

Black and Minority Ethnic Health Needs Assessment

Report for the Doncaster Health and Wellbeing Board

March 2017

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Introduction

Background to the Health Needs Assessment (HNA)

The last specific BME health needs assessment in Doncaster was 2004. This was an extensive piece of work which focused on engagement with key groups representing BME populations to identify needs. Since then, the health needs of BME communities have been identified through Joint Strategic Needs Assessments (JSNA) and latterly have been included in individual organisational approaches to equalities and are recognised in organisational strategies including the Health and Wellbeing strategy. It is recognised that the make-up of BME communities in Doncaster are changing and the 2015 Director of Public Health (DPH) annual report identified inequity of health outcome between Doncaster communities and recommended we undertake a BME HNA. During 2016, we have revisited BME health needs across the borough and under the auspices of the HWB and have carried out a multi staged needs assessment, which culminated in an *evidence safari* (see later). This report outlines the approach to assessing health needs and our findings. The recommendations are **visible** throughout the report and are repeated at the end of the document.

The BME HNA sits within work led by the Doncaster Public Health team to address health inequalities across the borough. By health inequality we mean ‘systemic differences in the health of people occupying unequal positions in society’ (Graham, 2009, p3. cited in Smith et al., 2016) This way of looking at inequality means that differences in health experience and outcomes are socially produced, avoidable, unfair and unjust (NHS England, 2015). In the UK, research around inequality has largely focused on social-economic determinants of health; however, there are other aspects of social position, such as ethnicity, that are important for health inequalities. Research focusing on other axes of inequality such as ethnicity acknowledges that outcomes in terms of inequality are more complex than a focus on a primary axes of socio-economic status (Hill, 2016). Of course individuals may experience a double or triple whammy in terms of health inequality because of their social status such as socio-economic, gender, ethnicity or sexuality (Graham, 2007 cited in Hill, 2016). This means that some people in our communities are living lives that are more short-lived, and more painful. Importantly, health inequality also represents lost opportunities for individuals, communities and economies.

Aims of the health needs assessment

Poor health outcomes in minority ethnic communities can, in large part, be explained by poorer economic status, but this is only part of the picture and this is why it is important for attention to focus on ethnicity (Allmark et al., 2010) . This BME HNA then aims to move our focus to ethnicity and health inequality.

One key idea underpinning Doncaster’s work on health inequalities is that of *making the invisible visible*. By this we mean, recognising the important role of systematically identifying, examining and raising awareness of unequal health outcomes, in this case ethnicity, and using this *visibility* to ensure concerted attention on the issue.

The content of this BME HNA report takes us on this journey and should be viewed as a starting point for making the *invisible visible*; it aims to do this and make actionable recommendations that will both continue to make the invisible visible but also contribute to reducing inequalities.

Objectives

We used three intertwined phases and these are explained in more detail at the head of each section reporting the findings:

- To explore demographic data on Doncaster's BME population;
- To use this data analysis to support an overview of national evidence on BME health;
- To undertake focused engagement activities with local people (including individuals and groups) and organisations.

We also aimed to access and re-analyse previously collected data wherever possible. It is key to note that each stage is connected and aims to inform the next and focuses the needs assessment which we believe is a methodological strength.

Scope and limitations of the HNA

Traditionally, health needs assessments are a way of establishing the gap (if any) between the expressed needs of particular groups and both access to and outcomes from the current range of available services, public, private or voluntary. In addition through discussion with the communities themselves a range of possible options for improvements may be generated with implications for both commissioners and providers of services. We have used the phases outlined above to carry out the BME HNA and in particular have ensured that activities aimed to raise awareness and change the conversation i.e. to make the invisible visible and this work is a key strand within the emerging approach to Health Inequalities here in Doncaster.

We recognise that *making the invisible visible* is not a one off activity, nevertheless, this BME HNA report is good summary of activity since the DPH annual report's recommendation on the need to examine BME needs assessment (Doncaster Metropolitan Borough Council, 2015). The recommendations fall from these activities and we intend that the work forms a concerted effort to reduce inequity in health outcomes due to ethnicity. This needs assessment then should be viewed as a living document and progress on its recommendations will be updated via the DPH annual report.

There are inevitably limitations to both the report and the method and we identify these in the body of the text. We are aware that one major limitation is quality of data recording in terms of ethnicity; this is recognised issue and limits our ability to link local data to outcomes (Allmark et al., 2010). Nationally, work is being undertaken to improve data monitoring on health inequalities which recognises the complexity of the issue and offers guidance on data collection beyond the legal requirements of the protected characteristics

(NHS England, 2015). **Locally, we know we have not yet been able to fully assess differences in access to and outcomes of health and social care services. This is a gap which we need to fill and this will form a work package for the Joint Strategic Needs Assessment (JSNA) which itself should not be considered to be a one off activity.**

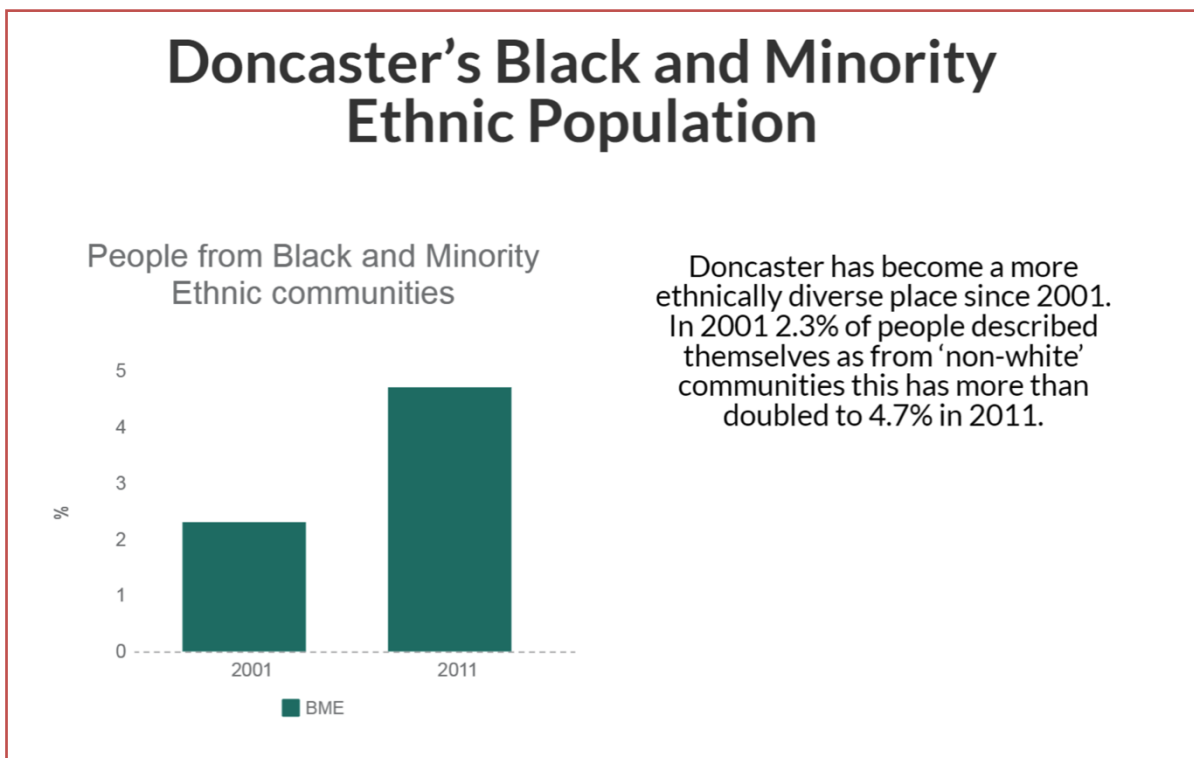
We have also undertaken a very focused (data driven approach to engagement) and recognise that this means we have not engaged with the breadth of minority ethnic populations in Doncaster. Work is being undertaken to develop a comprehensive engagement strategy and we make a recommendation around partnership work to ensure this includes an ethnicity perspective.

Definition of terms

It is important to recognise that ethnicity is a form of collective social identity that includes language, culture, shared histories and common ancestry (Karlsen and Nazroo, 2006 cited in Hill, 2016). We have found the following material produced by the Evidence in Ethnicity and Commissioning research project a valuable resource in terms of defining terms and have adopted it for our work (see Annexe 1).

Phase 1: Demographic information

Figure 1 Doncaster's BME population



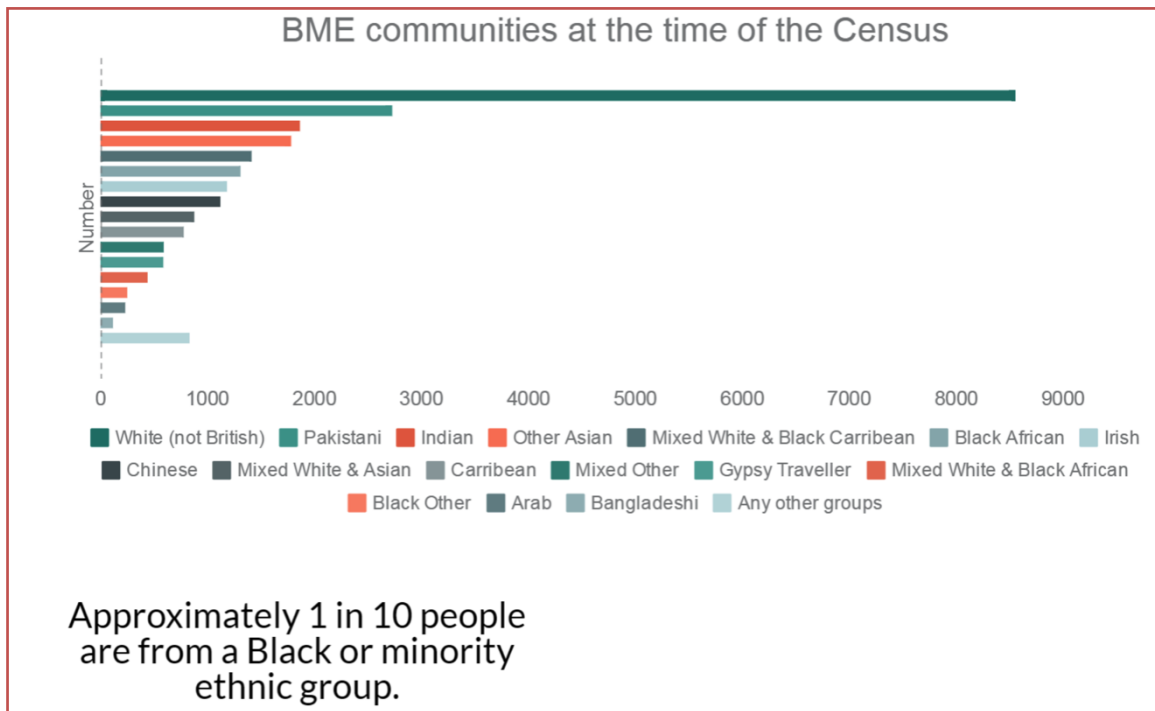
Phase 1 aimed to establish baseline demographic details using the most recent national census data, NHS data and other local census data e.g. school census data. The DPH annual report 2015 recognised that there were inequities in health outcomes for BME communities and used data from the 2011 census to provide an up-to-date picture of the

differences in health and the factors improving or damaging health (Doncaster Metropolitan Borough Council, 2015). Key issues identified from this analyses included:

- Overall Asian and Black groups had higher self reported health status (95.8% and 95.4%) than White British groups (91.3%), although both Asian and Black groups are less active than the general population.
- White British groups show twice the level of alcohol dependency than other groups, however both White and Black groups show the same level of drug dependence. The Asian group has the lowest levels of alcohol and drug dependency.
- National data shows that the Black population suffer from at least double the amount of Post Traumatic Stress Disorder than other populations and as much as 10 times the levels of severe mental illness (including psychosis).
- Other health conditions are more common in some ethnic groups, so heart disease is more common in the Asian population, stroke and hypertension more common in the Black population and both Asian and Black populations have high levels of infant mortality.
- The census also shows that the level of educational qualification varies across the ethnic groups with White Irish, Asian and Black groups having higher numbers of people with level 4 (degree level) qualifications than the general population. Asian and Black groups are also more likely to be students and as a result of being younger populations are more likely to be unemployed and less likely to be retired than the general population.

Based on Census 2011 data, the proportion of the total population in Doncaster classified as 'White British' equates to 91.8% (4.7% less than in 2001), and the national average is 80.45%. Those from BME backgrounds represent 8.2% of the total population. Young people from BME backgrounds represent 10.2% of the total 0-19 population. The working age population from a BME background represent 8.8%, and older people from BME backgrounds represent 2.9%. The proportion of BME population is not as large as the national average however key minority groups do exist in Doncaster. The ethnic group that is the second largest in Doncaster is 'white other' which includes 0.4% Irish, 0.2% Gypsy or Irish Traveller, and 2.8% White Other. Figure 2 below illustrates the BME communities at the time of the Census.

Figure 2: BME communities at the time of the Census



We recognise that, like many places, the make up of Doncaster has changed since the 2011 Census and so have used examined languages spoken and migration patterns to help us uncover evidence on newer populations.

Figure 3: Languages spoken in Doncaster



As can be seen from figure 3 above we have data which identifies languages spoken across Doncaster. Language spoken may be relevant in terms of an individual's ability to both access and navigate health and social care services as well as participate more broadly in

society and access resources within the Borough. The refresh of the HWB strategy identified gaps in services in relation to access to education and English courses. We have explored health and social care organisation responses to language in terms of availability within the provider survey undertaken in Phase 3.

Analysis undertaken by Migration Yorkshire (2016) on Doncaster migration patterns identifies reasons for migration and in particular around work and protection.

Table 1 Migration to Doncaster for work reasons during 2015

	Numbers of new migrant workers
EU accession countries	3070
Non-accession countries.	420

Data source: (Migration Yorkshire, 2016, p.2).

In terms of migration for work purposes the top countries of origin being Sudan and Spain. In terms of protection, according to Home Office figures at the start of April 2016, 269 people were being supported in Doncaster while awaiting a decision on their claim [known as Section 95 support]: 265 people were being accommodated, and there were four people receiving subsistence-only support i.e. no accommodation (Migration Yorkshire, 2016, p.3).

Migration Yorkshire analysis also identifies what it terms ‘indicators of diversity’(2016) and these are listed below:

- Doncaster has 6% of the overall population in Yorkshire and Humber, but most counts of migration show it receives less than 6% of newcomers.
- In Doncaster, 8% of the community are non-British, a rise on the previous year, raising it above the Yorkshire and Humber regional average of 6%.
- 9% of the population were not born in the UK, an increase on the previous year, and now on par with the Yorkshire and Humber as a whole. They have settled particularly in Central, Wheatley and Town wards.
- Just over 3100 pupils at school in Doncaster have a first language that is not English. This is equivalent to 9% of primary pupils and 7% of secondary pupils; both figures are small increases on the previous year, but remain much lower than the Yorkshire and Humber averages of 17% and 13% respectively.
- 6 in every 1000 new GP registrations in Doncaster are made by people who previously lived abroad, compared with an average of 9 per 1000 across Yorkshire and Humber.

- The fertility rate in Doncaster has been in decline since 2009, and is now on par with the regional average. Births to mothers who were born outside the UK are lower than average but increasing over time; totaling 15% of all new births in 2014 compared to 20% across the Yorkshire and Humber.

Work undertaken to support the HWB strategy refresh identified gaps in services in relation to housing and homelessness for asylum seekers and refugees. Moreover, these analyses informed the next phases of the needs assessment and directed where we sought further evidence, for example, evidence around the health needs of migrants and engagement with services for refugees and migrants such as Health Access for Refugees Programme (HARP) and the Conversation Club.

In January of this year, the Manchester Centre on Dynamics and Ethnicity (CoDE) published local Ethnic Inequality Briefings¹ which were the culmination of work started in 2014 and funded by the Economic and Social Research Council (ESRC). We have taken aspects of this approach i.e. comparison of 2001 and 2011 data and applied it locally. It is important to note that it is more difficult to do these analyses in Doncaster because of our relatively small BME population (Gulliver, 2016). From a technical point of view this has meant that we have needed to collapse categories of ethnicity, and from an interpretation point of view it means that it is difficult to discern key messages from the data.

We have though in addition, to examining general health and disability looked at number of qualifications as an education indicator and have examined, overcrowding, and no central heating as an accommodation indicator. These analyses are presented below (figures 4 to 8). In terms of reading these figures, it is important to note that they compare the 2001 and 2011 census data. The important line to note is labelled zero, a bar to the right of this line indicates better positive health than the Doncaster average and to the left indicates worse than the Doncaster average.

In the accompanying commentary we have elected to highlight only where there seems to be area that may require attention. The CoDE team used their analyses to support engagement and develop insight and we recommend that this data is used to form a specific piece of BME engagement work utilising existing forums and networks.

¹ See <http://www.ethnicity.ac.uk/research/outputs/briefings/inequality-briefings/>

Figure 4: Ratio of people reporting poor general health

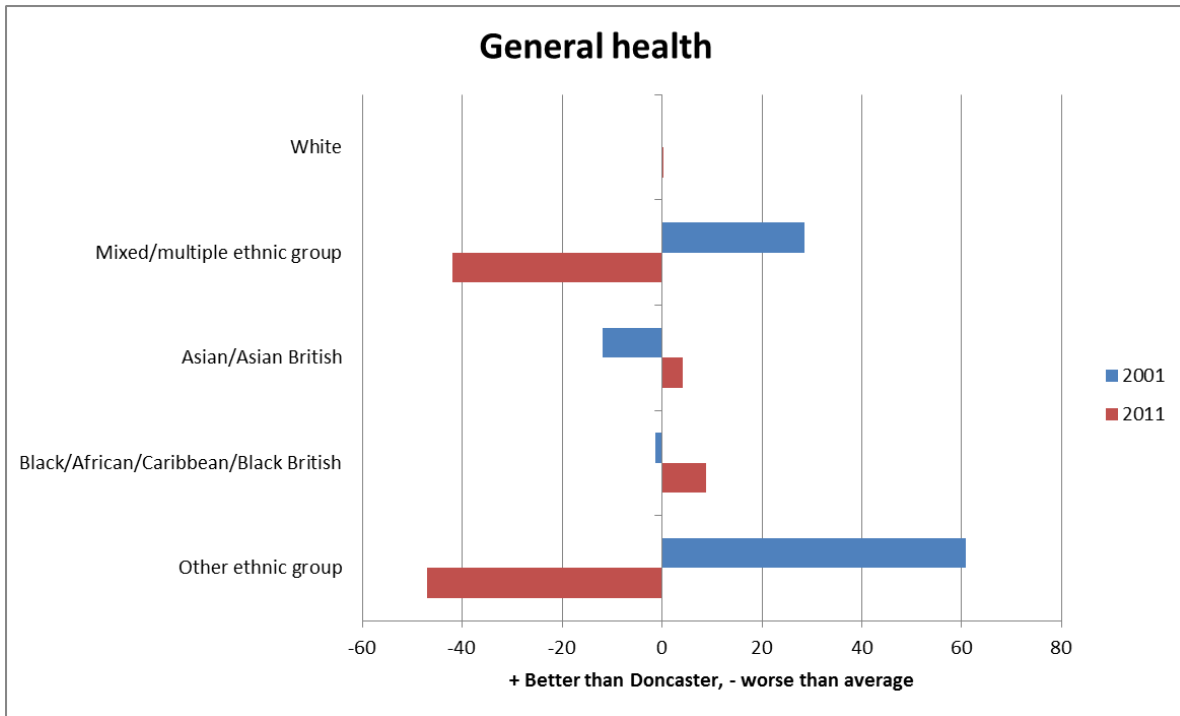


Figure 5: Ratio of people reporting a health problem or disability that is expected to last 12 months or more

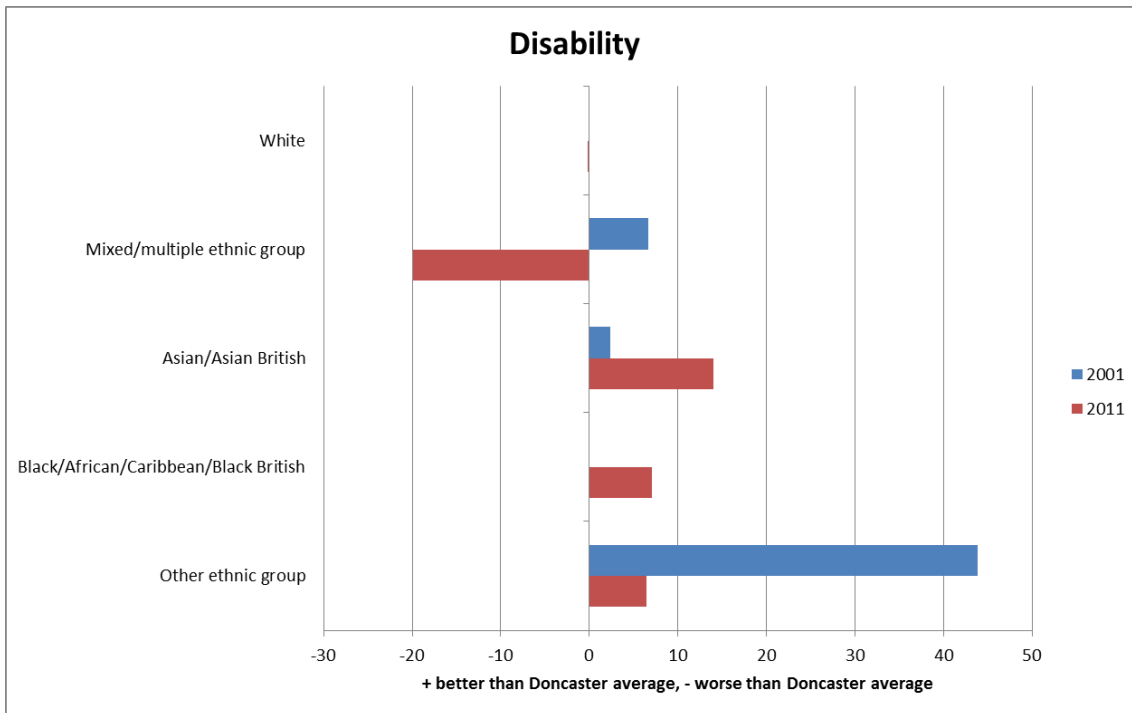
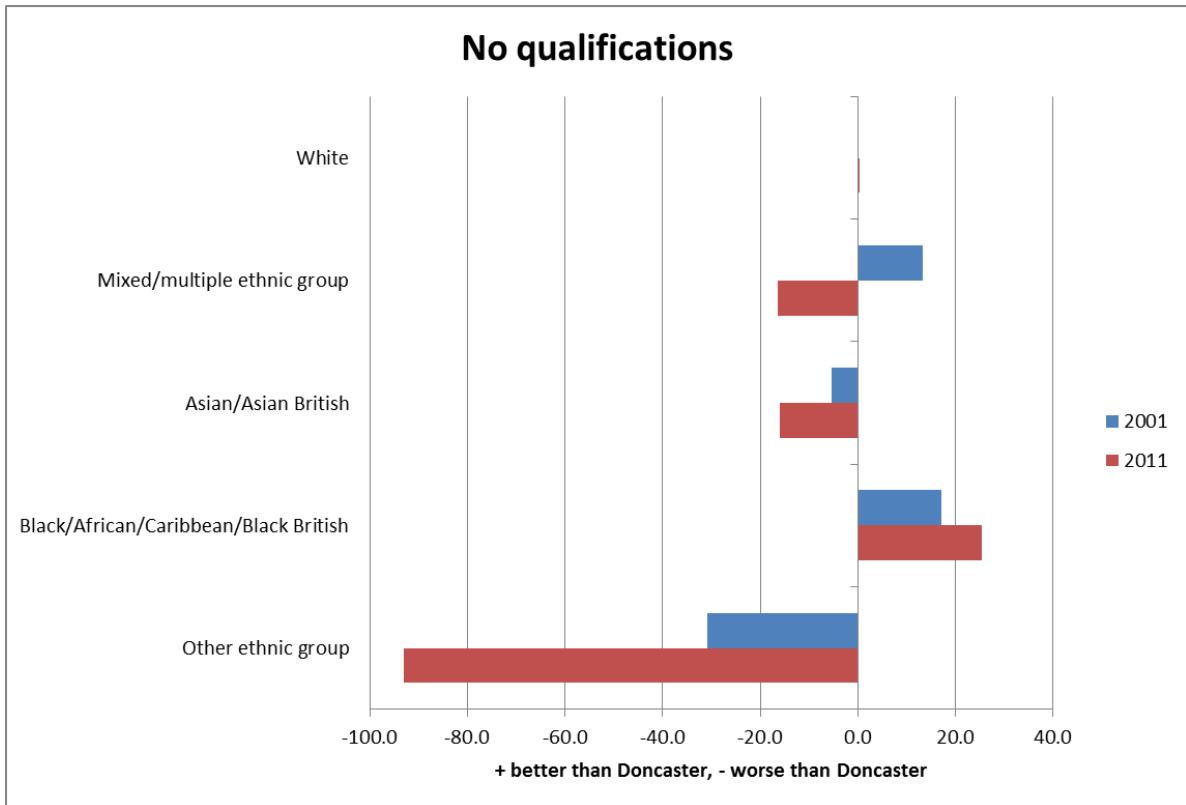


Figure 6: Ratio of people with no qualifications



In 2001, Black/African/Caribbean/Black British people were more likely to have a form of qualification than the Doncaster average and in 2011 this group was even more likely to have a qualification. The group most likely to not have a qualification was the ‘other ethnic group.’

Figure 7: Ratio of people resident in overcrowded accommodation

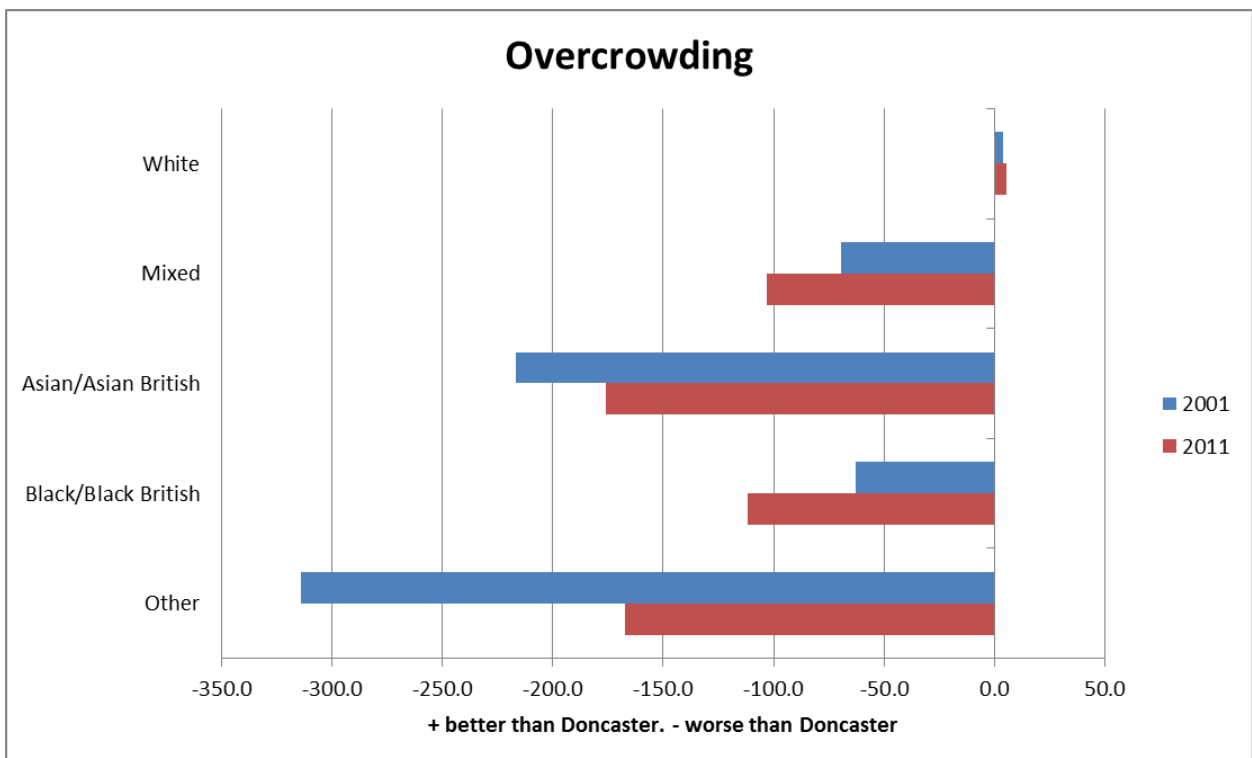
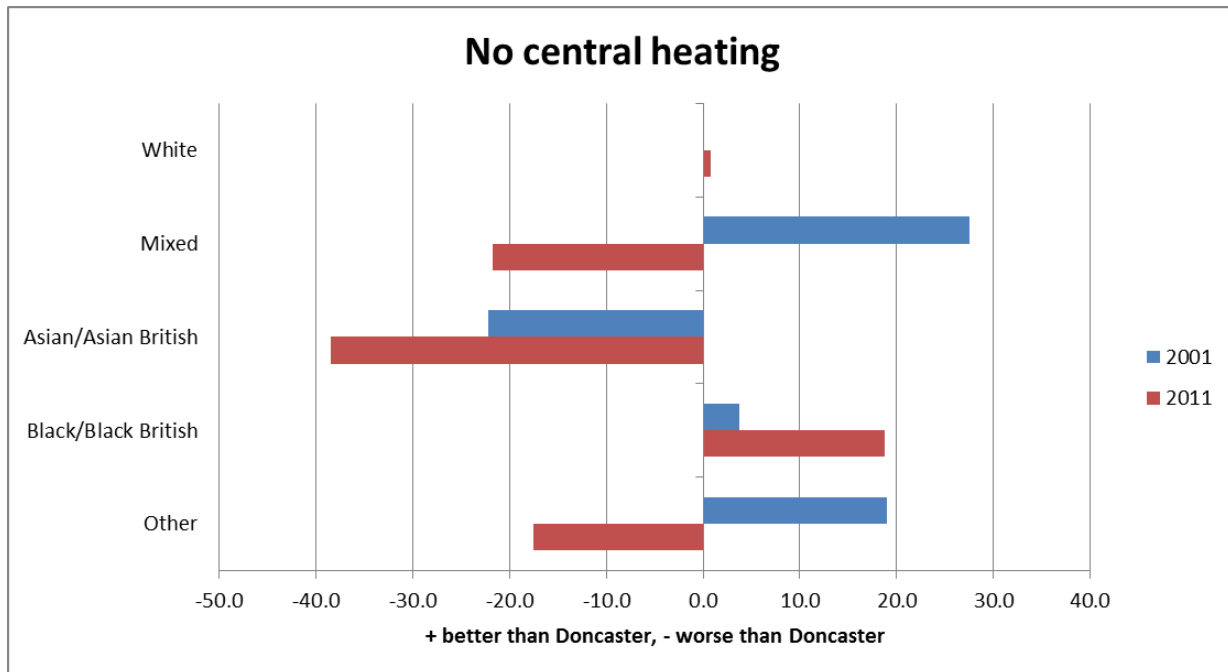


Figure 7 shows the ratio of people resident in overcrowded accommodation. This is defined as people resident in households with less than 1 room (excluding kitchen and bathroom) per person. This does seem to show people from non-white groups continue to live in more overcrowded accommodation.

Figure 8: Ratio of people resident on house with no central heating



Implications of phase 1

We have set out the data which explains the population make up of Doncaster in terms of BME communities. Doncaster has relatively small BME population but this analysis suggests that a key group for further attention is migrants and new arrivals. This also reflects evidence highlighted during the HWBB Strategy refresh work. We have used these insights to direct Phase 3 of the HNA.

These analyses also suggest areas for attention in terms of trawling the literature and highlight migrant health, mental health, and housing and our approach and findings from Phase 2 of the HNA. In addition, we were also conscious of the need to pay attention to how ethnicity can lead to ‘differential exposure to health –related risk’ and that can include harassment or discrimination. We included this in Phase 2 and 3 of the HNA.

It is also important to note that we further work is required to analyse health outcomes by ethnicity and this will form a work package in the Joint Strategic Needs Assessment.

Phase 2: Evidence from the literature

Approach to accessing the literature

Research on ethnicity and health is not located in one readily accessible place. Moreover, given the methodological complexity of evaluating outcomes of interventions designed to address health inequalities single studies can be misleading (Barr et al., 2016, p.260). Indeed, evidence based policy tends to advocate that it is best to use systematic reviews of high quality studies of evidence to guide policy and practice (Lavis et al., 2003). Ideally, then this section would comprise an overview of relevant (i.e. on issues such as mental health identified earlier) systematic reviews and guidance for practice. However, to date there are very few systematic reviews which address health inequalities (Bambra et al 2009, cited in Barr et al., 2016). There are also methodological challenges with using traditional systematic review approaches in the world of social policy intervention and more latterly synthesis which includes evidence from diverse sources has been advocated (Pawson, 2002).

We have not attempted to undertake such a review but have explored diverse sources to underpin the next section. In particular, we aimed to ensure that evidence on BME health needs sought from the literature and presented, was guided by issues identified during the HWBB refresh and as well as consideration of the issues arising from Phase 1 of this needs assessment specifically, migrant health, mental health, housing, and harassment.

Public Health England produce a guide on sources of evidence on ethnicity and inequality and this was our starting point (Public Health England, 2016a). Our approach to accessing the literature consisted of a number of strands of activity. Firstly, we revisited an NHS Evidence search undertaken by Knowledge and Library Services at Doncaster and Bassetlaw Teaching Hospitals (DBTH) in 2014. We then accessed centres of interest on health and ethnicity such as Sheffield University's Health Equity and Inclusion Unit (<http://scharr.dept.shef.ac.uk/healthequity/>) or Manchester's Centre on Dynamics and Ethnicity (<http://www.ethnicity.ac.uk>). Finally, we utilised an approach to evidence gathering that has taken advantage of networks, communities of practice and interest lists and the mainstream media (for example, recent reporting on breast cancer rates and Black women²) to scan for forthcoming and relevant research or publications.

It is important to recognise that this evidence is not a systematic review and is instead a series of tailored forays into the literature. We have wherever possible utilised evidence that is in itself summary evidence of what is known rather than single studies.

We recommend that this approach is systemised under DMBC's Strategy and Performance Unit (SPU) work plan and acts as the means of horizon scanning for evidence to address inequalities for BME communities.

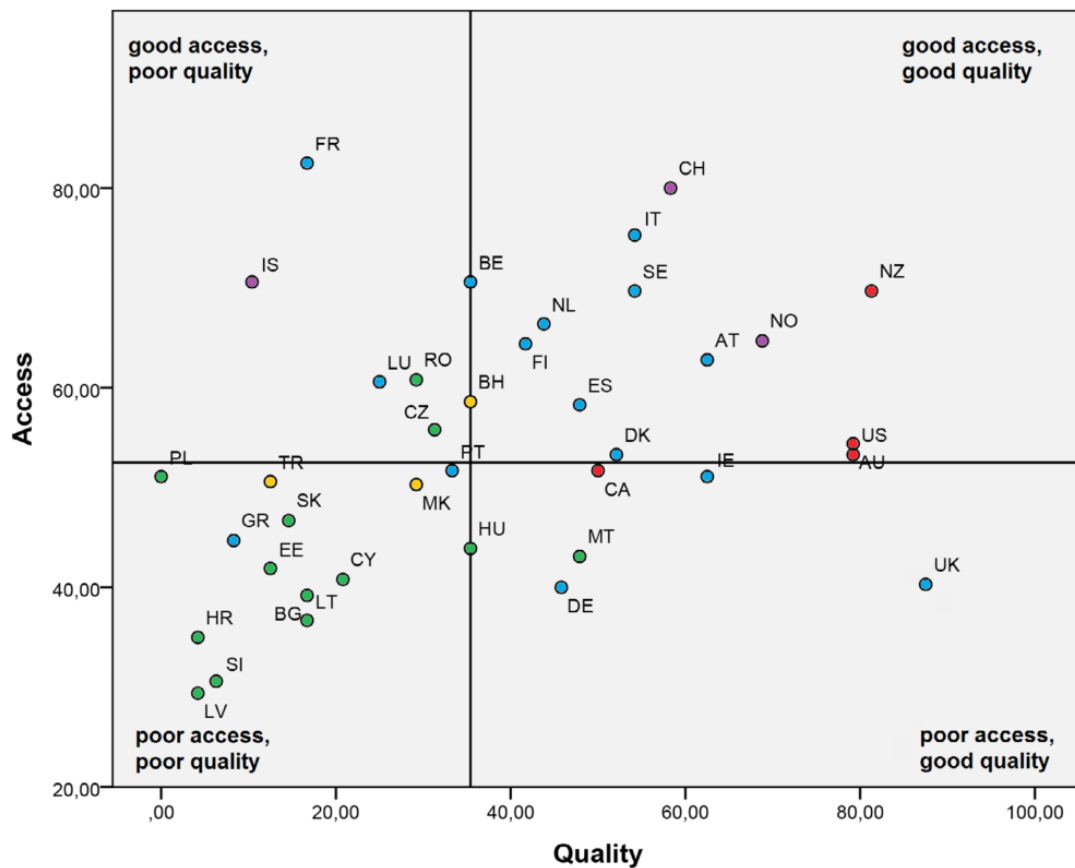
² <http://www.bbc.co.uk/news/health-37991460>

The forays into the literature enabled the development of evidence boards which were used in the *evidence safari* and this event was intended to provoke discussion and raise awareness. We have not reproduced these here but rather have set out key insights from the literature. At the end of the section we identify implications of this literature drawn from our analyses and from comments made at the evidence safari event.

Evidence from the literature on migrant health

We started with a recent international study on migrant health (IOM Migration Research Series, 2016). Figure 9 contains this international data which suggests that migrants coming to the UK receive high quality services but may have poorer experiences of access to services (IOM Migration Research Series, 2016).

Figure 9: Relation between access and quality



Key to colours:

- Blue: EU15 countries
- Green: Post-2000 accession countries
- Purple: EFTA countries
- Yellow: EU neighbour countries
- Red: Non-European countries

Work within phase 3 (engagement and the evidence safari) has helped us understand how the local experience of these issues. One key issue within the literature is how primary care is able to adapt to new migrants. Staff at Sheffield University's Health Equity and Inclusion

group³) have been undertaking research in this area (Such et al., 2016). More information on the project can be found here <https://newmigrantsinprimarycare.wordpress.com/>

Key findings included:

- 84% of survey respondents reported migration had increased rapidly or steadily in their area in the past five years;
- One in five (21%) survey respondents did not identify any adaptations in service delivery for new migrant populations
- On average, respondents identified four barriers to adapting services for new migrants. The most frequently cited barriers were lack of funding (73%), lack of time (64%), insecurity of funding (47%), lack of staff (43%) and personal fatigue/'burn out' (34%);
- Adaptations were varied, including signposting patients to support agencies, coordinating primary care services with other agencies e.g. housing associations, providing cultural competency training for staff and providing 'one stop shop' clinics for new migrant patients. Case study organisations adapted their services in multiple ways.
- Drivers for adapting services included practitioner, organisational and wider contextual factors.
- Organisational and practitioner commitment to equity appeared to be critical.
- Adaptations aimed to enhance patient access, identify complex need, address the social determinants of health and improve patient-practitioner communication and trust

The team has successfully applied to the Health Foundation to take part in the Evidence into Practice programme to develop 'online tools for GPs to help support new migrants in primary care. As a result of existing collaborations and relationships we are able to be part of this research project and can offer to work in partnership to co-develop these tools.

³ <http://scharr.dept.shef.ac.uk/healthequity/>

Evidence from the literature on mental health

Mental health was identified as a key issue from earlier work to refresh the HNA. Rees et al in their review of the prevalence of health disorders in adult minority ethnic populations in England identified that there was limited information from appropriately designed surveys (Rees et al., 2016) and make recommendations to improve this.

We set out below what they have been able to glean in the areas of suicidal thoughts and depression and anxiety.

Suicidal thoughts

The review of the prevalence of mental health disorders in adult minority ethnic populations found a relatively strong patterns for suicidal thoughts in both men and in adults although for different ethnic groups in each case (Rees et al., 2016). The picture was complex for both cases:

- A strong pattern was seen among analyses of the prevalence of suicidal thoughts in men and suggested that prevalence was relatively low for South Asian men and lower for South Asian men than it was for White men;
- A strong pattern was seen among analyses of the prevalence of suicidal thoughts for adults as a whole and suggested that prevalence was relatively low for Black adults, and lower for this group than it was for White adults;
- A pattern was seen among women in the prevalence of suicidal thoughts, with South Asian women having a relatively low prevalence when compared with women from one or more other ethnic groups (White women in particular);
- A pattern was seen among men in the prevalence of suicide attempts, with South Asian men having a relatively low prevalence when compared with men from one or more other ethnic groups (White men in particular).

Doncaster is developing a suicide prevention strategy which follows national guidance which identifies groups clearly at risk and is reflective of this evidence in terms of its focus. (Public Health England, 2016b).

Depression and anxiety

Rees et al identify the following patterns (2016):

- A pattern was found among adults in the prevalence of Any Common Mental Disorder, with adults from some South Asian ethnic groups (Pakistani in particular) possibly having a relatively high prevalence when compared with adults from one or more other ethnic groups (White adults in particular);
- A pattern was seen among women in the prevalence of Mixed Anxiety and Depressive Disorder, with South Asian women (Pakistani women in particular)

possibly having a relatively high prevalence when compared with women from one or more other ethnic groups;

- A pattern was seen among women in the prevalence of Any Depressive Episode, with South Asian women (Indian and Pakistani women in particular) possibly having a relatively high prevalence when compared with women from one or more other ethnic groups (White women in particular);
- A pattern was seen among adults in the prevalence of Any Depressive Episode, with adults from some South Asian ethnic groups (Indian and Pakistani) having a relatively high prevalence when compared with one or more other ethnic groups (White adults in particular);

These patterns suggest the need to examine access to psychological therapies (Health and Social Care Information Centre, 2014) within Doncaster and we recommend that is undertaken as part of the JSNA work package.

Finally, through the NIHR knowledge mobilisation fellow⁴ we can have access to a case study on mobilising evidence on mental health and ethnicity which draw on the above sources (and others) and have an opportunity to learn from and apply this work in Doncaster and we recommend this course of action.

Evidence from the literature on housing

Nationally, Gulliver et al have undertaken a research project to examine progress over the last 40 years and conclude that progress has been made but that there is still much to be done. Specifically, Gulliver highlight that BME households are more likely to live in older, fuel poor and overcrowded housing and in flats, and terraced homes and be over concentrated in more deprived communities. Other findings included:

The level of housing deprivation is greater for the BME population. BME households account for more than 1 in 3 homeless acceptances by local authorities in England in contrast to their 1 in 7 presence in the general population.

Homelessness has grown proportionately more for BME groups over the last two decades from 17 to 37 per cent of the total. They are also more likely to be among the non-statutory and/or hidden homeless (2016).

Phase 1 of this HNA identified that some evidence that non-white groups in Doncaster continue to live in more overcrowded conditions. We did not specifically address this issue in the engagement phase of the needs assessment work and this is a gap, which we recognised during our stakeholder identification phase (described later). We recommend that this evidence be highlighted within current Health and Housing work and that Equality Impact Assessment is useful mechanism to facilitate this process (EEiC, 2016).

⁴ <http://www.ethnicitycommissioning.group.shef.ac.uk/index.php/blog/>

Evidence from then literature on harassment

We used an ESRC funded study which examines over time using a national survey the prevalence and persistence of ethnic and racial harassment and its impact on health (Nandi et al., 2015). Key findings included:

- Ethnic minorities are most likely to experience ethnic and racial harassment and anticipate it in streets, shops and public transport;
- Chinese men and women, Pakistani men, Indian-Sikh men, Indian-Muslim men and Bangladeshi women are more likely to report such experiences than others – around 15%;
- For most ethnic groups, twice as many people anticipate or fear harassment than actually experience it, with the exception of black Caribbean and black African groups;
- Women are more likely than men to feel unsafe and avoid places, but men are more likely to report actually experiencing ethnic and racial harassment;
- These patterns persist after account for contextual factors that vary across ethnic groups;
- The likelihood of experiencing ethnic and racial harassment is lower for those living with a higher proportion of their own ethnic group members after taking into account area level deprivation.

The NHS Workforce Race Equality Scheme (WRES) work (NHS Equality and Diversity Council, 2016) also examine these issues. Nandi et al work is in an early phase and will go on to examine the impact of harassment, identify risk and protective factors (2015). We recommend that the Health Inequalities Working Group keep up to date with this work and that that a representation from the Safer and Stronger Doncaster Partnership is sought for the Health Inequalities Working Group.

Implications of Phase 2

Phase 2 provided insights that we wanted to test in our engagement phase specifically around experiences of new arrivals and refugees. A key issue throughout this literature is also access to services and phase 3 needed to consider how to access insights or local voice on accessing health and social care services.

This phase also has limitations in that our approach to needs assessment has involved outputs from one phase guiding the steps in the next phase (and this has largely being a chronological process. However, it does mean that the literature was focussed on specific issues rather than summarising evidence on, for example, poorer outcomes for cardiovascular disease. This is obviously a gap but this can be addressed as part of the proposed JSNA work package around health outcomes and BME populations.

As a result of this phase we have also identified specific opportunities such as the chance to be part of work to develop online tools for GPs to support new migrants. We have also had the opportunity to take part in a regional practice sharing on meeting the physical activity needs of minority ethnic populations. Finally, we have the opportunity to work to mobilise knowledge on mental health and ethnicity using approaches developed during the NIHR Knowledge Mobilisation case study.

Phase 3: Engagement with local people and organisations

As stated earlier outputs from phases 1 and 2 informed our approach to engagement. In addition, in July 2016 we held an independently facilitated workshop and with a range of DMBC and NHS staff using the EEiC Stakeholder Identification and “In their shoes” tools.⁵ These activities helped us identify a broad range of stakeholders and together with earlier phases resulted in the approach outlined in Table 2. We were also concerned to test innovative engagement approaches so that lessons learned might inform wider engagement approaches.

Table 2: overview of our approach to engagement with local people and organisations

Stakeholder group	Identified via:	Summary of engagement approach
New arrivals	Phases 1 and 2	<p>Access organisations supporting these groups such as HARP, Doncaster Conversation Club and the Changing Lives Project</p> <p>Re-analyse of data collected as part of the HWBB refresh (4 focus groups – 2 BME from various background, 1 Polish participants, 1 gypsy and traveller community held at Changing Lives; 1 focus group Conversation club); documentary analysis</p>
Settled communities	Stakeholder identification exercises	Collection of ‘experience of using services’ stories via the Doncaster Healthwatch Feedback Centre
HWB member organisations	Stakeholder identification exercises	Development and administration of survey instrument on ‘common areas for attention’
Established groups	Stakeholder identification	We elected to focus on

⁵ <http://ethnicitycommissioning.group.shef.ac.uk/about.html>

exercises

groups supporting new
migrants (see below)

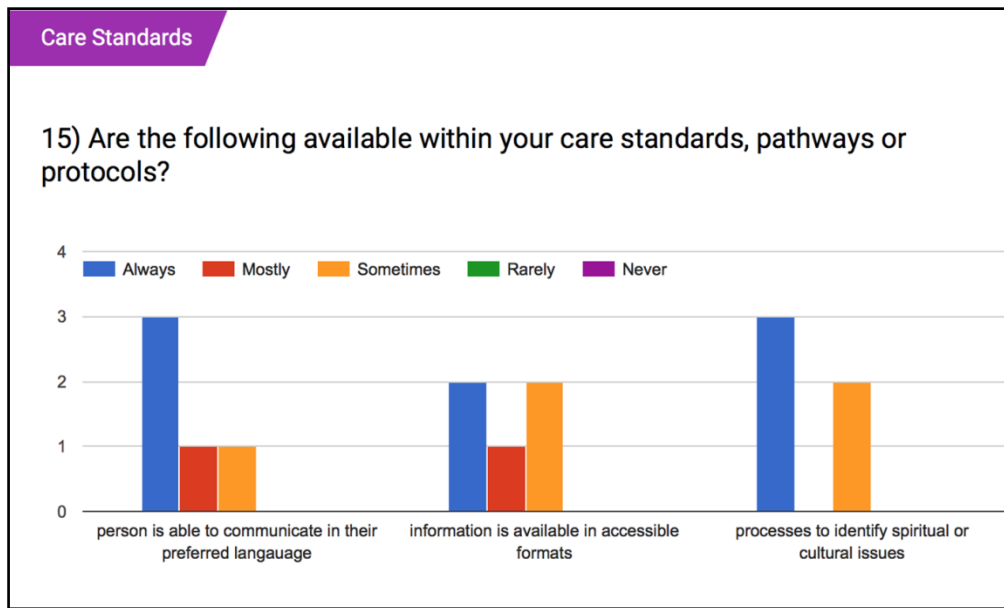
Partners

In terms of partners we designed and administered a survey on 'common issues' or areas for attention for improving services for multi-ethnic populations that had been identified by the EEiC project. This was administered to member organisations of the HWB (40% of which responded and key findings are outlined below.

- Respondents were asked whether they accessed national guidance or best practice on minority ethnic needs, over half stated that they did always or most of the time and produced list of sources they would consult.
- A third of respondents stated that they analysed complaints and compliments by ethnic group.
- Respondents were asked about activities to address minority ethnic needs such as outreach, awareness raising, monitoring referrals by ethnicity and monitoring DNA rates by ethnicity. The majority of respondents did not undertake this type of work.
- Half of all respondents stated that their organisation staff profile represented the ethnic profile of their local population. A third of respondents also said their staff undertook cultural competence training. In addition, we are aware that NHS partners have responded to other survey work on this issue. Indeed, the introduction of the Workforce Race Equality Standard (WRES), aims to prompt inquiry to better understand why it is that BME staff often receives much poorer treatment than White staff in the workplace and to facilitate the closing of those gaps (NHS Equality and Diversity Council, 2016).
- In terms of signage in relevant language few organisation always did this. However, local data suggests that we have relatively large percentage of residents who speak English at home (96%).
- None of the respondents stated that single sex accommodation; dietary and spiritual needs were rarely available.

Finally, organisations were asked about Care Standards and the figure 9 outlines responses.

Figure 9: responses to Care Standards question



This survey has produced some useful finding, although we recognise not all organisations were able to respond within the time frame. **Response to the local survey suggests that there is interest in understanding and addressing the areas of attention identified by the EEiC project. We recommend using these identified issues together with local analysis of the NHS organisation survey (NHS Equality and Diversity Council, 2016) and work with partners to develop an auditable local good practice statement.**

Engagement with local people

Previous direct engagement work had focussed on engaging with existing groups and so this time we aimed to engage with a wider population of people who perhaps did not attend groups. We were concerned to collect insight around the experience of new arrivals in Doncaster as well as insights from members of BME communities living in Doncaster to understand their experiences of accessing health and social care services. Access to services was identified as key issue in the literature (Allmark et al., 2010; IOM Migration Research Series, 2016; Such et al., 2016) and as part of the HWBB strategy refresh

Data collected via the Healthwatch Feedback Centre

During November 2016, we encouraged local people from BME background to access the Doncaster Healthwatch Feedback Centre to tell us about their experiences of accessing health and social care services. Participants wanting to give feedback in languages other than English are able to do so via the Feedback Centre. The participant is also able to select from a variety of services and give outline their experience as well as score their experience. The specific questions are outlined in the figure 10 below.

In terms of encouraging participation we used 4 routes:

1. Promotion of the activity using a leaflet and landing page via networks and using social media (details of the social media campaign can be found here <https://storify.com/Hampshaw/hwbbvoices>)
2. Staff from DMBC's Strategy and Performance Unit and Community team were given access to general practices located in areas with higher BME populations and supported local people to complete paper copies of the survey;
3. These staff also spent time in DMBC's One Stop Shop encouraging participation in the survey by people visiting this venue
4. Finally, volunteers from Doncaster Healthwatch visited the town centre to recruit participants to the survey.

Staff attended briefing sessions and received written guidance to support them in recruiting and we undertook an After Action Review⁶, which will be used to develop any further engagement work.

⁶ http://www.betterevaluation.org/en/evaluation-options/after_action_review

Figure 10 Healthwatch Feedback Centre

Leave feedback

How do you rate your overall experience of this service?*



Summary of your experience* (max 45 characters)

Give a brief description of your experience, or highlight a key observation

Tell us more about your experience*

Expand on your experience here. Why was your experience a good / bad one? List any reasons or specific detail that might help explain

Where do you live? (town/city)

Doncaster

Your ratings (select if applicable)

- Staff Attitude ☆☆☆☆☆ (
- Waiting time ☆☆☆☆☆ (
- Treatment explanation ☆☆☆☆☆ (
- Quality of care ☆☆☆☆☆ (
- Appointments ☆☆☆☆☆ (
- Interpreting services ☆☆☆☆☆ (
- Admission ☆☆☆☆☆ (
- Discharge ☆☆☆☆☆ (
- Prescriptions ☆☆☆☆☆ (
- Reception ☆☆☆☆☆ (

Findings

- During the data collection period (9th-18th November 2016) 153 feedback forms were received (either online or paper copies).
- All respondents were encouraged to define their ethnicity and religion. 38% of those who described their ethnic identity were from respondents with a BME background and these backgrounds were varied and reflective of BME people living in Doncaster.
- The largest groups of respondents defined themselves as Asian (34%) or Other white background (32%).
- The majority of comments (68%) were positive about the experience of using health care services in Doncaster and the following quotations are illustrative of this data:

‘Not any long waiting times and the doctors are nice there’ (Female, any other mixed, multiple ethnic background)

“All staff are excellent and I would not fault them” (Male, Chinese)

“Excellent doctors and communication here” (Male, any other Asian background)

“Appreciate the service’ ‘Frequently visit with mental health issues – very supportive” (female, Gypsy-Irish Traveller)

“Helpful and supportive”(Male, African)

- There were concerns about whether services were listening and the next quotations are illustrative of these concerns:

“Very long waiting times, feels like nobody cares there”(Male, Any other Black / African / Caribbean background)

“Don't feel like they always listen to me properly. So don't feel like I should come unless I need to.” (Female, White and Black Caribbean)

“Unable to get to the bottom of current health problems.” (Male, Pakistani)

Insight from groups supporting new arrivals

We gathered information on experience of arriving in Doncaster via three key sources:

- Insight from Doncaster Conversation Club using focus group data from the HWBB refresh and a documentary analysis of the Club’s newsletters⁷.

⁷ <http://www.doncasterccg.nhs.uk/2914/doncaster-conversation-club-newsletter/>

- Insight from attendees at the Doncaster Women’s Centre Changing Lives project using focus group data from the HWBB refresh and additional data requests facilitated by staff at the Women’s Centre.
- During the evidence safari we worked with Doncaster’s Health Access for Refugee Programme (HARP) and highlighted their work to support refugees to access health and social care services. We include two illustrative case studies below.

We have analysed this data to identify themes and these are outlined below together with illustrative quotations. We have also included poetry produced by members of the Conversation Club as these offer insight into arrival experiences and contribute to making the *invisible visible*.

In terms of evidence from the women we talked to we identified the following themes:

Knowledge about health issues and managing illness

- Generally, participants in all of the focus group were knowledgeable about key health messages. There was less certainty about how to navigate the health system, where to go to find out information and valued the Women’s Centre for information. Translation was also an issue with some participants identifying that translator add a layer of interpretation or opinion to the issue being discussed rather than using the actual words used by the women.
- When asked about feeling ill and how to manage these the women talked about the importance of simple remedies such as paracetamol and sleep. Women would also seek help from a GP; the gypsy and traveller group participants talked about seeking advice about GP attendance from within their community.
- In terms of caring for children, the women expressed the importance of seeking acting quickly if a child was unwell and used the term “*children are emergencies;*” some of the women said they would call an ambulance if their child was not well.

Access to services

- All but one of the women in the mixed groups were registered with a GP and said it was an easy process. However, the Polish group were not registered as they return home for their treatment. The gypsy and traveller group reported issues of accessing a GP whilst travelling in the UK and that some of the older members of the community were reluctant to travel because of this issue. In terms of dentistry, many of the group were not registered unsure of the process or in the case of the Polish group travelled home for dental treatment
- During the needs assessment we also collected stories from the women about navigating the system and this quotation illustrate issues identified:

“I have problems with housing my landlord does no repairs my home very dangerous to our health. Been refused Asylum 2, it is so very hard. My home is horrible but can’t

complain because they will say I am not grateful. I live in a shared house but people in there are not very nice. I stay in my room with my child or try to go out all the time which is hard as I have no money”

Preventative services

- Participants were asked about screening programmes and the majority had attended appointments for cervical smears and commented on the efficiency of the process. It was more difficult to discuss this issue with the gypsy and traveller group (see later).
- In terms of the child health programme, again the importance of protecting the young was a key theme and for most participants their children were up to date. The gypsy and traveller group participants expressed concerns about immunisation. There were also broader concerns about the HPV vaccine

Social isolation and loneliness

- The women talked about the value of socialisation, conversation and the information exchange role of the Women’s Centre and this following quotations collected during the needs assessment illustrated this:

“ I was very isolated with having limited English. I had no friends till I came to women centre and my husband is ok with it as there is no men” (A lady from Czech Republic)

“I feel very stressed I left my country not happy but I had to for danger not safe but now when I come to centre I feel less stressed with nice people around me and a good teacher that listens and helps me with my problems.” (A lady from Algeria)

“I like centre because when I lost my husband I had no family in England, so I have new friends and can talk to someone as I was very lonely. So it makes me forget my pain”. (A lady from Pakistan)

In terms of evidence from participants from the Conversation Club again the main theme was around accessing and navigating services to meet their perhaps complex needs:

- Participants explained that their issues are often complex and GPs and other services may not be able to respond. Adaption of primary care services to meet complex needs is an occurring theme (phase 2; Such et al., 2016).
- Participants also talked about knowing how to navigate the system and access services particularly for single people transitioning from M25 support and their own accommodation; concerns about homelessness (Gulliver, 2016). The issue of access to college courses including English was also raised.
- Participants also made suggestions to provide solutions to some of their concerns, for example the idea of a ‘welcome to Doncaster’ pack or ‘some of kind of induction for new arrivals.’ This idea was also suggested by participants at the *evidence safari*.

Finally, we include a poem written by a Conversation Club member:

Litany by Denise – Issue 22

To live my life
I risk my life.
To live my life
I leave life.
To live my life
I leave my love.
I am person
Full of love.
I am here
My loves are there.
There is love.
I am lie down.
They lie me down
Like animal. Rape.
Cold like robot.
No love.
Men bring me
Beat me.
Hot water burn me.
Scars.

No love touch.
No eating
No drink
No bed
No human
No love.
I am here now.
Safe?
But they are there
Still. Still
Far away love.
Here I dream fear
Here I remember,
Mind shackled
Alone, different.
No one love
Here safe
But emptiness
But missing
But longing
For love

In terms of evidence from HARP, national evaluation of the programme identifies that asylum seekers that asylum seekers and refugees are prone to poorer states of health arising from situations in their respective countries of origin, the conditions they experience in their journeys to the UK and their lack of understanding of how to access health care services once they reach the UK. The evidence also shows that access is not just a demand-side issue. On the supply-side health practitioners have a responsibility to consider their own practices and how they enable or disable access by asylum seekers and refugees. HARP sets out to address these issues by training migrant volunteers to both support newly arrived people and train health service staff to understand specific needs of arrivals.

HARP have provided evidence to support this needs assessment:

- Since June 2016, over 30 volunteers in Doncaster have been trained to work directly with newly arrived asylum seekers and refugees supporting them to access local health services in an appropriate way. All volunteers are asylum seekers and refugees themselves and on average each volunteer stays over four months volunteering with the HARP. Most HARP clients have difficulties in language and they rely on our volunteers to support them with interpreting and advocating on their behalf.
- HARP runs advice and advocacy sessions. Since June 2016 volunteers have assisted 315 unique service users during the 25 separate sessions. Out of this 74 clients are female and 241 male from 30 different countries including the Albania, Afghanistan, Iraq, Iran, Ethiopia, Eritrea, Sudan Somalia and Syria.
- Since June 2016, 67 newly dispersed asylum seekers have attended the NHS Access course which is held and delivered by HARP volunteers at the Refugee Council Office on the Bennethorpe Road, Doncaster.

The following two case studies illustrate the health access journeys:

The client was suffering from kidney failure and he was in pain for a period of three months. Due to language problem, he couldn't describe what he was suffering from and the interpreters were not able to give a full picture of his illness. Possibly due to different dialects.

He was referred to the HARP and was given one of the volunteers to mentor him and escort him to the hospital as his interpreter. It was at this time that the GP got a full picture and referred him to the hospital where he was diagnosed of an acute kidney failure. The doctors carried out an operation immediately because the left kidney was completely damaged.

(male, Eritrean Asylum Seeker)

The client received a penalty charge from the hospital due to an expired HC2* which was not renewed for over two months. The client got so confused that he did not eat for 2 days and did not know what the outcome would be. He said many thoughts surrounded his mind as he thought that they might arrest him because he didn't have the money being demanded and also thought that was going to affect his asylum case. He said, he cried and cried until '*a drop in day*'.

When he came to the drop he was in devastated state and never expected there was any solution. He was depressed and still sobbing. The NHS Prescription Exemption Checking (PEC) office was called and explained that he was an asylum seeker and his HC2 delayed, the fine was cancelled. Called the Support Team to follow up on the HC2 and was advised that it would be in within 5 days.

With these simple steps, [there was a visible] change in the client. He literally couldn't believe it and his countenance brightened up and he started chatting with other people. He enrolled to be one of the HARP volunteers and he is now one the most committed volunteer helping other asylum seekers to renew HC2 and cancelling PEC fines.

(Male, Sri-Lanka, Asylum Seeker) (* see

<http://www.nhsbsa.nhs.uk/HelpWithHealthCosts.aspx> for further details on processes around

Implications of Phase 3

These comments captured via the Healthwatch feedback, Conversation Club and Changing Lives project offer some insight into the experience of BME communities accessing health and social care. Our earlier stakeholder analysis identified the importance of seeking the experience of people who were not necessarily part of established community groups. We were also keen to collect stories that might reveal issues with accessing services.

The engagement approach has met these aims and produced evidence to inform the evidence safari. However, we are conscious that BME engagement within policy development needs to be strengthened and recommend work to develop evidence based approaches to engagement in a multi-ethnic population. The CoDE team used their analyses to support engagement and develop insight and we recommend that this forms part of a specific piece of BME engagement work utilising existing forums and networks.

Bringing it all together: an evidence safari to make the invisible visible

What is an evidence safari?

The evidence identified above was used within a December HWB workshop. We used an evidence safari approach a technique promoted and advocated within the national Open Policy Toolkit.⁸ This technique is particularly useful to explore need and therefore helpful in terms of examining BME health needs and supports our ambition of making the *invisible visible*.

The format⁹ of the event consisted of an opening video from CODE¹⁰ and an overview of the session. Participants worked in small groups and visited several evidence stations: an overview of the approach; who lives in Doncaster; local voices; what do we know about health needs & what works; migrant health (live workshop input from HARP project and Dr Victor Joseph.) At each station, participants were asked to read, discuss and write down their responses to the evidence. The whole group reconvened to identify gaps in the data or process, actions to support future stages and were able to prioritise the identified actions.



⁸ <https://www.gov.uk/guidance/open-policy-making-toolkit>

⁹ more detail can be found here <https://storify.com/Hampshaw/hwbbsafari>

¹⁰<https://www.youtube.com/watch?v=eVklWWrmB1Y&index=4&list=PLu4jsRxIimNGgH7nTgKRgXuGnCb6a7zvF>

Event summary and outcomes

44 people attended the event from a variety of organisations. Evaluation data is positive and included very helpful suggestions around the organisation of the evidence safari (in terms of the use of boards, number of stations, specific questions and widening attendance etc.) and these will be used to inform future work. Feedback also suggests that the use of an evidence safari is helpful in terms of our approach to tackling health inequalities as many participants felt the event had opened up their thinking and raised awareness. Overall, the event was well received. We have themed the actions below:

- Actions around building stronger engagement with BME communities and that this engagement needs to recognise the diversity within our BME population and that work should strengthen BME communities by seeking collaboration opportunities. Ideas for engagement included community development approaches; single gender groups; use of pharmacies
- Actions that ensure high quality and accessible interpretation and translation
- Actions to develop community understanding (seek opportunities to bring people together) challenge prejudice (from all sources offer training on cultural competence; unintended bias) and celebrate and value diversity
- Actions which focus on other determinants of health such as education (including education around navigating the system and induction for new arrivals and access to English courses)
- Actions which focus on more intelligence gathering from our BME populations
- Actions which focus on making sure the recommendations of the HNA are implemented (such as strong leadership, clear outcomes; reporting on protected characteristics)

This data together with all the evidence we have identified throughout this needs assessment report are to be tested via a Fairness and Inclusion Forum event at the end of April 2017.

Concluding remarks and recommendations

As stated earlier, this BME HNA sits within work to reduce health inequality within Doncaster and aimed make health inequity related to ethnicity more visible and develop actionable recommendations. These actionable recommendations have been described throughout this report and are repeated below.

However, it is clear that to implement these recommendations requires ownership, buy in, and on-going engagement and as a starting point these recommendations will be road-tested at a forthcoming Fairness and Inclusion event.

Recommendation 1 - assessing differences in access to and outcomes of health and social care services

Nationally, work is being undertaken to improve data monitoring on health inequalities which recognises the complexity of the issue and offers guidance on data collection beyond the legal requirements of the protected characteristics (NHS England, 2015). Locally, we know we have not yet been able to fully assess differences in access to and outcomes of health and social care services. This is a gap which we need to fill and this will form a work package for the Joint Strategic Needs Assessment (JSNA) which itself should not be considered to be a one off activity. Two key areas for the JSNA work package are outlined below:

- The work package should examine access to psychological therapies (Health and Social Care Information Centre, 2014) within Doncaster.
- Phase 1 of this HNA identified that some evidence that non-white groups in Doncaster continue to live in more overcrowded conditions. We did not specifically address this issue in the engagement phase of the needs assessment work and this is a gap, which we recognised during our stakeholder identification phase (described later). We recommend that this evidence be highlighted within current Health and Housing work and that Equality Impact Assessment is useful mechanism to facilitate this process (EEiC, 2016).

Recommendation 2 - accessing the evidence base

We have utilised an approach to evidence gathering that has taken advantage of networks, communities of practice and interest lists and the main steam media to scan for forthcoming and relevant research or publications. It is important to recognise that this evidence is not a systematic review and is instead a series of tailored forays into the literature. We have wherever possible utilised evidence that is in itself summary evidence of what is known rather than single studies. We recommend that this approach is systemised under the SPU work plan and acts as the means of horizon scanning for evidence to address inequalities for BME communities.

Recommendation 3 – developing the evidence base

During the course of the needs assessment process we have sought opportunities via networks to work for partners to develop the evidence base around what works to reduce inequity of outcomes. We have key opportunities to continue this work and these are outlined below:

- The team at Sheffield University has successfully applied to the Health Foundation to take part in the Evidence into Practice programme to develop 'online tools for GPs to help support new migrants in primary care. As a result of existing collaborations and relationships we are able to be part of this research project and can offer to work in partnership to co-develop these tools.
- Through the NIHR knowledge mobilisation fellow¹¹ we can have access to a case study on mobilising evidence on mental health and ethnicity which draw on the above sources (and others) and have an opportunity to learn from and apply this work in Doncaster and we recommend this course of action

In addition, the HWBB is sponsoring the Doncaster Research Festival in October 2017 and we recommend showcasing this work during the festival week.

Recommendation 4 - partnership working

Work by Nandi et al (2015) and NHS WRES work (NHS Equality and Diversity Council, 2016) examine the harmful impact of harassment and we recommend that that a representation from the Safer and Stronger Doncaster Partnership is sought for the HIWG. Work by the Gulliver (2016) highlights issues faced by BME communities in terms of housing and it is recommended that a representative from housing is sought for the HIWG.

Recommendation 5 - setting evidence based standards

Response to the local survey suggests that there is interest in understanding and addressing the areas of attention identified by the EEiC project. We recommend using these identified issues together with local analyse of the NHS organisation survey (NHS Equality and Diversity Council, 2016) and work with partners to develop an auditable local good practice statement.

Recommendation 6 – engagement approaches

Our earlier stakeholder analysis identified the importance of seeking the experience of people who were not necessarily part of established community groups. We were also keen to collect stories that might reveal issues with accessing services as this was theme identified in both the literature and earlier work to support the HWB strategy refresh. The engagement approach has met these aims and produced evidence to inform the evidence safari. This means we have used a very focussed (data driven approach to engagement) and recognise that this means we have not engaged with the breadth of minority ethnic populations in Doncaster.

¹¹ <http://www.ethnicitycommissioning.group.shef.ac.uk/index.php/blog/>

However, we are conscious that BME engagement within policy development needs to be strengthened and recommend work to develop evidence based approaches to engagement in a multi-ethnic population. The CoDE team used their analyses to support engagement and develop insight and we recommend that this data be used to form a specific piece of BME engagement work utilising existing forums and networks and that this should be part of the broader system engagement work.

Recommendations 7 – evidence safari actions

Several areas for action were identified and we recommend that these be tested via the Fairness Forum proposed event in April along side recommendation 1-6.

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Annexe 1: EEiC definition of terms



EEiC

Thinking Clearly

Understand: Thinking tools
July 2013

What is ethnicity?

A complex term with many meanings

Though the terms 'ethnicity' and 'ethnic group' are used frequently in Britain today, their meaning is not always clear. Indeed, 'ethnicity' can be used to mean a range of different things, and is measured in a variety of ways, making it a confusing and contentious concept.

A form of 'bio-social' identity

Ethnic identity draws on a range of social and biological characteristics often linked to notions of ancestry, heritage, culture and appearance – 'where you come from', 'what you believe', 'what you do' and 'what you look like'.

Flexible not fixed

Ethnic identities are not natural or fixed. The meaning and importance of ethnicity varies across space and time.

A product of social relations

Ethnic identities are a product of the societies in which we live. In each social context particular bio-social characteristics become important markers of individual and group identity. Societal structures and ideologies reinforce feelings of 'belonging to' and 'difference from' particular groups or communities. Ethnic identities are hierarchical and shape access to resources within society. Minority ethnic identities are commonly constructed as inferior and minority ethnic people may face significant discrimination and exclusion.

A proxy for factors affecting health

Because ethnicity is operationalised in society along the lines of physical features, ancestry, religion and so on, ethnicity can often be a useful proxy for factors that affect health including: access to health-promoting resources; exposure to health risks; and health-seeking behaviours.

Ethnic groups and categories

There is a popular misconception that groups categorised using ethnicity are homogenous with innate genetic differences or distinct cultures. In fact, there is much heterogeneity within ethnic groups. Nevertheless, such categories are not meaningless and can be useful when they identify groups of people who are at risk of particular disadvantage. The categories used by government agencies – such as the Census 2011 categories – undergo extensive testing for acceptability and relevance, and are revised over time to reflect changes in this fluid concept. Nevertheless, these categories will not always be useful and meaningful.

An important measure of need and access

Because social relations influence the provision of healthcare, and because biological and social characteristics influence health need, we often find significant inequalities between ethnic groups in health outcomes and healthcare access and experience. Ethnicity is therefore an important variable to consider in planning health and social care services.

Now see Thinking Clearly! What are the links between ethnicity and health?

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