BLACK, ASIAN AND MINORITY ETHNIC COMMUNITIES IN WEST SUSSEX, 2016

Produced by the West Sussex, Public Health and Social Research Unit

HEALTH AND SOCIAL CARE NEEDS ASSESSMENT

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west sussex county council | JSNA
Public Health & Social Research Unit

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Foreword

As Director of Public Health here at West Sussex County Council, I am pleased to introduce our first Black, Asian and Minority Ethnic (BAME) needs assessment.

This set of documents, aim to be a key driver in making sure that West Sussex BAME residents enjoy the support they need to live happy and healthy lives, but when and where they need to, can rely on services and support that are equitable, accessible and culturally appropriate. This is a growing sector of our population that continue to make a vital contribution to the culture, life and economy of West Sussex.

Having similar life opportunities regardless of background and circumstances remains a priority, and here at West Sussex County council our aim is to ensure that we give children the best start in life, allow people to fulfil their potential and contribute to the economy, and support people to live independently for longer.

Reducing health inequalities is at the heart of what we do in Public Health and we know that continuing to foster relationships within BAME communities and working together with partner organisations and community groups is key to achieving this.

We have spoken with a number of BAME residents to find out what is important to them. This report set outs a number of recommendations for action to increase focus and activity on the issues most important in the lives of our BAME residents.

This report is just the beginning. We will continue to consider these findings in our work going forward, and we will seek to measure progress against the recommendations made.

We will ensure that we provide clear and visible leadership on these important issues and continue to hold ourselves to account; and work towards a socially cohesive West Sussex where everyone feels safe and secure with a positive support network; where older residents will have the support they need to live full and independent lives for as long as possible.

Dr Nike Arowobusoye

Director of Public Health

Message from the West Sussex Cabinet

As cabinet lead for Health and Wellbeing here at WSCC, I am delighted to welcome the publication of the Black, Asian and Minority Ethnic needs assessment report.

As residents and as councillors we can continue to take pride that West Sussex is a fantastic place to live and work. This report shows that on the whole our vibrant and diverse communities are living happy and healthy lives. However, this report also shows that for some people in BAME communities, challenges in their daily lives because of their ethnicity remain.

Ours is an organisation which is here to provide residents with the support they need to live happy and healthy lives. From the early years, through to later life our commitment to supporting all our residents remains at the heart of our vision for a happy, healthy and vibrant West Sussex. Our BAME residents are very much part of that vision for a socially cohesive and diverse society.

I welcome this report which provides a clear set of actions for improvements and developments across organisations and communities. It contains recommendations that we can measure progress against and be accountable to; giving WSCC a clear leadership role in setting exemplar policies which reflect our commitment to our priorities in an inclusive way.

Above all, this report shows that we can achieve far more if we work collaboratively; and I welcome the opportunities identified in this report to work together for a better and stronger West Sussex.

Christine Field

Cabinet Member for Community Wellbeing

Executive summary

Introduction

In the most recent comprehensive joint strategic needs assessment (JSNA), it was highlighted that there was an increasing ethnically diverse population in West Sussex, especially in younger groups. Minority ethnic groups were identified as having specific or additional health needs and so the West Sussex Health and Wellbeing Board asked the Public Health and Social Research Unit (PHSRU) to conduct a needs assessment for Black, Asian and minority ethnic (BAME) groups. The aim of this work was to identify overarching as well as specific issues in minority ethnic groups; to understand what life is like for these groups and communities living in West Sussex; what their needs are and which of these require commissioned services or which of these the communities provide for themselves; how they access a range of existing services and whether these services are currently meeting their needs; and what challenges and barriers there are in accessing services or participating in life in West Sussex.

By using a number of methods to gather this information, this work will provide an overall picture of life, health and wellbeing in West Sussex for people in BAME groups; and most importantly, identify where there are opportunities for improving their health and wellbeing.

The only thing I miss is establishing a relationship with my GP. Every time, you see someone different, you don't have your 'GP friend' here (Male, Italian, 25–64).

It's important to know how to get past the receptionist… you have to know how to beat the system (Female, Ugandan, 25–64).

When I asked my GP if I can have a female examiner – as I am a female and I don't feel comfortable being examined by a man – I could not be given one. As a Muslim this is very important to me. So what was the point of asking me what religion I am if when it matters they don't care? (Female, Morocco, 25–64).

I am scared to ask for too much. My leave to stay here is not permanent and if I ask for too much I am scared that they will tell me to leave. I am not sure if the amount of care I access affects my residency so I just don't risk it. My family take on the burden (Male, Pakistani, 75+).

A wife would be ruining her husband's name in the community if it [abuse] ever got out (Female, Sri Lankan, 18–24).

Overall the services have very much improved, culturally everything has vastly improved … [before] we didn't have temples, we didn't have anything … people are well informed… yes you will get ignorance here and there and get remarks, but a lot has changed' (Male, Sri Lankan, 25–64).

I would never tell anybody I am a Traveller. I don't tell employer/landlords or any services (Gypsies and travellers group).

I drive and would go anywhere in West Sussex to be able to pray, light a candle for the health of my family in Estonia and to simply stand in silence in our church, where even the walls give you support (Female, Estonian, 25–64).

I have a Russian speaking friend – who has 5 children and with such a big family does not have time to learn English – who feels isolated (Female, Estonia, 25–64).

Section 1a: Population & diversity

History shows that West Sussex has always had a changing population, with inward and outward migration at varying levels across the ages.

Section 1.a Current population

The 2011 census data show that the largest ethnic group is "White: Other white" comprising four per cent of the total population in West Sussex. The next highest groups are Asian/Asian British, predominantly: Indian (1.2%), Pakistani (0.6%) and Bangladeshi (0.3%) with 1.4% Chinese or 'Other'.

Table 1, Ethnic background of West Sussex population

2011 Census Data	Numbers *(Figures rounded so may not sum)*			Percentage		
	West Sussex	SOUTH EAST	ENG	West Sussex	SOUTH EAST	ENG
	806,890	8,634,800	53,012,500			
White: English/Welsh/Scottish/Northern Irish/British	717,550	7,359,000	42,279,200	88.9%	85.2%	79.8%
White: Irish	5,980	73,600	517,000	0.7%	0.9%	1.0%
White: Gypsy or Irish Traveller	1,070	14,500	54,900	0.1%	0.2%	0.1%
White: Other White	31,900	380,700	2,430,000	4.0%	4.4%	4.6%
Mixed/multiple ethnic group: White and Black Caribbean	2,890	46,000	415,600	0.4%	0.5%	0.8%
Mixed/multiple ethnic group: White and Black African	2,060	22,800	161,600	0.3%	0.3%	0.3%
Mixed/multiple ethnic group: White and Asian	4,270	58,800	332,700	0.5%	0.7%	0.6%
Mixed/multiple ethnic group: Other Mixed	2,940	40,200	283,000	0.4%	0.5%	0.5%
Asian/Asian British: Indian	9,660	152,100	1,395,700	1.2%	1.8%	2.6%
Asian/Asian British: Pakistani	5,240	99,200	1,112,300	0.6%	1.1%	2.1%
Asian/Asian British: Bangladeshi	2,350	28,000	436,500	0.3%	0.3%	0.8%
Asian/Asian British: Chinese	2,960	53,100	379,500	0.4%	0.6%	0.7%
Asian/Asian British: Other Asian	8,130	119,700	819,400	1.0%	1.4%	1.5%
Black/African/Caribbean/Black British: African	4,570	87,300	977,700	0.6%	1.0%	1.8%
Black/African/Caribbean/Black British: Caribbean	1,340	34,200	591,000	0.2%	0.4%	1.1%
Black/African/Caribbean/Black British: Other Black	1,240	14,400	277,900	0.2%	0.2%	0.5%
Other ethnic group: Arab	1,080	19,400	221,000	0.1%	0.2%	0.4%
Other ethnic group: Any other ethnic group	1,680	31,700	327,400	0.2%	0.4%	0.6%

Source: ONS, 2011 Census

Many BAME communities have been increasing since 2001, in line with the introduction of free movement within the EU. Groups are largely concentrated in Crawley and along the coastal area in Bognor Regis, Littlehampton and Worthing.

1a.2 Age

The BAME population are broadly younger than the general population with the largest proportion being of working age (24-45 years), particularly in the 'White Other' groups. With this population having a higher proportion of working age and lower proportion of older, retired age people, BAME groups are more likely to be economically active and so support the aging population.

1a.3 Religion

Around 4% of West Sussex residents identify with a minority religion. The largest minority religion is Islam, with 1.6% identifying as Muslim, a figure much lower than regional and national averages. The greatest concentration of minority religion is in Crawley with 13.4% identifying with a minority religion, of which most are Muslim (7.2%) or Hindu (4.6%).

1a.4 Language

A total of 21 languages are spoken by at least 500 people in West Sussex, with Polish the most widely spoken.

Table 2, Main languages spoken in West Sussex, by at least 500 people.

Main Language	**West Sussex**	Adur	Arun	Chichester	Crawley	Horsham	Mid Sussex	Worthing
All residents aged 3+ years	**779,010**	59,050	145,040	110,445	101,600	127,080	134,945	100,850
English	**742,040**	57,620	138,320	107,370	88,305	123,650	130,305	96,470
(English Percentage)	95.25%	97.58%	95.37%	97.22%	86.91%	97.30%	96.56%	95.66%
Polish	**6,300**	135	2,545	650	1,670	325	450	525
Portuguese	**1,955**	35	450	150	960	75	135	145
Gujarati	**1,650**	25	50	40	1,355	35	85	65
Tagalog/Filipino	**1,500**	20	195	135	165	260	380	345
Urdu	**1,440**	10	35	15	1,230	40	55	55
French	**1,435**	75	145	155	420	220	265	150
Lithuanian	**1,320**	-	525	85	415	35	35	220
Tamil	**1,310**	5	50	25	1,035	25	90	80
Bengali	**1,225**	140	185	75	270	80	160	315
Spanish	**1,185**	60	125	140	300	180	240	145
German	**1,045**	60	155	195	120	145	260	115
Italian	**1,005**	45	65	70	255	155	180	235
Hungarian	**920**	35	135	45	340	160	150	55
Russian	**895**	40	360	75	175	60	85	105
Malayalam	**750**	10	90	80	70	140	285	75
Arabic	**700**	160	55	40	250	50	50	95
Panjabi	**650**	10	5	-	580	20	15	20
Latvian	**630**	15	320	40	160	20	35	40
Romanian	**620**	15	105	50	165	125	120	40
Slovak	**580**	15	70	45	195	95	85	75
Turkish	**540**	35	75	40	130	35	105	115

Source: ONS, 2011 Census

In Crawley 13% of residents do not use English as their main language; whilst in Bognor, three quarters of people whose main language is other than English, speak an EU language (that is not French, Spanish or Portuguese). This shows a potential demand for English language courses, as well as translation and interpreting services. The ages of those needing these types of services vary between groups and between areas. There is a desire across communities to have access to affordable English language classes. Commissioning this type of service has multiple benefits; ability to speak English will promote integration in and between communities; reduces reliance on interpreting/translation services; and increase awareness and appropriate use of health and social care systems.

Being less able to speak English well appears to influence the type of jobs in which residents might gain employment, with people in this group more likely to be working in the service or agricultural sector, than in the general population. They are also less likely to be employed in the public sector, than those with a better grasp of English.

1a.5 Family

Families in Asian/Asian British households in West Sussex are less likely to be lone parent households. Mixed ethnic families and Black/Black British families are more likely, than the general population. In general, families in west Sussex are less likely to be lone parent households compared to similar ethnic groups around the UK.

1a.6 Children and young people in school

Though lower than the regional and national averages, the proportion of children from BAME groups is growing. This is partly because the average age of many BAME groups is lower than that of the general population and so more per capita are likely to be of childbearing age.

Young people from BAME groups are more likely to attend higher educations than their White British peers, though Black groups remain underrepresented in the most selective institutions.

Section 1b: Migration

1b.1 None-UK passport holders

Non-UK passport holders are particularly difficult to track in the resident population, in the decade between national-level censuses. Fewer than 1% of GP registrations in recent years were to non-UK passport holders.

Table 3, Inward and outward migration in West Sussex

	Moved in from inside the UK	Moved out to inside the UK	Moved in from outside the UK
All residents	12,785	12,810	6,920
White groups	11,090	11,090	5,305
All groups other than 'White'	1,690	1,715	1,615
(%) other than white	(13%)	(13%)	(23%)

Note: Due to the 'Harmonised Concepts and Questions for Social Data Sources Primary Standards' used for this data, all White ethnic groups have been combined to one single category.
Source: ONS 2011 census

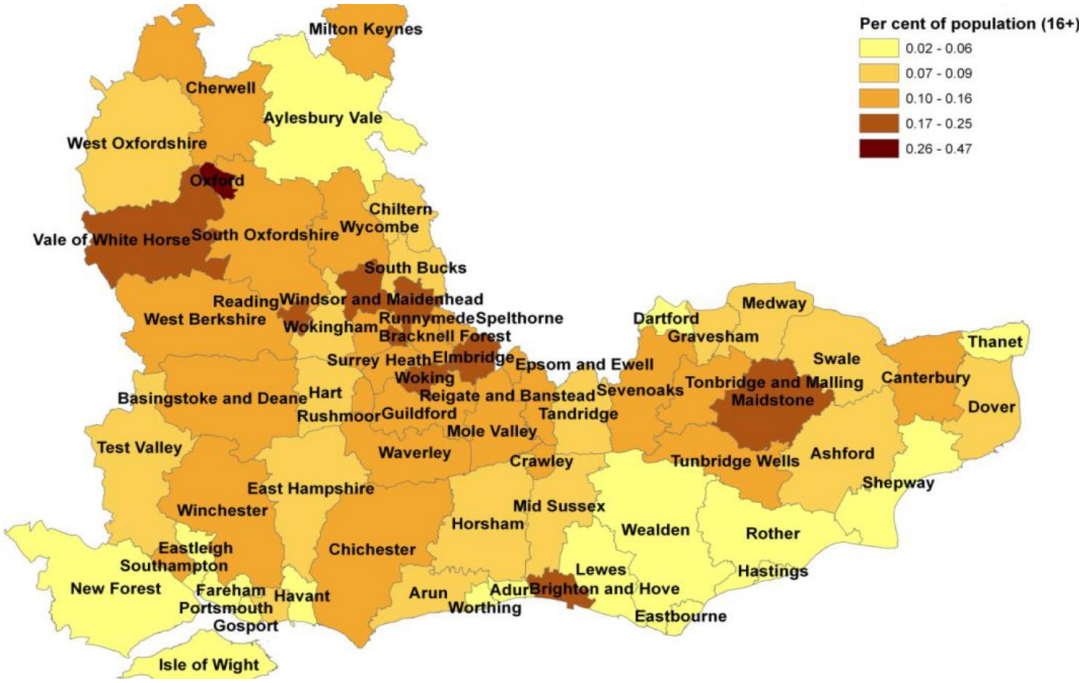
Estimates suggest there are roughly fifty non-UK passport holders for every 1,000 people in the resident population in West Sussex, (2013). Roughly 1:4 of these applied for a national insurance number (NINo) and around half of those had registered with a GP. The proportion of new non-British nationals in the population is believed to be decreasing.

Most non-UK passport holders tend to live in urban areas, and in West Sussex are mostly concentrated in the north of the county and the coastal strip.

1b.2 Migrant workforce

The majority of migrants in the UK are mainly here for the purpose of work (with full time education coming second). Relative to the UK-born population, immigrants make up a greater proportion of the resident adults in employment in less diverse areas like Chichester district than in more diversely populated areas like Worthing borough.

Figure 1, Distribution of short-term migrants in employment



Source: South East Strategic Partnership on Migration, using UK Census, 2011

1b.3 Irregular migrants

The number of irregular (illegal) migrants in the area is unknown, though research does cite a number of barriers to support and services which are largely in line with those linked to registered/documented migrants, discussed later in the report

1b.4 Asylum seekers

Nationally, in 2015, asylum applications from main applicants increased by 29% to 32,414, with the majority coming from Eritrea, Iran, Sudan and Syria. Even with this increase the UK ranks 17th in the EU for the per capita asylum applications it receives. West Sussex is set to receive 240 Syrian refugees to the county over the next four years – with some families expected to arrive early in 2016.

Section 1c: Gypsies and Travellers

A comprehensive health needs assessment for Gypsies and Travellers was conducted in 2010 and, as a result, they are not examined in this report. Progress on the findings and recommendations of the 2010 report, are discussed in sections 6 and 7.

1c.1 West Sussex population

Accurate numbers for Gypsies and Travellers in West Sussex are unknown, and many choose not to identify as Gypsy or Traveller on ethnic records. Fear of discrimination is often given as a reason for not publically identifying as Gypsy/Traveller.

Table 4, Numbers of traveller caravans in West Sussex, 2014-15

	West Sussex		Adur		Arun		Chi		Hor		Mid Sx	
	Jul-14	Jan-15	Jul-14	Jan-15	Jul-14	Jan-15	Jul-14	Jan-15	Jul-14	Jan-15	Jul-14	Jan-15
Authorised sites (with planning permission)	248	293	12	12	43	43	88	124	67	75	38	39
Unauthorised sites (without planning permission)	59	75	0	20	3	1	23	15	31	39	2	0
Total All Caravans	**307**	**368**	**12**	**32**	**46**	**44**	**111**	**139**	**98**	**114**	**40**	**39**

Source: Department for Communities and Local Government, Count of Traveller Caravans, 2015

At the most recent count, there are 131 authorised caravan pitches on 10 managed sites in West Sussex. Management of these sites is outsourced to Home Space Sustainable Accommodation. The twice-annual National Caravan Count found that there are between 300 and 400 traveller caravans in West Sussex, varying by the time of year.

Research suggests that members of Gypsy and Traveller communities are more likely to have lower health outcomes and health literacy.

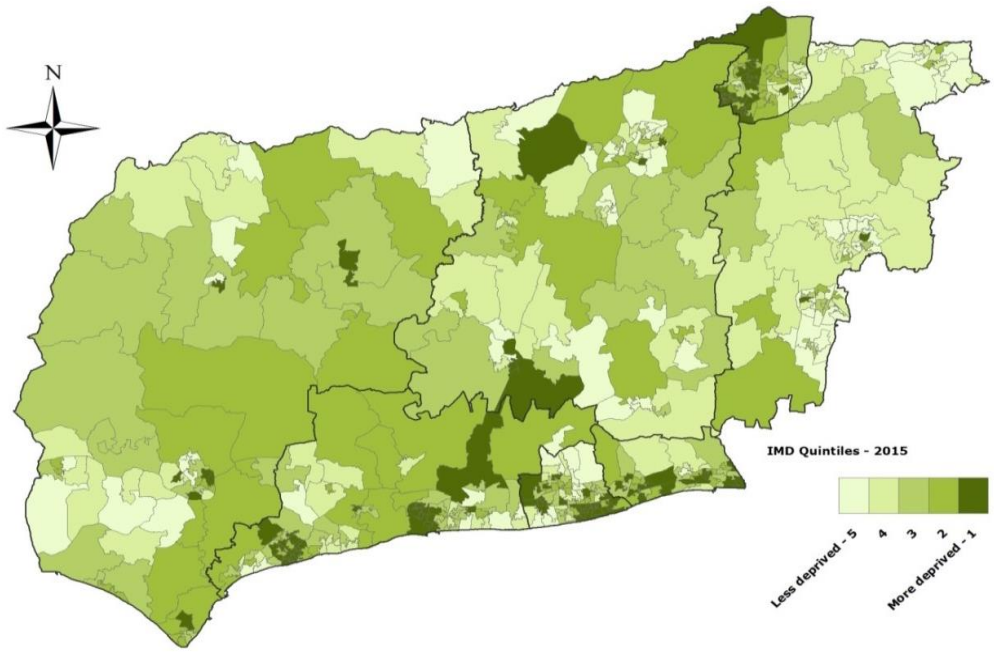
Section 2: Wider determinants of health

2.1 Deprivation

We are constantly influenced by a number of social, economic and environmental factors such as our families, work opportunities and household income, and where we live.

Deprivation is a well-recognised indicator of poor health outcomes in the population. Many of the minority ethnic communities identified in section 1 live within or near the areas of West Sussex which are the most deprived in the county: central Bognor Regis and Worthing and west Crawley.

Figure 2, Indices of Multiple Deprivation for West Sussex



Source: ONS (2015) IMD statistical release

2.2 Housing

2.2.1 Overcrowding

Locally, BAME households were far more likely to live with more than one person per room than White British households, which is a sign of overcrowding.

2.2.2 Living alone

Those from Black, Chinese, Arab or Mixed ethnic backgrounds (of working age) are more likely to live alone than White British residents.

2.2.3 Tenure

Home ownership for Chinese, Indian and Bangladeshi residents has fallen heavily (when compared to White British residents) in recent decades. Locally, White British and Irish are the most likely to own their home (with a mortgage or outright). Those within the White Other census category (including many from the Eastern EU) are amongst the least likely to use social rented housing and are the most likely to use private renting, of any ethnic group.

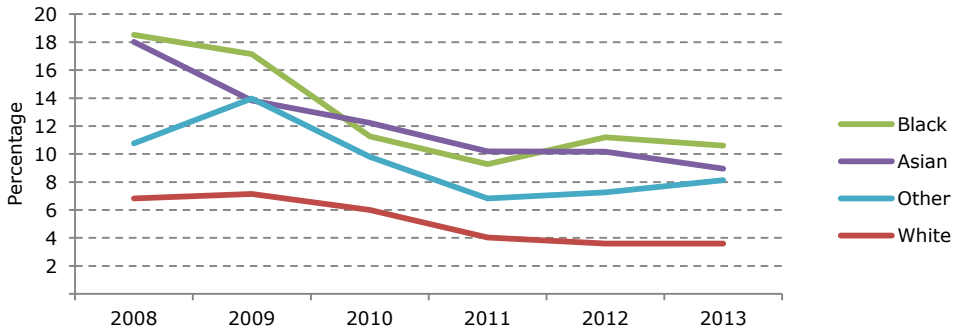
2.2.4 Homelessness

Within West Sussex, of the 567 households accepted as homeless, 20.6% are from BAME groups. This increases to 38.7% in Crawley.

2.2.5 Non-decent homes

People from BAME groups are more likely to live in a home with damp or mould. This may be linked to cold homes and fuel poverty. This has been linked to long term respiratory problems and poor educational outcomes in children.

Figure 3, Damp or mould in homes, by ethnicity, England



Source: English Household survey, 2008-2013

2.3 Education and skills

2.3.1 School readiness

West Sussex has the lowest school readiness performance in the South East and is significantly below the national average. However, the data suggests that ethnicity is not a principal factor in this, despite some groups performing worse on average than the general population.

Table 5, Proportion of eligible children with a 'good level of development' at the Early Years Foundation stage by ethnic group in West Sussex (2014/15)

Ethnic Group	Total number of pupils assessed	% with a GLD
White	7,800	64.7%
Mixed	450	62.8%
Asian or Asian British	440	57.1%
Black or Black British	40	51.2%
Chinese	20	80.0%
Other Ethnic Groups	40	38.5%
Refused to disclose	70	72.3%
Information Not Yet Obtained	710	58.3%
Unknown	100	54.6%

Note: Figures rounded to the nearest 10
Source: EYFS Profile data 2014/15 for West Sussex (EPoD) provided by the Early Years Childhood Service

2.3.2 Performance in schools

Boys from Black ethnic groups typically perform far worse in West Sussex at GCSE level than other Black boys around England. Although the reasons for this remain unclear, it could be a reflection of the teaching workforce composition and a reduction in the impact of equality policies.

2.3.3 Highest qualification level

The BAME population generally has higher qualifications than the White British population; the only exceptions to this being Bangladeshi and Gypsy/Irish Traveller groups.

Table 6, Highest level of qualification, by ethnicity, in West Sussex

	No qual's	Level 1 qual's	Level 2 qual's	Level 3 qual's	Level 4 qual's and above	Apprentice -ship	Other qual's
All categories	**20%**	**14%**	**17%**	**12%**	**28%**	**4%**	**5%**
Asian/Asian British: Indian	11%	9%	10%	8%	46%	1%	17%
Black/Black British: African	8%	12%	16%	12%	41%	1%	10%
White Irish	24%	8%	11%	11%	36%	3%	8%
Arab	14%	9%	11%	9%	36%	1%	22%
Asian/Asian British: Chinese	17%	11%	11%	9%	35%	1%	16%
Black/Black British: Caribbean	13%	16%	17%	10%	33%	3%	9%
White: Other White	11%	6%	9%	9%	32%	2%	31%
Asian/Asian British: Pakistani	15%	15%	12%	9%	30%	1%	18%
Mixed/multiple ethnic group	14%	15%	20%	14%	28%	2%	7%
White British	21%	15%	18%	13%	27%	4%	3%
Asian/Asian British: Bangladeshi	23%	17%	11%	9%	18%	1%	22%
Gypsy or Irish Traveller	55%	13%	11%	5%	9%	2%	4%

Source: ONS Census 2011

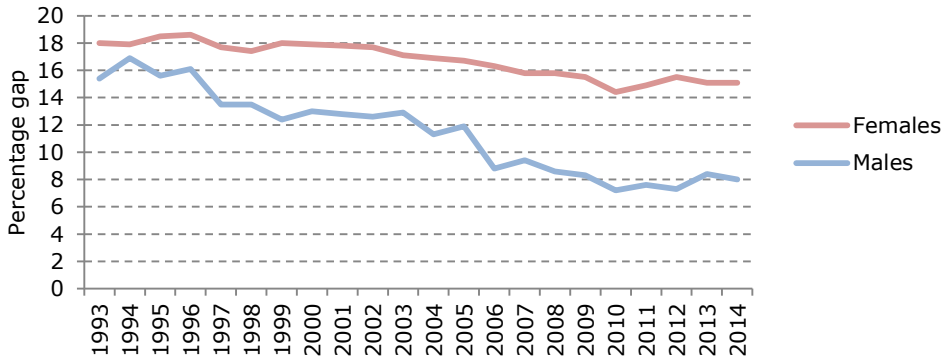
2.4 Workforce

2.4.1 Employment

Those from BAME groups were more likely to be 'economically active but unemployed' in 2011 than White British residents in West Sussex, particularly in the under 24 year age group.

In 2011, 44% of in-work residents from Black ethnic backgrounds worked in public administration, health and education. As this area has seen large scale government cutbacks in this period, it is possible that this group has been disproportionately affected in recent years.

Figure 4, Percentage gap between BAME employment rate and White employment rate



Note – The percentage gap is calculated by subtracting the average employment rate of all BAME groups from the average employment rate of the White groups.
Source: DWP 2015, Labour market status by ethnic group annual data to 2014 (ONS Labour force survey)

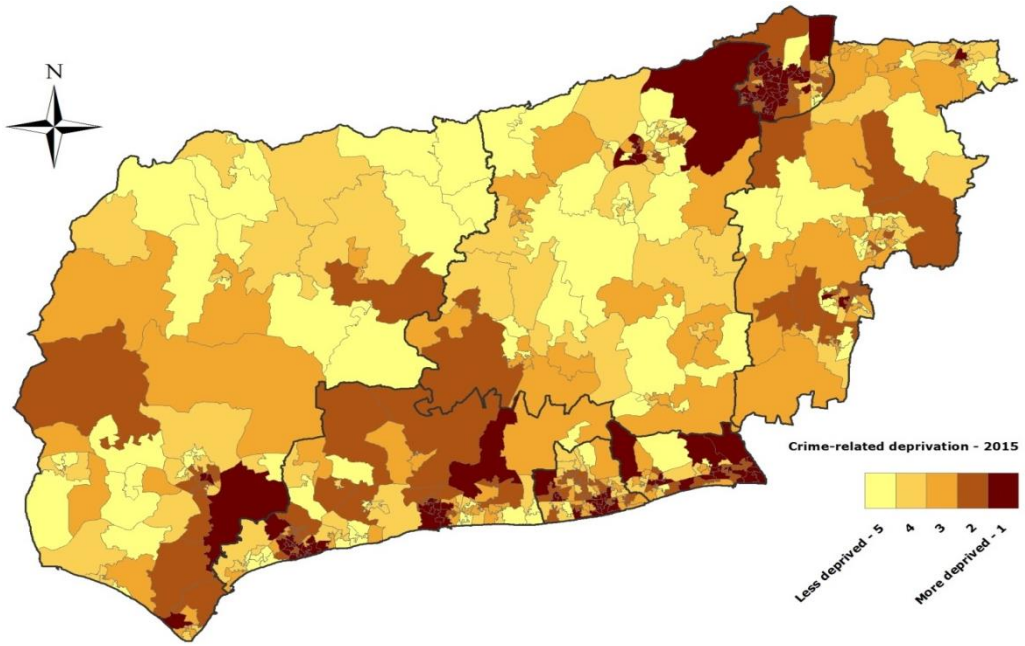
Whilst differences in the employment rate between BAME groups and White groups have narrowed over recent decades for men, it has remained at a consistent level for women. Pakistani and Bangladeshi women in particular were far more likely to be unemployed than women from other ethnic backgrounds.

The ethnic demography of WSCC employees does not reflect that of the resident population, though large gaps exist in the data. – Ethnicity is unknown for 21% of employees and efforts to improve recording are believed to be ongoing.

2.5 Community safety

BAME groups tend to be concentrated in areas of higher crime-related deprivation.

Figure 5, West Sussex LSOAs showing areas of high crime-related deprivation



Source: ONS (2015) IMD statistical release

Sussex Police publish much data on ethnicity, though with poor recording in some fields, often the data leaves wide margins of error.

2.5.1 Searches and arrests

Despite low BAME arrest numbers, residents of a Black ethnic background are far more likely to be arrested (per capita) than White residents; 33 times more likely in Adur and Worthing and 13 times more likely over all of Sussex. Black groups also have a higher rate of stop and search; fourteen times higher than the White British residents in Worthing and Adur.

Table 7, Likelihood that a member of an ethnic group was arrested compared to White groups

	x times more likely to be arrested than White				
	White	Mixed	Asian	Black	Other
Adur & Worthing	1.0	2.5	0.2	33.3	-
Arun	1.0	1.0	-	8.4	-
Chichester	1.0	-	2.2	10.9	-
Crawley	1.0	0.6	0.8	5.0	0.6
Horsham	1.0	-	1.8	-	10.9
Mid Sussex	1.0	1.0	1.2	7.6	-
Sussex Police Force (Minus Gatwick)	1.0	1.7	1.4	13.5	1.1

Note: In Sussex Police records, all White ethnic groups are combined
Source: Sussex Police statistics, 2015

Residents from a BAME background are more likely to be arrested for drug offenses than White residents. Nationally, the Black stop and search rate per 1,000 residents was four and a half times higher than White groups (2013/14). White residents are more likely to be convicted of the crime for which they are being prosecuted.

2.5.2 Victims of crime

Nationally, those from BAME backgrounds are more likely to believe they will be a victim of crime in the future, which matches police records of past crimes. Where data exist, residents from BAME communities are more likely to be victims of violent crime than White groups. Locally, there has been a rise in racist incidents recorded by Sussex Police.

2.5.3 Reporting taboo crime

BAME residents only make up 6% of reported domestic abuse in the past two years (where ethnicity is known), which may highlight an issue with underreporting within the community. Qualitative evidence indicates that some communities may attempt to keep taboo issues unreported where possible.

2.5.4 Diversity in Sussex Police

The makeup of Sussex Police for does not reflect that of the community, with only a handful of officers identifying as having a minority religion, and less than 2% of the West Sussex division coming from BAME backgrounds. – Sussex Police are attempting to find ways to increase BAME recruitment.

Section 3: Lifestyles, risk behaviours and health protection

Section 3.1 Tobacco, alcohol and substance misuse

3.1.1 Smoking

Bangladeshi and Irish men were more likely to report smoking cigarettes, than those in the general population, as were Irish women and Black Caribbean women.

BAME groups generally have the lowest 'quit rate' of those who access services, with Asian groups being the most likely to quit (35%).

3.1.2 Smokeless tobacco

Current figures are unreliable, but indicate that Bangladeshi men and women were far more likely to use chewing tobacco than other minority groups in the population.

3.1.3 Alcohol

Most BAME groups have higher rates of abstinence and lower levels of drinking and drug use compared to White British residents, though this may change over time as cultures integrate. Irish, Scottish and Indian men have higher than average alcohol related deaths, nationally and Sikh men over-present for liver cirrhosis. Mixed-background groups have higher rates of substance misuse.

3.1.4 Substance misuse

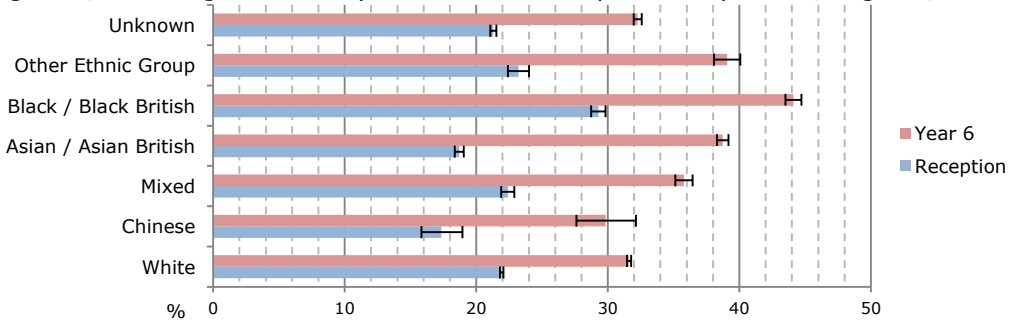
BAME groups are underrepresented in seeking treatment, despite having similar levels of alcohol or drug dependence/addiction, (being a separate issue to occasional use). There may be a cultural stigma around seeking help for substance dependence.

3.2 Obesity and physical activity

3.2.1 Obesity

There are a range of obesity-related illnesses which show higher or lower prevalence in specific ethnic groups.

Figure 6, Overweight or obesity in children at reception and year six, England, 2014/15



Source, HSCIC, 2016, National Childhood Measurement Programme data release (2014/15)

Children from Asian, Black and mixed ethnic backgrounds are more likely to be overweight or obese at Year 6 than those from other backgrounds in the general population. Particularly children from Black backgrounds are more likely to be overweight or obese by age 4-5 years.

Black and South Asian groups also tend to have higher BMI scores than those from White or East Asian backgrounds in adulthood.

The National Obesity Observatory suggests that people form Black backgrounds tend to carry less body fat than other groups and people from South Asian backgrounds tend to carry more body fat that other groups, when controlling for BMI. This may have led to an overestimation of obesity among African and an underestimation among South Asian adults.

3.2.2 Physical activity

South Asian groups have been found to have lower overall activity levels than the general population. Those from Mixed ethnic backgrounds had higher activity levels than the general population.

There may be a range of perceived barriers to some BAME groups taking up physical activities, such as higher modesty concerns, or a lack of culturally appropriate exercise services. A need for gendered physical activity sessions has been highlighted, for Muslims of older age groups.

3.3 Sexual health, screening and vaccinations

3.3.1 Sexual health

Sexual health and screening services do not robustly record data and this may be a reflection of the desire to not be identified by some in the community.

Further to this, anecdotal evidence suggest that some women may be unwilling to engage with screening programmes due to the manner in which results are often posted to the individual's home, where the husband/father will often be solely responsible for reading mail. – Alternatives may therefore be needed in place for all immunisations and screenings programmes.

3.3.2 Screening and vaccinations

Some key groups are at risk of not fully immunising their children against preventable diseases. These may include migrant families who have undergone immunisation programmes in native countries, which do not address the same conditions as the UK programmes.

Tuberculosis rates are relatively low in West Sussex, though those born outside of the UK, and particularly those born in India, represent a notably high proportion of those identified.

Section 4: Health status and long term conditions

4.1 General health and long term limiting illness

There are significant data gaps in traditional quantitative sources, such as service-level data, health data and life expectancy, due to immigration and poor recording/disclosure of ethnicity at these levels.

In 2011, more Crawley residents reported having bad or very bad health (14%) than those of the other areas of the county, particularly Asian/Asian British residents (24%).

Table 8, Residents with self-reported bad or very bad health, by ethnicity and CCG locality

	Horsham & Mid Sussex CCG		Crawley CCG		Coastal CCG	
	50 - 64 yrs	65+ yrs	50 - 64 yrs	65+ yrs	50 - 64 yrs	65+ yrs
All categories	4%	10%	8%	14%	6%	11%
White British	4%	10%	8%	14%	6%	11%
White Irish	5%	12%	9%	14%	7%	13%
Other White	4%	10%	7%	15%	6%	14%
Mixed/multiple ethnicity	4%	11%	10%	16%	11%	12%
Asian/Asian British	4%	11%	10%	24%	5%	13%
Black/African/Caribbean/Black British	4%	7%	10%	15%	6%	13%
Other	1%	5%	16%	37%	8%	13%

Source: ONS, 2011 Census

With the exception of Black/Black British residents in Crawley, more residents from all ethnic groups in West Sussex considered themselves to be healthy than those at a national and regional level.

4.2 Reported disability

4.2.1 Sensory impairments

People of African Caribbean descent are four times more likely to suffer from glaucoma and South Asian people more likely to have diabetic retinopathy.

Although there may not be accurate figures available for levels of hearing loss in minority ethnic groups, migrants from areas of high levels of poverty, poor health care and low levels of immunisation against diseases such as rubella, may be more at risk.

4.2.2 Learning disabilities

Local knowledge is low and further research could be directed at BAME perceptions of disabilities and how families and services interact.

Table 9, Learning disability patients by ethnic group, England and Wales

	2010	2009	2008
	Percentage (%)		
White British	85.3	86.7	88.9
White Irish	1.3	1.5	1.3
Other White	2.9	2.3	2.6
White and Black Caribbean	1.0	1.0	0.7
White and Black African	0.2	0.1	0.0
White and Asian	0.4	0.4	0.3
Other Mixed	0.7	0.5	0.3
Indian	0.9	0.9	0.7
Pakistani	0.7	0.9	0.7
Bangladeshi	0.5	0.6	0.3
Other Asian	0.4	0.3	0.3
Black Caribbean	2.6	2.2	2.3
Black African	0.8	0.9	0.7
Other Black	0.4	0.4	0.4
Chinese	0.0	0.1	0.1
Other	0.2	0.2	0.4
Not Stated	1.9	1.0	0.9
Total	100.0	100.0	100.0

Source: Care Quality Commission, 2010, 'Count me in' census

The Faculty of the Psychiatry of Learning Disability (Royal College of Psychiatrists) conducted a review of available literature and identified a series of potential barriers to services including communication, cultural views of the roots of disability, extended communities of decision makers who are not necessarily in contact with the professionals.

The faculty makes four recommendations around improving service access and provision, including meaningful engagement; meaningful information; professionals making efforts to understand barriers and

making efforts to overcome these; and lastly, a culturally competent workforce, developed with communities.

4.3 Mental health

4.3.1 Severe/enduring mental health

Previous needs assessments have commented on the link between mental health and risk factors such as low educational attainment/employment, deprivation and social exclusion. This being so we can assume a higher level of risk in some Black/Black British communities where such risk factors are more prevalent. – Specifically African Caribbean people are three to five times more likely than any other group to be diagnosed and admitted to hospital for schizophrenia.

4.3.2 Improving access to psychological therapies

A health equity audit (HEA) has shown that all minority groups are under-represented per capita in local mental health services, when compared to White British residents. Particularly striking are Asian/Asian British residents (at 58% of the White British take-up).

Table 10, Equity of access by ethnicity in West Sussex

Ethnicity	Census population (2011)	IAPT	% seen	Relative Gap (to white uptake rate)
White	634,800	11,991	1.9	100%
Asian / Asian British	22,100	243	1.1	58%
Black / Black British	5,600	92	1.7	88%
Mixed	6,700	121	1.8	95%
Other	2,200	88	3.9	208%

Note: White refers to all white ethnic classifications from the census
Source: Public Health Research Unit, IAPT Health Equity Audit, 2015

The HEA makes two relevant recommendations: that efforts should be made to improve recording of ethnicity and to increase take-up of psychological services amongst minority populations by engaging with communities and investigating perceptions and barriers to services. Little appears to have changed since the 2009 IAPT report into developing appropriate and accessible services for residents of minority communities. The IAPT recommendations are therefore still valid today and can work as a starting point for local efforts.

4.3.3 Community views of mental health

Qualitative evidence suggests that minority communities, particularly form South Asia or Africa, have a less open view of mental health problems, making accepting treatment less likely without concerted efforts to inform opinions.

Language can be a barrier to receiving treatment as those needing support cannot communicate complex emotive thoughts in English.

4.4 Chronic illness

People from BAME groups are more likely to encounter barriers to diagnosis, receive lower quality care, and experience poorer health outcomes.

4.4.1 Dementia

The all-party parliamentary group on Dementia predicts that, due to current age profiles of BAME groups, the number of those with dementia will increase seven fold by 2051, from 25,000 to 127,000 nationally.

It is likely that dementia is more common among Asian and Black Caribbean communities, because high blood pressure, diabetes, stroke and heart disease, which are risk factors for dementia, are more common among Asian and Black Caribbean communities

Recommendations around raising awareness; preventative work; sharing local knowledge and good practice; improving accessibility and knowledge and skills, were developed by the all-party parliamentary group.

4.4.2 Diabetes and cardiovascular disease

The risks of developing diabetes, cancer and cardiovascular disease are higher within some minority ethnic groups when compared with people classed as white British. These differences depend on many factors of lifestyle and demographics, as well as age.

Broadly, South Asians have a much higher incidence of heart attack and premature death than white British counterparts; Men born in the Caribbean are 50% more likely to die from stroke than the general population; Type 2 diabetes is six times more prevalent in South Asians and three times more prevalent in African and African-Caribbean populations; genetic differences in the distribution of fat in South Asians also increase risk.

4.4.3 Cancer

Cancers are generally higher in White British groups, for a range of reasons; however, there are many exceptions to this, when looking at individual cancers or specific ethnic groups.

4.4.4 Dual diagnosis

BAME groups have been cited as presenting with a higher instance of co-occurring mental health and alcohol/drug problems, locally.

4.5 Carer status

West Sussex has a higher proportion of carers compared to the South East or England, due to the relatively older population in West Sussex

Young carers and young adult carers aged 0-24 years in West Sussex have increased by 32% since 2001 (3,900 residents). Young carers are one and a half times more likely than their peers to be from minority ethnic backgrounds and are twice as likely to not speak English as their first language.

In West Sussex, 7% of carers identified themselves as from a minority ethnic group, though this will likely increase as population ages align with those of the general population.

Table 11, Provision of unpaid care in West Sussex

	Provides no unpaid care		1 to 19 hours a week		20 or more hours a week		Provides unpaid care total	
	Number	(%)	Number	(%)	Number	(%)	Number	(%)
All categories	722,495	89.5	58,320	7.2	26,070	3.2	84,395	10.5
White British	639,360	89.1	54,520	7.6	23,670	3.3	78,195	10.9
White Irish	5,265	88.0	470	7.9	245	4.1	715	12.0
White Other	30,945	93.9	1,275	3.9	755	2.3	2,025	6.1
Mixed/multiple ethnic group	11,480	94.4	460	3.8	215	1.8	675	5.6
Asian/Asian British	26,125	92.2	1,275	4.5	940	3.3	2,210	7.8
Black/African/Caribbean/Black British	6,725	94.1	245	3.4	180	2.5	425	5.9
Other ethnic group	2,600	94.2	85	3.1	70	2.5	155	5.6

Source, ONS, 2011 Census

4.6 Dental Health

Dental health service user data is not widely available, though when surveyed residents from BAME groups were somewhat less able to access dental services; and particularly so in Horsham and Mid Sussex.

Table 12, Access to NHS dentist, tried to get an appointment in the last two years, by CCG

	Tried to get an appointment in the last two years			Percentage successful in getting an appointment		
	Total response (weighted)	White	Other ethnicity	All	White	Other ethnicity
England	248,770	217,950	30,820	93.1%	94.2%	85.1%
NHS Coastal West Sussex	2,040	1,985	55	92.1%	92.1%	91.2%
NHS Crawley	525	435	90	92.2%	92.9%	90.9%
NHS Horsham and Mid Sussex	1,015	975	40	95.1%	95.5%	85.4%

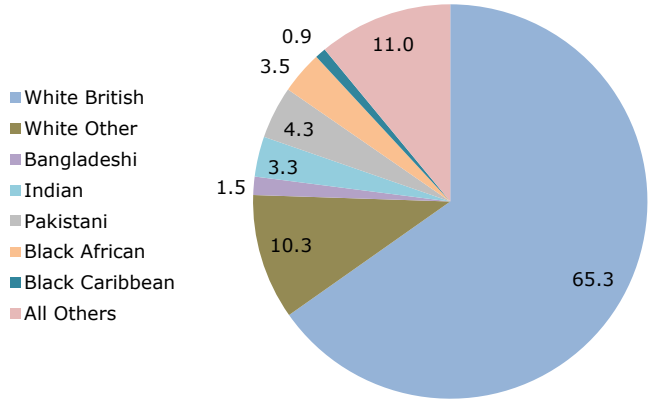
Source: GP Patient Survey dental results, January to March 2015

Perceptions of English dental care services are mixed amongst BAME groups, but foreign nationals, who are accustomed to other systems, generally think that English dentistry is poor in comparison to their home countries, whether they be in South Asian, East Asian or Eastern European countries.

4.7 Pregnancy, maternal and infant health

Whilst White British residents account for 80% of the England population, they only account for 65% of live births and 68% of all pregnancy terminations nationally.

Figure 8, Percentage of total live births by each ethnic group, England and Wales, 2014



Note: 'All others' include Chinese, Other Asian, Other Black, Other, and all Mixed groups.
Source: ONS (2015), Live births by ethnic group, England and Wales, 2014

Women from White British backgrounds and mixed ethnic backgrounds are more likely to have children younger than those from other minority groups.

Crawley has the highest percentage of live births to mothers born outside of the UK, with roughly a third coming from EU countries, a third from the Middle East and Asia.

Table 13, Live births, country of birth of mother and area of usual residence, 2014

Area of usual residence of mother	**All live births**	Mothers born within United Kingdom	Mothers born outside United Kingdom					
			Total (%)	EU	(Including New EU*)	Rest of Europe (non EU)	Middle East and Asia	Africa	Rest of World
Adur	**692**	605	87 (13%)	29	(19)	5	31	13	9
Arun	**1,463**	1,176	287 (20%)	210	(186)	9	37	14	17
Chichester	**1,060**	886	174 (16%)	84	(45)	9	36	19	26
Crawley	**1,618**	993	625 (39%)	213	(153)	20	232	139	21
Horsham	**1,229**	1,055	174 (14%)	82	(41)	14	34	20	24
Mid Sussex	**1,521**	1,251	270 (18%)	120	(72)	13	72	28	37
Worthing	**1,136**	928	208 (18%)	87	(60)	15	67	30	9
West Sussex	**8,719**	6,894	1,825 (21%)	825	(576)	85	509	263	143

Note: New EU includes those nations who joined the EU in 2004 or after
Source: ONS (2015), Parents' country of birth, 2014

4.7.1 Unplanned pregnancies and terminations

In 2014, women from minority ethnic groups accounted for 30% of legal abortions in England and Wales, despite only making up 20% of the UK population. Some of this may be a result of the lower population age of these groups, but contrast with perceived cultural aversions to terminations.

Table 14, Legal abortions in England and Wales, by age and ethnicity

	All ages		Under 20		20-34		35 and over		*(Percentage of regular population)*
Ethnic group	no.	**%**	no.	**%**	no.	**%**	no.	**%**	**%**
White: British	121,155	***67.8***	21,120	***79.6***	83,555	***66.9***	16,480	***60.5***	***79.8***
White: Irish	820	***0.5***	70	***0.3***	590	***0.5***	160	***0.6***	***1.0***
White: Other White	15,785	***8.8***	1,090	***4.1***	11,625	***9.3***	3,070	***11.3***	***4.7***
Mixed ethnic group	6,050	***3.4***	1,165	***4.4***	4,360	***3.5***	530	***1.9***	***2.2***
Asian: Indian	6,375	***3.6***	275	***1.0***	4,705	***3.8***	1,395	***5.1***	***2.6***
Asian: Pakistani	3,825	***2.1***	265	***1.0***	2,790	***2.2***	775	***2.8***	***2.1***
Asian: Bangladeshi	1,685	***0.9***	185	***0.7***	1,190	***1.0***	315	***1.2***	***0.8***
Asian: Other Asian	4,350	***2.4***	280	***1.1***	3,010	***2.4***	1,060	***3.9***	***1.5***
Black: Caribbean	4,540	***2.5***	670	***2.5***	3,220	***2.6***	645	***2.4***	***1.1***
Black: African	9,295	***5.2***	970	***3.7***	6,520	***5.2***	1,805	***6.6***	***1.8***
Black: Any other	775	***0.4***	115	***0.4***	540	***0.4***	120	***0.4***	***0.5***
Chinese	1,685	***0.9***	105	***0.4***	1,245	***1.0***	335	***1.2***	***0.7***
Any other ethnic group	2,400	***1.3***	225	***0.8***	1,615	***1.3***	560	***2.1***	***1.0***
Not known/not stated	5,825	***-***	920	***-***	4,025	***-***	880	***-***	***-***

Source: Department of Health (2015), Abortion statistics, England and Wales

4.7.2 Maternal and perinatal health (including mental health)

Evidence consistently shows that women from BAME are over-represented in the numbers of women dying or experiencing serious complications during pregnancy, childbirth and in the post-natal period. This includes mental health issues and suicide. We also know that the infants of women from BAME populations are also at a greater risk of dying or becoming ill in the postnatal period.

There are additional socio-economic characteristics known to increase risks of poor outcomes, however ethnicity remains a key factor.

Table 15, Maternal deaths by ethnicity

Ethnic Group	Total maternities	Total deaths	Rate per 100,000 maternities	95% confidence interval	Relative risk (RR)	95% confidence interval
White	1,582,626	123	7.8	6.5-9.3	1(ref)	-
Indian	63,524	7	11.0	4.4-22.7	1.42	0.56–3.01
Pakistani	81,759	13	15.9	8.5–27.2	2.05	1.06–3.63
Bangladesh	27,297	4	14.7	4.0–37.5	1.89	0.51–4.95
Other Asian	57,295	4	7.0	1.9–17.9	0.90	0.24–2.36
Caribbean	19,690	4	20.3	5.5–52.0	2.61	0.70–6.86
African	67,047	19	28.3	17.1–44.3	3.65	2.12–5.94
Others/mixed	103,524	6	5.8	2.1–12.6	0.75	0.27–1.67

Source: Saving Lives, Improving Mothers' Care Surveillance of maternal deaths in the UK, 2011-13

4.7.3 Low birth weights and stillbirth

Asian women are particularly overrepresented in the low birthweight statistics. We also know that Asian women are 1.5 times likely to have a baby die in utero.

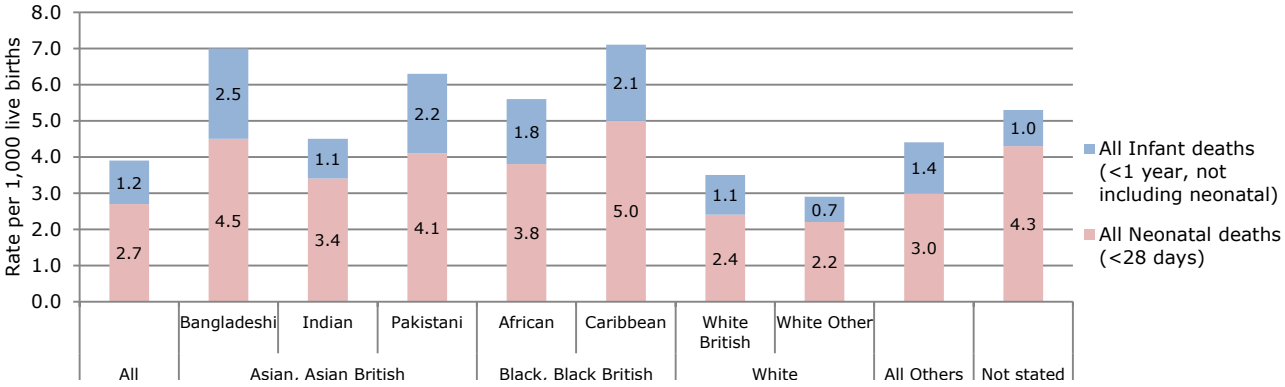
These poor neonatal outcomes may be due to higher incidences of metabolic disease in pregnancy such as gestational diabetes in this population, which often go undiagnosed. This may be the impact of the barriers in accessing high quality care that people in some BAME groups experience.

4.7.4 Infant death

The Marmot review found that in a study of all infant deaths in England and Wales variables such as non-white ethnicity were all independently associated with an increased risk of infant mortality.

Specifically, those form Bangladeshi and Black Caribbean ethnic backgrounds have twice the rate of infant deaths as White British mothers.

Figure 9, Rate of neonatal and infant deaths by ethnicity, England and Wales, 2012



Source: ONS (2015), Revised gestation-specific infant mortality In England and Wales, 2012 tables

4.7.5 Breastfeeding

Across the UK, the highest incidences of breastfeeding were from minority ethnic groups, with 97% for Chinese or other ethnic groups, 96% for Black and 95% for Asian ethnic groups in 2010 . The initial breastfeeding rate for all mothers across the UK was 81%.

Nationally mothers over the age of 35 and mothers from minority communities were far more likely to breastfeed at their 6-8 week check-up than other groups. Importantly, the positive effect of ethnic diversity in a population outweighed other negative local factors, such as deprivation or young maternal age.

4.7.6 Drug and alcohol use in pregnancy and breastfeeding

Mothers from a White ethnic background were more likely to drink alcohol before and during their pregnancy than any other ethnicity (46%). Evidence to suggest why this is the case is scant, though cultural views of intoxicating substances will vary, with many Muslims choosing not to consume alcohol or drugs at all.

4.8 Domestic violence and sexual exploitation

Despite significant progress within the criminal justice system and social/health services it is believed that victims from ethnic minorities underutilise services.

Cultural barriers noted include social stigma, rigid gender roles, marriage obligations, expected silence, loss of social support after migration, limited knowledge about available resources and myths about partner abuse. Divulging information to interpreters or relatives is a problem because of lack of confidentiality and gossiping in the community.

Pressure can exist within a community from older/senior family members onto younger victims not to report cases of abuse. Many cases are often seen as something to be dealt with internally.

Generally, it is felt that if religious and community leaders could be more effectively engaged, they could be influential in changing attitudes.

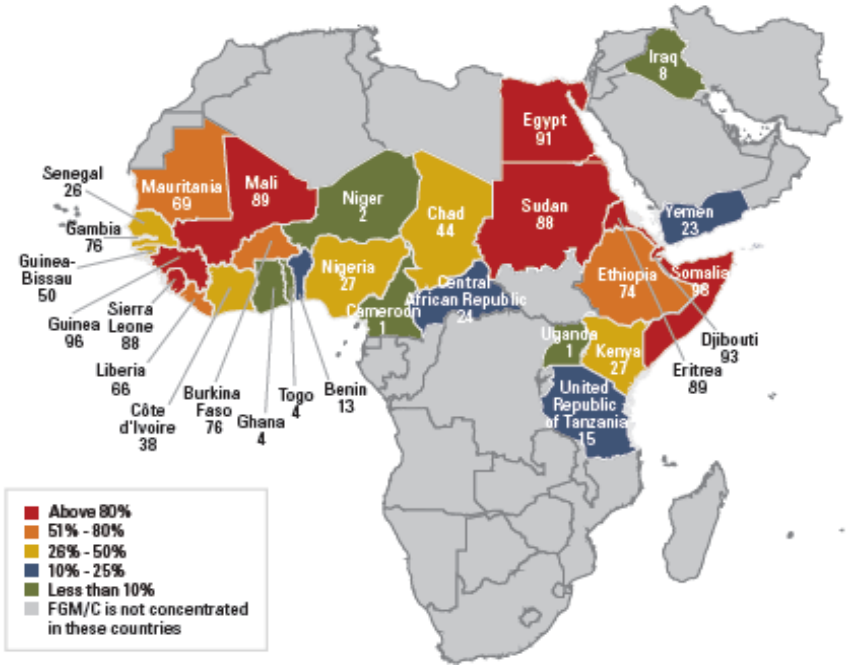
Trust in the police can be historically low, due to the poor reputations of other national systems. Developing trust in community policing and the appropriateness of their response is key to making some victims come forwards.

4.9 Female Genital Mutilation (FGM)

FGM is not an issue that can be decided on by personal preference – it is an illegal form of child abuse.

FGM cannot be clearly linked to any one region, country, religion, demographic, or ethnicity; nor can it be linked to one motivation, drive or purpose; it is not predominantly enforced by any one generation, gender or social class. It is predominantly a culture native to Western, sub-Saharan and Eastern Africa, with some prevalence in Iraq, Yemen and Indonesia.

Figure 10, Percentage of girls and women aged 15 to 49 years who have undergone FGM/C, by country



Map taken from: 'Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change', UNICEF, 2013. pp. 26

In some countries, it is estimated by UNICEF that more than 90% of females have undergone FGM, i.e. Guinea, Egypt and Somalia. The majority of FGM is believed to occur before the child is 5 years of age, and only few cases are conducted after the onset of adolescence.

It is likely that most newly reported cases are historically quite old and are a combination of new recording efforts and inward migration, rather than examples of recent abuse.

In most cases, data on the type of FGM, (Types 1-4, including full infibulation) and other key fields are logged by HSCIC as "not reported", leaving considerable data gaps to inform on prevention strategies.

Research from a range of studies recommends that outreach work, education and reporting be conducted from within communities; not by 'outsiders', who may alienate the target groups. Targeting at-risk communities will require triangulating census data, known nationality of the parents and community-level knowledge of families and attitudes.

Currently, a London-based organisation (Imkaan) has been commissioned to further investigate FGM in West Sussex and a full report into the method of viable outreach and education is expected for late 2016.

Section 5: Access to and use of services

5.1 Primary care

Accessing data on ethnic use of general practice primary care is currently believed to be unfeasible due to inconsistent intelligence sharing.

Problems exist with the GP appointment booking call-back system where language is a barrier, because the friend or family member who made the initial call must wait with the individual for longer to receive the second call.

A structural reliance on GP appointments over walk-in clinics is disappointing for many respondents used to other systems of primary care and deters some from accessing primary care at all. GPs are commonly viewed as non-professionals and some European and Asian respondents were found to access health checks in native countries, which they trust more.

Residents who live here in the short to mid-term; notably Eastern European communities, can face added difficulties in registering for primary healthcare. Many are not the named bill-payer or homeowner and cannot acquire a proof of local residence requested by some local practices.

5.2 Elective and non-elective (acute) admissions

There is little evidence from local admissions data to suggest that those from minority communities have a higher tendency to go into hospital by emergency admission. Data recording/reporting is poor, however and caveats apply.

Table 16, Count of patient spells, by ethnicity, gender and method of admission, West Sussex 2013/14

	Elective		Emergency		Grand total	
Ethnicity	M	F	M	F	Number	**(%)**
British (White)	41,233	44,548	32,209	35,984	153,974	**76.5%**
Not stated	11,071	11,822	5,325	5,580	33,798	**16.8%**
Any other White background	1,879	2,035	1,469	1,585	6,968	**3.5%**
Any other Asian background	278	281	281	256	1,096	**0.5%**
Irish (White)	260	329	187	193	969	**0.5%**
Indian (Asian or Asian British)	221	227	216	195	859	**0.4%**
Any other ethnic group	189	199	238	199	825	**0.4%**
Pakistani (Asian or Asian British)	162	201	115	127	605	**0.3%**
Any other Mixed background	116	144	158	122	540	**0.3%**
African (Black or Black British)	87	94	89	101	371	**0.2%**
White and Asian (Mixed)	68	82	44	64	258	**0.1%**
Any other Black background	49	69	66	56	240	**0.1%**
Bangladeshi (Asian or Asian British)	46	49	53	41	189	**0.1%**
Caribbean (Black or Black British)	50	53	42	29	174	**0.1%**
Chinese (other ethnic group)	54	57	31	30	172	**0.1%**
White and Black Caribbean (Mixed)	24	47	30	37	138	**0.1%**
White and Black African (Mixed)	27	48	31	15	121	**0.1%**
Grand Total	55,814	60,285	40,584	44,614	201,297	**100.0%**

Source: HES database, 2015

The reduction in hospital services in Crawley have been thought to hit some older Asian residents disproportionately, as they are unable to drive and not confident using public transport. This increases reliance on family members/friends.

5.3 Memory assessment services and children and adolescent mental health services

5.3.1 Memory assessment services

Data recording/reporting on ethnicity for MAS referrals is considered poor (over 40% unknown). Data for MAS assessments is more robust (roughly 10% unknown), and recently BAME residents have been under-represented in receiving assessments, when compared to White British residents. Evidence discussed elsewhere supports the view that efforts should be made to improve uptake.

5.3.2 Children and adolescent mental health services

CAMHS data suggests that BAME use of young people's mental health Tier 3 and 4 services has improved since the 2014 children and young people's mental health and wellbeing needs assessment. – Service use generally reflects that of the local population.

5.4 Social care

5.4.1 Fostering and adoption

It is not known if there is an adequate or inadequate pool of potential fostering or adopting households from minority ethnic communities. Nationally, the proportion of children from BAME groups who were adopted was roughly representative of the population, though with an increased proportion of children from a mixed ethnic background.

White ethnic children under the age of 5 in care in 2015 roughly matched that of the general child population.

Nationally, there were 2,630 unaccompanied asylum seeking children being looked after on 31st March 2015. These were predominantly late-teenage boys.

5.4.2 Residential care

As of 2011, West Sussex children from minority ethnic backgrounds accounted for 30% of all those living in communal establishments. This may have included many living within residential care homes, but also some who are living in boarding school accommodation.

Table 17, Children under 16 years living in a communal establishment, 2011 census

	West Sussex		England	
	Count	**%**	**Count**	**%**
All categories: Ethnic group	1,665	100.0%	37,650	100.0%
White: English/Welsh/Scottish/Northern Irish/British	1,160	69.7%	26,145	69.5%
White: Irish	15	0.9%	210	0.6%
White: Other White	120	7.2%	2,630	7.0%
Mixed/multiple ethnic group: Total	110	6.5%	1,755	4.7%
Asian/Asian British: Indian	<5	0.2%	440	1.2%
Asian/Asian British: Pakistani	<5	0.2%	580	1.5%
Asian/Asian British: Bangladeshi	<5	0.0%	710	1.9%
Asian/Asian British: Chinese	60	3.6%	1,965	5.2%
Asian/Asian British: Other Asian	65	3.8%	1,235	3.3%
Black/African/Caribbean/Black British: Total	120	7.3%	1,610	4.3%
Other ethnic group: Arab	<5	0.1%	105	0.3%
Other ethnic group: Any other ethnic group	5	0.4%	185	0.5%

Source, ONS, 2011 Census

For older residents in communal establishments, 99% were White British, though it is not known if this is because of differences in community views of caring for older family members or because the BAME populations are far younger than the White British population.

5.5 Public Health commissioned Services

5.5.1 Health checks

Where health checks are conducted in the workplace, ethnicity is roughly in line with that of the wider population. However, the GPs and pharmacies, which perform most health checks, are not obliged to report on ethnicity.

5.5.2 Smoking Cessation

Bangladeshi and Irish men were the most likely, and Indian men lest likely, to report smoking. Minority ethnic women were generally less likely to report smoking, with the exception of those from Irish and Black African groups.

Ethnicity has not been robustly recorded in stop-smoking services, leaving uncertainty in smoking service access and quit rates.

Recommendations set out by the Health Equity Audit to improve data recording and accessibility for minority groups are being investigated for the Tobacco Control needs assessment (2016).

5.5.3 Wellbeing hubs

A view exists that with small adjustments, on the back of engagement with local communities, wellbeing hubs could provide better services and increase uptake for minority ethnic groups. However, ethnicity recording is currently poor, with 21% of the 9,528 referrals to the hubs being "unknown".

Table 18, Ethnic breakdowns of West Sussex wellbeing hub activity, 2014/15

Ethnicity	Ad	Ar	Ch	Cr	Hm	MS	Wg	Total
White English / Welsh / Scottish / Northern Irish / British	513	859	1,000	1,029	1,340	1,426	811	6,978
White Irish	1	3	-	11	1	3	2	21
Gypsy or Irish Traveller	-	-	-	2	-	-	-	2
Other White Background	2	38	22	47	17	16	20	162
White & Black Caribbean	-	1	1	3	-	-	1	6
White & Black African	2	2	3	4	1	-	3	15
White & Asian	2	3	1	13	2	1	2	24
Any Other Mixed / Multiple Background	3	5	3	6	6	2	3	28
Indian	-	1	4	55	3	4	1	68
Pakistani	-	1	-	31	1	1	-	34
Bangladeshi	-	1	-	2	-	1	1	5
Chinese	1	1	3	2	1	3	-	11
Any Other Asian Background	2	5	1	35	3	5	3	54
Black African	-	1	6	22	5	-	2	36
Black Caribbean	1	3	-	3	1	-	-	8
Black British	-	-	6	14	2	-	1	23
Any Other Black / African / Caribbean Background	-	-	5	5	2	1	4	17
Arab	-	-	-	1	1	-	-	2
Any Other Ethnic Group (Please Specify)	-	9	12	13	16	-	-	50
Do Not Wish to Say	16	78	11	151	25	7	9	297
Not Asked	23	64	122	9	17	58	78	371
Not Recorded	37	472	584	44	98	1	80	1,316
% Not Recorded	6%	31%	33%	3%	6%	0.1%	8%	14%

Source, West Sussex Public Health data, 2015

5.5.4 Drugs and alcohol action team

Stigma may exist around utilising Drug and Alcohol support services, with the national take-up being almost exclusively White, despite dependency being just as common amongst those who use alcohol/drugs. – The West Sussex DAAT is redesigning services in 2016 with intentions to explore these issues.

5.6 Palliative and end of life care

Current evidence suggests that, although much has been done, inequalities still exist in the care that different groups of people receive at the end of life.

Issues surrounding access to palliative and end of life care included a lack of referrals; a lack of awareness of relevant services; previous bad experiences when accessing care; a lack of information in relevant languages or formats; family/religious values conflicting with the idea of hospice care.

Issues surrounding the care received were principally formed around communication between professionals and patients/families; specifically a lack of sensitivity to cultural/religious differences; a lack of availability of translators; low availability of training for healthcare professionals.

Recommendations made in the multi-agency publication, for policy, practice and future research, closely align with other issues presented throughout this needs assessment.

Confusion exists within communities over accessibility and service provision; trust is also low in some cases and feelings of discrimination exist due to a lack of communication.

Examples of good practice have been published, around appropriate engagement and service redesign, raising standards and service uptake. Changes included adding provisions for cultural practice, training staff around cultural distinctions and sensitivities, and promoting services in multiple community languages.

5.7 Children and family centres and other children's services

In Crawley, one in three children is from a BAME group; other local authorities in West Sussex range from 84.6% in Worthing to 90.6% in Chichester. Asian and Asian British children and Black/African/ Caribbean/Black British children account for 17.4% and 4.9% of the under-5 population in Crawley.

Table 19, Under 5's population in West Sussex

	West Sussex	Arun	Adur	Chichester	Crawley	Horsham	Mid Sussex	Worthing
% White British	**83.6%**	89.6%	87.5%	90.6%	62.2%	89.6%	87.5%	84.6%
% White Irish and White Other	**4.5%**	2.7%	6.8%	3.2%	6.6%	3.2%	3.9%	3.2%
% Mixed/Multiple	**4.7%**	4.2%	3.2%	2.8%	7.7%	4.1%	4.0%	6.4%
% Asian	**5.5%**	2.3%	2.0%	2.1%	17.4%	2.5%	4.0%	4.6%
% Black	**1.3%**	0.4%	0.3%	0.9%	4.9%	0.4%	0.6%	0.8%
% Other	**0.5%**	0.9%	0.2%	0.4%	1.3%	0.2%	0.1%	0.4%
% Total	**100.0%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
% BAME	**16%**	10%	12%	9%	38%	10%	13%	15%
Numbers BAME under 5	**7,645**	370	925	530	3,050	745	1,045	980

Source: ONS, 2011 Census

In Crawley, 9% of children and young people do not use English as their first language; between 1% and 3% elsewhere. Roughly one in six children cannot speak English well or at all, amounting to nearly 600 county-wide.

5.7.1 Free childcare entitlement for preschool children

Some of the barriers identified for the low uptake of free childcare include access to information, location of services, language and cultural considerations, particularly for ethnic minority groups.

5.7.2 Healthy child programme

Parents of children from minority ethnic backgrounds are less likely to self-identify their child as overweight – and are less likely to self-refer them to healthy weight programmes.

Section 6: Views and experiences

6.1 Findings from the community engagement research

Excerpts from the research are presented throughout this summary document, and the findings have been used, to shape a number of the recommendations. This stand-alone document, containing an independent Executive Summary can be viewed at http://jsna.westsussex.gov.uk.

6.2 Gypsies and Travellers

Findings from recent qualitative work with Gypsies and Travellers through the voluntary sector are contained in a full report on http://jsna.westsussex.gov.uk

6.2.1 Life in West Sussex

Most participants enjoy the green spaces in the county. Many expressed the difficulties of setting up and feeling secure, with specific difficulties accessing local authority sites. There is a lack of new sites being authorised in the county.

6.2.2 Public perceptions and discrimination

All participants are aware of negative media around unauthorised encampments in West Sussex. This in turn brought about negative opinion from parts of the settled community. Aggression from police and being turned away from GPs surgeries were some examples of negative experiences, as well as feeling judged about their reading and writing skills.

6.3 Children and family support services

As part of the Early Years Needs Assessment, published this year to inform the redesign of the Health Child Programme, a number of focus groups and interviews were undertaken with local families, including those from some ethnic minority groups.

6.3.1 Early years needs assessment: Eastern European mothers

Eastern Europeans parents were not easy to recruit for this research… and this is an indication of the challenge of reaching this group (from a council perspective). In all eight mothers attended a discussion group and two more attended one-to-one discussions.

6.3.2 Children and Family Centres

Some mothers from Eastern Europe gave birth before coming to the UK often did not access local social activities for a while. Isolation, whilst partners are at work and a lack of understanding about how and when to access CFCs was reported; they were not commonly seen as a place to go for advice.

In seeking advice from professionals Eastern European parents struggle with bureaucracy and are wary of authority and can feel distressed when they are unable to understand what is being asked of them. Some found consultations with GPs particularly stressful as there is insufficient time to explain when language is an issue.

6.3.4 Eastern European mother's ideas for service development

Eastern European parents were more focused on the need for activities for their children but they also wanted opportunities to mix more with English people, which is sometimes a challenge. The respondents had many ideas for how to engage with communities.

6.3.5 Health services

Eastern Europeans consider health checks to be very important and are motivated to attend these but find them stressful if they do not speak English. They are very relieved if a member of CFC staff can speak the Polish language (which is also usually understood by other Eastern Europeans).

6.4 Caring for older minority ethnic residents

Separate to this needs assessment, in 2014 WSCC published research into the health and social care needs of older residents from Asian minority communities in Crawley.

6.4.1 Language barriers

Language was identified as the main barrier when accessing services by almost 90% of people who were interviewed. This caused poor communication and cultural misunderstandings that figured prominently in service user's experience of attending social groups.

Verbal information provided by a knowledge-expert may be more useful than written information in complex English or Asian languages as many older people from the first generation of BAME communities are not fully literate in their own language.

6.4.2 Cultural and religious barriers

One of the clear feelings among Asian community expressed is that diversity is ignored and cultural and religious needs were not examined in designing and commissioning the care services.

Asian communities feature various and diverse faiths and practices so individuals are less likely to access social activities designed to offer 'one service for all'. Practical issues such as accessible transport to appointments and day care services have been cited by many as a serious issue for disable and old people.

The importance of designing the service that is more culturally sensitive and allow BAME older people with a religious faith to practice their religion and to eat the sort of food that they enjoy was emphasized by everyone who was consulted.

6.4.3 Social isolation

Increasing family dispersal due to jobs in other cities or abroad and marriages has left parents socially isolated and lonely in Asian communities as well, who normally expected their older life to be playing with their grandchildren. Many typically prefer isolation in their own home due to language, cultural and some extent religious barriers.

Almost 80% of participant pressed on that they feel that they should be centrally important and held in mind by authorities when they plan and design services for the community.

6.4.4 Mental health issues

Stigma about mental health continues to be an issue across society, but may be greater in some BAME communities. Older people from BAME community perceive mental health issues differently from their younger generation.

6.4.5 Survey results

Accompanying this study was a survey of 250 older Asian people in Crawley. The report discusses these results in full and we would encourage you to access the full research report by the Young Foundation, published alongside this report.

For further information on any of the sections in this report, please refer to the comprehensive BAME needs assessment report.

Summary

Although West Sussex is largely an enjoyable place to live for many BAME people, there remain areas for improvement and development.

In order to increase community resilience, ensure social cohesion and equality there are a number of recommended actions arising from the report findings. These need to be targeted at a number of organisations and communities. There is a clear role for WSCC in providing leadership and exemplar policies in this area.

Summary of recommendations

A total of 20 recommendations were formed and are presented in full in the Section 7 of the full report. The recommendations are grouped into themes and can be summarised as follows:

Targeting specific services/needs

Action required by	Recommendation
Commissioners and providers of maternity services Public health commissioners and practitioners	a. Staff have adequate tools to assess risk and have clear referral pathways for women in those BAME groups at most risk of **gestational diabetes**, **perinatal mental illness;** and other factors associated **with intra-uterine deaths** or **poor neonatal outcomes**; using appropriate interpreting service (i.e. not a family member or friend) and translated literature where required. b. Local **childhood immunisation programmes** contain a **targeted** element to **BAME** groups, working with NHS England and Public Health England colleagues.
West Sussex Fire & Rescue Service, Sussex Police and South East Coast Ambulance service and community groups	**Increase awareness** in BAME groups (i.e. through campaigns) to highlight that you **can** contact **999 emergency** services even if you **cannot speak English**.

Use of VCS for prevention, design and outreach

Action required by	Recommendation
Commissioners of VCS	a. Fund an **evaluated pilot** for a **local VCS** to work with their community and **co-develop resources**, (eg literatures, training events, etc.) which people would find accessible and effective in *tackling taboo issues* and highlighting the services to support those experiencing **domestic abuse, mental health issues, alcohol and drug misuse** or **disabilities.** b. Work with the **VCS** to provide **opportunities** (physical spaces, small grants) to cultural and religious **communities** seeking to **maintain links** to their traditional **culture or religion**.

Meaningful engagement and design of culturally appropriate services

Action required by	Recommendation
Commissioners and providers of health and social care	Ensure there are **clear and transparent care packages** with **clear decision criteria**. These care packages should be **culturally** and **linguistically appropriate.**
Clinical commissioning groups and local authorities	Support service providers to provide **clear pathways** for referral into **culturally appropriate services** (i.e. for **end of life and palliative care**) to support BAME **families and friends**. This should include: a. **Training** to ensure providers and staff are aware of specific **cultural issues** especially around **end of life** care in some groups. b. **Meaningful** engagement with communities to **co-design** services.

Providing and promoting services which are culturally appropriate

Action required by	Recommendation
Commissioners of healthy lifestyle programmes	a. Ensure that **healthy weight initiatives** have **culturally appropriate targeted activity**, especially for Black and South Asian groups and for a range of ages. These should clear **self-referral** mechanisms. b. Ensure that there is **sufficient provision** of, and awareness-raising activity around, **culturally appropriate physical activity opportunities** across all age groups.

Commissioners, health visitors and children and family centre staff	**Information** about **free childcare** provision should be **accessible and available** to all, including BAME groups. **Commissioners, health visitors** and **children's and family centre** staff have a **role** in ensuring they have **information** in a **range of languages** which reflect their local population.

Languages and interpreting/translation

Action required by	Recommendation
Local authority commissioners	**Commissioners** should **fund** high quality **affordable/accessible English language courses** aimed specifically at people coming to live in West Sussex. These services should take into account that the **ages** and **cultures** of those needing to access these services will **vary** from area to area and will also include school age children.
Providers of health and social care services, other public services and voluntary and community sector organisations	a. Train frontline **staff** on how to refer those expressing **difficulties** with **English** to an **interpreting** service. b. Ensure frontline staff do not use family/friends/community members as casual/ convenient sources of interpreting. c. Have clear **referral mechanisms** into locally available, accessible and affordable **language classes** for those who use interpreting services.
Providers and organisations	**Use local data** to identify **commonly spoken languages** within the ethnic communities and provide: a. Appropriate, **clear and prominent signage/literature** to highlight **interpreting services.** b. **Literature** around **services** and **specific health conditions,** which allow for low literacy levels.

Awareness of specific issues when providing services

Action required by	Recommendation
Commissioners	**Support funding** for culturally and **linguistically appropriate talking therapies** for mental health conditions.
Commissioners and providers	Provide/incorporate into current training for frontline staff on: a. How **immigration/residency status** may **affect disclosure** of domestic abuse. b. Understanding **ethnicity** as a **risk factor** for social **isolation**. c. How **housing quality** can affect the **health** of BAME groups, **disproportionately.**
Trusts, providers and organisations	**Trusts, providers** and **organisations** should ensure that when a person accessing a service is known to have specific cultural or religious preferences that: a. **Information** for front line staff is **available** and **accessible**, in order to **deliver high quality**, **culturally sensitive** care; for example, reviewing catering provision and gender specific personal care. b. **Safeguarding practices** specifically **include processes** for **identifying and protecting children and adults** who may be at more **at risk** due to their **cultural backgrounds.**

Policy and strategy

Action required by	Recommendation
Commissioners and policy decision makers	The **process** of commissioning of **services** and formation of **policy** should include an **Equality impact assessment.**
Public services (including Sussex police)	Carry out a **review** of **workforce diversity** and ensure that their **recruitment policies** positively **reflect** their **local populations**, to increase confidence and cohesion.

Commissioners and procurement	**Commissioning processes** for **residential, domiciliary and inpatient facilities** should include providing **evidence** of a **comprehensive anti-discrimination policy**, which includes **training** for **all staff** and a **transparent reporting processes** for service users and staff where **discrimination** occurs.
Clinical commissioning groups	**CCG**s should **support GP** practices to ensure that frontline **staff act** in accordance **with national guidance** regarding **registration** for services. I.e. practices should not refuse registration on the grounds that a patient is unable to produce evidence of identity, immigration status or proof of address.
All organisations	Efforts need to be made across **all** organisations to **increase** the quantity and quality of **data recording ethnicity**. Commissioners of health and social care services and the voluntary and community sector should ensure that this is **explicit in service specifications** with their providers.

School/early years

Action required by	Recommendation
Care Wellbeing and Education directorate (WSCC), schools and boards of governors	Work with **schools** and boards of **governors** to undertake a **review** of policies to: a. **Identify** and visibly **tackle racially motivated bullying**, to ensure an **evidence-based** and consistent zero tolerance approach. b. Ensure that **teachers** have clear **guidance** on identifying and supporting minority ethnic **pupils** who may be **underperforming**, with culturally appropriate support.

Recommendations from previous research

Action required by	Recommendation
All	Any recommendations made in this report should be aligned with those contained in the: 1. Gypsies and Travellers needs assessment (2010) 2. Improving Access to Psychological Therapies report (2015) 3. Early Years needs assessment (2016)

Acting on recommendations in this report would impact on the following indicators:

West Sussex County Council organisational Priorities:

- giving children the best start in life
- having a strong and diverse economy
- independent for longer in later life.

Public Health Outcome Framework indicators:

The Public Health Outcomes Framework (PHOF) indicators are a set of measurable outcomes of population health. Public Health England are responsible for the measuring, monitoring and publication of local authorities' performance against these indicators. These results are published nationally, allowing comparisons to be made between local authorities, regionally and nationally. The results will indicate whether improvements have been made against these indicators; whether they have stayed the same; or whether they have deteriorated.

Indicator	Outcome
1.1	Children in poverty
1.2	School readiness
1.3	Pupil absence
1.5	16 – 18 year olds not in education, employment or training
1.15	Statutory homelessness
1.18	Social isolation
2.8	Emotional well-being of looked after children
2.10	Self-harm
2.23	self-reported well-being
2.3	Smoking status at time of delivery
2.5	Child development at 2 – 2 ½ years
2.21	Access to non-cancer screening programmes
2.22	Take up of the NJS Health Check programme – by those eligible
3.3	Population vaccination coverage
3.5	Treatment completion for TB
3.7	Comprehensive, agreed inter-agency plans for responding to health protection incidents and emergencies
4.8	Mortality rate from communicable diseases
4.10	Suicide rate
4.13	Health-related quality of life for older people
4.15	Excess winter deaths
4.12	Preventable sight loss

Introduction

Why do we have needs assessments?

The West Sussex Joint Strategic Needs Assessment (JSNA) was recently published in 2014. The executive summary contained two points concerning residents of minority ethnic communities[1]. That:

- *There are a number of groups identified in West Sussex who may have specific and/or additional health needs; these includes black and ethnic minorities, Gypsies and Travellers, students, carers (including young carers) and people who are sleeping rough or homeless.*

And

- *The population is increasingly ethnically diverse. Ethnic diversity is greatest amongst the young, but an increasing number of older people are from ethnic minority backgrounds.*

Traditionally, ethnicity is considered within all health needs assessments, though this may hold the microscope too close to one area of need or one condition (Children with disabilities; Adults' mental health; Radiotherapy services) and can fail to miss the 'big picture'. To explore these issues, in early 2014 the West Sussex Health and Wellbeing board asked the Public Health Research Unit to conduct a comprehensive Health and Social Care Needs Assessment for local residents from Black, Asian and Minority Ethnic (BAME) communities, which would look for specific, but also overarching issues that affect peoples of different nationalities and ethnic groups as a result of a lack of awareness or provision by the current systems in place.

The Needs Assessment is, in this context, a systematic method for reviewing issues in health and social care facing a defined population, allowing for actionable and measureable recommendations to be set, based on the evidence available. Evidence is gathered from **quantitative sources** (service-use reports, population statistics, local demographics, prevalence of physical or mental health conditions) **qualitative sources** (stakeholder views and feedback, public engagements, focus groups and interviews/surveys) and **desk research** (evidence reviews, published research, calls-for-evidence, national and local guidelines and strategies).

What is included in this needs assessment?

To maintain focus, the Research Unit developed clear criteria of what was considered 'Within the scope of the research' and 'Out of the scope of the research' and formed a set of intentions to be guided by key questions.

In scope

- People living within West Sussex who would self-identify as other than White British within the UK Census.
- Issues or needs that are directly or indirectly attributable to ethnicity.
- Asylum seekers and refugees.

Out of scope

- Individuals and groups within West Sussex who self-identify as White British within the UK census.
- Issues or needs not directly or indirectly attributable to ethnicity.
- Religious groups not commonly associated with an ethnic background, e.g. Mormonism, Scientology.

[1] West Sussex Joint Strategic Needs Assessment: Executive Summary, 2014*, (pp.5).* Available at http://jsna.westsussex.gov.uk/west_sussex_joint_strategic_needs_assessment___summary_version_2014

Why are we doing this?

This assessment will:

- Examine current and future health, social care and wellbeing needs^ of all distinct BAME communities, asylum seekers and refugees currently living in West Sussex together with those of asylum seekers and refugees
- Identify existing assets and services in the community, primary and acute health sector, social care sector and the private and voluntary sector
- Identify gaps in services or barriers and challenges to accessing services
- Identify opportunities for health promotion, prevention and building resilience
- Identify how services are provided against national guidelines / performance
- To identify opportunities for increasing awareness in communities and organisations; including training and engagement
- Understand how discrimination deters people from engaging with health and social care services
- Establish the prevalence of discrimination in health and social care and the prevention strategies in place

^ Beyond those experienced by non-BAME communities.

What questions do we need to ask?

We developed the following questions:

- What are the characteristics of the BAME population of West Sussex (e.g. who are they, where do they live, work or go to school)?
- What enables or prevents people from accessing services within these communities?
- What are the health, social care and wellbeing needs within these communities? Which of these require commissioned services and which of these do communities provide for themselves?
- What services are currently provided to meet those needs?
- How well are current services meeting those needs? What gaps and/or barriers, if any, need to be addressed?

How did we gather the evidence and information for this needs assessment?

Evidence and information was gathered by the following methods:

1. A literature search including a review of BAME needs assessments from similar local authorities was conducted to establish an evidence base.
2. An initial demographic and statistical analysis, to establish the location, size, age, etc. of the BAME population.
3. We shared this evidence with known partners, (including community groups, commissioners, managers and third sector organisations) and invited further evidence from these organisations; the full list of those approached in this is included in the appendix. We received a small number of responses. From this we were able to establish the following:
    a. Much is still unknown about how these communities perceive the systems of health and social care available and if there are barriers to access.
    b. Where service managers and commissioners responded, they acknowledged difficulties in identifying and engaging with these groups and they wished to understand more about their particular area of provision. Service-level data is widely believed to be incomplete or inconsistently, making outreach work difficult to evidence.
    c. Where community groups responded, they highlighted frustrations with poor engagement and "promise-fatigue" from the public sector providers.

d. Where third sector groups responded, they referenced funding cuts and financial difficulties as hampering their engagement efforts, whilst expectations remained that these groups would continue to provide the local authority with access to communities.
e. General issues such as language, translation and confidentiality; aging first generation residents and younger families in the European populations, and differences in culture regarding taboo subjects, such as mental health, were widely highlighted.
f. Advocacy is perceived to be low in key areas (i.e. adults social care), and there is a general lack of robust qualitative data available to inform on service provision.

4. Due to the lack of evidence (particularly qualitative evidence), it was necessary to look beyond the existing channels for engagement and reach residents in their communities.
5. Following a successful bid to carry out as community engagement the Young Foundation[2] recruited ten researchers from within local BAME communities. A total of 114 West Sussex residents were interviewed on a range of social issues, which took between one and two hours each. A full report of this qualitative work is available from both the Young Foundation and the Public Health and Social Research Unit's JSNA website: http://jsna.westsussex.gov.uk
6. Whilst this research was underway (summer 2015), the Research Unit continued the quantitative analysis and desk research described above.
7. All evidence was triangulated where possible to form clear recommendations.

As many of these tables pertain to small populations, figures have been rounded, where necessary to the nearest five, or excluded where under five. As a result, not all totals within data tables will sum correctly.

Strengths and weaknesses of our approach

Whilst extensive efforts were made on behalf of the Research Unit and all those who contributed to the gathering of this evidence to be inclusive of all communities and voices, it became apparent in the early stages of the project that access into BAME communities, - both via community leaders and beneath these traditional nodes, - is fragmented and inconsistent in West Sussex. Whilst one area for recommendations concerns the establishing of effective links to advocacy at grass roots levels, the research at hand may have suffered and may not include all voices from all walks of life. Where data is lacking or inconsistent, consideration has been given to ensure that false positives/negatives are not emphasised.

This being said, the approach to combine primary research at a community level with peer researchers is a new and relatively innovative approach, which has already received praise and helped, not only to raise the profile of the project, but to increase stakeholder confidence in the findings. The method has already been incorporated into other ongoing needs assessments, conducted by the Public Health and Social Research Unit, such as the tobacco control needs assessment (due in 2016).

In addition to the use of community level peer researchers, our NHS librarian was able to conduct a systematic literature search to compliment the research. These tireless efforts to not rest with what was readily available go to explain the scale and breadth of this project and this final report.

What is covered in this report?

The following report contains six sections laying out the available evidence and a final section summarising the recommendations and areas for further research and data. We have presented the recommendations separately from the main text and highlighted key findings throughout the report. The sections are as follows:

[2] The Young Foundation, est 1954, London. Registered charity number: 274345
http://youngfoundation.org

1. **Population and diversity** – *the visible population and its demographic characteristics*
2. **Wider determinants of health** – *characteristics commonly attributed to health (i.e. education)*
3. **Lifestyles, risk behaviours and health protection** – *behaviours affecting health (i.e. smoking)*
4. **Health status and long term conditions** – *health conditions and disabilities in the population*
5. **Access to and use of services** – *how available services are currently accessed/perceived*
6. **Views and experiences** – *a summary of the qualitative research included in the wider report*
7. **Recommendations and future action** – *a framework for future action*

Section 1: Population and diversity

1.1 The people of West Sussex – a brief history

Though nomadic communities had lived in Sussex for thousands of years, the first settled communities were established around 6,000BC, most notably in areas close to Haywards Heath and Hassocks. These formed around access to rock shelters in the hillsides, used for hunting parties and later around flint mines (3,500BC). Through the Stone and Bronze Ages, agriculture had become the major priority, developing areas of the Western Weald (Chichester) and coastal plains (Arun and Worthing). By 1,000BC hill-forts had become centres of population, though communities moved from these enclosures by the middle Iron Age (400-100BC).

Around 100BC, trade with Romans in Gaul and the expansion of coinage created market communities and farmsteads (such as the one in Oving). This regional 'Romanisation' is believed to have been promoted by the successive tribal leaders of the *Atrebates* from the regional seat of power in Chichester. It was Verica who, fleeing civil strife at home, approached Emperor Claudius in Rome for assistance in AD40. It is believed that this request was the political incentive for the renewed Roman invasion of Southern Britain.

After the invasion, the region became the civitas of Regni, with its capital at Chichester. Roads linking Chichester to London, via Pulborough and also to Winchester, Silchester, Hassocks and Lewes, connected the surrounding areas and Roman culture was embedded in the South.

Saxon raiding had an impact on Roman Sussex during the 3rd and 4th centuries, leading to defences being built at Chichester and a fort at Pevensy. Communities along the coast dwindled in this time but prospered further inland. To bolster their declining rule and maintain peace, the Roman aristocracy recruited many mercenaries from the Northern Empire who, with their families, grew in numbers and rebelled in the early 5th century. This collapse of Roman power in Britain led to the withdrawal of the military around AD410. Aelle, King of the Saxons, arrived in Sussex at around AD480, though there is little knowledge of the speed of change from Romano-British to Anglo-Saxon cultures.

Throughout the next 400 years, the Saxons settled townships and slowly established Christianity. Northern areas of the county were sparsely populated, though by the 10th century, Vikings had begun raiding the coastal areas, pushing populations inland and building up defences around the major water channels.

The 1066 Norman Conquest, via the Sussex coast, completely altered the administrative and cultural character of the county. Baronial castles were established at Arundel, Bramber, Lewes, Pevensy and Hastings, along with the diocese of Chichester, to control the region. Churches also expanded heavily, particularly in the wilder northern Wealden areas. The wealthy areas of the county for these centuries were the coastal regions and lower escarpment. Agricultural trade allowed more specialised cultivation and the region was prosperous. Ports were expanded and trade with Europe increased.

From the 17th century, population growth in the eastern weald generally outstripped that of the coastal areas. All areas were pocketed by local epidemics and the 1665 plague, along with general migration towards London. There was an estimated 80,000 residents in Sussex in 1676 (census records). This population remained stagnant for 100 years, but by 1800 it had grown to over 160,000. Throughout the 18th and early 19th centuries, roads and waterways were expanded and transport was widespread. Railways opened from 1840.

Democracy was unrepresentative, with a minimum property asset of 40 shillings, dating back to 15th century rules, required to vote. A property of £600 was a prerequisite to stand for a county MP seat (£300 for a borough seat). To curry favour with local populations, the right to vote in a borough election was later lowered to the owners of a £10/annum property. Male suffrage only came at 1918 and universal suffrage by 1928.

Date of election	Sussex population	Registered voters	% of total pop.
1826	233,019 (1821)	3,187	1.4
1832	272,012 (1831)	5,803	2.1
1868	363,735 (1861)	31,847	8.7
1885	490,505 (1881)	74,658	15.2

The population grew all over England, though in Sussex it doubled, from 160,000 to 336,000 in the fifty years from 1801 to 1851. In the coastal areas, the population increased by over 200% in this period. Brighton expanded from 7,000 to 24,000 in just 20 years (1801-21). By 1831, rural areas (particularly in the Chichester and Pevensy districts) had begun to depopulate in favour of the urban and coastal market towns and ports. Emigration to Upper Canada (Ontario) was a large factor in the declining rural populations. Temporary rural residents for the railway development are believed to have inflated the actual rural population and the permanent population was lower than reported.

The population doubled again from 337,000 in 1851 to 633,000 in 1901. This was more heavily in the coastal parishes and central urban settlements around the Brighton-London railway, with the East and West experiencing further population reduction. Brighton increased from 70,000 in 1851 to 174,000 in 1901. Eastbourne increased 1,174%, Bexhill 613% and Worthing 346% in this period. Migration from the rural hinterland, from London and from the inland urban areas of the South East has been described as the major factor for this growth. A high proportion of these new migrants were over 65 or widowed and by 1911 around half the population lived on this coastal strip, with this demography distinguishing Sussex from its neighbours.

From 1911 to 1951, the Sussex population rose by 41% from 663,378 to 937,339. The birth rate was relatively low and death rate relatively high, and much of the population increase was from inward migration. The growth was heavier in western Sussex. The 1921 census describes the First World War deaths as "loses by migration".

The Second World War led to huge swathes of the population moving from the coast and into rural areas, and then back again. The government after the war used planning regulations to stop the continuing expansion of the coastal strip and developed the town of Crawley.

The rate of increase was fastest in the 60s and 70s. Two thirds of the growth in the latter half of the 20th century was seen in West Sussex, whose population doubled. The population of Littlehampton/Rustington doubled. Surrounding villages expanded and joined the larger urban town which they orbited. Crawley saw a nine-fold increase to 97,000. Inward migration, particularly for the retirement and post-retirement groups had been a major cause of this growth, except in Crawley where younger workers have settled.

Source: 'An Historical Atlas of Sussex', by Kim Lesley and Brian Short.

Published by Pillimore and Co Ltd, Chichester, 1999

1(a) Ethnicity

It's hard for me – I can't do the simplest of things like do my shopping because I don't understand and people don't understand me – it's a lonely place to live without a common language (Male, Indian, 25–64).

I have a Russian speaking friend – who has 5 children and with such a big family does not have time to learn English – who feels isolated (Female, Estonia, 25–64).

I don't feel 'different' because of my background; people are generally very accepting and tolerant here. (Female, Ghanaian, 25–64).

People could live here all their lives in one house and still not know all the neighbours that surround them (Female, South African, 25–64).

I drive and would go anywhere in West Sussex to be able to pray, light a candle for the health of my family in Estonia and to simply stand in silence in our church, where even the walls give you support (Female, Estonian, 25–64).

The first few years were difficult…there was a lot of crying. The children just wanted to go back to Bulgaria.' (Female, Bulgarian, 25–64).

Yes you will get ignorance here and there and get remarks, but a lot has changed' (Male, Sri Lankan, 25–64).

1(a).1 The minority ethnic population of West Sussex

1(a).1.1 Populations

The most numerous ethnic minority groups in West Sussex fall under the census category "White: *Other White*" (31,900 residents in 2011; 4% of total population). This broad category can include individuals from the EU and wider European continent or Russia, North and South America, Australia/New Zealand and any other region of the world, providing their genealogy is of typically white European ancestry. Simply, the category describes all those of a traditional European ancestry who are not British, Irish or Gyspy/Traveller and in this, much detail can be lost.

The next highest groups are Asian/Asian British: Indian, Pakistani and Bangladeshi (9,660, 5,240 and 2,350 residents respectively). In Britain, the "Asian community" is commonly intended to include residents whose ancestry originates from South Asia, and as such does not typically include those from East or South East Asia, Northern/Central Asia, or the Middle East. Full breakdowns are included in Table 1(a).1, with exhaustive figures for "Other" categories in Appendix Table A1.1.

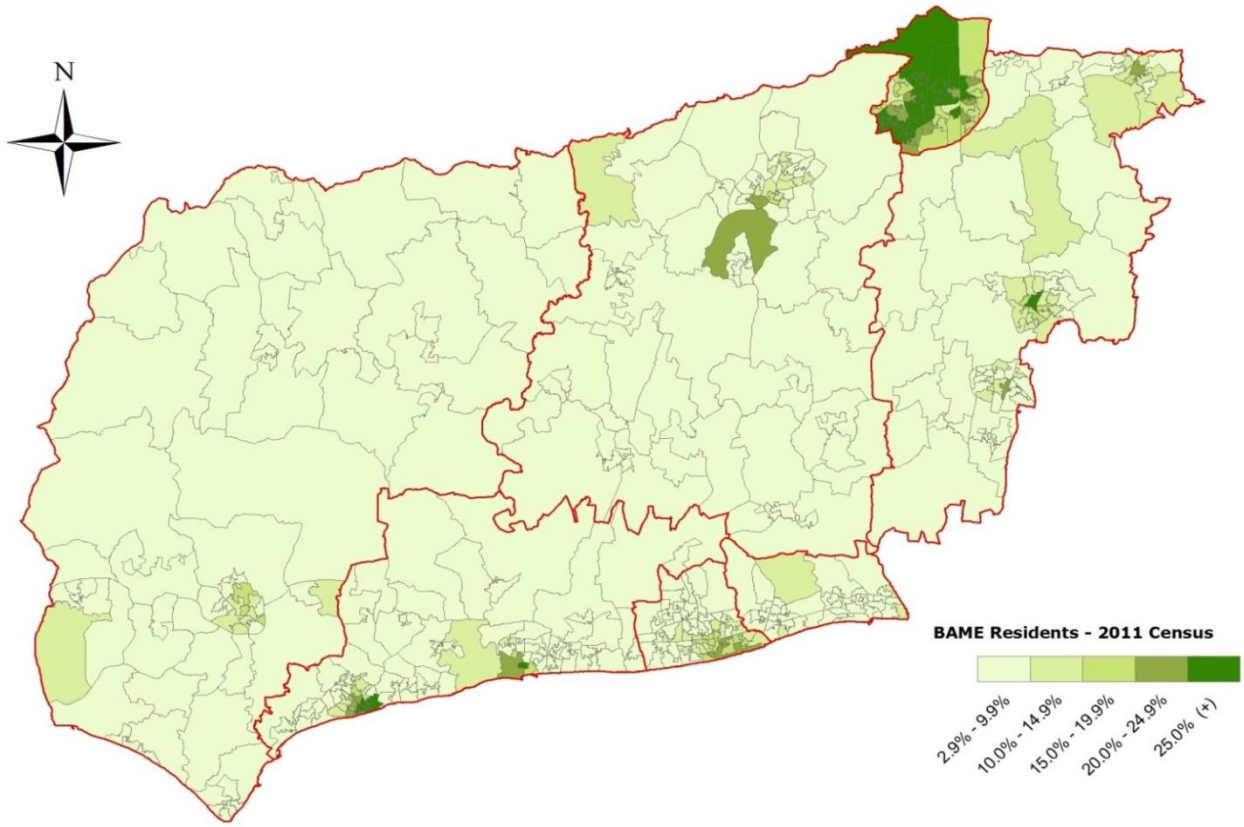
Table 1(a).1, Ethnic background of West Sussex population

2011 Census Data	**Numbers** *(Figures rounded so may not sum)*			**Percentage**		
	West Sussex	**SOUTH EAST**	**ENG**	**West Sussex**	**SOUTH EAST**	**ENG**
	806,890	8,634,800	53,012,500			
White: English/Welsh/Scottish/Northern Irish/British	717,550	7,359,000	42,279,200	88.9%	85.2%	79.8%
White: Irish	5,980	73,600	517,000	0.7%	0.9%	1.0%
White: Gypsy or Irish Traveller	1,070	14,500	54,900	0.1%	0.2%	0.1%
White: Other White	31,900	380,700	2,430,000	4.0%	4.4%	4.6%
Mixed/multiple ethnic group: White and Black Caribbean	2,890	46,000	415,600	0.4%	0.5%	0.8%
Mixed/multiple ethnic group: White and Black African	2,060	22,800	161,600	0.3%	0.3%	0.3%
Mixed/multiple ethnic group: White and Asian	4,270	58,800	332,700	0.5%	0.7%	0.6%
Mixed/multiple ethnic group: Other Mixed	2,940	40,200	283,000	0.4%	0.5%	0.5%
Asian/Asian British: Indian	9,660	152,100	1,395,700	1.2%	1.8%	2.6%
Asian/Asian British: Pakistani	5,240	99,200	1,112,300	0.6%	1.1%	2.1%
Asian/Asian British: Bangladeshi	2,350	28,000	436,500	0.3%	0.3%	0.8%
Asian/Asian British: Chinese	2,960	53,100	379,500	0.4%	0.6%	0.7%
Asian/Asian British: Other Asian	8,130	119,700	819,400	1.0%	1.4%	1.5%
Black/African/Caribbean/Black British: African	4,570	87,300	977,700	0.6%	1.0%	1.8%
Black/African/Caribbean/Black British: Caribbean	1,340	34,200	591,000	0.2%	0.4%	1.1%
Black/African/Caribbean/Black British: Other Black	1,240	14,400	277,900	0.2%	0.2%	0.5%
Other ethnic group: Arab	1,080	19,400	221,000	0.1%	0.2%	0.4%
Other ethnic group: Any other ethnic group	1,680	31,700	327,400	0.2%	0.4%	0.6%

Source: ONS, 2011 Census

Using geographical analysis, we know that in 2011 resident BAME populations were predominantly centred within the Crawley, Worthing and urban Arun areas. Short term migration and seasonal workers may well have altered this picture in recent years, though local knowledge confirms that these towns remain the areas of highest concentration.

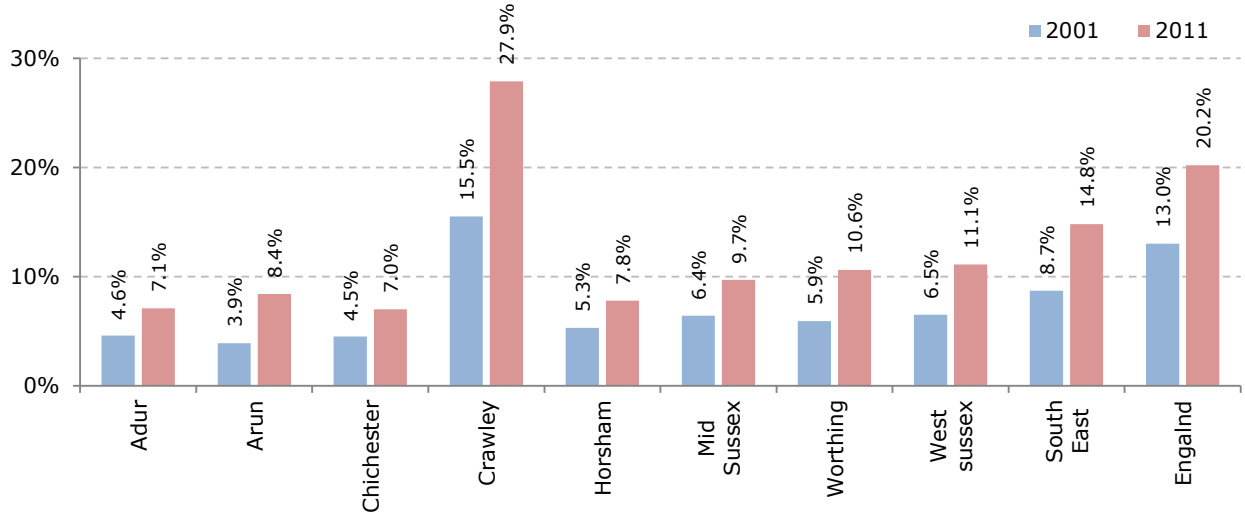
Figure 1(a).1, Population density of BAME residents in West Sussex



**Note – When using Lower Super Output Areas, large geographical boundaries (in rural areas) will contain a similar number of residents to very small geographical boundaries (in urban areas)*
Source: ONS, 2011 Census

Many BAME communities have been increasing in size since 2001, particularly with the introduction of free travel within the European Union. Many areas have doubled their BAME populations in ten years, and Crawley has increased 16% to 28%.

Figure 1(a).2, BAME composition by West Sussex unitary authority, from 2001-2011

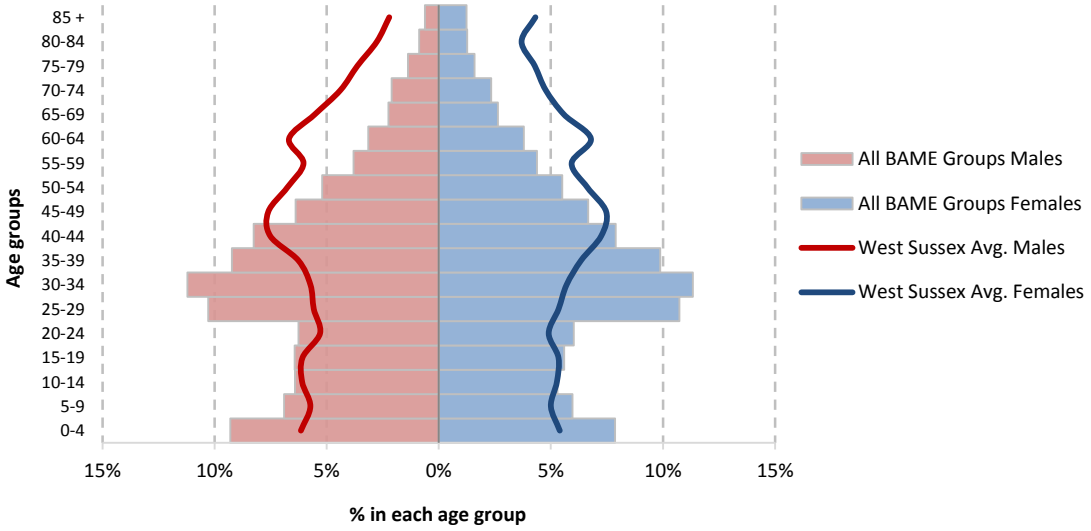


Source: ONS, 2001/2011 Census

1(a).1.2 Age composition

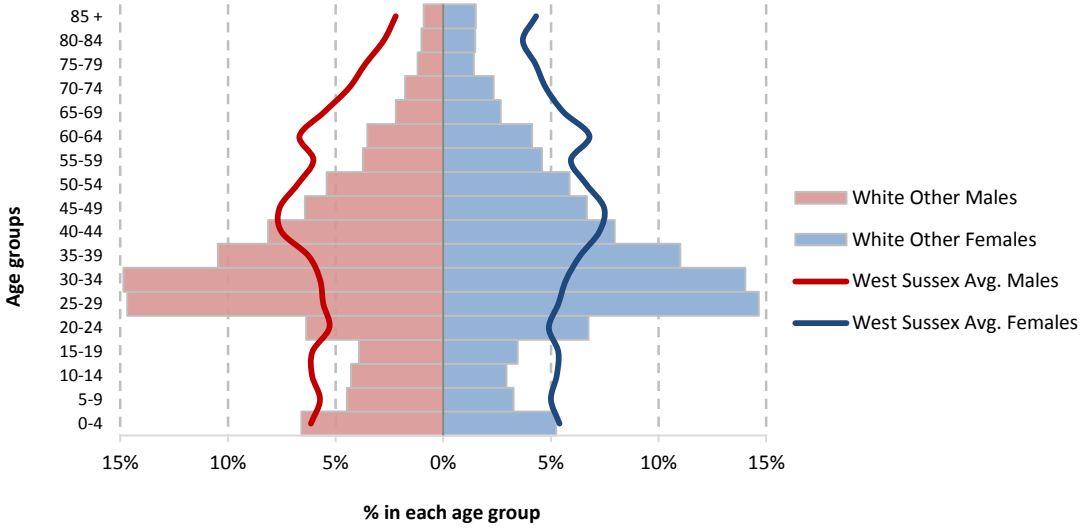
Using census figures supplied by the Office for National Statistics (ONS), we are able to produce a picture of the age of a population, by calculating what percentage of that ethnic group is within each five year age-bracket. This allows us to see how a resident ethnic group differs in age to that of the county population as a whole. For ease of comparison, the red and blue lines represent the total resident population (males and females) of West Sussex. These will also include the BAME group in question, though, as the largest measurable ethnic group (White Other) only accounts for 4% of the total county population, this should not distort the comparison.

Figure 1(a).3, West Sussex Population Age Structure, all BAME groups



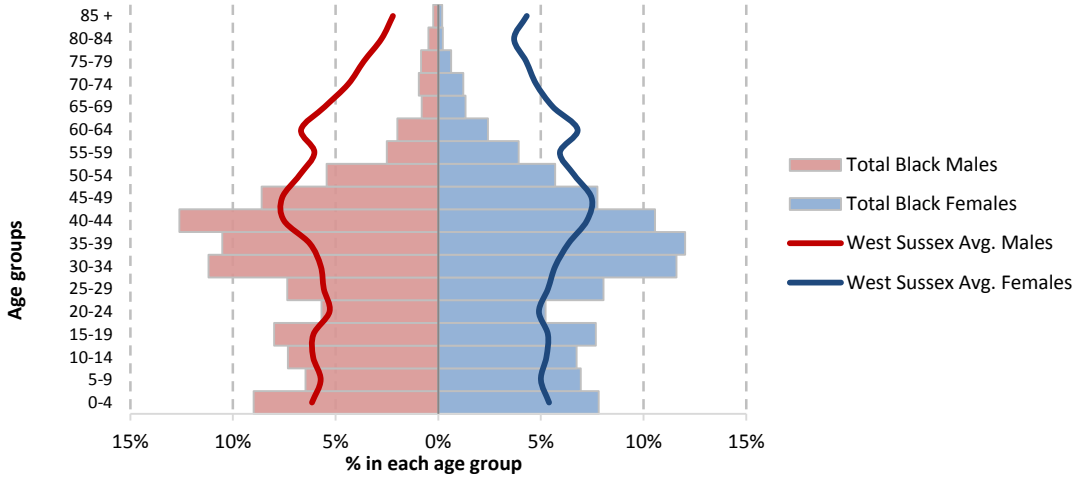
Source: ONS, 2011 Census

Figure 1(a).4, West Sussex Population Age Structure, White Other



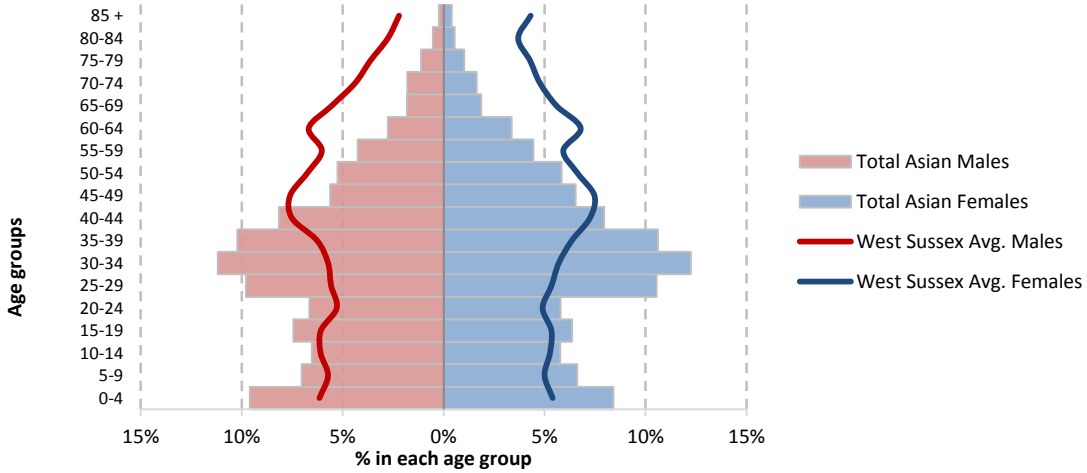
Source: ONS, 2011 Census

Figure 1(a).5, West Sussex Population Age Structure, All Black ethnicities



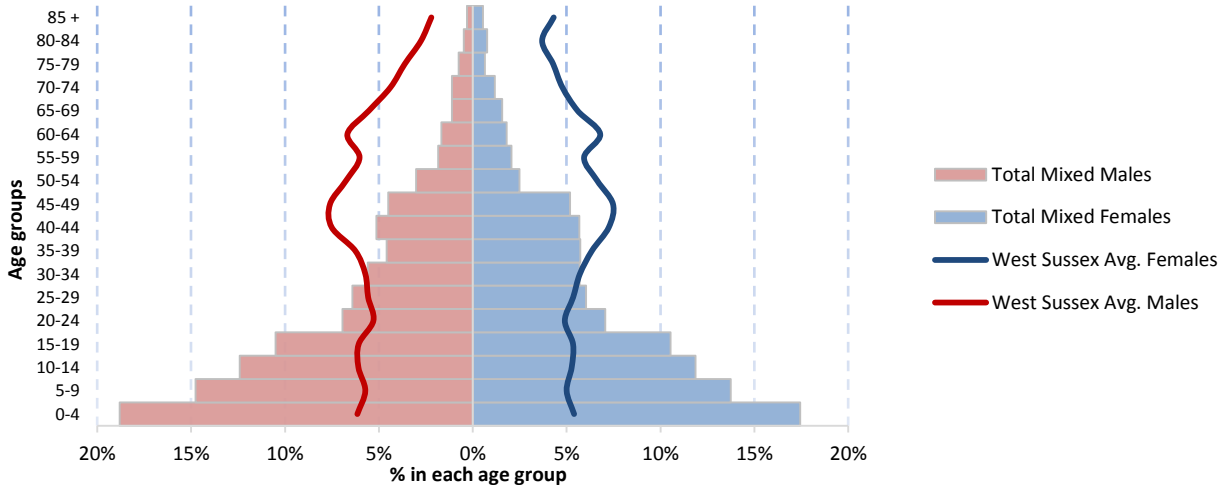
Source: ONS, 2011 Census

Figure 1(a).6, West Sussex Population Age Structure, All Asian ethnicities



Source: ONS, 2011 Census

Figure 1(a).7, West Sussex Population Age Structure, All mixed ethnicities



Source: ONS, 2011 Census

As a whole, the BAME population in West Sussex is younger than the total resident population, with fewer residents over the age of forty five and a far greater percentage in the twenty five to forty year-old range (Figure 1(a).3). There is also a larger proportion in the pre-school age of 'under 5 years'. The age breakdown of the BAME population in West Sussex is similar to that of England as a whole, though we have fewer young people; a pattern also seen with the local White British population. Regionally, we are in line with the South East, in this regard.

The 'White Other' population is a major contributor to the lower net age of BAME residents. At the time of the census (2011), 29% of 'White Other' residents were between the ages of twenty five and thirty five years; compared to just 11% for the total West Sussex population.

The Black and Asian communities are of a similar age structure to each other, with relatively few residents near or past retirement age. Both have a large concentration of their residents at working age and higher than average children of school and pre-school age. (Figures 1(a).5 and 1(a).6)

There is evidence here to suggest that those of traditional ethnic groups are starting families with people from other ethnicities, creating a younger population of 'mixed' ethnicities (Figure 1(a).7). Over half of all residents of a mixed ethnic background were under the age of twenty, in 2011.

These graphs show that the resident BAME communities will likely have a net benefit for our local authority. West Sussex's population is known to be aging, and the 'Future West Sussex Plan (2015-2019)[3] states one of our challenges in having an aging population is having "a smaller workforce to pay for care" (p20) and it is projects that by 2019 "Care for the elderly will take up more than half of the council's budget". This younger BAME population will likely dilute our aging local population; with far fewer using health and social care systems for older residents than the White British population. Any increased presence within public services will likely be in the schools, pre-schools and children and family support services. In parallel with this, a problem may be that ethnicity-sensitive support may be harder to fund in services for older residents, as they make up such a small proportion of the general client-base.

The County Council predicts that there will be a £124m deficit in funding from 2015 to 2019, from income *"via council tax, business rates and government grant and the amount of money needed provide public services in 2019. It takes into account increased demand and cost as more and more people will require care support as the population gets older." – p25*

[3] WSCC, Future West Sussex Plan, 2015-2019

Key points

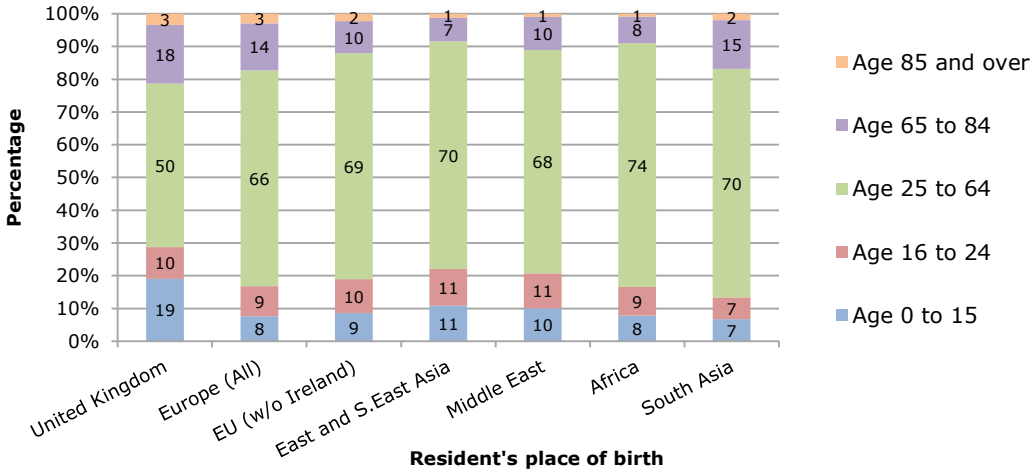
- West Sussex has a smaller BAME population (11%) than that of the South East (15%) and England (20%). These have increased from 7%, 9% and 13% in the ten years from 2001.
- Residents who identified as 'White Other' on the 2011 UK Census (which include Eastern and Southern Europeans) make up the largest BAME group (4%), more than all Asian/Asian British ethnic groups combined (3.5%).
- BAME groups are concentrated in Crawley, Bognor Regis, Littlehampton and Worthing, with smaller communities present in other urban areas.
- The BAME populations are younger than the total resident population, with far more being of a working age, i.e. 25-45 years. This is particularly so for the 'White Other' residents.
- Due to the 2011 census figures being five years old, we can assume that there is now an increased proportion of BAME children within local primary schools.
- The BAME population, (in particular 'White Other' groups) will likely have a new benefit on the council's funding, as the higher proportions of working age and lower retirement age can help to offset the costs of the aging local population.

Relevant recommendation(s): 15.

1(a).2 County of birth

A greater proportion of those born outside the UK are of working age than UK-born residents (Figure 1(a).8). This, further to the ethnicity age-profiles above, shows that those born outside the UK are more likely to be of an economically active age and therefore could help detract from the costs of the aging local population. Only 50% of the UK-born residents are between the ages of 25 and 65 years.

Figure 1(a).8, Age breakdown of West Sussex residents by their place of birth



Source: ONS, 2011 Census

Different local authorities in West Sussex have different proportions of their residents born outside the UK. In Crawley, 8% of residents under 16 years old were born outside the UK, compared to 2.5% in Adur; 4.6% for West Sussex (Table 1(a).2).

Table 1(a).2, Place of birth for residents aged under 16 years

	West Sussex	Adur	Arun	Chichester	Crawley	Horsham	Mid Sussex	Worthing
Born in UK	138,290	10,335	22,455	17,940	20,295	23,455	25,870	17,935
Born outside UK	6,665	270	895	690	1,755	1,085	1,235	735
Born outside UK (%)	(4.6%)	(2.5%)	(3.8%)	(3.7%)	(8.0%)	(4.4%)	(4.6%)	(3.9%)
All	**144,955**	**10,605**	**23,355**	**18,635**	**22,050**	**24,545**	**27,105**	**18,670**

Source: ONS, 2011 Census

Similarly, service provision for older residents in Crawley may need to account for an increased proportion of their residents being born outside the UK (14.6%), with the possibilities of language difficulties and cultural differences in service use.

Table 1(a).3, Place of birth for residents aged 65 years and over

	West Sussex	Adur	Arun	Chichester	Crawley	Horsham	Mid Sussex	Worthing
Born in UK	154,890	12,740	37,140	26,130	11,510	23,920	23,445	20,005
Born outside UK	11,685	695	2,185	1,765	1,960	1,650	1,860	1,565
Born outside UK (%)	(7.0%)	(5.2%)	(5.6%)	(6.3%)	(14.6%)	(6.4%)	(7.4%)	(7.3%)
All	**166,575**	**13,435**	**39,330**	**27,895**	**13,470**	**25,570**	**25,305**	**21,575**

Source: ONS, 2011 Census

Key points

- Similarly to the broad ethnic groups, those born abroad are more likely to be aged 25-64 than UK-born residents. This adds to the growing picture that BAME residents have the potential to be a net contributor to the cost of local adults' health and social care services.

- This is coupled with the likelihood that schools and children and family services face an increasingly diverse population and may require further support to meet his need.

Indicator	**Outcome**
1.2 1.3 1.5	School readiness Pupil absence 16 – 18 year olds not in education, employment or training
2.8	Emotional well-being of looked after children
3.3 3.7	Population vaccination coverage Comprehensive, agreed inter-agency plans for responding to health protection incidents and emergencies
4.8	Mortality rate from communicable diseases

1(a).3 Religion

West Sussex is roughly in line with the South East and English averages in terms of religious identification. Three in five would identify themselves as a Christian and roughly a quarter as having 'no religion'.

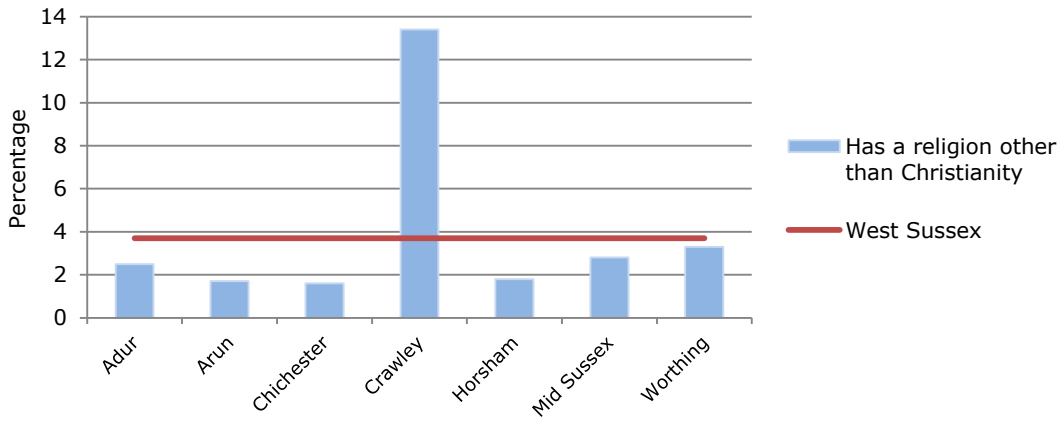
Table 1(a).4, Religion

Religion	Number of people *(figures are rounded so may not sum)*			% of total population		
	West Sussex	South East	England	West Sussex	South East	England
Christian	498,350	5,160,150	31,479,900	61.8%	59.8%	59.4%
Muslim	12,650	201,650	2,660,100	1.6%	2.3%	5.0%
Hindu	7,350	92,500	806,200	0.9%	1.1%	1.5%
Buddhist	3,050	43,950	238,650	0.4%	0.5%	0.5%
Jewish	1,450	17,750	261,300	0.2%	0.2%	0.5%
Sikh	1,150	54,950	420,200	0.1%	0.6%	0.8%
Other religion	4,100	39,650	227,850	0.5%	0.5%	0.4%
No religion	216,850	2,388,300	13,114,250	26.9%	27.7%	24.7%
Religion not stated	61,900	635,850	3,804,100	7.7%	7.4%	7.2%

Source: ONS, 2011 Census

Residents who identify with a religion other than Christianity make up 3.7% of the population (Figure 1(a).9). Overwhelmingly, the non-Christian population concentrates in Crawley, where 13.4% registered a religion other than Christian in the 2011 census, rising from 9.1% in 2001.

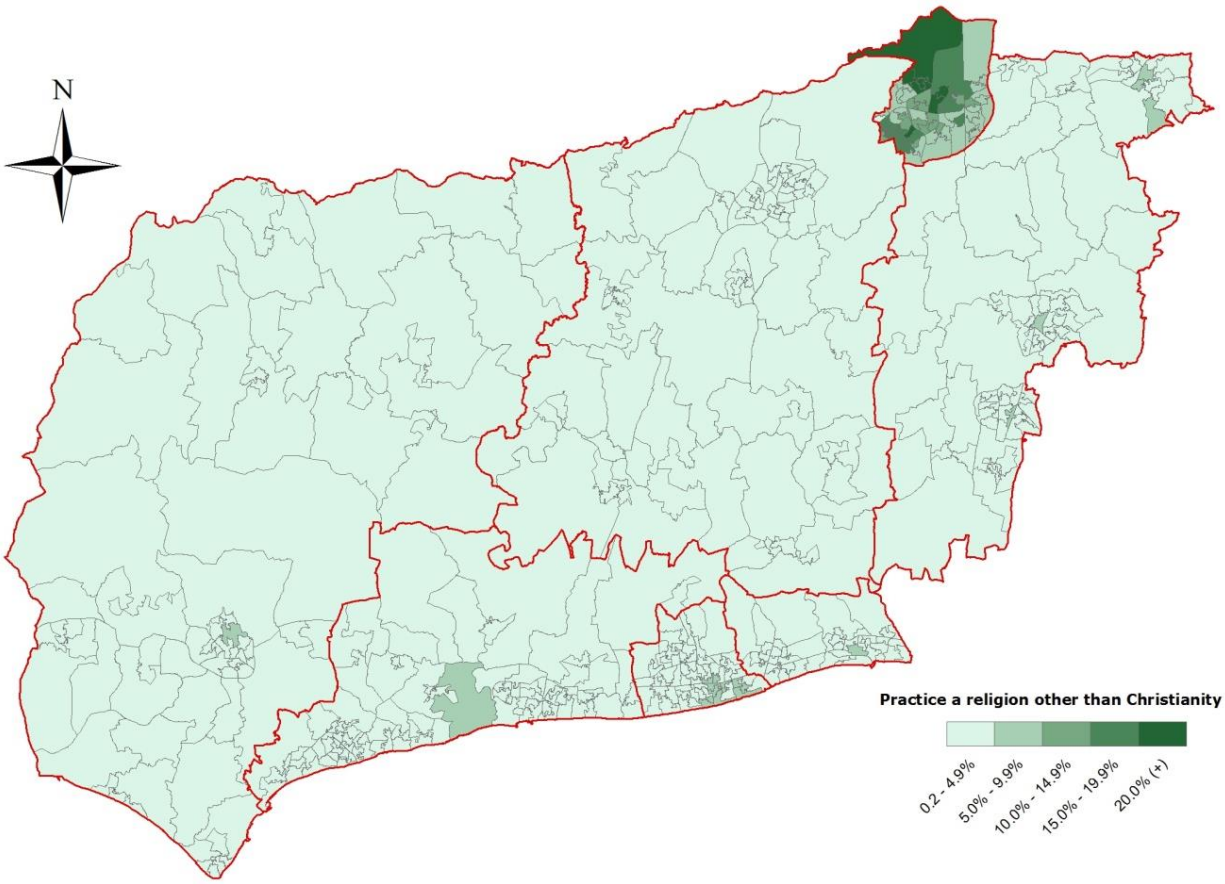
Figure 1(a).9, Residents identifying as having a religion other than Christian



Source: ONS, 2011 Census

Though Crawley district is more concentrated with minority religions, locally there are inconsistencies, with some neighbourhoods having less than 10% minority religion and others have more than 20% (Figure 1(a).10). It should be noted that the recent BAME community engagement commissioned in West Sussex found that many Eastern European residents from coastal Arun area do practice a minority religion, in Orthodox Christianity, though there is no formal place of worship available locally. This is hidden from available statistics due to the UK census only recording 'Christianity' as one broad religion, much in the same light as 'Islam', though many distinct cultural sects exist.

Figure 1(a).10, Minority religious practice in West Sussex



Source: ONS, 2011 Census

The religious makeup of Crawley is 54% Christian and 13.4% for minority religions (Table 1(a).5). Seven percent of residents said they identified as Muslim and 4.6% as Hindu. A further 26% stated they had no religion and 6.4% declined to respond.

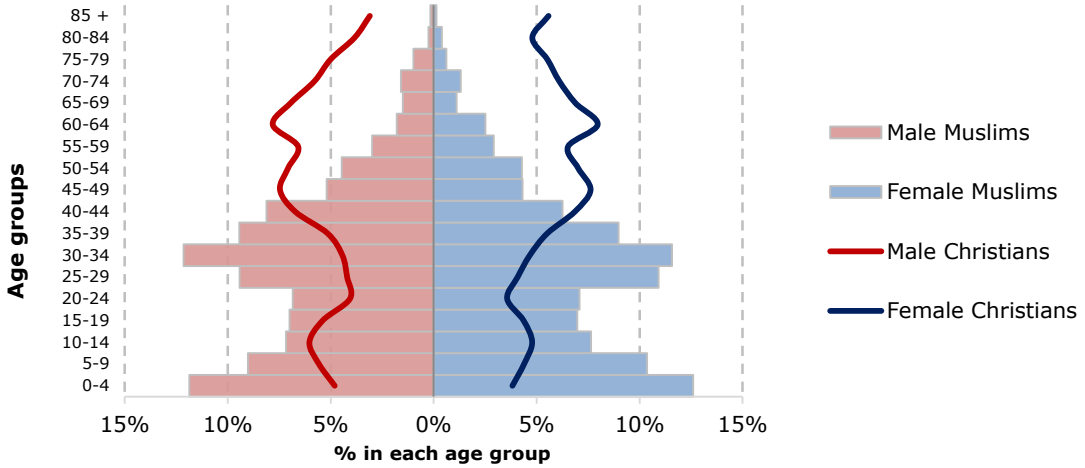
Table 1(a).5, Crawley residents who identify with a religion other than Christianity

	Buddhist	Hindu	Jewish	Muslim	Sikh	Other religion	Total
Numbers	400	4,890	100	7,680	730	450	14,250
Percentage	0.4	4.6	0.1	7.2	0.7	0.4	13.4

Note - Table does not show responses for No religion or Religion not stated.
Source: ONS, 2011 Census

The West Sussex Muslim population is much younger than the Christian population (Figure 1(a).11) with the majority of Muslim men and women are under forty five years old; a similar pattern is found for Hindu and Sikh residents.

Figure 1(a).11, West Sussex Christian and Muslim populations



Source: ONS, 2011 Census

Key points

- Roughly 4% (approx. 30,000) of West Sussex residents identify with a minority religion, which is held up by a concentrated population in Crawley (13.4% locally); including mainly Muslim (7.2%) and Hindu (4.6%) residents.
- The largest known minority religion in the county is Islam, with 1.6% identifying as Muslim, which is considerably lower than the 2.3% regionally and 5.0% nationally. These residents are likely to be much younger than resident Christian populations and many are of school-age.
- There are hidden communities of Orthodox Christians not represented by census statistics and qualitative evidence suggests that they may be unable to access cultural centres locally.

Indicator	Outcome
1.18	Social isolation
2.11 2.23	Diet Self-reported well-being

1(a).4 Main language

1(a).4.1 Language use

The range of main language spoken in West Sussex is extensive. Twenty one languages were recorded as spoken by at least 500 people across the county (Table 1(a).6). A further 19 languages are spoken by at least 100 people and a full table is shown in the appendix. In Crawley 13% of residents do not use English as their main language. Polish is the most widely spoken main language, with nearly as many as the next four languages combined.

* In the UK national census, 'main language' is not tightly defined, but respondents are asked "What is your main language?" and are supplied with a free-text response box to enter their answer.

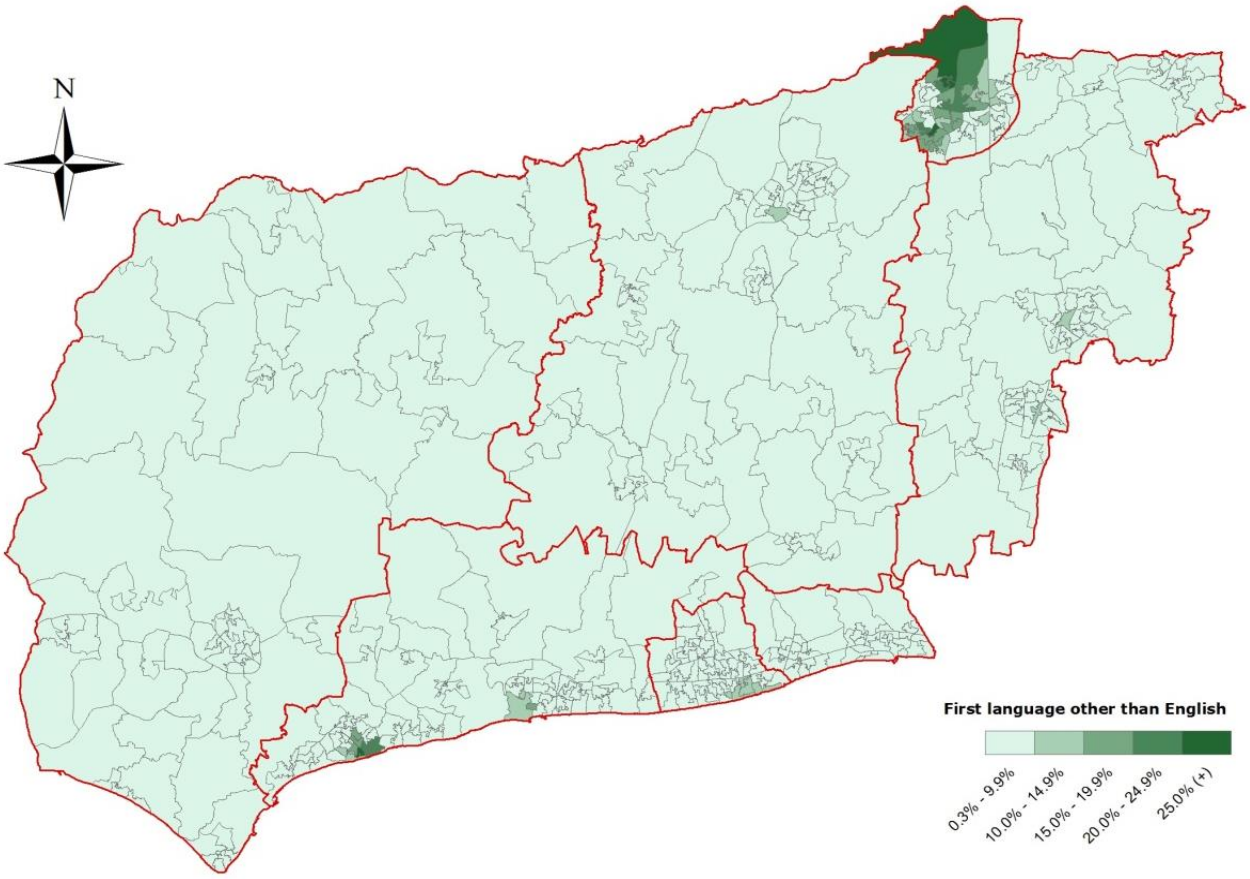
Table 1(a).6, Main languages spoken in West Sussex by at least 500 people

Main Language	**West Sussex**	Adur	Arun	Chichester	Crawley	Horsham	Mid Sussex	Worthing
All residents aged 3+ years	**779,010**	59,050	145,040	110,445	101,600	127,080	134,945	100,850
English	**742,040**	57,620	138,320	107,370	88,305	123,650	130,305	96,470
(English Percentage)	95.25%	97.58%	95.37%	97.22%	86.91%	97.30%	96.56%	95.66%
Polish	**6,300**	135	2,545	650	1,670	325	450	525
Portuguese	**1,955**	35	450	150	960	75	135	145
Gujarati	**1,650**	25	50	40	1,355	35	85	65
Tagalog/Filipino	**1,500**	20	195	135	165	260	380	345
Urdu	**1,440**	10	35	15	1,230	40	55	55
French	**1,435**	75	145	155	420	220	265	150
Lithuanian	**1,320**	-	525	85	415	35	35	220
Tamil	**1,310**	5	50	25	1,035	25	90	80
Bengali	**1,225**	140	185	75	270	80	160	315
Spanish	**1,185**	60	125	140	300	180	240	145
German	**1,045**	60	155	195	120	145	260	115
Italian	**1,005**	45	65	70	255	155	180	235
Hungarian	**920**	35	135	45	340	160	150	55
Russian	**895**	40	360	75	175	60	85	105
Malayalam	**750**	10	90	80	70	140	285	75
Arabic	**700**	160	55	40	250	50	50	95
Panjabi	**650**	10	5	-	580	20	15	20
Latvian	**630**	15	320	40	160	20	35	40
Romanian	**620**	15	105	50	165	125	120	40
Slovak	**580**	15	70	45	195	95	85	75
Turkish	**540**	35	75	40	130	35	105	115

Note – Numbers have been supressed where fewer than 5 people were in an area
Source: ONS, 2011 Census

Throughout the majority of the county, less than one in ten residents have a main language other than English (only 2% in rural areas and 5.5% in urban areas), though this rises in Littlehampton and Worthing and considerably so in Bognor Regis and Crawley.

Figure 1(a).12, Population density of West Sussex residents who speak a first language other than English



Source: ONS, 2011 Census

From this map we can see the concentration of people whose main language is other than English, although it is difficult to visualise due to scale. For example, of the eleven electoral wards which comprise the greater Bognor Regis area, nine had more than half the resident non-native English speakers reporting to speak an EU language (other than French, Portuguese or Spanish). In Bognor Regis, 4.7% of the population aged over 3 years speaks one of these as a primary language. Though not exclusive, this shows the greatest potential demand for translation and interpreting services in these coastal areas.

Table 1(a).6, Bognor Regis residents whose first language is an EU language

2011 census electoral ward	First Language is an EU language*	% of all residents (over 3yrs)	% of residents for whom English is a second language
Aldwick East	95	2.0	59.6
Aldwick West	65	1.4	71.9
Bersted	305	3.7	66.5
Felpham East	30	0.6	43.3
Felpham West	40	0.8	48.1
Hotham	715	11.3	78.2
Marine	695	13.3	78.4
Middleton-on-Sea	40	0.8	66.7
Orchard	490	8.3	71.1
Pagham and Rose Green	90	1.2	60.4
Pevensey	415	7.3	73.4
All Bognor Regis wards	**2,980**	**4.7**	**72.3**

Source: ONS, 2011 Census

Note: EU languages from the 2011 European Union, and not including French, Spanish or Portuguese*

In Crawley, where 13% of the population did not consider English to be a main language, the native language is distributed largely between EU (28%) and South Asian languages (37%). In more diverse electoral wards, this overall percentage is larger (i.e. Langley Green, 25%; Northgate, 21%; Broadfield North, 20% and Bewbush, 18%).

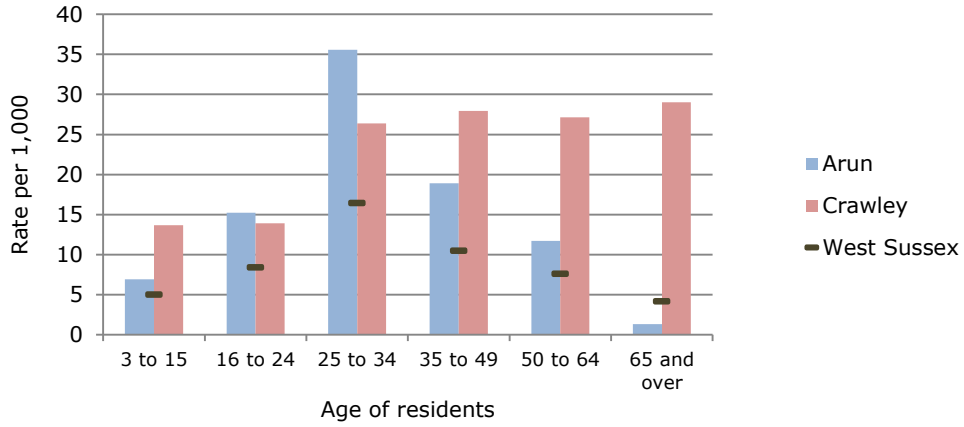
The mapping and data show the potential demand for interpreting services across the county. In Arun district, 3.6% of adults from the age of 25 to 34 cannot speak English well or at all, but this need drops to 0.1% of over 65's. In Crawley, however, 2.6% of those aged 25 to 34 and 2.9% of over 65's cannot speak English well or at all (Figure 1(a).13). These age groups have specific needs when accessing language courses.

Qualitative research conducted by The Young Foundation in West Sussex (*'BAME community engagement', 2015*) has indicated that there is a keen demand for English language classes amongst foreign speaking residents, particularly amongst Europeans in the Arun district area. There has been a concern that most classes are either in short supply or are unaffordable/hard to access. There also appears to be a reliance on translation and interpreting services, though some third sector organisations are finding it difficult to maintain community networks in recent years:

> *"Those organisations that assist people with translating or interpreting are highly valued. Many people report needing help with everyday issues like applying for jobs or dealing with the welfare system" - p. 10.*

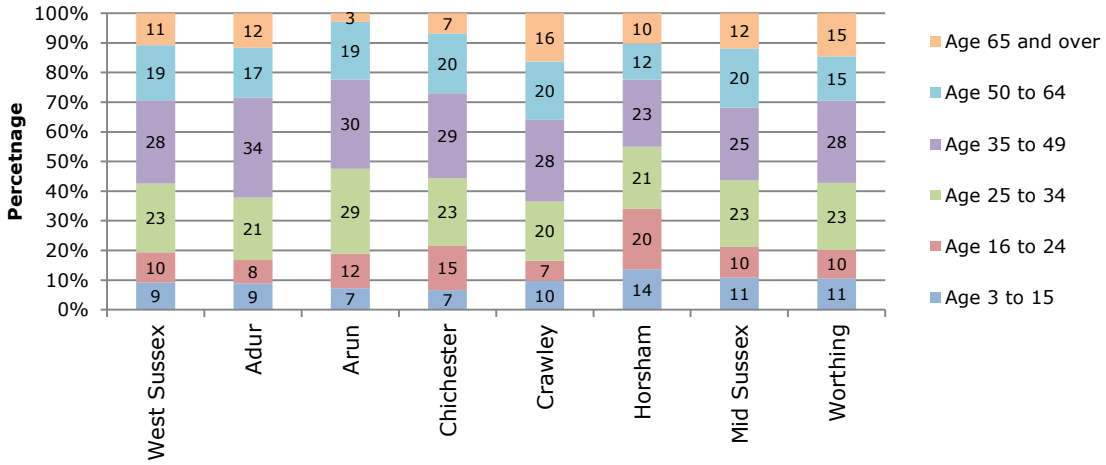
This represents an opportunity for investment in English courses verses the eventual cost to the service provider of interpreting services and translating materials. This has value as a sustainable alternative to high-cost translation and interpreting services. Locally there are far fewer residents with difficulties using English than nationally. This is particularly so with older residents, aged 65 and over (Table 1(a).6).

Figure 1(a).13, Residents in the general population who cannot speak English well or at all; rate per 1,000 internal residents



Source: ONS, 2011 Census

Figure 1(a).14, Age structure of those who cannot speak English well or at all, within each LA



Source: ONS, 2011 Census

Table 1(a).6, First language is not English, as a percentage of the total population within each age group

	West Sussex		South East		England	
	Can speak English well or very well	Cannot speak English well or at all	Can speak English well or very well	Cannot speak English well or at all	Can speak English well or very well	Cannot speak English well or at all
All ages over 3	**3.9%**	**0.8%**	**4.9%**	**0.9%**	**6.3%**	**1.7%**
Age 3 to 15	2.6%	0.5%	3.3%	0.6%	4.9%	0.9%
Age 16 to 24	4.7%	0.8%	6.3%	0.7%	8.0%	1.1%
Age 25 to 34	11.6%	1.6%	12.3%	1.6%	14.2%	2.5%
Age 35 to 49	5.0%	1.0%	5.8%	1.1%	7.3%	2.1%
Age 50 to 64	2.1%	0.8%	2.5%	0.8%	3.5%	1.7%
Age 65 and over	0.9%	0.4%	1.3%	0.7%	1.8%	1.5%

Source: ONS, 2011 Census

1(a).4.2 English language and employment

Those residents who do not have a good grasp of English tend to work in different industries to foreign nationals who can speak English well; with an increase in hospitality services and agriculture and far lower representation in public administration, education and health settings (Table 1(a).7). Those who can speak English well tend to work in similar industries to the resident British population. It is feasible therefore that English comprehension contributes to barriers to diversity in the workforce and representation in public services.

Nationally, the picture is similar, though with a relative increase in manufacturing, rather than in agriculture for those with poor English skills, which can be expected due to the shift in regional economies and the large role of rural agriculture locally.

Table 1(a).7, Use of English and industry of employment in West Sussex

	All those in work	Main language is English	English not first language	
			Can speak English well or very well	Cannot speak English well or at all
All industries	**397,884**	**373,847**	**20,522**	**3,515**
Public administration, education and health	27%	27%	27%	11%
Distribution, hotels and restaurants	21%	21%	29%	36%
Financial, Real Estate, Professional and Administrative	19%	19%	14%	20%
Transport and communication	10%	10%	12%	6%
Construction	8%	8%	3%	4%
Manufacturing	7%	7%	9%	11%
Agriculture, energy and water	3%	2%	3%	9%
Other	5%	5%	3%	3%

Source: ONS, 2011 Census

Key points

- Polish is the most widely spoken foreign main language in West Sussex, with nearly as many as the next four languages combined.
- In Crawley, 13% of residents do not use English as their main language.
- In Bognor Regis three quarters of those with a foreign main language speak an EU language (not including French, Spanish or Portuguese), representing the greatest potential demand for translation and interpretation services.
- The ages of those who may need support with speaking or understanding English varies greatly from area to area, which will determine how/where support is targeted and commissioned.
- A recent community engagement found evidence of a desire in the community for more investment in affordable and accessible language classes. This presents an opportunity to reduce the costs of obligatory translation and interpretation, required by service providers.
- Those residents who cannot speak English well or at all are more likely to work in hospitality services and agricultural roles than other in the population. They are also less likely to be employed in public services than peers with a better grasp of English, suggesting that English comprehension is a barrier to diversity in the workforce and representation in public services.
- The benefits from investing in better English language comprehension in migrant communities include better integration within the wider community; more appropriate use of services; better communication with professionals, leading to better care and a decreased burden on acute services; increased economic activity and employability; and more effective community campaigns.

Relevant recommendation(s): 7., 8., 9., 10., 11., 14., 15., 16., 17., 19., 20.

Indicator	Outcome
1.1	Children in poverty
1.2	School readiness
1.5	16 – 18 year olds not in education, employment or training
1.15	Statutory homelessness
1.18	Social isolation
2.3	Smoking status at time of delivery
2.5	Child development at 2 – 2 ½ years
2.21	Access to non-cancer screening programmes
2.22	Take up of the NHS Health Check programme – by those eligible
2.23	Self-reported wellbeing
3.3	Population vaccination coverage
3.5	Treatment completion for TB
4.8	Mortality rate from communicable diseases
4.10	Suicide rate
4.12	Preventable sight loss
4.13	Health-related quality of life for older people

1(a).5 Household composition

There are approximately 12,205 households in West Sussex where a resident from a minority ethnicity is the head of household with dependent children living with them (Table 1(a).8).

The 2014 call for evidence revealed a perception that families from some ethnic minority groups tended to be both larger and more likely to live with their older family members at home. It is possible that this pattern is in decline as communities integrate. Families from BAME groups were generally less likely to be lone parent families than the White British population; however, those from mixed-ethnic backgrounds were the highest group (with 28% identifying as single parent).

Nationally, more households with parents from Black/Black British or Mixed ethnic backgrounds are likely to be lone parent households than in the South East or West Sussex. Families from other ethnic backgrounds do see a smaller, but still visible, increase (Table 1(a).9). This appears to match the relative affluence of West Sussex, as single parent households can be expected to cluster in more affordable areas.

Table 1(a).8, Composition of households with dependent children

	All households with dependent children	Couple families			Lone parent families		Other households
		Total	Married or civil partnership	Cohabiting	number	% of total	
All ethnic groups	93,095	67,360	55,110	12,250	18,695	20.1%	7,040
White British	80,890	58,890	47,755	11,130	16,800	20.8%	5,200
White Irish	675	510	440	70	120	17.8%	45
White Other	4,265	2,960	2,395	565	675	15.8%	630
Mixed/multiple ethnic group	1,090	695	530	165	300	27.5%	95
Black/African/Caribbean/ Black British	1,445	830	695	135	315	21.8%	300
Asian/Asian British: Indian	1,350	1,090	1,050	35	80	5.9%	180
Asian/Asian British: Pakistani	740	575	560	20	85	11.5%	80
Asian/Asian British: Bangladeshi	345	275	270	10	25	7.2%	45
Asian/Asian British: Chinese	430	235	220	15	45	10.5%	150
Other ethnic group: Arab	205	160	155	10	30	14.6%	15
All BAME groups	**10,545**	**7,330**	**6,315**	**1,025**	**1,675**	**15.9%**	**1,540**

Note – 'Other households' includes dependent children living with non-parental relatives and 'hidden families' which live with others and the parent may not be the head of the household.
Source: ONS, 2011 Census

Table 1(a).9, Percentage of households with dependent children which are lone parent households

	West Sussex	**South East**	**England**
All ethnic groups	20%	21%	24%
White British	21%	22%	25%
White Irish	18%	18%	23%
White Other	16%	15%	18%
Mixed/multiple ethnic group	27%	31%	44%
Black/African/Caribbean/ Black British	24%	29%	42%
Asian/Asian British: Indian	5%	7%	9%
Asian/Asian British: Pakistani	10%	12%	13%
Asian/Asian British: Bangladeshi	6%	9%	12%
Asian/Asian British: Chinese	14%	14%	16%
Other ethnic group: Arab	15%	12%	17%
All BAME groups	**16%**	**17%**	**24%**

Source: ONS, 2011 Census

Key points

- Families in Asian/Asian British backgrounds are **less likely** to be lone parent households and families from Black/Black British or mixed ethnic backgrounds are **more likely** to be lone parent households the general population.

- Generally, families in West Sussex are less likely to live in lone parent households than families from similar ethnic groups around the country

Relevant recommendation(s): 1., 7., 8., 12., 14., 18., 19., 20.

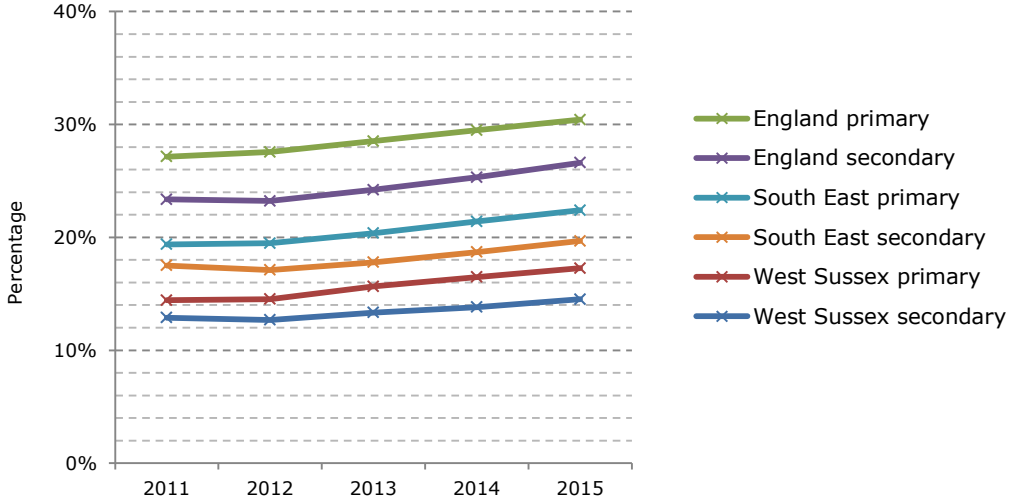
Indicator	Outcome
1.1 1.2 1.18	Children in poverty School readiness Social isolation
2.5 2.23	Child development at 2 – 2 ½ years Self-reported wellbeing
3.3	Population vaccination coverage
4.1 4.2	Infant mortality Tooth decay in children aged 5

1(a).6 Populations in education

1(a).6.1 School population

The percentage of minority ethnic children in state-funded primary schools has been increasing over the past five years, in line with national and regional levels, it follows that there will be a further rise to the secondary school BAME population in coming years (Figure 1(a).14).

Figure 1(a).14, Minority ethnic pupils within state-funded education



Source: School census, 2011-2015

1(a).6.2 Higher education population and language

Not all the higher education facilities were forthcoming with demographics data though from those who did (Chichester University and Worthing college) we can see that whilst the University will be taking students from outside the county lines, minority groups (taken as non-white in these statistics) make up a lower proportion of the student population than the county population.

Table 1(a).10, Chichester University, ethnicity and nationality

	White	BAME	Unknown	Total No.
British	91.7%	6.0%	2.3%	5,187
Other Nationality	43.6%	40.9%	15.4%	259
All	**89.4%**	**7.6%**	**3.0%**	**5,446**

Source: Chichester University HESA, 2014/15

Students at Chichester University are asked for their primary language (if not English) on admission and the largest portion in 2014/15 were Chinese, and Cantonese also featuring highly (Table 1(a).11). After this, Polish was the most common language spoken. Foreign exchange students are not included in these figures as their exchange programme counts them as enrolled at their local University abroad.

Table 1(a).11, Students who declared their first language was not English

First Language	(n=189)
Chinese *(largely Mandarin)*	16%
Polish	8%
Shona	6%
Cantonese	6%
Portuguese	5%
Japanese	4%
Spanish	4%
French	4%
Greek	4%
Estonian	3%
German	3%
Italian	3%
Other languages* with less than 5 speakers	34%
Total	**100%**

**Other languages includes: Afrikaans, Arabic, Bengali, Bosnian, Bulgarian, Catalan, Creole, Croatian, Czech, Danish, Dutch, Ghanian, Gujarati, Hungarian, Igbo, Kiswahili, Korean, Latvian, Maltese, Mandarin, Ndebele, Nepali, Norwegian, Persian, Punjabi, Romanian, Russian, Swedish, Tagalog, Turkish, Urhobo, Vietnamese, Welsh and Zulu)*
Source: Chichester University HESA, 2014/15

Table 1(a).12, Ethnicity Breakdown based on all Nationalities (Chichester University, 2014/15)

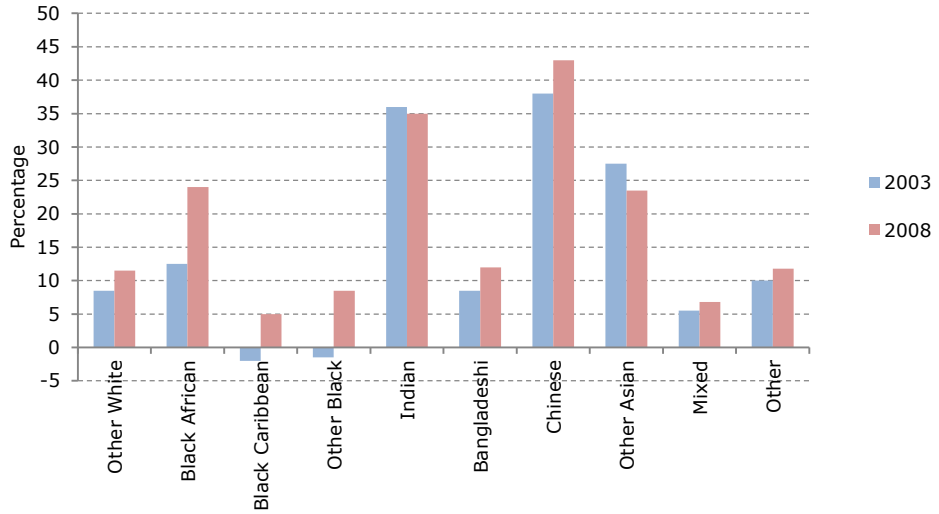
Ethnic Group	**Ethnicity breakdown**	**Total**
White Total		**89.4%**
BAME Total		**7.6%**
BAME detailed	Black or Black British - African	19.8%
	Mixed - White and Black Caribbean	14.0%
	Chinese	10.1%
	Asian or Asian British - Indian	9.4%
	Mixed - White and Asian	8.0%
	Other mixed background	6.7%
	Black or Black British - Caribbean	6.5%
	Other ethnic background	6.3%
	Other Asian background	5.8%
	Asian or Asian British - Bangladeshi	4.8%
	Mixed - White and Black African	4.3%
	Other Black background	2.2%
	Arab	1.2%
	Asian or Asian British - Pakistani	1.0%
Unknown Total		**3.0%**

Source: Chichester University HESA, 2014/15

Nationally, research by the Department for Business, Innovation and Skills (2015)[4] found that White British young people are the least likely to go on to higher education (Figure 1(a).15). Whist it was Black Caribbean/Black Other groups in 2003, this had shifted considerably by 2008. Whilst White British pupils increased by around 4% during this period, all other groups (besides Indian and Other Asian) increased faster. Interestingly, during this time, pupils from Black Caribbean and Black Other groups were still less represented than White British pupils at the nation's most selective institutions (those in the top third of average UCAS tariff scores amongst entrants), though this difference is believed to be slowly narrowing. - The authors are unable to explain the root of the difference between ethnic groups, after controlling for affluence and location.

[4] Socio-economic, ethnic and gender differences in HE participation. Dpt. For Business, Innovation and Skills, 2015, p44

Figure 1(a).15, Difference in HE participation at age 18 or 19 relative to White British pupils amongst cohorts who took their GCSEs 2003 to 2008



Note: White British rates represent 0% in this chart
Source: Dpt. for Business Innovation and Skills, 2015

Key points

- The proportion of children in West Sussex schools from ethnic minority backgrounds is increasing, though still lower than both regional and national averages.
- Young people from minority ethnic groups are more likely to attend higher education than White British groups, though some Black groups may still be under represented in the most selective institutions.
- Further work with higher education and colleges could allow for a better understanding of the needs of young people in this cohort.

Relevant recommendation(s): 8., 14., 15., 18., 19., 20.

Indicator	**Outcome**
1.2	School readiness
1.3	Pupil absence
1.5	16-18 year olds not in education, employment or training

1(b) Migration

I'm a bit disappointed because I found it's very hard to make friends with English people. It's weird to live in a country where I don't have a close relationship with any local people (Male, Spanish, 25–64).

There is a big tolerance for foreigners (Female, Polish, 25–64)

It's difficult to make friends with local people, so with resignation I have to say it's almost impossible (Male, Italian, 25–64).

Interpreting services are available just not everyone knows it (Female, Indian, 25–64).

It was difficult to find somewhere to live rent is very high (Female, Indian, 25–64).

In Uganda you can never be alone in your house for more than five minutes… it's a good thing (Female, Uganda, 25–64)

I think people don't spend too much time together in the UK because they all work very hard (Female, Uganda, 25–64).

[Not being able to speak English well] I felt embarrassed and ashamed (Female, Hungarian, 25–64).

1(b).1 Measuring migration

West Sussex residents who have moved into the area from another country represent a different array of issues regarding health and social care provision, to those who are more familiar with how public services function in England. Many of these residents will be seasonal workers, or short to mid-term residents seeking employment or a change in culture, whilst others might intend to stay in the country indefinitely and start families and careers in the long term. On top of this there may be refugees and asylum seekers (those awaiting refugee status), who may have experienced violence, intimidation, oppression or war in foreign countries.

1(b).1.1 Population change

One method of monitoring migration in and out of the county is to use the UK census, which asks where the respondent (and any dependents) lived one year previously. Concerning those already living in the UK, the 2011 census showed a consistent inward and outward migration in West Sussex, from both white ethnic groups and others. This is contrasted with an additional inward migration from outside the UK of roughly 7,000. It is not known how many people leave the UK from West Sussex.

In 2010, the population of West Sussex was estimated to be 803,200[5], rising to 808,900 in 2011. This 5,700 person increase may be partially explained by this inward migration from outside the UK, though other factors such as natural population increase due to childbirth could also contribute.

Table 1(b).1, Inward and outward migration in West Sussex

	Moved in from inside the UK	Moved out to inside the UK	Moved in from outside the UK
All residents	12,785	12,810	6,920
White groups	11,090	11,090	5,305
All groups other than 'White'	1,690	1,715	1,615
(%) other than white	(13%)	(13%)	(23%)

Note: Due to the 'Harmonised Concepts and Questions for Social Data Sources Primary Standards' used for this data, all White ethnic groups have been combined to one single category.
Source: ONS, 2011 Census

1(b).1.2 International migration

In terms of migration, the overall net movement of people into West Sussex takes into account both people moving in and out of the county. Overall, there are significantly more people moving away from West Sussex than in (12,808 versus 6,922). The vast majority of this net migration (98.2%) was from individuals who considered themselves to be White British, BAME groups accounted for only 1.8% of all net migration out of West Sussex. Aside from 27 recorded BAME individuals moving into Crawley, no single area saw an overall increase in population, either white or BAME. Of those moving into West Sussex, just over 1,700 were asylum seekers, the majority of whom settled in Crawley, Worthing or Mid Sussex. No local data were available pertaining to unaccompanied child asylum seekers.

Particularly due to the open boarders of the European Economic area, it is difficult to know the numbers of migrants living in West Sussex, from the EU and non-EU countries in the years in between the national censuses. Recent GP registration data shows that for every 1,000 residents in the general population, roughly 7 new GP registrations were completed by non-UK residents (Figure 1(b).1). This of course does not tell us the national origins of the resident, which will have knock on effects for language barriers, commissioning of foreign language materials and investment in English language courses.

Nationally the net internal migration for both EU citizens and non-EU citizens was between 190,000 and 200,000 per annum in 2015.

Figure 1(b).1, Migrant GP registrations per 1,000 resident population

[5] ONS population projections

Source: South East Strategic Partnership for Migration, 2014

Another indicator of economic migration is new National Insurance Number registrations, or which there were 10 per 1,000 resident-population in West Sussex in 2012 and 2013. Nationally, the NI registrations are known to mainly come from EU citizens (roughly 3:4 in 2014/15). In West Sussex, we know that the majority of new NINo registrations came from residents from Eastern Europe (EU), being those countries who joined the EU in 2004, (referred to as EU8) and Romania and Bulgaria (referred to as EU2) - Table 1(b).2 below. These figures have stayed level for the five years leading up to 2013.

Figure 1(b).2, Migrant National Insurance Number registrations per 1,000 resident population

Source: South East Strategic Partnership for Migration, 2014

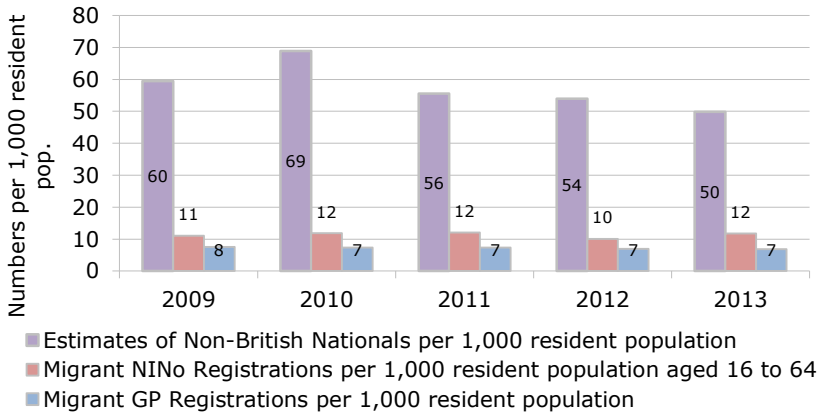
Table 1(b).2, NINo registrations to adult overseas nationals entering the UK, 2014/15

	West Sussex	Adur	Arun	Chichester	Crawley	Horsham	Mid Sussex	Worthing
EU15	1,655	85	145	180	610	205	235	195
EU8	2,330	40	870	305	615	120	185	195
EU2	2,275	45	345	525	680	195	240	245
European Other	150	5	30	5	50	20	15	25
Asia	655	15	40	40	350	65	60	85
Sub-Saharan Africa	155	5	20	20	65	15	15	15
Other	275	25	20	50	60	35	55	30
Total	7,530	215	1,485	1,135	2,430	670	805	790

Source: ONS, for Department for Work and Pensions, 2016

The South East Strategic Partnership for Migration estimates that there are roughly fifty non-British nationals for every 1,000 in the resident population in West Sussex, as of 2013. From this we can see that roughly one in four of these applied for a National Insurance Number and around half of those had registered with a GP. The proportion of new non-British nationals in the population is believed to be decreasing.

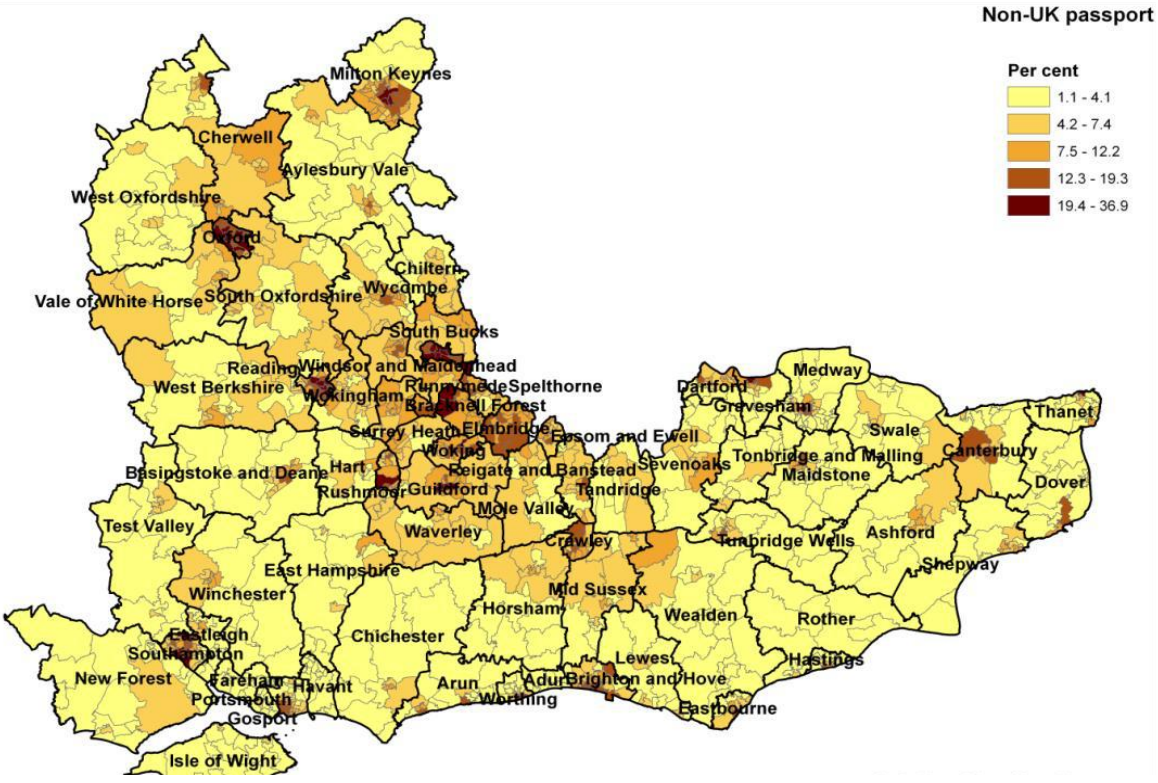
Figure 1(b).3, Estimates of Non-British Nationals in West Sussex population and NI/GP registrations



Source: South East Strategic Partnership for Migration, 2014

Relatively speaking, West Sussex has fewer non-UK passport holders than many other local authorities in the South East, particularly the coastal cities and those closer to London (Figure 1(b).4). Central Bognor Regis, Littlehampton and Worthing have higher populations, but it is more the north of the county, presumably due to Crawley and Gatwick, which hold more non-UK passport holders in the general population.

Figure 1(b).4, Distribution of non-UK passport holders in S.E. England

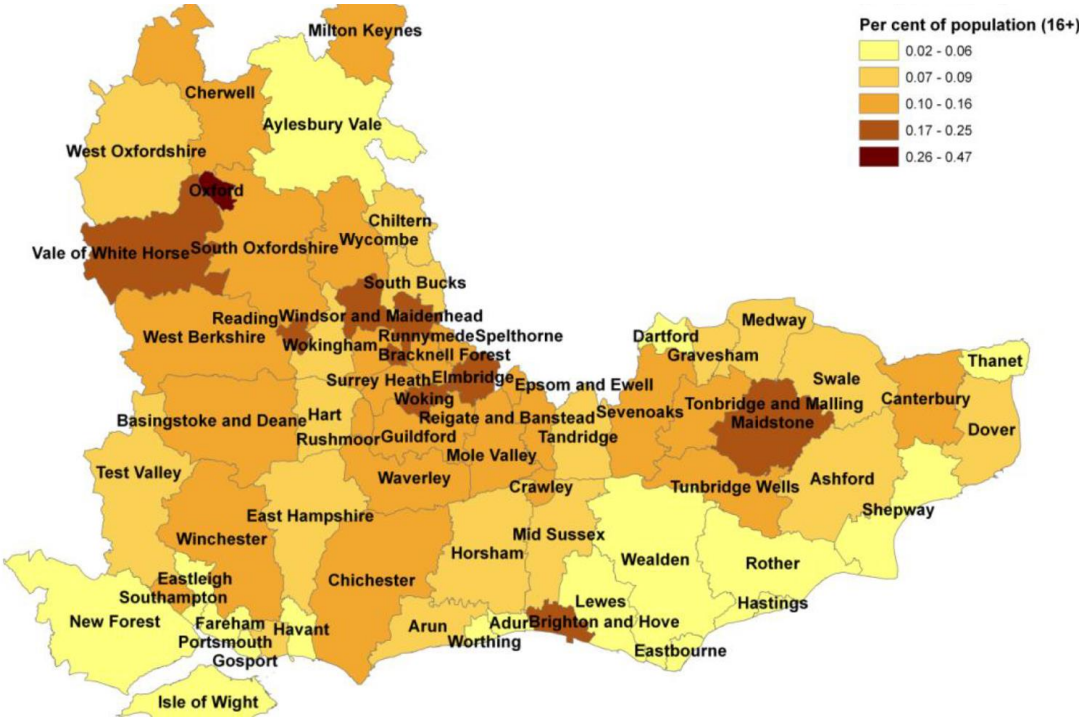


Source: South East Strategic Partnership on Migration, using UK Census, 2011

1(b).1.3 An international workforce

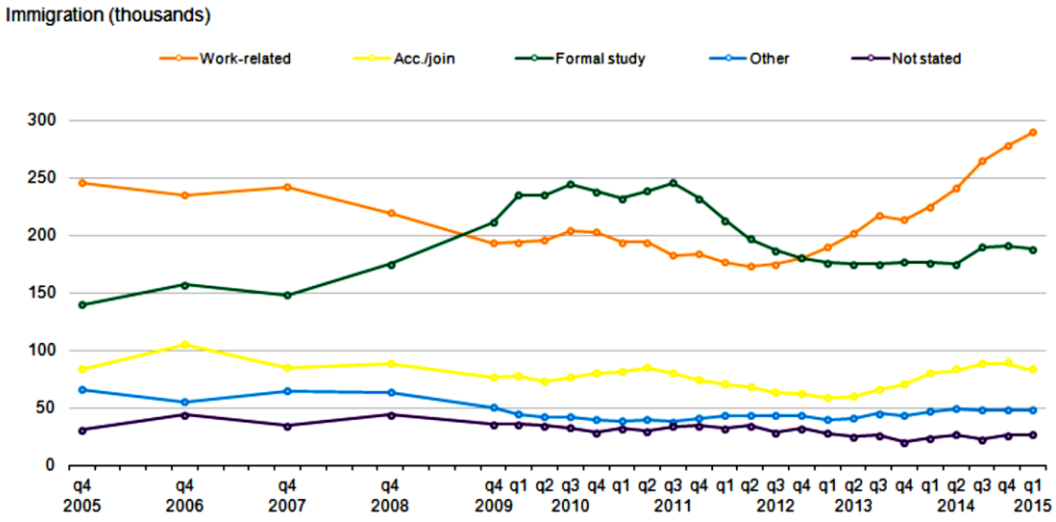
Depending on the age profile of the resident UK citizens, those moving in from abroad may make up a larger or smaller proportion of the workforce. In Worthing, for example, the percentage of the population in employment is lower than in Chichester (Figure 1(b).5). The ONS estimates that the number of long term international immigration for purposes of work, is meant to rise nationally, and has exceeded those intending to study full time.

Figure 1(b).5, Distribution of short-term migrants in employment



Source: South East Strategic Partnership on Migration, using UK Census, 2011

Figure 1(b).6, Long-Term International Migration estimates of immigration to the UK, by main reason for migration



Source: Long-term International Migration - Office for National Statistics, p 15[6].

[6] ONS Statistical bulletin, 2015, Migration Statistics Quarterly Report, August 2015

In 2013, the South East Strategic Partnership on Migration (SESPM) commissioned the University of Reading[7] to research 'irregular migrants'; a term which is internationally preferred to the more common term: 'illegal migrants'. The authors found that, regarding health care:

Irregular migrants face various barriers from:

- Inadequate information about how the health care systems in the UK work Insufficient support in interpreting and translating and limited English fluency
- Poor housing conditions and stress caused by the effects of uncertain immigration status Lack of access to transport to get to services
- Poor services in areas of deprivation where many irregular migrants live Confusion around entitlement to some types of services (e.g. not entitled to some services, for instance free hospital care, except for emergency care or treatment for HIV)
- Lack of knowledge and understanding of regulations regarding entitlements among surgery staff

Due to obvious problems with coming forwards, the number of irregular migrants in the area is unknown. However, these findings largely coincide with those of registered ('regular') migrants, discussed throughout this report.

1(b).1.4 Asylum seekers and refugees

The monitoring of populations of asylum seekers and refugees is difficult at a local level. The national charity: City of sanctuary, reports that *'statistics and superlatives have a short life span when it comes to refugees'.*[8]

Nationally, in 2015, asylum applications from main applicants increased by 29% to 32,414, the highest number of applications since 2004 (33,960). In 2015, the largest number of applications for asylum in the UK came from nationals of Eritrea (3,729), followed by Iran (3,248), Sudan (2,918) and Syria (2,609). In the same period, asylum applications from Sudanese nationals more than doubled to 2,918, from 1,449 in 2014.

Including dependants, the number of asylum applications increased by 20% from 32,344 in 2014 to 38,878 in 2015, and there were around 1 dependant for every 5 main applicants.[9] On average, roughly 60-65% of applications are refused each year. However, 2011-2013 data shows that 45% of applicants originally refused (and who logged an appeal) are eventually granted asylum.

Home Office figures show the UK had the ninth highest number (39,000) of asylum applications within the EU in 2015, including dependants (*and ranks 17th in terms of asylum applicants per head of resident population*). Germany (431,000), Sweden (163,000) and Hungary (163,000) were the 3 EU countries that received the highest number of asylum applications, (62% of all EU applications). The total number of asylum applications to the European Union in 2015 was an estimated 1,225,000, more than double the number in 2014 (590,000).

At the end of 2015, 34,363 asylum seekers and their dependants were being supported in the UK under Section 95 (either in supported accommodation or receiving subsistence only support), compared with 29,753 at the end of 2014.

[7] Nygaard and Francis-Brophy, 2013. *Irregular Migration Project: A desktop analysis: Review of drivers of irregular migration in the South East, University of Reading.*

[8] City of Sanctuary, 2014, Annual report. Available at: https://cityofsanctuary.org/wp-content/uploads/2015/01/City-of-Sanctuary-annual-report-final-version.pdf

[9] Home Office national statistics, 2016, Asylum, Available at https://www.gov.uk/government/publications/immigration-statistics-october-to-december-2015/asylum#key-facts

West Sussex is set to receive 240 Syrian refugees to the county over the next four years – with some families expected to arrive early in 2016.

1(b).1.5 Unaccompanied asylum-seeking children

An Unaccompanied Asylum-Seeking Child (UASC) is a person under 18, or who, in the absence of documentary evidence establishing age, appears to be under that age, is applying for asylum on his or her own right and has no relative or guardian in the United Kingdom.

There were 3,043 asylum applications from UASC's in 2015, an increase of 56% from 1,945 in 2014. Overall, UASC applications represented 9% of all main applications for asylum. Despite the recent increase in UASC applications, they remain below the peak of 3,976 in 2008. The countries with the highest number of UASC applications in the UK were Eritrea (694), followed by Afghanistan (656) and Albania (456). These three countries contributed to more than half (59%) of total applications.

As of the end of 2015/16 West Sussex looked after 137 Children and young people who had been unaccompanied asylum seekers. Of these,

- 15 were under age 16 years
- 48 were aged 16 & 17 years
- 57 were aged 18 – 21 years
- 17 were aged 21 years or older

Those over the age of 18 would have applied as children and continued statutory support as care leavers. The majority come from Afghanistan or Iran and the country of origin for these young people are as follows (numbers are suppressed where fewer than five).

- Afghanistan, – 30
- Albanian, - 16
- Angola, - <5
- Bangladesh, - <5
- China, - <5
- Eritrea, - 13
- Ethiopia, - <5
- Guinea, - <5
- Iran, - 24
- Iraq, - 14
- Nigeria, - <5
- Pakistan, - <5
- Sierra Leone, - <5
- Somalia, - 8
- Sudan, - 5
- Syria, - 8
- Vietnam, - <5
- Zimbabwe, - <5

Commissioners have reason to believe that 13 young people may have been purposefully trafficked into the country, due to their leaving support services soon after arriving. In the past year, 2015/16, there were 99 unaccompanied asylum seeking children that were referred to West Sussex – not all were accommodated.

Key points

- Non-UK passport holders are particularly difficult to track in the resident population, in the decade between national-level censuses.
- Fewer than 1% of GP registrations in recent years were to non-UK passport holders
- Nationally, roughly 3:4 NINo registrations of non-UK passport holders come from residents of the EU. Locally the majority of NINo registrations come from EU countries which have joined since 2004.
- Estimates suggest there are roughly fifty non-UK passport holders for every 1,000 people in the resident population in West Sussex, (2013). Roughly 1:4 of these applied for a NINo and around half of those had registered with a GP. The proportion of new non-British nationals in the population is believed to be decreasing.
- When mapping the distribution of non-UK passport holders in West Sussex (per capita), the majority lie inside either the central urban areas of the coastal strip or more generally the north of the county around Crawley and Gatwick.
- The majority of migrants in the UK are mainly here for the purpose of work (with full time education coming second). Locally they make up a greater proportion of the adults in employment in Chichester district than in Worthing borough.
- The number of irregular (illegal) migrants in the area is unknown, though research does cite another of barriers to support and services which are largely in line with those linked to registered/documented migrants, discussed later in the report
- Nationally, in 2015, asylum applications from main applicants increased by 29% to 32,414, with the majority coming from Eritrea, Iran, Sudan and Syria. Even with this increase the UK ranks 17th in the EU for the per capita asylum applications it receives.
- West Sussex is set to receive 240 Syrian refugees to the county over the next four years – with some families expected to arrive early in 2016.
- The majority of the unaccompanied asylum seeking children in care in West Sussex came from Afghanistan or Iran; some UASC are vulnerable to people trafficking.

Relevant recommendation(s): 7., 8., 9., 10., 15., 17., 19., 19.

Indicator	Outcome
1.1	Children in poverty
1.5	16 – 18 year olds not in education, employment or training
1.15	Statutory homelessness
1.17	Fuel poverty
1.18	Social isolation
2.13	Proportion of physically active and inactive adults
2.20	Cancer screening coverage
2.21	Access to non-cancer screening programmes
2.23	Self-reported well-being
3.3	Population vaccination coverage
3.5	Treatment completion for TB
4.10	Suicide rate
4.12	Preventable sight loss
4.13	Health-related quality of life for older adults
4.15	Excess winter deaths

1(c) Gypsies and travellers

There is an abundance of green space…it is one of the joys living in West Sussex (Gypsies and travellers group).

I left school at 14 years old in West Sussex because of the bullying and being treated badly because I am a Gypsy. I no longer give Gypsy down as my ethnicity because so much prejudice and discrimination comes of it. I feel like I have to hide my ethnicity… I do not want my children suffering because of who they are (Gypsies and travellers group).

I would never tell anybody I am a Traveller. I don't tell employer/landlords or any services (Gypsies and travellers group).

I am very happy with the school. My three children attend and they are very supportive. The teaching staff know that my children are Gypsy children and they always celebrate the Gypsy culture. (Gypsies and travellers group).

I spent years as a child and adult travelling around the County with my family going from one camp to another. The older I got the less places were open for us to pitch down for a few days. It is a very stressful way of life and your nerves can go against you (Gypsies and travellers group).

I have got used to it over the years [being treated differently]. If shops or pubs find out you are from the Travelling community you are not allowed in. There have been signs in windows before (Gypsies and travellers group).

Police always tend to view you differently and are less likely to believe you than they would if you were from the settled community (Gypsies and travellers group).

[Reading and writing] was a barrier and some things are still difficult. I regularly help people to read and understand letters etc. (Gypsies and travellers group).

Many do not understand the issues and you could feel that there was little sympathy in some of the advice workers…but others were helpful and not so judgemental. (Gypsies and travellers group).

My children go to school and are doing well. Nobody knows that they are Gypsy kids. I don't tell anybody (Gypsies and travellers group).

I do know of an elderly couple on site where I live who would greatly benefit from support. Nobody ever visits sites and helps these people (Gypsies and travellers group).

1(c).1 Updating the 2010 figures

The reduced differences in life expectancy and healthy life expectancy for people within the Travelling Community are well documented at a National level. Even after controlling for socio-economic status and comparing to other marginalised groups, Gypsies and Travellers have worse health than others: 38 per cent of a sample of 260 Gypsies and Travellers had a long-term illness, compared with 26 per cent of age- and sex-matched comparators (Sheffield report, Parry et al., 2004).

It is possible that the barriers to accessing health services and the high level of loss and bereavement (see Parry et al., 2004) faced by Gypsies and Travellers contribute to the poor mental health of many of the communities members. The majority of Gypsies and Travellers live in very close-knit families and the sudden loss of a family member can be devastating. There are concerns about the high suicide and parasuicide levels within the Communities.[10]

In 2010, a comprehensive health and social care needs assessment was conducted in West Sussex to inform policy and practice around this specific ethnic group. The needs assessment identified a number of district subgroups within the UK under the umbrella term 'Gyspy and Traveller':

- English Gypsies (also known as Romany Gypsies)
- Scottish Gypsies or Scottish Travellers (also of Romany origin)
- Welsh Gypsies or Welsh Travellers (Kale) (also of Romany origin)
- Irish Travellers
- Roma people
- Bargees (boat dwellers)
- Show, fairground and circus people
- New Travellers

In West Sussex, there are 131 authorised caravan pitches on 10 managed sites. At present, legal West Sussex sites are managed by Home Space Sustainable Accommodation and are located at the following:

- Adversane – Billingshurst, 14 pitches
- Bedelands – Burgess Hill (managed by Mid Sussex District Council), 10 pitches
- Cousins Copse – Five Oaks near Horsham, 12 pitches
- Easthampnett – near Tangmere, 23 pitches
- Fairplace Hill – Burgess Hill, 9 pitches
- Horsgate – Cuckfield, 3 pitches
- Ryebank – Yapton, 12 pitches
- Walstead – Haywards Heath, 5 pitches
- Westbourne – Emsworth, 17 pitches
- Withy Patch – near Lancing, 12 pitches

Accurate numbers for Gypsies and Travellers in West Sussex are unknown, as many who might fit under this umbrella term move through the region at regular intervals and many who stay local chose not to identify as Gypsy or Traveller on ethnic records. Instead they may choose to identify as 'White British', 'White Irish', or 'White Other'. Fear of discrimination is often given as a reason for not publically identifying as Gypsy/Traveller.

The twice-annual National Caravan Count, conducted by the Department for Communities and Local Government, found that there are between 300 and 400 traveller caravans in West Sussex, depending on the time of year, as more caravans are often counted in the Winter.

[10] Friends Families and Travellers (FFT), Report for West Sussex County Council Public Health, May 2015

Table 1(c).1, Numbers of traveller caravans in West Sussex, 2014-15

	West Sussex		Adur		Arun		Chi		Hor		Mid Sx	
	Jul-14	Jan-15	Jul-14	Jan-15	Jul-14	Jan-15	Jul-14	Jan-15	Jul-14	Jan-15	Jul-14	Jan-15
Authorised sites (with planning permission)	248	293	12	12	43	43	88	124	67	75	38	39
Unauthorised sites (without planning permission)	59	75	0	20	3	1	23	15	31	39	2	0
Total All Caravans	**307**	**368**	**12**	**32**	**46**	**44**	**111**	**139**	**98**	**114**	**40**	**39**

Source: Department for Communities and Local Government, Count of Traveller Caravans, 2015

The 2010 needs assessment cited a number of recommendations for the Primary Care Trust at the time, NHS West Sussex, and the local authority, WSCC. To assess the progress made on these recommendations in recent years, the third sector organisation Friends, Families and Travellers was approached to comment on the recommendations. This response is stored in the appendix* to this document, with a link to the full needs assessment. Themes included are:

- Partnership working and an integrated approach
- Cross-boundary approaches
- Ethnic monitoring
- Improving cultural awareness
- Specialist and generalist services
- Child and maternal health
- Investing to develop relationships and trust
- Outreach services for health promotion
- Clarification on abilities and capabilities of health visitors
- Provision and quality of authorised sites
- Settled housing
- Guidance for GPs
- Dental and oral health
- Patient-held records
- Investing in developing community capacity and social capital within communities
- Continuity of care and access to secondary care
- Supporting improved access to social care

*See Appendix 2: Progress on the gypsies and travellers needs assessment recommendations

Key points

- Accurate numbers for Gypsies and Travellers in West Sussex are unknown, and many chose not to identify as Gypsy or Traveller on ethnic records. Fear of discrimination is often given as a reason for not publically identifying as Gypsy/Traveller.

- A comprehensive health needs assessment for Gypsies and Travellers was conducted in 2010 and, as a result, they are not examined in this report. We have sought feedback from stakeholders and communities on the progress made to address the findings and recommendations of the 2010 report, discussed in sections 6 and 7.

- At the most recent count, there are 131 authorised caravan pitches on 10 managed sites in West Sussex. Management of these sites is outsourced to Home Space Sustainable Accommodation.

- Research suggests that members of Gyspy and Traveller communities are more likely to have lower health outcomes and health literacy.

- The twice-annual National Caravan Count found that there are between 300 and 400 traveller caravans in West Sussex, varying by the time of year.

Relevant recommendation(s): 18., (also, see Section 7.2 for progress made)

Indicator	**Outcome**
1.1	Children in poverty
1.9	Sickness absence rate
1.17	Fuel poverty
1.18	Social isolation
2.5	Child development at 2 – 2 ½ years
2.6	Excess weight in 4-5 and 10-11 year olds
2.11	Diet
2.12	Excess weight in adults
2.13	Proportion of physically active and inactive adults
2.17	Recorded diabetes
2.23	Self-reported well-being
4.3	Mortality rate from causes considered preventable
4.4	Under 75 mortality rate from all cardiovascular disease
4.5	Under 75 mortality rate from cancer
4.6	Under 75 mortality rate from liver diseases
4.7	Under 75 mortality rate from respiratory diseases
4.8	Mortality rate from communicable diseases
4.10	Suicide rate
4.12	Preventable sight loss
4.13	Health-related quality of life for older people
4.15	Excess winter deaths
4.16	Estimated diagnosis for people with dementia

Section 2: Wider Determinants of Health

I am used to racism… If I let racism affect me I would not move, I try my best not to be affected because there is no point (Female, Namibian 25–64).

With a Black African background, you are more likely to be stopped by the police or if you are in a group in an area you are most likely to be seen as you are doing something bad or [posing] a threat to individuals (Female, 18–24, Gambian).

They walked across the road and just punched me in the face because they heard we were speaking Polish (Male, Polish, 25–64).

My kids are so behind with education – they give them good support. They do their best to help my kids (Female, Mauritian, 25–64).

We cannot get a flat from landlord and agency because we do not have a permanent job and a contract from work, and as we cannot get a contract from the landlord, we cannot register with a doctor (Female, Eastern European, 25–64).

I see the way people look at me (Female, South African, 25–64).

[The police]… they see it as an Asian Community problem (Female, Pakistani, 25–64).

The wider determinants of our health and wellbeing are all around us. We are constantly influenced by a number of social, economic and environmental factors such as our families, work opportunities and household income, and where we live. We cannot always control these factors and they often limit as well as influence the choices we make and the lifestyle we lead. These factors are often referred to as the 'causes of the causes' of health and wellbeing. These factors influence the personal, social and material resources available to a person to meet basic needs, achieve their aspirations and the extent to which they can deal with changes and challenges in their lives.

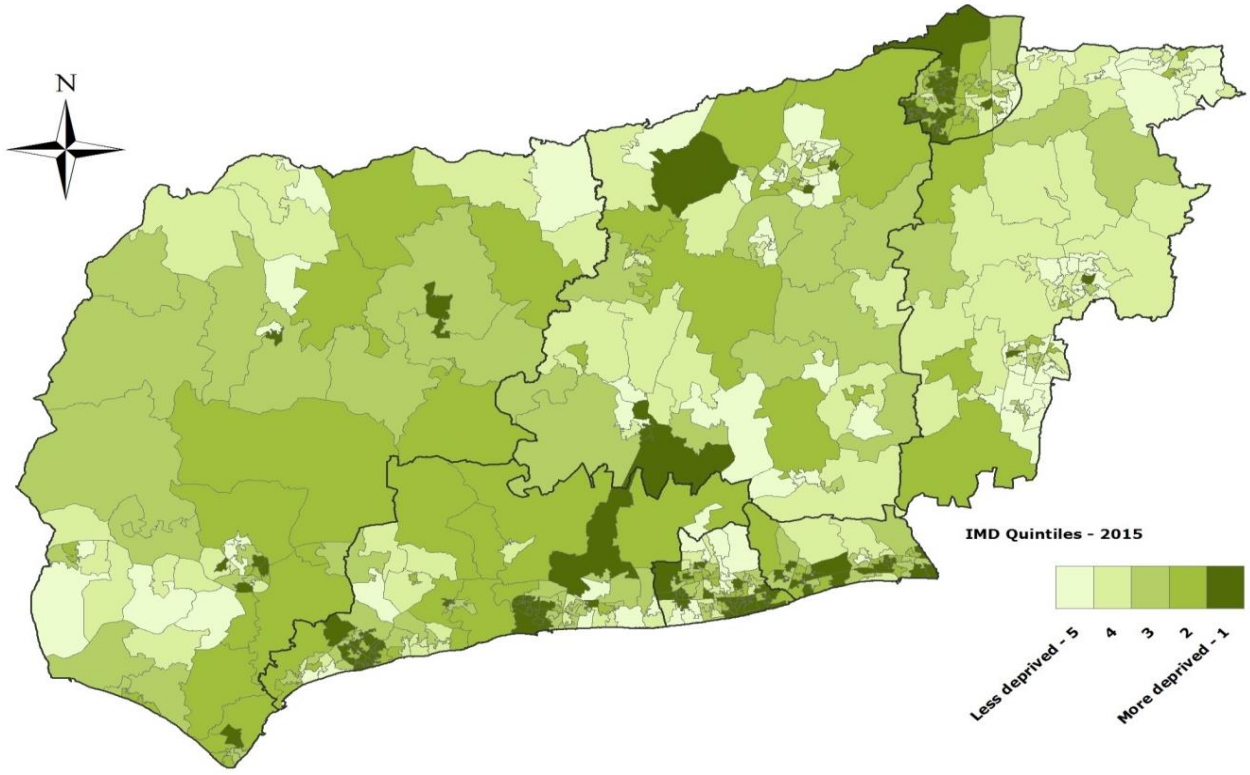
The wider determinants are broadly affected by the distribution of wealth and power, both locally and globally.

2.1 Deprivation

The index of multiple deprivations (IMD) has long been used to identify inequalities in health, education, crime/safety, income, poverty and access to housing and services. Whilst the IMD does not record differences in ethnicity, it is possible to identify key geographical areas where inequalities are more concentrated and match them to the areas where ethnic minority residents are known to live, from the 2011 census.

Taking all indices together, the more deprived areas of the county are largely concentrated in the urban areas of the coastal strip and in Western Crawley. This matches with the BAME census population seen in section 1, suggesting that concentrated minority ethnic populations are more likely to live in deprived areas of West Sussex.

Figure 2.1, Relative deprivation in West Sussex, according to IMD, 2015



Source: ONS (2015), IMD statistical release

Key points

- We are constantly influenced by a number of social, economic and environmental factors such as our families, work opportunities and household income, and where we live.

- Deprivation is a well-recognised indicator of poor health outcomes in the population. Many of the minority ethnic communities identified in *section 1* live within or near the areas of West Sussex which are the most deprived in the county: central Bognor Regis and Worthing and west Crawley.

Relevant recommendation(s): 3., 4., 5., 6., 7., 8., 9., 10., 11., 12., 13., 14., 15., 18., 19., 20.

Indicator	**Outcome**
1.1	Children in poverty
1.2	School readiness
1.3	Pupil absence
1.4	First time entrants into the youth justice system
1.9	Sickness absence rate
1.14	The percentage of the people affected by noise
1.15	Statutory homelessness
1.16	Utilisation of outdoor space for exercise / health reasons
1.17	Fuel poverty
1.18	Social isolation
1.19	Older people's perception of community safety
2.5	Child development at 2 – 2 ½ years
2.10	Self-harm
2.11	Diet
2.13	Proportion of physically active and inactive adults
2.17	Recorded diabetes
2.20	Cancer screening coverage
2.21	Access to non-cancer screening programmes
2.22	Take up of the NHS Health Check programme
2.23	Self-reported well-being
3.1	Fraction of mortality attributable to particulate air population
3.3	Population vaccination coverage
3.5	Treatment completion for TB
4.2	Tooth decay in children aged 5
4.3	Mortality rate from causes considered preventable
4.4	Under 75 mortality rate from all cardiovascular diseases
4.5	Under 75 mortality rate from cancer
4.6	Under 75 mortality from liver disease
4.7	Under 75 mortality rate from respiratory diseases
4.8	Mortality rate from communicable diseases
4.10	Suicide rate
4.12	Preventable sight loss
4.13	Health-related quality of life for older people
4.15	Excess winter deaths

2.2 Housing

2.2.1 Overcrowding

One indicator of overcrowding is to examine the average number of people per room at a residence (Table 2.1). In all areas of the county, Asian and Asian British residents were more likely to live with more than 1.0 people per room in their household. All BAME groups were higher than the White British and White Irish residents, with 6.1% countywide living with more one or more people to a room, compared to the White British 0.8%. Regionally and nationally, the picture is very much the same, though overcrowding is slightly more common for all groups at a national level.

Table 2.1, Overcrowding, households with more than one person per room

	West Sussex	Adur	Arun	Chi	Craw	Hors	Mid Sx	Worth
Ethnic Group	Percentage (%)							
White British	0.8%	0.9%	0.8%	0.8%	1.2%	0.6%	0.7%	0.9%
White Irish	0.7%	1.8%	0.6%	0.8%	1.2%	0.7%	0.6%	0.0%
White: Other White	5.6%	2.9%	9.3%	2.9%	7.8%	1.9%	3.6%	5.1%
Mixed/multiple ethnic group	3.5%	3.0%	4.6%	1.6%	6.1%	1.7%	2.2%	1.9%
Asian/Asian British	9.9%	7.6%	10.5%	4.9%	10.4%	12.0%	9.0%	10.3%
Black/African/Caribbean/Black British	6.0%	2.5%	5.8%	3.8%	7.0%	5.5%	3.9%	6.9%
All BAME	**6.1%**	**4.1%**	**7.7%**	**3.0%**	**8.3%**	**4.4%**	**4.5%**	**5.8%**

Note: The definition of a room does not include bathrooms, toilets, halls or landings, or rooms that can only be used for storage. All other rooms, for example, kitchens, bedrooms, utility rooms, studies and conservatories are counted.
Source: ONS, 2011 Census

2.2.2 Living alone

Social isolation is recognised as different to 'loneliness', though they can exist in parallel.[11] Public Health England suggests that *"successful interventions to tackle social isolation reduce the burden on health and social care services".* Particularly, those of an older age may experience social isolation and need practical support or with provision of transport. Those from minority communities are less likely to live alone past retirement age than the white British population. Only White Irish have a larger proportion of their live-alone residents over the age of 65.

Considering loneliness, the West Sussex BAME community engagement (2015) discovered that loneliness can be common amongst BAME groups (p10), who reported a perception that people in the UK were not as social as communities within other countries. Looking at the 2011 census, we find that some BAME groups are more likely to live alone than the general population, (Black, Chinese, Arab and Mixed groups), whilst South Asian groups are less likely to live alone. This is very much in line with the regional and national picture. When considering all those who live alone, White British residents are more likely to be older (over 65 years) than all minority groups, besides White Irish.

[11] PHE, 2015, 'Reducing social isolation across the lifecourse', available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/461120/3a_Social_isolation-Full-revised.pdf

Table 2.2, West Sussex residents and the percentage of those of live alone, by age group

	Under 65 years	Aged 65(+) years
All residents (who live alone)	16%	15%
White: British	16%	16%
White: Irish	16%	20%
White: Other	16%	6%
Mixed/multiple ethnic group	25%	6%
Asian/Asian British: Indian	12%	4%
Asian/Asian British: Pakistani	9%	3%
Asian/Asian British: Bangladeshi	10%	1%
Asian/Asian British: Chinese	22%	5%
Black/African/Caribbean/Black British	27%	3%
Arab	25%	2%

Source: ONS, 2011 Census

Table 2.3, Percentage of all residents who live alone who are above 65 years of age

	West Sussex	Adur	Arun	Chi	Craw	Hors	Mid Sx	Worth
All residents (who live alone)	**49%**	**52%**	**56%**	**54%**	**37%**	**48%**	**47%**	**44%**
White British	50%	53%	57%	55%	40%	49%	48%	46%
White Irish	55%	66%	65%	52%	54%	50%	53%	51%
White Other	28%	34%	26%	36%	19%	31%	32%	26%
Mixed/multiple ethnic group	20%	30%	22%	25%	14%	16%	28%	16%
Asian/Asian British	22%	28%	22%	17%	26%	22%	23%	12%
Black/African/Caribbean/ Black British	9%	13%	18%	22%	7%	11%	12%	3%
Arab	7%	15%	11%	8%	5%	0%	22%	0%

Note: - Numbers for Arabs are very low.

Source: ONS, 2011 Census

2.2.3 Tenure

Compared to nationally, those from the general population in the South East and in particular West Sussex are more likely to be homeowners, reflecting the relative affluence of the area. The White British population of West Sussex were the more likely to own a home than BAME residents (Table 2.4). This may be explained by the younger age profiles of these groups, (see section 1). Analysis by the University of Manchester and the Joseph Rowntree Foundation[12] found that whilst flexibility can be of benefit to renters, moreover this flexibility *"carries instability in tenure and unpredictability in rent prices, which has adverse effects especially on families with young children"*. Looking at previous census records, the authors found that:

- The drop in home ownership 1991-2011 was proportionately greatest for the Pakistani (-18%), Chinese (-17%) and Indian (-16%) groups and least for the White and Bangladeshi groups (-3% each). – (p.1)

Knowing that many short-term migrants from the EU area are likely to fit within the 'White Other' census category, it is not surprising that 54% of these residents are privately renting. More interesting is that the vast majority of these (46% overall) are privately renting, as opposed to using social renting (8%) systems; the only other group who rent social housing as little as this are Indian/Indian British, who generally rent less overall. Given the issues in the private renting sector with such variation in housing quality, i.e. poor housing or high rent, it would seem that these groups are disproportionately affected by the social housing shortage.

There are a number of significant ways which BAME groups are affected by the current housing system. Findings from the community engagement suggest that some residents from these communities find language difficulties to be a barrier to using publicly available services, which could help to explain this difference, as well as onerous conditions placed on recent immigrants, such as proof of income before

[12] How has the rise in private renting disproportionately affected some ethnic groups? http://www.ethnicity.ac.uk/medialibrary/briefingsupdated/how-has-the-rise-in-private-renting-disproportionately-affected-some-ethnic-groups.pdf

finding housing; housing before registering with a bank; having a bank account before finding employment, etc. (p10).

Table 2.4, Tenure by ethnic group (West Sussex)

Ethnic Group	Owned			Rented	
	Total Owned	Owned outright	Owned with mortgage	Social rented	Private rented or living rent free
All categories	71%	36%	35%	13%	16%
White: British	73%	38%	35%	13%	14%
White: Irish	72%	40%	32%	13%	15%
White: Gypsy or Irish Traveller	37%	23%	14%	44%	19%
White: Other White	46%	19%	27%	8%	46%
Mixed/multiple ethnic group	51%	16%	34%	21%	28%
Asian/Asian British: Indian	64%	21%	43%	8%	28%
Asian/Asian British: Pakistani	62%	16%	47%	22%	16%
Asian/Asian British: Bangladeshi	46%	7%	39%	26%	28%
Black/African/Caribbean /Black British	34%	7%	28%	24%	41%
Arab	48%	17%	30%	23%	29%

Source: ONS, 2011 Census

2.3.4 Homelessness

Within West Sussex there are 567 households which are accepted as homeless, where the local authority is aware of a need to house individuals/families. Of this number, 79.4% are from white ethnic backgrounds, the remaining 20.6% are from BAME groups. Compared to the national figures (White 61.3%; BAME 38.7%), BAME groups are under-represented in this statistic. However, this may simply be a reflection of the demographic structure of the county. In terms of local distribution, Crawley has the highest distribution of homeless BAME households (39.8%). However, with the exception of Worthing, homeless White households are fairly evenly distributed throughout West Sussex.

The Public Health and Social Research Unit is currently conducting a homelessness health needs audit in conjunction with Worthing church

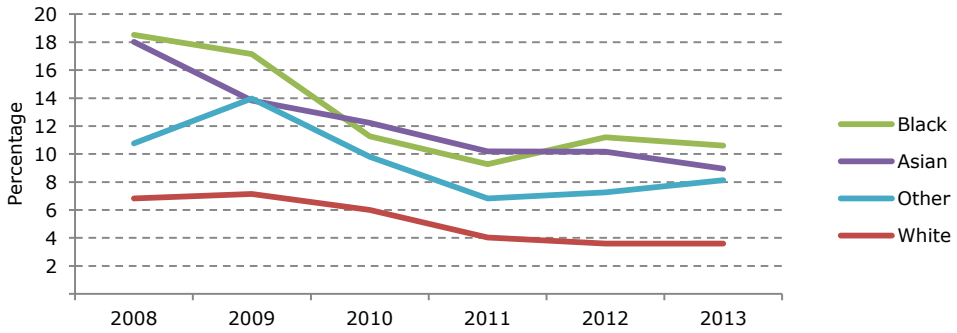
2.3.5 Non-decent homes

The English Household Survey, conducted every year, has found that whilst all homes in England have shown improvements in lowering levels of damp or mould, consistently more of those from ethnic minority communities live with damp or mould than those from White communities. As with previous indicators for wellbeing, we have seen that those from BAME groups are more likely to live in less affluent areas, it would follow that the housing was, on average, more susceptible to damp or mould. This can have ongoing effects on health, (including respiratory problems), and has been linked to low educational outcomes in children. [13] Overall, the costs of illnesses from cold and damp housing conditions to the NHS are estimated at over £0.6 billion per year, nationally.

Nationally a third of private rented homes are failing decency standards. In contrast just 15 % of social renting homes failed the same standards. This, in line with the increased use of private renting amongst some BAME groups, demonstrates that they are likely to be disproportionately affected by this.

[13] Chartered Institute for Environmental Health, 2013, 'Effective Strategies and Interventions: Environmental health and the private housing sector'

Figure 2.2, Damp or mould in homes, by ethnicity, England



Source: English Household survey, 2008-2013

Key points

- Locally, BAME households were far more likely to live with more than one person per room (6.1%) than White British households (0.8%), which is a sign of overcrowding.

- Those from Black, Chinese, Arab or Mixed ethnic backgrounds (of working age) are more likely to live alone than White British residents. Qualitative evidence does suggest that social isolation exists in some communities, particularly where language is a barrier. Some have suggested that the British are not as open or receptive to strangers as those from other cultures.

- Home ownership for Chinese, Indian and Bangladeshi residents has fallen heavily (when compared to White British residents) in recent decades. Locally, White British and Irish are the most likely to own their home (with a mortgage or outright).

- Those within the White Other census category (including many from the Eastern EU) are amongst the least likely to use social rented housing and are the most likely to use private renting, of any ethnic group.

- BAME are more likely to live in a home with damp or mould. This has been linked to long term respiratory problems and poor educational outcomes in children.

Relevant recommendation(s): 3., 4., 5., 8., 9., 10., 12., 13., 14., 15,. 18., 20.

Indicator	Outcome
1.1	Children in poverty
1.9	Sickness absence rate
1.15	Statutory homelessness
1.17	Fuel poverty
1.18	Social isolation
2.5	Child development at 2 – 2 ½ years
2.10	Self-harm
2.11	Diet
2.13	Proportion of physically active and inactive adults
2.17	Recorded diabetes
2.20	Cancer screening coverage
2.21	Access to non-cancer screening programmes
2.22	Take up of the NHS Health Check programme
2.23	Self-reported well-being
3.1	Fraction of mortality attributable to particulate air population
3.3	Population vaccination coverage
3.5	Treatment completion for TB
4.1	Infant mortality
4.3	Mortality rate from causes considered preventable
4.4	Under 75 mortality rate from all cardiovascular diseases
4.5	Under 75 mortality rate from cancer
4.6	Under 75 mortality from liver disease
4.7	Under 75 mortality rate from respiratory diseases
4.8	Mortality rate from communicable diseases
4.10	Suicide rate
4.12	Preventable sight loss
4.13	Health-related quality of life for older people
4.15	Excess winter deaths

2.3 Education and skills

The Department for Education (2015)[14] states that – counter to the trend we might be seeing here in West Sussex (see below) – gaps in attainment between ethnic groups have narrowed. The only exception to this is the White Other pupils whose average attainment has declined relative to that of White British pupils. Even when controlled for socio-economic status, all ethnic groups in receipt of free school meals outperformed White pupils who are similarly entitled. Improvements in language skills seem to account for the overall gap closing – this is something which has been highlighted as a specific need within West Sussex – whether this accounts for the differences observed here is not clear.

2.3.1 School readiness

School readiness is a measure of how prepared a child is for the transition to school, in order to succeed in key developmental domains such as cognitive, social and emotional domains. By the end of reception year, West Sussex has the worst levels of readiness for schools in the South East (63.5%) and is the only authority within the region to be significantly worse than the national average (66.3%)[15]. The difference between boys and girls is large (55% to 73% respectively). For those in receipt of free school meals only 36% of boys and 54% of girls are considered to have a 'good level of development' by this age, also significantly worse than the national average.

Considering ethnicity, in the UK, Pakistani and Bangladeshi children lag far behind White children in school readiness and vocabulary[16]. Moreover, Black children (including Black British, Black Caribbean and Black African children) also perform lower than White children, particularly in vocabulary. On the other hand, whilst Indian children lag behind in vocabulary at age three, they caught up with their peers by age five, scoring comparably to White children on school readiness at age three. The weight of the impact of poverty, ethnicity and gender on school readiness suggest that poverty has the highest impact, followed by gender and then ethnicity. This indicates that boys from poor socio-economic backgrounds, regardless of ethnicity are likely to be one of the more disadvantaged groups.

In West Sussex, the percentage of eligible children who were achieving a good level of development varies by ethnicity (Table 2.5). For example, in 2014/15 Asian pupils tended to perform less well (57.1%) when compared to White pupils (64.7%). However, small numbers of pupils for some ethnic groups means that comparisons between ethnicity should be made with caution. Data for England suggests less variation between ethnicities (ranging from 68% of pupils of mixed ethnicity to 64% of Asian pupils).

Table 2.5, Proportion of eligible children with a 'good level of development' at the Early Years Foundation stage by ethnic group in West Sussex (2014/15)

Ethnic Group	Total number of pupils assessed	% with a GLD
White	7,800	64.7%
Mixed	450	62.8%
Asian or Asian British	440	57.1%
Black or Black British	40	51.2%
Chinese	20	80.0%
Other Ethnic Groups	40	38.5%
Refused to disclose	70	72.3%
Information Not Yet Obtained	710	58.3%
Unknown	100	54.6%

Note: Total number of pupils have been rounded to the nearest 10
Source: EYFS Profile data 2014/15 for West Sussex (EPoD) provided by the Early Years Childhood Service

[14] Department for Education (2015) A compendium of evidence on ethnic minority resilience to the effects of deprivation on attainment
[15] Public Health Outcomes Framework, 2014/15
[16] The Centre for Research in Early Childhood, 'Early Years Literature Review', The Centre for Research in Early Childhood, (2014) <www.crec.co.uk>

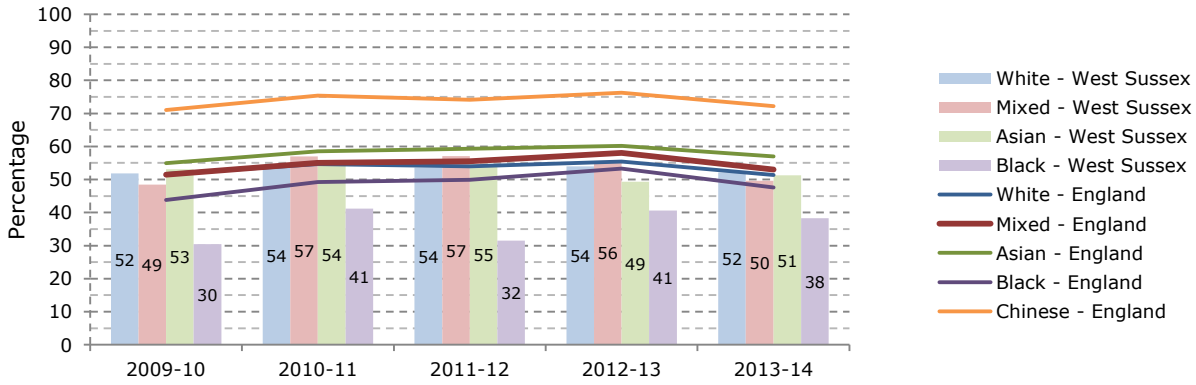
2.3.2 Performance in schools

West Sussex boys tend to perform near to the national average, in attaining five or more A*-to-C grades at GCSE level (Figure 2.3). In recent years, boys from an Asian background have recently performed lower than other Asian boys across the country (51% to 57% in 2013/14). A larger difference is that West Sussex boys from a Black ethnic group typically perform far worse than other Black boys around England (38% to 47% in 2013/14).

BAME girls fared better in West Sussex in recent years, with most ethnic groups exceeding the national averages. However, girls from a Black background were consistently underperforming in West Sussex when compared to other Black girls form across the nation (48% to 60% in 2013/14).

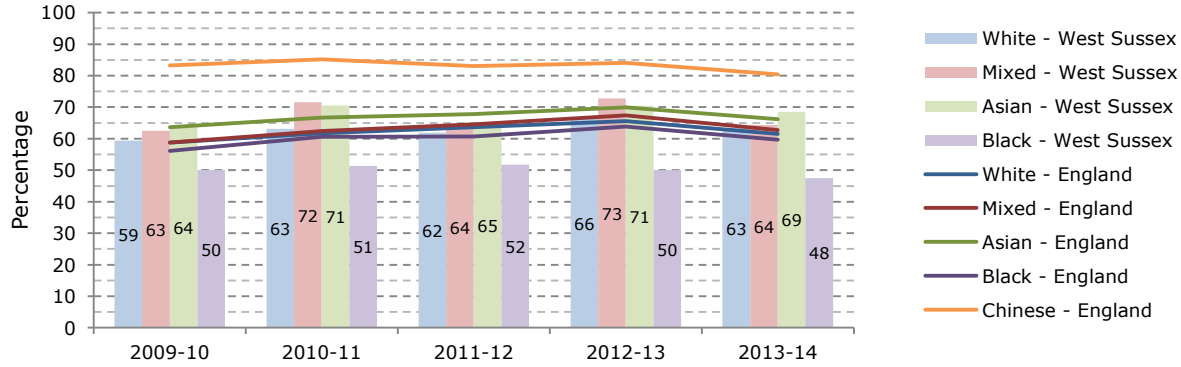
Pupils of a Chinese background out performed all other groups, nationally, but numbers were too small to examine at a local level. Numbers for Chinese boys in West Sussex were omitted as small sample numbers could be statistically misleading.

Figure 2.3, Boys achieving 5+ A*-C grades inc. English & mathematics GCSEs, by ethnicity



Note1: Methods used to collect data changed in 2013-14, which means these figures are not directly comparable to the previous years
Source: National pupil database (2009/10 to 2012/13) and key stage 4 attainment data (2013/14)

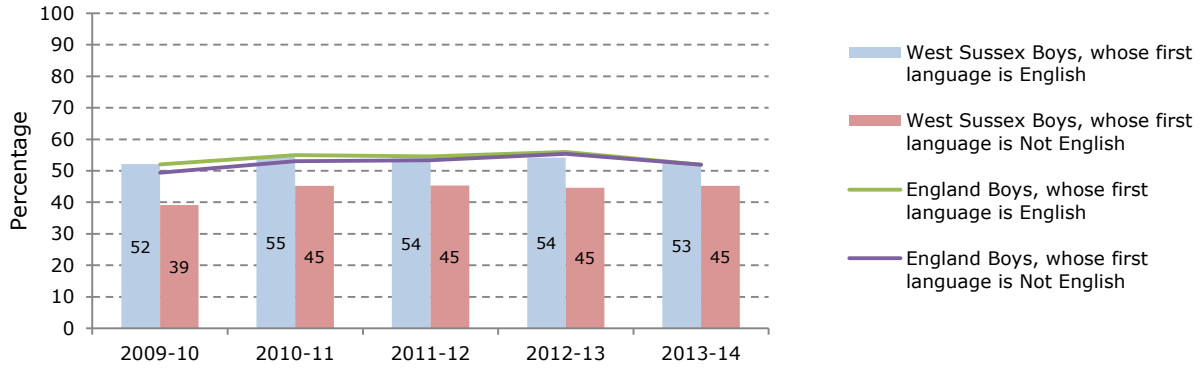
Figure 2.6, Girls achieving 5+ A*-C grades inc. English & mathematics GCSEs, by ethnicity



Note1: Methods used to collect data changed in 2013-14, which means these figures are not directly comparable to the previous years
Source: National pupil database (2009/10 to 2012/13) and key stage 4 attainment data (2013/14)

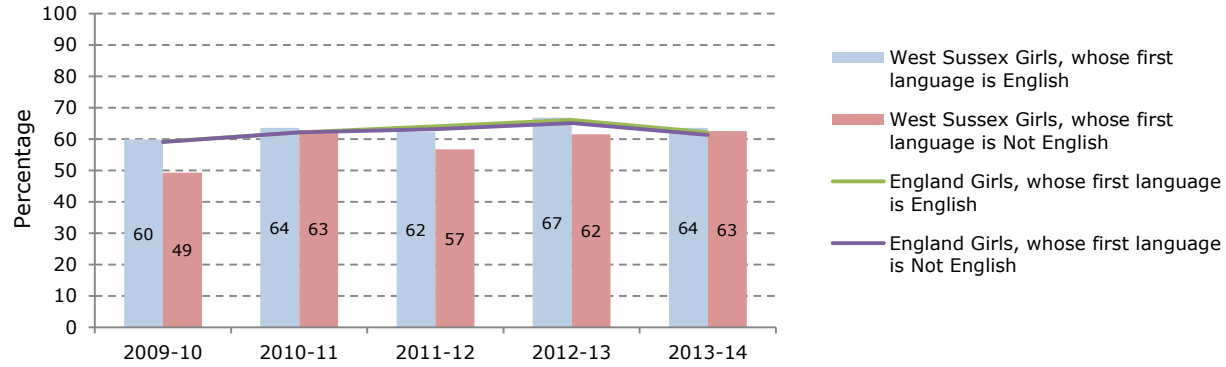
A similar attainment gap is seen in West Sussex schools when considering language, rather than ethnic background. Those pupils in West Sussex schools whose first language is not English (in particular boys) typically perform far below their peers at a national level. – The attainment gap for girls has closed in recent years.

Figure 2.7, Boys achieving 5+ A*-C grades inc. English & mathematics GCSEs, by first language



Note: Methods used to collect data changed in 2013-14, which means these figures are not directly comparable to the previous years
Source: National pupil database (2009/10 to 2012/13) and key stage 4 attainment data (2013/14)

Figure 2.8, Girls achieving 5+ A*-C grades inc. English & mathematics GCSEs, by first language



Note: Methods used to collect data changed in 2013-14, which means these figures are not directly comparable to the previous years
Source: National pupil database (2009/10 to 2012/13) and key stage 4 attainment data (2013/14)

The paper by Law et al (2012)[17] explored a number of factors which influence the educational journey of young Black men. It highlights the struggles to balance wanting to do well, whilst meeting the expectation of their peer groups to behave in a way that makes them popular. In short, masculine hegemony and the values of excelling at sport, being popular and adopting casual attitudes to schoolwork are all competing with the desire to achieve academically. Academic application is not viewed as valued behaviour and look at such behaviour as undermining the concept of masculinity and using pejorative terms to describe those that do not conform to this masculine ideal. Interestingly there is some suggestion that the effects of 'social class' as a predictor of academic success in Black pupils is not as strong as the effect in their white peers. These findings are supported in a paper by Frumkin & Koutsoubou (2011)[18] , though the authors suggest that specifically for Black Caribbean boys there is a dearth of evidence to answer why these boys appear to do well at primary school, but less well in senior school.

There is some suggestion that lack of cultural alignment between students and teachers may be pivotal in senior school environments. It may therefore be that if we have a significant lack of teachers in the Black ethnic groups, that this is reflected in the performance in West Sussex.

[17] Law, I., Finney, S. and Swann S.J., (2012) Searching for Autonomy: young black men, schooling and aspirations
[18] Frumkin, L.A. & Koutsoubou, M., (2013) Exploratory investigation of drivers of attainment in ethnic minority adult learners

There is no evidence available as to why these differences are so marked in West Sussex, however. The Laws et al. paper mentioned above does suggest that equality and diversity policy initiatives have had less impact over the past seven years or so.

2.3.3 Highest qualification level

In West Sussex, the BAME population generally has higher qualification levels than the White British residents, with the exception of Bangladeshi and Gyspy/Irish Travellers (Table 2.6). Indian/Indian British and Black African/British were the most qualified, with 46% and 41% achieving level 4 qualifications or above (degree level), compared to the county average of 28%.

- ***Level 1:***
  1-4 O Levels/CSE/GCSEs (any grades), Entry Level, Foundation Diploma, NVQ Level 1, Foundation GNVQ, Basic/Essential Skills

- ***Level 2:***
  5+ O Level (Passes)/CSEs (Grade 1)/GCSEs (Grades A-C), School Certificate, 1 A Level/ 2-3 AS Levels/VCEs, Intermediate/Higher Diploma, NVQ level 2, Intermediate GNVQ*

- ***Level 3:***
  2+ A Levels/VCEs, 4+ AS Levels, Higher School Certificate, Progression/Advanced Diploma, Welsh Baccalaureate Advanced Diploma, NVQ Level 3; Advanced GNVQ

- ***Level 4 and above:***
  Degree (BA, BSc), Higher Degree (MA, PhD, PGCE), NVQ Level 4-5, HNC, HND, RSA Higher Diploma, BTEC Higher level, Foundation degree (NI), Professional qualifications (teaching, nursing, accountancy)

Table 2.6, Highest level of qualification, by ethnicity, in West Sussex

	No qual's	Level 1 qual's	Level 2 qual's	Level 3 qual's	Level 4 qual's and above	Apprentice -ship	Other qual's
All categories	**20%**	**14%**	**17%**	**12%**	**28%**	**4%**	**5%**
Asian/Asian British: Indian	11%	9%	10%	8%	46%	1%	17%
Black/Black British: African	8%	12%	16%	12%	41%	1%	10%
White Irish	24%	8%	11%	11%	36%	3%	8%
Arab	14%	9%	11%	9%	36%	1%	22%
Asian/Asian British: Chinese	17%	11%	11%	9%	35%	1%	16%
Black/Black British: Caribbean	13%	16%	17%	10%	33%	3%	9%
White: Other White	11%	6%	9%	9%	32%	2%	31%
Asian/Asian British: Pakistani	15%	15%	12%	9%	30%	1%	18%
Mixed/multiple ethnic group	14%	15%	20%	14%	28%	2%	7%
White British	21%	15%	18%	13%	27%	4%	3%
Asian/Asian British: Bangladeshi	23%	17%	11%	9%	18%	1%	22%
Gypsy or Irish Traveller	55%	13%	11%	5%	9%	2%	4%

Source: ONS, 2011 Census

Key points

- West Sussex has the lowest school readiness performance in the South East and is significantly below the national average. However, the data suggests that ethnicity is not a factor in this.

- Boys from Black ethnic groups typically perform far worse in West Sussex at GCSE level than other Black boys around England. Although the reasons for this remain unclear, it could be a reflection of the teaching workforce composition and a reduction in the impact of equality policies.

- The BAME population generally has higher qualifications than the White British population; the only exceptions to this being Bangladeshi and Gypsy/Irish Traveller groups.

Relevant recommendation(s): 7., 8., 9., 10., 13., 14., 15., 18., 19., 20.

Indicator	**Outcome**
1.2 1.3 1.5	School readiness Pupil absence 16 – 18 year olds not in employment, education or training
2.5	Child development at 2 – 2 ½ years

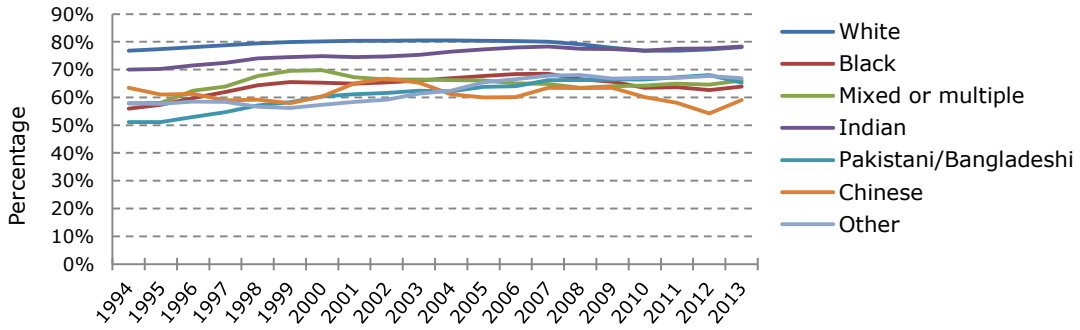
2.4 Workforce

2.4.1 Employment

Currently there is no recent data available on the ethnic composition of the workforce in West Sussex. Census figures can describe the picture from 2011, though with significant changes in the economy over the past five years, these values may be misleading. At the time, those from the 16 to 24-year age bracket were more likely to be unemployed (though still 'economically active') than older residents. As those from minority groups are younger as a population, this increase adds to the fact that those from BAME groups were also more likely to be unemployed overall.

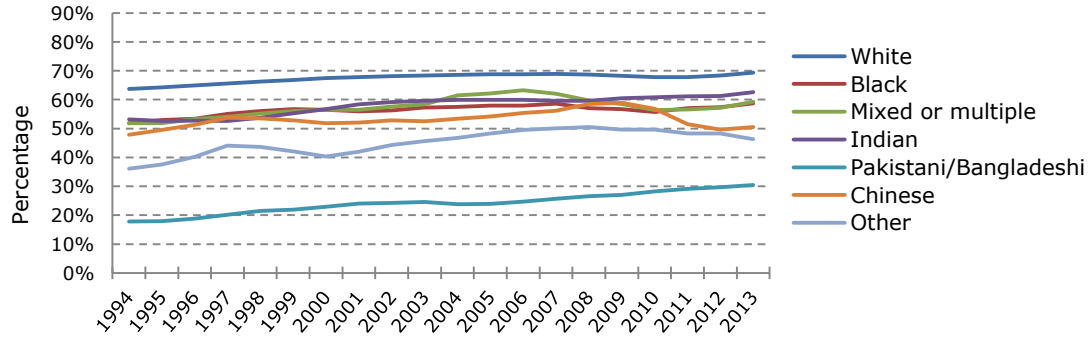
In the UK, residents aged 16 to 64 from minority ethnic groups have been less likely to be in employment than those from White backgrounds, particularly with women (Figures 2.9 and 2.10). In 2013, 30% of Pakistani/Bangladeshi women were in employment, compared to 63% of Indian women and 68% of white women. All groups were lower than Indian and white men, of whom 78% were in employment. *(In these DWP figures, European and other White ethnicities are combined with White British.)*

Figure 2.9, UK males, 16 to 64 years employment rate



Note - Three year rolling averages
Source: DWP 2015, Labour market status by ethnic group annual data to 2014 (ONS Labour force survey)

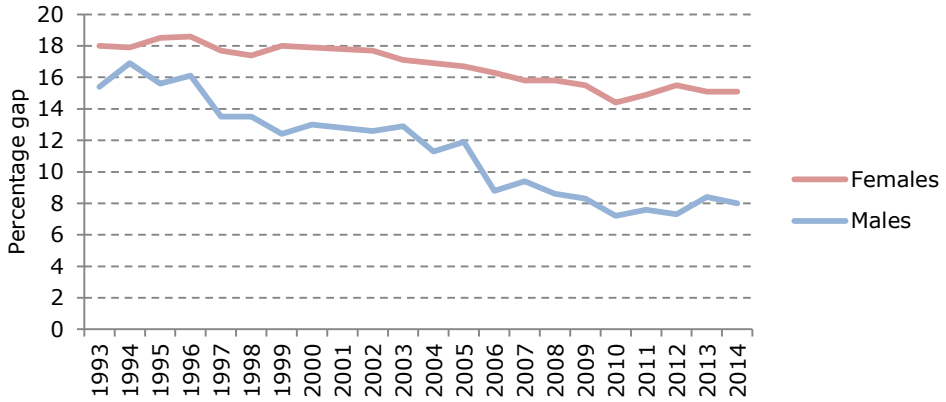
Figure 2.10, UK females, 16 to 64 years employment rate



Note - Three year rolling averages
Source: DWP 2015, Labour market status by ethnic group annual data to 2014 (ONS Labour force survey)

Nationally, the employment rate gap between White and minority groups has been closing for men, since 1993, though it has remained consistently high for women (Figure 2.11).

Figure 2.11, Percentage gap between BAME employment rate and White employment rate



Note – The percentage gap is calculated by subtracting the average employment rate of all BAME groups from the average employment rate of the White groups.
Source: DWP 2015, Labour market status by ethnic group annual data to 2014 (ONS Labour force survey)

2.4.2 Local employment

In 2011, the largest sector of employment in West Sussex was public administration, health and education. Of those residents from Black ethnic groups in employment, 44% were employed in this sector, compared to 27% of White British. *Note: Since these figures were released, government reforms may have significantly altered this picture.*

Table 2.6, Industry, All usual residents aged 16 and over in employment the week before the census

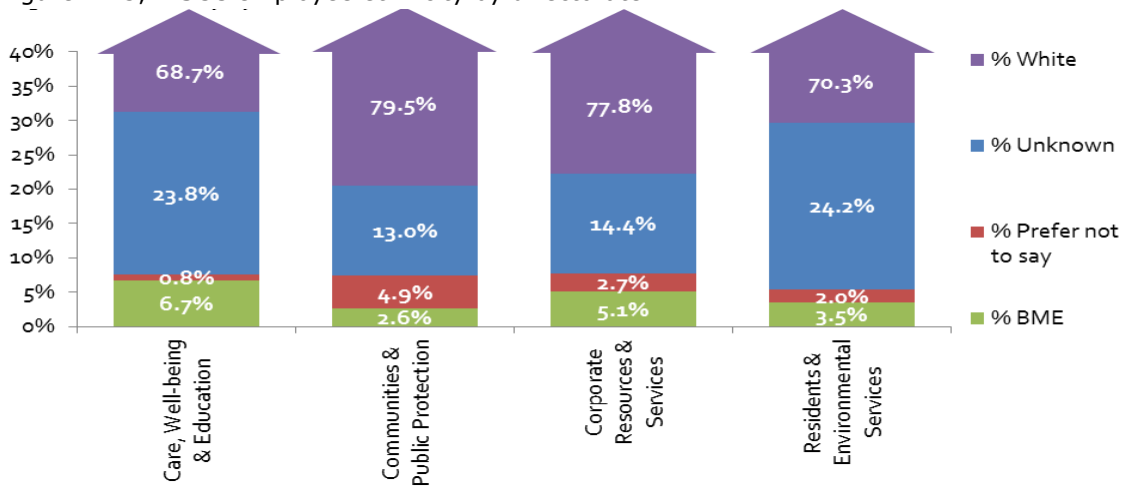
	All categories		White			Mixed/ multiple ethnicity	Asian/ Asian British	Black/ African/ Caribbean/ Black British	Other ethnic group
	Number	%	British	Irish	Other White				
Agriculture, energy and water	10,249	2.6%	2.5%	1.5%	4.3%	2.2%	1.4%	1.4%	1.8%
Manufacturing	29,481	7.4%	7.4%	5.1%	10.4%	5.5%	5.4%	4.4%	6.3%
Construction	30,865	7.8%	8.3%	8.2%	4.6%	5.3%	1.8%	3.0%	2.8%
Distribution, hotels, restaurants	84,055	21.1%	20.5%	13.6%	25.9%	25.0%	29.3%	15.8%	27.7%
Transport and communication	41,567	10.4%	10.2%	12.1%	10.9%	10.9%	15.4%	10.9%	13.8%
Financial, Real Estate, Professional, Administration	74,666	18.8%	19.0%	20.1%	18.0%	19.5%	14.3%	17.8%	14.5%
Public administration, education and health	106,129	26.7%	26.6%	34.9%	21.6%	25.9%	29.7%	43.6%	28.7%
Other	20,872	5.2%	5.4%	4.5%	4.3%	5.8%	2.7%	3.1%	4.3%
Total	397,884	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Source: ONS, 2011 Census

2.4.3 Public sector employment in West Sussex

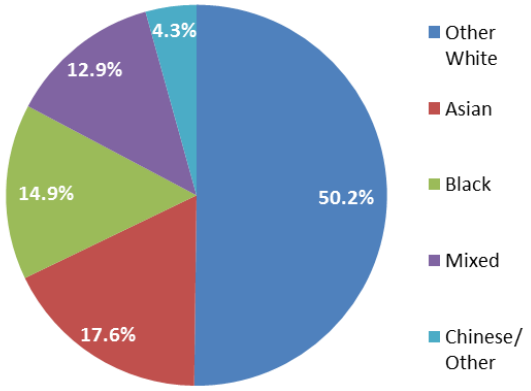
As providers, administrators and commissioners, the ethnic demography of WSCC employees does not reflect that of the resident population, though large gaps exist in the data. 72% are recorded as White British/Irish and 5% as BAME, whilst 2% '*prefer not to say'* and 21% are '*unknown*'. Of the BAME category, over half are recorded as 'Other White' (Figures 2.13 and 2.14)

Figure 2.13, WSCC employee ethnicity by directorate



Source: Insight Team, HR Diversity Monitor Workforce Analysis, 2015

Figure 2.14, WSCC employee ethnic breakdown of total BAME



Source: Insight Team, HR Diversity Monitor Workforce Analysis, 2015

Religion is recorded in WSCC employment records, though 69% of staff are recorded as Unknown or prefer not to say. Efforts to improve data collection methods are ongoing.

2.4.4 Unpaid work

The percentages who provide unpaid care may relate closely to the general age-structure of the ethnic group. White Irish were the group with the highest percentage of unpaid carers 12%), whereas the younger "Mixed/multiple" ethnic groups were lower at 5.6%. Overall, proportionally less of those from BAME groups provided unpaid care, which matches their overall younger demographic.

Table 2.7, Provision of unpaid care in West Sussex

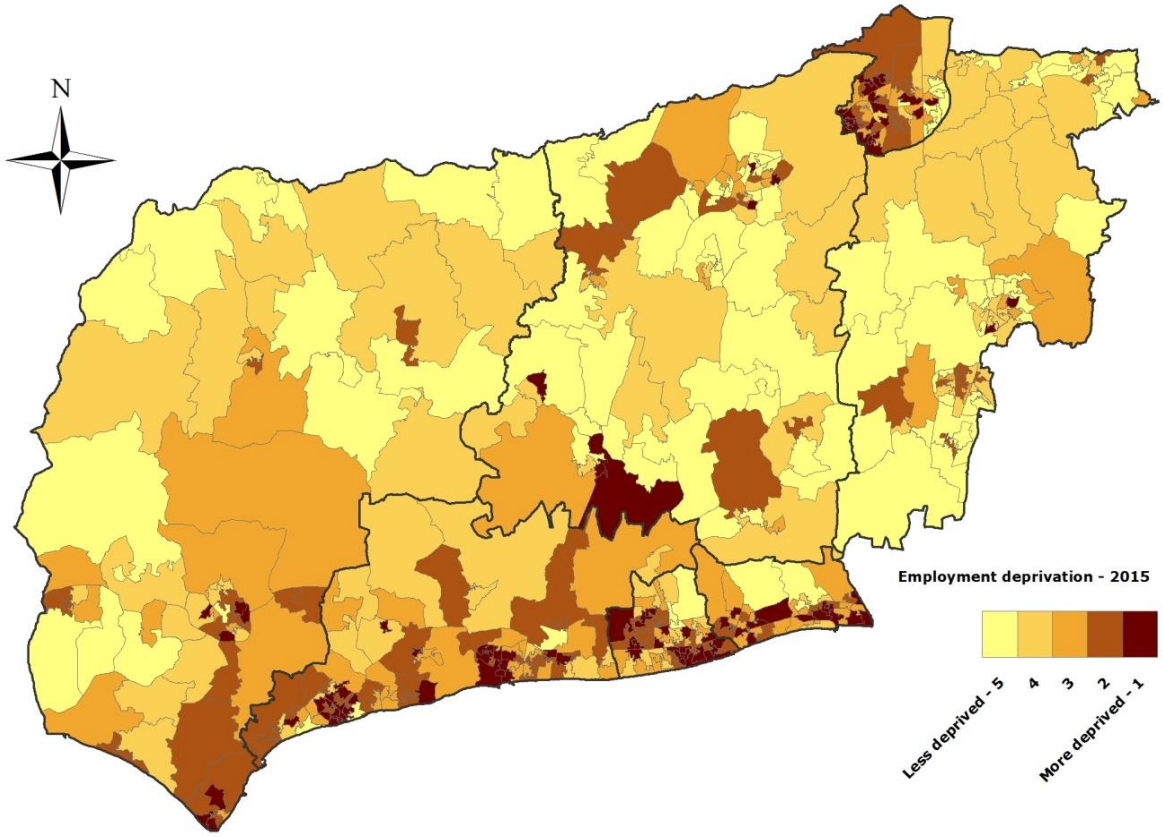
	Provides no unpaid care		1 to 19 hours a week		20 or more hours a week		Provides unpaid care total	
	Number	(%)	Number	(%)	Number	(%)	Number	(%)
All categories	722,495	89.5	58,320	7.2	26,070	3.2	84,395	10.5
White British	639,360	89.1	54,520	7.6	23,670	3.3	78,195	10.9
White Irish	5,265	88.0	470	7.9	245	4.1	715	12.0
White Other	30,945	93.9	1,275	3.9	755	2.3	2,025	6.1
Mixed/multiple ethnic group	11,480	94.4	460	3.8	215	1.8	675	5.6
Asian/Asian British	26,125	92.2	1,275	4.5	940	3.3	2,210	7.8
Black/African/Caribbean/Black British	6,725	94.1	245	3.4	180	2.5	425	5.9
Other ethnic group	2,600	94.2	85	3.1	70	2.5	155	5.6

Source: ONS, 2011 Census

2.4.5 Having less employment opportunities

Though ethnicity-specific employment is not available locally, what we do know in West Sussex is that data from the Office for National Statistics show that the areas which have more concentrated minority ethnic populations, such as coastal urban towns and western Crawley, are also more deprived of employment opportunities. Less employment opportunities is known to be linked to poor health outcomes at a population level.[19]

Figure 2.15, West Sussex LSOAs showing areas of high employment deprivation



Note: Employment deprivation is based on involuntary exclusion of people of working age from work
Source: ONS (2015), IMD statistical release

19 'Is work good for your health and well-being?', by Waddell & Burton, 2006. The Statutory Office, available from: www.tsoshop.co.uk

Key points

- Those from BAME groups were more likely to be 'economically active but unemployed' in 2011 than White British residents, particularly in the under 24 year age group.
- Whilst differences in the employment rate between BAME groups and White groups have narrowed over recent decades for men, it has remained at a consistent level for women. Pakistani and Bangladeshi women in particular were far more likely to be unemployed than women from other ethnic backgrounds.
- In 2011, 44% of in-work residents from black ethnic backgrounds worked in public administration, health and education. As this area has seen large scale government cutbacks in this period, it is possible that this group has been disproportionately affected in recent years.
- The ethnic demography of WSCC employees does not reflect that of the resident population, though large gaps exist in the data. – Ethnicity is unknown for 21% of employees and efforts to improve recording are believed to be ongoing.

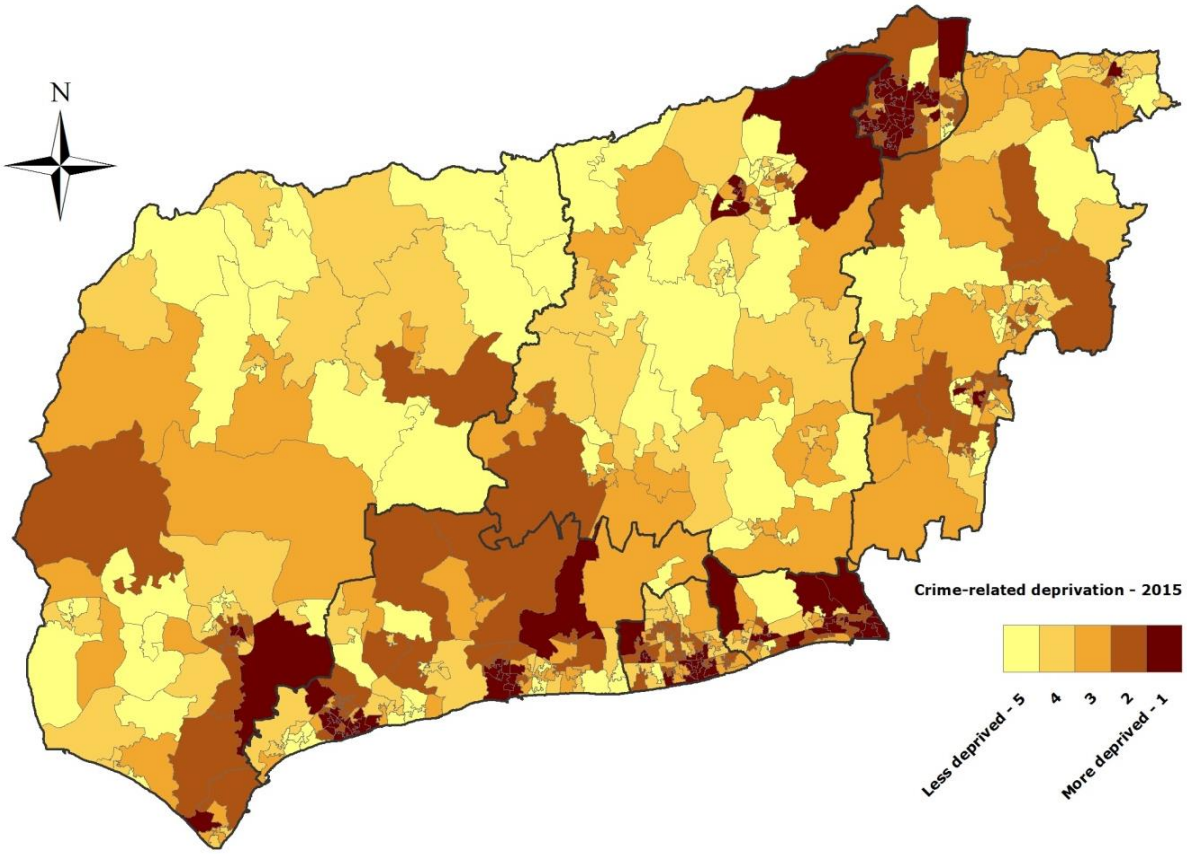
Relevant recommendation(s): 7., 8., 9., 10., 15., 18., 20.

Indicator	**Outcome**
1.1 1.5 1.9 1.17	Children in poverty 16 – 18 year olds not in employment, education or training Sickness absence rate Fuel poverty
2.23	Self-reported wellbeing

2.5 Community safety

Urban areas of the coastal strip and Western Crawley, where minority ethnic populations are most concentrated, contain the neighbourhoods with the highest risk of being a victim of crime.

Figure 2.16, West Sussex LSOAs showing areas of high crime-related deprivation



Note: The crime domain measures the risk of personal and material victimisation at local level.
Source: ONS (2015) IMD statistical release

2.5.1 Searches and arrests

In West Sussex, residents from BAME groups are less likely to be arrested than White ethnic groups, with only 6% of recorded arrests, compared to 11% of the county population and also having a lower age demographic. Concerning gender, males made up a larger proportion of the arrests for BAME groups than for the general population. Twenty five percent of arrests did not record ethnicity, leaving uncertainty in the data, though the gender breakdown of those not supplying a gender does match more closely that of the White populations than that of the BAME arrests (Table 2.7). There is no difference between the age-breakdowns of arrests in minority groups and White groups.

Table 2.7, Arrests in West Sussex (2013-15)

	West Sussex arrests (Oct 2013- Sept 2015)		*(Where gender is known)*	
	count	**(%)**	*females*	*males*
BAME	1,337	**6%**	*15%*	*85%*
Not stated	5,252	**25%**	*19%*	*81%*
White (all)	14,785	**69%**	*21%*	*79%*
Total	21,374	**100%**	*20%*	*80%*

Note: In Sussex Police records, all White ethnic groups are combined
Source: Sussex Police statistics, 2015

Despite low BAME arrest numbers, relative to the White population, residents of a Black ethnic background are far more likely to be arrested (per capita) than White residents; however, this does not tell us whether or not these arrests lead to successful convictions. In Adur and Worthing in 2015 Black residents were 33 times more likely to be arrested than a White resident (over 13 times more likely over all of Sussex). Black groups also have a higher rate of stop and search; most notably they are fourteen times higher than the White British residents in Worthing and Adur (Tables 2.8 and 2.9). This may go some way to explain the higher arrest numbers, but without adequate context this is an area that will need further investigation.

Table 2.8, Likelihood that a member of an ethnic group was arrested compared to White groups

	x times more likely to be arrested than White				
	White	Mixed	Asian	Black	Other
Adur & Worthing	1.0	2.5	0.2	33.3	-
Arun	1.0	1.0	-	8.4	-
Chichester	1.0	-	2.2	10.9	-
Crawley	1.0	0.6	0.8	5.0	0.6
Horsham	1.0	-	1.8	-	10.9
Mid Sussex	1.0	1.0	1.2	7.6	-
Sussex Police Force (Minus Gatwick)	1.0	1.7	1.4	13.5	1.1

Note: In Sussex Police records, all White ethnic groups are combined
Source: Sussex Police statistics, 2015

Table 2.9, Likelihood that a member of an ethnic group was stopped and searched, compared to White groups

	x times more likely to be stopped than White				
	White	Mixed	Asian	Black	Other
Adur & Worthing	1.0	1.6	0.8	13.9	0.4
Arun	1.0	0.6	-	10.2	-
Chichester	1.0	1.4	3.3	6.2	1.3
Crawley	1.0	1.1	1.0	4.5	0.4
Horsham	1.0	0.6	1.2	4.9	2.5
Mid Sussex	1.0	1.0	0.8	4.6	1.1
Sussex Police Force (Minus Gatwick)	1.0	1.4	1.3	8.4	0.9

Note: In Sussex Police records, all White ethnic groups are combined
Source: Sussex Police statistics, 2015

Whilst White groups are more likely to be arrested in connection with burglary, criminal damage, and theft and handling, BAME groups were far more likely to be arrested in connection with drug offenses (23% to 15%). Both cohorts were most likely to be arrested in connection with violent crimes, with 41% of all arrests in the two year period. – Similarly to above, the 'missing or not stated' category, which accounts for 25% of all arrests, appears to match more closely that of the recorded White population.

Table 2.10, Arrests in West Sussex by category of crime (2013-15)

		Burglary	Criminal Damage	Drug Offences	Theft and Handling	Violent Crimes	Other	Total
BAME groups	female	0%	2%	10%	39%	41%	6%	100%
	male	2%	6%	26%	19%	41%	6%	100%
	All	**1%**	**6%**	**23%**	**22%**	**41%**	**6%**	**100%**
White (all)	female	1%	5%	9%	37%	44%	4%	100%
	male	5%	10%	17%	23%	40%	5%	100%
	All	**4%**	**9%**	**15%**	**26%**	**41%**	**4%**	**100%**
Missing or not stated	female	1%	4%	8%	38%	44%	5%	100%
	male	5%	9%	18%	24%	40%	4%	100%
	All	**4%**	**8%**	**16%**	**27%**	**41%**	**4%**	**100%**
All		**4%**	**9%**	**16%**	**26%**	**41%**	**4%**	**100%**

Note: In Sussex Police records, all White ethnic groups are combined
Source: Sussex Police statistics, 2015

In 2013/14, in England and Wales, White suspects accounted for 75% of all stops and searches, despite accounting for 87% of the population – This difference is currently decreasing from year to year, though the Black stop and search rate per 1,000 residents was still four and a half times higher relative to the

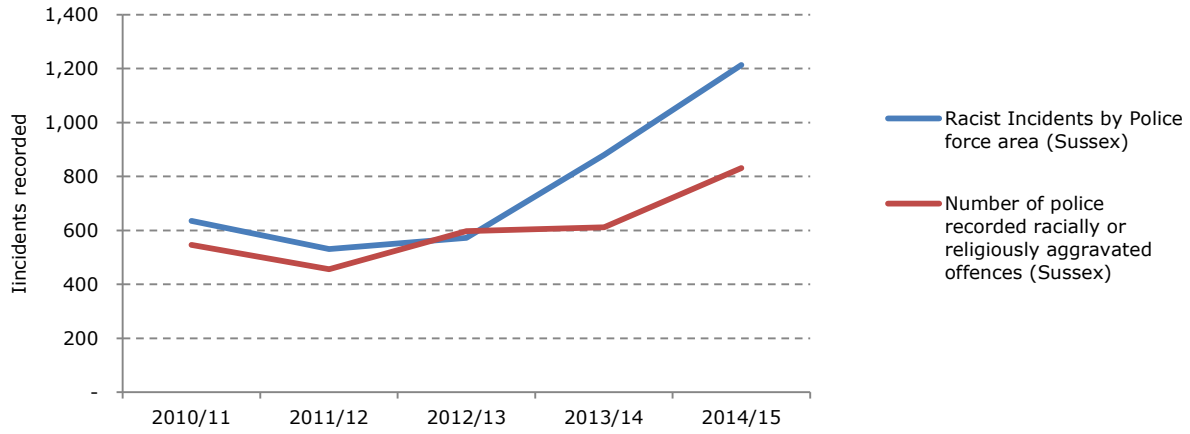
White ethnic group. In the same year, the conviction ratio for all indictable offenses was higher for White residents than Black residents, and also for when breaking down figures to the offense type.[20]

2.5.2 Victims of crime

Nationally, White residents have been less likely to be victims of crime than other ethnic groups from 2008/09 to 2014/15, with infrequent exceptions for Asian/Asian British groups. In the past year, more Black and Asian minority groups believed it was 'likely' or 'very likely' that they would be a victim of crime in the coming year (24% and 29%) compared to White groups (17%)[21].

Locally, there has been a rise in recorded racially motivated incidents and offenses by Sussex Police, according to nationally compiled data by the ONS, (Figure 2.17). Sussex Police regularly report feedback on levels of 'victim satisfaction' on their website (www.Sussex.Police.UK) for which they have recently recorded 82% satisfaction levels for victims of hate crimes (Aug 2015).

Figure 2.17, Victims of racially motivated incidents or racially/religiously motivated offenses, Sussex



Source 1: ONS, Hate crime in England and Wales, 2014/15,
Source 2: ONS, Using Home Office data, 'Crime in England and Wales, Year Ending March 2015'

When analysing the different types of recorded crime, we can see that West Sussex residents from BAME communities are more likely to have been a victim of a violent crime than White residents (56% to 49%) and there is little difference in the figures for burglary (Table 2.11). The data does contain large gaps, with 49% of all victims' ethnicities not recorded.

Table 2.11, Victims of crime by gender and ethnic background, two years, 2014-15

		Burglary	Criminal Damage	Drug Offences	Fraud & Forgery	Other Offences	Theft & Handling	Violent Crime	Total
BAME	female	12%	11%	0%	0%	1%	13%	63%	100%
	male	10%	13%	0%	0%	1%	24%	53%	100%
	unknown, comp or gov	10%	10%	0%	0%	0%	10%	70%	100%
	Total	11%	12%	0%	0%	1%	20%	56%	100%
Not Stated	female	10%	21%	0%	0%	1%	41%	27%	100%
	male	13%	20%	0%	0%	1%	42%	25%	100%
	unknown, comp or gov	8%	13%	16%	1%	6%	50%	5%	100%
	Total	10%	16%	9%	0%	4%	46%	14%	100%
White	female	10%	15%	0%	0%	1%	20%	52%	100%
	male	13%	15%	0%	0%	1%	26%	45%	100%
	unknown, comp or gov	5%	9%	0%	0%	3%	10%	73%	100%
	Total	12%	15%	0%	0%	1%	23%	49%	100%
All		**11%**	**16%**	**5%**	**0%**	**2%**	**35%**	**32%**	**100%**

Source: Sussex Police, victims of crime, 2014-15

[20] MoJ, 2015, Statistics on Race and the Criminal Justice System 2014
[21] ONS, 2015, Crime Survey for England and Wales

Qualitatively, the recent community engagement in West Sussex found that:

> *There are a number of positive experiences of engaging with the police but there are also examples of distrust… – p13*

Respondents cited what they perceived as an increased rate of localised burglaries aimed at Asian residents, under the perception that Asians *"keep large amounts of gold jewellery around".*

> *Although most feel that the police are quick to respond to 999 calls and welcomed police engagement events, some feel they still do not take the problem seriously enough, 'they see it as an Asian Community problem' (Female, Pakistani, 25–64).*

A lack of known arrests at the time was seen as evidence that the issue was a low priority for Sussex Police, which eroded trust in the effectively of community safety. The authors of the report believed that:

> *This is having a knock-on effect with many Asian people, particularly older residents, becoming fearful and distrusting of callers and offers. For example, people are not taking up their entitlement to free home insulation because they fear that it is just a scam to gain entry to homes and that they are being specifically targeted as a result of their ethnicity.*

Those in Eastern European communities admitted to being generally unsure of police officers, but that this was likely due to poor perceptions of law enforcement and community safety in native countries. Where local police officers were recruited from within the community, this was celebrated by all; repeated references were made of the 'Polish Policeman', who was held in high regard by those in the Bognor Regis area.

2.5.3 Reporting taboo crime

Sussex Police data shows that there were 166 recorded instances where a female from a minority ethnic group was the victim of domestic abuse in 2015. In the same period, there were 2,771 recorded instances where a female from a White ethnic background was the victim of domestic abuse. This amounts to just 6% of all cases coming from BAME residents. Qualitative evidence suggests that some residents of minority communities are less likely to report domestic abuse to the police and that a culture exists to 'handle it' within the community; a view that was reinforced by the recent 2015 community engagement.

2.5.4 Diversity in Sussex Police

Sussex Police HR data show that in 2014 the pan-Sussex force employed fewer than ten police officers who identified as Muslim, and fewer than five who identified as Hindu. Additionally, in the West Sussex Division they had twenty police officers from a BAME background (1.6% of the West Sussex division). Overall 2.3% of Sussex Police's workforce identifies as BAME. Nationally, only 5% of police officers have a BAME background.[22]

22 Sussex Police, Diversity Analysis 2014. Available at: http://www.sussex.police.uk/media/10562/equality_analysis_data_2014v2.pdf

Key points

- BAME groups tend to be concentrated in areas of higher crime-related deprivation.
- Sussex Police publish much data on ethnicity, though with poor recording in some fields often the data leaves wide margins of error.
- Despite low BAME arrest numbers, residents of a Black ethnic background are far more likely to be arrested (per capita) than White residents; 33 times more likely in Adur and Worthing and 13 times more likely over all of Sussex. Black groups also have a higher rate of stop and search; fourteen times higher than the White British residents in Worthing and Adur.
- Residents from a BAME background are more likely to be arrested for drug offenses than White residents.
- Nationally, the Black stop and search rate per 1,000 residents was four and a half times higher than White groups (2013/14). White residents are more likely to be convicted of the crime for which they are being prosecuted.
- Nationally, those from BAME backgrounds are more likely to believe they will be a victim of crime in the future, which matches police records of past crimes.
- Locally, there has been a rise in racist incidents recorded by Sussex Police and, (where data exists) residents from BAME communities are more likely to be victims of violent crime than White groups.
- BAME residents only make up 6% of reported domestic abuse in the past two years (where ethnicity is known), which may highlight an issue with underreporting within the community. Qualitative evidence indicates that some communities may attempt to keep taboo issues unreported where possible.
- The makeup of Sussex Police for does not reflect that of the community, with only a handful of officers identifying as having a minority religion, and less than 2% of the West Sussex division coming from BAME backgrounds. – Sussex Police are attempting to find ways to increase BAME recruitment.

Relevant recommendation(s): 2., 3., 8., 9., 10., 12., 13., 14., 15., 16., 18., 20.

Indicator	Outcome
1.4 1.11 1.12 1.13 1.16 1.19	First time entrants to the youth justice system Domestic abuse Violent crime Re-offending levels Utilisation of outdoor space for exercise / health reasons Older people's perception of community safety
2.7	Hospital admissions caused by unintentional and deliberate injuries in children and young people aged 0-14 and 15-24 years

Section 3: Lifestyles, risk behaviours and health protection

Public services are to provide a service equally for everyone, where does religion or culture come into it? (Male, Indian, 25–64).

Overall the services have very much improved, culturally everything has vastly improved … [before] we didn't have temples, we didn't have anything … people are well informed…yes you will get ignorance here and there and get remarks, but a lot has changed' (Male, Sri Lankan, 25–64).

They don't need to take into account my religion or culture. They don't ask and I don't tell them. They just need to treat me. (Male, Pakistani, 25–64).

British people value health above anything. They don't value friendship, or at least their social networks are rubbish-ish, but when it comes to health they are up there. You wouldn't have an accident and not have help (Female, Ugandan, 25–64).

If you've been to Africa you can't complain, I know that people here say 'oh the NHS quality is going down'…but still, in the world the NHS is ranked as one of the best.' (Female, Ugandan, 25–64).

It is a matter of getting services known about in the public domain (Male, Indian, 65–74).

In our society they [women] are usually staying at home as housewives so they would not really know about these services; they only know what is going on in their house and temple (Female, Sri Lankan, 18–24).

3.1 Tobacco, alcohol and substance misuse

3.1.1 Smoking

Across England, self-reported cigarette smoking prevalence for men is greater in ethnic minority groups than in the general population. A recent health equity audit[23] details the local and national picture, however in 2004 the HSE reports that levels were at 40% among Bangladeshi, 30% Irish, 29% Pakistani, 25% of Black Caribbean, 21% Black African and Chinese, and 20% in Indian men, compared with 24% among men in the general population. After adjusting for age in the prevalence figures, Bangladeshi and Irish men were more likely to report smoking cigarettes, compared with men in the general population. Indian men are less likely to report smoking than those in the general population. Self-reported smoking prevalence was higher among women in the general population (23%) when compared with most ethnic groups. The exceptions to this are women in Irish groups (26%) and Black Caribbean women (24%). Ten per cent of Black African, 8% of Chinese, 5% of Indian and Pakistani, and 2% of Bangladeshi women reported smoking cigarettes.

In terms of accessing smoking services, quit rates vary from 37% - 54% dependent on ethnicity reported, with Asian or British Asian having the highest quit rate and 'other' the lowest. - Use of these services locally is discussed in *Section 5.* In West Sussex there were estimated to be some 8,500 smokers who report their ethnicity as anything other than 'White' (Table 3.1).

Table 3.1, Smoking rates in West Sussex

Ethnic Group	Patients	Quitters	Access Rate	Quit Rate
White	6,110	3,020	4.5%	49.4%
Mixed	30	10	1.4%	26.7%
Asian	80	30	1.8%	35.0%
Black	35	10	3.5%	30.6%
Other	5	<5	0.7%	16.7%
(All non-white BME groups)	150	50	1.8%	31.6%
Not Stated	135	45	-	33.1%
Total	6,395	3,110	4.4%	48.7%

Source: West Sussex smoking cessation health equity audit 2013/14

3.1.2 Smokeless tobacco

Smokeless tobacco is used by some ethnic minority groups, particularly those from South Asia. Chewing tobacco is most commonly used by the Bangladeshi community with 9% of men and 19% of women reporting that they use chewing tobacco. However, these figures may reflect a degree of under-reporting by some respondents. For example, self-reported use of all tobacco products was 44% and 17% among Bangladeshi men and women respectively. Including respondents with a saliva cotinine level indicative of personal tobacco use, the estimates rise to 60% of men and 35% of women. A separate study which explored under reporting among Bangladeshi women found that 15% of women under-reported their personal tobacco use.[24]

3.1.3 Alcohol

A review of the UK literature on ethnicity and alcohol conducted in 2010 surmised that there is diversity both within and between ethnic groups. Most minority ethnic groups have higher rates of abstinence and lower levels of drinking compared to people from white backgrounds, but over time generational differences may emerge, for example, frequent and heavy drinking has increased for Indian women and Chinese men.

[23] PHSRU, 2015, West Sussex smoking cessation health equity audit 2013/14
[24] ASH, 2011, Tobacco and ethnic minorities

Moreover, people from some ethnic groups are more at risk of alcohol-related harm:

- Irish, Scottish and Indian men, and Irish and Scottish women have higher than national average alcohol-related deaths in England;
- Sikh men over present for liver cirrhosis;
- People from minority ethnic groups have similar levels of alcohol dependence compared to the general population, despite drinking less.

Yet, the review concluded, minority ethnic groups are under-represented in seeking treatment and advice for drinking problems.

3.1.4 Substance misuse

Similarly, in general, overall drug use is lower among ethnic minority ethnic groups than among the White population, although according to a review of the evidence undertaken by the UK Drug Policy Commission, this may change as young people become more absorbed into predominant national culture with the potential for increasing drug problems in these communities. Moreover, there are high rates of use among mixed race which 'may be of concern, as they are likely to be an increasing group in the future.'

As with specialist alcohol services, BAME groups are underrepresented in UK specialist drug misuse services. When relying on service-level data it is hard to conclude if the numbers reflect the need in the community or the result of barriers to service take-up. The UKDPC review concluded, however, that this was in part due to a lack of knowledge about such services and reluctance amongst this demographic to seek help due to stigma. A concerted effort to record ethnicity at service-level would identify reliable numbers and allow for further research to identify if this truly reflected the need at a community level.

Source: West Sussex Alcohol and Drug Needs Assessment, 2014

Key points

- Bangladeshi and Irish men were more likely to report smoking cigarettes, than those in the general population, as were Irish women and Black Caribbean women.
- BAME groups generally have the lowest 'quit rate' of those who access services, with Asian groups being the most likely to quit (35%).
- Current figures are unreliable, but indicate that Bangladeshi men and women were far more likely to use chewing tobacco than other minority groups in the population.
- Most BAME groups have higher rates of abstinence and lower levels of drinking and drug use compared to White British residents, though this may change over time as cultures integrate. Irish, Scottish and Indian men have higher than average alcohol related deaths, nationally and Sikh men over-present for liver cirrhosis. Mixed-background groups have higher rates of substance misuse.
- BAME groups are underrepresented in seeking treatment, despite having similar levels of alcohol or drug dependence/addiction, (being a separate issue to occasional use). There may be a cultural stigma around seeking help for substance dependence.

Relevant recommendation(s): 3., 4., 5., 11., 12., 13., 14,. 15., 18., 20.

Indicator	**Outcome**
2.3	Smoking status at time of delivery
2.9	Smoking prevalence – 15 year olds
2.14	Smoking prevalence – adults (over 18s)
2.15	Successful completion of drug treatment
2.16	People entering prison with substance dependence issues who are previously not know to community treatment
2.18	Alcohol-related admissions to hospital
3.4	People presenting with HIV at a late stage of infection
4.4	Under 75 mortality rate from all cardiovascular diseases
4.5	Under 75 mortality rate from cancer
4.6	under 75 mortality rate from liver disease
4.7	Under 75 mortality rate from respiratory disease
4.10	Suicide rate
4.11	Emergency readmissions within 30 days of discharge from hospital

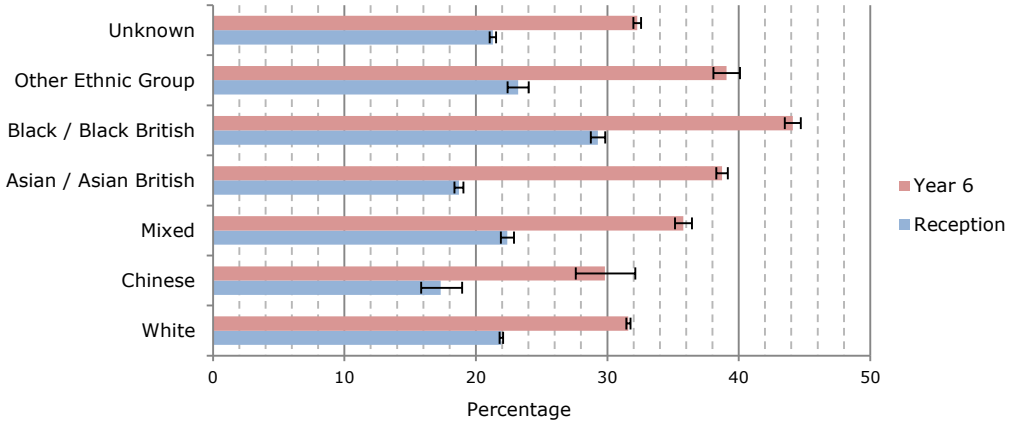
3.2 Obesity and physical activity

3.2.1 Obesity

The National Childhood Measurement Programme collects data on height and weight from school children all over the country, at Reception and Year 6 ages. At a national level, obesity amongst children is higher in urban areas than rural areas and locally West Sussex has lower overweight and obesity levels at both Reception and Year 6 (20% and 30%) than in England as a whole (22% and 33%). The strongest indicator is deprivation, where more of those in the most deprived decile are overweight or obese at Reception and Year 6 (26% and 40%) than the least deprived decide (17% and 24%).

These indicators are commonly aligned with some ethnic minority groups, which also show higher levels of childhood overweight and obesity (Figure 3.1). Nationally, children of a Black ethnic background were most commonly measured as overweight or obese at both Reception and Year 6 (29% and 44%). Children from an Asian background showed the largest change in childhood, with 19% overweight or obese at age 4 to 5 increasing to 39% by age 10 to 11.

Figure 3.1, Overweight or obesity in children at reception and year six (England, 2014/15)



Source, HSCIC, 2016, National Childhood Measurement Programme data release (2014/15)

Different ethnic groups have different physiological responses to fat storage (National Obesity Observatory, 2011).

> *When using BMI as a measure, findings suggest that compared to the general population, obesity prevalence is lower among men from Black African, Indian, Pakistani, and, most markedly, Bangladeshi and Chinese communities. Among women, obesity prevalence appears to be higher for those from Black African, Black Caribbean and Pakistani groups than for women in the general population and lower for women from the Chinese ethnic group.*
>
> *Analysis by the British Heart Foundation found that this pattern changes when other measurements of overweight and obesity are used. Whilst men from Irish, Pakistani, Indian and Bangladeshi groups have similar prevalence of raised waist-to-hip ratio, as compared to men in the general population, those from Black Caribbean, Black African and Chinese communities are less likely to have a raised waist-to-hip ratio (Figure 1).Women from Bangladeshi, Black Caribbean, Pakistani and Irish groups are more likely to have a raised waist-to-hip ratio compared to women in the general population, with Bangladeshi women nearly twice as likely – p. 7*

The National Obesity Observatory described a series of issues surrounding the recording of obesity and ethnicity, including:

- *There is ongoing debate as to whether the current criteria for defining obesity in both adults and children are appropriate for non-European populations. Research has shown that for the same level of BMI, people of African ethnicity appear likely to carry less fat and people of South Asian ethnicity more fat than the general population. This may have led to an overestimation of obesity among African and an underestimation among South Asian groups.*

- *Ethnic groups are heterogeneous by nationality and religion, and thresholds for overweight and obesity may vary by sub-group. Using revised thresholds for some ethnic groups could greatly increase these estimates.*

Figure 3.2, Obesity-related illnesses and relevance to ethnic groups

Disease	Key points relevant to minority ethnic groups
Cardiovascular risk	Highest prevalence in men of Irish ethnicity[30] Lowest prevalence in men from Black African ethnic group and women from Bangladeshi ethnic group[30] Higher risk at a lower BMI in many Asian groups compared to White population[42]
Coronary heart disease	Highest prevalence in men from Indian and Pakistani groups[30] Lowest prevalence in men from Black African and Chinese groups[30] Mortality rates high for those dying in England and Wales but born in South Asia[24]
Hypertension	Prevalence three to four times higher in Black African population than in White population[43] Adolescents from Indian ethnic group at greater risk than White adolescents at lower BMI[34] South Asian and Chinese populations at elevated risk compared to European populations even if BMI is low[14]
Stroke	Chinese and Black populations at increased risk[44] Highest prevalence in men of Black Caribbean ethnicity[30] Highest prevalence in women from Bangladeshi and Pakistani groups[30] Mortality rates lower for Black population than the general population[45]
Metabolic syndrome	More prevalent in South Asian and Black African populations[46,47]
Type 2 diabetes	Men from Bangladeshi population almost four times as likely as the general population[30] Men from Pakistani and Indian populations almost three times as likely as the general population[30] Women of Pakistani ethnicity over five times more likely than the general population[30] Women from Bangladeshi and Black Caribbean populations over three times more likely than the general population[30] South Asians and Chinese populations at elevated risk compared to European populations even if BMI is low[14] Children from South Asian and Black African Caribbean ethnic groups at a greater risk than children from White ethnic groups[48]

Source: National Obesity Observatory, 2011, Obesity and ethnicity, extract p 14

3.2.2 Physical activity

According to the National Obesity Observatory report 'Obesity and Ethnicity' (2011)[25], studies have shown low levels of physical activity among minority ethnic groups in the UK – particularly South Asian populations:

- Bangladeshi residents have markedly lower levels of physical activity than other south Asian groups
- Those of Indian ethnicity have the highest levels
- All have lower activity levels than the white population

Regarding males, only Bangladeshi and Pakistani groups had lower rates meeting recommended levels of physical activity and these rates decrease with age and are lower for unemployed, retired or economically inactive men. Similarly for women, the numbers meeting recommended levels were lower for south Asian and Chinese groups and generally, the rates meeting recommendations were lower for retired or economically inactive.

Residents from mixed ethnic backgrounds showed consistently higher levels of participation in physical activity than any other group including White British, whereas South Asian children have lower levels of physical activity than White groups. The authors believe that negative attitudes towards physical activity can be instilled by parents of these children; for instance, the idea that sport and femininity are incompatible.

A combination of personal, socioeconomic, cultural and environmental barriers may discourage BAME groups

- South Asian women may have dress codes, higher concerns for modesty, or perceive a lack of single-sex facilities
- Difficulties finding suitable and safe walking routes
- Time constraints
- Dependant relative or availability of childcare
- Perceived lack of culturally appropriate exercise services

According to the BHF Physical activity for adults briefing, BAME adults are less likely to be physically active and children and young people have higher levels of TV viewing than White ethnic groups.

Second generation south Asians appear to be more physically active than the first generation, but still less active than the white British. This may be due to more positive attitudes towards physical activity. South Asian children all reported lower levels of physical activity than white British children, with girls being less physically active than boys – for all ethnicities[26]. Additionally, there is a recognised need for gendered physical activity sessions as this is important to initiating exercise among Muslim south Asians aged 60-70.

[25] National Obesity Observatory, 2011 'Obesity and Ethnicity'.
[26] Bhatnagar P, Shaw A, Foster C. Generational differences in the physical activity of UK South Asians: A systematic review. International Journal of Behavioral Nutrition and Physical Activity. 2015;12(1).

Key points

- There are a range of obesity-related illnesses which show higher or lower prevalence in specific ethnic groups.
- Children from Asian, Black and mixed ethnic backgrounds are more likely to be overweight or obese at Year 6 than those from other backgrounds in the general population. Particularly children from Black backgrounds are more likely to be overweight or obese by age 4-5 years.
- Black and South Asian groups also tend to have higher BMI scores than those from White or East Asian backgrounds in adulthood.
- The National Obesity Observatory suggests that people form Black backgrounds tend to carry less body fat than other groups and people from South Asian backgrounds tend to carry more body fat that other groups, when controlling for BMI. This may have led to an overestimation of obesity among African and an underestimation among South Asian adults.
- South Asian groups have been found to have lower overall activity levels than the general population. Those from Mixed ethnic backgrounds had higher activity levels than the general population.
- There may be a range of perceived barriers to some BAME groups taking up physical activities, such as higher modesty concerns, or a lack of culturally appropriate exercise services.
- A need for gendered physical activity sessions has been highlighted, for Muslims of older age groups.

Relevant recommendation(s): 3., 4., 5., 6., 14., 15., 17., 18., 20.

Indicator	Outcome
2.6	Excess weight in 4-5 and 10-11 year olds
2.11	Diet
2.12	Excess weight in adults
2.13	Proportion of physically active and inactive people
2.17	Recorded diabetes
2.23	Self-reported wellbeing
4.3	Mortality rate from causes considered to be preventable
4.4	Under 75 mortality rate from all cardiovascular diseases

3.3 Sexual health and screening/vaccinations

Twenty percent of all new STI diagnoses were recorded without an ethnicity and 30% without a world region of birth, creating a data gap for prevention strategies in this area. As it stands, Chlamydia accounts for roughly half of all new STI diagnoses. - These STIs are important, under a backdrop of increasing anti-microbial resistant Gonorrhoea and Syphilis.

3.3.1 HIV diagnoses

Nationally, the group with the highest incidence of HIV diagnoses is Black Africans, of whom there were 26,000 diagnoses in the UK, for the ten years to 2013 (Table 3.2). In contrast, there were only 2,200 diagnoses from Black Caribbeans. The majority of these cases, where exposure was likely to be from sexual contact, were from heterosexual women.

Table 3.2, New HIV diagnoses by year of first diagnosis, probable exposure category and sex among HIV infected Black Africans, in the UK

Probable exposure category		2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Total
Sex between men		55	60	50	65	65	60	75	55	110	70	**660**
Heterosexual contact	Men	1,265	1,185	1,025	965	850	710	625	595	470	395	**8,090**
	Women	2,430	2,415	2,140	1,820	1,745	1,330	1,175	1,010	910	645	**15,625**
	Heterosexual total	**3,695**	**3,600**	**3,165**	**2,785**	**2,595**	**2,040**	**1,800**	**1,605**	**1,380**	**1,040**	**23,715**
Injecting drug use		5	5	5	5	10	10	5	5	0	5	**55**
Mother to infant		130	110	110	100	95	100	95	85	60	60	**945**
Recipient of blood/ tissue products		15	20	20	10	10	5	5	5	5	5	**100**
Other/Not reported		35	20	35	30	50	45	40	45	60	85	**440**
Total		**3,935**	**3,815**	**3,385**	**2,995**	**2,825**	**2,260**	**2,020**	**1,800**	**1,615**	**1,265**	**25,915**

Source: Public Health England (2014), Prevention Group HIV data tables

3.3.2 Screening and vaccinations

Screening services do not robustly record ethnicity and gaps in quantitative data are a barrier to early intervention strategies. With some screening programmes, such as cervical screening, it is believed anecdotally that some women from some communities, in particular Asian communities, are less likely to take up screening opportunities due to the method by which results are offered. The default system has the results sent by mail to the individual's home address, where the husband or father is responsible for opening incoming letters. – A system where results can be received by the individual in confidence is needed to promote confidentiality.

Data could be made more available in the areas of AAA screening, Cervical screening, Breast screening, Diabetic retinal screening, Bowel screening as ethnic data on these is limited.

The National Haemoglobinopathy Registry does report annual figures and from this we can see that those from Black African backgrounds were more likely to be signed onto the register than other groups, though this does not necessarily reflect prevalence per capita.

Table 3.3, Sickle cell patients on the register as of March 2014

African	4435
Caribbean	1475
Any other Black background	600
Not Stated	530
White and Black African	95
Any other ethnic group	90
White and Black Caribbean	60
Any other mixed background	55
Indian	45
Any other Asian background	45
Any other White background	20
White - British	15
Pakistani	10
Bangladeshi	< 10
White and Asian	< 10
White - Irish	< 10

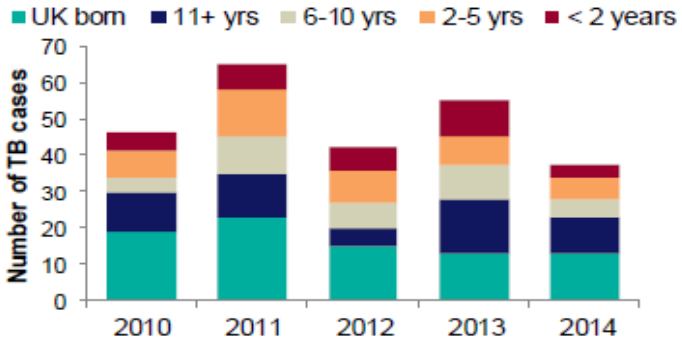
National Haemoglobinopathy Registry Report (2014)

Evidence has shown that some groups of children and young people are at risk of not being fully immunised (NICE PH21). These include:

- those from some minority ethnic groups
- those from non-English speaking families
- vulnerable children, such as those whose families are travellers, asylum seekers or are homeless.

Regarding tuberculosis, Public Health England create local authority profiles which show that numbers in West Sussex are relatively low, compared to the national average, with a rate of 5.0 per 100,000 residents. Of these, however, a disproportionately high number come from non-UK born residents and specifically India. Of the 42 cases identified in West Sussex in 2014, 13 were from the UK, 9 were from India and the others were suppressed for having less than 5 per country. In 2014, 92% of UK-born patients were white. Of non-UK born patients 52% were Indian and 16% white.

Figure 3.3, Number of TB cases for UK born or time since entry to UK (of non-UK born), 2011-14



Source: Public Health England, 2016, West Sussex profile

Key points

- Sexual health and screening services do not robustly record data and this may be a reflection of the desire to not be identified by some in the community.

- Further to this, anecdotal evidence suggest that some women may be unwilling to engage with screening programmes due to the manner in which results are often posted to the individual's home, where the husband/father will often be solely responsible for reading mail. – Alternatives should be set in place for all immunisations and screenings programmes if this is proven to be the case.

- Some key groups are at risk of not fully immunising their children against preventable diseases. These may include migrant families who have undergone immunisation programmes in native countries, which do not address the same conditions as the UK programmes.

- Tuberculosis rates are relatively low in West Sussex, though those born outside of the UK, and particularly those born in India, represent a notably high proportion of those identified.

Relevant recommendation(s): 1., 3., 4., 5., 13., 14., 17., 18., 20.

Indicator	**Outcome**
2.19	Cancer diagnosed at stage 1 & 2
2.20	Cancer screening coverage
2.21	Access to non-cancer screening
2.22	Take up of the NHS health check programme – by those eligible
3.2	Chlamydia diagnosis (15-24 year olds)
3.3	Population vaccination coverage
3.4	People presenting with HIV at the late stages of infection
3.5	Treatment completion for TB
4.5	Under 75 mortality rate
4.8	Mortality rate from communicable diseases from cancer

Section 4: Health status and Long Term Conditions

I am scared to ask for too much. My leave to stay here is not permanent and if I ask for too much I am scared that they will tell me to leave. I am not sure if the amount of care I access affects my residency so I just don't risk it. My family take on the burden (Male, Pakistani, 75+).

I live on a pension and they said I did not qualify for care support nurses, so my husband had to go to a care home and now he is alone and so am I (Female, Indian, over 75).

It is a big no-no to get services involved, like carers (Female, Indian, 25–64).

Mental problems are difficult, so I can't tell about it in English (Female, Polish, 25–64).

They tend to be cured and happy once they visit the temple (Male, Sri Lankan, 75 and over).

Suicide is a curse on a family (Female, Ugandan, 25–64).

There is a sense that sufferers should not put dirty laundry out for everyone to see (Female, Indian, 25–64).

A wife would be ruining her husband's name in the community if it [abuse] ever got out (Female, Sri Lankan, 18–24).

Maybe in five or six years the temple may be able to play a bigger role in helping out with services and teaching people about them but it doesn't seem likely any time soon (Female, Sri Lankan, 18–24,).

Unfortunately Hindu priests are not capable of informing people at the temple as they simply wouldn't care; their job is to carry out festivals etc., get paid, pray and go… even in Sri Lanka they are not trained for this sort of guidance in the community (Male, Sri Lankan, 25–64).

Women think twice about who they turn to because their partners could be deported which would have financial consequences (Female, Zambian, 25–64).

[They] refuse to acknowledge mental health problems, partly because back in Sri Lanka, you don't admit things like 'my son or daughter has a mental health problem' (Male, Sri Lankan, 25–64).

I wait 'til I go to Uganda, it's much cheaper there. We do have alternatives [to the UK system] (Female, Ugandan, 25–64).

- Traditional data such as Life expectancy estimates and health and service-level data are not available for this report, due to inconsistent data recording coupled with a wish not to disclose ethnicity and complications surrounding data disclosure, there are significant data gaps in traditional quantitative sources.

Because of this the following quantitative sources cannot be utilised to examine ethnicity, SUS Hospital data, or CCG data, GP data, QOF data. This creates prevention strategies

Traditionally, life expectancy calculations can develop insight into health inequalities between demographic groups. In this case, due to the increased relative numbers of first generation ethnic minorities and foreign nationals within the resident populations, life expectancy figures would not be an appropriate tool.

4.1 General Health and Long term limiting illness

In Crawley CCG, more residents over the age of 65 years reported having bad or very bad health (14%) than those of the other areas of the county, on the 2011 census (Table 4.1). Particularly high in Crawley was Asian/Asian British residents over the age of 65 years (24%).

When compared to ethnic groups at a national and regional level, with the exception of Black/Black British residents in Crawley, fewer residents (per capita) of minority groups in the three CCG localities of West Sussex reported poor health than elsewhere. The 'Other' ethnic group residents in Crawley represent low numbers (<50), so should be interpreted with caution.

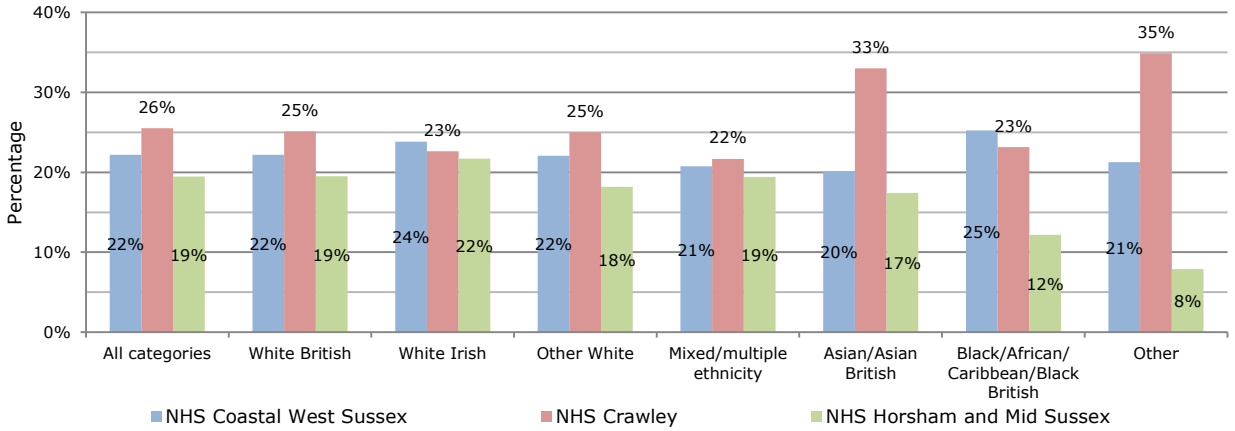
Regarding long term limiting illnesses, Asian/Asian British residents in Crawley are the only ethnic group in the county who fair worse than the national averages, with one in three reporting a long term condition or illness which limits their day-to-day activities a lot.

Table 4.1, Residents with self-reported bad or very bad health, by ethnicity and CCG locality

	Horsham & Mid Sussex CCG		Crawley CCG		Coastal CCG	
	50 - 64 yrs.	65+ yrs.	50 - 64 yrs.	65+ yrs.	50 - 64 yrs.	65+ yrs.
All categories	4%	10%	8%	14%	6%	11%
White British	4%	10%	8%	14%	6%	11%
White Irish	5%	12%	9%	14%	7%	13%
Other White	4%	10%	7%	15%	6%	14%
Mixed/multiple ethnicity	4%	11%	10%	16%	11%	12%
Asian/Asian British	4%	11%	10%	24%	5%	13%
Black/African/Caribbean/Black British	4%	7%	10%	15%	6%	13%
Other	1%	5%	16%	37%	8%	13%

Source: ONS, 2011 Census

Figure 4.1, Long term limiting illness in the over-65s, self-reported as 'Day-to-day activities limited a lot'



Source: ONS, 2011 Census

Key points

- There are significant data gaps in traditional quantitative sources, such as service-level data, health data and life expectancy, due to immigration and poor recording/disclosure of ethnicity at these levels.
- In 2011, more Crawley residents reported having bad or very bad health (14%) than those of the other areas of the county, particularly Asian/Asian British residents (24%).
- With the exception of Black/Black British residents in Crawley, more residents from all ethnic groups in West Sussex considered themselves to be healthy than those at a national and regional level.

Relevant recommendation(s): 3., 4., 5., 6., 8., 9., 10., 12., 13., 14., 16., 17., 18., 20.

Indicator	Outcome
2.17	Recorded diabetes
2.23	Self-reported wellbeing
4.3	Mortality rate from causes considered to be preventable
4.13	Health-related quality of life for older people

4.2 Reported Disability

4.2.1 Sensory impairments

Whilst the UK census can be used to identify ethnic groups with a higher rate of disability or long term limiting illness, the large differences in age profiles between these populations, coupled with the increased likelihood of health problems and disabilities with age, make direct comparisons difficult.

Bradford Borough Council recently conducted a Physical Disability and Sensory Impairment review[27] and found that, generally, there is a higher prevalence of visual impairment in some Black and ethnic minority groups. People of African Caribbean descent are four times more likely to suffer from glaucoma and South Asian people more likely to have diabetic retinopathy (ADSS, 2002)[28].

There is evidence to suggest that some minority ethnic groups may experience higher levels of deafness (Action on Hearing Loss, 2011)[29]. This is especially true of recent immigrants who have come from regions with greater levels of poverty, poor health care and low levels of immunisation against diseases such as rubella. The campaign group do insist, however, that *"there are no accurate figures available for levels of hearing loss in Black and minority ethnic groups."*

4.2.2 Learning disabilities

The Faculty of the Psychiatry of Learning Disability (Royal College of Psychiatrists)[30] conducted a review into learning disability service access and provision in 2011, and findings largely coincided with those seen elsewhere in this report; acknowledging that:

> *"Minority ethnic community is an umbrella term that covers many groups with significant variations in needs based on factors such as differences between subcultures, whether they comprise new or first-, second- or third generation immigrants, and migration pathways." – p5*

Regarding prevalence, the authors conducted a thorough literature review and found that estimates of prevalence are inconsistent, although the *"consensus is that there is no reason to expect large variations, and certainly it is extremely unlikely that there is a lower prevalence than in the general UK population."*

The Care Quality Commission[31] conducted a series of censuses on those who access mental health and learning disability services, shown in Table 4.2. Results indicate that the White British percentage is falling (as seen in the general population), and that aside from a larger (per capita) use from Black Caribbean residents, the makeup of the Learning disability services appears to largely reflect that of the country.

[27] Bradford BC, 2013, Physical Disability and Sensory impairment
[28] Association of Directors of Social Services, 2002, Progress in Sight: national standards of care for visually impaired adults
[29] Action on Hearing Loss, 2011, Facts and figures on hearing loss and tinnitus
[30] Faculty of the Psychiatry of Learning Disability of the Royal College of Psychiatrists, 2011, Minority ethnic communities and specialist learning disability services
[31] Care Quality Commission, 2010, Count me in (national census of patients)

Table 4.2, Learning disability patients by ethnic group, England and Wales

	2010	2009	2008
	Percentage (%)		
White British	85.3	86.7	88.9
White Irish	1.3	1.5	1.3
Other White	2.9	2.3	2.6
White and Black Caribbean	1.0	1.0	0.7
White and Black African	0.2	0.1	0.0
White and Asian	0.4	0.4	0.3
Other Mixed	0.7	0.5	0.3
Indian	0.9	0.9	0.7
Pakistani	0.7	0.9	0.7
Bangladeshi	0.5	0.6	0.3
Other Asian	0.4	0.3	0.3
Black Caribbean	2.6	2.2	2.3
Black African	0.8	0.9	0.7
Other Black	0.4	0.4	0.4
Chinese	0.0	0.1	0.1
Other	0.2	0.2	0.4
Not Stated	1.9	1.0	0.9
Total	100.0	100.0	100.0

Source: Care Quality Commission, 2010, 'Count me in' census

Other main findings of the faculty review identified issues around confusion around eligibility; stress for new migrants; financial burdens stemming from lower median incomes and resulting issues from this.

Specifically they raised concerns over increased rates of marriage amongst Asian communities for those on the learning disabilities register (9.4%; twice as high as the 4.4% of a White British background). The authors raised the point that those on the register who did marry in Asian communities were more likely to be younger, have children at home and a significantly lower average IQ than their White counterparts, raising discussions around culture, consent and mother/child wellbeing. (See page 11 of the review).

Other barriers to service which were highlighted were a specific lack of awareness and information amongst BAME groups and specifically, the role of family dynamics in determining engagement with services. The authors describe the hierarchical structure which can connect families within a community or extended family. Decisions to access services and support may be made outside of the immediate family unit, therefore, and individual interests may be sacrificed for "the best interests" of the extended family. The authors note that:

> *"Services and professionals must recognise that such decision-making may be based on principles similar to 'best interests', and is not necessarily suppression of the patient's right to consent. However, abuse is not unknown, and professionals must learn the skills to appropriately distinguish between well-meaning assent and unacceptable violation of rights." – p16*

Other barriers include the frictions which can arise from a family's cultural desire for self-reliance and a professional's view of a family being "secretive or difficult"; also issues around family decision makers (often patriarchal) and the mother, who is available to meet with a professional, not wanting to discuss or make decisions affecting a child without the 'decision maker' being present, leading to delays and confusion. Further to this is a cultural fatalism, where some communities believe that disability has roots in punishment, either from a deity, through reincarnation or fate, depending on their cultural upbringing. Such views can lead to an attempt to avoid support services, use prayer as a solution, or to view a disability as a 'confirmation' of a reason to be ashamed in the community. Attempts (often costly) can be made to search for a cure for a disability and the authors suggest that any attempt to steer a family away from these attempts to cure can further widen the gap between families and services.

The authors published four recommendations to improve access and provision:

> *1. Health organisations should have a strategic approach to **meaningful engagement** of the community including those from minority ethnic communities.*
>
> *2. **Providing information** on mental health problems in people with learning disabilities and the local availability of services to minority ethnic communities is vital in improving access. The information provided must be **accessible** and needs to convey an informed and genuine effort at engagement, rather than a merely tokenistic approach.*
>
> *3. Healthcare organisations should try to **understand the barriers** that minority ethnic communities face in relation to the access of mental health services and make efforts to address these.*
>
> *4. A **culturally competent workforce** is vital for the effective delivery of services to a multicultural community. With support, minority ethnic communities could play a vital role in the **development of a culturally competent workforce**.*

These four recommendations are largely transferable to other areas of health and social care provision and can be applied with due consideration to a number of services.

Key points

- People of African Caribbean descent are four times more likely to suffer from glaucoma and South Asian people more likely to have diabetic retinopathy.
- Although there may not be accurate figures available for levels of hearing loss in minority ethnic groups, migrants from areas of high levels of poverty, poor health care and low levels of immunisation against diseases such as rubella, may be more at risk.
- Local knowledge is low and further research could be directed at BAME perceptions of disabilities and how families and services interact.
- The Faculty of the Psychiatry of Learning Disability (Royal College of Psychiatrists) conducted a review of available literature and identified a series of potential barriers to services including communication, cultural views of the roots of disability, extended communities of decision makers who are not necessarily in contact with the professionals.
- The faculty makes four recommendations around improving service access and provision, including meaningful engagement; meaningful information; professionals making efforts to understand barriers and making efforts to overcome these; and lastly, a culturally competent workforce, developed with communities.

Relevant recommendation(s): 3., 4., 5., 6., 7., 8., 9., 10., 11., 12., 13., 14., 15., 16., 18., 19., 20.

Indicator	Outcome
2.17 2.23	Recorded diabetes Self-reported wellbeing
3.3	Population vaccination coverage
4.12 4.13	Preventable sight loss Health related quality of life for older people

4.3 Mental Health

4.3.1 Severe/enduring mental health

The comprehensive adults' mental health needs assessment, conducted in 2014 found that people from Black and minority ethnic groups were more vulnerable to, or were at greater risk of developing, mental health problems:

> *In relation to Black and ethnic minority groups, rates of hospital admission and detention are far higher for people from Black African, Black Caribbean groups, and notably for young men; but there is low identification of some mental health problems amongst Asian women; and there is a high coincidence with ethnic background and many risk factors including deprivation, employment and social exclusion.*
>
> *Overall people from BME groups have greater rates of diagnosis, and are dis-proportionately represented in relation to admission to hospital, have poorer outcomes and may be more likely to disengage from services, but while this is well evidenced in relation to people from Irish and Black Caribbean backgrounds but there is less evidence in relation from Asian minority groups. For example African Caribbean people are three to five times more likely than any other group to be diagnosed and admitted to hospital for schizophrenia.*
>
> *The relationship between ethnicity and mental health is also complex, as BME groups are more likely to live in poverty, have lower educational attainment and have higher rates of unemployment.*

Source: West Sussex Mental Health Needs Assessment (Adults), 2014 - (Extract)[32]

4.3.2 Improving access to psychological therapies (IAPT)

The IAPT programme implements NICE recommendations relating to psychological therapies for people suffering from depression and anxiety disorders. The programme aimed to achieve (by 2015) "secure sustainable and equitable access for at least 15% of the local adult population in need of effective evidence-based psychological therapies and a 50% recovery rate amongst those completing treatment". In a recent health equity audit for West Sussex, Asian and Asian British residents were found to be less likely to access psychological therapies (Table 4.3). This was similar for males and females. - This ethnicity-specific data is not published at a national level, making comparisons difficult.

Table 4.3, Equity of access by ethnicity in West Sussex

Ethnicity	Census population (2011)	IAPT	% seen	Relative Gap (to white uptake rate)
White	634,800	11,991	1.9	100%
Asian / Asian British	22,100	243	1.1	58%
Black / Black British	5,600	92	1.7	88%
Mixed	6,700	121	1.8	95%
Other	2,200	88	3.9	208%

Source: Public Health Research Unit, IAPT Health Equity Audit, 2015[33]
Note: White refers to all white ethnic classifications from the census

[32] WSCC, West Sussex Mental Health Needs Assessment (Adults), 2014
[33] Public Health Research Unit, IAPT Health Equity Audit, 2015

The 2015 health equity audit made two recommendations relating to recording data and targeting at risk groups:

- Improve recording within the service: Improving the completeness of information recording (specifically with respect to ethnicity and sexual orientation) will allow better identification of areas of unmet need. Evidence suggests that this effort could be focussed on individuals who fail to engage with the service.
- Engage population subgroups with low uptake: Areas of unmet need include males, people over 65 years of age, and Asians. Work can be done to identify the barriers that prevent individuals from these groups from accessing the service.

4.3.3 Community views of mental health

The 2015 BAME community engagement focused partly on mental health and described a series of problems in accessing support, and summarising that:

> *In many BAME communities people with mental health problems continue to face stigma. This appears to be particularly the case within Asian and African communities.*

Language was also referenced as a particular barrier to accessing mental health services, as this requires long conversations about internal feelings with a GP and then an English speaking counsellor, which some for whom English is a second language are unable to do.

> *One Polish woman describes how she ended up paying for counselling at a Polish clinic because she could not get counselling in her own language via the GP: 'mental problems are difficult so I can't tell about it in English' – p.21*

Regarding Asian communities the report noted that:

> *In the Indian, Pakistani and Sri Lankan communities, mental health issues often continue to be regarded as a source of shame, especially for the older generation. It is an issue which is 'very much stigmatised'. The Asian community 'refuses to acknowledge mental health problems, partly because back in Sri Lanka, you don't admit things like my son or daughter has a mental health problem'.*

Similar issues regarding mental health were believed to exist in Black African communities, and also a concern about medication being prioritised over higher tier cognitive behavioural therapies. One respondent was quoted as describing suicide as *'a curse on a family',* because of the amount of stigma associated with it in some African countries.

4.3.4 National guidelines

These findings coincide with the national view as seen from the IAPT: Black and Minority Ethnic (BME) Positive Practice Guide[34]. This report identifies a series of barriers including cultural differences and interpretations of mental health issues; cultural/community isolation and lack of awareness; potential language barriers; a lack of understanding of therapies available. - The report also states that:

> *Proper and effective engagement with individuals from BME groups is essential if IAPT services are to meet the needs of the whole community.*

To achieve this engagement and to develop effective and accessible IAPT services, the report makes a series of recommendations which can be applied to West Sussex in the present day:

[34] NHS, Improving Access to Psychological Therapies, 2009: Black and Minority Ethnic (BME) Positive Practice Guide

IAPT: Engaging with BME communities

1) Collaborative working with local community organisations and groups is crucial. The voluntary sector has a history of leading the development of culturally appropriate services for BME groups. IAPT services need to be appropriately diverse, and provided through both statutory and voluntary agencies. Community and faith groups can also offer knowledge about what is effective for specific individuals from BME communities.

2) It is often much easier to consult individuals, voluntary or community groups and organisations that are already known. Investing time and effort in engaging with specific communities with which there had previously been limited contact may be more challenging. However, there are ways of reaching most groups in the community, although some may require additional support in order to engage. Commissioners may need to talk to the target group about the best way to consult and involve them.

3) Ensuring that language-appropriate services are available enables the correct assessment of individuals to be made within a supportive environment. Translated reading material about IAPT services will also raise awareness and promote the use of interpreters and translators within the service. Ways that the language barrier can be removed include:

- *producing leaflets, pamphlets and flyers in languages representing the local community;*
- *providing therapists able to speak other languages; and*
- *ensuring that interpretation and translation services are available.*

4) Commissioners will want to ensure that the location of the IAPT service encourages engagement. A location that offers some form of anonymity would help to engage people who fear the perceived stigma of having mental health problems, or who feel isolated from – or anxious about using – statutory services.

5) Recruiting low-intensity and high-intensity workers from represented BME communities or religious groups should be encouraged. The level of engagement between the therapist and the service-user may be enhanced if there is a shared ethnic or cultural background. Individuals may feel more confident in talking to 'strangers' in their own language, or from the same culture or religious group.

Source: IAPT, 2009. Black and Minority Ethnic (BME) Positive Practice Guide, pp10-12[35]

4.3.5 Suicide

Public Health has conducted periodic suicide audits in the hope of identifying patterns and trends which may enable safeguarding and prevention strategies. The last suicide audit was conducted in 2014, from 2011-12 records. Ethnicity is widely recorded, though of the 115 West Sussex resident suicides in this two year period, 14 were of an 'unknown' ethnicity. Suicides by residents identified as "White Other" were disproportionately high (8%), though with small numbers further data is needed. From 2016, annual suicide audits are to be conducted by the Public Health Research Unit. With long term data, trends may be identifiable in the future.

[35] IAPT, 2009. Black and Minority Ethnic (BME) Positive Practice Guide, pp10-12

Key points

- Previous needs assessments have commented on the link between mental health and risk factors such as low educational attainment/employment, deprivation and social exclusion. This being so we can assume a higher level of risk in some Black/Black British communities where such risk factors are more prevalent. – Specifically African Caribbean people are three to five times more likely than any other group to be diagnosed and admitted to hospital for schizophrenia.

- A health equity audit (HEA) has shown that all minority groups are under-represented per capita in local mental health services, when compared to White British residents. Particularly striking are Asian/Asian British residents (at 58% of the White British take-up).

- The HEA makes two relevant recommendations: that efforts should be made to improve recording of ethnicity and to increase take-up of psychological services amongst minority populations by engaging with communities and investigating perceptions and barriers to services.

- Qualitative evidence suggests that minority communities, particularly form South Asia or Africa, have a less open view of mental health problems, making accepting treatment less likely without concerted efforts to inform opinions.

- Language can be a barrier to receiving treatment as those needing support cannot communicate complex emotive thoughts in English.

- Little appears to have changed since the 2009 IAPT report into developing appropriate and accessible services for residents of minority communities. The IAPT recommendations are therefore still valid today and can work as a starting point for local efforts.

Relevant recommendation(s): 3., 4., 5., 6., 8., 9., 10., 11., 12., 13., 14., 15., 16., 17., 18., 19., 20.

Indicator	Outcome
1.6	Adults with a learning disability / in contact with secondary mental health services who live in stable and appropriate accommodation
1.7	People in prison who have a mental illness or a significant mental illness
1.9	Sickness absence rate
2.8	Emotional well-being of looked after children
2.10	Self-harm
2.23	Self-reported wellbeing
4.9	Excess under 75 mortality rate in adults with serious mental illness
4.10	Suicide rate
4.13	Health-related quality of life for older people

4.4 Chronic illness

Although many of the health issues which affect people in the BAME population are similar to those which affect white British groups, there are certain disease groups where the risks are higher *within* the BAME population, when compared with people classed as white British. These diseases are; diabetes, cancer and cardiovascular disease.

We also know that there are different patterns of these risks *between* BAME groups too. The reasons for the difference in risks are likely to be environmental and biological and some groups will have a higher risk of being affected by certain illnesses than other groups. As with the white British population, ethnic differences vary across age groups, with the greatest variation noted in the elderly. The differences also vary between men and women, and between different generations and geographic area.

4.4.1 Dementia

In 2013, the all-party parliamentary group on Dementia published the comprehensive report 'Dementia does not discriminate: The experiences of Black, Asian and minority ethnic communities'[36]. This report included the headline finding that:

> *"…there are tens of thousands of people living with dementia every day who are not getting the services they are entitled to. And disproportionately it is people from Black, Asian and minority ethnic (BAME) communities who are being failed by the system." – p5*

The report provides an estimate that there are roughly 25,000 people with dementia in England and Wales from BAME communities and (due to the currently younger age profile of BAME residents) this is projected to rise seven-fold to 127,000 by 2051. Importantly, the report acknowledges that it does not use figures from the 'White Other' census group. Seeing as this is West Sussex's largest BAME cohort, future estimates will need to take account of this.

Regarding risk factors, the report finds that:

> *"It is likely that dementia is more common among Asian and Black Caribbean communities. This is because high blood pressure, diabetes, stroke and heart disease, which are risk factors for dementia, are more common among Asian and Black Caribbean communities. These are modifiable risk factors and preventative work is vital to reduce significantly the burden of dementia among BAME communities." – p10*

A series of recommendations were also drawn up sounding key areas:

Raising awareness; with community-level campaigns co-designed by community and faith groups, with school-level campaigns to educate children, and also through existing dementia organisations to reach those with dementia and their carers.

Preventative work; specifically targeted at people from Asian and Black Caribbean communities, and CCGs should look at linking practice between dementia services and stroke services in areas of high BAME populations.

Local knowledge; LAs and CCGs should ensure that the Joint Strategic Needs Assessment (JSNA) includes information on the numbers of people from BAME communities, their age profile and the resulting estimates of people with dementia, as well as assessing access to services and existing barriers.

[36] The all-party parliamentary group on Dementia, 2013, 'Dementia does not discriminate: The experiences of Black, Asian and minority ethnic communities

Share good practice; with the DH mapping out support services for those with dementia in the BAME community and also the Social Care Institute for Excellence (SCIE) should act as a hub for an online library of good practice.

Improve local access to services; including Health and Wellbeing Boards encouraging joined up working, local Health Watch ensuring they are accessible, reaching out to diverse communities and tailoring services to meet needs where necessary.

Improve knowledge and skills; with guidance from the Royal college of General Practitioners to improve diagnosis rates amongst BAME groups, and training for all providers to ensure culturally sensitive care.

Access to the West Sussex Memory Assessment Service (MAS) for dementia support is covered in Section 5.

4.4.2 Cardiovascular disease

It is know that broadly, South Asian people living in the UK have a much higher incidence of heart attack and premature death than their white British counterparts (46% higher for men; 51% higher for women). In addition, men born in the Caribbean are 50% more likely to die from stroke than the general population. However, they do enjoy lower mortality from coronary heart disease (Tidy, 2014)[37]. Socio-economic status and lifestyle factors may have a significant influence on health (Kandula et al., 2013)[38]. Cardio-vascular disease is a particular concern in South Asian populations, who are more likely to eat a diet which is linked with an increased risk of cardio-vascular disease and less likely to engage in physical activity. We also understand that important cultural and religious beliefs impact on healthy lifestyle choices.

Of particular concern is that as well as these factors, people from BAME groups are more likely to encounter barriers to diagnosis, receive lower quality care, and experience poorer health outcomes (Ski et al., 2014, Lepièce et al., 2014)[39, 40]. This may be because members of BAME groups are more likely to display significantly different patterns of symptoms, but may also be because of other barriers, which are discussed within this report.

4.4.3 Diabetes

The prevalence of diabetes is higher in people from BAME groups (Chandler and Monnat, 2015)[41]. Type 2 diabetes in particular, is six times more prevalent in South Asians and three times more prevalent in African and African-Caribbean populations when compared to white British cohorts (Stratton et al., 2000)[42]. One of the key factors to consider here is the role of genetics (Vann, 2012)[43]. Obesity is a particular problem among south Asian groups, due to differences in the distribution of body fat, which increases the propensity for developing insulin resistance. This, combined with the factors outlined above, increase the risk of type 2 diabetes and gestational diabetes (diabetes in pregnancy) in South Asian groups within the UK, as well as increasing risks of illness and death from these conditions.

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37 TIDY, C. 2014. Epidemiology of Coronary Heart Disease
38 KANDULA, R., et al., 2013. The South Asian Heart Lifestyle Intervention (SAHELI) study to improve cardiovascular risk factors in a community setting: design and methods. Contemporary clinical trials, 36, 479.
39 LEPIÈCE, B., REYNAERT, C., VAN, M. P. & LORANT, V. 2014. General practice and ethnicity: an experimental study of doctoring. BMC family practice, 15, 89.
40 SKI, C. F., KING-SHIER, K. M. & THOMPSON, D. R. 2014. Gender, socioeconomic and ethnic/racial disparities in cardiovascular disease: A time for change. International Journal of Cardiology, 170, 255-257.
41 CHANDLER, R. & MONNAT, S. 2015. Racial/ethnic differences in use of health care services for diabetes management
42 STRATTON, I., et al. 2000. Association of glycaemia with macrovascular and microvascular complications of type 2 diabetes (UKPDS 35): prospective observational study. British Medical Journal, 321, 405/412.
43 VANN, M. 2012. How ethnicity affects type 2 diabetes risk

4.4.4 Cancer

The overall incidence of cancer is significantly lower in BAME groups. There are some types of cancer more common in some BAME groups. Mouth cancers more common among south Asians; liver cancer is higher among Bangladeshi and Chinese people, and African-Caribbean men are around three times more likely to develop prostate cancer (Cancerequality, 2015)[44]. Black groups have significantly higher rates of multiple myeloma, stomach, liver, cervical and prostate cancer. This may be partly due to barriers among BAME groups to engaging with screening programmes (Martins et al., 2015, Marlow et al., 2015)[45, 46] where negative experiences, embarrassment and lack of awareness are considered to play a role (Mundasad, 2014)[47]. In terms of disease survival, while breast cancer survival is lower among BAME groups, they do experience improved survival from lung cancer (Cancer Research UK 2014)[48].

4.4.5 Dual diagnosis

A dual diagnosis needs assessment was conducted in 2014, though ethnic minorities did not feature highly as a subject. However, BAME groups were cited by Sussex Partnership Foundation Trust as presenting with a higher instance of co-occurring mental health and alcohol/drug problems. Residents from ethnic minority communities were cited by the authors as a cohort who is not sufficiently catered for by the range of services available in West Sussex.

Included was a reference to the charity, Time to Change, which has national programmes designed to end mental health discrimination by *"Focusing work with Black and Minority Ethnic communities, starting with African and Caribbean audiences." – p135*[49]

No specific recommendations were drawn regarding BAME groups, though attention can be drawn here in future.

[44] CANCEREQUALITY. 2015. Ethnic Minority Cancer Awareness Month
[45] MARTINS, T., et al. 2015. Ethnic differences in patients' preferences for prostate cancer investigation: A vignette-based survey in primary care. British Journal of General Practice, 65, e161-e167.
[46] MARLOW, L., WALLER, J. & WARDLE, J. 2015. Barriers to cervical cancer screening among ethnic minority women: A qualitative study. Journal of Family Planning and Reproductive Health Care, 41, 248-254.
[47] MUNDASAD, S. 2014. Cancer awareness 'low in black and South Asian groups'
[48] CANCER RESEARCH UK. 2014. Cancer Incidence by Major Ethnic Group
[49] Figure 8 Consultancy Services, 2014, West Sussex alcohol and drug needs assessment

Key points

- The all-party parliamentary group on Dementia predicts that, due to current age profiles of BAME groups, the number of those with dementia will increase seven fold by 2051, from 25,000 to 127,000 nationally.
- It is likely that dementia is more common among Asian and Black Caribbean communities, because high blood pressure, diabetes, stroke and heart disease, which are risk factors for dementia, are more common among Asian and Black Caribbean communities
- Recommendations around raising awareness; preventative work; sharing local knowledge and good practice; improving accessibility and knowledge and skills, were developed by the all-party parliamentary group.
- The risks of developing diabetes, cancer and cardiovascular disease are higher within some minority ethnic groups when compared with people classed as white British. These differences depend on many factors of lifestyle and demographics, as well as age.
- Broadly, South Asians have a much higher incidence of heart attack and premature death than white British counterparts; Men born in the Caribbean are 50% more likely to die from stroke than the general population; Type 2 diabetes is six times more prevalent in South Asians and three times more prevalent in African and African-Caribbean populations; genetic differences in the distribution of fat in South Asians also increase risk.
- Cancers are generally higher in White British groups, for a range of reasons; however, there are many exceptions to this, when looking at individual cancers or specific ethnic groups.
- BAME groups have been cited as presenting with a higher instance of co-occurring mental health and alcohol/drug problems, locally.
- People from BAME groups are more likely to encounter barriers to diagnosis, receive lower quality care, and experience poorer health outcomes.

Relevant recommendation(s): 3., 4., 5., 6., 8., 9., 10., 12., 13., 14., 15., 16., 17., 18., 20.

Indicator	Outcome
1.8	Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services
2.11	Diet
2.12	Excess weight in adults
2.14	Smoking prevalence – adults (over 18s)
2.16	People entering prison with substance dependence issues who are previously not known to community treatment
2.17	Recorded diabetes
2.18	Alcohol-related admissions to hospital
2.19	Cancer diagnosed at stage 1
2.20	Cancer screening coverage
2.21	Access to non-cancer screening programmes
4.3	Mortality rate from causes considered preventable
4.4	Under 75 mortality rate from all cardiovascular diseases
4.5	Under 75 mortality rate from cancer
4.6	Under 75 mortality rate from liver disease
4.7	Under 75 mortality rate from respiratory diseases
4.11	Emergency readmissions within 30 days of discharge from hospital
4.12	Preventable sight loss
4.13	Health-related quality of life for older people
4.16	Estimated diagnosis rate for people with dementia

4.5 Carer status

There are approximately 84,400 carers in West Sussex, an increase of 14% over the last 10 years. The largest growth in total number of carers was in the highest unpaid care category, fifty or more hours per week. There was an increase of over 4,000 carers in this category, an increase of nearly one third since 2001 (32.5%). West Sussex has a higher proportion of carers compared to the South East or England due to the relatively older population in West Sussex.[50]

The Carers Support Service reports that there are gaps in statistics available until consistent data monitoring began in 2013 when Carers Support West Sussex was formed. Since 2013 the ethnicity of over 5000 carers is now known in West Sussex and 5% of new carers registered are from BAME communities. Ethnicity data for registered carers available to the WSCC Research Unit and Performance team to conduct the carers survey 2014/15 was found to be insufficient, with the ethnicity of nearly 45% of carers not recorded.

There are 3,823 young carers and young adult carers aged 0-24 years in West Sussex, an increase of nearly one third (32%) since 2001. Young carers are one and a half times more likely than their peers to be from minority ethnic backgrounds and are twice as likely to not speak English as their first language.

Nationally, the 2011 census showed that those from minority ethnic groups were not more likely to provide unpaid care, per capita, when compared to the general population. Those from 'Other White' backgrounds were the least likely to provide unpaid care, probably due to their younger (working age) demographic profile.

In West Sussex, census data indicates that the highest proportion of carers identify themselves as being of White British ethnicity (93%), with only 7% of those providing unpaid care identifying themselves from an ethnic minority group. Of those BAME carers, 36% were of an Asian/Asian British ethnicity, 33% were 'White Other' 11% was of mixed/multiple ethnic group, 7% were Black/African/Caribbean/British and 2% were of an 'Other' ethnic group.

Table 4.4, Provision of unpaid care in West Sussex

	Provides no unpaid care		**1 to 19 hours a week**		**20 or more hours a week**		**Provides unpaid care total**	
	Number	(%)	Number	(%)	Number	(%)	Number	(%)
All categories	722,495	89.5	58,320	7.2	26,070	3.2	84,395	10.5
White British	639,360	89.1	54,520	7.6	23,670	3.3	78,195	10.9
White Irish	5,265	88.0	470	7.9	245	4.1	715	12.0
White Other	30,945	93.9	1,275	3.9	755	2.3	2,025	6.1
Mixed/multiple ethnic group	11,480	94.4	460	3.8	215	1.8	675	5.6
Asian/Asian British	26,125	92.2	1,275	4.5	940	3.3	2,210	7.8
Black/African/Caribbean/Black British	6,725	94.1	245	3.4	180	2.5	425	5.9
Other ethnic group	2,600	94.2	85	3.1	70	2.5	155	5.6

Source: ONS, 2011 Census

[50] Public Health West Sussex, 2013, Looking Out for Carers in West Sussex

Key points

- West Sussex has a higher proportion of carers compared to the South East or England due to the relatively older population in West Sussex
- Young carers are one and a half times more likely than their peers to be from minority ethnic backgrounds and are twice as likely to not speak English as their first language. The number of Young carers in West Sussex has increased by 32% between censuses.
- In West Sussex, 7% of carers identify as from a minority ethnic group, though this will likely increase as population ages align with those of the general population.

Relevant recommendation(s): 3., 4., 5,. 6., 8., 9., 10., 12., 13., 20.

Indicator	Outcome
2.23	Self-reported wellbeing
2.24	Injuries due to falls in people aged 65 and over
4.13	Health-related quality of life for older people
4.14	Hip fractures in people aged 65 and over
4.15	Excess winter deaths

4.6 Dental health

Nationally, residents from ethnic groups other than White are less successful in a securing a dental appointment than White residents. Though in Coastal West Sussex and Crawley CCG areas, there is little difference in access, there is a 10% shortfall in Horsham and Mid Sussex CCG area. Though these numbers are small, there is no further data available on dental health services.

Table 4.5, Access to NHS dentist, tried to get an appointment in the last two years, by CCG

	Tried to get an appointment in the last two years			**Percentage successful in getting an appointment**		
	Total response (weighted)	White	Other ethnicity	All	White	Other ethnicity
England	248,770	217,950	30,820	93.1%	94.2%	85.1%
NHS Coastal West Sussex	2,040	1,985	55	92.1%	92.1%	91.2%
NHS Crawley	525	435	90	92.2%	92.9%	90.9%
NHS Horsham and Mid Sussex	1,015	975	40	95.1%	95.5%	85.4%

Source: GP Patient Survey dental results, January to March 2015

Participants of the 2015 community engagement were asked for their views on dental care and though perceptions were mixed, the authors identified some trends and similarities in responses, particularly amongst foreign nationals:

> *Many residents reported returning to their home country in order to access dentist services. Trips are rarely made for this specific reason, but the opportunity to visit a dentist is usually taken during other visits. Reasons for accessing services elsewhere range from a lack of trust in UK dentistry, to price and experience. I wait 'til I go to Uganda, it's much cheaper there. We do have alternatives [to the UK system]' (Female, Ugandan, 25–64)*
>
> *Eastern European residents in particular feel that you receive "VIP treatment" at home for the same price as basic care in the UK. Certain procedures are also far more available and affordable in Eastern Europe than the UK. The same is true to some extent among Asian communities but trips 'home' tend to be less frequent. Many spoke about the relationship they have with their family dentist from back home, with one Italian man stating that he returns home to Italy 'four times a year' and twice a year goes to visit the same dentist who has taken care of his teeth since he was a child (Male, Italian, 25–64). Whilst the tendency to go abroad for dentistry is particularly pronounced in the Eastern European community it did present across communities. – p19*

Key points

- Dental health service user data is not widely available, though when surveyed residents from BAME groups were somewhat less able to access dental services; and particularly so in Horsham and Mid Sussex.
- Perceptions of English dental care services are mixed amongst BAME groups, but foreign nationals, who are accustomed to other systems, generally think that English dentistry is poor in comparison to their home countries, whether they be in South Asian, East Asia or Eastern Europe.

Relevant recommendation(s): 3., 7., 8., 9., 10., 13., 14., 18., 20.

Indicator	**Outcome**
2.11	Diet
4.2	Tooth decay in children aged 5

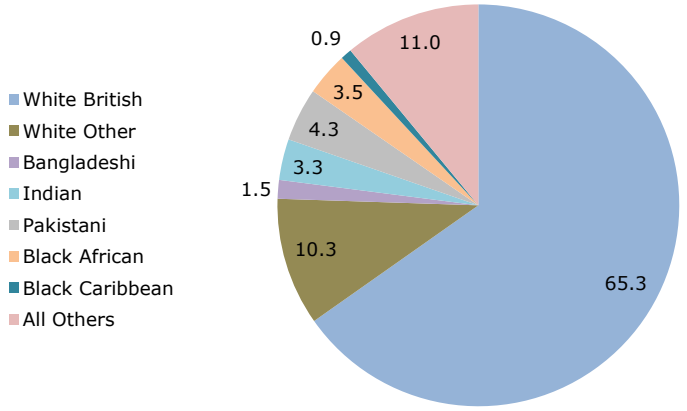
4.7 Pregnancy, maternal and infant health

4.7.1 Live births and fertility

Whilst White British residents account for 80% of the England population, they only account for 65% of live births and 68% of all pregnancy terminations nationally (Figure 4.2). Though this is partially explained by a historically lower birth rate amongst UK-born women, the difference between these two has been narrowing in recent years (Figure 4.3) and the disproportionate births could be explained by the younger population profiles seen in *section 1*. – These values are not available at a local level.

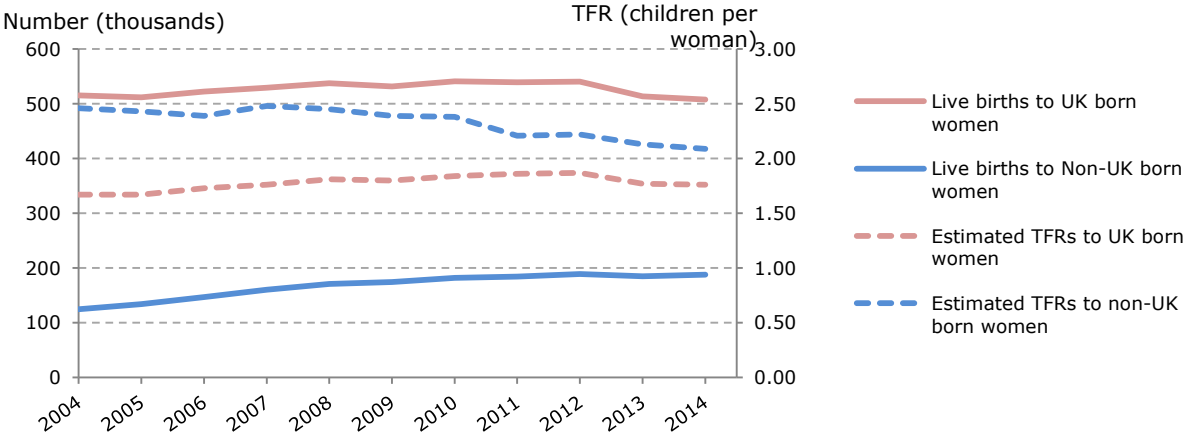
Those from White British backgrounds and mixed ethnic backgrounds are more likely to have children younger than those from other minority groups. Figure 4.4 shows England-wide births in NHS hospitals and 4.9% of mothers from mixed backgrounds giving birth in 2014-15 were under the age of 20 and a total of 23.5% were under the age of 25 (double the proportion of mothers from other ethnic minority backgrounds).

Figure 4.2, Percentage of total live births by each ethnic group, England and Wales, 2014



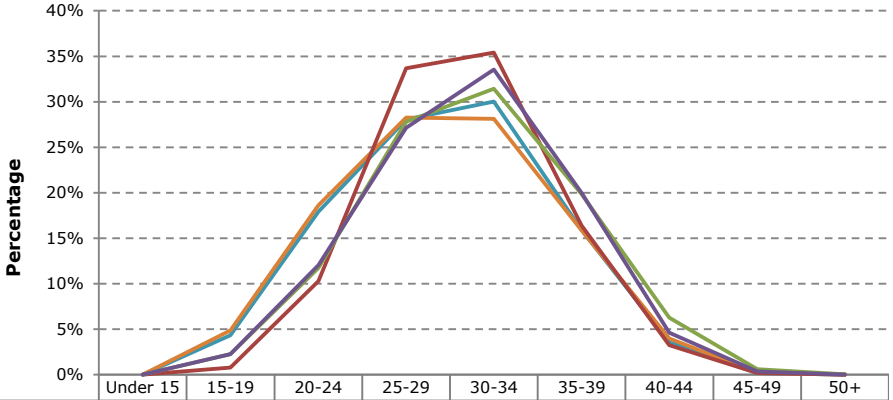
Note: 'All others' include Chinese, Other Asian, Other Black, Other, and all Mixed groups.
Source: ONS (2015), Live births by ethnic group, England and Wales, 2014

Figure 4.3, Estimated total fertility rates and number of live births to UK born and non-UK born women, England and Wales, 2004 to 2014



Source ONS (2015), Births in England and Wales by Parents' Country of Birth, 2014

Figure 4.4, Live births in each age band for wider ethnic groups (NHS hospitals, England 2014/15)



	Under 15	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50+
White	0.0%	4.3%	17.9%	28.0%	30.0%	15.9%	3.6%	0.2%	0.0%
Mixed	0.0%	4.9%	18.6%	28.3%	28.1%	15.9%	4.0%	0.2%	0.0%
Asian	0.0%	0.8%	10.3%	33.7%	35.4%	16.4%	3.2%	0.2%	0.0%
Black	0.0%	2.3%	11.7%	27.8%	31.4%	19.9%	6.3%	0.6%	0.0%
Chinese / Other	0.0%	2.3%	12.1%	27.1%	33.5%	20.0%	4.6%	0.4%	0.0%

Source: HSCIC Statistical Release (2015)

In West Sussex, Crawley has the highest percentage (39%) of live births to mothers born outside of the UK, with roughly a third of these coming from EU countries and roughly a third coming from the Middle East and Asia (Table 4.6). In Arun district two thirds of the new births from non-UK born mothers in 2014 (and one in six of all births) were by mothers from new EU member states (predominantly Eastern Europe). If the language issues described in *Section 1* continue over to issues surrounding maternity then there is a risk of failing to communicate effectively with women during pregnancy and labour. This poses significant challenges for midwifery services in areas with high migration. This issue was discussed by some respondents of the community engagement and the authors found that:

> *Many women have given birth in the UK and this is an instance where quality and safety of care can be severely compromised if language is a problem, especially if 'technical terms' are not understood. Several reported that their partners had needed to interpret during labour and that this was very stressful for all parties – p.18*

Table 4.6, Live births, country of birth of mother and area of usual residence, 2014

Area of usual residence of mother	**All live births**	Mothers born within United Kingdom	Mothers born outside United Kingdom					
			Total (%)	EU	(Including New EU*)	Rest of Europe (non EU)	Middle East and Asia	Africa	Rest of World
Adur	**692**	605	87 (13%)	29	(19)	5	31	13	9
Arun	**1,463**	1,176	287 (20%)	210	(186)	9	37	14	17
Chichester	**1,060**	886	174 (16%)	84	(45)	9	36	19	26
Crawley	**1,618**	993	625 (39%)	213	(153)	20	232	139	21
Horsham	**1,229**	1,055	174 (14%)	82	(41)	14	34	20	24
Mid Sussex	**1,521**	1,251	270 (18%)	120	(72)	13	72	28	37
Worthing	**1,136**	928	208 (18%)	87	(60)	15	67	30	9
West Sussex	**8,719**	6,894	1,825 (21%)	825	(576)	85	509	263	143

Note: New EU includes those nations who joined the EU in 2004 or after
Source: ONS (2015), Parents' country of birth, 2014

4.7.2 Unplanned pregnancies and terminations

In 2014, women from minority ethnic groups accounted for 30% of legal abortions in England and Wales, despite only making up 20% of the UK population (Table 4.7). Over a ten year period, these levels have remained broadly consistent. Some of this may be a result of the lower population age of these groups, described in *Section 1*; however this appears to be in contrast to a cultural aversion to abortion, traditionally associated with minority cultures and particularly those with strong religious backgrounds,

such as Islam. The specific rises in abortion rates for any given ethnic group do appear to match their age profile, with respect to the general population. For example legal abortions amongst mixed ethnic groups are higher under the age of 35 years, reflecting the younger second generation inter-relationships of diversifying groups; whilst abortions amongst White Other groups are lower amongst the under 20s, but much higher in the '20 to 34 years' and '35 years and over' brackets, as this represents the working age of many Europeans in the population.

Specifically, the cultural aversion to abortion in many Asian and Arab communities does go against the statistical rates being higher than the per-capita; one would expect the figures to be lower. Whilst it could be hypothesised that legal abortion rates are affected by gender-selective abortions (where a female foetus is aborted, as male children are more preferable to the family), the DH published a full investigation in gender birth rates and found that "*analyses by country of birth and ethnicity do not offer evidence of sex selection taking place within England and Wales*"[51]. More plausible is the issue of abortions for pregnancies out of wedlock, where an abortion is sought in order to avoid pressures to marry or shame from senior family members. In England and Wales, roughly 80% of abortions are for unmarried women, though two thirds of these are currently in relationships with their partner, and though these figures are not available by ethnicity, it is possible that they transfer to the Asian and Arab communities. In such cases, those seeking such abortions may be more vulnerable than those in the general population, as they would lack traditional family or social support networks.

A further possibility is that of co-sanguinity, where marriage between extended family members produces a higher rate of genetic abnormalities, resulting in abortions.

Further research could be directed here, to investigate the highly sensitive issues surrounding abortions in these communities. Regarding multiple abortions, women from Black or Mixed ethnic backgrounds were more likely to have had one or more previous abortions than those from the general population[52], putting them at more risk of health risks associated with carrying out an abortion (Table 4.8).

Table 4.7, Legal abortions in England and Wales, by age and ethnicity

	All ages		Under 20		20-34		35 and over		*(Percentage of regular population)*
	no.	**%**	no.	**%**	no.	**%**	no.	**%**	**%**
White: British	121,155	***67.8***	21,120	***79.6***	83,555	***66.9***	16,480	***60.5***	***79.8***
White: Irish	820	***0.5***	70	***0.3***	590	***0.5***	160	***0.6***	***1.0***
White: Other White	15,785	***8.8***	1,090	***4.1***	11,625	***9.3***	3,070	***11.3***	***4.7***
Mixed ethnic group	6,050	***3.4***	1,165	***4.4***	4,360	***3.5***	530	***1.9***	***2.2***
Asian: Indian	6,375	***3.6***	275	***1.0***	4,705	***3.8***	1,395	***5.1***	***2.6***
Asian: Pakistani	3,825	***2.1***	265	***1.0***	2,790	***2.2***	775	***2.8***	***2.1***
Asian: Bangladeshi	1,685	***0.9***	185	***0.7***	1,190	***1.0***	315	***1.2***	***0.8***
Asian: Other Asian	4,350	***2.4***	280	***1.1***	3,010	***2.4***	1,060	***3.9***	***1.5***
Black: Caribbean	4,540	***2.5***	670	***2.5***	3,220	***2.6***	645	***2.4***	***1.1***
Black: African	9,295	***5.2***	970	***3.7***	6,520	***5.2***	1,805	***6.6***	***1.8***
Black: Any other	775	***0.4***	115	***0.4***	540	***0.4***	120	***0.4***	***0.5***
Chinese	1,685	***0.9***	105	***0.4***	1,245	***1.0***	335	***1.2***	***0.7***
Any other ethnic group	2,400	***1.3***	225	***0.8***	1,615	***1.3***	560	***2.1***	***1.0***
Not known/not stated	5,825	**-**	920	**-**	4,025	**-**	880	**-**	**-**

Source: Department of Health (2015), Abortion statistics, England and Wales

[51] DH, 2014, Birth Ratios in England and Wales: A report on gender ratios at birth in England and Wales
[52] DH, 2014, Abortion Statistics, England and Wales

Table 4.8, Percentage of women who had one, two and three or more previous abortions, by ethnic group

	1	2	3 or more
White	27%	7%	2%
Mixed	31%	11%	4%
Asian or Asian British	26%	6%	2%
Black or Black British	32%	11%	5%
Chinese	22%	5%	2%
Any other ethnic group	25%	8%	3%
Not known/not stated	23%	6%	2%
All women	27%	8%	3%

Source: Department of Health (2014), Abortion statistics, England and Wales

4.7.3 Maternal and perinatal health

Evidence consistently shows that women from BAME are over-represented in the numbers of women dying or experiencing serious complications during pregnancy, childbirth and in the post-natal period. We also know that the infants of women from BAME populations are also at a greater risk of dying or becoming ill in the postnatal period. The most recent report published by the Maternal, Newborn and Infant Clinical Outcome Review Programme[53], suggests that rates of maternal mortality are higher amongst women from some ethnic minority groups. There are additional socio-economic characteristics known to increase risks of poor outcomes, however ethnicity remains a key factor.

Table 4.9, Maternal Deaths by ethnicity

Ethnic Group	Total maternities	Total deaths	Rate per 100,000 maternities	95% confidence interval	Relative risk (RR)	95% confidence interval
White	1,582,626	123	7.8	6.5 - 9.3	1 (ref)	-
Indian	63,524	7	11.0	4.4 - 22.7	1.42	0.56 – 3.01
Pakistani	81,759	13	15.9	8.5 – 27.2	2.05	1.06 – 3.63
Bangladesh	27,297	4	14.7	4.0 – 37.5	1.89	0.51 – 4.95
Other Asian	57,295	4	7.0	1.9 – 17.9	0.90	0.24 – 2.36
Caribbean	19,690	4	20.3	5.5 – 52.0	2.61	0.70 – 6.86
African	67,047	19	28.3	17.1 – 44.3	3.65	2.12 – 5.94
Others/ mixed	103,524	6	5.8	2.1 – 12.6	0.75	0.27 – 1.67

Source: Saving Lives, Improving Mothers' Care Surveillance of maternal deaths in the UK, 2011-13

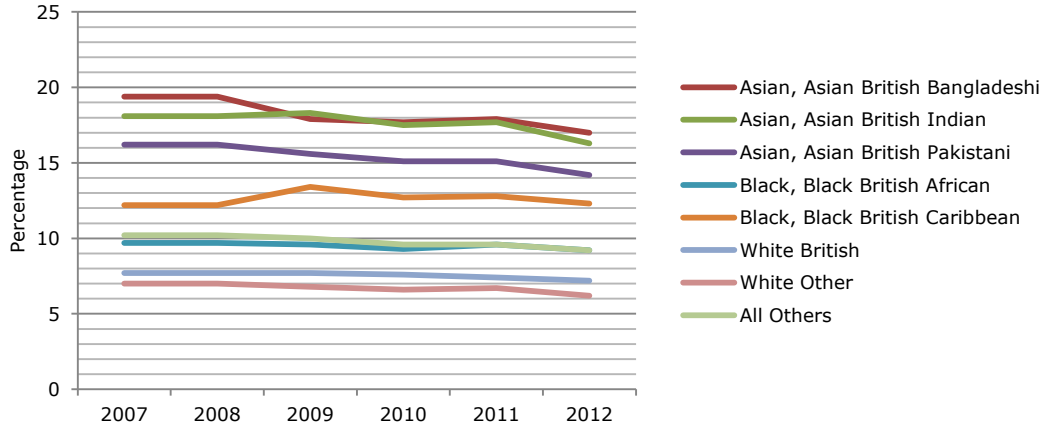
Specifically those who are of African origin are three times more likely to die than their white counterparts. It should be noted that the confidence intervals are wide, and with the exception of the Pakistani and black African groups, the relative risks are not statistically significant. This is due to the fact that maternal deaths continue to be rare, relative to the overall numbers of maternities.

The reasons for the disparity in outcomes are not clear, but are likely to be due to barriers in accessing appropriate and high quality healthcare, due to a number of issues such as language barriers and other cultural/ethnic and institutional factors.

[53] 'Saving Lives, Improving Mothers' Care Surveillance of maternal deaths in the UK 2011-13 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-13'

4.7.4 Low birth weights

Figure 4.5, Per cent Small for Gestational Age, by ethnicity 2007-2012



Note[1]: Small for Gestation Age (SGA) denotes those whose birth weight lies below the 10th percentile for each gestational age.
Note[2]: Figures for 2007/08 were reported together in the ONS source and cannot be separated
Source: ONS Revised Gestation-specific infant mortality in England and Wales 2007-2012

4.7.5 Still births

Although there is no ethnic data available locally pertaining to the rates of stillbirth and neonatal death among the various ethnic groups, it is worth noting that Public Health England have reported that mothers from Asian backgrounds are 1.5 times more likely to experience still birth.

The most recent report, 'MBRRACE-UK 2015 Perinatal Confidential Enquiry Term', explains that one of the major maternal characteristics identifiable at booking associated with the risk of stillbirth include Black race/ethnicity (Adjusted OR = 2.1) [54]. Therefore the risk of having a baby stillborn is twice that of the white (reference) population.

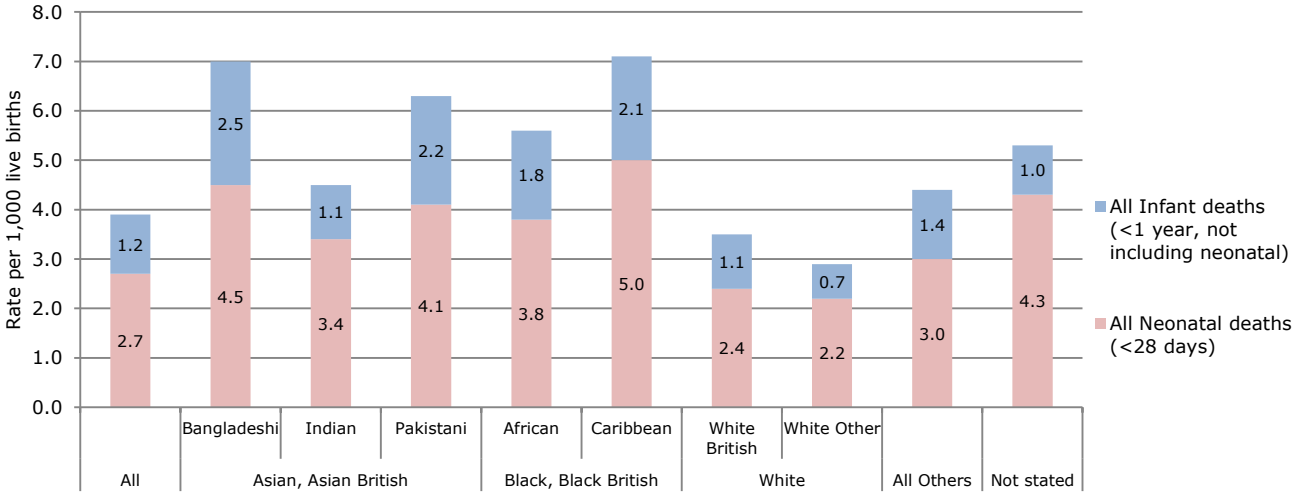
This report specifically highlights that gestational diabetes is higher in ethnic groups and half of all cases in ethnic groups at high risk of gestational diabetes were untested. This might be due to the reasons suggested above. Reasons for this level of testing were not made clear in this report. It is reasonable to assume that those factors which repeatedly prove to be barriers to people in ethnic groups accessing appropriate high quality care may influence this.

4.7.6 Cause of infant death

Risk factors for infant mortality are similar to the risk factors for low birth weight, such as smoking, alcohol and substance misuse in pregnancy, domestic violence, maternal mental health, and deprivation. The Marmot review found that in a study of all infant deaths in England and Wales (excluding multiple births), deprivation, births outside marriage, non-white ethnicity of the infant, maternal age under the age of 20 and male gender of the infant were all independently associated with an increased risk of infant mortality[55]. These may explain the increase in infant deaths seen in Black African/Caribbean and Pakistani/Bangladeshi communities, seen in Figure 4.6. Specifically, those form Bangladeshi and Black Caribbean ethnic backgrounds have twice the rate of infant deaths as White British mothers. More direct factors for this may be the higher level of congenital abnormalities in infants of Asian/Asian British mothers and the higher level of immaturity-related conditions in infants of Black Caribbean/British mothers (Table 4.10).

[54] 'MBRRACE-UK, 2015, Perinatal Confidential Enquiry Term, singleton, normally-formed, antepartum stillbirth
[55] M. Marmot, 'Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England Post 2010', in Marmot review (London: Institute of Health Equity, 2010).

Figure 4.6, Rate of neonatal and infant deaths by ethnicity, England and Wales, 2012



Source: ONS (2015), Revised gestation-specific infant mortality In England and Wales, 2012 tables

Table 4.10, Infant mortality by ONS cause groups and broad ethnic group, England and Wales, 2012

	All categories		Asian		Black		White		Mixed, Chinese & any other ethnic group		Ethnicity not stated	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Immaturity related conditions	1235	44%	155	38%	120	55%	790	43%	105	44%	65	50%
Congenital anomalies	870	31%	165	41%	55	25%	530	29%	75	31%	45	35%
Asphyxia, anoxia or trauma (intrapartnum)	175	6%	20	5%	10	5%	125	7%	10	4%	10	8%
Sudden infant deaths	155	5%	10	2%	10	5%	120	7%	15	6%	-	0%
Infections	125	4%	20	5%	5	2%	90	5%	10	4%	5	4%
Antepartnum infections	50	2%	5	1%	5	2%	35	2%	5	2%	-	0%
External conditions	30	1%	-	0%	-	0%	25	1%	-	0%	-	0%
Other specific conditions	25	1%	5	1%	-	0%	15	1%	-	0%	-	0%
Other conditions	165	6%	30	7%	10	5%	100	5%	20	8%	5	4%
All infant deaths	**3,080**	**100%**	**420**	**100%**	**285**	**100%**	**1,985**	**100%**	**220**	**100%**	**180**	**100%**

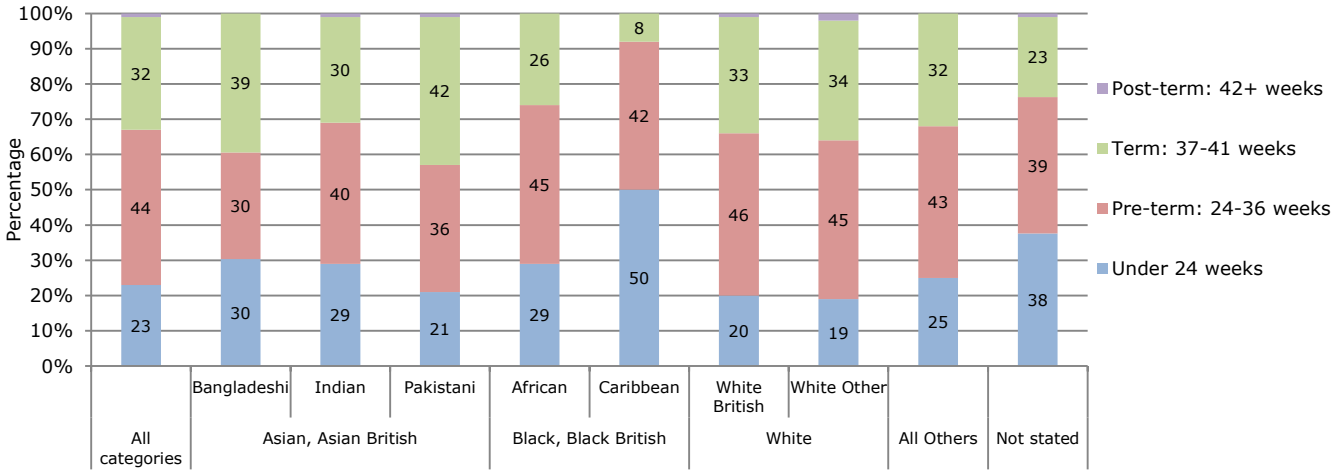
Source: ONS (2015), Revised gestation-specific infant mortality In England and Wales, 2012

The numbers of unexplained deaths in infants of women born outside the UK are significantly fewer than those born in the UK. In 2013, the unexplained infant death rate was 0.41 per 1,000 live births for babies of mothers born in England and Wales and 0.22 for babies of mothers born in other countries.

This reflects the difference in relative rates of maternity, however, and so therefore it remains unclear as to whether ethnicity is a risk factor for unexplained deaths in infancy. Recent statistics show that in 2013 the rate of unexplained infant deaths for low birthweight babies (less than 2,500 grams) was 1.04 deaths per 1,000 live births. This is more than three times higher than babies whose birthweight was 2,500 grams and over (0.3 deaths). We can see from the graph above that some ethnic Asian groups are over-represented in those women who have low birthweight babies and this may go some way to explain why the rate in this particular ethnic group is greater than those in other groups.

There is some evidence to suggest that ethnicity may be a protective factor, however, this research was carried out in countries other than the UK, which may affect the generalisability of these findings. The mothers of Black Caribbean background had a much higher rate of premature births (those births occurring up to 36 weeks after conception), representing a high-risk group.

Figure 4.7, Gestation period for births resulting in infant deaths, by ethnicity, 2012



Source: ONS (2015), Revised Gestation-specific infant mortality In England and Wales, 2012 tables

4.7.7 Breast feeding

Across the UK, the highest incidences of breastfeeding were from minority ethnic groups, with 97% for Chinese or other ethnic groups, 96% for Black and 95% for Asian ethnic groups in 2010[56]. The initial breastfeeding rate for all mothers across the UK was 81%. For mothers under the age of 20, however, this drops sharply, to 56%. Similarly, mothers who finished education at age 16 were far less likely to initiate breastfeeding (63%) than those who continued past age 18 (90%). Though causation is not established, these go a little way in linking local White British mothers, who tend to have children younger and tend to be less qualified (on average) than BAME mothers, to a lower likelihood of initiating breast feeding. A five year update on these figures is expected in 2016.

A recent national study (2013)[57] investigated which factors were associated with breastfeeding in England found that mothers outside of London were far less likely to breastfeed (at all) at 6-8 weeks; a factor mainly attributed to the large BAME populations of London CCGs (mean population, 40%). Nationally, mothers in deprived areas, mothers under the age of 20 years and mothers who smoked at delivery were all less likely to breastfeed, whilst mothers aged over 35 years and mothers from minority communities were far more likely to breastfeed at their 6-8 week check-up. Importantly, the positive effect of ethnic diversity in a population outweighed other negative factors, such as deprivation or young maternal age. The report concluded that:

> *Outside London, the proportion of the PCT population from a BME background was associated with breastfeeding, with a unit increase in BME population resulting in a 1–3% increase in the odds of breastfeeding. Non-white ethnicity has consistently been linked to increased breastfeeding in individual level studies, although there is some variation between individual ethnic groups and by acculturation status. The existing literature suggests that the strongest overall effect of ethnicity is on initiation and continuation, with minimal differences by ethnicity in the number of women who breastfeed exclusively*

Locally, in West Sussex, roughly 40% of mothers continue to breastfeed at 6-8 weeks, which is slightly lower than the national 45%, though this is in line with the above view that areas of higher White British populations will have lower breastfeeding rates across the population.

[56] HSCIC – Infant Feeding Survey UK 2010 (released Nov-2012)

[57] Oakley LL, Renfrew MJ, Kurinczuk JJ, et al. Factors associated with breastfeeding in England: an analysis by primary care trust BMJ Open 2013;3: e002765. doi:10.1136/ bmjopen-2013-002765

4.7.8 Drug and alcohol use in pregnancy and breastfeeding

The Infant Feeding Survey collects retrospective data from new mothers on drinking behaviour before, during and after pregnancy. In 2010, 41% of mothers reported that they drank alcohol during their pregnancy in England. This compares to 55% of mothers in 2005. Mothers from a White ethnic background were more likely to drink alcohol before and during their pregnancy than any other ethnicity (46%). Evidence to suggest why this is the case is scant, though cultural views of intoxicating substances will vary, with many Muslims choosing not to consume alcohol or drugs at all. Alcohol dependence is more common in White men and women than in those from minority ethnic groups and White mothers were the most likely to drink before becoming pregnant and the least likely to cut down or quite drinking during the pregnancy, followed by mixed background mothers, of whom 34% drank during pregnancy (Table 4.11).

Table 4.11, Drinking behaviour before and during pregnancy, by mother's ethnicity, UK

	White	Mixed	Asian or Asian British	Black or Black British	Chinese or other ethnic group
Drank before pregnancy	90%	76%	24%	49%	48%
Drank during pregnancy	46%	34%	6%	23%	23%
Gave up drinking *(% of those who drank before)*	49%	54%	71%	52%	50%
Drank less	47%	44%	21%	36%	44%
No change / drank more	2%	1%	1%	5%	4%

Source: HSCIC (2012), Infant Feeding Survey UK, 2010

Key points

- Whilst White British residents account for 80% of the England population, they only account for 65% of live births and 68% of all pregnancy terminations nationally.
- Women from White British backgrounds and mixed ethnic backgrounds are more likely to have children younger than those from other ethnic groups.
- Crawley has the highest percentage of live births to mothers born outside of the UK, with roughly a third coming from EU countries, a third from the Middle East and Asia.
- In 2014, women from minority ethnic groups accounted for 30% of legal abortions in England and Wales, despite only making up 20% of the UK population. Some of this may be a result of the lower population age of these groups, but contrast with perceived cultural aversions to terminations.
- Evidence consistently shows that women from BAME are over-represented in the numbers of women dying or experiencing serious complications during pregnancy, childbirth and in the post-natal period. We also know that the infants of women from BAME populations are also at a greater risk of dying or becoming ill in the postnatal period. There are additional socio-economic characteristics known to increase risks of poor outcomes, however ethnicity remains a key factor.
- Asian women are particularly overrepresented in the low birthweight statistics. We also know that Asian women are 1.5 times likely to have a baby die in utero.
- These poor neonatal outcomes may be due to higher incidences of metabolic disease in pregnancy such as gestational diabetes in this population, which often go undiagnosed. This may be the impact of the barriers in accessing high quality care that people in some BAME groups' experience.
- The Marmot review found that in a study of all infant deaths in England and Wales variables such as non-white ethnicity were all independently associated with an increased risk of infant mortality. Specifically, those form Bangladeshi and Black Caribbean ethnic backgrounds have twice the rate of infant deaths as White British mothers.
- Across the UK, the highest incidences of breastfeeding were from minority ethnic groups, with 97% for Chinese or other ethnic groups, 96% for Black and 95% for Asian ethnic groups in 2010. The initial breastfeeding rate for all mothers across the UK was 81%.
- Nationally mothers over the age of 35 and mothers from minority communities were far more likely to breastfeed at their 6-8 week check-up than other groups. Importantly, the positive effect of ethnic diversity in a population outweighed other negative factors, such as deprivation or young maternal age.
- Mothers from a White ethnic background were more likely to drink alcohol before and during their pregnancy than any other ethnicity (46%). Evidence to suggest why this is the case is scant, though cultural views of intoxicating substances will vary, with many Muslims choosing not to consume alcohol or drugs at all.

Relevant recommendation(s): 1., 2., 3., 4., 5., 7., 8., 9., 10., 12., 13., 14., 15., 16., 17., 18., 20.

Indicator	Outcome
2.1	Low birth weight babies
2.2	Breastfeeding
2.3	Smoking status at time of delivery
2.4	Under 18 conceptions
2.5	Child development at 2 – 2 ½ years
2.6	Excess weight in 4-5 and 10-11 year olds
2.11	Diet
2.17	Recorded diabetes
2.21	Access to non-cancer screening programmes
3.2	Chlamydia diagnoses (15-24 year olds)
3.3	Population vaccination coverage
4.1	Infant mortality
4.3	Mortality rate from causes considered preventable
4.8	Mortality rate from communicable diseases
4.9	Excess under 75 mortality rate in adults with serious mental illness
4.10	Suicide rate

4.8 Domestic violence and sexual exploitation

Within the research literature little attention has been given to the experiences of women from ethnic minorities who have been involved in intimate partner violence. Despite significant progress within the criminal justice system and social/health services it is believed that victims from ethnic minorities underutilise services. It is suggested that their help-seeking behaviours differ from those of the dominant culture.

Cultural barriers noted include social stigma, rigid gender roles, marriage obligations, expected silence, loss of social support after migration, limited knowledge about available resources and myths about partner abuse. In one study women were said to turn for help only after experiencing pronounced mental and physical health problems. Another study highlighted that health-care professionals must understand that women take serious measures to hide the fact that they are victims of abuse in order to preserve family honour. Divulging information to interpreters or relatives is a problem because of lack of confidentiality and gossiping in the community. It is possible that attitudes could change with second and third generation ethnic minorities, though this is anecdotal rather than evidenced.[58]

Local qualitative evidence is available from the 2015 community engagement. This topic was widely discussed and whilst the full transcript is available the key points are as follows:

- Across all ethnic groups, domestic abuse is seen as a source of shame and something sufferers would be likely to cover up, at least initially. This attitude seems to be understood as pretty universal with some subtle differences between ethnic groups.

- In the Asian community, it is an issue of balancing family pride and shame and concerns that a wife would be "ruining her husband's good name".

- For non-UK citizens there is an issue of right-to remain, if a wife was to separate from her husband, who is often the employed spouse in the relationship; similarly so if the victim is in a relationship with a UK citizen.

- When tackling domestic violence, a common view is that this can and should be tackled within the wider family network, particularly in the older Asian community; that 'it is not a good idea to go outside the family; rather the elders would deal with it, visiting the man and telling him to stop'. This pressure is often put on younger couples from older relatives.

- In the Eastern European community, there is a sense that domestic abuse is taken more seriously in the UK than in home countries and people here are more likely to get authorities involved. They also see it as a very personal issue which is better to address with close friends and family.

- Some Black Africans felt that the looser community bonds in the UK mean that domestic abuse could more easily go unchallenged.

- Eastern European residents did note that many people within their community have an embedded distrust of the police which hangs over from experiences in their home countries. They suggest that this may be a barrier to victims of domestic abuse reporting incidents to the police.

- There is ambivalence about whether religious communities could play a role. In general though, it is felt that if religious and community leaders could be more effectively engaged, they could be influential in changing attitudes.

[58] Rouse, P., 2015, Public Health and Social Research Unit

Key points

- Despite significant progress within the criminal justice system and social/health services it is believed that victims from ethnic minorities underutilise services.
- Cultural barriers noted include social stigma, rigid gender roles, marriage obligations, expected silence, loss of social support after migration, limited knowledge about available resources and myths about partner abuse.
- Divulging information to interpreters or relatives is a problem because of lack of confidentiality and gossiping in the community.
- Pressure can exist within a community from older/senior family members onto younger victims not to report cases of abuse. Many cases are often seen as something to be dealt with internally.
- Trust in the police can be historically low, due to the poor reputations of other national systems. Developing trust in community policing and the appropriateness of their response is key to making some victims come forwards.
- Generally, it is felt that if religious and community leaders could be more effectively engaged, they could be influential in changing attitudes.

Relevant recommendation(s): 2., 3., 4., 5., 8., 9., 10., 12., 13., 14., 15., 18., 20.

Indicator	**Outcome**
1.11 1.12 1.13 1.18	Domestic abuse Violent crime (including sexual violence) Re-offending levels Social isolation
2.7 2.8 2.23	Hospital admissions caused by unintentional and deliberate injuries in children and young people aged 0-14 and 15-24 years Emotional well-being of looked after children Self-reported well being
4.1 4.3 4.10	Infant mortality Mortality rate from causes considered preventable Suicide rate

4.9 FGM

Female Genital Mutilation (also known as female circumcision) typically involves the cutting and removal of portions of the female genitalia. Originally the campaign against FGM was on the grounds of known health risks, though at the 1993 World Conference in Vienna, it was reconceptualised as a human rights violation. The Department for Health (*'Female Genital Mutilation Risk and Safeguarding', 2015*) describes FGM as *"not an issue that can be decided on by personal preference – it is an illegal, extremely harmful practice and a form of child abuse and violence against women and girls."* From 31 October 2015, regulated health and social care professionals and teachers in England and Wales must report 'known' cases of FGM in under 18's which they identify in the course of their professional work to the police. At the present there is no clear picture of if the police will share this data with other intelligence functions around the county.

For more guidance on definitions and variations of FGM or the recording of UK data, please see:

- WHO, Media Centre, Female Genital Mutilation (Factsheet 241, - Feb '14)
- DoH and HSCIC, FGM Prevention Programme, Understanding the FGM Enhanced Dataset (Sep '15)

A study by UNICEF[59] identified the countries where FGM is most common (Figure 4.8) and examined the relationship with demographic and lifestyle factors.

FGM is seen to be predominantly conducted in Sub-Saharan Africa and some Middle East countries and parts of Indonesia; it is decreasing slightly, with a lower proportion of 15-19 year olds than 45-49 year olds having undergone FGM. Support for the practice varies from region to region, but is often lower than the actual occurrence, amongst both men and women separately. The majority of cases occur when the girls are under 5 years old. Girls whose mothers have undergone FGM are far more likely to undergo FGM. In most cases, traditional practitioners (*e.g. dayas, ghagarias, barbers*) conduct the FGM, but in recent decades there has been a rise in procedures conducted by health personnel (*e.g. doctors, nurses*), particularly in developing nations such as Egypt. This may be an attempt to intervene and make procedures safer, though some fear that it has legitimised the practise further (*pp. 109*).

Those who have been cut are more likely to think the practice should continue than those who have not been cut. This is highest in Gambia and Mali where 82% and 81% of those who have undergone FGM think it should continue, compared to 5% and 7% of those who have not undergone FGM. Prevalence of FGM is *generally* higher in more rural areas and less affluent areas. Internally in any given country, there can be a wide range of social attitudes towards FGM and its application is not evenly distributed from area to area.

There is no clear causation from religious beliefs to the application of FGM. Though some people from nations where FGM is widespread believe there is a religious purpose to the practice, UNICEF is quick to affirm that there is no mandate in religious scripture for FGM and cites many cases where national Muslim Councils have attempted to inform their followers of this. FGM predates Christianity, Islam and Judaism and UNICEF argues that the culture exists alongside and separate to present religions and these may have been conflated into a single cultural identity. In Guinea, roughly 98% of Muslims and 80% of (non-Roman Catholic) Christians have undergone FGM, similar to Sierra Leone. To contrast, in Niger and Nigeria FGM is more common amongst some Christian groups than Muslim groups.
When asked, the most widely reported reason/benefit for undergoing FGM, given by both men and women, was firstly that 'there is no benefit' and was secondly for 'social acceptance' (*pp. 67-68*).

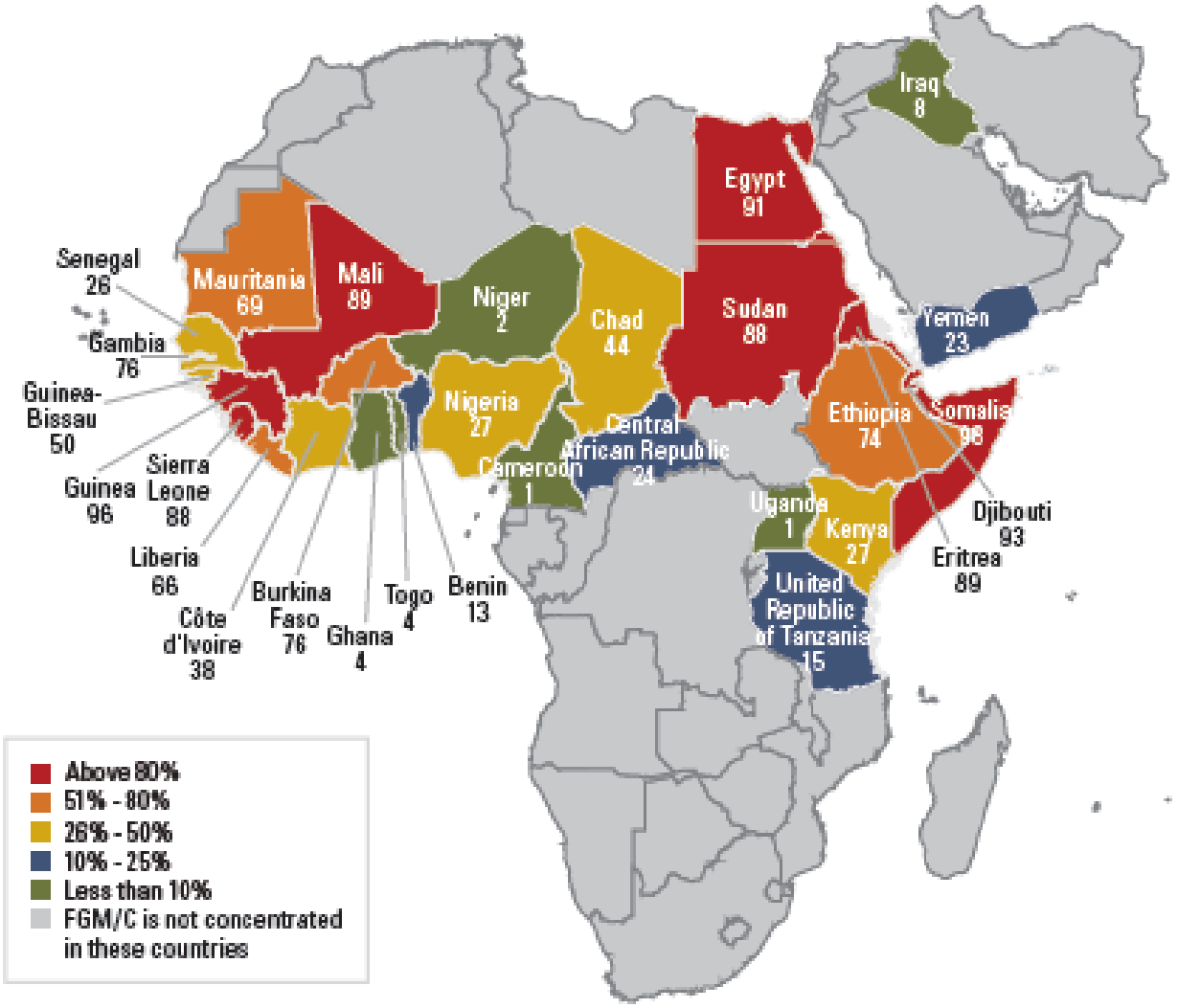
Recent research in Manchester by AFRUCA (2015)[60] ran focus groups with 110 participants from Black African communities and formed a series of recommendations around educating professionals; separate outreach and education work with both female and male members of target communities; outreach and education amongst children and young people; an emphasis on the role of community leaders; the

[59] UNICEF, 2013, Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change

[60] AFRUCA, 2015. Voices of the community: Exploring female genital mutilation in the African community across Greater Manchester. Available from http://www.afruca.org/reports_from_afruca/afruca-fgm-report

establishment of accessible support services and interagency working. Similar to the above, the authors found that "*there is no targeted approach to identifying and working with specific communities where women and children would be at risk".*

Figure 4.8, Percentage of girls and women aged 15 to 49 years who have undergone FGM/C, by country



Map taken from: 'Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change', UNICEF, 2013. pp. 26

The charity, Refuge, *'For Women and Children, against domestic violence',* cites a series of health risks and at risk groups for FGM.

Health risks of FGM include:

- Shock, heavy bleeding
- Wound infections, including tetanus and gangrene, as well as blood-borne viruses such as HIV, hepatitis B and hepatitis C
- Damage to other organs, such as the urethra (where urine passes) and the bowel
- Chronic vaginal and pelvic infections
- Difficulty passing urine and persistent urine infections
- Abnormal periods – increased pain, prolonged blood flow due to reduced vaginal opening
- Kidney impairment and possible kidney failure
- Permanently tender scar tissue
- Pain during sex, lack of pleasurable sensation and related lack of interest in sex
- Damage to the reproductive system, including infertility
- The need for later surgery to open the lower vagina for childbirth
- Complications in pregnancy and labour, including increased risk of death of mother and new-born baby
- Post-traumatic stress disorder (PTSD)
- Depression, anxiety and low self esteem
- Death

Who is at risk?

Those who have family members who have experienced FGM
Those whose partner/husband's family has experienced FGM
Those whose family or partner/husband's family come from an FGM practising country
Those whose family or friends are talking about a 'special procedure', 'special occasion' or 'becoming a woman'
Those whose family are planning a long holiday
If female elder is coming to visit

Extract from: *Refuge, 2016.* www.refuge.org.uk[61]

Though the evidence suggests it is difficult to target communities based on demographic data, the group most at risk are young girls from Black African backgrounds. Census records allow us to get a rough picture of how many this may apply to at a district level (Table 4.12). These communities can be crossed against the UNICEF national prevalence map and with local knowledge to further identify high risk groups.

Table 4.12, Girls and young women in West Sussex from a Black African ethnic background*

	West Sussex	Adur	Arun	Chichester	Crawley	Horsham	Mid Sussex	Worthing
Age 0-4 years	175	<5	5	10	110	10	20	20
Age 5-14 years	345	15	15	20	155	60	40	40
Age 15-24 years	315	10	25	25	115	75	25	40
Total (aged 0-24 years)	830	30	45	55	380	140	80	100

**As of 2011*
Source: ONS, 2011 Census

At present HSCIC has made available monthly data and recently, there have been between 300 and 500 new cases in England reported each month. Roughly half of all cases come from CCGs in London and other areas of high reporting include Manchester, Birmingham and Bristol. In West Sussex CCGs, data is consistently supressed, as *fewer than five* cases were reported for any given quarter. It is therefore unknown if any instances have been reported locally or not.

From October to December 2015 (most recent) there were 1,316 newly recorded cases of FGM reported in England. Of these 97% were 18 or over at the time of reporting. Of these, 695 were known to be self-reported and 250 discovered upon examination. It is likely, therefore, that many newly reported cases are historically quite old and are a combination of new recording efforts and inward migration, rather than examples of recent abuse.

[61] *Refuge, 2016. url:* www.refuge.org.uk

There are problems with the data recording which leave many questions unanswered:

- **The type of FGM** discovered is largely unreported or unknown (roughly two thirds of cases).
- The **number of daughters under the age of 18** which the identified individual may have is largely unreported or unknown (three quarters of cases).
- The **referring organisation** is largely unknown or unreported (nearly half of all cases).
- The **country of birth** of the individual is largely unknown or unreported (roughly three quarters of all cases).
- The **country where the FGM was undertaken** is largely unknown or unreported (roughly three quarters of all cases).

Further to this, the data only covers cases submitted via a heath setting and this database will not necessarily be reconciled with reported cases from teachers, social workers and other professionals.

Key points

- FGM is not an issue that can be decided on by personal preference – **it is an illegal form of child abuse**.
- FGM cannot be clearly linked to any one region, country, religion, demographic, or ethnicity; nor can it be linked to one motivation, drive or purpose; it is not predominantly enforced by any one generation, gender or social class. It is predominantly a culture native to Western, sub-Saharan and Eastern Africa, with some prevalence in Iraq, Yemen and Indonesia.
- In some countries, it is estimated by UNICEF that more than 90% of females have undergone FGM, i.e. Guinea, Egypt and Somalia.
- The majority of FGM is believed to occur before the child is 5 years of age, and only few cases are conducted after the onset of adolescence.
- It is likely that most newly reported cases are historically quite old and are a combination of new recording efforts and inward migration, rather than examples of recent abuse.
- In most cases, data on the type of FGM, (Types 1-4, including full infibulation) and other key fields are logged by HSCIC as "not reported", leaving considerable data gaps to inform on prevention strategies.
- Research from a range of studies recommends that outreach work, education and reporting be conducted from within communities; not by 'outsiders', who may alienate the target groups.
- Targeting at-risk communities will require triangulating census data, known nationality of the parents and community-level knowledge of families and attitudes.
- Currently, a London-based organisation (Imkaan) has been commissioned to further investigate FGM in West Sussex and a full report into the method of viable outreach and education is expected for late 2016.

Relevant recommendation(s):1., 3., 4., 5., 8., 9., 10., 12., 13., 14., 15., 18., 20.

Indicator	Outcome
1.11	Domestic abuse
1.12	Violent crime (including sexual violence)
1.13	Re-offending levels
1.18	Social isolation
2.7	Hospital admissions caused by unintentional and deliberate injuries in children and young people aged 0-14 and 15-24 years
2.8	Emotional well-being of looked after children
2.23	Self-reported well being
4.1	Infant mortality
4.3	Mortality rate from causes considered preventable
4.10	Suicide rate

Section 5: Access to and use of services

This new call on the phone service before your appointment to speak or see a GP is not suited for everyone (Female, Indian, 25–64).

They [GPs] don't take very good care of children (Female, Bulgarian, 25–64).

The care home industry has a big problem with institutional racism, both in the private care homes and those funded by the NHS (Female, Namibian, 25–64).

What could be a better system here is to have walk-in centres, this is how it works in my country (Female, Ghanaian, 25–64).

It would be safer if children were seen by paediatricians not GPs (Female, Hungarian, 25–64).

What is the point of seeing a person in 5 days when they are ill now? This would never happen in India, I would go to the clinic and see a doctor straight away, I don't need to make an appointment and wait for days (Male, Indian, 25–64).

It's important to know how to get past the receptionist… you have to know how to beat the system (Female, Ugandan, 25–64).

The only thing I miss is establishing a relationship with my GP. Every time, you see someone different, you don't have your 'GP friend' here (Male, Italian, 25–64).

When I asked my GP if I can have a female examiner – as I am a female and I don't feel comfortable being examined by a man – I could not be given one. As a Muslim this is very important to me. So what was the point of asking me what religion I am if when it matters they don't care? (Female, Morocco, 25–64).

People go to the temple to find peace, however the root of the mental health problem cannot simply be fixed by the temple (Female, Sri Lankan, 65–74).

Simply put, if my health concern is immediate and GPs are anything but immediate with their care, I would go to a hospital (Female, Indian, 25–64).

5.1 Use of acute services

5.1.1 Primary care

Local GP surgeries are known to record ethnicity when a new resident registers at a practice. In principle, it is possible to request access to this practice-level data, though facilitating this is believed to be unfeasible by local health analysts at the current time and data-sharing is perceived to be a problem.

Qualitative evidence has highlighted a series of issues surrounding access to primary care. It can be surmised that the intended drive for efficiencies which have been built into the Primary care system are often perceived as bureaucratic gatekeeping and barriers to specialist advice, particularly by those who have grown up with other national healthcare systems. Specifically, the 2015 community engagement covered this in detail with the following findings:

- The appointment booking system used in many GP surgeries, which requires patients to speak to a receptionist and wait for a call-back from the doctor, is often frustrating for many who have difficulty communicating in English. Problems exist because the friend or family member who made the initial call must wait with the individual for longer to receive the second call.

- A structural reliance on GP appointments over walk-in clinics is disappointing for many respondents used to other systems of primary care.

  "What is the point of seeing a person in 5 days when they are ill now? This would never happen in India, I would go to the clinic and see a doctor straight away, I don't need to make an appointment and wait for days." (Male, Indian, 25–64). "What could be a better system here is to have walk-in centres; this is how it works in my country" (Female, Ghanaian, 25–64). - p17

- Whilst registering with a GP was generally seen to be simple across communities, inconsistencies exist around what personal documentation is needed to register; barriers have been identified, particularly with foreign nationals, who report needing to show named utility bills as proof of address, but with temporary house-sharing common in many Eastern European communities, many are not the named bill-payer and cannot provide this documentation. This has developed a view that GP receptionists are 'the gatekeepers' to healthcare.

  "It's important to know how to get past the receptionist… you have to know how to beat the system." (Female, Ugandan, 25–64). – p.17

- European and Asian respondents were found to have failed expectations of preventative care and health checks. Many reported that they paid for full health checks and tests when they visited home because there was not sufficient capacity to do this with the local NHS in England.

- Typically, the system of booking GP appointments in order to get referrals was seen as inefficient by those who were used to specialists being available at the first instance; specialists such as paediatricians, dermatologists, gynaecologists. This poor perception is so widespread that it may be deterring residents from engaging with the Primary care systems as designed. Some respondents referenced visiting sexual health clinics instead of visiting their GP for gynaecological concerns, as they believed this is where they would receive timelier and more specialist advice.

Regarding identification needed for registering with a GP, the British Medical Association has published guidance on their website which states that no one should be refused registration on the grounds of a lack of identification. Healthwatch West Sussex have asked that any examples of this be referred to them in the future for guidance and support.

BMA, Guidance for GP Practices (extract)

Registering without proof of identity and address:

- There is no contractual duty to seek evidence of identity or immigration status or proof of address. Therefore practices should not refuse registration on the grounds that a patient is unable to produce such evidence.
- Anyone who is in England is entitled to receive NHS primary medical services at a GP practice and applications for registration for any patient in England must be considered in exactly the same way, regardless of country of residence.

Registering temporary or permanent residents:

- The length of time that a patient is intending to reside in an area will determine whether a patient is registered as a temporary or permanent patient.
- Patients should be registered as a temporary resident if they are intending to reside in the practice area for more than 24 hours but less than 3 months.

Source: BMA, Guidance for GP Practices. (http://www.bma.org.uk/support-at-work/gp-practices/service-provision/patient-registration-for-gp-practices, accessed 19th April 2016)

5.1.2 Elective and non-elective admissions

Regarding non-elective admissions, as opposed to elective care, there is a small difference in the data, across all ethnic minority groups, (when transfers and maternities are excluded). Amongst White British residents, 44% of admissions to hospital in 2013/14 were logged as emergency, rather than elective. The second largest census group (White Other) also stood at 44% emergency admission; some groups were more likely and some less likely than this to be admitted as an emergency, ranging from 35% (for Chinese) to 51% (for Black African/British). There is little evidence from these figures to suggest that those from minority communities have a higher tendency to go into hospital by emergency admission.

Data is inconsistent here when broken down by district/borough authority: Roughly 28% of residents from Crawley did not provide their ethnicity when admitted to hospital, compared to just 11% of residents from Mid Sussex.

Table 5.1, Count of patient spells, by ethnicity, gender and method of admission, West Sussex 2013/14

	Elective		Emergency		Grand total	
Ethnicity	M	F	M	F	Number	**(%)**
British (White)	41,233	44,548	32,209	35,984	153,974	**76.5%**
Not stated	11,071	11,822	5,325	5,580	33,798	**16.8%**
Any other White background	1,879	2,035	1,469	1,585	6,968	**3.5%**
Any other Asian background	278	281	281	256	1,096	**0.5%**
Irish (White)	260	329	187	193	969	**0.5%**
Indian (Asian or Asian British)	221	227	216	195	859	**0.4%**
Any other ethnic group	189	199	238	199	825	**0.4%**
Pakistani (Asian or Asian British)	162	201	115	127	605	**0.3%**
Any other Mixed background	116	144	158	122	540	**0.3%**
African (Black or Black British)	87	94	89	101	371	**0.2%**
White and Asian (Mixed)	68	82	44	64	258	**0.1%**
Any other Black background	49	69	66	56	240	**0.1%**
Bangladeshi (Asian or Asian British)	46	49	53	41	189	**0.1%**
Caribbean (Black or Black British)	50	53	42	29	174	**0.1%**
Chinese (other ethnic group)	54	57	31	30	172	**0.1%**
White and Black Caribbean (Mixed)	24	47	30	37	138	**0.1%**
White and Black African (Mixed)	27	48	31	15	121	**0.1%**
Grand Total	55,814	60,285	40,584	44,614	201,297	**100.0%**

Source: HES database, 2015

Regarding secondary care, the respondents in the community engagement were reported to be *'predominantly positive in terms of treatment received'.* However:

> *Some residents also raised the reduction of services at Crawley hospital as a particular issue. They are now required to travel further to East Surrey hospital in Redhill for outpatient care. This was flagged as a particular concern for older Asian women who do not drive and feel nervous using public transport, further increasing reliance on family members or friends. - p.18*

Key points

- Accessing data on ethnic use of general practice primary care is currently believed to be unfeasible due to inconsistent intelligence sharing.
- Problems exist with the GP appointment booking call-back system where language is a barrier, because the friend or family member who made the initial call must wait with the individual for longer to receive the second call.
- A structural reliance on GP appointments over walk-in clinics is disappointing for many respondents used to other systems of primary care and deters some from accessing primary care at all. GPs are commonly viewed as non-professionals and some European and Asian respondents were found to access health checks in native countries, which they trust more.
- Residents who live here in the short to mid-term; notably Eastern European communities, can face added difficulties in registering for primary healthcare. Many are not the named bill-payer or homeowner and cannot acquire proof of local residence.
- There is little evidence from local admissions data to suggest that those from minority communities have a higher tendency to go into hospital by emergency admission. Data recording/reporting is poor, however and caveats apply.
- The reduction in hospital services in Crawley have been thought to hit some older Asian residents disproportionately, as they are unable to drive and not confident using public transport. This increases reliance on family members/friends.
- Those facing barriers to GP registration (particularly regarding proof of address or identification) have been asked by Healthwatch West Sussex to contact them for guidance http://www.healthwatchwestsussex.co.uk/.

Relevant recommendation(s): 1., 2., 3., 4., 5., 8., 9., 10., 11., 12., 13., 14., 15., 16., 17., 18., 20.

Indicator	Outcome
1.3	Pupil absence
1.9	Sickness absence rate
2.4	Under 18 conceptions
2.6	Excess weight in 4-5 and 10-11 year olds
2.11	Diet
2.12	Excess weight in adults
2.13	Proportion of physically active and inactive adults
2.14	Smoking prevalence – adults (over 18s)
2.17	Recorded diabetes
2.19	Cancer diagnosed at stage 1 and 2
2.20	Cancer screening coverage
2.21	Access to non-cancer screening programmes
2.22	Take up of the NHS Health Check programme – by those eligible
2.23	Self-reported well being
3.2	Chlamydia diagnoses (15-24 year olds)
3.3	Population vaccination coverage
4.1	Infant mortality
4.3	Mortality rate from causes considered preventable
4.4	Under 75 mortality rate from all cardiovascular diseases
4.5	Under 75 mortality rate from cancer
4.6	Under 75 mortality rate from liver disease
4.7	Under 75 mortality rate from respiratory diseases
4.8	Mortality rate from communicable diseases
4.9	Excess under 75 mortality rate in adults with serious mental illness
4.10	Suicide rate
4.11	Emergency readmissions within 30 days of discharge from hospital
4.12	Preventable sight loss
4.13	Health-related quality of life for older people
4.16	Estimated diagnosis rate for people with dementia

5.2 MAS and CAMHS

5.2.1 Memory Assessment Service

The Memory Assessment Service (MAS) is commissioned out to Sussex Partnership NHS Foundation Trust in partnership with The Alzheimer's Society and is aimed at investigating and diagnosing memory and other associated problems as early as possible in order to offer them access to any treatment, advice and support they may need. Referrals are made by GPs and other health professionals.

The current provider, Sussex Partnership NHS Foundation Trust, releases regular performance data.

As of February 2016, 287 people were on the system for referrals to the MAS, of which 156 were White British, 4 were of an 'Other White' background and 127 were not known or not stated.

When looking at the 222 assessments on the system for February 2016, 190 were White British, 5 were of an 'Other White' background, 2 were 'Asian' or 'other' and 25 were not stated or not known. Of the 174 who received a diagnosis, 163 (94%) were White British, 8 were White Irish or other and 3 were Asian British or other.

It is clear, therefore, that the MAS does not capture the appropriate level of detail to understand if BAME communities are accessing the service, - and where ethnicity is recorded, at diagnosis, BAME groups are highly under-represented. This links in with the findings of the 2013 all-party group on Dementia report, discussed in section 4, and their recommendations for improving access to dementia services appear to fit within the local context.

5.2.2 Child and Adolescent Mental Health Services

The Children and Adolescent Mental Health Services (CAMHS) provider, Sussex Partnership Foundation Trust (SPFT) release quarterly service-level reports which show the CCG-level take-up of Tier 3 and 4 mental health support (Table 5.2). In previous years (and at the time of the Children and young people mental health needs assessment – 2014) BAME take-up of services was lower though the most recent data shows an ethnic makeup of services users that widely reflects that of the county population, with 22% BAME in Crawley and 13% BAME overall.

Table 5.2, Ethnic Background of Tier 3 and 4 service users (Snapshot data February 2016)

	Coastal CCG	Crawley CCG	Horsham and Mid Sussex	West Sussex Overall	Sussex (Exc. WSx)
White British	1,440	275	530	2,245	2,885
White Other (including White Irish)	125	55	60	240	65
Asian	10	5	5	20	15
Black	15	5	5	25	20
Mixed	30	15	5	50	80
Other (inc Chinese)	15	5	<5	20	30
Not known	230	75	220	525	1200
Total	1,865	435	825	3,125	4,295
% (of known from BME background)	11.1%	22.5%	12.4%	13.0%	5.9%

Source: SPFT service-level reports

Key points

- Data recording/reporting on ethnicity for MAS referrals is considered poor (over 40% unknown).
- Data for MAS assessments is more robust (roughly 10% unknown), and recently BAME residents have been under-represented in receiving assessments, when compared to White British residents. Evidence discussed elsewhere supports the view that efforts should be made to improve uptake.
- CAMHS data suggests that BAME use of young people's mental health Tier 3 and 4 services has improved since the 2014 children and young people's mental health and wellbeing needs assessment. – Service use generally reflects that of the local population.

Relevant recommendation(s): 3,. 4., 8., 9., 10., 11., 13., 14., 15., 16., 18., 20.

Indicator	Outcome
1.3	Pupil absence
1.4	First time entrants to the youth justice system
1.5	16-18 year olds not in education, employment or training
1.9	Sickness absence rate
1.18	Social isolation
2.8	Emotional well-being of looked after children
2.10	Self-harm
2.18	Alcohol-related admissions to hospital
2.23	Self-reported wellbeing
4.3	Mortality rate from causes considered preventable
4.9	Excess under 75 mortality rate in adults with serious mental illness
4.10	Suicide rate
4.13	Health-related quality of life for older people
4.15	Excess winter deaths
4.16	Estimated diagnosis rate for people with dementia

5.3 Social Care

5.3.1 Fostering and adoption

Traditionally, efforts are made to link children in need of fostering or adoption to parents of a similar ethnic group, though with relatively low numbers of adult couples from minority backgrounds in the county (see section 1), this may prove more difficult locally. More data on local fostering and adoption placement could help form policy, if potential parents/carers are coming up short.

In the UK, 5,330 children were adopted from care during the year ending 31st March 2015, compared to 5,050 in 2014[62]. The following ethnic backgrounds were recorded of the children:

- 83% (4,400) were white
- 11% (580) were of mixed racial background
- 2% (120) were Black or Black British
- 2% (90) were Asian or Asian British
- 1% (50) were from other ethnic groups
- 2% (100) were other (refused or information not yet available)

The United Kingdom Border Agency (UKBA) defines an unaccompanied refugee or asylum seeking young person as someone who is under the age of 18, is claiming asylum in their own right and who has no adult relative or guardian in the UK to provide care (Home Office 2002).

Nationally, there were 2,630 unaccompanied asylum seeking children were being looked after on 31st March 2015; of these, 90% (2,360) were boys and 10% (260) were girls; the majority of which (75%) were aged 16 and over.

5.3.2 Residential

The 2011 Census revealed that in West Sussex the majority of children under the age of 5 are White British (83.6%). This proportion is considerably higher than in England (70.7%) and the South East (78.8%). The majority of children looked after in West Sussex under the age of 5 were of white ethnicity (86.1%).[63]

As of 2011, West Sussex children from minority ethnic backgrounds accounted for 30% of all those living in communal establishments. This may have included many living within residential care homes, but also some who are living in boarding school accommodation. This overall figure is largely in line with the English average, although some ethnic groups vary considerably, (Table 5.3).

Of the roughly 6,500 older residents living in communal establishments in West Sussex (those aged over 75 years), over 99% were of a White ethnic background. Similarly, over England, 98% were from a White background, adding weight to the idea that far fewer minority communities will use communal establishments in their later years. We should note however, that these populations are far younger (per capita) and this may explain the low numbers of older residents in communal establishments.

[62] Government statistics; accessed by Coram BAAF. Available at: http://corambaaf.org.uk/res/statengland#uas
[63] WSCC, Early Years Needs Assessment

Table 5.3, Children under 16 years living in a communal establishment, 2011 census

	West Sussex		England	
	Count	**%**	**Count**	**%**
All categories: Ethnic group	1,665	100.0%	37,650	100.0%
White: English/Welsh/Scottish/Northern Irish/British	1,160	69.7%	26,145	69.5%
White: Irish	15	0.9%	210	0.6%
White: Other White	120	7.2%	2,630	7.0%
Mixed/multiple ethnic group: Total	110	6.5%	1,755	4.7%
Asian/Asian British: Indian	<5	0.2%	440	1.2%
Asian/Asian British: Pakistani	<5	0.2%	580	1.5%
Asian/Asian British: Bangladeshi	<5	0.0%	710	1.9%
Asian/Asian British: Chinese	60	3.6%	1,965	5.2%
Asian/Asian British: Other Asian	65	3.8%	1,235	3.3%
Black/African/Caribbean/Black British: Total	120	7.3%	1,610	4.3%
Other ethnic group: Arab	<5	0.1%	105	0.3%
Other ethnic group: Any other ethnic group	5	0.4%	185	0.5%

Source: ONS, 2011 Census

Key points

- It is not known if there is an adequate or inadequate pool of potential fostering or adopting households from minority ethnic communities.
- Nationally, the proportion of children from BAME groups who were adopted was roughly representative of the population, though with an increased proportion of children from a mixed ethnic background.
- Nationally, there were 2,630 unaccompanied asylum seeking children were being looked after on 31st March 2015. These were predominantly late-teenage boys.
- White ethnic children under the age of 5 in care in 2015 roughly matched that of the general child population.
- As of 2011, West Sussex children from minority ethnic backgrounds accounted for 30% of all those living in communal establishments. This may have included many living within residential care homes, but also some who are living in boarding school accommodation.
- For older residents in communal establishments, 99% were White British, though it is not known if this is because of differences in community views of caring for older family members or because the BAME populations are far younger than the White British population.

Relevant recommendation(s): 3., 4,. 5., 8., 9., 10., 11,. 12., 13., 14., 15., 16., 18., 19,. 20.

Indicator	**Outcome**
1.2	School readiness
1.3	Pupil absence
1.4	First time entrants into the youth justice system
1.5	16-18 year olds not in education, employment or training
1.6	Adults with a learning disability / in contact with secondary mental health services who live in stable and appropriate accommodation
1.11	Domestic abuse
1.15	Statutory homelessness
2.5	Child development at 2 – 2 ½ years
2.7	Hospital admissions caused by unintentional and deliberate injuries in children and young people aged 0-14 and 15-24 years
2.8	Emotional well-being of looked after children
4.13	Health-related quality of life for older people

5.4 Public Health commissioned services

5.4.1 Health checks

Ethnicity is recorded by Health Check providers as part of the Risk Assessments. Though ethnicity is a contributing factor to identifying those at risk, the output of these assessments is the only information available to Public Health, as a single number, rather than the details and demographics which led to this number. The GPs and pharmacies who collect this data are not obliged to report on ethnicity and commercial providers who do outreach work tend to operate more on an opportunity basis.

The prevention and assessment nursing teams (PAT) conduct health checks at venues across the county. Whilst numbers are low, it appears that White British residents amount for a larger than average proportion of those receiving health checks from PAT nurses.

'To Health' is a UK health screening service provider, commissioned in West Sussex to conduct workplace health screening. Whilst these are only in work health checks, the increase in numbers provides more robust data and the numbers collected more closely represent the BAME population of West Sussex (Table 5.5).

Table 5.4, Health checks conducted by PAT nurses in West Sussex

	Count	(%)
White British	820	94%
White Other	15	2%
Asian	25	3%
Black	5	1%
Mixed	5	1%
Other	<5	0%
Total	**878**	**100%**

Source: CCG data, 2014/15

Table 5.5, Health checks conducted by To Health in West Sussex

	Count	(%)
White British	4840	86.6%
White Irish/Other	290	5.2%
Asian	260	4.7%
Black	90	1.6%
Mixed	50	0.9%
Other	55	1.0%
Total	**5590**	**100.0%**

Note: this includes people who are not registered with a GP, but who do live within West Sussex. (Excludes not registered with a GP and live outside West Sussex)

Source: CCG data, 2014/15

5.4.2 Smoking cessation

Across England, self-reported cigarette smoking prevalence for men is greater in ethnic minority groups than in the general population. The West Sussex Health Equity Audit details the local and national picture, however in 2004 the HSE reports that levels were at 40% among Bangladeshi, 30% Irish, 29% Pakistani, 25% of Black Caribbean, 21% Black African and Chinese, and 20% in Indian men, compared with 24% among men in the general population. After adjusting for age in the prevalence figures, Bangladeshi and Irish men were more likely to report smoking cigarettes, compared with men in the general population. Indian men are less likely to report smoking than those in the general population.

Self-reported smoking prevalence was higher among women in the general population (23%) when compared with most ethnic groups. The exceptions to this are women in Irish groups (26%) and Black Caribbean women (24%). Ten per cent of Black African, 8% of Chinese, 5% of Indian and Pakistani, and 2% of Bangladeshi women reported smoking cigarettes. In terms of accessing smoking services, quit rates vary from 37% - 54% dependent on ethnicity reported, with Asian or British Asian having the highest quit rate and 'other' the lowest.

In West Sussex there were estimated to be some 8,500 smokers who report their ethnicity as anything other than 'white'. Between April 2014 and March 2015, 26 people whom were recorded as being of minority ethnic background set a quit date in West Sussex; of these 18 (69%) were successful, with 11 being CO verified. Although the quit rate in this group is significantly higher than in other groups, overall, access rates of smoking services are much lower in populations classed as 'non-white' or 'white other'. These data highlight that the access rate remains well below the five per cent target set out by NICE and given the prevalence of smokers in this target group, remain low at less than one quarter of one per cent. However, it is likely that there are issues with the recording of ethnicity and so these access rates should be interpreted with caution.[64]

Source: West Sussex Specialist Rapid Needs Assessment, 2015

Table 5.6, West Sussex smokers by gender and ethnicity, 2014

Ethnicity	West Sussex	Adur	Arun	Chichester	Crawley	Horsham	Mid Sussex	Worthing
Male								
White	66,689	5,161	12,595	9,610	7,665	11,192	11,858	8,608
Mixed	1,109	80	133	100	292	157	174	173
Asian	2,422	86	165	114	1,297	188	291	281
Black	613	28	53	46	300	51	61	74
Other	492	46	59	50	142	53	65	77
Total	71,325	5,401	13,005	9,920	9,696	11,641	12,449	9,213
Female								
White	69,032	5,344	13,439	10,180	7,722	11,443	11,958	8,946
Mixed	1,072	79	136	94	266	161	179	157
Asian	1,983	65	189	158	696	245	311	319
Black	403	15	26	28	199	38	51	46
Other	315	26	30	28	98	38	46	49
Total	72,805	5,529	13,820	10,488	8,981	11,925	12,545	9,517
Persons								
White	135,721	10,505	26,034	19,790	15,387	22,635	23,816	17,554
Mixed	2,181	159	269	194	558	318	353	330
Asian	4,405	151	354	272	1,993	433	602	600
Black	1,016	43	79	74	499	89	112	120
Other	807	72	89	78	240	91	111	126
Total	144,130	10,930	26,825	20,408	18,677	23,566	24,994	18,730

Source: West Sussex smoking cessation health equity audit, 2014

[64] West Sussex Specialist Rapid Needs Assessment, 2015

Table 5.7, Percentage of smokers accessing smoking cessation service in West Sussex, 2014

Ethnicity	West Sussex	Adur	Arun	Chichester	Crawley	Horsham	Mid Sussex	Worthing
Male								
White	4.38%	5.27%	5.95%	4.39%	5.64%	1.46%	3.59%	5.43%
Mixed	1.62%	1.25%	1.50%	1.00%	2.74%	0.00%	0.57%	2.89%
Asian	2.64%	9.30%	4.85%	0.88%	2.78%	1.60%	2.06%	0.71%
Black	4.24%	3.57%	18.87%	0.00%	2.33%	3.92%	4.92%	4.05%
Other	0.81%	0.00%	3.39%	0.00%	0.00%	1.89%	0.00%	1.30%
Female								
White	4.62%	6.51%	5.31%	5.02%	6.80%	1.51%	3.17%	6.11%
Mixed	1.12%	2.53%	2.21%	0.00%	1.50%	0.62%	0.00%	1.27%
Asian	0.81%	3.08%	0.00%	0.63%	0.72%	1.22%	0.32%	1.25%
Black	2.48%	0.00%	0.00%	0.00%	2.51%	0.00%	1.96%	8.70%
Other	0.63%	3.85%	0.00%	0.00%	0.00%	0.00%	2.17%	0.00%
Persons								
White	4.50%	5.90%	5.62%	4.71%	6.22%	1.48%	3.38%	5.78%
Mixed	1.38%	1.89%	1.86%	0.52%	2.15%	0.31%	0.28%	2.12%
Asian	1.82%	6.62%	2.26%	0.74%	2.06%	1.39%	1.16%	1.00%
Black	3.54%	2.33%	12.66%	0.00%	2.40%	2.25%	3.57%	5.83%
Other	0.74%	1.39%	2.25%	0.00%	0.00%	1.10%	0.90%	0.79%

Source: West Sussex smoking cessation health equity audit, 2014

The 2013-14 West Sussex smoking cessation health equity audit came out with two recommendations concerning ethnicity:

> *2) To improve the quality of future HEAs there needs to be an improvement in data completeness and usability in particular that relating to occupation and ethnicity such as capturing better data about the non-white British population.*
>
> *7) Improve our understanding of how the service could meet the needs of smokers from non-white ethnic groups.*

These will be explored by the upcoming Tobacco control needs assessment.

5.4.3 Wellbeing hubs

The Wellbeing hubs in West Sussex are used to provide local services for residents. Much information on the provision for and uptake of services for BAME groups is anecdotal; some suggestions have included the recording of nationality, rather than ethnicity, particularly for the coastal areas where recording "White Other" leaves little statistical nuance and evidence for future targeted work is lacking therefore. Providers are often unclear on why demographic recording is required or beneficial.

Where commissioners have described being successful in delivering services which directly benefit particular ethnic groups they say they have directly engaged with people from those groups and understood cultural differences. A view exists that in most services there can be small adjustments in delivery which result in improved take-up from targeted groups, in other instances larger changes (such as translation) can have positive effects.

Of the 9,528 referrals to the Hubs in financial year 14/15, 21% did not record ethnicity, (non-disclosure, not asked, or not recorded, in table). Where ethnicity was known, 92% were White British (73% overall). Ethnicity was not provided at a rate of more than one in three, in Chichester and Arun localities.

Table 5.8, Ethnic breakdowns of West Sussex wellbeing hub activity, 2014/15

Ethnicity	Ad	Ar	Ch	Cr	Hm	MS	Wg	Total
White English / Welsh / Scottish / Northern Irish / British	513	859	1,000	1,029	1,340	1,426	811	6,978
White Irish	1	3	-	11	1	3	2	21
Gypsy or Irish Traveller	-	-	-	2	-	-	-	2
Other White Background	2	38	22	47	17	16	20	162
White & Black Caribbean	-	1	1	3	-	-	1	6
White & Black African	2	2	3	4	1	-	3	15
White & Asian	2	3	1	13	2	1	2	24
Any Other Mixed / Multiple Background	3	5	3	6	6	2	3	28
Indian	-	1	4	55	3	4	1	68
Pakistani	-	1	-	31	1	1	-	34
Bangladeshi	-	1	-	2	-	1	1	5
Chinese	1	1	3	2	1	3	-	11
Any Other Asian Background	2	5	1	35	3	5	3	54
Black African	-	1	6	22	5	-	2	36
Black Caribbean	1	3	-	3	1	-	-	8
Black British	-	-	6	14	2	-	1	23
Any Other Black / African / Caribbean Background	-	-	5	5	2	1	4	17
Arab	-	-	-	1	1	-	-	2
Any Other Ethnic Group (Please Specify)	-	9	12	13	16	-	-	50
Do Not Wish to Say	16	78	11	151	25	7	9	297
Not Asked	23	64	122	9	17	58	78	371
Not Recorded	37	472	584	44	98	1	80	1,316
% Not Recorded	6%	31%	33%	3%	6%	0.1%	8%	14%

Source, West Sussex Public Health data, 2015

5.4.4 Drugs and alcohol action team

The Drugs and Alcohol Action Team (DAAT) treatment service is required to collect data on ethnicity as part of the reporting requirements to the National Drug Treatment Monitoring System (NDTMS).

BAME groups are underrepresented in seeking treatment, despite having similar levels of alcohol or drug dependence when the substance is used, and there may be a cultural stigma around seeking help for substance dependence.

Typically in West Sussex the majority of DAAT service users are White British. However, the Crawley service hub and also the young people's service both had greater ethnic diversity. Nationally, the ethnic origin of service user is almost exclusively White British (with the second highest group (roughly 4%) being 'White Other').

West Sussex have recently redesigned and procured a service for people who use alcohol/drugs, to start in May 2016. A key focus of the new service will be to reach and engage individuals/groups/populations who need support and who haven't traditionally engaged with drug and alcohol services. This will include people from a broader range of ethnic groups, taking into account cultural sensitivities around drug/alcohol use and any connected barriers to seeking help.

Key points

- Where health checks are conducted in the workplace, ethnicity is roughly in line with that of the wider population. However, the GPs and pharmacies, which perform most health checks, are not obliged to report on ethnicity.
- Bangladeshi and Irish men were the most likely, and Indian men lest likely, to report smoking. Minority ethnic women were generally less likely to report smoking, with the exception of those from Irish and Black African groups.
- Ethnicity has not been robustly recorded in stop-smoking services, leaving uncertainty in smoking service access and quit rates.
- Recommendations set out by the Health Equity Audit to improve data recording and accessibility for minority groups are being investigated for the Tobacco Control needs assessment (2016).
- A view exists that with small adjustments, on the back of engagement with local communities, wellbeing hubs could provide better services and increase uptake for minority ethnic groups. However, ethnicity recording is currently poor, with 21% of the 9,528 referrals to the hubs being "unknown".
- Stigma may exist around utilising Drug and Alcohol support services, with the national take-up being almost exclusively White, despite dependency being just as common amongst those who use alcohol/drugs. – The West Sussex DAAT is redesigning services in 2016 with intentions to explore these issues.

Relevant recommendation(s): 3., 5., 6,. 8., 9., 10,. 11., 13., 14., 18., 20.

Indicator	Outcome
1.4	First time entrants to the youth justice system
1.9	Sickness absence rate
1.16	Utilisation of outdoor space for exercise / health reasons
2.3	Smoking status at time of delivery
2.9	Smoking prevalence – 15 year olds
2.11	Diet
2.12	Excess weight in adults
2.13	Proportion of physically active and inactive adults
2.14	Smoking prevalence – adults (over 18s)
2.15	Successful completion of drug treatment
2.16	People entering prison with substance dependence issues who are previously not known to community treatment
2.18	Alcohol-related admissions to hospital
2.22	Take up of the NHS Health Check programme – by those eligible
2.23	Self-reported wellbeing
4.3	Mortality rate from causes considered preventable
4.4	Under 75 mortality rate from all cardiovascular diseases
4.6	Under 75 mortality rate from liver disease
4.9	Excess under 75 mortality rate in adults with serious mental illness
4.10	Suicide rate

5.5 Palliative and end of life care

A multi-agency publication: 'Palliative and end of life care for Black, Asian and Minority Ethnic (BAME) groups in the UK' (2013)[65], conducted a meta-review of 45 separate literature reviews on the issues facing BAME groups when accessing palliative care and asserted that:

"The End of Life Care Strategy[66] highlights that although much has been done, inequalities still exist in the care that different groups of people receive at the end of life."

The authors noted that, across all available literature reviews, two main themes emerged; access to and receipt of care. Access to palliative and end of life care was seen to be lower amongst BAME populations than White British and was associated with a range of factors:

- a lack of referrals
- a lack of awareness of relevant services
- previous bad experiences when accessing care
- a lack of information in relevant languages or formats
- family/religious values conflicting with the idea of hospice care

Disparities and unmet needs when receiving care were also examined and revealed that communication between healthcare professionals and the patient/family was the most widely discussed issue. In this were barriers found in other areas of health and social care provision:

- a lack of sensitivity to cultural/religious differences
- a lack of availability of translators
- low availability of training for healthcare professionals

Issues surrounding advanced care planning were repeated, with many service users reporting that care plans are guided by *"Western values of autonomy and self-determination which are not applicable to several populations with a collective approach to decision making" (p. 9).*

The authors summarised the recommendations found throughout the literature reviews into three groups:

Recommendations for policy:

- Making use of knowledge and supporting its development
- Reaching out, listening to and involving BAME communities:
- Policies enacted at a national level

Recommendations for practice:

- Staff training
- Open, non-judgemental and ongoing communication
- Reaching, listening to and involving BAME communities
- Building and sharing knowledge

Recommendations for research:

- Self-awareness and understanding of the current social context
- Better understanding cultural competency
- More evidence on needs, experiences and health outcomes for BAME populations
- More evidence on the effect of interventions on health outcomes – moving from descriptive studies
- Including ethnicity more often as a variable in studies – and analysing it appropriately

65 Natalia Calanzani, Dr Jonathan Koffman, Irene J Higginson, 2013. Palliative and end of life care for Black, Asian and Minority Ethnic (BAME) groups in the UK, King's College London, Cicely Saunders Institute

66 DH, 2008. End of Life Care Strategy: Promoting high quality care for all adults at the end of life

Due to relatively low numbers of older BAME residents locally and the available sample size for the 2015 community engagement, direct feedback on these issues at a local level is limited. What was available, however, was largely in line with the national review described above. Confusion exists locally over the level of service one is entitled to and some feel that White residents may be favoured for more support. What is important is that local minority ethnic communities do not have sufficient confidence to be sure that this is not discrimination or just confusion of a system they don't understand and potential language barriers. Regarding social care in general, one older resident said:

> *'I am scared to ask for too much. My leave to stay here is not permanent and if I ask for too much I am scared that they will tell me to leave. I am not sure if the amount of care I access affects my residency so I just don't risk it. My family take on the burden. Although they are all working and have young children of their own they have to take care of me too.' (Male, Pakistani, 75+) – p. 19*

One key finding from the report was that:

> *Use of social care services requires families to realise and accept the need for help, that they understand how to go about accessing it, and that they do not feel ashamed to do so. Issues around acceptance seem particularly pronounced in the Asian community – p19*

An *NHS: Improving Quality* paper was released (2015)[67] to highlight the good practice of Marie Curie Hospice, in Cardiff and the Vale, regarding increasing palliative care services for BAME communities. In this case study, a key worker was employed to consult with 130 community members and identify barriers and needs; including to increase awareness and improve access.

Some changes were enacted from the listening process, including installing a new 'quite room' and washing facilities for prayer or contemplation; reviewing the number of visitors allowed; improving information for staff around diet, religion, cultural calendars. Signposting was also reported to be improved, including to immigration advice for visiting family members, counselling in other languages, and support for isolated individuals. Additionally, a resource pack for staff with a directory for community based services was developed. These included: writing an Islamic Will, accessing to paid carers who meet cultural or religious needs. Further to this, volunteer community champions were employed to promote the hospice; promotional DVDs in six community languages were developed, as well as other written materials; a report into barriers to access was widely disseminated and lessons learnt were shared at a national level.

[67] NHS Improving Quality, 2015, End of Life Care: Case study. 'Increasing the number of people from a Black, Asian and Minority Ethnic (BAME) background accessing palliative care services' Marie Curie Hospice, Cardiff and the Vale.

Key points

- Current evidence suggests that, although much has been done, inequalities still exist in the care that different groups of people receive at the end of life.
- Issues surrounding access to palliative and end of life care included a lack of referrals; a lack of awareness of relevant services; previous bad experiences when accessing care; a lack of information in relevant languages or formats; family/religious values conflicting with the idea of hospice care.
- Issues surrounding the care received were principally formed around communication between professionals and patients/families; specifically a lack of sensitivity to cultural/religious differences; a lack of availability of translators; low availability of training for healthcare professionals.
- Recommendations made in the multi-agency publication, for policy, practice and future research, closely align with other issues presented throughout this needs assessment.
- Confusion exists within communities over accessibility and service provision; trust is also low in some cases and feelings of discrimination exist due to a lack of communication.
- Examples of good practice have been published, around appropriate engagement and service redesign, raising standards and service uptake. Changes included adding provisions for cultural practice, training staff around cultural distinctions and sensitivities, and promoting services in multiple community languages.

Relevant recommendation(s): 3., 4., 5., 8., 9., 10,. 12,. 13., 14., 15., 16., 18., 20.

Indicator	**Outcome**
1.18	Social isolation
4.13	Health-related quality of life for older people

5.6 Children and family centres/other children's services

5.6.1 Under 5's in West Sussex

In West Sussex the majority of children aged under-5 are White British (83.6%; Table 5.9). This proportion is considerably higher than in England (70.7%) and the South East (78.8%). Children from the 'Other White background' category made up 4% of the under-5 population county-wide.

In Crawley, the proportion of White British children under the age of 5 is lower (62.2%) than for the other local authorities in West Sussex (ranging from 84.6% in Worthing to 90.6% in Chichester). Asian and Asian British children and Black/African/Caribbean/Black British children account for 17.4% and 4.9% of the under-5 population in Crawley.

Table 5.9, Under 5's population in West Sussex

	West Sussex	Arun	Adur	Chichester	Crawley	Horsham	Mid Sussex	Worthing
% White British	**83.6%**	89.6%	87.5%	90.6%	62.2%	89.6%	87.5%	84.6%
% White Irish and White Other	**4.5%**	2.7%	6.8%	3.2%	6.6%	3.2%	3.9%	3.2%
% Mixed/Multiple	**4.7%**	4.2%	3.2%	2.8%	7.7%	4.1%	4.0%	6.4%
% Asian	**5.5%**	2.3%	2.0%	2.1%	17.4%	2.5%	4.0%	4.6%
% Black	**1.3%**	0.4%	0.3%	0.9%	4.9%	0.4%	0.6%	0.8%
% Other	**0.5%**	0.9%	0.2%	0.4%	1.3%	0.2%	0.1%	0.4%
% Total	**100.0%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
% BAME	**16%**	10%	12%	9%	38%	10%	13%	15%
Numbers BAME under 5	**7,645**	370	925	530	3,050	745	1,045	980

Source: ONS, 2011 Census

In Crawley, 9% of children and young people do not use English as their first language; this is between 1% and 3% elsewhere. Of these, roughly one in six cannot speak English well or at all, amounting to nearly 600 county-wide. This is highest in Adur (21%) and lowest in Arun and Mid Sussex (12%).

Table 5.10, Proficiency in English (3 - 15 years)

	West Sussex	Arun	Adur	Chichester	Crawley	Horsham	Mid Sussex	Worthing
Main language is not English (Total)	**3,675**	165	625	210	1,505	365	410	400
Main language is not English but can speak English well or very well	**3,090**	145	495	180	1,270	310	360	330
Main language is not English and cannot speak it or speak it well	**585**	20	130	30	235	55	50	70
(%) Main language is not English and cannot speak it or speak it well	**(15.9%)**	(11.7%)	(20.9%)	(14.4%)	(15.5%)	(14.5%)	(11.9%)	(17.8%)

Source: ONS, 2011 Census

5.6.2 Free childcare entitlement for preschool children

Disadvantaged two year olds, who meet the eligibility criteria, are entitled to access 570 hours of free early education, equivalent to 15 hours of provision a week for 38 weeks per year. Similarly, all 3 to 4-year-olds in England can get 570 hours of free early education or childcare per year. An analysis of take-up of formal childcare by two, three and four year olds showed that take-up is lower amongst the more disadvantaged groups for whom it is more beneficial (compared to the richest quintile). Some of the barriers identified for the low uptake of services include access to information, location of services, language and cultural considerations, particularly for ethnic minority groups.[68]

68 Khan O. Ahmet A. and Victor C, 'Poverty and Ethnicity: Balancing Caring and Earning for British Caribbean, Pakistani and Somali People', (York: Joseph Rowntree Foundation, May 2014).

5.6.3 Healthy child programmes

Research found that families from minority ethnic backgrounds and low-income populations were less likely to identify their children as obese, and therefore may not request or engage with additional support from services. Consequently, programmes to address child overweight and obesity may not be effective as the family may not recognise that the child is obese.[69]

Data from the Early Years Foundation Stage Profile shows that while overall 63.5% of children in West Sussex attained a 'Good Level of Development' (GLD), for children from BAME backgrounds, this was approximately 8% lower.

Key points

- In Crawley, one in three children is from a BAME group; other local authorities in West Sussex range from 84.6% in Worthing to 90.6% in Chichester. Asian and Asian British children and Black/African/Caribbean/Black British children account for 17.4% and 4.9% of the under-5 population in Crawley.
- In Crawley, 9% of children and young people do not use English as their first language; between 1% and 3% elsewhere.
- Roughly one in six children cannot speak English well or at all, amounting to nearly 600 county-wide.
- Some of the barriers identified for the low uptake of free childcare include access to information, location of services, language and cultural considerations, particularly for ethnic minority groups.
- Parents of children from minority ethnic backgrounds are less likely to self-identify their child as overweight – and are less likely to self-refer them to healthy weight programmes.
- Children from minority ethnic groups are less likely to achieve a "good level of development" than White British children.

Relevant recommendation(s): 3,. 6., 7., 8., 9,. 10., 12., 13., 14., 15., 16., 18., 19,. 20.

Indicator	Outcome
1.1	Child poverty
1.2	School readiness
1.3	Pupil absence
1.5	16-18 year olds not in education, employment or training
2.2	Breastfeeding
2.5	Child development at 2 – 2 ½ years
2.6	Excess weight in 4-5 and 10-11 year olds
2.7	Hospital admissions caused by unintentional and deliberate injuries in children and young people aged 0-14 and 15-24 years
2.8	Emotional well-being of looked after children
3.3	Population vaccination coverage
4.1	Infant mortality
4.2	Tooth decay in children aged 5

69 Barlow J. et al Axford N., 'Rapid Review to Update Evidence for the Healthy Child Programme 0-5', ed. by Public Health England (London: Public Health England: Dartington Social Research Unit, Warwick Medical School, University of Warwick, Centre for Children and Families Applied Research (CCFAR), Coventry University, Plymouth University Peninsula Schools of Medicine & Dentistry, and NIHR CLAHRC South West Peninsula., 2015).

Section 6: Views and experiences

When we go back home the service is better as they resolve the problem, but we do have to pay for it (Female, Sri Lankan, 18–24).

If you make a complaint, the English people stick up for each other even if they know they are wrong, so people like me have no hope (Male, Pakistani, 25–64).

Most of the people who are racist are not educated or have not travelled (Female, Ugandan, 25–64).

Illnesses do not take the weekend off (Female, Indian, 25–64).

The interpreter understands properly what I am saying and interprets it exactly, more than what my husband or daughter can do; it's not their fault but they cannot interpret properly (Female, Pakistani, 25–64).

Try to understand an explanation of something difficult about a language you do not speak given in that same language which you are struggling to learn. We are not used to this system of teaching (Male, Latvian, 25–64).

My husband acted as my interpreter and this is not right because what I want to talk about is my personal business and I want someone who is not connected to me or my family to speak for me (Female, Morocco, 25–64).

In Estonia the attitude among police is that: 'what happens in your family – it is your home problem' (Female, Estonia, 25–64).

New generations are not all aware of mental health (Indian, Female, 25–64).

We are not part of the same sort of community or family setting now and so a lot of people still suffer in silence and alone and do not get help (Female, Namibian, 25–64).

6.1 Findings from the Community Engagement

To advise on the needs assessment, a qualitative community engagement was commissioned, to be conducted by an independent research body. This report sits separately to the full needs assessment and contains its own findings and recommendations. These findings are included below and quotes from participants in this research have been used throughout the body of this report. The full report can be found at: http://jsna.westsussex.gov.uk/reports. - *Stakeholders are encouraged to read the full document due to the depth of the discussion and findings.*

The work was delivered by The Young Foundation, using a participatory approach with community researchers. Over 100 people from BAME communities were engaged with expert support from The Young Foundation. Community researchers also contributed to the analysis of the data and reviewed the final report.

The research had four main aims:

- to obtain a detailed understanding of the wellbeing and health and social care needs of the BAME population
- to identify gaps in service provision and the extent to which existing services meet the needs of the population
- to determine the barriers and enablers to accessing services and exploring what changes are required in order for those barriers to be overcome
- to identify priorities for action and indicators for monitoring progress towards change

6.1.1 Life and wellbeing in West Sussex

West Sussex is broadly perceived to be a peaceful, safe and stable area in which to live and raise a family, benefiting from close proximity to scenic countryside and coastal areas. That said, many newer arrivals are feeling the effects of the housing shortage.

The area has experienced considerable change as a result of immigration, particularly in the larger towns, and there is a sense from many people that the area has adapted in response.

Although there were a number of positive aspects identified from the groups interviewed, a number of barriers and challenges remain.

There is largely a strong sense of belonging and integration with local society, with many actively involved in cultural and religious groups which help to reduce isolation and foster a sense of belonging. Conversely, many others feel more isolated and separated, with proficiency in English identified as major determinant of isolation. This is compounded by a lack of free or affordable local English classes.

Time constraints or a lack of access to transport, particularly in communities where there is a high prevalence of shift and night work, also hinder integration.

Discrimination and racist abuse in public were reported, although described as isolated incidents caused by individual ignorance. Specific services were highlighted as sources of repeated discrimination, including a specific GP practice was and the care home sector.

Local schools are perceived to be very good, with many praised for providing additional support to students for whom English is a second language. Concerns were raised by Eastern European families, about racist bullying in secondary.

Perceptions of the police differ significantly across communities; with Eastern European community attitudes shaped by negative experiences in home countries. Among the Asian community in Crawley perceptions have been shaped by a spate of crime directed at this group.

When problems arise, Citizen's Advice Bureaux are generally well-known and well regarded.

6.1.2 Using health and social care services

Perception of health care services are typically shaped by experience of health systems in "home" countries, where, for those who can afford it, the service is more comprehensive and efficient, when compared with the NHS. Specifically, widespread dissatisfaction with GP services was reported.

The standard of dental care is considered to be poor. It is not uncommon for people to access more affordable and better quality services abroad.

Language barriers present a major challenge for accessing health and social care. On the whole, the majority suggest they neither want nor expect services to be tailored to the specific needs of their community. Their expectation is simply that they should have access to the same quality of services as the majority community. However, there are some specific religious/ cultural needs that some groups feel should be respected and accommodated.

6.1.3 Tackling taboos (mental health and domestic abuse)

Many people with mental health problems continue to face stigma. Stigma has its roots in traditional attitudes and cultural beliefs, which vary among the different ethnic groups.

Religious and cultural leaders are generally considered to be poor at offering appropriate support for mental health issues, although at times they may play a role in signposting to local services.

Domestic abuse is often a source of shame and subject to high levels of secrecy. Reporting of domestic abuse is seen as an action of last resort and often only dealt with in the family, or in the immediate community, if at all.

Key points

- To provide up to date qualitative evidence, over 100 people from BAME communities were interviewed by peer researchers from the local community.
- Due to the depth of discussion, stakeholders are encouraged to read the full document which can be found at the Public Health and Social Research Unit website: http://jsna.westsussex.gov.uk/reports.
- Many of the findings from this report have been referenced through this needs assessment to aid interpretation of literature, quantitative data and service-level data.

Relevant recommendation(s): 1., 2., 3., 4., 5., 6., 7., 8., 9., 10., 11., 12., 13., 14., 15., 16., 17., 19., 20.

6.2 Gypsies and Travellers

To inform on how residents from the Gyspy and traveller communities perceived life in West Sussex and health and social care systems, the charity Friends, Families and Travellers (FFT)[70] were commissioned to run a focus group with a similar structure to those of the Young Foundation. A full report of this focus group is available from: http://jsna.westsussex.gov.uk, though the abridged findings are included here.

Twelve people were interviewed, (eight female and four male). Ten participants were between 25 and 64 and two were between 18 and 24. Most had spent more than four years in the county.

6.2.1 Life in West Sussex

The group mentioned how much they enjoyed the green spaces within the County; no matter which area or which housing status group they were living. One Female Traveller quoted *'there is an abundance of green space…it is one of the joys living in West Sussex.'*

Many expressed how difficult it has been to set up and feel secure within West Sussex. Some people explained that it was very hard to get access to a local authority site and that there are no New Traveller local authority sites available in the County. Multiple cases were given on how difficult it is to obtain a local authority pitch, which can lead to a range of serious problems. *"The older I got the less places were open for us to pitch down for a few days. It is a very stressful way of life and your nerves can go against you."*

6.2.2 Public perceptions and discrimination

Everybody commented about the negative media stories particularly around unauthorised encampments within the County. This in turn brought about negative opinion from parts of the settled community. This led on to the question 'Do you ever feel that you are treated differently because of your ethnicity when accessing public services'. Most said that they felt that they were treated differently.

Examples were given of police services that had been aggressive and negative in the past, or targeted them unfairly and how friends were turned away from registering at a GP surgery in the Crawley area because of their Traveller surname. Other problems or prejudice related to having lower reading and writing skills when interacting with public services and feeling judged.

> *"I have been publicly abused, blacklisted by committees and my details have been published in newspapers. I feel let down by The Police, local politicians, and council public servants. I feel that there is a Hate campaign against me.'*
>
> *"There have been signs in windows before and I have been turned away at pubs and clubs as have members of my family- just because of us being Travellers."*
>
> *"I no longer give Gypsy down as my ethnicity because so much prejudice and discrimination comes of it."*
>
> *"I would never tell anybody I am a Traveller. I don't tell employer/landlords or any services. I feel the council won't help me because they have had trouble with other Travellers in the past. I keep my ethnicity to myself."*

[70] Friends, Families and Travellers, est 1994. Registered charity: 1112326
http://www.gypsy-traveller.org

6.2.3 Language

When discussing 'is written language a barrier to you? Or have you helped others to understand or read literature?' there was a mixed response. Some said that they could read adequately and often had to help others in the community with poor literacy with forms or materials. FFT was mentioned as sources of assistance for those needing to create C.V.'s and fill out forms. Some who could read cited leaflets and information as too complex in wording and wished information was simpler.

6.2.4 Accessing public services

All but two people were registered with a GP. The majority of respondents were living in secure accommodation with an address which could be used to register. Although one woman gave an example about how someone she knew was denied access to a surgery because she was a Traveller.

FFT believe that people who are living on unauthorised encampments find it much harder to access GP services - often because they cannot produce address ID. NHS England has clear guidelines which reiterate that nobody who is eligible for healthcare should be denied because of lack of address ID - and that in such circumstances they could register their contact details from the surgery.

Generally, people were happy with their GP and would use the service if they had any worries about their health. Three people flagged up the issue that they found receptionists to be gate-keepers and had to fight their way through to get an appointment.

Several people said that they *would not* be happy about contacting police services, as they felt judged by the police. A majority said they would be unlikely to report a hate crime or any minor incidents because they would fear of not being listened to or treated in a fair manner. There was a general feeling from all that the police have a very negative image of Travellers and therefore Travellers avoid contacting them – although they said they would contact should they need to report a serious incident. Some said that they would ask advice from FFT should they feel it necessary to report a hate crime.

When discussing other services nobody had had cause to contact Adult Social Care, transport and community services or care support services. Three female respondents mentioned schools within the County.

> *'I am very happy with the school. My three children attend and they are very supportive. The teaching staff know that my children are Gypsy children and they always celebrate the Gypsy culture. I am very happy with the school.'*
>
> '*My children go to school and are doing well. Nobody knows that they are Gypsy kids. I don't tell anybody. I don't want them to suffer bullying like I did.'*

When the question was posed –'How do you think these services can be improved?' there were some reoccurring themes. Cultural training was a main recommendation. There were no comments on how police services could be improved or redesigned.

6.2.5 Accessing support

A general conversation took place about supporting community members and carers. All the respondents were keen to reiterate that they tended to look after their own and would not call in any help from outside agencies. However, this does not apply to all cases, as some vulnerable groups exist, who would benefit from caring support.

When asked 'Why do you think they've not tried or accessed support?' the answers centred on lack of knowledge, not knowing what services were available and where to signpost people. People who lived on sites stated that there was never any interest in helping Travellers on sites, although all mentioned the outreach service at FFT as positive.

6.2.6 Influencing change

When asked if they could 'Influence how services are provided and if they think they have a voice', three men and two women said *'not at all'* - The same respondents also felt that nothing could be done or put in place to give them any voice at all. Although one woman said if there were regular site or residents meeting then that may help. Some said that through organisation likes FFT they were able to get their voice heard. One noted that this focus group was allowing an unheard voice to be heard with the responses.

6.2.7 Mental health and domestic abuse

When discussing the subject of mental health within the community everybody agreed that it was still a taboo subject. One man said that both Travellers and the wider community still had serious issues around accepting mental health.

It was generally felt that mental health issues are hidden because of fear and even when community members are aware of an issue it is treated unsympathetically or ignored because it is still stigmatised. Some people mentioned that people would even be reluctant to go to any service because they would be fearful that they would be deemed unfit to care for their children if they were depressed.

Discussing Domestic abuse within the Traveller community produced similar answers to mental health issues. One person commented:' *it is hidden – not talked about. The elephant in the room'*

> *'I have called the police before because I knew it was going on. I think attitudes are slowly changing'*
>
> *'I called the police but it made my situation worse because after I had escaped I had social services involvement and I felt like I was the one in the wrong. I felt blamed for it all'*
>
> *'It is part of life and very sad. More people talk about it now but it is accepted. People rarely call police because they don't want their kids taken off them. Children mean everything.'*
>
> *'It is ignored until it becomes very severe.'*
>
> *'Some would put up with it. Lots put up with it and won't say anything. It's not acceptable but still goes on behind closed doors.'*

Key points

- Twelve people were interviewed to inform on how residents from the Gyspy and traveller communities perceived life in West Sussex and health and social care systems.
- Though there is an abundance of green space and countryside, multiple examples were given on how difficult it is to obtain a local authority pitch.
- Everybody commented about the negative media stories particularly around unauthorised encampments within the County and they all felt as though they were treated differently because of their identity.
- Literacy continues to be low for some community members, who ask others to help them when needed.
- There was a general feeling from all that the police have a very negative image of Travellers and therefore Travellers avoid contacting them. – A majority said they would be unlikely to report a hate crime or any minor incidents because they would fear of not being listened to or treated in a fair manner.
- All the respondents were keen to reiterate that they tended to look after their own and would not call in any help from outside agencies. However, this does not apply to all cases, as some vulnerable groups exist, who would benefit from caring support.
- Some expressed feelings that nothing could/would ever be put in place which would give them a genuine democratic voice.
- It was generally felt that mental health issues are hidden because of fear/uncertainty and even when community members are aware of an issue it is ignored or treated unsympathetically because it is still stigmatised.
- Serious issues still exist around domestic abuse: 'Some would put up with it. Lots put up with it and won't say anything. It's not acceptable but still goes on behind closed doors.'

Relevant recommendation(s): 1., 3., 4,. 5,. 6., 7., 10., 11., 12., 13., 14., 15., 16., 17., 18., 19., 20.

6.3 Children and family support services

As part of the West Sussex Early Years Needs Assessment (2016), a selection of semi-structured interviews and focus groups were conducted with demographic groups who were believed to be under-represented in Children and Family Centres and other support services. One such group was Eastern European families from the coastal Arun area. The full report into this work is available from the West Sussex JSNA website, though an abridged summary is included here:

6.3.1 Early years needs assessment: Eastern European mothers

In West Sussex, families are registered at Children and Family Centres by, either CFC staff, or Health Visitors, and the number of times they attend the CFC is recorded. However this varies as:

- Some families do not attend at all
- Some attend less than 6 times a year
- Some children are brought to the centres by others nannies, au pairs, child-minders, grandparents

Registration and attendance data is collected and reported by population in the reach area and by target groups.

Eastern Europeans parents were not easy to recruit for this research… and this is an indication of the challenge of reaching this group (from a council perspective); Participants were mainly found through service providers such as a community tutor, and a primary school head teacher. In all eight mothers attended a discussion group and two more attended one-to-one discussions.

6.3.2 Children and Family Centres

CFCs were set up to provide support and advice for parents of children from 0-5. Research participants were asked about their experiences of becoming a parent, and where they received support and advice.

Some of the Eastern European mothers had given birth in their country of origin and brought their children to the UK whilst they were young. They had some concerns in general about the health service in the UK but those who gave birth here did not raise any particular difficulties about maternity care.

Some mothers from Eastern Europe gave birth before coming to the UK often did not access local social activities for a while; one said she sat at home for 2 years 'doing nothing'. Their only contact in some cases was a Health Visitor and one visit is not sufficient to understand or be encouraged to access local services. For example one mother described a home visit when she came to the UK when she was given advice about immunisations. However she did not recall receiving any information about local facilities. She regrets that she did not find out about swimming lessons for mothers and babies.

The husbands of the Eastern European mothers were in full time employment, often working long hours in shifts, so they found it difficult to take part in organised activities. One described the loneliness when her husband was working: *Sometimes at the sea, but with two children and I'm alone, it's not easy, because my partner works. He works usually all day.*

CFCs are not thought of as a place to go for advice. Some use websites and social media as the main source of information.

In seeking advice from professionals Eastern European parents struggle with bureaucracy and are wary of authority and can feel distressed when they are unable to understand what is being asked of them. Some found consultations with GPs particularly stressful as there is insufficient time to explain when language is an issue.

Families found it difficult to understand how things are done in the UK and needed advice on housing, employment, and benefits. During the course of the research some mothers in a local playground were

interviewed in Polish and they took the opportunity to ask advice about applying for school places for their children. It was clear they were very worried about this and relieved to find a Polish speaker to advise them.

There was very little awareness of the CFC until Midwife or Health Visitor told the mothers about the drop in clinic there. Some Eastern European mothers did not know about services in their area and most did not know about CFCs*. "I didn't know anything about the [locality] or anyone. We would just go to the park and to the sea front and spend some time with friends and they play together. That's all, most of the times."*

Some who were visiting a CFC for the first time found it difficult to understand what they offered:

> ***Mother:*** *You can meet here…?*
> ***Interviewer:*** *Like you came here today in the afternoon*
> ***Mother:*** *But it's empty, there is no-one here. Why?*

Young mothers lack the detailed information about universal activities at CFCs that they would like. Some young parents found the information leaflet from CFCs useful but several found it difficult to follow. The Eastern European mothers were unaware that this information was available (and may not be able to make use of it as it is only available in English).

6.3.4 Eastern European mother's ideas for service development

Eastern European parents were more focused on the need for activities for their children but they would like opportunities to mix more with English people which is sometimes a challenge. One talented group of Polish parents would like to set up a drama and singing group for with English and Eastern European mothers. They felt it would be an enjoyable way to bring the communities together. Other suggestions to encourage engagement in CFCs included:

- Posters about CFCs in Polish shops
- A lending library of children's books in their first language
- Advice on employment and on applying for school places
- More information about what to expect when your child starts school
- Information about when centres are open for children to play
- For children; music, dancing and singing from around the world

6.3.5 Health services

Eastern Europeans do not think the health checks happen frequently enough as their child gets older. They consider health checks very important and are motivated to attend these but find them stressful if they do not speak English. They are very relieved if a member of CFC staff can speak the Polish language (which is also usually understood by other Eastern Europeans).

The Eastern European mothers talked about their concerns about the NHS in interviews. As outlined above, they are disappointed with health services in the UK. Checks are not as frequent and they are less able to access paediatric care. One had particular problems getting dental treatment for her daughter and described waiting two to three months for a treatment which would have happened inside a week in Poland.

6.3.6 Core messages

- The researchers devised a series of core messages to attract target groups to go to Children and Family Centres.

- Clarity about what is on offer and for whom. Clear communication in language and place appropriate for target audiences

- Effective relationship building with community champions
- Knowledge and understanding of target groups through increased participation and an involvement cycle: reviewing what works and what hinders access to services by listening to the parents.
- Building on and extending the CFCs structure and partnership with other early years providers.

Key points

- As part of the West Sussex Early Years Needs Assessment (2016), a selection of semi-structured interviews and focus groups were conducted, including an Eastern European group from the coastal Arun area.
- Many mothers with young children spend long periods isolated, when partners work long hours. Many may wish to engage with social/developmental activities locally, but are unaware of what is available.
- CFCs are not thought of as a place to go for advice. Some use websites and social media as the main source of information.
- Eastern European parents struggle with bureaucracy and are wary of authority and can feel distressed when they are unable to understand what is being asked of them. Some found consultations with GPs particularly stressful as there is insufficient time to explain when language is an issue.
- Families can find it difficult to understand how things are done in the UK and may need advice on housing, employment, and benefits in a language with which they are comfortable.
- Mothers from the community had many practical recommendations for improving integration and service accessibility.
- Many families from Eastern Europe were reported as 'disappointed' with the English primary care system, citing a lack of access to paediatric specialists and long waiting times. Poor opinions of the health service may deter them from utilising services as intended.
- The core messages from the research roughly align with those of this report.

Relevant recommendation(s): 1., 3., 4., 5., 6., 7., 8., 9., 10., 12., 13., 14., 15., 17., 19., 20.

6.4 Health and social care for older Asian residents

Separate to this needs assessment, in 2014 WSCC published research into the health and social care needs of older residents from minority communities in Crawley[71]. The full report is available from the West Sussex JSNA website, though an abridged summary is included here:

The study was carried out in order to identify the health and social care needs of older people from Asian communities in Crawley, West Sussex in relation to their specific religious and cultural needs. The study focused on Crawley in West Sussex, where a large number of first and second-generation older people from India, Pakistan, Bangladesh and Sri Lanka are living with (or close to) their third and fourth generation families. The primary source of data collection was utilising structured, semi structured and unstructured interviews as appropriate. Also a questionnaire to gain in depth information was used in structured interviews.

6.4.1 Language barriers

Language was identified as the main barrier when accessing services by almost 90% of people who were interviewed for this study. This caused poor communication and cultural misunderstandings that figured prominently in service user's experience of attending social groups. Some people from BAME communities are educated and hold qualifications from recognised institutions in their native land. However, once faced with language barriers or social or cultural environments they felt that their qualification was irrelevant or lost confidence in their ability. Consequently, they compromised with circumstances that were not suitable for them without demanding any change in the existing service.

Communication between service provider and people from BAME communities has been highlighted by many as a significant impact on their social life. Having access to good information about services was an issue highlighted by many individuals. Verbal information provided by a knowledge-expert may be more useful than written information in complex English or Asian languages as many older people from the first generation of BAME communities are not fully literate in their own language.

6.4.2 Cultural and religious barriers

One of the clear feelings among Asian community expressed is that diversity is ignored and cultural and religious needs were not examined in designing and commissioning the care services.

Asian communities feature various and diverse faiths and practices so individuals are less likely to access social activities designed to offer 'one service for all'. Practical issues such as accessible transport to appointments and day care services have been cited by many as a serious issue for disable and old people.

Using day care services is not common in older people from BAME communities due to language and cultural barriers. Many stressed the value of day care services or Day centre with staff and fellow users from the similar background, who can provide an environment where they feel at home and not isolated.

The importance of designing the service that is more culturally sensitive and allow BAME older people with a religious faith to practice their religion and to eat the sort of food that they enjoy was emphasized by everyone who was consulted.

6.4.3 Social isolation

Traditionally, in Asian cultures, it was the responsibility of younger generation to not only care for their parents and grandparents, but they were also expected to take the responsibility for financial support of their brothers and sister who were less stable due to unemployment or low paid jobs. Now, their children

[71] Shamim, R., 2014. 'Understanding the changing health and social care needs of older people from Asian communities in Crawley'. West Sussex County Council. Available from http://jsna.westsussex.gov.uk/

have adopted a western way of life. This kind of social and cultural change was unexpected. They found that their values may not hold the same significance as they would have hoped for even if they wish to stay at home with their families.

Increasing family dispersal due to jobs in other cities or abroad and marriages has left parents socially isolated and lonely in Asian communities as well, who normally expected their older life to be playing with their grandchildren. Many typically prefer isolation in their own home due to language, cultural and some extent religious barriers. In families where older people living with their grandchildren playing and walking them to park or school find a purpose of life there was noticeable positive impact on their health which prevented them from deteriorating mentally and physically.

Almost 80% of participant pressed on that they feel that they should be centrally important and held in mind by authorities when they plan and design services for the community.

6.4.4 Mental health issues

Stigma about mental health continues to be an issue across society, but may be greater in some BAME communities. Older people from BAME community perceive mental health issues differently from their younger generation. There are barriers in accessing care for mental health issues including fear of being labelled as mad.

6.4.5 Survey results

Accompanying this study was a survey of 250 older Asian people in Crawley was conducted. The report discusses these results in full.

Key points

- In 2014, a study was carried out in order to identify the health and social care needs of older people from Asian communities in Crawley, West Sussex in relation to their specific religious and cultural needs.
- Language was identified as the main barrier when accessing services by almost 90% of people who were interviewed for this study. This caused poor communication and cultural misunderstandings that figured prominently in service user's experience of attending social groups.
- Verbal information provided by a knowledge-expert may be more useful than written information in complex English or Asian languages as many older people from the first generation of BAME communities are not fully literate in their own language.
- The importance of designing a service that is more culturally sensitive was emphasized by everyone who was consulted.
- Generational changes towards a Western family structures/behaviours means that many older Asian residents are less supported by their family than they had traditionally expected. This, matched with wider family dispersal results in increased social isolation.

Relevant recommendation(s): 3., 4., 5., 6., 7., 8., 9., 10., 11., 12., 13., 14., 15., 16., 20.,

6.5 Healthwatch West Sussex

Healthwatch West Sussex has been in contact with the Research Unit and has fed back on the findings from the community engagement. Whilst Healthwatch are already a valuable resource for community and individual-level advocacy, they are currently planning to conduct further research into the perceptions and barriers to services amongst members of minority ethnic communities, in the future as well as an investigation into Adults Safeguarding.

Healthwatch West Sussex also encourage any residents encountering barriers to services to contact them for guidance and support, (details can be found here, http://www.healthwatchwestsussex.co.uk).

Section 7: Recommendations and future action

7.1 Recommendations

After consideration of the findings and discussion of the engagement element of this needs assessments; the following recommendations can be made:

Targeting specific services/needs

1. Commissioners and providers of maternity services, public health commissioners and practitioners should ensure that:
    a. Staff have adequate tools to assess risk and have clear referral pathways for women in those BAME groups at most risk of **gestational diabetes**, **perinatal mental illness;** and other factors associated **with intra-uterine deaths** or **poor neonatal outcomes**; using appropriate interpreting service (i.e. not a family member or friend) and translated literature where required.
    b. Local **childhood immunisation programmes** contain a **targeted** element to **BAME** groups, working with NHS England and Public Health England colleagues.

2. **West Sussex Fire and Rescue services,** in partnership with **Sussex Police** and **South East Coast Ambulance Service** and communities, should **increase awareness** in BAME groups (i.e. through campaigns) to highlight that you can **contact 999 emergency** services even if you **cannot speak English.**

Use of VCS for prevention, design and outreach

3. Commissioners should:
    a. Fund an **evaluated pilot** for a **local VCS** to work with their community and **co-develop resources**, (eg literatures, training events, etc.) which people would find accessible and effective in *tackling taboo issues* and highlighting the services to support those experiencing **domestic abuse, mental health issues, alcohol and drug misuse** or **disabilities.**
    b. Work with the **VCS** to provide **opportunities** (physical spaces, small grants) to cultural and religious **communities** seeking to **maintain links** to their traditional **culture or religion**.

Meaningful engagement and design of culturally appropriate services

4. **Commissioners** and providers of health, social care and allied health services should ensure there are **clear and transparent care packages** with **clear decision criteria**. These care packages should be **culturally** and **linguistically appropriate.**

5. **CCGs** and **local authorities** should support service providers to provide **clear pathways** for referral into **culturally appropriate services** (i.e. for **end of life and palliative care**) to support BAME **families and friends**. This should include:
    a. **Training** to ensure providers and staff are aware of specific **cultural issues** especially around **end of life** care in some groups
    b. **Meaningful** engagement with communities to **co-design** services.

Promoting services and making them appropriate

6. Commissioners of healthy lifestyle programmes should:
    a. Ensure that **healthy weight initiatives** have **culturally appropriate targeted activity**, especially for Black and South Asian groups and for a range of ages. These should clear **self-referral** mechanisms.
    b. Ensure that there is **sufficient provision** of, and awareness-raising activity around, **culturally appropriate physical activity opportunities** across all age groups.

7. **Information** about **free childcare** provision should be **accessible and available** to all, including BAME groups. **Commissioners, health visitors** and **children's and family centre** staff have a **role** in ensuring that they have **information** in a **range of languages** which reflect their local population.

Languages and interpreting/translation

8. **Commissioners** should **fund** high quality **affordable/accessible English language courses** aimed specifically at people coming to live in West Sussex. These services should take into account that the **ages** and **cultures** of those needing to access these services will **vary** from area to area and will also include school age children.

9. **Providers** should:
    a. Train frontline **staff** on how to refer those expressing **difficulties** with **English** to an **interpreting** service.
    b. Ensure frontline staff do not use family/friends/community members as casual/ convenient sources of interpreting.
    c. Have clear **referral mechanisms** into locally available, accessible and affordable **language classes** for those who use interpreting services.

10. **Providers** and **organisations** should **use local data** to identify **commonly spoken languages** within the ethnic communities and provide:
    a. Appropriate, **clear and prominent signage/literature** to highlight **interpreting services**
    b. **Literature** around **services** and **specific health conditions,** which allow for low literacy levels.

Awareness of specific issues when providing services

11. Commissioners should **support funding for** culturally and **linguistically appropriate talking therapies** for mental health conditions.

12. Commissioners and providers should provide/incorporate into current training for frontline staff on:
    a. How **immigration/residency status** may **affect disclosure** of domestic abuse
    b. Understanding ethnicity as a risk factor for social isolation.
    c. How housing quality can affect the health of BAME groups, disproportionately.

13. **Trusts, providers** and **organisations** should ensure that when a person accessing a service is known to have specific cultural or religious preferences that:
    - **a.** Information for front line staff is available and accessible, in order to deliver high quality, culturally sensitive care; for example, reviewing catering provision and gender specific personal care.
    - **b. Safeguarding practices** specifically **include processes** for **identifying and protecting children and adults** who may be at more **at risk** due to their **cultural backgrounds.**

Policy and strategy

14. The **process** of commissioning of **services** and formation of **policy** should include an **Equality impact assessment.**

15. **Public services**, including Sussex Police, should carry out a **review** of **workforce diversity** and ensure that their **recruitment policies** positively **reflect** their **local populations**, to increase confidence and cohesion.

16. **Commissioning processes** for **residential, domiciliary and inpatient facilities** should include providing **evidence** of a **comprehensive anti-discrimination policy**, which includes **training** for **all staff** and a **transparent reporting processes** for service users and staff where **discrimination** occurs.

17. **CCG**s should **support GP** practices to ensure that frontline **staff act** in accordance **with national guidance** regarding **registration** for services. I.e. practices should not refuse registration on the grounds that a patient is unable to produce evidence of identity, immigration status or proof of address

18. Efforts need to be made across **all** organisations to **increase** the quantity and quality of **data recording ethnicity**. Commissioners of health and social care services and the voluntary and community sector should ensure that this is **explicit in service specifications** with their providers.

School/early years

19. The **care wellbeing and education directorate** in West Sussex County Council should work with **schools** and boards of **governors** to undertake a **review** of policies to:
    a. **Identify** and visibly **tackle racially motivated bullying**, to ensure an **evidence-based** and consistent zero tolerance approach.
    b. Ensure that **teachers** have clear **guidance** on identifying and supporting minority ethnic **pupils** who may be **underperforming**, with culturally appropriate support

Recommendations from previous research

20. Any recommendations made in this report should be aligned with those contained in the:
    a. Gypsies and Travellers needs assessment (2010)
    b. Improving Access to Psychological Therapies report (2015)
    c. Early Years needs assessment (2016)

West Sussex County Council organisational Priorities

Acting on these recommendations would impact on the following measurable indicators:

- giving children the best start in life
- having a strong and diverse economy
- independent for longer in later life.

Public Health Outcome Framework indicators

The Public Health Outcomes Framework (PHOF) indicators are a set of measurable outcomes of population health. Public Health England are responsible for the measuring, monitoring and publication of local authorities' performance against these indicators. These results are published nationally, allowing comparisons to be made between local authorities, regionally and nationally. The results will indicate whether improvements have been made against these indicators; whether they have stayed the same; or whether they have deteriorated.

Indicator	Outcome
1.1	Children in poverty
1.2	School readiness
1.3	Pupil absence
1.5	16 – 18 year olds not in education, employment or training
1.15	Statutory homelessness
1.18	Social isolation
2.8	Emotional well-being of looked after children
2.10	Self-harm
2.23	self-reported well-being
2.3	Smoking status at time of delivery
2.5	Child development at 2 – 2 ½ years
2.21	Access to non-cancer screening programmes
2.22	Take up of the NJS Health Check programme – by those eligible
3.3	Population vaccination coverage
3.5	Treatment completion for TB
3.7	Comprehensive, agreed inter-agency plans for responding to health protection incidents and emergencies
4.8	Mortality rate from communicable diseases
4.10	Suicide rate
4.13	Health-related quality of life for older people
4.15	Excess winter deaths
4.12	Preventable sight loss

7.2 Progress made on recommendations for Gypsy and Traveller communities

In 2010 a full health needs assessment for Gypsies and Travellers was published by West Sussex County Council. This document contained a full set of recommendations for organisations under whose remit was the health and wellbeing of these communities. Rather than repeating this work in full, the Research Unit approached the community organisation Friends Family and Travellers to comment on the developments recently made to attaining these recommendations, as they perceived them. FFT acknowledge that since these recommendations were made, the shape of primary and secondary health provision has changed.

(The full response in included in the appendix and an abridged summary is as follows. This response was dated January, 2015.)

- **Partnership working and an integrated approach**
  Joint commissioning between local authority public health and CCGs would enable resources to be pooled to invest in services to reduce health inequalities. The need to clarify legal duties to address health inequalities and act upon these duties remains from the 2010 report, as does the need for strong leadership to gain momentum around this issue in a time of austerity.

- **Cross-boundary approaches**
  To date the possibility of joint commissioning targeted at Gypsy Traveller communities has not been explored. It remains the case that working in partnership with Brighton & Hove and East Sussex CCGs/HWBs should lead to greater service consistency and more cost-effective use of resources.

  There is no pan-Sussex meeting with a focus on Gypsy Traveller health.

- **Ethnic monitoring**
  Whilst 'Gypsy/Traveller' is not currently included in the NHS data dictionary in line with the 2011 census, this should not stop CCGs taking steps to improve the ethnic monitoring of future services.

- **Improving cultural awareness**
  How many GP practices have undergone Gypsy Traveller cultural competency training since 2010? The development of a training programme needs to be resourced and supported in recognition of the fact that the base level of prejudice against Gypsies and Travellers in society is high. The programme should be mandatory and take a practice-wide approach in order achieve culture change at an organisational level. The needs of Gypsy Traveller communities can get lost in mandatory Equality & Diversity training that is based upon the Equality Act 2010 as the focus is on the nine 'protected characteristics' where 'Gypsy/Traveller' is a sub-category of race.

- **Specialist and generalist services**
  The needs assessment states that specialist services "are able to devote dedicated resource and focus, develop long-term relationships with the Gypsy and Traveller community, bring deep insight and understanding of Gypsies' and Travellers' culture and needs, and share learning and expertise with other services."
  What has been done by CCGs / West Sussex County Council to improve the accessibility of generalist services?
  What specialist, targeted services have been commissioned to support Gypsy Travellers?

- **Child and maternal health**:
  The needs assessment acknowledges that - "the wellbeing of their children is a major motivating factor for Gypsies and Travellers, and influences many decisions about health, accessing services, and living, accommodation and travelling arrangements."
  Immunisation is one of many childhood health issues. Encouraging access to ante-natal care and culturally competent support for breastfeeding initiation and continuation are also key issues.

- **Investing to develop relationships and trust**

The recommendation is for individual GP practices to take the lead in developing more inclusive practise. For example, Market Harborough Medical Centre provided an enhanced service for Gypsies and Travellers where all staff were trained in the health needs of Traveller communities and the practice takes a 'more relaxed' position on appointments – if Travellers turn up without an appointment, rather than turn them away, staff will see them at the end of the clinic – an arrangement that works well for all.

Since 2010 what work has FFT done in West Sussex – what has been commissioned / de-commissioned?

- **Outreach services for health promotion**
  FFT is currently funded through the district council Health & Wellbeing Hubs to provide health improvement outreach to Gypsies and Travellers across West Sussex. This service consists of a part-time Gypsy Traveller health promotion worker and a part-time mental health and wellbeing worker. The recommendation is that outreach services should link in with children's services such as playbuses and family centres and includes oral health promotion. FFT work with a whole family approach but this outreach work is targeted at adults with a focus on reducing cardiovascular disease as this is the aim of the hubs.

  FFT does not currently receive any funding from the CCGs in West Sussex for outreach work.

- **Clarify abilities and capabilities of health visitors**
  Responsibility for commissioning health visiting moves into local authority in 2015. This opportunity should be used to clarify the role of health visitors in engaging with Gypsy Traveller families "in terms of discretion and flexibility to allow greater than standard frequency and intensity of contact with Gypsy Traveller families."

- **Provision and quality of authorised sites –**
  In an initial discussion with FFT outreach who workers regularly visit authorised sites across West Sussex the following issues were raised – (See appendix)

  GTANAs should be consulted and incorporated into the JSNA as the data in these documents remains relevant. – (See appendix)

  Site managers should be contacted for information regarding site conditions in West Sussex. Home Space Accommodation CIC took over the management of all the sites in West Sussex in November 2014.

- **Settled housing**
  The needs assessment documents the negative impact of moving into housed accommodation on mental health of Gypsies and Travellers including higher rates of anxiety and depression. There is currently no mental health service targeted at Gypsy Travellers that matches the high level of need within these communities.

- **Guidance for GPs**
  CCGs should ensure that GPs are aware of their duties around registering Gypsy Traveller patients. If a GP refuses to register a patient they must be given the reason for the decision in writing.

  If patients have problems registering with GPs it is the responsibility of the CCG (or NHS England) to help the patient find a practice (see Citizens Advice information on NHS patient rights). CCGs have the power to issue a memo to all practices regarding registration of Gypsy Traveller patient, reiterating the duty to register Gypsy Traveller patients onto their books.

- **Dental and oral health**
  There is currently no targeted outreach around oral health promotion. Gypsies and Travellers may struggle to find an NHS dentist and may have concerns about the cost of NHS dental treatment and not be aware of their entitlement to free dental care if on certain benefits, for example.

- **Patient-held records**
  There is still little evaluation of the effectiveness of hand-held records.

- **Invest in developing community capacity and social capital within Gypsy and Traveller communities**
  The health trainer model of peer education has a lot of potential for developing social capital and skills within the Gypsy Traveller community. FFT offers the RSPH level 1 and 2 in health improvement and is currently registering as an RSPH centre in order to be able to offer this qualification in a more flexible manner.

- **Continuity of care and access to secondary care**
  The problem of lack of continuity of access to secondary care will continue to arise for Gypsies and Travellers with high level of mobility. Professionals need to be aware of the difficulties people face if they are travelling in keeping appointments and demonstrate cultural understanding. Lack of transit site provision has a direct impact on continuity of care.

- **Supporting improved access to social care**
  FFT has had funding from NHS England, West Sussex Coastal CCG and Bright & Hove CCG to support the implementation of personal health budgets providing support and advocacy for clients who may be eligible for budgets. FFT continues to work with a high number of Gypsy Traveller carers through our outreach work and supports access to social care where necessary.

7.3 Gaps in data

The following gaps in data exist within this report. In some instances, it is possible that in the future efforts can be made between partner organisations/providers to improve data collection, sharing and analysis:

1. West Sussex has one university and three major colleges open to adults, in Worthing, Chichester and Crawley. An understanding of ethnic minority use of higher education and the social networks there in would give insight into the needs of these groups and how outreach work can impact on communities.

2. Non-UK passport holders are particularly difficult to track in the resident population, in the years in between censuses. Estimates may be outdated and cannot account for seasonal or short term residents who neither complete the national census, nor register with public services; similarly with irregular migrants, who may attempt to avoid being known to any public services, for fear of disclosure or deportation.

3. Due to their transient lifestyle, accurate numbers for gypsies and travellers are difficult to maintain. Adding to this is a fear of prejudice/discrimination, which can lead to false ethnicity reporting when registering with public services.

4. The figures for smoking prevalence are often based on small sample sizes, and this is exacerbated by splitting samples by many distinct ethnic groups; the Tobacco Control Needs Assessment (2016) is examining this issue closer.

5. Sexual health and screening services do not robustly record data and this may be a reflection of a desire to not be identified by some in the community, - withholding personal information.

6. There are significant data gaps in traditional service-level data sources for health needs assessment (SUS hospital data, CCG data, GP data, QOF data) due to poor recording/disclosure of ethnicity. Life expectancy is also unreliable, due to high amounts of international immigration in these cohorts making figures meaningless.

7. Accurate figures for hearing loss in minority ethnic groups are needed as some migrants are believed to be at higher risk.

8. Local knowledge of how communities view those with disabilities and interact with professionals is needed to address concerns raised in the literature.

9. A health equity audit into Improving Access to Psychological Therapies (IAPT) in West Sussex recommended that ethnicity recording should be improved so that areas of unmet need can be assessed.

10. The recorded ethnicity of carers known to WSCC is insufficient to draw an accurate local picture, with nearly half of all known carers' ethnicities unknown. This is also the case with the Memory Assessment Service, which is essential in improving Dementia-related outcomes.

11. Where health checks are conducted in the workplace, ethnicity is roughly in line with that of the wider population. However, the GPs and pharmacies, which perform most health checks, are not obliged to report on ethnicity. As a central component of preventative care, understanding local uptake numbers would be valuable.

12. Dental health service user data is not widely available, due to fractured services. Improving this could highlight many wider issues, as oral health is a common indicator for health outcomes.

13. It is not known how well local ethnic minority communities perceive or access services relating to domestic violence or sexual exploitation. It is believed in the literature that many underutilise services.

14. Data surrounding FGM is poorly recorded/reported by health professionals, leaving little quantitative data to inform on local/national prevention strategies.

15. It is not known if there is an adequate or inadequate pool of potential fostering or adopting households from minority ethnic communities to allow young people to be placed with parents or carers of a similar ethnic background.

16. With the vast majority of older residents in communal establishments being White British (99%), further targeted work is needed to ascertain whether or not this will change significantly with BAME populations aging over the next generation, or if they will remain with family members.

17. During the 2015 community engagement, a question was included on the interview schedule concerning the community voice and being able to affect change at a local level by informing policy. Due to the length of the interview, this was widely omitted, leaving little data to inform on how to best develop dialogues with these communities and being to address many of the issues with the report.

References and sources in the text:

1. WEST SUSSEX JOINT STRATEGIC NEEDS ASSESSMENT: Executive Summary, 2014, [Online]. Available: http://jsna.westsussex.gov.uk/

2. THE YOUNG FOUNDATION, 2015. BAME Needs Assessment West Sussex: Findings from the community engagement, [Online]. Available: http://jsna.westsussex.gov.uk/

3. WSCC, Future West Sussex Plan, 2015-2019 [Online]. Available: http://www2.westsussex.gov.uk/ds/cttee/cc/cc121214i5aa.pdf

4. CRAWFORD, C., & GREAVES, E., 2015. Socio-economic, ethnic and gender differences in HE participation. Dpt. For Business, Innovation and Skills, [Online]. Available: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/474273/BIS-15-85-socio-economic-ethnic-and-gender-differences.pdf

5. ONS, 2014. Population projections [online]. Available: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections

6. ONS STATISTICAL BULLETIN, 2015. Migration Statistics Quarterly Report, August 2015 [Online]. Available: http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/internationalmigration/bulletins/migrationstatisticsquarterlyreport/2015-08-27

7. NYGAARD, C., & FRANCIS-BROPHY, E., 2013. Irregular Migration Project: A desktop analysis: Review of drivers of irregular migration in the South East, University of Reading [Online]. Available: http://www.secouncils.gov.uk/wp-content/uploads/2012/04/Irregular_Migration_Project_FINAL-web.pdf

8. CITY OF SANCTUARY, 2014, Annual report [Online] Available: https://cityofsanctuary.org/wp-content/uploads/2015/01/City-of-Sanctuary-annual-report-final-version.pdf

9. HOME OFFICE NATIONAL STATISTICS, 2016, Asylum, [Online]. Available: https://www.gov.uk/government/publications/immigration-statistics-october-to-december-2015/asylum#key-facts

10. Friends Families and Travellers (FFT), Report for West Sussex County Council Public Health, May 2015 [Online]. Available: http://jsna.westsussex.gov.uk/

11. PHE, 2015, 'Reducing social isolation across the lifecourse', available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/461120/3a_Social_isolation-Full-revised.pdf

12. FINNEY, N., HARRIES, B., 2013. How has the rise in private renting disproportionately affected some ethnic groups? Centre on Dynamics of Ethnicity, University of Manchester [Online]. Available: http://www.ethnicity.ac.uk/medialibrary/briefingsupdated/how-has-the-rise-in-private-renting-disproportionately-affected-some-ethnic-groups.pdf

13. STEWART, J., 2013, 'Effective Strategies and Interventions: Environmental health and the private housing sector'. Chartered Institute for Environmental Health [Online]. Available: http://www.cieh.org/policy/Effective_Strategies_and_Interventions_Environmental_health_and_the_private_housing_sector.html

14. STOKES, L., ROLFE, H., HUDSON-SHARP, N., & STEVENS, S., 2015. A compendium of evidence on ethnic minority resilience to the effects of deprivation on attainment. National Institute of Economic and Social Research [Online]. Available: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/439861/RR439A-Ethnic_minorities_and_attainment_the_effects_of_poverty.pdf

15. PUBLIC HEALTH OUTCOMES FRAMEWORK, 2014/15 [Online]. Available: http://www.phoutcomes.info/

16. BERTRAM, T., PASCAL, C., 2014. 'Early Years Literature Review'. The Centre for Research in Early Childhood, [Online]. Available: https://www.early-education.org.uk/early-years-literature-review

17. LAW, I., FINNEY, S. AND SWANN S.J., 2012. Searching for Autonomy: young black men, schooling and aspirations. University of Leeds, School of Sociology and Social Policy [Online]. Available: http://www.tandfonline.com/loi/cree20#.VwU4t_BwbIU

18. FRUMKIN, L.A., & KOUTSOUBOU, M., 2013. Exploratory investigation of drivers of attainment in ethnic minority adult learners. Journal of further and higher education, vol 37, issue 2.

19. Waddell, G., & Burton, K., 2006. Is work good for your health and well-being?. The Statutory Office [Online]. Available: www.tsoshop.co.uk

20. MJ, 2015, Statistics on Race and the Criminal Justice System 2014 [Online]. Available: https://www.gov.uk/government/statistics/race-and-the-criminal-justice-system-2014

21. ONS, 2015, Crime Survey for England and Wales [Online]. Available: http://www.crimesurvey.co.uk/

22. SUSSEX POLICE, 2014, Diversity Analysis [Online]. Available: http://www.sussex.police.uk/media/10562/equality_analysis_data_2014v2.pdf

23. BAILEY, K., LEOW, T., CARMICHEAL, S., STEWART, S., 2015. West Sussex smoking cessation health equity audit 2013/14, West Sussex Public Health Research Unit [Online]. Available: http://jsna.westsussex.gov.uk

24. ASH, 2011. Tobacco and ethnic minorities [Online]. Available: http://ash.org.uk/files/documents/ASH_131.pdf

25. NATIONAL OBESITY OBSERVATORY, 2011. Obesity and Ethnicity [Online]. Available: https://www.noo.org.uk/uploads/doc/vid_9444_Obesity_and_ethnicity_270111.pdf

26. BHATNAGAR, P., SHAW, A., FOSTER, C., Generational differences in the physical activity of UK South Asians: A systematic review. International Journal of Behavioral Nutrition and Physical Activity. 2015;12(1).

27. BEDFORD BOROUGH COUNCIL JSNA, 2013. Physical Disability and Sensory impairment [Online]. Available: https://www.bedford.gov.uk

28. ASSOCIATION OF DIRECTORS OF SOCIAL SERVICES DISIBILITIES COMMITTEE, 2002. Progress in Sight: national standards of care for visually impaired adults. Association of Directors of Social Services, London.

29. ACTION ON HEARING LOSS, 2011. Facts and figures on hearing loss and tinnitus [Online]. Available: http://actiononhearingloss.org.uk

30. FACULTY OF THE PSYCHIATRY OF LEARNING DISABILITY OF THE ROYAL COLLEGE OF PSYCHIATRISTS, 2011. Minority ethnic communities and specialist learning disability services [Online]. Available: http://www.rcpsych.ac.uk/pdf/FR_LD_2%20for%20web.pdf

31. CARE QUALITY COMMISSION, 2010. Count me in 2010: Results of the 2010 national census of inpatients and patients on supervised community treatment in mental health and learning disability services in England and Wales [Online]. Available: http://www.cqc.org.uk/sites/default/files/documents/count_me_in_2010_final_tagged.pdf

32. WEST SUSSEX PUBLIC HEALTH RESEARCH UNIT, 2014. West Sussex Mental Health Needs Assessment (Adults) [Online]. Available: http://jsna.westsussex.gov.uk/

33. WEST SUSSEX PUBLIC HEALTH RESEARCH UNIT, 2015. IAPT Health Equity Audit, [Online]. Available: http://jsna.westsussex.gov.uk/

34. IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES, 2009. Black and Minority Ethnic (BME) Positive Practice Guide, [Online]. Available: http://www.iapt.nhs.uk/silo/files/black-and-minority-ethnic-bme-positive-practice-guide.pdf

35. IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES, 2009. Black and Minority Ethnic (BME) Positive Practice Guide, pp. 10-12 [Online]. Available: http://www.iapt.nhs.uk/silo/files/black-and-minority-ethnic-bme-positive-practice-guide.pdf

36. THE ALL-PARTY PARLIAMENTARY GROUP ON DEMENTIA, 2013. Dementia does not discriminate: The experiences of Black, Asian and minority ethnic communities [Online]. Available: https://www.alzheimers.org.uk

37. TIDY, C. 2014. Epidemiology of Coronary Heart Disease [Online]. Available: http://patient.info/doctor/epidemiology-of-coronary-heart-disease [Accessed 30/11/2015 2015].

38. KANDULA, R., PATEL, Y., DAVE, S., SEGUIL, P., KUMAR, S., BAKER, W., SPRING, B. & SIDDIQUE, J. 2013. The South Asian Heart Lifestyle Intervention (SAHELI) study to improve cardiovascular risk factors in a community setting: design and methods. Contemporary clinical trials, 36, 479.

39. LEPIÈCE, B., REYNAERT, C., VAN, M. P. & LORANT, V. 2014. General practice and ethnicity: an experimental study of doctoring. BMC family practice, 15, 89.

40. SKI, C. F., KING-SHIER, K. M. & THOMPSON, D. R. 2014. Gender, socioeconomic and ethnic/racial disparities in cardiovascular disease: A time for change. International Journal of Cardiology, 170, 255-257.

41. CHANDLER, R. & MONNAT, S. 2015. Racial/ethnic differences in use of health care services for diabetes management [Online]. Health Education & Behaviour. Available: http://heb.sagepub.com/content/early/2015/04/02/1090198115579416.abstract [Accessed 30/11/2015 2015].

42. STRATTON, I., ADLER, A., NEIL, A., MATTHEWS, D., MANLEY, S., CULL, C., HADDEN, D., TURNER, R. & HOLMAN, R. 2000. Association of glycaemia with macrovascular and microvascular complications of type 2 diabetes (UKPDS 35): prospective observational study. British Medical Journal, 321, 405/412.

43. VANN, M. 2012. How ethnicity affects type 2 diabetes risk [Online]. Available: http://www.everydayhealth.com/type-2-diabetes/ethnicity-and-your-diabetes-risk.aspx [Accessed 30/11/2015 2015].

44. CANCEREQUALITY. 2015. Ethnic Minority Cancer Awareness Month [Online]. Available: http://www.cancerequality.co.uk/site/emcaw/ [Accessed 30/11/2015 2015].

45. MARTINS, T., UKOUMUNNE, O. C., BANKS, J., RAINE, R. & HAMILTON, W. 2015. Ethnic differences in patients' preferences for prostate cancer investigation: A vignette-based survey in primary care. British Journal of General Practice, 65, e161-e167.

46. MARLOW, L., WALLER, J. & WARDLE, J. 2015. Barriers to cervical cancer screening among ethnic minority women: A qualitative study. Journal of Family Planning and Reproductive Health Care, 41, 248-254.

47. MUNDASAD, S. 2014. Cancer awareness 'low in black and South Asian groups' [Online]. Available: http://www.bbc.co.uk/news/health-29847644 [Accessed 30/11/2015 2015].

48. CANCER RESEARCH UK. 2014. Cancer Incidence by Major Ethnic Group [Online]. Available: http://www.cancerresearchuk.org/health-professional/cancer-statistics/incidence/ethnicity#heading-Zero [Accessed 30/11/2015 2015].

49. WEST SUSSEX PUBLIC HEALTH, 2013, Looking Out for Carers in West Sussex, [Online]. Available: http://jsna.westsussex.gov.uk/

50. FIGURE 8 CONSULTANCY SERVICES, 2014. West Sussex alcohol and drug needs assessment [Online]. Available: http://jsna.westsussex.gov.uk/

51. DH ANALYTICAL TEAM, 2014. Birth Ratios in England and Wales: A report on gender ratios at birth in England and Wales, [Online]. Available: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/313559/Sex_Selection_in_England_and_Wales_analysis_April_2014_NM_comments.pdf

52. DH, 2014. Abortion Statistics, England and Wales: 2014 [Online]. Available: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/433437/2014_Commentary__5_.pdf

53. KNIGHT, M., TUFFNELL, D., KENYON, S., SHAKESPEARE, J., GRAY, R., KURINCZUK, J., 2015. Saving Lives, Improving Mothers' Care Surveillance of maternal deaths in the UK 2011-13 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-13. National Perinatal Epidemiology Unit, for MBRRACE-UK [Online]. Available: https://www.npeu.ox.ac.uk/

54. DRAPER, E., KURINCZUK, J., KENYON, S., 2015. Perinatal Confidential Enquiry. Term, singleton, normally-formed, antepartum stillbirth. University of Leicester for MBRRACE-UK [Online]. Available: https://www.npeu.ox.ac.uk/

55. MARMOT, M, 2010. Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England Post 2010, in Marmot review, London: Institute of Health Equity. [Online]. Available: http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

56. MCANDREW, F., THOMPSON, J., FELLOWS, L., LARGE, A., SPEED, M., & RENFREW, M., 2012. Infant Feeding Survey UK, 2010. HSCIC [Online]. Available: http://www.hscic.gov.uk/catalogue/PUB08694/Infant-Feeding-Survey-2010-Consolidated-Report.pdf

57. OAKLEY L, RENFREW M, KURINCZUK J, ET AL. Factors associated with breastfeeding in England: an analysis by primary care trust. BMJ Open 2013;3: e002765. doi:10.1136/ bmjopen-2013-002765

58. ROUSE, P., 2015, Personal communication. Public Health and Social Research Unit

59. UNICEF, 2013. Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change [Online]. Available: http://www.unicef.org/publications/index_69875.html

60. AFRUCA, 2015. Voices of the community: Exploring female genital mutilation in the African community across Greater Manchester. Available from http://www.afruca.org/reports_from_afruca/afruca-fgm-report

61. REFUGE, 2016. Female Genital Mutilation (FGM) [Online]. Available: http://www.refuge.org.uk

62. CORAM BAAF, 2016. Children in public care. Available at: http://corambaaf.org.uk/res/statengland#uas

63. PUBLIC HEALTH AND SOCAIL RESEARCH UNIT, 2015. Early Years Needs Assessment [Online]. Available: http://jsna.westsussex.gov.uk/

64. WEST SUSSEX PUBLIC HEALTH, 2015. West Sussex Specialist Rapid Needs Assessment, [Online]. Available: http://jsna.westsussex.gov.uk/

65. CALANZANI, N., KOFFMAN, J., HIGGINSON, I., 2013. Palliative and end of life care for Black, Asian and Minority Ethnic (BAME) groups in the UK, King's College London, Cicely Saunders Institute [Online]. Available: https://www.mariecurie.org.uk/globalassets/media/documents/policy/policy-publications/june-2013/palliative-and-end-of-life-care-for-black-asian-and-minority-ethnic-groups-in-the-uk.pdf

66. DH, 2008. End of Life Care Strategy: Promoting high quality care for all adults at the end of life [Online]. Available: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/136431/End_of_life_strategy.pdf

67. NHS IMPROVING QUALITY, 2015. End of Life Care: Case study. 'Increasing the number of people from a Black, Asian and Minority Ethnic (BAME) background accessing palliative care services'. Marie Curie Hospice, Cardiff and the Vale [Online]. Available: http://www.nhsiq.nhs.uk/media/2690832/casestudy_increasing_awareness_palliative_care_final.pdf

68. KHAN, O., AHMET, A., & VICTOR, C., 2014. Poverty and Ethnicity: Balancing Caring and Earning for British Caribbean, Pakistani and Somali People. Joseph Rowntree Foundation [Online]. Available: https://www.jrf.org.uk/report/caring-and-earning-among-low-income-caribbean-pakistani-and-somali-people

69. AXFORD N., ET AL., (PHE), 2014. Rapid Review to Update Evidence for the Healthy Child Programme 0-5. Public Health England, London [Online]. Available: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/429740/150520RapidReviewHealthyChildProg_UPDATE_poisons_final.pdf

70. FRIENDS, FAMILIES AND TRAVELLERS, 2015. Public health focus group. [Online]. Available: http://jsna.westsussex.gov.uk

71. SHAMIM, R., 2014. Understanding the changing health and social care needs of older people from Asian communities in Crawley'. West Sussex County Council. Available at http://jsna.westsussex.gov.uk/

Appendix 1: Full Tables

Table A1.1, Full ethnic breakdowns, 2011 Census

(with percentages for groups within "Other" categories, not shown in Section 1)

Ethnic Group, 2011 Census Data		Numbers			Percentage		
		West Sussex	South East	England	West Sussex	South East	England
All categories: Ethnic group		806,890	8,634,750	53,012,455			
White: English/Welsh/Scottish/Northern Irish/British		717,550	7,359,000	42,279,235			
White: Irish		5,980	73,570	517,000			
White: Gypsy or Irish Traveller		1,075	14,540	54,895			
Other White groups	Afghan	-	110	1,515	0.0%	0.0%	0.1%
	Albanian	35	1,275	12,970	0.1%	0.3%	0.5%
	Anglo Indian	25	270	1,275	0.1%	0.1%	0.1%
	Argentinian	30	345	1,705	0.1%	0.1%	0.1%
	Australian/New Zealander	985	13,670	82,105	3.1%	3.6%	3.4%
	Baltic States	1,835	12,450	106,350	5.8%	3.3%	4.4%
	Bosnian	5	255	3,270	0.0%	0.1%	0.1%
	Brazilian	145	1,950	14,335	0.5%	0.5%	0.6%
	British Asian	-	80	680	0.0%	0.0%	0.0%
	Burmese	-	30	125	0.0%	0.0%	0.0%
	Chilean	15	140	1,110	0.0%	0.0%	0.0%
	Colombian	10	250	2,480	0.0%	0.1%	0.1%
	Commonwealth of (Russian) Ind. St.	695	9,000	56,270	2.2%	2.4%	2.3%
	Croatian	50	645	4,205	0.2%	0.2%	0.2%
	Cuban	5	60	295	0.0%	0.0%	0.0%
	Cypriot (part not stated)	45	1,525	15,190	0.1%	0.4%	0.6%
	Ecuadorian	5	45	400	0.0%	0.0%	0.0%
	European Mixed	4,525	48,835	298,400	14.2%	12.8%	12.3%
	Filipino	15	150	960	0.0%	0.0%	0.0%
	Greek	250	5,760	42,850	0.8%	1.5%	1.8%
	Greek Cypriot	65	1,340	25,775	0.2%	0.4%	1.1%
	Iranian	85	1,135	8,865	0.3%	0.3%	0.4%
	Israeli	30	320	3,235	0.1%	0.1%	0.1%
	Italian	1,505	17,210	117,745	4.7%	4.5%	4.8%
	Japanese	-	30	260	0.0%	0.0%	0.0%
	Kashmiri	-	-	105	0.0%	0.0%	0.0%
	Kosovan	20	765	13,465	0.1%	0.2%	0.6%
	Kurdish	30	345	9,035	0.1%	0.1%	0.4%
	Latin/South/Central American	225	2,760	22,485	0.7%	0.7%	0.9%
	Malaysian	5	25	130	0.0%	0.0%	0.0%
	Mexican	15	300	1,420	0.0%	0.1%	0.1%
	Moroccan	25	95	1,085	0.1%	0.0%	0.0%
	Multi-ethnic islands	30	240	1,090	0.1%	0.1%	0.0%
	Nepalese (includes Gurkha)	-	270	510	0.0%	0.1%	0.0%
	Nigerian	-	5	105	0.0%	0.0%	0.0%
	North African	25	525	5,385	0.1%	0.1%	0.2%
	North American	1,225	18,930	97,950	3.8%	5.0%	4.0%
	Other Eastern European	2,525	29,935	187,415	7.9%	7.9%	7.7%
	Other Middle East	30	485	5,045	0.1%	0.1%	0.2%
	Other Western European	6,485	76,200	387,325	20.3%	20.0%	15.9%
	Peruvian	5	65	395	0.0%	0.0%	0.0%
	Polish	5,725	71,475	494,355	17.9%	18.8%	20.3%
	Polynesia/Micronesia/Melanesia	5	45	280	0.0%	0.0%	0.0%
	Serbian	45	950	7,310	0.1%	0.2%	0.3%
	Somali	-	20	725	0.0%	0.0%	0.0%
	Somalilander	-	5	140	0.0%	0.0%	0.0%
	Sri Lankan	10	90	775	0.0%	0.0%	0.0%
	Tamil	5	15	200	0.0%	0.0%	0.0%
	Thai	5	115	475	0.0%	0.0%	0.0%
	Turkish	340	4,455	61,725	1.1%	1.2%	2.5%
	Turkish Cypriot	15	320	10,275	0.0%	0.1%	0.4%
	Venezuelan	5	115	500	0.0%	0.0%	0.0%
	Vietnamese	-	35	315	0.0%	0.0%	0.0%
	White African	110	1,315	5,010	0.3%	0.3%	0.2%

	White Caribbean	10	110	560	0.0%	0.0%	0.0%
	Any other ethnic group	4,615	53,815	312,055	14.5%	14.1%	12.8%
	WHITE OTHER TOTAL	**31,895**	**380,705**	**2,430,015**	**100.0%**	**100.0%**	**100.0%**
Mixed/multiple ethnic group: White and Black Caribbean		2,885	45,980	415,615			
Mixed/multiple ethnic group: White and Black African		2,060	22,825	161,550			
Mixed/multiple ethnic group: White and Asian		4,270	58,765	332,710			
Other Mixed/multiple ethnic groups	Afghan	5	70	695	0.2%	0.2%	0.2%
	African/Arab	-	20	325	0.0%	0.0%	0.1%
	Albanian	-	30	220	0.0%	0.1%	0.1%
	Anglo Indian	50	585	2,835	1.7%	1.5%	1.0%
	Australian/New Zealander	15	95	785	0.5%	0.2%	0.3%
	Baltic States	5	40	460	0.2%	0.1%	0.2%
	Black and Asian	30	540	6,220	1.0%	1.3%	2.2%
	Black and Chinese	-	45	505	0.0%	0.1%	0.2%
	Black and White	80	1,500	13,415	2.7%	3.7%	4.7%
	Black British	10	150	3,085	0.3%	0.4%	1.1%
	Black European	-	10	195	0.0%	0.0%	0.1%
	Black/African American	5	110	850	0.2%	0.3%	0.3%
	Brazilian	20	465	3,190	0.7%	1.2%	1.1%
	British Asian	-	60	640	0.0%	0.1%	0.2%
	Burmese	5	30	280	0.2%	0.1%	0.1%
	Caribbean Asian	15	230	2,235	0.5%	0.6%	0.8%
	Chilean	5	30	150	0.2%	0.1%	0.1%
	Chinese and White	160	2,330	13,025	5.5%	5.8%	4.6%
	Colombian	-	45	545	0.0%	0.1%	0.2%
	Commonwealth of (Russian) Ind. St.	5	115	795	0.2%	0.3%	0.3%
	Cuban	-	15	120	0.0%	0.0%	0.0%
	Cypriot (part not stated)	10	100	910	0.3%	0.2%	0.3%
	East African Asian	5	110	750	0.2%	0.3%	0.3%
	Ecuadorian	-	10	115	0.0%	0.0%	0.0%
	European Mixed	85	990	6,525	2.9%	2.5%	2.3%
	Filipino	20	335	2,110	0.7%	0.8%	0.7%
	Greek	5	180	1,780	0.2%	0.4%	0.6%
	Greek Cypriot	5	80	705	0.2%	0.2%	0.2%
	Indonesian	-	35	235	0.0%	0.1%	0.1%
	Iranian	30	430	2,925	1.0%	1.1%	1.0%
	Israeli	-	15	160	0.0%	0.0%	0.1%
	Italian	40	350	2,865	1.4%	0.9%	1.0%
	Japanese	-	120	755	0.0%	0.3%	0.3%
	Kashmiri	-	10	125	0.0%	0.0%	0.0%
	Korean	-	35	210	0.0%	0.1%	0.1%
	Kosovan	-	10	125	0.0%	0.0%	0.0%
	Kurdish	5	65	1,050	0.2%	0.2%	0.4%
	Latin/South/Central American	85	1,430	11,945	2.9%	3.6%	4.2%
	Malaysian	-	100	605	0.0%	0.2%	0.2%
	Mexican	20	185	1,245	0.7%	0.5%	0.4%
	Moroccan	25	125	960	0.9%	0.3%	0.3%
	Multi-ethnic islands	190	1,500	7,095	6.5%	3.7%	2.5%
	Nepalese (includes Gurkha)	-	105	240	0.0%	0.3%	0.1%
	Nigerian	5	10	125	0.2%	0.0%	0.0%
	North African	15	335	2,735	0.5%	0.8%	1.0%
	North American	20	320	1,615	0.7%	0.8%	0.6%
	Other Eastern European	5	175	1,710	0.2%	0.4%	0.6%
	Other Middle East	5	160	1,385	0.2%	0.4%	0.5%
	Other Western European	80	1,300	8,620	2.7%	3.2%	3.0%
	Peruvian	-	35	210	0.0%	0.1%	0.1%
	Polish	15	260	1,980	0.5%	0.6%	0.7%
	Polynesia/Micronesia/Melanesia	25	290	1,575	0.9%	0.7%	0.6%
	Somali	-	25	600	0.0%	0.1%	0.2%
	South Asian and Chinese	5	85	710	0.2%	0.2%	0.3%
	Sri Lankan	10	125	900	0.3%	0.3%	0.3%
	Tamil	-	10	125	0.0%	0.0%	0.0%
	Thai	15	130	650	0.5%	0.3%	0.2%
	Turkish	45	655	6,265	1.5%	1.6%	2.2%
	Turkish Cypriot	5	35	560	0.2%	0.1%	0.2%
	Venezuelan	-	25	130	0.0%	0.1%	0.0%
	Vietnamese	5	30	350	0.2%	0.1%	0.1%
	White African	20	260	1,625	0.7%	0.6%	0.6%
	White and Arab	105	1,285	8,710	3.6%	3.2%	3.1%
	White and East Asian	50	825	3,590	1.7%	2.1%	1.3%
	White and North African or Middle Eastern	15	315	1,765	0.5%	0.8%	0.6%

	White and South Asian	35	580	3,040	1.2%	1.4%	1.1%
	White Caribbean	5	140	980	0.2%	0.3%	0.3%
	Any other ethnic group	1,505	19,965	139,050	51.5%	49.7%	49.1%
	OTHER MIXED TOTAL	**2,925**	**40,210**	**283,010**	**100.0%**	**100.0%**	**100.0%**
Asian/Asian British: Indian or British Indian		9,660	152,130	1,395,700			
Asian/Asian British: Pakistani or British Pakistani		5,235	99,245	1,112,280			
Asian/Asian British: Bangladeshi, British Bangladeshi		2,345	27,950	436,515			
Asian/Asian British: Chinese		2,960	53,060	379,505			
Other Asian groups	Afghan	150	4,845	65,535	1.8%	4.0%	8.0%
	Anglo Indian	85	910	4,920	1.0%	0.8%	0.6%
	British Asian	180	2,560	24,760	2.2%	2.1%	3.0%
	Burmese	60	685	7,275	0.7%	0.6%	0.9%
	Cambodia	5	260	860	0.1%	0.2%	0.1%
	Caribbean Asian	20	270	1,960	0.2%	0.2%	0.2%
	Commonwealth of (Russian) Ind. St.	5	445	3,455	0.1%	0.4%	0.4%
	East African Asian	55	795	7,485	0.7%	0.7%	0.9%
	European Mixed	-	20	165	0.0%	0.0%	0.0%
	Ethnic Group (Unspecified)	2,685	23,100	122,760	33.0%	19.3%	15.0%
	Indonesian	65	935	5,035	0.8%	0.8%	0.6%
	Iranian	190	3,115	30,310	2.3%	2.6%	3.7%
	Italian	-	15	100	0.0%	0.0%	0.0%
	Japanese	320	4,690	32,390	3.9%	3.9%	4.0%
	Kashmiri	35	1,530	24,685	0.4%	1.3%	3.0%
	Korean	80	3,555	21,465	1.0%	3.0%	2.6%
	Kurdish	15	530	7,650	0.2%	0.4%	0.9%
	Latin/South/Central American	5	50	400	0.1%	0.0%	0.0%
	Malaysian	100	2,545	17,220	1.2%	2.1%	2.1%
	Multi-ethnic islands	270	3,220	24,330	3.3%	2.7%	3.0%
	Nepalese (includes Gurkha)	165	22,915	56,575	2.0%	19.2%	6.9%
	North American	-	30	145	0.0%	0.0%	0.0%
	Other Eastern European	-	5	130	0.0%	0.0%	0.0%
	Other Middle East	5	505	8,655	0.1%	0.4%	1.1%
	Other Western European	40	235	1,855	0.5%	0.2%	0.2%
	Polynesia/Micronesia/Melanesia	5	145	795	0.1%	0.1%	0.1%
	Punjabi	5	335	2,460	0.1%	0.3%	0.3%
	Sinhalese	10	225	1,665	0.1%	0.2%	0.2%
	Somali	-	5	255	0.0%	0.0%	0.0%
	Sri Lankan	1,955	16,675	145,280	24.1%	13.9%	17.7%
	Taiwanese	15	295	1,940	0.2%	0.2%	0.2%
	Tamil	185	1,970	24,035	2.3%	1.6%	2.9%
	Thai	555	6,390	32,590	6.8%	5.3%	4.0%
	Turkish	55	420	6,105	0.7%	0.4%	0.7%
	Turkish Cypriot	-	15	150	0.0%	0.0%	0.0%
	Vietnamese	190	2,295	26,990	2.3%	1.9%	3.3%
	Any other ethnic group	615	13,110	107,025	7.6%	11.0%	13.1%
	OTHER ASIAN/ASIAN BRITISH TOTAL	**8,125**	**119,645**	**819,410**	**100.0%**	**100.0%**	**100.0%**
Black/African/Caribbean/Black British: African		4,570	87,345	977,740			
Black/African/Caribbean/Black British: Caribbean		1,340	34,225	591,015			
Other Black groups	Afghan	-	20	135	0.0%	0.1%	0.0%
	African/Arab	-	15	170	0.0%	0.1%	0.1%
	Black British	435	6,455	133,880	34.9%	44.7%	48.2%
	Black European	-	60	910	0.0%	0.4%	0.3%
	Black/African American	10	330	3,990	0.8%	2.3%	1.4%
	Brazilian	5	60	750	0.4%	0.4%	0.3%
	Caribbean Asian	15	315	2,230	1.2%	2.2%	0.8%
	Colombian	-	5	140	0.0%	0.0%	0.1%
	Cuban	-	5	100	0.0%	0.0%	0.0%
	European Mixed	-	30	530	0.0%	0.2%	0.2%
	Filipino	-	15	110	0.0%	0.1%	0.0%
	Italian	-	10	155	0.0%	0.1%	0.1%
	Latin/South/Central American	10	230	3,745	0.8%	1.6%	1.3%
	Moroccan	30	50	780	2.4%	0.3%	0.3%
	Multi-ethnic islands	220	640	4,695	17.7%	4.4%	1.7%
	Nigerian	10	120	1,990	0.8%	0.8%	0.7%
	North African	15	90	1,815	1.2%	0.6%	0.7%
	North American	5	120	1,400	0.4%	0.8%	0.5%
	Other Western European	10	235	3,495	0.8%	1.6%	1.3%
	Polynesia/Micronesia/Melanesia	30	375	1,435	2.4%	2.6%	0.5%
	Somali	15	870	37,000	1.2%	6.0%	13.3%

	Somalilander	-	130	4,840	0.0%	0.9%	1.7%
	Sri Lankan	5	30	190	0.4%	0.2%	0.1%
	Any other ethnic group	430	4,235	73,365	34.5%	29.3%	26.4%
	OTHER BLACK TOTAL	**1,245**	**14,445**	**277,850**	**100.0%**	**100.0%**	**100.0%**
Other ethnic group: Arab		1,080	19,365	220,985			
Any other ethnic groups	Afghan	5	335	4,355	0.3%	1.1%	1.3%
	African/Arab	20	280	2,765	1.2%	0.9%	0.8%
	Albanian	-	60	700	0.0%	0.2%	0.2%
	Anglo Indian	5	40	250	0.3%	0.1%	0.1%
	Australian/New Zealander	5	75	700	0.3%	0.2%	0.2%
	Baltic States	5	75	930	0.3%	0.2%	0.3%
	Bosnian	-	-	130	0.0%	0.0%	0.0%
	Brazilian	35	320	2,835	2.1%	1.0%	0.9%
	Burmese	5	30	400	0.3%	0.1%	0.1%
	Caribbean Asian	5	105	710	0.3%	0.3%	0.2%
	Chilean	5	20	230	0.3%	0.1%	0.1%
	Colombian	5	80	1,290	0.3%	0.3%	0.4%
	Commonwealth of (Russian) Ind. St.	10	330	2,335	0.6%	1.0%	0.7%
	Cypriot (part not stated)	5	140	2,520	0.3%	0.4%	0.8%
	Ecuadorian	5	15	495	0.3%	0.0%	0.2%
	European Mixed	60	595	4,200	3.5%	1.9%	1.3%
	Filipino	55	870	6,755	3.2%	2.7%	2.1%
	Greek	10	195	2,265	0.6%	0.6%	0.7%
	Greek Cypriot	10	225	4,250	0.6%	0.7%	1.3%
	Indonesian	-	30	260	0.0%	0.1%	0.1%
	Iranian	195	3,565	31,980	11.5%	11.2%	9.8%
	Israeli	5	85	885	0.3%	0.3%	0.3%
	Italian	10	120	1,130	0.6%	0.4%	0.3%
	Japanese	5	190	1,050	0.3%	0.6%	0.3%
	Kashmiri	5	55	350	0.3%	0.2%	0.1%
	Korean	-	45	375	0.0%	0.1%	0.1%
	Kosovan	-	35	710	0.0%	0.1%	0.2%
	Kurdish	35	1,500	30,090	2.1%	4.7%	9.2%
	Latin/South/Central American	140	2,570	31,830	8.3%	8.1%	9.7%
	Malaysian	5	120	1,065	0.3%	0.4%	0.3%
	Mexican	5	195	1,380	0.3%	0.6%	0.4%
	Moroccan	50	250	3,745	2.9%	0.8%	1.1%
	Multi-ethnic islands	175	1,465	9,805	10.3%	4.6%	3.0%
	Nepalese (includes Gurkha)	5	720	1,535	0.3%	2.3%	0.5%
	North African	90	1,310	11,635	5.3%	4.1%	3.6%
	North American	10	110	1,165	0.6%	0.3%	0.4%
	Other Eastern European	10	755	4,950	0.6%	2.4%	1.5%
	Other Middle East	30	1,010	14,235	1.8%	3.2%	4.3%
	Other Western European	65	500	5,000	3.8%	1.6%	1.5%
	Peruvian	5	55	390	0.3%	0.2%	0.1%
	Polish	5	225	1,720	0.3%	0.7%	0.5%
	Polynesia/Micronesia/Melanesia	30	665	2,900	1.8%	2.1%	0.9%
	Punjabi	-	15	130	0.0%	0.0%	0.0%
	Somali	-	195	6,020	0.0%	0.6%	1.8%
	Somalilander	-	20	770	0.0%	0.1%	0.2%
	Sri Lankan	10	100	995	0.6%	0.3%	0.3%
	Tamil	5	30	530	0.3%	0.1%	0.2%
	Thai	10	120	785	0.6%	0.4%	0.2%
	Turkish	125	1,730	26,135	7.4%	5.5%	8.0%
	Turkish Cypriot	5	285	8,035	0.3%	0.9%	2.5%
	Vietnamese	5	55	845	0.3%	0.2%	0.3%
	Other ethnic group: Any other ethnic group	405	9,820	86,885	23.9%	30.9%	26.5%
	ANY OTHER ETHNIC GROUPS TOTAL	**1,695**	**31,735**	**327,430**	**100.0%**	**100.0%**	**100.0%**

Note – Numbers have been rounded to nearest 5

Source: ONS, 2011 census

Table A1.2, Main languages spoken in West Sussex, 2011 Census

Main Language	West Sussex	Adur	Arun	Chichester	Crawley	Horsham	Mid Sussex	Worthing
All usual residents aged 3 and over	779,009	59,049	145,041	110,443	101,602	127,080	134,943	100,851
English	742,041	57,620	138,321	107,370	88,303	123,650	130,305	96,472
Polish	6,299	134	2,545	652	1,670	323	452	523
Portuguese	1,954	37	452	149	959	77	133	147
Gujarati	1,652	26	49	38	1,354	35	84	66
Tagalog/Filipino	1,499	21	194	134	166	259	379	346
Urdu	1,438	8	35	16	1,229	39	54	57
French	1,435	77	146	156	421	220	264	151
Lithuanian	1,321	-	527	84	416	35	37	220
Tamil	1,312	5	51	27	1,037	25	89	78
Bengali (w/ Sylheti & Chatgaya)	1,226	142	184	76	268	78	161	317
Spanish	1,187	59	126	139	302	178	240	143
German	1,043	59	154	193	120	143	260	114
Italian	1,006	47	66	70	256	154	179	234
All other Chinese	969	78	143	148	127	137	166	170
Hungarian	922	34	134	44	341	162	151	56
Russian	895	42	359	73	175	60	83	103
All other languages	866	6	17	19	731	19	45	29
Malayalam	750	10	92	78	68	141	286	75
Arabic	700	159	55	41	251	51	48	95
Panjabi	652	10	7	-	580	21	15	18
Latvian	628	14	319	41	162	18	36	38
Romanian	620	16	103	51	165	126	121	38
Slovak	582	16	72	43	195	93	86	77
Turkish	538	35	76	38	132	37	106	114
Thai	440	27	77	40	56	67	78	95
Dutch	431	28	59	66	44	115	90	29
Bulgarian	400	23	74	41	89	25	96	52
Cantonese Chinese	393	38	44	49	63	58	87	54
Czech	383	15	50	52	64	55	85	62
Other African language	330	18	19	14	199	17	24	39
Pashto	305	8	10	5	267	5	-	7
Hindi	305	-	7	18	175	13	49	39
Persian/Farsi	284	22	20	36	73	33	23	77
Japanese	264	9	19	21	20	150	29	16
Shona	240	11	28	8	110	7	13	63
Swedish	232	19	18	21	31	64	44	35
Afrikaans	214	-	27	40	31	45	49	18
West African other	200	-	7	6	136	8	22	17
Danish	195	5	14	23	30	38	77	8
Greek	178	26	19	36	27	23	23	24
Sinhala	176	-	5	25	66	7	32	40
Mandarin Chinese	166	12	31	15	26	31	24	27
British sign language	160	12	24	5	38	12	33	36
South Asian other	147	-	9	13	88	-	13	17
Ukrainian	125	-	31	-	56	7	12	13
Other European (Northern non EU)	120	9	12	18	15	23	23	20
Nepalese	119	6	7	22	26	6	-	49
Vietnamese	113	-	8	34	18	-	6	42
East Asian other	104	-	17	10	11	23	18	23
Telugu	94	-	-	-	32	-	22	34
Swahili/Kiswahili	94	-	16	-	48	6	11	8
Kurdish	82	-	14	-	16	-	14	30
Serbian/Croatian/Bosnian	77	-	25	5	18	11	12	6
Finnish	73	7	7	11	7	11	17	13
Albanian	69	12	-	-	21	8	7	17
African Language: Luganda	66	-	5	12	39	-	-	6
Welsh/Cymraeg	63	-	9	15	5	9	17	5
Estonian	63	-	10	-	27	7	11	-
Marathi	59	-	-	-	26	10	5	14
Malay	56	6	11	-	13	7	9	7
Any Sign Communication System	53	5	7	-	9	-	9	16
West/Central Asian other	50	-	-	-	25	-	8	10
Korean	48	14	-	8	-	11	7	7
Igbo	45	-	-	-	26	13	-	-
Maltese	44	-	8	-	13	-	5	8
Oceanic language (any)	44	-	-	42	-	-	-	-
Sign Language (all other)	39	-	-	-	8	6	10	5
Hebrew	38	-	-	-	5	5	15	9
Akan	38	-	-	-	15	15	-	-
Yoruba	38	-	8	-	-	7	5	9

European Language (other non EU)	32	-	13	-	9	-	-	-
Any other Nigerian language	32	-	6	-	-	-	-	18
Somali	27	-	-	-	13	-	-	8
Any other European Language (EU)	21	-	5	6	-	-	-	-
African Language: Amharic	18	-	-	-	-	-	-	13
Scots	15	-	-	-	5	-	-	-
Pakistani Pahari (with Mirpuri and Potwari)	14	-	-	-	9	-	-	-
Romani language (any)	12	-	-	-	-	5	-	-
Slovenian	9	-	-	-	-	-	-	-
American language (any)	7	-	-	-	7	-	-	-
Gaelic (Not otherwise specified)	6	-	-	-	-	-	-	-
Tigrinya	6	-	-	-	-	-	-	-
Gaelic (Irish)	5	-	-	-	-	-	-	-

Note – Numbers have been supressed where fewer than 5 people were in an area

Source ONS, 2011 census

Appendix 2: Progress on the Gypsies and Travellers Needs Assessment Recommendations

Response from Friends, Families and Travellers (FFT)

- by Rachel Wemyss, Health Policy Officer, January 2015

What progress has been made on the recommendations in Health and social care needs of Gypsies and Travellers in West Sussex Council report to NHS West Sussex and West Sussex County, October 2010?
The commissioning landscape has changed significantly since the recommendations were made in 2010. As such, it is important to reflect on what progress was made on the recommendations made after this comprehensive needs assessment took place. Due to chronic social exclusion and entrenched health inequalities the information regarding the health needs of Gypsy Traveller communities is unlikely to have dated. Many of the recommendations in the report remain relevant but it is necessary to clarify responsibilities for actioning these recommendations at CCG and local authority level.

- **Partnership working and an integrated approach**
  Joint commissioning between local authority public health and CCGs would enable resources to be pooled to invest in services to reduce health inequalities. The need to clarify legal duties to address health inequalities and act upon these duties remains from the 2010 report, as does the need for strong leadership to gain momentum around this issue in a time of austerity. The health & social care act 2012 places a duty on CCGs and health and wellbeing boards to have due regard for the need to reduce inequalities in access to health care services and health outcomes. Through the health and wellbeing board local authorities and CCGs have a joint responsibility for producing JSNAs and Health & Wellbeing strategies that identify local inequalities and commissioning services to address these inequalities.

- **Cross-boundary approaches**
  To date the possibility of joint commissioning targeted at Gypsy Traveller communities has not been explored. It remains the case that working in partnership with Brighton & Hove and East Sussex CCGs/HWBs should lead to greater service consistency and more cost-effective use of resources.

  This is especially the case where FFT holds several contracts with Brighton & Hove / West Sussex / East Sussex for distinct projects that are delivered by the same small team of outreach staff.

  In response to Esther's comment – GTAG meetings are hosted by Sussex Police and primarily serve to improve accountability between police and Gypsy Traveller communities on the issue of unauthorised encampment and improve cultural awareness. There is no pan-Sussex meeting with a focus on Gypsy Traveller health.

- **Ethnic monitoring**
  NHS organisations should work to foster trust between health care professionals and Gypsy Traveller communities so that people have the confidence to ascribe their ethnicity on forms or verbally. The difficulties that the lack of reliable empirical data presents to commissioners must be acknowledged and an effort made to address these gaps. In future commissioning contracts should stipulate that the category 'Gypsy/Traveller' should be included in all ethnic monitoring in line with the 2011 census. Without robust ethnic monitoring in place it is impossible for CCGs to monitor whether services are being accessed by Gypsy Traveller communities.

  Whilst 'Gypsy/Traveller' is not currently included in the NHS data dictionary in line with the 2011 census, this should not stop CCGs taking steps to improve the ethnic monitoring of future services.

- **Improving cultural awareness**
  How many GP practices have undergone Gypsy Traveller cultural competency training since 2010?

  The development of a training programme needs to be resourced and supported in recognition of the fact that the base level of prejudice against Gypsies and Travellers in society is high. The programme should be mandatory and take a practice-wide approach in order achieve culture change at an organisational level. Cultural competent practice involves recognising the personal prejudices we all

carry so these views can be questioned and challenged in order to provide a professional, non-judgemental service.

The needs of Gypsy Traveller communities can get lost in mandatory Equality & Diversity training that is based upon the Equality Act 2010 as the focus is on the nine 'protected characteristics' where 'Gypsy/Traveller' is a sub-category of race.

(In response to Esther - the police are not a health service. Levels of trust between the police and Gypsy Traveller communities are historically low and the police have taken some action to address this in Sussex. Whilst prejudice and discrimination is a common thread, trust of healthcare services is a separate issue as it is affected by cultural beliefs (e.g. hygiene, modesty) and lack of understanding between communities and professionals.

- **Specialist and Generalist services (no comments on this recommendation from WSCC or CCGS)**
  There was a strong recommendation for an approach that improved the accessibility of generalist services whilst also commissioning specialist, targeted services for Gypsies and Travellers in recognition of "the complex, multi-factorial and inter-related nature of the health and wider social needs of Gypsies and Travellers, the cultural context in which they are embedded, and the profound disparities in health outcomes between Gypsies and Travellers and the mainstream community."

    - What has been done by CCGs / West Sussex County Council to improve the accessibility of generalist services?
    - What specialist, targeted services have been commissioned to support Gypsy Travellers?

  The needs assessment states that specialist services "are able to devote dedicated resource and focus, develop long-term relationships with the Gypsy and Traveller community, bring deep insight and understanding of Gypsies' and Travellers' culture and needs, and share learning and expertise with other services."

- **Child and maternal health**:
  The needs assessment acknowledges that - "the wellbeing of their children is a major motivating factor for Gypsies and Travellers, and influences many decisions about health, accessing services, and living, accommodation and travelling arrangements."
  Focusing on child and maternal health works to reduce health inequalities and improve engagement with services. Access to primary care is a key issue for Gypsy Traveller communities and the impact of poor or untimely access to primary care antenatal services has significant long-term consequences. National data points to higher rates of stillbirth, infant mortality and maternal death (Royal College of Gynaecologists, 2001) in Gypsy Traveller communities.

  Immunisation is one of many childhood health issues. Encouraging access to ante-natal care and culturally competent support for breastfeeding initiation and continuation are also key issues.

- **Investing to develop relationships and trust**
  The recommendation is for individual GP practices to take the lead in developing more inclusive practise. For example, Market Harborough Medical Centre provided an enhanced service for Gypsies and Travellers where all staff were trained in the health needs of Traveller communities and the practice takes a 'more relaxed' position on appointments – if Travellers turn up without an appointment, rather than turn them away, staff will see them at the end of the clinic – an arrangement that works well for all. For more information see the Inclusion Health Promising Practice guide – https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/307376/Promising_Practice.pdf

  Since 2010 what work has FFT done in West Sussex – what has been commissioned / de-commissioned?

- **Outreach services for health promotion**
  FFT is currently funded through the district council Health & Wellbeing Hubs to provide health improvement outreach to Gypsies and Travellers across West Sussex. This service consists of a part-time Gypsy Traveller health promotion worker and a part-time mental health and wellbeing worker. The recommendation is that outreach services should link in with children's services such as playbuses and family centres and includes oral health promotion. FFT work with a whole family approach but this

outreach work is targeted at adults with a focus on reducing cardiovascular disease as this is the aim of the hubs.

FFT does not currently receive any funding from the CCGs in West Sussex for outreach work.

- **Clarify abilities and capabilities of health visitors**
  Responsibility for commissioning health visiting moves into local authority in 2015.
  This opportunity should be used to clarify the role of health visitors in engaging with Gypsy Traveller families "in terms of discretion and flexibility to allow greater than standard frequency and intensity of contact with Gypsy Traveller families."

- **Provision and quality of authorised sites –**
  In an initial discussion with FFT outreach who workers regularly visit authorised sites across West Sussex the following issues were raised –
  - East Hampnett site - problems with kerbs on site for wheelchair users and push chairs
  - Small Dole – broken pavements, lack of utility blocks on one part of the site
  - Utilities on sites in West Sussex – residents do not have a choice about how and by who energy is provided. Electricity is currently paid for on a coin meter that provides electricity for the whole site with the cost being share equally between all residents (regardless of discrepancies in usage). Gas bottles are expensive and residents would like the option of having a mains gas supply. This has implications for fuel poverty and health.

  GTANAs should be consulted and incorporated into the JSNA as the data in these documents remains relevant.
  - Coastal West Sussex, April 2013, http://www.adur-worthing.gov.uk/media/media,114393,en.pdf
    Health and Safety
    - 3.64 Health and safety issues were of concern to one interviewee who expressed disquiet over the conditions on authorised sites, in particular: poor sanitation facilities; inadequate lighting and unsafe play areas.
    - 3.65 Improving access to primary care was deemed a priority - a number of suggestions were put forward to achieve greater accessibility and improve health outcomes:
      » Training provision for GP surgery support staff
      » A named health visitor for the community
      » Transit site provision.

  - Mid Sussex District, June 2013, http://www.midsussex.gov.uk/media/GTAA_FinalReport.pdf
    Health and Well-Being
    - 3.42 Most stakeholders were of the view that the health and well-being of the Gypsy and Traveller community on a national scale is poor.
    - 3.43 The District Council has a health and well-being team and effort have been made to improve the hygiene on sites through the provision of outside toilet facilities. A small number of stakeholders pointed out that the conditions on the Fairplace Hill site could contribute to poor health.

  - Horsham District, December 2012, http://www.horsham.gov.uk/__data/assets/pdf_file/0003/8967/HDC_Gypsy_Travellers_and_Traveling_Showpeople_Accommodation_Needs_Assessment_Dec_2012.pdf

  Site managers should be contacted for information regarding site conditions in West Sussex. Home Space Accommodation CIC took over the management of all the sites in West Sussex in November 2014.

- **Settled housing**
  The needs assessment documents the negative impact of moving into housed accommodation on mental health of Gypsies and Travellers including higher rates of anxiety and depression. There is currently no mental health service targeted at Gypsy Travellers that matches the high level of need within these communities.

- **Guidance for GPs**
  GP practices should show discretion and flexibility in registering Gypsy Traveller patients.

CCGs should ensure that GPs are aware of their duties around registering Gypsy Traveller patients. GP registration cannot be denied on the basis of race, gender, social class, age, religion, pregnancy or maternity, sexual orientation, appearance, disability or medical condition. If a GP refuses to register a patient they must be given the reason for the decision in writing.

If patients have problems registering with GPs it is the responsibility of the CCG (or NHS England) to help the patient find a practice. (see Citizens Advice information on NHS patient rights). CCGs have the power to issue a memo to all practices regarding registration of Gypsy Traveller patient, reiterating the duty to register Gypsy Traveller patients onto their books. It is in the CCGs interest to improve access to primary care as inaccessible primary care services put pressure on accident and emergency services.

- **Dental and oral health**
  There is currently no targeted outreach around oral health promotion. Gypsies and Travellers may struggle to find an NHS dentist and may have concerns about the cost of NHS dental treatment and not be aware of their entitlement to free dental care if on certain benefits, for example.

- **Patient-held records**
  There is still little evaluation of the effectiveness of hand-held records.

- **Invest in developing community capacity and social capital within Gypsy and Traveller communities**
  The health trainer model of peer education has a lot of potential for developing social capital and skills within the Gypsy Traveller community. FFT offers the RSPH level 1 and 2 in health improvement and is currently registering as an RSPH centre in order to be able to offer this qualification in a more flexible manner.

- **Continuity of care and access to secondary care**
  The problem of lack of continuity of access to secondary care will continue to arise for Gypsies and Travellers with high level of mobility. Professionals need to be aware of the difficulties people face if they are travelling in keeping appointments and demonstrate cultural understanding. Lack of transit site provision has a direct impact on continuity of care.

- **Supporting improved access to social care**
  FFT has had funding from NHS England, West Sussex Coastal CCG and Bright & Hove CCG to support the implementation of personal health budgets providing support and advocacy for clients who may be eligible for budgets. FFT continues to work with a high number of Gypsy Traveller carers through our outreach work and supports access to social care where necessary.

Appendix 3: Organisations/Groups & Departments Contact List for the Call for Evidence, 2014

Voluntary & Community Sector

1. Black and Minority Ethnic Community Services
2. Crawley Ethnic Minority Partnership (CEMP)
3. Crawley Kashmiri Women's Welfare Association
4. Sussex Ethnic Minority Support Agency (SEMSA)
5. Rivers of Women
6. Chinese Educational Development Project
7. Sussex Hungarian Society
8. Crawley Bangladeshi Welfare Association
9. Crawley Campaign Against Racism
10. Crawley Islamic Culture Centre (CICC)
11. Kerala Forum Worthing
12. Worthing Filipino Community
13. Worthing Indian Group
14. Asphaleia Action
15. Arun & Chichester Community Cohesion Group
16. Better Together Polish Association
17. CEMVO South East
18. Chagos Island Community Association (CICA)
19. Crawley Portuguese Association
20. Gatwick Detainees Welfare Group
21. Celtic and Irish Cultural Society (CICS)
22. Chagos Island Community Association (CICA)
23. Chagossian Elderly of West Sussex (Crawley)
24. Healthwatch
25. West Sussex CABs
26. West Sussex CVS/CVA
27. West Sussex VCS Chief Execs Group
28. Sussex Community Foundation
29. Friends Families and Travellers
30. STAG - Sussex Traveller Action Group
31. Sikh Community Centre Crawley
32. Soka Gakkai International – UK
33. Sri Lankan Muslim Welfare Association Crawley
34. Children in Care Councils
35. International Neighbours

Religious organisations

1. Afro Caribbean Association (ACA)
2. Ahmadiyya Muslim Association UK (Crawley)
3. Broadfield Christian Fellowship
4. Churches Together in Crawley
5. Crawley Interfaith Network
6. Crawley International Mela Association (CIMA)
7. Crawley Mosque
8. Gurjar Hindu Union (GHU)
9. Siri Guru Singh Sabha
10. Worthing Islamic Social & Welfare Society

Statutory Services

1. Police
2. Fire Service
4. Voluntary Sector Relationship Officers
5. Children and Family Centres

Strategic Partnership Forums
1. West Sussex Cooperative
2. Health and Wellbeing Cooperative
3. Health and Wellbeing Board & Business Planning Group

Commissioners
1. WSCC Health & Social Care Commissioners
2. Healthwatch Commissioner / JSNA
3. WSCC Public Health & Commissioning
4. CCG Commissioners – via CCG Engagement Officers

Statutory Sector Engagement Officers
1. Coastal CCG
2. Crawley CCG
3. Horsham & Mid Sx CCG
6. Adult Services Engagement & Consultation (BME Group)

Council commissioned / provided services
1. Chichester District Council and hub
2. Arun District Council and hub
3. Worthing Borough Council and hub
4. Adur District Council and hub
5. Horsham District Council and hub
6. Crawley Borough Council and hub
7. Mid Sx District Council and hub
8. West Sussex Local Assistance Network (LAN)
9. Environmental Health

Educational institutions
1. Chichester University (Black and Minority Officer)
2. Northbrook College

Service/Provider Forums
1. Think Family Executive Group
2. Countywide Transport Forum
3. West Sussex Forum for Independent Providers of Care
4. LD Provider Forum
5. MH Provider Forum
6. ABI Provider Forum (Acquired Brain Injury)
7. West Sussex Local Safeguarding Children Board
8. West Sussex Adults Safeguarding Board