Salford City Council

Black and Minority Ethnic Groups

Health Needs Assessment

2016

Dr Nicholas Riches

Specialist Trainee in Public Health

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1. EXECUTIVE SUMMARY

1.1. BME population data

Current BME demographics:

- There were 36,488 people in Salford from a BME background (15.6% of the total population) in 2011. This includes members of all groups except White British.
- The commonest ethic groups are Other White (which includes European migrants), Black African and White Irish.
- The wards with the highest proportion of BME communities are Broughton (33%), Ordsall (32%) and Irwell Riverside (29%). The Jewish community is centred on Kersal and Broughton.
- BME groups in Salford (apart from White Irish) have a younger age structure than the White British population.
- There are now 16,085 people in Salford who do not speak English as their main language, with over 70 languages being spoken in total.

Trends:

- Between 2001 and 2011:
    - Salford's BME population grew by 20,728 (132%) between 2001 and 2011 (compared to a 68% increase seen nationally)
    - The largest increases were seen in the Other White community increased by 7,002 (198%) and the Black African community which increased by 4,645 (655%)
    - There was a 48% increase in the Jewish population to 3.3% of the total Salford population, more than six times the national average.
- The proportion of the Salford population born outside the UK is increasing faster than the Greater Manchester average
- Based on projected population trends, by 2051 in Salford it is estimated that:
    - The BME population will have increased to approximately 90,000 people (31.7% of the total population)
    - There will be a particularly noticeable increase in the elderly BME population

1.2. National evidence review

Life expectancy: Men and women from the Other White ethnic group have the longest estimated life expectancy. Bangladeshi men and Pakistani women have the lowest estimated life expectancy

General health: White Irish and Gypsy Traveller communities report the poorest quality of health

Pregnancy: BME groups are at increased risk of severe complications in pregnancy and have higher neonatal and infant mortality rates in comparison to the White British population

Smoking: Rates are highest in White Irish populations and among Pakistani and Bangladeshi men

Alcohol: Rates of excess alcohol intake are lower in non-White groups

Exercise: Rates of physical inactivity are highest in Pakistani and Bangladeshi communities. BME groups are less likely to utilise outdoor green spaces.

Diet: BME populations typically have less fat and more fruit and vegetables in their diet compared to the national average

Obesity: Rates are highest in Pakistani and Black African women. Asian populations are likely to experience complications such as diabetes at lower BMI levels. Black children have higher levels of obesity in both Reception and Year 5.

Cardiovascular disease: Black populations have relatively high rates of stroke and hypertension but relatively low levels of coronary heart disease. South Asian populations are at increased risk of developing coronary heart disease.

Diabetes: Prevalence is highest among Asian and Black Caribbean groups.

Cancer: There is evidence that BME groups have reduced awareness of cancer symptoms and report facing barriers to accessing care. Overall, individuals from BME backgrounds (except Black men) appear to be at significantly reduced risk of all cancers compared to White populations, however compared to White populations:

- Asian women are at increased risk of mouth, liver cancer
- Asian men are at increased risk of liver cancer
- Black women are at increased risk of stomach, liver cancer and myeloma
- Black men are at increased risk of stomach, liver cancer, prostate and myeloma

STIs: Black and Mixed ethnic groups have higher than average rates of sexually transmitted infections.

HIV: 21% of new diagnoses are made in Black African people, most of which are late diagnoses. Heterosexual spread is most common and it is likely that most cases were acquired overseas.

TB: Rates are higher in all non-White groups and (among the UK-born population) are approximately ten times higher in Pakistani, Black African and Other Black communities in comparison with the White ethnic group.

FGM: It is estimated that there are 137,000 victims of female genital mutilation living in the UK, most of whom originate from Africa

Mental health: Schizophrenia rates are highest in Black Caribbean and White Irish populations. Suicide rates are highest among the White Irish community. Mental health problems are common in asylum seeker and Gypsy / Traveller communities.

Elderly care: Early-onset dementia is more common in BME groups. BME populations are also less likely to access palliative care.

1.3. Salford evidence review

General health: Only 60% of White Irish people in Salford report good or very good health and 39% report that their day-to-day activities are limited by illness. Gypsy / Traveller communities also report poor quality of health and functional ability.

Hospital admissions: Indian and Chinese communities are relatively less likely to use hospital services in Salford. People from Other White backgrounds appear more likely to attend A+E and White Irish people are more likely to be admitted to hospital

Smoking cessation: Smokers from Black African (men and women) and Asian (men) communities appear to be underrepresented with smoking cessation services.

STIs: Rates of STI diagnosis are relatively high among the Black and Mixed ethnic groups and relatively low in the White and Asian ethnic groups.

FGM: The estimated rate of FGM in Salford in 4.6 per 1,000 women. This equates to 535 female victims (including 50 girls aged 0-14). These rates are the second highest among Greater Manchester Local Authorities, after Manchester.

Asylum seekers: 161 asylum seekers registered with Salford GP practices in 2014-15, the majority of whom came from Sudan, Iran, Eritrea, Iraq and Syria. Primary care services for this group have recently been reorganised as part of the Salford Standard in order to better meet their needs.

Social determinants: BME groups in Salford experience above-average levels of deprivation including high rates of unemployment and overcrowding. Such factors are likely to partially explain inequalities in health.

1.4. Pathways to BME health inequalities in Salford

The 1974 Lalonde report [1] described four essential elements which determine health outcomes:

1. **Human biology**
2. **Lifestyle**
3. **Healthcare organisation**
4. **Environment**

Variations in each of these factors play a role in determining the ethnic inequalities in health described in this report. However, the contribution of each element will vary according to the health outcome being considered. Understanding the causal pathways to each specific inequality is critical to designing appropriate interventions to address them.

Human biology describes factors such as age and genetics. Applied to BME communities it is known that certain ethnic groups are predisposed to specific genetic conditions. For example, Sickle Cell disease is a genetic condition which is relatively more common among people from the Black ethnic group. As a genetic condition it is not possible to eliminate the inequality in disease prevention and

attention must focus on how to improve case finding, ensure adequate capacity within service and seek to mitigate any complications.

The prevalence of **lifestyle** factors which determine health can vary between ethnic groups. For example, rates of smoking are particularly high in Bangladeshi men while alcohol intake is relatively low in all BME groups besides the White Irish population. The increased prevalence of Coronary Heart Disease (CHD) in Asian populations is likely to result from a combination of both genetic and lifestyle (including diet and exercise) factors. Therefore a targeted health promotion approach looking to target these risk factors within the at-risk population has been suggested as part of a strategy to reduce CHD prevalence in this group.

Healthcare organisation describes aspects of the healthcare system which determine the health outcomes of individuals. This can include **preventative** services such as screening and immunisation which focus on the early diagnosis or prevention of disease or **treatment** services which meet the health needs of patients once they become ill. There is evidence that certain minority groups can face barriers to accessing healthcare services which may lead to delayed diagnosis or treatment for a range of conditions – and subsequently worse health outcomes.

Environmental factors describe aspects of the built and social environments which influence health outcomes. Increasing evidence suggests that the most significant factor in explaining inequalities in health is socioeconomic deprivation. BME groups are known to experience a greater level of material disadvantage compared to other groups. Given the clear links between deprivation and health it is likely that factors such as unemployment and poor housing are responsible for creating, maintaining and exacerbating illness among BME groups in Salford. Finally, an aspect of the social environment which is likely to compound the impact of socioeconomic deprivation is racism, and its impact on individuals. Research has suggested a link between all forms of racism (including interpersonal and institutional racism) and adverse physical and mental health outcomes.

Ultimately, the pathways to BME health inequalities are complex and best understood by the communities themselves. Ideally, interventions should be co-produced with community members and should consider how to address inequalities in the wider social determinants of health in addition to improving existing healthcare and Public Health interventions.

2. RECOMMENDATIONS

Actions to address the health needs of BME groups in Salford need to consider how they can address both existing health needs and future trends in the BME population. As the BME population increases it will require the capacity of all services (e.g. memory clinics, smoking cessation services) to be more responsive to the needs (e.g. interpretation services) and expectations of these groups. These trends may also require new services to be designed and delivered to better reflect the health needs of BME groups. For example, the large growth in the Black African population will require greater consideration to be given, for example, to support for FGM victims.

The success of any planned interventions within BME groups will depend on their acceptability and appropriateness to community members. This will require extensive and ongoing communication and collaboration with BME groups, which can be partly facilitated by the new CCG engagement worker. It is intended that this work will lead to the following recommendations being further developed in order to meet the needs of BME groups.

The recommendations themselves are grouped according to the elements of Lalonde's model. Human biology is not included since this is considered to be non-modifiable. Healthcare organisation is divided into aspects relevant to prevention and aspects relevant to treatment, to reflect the different organisations responsible for delivering these services. These recommendations have been constructed to take the form of general statements or questions to reflect the need to further develop them in collaboration with community members and other stakeholders. It is expected that this process will then lead to the selection of a number of specific objectives which can then be monitored as part of the ongoing work within Salford on BME health outcomes.

2.1. Lifestyle factors	
Smoking	• Develop interventions to increase the uptake of smoking cessation services among groups currently underrepresented within the service in Salford (Asian men and Black African men and women)
Alcohol	• Work to improve the provision of alcohol services for Eastern European populations. For example, through the employment of a Polish-language alcohol worker[1] (see section 2.6: 'Devo Manc.')
Physical activity	• Consider interventions to increase the uptake of physical activity in groups currently reporting high levels of physical inactivity (including Pakistani and Bangladeshi communities)
Sexual health	• Consider targeted health promotion work in groups reporting relatively high rates of STIs in Salford (Table 41)

[1] According to the 2011 Census Polish is the most widely-spoken Eastern European language in Salford (3,526 native speakers), followed by Slovak (359 native speakers)

2.2. Healthcare organisation (prevention)	
Health promotion	• When designing health promotion strategies for different neighbourhoods in Salford, consider the composition of the area in terms of BME groups (Appendix 2) in addition to the health problems known to be specific to different ethnic groups (Appendix 3). • Health promotion interventions for BME groups should include a focus (appropriately targeted) on cardiovascular disease, diabetes, renal disease, cancer prevention, smoking, alcohol and sexual health. • Await the results of the Unique Improvement study investigating barriers to the uptake of Health Checks among BME communities
Children's services	• Ensure mechanisms are in place to ensure that the children of newly-dispersed asylum seekers receive timely input regarding their health (e.g. vaccination status) and social care (e.g. education) • Work with the Jewish communities to review how best to integrate school-based interventions within independent Jewish schools • Work with Gypsy / Roma Traveller community to understand issues of access and uptake of routine child health services (e.g. vaccination, health visitors)
Cardiovascular disease	• Ensure health promotion interventions focusing on cardiovascular disease reflect the varying prevalence of disease according to ethnicity – for example, relatively high rates of coronary heart disease in South Asian populations and relatively high rates of stroke in Black populations
Sexual health	• Support work within the Black African community to reduce stigma around HIV and encourage testing. • Work with communities to ensure that the HIV point-of-care intervention is appropriate and accessible to these populations.
Cancer	• Ensure that details of screening are available in a range of languages. • Work with community groups to raise awareness of cancer symptoms and routes to access appropriate care. • Consider more targeted health promotion interventions based on evidence of ethnic variations in cancer prevalence. For example, highlighting the symptoms of prostate cancer and myeloma among those of Black ethnicity using appropriate resources (e.g. Prostate Cancer UK has resources specifically targeted at the Black community)

Mental health	• Consider interventions focused on reducing stigma around mental health among groups thought to have relatively high prevalence (e.g. White Irish, Gypsy / Traveller and Black Caribbean) such as mental health champions or peer support networks
Asylum seekers	• Consider whether a dedicated asylum seeker liaison worker could act as a point of contact and improve the co-ordination of health and social care services for this group.
FGM	• Support third sector organisations already engaged with this issue to design and deliver training to community members aiming to modify social norms regarding FGM.

2.3. Healthcare organisation (treatment)	
Access to healthcare	• Engage with all BME groups to identify perceived barriers to accessing primary care services. • Work with refugee and asylum seeker groups to ensure that they are not facing problems with GP registration. • Work with Eastern European populations to understand and address the apparent preference for A+E services over GP services.
FGM	• Review funding and capacity of existing adult psychological support services for adults in Salford and ensure they have capacity to meet growing the population of FGM victims. • Continue work at a GM level on developing psychological services for child victims and to ensure pathways for acute referrals have sufficient capacity. • Consider asking health visitors to routinely enquire about FGM to improve detection rates[2]. Training resources for GPs and practice nurses need to continue to be developed. • Review the capacity of Gynaecology services in Salford to offer FGM correction procedures where indicated(e.g. deinfibulation)
TB	• Educate GP practices regarding TB screening in primary care. • Review attainment of linked Salford Standard outcome 6.5. Compare data on country of origin of new GP registrations with TB screening rates to ensure this need is being met.

[2] The Institute of Health Visitors has resources on FGM: http://ihv.org.uk/for-health-visitors/resources/minority-groups/

Asylum seekers	• Monitor the number of asylum seekers being managed according Salford Standard outcomes 5.5. Compare this with the Home Office figures and numbers of asylum seekers coded in medical records to ensure that the new service is meeting demand. • Consider arranging GP training on the asylum process, targeting the practices which are registering most asylum seekers. • Consider developing resources to help non-specialist GPs perform initial health assessments with asylum seekers (including consideration of FGM). • Ensure that pregnant asylum seekers dispersed to Salford are able to rapidly access appropriate antenatal care.
Mental health	• Work with all BME groups to identify barriers to reporting mental health problems and educate community members of the types of help available, particularly in high-risk groups (e.g. Black Caribbean, Gypsy / Traveller, White Irish). • Continue to develop culturally-sensitive psychological services which are accessible in a range of languages to reflect the increasing diversity in Salford. Ensure that the Tier 2 mental health service is widely advertised in relevant settings (e.g. A+E department and GP practices). Work with service providers to improve coding of ethnicity to allow any ethnic inequalities in access and treatment to be identified.
Dementia	• Work with all BME groups to understand reasons for delayed presentations with memory problems. Provide education on the type of help available and how to access it in a range of settings and languages • Work to ensure relevant services (including the memory clinic) have the capacity and expertise to accommodate increasing numbers of people from the BME community (some of whom may speak English as a second language).
Palliative care	• Work with all BME groups to identify preferences in relation to palliative care and any barriers to accessing this (including hospice services). Provide education on support available and involve faith leaders in tailoring existing services to meet the specific needs of faith communities. • Consider working with community groups to develop training in cultural issues relevant to end-of-life care for different ethnic groups. Deliver this to healthcare workers involved in delivering palliative care.

2.4. Environmental factors	
Social determinants	• Ongoing work is required within Council departments (e.g. housing, education) to consider the impact of their work on BME groups – and the explicit connection with improved health outcomes. • Data collection practices need to be reviewed to ensure that they capture ethnicity data where appropriate, in order to better understand the links between ethnicity, deprivation and health in Salford.
Green spaces	• Consider researching the levels of participation in green space activity among BME groups. If low, considered targeted intervention to improve participation

2.5. Research and surveillance	
FGM	• The number of incident cases being reported needs to be monitored. • Qualitative research within the relevant communities could be conducted to explore knowledge and beliefs in relation to FGM
Health data	• Consider making an application to the Salford Integrated Record system to further interrogate any available health data with sufficient coding of ethnicity. Now that hospital data is being recorded more consistently it should be possible to evaluate a range of BME health experiences and outcomes, for example: o memory clinical access o cancer referrals) o child mortality data • At a national level, data on lifestyle risk factors according to ethnicity needs to be updated since most quoted evidence derives from the 2004 Health Survey for England • Work with Greater Manchester West (GMW) to identify the uptake of secondary care psychiatry interventions according to ethnic group • Ensure that this needs assessment is subject to periodic review and updating (according to a schedule to be agreed by the JSNA executive committee)
Population projections	• Update the ethnicity population projections for Salford following publication of the updated ETHPOP dataset in 2016[3]. Update all demographic data following the 2021 Census.
Screening	• Work is required to review paper records of coded ethnicity data (where available) to identify current uptake of cancer screening programmes within BME groups
Vaccination	• Further research is needed into the current uptake of routine childhood vaccinations among all ethnic groups in Salford, including the Orthodox Jewish and Gypsy / Traveller communities

[3] https://www.ethpop.org

2.6. Cross-cutting themes	
Coding	• Move to routine electronic coding of ethnicity across health and social care services, including screening services and in primary care.
BME user group	• Consider establishing a BME user group which is representative of the different ethnic groups and religious groups in the city. This group would make it easier to involve the BME community in the design and implementation of services.
Community consultation	• Identify the priority health issues for those groups with the worst health outcomes (e.g. Gypsy / Traveller, White Irish, Bangladeshi and Pakistani). Focus on the areas with the greatest proportions of these communities (Appendix 1). • Consider developing an accessible web-based resource of BME community assets in Salford (regularly updated) which can act as a gateway for BME members seeking support • Consider identifying and training community champions for health among different BME groups, a method used elsewhere[4]
'Devo Manc.'	• Consider working at a Greater Manchester level to develop new models of care to address the health needs of certain populations (e.g. White European, asylum seekers) which are dispersed across the region. Operating at scale may make it financially viable to; for example, employ a Polish-language alcohol worker to work across Local Authorities.
Language	• Ensure that GP practices in areas of high BME prevalence (Appendix 2) have patient information leaflets in a variety of languages. • Encourage Council and NHS services to use face-to-face interpreters wherever practical. • As the proportion of services being delivered or signposted to electronically increases consider how to improve the access to such resources among those who do not speak English

[4] One example comes from the Marmot report where taxi drivers of South Asian descent in Sheffield were trained up to act as health champions within their community

3. BACKGROUND

3.1. Introduction

In 2016 Salford City Council published an Equal Opportunities Policy. This states that everyone in Salford, regardless of gender, age, ethnicity or sexuality should:

- be treated fairly and with dignity and respect
- have equal access to opportunities
- feel included and part of their community

The legal context for this Policy includes the Equality Act 2010 which protects individuals from discrimination, including in relation to certain protected characteristics (Table 1):

Table 1: Protected characteristics
Age
Disability
Gender reassignment
Marriage and civil partnership
Pregnancy and maternity
Race, including ethnic or national origins, colour or nationality
Religion and belief, including lack of belief
Sex or gender
Sexual orientation or identity
Source: Equality Act 2010 [2]

Linked to this Act is the Public Sector Equality Duty 2011 which requires public bodies to have 'due regard' to the need to:

- "Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not."

Quoted from: EHRC [3]

It is acknowledged that these protected characteristics are not mutually exclusive and that an individual may identify with more than one. This highlights the importance of considering the combined impact of all these characteristics when exploring the health status of BME communities.

3.2. Definitions

3.2.1. Ethnicity

For the purposes of this needs assessment, the term Black and Minority Ethnic (BME) groups refers to all ethnic groups except White British. This therefore includes groups such as White Irish, Gypsy, Irish Traveller and Other White (including White European), in addition to all non-White groups.

The ethnic group categories from the 2011 National Census are used to classify populations where possible. These classify ethnicity into 5 Major and 18 Minor groups (Table 2). These terms are used throughout the report to refer to different ethnic groups. Depending on the level of detail this may require using a Major ethnic group term (e.g. White, Black or Asian) or a Minor ethnic group term (e.g. White Irish, Pakistani or Black African).

The identity of an individual is determined by many factors other than ethnicity and ethnic group categories themselves may be misleading (e.g. someone in the 'Black African' group may be UK-born). However, for clarity and consistency the report will use these official categories to describe ethnicity.

Table 2: National Census ethnic categories

MAJOR GROUP	MINOR GROUP
WHITE	British
	Irish
	Gypsy or Irish traveller
	Any other White background
ASIAN	Indian
	Pakistani
	Bangladeshi
	Chinese
	Any other Asian background
BLACK	African
	Caribbean
	Any other Black background
MIXED	White / Black Caribbean
	White / Black African
	White / Asian
	Any other Mixed background
OTHER	Arab
	Any other ethnic group

Source: ONS [4]

There is still inadequate coding of ethnicity in many routine datasets including primary care data and death registration. Historically the datasets with best monitoring of ethnicity were those relating to HIV/AIDS and the School Census [5]. Until recently, information on hospital admissions (Hospital Episode Statistics) had limited coding of ethnicity but this is now improving in Salford.

In addition to these ethnic groups, this report will also consider the health needs of Refugees and Asylum Seekers and of the Orthodox Jewish population in Salford, neither of which group fits into the Census classification system. The Refugee community consists of people from a variety of countries and ethnicities but who have several specific health and social care needs. Orthodox Judaism is a religion rather than an ethnic group and its members come from a variety of ethnic backgrounds. However, members of the Orthodox Jewish community in Salford have many shared cultures and practices and also experience some unique health and social care needs and therefore will be considered as a minority group for the purposes of this report.

3.2.2. Health needs

For the purposes of this needs assessment, health is conceptualised in its broadest sense, as defined by the World Health Organisation in 1948:

> *"a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity"* **Quoted from WHO** [6]

This definition acknowledges the range of factors which determine health and wellbeing, including mental health and social circumstances. The scope of the review is limited in part by the quality and quantity of data available. This has dictated that most of the evidence presented relates to physical health and its direct determinants. There is little reliable evidence available on mental health issues according to ethnicity, which prevents direct comparison of outcomes by ethnic group. Ethnicity coding of data on social determinants of health is also generally inadequate and therefore these factors are not considered in detail.

3.3. Aim and objectives

The aim of this Health Needs Assessment is to systematically review current health needs within Salford BME populations and to evaluate how well existing services are addressing these.

In order to achieve this, the report has the following objectives:

1. Analyse the current characteristics of BME groups in Salford, including age and geographical distribution
2. Describe recent time trends in the BME population in Salford
3. Review national evidence on health needs within BME groups
4. Analyse data on the current health needs of BME groups in Salford
5. Identify the priority health issues for BME community groups in Salford
6. Make recommendations which can be generalised across Salford but also made specific to BME populations within individual neighbourhoods

It is intended that this document will be a practical resource for a range of individuals and organisations in Salford. There is additional information in the Appendices which are designed as a reference source for those who are designing and delivering services for BME groups in communities across Salford:

- **Appendix 1** illustrates the relative population density of 13 different ethnic groups across each of the 20 Salford City Council wards. This will provide valuable information to groups looking to develop interventions targeting specific BME groups.
- **Appendix 2** provides a detailed breakdown of the BME population for each Council ward which will help those looking to develop interventions at a neighbourhood level which are sensitive to the needs of local BME populations.
- **Appendix 3** gives a comprehensive list of health problems which are specific to one or more BME groups

3.4. Methodology

This report represents the first stage in a process of identifying and addressing ethnic inequalities in health in Salford. Data on BME health outcomes was compiled from a number of national and regional sources. This data was analysed and used to draw conclusions relevant to BME health in Salford, broken down to ward-level where possible.

In order to review the national evidence on health in BME groups, a literature review was undertaken. This involved reviewing a number of guidelines, primary research studies and review articles. Due to the broad scope of the review it was not possible to define specific terms for a structured review. On the basis of prior work, a number of key review documents regarding the health of BME groups were highlighted. These were reviewed, in addition to relevant references and other studies which emerged during the process of writing the assessment.

Consulting community groups was challenging since there is currently no umbrella organisation for BME groups in Salford. Instead there are a large number of individual organisations, each representing different communities. It was outwith the scope of this report to establish a BME user group and so it was agreed to conduct a limited consultation with key community stakeholders with a focus on communities (e.g. Eastern European, Refugee and Jewish communities) not well described by other forms of evidence which focus on the conventional ethnic groups listed in Table 2. These stakeholders were interviewed in various locations using a semi-structured interview method with descriptive analysis based on contemporaneous notes.

4. DEMOGRAPHIC INFORMATION

4.1. National Census 2011

The National Census gives the most accurate account of the size and distribution of different ethnic groups. The most recent data comes from the 2011 Census, since the ONS mid-year population projections do not include ethnicity data.

According to the 2011 Census the population of Salford is 233,933, with a total BME population of 36,488. Table 3 shows the population of each major and minor ethnic group in Salford. The commonest major ethnic group is White, accounting for 90.1% of Salford residents. This is followed by Asian (4.0%), Black (2.8%) and Mixed (2.0%).

The commonest White group is White British (84.4% of Salford total). There are 2,882 White Irish residents (1.2%) and 193 from a Gypsy / traveller background. Compared with the average North West population the relative size of the White British population is slightly smaller, while the White Irish and Other White groups are larger.

The commonest Asian ethnic groups in Salford are Indian (1.1%) and Chinese (1.1%), followed by Pakistani (0.8%), Other Asian (0.8%) and Bangladeshi (0.3). Overall the Asian ethnic group is smaller than national and North West populations, with the relative size of the Pakistani community being noticeably smaller.

The Black major ethnic group is more than twice the size of the North West average. This is primarily due to the size of the Black African population (2.3%) which is also bigger than the average for England (1.8%). The Black Caribbean community in Salford (0.3%) is of a similar size to the North West average. The relative size of the Mixed major ethnic group is similar to the North West and English populations, besides a noticeably larger White/Black African group.

The Arab ethnic group was added for the 2011 Census which showed that it is the 10th largest ethnic group in Salford. In 2011 there were 1,425 people in the Arab ethnic group accounting for 0.5% of the Salford population which is higher than the North West average.

Table 3: Population size by ethnic group

ETHNIC GROUP		SALFORD POPULATION	PROPORTION OF POPULATION		
Major	Minor		Salford	North West	England
WHITE	British	197,445	**84.4%**	87.1%	79.8%
	Irish	2,882	**1.2%**	0.9%	1.0%
	Gypsy / traveller	193	**0.1%**	0.1%	0.1%
	Other	10,342	**4.4%**	2.1%	4.6%
	TOTAL	210,862	**90.1%**	90.2%	85.5%
ASIAN	Indian	2,553	**1.1%**	1.5%	2.6%
	Pakistani	1,843	**0.8%**	2.7%	2.1%
	Bangladeshi	605	**0.3%**	0.7%	0.8%
	Chinese	2,547	**1.1%**	0.7%	0.7%
	Other Asian	1,881	**0.8%**	0.7%	1.5%
	TOTAL	9,429	**4.0%**	6.3%	7.7%
BLACK	African	5,354	**2.3%**	0.8%	1.8%
	Caribbean	666	**0.3%**	0.3%	1.1%
	Other Black	521	**0.2%**	0.2%	0.5%
	TOTAL	6,541	**2.8%**	1.3%	3.4%
MIXED	White / Black Caribbean	1,647	**0.7%**	0.6%	0.8%
	White / Black African	1,058	**0.5%**	0.3%	0.3%
	White / Asian	929	**0.4%**	0.4%	0.6%
	Other Mixed	982	**0.4%**	0.3%	0.5%
	TOTAL	4616	**2.0%**	1.6%	1.9%
Arab		1,425	**0.6%**	0.3%	0.4%
Other ethnic group		1,060	**0.5%**	0.3%	0.6
Total population		233,933			

Source: Nomis – 2011 Census [7]

Age distribution

Figure 1 shows that, compared with the total White population, non-White groups are significantly younger with greater proportions in both the 0 to 15 and 16 to 49 age bands. The groups with the highest proportion of people aged 0 to 15 are Mixed (42.2%) and Black (26.6%).

In the 16 to 49 age band, the groups with the relatively largest proportions are Other White (71.8%), which includes European migrants, Asian (67.6%) and Black (66.8%). In the older age range, the White Irish group is the only group in which a majority of the population is aged 50 and over (63.8%), similar to the pattern for this group at a national level [5].

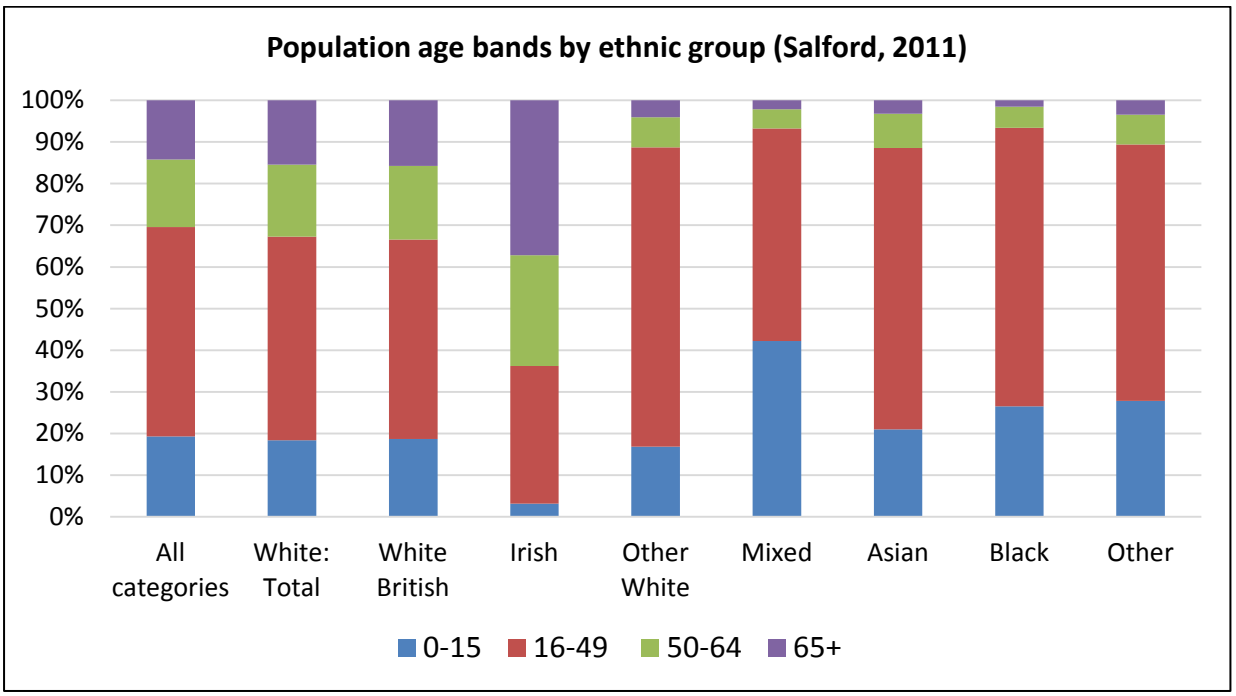


Figure 1: Population age bands by ethnic group
Source: Nomis – 2011 Census [7]

Figure 2 illustrates the changing population structures in Salford. Based on 2011 Census data, the proportion of 0 to 4 year-olds from non-White ethnic groups is now 17.3%. This proportion progressively falls in older age bands to an average of 9.9% in adults aged 18 and over. This trend is likely to lead to a sustained increase in Salford's BME population in future years.

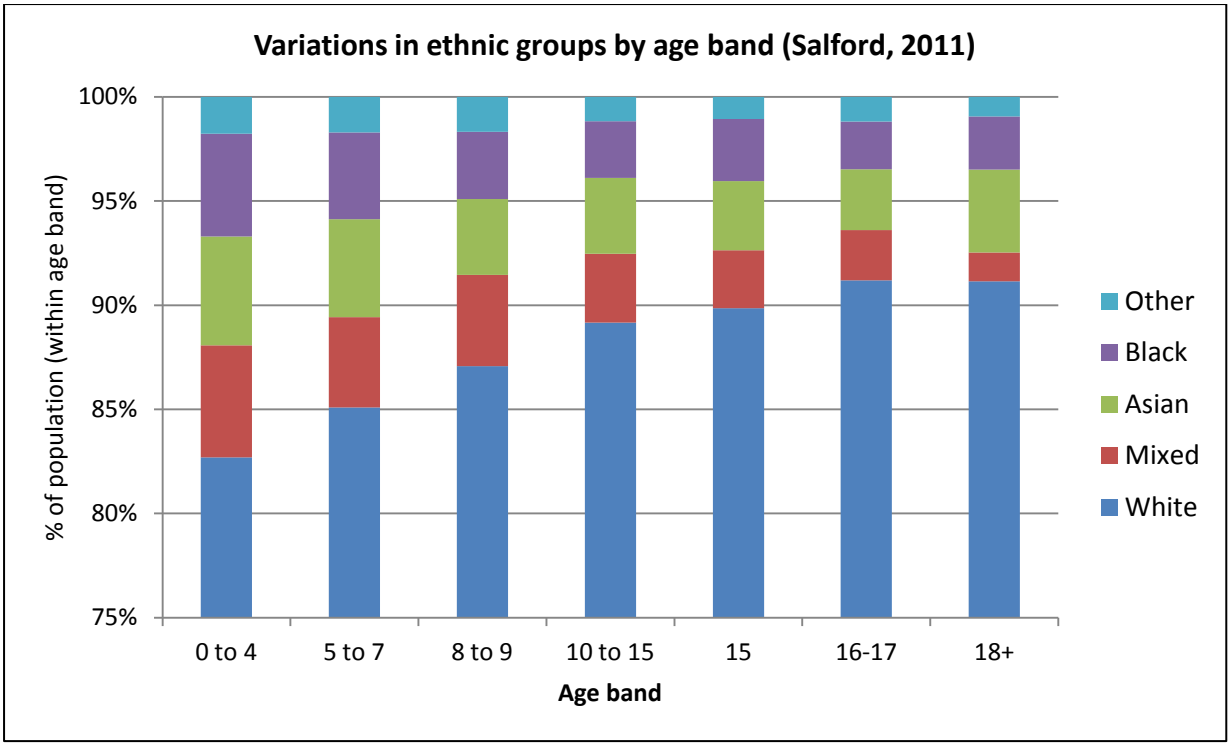


Figure 2: Variations in ethnic group structure according to age band, 2011
Source: Nomis – 2011 Census [7]

The proportion of children in relation to the total population of each ethnic group in Salford is shown in Figure 3. Groups with relatively large populations of children are Black Other (44%), Mixed (42%) and Arab (31%). The populations with the lowest proportion of children are White Irish (3%), Black Caribbean (12%) and Chinese (15%).

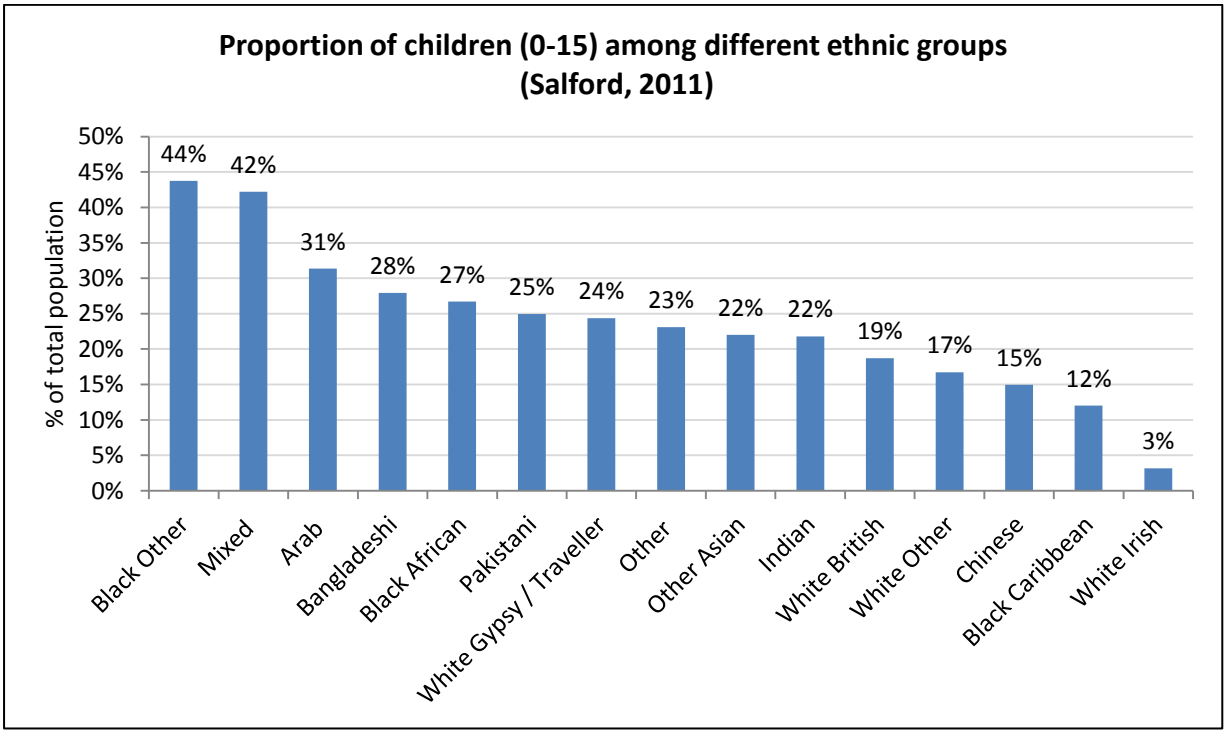


Figure 3: Proportion of children (0-15) among different ethnic groups in Salford
Source: Nomis – 2011 Census [7]

Place of birth

There is not a consistent relationship between ethnicity and place of birth. This is illustrated in Table 4 which shows the proportion of people in each ethnic group who were born in the UK. This is predictably highest for White British (98.5%) but is also high for Mixed (79.7%), Gypsy / Irish Traveller (75.1%) and Black Caribbean ethnic groups (70.0%).The UK-born proportion is lowest among Other White (14.7%), Other Asian (19.4%) and Black African communities (21.5%).

Table 4: Proportion of ethnic groups in Salford born in the UK

Ethnic group	% born in UK
White British	98.5%
Mixed	79.7%
Gypsy or Irish Traveller	75.1%
Caribbean	70.0%
Other Black	57.0%
Bangladeshi	51.1%
Pakistani	46.8%
Indian	38.9%
Any other ethnic group	35.9%
Irish	28.1%
Chinese	27.3%
Arab	26.3%
African	21.5%
Other Asian	19.4%
Other White	14.7%

Source: Nomis – 2011 Census [7]

Table 5 provides more information on the birthplace of members of the 'Other White' ethnic group in Salford. It shows that the majority of this group were born in the Eastern European accession countries which became EU members between 2001 and 2011. This is followed by smaller proportions from previous EU member countries (15.6%) and the UK.

Table 5: Birthplace of 'Other White' ethnic group in Salford

Place of birth	Number	%
EU Accession countries (April 2001 to March 2011)	5,309	51.3%
EU Member countries in March 2001	1,608	15.6%
UK	1,516	14.7%
Rest of Europe	536	5.2%
Middle East	307	3.0%
North America and the Caribbean	293	2.8%
Central and South America	235	2.3%
South and Eastern Africa	182	1.8%
Oceania	146	1.4%
North Africa	50	0.5%
Ireland	44	0.4%
Central and Western Africa	41	0.4%
Southern Asia	27	0.3%
South-East Asia	22	0.2%
Eastern Asia	18	0.2%
Central Asia	8	0.1%

Source: Nomis – 2011 Census [7]

Geographical distribution

The distribution of BME groups varies across Salford. According to 2011 Census data, the wards with the highest proportion of people from a BME group are Broughton (33%), followed by Ordsall (31.8%) and Irwell Riverside (29.2%). The wards with the lowest proportions are Walkden South (6.2%), Irlam (7.0%) and Worsley (7.2%).

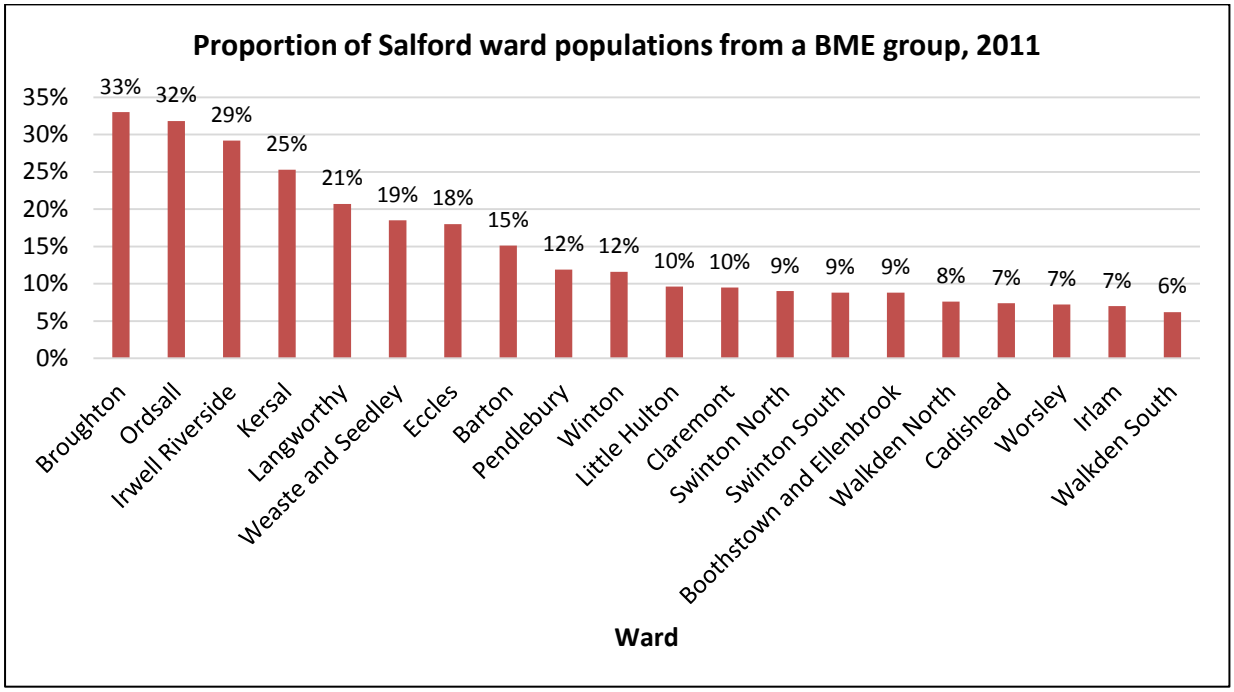


Figure 4: Proportion of population from BME groups in Salford wards
Source: Nomis – 2011 Census

Appendix 1 has a series of charts which describe the relative population density of each ethnic group across Salford wards. Table 6 summarises this information by listing, for each ethnic group, the three Council wards with the highest proportion of the relevant group. The rest of this section will then give a more detailed description of each ethnic group in Salford.

Table 6: List of Salford wards with the highest prevalence of each ethnic group

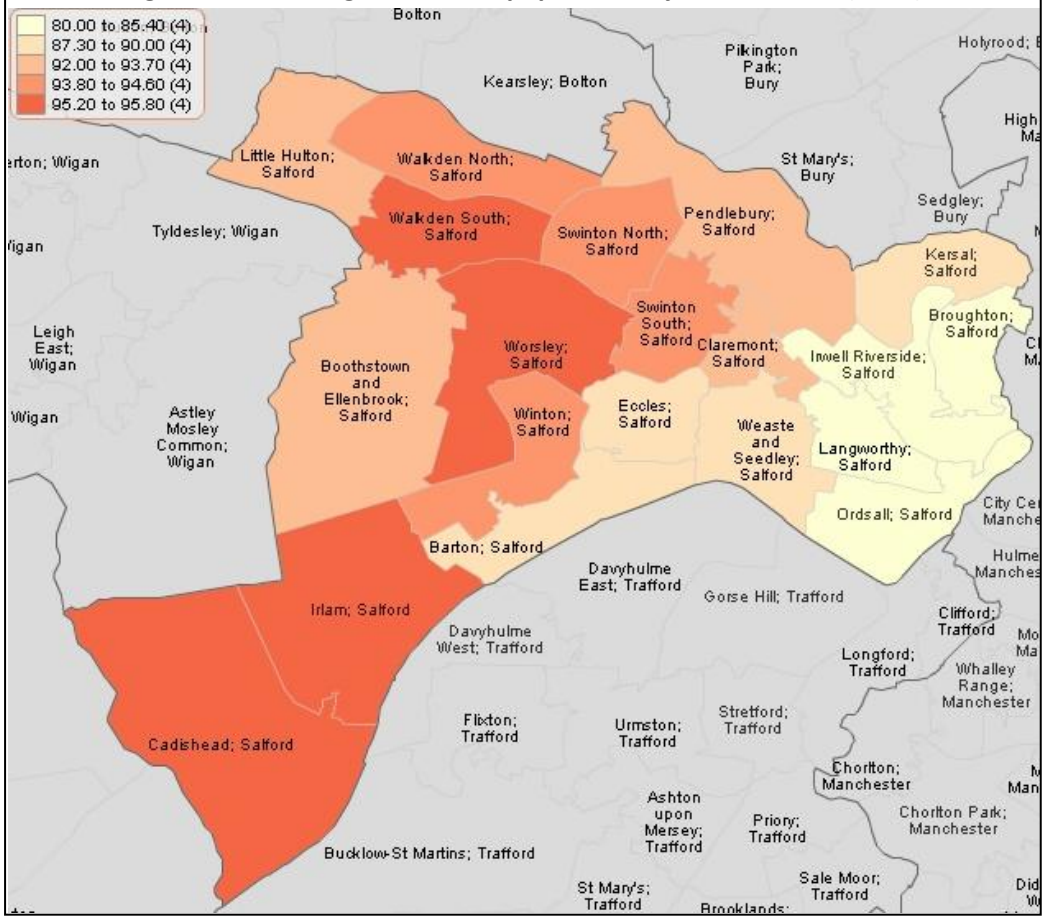
ETHNIC GROUP	RANKING ACCORDING TO RELATIVE SIZE OF POPULATION (1=LARGEST)		
	1st	2nd	3rd
White British	Walkden South	Irlam	Worsley
White Irish	Broughton	Eccles	Irwell Riverside
Gypsy / Traveller	Irwell Riverside	Broughton	Pendlebury
Other White	Kersal	Broughton	Ordsall
Mixed	Broughton	Irwell Riverside	Ordsall
Indian	Ordsall	Boothstown / Ellenbrook	Weaste / Seedley
Pakistani	Broughton	Ordsall	Eccles
Bangladeshi	Eccles	Barton	Swinton North
Chinese	Ordsall	Irwell Riverside	Langworthy
Black African	Broughton	Irwell Riverside	Langworthy
Black Caribbean	Ordsall	Broughton	Irwell Riverside
Arab	Eccles	Ordsall	Barton

Source: Nomis – 2011 Census [7]

White Ethnic Groups

The wards with the largest White populations (including non-White British) are Walkden South (95.8%), Irlam (95.8%) and Worsley (95.4%), while the smallest populations are in Broughton (80.0%), Ordsall (80.2%) and Irwell Riverside (81.7%) [Figure 5]

Figure 5: Percentage of 'White' population by Salford ward (2011)



Source: PHE Local Health [8]

Figure 6 illustrates the population pyramid for White British people in Salford. Compared to other BME groups, this shows that the White British population in Salford includes a greater proportion of elderly people, particularly women.

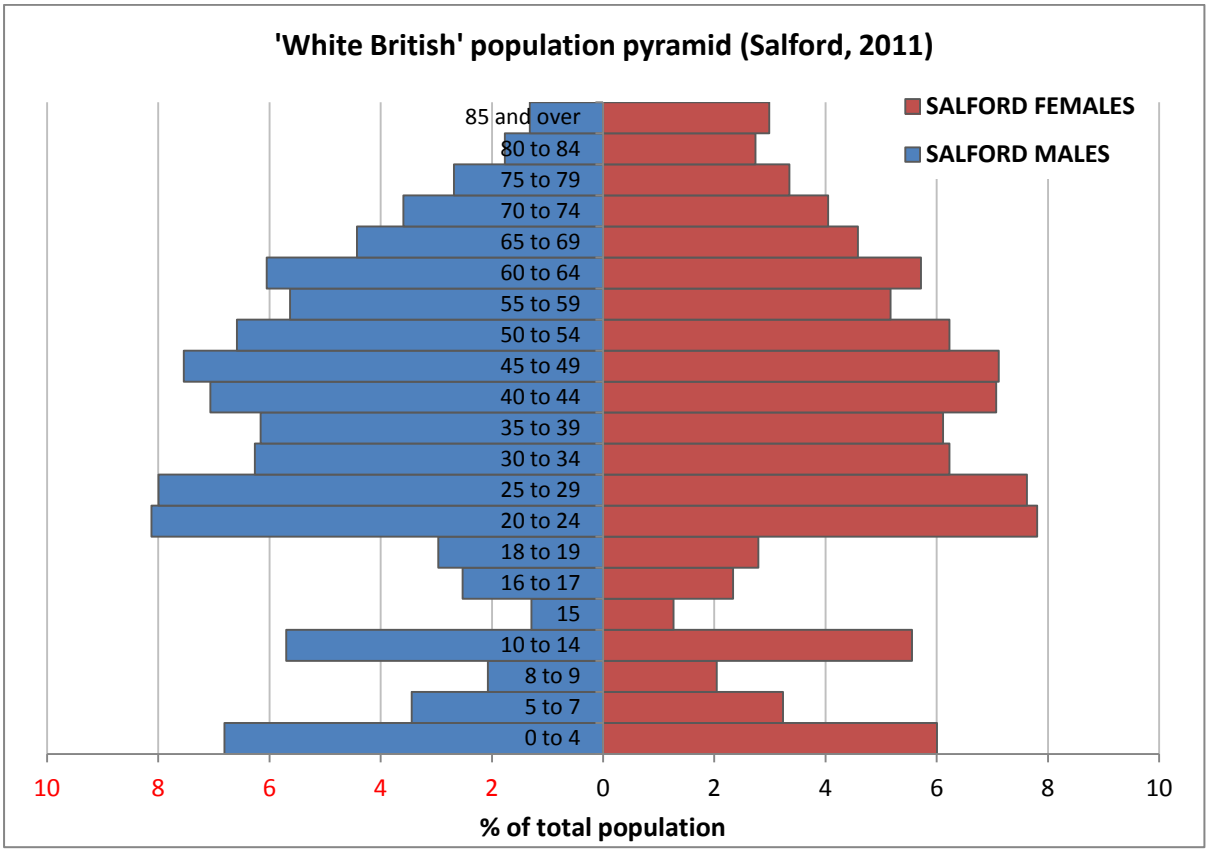
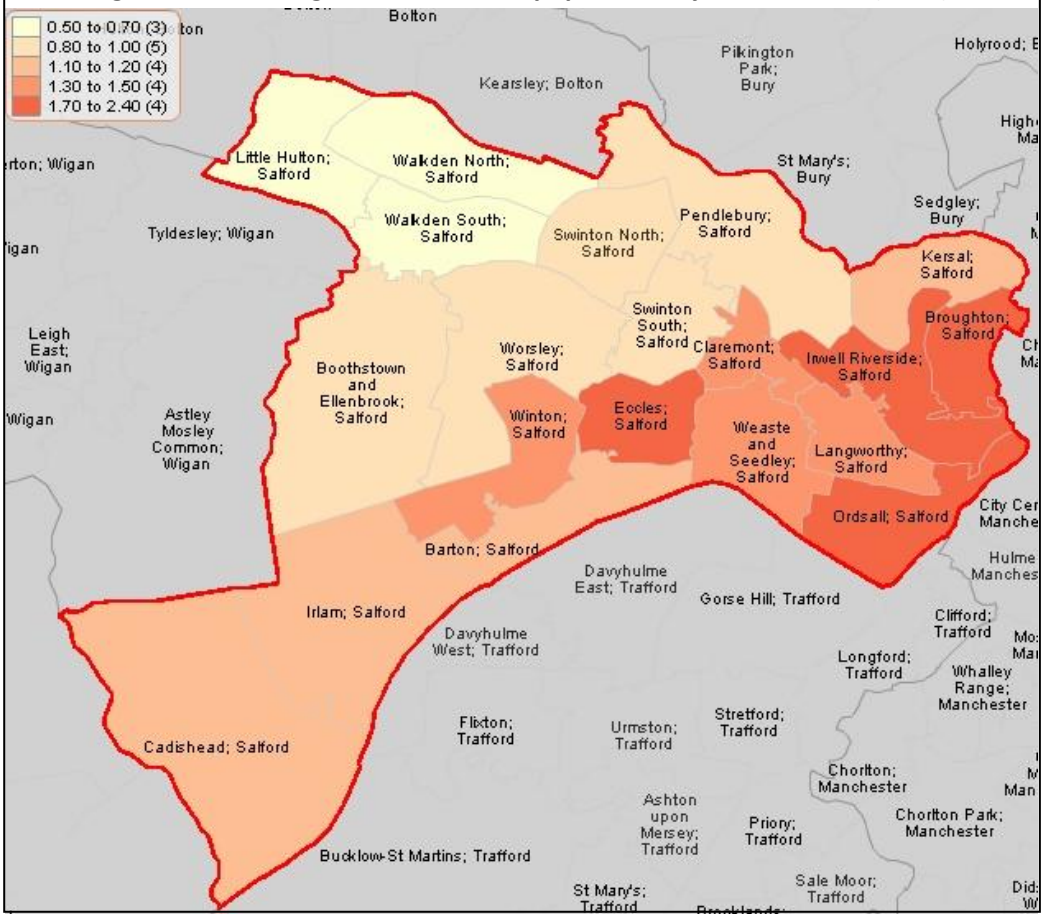


Figure 6: Population pyramid for White British population in Salford
Source: Nomis – 2011 Census [7]

Unlike the White British population, the proportion of residents of White Irish population is greatest in Broughton (2.4%) and Eccles (1.9%), and lowest in Walkden North (0.5%) and Little Hulton (0.6%) [Figure 7].

Figure 7: Percentage of 'White Irish' population by Salford ward (2011)



Source: PHE Local Health [8]

The population structure for the White Irish population is shown in Figure 8. Compared to the White British population this demonstrates an even greater skew towards an elderly population, particularly in women. Very few children in Salford are now identified as having White Irish ethnicity.

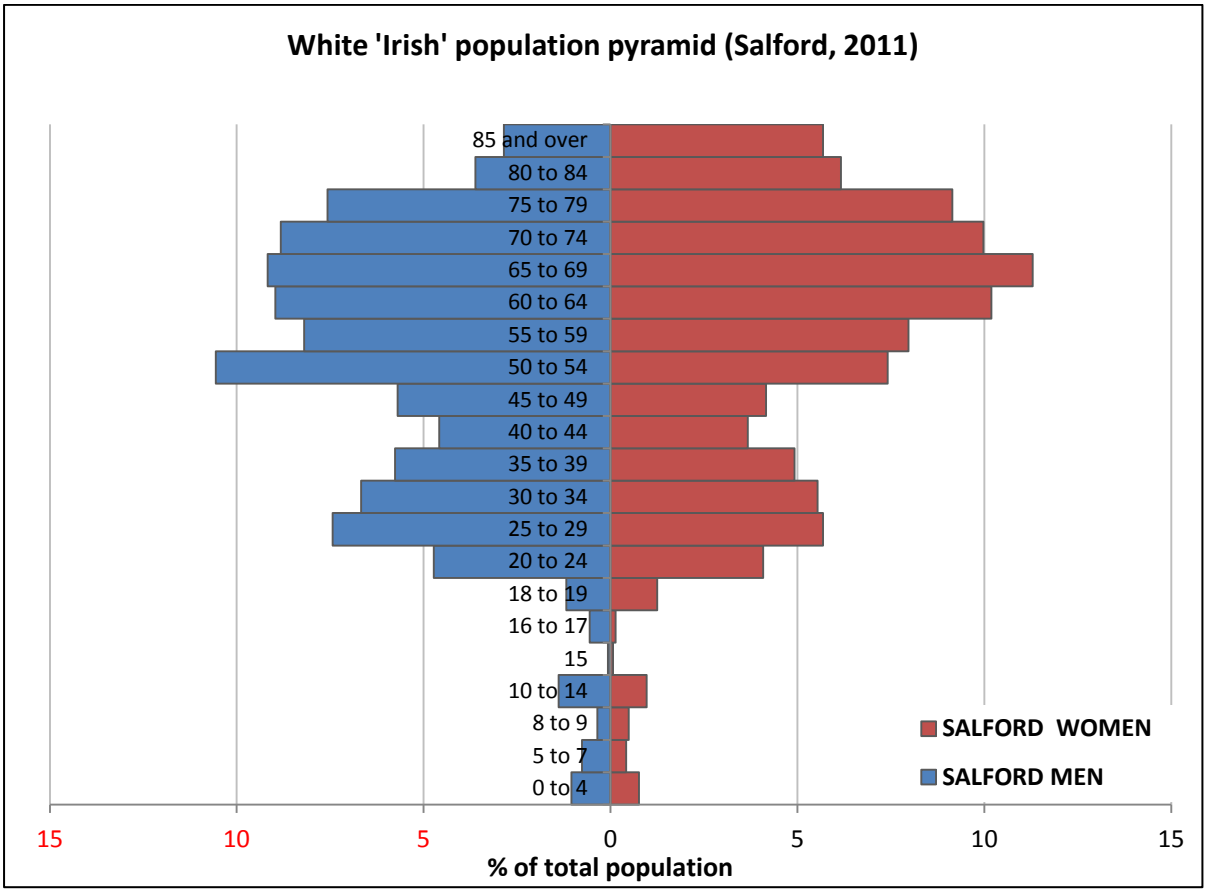


Figure 8: Population pyramid for White Irish population in Salford

Source: Nomis – 2011 Census [7]

Figure 9 shows the population pyramid for the White Other population, a group which includes White Europeans. The structure is significantly different to that of the ageing White Irish population. The most common age band is 25-29 which alone accounts for 21% of the male population and 22% of the female population. This may partly be explained by recent trends in young adults entering the UK labour market from other European countries.

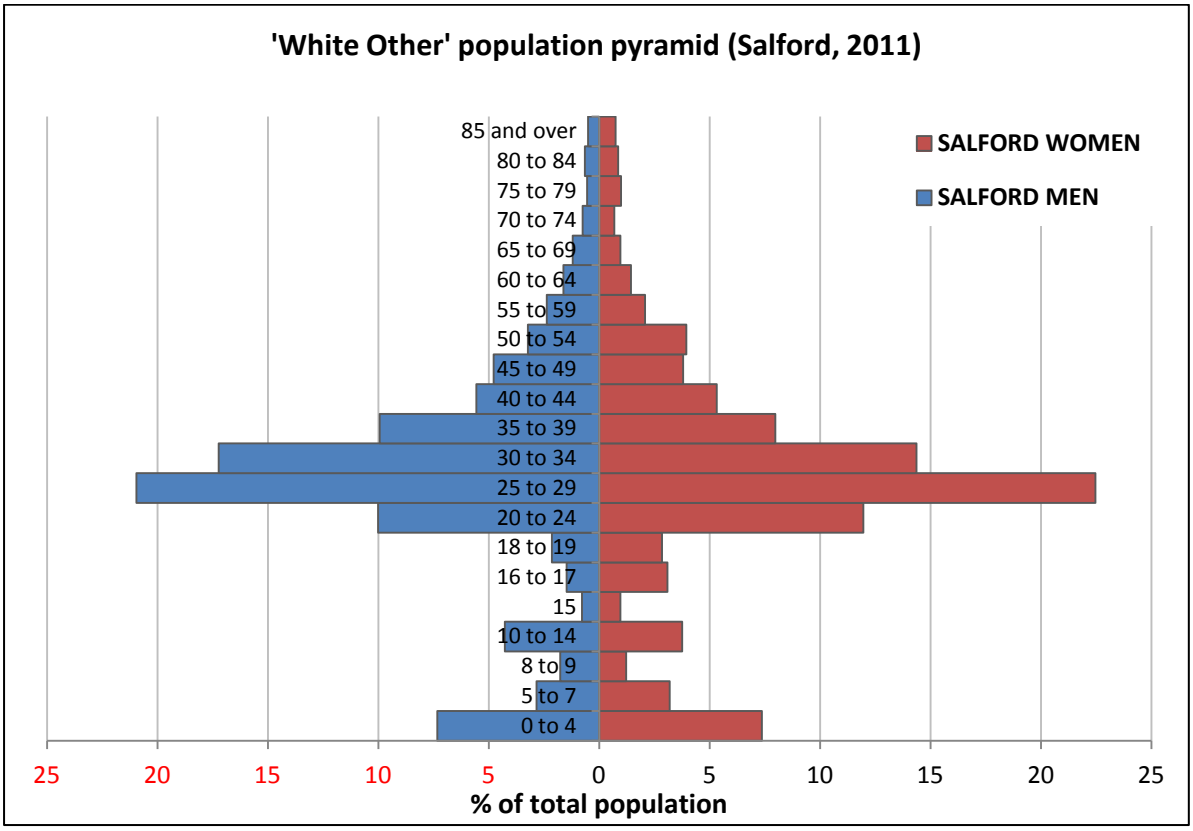


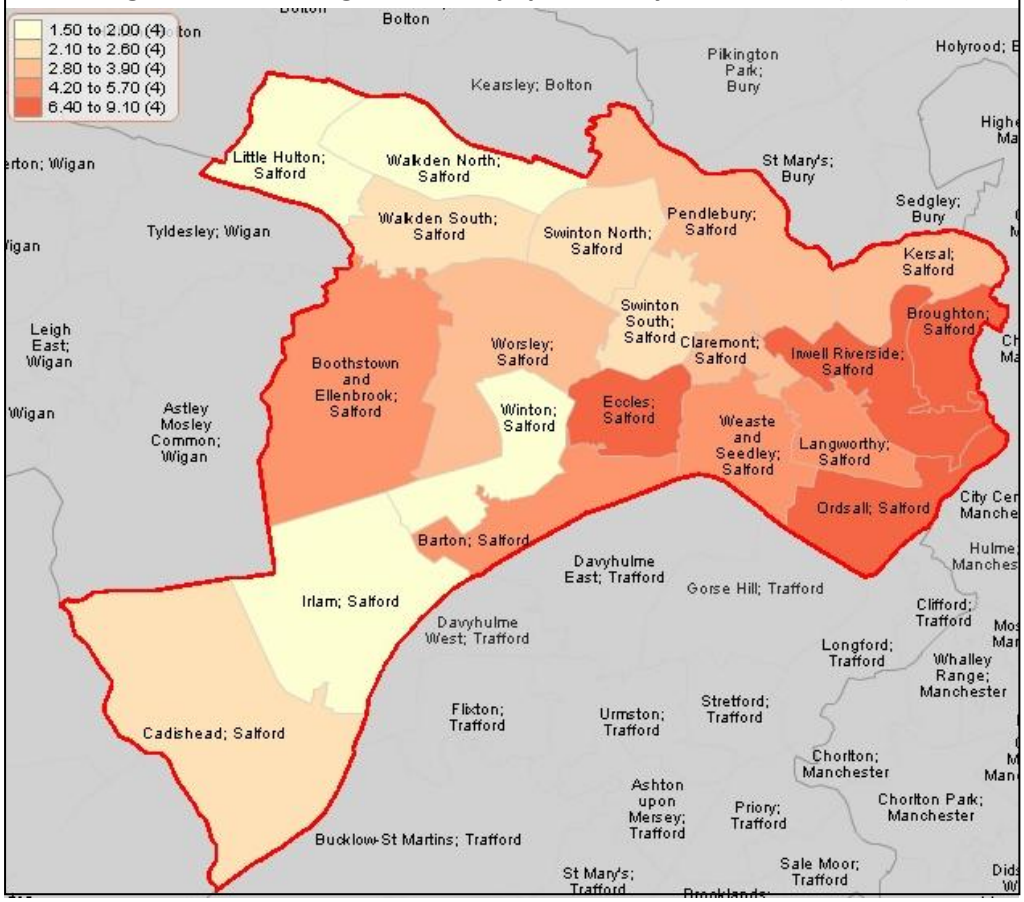
Figure 9: Population pyramid for White Other population in Salford

Source: Nomis – 2011 Census [7]

Asian Ethnic Groups

The wards with the highest proportion of Asian populations are Ordsall (9.1%), Irwell Riverside (7.1%) and Broughton (6.7%). Little Hulton has a relatively small Asian population (1.5%) followed by Irlam (1.6%) and Walkden North (1.8%) [Figure 10].

Figure 10: Percentage of 'Asian' population by Salford ward (2011)



Source: PHE Local Health [8]

Population pyramids for the Indian (Figure 11), Pakistani (Figure 12), Bangladeshi (Figure 13) and Chinese (Figure 14) populations show that Asian populations in Salford have a much younger age distribution than White groups. There are marked peaks in the 0-4 age band for Indian, Pakistani and Bangladeshi populations. In this age band the greatest peak for girls is in the Indian population (12.1%), and for boys is in the Bangladeshi population where 10% are in this age band.

The Chinese population structure differs from the pattern in other Asian groups (Figure 14). It also has relatively few elderly people but has a smaller proportion of younger children. Instead there is a very large young adult population with the majority of the male and female population being aged between 20 and 40.

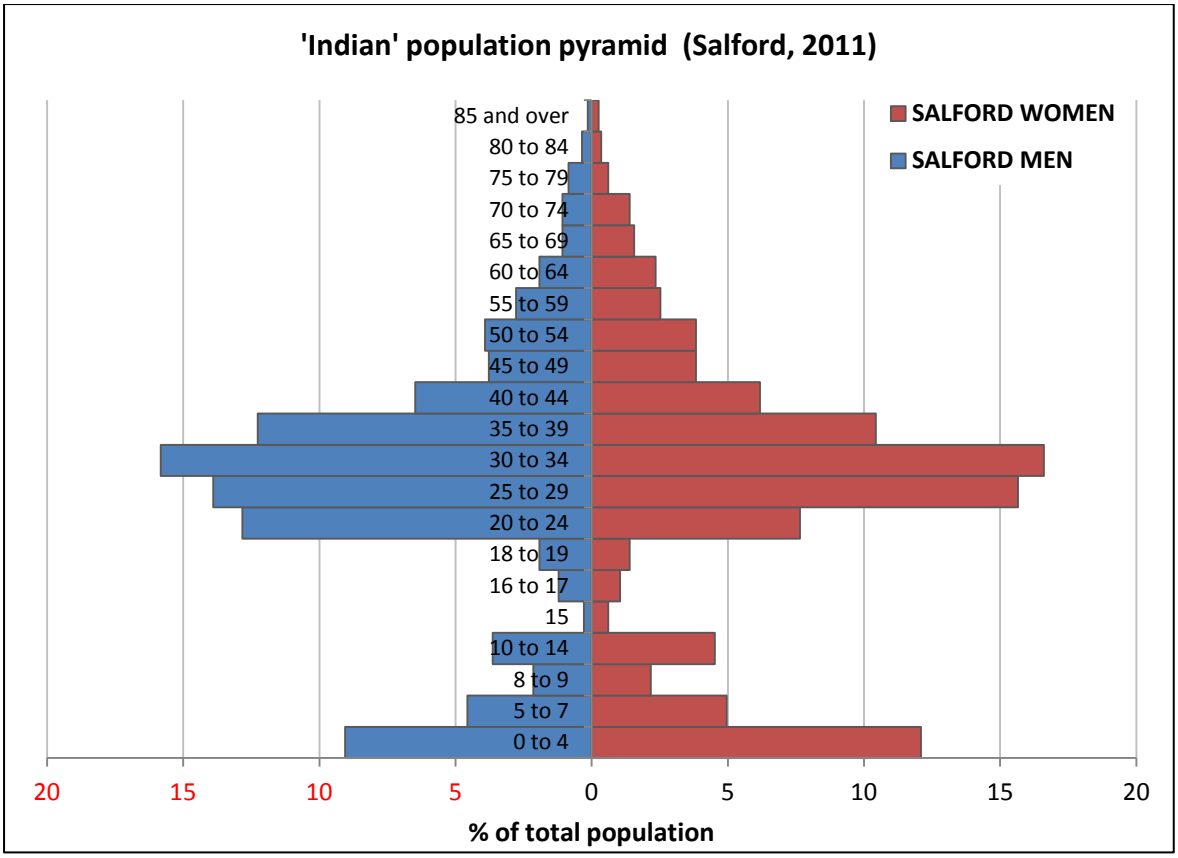


Figure 11: Population pyramid for Indian ethnic group in Salford

Source: Nomis – 2011 Census [7]

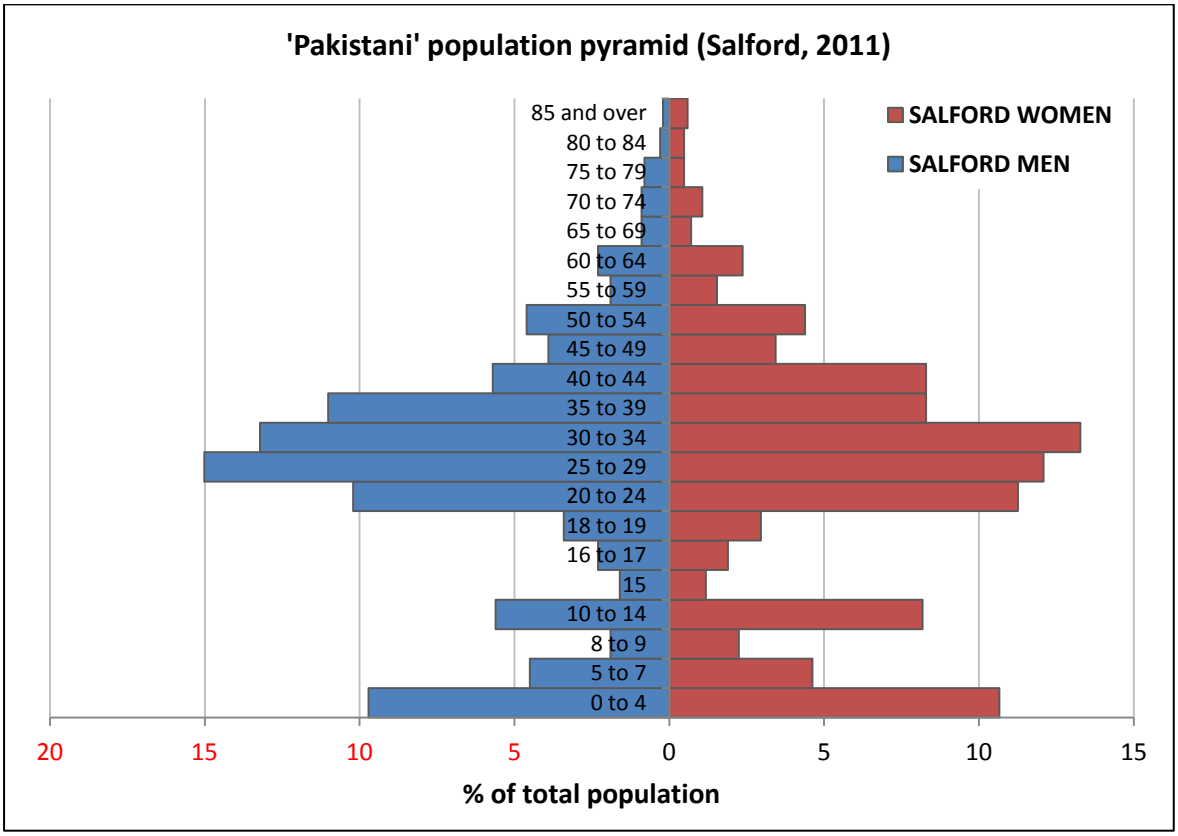


Figure 12: Population pyramid for Pakistani ethnic group in Salford

Source: Nomis – 2011 Census [7]

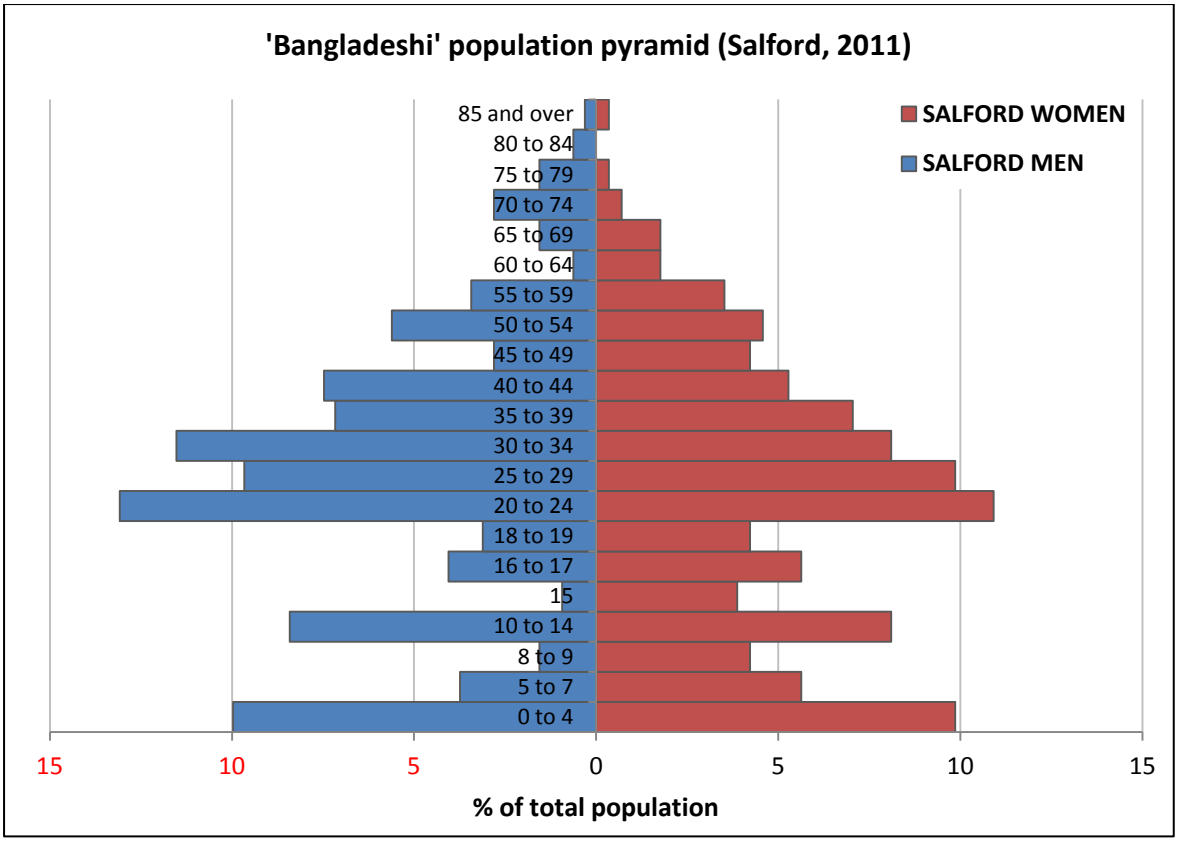


Figure 13: Population pyramid for Bangladeshi population in Salford

Source: Nomis – 2011 Census [7]

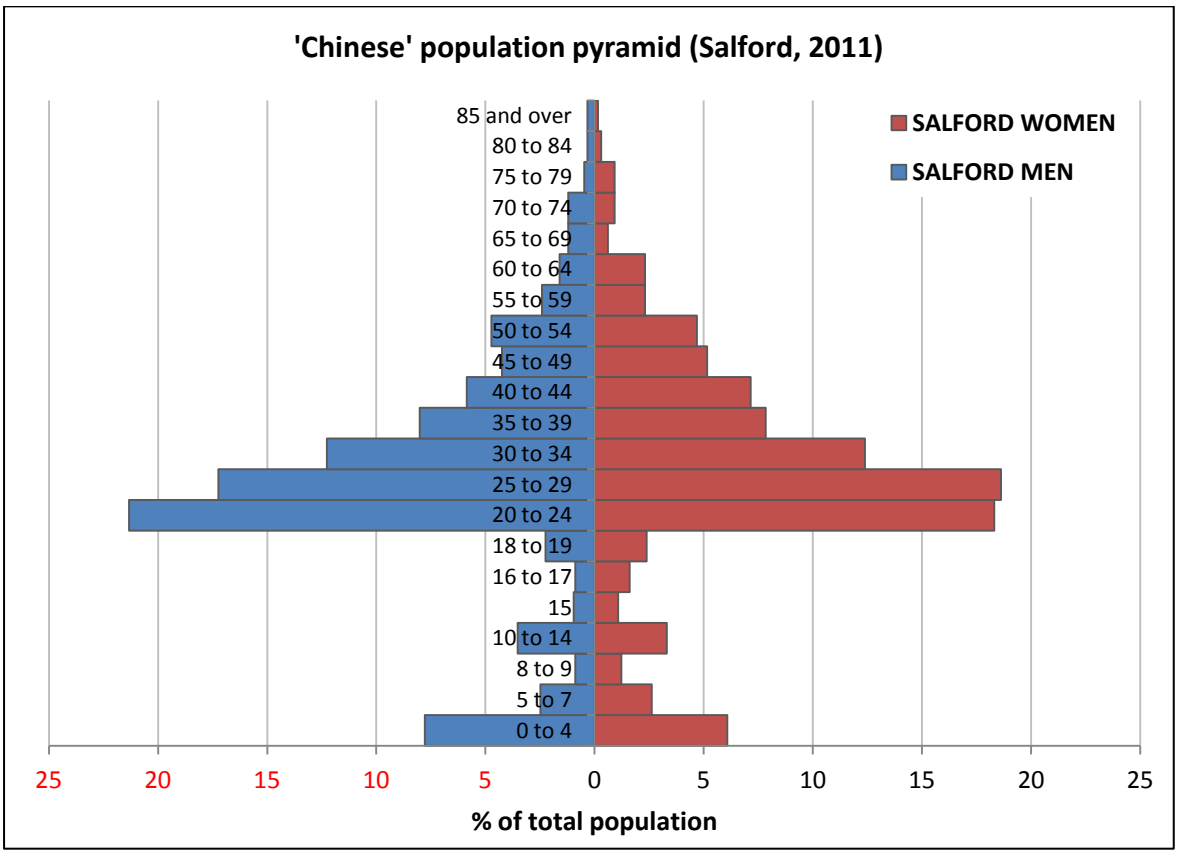


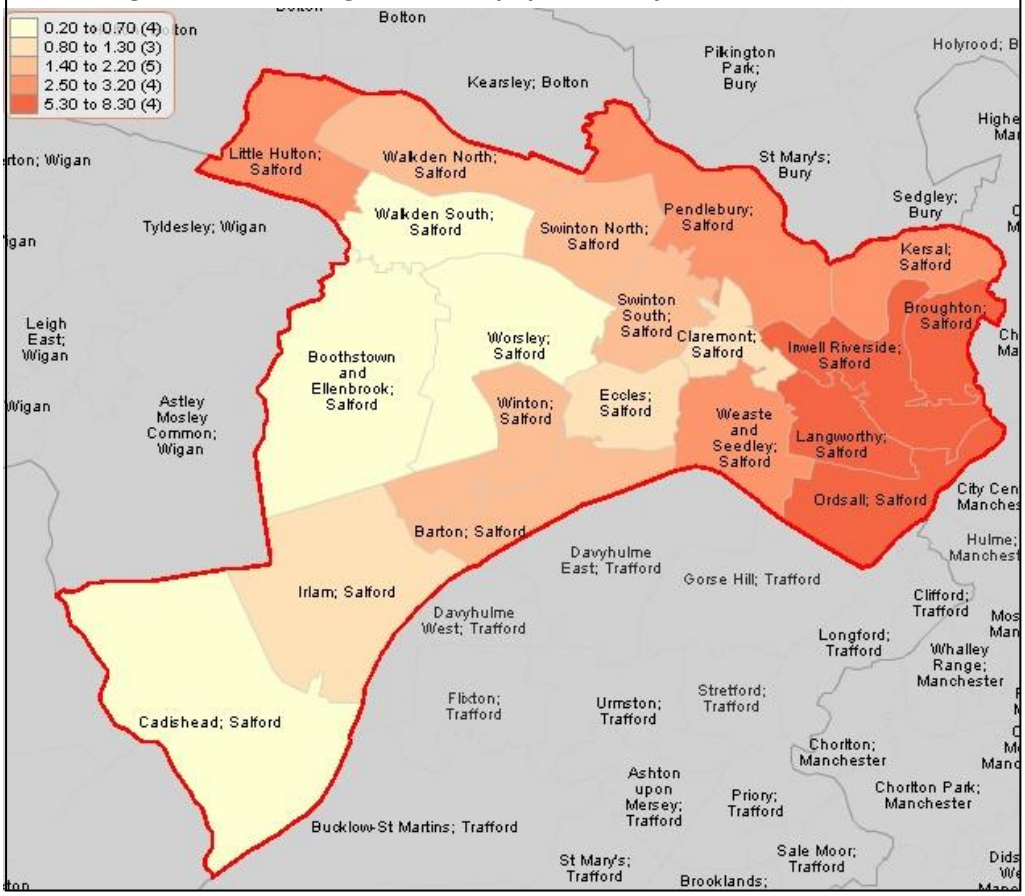
Figure 14: Population pyramid for Chinese population in Salford

Source: Nomis – 2011 Census [7]

Black Ethnic Groups

The wards with the highest proportion of Black ethnic groups are Broughton (8.3%), Irwell Riverside (6.7%) and Langworthy (6.0%) while Worsley (0.2%), Boothstown and Ellenbrook (0.5%) and Walkden South (0.6%) have the lowest proportions [Figure 15].

Figure 15: Percentage of 'Black' population by Salford ward (2011)



Source: PHE Local Health [8]

Both the Black African (Figure 16) and Black Caribbean (Figure 17) age structures are noticeably younger than that of the White British population in Salford. The majority of both populations are aged between 20 and 50. However, the Black African group has a much higher frequency of very young (aged 0 to 4) children: 11% of boys and 14.3% of girls.

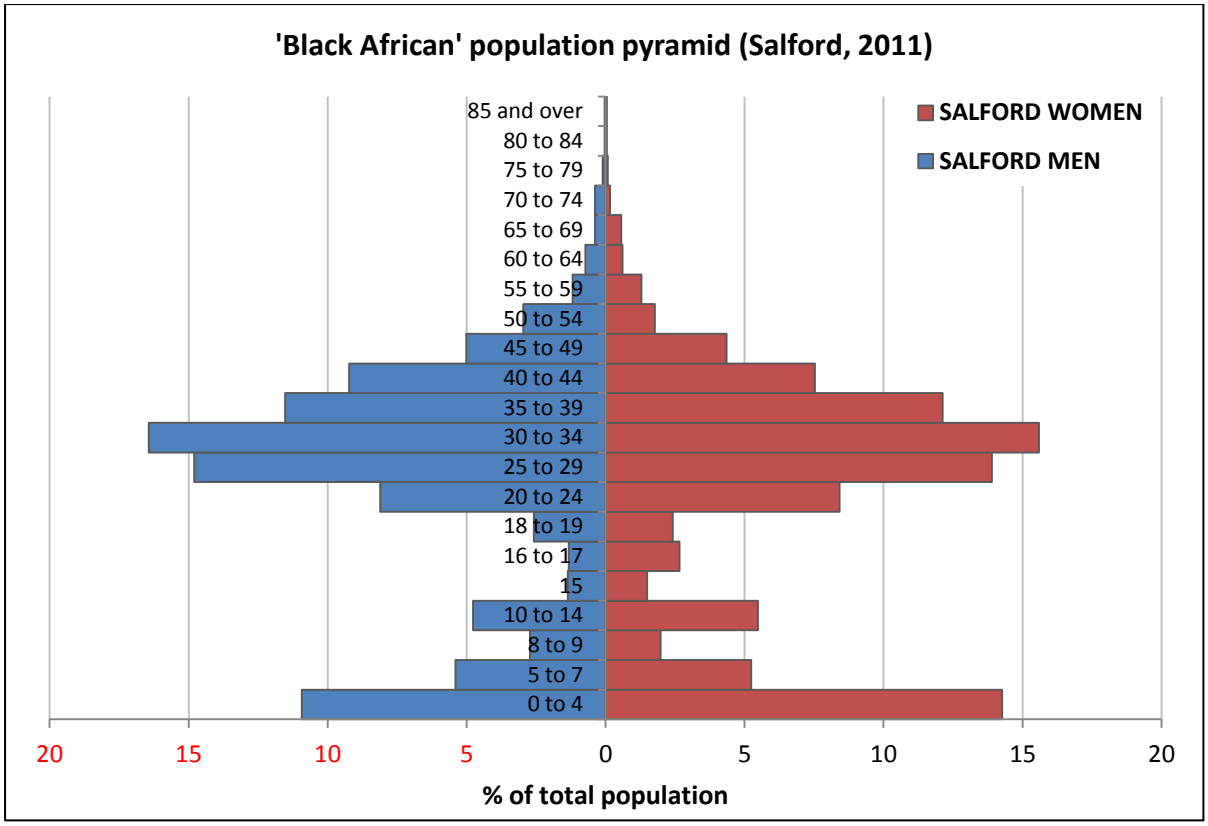


Figure 16: Population pyramid for Black African population

Source: Nomis – 2011 Census [7]

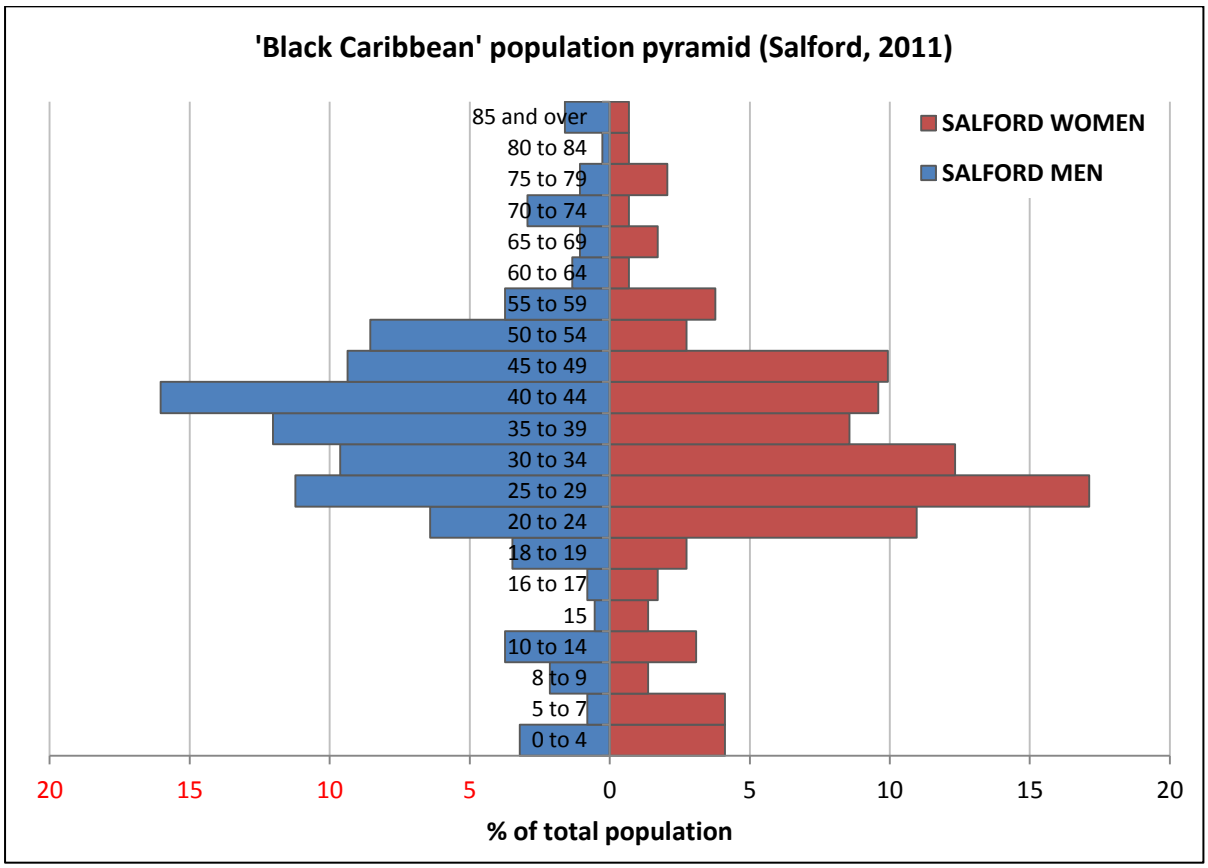


Figure 17: Population pyramid for Black Caribbean population in Salford

Source: Nomis – 2011 Census [7]

Other Ethnic Groups

The 1,425 members of the Arab ethnic group in Salford are also relatively young, with few aged over 50 (Figure 18). The relative size of the 0-4 age group is larger than for any other ethnic group in Salford with the peak in girls (18.2% of the population) being greater than the corresponding value for boys (11.0%).

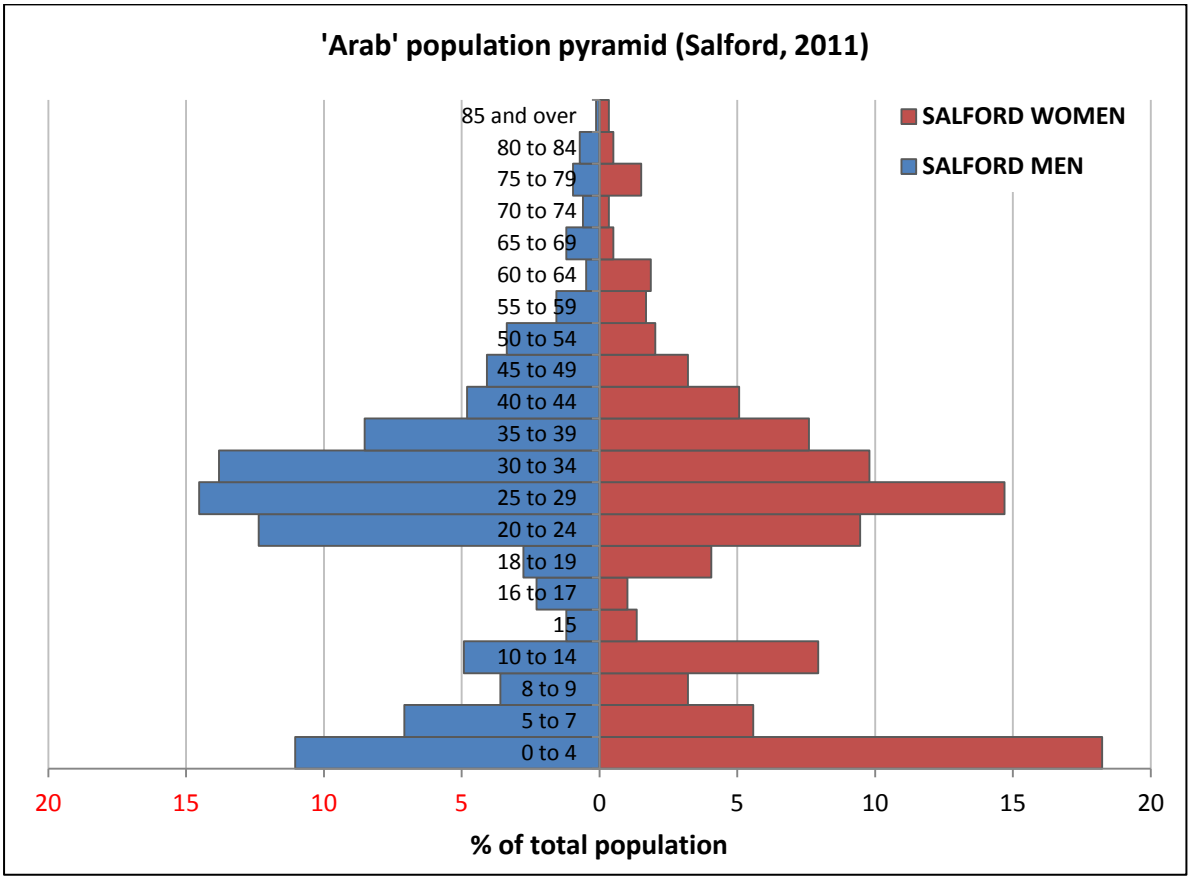


Figure 18: Population pyramid for Arab population in Salford
Source: Nomis – 2011 Census [7]

Trends

The population of Salford grew by 17,830 (8%) between 2001 and 2011 [Table 7]. This included a 20,728 (132%) increase in the BME population overall, much higher than the national average (68%) for this period. In terms of specific ethnic groups, Salford's Black African population rose by 4,645 (655%), with other major increases seen for Other Asian (1,453; 339%), Other Black (387; 289%), White/Black African (740; 233%) and White Other (7,002; 198%). Over the same period the White British population fell slightly (-2,898; -1%), while the White Irish population fell by 988 (26%), consistent with national trends.

Table 7: Trends in ethnicity in Salford

ETHNIC GROUP		SALFORD POPULATION		TREND (2001 – 2011) n (%)	
		2001	2011	Salford	England
WHITE	White British	200,343	197,445	-2,898 (-1%)	-467,900 (-1%)
	White Irish	3,870	2,882	-988 (-26%)	-107,114 (-17%)
	Other White	3,533	10,535	7,002 (198%)	1,176,795 (90%)
ASIAN	Indian	1,196	2,553	1,357 (113%)	367,156 (36%)
	Pakistani	963	1,843	880 (91%)	405,743 (57%)
	Bangladeshi	402	605	203 (50%)	161,120 (59%)
	Chinese	1,191	2,547	1,356 (114%)	158,822 (72%)
	Other Asian	428	1,881	1,453 (339%)	581,592 (245%)
BLACK	Black African	709	5,354	4,645 (655%)	501,803 (105%)
	Black Caribbean	417	666	249 (60%)	29,770 (5%)
	Other Black	134	521	387 (289%)	182,533 (191%)
MIXED	White / Black Caribbean	839	1,647	808 (96%)	184,192 (80%)
	White / Black African	318	1,058	740 (233%)	85,052 (111%)
	White / Asian	495	929	434 (88%)	148,694 (81%)
	Other Mixed	494	982	488 (99%)	131,568 (87%)
OTHER ETHNIC GROUP		771	2,485	1,714 (222%)	333,799 (156%)
BME POPULATION		15,760	36,488	20,728 (132%)	4,341,525 (68%)
TOTAL POPULATION		216,103	233,933	17,830 (8%)	3,873,625 (8%)

Source: Nomis – 2001 & 2011 Census [7]

At a ward level it is difficult to make direct comparisons between the BME populations over the same period due to boundary changes. Table 8 compares the proportion of the ward population from a BME group in 2001 and 2011. Even where wards have the same name, their boundaries may have changed slightly. Nevertheless, there were significant increases in the BME population in all wards with the greatest absolute increases appearing to be in Eccles, Kersal, Ordsall and Weaste and Seedley.

Table 8: Trend in BME population % in Salford wards: 2001 to 2011

WARD NAME	2001[5]	2011
Barton	6.8%	15.1%
Blackfriars	16.1%	N/A
Boothstown and Ellenbrook	N/A	8.8%
Broughton	N/A	**33.0%**
Cadishead	4.1%	7.4%
Claremont	7.0%	9.5%
Eccles	10.4%	18.0%
Irlam	4.0%	7.0%
Irwell Riverside	N/A	29.2%
Kersal	14.9%	25.3%
Langworthy	N/A	20.7%
Little Hulton	3.5%	9.6%
Ordsall	11.7%	31.8%
Pendlebury	4.7%	11.9%
Pendleton	13.0%	N/A
Swinton North	4.1%	9.0%
Swinton South	4.1%	8.8%
Walkden North	4.2%	7.6%
Walkden South	3.8%	6.2%
Weaste and Seedley	7.9%	18.5%
Winton	5.6%	11.6%
Worsley[6]	4.8%	7.2%

Source: Nomis – 2001, 2011 Census [7]

[5] 2001 data reported according to previous 2003 ward boundaries
[6] 2001 ward is 'Worsley and Boothstown'

Greater Manchester comparison

Figure 19 shows that Salford has a lower proportion of its population from a BME background (15.6%) in comparison to the Greater Manchester average (20.2%). However, due to recent population trends it now has (in comparison to the Greater Manchester average), larger populations (as a proportion of total population) from Other White (Figure 20), Chinese (Figure 21), Black African (Figure 22) and Arabic ethnic groups (Figure 23).

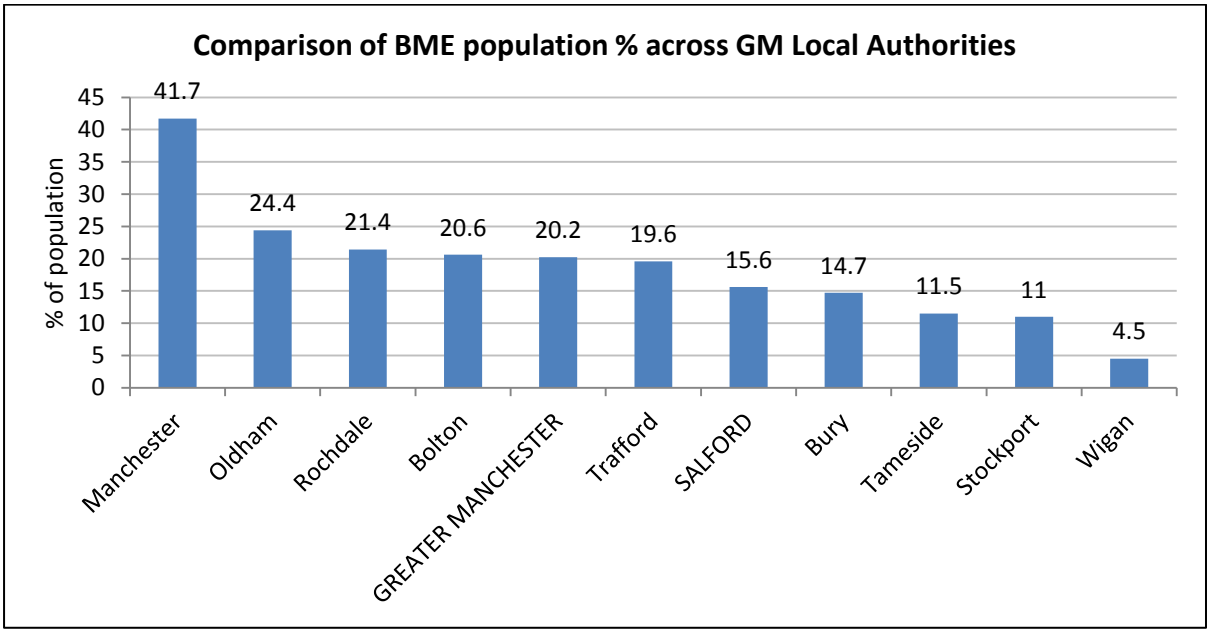


Figure 19: Comparison of BME population % across GM Local Authorities
Source: Nomis – 2011 Census [7]

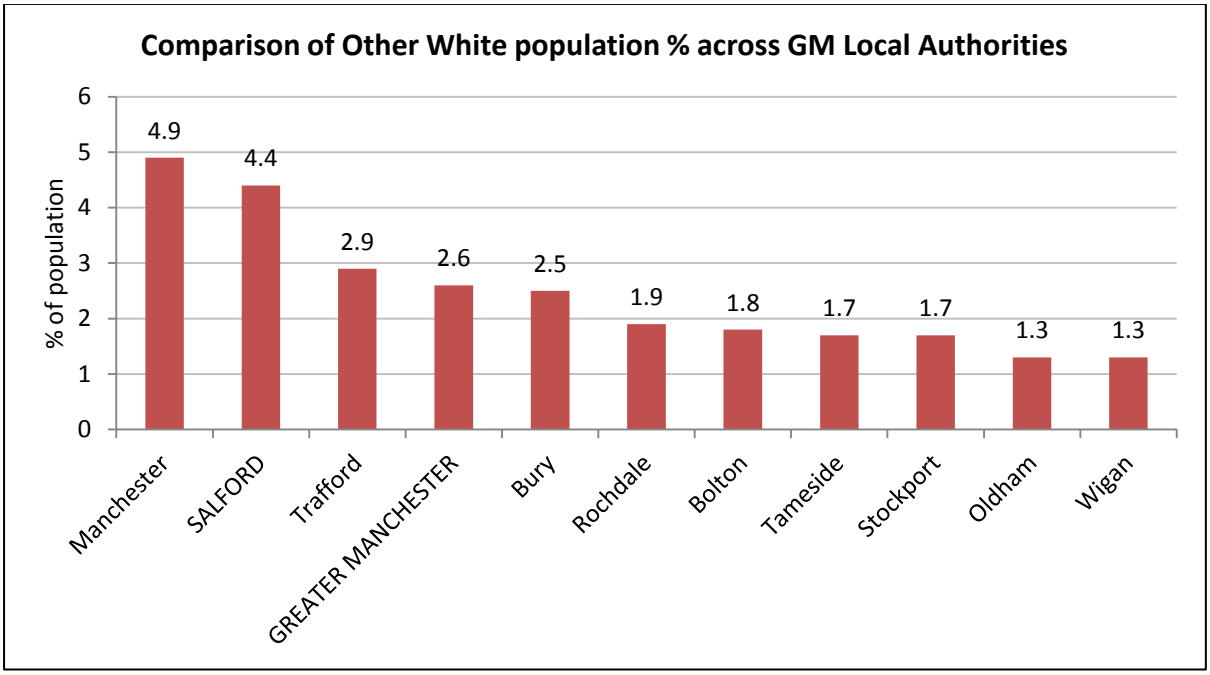


Figure 20: Comparison of Other White population % across GM Local Authorities
Source: Nomis – 2011 Census [7]

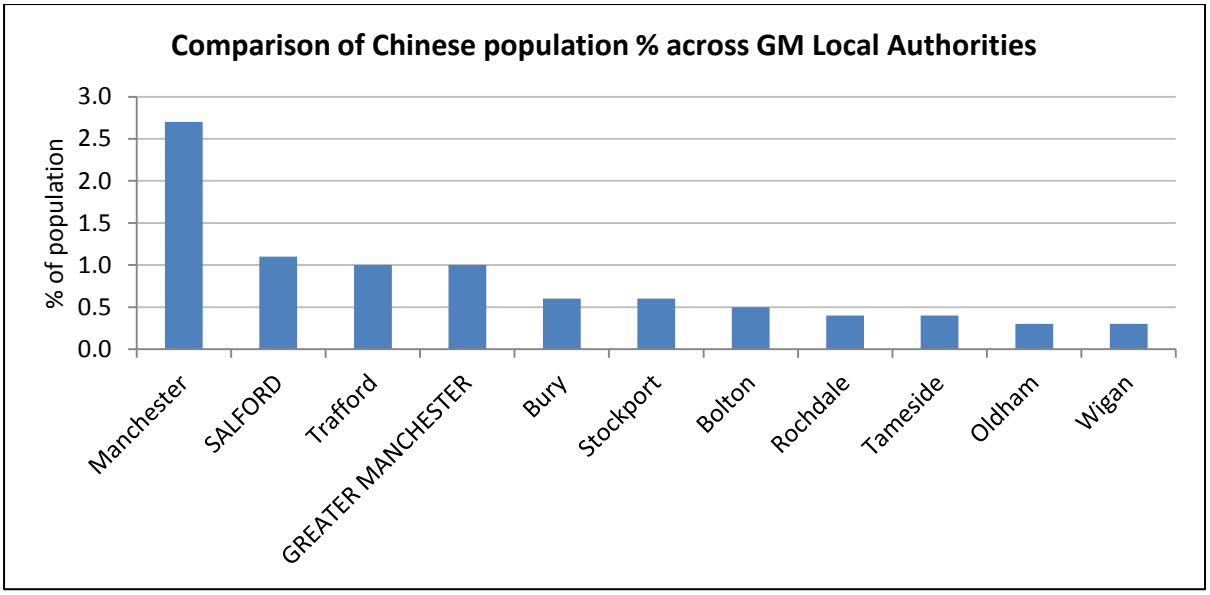


Figure 21: Comparison of Chinese population % across GM Local Authorities
Source: Nomis – 2011 Census [7]

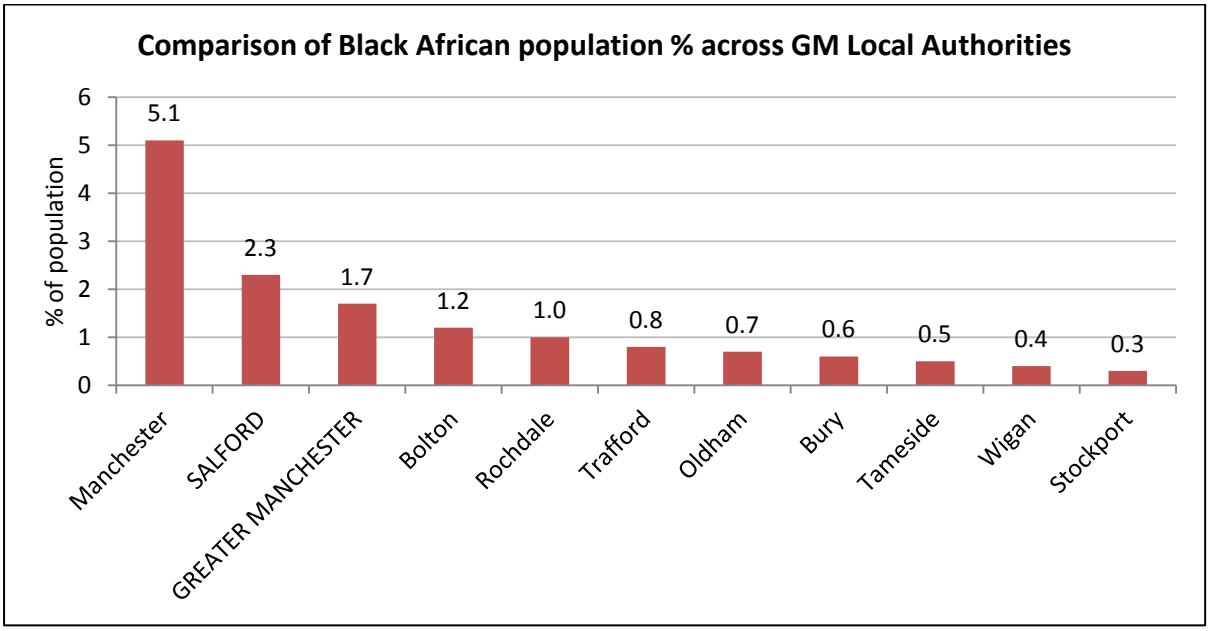


Figure 22: Comparison of Black African population % across GM Local Authorities
Source: Nomis – 2011 Census [7]

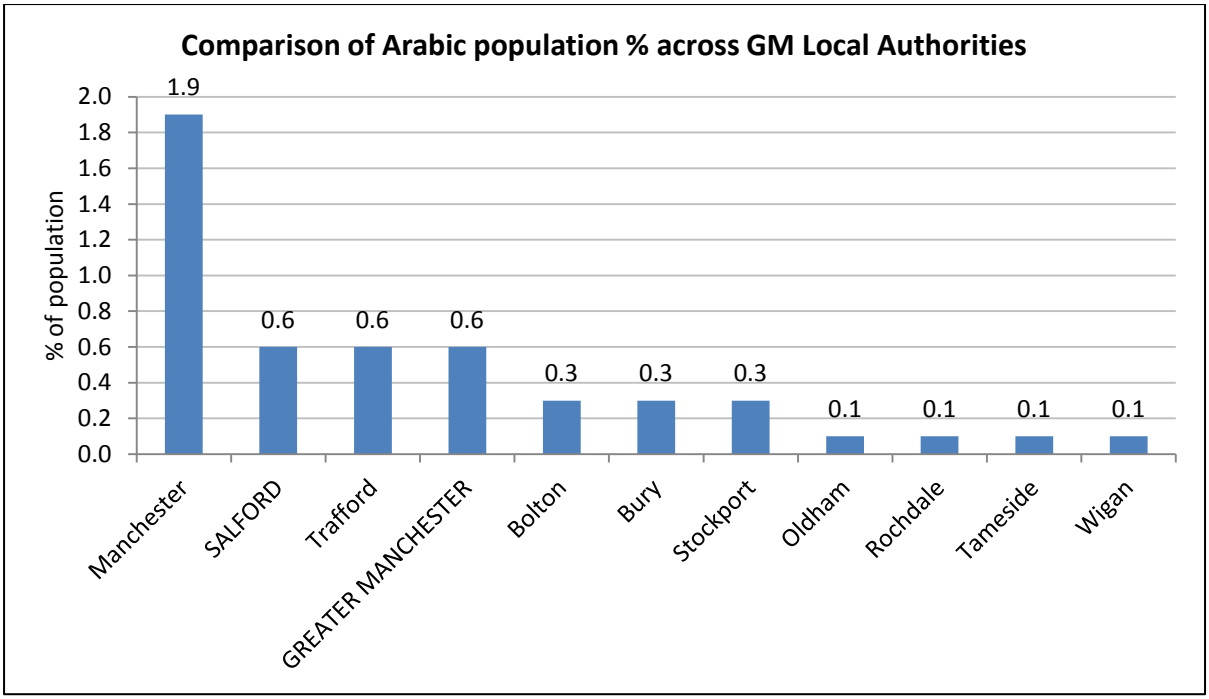


Figure 23: Comparison of Arabic population % across GM Local Authorities
Source: Nomis – 2011 Census [7]

Religion

Based on 2011 Census data, most Salford residents identify as Christian (64.2%) followed by "No Religion" (Table 9). Unlike the national average, the next most frequent religion is Judaism. 3.3% of Salford residents were Jewish, compared with only 0.5% of the English population [Figure 24]. The Muslim community is the next largest in Salford but this is relatively small (2.6%) compared to the average for England (5.0%). Both populations have grown since 2001 with the Jewish community increasing by 2,508 people (48.4%) and the Muslim community by 3,430 (131.9%).

Table 9: Self-reported religion in Salford, 2011

Faith	Number	% of population
Christian	150,111	64.2%
Buddhist	1,040	0.4%
Hindu	1,504	0.6%
Jewish	7,687	3.3%
Muslim	6,030	2.6%
Sikh	324	0.1%
Other religion	691	0.3%
No religion	52,105	22.3%
Religion not stated	14,441	6.2%

Source: Nomis – 2011 Census [7]

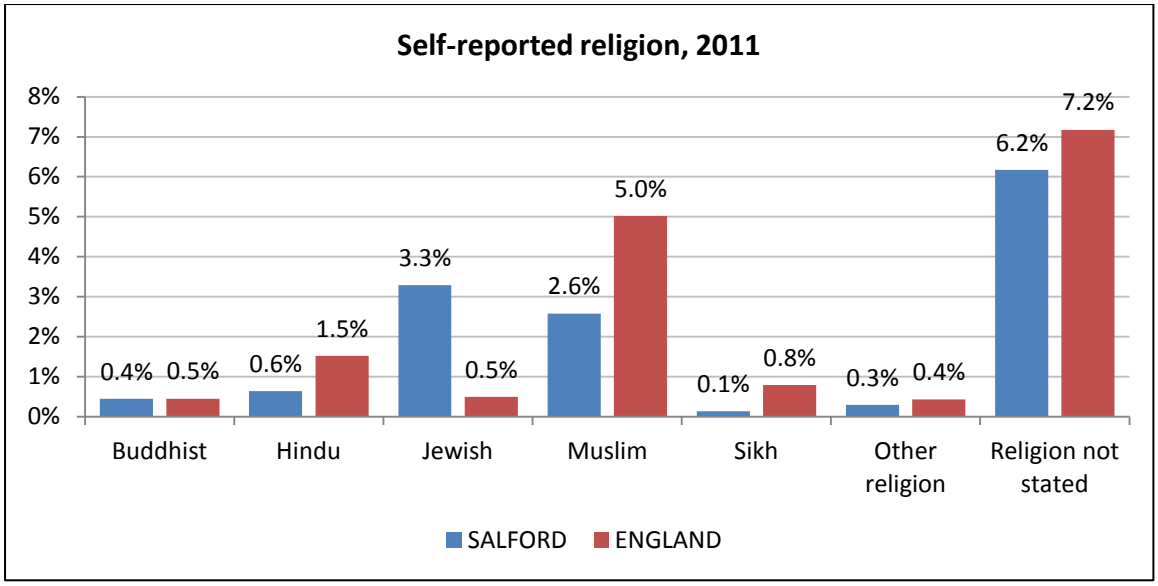


Figure 24: Self-reported religion (excluding Christianity / no religion) in Salford and England, 2011
Source: Nomis – 2011 Census [7]

The Orthodox Jewish community in Salford forms part of the second largest Orthodox Jewish community in the UK which spans three Local Authorities: Bury, Manchester and Salford. More than two-thirds of the population lives in Kersal ward (67.6%) with most of the remainder in Broughton (25.6%).

It has a relatively young population. The population pyramid in Figure 25 demonstrates that there is a relatively large population of young children. 41.2% of the population are aged 0-15 compared to an average of only 19.3% for the rest of Salford [Figure 26].

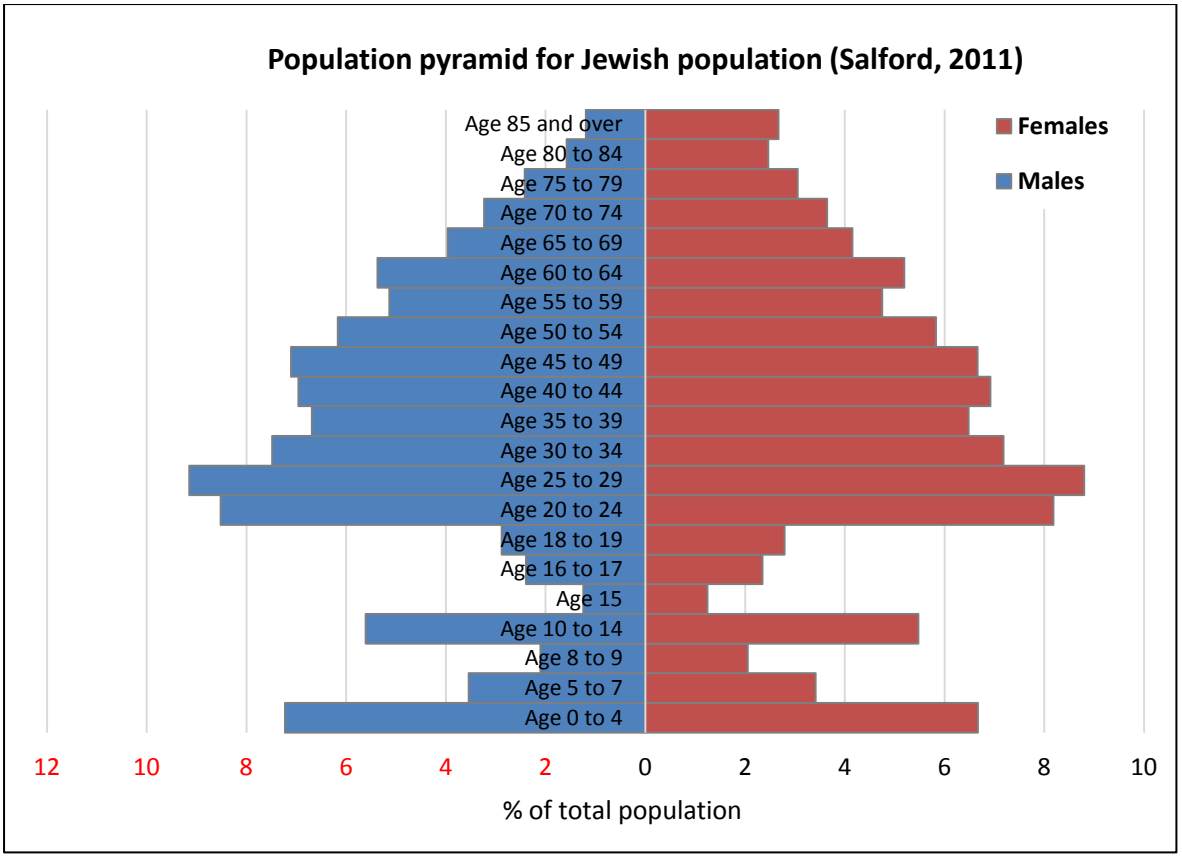


Figure 25: Population pyramid for Jewish population in Salford
Source: Nomis – 2011 Census

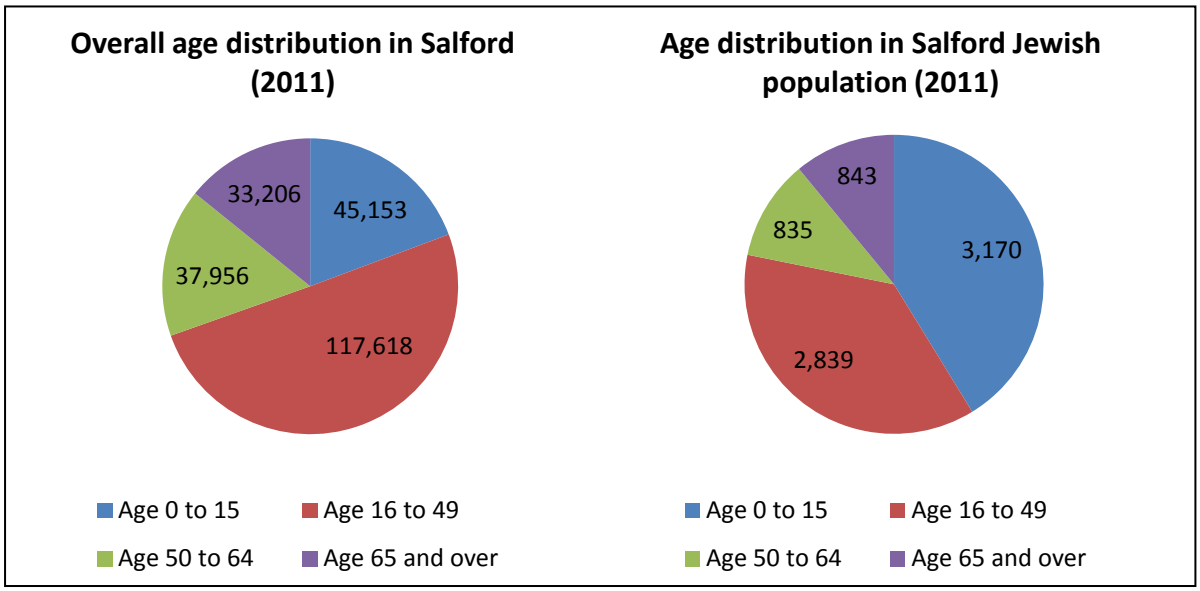


Figure 26: Comparison of age structures between the Salford Jewish community and the overall population
Source: Nomis – 2011 Census [7]

The Jewish population in Salford comes from a range of ethnic groups. The majority of Jewish people identify as White British (77.0%) followed by Other White (16.4%), but a variety of other groups are also represented [Table 10].

Table 10: Self-reported ethnicity of the Jewish population in Salford (2011)

Ethnic Group	Number	%
White British	5,922	77.0%
Other White	1,259	16.4%
Any other ethnic group	339	4.4%
Mixed total	62	0.8%
Irish	48	0.6%
Other Asian	16	0.2%
Indian	14	0.2%
African	8	0.1%
Pakistani	7	0.1%
Chinese	5	0.1%
Other Black	3	0.0%
Arab	3	0.0%
Bangladeshi	1	0.0%

Source: Nomis – 2011 Census

4.2. Languages

According to the 2011 Census there are now over 70 languages described by Salford residents as their main language. 16,085 people do not speak English as their main language (Table 11).

Table 11: Main languages spoken by Salford residents (aged 3 and over) in 2011

Main Language	n	%
English	207,827	92.8%
Polish	3,526	1.6%
Arabic	1,047	0.5%
French	841	0.4%
Portuguese	785	0.4%
Urdu	524	0.2%
Yiddish	464	0.2%
Persian/Farsi	380	0.2%
Slovak	359	0.2%
Spanish	328	0.1%
Other	6,434	2.9%

Source: Nomis – 2011 Census

4.3. School Census data

The Salford School Census surveys children at school in Salford[7] and provides the most up-to-date data on ethnicity in Salford (from 2015). Its focus on children also helps to identify emerging trends and changes to the population structure. In the following tables, cells shaded purple represent areas with populations significantly higher than the Salford average, while cells shaded yellow are areas with populations that are significantly[8] lower than the Salford average.

Boothstown and **Worsley** have a significantly higher proportion of children from White British, Indian and Mixed White/Asian groups, with significantly lower proportions of children from Other White, Other Asian, Other Black, Mixed White/African and Mixed White/Black Caribbean.

Claremont and **Weaste** have significantly higher proportions of Indian and Pakistani children. **East Salford** has higher proportions of Other Asian, Pakistani, Black African, Mixed White/Black African, Mixed White/Black Caribbean, Other Mixed and Other White and significantly fewer White British children.

Eccles has a relatively large population of children from Bangladeshi and White Gypsy/Roma communities. **Irlam** and **Cadishead** have significantly higher proportions of children from White

[7] Children who are Salford residents but attend school elsewhere are not included
[8] In this context, 'significant' means that we can be more than 95% confident that there is a true difference between the shaded figure and the Salford average

British and White Traveller populations and relatively smaller populations from Other Asian, Other Black, Mixed White/Asian and Other White backgrounds.

Little Hulton and **Walkden** have significantly smaller populations of children of Pakistani and Chinese origin. **Ordsall** and **Langworthy** has significantly larger populations of Black Caribbean, Other Black, Chinese and Other Mixed groups and smaller populations from a White British background. **Swinton** schools have significantly higher numbers of children from Chinese backgrounds.

Table 12: Salford School Census – Frequency of 'White' ethnic groups by ward (2015)

AREA	WHITE ETHNIC CATEGORY			
	British	Traveller	Gypsy/Roma	Other
Boothstown & Worsley	88.8%	0.0%	0.0%	2.2%
Claremont & Weaste	78.1%	0.1%	0.1%	5.9%
East Salford	57.3%	0.2%	0.1%	10.7%
Eccles	74.5%	0.0%	0.7%	7.6%
Irlam & Cadishead	89.5%	0.4%	0.0%	2.8%
Little Hulton & Walkden	84.4%	0.0%	0.0%	4.3%
Ordsall & Langworthy	63.9%	0.2%	0.0%	8.9%
Swinton	80.5%	0.1%	0.0%	5.0%
SALFORD TOTAL	76.9%	0.1%	0.1%	6.1%

Source: Salford School Census, 2015

Table 13: Salford School Census – Frequency of 'Asian' ethnic groups by ward (2015)

AREA	ASIAN ETHNIC CATEGORY				
	Bangladeshi	Indian	Pakistani	Chinese	Other Asian
Boothstown & Worsley	0.0%	1.9%	0.3%	0.2%	0.2%
Claremont & Weaste	0.0%	2.4%	1.4%	0.2%	0.6%
East Salford	0.0%	1.4%	1.8%	0.3%	1.1%
Eccles	1.6%	0.7%	1.2%	0.1%	0.6%
Irlam & Cadishead	0.2%	0.6%	0.5%	0.2%	0.1%
Little Hulton & Walkden	0.0%	0.2%	0.2%	0.0%	0.4%
Ordsall & Langworthy	0.0%	0.5%	0.4%	0.4%	0.7%
Swinton	0.5%	0.5%	0.6%	0.4%	0.6%
SALFORD TOTAL	0.4%	0.9%	0.8%	0.2%	0.6%

Source: Salford School Census, 2015

Table 14: Salford School Census – Frequency of 'Black' ethnic groups by ward (2015)

AREA	BLACK ETHNIC CATEGORY		
	African	Caribbean	Other
Boothstown & Worsley	0.0%	0.0%	0.1%
Claremont & Weaste	1.9%	0.1%	0.7%
East Salford	10.0%	0.3%	1.7%
Eccles	1.5%	0.1%	0.4%
Irlam & Cadishead	0.4%	0.0%	0.2%
Little Hulton & Walkden	2.1%	0.3%	1.0%
Ordsall & Langworthy	5.7%	0.6%	2.4%
Swinton	1.8%	0.1%	1.1%
SALFORD TOTAL	**3.0%**	**0.2%**	**1.0%**

Source: Salford School Census, 2015

Table 15: Salford School Census – Frequency of 'Mixed' ethnic groups by ward (2015)

AREA	MIXED ETHNIC CATEGORY			
	White / Black African	White / Black Caribbean	White / Asian	Other Mixed
Boothstown & Worsley	0.3%	0.3%	1.1%	3.1%
Claremont & Weaste	0.6%	0.8%	0.8%	3.6%
East Salford	1.2%	1.1%	0.6%	6.7%
Eccles	0.6%	0.7%	0.4%	3.4%
Irlam & Cadishead	0.5%	0.6%	0.3%	2.6%
Little Hulton & Walkden	0.7%	0.7%	0.6%	3.2%
Ordsall & Langworthy	1.4%	1.1%	0.6%	7.4%
Swinton	0.6%	1.0%	0.4%	3.9%
SALFORD TOTAL	0.7%	0.8%	0.6%	4.1%

Source: Salford School Census, 2015

Trends in school census data between 2010 and 2015 show that the greatest relative increases in the school population were seen for the White European (148%), Other Black (109.4%), Other Asian (83.1%) and Black African (78.1%) ethnic groups (Table 16). The number of children from the Other White ethnic group has fallen, while the smallest increases were seen among the White British (8.2%), Chinese (8.9%) and Bangladeshi (9.2%) groups.

Table 16: Trends in Salford School Census data

		2010		2015		Change	
		Number	%	Number	%	Number	%
WHITE	British	15124	80.6%	16367	73.9%	1243	8.2%
	Irish	61	0.3%	71	0.3%	10	16.4%
	European	437	2.3%	1084	4.9%	647	148.1%
	Other	595	3.2%	390	1.8%	-205	-34.5%
ASIAN	Bangladeshi	65	0.3%	71	0.3%	6	9.2%
	Indian	196	1.0%	250	1.1%	54	27.6%
	Pakistani	150	0.8%	234	1.1%	84	56.0%
	Chinese	45	0.2%	49	0.2%	4	8.9%
	Other	71	0.4%	130	0.6%	59	83.1%
BLACK	African	457	2.4%	814	3.7%	357	78.1%
	Caribbean	39	0.2%	51	0.2%	12	30.8%
	Other	117	0.6%	245	1.1%	128	109.4%
MIXED		951	5.1%	1661	7.5%	710	74.7%

Source: Salford School Census, 2010 & 2015

4.4. Projected population trends

Due to the degree of population growth among the BME community in Salford seen since the 2001 Census, it is difficult to produce reliable estimates of future growth specific to Salford. At a national level, in 2010 the Centre for Policy on Aging published a report which used complex modelling techniques to project the BME population in England and Wales in five year intervals until 2051. This was based on ONS data up to 2007 but the calculations have not been updated with 2011 Census data.

Figure 27 illustrates the significant expansion in BME groups expected by 2051 when it is estimated that the BME population of England and Wales will number 25.1 million. This accounts for 36% of the total population, compared with 12.2% in 2016.

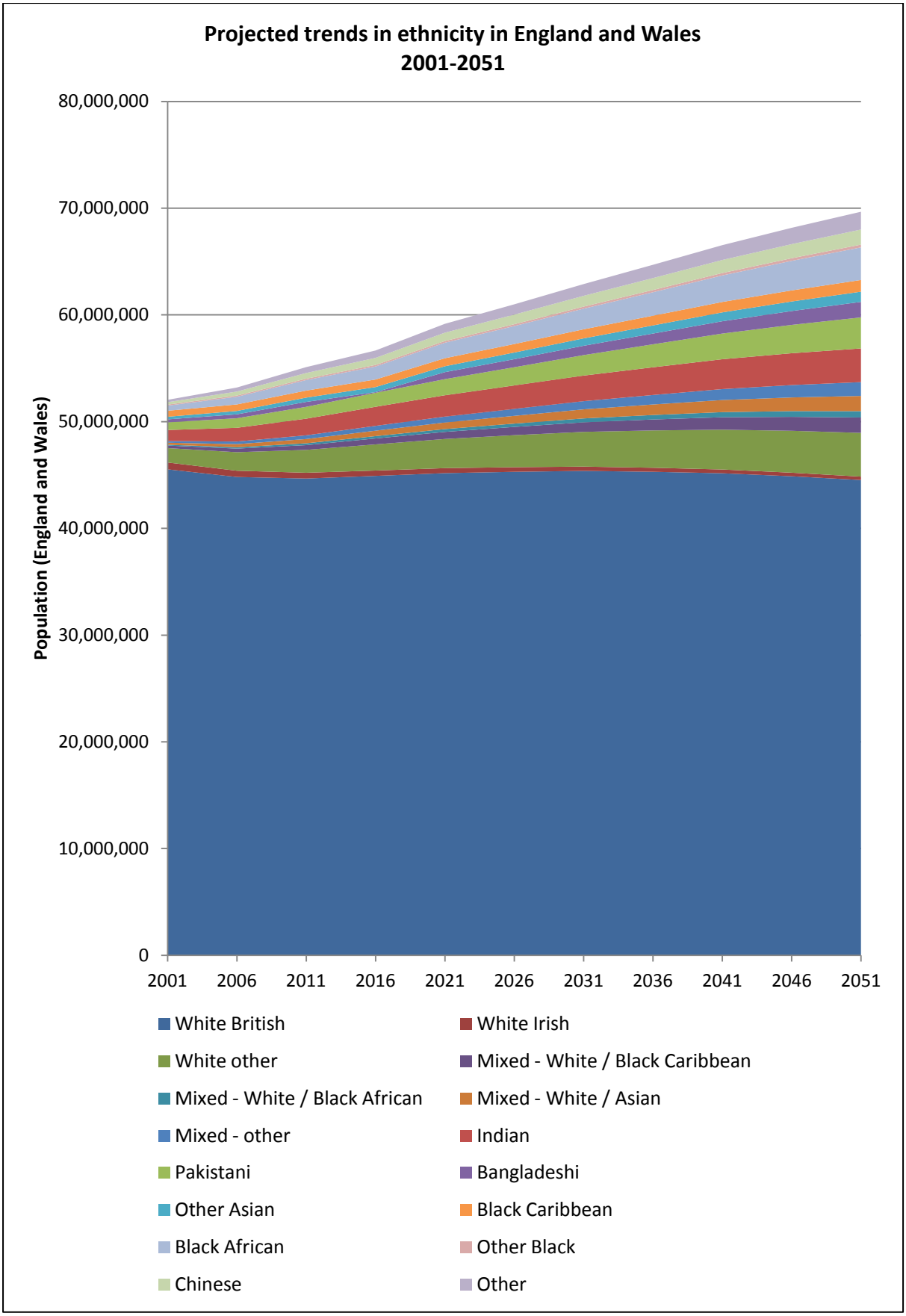


Figure 27: Projected trends in BME population in England and Wales, 2001-2051
Source: Centre for Policy on Ageing [9]

There is projected to be a particularly rapid increase in the BME population aged 50 and over. This group is expected to increase from 1.7 million in 2007 to 7.4 million by 2051 (Figure 28).

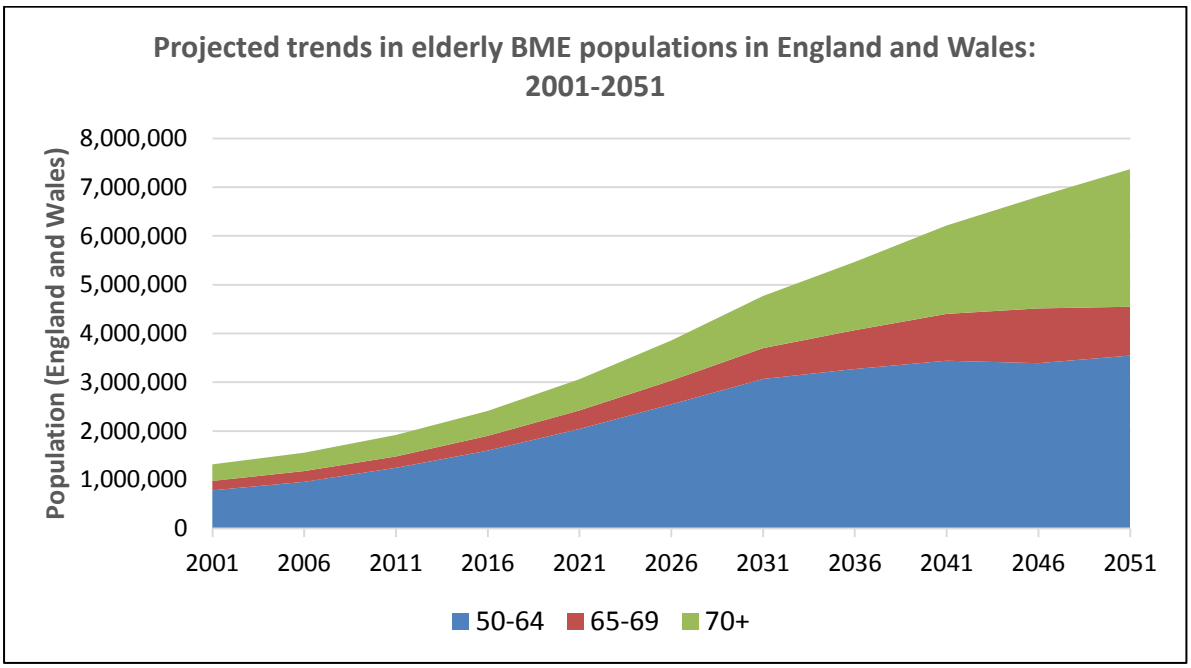


Figure 28: Projected tends in elderly BME populations in England and Wales, 2001-2051
Source: Centre for Policy on Aging [9]

Since the report was published it is likely that some of the assumptions underlying these estimates have changed, in addition to the baseline population numbers. This means the accuracy of the projections is reduced. It is also likely that the growth rates in Salford of each minority group will differ from the national picture due to local factors. However, bearing this in mind, the growth projections can be cautiously applied to the Salford population (based on 2011 Census data) as shown in Table 17:

Table 17: Projected population trends (2011-2051) according to ethnic group							
ETHNIC GROUP		**2011 POPULATION**		**2011-2051 TREND**		**2051 POPULATION**	
Major	Minor	**Number**	%	Number	%	Number	%
WHITE	British	197,445	84.4%	-592	-0.3%	196,853	69.3%
	Irish	2,882	1.2%	1,187	-41.2%	4,069	0.6%
	Other	10,535	4.5%	9,618	91.3%	20,153	7.1%
ASIAN	Indian	2,553	1.1%	2,612	102.3%	5,165	1.8%
	Pakistani	1,843	0.8%	2,991	162.3%	4,834	1.7%
	Bangladeshi	605	0.3%	1,293	213.8%	1,898	0.7%
	Chinese	2,547	1.1%	4,185	164.3%	6,732	2.4%
	Other Asian	1,881	0.8%	2,607	138.6%	4,488	1.6%
BLACK	African	5,354	2.3%	11,222	209.6%	16,576	5.8%
	Caribbean	666	0.3%	443	66.5%	1,109	0.4%
	Other Black	521	0.2%	549	105.3%	1,070	0.4%
MIXED	White / Black Caribbean	1,647	0.7%	3,709	225.2%	5,356	1.9%
	White / Black African	1,058	0.5%	2,576	243.5%	3,634	1.3%
	White / Asian	929	0.4%	2,382	256.4%	3,311	1.2%
	Other Mixed	982	0.4%	2,684	273.3%	3,666	1.3%
OTHER		2,485	1.1%	5,032	202.5%	7,517	2.6%
TOTAL		**233,933**	**100%**	**52,498**	**100%**	**286,431**	**100%**

Source: Centre for Policy on Ageing [9]

Based on these calculations it can be seen that the proportion of the White British population in Salford is projected to fall to 69.3% by 2051. All BME populations will increase markedly except for White Irish, which will continue to reduce. Every group besides Other White and Black Caribbean will see their population more than double.

As discussed, these figures need to be interpreted with caution. In 2016 a separate academic unit called ETHPOP (based at the University of Leeds) will be publishing updated ethnic minority population projections for Local Authorities [10]. It is likely that these estimates will represent a more reliable source of future projections than the calculations above.

4.5. National Insurance Number registrations

A further useful source of data in identifying trends in ethnicity is the registration of National Insurance numbers, which provides evidence on the country of origin of new arrivals. Information comes from a Home Office database which provides information on the country of origin for working age applicants. Figure 29 shows a gradual upwards trend in the number of registrations from people entering the country from overseas. The number of overseas nationals applying for work has increased by 164% between 2004/5 (1,657) and 2014/15 (4,368).

In 2002 the majority of overseas registrations were from people outside the EU. Due to changing immigration rules this trend has reversed and since 2010 there has been a wide divergence between these groups. In 2014/15 there were 3,099 EU applicants for National insurance numbers compared to only 1,269 non-EU applicants.

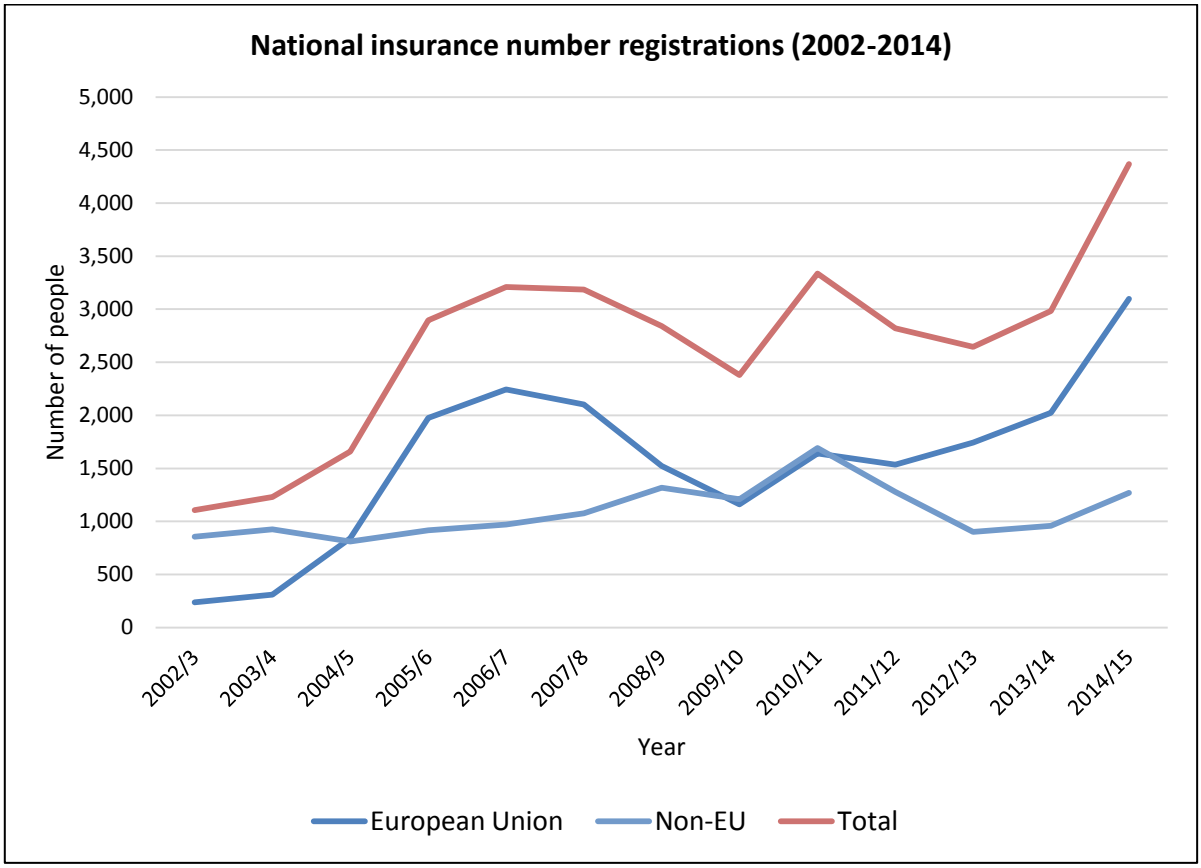


Figure 29: Trends in National insurance number registrations in Salford 2002-2014
Source: Department for Work and Pensions - Stat-Xplore [11]

The region of origin for non-EU applicants in 2014/15 is shown in Figure 30. The largest group of new applicants comes from sub-Saharan Africa (41%), followed by South Asia (16%) and the Middle East and Central Asia (12%).

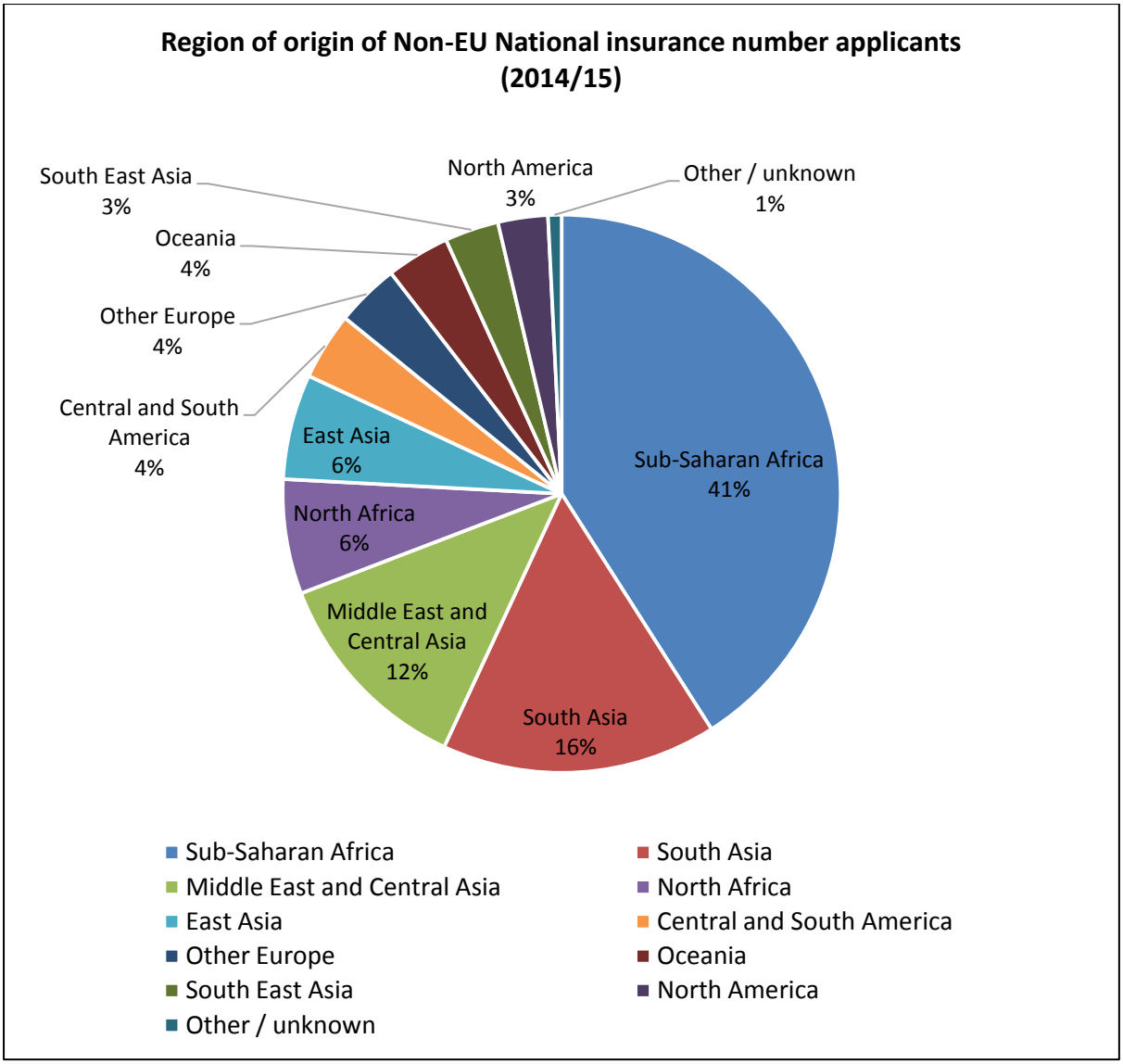


Figure 30: Region of origin of Non-EU National Insurance number registrants in Salford 2014/15
Source: Department for Work and Pensions - Stat-Xplore [11]

4.6. ONS Local Migration Indicators

The Office for National Statistics also provides data on migration. Figure 31 shows that the proportion of Salford residents born overseas has risen from 5.6% in 2004 to 13.4% in 2014, which represents approximately 32,000 residents. This increase has been more rapid than that seen in Greater Manchester or England overall. Indeed over the same period in Greater Manchester the proportion of the population born overseas has only increased by 3.5%, compared with 7.8% in Salford.

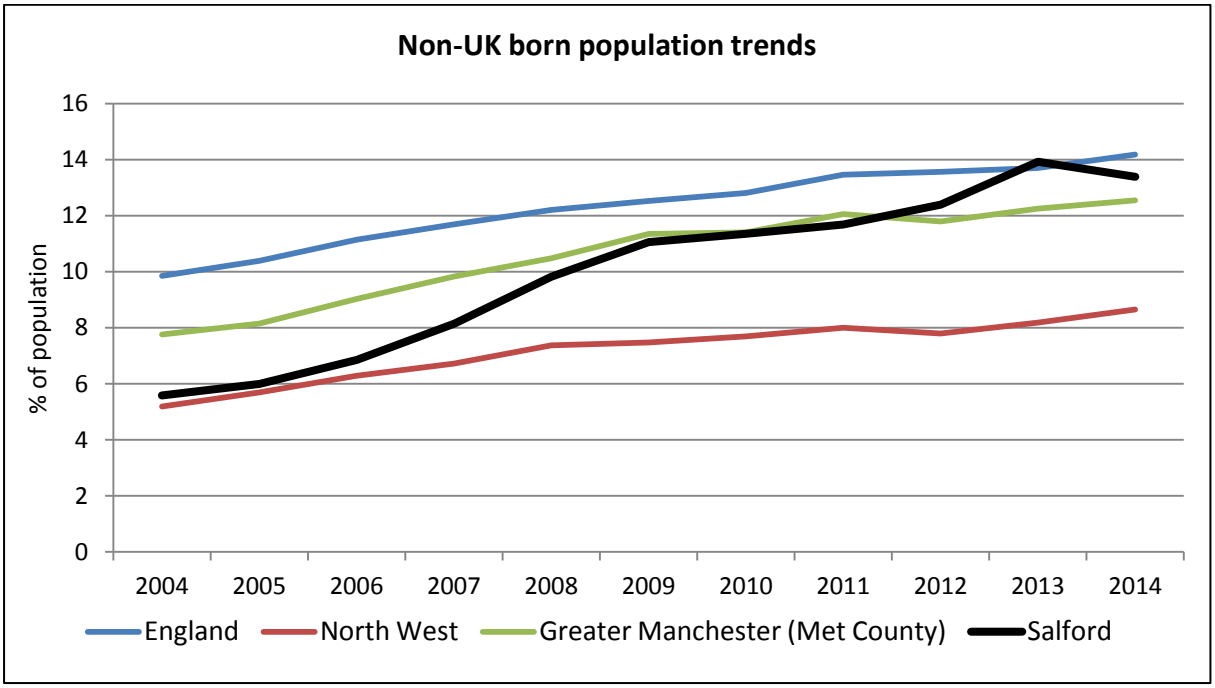


Figure 31: Comparison of regional and national trends in non-UK born population 2004-2014
Source: ONS Local Migration Indicators [12]

The impact of this trend in healthcare services is illustrated in Figure 32 which shows that in 2014 there were 4,128 new GP registrations by Salford residents who have recently arrived in the UK. This figure has increased from 1,933 in 2004.

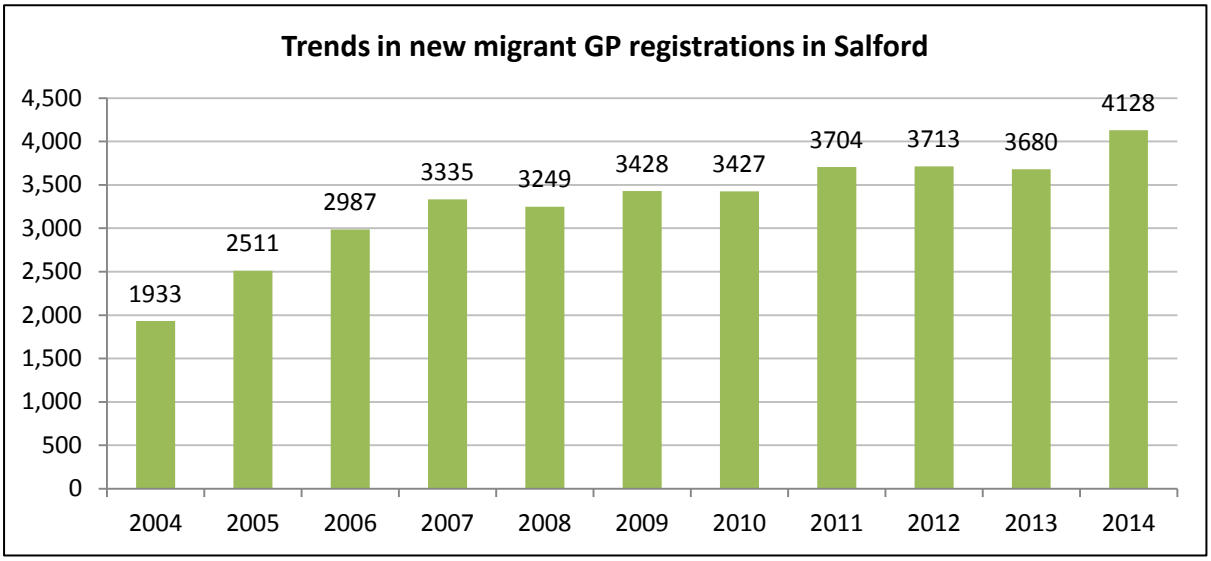


Figure 32: Trends in new migrant GP registrations in Salford 2004-2014 (ONS)
Source: ONS Local Migration Indicators [12]

Finally, Figure 33 shows the proportion of births in Salford to non-UK born mothers. This shows a similar picture to Figure 31 with a much greater increase in these births in Salford than elsewhere. The proportion of births rises from 15.1% in 2005 to 27.7% in 2014.

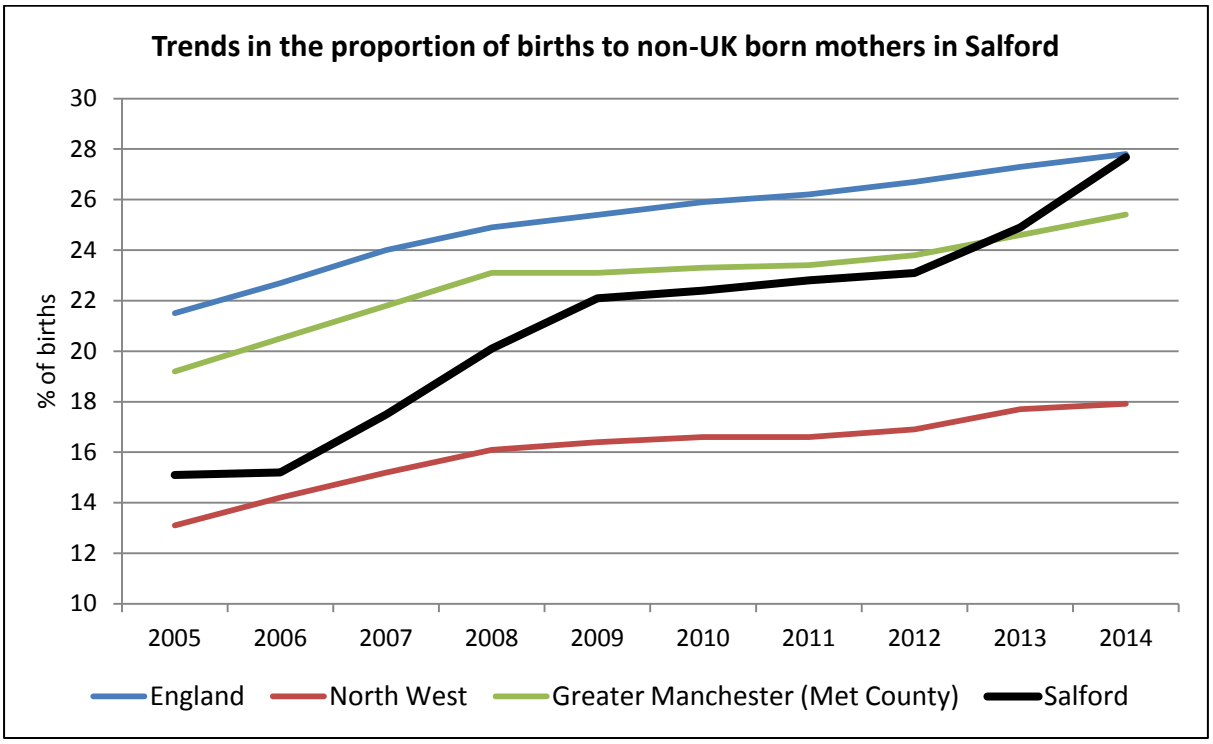


Figure 33: Trends in the proportion of births to non-UK born mothers in Salford 2005-2014 (ONS)
Source: ONS Local Migration Indicators [12]

4.7. UK Border Agency dispersal data

In line with national and regional trends, the number of asylum seekers in Salford (with ongoing claims) has been falling over the last decade, although there has been a slight increase since 2013 from 539 (2013) to 567 (2015). These figures reflect the total population at the end of Quarter 1 each year, rather than an annual total.

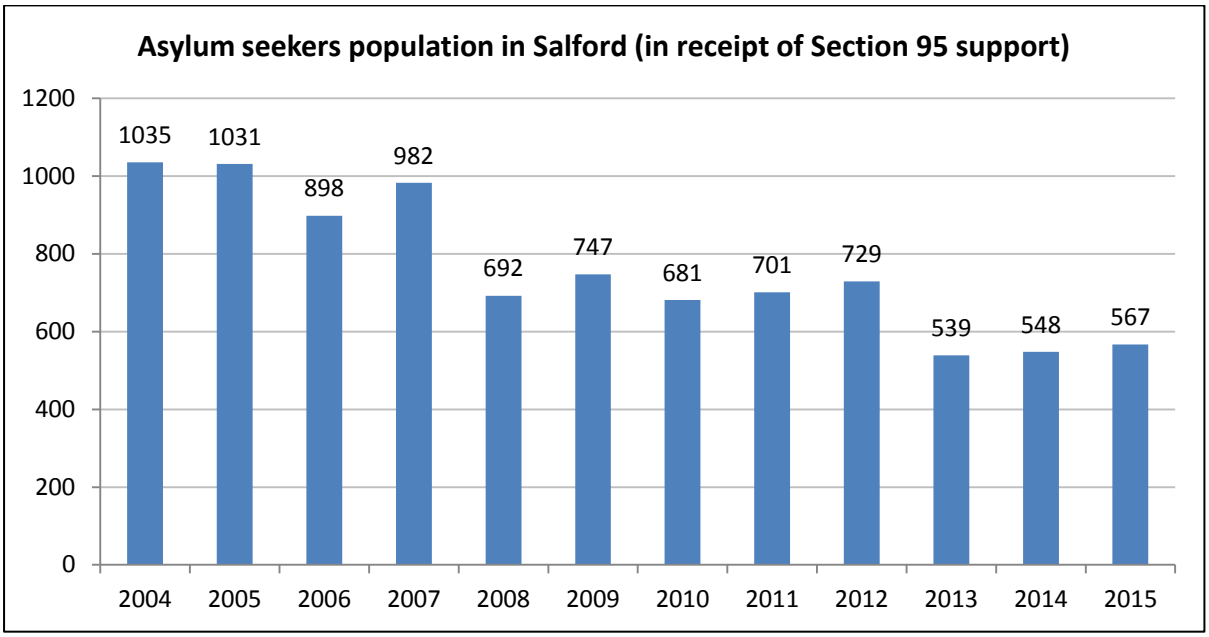


Figure 34: Asylum seeker population in Salford in receipt of Section 95 support (end-Quarter 1)
Source: UK Border Agency [13]

5. NATIONAL EVIDENCE REVIEW

5.1. Life expectancy

Ethnicity is not coded as part of the death registration process. However, a research paper published in 2015 used complex modelling techniques to estimate life expectancy for different ethnic groups based on 2001 Census data. The results are shown in Table 18 and show that, among men, those from Other White populations have the longest life expectancy (77.1 years) and those from the Bangladeshi ethnic group have the shortest (74.2 years). Other White women also have the longest life expectancy (82.9 years), compared with 79.3 years for Pakistani women.

Table 18: Life expectancy at birth by ethnic group (years)

ETHNIC GROUP		Men	Women
WHITE	White British	76.4	80.8
	White Irish	76	82.2
	White Other	77.1	82.9
ASIAN	Indian	76	82.6
	Pakistani	74.2	79.3
	Bangladeshi	73.3	80.1
	Chinese	75.4	81.6
	Other Asian	76.3	82.8
BLACK	Black Caribbean	75	82.7
	Black African	74.6	81.3
	Other Black	74.8	79.9
MIXED	White/Black Caribbean	75.1	79.6
	White/Black African	74.3	81.5
	White/Asian	76.6	81.8
	Other Mixed	75.8	81.4
OTHER		76.2	83
ENGLAND AND WALES AVERAGE		76.4	80.8

Source: Wohland et al. [14]

In addition to total life-expectancy the paper also calculated disability-free life expectancy (DFLE). This is the amount of time an individual can be expected to live free of significant disability. Figure 35 shows the wide variation in this figure in men, according to ethnic group. On average, Bangladeshi men are only expected to have 54.3 years of DFLE compared with 64.7 years for Chinese men.

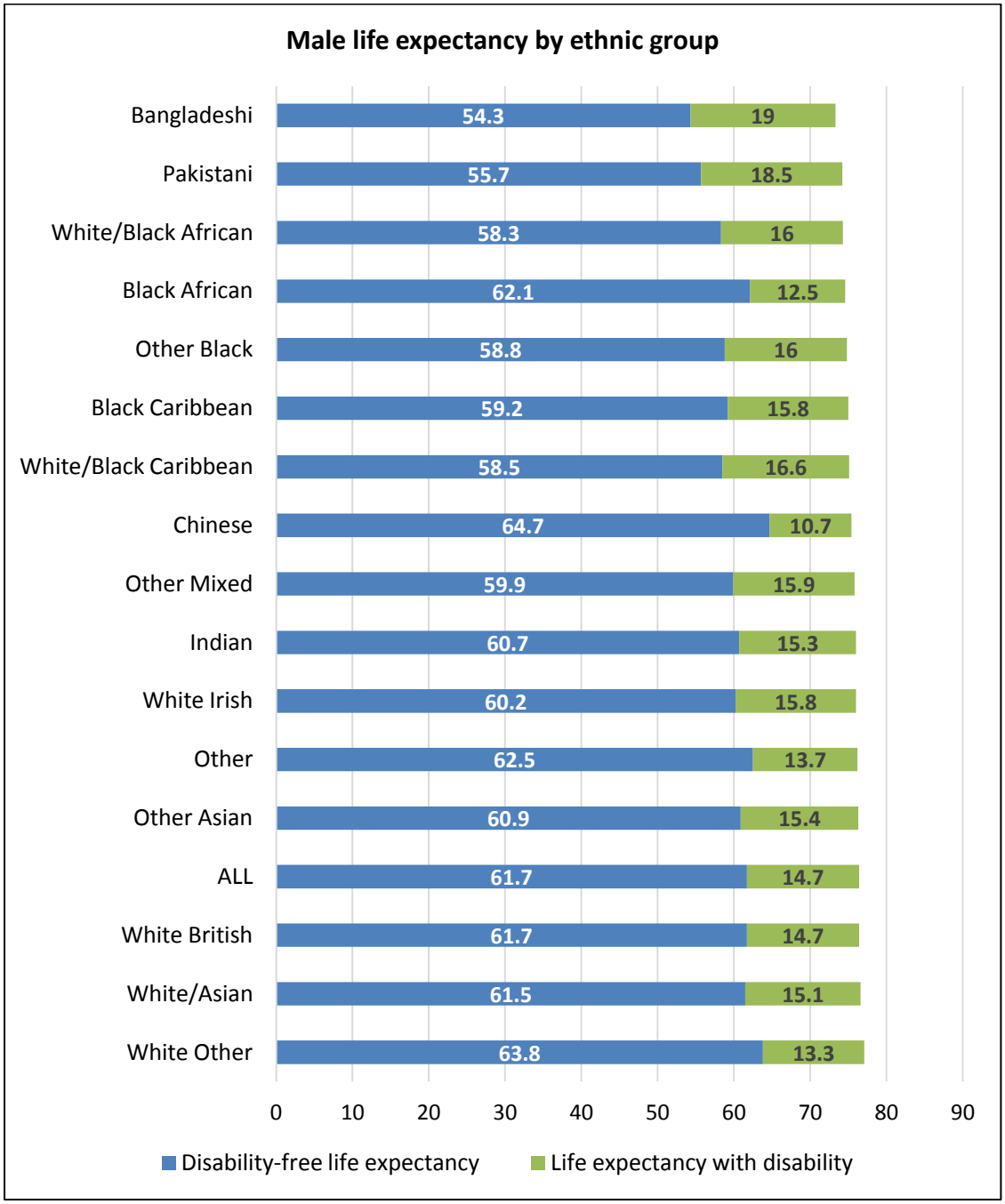


Figure 35: Male life expectancy by ethnic group (including disability-free life expectancy)
Source: Wohland et al. [14]

For women, the variation is even more pronounced. Pakistani women are estimated to have 55.1 years of DFLE, compared with 67 years for Chinese women – a gap of almost 12 years.

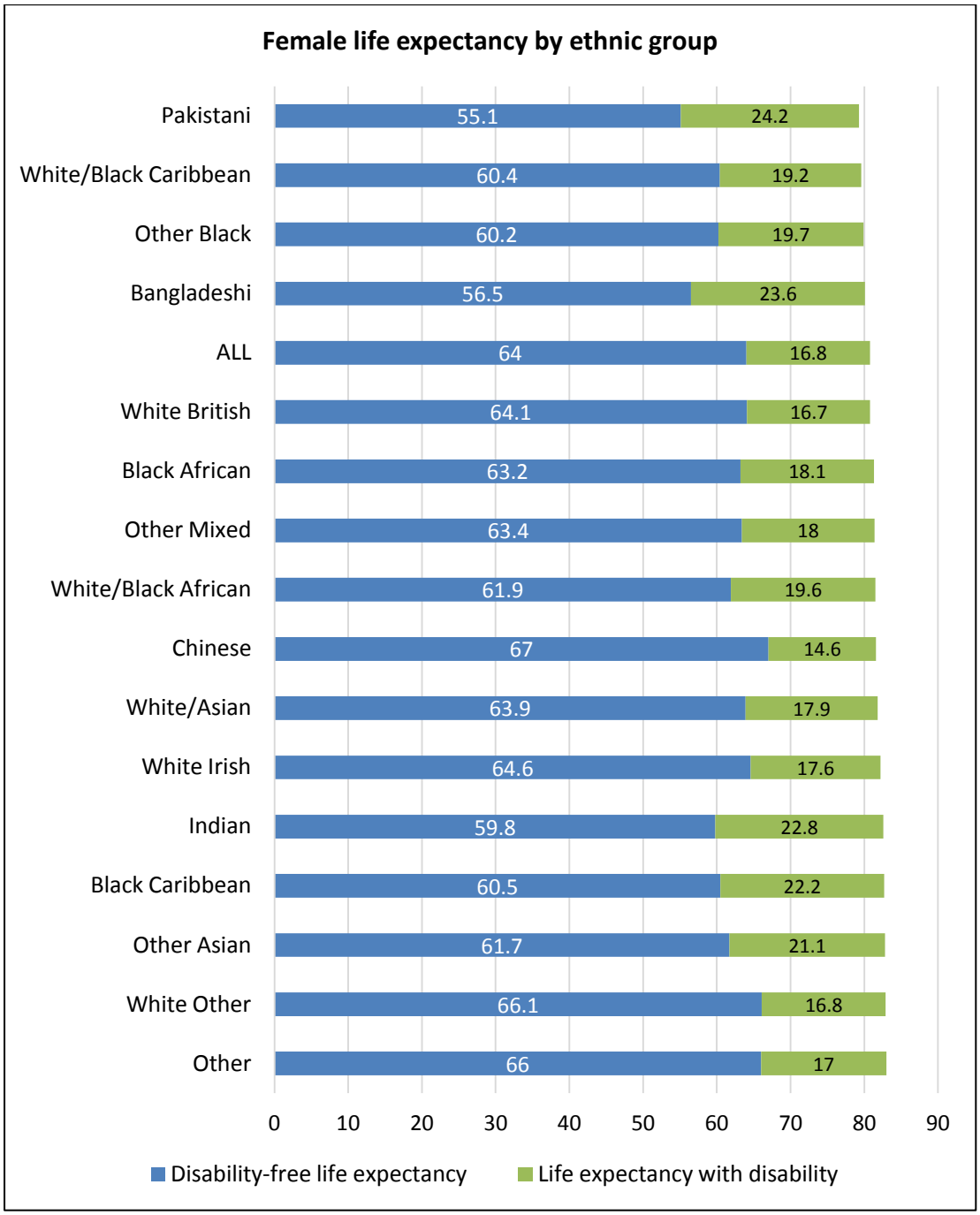


Figure 36: Female life expectancy by ethnic group (including disability-free life expectancy)
Source: Wohland et al. [14]

The study did not contain estimates for the Gypsy / Traveller community. A Parliamentary report in 2012 reviewed the evidence on health outcomes amongst this group and found that life expectancy was consistently 10% lower than the national average [15]. This would give them the shortest life expectancy of any ethnic group.

5.2. General health

The 2011 Census reported data on self-reported health state by ethnic group. Figure 37 shows that the highest rates of good or very good health are seen in Black African (92%), Mixed (90%) and Chinese (90%) ethnic groups. Lowest rates of good health are seen in the Gypsy / Irish Traveller communities (71%), White Irish (72%) and Black Caribbean (77%), with correspondingly high levels of poor health. 1 in 7 people from Gypsy / Irish Traveller background reported bad or very bad health.

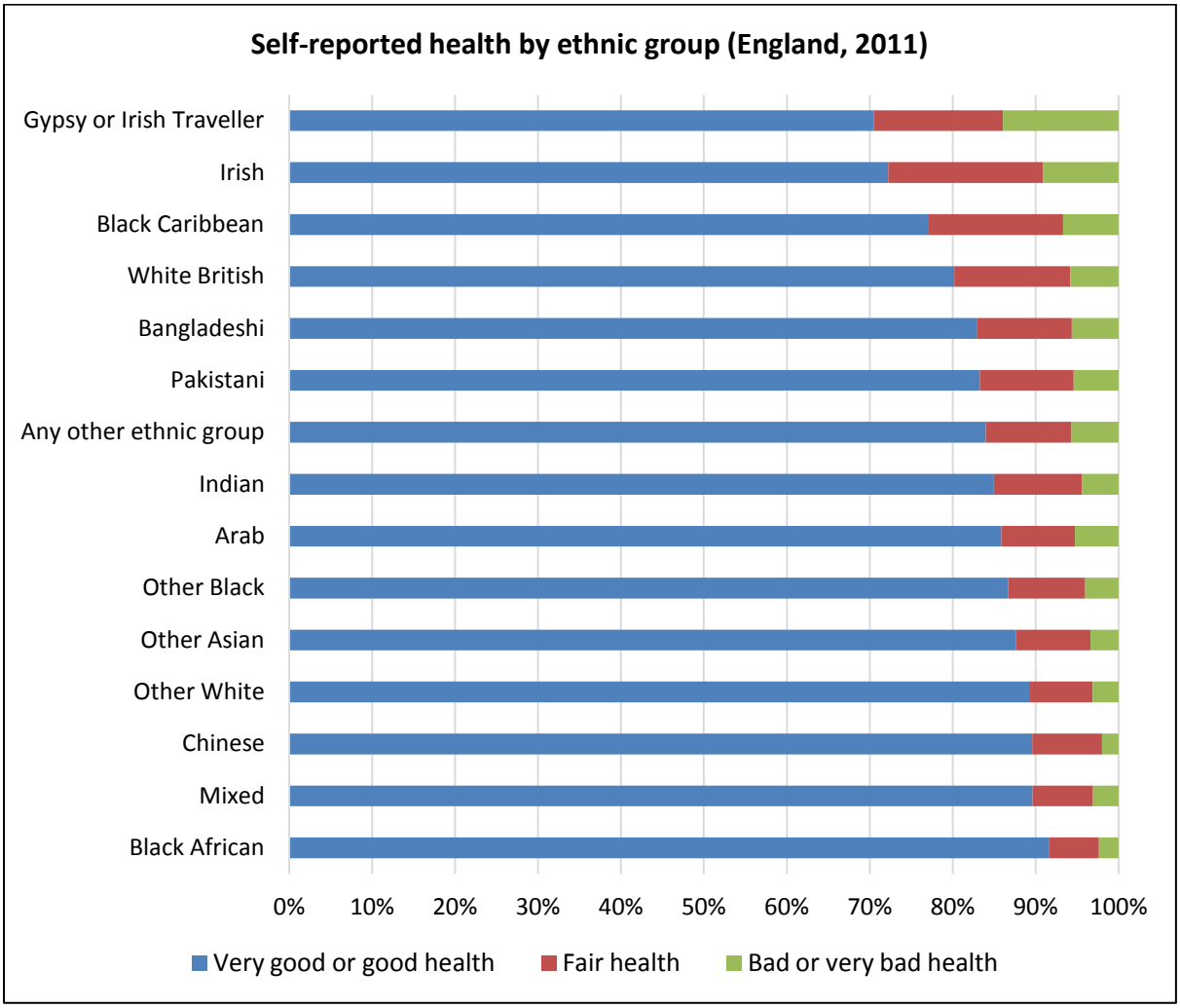


Figure 37: Self-reported health state by ethnic group in England, 2011
Source: Nomis – 2011 Census [7]

The Census also asked respondents about their ability to complete day-to-day activities. Figure 38 again shows the worst outcomes among White Irish and Gypsy / Traveller populations. Chinese, African and Other White populations report the lowest levels of impairment with normal daily activities. More than four times as many White Irish people (26%) report some limitation in their functional ability compared to the rate in the Chinese population (6%).

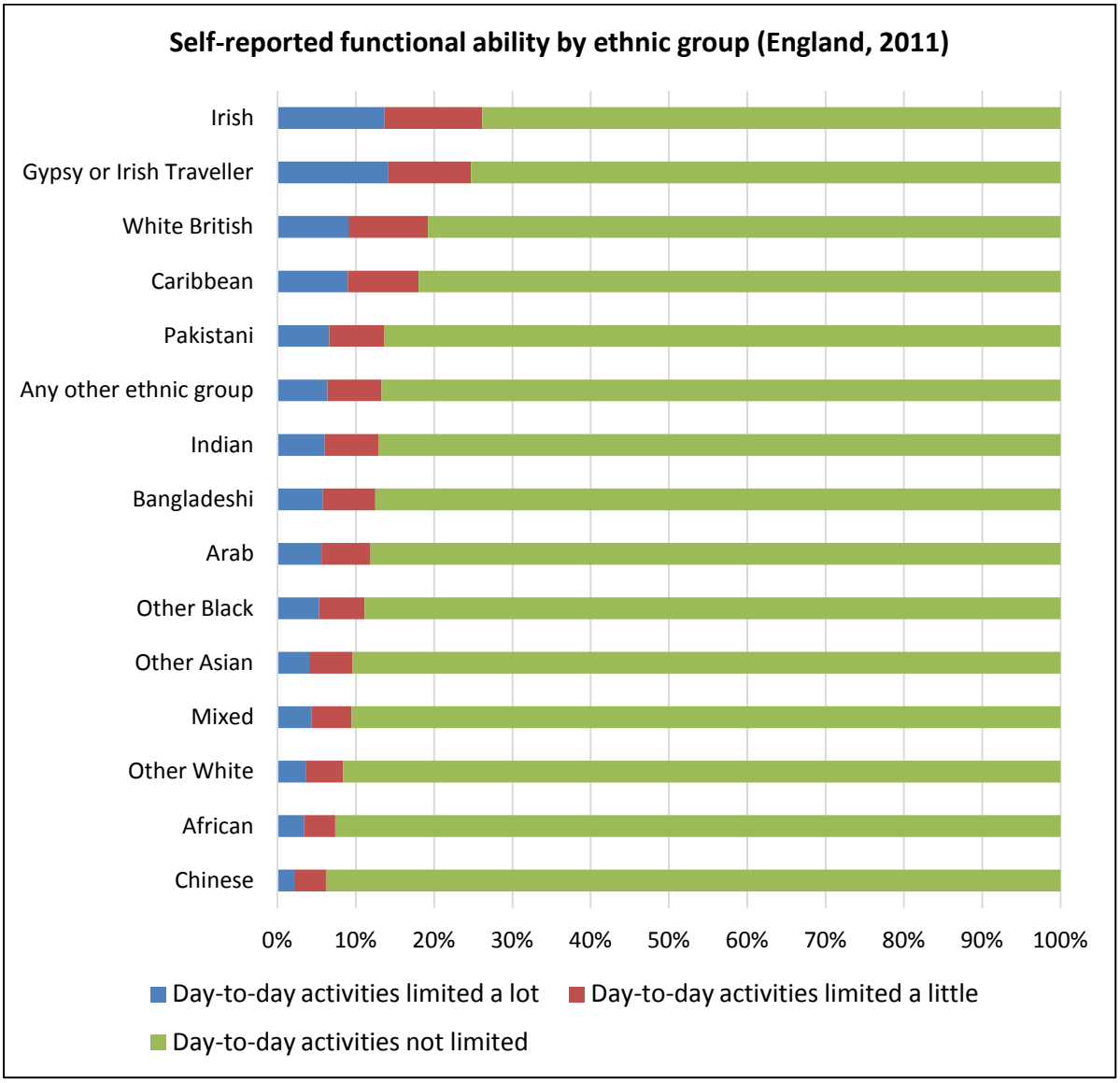


Figure 38: Self-reported functional ability by ethnic group in England, 2011
Source: Nomis – 2011 Census [7]

5.3. Maternal health

A 2014 British study reviewed the case notes of 1,753 women who experienced severe complications in pregnancy[9]. The researchers found that all BME groups studied (except Indian mothers) had a higher risk of severe complications compared with the White population. This difference was statistically significant[10] for all groups except Other Asian and Mixed.

The greatest risk was seen in the Black African population, for whom the odds ratio of severe complications was 1.83. This means that mothers are at 83% increased risk of these complications [16]. Black Caribbean (80% increased risk), Bangladeshi (74% increased risk) and Pakistani mothers (43% increased risk) were the other groups at significantly increased risk. The odds ratios (illustrated in Figure 39) are adjusted for potential confounding factors including anaemia, diabetes and smoking. The authors suggest that it may be appropriate to incorporate ethnicity measures into obstetric risk stratification tools in the future, but there are currently no national recommendations on this.

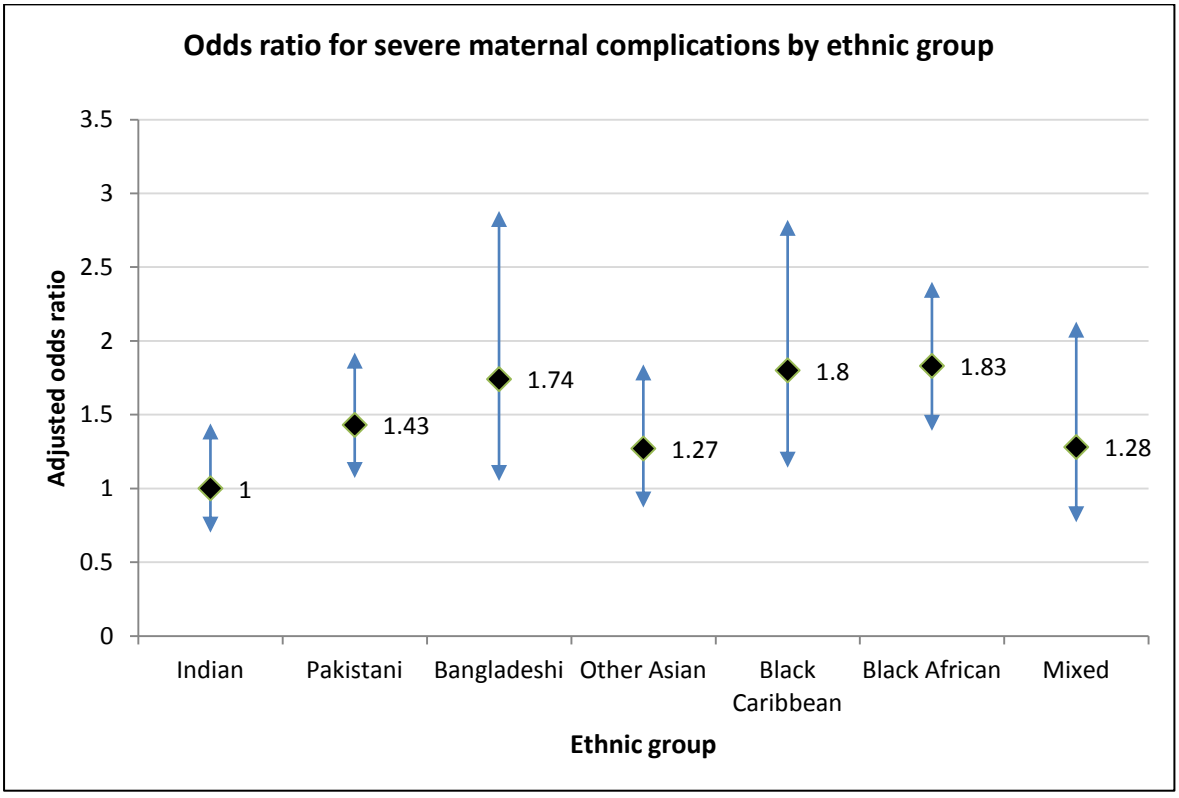


Figure 39: Adjusted odds ratio for severe maternal mortality by ethnic group
Source: Nair et al. [16]

In addition to these ethnic groups there is also evidence that asylum seekers are at significantly increased risk during and after pregnancy. They are three times more likely to die in childbirth and four times more likely to suffer with postnatal depression [17].

[9] Including pulmonary embolism, stroke, sepsis and eclampsia
[10] The confidence intervals (denoted by the arrows) do not cross 1 for the statistically significant associations

5.4. Child health

There are variations in both neonatal and infant mortality rates according to ethnic group based on ONS data for England and Wales between 2007 and 2012. Neonatal mortality rates (deaths between 0 and 28 days following delivery) in Black Caribbean (5.2 per 1,000 live births), Pakistani (4.5/1,000) and Black African (4.5/1,000) groups are more than double the rates of White British (2.4/1,000) and Other White (2.0) populations.

A similar pattern is seen in infant mortality rates with rates highest in Pakistani (6.8/1,000), Black Caribbean (6.7/1,000) and Black African (6.4/1,000) groups and lowest in White British (3.4/1,000) and White Other (2.7/1,000) groups. The Gypsy / Traveller community (not included in these figures) is also thought to have excess rates of miscarriages, stillbirth, neonatal deaths and deaths of older children [18].The explanation for these trends are complex but socioeconomic deprivation is likely to play a significant explanatory role.

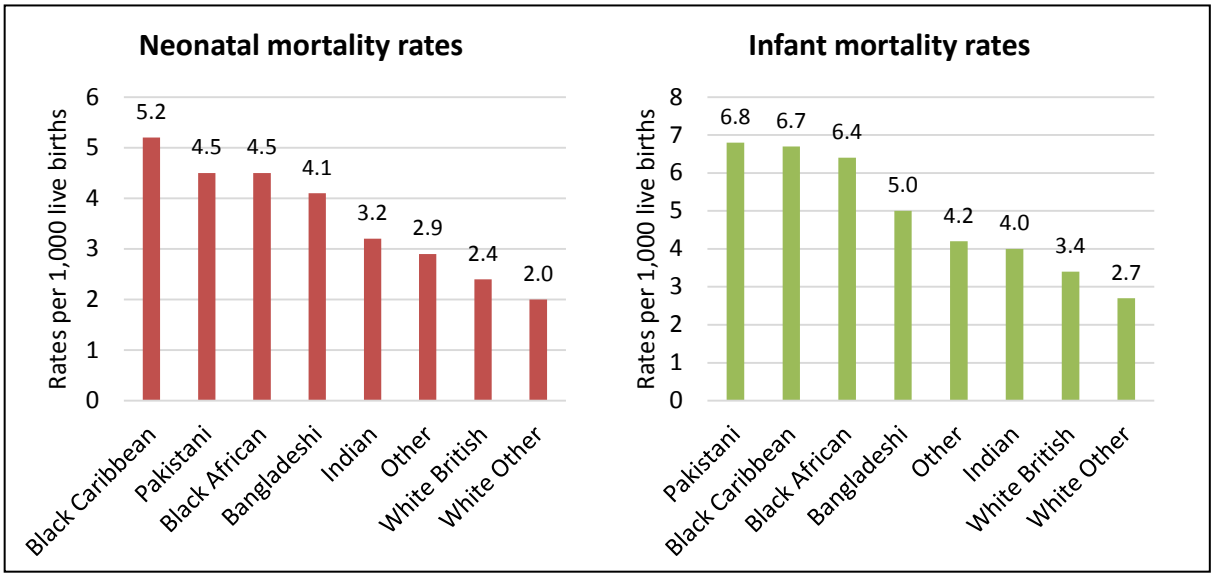


Figure 40: Neonatal and infant mortality rates, 2007-2012 by ethnic group
Source: ONS [19]

There are also ethnic differences in the causes of infant deaths [Table 19]. Congenital anomalies account for a noticeably larger proportion of infant deaths in Asian populations than other groups. Black populations appear more susceptible to immaturity related conditions and infections while sudden infant deaths appear relatively more common in White populations.

Table 19: Causes of infant deaths by ethnic group (England and Wales, 2013)

ONS Cause groups	All	Asian	Black	White	Other [11]	Not stated
Congenital anomalies	28.1%	41.3%	24.2%	25.4%	27.8%	31.0%
Antepartum infections	2.4%	1.0%	3.5%	2.3%	3.8%	3.5%
Immaturity related conditions	43.8%	39.3%	53.3%	43.7%	42.1%	45.1%
Asphyxia, anoxia or trauma (intrapartum)	7.1%	6.1%	5.3%	8.0%	5.7%	4.2%
External conditions	1.5%	1.0%	1.3%	1.4%	3.3%	1.4%
Infections	3.8%	3.3%	5.3%	3.8%	3.8%	2.1%
Other specific conditions	1.6%	0.5%	0.4%	2.0%	1.4%	2.8%
Sudden infant deaths	5.1%	2.3%	2.6%	6.5%	5.3%	1.4%
Other conditions	6.5%	5.1%	4.0%	7.1%	6.7%	8.5%

Source: ONS [20]

Uptake of routine childhood vaccinations is noticeably lower in areas with relatively high Muslim populations and with relatively high overall BME populations, according to a 2016 Public Health England report [21]. There is also evidence for relatively low uptake of vaccinations in Gypsy/Traveller and Orthodox Jewish communities [18, 22].

A recent review by Salford City Council considered the primary care provision for the Orthodox Jewish population. It found that the GP practices with a high proportion of Jewish patients (80% of the list) had relatively low uptake of routine childhood vaccinations [23]. The recent Salford Jewish Community Health Research Report found that, among those with children yet to be vaccinated, 74% of parents stated they were very likely to immunise, 12.5% likely, 8.6% unlikely and 4.7% said they would definitely not immunise [24].

[11] Includes Mixed, Chinese and Any Other ethnic groups

5.5. Lifestyle factors

The latest available national data on many lifestyle factors (and other health outcomes) for different ethnic groups comes from the Health Survey for England (HSE) in 2004. This is an annual survey which collects data on self-reported health and takes a number of measurements including weight and blood pressure. In 2004 it was conducted with a 'boost' sample from BME groups in order to have sufficient numbers to describe trends within these populations. This has not been repeated since and so remains the most reliable source for making comparisons between ethnic groups for various health topics.

5.5.1. Smoking

According to HSE 2004 data, smoking rates among men in the Bangladeshi community are 40%, markedly higher than in women (2%). Rates in Irish (30%), Pakistani (29%) and Black Caribbean (25%) men are also higher than the average for England, with the lowest rates seen in Indian men. Among women the highest rates are reported among Irish (26%) and Black Caribbean (24%) women. Data on smoking cessation is limited by inadequate coding of ethnicity [5].

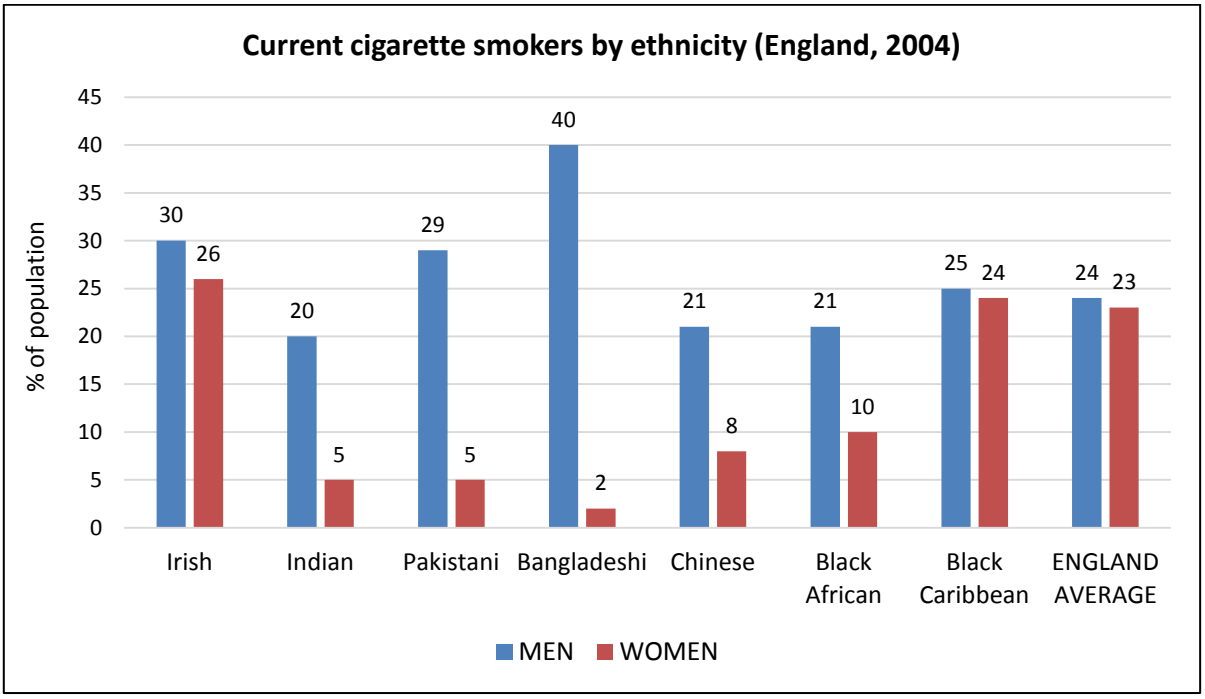


Figure 41: Smoking prevalence in BME communities by sex
Source: Health Survey for England 2004 [25]

5.5.2. Alcohol

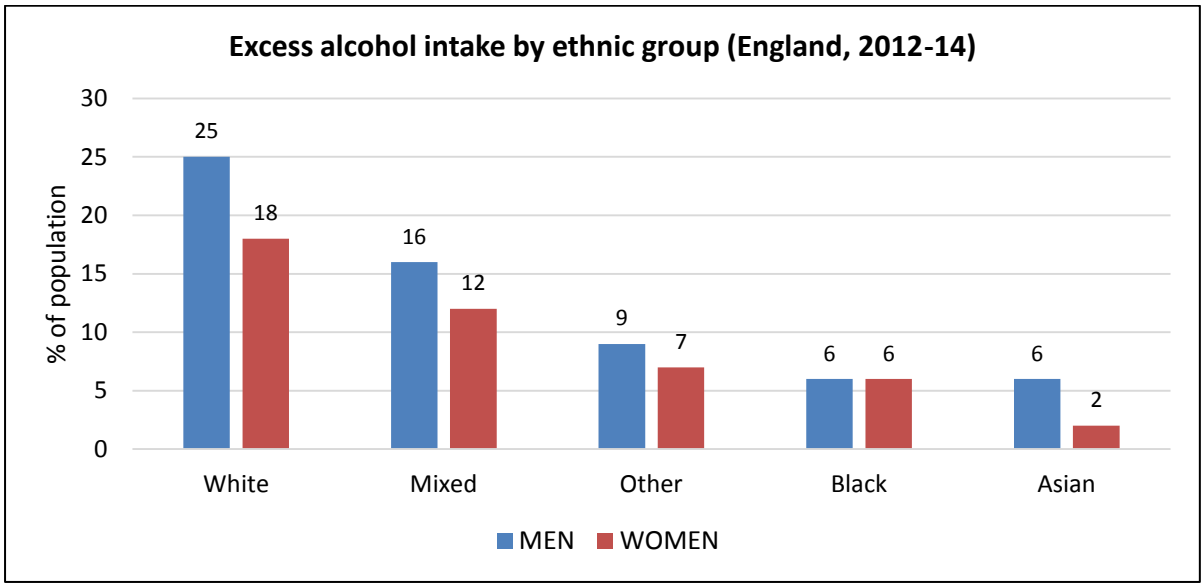


Figure 42 shows the rates of excess alcohol intake by ethnic group based on Health Survey for England pooled data from 2012-2014. This found that excess alcohol intake (at the time defined as >21 units for men and >14 units for women) was highest among the White population for both men (25%) and women (19%). Rates of alcohol excess were lowest in Black and Asian men (6%) and particularly low in Asian women (2%).

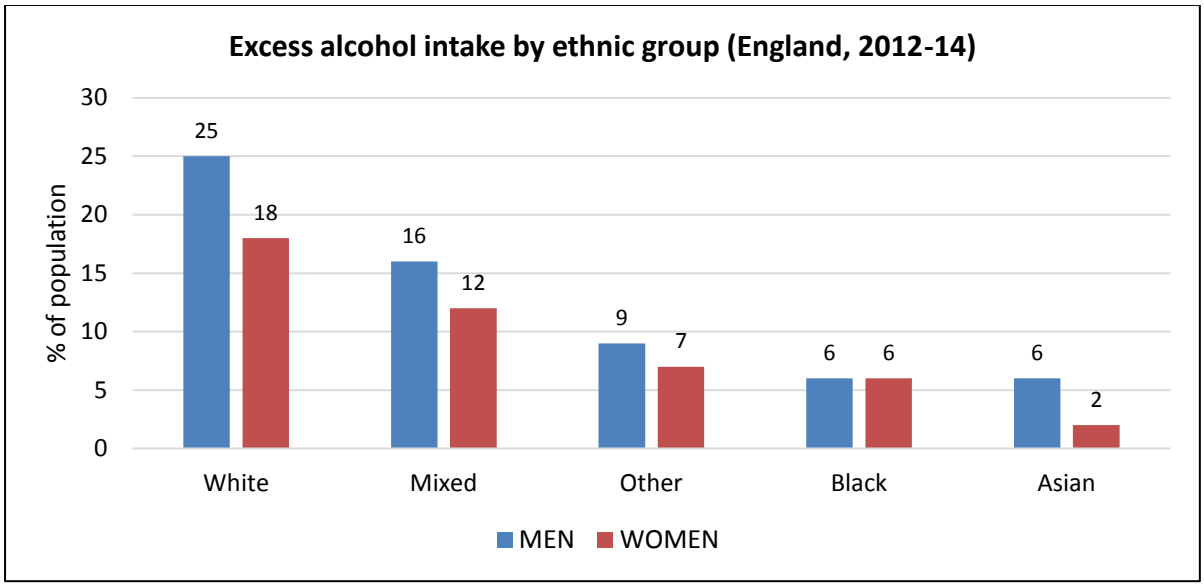


Figure 42: Prevalence of excess alcohol intake by major ethnic group and sex
Source: Health Survey for England 2014 [26]

HSE 2004 reported data on minor ethnic groups and found that excess alcohol intake in men (drinking at least 5 days each week) was more common in Black Caribbean (15%) than Black African populations (8%). Among Asian populations rates were higher in Indian (10%) than Pakistani (1%) or Bangladeshi (0%) populations. Similar relationships were also seen for women. Rates of treatment for substance misuse are lowest in Asian populations and highest in the Mixed ethnic group [5].

5.5.3. Physical activity

HSE 2004 also reported data on physical activity levels (Figure 43). Among men the highest rates of physical inactivity (defined as less than 30mins of moderate or vigorous activity per week) are in the Pakistani (51%) and Bangladeshi (51%) communities. Women from the Bangladeshi (68%) and Pakistani (52%) communities have the lowest levels of physical activity. Irish women are the only BME group with inactivity rates greater than the average value for England.

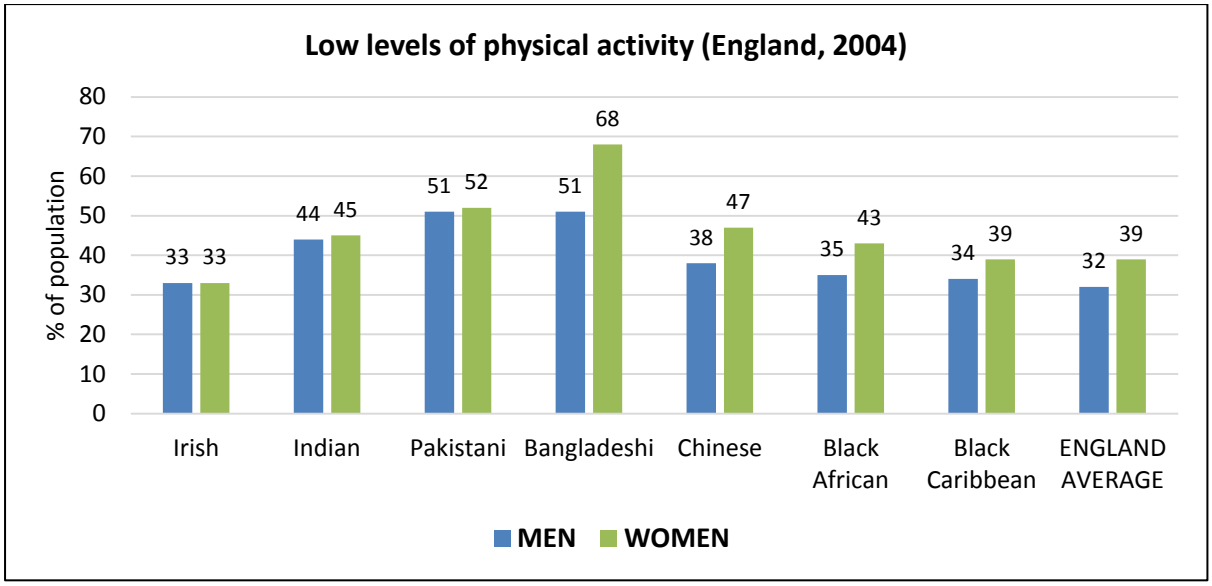


Figure 43: Prevalence of low levels of physical activity by ethnic group
Source: Health Survey for England 2004 [25]

In terms of the type of physical evidence undertake, there is also evidence from a Natural England report that people from BME backgrounds are less likely to make use of green outdoor spaces [27].

5.5.4. Diet

Regarding diet, Figure 44 shows that the Chinese ethnic group have the highest average number of daily fruit and vegetable portions for both men (4.4) and women (4.9). However, all groups are above the average intake for England, apart from Bangladeshi women who eat an average of 3.6 portions per day, the same as the national average.

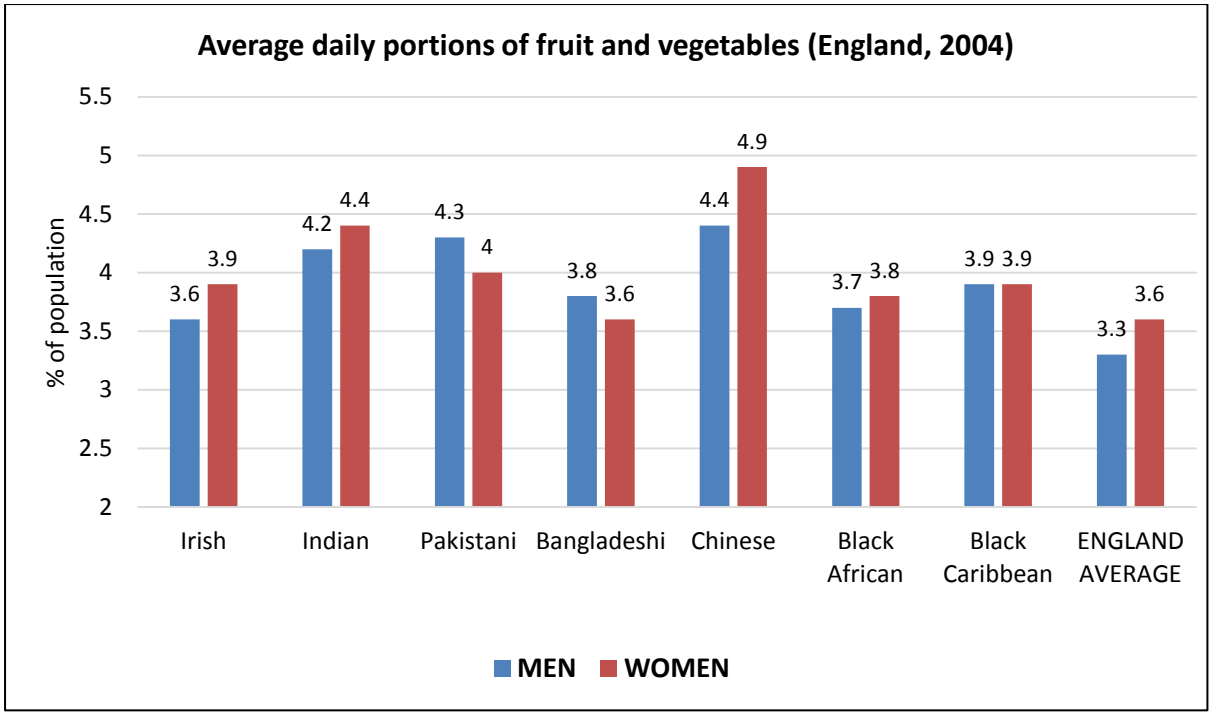


Figure 44: Average daily intake of fruit and vegetables by ethnic group [25]
Source: Health Survey for England 2004 [25]

In terms of fat intake, Figure 45 shows that men in all BME communities report having, on average, lower fat levels in their diets than the national average. Particular high rates of low fat intake are seen among Indian men (89%), Chinese men (86%) and Black African men (86%). Among women the lowest fat intake is seen among Indian women (94%) and Black Caribbean women (89%). By contrast, Black African women have relatively more fat in their diet than the national average.

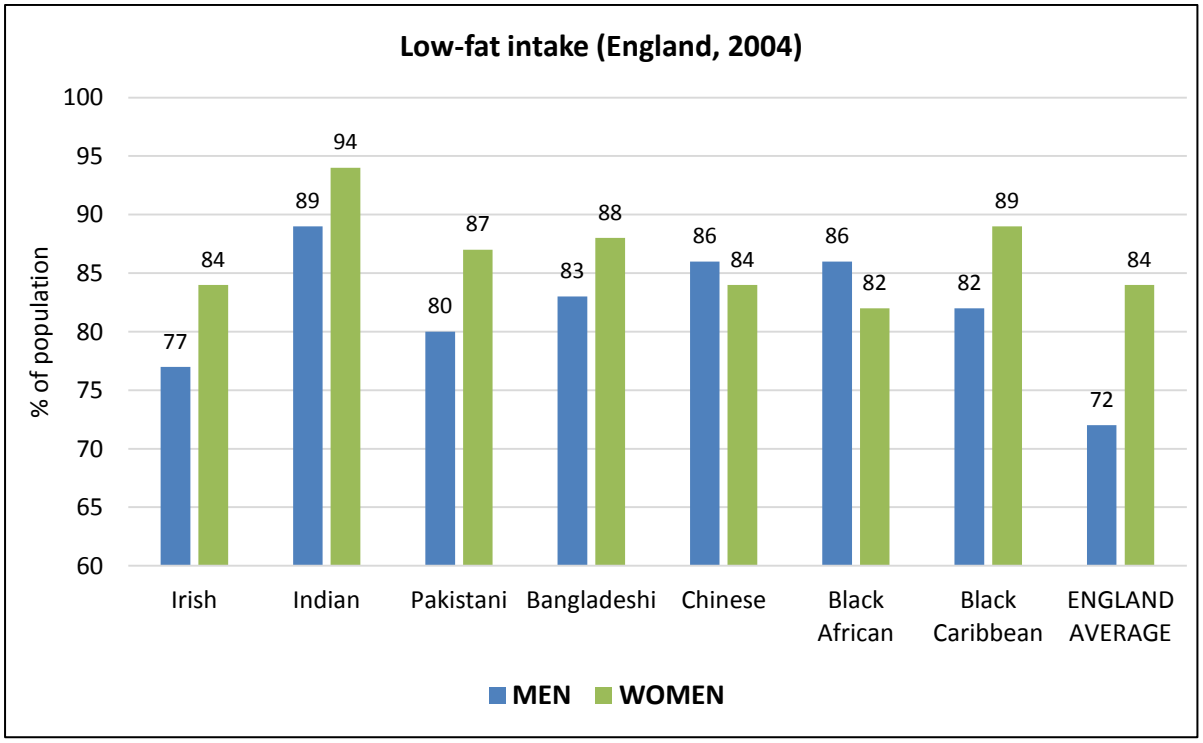


Figure 45: Proportion of population reporting low fat intake by ethnic group
Source: Health Survey for England 2004 [25]

5.6. Weight

The prevalence of obesity varies significantly by ethnic group. Figure 46 shows data compiled by Public Health England summarising data from the 2006-2010 Health Surveys for England. It shows that male obesity rates are highest among members of the White (18.8%) and Black Caribbean (20.9%) ethnic groups and lowest in the Bangladeshi (11.5%) and Pakistani ethnic groups. Female rates are higher than male rates in all groups except Indian, Irish and White populations and are highest in Black African women (31.6%) and Pakistani women (26.2%).

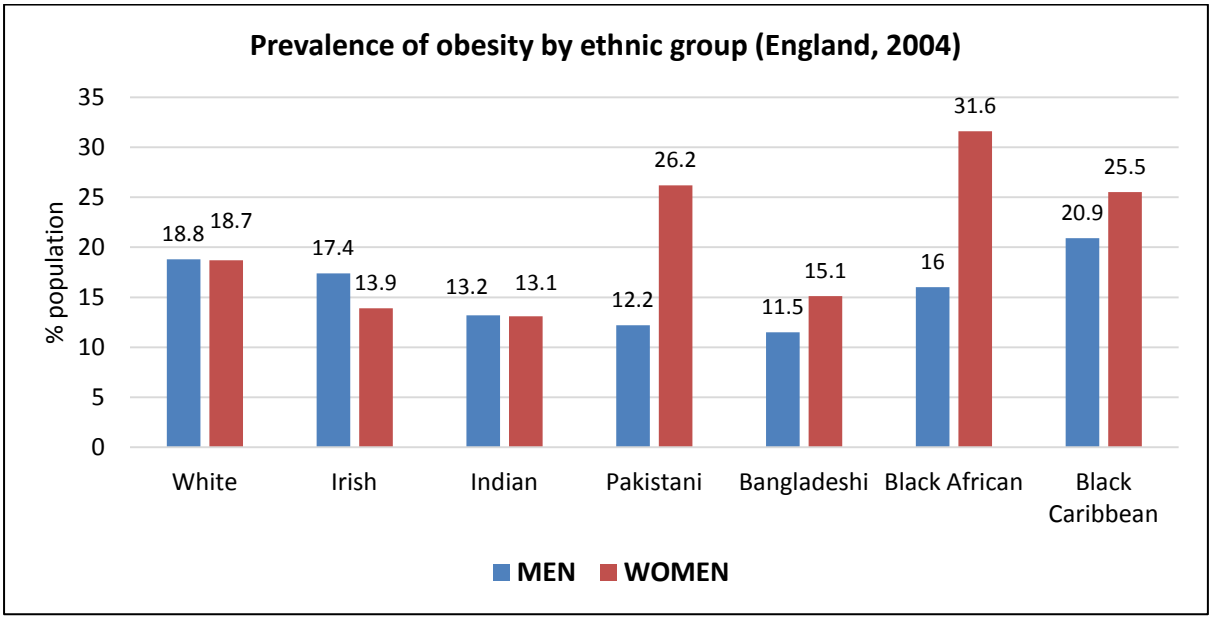


Figure 46: Age-adjusted 16+ obesity prevalence by ethnic group
Source: Public Health England [28]

The latest data on childhood obesity (Figure 47) shows that obesity prevalence is greatest among Black children in both Reception (14.7%) and Year 5 (27.9%). Rates in Asian children at both ages are also higher than those in White children.

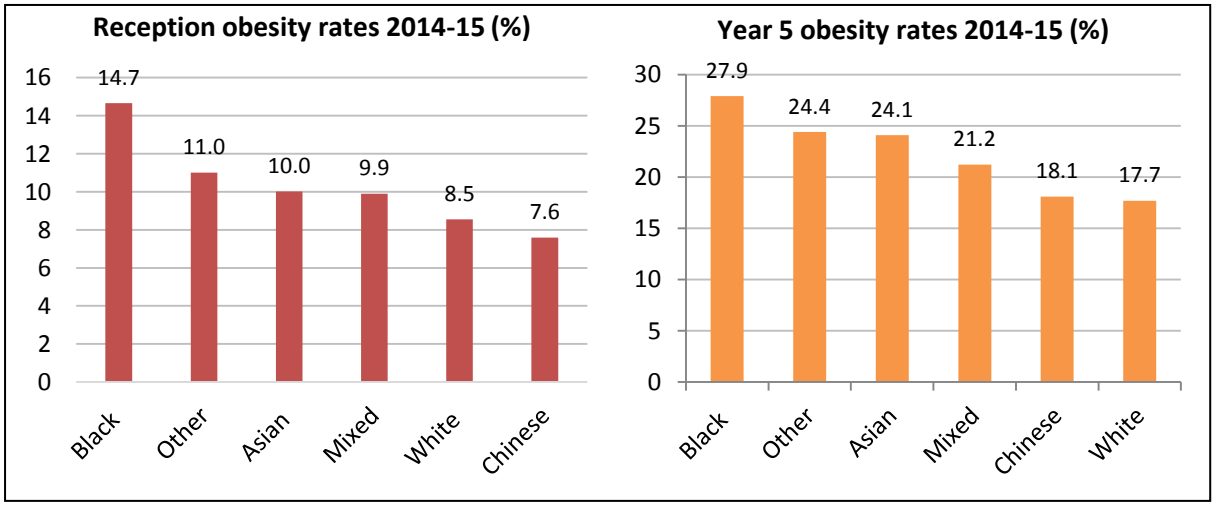


Figure 47: National childhood obesity in Reception and Year 5 by ethnic group
Source: Public Health England [29]

Obesity rates are significant because obesity is a major risk factor for many diseases including cardiovascular disease and some forms of cancer. There is evidence that the relationship between body mass and cardiovascular disease may vary between ethnic groups. Specifically, research has found that Asian populations (including Chinese) develop an increased risk of cardiovascular disease at a lower BMI than other populations [30].

Within this group, it is thought that South Asian people being more likely to accumulate fat around the abdomen and waist. Fat in these areas is felt to be more significant and is also associated with insulin resistance and diabetes. In addition to this they also normally have a higher proportion of body fat at a given BMI [31].

As a result of this evidence, in 2013 NICE recommended using alternative cut-off rates in Asian populations to assess risk of developing type 2 diabetes. They recommend that the healthy BMI range for people of South Asian, Chinese, Black African or Black Caribbean descent is likely to be between 18.5 to 22.9 km/m^2 (compared to 18.5 to 24.9 in other groups) but that the evidence is not yet strong enough to make a recommendation on changing existing weight categories for classifying levels of overweight and obesity [31, 32].

However, they do recommend the use of different thresholds for people of South Asian, Chinese, Black African or Black Caribbean descent when assessing the risk of developing type 2 diabetes (and therefore the point at which to offer interventions) as shown in Table 20:

Table 20: NICE guidance on BMI thresholds for risk of diabetes

DIABETES RISK	ETHNIC GROUP	
	Asian / Black	White / Other
Increased risk	23-27.5	25-30
High risk	≥27.5	≥30

Source: NICE [31]

Reflecting this evidence, ethnicity is included as a domain in common diabetes risk stratification tools including the Diabetes UK risk stratification tool (currently being used as part of the diabetes prevention programme trial in Salford) and QDiabetes. For the Diabetes UK tool, extra weighting is then applied to anyone reporting an ethnicity other than White European.

At a national level there are also variations in the rates of underweight children according to ethnicity. Figure 48 shows that the rates of underweight children from BME groups in Reception are significantly higher[12] than the White group, except for the children of Chinese ethnicity. The highest rates of underweight are seen in children from Asian backgrounds (3.7%). The pattern changes by Year 6, by which time it is only the Asian, Chinese and Other groups which remain significantly higher than the White group (Figure 49).

[12] This is because the lower 95% confidence intervals for these groups does not overlap with the confidence interval range for the White group, meaning we can be 95% confident that there is a true difference between these rates.

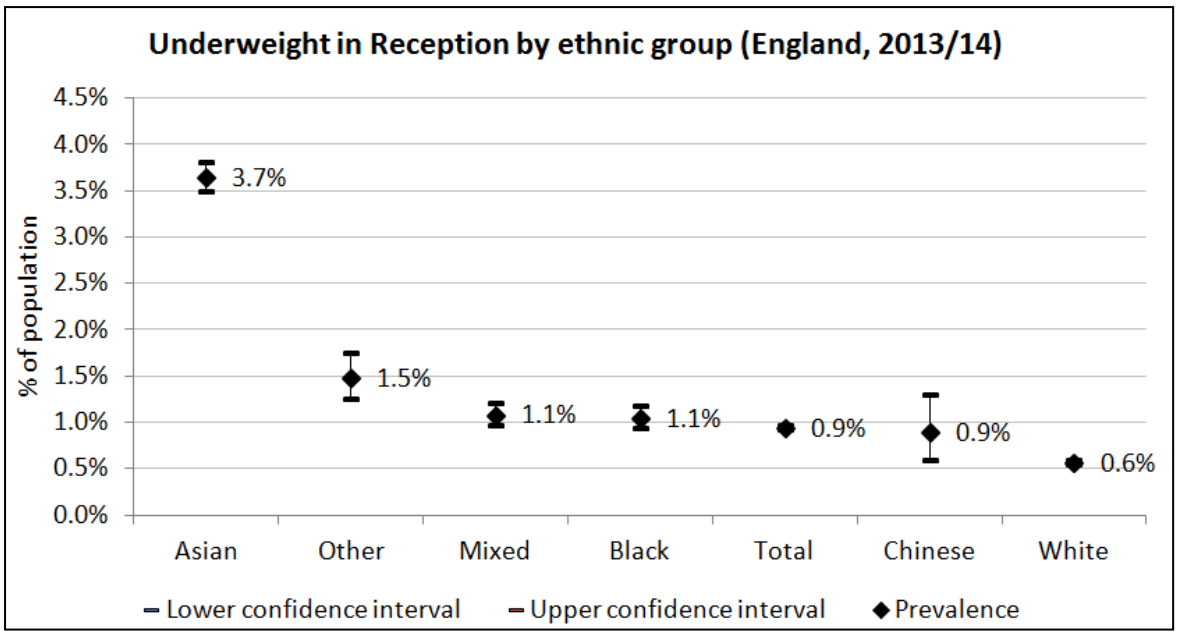


Figure 48: Prevalence of underweight in Reception by ethnic group in England with 95% confidence intervals (2013/14)
Source: NCMP [33]

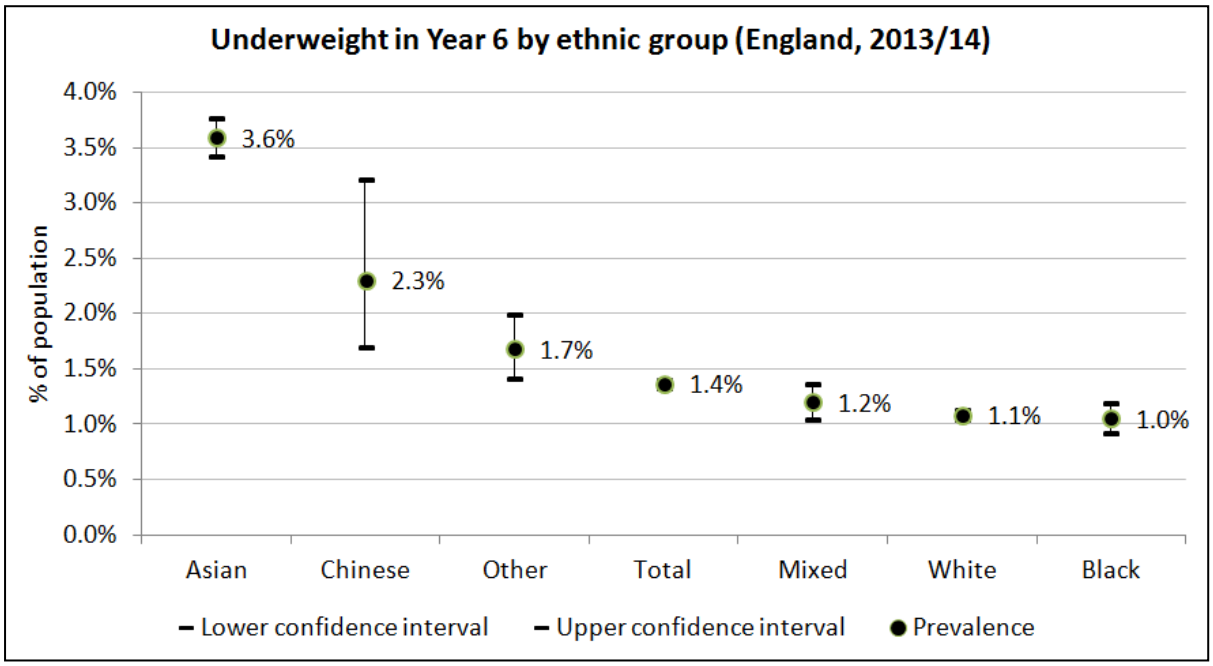


Figure 49: Prevalence of underweight in Year 6 by ethnic group in England with 95% confidence intervals (2013/14)
Source: NCMP [33]

5.7. Cardiovascular health

The risk of Coronary Heart Disease and associated hospital admissions is higher among Pakistani, Bangladeshi and Indian groups [5, 34, 35]. By contrast, Black populations have relatively high rates of stroke and relatively low rates of coronary heart disease. The Heath Survey for England 2004 did not report prevalence data for Black African populations on heart attack and stroke, but other evidence suggests that, compared with a European population, they are at increased risk of hypertension and stroke and reduced risk of overall coronary heart disease [36].

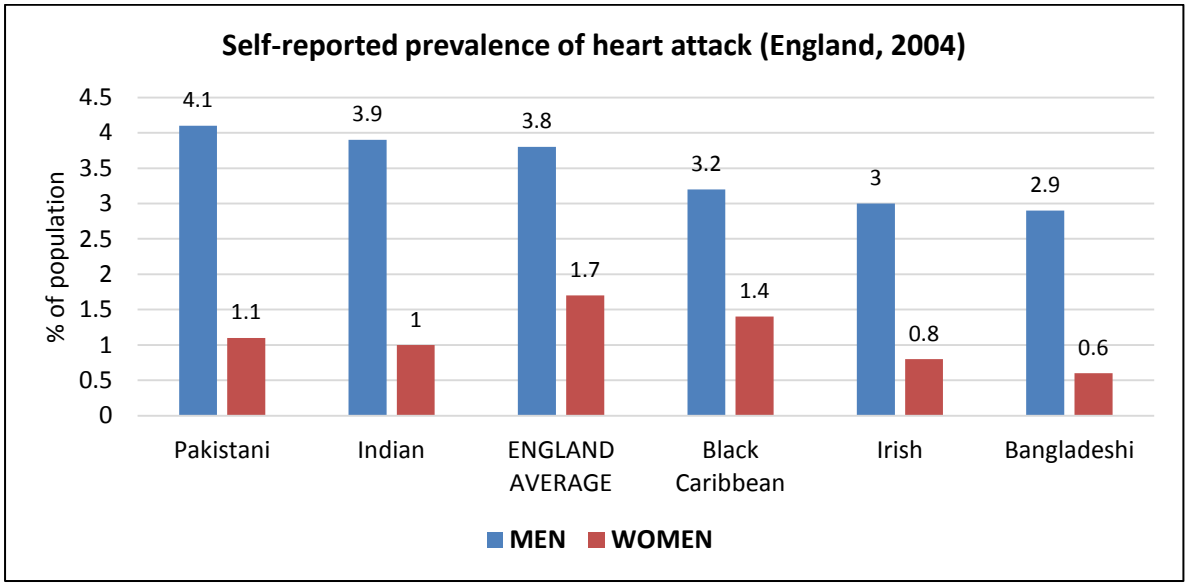


Figure 50: Self-reported prevalence of heart attack by ethnic group and sex in England
Source: Health Survey for England 2004 [25]

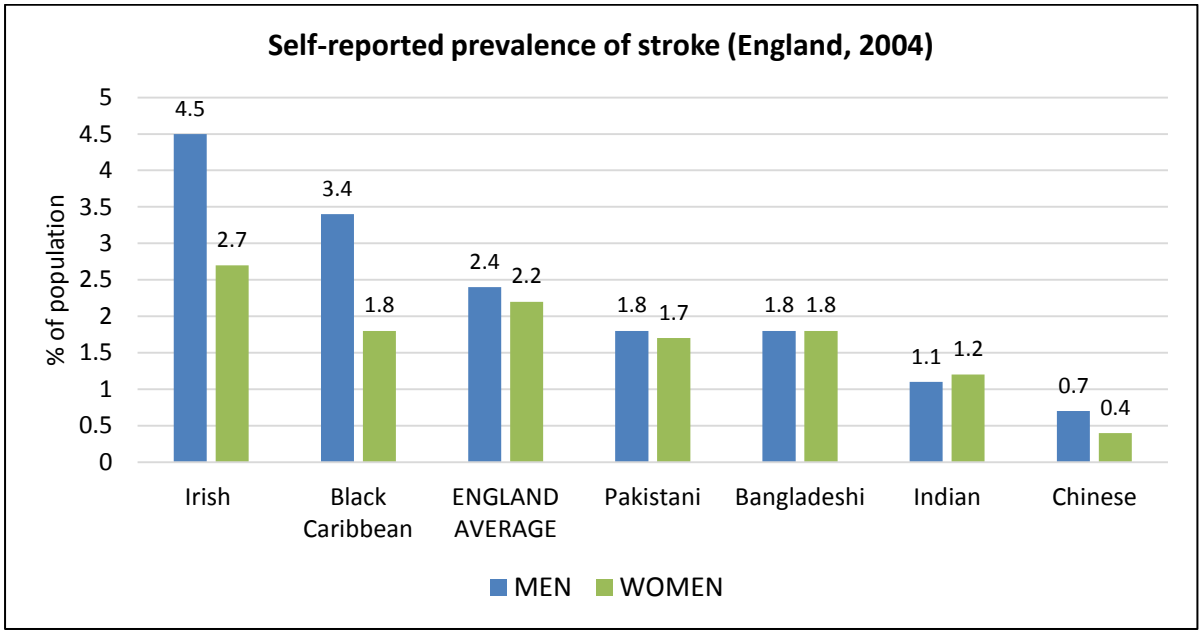


Figure 51: Self-reported prevalence of stroke by ethnic group and sex in England (Source: HSE 2004)
Source: Health Survey for England 2004 [25]

Blood pressure (BP) is a major risk factor for the development of cardiovascular disease. Figure 52 is based on data collected during the 2004 Health Survey for England and displays the average systolic BP according to ethnic group and sex. Irish and Black Caribbean men have slightly raised BP compared to the England average, but these differences are not statistically significant. BP values for all other groups are below the England average. This suggests that other factors including weight and diet may be more influential in explaining the differences in cardiovascular outcomes seen between ethnic groups.

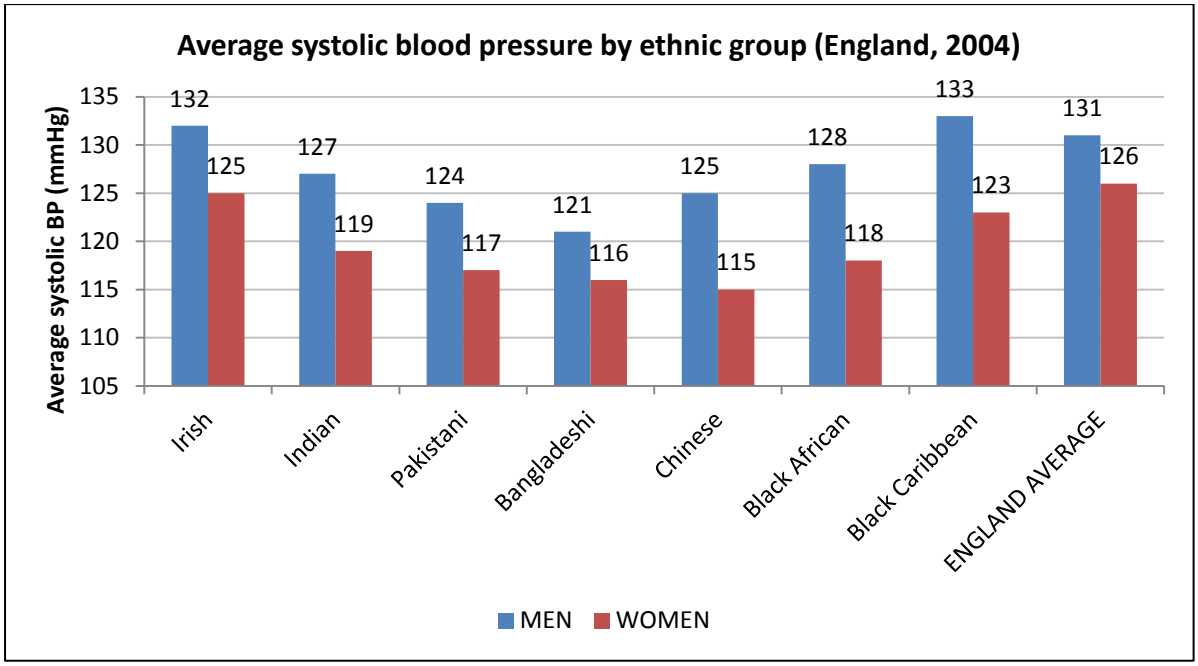


Figure 52: Average systolic blood pressure by ethnic group
Source: Health Survey for England 2004 [25]

Reasons for the variation in cardiovascular risk between ethnic groups are complex and are likely due to a combination of genetic and lifestyle factors. For example, South Asian populations have been found to have smaller LDL particles (a form of cholesterol). This form of LDL is more likely to promote atheroma formation in coronary arteries, increasing the risk of coronary heart disease [37].

5.8. Diabetes

The HSE 2004 also demonstrated significant variations in diabetes prevalence by ethnic group. The prevalence values are likely to have increased since then due to the rising prevalence of diabetes in society, however it is probable that the differences seen between groups in 2004 are still accurate, as they are consistent with other findings on the link between diabetes and ethnicity. Self-reported diabetes prevalence in men is highest Indian (10.1%), Black Caribbean (10.0%) and Bangladeshi (8.2%) populations. Rates in Pakistani and Black African men are also above-average.

Among women, the highest reported rates are in Pakistani women (8.6%) and Black Caribbean women (8.4%). Indian and Bangladeshi women also have above-average rates of diabetes. The Pakistani group is the only one where the female prevalence of diabetes appears to be higher than the male prevalence.

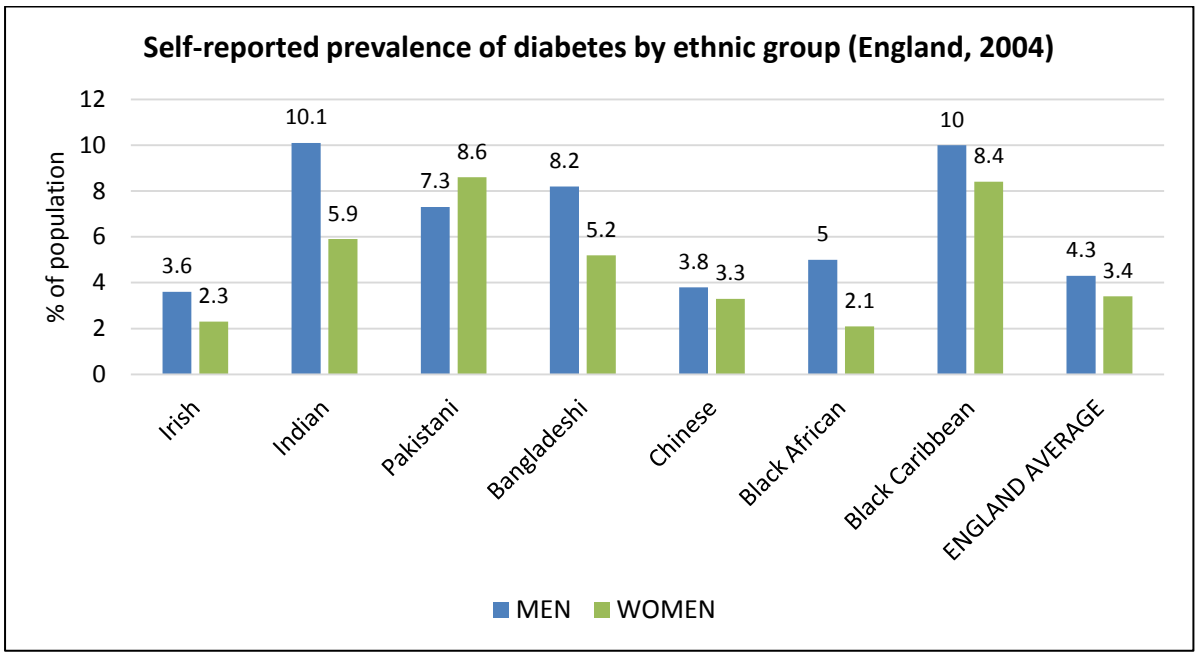


Figure 53: Self-reported prevalence of diabetes by ethnic group and sex
Source: Health Survey for England 2004 [25]

In addition to these findings, diabetes is thought to present at a younger age and progress more rapidly in South Asian populations [38]. Admission rates due to diabetes have been found to be higher among Asian, Black Caribbean and Other Black groups [5].

Diabetes is associated a risk factor for several conditions including coronary heart disease and stroke. It can also progress to affect the kidneys (diabetic nephropathy), eyes (diabetic retinopathy) and nerves (diabetic neuropathy). Rates of renal replacement therapy are 4.2 times higher in Asian populations and 3.7 times higher in Black populations, with diabetic nephropathy being the most common underlying cause [39]. Diabetes is also one of the main risk factors for the formation of cataracts and may explain why Indian and Pakistani groups have above-average rates of cataract surgery [5]

5.9. Haematological conditions

Sickle cell disease and thalassaemia are red blood cell disorders which predispose to a variety of complications including infection, anaemia, pain and stroke. Thalassaemia is particularly common among people originating from around the Mediterranean, the Middle East and Central and Southern Asia. Sickle Cell disease is most common in people originating from Sub-Saharan Africa with the gene also being found in Middle Eastern, Mediterranean and some Asian populations.
In the UK, babies are screened for these conditions shortly after birth. Rates are significantly higher in Black populations, as shown in Figure 54.

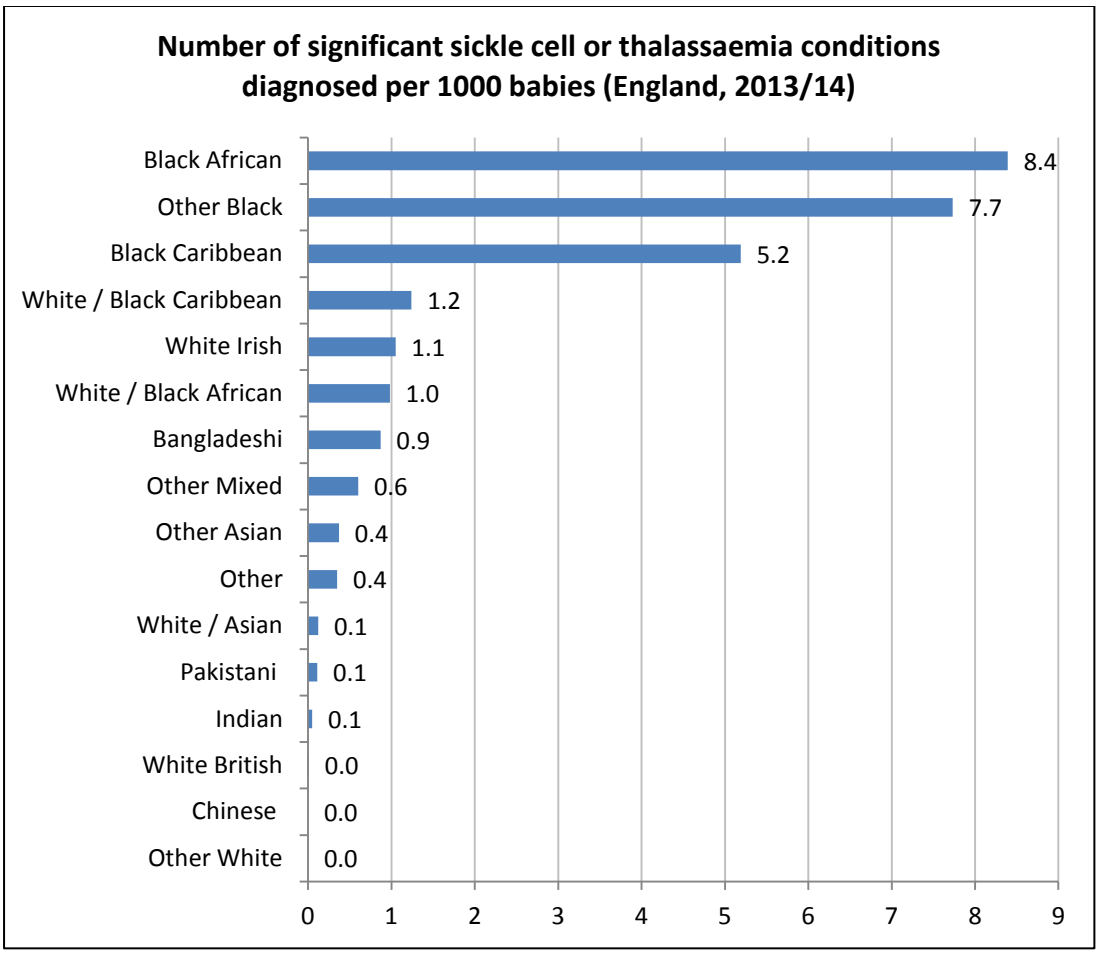


Figure 54: Number of significant sickle cell or thalassaemia conditions diagnosed per 1000 babies (England, 2013/14)
Source: NHS screening programmes [40]

5.10. Cancer

There are major variations in cancer prevalence according to ethnicity. Most of the data presented here comes from a review of almost 600,000 cancer cases during 2002 to 2006 by the National Cancer Intelligence Network (NCIN) based on Hospital Episode Statistics (HES). This work has not been repeated subsequently. The data presented relates to people of all ages. Where different associations are seen in different age groups this is indicated in the text.

Overall, 24% of these cancer cases were not coded for ethnicity therefore various assumptions were made about how to code the missing data. The main assumption was that the ethnic composition of missing cases was the same as that of coded cases. The rate ratios presented in these cancer tables is based on this assumption. A rate ratio of 1 indicates that the risk of cancer is in the specified group is the same as that of the White ethnic group. A rate of 0.5 indicates that the group is at 50% lower risk. A rate of 1.2 indicates that the group is at 20% higher risk. The 95% confidence interval listed next to the main rate ratio figure indicates the range within which we can be 95% certain the true rate ratio value lies in. For example, a 95% confidence interval of 04-0.8 indicates that we can be 95% confident that the true value for the rate ratio lies between 0.4 and 0.8 meaning that the risk for the group is between 20-60% that of the White ethnic group.

Due to the missing data, researchers also calculated 'extreme assumptions' based on either: (i) all the missing cases being of White ethnicity, or (ii) the missing cases having a disproportionately high prevalence of BME groups. The most extreme values of the confidence interval for these assumptions are also listed in the table. A relationship was only felt to be significant if this 'extreme assumptions' range did not cross 1 (the point of no association).

Again, this data is not adjusted for other factors so differences seen between other groups may be partly explained by variations in other risk factors, such as smoking, in addition to any underlying genetic predisposition. It is thought that smoking and BMI are leading causes of BME cancer inequalities [41]

All cancer

Table 21 shows that the risk of getting cancer is lower for all four ethnic groups considered except for black men (this may be due to their increased risk of prostate cancer). The rate ratio for Asian men is 0.55 which means that they are at 45% reduced risk of getting cancer overall in comparison to the White ethnic group. Asian women are at 38% reduced risk of getting cancer compared to the White ethnic group. Similar risk reductions are seen for Chinese men (43%) and women (44%) but the risk reduction for Black women is lower (20%).

Table 21: Relative risk of All Cancer by ethnic group

ALL CANCER[13]					
Ethnic group		Standard assumption		Extreme assuptions 95% C.I. range	Interpretation of risk (compared to White ethnic group)
		Rate ratio	95% C.I.[14]		
ASIAN	Men	0.55	0.54-0.56	0.41-0.63	**Significantly lower risk**
	Women	0.62	0.61-0.63	0.47-0.71	**Significantly lower risk**
BLACK	Men	1.04	1.02-1.06	0.76-1.20	No significant difference
	Women	0.80	0.78-0.82	0.60-0.91	**Significantly lower risk**
CHINESE	Men	0.57	0.54-0.60	0.41-0.68	**Significantly lower risk**
	Women	0.56	0.53-0.58	0.41-0.65	**Significantly lower risk**
MIXED	Men	0.60	0.58-0.63	0.43-0.70	**Significantly lower risk**
	Women	0.60	0.58-0.62	0.45-0.70	**Significantly lower risk**

Source: National Cancer Intelligence Network [42]

[13] Excluding non-melanoma skin cancer
[14] C.I. = Confidence interval

Colorectal cancer

Colorectal cancer risk is lower in all four ethnic groups considered (Table 22). The Asian ethnic group again appears at lower risk in both men (55% reduced risk) and women (57% reduced risk).

Table 22: Relative risk of Colorectal Cancer by ethnic group

COLORECTAL CANCER					
Ethnic group		Standard assumption		Extreme assuptions 95% C.I. range	Interpretation of risk (compared to White ethnic group)
		Rate ratio	95% C.I.		
ASIAN	Men	0.45	0.43-0.47	0.36-0.50	**Significantly lower risk**
	Women	0.43	0.41-0.46	0.34-0.50	**Significantly lower risk**
BLACK	Men	0.70	0.66-0.74	0.55-0.80	**Significantly lower risk**
	Women	0.79	0.73-0.84	0.60-0.92	**Significantly lower risk**
CHINESE	Men	0.68	0.59-0.78	0.50-0.85	**Significantly lower risk**
	Women	0.66	0.56-0.77	0.46-0.84	**Significantly lower risk**
MIXED	Men	0.49	0.44-0.55	0.37-0.59	**Significantly lower risk**
	Women	0.61	0.53-0.70	0.44-0.77	**Significantly lower risk**

Source: National Cancer Intelligence Network [42]

Lung cancer

Lung cancer risk (in addition to cancer of the trachea and bronchus) is also significantly lower in all four groups (Table 23). Female risk is lower than male risk for each group with particularly low risk in Asian women (71% reduced risk) which is probably linked to the lower smoking prevalence in this group. Men in the Asian group also have the most reduced risk (49% less) followed by the Mixed (45% less) and Chinese (40% less) groups.

Table 23: Relative risk of Cancer of the Trachea, Bronchus or Lung by ethnic group

CANCER OF TRACHEA, BRONCHUS OR LUNG					
Ethnic group		Standard assumption		Extreme assuptions 95% C.I. range	Interpretation of risk (compared to White ethnic group)
		Rate ratio	95% C.I.		
ASIAN	Men	0.51	0.49-0.54	0.38-0.60	**Significantly lower risk**
	Women	0.29	0.27-0.30	0.21-0.34	**Significantly lower risk**
BLACK	Men	0.67	0.63-0.71	0.50-0.79	**Significantly lower risk**
	Women	0.35	0.32-0.37	0.26-0.41	**Significantly lower risk**
CHINESE	Men	0.60	0.52-0.69	0.50-0.78	**Significantly lower risk**
	Women	0.53	0.45-0.62	0.34-0.70	**Significantly lower risk**
MIXED	Men	0.55	0.49-0.62	0.38-0.68	**Significantly lower risk**
	Women	0.42	0.37-0.48	0.29-0.54	**Significantly lower risk**

Source: National Cancer Intelligence Network [42]

Female cancers

Breast cancer risk is lowest in the Chinese groups, being 51% lower than in the White ethnic group, but all groups report significantly reduced risk (Table 24). Data on other female cancers is only available for the Asian and Black groups due to the limited number of cases in other groups. This shows that Asian women are at 38% reduced risk of cervical cancer but Black women have the same risk. Rates of uterine cancer are not significantly different in either group. Rates of uterine cancer are significantly lower in both groups, particularly in Black women who are at 45% lower risk than White women.

Table 24: Relative risk of Women's Cancer by ethnic group

Ethnic group	Standard assumption		Extreme assuptions 95% C.I. range	Interpretation of risk (compared to White ethnic group)
	Rate ratio	95% C.I.		
BREAST CANCER				
ASIAN	0.65	0.63-0.67	0.48-0.75	**Significantly lower risk**
BLACK	0.75	0.73-0.78	0.56-0.88	**Significantly lower risk**
CHINESE	0.49	0.46-0.53	0.35-0.60	**Significantly lower risk**
MIXED	0.58	0.55-0.62	0.42-0.70	**Significantly lower risk**
CERVICAL CANCER (<65)				
ASIAN	0.62	0.56-0.69	0.45-0.76	**Significantly lower risk**[15]
BLACK	1.08	0.95-1.23	0.75-1.36	No significant difference[16]
UTERINE CANCER				
ASIAN	0.87	0.81-0.94	0.63-1.05	No significant difference[17]
BLACK	1.13	1.02-1.25	0.79-1.39	No significant difference
OVARIAN CANCER				
ASIAN	0.73	0.68-0.79	0.53-0.88	**Significantly lower risk**
BLACK	0.55	0.50-0.61	0.39-0.68	**Significantly lower risk**

Source: National Cancer Intelligence Network [42]

[15] Rates in women aged 65 and over are significantly higher
[16] Significantly higher rate for women aged 65 and over
[17] Significantly lower rate for women aged 65 and over

Further analysis of HES data by the NCIN (Table 25) found that Black women present, on average, at an earlier age (50 years) than other groups, including White women (62 years). This is significant because screening for breast cancer currently only starts at age 50 which may explain why only 44.6% of breast cancer in Black populations is detected through screening. It is also known that breast cancer in Black women is more likely to be an aggressive form which may already have spread at the point of presentation [43]. Other research in England has shown that Indian, Pakistani, Black Caribbean and Black African women are significantly more likely to present with metastatic cancer (which has spread beyond breast tissue) than White women [44].

Table 25: Route to breast cancer diagnosis by ethnicity 2006

Ethnic group	Median Age at Diagnosis (IQR[18])	Women aged 50-70	
		No.	Screen-detected (%)
White	62 (52-72)	14,500	56.3%
Asian	55 (47-65)	359	52.1%
Black	50 (43-63)	177	44.6%
Chinese	53 (48-59)	43	53.5%
Mixed	52 (43-67)	44	50.0%
Other Ethnicity	55 (48-66)	122	57.4%
TOTAL ENGLAND	**62 (52-73)**	**21,536**	**55.6%**

Source: National Cancer Intelligence Network [43]

Other Gastrointestinal Cancers

Again, data for other gastrointestinal cancers is only available for Asian and Black ethnic groups (Table 26). Asian women are at 65% increased risk of mouth cancer compared to White women. By contrast, Black men and women are at significantly lower risk, while the risk for Asian men appears similar to White men. Oesophageal cancer is significantly less likely among Asian and Black people of both sexes. The risk is lowest for Asian women who are at 65% reduced risk compared to White women.

Black men and women are at significantly increased risk of stomach cancer. Rates for men are 50% higher and rates for women are 87% higher. Asian men and women are at significantly lower risk. Liver cancer is significantly more likely in both groups, particularly Black men (122% more likely) and Asian men (109% more likely). The risk of pancreatic cancer is lower in Asian people but unchanged among the Black ethnic group.

[18] Inter-quartile range: the range where the middle 50% of possible values lies

Table 26: Relative risk of Other Gastrointestinal Cancers by ethnic group					
Ethnic group		Standard assumption		Extreme assuptions 95% C.I. range	Interpretation of risk (compared to White ethnic group)
		Rate ratio	95% C.I.		
MOUTH CANCER					
ASIAN	Men	0.86	0.77-0.97	0.62-1.06	No significant difference
	Women	1.65	1.40-1.95	1.11-1.55	**Significantly higher risk**
BLACK	Men	0.65	0.55-0.77	0.45-0.84	**Significantly lower risk**
	Women	0.61	0.50-0.74	0.40-0.82	**Significantly lower risk**
OESOPHAGEAL CANCER					
ASIAN	Men	0.35	0.32-0.38	0.27-0.41	**Significantly lower risk**
	Women	0.65	0.56-0.74	0.47-0.80	**Significantly lower risk**
BLACK	Men	0.59	0.52-0.66	0.45-0.71	**Significantly lower risk**
	Women	0.61	0.51-0.73	0.42-0.80	**Significantly lower risk**
STOMACH CANCER					
ASIAN	Men	0.49	0.45-0.54	0.38-0.45	**Significantly lower risk**
	Women	0.70	0.62-0.80	0.50-0.88	**Significantly lower risk**
BLACK	Men	1.50	1.34-1.69	1.10-1.84	**Significantly higher risk**
	Women	1.87	1.41-2.03	1.12-2.24	**Significantly higher risk**
LIVER CANCER					
ASIAN	Men	2.09	1.81-2.41	1.36-2.73	**Significantly higher risk**
	Women	2.04	1.65-2.52	1.26-1.93	**Significantly higher risk**
BLACK	Men	2.22	1.84-2.69	1.35-3.06	**Significantly higher risk**
	Women	1.74	1.33-2.28	1.03-2.55	**Significantly higher risk**
PANCREATIC CANCER					
ASIAN	Men	0.66	0.59-0.73	0.45-0.56	**Significantly lower risk**
	Women	0.57	0.51-0.64	0.39-0.72	**Significantly lower risk**
BLACK	Men	1.09	0.95-1.25	0.73-1.39	No significant difference
	Women	1.16	0.99-1.35	0.75-1.52	No significant difference
Source: National Cancer Intelligence Network [42]					

Urological cancers

Prostate cancer is significantly more common in Black men, who are more than twice as likely to develop it as White men (Table 27). By contrast, Asian and Chinese men are at significantly lower risk. Data on other urological cancers is again only available for Asian and Black groups. These groups are both at reduced risk of bladder and kidney cancer (apart from Black women who have rates of kidney cancer which are similar to the White ethnic group).

Table 27: Relative risk of Urological Cancer by ethnic group

Ethnic group		Standard assumption		Extreme assuptions 95% C.I. range	Interpretation of risk (compared to White ethnic group)
		Rate ratio	95% C.I.		
PROSTATE CANCER					
ASIAN	Men	0.50	0.48-0.52	0.30-0.62	**Significantly lower risk**
BLACK	Men	2.08	1.99-2.17	1.21-2.61	**Significantly higher risk**
CHINESE	Men	0.38	0.34-0.42	0.21-0.51	**Significantly lower risk**
MIXED	Men	0.83	0.75-0.91	0.46-1.09	No significant difference[19]
KIDNEY CANCER					
ASIAN	Men	0.66	0.60-0.72	0.48-0.80	**Significantly lower risk**
	Women	0.51	0.45-0.58	0.36-0.64	**Significantly lower risk**
BLACK	Men	0.76	0.67-0.86	0.53-0.95	**Significantly lower risk**[20]
	Women	0.80	0.68-0.94	0.55-1.04	No significant difference[21]
BLADDER CANCER					
ASIAN	Men	0.42	0.39-0.45	0.34-0.49	**Significantly lower risk**
	Women	0.35	0.30-0.40	0.26-0.43	**Significantly lower risk**
BLACK	Men	0.39	0.35-0.43	0.30-0.45	**Significantly lower risk**
	Women	0.47	0.39-0.56	0.33-0.60	**Significantly lower risk**

Source: National Cancer Intelligence Network [42]

[19] Significantly lower risk in men aged 65 and over
[20] Not significantly different for men aged 65 and over
[21] Significantly lower risk in women aged 65 and over

Haematological cancers

Table 28 shows that rates of Myeloma are almost double those of the White population in both Black Men (2.40) and Black women (2.32). Asian men and women appear at reduced risk of Leukaemia but otherwise no significant differences were found for other Haematological cancers.

Table 28: Relative risk of Haematological Cancers by ethnic group

Ethnic group		Standard assumption		Extreme assuptions 95% C.I. range	Interpretation of risk (compared to White ethnic group)
		Rate ratio	95% C.I.		
HODGKIN'S LYMPHOMA					
ASIAN	Men	1.35	1.16-1.57	0.94-1.73	No significant difference
	Women	1.14	0.95-1.37	0.79-0.49	No significant difference
BLACK	Men	1.03	0.83-1.27	0.67-1.40	No significant difference
	Women	1.00	0.79-1.26	0.66-1.37	No significant difference
NON-HODGKIN'S LYMPHOMA					
ASIAN	Men	0.89	0.82-0.96	0.64-1.06	No significant difference
	Women	0.86	0.78-0.94	0.62-1.04	No significant difference[22]
BLACK	Men	1.01	0.92-1.12	0.72-1.24	No significant difference
	Women	1.08	0.97-1.21	0.76-1.34	No significant difference
MYELOMA					
ASIAN	Men	0.82	0.72-0.94	0.59-1.03	No significant difference
	Women	0.86	0.73-1.02	0.59-1.12	No significant difference
BLACK	Men	2.40	2.01-2.86	1.65-3.12	**Significantly higher risk**
	Women	2.32	1.89-2.86	1.55-3.11	**Significantly higher risk**
LEUKAEMIA					
ASIAN	Men	0.71	0.65-0.77	0.51-0.85	**Significantly lower risk[23]**
	Women	0.80	0.72-0.89	0.56-0.99	**Significantly lower risk[24]**
BLACK	Men	0.91	0.81-1.03	0.63-1.15	No significant difference
	Women	0.94	0.82-1.09	0.64-1.21	No significant difference

Source: National Cancer Intelligence Network [42]

[22] Significantly lower risk in women aged less than 65
[23] Not significantly different for men aged less than 65
[24] Not significantly for women aged less than 65

Other cancers

Asian and Black populations are at very significantly reduced risk of malignant melanoma (Table 29). Asian women are 96% less likely to develop melanoma than the White population. This finding is probably linked to the protective effect of skin pigmentation. Men and women in Asian and Black ethnic groups are also at significantly lower risk of brain and CNS cancer than other ethnic groups.

Table 29: Relative risk of Other Cancers by ethnic group

Ethnic group	Sex	Standard assumption		Extreme assuptions 95% C.I. range	Interpretation of risk (compared to White ethnic group)
		Rate ratio	95% C.I.		
MALIGNANT MELANOMA					
ASIAN	Men	0.04	0.04-0.04	0.02-0.05	**Significantly lower risk**
	Women	0.05	0.04-0.05	0.03-0.06	**Significantly lower risk**
BLACK	Men	0.13	0.11-0.14	0.07-0.16	**Significantly lower risk**
	Women	0.16	0.15-0.18	0.09-0.21	**Significantly lower risk**
BRAIN AND CNS CANCER					
ASIAN	Men	0.64	0.58-0.71	0.49-0.76	**Significantly lower risk**
	Women	0.63	0.56-0.72	0.47-0.78	**Significantly lower risk**
BLACK	Men	0.50	0.44-0.57	0.37-0.62	**Significantly lower risk**
	Women	0.59	0.50-0.69	0.42-0.75	**Significantly lower risk**

Source: National Cancer Intelligence Network [42]

Other ethnic groups

There is evidence for increased cancer risk in other ethnic groups not considered in these tables. A comprehensive review of this is outwith the scope of this study, although it is significant to note that the standardised cancer mortality rates for the White Irish population have been found to be significantly higher at all ages compared to the national population of England and Wales. This effect appears to persist to the second and third generation of Irish immigrants [45].

Screening and access to services

Coding of ethnicity in screening programmes has been poorly recorded historically which means it is hard to identify differential uptake between groups, although there is some evidence for lower uptake of breast, cervical and colorectal screening services in BME populations [46]. This may be partly explained by cultural factors and deprivation [44].

There is also some evidence that members of BME groups face barriers to accessing timely cancer care. A UK study of 1500 people from BME backgrounds found that all participants from all ethnic

groups had lower awareness of cancer symptoms and reported emotional and practical barriers to accessing help. These findings were seen most frequently in the Black African population [46].

5.11. Sexual health

At a national level, the diagnosis rates of new sexually transmitted infections (STIs) are higher in those from the Black ethnic group. Rates of Chlamydia, Gonorrhoea and Herpes are also between 2 to 5 times the national average (Figure 55). Mixed and other ethnic groups also have higher rates of STIs than the White average but the Asian population has lower overall rates.

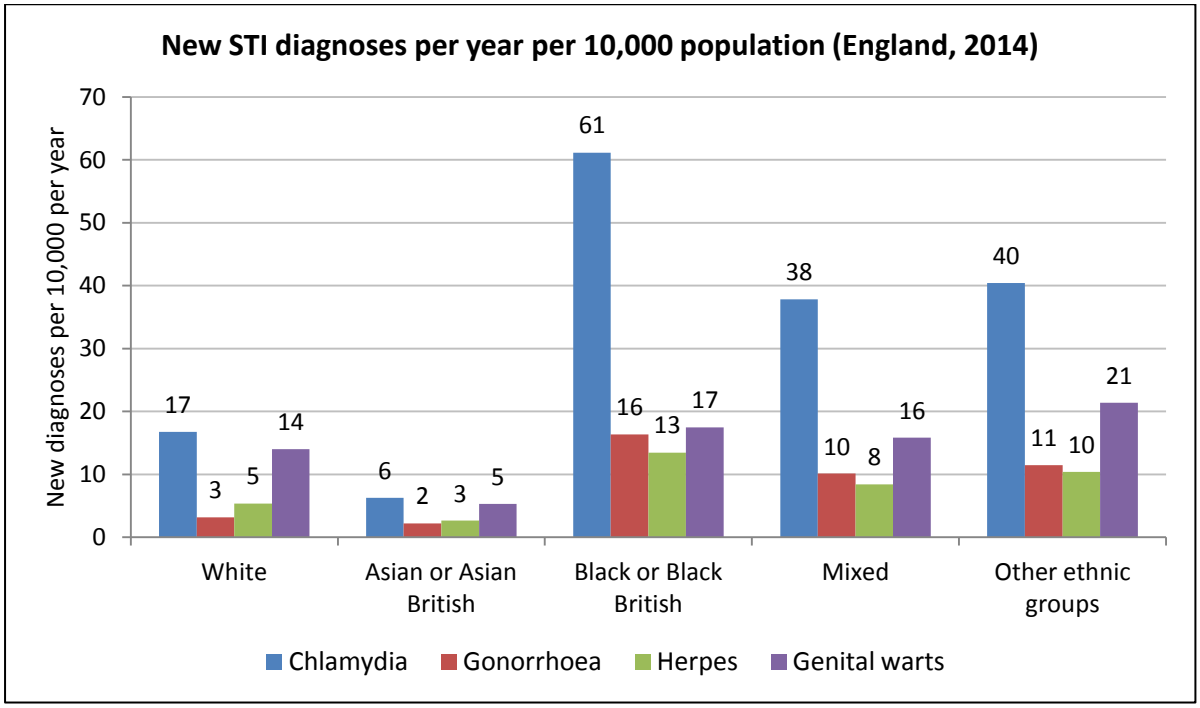


Figure 55: New STI diagnoses per 10,000 population according to ethnic group
Source: 2011 Census; PHE, 2014 [47]

Table 30 shows the proportion of new HIV diagnoses in England according to ethnic group. The majority of new diagnoses are in White people, particularly White men (48.8% of total). However, 20.7% of new diagnoses are in Black African people, despite this group only making up 1.8% of the national population. Unlike among the White population, transmission is primarily via heterosexual intercourse which may explain why, unlike in the White population, the incidence is actually higher in women than men.

Table 30: New HIV diagnoses in England by ethnic group (2014)			
Ethnic group		New HIV diagnoses	
		Number	%
WHITE	Men	2,713	48.8%
	Women	330	5.9%
	Total	**3,043**	**54.7%**
BLACK AFRICAN	Men	478	8.6%
	Women	673	12.1%
	Total	**1,151**	**20.7%**
BLACK CARIBBEAN		149	2.7%
OTHER / MIXED		761	13.7%
NOT REPORTED		455	8.2%
TOTAL		**5559**	
Source: Public Health England [48]			

The majority of new HIV cases are now diagnosed in people who were born overseas (54% of cases with known region of birth). The most common region of birth is Africa (21.2%) followed by the rest of Europe (15.2%) (Table 31).

Table 31: New HIV diagnoses in England by region of birth (2014)		
Region of birth	New HIV diagnoses	
	Number	%
UK	2,323	41.8%
Rest of Europe	846	15.2%
Africa	1,181	21.2%
Asia	290	5.2%
Other	412	7.4%
Not reported	507	9.1%
TOTAL	**5,559**	**100%**
Source: Public Health England [49]		

Figure 56 indicates the proportion of different ethnic groups which accesses HIV services in England. Data is taken from 2011 in order to compare with the Census data from that year. This shows a similar picture to the incidence pattern in Table 30. Rates among the Black African population (244.2 per 10,000 people) are noticeably higher than any other group, followed by Other Black (52.8/10,000) and Black Caribbean (38.0/10,000).

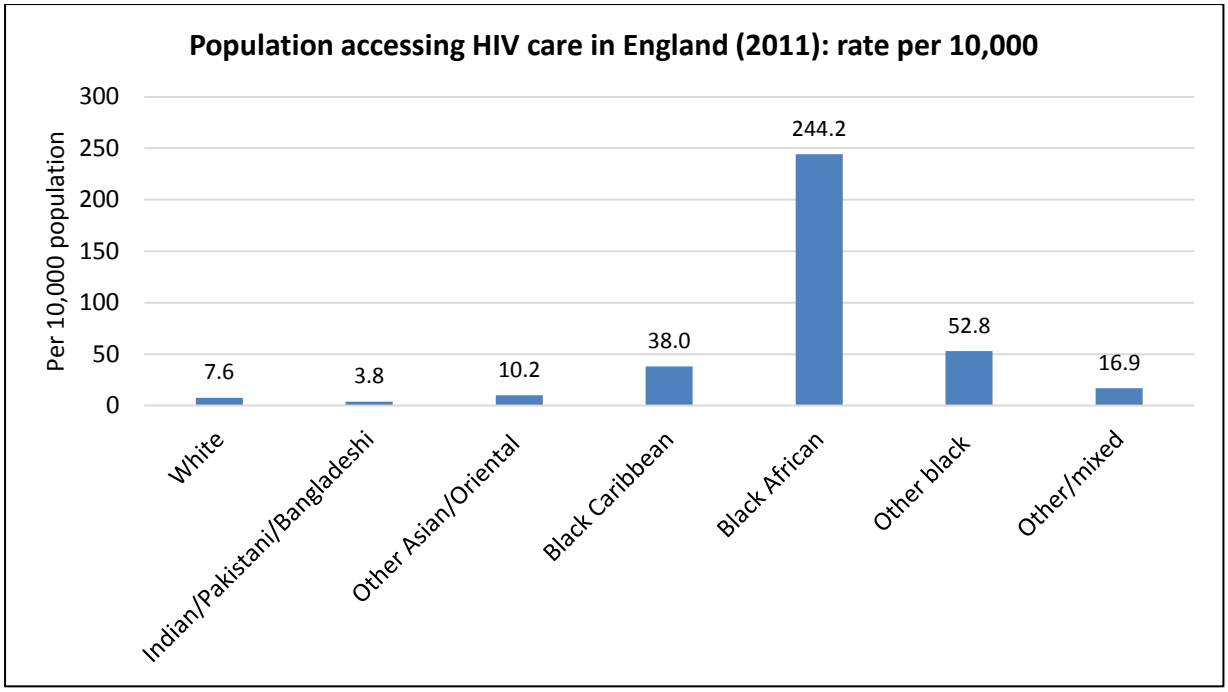


Figure 56: Population accessing HIV care per 10,000 by ethnic group
Source: Public Health England [49] and 2011 Census [4]

Overall, 42% of cases acquired through heterosexual intercourse in the UK are in people from the Black African ethnic group [50], compared to only 2% of the MSM (men who have sex with men) group. 58% of the Black African group are also diagnosed late with HIV, higher than other groups [50]. Prevalence of HIV is higher in Black African women (1 in 22) than Black African men (1 in 56) [51]. These rates are continuing to rise [51] and it is estimated that among existing HIV cases 16% of Black African men remain undiagnosed and 12% of Black African women [51]. There are known to be issues of stigma relating to HIV testing in BME communities, including among Black African groups, which may partly responsible [41].

NICE issued guidance in 2011 on measures which should be taken to increase the uptake of HIV testing among Black Africans. Recommendations included advice to engage with local community groups to change attitudes towards testing and to offer testing in more accessible, non-healthcare settings [52].

5.12. Tuberculosis

The risk of contracting Tuberculosis is higher in BME communities. In 2014 38% of new TB cases were in minority ethnic groups [53]. Figure 57 shows that, among the UK-born population, the rate of new TB diagnoses is highest in Other Black populations (40 per 100,000) followed by Pakistani (29/100,000) and Black African (28/100,000). All BME groups have higher incidence rates than those of the White population.

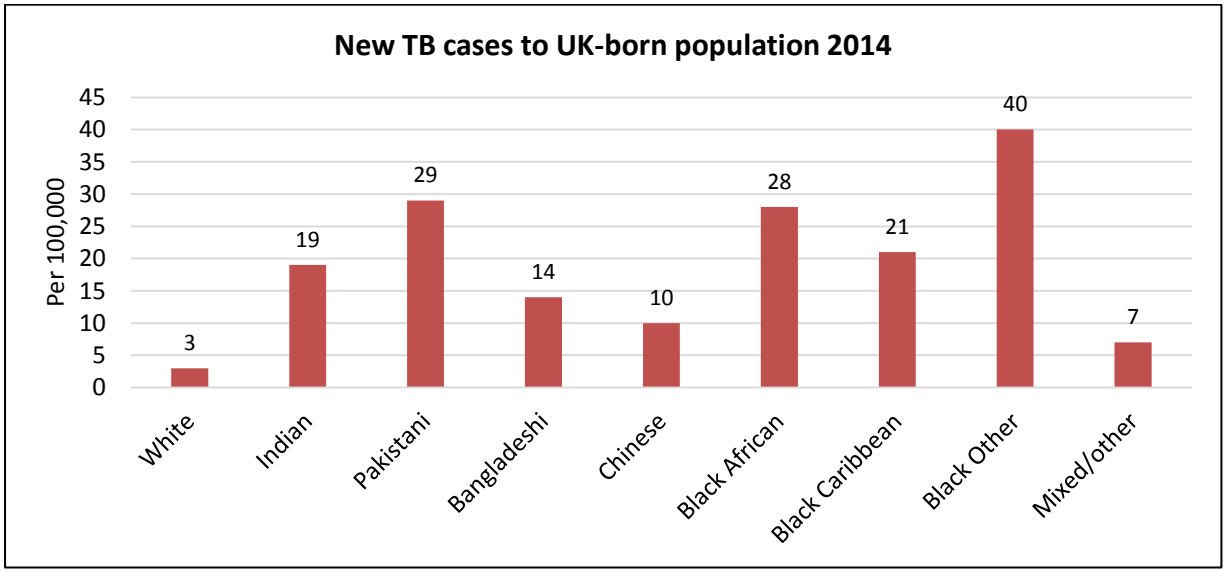


Figure 57: Incidence of TB among UK born population in 2014
Source: Public Health England [53]

Figure 58 shows that the overall incidence of TB is much higher in cases born overseas. Rates are highest in Indian (172/100,000), Pakistani (165/100,000) and Black African (133/100,000) community members born overseas. Overall there is a trend towards declining incidence of HIV in the non-UK born community but this may be partly linked to changing immigration policy reducing the numbers of new entrants to the UK from non-EU countries [53].

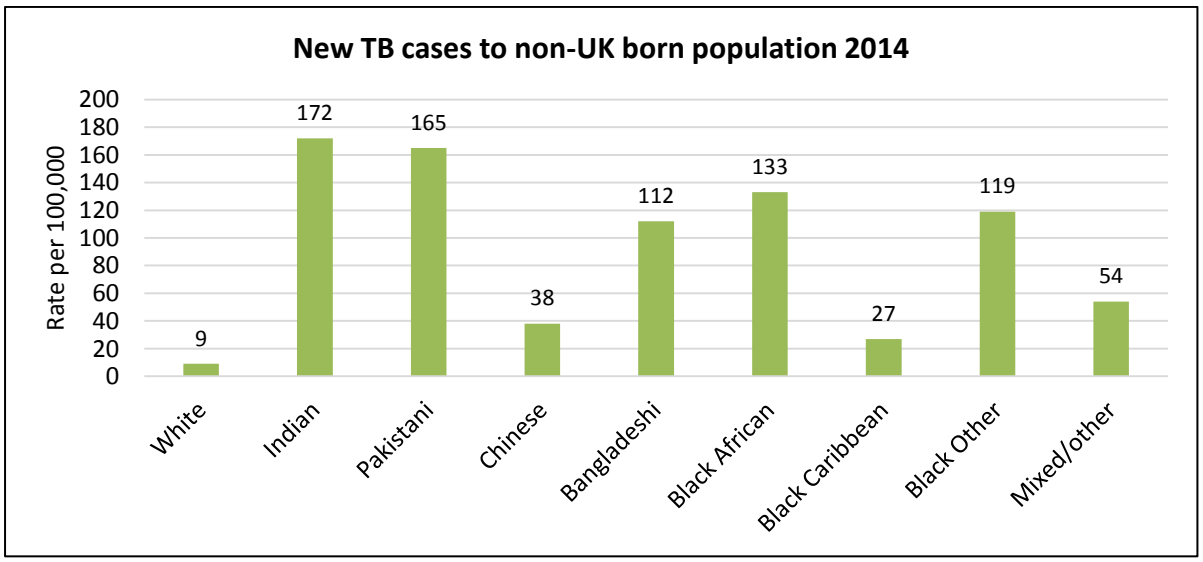


Figure 58: Incidence of TB among non-UK born population in 2014
Source: Public Health England [53]

Table 32 lists the countries of birth which are associated with the highest number of new TB cases. After the UK, the most likely countries are India, Pakistan and Somalia. On average it takes 9 years following entry to the UK for TB to be diagnosed.

Table 32: Most frequent countries of birth for non-UK born TB diagnoses in England (2014)

Country of birth	Number of cases	Percentage of cases (%)	Median time since entry to UK (yrs)
UK	1,774	28.2	
India	1,288	20.5	7
Pakistan	791	12.6	10
Somalia	230	3.7	10
Bangladesh	207	3.3	8
Nepal	168	2.7	4
Nigeria	118	1.9	7
Philippines	111	1.8	9
Zimbabwe	107	1.7	11
Afghanistan	96	1.5	8
Romania	88	1.4	1
Eritrea	83	1.3	3
Kenya	81	1.3	19
Sri Lanka	78	1.2	11
Poland	70	1.1	6
Others (each <1%)	1,007	15.8	8
TOTAL	**6,297**	**100**	**9**

Source: Public Health England [53]

The demographics of White and non-White TB cases vary. There are relatively more cases in younger non-White people aged 0-44, in comparison to the White population which has relatively more diagnoses in people aged 65 and over.

PHE recommend screening for latent TB infection in those who have recently arrived in England from high-risk countries (Appendix 4) where the incidence of TB is 150 cases per 100,000 population or more [54]. The Salford Standard recommends that screening using a blood test (interferon gamma release assay) should take place when individuals meeting these criteria (aged 16 and over) register with a Salford GP [55].

5.13. Female Genital Mutilation

The World Health Organisation (WHO) states that Female Genital Mutilation (FGM):

'Comprises of all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons'

Quoted from: WHO [56]

The WHO classifies FGM according to the system listed in Table 33. The health effects of these procedures may be immediate (e.g. bleeding, infection) or long-term (e.g. infertility, psychological damage, infertility).

Table 33: WHO Classification of FGM by Type

Type	Description
I	Partial or total removal of the clitoris and/or the prepuce (clitoridectomy). **Type Ia**, removal of the clitoral hood or prepuce only **Type Ib**, removal of the clitoris with the prepuce.
II	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision). **Type IIa**, removal of the labia minora only; **Type IIb**, partial or total removal of the clitoris and the labia minora; **Type IIc**, partial or total removal of the clitoris, the labia minora and the labia majora.
III	Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation). **Type IIIa**: removal and apposition of the labia minora; **Type IIIb:** removal and apposition of the labia majora.
IV	Unclassified: All other harmful procedures to the female genitalia for non-medical purposes, for example, pricking, piercing, incising, scraping and cauterisation.

Source: City University London [57]

Female Genital Mutilation has been illegal in the UK since the 1985 *Prohibition of Female Circumcision Act*. In 2003, the Female Genital Mutilation Act extended the legislation to prohibit UK residents from having FGM performed abroad. It also became illegal to facilitate someone else having FGM abroad [58]. The Serious Crime Act 2015 created a new offence of failing to protect a girl from FGM which can lead to up to 7 years in jail [58].

Since 2015 it has been possible to take out a FGM Protection Order from the family court in order to protect a girl from FGM (e.g. by preventing her from leaving the country). Since this time a mandatory duty to report FGM has been introduced. This applies to a range of professionals, including those in health and social care, and requires them to refer any case of FGM either disclosed or witnessed in a child under 18 years old [58].

Table 34 shows the countries with the highest prevalence of FGM, categorised according to the severity of FGM. All the countries in Groups 1.1 and 1.2 are in Africa.

Table 34: FGM-practising country groups		
Group	**Description**	**Countries**
1.1	Almost universal FGM, over 30% FGM Type III	Sudan (north), Somalia, Eritrea, Djibouti
1.2	High national prevalence of FGM, WHO Type I and II	Egypt, Ethiopia, Mali, Burkina Faso, Gambia, Guinea, Sierra Leone
2	Moderate national prevalence of FGM, WHO Type I and II	Central African Republic, Chad, Cote D'Ivoire, Guinea Bissau, Iraq (Kurdistan), Kenya, Liberia, Mauritania, Nigeria, Senegal, Togo
3	Low national prevalence of FGM WHO, Type FGM I and II	Benin, Cameroon, Ghana, Niger, (Democratic Republic of Congo), Tanzania, Togo, Uganda
Source: City University London [57]		

Overall, it is estimated that there are 137,000 women and girls living in England and Wales who have been subjected to FGM prior to entering the UK. This figure includes approximately 10,000 girls aged under 15 [57].

5.14. Mental health

Evidence on ethnicity trends in mental illness mainly comes from original research studies rather than national datasets, meaning it is difficult to make direct comparisons between groups. White Irish people are known to be frequent users of mental health and alcohol services and have Schizophrenia rates which are only second to those of the Black Caribbean population [59]. They have a higher suicide rate than any other BME group [60]

Self-harm rates are below-average among South Asian and Black groups [61], however the suicide risk for young Asian women is nearly double that of young White women [62]. Indian and Chinese groups have lower than average admission rates to psychiatric services [61]. People from the Black ethnic group have admission rates at least double the national average and young Black men are six times more likely to be sectioned for compulsory treatment under the Mental Health Act [62].

Mental health problems are also common among asylum seekers, including depression, anxiety and post-traumatic stress disorder [63]. Rates of depression, anxiety and suicide are also high in Gypsy and Traveller communities [15].

5.15. Older people

Early onset dementia (before 65 years) has been shown to be more common in BME communities than White groups. A 2015 Public Health England review of dementia found evidence for its increased prevalence among African-America, Black Caribbean and Hispanic communities [64]. There is also some evidence that BME populations are likely to be at a more advanced stage of dementia when they do present, which may be due to delays in accessing care [41].

Members of BME groups appear to be less likely to access palliative care services, particularly in their own homes. There is also some evidence that pain control in the terminal stages of illness may be a greater problem in these groups [41, 65]. Reasons for this may include low levels of awareness regarding palliative care and hospice provision [44]. Cultural and religious issues may also play a part [65].

6. SALFORD EVIDENCE REVIEW

Data on the physical health of Salford residents according to ethnic group is limited because of low levels of ethnicity coding in records, especially in primary care. In the FARSITE database which summarises primary care data in Salford, ethnicity data was available for only 38% of men and 41% of women, preventing any meaningful interpretation of the data.

6.1. General health

Self-reported health

2011 Census data can be used to describe the self-reported health of Salford residents, according to ethnicity (Figure 59). This demonstrates that (besides the Other White group) the non-white groups have the best self-reported health. The Black African population has the highest self-reported rate of either good or very good health. Highest self-reported health is seen for in the Black African ethnic group with 92% reporting either good or very good health. By contrast, only 60% of the White Irish group report good or very good health.

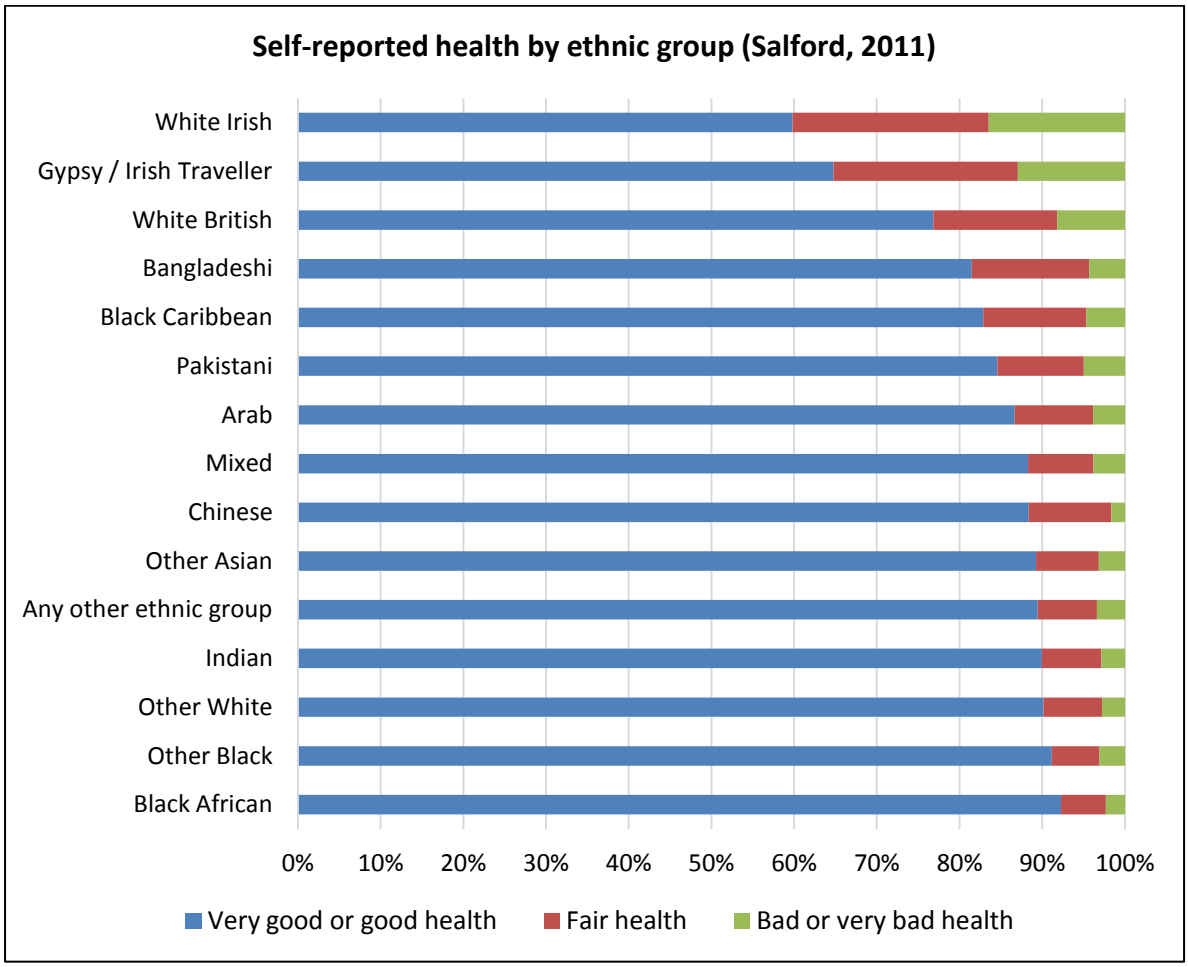


Figure 59: Self-reported health by ethnic group in Salford
Source: Nomis – 2011 Census [7]

Figure 60 compares self-reported health in Salford with the England average, according to 2011 Census data. This shows that the proportion of White Irish people reporting good or very good health in Salford (60%) is much lower than the England average (72%). This is likely to be partly due to the relatively higher proportion of the elderly in this population, as discussed. The health status of the Gypsy / Traveller community is also noticeably worse. By contrast, most non-white BME groups report similar or better health than the English average.

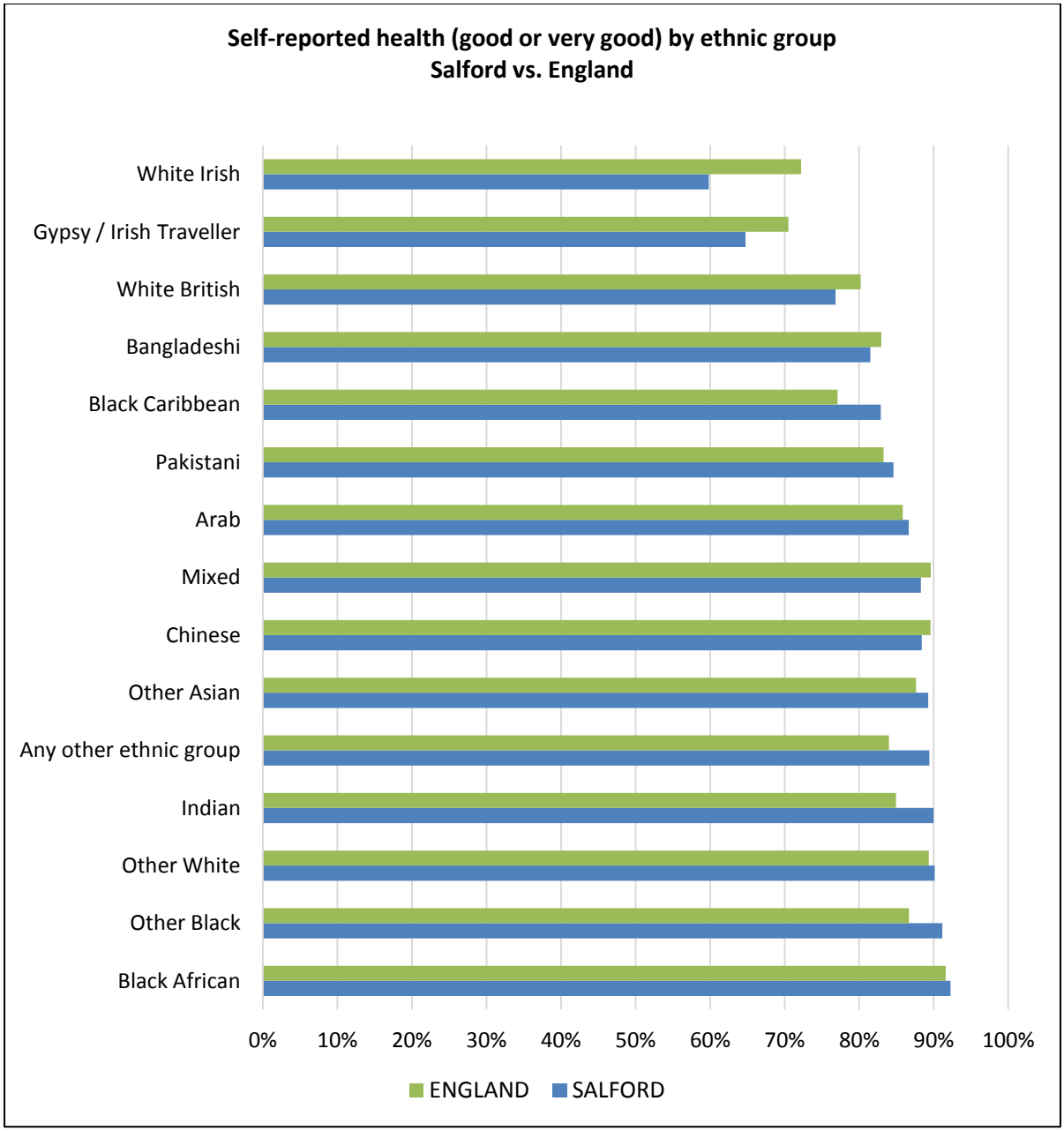


Figure 60: Comparison of self-reported health (very good or good) between ethnic groups in Salford and England
Source: Nomis – 2011 Census [7]

The Census also provides data on self-reported functional activity. Again, the White Irish group report poorest functional health with 39% reporting that their day-to-day activities are limited either

a little or a lot which is much higher than any other ethnic group (Figure 61). Overall, non-White ethnic groups report higher levels of function than other groups, apart from the Other White group.

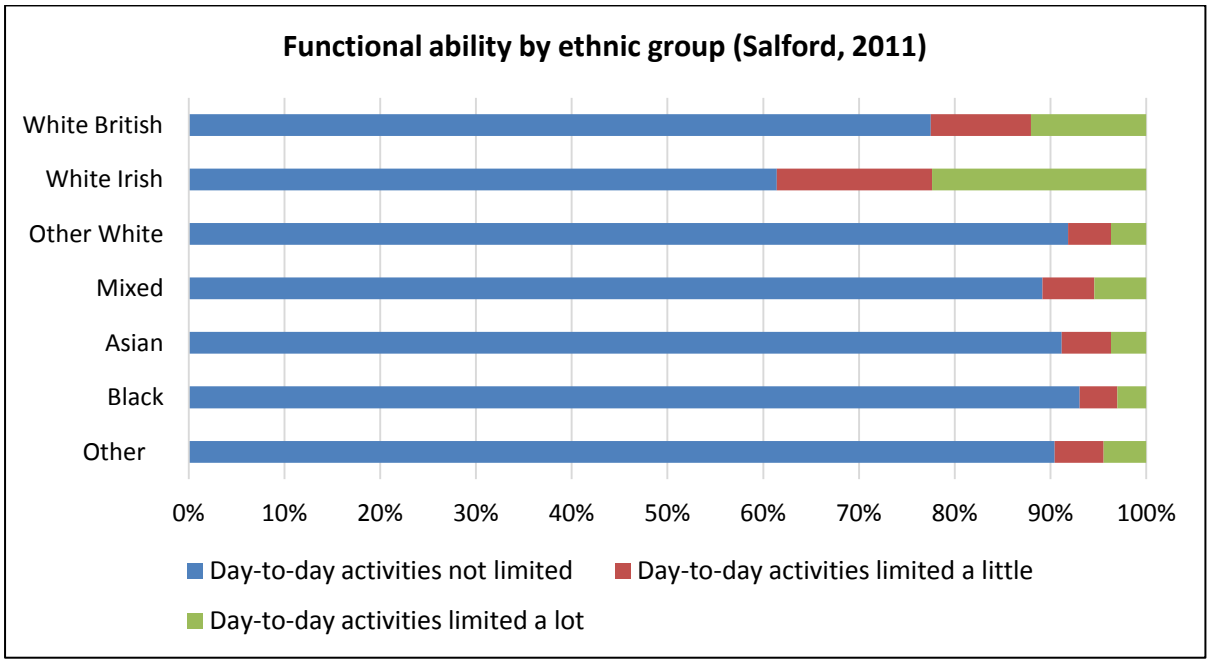


Figure 61: Long-term health in Salford by ethnic group
Source: Nomis – 2011 Census [7]

Overall there are no large differences in functional activity by sex for any ethnic group, although for all ethnic groups (except Mixed), women are more likely to report limited day-to-day activities than men (Table 35). This difference is greatest for the White Irish population.

Table 35: Functional ability according to ethnicity and sex in Salford

ETHNIC GROUP		DAY-TO-DAY ACTIVITIES		
		Not limited	Limited a little	Limited a lot
WHITE BRITISH	Men	78.5%	9.9%	11.5%
	Women	76.5%	11.0%	12.5%
WHITE IRISH	Men	63.1%	14.9%	22.0%
	Women	59.7%	17.5%	22.7%
OTHER WHITE	Men	92.3%	4.3%	3.4%
	Women	91.4%	4.6%	4.0%
MIXED	Men	88.7%	5.6%	5.7%
	Women	89.7%	5.2%	5.1%
ASIAN	Men	91.7%	4.6%	3.8%
	Women	90.6%	5.8%	3.6%
BLACK	Men	93.3%	3.8%	2.9%
	Women	92.8%	4.1%	3.2%
OTHER	Men	90.6%	5.2%	4.2%
	Women	90.2%	5.0%	4.8%

Source: Nomis – 2011 Census [7]

Figure 62 presents the functional ability of Salford residents according to religion. It shows that the lowest rates of functional limitation are seen in the Hindu (8.6%) and Jewish (11.8%) populations.

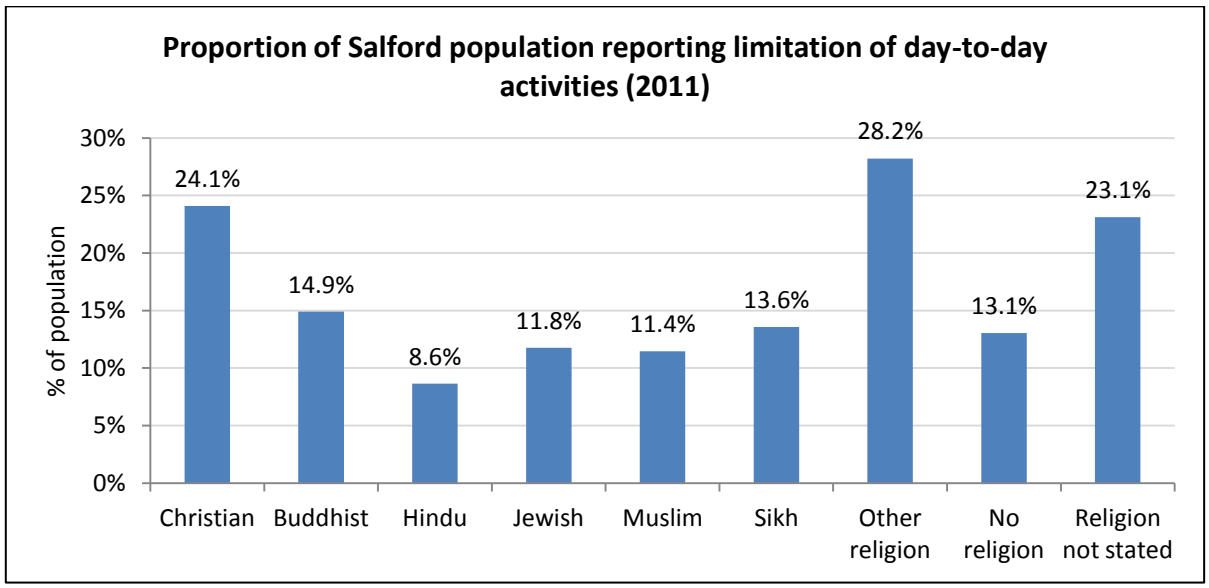


Figure 62: Proportion of Salford population reporting day-to-day activities limited a little or a lot, 2011
Source: Nomis – 2011 Census [7]

A similar pattern is seen in Figure 63 which shows that, in Salford, the highest rates of 'good' or 'very good' health are seen in Hindu (90%) and Jewish (89%) populations.

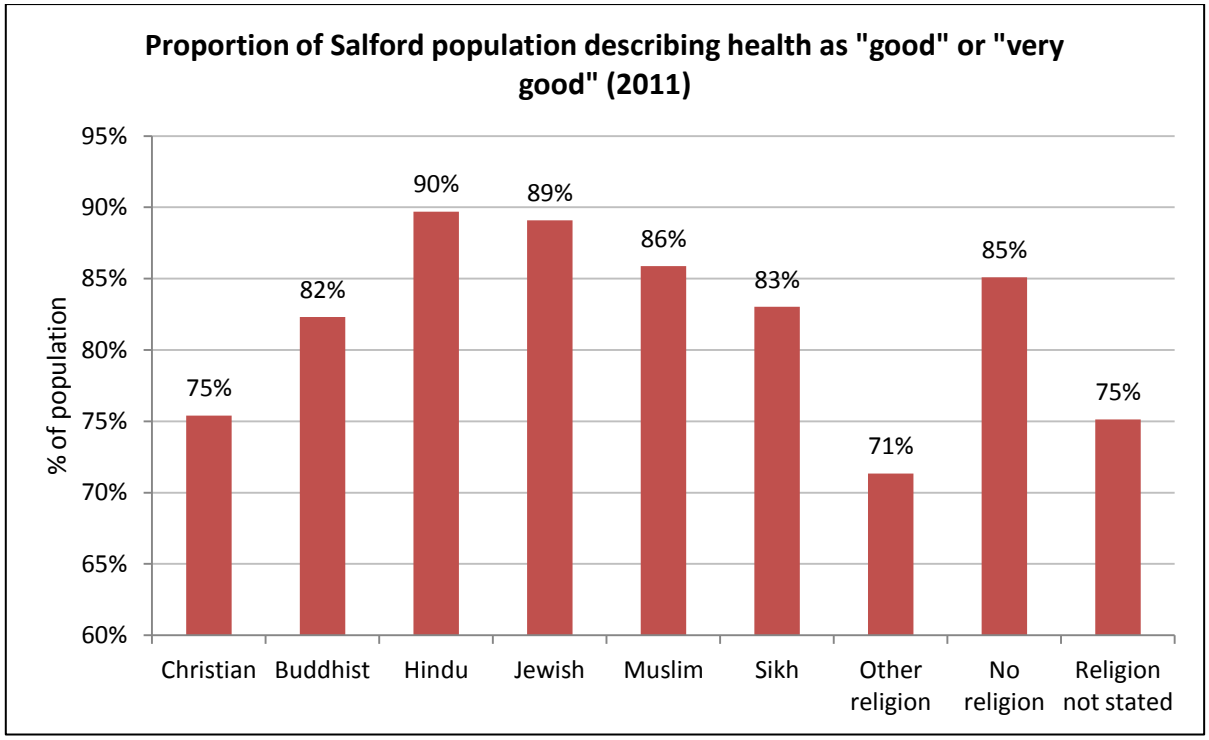


Figure 63: Proportion of Salford population describing health as "good" or "very good" health according to religion
Source: Nomis – 2011 Census [7]

6.2. Child obesity

The school National Child Measurement Programme records data on ethnicity. Table 36 and Table 37 show the weight measurements for children in Salford in 2014-15 according to ethnic group. This data shows that in Reception, the prevalence of excess weight is highest in children from Black ethnic groups (28.3%), followed by children of White ethnicity (22.6%). By Year 6 the prevalence of excess weight in Black children has risen to 43%, followed by children of Mixed ethnicity (37.8%). The proportion of underweight children is highest within the Asian ethnic group but numbers are very small and so it is hard to draw conclusions from this.

Table 36: Reception child weight measurements in Salford 2014-15

Ethnic group	Healthy weight	Underweight	Excess weight	TOTAL
White	1795 (76.9%)	12 (0.5%)	528 (22.6%)	**2335**
Asian	82 (78.8%)	5 (4.8%)	17 (16.3%)	**104**
Black	112 (70.4%)	2 (1.3%)	45 (28.3%)	**159**
Mixed	199 (79.3%)	3 (1.2%)	49 (19.5%)	**251**
Other	90 (81.8%)	2 (1.8%)	18 (16.4%)	**110**

Source: NCMP (local data)

Table 37: Year 6 child weight measurements in Salford 2014-15

Ethnic group	Healthy weight	Underweight	Excess weight	TOTAL
White	1270 (62.4%)	40 (2.0%)	726 (35.7%)	**2036**
Asian	50 (64.9%)	3 (3.9%)	24 (31.2%)	**77**
Black	72 (56.3%)	1 (0.8%)	55 (43.0%)	**128**
Mixed	101 (61.6%)	1 (0.6%)	62 (37.8%)	**164**
Other	37 (67.3%)	1 (1.8%)	17 (30.9%)	**55**

Source: NCMP (local data)

6.3. Uptake of smoking cessation

Table 38 describes the uptake of smoking cessation services (as measured by those setting a quit date) according to ethnic group. This shows that of those setting a quit date 90.4% of Salford men and 93.7% of Salford women are of White British ethnicity. For both men and women, those of Other White ethnicity are next most likely to have set a quit date.

Table 38: Salford residents setting a quit date by ethnic group (2015/16)

ETHNIC GROUP		MEN		WOMEN		TOTAL	
		n	%	n	%	n	%
WHITE	British	1043	90.4%	1108	93.7%	2151	92.0%
	Irish	22	1.9%	11	0.9%	33	1.4%
	Other	25	2.2%	41	3.5%	66	2.8%
ASIAN	Indian	9	0.8%	0	0.0%	9	0.4%
	Pakistani	5	0.4%	2	0.2%	7	0.3%
	Bangladeshi	1	0.1%	0	0.0%	1	0.0%
	Chinese	1	0.1%	0	0.0%	1	0.0%
	Other Asian	9	0.8%	1	0.1%	10	0.4%
BLACK	Black Caribbean	6	0.5%	1	0.1%	7	0.3%
	Black African	4	0.3%	8	0.7%	12	0.5%
	Other Black	4	0.3%	0	0.0%	4	0.2%
MIXED		15	1.3%	9	0.8%	24	1.0%
OTHER		10	0.9%	2	0.2%	12	0.5%
TOTAL		**1182**		**1209**		**2391**	

Source: Local smoking cessation data

Figure 64 and Figure 65 apply the estimated smoking prevalence in each ethnic group (using data from the 2004 Health Survey for England – see Figure 41) to the Salford population from the 2011 Census. This produces an estimate of the total proportion of smokers in Salford who come from each ethnic group.

It is then possible to compare this value with the overall uptake of smoking cessation services, according to ethnic group. This shows that men from Pakistani, Bangladeshi, Chinese and Black African ethnic groups appear to be noticeably under-represented within smoking cessation services. Women from White Irish, Indian, Chinese and Black African communities also appear to be under-represented (although these figures need to be interpreted with caution due to the relatively low numbers involved).

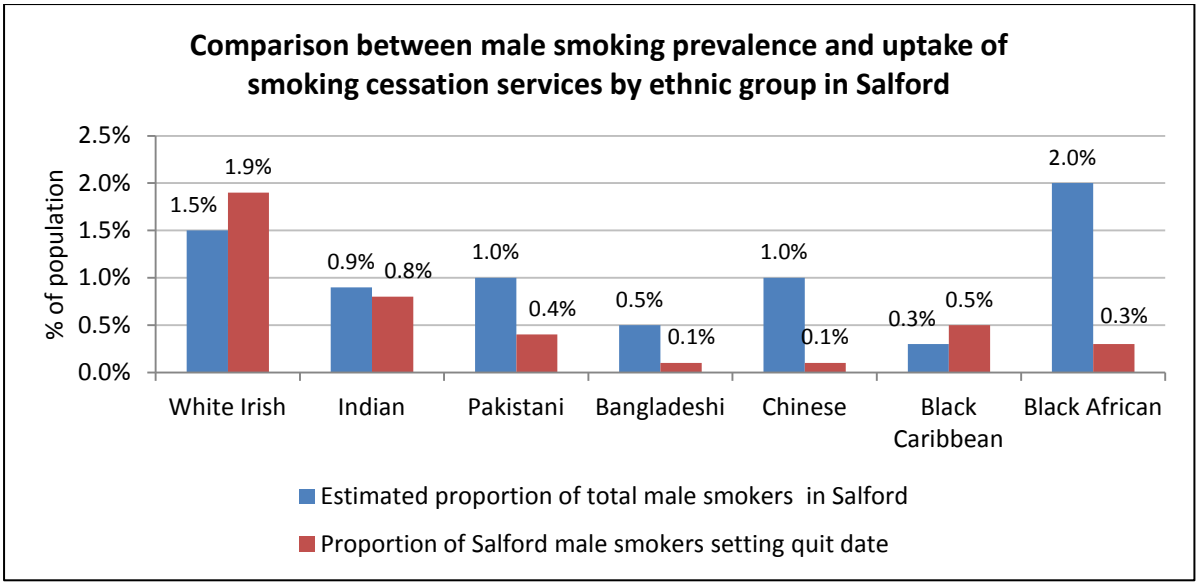


Figure 64: Comparison between male smoking prevalence and uptake of smoking cessation services by ethnic group in Salford
Source: Local smoking cessation data

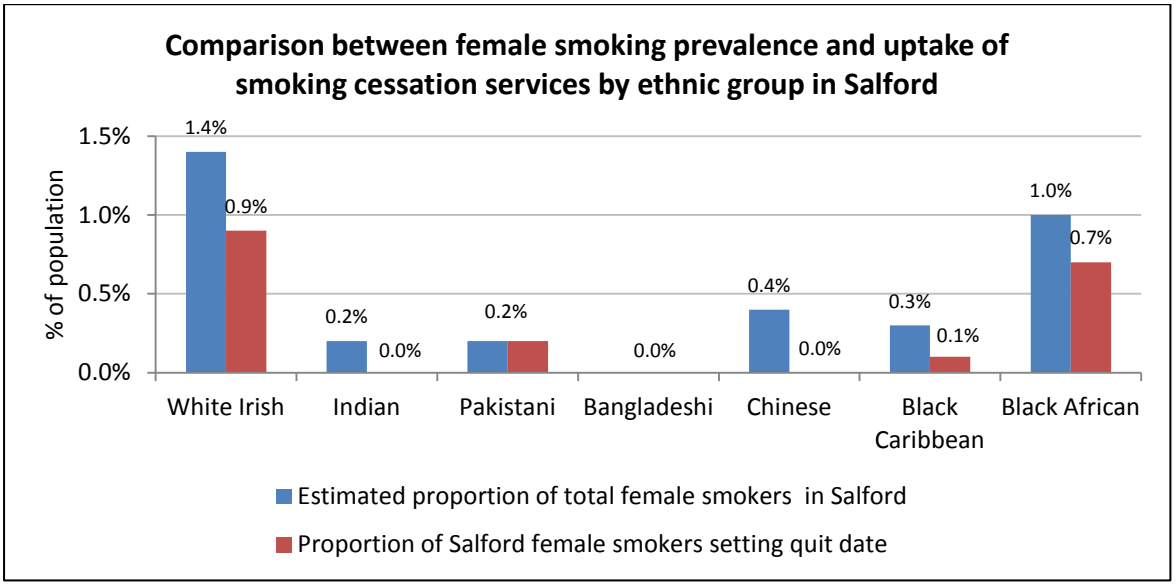


Figure 65: Comparison between female smoking prevalence and uptake of smoking cessation services by ethnic group in Salford
Source: Local smoking cessation data

6.4. Screening uptake

NHS screening programmes do not currently record ethnicity routinely. Salford-specific ethnicity data is available for the Abdominal Aortic Aneurysm (AAA) screening programme which screens men at the age of 65. 93.5% of men screened in Salford during 2015-16 were White British. This value matches the total proportion of White British people in Salford at this age (using the 65-69 age band from the 2011 Census). It is not possible to make robust comparisons between the screening data and Census data for specific minority groups due to the low numbers involved, although it appears that uptake of AAA screening among White Irish men may be relatively low.

Table 39: AAA screening uptake by ethnic group in Salford (2015-16)

Ethnic group	AAA uptake: number (%)	% of total population[25] (2011 Census)
White British	763 (93.5%)	93.5%
White Irish	14 (1.7%)	2.8%
Other White	9 (1.1%)	1.3%
Asian	19 (2.3%)	1.2%
Black	5 (0.6%)	0.3%
Mixed	2 (0.2%)	0.3%
Other	4 (0.5%)	0.4%
Grand Total	**816**	

Source: GM screening data, 2011 Census

A review by Salford City Council found that the GP practices with a high proportion of Jewish patients (80% of the list) had relatively low uptake of cervical screening [23]. Although there is some coding of ethnicity in the screening programmes within Salford, this is linked to paper records and review of these was out-with the scope of this project.

[25] Aged 65-69

6.5. Hospital Episode Statistics

Data on hospital admissions comes from routinely collected Hospital Episode Statistics [66]. It describes all hospital attendances for residents registered with Salford GPs. The data presented is from between April and August 2015. 73,632 out of 78,574 (93.7%) episodes during this period had ethnicity recorded. Data from 2014/15 was more incomplete with only 78.1% of episodes having ethnicity coded and so this was not analysed.

Table 40 describes the hospital admission rates for each ethnic group during this time period. It is not possible to comment on the significance of any differences seen.

Table 40: Hospital admissions according to ethnic group in Salford, 2015-16

Ethnic Group		Inpatient Admissions		A+E attendances		Total hospital episodes	
		N	%	N	%	N	%
WHITE	British	30,074	84.7%	32,105	83.8%	62,179	84.4%
	Irish	771	2.2%	399	1.0%	1,170	1.6%
	Other White	1,398	3.9%	1,849	4.8%	3,247	4.4%
	TOTAL WHITE	**32,243**	90.8%	**34,353**	89.7%	**66,596**	90.4%
ASIAN	Indian	252	0.7%	196	0.5%	448	0.6%
	Pakistani	337	0.9%	357	0.9%	694	0.9%
	Bangladeshi	220	0.6%	44	0.1%	264	0.4%
	Chinese	138	0.4%	197	0.5%	335	0.5%
	Other Asian	320	0.9%	384	1.0%	704	1.0%
	TOTAL ASIAN	**1,267**	3.6%	**1,178**	3.1%	**2,445**	3.3%
BLACK	African	728	2.1%	905	2.4%	1,633	2.2%
	Caribbean	110	0.3%	118	0.3%	228	0.3%
	Other Black	109	0.3%	310	0.8%	419	0.6%
	TOTAL BLACK	**947**	2.7%	**1333**	3.5%	**2280**	3.1%
MIXED	White / Asian	39	0.1%	90	0.2%	129	0.2%
	White / Black African	140	0.4%	122	0.3%	262	0.4%
	White / Black Caribbean	176	0.5%	94	0.2%	270	0.4%
	Other mixed	158	0.4%	289	0.8%	447	0.6%
	TOTAL MIXED	**513**	1.4%	**595**	1.6%	**1108**	1.5%
Any other ethnic group		539	1.5%	844	2.2%	1383	1.9%
TOTAL[26]		37,144	100%	41,610	100%	78,574	100%

Source: Hospital Episode Statistics

The figures below compare both the hospital admission and A+E attendance rates for men and women in Salford according to ethnic group. These rates are standardised against the White British rate (represented by a value of 100). Rates for BME groups are illustrated with 95% confidence intervals. If these intervals do not span 100 then they can be considered to be significantly different from the White British value.

[26] Excluding 4,942 cases (6.3% of total cases where ethnicity unknown)

Figure 66 shows that male admission rates are significantly higher among White Irish and Bangladeshi communities. Female admission rates are higher in Bangladeshi, Other, Caribbean, Pakistani and Other Black groups (Figure 67). In terms of A+E attendance, rates are significantly higher than the White British average in Other Black, Other, Other Asian and Other White communities (Figure 68). Figure 69 shows that female A+E attendance is highest among Other Black, Other, Pakistani and Black African women.

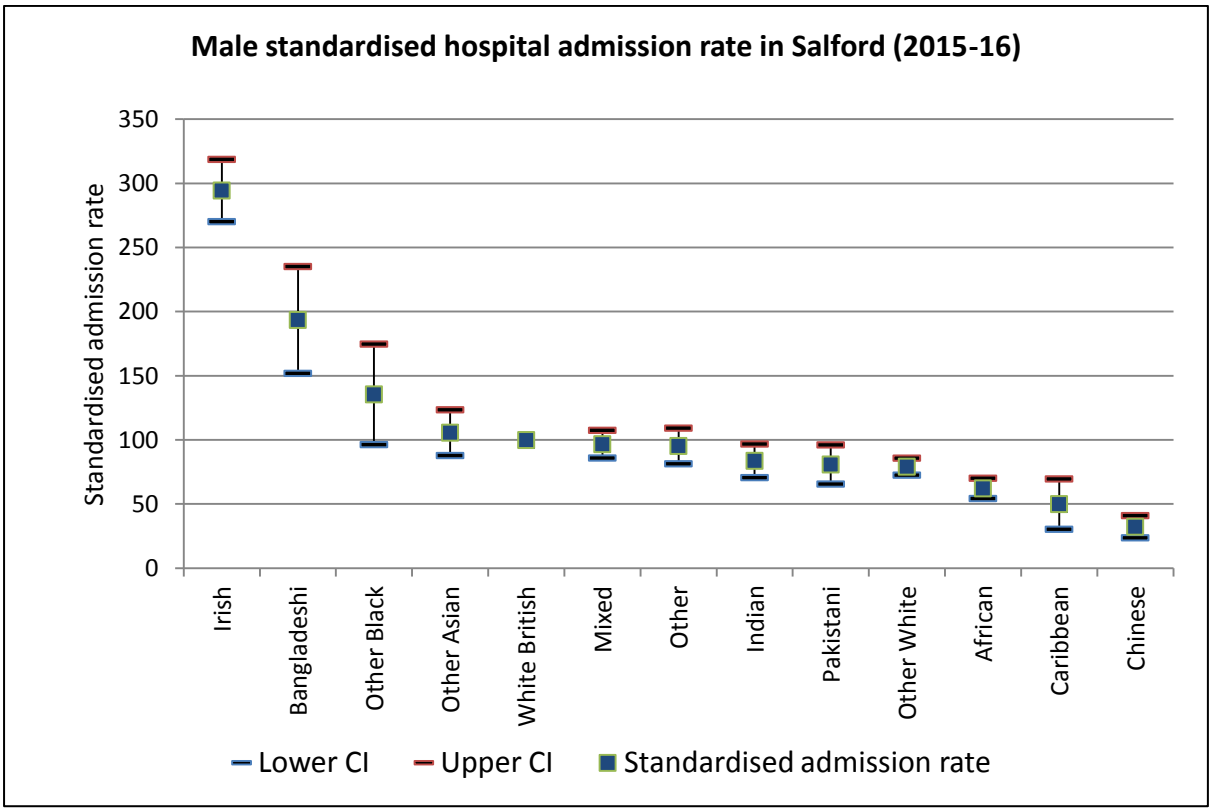


Figure 66: Male standardised hospital admission rates in Salford

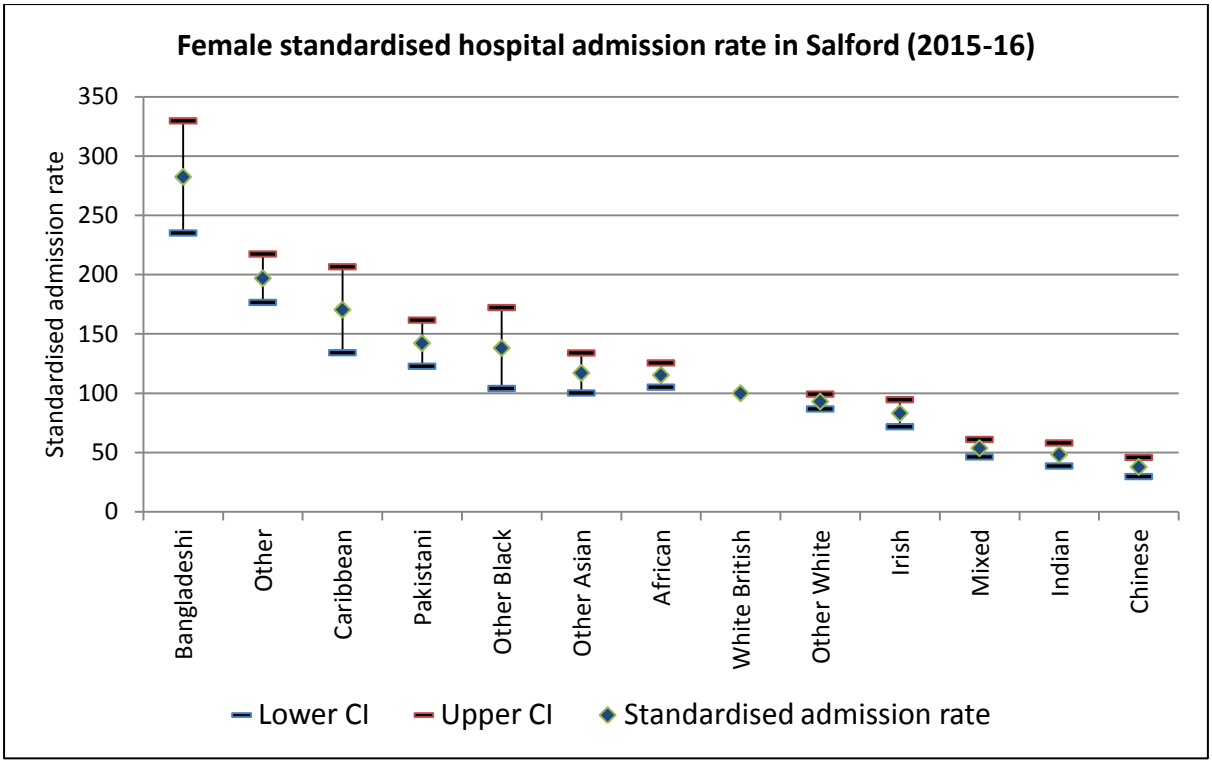


Figure 67: Female standardised hospital admission rates in Salford

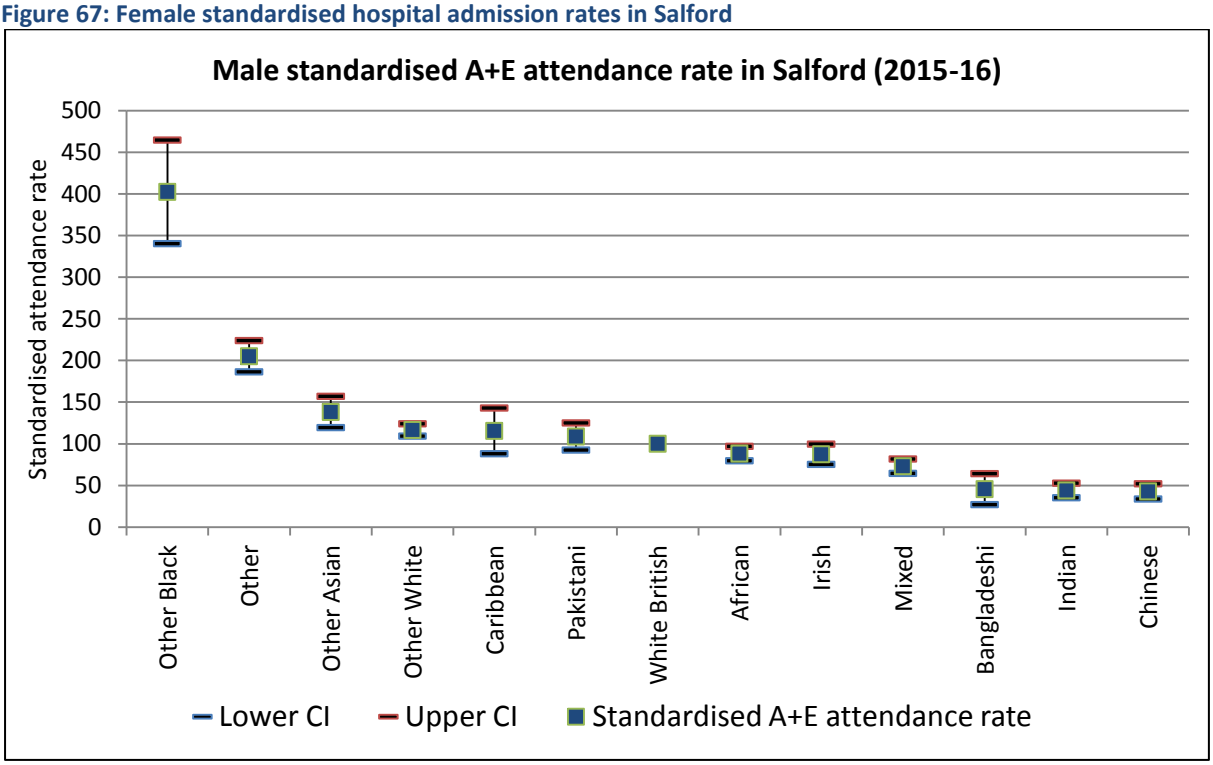


Figure 68: Male standardised A+E attendance rate in Salford

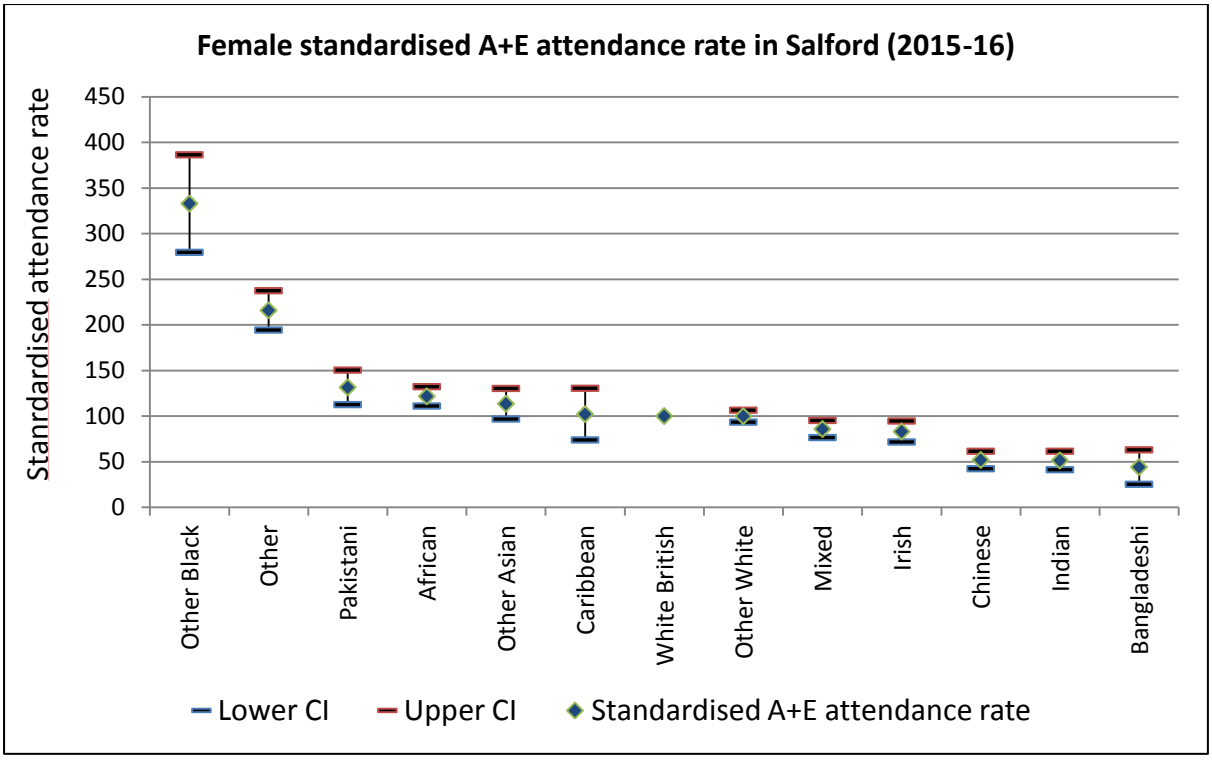


Figure 69: Female standardised A+E attendance rate in Salford

6.6. Sexual health data

Salford data on STIs is consistent with the national evidence and shows a disproportionately high rate of diagnosis among Black ethnic groups and relatively low diagnosis rates in Asian communities. The reason for this pattern is unclear and it may be partly related to the relative willingness of these groups to access specialist GUM services (on which these figures are based).

Table 41: Number and proportions of new STIs by ethnic group in Salford (GUM diagnosis only) in 2013

Ethnic group	Proportion of Census population	Cases of STI	
		Number	%[27]
WHITE	90.1%	1365	84.7%
ASIAN	4.0%	33	2.0%
BLACK	2.8%	108	6.7%
MIXED	2.0%	67	4.2%
OTHER	1.1%	38	2.4%

Source: Salford Sexual Health Needs Assessment, 2015 [67]

Figure 70 shows the rates of new STI diagnoses according to ethnic group in both Salford and England. A similar pattern is evident across both areas with the highest rates seen in Black (1,651/100,000 per year) and Mixed (1,451/100,000 per year) ethnic groups.

[27] Excluding 79 cases where ethnicity not specified

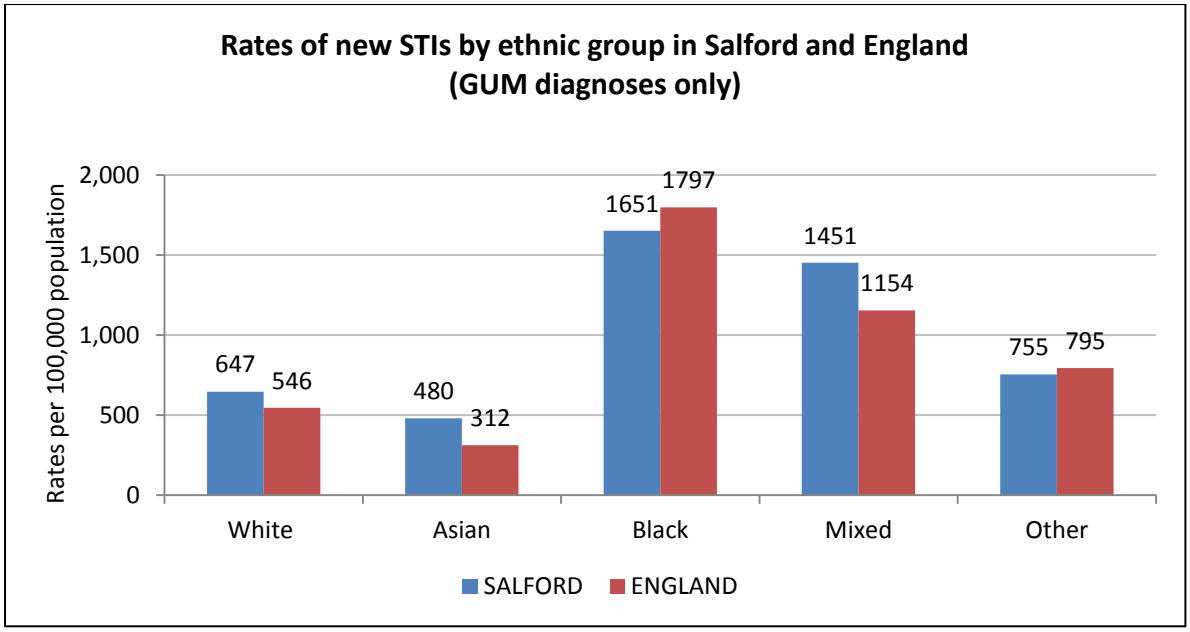


Figure 70: Rates of new STIs by ethnic group in Salford and England (GUM diagnoses only)
Source: Salford Sexual Health Needs Assessment, 2015 [67]

6.7. Female Genital Mutilation data

City University London published estimates of the prevalence of FGM by Local Authority area in 2015. These are based on Census data regarding country of birth. In Salford the estimated prevalence of FGM is 4.6 per 1,000 women. This compares to a value of 5.0 per 1,000 in England and 2.3 per 1,000 in the North West (Table 42). Prevalence is greatest in the 15-49 age group.

Table 42: Prevalence of FGM in Salford

Age range	Estimated number	Prevalence[28] (per 1,000 women)
0-14	50	2.4
15-49	450	7.6
50+	35	0.9
Total	**535**	**4.6**

Source: City University [68]

At a Greater Manchester level (Figure 71), FGM rates in Salford are second only to those in Manchester City Council (16.2 per 1,000).

[28] Estimated prevalence based on ONS data on country of origin

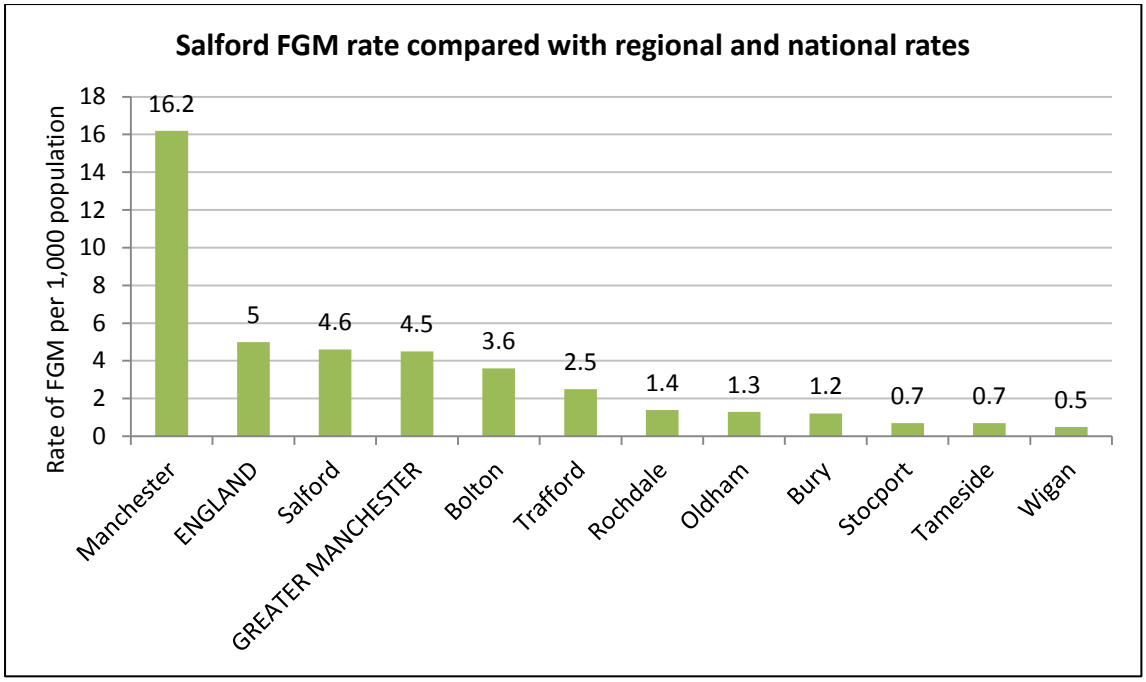


Figure 71: Salford FGM rate compared with regional and national rates

The Greater Manchester FGM strategy states that GM Local Authorities should anticipate that levels of FGM reporting will increase in response to growing awareness of the condition and changing patterns of migration, as seen in Salford [69]. There is an existing service at a Greater Manchester level which accepts acute referrals but this is being reviewed to ensure it is able to accommodate increasing demand [69].

The Greater Manchester FGM Board was established in 2011 and has produced a FGM protocol to inform all agencies of their responsibilities. Work on addressing FGM in Salford is led by the Violence Against Women Board [70].

Key components of the FGM strategy include community education and early engagement to change attitudes and prevent children from being taken overseas for FGM [69]. This is currently being provided by third sector community groups in Salford including Warm Hut, NESTA, AFRUCA and Hosla [69]. It is recommended that this communication is co-ordinated at a GM level and brings different agencies together to give a consistent message [69]. The strategy also recommends that health assessments for asylum seekers should involve asking about FGM whenever appropriate.

The Department of Health guidance on FGM highlights the importance of culturally appropriate psychological support for victims [69]. There are currently groups providing this in Salford for adult victims but the GM strategy has recognised that support services may lack capacity for growing demands and often focus on victims from African countries [69]. There is also no consistent approach to dealing with child victims [69]. Physical needs may involve de-infibulation and fistula repair which the CCG is responsible for funding.

6.8. Asylum seeker health

Between 2004 and 2012 Salford NHS Primary Care Trust commissioned a dedicated primary care service for asylum seekers called the Horizon Centre. In 2012 this was replaced by a Locally Commissioned Service (LCS) which GP surgeries could enrol in.

A survey of 27 asylum seekers in Salford was conducted by the United for Change Health Group in 2013. The results showed that 63% found the process of registering with a GP to be not very easy or not at all easy, mainly due to problems finding acceptable proof of address. 36% of those with additional language needs were not offered an interpreter. There was also a perception that having a telephone interpreter was inferior to a face-to-face interpreter [71].

By 2015 there were 167 Salford patients who had been coded as asylum seekers in the previous 15 months. Only 68 (41%) were registered at practices signed up to the LCS. Consequently the LCS was decommissioned and a new system created as part of the Salford Standard which was launched in April 2016 [55]. This allows any GP surgery to claim funding for looking after asylum seeker patients according to set of performance indicators. These indicators include guidance on GP consultation length and arranging face-to-face translation where possible.

Salford also provides an Asylum Seeker Mental Health Consultation service, funded by Greater Manchester West. This service runs twice-weekly and accepts referrals from primary care, A+E, mental health teams and allows self-referral for those not yet registered with a GP. It offers appointments with specialist GPs and also provides advice and support regarding a range of social issues.

The commonest countries of origin for asylum seekers registering with Salford GP practices are Sudan, Iran, Eritrea, Iraq and Syria based on data from 2014-15 (Table 43). Table 44 lists the primary languages of this group over the same period, showing that Arabic is the most widely spoken language. Of these asylum seekers, almost half (48.4%) were registered with Salford Health Matters.

Table 43: Country of origin for asylum seekers registered with GP practices in Salford (2014-15)

Country of origin	Number (%)
Sudan	41 (25.5%)
Iran	27 (16.8%)
Eritrea	23 (14.3%)
Iraq	19 (11.8%)
Syria	15 (9.3%)
Kuwait	8 (5.0%)
Pakistan	6 (3.7%)
Afghanistan	5 (3.1%)
Ethiopia	4 (2.5%)
Not recorded	4 (2.5%)
Albania	2 (1.2%)
Libya	2 (1.2%)
Egypt	1 (0.6%)
India	1 (0.6%)
Somalia	1 (0.6%)
Uganda	1 (0.6%)
Ukraine	1 (0.6%)

Source: Salford CCG data

Table 44: Primary language of asylum seekers registering with GPs in Salford (2014-15)

Language	Number (%)
Arabic	70 (43.5%)
Kurdish	18 (11.2%)
Tigrean	18 (11.2%)
Farsi	17 (10.6%)
Not recorded	13 (8.1%)
Sorani	7 (4.3%)
Amharic	4 (2.5%)
Dari	4 (2.5%)
English	3 (1.9%)
Albanian	2 (1.2%)
Punjabi	2 (1.2%)
Urdu	2 (1.2%)
Russian	1 (0.6%)

Source: Salford CCG data

6.9. Social determinants of health

One limitation of this evidence review is that most of the data summarising health in different ethnic groups does not consider the effects of other factors which influence health. These factors include age (as discussed) and socioeconomic status. It is likely that part of the explanation for the worse health outcomes seen in BME groups is that they experience more socioeconomic deprivation.

Figure 72 shows data for Salford on the proportion of each ethnic group who have either never worked or are long-term unemployed. Arab, Bangladeshi and Pakistani groups have rates between 3 and 4 times higher than the White British average. All other ethnic groups except Other White also have higher rates of long-term unemployment than the White British population. The comparable rate for the Jewish population in Salford is 10.4%.

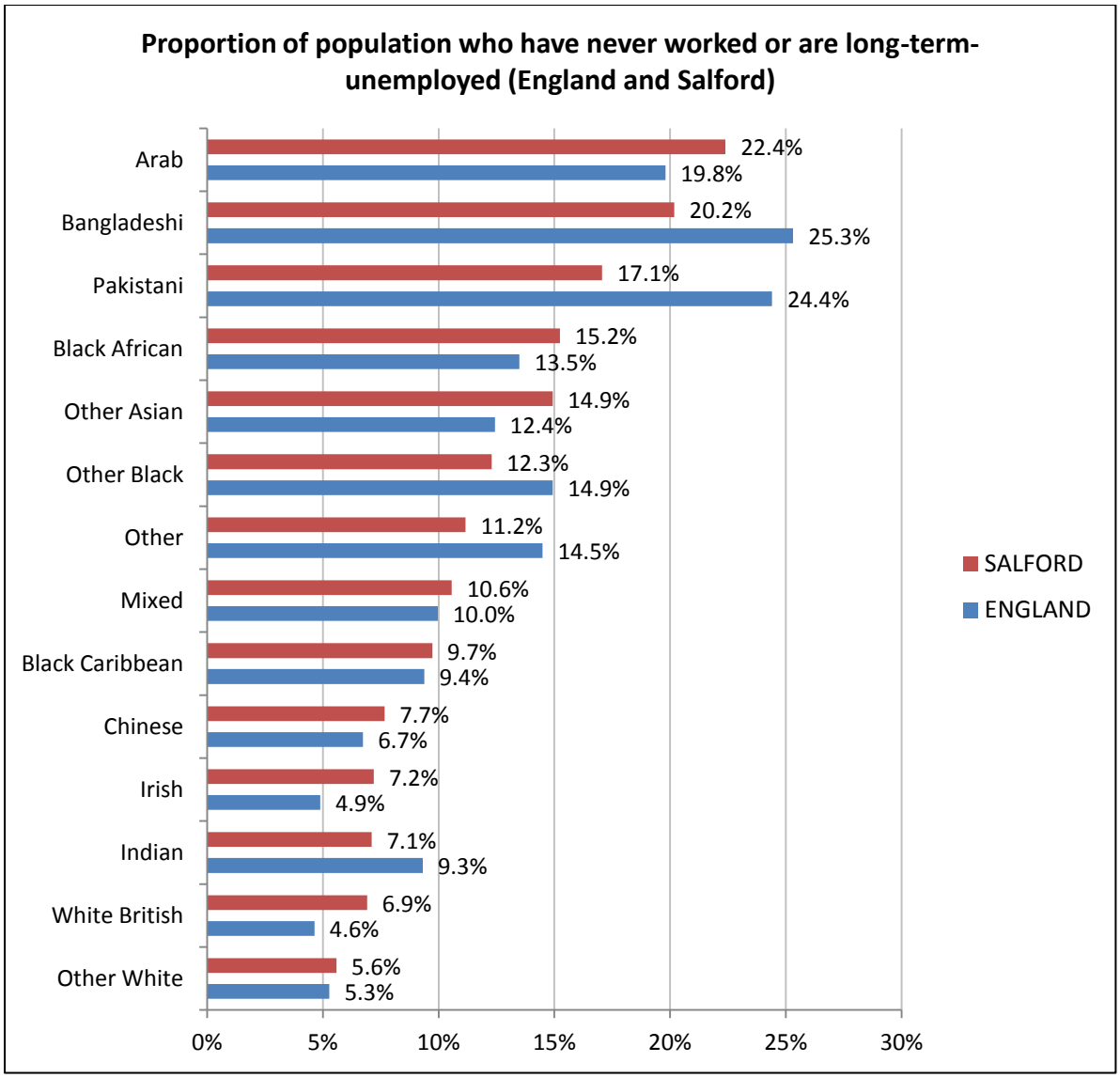


Figure 72: Proportion of population in NS-SeC Class 8 (Never worked and long-term unemployed) in England and Salford

Source: Nomis – 2011 Census [7]

Part of this variation is explained by the fact that members of BME communities are more likely to live in deprived areas of Salford with the attendant disadvantage which this brings. However, even when looking at Broughton (the ward with the highest rate of long-term unemployment according to the 2011 Census), there is still a clear ethnic gradient, with rates of long-term unemployment being at least 50% higher in Asian and Black communities in comparison to the White British community (Figure 73).

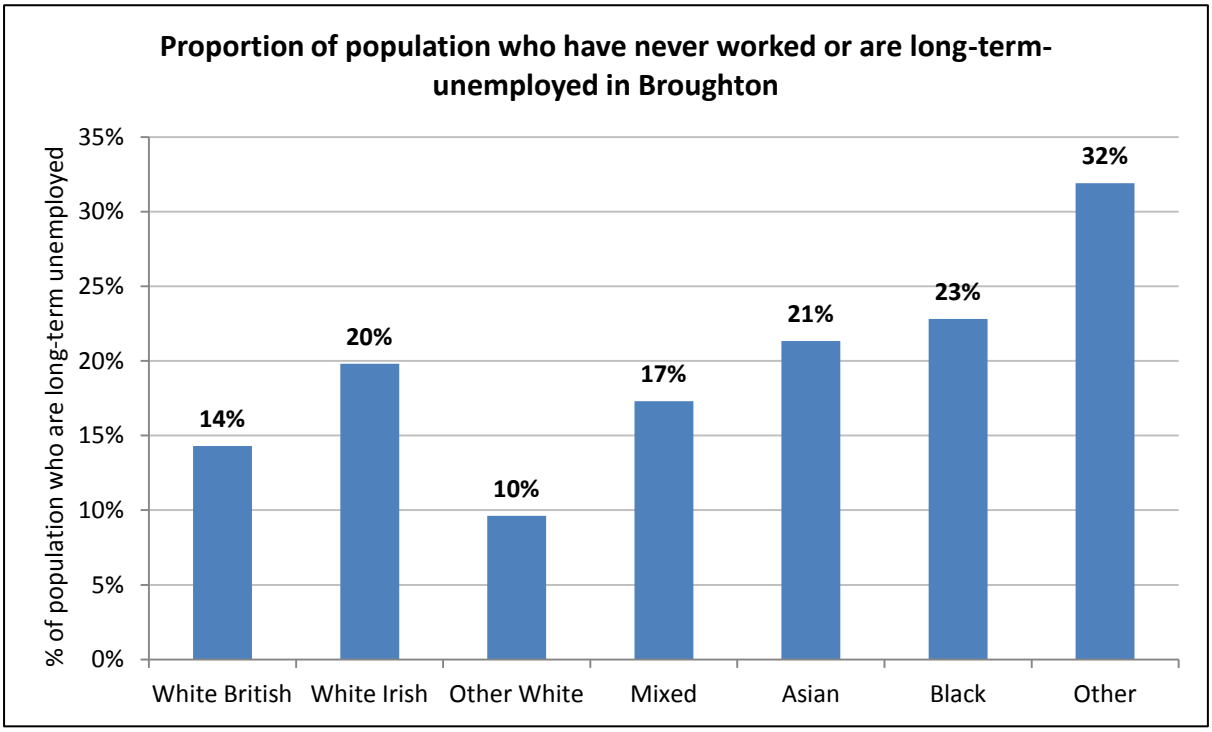


Figure 73: Proportion of population who have never worked or are long-term-unemployed in Broughton
Source: Nomis – 2011 Census [7]

Reduced employment leads to material disadvantage and child poverty rates have been found to be higher for BME groups, especially those from a Bangladeshi or Pakistani background [72]. According to national figures, the ethnic groups with the highest proportion of pupils eligible for free school meals are Irish Travellers, Gypsy / Roma, Bangladeshi and Black African [5]

Deprivation is also associated with inadequate housing.

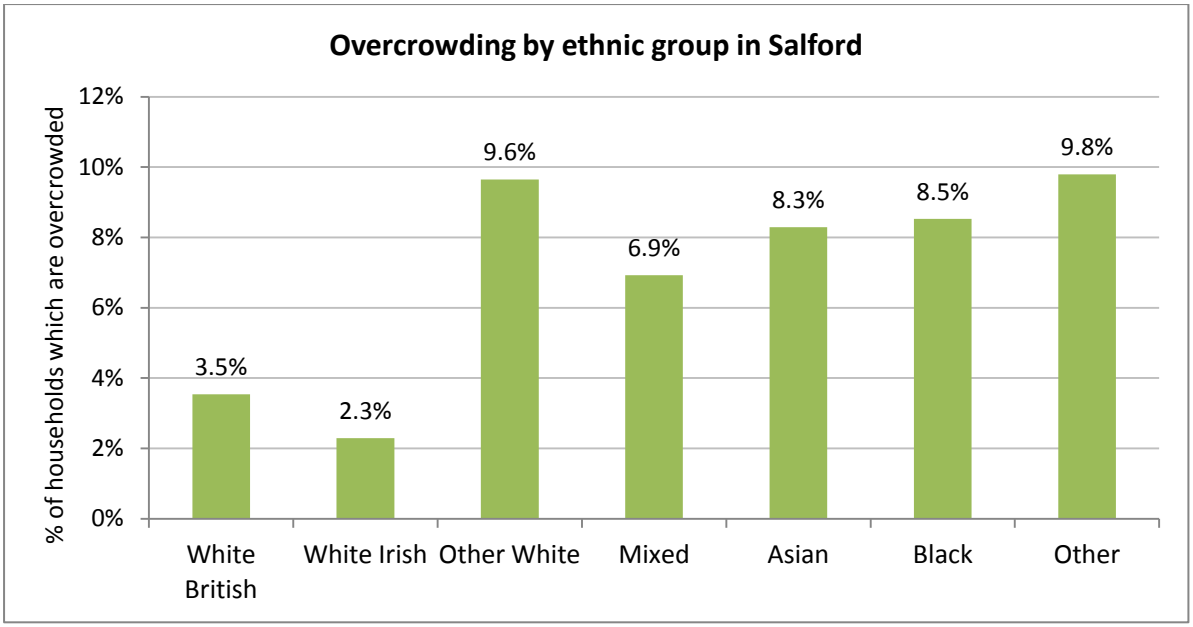


Figure 74 illustrates the proportion of people in Salford within each ethnic group living in a house which is overcrowded according to the ONS definition. This shows that overcrowding rates in most BME groups are far higher than the White British average and are particularly high among the Bangladeshi (32%), Gypsy / Irish Traveller (27%) and Arab (24%) communities.

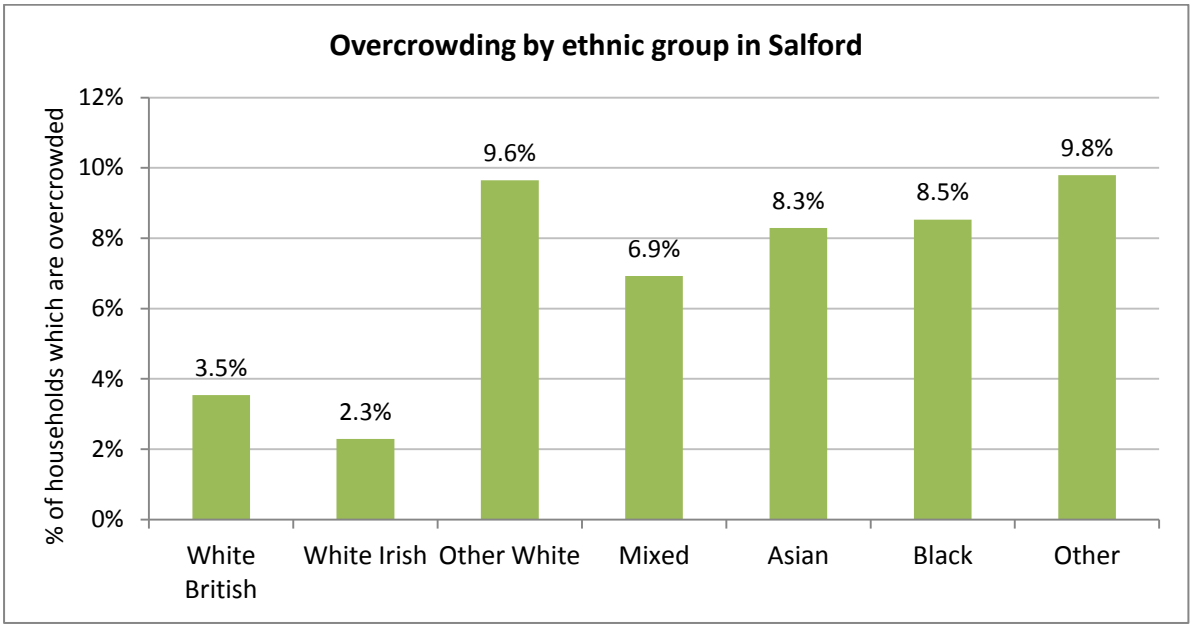


Figure 74: Proportion of households experiencing overcrowding by ethnic group in Salford
Source: Nomis – 2011 Census [7]

The level of overcrowding[29] from the same dataset for the Salford Jewish population is 7.2%, more than double the average for the White British population.

Again this variation is partly explained by deprivation but Figure 75 shows the rates of overcrowding by ethnic group in Irwell Riverside, the ward with the highest rates of overcrowding according to the 2011 Census. This shows that even in this area, rates of overcrowding among residents from Asian and Black communities are approximately double that of White British communities.

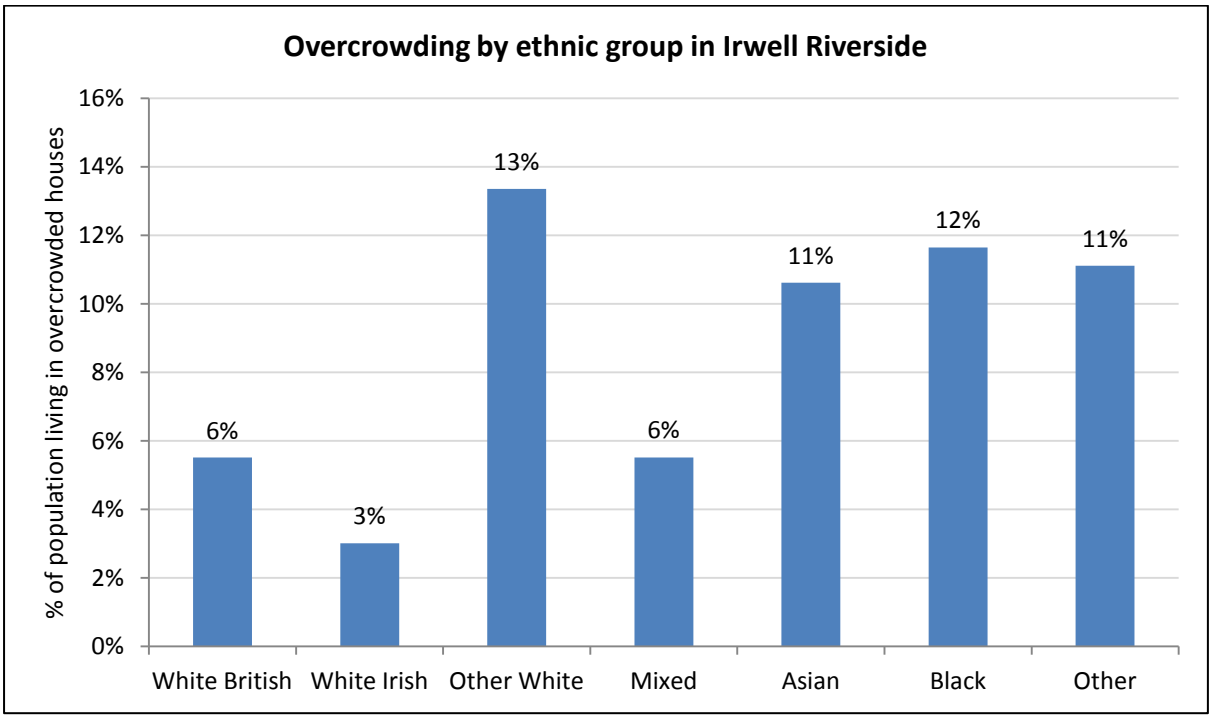


Figure 75: Proportion of households experiencing overcrowding by ethnic group in Irwell Riverside
Source: Nomis – 2011 Census [7]

6.10. Community research projects in Salford

In addition to the evidence presented, there have been two notable community research projects which have recently been undertaken in Salford. In 2015 Salford CCG funded a research project looking at healthcare issues within the Orthodox Jewish community [24]. The team conducted focus groups with 72 community members and distributed a quantitative survey which had 507 responses. Based on the findings, a number of recommendations were made which are listed in Appendix 4.
In 2014, an Action Research project involving the Gypsy Roma and Irish traveller community made several recommendations designed to empower the community and improve their interactions with public services [73]. This involved developing local policy setting out how the health and other needs of the community could be met and to develop specialist resources for health professionals to access when working with community members. The recommendations from this project can be found in Appendix 5.

[29] Overcrowding is defined as a house having one fewer bedroom than required

7. CONSULTATION SUMMARY

Table 45 lists the groups which were interviewed as part of the consultation work:

Table 45: Overview of stakeholder consultation

GROUP	DESCRIPTION	DATE INTERVIEWED
Europia	Charity providing support to Central and Eastern European migrants across Greater Manchester	19/10/15
Interlink-NW	Community group representing the Orthodox Jewish community in Salford	16/11/15
Six-degrees	Social enterprise which delivers mental health services in Salford	16/11/15
Salford Refugee Forum	Community group representing refugees and asylum seekers living in Salford	7/12/15
Warm Hut	Charity supporting Refugees and Asylum speakers in Salford, particularly those from French-speaking African countries	11/1/16

The information presented comes primarily from the interviews themselves but is supplemented by additional material provided by the organisations and their websites.

Europia

Europia was founded in 2009 to represent Eastern and Central European migrants in Greater Manchester. It has approximately 30 volunteers working within these communities of which 5-7 are based in Salford. At the time of the interview they ran various services including 'Tea Time' – a support group for those with low-level mental health problems in Salford. They also delivered English classes and provided a monthly drop-in service at their Manchester hub to provide support on a range of social issues. Table 46 lists the concerns of Europia about the groups they represent and Table 47 lists improvements which were suggested.

Table 46: Europia – concerns expressed	
AREA	**CONCERNS**
Mental health problems	• Anxiety and low levels of wellbeing are reportedly common in this population
Lifestyle factors	• Alcohol and drug misuse are major problems. Late presentation is common due to a poor understanding of safe limits and language barriers to accessing support. • Smoking and poor diet are also major problems in the community
Access to healthcare	• There is a perception that Eastern European communities have an expectation of same day access to a doctor based on practices in their native country. This can lead to them presenting to A+E rather than waiting for a GP appointment
Social problems	• Homelessness is a major issue and often co-exists with substance misuse • Job satisfaction is often poor with many European migrants being over-qualified for their jobs

Table 47: Europia - suggested improvements	
AREA	**SUGGESTED IMPROVEMENTS**
Access to healthcare	• The European population in Greater Manchester is widely dispersed across Local Authorities, which makes it hard for individual authorities and CCGs to justify providing specific services (e.g. a Polish-language alcohol worker). • 'Devo-Manc' may provide the economies of scale to do this at a GM-level, perhaps with a job description split between different areas.

Interlink-NW

Interlink-NW is the North West base of Interlink, a national charity representing the Orthodox Jewish community. Approximately 70% of its current clients are Salford residents. It provides support to a number of Salford-based Jewish groups.

At the time of the interview it was providing twice weekly advice sessions where community members could come to receive advice on social issues such as welfare benefits and housing. It was co-ordinating a mental health strategy group to investigate ways to improve the provision of mental health services to Jewish populations. They were also delivering Safeguarding training to schools and other groups. Concerns expressed by Interlink and suggested improvements are listed in Table 48 and Table 49.

Table 48: Interlink-NW - concerns expressed

AREA	CONCERNS EXPRESSED
Mental health problems	• It was suggested that there may be a significant level of undiagnosed psychiatric illness in the Jewish community • If was suggested that low-intensity psychological interventions (e.g. counselling) will be most effective if delivered by practitioners with knowledge of Orthodox Jewish beliefs • Concerns were expressed that some Jewish children are discharged too early from Psychiatric services
Maternity services	• The Orthodox Jewish community has a number of specific cultural practices relating to the period before and after delivery, which are not well understood by NHS services
Children's services	• Many Orthodox Jewish children attend independent faith schools • Several child health services (e.g. screening and speech and language therapy) are now being delivered through the state school infrastructure with no comparable systems in place for independent schools
End-of-life care	• The Orthodox Jewish faith has specific priorities and concerns in relation to aspects of end-of-life care - such as the withdrawal of food and fluid – which are not always recognised and understood within the health service
Access to healthcare	• GPs in the community are popular and well-respected but the population favour a small number of Jewish GP practices which is reportedly causing problems with patient access for consultations.
Social problems	• Over-crowding is relatively common due to large family sizes • There is a perception that care is often inadequate for those requiring it due to a lack of resources. Many elderly Jewish people emigrate to Israel or move out of Salford to live with family.

Table 49: Interlink-NW - suggested improvements	
AREA	**SUGGESTED IMPROVEMENTS**
Mental health problems	• Interlink-NW is working to improve awareness of mental illness within the Jewish community in Salford, including how to access existing services • Interlink-NW working with providers of mental health services (including Six Degrees) to ensure that services are sensitive to the needs of the Orthodox Jewish community. It also recommends that organisations consider a focus on the unique mental health requirements of remaining Holocaust survivors
Children's services	• Focus on improving the delivery of routine healthcare services within Jewish independent schools
End-of-life care	• Interlink-NW has developed a resource called *Chayim* Aruchim which focuses on issues around end-of-life care. This involves providing advice and training to community members and Rabbis on issues such as advance directives and living wills

Six degrees

Six degrees is funded by Salford CCG and provides a range of mental health services, including some targeting minority groups. These include a Polish-language service which delivers cognitive-behavioural therapy and guided self-help. It also delivers include psychological interventions focused on the Polish and Orthodox Jewish community. Their Eis L'Daber programme employs an Orthodox Jewish therapist in to deliver Psychological interventions to Orthodox Jewish members. It also offers group therapy and works to support other community—based organisations which look to provide support with mental health problems.

Salford Refugee Forum

Salford Refugee Forum was founded in 2009 to represent various refugee and asylum seekers community groups in Salford. It has no formal membership list but 50-100 people attend its meetings which are held twice-monthly. It estimates that it represents people from approximately 20 different countries.

It runs a regular advice clinic to which people can be referred for help with social problems including housing and benefits issues. This runs alongside the Asylum Seeker Mental Health service which is commissioned by Greater Manchester West. Salford Refugee Forum is also partnered with a Social Enterprise called Visible Outcomes which runs various projects for the refugee community including a work club and various training courses. Table 50 and Table 51 list the concerns and possible improvements suggested by the Forum.

Table 50: Salford Refugee Forum - concerns expressed

AREA	CONCERNS EXPRESSED
Mental health	• Post-traumatic stress disorder is common within this community and is often secondary to torture • Problems with alcohol misuse are seen frequently • Depression is very common, including suicidal thoughts. There is often associated loneliness and isolation. Family breakdown is common.
Infectious diseases	• HIV and TB are both common within this group
Access to healthcare	• Pregnant women report experiencing barriers to accessing antenatal care • Children with disabilities within the asylum process do not receive funding to access specialist services • Numerous barriers reported to accessing GP care including complex registration procedures and difficulties requesting consultations due to language barriers • People are often unsure how the healthcare system works and so end up using A+E to access help
Social problems	• Poor quality housing common for those in the asylum system. Destitute asylum seekers often end up homeless and are unable to access social services. • There is a perception that racism and hate crime is increasing, and that it is often under-reported due to fear associated with contacting the police. • Many council services do not provide interpreting services meaning children need to be used instead. Language barriers can lead to sanctions by the job centre due to a misunderstanding of the system. • Adults can find it difficult to access further education if they have only been granted discretional leave to remain

Table 51: Salford Refugee Forum - suggested improvements	
AREA	**SUGGESTED IMPROVEMENTS**
Access to healthcare	• An engagement and outreach worker with a specific focus on the Refugee community could help individuals to access and co-ordinate health and social care services of relevance to them (a similar role has reportedly been created in Bury) • 'Devo-Manc' may have the potential to improve how services are organised and lead to a more strategic and co-ordinated approach to dealing with refugee groups across the city

Warm Hut

Warm Hut was founded in 2009 and is a charity which supports refugees and asylum seekers living in Salford, with a particular focus on the French-speaking African community. Currently about 500 people access its services across Salford. It provides training including ICT and English classes and runs a weekly homework club to support the children of clients accessing its service. A drop-in service exists to signpost people to various organisations and to help with social problems. It also delivers a service which provides emotional support to women who have been victims of FGM. Warm Hut described various issues facing this community which are listed in Table 52.

Table 52: Warm Hut - concerns expressed	
Area	**Concerns expressed**
Female Genital Mutilation	• A relatively common problem in the Black African community
HIV	• Significant stigma still remains in the community, including in relation to HIV-testing
Access to healthcare	• Translation is a major issue for clients who often report problems accessing interpreting services.
Social problems	• Homelessness and destitution is common in the asylum seeker population, especially among those whose claims are rejected but cannot return home • Unemployment is common among those otherwise able to work. Qualifications from a person's country of origin are often not recognised. • Parents report finding it hard to support their children's education due to their own problems with the English language.

8. LIMITATIONS OF HEALTH NEEDS ASSESSMENT

This Health Needs Assessment has attempted to review national and local evidence on health outcomes relevant to BME groups. The Census is the data source which codes ethnicity in the most consistent way and unfortunately this data is now five years old. Although the ONS produces mid-year population estimates, these do not include projections for different ethnic groups.

A wider problem is the inadequate coding of ethnicity in many routine datasets. This means it is not possible to ascertain (within Salford) the ethnic inequalities in issues such as life expectancy, chronic disease prevalence, screening and mental health outcomes. There is evidence that some areas are starting to improve coding (such as Salford Royal NHS Foundation Trust) but further progress is urgently required across the system in order to identify the expected variation in health outcomes between ethnic groups.

Where ethnicity data is available, there are inherent problems in applying it to large, diverse populations. Ethnic categories (particular the major ethnic groupings) summarise individuals from a range of cultures and faith backgrounds, while the country of birth (including the UK) will also differ. Even where these factors are consistent there may be other factors which are far more significant in determining health outcomes. For example, a member of the Black African community living in Broughton may experience very different challenges and opportunities compared with one living in Worsley.

A problem common to most of the data sources is that they do not correct for confounding factors which may partly or largely explain some of the relationships seen between ethnicity and health. As mentioned, these include age and socioeconomic status. However, regardless of cause, the data presented should be sufficient to highlight the most disadvantaged communities. Subsequent work then needs to focus on prioritising the various health and social care factors which contribute to poor health outcomes as part of a co-ordinated response between the Council, CCG and other relevant agencies.

A further problem with some of the data (including that from the Census and HSE 2004) is that it is only possible to describe patterns and trends rather than commenting on statistical significance because the data is not sufficient to allow this. Therefore some of the patterns described may be due to chance rather than indicating true differences.

The stakeholder consultation was limited by the capacity of the author to arrange and conduct interviews. The views expressed in this section cannot be considered as representative of the BME population in Salford but they do generate ideas which can feed into subsequent interventions in this area. Further community consultation is required and this should survey a wider range of community groups and their members.

9. RECOMMENDATIONS

9.1. Understanding the causes of health inequalities in Salford

There are clear inequalities in health between BME groups and White British communities. However, the reasons for these differences are complex. At a national level, rates of deprivation in BME groups are higher and this is thought to be the major factor in explaining the observed differences [74, 75]. It is unclear to what degree these differential health outcomes exist in areas, such as Salford, which has above-average rates of deprivation (including in the White British population). It is likely that BME groups in Salford are relatively more deprived than White British groups but data to demonstrate this is limited.

However, as discussed, there are also some patterns of disease in ethnic groups which are independent of deprivation and caused by variations in human biology, lifestyle or healthcare factors. For example, increased rates of coronary heart disease in South Asian populations and increased rates of prostate cancer in Black populations. However, as well as variation in health outcomes between ethnic groups, there is also significant variation within ethnic groups which again is likely to be partly liked to relative deprivation.

Overall, there is limited evidence at a national level that access to care and treatments varies significantly between ethnic groups [75]. However, there is evidence for lower uptake of some preventative services such as screening and for issues with accessing cancer services and palliative care. Within Salford there is anecdotal evidence of barriers to accessing health services for certain groups including asylum seekers, Eastern Europeans and the Orthodox Jewish population.

A further explanation of ethnic inequalities relates to the impact of racism on health. There is evidence that experiences of racism (whether interpersonal or institutional) can have an adverse effect on a range of physical and mental health outcomes [76, 75].

Uncertainty about causal pathways to ethnic inequalities in health makes it harder to design interventions to address them. Healthcare-focused interventions are likely to improve the experiences and outcomes of BME patients from the point at which they become ill. Improving the targeting of Public Health interventions (e.g. screening, sexual health) may stop or prevent the development of disease in at-risk individuals.

However, addressing the root causes of ethnic health inequalities in Salford will require a systems-wide approach which aims to address the underlying deprivation which is likely to be responsible for most of the observed differences in health outcomes. This requires Council departments (e.g. housing, education) to have an explicit focus on improving services for BME groups and an understanding of the clear links between this work and improved health outcomes across these communities.

9.2. Recommendations

Actions to address the health needs of BME groups in Salford need to consider how they can address both existing health needs and future trends in the BME population. As the BME population increases it will require the capacity of all services (e.g. memory clinics, smoking cessation services) to be more responsive to the needs (e.g. interpretation services) and expectations of these groups. These trends may also require new services to be designed and delivered to better reflect the health needs of BME groups. For example, the large growth in the Black African population will require greater consideration to be given, for example, to support for FGM victims.

The success of any planned interventions within BME groups will depend on their acceptability and appropriateness to community members. This will require extensive and ongoing communication and collaboration with BME groups, which can be partly facilitated by the new CCG engagement worker. It is intended that this work will lead to the following recommendations being further developed in order to meet the needs of BME groups.

The recommendations themselves are grouped according to the elements of Lalonde's model. Human biology is not included since this is considered to be non-modifiable. Healthcare organisation is divided into aspects relevant to prevention and aspects relevant to treatment, to reflect the different organisations responsible for delivering these services. These recommendations have been constructed to take the form of general statements or questions to reflect the need to further develop them in collaboration with community members and other stakeholders. It is expected that this process will then lead to the selection of a number of specific objectives which can then be monitored as part of the ongoing work within Salford on BME health outcomes.

Lifestyle factors	
Smoking	• Develop interventions to increase the uptake of smoking cessation services among groups currently underrepresented within the service in Salford (Asian men and Black African men and women)
Alcohol	• Work to improve the provision of alcohol services for Eastern European populations. For example, through the employment of a Polish-language alcohol worker[30] (see section 2.6: 'Devo Manc.')
Physical activity	• Consider interventions to increase the uptake of physical activity in groups currently reporting high levels of physical inactivity (including Pakistani and Bangladeshi communities)
Sexual health	• Consider targeted health promotion work in groups reporting relatively high rates of STIs in Salford (Table 41)

[30] According to the 2011 Census Polish is the most widely-spoken Eastern European language in Salford (3,526 native speakers), followed by Slovak (359 native speakers)

Healthcare organisation (prevention)	
Health promotion	• When designing health promotion strategies for different neighbourhoods in Salford, consider the composition of the area in terms of BME groups (Appendix 2) in addition to the health problems known to be specific to different ethnic groups (Appendix 3). • Health promotion interventions for BME groups should include a focus (appropriately targeted) on cardiovascular disease, diabetes, renal disease, cancer prevention, smoking, alcohol and sexual health. • Await the results of the Unique Improvement study investigating barriers to the uptake of Health Checks among BME communities
Children's services	• Ensure mechanisms are in place to ensure that the children of newly-dispersed asylum seekers receive timely input regarding their health (e.g. vaccination status) and social care (e.g. education) • Work with the Jewish communities to review how best to integrate school-based interventions within independent Jewish schools • Work with Gypsy / Roma Traveller community to understand issues of access and uptake of routine child health services (e.g. vaccination, health visitors)
Cardiovascular disease	• Ensure health promotion interventions focusing on cardiovascular disease reflect the varying prevalence of disease according to ethnicity – for example, relatively high rates of coronary heart disease in South Asian populations and relatively high rates of stroke in Black populations
Sexual health	• Support work within the Black African community to reduce stigma around HIV and encourage testing. • Work with communities to ensure that the HIV point-of-care intervention is appropriate and accessible to these populations.
Cancer	• Ensure that details of screening are available in a range of languages. • Work with community groups to raise awareness of cancer symptoms and routes to access appropriate care. • Consider more targeted health promotion interventions based on evidence of ethnic variations in cancer prevalence. For example, highlighting the symptoms of prostate cancer and myeloma among those of Black ethnicity using appropriate resources (e.g. Prostate Cancer UK has resources specifically targeted at the Black community)

Mental health	• Consider interventions focused on reducing stigma around mental health among groups thought to have relatively high prevalence (e.g. White Irish, Gypsy / Traveller and Black Caribbean) such as mental health champions or peer support networks
Asylum seekers	• Consider whether a dedicated asylum seeker liaison worker could act as a point of contact and improve the co-ordination of health and social care services for this group.
FGM	• Support third sector organisations already engaged with this issue to design and deliver training to community members aiming to modify social norms regarding FGM.

Healthcare organisation (treatment)	
Access to healthcare	• Engage with all BME groups to identify perceived barriers to accessing primary care services. • Work with refugee and asylum seeker groups to ensure that they are not facing problems with GP registration. • Work with Eastern European populations to understand and address the apparent preference for A+E services over GP services.
FGM	• Review funding and capacity of existing adult psychological support services for adults in Salford and ensure they have capacity to meet growing the population of FGM victims. • Continue work at a GM level on developing psychological services for child victims and to ensure pathways for acute referrals have sufficient capacity. • Consider asking health visitors to routinely enquire about FGM to improve detection rates[31]. Training resources for GPs and practice nurses need to continue to be developed. • Review the capacity of Gynaecology services in Salford to offer FGM correction procedures where indicated(e.g. deinfibulation)
TB	• Educate GP practices regarding TB screening in primary care. • Review attainment of linked Salford Standard outcome 6.5. Compare data on country of origin of new GP registrations with TB screening rates to ensure this need is being met.

[31] The Institute of Health Visitors has resources on FGM: http://ihv.org.uk/for-health-visitors/resources/minority-groups/

Asylum seekers	• Monitor the number of asylum seekers being managed according Salford Standard outcomes 5.5. Compare this with the Home Office figures and numbers of asylum seekers coded in medical records to ensure that the new service is meeting demand. • Consider arranging GP training on the asylum process, targeting the practices which are registering most asylum seekers. • Consider developing resources to help non-specialist GPs perform initial health assessments with asylum seekers (including consideration of FGM). • Ensure that pregnant asylum seekers dispersed to Salford are able to rapidly access appropriate antenatal care.
Mental health	• Work with all BME groups to identify barriers to reporting mental health problems and educate community members of the types of help available, particularly in high-risk groups (e.g. Black Caribbean, Gypsy / Traveller, White Irish). • Continue to develop culturally-sensitive psychological services which are accessible in a range of languages to reflect the increasing diversity in Salford. Ensure that the Tier 2 mental health service is widely advertised in relevant settings (e.g. A+E department and GP practices). Work with service providers to improve coding of ethnicity to allow any ethnic inequalities in access and treatment to be identified.
Dementia	• Work with all BME groups to understand reasons for delayed presentations with memory problems. Provide education on the type of help available and how to access it in a range of settings and languages • Work to ensure relevant services (including the memory clinic) have the capacity and expertise to accommodate increasing numbers of people from the BME community (some of whom may speak English as a second language).
Palliative care	• Work with all BME groups to identify preferences in relation to palliative care and any barriers to accessing this (including hospice services). Provide education on support available and involve faith leaders in tailoring existing services to meet the specific needs of faith communities. • Consider working with community groups to develop training in cultural issues relevant to end-of-life care for different ethnic groups. Deliver this to healthcare workers involved in delivering palliative care.

Environmental factors	
Social determinants	• Ongoing work is required within Council departments (e.g. housing, education) to consider the impact of their work on BME groups – and the explicit connection with improved health outcomes. • Data collection practices need to be reviewed to ensure that they capture ethnicity data where appropriate, in order to better understand the links between ethnicity, deprivation and health in Salford.
Green spaces	• Consider researching the levels of participation in green space activity among BME groups. If low, considered targeted intervention to improve participation

Research and surveillance	
FGM	• The number of incident cases being reported needs to be monitored. • Qualitative research within the relevant communities could be conducted to explore knowledge and beliefs in relation to FGM
Health data	• Consider making an application to the Salford Integrated Record system to further interrogate any available health data with sufficient coding of ethnicity. Now that hospital data is being recorded more consistently it should be possible to evaluate a range of BME health experiences and outcomes, for example: o memory clinical access o cancer referrals) o child mortality data • At a national level, data on lifestyle risk factors according to ethnicity needs to be updated since most quoted evidence derives from the 2004 Health Survey for England • Work with Greater Manchester West (GMW) to identify the uptake of secondary care psychiatry interventions according to ethnic group • Ensure that this needs assessment is subject to periodic review and updating (according to a schedule to be agreed by the JSNA executive committee)
Population projections	• Update the ethnicity population projections for Salford following publication of the updated ETHPOP dataset in 2016[32]. Update all demographic data following the 2021 Census.
Screening	• Work is required to review paper records of coded ethnicity data (where available) to identify current uptake of cancer screening programmes within BME groups
Vaccination	• Further research is needed into the current uptake of routine childhood vaccinations among all ethnic groups in Salford, including the Orthodox Jewish and Gypsy / Traveller communities

[32] https://www.ethpop.org

Cross-cutting themes	
Coding	• Move to routine electronic coding of ethnicity across health and social care services, including screening services and in primary care.
BME user group	• Consider establishing a BME user group which is representative of the different ethnic groups and religious groups in the city. This group would make it easier to involve the BME community in the design and implementation of services.
Community consultation	• Identify the priority health issues for those groups with the worst health outcomes (e.g. Gypsy / Traveller, White Irish, Bangladeshi and Pakistani). Focus on the areas with the greatest proportions of these communities (Appendix 1). • Consider developing an accessible web-based resource of BME community assets in Salford (regularly updated) which can act as a gateway for BME members seeking support • Consider identifying and training community champions for health among different BME groups, a method used elsewhere[33]
'Devo Manc.'	• Consider working at a Greater Manchester level to develop new models of care to address the health needs of certain populations (e.g. White European, asylum seekers) which are dispersed across the region. Operating at scale may make it financially viable to, for example, employ a Polish-language alcohol worker to work across Local Authorities.
Language	• Ensure that GP practices in areas of high BME prevalence (Appendix 2) have patient information leaflets in a variety of languages. • Encourage Council and NHS services to use face-to-face interpreters wherever practical. • As the proportion of services being delivered or signposted to electronically increases consider how to improve the access to such resources among those who do not speak English

[33] One example comes from the Marmot report where taxi drivers of South Asian descent in Sheffield were trained up to act as health champions within their community

9.3. Planned projects

These recommendations need to be considered in the context of a number of projects planned or underway in Salford which are looking to address the health needs of BME groups.

i. Salford CCG has recruited a BME engagement officer who is developing the findings of this work through collaboration with local BME groups in Salford

ii. Salford Council is currently undertaking a needs assessment of its Orthodox Jewish population in collaboration with Manchester and Bury Local Authorities. This work is exploring issues surrounding wellbeing and access to public services (including cross-border issues) for children and families in the local Jewish community.

iii. A team at the University of Salford have been awarded a Joint Health and Well-Being Innovation grant from Salford City Council which aims to improve access to dementia services for BME communities in Salford [77]

iv. Unique Improvements (a Salford based social enterprise) is conducting work supported by Salford CCG which is aiming to identify and address the reasons behind low uptake rates of health checks in BME communities, focusing initially on the Yemeni community in Eccles.

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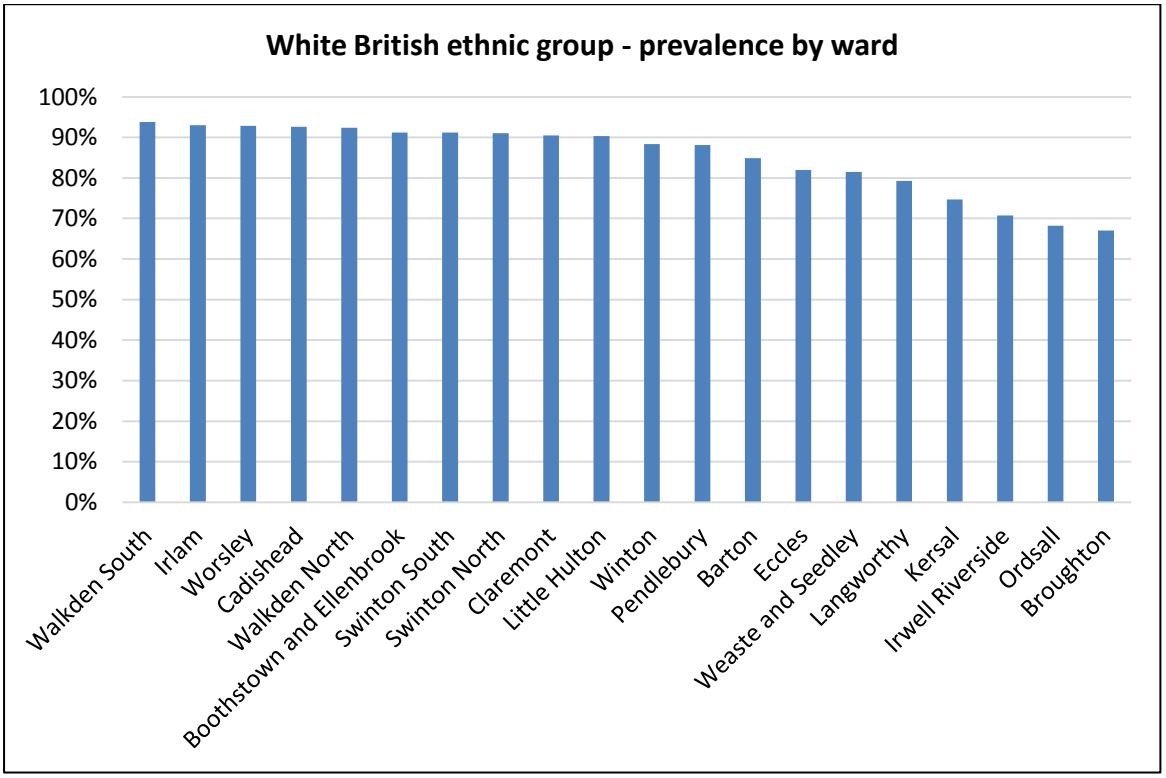
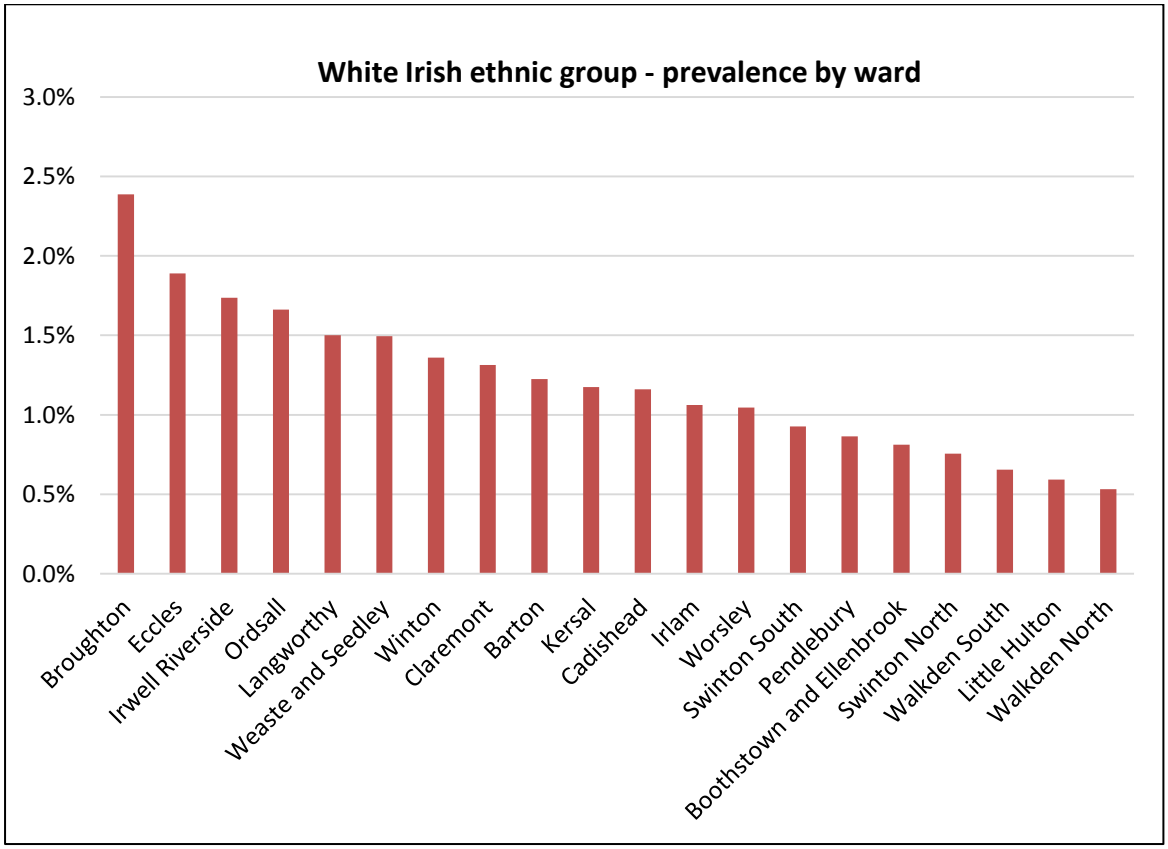
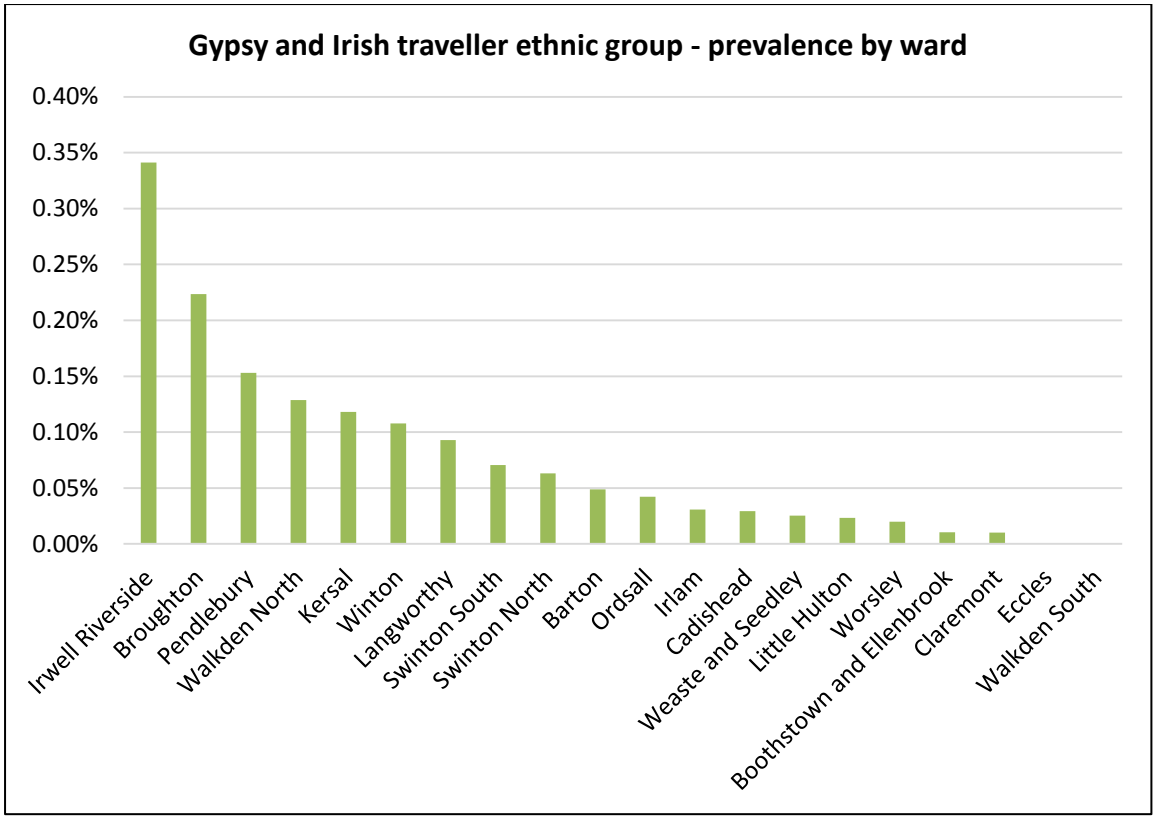
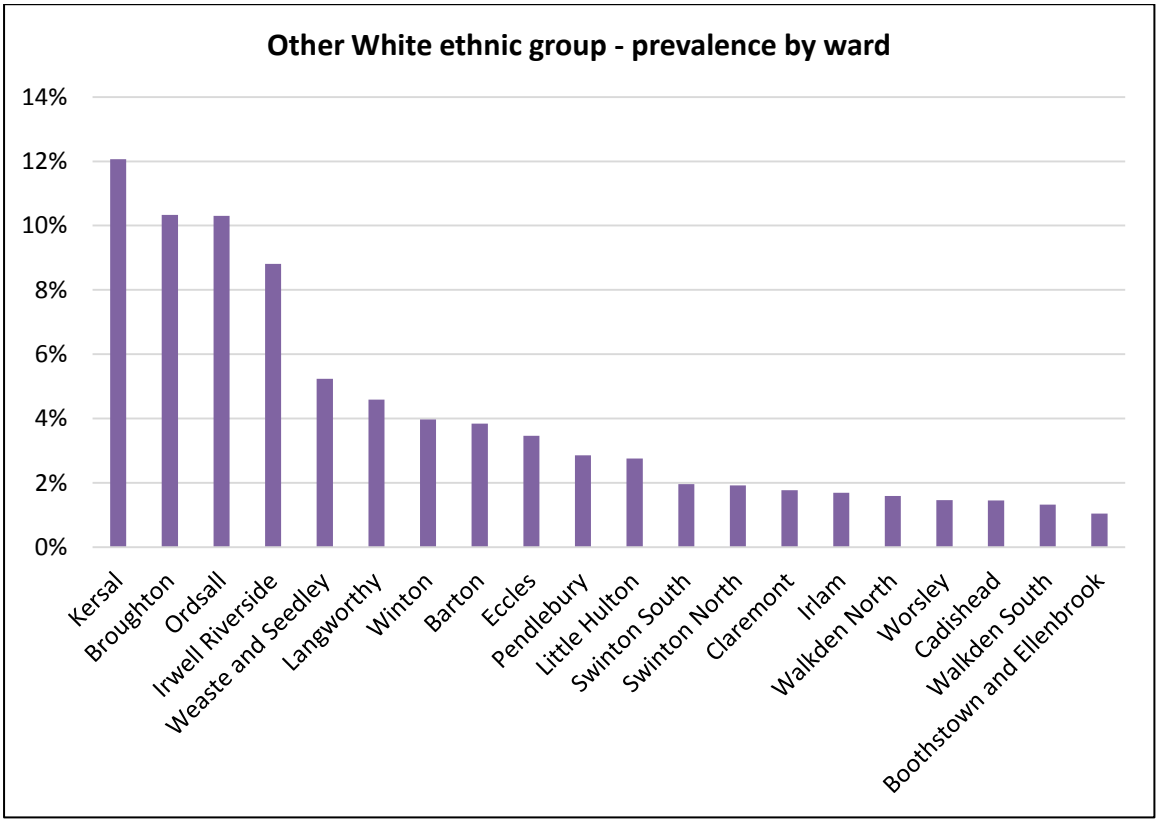
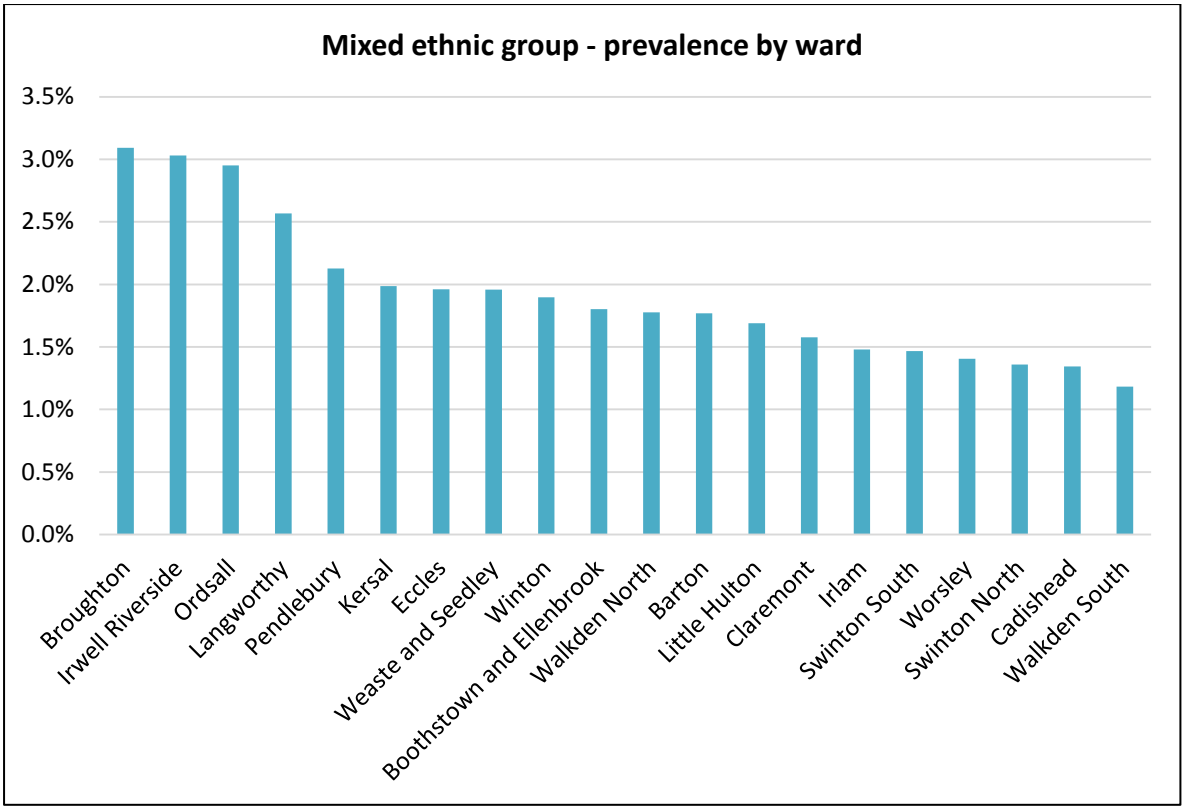
Appendix 1: Population density of ethnic groups across Salford Council (2011 Census)

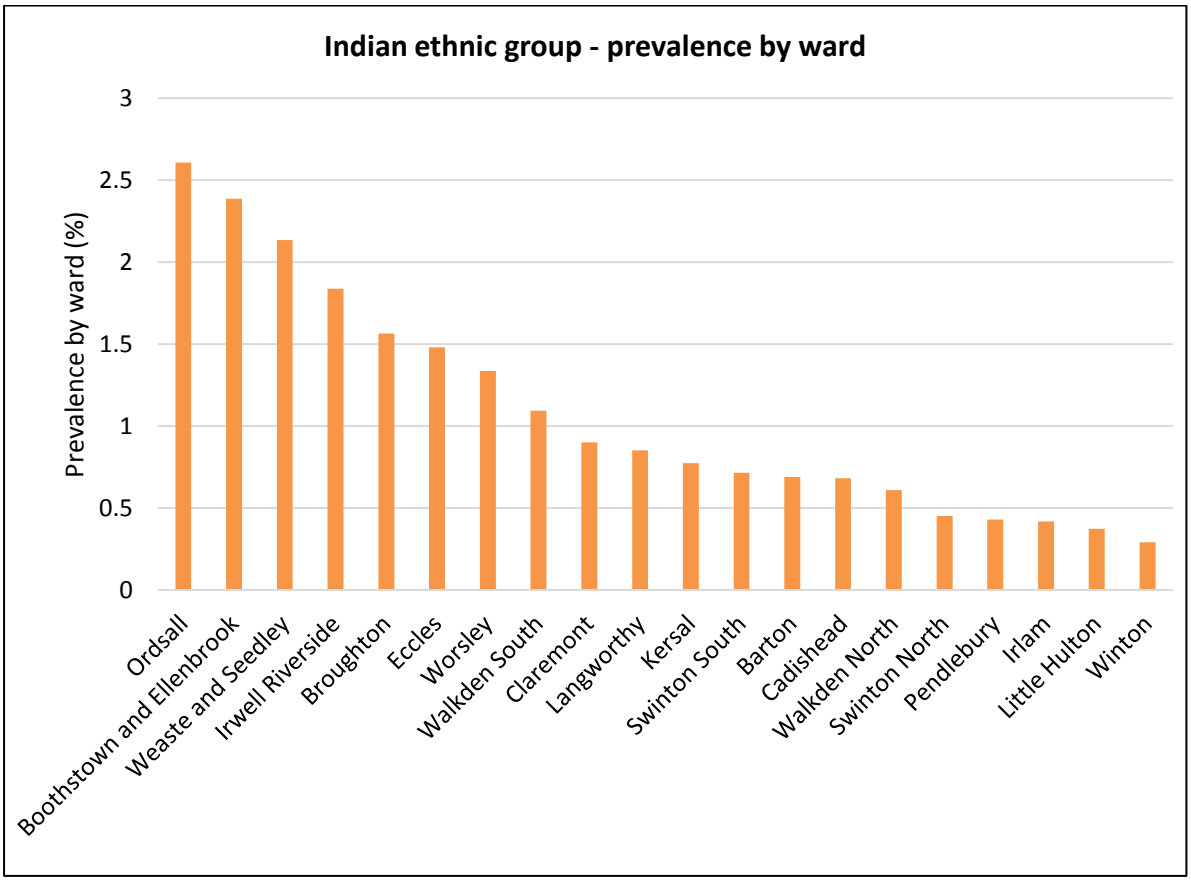


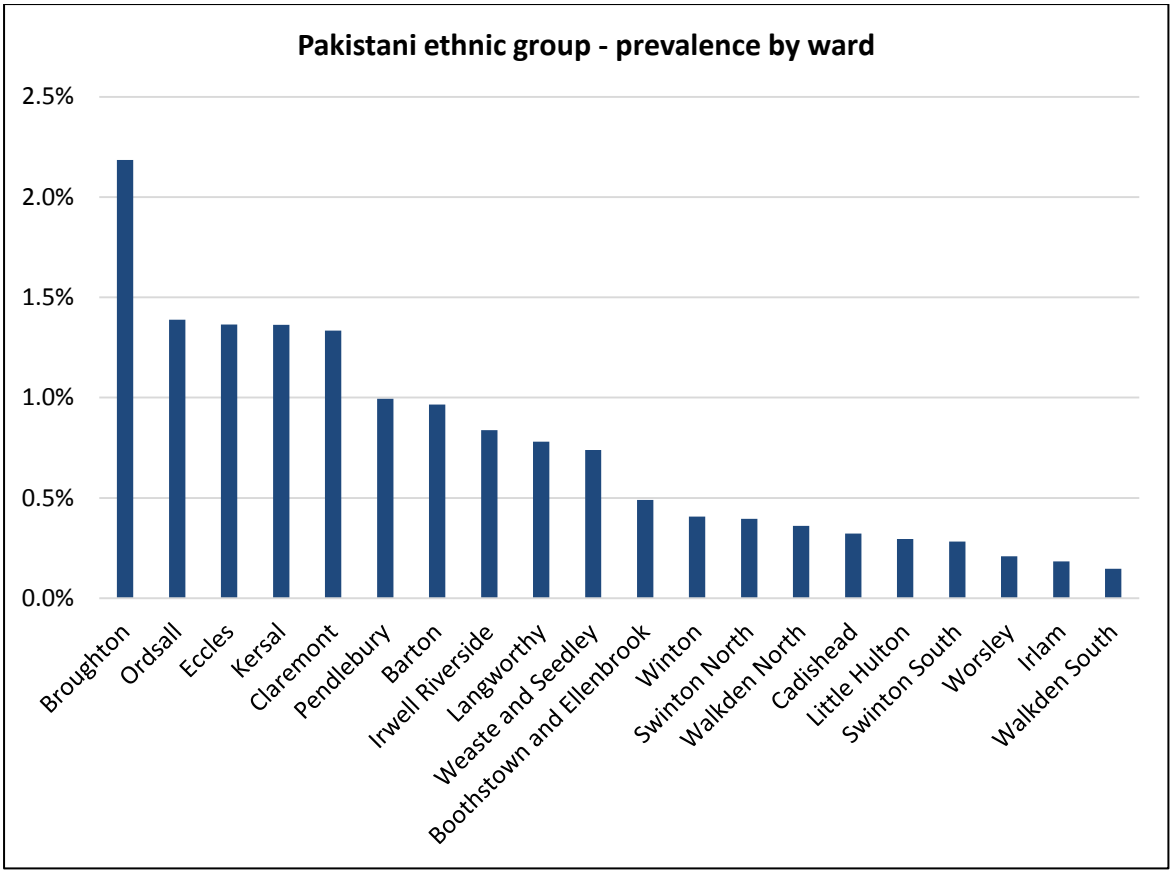


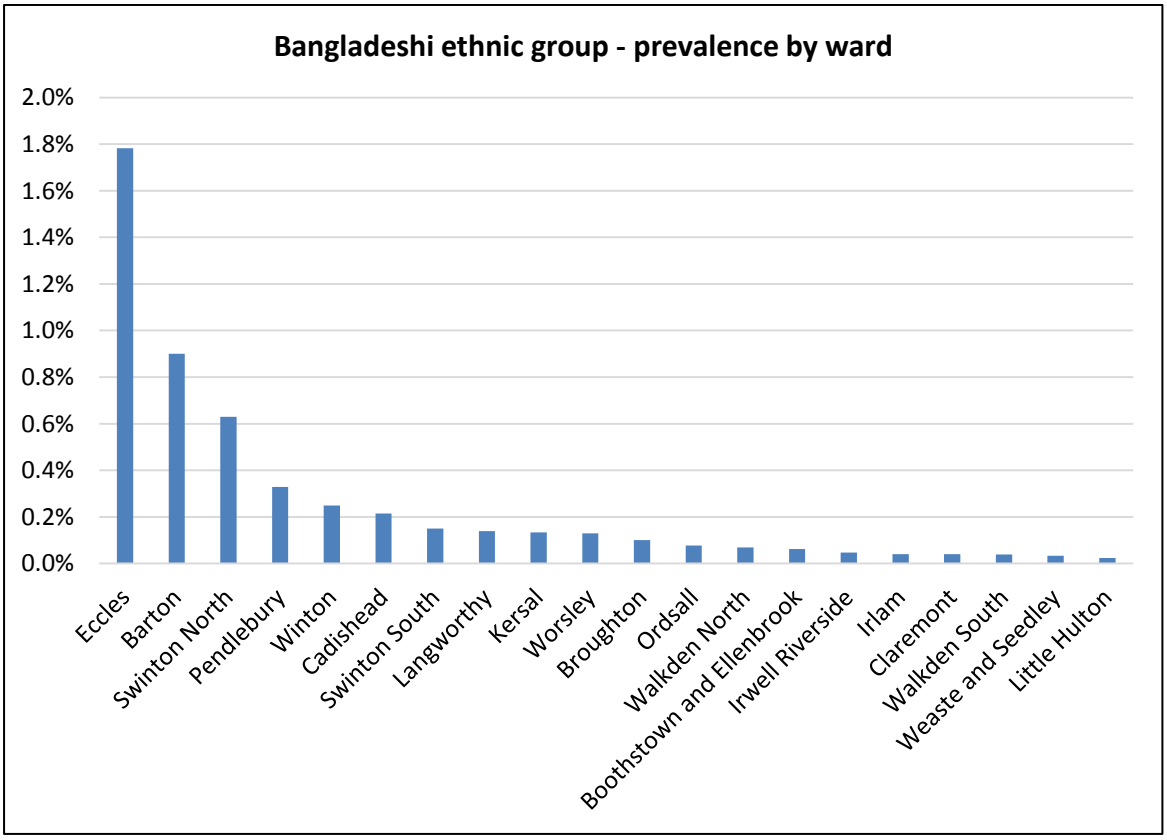

Gypsy and Irish traveller ethnic group - prevalence by ward
0.40%
0.35%
0.30%
0.25%
0.20%
0.15%
0.10%
0.05%
0.00%
Irwell Riverside
Broughton
Pendlebury
Walkden North
Kersal
Winton
Langworthy
Swinton South
Swinton North
Barton
Ordsall
Irlam
Cadishead
Weaste and Seedley
Little Hulton
Worsley
Boothstown and Ellenbrook
Claremont
Eccles
Walkden South

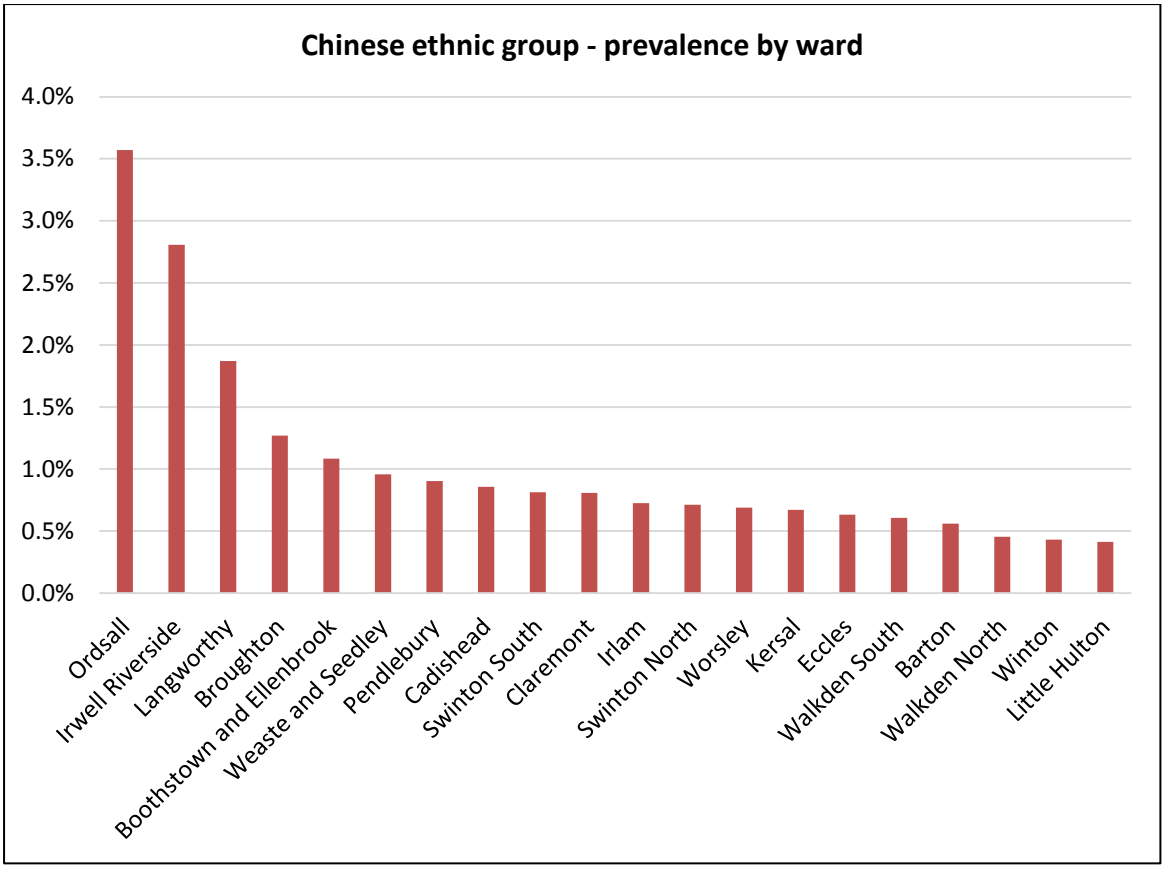

Other White ethnic group - prevalence by ward
14%
12%
10%
8%
6%
4%
2%
0%
Kersal
Broughton
Ordsall
Irwell Riverside
Weaste and Seedley
Langworthy
Winton
Barton
Eccles
Pendlebury
Little Hulton
Swinton South
Swinton North
Claremont
Irlam
Walkden North
Worsley
Cadishead
Walkden South
Boothstown and Ellenbrook

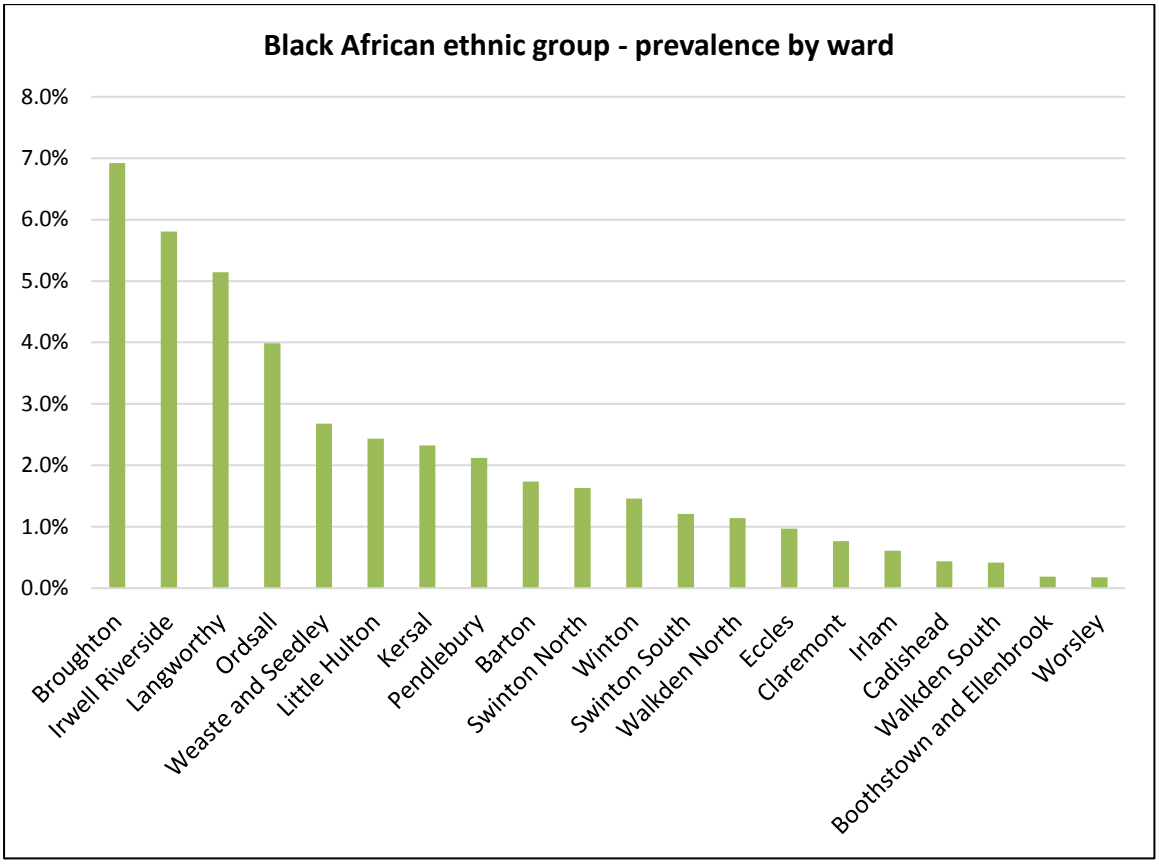

Mixed ethnic group - prevalence by ward
3.5%
3.0%
2.5%
2.0%
1.5%
1.0%
0.5%
0.0%
Broughton
Irwell Riverside
Ordsall
Langworthy
Pendlebury
Kersal
Eccles
Weaste and Seedley
Winton
Boothstown and Ellenbrook
Walkden North
Barton
Little Hulton
Claremont
Irlam
Swinton South
Worsley
Swinton North
Cadishead
Walkden South

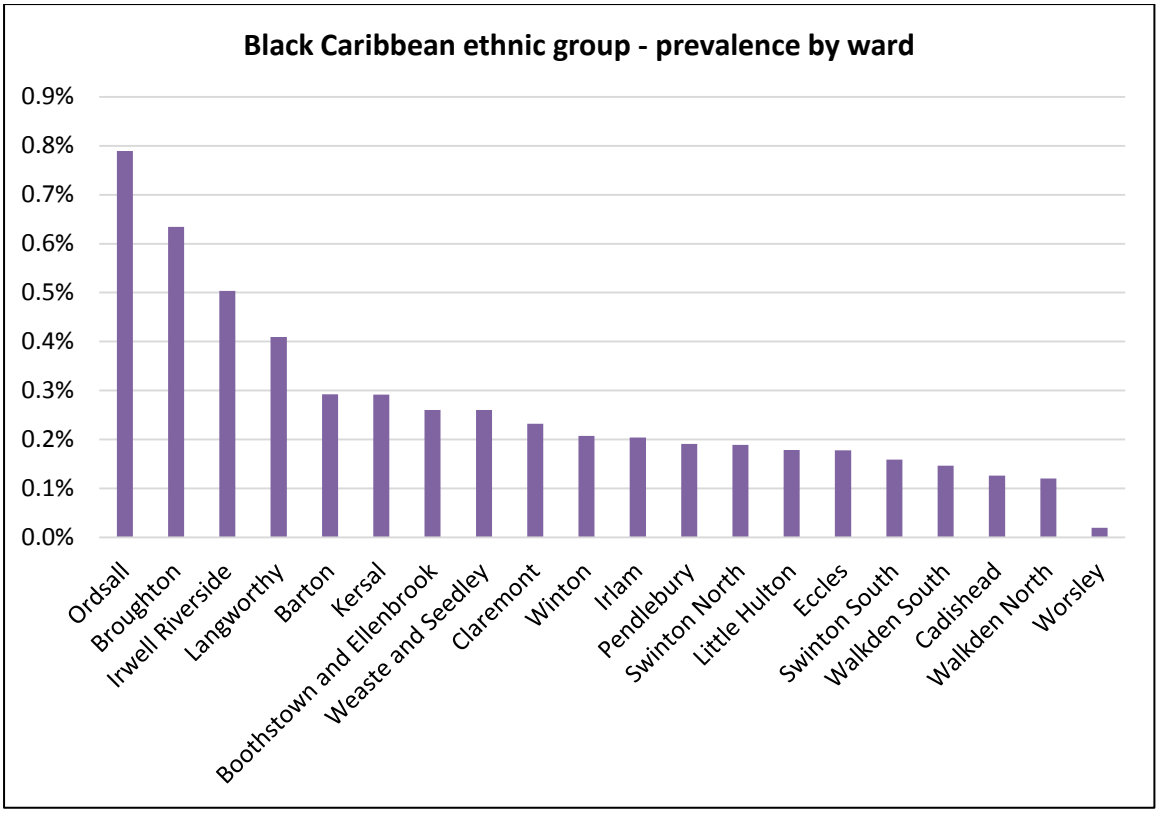

Indian ethnic group - prevalence by ward
Prevalence by ward (%)
3
2.5
2
1.5
1
0.5
0
Ordsall
Boothstown and Ellenbrook
Weaste and Seedley
Irwell Riverside
Broughton
Eccles
Worsley
Walkden South
Claremont
Langworthy
Kersal
Swinton South
Barton
Cadishead
Walkden North
Swinton North
Pendlebury
Irlam
Little Hulton
Winton

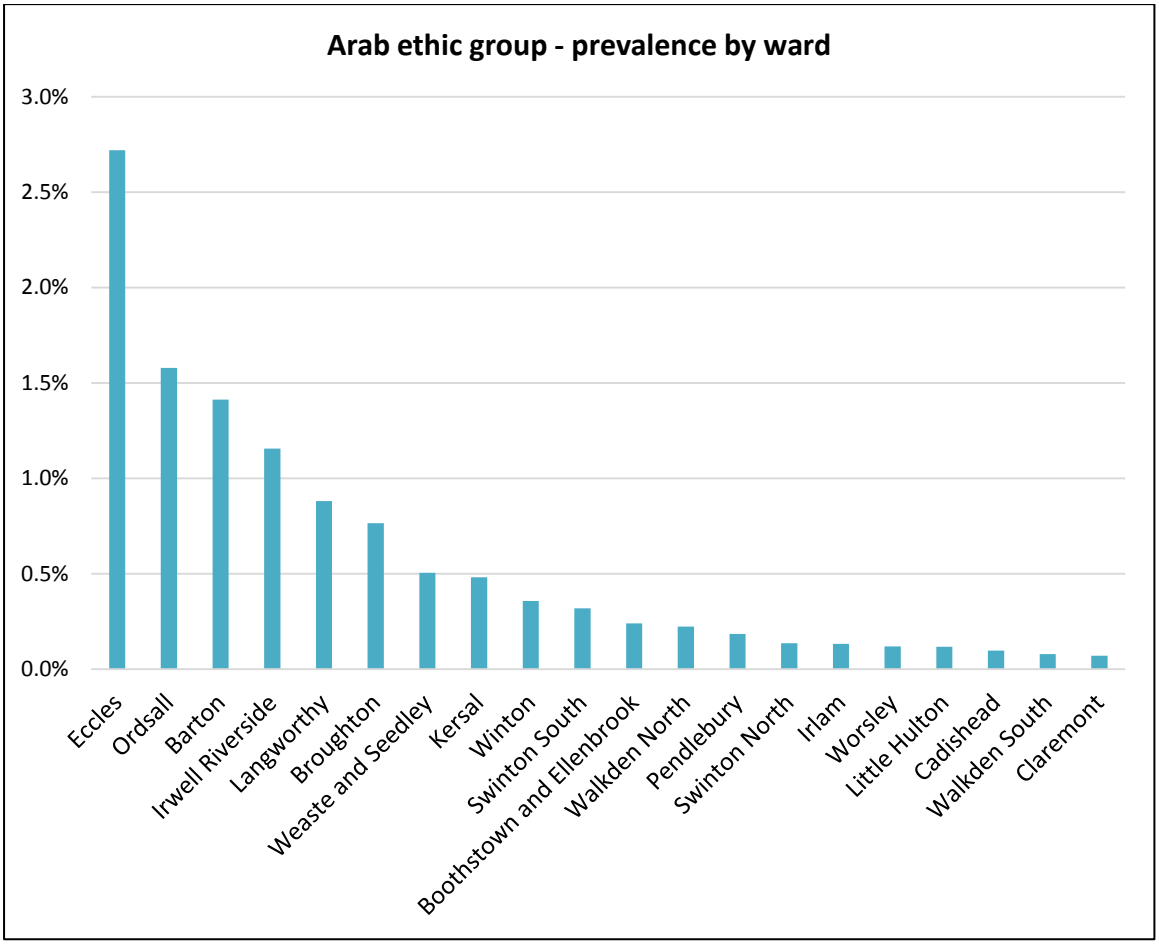

Pakistani ethnic group - prevalence by ward
2.5%
2.0%
1.5%
1.0%
0.5%
0.0%
Broughton
Ordsall
Eccles
Kersal
Claremont
Pendlebury
Barton
Irwell Riverside
Langworthy
Weaste and Seedley
Boothstown and Ellenbrook
Winton
Swinton North
Walkden North
Cadishead
Little Hulton
Swinton South
Worsley
Irlam
Walkden South

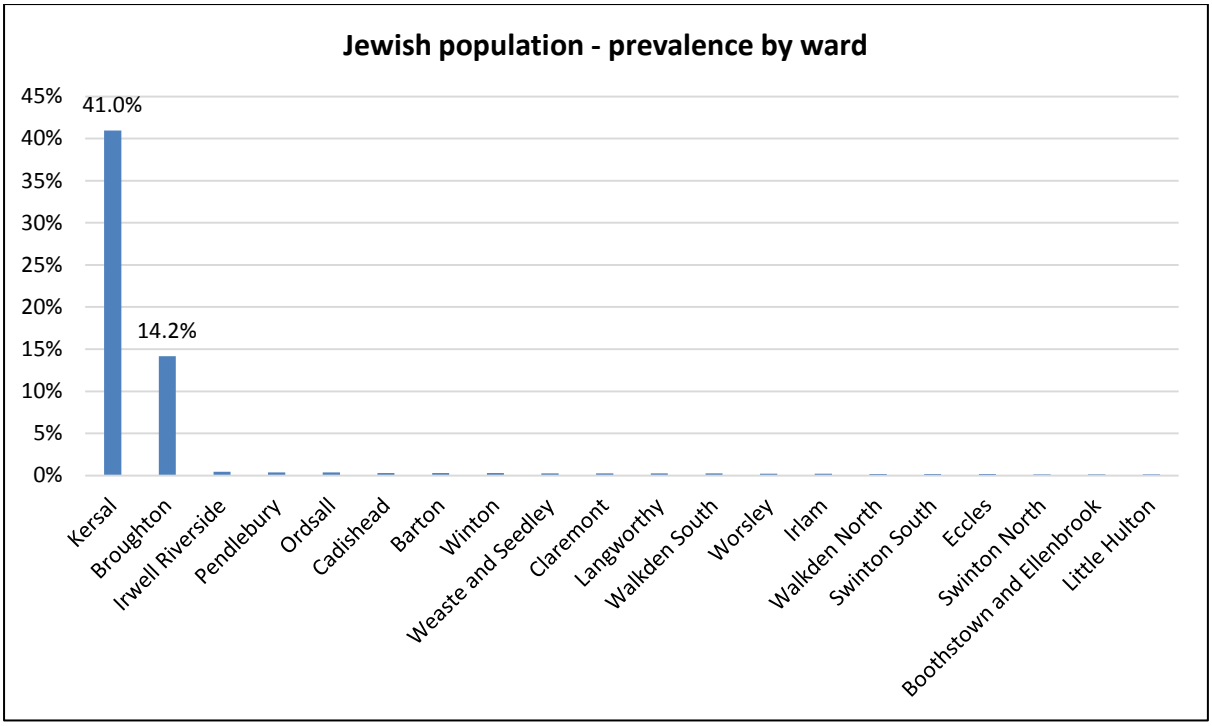

Bangladeshi ethnic group - prevalence by ward
2.0%
1.8%
1.6%
1.4%
1.2%
1.0%
0.8%
0.6%
0.4%
0.2%
0.0%
Eccles
Barton
Swinton North
Pendlebury
Winton
Cadishead
Swinton South
Langworthy
Kersal
Worsley
Broughton
Ordsall
Walkden North
Boothstown and Ellenbrook
Irwell Riverside
Irlam
Claremont
Walkden South
Weaste and Seedley
Little Hulton


Chinese ethnic group - prevalence by ward
4.0%
3.5%
3.0%
2.5%
2.0%
1.5%
1.0%
0.5%
0.0%
Ordsall
Irwell Riverside
Langworthy
Broughton
Boothstown and Ellenbrook
Weaste and Seedley
Pendlebury
Cadishead
Swinton South
Claremont
Irlam
Swinton North
Worsley
Kersal
Eccles
Walkden South
Barton
Walkden North
Winton
Little Hulton


Black African ethnic group - prevalence by ward
8.0%
7.0%
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
Broughton
Irwell Riverside
Langworthy
Ordsall
Weaste and Seedley
Little Hulton
Kersal
Pendlebury
Barton
Swinton North
Winton
Swinton South
Walkden North
Eccles
Claremont
Irlam
Cadishead
Walkden South
Boothstown and Ellenbrook
Worsley


Black Caribbean ethnic group - prevalence by ward
0.9%
0.8%
0.7%
0.6%
0.5%
0.4%
0.3%
0.2%
0.1%
0.0%
Ordsall
Broughton
Irwell Riverside
Langworthy
Barton
Kersal
Boothstown and Ellenbrook
Weaste and Seedley
Claremont
Winton
Irlam
Pendlebury
Swinton North
Little Hulton
Eccles
Swinton South
Walkden South
Cadishead
Walkden North
Worsley


Arab ethic group - prevalence by ward
3.0%
2.5%
2.0%
1.5%
1.0%
0.5%
0.0%
Eccles
Ordsall
Barton
Irwell Riverside
Langworthy
Broughton
Weaste and Seedley
Kersal
Winton
Swinton South
Boothstown and Ellenbrook
Walkden North
Pendlebury
Swinton North
Irlam
Worsley
Little Hulton
Cadishead
Walkden South
Claremont


Jewish population - prevalence by ward
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
41.0%
14.2%
Kersal
Broughton
Irwell Riverside
Pendlebury
Ordsall
Cadishead
Barton
Winton
Weaste and Seedley
Claremont
Langworthy
Walkden South
Worsley
Irlam
Walkden North
Swinton South
Eccles
Swinton North
Boothstown and Ellenbrook
Little Hulton

Appendix 2: Ward-specific ethnicity data (2011 Census)

BARTON		
ETHNIC GROUP	**POPULATION**	**%**
White British	10,457	84.9%
White Irish	151	1.2%
Other White	480	3.9%
Mixed	218	1.8%
Asian	541	4.4%
Black	268	2.2%
Other	206	1.7%
TOTAL	**12,321**	

BOOTHSTOWN AND ELLENBROOK		
ETHNIC GROUP	**POPULATION**	**%**
White British	8,757	91.2%
White Irish	78	0.8%
Other White	101	1.1%
Mixed	173	1.8%
Asian	399	4.2%
Black	47	0.5%
Other	44	0.5%
TOTAL	**9,599**	

BROUGHTON		
ETHNIC GROUP	**POPULATION**	**%**
White British	9,298	67.0%
White Irish	331	2.4%
Other White	1,464	10.6%
Mixed	429	3.1%
Asian	927	6.7%
Black	1,148	8.3%
Other	272	2.0%
TOTAL	**13,869**	

CADISHEAD		
ETHNIC GROUP	**POPULATION**	**%**
White British	9,503	92.6%
White Irish	119	1.2%
Other White	152	1.5%
Mixed	138	1.3%
Asian	238	2.3%
Black	68	0.7%
Other	46	0.4%
TOTAL	**10,264**	

CLAREMONT		
ETHNIC GROUP	**POPULATION**	**%**
White British	8,953	90.5%
White Irish	130	1.3%
Other White	176	1.8%
Mixed	156	1.6%
Asian	351	3.5%
Black	102	1.0%
Other	23	0.2%
TOTAL	**9,891**	

ECCLES		
ETHNIC GROUP	**POPULATION**	**%**
White British	9,195	82.0%
White Irish	212	1.9%
Other White	389	3.5%
Mixed	220	2.0%
Asian	715	6.4%
Black	142	1.3%
Other	344	3.1%
TOTAL	**11,217**	

IRLAM		
ETHNIC GROUP	**POPULATION**	**%**
White British	9,119	93.0%
White Irish	104	1.1%
Other White	169	1.7%
Mixed	145	1.5%
Asian	159	1.6%
Black	83	0.8%
Other	24	0.2%
TOTAL	**9,803**	

IRWELL RIVERSIDE		
ETHNIC GROUP	**POPULATION**	**%**
White British	9,129	70.8%
White Irish	224	1.7%
Other White	1,181	9.2%
Mixed	391	3.0%
Asian	911	7.1%
Black	866	6.7%
Other	199	1.5%
TOTAL	**12,901**	

KERSAL		
ETHNIC GROUP	**POPULATION**	**%**
White British	9,486	74.7%
White Irish	149	1.2%
Other White	1,546	12.2%
Mixed	252	2.0%
Asian	494	3.9%
Black	369	2.9%
Other	398	3.1%
TOTAL	**12,694**	

LANGWORTHY		
ETHNIC GROUP	**POPULATION**	**%**
White British	10,252	79.3%
White Irish	194	1.5%
Other White	605	4.7%
Mixed	332	2.6%
Asian	607	4.7%
Black	775	6.0%
Other	170	1.3%
TOTAL	**12,935**	

LITTLE HULTON		
ETHNIC GROUP	**POPULATION**	**%**
White British	11,611	90.4%
White Irish	76	0.6%
Other White	357	2.8%
Mixed	217	1.7%
Asian	195	1.5%
Black	363	2.8%
Other	32	0.2%
TOTAL	**12,851**	

ORDSALL		
ETHNIC GROUP	**POPULATION**	**%**
White British	9,685	68.2%
White Irish	236	1.7%
Other White	1,468	10.3%
Mixed	419	3.0%
Asian	1,298	9.1%
Black	747	5.3%
Other	341	2.4%
TOTAL	**14,194**	

PENDLEBURY		
ETHNIC GROUP	**POPULATION**	**%**
White British	11,513	88.1%
White Irish	113	0.9%
Other White	393	3.0%
Mixed	278	2.1%
Asian	406	3.1%
Black	328	2.5%
Other	38	0.3%
TOTAL	**13,069**	

SWINTON NORTH		
ETHNIC GROUP	**POPULATION**	**%**
White British	10,109	91.0%
White Irish	84	0.8%
Other White	221	2.0%
Mixed	151	1.4%
Asian	290	2.6%
Black	218	2.0%
Other	35	0.3%
TOTAL	**11,108**	

SWINTON SOUTH		
ETHNIC GROUP	**POPULATION**	**%**
White British	10,330	91.2%
White Irish	105	0.9%
Other White	230	2.0%
Mixed	166	1.5%
Asian	271	2.4%
Black	164	1.4%
Other	59	0.5%
TOTAL	**11,325**	

WALKDEN NORTH		
ETHNIC GROUP	**POPULATION**	**%**
White British	10,758	92.4%
White Irish	62	0.5%
Other White	200	1.7%
Mixed	207	1.8%
Asian	211	1.8%
Black	168	1.4%
Other	41	0.4%
TOTAL	**11,647**	

WALKDEN SOUTH		
ETHNIC GROUP	**POPULATION**	**%**
White British	9,605	93.8%
White Irish	67	0.7%
Other White	136	1.3%
Mixed	121	1.2%
Asian	215	2.1%
Black	62	0.6%
Other	31	0.3%
TOTAL	**10,237**	

WEASTE AND SEEDLEY		
ETHNIC GROUP	**POPULATION**	**%**
White British	9,705	81.5%
White Irish	178	1.5%
Other White	626	5.3%
Mixed	233	2.0%
Asian	681	5.7%
Black	381	3.2%
Other	102	0.9%
TOTAL	**11,906**	

WINTON		
ETHNIC GROUP	**POPULATION**	**%**
White British	10,664	88.4%
White Irish	164	1.4%
Other White	492	4.1%
Mixed	229	1.9%
Asian	243	2.0%
Black	218	1.8%
Other	57	0.5%
TOTAL	**12,067**	

WORSLEY		
ETHNIC GROUP	**POPULATION**	**%**
White British	9,316	92.8%
White Irish	105	1.0%
Other White	149	1.5%
Mixed	141	1.4%
Asian	277	2.8%
Black	24	0.2%
Other	23	0.2%
TOTAL	**10,035**	

Appendix 3: Health issues of specific ethnic groups

WHITE ETHNIC GROUP	
IRISH	• Relatively high self-reported rates of 'bad' or 'very bad' health [7] • Relatively high self-reported rates of limitation to day-to-day activities [7] • Men and women have relatively high rates of smoking [25] • Men and women have above-average rates of stroke [25] • High rates of depression, alcohol misuse and schizophrenia [59] • High suicide rate [60] • Above-average hospital admission rates in Salford [66]
GYPSY / IRISH TRAVELLER	• Relatively short life-expectancy [15] • Relatively high self-reported rates of 'bad' or 'very bad' health [7] • Relatively high self-reported rates of limitation to day-to-day activities [7]
OTHER WHITE	• Above-average A+E attendance rates in Salford [66]

ASIAN ETHNIC GROUP	
ALL	• Congenital anomalies are a disproportionately high cause of infant deaths [20] • Above-average obesity rates in Reception and Year 5 (Chinese rates only higher in Year 5) [29] • Significantly higher rates of underweight children in comparison with the national average [33] • Acquire increased risk of diabetes and cardiovascular disease at lower BMI than non-Asian population [30] • Men and women at lower risk of colorectal, lung cancer, oesophageal, stomach, pancreatic cancer, kidney, bladder, leukaemia, malignant melanoma, brain/CNS cancer[34] [42] • Women at lower risk of breast, cervical cancer and ovarian cancer[35] [42] • Women at higher risk of mouth cancer (no data available for Chinese population) [42] • Men at lower risk of prostate cancer [42] • Young Asian women have double the suicide risk of young White women [62]
INDIAN	• Men and women have relatively high rates of physical inactivity [25] • Men and women have above-average rates of diabetes [25] • More likely to present with metastatic breast cancer than white women [44] • Relatively high TB rates (very high in non-UK born group) [53] • Below-average A+E attendances and hospital admissions in Salford [66]

[34] Data unavailable for Chinese population for oesophageal, stomach, pancreatic, kidney, bladder, leukaemia, malignant melanoma and brain / CNS cancer
[35] Data unavailable for Chinese population for cervical and ovarian cancer

ASIAN ETHNIC GROUP (cont.)	
PAKISTANI	• Women have the shortest life expectancy of any ethnic group [14] • Men have relatively high rates of smoking [25] • Men and women have relatively high rates of physical inactivity [25] • Women have an above-average prevalence of adult obesity [28] • Women have increased risk of severe maternal morbidity • Men have above-average rates of heart attack [25] • Men and women have above-average rates of diabetes [25] • More likely to present with metastatic breast cancer than white women • Relatively high TB rates (very high in non-UK born group) [53] • Above-average A+E attendances and hospital admissions in Salford [66]
BANGLADESHI	• Men have the shortest life expectancy of any ethnic group [14] • Relatively high neonatal mortality rates [20] • Relatively high infant mortality rates [20] • Women have increased risk of severe maternal morbidity [16] • Men have high rates of smoking [25] • Men and women have relatively high rates of physical inactivity [25] • Men and women have above-average rates of diabetes [25] • Relatively high TB rates (very high in non-UK born group) [53] • Below-average A+E attendances and above-average hospital admissions in Salford [66]
CHINESE	• Men and women have high rates of physical inactivity [25] • Below-average A+E attendances and hospital admissions in Salford [66]
OTHER ASIAN	• Above-average A+E attendances and hospital admissions in Salford [66]

BLACK ETHNIC GROUP	
ALL	• Black children have the highest rates of obesity in Reception and Year 5 of all major ethnic groups [29] • Increased prevalence of sickle cell disease [40] • Men and women at lower risk of colorectal, lung, mouth, oesophageal cancer, bladder, melanoma, brain/CNS cancer [42] • Men and women at higher risk of stomach, liver cancer, myeloma [42] • Women have lower risk of breast and ovarian cancer [42] • Women at increased risk of presenting with more aggressive forms of breast cancer at younger ages. [43] • Men at higher risk of prostate cancer [42] • Men at lower risk of kidney cancer [42] • Above-average diagnosis rates for Chlamydia, Gonorrhoea, Herpes and genital warts nationally [47] • Above-average rate of STIs in Salford [47] • Above-average psychiatric admission rates [62] • Below-average self-harm rates [61] • Young men more likely to be sectioned under Mental Health Act [62]
AFRICAN	• Women have increased risk of severe maternal morbidity [16] • Women have an above-average rate of adult obesity [28] • Men and women at increased risk of stroke [36] • Men have above-average rates of diabetes [25] • Acquire increased risk of diabetes at lower BMI levels than White population [30] • Poor uptake of smoking cessation services in Salford • More likely to present with metastatic breast cancer than white women [44] • Very high HIV prevalence compared with other ethnic groups [51] • Relatively high TB rates (very high in non-UK born group) [53] • All highest risk (groups 1.1 and 1.2) countries for FGM are in Africa [57] • Below-average hospital admission rates in Salford [66]

BLACK ETHNIC GROUP (cont.)	
CARIBBEAN	• Women have increased risk of severe maternal morbidity [16] • Relatively high neonatal mortality rates [20] • Relatively high infant mortality rates [20] • Men and women have an above-average rate of adult obesity [28] • Men have above-average rates of stroke [25] • Acquire increased risk of diabetes at lower BMI levels than White population [30] • Men have above-average systolic BP [25] • Men and women have above-average rates of diabetes [25] • More likely to present with metastatic breast cancer than white women [44] • High rates of schizophrenia [59]
OTHER BLACK	• Relatively high TB rates (very high in non-UK born group) [53]

OTHER GROUPS	
MIXED (ALL)	• Above-average rates of Reception and Year 5 obesity [29] • Men and women at lower risk of colorectal cancer [42] • Men and women at lower risk of lung cancer [42] • Women have lower risk of breast cancer [42] • Above average diagnosis rates for Chlamydia, Gonorrhoea, Herpes and genital warts [47]
ASYLUM SEEKERS	• Increased rates of depression, anxiety and post-traumatic stress disorder [63]. • Asylum seekers are three times more likely to die in childbirth and four times more likely to suffer postnatal depression [17].

Appendix 4 : List of countries with incidence of TB >150 per 100,000 people (2015 data)[36]

WESTERN PACIFIC	
COUNTRY	**INCIDENCE (PER 100,000)**
Cambodia	390
Kiribati	497
Laos	189
Marshall Islands	335
Micronesia (F. States of)	195
Mongolia	170
Papua New Guinea	417
Phillipines	288
Tuvalu	190

SOUTH EAST ASIA	
Bangladesh	227
Bhutan	164
Burma	369
East Timor	498
India	167
Indonesia	399
North Korea	442
Nepal	158
Thailand	171

EASTERN MEDITERRANEAN	
Afghanistan	189
Djibouti	619
Pakistan	270
Somalia	274

EUROPE	
Greenland	197
Moldova	153

AMERICA	
Haiti	200

AFRICA	
COUNTRY	**INCIDENCE (PER 100,000)**
Angola	370
Botswana	385
Cameroon	220
Central African Republic	375
Chad	159
Congo	381
Democratic Republic of Congo	325
Equatorial Guinea	162
Ethiopia	207
Gabon	444
Gambia	174
Ghana	165
Guinea	177
Guinea-Bissau	369
Ivory Coast	165
Kenya	246
Lesotho	852
Liberia	308
Madagascar	235
Malawi	227
Mozambique	551
Namibia	561
Nigeria	322
Sierra Leone	310
South Africa	834
Swaziland	733
Tanzania	327
Uganda	161
Zambia	406
Zimbabwe	278

[36] Taken from: http://www.health.nsw.gov.au/Infectious/tuberculosis/Documents/countries-incidence.pdf

Appendix 5:
Recommendations of Salford Jewish Community Health Research Report (2015) [24]

Engagement & Communications

1. A new, hard-hitting marketing campaign on immunisation should be developed, with the involvement of local Jewish doctors, community workers and Rabbis. The use of a stall over 2 weeks around the Broughton Park area, with a bespoke leaflet endorsed by doctors and Rabbis, should be considered as well as working with the Hershel Weiss Centre.
2. Consider funding a directory of health and care services or other means to promote awareness of what is available.
3. A new health resource to be produced for all homes with key information on nutrition, healthcare, safeguarding, mental health, immunizations etc. This would needs to be written with the community (doctors, community workers and Rabbis) to allay any fears. Possible production in Yiddish should also be explored.
4. A specific leaflet giving clear information on the role of pharmacists in giving health advice should be produced and disseminated regularly.

Developing Services

5. A major new initiative on men exercising should be put in place as soon as possible.
6. The possibility of a walk-in clinic near to the main Salford Jewish community should be considered.
7. A wider, and substantial, healthy living activity programme should be created and promoted through a partnership of voluntary & community sector organisations with the NHS and Local Authority. This should include gender and age appropriate approaches.
8. A new, proactive mental health programme should be created and promoted through a similar partnership. This would include new group work and an active programme of promotion to reduce stigma in the community.
9. Both the NHS and voluntary and community sector organisations should address the need for more Counsellors and explore social enterprise and volunteering approaches.
10. There is a need to recruit male nurses to support Orthodox Jewish men where requested.
11. Voluntary sector agencies should look to meet the need for improved access to speech and occupational therapies and mental health services.
12. The possibility of a Salford Jewish Health Helpline should be explored to better support those who do not use the internet.
13. Further work should be undertaken to see whether a separate helpline, or one that gives information on a range of services – health, education, benefits etc. – would best serve the community.

Addressing Barriers and Challenges

14. A comprehensive training programme for all health professionals who may encounter members of the Orthodox Jewish community should be in place so that they have an understanding of religious and cultural issues and can empathise with patients.

15. Both the NHS and voluntary organisations should develop the role of advocates from the Jewish community to help address difficulties in engagement between some patients and health professionals, especially with regard to in hospital care and end of life support.

16. The Local Safeguarding Boards should work with Jewish charities on raising awareness of child and domestic abuse, support available and strengthening those support systems.

17. There should be reviews of the internal workings of hospitals, mental health services, GP services, maternity care and therapy services in response to these findings to improve their engagement with the Jewish community.

18. Local Jewish voluntary & community sector organisations should undertake a review of SEN services in response to these findings to improve the experience of families within the community.

19. A new End of Life Care pathway should be developed and promoted by a partnership of NHS and local Jewish voluntary & community sector organisations to reassure the community of their safety.

Appendix 6:
Recommendations of Salford Council Gypsy / Traveller action research project (2014)

1. Develop better systems to gather accurate and detailed data in relation to Gypsy Roma and Traveller (GRT) children (including those involved in social services and the care system.)

2. Develop a specific local policy setting out how the needs of Gypsy Roma and Traveller children and their families living in Salford will be met (including health and education.)

3. Put in place arrangements for officers and health professionals to access specialist advice and resources when working with Gypsy Roma and Traveller families.

4. Appropriate and relevant training on GRT awareness and cultural competency should be made available to all children's services officers and partners who are working to support Gypsy Roma Traveller families.

5. Opportunities for GRT community members to take a more active role in society should be positively encouraged: examples include, positive discrimination for work experience, work placements and educational opportunities particular for young GRT people.

6. A commitment to flexible working and a willingness to search for creative solutions to reach out to GRT communities to improve outcomes for GRT children and young people.

7. A commitment to quality outreach work for these marginalised communities in order to develop and maintain a trusting and mutual respectful relationship