Sussex Black, Asian and Minority Ethnic (BAME) Population Needs Review - 2020

Definition of BAME

[1]According to the Institute of Relations the term BAME is:-
Black and Minority Ethnic or Black, Asian and Minority Ethnic is the terminology normally used in the UK to describe people of non-white descent.

For the purpose of this review it will use this interpretation with the inclusion that these groups identify with each other through a common heritage, often consisting of a common language, common culture (which can include a religion) and or an ideology which stresses a common ancestry. In very few instances some data may include:-

- Irish
- Gypsy or Irish Traveller
- Other White
- Roma

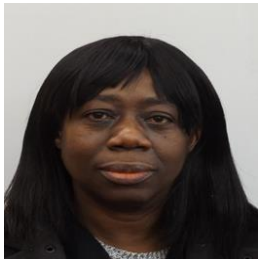
Version	Date	By	Comments
Version 1-11	22/12/2020	BAME Needs Review Task and Finish Group	Update data and narrative
Version 1.2	28/12/2020	Claire Scott, Population Project Manager	Narrative update after discussion with Jen Bayley and Tanya Brown-Griffith
Version 1.3 - 1.9	30/12/2020	Tanya Brown-Griffith, Programme Director	Reviewed and updated formatting
Version 2.1	29/01/2020	Tanya Brown-Griffith, Programme Director	Following Jan TTTO Board and Public Health comments
Version 2.2	08/02/2021	Tanya Brown-Griffith, Programme Director	Following Feb TTTO Board meeting
Version 2.3	15/02/2021	Claire Scott, Population Project Manager	Update with Mental Health and Cancer data
Version 2.4	15/02/2021	Olesya Buck, Programme Support Officer	Editing and formatting
Version 2.5	15/3/2021	Claire Scott, Population Project Manager Simon Ng, Analyst Kent Surrey Sussex Academic Health Science Network	Final Editing and formatting

[1] https://irr.org.uk/research/statistics/definitions/

Foreword

Adam Doyle,
Co-Chair Sussex Turning the Tide Oversight Board and Chief Executive Officer, Sussex CCG and Sussex ICS Lead

Difference should not lead to disadvantage. Everyone in Sussex deserves the same opportunities to lead a healthy life, no matter where they live, their background, culture, religion and whether they are wealthy or not. Our Sussex leaders are committed and the collective strength behind this report will give it the determined force to focus on key areas of work to address racism, workforce disparities and health inequalities in order to improve the experience and outcomes for our Black, Asian and Minority Ethnic communities.



Lola Banjoko,
Co-Chair Turning the Tide Oversight Board and Executive Managing Director, Sussex CCGs

The disproportionate impact of the COVID-19 pandemic on our ethnically diverse communities has been heart breaking to see particularly as it highlights the significant inequalities that continue to exist. This report, as well as the work that the BAME Disparity Response Programme has been doing, is a move in the right direction to address these inequalities in a more sustainable way in Sussex.

Rob Persey,
Director of Adult Social Service, Brighton and Hove City Council

This Rapid Review of our Sussex BAME population against the national context has highlighted where we need to address inequalities. The NHS and the Local Authority are working in partnerships like never before and this affords us the ability to work closely to develop more robust plans to address these inequalities both for health as well as for the wider determinants of health. Our aim is to address inequality of experience and promote inclusion in everything we do.

Typed: Rob Persey

Keith Hinckley,
Director of Adult Social Service, West Sussex and East Sussex County Councils

The information within this report gives added context for why it is so important to work together as Health and Care Organisations to address systemic inequalities and to adopt a Population Health Approach that is equitable and addresses varying needs effectively. Our joint work across the Sussex Health and Care Partnership is making sure there is equality of provision for our staff and residents when it comes to providing or accessing services while responding to the enhanced needs owing to the COVID-19 pandemic.

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Executive Summary

The COVID-19 pandemic has affected every person within Sussex with significant impacts experienced by Black, Asian and Minority Ethnic communities (BAME) and those from the most economically disadvantaged areas. This pandemic has highlighted and adds to known evidence that shows that people from Black, Asian and Minority Ethnic communities continue to face health inequalities, discrimination and disadvantages placing them at increased risk both in the workplace and wider community. Closing these gaps which exist remains a significant challenge but with the renewed commitment from National Leaders, Sussex Health and Care Leaders, Voluntary and Community Leaders we have the opportunity and impetus to act with greater energy and focus as never before.

This review builds on previous partnership Joint Needs Assessments across Sussex (West Sussex, East Sussex and Brighton and Hove) and brings together a wealth of available data sources on ethnicity at national, regional and local authority level, in order to draw an overview of the BAME population needs. It contains data on resident population and social determinants, including employment, education, housing and life style data. It also looks at health data from national surveys and local secondary healthcare providers, and at COVID-19 data from ONS and local data sets. Further, it includes local data on BAME workforce across NHS and Local Authorities.

The purpose of this document is to examine current health, care and wellbeing needs of the BAME population across Sussex; to understand the geographical and social impact and wider determinants of BAME health and its intersectionality with race, age, gender, with discrimination and disadvantage. Some of the challenges in producing this report were time and capacity during the current health and care challenges of a pandemic but more so the lack of routine and timely ethnicity data at local level.

The main findings identified from the review were:

- There is inadequate ethnicity recording at local and service level across most health and care services which impeded a more comprehensive review. Therefore some of the data was estimated or modelled from survey samples, such as the resident population data, lifestyle data and disease prevalence data.
- There are many areas where inequalities for BAME communities were significant around access to health and care interventions both preventative and for disease management
- People living in very deprived geographical areas across Sussex especially where this intersects with high BAME communities face significantly more disadvantages that result in poor health and life outcomes.
- Inconsistent access to linguistic/ translating services across Primary, Community and Acute services
- Lack of consistent and culturally aware messaging and service delivery at Place and system

Broad Recommendations proposed are:

1. It is fundamental to create ways of routinely collecting ethnicity data in a timely way at local level. Whether commissioning, delivering or monitoring and evaluating local services, it is important to understand the ethnicity of the local population and of service users. Sussex ICS needs to adopt consistent ethnicity reporting categories and routine monitoring of data quality progress.
2. Specific BAME led community taskforce resource to improve outcomes in population areas showing worst health and socio-economic outcomes particularly in Brighton Central and East Areas, Crawley, Hastings and St. Leonards, Arun and Adur areas.
3. Sussex ICS Cultural Communication/Engagement strategy with increased availability of culturally relevant messaging and forums targeted at community level
4. Sussex ICS to develop and deliver a robust mandatory culturally competent training to staff across Health and Care organisations which acknowledges the impact of discrimination on population and workforce experience and outcome
5. Deliver programmes in communities that enable Linguistic Competence and Health and Digital literacy in order to improve service access
6. All Health and Care services to have a Standard Operating Process which enables consistent access to translating services and links to BAME advocate workers
7. Targeted partnership approach across Sussex ICS to improve the experience and diversity of Staff and address known Health and Care workforce disparities will improve population benefits
8. More community resource in place for BAME and Faith led programmes targeted at BAME communities particularly around prevention services including BAME led dietary and healthy life style support
9. Further analysis of the data within this report by a dedicated working group to identify more specific actions to be taken at Place level. Where there is no data or limited data public engagement/involvement should be carried out to gain insights from BAME communities.

Chapter 1: Introduction

The COVID-19 global pandemic, the death of George Floyd and the "Black Lives Matter" social movement exposed the issues that disproportionately affect people from Black, Asian and minority (BAME) communities where they experience worse health outcomes than their white counterparts. These events are the manifestation of deep inequalities that continue to exist across our society, including in the health and care system. We also know that BAME staff working in health and care services consistently report worse experiences in terms of bullying, harassment, abuse, discrimination and opportunities for career progression and are greatly under- represented in senior positions.

There have been numerous calls for action to tackle and improve health inequalities that date back to the 1980s. The Black Report[2], 1980 concluded that whilst health inequalities in vulnerable communities were being addressed, much more needed to be done. It called for appropriate measures to be set in place to improve poor healthcare outcomes for disadvantaged populations. By 2005, the World Health Organisation commission on the social determinants of health sought to draw the attention of governments on the social determinants of health. It called for better social conditions for health and improvement, particularly among the most vulnerable people which included people from BAME communities.[3] In 2010, the Marmot Review highlighted that people from disadvantaged backgrounds were more likely to have underlying health conditions, and shorter life expectancies. Marmot asserted that outcomes were "even worse for minority ethnic population groups and people with disabilities". In addition these communities were more likely to be impacted by the wider determinants of health such as, housing, education employment and access to healthcare that intersects with their age, sex, religious beliefs, ethnicity and gender.

Ten years on after the first Marmot Review, the outbreak of COVID-19 in 2020 highlighted the inequalities that still exist and just how disproportionately the BAME population were impacted by the virus and with a greater risk of mortality and morbidity. Marmot Review 2020[4] also again outlined "clear systematic inequalities".

In addition to health inequalities, the structural, institutional and interpersonal drivers of racism have a direct impact on the physical, mental, psychological and physiological wellbeing of BAME communities. These are outlined in the Turning the Tide Strategy[5] which states that "once we understand the way BAME health inequalities are driven, we need to consider how our daily decisions and considerations either reaffirm and strengthen the elements that will lead to more inequality in health and society or we can actively and consciously look to dismantle these through how we deliver our core functions".

Sussex has an ethnically diverse population and the impact of these inequalities directly affects our BAME population health and wellbeing needs. Despite many actions taken within Health and Care Organisations over many years to address these inequalities it was

[2] Tackling Health Inequalities in the United Kingdom: The Progress and Pitfalls of Policy
[3] https://ec.europa.eu/health/ph_determinants/socio_economics/documents/uk_rd01_en.pdf
[4] Marmot, 2020
[5] Turning the Tide, 2020

recognised this year that Sussex needed to do much more and so the Sussex Health and Care Partnership established the Sussex Covid-19 BAME Disparity Response Programme in May 2020. This programme focussed on ensuring actions were being taken to safeguard our BAME workforce and population from the COVID-19 virus and to specifically look at the disproportionate impact on the BAME population and broaden our understanding about the social disadvantages that exacerbate these disparities. The programme scope was expanded in September 2020 and aligned its priorities to the Turning the Tide Strategy to address deep rooted inequalities within the BAME Population, Workforce and Communication and Engagement areas.

This BAME Population Needs Review was coordinated by the Sussex Health and Care Partnership's BAME Disparity Response Programme working with all partners to identify where apparent and hidden inequalities exist across Sussex. The partnership has committed to address racial and health inequalities and this review will help to identify through a system led analysis of qualitative and quantitative data the current challenges, gaps and barriers that BAME communities face from accessing services to the wider context of participating in everyday life in Sussex. It will provide a series of high level recommendations for system and place.

Chapter 2: Data usage

It is important to comment on the data used within this review and highlight some of the caveats around some of the limitations of its use.

- It is important to note that the 2011 Office of National Statistics (ONS) Census data is nine years out of date. This limits the accuracy of our understanding of the proportion of the population who are of BAME, and how that has changed since. For the purpose of this review we will also be using both patients' registered GP practice data published by NHS Digital and ONS to provide a fuller data rich picture of the BAME population in Sussex.
- Outside of the Census, data on ethnicity is often collected in routine administrative datasets. However, these are collected for specific purposes such as people who wish to claim a benefit, or children attending local schools, this means they do not cover the entire local population.
- Assuming that most of the population is registered with a GP, primary health data is potentially one of the most comprehensive datasets and, if well collected, this could provide a more up-to-date view of ethnicity in Sussex.
- There will be times when reporting information by BAME group is not possible or robust, such as when there are small numbers. However, reporting at Sussex level means that this should be less of a problem and there should be an expectation that data, including performance data, are, or can be, routinely broken down by BAME background. This should not be considered ad hoc.
- Some of the data was estimated or modelled from survey samples, such as the resident population data, lifestyle data and disease prevalence data, and therefore may not be an accurate representation of the actual Sussex picture.

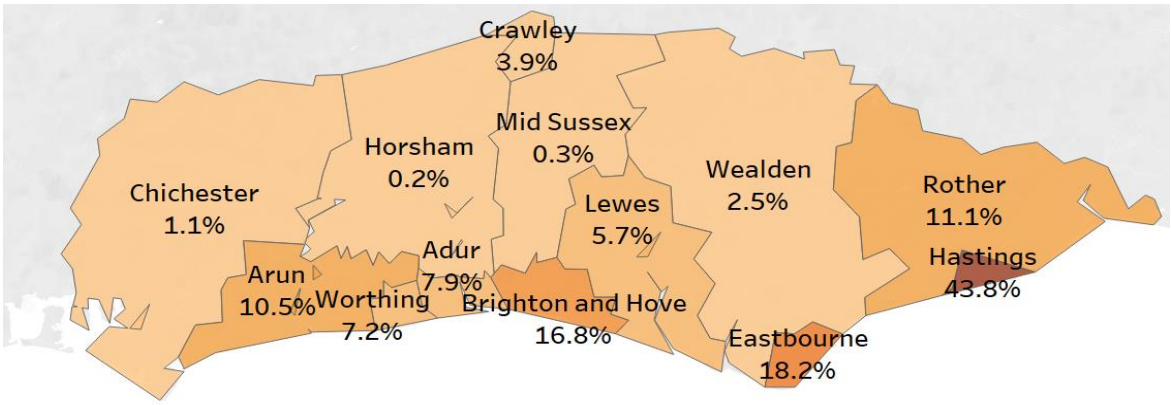
Chapter 3 – Population

3.1 Sussex Population Demographics

The population across Sussex has changed since the last census in 2011 and data from alternative sources suggest many areas are now more ethnically diverse. Sussex has three local authority areas; West Sussex, East Sussex and Brighton and Hove. In 2011 the total population of Sussex was 1.6 million. 6% of the Sussex residents were from a Black, Asian and Minority Ethnic (BAME) background compared to 93.7% from White background.

The two maps below outline the most recent data sourced over 2019 and 2020. Figure 1 shows distribution of areas of deprivation, Figure 2 shows the estimated proportion of BAME population across Sussex between 2011 and 2017 and Figure 3 depicts the areas across Sussex which are in Quintile 1 - areas of greatest deprivation nationally.

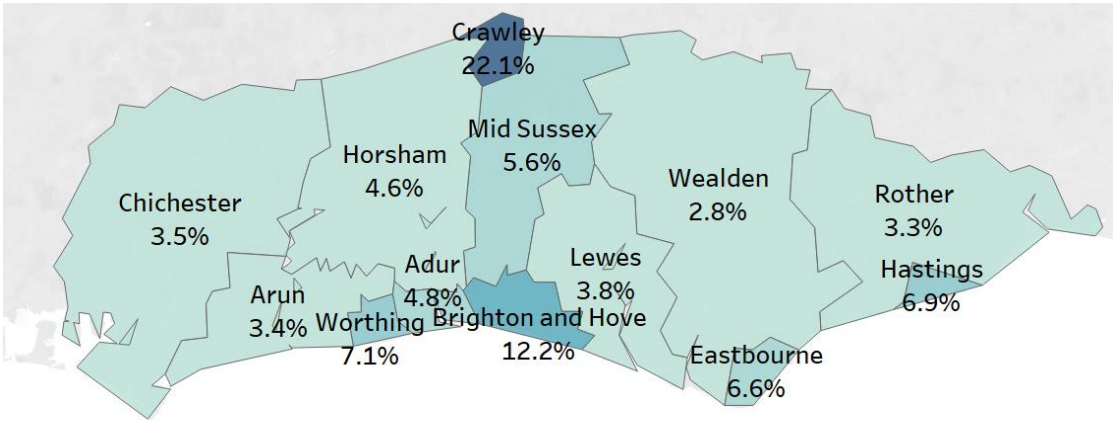
Figure 1: Sussex geography depicting areas of deprivation (%of population living in most deprived 20% of areas in England (quintile 1).



© 2020 Mapbox © OpenStreetMap

Source – https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019

Figure 2- Sussex BAME proportion 2011-2017.

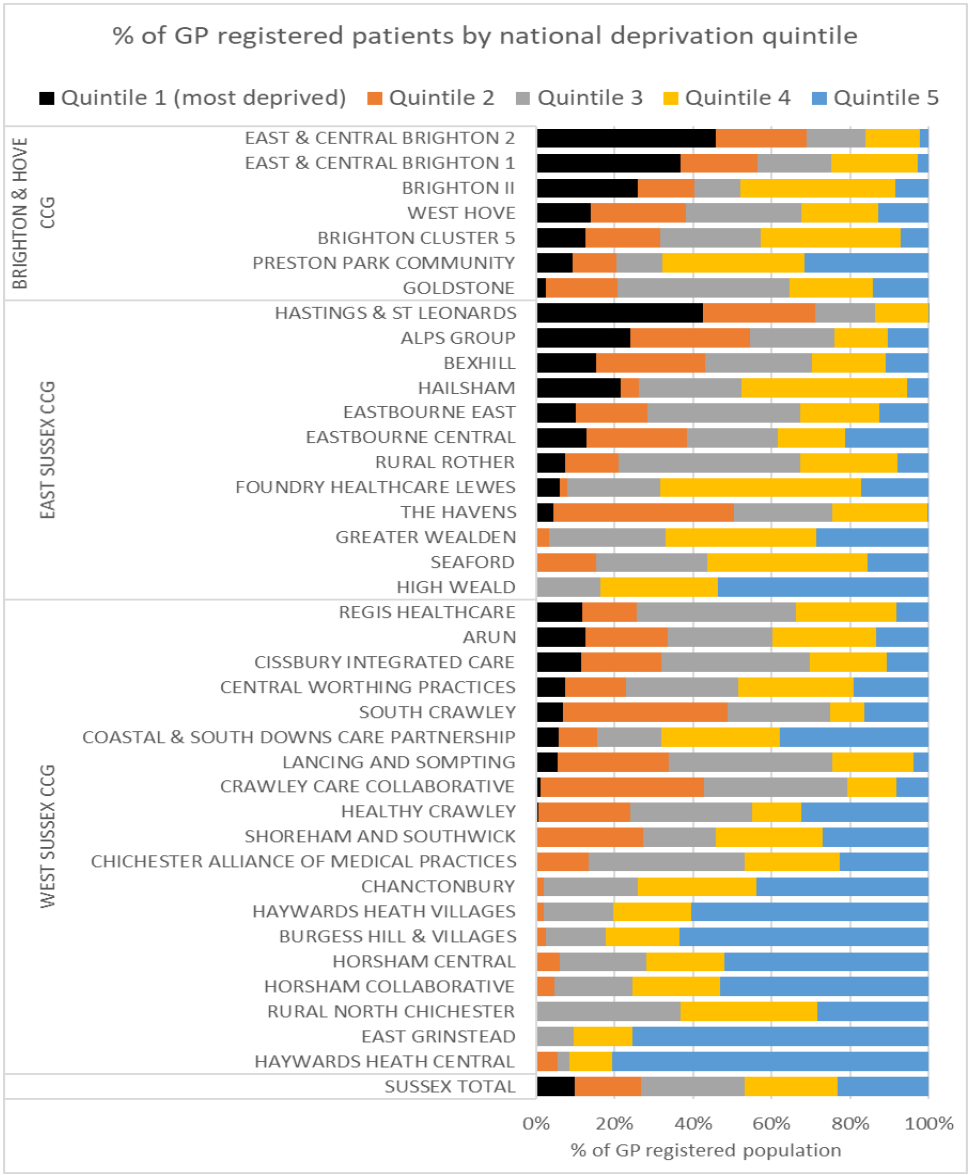


© 2020 Mapbox © OpenStreetMap

Source:https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/adhocs/008781populationdenominatorsbybroadethnicgroupandforwhitebritishlocalauthoritiesinenglandandwales2011to2017

Data source caveat: These denominators are neither National Statistics nor standard published experimental statistics and have not been produced using methods which have undergone formal Quality Assurance. They have been produced specifically for use as part of the Race Disparity Audit, following discussion with the Race Disparity Unit of their specific requirements and timeframe.

Figure 3: % GP registered patients in each Primary Care Network by national deprivation quintile



Source: 2020 GP Registrations from NHS Digital

When looking at the breakdown for ethnicity categories the data of greatest reliance is the 2011 census as outlined in Table 1 below.

Table 1: Resident Population –Sussex Overall

Ethnic Group	West Sussex	East Sussex	Brighton and Hove	Sussex
All categories: Ethnic group	100.00%	100.00%	100.00%	100.00%
White: English/Welsh/Scottish/Northern Irish/British	88.93%	91.66%	80.48%	88.39%
White: Irish	0.74%	0.75%	1.38%	0.85%
White: Gypsy or Irish Traveller	0.13%	0.15%	0.07%	0.13%
White: Other White	3.95%	3.39%	7.14%	4.31%
Mixed/multiple ethnic group: White and Black Caribbean	0.36%	0.37%	0.80%	0.44%
Mixed/multiple ethnic group: White and Black African	0.26%	0.19%	0.74%	0.32%
Mixed/multiple ethnic group: White and Asian	0.53%	0.49%	1.23%	0.63%
Mixed/multiple ethnic group: Other Mixed	0.36%	0.36%	1.04%	0.48%
Asian/Asian British: Indian	1.20%	0.43%	1.10%	0.93%
Asian/Asian British: Pakistani	0.65%	0.06%	0.24%	0.39%
Asian/Asian British: Bangladeshi	0.29%	0.20%	0.50%	0.30%
Asian/Asian British: Chinese	0.37%	0.37%	1.10%	0.49%
Asian/Asian British: Other Asian	1.01%	0.68%	1.20%	0.93%
Black/African/Caribbean/Black British: African	0.57%	0.34%	1.06%	0.58%
Black/African/Caribbean/Black British: Caribbean	0.17%	0.15%	0.32%	0.19%
Black/African/Caribbean/Black British: Other Black	0.15%	0.06%	0.15%	0.12%
Other ethnic group: Arab	0.13%	0.12%	0.80%	0.24%
Other ethnic group: Any other ethnic group	0.21%	0.21%	0.66%	0.28%

Source: ONS, 2011

3.2 West Sussex

Crawley has the more diverse population, with higher levels of deprivation compared to the rest of the county. It has a large Asian population where Guajarati, Urdu, and Tamil are commonly spoken. There is also a large speaking Polish community (13% of residents said English was not main language).

Other areas of deprivation are Worthing and Bognor Regis with significant Filipino and Polish speaking populations, and in Arundel, Bognor Regis, and Littlehampton there is a growing eastern European community. In these areas there are many Lithuanian, and Russian, Romanian speakers.

West Sussex has a young BAME population compared to the general population with the largest proportion being of working age (24-45 years).

The Black and Asian communities are of a similar age structure to each other, with relatively few residents near or past retirement age. Both have a large concentration of their residents at working age and higher than average children of school and pre-school age. Around 4% of West Sussex residents identify with a minority religion, with 1.6% identifying as Muslim, figure much lower when compared to the rest of the country at 4.4%

3.3 East Sussex

East Sussex has the lowest BAME population in Sussex with the 2011 census depicting just over 4.3% of the East Sussex population are from BAME groups with a further 4.3% from other White non-British groups.

The BAME population has a much younger age profile with the 2011 Census showing that 26% were aged under 15 years, 68% aged 15-64 years, and 6% aged 65 years and over. This compares to 16% (under 15), 61% (15-64), and 23% (65 and over) for the White population.

Eastbourne, Hastings and St Leonards-on-Sea, which have high levels of deprivation[6], also have the highest proportion of BAME people and also people where English is an additional language.

3.4 Brighton and Hove

There is a large student population in the city; at the time of the 2011 census full time students aged over 16 accounted for 14.1 per cent of the population. A third of these from BAME backgrounds.

8.3% of the B&H population do not have English as their main/first language[7]and the county is reliant on Sussex Interpreting Services (SIS) to provide community interpreting sessions for over 3,200 different service users in 48 different languages.

Three out of five migrants are from countries outside of the EU. This includes Asia, Sub-Saharan Africa, North Africa, North America and Central and South America and Oceania.[8] Two out of five migrants in the city (40%, 21,000 people) were born in the EU.

A 2015 report shows that the Brighton has a young mixed BAME background whilst White Irish and White UK/British residents have an older profile.[9] There is larger proportions of 20-44 year olds and a peak of Black/Black British residents aged 20 to 24 years.

There were comparatively few BAME residents aged over 65, and very few aged over 85 years at the time of the census. Just 8.1 per cent of residents aged over 65 years were from BME backgrounds in 2011

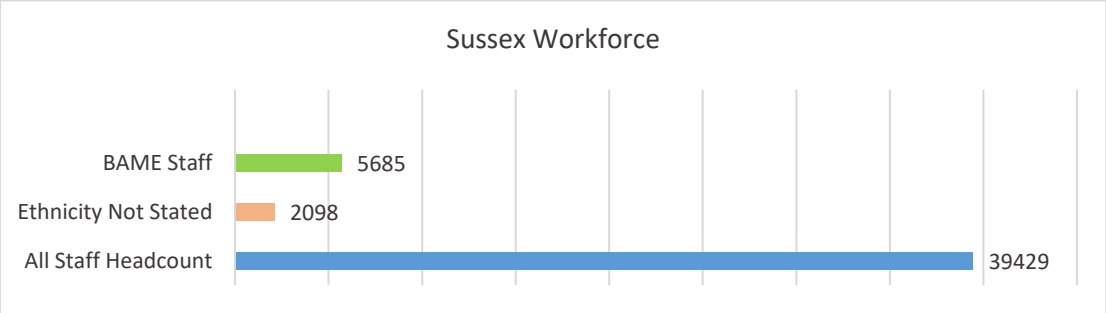
[6] : Public Health, East Sussex County Council, www.eastsussexjsna.org.uk
[7] Brighton and Hove JSNA 2018
[8] Brighton & Hove JSNA summary Population, 2018
[9] Black and Minority BAME Communities in Brighton & Hove, 2015

Chapter 4 –Workforce

In 2020, 14.7% (approximately 5685 headcount) of staff working for the Sussex NHS Providers identify from a BME background which is equal to the England average but lower than South East Average of 20%. The exact population profile in 2020 is unknown.

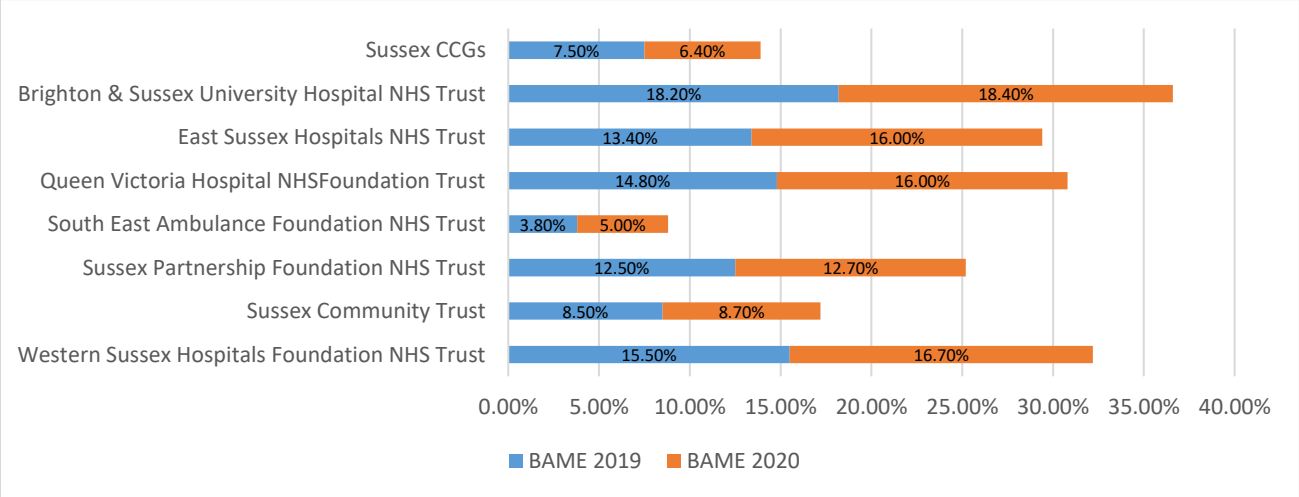
According to 2020 Workforce Race Equality Standard (WRES) Data, all Sussex NHS organisations increased the percentage of BAME staff within their organisations except Sussex CCG Where there was a decrease from 7.5 % to 6.4%.

Figure 4 – Sussex BAME Workforce-WRES (2019)



The table below shows numbers and percentages of BAME employ

Figure 5: Sussex workforce ethnicity profile 2019 and 2020 (WRES)



Across the Local Authorities, West Sussex County Council (WSCC) has 4.69% of workforce identified as BME although there was a significant number of “not stated”, Brighton and Hove City Council (BHCC) have 7.74% based on equalities monitoring data (ethnicity recorded) for 87.36% of (non-schools) workforce and East Sussex County Council (ESCC) – has 4.7% identified as BME in (non-schools) workforce.

4.2 Workforce disparities across the NHS

There are many disparities in workforce data which indicate that staff from a Black, Asian and Minority Ethnic background face disadvantages when compared to their white colleagues in many areas which include:

1. Lower representation in senior, very senior and Board level roles
2. Lower likelihood of staff being appointed from shortlisting
3. Lower access to Training and development
4. Greater likelihood of staff entering the formal disciplinary process
5. Lower likelihood of staff accessing non-mandatory training/CPD
6. Greater percentage of staff experiencing harassment, bullying or abuse from staff, patients, relatives or the public in last 12 months

According to 2020 workforce race equality standard data in comparison with 2019 data, the relative likelihood of white applicants being appointed from shortlisting compared to BAME applicants increased for Brighton Sussex University Hospitals (BSUH), Western Sussex Hospitals Foundation Trust (WSHFT), Queen Victoria Hospital (QVH) and Sussex Community Foundation Trust (SCFT). In two cases the relative likelihood was 2 to 3 times more likely that white applicants being appointed from shortlisting compared to BAME applicants.

The relative likelihood of BAME staff entering the formal disciplinary process compared to white staff decreased in East Sussex Hospital Trust (ESHT), Sussex Partnership Foundation Trust (SPFT), South East Coast Ambulance Service (SECAMB) and BSUH but increased for QVH, WSHFT and SCFT (range of 1 to 1.8 times more likely).

The relative likelihood of white staff accessing non-mandatory training and CPD compared to BAME staff increased (range or 1 to 1.37 times more likely) in all organisations except QVH and SPFT.

4.3 BAME representation in senior NHS roles:

- Only Sussex Community Foundation Trust (SCFT) have no BAME representation in 8b role
- SCFT, Queen Victoria Hospital (QVH), Western Sussex Hospitals Foundation Trust (WSHFT) and CCG have no BAME representation in Band 8d
- QVH, East Sussex Hospitals Trust (ESHT), WSHFT and Brighton Sussex University Hospitals (BSUH) does not BAME representation in Very Senior Management (VSM) roles.
- Only ESHT and BSUH have BAME representation in Band 9

4.4 NHS Board representation

- Except for Sussex Partnership NHS Foundation Trust, BAME representation on the Board is significantly lower than BME representation in the workforce.

- Three NHS Trusts SCFT, BSUH and WSHFT have no BAME representation on the Board in 2020.

4.5 Sussex Workforce Vision and Priorities

The vision of the workforce work stream of BAME Disparity response programme is to: "Establish a consistent 'Sussex-wide' approach in the way our people practices promote fair treatment and equality of opportunity for all staff; encourage and celebrate diversity; and demonstrate intolerance of discriminatory behaviours."

The key priorities identified are:

1. Increased BAME representation in senior roles
2. Reduced disparities in the recruitment and selection process.
3. Reduced disparities in disciplinary process
4. Eliminating bullying, harassment and discrimination

In order to increase Workforce Diversity and improve staff workplace experience many discussions have started on developing joint posts, joint recruitment and stakeholder panels which will help to increase diversity. Further actions are in progress to implement cross-organisational secondments, rotation and shadowing arrangements to encourage BAME workforce interested in increasing skills, enriching experience or progressing in career. Sharing learning from organisations that have performed well in workforce performance indicators will help to improve the BAME workforce experience.

Chapter 5- COVID-19

5.1 National Context

National data emerged during the spring of 2020 that indicated a markedly higher mortality risk from COVID-19 among Black, Asian and Minority Ethnic (BAME) groups. We know that COVID-19 does not affect all population groups equally. Many analyses have shown that older age, ethnicity, male sex and geographical area, for example, are associated with the risk of getting the infection, experiencing more severe symptoms and higher rates of death. Moreover, The highest age standardised diagnosis rates of COVID-19 per 100,000 population were in people of Black ethnic groups (486 in females and 649 in males) and the lowest were in people of White ethnic groups (220 in females and 224 in males)[10]. In effect the BAME population are disproportionately affected by the ongoing Pandemic.

Key points to highlight:

- The higher % of known ethnicity in the early months of the pandemic may reflect the fact that many of those tested were tested within a hospital setting, where background data from medical records were available. In wide scale community testing people were asked to state their ethnicity.
- The rates of the "other" ethnic group are likely to be an overestimate due to the difference in the method of allocating ethnicity codes to the cases.[11]

Table 2: Sussex Residents Tested Positive for COVID -19

Sussex Overall Positive Cases	April	May	June	July	Aug	Sept	Oct	Nov
Any Other Group	39	28	6	<3	9	24	72	115
Asian-Bangladeshi	<3	<3	6	0	0	5	12	37
Asian-Indian	48	32	6	1	5	13	56	100
Asian-Other	79	39	5	6	5	14	56	80
Asian-Pakistani	14	8	2	6	5	5	21	40
Black-Caribbean	6	0	0	0	<3	<3	6	17
Black-Other	13	8	3	1	<3	<3	12	25
Black-African	28	13	11	8	<3	13	63	57
Chinese	9	4	0	0	<3	5	10	15
Mixed	29	19	8	7	7	24	64	80
White-Other	134	89	25	27	21	46	277	315
White-Irish	17	7	<3	0	<3	4	27	29
White-Irish and Other	151	96	28	27	23	50	254	344
White-British	1622	871	294	172	189	667	3025	4341
Missing/Not Known	431	375	86	94	113	308	1366	1687
% with Known Ethnicity	83%	75%	81%	71%	69%	73%	73%	76%
% known from BAME groups	20%	22%	20%	26%	23%	19%	17%	17%

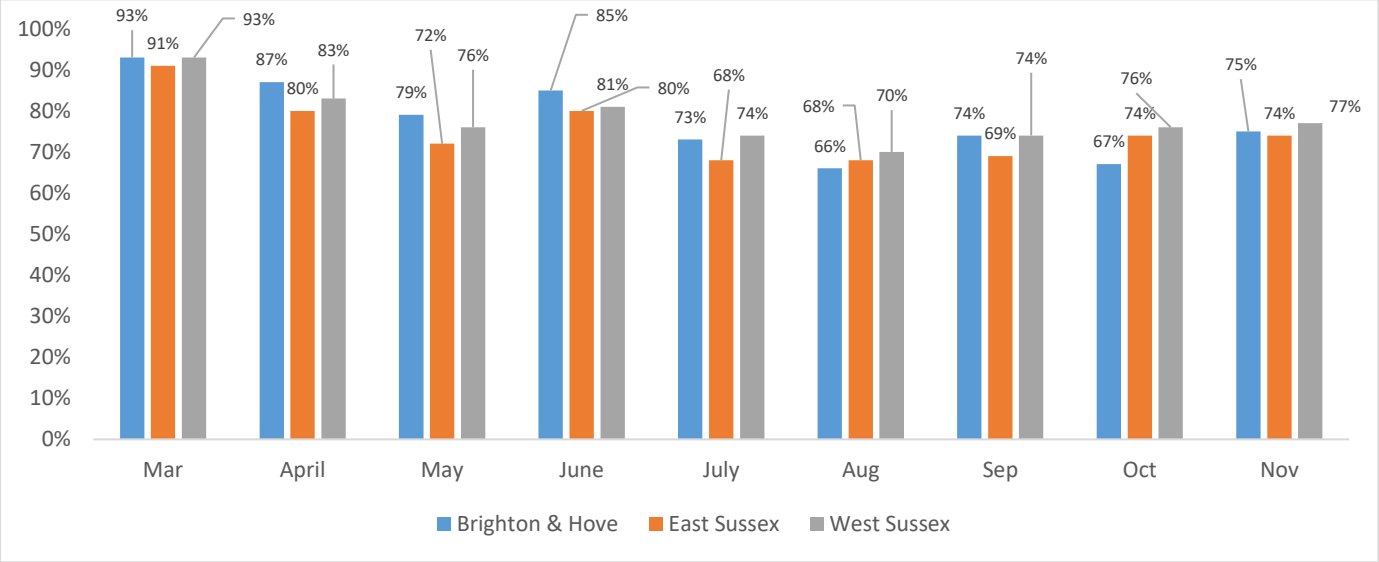
Source: Data provided by LA Public Health Teams. April to November

[10] Disparities in the risk and outcomes of COVID-19, PHE August 2020

[11] Data provided by LA Public Health Teams

Table 2 shows that 20-26% of cases during first wave were from BAME groups reducing over summer and autumn and Figure 6 shows % of cases where ethnicity is recorded (i.e. second from bottom row of table 2)

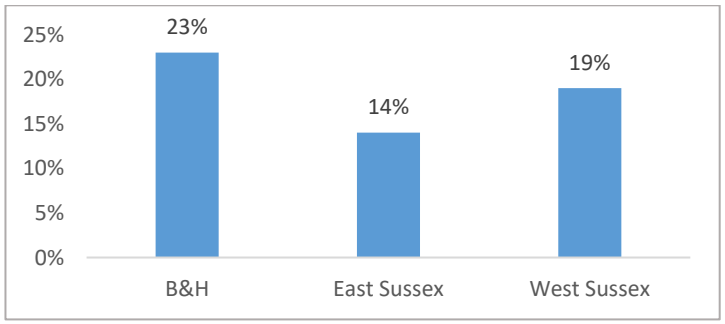
Figure 6: % of Positive Cases (where ethnicity known) - Total months from April to November, 2020



Data: provided by LA Public Health Teams, 2020

As the number of cases in the summer months were relatively low, there is combined data, for each of the local authority areas.

Figure 7: % of Positive Cases (where ethnicity known) from Ethnic Minority Groups. Total months from April to November, 2020



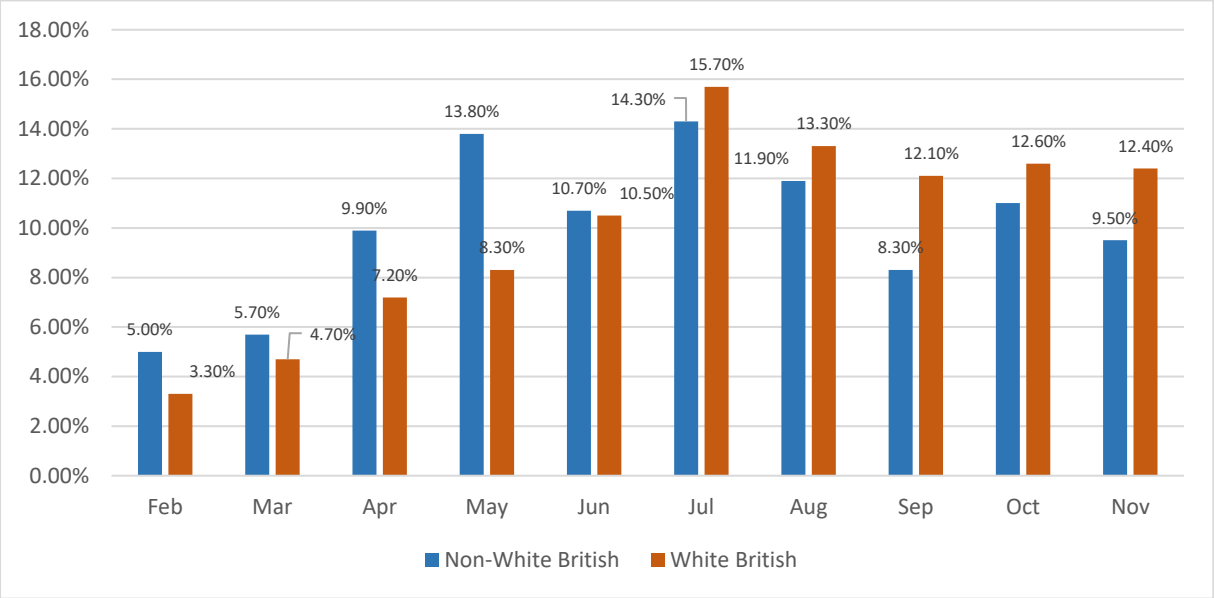
Data: provided by LA Public Health Teams, 2020

5.2 COVID -19 Positive Testing

Using the home postcode of the person who has tested positive and grouping people according to deprivation decile groups (with decile 1 being within the most deprived areas of England, and decile 10 being in the least deprived areas of England), the graph below in Figure 8 shows that approximately a third of people from minority ethnic groups in Sussex who tested positive lived within the 40% most deprived areas of England compared to approximately a quarter of White British people who tested positive.

Note: This should be treated with some caution as we know that many people tested early on in the pandemic were older people in care homes, although these are not robustly flagged on the dataset.

Figure 8: Positive Cases – Ethnic Groups by Deprivation Decile of Home Postcode February to November 2020 – Sussex Overall



Source: Data provided by LA Public Health Teams, 2020

Figure 9: Age / Sex of All People Who Have Tested Positive February to November 2020 – Sussex Overall

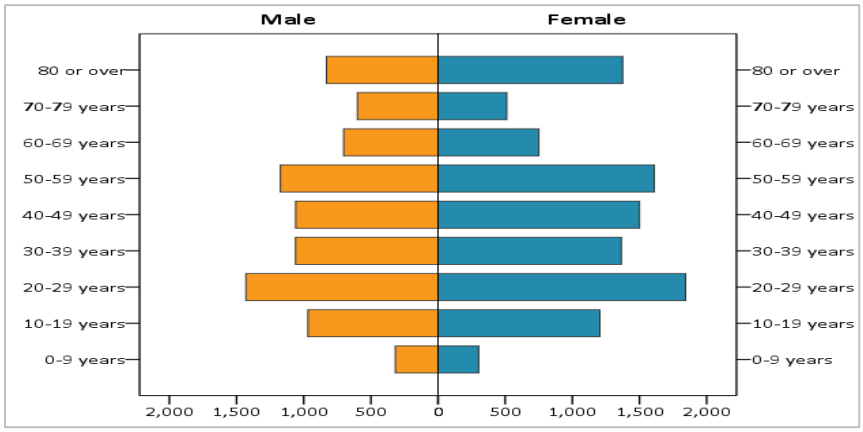
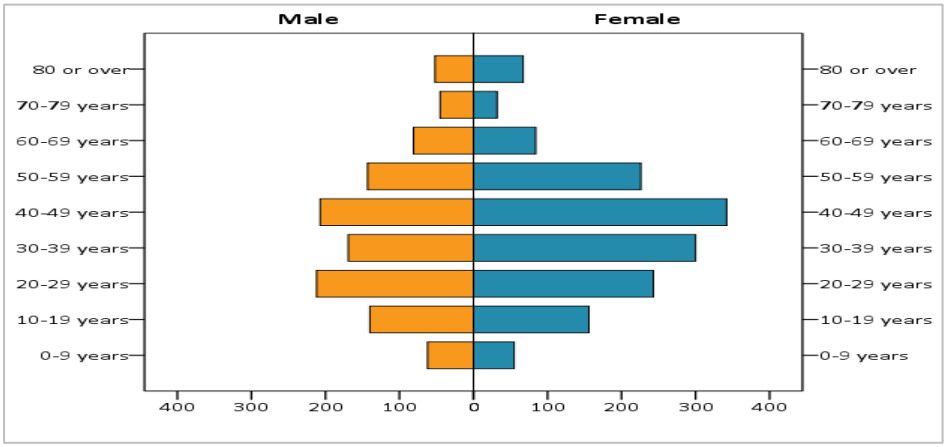


Figure 10: Age / Sex of All People Who Have Tested Positive – Ethnic Minority Groups ONLY February to November 2020 – Sussex Overall



Source: Data provided by LA Public Health Teams

5.3 Key Workers and Covid-19

Although data is not complete, we know that for 6% of all the people who have tested positive stated that they worked in a care home, this is higher amongst some ethnic groups, notably people of Black ethnic groups where this figure rises to 16%. This is slightly above the national average of 12%

5.4 Disparities in COVID-19

National data from the ONS and PHE (Public Health England) show a strong association between economic disadvantage and COVID-19 diagnoses, incidence and severe disease. Also, economic disadvantage is also strongly associated with the prevalence of smoking, obesity, diabetes, hypertension and their cardio-metabolic complications, which all increase the risk of disease severity. There is also intersectionality with gender and age, and geography. BAME people who live in deprived areas have higher diagnosis rates and death rates than those living in less deprived areas.

In Sussex we know that our deprived areas such as Crawley, Hastings, St Leonards - on-Sea and Brighton are more likely to have had higher positive rates than the rest of Sussex although not particularly high compared to the rest of country. Cumulative rate since the start of the pandemic in March is still only just over 50% of the highest in the country 10.134 (Merthyr Tydfil) Hastings = 5633, Brighton 4104. Worthing 3620, Crawley 5294) be tested positive for COVID-19. Death rates were highest among people of Black and Asian ethnic groups.

In addition based on findings in the Public Health, “Beyond the data” Report racism and discrimination experienced by BAME communities has been identified nationally as a root cause affecting health, COVID-19 exposure risk and disease progression risk. It also affects

people's life chances and the stress associated with being discriminated against based on race/ethnicity affects mental and physical health[12].

5.5 Public Engagement and Research into impact of COVID-19 on BAME Communities

In response to the health inequalities NHS Sussex commissioners commissioned a series of public involvement surveys to understand the experience of Black, Asian and Minority Ethnic (BAME) and refugee groups' access and consumption of information about COVID-19, during the first lockdown. Engagement took place with over 600 ethnically diverse people across Sussex with over 55 self-defined ethnicities. The methodology was co-designed through an oversight group comprising statutory sector partners, engagement delivery partners and communication support organisations. The research included: 208 interviews, 7 focus groups, 420 survey responses and support from interpreters of 12 community languages.

5.5.1 Brighton and Hove Public Research Findings[13]

Their research showed the following:-

- 13 per cent of all respondents (Total = 40) across surveys, interviews and focus groups said that either they or a household member had contracted COVID.

> *"She went in with breathing difficulties, high temperature and had underlying health conditions and it got into her lungs …….she died immediately"*

- 95% of people interviewed appeared to have a very good grasp of what COVID-19 symptoms were. Typical answers mentioned a new continuous cough and a high temperature, fewer people mentioned loss or change of taste.
- 33% of respondents were key workers, which is largely in line with Brighton and Hove demography, where 31.3 per cent of the workforce are key workers
- How a BAME person experienced the NHS was determined by multiple factors, it could include the colour of a person's skin, their accent, their ability to speak English, their clothes, their religion and/or their difference, perceived or real.

Recommendations

- To improve working conditions and support and encourage employers to implement Equality Assessment Frameworks
- Improve Information, communication and messaging and provide unambiguous and simple information about the local health context
- Addressing barriers to accessing NHS care. Carry out Equality Impact Assessments on access to healthcare
- In the event of a second COVID-19 and the lockdown experience build closer, collaborative relations with the BAME communities in Brighton and Hove

[12] Beyond the data: Understanding the impact of COVID-19 on BAME groups, 2020

[13] The NHS, COVID-19 and Lockdown: The Black, Asian and Minoritised Ethnic Refugee Experience in Brighton and Hove, 2020

- Support people with lived experience to develop knowledge, skills, and confidence to make a meaningful contribution to co-production – links to the Personalised Care Peer Leadership programme and Community Ambassador Programme.

5.5.2 West Sussex (Crawley) Public Research Findings[14]

Crawley is the most diverse area in West Sussex, with 20.1% of people identifying as non-white and whilst the incidence for Crawley was lower than the average in England this did not detract from BAME people's personal experience.

Those who shared their views felt that socio economic, cultural and biological factors impacted their experience. Some felt that were treated unfairly and others were given preferential treatment. Language and communication barriers influencing access, diagnosis and treatment; treated worse by employers and society and put them in positions of greater harm.

A few sought medical advice such as 111 but most used resources provided by their GP. Some had sought advice with difficulty due to communication barriers.

Sarah, 19 – Young Adult said that would like information from the NHS in plain language, posters, TV and the NHS website. She would speak with a GP, 111 or an experienced family member if she had symptoms of coronavirus, she would also quarantine.

Recommendations

- To continue to engage and ensure that work is ongoing to reach out to young people
- Tangible deliverables are needed to build trust with the BAME community so actions are visible and experienced.
- Ensure curated interventions and key messages target BAME people. One size does not fit all.
- Address wider socioeconomic determinants to prevent ongoing disparity in Covid-19 and other reduced health outcomes.

[14] Exploring the disparity of Covid-19 with the Crawley BAME Community

5.5.3 East Sussex (Hastings and St. Leonards) Public Research findings[15]

This study focused on assessing awareness of the personal risks faced by the BAME population living in Hastings and St Leonards - on- Sea in the context of the current COVID-19 pandemic.[16]

Key Findings

- The strongest connecting factor between all participants was experience of accessing health services as a person of colour and especially if English was not first language. Many participants described what they felt was discriminatory behaviours from GP admin staff, call centres and clinical staff.
- There was stigma about COVID-19 been labelled as a "BAME virus" and should be avoided at all costs
- Resistance to the term "BAME" Although used throughout this report the participants, saw this as a barrier that they needed to overcome before meaningful engagement could be undertaken

"Reading up, it seems BAME backgrounds disproportionately affected (although how much this is due to living/working conditions as opposed to genetic factors/vitamin D am unsure. I am a keyworker as is my husband, so risk of exposure greater. However, am lucky that I don't need to use public transport or live in multi-generational home but many are not so lucky"

5.6 Local Authority Outbreaks Plans

In addition to commissioner response, local authorities are required to ensure that plans are in place that meet BAME population needs during COVID-19. It is also part of the wider programme to tackle health inequality.

5.6.1 West Sussex Outbreak Plan[17]

To ensure that national, regional and local organisations and responses work together as an interdependent system to prevent and contain the spread of COVID-19 and that:-

- Targeted testing is in place for BAME communities
- That messaging is effectively communicated to BAME and vulnerable populations by using multiple channels and utilising community groups and teams both within WSCC and more widely through the voluntary and community sector.

This is key as we know that West Sussex is a diverse county with a BAME population of 11%. Areas such as Crawley that has a high Asian population with certain co-morbidities (diabetes, Heart disease), prevention programmes such as these are key to supporting these communities during COVID-19.

[15] Impact on the BAME Population of Hastings and St Leonards, 2020
[16] Coronavirus and the Impact on the BAME Population of Hastings and St Leonards
[17] WEST SUSSEX COVID-19 LOCAL OUTBREAK CONTROL PLAN

5.6.2 Brighton and Hove [18]

The local authority's ongoing plans are to collaborate with BAME, faith communities and neighbourhood forums/groups in disadvantaged areas to design and communicate prevention messages to ensure reach and impact. Alongside co-production evidence is considered from behaviour science to reduce the spread of COVID-19 in disadvantaged areas (which shows knowledge and information provision on its own will not be enough).

5.6.3 East Sussex

The plan includes community research and engagement and looking for alternative appropriate methods to ensure information reaches these communities. ESCC have developed a 'COVID-19 model risk assessment' which can be used to support employees in the workplace and includes BAME background as well as age and gender.

The communication and engagement plan attached to the Outbreak management plan also outlines how specific groups will be reached using online platforms, including how residents can be targeted by their locality (home or work) and /or their profession. It includes particular thinking on at-risk or potentially marginalised groups are reached, including the Black and Minority Ethnic (BAME) community, shielded groups, the homeless and people with impaired vision or hearing.

[18] Brighton & Hove City Council Local Covid-19 Outbreak Plan

Chapter 6-Wider Determinants

The wider determinants of COVID-19 and the more long term health inequalities are explored in this chapter which will explore how socio-economic disparities impact on health and wellbeing, contributing to poorer health outcomes throughout life. Some aspects have a direct impact on health, such as poor housing and employment, while others have indirect effects. For example, people in routine occupations are more likely to be on insecure zero-hours contracts, be lower paid, are more likely to work shifts and so are less economically resilient. During the COVID-19 pandemic this has meant that economic consequences of being out of work and or in self-isolation cannot be fully mitigated even by the financial support available to claim under the £500 Test and Trace Support Payment if you live in England and meet all the criteria.

There is a strong association between socio-economic disadvantage and ethnicity. This is a complex relationship. People from minority ethnic backgrounds are more likely to experience *multiple* aspects of deprivation, including having a low income, live in poorer housing, be victims of crime, experience unemployment or low paid work.

Geographically ethnicity and deprivation can act as proxies for each other, targeting interventions in the poorest neighbourhoods would also be targeting ethnic minority groups.

6.1 Education

6.1.1 Ethnic Background of the School Population

While data relating to the ethnicity of the overall population is infrequently collected and usually via national census (last Census, 2011), information is collected from maintained schools on an annual basis. This provides us with a detailed view of the school-aged population, although it should be noted that this excludes children attending private schools. In addition to the Census 2011 categories the school census also includes data on children from Gypsy/Roma groups and those of travellers of Irish heritage.

From the 2019/2020 School Census, approximately 20% of Sussex pupils in primary schools and special schools and slightly less at just over 18% in secondary schools in pupil referral units are from BAME groups as seen in Table 3.

The highest numbers of pupils are from white other, and from the mixed background groups.

Table 3: School Population - Pupils in Maintained Schools in Sussex School Census 2019/2020

	Primary Schools	Secondary Schools	Special Schools	Pupil Referral Units
White - White British	97,369	70,586	2,683	280
White - Irish	331	291	12	0
White - Gypsy/Roma	483	255	16	9
White - Traveller of Irish heritage	122	45	6	2
White - Any other White background	7,484	4,765	145	9
Asian - Bangladeshi	720	542	31	1
Asian - Indian	1,555	904	30	0
Asian - Pakistani	919	670	40	0
Asian - Any other Asian background	1,834	1,162	60	1
Black - Black African	1,158	793	53	4
Black - Black Caribbean	136	136	4	0
Black - Any other Black background	402	289	18	1
Chinese	424	285	7	0
Mixed - White and Asian	2,209	1,382	41	6
Mixed - White and Black African	1,461	883	39	8
Mixed - White and Black Caribbean	1,234	883	41	13
Mixed - Any other Mixed background	2,573	1,744	78	10
Any other ethnic group	1,087	830	44	0
Unclassified	1,384	1,303	41	8
Total	122,885	87,748	3,389	352
% of Pupils from BAME Groups	**19.9%**	**18.3%**	**19.9%**	**18.6%**

Source: Department of Education

6.1.2 First Language – Pupils in State Schools

In addition to ethnic background, the 2019/2020 school census of state schools collects information on the first language (home language) spoken by each pupil. 11% of children in primary schools and 9% in secondary schools had English as a second language as seen in Table 4. Note this does not assume the level of fluency in English as children may also be fluent in English, and their first language.

Table 4: Demographics – First Language – Pupils in State Schools School Census 2019/2020

	Known or believed to be English	Known or believed to be other than English	Language unclassified	Total	**% of pupils with a home that is not English**
Pupil referral unit	333	18	1	352	5%
State funded primary	109, 383	13,396	106	122,885	11%
State funded secondary	79, 964	7568	216	87,748	9%
State funded special school	3,105	282	2	3,389	8%
Total	192,785	21,264	325	214,374	10%

Source: department of Education

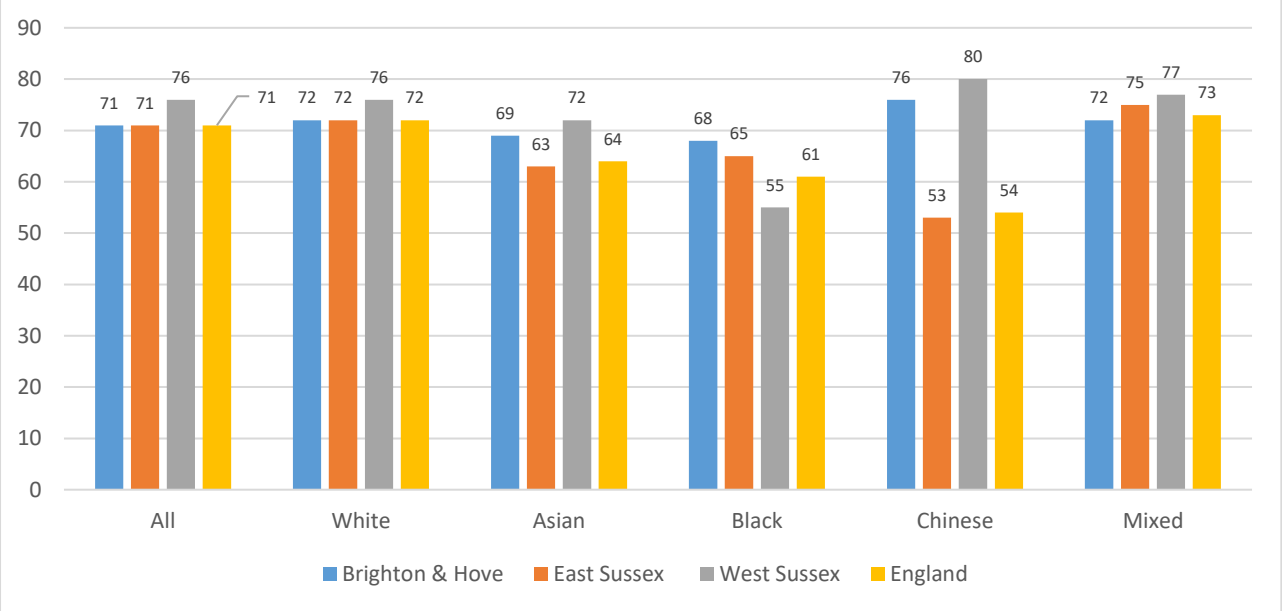
According the Young Foundation (2015), language barriers play a key part in levels of integration and this is particularly true for the Indian, Pakistani and Eastern European communities.

Language barriers can impact one's self worth and the availability and quality of English language lessons and or translation services is an important route to tackling obstacles to integration. The availability of translation services helps with everyday issues like applying for jobs, housing etc. and reduces feelings of isolation which language barriers often cause but young people entering university generally need to demonstrate a certain level of fluency in English to be admitted to university, so unlikely to be accepted if need translator to apply.

6.1.3 Attainment – Primary School

A lower percentage of Sussex pupils from Asian and Black BAME groups are assessed as meeting expected standards of development in 2018/19 at 4/5 years as seen in Figure 11. In West Sussex 55% of Black pupils were assessed as meeting expected development goals compared with 61% nationally. For Chinese children the picture is mixed across Sussex, with just half of Chinese pupils in East Sussex assessed as meeting development standards but this was significantly higher in West Sussex and Brighton and Hove. It should be noted that the number of Chinese pupils is relatively small.

Figure 11: % of 4/5 Year Olds Meeting Expected Development



Source: 2018/19 School Census

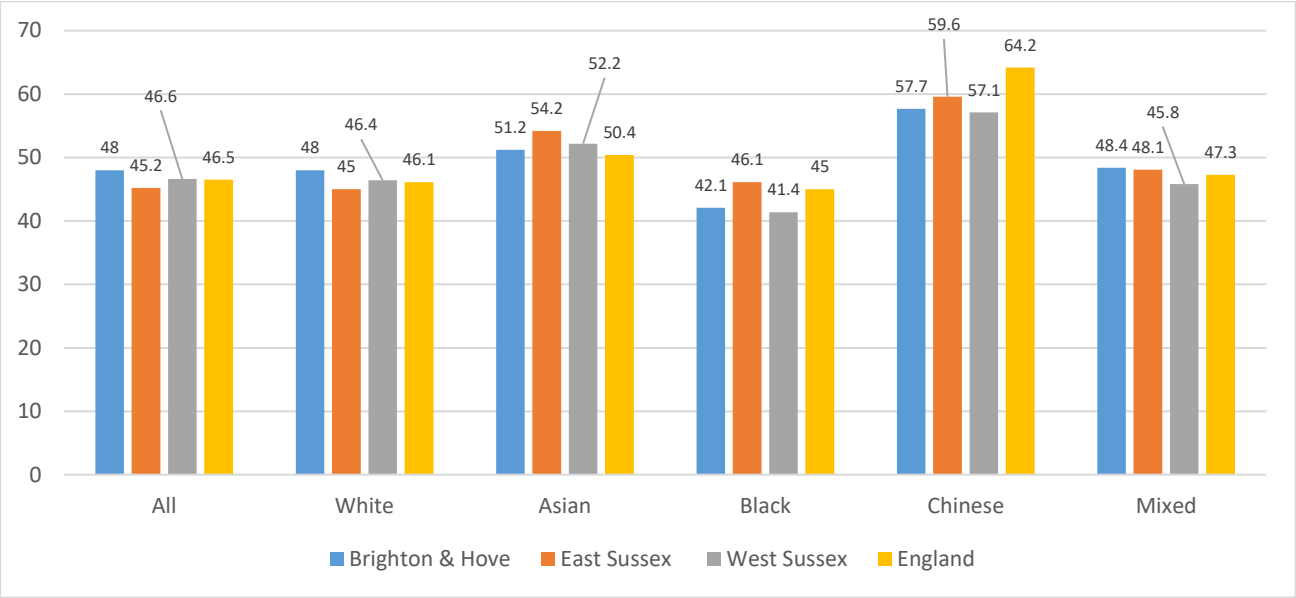
6.1.4 Attainment – GCSE's

In relation to these aggregated ethnic groups[19,20] after reviewing the 2018/19 School census, in Figure 12, it was noted that it was black pupils in Brighton and Hove and West Sussex who have, on average, lower Attainment 8 scores when compared with black pupils in East Sussex and also compared with England overall as seen in Figure 12.

Chinese and Asian pupils score better than their white and black counterparts – this is true for England and for Sussex.

[19] Brighton & Hove, JSNA, 2015
[20] West Sussex JSNA, 2018

Figure 12: Average Attainment 8 score by ethnicity 2018/19



Source: 2018/19 School Census

In an Equality and Human Rights Commission it found that pupils from Irish, Indian, white and Asian backgrounds achieved more that the national average for a good level of development, but pupils from Black, Bangladeshi and Pakistani BAME groups did not perform well.

The wider social issues and other factors that may contribute to Black Caribbean pupils' underachievement are outlined in Black Caribbean Underachievement in Schools in England. The report found:

- **Institutionalised racism** - the less overt more subtle nature of racism which less perceptible nature of racism.
- **Social class**- where a parents' social class has a greater impact on how well their children perform at school than 'good parenting' techniques such as reading bedtime stories, researchers have shown.
- **Cultural identity –** underpinned by the various categories used by government agencies and others, to classify different BAME groups. There seems also to be unwillingness by some in British society, to accept a person's own definition of who they are.
- **Media Representation**- the way in which the represented peoples who were different; different from what was considered acceptable in British society. Only until recently our differences were constructed as a negative sign and imbued with connotations of threat, invasion and crime

6.1.5 School Exclusions

There are relatively few permanent exclusions, and numbers are small when further broken down by ethnicity. In 2017/18 as seen in Table 5, children of Chinese and Asian background are less likely than others to have temporary exclusion. However, young Black and Mixed students were more likely to have temporary school exclusions and this likelihood increased for permanent exclusions (two to three times more likely) when compared to any other ethnic groups. This is 2 to 5 times more likely when compared to white students in East and West Sussex who make up a significant majority of the school population.

Table 5: Education – Temporary and Permanent School Exclusions 2017/18 by likelihood rate.

	TEMPORARY			PERMANENT		
	Brighton & Hove	East Sussex	West Sussex	Brighton & Hove	East Sussex	West Sussex
Asian	2.3	1.08	1.83	0	0	0
Black	4.7	5.3	4.88	0	0.21	0.5
Chinese	0	0	0.67	0	0	0
Mixed	5.5	6.2	6.1	0.06	0.3	0.3
White	5.4	6.3	4.3	0.04	0.1	0.1
Other	4.3	2.1	1.8	0	0	0

Source: Department of Education

6.1.6 Racist incidents and racist bullying

Schools in Sussex have a variety of internal systems to record pupil behaviour, some of which include racist incidents or bullying. Although there is no legal requirement for local authorities to collate the data from schools, OFSTED does ask to review individual schools' data on bullying and prejudice- based incidents, as part of their school inspection. It is therefore not possible for this report to include behaviour data in schools, although it may be a useful way to understand the emotional needs and personal experiences of racism of BAME children and young people.

6.2 Not in Education Employment or Training (NEET)

Underachievement in school is reflected in the number of BAME young people who are NEET[21] as seen in the 2020 NEET annual report - Table 6. Across the South East the percentage of all young people who are NEET is quite similar to the England average. However, when looking at Sussex, the percentage of young people who are NEET is significantly greater in West Sussex when compared to the other counties, the South East and England averages. Noticeably in West Sussex there is a significant overrepresentation of Black young people who are NEET or for whom their participation is unknown when considering the Black population percentage. At 24% this is twice as high when compared to White young people. It should be noted that West Sussex has a relatively high percentage (9.7%) of young people with incomplete data, compared with a national rate of 2.8% and rates in Brighton and Hove and East Sussex of 1% and 1.3% respectively.

21 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/869804/NEET_statistics_annual_brief_2019_statistical_commentary.pdf

Table 6: Number of 16/17 years old and Percentage of whom are NEET or not known (2020)

% 16/17 year olds recorded as NEET or not known	Brighton & Hove	East Sussex	West Sussex	South East	England
	3,850	9,290	14,580	137,190	739, 970
White	5%	6%	12%	7%	6%
	370	400	800	7480	45,770
Mixed ethnic background	6%	4%	12%	7%	6%
	90	80	110	3,960	54,690
Black/ Black British	6%	2%	24%	5%	4%
Asian/Asian British:	150	200	680	10,030	105,390
	3%	1%	9%	3%	2%
	20	30	40	580	3520
Chinese	0%	1%	9%	3%	2%
	170	40	170	2020	20,330
Other	1%	1%	7%	5%	5%
Total: 16-17 yr olds recorded as NEET or not known	4,770	10,330	16,630	180,170	1,143,000

6.3 Economic Activity and Employment

In September 2020, of the 7,750 claimants of Job Seekers Allowance[22] across Sussex, 665 claimants were known to have a BAME background. A quarter of all claimants (2,065) had missing Ethnicity data. There has been a considerable rise in the number of people claiming Job Seekers Allowance due to the impact of COVID-19, unfortunately this has been accompanied with a decline in data quality, with reduced reporting of Ethnicity.

Figure 13: Economic Inactivity of 16-64 Year Olds, 2019

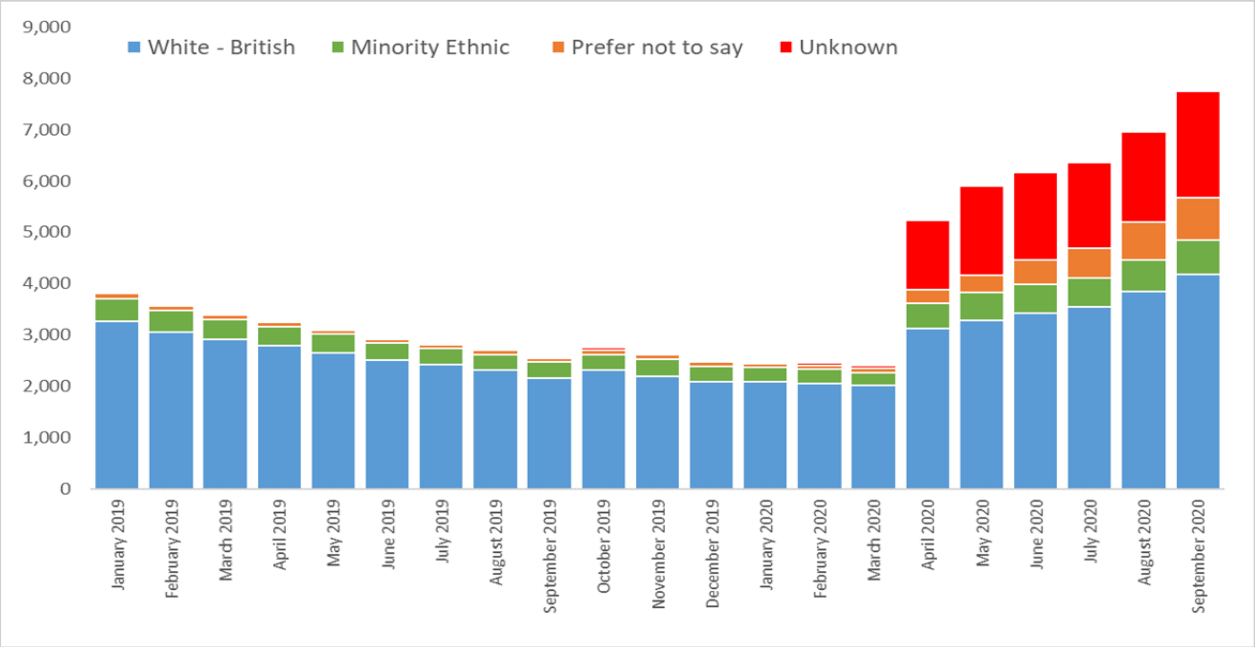
Source: Annual Population Survey 2019

6.4 Employment – Job Seekers Allowance

These figures show the number of people claiming Job Seekers Allowance and you can see the impact of the COVID-19 pandemic. Of note is the high number of claimants where BAME background is unknown. The raises concerns about the collection of data from the start of the pandemic and the commitment to recording of data to understand the impact on different groups within the community.

[22] https://www.nomisweb.co.uk/reports/lmp/gor/2092957698/report.aspx

Figure 14: Job Seeker Allowance – Claimant Count January 2019 to September 2020 by aggregated BAME Group[23]



The Socio-economic classification based on employment is strongly linked to health inequalities. People in the 'higher' socio-economic groups have better health outcomes compared to people in routine and manual occupations.[24]

In East Sussex, those living in Bexhill, Eastbourne and Hastings have the worst income and employment deprivation indicators and this correlates to the areas where many BAME communities reside. In West Sussex, those from BAME groups were more likely to be 'economically active but unemployed' as noted in the 2011 census than White British residents in West Sussex, particularly in the under 24 year age group.

6.5 Housing

For the purpose of this review, the official ONS definition of "overcrowding" housing is used. Overcrowding is when the "number of persons sleeping in the dwelling contravenes the bedroom standard (i.e. difference between the number of bedrooms needed to avoid undesirable sharing (given the number, ages and relationship of the household members) and the number of bedrooms actually available to the household".[25]

Data from the 2018 National Housing Survey (combined data for 2016-2019) at a national level from the English Housing Survey found that in all but the very lowest income band, White British households were less likely to be overcrowded than BAME households. Overcrowding was most frequent in Bangladeshi, Pakistani and Black African households.

[23] https://www.nomisweb.co.uk/articles/1220.aspx

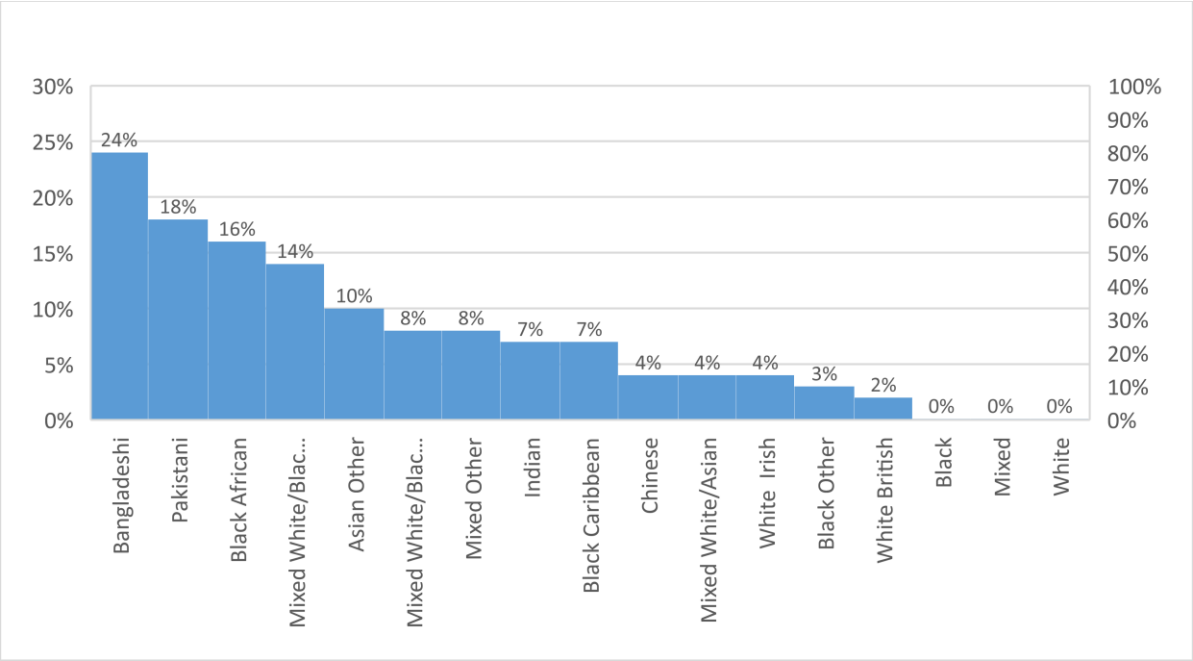
[24] Local action on health inequalities Understanding and reducing BAME inequalities in health, 2018, PHE

[25] https://publications.parliament.uk/pa/cm200203/cmbills/046/2003046.pdf

In West Sussex, 10% of the groups within the Asian community live in very large households (considered overcrowded according to ONS) compared to 0.9% of the white population. Local data suggests that home ownership for Chinese, Indian and Bangladeshi residents has fallen heavily when compared to White British residents.

Whilst overcrowding is linked to poor health outcomes for the BAME community, data does not take into account the BAME multi-generational experience. A 2019 research paper[26] found that living in a multigenerational household has a positive impact on members which is "determined by an individual's degree of agency and choice in the arrangement, rather than an ability to cope with wider structural pressures". This can be extended to the BAME community where we know that Asian families are more likely to live in 'over crowded' housing. However, during COVID-19 this has increased risks, where the rates transmission significantly increase, and where self-isolation is more difficult to manage.

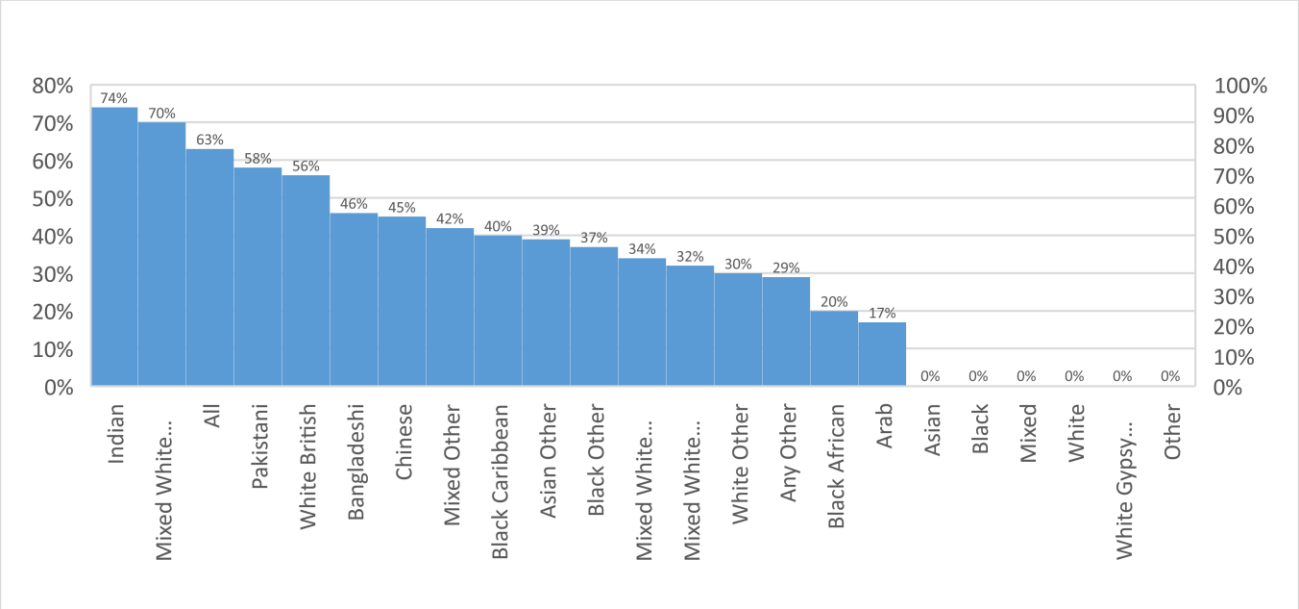
Figure 15: % living in overcrowded housing 2017 to 2018



Source: Housing Survey

In the 2018 National Housing Survey, over 55% of the residents from an Indian, Mixed white Asian, Pakistani and White British background owned their own home compared to less than 50% of the other ethnic categories owning their own home. Of note only 20% of Black African and 17% of Arab groups owned their own home.

Figure 16: House Ownership, English Housing Survey 2017 to 2018



Source: English-Housing-survey 2017-to-2018, ONS

6.6 Poverty and living standards

In National reviews,[27] Asian and Black households and those in the "Other" ethnic group were more likely to be poor and were the most likely to be in persistent poverty. Around 1 in 4 children in households headed by people from an Asian background or those in the "Other" ethnic group were in persistent poverty, as were 1 in 5 children in Black households compared to 1 in 10 from White British households.[28]

This is reflective in the patchy local data available where in East Sussex, more BAME communities reside in Hastings, Rother, Bexhill and St Leonards Hill areas and face many socio-economical disadvantages. Hastings is significantly worse than England average across a range of indicators around the wider determinants of health including deprivation and child poverty, GCSE attainment, pupil absence, long term unemployment, hospital admissions and fuel poverty. In Brighton and Hove, data shows that BAME communities particularly Bangladeshi are much more likely to be living in existing poverty.

In Brighton and Hove, BAME residents (particularly Pakistani, Bangladeshi, Black African and Black Caribbean) are more likely to be employed in hospitality sectors most impacted by COVID-19 and therefore are more likely to face unemployment. Many residents from BAME backgrounds, particularly Bangladeshi residents are more likely to live in some of the most deprived neighbourhoods in the city such as in East Central Brighton which has some of the most deprived wards in Sussex (most deprived nationally).

[27] Race Disparity Audit — Summary Findings from the Ethnicity Facts and Figures Website, Cabinet Office, October 2017, available at www.gov.uk
[28] https://app.croneri.co.uk/feature-articles/race-disparity-audit-40-years-legislative-failure-revealed

Chapter 7 - Health Behaviours

There are some risk factors which are not modifiable such as age or gender, but there are four main behavioural risk factor that individuals can modify:

- Smoking
- Diet (with poor diets high in sugar, fat and/or salt)
- Level of Physical activity
- Substance misuse (including alcohol consumption and drugs)

These risk factors act to increase blood pressure, blood sugar levels and increase obesity. In the COVID-19 pandemic these have contributed to weaken immunity, increase the risk of inflammation and the susceptibility to respiratory illnesses. Understanding whether we see different patterns of behaviour by people from different groups and communities, including from different ethnic backgrounds, is important if we are to target resources, and support people to lead healthier lives. It is also important to understand that tackling modifiable risk factors cannot be left to individuals and confined to information. We know from tobacco control, that a range of concerted action is needed and can be effective; smoking rates have fallen in the UK, obesity rates are rising.

In addition to the wider determinants of health inequality, the health-related behaviours of the BAME population also intersect with age, gender, cultural norms, socio-economic status and change over time.

7.1 Smoking

Data from the Annual Population Survey (APS) includes questions on smoking. When asked their current smoking status, 22% of men from Mixed BAME background said they were current smokers, this was the highest rate of any group**.**

It is important to note that the APS found greater differences within groups, when looking at the responses from men compared with women, than between groups. For example while Asian males had a smoking rate (13.9%) similar to that of White males (15.8%), whereas 2.8% of Asian women said they were smokers compared with 13.1% or White women. This highlights the fact that behaviours may differ by gender, age and over generations and there may also be a reluctance to report culturally unacceptable behaviour to surveys.

Locally, although data relating to smoking status by BAME group are not available, the APS does provide information on the smoking rate of routine and manual workers. In 2019 the smoking rates of routine and manual workers aged 18-64 years in each of the local authority areas were:

Brighton and Hove 30.1% (confidence interval of 20.4 to 39.7)
East Sussex 27.9% (confidence interval of 19.6 to 36.2)
West Sussex 17.3% (confidence interval of 11.2 to 23.5)

Information on smoking behaviours amongst young people broken down by ethnicity is scarce. A national survey of health-related behaviours, the "What About Youth Survey" (aka the WAY survey) was discontinued in 2016. However, 2018 West Sussex JSNA found that Bangladeshi men and women were far more likely to use chewing tobacco than other minority groups in the population

7. 2 Substance Misuse

7.2.1 Alcohol

A review of the UK literature on Ethnicity and alcohol conducted in 2010 surmised that there is diversity both within and between BAME groups. Most minority BAME groups have higher rates of abstinence and lower levels of drinking compared to people from white backgrounds, but over time generational differences may emerge, for example, frequent and heavy drinking has increased for Indian women and Chinese men. There are many indicators of association to living in poor economic situation as well as experiencing racism.

Moreover, people from some BAME groups are more at risk of alcohol-related harm:

- Irish, Scottish and Indian men, and Irish and Scottish women have higher than national average alcohol-related deaths in England;
- Sikh men over present for liver cirrhosis;
- People from minority BAME groups have similar levels of alcohol dependence compared to the general population, despite drinking less.
- Yet, the review concluded, minority BAME groups are under-represented in seeking treatment and advice for drinking problems.

Whilst literature research reports higher rates of abstention among minority communities, there are concerns about the prevalence of problematic alcohol use among Sikh males, refugees and asylum seekers.

There is limited local data across Sussex, key informants suggest that a true estimate of the prevalence of problematic alcohol use is currently unknown as it is not accurately recorded. Some contributing factors were identified such as the experiences of multiple exclusion (structural and institutionalised racism); younger age; in some communities older males were at higher risk due to social perceptions of masculinity; and the hidden nature of women's drinking across cultures are contributing factors. This results in a variety in the types of support available with a higher preference of provision through community organisations or from family and friends.

7.2.2 Drugs

In 2014, in a self-reported survey, Black people aged 16 and over were more likely than other ethnic groups to have had a drug dependency in the year before they were surveyed.[29]
Black men were more likely than men from other ethnic groups to have had a drug dependency with 11.5% of Black males reported at least one sign of drug dependency in the

[29] Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014

past year, compared with 4% of White British males. There was strong correlation to mental health conditions, socio-economic disadvantages and aspects of racism.

7.3 Physical Activity

The recent 'Sport for All[30]' report concluded that people from BAME backgrounds are far less likely to be physically active and less likely to volunteer in sport and enjoy the benefits associated with it.

South Asian groups have been found to have lower overall activity levels than the general population,[31] but those from Mixed Heritage backgrounds had higher activity levels than the general population.

In terms of low activity rates (meaning that children are, on average, doing less than 30 minutes of physical activity a day) overall, in 2018/19, 29% of 5 to 16-year olds were "less active". This survey found broad similarity between boys from different BAME groups, although 32% Asian boys were less active. There were considerable differences amongst girls, with girls from Asian and Black BAME backgrounds being far less active than other groups (38% and 39% respectively).

Similar patterns were observed amongst adults, again differences being greatest when comparing activity rates of men and women, rather than between BAME groups. Overall people from Asian and Other BAME backgrounds showed the lowest activity rates, with approximately 34% of adults being inactive.

There may be a range of perceived barriers to some BAME groups taking up physical activities, such as higher modesty concerns, or a lack of culturally appropriate exercise services. A need for gendered physical activity sessions has been highlighted, for Muslims of older age groups

7.4 Healthy Eating and Obesity

In a 2012 Brighton and Hove study[32] data from the Health Counts survey showed the difference between healthy eating habits between the White and BAME communities (five or more portions of fruit or vegetables a day). 35% of Mixed Heritage population and 47% of the Black community reported eating a healthy diet when compared to 68% of their White counterparts. Locally as well as nationally, it has been identified that members of BAME communities are amongst the groups most likely to experience food poverty which impacts on food eaten and thus on health outcomes.

[30] https://www.sportengland.org/news/sport-for-all

[31] BLACK, ASIAN AND MINORITY BAME COMMUNITIES IN WEST SUSSEX, 2016

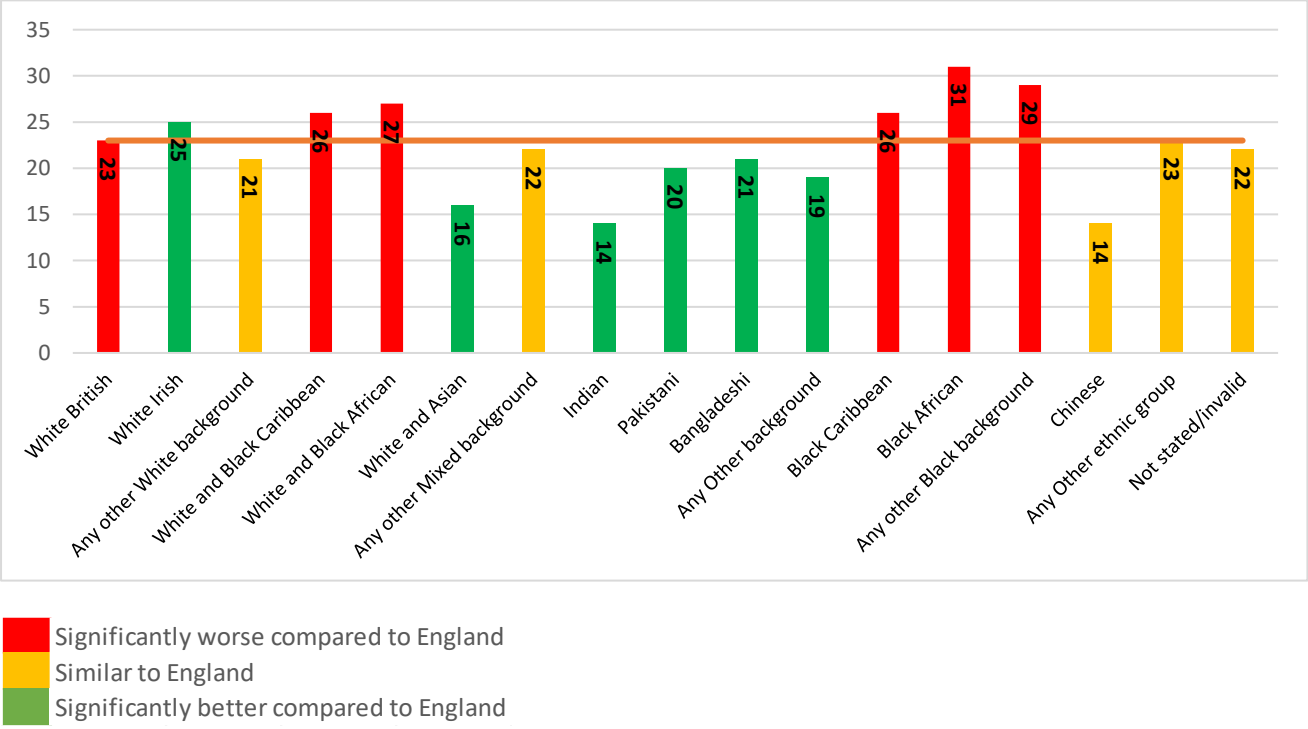
[32] Black and Minority BAME Communities in Brighton & Hove April 2015 Brighton & Hove City Council Policy, Scrutiny & Communities Unit

Each year the National Child Measurement Programme (NCMP) measures the height and weight of Year R pupils (aged 4 to 5) and Year 6 pupils (aged 10 to 11) to assess overweight and obesity in primary schools. Breakdown by ethnic background are available but due to the small numbers at lower geographies, data is presented for England and not available for Sussex. For children in reception year there is a mixed picture of overweight (including obesity) by ethnic background.

It should be noted that BMI acts as a proxy for lean and fat mass but does not reflect body composition or fat distribution. Inter-ethnic differences in body composition are a confounding factor in comparing obesity levels between ethnic groups: BMI has been found to underestimate body fat in South Asian children and over-estimate body fat in Black African children. Therefore some care should be taken when using this information.

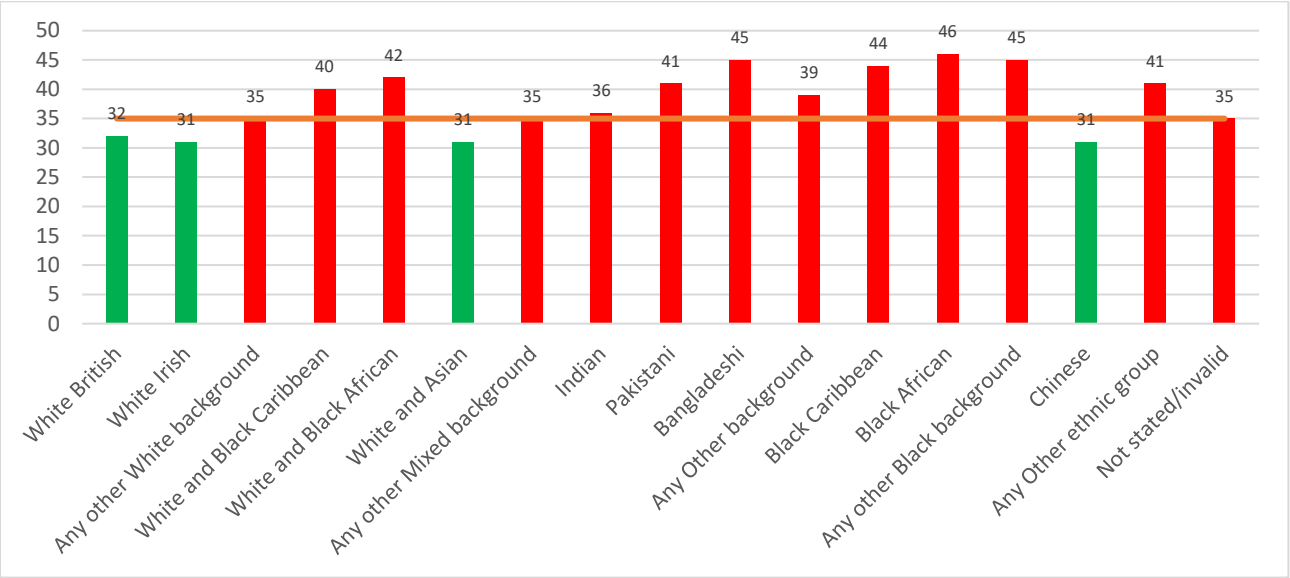
In 2018/19, Year R pupils from all Black ethnic categories were measured as overweight (including obese) when compared to England average as seen in Figure 17. It should be noted that the England average of 23% of children overweight or obese at Reception age is higher than many other European countries (State of Child Health, RCPCH 2017) so average is not good.

Figure 17: Percentage of Year R pupils overweight (including obese) – England average 2018/19



For children in Year 6, in most BAME groups the percentage of pupils who are overweight (including obese) is significantly higher compared to the England average, 2018/19. It is highest in Black African pupils where 46% are overweight (including obese) as seen in Figure 18.

Figure 18: Percentage of Year 6 pupils overweight (including obese) – England 2018/19



Literature research [33] suggests inequalities in Obesity risk within and among BAME minority groups relative to White groups in the UK. Black adults generally had higher risk for obesity than White adults. Both Chinese children and adults had lower risk for obesity than White groups. Whilst there are few studies on differences about the aetiology of obesity by BAME groups, it is important to understand that there are complexities around the measurement and analysis of obesity and BAME groups. There is ongoing debate as to whether the current criteria for defining obesity in both adults and children are appropriate for non-European populations.

[33] BAME inequalities in obesity among children and adults in the UK: a systematic review of the literature A. M. El-Sayed, P. Scarborough and S. Galea

Chapter 8 - Disease Prevalence and Health Inequalities

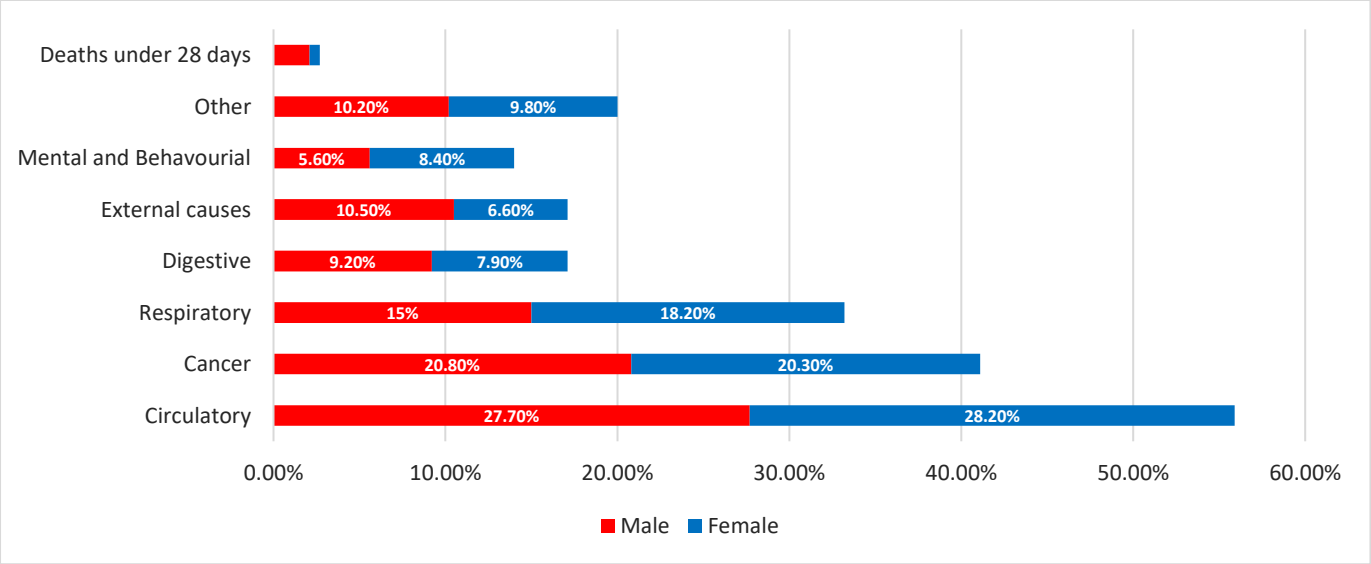
There are certain disease groups where data indicates that the prevalence is higher or the risk of developing the disease is greater in the BAME population. These include Diabetes, Cancer and Cardiovascular disease. Sickle Cell Anaemia is mainly found in people of Black African/Afro Caribbean descent. Thalassaemia, another blood disorder mainly affects people of Mediterranean, south Asian, southeast Asian and Middle Eastern origin.

We also know that there are different patterns of risk between groups too. The reasons for the difference in risks are likely to be socio economic as well as biological and some groups will have a higher risk of being affected by certain illnesses than others. As with the White British population, BAME differences vary across age groups, with the greatest variation noted in the elderly. The differences also vary between men and women, and between different generations and geographic area.

8.1 Cardiovascular Disease

The NHS Long Term Plan describes how Heart and circulatory disease, also known as cardiovascular disease (CVD), causes a quarter of all deaths in the UK and is the largest cause of premature mortality in deprived areas. This is the single biggest area where the NHS can save lives over the next 10 years.

Figure 19: CVD is a main cause of health inequalities Sussex and East Surrey STP (2018/19)
% Contribution to the gap in life expectancy



Data source: https://i.emlfiles4.com/cmpdoc/8/5/1/9/1/2/files/67637_link2-health-inequalities.pdf

Ethnicity is recognised as a risk factor for developing coronary heart disease and one that can lead to long term health inequality for the BAME population. Cardiovascular disease has a significant consequence for BAME individuals, their families and health care

organisations as it is predicted that cardiovascular disease will become the dominant cause of death and disability over the next decade.

In Sussex County / STP; East & West Sussex incl. Brighton & Hove – local heart and circulatory disease statistics from the British Heart Foundation, updated in July 2020 show:

The pandemic may further widen health inequalities, with higher death rates in BAME populations, and a 4 times higher likelihood of dying earlier for those living in most deprived areas.

- Cardiovascular disease, particularly diabetes & hypertension, is associated with poorer outcomes from COVID-19 (PHE review of disparities in COVID-19 risk and health outcomes), with significantly higher death rates for people from Bangladeshi, Chinese, Indian**,** Pakistani, Other Asian, Caribbean, and Other Black ethnic groups when compared to White British as well as for men and older people.
- The pandemic is likely to exacerbate existing health inequalities to which CVD is one of the largest contributors - if you live in England's most deprived areas, you are almost 4 times more likely to die prematurely than someone in the least deprived (PHE Health Matters, February 2019).
- Heart failure was already affected by health inequalities – the average age of a UK heart failure patient is 75, this drops to 69 for people from Black and minority ethnic backgrounds. The average is in the low 60s for some cohorts, including the most socioeconomically deprived.

Hospitalised heart failure patients with COVID-19 are at higher risk of mechanical ventilation and mortality. The COVID-19 pandemic has had a negative impact on cardiovascular disease (CVD) prevention. Targeted CVD prevention initiatives will directly reduce health inequalities and are highly effective at reducing stroke, myocardial infarction (MI) and other adverse cardiovascular events.

8.2 Hypertension

In England, there are over eight million people diagnosed with hypertension[34] and of this proportion and significant number are from BAME groups. Since the start of the COVID-19 pandemic, many patients will have missed routine and opportunistic screening that would previously have taken place face to face and those with cardiovascular risk factors may not be receiving their usual review and treatment adjustment in primary care for their hypertension.

Remote technology can be used to address the diagnosis gap and can also be used for ongoing monitoring of some conditions. Evidence supports the use of self- and telemonitoring of blood pressure (BP) vs normal care in primary care as it is cost effective[35]; saves GP time[36] by shifting care from GPs to other members of the multidisciplinary team; and reduces incidence of clinical events such as death, heart attack or stroke, over five years[37].

National evidence from deaths from COVID between x and y showed that hypertensive disease was mentioned on 19.6% of death certificates where COVID-19 was also mentioned. This proportion was higher in all BAME reported ethnic groups when compared to White ethnic groups as seen in Table 7. Among deaths with COVID-19 mentioned on the death certificate, a higher percentage mentioned the following compared to all cause deaths:

- Hypertensive diseases
- Diabetes
- Chronic kidney disease
- Chronic obstructive pulmonary disease
- Dementia

Care must be taken however as many of the above are strongly correlated with age and gender. Several studies, (measuring different outcomes from COVID-19), report an increased risk of adverse outcomes in obese or morbidly obese people.

Table 7: Comorbidities – Hypertension: national comparisons by ethnic group and with "usual" mortality experience

	Deaths where Covid-19 was mentioned	Deaths where Covid-19 and hypertensive diseases was mentioned	Percentage of Covid-19 and hypertensive diseases was mentioned	Lower 95% confidence limit	Upper 95% confidence limit	Difference between % of Covid-19 deaths mentioning hypertensive diseases of all deaths mentioning hypertensive diseases (statistical significance)
White	26,165	4363	16.7	16.2	17.1	Higher
Black/Black British	1541	619	40.2	37.7	42.6	Higher
Asian/Asian British	2211	739	33.4	31.5	35.4	Higher
Mixed Multiple Ethnic Groups	215	76	35.3	29.3	41.9	Higher
Any Other ethnic groups	712	201	28.2	25	31.6	Higher
No ethnicity information	865	203	23.5	20.8	26.4	Higher
Total	31,709	6201	19.6	19.1	20	Higher

[34] Quality and Outcomes Framework, 2019-20

[35] McManus et al., 2018

[36] Hammersley et al., 2020

[37] Margolis et al., 2020

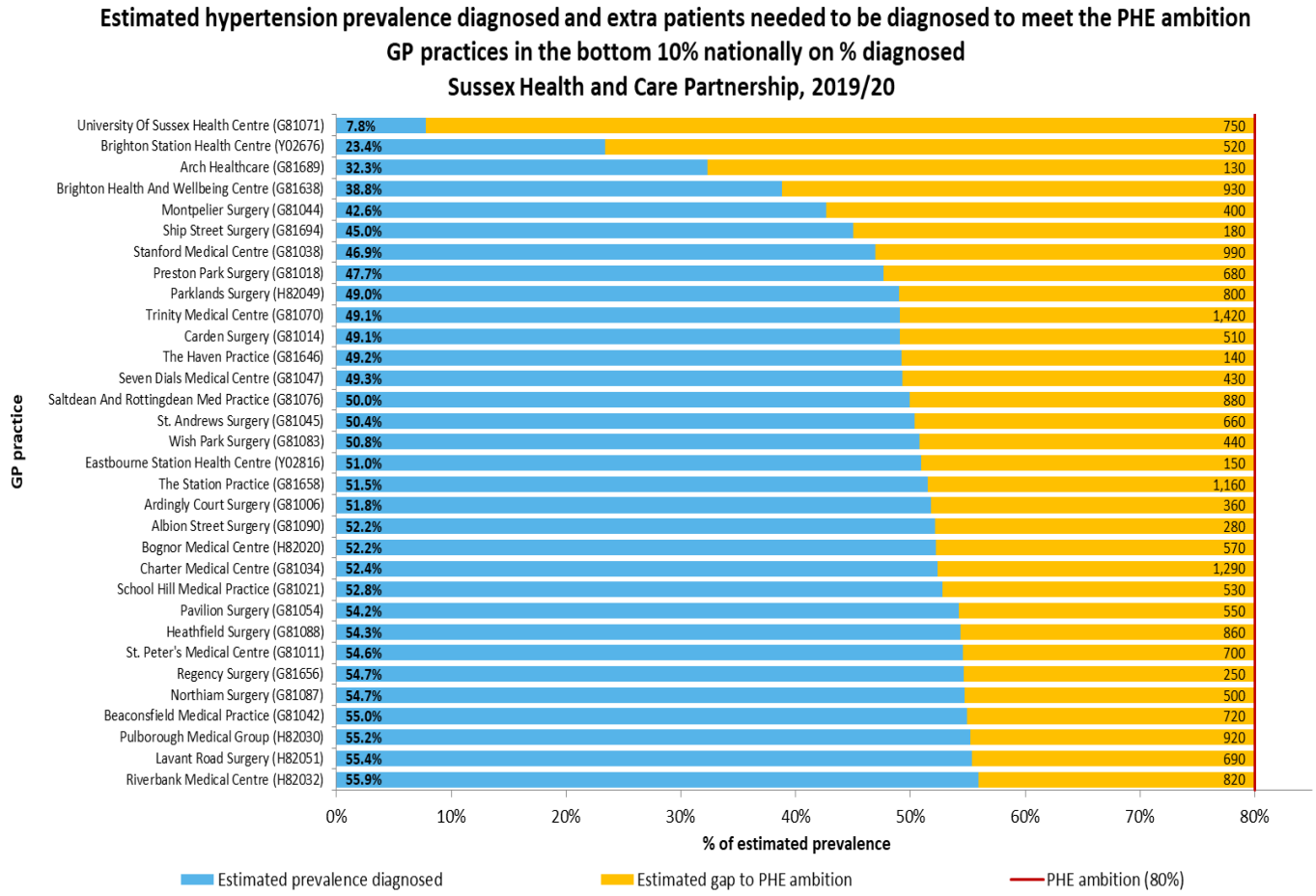
	Deaths where Covid-19 was mentioned	Deaths where Covid-19 and hypertensive diseases was mentioned	Percentage of Covid-19 and hypertensive diseases was mentioned	Lower 95% confidence limit	Upper 95% confidence limit	Difference between % of Covid-19 deaths mentioning hypertensive diseases of all deaths mentioning hypertensive diseases (statistical significance)
White	26,165	4882	17.8	17.4	18.3	Higher
Black/Black British	1541	685	44.5	42	46.9	Higher
Asian/Asian British	2211	953	43.1	41.1	45.2	Higher
Mixed Multiple Ethnic Groups	215	70	32.6	26.7	39.1	Higher
Any Other ethnic groups	712	193	27.1	24	30.5	Higher
No ethnicity information	865	133	15.4	13.1	17.9	Higher
Total	31,709	6916	21.1	20.7	21.6	Higher

Data source: PHE 'Disparities in the risk and outcomes of COVID-19' report, Table 8A, August 2020

In Hypertension and AF detection Sussex ICS is in the bottom 10% nationally when compared to the PHE ambition. As seen in Figure 20 there is a significant gap in the number of people that should be diagnosed to reach PHE ambition of 80% of expected cases detected.

NHS Health Checks programme commissioned by LA is a comprehensive, universal programme to detect and reduce the risk of developing cardiovascular diseases and diabetes. Everyone aged 40-74 year olds without already detected risk factors is eligible for a check every 5 years and given information on their risk of developing cardiovascular disease along with interventions to reduce risk (as appropriate these include weight management, smoking cessation, exercise, dietary advice, anti-hypertensives, statins). The programme has been suspended during the first and second waves of COVID due to national direction, but East Sussex are keen to restart with a more targeted approach – offering greater incentives for health checks carried out in people of BAME or from more deprived backgrounds.

Figure 20: Hypertension detection by Sussex GP practice, 2019/20



Source: QOF 2019/20 diagnosed figures, estimated prevalence from the NCVIN, 2020

N.B.Values shown at end of yellow bars are the estimated additional patients needed to be diagnosed to meet the PHE ambition, GP practice values rounded to nearest 10.

8.3 Diabetes

In reviewing national data, Type 2 diabetes is a major UK public health issue. Among minority ethnic communities, the prevalence is alarmingly high, approximately three to five times higher than in the white British population. Particularly striking is the earlier onset of Type 2 diabetes, which occurs some 10-12 years younger, with a significant proportion of cases being diagnosed before the age of 40 years. Diagnosed diabetes is four times higher in Bangladeshi men and almost three times in Pakistani and Indian men than the general population. It is also five times as likely among Pakistani women and at least three times as likely in Bangladeshi and Black Caribbean women, and two-and-a-half times as likely in Indian women compared to women in the general population.[38]

There are varying factors why the BAME population are more at risk. Type 2 diabetes risk increases with weight, and people from many BAME groups are more likely to be overweight or obese. The BAME community are more likely to experience generational, geographical and gender differences within ethnic minority groups. Diet and socioeconomic disadvantages such as food poverty play a significant role. Language barriers, lack of culturally appropriate

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information available to increase knowledge and limited interventions underpinned by behaviour science are other contributing factors to poor health outcomes.

In recent years, ethnicity identification in Diabetes diagnosis and treatment has improved but continues to remain as a barrier to acquiring knowledge related to black and minority ethnic health. There are also issues around the completeness of ethnicity in Hospital Episode Statistics. Table 8 shows that people from BAME who died with COVID were more likely to have diabetes than white people who died with COVID.

Table 8: Comorbidities – Diabetes mellitus (Type 1 & 2) COVID-19 comparisons by ethnic group and with "usual" mortality experience

	Deaths where Covid-19 was mentioned	Deaths where Covid-19 and hypertensive diseases was mentioned	Percentage of Covid-19 and hypertensive diseases was mentioned	Lower 95% confidence limit	Upper 95% confidence limit	Difference between % of Covid-19 deaths mentioning hypertensive diseases of all deaths mentioning hypertensive diseases (statistical significance)
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No ethnicity information	865	133	15.4	13.1	17.9	Higher
Total	31,709	6916	21.1	20.7	21.6	Higher

Data source: PHE 'Disparities in the risk and outcomes of COVID-19' report, Table 8a, August 2020

8.4 Stroke

The BAME Asian and Afro-Caribbean/African population are twice as likely to have a stroke compared to the rest of the UK population, and at a younger age[39]. Co-morbidities such as high blood pressure (which accounts for 53% of all stroke), Sickle cell and Diabetes are contributing factors along with smoking and obesity can increase the level of risk.

People of South Asian origin are likely to have a stroke at a younger age. The reasons for this are complex but we know that South Asian people are more likely to have Type 2 diabetes, which is a major risk factor for Stroke. National data in in Table 9 shows that 4.5% of the people who had a stroke in 2019/20 were Asian and 2.5% were Black / African / Caribbean / Black British while 86.1% were white.

[39] https://www.stroke.org.uk/

Table 9: National Stroke Incidence by Ethnic groups 2019/2020

Ethnicity Category	Number of people having stroke	Percentage of total number of strokes
Asian / Asian British	1,122	4.5%
Black / African / Caribbean / Black British	627	2.5%
Mixed / multiple ethnic group	89	0.4%
Other ethnic group	211	0.9%
Unknown	1,377	5.6%
White	21,278	86.1%

https://www.stroke.org.uk/

At a local Sussex level, Brighton and Hove has the highest incidence of Stroke within the BAME population with Asian groups in Brighton and Hove showing 7.7% incidence which is greater than national incidence of 4.5% for this ethnic group followed by Asian groups in West Sussex showing 2.7% as seen in Table 10. East Sussex had the highest proportion of white persons having a stroke at 99.7%, significantly greater than national prevalence of 86.1%.

Table 10: Sussex Stroke Incidence by Ethnic Group 2019/2020

Ethnicity Category	East Sussex	West Sussex	Brighton & Hove
Asian / Asian British	0.1%	2.7%	7.7%
Black / African / Caribbean	0.1%	1.1%	1.5%
Other ethnic group	0.0%	0.5%	0.0%
Unknown	0.1%	7.3%	0.0%

https://www.stroke.org.uk/

Social behaviours such as excessive alcohol intake, smoking and obesity in BAME communities with low socioeconomic status account for about half of these effects.[40] In addition, some communities have a very deep seated cultural belief that a stroke is brought on by a person's bad deeds in this lifetime. This is sometimes also seen as a punishment from God and as result there is an element of shame attached to this condition and thus less help is sought. A 2010 study found that culturally-appropriate, patient-centred care is often under-utilized, which overlooks both patient and clinician opportunities to improve healthcare outcomes.[41] In Sussex this should be particularly targeted towards our Asian communities in Crawley and Brighton.[42] Within the elderly population there is a definite barrier when it comes to providing targeting support. We need to ensure that vital literature are translated in the appropriate language and use BAME appropriate and culturally relevant messaging.

[40] Reasons Underlying Racial Differences in Stroke Incidence and Mortality, J Howard, 2014

[41] Assessing Culturally Competent Care in the Stroke Belt, by Greg Salinas, PhD Director of Research and Assessment Services, CE Outcomes, LLC

[42] Socioeconomic disparities in first stroke incidence, quality of care, and survival: a nationwide registry-based cohort study of 44 million adults in England, Benjamin D Bray, Lizz Paley, Alex Hoffman, Martin James, et al, on behalf of the SSNAP Collaboration

8.5 Cancer

According to the latest national data, the incidence of most types of Cancer is lower in the BAME population than that in the white population although this may be skewed by age where risk of cancer generally increases with age and white population is generally older than BAME population.[43] Asian, Chinese and Mixed ethnic groups have significantly lower risk of getting any of the four major cancers (breast, prostate, lung and colorectal) compared to White people. However, this varies for different groups and cancer types as below:

- Black males are up to three times more likely to get prostate cancer than white males
- Black people are nearly twice as likely as white people to get stomach cancer
- Black and Asian females aged 65 years and over, are at higher risk of cervical cancer compared with White females.

Cervical cancer has a detectable pre-cancerous stage detected by screening which may be missed until too late if regular screening is not done. There is a general sense in talking to Health Professionals across Sussex that this may be due in part to a low uptake of screening programmes by some BAME communities.

The latest data from NHS England and Improvement (NHSEI) and Public Health England in Table 11 shows that when looking at the non-white categories those recorded as 'unknown' population had the highest number of first treatments (FT's) in Surrey and Sussex (3,615 FT's); with Prostate Cancer, the most prevalent reason. This is followed by the Asian population who had 1,058 first treatments. Lower proportion of skin cancer patients are black (4/11225) than prostate cancer patients (60/7248)

Table 11: Surrey and Sussex Monthly, COVID-19 Cancer Equity Data Pack – First Treatment data

	All other	Breast	Gynaecological	Haematological	Head and Neck	Lower GI	Lung	Oesophago-gastric	Prostate	Skin	Upper GI/ Other	Urological / Other	Grand Total
Asian	52	256	96	118	99	88	74	28	114	16	36	81	1,058
Black	10	53	16	33	6	24	18	4	60	4	9	17	254
Mixed / Multiple	13	36	13	32	15	23	15	6	27	8	7	14	209
Other	24	124	37	44	66	53	62	30	110	66	24	56	696
Unknown	143	622	198	212	102	340	340	79	660	658	101	160	3,615
White	1,676	7,476	2,054	3,044	1,604	4,943	4,429	1,330	6,277	10,473	1,692	2,852	47,850
Grand Total	1,918	8,567	2,414	3,483	1,892	5,471	4,938	1,477	7,248	11,225	1,869	3,180	53,682

Source: NHS. PHE-Surrey and Sussex, 2018-2020

Some of these findings seemingly mirror national data where we know that BAME men are 2 to 3 times more likely to develop prostate cancer than White men and more likely to develop prostate cancer at a younger age.[44] However, we need to be cognisant of the small numbers recorded and how ethnicity is recorded overall. The lack of health education regarding cancer

[43] https://www.macmillan.org.uk/_images/cancer-statistics-factsheet_tcm9-260514.pdf

[44] Morris et al, 2015

and awareness of the availability of support services is limited among black and minority ethnic communities. As well as this, there is a lack of cultural competence education for health providers, especially in cancer awareness.

In terms of culturally appropriate service provision more than a quarter felt that the advice or support provided did not meet their cultural/religious/spiritual needs. They also felt that some health care providers have a poor understanding of their needs and lacked the cultural competency to manage their illness. A combination of these experiences prevent BAME patients from participating in other NHS services which inevitably delays their treatment and reduces their chances of survival. It is these factors that have a direct impact on the BAME population poor health outcomes and levels of in health inequality in the delivery of their care.

In addition, the health inequalities and the disparities they cause between local people and across local communities contribute to, and are a feature of, the health outcomes of local people. Cancer incidence, mortality and survival is routinely reported by deprivation, age, gender and ethnicity (although the latter is only just starting). It would require much more detailed local work to understand variation by other protected characteristics and to understand the reasons for this.

8.5.1 Addressing Health Inequalities in Cancer

Specific programmes of work are underway to address these inequalities:

- The ICS Cancer Team and Cancer Research UK are working with Primary Care Networks (PCNs) across the region to implement the PCN Cancer Direct Enhanced Service and Quality Outcomes Framework Quality Improvement component for Cancer. This work looks at auditing of referrals and improving the take up of Cancer Screening programmes a key component of which is understanding and engaging with non-responders. The non-responder element differs from practice to practice so they need to be aware of this in Bowel, Breast and Cervical and consider religious and cultural factors. This work is ongoing and expected to show significant improvement in take up over the coming year but recording quality ethnicity data is essential.
- The PCNs are engaging with communities where the mobile breast screening services are locating themselves in 2021 and running primary care educational sessions looking at screening and engagement as well as Learning Disabilities and Severe Mental Illness.
    - Working with the Cancer Alliance we are also building strong inter-faith working groups so that messaging can be adapted and circulated in the most appropriate ways.
    - Two week wait referral leaflets are now available in multiple languages and these are being embedded into the trust templates across the region.
    - Macmillan and Albion in the Community are working together to meet the demands of Cancer support by changing the function of the Horizon Centre in Brighton and the function of those other centres within Sussex, making it more accessible during COVID whilst also targeting specific community groups.

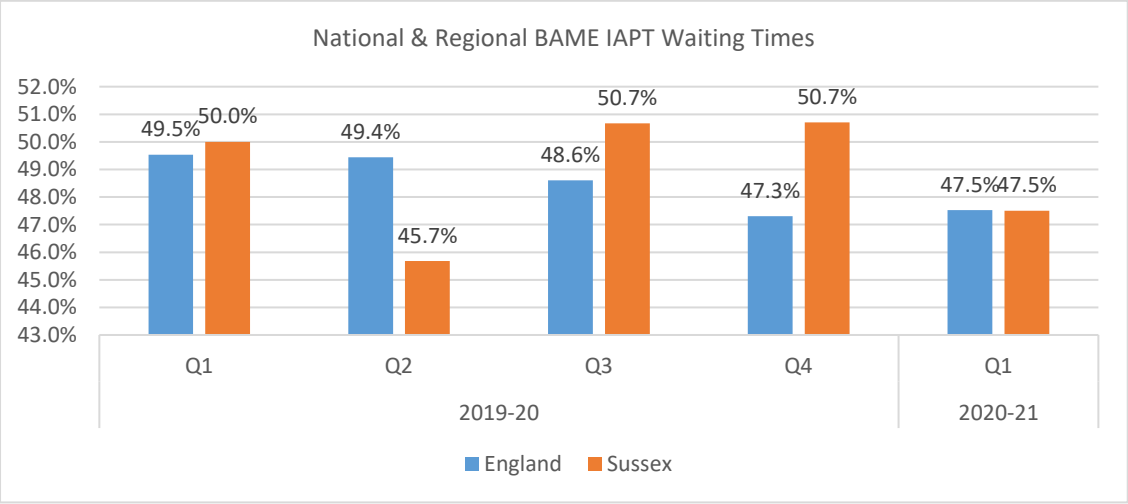
- Cultural diversity is a core element of the personised stratified follow up (PSFU) developments in the region which include prehab and rehab services. It is also a core component for new activities coming in 2021 to support Living with and beyond cancer (LWBC). With this in mind Health Watch in the region have started a programme around prostate cancer and are working currently to identify pathways and opportunities to engage patient group and the wider community especially focussing on ethnicity and tailoring of messages.

8.6 Mental Health

The disproportionate impact of COVID-19 on Black, Asian and Minority Ethnic communities has highlighted the inequalities in the mental healthcare system.[45] According to the Mental Health Foundation, The Adult Psychiatric Morbidity Survey found that Black men were more likely than their white counterparts to experience a psychotic disorder in the last year. Also, the risk of psychosis in Black Caribbean groups is estimated to be nearly seven times higher than in the white population and the impact of the higher rates of mental illness is that people for these groups are more likely than average to encounter mental health services.

Detention rates under the Mental Health Act (MHA) during 2017/18 were four times higher for people in the Black British group than those in the White group. In addition, BAME individuals are affected by long waits to access IAPT services as seen is Figure 21 although Sussex BAME waits in Q1 of 2020 were in line with England waits.

Figure 21: National and Regional BAME IAPT waiting times

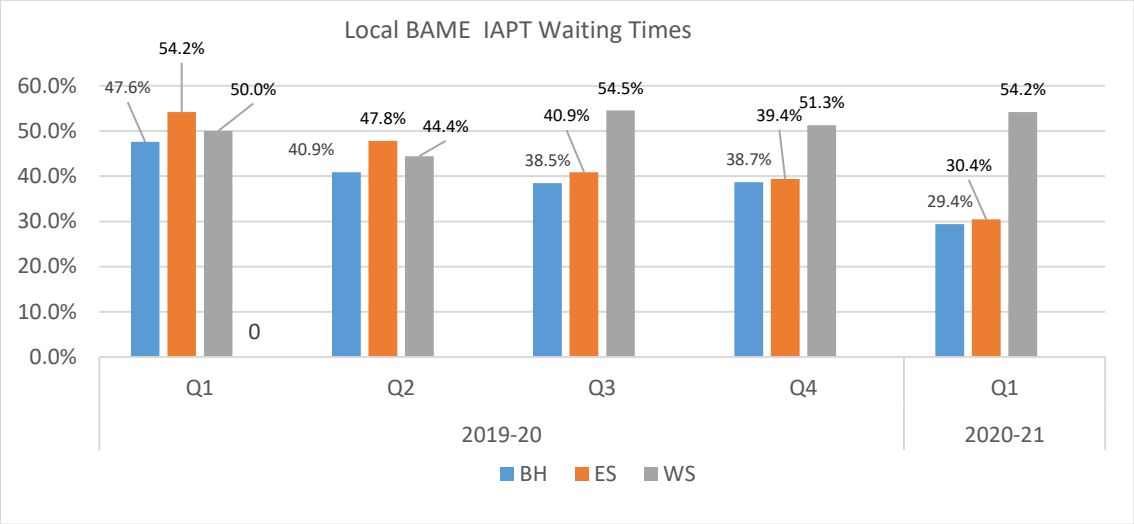


Data source: https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-report-on-the-use-of-iapt-services

This is mirrors local activity in Figure 22 where we can see that over the last year that the BAME population experienced long waits for Psychological Therapies.

[45] https://www.mind.org.uk/about-us/our-policy-work/equality-and-human-rights/our-work-on-race-and-ethnicity-in-mental-health/

Figure 22: Local BAME IAPT waiting times



Data Source: https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-report-on-the-use-of-iapt-services/june-2020-final-including-reports-on-the-iapt-pilots-and-quarter-1-data-2020-21

However, none have achieved their standard waiting times. This directly impacts our communities in Hastings and Rother and wards in Brighton where we know our BAME communities live which are overlaid by high levels of deprivation which leads to poor health outcomes.

In addition to long waits many Sussex BAME community groups have identified a lack of communication in accessible and culturally relevant formats. Data obtained from Sussex BAME communities after the height of the first COVID-19 wave highlighted the issue of lack of trust and confidence in mainstream statutory services. For example, In Brighton and Hove some local community and voluntary sector organisations reported that people were contacting their BAME wellbeing telephone line for COVID-19 support and wellbeing support as they were not confident that if they contacted mainstream services their concerns would be understood, listened to and the support adapted appropriately to be relevant for them.

During COVID-19 a survey of over 14,000 [46] adults revealed that existing inequalities in housing, employment, finances and other issues have had a greater impact on the mental health of people BAME groups than the white population.

- **Among 16-24 year olds, unemployment rates are highest for people from a Black background** (26%) and from a Pakistani or Bangladeshi background (23%) in comparison with their White counterparts (11%)
- Even when employed men and women from some ethnic groups are **paid less on average than those from other groups** with similar qualifications and experience
- Pakistani and Bangladeshi communities consistently have **high rates of poverty** as Black, Chinese and Other ethnic communities

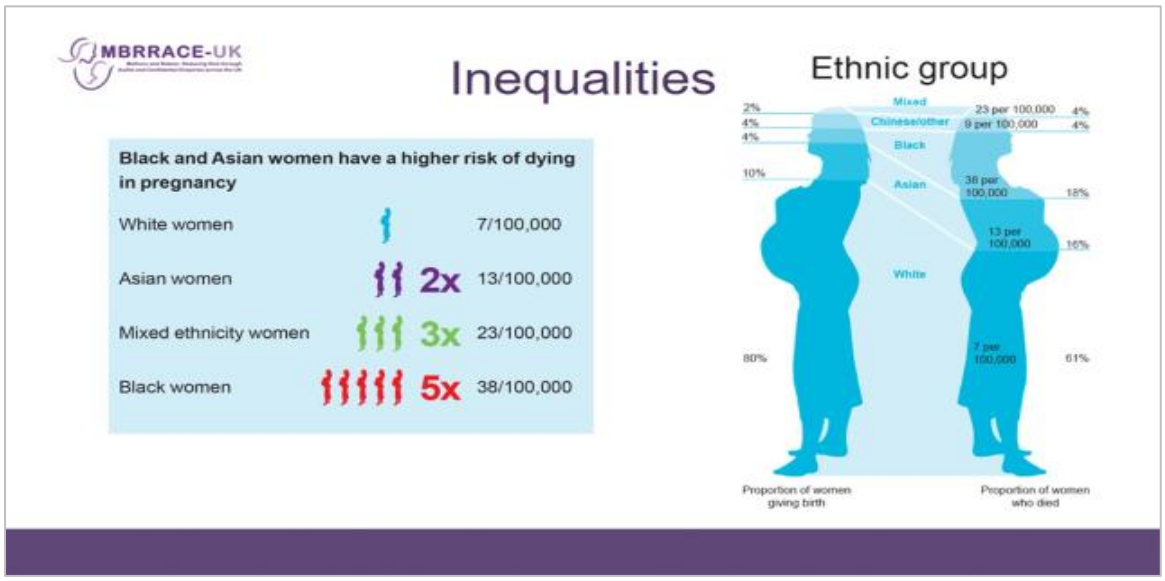
We know that BAME communities have heightened anxiety and distress from their increased risk to COVID-19 but also from some of the divisive or racist comments surrounding this in local and national media. We also know that this further increased during the global Black Lives Matter social movement for many reliving trauma current and past that they or a family member experienced. We also know that BAME groups are more likely to be arrested by the police following a crisis, which inevitably results in poorer health outcomes and often-coercive forms of care in locked wards. BAME communities accessing mental health care services do not always experience the quality of care to which they are entitled.

8.7 Maternity

Disparities exist in maternal and infant birth outcomes of BAME women giving birth in the United Kingdom (UK) compared to the wider population,[47] and that black women are five times more likely to die in pregnancy or up to six weeks postpartum compared with white women.[48] For women of mixed heritage, they are three times the risk and Asian women almost twice. During COVID-19 Asian women were 4 times as likely to be admitted to hospital with Covid-19 as the wider female population. These inequalities are all reflected in Figure 23 below which shows that 38 black women die per 100,000 births i.e. 1 in 2631.

[46] https://www.mind.org.uk/news-campaigns/news/existing-inequalities-have-made-mental-health-of-bame-groups-worse-during-pandemic-says-
[47] Specific antenatal interventions for Black, Asian and Minority Ethnic (BAME) pregnant women at high risk of poor birth outcomes in the United Kingdom: a scoping review, Rebecca Garcia, Nasreen Ali, Chris Papadopoulos & Gurch Randhawa
[48] MMBRACE, 2019

Figure 23: Maternity Inequalities



Source: MBRACE-UK

There is no evidence to suggest that maternity inequalities in Sussex are different to the national inequalities. Currently, the maternity services in Sussex are actively improving how they capture ethnicity data. This will enable us to look at inequalities and ethnicity along the maternity pathway. Table 12 indicates that data was not captured until August so represents only eight months.

Table 12 – Percentage of BAME births of the total births across Sussex 2019/20

BAME Women % in Sussex CCGs	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Total
Horsham	9.3%	14.0%	12.5%	12.2%	11.6%	14.0%	12.2%	14.6%	12.6%
Crawley	29.0%	26.7%	29.7%	29.0%	25.0%	30.0%	33.3%	24.0%	28.3%
Brighton and Hove	13.3%	17.0%	16.3%	15.6%	21.4%	14.5%	15.0%	14.6%	15.9%
High Wealds Lewes and Haven	14.8%	12.0%	7.7%	13.6%	8.0%	7.7%	8.7%	13.3%	10.8%
Coastal West Sussex	0.0%	25.0%	25.0%	20.0%	33.3%	25.0%	0.0%	20.0%	19.6%
Hastings and Rother	10.3%	12.1%	8.3%	10.7%	10.3%	12.1%	14.3%	14.3%	11.6%
Eastbourne, Hailsham and Seaford	11.8%	8.1%	11.1%	6.5%	8.3%	9.3%	7.1%	6.3%	8.7%
	14.0%	15.2%	15.2%	14.8%	15.5%	15.2%	13.9%	14.7%	14.8%

Data source: Maternity Services Dataset (MSDS)

Across Sussex, our most diverse communities are in Crawely, Hastings and Rother and Brighton and that these communities are more likely to face language and cultural barriers. Many women may not have access to properly skilled translators and many are unaware of service provision or how to access them. There is intersectionality with gender and religion and here survey studies have shown that some women would prefer to see a female physician. Also, faith and beliefs around child birth are undermined in favour of more 'western'

style treatments. This leads to making uninformed choices about their care. That combined with poor previous experience of health care services or stereotyped expectations from health care staff results in poor health outcomes and even death. Other contributory risk factors, such as socioeconomic status, including education status and income, and living in areas of high deprivation are frequently cited as distal determinants of poorer health outcomes.

8.7.1 Addressing Health Inequalities in Maternity

In response to these disparities in Maternity a number of actions to reduce inequality are in place nationally and also locally. Such as:

- A move to a new model of midwifery care, **Continuity of Carer,** which is associated with improved outcomes. Black/ Black British, Asian/ Asian British and Mixed race maternity service users are being proactively targeted for this support to achieve 75% by 2024 (35% by March 21, 51% by March 22) for the general maternity population the target is 51%. Also looking at deprivation and those in the 10% most deprived populations will be targeted to 75% as well.
- **Saving Babies Lives Care Bundle** this focuses on reducing stillbirths, neonatal deaths and maternal deaths through the implementation of best practice.
- **4 National actions.** These are learnings from COVID and includes a lower threshold for physically reviewing BAME service users in response to the evidence in the UK Obstetrics Surveillance System (UKSOSS) report which published COVID learning in maternity.
- **Community Hubs** –A business case is in development for a Maternity Community Hub in Crawley, to support the deployment of two geographical community midwifery teams which will support areas in Crawley where the majority of our BAME maternity service users live.
- **Data** – To improve ethnicity recording and data quality to provide better local data to support our clinicians to identify variation in outcomes locally
- **Maternity Information Systems** – Two local Trusts are implementing new maternity information systems which will give better data along the maternity pathway

Chapter 9: Service Use and Access

A range of factors can reduce access,[49] take up and outcomes. Some relate to practical issues such as location, opening times, communication problems, and discriminatory practices. And others relate to more personal, cultural and wider social environments such as not be able to recognise a problem, stigma of some issues and the impact of social groups and norms.

Service use is also informed by having access to high quality BAME patient data. Although there has been a steady growth in collection, levels of completion remain low,[50] this makes disparities in healthcare access difficult to monitor and evaluate. Low completion levels may partly be because of the perceived sensitivity of this area on the part of healthcare workers, and also possibly because the information collected may be insufficiently detailed for clinical care and health service planning purposes.

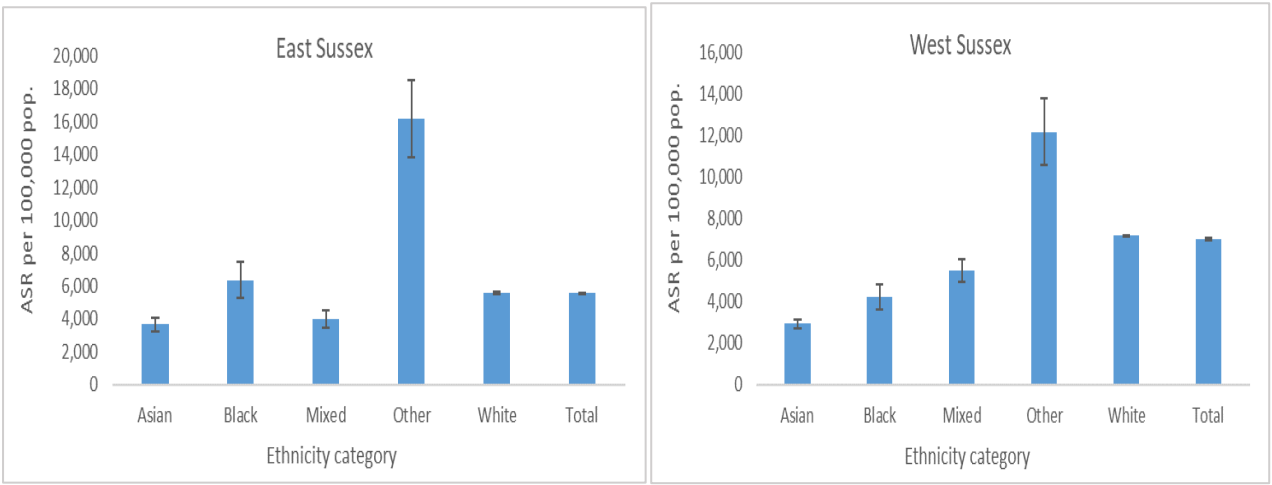
9.1 Hospital Activity

Although ethnicity recording in Hospitals have been increasing and in most Sussex Acute Trust showing 98-100% ethnicity data completeness the data indicated there is a significant number of people classified in the in the "other" and "unknown" category.

9.1.1 Outpatient Attendances

Figures 24-26 showing Sussex CCGs new outpatients attendances in October 2019 to September 2020 per 100,000 population by Ethnicity group reveal that the highest rate of new outpatient attendances in the Sussex BAME population was in the "Other" ethnic group. However, a total of 26% of Sussex activity is excluded from these charts, due to unknown ethnicity. Black ethnic group showed slightly higher outpatient attendances in Brighton & Hove than in West Sussex or East Sussex. Non-overlapping error bars denote a statistically significant difference in rates of activity but the numbers are very low.[51]

Figure 24-26: Sussex CCGs new Outpatient attendances for age and gender standardised activity rates per 100,000 population by Ethnicity group (Oct-19 to Sep-20)

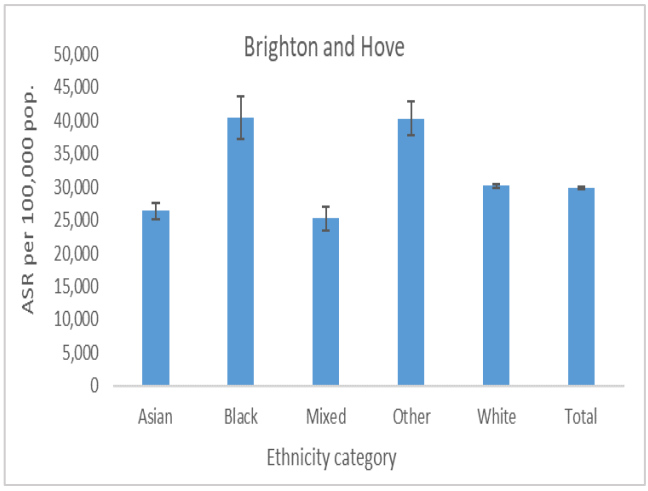


Source: Sussex CCG BI

[49] https://www.gov.uk/government/publications/inclusion-health-applying-all-our-health/inclusion-health-applying-all-our-health

[50] Access to health care for ethnic minority populations, BMJ,

[51] Activity data from Secondary Uses Service (SUS), including non-consultant-led and specialised (NHSE commissioned) activity. Rates may not be comparable across CCGs, due to differences in service configuration.

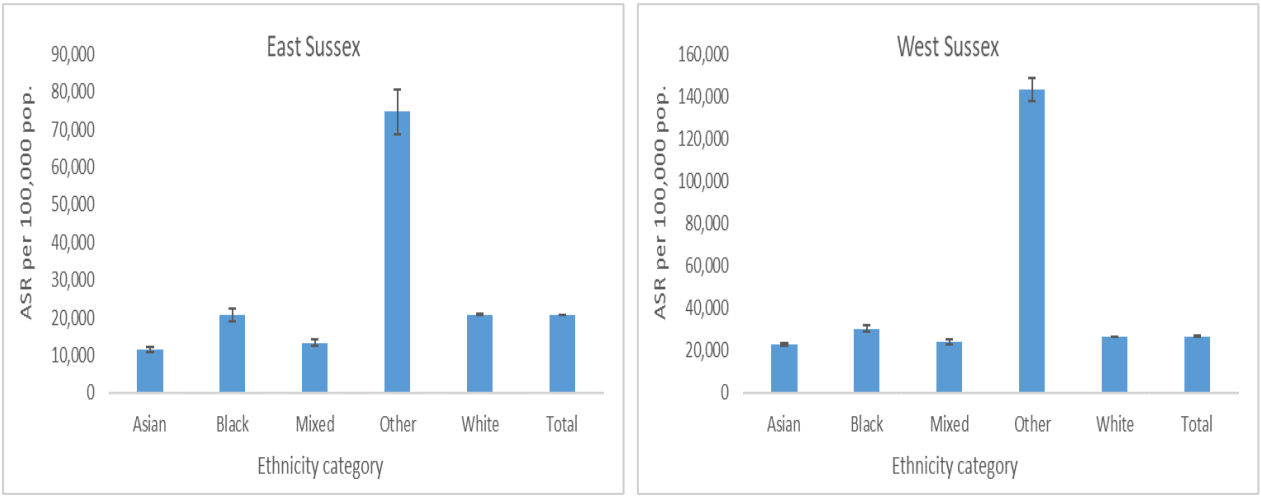


Source: Sussex CCGs BI

9.1.2 Accident and Emergency

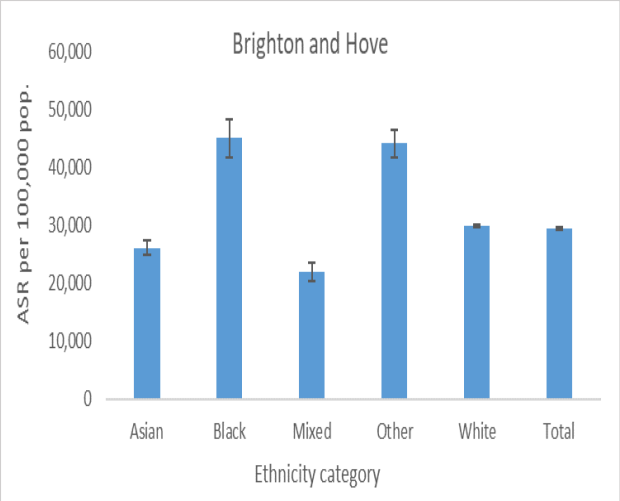
Similar to Outpatient attendance, Figures 27-29 show that the highest rate of Accident and Emergency (A&E) attendances in the BAME population in Sussex was in the "Other" ethnic group. A total 23% of Sussex activity is excluded from these charts, due to unknown ethnicity. A further 1% is missing due to unknown gender. Again the rate for the Black ethnic group slightly higher in Brighton & Hove. Non-overlapping error bars denote a statistically significant difference in rates of activity but the numbers are very low.

Figure 27-29: Sussex CCGs **A&E attendances** (Oct-19 to Sep-20) age and sex standardised activity rates per 100,000 population by Ethnicity group [52]



Source – Sussex CCGs BI

[52] Activity data from Secondary Uses Service (SUS), which excludes e.g. Brighton & Hove Walk In Centre. Rates may not be comparable across CCGs, due to differences in service configuration.

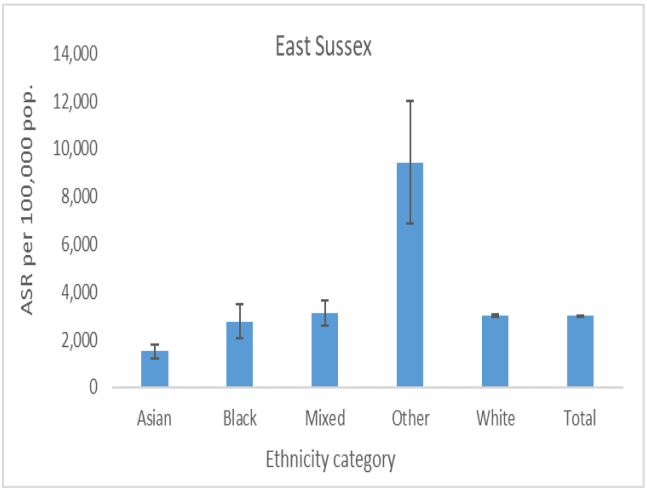


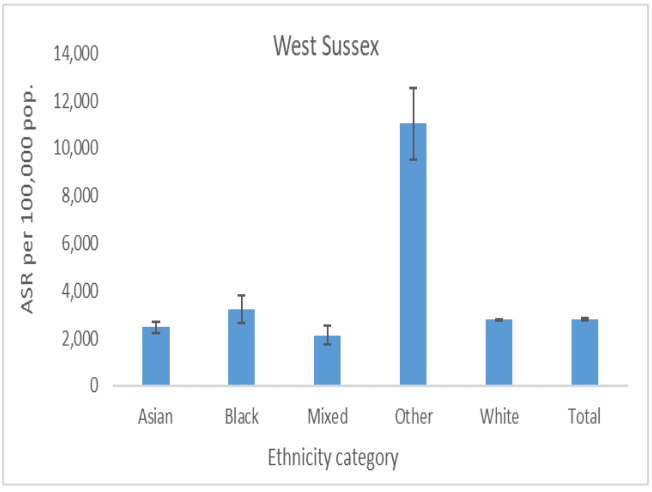
Source – Sussex CCGs BI

9.1.3 Elective and Non- Elective Spells

There is a similar picture for Elective and Non-Elective spells where Figures 30-32 show that the highest rate of Elective Spells in the BAME population in Sussex was in the "Other" ethnic group with the rate for the Black ethnic group higher in Brighton & Hove than other areas. Non-overlapping error bars denote a statistically significant difference in rates of activity but the numbers are very low. A total 24% of Sussex activity is excluded from Elective Spell charts, due to unknown ethnicity and a total of 17% excluded from Non-elective spells

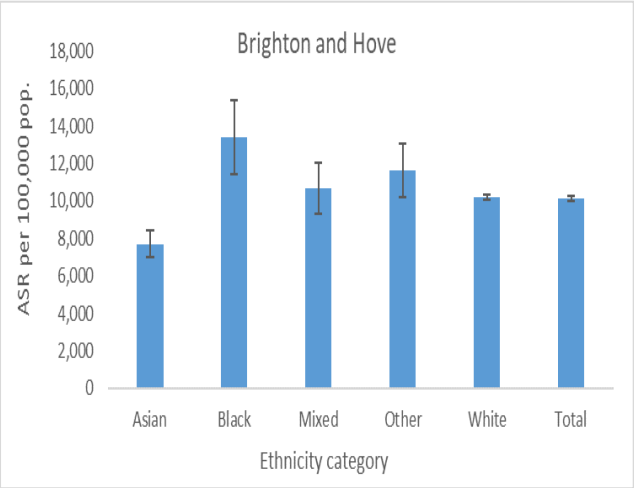
Figure 30-32: Sussex CCGs **Elective Spells** (Oct-19 to Sep-20) age and sex standardised activity rates per 100,000 population by ethnicity group [53]





Source – Sussex CCGs BI

[53] Activity data from Secondary Uses Service (SUS). Rates may not be comparable across CCGs, due to differences in service configuration.



Source – Sussex CCGs BI

It is difficult to make broad assumptions about patient flows and behaviour due to a number of reasons:-

- The 'Other' population is over represented in the activity reported.
- These datasets have incomplete data, sometimes up to 24% in some. The 'Unknown' category needs a full audit.

9.2 Primary Care Service Access and utilisation:

During this review there was no information sourced from Primary Care due to inconsistencies in ethnicity coding and recording. There is a real need to improve and increase ethnicity recording in primary care settings and whilst we know that ethnicity identification and recording has improved in recent years, there are still issues around data completeness and quality.[54]

[54] Recording ethnicity in primary care: assessing the methods and impact

Chapter 10- Local Action to address Inequalities

A number of local actions have been undertaken by Sussex Health and Care Partnership HCP to tackle the short and long term health inequalities as previously highlighted in this review.

10.1 Sussex BAME Disparity Response Programme

The Sussex Covid-19 BAME Disparity Response Programme was established by Sussex Health and Care Partnership (SHCP) in May 2020 in response to the evidence emerging from the Office for National Statistics around the disproportionate impact of COVID-19 on Black, Asian and Minority Ethnic (BAME) communities. The programme is based on national guidance and focused on staff in all health and care settings as well as patients and communities across Sussex. Initially the programme covered three domains; Safeguarding/Protecting our BAME staff, Safeguarding our BAME communities and Communications and engagement but as Sussex Health and Care Partnership moved into restoration and recovery over the summer, the new programme team have extended scope to addressing longstanding health and race inequalities across Sussex.

The programme plan states how the partnership is tackling the health inequalities, the institutional barriers and accessibility of services to improve outcomes for our BAME Communities. The Programme's objectives and deliverables are aligned to the Turning the Tide Strategy, published in June 2020 and local governance structure has been developed to include alignment with the People Committee and the Population Health and Prevention Boards and with assurance monitored by the established Sussex Turning the Tide Oversight Board. The Board will review system level decisions through a race equality lens to accelerate development of sustainable and impactful responses including:

- Developing a BAME Co-leader model
- Creating a safe space for open discussion on race and health inequalities
- Gathering data and evidence to understand current position
- Identifying areas which require priority action
- Developing robust plans to address gaps and risks to BAME Workforce and communities
- Creating accountability through ongoing measurement of progress

10.2 BAME Locally Commissioned Service (LCS)

The BAME LCS Steering Group was set up to provide some oversight and assurance on the development and review of the BAME/Vulnerable Groups LCS across Sussex. It was part of a rapid response exercise to address the emerging issues around the BAME and vulnerable population. This Locally Commissioned Service (LCS) is designed to protect the most vulnerable groups e.g. patients from a BAME background, those living in an area representing Quintile 1 for deprivation and those who are clinically at high risk.

It aims to address factors which may put individuals at increased risk, as well as identifying problems early in those at risk who contract COVID-19. GPs are 'best placed to offer bespoke care for individuals in a way that can promote trusting relationships to support these groups'.

We have had 98% GP sign up, over 27,679 letters in 36 languages sent out, over 1750 holistic reviews and 165 saturation probes have been provided by way of pulse oximetry @home thus increasing daily monitoring of those with Covid-19 symptoms.

Feedback:

'This is a fantastic example of how we can use lessons learned from past experiences to provide a safer, more proactive and more supportive service for those at risk.' **Medical Association of Nigerians Across Great Britain (MANSAG**)

'It is heartening to see an initiative that focuses on the groups that have borne the brunt of Covid-19. We welcome such initiatives that can help tackle the health inequalities faced by BAME groups and hence, reduce the "modifiable" risk factors. **British Association of Physicians of Indian Origin (BAPIO)**

"I felt good getting a letter from my GP advising me about Covid and asking me to contact them if I needed any help controlling my diabetes. I did contact them and got useful help". **Male person in a Mosque talking to a Clinical Professional**

"She got a letter in Punjabi from her GP for the first time and she felt so special when she could read it herself and did not need to call her Grandchildren to translate it". **Granddaughter emailing on behalf of Grandmother of South Asian heritage.**

10.3 Population Health Management and Personalised Care Programme

Sussex has commenced the roll out of the national Population Health Management (PHM) Accelerator Programme which will be essential in identifying and tackling disproportionate health impacts across the population including on the BAME community. Working with primary, community and secondary care providers PHM tools will support key population groups with personalised care models. PHM is seen as central to the development of Integrated Care Systems (ICSs) and the delivery of care.

Sussex has implemented a programme of work to embed the Universal Model of Personalised care and ensure it is business as usual by 2024. Personalised care is one of the five critical changes outlined in the NHS Long term plan and is a key underpinning principle in the development of the future model of care in Sussex. Personalised care particularly beneficial to address health inequalities as it gives people choice and control over the way their care is planned and delivered based on 'what matters' to them.

10.4 Workforce Inequalities

Some actions taken to date include:

- Risk assessments -100% completed and review process in place
- Increased BAME Staff engagement – BAME Network Chairs Forum, BAME Staff Conferences in June and October with 300 plus attendees - good spread across the ICS, provide advice and support to new Network chairs and EDI leads
- BAME Workforce Disparities Reduction Roadmap in place with 5 key priorities agreed
- Establishing a BAME Workforce Steering Group reporting into the People Committee to monitor and report progress
- Sharing learning and adopting joint ventures on secondments and rotations with HR colleagues.

Chapter 11 Key Findings

Population

- Sussex is an increasingly more BAME diverse county with growing younger age.
- West Sussex has the highest BAME community and East Sussex the least
- Some of the most deprived areas in Sussex and nationally such as Crawley, Hastings, Eastbourne and Brighton overlap with high BAME population.

Wider Determinants

- Education- Significant disparities exist across Sussex:
  - Mixed BAME pupils overrepresented in pupil referral units (20% of pupils in referral units in primary schools and special schools are from BAME groups).
  - In terms of attainment, a lower percentage of Sussex pupils from Asian and Black BAME groups were assessed in 2019/20 as meeting expected standards of development at 4/5 years.
  - Young Black and Mixed students were more likely to have temporary school exclusions and this likelihood increased for permanent exclusions (two to three times more likely) when compared to any other ethnic groups. This is 2 to 5 times more likely when compared to white students in East and West Sussex.
- Housing – In West Sussex, 10% of the groups within the Asian community live in very large households (considered overcrowded according to ONS) compared to 0.9% of the white population.
- Employment – More BAME young people that White young people across Sussex between 16-17 years are not in Education, Employment or Training (NEET). Most noticeably, in West Sussex there is a significant overrepresentation of Black young people who are NEET or for whom their participation is unknown when considering the Black population percentage.

Intersectionality

- Faith beliefs and practices play an important role in the diagnosis and daily management of a long-term condition for BAME groups. The conventional approach to preventing disease through lifestyle modification is difficult to apply to BAME.
- Geography, country of origin and migration history has a major effect in shaping health-related behaviour, belief and practice.
- Gender differences in knowledge and attitude also shape methods used to control the progression of Long Term diseases such as Diabetes, Cancer and CVD Disease.

Health Behaviours

- Smoking- Asian males had a smoking rate (13.9%) compared to 15.58 of White males (15.8%). 2.8% of Asian women said they were smokers compared with 13.1% of White women

- Physical Activity - South Asian population have been found to have lower overall activity levels than the general population, but those from Mixed Heritage backgrounds had higher activity levels than the general population
- Obesity- For children in Year 6, in most BAME groups the percentage of pupils who are overweight is significantly higher compared to the England average. It is highest in Black African pupils where 46% are overweight (including obese).

Disease Prevalence

- Cancer - Black males are up to three times more likely to get prostate cancer than white males and Black people are nearly twice as likely to get stomach cancer.
- Diabetes-Diagnosed diabetes is four times high in Bangladeshi men and almost three times in Pakistani and Indian men than in men in the general population.
- Stroke- Brighton has the highest prevalence of Diabetes particularly among the Asian population across the 3 Places. This also reflects what we know nationally that this group are more likely to have Type 2 diabetes than the wider population.
- CVD – Many BAME communities have increased risks of developing coronary heart disease and one that can lead to long term health inequality. Cardiovascular disease, is predicted to become the dominant cause of death and disability over the next decade.
- Mental Health- BAME communities experience long waits for IAPT services. Both East Sussex and Brighton waiting times have worsened whilst West Sussex has slightly improved. Excessive long waits can have a major impact on existing health problems.
- Maternity- Black women are five times more likely to die in pregnancy or up to six weeks postpartum compared with white women. For women of mixed heritage they are three times the risk and Asian women almost twice.
- Language barriers are just some of the reasons for the low uptake of services. It affects an individual's ability to communicate with health professionals about their condition. This is a key indicator of health inequality leading to poor health outcomes.
- Studies show that BAME people with limited health literacy are less likely to use preventive services and more likely to use emergency services.
- Studies show that BAME residents are less likely than non-BAME residents to report poor health, this is due to the younger age profile of BAME residents which masks trends amongst older BAME residents[55].

Workforce

- BAME staff are overrepresented in lower roles and underrepresented in senior roles. 2019 and 2020 WRES data and NHS Staff Survey revealed disparities in recruitment, experience of discrimination, bullying and disciplinary and less access to training and development when compared to white staff.

[55] [55] Making the most of primary and community services: what works for BAME people with long-term conditions? CRESR, 2016

Chapter 12 –Recommendations

In order to better address Sussex BAME population needs there are many actions recommended across Sussex.

1. Improved Ethnicity Recording across all Organisations and Services by:

- GP records and hospital activity datasets have significant levels of incomplete data. Work should be undertaken to disaggregate this information so that we can begin to understand which BAME population groups are being captured in the POD datasets. In-depth review of the 'Other' and 'Unknown' groups within Acute Services is needed.
- Focus more effort on "ensuring that datasets are complete and timely, to underpin understanding of and response to inequalities"[56]. Health and Care organisations should "proactively review and ensure the completeness of ethnicity data". We know that work is being undertaken to address local ethnicity gaps but more effort is required using levers such as the General Practice COVID-19 Capacity Expansion Fund programme which should ensure robust processes are in place within Primary Care to address health inequalities through improving ethnicity recording and increasing support offered to patients from areas of deprivation and BAME communities.
- Ethnicity should be self-reported and provided on a voluntary basis but due to know distrust from the Public the SHCP should focus dedicated resource to working with Local BAME Voluntary and Community Engagement Groups including Community Ambassadors to message out the benefits of ethnicity recording.

2. Dedicated system focus on addressing Health Inequalities

- Develop a Health Inequalities Sussex Steering Group to focus on addressing health inequalities across our Population including for BAME communities, Travelling/Roma communities, communities living in and experiencing high deprivation and those within other protected characteristic grouping. This will ensure that the BAME Disparity Population Workstream deliverables are sustained and embedded across the system and actions are taken.
- Establish a centralised/strategic forum for reviewing new and existing Equality Health Impact Assessments (EHIAs)[57]. Equality & Health Inequalities Impact Assessments are useful in that broader considerations are included as well as the protected characteristics - this would also include socio economic status, occupation & geographical location. All of which can have a profound effect on someone's ability to access services, care and work. EHIAs should be embedded into SHCP programmes with robust processes are set in place when developing and reviewing policy, or designing, and delivering services
- Key interventions such as targeted culturally relevant health promotion and awareness can help reduce risk, disparity and poor health outcomes.

[56] Implementing phase 3 of the NHS response to the COVID-19 pandemic, 2020

[57] Equality and Health Inequalities Impact Assessment (EHIA) Policy-East Surrey and Sussex Commissioners 2020

3. Cultural Competence:

- In a range of clinical areas where access is shown to be poor, healthcare services now need to develop policies and structures to begin to tackle such disparities.
- Dedicated training on cultural competence/relevance should be embedded in programme planning moving forward. This should be considered as key part of the development of personalised care programme. Understanding the broader diets of different BAME communities, acknowledging faith based beliefs and value systems etc. is critical and this includes the recognition of how cultural diversity can influence how the BAME population access healthcare services [58]. This also informs how the BAME population manage their illness and what is perceived as the cause of their illness.

4. Embedding of Personalised Care:

- Equip the workforce with the skills to work in this person-centred way, using approaches such as shared decision making, personalised care and support plans. Ensuring tailored care and support, understanding '*what matters to you*' rather than focussing entirely on '*what's the matter with you*' and enabling people to have the confidence, knowledge and skills to engage in their care. Evidence indicates benefits are associated with health coaching/asset based approaches to support self-management and increase activation thus giving people choice and control over their mental and physical health. A one-size-fits-all health and care system simply cannot meet the increasing complexity of people's needs.
- Ensure a whole-system approach, integrating services around the person including health, social care, public health and wider services.

5. Linguistic Competence:

- Improved access to services for the BAME population will require provision of bilingual and recruitment of more diverse staff.[59]
- Access to translating services and links to BAME advocate workers are also key to reducing health inequality. Materials such as posters, leaflets etc. should be produced through a BAME diverse cultural lens which should include hospital signage, health education materials, public awareness materials and campaigns; and ethnic media in languages other than English, for example, television, radio, internet, newspapers, periodicals.

6. Health literacy:

- Implementing health literacy programmes should be developed to ensure that BAME patients have the appropriate skills and knowledge to understand and navigate health and social care information and services. In recent years the term

[58] Access to health care for ethnic minority populations, A Szczepura

[59] Access to health care for ethnic minority populations, A Szczepura

'health literacy' has been used to describe how the BAME community engage with health and social care services. This can be developed to ensure that BAME patients have the appropriate skills and knowledge to understand and navigate health and social care information and services. Studies show that people with limited health literacy are less likely to use preventive services and more likely to use emergency services.

7. Digital Literacy:

- Improving digital literacy though focussed programmes across the elderly population groups and especially for those who are BAME and elderly whose first language is not English.

8. Cultural Communication/Engagement strategy and messaging

- The need for cultural messaging[60], targeted at the BAME communities particularly around prevention services including BAME led dietary and healthy life style support is important to improve BAME people accessing services.
- Community resource for BAME and Faith led programmes should be available. For example, targeted community support programmes for Asian men who are prone to stroke, Black Caribbean people who more prone to Hypertension and some Cancers, Black and Asian groups who are more prone to Diabetes and for Black African and Caribbean pregnant ladies who are four times more likely to die in pregnancy and childbirth.

9. Workforce:

- To improve working conditions and support for BAME staff, NHS and Local Authority organisations should encourage the implementation and continuous review of the Equality Assessment Framework.
- There needs to be dedicated resource and capacity to tackling workforce disparities and support the projects within the Sussex BAME Workforce Steering Group.
- Anti-racism training is being done in some areas but a more consistent approach is recommended across all Health and Care sectors.

10. Race equality in schools

- For Local Authorities in Sussex to work with schools to identify best practice and develop with them a model policy for the collection and reporting of racist or bullying incidents. Local authorities could also work on a shared approach to actively promote race equality, prevent racist incidents and bullying, in order to level up practice across Sussex.

[60] Socioeconomic disparities in first stroke incidence, quality of care, and survival: a nationwide registry-based cohort study of 44 million adults in England, Benjamin D Bray, Lizz Paley, Alex Hoffman, Martin James, Patrick Gompertz, Charles D A Wolfe, Harry Hemingway, Anthony G Rudd, on behalf of the SSNAP Collaboration

Appendices

Appendix 1 - Methodology

It is important to note that a Population Health Needs Assessment (HNA) is a comprehensive and systematic method for reviewing the health issues facing a defined population. At the end of this assessment there should be actionable and measurable recommendations. Evidence may be quantitative (service-use reports, population statistics, local demographics, prevalence of physical or mental health conditions) or qualitative (stakeholder views and feedback, public engagements, focus groups and interviews) and also be from desk research (evidence reviews, published research, calls-for-evidence, national and local guidelines and strategies).

It is important to acknowledge that time constraints have meant that we have not had time to engage with public stakeholders, and so have called this a “Needs Review” rather than a detailed assessment. We anticipate that this report is part of an on-going process.

To produce this report a weekly task and finish group was established at the beginning of November 2020 and met weekly (via MS Teams) to review data, identify gaps and contribute to the overall narrative of this piece of work.

The group consists of:-

- Local Authority Public Health Consultants and Intelligence Lead – East Sussex
- Local Authority Public Health Consultant and Intelligence Lead – West Sussex
- Local Authority Public Health Consultant and Intelligence Lead – West Sussex
- Research Officer, Public Health and Social Research Unit- West Sussex
- Programme Director, Sussex BAME Disparity Programme
- Project Manager-Thriving Communities-Sussex BAME Disparity Programme
- Project Manager-Thriving Workforce-Sussex BAME Disparity Programme
- Project Manager for Inclusive Comms and Engagement- Sussex BAME Disparity Programme
- Deputy Director of Performance and Intelligence - Sussex NHS Commissioners
- Lead Performance and Intelligence Manager Sussex NHS Commissioners