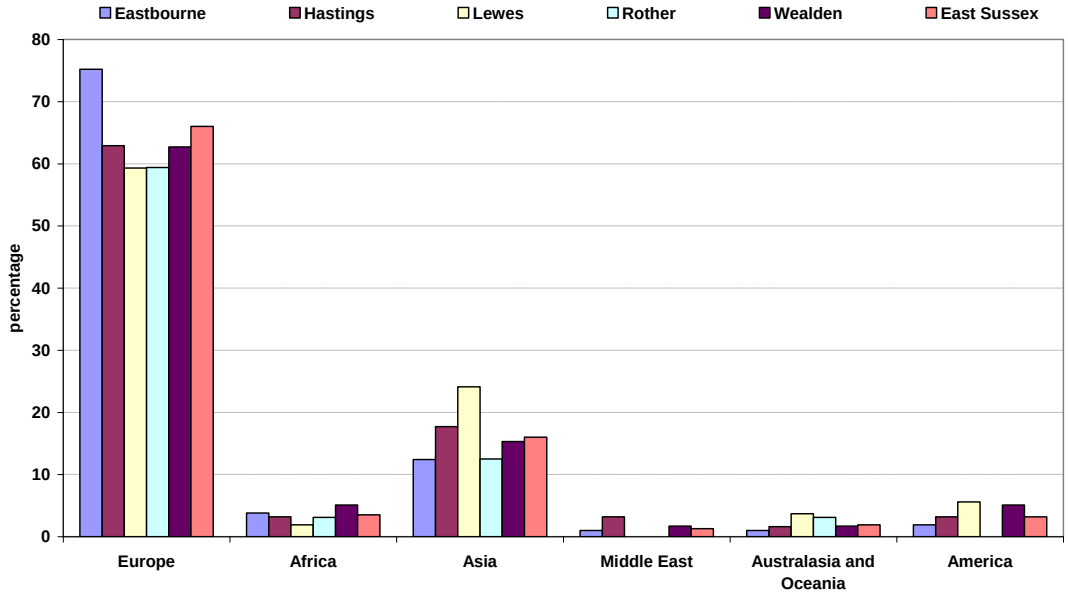


All people working legally in the UK have the same rights as British nationals. A National Insurance Number (NINo) is a unique personal number which is required by anyone who is working in the UK (whether as an employee or self-employed) as well as those claiming benefits. However there is no requirement to relinquish the number on leaving the country, so monitoring them will not reflect emigration (migrant who leave the UK) or overall migrant population. The number of nationals of new EU Accession countries being allocated National Insurance Numbers (NINos) doubled in the second year of joining the EEA, while allocations to other nationalities declined (Fig 7).

A total of 3,120 migrants were registered to work in East Sussex in 2007. The majority (1,050) of workers were registered to work in Eastbourne compared to just 320 in Rother. 66% of migrant workers in East Sussex came from Europe, 47.1% being from EU Accession countries, 16% from EU non Accession countries and 3.2% from Non- EU countries. Of the 34% of migrant workers not from European countries, 16% were from Asia.

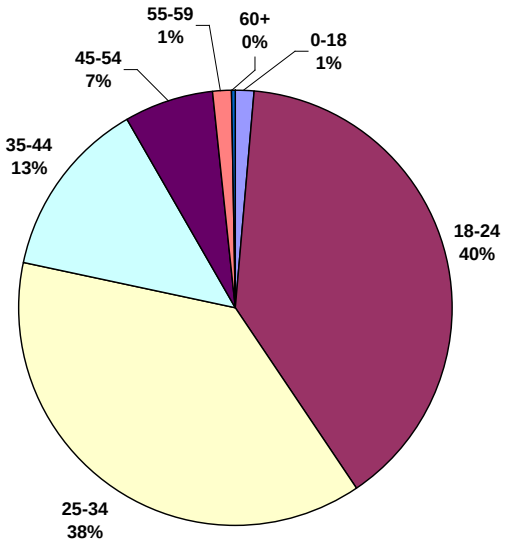
The majority (78%) of migrant workers in East Sussex are under 35 years.(Figure 8) The largest proportion are based in Eastbourne (35%) with only 9% in Rother.

Figure 7: Percentage of National Insurance registrations by nationality, 2007



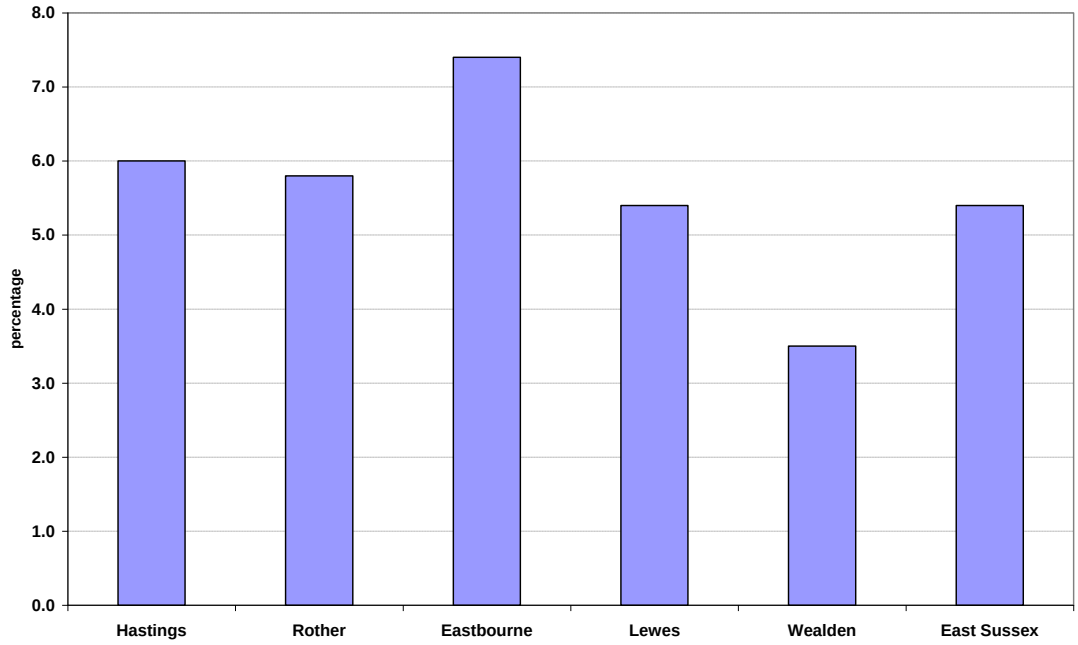
Source: Department of Work and Pensions

Figure 8: Percentage of National Insurance registrations by age groups, 2007, ONS



The Office of National Statistics uses various surveys and sample boosts to produce annual estimates of the number of people born/not born in the UK. Figure 9 shows the percentage of the population born outside the UK, by country of birth, for East Sussex and district councils. On average 5.4% of the population in East Sussex have non UK country of birth, with higher percentages in Eastbourne (7.4%) and Hastings (6.0%).

Figure 9: Percentage of residents in East Sussex with non-UK country of birth, 2007



None of the above figures capture the size of the illegal, or temporary migrant population.

3.4 Gypsies and Travellers

For the purposes of the Race Relations (Amendment) Act 2000 Gypsies have been recognised as a specific ethnic minority since 1988.
Gypsies and Travellers in East Sussex fall into three groups:[6]

- Gypsies
- Irish Travellers
- New travellers

Gypsies and Travellers were traditionally welcomed in East Sussex as useful seasonally available rural work force. In East Sussex the rural tradition of stopping places continues with Gypsy encampments in the county occurring in rural locations outside of the urban conurbations.

For the purposes of the Race Relations Amendment Act Irish Travellers have been recognised as a distinct & separate group since 2000, although they have similarities with the Gypsy culture, and a shared nomadism. The age profile of Irish Travellers is very young, and they marry earlier than the general population and have large families (average of 8 children). Irish Travellers are usually Catholic. Their faith is an important part of their culture and family life.[7]

New Travellers is the name given to people who, since the 1960s, have moved from houses and started to live on the road in an assortment of caravans, buses, vans and trucks. Their reasons for taking up the nomadic life are many and various. Each Traveller has a different story. They form a distinct Traveller group in East Sussex. The majority of New Traveller encampments occur in Brighton & Hove. Not all New Travellers remain on the road all their lives, but a number now have children travelling with them who have known no other life.[8]

The number of Gypsies and Travellers in East Sussex are difficult to estimate because of the nomadic nature of their life. The East Sussex Travellers Strategy 2005 estimates the number as 1,000, with about 500 settled. It has an accommodation needs assessment as an Annex with recommendations on sites, site size etc for settled and transient dwellers. The numbers of children from Travellers of Irish Heritage and Gypsy/Roma at the 2009 school census is given in Table 4.

3.5 Asylum seekers and refugees

An asylum seeker is someone who has made a formal application for safety or protection in the UK, and is awaiting a decision about their status. If their application is accepted, they become a refugee. By law, anyone has the right to apply for safety or protection and remain in the UK until a decision on their application has been made. Asylum seekers are eligible to receive a number of services whilst they are waiting for their application to be considered. These include access to local doctors, dentists, opticians, schools and adult social care.

Failed asylum seekers and those who have disappeared from the authorities do not receive any financial or other support and may not wish to make themselves known to any health services, even when they need them, as they wish to remain hidden.

The exact numbers of asylum seekers and refugees in East Sussex could not be obtained from the UK Border Agency. Refugees and asylum seekers are not recorded as a specific group on the GP or Dentist register, although they may be included in the migrant figures. The Comprehensive Sexual Health Needs Assessment (CSHNA) [9] for East Sussex PCTs done in 2008 reported that there were 83 asylum seekers supported by the National Asylum Support Service in Hastings, plus an additional 15 who were living with their own contacts in the town. Service providers estimate that the actual number of asylum seekers and failed asylum seekers may be double that.

The CSHNA further states that 3-4 year ago there were 250 bed spaces in hostels for asylum seekers in Hastings. Under the 2007 New Asylum Model asylum seekers and refugees will no longer be in supported housing in Hastings, but until the new system is embedded Hastings will retain 100 bed-spaces. People have been moved

into flats or independent living, but this has apparently led to increased isolation. It is likely that undocumented asylum seekers and refugees, and those caught in the transition between systems, will remain in the area.

The profile of asylum seekers has changed over recent years with more from Africans from Zimbabwe, Eritrea, Sudan, Cameroon, Congo and the Ivory Coast. Previously asylum seekers tended to be single, young men from the Middle East (Iran, Iraq, Kurdish areas, Palestine, Turkey). Although numbers appear to be reducing those who become known to services are staying in the area and are anecdotally reported to be complex cases needing multi-agency support.

3.6 Rural isolates

Most ethnic minority people live in towns in East Sussex. It is not possible using routinely available data so long after the Census, and with such relatively small numbers, to give detailed breakdown of rural communities by ethnic mix, or the demographics of the rural ethnic groups. However it might be predicted that any migrants, asylum seekers or refugees in the rural populations would disproportionately feature in the numbers of rural poor.

A report for the Commission for Rural Communities finds that for 11 of the 37 poverty and social exclusion indicators the rural figures are "somewhat better" than they are for the urban equivalents. For instance 19% of people in rural districts live in low-income households, compared with 25% in urban districts. Rural districts score worse for quality of housing, including fuel poverty and access to transport but are much better than urban areas for quantity of housing and employment. [10] The wide distribution of social exclusion across rural areas contrasts with the much more visible concentration in particular urban communities and neighbourhoods.

4. Deprivation

Evidence suggests that the poorer socioeconomic position of Black and minority ethnic groups is the main factor driving their health inequalities.

4.1 Index of Multiple Deprivation 2007

IMD 2007 is a means mapping measures of deprivation to small geographic areas. It is underpinned by 7 separate dimensions of deprivation which are weighted to give an overall deprivation score. The Joint Strategic Needs Assessment gives the latest IMD data and maps.[11] None of the dimensions of IMD 2007 relates deprivation specifically to ethnicity, but ethnic minority populations are known to live in highest concentrations in geographic areas with high deprivation scores, such as Hastings.

4.2 Free school meals

Eligibility for free school meals is an indicator of deprivation. Comparing deprivation by ethnic group helps identify potential health inequalities between the groups. This dimension was one that was reported in the 2009 Health Profile for East Sussex (APHO), and Table 6 compares the percentage of children aged 5-16 years in each ethnic group who were eligible for free school meals (2008).

In East Sussex 6200 school children were eligible for free school meals, and of this number 410 (6.6%) were from Black and minority ethnic groups (excluding the White Irish and White Other group). The highest eligibility for free school meals was found in the Black ethnic group at almost 22%. There will be differences in distribution of eligibility across schools in the county. Rates of eligibility for free school meals were less than the average for England.

Table 6 Eligibility for free school meals, by ethnic group in East Sussex 2008.

Ethnic group	% eligible	Nos eligible
White	10.9	5790
Mixed	15.1	250
Asian	8.6	60
Black	21.9	70
Chinese/Other	8.1	30
Total		6200

Source: APHO

5. Ethnicity and Health

There are a number of ways in which ethnicity can impact on health. The determinants of health may differ between ethnic groups, for example through genetic differences, population structures, culture, and socio-economic factors. There is evidence that racial inequalities persist in the UK, and the combined impact of lower job status, unemployment, and poor and overcrowded living conditions are important when looking at ethnic differences in health. Racism (whether direct in the form of racist abuse or indirect via structural discrimination) can also have an impact on health [2].

This section described the expected health needs of Black and minority ethnic populations based on the findings of surveys, needs assessment, and research literature from the UK. Where available, findings from East Sussex population studies have been included for comparison.

5.1 Health Survey for England

The Health Survey for England (HSE) is an annual survey that gathers information from a sample of the public on a range of aspects concerning their health. The 2004 HSE focused on the health of adults and children from the seven largest minority groups in England; Black Caribbean, Black African, Indian, Pakistani, Bangladeshi, Chinese and Irish. It does not include information on the health of people from the European Union who are living in the UK. The previous HSE focusing on Black and minority ethnic groups was in 1999.

Table 7 gives the key health & lifestyle issues found in the adult sample population of Black and minority ethnic groups, and Table 8 gives the relative frequency compared with the general population. The main health problems experienced by Black and minority ethnic groups are the same as those of the general population i.e. coronary heart disease (CHD), Stroke, Cancers and Respiratory Diseases, and these conditions affect large numbers of the population.[12] It is necessary to be aware of the conditions that are specific to, or more frequent in, some ethnic minority groups, but the numbers involved will be small. In other words the absolute numbers of Black and minority ethnic people suffering conditions is more important to service planning than whether they suffer the conditions with more or less frequency than the general population. An exception to this adage is diabetes, where doctor diagnosed diabetes is several times more common in Pakistani, Bangladeshi, and Indian men, and Pakistani, Bangladeshi, Black Caribbean and Indian women. There was a significant increase in prevalence of cardiovascular disease in Pakistani men and Indian women between 1999 and 2004.

Table 7: Key health and wellbeing issues by ethnic groups

Ethnic group	Key health and wellbeing issues	
	Male	Female
Black Caribbean	Type 2 diabetes	Type 2 diabetes
	Prostate cancer	Obesity
		Increased waist circumference
Black African	Type 2 diabetes	Type 2 diabetes
	Prostate cancer	Obesity
		Increased waist circumference
Indian	IHD	IHD
	Type 2 diabetes	Type 2 diabetes
	Low levels of physical activity	Low levels of physical activity
	Kidney failure	Kidney failure
Pakistani	Poor psychosocial health	Self reported life long limiting illness
	IHD	Poor psychosocial health
	Type 2 diabetes	IHD
	Smoking	Type 2 diabetes
	Increased waist circumference	Obesity
	Low levels of physical activity	Increased waist circumference
	Kidney failure	Low levels of physical activity
		Kidney failure
Bangladeshi	Self reported life long limiting illness	IHD
	Poor psychosocial health	Type 2 diabetes
	IHD	Chewing tobacco
	Type 2 diabetes	Increased waist circumference

	Smoking	Low levels of physical activity
	Chewing tobacco	Kidney failure
	Low levels of physical activity	
	Kidney failure	
Chinese	Type 2 diabetes	Type 2 diabetes
	Low levels of physical activity	Low levels of physical activity
Irish	Smoking	Smoking
	Lung cancer	Lung cancer
	Increased suicide rate	Increased suicide rate

HSE (2004), Aspinall and Jacobson (2004) and Johnson et al (2004)
IHD = ischaemic heart disease

Table 8. Summary of relative frequency of diseases in Black and minority ethnic groups compared with the majority population

Diseases that are common in one or more Black and minority ethnic group	**Less common**	**Uncertain frequency**
Infectious diseases including TB and Malaria	Lung and breast cancer	Mental disorders
Diabetes	Diseases of the nervous system	
Perinatal mortality		
Hypertension and Stroke		
Cancers of the mouth & pharynx; liver and prostate		
Haemoglobinopathies		
Vitamin D deficiency		

Source: HSE 2004

Neoplasms

Overall, cancers tend to be less common in Black and minority ethnic populations than in the 'white' population (but a major problem, nonetheless). Some cancers are much less common, e.g. lung cancer, related to lower smoking rates. However, lung cancer remains the top ranking cancer in men on the basis of the numbers of deaths caused. Oropharyngeal cancers are commonest in South Asian populations and prostate cancer in African populations. Cancer variations are usually attributed to environmental factors, including lifestyle.[12]

Infections

The common respiratory and gastrointestinal infections are important in all ethnic groups. Diseases that are associated with warm climates, such as malaria, are much more likely in Black and minority ethnic groups. Tuberculosis is much more common in a number of Black and minority ethnic groups, particularly South Asian populations. The causes are complex relating to opportunities for exposure (travel, migration, etc.), immunity, and living conditions in the UK. The latter seems to be an important factor in maintaining the high level of tuberculosis in South Asians settled in the UK.[13]

Haemoglobinopathies

The thalassaemias and sickle cell disorders are important genetic conditions that affect people who originate from Africa, the Caribbean, the Middle East, Asia and the Mediterranean.

Self reported health and wellbeing

According to the HSE a number of Black and minority ethnic groups are more likely to report that they have a longstanding limiting illness (an illness or disability that has affected them over a period of time), in particular Pakistani (women) and Bangladeshi (men). On the other hand Chinese men and women, and Black African men were less likely to report a longstanding limiting illness.

Children's health

The HSE 2004 also reported on the health of ethnic minority children, and a summary of the findings in comparison to the general population of their peers is given below. (Table 9)

Table 9. Relative frequency of health conditions or lifestyle factors in Black and minority ethnic children compared with their peers in the general population

Factor	More frequent	Same	Less frequent
Acute illness		Irish M&F, and Pakistani M	All Others
Emotional & Behavioural Disorders		Most	Chinese M, Black African F
Respiratory Symptoms		Black Caribbean, Irish, & Chinese M Black Caribbean, Irish F	All others
Good/very good health		Most	Bangladeshi M, Black Caribbean F
Limiting long standing illness		Irish, Black Caribbean	All Others
Ever Smoked		Black Caribbean M&F, Irish M&F, Black African & Bangladeshi M	Chinese
Tried Alcohol	Irish F	Black Caribbean M&F, Irish M	Most
Physical activity		Pakistani M, Irish M&F	Most
Fruit & Veg consumption	Most	Chinese M, Bangladeshi F, Irish M&F	

M- Male, F- Female

Oral health

In a previous HSE undertaken in 1999, in all minority ethnic groups, both men and women, regular dental attendance was significantly lower than that of the general population. Most minority ethnic groups were significantly more likely than the general population never to visit a dentist or to go only when having trouble with their teeth.[14]

5.2 Black and Minority Ethnic Young people

Overall the prevalence of diseases for ethnic minority children is less well researched than for White children. The prevalence of mental disorders was not distributed equally across ethnic groups in the second national psychiatric morbidity survey. Higher rates of mental health disorder were recorded by those suffering a number of measures of disadvantage or deprivation. Because deprivation and disadvantage often disproportionately affect ethnic minorities, especially if they are refugees, asylum seekers, or homeless, high levels of mental disorder would be expected. Knowledge about services, their responsiveness, and cultural attitudes are likely to affect how many of the children and young people with mental health disorders present to services.[15]

A systematic review of differences in child mental health amongst ethnic group in Britain found that children in the main minority ethnic groups have similar or better mental health than White British children for common disorders, but may have higher rates for some less common conditions. The causes of these differences are unclear. In addition there may be unmet need for services among Pakistani and Bangladeshi children.[16]

5.3 Black and Minority Ethnic Older people

The Public Health Resource Unit published "Older people in East Sussex: an epidemiological health needs assessment" in 2007[17], a report that described members of ethnic minorities as often having worse health than the White majority. This may arise from relative socio-economic deprivation, from the higher prevalence of risk factors for disease and from inequalities of access to health care. When compounded by the poorer health experiences of many older people, these effects can be serious. A survey on quality of life among older people from different ethnic groups living in England and Scotland came to similar conclusions. It showed that differences in health, income and social support among the ethnic groups is evident[18], and partly due to the cumulative effects of health and material disadvantage, and the experience of racism.

5.4 Maternity and Black and Minority Ethnic women's health

5.4.1 Antenatal and maternity care

Maternal mortality is rare in this country, but has long been recognised as an indicator of the quality of maternity care. *Saving Mother's Lives*, the 7th Report of the Confidential Enquiry into Maternal Deaths in the United Kingdom reports the rate, when investigated in depth, as 14 per 100,000 for the period 2003-05, and that it has not been falling. Among the possible reasons they give for this are the rising numbers of births to women born outside the UK, and the increasing number of deaths in migrant women. These communities tend to have more complex pregnancies, more underlying conditions and poorer overall health. Vulnerable

women with complex lives are less likely to seek early antenatal care or stay in contact with maternity services consistently. Black African women including asylum seekers & newly arrived refugees have a maternal mortality rate 6 times higher than White women, and the rate in Black Caribbean and Middle Eastern women is raised, but not to this extent.[19]

Differences in perinatal mortality (stillbirths and deaths within on week of birth) are also observed between ethnic groups. The rate is particularly high in Pakistani babies, along with congenital anomalies. The reasons for these differences are believed to be multiple, including less uses of antenatal care, high fertility, consanguinity and childbearing late into the reproductive period.[20]

The Health ASERT Programme for Wales[21] commissioned a literature review on health beliefs, behaviour, & use of services by minority ethnic populations, reporting in 2006. One paper reviewed concluded that in the UK 'the evidence for an association between ethnicity and late or poor attendance for antenatal care may be slightly stronger than for social class'. Further papers suggest that women of South Asian origin are more likely to initiate care later and have fewer antenatal visits. The reasons for late booking amongst ethnic minority women have not been fully explored but may include barriers perceived by the woman, such as language and cultural issues, or high levels of geographical mobility in some groups. There is other evidence to suggest that South Asian women are less likely to be offered and to receive prenatal screening, again indicating that there may be inequity in access to antenatal care for women from minority ethnic groups.

5.4.2 Domestic violence

The Health ASERT literature review also reports a paper that found no statistically significant differences in the prevalence of domestic violence across ethnic groups (White, Black, Asian, Other), although Black women were least likely to ever have experienced physical violence.

5.4.3 Screening

Data on ethnic group is not routinely collected by breast & cervical cancer screening programmes. There is only limited evidence on participation rates in cervical screening among different ethnic groups, and it comes mainly from an early stage in the programme. The strongest evidence of low uptake comes from the Health Education Authority Health and Lifestyles Survey. Amongst the UK sample of 16 to 74 year old women, 60 per cent reported ever having been screened for cancer of the cervix. Rates were lower in all the minority ethnic groups. Concern continues that women from Black and minority ethnic groups are not being reached or taking up the programmes and a Populus Poll for the NHS Cervical Cancer Screening Programme, reporting in July 2009, found differences in awareness between Black and minority ethnic groups and White counterparts on their own risk of the condition and the risks that the condition poses to them.

5.5 Migrants

5.5.1 SEEDA Report 2008

The South East of England Development Agency (SEEDA)[22] commissioned a report on "Migrant Workers in the South East Regional Economy", published in 2008. It

found that only 55% of migrants were registered with a GP making it difficult to estimate need and demand for health care. In addition, A&E departments report seeing a disproportionate number of migrant workers from the A8 (European Accession) countries. Anecdotal evidence suggests that this reflects common practice in the health care systems of their countries, where there is no equivalent primary care service.

5.5.2 Infections

The Health Protection Agency produced a report on Migrant Health[13] in 2006. Most legal migrants are young adults and are thought to have similar health needs to their peers. Infection rates can be an exception to this. Among cases for which information was available, 70% of TB cases and HIV cases reported in England, Wales and Northern Ireland and 70% of malaria cases reported in the UK in 2004 had been born outside the UK. In any given year, it is also estimated that the majority of chronic hepatitis B infections newly added to the existing numbers of such infections in England and Wales are likely to be in the non-UK born.

5.5.3 Sexual health

The Comprehensive Sexual Health Needs Assessment reports that female sex workers are largely White British, but there are increasing numbers of Polish and other Eastern European women. There are ethnic tensions among the sex workers linked to protecting patches.[9]

5.5.4 Mental health

Migrants to and from a variety of countries have higher rates of admission to psychiatric hospitals than native born populations. A prospective study of incident psychosis found that annual incidence of schizophrenia and other non-affective psychoses was higher in all Black and minority ethnic populations than in the White population, but the difference was only significant for the Black population.

5.5.5 Employment

The NHS is one of the largest employers of migrants in the UK. According to the medical workforce survey 2004, 35.4 per cent of medical staff and 10.9 per cent of non-medical staff in the South East are from Black and minority ethnic groups compared to 5.2 per cent of the population of the South East aged 15-64 being from the Black and minority ethnic groups (2001 Census). These employees are likely to have reasonably good English, but other migrants who come to work here may not have. The Comprehensive Sexual Health Needs Assessment[9] supports this by reporting that two-thirds of employers did nothing to help workers whose English language skills needed development, and little training was offered by most employers beyond health & safety and inductions.

5.5.6 EU accession country migrants

A rapid literature search revealed no specific studies that looked at the health needs of people from EU accession countries compared to the UK. Information on specific health indicators for each of the EU accession countries has been extracted (see Data Appendix Tables 10 & 11) and the average figure calculated in order to compare with the UK. Based on these figures the health issues for migrants from EU Accession countries are, smoking, teenage pregnancy and mental health.

5.5.7 Illegal/irregular migrants

The health needs of migrants who arrive and work legally in this country are easier to ascertain than the health needs of those whose presence is not official. In the UK, irregular (illegal) migrants often fill low skilled job vacancies particularly within construction, agriculture/horticulture, contract cleaning and residential care. They may not know their rights, if they have any, and consequently may be exploited (e.g. low wages, unregulated work, poor accommodation, overcrowded accommodation and violence). They may be highly dependent on traffickers, especially women who are trafficked mainly for the sex industry (with concomitant risks of sexually transmitted infections). Despite probable increased health needs, undocumented migrants are largely hidden to health services and public health initiatives.

5.6 Gypsies and Travellers Health

A number of studies found that Gypsies and Travellers have significantly poorer health and more self-reported symptoms of ill health than other UK resident, English speaking ethnic minorities and economically disadvantaged White UK residents' [23,24]. Living in a house for Gypsies and Travellers is associated with long term illness, poorer health state, and anxiety. The poorest health is in those who travel rarely.

The health inequality between Gypsies and Travellers and the UK general population is large. Reported health care problems are between twice and five times more prevalent than the wider population.[23] Chest pain, respiratory problems, and arthritis were more prevalent in the Traveller group. There is also an excess prevalence of miscarriages, stillbirths, neonatal deaths and premature death of older offspring. Ill health can be seen as normal, and stoically and fatalistically accepted.[25]

Poor access to health care has been reported as an almost universal experience of Travellers. Social exclusion experienced by Travellers is one of the most important factors influencing their health. The lack of a flexible approach within health provision to a nomadic lifestyle means that Travellers often miss out on basic levels of health care, especially in ante and post natal care and treatment of chronic illnesses. There are widespread communication difficulties between health workers and Gypsies & Travellers. Barriers to health care are experienced, with several contributory causes, including reluctance of GPs to register Travellers or visit sites. This can lead to expectations amongst Travellers of racism and prejudice.[23]

However the most recent study done for Families, Friends and Travellers (FFT)[26] in the Brighton and Hove area showed the large majority of participants did use either primary or hospital-based urgent care services, but their experiences were often sub optimal. Gypsies and Travellers have coherent cultural beliefs and attitudes that underpin health-related behaviour, and health experiences must be understood in this context. This contradicts the perception that they use hospital services inappropriately. However, their experiences of using the services are less favourable when compared with data from the local general population. Although a large number of Gypsies and Travellers reported poor experiences, none had formally complained.[24]

Lack of education is another factor that can adversely influence health. Low literacy attainment is still a major problem for most adult Travellers, mainly because so few attended school on a regular basis, if at all. The low literacy level within the community leaves it vulnerable to information conveyed almost solely by television, the press and their peers. Professionals have an important role in dispelling myths and spending extra time in explaining medical matters clearly to a population with limited access to written information.[23]

Young females are often removed from sex education classes in schools. Young travellers are often kept away from drugs awareness knowledge in line with the reasoning that any knowledge about the subject is likely to lead to an increase in the desire to experience it.[26]

5.7 Asylum seekers

Most asylum seekers & refugees are escaping extremely adverse situations in their home country, where they have suffered physical violence (including rape) or feared for their life. They arrive bearing the physical consequences of their experiences, and concomitant emotional and mental health problems. Post-Traumatic Stress Disorder (PTSD) and an increased risk of suicide are not uncommon. Nationally there is a lack of appropriate therapeutic services available for these conditions.
Asylum seekers are often young and single and sexual health is therefore an issue. This includes culturally appropriate, contraceptive, genitourinary, and maternity services. As in the general population, women are more engaged with contraception than men, who tend only to engage with getting condoms, and do not appear to be involved in discussing contraception options with their female partners.[9] Asylum seekers, both male & female, may have suffered rape and need sympathetic treatment for the outcome (pregnancy, STIs).

5.8 Rural isolates

Nothing is known from routinely available data about the specific health needs of ethnic minorities living in rural communities. There is no reason to assume it is better than that of the indigenous population. Stigma, isolation, and lack of access or choice of service, may be particularly severely felt by people from ethnic minorities.

5.9 Modelled estimates of need by disease

Models of disease prevalence in a population have been developed to help local planning and commissioning, and they include projections up to 2020. The detailed findings are in Appendix 2 but the Summary of predictions is as follows:

- The prevalence of coronary heart disease (CHD) in both PCTs is expected to rise in all ethnic groups up to 2020.
- The highest prevalence rate of CHD is in the White group followed by Asian and then Black.
- The prevalence of CHD in all ethnic groups in both PCTs at almost all time up to & including 2020 is higher than the England equivalent.
- In 2005 the prevalence of diabetes was predicted to be highest in the Asian group followed by Black and White.

- The prevalence of diabetes in both PCTs and all ethnic groups was higher than the England estimate in 2005.
- The prevalence of hypertension (a proxy for stroke) is predicted to rise in all ethnic groups in both PCTs up to 2020.
- The prevalence of hypertension is highest in the White group followed by Black and Asian.
- The prevalence of hypertension in both PCTs and all ethnic groups up to & including 2020 is higher than the England equivalent.
- The prevalence of chronic obstructive pulmonary disease (COPD) is expected to rise in all ethnic groups up to 2020.
- The highest prevalence of COPD is in the White group followed by the Black and Asian.
- Prevalence rates are below the England equivalent, except for the White group in East Sussex Downs & Weald where it is higher.

5.10 Lifestyle and Black and Minority Ethnic Groups

5.10.1 Smoking

The HSE 2004 found that Bangladeshi men were considerably more likely to report smoking than the general population. The difference between males and females was most pronounced in Bangladeshi and Pakistani populations. Questions about chewing tobacco, identified that this activity was most popular amongst the Bangladeshi community with more women (16%) than men (9%) participating in this activity.[12]

5.10.2 Obesity

The HSE 2004 found that obesity rates were generally higher amongst females, with women from the Black African and Black Caribbean groups much more likely to be obese. The Chinese populations were considerably less likely to be obese than any other Black and minority ethnic group. After age standardisation, the risk of an increased waist circumference (greater than 102cm for men and 88cm for women) varied between and within Black and minority ethnic groups. Most at risk of a high waist circumference were Pakistani men, Black Caribbean women, Black African women, Pakistani women, Bangladeshi women. The least likely to have a raised waist circumference were Bangladeshi men, and Chinese men and women.

5.10.3 Alcohol

In the general population surveyed in 2004, 18% of men and 10% of women said that they drank alcohol almost every day. The Black and minority ethnic community reported drinking less frequently than the general population apart from the Irish who drank as often. The EU accession country data (Data Appendix Table 10) show only Hungary & the Czech Republic consuming more alcohol per capita than the UK.

5.10.4 Activity levels

In the general population surveyed in HSE 2004, 37% of men and 25% of women reported meeting the government recommended levels of physical activity. After age standardising the data, Indian, Pakistani, Bangladeshi and Chinese populations were less likely to meet these recommended levels of physical activity.

5.10.5 Fruit and vegetable consumption

In the general population surveyed in HSE 2004, 23% of men and 27% of women reported eating five daily portions of fruit and vegetables. Overall, Black and minority ethnic groups consumed more fruit and vegetables. The Chinese and Indian populations were particularly more likely to eat five daily portions than the general population.

6. Service available and services used

In order to comment on the use of services (& outcomes) by people from ethnic minority groups the data must record activity by ethnicity. Ethnicity at present is not recorded on either birth or death certificates in the United Kingdom countries.[21] Ethnicity recording on the core demographic and health datasets nationally is generally not good.

6.1 Primary Care services

Primary Care is ideally placed to respond to health needs in the community. Table 10 shows the percentage of ethnicity recorded in Primary Care for both of the PCTs for the last three years. Hasting and Rother PCT has a higher percentage of new registrations with valid ethnic origin recorded than East Sussex Downs and Weald PCT. This measure does not demonstrate how many existing Black and minority ethnic patients have their ethnicity recorded but it is likely to be low, in common with the rest of the country. The paucity of ethnic recording means that it is not possible to give quantitative estimates of the relative uptake of services between ethnic groups and the rest of the population, or whether the predicted health needs in ethnic groups are being adequately or equitably met.

Table 10: QOF indicator records 21 - Ethnic origin is recorded for 100% of new registrations

ESDW PCT	2006/07	2007/08	2008/09
Number of practices	45	45	44
Number achieving 100%	22	19	24
% of practices achieving 100%	49%	42%	55%
Average completeness* of records	68%	78%	80%

**Percentage of new registrations with valid ethnic origin recorded*

H&R PCT	2006/07	2007/08	2008/09
Number of practices	35	34	34
Number achieving 100%	14	19	16
% of practices achieving 100%	40%	56%	47%
Average completeness* of records	79%	86%	87%

**Percentage of new registrations with valid ethnic origin recorded*
Source: QMAS downloaded 30th June 2009

6.2 Hospital services

Hospital Episode Statistics (HES) have better recording of ethnicity of patients than primary care. Reviewing data from the Trusts who cared for 1000 or more people registered with GPs in East Sussex in the period 1st April 2006 to 31st March 2009, the ethnicity recording ranges from a private provider at 0, to 100%. Breaking the attendance down by ethnic sub-group produced small numbers so an analysis has been done comparing Black and minority ethnic and White groups.

Table 11 shows the directly age standardised rates (DSR) per 10,000 of attendances by Black and minority ethnic groups compared with White British. (DSR allows for the differences in age profile of the populations). The data covers codes in the first inpatient episode for all admissions between 1st April 2006 and 31st March 2009, and covers residents of East Sussex Downs & Weald PCT and Hasting & Rother PCT based on their postcode. It shows the rates of admission for elective and emergencies procedures are higher in Black and minority ethnic groups, and this is statistically significant (see Appendix 3). This may reflect additional need, and/or lack of use of primary care services.

Table 11. Directly standardised rates (DSR) per 10,000 of attendance of Black and minority ethnic groups compared with White British group in East Sussex.

Types of admission to hospital	**White British**	**Black and Minority Ethnic**
Elective admissions	5.5	19.4
Emergency admissions	43.6	142.6

See the Appendix 3 for details of the ethnicity monitoring by hospital Trust, and DSR calculations.

6.3 Mental health services

The recent CAMHS Needs Assessment report[15] on the November 2008 CAMHS Mapping data is as follows "Ethnicity recording by Sussex Partnership Trust is 100% (i.e. none are recorded as "not stated"), so it can be concluded that non-White ethnic groups are over represented in the Looked After Children and Primary Mental Health Worker team (except the latter are specifically working with these groups) and underrepresented in the generic teams and Learning Disabilities team (compared with the percentage non-White in the population)." The Needs Assessment for Adult Mental Health in East & West Sussex[27] does not compare activity by ethnic group, despite commenting that the needs of asylum seekers and refugees will be high. It does recommend that new ways to engage hard to reach groups such as ethnic minorities are needed, and say that better ethnic recording would allow the validating of predicted need.

The Race Equality in Mental Health Service (REMHS) is funded by the PCTs and based in ESCC Adult Social Care. It is part of the national Delivering Race Equality (DRE) in Mental Health Care programme to tackle mental health inequalities. This programme is a five year plan established in 2005 to improve access, outcomes and experiences for Black and minority ethnic people with mental health needs and improve their confidence in mental health services. The REMHS supports communities in promoting the mental health of Black and minority ethnic people, working with them to help build capacity within them and to ensure that their views are taken into account by commissioners and providers during the planning and delivery of services. REMHS provides services to all age groups, including children and older people and for those of Irish or white European descent, Gypsies, Travellers, migrants, people with refugee status, asylum seekers and, where appropriate, foreign national prisoners. Much of the work so far has been to develop links with Black and minority ethnic people in a local area and helping them to meet regularly to identify how they can meet their aspirations as a means to raise issues about their mental health experiences and needs. The initial session is used to get to know the community members as individuals and find out about their issues, what the barriers are and what issues they want to bring up about how services can be improved.

6.4 Sexual health services

The data collection for HIV cases is called SOPHID and it records ethnicity (Table 12). The Comprehensive Sexual Health Needs Assessment gives data for 2006. A comparative table for the two PCTs is given below. Most of the cases are aged over 35 years.

Table 12: SOPHID data 2006, for PCTs in East Sussex.

Ethnic group	Factor	ESDW	H&R
Black African M	Rate HIV /1000	104.3	15
Black African F	Rate HIV /1000	177	37
White M	Rate HIV /1000	1.2	0.85
White F	Rate HIV /1000	0.1	0.12
	% seeking treatment out of area	52%	47%

There is data for the two East Sussex genitourinary medicine clinics on STIs (sexually transmitted infections) by diagnosis, and sexual health screens, by ethnicity. And for the period 2007 and 2008 the ethnic category is recorded as at least 95% of diagnoses/screens.

6.5 Maternity services

The East Sussex Maternity Strategy 2009-12 is a response to the Independent Reconfiguration Panel report, and aims to achieve the national vision for quality maternity care. The Panel report recommended the continuation of consultant led services at the District General Hospital in Eastbourne and at the Conquest Hospital in Hastings. A Maternity needs assessment is underway. It is expected that the contribution of ethnic minorities to the numbers of births, antenatal, intra-partum, and post partum incidents will be analysed as a component of this.

6.6 Rural services

Primary and Community health care services, and social care services are available in rural areas. Lower concentrations of population may mean they are available less frequently than in more densely populated areas eg fewer clinics per week. This applies to the whole population including Black and minority ethnic groups.

Action in Rural Sussex participates in a wide range of programmes, operating projects and services across East and West Sussex. Action in Rural Sussex particularly work on health and wellbeing issues with rural young people helping them to access support that those in more urban areas take for granted. The Action in Rural Sussex mobile health project, Your Bus Your Call, was initially set up under the Lottery Healthy Living Centre programme, and continues to provide assertive outreach work to young people living rurally.

6.7 Services specifically for Black and Minority Ethnic groups

6.7.1 Service mapping

All NHS services are available to all Black and minority ethnic groups who are legally resident in the country. In the time available it was not possible to do a full mapping of health services available specifically for Black and minority ethnic groups. The services, agencies, and partners working on Black and minority ethnic specific issues or providing services, have been identified from documents, interviews and focus groups undertaken as part of this needs assessment, and are to be found in the Appendix 6 of the report. They include those provided by the NHS (Specialist Black and minority ethnic
services of NHS East Sussex Community Health Service), the local authority, and voluntary organisations.

6.7.2 Language services, translation & interpreters

The County Council lead on a county wide translation contract for interpreting and translation services provided by Applied Language Solutions, Sussex Interpreting Services (SIS) and Southeast Interpreting and Translation Services (SITS) (telephone and face to face). There are other providers. GPs tend to use Language Line although the PCT will fund SITS. Feedback from the qualitative research for this report records "Links, like other voluntary organisations, cannot afford to register with Language Line or hire interpreters".

6.8 Policies and strategies influencing services for Black and Minority Ethnic groups

Both PCTs in East Sussex have adopted Single Equality Schemes and an extract from the Equality & Diversity Action Plan that is relevant to Black and minority ethnic groups is given in Table 13 below.

Table 13. Extract from the East Sussex PCT's Equality & Diversity Action Plan

Explore option of establishing a Black and minority ethnic health and social care forum, jointly with ESCC, involving other local NHS Trusts where appropriate.	Assurance & Engagement (E + HRi Manager)	Mar-10	Scoping paper produced
Develop Black and minority ethnic practitioner network to include practice staff	ESCHS & E+HRi Manager	Jan 10	Network membership list and meeting minutes
Report on monitoring data from services for whom we are lead commissioner to build targets into service specifications for contract reviews in future	Public Health	Mar-10	Included in E + D Annual report
Explore what data is collected by the prison health service	Public Health	Mar-10	E + D Committee minutes

Consider options for disaggregating 'White Other' category, consistent definitions (e.g. Black and minority ethnic) and recommend data collection standards for publication on the website extranet	Public Health	Mar 10	Published on website
Review the translation and interpreting arrangements and contracts currently in place with various providers and produce staff guidance	Assurance &Engagement	Dec-09	Contract reviewed, policy in place and staff guidance distributed
Create detailed race improvement plans for Diabetes; Perinatal mortality; Coronary heart disease and stroke	Public Health	Nov 09	Plans incorporated into E + D Action plan
Undertake a Black and minority ethnic Comprehensive needs assessment & report findings to Equality and Diversity Committee	Public Health	Jan 10	Black and minority ethnic JSNA Report, E + D Committee minutes
Define and agree access to translation and interpreting services as part of 3rd sector agreements	Public Health	Mar 10	Arrangements included in SLA
Report on Equality and Diversity monitoring data built in to 3rd sector commissioning agreements	Public Health	Mar 10	E + D Annual report

East Sussex County Council Adult Social Care Department have an 'Equality & Diversity Improvement Plan' for 2007-2010. It states that:

"*The key to delivering suitable provision in forthcoming years is*

- *involvement of minority communities in developing new services and better commissioning/procurement*
- *capacity building in minority communities*
- *capacity building in independent sector to deliver inclusive services*
- *workforce planning in statutory & independent & voluntary sector*
- *drawing from minority communities to strengthen the social & healthcare labour force in all sectors*
- *monitoring for equity including better data collection*

A Black & Minority Outreach Project (2006-09) has been key to delivery, working through the partner organisations Sompriti and Families, Friends & Travellers. East Sussex Council has produced a strategy and action plan for Travellers in East Sussex. The Traveller Strategy was adopted in 2006 and recognises Gypsies' and Travellers' rights to:

- a nomadic lifestyle
- equal access to services such as education, health and accommodation
- protection from discrimination and harassment

This strategy recognises the good practice in Hastings and Rother where there is flexible service, and close inter agency working.

6.9 Research evidence on service utilisation

The HSE 2004[12] compared the utilisation of services across minority ethnic groups and showed that rates of GP consultations are higher in minority ethnic groups, particularly South Asian groups. The notable exceptions are Chinese people, who have low rates of utilisation for all health services, including inpatient and outpatient services. South Asian and Black Caribbean men were more likely than the general population to have consulted their GP in the past two weeks and to have more than one consultation over this period. Among women, contact rates were significantly higher for South Asian and Irish women compare to other ethnic groups.

The recently published DH report on the "Self reported experience of patients from black and minority ethnic groups"[28] examines variations in the self-reported views of NHS patients from different ethnic groups, based on results from the 2008/09 adult inpatient, 2008/09 emergency department, 2007/08 primary care services and 2007/08 community mental health patient surveys. Results show a range of variations between Black and minority ethnic groups and their White British counterparts. Where differences do exist, most are negative, indicating that Black and minority ethnic groups are less likely to report a positive experience. However many areas show no difference, with some showing a positive difference.

- Patients from the White Irish group were more likely to give positive responses, across the majority of questions, compared with the White British baseline.
- Patients from the Asian and Chinese/Other groups were less likely to give positive responses compared with the White British group.
- Patients from the White Other and Mixed groups were again typically less likely to give positive responses, but less consistently than the Asian and Chinese groups.
- Results for Black patients were mixed, although they were slightly less likely to give positive responses, particularly in the primary care and A&E surveys.
- Black and minority ethnic groups tended to be less positive about questions relating to 'access and waiting' or to 'better information and more choice'.
- Across survey settings, differences were seen most in the primary care survey, where all Black and minority ethnic groups (except the White Irish) were less likely to give positive responses. Very few differences were found in the community mental health survey.

There is no clear explanation of the reason for the differences which may be due to one or more of different expectations, perceptions, or cultural norms.

There are not many studies that looked at accessibility of services from East European group separately, but there is some anecdotal evidence that these populations are not currently accessing services. This may be because they are inherently well, &/or they use A&E when ill.

7. Good Practice

A list of "Good Practice" examples identified in other published reports and from the literature review is compared with local initiatives below.

Table 14. National and local "Good Practice" initiatives to reach Black and minority ethnic groups

	"Good Practice" examples identified nationally	**"Good Practice" examples - locally in East Sussex**
1	"Welcome pack" for asylum seekers and refugees	Specialist Black and minority ethnic services, NHS East Sussex Community Health Service. A welcome pack has been produced by CDW for Black and minority ethnic population but needs reprinting as some of the details have changed
2	Visiting and assisting the new arrivals in a borough by health professional e.g. health visitor	Specialist Black and minority ethnic services, NHS East Sussex Community Health Service. Health visitor for homeless and asylum seekers
3	Hand held records	Pacesetters "Personal Adult Health Records" - for Gypsy and Travelling community, to be implemented in 2009. Specialist Black and minority ethnic services, NHS East Sussex Community Health Service.
4	Drop in service for Black and minority ethnic people	"Ore Clinic" - Sexual Health check for asylum seekers. Links in Hastings provides drop-in service for asylum seekers, refugees, migrants and the wider Black and minority ethnic population
5	Improving the recording of ethnicity in primary and secondary care	
6	"Peer education" model to cascade training by the community health workers	
7	Using interpreters or Language Line type services	Applied Language Solutions, Sussex Interpreting Services (SIS) and Southeast Interpreting and Translation Service (SITS) Sompriti (bi-lingual advocacy services)
8	Involving the community organisations in making health decisions	"Pride of Place" Strategy in 2007 There are Black and minority ethnic

		forums in both Hastings and Rother
9	Diversity networking between statutory and voluntary organisation	Rother Race Action Forum – aims to raise awareness, influence and develop race equality amongst statutory and voluntary agencies in Rother district. Black and minority ethnic forums for frontline staff in both Hastings and Rother are multidisciplinary and across agencies and sectors East Sussex Equality Co-ordination Group, ESCC Black and minority ethnic Health and Social Care Practitioners Group and Hastings Black and minority ethnic Practitioners Group
10	Training NHS staff on diversity and cultural issues	Now mandatory for community staff and NHS Hastings & Rother staff as part of the "Pacesetter" project. Training packs have been developed by CDW for Black and minority ethnic population. Also CDW for Black and minority ethnic population teaches on BSc Degree Nursing Course on health of asylum seekers which incorporates Transcultural nursing.
11	Free access to English classes (ESOL)	ESOL classes – occur at Links and HEMAS. as well as Eastbourne Cultural Communities Network

7.1 Sompriti

This is project based at South Downs Council for Voluntary Sector (CVS) in Lewes, Sussex. It covers all five local authority districts in East Sussex and has 18 staff (mainly part time) working on capacity building, addressing racial harassment, education and employment development. Sompriti has acted as a link between the CVS in East Sussex and the local Black and minority ethnic groups.

Sompriti led a three-year Home Office sponsored project, called Connecting Communities, across most of East Sussex. Fairly detailed work has been carried out with Black and minority ethnic people about their knowledge of health services available, access to these services and experience of using the services. As part of this work Sompriti provided a bilingual support service as a pilot to better support people in accessing primary and community health services. The project was extended into Connecting Communities Plus, an evaluation of which was published in May 2009[29]. The evaluation was provided as a thematic report of which the 18 main themes are given in the appendices. The health service specific endorsements of the benefits of joint working were with health visitors, namely:

1. Collaborative approach to support parental effectiveness – early years support

2. Empowering patients to self-manage their treatment programme for cost-savings and effectiveness
3. Raising awareness of GP entitlements for isolated, "invisible" Black and minority ethnic clients

7.2 Pacesetters

Pacesetters is a national initiative[30], led by the Equality & Human Rights group of the Department of Health (DH), to promote diversity & challenge discrimination. East Sussex is one of the pilot sites, where a Personal Adult Health Record (the Blue Book) for adult Gypsies and Travellers is being designed and implemented. The project steering group includes members of the Gypsy and Traveller communities along with equality and diversity and health professionals and a representative from the DH. Three local trusts are involved in implementing the health record, namely, NHS Hastings and Rother, Surrey and Borders Partnership Trust and East Kent Hospital Foundation Trust.

The programme aims to deliver equality and diversity improvements and innovations resulting in:

- Patient and user involvement in the delivery of services.
- Reduced health inequalities for patients and service users.
- Working environments that are fair and free of discrimination.

The project will be evaluated by the University of Sheffield and, if successful, will be implemented in England and Wales. NHS Hastings and Rother has a second project in progress with the following objective: *To raise awareness of the health needs of the Gypsy and Traveller population, across the whole health economy, to include Primary and Secondary Care, South East Coast Ambulance service, Accident and Emergency and community services, with community member participation from the outset.*

8. Stakeholder input

8.1 Methodology

It was requested that this assessment of the needs of Black and minority ethnic groups concentrate on the following groups:

- Asylum seekers
- Migrants workers
- Rural isolates
- Gypsies and Travellers
- Older people from ethnic groups

When assessing need it is important to hear from the people and services involved, as well as collecting statistics and research findings. Reaching the people in a limited timescale becomes the art of the possible; it depends on introductions, capitalising

on meetings already planned, meeting places, and a willingness of people to meet with the researchers. These findings cannot be construed as a representative sample – there is no knowing how many people have these concerns over how many services, or whether the issues are localised or generalised. However, they do reflect issues of concern that have been expressed by more than one person, and have been ascertained by professionals trained and experienced in qualitative research. The project succeeded in collecting qualitative information (what people see, feel, experience) from the sources below:

1. Focus group with Bengali women
2. Focus group with Bengali men
3. Meetings with staff and users at Links
4. Telephone interview with the PCT's Equality & Diversity Lead
5. Face to face interview with the PCT's lead on the health of Black and minority ethnic individuals, groups and (geographic) communities
6. Focus group with professionals held in Hastings
7. Focus group with professionals held in Eastbourne
8. Interviews with Travellers in Marsfield
9. Interviews with members of the public at a Hastings cultural event
10. Interviews with community leaders held at a Hastings cultural event
11. Telephone interview with a member of the Families, Friends and Travellers team

In addition recent relevant qualitative information collected by East Sussex professionals was taken into consideration including:

1. Interviews captured on DVD from Gypsies and Travellers produced in summer 2008.
2. Notes from a meeting with Gypsies and Travellers in Eastbourne held on 28th October 2009
3. Notes from a Black and minority ethnic forum meeting held on 5th November 2009.

Questions and Themes

As the key messages coming from professionals, community leaders and members of the public were broadly similar the researcher has clustered the results into themes. The key questions behind these themes are:

- What are the key issues facing the Black and minority ethnic communities in East Sussex?
- How do members of the Black and minority ethnic community know their rights and which services exist?
- Do they want to use the statutory services?
- Do they know how to make an appointment?
- Can they get to the appointment?
- If they can get to them can they make themselves understood when they get there?
- If they need referral to secondary services is the transition smooth?
- What documentation exists/needs to exist and how do the groups relate to it?
- Are there any specific issues relating to mental health?
- Are there any specific issues relating to older people?
- Are there any specific issues relating to vaccinations?

- Are there any specific issues relating to secondary care?
- Do Black and minority ethnic groups engage in health prevention/health promotion activities?
- Is prejudice / hate crime an issue?
- What exists to integrate community groups?
- How is strategy formed and cascaded?
- How are staff informed and organised?

8.2 What are the key issues facing the Black and Ethnic Minority communities?

All agree that there are many disparate groups rather than a few specific minority groups, and that often these groups are not visible to providers of health services. The exceptions are in places like St Leonard's, where the work of individuals or teams focuses on services for the marginalised.

In Hastings many Black and minority ethnic migrants are new to England, not just the area.

Some Black and minority ethnic people fear the locals and sense undertones of racism, especially toward Gypsies and Travellers. The far right political groups are active in Hastings, but have not won any elections.

Asylum Seekers that come to Hastings often have complex health issues, which are frequently exacerbated by poverty and social needs.

Some Asylum seekers are living rough.

Health used to know about the people arriving, but now can only find out about them via the Housing department if they have housing need, or via the National Asylum Support Service (NASS).

There are some services in Hasting and Rother specifically supporting Black and minority ethnic groups.

Hastings has 2 specialist Health Visitors and a nursery nurse who work with asylum seekers and homeless families. Hastings also has a health visitor who works with Gypsies and Travellers. Hastings has some targeted smoking cessation activities and some health trainers. However, this is not replicated across the county.

NHS Hasting & Rother is a 'Race for Health' PCT. It is also a 'Pacesetter' pilot area for Gypsies and Travellers. These initiatives will provide an opportunity for more targeted Black and minority ethnic support, however the learning from these will need to be applied across East Sussex.

In Eastbourne there are more settled Black and minority ethnic communities, but several professionals had stories that suggest certain groups are more hidden from statutory services, such as the Chinese. One example was a Chinese man coming forward with stomach pains who had no papers.

The recent Black and minority ethnic forum meeting in Eastbourne identified other members of the Chinese community not understanding how to access basic services such as education.

Eastbourne has a homeless team that deals with the Asylum Seekers, who are not housed by the National Asylum Support Service (NASS). The team includes Health Visitors and district nurses, and they assess risk.

Key issues affecting health, as perceived by community leaders and members of the public, are:

- Language barriers
- Lack of interpreters / not using existing interpreting services
- Difficulties in getting to appointments
- Transport issues
- Fear of being judged
- Overt and covert prejudice
- Lack of understanding of how the system works
- Time to ask questions of 'why' rather than just 'what'
- Lack of understanding of how the UK system fits with advice from birth country eg. how to make decisions about immunisations, how to live with recurring conditions like malaria

Professionals agree with the above issues, but included some additional factors:

- Gypsies and Travellers understanding of healthy eating, weaning, smoking and need for exercise.
- There are concerns about level of domestic violence in the Gypsy and Traveller community and the extent to which this is tolerated
- Bengali population's understanding the risks of poor diet, smoking and lack of exercise
- Lack of engagement by Black and minority ethnic groups in early years children's centres (except in St Leonard's)
- Poor engagement in and access to Mental Health Services
- The engagement of older people from the Black and minority ethnic community

8.3 How do members of the Black and Minority Ethnic community know their rights and which services exist?

Those community leaders and members of the public interviewed were by definition likely to be better informed than others.

They described finding out or telling others about services through:

- Friends and family
- Links Centre for Asylum Seekers in St Leonards
- The web
- A Bengali TV station
- The Interfaith Forum
- Cultural events such as 'Hastings Got Culture'
- An event held at the Jameah Islameah centre

Some community leaders see themselves as acting as volunteer advocates or be-frienders who informally request help.

A community leader from the Hastings Interfaith Forum could name a person from the County Council and the PCTs as key sources of information.

Asylum Seekers at Links referred to the Sexual Health Improvement Worker by name as one of the people who had informed many of them how to register with a GP, given them a map, and /or made phone calls on their behalf.

Four of the 8 people interviewed at Links did not know that they could receive NHS dental treatment.

Professionals also mentioned:

- There are a few simplified leaflets in existence but this needs further development
- Welcome packs, which are under development
- Women's Health day
- Increasing use of Health Trainers
- DVD produced by Travellers Education
- The role of the voluntary sector e.g. Family, Friends and Travellers, and Sompriti
- Specialist workers such as Gypsy and Traveller Health Visitors

8.4 Do Black and Minority Ethnic people want to use existing services and are they welcomed by existing services?

Black and minority ethnic members of the public who were interviewed did want to use existing services. However 2 of the 8 Asylum Seekers at Links reported difficulty registering with a GP. Once registered, however no-one reported difficulties getting appointments or the treatment they received from the doctor.

Some Gypsies have found it hard to find a GP willing to take them on. However, word spreads around the Gypsy community as to which GPs are sympathetic.

An example was given of a failed attempt to register at a practice in Eastbourne. When refused a place the Gypsy did not feel able to challenge nor was she aware of the process of temporary registration. Registration without ID proves difficult and stories were told of receptionists decisions overriding doctor's willingness to see people.

One story told by a professional was of a Gypsy mother who visited two GP surgeries with a baby who was clearly in severe pain and had a rash. Both practices sent the child away and it required a member of the Traveller Education Team to intervene and arrange for a Health Visitor to see the child where the family resided.

An Asylum Seeker mother with a daughter aged two years described taking her to A&E with diarrhoea and vomiting at 11.30pm. The mother reported that on arrival she felt that attitudes changed when she said she was an Asylum Seeker. She waited

in the public area for 2 hours before seeing a doctor. During this time, the child continued to vomit and no one helped her, not even with cleaning materials. The doctors who examined her child, did not discuss the outcome, but gave her a sealed letter to take to her GP. The mother spoke fluent English.

The DVD of Gypsy views showed the young woman interviewed saying she felt judged by statutory services and gave an example of where she had denied her Gypsy heritage in order to avoid stigma.

The Bengali women expressed a desire for some women-only services. They felt this was addressed by the NHS, but in the broader aspects of health, such as access to swimming and gyms it was not.

Some of the people interviewed commented that many front line staff are not culturally aware or lack sympathy to the particular needs of different groups. There was a feeling that the front line staff at agencies providing services come from the same population that the far right political groups have targeted, and that the cultural awareness and responsiveness of such staff is a key issue.

One Asylum Seekers told how he felt embarrassed by a receptionist shouting across the waiting room 'have you got your urine sample', and when he questioned her about this, she said that it was standard practice and not embarrassing.

Another described where a woman had been harassed by another member of the public, but the receptionist did nothing to challenge or calm the situation down.

8.5 Do people know how to make an appointment and can they get to them?

Choose and Book was seen to be a challenge for the Bengali women (eg how to chose, why to chose, where to chose). One of the women at the Women's Forum said that transport issues and work patterns meant that she could not attend her cervical screening test without taking a full-day off work.

There was some feeling by staff working with the Gypsy community that the concept of appointments was not in the Gypsy culture. The way of life is more about the here and now, so appointments are less likely to be kept, if something more pressing occurs in the meantime. (This insight may need to be linked to the greater use of A&E services by this group and the potential use of walk-in centres)

8.6 Language Issues

This was a major issue for both staff and members of the public. All were concerned about the apparent lack of use of interpreters. Very few non-professionals were aware of Language Line e.g. none of the women at the Bengali Women's Forum had heard of it. Most members of the Black and minority ethnic community reported being led to believe that they should provide their own interpreters.

The view of the professional interviewed at the focus group was that Language Line should be used for emergencies and that follow up appointments should include the option of an interpreter. Examples of good practice mentioned from neighbouring Brighton and Hove GP services included where the user rang a central number and booked their own interpreter.

There appeared to be confusion over who paid for interpreting services. Professionals interviewed at the focus group believed this was paid for centrally so that GPs had no financial reason to resist the service.

Examples were given where inappropriate community members were acting as interpreters, such as children. A Bengali male community leader reported accompanying separated Bengali women to the doctor to discuss issues of an intimate nature, because the GP would not provide an interpreter.

The need to be understood worked at many layers. Whether via a formal interpreter or a community member, it seemed that eventually people were understood enough to get some health care, but questions remain about the quality and timeliness of the diagnoses. And there were people who said things like, 'I can understand enough at the diabetes clinic to get by, but not enough to ask the questions that really worry me'.

One professional gave the example of a Portuguese woman who had tried on numerous occasions to explain to her GP that she was depressed. As the person relaying the story put it , 'Some cultures spend a long time going around the story before getting to the point and the GP had run out of time before the point was reached'.

A male who had suffered from malaria in the past believed that his GP put every ailment he had down to a possible recurrence of that malaria, before searching for other causes.

Both Bengali and the Iranian women spoke about professionals not explaining why their children should have certain vaccinations. They were especially concerned as the advice being given was at odds with advice from their birth country.

8.7 Transition to secondary care services

Some examples were given of Black and minority ethnic patients being referred to secondary care and then finding the same interpreter issues as in Primary care. An Iranian women working with the Multi Faith Forum found herself taking people to hospital appointments in her own car, in her own time, and using her own petrol, because people were afraid to go unaccompanied. News of her kindness had spread beyond her own community and others were approaching her for help. She now regards herself as an unpaid advocate.

Gypsies reported that they like to take in their own food to hospital and this is frowned on. Also traveller families feel it is important to visit as a group and many hospitals have a policy of only 2 people at a time.

Signage can be a problem. This was felt by 2 of the Gypsies interviewed to be confusing as they include long words and jargon. They would like more visual pictures.

More time to give explanations of what is wrong was a common theme by all groups. Many felt they were told what to do e.g. in terms of medication, but go home not really understanding what is wrong with them. Language becomes a key barrier to real understanding either because English is not the first language or because of jargon.

One Mixed race member of the public interviewed who had Aspergers syndrome was concerned that older patients were not given assistance with eating their meals in hospital.

8.8 What documentation exists/needs to exist and how do the groups relate to it?

While letters, leaflets and documentation can be off putting for some, certain items were perceived by the professionals to be treated with great care by patients. For example, the Red Book was treasured by many mothers in the Gypsy and Traveller community, who felt that it provided an easy way of communicating with professionals. The book is handed over to whoever sees the child without the mother having to answer questions that are often, for this group, better recorded. Professionals thought that the personalised nature of this book and the association with the birth made it important. This was compared with school learning records, which Travellers 'either seem to have loads of or none of'.

Another valued document was the 'Leave to Remain" that confirms the right of an Asylum Seeker to remain in the UK. The apparently psychological attachment to these documents may be worth understanding more fully when entering into projects such as Hand Held records.

8.9 Are there any specific issues relating to mental health?

Access to mental health service by Black and minority ethnic communities has been assisted by four workers (REMHS see para 6.3), funded with Department of Health money via the PCT to the county council. While the roles are intended to be strategic, there is scope for these workers to highlight vulnerable groups and undertake some short term work with them. An example of this is the running of community meetings with Bengali women in Crowborough. These women, many of whom do not drive, can get isolated because they are tied to the school day and their husbands are absent during the day.

There is no word for depression in some Black and minority ethnic languages, and it is widely accepted that some people are ashamed of disclosing the extent of their torment. The questionnaires used to get access to counselling and therapies require a high level of psychological disclosure, which many do not feel able to give at that stage.

Questions such as 'Do you feel suicidal?' are said by those supporting Black and minority ethnic groups to have the potential to be culturally unacceptable, and it is has been requested on previous occasions that these be removed.

8.10 Are there any specific issues relating to older people?

There is an Older People Worker in Health who commented that she has been finding it difficult to engage with older people from Black and minority ethnic communities. The 'lunch club' type activities are very White focussed. For example, her team leader is not aware of any place where older Afro-Caribbeans could readily relax or go to play dominoes. Age Concern were given some money to advocate for older people, but they do not appear to be collecting evidence of how and which Black and minority ethnic communities they are reaching.

Professional are concerned that there may be some cultural assumptions, which could be seen as excuse for lack of outreach e.g. 'Chinese people look after their own' and 'Gypsies want to keep to themselves'.

Discussion at the focus group suggested that while some elders may be expecting the younger generation to look out for them, this is becoming less likely as the younger generation get absorbed into local society and adopt English norms. There was also some discussion at the focus group about how to use the younger generation to gain access to the older generation. Creating links between school and older people services was one idea suggested, as was more use of family day events which draw in the whole community.

8.11 Are there any specific issues relating to vaccinations?

The Bengali women mentioned the fact that they were just sent appointment letters about vaccinations for their children with no explanation. One woman explained her disquiet at there being no opportunity to discuss fear or concerns about vaccinations.

The Iranian community leader said she felt that those coming to this country may have been part of a vaccination programme elsewhere, but that the GPs and nurses did not take this into account, and just wanted to start all over again, which was a cause of concern to mothers.

The Gypsy and Traveller Health Visitor said that the idea of booking appointments was not in the Gypsy culture, and that the most effective way of completing a vaccination programme was to do them when women take their children to the GP for other reasons.

8.12 Do Black and Minority Ethnic groups engage in health prevention / health promotion activities?

There was little evidence from either the professional or the community members themselves of active engagement in health promotion or health prevention activities.

The newly developed role of health trainers will hopefully improve this situation. These currently already exist in Hastings and are under development in Eastbourne. However there is not a countywide approach as yet.

In addition the community development workers in the race and mental health team have been focussing on health issues such as encouraging breast and cervical screening, and physical exercise at pools & gyms. These activities have to a large extent been focussed on women (e.g. Bengali) who are keen to have women only groups. At this stage, the consensus seems to be that it is very difficult to persuade many Black and minority ethnic men to limit smoking and exercise.

The Travellers interviewed as part of the need assessment were observed smoking through the meetings and their children appeared to be very overweight. Many felt that Travellers only asked for help when the need became very obvious, such as maternity services or extreme dental pain.

Gypsies & travellers interviewed confirmed that their culture doe not agree with sex education and sexual health being taught in schools. It also restricts to large degree the sharing of information relating to reproductive health between adult males and females. Thus, a Gypsy woman is far less likely to speak frankly to a male doctor. The DVD gave a very clear indication that the community chooses if, when and how to give sex education to girls. Breast and cervical screening were also topics of embarrassment. It is not clear how these views might impact on the take up of HPV injections.

Other groups, including a Japanese woman interviewed, shared the impression that people go for help when the need becomes more acute, rather than being informed about prevention, acting on such information, or presenting with early symptoms.

Cultural events seem to be an effective vehicle for engaging with community groups who may, once trust is established, be willing to enter into more health specific conversations.

Similarly, the meetings held by the community development workers and the availability of activities like Links appeared to build trust and encourage Black and minority ethnic communities to make better use of existing services. This has been achieved by a combination of:

- Meeting a range of social needs
- Multi-disciplinary co-operation and making a number of professionals more accessible
- Explaining how health services run and can be accessed.
- Help with filling in forms
- Telephoning to pave the way to registration and booking appointments

There is also strong encouragement to take up English classes.

8.13 Is prejudice or hate crime an issue?

There is some evidence of hate crime and prejudice. Examples were given of bus drivers refusing to drop off and pick up passengers at the Jameah Islameah Centre. Gypsies reported feeling that others look down on them, and mini-cabs refusing to go to a Traveller site, even when told the call was for a doctor's appointment.

The Japanese woman who was interviewed, had worked for a number of years as a hospital nurse, said 'If you speak English well, you are well treated. If you do not then even if English is your first language, you are treated like an outsider'.

8.14 What exists to integrate community groups?

A number of events and initiatives were described to encourage Black and minority ethnic community groups to engage with each other as well as with the rest of the population. Tables identifying Black and minority ethnic groups, practitioners working with them, and projects working with people from Black and minority ethnic communities are at Appendix 5.

8.15 How is Black and Minority Ethnic strategy formed and Cascaded?

Within the PCT the Black and minority ethnic agenda is influenced via the:

- Equalities & Diversity Officer
- PCT Equality and Diversity Steering Group
- Single Equality Scheme Policies
- Equality and Diversity Action Plan.

ESCC Adult Social Care (ASC) has 2 Service Development Managers - Equality (job share) who both work on health, social care and Black and minority ethnic issues. They manage an Equality Team which includes an Equality Officer (Community Engagement) who facilitates the Black and minority ethnic Health and Social Care Practitioners Group and 3 Black and minority ethnic Health and Social Care Forums for Black and minority ethnic people across East Sussex. The Team also includes the REMHS team and another Equality Officer who provides support for Equality Impact Assessments. The Equality Officer (Community Engagement) and his work are part of the outcomes of a 3 year government funded Black and minority ethnic Outreach and Engagement Project. The PCTs Public Health lead on Black and minority ethnic communities assists in the running of the Health and Social Care forum for professionals, and one for users.

The Steering Group for the Health Needs Assessment is made up from members of both the PCT and the County Council, but it is not clear how any recommendation from this group will feed into the PCT Diversity Steering Group or the ASC Equality and Diversity Steering Group. The relationship between the Steering Group of this project, the PCT Equality and Diversity Group and the Health and Social Care Forum for Professionals is also unclear. Absence of a clear decision pathway could make implementation of recommendations more difficult.

8.16 How are staff informed of strategic direction?

During interviews or focus groups with staff there were instances of staff feeling confused and/or disaffected by changes in policy and job roles. The removal of the Sexual Health Improvement Worker from Links, and the removal of the Health Visitor post from the Friends, Families and Traveller's (FFT) Team, appeared to those on the ground to be cuts in service with significant impact on health equity for Black and minority ethnic groups. Discussion across the health community showed that some of these decisions are part of a wider plan regarding the redistribution of resources, but the absence of a communications plan has left both users and staff disturbed. At focus groups, staff have expressed a belief that whilst there is some joined up working there is plenty of scope for more and a better spreading of good practice. Additionally they see the need for commissioners to hold providers, such as GPs and Age Concern, to account regarding issues such as interpreting, advocacy and equity.

8.17 Management issues identified

Observations from the researchers are that there seem to be lots of bits of good practice but they are not joined up. There is obviously some collaborative working between County Council and PCTs, but extensive opportunities for more synergy exist, for instance between the community development team and health trainers. Another example is the Gypsy and Travellers agenda, with multiple players from the statutory and voluntary sector, but no evidence of a joined up approach. There is an initiative bubbling to explore a cross East and West Sussex approach for Gypsies & Travellers that could be further explored.

There is a need to map how different working groups interlink, and where the governance is (responsibility, authority, performance), so that it is clear to clients, and statutory agencies delivering services. The County Council and PCTs could do more to demonstrate genuine partnership working for Black and minority ethnic people. Clarity is needed on how this health needs assessment will link to work on developing a (joint) strategy, and how the actions identified will be implemented.

There is plenty of anecdotal evidence that frontline staff are not diversity aware, especially in GP surgeries, and therefore not overtly welcoming of different groups.

Frontline workers have successfully built rapport with community groups. Their approach seems to have been:

- Step 1 Develop a relationship
- Step 2 Discuss non controversial issues such as ESOL and swimming
- Step 3 Discuss health issues such as dentistry and immunisations
- Step 4 Explore more challenging issues such as sexual and mental health

The researcher noted a general consensus from those consulted that what is required in East Sussex are trusted people linked to community groups, to encourage those groups to have the confidence to use services that already exist. The 'trusted people' could be any/all of the following:

- Community development workers
- Health trainers
- Advocates

Black and minority ethnic people, when they arrive in services, should then be greeted by staff trained to deal sensitively with their cultural needs, if full satisfaction is to be achieved.

9. Key Points & Recommendations

A comprehensive health needs assessment of Black and Minority Ethnic groups, including Gypsies and Travellers, was commissioned from PHAST by the East Sussex Downs & Weald and Hastings & Rother PCTs and East Sussex County Council, following on from the Joint Strategic Needs Assessment process and as part of the Race for Health Action Plan.

The principle groups on which they wished to concentrate were:

- Asylum seekers
- Migrants workers
- Rural isolates
- Gypsies and Travellers
- Older people from ethnic groups

The methodology used was the epidemiological healthcare needs assessment approach expounded by Stephens and Rafferty in www.hcna.bham.ac.uk/

The definition of race, ethnicity and the contribution of religion, faith or belief to the culture are blurred in the research literature. In this report the term "Black and Minority Ethnic" will usually include not only those who do not consider themselves White e.g. from South Asia, China, Africa, Caribbean, but also White Others such as Irish, Italian, or Polish who do not make up the majority of the population. "All White" is the term that will be used for White British, White Irish and White other groups added together, and in this context Black and minority ethnic will be the remainder. The term Black and minority ethnic will overlap with terms such as migrant workers, asylum seekers & refugees, and Gypsy and Travellers. Black and minority ethnic communities may be first, or a later, generation.

9.1 Population

- The most comprehensive profile of the population is from the Census 2001. However, this is unlikely to represent the current situation, as it does not incorporate subsequent migration or births. Therefore the 2007 experimental data produced by ONS is used as a best estimate of the current situation.
- The Census had a large number of ethnic categories from which people could self declare. These are aggregated into a smaller number of groups, especially where the numbers/percentage are relatively small in the total population. One such group is White, which is made up of White British, White Irish, and White Other. The numbers/percentage of Black and minority ethnic groups in a population can differ noticeably depending on whether White Irish and White Other are included or not.
- In 2007 the estimated number of Black and minority ethnic people (excluding the White Other group) is 25,600 (5.2% of total population), of which 31% are Asian or Asian British. If the White Other group is included in Black and minority ethnic figures the number increases to 45,700 (9.0% of total

population) of which 41% are White Irish and White other group. The different methods of calculation produce a difference in number of 19,200.

- If the number of Black and minority ethnic groups continues to increase in the same patterns as from 2001 to 2007 then it is estimated that the number of All Asian and Asian British, and Black and Black British, will more than double by 2015 and 2020.
- Black and minority ethnic people are widely dispersed geographically and co ethnically, ranging from 10% in Hasting and Eastbourne to 7.2% in Rother.
- Compared to the White population the Black and minority ethnic group has a younger age profile, with almost 70% aged under 60 years old.
- There is an annual School Census for pupils aged 5-16 years. This shows the highest number & percentage of pupils are from the Mixed ethnic group. A young Mixed ethnic group suggests stability of at least part of the population, inter-marriage and child bearing.

9.1.1 Migrants

- There is no single comprehensive system for collecting data on the movement of migrants to and from the UK. International migration to and from districts is estimated through the International Passengers Survey. All International migrants who intended to stay/leave for at least one year are included as international migrants.
- In East Sussex the net flow of migrants has decreased since 2004-05, except in Lewes where it has risen. This rise has not been matched by in-migrant registrations at GP practices serving Lewes.
- A total of 3,120 migrants were registered to work in East Sussex in 2007.
- The majority (1,050) of workers were registered to work in Eastbourne compared to just 320 in Rother.
- 66% of workers in East Sussex came from Europe, 47.1% being from EU Accession countries, 16% from EU not Accession countries and 3.2% from Non-EU countries. 34% workers in East Sussex came from non European countries from which 16% were from Asia.
- The majority (78%) of migrant workers in East Sussex are under 35 years. The biggest proportion of them are based in Eastbourne (35%) and only 9% in Rother.
- The NHS is one of the largest employers of migrants in the UK. According to the medical workforce survey 2004, 35.4 per cent of medical staff and 10.9 per cent of non-medical staff in the South East are from Black and minority ethnic groups, compared to 5.2 per cent of the working age population of the South East.
- Migrants (along with the majority of illegal migrants) make up a large proportion of the workforce in agriculture, construction and hospitality. These are traditionally industries with a large number of unskilled workers.

9.1.2 Asylum seekers, Refugees and Gypsy and Travellers

- There is incomplete knowledge of the number of asylum seekers, refugees and Gypsy and Travellers living in East Sussex at the current time. The East Sussex Travellers Strategy 2005 estimates the number as 1,000, with about 500 settled. The School Census of January 2009 recorded 180 Gypsy and Traveller

children aged 5-16 years. It is expected that estimates of population numbers for all these groups will be under estimates.

9.2 Deprivation

- Evidence suggests that the poorer socioeconomic position of Black and minority ethnic groups is the main factor driving their health inequalities. None of the dimensions of IMD 2007 relates deprivation specifically to ethnicity, but ethnic minority populations are known to live in highest concentrations in geographic areas with high deprivation scores, such as Hastings.
- In East Sussex in 2008, 6200 school children were eligible for free school meals, and of this 410 (6.6%) were from Black and minority ethnic groups (excluding the White Irish and White Other group). The highest eligibility for free school meals was found in the Black ethnic group at almost 22% of that population. There will be differences in distribution of eligibility across schools in the county. Rates of eligibility for free school meals were less than the average for England.

9.3 Ethnicity and health

- The health related needs of Black and minority ethnic groups can be described in terms of scale (absolute numbers), and relative differences to the general population. The Health Survey for England (HSE) 2004 found that overall, the main health problems of Black and minority ethnic groups are the same as the general population (coronary heart disease, stroke, cancers, and respiratory disease).
- Relatively, the conditions that affect Black and minority ethnic populations more than the general population are infectious diseases, diabetes, perinatal mortality, hypertension and stroke, cancers of the mouth, pharynx, liver, and prostate, haemoglobinopathies, and vitamin deficiency.
- The underlying risk factors for poorer health in Black and minority ethnic groups are the same as the general population. The lifestyle factors that are relatively more prevalent in Black and minority ethnic groups, according to HES 2004, are:
    - Smoking: higher prevalence in Bangladeshi
    - Obesity as per centrally distributed fat (waist to hips ratio): Pakistani men and Black Caribbean women
    - Physical exercise: Black and minority ethnic groups were less likely to meet the recommended levels of physical activity
    - Alcohol: intake was generally less in Black and minority ethnic groups
    - Fruit and vegetable consumption: generally higher in Black and minority ethnic groups

  There is some evidence that socio-economic factors determine lifestyle choices rather than ethnicity.
- Issues identified from the literature & relating to the uptake of health services are:
    - Understanding the role of General Medical Practice and the structures within the NHS for those people from countries that have either a fundamentally different healthcare structure, or very little health care at all.

- The cultural understanding of health issues, and culturally appropriate responses to them, may not be the same across Black and minority ethnic groups and the general population. Two examples are mental health, and sexual health.
- Asylum seekers, refugees, illegal immigrants, seasonal workers, and itinerant groups are more likely to have communication difficulties, whether due to language, education, or literacy.
- There is evidence that the use that is made of services by Black and minority ethnic groups fits into a coherent belief system, and comes from attitudes that can be more accepting of ill health than the general population.
- The attitudes of staff, their cultural awareness and perceptions can influence the experience of use of services by Black and minority ethnic groups. One example of an increasingly outdated assumption by service providers is the willingness of Black and minority ethnic families to act as primary carers for their older relatives.
- These factors are believed to explain much of the low uptake of services such as screening, not being registered with a GP, the 'inappropriate' attendance at A&E etc. But additionally there is evidence that people do not know what is available or how to access it, and if they did know they would use services.
- There is little or no evidence about ethnicity & health in rural areas. The 'rural idyll' effect may be offset by isolation, lack of choice of services and socio-economic disadvantage.
- Modelled estimates of the prevalence of CHD, Stroke (using hypertension as a proxy), diabetes, and respiratory disease (COPD), by major ethnic group up to 2020, are given in the Appendix 3.
- For each condition the prevalence is expected to rise up to 2020, and in all but COPD, the prevalence rates are higher than the England average across each ethnic group.

9.4 Services available & services used

- To assess the relative uptake of services between ethnic groups and the rest of the population, or whether the predicted health needs in ethnic groups are being adequately or equitably met, requires there to be comprehensive ethnicity coding on health service records.
- Ethnic coding in primary care is poor, but improving as new registrations are coded. This is a common problem across the country.
- Ethnic coding at hospital level is better than primary care, but suffers from a small numbers effect when separate conditions in separate ethnic groups are considered. If Black and minority ethnic rates of admission for elective procedures, and emergencies, are compared with the White population they are shown to be higher. This may reflect additional need, and/or lack of use of primary care services.
- Ethnic coding in mental health services is important in order to assess whether Black and minority ethnic groups are being seen, are being seen in the numbers expected and to identify if the pattern of diagnoses is different to the general population. It appears to be better in CAMHS than adult MH services.

- Sexual health services (GUM clinics) appear to have good ethnic coding and can look back at trends. However many East Sussex patients are treated out of county.
- NHS services are available to all Black and minority ethnic groups legally resident in the country. Practitioners and projects specifically for Black and minority ethnic groups are listed in the Appendix 5. Many are there for advocacy, befriending, signposting, and outreach. They are not distributed consistently across the county.

9.5 Good Practice

- Good practice has been identified from the research literature and compared with what exists locally. See Table 14.

9.6 Stakeholder input

- Stakeholder views were sought in a limited timescale and are not therefore a representative sample. This is also true of most other Participation or Engagement activities.
- Stakeholder views were obtained through a number of routes, namely focus groups, face to face or telephone interviews, attending meetings opportunistically, attending a cross cultural event.
- The issues emerging from discussion with staff, and Black and minority ethnic users of services, were similar so were recorded as themes.
- The attitudes, behaviours and experiences of Black and minority ethnic people interviewed in East Sussex match what would be expected from the research literature (see Ethnicity & Health Section).
- There is evidence that Black and minority ethnic people are willing to use existing services, but come with their own understanding of health and appropriate responses to ill health.
- Access if not made easy where there is a lack of knowledge about services, where services do not facilitate language difficulties being overcome, and where the attitudes of staff are off-putting (unwelcoming).
- Black and minority ethnic groups also report the same issues as the general population in terms of access to services, namely transport, and timing of appointments (eg resulting in time off work, or not taking child care into account).
- The themes emerging provide local support for the components of Good Practice in Table 14, and the PCT's Equality & Diversity Action Plans.

9.7 Key Points for the 5 specific groups on which the needs assessment was to focus.

The East Sussex Black and minority ethnic health needs assessment project was asked to look in particular at the following groups:

- Asylum seekers
- Migrants
- Gypsies & Travellers
- Older people from ethnic groups
- Rural isolates

This could only happen effectively if there was data and research available by these categories, and if access to these groups (for qualitative research) could be made available in the timescales. There is research available for all groups except 'Rural

isolates' that guides what might be expected to happen locally. Data however is limited, and tends to be recorded by ethnic groups (White, Black, Asian etc), although Gypsies & Travellers are not one of the groups recorded. The qualitative aspects of the project managed to hear mostly from or about asylum seekers, or Gypsies & Travellers.

The following are key points elicited from this project that refer specifically to the 5 categories above in East Sussex, (or are expected to).

9.7.1 Asylum seekers

- Asylum seeker numbers are not known but estimates range between 100 - 200 in East Sussex. Their number may be subsumed in figures for Migrants.
- Asylum seekers is not a field in GP ethnic recording systems
- Two specialist health visitors & a nursery nurse work with asylum seekers in Hastings, where complex health needs, poverty, and social needs are reported in this group, as well as some of them sleeping rough.
- A health visitor and district nurse and the homeless team work with asylum seekers in Eastbourne who have not been housed by NASS.
- There are reports of difficulty registering with GPs, and poor attitudes to asylum seekers in some general practices and A&E.
- The Leave to Remain documents are 'treasured' by asylum seekers.

9.7.2 Migrants

- Migrant numbers are calculated from the International Passenger Survey, GP registrations, National Insurance Numbers (NINos) registration, and by ONS in 'non-UK born' statistics. Two of these measures do not count outward migration or onward movement.
- From 2001 – 08 Lewes has had a net inflow of migrants, unlike the remainder of the local authorities in East Sussex who experienced a net outflow from 2004-05.
- GP in-migrant registrations for Lewes do not reflect this net inflow of migrants.
- NINos registrations indicate not only numbers of migrants but also their age, where they work/live, and where they come from. It is probably the best way of estimating migration from the EU Accession countries.
- No figures reliably pick up illegal or temporary immigrants.
- The SEEDA report on 'Migrant Workers in the SE Regional Economy 2008' records that only 55% are registered with a GP, and that they use A&E services disproportionately.
- The HPA report 'Migrant Health 2006' records them (nationally) as being mostly young, having similar health needs to UK peers except for infections, where TB, HIV and Chronic hepatitis B rates can be higher.
- Comparing EU data for Accession states with UK data suggests that EU Accession country migrants would have smoking cessation, teenage pregnancy prevention, and mental health needs.

9.7.3 Gypsies & Travellers

- Numbers of Gypsies & Travellers are difficult to estimate, not least because of their nomadic lifestyle. The East Sussex County Council Gypsy and Traveller Strategy of 2005 estimates the numbers as 1000, with 500 of them settled.
- The annual Schools Census allows for more up to date data on those children aged 5-16years, who are in education and admit to being a Gypsy or Traveller. The School Census of January 2009 gave the total as 180.
- The research suggests that Gypsies & Travellers have poorer health than other UK residents (even those who are disadvantaged), suffering from chronic diseases (eg of heart and lung), and having maternal & child health problems.
- These poorer health outcomes may be related to lifestyle, attitudes (to life, health, services), and literacy, as well as the flexibility and sensitivity of services. Evidence shows that service use reflects coherent cultural attitudes, beliefs and behaviours.
- It is particularly important for services to be aware that sexual health, sex education in schools, and the importance of lifestyle are areas where Gypsies & Travellers have a different viewpoint to the mainstream.
- The qualitative aspects of this needs assessment found reports of:
    - GPs/receptionists refusing registration to Gypsies & Travellers
    - The 'here & now' way of living of Gypsies & Travellers not fitting with the planned appointments system used by services
    - The culture of feeding ones own and visiting en masse not fitting with hospital in-patient systems.
    - Taxis refusing to pick them up from their sites
    - The Red Book for children being much appreciated
- A specialist health visitor service for Gypsies & Travellers is available in Hastings.

9.7.4 Older People from ethnic groups

- The 2007 experimental figures from ONS estimate the percentage of over 65 people in East Sussex from ethnic groups as 8%, compared with 17% White. It is expected that the proportion of older people in Black and minority ethnic groups will increase over the next 10-15 years.
- The report 'Older People in East Sussex: an epidemiological health needs assessment' concluded that Black and minority ethnic older people had worse health than the White majority. They put this down to relative socioeconomic deprivation, a higher prevalence of risk factors, and inequalities in access to healthcare.
- The qualitative aspects of this needs assessment found comments that there were not enough social activities for older people from Black and minority ethnic groups, for instance, the luncheon clubs were said to be White focused.
- Discussion in the Black and minority ethnic groups visited recognised that older people from Black and minority ethnic groups were less likely to be looked after by their own (even if they expected to be) as the young were increasingly assimilated into local society and adopted English norms.

9.7.5 Rural isolates

- Numbers of people from Black and minority ethnic groups who live in rural areas is difficult to predict accurately such a long time after the Census.
- If they do live in rural areas it would be reasonable to believe that stigma, isolation, lack of access or choice of services would be felt by them at least as much as White rural dwellers.
- Research would suggest that Black and minority ethnic people feature disproportionately in low socioeconomic groups, which is a reason to believe they could suffer rural deprivation when living in rural areas.

9.7.6 Conclusion

The findings for the 5 categories above do not alter the Recommendations of the report, but should be taken into account when tailoring the implementation of it for the 5 groups.

9.8 Recommendations

During the research for this needs assessment it was evident to researchers that, although there was much good work to build on, there was room for improvement in joint working. Managers and workers were not fully aware of what initiatives their partners had, or what services were being provided. This applies from the highest level (having joint strategies across the statutory sector, being clear about lines of responsibility, accountability & performance monitoring) to grass roots (eg not duplicating production of Welcome Packs). Success at improving joint working is a function of leadership.

The following are more detailed recommendations. Where 'Black and minority ethnic' is used below the recommendations apply equally to Gypsies & Travellers:

1. Agree joint approaches to working with Black and minority ethnic communities by the NHS and Social Care agencies.
2. Develop further the Black and minority ethnic network(s) to bring practitioners (health, social care, third sector) together to share experiences and practice, and to change practice or service delivery as a result of what they have heard from Black and minority ethnic people. The networks could develop as 'communities of interest'.
3. Investigate the disparity between GP registration of in-migrants and the net inflow of migrants since 2004-05. Use the learning from this to improve GP registration by people who are migrants (long and short term).
4. Identify mechanisms to improve access to primary care for Black and minority ethnic groups e.g. the 4 Step process of paragraph 8.17. This is likely to require outreach &/or advocacy workers.
5. Ensure universal and comprehensive equality and diversity training, particularly regarding cultural issues where there are sensitivities (eg mental health, sexual health), and where literacy or poor comprehension are the problem. Measure how the training has resulted in better experience of frontline services by Black and minority ethnic groups.
6. Research would suggest that a coherent belief system underlies the choices that people from minority ethnic groups make in relation to use of services. Ensure that training engenders respect for these different beliefs, and helps

practitioners realise that their services are 'hard to reach' for some people (rather than it being the people who are 'hard to reach').
7. Improve data recording of ethnicity in primary care and link this to performance reward mechanisms e.g. QOF
8. Improve data recording of ethnicity in all commissioned services e.g. by incorporating into contractual frameworks, and performance monitor them.
9. Review categories for data collection in the light of local population profile e.g. explore whether 'White Other' can be disaggregated in local systems.
10. Improve knowledge and skills in appropriate use and access to language and translation services for all frontline professionals, monitor the change in use of services, and measure the satisfaction of Black and minority ethnic people with the improved access.
11. Ensure equity in provision of language and translation services between directly provided and commissioned services e.g. access to Language Line.
12. Recognise that the major health and lifestyle issues for Black and minority ethnic people are the same as the rest of the population, although their cultural, religious, and life-choices (eg nomadic) may mean that the priorities they give to accessing services, and the meaning they give to ill health, are not the same. Tailor services accordingly rather than providing a one-size fits all.
13. Ensure that a system is built to store and share the rich seam of qualitative findings from staff working with ethnic minority communities (as demonstrated in this needs assessment), so that it is widely available for use in commissioning and service design.
14. Work with local Black and minority ethnic communities to identify ways of improving access to and take up of healthy lifestyle services and messages. This will include providing information about services in a place, time, and manner that they find helpful.
15. Explore the use of peer education approaches to improving health outcomes for Black and minority ethnic communities.
16. Ensure the specific needs of Black and minority ethnic groups are considered in the development and provision of services for key disease areas e.g. diabetes, and monitor that they are accessed and delivered accordingly.
17. Identify ways in which knowledge of the range of health and social care services available and how to access these can be improved, in particular for new residents, and temporary migrants. This may be by providing 'Welcome Packs', and using community venues as outlets for information, whilst all the time being aware of literacy and communication (eg sensory, learning difficulty) issues.
18. Communicate any action plans resulting from this needs assessment to partners and participants, to enable people to understand how their input has contributed to improvement, and to enable them to hold statutory services to account for implementation.
19. Work with Black and minority ethnic communities and other local partners, e.g. adult education to improve access to opportunities to develop English language skills for speakers of other languages.

An additional means of presenting the recommendations is given in Appendix 6. It cross references the relevant parts of the PCTs' Equality & Diversity Action Plan, the Good Practice identified from the literature (Table 14) with the recommendations falling out of this needs assessment. There is a good deal of common ground and it

is hoped that this will make acting upon the needs assessment more likely, and simpler.

As this work was progressing it became clear that there were several other pieces of work that could usefully add to the picture of health of Black and minority ethnic groups. These include:

- Creating a database of all initiatives, organisations, services, and policies for Black and minority ethnic groups by geographic area in East Sussex.
- Ensure the Maternity Services needs assessment adequately covers the issues relating to ethnic minority mothers (eg EU Accession country migrants, asylum seekers, people with nomadic lifestyles).
- Investigate the use of A&E services by ethnic minority peoples. Are they using them disproportionately, and if so, why?
- Plan a health equity audit for Black and minority ethnic groups once the ethnicity recording is improved.
- Explore the potential benefits of a joint East & West Sussex approach to Gypsies & Travellers since the travel paths appears to cover both counties.

Appendices

Appendix 1: Data appendix

Table 1: Number and percentage of ethnic groups by Local authorities, Census 2001, ONS

Ethnic groups	White British		Black and Minority Ethnic		Black and Minority Ethnic, White Irish and White other	
	Number	Percentage	Number	Percentage	Number	Percentage
Hastings	80,000	94.0	2,500	2.9	5,100	6.0
Rother	81,300	95.4	1,600	1.9	3,900	4.6
Eastbourne	83,000	92.5	2,900	3.2	6,700	7.5
Lewes	87,700	95.2	1,900	2.1	4,400	4.8
Wealden	133,400	95.2	2,300	1.6	6,700	4.8
East Sussex	465,500	94.4	12,000	2.4	27,600	5.6
South East	7,315,900	91.2	400,200	5.0	707,400	8.8
England	42,925,800	86.8	4,552,800	9.2	6,523,900	13.2

Table 2: Number and percentage of ethnic groups by Local authorities, experimental 2007, ONS

Ethnic groups	White British		Black and Minority Ethnic		Black and Minority Ethnic inc White Irish and White other	
	Number	Percentage	Number	Percentage	Number	Percentage
Hastings	77,300	89.7	5,200	6.0	8,600	10.0
Rother	81,400	92.3	3,500	4.0	6,400	7.3
Eastbourne	85,400	89.3	5,900	6.2	9,900	10.4
Lewes	86,300	91.3	4,600	4.9	8,100	8.6
Wealden	132,200	91.9	6,100	4.2	11,500	8.0
East Sussex	462,600	91.0	26,500	5.2	45,700	9.0
South East	7,246,600	87.2	661,200	8.0	1,062,300	12.8
England	4,273,6100	83.6	6,009,100	11.8	8,355,900	16.4

Supplied by ESiF

Table 3: Number and percentage of All White and Black and Minority Ethnic, by age groups, experimental 2007, ONS

			Persons 0-15	Persons 16-64/59	Persons 65/60+
All White		**Num**	84500	265900	131400
	East Sussex	%	92.6	93.8	98.4
		Num	1421000	4639400	1587300
	South East	%	89.7	91.0	97.5
		Num	8133700	27704400	9244800
	England	%	84.2	87.1	95.9
BME		**Num**	6800	17500	2200
	East Sussex	%	7.4	6.2	1.6
		Num	163600	456300	41100
	South East	%	10.3	9.0	2.5
		Num	1522100	4087300	399700
	England	%	15.8	12.9	4.1

Supplied by: ESiF

Table 4: International migrants to and from East Sussex, 2001-2008 by local authority

Year	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08
Eastbourne	-150	320	220	370	-110	-400	-270
Hastings	300	280	80	130	-190	-300	-370
Lewes	-370	-360	-190	-60	-140	50	130
Rother	-310	40	40	60	-280	-400	-290
Wealden	-240	330	380	450	-240	-630	-330
East Sussex	-770	610	530	930	-960	-1,670	-1,130
South East	4,970	19,930	16,790	32,540	15,710	20,110	22,660
England & Wales	155,070	151,020	173,160	251,190	167,410	173,400	174,160

Supplied by: ESiF

Table 5: International in-migrant GP registrations, 2000-2008 by local authority

	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08
Eastbourne	730	762	1,033	1,069	1,079	988	1,040	1,079
Hastings	538	477	672	530	757	572	603	542
Lewes	409	393	408	359	391	368	469	443
Rother	299	415	457	416	360	728	368	430
Wealden	816	695	901	809	725	768	788	802
East Sussex	2,792	2,742	3,471	3,183	3,312	3,424	3,268	3,296
South East	62,950	66,088	70,946	73,284	80,437	86,758	90,570	90,812
England & Wales	406,775	429,752	456,757	473,409	534,995	567,474	598,841	605,676

Supplied by: ESiF

Table 6: Numbers and percentage of National Insurance registrations by broad nationality, 2007. Supplied by ESiF

	Europe		Africa		Asia		Middle East		Australasia and Oceani		America	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Hastings	390	62.9	20	3.2	110	17.7	20	3.2	10	1.6	20	3.2
Rother	190	59.4	10	3.1	40	12.5	0	0	10	3.1	0	0
Eastbourne	790	75.2	40	3.8	130	12.4	10	1	10	1	20	1.9
Lewes	320	59.3	10	1.9	130	24.1	0	0	20	3.7	30	5.6
Wealden	370	62.7	30	5.1	90	15.3	10	1.7	10	1.7	30	5.1
East Sussex	2060	66	110	3.5	500	16	40	1.3	60	1.9	100	3.2
South East	58180	62.4	7760	8.3	19000	20.4	760	0.8	3320	3.6	4150	4.5
England	423260	61.1	58570	8.5	138750	20	8290	1.2	31890	4.6	31030	4.5

Table 7: Percentage of National Insurance registrations by nationalities, 2007

Nationality	EU excluding accession countries	EU accession countries	Non-EU countries	South Africa	Rest of Africa	India	Pakistan	Philippines	Rest of Asia	USA	Canada	Brazil	Colombia
Hastings	8.1	50	4.8	1.6	1.6	3.2	0	4.8	9.7	0	1.6	0	1.6
Rother	9.4	50	0	3.1	0	3.1	0	6.2	3.1	0	0	0	0
Eastbourne	21	50.5	3.8	1.9	1.9	1.9	0	2.9	7.6	1	0	1	0
Lewes	16.7	40.7	1.9	1.9	0	13	1.9	3.7	5.6	3.7	1.9	0	0
Wealden	18.6	42.4	1.7	3.4	1.7	3.4	0	3.4	8.5	1.7	1.7	1.7	0
East Sussex	16	47.1	2.9	2.2	1.3	4.5	0.3	3.8	7.4	1.3	1	0.6	0.3
South East	14.3	46	2.2	2.9	5.4	6.2	2.7	1.6	9.9	1.7	0.8	0.7	0.2
England	14.5	44.3	2.3	1.9	6.5	6.9	3.8	1.1	8.3	1.5	0.7	0.8	0.4

Table 8: Numbers and percentage of National Insurance registrations by age groups, 2007

Age group	0-18		18-24		25-34		35-44		45-54		55-59		60+	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Hastings	10	1.6	220	35.5	220	35.5	90	14.5	60	9.7	0	0	0	0
Rother	0	0	110	34.4	120	37.5	60	18.8	20	6.2	10	3.1	0	0
Eastbourne	20	1.9	450	42.9	400	38.1	120	11.4	50	4.8	10	1	0	0
Lewes	0	0	220	40.7	210	38.9	50	9.3	40	7.4	10	1.9	10	1.9
Wealden	10	1.7	220	37.3	220	37.3	90	15.3	40	6.8	10	1.7	0	0
East Sussex	40	1.3	1220	39.1	1170	37.5	410	13.1	210	6.7	40	1.3	10	0.3
South East	1370	1.5	35360	37.9	38150	40.9	11510	12.3	5510	5.9	930	1	420	0.5
England	7930	1.1	260620	37.6	297220	42.9	82500	11.9	36270	5.2	5670	0.8	2530	0.4

Supplied by: ESiF

Table 9: UK and non-UK country of birth, 2007

Country of birth	UK country of birth		Non-UK country of birth	
	Number	%	Number	%
Hastings	80000	95.2	5000	6.0
Rother	80000	93.0	5000	5.8
Eastbourne	87000	92.6	7000	7.4
Lewes	87000	93.5	5000	5.4
Wealden	137000	96.5	5000	3.5
East Sussex	471000	94.4	27000	5.4
South East	7381000	90.4	787000	9.6
England	44524000	88.3	5874000	11.7

Table 10 and 11 over show the calculation of a number of health indicators for EU Accession countries relative to the UK.

They show that the Migrants from EU Accession countries are more likely to have the following health needs compare to the UK.

- Higher smoking prevalence
- Higher teenage pregnancy
- Mental health needs for both genders (considerably high suicide rate for both genders)

Table 10. Comparison of rates of health and lifestyle indicators across EU Accession countries and UK

	UK	Bulgaria	Czech Republic	Estonia	Hungary	Latvia	Lithuania	Poland	Romania	Slovak Republic	Slovenia
Alcohol consumption **Source:** OECD Health Data 2005	11.2 l per capita (2005)		12.1 l per capita (2005)		13.4 l per capita (2005)			8.1 l per capita (2005)		7.6 l per capita (2005)	
Daily smokers **Source:** World Health Organization	26%		24.1%		33.8%			27.6%		24.3%	
Obesity **Source:** UNICEF (United Nations Children's Fund). 2002.	23% (2002)		14.8% (2002)		18.8% (2002)					22.4% (2002)	
Breast Cancer incidence **Source:** OECD	26 per 100,000		22.2 per 100,000		26.2 per 100,000			17.9 per 100,000		19.2 per 100,000	
Age of woman at first child **Source:** CIA World Factbook, December 2003	29.1 years old		24.9 years old		25.1 years old			24.5 years old		24.2 years old	
Maternal mortality **Source:** All CIA World Factbooks 18 December 2003 to 18 December 2008	7 per 100,000	15 per 100,000	9 per 100,000	50 per 100,000	15 per 100,000	45 per 100,000	18 per 100,000	8 per 100,000	42 per 100,000	9 per 100,000	11 per 100,000
Suicide rate Female **Source:** World Bank. 2002. World Development Indicators 2002.	3.3 per 100,000 (2002)	9.7 per 100,000 (2002)	9.5 per 100,000 (2002)	14.2 per 100,000 (2002)	16.8 per 100,000 (2002)	14.1 per 100,000 (2002)	13.4 per 100,000 (2002)	4.5 per 100,000 (2002)	4.9 per 100,000 (2002)	12.6 per 100,000 (2002)	1.6 per 100,000 (2002)
Suicide rate Male **Source:** World Bank. 2002.	11 per 100,000 (2002)	25.3 per 100,000 (2002)	28.1 per 100,000 (2002)	64.6 per 100,000 (2002)	55.5 per 100,000 (2002)	71.4 per 100,000 (2002)	81.9 per 100,000 (2002)	24.7 per 100,000 (2002)	18.5 per 100,000 (2002)	45.1 per 100,000 (2002)	6.6 per 100,000 (2002)

World Development Indicators 2002.											
Teen birth rate **Source:** Annual figures:WHO databank, National Bureaux of Statistics	33	59	46	34	41	35	32	28	41	30	12
Amphetamine use **Source:** Wikipedia: Happy Planet Index	3%		0.32%		0.03%			0.3%			
Cannabis use **Source:** OECD	9%		3.6%		1.19%			3.38%			
Infant mortality rate per 1000 live births **Source:** World Development Indicators database	5 per 1,000 live births	12 per 1,000 per live births	3 per 1,000 live births	6 per 1,000 live births	7 per 1,000 live births	9 per 1,000 live births	7 per 1,000 live births	6 per 1,000 live births	16 per 1,000 live births	7 per 1,000 live births	3 per 1,000 live births
Incidence of Tuberculosis http://www.nationmaster.com		39.9 per 100,000 (2005)	10.37 per 100,000 (2005)	42.7 per 100,000 (2005)	21.6 per 100,000 (2005)	62.6 per 100,000 (2005)	62.5 per 100,000 (2005)	26 per 100,000 (2005)	134.2 per 100,000 (2005)	17.1 per 100,000 (2005)	14.6 per 100,000 (2005)
Tobacco Total adult smokers **Source:** World Health Organization		36.5		32	35.5	31	33.4	34.5	43.5	42.6	25.2

Source: http://www.nationmaster.com

Table 11. Comparison of Average EU Accession country health indicators with the UK.

	UK	Average EU Accession countries
Alcohol consumption **Source:** OECD Health Data 2005	11.2 l per capita (2005)	10.3
Daily smokers **Source:** World Health Organization	26%	27.5
Obesity **Source:** UNICEF (United Nations Children's Fund). 2002.	23% (2002)	14.9
Breast Cancer incidence **Source:** OECD	26 per 100,000	21.4
Age of woman at first child **Source:** CIA World Factbook, December 2003	29.1 years old	24.7
Maternal mortality **Source:** All CIA World Factbooks 18 December 2003 to 18 December 2008	7 per 100,000	22.2
Suicide rate Female **Source:** World Bank. 2002. World Development Indicators 2002.	3.3 per 100,000 (2002)	10.1
Suicide rate Male **Source:** World Bank. 2002. World Development Indicators 2002.	11 per 100,000 (2002)	42.2
Teen birth rate **Source:** annual figures:WHO databank, National Bureaux of Statistics	33	35.8
Amphetamine use **Source:** Wikipedia: Happy Planet Index	3%	0.2
Cannabis use **Source:** OECD	9%	2.7

Infant mortality rate per 1000 live births **Source:** World Development Indicators database	5 per 1,000 live births	7.6
Incidence of Tuberculosis http://www.nationmaster.com		43.2
Tobacco Total adult smokers **Source:** World Health Organization		34.9

Source: http://www.nationmaster.com

Appendix 2: Modelled estimates of disease prevalence by ethnic group

Cardiovascular disease:

Table 10. shows the estimates and projections of the prevalence of CHD in people aged 16+ that have been calculated using a model developed at the Department of Primary Care and Social Medicine, Imperial College, London. The model takes into account age, sex, ethnicity, smoking status and deprivation score. It predicts that the prevalence of CHD will increase over the years to 2020 in all ethnic groups in East Sussex. The highest prevalence of CHD is amongst White followed by Asian and Black groups in both Hastings and Rother and East Sussex Downs and Weald PCT's. Both PCT's are predicted to have a higher prevalence of CHD than the England average.

Table 10: Modelled estimates and projections of prevalence of CHD for PCTs in East Sussex. Source: APHO

		2009		2010		2015		2020	
		Number	Prevalence	Number	Prevalence	Number	Prevalence	Number	Prevalence
Hastings and Rother	White	18514	6.9%	18779	7.0%	20773	7.4%	22937	7.8%
	Mixed	35	1.6%	35	1.6%	38	1.7%	41	1.8%
	Black	50	2.0%	51	2.0%	56	2.2%	60	2.3%
	Asian	170	4.5%	173	4.5%	190	4.8%	205	5.1%
	Other	40	1.2%	40	1.2%	44	1.3%	47	1.4%
East Sussex Downs and Weald	White	11557	8.2%	11721	8.3%	12842	8.7%	14065	9.2%
	Mixed	27	2.0%	27	2.0%	30	2.1%	32	2.3%
	Black	47	2.5%	48	2.5%	52	2.7%	55	2.9%
	Asian	115	5.4%	116	5.5%	126	5.8%	135	6.2%
	Other	20	1.6%	20	1.6%	22	1.7%	23	1.8%
England	White	2248608	5.9%	2280319	6.0%	2485223	6.3%	2706478	6.6%
	Mixed	5616	1.2%	5679	1.2%	6069	1.3%	6502	1.4%
	Black	23506	2.1%	23712	2.1%	25235	2.2%	26845	2.3%
	Asian	85179	4.0%	86067	4.0%	91766	4.1%	97793	4.3%
	Other	6992	1.1%	7073	1.1%	7539	1.1%	8063	1.2%

Diabetes

Using the PBS diabetes prevalence model (Yorkshire and Humber Public Health Observatory) it has been estimated that in East Sussex Downs and Weald PCT and Hastings and Rother PCT the prevalence of Diabetes (Type 1 and Type 2) is highest in Asian followed by Black groups. Also both of the PCT's have higher overall prevalence of diabetes in each of the Black and Minority Ethnic groups compared to the England average.

Table 11: Estimated prevalence of Type 1 and Type 2 diabetes (diagnosed + undiagnosed), 2005. Source APHO.

	White		Black		Asian		Other	
	Number	Prev.	Number	Prev.	Number	Prev.	Number	Prev.
East Sussex Downs and Weald	860	5.10	1084	6.43	1379	8.18	386	2.29
Hastings and Rother	543	5.53	714	7.27	903	9.20	242	2.46
England	97966	4.33	134618	5.95	156790	6.93	45928	2.03

Stroke - hypertension

The HSE 2004 found the rates of stroke highest in African Caribbean populations, and relatively high in Chinese and South Asian populations. The major known associated risk factor is high blood pressure (hypertension), which is very common in African Caribbean populations. Hypertension is used below as a proxy for stroke.

Table 12 shows the estimates and projections of the prevalence of hypertension in people aged 16+ that have been calculated using a model developed at the Department of Primary Care and Social Medicine, Imperial College, London. The prevalence of the hypertension is predicted to increase over the years. The White group has the highest prevalence of hypertension followed by Black and Asian groups in each of the years, and both PCTs are forecast to have a prevalence of hypertension that is higher than the England average.

Table 12: Modelled estimates of prevalence of hypertension in East Sussex

		2009		2010		2015		2020	
		Number	Prevalence	Number	Prevalence	Number	Prevalence	Number	Prevalence
Hastings and Rother	White	53151	37.8%	53712	38.0%	57604	39.2%	61569	40.4%
	Mixed	266	19.5%	269	19.6%	281	20.2%	292	21.1%
	Black	620	33.2%	625	33.3%	650	34.3%	669	35.0%
	Asian	537	25.5%	542	25.6%	571	26.4%	592	27.1%
	Other	267	21.2%	269	21.3%	281	21.7%	290	22.2%
East Sussex Downs and Weald	White	98315	36.9%	99621	37.0%	107699	38.2%	116158	39.5%
	Mixed	402	18.1%	406	18.2%	427	18.8%	447	19.5%
	Black	782	31.0%	790	31.2%	827	32.2%	857	32.9%
	Asian	907	23.9%	919	24.0%	976	24.8%	1023	25.5%
	Other	632	19.1%	640	19.2%	671	19.7%	699	20.2%
England	White	11895916	31.5%	12038301	31.6%	12857351	32.4%	13703118	33.4%
	Mixed	67527	14.5%	68179	14.6%	71206	15.0%	74078	15.4%
	Black	315192	28.6%	318068	28.7%	332526	29.3%	346051	29.8%
	Asian	443461	20.6%	447963	20.7%	470740	21.1%	491033	21.6%
	Other	106823	16.6%	108069	16.7%	113615	16.9%	118532	17.3%

Respiratory diseases - COPD

These tend to get little attention. The mortality and morbidity from these diseases is usually slightly less than in the white population.

Table 13 shows the estimates and projections of the prevalence of COPD for Hastings and Rother and East Sussex Downs and Weald PCTs' and England, based on a model developed by Nacul & Soljak

Table 13: Estimated prevalence of COPD by sex, by broad ethnic group and by age band for 2005 – 2020. Source APHO.

		2009		2010		2015		2020	
		Number	Prevalence	Number	Prevalence	Number	Prevalence	Number	Prevalence
Hastings and Rother	White	9301	3.4%	9426	3.4%	10277	3.6%	11203	3.7%
	Black	73	2.9%	74	2.9%	78	3.0%	82	3.1%
	Asian	74	2.0%	75	2.0%	81	2.1%	86	2.1%
East Sussex Downs	White	5801	4.1%	5880	4.1%	6349	4.2%	6862	4.4%
	Black	67	3.6%	67	3.6%	71	3.7%	74	3.9%
	Asian	47	2.2%	48	2.3%	51	2.4%	54	2.4%
England	White	1454885	3.7%	1471524	3.8%	1570793	3.9%	1680418	4.0%
	Black	46930	4.3%	47284	4.3%	49281	4.3%	51428	4.4%
	Asian	51039	2.4%	51511	2.4%	54049	2.4%	56623	2.5%

Appendix 3: Hospital Episode Statistics

All admissions between 1st April 2006 and 31st March 2009 for residents of ESDW or H&R PCT

In this table are listed providers with over 1000 admissions. The coding of ethnicity varies between them 0% in Private healthcare provider to 100% Sussex Partnership Trust.

Table 14: Number and percentage of all admissions between 1st April 2006 and 31st March 2009 for residents of ESDW or H&R PCT

Provider Name	Total admissions	Number of admissions coded	Percentage of admissions coded	Blank or invalid or not stated	Percentage of blank or invalid or not stated
EAST SUSSEX HOSPITALS NHS TRUST	195,925	168,244	**86**	27,681	**14**
BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST	42,398	36,572	**86**	5,826	**14**
MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	16,261	11,129	**68**	5,132	**32**
QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST	5,151	4,681	**91**	470	**9**
EAST SUSSEX DOWNS AND WEALD PCT	2,759	2,500	**91**	259	**9**
OTHER PRIVATE HEALTHCARE PROVIDERS	2,575	0	**0**	2,575	**100**
SUSSEX PARTNERSHIP NHS TRUST	2,559	2,548	**100**	11	**0**
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	2,246	1,339	**60**	907	**40**
THE HORDER CENTRE CROWBOROUGH (NON-NHS)	2,165	701	**32**	1,464	**68**
THE ROYAL MARSDEN NHS FOUNDATION TRUST	1,852	1,803	**97**	49	**3**
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	1,589	1,222	**77**	367	**23**
HASTINGS AND ROTHER PCT	1,197	928	**78**	269	**22**
SUSSEX ORTHOPAEDIC NHS TREATMENT CENTRE (NON-NHS)	1,153	178	**15**	975	**85**
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	1,005	842	**84**	163	**16**

Table 15: DSR per 10,000 elective admissions of White British, April 2006 – March 2009

Directly Standardised Rates and Proportions

Population Subgroups *Age*	Local Observed Events O_i	Local Population n_i	Reference Population w_i	$\frac{w_i O_i}{n_i}$	$\frac{w_i^2 O_i}{n_i^2}$
0-4	13	27,500	8,000	4	1
5-9	3	27,500	7,000	1	0
10-14	8	27,500	7,000	2	1
15-19	1	25,340	7,000	0	0
20-24	5	25,340	7,000	1	0
25-29	12	25,340	7,000	3	1
30-34	11	25,340	7,000	3	1
35-39	23	25,340	7,000	6	2
40-44	35	25,340	7,000	10	3
45-49	19	25,340	7,000	5	1
50-54	26	25,340	7,000	7	2
55-69	20	25,340	6,000	5	1
60-64	14	25,340	5,000	3	1
65-69	12	25,340	4,000	2	0
70-74	5	25,340	3,000	1	0
75-79	10	25,340	2,000	1	0
80-84	9	25,340	1,000	0	0
85+	9	25,340	1,000	0	0
Total	235	462,600	100,000	55	14

Directly Standardised Rate

Rate *(DSR per 10,000)*	95% Confidence Interval DSR_{lower}	95% Confidence Interval DSR_{upper}	Confidence level 100(1–α)%	Multiplier
5.5	4.7	6.2	95.0%	10,000

α =

Table 16: DSR per 10,000 emergency admissions of White British, April 2006 – March 2009

Directly Standardised Rates and Proportions

Population Subgroups *Age*	Local Observed Events O_i	Local Population n_i	Reference Population w_i	$\frac{w_i O_i}{n_i}$	$\frac{w_i^2 O_i}{n_i^2}$
0-4	795	27,500	8,000	231	67
5-9	111	27,500	7,000	28	7
10-14	69	27,500	7,000	18	4
15-19	69	25,340	7,000	19	5
20-24	42	25,340	7,000	12	3
25-29	40	25,340	7,000	11	3
30-34	36	25,340	7,000	10	3
35-39	43	25,340	7,000	12	3
40-44	36	25,340	7,000	10	3
45-49	38	25,340	7,000	10	3
50-54	39	25,340	7,000	11	3
55-69	49	25,340	6,000	12	3
60-64	68	25,340	5,000	13	3
65-69	39	25,340	4,000	6	1
70-74	107	25,340	3,000	13	1
75-79	92	25,340	2,000	7	1
80-84	115	25,340	1,000	5	0
85+	209	25,340	1,000	8	0
Total	1,997	462,600	100,000	436	114

Directly Standardised Rate

Rate *(DSR per 10,000)*	95% Confidence Interval DSR_{lower}	95% Confidence Interval DSR_{upper}	Confidence level 100(1–α)%	Multiplier
43.6	41.5	45.7	95.0%	10,000

α =

Table 17: DSR per 10,000 elective admissions of Black and minority ethnic patients, April 2006 – March 2009

Directly Standardised Rates and Proportions

Population Subgroups *Age*	Local Observed Events O_i	Local Population n_i	Reference Population w_i	$\frac{w_i O_i}{n_i}$	$\frac{w_i^2 O_i}{n_i^2}$
0-4	4	2,900	8,000	11	30
5-9	1	2,900	7,000	2	6
10-14	0	2,900	7,000	0	0
15-19	1	3,010	7,000	2	5
20-24	2	3,010	7,000	5	11
25-29	9	3,010	7,000	21	49
30-34	5	3,010	7,000	12	27
35-39	22	3,010	7,000	51	119
40-44	9	3,010	7,000	21	49
45-49	3	3,010	7,000	7	16
50-54	3	3,010	7,000	7	16
55-69	4	3,010	6,000	8	16
60-64	8	3,010	5,000	13	22
65-69	4	1,380	4,000	12	34
70-74	9	1,380	3,000	20	43
75-79	1	1,380	2,000	1	2
80-84	0	1,380	1,000	0	0
85+	2	1,380	1,000	1	1
Total	87	45,700	100,000	194	446

Directly Standardised Rate

Rate *(DSR per 10,000)*	95% Confidence Interval DSR_{lower}	95% Confidence Interval DSR_{upper}	Confidence level 100(1–α)%	Multiplier
19.4	15.5	24.0	95.0%	10,000

α =

Table 18: DSR per 10,000 emergency admissions of Black and minority emhnic patients, April 2006 – March 2009

Directly Standardised Rates and Proportions

Population Subgroups *Age*	Local Observed Events O_i	Local Population n_i	Reference Population w_i	$\frac{w_i O_i}{n_i}$	$\frac{w_i^2 O_i}{n_i^2}$
0-4	233	2,900	8,000	643	1,773
5-9	58	2,900	7,000	140	338
10-14	35	2,900	7,000	84	204
15-19	35	3,010	7,000	81	189
20-24	24	3,010	7,000	56	130
25-29	15	3,010	7,000	35	81
30-34	10	3,010	7,000	23	54
35-39	19	3,010	7,000	44	103
40-44	16	3,010	7,000	37	87
45-49	16	3,010	7,000	37	87
50-54	7	3,010	7,000	16	38
55-69	8	3,010	6,000	16	32
60-64	22	3,010	5,000	37	61
65-69	20	1,380	4,000	58	168
70-74	20	1,380	3,000	43	95
75-79	22	1,380	2,000	32	46
80-84	21	1,380	1,000	15	11
85+	38	1,380	1,000	28	20
Total	619	45,700	100,000	1,426	3,515

Directly Standardised Rate

Rate *(DSR per 10,000)*	95% Confidence Interval DSR_{lower}	95% Confidence Interval DSR_{upper}	Confidence level 100(1–α)%	Multiplier
142.6	131.2	154.7	95.0%	10,000

α =

Appendix 4: Key Themes from the CCplus Thematic Report, May 2009[29]

1. There remains a need for some investment in a "safety net" to reach those Black and minority ethnic people still unaware of services to which they are entitled or how to apply for those they are
2. Clear Standards for customer response are important for better outcomes and cost savings
3. Services to be capable of being offered in a tailor-made way, rather than assuming one-size fits all
4. Applicant timescales to be relevant to customer situations and not inflexibly applied
5. Collaboration with and referrals to Sompriti can result in savings by reducing errors, queries and processing time
6. Vulnerable Black and minority ethnic clients to be identified and supported from first access through to outcome
7. Accessing appeals/challenging decisions may be more difficult for some Black and minority ethnic clients and good information and access to support and advocacy is especially important for them
8. Early referrals and interventions are key to better outcomes and cost saving
9. Black and minority ethnic businesses play an important role in strong local economies and partner PA's gain from proactive and collaborative work with Sompriti to support these businesses to thrive
10. Point-of-contact services continue to have the greatest impact on perceptions of service and some Black and minority ethnic clients ability to access them
11. A clear rationale for PA processes inspires confidence in some Black and minority ethnic clients feeling that they are not being treated differently or discriminated against
12. Enforcement and other notices need to be written and followed up in a way that ensures that they are understood by Black and minority ethnic clients
13. Providing information on alternative options improves outcomes, and can reduce waiting lists, especially relating to Housing
14. Independent information and support for some Black and minority ethnic clients helps ensure better compliance with requirements, medical and social regimes.
15. Copying Correspondence to support workers helps ensure more efficient and effective outcomes
16. Distinguishing between ethnicity and nationality can be confusing to some Black and minority ethnic people
17. A holistic understanding and support of the whole situation of the client can be provided by Sompriti, helping to ensure effective access of other services and information a Black and minority ethnic client may need to access the original service
18. The trust and confidence that is built through ongoing support from an independent agency like Sompriti enables Black and minority ethnic people to build trust in the PA and confidence in the fairness of their service provision.

Appendix 5: Black and Minority Ethnic groups, practitioners, and projects, working with Black and minority ethnic communities in East Sussex

Black and Minority Ethnic groups
Bengali Women's group – Hastings
Black and minority ethnic Health and social care user group
Diversity Resource International
Congolese Community in Sussex
Eastbourne Mosque
Eastbourne District Chinese Community Association
Friends Families of Travellers
Black and minority ethnic Health and Social Care Practitioners Group
Hastings Intercultural Organisation
Hastings and Rother Interfaith Forum
Hastings and Rother Intercultural organization
East Sussex Traveller Forum
E.S.ME. group
Migrant Impact Group
Rother Race Action Forum
Sompriti
PPF Advocacy Project – Putting People First
Local Action Team Meeting

Practitioners working with Black and minority ethnic groups
Race and Faith Hate Crime officer
Community Cohesion Officer, Hastings Borough Council
Primary care mental health worker – Hastings and Rother
Co-ordinator – Hemas, Chapel Park Community Centre
Race Equality Mental Health Team, East Sussex County Council
Locality Manger, Health Visiting Services Hastings and Rother PCT Lead – Pacesetters Programme – Personal Adult Health Record for Travellers and Gypsies
Equality Advisor, Children's Services, East Sussex County Council
Specialist Black and minority ethnic services
Specialist Health Visitor – Asylum Seekers, Refugees, Homeless Families
Specialist Health Visitor – Travellers and Gypsies
Team leader, Eastbourne Homeless Team
Active Hastings, Renaissance House
Health Trainers Co-ordinator, Public Health Clinical Business Unit
PCTs Equality & Diversity Lead & Lead – Race for Health
Patient and Public Involvement, Hastings and Rother PCT
Co-ordinator – Links project
CAMHS
Traveller Liaison Manger, Traveller Team, East Sussex County Council
Co-ordinator - Children's centres
Clearsprings Accommodation
Eastbourne Homes – Black and minority ethnic worker
Eastbourne District Hospital
Sussex Police
Hastings Voluntary Action

Projects working with people from Black and minority ethnic Communities
Cultural Communities Network, Eastbourne
Churches Together in Eastbourne
English in the Communities
Migrant Helpline
Oasis – Ore Valley
Homestart
Refugee Research Project
Petsalozzi International Village, Sedlescombe
H.E.M.A.S.
SE Interpreting
Circle of Life Rediscovery
Refugee Legal Centre
Links Committee

Appendix 6. Recommendations from the needs assessment compared with Good Practice and PCT Equality & Diversity Action Plans

Extract from the Equality & Diversity Action Plan a.	Good practice b.	Recommended by needs assessment c.	Comment d.
1. Explore option of establishing a Black and minority ethnic health and social care forum, jointly with ESCC, involving other local NHS Trusts where appropriate.		Yes. Develop the synergies between practitioners and projects working with Black and minority ethnic individuals, groups, & communities.	As an extension and pre-requisite for this, develop clear lines of responsibility, accountability, and performance monitoring ie the governance aspects of a partnership, between the two statutory organisations and providers of services to Black and minority ethnic groups.
2. Develop Black and minority ethnic practitioner network to include practice staff	Could meet Good Practice: 9. Diversity networking between statutory and voluntary organisations 10. Training NHS staff on diversity & culture	Yes. Develop communities of interest to learn and share together. Be particularly aware of the differences in approach to sexual health, mental health, and the use of services. Respect people for their different views, and make services less hard to reach, rather than treating Black and minority ethnic people as the hard to reach. Link GP performance on these issues to QOF. Further training, on sensitively managing illiteracy and poor comprehension would also be valuable.	In addition develop cultural awareness training and customer services training, particularly in primary & community care. Much of what the Black and minority ethnic respondents reported had nothing to do with ethnicity eg calling across a crowded waiting room about urine tests; it was poor practice. Institute a rolling programme so that all frontline staff receive the training.
3. Report on monitoring data from services for whom we are lead commissioner to build targets into service specifications for contract reviews in future	Could meet Good Practice: 5. Improving the recording of ethnicity in primary & secondary care	Yes.	East Sussex needs to decide who are in/out of the Black and minority ethnic category. Once the ethnicity recording is better it will be possible (desirable) to undertake a Health Equity Audit.
4. Explore what data is collected by the prison health service		Yes, but it would be good to lead by example!	

5. Consider options for disaggregating 'White Other' category, consistent definitions (e.g. Black and minority ethnic) and recommend data collection standards for publication on the website extranet		Yes.	See 3d above. To do this well may need to wait until after the next Census, but it will be useful to influence the planning of that process (eg new categories of ethnicity, new aggregations of ethnic groups)
6. Review the translation and interpreting arrangements and contracts currently in place with various providers and produce staff guidance	Could meet Good Practice: 7. Using interpreters or Language Line	Yes. Language & interpreting came up repeatedly as a problem. Practitioners need training to know what exists, how to use it, and how it can help them as well as the patient. Improved language & interpreting services should remove the reports that people go away knowing what they've been told to do, but not why, and without their questions answered. Ways to hold people to account for using these services should be developed. Language & interpreting are particularly important to Black and minority ethnic people with mental health conditions, and to providing services eg counselling to them. This needs to be explored further.	Translation & interpreting services are not sufficient in themselves. It could be extended to cover Good Practice: 1. 'Welcome Packs' for asylum seekers & refugees (but coordinated – several Welcome Packs are underway in East Sussex at present) 2. Visiting and assisting the new arrivals by health professional (this will require multi-agency working in order to identify them). 11. Free access to English classes (ESOL) (and at suitable times places to facilitate working and travel) with childcare or other carers expenses and facilities where required
7. Create detailed race improvement plans for Diabetes; Perinatal mortality; Coronary heart disease and stroke	Could meet Good Practice: 6. 'Peer education' model cascading training by community health workers	Yes. This may need appropriate language and interpreter support.	Use the rich findings from the qualitative part of this needs assessment as the basis. Use the methods of building rapport described in para 8.17.
8. Undertake a Black and minority ethnic Comprehensive needs assessment & report findings to Equality and Diversity Committee		Yes.	And from there beyond, to the full governance structure, so that management action is taken, monitored, and reported.
9. Define and agree access to translation and interpreting	Could meet Good Practice: 7. Using	Yes. If services are to be delivered via the third sector they must have available the	Alternatively they may have the advantage of already having several

services as part of 3rd sector agreements	interpreters or Language Line	same language & interpreter tools as the statutory sector.	languages 'on the tip of their tongues' literally. Build on third sector befriending and advocacy services.
10. Report on Equality and Diversity monitoring data built in to 3rd sector commissioning agreements		Yes.	
	Good Practice: 8. Involving the community organisation on health making decisions	Yes. Use relationships with communities and their leaders to develop health messages and ways to deliver them. Include within this first aid mental health training.	
	Good Practice: 12. Empowering the Black and minority ethnic groups	Yes. Produce a calendar of culture, social and community events across the county and encourage health services to attend these, especially those where more private conversations can take place (listening) and many can be reached during consultations. Support health training by community groups or individuals with links to Black and minority ethnic communities.	

References

[1] Bhopal R, Kohli H, Rankin J. "Editors practice and views on terminology in ethnicity and health research". Department of Epidemiology and Public Health, University of Newcastle upon Tyne. 1997.

[2] Cruickshank J. K, Beevers D. G."Ethnic Factors in Health and Disease" Oxford, 1994

[3] Bhopal R; Donaldson L; White, European:"Western Caucasian or what?" Department of Epidemiology and Public Health, University of Newcastle upon Tyne, 1998.

[4] R. Warburton; "Turning Evidence into Action – Ethnicity Data"

[5] Cyprus, Chech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia and Slovenia which joined on the European Union in May 2004 and Romania and Bulgaria who joined in January 2007

[6] http://www.eastsussex.gov.uk/community/travellers/download.htm

[7] http://www.eastsussex.gov.uk/community/travellers/groups.htm

[8] http://www.eastsussex.gov.uk/community/asylum/default.htm

[9] Design Options. "Comprehensive Sexual Health Needs Assessment for East Sussex Downs and Weald and Hastings and Rother PCTs", March 2008.

[10] Palmer G; "A Report for the Commission for Rural Communities" http://www.ruralcommunities.gov.uk/

[11] Joint Strategic Needs Assessment http://www.hastingsandrother.nhs.uk/about-us/strategic-documents/joint-strategic-needs-assessment/

[12] Health Survey for England 2004: Health of Ethnic Minorities - Full Report http://www.ic.nhs.uk/pubs/hse04ethnic

[13] HPA. "Migrant Health" Health Protection Agency, England 2006

[14] HSE. Health Summary - The Health of Minority Ethnic Groups '99; http://www.archive.officialdocuments.co.uk/document/doh/survey99/hses-02.htm

[15] Lodge L, Charman S, Helowicz R. "Assessment of the needs of children & adolescents in East Sussex for mental health services"; CAMHS, March 2009

[16] Goodman A; Patel V; Leon A.A. "Child mental health differences amongst ethnic groups in Britain: BMC Public Health 2008.

[17] Older people in East Sussex: an epidemiological health needs assessment; Public Health Resource Unit, 2007

[18] Moriarty J; Butt J. "Inequalities in quality of life among older people from different ethnic groups". Social Care Workforce Research Unit, King's College London. REU Consultancy, London

[19] Saving Mother's Lives: The 7th report of the Confidential Enquiry into Maternal Deaths in the UK 2003 -05. CEMACH, Dec 2007.

[20] Tina Lavender, Soo Downe, Kenny Finnlayson, Denis Walsh. Access to antenatal care: A systematic Review Report. February 2007.

[21] Aspinal P. "Health ASERT Programme Wales", Wales NHS, 2006

[22] Green A, Owen D, Jones P. "Migrant Workers in the South East Regional Economy" University of Warwick and BMG research, 2008

[23] University of Sheffield "The Health Status of Gypsies and Travellers in England. University of Sheffield", 2004

[24] Parry G, Cleemput P.V, Peters J, Walters S, Thomas K, Cooper C "Health Status of Gypsies and Travellers in England". Journal of Epidemiology and Community Health 2007;61:198-204

[25] Cleemput P.V, Parry G, Thomas K, Peters J, Cooper C. "Health-related beliefs and experiences of Gypsies and Travellers": a qualitative study Journal of Epidemiology and Community Health 2007;61

[26] Gypsies' and Travellers' experience of using urgent care services within NHS Brighton and Hove boundaries; Friends, Families and Travellers;2009

[27] Saunders Dr L. Mental Health Needs Assessment East and West Sussex PCTs: working aged adults 16 -64. v1, July 2007

[28] Report on self reported experience of patients from black and minority ethnic groups. DH & National Statistics, June 2009

[29] CCplus Thematic report. Sompriti, May 2009

[30] Edmunds F, Cuppini E. Pacesetters "Personal adult health records" – for Gypsy and travelling community

Other documents to which reference was made:

Canning K. "Black and Minority Ethnic groups in Surrey and Sussex". West Sussex Public Health Observatory, 2006.

A practical guide to ethnic monitoring in the NHS and Social Care. DH, NHS Health & Social Care Information Centre, NHS Employers, July 2005.

Better Health Briefings. Race Equality Foundation, October 2009.