

MANCHESTER JOINT STRATEGIC NEEDS ASSESSMENT

ADULTS AND OLDER PEOPLE

CHAPTER: Key Groups

TOPIC: Health of Black and Minority Ethnic (BME) Groups

WHY IS THIS TOPIC IMPORTANT?

The focus of this chapter is on Black and Minority Ethnic (BME) groups. This covers all categories of non-white groups, including non-white British groups such as Irish, Gypsy, Roma, Irish Traveller and White European. The chapter has been produced by Manchester Health and Commissioning (MHCC) in collaboration with the [BHA for Equality](#) - a health and social care charity which exists to challenge and address health and social care inequalities and support individuals, families and communities to improve their health and well-being.

The [Marmot Review \("Fair Society Healthy Lives"\)](#) demonstrated that inequalities in health exist across a range of social and demographic indicators, including income, social class, occupation and parental occupation, level of education, housing condition, neighbourhood quality, geographic region, gender and ethnicity. Inequalities are evident in many health outcomes, including mortality, morbidity, self-reported health, mental health, death and injury from accidents and violence.

Differences in the health of BME groups are most evident in the following areas of health: mental health, cancer, heart disease and related illnesses such as stroke, Human Immunodeficiency Virus (HIV), Tuberculosis (TB) and diabetes. Additionally, an increase in the number of BME older people is likely to lead to a greater need for provision of dementia services as well as the provision of culturally competent social care and palliative care. Groups such as Roma, Irish Travellers and Gypsies also face significant health inequalities.

Within BME groups, there are sub groups, such as asylum seekers and refugees, whose health is further compounded by other issues including immigration status. Issues in relation to refugees, asylum seekers and new migrant communities are covered in a separate chapter within the Adults and Older People's JSNA (currently in development).

Differences in health based on an individual's ethnicity, compared to the rest of the population, are well documented nationally, whether from work delivered through national government led programmes such as [Delivering Racial Equality \(2005\)](#) which was a five-year strategy to address ethnic inequalities in mental health, or from the national health survey that indicate that some ethnic groups have less positive experiences when using health service. Such differences are also evident across several risk factors for disease and disability such as smoking, obesity and lack of physical exercise. For example, there are higher tobacco consumption rates in Bangladeshi men in comparison to the general population.

THE MANCHESTER PICTURE

The BME population of Manchester

The most commonly used categorisation of non-white ethnic groups is that which was adopted in the 2011 Census. In the 2011 Census, people were asked to describe their ethnic group using one of 18 detailed categories (see question below). They were also able to write in their ethnic group, which were then condensed into 91 groups.

16 What is your ethnic group?

➔ Choose **one** section from A to E, then tick **one** box to best describe your ethnic group or background

A White

☐ English/Welsh/Scottish/Northern Irish/British

☐ Irish

☐ Gypsy or Irish Traveller

☐ Any other White background, write in

B Mixed/multiple ethnic groups

☐ White and Black Caribbean

☐ White and Black African

☐ White and Asian

☐ Any other Mixed/multiple ethnic background, write in

C Asian/Asian British

☐ Indian

☐ Pakistani

☐ Bangladeshi

☐ Chinese

☐ Any other Asian background, write in

D Black/African/Caribbean/Black British

☐ African

☐ Caribbean

☐ Any other Black/African/Caribbean background, write in

E Other ethnic group

☐ Arab

☐ Any other ethnic group, write in

Data from the 2011 Census shows that around 205,000 people in Manchester identified themselves as being from a BME group. This is equivalent to around 41% of the population of the city - twice the average for English local authorities as a whole (20%). In 2011, Manchester was the only local authority outside London to have residents in each of the 90 detailed ethnic groups listed in the Census.

The proportion of the population from a BME group varies across different parts of the city. In 6 out of the 32 wards in Manchester (Longsight, Moss Side, Cheetham, Rusholme, Ardwick and Whalley Range), over half of the population identified themselves as being from a BME group.

In Longsight and Moss Side, people from a BME group make up over two-thirds of the population. In contrast, less than 15% of the population in Sharston, Northenden, Moston, Brooklands and Woodhouse Park identified themselves as being from a BME group.

Broadly speaking the population of areas in the North East of the city and in Wythenshawe (south of the River Mersey) tends to contain a lower proportion of BME groups than areas towards the centre of the city.

However, some of the larger ethnic groups are clustered in particular wards across Manchester. At the time of the 2011 Census:

- More than a third of the Pakistani population was based in Longsight (36%), more than a quarter in Cheetham ward (28%) and more than a fifth in the wards of Whalley Range, Crumpsall and Levenshulme

- The Black African group was clustered in the wards of Moss Side (17%), Bradford (11%), Harpurhey (11%), Ardwick (11%) and Gorton North (10%).
- The 'Mixed' ethnic group was most commonly located in Moss Side (7%), Hulme (8%) and Ardwick (6%) wards.
- The Gypsy or Irish Traveller group had its largest population in Longsight. At the time of the 2011 Census, this group numbered 71 people (0.6%).¹

The number of people identifying themselves as being from a BME group doubled between 2001 and 2011 (41% in 2011 compared with 26% in 2001). The population increased across all BME groups except for the (much older) Irish population. The Asian population grew from 10% of the population in 2001 to 17% in 2011 and the Black population from 5% of the population in 2001 to 9% in 2011. The 'Other White' population (which includes White Europeans) grew from 3% of the population in 2001 to 5% in 2011.

The population of Manchester has increased in size since the 2011 Census was carried out. The figures in the table below show the estimated number of people from BME groups living in Manchester in 2017, based on the City Council's own forecasting model.

	Number of people	% of total population
White British	329,556	58.9%
White Irish	13,100	2.3%
White Gypsy/Irish Traveller	573	0.1%
Other White	27,494	4.9%
Mixed White/Black Caribbean	9,926	1.8%
Mixed White/Black African	4,926	0.9%
Mixed White/Asian	5,318	1.0%
Other Mixed	5,691	1.0%
Indian	12,698	2.3%
Pakistani	47,844	8.6%
Bangladeshi	7,145	1.3%
Chinese	15,438	2.8%
Other Asian	13,137	2.3%
Black African	29,312	5.2%
Black Caribbean	10,905	1.9%
Black Other	9,207	1.6%
Arab	10,658	1.9%
Other	6,603	1.2%
Total	559,531	100.0%

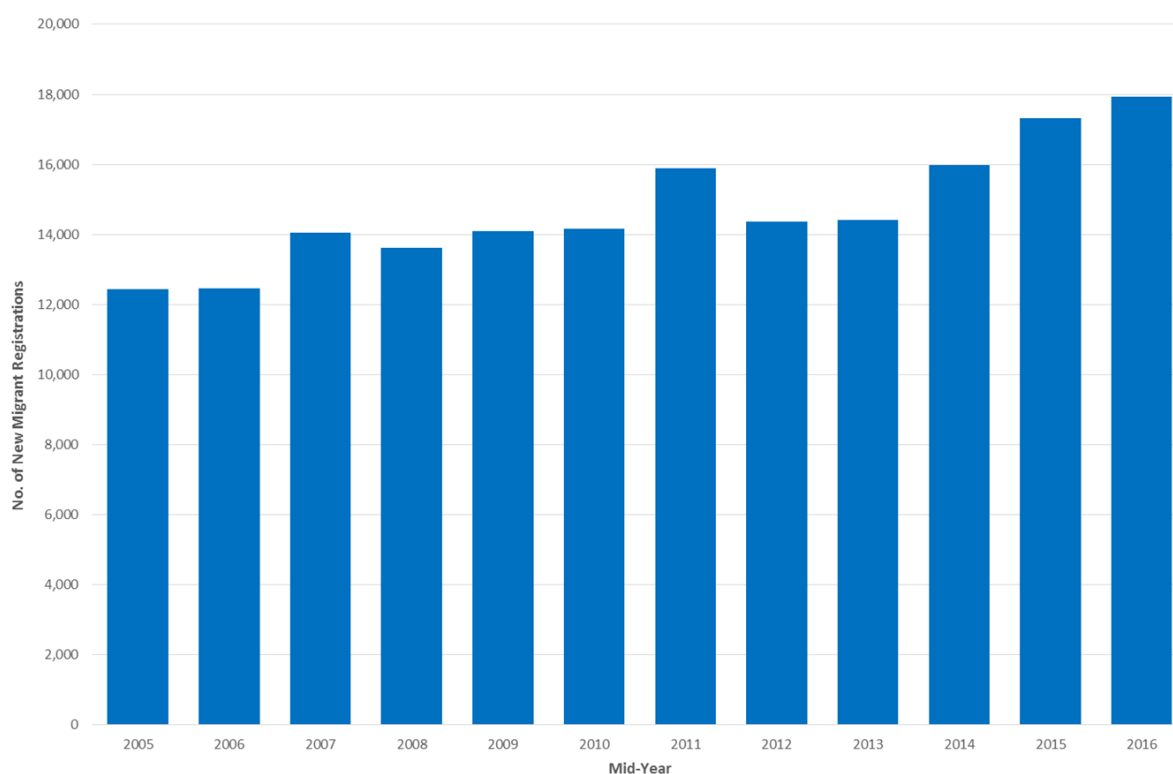
In absolute terms, it is estimated that the number of people identifying themselves as being from a BME group has increased from around 205,000 people in 2011 to around 230,000 in 2017 (assuming the proportion of the population from a BME group has remained unchanged since the 2011 Census).

¹ [Ethnic Group Summary: 2011 Census. Manchester City Council Research and Intelligence Team, 2013](#)

The BME community is constantly changing due, in part, to the different 'waves' of migration into Manchester that have occurred since the end of the 19th century. Many people identifying themselves as being from a BME group are from communities which established themselves in Manchester several generations ago but others are more recent arrivals. Data from the 2011 Census shows that most of the non-UK born residents living in Manchester arrived in the UK between 2001 and 2011, the main exception being those born in Ireland, over a third of whom arrived in the UK in the years before 1961. This is reflected in data from the annual [School Census](#) for 2016 which shows that there are around 149 different languages spoken by primary and secondary school children in Manchester.

When an individual born outside the UK registers with a GP for the first time (or if their previous address is reported as being outside of the UK), a 'flag' is generated on their record (known as a Flag 4). The chart below shows the number of GP registrations to new migrants in the period between the middle of 2005 and the middle of 2016.

Figure 1: Number of GP registrations to new migrants, mid-2005 to mid-2016



The latest data shows that between mid-2015 and mid-2016, there were nearly 18,000 new migrant registrations by GP practices in Manchester - a rate of 33.1 per 1,000 resident population. This is nearly 3 times higher than the England average rate of 12.0 per 1,000 resident population.

The impact of immigration on the diversity of the BME population can also be seen in the increase in the proportion of live births where the mother was born outside of the UK. In 2001, around 25% of live births in Manchester were to mothers born outside of the UK, By 2016, this had increased to 47%. Over half (55%) of these births were where either one or both parents were born outside of the UK. This compares with an England

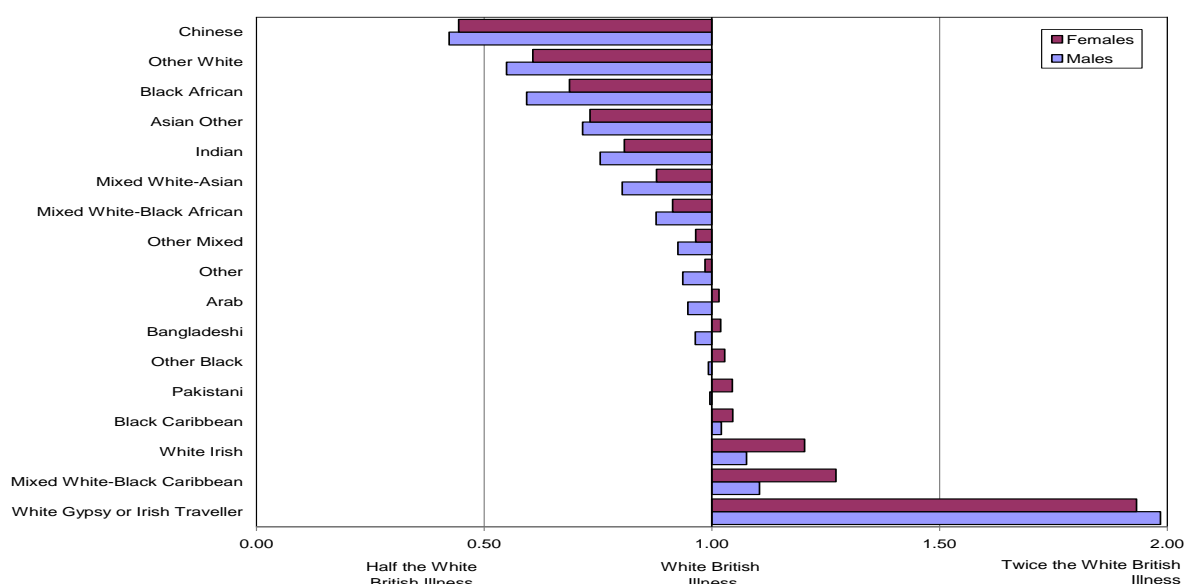
average of 35%. Although the proportion of births to mothers born in the countries within the European Union (EU) has increased, in numerical terms, births to mothers born in the Middle East and Asia and in Africa still make up the vast majority of births to non-UK born mothers living in Manchester.

Health issues among BME groups

The 2011 Census included two measures of health: limiting long-term illness (LLTI) and general self-reported health. Limiting long-term illness was measured by asking ‘Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?’

The following chart shows levels of limiting long-term illness (i.e. long-term illness that limits a person’s day-to-day activities in some way) by BME group for men and women based on data from the 2011 Census. The data shown are age-standardised ratios which allow us to properly compare ethnic groups with very different age structures.

Figure 2: Standardised rate of limiting long-term illness by BME group and gender



The chart shows that men from the White Gypsy or Irish Traveller, Mixed White-Black Caribbean, White Irish and Black Caribbean groups had **higher** rates of reported limiting long term illness than White British men. In contrast, Bangladeshi, Arab and Pakistani men reported **lower** rates of limiting long-term illness than White British men. White British women had similar rates of illness as White British men. White Gypsy or Irish Traveller women had the highest rates of limiting long term illness, almost twice that of White British women. Pakistani and Bangladeshi women also had worse health than the White British group. In contrast, Chinese, Other White and Black African women had **lower** rates of limiting long-term illness than White British women.

There is a general absence of locally specific data that can be used to estimate with any reliability the prevalence of diseases or health conditions among BME groups living in Manchester. However, it is likely that the diseases or health conditions that are most commonly found among BME groups in Manchester will be similar to those found among

BME groups across the UK. A BME health needs assessment carried out by the Public Health Team at Salford City Council contains a detailed review of the national evidence base in respect of the health problems faced by BME communities. This can be found on the [Salford City Partnership website](#).

In summary, national evidence suggests that the following health conditions have a particular impact on BME communities.

Condition		BME Groups
Sexually transmitted infections (STIs)	HIV	Black African New Migrants Men who have Sex with Men(MSM) Other BME people
	Other STIs	Syphilis Gonorrhea Hepatitis B Chlamydia Black African/Black Caribbean Black African/Black Caribbean Black African Black Caribbean women
Co-morbidities with HIV	Hepatitis C	South Asian (Pakistani) Black Africans and others testing for HIV
Infectious Disease	Tuberculosis	South Asian Black African
Diabetes	Diabetes	South Asian Black African/Black Caribbean
	Diabetic Retinopathy	Black African/Black Caribbean South Asian
Vitamin D deficiency	Rickets	South Asian
Mental health	Diagnosis of schizophrenia	Black Caribbean/Black African Irish
	Depression	South Asian Women BME groups with long term conditions Refugees and Asylum seekers BME groups diagnosed with HIV
	Suicide rate	Irish
Cardiovascular	Coronary Heart Disease	South Asian Black African/Black African
	Hypertension	Black African/Black Caribbean
	Stroke	South Asian Black African/Black Caribbean
Cancer	Prostate Cancer	Black African/ Black Caribbean men
	Breast Cancer	South Asian (Indian/Pakistani) Black African/Black Caribbean

	Cervical Cancer	Black African/Black Caribbean South Asian
	Bowel Cancer	South Asian Black African/Black Caribbean
	Lung Cancer	South Asian Black African/Black Caribbean Roma communities
	Stomach Cancer	Black African/Black Caribbean
	Multiple Myeloma	Black African/Black Caribbean
	Mouth Cancer	South Asian
	Liver Cancer	Black African/Black Caribbean
Inherited Disorders	Sickle Cell Disease	Black African/Black Caribbean South Asian (Indian) People of Mediterranean descent
	Haemochromatosis	Irish
	Thalassaemia	Black African/Black Caribbean Chinese Other Asian

In some cases, the disproportionate impact of certain health conditions on BME groups can be accounted for by genetic factors, which means that some BME groups have an inherited risk of specific diseases (e.g. Sickle Cell Disease among Black African and Black Caribbean communities). Cultural and religious practices, such as Female Genital Mutilation (FGM) can also play a part. Issues in relation to [Female Genital Mutilation](#) in Manchester are discussed in the Children and Young People's JSNA.

In other cases, the disproportionate impact of certain health conditions on BME groups is linked to socio-economic and other lifestyle risk factors, such as low income, housing, smoking, diet and alcohol consumption. For example:

- Smoking prevalence is significantly higher in Bangladeshi men compared with the general population. This may be linked to consistently reported high prevalence of pan (or pan and betel) use
- The prevalence of obesity is higher among women of Black Caribbean, Black African and Pakistani origin compared with other ethnic groups. The prevalence of obesity among children starting school is highest among Black African, Other Black and Mixed White and Black African groups
- Alcohol is a particular issue for men from Irish, Polish and other eastern European populations

Levels of illicit drug use are higher in mixed ethnic backgrounds than in other ethnic groups. Cannabis use was highest among adults from a mixed ethnic background than for adults from other ethnic groups. This may reflect the younger age profile of these individuals. Black men and women are most likely to report symptoms of drug dependence

Mental health is also a key issue among BME groups. National data from the Mental Health Minimum Dataset (MHMDS) and the Mental Health and Learning Disabilities Dataset (MHLDDS) shows that people from a mixed ethnic group are the least likely to be in contact with mental health and learning disability services. People from Black or Black British ethnic groups in contact with mental health and learning disability services were twice as likely as White groups to have spent at least one night in hospital and were also more likely than other ethnic groups to be detained under the Mental Health Act 1983. Black or Black British ethnic group were most likely to be cared for under the Care Programme Approach (CPA). Source: [NHS Digital Mental Health Bulletin: 2015-16. Annual Report.](#)

It is also known that access to (and use of) health and care services among BME groups is variable and that BME residents are less likely to access local services that we would expect. For example:

- BME women may be accessing maternity services less frequently (and later in their pregnancy) due to previous experience and uncertain awareness of important prenatal testing
- Similarly, BME elders may not be accessing palliative care services because of language difficulties and lack of awareness of provision
- Learning Disability services are disproportionately accessed less by BME residents, as are specific services for sight loss and deaf BME residents.

Issues in relation to differences in the uptake of [routine childhood vaccinations](#) among BME groups in Manchester are discussed in the Children and Young People's JSNA. Poorer take up of national screening programmes for breast, bowel and cervical cancers among some BME group may mean that these cancers are diagnosed at a later stage when the chance of survival is lower, leading to poorer long term outcomes. This is discussed in the JSNA chapter on [cancer](#).

Analysis of local data suggests that the users of adult social care in Manchester (including mental health, learning disability and physical disability services as well as services for older people as a whole) are more 'white' and less ethnically diverse than the population of the city as a whole. This may be linked to the fact that families, communities and religious organisations are more likely to provide support to BME groups compared to White ethnic groups. This means that a referral for Adult Social Care is either less likely or delayed. It may also be linked to a lack of awareness of how to access social care among BME groups.

The Manchester picture: lived experience

BME groups have different cultural practices, languages and religions. Their lives may have been affected by discrimination and harassment and those people that arrive in the UK as migrant workers or asylum seekers have to make the transition to life in the UK including understanding the health care system.

Detailed information related to health and social care experiences of BME communities in Manchester is limited but some evidence can be drawn from consultations, focus groups and BME patient experience surveys gathered by statutory and Voluntary, Community and Social Enterprise (VCSE) organisations. Issues identified from these sources include the following:

- BME groups have similar concerns to White groups relating to waiting times for GP appointments and referrals to hospital/consultants. Additionally, some BME groups have a poor experience in accessing interpreters in primary care, or the quality of interpretation is poor. This is particularly noted for people of Polish, Roma and Somali origin. The issue of dentists not providing an interpreter is a consistent problem that has arisen over the last few years with some dentists only providing an interpreter if a patient is receiving an anaesthetic. Such issues can lead to poor patient-provider communication, negative service experiences and poor outcomes. For disadvantaged groups with transitory lifestyles - such as Gypsies and Irish Travellers - difficulty registering with a GP is a barrier to accessing primary care
- Black men have double the risk of prostate cancer and are likely to be diagnosed with it at an earlier age than White men. However, there is evidence to suggest that some GPs in Manchester may be unaware of this and therefore reluctant to provide Black men with access to a prostate-specific antigen (PSA) test (a blood test used to screen for prostate cancer). Alongside this there is still a widespread lack of awareness amongst Black men about their heightened risk of prostate cancer.
- Some individuals with long term conditions experience poorer quality of care because of the stigma attached to their condition and the lack of understanding about the transmission of particular conditions by health care professionals. For example, there have been a number of reported breaches of confidentiality involving the HIV status of individuals being openly shared within non-clinical staff such as ambulance drivers and porters.
- Older people generally tend not to complain about health services but BME older people are even more reluctant to complain about services. This is exacerbated by the fact that there is anecdotal evidence to suggest that patient experience surveys undertaken in secondary care fail to fully gather the views of BME communities. This is further exacerbated by poor collection of equality data relating to complaints.
- Some social care provision (day care) is provided by BME VCSE organisations that are commissioned by the Manchester Health and Care Commissioning (MHCC). However, there is a lack of home care provision that reflect the cultural, linguistic and religious needs for BME individuals and those living with dementia or having high level care needs.
- Conditions such as sickle cell, thalassaemia, haemochromatosis and prostate cancer are biological/genetic traits within BME communities yet, apart from some work on sickle cell led by Public Health England and delivered at a local level, there is no clear local strategy or targeted campaigns relating to these other conditions.
- The stigma linked to particular health conditions has an impact on the way in which people respond. For example, within BME communities, greater levels of stigma are often linked to long term conditions such as cancer, mental health, HIV and dementia. This may lead to reluctance to act upon signs and symptoms, a reluctance to use services, fear of the reaction to the diagnosis by members of a BME community and carers may also suffer stigma by association. The stigma attached to mental health problems amongst some groups and cultures may result in people avoiding acknowledging their mental health problems and seeking help.

WHAT WOULD WE LIKE TO ACHIEVE?

While there is much research published on the needs of BME groups in general, there is a lack of published evidence on initiatives which positively improve the health and wellbeing of BME people and such initiatives tend to be short term. To be effective any provision of services to BME groups should concentrate on the following:

Raising Awareness

It is necessary to raise awareness of specific health conditions in BME communities to reduce stigma and facilitate the necessity of early diagnosis and access to appropriate support. Education about cancers, mental health disorders, dementia and the treatment process is critical to reducing barriers to treatment. Suggestions for overcoming these barriers include a local public education campaign, education presentations at community venues and open information sessions at local mental health clinics. The recruitment of health champions within BME communities is also a way of targeting the education programme and tackling taboos about certain health conditions.

Within BME groups, there are sub groups that face further disadvantage. Health promotion campaigns should be targeted at BME groups such as refugees and asylum seekers in tandem with helping with practical needs or good signposting to other agencies. This is explored further in a separate JSNA chapter on refugees, asylum seekers and new migrant communities (currently in development).

Involving BME VCSE organisations and faith groups in community based education interventions can be an effective way of reducing health inequalities. Community led interventions have, for example, shown a higher level of success in registration of blood donors than those solely reliant on the mass media, improvements in the promotion of sickle cell and thalassaemia and more recently in tackling latent TB in South Asian communities. The BMJ, Public Health England and TB Alert have acknowledged the necessity to have community based interventions delivered by BME organisations to achieve positive outcomes within BME communities.

Current initiatives relating to cancer and dementia need to reflect the above good practice. Information about existing cancer services and the features of the Manchester Locality Plan for Cancer is contained in the in the JSNA chapter on [cancer](#).

Improved Access to Services/Prevention Programmes

It is important to provide culturally sensitive services and information for service users and carers. For example, with the increase in older people within some BME communities, access to social care and dementia support services should offer linguistic and cultural provision to meet the needs of a diverse BME community.

It is also important to recognise that early intervention and preventive health programmes among marginalised groups demonstrably reduces both the incidence and costs of, for example, heart disease, stroke, cancers and diabetes. Such programmes should draw from good practice examples in commissioning such services from the BME VCSE.

There should be improved access to GP services and adequate hospital care in an environment that allows space and the opportunity to recover for individuals with a psychotic illness such as schizophrenia. Additionally, there should be provision of

specialist mental health services, to enable those who need additional support, to receive that in their own community rather than a hospital setting.

Good quality interpretation services enable individuals who speak little or no English to feel confident in accessing health services. Additionally, it is essential to source appropriately trained and experienced interpreters who have worked with the deaf BME community to ensure effective access to mainstream services. For example, it may be necessary to use the services of a deaf BME Relay Interpreter, who would be able to culturally mediate this information from differing BME backgrounds. Older BME family carers have greater need for structured translation and interpretation support suggesting that targeting of resources could help. The importance of local support to overcome language barriers needs to be properly addressed on a continuing basis as local BME communities develop and change.

Diagnosis, Treatment and Quality of Services

There is a legal obligation for statutory authorities to give 'due regard' in implementing the Public Sector Equality Duty within the Equality Act. Therefore, any transformational work such as the development of new services, the redesign of existing care pathways, or the decommissioning of provision needs to pay detailed attention to the potential negative impact on BME groups and encourages involvement of such groups.

There is a lack of recognition of BME carers who do not take up services. The role of carers should be reviewed to ensure that a carer's assessment reflects the role of a carer as a partner in decision making about an individual's health and not as someone who is informed as an afterthought.

Services should also be responsive and seek to understand the social, cultural issues and the impact racism and discrimination may have on some BME groups that had led to their ill health e.g. mental health.

Improved quality of information on what palliative and end of life care entails and public health campaigns informing the general population and campaigns targeting specific BME groups to raise awareness of available palliative care services and how to access them.

The provision of culturally and linguistically appropriate information material and translation services are also essential to ensuring that BME groups can navigate the health care system effectively and access all the benefits to which they are entitled.

There should be greater support following treatment. This can relate to types of counselling, peer support or support groups that can meet the linguistic and cultural needs of services users and enables them to be comfortable in using those services. Support should be provided to individuals to address social problems through identifying and securing accommodation, offering routes into employment and providing access to welfare rights information. Evidence has consistently shown that employment is better for mental and physical health than unemployment. However, this only applies to good quality work which is characterised by a living wage, having control over work, being respected and rewarded, being provided with good quality in-work services such as occupational health services and with adequate support to return to work after absence.

Training and Recruitment of NHS Professionals

Increasing the number of under-represented groups in the health profession can help address healthcare disparities by both improving access and responding more effectively to the needs of BME communities. Greater progress need to be made by NHS to increase the representation of BME communities in the workplace in key positions.

Adequate training programmes for NHS staff on the prevalence of certain conditions within BME communities. For example, GPs should be aware of the heightened risks of prostate cancer and other conditions within BME communities to enable relevant tests to be offered. Additionally, there is a lack of knowledge of the transmission and treatment of certain viruses such as HIV in both primary and secondary care services. Finally, there needs to be a greater focus on the provision of a culturally appropriate health and social care service.

Commissioning of Services

Commissioning needs to be used to effectively tackle the disparities that exist by commissioning health services that meet the needs of BME communities and thereby help reduce ethnic inequalities in health-care access, experiences and health outcomes. This can be done by ensuring that existing services and interventions provide equitable access, experiences and outcomes for all service users and carers regardless of ethnicity and establishing whether existing services match BME health needs and respond to significant gaps through design/procurement of specialist services.

In the shift towards prevention, it is also important to ensure that services are targeted on the most disadvantaged areas and BME groups in a more equitable manner, i.e. in line with their greater need.

Future commissioning for mental health services should acknowledge the contribution of BME groups in the voluntary sector and maintain their role in assisting service users, some of whom may have had negative experiences of mainstream psychiatric services.

There are nationally recognised models of good practice that clearly show the benefits of commissioning voluntary and community BME organisations to deliver health interventions.

Improved data collection

The delivering Race Equality Review published in 2010 made it clear that better monitoring and collection of information and improved use of data to inform commissioning and provision intentions in health and social care is required. This should focus on what works for which communities and how it can be captured to change and improve existing systems and processes, including developing targeted interventions to improve the quality of care delivered to specific population groups.

Current cancer programmes in Manchester put a lot of emphasis on user involvement but it is important to ensure that this includes the whole range of BME communities. For example, the work undertaken by the Macmillan Cancer Improvement Partnership on early diagnosis of lung cancer has resulted in a significant uptake of lung cancer screening but it will be important to identify the levels of uptake among BME groups to understand whether BME are sufficiently involved in this programme of work.

The Equality Delivery System (EDS) includes monitoring as one of its goals as does the Workforce Race Equality Standard (WRES). An increase of representation of BME communities could assist in the provision of culturally competent services and change some of the trend outlined causing disparities in health.

WHAT DO WE NEED TO DO TO ACHIEVE THIS?

The tailoring and targeting of programmes to the needs of specific communities is a positive step and is necessary to reduce the number of people in deprived or BME groups who do not access health services. As part of this, it is necessary to improve the way that BME status is recorded to improve data accuracy and allow more robust analysis of data from primary and secondary care and other systems.

It is evident that low levels of awareness and low take up of screening is an issue among some BME groups. There is a need to equalise the uptake of cancer screening services between groups with high uptake rates (generally the most affluent) and communities and groups with traditionally low uptake of screening services. This could be achieved through targeted information and support, improving the accessibility of screening services and the communication skills of health care providers who can influence an individual's behaviour. More information about work to address low levels of awareness and take up of screening among some BME groups is contained in the in the JSNA chapter on [cancer](#).

The above should be supported by programmes to create sustained behavioural change. The impact of such programmes should be monitored and evaluated in a timely manner and influence future health strategy. Such programmes should include awareness raising sessions and events to engage, inform and empower communities to access relevant services, inform BME groups about the low uptake of screening and the impact of late diagnosis; develop support networks that provide information and advice to patients, carers and their families and meet the cultural, linguistic and religious needs of BME groups.

There should be support for development of BME Experts patient programmes for conditions that disproportionately affect BME communities e.g. TB, HIV, diabetes etc.

Older age is strongly associated with a decrease in health. As most BME groups are younger than the White British group, the overall proportion of a group that is ill can appear to be low even when their illness rates are high at each age. However, the increase in the number of older BME people in the UK is likely to lead to a greater need for provision of dementia services (because higher levels of hypertension and stroke in BME communities are attributable to the development of vascular dementia) and also increase the need for the provision of culturally competent social care and palliative/end of life care.

WHAT ARE WE CURRENTLY DOING?

A Greater Manchester Cancer Strategy is in place and its delivery is monitored by the Greater Manchester Cancer Board. This is supported by a VCSE Cancer Advisory Group. Current representation of BME VCSE organisation is low but there is involvement from the newly established BME Cancer Partnership. The Cancer Strategy incorporates work being undertaken by the Macmillan Cancer Improvement Partnership (MCIP) and Manchester Vanguard as well as a proposal to increase the number of cancer champions across Greater Manchester. More information about this area of work is contained in the in the JSNA chapter on [cancer](#).

There has been further investment in Improving Access to Psychological Therapies (IAPT) by Manchester Health and Care Commissioning (MHCC) to integrate talking therapies into an individual's treatment. This is available to VCSE organisations through a grants process and will assist in encouraging better access to IAPT services by BME communities although the funding is short term.

Additional investment is being sought to provide enhanced registration, assessment and treatment of vulnerable migrants in primary care, in particular, refugee and asylum seekers (RAS). This investment will deliver elements of essential or additional services delivered to a higher specification. This is described in more detail in the JSNA chapter on refugees, asylum seekers and new migrant communities (currently in development).

Community Education programmes related to HIV and sexual health are operated through the integrated sexual health service and organisations go through a commissioning process to bid for the contract. The current contract is delivered via a partnership of national charity and local VCSE organisations which include a BME VCSE. More information about this area of work is contained in the in the JSNA chapter on [sexual health](#).

There are a range of voluntary and community sector organisations funded by MHCC to work specifically with BME communities on health issues. For example, the programme for the delivery of community education programmes on latent TB is currently commissioned to a VCSE BME organisation that works specifically with South Asian communities in Oldham and Manchester.

The NHS Equality Delivery System 2 (EDS 2) is a performance framework enabling organisations to review their performance on equality and diversity, and to identify future priorities and actions. It is designed to help organisations to deliver better outcomes for patients and communities and better working environments for staff. Central to the EDS 2 is a set of 18 outcomes aligned to four goals. These outcomes focus on the issues of most concern to patients, carers, communities, NHS staff and Boards. The four EDS goals are:

- Better health outcomes for all
- Improved patient access and experience
- A represented and supported workforce
- Inclusive leadership

During 2016, in line with NHS England mandatory EDHR requirements, the former North, Central and South Manchester CCGs looked at Goal 2 (Improved Patient Access and Experience) and was Graded overall 'Developing'.

Manchester CCG has published its annual Workforce Race Equality Standard (WRES) and an action plan will be developed to support identified gaps. A newly formed Inclusion Health Group is being established to address a number of primary care areas that affect BME communities. This includes improving data quality across equality groups, translation and interoperation, services for new entrants (asylum seekers) and raising awareness around the equality and diversity agenda within primary care.

OPPORTUNITIES FOR ACTION

Increased integration between health services, social care and public health provides an opportunity to develop joint programmes targeting health inequalities and inequalities of access for BME communities. An approach should be adopted that integrates awareness raising, easier access to preventative programmes and screening. This should draw together the skills and experience of BME community groups, public health and clinicians and can be extended from a few current programmes eg blood borne virus, to tackling a wider range of health conditions.

A programme agreed by commissioners to develop BME health champions using a common model across a range of health conditions offers an opportunity to engage with, and support, the BME VCSE on a longer-term basis and to develop links between the sector and clinicians in both public health and NHS services.

The wider programme of integration, as part of the devolution of power to a Greater Manchester Mayor and GM Combined Authority, provides an opportunity to both increase the profile of health inequalities faced by BME communities and to tackle these at scale. Many BME communities, particularly those who have transitory and temporary accommodation (Roma, White European migrants, asylum seekers and refugees), can be better reached through GM-wide programmes.

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It is hoped that you have found this topic paper useful. If you have any comments, suggestions or have found the contents particularly helpful in your work, it would be great to hear from you.

Responses can be sent to jsna@manchester.gov.uk