

### Why is this issue important?

*“Ethnicity results from many aspects of difference which are socially and politically important in the UK. These include race, culture, religion and nationality, which impact on a person’s identity and how they are seen by others. People identify with ethnic groups at many different levels. They may see themselves as British, Asian, Indian, Punjabi and [Brightonian] at different times and in different circumstances”.*<sup>1</sup>

Black and Minority Ethnic (BME) groups in the UK, including Gypsies and Travellers, share many of the same health and wellbeing risks and needs as the rest of the population. However, there are some key differences in risk and protective factors, incidence and prevalence of certain diseases, access to services and the resulting health and wellbeing outcomes.

Given the variations both within and between groups, caution needs to be used if considering ethnicity as the main explanation for these differences. Other influences include:<sup>2</sup>

- Racism and discrimination
- Socio-economic status
- Long-term effect of migration
- Lack of cultural awareness in service delivery
- Lower uptake of services
- Differences in culture and lifestyle choices
- The importance of seeing the person, not the stereotype

National evidence highlights that some groups are at increased risk of some conditions:<sup>3</sup> South Asians have higher levels of stroke, coronary heart disease and diabetes; Black African, Black Caribbean and Black British people have higher levels of hypertension and stroke.<sup>4</sup>

There are also strong associations between ethnic group and specific health conditions e.g. raised risk of sickle cell disease in Black African, Black Caribbean and Black British groups.<sup>5</sup>

Overall, cancer rates tend to be lower in BME groups. For lung cancer, mortality rates are lower in people of South Asian, Caribbean and African, backgrounds (related to lower levels of smoking).<sup>5</sup>

Ethnic differences in mental health are controversial since most of the data are based on treatment rates, which show that individuals from BME groups are much more likely to receive a diagnosis of mental illness than those who are White British.<sup>5</sup> Studies show that the rate of new diagnoses of psychosis is up to seven times higher among Black Caribbean than White British groups.<sup>6</sup> However, surveys on the prevalence of mental illness in the community show smaller ethnic differences.

There is evidence of ethnic differences in risk factors that operate before people come into contact with health services, such as discrimination, social exclusion and urban living.<sup>5</sup>

Nationally, almost half of all children from ethnic minorities live in low-income households compared with a quarter of White British children, with 66% of Bangladeshi and Pakistani children and 50% of Black and Black British children living in poverty.<sup>7,8</sup>

The degree to which families in Brighton & Hove reflect this picture is not entirely clear from existing data. However, using the Index of Multiple Deprivation 2015 (which is based on data from 2013) and the 2011 Census shows that 27% (368 people) of Bangladeshi residents live in the 10% most deprived areas in England with 40% (551 people) living in the 20% most deprived. Other ethnic populations with higher than expected numbers living in the 10% most deprived areas in England are: Black African (17%, 494 people), Arab (15%, 328 people), White and Black Caribbean

<sup>1</sup> Parliamentary Office of Science and Technology. Ethnicity and Health. January 2007. Postnote Number 276.

<sup>2</sup> Barnard H, Turner C. Poverty and ethnicity; a review of evidence. York: Joseph Rowntree Foundation. 2011.

<sup>3</sup> Diseases and different ethnic groups [Online]. 2011 Available from URL : <http://www.patient.co.uk/doctor/Diseases-and-Different-Ethnic-Groups.htm>. [Accessed April 2012].

<sup>4</sup> Stansbury JP, Jia H, Williams LS, et al. Ethnic disparities in stroke: epidemiology, acute care, and post-acute outcomes. Stroke. 2005 Feb;36(2):374-86. Epub 2005 Jan 6. [abstract].

<sup>5</sup> Health and Social Care Information Centre. Health Survey for England 2004: The health of minority ethnic groups - headline tables. 2005.

<sup>6</sup> Raleigh VS, Irons R, Hawe E, et al. Ethnic variations in the experiences of mental health service users in England: results of a national patient survey programme. Br J Psychiatry. 2007;191:304-312.

<sup>7</sup> The poverty site. Low income and ethnicity. Available from: <http://www.poverty.org.uk/06/index.shtml> [Accessed August 2015].

<sup>8</sup> Kenway P, Palmer G., Poverty among ethnic groups how and why does it differ? JRF New Policy Institute. York. 2007. <http://www.poverty.org.uk/reports/ethnicity.pdf> [Accessed 20/08/2012].

## 4.2.2 Ethnicity

(15%, 329 people), White and Black African (15%, 329 people) and Gypsy or Irish Traveller (15%, 30 people).

The health status of Gypsies and Travellers is much poorer than that of the general population,<sup>9</sup> with life expectancy being 15-25 years less than for the general population; an infant mortality rate of one in 20; and 38% of Gypsies and Travellers having a long-term illness. Poor access to, and uptake of, health services is a major factor in Gypsy and Traveller health. There are an estimated 300,000 Gypsies and Travellers in the UK of whom two thirds live in settled housing.<sup>10</sup>

### Key outcomes

None of the indicators in the Public Health, NHS or Adult Social Care Outcomes Frameworks are specifically focused on ethnicity. However ethnicity is a 'protected characteristic' in the Equality Act 2010 and public sector organisations are required to have due regard to the need to advance equality of opportunity and eliminate discrimination faced by people based on their ethnicity.<sup>11</sup>

### Impact in Brighton & Hove

The most recent population estimates (2011) show that 80.5% of the city's population are White British and 19.5% are from a BME group (compared to 12% in 2001). This is now a lower proportion than England (20.2%), but higher than the South East (14.8%).<sup>12</sup>

	Brighton & Hove 2011	Brighton & Hove 2001	England
White	89.1% (243,512)	94.3%	85.4%
White British	80.5% (220,018)	88.0%	79.8%
White Irish	1.4% (3,772)	1.6%	1.0%

<sup>9</sup> EHRC. Inequalities Experienced by Gypsy and Traveller Communities: a review: EHRC: 2009.

<sup>10</sup> Cemlyn S, Greenfield M, Whitwell C, Matthews Z, Burnett S. Inequalities experienced by Gypsy and Traveller communities, a literature review. London: Equalities and Human Rights Commission. 2009.

<sup>11</sup> <http://www.equalityhumanrights.com/legal-and-policy/equality-act/>

<sup>12</sup> ONS Neighbourhood statistics Ethnic Group (KS201EW) Census 2011 13<sup>th</sup> Jan 2013

Other White	7.1% (19,524)	4.6%	4.7%
Mixed/Multiple Ethnic Group	3.8% (10,408)	1.9%	2.3%
Asian or Asian British	4.1% (11,278)	2.4%	7.8%
Black or Black British	1.5% (4,188)	0.8%	3.5%
Chinese	1.1% (2,999)	0.5%	0.7%
Other non-White ethnic group	0.7% (1,799)	0.6%	0.6%

Source: Office for National Statistics (ONS)

Table 1 gives the total population by ethnic group. The largest BME community is Other White with 19,524 people, over a third (36.6%) of the BME population. Numerically, the Other White community has seen the largest increase since 2001 (8,041 people).

The 2011 Census was the first time that Gypsy/Traveller was included as an ethnic category. In Brighton & Hove there were 198 Gypsies/Travellers identified in the Census.<sup>13</sup> However, community estimates suggest that Census data show an undercount to a ratio of 1:5 due to unwillingness to ascribe due to fear of discrimination, and barriers to completing the census such as low literacy levels and enforced mobility.<sup>14</sup>

All BME groups (apart from Irish) have seen a significant increase in their population since the 2001 census. The Other Asian community has seen the biggest increase, increasing two and a half times (255.9%) from just 918 people in 2001 to 3,267 people in 2011. All mixed / multiple ethnic groups have also seen their populations double and increase by more than a 1,000 people as have the Chinese and the Black African communities.

Of the city's population who are aged over three years, 8.3% do not have English as their preferred or first language, compared to 5.8% in the South East and 8% in England. Arabic (0.8%) is the most

<sup>13</sup> Office for National Statistics. 2011 Census data taken from ONS table KS201EW. As presented in the Brighton & Hove Census Bulletin: Equalities. Available at <http://www.bhconnected.org.uk/content/reports>

<sup>14</sup> Families, Friends and Travellers. Inclusion of Gypsy Traveller health needs in Joint Strategic Needs Assessments: A review. 2015. Submitted as part of the JSNA call for evidence 2015. Available at [http://www.gypsy-traveller.org/wp-content/uploads/2015/03/FFT\\_Inclusion-of-Gypsy-Traveller-health-needs-in-JSNA\\_FINAL.pdf](http://www.gypsy-traveller.org/wp-content/uploads/2015/03/FFT_Inclusion-of-Gypsy-Traveller-health-needs-in-JSNA_FINAL.pdf)

widely spoken language in the city besides English, followed by Polish (0.8%) and Chinese (0.7%).<sup>15</sup>

In 2014-15, Sussex Interpreting Services (SIS) provided 14,550 community interpreting sessions for 3,200 different service users in 48 different languages. Compared to 2013-14 this was an increase of 2,970 sessions (25%) with 558 more service users (21%). Over 66% of sessions relate to Brighton & Hove, including 4,631 sessions for Sussex University Hospital Trust's (BSUHT), 3,634 for Brighton & Hove CCG and 1,029 for Brighton & Hove City Council. Similar to last year the most frequently required languages were: Arabic (34%), Polish (9%) and Farsi (7%).<sup>16</sup>

Between 2011 and 2013, 30% of BSUHT use of interpreting services has related to maternity care, with services in the Trevor Mann baby Unit rising by 274% from 0.26% of all BSUHT interpreting services in 2011-12 to 2.1% in 2012-13.<sup>16</sup>

A cross-sector event looking at engaging people who use interpreting services in relation to health needs highlighted a lack of knowledge of urgent care services outside of GPs and Accident and Emergency. Continuity of service, face-to-face interpreting, confidentiality and information giving were identified as building confidence, broadening opportunity and increasing service accessibility for this cohort.<sup>17</sup>

The January 2016 School Census for Brighton & Hove schools shows 25.0% (7,837 pupils) to be from a BME background, lower than the national figure of 28.6%. In January 2015 the proportion of BME pupils in the city was 23.7% and has increased from 15.2% in 2007. Primary schools (26.4%, 4,951 children) have the highest proportion of BME pupils, compared to secondary schools (23.1%, 2,790 pupils) and Special schools (19.6%, 84 pupils).<sup>18</sup> In England the proportion BME pupils in primary schools is 31.4%, secondary schools 27.9% and special schools 25.9%.<sup>19</sup> Nearly a half (47%) of

BME pupils has English as an additional language (EAL), and 93% of the EAL group are BME pupils.

Qualitative data from a 2012 needs assessment on the health and wellbeing needs of the Gypsy and Traveller community in the city identified the following determinants on Traveller health: stress; isolation; stigma; adaptability; gender roles; literacy; education and employment access; physical environment; high rates of smoking; poor diet and low breastfeeding rates. Specific health priorities identified include, amongst others, obesity, oral health, mental health, and health care accessibility.

### Where we are doing well

The BME community partnership (BMECP) is a gateway organisation funded by the PCT to enable participation by BME communities in health-related developments. The partnership comprises 45 BME community groups with membership size ranging from 10 to 3,000 members.

The Bilingual Advocacy Project aims to support people with long term conditions to access services. The 19 Bilingual Advocates speak 15 languages, representing 85% of the language needs of SIS users. Between February 2015 and January 2016 the project received 101 referrals, resulting in 811 hours of advocacy and 45 completed cases. Arabic was the most frequently requested language for advocacy (26), followed by Cantonese and Farsi (12). 85% (n=41) of service users with completed cases between February 2015 and January 2016 felt their level of empowerment had improved.

The Friends, Families and Travellers group is based in Brighton and works closely with Gypsy and Traveller communities, providing an important opportunity to engage with these communities.

A health needs assessment of Gypsies and Travellers was undertaken in 2012 which helped to address a paucity of local information about this group.<sup>20</sup>

<sup>15</sup> ONS Neighbourhood statistics Census 2011 [accessed 11<sup>th</sup> June 2013]

<sup>16</sup> Sussex Interpreting Services Annual Review 2014 to 2015  
<http://www.sussexinterpreting.org.uk/annualreview/2014-15/sis-annual-review-14-15-EN-lo-res.pdf>

<sup>17</sup> A partnership between the Brighton & Hove Clinical Commissioning Group, Sussex Interpreting Services and the Black and Minority Ethnic Community Partnership.

<sup>18</sup> Brighton & Hove School Census, January 2016.

<sup>19</sup> DfE, School pupils and their characteristics 2016

<sup>20</sup> NHS Sussex. Brighton & Hove Gypsy & Traveller Rapid Health Needs Assessment. Brighton & Hove: NHS Sussex; 2012 [accessed 2015 March 18]. Available from URL: <http://www.bhconnected.org.uk/content/needs-assessments>

The health of Gypsies and Travellers is much poorer than the general population,<sup>21</sup> with life expectancy 15-25 years less; an infant mortality rate three times higher; and parents 18 times more likely to experience the death of a child before they reach maturity, compared to other members of the population. Poor access to, and uptake of health services are factors in Gypsy and Traveller health. The 2012 needs assessment identified the following determinants of health:

**Social stress;** isolation; stigma; adaptability; gender roles; literacy;

**Economic:** education and employment;  
Environmental: water and sanitation; waste disposal; warmth; transport;

**Lifestyles:** smoking; poor diet; low breastfeeding rates and high sun-bed use. Specific health priorities included obesity, oral health, mental health, and health care accessibility.

Friends, Families and Travellers (FFT) run a health improvement project with both housed and mobile Gypsies and Travellers in the city. A Health Promotion Outreach Worker visits sites to provide information health topics, supporting people to stop smoking and takes a holistic approach on a number of issues including mental health.

Both the City Council and the Clinical Commissioning Group have a clear commitment to developing further work with BME communities.

The 2014-17 Brighton and Hove Commissioning Prospectus outlines the intention to commission a service providing psychosocial support to improve the mental health management and well-being of BME communities, particularly those who have limited knowledge of, or access to, community mental healthcare services.

### Local inequalities

The proportion of the population that are from BME groups varies by age: 21% of children and young people aged 0-15 years are from BME groups; 21% of people of working age; and just 8% of people of retirement age or older.<sup>22</sup> So the BME

population of the city is considerably younger than the White British population.<sup>17</sup>

According to the 2011 Census there were 198 Gypsies and Travellers living in Brighton and Hove which amounts to 0.1% of the city's population. This amounts to fewer travellers per capita than would be expected for the population, yet according to local research the lack of suitable stopping places means Travellers are four times more likely than the national average to be on an unauthorised site.<sup>23</sup> Since the publication of the Traveller Commissioning Strategy in the city, a site has been agreed for a 16 pitch permanent traveller site.<sup>24</sup>

Brighton & Hove's BME communities live throughout the city, however, more than a third, (39%, 20,549 people) of our total BME population live in the six city centre wards of Central Hove, Brunswick & Adelaide, Regency, St. Peter's & North Laine & Goldsmid. This includes nearly a half, (49%, 9,475 people) of the Other White population. North Portslade, Patcham and Woodingdean wards have BME populations of 10% or less.<sup>25</sup>

### Population groups

#### Pregnancy and maternity:

Across England, there has been a continued rise in the proportion of births to mothers born outside the UK, from 14% of births in 1998 to 29% in 2009. However, since 2010 there has been a slight fall, with 27% of births to mothers born outside the UK in 2014.<sup>26</sup> In Brighton & Hove the picture was similar: in 1998, 14% of births were to mothers born outside the UK, rising to 26% of births in 2011, locally there has been a further rise to 29% in 2014.<sup>27</sup> In 2014 there were 2,987 live births to mother in Brighton & Hove. 377 births were to mothers born outside the UK but within the EU (13% of all births), 50 from the rest of Europe (2%), 191 from the Middle East and Asia (6%), 134 from

<sup>23</sup> NHS Sussex (2012) Brighton & Hove Gypsy & Traveller Rapid Health Needs Assessment December 2012

<sup>24</sup> Brighton and Hove City Council, (2013) Travellers Service Update [June 2013] <http://www.brighton-hove.gov.uk/content/housing/travellers>

<sup>25</sup> ONS 2011 Census Statistic, Table KS201EW Ethnicity by wards

<sup>26</sup> Office for National Statistics. Parents' Country of Birth - England and Wales, 2013. Published August 2014. Available at: <http://www.ons.gov.uk/ons/rel/vsob1/parents--country-of-birth--england-and-wales/index.html> [Accessed 04/07/2016]

<sup>27</sup> Office for National Statistics. Vital Statistics Tables. Produced by the Brighton & Hove City Council Public Health Intelligence team

<sup>21</sup> Cemlyn S, Greenfield M, Whitwell C, Matthews Z, Burnett S. Inequalities experienced by Gypsy and Traveller communities, a literature review. London: Equalities and Human Rights Commission; 2009.

<sup>22</sup> ONS Neighbourhood statistics Ethnic group by sex by age (DC2101EW) Census 2011 [accessed 11<sup>th</sup> June 2013]

Africa (4%) and 98 from the rest of the world (3%).<sup>28</sup> Poland (77 births, 2.6%) was the most common country of birth for non UK born mothers. The next highest was Germany (44 births) and India (35 births).

**Carers:** According to the 2011 census, just over one in twenty (6%, 3,201 people) of the city's BME population provide at least one hour of un-paid care to a family member, friend or neighbour. This compares to just under one in ten (9%) of the White UK/British population. Gypsy or Irish Travellers (16%) are most likely to be carers, followed by White Irish (10%).<sup>29</sup>

**Military veterans:** There is no specific data on ethnicity of military veterans but at national level an estimated 99% are White.<sup>30</sup>

**Students:** There is a substantial student population in the city; at the time of the 2011 census full time students aged over 16 accounted for 14.1% of the population living in the city (32,920 people), with a third of these (11,206 people) being from BME backgrounds. In total a quarter of our adult (aged 16 or more) BME population (11,206 people) were students, rising to 37% of the Asian population (3,543 people) and 35% of the Black population (1,274 people).<sup>31</sup>

High proportions of BME residents are full-time students. Whilst 12% of the White UK/British population are students, for all other ethnic groups except White Irish the proportion is at least 6% higher. As a proportion of the population Chinese have the highest proportion at 56% (1,534 people) whilst Other White has the lowest at 18% (3,198 people).<sup>32</sup>

From University of Sussex and Brighton University 2014-15 equality data and noting that not all students at the universities live in the city, 37% of students at Sussex and 23% at Brighton were from a BME background.

### Wider determinants of health

<sup>28</sup> Office for National Statistics. Parents' country of birth. Available at <http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/datasets/parentscountryofbirth> [Accessed 06/07/2016]

<sup>29</sup> ONS, 2011 census, table DC2301EW

<sup>30</sup> Royal British Legion. Profile and Needs of the Ex-Service Community 2005-2020. Royal British Legion. 2006.

<sup>31</sup> ONS. 2011 census

<sup>32</sup> ONS. 2011 census

### Children, young people and families

**Children in need and looked after children:** Almost a quarter of Children in Need (CiN) and Children Looked After (CLA) are not White British compared to 21% of children aged under 18 in the city at the time of the 2011 Census. Based on the ethnic profile of the city's children this is in line with what we would expect if all other things were equal, as 21% of under 18s were not White UK/British at the time of the 2011 census.

Three in ten children (30% or 92 children out of 304 with recorded ethnicity) who were the subject of a Child Protection Plan in December 2014 were not White UK/British. This means that there are more BME children with CPPs in place than we would expect based on the ethnic profile of children aged under 18 in the city at the time of the 2011 census, when 21% were not White UK/British. This is also an 8% increase in the proportion of BME children with CPPs compared to July 2012.

**Education:** Many young people from minority ethnic backgrounds achieve at the highest level, but for some groups, attainment gaps remain. One of the biggest barriers to attaining can be for pupils for whom English is an Additional Language (EAL).

In 2016, 12.8% of Brighton & Hove pupils (reception year and above) have English as an Additional Language (EAL). This is lower than the national figure of 17.3% (2015). In January 2016 there were 4,004 pupils (an increase of 275 since January 2015) with at least 98 different languages other than English (including British Sign Language), attending Brighton and Hove schools. The three most widely spoken languages other than English are Arabic (885 pupils), Polish (376 pupils) and Bengali (340 pupils).<sup>33</sup> The proportion of EAL pupils in the city has increased since 2007 when it stood at 6.7%.

At Key Stage 2 in 2015 many BME groups have improved relative to 2014 results with successes being White and Black Caribbean who have increased combined attainment in reading writing and maths by 14 percentage points and Any Other Asian background who have increased by 16 percentage points. This can be partly attributed to

<sup>33</sup> Brighton & Hove, School Census Trend Report Summary Spring (January) 2016.

the Closing the Gap strategy and a focus on Mixed Race Achievement.

At Key stage 4 in 2015 the EAL and BME cohort outperformed the non-EAL and White British cohort in general attainment and progress measures. However, the following ethnic groups have lower GCSE attainment, and there is an association with income deprivation which locally is more likely in these groups: Black Caribbean; Black African and Other Black backgrounds; Mixed White and Black Caribbean, and Mixed White and Black African.

**Physical activity:** There is no significant difference in physical activity levels between those who are White British and BME groups. However, White Irish women are the most likely cohort of all ethnic groups to participate in the recommended level of physical activity for 5 or more days of the week (44%), followed by White Gypsy/Traveller males (40%). People of Black or Black British ethnicity are least likely to do the recommended levels of physical activity 5 or more days a week (4%).<sup>34</sup>

Among young people there is little difference in participation by ethnic group for team and solo sports.<sup>35</sup>

### **Not in education, employment or training (NEET):**

At the end of June 2016, in Brighton & Hove, 17% of Black or Black British Caribbean young people with an academic age 16 to 18 were NEET. More than three times the city figure (4.7%). Young White and Black Caribbean people (8.3%) are also nearly twice as likely to be NEET. However, young Black Africans (3.8%) and Black Other (1.9%) are less likely to be NEET. Other ethnic groups less likely to be NEET are Bangladeshi (3.1%), White and Asian (2.2%) and Other Asian (1.4%). Young people of White ethnicity (5.1%), White and Black African (5.4%) and other Mixed ethnicities (5.1%) are no less or more likely to be NEET than the city average. There is no data available for young Indian, Pakistani or Chinese people.

**Employment and work:** Information on economic activity is based on 2011 Census data about people aged 16-74 years, and thus includes people of retirement age. Overall, for all BME groups,

Brighton and Hove (55%) slightly higher proportion of economically active adults compared with UK average (52%). This is particularly true of: White Gypsy or Irish Travellers (56%) compared with 32% nationally; and Other Black people (60%) compared with 42% nationally. Lower levels of economic activity compared with the UK are found among Mixed, Black African and Chinese groups in the city.<sup>36</sup>

### **Community safety and crime reduction:**

Nationally, in 2014, the Crime Survey for England and Wales estimated that non-White respondents had more faith in the Criminal Justice System than White respondents. In fact 62% of non-White respondents were confident that the Criminal Justice System was effective, compared with 47% of White respondents. Amongst non-White groups those from a Mixed background were the least positive, with just 44% reporting they had confidence in the effectiveness of the system. And 70% of non-White respondents felt the system was fair compared to 64% of White respondents. Again, respondents of Mixed ethnic backgrounds were the least positive with 57% saying they are confident the system, as a whole, is fair.<sup>37</sup>

In 2013/14 there were 188 racist and religiously motivated incidents and crimes recorded by the police, an increase of 14.6% compared with the previous year when 164 incidents were recorded. This rise is in common with other types of hate incident. It is difficult to interpret this trend because it may be influenced by a number of factors: the actual number of incidents taking place, the reporting rate, the identification and recording by the police as a hate incident, and general improvements in the recording of crime by the police.

Women with an ethnicity other than White were less likely to appear in police recorded statistics as victims of crime in Brighton & Hove in 2013/14 than White women, and also less likely than all men. Women with an ethnicity other than White (North or South European) had a victimisation rate of 23.1 crimes per 1,000 members of the

<sup>36</sup>ONS Neighbourhood statistics DC6201EW - Economic activity by ethnic group by sex by age Census 2011 [accessed 11<sup>th</sup> June 2013]

<sup>37</sup>The Crime Survey for England and Wales, 2014 Q2 reporting Data tables available herein Table 05e:

<http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tc%3A77-353718>

<sup>34</sup> NHS Brighton and Hove (2012) Health Counts: A survey of people in Brighton and Hove. University of Kent Centre for Health Services Studies

<sup>35</sup> Brighton and Hove City Council. Safe and Well at School Survey 2015

population, compared with 34.5 for White women. The victimisation rates for all women are higher in 2013/14 than in 2011/12 when women with an ethnicity other than White had a victimisation rate of 15.0 compared to 30.1 for White women.

Men with an ethnicity other than White remain more likely than White men to appear in police recorded statistics as victims of crime. In 2013/14 they had a victimisation rate of 45.7 crimes per 1,000 members of the population compared to 36.9 for White males. The difference between non-White and White males' victimisation rates has widened between 2012/13 and 2013/14 (2012/13 data showed a victimisation rate of 34.9 for White males, compared with 38.7 for non-white males).

Data for 2012/13 show a charge rate of 51.6 per 1,000 population of BME males, compared with 38.8 for White UK/British males. This marks a widening trend between the rate of charges (sometimes called the offending rate) of BME males, compared with White UK/British males. In 2011/12 the offending rate of BME males was 47.9 compared with 40.7 amongst White UK/British males. Note that where offenders commit multiple crimes they will appear in the data multiple times and that offenders who are charged with crimes may not be convicted of them in court.

In fact, in 2012/13 BME males had a higher offending rate than White UK/British males and women of any ethnicity. Conversely, BME women had a low offending rate compared with White UK/British women and all men. There were 6.5 female offenders per 1,000 members of the population who were from a BME background compared to 11.4 per 1,000 members of the White UK/British female population. In 2011/12 the comparable rates were 8.9 female BME offenders and 11.1 White UK/British offenders per 1,000 population.

In Brighton & Hove the Black and Minority Ethnic (BME) population of young offenders is proportionate to that of the city as a whole. However, it has been found that BME young men are more likely to remain in the youth justice system.

### **Sustainable communities and places:**

In 2015, nearly nine out of ten BME (88%) and White UK/British (86%) residents report being fairly or very satisfied with Brighton & Hove as a place to live. Likewise, when asked about satisfaction with the local area BME (93%) and White UK/British (89%) responses were similar.<sup>38</sup>

BME residents (72%) are more likely to feel very or fairly safe in the city centre after dark than are White UK/British residents (62%). However, BME residents (79%) and White UK / British residents (79%) are equally likely to feel safe in their local areas after dark.

### **Housing and homelessness:**

Across all BME groups lower proportions live in owned, or part owned, homes than White UK/British residents. Three out of five (59%) of White UK/British residents live in an owned, or part owned, home compared to two out of five (40%) BME residents.<sup>39</sup>

Proportionally fewer BME residents (12%) live in social rented homes than White UK/British residents (15%). However, there are big differences between BME groups. Whilst a third of Bangladeshi residents (33%) and Gypsy or Irish Travellers (32%) lived in social housing only a twentieth (5%) of Indian residents do.

Proportionally nearly twice as many BME residents (45%) were renting their homes from private landlords than White UK/British residents (24%). Looking across all ethnic groups only Bangladeshi residents (17%) had proportionally less residents living in rented accommodation than White UK/British residents. More than half of Other White residents (56%) rented privately as did nearly half of all Black/Black British residents (48%).<sup>40</sup>

Looking at homeless prevention case work during 2013-14, BME households are less likely to be prevented from becoming homeless (60%) than White UK/British households (65%). This is similar to what was seen between 2009 and 2013 when the prevention rate for White UK/British households was 75% and 66% for BME households.

<sup>38</sup> Brighton & Hove City Council. Brighton & Hove City Tracker. 2015

<sup>39</sup> ONS 2011 Census

<sup>40</sup> ONS, 2011 census

A quarter (25% or 328) of all Homeless Applications were from BME groups in 2013/14, compared to a third (34%) in the previous year. 37% of BME homelessness applications were accepted compared to an average of 38%. In 2012/13 50% of BME applications were accepted compared to an average of 46% and 44% for White UK/British households.

**Good nutrition and food poverty:** Nationally it has been identified that members of BME communities are amongst the groups most likely to experience food poverty.<sup>41</sup> City Tracker results show BME residents (28%) are more likely to disagree that they will have enough money after housing cost to meet basic living cost (food, water and heating) than are White UK/British residents (21%).<sup>42</sup>

Local evidence suggests that White Irish people are the most likely ethnic group to eat five or more portions of fruit and vegetables a day and men of Mixed/Multiple ethnicity are least likely.<sup>43</sup>

### Wellbeing and community resilience

**Happiness and wellbeing:** Analysis of results from the ONS Annual Population Survey across the UK for April to September 2011 showed that Mixed and Black or Black British groups reported lower ratings for 'life satisfaction'.<sup>44</sup> In contrast, findings from Health Counts data (2012) indicate that Black or Black British men are most likely of all ethnic cohorts to report higher levels of life satisfaction in Brighton & Hove, and those of mixed/multiple ethnicities were least likely of all ethnic groups report medium/high levels of life satisfaction, with two thirds of males in this cohort reporting they have low or very low life satisfaction.<sup>37</sup>

With the exception of people of Asian/Asian British or Mixed Multiple ethnicity, between 70% and 75% of all ethnic groups reported that they feel happy and that the things they do are worthwhile. People from a White Gypsy/Traveller or Other ethnic

background are more likely to report higher levels of anxiety.<sup>45</sup>

Children and young people of Asian, Asian British or 'other' ethnic groups and those eligible for free school meals are less likely to participate in group activities, with non-participation linked to higher levels of vulnerability and to risk taking.<sup>46</sup>

In general there is no significant difference in those reporting being bullied at school between Black & Minority Ethnic students (16%) and those who identify as White UK/British (13%), but Chinese students are significantly more likely to state having been bullied (30%).<sup>47</sup>

In a 2014 event hosted by the Trust for Developing Communities brought together people from diverse BME communities across the city, with over 50 participants, to discuss mental health and wellbeing.<sup>48</sup> When asked whether there are there any specific needs that the BME community have which could help to improve these services or help people to find out about them participants said:

- Many people don't use the internet: you need to speak to our community leaders
- There are specific needs around language and interpretation, with issues also around dependence on an interpreter. If family members are interpreters it can cause problems if they don't want them to know. Issues can also be lost in translation: it's difficult for interpreter to express the feelings of the patient or medical jargon. There is a lack of translated materials. There needs to be more targeted information. People should be offered translation rather than assuming they will ask themselves.
- There is a lack of cultural knowledge and understanding. The services need to be sensitive to gender, age, and disability. There is a need for more BME health workers and counsellors

<sup>41</sup> National Heart Forum. Nutrition and food poverty: a toolkit. 2004.

<sup>42</sup> Brighton & Hove City Council. Brighton & Hove City Tracker. 2015

<sup>43</sup> NHS Brighton and Hove (2012) Health Counts: A survey of people in Brighton & Hove 2012. University of Kent centre for Health Services Studies.

<sup>44</sup> ONS. Analysis of experimental subjective wellbeing data from the Annual Population Survey, April to September 2011. February 2012.

[http://www.ons.gov.uk/ons/dcp171776\\_257882.pdf](http://www.ons.gov.uk/ons/dcp171776_257882.pdf) [Accessed 20/08/2012].

<sup>45</sup> NHS Brighton and Hove (2012) Health Counts: A survey of people in Brighton & Hove 2012. University of Kent centre for Health Services Studies.

<sup>46</sup> NHS Brighton and Hove & Brighton & Hove City Council. Annual Report of the Director of Public Health – Resilience. 2010.

<http://www.bhlis.org/needsassessments/publichealthreports> [Accessed 20/08/2012].

<sup>47</sup> Brighton and Hove Safe and Well at School survey 2015

<sup>48</sup> Trust for Developing Communities. DRAFT Report of the All Our Voices Event. 12 June 2014. Submitted as part of the JSNA 2015 call for evidence

- There is a need to reduce stigma around mental health. There should be more choice offered - not just medication – more talking therapies
- The complexity of immigration law creates difficult situations for accessing treatment. There is a need for people with no recourse to public funds to have health needs recognised. It is a struggle for LGBT groups to access community groups.

### Improving health

#### Starting well

**Antenatal and newborn screening:** Based on national data, one baby every seven months will be born with Sickle Cell Disease in Brighton & Hove.<sup>49</sup>

#### Maternal and infant health:

In 2014/15 mothers under the age of 20 years, 20% smoke at the time of delivery. For those aged 20-24 years 17% smoke. This falls dramatically to just 2% of mothers aged 35 years or over. Prevalence in White British mothers is higher (8%) than the overall average (6%) and this group comprise 88% of the smoking at delivery population.<sup>50</sup>

In contrast to the pattern for maternal smoking, the youngest mothers (<20 years) are least likely to initiate breastfeeding (68%). There is a clear age affect with breastfeeding rates increasing with maternal age up to a rate of 95% among mothers aged 35 years or over. There has been little change in this effect over time.

Highest prevalence is among White other mothers (96%) and Black African mothers (98%) having significantly higher rates. White Irish (80%), White British (86%) and Mixed White and Black Caribbean mothers (83%) have the lowest prevalence.

#### Developing well (children and young people)

**Healthy weight:** As was the case in 2011/12, Black or Black British (29 per cent) and Asian or Asian British (21 per cent) children aged 10-11 years (Year 6) were significantly more likely to be obese than other ethnic groups in 2013/14; 14 per cent of White UK/British children were obese. However,

data on childhood weight for some ethnic groups are based on small numbers and so it may not be possible to identify important differences. In reception year (4-5 years) Black or Black British children are more likely to be obese with 17 per cent of this cohort classified as such<sup>51</sup>

Across England, obesity prevalence is significantly higher for Asian or Asian British, Any Other Ethnic Group, Mixed ethnicities and Black or Black British children and significantly lower for Chinese and White children.<sup>52</sup>

**Smoking:** For 11-16 year old secondary pupils 76% have never smoked with little difference by ethnic group.<sup>53</sup>

**Alcohol and substance misuse:** Local data indicates that White British secondary school pupils are more likely to have tried alcohol than their BME peers.

**Sexual health:** The sexual health needs assessment reported that Chlamydia detection rates were highest in Asian or Asian British young people.<sup>54</sup>

Local data from 2014 for 14-16 year olds indicates that White Other pupils (20%) were more likely to have had sex than pupils of other ethnicities. Any Other Ethnic Group (7%) and Asian / Asian British (10%) were least likely to have had sex. For all other broad ethnic groups the rate is between 15% and 18%.<sup>55</sup>

Contraception and Sexual Health services:<sup>47</sup> 85% of under 18 year olds in the city who had a termination of pregnancy between 2010 and 2012 were White British<sup>56</sup>.

#### Living well (adults and older people)

**Healthy weight:** Nationally there is a correlation between obesity and ethnicity, with Black African and Black Caribbean populations exhibiting the highest obesity rates amongst all ethnic minority populations, and Chinese and Bangladeshi populations the lowest. Women have a higher

<sup>49</sup> Foetal anomaly screening programme –standards and policies <http://fetalanomaly.screening.nhs.uk/standardsandpolicies> [Accessed 20/08/2012].

<sup>50</sup> Public Health Directorate, Birth Notification files

<sup>51</sup> National Child Measurement Programme (2014) 2007/08 to 2013/14 data Brighton & Hove <http://www.ic.nhs.uk/ncmp>

<sup>52</sup> National Child Measurement Programme results, Information Centre for Health and Social Care <http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/obesity> [Accessed 30/07/2014].

<sup>53</sup> Brighton and Hove Safe and Well at School survey 2015

<sup>54</sup> Brighton and Hove Sexual Health Needs Assessment 2010

<sup>55</sup> Brighton and Hove Safe and Well at School survey 2014

<sup>56</sup> British Pregnancy Advisory Services (2012) Monthly monitoring data

prevalence of obesity in every ethnic group; the gender difference is significant amongst Pakistani, Bangladeshi, and Black African populations.<sup>57</sup>

Similarly to the national picture, local data<sup>58</sup> indicates that a higher proportion of Black or Black British (54%) or White Irish (57%) people are overweight or obese than other ethnic group. People of White Gypsy/Traveller or Other descent (32%) and of Mixed/Multiple ethnicity (33%) have lower levels of overweight or obese, but the latter has the highest level of underweight people (9%).

**Physical activity:** Local research has found that BME groups lack targeted sports and physical activity provision, especially for Muslim women; those who are disabled and those prone to clinical obesity; and in cases where language is the key barrier to participation.<sup>59</sup>

Local data<sup>45</sup> indicates that within this sample, *White Irish women are the most likely cohort to participate in the recommended level of physical activity for 5 or more days of the week (44%), followed by White Gypsy/Traveller males (40%).* People of Black or Black British ethnicity are least likely to do the recommended levels (4%) with low levels also reported by people from Other ethnic groups (13%) and Asian or Asian British people (14%).

Local research on ethnic differences in mental health also identified higher risks among BME populations as well as evidence that Brighton & Hove follows the national trend for twice the rate of mental health hospital admissions among people from a BME background and lower uptake of primary care mental health services. However, this data is based on a small population for whom data was available, and community surveys show smaller ethnic differences alongside differences in risk factors operating before contact with health services, such as discrimination and social exclusion.

**Substance misuse:** There is an under representation in the substance misuse treatment

population from the BME community groups, particularly members of the Other White, White Asian, Indian, Pakistani, Bangladeshi, Caribbean, African and Chinese Communities<sup>60</sup>. Local research<sup>51</sup> indicates that people of Mixed/Multiple ethnicity are most likely of all BME groups to have tried non-prescription/over the counter drugs, and Asian or Asian British people least likely.

**Alcohol:** Data on assaults recorded by A&E or the police, or in all alcohol related attendances at A&E, does not highlight ethnicity to be a significant factor. Between April and November 2012 84 per cent (9,374) of alcohol related admissions to hospital were for White UK/British people, 3.7 per cent (417) were for Other White people, 1.6 per cent (182) were for Asian people with all other broad ethnic categories accounting for less than one per cent of alcohol related admissions.<sup>61</sup>

Between January and December 2014, 10% of the 892 people in alcohol treatment programmes in Brighton & Hove (where ethnicity was stated) were BME. This is broadly consistent with data from previous years, but does show a slight increase (1%) in the proportion of BME clients in treatment when compared with 2012. Compared with the ethnicity of the city as a whole there are 9.2% more White UK/British clients in treatment than would be expected. Of the 10% who were BME, 3.5% were Other White, although we might expect there to be a higher proportion as Other White residents account for 7.9% of the city's population. During 2014 there were no clients in treatment of Pakistani, Bangladeshi or Chinese ethnic origin.

Local data<sup>62</sup> suggests that people of White Irish ethnicity are significantly more likely than any other ethnic group to be at increasing/high risk of alcohol related harm (25% compared to 18% across all ethnic groups in the city). Other Ethnic, Asian or Asian British and Black or Black British groups are more likely not to drink alcohol. These findings correspond to national research<sup>63</sup>.

<sup>57</sup> National Obesity Observatory 2010. Demography and Health Inequalities of Obesity.

[http://www.noo.org.uk/NOO\\_about\\_obesity/adult\\_obesity/demography\\_in\\_inequalities](http://www.noo.org.uk/NOO_about_obesity/adult_obesity/demography_in_inequalities) [Accessed 20/08/2012].

<sup>58</sup> NHS Brighton and Hove (2012) Health Counts: A survey of people in Brighton & Hove 2012. University of Kent centre for Health Services Studies.

<sup>59</sup> Brighton and Hove needs assessment stakeholder interviews 2011.

<sup>60</sup> Brighton and Hove Drug and Alcohol Action Team (2012) Substance Misuse (Drugs) Needs Assessment 2012-13

<sup>61</sup> SUS Spells & Episodes Tables - 2011/12 & 2012/13 (April - November 2012 only)

<sup>62</sup> NHS Brighton and Hove (2012) Health Counts: A survey of people in Brighton & Hove 2012. University of Kent centre for Health Services Studies.

<sup>63</sup> Hurcombe, R., Bayley, M., and Goodman, A (July 2010) Ethnicity and Alcohol: A review of the UK literature. Joseph Rowntree Foundation.

**Smoking:** Local data<sup>64</sup> indicates there was no difference in smoking prevalence between BME and White British respondents (23%). Smoking prevalence is highest in Mixed ethnic groups (32%) although this difference isn't significant. Black or Black British people are significantly more likely to be ex-smokers or non-smokers (96%) than any other ethnic group.

### Dental decay

The relationship between ethnicity and dental decay is complex and controversial.<sup>65</sup> Asian adults have been found to have higher levels of gum disease than other ethnic groups.<sup>66</sup> People from Black and Minority Ethnic (BME) groups are less likely to access NHS dental services with barriers including cost, language problems, and mistrust of dentists as well as cultural and religious influences.<sup>67</sup>

The Brighton & Hove Gypsy and Traveller Rapid Health Needs Assessment 2012 identified oral health as a priority health condition in the local gypsy and traveller population, due to a high consumption of fizzy drinks and poor oral hygiene.

### Preventing ill-health

**Preventable sight loss:** National evidence shows that there is a higher rate of glaucoma and age-related macular degeneration in Black ethnic groups, and a higher rate of diabetic retinopathy in South Asian populations.<sup>68</sup>

**Suicide:** Our best information about suicides in the city indicates that 13 per cent of suicide, open or narrative coroner verdicts between 2007 and 2010 were people from BME groups and seven of the 36 deaths in 2011 were. Death certification and coroners' records do not record ethnicity, although post-mortem pathology reports commonly include terms such as 'Caucasian' and a place of birth is normally recorded. Coroner's reports also include people who are not Brighton & Hove residents, all

of which means that direct comparisons between census and coroner's data are difficult. As noted, it is hard to make generalisations from such small numbers due to a number of factors which could influence these data.<sup>69</sup>

Migration does not appear to increase risk of suicide, with suicide rates among migrants in England and Wales generally reflecting patterns in the country of origin<sup>70</sup>.

### Improving health and promoting independence

**Mental health:** The 2007 mental health needs assessment for working age adults in Brighton & Hove identified higher risks among BME populations.<sup>71</sup> There is evidence that Brighton & Hove follows the national trend for twice the rate of mental health hospital admissions among people from a BME background and lower uptake of primary care mental health services.<sup>72</sup>

Qualitative research into BME mental health has been conducted with the University of Brighton and found that the identified obstacles to maintaining good mental health in Brighton and Hove, namely: experience of racism; poverty; poor education; and acculturation difficulties are prevalent throughout BME populations in the UK. 81% of respondents in this study reported experiencing barriers to getting help, most commonly stigma which was particularly prevalent amongst less acculturated members of BME communities.<sup>73</sup> The most popular sources of support locally were mental health and wellbeing services (61%), and complementary services and peer support groups were viewed as more satisfactory than GP and specialist mental health services.<sup>53</sup>

**Adults with learning disabilities:** The overall prevalence estimate of learning disability in BME communities in the UK is not known<sup>74</sup>, but research

<sup>64</sup> NHS Brighton and Hove (2012) Health Counts: A survey of people in Brighton & Hove 2012. University of Kent centre for Health Services Studies.

<sup>65</sup> Race Equality Foundation (2013) Oral Health and Access to Dental Services for people from Black and Minority Ethnic Groups.

<sup>66</sup> Conway D et al.(2007) Dental Caries in 5 year old children attending multi-ethnic schools in Greater Glasgow – the impact of ethnic background and levels of deprivation. *Community Dental Health*, 24(3):161-5.

<sup>67</sup> Race Equality Foundation (2013) Oral Health and Access to Dental Services for people from Black and Minority Ethnic Groups.

<sup>68</sup> Access Economics. *Future Sight Loss UK 1: Economic Impact of Partial Sight and Blindness in the UK Adult population*. 2009.

<sup>69</sup> Brighton & Hove City Suicide Prevention Strategy Group (2012) Audit of HM Coroner's records of deaths by suicide in Brighton & Hove 2003-2010

<sup>70</sup> Gill P.S., Kai J., Bhopal R.S. and Wild S. (2007) Black and Minority Ethnic Needs Assessment

<sup>71</sup> Government Office for Science. *Mental capital and wellbeing: making the most of ourselves in the 21st century - Foresight Report*. 2008.

<sup>72</sup> Brighton and Hove City PCT. *Black and minority ethnic health needs analysis*. 2008.

<sup>73</sup> NHS Brighton and Hove (2012) A Qualitative Study of BME Mental Health and Wellbeing in Brighton and Hove. University of Brighton

<sup>74</sup> Raghu Raghavan (2009) *Improving Access to Services for Minority Ethnic Communities*. September 2009, Volume 12, Number 7. *Learning Disability Practice*

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indicates that there is an increased prevalence of severe learning disability in the UK's south Asian community.<sup>75</sup>

**Children with special needs:** Compass Brighton & Hove (a register of children with special needs) has slightly lower rates of Black, Asian or Minority Ethnic Groups (BAME) represented in 0-19 year olds than are seen in the population of Brighton & Hove as a whole - with 18.1% BAME and 80.7 % White British compared to 21.7% BAME and 78.2% White British in 0-19 year olds across Brighton & Hove (from Census 2011).

**Diabetes:** Diabetes is more common in certain ethnic groups: it is up to six times more common in people of South Asian descent and up to three times more common in those of African and African-Caribbean descent.<sup>76</sup>

**Coronary heart disease:** South Asian men are more likely to develop coronary heart disease at a younger age, and have higher rates of heart attacks.<sup>77</sup>

**Stroke:** Nationally, there is known to be higher prevalence of stroke in some BME groups.<sup>78</sup> In Brighton and Hove Black people have the highest stroke mortality rates.<sup>68</sup>

**Chronic Obstructive Pulmonary Disease (COPD):** Modelled prevalence of COPD by ethnic group indicates that in Brighton & Hove 5% of adult White and Mixed groups had COPD (compared with 4% in England) and 4% of the Black population and 2% of the Asian population had COPD (compared with

similar rates in England).<sup>79</sup>

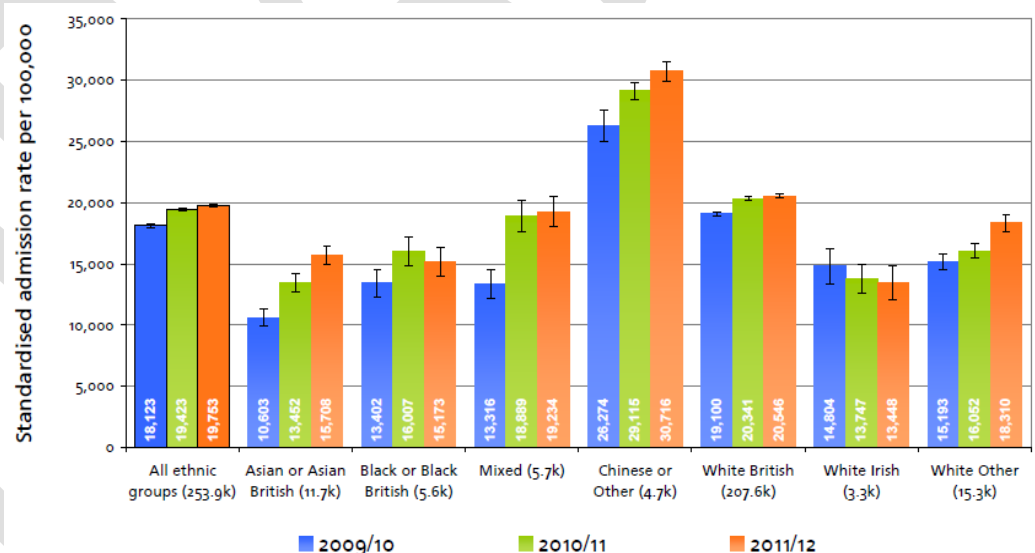
**HIV and AIDS:** Information from Brighton & Sussex University Hospitals shows that 87% of HIV patients accessing treatment in 2013 were White and seven per cent were Black African, although 54% of women in Brighton & Hove with HIV are Black African. Data does not include people with HIV who do not attend NHS treatment services, or people who do not know they have HIV. In 2013, 1,670 people with HIV in Brighton & Hove attended NHS HIV treatment services, an increase of 9% from 2011. Of this cohort, 87% were White.<sup>80</sup>

More than 90% of HIV infected males living in the city are White and around 53% of HIV-infected females are Black African.<sup>81</sup>

**Musculoskeletal conditions:** Research conducted in Manchester found that disability prevalence due to musculoskeletal pain is higher for Indian and Bangladeshi people than White people.<sup>82</sup>

### Secondary care:

**Figure 1: Admissions to hospital by ethnic group, Brighton & Hove, 2009/10 to 2011/12**



Source: Hospital Episode Statistics

<sup>75</sup> Emerson E, Azmi S, Hatton C et al (1997) is there an increased prevalence of severe learning disabilities among British Asians? Ethnicity and Health. 2, 4, 317-321.

<sup>76</sup> Department of Health. Who gets diabetes - Health Inequalities [http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Publicationandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH\\_4\\_899972](http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Publicationandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_4_899972) [Accessed 20/08/2012].

<sup>77</sup> SEPHO. Cardiovascular disease PCT health profile. Brighton & Hove City PCT 2013.

<sup>78</sup> Primatesta and Brookes. Health Survey for England: the health of minority ethnic groups: Cardiovascular disease. Information Centre for Health and Social Care. 1999

<sup>79</sup> East of England Public Health Observatory. COPD prevalence estimates. December 2011.

<sup>80</sup> Health Protection Agency, HIV prevalence by Local Authority in England 2011. Available at [http://www.hpa.org.uk/webc/HPAwebFile/HPAweb\\_C/1228207184991](http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1228207184991)

<sup>81</sup> Public Health England. Survey of Prevalent HIV infection Diagnosed (SOPHID): 2014

<sup>82</sup> Allison T et al. Musculoskeletal pain is more generalised among people from ethnic minorities than among white people in Greater Manchester. Ann Rheum Dis.2002;61:151-156. doi:10.1136/ard.61.2.151.

There was little difference in A&E attendance for BME groups (17.7%) compared to the general BME population recorded by the 2011 census (19.5%) in 2014/15.<sup>83</sup>

**Hospital admissions:** Between 2009/10 and 2011/12, age standardised admission rates to hospital have shown significant year-on-year increases for Asian or Asian British, and Chinese or Other populations in Brighton and Hove (Figure 1).

### Maternity care

In 2014/15, 31% of mothers giving birth at the Royal Sussex County Hospital were from BME groups.<sup>84</sup>

A local 2012 report found that Traveller communities experienced challenges to accessing antenatal care, including that they tend to present to services at a late stage. Handheld maternity records were reported to work well, though it was not possible to access notes from a previous pregnancy.<sup>85</sup>

### Predicted future need

Brighton and Hove's Black and Minority Ethnic communities are growing. At the time of the 2001 census 12% of the city's population (29,683 people) were from a BME background. By the 2011 census this reached 20.5% (53,351 people).<sup>86</sup> The population of the city and older people in particular, is expected to become more ethnically diverse with implications for services.

### What we don't know

Whilst some ethnicity data is available it does not provide a full picture of service uptake or suitability. Ethnicity is incompletely monitored in primary care.<sup>87</sup> A 2012 BME mental health needs assessment has gone some way to pulling together the available ethnicity data.

Ethnicity is not recorded on death certificates. Country of origin is recorded but this only provides partial information on first generation immigrants and misses out subsequent generations.

### Key evidence and policy

Tackling Health Inequalities: A Programme for Action 2003. The Acheson Inquiry made three recommendations for reducing ethnic health inequalities:

- Policies to reduce socio-economic inequalities should consider the needs of BME groups.
- Services should be sensitive to the needs of BME groups and promote awareness of their health risks.
- The needs of BME groups should be specifically considered in planning and providing health care.

Delivering racial equality (DRE) in mental health care 2005.

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4100773](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4100773)

The Equality Act 2010 expands and clarifies anti-discriminatory legislation and creates a duty on statutory organisations to evidence that they have considered the impact of their functions on excluded communities (including BME communities) and that they are actively removing disadvantage, discrimination and barriers to services.

In 2008, the Department of Health published 'No Patient Left Behind: how can we ensure world class primary care for BME people?' which identified barriers and proposed recommendations:

- Supporting patient 'choice and voice'
- Commission for diverse communities
- Routine ethnicity data collection
- Training of primary care staff
- Nurturing diverse workforce
- Leadership and commitment
- Focus of a National Improvement Team project [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_084971](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084971)

Health Inequalities: a guide for general practitioners; Royal College of General Practice Health Inequalities standing group; London 2008.

<sup>83</sup> Brighton & Hove City Council. Public Health Intelligence team

<sup>84</sup> Analysis of HES data produced by Public Health Intelligence team, August 2015

<sup>85</sup> Brighton & Hove Gypsy & Traveller Rapid Health Needs Assessment (2012) <http://www.bhconnected.org.uk/content/needs-assessments>

<sup>86</sup> A census is a count of people & households undertaken every decade, & is used to set policies & estimate resources required to provide services for the population. It is the most complete source of information about the population that we have. The latest census was held on 27 March 2011.

<sup>87</sup> Alves B. Health and health service usage of BME populations in Brighton & Hove. Brighton & Hove City PCT. 2006.

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<http://www.rcgp.org.uk/pdf/Health%20Inequalities%20Text%20FINAL.pdf>

### Recommended future local priorities

1. Continue to work with Community and Voluntary sector representatives and gateway organisations, and ensure communities' 'voices' are present in service development and evaluation.
2. Take forward the recommendations in the Brighton & Hove City Council Traveller Commissioning Strategy 2012 and the 2012 needs assessment of the health and wellbeing issues for Gypsy and travelling communities.
3. Continue cultural awareness training for all services.

### Key links to other sections

Ethnicity is considered throughout the JSNA.

### Further information

The Brighton & Hove equalities profile and BME snapshot report are both available at <http://www.bhconnected.org.uk/content/reports>

### Last updated

October 2016