

# Health Needs Assessment of BME Communities in Nottingham City: Executive Summary

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## **Executive summary**

Nottingham City's population is increasing and projected to continue to rise. International migration and natural change, the excess of births over deaths, are the main reasons for the population growth; the number of births has risen considerably in recent years.

Nottingham has a young population; the latest mid-year population estimates (2014) suggest that 28% of the City's population are aged 18 to 29 years. This is due largely, but not entirely, to the presence of two universities. Full-time university students account for approximately 1 in 8 of the population. The percentages in other age-groups are lower than the average for England, with the proportions of those between 65 and 74 being particularly low.

The City of Nottingham is the 8th most deprived local authority area in England (Index of Multiple Deprivation, 2007). Estimates suggest that one in four children and adults in Nottingham live in relative poverty. Deprivation and poor health at every age are linked, with poorer health outcomes in areas with higher deprivation.

Health and wellbeing in Nottingham is generally below average for most indicators, reflecting the close link between poor health and deprivation but also reflecting peoples own personal choices as well as the influence of services and opportunities. Health inequalities in Nottingham are stark, with life expectancy varying by up to ten years between neighbourhoods, reflecting the different life experiences of Nottingham's communities.

Nottingham City has a large Black and Minority Ethnic (BME) population which accounts for just over one third of the total population, having increased from just under a fifth in 2001. Given the changes in ethnic groups between the 2001 and 2011 census, and the younger age profile of BME groups in the City, the percentage of the population in BME groups is likely to continue to rise.

An increase in population can result in an increase in the proportion of citizens with ill-health. The contact that health services will have with BME communities is likely to increase in line with the increase in population, and this will test the ability of commissioners to deliver services that are appropriate, assessable and culturally sensitive and meet the needs of an expanding and changing population.

National and international evidence has evidenced inequalities in the health, and the healthcare experiences, of BME groups. The diverse experiences and needs of BME populations are often defined by other markers of identity such as age, faith, gender, sexuality, disability, marital status, education and socio-economic status. Often these issues play a critical role in relation to how people live and interact with the processes around them (Healthcare Commission, 2006).

Poorer health outcomes for BME communities are often compounded by poor access to services for reasons including language barriers, lack of awareness or information, social isolation, lack of culturally sensitive services and negative attitudes about communities, and differing expectations about how services can help them (DOH, 2014).

The particular needs of individuals from BME communities can only be addressed from within structures and systems that pay attention both to the diversity or differences between and within communities. Policy makers and practitioners must ensure the diversity of experience of BME groups are addressed, and due attention is given to how BME groups are engaged in order to identify support needs as evidence shows that people from BME groups tend to report poorer health than their white counterparts (DOH, 2014)

## Health Needs Assessment Methodology

Nottingham City Council (NCC) and Nottingham Clinical Commissioning Group (CCG) requested an assessment of the health needs of Nottingham's BME to inform the commissioning and delivery of services. A multi-agency steering group was established to provide advice and support including commenting on survey design and developing a robust community engagement plan.

The HNA is underpinned by a comprehensive literature review and a robust engagement plan which optimised the spread and depth of views gathered. The extensive engagement with BME communities has been a key success of this HNA and has highlighted the approaches and techniques successfully engage local communities. The engagement has enabled understanding of how local citizens perceive health and experience healthcare and other services.

Data analysis was limited by gaps in the routine recording of ethnicity but nonetheless gives a useful snapshot of health service usage. Knowing the size and, at least to some extent, the overall composition of the BME populations in Nottingham is of relatively limited value without knowing how these communities are using health services and whether any are disproportionately affected by disease and/or health conditions. The lack of ethnic monitoring data by local services is especially limiting in attempting an assessment of the differences in health outcomes at a local level for different BME populations.

In some instances, it has only been possible to relate information gained through engagement activity with wider research evidence. This presents a significant challenge when attempting to assess health at a population level and requires a shift in strategic direction to make the collection of ethnic monitoring data a compulsory requirement for all services. This will help to improve the health and wellbeing of the BME populations as when routine ethnic monitoring data is combined with an established evidence base on the prevalence and variation in outcomes for different BME populations, informed decisions can be made about commissioning priorities and resource allocation to address the health needs of BME communities.

## Key themes

The themes arising from the community engagement echo those in the published literature and locally commissioned research. This resonance between the fieldwork and the literature validates the findings. The following themes emerged from the responses:

- Many participants felt that **mental health** problems were common in their communities with problems exacerbated by cultural bias, experience of discrimination and stigma and challenges in accessing appropriate services.
- **The importance of the built environment** was a strong theme in the survey responses and focus groups including planning of fast food outlets, obesity, accessing open spaces, housing and homelessness, fuel poverty, sense of belonging and affordability.
- **Life style risk factors** were highlighted by the majority of participants including diet, smoking, exercise and the role of personal responsibility. Interestingly, participants were divided on whether traditional or western diets were more likely to contribute to obesity and whether smoking could be seen as a 'cultural' behaviour.
- **Cultural and social norms** were hotly debated including whether services should be tailored to meet the needs of BME communities, BME specific and/or whether all services should develop cultural competent. Support for communities around managing long-term conditions and lack of knowledge related to these conditions. Gender was also seen as a culturally determined predictor of health service use.
- **Education**, in the broadest sense, was seen as important, including accessible information, health messages and health promotion tailored to BME communities. Participants suggested that social media could be used more effectively and the role of schools in informing people about healthy lifestyles.

- Participants stressed the importance of **employment** for health including managing stress at work, unhealthy lifestyles choices being influenced by work, low paid jobs reducing the chance of leading a healthy life, language skills restricting work opportunities and isolation for those unable to work. In addition, some participants suggested that discrimination affected their employment choices and contributed to mental health problems.
- **Access to services** including GP appointment times, long waits for services, GPs not understanding cultural needs and reception staff acting as a barrier to access was described by many participants. Some participants requested culturally tailored services with some wanting to see a professional of the same ethnicity and others not due to fear of stigma from their own community. In addition, participants whose first language wasn't commented on issues in accessing interpreters.
- Cultural dimensions of **health seeking behaviour**. Many participants commented on how citizens from different ethnicities and cultures use health services differently. Gender was also seen as an important factor in service use with men seen as less likely to use services proactively.
- **Stigma and/or racism and discrimination**. Some participants felt that many statutory services discriminated against them including employment, mental health services, and 'general' health and wellbeing services.

The report conclusively demonstrates that BME communities are not homogenous in their health needs; different BME groups experience different health outcomes. Whereas the major health concerns may be similar between ethnic groups, belief systems, attitudes to health and life, lifestyle behaviours, access to, and experience of, health services vary widely.

A cross-sector, multidisciplinary approach is needed to improve the health of BME communities. As socio-economic and environmental factors have considerable impact on the health wellbeing of individuals and communities responses should be strategic and recognise the impact of discrimination and associated exclusion as a key public health issue.

### **Recommendations**

The recommendations have been identified using a synthesis of the evidence base and quantitative and qualitative methodologies and have been thematically grouped.

### **Access to services**

- National and international evidence suggests that ethnicity should be consistently considered when developing health services, specifically, to ensure services are culturally sensitive. The citizens consulted through this HNA suggest more could be done to improve the experiences of BME populations accessing local health services. This will be best achieved through continued dialogue with patients and their families, health professionals and the community and voluntary sector.
- Commissioners should consider how they can be assured that health services are delivered in a person-centred and culturally sensitive manner. For example, to what extent are local services aware of the diverse but specific barriers to access for people from BME communities?
- Local health service providers should consider delivering regular training for their staff on the needs of different BME communities.
- Intelligence gathered collected through this HNA suggests that some BME communities are not accessing health and social care services in accordance with their level of need. More work is needed to understand the mechanism underpinning this.

- Feedback from BME communities suggests that health and care needs, as can be expected, vary by age. A scoping exercise of the current provision of age appropriate activities for elders from BME communities could inform future commissioning.
- A number of participants suggested there is not enough youth provision across Nottingham City and felt there needed to be more youth centres. A review should be undertaken to explore this further.

### **Mental health**

- Local intelligence suggests that some BME communities find it difficult to engage with mental health services for 'cultural reasons' and/or because they believe the service will not meet their needs.
- Local services could consider targeted work with BME communities to encourage access to mainstream mental health services
- Participants suggested that greater investment is needed to increase access to responsive, culturally appropriate mental health services in Nottingham that have the capacity and resources to prevent as well as treat mental health problems.

### **Data collection**

- The lack of robust monitoring of ethnicity by local, and national, health services means there is a significant gap in understanding the needs of BME communities. Service providers need to work with staff to stress the importance of collecting ethnic monitoring data and put robust measures in place to support routine data collection such as removing the 'not known' category in ethnic monitoring. This will enable the appropriate planning and commissioning of services and ensure equity of access.

- The HNA did not have a specific focus on inherited blood disorders which disproportionately affect African and Caribbean communities. The Local Authority need to consider whether a JSNA chapter on sickle cell and thalassemia is needed.

### **Community engagement**

- Citizens and stakeholders suggested that, in Nottingham, we have a tendency to keep consulting, sometimes duplicating previous consultations, without always demonstrating how we have responded to consultations. A city wide consultation strategy with shared objectives and pooled resources could help reduce duplication and address the issue of limited funding for large-scale consultations.
- Participants suggested that services should improve their routine engagement with BME communities to provide more opportunities for citizens to inform the planning and commissioning of health services. This will help to ensure services are accessible and meet the needs of Nottingham's diverse communities.
- Eastern European communities were not sufficiently represented in the engagement activity. Further work is needed to understand how best to engage with Eastern European communities.

### **Communication and resources**

- Participants suggested that there is a lack of printed materials on health in a variety of languages in local services such as general practice. The availability of interpreters is also 'patchy'. A review of translation and interpreting services in Nottingham is warranted.
- Commissioners and providers should work together to ensure that health promotion materials are available in the most commonly spoken languages. In addition, services

should ensure that self-help materials are available in a wide range of formats, including computerised resources, books and leaflets, audiotapes and further resources for those with literacy difficulties.

- Participants suggested that they are not always aware of the range of local services. Communication platforms, such as on-line directories, should be accessible to diverse communities so citizens are aware of local services and how to access them.

### **Partnership working**

- Local partners and community members stressed the importance of the community and voluntary sector in influencing the health and wellbeing of BME communities in Nottingham. However, the capacity of the sector has diminished significantly. Participants suggested that further work is needed to rebuild this sector and work with organisations, faith groups and community leaders to promote the health and well-being of Nottingham's BME communities.
- Schools were identified as a powerful communication channel for sharing health messages and influencing health behaviours. Further work is needed to explore the role of schools in delivering health and wellbeing initiatives directed at BME communities.
- Commissioners and providers of health services in Nottingham need to look outside traditional structures in order to meet the diverse needs of BME communities. Partnership working with the private sector and other public services and community groups is essential in achieving a positive impact on the mental and physical health of the whole community. For example, participants suggested more could be done to engage communities through churches, mosques and other places of worship.

## Discrimination

- Many participants identified discrimination as a barrier to living a healthy and happy life with some stating that discrimination would be minimised if the workforce was more reflective of the BME communities in Nottingham. Measures should be put in place to ensure organisations recruit, develop and retain a workforce that reflects the city and is able to deliver high quality services that are fair, accessible, reflective and responsive to the needs of different groups and communities.

## Lifestyle risk factors

- Participants identified a range of factors that reduced the opportunity for physical activity. While some of these barriers were described as cultural or religious, e.g. Muslim women only able to attend female only sports sessions, others were related to access to facilities. Initiatives that encourage participation of BME communities should be identified.
- Education and information for BME communities regarding healthier diets and food preparation are provided through programmes such as *Cook and Eat* sessions but the financial support for these sessions has reduced. Work should be undertaken to explore potential funding of these sessions including through local businesses and supermarkets as part of their social responsibility commitment.
- A review of campaigns designed to address attitudes for members of BME communities is needed. Approaches that are more culturally aligned with the perceptions and lifestyles of BME communities may prove more successful, as might be a social marketing approach engaged around what works for these communities.
- Some national campaigns, such as *Change for Life*, participants suggested, appear targeted at White communities as they are not culturally aligned with the perceptions and lifestyles of BME communities. Conversely, *Be Clear on Cancer* was

seen to reflect the needs of BME communities. Local social marketing campaigns should be developed using similar approaches

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