Joint Strategic Needs Assessment for Black and Ethnic Minorities in Sandwell

Sandwell PCT

Public Health Information & Intelligence Team

September 2010

Content

Acknowledgements

Executive Summary

We already have a good of understanding of the needs of our ethnic minority populations, through previous JSNAs and other work carried out by the PCT and partner agencies. This report does not aim to reproduce the findings of these reports, instead this document explores, in more detail than has been afforded in existing needs assessments, the demographic, geographic and socioeconomic distribution of BME populations, within Sandwell. The document also explores the general challenges to conducting health related analysis by ethnicity and specifically addresses the uptake of lifestyle services offered by the PCT by minority ethnic groups, as this forms a common underpinning factor for many of our needs assessments but has not been explored fully.

Aims and objectives

The aims of this report are to:

1. Provide a detailed description of black and minority ethnic populations in Sandwell
2. To consider some of the challenges to conducting analysis by ethnicity and identify solutions to these challenges
3. To examine uptake of lifestyle services by ethnicity and make any necessary recommendations.

Main findings

Based on experimental statistics produced by ONS for 2007, Sandwell's BME population makes up 22% of the population.

The higher fertility rates in BME groups, coupled with a higher proportion of their populations being in the child bearing years, is likely to result in: higher fertility rates for the population overall; a growth in the total BME population and a growth in the number of children and young people in these groups and the population overall, over time.

It is recognised by the World Health Organisation that Asians are at higher risk than the White population at lower BMI's, however the evidence has not lead them to a clear BMI cut off for Asians. Waist to hip ratio may be an appropriate additional

measure for risk in BME groups and should be explored further. No significant variations in obesity for children could be identified by ethnicity, although they are evident nationally.

The estimated proportion of smokers accessing smoking cessation services was lower for Indian males and females, Bangladeshi males and Black Caribbean males, than the White population. The reasons for the low uptake of the service from these groups' needs to be investigated and actions taken to attract them to the service. There is a good representation of BME groups in walking and cycling activities offered by the PCT.

To develop our understanding of need by ethnicity we need to be able to analyse primary care data by ethnicity. This is currently limited by the level of ethnicity recording in primary care, currently at 57%.

No relationship between all causes of mortality and the proportion of ethnic minorities at a ward level, could be identified. We will continue to explore the relationship between mortality and ethnicity for specific causes as we develop future JSNAs.

Recommendations

1. There is likely to be an increase in the number of births and children from BME groups and therefore the whole population. These increases need to be considered in planning maternity and children's services.

2. The use of waist to hip ratio as an additional measure of risk for BME populations, should be researched and given further consideration.

3. Continue to monitor obesity by ethnicity in children, pooling several years data to make the data more robust

4. The reasons for low uptake of the smoking cessation service by Indian males, Bangladeshi males and Caribbean males need to be investigated and actions taken to attract them to the service.

5. Invest in improving ethnicity recording in primary care

Chapter 1: Introduction

Sandwell has a diverse population with an estimated 22% from black and minority ethnic (BME) backgrounds, compared to 12% nationally.

We already have a good of understanding of the needs of our ethnic minority populations, gathered through needs assessments that have been carried out and through the PCT's engagement with the voluntary sector, patients and the public and through work carried out by partner agencies. As a general principle, joint strategic needs assessment, routinely consider variations by ethnicity, alongside other demographic factors such as age, gender and social class. This document will not reproduce the findings of these existing needs assessments and will not cover the ground of forthcoming needs assessments. Instead this document will explore, in more detail than has been afforded in existing needs assessments, the demographic, geographic and socioeconomic distribution of BME populations, within Sandwell. The document will also explore the general challenges to conducting health related analysis by ethnicity and specifically addresses the uptake of lifestyle services offered by the PCT by minority ethnic groups, as this forms a common underpinning factor for many of our needs assessments but has not been explored fully.

The first JSNA for Sandwell focused on the 8 themes in the Sandwell Plan: More and Better Homes; Improving Health; Supporting Independence; Reduce High Volume; Crime; Children Having a Good Start in Life; Successful Young People; Cleaner, Safer Active Communities and More People in Employment. The report included some description of ethnicity in Sandwell and some analysis of ethnicity was included within the chapters. The second iteration of the JSNA included some specific studies of the Sikh and Pakistani populations and Alcohol and Coronary Heart Disease needs assessments, in which due consideration was given to ethnicity. We are also currently working on an Obesity needs assessment, which will include analysis by ethnicity and an Asylum Seeker and New Migrant needs assessment. Based on a prioritisation and consultation process, we will be carrying out the following needs assessments during the next year: mental well being; multiple long term conditions; acute mental health focusing on physical health and prevention of high intensity service use.

Aims and objectives

The aims of this report are to:

4. Provide a detailed description of black and minority ethnic populations in Sandwell

5. To consider some of the challenges to conducting analysis by ethnicity and identify solutions to these challenges

6. To examine uptake of lifestyle services by ethnicity and make any necessary recommendations.

Scope of this needs assessment

- **Asylum seekers and new migrants**

Asylum seekers and new migrants may be viewed as distinct subsets within the BME population. They have distinct needs and in some cases very complex needs. It is considered an important topic for Sandwell and because of the complexity of the issues and some of the specific problems that these subgroups face, this topic will be the focus of a separate but linked needs assessment.

- **Religion**

Religion is a notable factor in determining the health outcomes experienced by people. This may operate in a number of different ways, for example, through variations in attitudes to risk or in lifestyle behaviours, for example sexual behaviour or alcohol consumption. However there are many complicating and confounding factors, such as ethnicity, class and culture, which make it difficult to consider religion in isolation. Many cultural traits will be shared by people of different religious groups (eg the Asian diet) and many religions include people from a number of ethnic groups (eg Islam). For these reasons, religion has not been included in the analysis presented here.

Chapter 2: The ethnic make up of our population

The most robust source of data available to us, on the ethnic make up of our population, is the Census. The Office for National Statistics (ONS) have subsequently produced mid year estimates and the methodology for these is described in the footnote below[1]. These data have been given the status of 'experimental statistics' by ONS, which means that they have not yet met the quality standards required by ONS, but have been published to involve users in their development.   The latest estimates were produced in 2007. Whilst these data may be limited by uncertainties regarding the quality of estimates produced, we know that the data in the 2001 Census is out of date. For this reason we have decided to use the mid year estimates to describe the overall ethnic make up of our population, as appropriate.

There are further limitations to both the 2001 Census data and the mid year estimates in relation to the extent that ethnicity is broken down. For example, neither source of data helps us to identify the number of European migrants to Sandwell nor which African countries, those in the African category come from. Nevertheless they still form our best available knowledge on the ethnic make up of our population.

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"***Summary of the cohort component method***
Take the previous mid-year resident population and age-on by one year;
Then estimate the population change between 1 July and 30 June by;
Adding births occurring during the year
Removing deaths occurring during the year;
Allowing for migration to and from the area
In addition to the process summarised above, adjustments are also made for some special population groups that are not captured by the internal or international migration estimates: members of the armed forces, prisoners and pupils in boarding schools. These populations have specific age structures, which remain fairly constant over time. Therefore these groups are not aged-on with the rest of the population. "
 Population Estimates by Ethnic Group: Methodology Paper,
ONS*www.statistics.gov.uk/downloads/theme_population/MethodologyforPEEG.pdf Accessed 23rd July,2010*
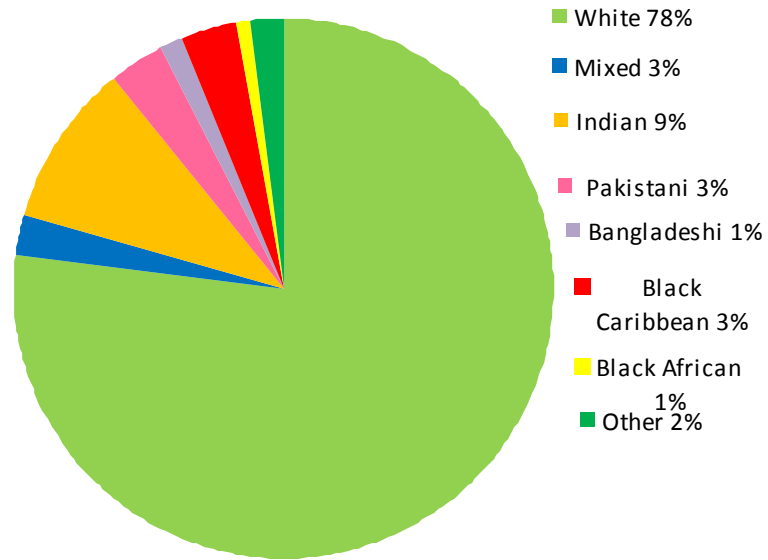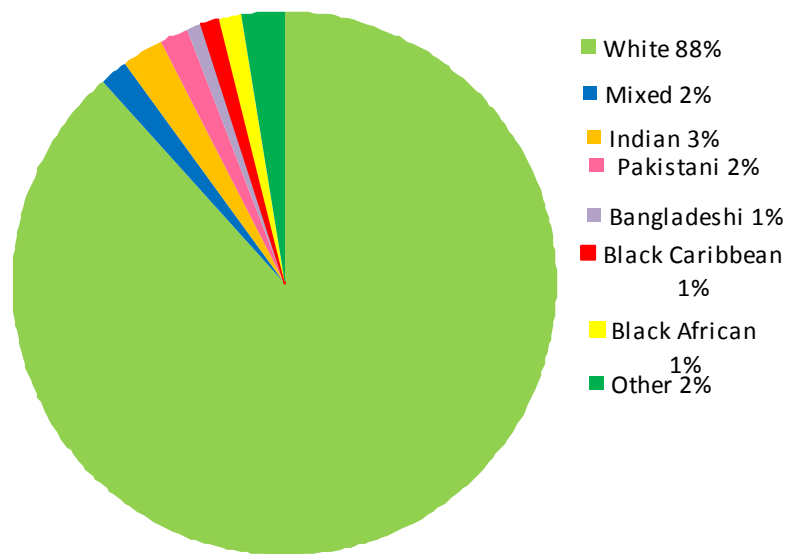
Figure1: Sandwell Ethnic Population, 2007

Legend:
- White 78%
- Mixed 3%
- Indian 9%
- Pakistani 3%
- Bangladeshi 1%
- Black Caribbean 3%
- Black African 1%
- Other 2%

Figure 2: England Ethnic Population, 2007

Legend:
- White 88%
- Mixed 2%
- Indian 3%
- Pakistani 2%
- Bangladeshi 1%
- Black Caribbean 1%
- Black African 1%
- Other 2%

The pie charts above show that black and ethnic minority populations make up an estimated 22% of the population in Sandwell, compared to 12% in England. Indians make up the largest minority ethnic group in Sandwell and account for a large proportion of the difference between England and Sandwell. Sandwell also has higher proportions of Mixed, Pakistani and Black Caribbean populations.

Changes in the ethnic population

This graph compares the 2007 population estimates to the 2001 Census breakdowns. Whilst there has been a relatively small increase in the number of Mixed, Indian, Pakistani, Bangladeshi groups, these represent large proportional increases (23%, 5%, 18% and 20% respectively). The large increase in the Other category equates to a 205% increase. There has been a 2.5% decrease in the White population.

Figure 3: Sandwell population change from 2001 Census to 2007 population estimates
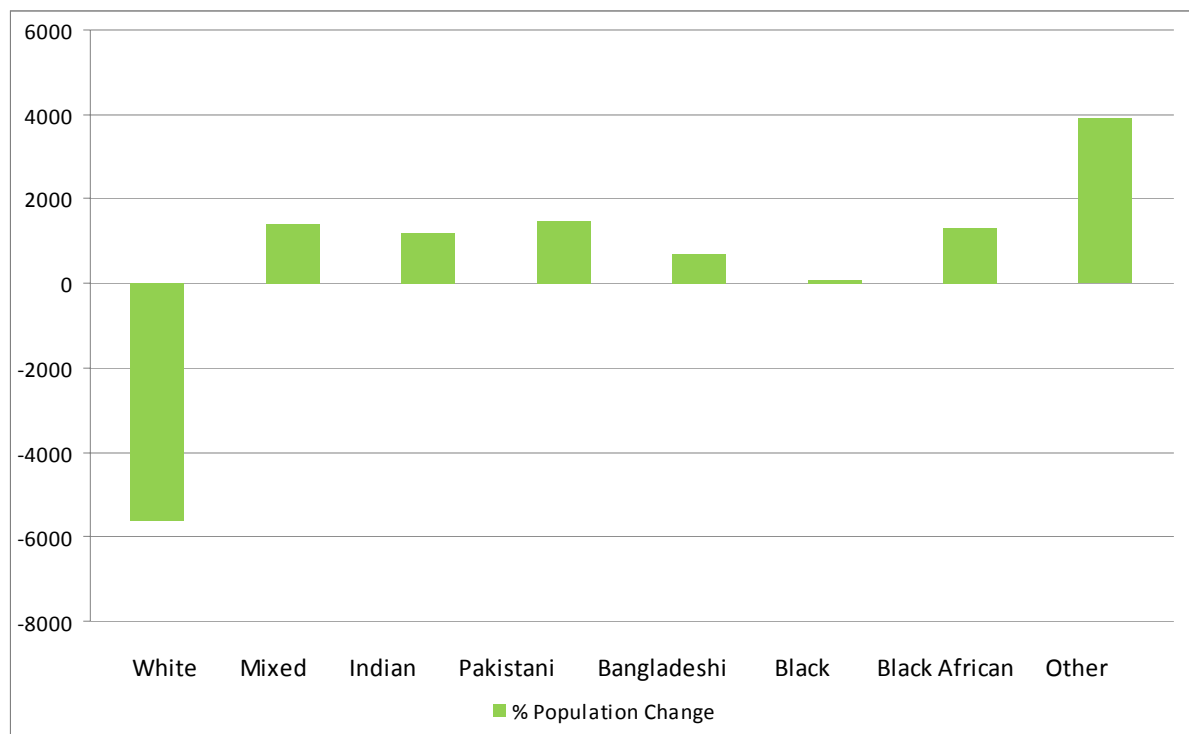
Comparisons of the mid year estimates of ethnic breakdown with data on the country of birth suggests that many of our ethnic minorities are fairly stable in terms of migration as relatively small proportions of new registrations are born in countries

outside of the United Kingdom. The largest group of registrations are for Indians reflecting the fact that Indians make up the largest BME group in Sandwell.

Figure 4: Country of birth of people registering with a GP, 2008

% of Population Registered
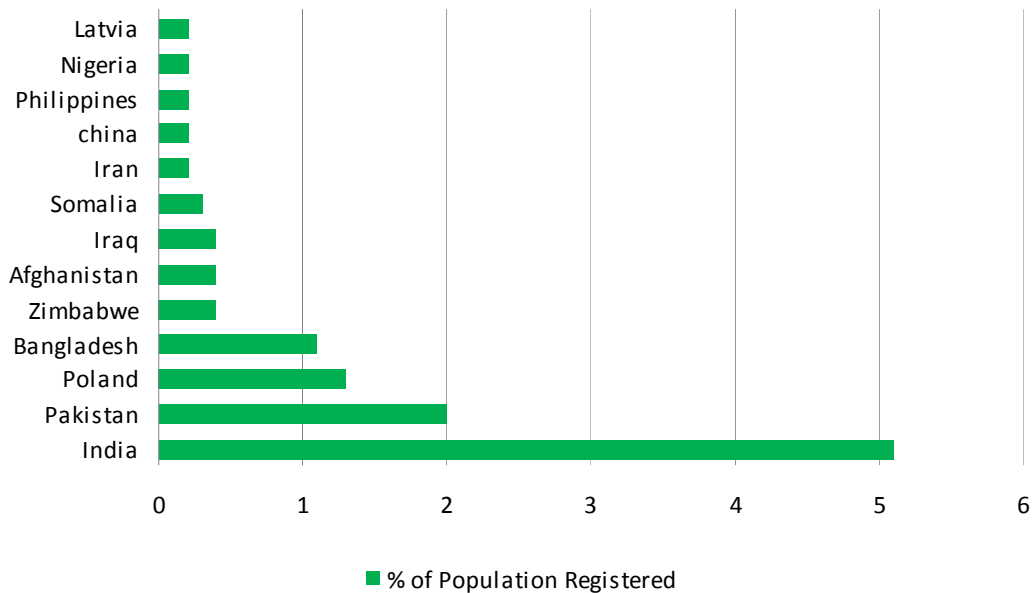
Age breakdowns of the country of birth of new registrants with GPs suggests that most new registrants from India, Poland, Pakistan and Bangladesh were aged between 25 and 44, together with the low number of young people registering with a country of birth recorded as India, Pakistan or Bangladesh, suggests that our younger populations from this group are second or even third generation populations.

**Figure 5: Age of those registering with a GP by country of birth, 2008**
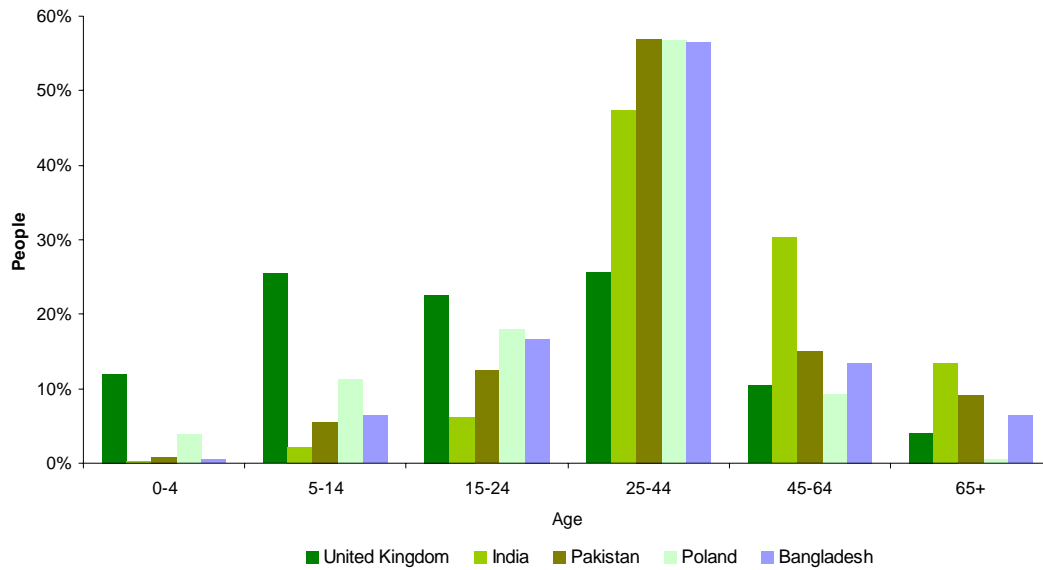
Ethnicity by ward

There is considerable variation in the ethnic make up of the population by ward. St Pauls has the highest proportion of black and minority ethnic people, followed by Soho and Victoria, West Bromwich Central and Smethwick. Friar Park, Princes End, Rowley and Tividale have the lowest proportions of ethnic minorities.

Figure 6: Sandwell Ethnic Population Percentage by Ward, 2001

Legend: White, Mixed, Indian, Pakistani, Bangladeshi, Black Caribbean, Black African, Others
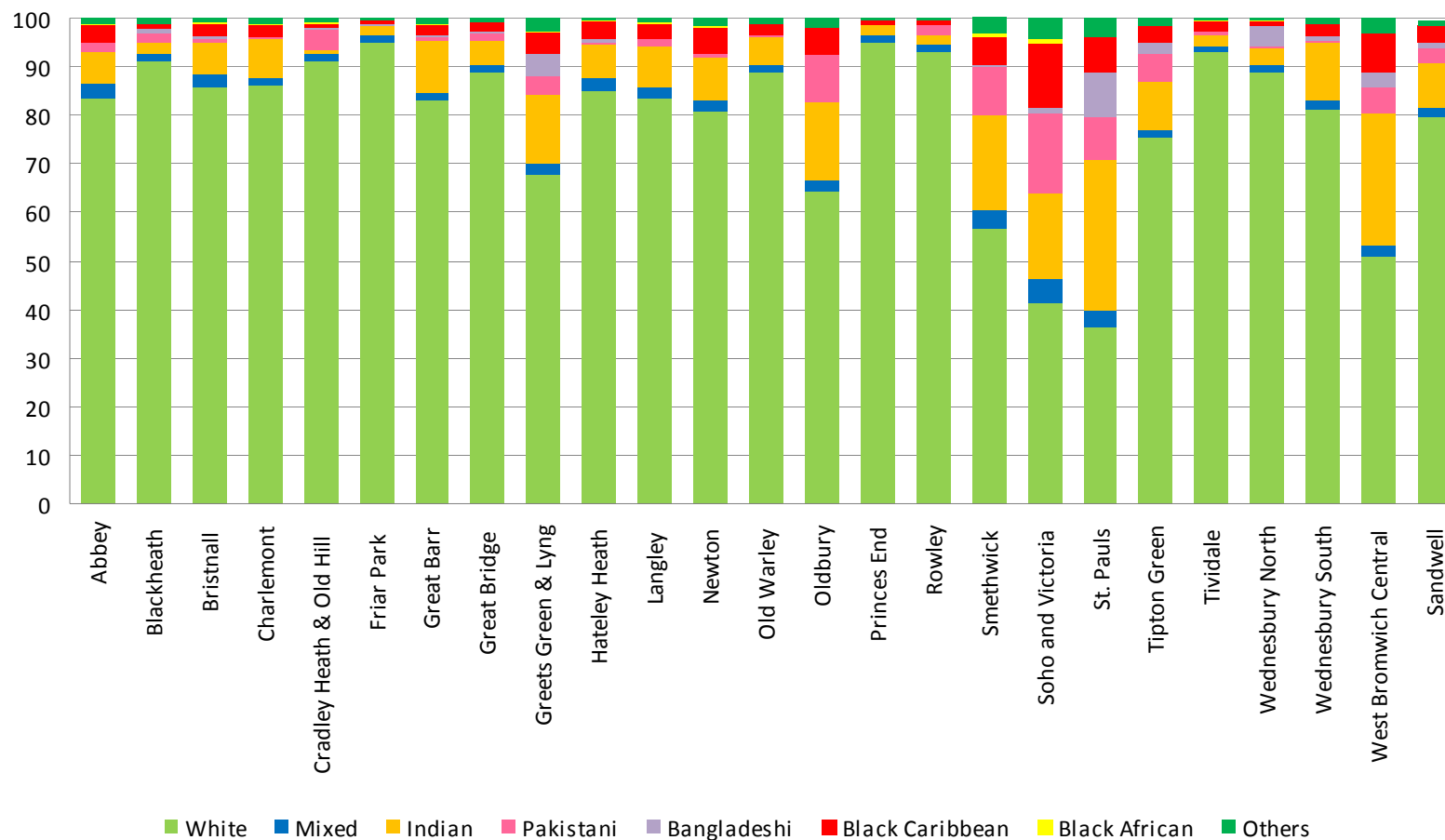
Age structure by ethnic group

Analysis of the age structure of each ethnic group has been presented here with England as a comparator. Variations in age structure by ethnic group are a reflection of variations in fertility, migration and deaths. These graphs can help us to understand how services might be targeted towards particular age groups, within each ethnic group and also provide some indication of changes in size and age structure of each ethnic group, which may help us to plan future service provision.

**Figure 7: Sandwell Percent White British Population compared to Irish Population (Persons), 2006**
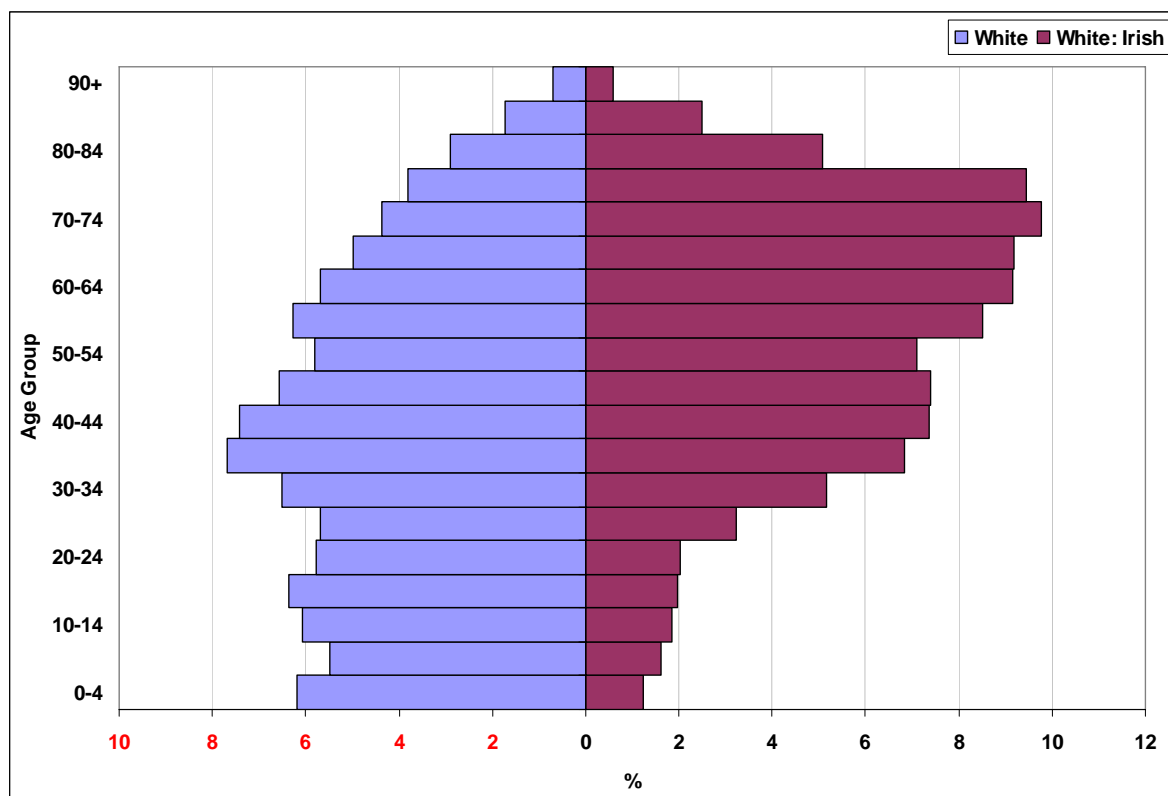
The Irish population makes up an estimated 0.87% of the Sandwell population. The above figure shows fewer people in the younger age ranges within the Irish population than in the 30 plus age ranges. There is a particularly high proportion in the 60 years plus ranges, likely to be a reflection of historical migration. The lower percentage in the below 20 years age ranges, may be a reflection of the older generation of Irish migrants

marrying English people and the second generation being less likely to record themselves as Irish.

Figure 8: Sandwell Percent White British Population compared to (mix White, Black Caribbean, Black African, Asian and other Population), (Person), 2006.
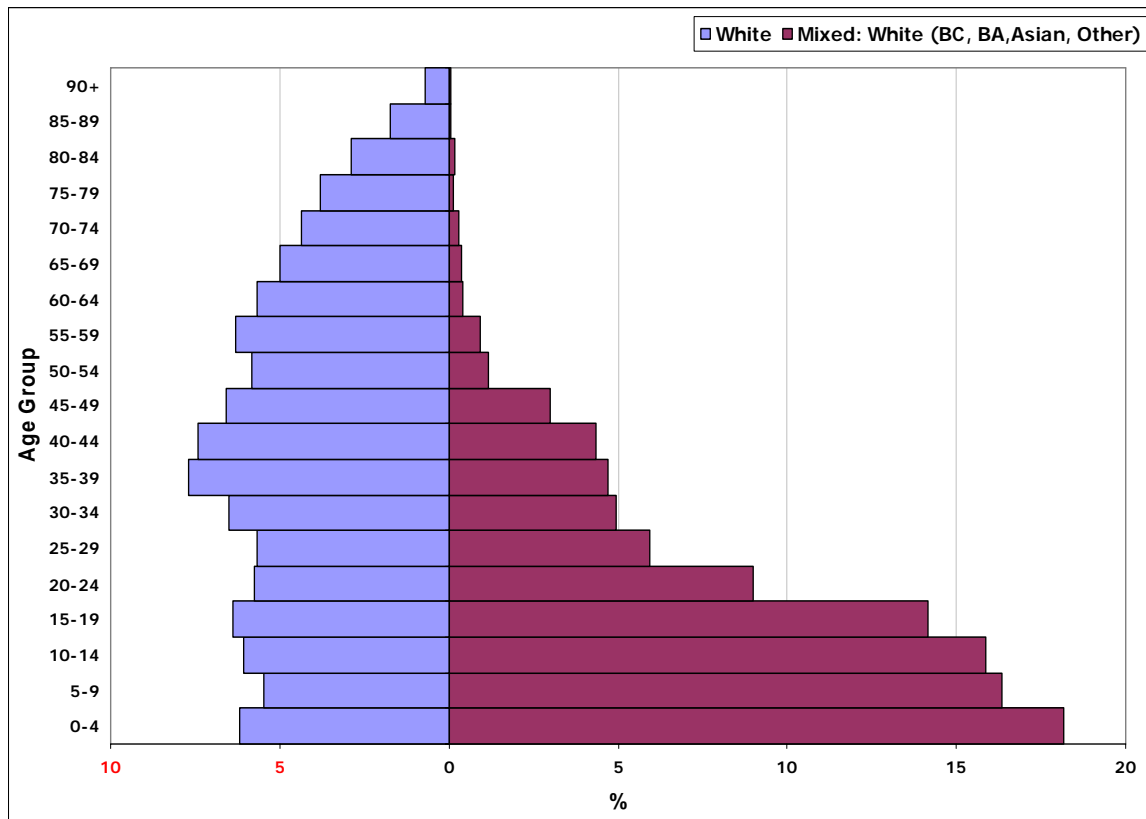
The mixed White, Black Caribbean, Black African, Asian and other, group is a particularly young group and a rapidly growing group, reflecting an increasing number of mixed partnerships. Clearly this is not a homogenous group and will have a range of needs, that will be the result of both ethnicity and social class.

Figure 9: Sandwell; Percent White British Population compared to mix Asian/Asian British (Indian, Pakistani, Bangladeshi) and other Asian (Person), 2006.
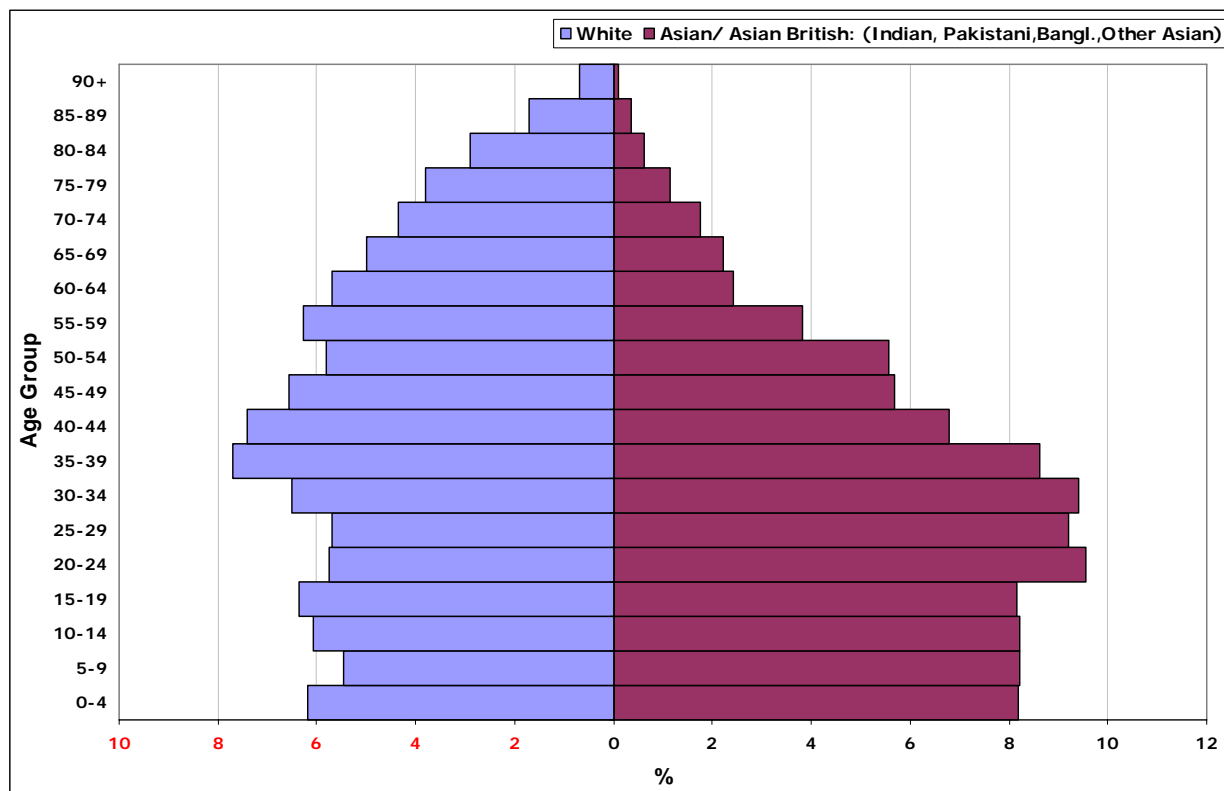
The Asian population is younger than the White population, with the highest proportion of Asians being in the 20 to 39 years age groups. There are also a higher proportion of Asians in the below 20 years age ranges. This is likely to be reflective of the higher proportion in the child bearing ages and a higher fertility rate for this ethnic group. The low proportion of Asians in the 60 years plus age ranges is likely to be due to a combination of factors, which may include: the high proportion of young people, time of migration and lower life expectancy. In the medium term, as the Asian population ages and more people enter the 40 plus age ranges, this may impact on the prevalence of conditions for which Asians are at higher risk, such as diabetes and coronary heart disease. Again it is important to note that this is not a homogenous group and Pakistanis, Indians and Bangladeshis, will have different patterns of migration in and out, fertility and social class.

Figure 10: Sandwell Percent White British Population compared to Black/Black British (Black Caribbean, black African, and Black other (Person), 2006
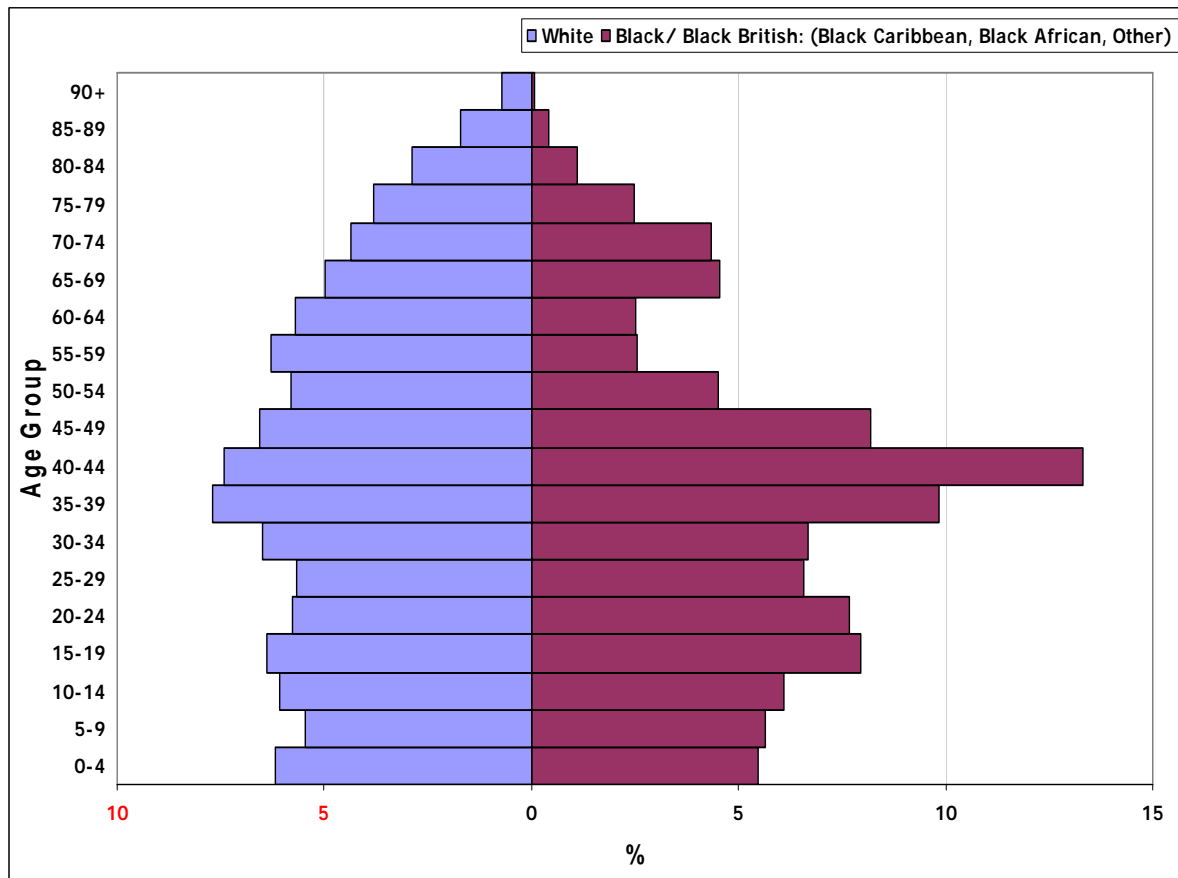
Source: ONS

As with the Asian group, the Black group is also not an homogenous group, made up from people with different countries of origin, migration patterns, fertility and culture. The graph above shows a peak in the 40-44 age group and high proportions, generally in the middle years. The next largest group is 15-24 year olds, there is also a smaller peak in the 65-74 year olds. It is likely that these separate peaks reflect the migration of different ethnic subgroups within the Black group.

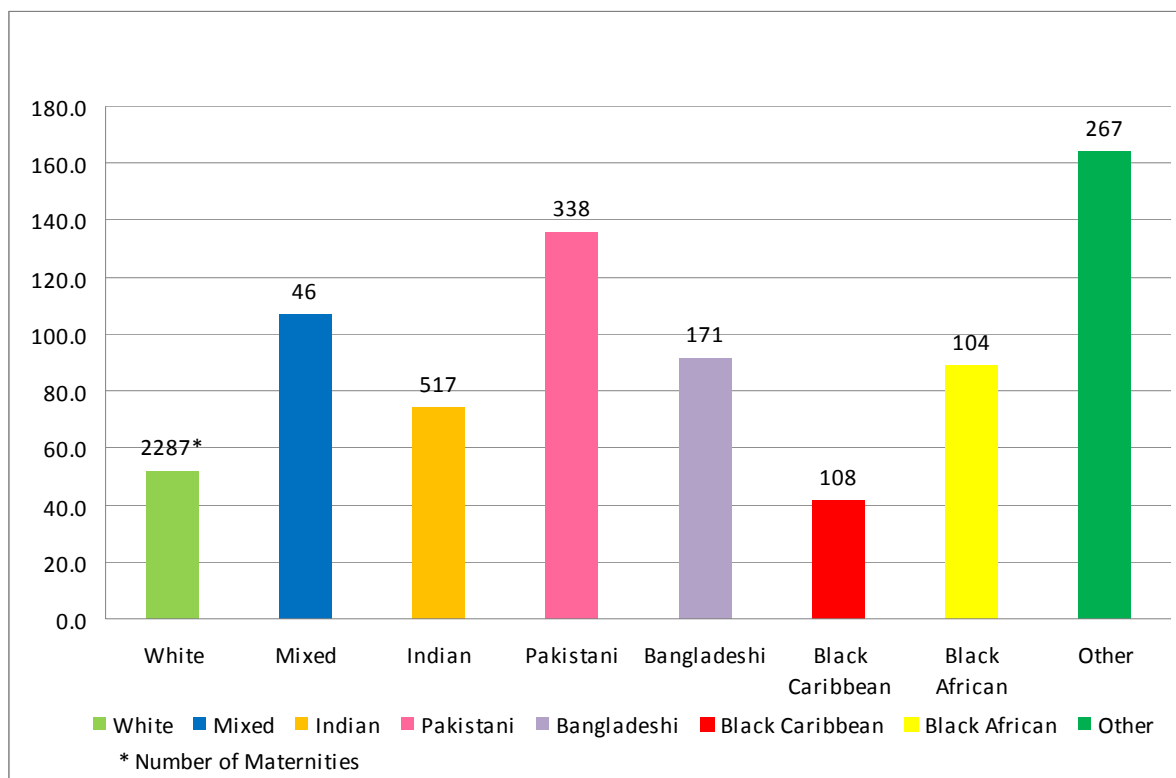**Figure 11: Sandwell Percent White British Population compared to Chinese/Other Ethnic group Chinese (Person), 2006**
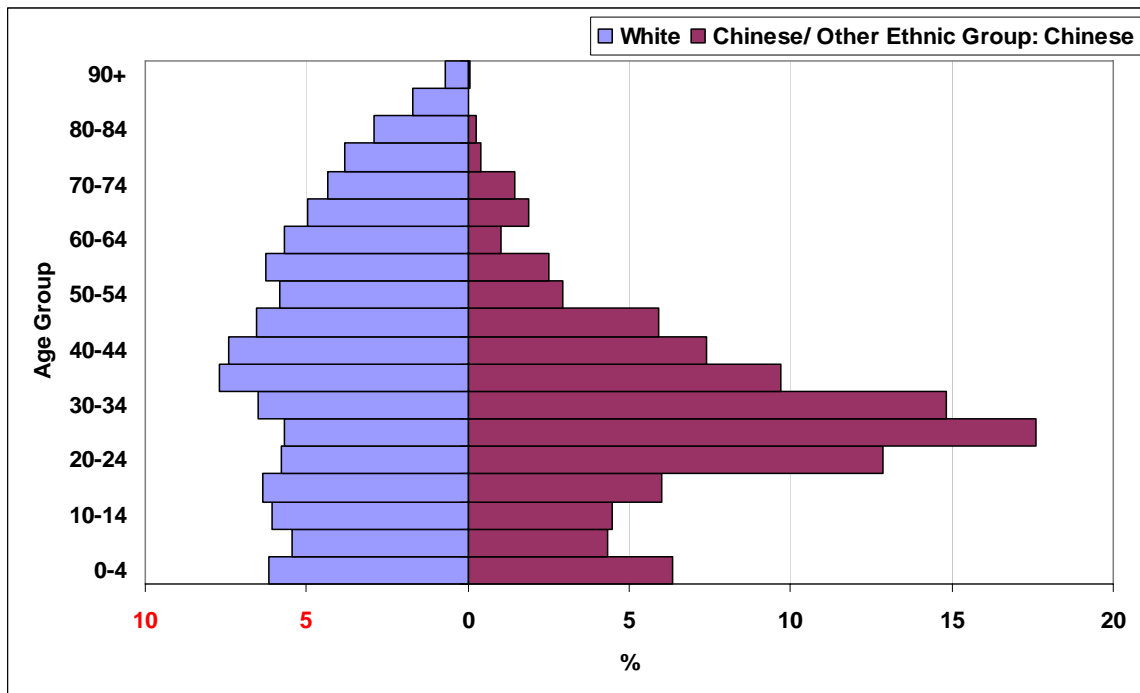
The above figure shows that the Chinese/ Other ethnic group are heavily biased towards the working age population, reflecting migration of economically active adults.

Figure 12: Sandwell Fertility rate per 1000 by ethnicity, 2006

The fertility rate for each ethnic category has been calculated by dividing the number of live births by the number of females in child bearing years (15-44). This graph shows that those in the Other category have the highest fertility rate, these are people with a number of different ethnicities. The graph shows that all ethnic minority groups have a higher fertility rate than the White population, with the exception of Black Caribbean. This may be masked by the high fertility rate for the Mixed group, which may appear high due to the lower number of females aged 15-44 in this category and that fact that most Mixed births will be the result of mothers who are of a an ethnicity other than Mixed and a high proportion may be Black Caribbean. The higher fertility rates in the BME groups, coupled with a higher proportion of their populations being in the child bearing years, is likely to result in: higher fertility rates for the population overall; a growth in the total BME population and a growth in the number of children and young people in these groups, over time.

Chapter 3: Socio-economic characteristics

Deprivation

There is an established association between ethnicity and deprivation, although the level of deprivation experienced, varies by ethnic group. This in turn impacts on the health outcomes experienced by different ethnic groups. The association between socio-economic factors and ethnicity is explored below.

Unemployment and ethnicity

There is an established evidence base for the link between unemployment and poor health, which will not be repeated here. Patterns of unemployment vary by ethnicity and nationally, Pakistani and Bangladeshi populations have the highest proportion of their working age populations, not in employment and the white population has the lowest proportion not in employment.

Figure 13: Percent of working age population claimant unemployment by ethnicity, Sandwell, January 2009
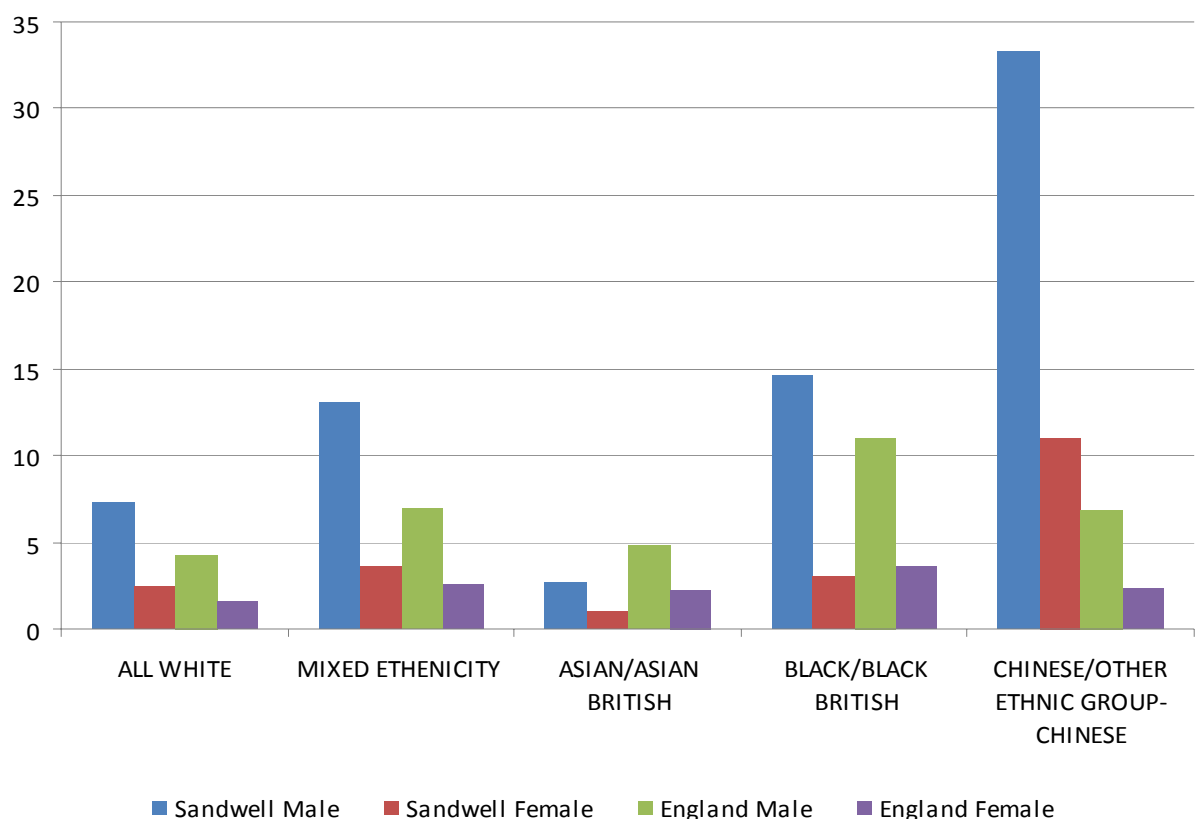

Source: Office for National Statistics (ONS)

Local data presents a different picture, with Asians being the least likely to be claiming unemployment benefits. All ethnic groups, with the exception of Asians and Black females, are more likely to be experience unemployment than their counterparts across England. The Chinese group was the most likely to be experiencing unemployment and the Mixed and Black groups were also more likely to be unemployed than the White group.

The broad ethnic groups for which Sandwell data is presented, masks a more complicated picture. The majority of our Asian population is made up of Indians, there is likely to be a much higher rate of unemployment amongst Bangladeshi's and Pakistani's. Sandwell has been disproportionately affected by the recession which has had a major impact on manufacturing industries locally. The White population are more likely to be working in manufacturing industries, than other ethnic groups and therefore may have been disproportionately affected by the recession. Black populations have a high proportion working in the public sector and may be disproportionately affected by the forthcoming public sector cuts, particularly black women. Variations in employment by ethnicity will result in inequalities in health outcomes.

Figure 14: Occupation type by ethnic group
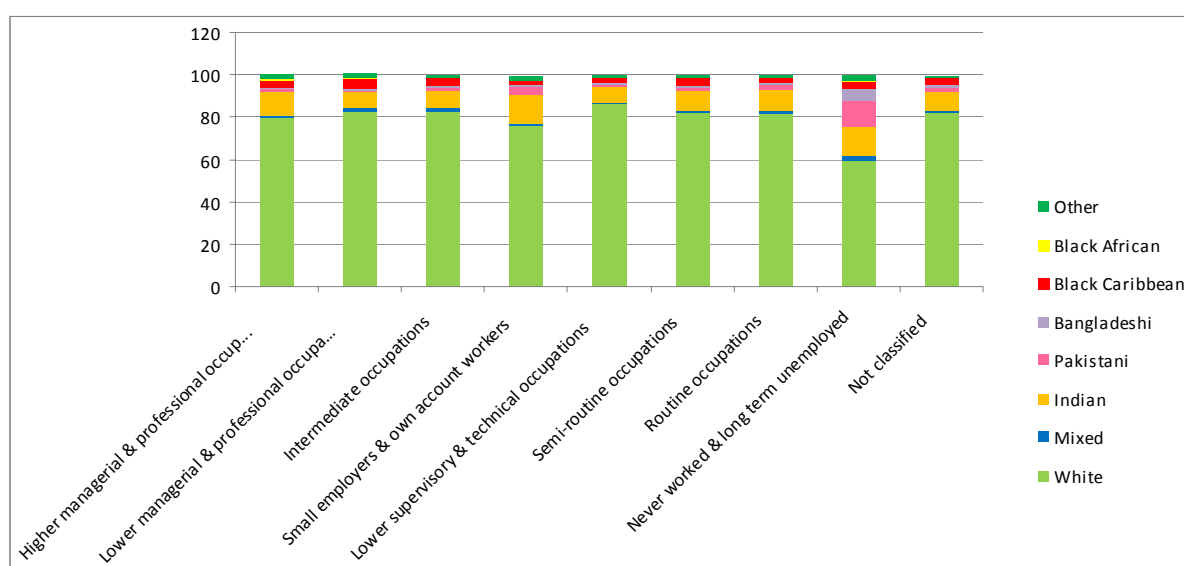
Housing and ethnicity

Sandwell Housing Needs & Demand Study 2007 included 511 returns from ethnic minorities. These have been drawn from the survey and analysed separately to give an insight into the specific housing needs of BME households in the Borough. The survey highlighted over-occupation as a particular issue for BME communities with 13.5% of households in this community affected, almost three times the level in the whole population (5.0%). The quality of the neighbourhood was more likely (39.9%) was much more likely to be cited as a reason for BME households leaving Sandwell than the whole population (23.4%). The survey also looked at household income by ethnicity and this is presented in the table below.

**Table 1: Gross Annual Income of BME Households**

Annual income	%	Cumulative %	All households cumulative %
Below £10,000	41.8	41.8	37.1
£10,000 - £15,000	16.1	57.9	52.1
£15,001 - £20,000	11.1	69.0	63.1
£20,001 - £27,500	11.4	80.4	74.0
£27,501 - £32,500	7.7	88.1	83.1
£32,501 - £40,000	4.8	92.9	90.1
£40,001 - £50,000	2.2	95.1	94.7
£50,001 - £60,000	2.4	97.5	97.5
£60,001 - £75,000	1.3	98.8	99.1
Above £75,000	1.2	100.0	100.0

The table suggests that BME households are more likely to have a household income of below £10 000 than the whole population. Clearly analysis by specific ethnic groups would show a more complex picture.

Deprivation in childhood

Eligibility for free school meals is an indicator of deprivation in childhood. The figure below shows the percentage of children by ethnic group who are eligible for free school meals (2008).

Figure 15: Sandwell Percent of children eligible for free school meals
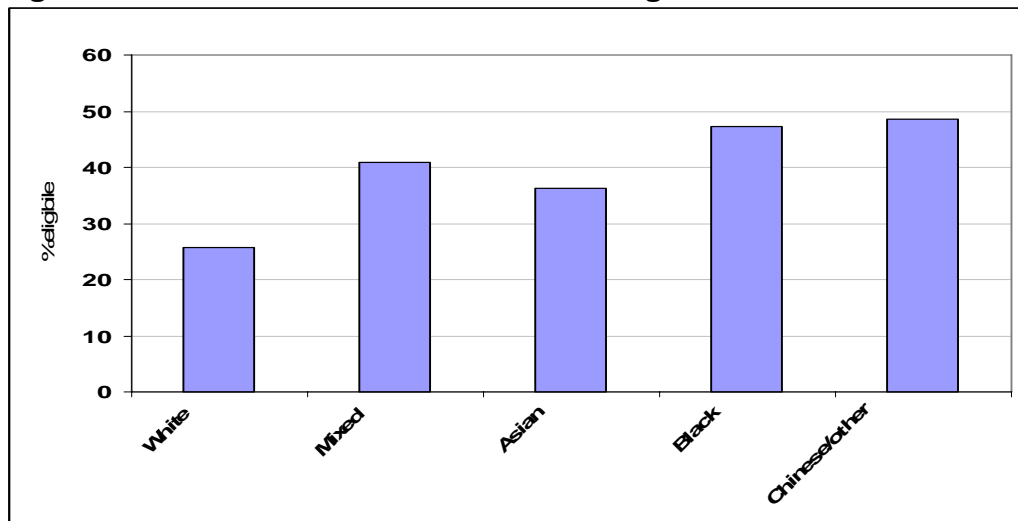
Source: Sandwell Health profile 2008

Chapter 4: Lifestyle risk factors and access to preventative services

We know from many of our existing needs assessments, that BME populations experience disproportionately high rates of mortality from preventable causes. Some of the diseases that affect ethnic minorities disproportionately, diabetes, coronary heart disease and stroke, are associated with lifestyle risk factors such as poor diet, lack of physical activity, smoking and alcohol consumption. Local surveys of the Sikh and Pakistani community suggest a high prevalence of certain risk factors[2,3]. The Sikh Health Profile together with the Alcohol Needs Assessment[4], suggest high rates of alcohol consumption amongst Sikh males. This issue has been explored in detail in the Alcohol JSNA. Both the Sikh profile and Pakistani profile indicate that the majority of people from these groups are not taking the recommended level of physical activity. This is corroborated by national data from the Health Survey for England which suggests that Indian, Pakistani, Bangladeshi and Black African men and women were less likely to participate in sports and exercise.
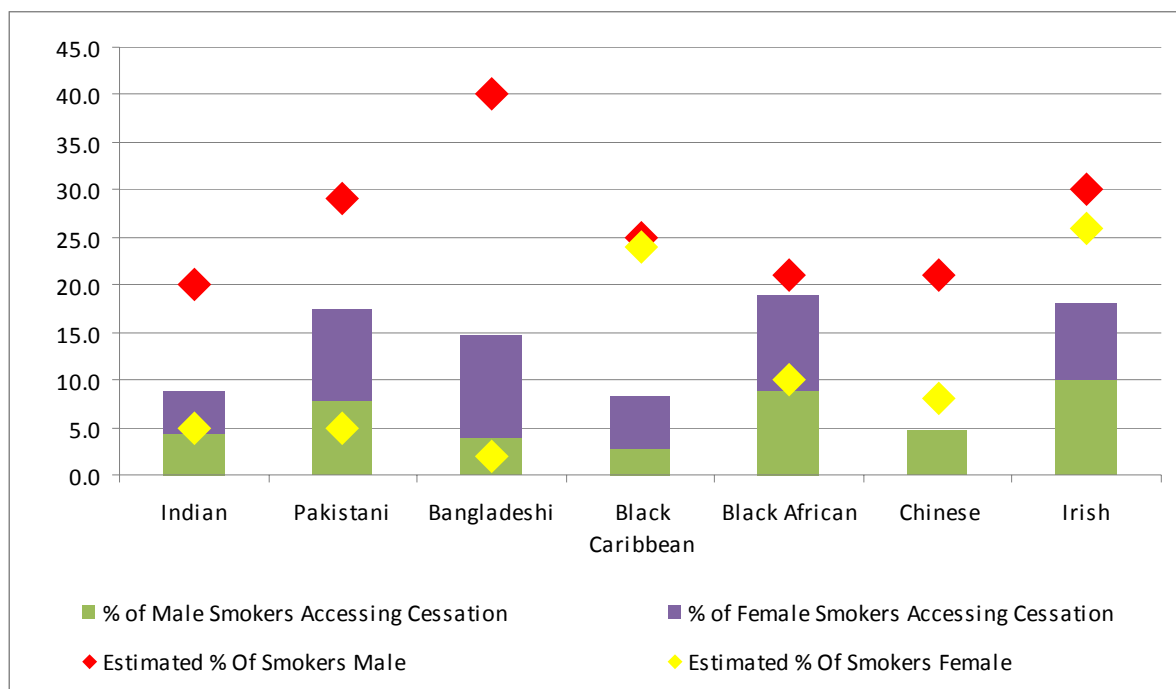
Smoking and smoking cessation

Our best local information on smoking prevalence now comes from primary care records and suggests that prevalence is approximately 27% overall, however we do not have this data broken down by ethnicity. Therefore we have applied national estimates of smoking prevalence by ethnicity, from the Health Survey for England, to our local population, to estimate the number of smokers by ethnic group, locally. We have then used this to estimate the proportion of smokers in each ethnic group accessing smoking cessation services.

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[2] Sikh Health Improvement Group, Sikh Health Profile in Sandwell 2008, April 2009.
[3] Smethwick Pakistani Muslim Association, Pakistani Health Profile in Sandwell, January 2009.
[4] Public Health Information and Intelligence Team, JSNA, Alcohol, January 2010,

Figure 16: Proportion of smokers by ethnic group, access Sandwell Stop Smoking Service 2009/10


Source: Sandwell Stop Smoking Service and Health Survey for England

There is considerable variation in estimated smoking prevalence by ethnicity and gender, with Bangladeshi males having the highest prevalence of smoking and Bangladeshi women having the lowest prevalence of smoking. For all ethnic groups, with the exception of Indian and Chinese, female smokers are much more likely to access the service than males. The rate of access to the service, for Pakistani males and females, is similar to their White counterparts, and Irish males have a higher rate of access than their other White counterparts, as do Black African, Bangladeshi and Pakistani females (bearing in mind that these are a relatively small number for 2009/10). However Indian males and females, Bangladeshi males and Black Caribbean males all have a lower rate of access than their White counterparts. The reasons for the low uptake of the service from these groups needs to be investigated and actions taken to attract them to the service.

Obesity

Understanding the risks associated with obesity by ethnicity is not straight forward. The World Health Organisation recognises that people from different ethnic groups are at risk at different levels of obesity, with Asians likely to be at high risk at lower levels of obesity. However the evidence does not lead to a clear Body Mass Index (BMI) cut off for Asians. This makes the interpretation of any data on obesity by ethnicity difficult[5].

Figure 17: Chart showing mean BMI and percent with a BMI over 30 for males and females, by ethnicity
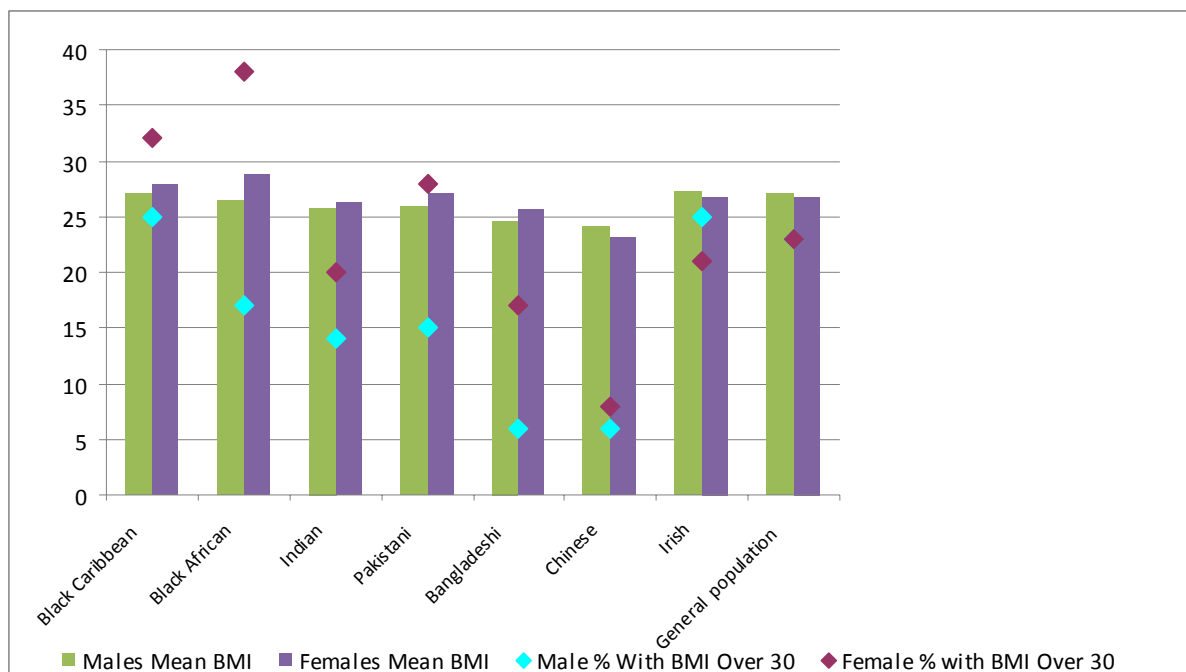
Source: Health Survey for England

The chart above shows that despite the established higher risk of diabetes and heart disease for the Asian groups, mean BMI is lower for Asian males and females than the general population. Male Asian groups also have a much lower proportion of people with a BMI over 30.

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[5] WHO Expert Consultation, Appropriate body-mass index for Asian populations and its implications for policy and intervention strategies, *Lancet,* 2004; 363: 157–63

Figure 18: Chart showing and mean hip to waist ratio and percentage with a waist to hip ratio over 0.95 for males and 0.85 for females, by ethnicity
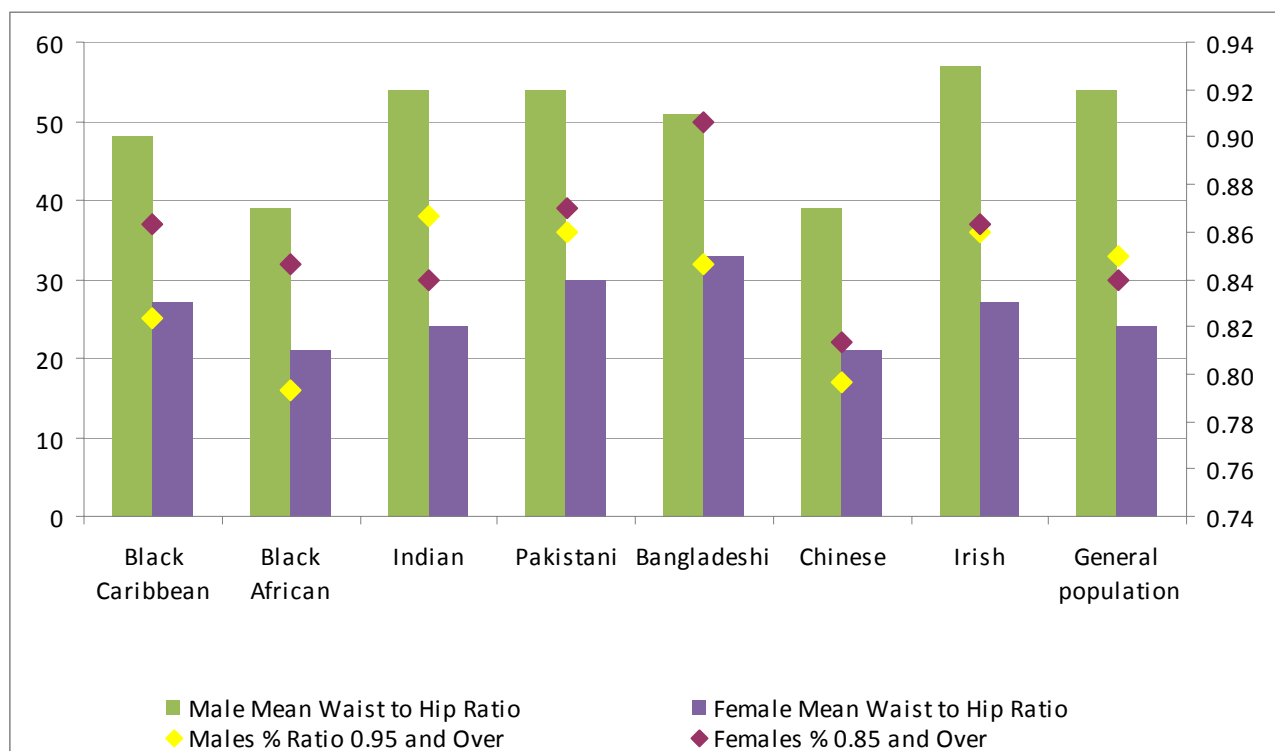
Waist to hip ratios and waist circumference have also been considered as measures of risk and may be better measures than BMI for identifying risk amongst BME groups[6]. Pakistani and Indian males have the same mean waist to hip ratio as the general population and have a higher percentage with a ratio of 0.95 or higher. Pakistani and Bangladeshi females also have a higher proportion of people with a waist to hip ratio of 0.85 or higher, than the general population. Waist to hip ratio should be explored as an additional measure to BMI.

Our main source of data, locally, on adult obesity is through the Quality and Outcomes Framework, which draws upon primary care data. The QOF data only provides a summary figure for the number of people with obesity and does not allow for analysis by ethnicity.

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[6] Yusuf , S *et al* Obesity and the risk of myocardial infarction in 27 000 participants from 52 countries: a case-control study, **Lancet,** Volume 366, Issue 9497, pp1240-1649, 5 Nov 2005

We have a good picture of obesity by ethnicity in children, gathered through the National Childhood Measurement Programme. However these use standard cut offs to define those who are overweight and obese, regardless of ethnicity.

Table 2: BMI cut offs for children

| Underweight	below or = the 5th percentile
Desirable	between the 5th and 85th percentiles
Overweight	between the 85th and 95th percentiles
Obese	> or = the 95th percentile

Analysis of these data did not identify any statistically significant differences between ethnic groups. This may be due to the small numbers of children in some ethnic groups. National data from the National Childhood Measurement Programme found that at Year 6 all non White British ethnic categories, showed a statistically significant, higher rate of obesity. That includes: White Other, Bangladeshi, Indian, Pakistani, Black African, Black other and Mixed. For girls at Year 6 there was a statistically higher rate of obesity in the following groups: White other, Bangladeshi, Pakistani, Black African, Black Other and Mixed[7]. We will need to continue to monitor this locally to see if a similar pattern emerges, pooling several years data may provide sufficient numbers to identify any significant differences.

Physical activity

Sandwell PCTs approach to increasing physical activity is to promote ordinary low cost activities that can be incorporated into everyday life, such as walking and cycling. The proportion of people from each ethnic group attending and registering with Walk to Beijing, our walking service, is shown in the graph below.

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[7] National Obesity Observatory, *National Child Measurement Programme, Changes in children's body mass index between 2006/07 and 2008/09. http://www.noo.org.uk/uploads/doc/vid_6540_NOO_NCMP_v1.pdf*

Figure 19: Percentage of Sandwell residents registering with and attending Walk to Beijing appointments 2009/10, by ethnicity
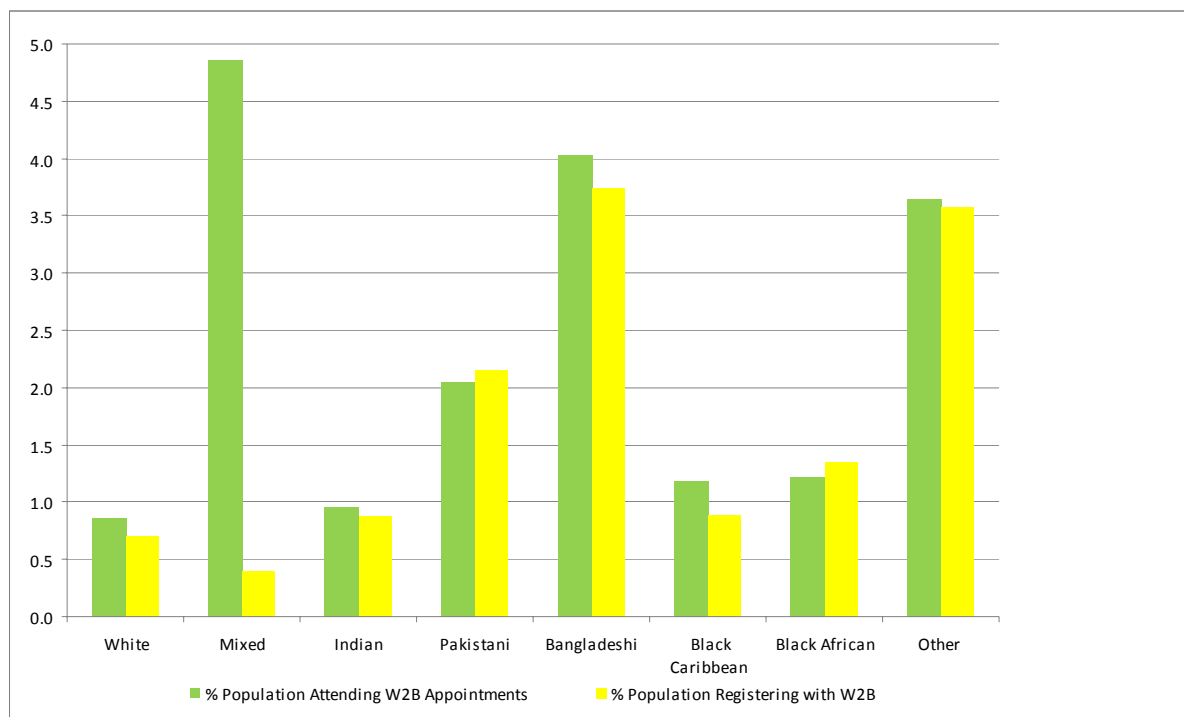
The spikes in the Mixed, Pakistani, Bangladeshi and other groups may be due to the fact that there are relative small numbers of people from these groups in the Sandwell population. However there is generally a good representation of BME groups accessing this service, with higher proportions of most ethnic groups accessing the service than the White population.

Figure 20: Percentage accessing cycling services by ethnic group
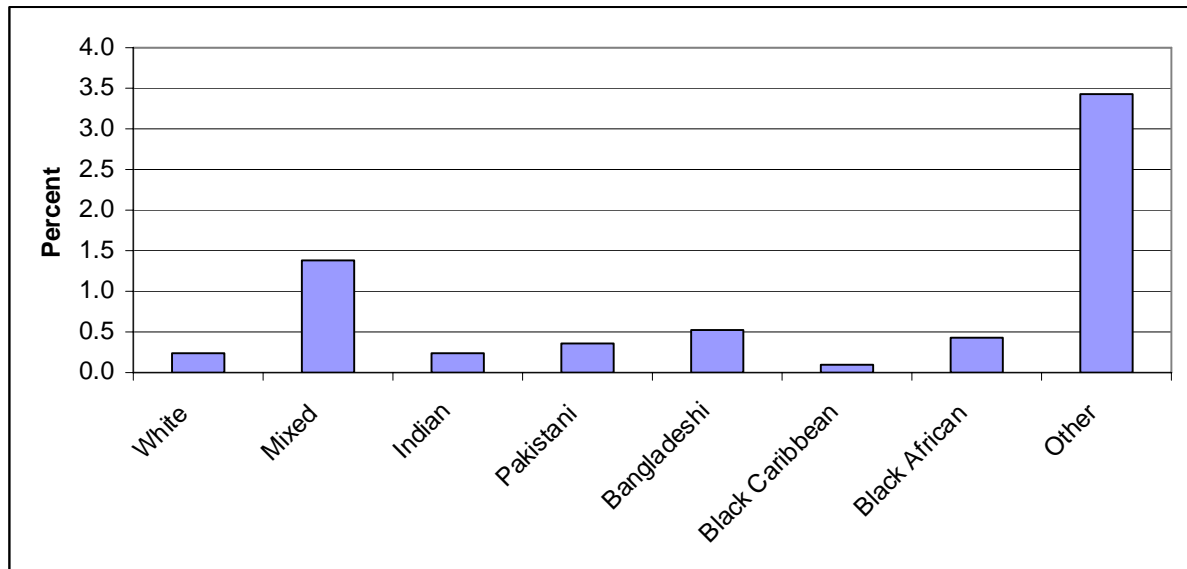
Participation in cycling is lower than that for walking and we see similar patterns for groups that are relatively small in the Sandwell population. Generally BME representation is good for participation in cycling, except for the Black Caribbean group. More focused work may be required for this group to attract them to the service.

Chapter 5. Morbidity

Historically, we have drawn largely on secondary care data to inform our needs assessments. This data set has a high degree of ethnicity recording (more than 90%) and our JSNA documents have provided analysis of these data by ethnicity. However as a measure of health it has limitations:

- It does not provide a true reflection of disease prevalence

- It does not tell us about the opportunities we may have had to prevent disease or manage it better in the community

- Low hospital use by a particular ethnic group may be due to lower prevalence, poorer access to health services or better self management.

- Lower prevalence of conditions related to ageing may be due to some ethnic groups having a younger age profile

Primary care records have the potential to provide a better understanding of some of these issues. Over the last decade, the introduction of the Quality and Outcomes Framework (QOF) has provided us with some understanding of disease prevalence and the management of disease, for a number of key diseases. We have also drawn upon this data to inform our needs assessments, however, QOF only provides summary data and does not allow distinction of demographic characteristics, such as age, gender or ethnicity. It is also limited to the people that have been identified as having disease and identification may vary by ethnicity.

Analysis of primary care data by ethnicity has historically been limited by poor access to primary care data generally as well as poor recording of ethnicity data within primary care. Over the last five years our access to primary care data has improved through our use of Merck Sharp and Dohme informatics (MSDi), who have developed software to query a range of primary care computer systems. Our ability to analyse this by ethnicity is now limited by the level of recording of ethnicity in primary care.

Figure 21: Percentage recording of ethnicity by GP practice
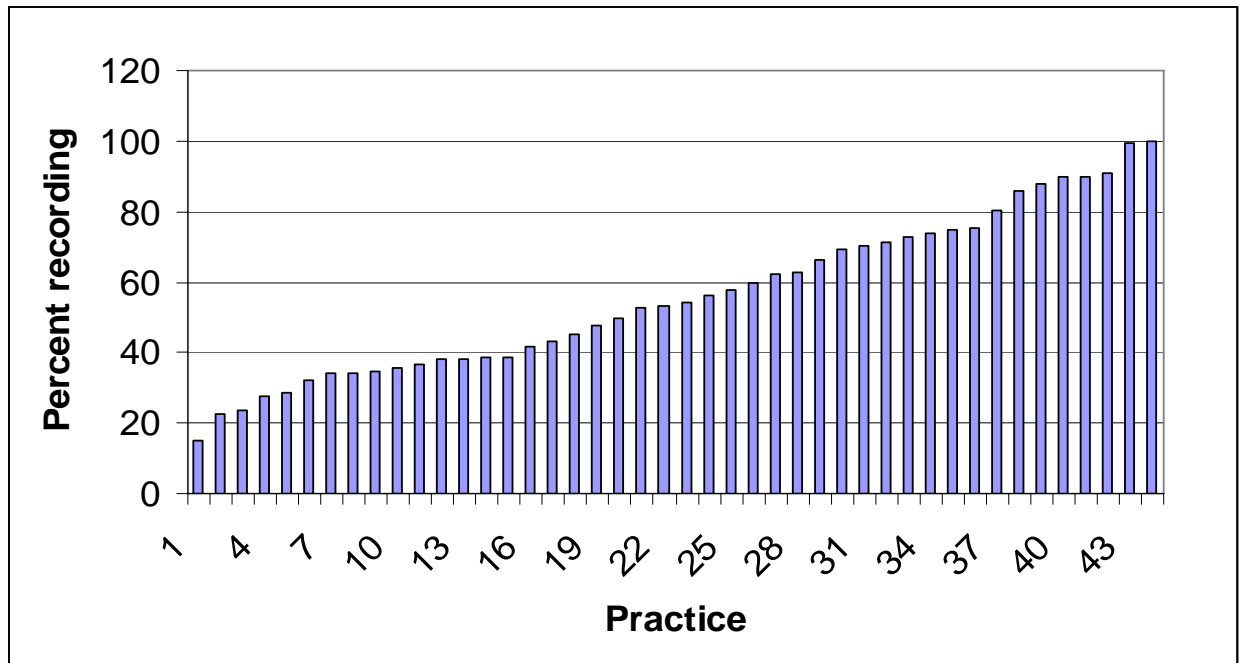
Source: MSDi data extraction from primary care records

The graph above shows recording of ethnicity by practice. The average recording of ethnicity in Sandwell in 57% although there is a large degree of variation by practice. This is not a sufficient level of recording to allow meaningful analysis of primary care data by ethnicity. Further steps need to be taken to improve ethnicity recording in primary care.

Chapter 6. Mortality

Our ability to understand patterns of death by ethnicity is limited as country of birth is recorded on death certificates and not ethnicity. If ethnicity was recorded on death certificates, analysis could be carried out to identify variations in different causes of death by ethnicity. As this data is not available, we have produced a scatter plot of directly standardised mortality from all causes on the y axis and the percentage of ethnic minorities on the x axis, for all wards in Sandwell. Generally no pattern could be identified. However Smethwick has both a high rate of deaths and ethnic minorities. This lack of relationship may be due to the fact that all causes of mortality have been considered together resulting in variations for specific causes being masked. Grouping all BME groups together may also be masking ethnic group specific variations. We will continue to investigate these relationships for specific causes and ethnic groups as we develop further JSNAs. An alternative explanation is that the picture is confounded by social class and deprivation as we also know that Sandwell's White population is relatively deprived.

Figure 22: Directly standardised mortality for all causes by percentage BME populations by Sandwell wards (2004-2008)
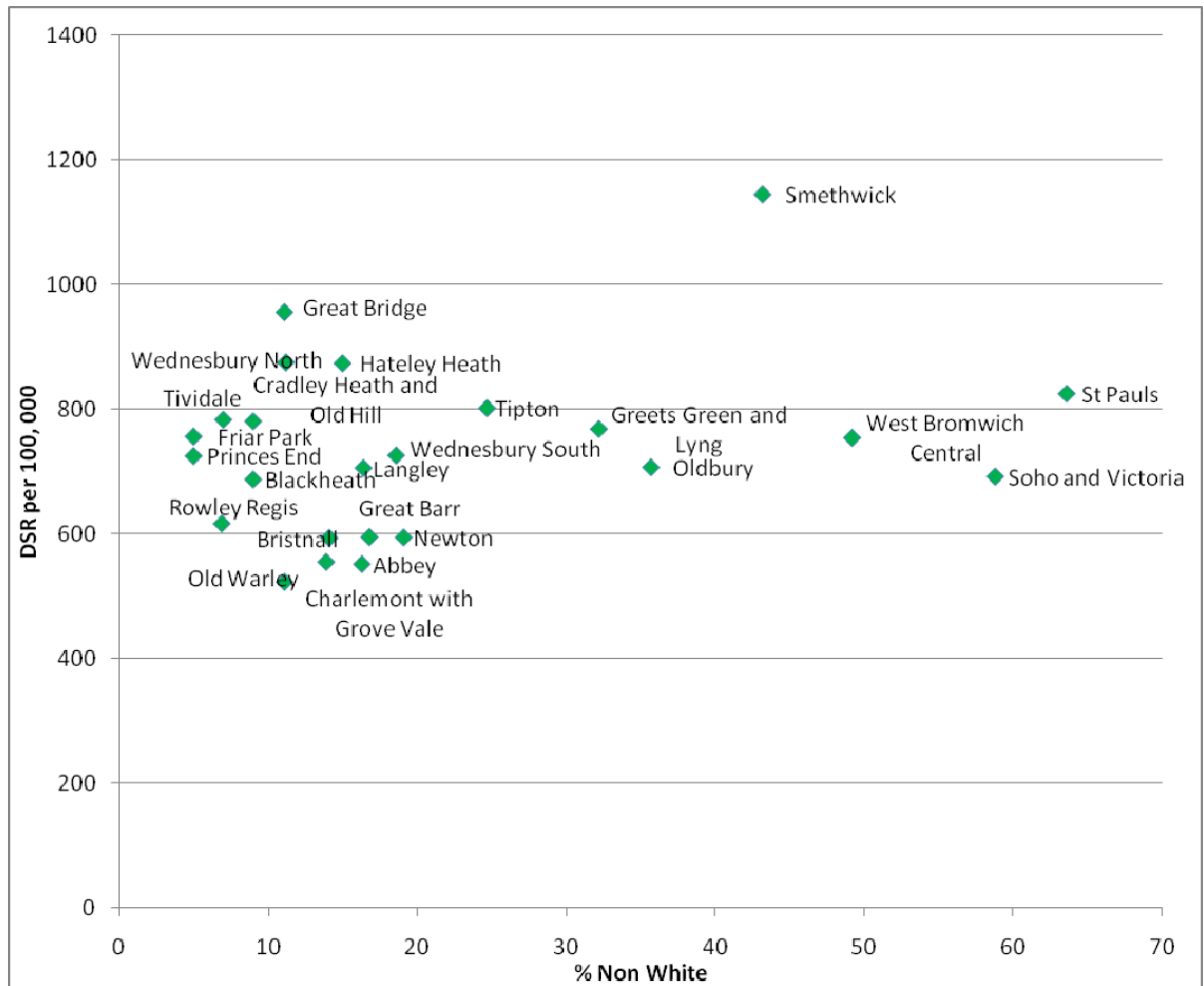
Chapter 7: Conclusion and Recommendation

Based on experimental statistics produced by ONS for 2007, Sandwell's BME population makes up 22% of the population, compared to 12% across England. Based on data from the 2001 Census, there is considerable variation in ethnic make up by ward, with the BME population ranging from 5% to 64%. There is also considerable variation in the age structures of our different BME populations.

Those identifying themselves as Irish are largely in the 35 years plus age ranges, the Mixed population is largely below 25 years, the majority of the Asian population is aged under 40 years, the Black group has a peak in the 40-44 year age band and the Chinese population is largely clustered around the 20 to 40 years age bands. In the medium term, as the Asian population ages, there may be an increase in the diseases for which Asians are at higher risk, included diabetes and coronary heart disease.

There has been a decrease in the estimated number of White people living in Sandwell and an increase in all other ethnic groups. This is likely to continue due to higher birth rate in all BME groups, except Black Caribbean, which may be masked by the increase in the Mixed group. The higher fertility rates in BME groups, coupled with a higher proportion of their populations being in the child bearing years, is likely to result in: higher fertility rates for the population overall; a growth in the total BME population and a growth in the number of children and young people in these groups and the population overall, over time. These changes will need to be considered when planning services, particularly maternity services and children's services.

All ethnic groups, with the exception of Asians and Black females, are more likely to be experience unemployment than their counterparts across England. The Chinese group was the most likely to be experiencing unemployment and the Mixed and Black groups were also more likely to be unemployed than the White group. Asians were less likely to be unemployed than the White group. However children from all BME groups were more likely to be receiving free school meals than the White population.

BME populations experience disproportionately high rates of mortality from preventable causes, some of which are associated with lifestyle risk factors such as poor diet, smoking, lack of physical activity and alcohol. The appropriateness of BMI as a measure of risk for BME communities is considered in this report as well as uptake of smoking cessation and physical activity opportunities offered by the PCT, by ethnicity, are considered in this report. It is recognised by the World Health Organisation that Asians are at higher risk than the White population at lower BMI's, however the evidence has not lead them to a clear BMI cut off for Asians. Waist to hip ratio may be an appropriate additional measure for risk in BME groups and should be explored further. No significant variations in obesity for children could be identified by ethnicity, although they are evident nationally. We will need to continue to monitor this.

The estimated proportion of smokers accessing smoking cessation services was lower for Indian males and females, Bangladeshi males and Black Caribbean males, than the White population. The reasons for the low uptake of the service from these groups' needs to be investigated and actions taken to attract them to the service. There is a good representation of BME groups in walking and cycling activities offered by the PCT.

Our understanding of local need by ethnicity, comes largely from the Hospital Episode Statistics (secondary care data). This provides us with only a limited understanding of need. To develop our understanding further we need to be able to analyse primary care data by ethnicity. This is currently limited by the level of ethnicity recording in primary care, currently at 57%. Investments need to be made to improve ethnic recording in primary care.

Our ability to understand patterns of death by ethnicity is limited by the lack of recording of ethnicity on death certificates. We have carried out an analysis of the association between all cause mortality and ethnicity at a ward level and no relationship between mortality and proportion of ethnic minorities could be identified. We will continue to explore the relationship between mortality and ethnicity for specific causes as we develop future JSNAs.

Recommendations

6. There is likely to be an increase in the number of births and children from BME groups and therefore the whole population. These increases need to be considered in planning maternity and children's services.

7. The use of waist to hip ratio as an additional measure of risk for BME populations, should be researched and given further consideration.

8. Continue to monitor obesity by ethnicity in children, pooling several years data to make the data more robust

9. The reasons for low uptake of the smoking cessation service by Indian males, Bangladeshi males and Caribbean males need to be investigated and actions taken to attract them to the service.

10. Invest in improving ethnicity recording in primary care